DEPARTMENT of HEALTH and HUMAN SERVICES

Centers for Medicare & Medicaid Services

FY 2012 Online Performance Appendix

Introduction

The FY 2012 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Summary of Performance and Financial Information (SPFI). These documents are available at http://www.hhs.gov/budget/.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2009 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS SPFI summarizes key past and planned performance and financial information.

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Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) FY 2012 Online Performance Appendix to the FY 2012 Annual Performance Budget. While CMS is the largest purchaser of health care in the United States, serving almost 105 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries, we have the new opportunity to serve millions of Americans through the establishment of the Center for Consumer Information and Insurance Oversight. CMS' three-part goal is better care for individuals, better health for the population and lower cost through improvements as we are tasked with implementing the new law that will transform health care.

In March 2010, the President signed into law the Patient Protection and Affordable Care Act followed by the Health Care and Education Reconciliation Act, collectively known as the Affordable Care Act. Numerous provisions impact CMS, including: a major expansion of the Medicaid program; a two-year extension of CHIP, the gradual elimination of the Medicare prescription drug "donut hole"; and the creation of a CMS Innovation Center, which will explore different payment models in Medicare, Medicaid, and CHIP. CMS will make affordable health insurance available to all Americans by helping States establish health insurance Exchanges, increasing the number of young adults under age 26 who are covered as a dependent on their parent's employer-sponsored insurance policy, and establishing the Pre-existing Condition Insurance Plan (PCIP) program designed to provide comprehensive health insurance coverage for uninsured individuals with pre-existing conditions in all 50 States and the District of Columbia. The legislation also expands value-based purchasing, promotes better health through wellness, prevention and integrated care, and gives CMS unprecedented new tools as well as new resources for fighting fraud, waste, and abuse. Health reform implementation will be a major focus for CMS in FY 2012, and new performance measures were added to our Online Performance Appendix to represent this massive effort.

CMS performance bolsters the new HHS Strategic Plan 2010-2015 and among the Administration's High Priority Performance Goals is our priority to *Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid.*

This CMS Online Performance Appendix includes representative performance goals that reflect CMS' mission to be a major force and a trustworthy partner for the continual improvement of health and health care for all Americans. Over the years, our dedicated workforce has managed and implemented our programs, made sure those who provide health care services are paid the right amount at the right time, worked toward a high-value health care system, increased consumer confidence by making more information available, and continued to develop collaborative partnerships. Our Online Performance Appendix highlights our progress on agency performance goals and our effective and efficient management of our programs.

In some programs, particularly new programs created by the Affordable Care Act, we will continue to modify and update our performance measures as these programs develop. 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 customers and beneficiaries, I thank you for your continued support of CMS and its FY 2012 Online Performance Appendix**.**

/Donald M. Berwick, M.D./
Donald M. Berwick, M.D.

TABLE OF CONTENTS

Transmittal Letter 3
Summary of Targets and Results Table 6
Program: Program Operations 7
Program: Private Health Insurance 49
Program: Medicaid 61
Program: Medicare Benefits 76
Program: Children's Health Insurance Program 83
Program: Health Care Fraud and Abuse Control/Medicare Integrity Program (MIP) 89
Program: State Grants and Demonstrations 100
Program: Clinical Laboratory Improvement Amendments (CLIA) 103
Program: Quality Improvement Organizations (QIO) 105
CMSLinkages to HHS Strategic Plan 119
CMS Summary of Full Cost 121
Summary of Findings and Recommendations from Completed Program Evaluation .. 123
CMS Priority Goal 124
GAO High-Risk List Items 126

Summary of Targets and Results Table

Centers for Medicare & Medicaid Services (CMS)

Fiscal Year	Total Targets	Targets with Results Reported	*Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	46	46	100%	42	91%
2008	53	52	98%	46	88%
2009	52	51	98%	42	82%
2010	55	33	60%	27	82%
2011	73	4	5%	4	100%
2012	74	0	0%	0	0%

**All targets have not yet been reported due to data lags.*

PROGRAM: PROGRAM OPERATIONS

Measure	FY	Target	Result
MCR3.1a: Beneficiary Survey Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006	*2009*	Target discontinued	N/A
	2008	63%	64% (Target Exceeded)
	2007	62%	63% (Target Exceeded)
MCR3.1b: Beneficiary Survey: Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	*2012*	74%	Feb 28, 2013
	2011	73%	Feb 28, 2012
	2010	72%	Feb 28, 2011
	2009	71%	73% (Target Exceeded)
	2008	65%	75% (Target Exceeded)
	2007	64%	69% (Target Exceeded)
MCR3.1c: Beneficiary Survey: Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	*2012*	63%	Feb 28, 2013
	2011	62%	Feb 28, 2012
	2010	61%	Feb 28, 2011
	2009	60%	62% (Target Exceeded)
	2008	46%	69% (Target Exceeded)
	2007	45%	68% (Target Exceeded)
MCR3.2: Program Management/ Operations	*2009*	Add "Patient Safety" measures and refresh all report card measures	Published the 2008 High Risk Medication patient safety measure (Target Met)
	2008	Publish the 2007 report card of Part D plan sponsor performance	Published the 2007 report card of Part D plan sponsor performance (Target Met)
	2007	Publish Part D sponsor performance metrics on the Medicare Prescription Drug Plan Finder (MPDPF) tool	Published Part D sponsor performance metrics on the MPDPF tool (Target Met)
MCR3.3: Enrollment Increase percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources	*2012*	Target discontinued	N/A
	2011	91%	Feb 28, 2011
	2010	91%	90% (Target Not Met)
	2009	91%	90% (Target Not Met)
	2008	N/A	90% (Target Not In Place)
	2007	Set Baseline	90% (Baseline)

Measure	Data Source	Data Validation
MCR3.1a MCR3.1b MCR3.1c MCR3.2 MCR3.3	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.

MCR3: Implement the Medicare Prescription Drug Benefit

CMS' prescription drug benefit measure has addressed 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 began reporting under GPRA in FY 2009.

During the initial enrollment period and the first open enrollment period, CMS implemented intensive outreach and education campaigns, with associated media activities. As a result, under the Beneficiary Survey component of this measure, CMS was able to exceed its FY 2007 and FY 2008 targets. In exceeding these targets, there is a clear indication that the open enrollment outreach and education campaigns have been very effective. Despite its success, the first target, which reflects global awareness that drug coverage is available to Medicare beneficiaries, was pertinent when CMS was originally rolling out Part D, but is not as relevant now that the program has matured. Because of this, CMS removed this metric for FY 2009 and beyond. The remaining two targets, which assess specific awareness that costs can vary by Part D plan, and specific awareness that formulary can vary by Part D plan, continue to be tracked.

CMS faces a challenge in continuing to increase beneficiary knowledge about Part D, given that 2009 was 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 specific details of what they know about the program, the likely result is a decline in the potential for improvement, and eventual plateau, in Part D knowledge across all beneficiaries. CMS will continue to engage in communication activities to try to counter this decline and will continue to track beneficiary knowledge to gauge the effectiveness of these efforts. t is important to remember that maintaining behavioral performance, as shown in many studies of consumer behavior in health care, continues to require a strong and persistent effort. In the absence of increased funding for open enrollment efforts, it is likely that performance on this metric could flatten further or even decline. Indeed, even though we met our goals in FY 2009, both measures were lower than they were in FY 2008. We are continuing to work closely with our partners in community based organizations, the provider community, and the State Health Insurance Programs (SHIPs) to be sure that our beneficiaries have the information they need to make good health care choices.

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 2009 Annual Enrollment Period to help Medicare beneficiaries choose a Medicare Prescription Drug Plan that is best suited for their needs, CMS published the final 2008 performance measures and report card for Part D sponsors. These performance ratings help people with Medicare review their current plan or choose a new plan that meets their needs and performs well in the rating categories; making it easy for people with Medicare to compare drug plans based on cost, quality and performance ratings. As a result, CMS has received very positive feedback from beneficiaries and other stakeholders, and continues to improve performance ratings to show more variation among plan options. This project not only increases public confidence in choosing a Medicare Prescription Drug Plan or a Medicare Advantage Plan with a drug benefit, but also provides a clear differentiation of the various Plans to beneficiaries, assures accountability of Plans for performance requirements, and ensures reliable and effective data is identified and used for operations and plan evaluation purposes. The project's future focus is to develop new patient safety and enrollment timeliness measures, and expand customer service measures in order to further support the Agency "transparency" initiative. Due to the successful launch and operation of the Part D program, this metric is no longer pertinent and was discontinued after FY 2009.

For the enrollment performance measure, the data is now reported in terms of fiscal year (FY) 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; however, the enrollment rate for FY 2009 remained at 90 percent, and enrollment continued to remain stable at 90 percent for FY 2010. Given the high rates of enrollment, it is challenging to increase the enrollment rates further; therefore, we have decided to discontinue this target after FY 2011.

Measure	FY	Target	Result
MCR4: Decrease the prevalence of restraints in nursing homes	*2012*	TBD	Feb 28, 2013
	2011	New baseline	Feb 28, 2012
	2010	3.8%	Feb 28, 2011
	2009	5.1%	3.3% (Target Exceeded)
	2008	6.1%	4.0% (Target Exceeded)
	2007	6.2%	5.0% (Target Exceeded)

Measure	Data Source	Data Validation
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. This physical restraints quality measure 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. Beginning with the FY 2011 reporting period, the data source is changing from MDS version 2.0 to MDS version 3.0. Nursing Homes will separately report the use of restraints for those that are used in bed and those that are not used in bed, while the quality measure will report on a combined number. For this reason, we anticipate that the restraints prevalence will change, but we are unsure if the results will increase or decrease.	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. Beginning in FY 2011, the data source is changing from MDS version 2.0 to MDS version 3.0.

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 is 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 of residents. Most recently, CMS exceeded its FY 2009 target of 5.1 percent by achieving a rate of 3.3 percent. If we compare the prevalence of restraints from the last quarter of FY 2003 to the last quarter of FY 2009, there are almost 60 percent fewer nursing home residents in restraints each week—from more than 95,000 residents in 2003 to about 39,000 residents in 2009.

CMS continues to believe that nursing homes' recent success in reducing restraint use has accelerated as a result of the intense collaboration between survey and certification and the Quality Improvement Organizations, as well as careful work between CMS and nursing homes in the national *Advancing Excellence in America's Nursing Homes* campaign. CMS is working to improve surveyor training so that surveyors will be better able to detect inappropriate restraint use. Nonetheless, despite the exceptional progress that we have made, we expect the future rate of decrease to diminish as increasing numbers of nursing homes meet targeted rates.

Since 2002, CMS has used Minimum Data Set (MDS), version 2.0, Quality Measures as the source for the restraints measure. Beginning with the FY 2011 reporting period, the data source is changing from MDS version 2.0 to MDS version 3.0. Nursing homes will separately report the use of restraints for those that are used in bed and those that are not used in bed, while the quality measure will report on a combined number. Because of the changes in the Minimum Data Set and the consequent effects on the restraints quality measures, CMS is proposing to rescale and rebase both measures beginning in 2011. The FY 2012 target will be set after the new baseline is reported.

Measure	FY	Target	Result
MCR5: Decrease the prevalence of pressure ulcers in nursing homes	*2012*	TBD	Feb 28, 2013
	2011	New baseline	Feb 28, 2012
	2010	8.1%	Feb 28, 2011
	2009	8.2%	7.6% (Target Exceeded)
	2008	8.5%	8% (Target Exceeded)
	2007	8.6%	8.1% (Target Exceeded)

Measure	Data Source	Data Validation
MCR5	CMS reports the prevalence of pressure ulcers with 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. Since 2002, CMS has used MDS, version 2.0, Quality Measures as the source for the pressure ulcer measure. Beginning with the FY 2011 reporting period, the data source is changing from MDS version 2.0 to MDS version 3.0. The pressure ulcer measure will exclude less serious Stage 1 pressure ulcers.	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. Beginning in FY 2011, the data source is changing from MDS version 2.0 to MDS version 3.0.

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. We exceeded our FY 2009 target of 8.2 percent with an actual prevalence of 7.6 percent.

Beginning in 2007, for the first time since CMS began tracking this measure, we have reported a steady decrease in the reported prevalence of pressure ulcers. We are encouraged by recent downward trends--a decrease in the prevalence of pressure ulcers of even 0.1 percentage points represents more than 1,000 fewer nursing home residents with a pressure ulcer. We are, however, not yet certain that the trend will last. The prevalence of pressure ulcers is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers. If

standards are not followed, patients may leave a hospital and arrive at a nursing home at increased risk of pressure ulcers. While the FY 2009 result exceeds future targets, in past years we have made only modest gains from one year to the next.

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 other QIO efforts should help continue the momentum.

Since 2002, CMS has used Minimum Data Set (MDS), version 2.0, Quality Measures as the source for the pressure ulcer measure. Beginning with the FY 2011 reporting period, the data source is changing from MDS version 2.0 to MDS version 3.0. The pressure ulcer measure will exclude less serious Stage 1 pressure ulcers. CMS, endorsed by the National Quality Forum, believes that this change in the pressure ulcer measure will reduce both measurement error (by eliminating false negatives and false positives) and potential bias (nursing homes with skilled nursing staff will be more likely to report higher pressure ulcer rates and nursing homes with higher proportions of residents with darker skin may be less likely to detect stage 1 pressure ulcers). Because of the changes to the MDS, CMS is proposing to rescale and rebase this measure beginning in 2011. The FY 2012 target will be set after the new baseline is reported.

Measure	FY	Target	Result
MCR6: Percentage of States that survey nursing homes at least every 15 months	*2012*	97%	Apr 30, 2013
	2011	97%	Apr 30, 2012
	2010	95%	Apr 30, 2011
	2009	85%	96% (Target Exceeded)
	2008	80%	96% (Target Exceeded)

Measure	Data Source	Data Validation
MCR6	Information on State performance is obtained from the CMS/Center for Medicaid & State Operations National Performance Standards Database. 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.

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. This measure evaluates 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.

CMS exceeded its FY 2009 target with an actual result of 96 percent. We set the FY 2012 goal at 97 percent. The major internal factor affecting this measure is the requirement that CMS ensure that 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 in measure MCR8.

CMS and State survey agencies face significant challenges as they seek to ensure quality in the provision of Medicare and Medicaid services. One challenge is 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 (e.g., budget shortfalls, hiring freezes, and furloughs) 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, as needed, to increase program efficiency and effectiveness.

Measure	FY	Target	Result
MCR7: Percentage of States that survey Home Health Agencies at least every 36 months	*2012*	96%	Apr 30, 2013
	2011	95%	Apr 30, 2012
	2010	90%	Apr 30, 2011
	2009	75%	94% (Target Exceeded)
	2008	70%	94% (Target Exceeded)

Measure	Data Source	Data Validation
MCR7	Information on State performance is obtained from the CMS/Center for Medicaid & State Operations National Performance Standards Database. 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.

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. This measure quantifies 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.

CMS exceeded its FY 2009 target with an actual rate of 94 percent. The FY 2012 target is 96 percent. 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. 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 management improvement. For States that do not meet statutory requirements, CMS may make a non-delivery deduction from the State's subsequent funding, as described under performance measure MCR8.

Measure	FY	Target	Result
MCR8: Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds for those States that fail to complete all statutorily-required surveys	*2012*	92%	April 30, 2012
	2011	90%	Apr 30, 2011
	2010	80%	100% (Target Exceeded)
	2009	75%	100% (Target Exceeded)
	2008	70%	75% (Target Exceeded)

Measure	Data Source	Data Validation
MCR8	Information on State performance reviews are obtained from the CMS/Center for Medicaid & State Operations 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.

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 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 overall survey and certification budget. In FY 2010, we exceeded the 80 percent target by also imposing a non-delivery deduction in 100 percent of applicable cases. We set the FY 2012 target at 92 percent.

It may not always make sense to impose deductions in 100 percent of applicable circumstances. In certain situations and despite systems that encourage full compliance with conducting statutorily-mandated surveys, imposition of a routine non-delivery deduction would only exacerbate poor State performance in the future. In any non-delivery deduction situation, we 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. For that reason we do not recommend a target of 100 percent in future years.

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.

Measure	FY	Target	Result
MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act	*2012*	90%	Oct 31, 2012
	2011	90%	Oct 31, 2011
	2010	90%	98% (Target Exceeded)
	2009	90%	97% (Target Exceeded)
	2008	90%	97% (Target Exceeded)
	2007	90%	95% (Target Exceeded)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	*2012*	90%	Oct 31, 2012
	2011	90%	Oct 31, 2011
	2010	90%	99% (Target Exceeded)
	2009	90%	96% (Target Exceeded)
	2008	90%	94% (Target Exceeded)
	2007	90%	97% (Target Exceeded)
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	*2012*	90%	Oct 31, 2012
	2011	90%	Oct 31, 2011
	2010	90%	98% (Target Exceeded)
	2009	90%	93% (Target Exceeded)
	2008	90%	94% (Target Exceeded)
	2007	90%	94% (Target Exceeded)
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey	*2012*	90%	Oct 31, 2012
	2011	90%	Oct 31, 2011
	2010	90%	90%

Measure	Data Source	Data Validation
MCR9.1a MCR9.1b MCR9.1c	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.
MCR9.3	CMS designs each survey method from a list of questions approved by the Office of Management and Budget. These questions are based on a set of customer service dimensions, which include overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution.	The Independent Quality Assurance (IQA) Customer Satisfaction Survey report is reviewed on a regular basis by CMS. CMS plans to validate Customer Satisfaction Survey data through the random sampling of calls by an independent contractor.

MCR9: Ensure 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. During this year the BCC responded to 500,000 inquiries related to the Affordable Care Act. 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 2010 target of 90 percent for each standard by a minimum of three percentage points. Despite exceeding targets in previous reporting years, we will continue to maintain the quality standards target levels at 90 percent since committing to increase these levels would require additional resources that are better utilized elsewhere.

Beginning in FY 2009, the BCC has been assessed by an independent quality assurance (IQA) contractor. 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.

CMS began collecting data for a new customer satisfaction measure in FY 2009. This new measure is based on survey methods designed by CMS with questions approved by the Office of Management and Budget. The survey measures a variety of customer service dimensions, including overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution. This measure captures an aggregated score of these dimensions. The target for this measure was achieved in FY 2010.

Measure	FY	Target	Result
MCR10.1: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for Fiscal Intermediaries	2012	95%	Nov. 30, 2012
	2011	95%	Nov. 30, 2011
	2010	95%	99.8% (Target Exceeded)
	2009	95%	99.7% (Target Exceeded)
	2008	95%	99.8% (Target Exceeded)
	2007	95%	99.8% (Target Exceeded)
MCR10.2: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for Carriers	2012	95%	Nov. 30, 2012
	2011	95%	Nov. 30, 2011
	2010	95%	99.0% (Target Exceeded)
	2009	95%	99.4% (Target Exceeded)
	2008	95%	98.9% (Target Exceeded)
	2007	95%	99.0% (Target Exceeded)
MCR10.3: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims for A/B Medicare Administrative Contractors	2012	95%	Nov. 30, 2012
	2011	N/A	Nov. 30, 2011
	2010	N/A	98.7% (Historical Actual)
	2009	N/A	99.6% (Historical Actual)
	2008	N/A	99.2% (Historical Actual)
	2007	N/A	98.3% (Historical Actual)

Measure	Data Source	Data Validation
MCR10.1 MCR10.2 MCR10.3	The primary data source is the Contractor Reporting of Operational and Workload Data (CROWD) system. CROWD contains monthly contractor-specific bills/claims processing timeliness rates. Success in achieving the desired target will be measured at the national level.	CMS uses Contractor Performance Evaluation (CPE) for Fiscal Intermediaries and Carriers and Quality Assurance Surveillance Plan (QASP) reviews for Medicare Administrative Contractors to determine whether Medicare contractors are meeting claims processing timeliness requirements. Through CPE and QASP, CMS measures and evaluates Medicare contractor performance to determine compliance with specific responsibilities defined in the contract with CMS, and also with responsibilities outlined in Medicare law, regulations, and instructions.

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 Fiscal Intermediaries (FIs), 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. In regards to mandatory claims payment timeliness in the evolving Medicare Contracting environment, CMS measures statutory claims processing timeliness in the MAC environment through Quality Assessment Surveillance Plan reviews.

CMS exceeded its FY 2010 targets for Medicare FIs (95 percent), Carriers (95 percent), by achieving levels of 99.8 percent and 99 percent respectively. We are adding an FY 2012 measure for the A/B MACs and have included trend data from the MACs for FYs 2007 - 2009. Due to CMS' directions to Medicare contractors to hold claims payments during the month of June 2010, carriers may have experienced delays in claims payment processing during the month of July. As a result, contractors were not penalized for not meeting the claims processing timeliness standard in July.

While results have consistently exceeded targets in recent years, CMS has determined not to increase future targets at this time, as the transition to MACs as part of contracting reform may make it more challenging to maintain this high level of performance. As a result, for FYs 2011 and 2012, targets remain in place to maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims, allowing new MACs time to stabilize their operations and performance. Continued success of this measure results in the assurance of timely claims processing for Medicare beneficiaries and providers.

Measure	FY	Target	Result
MCR11.2a: Electronic Remittance Advice Rates for Fiscal Intermediaries (FIs)	*2011*	Goal discontinued	N/A
	2010	60%	67% (Target Exceeded)
	2009	60%	59.71% (Target Not met but Improved)
	2008	59%	59.68% (Target Exceeded)
	2007	55%	58.14% (Target Exceeded)
	2006	50%	53.27% (Target Met)
MCR11.2b: Electronic Remittance Advice Rates for Carriers	*2011*	Goal discontinued	N/A
	2010	50%	55% (Target Exceeded)
	2009	46%	50.34% (Target Exceeded)
	2008	45%	46.13% (Target Exceeded)
	2007	37%	44.02% (Target Exceeded)
	2006	35%	32.96% (Target Not Met but Improved)

Measure	Data Source	Data Validation
MCR11.2a MCR11.2b	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. Starting in FY 2006, CMS began collecting additional data for transactions covered by HIPAA that are processed by means other than EDI (e.g. telephone or internet) 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.

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 other manual processes. Electronic Remittance Advice (ERA) is a notice of payments and adjustments sent to providers, billers, and suppliers explaining how Medicare has adjudicated a claim. A Medicare contractor produces the ERA once a claim has been adjudicated and finalized. The ERA may serve as a companion to a claim payment(s) providing explanation when payment is different from billed charges or when there is no payment.

In FY 2010 we exceeded the target by 7 percent and 5 percent for Part A and Part B respectively Actions like improving the quality and consistency of ERA across the board, standardizing the code usage, and continuously enhancing free software for ERA based on user feedback, have contributed to our success in this measure. 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. While continuous monitoring and taking quick and effective corrective actions have helped to raise confidence in ERA among providers/suppliers and resulted in a positive impact in usage of ERA, we believe we have reached a saturation point for ERA use.

CMS is in the midst of the Medicare Administrative Contractor (MAC) transition that will continue for the next few 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. A detailed analysis has shown that the ERA rates are higher among the MACs as compared to legacy contractors for both Part A and Part B mainly as a result of higher level of awareness and close monitoring.

CMS is also in the process of implementing the next version of Electronic Data Interchange standard for ERA that has been adopted by the Secretary as the next Health Insurance Portability and Accountability Act (HIPAA) standard, and becomes effective on January 1, 2012. CMS is expected to be ready for external user testing by January 1, 2011 following the timeline in the final rule published on January 16, 2009. 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 on CMS's part combined with provider transition to the new standard may impact the level of ERA in the coming years and add to the challenge to continue at the current level. Taking all of the mitigating factors into consideration, this measure will be discontinued after FY 2010.

Measure	FY	Target	Result
MCR12: Maintain an unqualified opinion	*2012*	Maintain	Nov 30 2012
	2011	Maintain	Nov 30, 2011
	2010	Maintain	Target Met
	2009	Maintain	Target Met
	2008	Maintain	Target Met
	2007	Maintain	Target Met

Measure	Data Source	Data Validation
MCR12	The annual audit opinion for CMS' financial Statements is issued by a Certified Public Accounting (CPA) firm with oversight by the Office of Inspector General (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 Health and Human Services, of which CMS' outlays are a vast majority.

MCR12: Maintain CMS' Improved Rating on Financial Statements

The Chief Financial Officers Act of 1990 creates a framework for the Federal Government to focus on the integration of accounting, budget, and other financial activities under one umbrella. This is meant to reduce waste and to provide complete, reliable, timely, and consistent information to Congress on the financial status of the Federal Government.

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 contractors.

CMS met its FY 2010 target of maintaining an unqualified opinion – a target CMS has met for twelve consecutive fiscal years. During FY 2010, CMS continued to improve its financial management performance in many areas. Specifically, CMS was successful in addressing the material weakness noted in the FY 2009 audit – Information System Controls. For FY 2010, CMS is substantially compliant with the Federal Financial Management Improvement Act (FFMIA). CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems,* since, as of September 2010; CMS has 88 percent of total Medicare program payments accounted for in HIGLAS. In addition, HIGLAS is CMS' official financial system of record, as we prepared our first auditable financial statements via HIGLAS during FY 2010.

During FY 2010, 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.

Measure	FY	Target	Result
MCR13.1: Award Medicare Fee-for-Service (FFS) Workload to Medicare Administrative Contractors (MACs)	*2012*	Award 3 A/B MAC Workloads	November 30, 2012
	2011	Award 3 DME and 2 A/B MACs (2nd round) Award MAC 1st round bid corrective actions	Nov 30, 2011
	2010	Award 3 DME MACs (2nd round)	Award 1 DME MAC (2nd round) (Target Not Met)
	2009	Award 100% (1st round)	Award 100%*** (Target Met)
	2008	Award 79.6%	Award 62.3% (Target Not Met but Improved)
	2007	Award 54.1%	Award 22.2% (Target Not Met but Improved)
MCR13.2: Implement Medicare FFS Workload to MACs	*2012*	Implement 1 DME MAC and 3 A/B MACs (2nd round) Finish implementing MAC 1st round contracts	Nov 30, 2012
	2011	Implement 3 DME MACs (2nd round)	Nov 30, 2011
	2010	Implement 100%	Implement 65.6% (Target Not Met)
	2009	Implement 74%	Implement 65.2% (Target Not Met but Improved)
	2008	Implement 54.4%	Implement 40.6% (Target Not Met but Improved)
	2007	Implement 8.8%	Implement 9.1% (Target Exceeded)

*** As of the end of calendar year 2010, the progress regarding the six MACs which have not been fully implemented and comprise 34% of FFS claims, is as follows: CMS is actively implementing two A/B MACs following recent GAO decisions sustain the contract awards. CMS anticipates one of these contracts be fully implemented by Q2 of FY11 and the other contract to be fully implemented by October 2011. Two A/B MACs remain in procurement corrective action, and two A/B MACs will be consolidated and re-competed with other jurisdictions.

Measure	Data Source	Data Validation
MCR13.1 MCR13.2	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 the Federal Acquisition Regulation (FAR).	CMS staff will review all reports with cited data to ensure that the reports are accurate, complete and understandable.

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 legacy 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 has significantly improved the operating efficiency of Medicare FFS claims operations, generating administrative savings far in excess of projections (i.e., since 2005, Medicare FFS operating expenses have been reduced by several hundred million dollars annually). CMS also believes that Medicare Contracting Reform has yielded qualitative improvements in Medicare benefit payment activities (and some trust fund savings), though these improvements are difficult to quantify.

For FY 2007, CMS implemented 9.1 percent of the FFS workload (four DME MAC contracts and one A/B MAC contract). 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 suspended performance on several of these MAC contracts due to GAO bid protests.)

The slippage in the FY 2009 projection for implementation (8.8 percent behind target) was largely due to additional bid protests to GAO and resulting procurement corrective actions. During FY 2010, CMS continued to work through six pending MAC procurement corrective actions. As of the end of calendar year 2010, the progress regarding the six MACs which have not been fully implemented and comprise 34 percent of FFS claims, is as follows: CMS is actively implementing two A/B MACs following recent GAO decisions that sustained the contract awards. CMS anticipates one of these contracts be fully implemented by Q2 of FY 2011 and the other contract to be fully implemented by October 2011. Two A/B MACs remain in procurement corrective action, and two A/B MACs will be consolidated and re-competed with other jurisdictions.

To address the challenges associated with bid protests, CMS has implemented process improvements to better manage the MAC procurements. These process improvements are bearing results, as CMS completed procurement corrective action on two A/B MAC contracts during FY 2010, and the agency has actively begun to implement these contracts following GAO's sustainment of the agency's contract awards.

The delays in MAC awards do not adversely impact beneficiary receipt of Medicare benefits. Providers may be served by legacy fiscal intermediaries or carriers for a somewhat longer period than originally anticipated, but this should be relatively transparent to these stakeholders. CMS also believes that the final "Round I" MAC procurements (now in corrective action) will generate additional operating savings when the contracts are awarded, provided CMS' mitigating actions are effective.

In FY 2010, as the Round I MACs neared the end of their 5-year performance period, CMS began the re-competition phase ("Round II") by soliciting 3 DME MAC jurisdictions during the fiscal year. In September 2010, CMS awarded the first of these "Round II" DME MAC contracts; this contract was not protested and was implemented in December 2010.

CMS had planned to complete the award of the other two DME MAC re-bids by November 30, 2010, but CMS continues to evaluate the proposals received and presently projects that these contract awards will occur in the first quarter of calendar 2011. Moreover, during FY 2011, CMS expects to re-bid and award the fourth DME MAC jurisdiction, as well as a MAC contract consolidating Jurisdictions 2 and 3. During FY 2011, CMS also expects to re-bid and award an A/B MAC contract consolidating Jurisdictions 4 and 7. As a result, our FY 2011 target to award A/B MACs increased from one to two. Some of these contracts, however, will not be fully implemented until early FY 2012. These re-competitions are already underway, and CMS is actively planning additional MAC contract re-bids.

CMS is incorporating into its re-procurement processes many of the lessons learned from the first round of MAC awards, such as approaches to streamlining and improving the effectiveness of the evaluation process

On July 22, 2010, CMS announced plans to further consolidate A/B MAC jurisdictions during the second round of A/B MAC procurements. Through a series of incremental actions, CMS plans to reduce the number of A/B MACs to 10 by 2016.

Measure	FY	Target	Result
MCR18: Increase final percent of possible cost sharing flags without high cost sharing review flags for Medicare-covered services	*2011*	Discontinued	N/A
	2010	95.2%	100% (Target Exceeded)
	2009	94.2%	94.8% (Target Exceeded)
	2008	N/A	93.6% (Historical Actual)

Measure	Data Source	Data Validation
MCR18	CMS reviews Medicare Advantage health plan benefit packages, which are submitted in the Health Plan Management System (HPMS). This information is extracted from HPMS and allows CMS to provide focused benefit reviews of plans, as well as flag those plans for review for high cost sharing for Medicare covered services.	The Health Plan Management System

MCR18: Improve Medicare's Administration of Beneficiary Enrollment and Plan Operations

As required by 42 CFR 422.100 (f)(2), CMS ensures that Medicare Advantage Organizations (MAOs) do not design benefits that discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage dis-enrollment, steer subsets of Medicare beneficiaries to particular Medicare Advantage (MA) plans, or inhibit access to services. CMS annually reviews each MA plan's service-category cost-sharing amounts and total out-of-pocket expense liability for members to identify health care benefit plans that do not comply with established laws and guidance on acceptable cost sharing and benefit package design. Cost sharing describes the out-of-pocket expense incurred by a beneficiary to access the health services provided by an MAO and is typically expressed as a specific dollar amount (co-payment) per service, per visit or per day, or as a set percentage of covered cost (coinsurance).

CMS reviews benefit packages for high cost sharing and possible discrimination using a methodology that evaluates the MA service categories representing services with the most expensive out-of-pocket costs. As part of this process, CMS establishes cost-sharing parameters each year and uses a review tool to electronically evaluate all bids based on cost-sharing amounts above the established parameters. The system generates review flags for each service category where cost-sharing amounts are higher than the CMS-established parameters. For example, if CMS focuses their reviews on 12 service categories, then there would be a universe of 12 possible review flags for each MA plan. CMS negotiates with the MAOs with review flags in order to better align their cost sharing amounts with CMS' parameters.

This goal is measured by dividing the total number of high cost sharing review flags after CMS completes its review and negotiations by the total number of possible review flags across the entire MA program. It is expressed as a percentage of overall review flags since the total number of plans or the number that will be flagged for high cost sharing is unknown and can vary from year-to-year. This GPRA goal demonstrates CMS' effectiveness in working with MA plans to design plan benefit packages that are non-discriminatory and offer high-value health care to Medicare beneficiaries and protect them from excessively high or unexpected cost sharing.

CMS used the FY 2008 benefits data as the baseline for making improvements in FY 2009. In FY 2008, there were 2,414 high cost sharing benefit review flags, out of a universe of 37,598

possible flags. These data yield a 6.4 percentage of high cost sharing flags, establishing a baseline of 93.6 percent of benefit review flags that do not exhibit high cost sharing. For FY 2009, CMS experienced 2,161 high cost sharing benefit review flags out of a universe of 41,772. The data yield a 5.2 percentage of high cost sharing flags, and a result of 94.8 percent of flags that do not exhibit high cost sharing. This result exceeds the FY 2009 target of 94.2 percent by 0.6 percent, and the FY 2010 result was 100 percent. CMS attributes this continued improvement to the imposition of more stringent bid review criteria for each year.

From 2006-2009 contract years, CMS performed the cost sharing discrimination reviews based on identification of plans that exceeded cost sharing parameters set by CMS. Plans that exceeded these cost sharing parameters were contacted and negotiations were conducted to try to reduce the plans' cost sharing to CMS cost sharing parameters. CMS had good success with bringing the number of cost sharing flags down each year as demonstrated in our attainment of our goals, shown below.

However, in 2009, CMS changed its approach for reviewing cost sharing. The agency established cost sharing standards which plans could not exceed and have their bids approved. In the first year of this different approach to reducing high cost sharing, the result was 100 percent compliance with our standards. CMS bid reviewers did not engage in negotiations, but provided plans with the standards so they could comply and get their bids approved. Therefore, this approach is different from the prior approach. The prior approach is obsolete because we no long look for plans to reduce their cost sharing through negotiation. Further, in 2010, for Contract Year 2011, CMS has published its standards for MA plans cost sharing. Like 2010 bids, we expect full compliance with the standards for contract year 2011 or the plans bids will not be approved. As a result of this change in approach, we are discontinuing this goal after FY 2010.

Measure	FY	Target	Result
MCR19: Decrease the appeal overturn rates at the first level of appeal for overpayments identified by the Recovery Audit Contractor (RAC) Program	*2012*	Target below FY 2011 baseline	Oct 31, 2012
	2011	Establish baseline appeals overturn rate	Oct 31, 2011
	2010	Implement the Recovery Audit Contractor program in all 50 States and U.S. Territories	Target met

Measure	Data Source	Data Validation
MCR19	Appeal reports and statistics provided to CMS by the first level appeal adjudicators.	CMS staff will collect and review the monthly appeal reports received from the claim processing contractors who are the adjudicators of the first level of appeal. An annual appeal overturn rate will be calculated and initially compared to the 2011 fiscal year overturn rate at the first level.

MCR19: Ensure Accuracy of the Recovery Audit Contractor (RAC) Program

As mandated by Section 302 of the Tax Relief and Health Care Act of 2006, CMS implemented the Recovery Audit Contractor (RAC) program in all 50 States. The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments. Overpayments may occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies. Underpayments may occur when health care providers submit claims for a simple procedure, but the medical record reveals that a more complicated procedure was actually performed. Health care providers that may be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Parts A and B.

The national RAC program is the outgrowth of a successful demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. The demonstration resulted in over $900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008 and nearly $38 million in underpayments returned to health care providers.

A decreasing overall appeal overturn rate means an increasing level of accuracy in recoveries obtained due to contractor auditing. During the RAC demonstration, CMS released annual statistics regarding appeal overturn rates by each contractor. An overall appeal overturn rate was calculated for the entire demonstration project. While CMS continues to update the figures as additional claims go through the appeal process, the latest figure released from the demonstration was an overall overturn rate of 8.2 percent through all levels of appeal.

Preliminary appeals information was gathered in FY 2010; however, it was not representative of all claim and provider types that may be appealed. FY 2011 will be representative of all claim and review types and will allow CMS to establish a realistic baseline appeal rate. Beginning in FY 2012, CMS will utilize the appeal rate established the prior fiscal year as the target rate and will continually work to decrease the appeal rate going forward.

Measure	FY	Target	Result
MCR20: Implement the International Classification of Diseases (ICD)-10	*2012*	1. Continue external ICD-10 outreach and communications 2. Update ICD-10 industry compliance level and State Medicaid program readiness baselines	1. October 1, 2011 and ongoing 2. December 1, 2011 and May 1, 2012
	2011	1. Finalize ICD-10 Implementation Planning Recommendations 2. Update ICD-10 industry compliance level and State Medicaid program readiness baselines 3. Continue external outreach and communications	1. October 1, 2010 (Target Met) 2. December 1, 2010, (Target Met) and May 1, 2011 3. October 1, 2010 (Target Met) and ongoing
	2010	1. Complete CMS ICD-10 Implementation Plan 2. Initiate External ICD-10 outreach and communications plan 3. Develop ICD-10 industry compliance level baselines 4. Update State Medicaid program readiness baseline	1. March 1, 2010 (Target Met) 2. March 1, 2010 (Target Met) 3. Industry compliance level baselines developed (Target Met) 4. May 1, 2010 (Target Met)
	2009	New in FY 2010	1. Phase II ICD-10 Impact analysis completed 2. Final ICD-10 rule published 3. State Medicaid program ICD-10 readiness baseline established

Measure	Data Source	Data Validation
MCR20	The data used for the measures above were derived from a study contracted by CMS with the American Health Information Management Association (AHIMA), the ICD-10 impact analysis conducted by Noblis and the subsequent ICD-10 CMS implementation plan.	The information used for the milestones above is validated by CMS to ensure that we have the correct information in developing the implementation plan and execution.

MCR20: Implement ICD-10

By October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) – along with the entire U.S. health care industry – must transition to the International Classification of Diseases (ICD) 10th Edition (ICD-10) code set from the current ICD 9th Edition (ICD-9) code set, per regulation enacted by the U.S. Department of Health and Human Services on January 16, 2009[1]. This performance goal highlights critical action steps needed for CMS to transition to ICD-10.

The new ICD-10 code set will accommodate new procedures and diagnoses unaccounted for in the ICD-9 code set and will provide greater specificity of diagnosis-related groups and preventive services and will permit more rigorous program integrity efforts. This transition will lead to improved reimbursement for medical services, fraud detection, and historical claims and diagnoses analysis for the U.S. health care industry, which will be able to make more informed decisions regarding health programs to improve health outcomes for all Americans.

The ICD permits the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times. It is used to translate diagnoses of diseases and other health problems from words into an alphanumeric code, which permits easy storage, retrieval and analysis of the data. The current code set – ICD-9 (volume 3) is over 30 years old, is quickly running out of space for new procedures, and cannot accurately reflect modern diagnoses, technologies and inpatient procedures. The U.S. is the only "big seven" nation not yet transitioned from ICD-9 to ICD-10, which hampers our ability to share diagnosis and other information, such as pandemic data, with other countries.

The industry has long anticipated the adoption of the ICD-10 CM and ICD-10-PCS code sets and the prerequisite Version 5010 of the HIPAA transaction standards (effective January 1, 2012), as they represent technical and operational improvements, a key component of the Administration's move toward health care transparency and health care system enhancements. Adoption will move the industry toward an electronic health information environment through the increased use of electronic data interchange (EDI), which supports use of the ICD-10-CM and ICD-10-PCS code sets. The transition to ICD-10 will affect systems, business processes, payments and policies across the entire health care spectrum. It will result in robust data to support the agency's quality measurement efforts, designed to better inform CMS coverage policy decisions.

ICD-10 is essential to achieving Affordable Care Act initiatives, specifically in the areas of fraud, waste, and abuse; value-based purchasing system; and the overall Affordable Care Act implementation. Reducing fraud, waste, and abuse is both a major priority of the Administration as well as a central goal of the Affordable Care Act. Implementation of ICD-10 will help ensure that claims are paid accurately. ICD-10 is needed to move the current volume-based system to a value-based purchasing system, which is another central goal of the Affordable Care Act. Additionally, implementation of Affordable Care Act programs and provisions using ICD-9 codes instead of ICD-10 codes will result in backtracking and extra work.

ICD-10 data also will be relied upon for various American Recovery and Reinvestment Act of 2009 (Recovery Act) provider incentive programs. For example, the Recovery Act calls for CMS to pay incentives to eligible professional and hospitals based on "meaningful use of certified electronic health record (EHR) technology" and quality measures determined by CMS. The

[1] CMS-0013-F, "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS" (45 CFR Part 162, published in the Federal Register on January 16, 2009)

proposed quality measures are precise and the more detailed nature of the ICD-10-CM and ICD-10-PCS codes will enhance the provider's ability to document that they have met the quality measure criteria for the incentive payment program.

In preparation for ICD-10 adoption, CMS has already conducted an agency-wide identification of ICD-9 (and presumed ICD-10) touch points across all its business processes and systems, and has noted 67 processes and 68 systems that will be impacted by the agency's transition to ICD-10.

In FY 2010, CMS completed an impact analysis that maps the interconnectivity between the various business processes and systems; developed a prioritized risk and opportunities assessment; vetted concept solutions; and completed an implementation plan with option recommendations. Additionally, this phase of the project included outreach and education planning, and development of both industry compliance level and State Medicaid program readiness baselines to measure their respective progress toward compliance.

Additional FY 2011 targets represent efforts leading up to FY 2012 targets. At the beginning of FY 2011, ICD-10 implementation recommendations that were vetted and approved through the agency's ICD-10 Steering Committee were in place, and 18 ICD-10 project areas began reporting their progress on key milestones in their respective implementation plans through a dashboard mechanism. Analysis change requests to CMS Medicare Administrative Contractors were released, and results are being analyzed in preparation for a consolidated contractor implementation effort. An industry compliance level environmental scan was released to industry partners and pending results, and the CMS completed a national conference call campaign to assess Version 5010/ICD-10 readiness on a State by State basis. While still being analyzed, initial results reveal that some States have made significant progress toward planned Version 5010 compliance, while others will need resources and assistance. Compliance targets and timing are critical. HIPAA covered entities should start testing Version 5010, the precursor to ICD-10, in January 2011, and then begin implementation of ICD-10 in earnest soon thereafter. If Medicare, any health care industry segment and/or State Medicaid programs are not making timely progress towards implementation, it would create a domino effect, negatively impacting provider reimbursement, claims processing and operational workflows. The earlier these potential impacts are identified, the faster we can provide resources and assistance to affected entities. Targeted industry and State Medicaid program environmental scans, and increased outreach and education through webinars, conference participation, national call-in programs, etc, and onsite visits to State Medicaid programs are among the activities planned for this fiscal year. FY 2012 will see continuation of all of FY 2011 activities, with the addition of the initiation of Level 1 industry ICD-10 testing activities soon after the January 1, 2012 deadline for Version 5010 compliance. All these activities will provide impacted CMS business areas with the support mechanisms to ensure timely CMS, contractor and industry transition to ICD-10-CM and ICD-10-PCS on October 1, 2013.

Measure	FY	Target	Result
MCR21.1: Percent of CMS Federal Information System Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems. Baseline: 127 out of 163 Systems have an active authority to operate (ATO) as of 12/2010	*2012*	90%	Oct 31, 2012
	2011	80%	Oct 31, 2011
	2010	New in 2011	78% (Trend)
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution Baseline: 0% FY 2009	*2012*	95%	Oct 31, 2012
	2011	75%	Oct 31, 2011
	2010	New in 2011	63% (Trend)
MCR21.3: Percent of information technology (IT) projects that have adapted to the Enterprise Performance Life Cycle (EPLC) framework Baseline: 10% FY2009	*2012*	85%	Dec 31, 2012
	2011	75%	Dec 31, 2011
	2010	New in 2011	N/A
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) Baseline: 0 PIR FY2009	*2012*	4 PIRs	Dec 31, 2012
	2011	2 PIRs	Dec 31, 2011
	2010	New in 2011	N/A

Measure	Data Source	Data Validation
MCR21.1 MCR21.2	FISMA Reporting tool Enterprise Vulnerability Management solution	The annual Office of Inspector General (OIG) conducts annual FISMA and CFO audits which provide an independent validation of the results. The Certification and Accreditation and Plan Of Actions and Milestones programs are reviewed to assess CMS' ability to meet the FISMA and financial management internal control reviews. The system-level operating system patching and hotfix patches are independently reviewed by the OIG.
MCR21.3 MCR21.4	CMS Portfolio Management Tool and tracking sheet. CMS IT Investment Review Board meeting minutes	The results of the EPLC and PIR reviews are presented to governing bodies, such as the Technical Review Board or the IT Investment Review Board, and summary reports are prepared for the CMS Chief Information Officer.

MCR21: Effectively Manage Information Technology (IT) Systems and Investments to Minimize Risks and Maximize Returns

The purpose of this performance measure is to gain insight into the effectiveness of CMS' management of its IT systems and IT investments. Establishing these four performance metrics under this goal will help us report better data and determine if we need to make any changes to our current process and procedures so that we can increase transparency, and measure the efficiency, effectiveness and success of our governance processes and investments in IT. CMS is measuring success in two key areas: Enterprise Performance Life Cycle and Information Security.

The Government Accountability Office (GAO) recommended that CMS develop and implement a plan to improve its IT investment management processes, including conducting post-implementation reviews (PIR) (GAO-06-11). CMS recognized the importance of conducting a PIR and the insights that can be gained by performing them; realizing customer satisfaction and performance measures, conducting lessons learned and applying them to improve our processes will only make us better stewards of the citizen's money. CMS's plan is to implement best practices for managing IT projects and systems by following rigorous investment life cycle (ILC) and information security processes.

CMS established an initial version of the ILC Framework in October 2004 and updated it in November 2006 to better serve the needs of the Agency and to align with the Department of Health and Human Services (DHHS) Enterprise Performance Life Cycle (EPLC). The EPLC is a comprehensive set of policies, processes, procedures, standards, artifacts, reviews, and resources that provides guidance for IT investment and system life cycle management. The EPLC provides a foundation and supporting structure designed to aid in the successful planning, engineering, implementation, maintenance, management, and governance of CMS' IT investments, systems, and system life cycle projects. To achieve this goal, we will monitor the number of projects that follow the EPLC and determine which would be good candidates for a PIR. Monitoring the number of projects that follow the EPLC and conducting post implementation reviews will provide objective evidence that CMS is managing IT projects effectively. This evidence will be stored in a centralized repository and will be reviewed periodically for analysis, and the findings and recommendations resulting from PIRs will be presented to a governing body and tracked to completion.

Post-implementation reviews enable the evaluation of actual investment cost, schedule and performance against original and latest baselines and measure the level of stakeholder and customer satisfaction. In 2010, CMS is writing PIR procedures and training staff on how to conduct comprehensive PIRs. Successfully conducting two PIRs in 2011 and four PIRs in 2012 represents a 400 percent increase; and increasing the number of projects adapting to the EPLC from 10 percent to 75 percent in 2011 and 85 percent in 2012 percent represents a dramatic increase in our ability to manage IT projects, to learn from recently implemented projects, to share best practices and continuously improve our IT investment management processes. Both of these measures are extremely ambitious and are meaningful measures of our success to fully implement IT investment management practices.

The DHHS Office of Inspector General (OIG) issued a Management Implication Report (MIR) in May 2009 that led to subsequent memoranda from the Secretary and Deputy Secretary of HHS urging Operating Divisions to increase vigilance in several areas in information security. Specifically, the Certification and Accreditation (C&A) program which provides a system's authority to operate (ATO) was identified as a key area for improvement. CMS continues to

aggressively work to resolve the identified issues and has made significant progress by expanding CMS' system inventory to be all-inclusive. As of December 2010, CMS has completed the majority of work required to break up the system families to provide the appropriate granularity of reporting and deficiency tracking. CMS completed the replacement of the legacy Plan Of Actions and Milestones (POA&M) application which is expected to resolve a substantial number of audit findings. CMS also completed the work needed to identify an appropriate cost-effective and risk-based solution that meets the Federal Information Security Management Act requirements for the 150+ analytical contractors that perform work on our behalf.

The OIG MIR also identified the lack of independent oversight of CMS systems over our systems as a critical weakness. CMS is aggressively working to resolve the identified issues by implementing an enterprise class vulnerability and configuration management solution. The strategic solution has been engineered and implemented at 145 sites across the CMS enterprise environment and is currently scanning over 26,000 IT assets (Note IT assets = servers, workstations, routers, etc.) The goal to have 95 percent of all CMS FISMA systems scanned and monitored by a centralized vulnerability management solution in 2011 was changed to 75 percent in 2011. This is still very ambitious, and represents a dramatic improvement in the CMS information security posture. CMS depends heavily on contractor owned and contractor managed data centers for all but one of our data centers. The deployment of a centralized vulnerability management solution that scans well over one hundred contractor facilities has been met with some level of pushback. In addition, the continued implementation of the vulnerability management tool will require additional resources due to the complexity of the CMS networks that were not known before this project documented the architectures.

Likewise, CMS has made tremendous improvements with increasing the percentage of systems authorized to operate on our networks. After consulting with the National Institute of Standards and Technology (NIST) Computer Security Division, Computer Security Resource Center (CSRC) and the U.S. Department of Health and Human Services (DHHS) Office of the Chief Information Officer (OCIO), the aforementioned cost effective and risk based solution allowed CMS to group approximately 150 systems performing research oriented work on behalf of CMS into one virtual system that has been authorized to operate. This lowered the baseline of CMS systems from 311 to 163. This, along with constant efforts to communicate the benefits and federal requirements to obtain an authority to operate (ATO), has produced significant improvements in our ATO percentage.

CMS manages over $1 billion annually in IT investments and its IT systems, and the sensitive information that they contain are critical to the Medicare and Medicaid programs. Ensuring that IT investments are managed effectively by adhering to the EPLC, by conducting post-implementation reviews, by ensuring that CMS IT systems have a formal ATO, and are included in a vulnerability management program, will protect these key assets and help maintain the public trust in CMS.

Measure	FY	Target	Result
MCR22 Reduce the growth of health care costs by identifying, reviewing, and appropriately valuing potentially misvalued codes (i.e. high expenditure or high cost) under the Medicare Physician Fee Schedule (PFS) through the potentially misvalued code analysis process.	*2012*	20%	December 2012

Measure	Data Source	Data Validation
MCR22	The PFS rules and regulations; the Relative Value Scale Update Committee (RUC) database; relevant PFS utilization data available at the time of analysis.	Developmental. We will devise a process to compare the values from multiple data sources and incorporate clinical review to check the appropriate valuation of the codes identified as potentially misvalued.

MCR22: Reduce the growth of health care costs by identifying, reviewing, and appropriately valuing potentially misvalued codes under the Medicare Physician Fee Schedule (PFS) system through the potentially misvalued code analysis process

The purpose of this measure is to achieve more accurate pricing under the Medicare physician fee schedule, consistent with CMS' goal of moving to a value driven health care system. The Medicare Physician Fee Schedule (PFS) is a payment system used to reimburse practitioners for Medicare services. In this process, each service is assigned a unique code and a relative value unit (RVU), which helps Medicare determine the reimbursement for the services. Like other payment systems, the Medicare PFS is not perfect and is vulnerable to mispricing. In order to achieve CMS' goal of moving to a value driven health care system, it is imperative to have a payment system that provides accurate reimbursement for the services rendered. This measure aims to quantify CMS' progress in determining which services under the Medicare PFS are misvalued and setting the appropriate RVU's for those services.

As noted in a 2006 Medicare Medical Payment Advisory Committee (MedPAC) report, "misvalued services can distort the price signals[2] for physicians' services as well as for other health care services that physicians order[3]," such as hospital services. For example, services can be overvalued when new technology lowers costs or undervalued if a physician's work increases or practice expenses rise.

[2] Price signals are a way of alerting the public to a product or service's true value. A distortion of price signals can lead to misvalued products and service; in this case Medicare services.

[3] MedPAC. (2006). MedPAC Public Meeting: Report to Congress. MedPAC Report to Congress (pp. 10-11). Washington, D.C.: MedPAC. http://www.medpac.gov/transcripts/10_06_medpac_all.pdf

To address this issue, the Affordable Care Act provision 3134, directed the Secretary of Health and Human Services to specifically examine potentially misvalued services in the following seven high risk categories where this issue is most likely to occur:

(1) Codes and families of codes for which there has been the fastest growth.
(2) Codes and families of codes that have experienced substantial changes in practice expenses.
(3) Codes that are recently established for new technologies or services.
(4) Multiple codes that are frequently billed in conjunction with furnishing a single service.
(5) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
(6) Codes which have not been subject to review since the implementation of the Resource-Based Relative Value Scale (RBRVS) (the so-called 'Harvard-valued codes').
(7) Other codes determined to be appropriate by the Secretary.

Over the last several years, CMS has identified and reviewed a number of potentially misvalued codes in all seven of the aforementioned categories and we plan to continue our work examining potentially misvalued codes in these areas over the upcoming years, consistent with Affordable Care Act legislation. In the current process, CMS determines appropriate adjustments to the RVUs, taking into account the recommendations provided by the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC) and MedPAC. The explanations for the basis of these adjustments are then published in the Medicare PFS proposed and final rules.

CMS will procure analytic contractors to identify and analyze potentially misvalued codes. After conducting surveys or collecting data, the contractors will make recommendations on the review and appropriate adjustment of potentially misvalued services, enhancing the current process of reviewing codes with the AMA RUC. We anticipate that the contractor will be in place in 2011 in order to develop a baseline and provide initial estimates of potentially misvalued codes. In 2012, we plan to have reviewed and appropriately valued at least 20 percent of the total estimated potentially misvalued codes identified through the potentially misvalued code analysis process which will include codes that CMS identifies through the AMA RUC as well as the contractor. We note that currently, there are approximately 7,500 codes payable under the Medicare PFS of which a subset will ultimately be identified as potentially misvalued.

Measure	FY	Target	Result
MCR24: Implement delivery system reform. Developmental	*2012*	TBD	TBD

Measure	Data Source	Data Validation
MCR24	TBD	TBD

MCR24: Implement delivery system reform

The Medicare program will be instrumental in driving the much needed delivery system reforms that are now written into statute. Significant changes will occur in payment design and incentives to assure the American people have access to the highest quality of care at an affordable cost. The Affordable Care Act will require an immediate embrace of operational efficiencies and rapid transformation of the current system.

CMS will strive to bring improved healthcare to the population as a whole and to bring better care to individuals, all while lowering costs through system and process improvement. CMS will rely on innovation in every facet of administration and oversight to drive these changes. Better health and quality care will require a focus on streamlining health care enrollment to address accessibility issues. We will strategically align the delivery system, values, and incentives to realize the full benefits to be derived from the Affordable Care Act provisions.

We are working toward a revamped healthcare delivery system that will reduce hospital readmissions and at the same time create incentives to foster a more person-centered health care approach. We envision healthcare truly becoming an integrated, collaborative approach as diagnoses, prescriptions, and patient interactions are captured, stored, and immediately available to relevant health care providers. Our ultimate goal of eliminating redundancies, needless delays, and unwarranted referrals will be realized, in addition to cost savings, integrated healthcare, improved processes, and better care.

Measure	FY	Target	Result
MCR26: Reduce all-cause hospital readmission rate	*2012**	Baseline	FY 2012

*Note: baseline is determined in FY 2012 based FY 2009 to FY 2011 data

Measure	Data Source	Data Validation
MCR26	Medicare claims data. The data used to calculate the performance measures are administrative claims data submitted by hospitals and Medicare Advantage plans. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website. As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based models perform well in predicting readmission compared with models based on chart reviews. Similar to what is described on the Hospital Compare website, the administrative claims data has a risk-adjustment model applied to adjust for differences in patients' risks unrelated to their hospital care.	The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. CMS uses national administrative inpatient hospital claims data to calculate the readmission rate measure. The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. Inpatient hospital claims information is assumed to be accurate and reliable as presented in the database.

MCR26: Reduce all-cause hospital readmission rate

The increasing hospital readmission rate is a growing area of concern which results in poor patient quality care and places a heavy financial burden on the health care system. A "hospital readmission" is when a patient, who has recently been discharged from a hospital (within 30 days), is once again readmitted into a hospital. The Medicare Payment Advisory Commission (MedPAC) reported in its June 2007 *Report to Congress* that discharges from a hospital are a critical transition point in a patient's care. Incomplete handoffs at discharge can lead to adverse events for patients and avoidable rehospitalization. Hospital readmissions may indicate poor care or missed opportunities to coordinate care better. Additionally, MedPAC states that in 2005, 6 percent of acute care hospitalizations of Medicare beneficiaries resulted in readmission within 7 days; 18 percent of hospitalizations resulted in readmission within 30 days. The 18 percent of hospital readmissions accounted for $15 billion in Medicare spending. Most potentially preventable readmissions can be prevented if the best quality of care is rendered and clinicians use current standards of care.

The purpose of this measure is to reduce unnecessary all-cause hospital readmissions in order to reduce Medicare payments, while ensuring patient quality. This is consistent with CMS' goal of reducing the growth of health care costs while promoting high-value, effective care. Many studies have pointed to opportunities for improvement. While there is variability in the rates of potentially preventable readmissions, up to 50 percent of readmissions can be identified as preventable.

The Affordable Care Act places significant emphasis on reducing hospital readmissions and has several provisions dedicated to improving these rates. Section 3025 directs the Secretary of HHS, in FY 2013, to establish a hospital readmissions reduction program for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions (heart attack,

pneumonia, and congestive heart failure). Beginning in FY 2015, the number of applicable conditions will be expanded beyond the initial three conditions to four additional conditions that were identified by MedPAC and other appropriate conditions[4]. These conditions were selected because they are associated with high volume, high cost and high and variable readmission rates. The readmission information for acute care hospitals is to be made publicly available on the Hospital Compare website (www.hospitalcompare.hhs.gov) after a hospital has the opportunity to review and correct the data prior to being made public. Under this program, a portion of Medicare's payment amounts to certain hospitals could be reduced by an adjustment factor depending on a hospital's performance on measures of excess hospital readmissions.

CMS will assess its performance to reduce readmission rates of acute care hospitals based on the "all-cause hospital readmission rate per year." We are currently collecting data on readmissions under various projects and this performance measure will be built upon our existing data collection process. For the purposes of this performance measure, a readmission is defined as a case of a Medicare beneficiary who is discharged from an acute care hospital and admitted to the same or another acute care hospital within 30 days from the date of the original hospital discharge. Medicare beneficiaries are defined as those in fee-for-service Medicare and those enrolled in Medicare Advantage Plans. While current efforts for Hospital Compare examine readmission rates for certain conditions, the readmission rate for this performance measure will apply *to all conditions*.

The rate of readmissions is calculated as the number of readmissions to the same or another acute-care hospital that occur within 30 days of discharge from an acute care hospital compared to total hospital admissions for that time period. The numerator will be the number of hospital readmissions to any acute care hospital within 30 days of an acute care hospital discharge. The denominator is the total number of admissions for that time period.

The data used to calculate the all-cause hospital readmission rate year will be based on administrative claims data. Data to calculate the all-cause hospital readmission rate for beneficiaries in Medicare Advantage plans will be collected from the plans. It will be adopted as a new Health Effectiveness Data and Information Set (HEDIS®) measure being introduced by the National Committee for Quality Assurance (NCQA) this year. Medicare Advantage contracts will first submit the all-cause re-admission rates in June 2011 to NCQA/CMS.

The baseline will be measured in FY 2012. It will be based on fee-for-service claims data from FY 2009 to FY 2011 and data submitted from Medicare Advantage plans. The readmission rate will be updated annually through FY 2015 and compared to the baseline from FY 2012. The target is an annual reduction of readmission rate of 5 percent relative to the previous year. The baseline data will be available in FY 2012. The data will be updated annually through FY 2015.

[4] The Secretary of HHS may add the following conditions: Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Bypass Graft (CABG), Percutaneous Transluminal Coronary Angioplasty (PTCA), and other vascular procedures. These 7 conditions were identified by MedPAC as conditions that make up almost 30 percent of Medicare spending on readmissions. In addition to these 7 measures, CMS is developing readmission measures for Stroke, Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA).

Measure	*FY*	Target	Result
Number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use			
MCR27.1:Medicare 2010 Baseline = 0	*2012*	TBD	TBD
	2011	TBD	TBD
MCR27.2: Medicaid 2010 Baseline = 0	*2012*	TBD	TBD
	2011	N/A	TBD
Total Medicare and Medicaid *2010 Baseline = 0*	*2012*	N/A	TBD
	2011	N/A	TBD
*Number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use			
MCR27.3: Medicare 2010 Baseline = 0	*2011*	TBD	TBD
MCR27.4: Medicaid 2010 Baseline = 0	*2012*	TBD	TBD
	2011	N/A	TBD
Total Medicare and Medicaid *2010 Baseline = 0*	*2012*	N/A	TBD
	2011	N/A	TBD
Number of Providers receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program			
MCR27.5: Eligible Professionals 2010 Baseline = 0	*2012*	TBD	TBD
	2011	TBD	TBD
*MCR27.6: Eligible Hospitals 2010 Baseline = 0	*2011*	TBD	TBD

*Eligible hospitals may receive incentive payments from both the Medicare and Medicaid incentive programs, therefore the total number of hospitals may contain duplicates.

Measure	Data Source	Data Validation
MCR27	National Level Repository	The National Level Repository (NLR) contains information on eligible providers who receive Medicare and Medicaid EHR incentive payments. Information from the NLR will be populated from other CMS systems, including the Provider Enrollment, Chain, and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES). See Final Rule for further detail[5].

[5] http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

MCR27: Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals (EP) and hospitals

The American Recovery and Reinvestment Act of 2009 (Recovery Act), among other things, was designed to stimulate the economy through measures that preserve and improve access to affordable health care while transforming and modernizing the Nation's health care system.

The Health Information Technology for Economic and Clinical Health (HITECH) Act in the Recovery Act provides incentive payments to eligible providers serving Medicare and Medicaid beneficiaries who adopt and meaningfully use certified electronic health records (EHR) technology. The promotion of health information technology is a joint effort by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC)[6], and directly corresponds to the Department of Health and Human Services (HHS) strategic objective of improving health care quality, safety, efficiency and value. Increased use of EHRs will improve coordination and care across providers and settings and improve health care delivery. It is believed that it can lead to increased quality of care and reduced medical errors.

The EHR incentive programs provide payments between 2011 and 2021 to eligible providers who successfully demonstrate meaningful use based on the established criteria for each of the three stages of meaningful use. To earn meaningful use incentive payments during Stage 1, providers are required to use the EHR technology to:

- improve care coordination;
- reduce healthcare disparities;
- engage patients and their families;
- improve population and public health; and
- ensure adequate privacy and security.

Under the Medicaid EHR incentive programs, providers may also adopt, implement, or upgrade (A/I/U) their certified EHR technology in their first year of participation as an alternative to demonstrating meaningful use. For A/I/U, providers must demonstrate a legal and/or financial commitment to possessing certified EHR technology.

Sections 4101 and 4102 of the Recovery Act provide Medicare incentive payments to EPs between calendar years 2011 to 2016 and to eligible hospitals and critical access hospitals (CAHs) between fiscal years 2011 to 2016. Starting in 2015, eligible professionals, eligible hospitals, and CAHs that fail to demonstrate meaningful use of certified EHRs will receive reduced Medicare payments.

Section 4201 of the Recovery Act established 100 percent Federal Financial Participation (FFP) to States for incentives to eligible Medicaid professionals to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The section also established 90 percent FFP for State administrative expenses related to carrying out this provision. While eligible hospitals can receive incentive payments from both the Medicare and Medicaid incentive programs, EPs must choose to participate in one or the other. Many States have been moving toward interoperable health care technology and information exchange for the last several years. This provision affords States and their Medicaid providers with a unique opportunity to leverage these existing efforts to achieve the vision of interoperable information technology for health care with State Medicaid agencies playing a critically important role in fulfilling that vision.

[6] ONC is responsible for establishing standards for EHRs and certifies EHR products.

Medicaid EHR incentive payments are available through 2021, though the last year a provider can start receiving an incentive payment is 2016.

CMS has made great progress in the submittal and approval of State Medicaid planning documents for the Medicaid EHR incentive program. These documents include State Medicaid HIT Plans (SMHP), Health Information Technology Planning Advance Planning Document (PAPD), and Health Information Technology Implementation Advance Planning Document (IAPD) These three documents lay out the process States are proposing to implement and oversee the Medicaid EHR incentive program and help States construct a roadmap to support providers in their adoption and meaningful use of certified EHR technology. We have already received 30 final SMHPs and have approved 16; the remaining 14 are currently under CMS review. All 56 States and Territories have an approved PAPD ($87 Million Federal Share.) Additionally, we have received 26 IAPDs and have approved 15 ($125 Million Federal Share), with the remaining 9 under CMS review.

These performance measures will measure the number of EPs, eligible hospitals, and CAHs receiving incentive payments for successfully demonstrating adoption and meaningful use under the Medicare and Medicaid incentive programs. Since the focus of FY 2011 for the Medicaid EHR incentive program is eligible providers who adopt, implement or upgrade to certified EHR technology, we will not measure the number of providers receiving meaningful use payments for that year. For Medicaid, the earliest we expect to see meaningful use payments made is January 2012 for eligible hospitals and April 2012 for eligible professionals.

The denominator will be defined. The table below illustrates the percentage of EPs and hospitals in Medicare and Medicaid receiving EHR incentive payments.

Measure	FY	Number	Percentage
EPs receiving Medicare EHR incentive payments for meaningful use	2011		
EPs receiving Medicaid EHR incentive payments for meaningful use	2012		
Eligible Hospitals and CAHs receiving Medicare EHR incentive payments for meaningful use	2011		
Eligible Hospitals receiving Medicaid EHR incentive payments for meaningful use	2012		
EPs receiving Medicaid AIU incentive payments	2011		
Eligible Hospitals receiving Medicaid AIU incentive payments	2011		

Measure	FY	Target	Result
MCR28: Reduce Hospital Acquired Conditions Developmental	*2012*	TBD	TBD

Measure	Data Source	Data Validation
MCR28	TBD	TBD

MCR28: Reduce Hospital Acquired Conditions

In its landmark 1999 report ''To Err is Human: Building a Safer Health System,'' the Institute of Medicine found that medical errors, particularly hospital-acquired conditions (HACs) caused by medical errors, are a leading cause of morbidity and mortality in the United States. As one approach to combating HACs (including infections), in 2005, with Section 5001 (c) of the Deficit Reduction Act, Congress authorized the Centers for Medicare and Medicaid Services (CMS) to adjust Medicare Inpatient Prospective Payment System (IPPS) hospital payments to encourage the prevention of these conditions. The preventable HAC provision at section 1886(d) (4) (D) of the Act is part of an array of tools that CMS is using to promote increased quality and efficiency of care. This performance measure is cross-cutting, effecting both Medicare and Medicaid providers.

The Affordable Care Act places significant emphasis on patient quality and safety and seeks to transform CMS from a payer of claims into a major force for the continual improvement of health and health care. The Affordable Care Act imposes Medicare IPPS payment penalties on the 25 percent of hospitals that have the highest rate of hospital acquired conditions beginning in FY 2015. These hospitals would be paid 99 percent of what they would have otherwise been paid. Additionally, the Affordable Care Act requires to agency to submit a report to Congress on expanding the payment policy set forth by the Deficit Reduction Act to other provider settings. These provisions will ultimately affect all payers and all consumers, lending to improved overall quality. CMS has also issued new quality reporting mechanisms to make HACs more transparent to patients and providers.

Section 2707 of the Affordable Care Act requires CMS to promulgate regulations, effective July 1, 2011, identifying current State practices that prohibit payment for Health Care Acquired Conditions (HCACs) and incorporating the practices identified, or elements of such practices, that the Secretary determines appropriate for application to the Medicaid program. Additionally, payments are prohibited to States under section 1903 of the Social Security Act for HCACs specified in the regulations, while stipulating that the prohibition on payment may not result in a loss of access to care or services for Medicaid beneficiaries. The statute requires that Medicaid's regulations be consistent with Medicare's existing statutory and regulatory language in significant ways, but also allows Medicaid flexibility in recognition of the operational differences between the two programs.

Measure	FY	Target	Result
MCR29.1: Develop drafts and final rules for payment years (PY) 2013 and 2014	*2012*	Publish PY 2014 final rule	Dec 31, 2011
	2011	Publish PY 2013 final rule	Sep 30, 2011
MCR29.2. Obtain monitoring and evaluation contractor and implement monitoring strategy	*2011*	Procure contractor	Jun 30, 2011
MCR29.3: Implementation of payment reduction for 2012 (met statutory requirement)	*2012*	Adjust payment for facilities not meeting performance standards	Jan 31, 2012

Measure	Data Source	Data Validation
MCR29.2, MCR29.3	Medicare Claims Data	Process to be developed

MCR29: Protect the Health of Medicare Beneficiaries by Implementing the First Value-Based Purchasing Program: End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Individuals are diagnosed with ESRD when their kidneys are no longer able to remove excess fluids and toxins from their blood. ESRD can be cured only with a kidney transplant. ESRD patients who have not received a transplant rely on dialysis to perform the life-saving filtering function. Nearly 400,000 individuals in the United States are being treated for ESRD under Medicare, at a cost of nearly $9 billion each year.

Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that the Secretary implement an ESRD quality incentive program that will result in payment reductions to providers of services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures. The payment reductions, which will be up to 2.0 percent of payments otherwise made to providers and facilities, will apply to payments for renal dialysis services furnished on or after January 1, 2012. This reduction of payment will only include the year involved and it will not factor into future payment years.

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on December 29, 2010, that will establish performance standards for dialysis facilities and provide payment adjustments to individual End-Stage Renal Disease (ESRD) facilities based on how well they meet these standards. The ESRD Quality Incentive Program (QIP) is designed to promote high-quality dialysis services at Medicare facilities by linking CMS payments directly to facility performance on quality measures.

CMS finalized three measures as the initial measure set during the first program year (2012). Two of these measures are designed to assess whether patients' hemoglobin levels are maintained in an acceptable range, while the third measures the effectiveness of the dialysis treatment in removing waste products from patients' blood. The three measures were chosen because they represent important indicators of patient outcomes and quality of care. In future years CMS plans to add quality measures and establish additional performance standards that ESRD facilities will need to meet in order to receive full payment for the services they furnish to Medicare beneficiaries. CMS expects that the new quality measures and performance standards will help to drive quality improvements for dialysis services.

Specifically, we anticipate strengthening the performance standard for each measure in future years of the QIP, including potentially moving away from using the national performance rate as the performance standard and instead identifying absolute standards that reflect performance goals widely recognized by the ESRD medical community as demonstrating high quality care for ESRD patients. Additionally, for these initial three finalized measures, we intend to establish the national performance rates of each of these measures as "floors", such that the performance standards will never be lower than those set for the previous year; even if provider/facility performance -- and therefore the national performance rate -- fails to improve, or even declines, over time. This will better ensure that the quality of ESRD patient care will continue to improve over time. Furthermore, section 1881(h)(2)(A) of the Act requires that the measures include, to the extent feasible, measures on patient satisfaction, as well as such other measures that the Secretary specifies, including iron management, bone mineral metabolism (i.e. calcium and phosphorus), and vascular access. CMS is currently developing measures in each of the areas specified in section 1881(h)(2)(A) of the Act and is also moving forward with developing additional measures such as Kt/V, access infection rate, fluid weight management, and pediatric measures. CMS expects that the new quality measures and performance standards will help to drive quality improvements for dialysis services.

Under this Quality Incentive Program (QIP), CMS is required to develop a methodology for assessing the total performance of each provider of services and renal dialysis facility based on performance standards with respect to measures that fall within specific categories described in MIPPA 153(c) Section 1881(h)(2)(A). CMS must also establish performance standards for the selected measures, performance periods, and a methodology for assessing the total performance of each provider/facility based on the performance standards. CMS will accomplish this through rulemaking, as noted above. In addition, as part of this program, CMS must develop procedures for making performance information available to the public, as well as procedures for ensuring that providers/facilities have an opportunity to review the information that is to be made public. A monitoring and evaluation contractor will assist CMS in monitoring the quality and access to care for beneficiaries under the ESRD Prospective Payment System (PPS) and QIP.

PROGRAM: PRIVATE HEALTH INSURANCE

Measure	FY	Target	Result
PHI1.1: Percent of eligible individual health insurance market plans reporting data that is accurate and displayed on HealthCare.gov 2010 Baseline = 56%	*2012*	85%	Oct 15, 2012
	2011	80%	Oct 15, 2011
PHI1.2: Number of daily "hits" on the HealthCare.gov online portal 2010 Baseline = 6,150 hits	*2012*	12,300 hits	Oct 15, 2012
	2011	9,225 hits	Oct 15, 2012

Measure	Data Source	Data Validation
PHI1.1	CMS data collection (HIOS and Content Management Portal)	Developmental
PHI1.2	CMS data collection	

PHI1: Increase the effectiveness and utilization of HealthCare.gov

The establishment of HealthCare.gov is a significant milestone in health reform and will help expand the visibility and use of health insurance coverage information, empowering individual consumers and small businesses to make informed decisions when purchasing coverage. The Affordable Care Act required the establishment of a web portal – now named HealthCare.gov – through which individuals and small businesses can identify affordable health insurance options that may be available to them and can obtain pricing and benefits information related to such options. Previously, individuals and small businesses often faced significant challenges in identifying and obtaining affordable health insurance and information about coverage options was sometimes misleading or nonexistent.

The portal will make it easy for consumers and small businesses to compare health insurance plans in both the public and private sectors and find other important health care information from more than 7,500 private, State-authorized insurance plans. CMS's Health Insurance Oversight System (HIOS) collects issuer and product information directly from issuers, as well as aggregated data from the States. CMS has begun comparative analyses to determine how the number and type of insurers reporting data through the HIOS system compare to insurers captured in third party databases, such as those of the National Association of Insurance Commissioners and AM Best, an Independent Financial Rating Agency.

PHI1.1: This measure is an indicator of the website's success in capturing market data for use by its target audience. By tracking the percent of State-authorized plans that are reporting an accurate representation of their products, CMS will be able to understand the completeness of the data it offers to the public.

CMS will create baseline measures to evaluate insurer information captured through HIOS, identify outliers, and examine insurers that are not within normal parameters. This will allow CMS to accurately and efficiently identify what companies, products and plans are available in the market, and if they are accurately and properly represented on the Healthcare.gov Insurance Finder. CMS staff will analyze the data provided by insurance companies, create

baseline metrics to test the data against, and then further analyze any outliers to assure that the information regarding pricing and benefits accurately reflects what is available and is the best information we can provide to consumers.

PHI1.2: This measure tracks the numbers of times HealthCare.gov is accessed by an outside computer (or number of "hits") and is an indicator of the website's success in reaching its target audience. As the public becomes more aware of the website and begins to access it in search of information, the number of hits will increase.

CMS will continue to conduct consumer social marketing research to ensure that the web portal conveys information in a way that makes sense to consumers. CMS staff will conduct periodic analyses related to benefits and pricing, and will continually evaluate the best way to disseminate information to the public. CMS works with staff members from the Assistant Secretary for Public Affairs (ASPA) who have expertise in providing these services and intends to continue to evolve the website to meet the needs of as many consumers as possible. Included in these efforts are plans to create a mobile version of the Healthcare.gov Insurance Finder for smart phones, as well as continuing to grow social media and constantly add fresh and relevant content to Healthcare.gov.

Measure	FY	Target	Result
PHI2: Number of young adults ages 19 to 25 who are covered as a dependent on their parent's insurance policy 2010 Baseline = 5.7 Million	*2012*	7.8 million	Oct 15, 2012
	2011	7.4 million	Oct 15, 2011

Measure	Data Source	Data Validation
PHI2	Current Population Survey	TBD

PHI2: – Increase number of young adults ages 19 to 25 who are covered as a dependent on their parent's insurance policy

In order to extend coverage for a segment of the American population that is disproportionately uninsured, CMS is monitoring the implementation of a regulation that allows adult children to remain on their parents' health insurance plans through age 26. The new requirement applies to health coverage in the small group, large group, individual, and self-funded marketplace. CMS, along with the Departments of Labor and Treasury, is responsible for monitoring compliance with the new guideline and implementing the regulation.

Section 2714 of the Affordable Care Act requires group health plans and private health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children to continue to cover an adult child until the age of 26. The provision does not require a health plan or health insurance issuer to cover a child of a child receiving dependent coverage. The provision went into effect on September 23, 2010.

CMS' goal is to increase the number of adult children covered as dependents on a parent's insurance policy to 7.8 million by 2012. This number is derived from the mid-range estimate of the take-up rate for dependent coverage in the Interim Final Rule (IFR) released by CMS. The underlying data on the number of potentially-affected individuals were derived from the Current Population Survey.

CMS plans to use audits to monitor compliance with the requirement that issuers offer coverage for young adults ages 19-25.

Measure	FY	Target	Result
PHI3.1: Proportion of privately insured children ages 10-17 who received a well-child check-up in the last 12 months 2009 Baseline = 73.6%	*2012*	74.5%	July 1, 2013
	2011	74%	July 1, 2012
	2010	N/A	July 1, 2011 (Historical Actual)
PHI3.2: Colorectal cancer screening for privately insured adults age 50 – 64 2010 Baseline = TBD July 1, 2011	*2012*	67%	July 1, 2013
	2011	66%	July 1, 2012
PHI3.3: Flu shot in last year for privately insured adults age 50-64 2009 Baseline: 43.8%	*2012*	47%	July 1, 2013
	2011	46%	July 1, 2012
	2010	N/A	July 1, 2011 (Historical Actual)

Measure	Data Source	Data Validation
PHI3	National Health Interview Survey (NHIS)	NHIS is a cross-sectional household interview survey, conducted and validated by CDC.

PHI3: Increase the Percentage of Individuals who Receive the Following Affordable Care Act Targeted Clinical Preventive Services

In order to ensure that Americans are able to take full advantage of preventive care measures that will detect health problems at an early stage and allow for more effective and cost-efficient interventions, CMS is monitoring the implementation of new rules that eliminate patient cost sharing for preventive care procedures. The new requirement applies to new health coverage in the small group, large group, individual, and self-funded marketplace. CMS, along with the Departments of Labor and Treasury, is responsible for monitoring compliance with the new guideline and implementing the regulation.

Section 2713 of the Affordable Care Act requires that a new group health plan and a health insurance issuer offering group or individual health insurance coverage must provide coverage for, and not impose any cost sharing requirements on, recommended preventive health services when delivered by in-network providers. Examples of recommended preventive health services include: mammograms, colonoscopies, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

CMS will track the rate of three selected preventive services within given populations:

Well-Child Visits:

Well-child visits are a means of monitoring the healthy development of children. This measure indicates children are receiving quality care. CMS plans to provide guidance to issuers and States regarding the requirements of Section 2713, and to monitor through audits issuer compliance with the requirement that coverage for this Health Resources Services Administration (HRSA) endorsed preventive health service be offered.

Colorectal Cancer Screening:

The United States Preventative Services Task Force recommends screening for colorectal cancer (CRC) in adults, beginning at age 50 years and continuing until age 75 years. Screening for colorectal cancer can detect cancer at an earlier stage, where it is more treatable. CMS plans to provide guidance to issuers and States regarding the requirements of Section 2713 and to monitor through audits issuer compliance with the requirement that coverage for this preventive health service be offered.

Flu Shots for Adults:

The CDC recommends that adults receive an annual flu shot every fall or winter. CMS plans to provide guidance to issuers and States regarding the requirements of Section 2713 and to monitor through audits issuer compliance with the requirement that coverage for this preventive health service be offered.

Measure	FY	Target	Result
PHI4.1: Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning process 2010 Baseline = 0	*2011*	50 States +DC	January 31, 2012
PHI4.2: Number of States that have the necessary legal authority to establish and operate an Exchange that complies with Federal requirements 2010 Baseline = 0	*2012*	50 States +DC	January 31, 2013
PHI4.3: Number of States in which there is an agreement drafted regarding coordination with State Medicaid, Department of Insurance and applicable State health subsidy programs, as appropriate 2010 Baseline = 0	*2012*	50 States +DC	January 31, 2013
PHI4.4: Number of States in which an information infrastructure plan is developed that assesses existing information systems, identifies gaps and needs, and proposes strategies to achieve seamless eligibility and enrollment 2010 Baseline = 0	*2012*	50 States +DC	January 31, 2013

Measure	Data Source	Data Validation
PHI4	CMS Program Data Quarterly reporting from State grantees.	CMS will report on its activities with States and the Federally-operated Exchange. Project Officers will continually monitor each State's progress against the performance measures. Data will be validated through CMS project officer review of quarterly grantee reports and corroborated with project officers' knowledge of grantees' planning and establishment activities

PHI4: Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Healthcare Insurance Exchanges and Implementing Medicaid Expansion

Note: As Health Insurance Exchanges (Exchanges) and Medicaid expansion will not be fully in place until 2014, CMS is reporting on the process measure below in the interim. This interim measure tracks CMS's progress towards setting up the Exchanges that are instrumental in expanding health insurance coverage. Tracking the proportion of residents with health insurance allows CMS to track its progress towards achieving the goal of providing quality, affordable health insurance to all Americans.

Number of States in which the following key milestones for the establishment of Exchanges, either State or Federally-operated, have occurred:

1. Stakeholder consultation is performed to gain public input into Exchange planning process. [FY 2011 Target]
2. The necessary legal authority exists to establish and operate an Exchange that complies with Federal requirements. [FY 2012 Target]
3. Agreement drafted regarding coordination with State Medicaid, Department of Insurance and applicable State health subsidy programs, as appropriate. [FY 2012 Target]
4. Information infrastructure plan developed that assesses existing information systems, identifies gaps and needs, and proposes strategies to achieve seamless eligibility and enrollment. [FY 2012 Target]

In addition, we will establish financial integrity and auditing protocols for Exchange in 2013.

Exchanges are a keystone of the health insurance reform provided by the Affordable Care Act of 2010. The Affordable Care Act provides each State with the option to set up an Exchange, or to have the Federal government set up an Exchange in that State. An Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers.

Although States are at various stages of readiness to operate Exchanges, CMS and all States that elect to establish their own Exchanges will undertake significant work to prepare for open enrollment prior to January 1, 2014. Section 1311 of the Affordable Care Act (P.L. 111-148) provided amounts necessary to enable the Secretary to award Planning and Establishment Grants to States no later than March 23, 2011 and allowed for renewal of grants through January 1, 2015, at which time Exchanges will be self-sustaining. This funding will allow for the completion of the work necessary to develop policies, establish a governance structure, build

information technology (IT) systems, develop marketing and consumer outreach campaigns, and the other work necessary to establish an Exchange. Continuation of funding under the grants is contingent upon States meeting specific milestones, such as the ones outlined in this goal. In the event that a State does not implement its own Exchange, CMS will perform the necessary work to establish a Federally-operated Exchange.

1: Stakeholder consultation is performed to gain public input into Exchange planning process.

Section 1311(d)(6) of the Affordable Care Act requires that each Exchange consult with a variety of key stakeholders in the planning, establishment and ongoing operation of Exchanges. Successful Exchanges will undertake multi-faceted outreach to inform the public of their services and coverage options and will work closely with a variety of stakeholders including, but not limited to consumer advocates, representatives of small businesses, health plans, State Medicaid offices, State Departments of Insurance, and health care consumers. Like the State-operated Exchange, the Federally-operated Exchange will partner with stakeholder groups in the establishment of the Exchange.

2: The necessary legal authority exists to establish and operate an Exchange that complies with Federal requirements

Section 1321(b) of the Affordable Care Act requires that by January 1, 2014, a State that elects to establish an Exchange must adopt and have in effect the Federal standards for Exchanges that will be issued by HHS or that the State have in effect a State law or regulation that implements these standards. Each State should ensure that it provides its Exchange with the authority necessary to meet all the Exchange requirements of the Affordable Care Act. The State must determine all the necessary steps it must take to pass enabling legislation/regulations as necessary to establish its Exchange. In the case of the Federally-operated Exchange, the Affordable Care Act and forthcoming regulations meet this requirement.

3: Agreement drafted regarding coordination with State Medicaid, CHIP, Department of Insurance and applicable State health subsidy programs, as appropriate.

The Exchange, be it State or Federally-operated, will need to work closely with the State Medicaid program in order to ensure seamless eligibility verification and enrollment processes across the two programs, as required by Section 1413 of the Affordable Care Act. To reach this goal, the Exchange and the State Medicaid agency will need to closely partner on systems development and operational procedures. Each Exchange will also need to work closely with the State Department of Insurance in order to successfully carry out the activities of the Exchange. The State Department of Insurance will oversee the insurance markets in which the Exchange offers qualified health plans. In addition, the State Department of Insurance may be the State entity that processes consumer coverage appeals and complaints. Working with the State Department of Insurance will be essential in addressing the financial stability of insurance companies, certification of plans, rate review, State licensure, solvency, and market conduct. Key issues, such as adverse selection, related to the functioning of the individual and small group markets inside and outside the Exchange will be important to Exchange success.

4: Information infrastructure plan developed that assesses existing information systems, identifies gaps and needs, and proposes strategies to achieve seamless eligibility and enrollment.

As a necessary part of the design and development of an IT infrastructure, the Exchange, be it State or Federally-operated, must conduct an IT Gap Analysis on the technical architecture and standards such as HIPAA, Security, and Section 1561 recommendations of the Affordable Care Act.

Measure	FY	Target	Result
PHI5: Number of individuals enrolled in the Pre-existing Condition Insurance Plan (PCIP) program nationally	*2012*	TBD	Dec 31, 2012
	2011	Establish Baseline	Dec 31, 2011

Measure	Data Source	Data Validation
PHI5	Enrollment reports provided by States and the National Finance Center (NFC)	Quality checks are run by CMS and CMS contractors for State-run PCIP monthly reporting and Federally-run PCIP reporting.

PHI5: Increase the Number of Individuals Enrolled in the Pre-existing Condition Insurance Plan (PCIP) Program Nationally

Established under the Affordable Care Act, the PCIP program was designed to provide comprehensive health insurance coverage for individuals with pre-existing conditions in all 50 States and the District of Columbia who have been without health coverage for at least six months. Most of these individuals have had access to few, if any, comprehensive and affordable health insurance options in their States prior to the establishment of the PCIP program. This measure will focus on the PCIP program's enrollment. The baseline will be based on FY 2011 enrollment. Once the baseline is established, future enrollment targets will be determined for FY 2012 and FY 2013.

The enrollment figure will represent enrollees in the 27 State-run PCIP programs and the Federally-run PCIP program operating in 23 States plus the District of Columbia. Several reports have estimated the likely number of enrollees in the PCIP program by using survey data and applying a participation rate to the approximate number of people eligible for the PCIP program. As cited in the 45 CFR, there are several sources citing different enrollment projections scenarios, including the Congressional Budget Office and the CMS Office of the Actuary. Estimates from these sources indicate that 200,000 to 400,000 could be served by this program.[7] A baseline for this measure will be determined using FY 2011 enrollment data.

In the first six months of the program, efforts were focused on establishing the program within the 90-day statutory window required under the Affordable Care Act. The State-run PCIP program and Federal-PCIP program worked on a compressed implementation schedule to erect systems for this new and unique program. For example, PCIP program called for new claims adjudication, enrollment and premium collection systems to be developed.

Starting on January 1, 2011, new plan options and reduced premiums became available in the Federally-run PCIP program. Some State-run PCIP programs are also redesigning their benefits and premiums to increase enrollment and make the program more attractive to eligible individuals. CMS expects enrollment to increase as it undertakes a more focused and targeted education campaign.

[7] 45 CFR Part 152, Pre-Existing Condition Insurance Plan Program; Interim Final Rule, Department of Health and Human Services. http://edocket.access.gpo.gov/2010/pdf/2010-18691.pdf

CMS is working collaboratively with States, other Federal agencies, and stakeholders to increase enrollment in the PCIP program. These efforts include:

- CMS will work with Social Security Administration (SSA) to communicate the availability of the PCIP program to Supplemental Security Income (SSI) applicants and SSA-approved individuals who are in the 24-month waiting period for Medicare coverage.

- CMS will partner with States so that health insurance issuers include information on the PCIP program in any denial letters.

- CMS will educate stakeholder and disease groups about the PCIP program's eligibility requirements and plan benefits. This action will ensure that PCIP-eligible individuals who make use of these resources will receive program information from alternate and trusted sources.

Measure	FY	Target	Result
PHI6: Number of consumers who are helped by consumer assistance programs	*2012*	TBD	April 2013
	2011	TBD	April 2012

Measure	Data Source	Data Validation
PHI6	TBD	TBD

PHI6: Increase the number of consumers who are helped by consumer assistance programs

The Affordable Care Act provided for grants to States to establish, expand, or provide support for the establishment of independent Consumer assistance programs. These programs help consumers navigate insurance choices and subsidies to find the most affordable health insurance coverage that meets their needs; assist consumers with enrollment into health coverage; collect data on consumer inquiries and complaints to identify problems in the marketplace; educate consumers on their rights and responsibilities, including new protections provided by the Affordable Care Act; and assist health consumers with filing complaints and appeals.

This measure will be used to evaluate the ability of CMS to maximize the number of consumers that receive help in navigating the complex health insurance coverage marketplace. Achieving future targets will include not only assisting consumer assistance programs, but increasing the visibility and awareness of these programs so that consumers know to contact the programs when they need assistance. CMS is working to increase the visibility of these programs.

PROGRAM: MEDICAID

Measure	FY	Target	Result
MCD1.1: Estimate the Payment Error Rate in the Medicaid Program	*2012*	Report rolling average error rate in the 2013 AFR based on States measured in 2011-2013. Meet or exceed the target error rate of 6.4%.	Nov 30, 2013
	2011	Report rolling average error rate in the 2012 AFR based on States measured in 2010-2012. Meet or exceed the target error rate of 7.4%	Nov 30, 2012
	2010	Report rolling average error rate in the 2011 AFR based on States measured in 2009-2011. Meet or exceed the target error rate of 8.4%.	Nov 30, 2011
	2009	Report baseline rolling average error rate based on States measured in 2007 – 2009. Develop baseline and future targets.	9.4% Target met
	2008	Report national error rates in the FY 2009 AFR based on 17 States measured in FY 2008.	Target met
	2007	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 AFR.	Target met
MCD1.2: Estimate the Payment Error Rate in the Children's Health Insurance Program (CHIP)	*2012*	Report national error rates in the 2013 AFR based on 17 CHIP States measured in FY 2012.	Nov 30, 2013
	2011	Report national error rates in the 2012 AFR based on 17 CHIP States measured in FY 2011.	Nov 30, 2012
	2010	Publish Final Regulation in accordance with Section 601 of CHIPRA.	Target met. Final Regulation published 8/11/2010.
	2009	Publish Final Regulation in accordance with Section 601 of CHIPRA.	Target not met. Final Regulation delayed until FY 2010.
	2008	Report national error rates in the FY 2009 AFR based on 17 CHIP States measured in FY 2008.	Target not met. Due to legislation, calculation of error rates suspended pending publication of final regulation.

Measure	FY	Target	Result
	2007	Begin full implementation of measuring FFS, managed care and eligibility in 16 States (excludes Tennessee). Report national error rate in FY 2008 AFR.	Target met

Measure	Data Source	Data Validation
MCD1.1 MCD1.2	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors 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.

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

The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for-service, managed care, and eligibility components of both Medicaid and the Children's Health Insurance Program (CHIP). 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 the Department of Health and Human Services Agency Financial Report (AFR) reporting.

Each year, 17 States participate in the PERM 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 were measured again in FY 2009.

CMS reported a preliminary Medicaid fee-for-service error rate in the 2007 AFR and the final error rate in the 2008 AFR, both based on FY 2006 claims data. In FY 2007, we began full implementation of the PERM program in Medicaid and CHIP and reported the first CHIP error rates in the 2008 AFR. Likewise, we reported Medicaid error rates in the 2009 AFR as well as a 2-year weighted average national error rate that includes data from the past two cycles. The 2010 AFR reported the three-year weighted average national error rate that included data reported in the AFR for 2008, 2009, and 2010. The reported three-year rolling error rate is 9.4 percent. The 2010 AFR also reported weighted national error components rates which are as follows: Medicaid FFS: 4.4 percent; Medicaid managed care: 1.0 percent; and Medicaid eligibility: 5.9 percent. Going forward, the reported rate will remain a "rolling average" of the most recent three years.

For the CHIP PERM, CMS was required by Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to develop and publish a new final regulation. CHIPRA prohibits CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new PERM final rule is in effect. Therefore, CMS temporarily suspended the CHIP PERM reviews. Additionally, CHIPRA provides States measured for FY 2007 or FY 2008 the option to elect to accept the CHIP PERM error rate determined in whole or in part on the basis of data for the fiscal year for which they were measured (FY 2007 or FY 2008) or these States may elect instead to consider its CHIP PERM measurement for

FY 2010 or FY 2011 as the first fiscal year for which PERM applies to the State. This will impact the baseline error rate for CHIP.

The new final rule for PERM required by CHIPRA was published on August 11, 2010 and was effective on September 10, 2010. CMS will resume CHIP measurement with the FY 2011 cycle and establish a baseline in the FY 2014 AFR. After establishing a baseline, HHS will set out-year reduction targets.

In addition to the ongoing error rate measurement activities, in response to Executive Order 13520 *Reducing Improper Payments and Eliminating Waste in Federal Programs*, CMS is working with States to study highly vulnerable areas in Medicaid. Initial results will be reported in 2011. In addition, CMS is reporting improper payment information on www.paymentaccuracy.gov.

Trend analysis:

CMS has now measured improper payments in Medicaid in every State. Error data from the first three cycles reveals certain findings:

- State Medicaid claims processing systems appear to make most individual payments accurately, with very few data processing errors detected in any of the first three PERM cycles. Many of the data processing errors identified were pricing errors, where the amount paid was different from the amount that should have been paid, but the claim itself was not in error. Most other data processing errors are due to non-covered service errors where the service is not covered by Medicaid or the provider is not registered or licensed according to regulation.
- While the PERM error rates consider both underpayments and overpayments as improper, that is, the absolute value of underpayments is counted in the error rate and they do not offset overpayments, underpayments account for a substantially smaller proportion of payment errors than overpayments, averaging less than 10 percent of projected dollars in error each year. States also do not appear to be systematically denying claims improperly.
- States make vastly fewer errors processing managed care payments than fee-for-service payments. This would be expected, as the number of payees for managed care is smaller—typically a few health plans versus thousands of individual providers for FFS—and the types of payments made are less varied—typically a few dozen all-inclusive rates for managed care, versus individual fees for thousands of different services and procedures in FFS.
- Eligibility errors contribute significantly to the Medicaid payment error rate. Eligibility errors include both errors due to beneficiaries who are receiving services but are not eligible and beneficiaries for whom States are not able to verify eligibility.

In order to reduce the national Medicaid error rate, States are required to develop and submit corrective action plans to CMS. CMS works with the States to develop and implement corrective actions to:

- Reduce eligibility errors caused by caseworker errors and lack of internal controls;

- Reduce medical review errors caused by providers not submitting required documentation or not recording sufficient information in records to meet States' policy requirements; and
- Correct data processing errors caused by untimely updates of fee schedules in claims processing systems, non-current provider registrations and non-functioning system edits.

Measure	FY	Target	Result
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.	*2011*	Goal discontinued	N/A
	2010	10 States	Mar 31, 2011
	2009	9 States	9 States (Target Met)
	2008	8 States	8 States (Target Met)
	2007	0 States	0 States (Target Met)

Measure	Data Source	Data Validation
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.

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), a 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 met targets in both FY 2008 and FY 2009 by completing eight QARs in FY 2008 and one QAR in FY 2009, for a total of nine QARs in FY 2009 since FY 2007. The FY 2010 target is to complete ten QARs and CMS is in the process of completing the QAR for 2010 to meet this target.

Title IV of the *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA) (P.L. 111-3), Strengthening Quality of Care and Health Outcomes, focuses on national initiatives to strengthen efforts to measure and improve quality of care in State Medicaid and CHIP programs. CHIPRA requires that a national pediatric quality measures program will be established at CMS. CMS partnered with the Agency for Health Care Research and Quality (AHRQ) to develop an initial core measure set for States to voluntarily collect and report, which was published in December 2009. This voluntary reporting will subsequently inform the establishment of a national pediatric quality measures program designed to build a system of high-quality care in States.

The QARs were instrumental in assessing barriers and gaps in quality measurement and improvement within States, however as CMS works to implement more national quality initiatives under CHIPRA, the Recovery Act, and the Affordable Care Act, CMS will terminate this Medicaid Quality Goal (which focuses on individual State efforts) after 2010, as States transition to new national quality reporting mechanisms. CMS has developed a new measure to address child health quality in both Medicaid and CHIP (see MCD6) and a new measure to address adult health quality in Medicaid (MCD8).

Measure	FY	Target	Result
MCD3: Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	*2012*	Goal discontinued	N/A
	2011	47.1%	Mar 31, 2012
	2010	47%	Mar 31, 2011
	2009	46%	47.7% (Target exceeded)
	2008	45%	45.9% (Target exceeded)
	2007	Set Baseline	45.6%

Measure	Data Source	Data Validation
MCD3	Medicaid Managed Care Enrollment Report - The report is composed annually, using States reported data.	The information is collected from State Medicaid Agencies with the assistance of CMS Regional Offices. Data validation is jointly performed by 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.

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.

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

The Medicaid MCO enrollment trend may be leveling off because approximately 71 percent of the Medicaid population is already enrolled in some type of managed care entity as noted in the 2008 Medicaid Managed Care Enrollment Report. The rest of the Medicaid population are either in extremely rural or frontier areas, or are institutionalized. While the Federal government does not control whether States elect to use Medicaid managed care contracts or any specific type of managed care entity in delivering health care to their populations, we will continue to provide parameters and guidelines to assist States in operating their Medicaid programs efficiently and cost effectively.

While it can be argued that enrolling Medicaid beneficiaries in comprehensive Medicaid managed care organizations (MCOs) provides financial predictability and easier outcome measurements for States, CMS does not express a programmatic preference for a managed care delivery system. Because MCO enrollment targets for this goal increase enrollment year after year, CMS will be faced with the real possibility of not achieving this goal in the near future. Given major efforts underway to develop a system of quality measurement and reporting for children and adults in Medicaid (as required by CHIPRA and the Affordable Care Act), CMS will discontinue this measure to refocus our measurement efforts in those areas.

Measure	FY	Target	Result
MCD4: Percentage of Beneficiaries who Receive Home and Community-Based Services	*2012*	1% over prior FY	Sep 30, 2014
	2011	1% over prior FY	Sep 30, 2013
	2010	1% over prior FY	Sep 30, 2012
	2009	3% over prior FY	Sep 30, 2011
	2008	3% over prior FY	+8.3% over FY 2007 (1,053,733 Beneficiaries) (Goal exceeded)
	2007	2.1%	Baseline (972,912 Beneficiaries)

Measure	Data Source	Data Validation
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 difference between prior year and current year beneficiaries, and the denominator is the prior year beneficiaries.	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.

MCD4: Percentage of Beneficiaries who Receive Home and Community-Based Services
This measure was developed during an assessment of the Medicaid Program in 2006 and was a new measure for FY 2008. There is evidence that home and community-based services (HCBS) are more cost-effective than institutional care for some beneficiaries. 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 Affordable Care Act includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in the community, including a new option for States to provide HCBS; improvements to an existing State plan option to provide HCBS; additional financial incentives for States to rebalance the provision of long-term care to include HCBS; an extension of and improvements to the "Money Follows the Person Rebalancing Demonstration"; and an extension of the "spousal impoverishment" protections to people who receive HCBS. We believe that the new opportunities made available through the Affordable Care Act will further enhance State offerings in HCBS.

These new authorities may serve individuals already accounted in these figures, but we believe many authorities will provide cost effective alternatives to care for individuals heretofore unable to access HCBS (such as individuals with mental health or individuals declining but not yet at an institutional level of care). Beneficiaries experience more person-centered care and improved quality of life under HCBS compared with institutional services at the same level of care.

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; and, technical assistance and education for States concerning other authorities for HCBS.

The percentage increase of HCBS waiver enrollment for the FY 2010 target remains low as compared to prior years in response to updated MSIS enrollment information that demonstrates a downward trend in the growth of persons enrolled in HCBS waivers. This trend is due in large part to the presence of State budget deficits that reduce the capacity of State governments to appropriate additional funds to serve new waiver participants. The much slower than expected growth in HCBS can also be attributed to slower than expected transitions of persons from institutions to the HCBS waivers as part of the MFP demonstration. Given the approximate two-year lag in the recovery of State budgets post recession, even a 1 percent growth in enrollment may be difficult to achieve.

The baseline for this measure is 2.1 percent and reflects the percent of beneficiaries who received home and community-based services in 2007. The 2007 number excludes individuals who were in 1915(b)/(c) concurrent waivers. CMS exceeded its FY 2008 target by increasing the number of beneficiaries who received home and community-based services by 8.3 percent over FY 2007.

Measure	FY	Target	Result
MCD5: Percentage of Section 1115 demonstration budget neutrality reviews completed	*2012*	98%	Mar 31, 2013
	2011	98%	Mar 31, 2012
	2010	96%	Mar 31, 2011
	2009	94%	100% (Target exceeded)
	2008	92%	100% (Target exceeded)
	2006	N/A	100% (Baseline)

Measure	Data Source	Data Validation
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.

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

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 that 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 result for targeted reviews was 100 percent. CMS plans targeted reviews over three fiscal years to take advantage of reviews associated with demonstrations that States are applying to renew, and thus undergoing a budget neutrality review. CMS scheduled nineteen allotment and budget neutrality reviews in FY 2009 and completed review of 100 percent of the scheduled reviews. All were found to be budget/ allotment neutral. The FY 2012 target is to complete 98 percent of the targeted budget neutrality reviews to help ensure the demonstrations are operating within the agreed upon budget neutrality limits and will be available March 2013. While these targets are lower than the FY 2006 baseline, 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.

Measure	FY	Target	Result
MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives	*2012*	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures.	March 2013
	2011	Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	March 2012

Measure	Data Source	Data Validation
MCD6	Developmental. The core set of measures required under CHIPRA was published in December 2009. CMS will initially use the automated web-based system - CHIP Annual Reporting Template System (CARTS) for the reporting of quality measures developed by the new program. This is the same system that was used for the CHIP Quality GPRA goal that was discontinued after FY 2010 (MCD2).	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.

MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives

The purpose of this measure is to improve children's health care quality across Medicaid and CHIP. Section 1139A of the Social Security Act establishes a national pediatric quality measures program. The first step in the development of this program was the publication of a core set of quality measures in December 2009 for public comment. The core set consists of twenty-four quality measures for children, including three of the CHIP clinical performance measures that States reported under the discontinued CHIP Quality performance measure (CHIP2). While the use of the core set is voluntary for States, CMS is encouraging all States to use and report on the core set in order to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP programs.

Feedback from the public comments was used to enhance the initial core set of measures and to target technical assistance accordingly. To ensure the availability of complete, tested and validated specifications for the measures and domains identified in the public notice, technical clarifications and substitutions were made for the measures. The initial core set is now finalized and released to States via a State Health Official letter in February 2011.

In late fall of 2010, CMS provided States with instructions for annual reporting and held a webinar in December 2010 to demonstrate how to use and submit data to CMS via the CHIP Annual Reporting Template System (CARTS). Additionally, CMS released the CHIPRA Initial Core Set Technical Specifications Manual in February 2011, which contains the technical instructions for collecting and calculating the initial core set measures for Medicaid and CHIP programs. CMS will implement a national technical assistance program, which is anticipated to begin in early 2011, to support States in understanding how to collect, report, and analyze the core measures to target improvements in the quality of care for children.

Recognizing that State reporting of core set measures to CMS is voluntary and that for many States implementing the core sent may be resource intensive, CMS revised its targets to reflect a more phased approach. The FY 2011 target is for 70 percent of States to report on at least one measure in the core set of quality measures. The FY 2012 target will be for 80 percent of States to report on at least five of the quality measures in the core set. First, reporting on the set of quality measures represents the first time States will focus on a common set of quality measures using standardized specifications for calculating the measures. States may require sufficient time to re-program systems, identify data sources and conduct the appropriate contracting to collect and report the quality measures. Additionally, States may require technical assistance to facilitate collection and reporting. Further, the core set of quality measures were finalized in February 2011 and contracting for a technical assistance entity was delayed. The target for fiscal 2011 was revised downward in order to give States and CMS time to prepare for collecting and reporting the core set measures.

Initial State reporting on these measures will be submitted through CARTS, which is currently used in the CHIP program. Data will be available to CMS annually by March 31st of the year following the reporting period. CMS will continue to evaluate options to improve State quality reporting as Agency information systems are enhanced. In the long term, we intend to develop and publish health quality measures for Medicaid and CHIP, specifically focusing on areas of priority such as asthma, obesity, dental care, prenatal care, and immunization.

This performance measure also aligns with the Medicare & Medicaid Electronic Health Record (EHR) Incentive Program. Providers in Medicaid will qualify to receive incentive payments for adopting, implementing and upgrading EHRs in the first year, and meaningful use of certified electronic health record technology in future years. As part of meaningful use, providers will be required to report data on clinical quality measures. Three of the initial core set measures (childhood immunization status; weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents; and Chlamydia screening) are identified as meeting the meaningful use criteria for quality measures under the EHR Incentive Program. CMS will partner with the Office of the National Coordinator to develop specifications, where appropriate, for remaining CHIPRA core set measures for inclusion in subsequent Health Information Technology for Economic and Clinical Health rulemaking.

CMS is developing a new measure to improve adult health quality in Medicaid (MCD 8). The Affordable Care Act called for the establishment of an adult quality measures program. A recommended core set of measures that are applicable to Medicaid eligible adults was published in the Federal Register in December 2010 and an initial core set of adult health quality measures are to be published by January 1, 2012.

Measure	FY	Target	Result
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), who receive any preventive dental service.	*2012*	+2% over baseline	May 31, 2013
	2011	Set baseline	May 31, 2012

Measure	Data Source	Data Validation
MCD 7	Developmental. CMS will use the data reported by States on line 12b, 12d and 12 f of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) annual report, the CMS-416, for the reporting of this measure for Medicaid eligible children and children receiving dental services through a Medicaid expansion CHIP program. Lines 12b and 12f report the number of children who receive preventive dental services by a dental or other licensed professional. CMS will also use the data collected on the CHIP annual report, G. Dental Benefits to collect data for children in a stand-alone CHIP program.	The data for collecting information on preventive services is currently included on the CMS 416. The data for preventive dental services for the CHIP population as well as the data for dental sealants for both the Medicaid and CHIP enrollees will be collected for the first time starting in fiscal year 2010 and reported in 2011.

MCD7: Improve Access to and Utilization of Oral Health Care Services for Children covered by Medicaid or the Children's Health Insurance Program

Despite considerable progress in pediatric oral health care in recent years, tooth decay remains the single most preventable common chronic disease of childhood. Tooth decay can cause significant pain and loss of school days and lead to infections and even death. While all children covered by Medicaid or CHIP have coverage for dental services, access to these services remains a concern. While there is considerable variation across States, the data from the FY 2008 CMS-416 shows that the rate at which children enrolled in Medicaid had a preventive oral health care visit within the year averaged 34 percent across States. The purpose of this performance measure is to increase the number of children and adolescents enrolled in Medicaid or CHIP who receive preventive dental service. The FY 2012 target is to increase the national rate of low income children and adolescents, who are enrolled in Medicaid or CHIP, who receive any preventive dental service by 2 percent over the FY 2011 baseline.

CMS is undertaking many activities to assist States in increasing access. In 2010, CMS performed eight State Medicaid dental program reviews focused on practices and program innovations that have successfully increased utilization of dental care services in those States. Some of the innovations and initiatives identified include: partnerships and collaboration among State partners and stakeholders; collaboration with dental schools and loan repayment programs; increased reimbursement; and simplifying administrative processes. CMS has shared the results of these reviews with all States and has posted a summary on the CMS website. CMS also held two collaboration meetings with States in the fall of 2010 to discuss the dental goals and to obtain comments from States on the CMS dental strategy. The findings from the eight State reviews as well as findings from focus groups were shared at those meetings. In addition, CMS is committed to providing technical assistance to States as they work to reach this goal. In order to assist States, each State will be asked to prepare a dental action plan that will identify what the State has already done to increase access and what they intend to do to meet the targets. CMS will continue to share innovative practices and initiatives with States as they are identified.

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	*2012*	Publish core set of adult quality measures in the Federal Register	January 2012
	2011	Publish recommended core set of adult quality measures in the Federal Register	Goal met.

Measure	Data Source	Data Validation
MCD8	Developmental. For FY 2011 and FY 2012, the data source will be the link to the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. By January 1, 2013, CMS will provide States with technical specifications for reporting information on the adult quality core measures set, coupled with technical assistance to increase the feasibility of reporting. Information voluntarily reported to CMS by the end of 2013, will serve as the data source for assessing States' progress in reporting standardized adult quality measurement data to CMS.	Developmental. For FY 2011 and FY 2012, the data validation will be the link to the core set in the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978

MCD8: Improve Adult Health Care Quality Across Medicaid

The Affordable Care Act (P.L. 111-148) aims to address challenges to the effectiveness and efficiency of our current health system by providing ways to improve the delivery of quality health services for all Americans. Section 2701 of the Affordable Care Act, which added section 1139B(a) to the Social Security Act (the Act), requires the Secretary of the Department of Health and Human Services to develop and publish, for public comment by January 1, 2011, an initial recommended core set of quality measures for Medicaid-eligible adults. CMS met its deadline and published the recommended core set of adult quality measures in the Federal Register on December 30, 2010.

CMS provides Medicaid health care coverage to nearly 60 million people, of whom approximately half are adults twenty-one and over. The Affordable Care Act will extend coverage to the nation's uninsured population, with a projected 82 million persons anticipated to be covered by Medicaid or CHIP by 2019[8]. The core set measures will serve as the groundwork for creating a standardized approach to better understand the quality of care that adults in Medicaid receive, improve how this care is measured, and create opportunities to impact health outcomes.

Similar to the children's quality goal (MCD6), which measures development of a core set of children's quality measures, this goal focuses on creating a core set of adult quality measures for voluntary use by States to assess the care received by adults in the Medicaid program. By encouraging States to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid. Drawing from the lessons of the children's quality measurement implementation, CMS will establish quantifiable goals that target increased State reporting of the adult quality measures. In addition, the Secretary must establish a Medicaid Quality Measurement Program for Adult Quality Measures by January 1, 2012. The Quality Measures Program will develop,

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[8] https://www.cms.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp
https://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf

test, and validate new evidence-based measures. The Secretary will publish annual updates to the initial core set of adult quality measures.

This performance measure aligns with the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program under the Recovery Act of 2009. Providers in Medicaid can qualify to receive incentive payments for adopting, implementing, and demonstrating meaningful use of certified electronic health record technology. To comply with meaningful use requirements, providers may report data on clinical quality measures. Twelve of the measures proposed in the initial core set of adult measures are identified as meeting the meaningful use criteria for quality measures under the EHR Medicaid Incentive Program.

PROGRAM: MEDICARE BENEFITS

Measure	FY	Target	Result
MCR1.1a: Percent of beneficiaries in Medicare Advantage (MA) who report access to care	*2012*	90%	Dec 31, 2012
	2011	90%	Dec 31, 2011
	2010	90%	91% (Target Exceeded)
	2009	90%	90% (Target Met)
	2008	90%	90% (Target Met)
	2007	Set Baseline	90% (Baseline)
MCR1.1b: Percent of beneficiaries in Medicare Fee-for-Service (MFFS) who report access to care.	*2012*	90%	Dec 31, 2012
	2011	90%	Dec 31, 2011
	2010	90%	90% (Target Met)
	2009	90%	90% (Target met)
	2008	90%	90% (Target Met)
	2007	Set Baseline	91% (Baseline)
MCR1.2a: Percent of beneficiaries in MA who report access to prescription drugs.	*2012*	91%	Dec 31, 2012
	2011	91%	Dec 31, 2011
	2010	91%	93% (Target Exceeded)
	2009	91%	93% (Target Exceeded)
	2008	91%	93% (Target Exceeded)
	2007	Set Baseline	93% (Baseline)
MCR1.2b: Percent of beneficiaries in MFFS who report access to prescription drugs.	*2012*	91%	Dec 31, 2012
	2011	91%	Dec 31, 2011
	2010	91%	91% (Target Met)
	2009	90%	91% (Target Exceeded)
	2008	90%	91% (Target Exceeded)
	2007	Set Baseline	91% (Baseline)

Measure	Data Source	Data Validation
MCR1.1a MCR1.1b MCR1.2a MCR1.2b	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 4.0 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.

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

Passage of the Medicare Modernization Act (MMA) prompted modifications in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) to include measurement of experience and satisfaction with the care and services provided through the 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 MA Plans report they usually or always get needed care right away as soon as they thought they needed it
- Percent of persons with 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, baseline data on 2006 beneficiary experiences in the new plans were collected in FY 2007 and are reflected in the table preceding this discussion. The baselines were already high, and our future targets are to continue to achieve those high rates at 90 percent or over. We achieved our FY 2010 targets reflecting beneficiary experiences in 2009. Percentages in the table above are consistent with public reporting defined according to whole number measurements as reflected in Medicare.gov.

The FY 2012 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 performance on measures.

Measure	FY	Target	Result
MCR23: Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap.	*2012*	55%	January 2014
	2010	N/A	Baseline = 100%

Measure	Data Source	Data Validation
MCR23	The Prescription Drug Event (PDE) data	CMS has a rigorous data quality program for ensuring the accuracy and reliability of the PDE data. The first phase in this process is on-line PDE editing. The purpose of on-line editing is to apply format rules, check for legal values, compare data in individual fields to other known information (such as beneficiary, plan, or drug characteristics) and evaluate logical consistency between multiple fields reported on the same PDE. On-line editing also enforces business order logic which ensures only one PDE is active for each prescription drug event. The second phase of our data quality program occurs after PDE data has passed all initial on-line edits and is saved in our data repository. We conduct a variety of routine and ad hoc data analysis of saved PDEs to ensure data quality and payment accuracy.

MCR23: Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-LIS Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) amends Title XVIII (Medicare) of the Social Security Act by adding a new Voluntary Prescription Drug Benefit Program (Part D.) Since its inception, Medicare Part D has significantly increased the number of beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer total coverage. When a beneficiary has reached the plan's initial coverage limit, he/she is responsible for paying 100 percent of the prescription costs. Only once the beneficiary has reached the catastrophic limit does Medicare coverage recommence. This is known as the coverage gap. This "gap" in coverage is generally above $2,840 in total drug costs until one spends $4,550 out-of-pocket. For the 2011 benefit year, this means that the beneficiary has to pay 100 percent of the prescription costs from $2,840 to $4,550. These dollar amounts are subject to change each benefit year.

The Affordable Care Act includes provisions to reduce the out-of-pocket costs of prescription drugs for Medicare beneficiaries, including closing the coverage gap ("Donut hole"). The purpose of this performance measure is to reflect this Affordable Care Act initiative by reducing the average out-of-pocket costs paid by non-LIS Medicare beneficiaries while in the coverage gap. This new Affordable Care Act initiative requires that the coverage gap be closed completely by 2020.

In 2010, CMS provided a one-time rebate of $250 directly to any qualified Medicare beneficiary who reaches the coverage gap in any quarter of that year. This rebate program is limited to the calendar year (CY) 2010. In CY 2011, the brand-name manufacturers will provide a 50 percent discount of the negotiated price of drugs while a beneficiary is in the coverage gap. The discount will be applied at the point of sale, and 100 percent of the negotiated price would count toward the annual out-of-pocket threshold (True Out-of-Pocket Costs; TrOOP).

In addition to the discounts, CMS will increase the Medicare coverage for both generic (beginning in 2011) and brand name drugs (beginning in 2013) purchased while in the coverage gap according to a predetermined scale[1]. From 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of both generic and brand name drugs while in the coverage gap.

Measure	FY	Target	Result
MCR25: Proportion of Medicare beneficiaries, ages 50-75, who receive colorectal cancer screening.	*2012*	68%	12/2013
	2011	N/A	12/2012 (Trend)
	*2010**	N/A	N/A
	2009	N/A	67.9% (Trend)
	*2008**	N/A	N/A
	2007	N/A	63.8% (Baselines)

Measure	Data Source	Data Validation
MCR25	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.

*This question was not included in the MCBS for these years.

MCR25: Increase the Proportion of Medicare Beneficiaries, Ages 50-75, who Receive Colorectal Cancer Screening.

The purpose of this measure is to increase the awareness and utilization of the colorectal cancer screening benefit through the Medicare program. The Affordable Care Act removes the beneficiary co-pay for covered, recommended preventative services including colorectal cancer screening. The removal of the co-pay is intended to increase utilization of preventative services.

The United States Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen men and women 50 years of age until age 75 for colorectal cancer (CRC), using fecal occult blood testing, sigmoidoscopy, or colonoscopy. The USPSTF concluded that there is high certainty that the net benefit is substantial for CRC screening using fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy in adults age 50 to 75 years. The USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from CRC. The USPSTF also concluded that the benefits from screening substantially outweigh potential harms, but the quality of evidence, magnitude of benefit, and potential harms vary with each method.

The National Committee for Quality Assurance (NCQA) in "The State of Health Care Quality 2007" reports the Medicare beneficiaries enrolled in managed care health plans had a 53.3 percent CRC screening rate for 2006 based on the Health Plan Employer Data and Information Set (HEDIS) measure for CRC screening. Rates for 2004 and 2005 were 52.6 percent and 53.9 percent, respectively.

Through the use of the Quality Improvement Organizations (QIOs), efforts are ongoing to improve CRC screenings in the Medicare population. As a result of the QIOs 9th scope of work Prevention Theme, participating practices will increase Medicare beneficiaries' awareness, understanding and utilization of the CRC screening. Through the use of the electronic health records (EHRs), the Prevention Theme will engage the participating practices by implementing care management and tracking and improving their patients' receipt of the CRC screening.

Participating practices will utilize their EHRs to educate Medicare beneficiaries on the importance of disease prevention, early detection and lifestyle modifications that support a healthier life. It is expected that by the end of the 9th SOW, QIOs will show a 15 percent relative improvement in the CRC screening rate among patients of the participating practices.

Through the *Medicare & You* Handbook, the Centers for Medicare & Medicaid Services (CMS) has provided beneficiaries with information regarding the elimination of the co-payment for colorectal cancer screenings. In addition, CMS has provided beneficiaries with pamphlets explaining the Affordable Care Act through the mail; these are also available by contacting 1-800-MEDICARE or visiting Medicare.gov.

PROGRAM: CHILDREN'S HEALTH INSURANCE PROGRAM

Measure	FY	Target	Result
CHIP2: Improve Health Care Quality Across Children's Health Insurance Program (CHIP)	*2011*	Measure discontinued.	N/A
	2010	CMS will lead efforts to develop a National Quality Framework for CHIP. The target is to develop a consensus-based quality framework that States can use to create a high-quality "system" of care. States will be able to use the Framework as a guide for assessing their current quality programs and for determining next steps for future improvement.	The Affordable Care Act includes a provision to establish a National Quality Strategy by January 1, 2011. The FY 2010 target to develop a CMS national Quality Framework for CHIP was subsumed into efforts to develop a National Quality Strategy. (Target not met.)
	2009	Work with low performers. A "low performer" is any State that doesn't provide quantifiable and measurable performance measures in their FY 2006 CHIP annual report.	CMS provided technical assistance to 48 States and the District of Columbia on every section of the CHIP Annual Report – including focused assessment on the quality measures for each of those States. (Target Met)
	2008	Disseminate best practices	CMS analyzed States' responses to four clinical performance measures and communicated findings to States. Six promising practices from four States were posted to CMS website. CMS provided technical assistance to States and provided States with a reporting "checklist" on performance measures and has included CHIP performance quality improvement information in the Medicaid Quality Assistance reports provided to States. (Target Met)
	2007	Revise template to reflect State improvement efforts.	Revised template to reflect State improvement efforts. (Target Met)
	2006	25% of States reporting on 4 core performance measures.	At least 25% of States reported on four core performance measures. (Target Met)

Measure	Data Source	Data Validation
CHIP2	Beginning in FY 2003, CMS began collecting CHIP performance measures through the CHIP annual reports. In addition, CMS created an automated web-based system – CHIP Annual Reporting Template System (CARTS), 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 measures related to the CHIP core performance measures. States began reporting in CARTS, on a voluntary basis, for the CHIP 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.	CMS will monitor performance measurement data related to the CHIP core performance measures through CARTS. In addition, State performance data submitted through CARTS will be monitored to assure that individual State measures are consistent with the approved Title XXI CHIP 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.

CHIP2: Improve Health Care Quality Across the Children's Health Insurance Program
The purpose of this measure is to improve health care quality across CHIP. Since its inception, States have shown dramatic improvement in reporting CHIP 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.

CHIPRA appropriated $45 million annually for a number of activities aimed at improving child health quality: establishment of voluntary child health quality measures; demonstration projects for improving child health quality through evaluating new performance measures, health information technology, and provider-based models such as care management; and also development of a model electronic health record. CMS is also working diligently to implement quality provisions of the CHIPRA legislation. The first step was to identify and publish an initial core set of child quality measures. These measures were published in the Federal Register in December 2009. CMS will issue a letter to State Health Officials in early 2011 that describes the quality measures program and the vehicles for reporting data on the core set of measures. A national technical assistance program is also being developed to support States in their efforts to collect, report, and analyze the core quality measures.

In 2010, CMS planned to work with State CHIP Programs to incorporate the CMS National Medicaid Quality Framework into CHIP programs and provide guidance on focused efforts to improve health outcomes, specific to CHIP, as State health information systems and exchanges evolve. The focal point of this initiative was the development of a national, consensus-based guidance document that will serve as a comprehensive and visionary roadmap for States, CHIP programs and other stakeholders for improving health outcomes. The 2010 target to develop a

National Quality Framework for CHIP was subsumed into efforts to develop a National Quality Strategy by January 1, 2011, as required by the Affordable Care Act. This goal is being discontinued and is being replaced by MCD6.

Measure	FY	Target	Result
CHIP3.1: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP **This is a priority goal.**	*2012*	+11% over FY 2008 8,179,012 children	March 31, 2013
	2011	+9% over FY 2008 8,031,642 children	March 31, 2012
	2010	+5% over FY 2008 7,736,903 children	+4.6% over FY 2008 7,705,723 children (Goal not met)
	2009	+1% over FY 2008 7,442,164 children	+5% over FY 2008 7,717,317* children
	2008	6,732,000 children	+11% over baseline 7,368,479 children (Target Exceeded) (New baseline established FY 2009)
	2007	N/A	7,100,000 children (Historical Actual)
	2006	Set Baseline	6,600,000 children (Baseline)
CHIP3.2: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid **This is a priority goal.**	*2012*	+12% over FY 2008 33,536,341 children	March 31, 2013
	2011	+11% over FY 2008 33,236,910 children	March 31, 2012
	2010	Historical actual	34,441,217 children (+15% over FY 2008) (Historical Actual)**
	2009	N/A	32,292,253 children (+7.8% over FY 2008) (Historical Actual)
	2008	Baseline	29,943,162 children

*CHIP FY 2009 ever enrolled as reported in FY 2011 Congressional Justification. State adjusted FY 2009 enrollment was 7,695,264 upon release of FY 2010 enrollment numbers
**FY 2010 actual enrollment data became available shortly before publication. CMS is examining whether adjustments should be made to out-year targets based on this data

Measure	Data Source	Data Validation
CHIP3.1 CHIP3.2	States are required to submit quarterly and annual CHIP and Medicaid 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 CHIP and Medicaid. The enrollment counts presented reflect an unduplicated number of children ever enrolled during the year in separate CHIP, Medicaid expansion CHIP programs and the Medicaid program.	Each State must assure that CHIP enrollment information and Medicaid child enrollment information are accurate and correct when the information is submitted to SEDS by certifying that the information shown on the forms is correct and in accordance with the State's health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: **1:** Unduplicated Number Ever Enrolled During the Quarter. **2:** Unduplicated Number of New Enrollees in the Quarter. **3:** Unduplicated Number of Disenrollees in the Quarter. **4:** Number of Member-Months of Enrollment in the Quarter. **5:** Average Number of Months of Enrollment (item 4 divided by item 1). **6:** Number Enrolled At Quarter's End (point in time). **7:** Unduplicated Number Ever Enrolled in the Year" (4th Quarter only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there aren't any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.

CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid

This measure supports the Department's High Priority Performance Goal to, "Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid." The high priority goal was identified by the Department of Health and Human Services to be of particular focus over the next two years.

The CHIP measure is to increase enrollment by +11 percent over the FY 2008 baseline by the end of FY 2012 (from 7,368,479 children to 8,179,012 children).The Medicaid measure is to increase enrollment by +12 percent over the FY 2008 baseline by the end of FY 2012 (from 29,943,162 children to 33,536,341 children). Under CHIP, States submit quarterly and annual CHIP statistical forms, which report the number of children under age 19, who are enrolled in Medicaid, separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year.

Because CMS substantially exceeded its FY 2008 target to increase child enrollment in CHIP by two percent over the FY 2006 baseline, we designated FY 2008 as the new baseline beginning with FY 2009. CMS fell short of the FY 2010 target to increase CHIP enrollment by 5 percent since the growth in CHIP leveled off in 2010, likely influenced by the economic downturn which made more children eligible for Medicaid. The FY 2011 target to increase enrollment reflect increased funding and additional resources and incentives provided by CHIPRA to increase enrollment and improve retention. The FY 2012 target is to increase enrollment, as CMS continues efforts to enroll eligible children. In addition, experience from past recessions

suggests that enrollment will increase as the economy improves, as children move from Medicaid to CHIP as family incomes increase.

CHIPRA, which reauthorized CHIP through September 30, 2013, provides options for States to expand their title XXI program in several ways. CHIPRA increased funding by $44 billion through 2013 to maintain State programs and to cover more uninsured children. Many factors will affect CHIP enrollment, including States' economic situations and programmatic changes. Enrollment figures also rely on reporting accuracy and timeliness. The Affordable Care Act will also make significant changes to enrollment in the CHIP program as States expand their Medicaid programs. The Affordable Care Act also extends federal CHIP funding for an additional two years through September 30, 2015, authorizes the program through 2019, and requires the maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with our State and federal partners, continuing to implement CHIPRA provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering our data collection activities.

In February 2010, Secretary Sebelius issued a challenge for leaders in the government and private sector to find and enroll an estimated five million uninsured children who are eligible but not enrolled in Medicaid and CHIP. This effort, known as "Connecting Kids to Coverage", focuses on five key ways to improve CHIP coverage through:

- Cutting red tape to streamline the enrollment and renewal process;
- Capitalizing on technology to demonstrate how new tools can facilitate enrollment and renewal;
- Creating opportunities to apply;
- Focusing on renewal; and
- Forging partnerships to broaden outreach and enrollment opportunities.

During the summer of 2010, CMS launched *"Get Covered. Get in the Game- Campaign"*. Each year, many children who want to participate in school or community sports are sidelined because they don't have health insurance. They may not be able to afford a physical or their family worries they'll get hurt on the field. Without health insurance, they can't play. The initiative is in seven pilot States, including Colorado, Florida, Maryland, New York, Ohio, Oregon, and Wisconsin. The pilot is designed to bring coaches, schools, families and communities together to raise awareness about available health coverage and get eligible children enrolled. Getting covered will protect them both on and off the field.

Additionally, CMS is awarding targeted CHIPRA outreach grants to improve enrollment and retention in Medicaid and CHIP, particularly for children in rural areas, Hispanic children, American Indians and Alaskan Natives, teens, legal immigrants and other disadvantaged children. These local outreach efforts will be supplemented by a national outreach campaign that will continue through at least 2013. Additional examples of program improvements being adopted by States include streamlining enrollment procedures such as implementing the Express Lane eligibility option and expanding eligibility such as lifting the 5-year waiting period for eligible children who are lawfully residing in the United States.

PROGRAM: HEALTH CARE FRAUD AND ABUSE CONTROL/ MEDICARE INTEGRITY PROGRAM (MIP)

Measure	FY	Target	Result
MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program	*2012*	6.2%	Nov 30, 2012
	2011	8.5%	Nov 30, 2011
	2010	9.5%	10.5% (Target Not Met)
	2009[1]	3.5%	12.4% (Target Not Met)
	2008	3.8%	3.6% (Target Exceeded)
	2007	4.3%	3.9% (Target Exceeded)

Measure	Data Source	Data Validation
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.

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. Between FY 1997 and FY 2002, 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 (it should be noted

that the IPIA was amended in July 2010 and is now known as the Improper Payments Elimination and Recovery Act (IPERA); Public Law 111-204).

In FY 2009, HHS reported the Medicare FFS error rate as 7.8 percent which reflects the old review process used for most of the claims that year. The error rate for claims reviewed under the newer and more stringent criteria was 12.4 percent. Given the change in methodology, and that HHS is now using the new methodology, HHS is reporting the 2009 error rate as 12.4 percent in the FY 2010 Agency Financial Report.

CMS did not meet the 2010 target for this measure, reporting a Medicare FFS error rate of 10.5 percent. CMS continues to review claims in accordance with the significantly revised and improved methodology implemented in 2009. The new methodology calls for stricter enforcement of Medicare policies. The primary modification required the medical reviewers under CERT to strictly follow the documentation requirements outlined in Medicare regulation, statute and policy rather than allowing for clinical judgment based on billing history.

The modifications to the review criteria resulted in an increase in payment errors. A significant portion of the errors found in FY 2009 & FY 2010 were due to a strict adherence to policy documentation requirements, signature legibility requirements, the removal of claims history as a valid source for review information, and the determination that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim. It should be noted that due to these changes in the review methodology, the 2009 and 2010 error rates are not comparable to previous years' error rates.

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.

In addition to the ongoing error rate measurement activities, the President issued Executive Order 13520 *Reducing Improper Payments and Eliminating Waste in Federal Programs* on November 20, 2009. The purpose of the Executive Order was to further intensify efforts to eliminate payment error, waste, fraud, and abuse in federal programs. As a result of the Executive Order, the CERT program added several new requirements including supplemental measurement of high risk areas and reporting on treasury payment accuracy website. In order to comply with the Executive Order requirements, CMS worked with HHS and OMB to develop four supplemental measures in the Medicare fee-for-service program:

- Power Wheelchairs
- Pressure Reducing Support Surfaces
- Inpatient Hospital Short Stays
- Chiropractic Services

Initial results of these supplemental measures will be reported in 2011. Additionally, a Treasury Website will include program information and error rate data for annual and supplemental measures. Furthermore, pursuant to the President's directive to reduce improper payments by 50 percent by 2012, CMS strives to eliminate improper payments in the Medicare program, maintain the Medicare Trust Funds and protect beneficiaries.

Measure	FY	Target	Result
MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program.	*2012*	13.2% (target in FY 2010 AFR)*	Nov. 15, 2012
	2011	13.7% (target in FY 2010 AFR)*	Nov. 15, 2011
	2010	14.3% (target in FY 2009 AFR)*	14.1% (Target Exceeded)
	2009	Baseline error rate	15.4%

Measure	Data Source	Data Validation
MIP5	The Part C Composite Error Rate is made up of two components: Medicare Advantage Prescription Drug (MARx) payment system error (MPE): The MPE measures errors in the system which issues payments to Medicare Advantage Plans. Source data come from CMS' monthly Beneficiary Payment Validation (BPV) analyses, which are employed by CMS to ensure the accuracy of the monthly Part C payments calculated by MARx. Risk Adjustment Payment Error (RAE) Estimate: The RAE measures errors in diagnostic data submitted by plans to Medicare. The diagnostic data is used to determine risk adjusted payments made to plans.	Data used to determine the Part C composite payment error rate is validated by several contractors. The Part C MPE estimate is based on data from CMS' monthly payment validation process, beneficiary payment validation (BPV), and is confirmed and analyzed by multiple contractors. The Part C RAE estimate is based on data obtained from a rigorous Risk Adjustment Data Validation process in which medical records are reviewed by two independent coding entities in the process of confirming discrepancies for a national random sample of beneficiaries.

*The target reductions in the Health and Human Services' Annual Financial Report (HHS AFR) are set using three assumptions about the RAE portion of the Part C composite error: (1) the proportion of beneficiaries with diagnoses remains the same; (2) the number of diagnoses per beneficiary stays the same; and (3) the proportion between underpayments and overpayments remains constant.

MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program

The purpose of this measure is to reduce the percentage of improper payments in the Part C Medicare Advantage program. Measuring Part C payment errors protects the integrity of the Part C program by ensuring that CMS has made correct payments to contracting private health plans for coverage of original Medicare benefits.

The Part C composite error rate is based on two components: (1) the Medicare Advantage-Prescription Drug (MARx) payment system error (MPE) estimate for Part C payments; and (2) the risk adjustment payment error (RAE) estimate. The Part C MPE estimate reflects payment errors in the transfer/interpretation of source data and payment calculation errors in the MARx payment system. The RAE estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. Validation of diagnoses in medical records for sampled beneficiaries is performed during CMS' annual Medical Record Review process, where medical records are reviewed by two separate coding entities in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's composite error rate, the dollars in error for the MPE and RAE measures are summed, and then divided by the overall Part C payments for the year being measured.

CMS continues to pursue enhancement of program integrity and to report a composite error rate for the Part C program annually in the HHS Annual Financial Report (AFR). From FY 2009 to FY 2010 the composite payment error estimate decreased. The FY 2010 composite payment error estimate of 14.1 percent is below the target of 14.3 percent. Additionally, as a means to improve payment accuracy (per Executive Order 13520), CMS is developing a method for identifying risk adjustment diagnoses that impact payment error because they are less likely to be supported by medical records. This study will examine the reasons these high-risk diagnoses are problematic, with the intent to facilitate improvement in payment accuracy.

Measure	FY	Target	Result
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program DEVELOPMENTAL	*2012*	Report Composite Error Rate for the Part D Program that is lower than the FY 2011 rate	Nov. 15, 2012
	2011	Report Composite Error Rate for the Part D Program	Nov. 15, 2011
	2010	Further develop component measures of payment error for the Part D program	Additional component measure reported. (Goal Met)

Measure	Data Source	Data Validation
MIP6	The components of payment error measurement in the Part D program include: A rate that measures payment system errors. A rate(s) that measures payment errors related to low income subsidy (LIS) payments for beneficiaries dually-eligible for Medicare and Medicaid and non-duals also eligible for LIS status. A rate that measures payment errors due to errors in Prescription Drug Event (PDE) records. A PDE record represents a prescription filled by a beneficiary that was covered by the plan. A rate that addresses Medicaid errors as they relate to the Part D program. Data sources for the Medicaid error rate are being explored, and include using the PERM estimate from the Medicaid program to estimate impact on Part D payments.	For the Part D component payment error rates, the data to validate payments will come from multiple internal and external sources: Payment system error will measure errors in the system which issues payments to Medicare Prescription Drug Plans. Data come from CMS' monthly Beneficiary Payment Validation (BPV) analyses, which are employed by CMS to ensure the accuracy of the monthly Part D payments calculated by MARx. Data for the LIS payment error measure will come from CMS' internal payment and enrollment files. Data for the PDE data payment error measure will come from CMS internal files and from supporting documentation submitted to CMS by the Part D plans. Data sources for the Medicaid error rate are being explored, and include using the PERM estimate from the Medicaid program to estimate impact on Part D payments.

MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program

The purpose of this measure is to reduce the percentage of improper payments in the Part D Prescription Drug program. Measuring Part D payment errors protects the integrity of the Part D program by ensuring that CMS has made correct payments to contracting private health plans for coverage of Medicare-covered prescription drug benefits. CMS is on track to develop a composite improper payment error rate for the Part D program. CMS met its FY 2010 target to further develop component measures of payment error for the Part D program.

The Part D composite payment error rate will consist of several component error rates. CMS reported component error rates for Part D in the FY 201 Annual Financial Report. Additional component work is being developed this year for inclusion in the composite payment error rate to be reported in FY 2011. In the development of the Part D composite measure, Medicaid status errors will be further addressed. Once all component error rate methodologies and measurements have been established, CMS will combine the component error estimates into a single Part D composite payment error rate for the program. We are aiming to report a composite Part D error rate by FY 2011. The FY 2011 composite error rate may or may not provide us with a baseline measure from which to build targets, since this measure is developmental. Once a Part D composite payment error rate has been reported, CMS will be in a better position to examine the cause of error and use the results to improve the Part D program.

Measure	Fiscal Year (FY)	Target	Result
MIP7: Increase the Number of Law Enforcement (LE) Personnel with Training and Access to Near Real Time CMS Systems Data. Baseline (FY 2010): 158 LE personnel with training and access to Near Real Time CMS Systems Data.	*2012*	100% of the LE personnel referred for training/access*	September 23, 2012
	2011	100% of the LE personnel referred for training/access*	September 23, 2011
	2010	N/A	158 (Baseline)
	2009	N/A	150 (Trend)
	2008	N/A	28 (Trend)

*CMS can accommodate training/access for up to approximately 200 LE personnel annually.

Measure	Data Source	Data Validation
MIP7	The National Database (NDB) is utilized by LE personnel for purposes of obtaining data for ongoing fraud investigations. A log, organized by name and user ID, is kept of trained LE personnel. LE personnel include: 1) Department of Health and Human Services (HHS) Office of the Inspector General (OIG) 2) Department of Justice (DOJ) Assistant U.S. Attorney (AUSA) 3) DOJ Federal Bureau of Investigation (FBI) 4) OIG Railroad Retirement Board (RRB)	The data used to show the current number of LE personnel with training and access to near real time CMS systems data is validated by our contractor, Viable Information Processing Systems (ViPS), the System Administrator for the National Database. This data is provided through weekly updates with the CMS Central Office (CO).

MIP7: Increase Number of Law Enforcement Personnel with Training and Access to Near Real Time CMS Systems Data

Detecting and preventing health care fraud, waste, and abuse within the Medicare program is a major challenge for the Centers for Medicare & Medicaid Services (CMS). Based on 2009 CMS data, Medicare provides health care to roughly 46 million elderly and disabled individuals throughout the United States. As part of the response to the growing problem of Medicare fraud, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative was formed on May 20, 2009, as an inter-agency partnership between the Department of Health and Human Services (HHS) and the Department of Justice (DOJ). This HEAT initiative effectively combined the resources of these two agencies and strategically focused them towards identifying fraud, prosecuting criminals, and recovering fraudulently taken taxpayer dollars through inter-agency Strike Forces and data driven analysis. The Strike Forces have been designed to combat fraud, waste, and abuse at a targeted local level in areas which have shown spikes in the submission of fraudulent Medicare claims, specifically due to criminal activity.

In their efforts to fight fraud, waste, and abuse in the Medicare program, the HEAT Strike Forces have utilized real-time CMS systems data in order to examine claims payment data for aberrancies, to identify suspicious billing patterns/trends, and to conduct surveillance on target providers and suppliers under investigation for potentially fraudulent practices.

The purpose of this measure is to increase the number of law enforcement personnel (HHS/OIG, DOJ AUSA/FBI, and OIG/ RRB) with training and access to CMS systems and applications. As LE expands their HEAT efforts and resources, it is necessary to ensure that they have adequate access to CMS data as quickly as possible. In order for this effort to be successful, one-time, three-day training courses must be continuously provided to new LE personnel. Subsequently, access to CMS systems and applications must be given, immediately

following completion of the training, though dependent on connectivity between CMS and LE, so as to enable LE to support the ongoing HEAT Initiatives. Intermediate training classes are also made available to LE personnel who require advanced training in these CMS systems and applications.

Current efforts by the Strike Forces have focused on increasing their site visits to suppliers, preventing fraud through education on Medicare Compliance training and resources, and utilizing new state-of-the-art technology to combat fraud by expanding data sharing capabilities and improving information sharing between HHS and DOJ.

There are currently ongoing HEAT Strike Force actions in Baton Rouge, LA, Brooklyn, NY, Detroit, MI, Houston, TX, Los Angeles, CA, Miami-Dade, FL, and Tampa Bay, FL, with the potential for additional Strike Forces in other areas of the country. As a result of the ongoing expansion of HEAT Strike Forces, CMS will increase the number of LE personnel with training and access to near real time CMS systems data by up to 200 individuals in FY 2011 and up to 200 individuals in FY 2012.

Measure	FY	Target	Result
MIP8: Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment Actions Increase the percentage of Medicare enrollment site visits to "high-risk" providers and suppliers that result in administrative actions. FY 2011 Baseline: TBD	*2012*	15%	Nov. 30, 2012

Measure	Data Source	Data Validation
MIP8	Developmental. In *"CMS-6028-FC: Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*," CMS finalized three levels of risk, Limited, Moderate and High. Provider types were assigned to these risk levels based on reports from the HHS Inspector General, the Government Accountability Office, and CMS's own analytic work and experience. The provider types assigned to these risk levels would receive oversight and review that increases with the level of risk of fraud—the greater the level of risk, the greater the level of oversight and review. For example, all providers and suppliers in the moderate risk level would receive site visits, and all provider types in the high-risk level would receive site visits, criminal background checks, and fingerprinting (once those latter two screening provisions are implemented via subregulatory guidance). Medicare contractors will utilize CMS-developed reporting requirements to compile the data on the numbers of site visits conducted for provider types included in the high-risk level, and the percentage of the site visits that resulted in administrative action(s). Contractors will also track and report the results of the administrative actions (e.g., dollars denied as a result of prepayment review). While the goal is national, based on the aggregate number of high-risk level enrollment site visits conducted, individual contractors will be strongly encouraged to meet and exceed the national goal to the extent appropriate for the provider population in their jurisdiction.	Developmental. Procedures will be developed to validate the data reported via CMS' contractor oversight of the MACs, ZPICs and NSC.

MIP8: Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment Actions

The purpose of this measure is to strengthen CMS' Provider Enrollment actions to prevent fraudulent providers and suppliers from enrolling in the Medicare program and to assure that existing providers continue to meet enrollment requirements. CMS must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries. Since there is a linkage between billing fraud and enrollment fraud, CMS will perform enhanced provider enrollment reviews to prevent and detect Medicare fraud and to reduce waste, abuse and other improper payments. This goal will measure the proportion of the number of "high-risk" provider site visits that result in administrative action to the number of "high-risk" provider site visits conducted.

By conducting enrollment site visits for “high-risk” providers and suppliers and by taking appropriate and timely administrative actions, our contractors will focus their activities toward the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk based approach increases contractors’ efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud. This approach is designed to shrink the pool of unscrupulous providers over time. As new unscrupulous providers are prevented entry to the program and existing unscrupulous providers lose their billing privileges, the remaining provider pool will be relatively lower risk.

We have chosen the high risk level as the focus of this goal as a starting point and a means to validate the accuracy of assignment of specific provider and supplier categories to risk levels in general. One measure of whether the providers and suppliers in the high risk level pose the highest risk of fraud, waste and abuse, and are appropriately assigned to the high risk level, is whether they require additional action(s) following a site visit. We want to quantify the extent to which this occurs. To obtain a complete picture, we would want to know the extent to which provider and supplier categories assigned to other risk levels require additional administrative action. Once we determine the Goal performance in the high risk level, we would consider expanding the analysis of “post-site visit administrative actions taken” to the moderate risk level. Ultimately, we might want information about administrative actions taken in all three risk levels.

In *“CMS-6028-FC: Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*,” CMS finalized three levels of risk, Limited, Moderate and High. Provider types were assigned to these categories based on reports from the HHS Inspector General, the Government Accountability Office, and CMS’s own analytic work and experience. The provider types assigned to these risk levels would receive oversight and review that increases with the level of risk of fraud—the greater the level of risk, the greater the level of oversight and review. Medicare contractors will compile the data on the numbers of site visits conducted for provider types included in the high-risk category, as well as the percentage of those site visits that resulted in administrative action(s). In addition, they will track and report the results of the administrative actions taken; more than one administrative action may be implemented for an individual provider.

Close collaboration with our federal law enforcement partners is an essential component for the success of CMS’ efforts to prevent Medicare fraud and abuse and strengthen provider enrollment actions. CMS is partnering with HHS’ Office of General Counsel and the Office of Inspector General, the Department of Justice’s Office of the US Attorney and the Federal Bureau of Investigation to implement the full spectrum of administrative actions ranging from educational intervention through referral to law enforcement. Instances of potential fraud identified through enhanced provider enrollment reviews are referred to law enforcement for additional civil and criminal remedies such as prosecution; settlements, restitution and fines; asset forfeiture, civil monetary penalties and exclusion. These law enforcement actions are powerful tools to assist CMS to protect the integrity of the Medicare Trust Fund.

For purposes of this initiative, we have defined the range of administrative actions to be measured to include the following:

1. Targeted educational intervention with providers and suppliers who are not fully compliant with Medicare provider enrollment standards, but whose deficiencies do not rise to the regulatory threshold for revocation or deactivation. Providers and suppliers who receive these targeted educational interventions will be placed on a "watch list," their billing patterns will be closely monitored and they may be subject to additional unannounced enrollment site visits or observational site visits.

2. Pre-payment review of all or some of their claims prior to payment (provider-specific edits) and/or review of claims for particular services most likely to be non-covered, incorrectly coded and/or not medically necessary (service-specific edits).

3. Post-payment claims reviews, overpayment determinations and recoupment.

4. Revocation or deactivation of the provider's or supplier's Medicare billing privileges.

5. Suspension of Medicare payments to providers or suppliers.

6. Civil monetary penalties assessed against providers and suppliers and/or their exclusion from the Medicare program.

CMS recognizes that it will be easier for contractors in areas with greater numbers of high-risk provider types to reach these targets, while it will be more difficult for contractors to reach the targets if they have fewer high-risk provider and supplier types or lower volume billing and utilization. While the targets are national, based on the aggregate number of high-risk enrollment site visits conducted, individual contractors will be strongly encouraged to meet and exceed the national targets to the extent appropriate for the provider population in their jurisdiction. However, as all provider types in the high-risk category will be subject to site visits, the measure is keyed to the site visit, not the providers.

In 2011 we will establish the baseline to measure what percentage of Medicare enrollment site visits to high-risk providers and suppliers results in administrative actions. To meet our target for 2012, 15 percent of all Medicare enrollment site visits to high-risk providers or suppliers must result in administrative action(s).This percentage focuses on the Medicare enrollment site visit and not the number of administrative actions taken following a site visit.

PROGRAM: STATE GRANTS AND DEMONSTRATIONS

Measure	FY	Target	Result
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.	*2011*	Goal discontinued	N/A
	2010	Annual Report	Annual Report on CY 2009 produced. Target Met)
	2009	Annual Report	Annual Report on CY 2008 produced. (Target Met)
	2008	Annual Report	Annual Report on CY 2007 produced. (Target Met)
	2007	Annual Report	Annual Report on CY 2006 produced. (Target Met)
	2006	Annual Report	Annual Report on CY 2005 produced. (Target Met)

Measure	Data Source	Data Validation
SGD1	CMS uses internal information on grant award amounts and grant types; Medicaid Buy-In enrollment submitted by Medicaid Infrastructure Grant (MIG) States; data supplied by States through quarterly progress reports; employment and earnings records from the Social Security Administration (SSA); and administrative claims data on employment rates for people with disabilities.	Reports are compiled using a cadre of large national database sources. These statistical databases are validated internally by the respective State/Federal agency data and research personnel.

SGD1: Accountability through Reporting in the Medicaid Infrastructure Grant Program (MIG)

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 (beginning in 2006 covering calendar year 2005) on Section 203 of TWWIIA.

To meet our FY 2010 target, the fifth annual report was prepared in December 2010, summarizing the progress of Medicaid Infrastructure Grant (MIG) States during calendar year 2009.

The calendar year 2009 report on the MIG program highlights continuing achievements in existing measures, and builds on past reports using additional data collected from States. CMS uses 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. This measure is discontinued after FY 2010 due to the expiration of funding for this task as well as the end of the MIG program in 2011.

Measure	FY	Target	Result
SGD2: Medicaid Integrity Program, Percentage Return on Investment (ROI)	*2012*	ROI > 150%	Jan. 31, 2013
	2011	ROI > 125%	Jan. 31, 2012
	2010	ROI > 100%	Jan 31, 2011
	2009	ROI > 100%	175% (Target Exceeded)
	2008	ROI > 100%	300% (Target Exceeded)

Measure	Data Source	Data Validation
SGD2	1) The Medicaid Integrity Contractors (MICs) will compile the data on audits where overpayments are identified and States were instructed to recoup; (2) Results from State payment system audits identifying overpayments using algorithms; (3) Activities that are characterized as achieving cost avoidance of improper payments through the Medicaid Integrity Group's support and assistance to States.	Data will be validated through CMS oversight of the MICs and internal controls.

SGD2: Medicaid Integrity Program (MIP), Percentage Return on Investment (ROI)

The purpose of this measure is to ensure the implementation and success of the Medicaid Integrity Program (MIP). To calculate the Return on Investment (ROI) in 2008, the numerator included annual total Federal dollars identified as overpayments in accordance with the relevant Medicaid overpayment statutory and regulatory provisions. The denominator included the annual Federal funding of the Medicaid Integrity Contractors (MICs). CMS exceeded its target for FY 2008 (partial year, July-September) by reporting an ROI of 300 percent. Because the FY 2008 ROI calculation was based on partial year data, CMS was uncertain if a complete year of activity would yield similar results.

In the FY 2009 ROI calculation, a new formula was applied. The numerator included overpayments identified in FY 2009. The denominator included the annual Federal funding of the MIP for FY 2009. CMS exceeded its FY 2009 target with an actual result of 175 percent. As the program has evolved over the past three years, it has become apparent that our ability to identify overpayments is not, and should not, be limited to the activities of our MICs. In addition to the work of the MICs, data analysis activities performed by CMS staff have identified systemic errors in State payment systems, which have resulted in the identification and recovery of significant overpayment amounts, without requiring audits by the MICs. Additionally, we believe that other activities conducted by CMS (e.g., State program integrity reviews) have the potential to identify overpayments without necessarily needing to conduct audits. Therefore, we believe the revised methodology more accurately captures the full spectrum of CMS overpayment identification activities. Additionally, other activities (e.g., State education) allow States to mitigate vulnerabilities and avoid overpayments. We are evaluating how to characterize the benefits States are getting from the support and assistance that CMS provides them. We are currently working with a contractor to help us more fully characterize the return on these activities and anticipate implementing the broader definition of return for the FY 2012 period, reporting results in January 2013.

The FY 2010 target is for the annual ROI to be greater than 100 percent, the target for FY 2011 is for the ROI to be greater than 125 percent, and the target for FY 2012 is for the ROI to be greater than 150 percent. The modification to the FY 2011 ROI target from "greater than 200 percent" to "greater than 125 percent" is the result of recent legislation. Section 6411 of the Affordable Care Act requires States to expand the Recovery Audit Contractor (RAC) program to Medicaid. We anticipate this will impact the MIC audits. The Medicaid State RACs will target the high dollar, easily recouped claims, which will impact the audit leads that the MICs will have available. We therefore anticipate a decrease in potential ROI once the RACs are up and running. The State RACs could be in place for up to three quarters of FY 2011.

CMS has made good progress toward developing the MIP. As of January 2011, CMS has hired 78 full-time employees and plans to hire the remaining employees in 2011. CMS has hired audit, 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. The algorithms are used to determine if the claim payment made is consistent with the relevant policy or business rule. If the claim is not consistent, it is reported in transaction and summary format, by provider, in what we call "result" sets. In the aggregate, these result sets show State, regional and national trends in billing anomalies. These trends are used for a comparative analysis to identify best practices and, conversely, to identify information system billing vulnerabilities. The frequency and monetary level of the error is used to detect potential billing schemes that may be fraud or abuse.

PROGRAM: CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

Measure	FY	Target	Result
CLIA1: Percent of pathologists receiving an initial passing score of 90% or greater in gynecologic cytology proficiency testing.	*2012*	96.9%	Aug 31, 2013
	2011	95.0%	Aug 31, 2012
	2010	94.5%	Aug 31, 2011
	2009	94.0%	96.75% (Target Exceeded)
	2008	93.0%	96.6% (Target Exceeded)
	2007	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.	Target Partially Met (Target Not Met but Improved)

Measure	Data Source	Data Validation
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.

CLIA1: Improve Cytology Laboratory Testing

Gynecologic cytology testing provides the first indication of cervical cancer. CMS' continued commitment to improving cytology laboratory testing helps to assure accurate and reliable gynecologic cytology test results, an important issue in women's health.

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 of all pathologists (i.e., both those working with a cytotechnologist and without the aid of a cytotechnologist) to obtain a passing score of 90 percent or greater in gynecologic cytology PT. This measure focuses on the percent of pathologists obtaining a passing score for the initial testing event, and not for any subsequent testing event in a testing cycle period. The results for CY 2005 through CY 2009 are:

Testing Cycle period	All pathologists (combined) tested in gynecologic cytology PT	Percent with Passing score of 90% or greater
CY 2005	6280	88.4% (5554)
CY 2006	6197	93.7% (5809)
CY 2007	6200	95.9% (5950)
CY 2008	6184	96.6% (5972)
CY 2009	6282	96.75%(6078)

Closer data analysis reveals the following important observations:

a) Pathologists who work without the aid of a cytotechnologist have historically had a much lower passing rate on the initial proficiency test, and that has been of considerable concern to CMS. However, continued proficiency testing shows a positive trend with the passing rate on the initial test rising from 67 percent in 2005, to 83 percent in 2006, and 89 percent in 2007 and 2008. For 2009, this decreased 1 percent to 88 percent.

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 trend is also positive, rising from a 90 percent passing rate on the initial test in 2005 to 95 percent in 2006, and 97 percent in 2007, 2008 and 2009.

c) For 2009, our data indicates a decrease of cytologists and primary pathologists. This trend may be due to primary screeners becoming secondary screeners. If this is the case, this is a desirable outcome. Some cytologists have also left the field or retired.

d) Advancements in molecular test methodology have changed recommendations for longer screening intervals between the Pap test, and the advent of the HPV vaccine may contribute to a decline in the frequency of the Pap test.

CMS' interventions, which included education and retraining, resulted in an increase in knowledge and skills and the pathologists' performance showed improvement from 2005 to 2009.

A proposed rule for Gynecologic Cytology Proficiency Testing (PT) under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) was published on January 16, 2009. The proposed rule requested comments for changes recommended by the Clinical Laboratory Improvement Amendments Advisory Committee (CLIAC) and addressed concerns made by the cytology community. The closing date for comments was March 17, 2009. CMS is currently in the process of evaluating the comments received.

PROGRAM: QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

Measure	FY	Target	Result
QIO1: Increase influenza immunization (nursing home subpopulation)	*2012*[9]	86.8%	Dec 31, 2013
	2011	86%	Dec 31, 2012
	2010	81.8%	Dec 31, 2011
	2009	80%	84.23% (Target Exceeded)
	2008	79%	81.7% (Target Exceeded)
	2007	74%	79.2% (Target Exceeded)

Measure	Data Source	Data Validation
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.

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

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend 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 Quality Improvement Organization's (QIO) 9th Statement of Work (SOW) Prevention Theme, participating practices will increase Medicare beneficiaries understanding and utilization of the influenza immunization. Through the use of electronic health records (EHRs), the Prevention Theme will engage the participating practices by implementing care management and tracking and improving their patients' receipt of the influenza vaccine. Participating practices will utilize their EHRs to educated Medicare beneficiaries on the importance of disease prevention, early detection and lifestyle modifications that support a healthier life. It is expected that by the end of the 9th SOW, QIOs will show a 10 percent relative improvement in the influenza immunization rate among patients of the participating practices.

The FY 2009 nursing home influenza result of 84.23 percent exceeds the FY 2009 target of 80.0 percent and is a 2.53 percent improvement from the FY 2008 result of 81.7 percent. Since the FY 2009 result exceeded the FY 2010 target of 81.8 percent, our FY 2011 and FY 2012 targets are set at 86 percent and 86.8 percent, respectively. To achieve our targets, we will

[9] FY 2012 target is an estimate.

continue emphasis of the influenza immunization performance measures in the Prevention Theme of the QIO 9th SOW.

Although the results of this goal continue to improve, we believe that the QIOs have worked with the providers in their communities for many years to improve and sustain flu immunizations amongst Medicare beneficiaries. As a result of the QIOs work in the communities, the rate for flu immunization improvements will begin to level off shortly.

We will be looking into introducing a more comprehensive quality-related goal that reflects the new legislative mandates and focus. The development of a new goal will allow us to align our efforts and performance measurement with these mandates, identifying significant gaps and showing improvements in the quality of health care.

Measure[10]	CY	Target	Result
QIO3.1: Increase hemoglobin A1c (HbA1c) testing rate	*2012*[11]	89.5%	Sep 30, 2013
	2011	88.5%	Sep 30, 2012
	2010	87%	Sep 30, 2011
	2009	86%	88.2% (Target Exceeded)
	2008	85.5%	86.5% (Target Exceeded)
	2007	85%	86% (Target Exceeded)
QIO3.2: Increase cholesterol (LDL) testing rate	*2012*	84.1%	Sep 30, 2013
	2011	83.1%	Sep 30, 2012
	2010	82%	Sep 30, 2011
	2009	81%	82.7% (Target Exceeded)
	2008	80%	81.1% (Target Exceeded)
	2007	80%	80.25% (Target Exceeded)

Measure	Data Source	Data Validation
QIO3.1 QIO3.2	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 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.

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

CMS is committed to improving care for its diabetic beneficiaries by increasing the rate of hemoglobin A1c (HbA1c) and cholesterol (LDL) testing. Multiple studies have demonstrated a relationship between good control of blood sugars as measured by HbA1c 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.

[10] FY 2012 targets are estimates.

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 Calendar Year (CY) 2009 result for HbA1c was exceeded with results 88.2 percent against a target of 86 percent. These results were higher than the CY 2011 target of 87.5 percent; therefore, we updated the CY 2011 target to 88.5 percent. The CY 2009 result for cholesterol (LDL) was exceeded with results of 82.7 percent (target 81 percent). These results were higher than the CY 2011 target of 82.5 percent; therefore, we increased the CY 2011 target to 83.1 percent. We set the FY 2012 targets for HbA1c and cholesterol at 89.5 percent and 84.1 percent, respectively.

Measure[12]	FY	Target	Result
QIO4: Increase percentage of timely antibiotic administration	*2012*	96.0%	Jun 30, 2013
	2011	95.5%	Jun 30, 2012
	2010	92%	Jun 30, 2011
	2009	89%	95.6% (Target Exceeded)
	2008	85%	91.6% (Target Exceeded)
	2007	82%	88.2% (Target Exceeded)

Measure	Data Source	Data Validation
QIO4	Baseline State-level performance rates are calculated using self-reported and validated data abstracted from hospitals participating in the CMS Hospital Inpatient Quality Reporting (IQR) program formerly known as Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). 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 approximately 48 medical records per year by the CMS Data Abstraction Center (CDAC) for a random sample of 800 hospitals per year.

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 infections (SSI) are a major cause of patient morbidity, mortality, and health care cost. According to the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs), SSIs are the second leading cause of HAIs (the first is catheter-associated urinary tract infections). Surgical site infections cost hospitals an estimated $25,546 each in additional cost. With an estimated 290,485 SSIs per year, this is a $7.4 billion burden on the healthcare system each year. The incidence of infection increases intensive care unit admission by 60 percent, the risk of hospital readmission is five-fold, and doubles the risk of death. [1]

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), web link below, which is a multifaceted coalition with the goal of reducing surgical complications, including SSI.
http://www.qualitynet.org/dcs/ContentServer?c=MQParents&pagename=Medqic%2FContent%2FParentShellTemplate&cid=1228694349383&parentName=Category

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

[12] FY 2012 targets are estimates.

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.

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.)

There are several factors that may explain our better than expected historical outcomes. First QIOs have been working diligently with providers in their States by sponsoring collaborative learning sessions that targeted this and other SCIP measures during the 8th Statement of Work and now the 9th Statement of Work. The number of hospitals capturing and reporting this measure to the QIO Clinical Warehouse increased from 2,979 in Q1-2006 to 3,374 in Q1-2007 based on inclusion of the SCIP antibiotic measures in the CMS Hospital Inpatient Quality Reporting Program formerly known as RHQDAPU program. The Institute for Healthcare Improvement included quality improvement interventions related to surgical antimicrobial prophylaxis in their 5 Million Lives Campaign. 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.

In FY 2009 we surpassed our target of 89 percent to end at 95.6 percent. This result is a 4 percent increase from FY 2008 results. This result exceeded our targets for FY 2010 and 2011, which were 92 percent and 92.5 percent, respectively. Consequently, we increased the FY 2011 target to 95.5 percent, and set our FY 2012 target at 96 percent. To achieve our targets, we have continued to emphasize the performance measures of SCIP Infection in the Patient Safety Theme of the QIO 9th Statement of Work (SOW). CMS uses the performance measures for continued accountability through public reporting (RHQDAPU) and value-based purchasing. In addition, Section 3001 of the Affordable Care Act established a Hospital Value Based Purchasing Program which includes surgeries as measured by the SCIP project.

Measure[13]	FY	Target	Result
QIO5: Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	*2012*	59%	Nov 30, 2012
	2011	58%	Nov 30, 2011
	2010	57%	56.8% (Target Not Met)
	2009	54%	54% (Target Met)
	2008	51%	51% (Target Met)
	2007	47%	48% (Target Exceeded)

Measure	Data Source	Data Validation
QIO5	Data is self reported by the dialysis facilities. Dialysis facilities submit directly to the 18 End Stage Renal Disease (ESRD) Networks who then submit directly to CMS through a file transfer.	Prior to monthly ESRD Network dashboard publishing, edit checks are programmed to ensure that only eligible facilities are reporting. A further check is conducted using a trend report comparing over 70% of all reported data with historical trends to ensure that missing case rates and case counts are in line with monthly annual trends

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

Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD). Approximately 356,000 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: arteriovenous fistula (AVF), catheter, and graft. Of the vascular access options, an AVF 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 and hospitalizations related to 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 infections and other complications related to catheter or graft vascular access, which contributes over $1 billion to total Medicare inpatient costs.

The FY 2010 target, 57 percent of hemodialysis patients using an AVF as their primary method of vascular access, was not achieved. There was a 2.8 percent increase from FY 2009 results. The prevalent AVF rate in May 2010 was 55.5 percent. The prevalent AVF rate at the end of the fiscal year, September 30, 2010, was 56.8 percent. This is a 1.3 percent increase in 4 months, but 0.2 percent short of the 2010 target of 57 percent. One month later, October 31,

[13] FY 2012 target is an estimate.

2010, the rate was 57.1 percent; however, this rate is attributable to the beginning of FY 2011 and not FY 2010.

Quality improvement work continues as the ESRD Networks and a sub-group of QIOs reach 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 Statement of Work. In addition, the work of the Fistula First Breakthrough Initiative (FFBI) 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. The FFBI Strategic Plan was released in September 2009 (www.fistulafirst.org) and the renal community is engaged in implementing the tactics along with the ESRD Networks and QIOs. Barriers remain in placing AVFs; and the placement of AVFs in new patients prior to beginning hemodialysis continues to be a challenge. AVF takes several weeks to mature and become usable. In order to provide dialysis during that time period, a catheter is necessary. The rate of catheter use for new hemodialysis patients is around 80 percent while AVF placement rates for new patients are only at 30.2 percent. (These figures take into consideration instances where both AVF and a catheter are necessary.)

CMS has engaged Quality Improvement Organizations (QIOs) to work with the ESRD Networks in a sub-national effort within the 9th Statement of Work (SOW) from August 2008 through July 2011 to improve AVF rates for new patients beginning hemodialysis. 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 their annual report, the US Renal Data System (USRDS) analyzes healthcare costs associated with the different access types. Below, the chart illustrates the average 2007 and 2008 total expenditure for a Medicare beneficiary with each of the vascular access types. The figures are the latest available and found in the USRDS 2010 Atlas of End Stage Renal Disease.

ESRD COSTS

Vascular Access type	2007 Medicare Expenditure Per Person	2008 Medicare Expenditure Per Person
AVF	$60,000 per year	$64,700 per year
AV Graft	$72,700 per year	$79,300 per year
Catheter	$79,364 per year	$90,100 per year

After a growth in 2007 of 3.3 percent for catheter patients and 1.0–1.7 percent for those with a fistula or graft, costs in 2008 rose 12.8 percent for catheter patients and 8.2–8.6 percent for those with a fistula or graft. In addition, in 2008, the per person per year costs for vascular access events were highest for patients with an AV graft or a catheter, reaching $8,683 and $6,402 in 2008. Costs for patients with an AV fistula, in contrast, were $3,480 — 60 percent lower than those for AV graft patients.[1]

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.

The Fistula First Breakthrough Initiative contractor has performed a Root Cause Analysis (RCA) utilizing key experts to identify current barriers to AVF placement and use. This RCA was used by a technical expert panel in early June 2009 to update and develop strategies that aim to push

up AVF rates. These updated strategies are being implemented by the contractor and the FFBI coalition members and stakeholders as of September 2009 and the implementation continues. The 2011 and 2012 AVF goals reflect a degree of “leveling off” of improvement; yet a continuation of improvement as the updated FFBI Strategic Plan takes effect.

CMS will continue to hold its ESRD Network Organization and QIO contractors accountable for decreasing the quality deficits in their respective areas by increasing the number of prevalent and incident hemodialysis patients using AVFs in their facilities. CMS will continue to monitor statistics of AVF prevalence on a regional and national level using its existing ESRD data collection and analysis tools.

Measure[14]	FY	Target	Result
QIO6.1: Methodology for aggregating QIO performance with clinical outcome measures at the Theme level	*2009*	Develop methodology	Methodology developed. (Target Met)
QIO6.2: Management Information System (MIS)	*2009*	Implement MIS	MIS implemented (Target Met)
QIO6.3: Care Transitions, Patient Safety, and Prevention Themes	*2012*	**Prevention –** 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	December 31, 2012
		Patient Safety – 100% of the QIOs will achieve the recruitment goals by the 12th month (quarter 4)	December 31, 2012
		Care Transitions – 80% of the QIOs will meet the 12th month (quarter 4) I-4 (interim measure) performance expectation	December 31, 2012
	2011	**Prevention** – At least 85% of QIOs will meet expectations for the components of the Prevention Theme at the 28th month evaluation.	Jul 31, 2011
		Patient Safety- At least 85% of QIOs will meet expectation for the components of the Patient Safety Theme at the 28th month evaluation.	Jul 31, 2011
		Care Transitions – At least 80% of the QIOs will meet expectations of the Care Transitions Theme at the 28th month evaluation.	Jul 31, 2011
	2010	**Prevention** – At least 85% of QIOs will meet expectations for the components of the Prevention Theme at the 18th month evaluation.	The 18th month evaluation results show 92% of the QIOs met all performance targets in the Prevention Theme. Target Met.
		Patient Safety- At least 85% of QIOs will meet expectation for the components of the Patient Safety Theme at the 18th month evaluation.	The 18th month evaluation results show 99% of the QIOs met all performance targets in the Patient Safety Theme. Target Met.

[14] FY 2012 targets are estimates.

Measure[14]	FY	Target	Result
		Care Transitions – At least 80% of the QIOs will meet expectations of the Care Transitions Theme at the 18th month evaluation.	The 18th month evaluation results show 100% of the QIOs met all performance targets in the Care Transitions Theme. Target Met.
	2009	Establish baselines and targets	Baselines and targets established. 12 month Progress to Date* **Patient Safety** – 100% of QIOs meeting expectations for all components of Patient Safety Theme. **Prevention** – prevention core - 98% meeting expectations prevention CKD - 100% meeting expectations prevention disparities – 100% meeting expectations **Care Transitions** –100% QIOs currently meeting expectations. *Performance metrics become progressively more difficult as the contract matures thus percentage of expected success may decrease in out years. Target Met.
QIO6.4: Beneficiary Protection	*2012*	Beneficiary Protection – 80% of the QIOs will meet the 12th month (quarter 4) performance expectations	Dec 31, 2012
	2011	At least 80% of the QIOs will meet minimum performance criteria for the Beneficiary Protection Theme at the 28th month evaluation.	Jul 31, 2011
	2010	Establish baseline/progress and FY 2011 targets	Progress at the 18th Month Monitoring Period to date: 88% of the QIOs are meeting all performance targets, and FY 2011 target set. Target Met.

Measure	Data Source	Data Validation
QIO6.1 QIO6.2 QIO6.3 QIO6.4	Information on the QIOs' performance will be obtained from the Management Information System (MIS) which will be operational in preparation for the 18-month and 28-month contract evaluations, and the 9th SOW Program Evaluation. Initial baselines will be determined based on two quarters of Theme performance data after the launching of MIS.	Project Officers/Government Task Leaders will review quarterly reports from MIS and validate the information against actual performance of the QIOs.

QIO6: Improve the Oversight of Quality Improvement Organizations

The purpose of this goal is to ensure that CMS' efforts in overseeing the Quality Improvement Organizations (QIO) are aligned with the performance targets in the QIO 9th Statement of Work (SOW). These targets are important as they are designed to measure improvements in the quality of care for Medicare beneficiaries at a national level. CMS strives to ensure that beneficiaries receive quality health care.

The QIO program was legislated to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The 9th SOW, which began August 2008, is a 3-year contract that is significantly different from any previous QIO contracts since it now holds all QIOs accountable for meeting specific, predefined performance targets. CMS has been extremely successful in improving oversight by conducting routine quarterly monitoring of the metrics and requesting immediate correction of identified problems. A more formal evaluation was conducted at the 18th and will be conducted again at the 28th month of the contract, January 2010 and November 2010, respectively.

The performance targets come under four major Themes: Patient Care Transitions, Patient Safety, Prevention and Beneficiary Protection. Patient Care Transitions focuses on reducing unnecessary re-hospitalization of Medicare beneficiaries that both harm patients and drain the trust funds. Patient Safety efforts will reduce patient harm using proven interventions in areas with a record of QIO success in helping to improve safety. Prevention efforts emphasize evidence-based and cost-effective care proven to prevent and/or slow the progression of disease. Prevention has three components including the core national Theme and the chronic kidney disease and disparities sub-national Themes. Beneficiary Protection activities emphasize mandatory review activity and quality improvement. These activities will be reflected in performance measures QIO6.3 and QIO6.4, which will monitor the national success of the QIOs in implementing these Themes designed to improve care.

Monitoring is conducted quarterly and a formal evaluation was performed at the 18th month (January 2010). Contract action was taken for the QIOs that did not meet the performance metrics and ranged from a request for corrective action to removal of funding for a Theme or component of a Theme. Notice of possible contract actions were provided to QIOs in advance of the 18th month. QIOs that met their 18 month targets will be measured again at 28 months. Beneficiary Protection will be measured at 28 months to evaluate performance in keeping with the QIO 9th SOW. Performance related to this Theme will be addressed in keeping with the statutory and regulatory mandated requirements.

To prepare for the oversight of the QIOs, CMS developed a Management Information System (MIS) to capture QIO performance information. CMS is analyzing MIS information quarterly to determine if QIOs are meeting their targets and implement corrective actions as appropriate. In addition, towards the end of the 9th Statement of Work, CMS will evaluate the QIO program to evaluate its effectiveness and efficiency.

At the 12th month (July 2009) of the 9th SOW contract, CMS began preliminary analysis to determine the number and percentage of QIOs meeting expectations. To meet expectations for this goal, the QIOs must either pass the target initially or comply with CMS' plan of corrective action within 2 quarters of the request. Given the establishment of clear performance metrics and increased oversight, CMS was able to identify deficiencies in performance and request corrective actions through Performance Improvement Plans (PIPs) in 29 instances. The QIOs were very responsive to the requests and in all but one instance, the QIO corrected the deficiencies within 2 quarters of the request (between July 2009 and January 2010).

The national percentage of QIOs passing a Theme will be calculated as follows:

18th Month
Numerator: The number of QIOs that meet expectations for the Theme at the 18th Month Evaluation
Denominator: The total number of QIOs measured for that Theme.

28th Month
Numerator: The number of QIOs that meet expectations for the Theme at the 28th Month Evaluation
Denominator: The total number of QIOs measured for that Theme.

To meet expectations for this goal the QIO must either pass the target initially or comply with CMS' plan of corrective action within 2 quarters of the request.

The 9th SOW continues through July 31, 2011. Because the focus may change from one SOW the next, targets and performance measures will be reviewed to ensure consistency with the National Quality Strategy and new legislative and regulatory mandates, this performance measure will be updated.

Agency Support for HHS Strategic Plan

HHS' new FY 2010 – FY 2015 Strategic Plan reflects its mission to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. Several new CMS performance measures were introduced to reflect agency responsibilities and priorities, including those under the Affordable Care Act, and were included in the HHS Strategic Plan.

CMS' Strategic Goals support the HHS Strategic Plan, and outline specific goals for achieving our mission. CMS' Strategic Goals, the HHS Strategic Plan, the enactment of GPRA, the Secretary's priorities and other HHS and government-wide programs have all emphasized the themes of accountability, stewardship and a renewed focus on the beneficiary/consumer.

CMS has major responsibilities in supporting the HHS' goal to "*Transform Health Care"* and to *"Increase Efficiency, Transparency, and Accountability of HHS Programs"* as articulated in its mission "to be a major force and a trustworthy partner for the continual improvement of health and health care for all Americans". We will strive to achieve operational excellence in order to help provide better care for individuals, better health for populations, and at lower costs.

CMS is in the forefront of Transforming Health Care. Among our commitments is to enroll all eligible children in Medicaid and the Children's Health Insurance Program (CHIP), improve preventive services for our consumers and beneficiaries, explore new payment systems, decrease beneficiary out-of-pocket expenses for Part D prescription drugs, reduce unnecessary hospital readmission rates and hospital acquired conditions, and explore options to make healthcare delivery more patient-focused. CMS is also making affordable health insurance available by helping States establish health insurance Exchanges and implementing private market reforms that will increase the number of young adults under age 26 who are covered as a dependent on their parent's employer-sponsored insurance policy. The Center for Medicare & Medicaid Innovation, created under the Affordable Care Act, is another example of how CMS supports this Strategic Goal.

We also are leading contributors to the HHS Strategic Goal to "*Increase Efficiency, Transparency and Accountability of HHS Programs"* with our expanded program integrity efforts to be good stewards of taxpayer dollars and to combat fraud and abuse in the Medicare, Medicaid and CHIP programs,

The following table shows the alignment of CMS' Strategic Goals with the new FY2010 – FY 2015 HHS Strategic Plan goals.

CMS Linkages to HHS Strategic Plan

The table below shows the alignment of CMS' Strategic Goals with HHS Strategic Plan goals.

HHS Strategic Goals and Objectives	CMS Goal 1 Operational Excellence	CMS Goal 2 Better Care for Individuals	CMS Goal 3 Integrated Care of Population	CMS Goal 4 Better Health for the Population
1 Transform Health Care		X	X	
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured		X		
1.B Improve health care quality and patient safety		X	X	
1.C Emphasize primary and preventive care linked with community prevention services		X	X	X
1.D Reduce the growth of health care costs while promoting high-value, effective care		X	X	
1.E Ensure access to quality, culturally competent care for vulnerable populations		X	X	
1.F Promote the adoption of health information technology		X	X	
2 Advance Scientific Knowledge and Innovation				X
2.A Accelerate the process of scientific discovery to improve patient care				
2.B Foster innovation at HHS to create shared solutions	X	X	X	X
2.C Invest in the regulatory sciences to improve food and medical product safety				
2.D Increase our understanding of what works in public health and human service practice				
3 Advance the Health, Safety and Well-Being of the American People				X
3.A Ensure the safety, well-being, and healthy development of children and youth				
3.B Promote economic and social well-being for individuals, families and communities			X	X
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			X	
3.D Promote prevention and wellness				X

HHS Strategic Goals and Objectives	CMS Goal 1 Operational Excellence	CMS Goal 2 Better Care for Individuals	CMS Goal 3 Integrated Care of Population	CMS Goal 4 Better Health for the Population
3.E Reduce the occurrence of infectious diseases				
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies				
4 Increase Efficiency, Transparency, and Accountability of HHS Programs	X			
4.A Ensure program integrity and responsible stewardship of resources	X			
4.B Fight fraud and work to eliminate improper payments	X			
4.C Use HHS data to improve the health and well-being of the American people	X			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability				
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce	X			
5.A Invest in the HHS workforce to meet America's health and human services needs today and tomorrow	X			
5.B Ensure that the Nation's health care workforce can meet increased demands		X	X	
5.C Enhance the ability of the public health workforce to improve public health at home and abroad				X
5.D Strengthen the Nation's human services workforce	X	X	X	
5.E Improve national, State, and local surveillance and epidemiology capacity				

CMS Summary of Full Cost

(Budgetary Resources in Millions)

HHS Strategic Goals and Objectives	CMS		
	FY 2010	FY 2011	FY 2012
1 Transform Health Care	**817,777.74**	**857,795.9**	**834,449.5**
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured*	810,848.3	849,740.9	826,613.1
1.B Improve health care quality and patient safety	6,929.4	8,055.0	7,836.4
1.C Emphasize primary and preventive care linked with community prevention services			
1.D Reduce the growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality, culturally competent care for vulnerable populations			
1.F Promote the adoption of health information technology			
2 Advance Scientific Knowledge and Innovation			
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in the regulatory sciences to improve food and medical product safety			
2.D Increase our understanding of what works in public health and human service practice			
3 Advance the Health, Safety and Well-Being of the American People			
3.A Ensure the safety, well-being, and healthy development of children and youth			
3.B Promote economic and social well-being for individuals, families and communities			
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D Promote prevention and wellness			
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4 Increase Efficiency, Transparency, and Accountability of HHS Programs	**10,076.5**	**11,421.0**	**11,994.6**
4.A Ensure program integrity and responsible stewardship of resources			
4.B Fight fraud and work to eliminate improper payments	10,076.5	11,421.0	11,994.6
4.C Use HHS data to improve the health and well-being of the American people			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability			

5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce			
5.A Invest in the HHS workforce to meet America's health and human services needs today and tomorrow			
5.B Ensure that the Nation's health care workforce can meet increased demands			
5.C Enhance the ability of the public health workforce to improve public health at home and abroad			
5.D Strengthen the Nation's human services workforce			
5.E Improve national, State, and local surveillance and epidemiology capacity			
Total	**827,854.3**	**869,216.9**	**846,444.2**

Totals may not add due to rounding.
Medicare values reflect gross obligations.

Summary of Findings and Recommendations from Completed Program Evaluation

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.

CMS
Priority Goal

Resources and Performance
(dollars in millions)

	FY 2010 Enacted	FY 2011 President's Budget	FY 2012 Request
Children's Health Insurance Program	$12,518	$13,459	$14,982
Medicaid	$292,663	$260,782	$270,724
Total	$305,181	$274,241	$285,706

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP. (FY 2008 Baseline: 7,368,479 children)	+5% over FY 2008 7,717,317 children	+4.6% over FY 2008 7,705,723 children	+9% over FY 2008 8,031,642 children	+11% over FY 2008 8,179,012 children
Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid. (FY 2008 Baseline: 29,943,162 children)	31,926,974 children	34,441,217 children*	+11% over FY 2008 33,236,910 children	+12% over FY 2008 33,536,341 children

*FY 2010 actual enrollment data became available shortly before publication. CMS is examining whether adjustments should be made to out-year targets based on this data.

CMS's strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with our State and federal partners, continuing to implement CHIPRA provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering our data collection activities.

In February 2010, Secretary Sebelius issued a challenge for leaders in the government and private sector to find and enroll an estimated five million uninsured children who are eligible but not enrolled in Medicaid and CHIP. This effort, known as "Connecting Kids to Coverage", focuses on five key ways to improve CHIP coverage through:

- Cutting red tape to streamline the enrollment and renewal process;
- Capitalizing on technology to demonstrate how new tools can facilitate enrollment and renewal;
- Creating opportunities to apply;
- Focusing on renewal; and
- Forging partnerships to broaden outreach and enrollment opportunities.

During the summer of 2010, CMS launched *"Get Covered. Get in the Game Campaign"*. Each year, many children who want to participate in school or community sports are sidelined because they don't have health insurance. They may not be able to afford a physical or their families worry they'll get hurt on the field. Without health insurance, they can't play. The initiative is in seven pilot States, including Colorado, Florida, Maryland, New York, Ohio, Oregon, and Wisconsin. The pilot is designed to bring coaches, schools, families and communities together to raise awareness about available health coverage and get eligible children enrolled. Getting covered will protect them both on and off the field.

Additionally, CMS is awarding targeted CHIPRA outreach grants to improve enrollment and retention in Medicaid and CHIP, particularly for children in rural areas, Hispanic children, American Indians and Alaskan Natives, teens, legal immigrants and other disadvantaged children. These local outreach efforts will be supplemented by a national outreach campaign that will continue through at least 2013. Additional examples of program improvements being adopted by States include streamlining enrollment and enrollment procedures such as implementing the Express Lane eligibility option and expanding eligibility such as lifting the 5-year waiting period for eligible children who are lawfully residing in the United States. The passage of the Affordable Care Act will also make significant changes to enrollment in the CHIP program as States expand their Medicaid programs.

More information about this Priority Goal will be posted shortly at http://www.goals.performance.gov.

GAO HIGH-RISK LIST ITEMS
Department of Health and Human Services
Centers for Medicare &Medicaid Services

Summary of Plan for Improvement in the GAO High Risk Area

Medicare

Problem: The Medicare program is the second-largest social insurance program in the U.S. with 47 million beneficiaries and total gross expenditures of approximately $509 billion in 2010. Medicare faces increasing financial pressure and it is a critical Administration priority to increase the effectiveness and efficiency of the program. To achieve these goals, CMS continues to update and strengthen our payment systems, improve vulnerabilities and information control weakness in IT management and security, ensure Medicare/Medicaid dual eligible population enrollment into and coverage by Medicare prescription drug plans, and improve quality of care and efficiency while restraining costs.

Goals:

- 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

Refining Medicare payments to ensure they are appropriate, improving program integrity, and reducing improper payments

- **CY 2011 Home Health Prospective Payment System:** The CY 2011 final rule implements various Affordable Care Act provisions and enhances Medicare's program integrity. It applies a 3.79% reduction in CY 2011 to account for additional growth in aggregate case-mix that is unrelated to changes in patient health status.
    - The Affordable Care Act requires CMS to permanently cap outlier payments, reduces the market basket by 1 percent and increases accountability by requiring a physician or non-physician practitioner to have a face-to-face encounter with a patient to certify the patient's eligibility for the benefit. It requires a hospice physician or a nurse practitioner to see a patient prior to re-certifying the patients' eligibility for hospice services at the 180th day recertification of care and for all subsequent certifications.

- **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding** On July 1, 2010, CMS announced the single payment amounts for the Round 1 re-bid of the Competitive Bidding program. On November 3, 2010, CMS announced the contract suppliers. The contracts and payment amounts for the Round 1 re-bid became effective on January 1, 2011. CMS plans to conduct a second round of DMEPOS competitive bidding, covering an additional 91 areas, in 2011, and will implement competitive bidding or payment rate adjustments using competitively bid rates in all areas of the country by January 1, 2016.
- **End Stage Renal Disease (ESRD) Prospective Payment System (PPS)** CMS published the final ESRD PPS on August 12, 2010 and the new system became effective January 1, 2011.
- **2011 Inpatient Hospital Prospective Payment System (IPPS) Final Rule** The FY 2011 IPPS Final Rule implemented several provisions of the Affordable Care Act. These include:
  - Reducing the hospital market basket update by 0.25 percentage points.
  - Providing additional payments totaling $400 million for FYs 2011 and 2012 to IPPS hospitals located in a county that ranks within the lowest quartile of counties in the United States in per enrollee Medicare spending under parts A and B, adjusted for age, sex, and race.
  - Additionally, the law requires the Secretary to create a sliding- scale payment adjustment for low-volume Medicare hospitals, ranging from a 25 percent adjustment for hospitals with 200 or fewer Medicare discharges to no payment adjustment for hospitals with 1,600 or greater Medicare discharges.
  - Requiring CMS to adopt protections for frontier states by implementing hospital wage index that is not less than 1.0 for hospitals located in frontier states, beginning in FY 2011. Frontier states are defined in the law as states where at least 50 percent of the counties have a population density of less than six people per square mile. CMS will update this determination of frontier state status periodically as more recent data – such as data from the 2010 Census-- become available.
  - **Non – ACA Issue** CMS will continue to no longer pay hospitals a higher MS-DRG amount when selected conditions (including selected infections) are acquired during the hospitalization. CMS also expanded the list of quality measures that hospitals must publicly report in order to receive the full market basket update.

Improving Program Management: Fee-For-Service Contracting Practices and Reform

- As of February 2011, nine of fifteen A/B MAC contracts and all four DME contracts have been fully implemented, two A/B MAC contracts are being implemented, and four A/B MAC contracts (Jurisdictions 2,6,7, and 8) are in procurement corrective action or part of new solicitations.

- The nature, extent, and duration of each procurement corrective action depend on the specific circumstances of each A/B MAC procurement. CMS determines the appropriate course of action to take based on guidance from GAO (when the agency makes a formal decision on a bid protest) and HHS counsel. CMS expects that all of the "first-generation" MACs should be fully operational by early FY 2012.

Enhancing Program Integrity – Measuring Improper Payments

CMS continues to enhance our program integrity efforts and improve our improper payment measurement programs. CMS continues to implement and refine Medicare error rate measurement programs that comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA). CMS significantly revised and improved the way that it calculates the Medicare fee-for-service error rate to provide a more complete accounting of the error rate. CMS reported a payment error estimate that was below the established target for the Medicare Advantage program (Part C). For the Medicare Prescription Drug program (Part D), CMS reported new Part D component rates, and we are in the process of finalizing the error rate measurement methodology.

Enhancing Program Integrity – Reducing Improper Payments

CMS is working aggressively on efforts to lower the Medicare FFS paid claims error rate to meet the Presidential goal of reducing the FFS error rate by half by 2012. These efforts include:

- Conducting additional prepayment review on high risk claims by Medicare Administrative Contractors and additional post payment reviews by Recovery Auditors;
- Developing comparative billing reports (CBRs) to help Medicare contractors and providers analyze administrative claims data. CBRs compare a provider's billing pattern for various procedures or services to their peers on a state and national level. CMS also utilizes the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER allows Medicare inpatient hospitals to also analyze their billing patterns through a comparison to other providers in their state and in the nation;
- Increasing and refining educational contacts with providers found to be billing in error. Including commencing DME and A/B MAC task forces that consist of contractor medical review professionals that meet regularly to develop and implement strategies for provider education in error prone areas;
- Implementing the Electronic Submission of Medical Documentation (esMD) into the CERT review process will create greater program efficiencies, allow a quicker response time to documentation requests, and provide better communication between the provider, the CERT contractors, and CMS;
- Developing new data analysis procedures and predictive modeling to assist CMS in identifying payment aberrancies. As well as implementing private sector edits to stop improper payments before they occur; and
- Developing a Vulnerability Tracking System (VTS) which will track vulnerabilities identified by internal and external sources. CMS will use the VTS to inventory and prioritize vulnerabilities, and track corrective actions.

Enhancing Program Integrity – Combating Fraud and Abuse

Program integrity includes a wide range of functions that include the wide spectrum of causes of improper payments, ranging from fraud, abuse, and waste to billing or documentation errors. CMS is taking actions to assure that public funds are not diverted from their central purpose.

- In 2009, CMS partnered with DOJ, FBI and HHS OIG on the Health Care Fraud Prevention and Enforcement Action Team (HEAT). This effort has continued with the expansion of Medicare Strike Forces, National and Regional summits on health care fraud, and media campaigns to educate Medicare beneficiaries about how to protect themselves against fraud.

- CMS realigned program integrity functions by creating the Center for Program Integrity (CPI) to carry out the new responsibilities under the Affordable Care Act, to consolidate, coordinate and strengthen existing program integrity (PI) activities, and to position the agency strategically to address future PI issues.
- In an effort to identify state-of-the-art services, methods and products that could protect the Trust Funds and other public resources against losses from fraud and other improper payments and to improve the integrity of the health care system, CMS is conducting a two-phase market research initiative. CMS issued an RFI in December 2010 to obtain industry guidance on developing fully integrated approaches to a national program for preventing fraud, waste, and abuse by asking for innovation in the areas of provider screening, case management, predictive modeling, and data integration. CMS also issued in December 2010 a separate solicitation for multiple task order awards for predictive modeling and case management which will be implemented by July 2011. This work will build on efforts already in progress and jumpstart the development of a national program to prevent fraud, waste and abuse while meeting the provisions of the Small Business Jobs Act of 2010, H.R. 5297.
- The Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs) produced a total of $1.13 billion dollars in savings for Medicare Parts A and B through the first eleven months of FY 2010.
- Field offices continue to support, monitor, and oversee projects including the Los Angeles Field Office Tax Project, South Florida Hotline, High Volume Claims Beneficiary Project, Compromised Number Contract (CNC), and the DME Stop Gap Plan.
- CMS published a final rule that implements various provisions of the Affordable Care Act, including provider screening procedures, enhanced authority to impose payment suspensions and temporary moratoria on provider enrollment.

Enhancing Program Integrity – "Parts C and D"

- Parts C and D of Medicare rely on fundamentally different payment systems than are used in the FFS portion of our program.
- In Parts C and D we pay capitated monthly rates per beneficiary, as opposed to claims per service. Further, these rates are adjusted to account for the risk of each beneficiary in the program. For Part D, final payments can be further adjusted to account for whether or not plan costs were ultimately higher or lower than estimated in their initial bids.
- The error rate for the Part C program reported in the FY 2010 Agency Financial Report, declined from FY 2009 and was below the established target. To address the error rate, CMS is conducting audits of risk adjustment data and will conduct payment recovery based on the results. CMS has recently concluded medical record reviews of five plan contracts under a pilot risk adjustment data validation audit.
- For Part D we have reported component rates and are still in the process of developing an IPERA compliant rate. We expect to report a composite Part D payment error rate for FY 2011. For FY 2010, CMS reported four component measures, including a newly developed measure focusing on error related to prescription drug event validation. Once we have completed our methodology we will be developing out year targets and a mitigation plan.

- CMS changed the focus of the MEDIC work from two regional contractors that performed similar work to a functional contractor approach. One MEDIC now focuses on contract compliance oversight activities for the entire nation, while the other MEDIC has a national emphasis on fraud, waste and abuse oversight activities.

Enhancing Program Management – Managing IT and IT Security

- Established robust investment management policies, procedures and practices.
- Implemented the post-implementation review (PIR) process for major systems implementations.
- In FY 2010, a survey of all of the systems at CMS was conducted to develop the CMS System Inventory. This Inventory supports information security, records management, continuity of operations (COOP), the OMB Financial Management Systems Inventory, and the IT project management and Investment management in the CMS Investment Lifecycle operational programs, as well as all major IT initiatives such as HITECH, the Comparative Effectiveness Research Project, MACBIS, and the Affordable Care Act. OIS' Enterprise Architecture & Strategy Group, Division of Enterprise Architecture plans on completing an update to the CMS System Inventory by 4QFY 2011.

Overseeing Patient Safety and Care - Nursing Homes

- Conducting Targeted quality improvement assistance at high-risk special focus facility (SFF) nursing homes requiring the most assistance. CMS directed our State Quality Improvement Organization (QIO) contractors to recruit and assist one special focus facility per year between 2008 and 2010. Currently, QIOs are working with 100 SFF nursing homes to reduce high-risk pressure ulcers and use of restraints. CMS is currently monitoring QIO assistance to SFFs on a quarterly basis, and will evaluate contractor assistance during 2010 and 2011.

Department of Health and Human Services
Centers for Medicare and Medicaid Services

Summary of Plan for Improvement in the GAO High Risk Area

Medicaid

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. While GAO acknowledges that CMS has made improvements in this area, GAO believes that further efforts should be undertaken to strengthen the fiscal accountability of the Medicaid program. Additionally, GAO continues to believe CMS has not 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;
- To ensure that waiver programs are financed appropriately; and
- Improve fiscal integrity and financial management.

Challenge 1 – 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, and clarify or communicate its policies in several high risk areas, including supplemental payment arrangements.

- **Action 1 -** Strengthen the fiscal accountability of the Medicaid program. On May 25, 2007, CMS produced 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 prevented CMS from finalizing and/or implementing the regulation until after March 31, 2009. Section 5003(d) of Public Law 111-5, the American Recovery and Reinvestment Act of 2009, conveyed Congressional opposition to finalizing several rules, including Cost Limit for Providers rule. CMS is in the process of evaluating the need for further guidance on Medicaid financing requirements as well as evaluating Medicaid payment policies.

As required under section 7001(c)(2) of the Supplemental Appropriations Act, 2008 (Public Law 110-252), CMS retained an independent contractor to provide additional information to Congress and CMS on the policy and financial impact of certain proposed and final Medicaid regulations placed under moratorium by Congress. This report, entitled "Analysis of Impact and Issues Related to Four Medicaid Regulations," was published in 2009. CMS is using the findings from this report, as well as court decisions and Congressional guidance, to guide future regulatory and policy strategies on this topic.

- **Action 2 – 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 receives an introduction to the use of the Datamart tools during their orientation. We are also developing a Medicaid Data Dashboard to be used by policy makers, program integrity administrators, researchers, and program operations managers. The web-based Dashboard displays Medicaid spending, services and beneficiary information in a user friendly and intuitive format and provides a quick and comparative overview of Medicaid programs and their trends.

<u>Challenge 2</u> – To Ensure Waiver Programs Are Financed Appropriately.

The GAO has repeatedly criticized section 1115 demonstration practices with respect to budget neutrality. Budget neutrality ensures that approval of Section 1115 demonstrations do not increase Federal financial liability. Therefore, demonstrations that increase Federal financial liability beyond what it would have been without the demonstration should not be approved.

Action 1 – Review Section 1115 Demonstrations in Accordance With Program Objectives and Mitigate Budget Neutrality Risk

- 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.
- CMS will continue to provide States with technical assistance in accordance with budget neutrality principles and seek ways to improve the process to ensure that approved programs are budget neutral.
- CMS, in support of a new performance measure, has implemented an improved program for monitoring budget neutrality, in which the budget neutrality status of all 1115 demonstrations is routinely reviewed. CMS exceeded its goal for completing targeted budget neutrality reviews in FY 2008 and 2009.

Challenge 3 – Improve Fiscal Integrity and Financial Management

Action 1 – 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.
- The Medicaid Integrity Program (MIP) has been operational for four years and continues to learn and work to improve the program. In FY 2010, Executive Order 13520 and the program integrity provisions of the Affordable Care Act have increased the workload. We also integrated with Medicare PI to form the Center for Program Integrity.
- A major focus moving forward is to build on early work done in FY 2010 to increase focus on Medicaid audits involving cross-border, regional, and national issues. CMS believes that this broader approach will provide a greater opportunity for CMS and states to improve results through leveraging shared risk issue among states. It's still too early to assess if this approach will be more effective than our current methods in conducting provider audits. However, early adopter states have favored collaboration in identifying areas of risk, selecting audit subjects, and estimating reasonability of the potential outcome of the effort.
- Provider education is also a key component of CMS' strategy to mitigate inappropriate billing by providers. Although CMS has been conducting provider outreach since its inception, we are in the early stages of implementing provider and beneficiary outreach and education to target areas of perceived risk identified through the contractor's gap analysis including interviews conducted with Medicaid stakeholders and an environmental scan.
- Additionally, we will continue to apply significant effort and resources in implementing the Medicaid program integrity provisions of the Affordable Care Act specifically in the area of guidance to states on provider enrollment and state RACs and facilitating state reporting necessary for both provisions.