DEPARTMENT of HEALTH and HUMAN SERVICES

Centers for Medicare & Medicaid Services

FY 2011 Online Performance Appendix

Introduction

The FY 2011 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 2011 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS FY 2009 Summary of Performance and Financial Information. These documents are available at http://www.hhs.gov/budget/.

The FY 2011 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2009 Annual Performance Report and FY 2011 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS FY 2009 Summary of Performance and Financial Information summarizes key past and planned performance and financial information.

Preparation of this online performance appendix is performed exclusively by employees of the Centers for Medicare & Medicaid Services.

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Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) FY 2011 Online Performance Appendix to the FY 2011 Annual Performance Budget. CMS is the largest purchaser of health care in the United States, serving almost 102 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. We take this role very seriously, as our oversight responsibility impacts millions of lives and has grown dramatically over the last few years.

On February 17, 2009, the Administration committed to investing *American Recovery and Reinvestment Act of 2009* dollars with an unprecedented level of transparency and accountability so Americans know where their tax dollars are going and how they are being spent. We are committed to increasing transparency, reducing costs and ensuring that the dollars received by CMS are being invested in initiatives and strategies that make a difference for our beneficiaries.

In addition, the Department of Health and Human Services has identified a limited number of high priority performance goals that will be a particular focus over the next two years. Among these is CMS' goal to "*Broaden the availability and accessibility of health insurance coverage through implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) legislation".* By the end of FY 2011 we will increase CHIP enrollment by seven percent over the FY 2008 baseline levels.

This Online Performance Appendix illustrates CMS' vision to achieve a transformed and modernized health care system for America. 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 on improving program effectiveness.

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

On behalf of our beneficiaries, I thank you for your continued support of CMS and its FY 2011 Online Performance Appendix.

/Charlene Frizzera/
Charlene Frizzera

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Summary of Performance Targets and Results

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
2005	49	49	100%	39	80%
2006	45	45	100%	42	93%
2007	46	46	100%	42	91%
2008	53	52	98%	46	88%
2009	52	35	67%	27	77%
2010	53	2	4%	2	100%
2011	49	0	0%	0	0%

Program: Medicare Operations

Measure	FY	Target	Result
MCR2.1: Medicare Prescription Drug Program: Enhance Medicare Appeals System (MAS) functionality and support major maintenance releases	*2010*	Goal discontinued	N/A
	2009	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2008	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
MCR2.2: Medicare Advantage: Enhance MAS functionality and support major maintenance releases	*2009*	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2008	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2007	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2006	Fully integrate IRE data reporting into the MAS	Fully integrated IRE data reporting into the MAS (Target Met)
	2005	Begin integrating IRE data reporting into the MAS functionality	Began integrating IRE data reporting into the MAS functionality (Target Met)
MCR2.3: Fee-for-Service: Enhance MAS functionality and support major maintenance releases	*2009*	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2008	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2007	Enhance MAS functionality and support major maintenance releases	MAS functionality enhanced and major releases were supported (Target Met)
	2006	Develop the third increment of the MAS	Developed the third increment of the MAS (Target Met)
	2005	Develop the second increment of the MAS	Developed the second increment of the MAS (Target Met)

Measure	Data Source	Data Validation
MCR2.1 MCR2.2 MCR2.3	The Medicare Advantage Organization provides the Independent Review Entity (IRE) with appeals data to enable the IRE to report and maintain aggregate data in its system. The IRE ultimately will report data into the MAS. Aggregate FFS data are entered into the Contractor Reporting of Operational Workload Data (CROWD) system by Fiscal Intermediaries (FIs), carriers, and Medicare Administrative Contractors. The Medicare Appeals System tracks FFS data for the level two Qualified Independent Contractors and level three Administrative Law Judges.	CMS utilizes the Contractor Performance Evaluation (CPE) process to evaluate the performance of FIs and carriers.

MCR2: Improve Medicare's Administration of the Beneficiary Appeals Process

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

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

CMS met the FY 2009 goal with three major production releases on November 16, 2008, March 23, 2009, and July 25, 2009. These MAS releases expanded the MAS document importer to the Part B, C, and D QICs to allow access to images of case file documents, and provided read-only MAS access to the MACs.

Due to the successful implementation of the QICs and MAS, CMS is discontinuing the Appeals GPRA goal. Since the inception of the Appeals GPRA goal in FY 2005, CMS has fully implemented MAS at two levels of appeal, implemented document imaging for all Part A reconsiderations, and implemented a claims interface to obtain data directly from the claims processing shared systems. The MAS played a critical role in helping CMS meet the strict requirements of the Benefits and Improvements Protection Act of 2000 (BIPA) by simplifying the appeals process, and significantly reducing appeals processing timeframes. CMS will continue to enhance and expand MAS. With every improvement CMS makes to MAS it not only enhances our ability to perform appeals, but also improves upon our ability to better serve the Medicare beneficiary and provider communities.

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	*2008*	63%	64% (Target Exceeded)
	2007	62%	63% (Target Exceeded)
	2006	N/A	67% (Historical Actual)
MCR3.1b: Beneficiary Survey: Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	*2011*	73%	Feb 28, 2012
	2010	72%	Feb 28, 2011
	2009	71%	Feb 28, 2010
	2008	65%	75% (Target Exceeded)
	2007	64%	69% (Target Exceeded)
	2006	N/A	69% (Historical Actual)
MCR3.1c: Beneficiary Survey: Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	*2011*	62%	Feb 28, 2012
	2010	61%	Feb 28, 2011
	2009	60%	Feb 28, 2010
	2008	46%	69% (Target Exceeded)
	2007	45%	68% (Target Exceeded)
	2006	N/A	50% (Historical Actual)
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	*2011*	91%	Feb 28, 2011
	2010	91%	Feb 28, 2010
	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 addresses three aspects of the benefit: (1) a beneficiary survey measuring knowledge of the benefit; (2) a management/operations component involving Part D sponsor performance metrics published on the Medicare Prescription Drug Plan Finder (MPDPF) tool; and (3) an enrollment component measuring increase of Medicare beneficiaries with prescription drug coverage from Part D or other sources which 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 what they know about the program, the likely result is a decline, and eventual plateau, in Part D knowledge across all beneficiaries. CMS will continue to engage in communication activities to try to counter this decline and will continue to track beneficiary knowledge to gauge the effectiveness of these efforts.

CMS continues to work with Part D plans and other stakeholders to improve program operations and public knowledge of this valuable program. CMS wants to ensure that beneficiaries receive the best prescription drug coverage available and they have the data necessary to make the most informed decision about plan selection. To assist

beneficiaries making enrollment decisions, 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 will be discontinued following 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. Given the high rates of enrollment, it is becoming increasingly challenging to increase the enrollment rates further. The target will remain at 91 percent for FY 2010 and FY 2011.

Measure	FY	Target	Result
MCR4: Decrease the prevalence of restraints in nursing homes	*2011*	3.7%	Feb 28, 2012
	2010	3.8%	Feb 28, 2011
	2009	5.1%	Feb 28, 2010
	2008	6.1%	4% (Target Exceeded)
	2007	6.2%	5% (Target Exceeded)
	2006	6.4%	6.1% (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. The physical restraints quality measure used is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. We report the prevalence of physical restraints that are used continuously for at least one week, excluding side rails, in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. Restraints counted on admission assessments are excluded.	The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner.

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 2008 target of 6.1 percent by achieving a rate of 4.0 percent. If we compare the prevalence of restraints from the last quarter of FY 2003 to the last quarter of FY 2008, there are almost 50 percent fewer nursing home residents in restraints each week.

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 new national *Advancing Excellence in America's Nursing Homes* campaign. These efforts have been even more successful than anticipated in FY 2007 and 2008, leading CMS to exceed its performance targets.

CMS is working to improve surveyor training so that surveyors will be better able to detect inappropriate restraint use. The FY 2009 target is 5.1 percent, the FY 2010 target is 3.8 percent and the FY 2011 target is 3.7 percent. Despite the exceptional progress

that we have made, we expect that the future rate of decrease to diminish as more and more nursing homes meet targeted rates.

Measure	FY	Target	Result
MCR5: Decrease the prevalence of pressure ulcers in nursing homes	*2011*	8.0%	Feb 28, 2012
	2010	8.1%	Feb 28, 2011
	2009	8.2%	Feb 28, 2010
	2008	8.5%	8% (Target Exceeded)
	2007	8.6%	8.1% (Target Exceeded)
	2006	8.8%	8.2% (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.	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.

MCR5: Decrease the Prevalence of Pressure Ulcers in Nursing Homes

The purpose of this measure is to decrease the prevalence of pressure ulcers in nursing homes. The prevalence of pressure ulcers in nursing homes is an indicator of quality of care and may be considered a quality of life measure for nursing home residents. After many years of little or no progress, CMS has met or exceeded its targets since FY 2004, including FY 2008, where we exceeded our target of 8.5 percent with an actual prevalence of 8.0 percent.

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. While FY 2008 results exceed future targets, the decrease in each of the last two fiscal years was only 0.1 percentage point. Accordingly, our FY 2009 target is 8.2 percent, our 2010 target is 8.1 percent and our FY 2011 target is 8.0 percent.

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

Measure	FY	Target	Result
MCR6: Percentage of States that survey nursing homes at least every 15 months	*2011*	97%	Apr 30, 2012
	2010	95%	Apr 30, 2011
	2009	85%	Apr 30, 2010
	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 2008 targets with an actual result of 96 percent. Targets for FY 2009, FY 2010, and FY 2011 are 85 percent, 95 percent, and 97 percent, respectively. The major internal factor affecting this measure is the requirement that CMS ensure proper operational controls, such as training and regulations, are in place. CMS issues directions to States outlining the agency's policies and the statutory survey frequency requirements. These communications also prioritize the requirements for conducting recertification surveys for the non-statutorily mandated provider/supplier type to assure that the statutory survey timeframes are completed. CMS also conducts a formal assessment of whether the State survey agencies fulfill their outlined responsibilities through the State Performance Standards System. CMS uses this set of standards to determine whether the State survey agencies are meeting the requirements for the survey and certification program and to identify areas for improvement in management. For States that do not meet statutory requirements, CMS may make a non-delivery deduction from the State's subsequent funding, as described 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	*2011*	95%	Apr 30, 2012
	2010	90%	Apr 30, 2011
	2009	75%	Apr 30, 2010
	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 2008 target with an actual of 94 percent. Future targets are set at 75 percent for FY 2009, 90 percent for FY 2010, and 95 percent for FY 2011. 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 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.	*2011*	90%	Apr 30, 2011
	2010	80%	Apr 30, 2010
	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 2009, we exceeded the 75 percent goal by imposing a non-delivery deduction in 100 percent of applicable cases. The FY 2010 target is 80 percent and the FY 2011 target is 90 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 future State performance. 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.

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	*2011*	90%	Oct 31, 2011
	2010	90%	Oct 31, 2010
	2009	90%	97% (Target Exceeded)
	2008	90%	97% (Target Exceeded)
	2007	90%	95% (Target Exceeded)
	2006	N/A	93% (Historical Actual)
	2005	N/A	98% (Historical Actual)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	*2011*	90%	Oct 31, 2011
	2010	90%	Oct 31, 2010
	2009	90%	96% (Target Exceeded)
	2008	90%	94% (Target Exceeded)
	2007	90%	97% (Target Exceeded)
	2006	N/A	97% (Historical Actual)
	2005	N/A	98% (Historical Actual)
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	*2011*	90%	Oct 31, 2011
	2010	90%	Oct 31, 2010
	2009	90%	93% (Target Exceeded)
	2008	90%	94% (Target Exceeded)
	2007	90%	94% (Target Exceeded)
	2006	N/A	94% (Historical Actual)
	2005	N/A	98% (Historical Actual)
MCR9.2: Maintain and continue to develop Virtual Call Center Strategy (VCS) initiatives for handling beneficiary inquiries	*2008*	Maintain and continue to develop VCS initiatives for handling beneficiary inquiries	Maintained and continued to develop VCS initiatives for handling beneficiary inquiries (Target Met)
	2007	Maintain and continue to develop VCS initiatives for handling beneficiary inquiries	Maintained and continued to develop VCS initiatives for handling beneficiary inquiries (Target Met)

Measure	FY	Target	Result
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey	*2011*	90%	Oct 31, 2011
	2010	90%	Oct 31, 2010

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. 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 2009 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. Also, it is too early to tell if the recent change in scoring methodology will have a significant impact on the BCC's performance/scores for FY 2010 and beyond.

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 will be 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 will capture an aggregated score of these dimensions. CMS will begin reporting this new customer satisfaction measure in FY 2010.

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

Measure	FY	Target	Result
MCR10.1: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Fiscal Intermediaries	*2011*	95%	Nov 30, 2011
	2010	95%	Nov 30, 2010
	2009	95%	99.7% (Target Exceeded)
	2008	95%	99.8% (Target Exceeded)
	2007	95%	99.8% (Target Exceeded)
	2006	95%	99.8% (Target Exceeded)
	2005	95%	99.9% (Target Exceeded)
MCR10.2: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Carriers	*2011*	95%	Nov 30, 2011
	2010	95%	Nov 30, 2010
	2009	95%	99.3% (Target Exceeded)
	2008	95%	98.8% (Target Exceeded)
	2007	95%	99.0% (Target Exceeded)
	2006	95%	99.5% (Target Exceeded)
	2005	95%	98.4% (Target Exceeded)

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

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 annual Quality Assessment Surveillance Plan reviews.

CMS exceeded its FY 2009 targets for Medicare FIs (95 percent) and Carriers (95 percent) as contractors, by achieving levels of 99.7 percent and 99.3 percent, respectively. 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, the FY 2010 and FY 2011 targets are to maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims in a millennium compliant environment, to allow 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%	Oct 31, 2010
	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)
	2005	Complete analysis of baseline data	Completed analysis of baseline data (Target Met)
MCR11.2b: Electronic Remittance Advice Rates for Carriers	*2011*	Goal discontinued	N/A
	2010	50%	Oct 31, 2010
	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)
	2005	Complete analysis of baseline data	Completed analysis of baseline data (Target Met)

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.

The FY 2009 target for fiscal intermediaries was not met. Although we technically missed the target by only 0.29 percent, we have essentially met this measure. 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. The FY 2009 target for carriers was exceeded. Actions like improving the quality and consistency of ERA across the board, and continuously enhancing free software for ERA based on user feedback, have contributed to 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.

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.

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 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 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.

After taking FY 2009 actual data into consideration, we expect to maintain the current level of ERA for fiscal intermediaries and increase the rates for carriers to 50 percent to match the FY 2009 level in FY 2010.

Measure	FY	Target	Result
MCR12: Maintain an unqualified opinion	*2011*	Maintain	Nov 30, 2011
	2010	Maintain	Nov 30, 2010
	2009	Maintain	Target Met
	2008	Maintain	Target Met
	2007	Maintain	Target Met
	2006	Maintain	Target Met
	2005	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 Medicare contractors.

The CMS met its FY 2009 target of maintaining an unqualified opinion – a target CMS has met for eleven consecutive fiscal years. During FY 2009, CMS continued to improve its financial management performance in many areas. Specifically, CMS was successful in addressing one of the significant deficiencies noted in the FY 2008 audit – Statement of Social Insurance. The CMS also effectively transitioned one additional contractor to its Healthcare Integrated General Ledger System (HIGLAS) in FY 2009, bringing the total to fifteen Medicare contractors that have successfully transitioned. HIGLAS is now the system of record for these Medicare contractor sites.

During FY 2009, 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)	*2011*	Award 1 DME and 1 A/B MAC (2nd round)	Nov 30, 2011
	2010	Award 3 DME MACs (2nd round)	Nov 30, 2010
	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)
	2006	Award 8.8%	Award 9.1% (Target Met)
	2005	Deliver Report to Congress	Delivered Report to Congress (Target Met)
MCR13.2: Implement Medicare FFS Workload to MACs	*2011*	Implement 3 DME MACs (2nd round)	Nov 30, 2011
	2010	Implement 100%	Nov 30, 2010
	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)

** Six A/B MAC contracts remain in procurement corrective action

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 current Medicare FI and Carrier contracts, using competitive procedures, with new Medicare Administrative Contractor (MAC) contracts by October 2011. The new MAC

contracts may be renewed annually based on performance for a period of 5 years, but they must be re-competed every 5 years. The introduction of competitive contracting is expected to improve the operating efficiency of Medicare FFS claims operations, generating administrative savings. CMS also expects that Medicare Contracting Reform will yield $1.5 billion in trust fund savings through FY 2011.

For FY 2007, CMS implemented 9.1 percent of the FFS workload (five MAC contracts). Also, CMS awarded an additional two contracts to MACs, for a total award of 22.2 percent of the FFS workload.

In FY 2008, CMS implemented 31.5 percent of the FFS workload (across five MAC contracts), bringing the total FFS workload implemented to 40.6 percent. Also, CMS awarded an additional six contracts to MACs, for a total award of 62.3 percent of the FFS workload. (However, CMS has suspended performance on four 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 and resulting procurement corrective action. As of November 2009, six A/B MAC contracts remain in corrective action. To address these challenges, CMS has implemented process improvements to better manage these procurements.

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

In FY 2010, CMS will begin the re-competition phase with the award of 3 DME MAC jurisdictions (award of the final DME MAC jurisdiction, as well as the J3 A/B MAC will occur in FY 2011). Planning for these re-competitions is already underway. CMS is incorporating many of the lessons learned from the first round of MAC awards, as well as ways to streamline the evaluation process. CMS intends that, through these methods, staff time needed for proposal review will decrease, and that the government will be more successful in the outcome of Government Accountability Office decisions regarding bid protests.

Measure	FY	Target	Result
MCR14: Mature the Enterprise Architecture (EA) Program	*2010*	Goal discontinued	N/A
	2009	Mature EA Program: 1) Establish management practices, process and policies to develop and oversee EA. 2) Expand the EA Repository 3) Integrate EA with CMS' Certification Package of Internal Controls (CPIC) process	Target met
	2008	Continue maturing the EA: 1) Establish management practices, process and policies to develop and oversee EA. 2) Expand the EA Repository 3) Integrate EA with CMS CPIC process	Target met
	2007	Continue Maturing the EA	Target met
	2006	Continue Maturing the Enterprise Architecture	Target met

Measure	Data Source	Data Validation
MCR14	Approved standards and preferred Information Technology (IT) products are documented in the CMS Technical Reference Architecture document: http://cmsnet.cms.hhs.gov/hpages/oisnew/foffice/m/TRA.html All IT policies and subordinate documents are published in the Framework, a comprehensive library of all information relating to the acquisition and creation of IT systems. http://www.cms.hhs.gov/SystemLifecycleFramework A mechanism for measuring architecture maturity will be data in the Enterprise Architecture Repository: http://www.cms.hhs.gov/EnterpriseArchitecture/02_FEAF.asp	Compliance with the CMS EA standards and practices is monitored through checkpoints in the Framework that document when and where in the procurement and system development lifecycle EA reviews must take place.

MCR14: Mature the Enterprise Architecture (EA) Program

The purpose of this measure is to ensure that Information Technology (IT) requirements are aligned with the business processes that support CMS' mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS' IT Systems. CMS has met its targets for the past four years.

In FY 2009, CMS met its target to mature the EA Program by doing the following: 1) Established management practices, process and policies to develop and oversee Enterprise Architecture for the American Recovery and Reinvestment Act of 2009-Health Information Technology for Economic and Clinical Health Act (Recovery Act-HITECH) activities, new procurement intake process and business process modeling; 2) Identified opportunities for cost-savings and improved, consolidated, consistent information to beneficiaries in the customer service, control and oversight and administrative management segments; 3) Assisted with projects to support value based purchasing initiatives under the Medicare Improvements for Patients and Providers Act of 2008; 4) Expanded the EA Repository; and 5) Integrated EA with CMS' Certification Package of Internal Controls (CPIC) process.

This long-term measure was initiated in FY 2000 to address the Y2K millennium conversion and has evolved to measure the development of the CMS enterprise architecture. CMS has decided to discontinue this measure after FY 2009. The termination of the measure neither minimizes the extensive commitment and effort that this measure represents, nor does it mean that the activity will cease. CMS' business community will continue to benefit from the increased visibility into the Agency's processes. A continually maturing EA allows for realistic insight into the support networks, both technological and strategic, that provide the fundamental underpinnings to the work of the Agency.

Measure	FY	Target	Result
MCR15: Increase representation of EEO groups in areas where agency participation is less than the National and/or Federal baseline comparing the CMS workforce with the 2000 National Civilian Labor Force	*2010*	Goal discontinued	N/A
	2009	Increase	Partially Met (Target Not Met but Improved)
	2008	Increase	Partially Met (Target Not Met but Improved)
	2007	Increase	Increased (Target Met)
	2006	Increase	Increased (Target Met)
	2005	Increase	Increased (Target Met)

Measure	Data Source	Data Validation
MCR15	• Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 2000 official decennial census figures1 • The 2000 official decennial census figures • OPM's Central Personnel Data File (updated every pay period) • HHS' Workforce Inventory Profile System (WIPS) (updated every pay period) • The CMS Workforce Profiles (prepared using WIPS)	• 2000 Civilian Labor Force data - Validated and verified by the Census Bureau • Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 2000 official decennial census figures - Validated and verified by OPM. These are the standard government-wide statistics. • Central Personnel Data File - Validated and verified by OPM. • HHS' Workforce Inventory Profile System (WIPS) - Validated and verified by HHS. • The CMS Workforce Profiles – Validated and verified by CMS.

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

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

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

As of September 30, 2009, men comprised 32.87 percent and women comprised 67.13 percent of the workforce, compared to the NCLF representations of 53.20 percent and 46.80 percent, respectively.

Minorities accounted for 36 percent of the total CMS permanent workforce. The representation of minorities in CMS remained relatively unchanged between FY 2008 and FY 2009. Specific details on the changes that occurred within each racial/national origin group are shown below:

CMS Demographics	FY 2009 Net Change (%)	FY 2009 Net Change (#)	FY 2009 Net Change (%)	FY 2009 Net Change (#)	FY 2009 Net Change (%)	FY 2009 Net Change (#)
	Males	Males	Females	Females	Total	Total
Hispanic	1.85%	1	-4.86%	-7	-3.03%	-6
Non-Hispanic	0.88%	12	1.05%	29	1.00%	41
White	1.12%	12	0.48%	8	0.73%	20
African American	0.51%	1	1.10%	10	1.00%	11
American Indian	0.00%	0	-3.85%	-1	-2.63%	-1
Asian American	-1.16%	-1	8.22%	12	4.74%	11
Native Hawaiian/Pacific Islander	0.00%	0	0.00%	0	0.00%	0
Two or More Races/Unknown	0.00%	0	0.00%	0	0.00%	0
TOTAL		**13**		**22**		**35**

For the most part, representation among White females, African-American males, and Asian males at CMS was consistent with the NCLF. Especially interesting points include that African-American female representation at CMS (21.03 percent), was more than three and one-half times larger than the NCLF (5.70 percent), Asian female representation (3.63 percent) was more than double the NCLF (1.70 percent), and American Indian/Alaska Native female representation (0.57 percent) was just under twice the NCLF of 0.30 percent.

In FY 2009, the overall percentage of males at CMS (32.9 percent) was significantly lower than the 2000 civilian labor force percentage of 53.20 percent. As indicated above, this phenomenon was mainly due to underrepresentation among White and Hispanic/Latino males at the lower grades. Both of these groups were found primarily in the Official/Manager and Professional occupational categories. During fiscal year 2009, CMS was able to change from a pattern of net losses in males. This year, 88, or 39.46 percent, of CMS' 223 new hires were male (of which 73 were White and 1 was Hispanic), and CMS only lost 77 males (64 White, 1 Hispanic) during FY 2009. This resulted in a net increase of 1.12 percent and 1.85 percent for White males and Hispanic males, respectively. The agency continues to build upon its strategy to eliminate potential barriers and increase participation rates as is outlined in its FY 2009 Management Directive 715 report.

The seven-year trend of CMS participation rates of employees with disabilities reveals that the participation rate of employees with disabilities continues to decrease. The total number of employees identified with reportable disabilities decreased from 9.64 percent (416 employees) to 9.10 percent (396 employees). The number of employees with targeted disabilities and their participation rates decreased during FY 2009 from 1.74 percent (75 employees) to 1.66 percent (72 employees). There continues to be challenges in the hiring and retention of individuals with targeted disabilities. The agency continues to increase awareness of hiring flexibilities and is committed to attracting and developing the talent in this community.

CMS continues to measure itself against the standards established by the EEOC to achieve a model EEO program where every employee is free from employment barriers. We have decided to retire this performance goal after FY 2009, but we have instituted a more rigorous agency assessment and monitoring process to ensure that progress continues in addressing these issues. The CMS will continue to use the Federal Agency Annual EEO Programs Status Report (MD-715) to identify deficiencies and implement solutions in order to ensure workforce diversity at all levels.

Measure	FY	Target	Result
MCR18: Increase final percent of possible cost sharing flags without high cost sharing review flags for Medicare-covered services	*2011*	95.8%	Feb 28, 2011
	2010	95.2%	Feb 28, 2010
	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. Additionally, the result for FY 2009 matched the original FY 2010 target amount, so CMS revised the targets for FY 2010 and FY 2011 accordingly. CMS is on track to exceed the FY 2010 target amount and the target for FY 2011 is 95.8 percent. CMS attributes this continued improvement to the imposition of more stringent bid review criteria for each year.

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	*2011*	TBD	Preliminary data June 2010
	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 demonstration 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 is tasked with implementing the Recovery Audit Contractor (RAC) program in all 50 States by January 1, 2010. CMS is able to track the implementation of the program by attending/providing at least one outreach session in each State and U.S. Territory as well as monthly progress reports submitted by the RACs. As of October 29, 2009, the RAC program has been implemented in all 50 States and U.S. Territories.

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.

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 7.6 percent through all levels of appeal. CMS will use FY 2011 to collect data to determine the overturn rate at the first level of appeal and determine the appropriate targets for FY 2012 and beyond.

Measure	FY	Target	Result
MCR20: Implement the International Classification of Diseases (ICD)-10	*2011*	Update ICD-10 industry and State Medicaid program compliance measurement	May 1, 2010
	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 2. March 1, 2010 3. Industry compliance level baselines developed (Target Met) 4. Oct 1, 2010
	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.

[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)

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.

This 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 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 the first half of 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 will ultimately deliver an implementation plan with option recommendations. Additionally, this phase of the project included outreach and education planning, preliminary development of baseline industry and State Medicaid program implementation monitoring, and initiation of agency-wide project management and implementation activities, all of which will continue into the second half of FY 2010. FY 2011 activities will build upon those initiated in FY 2010, with a continuation of industry and State Medicaid program implementation monitoring. 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: 114 out of 311 FISMA Systems (36%) have an active Authority To Operate (ATO) (as of 10/2009)	*2011*	80%	Final results will be available 10/2011
	2010	New in 2011	Baseline is 311 FISMA Systems
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by centralized vulnerability management solution Baseline: 0% FY 2009	*2011*	95%	% provided 10/2011
	2010	New in 2011	% provided 10/2010
MCR21.3: Percent of information technology (IT) projects that have adapted to the Enterprise Performance Life Cycle (EPLC) framework Baseline: 10% FY2009	*2011*	75%	December 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% FY2009	*2011*	2 PIRs	December 31, 2010
	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 C&A and POA&M 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. Since we currently have no PIR process and only 10 percent of IT projects are following the EPLC, successfully conducting two PIRs in 2011 represents a 200 percent increase; and increasing the number of projects adapting to the EPLC from 10 percent to 75 percent represents a 650 percent increase. 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 is aggressively working to resolve the identified issues by 1) expanding CMS' system inventory to be all-inclusive, 2) replacing the legacy Plan Of Actions and Milestones (POA&M) application which is expected to resolve a substantial number of audit findings, and 3) CMS working with experts across government to identify an appropriate cost-effective and risk-based solution 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 solution has been procured and is currently being tested at multiple data centers across the CMS enterprise environment. The goal to have 95 percent of all CMS FISMA systems being scanned and monitored by a centralized vulnerability management solution in 2011 is very ambitious and represents a dramatic improvement in the CMS information security posture. Likewise, increasing our current percentage of systems authorized to operate in accordance with FISMA from 36 percent to 80 percent in 2011 represents a significant challenge and an ambitious goal for CMS to independently test, analyze and certify the security controls and/or accept the risk for over 130 systems during 2010.

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.

Program: Medicaid

Measure	FY	Target	Result
MCD1.1: Estimate the Payment Error Rate in the Medicaid Program	*2011*	Report national error rates in the FY 2012 AFR based on 17 States measured in FY 2011 and rolling average error rate based on States measured in FY 2009-FY 2011. Target below the baseline established in FY 2010.	Nov 30, 2012
	2010	Report national error rates in the FY 2011 AFR based on 17 States measured in FY 2010 and baseline rolling average error rate based on States measured in FY 2008-FY 2010.	Nov 30, 2011
	2009	Report national error rates in FY 2010 AFR based on 17 States measured in FY 2009.	Nov 30, 2010
	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)	*2011*	Report national error rates in the FY 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.	Nov 30, 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.
	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. We expect the FY 2009 Medicaid PERM rates will be published in the FY 2010 AFR.

CMS reported a preliminary Medicaid fee-for-service error rate in the FY 2007 AFR with a final error rate reported in the FY 2008 AFR, both based on FY 2006 claims data. In FY 2007, we began full implementation of the PERM program in Medicaid and CHIP. The fully implemented national Medicaid and CHIP program error rates based on FY 2007 claims data were reported in the FY 2008 AFR. Likewise, we reported the FY 2008 Medicaid PERM rates in the FY 2009 AFR. In addition, since the FY 2008 cycle is the second year that we calculated error rates for all components of the Medicaid program, we calculated and reported in the AFR a 2-year weighted average national error rate that includes data from the FY 2007 and FY 2008 cycles. Beginning with FY 2009, we will report a baseline error rate based on all 50 States and the District of Columbia measured over a three year period (FY 2007-FY 2009) for Medicaid. Going forward, the reported rate will be a "rolling average" of the most recent three years.

For the CHIP PERM, CMS is currently developing the final regulation required by Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). 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 has 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. Following publication of the final regulation, CMS will continue CHIP measurement and establish a baseline. The timing of publishing a rate and establishing a baseline will be dependent on the publication date of the final rule. After establishing a baseline, HHS will set out-year reduction targets.

Trend analysis:

At the conclusion of the FY 2008 cycle, 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, with managed care error rates under three percent in the two PERM cycles where CMS measured managed care. (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. In FY 2008, the eligibility error rate exceeded 6 percent and accounted for the majority of the overall Medicaid error rate. (In FY 2007, eligibility contributed less to the Medicaid error rate but was the most significant component of the national CHIP 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 definitively determine eligibility.

Based on this analysis and in order to reduce the national Medicaid error rate, CMS intends to work with States first on reducing eligibility errors caused by caseworker errors and lack of internal controls. States may need to aggressively pursue information needed to reduce the number of undetermined case errors. The second priority will be to reduce medical review errors caused by providers not submitting required documentation or not recording sufficient information in records to meet States' policy requirements. The third focus for reducing the error rate is for 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 nine QARs in FY 2009. The FY 2010 target is to complete ten QARs.

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 and the Recovery 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 is developing a new measure to address quality in both Medicaid and CHIP (see MCD6).

Measure	FY	Target	Result
MCD3: Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	*2011*	47.1%	Mar 31, 2012
	2010	47%	Mar 31, 2011
	2009	46%	Mar 31, 2010
	2008	45%	45.9% (Target exceeded)
	2007	Set Baseline	45.6%
	2006	N/A	43.6% (Trend)
	2005	N/A	41.6% (Trend)

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. Most of the rest of the Medicaid population are either in extremely rural or frontier areas, or 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.

Measure	FY	Target	Result
MCD4: Percentage of Beneficiaries who Receive Home and Community-Based Services	*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	Sep 30, 2010
	2007	2.1%	Baseline

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 number of beneficiaries who receive home and community-based services. The denominator is the total number of beneficiaries eligible for an institutional level of care.	MSIS data are submitted to CMS on 5 different files, an eligibility file and four files of claims: inpatient, long-term care, drugs and all other claims. The data files are subjected to quality assurance edits to ensure that the data are within acceptable error tolerances and a distributional review which verifies the reasonableness of the data. CMS contractors work directly with State staff to correct the data to ensure the files are accurate. The data are warehoused in CMS and a State Summary Data Mart provides users access to the information. Use of the data ensures the quality of cross-State statistics.

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. Most HCBS are provided under §1915(c) waivers, which are required to limit aggregate HCBS costs to less than the average institutional service the individual would otherwise receive. The Government Accountability Office found that the shift to home and community-based care has allowed some States to provide services to more people with the same dollars available. Beneficiaries experience more person-centered care and improved quality of life under HCBS compared with institutional services at the same level of care.

The Deficit Reduction Act (DRA) of 2005 made changes to the Home and Community-Based Services waiver (section 1915(c)). DRA Section 6086 established new authority under §1915(i) for States to offer home and community-based services through their traditional Medicaid State plan program, without a Medicaid waiver. Section 6071, Money Follows The Person Rebalancing Demonstration (MFP), encourages States to relocate persons from institutions to community-based settings and provide appropriate, high quality HCBS.

CMS is facilitating State decisions to increase the number of beneficiaries receiving HCBS, instead of institutional care, through: a revised application process for §1915(c) HCBS waivers, including a web-based application and published, consistent, review criteria; education and technical assistance outreach to help States implement §1915(i) HCBS; enhanced funding and technical assistance under MFP to reinforce and increase

State efforts to serve beneficiaries with quality HCBS rather than institutions; and, technical assistance and education for States concerning other authorities for HCBS including §1915(j) self-directed services waivers, §1115 waivers, and other demonstrations and grants.

The percentage increase in the target for the FY 2010 target is reduced 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.

Measure	FY	Target	Result
MCD5: Percentage of Section 1115 demonstration budget neutrality reviews completed	*2011*	98%	Mar 31, 2012
	2010	96%	Mar 31, 2011
	2009	94%	Mar 31, 2010
	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

This measure was developed during an assessment of the Medicaid program in 2006 and was a new measure for FY 2008. Under section 1115 of the Social Security Act, the HHS Secretary has the authority to grant waivers to allow States to test innovative reforms such as new health care delivery systems. The Administration maintains a policy that any State demonstration should be budget neutral, meaning the demonstration should not create new costs for the Federal government. CMS is responsible for reviewing State compliance with budget neutrality for Medicaid demonstrations. The number of demonstration administrative actions (renewals, amendments, etc.) processed during the year provides an opportunity to perform reviews on all targeted demonstrations.

CMS scheduled nineteen allotment and budget neutrality reviews in FY 2008 and completed review of 100 percent of the scheduled reviews. All were found to be budget/ allotment neutral. The FY 2011 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 2012. While these targets are lower than the most recent FY 2008 result, they are aggressive in terms of the number of reviews that are on schedule to occur.

Measure	FY	Target	Result
MCD6: Improve 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	*2011*	Work with States to ensure that 90 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.	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.

MCD6: Improve 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 401 of CHIPRA establishes a national pediatric quality measures program. The first step in the development of this program is the publication of a core set of quality measures, which was published in December 2009. 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 (CHIP 2). 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.

This performance measure also aligns with the American Recovery and Reinvestment Act of 2009 (Recovery Act) health IT incentives program. Providers in Medicaid will qualify to receive incentive payments for meaningful use of certified electronic health record technology. As part of meaningful use, providers will be required to report data on clinical quality measures.

The FY 2011 target is for ninety percent of States to report on at least one measure in the core set of quality measures. CMS will work with States to encourage them to use the core set. The FY 2012 target will be for ninety percent of States to report on at least five of the quality measures in the core set. The FY 2013 target will be for ninety percent of States to report on at least ten of the quality measures in the core set.

Initial State reporting on these measures will be submitted through the CMS CHIP Annual Reporting Template System (CARTS), which is currently used in the CHIP program. Data will be available 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.

Program: Medicare Benefits

Measure	FY	Target	Result
MCR1.1a: Percent of beneficiaries in Medicare Advantage (MA) who report access to care	*2011*	90%	Dec 31, 2011
	2010	90%	Dec 31, 2010
	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.	*2011*	90%	Dec 31, 2011
	2010	90%	Dec 31, 2010
	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.	*2011*	91%	Dec 31, 2011
	2010	91%	Dec 31, 2010
	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.	*2011*	91%	Dec 31, 2011
	2010	91%	Dec 31, 2010
	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 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

Our 2006 baselines are already high, and our future targets are to continue to achieve those high rates at 90 percent or over. 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. We achieved our FY 2009 targets reflecting beneficiary experiences in 2008. Percentages in the table above are consistent with public reporting defined according to whole number measurements as reflected in Medicare.gov.

The FY 2011 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.

Program: Children's Health Insurance Program (CHIP)

Measure	FY	Target	Result
CHIP2: Improve Health Care Quality Across Children's Health Insurance Program (CHIP)	*2011*	Goal 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.	Mar 31, 2011
	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.	Mar 31, 2010
	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 goals 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 goals 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.

CMS met the FY 2008 target to disseminate best practices to States. CMS analyzed States' responses to four clinical performance measures and communicated findings to States. In addition, six promising practices from four States were posted to the CMS website. CMS has provided technical assistance to States and provided States with a reporting "checklist" on performance measures. In addition, CMS has included CHIP performance quality improvement information in the Medicaid Quality Assessment Reports provided to States (see MCD2).

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

In 2010, CMS will work with State CHIP Programs to incorporate the CMS National Quality Framework into CHIP plans to 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 is 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 framework will: 1) provide guidance on targeted goals to improve the quality and efficiency of health care for children, 2) assist States in understanding options for measuring health outcomes for children enrolled in CHIP, and 3) facilitate States in establishing targeted initiatives to improve care and outcomes based on measurement performance toward established goals. Framework implementation will include sharing of lessons learned from our Medicaid Transformation Grant activity related to children's health care quality and health information technology innovations. The Framework will identify basic tenets of a comprehensive, national Quality Improvement program for improving quality outcomes and efficiencies in CHIP programs to achieve the HHS vision of safe, effective, efficient, patient-centered, equitable and timely care.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) 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 the CHIPRA legislation. The first step is the development and publication of a core set of quality measures, which were published in the Federal Register in December 2009. To best reflect the quality measures program under CHIPRA, CMS will replace this measure with a new measure in FY 2011(MCD6) that relates to the CHIPRA pediatric quality measures program for both Medicaid and CHIP.

Measure	FY	Target	Result
CHIP3: Decrease the Number of Uninsured Children by Working with States to Enroll Children in the Children's Health Insurance Program. **This is a high priority performance goal.**	*2011*	+7% over FY 2008 7,884,273 children	Mar 31, 2012
	2010	+5% over FY 2008 7,736,903 children	Mar 31, 2011
	2009	+1% over FY 2008 7,442,164 children	Mar 31, 2010
	2008	6,732,000 children	+11% over baseline 7,368,479 children (Target Exceeded) (New baseline established beginning FY 2009)
	2007	N/A	7,100,000 children (Historical Actual)
	2006	Set Baseline	6,600,000 children (Baseline)

Measure	Data Source	Data Validation
CHIP3	States are required to submit quarterly and annual CHIP statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly and annually on unduplicated counts of the number of children under age 19 who are enrolled in separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts presented reflect an unduplicated number of children ever enrolled during the year in separate CHIP and Medicaid expansion CHIP programs.	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information shown on the CHIP forms is correct and in accordance with the State's child 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 who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.

CHIP3: Decrease the Number of Uninsured Children by Working with States to Enroll Children in the Children's Health Insurance Program (CHIP)

The purpose of this measure is to decrease the number of uninsured children by working with States to enroll targeted low-income children in CHIP. This measure supports the Department's High Priority Performance goal "Broaden availability and accessibility of health insurance coverage through implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) legislation, by increasing CHIP enrollment by +7 percent over the FY 2008 baseline by the end of FY 2011 (from 7,368,479 children to 7,884,273 children)". The high priority goal was developed by the Department of Health and Human Services to be of particular focus over the next two years.

States submit quarterly and annual CHIP statistical forms, which report the number of children under age 19, who are enrolled in 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. The FY 2009 target is to increase enrollment by one percent over the FY 2008 baseline. The FY 2010 target is to increase enrollment by five percent over the FY 2008 baseline and the FY 2011 target is to increase enrollment by seven percent over the FY 2008 baseline to reflect increased funding and additional resources and incentives provided by CHIPRA to increase enrollment and improve retention.

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.

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	*2011*	TBD	Nov 30, 2011
	2010	Develop new baseline	Nov 30, 2010
	2009[2]	3.5%	7.8% (Target Not Met)
	2008	3.8%	3.6% (Target Exceeded)
	2007	4.3%	3.9% **(Target Exceeded)**
	2006	5.1%	4.4% (Target Exceeded)
	2005	7.9%	5.2% (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 measures 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

[2] For FY 2009, if HHS reported a national paid claims error rate for those claims reviewed under the strictest criteria, applied the entire year, the error rate would have been 12.4 percent. Given the change in the Medicare FFS methodology, HHS will use 12.4 percent as an estimated baseline, implement corrective actions to reduce improper payments, and set targets not greater than 9.5 percent, 8.5 percent, and 8.0 percent, respectively for FY 2010 through FY 2012.

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.

CMS did not meet the 2009 target for this measure due to significant changes during the 2009 reporting period. CMS significantly revised and improved the way that it calculates the Medicare FFS error rate. First, CMS changed the way it reviewed inpatient hospital claims for error rate Measurement. In the past, inpatient hospital review were completed in a separate program, the Hospital Payment Monitoring Program (HPMP); while the other Medicare FFS claim reviews were performed under the CERT program. Beginning with the 2009 report cycle CMS consolidated the HPMP under CERT. This consolidation ensures that the review procedures for inpatient hospital claims are now consistent with the procedures used for review of all other Medicare FFS claims. The addition of these claims into the CERT program increases the comparability of rates between Medicare programs by streamlining error rate calculation and program methodology. This transition also aligns the oversight of inpatient hospital claims with that of all other Medicare FFS provider types, allowing better prioritization of problems and more efficient use of error prevention efforts.

Second, CMS implemented revisions to the CERT review criteria to more strictly enforce 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 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 error rates are not comparable to previous years' error rates.

Due to these modifications, the CERT contractor was not able to meet the original measure of 120,000 reviewed claims. Approximately 99,500 claims completed the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria.

As a result of the revised and improved method for calculating the error rate, CMS will revise the baseline for this measure. Therefore, future targets have not yet been determined.

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.

Measure	FY	Target	Result
MIP2.1: Develop and Implement Internet-based Provider Enrollment Chain and Ownership System (PECOS)	*2010*	Goal discontinued	N/A
	2009	Implement internet-based PECOS for DMEPOS suppliers and continue making enhancements to PECOS	Target not met. Implementation scheduled for early 2010
	2008	Implement internet-based PECOS for all providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers continue making enhancements to PECOS	Target not met. Implementation delayed until FY 2009
	2007	Continue making enhancements to PECOS	Target met
	2006	Publish revised enrollment applications for all provider and supplier types and continue making enhancements to PECOS	Target met
	2005	Redesign provider enrollment applications; continue web-enabled enrollment process; establish an acceptable level of funding enrollment actions and maintain the level of inventory	Target not met but improved.
MIP2.2: Maintain Fee-for-Service Processing Timeliness Standards	*2010*	Goal discontinued	N/A
	2009	Maintain fee-for-service processing timeliness standards	Target met
	2008	Maintain fee-for-service processing timeliness standards	Target met
	2007	Maintain fee-for-service processing timeliness standards	Target not met
MIP2.3: Implement Provider Enrollment Appeals Process	*2008*	Publish final rule that implements Provider Enrollment Appeals Process	Target met: Final Regulation (CMS-6003-F) published on June 27, 2008
	2007	Publish proposed rule regarding Provider Enrollment Appeals Process	Target met. Proposed rule published March 2, 2007
	2006	Consistent with section 936 of MMA, develop a provider enrollment appeals process	Target met
MIP2.4: Publish a Medicare Enrollment Regulation	*2006*	Publish Final Enrollment Regulation	Target met. Regulation published April 21, 2006
	2005	Publish Final Enrollment Regulation	Target met. Published final enrollment regulation

Measure	Data Source	Data Validation
MIP2.1 MIP2.2 MIP2.3 MIP2.4	The Provider Enrollment, Chain and Ownership System (PECOS)	We use annual contractor performance evaluation protocol to assess Medicare contractor provider enrollment performance. PECOS data will be verified during annual, onsite surveys of contractors and through reports available from PECOS.

MIP2: Improve the Provider Enrollment Process

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

In FY 2007, we published a proposed regulation to establish a provider enrollment appeals process, continued our efforts to develop and implement internet-based PECOS for all providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. In some cases, our contractors did not meet or maintain the CMS process enrollment processing timeliness standards. CMS conducted on site visits to those contractors who were not meeting performance expectations and made recommendations to improve processing timeliness and accuracy. In addition, CMS meets regularly with contractors to discuss processing concerns. With the implementation of internet-based PECOS in FY 2009, we believe that contractors will be able to meet or exceed established processing standards. Established processing standards for paper applications require contractors to process 80 percent of initial enrollment applications within 60 days, and 80 percent of changes and reassignments within 45 days.

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

In 2009, we completed our FY 2008 target as we implemented internet-based PECOS for all providers and suppliers, except DMEPOS suppliers, continued making enhancements to PECOS and maintained fee-for-service processing timeliness standards.

While we have not completed the implementation of Internet-based PECOS for DMEPOS suppliers, we expect implementation to be complete in 2010. The implementation of internet-based PECOS for DMEPOS will complete the intensive portions of this measure, so this performance measure will be discontinued.

CMS will continue to enroll, update and revalidate providers and suppliers to ensure that all providers and suppliers continue to meet Federal regulations and State licensing requirements.

Measure	FY	Target	Result
MIP4: Percentage of Contractors with an error rate less than or equal to the previous year's national paid claims error rate	*2010*	Goal discontinued	N/A
	2009	90%	(Target not met)
	2008	85%	68.8% (Target not met)
	2007	75%	78.7% (Target Exceeded)
	2006	50%	82.8% (Target Exceeded)
	2005	25%	89.6% (Target Exceeded)

Measure	Data Source	Data Validation
MIP4	Contractors receive a semi-annual error rate report from the CERT contractors and can use the information on a monthly basis to look for trends and outliers.	The OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

MIP4: Reduce the Medicare Contractor Error Rates

The Comprehensive Error Rate Testing (CERT) program produces the Medicare national fee-for-service error rate. The CERT program provides overall detail and analysis of program vulnerabilities. For each Medicare contractor, CERT conducts reviews for a statistically valid sample of claims to determine if the contractor made the correct payment determination. The results reflect not only the contractor's performance, but also the billing practices of the health care providers in their region.

The CERT program reports estimated contractor-specific error rates. While the contractor specific error rates were not released publicly in FY 2008, contractors did receive their individual error rates. Based on the contractor specific information, CMS requires contractors to develop targeted error rate reduction plans to reduce payment errors. The error rate reduction plan reports a contractor's actions in provider education, medical review, and other error reduction activities. CMS also uses the contractor specific error rate information in contractor's annual performance evaluation.

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

CMS did not calculate contractor-specific rates in FY 2009. During the report period, CMS implemented revisions to the CERT review criteria to more strictly enforce Medicare policies. Due to these modifications, the CERT contractor was not able to meet the original goal of 120,000 reviewed claims. Approximately 99,500 claims completed

the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria. Because of the variance in review methodology applied throughout the report period and the decreased sample size, meaningful contractor error rates could not be calculated.

As the national paid claims error rate improves by smaller percentages, it is virtually impossible to achieve the target of increasing the percentage of contractors with an error rate less than or equal to the previous year's national rate. Because the national paid claims error rate is an average of all contractor error rates, there will likely be a significant number of contractors with error rates above the previous year's national error rate. Therefore, CMS is deleting this measure for FY 2010 and beyond.

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

*The target reductions are set using three assumptions about the Risk Adjustment Payment Error (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.

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 CMS contractors in the process of confirming discrepancies for a national random sample of beneficiaries.

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 independent CMS contractors 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 reported a baseline Part C composite payment error rate in the FY 2009 HHS Agency Financial Report (AFR). The rate was of 15.4 percent is based on calendar year (CY) 2007 payment year data.

CMS continues to pursue enhancement of program integrity and plans to report a composite error rate for the Part C program in the FY 2010 AFR and the FY 2011 AFR. In addition, targets have been identified for reducing the improper payment rate in the Part C program, and were disseminated for the first time in the 2009 AFR.

Measure	FY	Target	Result
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program DEVELOPMENTAL	*2011*	Further develop component measures of payment error for the Part D program.	TBD
	2010	Further develop component measures of payment error for the Part D program.	TBD

Measure	Data Source	Data Validation
MIP6	The data source is components of payment error measurement in the Part D program: 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.	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.

MIP6: Further develop measure of payment error for the Part D program

CMS is on track to develop a composite improper payment error rate for the Part D 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.

The Part D composite payment error rate will consist of several component error rates. To date, not all Part D component payment error rate methodologies have been developed and implemented. 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.

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	Dec 31, 2010
	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 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.

SGD 1: 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 2009 target, the fourth annual report was prepared, summarizing the progress of Medicaid Infrastructure Grant (MIG) States during calendar year 2008. The report is available at: http://www.cms.hhs.gov/TWWIIA/03_MIG.asp#TopOfPage. It focuses primarily on quantitative data currently available for all States with MIG funding, using selected measures that are expected to be reported reliably and consistently over time.

In its next annual report on the MIG program, CMS will highlight continuing achievements in these existing measures and build on this report using any additional data collected from States. CMS will use these reports to set conditions for future grants to the States, and believes that one of the strongest management tools it can employ is providing feedback to the grantees on their performance.

This measure will be 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	*2011*	ROI > 200%	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 recouped; (2) Results from state payment system audits identifying overpayments using algorithms.	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. 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.

For 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. The FY 2010 target is for the annual ROI to be greater than 100 percent and the FY 2011 target is for the annual ROI to be greater than 200 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 Medicaid Integrity Contractors (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.

The Deficit Reduction Act of 2005 increased CMS' obligations and resources to help prevent, detect and reduce fraud, waste, and abuse in Medicaid. In addition to hiring 100 new full-time employees, Congress mandated that CMS enter into contractual agreements with eligible entities to conduct provider oversight. Oversight is conducted by reviewing provider claims to determine if fraud and abuse has occurred or has the

potential to occur, conducting provider audits based on these reviews and other trend analysis, identifying overpayments and conducting provider education.

CMS has made good progress toward developing the MIP. As of December 2009, CMS has hired 95 full-time employees and plans to hire the remaining employees in 2010. 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.	*2011*	95%	Aug 31, 2012
	2010	94.5%	Aug 31, 2011
	2009	94%	Aug 31, 2010
	2008	93%	96.6% (Target Met)
	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 2008 are:

Testing Cycle period	All pathologists (combined) tested in gynecologic cytology PT	Percent with Passing score of 90% or greater
CY 2005	6280	88.0% (5554)
CY 2006	6197	93.7% (5809)
CY 2007	6200	95.9% (5950)
CY 2008	6184	96.6% (5972)

Closer data analysis reveals two 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.

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 and 2008.

As a result of CMS' educational approach and intervention, including remediation with resulting increase in knowledge and skills, the pathologists' performance showed improvement from 2005 to 2008. We expect at least 94 percent of all pathologists to obtain a passing score of 90 percent in CY 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 requests comments for changes recommended by the Clinical Laboratory Improvement Amendments Advisory Committee (CLIAC) and to address concerns made by the cytology community. The closing date for comments was March 17, 2009. CMS will address the comments in a final rule.

Program: Quality Improvement Organizations (QIO)

Measure	FY	Target	Result
QIO1.1: Increase influenza immunization (nursing home subpopulation)	*2011*	82%	Dec 31, 2012
	2010	81.8%	Dec 31, 2011
	2009	80%	Dec 31, 2010
	2008	79%	81.7% (Target Exceeded)
	2007	74%	79.2% (Target Exceeded)
	2006	N/A	78.4% (Historical Actual)
	2005	N/A	73.7% (Historical Actual)
QIO1.2: Increase national pneumococcal Immunization (Discontinued after FY 2008)	*2008*	71%	72.4% (Target Exceeded and Goal Discontinued)
	2007	69%	71.8% (Target Exceeded)
	2006	69%	69.6% (Target Exceeded)
	2005	69%	68.4% (Target Not Met but Improved)

Measure	Data Source	Data Validation
QIO1.1 QIO1.2	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 and a Lifetime Vaccination for Pneumococcal

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

As a result of the Quality Improvement Organization's 9th scope of work 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 2008 nursing home influenza result of 81.7 percent exceeds the FY 2008 target of 79.0 percent and is a 2.5 percent improvement from the FY 2007 result of 79.2 percent. Since the FY 2008 result exceeded the FY 2010 target of 80.5 percent, we are revising our FY 2010 target to 81.8 percent, and setting the FY 2011 target at 82 percent. To achieve our targets, we will continue emphasis of the influenza immunization performance measures in the Prevention Theme of the QIO 9th SOW.

The FY 2008 pneumococcal result of 72.4 percent exceeds the FY 2008 target of 71 percent by 1.4 percent, and is a .6 percent increase from FY 2007 results of 71.8 percent. It should be noted that we have made progress in improving the pneumococcal vaccination rate under this goal. However, despite efforts for improving the pneumococcal vaccination rate, the results have only increased by 8 percent from FY 2002 to FY 2008. In addition, recent literature indicates that the pneumococcal vaccination may not be as effective in the elderly population as previously believed. We continue to technically evaluate the adult immunization measures.

The pneumococcal goal is discontinued with the reporting of the FY 2008 results above, while the QIOs proceed with focusing their efforts on identifying and using strategies for increasing pneumococcal vaccination rates to meet required targets in the 9th SOW under the Prevention Theme. We will continue to measure and address our pneumococcal vaccination progress through the evaluation of the QIOs' performance.

Measure	FY	Target	Result
QIO2: Increase biennial mammography rates in women age 65 years and older	*2009*	Goal discontinued	N/A
	2008	53%	53.7% (Target Exceeded)
	2007	52.5%	53.2% (Target Exceeded)
	2006	52.5%	52.7% (Target Exceeded)

Measure	Data Source	Data Validation
QIO2	The National Claims History (NCH) file is the data source used to track the mammography goal. The percentage of women age 65 and older with paid Medicare claims for mammography services during a biennial period will be calculated. The denominator consists of women who are enrolled in both Parts A and B on an FFS basis. Medicare beneficiaries who are enrolled in an HMO for more than a month in either year of the biennial period are not included in the rate calculation.	The NCH is a 100 percent sample of provider claims submitted to Medicare. These claims are checked for completeness and consistency. Duplicates are eliminated to ensure that women who have more than one mammogram within the two-year period do not contribute to over counting. Mammography utilization rates for age groups, race and counties are calculated and compared to previous years' data to check for any unusual changes in data values.

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

CMS is committed to improving early detection of breast cancer through increasing the rate of mammography in women 65 years and older. Women over 65 face a greater risk of developing breast cancer than younger women, and a disproportionate number of breast cancer deaths occur among older African-American women. Encouraging breast cancer screening, including regular mammograms, is critical to reducing breast cancer deaths for those populations. Most recently the U.S. Preventive Services Task Force (USPSTF) issued guidelines supporting biennial screening for women aged 50-74 further supporting the goal.

We exceeded our FY 2008 target of 53 percent with a rate of 53.7 percent. The previous years' success was due to continued local community efforts to promote screening mammography, combined with national awareness efforts by CMS and distribution of educational materials created by CMS, the National Cancer Institute, and the Centers for Disease Control & Prevention. This effort is also reflected in the QIO 9th Scope of Work (SOW), which began in August 1, 2008.

Comparing the FY 2008 result (53.7 percent) with FY 2007 (53.2 percent) means that approximately 33,766 more women with Medicare age 65 and over had a mammogram during 2007-08, compared with 2006-07.

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

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

There has been a general flattening of rates for mammography. The results for this goal have increased only by one point five percent from FY 2002 (52.2 percent) to FY 2008 (53.7 percent). We are in the process of further technically evaluating this goal and these measures. The FY 2008 result is 53.7 percent (target – 53 percent). This goal is discontinued while the QIOs continue focusing their efforts on identifying and using strategies for increasing biennial mammography rates to meet required targets in the 9th SOW under the Prevention Theme. We will continue to measure and address our progress on biennial mammography through the evaluation of the QIOs' performance.

Measure	FY	Target	Result
QIO3.1: Increase hemoglobin A1c (HbA1c) testing rate	*2011*	87.5%	Sep 30, 2012
	2010	87%	Sep 30, 2011
	2009	86%	Sep 30, 2010
	2008	85.5%	86.5% (Target Exceeded)
	2007	85%	86% (Target Exceeded)
	2006	N/A	85.2% (Historical Actual)
QIO3.2: Increase cholesterol (LDL) testing rate	*2011*	82.5%	Sep 30, 2012
	2010	82%	Sep 30, 2011
	2009	81%	Sep 30, 2010
	2008	80%	81.1% (Target Exceeded)
	2007	80%	80.25% (Target Exceeded)
	2006	N/A	79.5% (Historical Actual)

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 measurement period will be for one year, January 1-December 31.	The NCH is a 100 percent sample of Medicare claims submitted by providers to Medicare and is checked for completeness and consistency. Utilization rates for age groups, race and gender are calculated and compared to previous years' data to check for any unusual changes in data values.

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. Testing hemoglobin A1c

and lipid levels and treating cholesterol and glucose levels to target levels have both been shown to significantly decrease the cardiovascular complications of diabetes.

The new Calendar Year (CY) 2008 result for HbA1c was exceeded with results of 86.5 percent (Target – 85.5 percent). The 2009, 2010, and 2011 targets are 86 percent, 87 percent, and 87.5 percent respectively. The new CY 2008 result for cholesterol (LDL) was exceeded with results of 81.1 percent (target 80 percent). The 2009, 2010, and 2011 targets are 81 percent, 82 percent, and 82.5 percent, respectively. We are further evaluating this goal and these measures, and will determine future strategies for obtaining results. In the 9th Scope of Work, Quality Improvement Organizations (QIOs) are focusing on increasing testing rates in minority populations in 33 States. As such, the QIOs will have some influence on raising the overall testing rates in a more focused way. Currently, as the testing rates in underserved populations fall short of those in the general public, this is an important task for the QIOs.

Measure	FY	Target	Result
QIO4: Increase percentage of timely antibiotic administration	*2011*	92.5%	Jun 30, 2012
	2010	92%	Jun 30, 2011
	2009	89%	Jun 30, 2010
	2008	85%	91.6% (Target Exceeded)
	2007	82%	88.2% (Target Exceeded)
	2006	75.4%	83.1% (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 Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. This data collection follows our previous plans to use methods that reflect the evolution of CMS quality improvement activities toward public reporting at the hospital level.	The accuracy and reliability of data from the QIO Clinical Warehouse are monitored constantly through reabstraction of a sample of medical records by the CMS Data Abstraction Center (CDAC) for each hospital that submits at least 6 cases to the Warehouse each quarter.

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. [3]

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=Medgic%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

[3] http://www.hhs.gov/ophs/initiatives/hai/introduction.html

benefit will be reduced need for and cost of rehospitalization for treatment of infections. The goal of administering the antibiotic before surgery is to establish an effective level of the antibiotic in the body to prevent the establishment of infection during the time that the surgical incision is open.

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 Scope of Work and now the 9th Scope 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 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 2008 we have surpassed our target of 85 percent to end at 91.6 percent. These results are a 3.4 percent increase from FY 2007 results. However, we are beginning to see signs of leveling off with the annual improvement rates achieved in FYs 2006, 2007 and 2008 being 5.6 percent, 3.1 percent, and 3.4 percent, respectively. We are planning to further evaluate this goal and these measures, and will determine future strategies for obtaining results. To achieve our targets, we have continued to emphasize the performance measures of SCIP Infection in the Patient Safety Theme of the QIO 9th Scope of Work (SOW). CMS uses the performance measures for continued accountability through public reporting (RHQDAPU) and value-based purchasing.

Measure	FY	Target	Result
QIO5: Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	*2011*	58%	Nov 30, 2011
	2010	57%	Nov 30, 2010
	2009	54%	54% (Target Met)
	2008	51%	51% (Target Met)
	2007	47%	48% (Target Exceeded)
	2006	40%	44% (Target Exceeded)

Measure	Data Source	Data Validation
QIO5	Data submitted by the dialysis facilities. Large dialysis facilities submit directly to CMS through a file transfer. The 18 ESRD Networks collect data from independent dialysis facilities. (The baseline data includes 75% of independent facilities. We are moving toward 100% submittal by independent facilities.)	Through the ESRD Clinical Performance Measures (CPM) project, ESRD Network staff will re-abstract the vascular access data from the records of a sample of patients to ensure that dialysis facilities are reporting data accurately.

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

Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD). Approximately 328,000 Medicare beneficiaries currently receive this treatment. Hemodialysis is a process of cleaning the blood of waste products when the kidneys can no longer perform this function. It requires removing the blood from the body, cleaning it, and returning it by means of a vascular access. Vascular access is one of the most critical issues in improving dialysis quality.

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

The FY 2009 target was to have 54 percent of prevalent hemodialysis patients use an AVF as their primary method of vascular access. Of the 349,754 patients treated with hemodialysis, 54 percent or 188,514 had an AVF as their primary method of vascular access as of September 2009, a 3 percent increase from FY 2008 results. The target for FY 2010 is 57 percent.

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 recently 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 Scope of Work (SOW) from August 2008 through July 2011 to improve AVF rates for new patients beginning hemodialysis. The effects of the QIO efforts in ten States on incident patient AVF placement shows an average improvement of 3.7 percent as of March 2009 when compared to CY 2007 incident AVF rates.

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. The 2009 analysis by the US Renal Data System (USRDS) estimated that fistula patients incur lower healthcare costs than other hemodialysis patients. A fistula patient incurs $60,000 in health care costs per year, while a graft patient incurs $72,729, and a catheter patient incurs $79,364. As a result of increasing AVF prevalence, CMS has taken great strides in improving the quality and safety of dialysis-related services provided for individuals with ESRD, as well as reducing the long-term resources required to maintain the health of these individuals.

To meet our FY 2010 target, 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. 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. The 2011 AVF goal reflects a degree of “leveling off” of improvement; yet a continuation of improvement as the updated strategic plan takes effect.

CMS will continue to monitor statistics of AVF prevalence on a regional and national level on a monthly basis, using its existing ESRD data collection and analysis tools.

Measure	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	*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.	Sep 30, 2010
		Patient Safety- At least 85% of QIOs will meet expectation for the components of the Patient Safety Theme at the 18th month evaluation.	Sep 30, 2010
		Care Transitions – At least 80% of the QIOs will meet expectations of the Care Transitions Theme at the 18th month evaluation.	Sep 30, 2010

Measure	FY	Target	Result
	2009	Establish baselines and targets	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.
QIO6.4: Beneficiary Protection Theme	*2011*	Beneficiary Protection Theme - Perform and respond to the 28th month QIO contract evaluation	Jul 31, 2011
	2010	Establish baseline/progress and FY2011 targets	Feb 28, 2010

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 Scope 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 will be conducted at the 18th and 28th months 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 will be performed at the 18th month (after January 2010) to determine the most appropriate contract action when performance metrics are not met. This could range 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 meet 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 Scope of Work, CMS will evaluate the QIO program to evaluate its effectiveness and efficiency.

At the 12th month 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.

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.

Agency Support for HHS Strategic Plan

CMS' strategic goals and objectives are developed in conjunction with the HHS Strategic Plan, and outline specific goals for achieving our mission. CMS' strategic goals, the HHS strategic plan, the enactment of GPRA, the 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.

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

The important work performed by CMS as outlined in our Strategic Action Plan helps support the strategic objectives of the Department HHS. CMS' vision for human capital management calls for a strategically-aligned workforce that supports the CMS and HHS mission, responds effectively in emergencies, positions bench strength to assume leadership positions, and becomes a most efficient organization, with the right people in the right position at the right time

To improve the safety, quality, affordability and accessibility of health care, CMS is developing and executing effective oversight and aggressive provider education and outreach, achieving strong financial performance for its programs and operations. Oversight will include expanded modernized program integrity for Medicare and Medicaid and preventing improper payments. We also increased oversight in the 9th Scope of Work (SOW) for our Quality Improvement Organizations which includes active monitoring and reporting of QIO activities. This increase in oversight makes this 9th SOW unique to any previous QIO contract. Development will begin for the QIO 10th SOW starting in FY 2011.

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

CMS helps to promote the economic and social well-being of individuals, families and communities by developing personal relationships with beneficiaries through the use of increasingly personalized tools and with the cooperation of a well-developed grassroots network of partners. The goal is to ensure that our beneficiaries become confident, well-informed consumers that make maximum use of the program.

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

The following table shows the alignment of CMS' Strategic Objectives with HHS Strategic Plan goals.

HHS Strategic Goals	**CMS Obj. 1:** Skilled, Committed and Highly Motivated Workforce	**CMS Obj. 2:** Accurate and Predictable Payments	**CMS Obj. 3:** High Value Health Care	**CMS Obj 4:** Confident, Informed Consumers	**CMS Obj. 5:** Collaborative Partnerships
1 Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.					
1.1 Broaden health insurance and long-term care coverage.			✓	✓	✓
1.2 Increase health care service availability and accessibility.		✓	✓	✓	✓
1.3 Improve health care quality, safety and cost/value.		✓	✓	✓	✓
1.4 Recruit, develop, and retain a competent health care workforce.	✓				
2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.					
2.1 Prevent the spread of infectious diseases.			✓	✓	
2.2 Protect the public against injuries and environmental threats.					
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.			✓	✓	✓
2.4 Prepare for and respond to natural and man-made disasters.	✓				✓
3 Human Services Promote the economic and social well-being of individuals, families, and communities.					
3.1 Promote the economic independence and social well-being of individuals and				✓	✓

HHS Strategic Goals	CMS Obj. 1: Skilled, Committed and Highly Motivated Workforce	CMS Obj. 2: Accurate and Predictable Payments	CMS Obj. 3: High Value Health Care	CMS Obj 4: Confident, Informed Consumers	CMS Obj. 5: Collaborative Partnerships
families across the lifespan.					
3.2 Protect the safety and foster the well being of children and youth.			✓	✓	
3.3 Encourage the development of strong, healthier and supportive communities.					
3.4 Address the needs, strengths and abilities of vulnerable populations.			✓	✓	
4 Scientific Research and Development Advance scientific and biomedical research and development related to health and human services.					
4.1 Strengthen the pool of qualified health and behavioral science researchers.					
4.2 Increase basic scientific knowledge to improve human health and human development.					
4.3 Conduct and oversee applied research to improve health and well-being.			✓		
4.4 Communicate and transfer research results into clinical, public health and human service practice.			✓		

CMS Summary of Full Cost
(Budgetary Resources in Millions)

HHS Strategic Goals and Objectives	FY 2009	FY 2010	FY 2011
1 Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care. (Total)			
1.1 Broaden health insurance and long-term care coverage.	774,172.9	811,732.7	841,373.9
1.2 Increase health care service availability and accessibility.			
1.3 Improve health care quality, safety and cost/value.	7,165.2	6,393.5	7,956.1
1.4 Recruit, develop, and retain a competent health care workforce.			
2 Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats. (Total)			
2.1 Prevent the spread of infectious diseases.			
2.2 Protect the public against injuries and environmental threats.			
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.			
2.4 Prepare for and respond to natural and man-made disasters.			
3 Human Services Promote the economic and social well-being of individuals, families, and communities. (Total)			
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.			
3.2 Protect the safety and foster the well being of children and youth.			
3.3 Encourage the development of strong, healthier and supportive communities.			
3.4 Address the needs, strengths and abilities of vulnerable populations.			
4 Scientific Research and Development Advance scientific and biomedical research and development related to health and human services. (Total)			
4.1 Strengthen the pool of qualified health and behavioral science researchers.			
4.2 Increase basic scientific knowledge to improve human health and human development.			
4.3 Conduct and oversee applied research to improve health and well-being.			
4.4 Communicate and transfer research results into clinical, public health and human service practice.			
Agency Total*	**781,338.1**	**818,126.2**	**849,330.0**

*Totals may not add due to rounding.

Summary of Full Cost Methodology

Due to the vast purview of the CMS programs, our annual performance goals are representative in nature. Our full cost methodology is based on this approach. The full cost estimates included in the Summary of Full Cost table show the funds expended by CMS to support annual performance goals that represent all seven CMS budget programs: Medicare, Quality Improvement Organizations, Health Care Fraud and Abuse Control (Medicare Integrity Program), Medicaid, Children's Health Insurance Program, State Grants and Demonstrations, and Clinical Laboratory Improvement Amendments. These performance measures are divided by major measure activity (benefits, financial management, quality, and other administrative) for which the total full cost is shown. As the HHS Strategic Plan is currently structured, our annual performance goals fall primarily under Strategic Goal 1, Objectives 1 (for benefits, financial management, and other administrative) and 3 (for quality). Performance program budgets and allocated full costs exclude obligations associated with State High-Risk Pool grants.

The chart assumes mandatory budgetary resources equal the amount needed to cover mandatory obligations. Discretionary budgetary resources equal estimated obligations plus estimated user fee obligations.

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

Summary of Findings and Recommendations from Completed Program Evaluations

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

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

Plan for Improvement in the GAO High Risk Area of Medicare
One-Page Summary - Medicare

Problem: The Medicare program is the second-largest social insurance program in the U.S. with 45.2 billion beneficiaries and total gross expenditures of $468 billion in 2008. Medicare faces increasing financial pressure and it is a critical Administration priority to increase the effectiveness and efficiency of Medicare. CMS builds on these efforts by updating and strengthening our payment systems, improving vulnerabilities and information control weakness in IT management and security, ensuring Medicare/Medicaid dual eligible population enrollment into and coverage by Medicare prescription drug plans, and improving quality of care and efficiency while restraining costs.

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 2010 Home Health Prospective Payment System (HH PPS): The CY 2010 HH PPS final rule contained additional refinements to the HH PPS resulting in more accurate payments under Medicare for home health services. Most notably, as part of a broader effort to address potential fraud and abuse, the CY 2010 final rule re-establishes the outlier pool to be no more than 2.5 percent of the estimated total HH PPS payments, returning 2.5 percent back into the base rate and caps individual home health agency outlier payments at 10 percent of their total HH PPS payments.
- DMEPOS Competitive Bidding Program: The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) terminated Round 1 contracts and established a new phase-in schedule for the DMEPOS competitive bidding program. On October 21, 2009, the 60-day bidding window opened to solicit bids for the Round 1 re-bid of the program. When fully implemented, the program is projected to save Medicare about $1 billion annually and provide greater value for beneficiaries through reduced coinsurance and continued high quality of service.
- New Bundled ESRD Prospective Payment System: CMS published the ESRD PPS proposed rule in the Federal Register on September 29, 2009. The rule proposes a case mix-adjusted bundled PPS and a conceptual model for a quality incentive program for Medicare outpatient ESRD facilities.
- CMS updated practice expense relative value units with updated survey information under the Physician Fee Schedule. CMS improved the accuracy of payment for the acquisition and pharmacy overhead costs for certain drugs and

biological under the Outpatient Prospective Payment System. CMS continued to implement payment reforms under the Inpatient Prospective Payment System and the Ambulatory Surgical Center system.

Enhancing Program Integrity – Measuring Improper Payments

CMS continues to enhance our program integrity efforts and **i**mprove our improper payment measurement programs. CMS continues to implement and refine Medicare error rate measurement programs that comply with the Improper Payments Information Act of 2002 (IPIA). 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 established an improper payment baseline for the Medicare Advantage program (Part C). For the Medicare Prescription Drug program (Part D), CMS reported a Part D component rate and we are in the process of finalizing the error rate measurement methodology.

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 payments were ultimately higher or lower than their initial bids.
- We have established a payment error baseline for part C errors and are reporting C targets for the out-years. Our primary reduction strategy is our risk adjustment data validation audits, where we take plan level samples of payments, determine the error rate associated with those payments, and recoup the extrapolated amount from the plan.
- For Part D we have reported component rates and are still in the process of developing an IPIA compliant rate, which we hope to have completed by 2012. Once we have completed our methodology we will be developing out year targets and a mitigation plan.

Enhancing Program Integrity – Reducing Improper Payments

CMS continues to strengthen Medicare program integrity activities and our efforts to reduce improper payments and Medicare waste, fraud and abuse. CMS published regulations and implemented provisions to strengthen the DMEPOS provider enrollment process to require DMEPOS providers to obtain surety bonds and to meet accreditation standards in order to participate in the Medicare program. The Recovery Audit Contractor (RAC) program to identify and correct improper payments was implemented nationwide in 2010. CMS continues to implement program integrity initiatives to address Medicare vulnerabilities and fraudulent business practices in high risk geographic areas. CMS implemented initiatives in the program integrity field offices (Los Angeles, Miami and New York) and three two-year demonstrations to address program vulnerabilities and the effectiveness of intensified provider enrollment scrutiny. CMS is involved in efforts to enhance data analysis capabilities to identify trends and support program safeguard efforts.

Improving Program Management – Fee-for -Service Contracting Practices and Report

- As required by the Medicare Modernization Act (MMA) of 2003, CMS is in the process of replacing the current Medicare FI and Carrier contracts with new Medicare Administrative Contractor (MAC) contracts.
- CMS plans to transfer 100 percent of the Medicare FFS claims workload to the new MACs by the end of FY 2011.
- In sum, as of November 2009, nine (of fifteen) A/B MAC contracts and all four DME MAC contracts have been fully implemented, while six A/B MAC contracts (Jurisdictions 2, 6, 7, 8, 11, and 15) remain in procurement corrective action.
- The nature, extent, and duration of each procurement corrective action depends 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 that agency makes a formal decision on a bid protest) and HHS counsel.
- Although resolving bid protests is a difficult process, CMS will continue to close out at least three MAC procurements corrective action by March 2010 and is working to re-compete the DME MAC contracts in the first half of 2010.

Enhancing Program Management – Managing IT and IT Security

- Updated and reissued CMS Policy in September 2009 for the Information Security Program and the Acceptable Risk Safeguards.
- Established robust investment management policies, procedures and practices.
- Implemented the post-implementation review (PIR) process for major systems implementations.
- Conducting a thorough IT System Census aimed at identifying the entirety of the CMS systems inventory. This will inform information security, IT investment management practices and enable CMS to develop a multi-year IT capital budget. The census will be complete in 2QFY10.
- CMS is in the process of implementing a security monitoring capability that is aimed at providing a view into the entire CMS enterprise, which currently consists of more than 40 data centers.

Overseeing Patient Safety and Care - Nursing Homes

- Starting in 2008, CMS 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, QIO's are working with 100 SFF nursing homes to reduce high-risk pressure ulcers and use of restraints. CMS is currently monitoring QIO assistance to SFF's on a quarterly basis, and will evaluate contractor assistance during 2010 and 2011.
- CMS plans to continue this targeted assistance through its QIO's after 2011 with a new group of high-risk SFF's requiring assistance.
- In Nov. 2007, CMS began public reporting of the names of Special Focus Facilities (SFF) on a quarterly basis. *(These are nursing homes subject to twice the frequency of annual routine inspections for quality purposes.)*
- In December, 2008 CMS launched the first-ever national nursing home Five-Star Quality Rating System now operational on CMS' Nursing Home Compare Web site.

- In 2008, CMS achieved 99.99% compliance with the statutory requirement for nursing home surveys at least once every 15 months for every nursing home.

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

Plan for Improvement in the GAO High Risk Area of Medicaid
One-Page Summary - 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 placed 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 has retained an independent contractor to produce a report which was due to Congress September 1, 2009 that will provide additional information to Congress and CMS on the policy and financial impact of

certain proposed and final regulations placed under moratorium by Congress. This report will also provide information and recommendations regarding the need for the regulatory language and/or the release of additional guidance in the areas addressed by the proposed regulations. Once the report is issued to Congress, CMS will seek to adopt strategies consistent with the report, taking into consideration Congressional feedback regarding additional guidance.

- **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 receive an introduction to the use of the Datamart tools during their orientation.

Challenge 2 – 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 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, is implementing 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 2007, 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.
- CMS will rely more heavily on data in its program integrity efforts and will deploy to States evidence-based tools that they can use to combat waste, fraud and abuse in Medicaid.
- CMS will also increase its focus on Medicaid audits involving cross-border, regional and national issues. CMS will increase collaboration between the

Medicaid and Medicare programs to address areas of common concern across both programs to help drive program integrity efforts. CMS is also strengthening its collaboration with law enforcement, particularly the HHS-OIG. We will continue to assess and address areas of program integrity vulnerability.

- CMS is taking actions to safeguard Federal funds and prevent improper payments by measuring error rates, performing program and fiscal oversight, and detecting and preventing fraud, waste and abuse.
- CMS developed Corrective Action Plans (CAPs) for Medicaid and the Children's Health Insurance Program (CHIP) based on the outcomes of previous improper payment rate measurements and is in the process of developing the 2009 CAP for Medicaid based on recent findings. In addition, CMS requires CAPs from each State measured.