Final FY 2003 GPRA Annual Performance Plan

Revised Final FY 2002 GPRA Annual Performance Plan

FY 2001 GPRA Annual Performance Report

January 2002

"WE ASSURE HEALTH CARE SECURITY FOR BENEFICIARIES."

Mission Statement From
The Centers for Medicare & Medicaid Services

For questions or comments on the CMS Annual Performance Plan/Annual Performance Report, please contact:

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EXECUTIVE SUMMARY

Background

The Government Performance and Results Act (GPRA) of 1993 requires Federal agencies to prepare:

- 5-year Strategic Plans setting out long-term goals and objectives;
- Annual Performance Plans (APPs) which link the Strategic Plan with the annual budget request by committing to short-term performance goals; and
- Annual Performance Reports (APRs) explaining and documenting how effective the Agency's actions have been in achieving these goals.

This APP for the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) sets out specific performance goals for the Agency for Fiscal Year (FY) 2003. It builds on previous APPs submitted to Congress and contains many enhancements. The CMS's APP complements and supports the Agency's FY 2003 budget, and is integral to it. In this APR, CMS is reporting on Agency performance for its FY 2001 GPRA goals.

The CMS Annual Performance Plan is divided by budget category as a means of integrating budget and performance. The GPRA goals identified under each budget category reflect CMS's overall management vision and are representative of its vital activities to perform its mission. Thus, the APP does not reflect every activity and challenge encountered by CMS. Using a representative approach is consistent with guidance from GAO based on the nature of the Agency's work.

In 2001 The President's Management Plan announced several reform initiatives with the primary objectives of making the Government more citizen-centered, results-oriented, and market-based. In response to the President's five management objectives, CMS developed initiatives to vigorously move the Agency forward with a focus on five primary objectives: integrating budget and performance; enhancing strategic management of human capital; increasing competitive sourcing; improving financial performance; and expanding electronic government.

The CMS's initiatives include process reengineering efforts, improved methods of working and management initiatives that will enable the Agency to effectively implement its Strategic Plan and long-term goals and objectives. For example, one of our strategies to expand electronic government makes use of technology-based learning, also known as computer based training, to educate our workforce on systems security issues, among many other subjects. This method enhances productivity because it allows the employee flexibility in scheduling so that training can be completed according to the employee's schedule and/or during "downtimes." It also provides a way for the employee to refer back to familiar training tools if necessary.

Summary of Plan and Report

An improvement in this year's plan is the addition of the goal write ups for those goals that are no longer carried in the plan but for which data continues to be included in the reports. We have also included reference numbers for each goal in the reference column of the reporting charts. For goals appearing in the reporting chart but no longer carried in the plan, we have included an additional 2 digit number indicating the last year the goal was included in the plan. We have included a chart in Appendix A.2 that summarizes the evolution of our Plan since FY 1999. The chart indicates the year(s) in which each goal was included and also tracks the performance of the goal in each GPRA reporting year.

The CMS's total number of FY 2003 goals is 37. We carried over the majority of the goals in the FY 2002 plan, with new targets appropriate for FY 2003. We will be reporting on the status of 33 FY 2001 performance goals.

Consistent with the President's Management Plan, CMS has adopted three new goals to the FY 2003 plan to reflect our efforts to improve our management structure, to strengthen and maintain a diverse workforce, and to restructure the Agency to be more citizen-focused. Through workforce planning efforts, CMS identified broad competency areas that need to be targeted for skill and knowledge gap reduction. One of the identified areas to be targeted is management and leadership. To address this, CMS has developed a Leadership and Management Development Strategy (LMDS) to strengthen and increase the effectiveness of the Agency's leadership. There is a strong business case for our goal to strengthen and maintain diversity at all levels of CMS, resulting in a workforce that mirrors the diverse population we serve thus improving our effectiveness. Our new goal to make CMS more citizen-focused emphasizes improved organizational efficiency. These goals, along with the Workforce Planing goal, will enable CMS and the Department of Health and Human Services (HHS) to effectively implement its Strategic Plan and long-term goals and objectives through a more effective workforce.

We have embarked on a National Media Campaign, which will help beneficiaries and their caregivers become active and informed participants in their health care decisions. In the Fall of 2001, we implemented a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. These included expanded phone service availability for 1-800-MEDICARE, expanded web-based capabilities to help consumers compare health plan choices, and a publicity campaign on the new choices and new ways to get information. These strategies support a number of our GPRA goals in this Annual Performance Plan.

The use of performance measures to improve health care quality in the Medicaid program has been primarily undertaken by State Medicaid agencies. At the national level, we do not have information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. Therefore, CMS is beginning to work with States to jointly explore a strategy for State and Federal use of

performance measures that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures; this effort is reflected in a new FY 2003 goal.

The CMS's FY 2003 plan reflects our continued efforts to strengthen our coordination with other organizations and to enhance data verification and validation. With respect to data issues, CMS has been careful to cite and describe data sources for each individual goal, as well as particular data concerns or limitations. Data issues are explored further in the Appendix, Section A.1.

The CMS continues to increase coordination with States in the performance plan process. State Medicaid agencies are directly involved in carrying out the goals for decreasing the number of uninsured children; assisting States in conducting Medicaid payment accuracy studies, linking Medicare and Medicaid data; and increasing rates of immunization for Medicaid children.

Consistent with GPRA principles, CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as steward of taxpayer dollars. The Agency is confident that performance measurement under GPRA will substantially improve CMS's programmatic and administrative performance. Each goal is outlined with targets for each fiscal year. Some goal targets are labeled “developmental” goals. We include these goals in our plan to show our commitment to certain priorities while acknowledging the challenges of developing a specific, measurable goal.

Performance measurement results will provide a wealth of information about the success of CMS's programs and activities. In fact, CMS is already beginning to use performance information to identify opportunities for improvement and to shape its programs. The use of GPRA goals also provides a method of clear communication of CMS’s programmatic objectives to our partners, such as national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges posed by our performance goals and are optimistic about our ability to meet them.

PART I - INTRODUCTION: AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

1.1 AGENCY MISSION AND LONG-TERM GOALS

The CMS's mission is to assure the health care security of our beneficiaries. Our Strategic Plan, developed in conjunction with the Strategic Plan of the Department of Health and Human Services, outlines our goals for achieving this mission over the next several years. The CMS's internal strategic planning process (begun in 1994), the HHS Strategic Plan, the enactment of GPRA, and other HHS and government-wide programs have all emphasized the themes of accountability, stewardship and a renewed focus on the customer.

For CMS, this has resulted in a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. In 1999, CMS released an updated Strategic Plan to the Congress and the public, which renews the Agency's commitment to meeting beneficiary needs (Exhibit 1). Our FY 2003 performance goals will track our progress toward achieving our Strategic Plan goals outlined in Appendix Section A.3.

We explicitly link our FY 2003 performance goals to the Department of Health and Human Services' Strategic Plan goals in Appendix Section A.3.

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1.2 ORGANIZATION, PROGRAMS, OPERATIONS, STRATEGIES AND RESOURCES

THE CMS AND ITS PROGRAMS

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services. The creation of CMS, formerly known as HCFA, in 1977 brought together, under one leadership, the two largest Federal health care programs--Medicare and Medicaid. These programs coordinate and finance health care for elderly, disabled, and low-income persons. When the programs were established in 1965, Medicare was created as a means of providing affordable health insurance to the elderly (and later to certain disabled persons). Medicaid was conceived as a Federal/State partnership in policy setting and funding and as part of the social safety net for low-income persons. The CMS has become the largest purchaser of health care in the United States, serving over 70 million Medicare and Medicaid beneficiaries.

Over time, CMS's statutory mission has grown beyond administration of Medicare and Medicaid to include responsibility for Federal oversight of clinical laboratories under the Clinical Laboratory Improvement Amendments (CLIA) and for individual and small group health insurance regulation under the Health Insurance Portability and Accountability Act (HIPAA).

Recent legislation, including the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000, has made significant changes in CMS's programs. These changes include:

- creating an array of new managed care and other health plan choices for Medicare beneficiaries;

- establishing the State Children's Health Insurance Program (SCHIP) to build on the Medicaid program, which covers nearly 20 million children in low-income families; and

- developing and implementing new payment systems for many Medicare services to improve payment accuracy and help restrain the growth of health care spending.

These elements of the Medicare and Medicaid programs continue to bring challenging new work to CMS.

1.3 PARTNERSHIPS AND COORDINATION

The CMS accomplishes its mission by working closely with many other organizations. This includes working relationships with CMS agents (Medicare contractors, State Medicaid Agency staff, State surveyors, and Peer Review Organizations—soon to be known as Quality Improvement Organizations), providers of care (hospitals, physicians, health plans, clinical laboratories, etc.), beneficiary and consumer organizations, accrediting bodies (the Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance), and researchers who work together to ensure high quality care for over 70 million people.

The CMS works closely with a number of other Federal agencies, both within and outside HHS, on special programs and crosscutting issues. For example:

- The CMS depends on assistance from the Centers for Disease Control and Prevention (CDC) in our efforts to increase influenza and pneumococcal vaccination rates.

- The CMS, the HHS Inspector General, the FBI, and the Administration on Aging work together to reduce fraud, waste, and abuse.

- The CMS, the Health Resources and Services Administration (HRSA), and other HHS agencies (e.g., CDC and Agency for Healthcare Research and Quality) are working together to improve children's access to health care services.

- The CMS and the CDC are providing ongoing technical assistance to States as they explore methodologies and develop baselines for measuring the number of Medicaid two-year olds who are fully immunized.

Working in partnership leverages resources and increases coordination, which is ultimately in the beneficiaries' best interest. Each performance goal narrative includes a coordination section.

1.4 SUMMARY OF FY 2001 PERFORMANCE REPORT

Accountability through Performance Measurement

Senior management has shown support for the process of performance measurement in CMS. Senior leadership has assumed responsibility for goals and for appointing responsible, accountable goal leads and contacts.

Strong technical support for performance measurement also exists within CMS. The Agency established a Performance Measurement Technical Advisory Group, which examines the technical appropriateness, feasibility, and measurability of each of CMS's performance goals.

For any given goal, the strengths and limitations of the data sources vary. The Data Issues section in Appendix A addresses these issues. In addition, the Verification/Validation section for each goal in Part II addresses data reliability and completeness.

One of the biggest challenges that we face in the analysis of performance data is timeliness. In some cases, there are inherent time lags between the actual data submission, data compilation, and the due dates for report submission.

Summary of FY 2001 Successes

Overall, CMS experienced positive results in FY 2001. Of the 33 goals being reported for FY 2001, we have 10 goals for which we do not have complete data. We have met or exceeded expectations for 17 of the 23 goals for which we have final data. For example:

- Improve Beneficiary Understanding of Basic Features of the Medicare Program
- Improve the Management of the Survey and Certification Budget Development and Execution Process
- Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries
- Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid
- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice
- Increase Medicare Secondary Payer Credit Balance Recoveries and/or Decrease Recovery Time to Recoup Dollar Recoveries
- Ensure HIPAA Compliance Through Policy Form Reviews
- Improve Oversight of Medicare Fee-for-Service Contractors
- Assess the Relationship Between CMS Research Investments and Program Improvements

Summary of FY 2001 Performance Challenges

Although we are not reporting success in meeting 6 of our goals in their entirety, we have made significant progress. For example:

- **Improve Medicare's administration of the beneficiary appeal process.** Pending implementation of a web-based tool needed to transmit data, our data collection of internal appeals data has been delayed until FY 2003.

- **Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance.** Though we met our FY 2001 goal to exceed the national enrollment rate in States that received a Federal grant, we did not meet the goal to increase enrollment by 4 percentage points in States where the FY 2000 target was not met.

- **Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.** We did not meet our FY 2001 target because of delays securing the necessary funding and formally recruiting pilot States. However, we ultimately recruited 9 States for the initial pilot, versus only 2 as initially projected. The State applications and funding were approved September 26, 2001. The actual pilot studies will be conducted in FY 2002.

- **Increase the use of electronic commerce/standards in Medicare.** We were successful in maintaining high percentages of electronic media claims of 97.7 percent and 83.0 percent for fiscal intermediaries and carriers, respectively. However, despite significant progress, we were delayed in implementing and testing HIPAA EDI standards and in developing baseline data for electronic claims.

- **Develop and implement an information technology architecture.** We made substantial progress toward reaching our FY 2001 targets to integrate ITA requirements into our internal project review process and develop standard configuration templates. These goals were not fully met due to staffing and budget shortfalls.

- **Improve CMS's information systems security.** The 2001 CFO report listed one material weakness, of which CMS was aware and has developed and approved a protocol-enhanced oversight; however, this protocol has not been fully implemented. Our target to have 95 percent of CMS staff trained in security awareness was to be achieved through computer based training (CBT). However, the CBT had to undergo a major rewrite to include section 508 of the Americans with Disabilities Act. A pilot has been deployed and this is expected to be achieved in FY 2002.

Performance Results Not Reported in the FY 2000 Performance Report

In the FY 1999 and FY 2000 Annual Performance Reports, we had several GPRA goals with pending data. We have now received final data for two of those goals.

- The CMS surpassed its goal to increase the percentage of Medicare beneficiaries age 65 and older who receive an influenza vaccine for both FY 1999 and FY 2000
- The CMS surpassed its FY 1999 goal to increase the percentage of Medicare beneficiaries age 65 and older who receive a mammogram

PART II - PROGRAM PLANNING AND ASSESSMENT

In this section, we present our report on CMS's performance for FY 2001, and goals planned for FY 2002 and FY 2003. The report and goals are organized by budget

category. We begin by describing the category and presenting a table summarizing our FY 2001 performance and FY 2002 and FY 2003 goals. A performance summary for each budget category follows, which is then followed by goal narratives for the performance goals in that budget category.

Each performance goal is displayed within the associated major budget category. In general, if the actions planned to improve performance are mainly funded out of a given budget category, that is the category associated with the performance goal. The funding levels shown are the total dollars enacted or requested for each budget category, of which only a portion may be funding the specific activities or interventions described in a performance goal. We have eliminated the Medicare+Choice User Fee budget category, since monies from this source no longer primarily support a representative GPRA goal.

The 37 individual goal narratives for FY 2003, contain the following sections:

- *Baseline:* the initial data reported for the starting point of reference includes the year of the baseline data;

- *Target:* the desired performance level we plan to accomplish;

- *Discussion:* the rationale for selecting the particular performance measure, pertinent background information, and activities/interventions under way or planned to accomplish the goal;

- *Coordination:* the extent to which CMS coordinates with other organizations, such as other Federal agencies, State agencies, local agencies, private entities, and advocacy organizations;

- *Data source(s):* a description of the data used for measuring progress toward the goal; and

- *Verification and Validation:* the means for ensuring the accuracy and reliability of the data source(s)

Note: We continue to reference all official CMS forms with the "HCFA" acronym, for example HCFA-1500. We are exercising fiscal restraint by exhausting our existing stock of forms.

Medicare Benefits

Medicare Benefits	FY 2000 Actual	FY 2001 Actual	FY 2002 Current Estimate	FY 2003 Estimate
Total Budget Authority	**$214.9 B**	**$236.5 B**	**$246.7 B**	**$254.8 B**

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the Nation's largest health insurance program, which covers 40 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For over three decades, this program has helped pay medical bills for millions of Americans, providing them with comprehensive health benefits they can count on.

Other representative goals related to this budget category but not listed in the chart are:

- Improve Heart Attack Survival Rates (QP1-03)
- Increase the Percentage of Medicare Beneficiaries Age 65 Years and Older who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal (QP2-03)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries through the National *Medicare&You* Education Program (MO8-03)
- Improve Beneficiary Telephone Customer Service (MO1-03)

Performance Goals	Targets	Actual Performance	Ref.
Improve satisfaction of Medicare beneficiaries with the health care services they receive			MB1
Managed Care * Access to care Increase percent of beneficiaries reporting they could usually or always get care for illness or injury as soon as they wanted, and * Referral to specialist Increase percent of beneficiaries reporting it was not a problem to get a referral to a specialist they needed to see	**FY 03:** Same as FY 2002 **FY 02:** Access to care: Direct efforts to achieve 93% by CY 2004 Referral to specialist: Direct efforts to achieve 86% by CY 2004 **FY 01:** Develop new baselines/future targets including data from disenrollee survey	**FY 03:** **FY 02:** **FY 01:** Access to care: 90.5% Referral to specialist: 83.7% (Baselines) New baselines/targets developed (Goal met)	
(FY 1999/2000 versions before addition of disenrollee data): Access to care Increase percentage of plans where at least 90 percent of the beneficiaries report they could usually or always get care of illness or injury as soon as they wanted, and Referral to specialist Increase percentage of plans where at least 80 percent of the beneficiaries report it was no problem to get a referral to a specialist they needed to see	**FY 00:** Access to care: 79% by CY 2003 Referral to specialist: 75% by CY 2003 (later revised to include disenrollee data--see above) **FY 99:** Develop target	**FY 00**: We continue to collect data on our progress in the area. (Future revised baseline/target will include disenrollee data in FY 2001) **FY 99:** Target developed (Goal met) **FY 98:** Access to care: 74% of plans Referral to specialist: 70% of plans (Baselines)	
Original Fee-for-Service (FFS) * Access to care Increase percent of beneficiaries reporting they could usually or always get care for illness or injury as soon as they wanted, and * Access to specialist Increase percent of beneficiaries reporting that it was not a problem to see a specialist they needed to see	**FY 03:** Same as FY 2002 **FY 02:** Access to care: 95% by CY 2004 Access to specialist: 85% by CY 2004 **FY 01:** Develop baselines/future targets based on survey results **FY 00:** Same as FY 1999 **FY 99**: Continue to develop measurement and reporting methodology	**FY 03:** **FY 02:** **FY 01:** Access to care: 92.8% Access to specialist: 82.8% (Baselines) New baselines/ targets developed (Goal met) **FY 00:** Survey fielded in FY 2001 with baseline data available fall 2001 (Goal met) **FY 99**: Development continuing with survey to be fielded in FY 2001 (Goal met)	

Performance Goals	Targets	Actual Performance	Ref.
Timely ("same month") processing of clean Medicare+Choice enrollments equal to the effective date on the transaction	**FY 02:** See new measure (BBA election provisions, below) **FY 01**: 98% **FY 00:** 98% **FY 99:** 98%	**FY 02:** N/A **FY 01:** 99.3% (Goal met) **FY 00**: 98.7% (Goal met) **FY 99**: 95.6% (Goal not met) **FY 98**: System updated with managed care enrollments the month following receipt of the transaction (Baseline)	MB3
Process beneficiary Medicare+Choice organization elections in compliance with the BBA beneficiary election provisions	**FY 03**: M+CO election transactions are accepted and used to update beneficiary data timely. Target percentage to be developed based on data collected in last quarter of FY 2002. **FY 02**: Develop a target that measures performance in processing enrollments/ disenrollments in compliance with the beneficiary election provisions of the BBA **FY 01:** New in FY 2002	**FY 03**: **FY 02**: **FY 01**: N/A	
Improve Medicare's administration of the beneficiary appeal process (Developmental)	**FY 03:** Medicare+Choice Organizations: Continue collecting data to establish baseline Fee-for-Service: TBD **FY 02**: Medicare+Choice Organizations: Issue OPL with reporting instructions Fee-for-Service: Evaluate data needs & capabilities **FY 01**: Publish Operational Policy Letter (OPL) and begin collecting baseline data **FY 00:** Have system in place for collection of managed care appeal data **FY 99:** New in FY 2000	**FY 03**: **FY 02**: **FY 01**: OPL132 04/27/01 Collection delayed (Goal not met) **FY 00**: Delayed due to burden to M+CO (Goal not met.) **FY 99**: N/A (Baseline developmental)	MB4

Performance Goals	Targets	Actual Performance	Ref.
Improve beneficiary understanding of basic features of the Medicare program (Developmental)	**FY 03:** Targets will be set in FY 2002 **FY 02:** Baselines/future targets to be developed **FY 01:** (1) Develop list of core features (2) Obtain advisory input (3) Design and test survey questions (4) Integrate questions (5) Field questions **FY 00:** New in FY 2001	**FY 03:** **FY 02:** **FY 01**: Steps 1-5 completed. Survey fielded (Goal met) **FY 00**: N/A (Baseline developmental)	MB5

Performance Results Discussion

Assuring health care security for our beneficiaries is our primary mission. While all of our GPRA goals support this mission in some way, we have attempted to identify several key measures to represent the Medicare benefits budget category. We want to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high-quality care, so it is important that we select goals that address a range of issues--administrative and care-related.

Beneficiary Satisfaction - Our multi-year efforts to improve beneficiary satisfaction with the health care received apply to both managed care and fee-for-service (FFS). Our efforts to improve beneficiary satisfaction continue by encouraging the use of the Consumer Assessment of Health Plan Survey (CAHPS) measures by health plans and Peer Review Organizations (soon to be known as Quality Improvement Organizations). Results of the measures for managed care and FFS are shared with beneficiaries as additional information for use in making health plan choices.

This goal has been improved to include national targets in managed care and FFS. In an effort to capture more complete information for the managed care portion, data from a managed care disenrollee survey is now combined with survey data from current managed care enrollees. Baselines and targets have been recalculated to reflect this change.

In order for the increases to be statistically significant, these are long-term targets with reporting due at the end of the 5-year period. Interim reporting will consist of updating specific activities toward meeting the goal.

Timely Enrollment - While encouraging our beneficiaries to choose the health plan best suited for their needs, we want to ensure timely enrollment into managed care with no interruption in health care delivery or payment. Unfortunately, we fell short of our FY 1999 target. The managed care organizations (MCOs) were unfamiliar with the new enrollment timeframes. Also the data extraction technique included some inappropriate transactions in the counts, resulting in the percentages being lower than they actually

should have been. The MCOs have since gained experience with the new enrollment timeframes, and the extraction technique has been improved to provide more accurate data. Thus, in FY 2000 and FY 2001, we met and exceeded our target of 98 percent. For FY 2002 and FY 2003 we are developing targets that measure performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA regarding lock-in provisions and plan benefit packages (PBPs).

Beneficiary Appeals - It is important that we address both managed care and FFS programs regarding appeals in Medicare. For example, appeals in the managed care program usually relate to "access to care" as opposed to appeals in the FFS program where nonpayment is usually the issue. In order to improve the appeal process, we plan to collect data on internal appeal activity from Medicare+Choice organizations beginning January 1, 2003 to determine baselines and targets. An Operational Policy Letter (OPL) was sent to these organizations April 27, 2001, outlining this process, which fulfilled part of the FY2001 target. The actual data collection however is pending development of a web-based tool needed for MCOs to transmit to CMS. This information will be analyzed to help develop the business requirements for the collection and reporting of appeals data. The Benefits Improvement and Protection Act of 2000 (BIPA) mandates several changes to the appeals process. When BIPA is implemented, the FFS appeals data will need to be re-evaluated to determine future needs for the improvement to the administration of this essential beneficiary protection.

Beneficiary Understanding - To advance one of CMS's strategic goals to promote beneficiary and public understanding of CMS and its programs, we are developing a goal to improve beneficiary awareness of (1) the core features of Medicare needed to use the program effectively, and (2) CMS sources from which additional information can be obtained. In FY 2001, we met our goal of completing actions necessary to field the Medicare Current Beneficiary Survey from which baselines and targets for this measure will be developed in FY 2002.

The CMS's strategy for improving beneficiary awareness includes an extensive media campaign begun in the Fall of 2001, corresponding with the open enrollment period, informing the general public about expanded services available to help Medicare beneficiaries get the information they need to make informed decisions about their health insurance options. These new and expanded services include the following:

- expanding phone service availability at 1-800-MEDICARE to 24 hours a day, 7 days a week;
- introducing a web-based Medicare Personal Plan Finder to help consumers compare their health plan choices (M+C plans, Medicare Fee-for-Service, and Medigap plans);
- enabling customer service representatives at 1-800-MEDICARE to provide more in-depth help to callers on finding the health plan choice that is best for them; and
- conducting a publicity campaign on the new choices and new ways to get information.

Performance Goal MB1-03

Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive

Baselines (New for FY 2002/2003 Goals[1]**):** FY 2001 Managed care - (a) Getting needed care for illness or injury: In 2000, about 90.5 percent of beneficiaries enrolled in a Medicare managed care plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: In 2000, about 83.7 percent of beneficiaries enrolled in a managed care plan reported that it was not a problem to see a specialist that they needed to see. FY 2001 Fee-for-service (FFS) - (a) Getting needed care for illness or injury: In 2000, about 92.8 percent of beneficiaries enrolled in the Original Medicare FFS health plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: In 2000, about 82.8 percent of beneficiaries enrolled in the Original Medicare FFS health plan reported that it was not a problem to see a specialist that they needed to see.
FY 2003 Targets: Same as FY 2002.
FY 2002 Targets: Managed Care - Direct efforts to achieve by the end of CY 2004, (a) 93 percent of beneficiaries enrolled in a Medicare managed care plan will report that they could usually or always get care for illness or injury as soon as they wanted. (b) 86 percent of beneficiaries enrolled in a managed care plan will report that it was not a problem to see a specialist that they needed to see. These efforts include: (1) continue to collect MMC-CAHPS and Disenrollee data and make available to Medicare managed care plans, Medicare Peer Review Organizations (PROs), soon to be known as Quality Improvement Organizations, and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice. FFS - Direct efforts to achieve by the end of CY 2004, (a) about 95 percent of beneficiaries enrolled in the Original Medicare FFS health plan will report that they could usually or always get care for illness or injury as soon as they wanted. (b) 85 percent of beneficiaries enrolled in the Original Medicare FFS health plan will report that it was not a problem to see a specialist that they needed to see. These efforts include: (1) continue to collect MFFS-CAHPS data and make available to Medicare PROs and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice.
FY 2001 Targets: Developmental. Managed care - Develop new baselines/future targets including data from disenrollee survey. FFS - Develop baselines/future targets based on survey results. **Performance:** Managed care - New baseline and 5-year target measures (see above) were developed using data collected from both the MMC and Disenrollee CAHPS for 2000, regarding beneficiary access to care and specialists. (Goal met) FFS - Baselines and 5-year target measures (see above) were developed from 2000 data collected in Round 1 MFFS-CAHPS for 2000, regarding beneficiary access to care and to specialists. (Goal met)

1 Managed Care - Data for beneficiaries who voluntarily disenrolled from their managed care plans became available in FY 2001 from the 2000 survey and were combined with Consumer Assessment of Health Plans Survey (CAHPS) data for current enrollees to get a more complete picture of plan performance.

FFS - Baselines established with Round 1 Medicare FFS (MFFS) CAHPS data from CY 2000.

Baselines for FY 2000 Goal Managed care without disenrollees - (a) Getting needed care for illness or injury: In 1998, in 74 percent of plans, at least 90 percent of beneficiaries reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Ease of getting referral to a specialist: In 1998, in 70 percent of plans, at least 80 percent of beneficiaries reported that it was not a problem to get a referral to a specialist that they needed to see. Fee-for-service (FFS) - Developmental. Baseline data will become available in FY 2001. The CAHPS FFS survey was fielded in Fall 2000.)
FY 2000 Targets: Managed care - Continue efforts to achieve by CY 2003, (a) in 79 percent of plans, at least 90 percent of beneficiaries report that they could usually or always get care for illness or injury as soon as they wanted, and (b) in 75 percent of plans, at least 80 percent of beneficiaries report that it was not a problem to get a referral to a specialist that they needed to see. FFS - Targets will be established after baseline data become available in FY 2001. **Performance:** Managed care - Our interventions to improve beneficiary satisfaction have continued with regard to encouraging health plans and the PROs to use CAHPS measures in their quality improvement efforts. In an effort to capture more complete data for this goal, input from disenrolled beneficiaries will be included in the CAHPS survey. Therefore, baselines and future targets will be recomputed. FFS - We began collecting CAHPS FFS data in Fall 2000.
FY 1999 Targets: Managed care - Develop target. FFS - Continue to develop measurement and reporting methodology. **Performance:** Managed care - Baseline and target developed. (Goal met) FFS - Development continuing with survey to be fielded in FY 2001. (Goal met)

Discussion: A basic principle of CMS's Strategic Plan is that beneficiaries are our primary customers and one of CMS's main reasons for being is to assure satisfaction in the experiences beneficiaries have in accessing care for illnesses and injuries when needed, including their access to care of specialists. In response to the need to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Health Plans Surveys (CAHPS). CMS fields these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care plan as well as those enrolled in the Original Medicare fee-for-service plan and provides comparable sets of specific performance measures collected in CAHPS to Medicare Peer Review Organizations (PROs), soon to be known as Quality Improvement Organizations, health plans, and beneficiaries through various means, including the National *Medicare&You* Education Program (NMEP).

Provision of CAHPS performance information serves to assist beneficiaries in their health plan choices under Medicare. Annual development of specific performance measures also permits use of CAHPS as a tool for monitoring beneficiary experiences in and satisfaction with differing care delivery modes and in different regions of the country. Plan-specific measures provide direct incentives for managed care plans to improve performance and health services quality. FFS measures, reported by geographic area, assist in development of strategies to improve care quality through targeted interventions implemented either directly by CMS or through State Medicare PROs and other partners. The performance indicators and satisfaction measures

disseminated through the NMEP also are part of a long-term strategy to monitor and evaluate the use of specific services provided through Medicare, and improve consumer satisfaction regarding the services received. CMS therefore conducts research on the use and understanding of these measures by beneficiaries as well as in the effectiveness of specific initiatives monitored by these measures in improving service quality. Our baselines for both managed care and FFS satisfaction are already fairly high. Given this type of survey for a large group of people and considering the unrelated factors that potentially could influence responses, we know that a target of 100 percent satisfaction is unrealistic. Nonetheless, our targets are challenging and are set for a 5 year period in order for the percentage increases to be large enough to be statistically detected.

Coordination: The development and implementation of Medicare consumer assessment measures is coordinated by CMS's central and regional offices. Dissemination of information sets based on these measures is also coordinated through an array of Federal, State, and local agencies, and advocacy groups, including the Social Security Administration, the Administration on Aging, American Association of Retired Persons, National Association of Area Agencies on Aging, National Caucus and Center on Black Aged, National Asian Pacific Center on Aging, and other groups. The CMS also coordinates specific quality improvement activities and information dissemination through the PROs and other partners.

Data Source(s): The Medicare CAHPS are a set of annual surveys of beneficiaries enrolled in all Medicare managed care plans and in the Original Medicare fee-for-service plan. The CAHPS for managed care, which was begun in FY 1998, was fielded with a sample of 600 beneficiaries in each of over 250 managed care plans in Fall 2000, i.e. FY 2001. Data collection for managed care disenrollees (beneficiaries who voluntarily left their plans) began in Fall 2000 within the same managed care plans. This survey obtains information about the experience of beneficiaries in their former health plan. Data from this survey are combined with the information collected from current enrollees to obtain a more complete picture of plan performance.

Data collection in CAHPS-FFS began in Fall 2000 with samples of 600 beneficiaries in 275 geographic areas nationally. Information comparable to that obtained from the MMC-CAHPS were available from the MFFS-CAHPS in FY 2001 and are available to beneficiaries and others on the Medicare Health Plan Compare web site. The Medicare managed care and the Medicare FFS CAHPS surveys consist of between 90-95 questions and have undergone extensive cognitive testing with Medicare beneficiaries. The information collected in the Medicare CAHPS is comparable to other CAHPS information collected in surveys of persons enrolled in commercial, i.e. non-Medicare health plans.

Verification and Validation: The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 2.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-

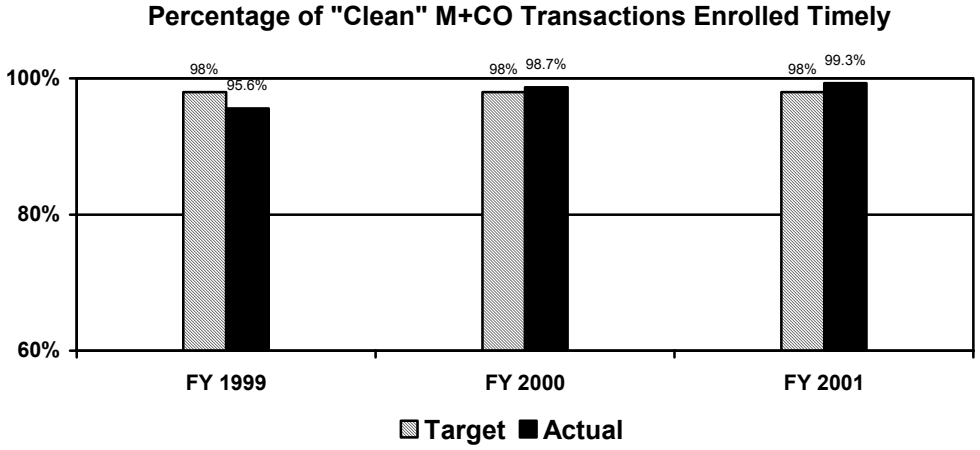
respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care - FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response. More detailed plan-level and geographic-area CAHPS results are also checked for consistency with the experience and satisfaction data collected both on a national and regional basis annually in the Medicare Current Beneficiary Survey (MCBS). Although MCBS satisfaction questions do not match those in CAHPS on an item-by-item basis, several measures are similar enough to be used for consistency checking especially with regards to national trending of beneficiary experience.

Performance Goal MB3-03

Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions

Baseline: Prior to CY 2002, there was no ability to track elections at the plan benefit package (PBP) level or to apply the lock-in provisions affecting enrollments/disenrollments.
FY 2003 Goal: Medicare+Choice organization (M+CO) election transactions are accepted and used to update beneficiary data timely. Target percentage to be developed based on data collected in last quarter of FY 2002.
FY 2002 Target: Developmental. Develop a target that measures performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA.

Baseline: In FY 1998, for clean* managed care plan enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system updates beneficiary records with requested enrollment effective dates by the first of the following month.
FY 1999-2001: For 98 percent of clean* Medicare+Choice organization (M+CO) enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system will update beneficiary records with enrollment effective dates equal to the effective dates on the transactions. (See chart below) *clean = information submitted by M+CO is correct



Discussion: For FY 1999 through FY 2001, this performance goal measured the timeliness of CMS systems' processing of Medicare beneficiary enrollment transactions received from Medicare+Choice organizations (M+COs) as specified by the Balanced Budget Act of 1997 (BBA).

The current performance goal (for FY 2002 and FY 2003) measures the processing of enrollment and disenrollment transactions received from M+COs in compliance with

the beneficiary election provisions of the BBA effective in 2002. M+COs contract with CMS to provide medical services to Medicare beneficiaries. In providing such services, M+COs may offer multiple plan benefit packages (PBPs) for members to elect. The Balanced Budget Act of 1997 (BBA) requires that beneficiary elections be tracked at the PBP level and also specifies time periods when beneficiaries may elect to enroll or disenroll from M+COs or to change PBPs. The CMS will maintain PBP information for all members of M+COs for the first time in 2002.

The BBA requires that if a beneficiary wishes to make an election during an open enrollment period (OEP), he/she must do so in the first 6 months of CY 2002 or the first 6 months of Medicare eligibility (for new Medicare beneficiaries). In addition, only one election may be made during this timeframe. This election period is reduced in calendar year 2003 to 3 months. Elections are defined as enrollments and disenrollments into and out of a M+CO as well as PBP changes within an M+CO. These requirements are known as the lock-in provisions. There are some exceptions to these provisions related to special election periods (e.g., the beneficiary moves out of the M+CO's service area; the M+CO terminates).

To support these requirements, M+COs must submit new data. In addition, since the lock-in provisions severely limit when such data can be submitted, it can only be accepted during certain times of the year. Currently, M+COs can submit enrollment/ disenrollment data at any time. The CMS receives and edits M+CO transaction data for validity. The system ensures that each enrollee is a Medicare beneficiary and entitled to make an election.

To meet this goal, CMS will refine its current system so that the BBA election provisions for M+COs will be processed. Finally, CMS will continue to provide program and technical support to M+COs submitting enrollment/disenrollment transactions to improve data quality and processing accuracy. This includes an annual training session and ongoing technical support. Improvements in the accuracy of transaction processing will reduce beneficiary confusion regarding the status of their medical coverage, reduce fee-for-service claims processing errors, and reduce provider payment problems. It will also result in accurate data for audit and research purposes.

Coordination: The CMS will coordinate its efforts with M+COs and beneficiaries. The improvements stated above are directly related to accurate submittals by M+COs. The CMS will reject noncompliant transactions and notify M+COs of errors. Beneficiaries will be informed about the election provisions so they are aware of the revised timeframes. In addition, as changes are made to the current system and/or as the new system modules become active, user-impacted changes will be communicated to the M+COs and training provided as necessary.

Data Source(s): The source of the data will be the Group Health Plan (GHP) system, which maintains enrollment and disenrollment information.

Verification and Validation: The GHP system will be equipped with edits to verify PBP data and the election timeframes. A percentage will be developed based on preliminary data received during the last quarter of FY 2002.

Performance Goal MB4-03

Improve Medicare's Administration of the Beneficiary Appeals Process

Baseline: Developmental. Baseline data collection for Medicare + Choice appeals will begin in FY 2002 and continue through FY 2003.
FY 2003 Target: Developmental. **M+CO:** Begin collecting data to establish baseline. **FFS:** Developmental
FY 2002 Target: Developmental. **M+CO:** Issue OPL with reporting instructions. **FFS:** Evaluate CMS's FFS appeal data needs and capabilities.
FY 2001 Target: Publish Operational Policy Letter (OPL) and begin collecting baseline data for M+COs. **Performance:** OPL published 04/27/2001, collection delayed.
FY 2000 Target: Implement system for collection of M+CO appeal data. **Performance:** Goal not met due to added burden to M+COs.

Discussion: The appeal 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 have the right to appeal a denial of payment by a Medicare fiscal intermediary (FI) or carrier. This appeal comes after the service has been provided. The appeal process takes on added significance under the Medicare+Choice program because these appeals may also involve pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

M+CO Data Collection:
Starting in FY 1999, CMS required M+COs to collect aggregate level appeal data in order to report to beneficiaries upon request. The CMS captures data on appeal activities not resolved at the M+CO level and which have proceeded to a higher level of review by an independent CMS contractor. The CMS does not yet capture data on plans' *internal* appeal activity, due to concerns regarding burdening plans with increased reporting requirements.

On April 27, 2001, OPL 132 was published, which under the authority of 42 C.F.R. §§422.111(f)(10)(iv) and 422.502(f)(2)(v), requires M+COs to report aggregate appeals data. The appeals data elements that M+COs would be expected to report are 15 of the same data elements that M+COs currently report to beneficiaries upon request, with the exception of quality of care grievances. Instructions as to how M+COs will submit data via a web-based tool are currently being developed.

The data collected will enable CMS to understand more about the number of appeals and their dispositions.

FFS Data Collection: In FY 2000, CMS awarded a contract to analyze FFS data from FI's and carriers. Further evaluative efforts will be undertaken to determine FFS data

needs as mandated by the Benefits Improvement and Protection Act (BIPA). This analysis will help CMS determine the extent to which new, additional data elements should be collected in order to improve its administration of this essential beneficiary protection.

Coordination: The CMS has worked closely with the Center for Health Dispute Resolution (CHDR), health insurance industry representatives from the American Association of Health Plans, Blue Cross Blue Shield Association, the Health Insurance Association of America, and representatives from specific managed care plans. The CMS has also sought input from the beneficiary advocacy community (e.g. the American Association of Retired Persons, Consumer Coalition for Quality Health Care, National Senior Citizens Law Center).

Data Source(s): Aggregate M+CO appeals data will be reported by the M+CO and CMS's independent review entity directly into the Health Plan Management System (HPMS) initially, and ultimately to the HPMS via the enhanced CMS Reconsideration System. FFS worklaod data is reported by FI's and carriers through the Contractor Reporting of Operational Workload Data (CROWD).

Verification and Validation: The CMS routinely utilizes the Contractor Performance Evaluation (CPE) for evaluating the operation of fiscal intermediaries, carriers and Durable Medical Equipment Regional Carriers (DMERCs).

Performance Goal MB5-03

Improve Beneficiary Understanding of Basic Features of the Medicare Program

Baseline: Developmental. Baseline data are not yet available. Baselines will be available in early CY 2002 from data collected in the Spring/Summer 2001 round of the Medicare Current Beneficiary Survey (MCBS).
FY 2003 Target: Developmental. Baselines and future targets will be developed in FY 2002.
FY 2002 Target: Developmental. Baselines and future targets will be developed.
FY 2001 Target: Complete all actions necessary to implement a measurement and reporting system, including: (1) developing a list of core features of Medicare that beneficiaries need to know in order to use the program effectively; (2) obtaining input on the list from relevant advisory bodies; (3) designing and testing survey questions to capture the extent to which beneficiaries are aware of the basic features on the list; (4) integrating the questions into existing MCBS computer assisted personal interviewing systems; (5) fielding the questions in the spring/summer 2001 round of the MCBS. **Performance:** Steps 1-5 completed. Survey fielded. (Goal met)

Discussion: Prior research has shown that many beneficiaries are not well informed about the basic features of Medicare. In 1999 the Medicare Current Beneficiary Survey (MCBS) asked a sample of beneficiaries whether people covered by Medicare could select among different kinds of health plans within Medicare. Forty-seven percent correctly answered "true," eleven percent incorrectly answered "false," and forty-two percent said they were not sure.

The purpose of this performance goal is not to turn every beneficiary into an expert on Medicare; consumer research has shown that beneficiaries generally seek information about the program only as specific needs arise. Our objectives in this goal are:

- to improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively, and
- to improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

The CMS has launched a national education campaign, called *Medicare&You*, to provide beneficiaries with information about Medicare and their health plan choices. Information about Medicare is made available to beneficiaries through a variety of channels, including print materials mailed to all beneficiaries, toll free telephone service, and an Internet site. This campaign is the major intervention through which we will promote improvement in beneficiary awareness of the core features of Medicare. The campaign also includes a publicity and promotion component which is designed to enhance beneficiary awareness of the importance of learning about Medicare, the education campaign, and the information channels available. This publicity campaign

is the major intervention through which we will promote improvement in awareness of CMS sources from which additional information can be obtained.

Coordination: The *Medicare&You* campaign is being coordinated with a wide range of Federal, State, and local agencies, and beneficiary advocacy groups. For example, CMS has built an alliance network of over 120 national organizations in one of three tiers (coordinating committee, task force, and educational affiliate). In addition, CMS formed a National Advisory Panel on Medicare Education. This group consists of about 13 national experts in consumer education and advises the CMS Administrator on ways to enhance our efforts in consumer awareness on Medicare.

Data Source(s): The primary source of data on beneficiary understanding of Medicare will be the MCBS. The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. Beginning in the spring/summer round of 2001, the MCBS will include questions that ask beneficiaries about their awareness of basic features of the Medicare program. A number of features will be considered. For example, the *Medicare&You 2000* handbook highlighted the following features for all beneficiaries:

- Medicare gives you choices in how you get your health care;
- Medicare does not pay for all of your health costs;
- you may be able to get more health care coverage;
- you may be able to get help paying your health care costs; and
- Medicare protects you and gives you rights.

Questions will likely be in a "true," "false," or "not sure" format. For ethical reasons, after asking questions, MCBS interviewers will make the correct answers to the questions available to the respondents (beneficiaries cannot inadvertently be left with any misperceptions about the program). Therefore, the act of surveying these respondents would confound subsequent measurement of their awareness of the program features. Sampled beneficiaries remain in the MCBS for 3 years and then rotate out of the survey. Thus, each year about one-third of the overall MCBS sample is new and two-thirds are returning. To avoid instrumentation bias, the questions will only be asked of new MCBS members. This new part of the MCBS sample is itself nationally representative of the Medicare population.

Verification and Validation: All data from the MCBS are carefully edited and cleaned prior to the creation of analytic data files. Sample weights will be prepared that allow adjustments to survey estimates to account for differential probabilities of selection in the MCBS sample, under-coverage, and differential patterns of survey non-response. Statistical precision will be calculated and presented with the estimates.

Quality of Care: Peer Review Organizations

Peer Review Organizations	FY 2000 Actual	FY 2001 Actual	FY 2002 Current Estimate	FY 2003 Estimate
Total Budget Authority	**$618.6 M**	**$110.9 M**	**$383.1 M**	**$542.9 M**

Under the Peer Review Organization (PRO) program, soon to be known as Quality Improvement Organizations (QIOs), CMS contracts with 53 independent physician organizations (one in each State, D.C., Puerto Rico, and the Virgin Islands) to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. PRO responsibilities are specifically defined in the portion of the contract called the Scope of Work (SOW). Each SOW is three years in duration and each SOW can vary the activities the PROs perform. Funding patterns tend to vary substantially from year to year. The PRO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

Performance Goal	Targets	Actual Performance	Ref.
Improve heart attack survival rates -- Lower the 1-year mortality rate for Medicare beneficiaries following hospital admissions for heart attack	**FY 03:** 27.4% **FY 02**: 27.4% **FY 01**: 27.4% **FY 00**: 27.4 % (Target period overlaps FY 2000 and FY 2001)	**02-03:** Expect data 6/05 **01-02:** Expect data 6/04 **00-01:** Expect data 6/03 **99-00:** Expect data 6/02 **98-99**: 32.3%◆ **97-98:** 31.8%◆ **96-97:** 31.1%◆ **95-96:** 31.2%*◆ **(Baseline)** (* revised from 31.4%) ◆data not risk adjusted	QP1
Increase rate of annual influenza (flu) vaccination (NHIS)	**FY 01:** Switched to new data source. (see below) **FY 00:** 60% **FY 99:** 59%	**FY 00:** 64% **(NEW DATA)** (Goal met) **FY 99:** 66% **(NEW DATA)** (Goal met) **FY 98:** 64% **FY 97:** 63% **FY 95:** 58% **FY 94:** 55% (NHIS) **(Baseline)**	QP2

Performance Goal	Targets	Actual Performance	Ref.
Increase annual influenza (flu) and lifetime pneumococcal vaccinations (MCBS)			
-- Flu	**FY 03:** 72.5% **FY 02:** 72 % **FY 01:** 72 % **FY 00:** N/A	**FY 03**: Expect data 12/04 **FY 02:** Expect data 12/03 **FY 01:** Expect data 12/02 **FY 00:** 70.4% **FY 99:** 69.1% * **FY 98:** 68.5 %* **FY 97:** 67.1 %* **FY 96**: 65 % **FY 95:** 61 % **FY 94:** 59% (MCBS) **(Baseline)**	
-- Pneumococcal	**FY 03:** 69% **FY 02:** 66% **FY 01:** 63% **FY 00:** N/A	**FY 03:** Expect data 12/04 **FY 02:** Expect data 12/03 **FY 01:** Expect data 12/02 **FY 00:** 62.7% **FY 99:** 61.2 %* **FY 98:** 56.1 %* **FY 97:** 50.9 %* **FY 96:** 44.1 % **FY 95:** 34.6 % **FY 94**: 24.6 % (MCBS) **(Baseline)** * includes community dwelling beneficiaries only	
Increase biennial mammography rates (NHIS)	**FY 01:** Switched to new data source (see below) **FY 00:** 60% **FY 99:** 59%	**FY 01:** N/A **FY 00:** 68.1% Provisional Expect data Spring '02 **FY 99**: 66.8% **(NEW DATA)** (Goal met) **FY 98**: 63.8% **FY 94:** 55% (NHIS) **(Baseline)**	QP3
Increase biennial mammography rates (Medicare claims data)	**FY 03:** 53% **FY 02:** 52% **FY 01:** 51% **FY 00:** N/A	**02-03:** Expect data 8/04 **01-02:** Expect data 8/03 **00-01:** Expect data 8/02 **99-00:** 50.5% **98-99:** 49% **97-98:** 45% (Medicare claims data) **(Baseline)**	
Improve the rate of biennial diabetic eye exams	**FY 03:** 68.9% **FY 02:** 68.6 % **FY 01:** 68.3 % **(69.0% recalculated)** **FY 00:** New in 2001	**01-03:** Expect data Spring '04 **00-02:** Expect data Spring '03 **99-01:** Expect data Spring '02 **98-00:** 68.1% **97-99:** 67.8% **(Baseline)** (*revised from 68.5%)	QP4

Performance Results Discussion

Improving the quality of care for Medicare beneficiaries is one of our primary objectives. The CMS's GPRA goals reflect quality priorities both in prevention and adhering to quality standards. Several of the PROs' national quality priorities are reflected in our performance goals. These health conditions represent those that impact a large number of our beneficiaries and impose a significant burden on the health care system. For example, heart disease is the most common condition for which Medicare beneficiaries are hospitalized.

Heart Attack Survival - The ambitious goal to increase the 1-year survival rate among beneficiaries who suffer a heart attack illustrates CMS's partnerships with the PROs to help improve the quality of care for our beneficiaries. This nationwide effort focuses on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks. The impact of these improvements may be especially dramatic in areas where providers have not fully introduced these lifesaving measures.

Recent data show 1-year mortality rate not decreasing, which may be due to several factors. First, CMS's national programmatic effort toward this goal has been phased in gradually, and not all States have participated to the same extent. Second, the age distribution of the Medicare population represented in these data has changed during this time; the median age has increased, which is a major risk factor for mortality. Third, the rate of concomitant diseases or severity of illness may also have changed, which can contribute to mortality. Also, we may be seeing a leveling off of mortality. Analyses are underway to try to determine the effect of these factors, and to modify the goal accordingly.

Adult Immunizations & Mammography - Promotion of preventive health is represented in our performance report by goals on adult immunizations (annual influenza and, commencing in FY 2001, lifetime pneumococcal) and regular mammograms for beneficiaries over age 65. FY 2001 marked the first reporting year for which new data sources were used to measure annual flu and lifetime pneumococcal immunization rates (Medicare Current Beneficiary Survey, MCBS) and the biennial mammography rates (Medicare claims). These data sources also include our institutionalized beneficiaries and more accurately reflect our interventions. Although final FY 2001 data will not be available until next year for these measures, recent data show excellent progress and reflect the success of these lifesaving campaigns for older Americans.

Final data from the National Health Interview Survey (NHIS) show that CMS surpassed its 1999 and 2000 targets (59 and 60 percent, respectively) to increase flu immunizations among Medicare beneficiaries age 65 and older. The rate attained in 1999 was 66 percent and for 2000 64 percent. We also surpassed our FY 1999 target of 59 percent of women age 65 and older to receive a biennial mammogram by reaching 66.8 percent in 1999, and provisional data indicate that we will achieve our FY 2000 of 60 percent target when final NHIS data are available for this measure in a few months.

The effects of the FY 2000 shortage of flu vaccine and delayed immunizations remain to be seen, and we eagerly await new trend data from various data sources to assess the impact of this shortage. Furthermore, the CDC has reported that there will be shortages and delays in influenza vaccine production and distribution again this year, and this will likely impact immunization rates for our beneficiaries. The inability to quantify the impact of these shortages to date reduces the confidence we have in achieving our targets for the affected years, and for reliably setting future targets.

The CMS and the CDC are not only actively addressing the unknown impact of the flu vaccine shortages on our adult immunization performance goals, but are closely analyzing recent trends of concern. Data analyses from different data sources point to an apparent leveling off of flu vaccination rates in the target population given current resources. We have revised our FY 2002 and FY 2003 targets accordingly.

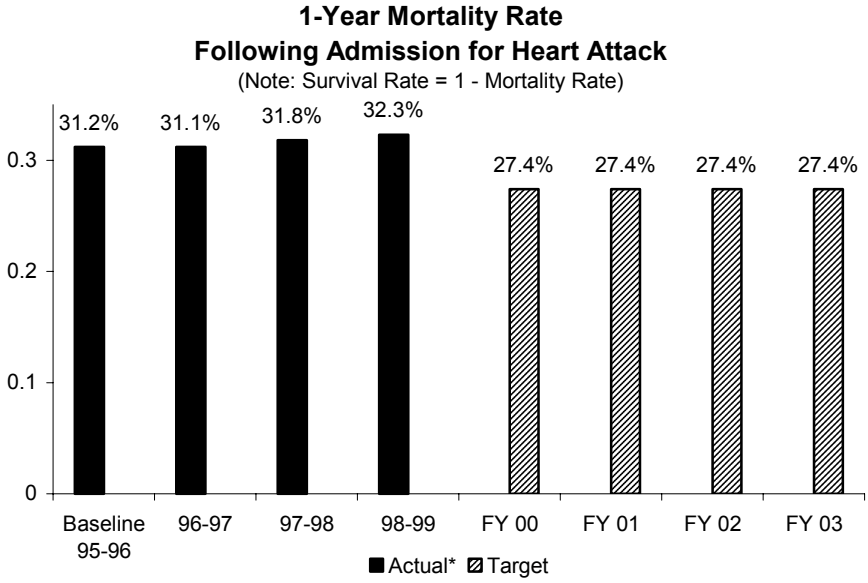
The pneumococcal vaccination rates showed better than expected trends and we revised our targets more aggressively to reflect this.

Diabetic Eye Exams - Diabetes is another highly prevalent condition in the Medicare population. Many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring and treatment. The CMS's quality goal to increase special eye exams for our diabetic beneficiaries reflects our commitment to improve diabetes care.

Data show positive progress in improving the biennial rates of diabetic eye exams. Due to a recently discovered programming error the 1997-99 baseline was revised from 68.5 percent to 67.8 percent, and targets have been revised accordingly. When we recalculated the new baseline we also calculated a new FY 2001 target of 68.3 percent (previously 69.0 percent), based on the intended 0.5 percent increase for that year.

Performance Goal QP1-03

Improve Heart Attack Survival Rates
By Decreasing Mortality



*Data not risk adjusted

The 1995 national baseline 1-year mortality rate among Medicare beneficiaries hospitalized for heart attack was 31.2 percent (corrected from previously-noted 31.4), based on hospital admissions for heart attack August 1995-July 1996). Rates calculated by CMS from Medicare Part A hospital claims and Medicare enrollment database.

Discussion: Improving treatment for heart attack has been a focus of CMS's Health Care Quality Improvement Program (HCQIP) since its inception in 1992. CMS will improve survival (by working to reduce deaths) from heart attack by assisting hospitals to improve their adherence to the following consensus-based treatment guidelines:

- Aspirin administered early in the hospital course (decreases clotting of the blood);
- Beta Blocker administered early in the hospital course (decreases heart's workload and oxygen need);
- Timely initiation of therapy to try to open blocked arteries in the heart (reperfusion therapy);
- Smoking cessation counseling during hospitalization;
- Aspirin prescribed at discharge;
- Beta Blocker prescribed at discharge; and
- Angiotensin Converting Enzyme (ACE) Inhibitor prescribed at discharge (reduces blood pressure) if the heart's pump function is impaired.

During the 1995 baseline period (August 1995 to July 1996) approximately 31.2 percent of Medicare beneficiaries hospitalized for heart attack died within a year. Since many patients are appropriate candidates for all or some of the treatments listed above, CMS

anticipates that patient survival following a heart attack can be improved by more widespread use of these proven therapies. The American College of Cardiology and the American Heart Association have also initiated efforts to increase the use of these recommended treatments, all of which are included in their published guidelines

Target rates for this goal are derived from data generated in a four-State pilot quality improvement effort conducted by Peer Review Organizations (PROs), soon to be known as Quality Improvement Organizations (QIOs), during 1994 through January 1995 to improve statewide rates focused on heart attack treatment. One-year mortality following heart attack was reduced by about one percentage point more than in other States. Starting in 1996, CMS expanded these efforts, and PROs nationwide began to phase in quality improvement activities related to heart attack treatment. In 1999, CMS began writing performance-based contracts with PROs, and we will be evaluating them on State-level improvement on these interventions.

The background rate of improvement in survival that occurred in the States not involved in the pilot project averaged about 0.6 percentage points per year. If this trend continues, the expected change after 5 years would be 3.0 percentage points. Therefore, the target assumes that this trend will continue; though this is somewhat uncertain and difficult to verify. A national intervention similar to the pilot project would be expected to improve 1-year mortality after heart attack by about 1 percentage point once the interventions are widely adopted; all PROs initiated these efforts by late FY 2000. Since approximately 323,000 Medicare beneficiaries are hospitalized for heart attacks per year (data from August 1995 through July 1996), a decrease of one percentage point translates into about 3,000 lives saved.

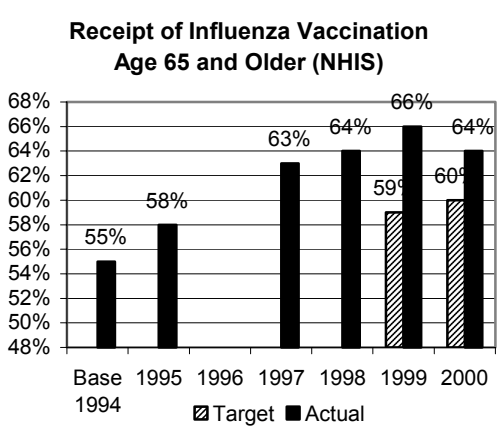
Coordination: The CMS has worked with the National Heart, Lung, and Blood Institute, the American College of Cardiology, the American Heart Association, the American Medical Association, the American Hospital Association, and multiple other organizations during the foundational stages of these efforts, and continues its partnerships with a number of these organizations. The CMS will also continue its ongoing collaboration around HCQIP with the PROs.

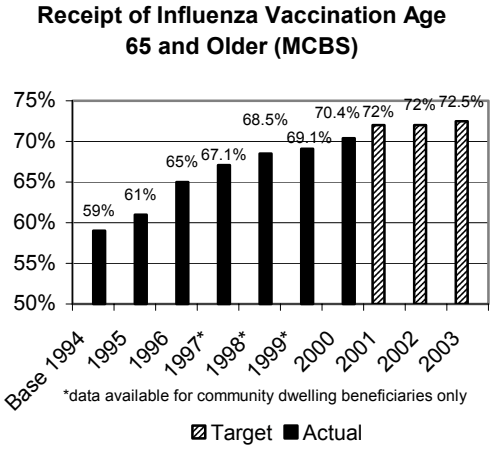
Data Source(s): The mortality rates are calculated from Medicare Part A hospital claims and the Medicare Enrollment Database. Since mortality data for the year following hospitalization are needed, there will be a lag in reporting results. For example, in order to know the 1-year mortality rate for patients hospitalized in August 2000 through July 2001, deaths occurring during August 2001 through July 2002 would need to be assessed. After updating the enrollment database, linking to the claims data, and performing the analysis, results would be expected in FY 2003. Neither the actual nor target rates have been adjusted for age or comorbidity, both of which may markedly affect the mortality rate.

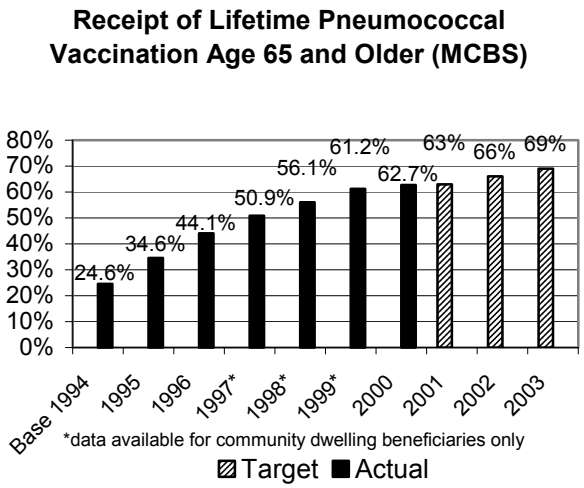
Verification and Validation: The Medicare eligibility file is derived from Social Security information, which is used as a basis for Social Security payments. Death data are validated against the National Mortality Index.

Performance Goal QP2-03

Increase the Percentage of Medicare Beneficiaries Age 65 Years and Older Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal







Discussion: Complications arising from pneumococcal disease and influenza kill more than 30,000 people a year in the United States -- typically resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza.

Coordination: The CMS, the Centers for Disease Control and Prevention (CDC) and National Coalition for Adult Immunization (NCAI) have formulated a long-term, structured campaign to increase the rate of influenza and pneumococcal vaccination among the Medicare population. One aspect of the campaign promotes the benefits of an annual influenza and lifetime pneumococcal vaccination directly to Medicare

beneficiaries. This aspect of the campaign has been conducted via direct mail emphasizing Medicare coverage and the medical benefits of vaccinations. Another aspect of the campaign targets health care providers and focuses on interventions designed to minimize missed opportunities for immunization status assessment and vaccination.

Peer Review Organizations (PROs), soon to be known as Quality Improvement Organizations (QIOs), are working in collaboration with beneficiaries, providers, managed care plans, community groups and other interested partners to design and implement immunization quality improvement projects. These projects are conducted in hospitals, long-term care facilities, dialysis facilities, physician offices, home health agencies and public health clinics. They combine education for healthcare workers, a plan for identifying high-risk patients, and efforts to remove administrative and financial barriers that prevent patients from receiving the influenza and pneumococcal vaccines. The most effective strategy noted in current literature is implementation of standing orders. This occurs when non-physician personnel vaccinate according to a protocol without direct physician involvement at the time of immunization. To support this evidence-based intervention, CMS and the CDC will collaborate to develop a strategy to increase the use of standing orders for influenza and pneumococcal vaccinations.

Data Source(s): Beginning with FY 2001, the Medicare Current Beneficiary Survey (MCBS) has been designated as the primary data source for this goal. The MCBS is an ongoing survey of a representative national sample of the Medicare population, including beneficiaries who reside in long-term-care facilities.

The National Health Interview Survey (NHIS), an annual national household interview of non-institutional persons, was designated as the primary data source for this goal through FY 2000. Limitations to the continued use of the NHIS as the primary data source include: (1) time lags between collecting and reporting NHIS data, and (2) exclusion of Medicare beneficiaries who reside in long-term care facilities.

The NHIS and the Behavioral Risk Factor Surveillance System (BRFSS) provide comparable data to the MCBS, for community-dwelling persons age 65 or older, and will be used as secondary data sources.

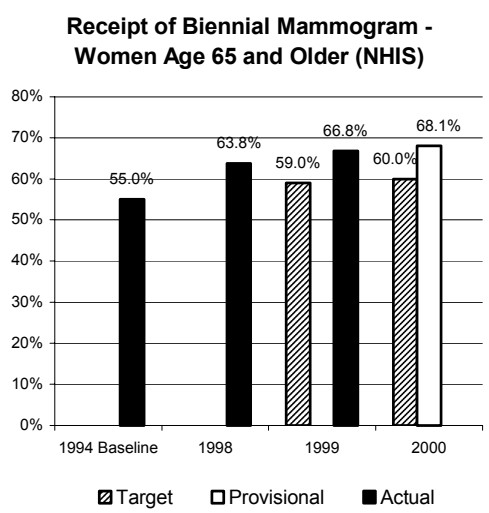
Medicare claims data provide another supplementary source of data but are likely to under-report vaccinations because the data exclude Medicare beneficiaries enrolled in managed care plans and beneficiaries who receive vaccinations outside the Medicare payment system (e.g., free clinics). Nevertheless, the information does provide great detail relating to demography, providers, geography, and vaccination opportunities missed. Medicare claims data show that Medicare paid for flu vaccinations for 43.2 percent of Medicare beneficiaries in 1996.

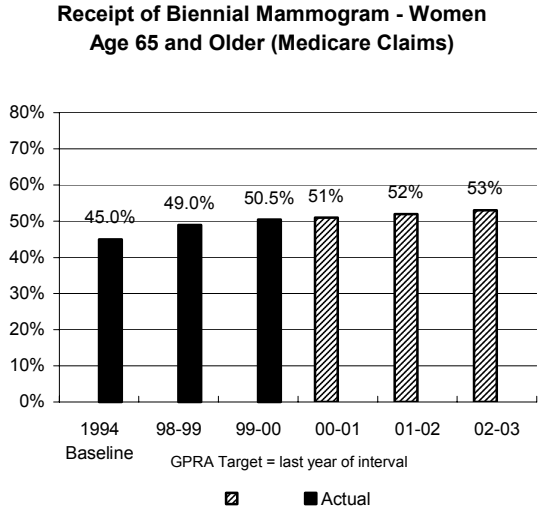
Verification and Validation: The MCBS uses Computer Assisted Personal Interview (CAPI) technology to perform data edits, e.g., range and integrity checks, and logical

checks during the interview. After the interview, consistency of responses is further examined and interviewer comments are reviewed.

Performance QP3-03

Increase the Percentage of Medicare Beneficiaries Age 65 Years and Older Who Receive a Mammogram





Discussion: The CMS intends to increase the percentage of Medicare women age 65 and over who receive a mammogram every two years. By taking advantage of the lifesaving potential of mammography, we hope to ultimately decrease mortality from breast cancer in the Medicare population. 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 these populations. The enactment of the Balanced Budget Act of 1997 expanded Medicare coverage to include annual screening mammograms for all Medicare eligible women effective January 1, 1998 and eliminated the part B deductible. Effective April 1, 2001, enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded Medicare coverage to include digital mammograms.

Coordination: The CMS has undertaken a National Medicare Mammography Campaign to increase awareness of the importance of regularly scheduled mammograms and the annual Medicare mammography benefit among Medicare women. This campaign relies on a variety of partnerships to reach both beneficiaries and providers with these important messages.

The CMS's Peer Review Organizations (PROs), soon to be known as Quality Improvement Organizations (QIOs), are charged with monitoring and improving quality of care for Medicare beneficiaries. PROs are directed to improve mammography rates among female Medicare beneficiaries (in their respective States). The PROs' contract performance will be evaluated, in part, on measured improvements in their Statewide mammography rates.

Data Source(s): Medicare claims data will be the primary data source used to track the FY 2003 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 Part A and B on a fee-for-service basis. Medicare beneficiaries who are enrolled in an HMO for more than a month in either year of the biennial period will not be included in the calculation of the rate. The baseline of 45 percent for 1997-98 includes mammography services paid for by Medicare for women ages 65 and older that were not enrolled in managed care.

Secondary data sources include the Medicare Current Beneficiary Survey (MCBS), the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS). The NHIS served as the primary data source for CMS's mammography goal through FY 2000.

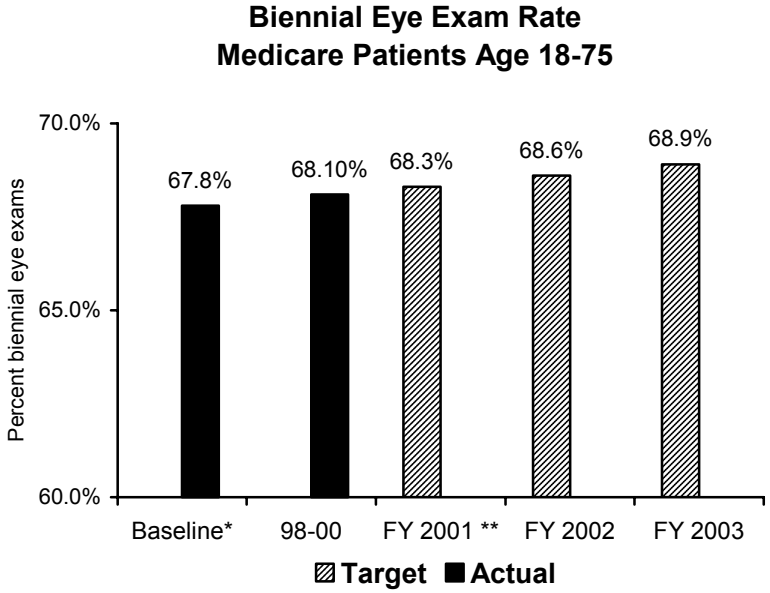
The CMS will continue to monitor recommendations by leading authorities such as the U.S. Preventive Service Task Force regarding the frequency of mammography and targeted age groups. As new developments dictate, CMS's staff will consider modifications to this goal to ensure consistency with evidence-based recommendations for mammography.

Verification and Validation: The National Claims History File (NCH) is a 100 percent sample of Medicare claims. Claims submitted by providers to Medicare are checked for completeness and consistency. Duplicates are eliminated to ensure that women who have more than one mammogram within the two-year period do not contribute to over counting. Mammography utilization rates for age groups, race and counties are calculated and compared to previous years' data to check for any unusual changes in data values.

The CMS will use these alternate data sources to verify and validate the reported trends that are based on the NCH. Since the alternate data sources are based on self-reports, the reported rates of mammography screening have historically been higher when based on these survey sources. Therefore, we will not directly compare the rates that derived from the secondary data sources with the official rate based on claims data. Instead, we will compare the year-to-year changes observed in each data source, to determine whether each reveals essentially equivalent rates of improvement.

Performance Goal QP4-03

Increase the Rate of Diabetic Eye Exams



* Baseline Revised from 68.5%
** FY 2001 target recalculated from 69.0%

Discussion: Diabetes is a major public health problem and is becoming more prevalent in all age groups. The increasing prevalence is attributed both to higher detection and to poorer health habits (increased rates of obesity being the primary culprit). In August 2000, the Centers for Disease Control and Prevention (CDC) reported the prevalence of diagnosed diabetes to have increased by 33 percent in the 1990s.

According to the National Health Interview Survey (NHIS), the prevalence of Type 2 diabetes (generally known as adult onset diabetes) is 1.3 percent at 18-44 years, 6.2 percent at 45-64 years, and 10.4 percent for those ages 65 and older. Based on oral glucose testing in the National Health and Nutrition Examination Survey, there is one undiagnosed case of diabetes for every diagnosed case. Diabetics have twice the death rate and two-to-three times the disability rate compared to the general U.S. population. The American Diabetes Association estimates the cost of diabetic care to be over $100 billion. Complications of diabetes include blindness, kidney failure, nerve damage and cardiovascular disease. Many of these complications can be prevented or delayed with appropriate monitoring and treatment. Studies in both fee-for-service and managed care settings indicate that care is suboptimal.

Among common diabetic complications is retinopathy, which can cause blindness. Diabetes is the main cause of blindness in the United States. Up to 21 percent of newly diagnosed patients with Type 2 diabetes have retinopathy, and many develop some retinopathy over time. Eye examinations prevent or greatly reduce visual impairment.

Coordination: The CMS has worked with the American Diabetes Association, the CDC, the Department of Veterans Affairs, the National Committee for Quality Assurance (NCQA) and many others in the development of this goal. The CMS has directed the Peer Review Organizations (PROs), soon to be known as Quality Improvement Organizations (QIOs), to improve the diabetic eye exam rate among Medicare beneficiaries in their respective States.

The CMS has joined forces with the American Academy of Ophthalmology and the American Optometric Association to launch a national eye care campaign which includes mailings to beneficiaries, a national outreach campaign with television star Bill Cosby as the spokesperson, and articles in popular and professional sources. Local PROs have also contributed to the national campaign. An evaluation of all these efforts is planned for late 2001 to identify successes to be duplicated on a national level.

Data Source(s): The National Claims History file (NCH) will be the primary data source. The percentage of diabetics ages 18-75 with paid Medicare claims for a retinal exam during a biennial period will be calculated. An age range 18-75 was selected in order to be consistent with the Health Plan Employer Data Information Set (HEDIS®) comprehensive diabetes measure used widely in managed care. The denominator consists of diabetics who are enrolled in both Part A and B on a fee-for-service basis. Medicare beneficiaries who are enrolled in a health maintenance organization (HMO) for more than a month in either year of the biennial period will not be included in the calculation of the rate.

The biennial baseline is based on Medicare claims data for 2 million diabetic beneficiaries. The measurement period varied depending on an individual State's PRO contract cycle. Each State fell into one of three measurement periods. The first period covered calendar years: 1997 and 1998; second: April 1, 1997 - March 31, 1999; third: July 1, 1997 - June 30, 1999. Future biennial rates will be calculated in a similar manner. A programming error required a revision of the 1997-99 baseline from 68.5 percent to 67.8 percent.

Secondary data sources include the NCQA HEDIS® data set and the NHIS. The NCQA HEDIS® data set is an annual survey of individual managed care plans. All Medicare+Choice plans are required to collect and report the rate of eye exams for their Medicare members who have diabetes. The NHIS is an annual national household interview of community-dwelling persons. The CMS will use these alternate data sources to verify and validate trends.

Verification and Validation: 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.

Medicare+Choice plans' HEDIS® data must be audited each year by an independent contract. These contractors implement a standard audit protocol that has been developed and tested by the NCQA, in conjunction with CMS. The NHIS is a validated survey which uses electronic data range checks and internal consistency checks.

Quality of Care:
Survey & Certification

Survey and Certification Program	FY 2000 Actual	FY 2001 Enacted	FY 2002 Appropriation	FY 2003 Estimate
Total Budget Authority	**$209.7 M**	**$242.1 M**	**$254.4 M**	**$247.6 M**

The State Survey and Certification program ensures that institutions providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety, and quality standards. Institutions covered include hospitals, nursing homes, home health agencies (HHAs), end-stage renal disease (ESRD) facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries. The CMS's investment in quality oversight includes initial inspections of providers who request participation in the Medicare program, annual recertification inspections, and visits in response to complaints. The survey and certification budget includes funds to strengthen and continue activities focused on ensuring that our beneficiaries in nursing homes receive quality care in a safe environment. As part of CMS's Nursing Home Oversight Improvement Program, surveyors have been instructed to pay particular attention to nursing homes' use of physical restraints and to their ability to prevent and treat pressure ulcers. In addition, CMS's public reporting initiatives have provided new information to consumers about these measures. For example, the Nursing Home Compare website (www.medicare.gov/nhcompare/home.asp) gives consumers access to this information on the Internet.

Performance Goals	Targets	Actual Performance	Ref.
Decrease the Prevalence of Restraints in Nursing Homes	**FY 03:** 10% **FY 02:** 10% **FY 01:** 10% **FY 00:** 10% **FY 99:** 14%	**FY 03:** **FY 02:** **FY 01:** Interim Data, 10.2% Final Data 3/02 **FY 00:** 10.0% (Goal met) **NEW DATA** **FY 99:** 11.9% (Goal met) **FY 96:** 17.2% **(Baseline)**	QSC1
Decrease the Prevalence of Pressure Ulcers in Nursing Homes	**FY 03:** 9.5% **FY 02:** 9.5% **FY 01:** 9.6 % **FY 00:** Establish baseline/targets **FY 99:** New in 2000	**FY 03:** **FY 02:** **FY 01:** Interim Data, 10.7% Final Data 3/02 **FY 00:** 9.8% (Goal met) **(Baseline)** **FY 99:** N/A	QSC2

Performance Goals	Targets	Actual Performance	Ref.
Improve the Management of the Survey and Certification Budget Development and Execution Process			QSC3
-- Develop a price-based methodology that will be used to develop and allocate survey and certification appropriation	**FY 03:** Allocate FY 2003 budget increase, at a minimum, to those States within the 15 percent threshold for unit survey hours for LTC & NLTC surveys	**FY 03:**	
	FY 02: Allocate FY 2002 budget increase, at a minimum, to those States within the 15 percent threshold for unit survey hours for LTC surveys	**FY 02:** Pending Appropriation	
	FY 01: Allocate FY 2001 budget increases to those States within the 15 percent threshold for unit survey hours	**FY 01:** (Goal met)	
	FY 00: New in 2001	**FY 00:** N/A	
-- Develop performance measures and baselines to measure quality of survey work performed	**FY 03:** Assure standards are met and identify appropriate corrective action plans	**FY 03:**	
	FY 02: Evaluate FY 01 performance results	**FY 02:** Pending FY 01 data results	
	FY 01: Develop measures	**FY 01:** Measures developed (Goal met)	

Performance Results Discussion

The CMS seeks to protect its beneficiaries by surveying facilities participating in the Medicare program. The performance goals to decrease the use of physical restraints and the prevalence of pressure ulcers represent CMS's focus on ensuring quality of care in long term care facilities. These targets have been maintained until data trends are better understood. Our goal to improve the survey and certification budget process moved CMS from the "cost" based approach to a "price" based methodology, which uses national standard measures of workload and costs to project individual State workloads and budgets.

Physical Restraints - The CMS's efforts to reduce the use of physical restraints through the State Survey and Certification Program have been successful. Use of restraints in nursing homes has decreased from 17.2 percent in 1996 to 10.0 percent in 2000, and our future target of 10 percent aims to decrease their use even further. Interim 2001 data indicate use of physical restraints remains just above 10.0 percent. Although we have achieved a large reduction in the use of physical restraints in recent years, we believe that current program efforts are achieving smaller reductions in

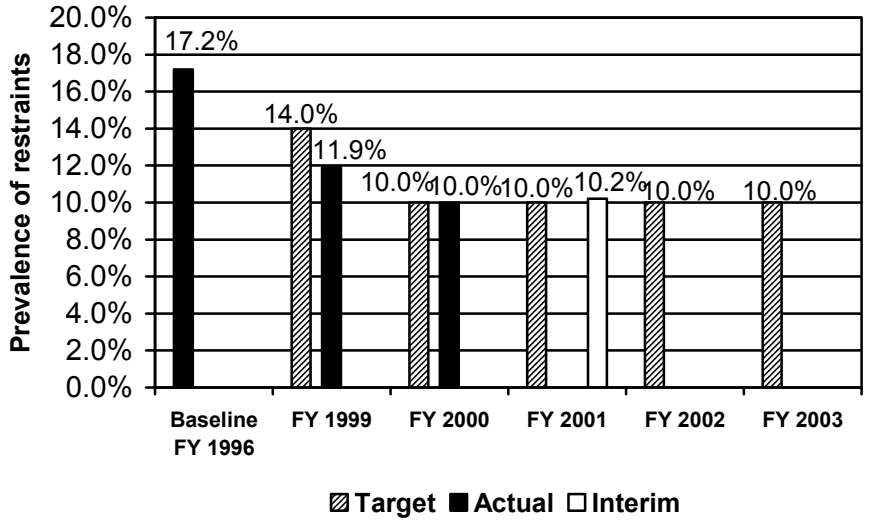
restraint use than they have previously. Future reductions in restraint use, while important, will likely be more difficult to achieve. While we are continuing to stress restraint reduction as a program goal, we are maintaining the GPRA target at 10 percent while we evaluate the effect of current policies and consider the introduction of new ones.

Pressure Ulcers - The CMS is also seeking ways to decrease the prevalence of pressure ulcers. New survey protocols were developed and published in 1998, and are being used by nursing home surveyors in identifying avoidable pressure ulcers. We developed uniform guidance for nursing home surveyors aimed at improving consistency among State Agency Surveyors in terms of scope and severity when citing facilities for pressure ulcer problems. Interim data indicate the prevalence of pressure ulcers is 10.7 percent.

Survey and Certification Budget - We met our FY 2001 target to allocate the FY 2001 budget increase to State Survey and Certification budget using a price-based methodology. We analyzed the combined national average survey times for long term care facilities. Any State that exceeded by 15 percent or more the combined national average survey time for long term care facilities was provided an FY 2001 base budget that assumed the FY 2000 funding level. All other States received a FY 2001 base budget increase not to exceed regional office State budget recommendations. Survey quality performance measures to enhance the survey process were communicated to regional offices and States in FY 2001. In early FY 2002 (October 2001), CMS issued new FY 2002 State Agency Performance Standards to all State Agencies.

Performance Goal QSC1-03

Decrease the Prevalence of Restraints in Nursing Homes



Discussion: "Physical restraint" refers to any manual method, mechanical device, material, or equipment attached or adjacent to the patient that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. Restraints should be used only as a last resort, only when required to treat medical symptoms, and only after careful assessment of the patient. Restraints should never be used as a substitute for adequate patient supervision.

The reduction of the use of physical restraints is one of CMS's major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care, and considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

One of the main ways in which CMS can promote reduced use of physical restraints is through the State Survey and Certification Program. State and CMS surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason. To reinforce this message, CMS will be conducting a training program for State surveyors in the near future. The topic of this program, which will be broadcast by satellite and carried live over the internet, will be on reducing physical restraint use in nursing homes.

In establishing performance goals for the quality area, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. Individuals in nursing homes are a particularly vulnerable population, and consequently, it is an area of considerable importance. A significant portion of

benefit dollars in both Medicare and Medicaid pay for care in nursing homes. For FY 2001, this will amount to 19 percent of benefit dollars for Medicaid and nearly 6 percent for Medicare.

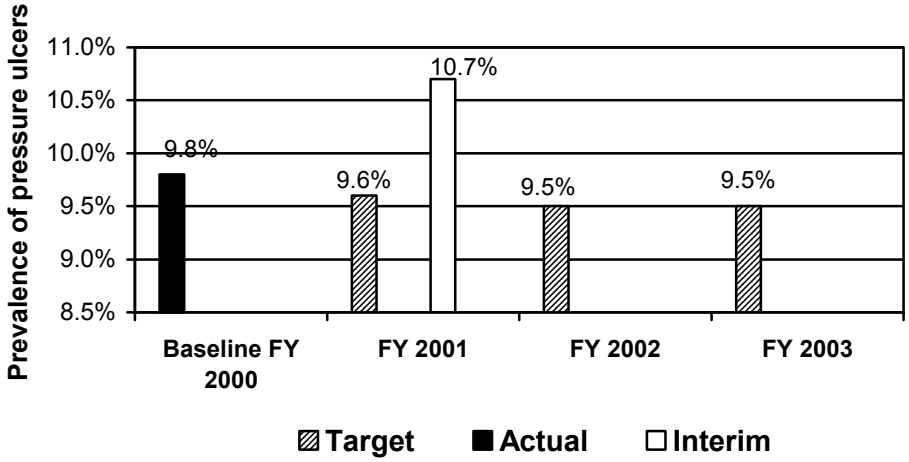
Coordination: The CMS coordinates with the American Health Care Association, National Citizens Coalition for Nursing Home Reform, American Association of Retired Persons, American Association of Home Services for the Aging, and State Survey Agencies.

Data Source(s): Data on the use of physical restraints are contained in the Online Survey and Certification and Reporting (OSCAR) database. In the future, as the Minimum Data Set (MDS) information becomes more widely available, CMS will use these data to further refine this goal.

Verification and Validation: Data are verified during annual, onsite surveys. During these surveys, surveyors do resident observations, which include interviews and validation of the number of residents in restraints reported by the facility.

Performance Goal QSC2-03

Decrease the Prevalence of Pressure Ulcers in Nursing Homes



Discussion: "Pressure ulcer" refers to any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers. The Institute of Medicine has identified the prevalence of pressure ulcers as an indicator of the quality of care provided by nursing homes. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents except those at very high risk.

The CMS sponsors a variety of pressure ulcer activities: a satellite broadcast education program; enhancing methods of surveyor detection of pressure ulcers using Minimum Data Set (MDS) data and quality indicator reports; more detailed guidance to surveyors to detect pressure ulcer assessment and treatment deficiencies; more effective enforcement procedures to sustain compliance with Federal requirements; national educational programs in the prevention and treatment of pressure ulcers; and campaigns to raise national awareness of this significant health care problem.

The prevalence of pressure ulcers in nursing homes appears to have increased slightly over the 2001 baseline. We can only speculate as to the cause(s) of this increase. This may be a random variation and may not represent a true increase. However, if it does represent a true increase, there could be several reasons for this. The prevalence rate would increase if (1) prevalence actually did increase; or (2) facilities change coding behavior and report pressure ulcers that would not previously have been reported. There are several plausible explanations for the increase in prevalence. First, if there has been an increase in case-mix (severity of illness) of the nursing home population, it is possible and even likely there would be an associated increase in the prevalence of related conditions, including pressure ulcers. Second, it is possible that we are seeing an increase in the prevalence of pressure ulcers because facilities have responded positively to our educational efforts, and are more carefully assessing residents and more accurately staging and coding pressure ulcers. In other words, due to our efforts

we are getting to a truer picture of the prevalence of pressure ulcers in the industry. Third, coding behavior of facility staff may change for a variety of reasons. For example, there may be certain financial incentives for nursing homes under the PPS system to make residents appear more ill.

The CMS has implemented a variety of programs to promote more accurate assessment and coding of pressure ulcers and will continue to work with providers and surveyors to ensure the accuracy of reported data. Finally, we will examine the methodology used to calculate the prevalence of pressure sores to see if improvements in that methodology may be made to decrease the effect of random variation on this reported measure. The CMS will continue to evaluate these data to determine whether or not they represent a true increase.

Coordination: We are actively pursuing participation of national provider associations, national experts on pressure ulcer reduction, the Peer Review Organizations, States and consumer advocates. We invited a nationally renowned clinical expert in the area of pressure ulcers to speak to State and Regional Office Resident Assessment Instrument Coordinators. In addition, as part of our effort to develop consistent scope and severity guidance, we have invited nationally recognized pressure ulcer experts from Yale University, and from the National Pressure Ulcer Advisory Panel to help us address pressure ulcer issues.

Data Source(s): We will use the MDS, including special reports derived from the database, such as the quality indicator reports, to measure prevalence of pressure ulcers in long term care facilities. This information is submitted to the State MDS database and in turn is captured in the national MDS database.

Verification and Validation: MDS data quality assurance currently consists of reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS. There are two questions on the MDS assessment form which ask the assessor to document information about the number and stage (measure of severity) of pressure ulcers.

Performance Goal QSC3-03

Improve the Management of the Survey and Certification Budget Development and Execution Process

Baseline: Allocate funding based on previous year's costs.
FY 2003 Target: Allocate FY 2003 State Survey and Certification budget using the price based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
FY 2002 Target: Allocate the FY 2002 State Survey and Certification budget using the price based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
FY 2001 Target: Begin moving States towards a price-based methodology by allocating budget increases to those States with unit survey hours that do not exceed 15 percent above the combined national average, for long term care surveys. Allocate FY 2001 budget increases to those States that are within the 15 percent threshold, as appropriate. Develop performance measures and associated baselines that can be used to measure the quality of the survey work performed. **Performance:** FY 2001 Target met for allocating FY 2001 Survey and Certification budget. Performance measures developed.

Discussion: The CMS's primary mission with the survey and certification program is to ensure that the nation's elderly and disabled are receiving high quality care. In order to ensure this high level of care, CMS has a responsibility to purchase high value survey services, verify that the survey services were performed as contracted, and assess the quality of the survey services performed.

To accomplish these objectives and to help ensure national consistency in the survey and certification budget process, CMS will continue to review and analyze State reported OSCAR 670 data in the area of survey hours reported for long term care facilities. For example, in FY 2001 CMS assumed the FY 2000 State funding levels as the budget base for States. Any increase to a State's FY 2001 base budget was contingent upon CMS's analyses of combined national average survey times for long term care facilities (skilled nursing and dually participating nursing facilities). Specifically, States that were within 15 percent or less than the combined national average survey time were provided with an FY 2001 base budget increase (not to exceed regional office budget recommendations) proportionate to each State's FY 2000 budget. Any State that exceeded the 15 percent combined average survey time threshold received a base budget that assumed the FY 2000 funding level.

The CMS did not award a contract in FY 2001 to evaluate pricing methods for paying State Survey Agencies as these efforts are being pursued in-house, i.e., CMS will continue to update historical data with State reported Online Survey and Certification and Reporting (OSCAR) data. By focusing on average survey hours as the cornerstone of a price-based methodology, CMS will use national standard measures of workload and costs to project State workloads and budgets for FY 2002.

In FY 2001, CMS issued State Performance Review Protocol Guidance and set a due date of March 2002 for completion of the first round of State performance reviews.

In early FY 2002 (October 2001), CMS issued new FY 2002 State Agency Performance Standards to all State Agencies.

Coordination: The CMS's coordination includes Survey and Certification Oversight Board (SCOB), Center for Medicaid and State Operations (CMSO), Office of Financial Management (OFM), CMS Regional Offices (ROs), and State survey agencies.

Data Source(s): Workload data obtained from State reported OSCAR data and State Survey and Certification Workload Reports (Form HCFA-434). The budget and expenditure data will be obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435). The baseline data may be obtained from actual appropriated funding levels or the President's Budget request.

Verification and Validation: OSCAR data are validated annually as part of annual onsite surveys. Form HCFA-434 and Form HCFA-435 data are validated through CMS Regional Office reviews.

Grants to States for Medicaid/Medicaid Agencies

Medicaid Activity	FY 2000 Actual	FY 2001 Actual	FY 2002 Current Estimate	FY 2003 Estimate
Budget Authority	**$117.7 B**	**$129.4 B**	**$144.6 B**	**$158.7 B**

Medicaid is a means tested health care entitlement program financed by States and the Federal Government. Approximately 43 percent of funding comes from the States and 57 percent from the Federal Government in FY 2001. All 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam) have elected to establish Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. Medicaid programs vary widely from State to State.

Another representative goal related to this budget category but is not listed in the chart is:

- Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and Increase Enrollment of Eligible Children in Medicaid (SCHIP1-03)

Performance Goal	Targets	Actual Performance	Ref.
Improve Access to Care for Elderly & Disabled Medicare Beneficiaries who do not have Public or Private Supplemental Insurance	**FY 02:** Goal discontinued. See FAC9 **FY 01:** Exceed national enrollment growth rates collectively in areas under CMS outreach and enrollment grant; Increase enrollment by 4 percentage points in States where FY 2000 target was not met **FY 00:** Increase enrollment by 4 percentage points nationally **FY 99:** Establish target	**FY 02:** N/A **FY 01:** 5 grantStates achieved a collective increase of 4.3% which surpassed the national enrollment average of 3.6% (Goal Met) **(NEW DATA)**; 2 out of 3 States did not meet a 4% increased enrollment (Goal not met) **(NEW DATA)** **FY 00:** 5,499,349 dual eligible beneficiaries, a 4.4% enrollment increase (Goal met) **FY 99:** Target established. 5,270,000* dual eligible beneficiaries **(**Goal met) **FY 98:** 5,167,000* dual eligible beneficiaries **(Baseline)** *FY 98 &99 data approximated based on trend of 2% increase per year	MMA1

Performance Goal	Targets	Actual Performance	Ref.
Increase the Percentage of Medicaid Two-Year Old Children Who are Fully Immunized (Developmental)		**(See Appendix B NEW DATA)**	MMA2
-- Group I	**FY 03:** Measure State-specific immunization rate-Achieve State target **FY 02:** Measure State-specific immunization rates **FY 01:** Measure State-specific immunization rates **FY 00:** Complete development of State-specific methodologies and baselines **FY 99:** New in FY 2000	**FY 03:** **FY 02:** **FY 01:** All methodologies, baselines and targets set. 11 of 16 report first remeasurements (see Appendix B) **FY 00:** 13 of 16 States completed methodologies and baselines (See Appendix B) **FY 99:** Identified Group I States and began developing State-specific methodology and baselines	
-- Group II	**FY 03:** Measure State-specific immunization rate **FY 02:** Measure State-specific immunization rate **FY 01:** Establish State-specific baselines and targets **FY 00:** Identify; begin developing State-specific methodologies and baselines **FY 99:** New in FY 2000	**FY 03:** **FY 02:** **FY 01:** 10 of 10 States complete methodologies; 6 of 10 report baselines and targets (See Appendix B) **FY 00:** Identified Group II States and began developing State-specific methodology and baselines **FY 99:** N/A	
-- Group III	**FY 03:** Measure State-specific immunization rate. **FY 02:** Establish State-specific baselines and targets **FY 01:** Identify; begin developing State-specific methodologies and baselines **FY 00:** N/A **FY 99:** New in FY 2000	**FY 03:** **FY 02:** **FY 01:** Group III States Identified; began developing State-specific methodologies and baselines **FY 00:** N/A **FY 99:** N/A	

Performance Goal	Targets	Actual Performance	Ref.
Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries	**FY 03:** Goal not continued **FY 02:** 56 States/ Territories **FY 01:** 56 States/ Territories **FY 00:** 56 States/ Territories **FY 99:** 27 States	**FY 03:** N/A **FY 02:** **FY 01:** 56 States/Territories **(**Goal met) **FY 00:** 56 States/Territories **(**Goal met) **FY 99:** 27 States **(**Goal met) **FY 98:** 12 States **(Baseline)**	MMA3
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates.	**FY 03:** Assess results of pilot study **FY 02:** Pilot study in 9 States **FY 01:** Pilot study in two States **FY 00:** New in FY 2001	**FY 03:** **FY 02**: **FY 01:** (Goal not met) **FY 00:** N/A **Baseline:** To be determined	MMA4
Improve Health Care Quality Across Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project	**FY 03:** To begin working with States on the Performance Measurement Partnership Project. **Medicaid & SCHIP** - Report on results of the meeting with State representatives and identify a timeline for implementing recommendations - Initiate action steps for implementing recommendations **SCHIP** - Begin to implement core SCHIP performance measures **FY 02:** New in FY 2003	**FY 03:** **FY 02:** N/A	MMA5

Performance Results Discussion

The Medicaid program is a Federal-State partnership intended to provide health care to vulnerable populations. In order to allow time to negotiate meaningful Medicaid performance goals with the States, CMS requested and was granted by the Office of Management and Budget a one-year waiver of GPRA rules for the Medicaid program for FY 1999.

Improve Access for Dual Eligible Beneficiaries - One of our most vulnerable populations is our low-income Medicare beneficiaries who do not have public or private supplemental insurance. Due to the overwhelming success of so many States in

FY 2000, we modified our approach to measuring this area for FY 2001. Instead of setting a goal to achieve a national rate increase, we focused on States that received CMS grants for outreach activities and States that did not meet the FY 2000 target. Additionally, we implemented a strategy for increasing enrollment of dual eligible population that was established as part of the FY 1999 performance plan that called for an increase in partnerships.

We exceeded the first part of our FY 2001 target (to exceed the national enrollment rate of 3.6 percent in States receiving a Federal grant) by achieving a 4.3 percent collective enrollment rate in those grant States. We partially met the second target (to achieve a four percent increase in those three States that did not achieve their FY 2000 targets). All three States increased the number of dual eligibles enrolled; however, two of those three States increased enrollment rates by 1.6 and 0.3 percent, falling slightly short of the 4% target increase. This may be because as 2001 unfolded, CMS chose to focus on a national technical assistance and tool development strategy rather than focus limited resources on just three States. We will continue the national partnerships developed over the life of this goal as we distribute revised outreach tool kits, videos and public service announcements in a series of national State, local and grass roots organizations training conferences in Spring 2002. As State partnerships continue, we are refocusing our efforts on the low income Medicare beneficiaries beginning in FY 2002 with a new performance goal measuring their increased of awareness of the Medicare Savings Program (see FAC 9-03).

Childhood Immunizations - Despite significant challenges, there has been real progress in our State partnerships to increase childhood immunization rates for Medicaid two-year olds. The CMS continues to help States focus on this at-risk population by assisting them in developing State-specific measurements of childhood immunization.

All Group I States (16) have completed development of their methodologies, baselines, and 3-year targets. Due to report their first remeasurement this year, eleven of 16 did report their progress on schedule; the remain five States were delayed and will do so in 2002. The ten Group II States made excellent progress during their developmental period, which ended in FY 2001. These States have defined their State-specific methodologies. Six of ten set their baseline and 3-year target rates; the remaining four in Group II were delayed and will do so in 2002. Recruitment efforts for the final group of States (Group III) have been successful and these States are working on defining their State-specific measures during their developmental period.

Details on Group I and II States can be found in Appendix B. This Appendix summarizes each State's methodology, relevant definitions, numerical baselines and 3-year targets, and interim remeasurements.

Provide States Linked Medicare and Medicaid Data - The aim of our goal to provide States linked Medicare and Medicaid data files for dually eligible beneficiaries is to enable States to analyze linked Medicaid and Medicare information. In FY 2001, we

continue to provide identifiers and make Medicare utilization data available to States. The States will do their own linking with their Medicaid files. This change enables States to match more current Medicaid data as opposed to using the State Medicaid Research Files (SMRF) that can lag behind two to three years. We met our FY 2001 goal by making Medicare utilization data available to 50 States and six Territories.

Medicaid Payment Error Rate - The FY 2001 goal to assist States in conducting Medicaid payment accuracy studies seeks to measure and ultimately reduce Medicaid payment error rates. Our FY 2001 target was to work with two States to conduct payment accuracy studies. The data from these studies would be used to help refine payment accuracy measurement methodologies and assess the feasibility of constructing a single methodology usable by all States. We did not meet our FY 2001 target because of delays securing the necessary funding and formally recruiting pilot States. However, we ultimately recruited 9 States for the initial pilot, versus only two as initially projected. The State applications and funding were approved September 26, 2001. The actual pilot studies will be conducted in Federal FY 2002. Also in September, CMS contracted with The Lewin Group to work with CMS and the pilot States and help develop promising Medicaid payment accuracy measurement methodologies for field testing.

Improve Health Care Quality Across Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project - We are introducing a new goal to establish formal Federal-State collaborations for improving health care delivery and quality for Medicaid and SCHIP populations using performance measures. In FY 2002, CMS is meeting with States to jointly explore a strategy to effectively use performance measures to quantify and stimulate measurable improvement in the delivery of quality health care. In FY 2003 we plan to establish a formal process to develop evidence-based Medicaid health improvement priorities (including performance measure specifications and targeted improvement models).

Performance Goal MMA1-01

Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Insurance

Baseline: There were 5,167,000 beneficiaries enrolled in dual eligible programs as of September 30, 1998.
FY 2002 Target: Goal discontinued. See FAC9.
FY 2001 Target: Exceed the national enrollment growth rate collectively in the areas of the country where activities are being performed under a CMS outreach and enrollment grant. In the States where the FY 2000 target was not met, the FY 2001 target is a 4% enrollment increase. **Performance:** First portion of the goal was met. The five States receiving grants exceeded the target by achieving a collective increase of 4.3%, surpassing the national enrollment average of 3.6%. The second portion of the goal was partially met. One of these three States met the target; the other two increased their enrollment, but fell short of the 4% increase.
FY 2000 Target: Increase FY 1999 enrollment of dual eligible population by 4%. **Performance:** Goal met. Actual enrollment for FY 2000 was 5,499,349, an increase of 4.4%.
FY 1999 Target: The CMS will work with States to establish an enrollment target and to design a strategy to increase enrollment of eligible Medicare beneficiaries (both elderly and persons with disabilities) in programs for dually eligible beneficiaries, such as the Qualified Medicare Beneficiary (QMB) program, and the Specified Low-Income Medicare Beneficiary Program (SLMB). **Performance:** Goal met.

Discussion: One of CMS's central concerns is that Medicare beneficiaries are able to get the care they need when they need it, and that they are not impeded by factors such as cost, health status, location, or availability of primary care physicians or specialists. This is true not only for beneficiaries as a class, but most especially for vulnerable subgroups such as persons with disabilities and members of minority and economically disadvantaged populations.

Although Medicare provides beneficiaries with a basic set of health benefits, the beneficiaries still are required to pay a significant amount out-of-pocket for premiums, deductibles, and co-insurance. This cost can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance.

The dual eligible programs include, among others, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), and Qualifying Individual (QI). These programs were enacted to help low-income Medicare beneficiaries with their Medicare cost-sharing expenses. Despite the existence of these programs, a substantial proportion of individuals eligible for these programs are not enrolled. Two recent studies estimated non-participation rates for QMBs and SLMBs range between 46 to 53 percent.

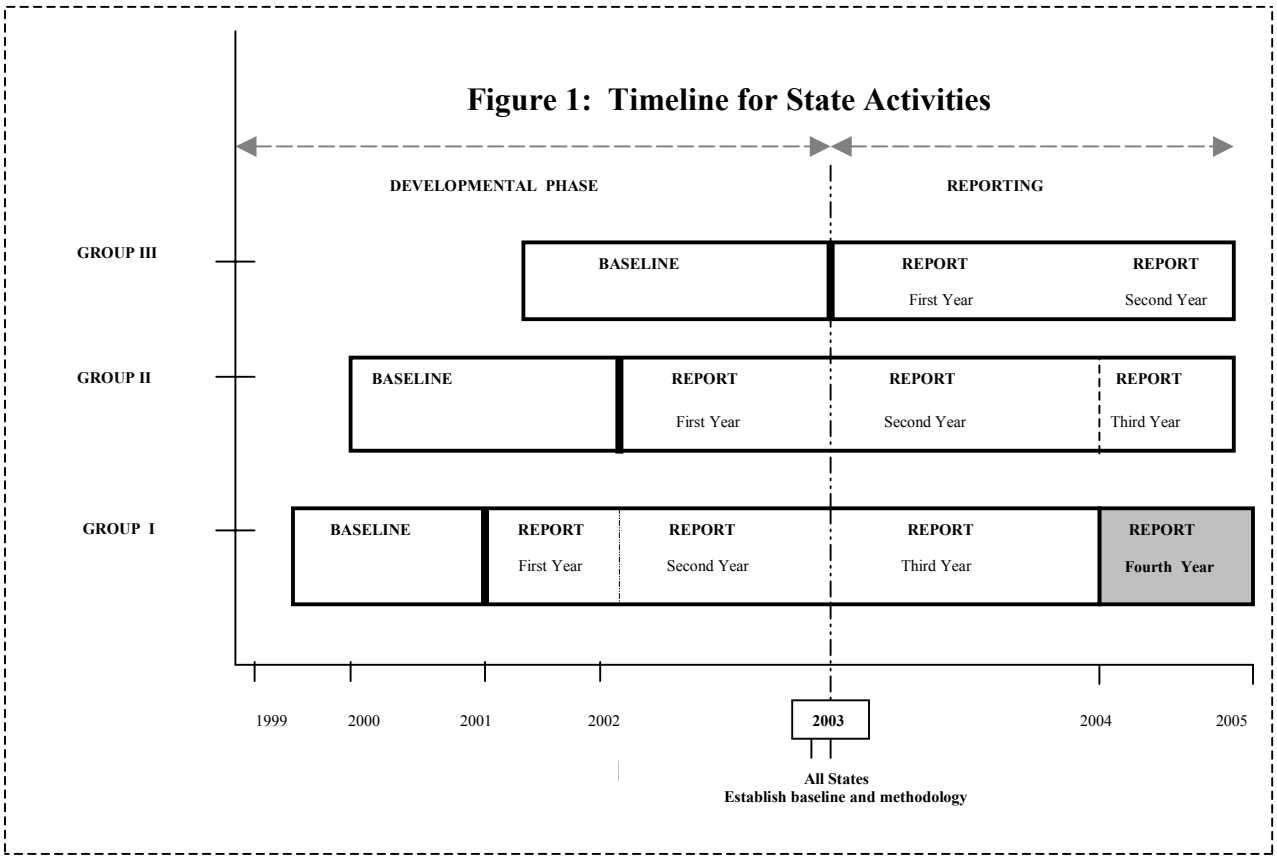
Coordination: The CMS has conducted a number of activities in the area of outreach and enrollment in partnership with other Federal agencies, States, providers, and community organizations. These activities included: direct mailings to beneficiaries; grants to State Health Insurance Assistance Programs (SHIPs), States, and ombudsman for innovative outreach and enrollment assistance; and funding for research and evaluation of best practices and care costs for the dual eligible population. The CMS also co-sponsored five regional training sessions and developed an Outreach Kit and Resource Guide specific to the dual eligible population. In FY 2001, CMS will continue to provide grants to States working with coalitions of local community groups to pilot innovative outreach and enrollment techniques. In addition, the outreach and enrollment strategy contains elements that can only be operated through continuation of the partnerships that have been formed with other Federal agencies such as the Social Security Administration and the Health Resources and Services Administration.

Data Source(s): The data source for the FY 2001 goal was the Medicaid Statistical Information System (MSIS) or an alternative State information system. We worked with States to transition to this data system from the Third Party Medicare Premium Billing System as part of the FY 2000 goal.

Verification and Validation: Data verification and validation procedures will occur as part of the overall MSIS quality assurance activities and through a cross walk to the CMS Third Party Medicare Premium Billing System.

Performance Goal MMA2-03

Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized



Discussion: Providing children with the complete series of vaccinations in the first two years of life is a widely accepted public health goal. It is a highly effective intervention to prevent certain diseases, including measles, mumps, rubella (German measles), polio, tetanus, diphtheria, pertussis (whooping cough), and meningitis. Children are required to be immunized in order to enter school and 95 percent or more of American children are adequately vaccinated by kindergarten. However, approximately one million pre-school age children are not adequately protected against possibly fatal illnesses. With increasing numbers of children more readily exposed to infectious disease in day-care settings and elsewhere, complete immunization by age two is critical.

Healthy People 2010 continues to strive for 90 percent immunization coverage level for two-year olds as a national health promotion and disease prevention objective. Currently, 77 percent of two-year olds are fully immunized. However, studies indicate that certain subgroups have much lower coverage rates. The CMS, working in conjunction with the States and the District of Columbia, has developed a three-stage process for its Medicaid Immunization Goal. Figure 1 outlines the time frames

associated with the development of individual State baselines and methodologies for reporting immunization coverage for two-year old children enrolled in Medicaid. The phase-in process of Group I, Group II, and Group III States and their subsequent reporting years are also identified. Once a State has established a baseline, it will set a target for improvement to be achieved after the third year of re-measurement. Quality improvement interventions will also be identified to help reach the target.

During the baseline development years, CMS will work closely with the group of States to assist them with developing a baseline methodology to measure immunization rates of two-year old Medicaid children. Technical assistance will be provided through the Centers for Disease Control and Prevention (CDC) and CMS as determined necessary by States and CMS.

States have a number of options to select as they collect immunization coverage information on two-year old Medicaid children. Since Medicaid is a State-run program it is best for States to determine how to measure their own immunization rates and to determine their own performance targets. As such, comparisons between States will not be useful or meaningful.

The methodologies chosen by individual States will depend on a number of factors. For example: the service delivery systems used in that State, the existence of functional State or regional registries, and the average duration a Medicaid beneficiary remains enrolled in the program. The baseline measure will define for each State, continuous enrollment in Medicaid, the State's classification of a two-year old, and the State's classification of "fully-immunized." For Medicaid beneficiaries who are in managed care, continuous enrollment refers to enrollment in a specific managed care plan for the specified length of time. For Medicaid beneficiaries in primary care case management (PCCM) and fee-for-service (FFS), it refers to continuous enrollment in the Medicaid program for the specified length of time.

The original development timeline for the goal allotted one year for development and reporting of baseline measures for the States. After working with Group I States for a year, it became evident that more time would be needed by States to fully develop both their measurement methodologies. Reasons for the extension include variations in State reporting cycles for immunization data, data problems, and staff and resource limitations.

Coordination: The CMS has worked closely with States, the CDC, and the American Public Human Services Association (APHSA) to develop a strategy for this goal. APHSA will continue to act as a liaison between the States and CMS. The CDC will continue to partner with CMS, as we provide technical assistance to all States over the course of this goal. The Value-Based Purchasing Group, comprised of State Medicaid Directors and representatives of CMS senior management, have distributed an Immunization Resource Guide to Medicaid Directors. This guide supports the immunization goal by providing information about value-based, quality-focused immunization purchasing strategies.

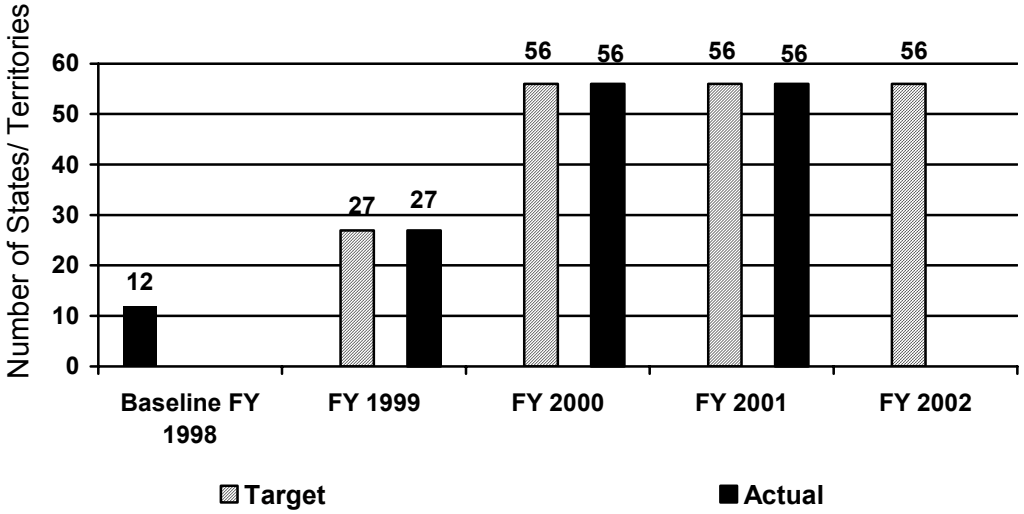
Data Source(s): Due to the various data collection and reporting methodologies likely to be used by individual States, immunization coverage levels will not be directly comparable across States. However, each State will measure its own progress, using a consistent measurement methodology.

The Health Plan Employer Data Information Set (HEDIS®), the Clinical Assessment and Software Application (CASA), and immunization registries provide standardized measurement of childhood immunization. HEDIS provides a plan-based measure of the care delivered to enrollees; it is the national standard in performance measurement for managed care organizations (MCOs). The HEDIS® Childhood Immunization Measure estimates the percentage of children in an MCO who received all of the appropriate immunizations by their second birthday. CASA is a public domain tool that was developed by the CDC for measuring immunization performance at the provider or clinic level.

Verification and Validation: The means for verifying and validating immunization data will vary from State to State, depending on the State-specific data collection methodology. A key part of the technical assistance provided by CMS and the CDC will include helping States address data reliability.

Performance Goal MMA3-02

Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries



Discussion: Individuals who are dually eligible for Medicare and Medicaid are an important and growing population. In 1995, there were approximately six million individuals dually eligible for Medicare and Medicaid at some point in the year. Although dually eligible beneficiaries represent about 16 percent of the Medicare population, they represent 30 percent of total Medicare expenditures. Similarly, while dual eligibles represent approximately 19 percent of the Medicaid population, they represent about 35 percent of total Medicaid expenditures.

Through continued innovation and reform in the Medicare and Medicaid programs, CMS hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries. In order to do this, State Medicaid program administrators need information on their dually eligible populations.

States, as well as providers of care, are increasingly interested in assessing how well our programs respond to the needs of dually entitled beneficiaries. The CMS's development of a tool for matching State finder files against Medicare enrollment files will be of assistance to States to improve the efficiency and effectiveness of the acute and long-term care services received by persons eligible for both Medicare and Medicaid. States will be able to use data from the Medicare linked files to perform analyses that can improve the understanding of the program interactions between Medicare and Medicaid and how the interactions affect access to care, costs, and quality of services. For example, the dual eligible Medicaid/Medicare data will strengthen the ability of CMS and States to develop efficient and effective risk-adjusted payment methods for dual eligibles.

Coordination: The Department of Health and Human Services and CMS have worked together to develop CMS systems tools that will support matching of State finder files

against Medicare enrollment and Group Health data, and provide that matched data back to States in a standard format. This effort has included collaboration with States to establish useful access to Medicare operational data.

Data Source(s): The joint Federal and State interest in dual eligibles has resulted in an examination of the data that are available to obtain knowledge about the demographic characteristics, health status, disease episodes, support services, health services utilization, and expenditures of this diverse population. The best and most current source for Medicare enrollment and Group Health data is the Medicare enrollment database (EDB). By matching current EDB data against State-submitted Medicaid finder files, CMS can provide States with accurate data identifying dual eligibles in their Medicaid populations. Based on these data, States can perform valuable analyses of their dual eligible populations. States can also then develop target populations for which they can request Medicare billing data. This combination of enrollment and Medicare billing data provides the States a powerful analytic base against which they can evaluate many aspects of dual eligibility.

Verification and Validation: All of the systems serving as sources are crucial operational systems that have built in quality assurance checks.

Performance Goal MMA4-03

Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates

Baseline: Currently, Illinois has established one methodology, but its potential utility in other States has not been determined.
FY 2003 Target: Assess the pilot State experience to date and work with States, our expert consultant, and others in CMS and OIG to define one or more practical payment accuracy measurement methodologies for use on a State-specific and possibly nationwide basis.
FY 2002 Target: Nine pilot States will conduct payment accuracy measurement studies. CMS and The Lewin Group (contractor) will work with the pilot States, and assess Medicare and other Medicaid payment accuracy measurement experience to define several promising methodologies for testing in FYs 2003 and 2004. Contingent upon the availability of special grant funds, we will solicit participation by up to 15 States in Year 2 of the pilot (FY 2003).
FY 2001 Target: Establish the feasibility of conducting pilot projects within States. We will work with two States to conduct payment accuracy studies. The preliminary data gathered from these two States will be used to help refine payment accuracy methodologies and assess the feasibility of constructing a single methodology that could be used by all States. **Performance:** Goal not met. Delays in receipt of funding to support State pilot studies and outside consultant assistance, and in soliciting State participation in the pilot, resulted in our not approving until late September 2001 the outside contractor and the initial group of pilot States.

Discussion: The CMS is committed to assisting interested States in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates. The purpose of this goal is to explore the utility and feasibility of conducting Medicaid payment accuracy studies in all States using a single methodology. No accepted methodology for Medicaid payment accuracy measurement (PAM) currently exists, and only a handful of States have done any work in this area. Those that have done so have all used different approaches, and none have addressed PAM in a managed care environment.

During FY 2000, CMS together with the American Public Human Services Association established a National Medicaid Payment Accuracy Workgroup to help define, guide and coordinate this Federal-State collaborative project. Information was collected on the significant Medicaid payment accuracy studies conducted to date (by Illinois, Texas and Kansas), and discussions were initiated with several States that might be interested in participating in the pilot studies.

Resource constraints have proved a major obstacle to States conducting Medicaid payment accuracy studies. In order to support States in these activities, in FY 2001 and

FY 2002 CMS requested funding from the "wedge" portion of the Health Care Fraud and Abuse Control (HCFAC) account which was approved.

The HCFAC program funding will be used to retain a consultant to work on the project and to subsidize State participation in our demonstration project. The consulting contract was awarded in September 2001 to The Lewin Group. A letter requesting proposals was sent to all State Medicaid and Program Integrity Directors on July 3, 2001. We approved funding for all nine States that applied: Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington and Wyoming. The approved first-year budgets total $3.6 million. The pilots will be 100 percent federally funded, with the participating States being reimbursed roughly half their costs through regular Medicaid funds and the other half from the HCFAC grant funds. The participating States will test various approaches to Medicaid PAM, and work with CMS and our technical consultant to maximize the collective learning. We anticipate expanding the pilot to about 15 States in the second year, contingent upon State interest and the continued availability of HCFAC funds. Our goal is to develop one methodology that could be used to develop State-specific and national Mediaid payment accuracy rates.

Coordination: Coordination within CMS will occur to ensure that our relevant Medicare, Medicaid and program integrity staff work together and with the Office of Inspector General. CMS will work with closely with the pilot States, as well as with States collectively through the National Association of State Medicaid Directors.

Data Source(s) and Verification/Validation: The pilot States will use their own Medicaid paid claims and encounter data and related medical records, and will test differing PAM methodologies. CMS and our technical consultant will work with the pilot States, Medicare and the Inspector General to evaluate the various PAM methodologies, including the data sources and validation techniques.

Performance Goal MMA5-03

Improve Health Care Quality Across the Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project

Baseline: Developmental.
FY 2003 Target: To begin working with States on the Performance Measurement Partnership Project. Medicaid & SCHIP - Report on results of the meeting with State representatives and identify a timeline for implementing recommendations. - Initiate action steps for implementing recommendations. SCHIP - Begin to implement core SCHIP performance measures.

Discussion: The use of performance measures to improve health care quality is widespread in the public and private sectors. However, its use in the Medicaid program has been primarily undertaken by State Medicaid agencies. At the national level, we do not have information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. This has limited the Medicaid program's ability to most fully respond to, and take advantage of, the Government Performance and Results Act (GPRA) in a manner that best achieves the stated purposes of the Act.

The CMS took a first step in 1999 to improve health care quality for a high priority population of Medicaid beneficiaries--children--with its GPRA goal to improve childhood immunization (MMA2-03).

The following evidence supports the position that the use of performance measurement can improve service delivery to those individuals it is intended to serve:

- knowledge and experience we gained from the childhood immunization project;
- expanding use of performance measures in the health care industry;
- increasing experience of States in using performance measures in Medicaid programs, and
- provisions of the Balanced Budget Act of 1997 requiring the use of performance measures for the SCHIP program

Because of the Federal-State partnership in the Medicaid and SCHIP programs, improvements in the use of performance measures would be best accomplished if jointly identified by both CMS and States.

In FY 2002, CMS is beginning to work with States to jointly explore a strategy for State and Federal use of performance measures. CMS will ask States to help chart a course of

action that would effectively use reliable and valid performance measures to quantify and stimulate measurable improvement in the delivery of quality health care.

The purpose of this goal is to utilize the information gathered from States to establish formal collaborations that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures.

By the end of FY 2002, CMS and States will have agreed on a strategy for the coordinated use of performance measures within and across Medicaid and SCHIP programs for quality improvement in both fee-for-service and managed care delivery systems. Our communications with States to-date indicate that they will be supportive of this position. As CMS and States proceed to implement this mutually-agreed upon strategy, we will identify multiple approaches to using performance measures to achieve improvements in health care quality.

Coordination: The CMS will work with State Medicaid and SCHIP programs to develop a strategy for performance measurement to improve health care delivery and quality for Medicaid and SCHIP populations.

Data Source(s): Developmental. Once CMS and the States have identified the strategy for appropriate use of performance measurement, we will develop data sources to measure accomplishment of this strategy.

Verification and Validation: Developmental.

State Children's Health Insurance Program

State Children's Health Insurance Program	FY 2000 Enacted	FY 2001 Enacted	FY 2002* Current Law	FY 2003** Current Law
Total Budget Authority	**$4.2 B**	**$6.3 B**	**$3.1 B**	**$3.2 B**

* Does not reflect redistribution amounts from FY 1998 and/or FY 1999 allotments.
** Does not reflect redistribution amount from FY 2000 allotment.

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP). This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. The statute authorizes and appropriates an annual amount that CMS grants to States and Territories with an approved SCHIP plan. States were given the option to expand their Medicaid program, establish a separate SCHIP program or a combination of both. Currently, all States and Territories have approved SCHIP plans. Many States are submitting plan amendments and 1115 waivers to further expand insurance coverage under SCHIP.

Another representative goal related to this budget category but is not listed in the chart is:

- Improve Health Care Quality Across Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project (MMA5-03)

Performance Goal	Targets	Actual Performance	Ref.
Decrease the number of uninsured children by working with States to implement SCHIP and by enrolling children in Medicaid -- Increase the number of children enrolled in regular Medicaid or SCHIP	**FY 03:** TBD **FY 02:** + 1,000,000 over 2001 **FY 01:** + 1,000,000 over 2000 **FY 00:** + 1,000,000 over 1999 **FY 99:** Develop goal; set baseline and targets	**FY 03:** **FY 02:** **FY 01:** Additional 3,441,000 children enrolled in SCHIP and Medicaid (Goal met) **(NEW DATA)** **FY 00:** Additional 1,679,000 children enrolled in SCHIP and Medicaid (Goal met) **FY 99:** Baselines and targets set (Goal met); 21,980,000 **FY 98:** 21,180,000 **FY 97:** 21,000,000 in Medicaid, none in SCHIP **(Baseline)**	SCHIP1

Performance Results Discussion

Decrease Uninsured Children - The implementation of SCHIP has driven enormous change in the availability of health care coverage for children and in the way government-sponsored health care is delivered. The energy invested by States and Territories, communities, and the Federal Government has resulted in significant expansions in coverage, as well as new systems for enrolling children. The CMS and the States exceeded our FY 2001 goal to enroll an additional 1,000,000 children in SCHIP or Medicaid over the previous year's level. In fact, due to the overwhelming success of the program, we enrolled 3,441,000 children over FY 2000's level. We have decided to maintain our FY 2002 target to increase enrollment by 1 million over FY 2001. We are unsure about future projections given our outstanding progress in FY 2001 and the financial challenges that the States are currently facing.

Due to program changes and enrollment trends within the SCHIP program, we are delaying setting an FY 2003 target. Currently, we are in the process of re-evaluating the goal and anticipate releasing a revised goal early in CY 2002.

Performance Goal SCHIP1-03

Decrease the Number of Uninsured Children[2] by Working with States to Implement SCHIP and by Enrolling Children in Medicaid

Baseline: In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid, and none in SCHIP.
FY 2003 Target: To be determined. Currently, we are in the process of re-evaluating the goal and anticipate releasing a revised goal in early FY 2002.
FY 2002 Target: Same as below.
FY 2001 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. **Performance:** Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 3,441,000 from the previous year.
FY 2000 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. **Performance:** Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 1,679,000 from the previous year.
FY 1999 Target: Develop a goal; set baseline and targets. **Performance:** Goal met.

Discussion: Enacted through the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP), under Title XXI of the Social Security Act, allocates nearly $40 billion over 10 years to extend health care coverage to low-income, uninsured children. SCHIP enables States to establish separate SCHIP programs, expand existing Medicaid programs, or use a combination of both approaches. Although estimates of insurance coverage for children vary, the Bureau of Census' annual March health insurance supplement to the Current Population Survey (CPS) is the most widely cited source. The CPS data for 1999 suggested that there were approximately 10 million children under the age of 19 who lacked health insurance coverage. Approximately one-third of uninsured children are eligible for Medicaid and are not enrolled in the program.

The implementation of SCHIP has driven enormous change in the availability of health care coverage for children and in the way government-sponsored health care is viewed and delivered. The energy invested by States, communities, and the Federal Government in the SCHIP program has resulted in significant expansions in coverage as well as new systems for enrolling children into publicly funded coverage programs. Mail-in applications for children are used in separate SCHIP-funded child health programs and in Medicaid in most States, and paperwork requirements imposed on

2 Children = up to age 19 for SCHIP and up to age 21 for Medicaid.

families applying for coverage have been reduced significantly in many States. Approximately 4.6 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2001, and many more were enrolled in "regular" Title XIX Medicaid through increased outreach efforts and application simplification strategies undertaken as a result of SCHIP.

When CMS conducted on-site reviews of States' Temporary Assistance for Needy Families (TANF) and Medicaid application and enrollment procedures in 1999, we found that the degree of investment States make to redesign their strategies--both to adapt to changes in law and to address longstanding barriers--profoundly affect whether or not eligible children and families receive Medicaid. Enrollment simplification, outreach, and attitude change can make a difference. Many States have simplified the application process for children, and CMS is encouraging States to make further improvements. However, many States have not made efforts to streamline and simplify practices for low-income families to the extent that they have for children; these Medicaid application procedures for families often remain tied to welfare program procedures. This has meant that the poorest children and their families often experience more barriers to coverage.

Despite many successes prompted by SCHIP, many children and families eligible for SCHIP and Medicaid have not been enrolled. Recent studies reveal that key remaining barriers include: 1) burdensome application or eligibility determination processes, 2) lack of awareness about the programs, 3) assumptions on the part of families that they are not eligible for the programs, and 4) the lingering stigma attached to government-sponsored assistance.

The best available data show 21 million children ever enrolled in Title XIX Medicaid during FY 1997 (before the inception of SCHIP***).***

Year	**Children Served by SCHIP (Title XXI)**	**Children Served by Medicaid (Title XIX)**	**Total Number of Children Served by SCHIP & Medicaid**	**Yearly Increase in Number of Children Served by SCHIP & Medicaid**	**GPRA Target** *(yearly increase in number of children served)*
1997	0	21,019,000 3	21,019,000	---	
1998	980,000	*20,200,000*	*21,180,000*	*161,000*	
1999	1,980,000	*20,000,000*	*21,980,000*	*800,000*	
2000	3,334,000	*20,325,000*	*23,659,000*	*1,679,000*	1,000,000
2001	4,600,000	*22,500,000*	*27,100,000*	*3,441,000*	1,000,000

3 Ku, Leighton and Brian Bruen, "The Continuing Decline in Medicaid Coverage," December 1999. Available on The Urban Institute website at http://newfederalism.urban.org/html/anf_a37.html).

Year	Children Served by SCHIP (Title XXI)	Children Served by Medicaid (Title XIX)	Total Number of Children Served by SCHIP & Medicaid	Yearly Increase in Number of Children Served by SCHIP & Medicaid	GPRA Target *(yearly increase in number of children served)*
2002	--	--	--	--	1,000,000
2003	--	--	--	--	TBD

Note: Italicized figures are estimates based on incomplete Title XIX data submitted by the States. These estimates will be updated as edited HCFA-2082 data become available.

Coordination: To assure that both Medicaid and SCHIP fulfill their potential, CMS is working with States, other parts of HHS, other Federal Government agencies, and the private sector on a broad array of outreach activities. These activities include providing technical assistance to States, providing new resources to States to help them improve their programs, working with other Federal agencies; and promoting the exchange of information among States, community-based organizations, advocacy groups, Government grantees, and private sector groups -- just to mention a few.

For example, CMS has contracted with Maximus to develop model applications for the Medicaid and SCHIP programs. The applications will be designed to target the appropriate reading levels of potential enrollees and be available in both English and Spanish. Additionally, Maximus will develop model notices that are most frequently sent to Medicaid and SCHIP enrollees for States to adopt into their programs. These efforts serve not only to improve the readability of applications and notices but also to provide a better understanding of how to enroll and access services under Medicaid and SCHIP. Related efforts include convening regional conferences and the National Summit on School-Based Outreach for SCHIPs; identifying successful school-based outreach and enrollment strategies for SCHIP and Medicaid; and collaborating with the American Public Human Services Association to exchange best practices among States.

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

The estimate of 21,000,000 for Medicaid enrollment for FY 1997 is based on HCFA-2082 data edited by The Urban Institute and published in December 1999. Although we previously reported a 1997 baseline of 22,700,000 children enrolled in Medicaid, this was based on unedited HCFA-2082 data and incomplete data reported by the States

through SEDS. The CMS and the States consider the 21,000,0000 Medicaid enrollment figure to be a final estimate for 1997. This figure is also cited in the first annual report of the CMS-funded evaluation of SCHIP by Mathematica Policy Research (posted on the web at www.hcfa.gov/init/fy2000.pdf).

The 1998-2001 Medicaid enrollment counts presented are estimates based on interim data submitted by the States through SEDS and are therefore subject to change when edited HCFA-2082 data become available. In general, edited data for a fiscal year are available about two years after the end of the year.

States may eventually report all of their SCHIP and Medicaid data through the Medicaid Statistical Information System (MSIS). Reporting Medicaid data through MSIS is now required for all States; and we are working with States to help them use MSIS to streamline their Medicaid and SCHIP reporting and improve CMS's ability to analyze data across programs. However, there are significant time lags in collecting and editing these data through MSIS. Therefore, we will continue to rely on the States' quarterly and annual statistical report submissions through SEDS, with updates from edited HCFA-2082 data, as such data become available.

Verification and Validation: The program enrollment data that States submit through SEDS are reviewed by CMS personnel every quarter. These data also are subject to audit and are being reviewed and analyzed as part of a National Evaluation contract awarded to Mathematica Policy Research.

CMS will measure, to the extent possible, the unduplicated count of the number of children who are enrolled in any of the following programs: regular Medicaid; expansions of Medicaid through SCHIP; and separate SCHIP programs as reported by the States. While we consider an unduplicated count to be an appropriate measure for this goal and we can measure the unduplicated count within each program, some children may be enrolled in Medicaid at one point in the year and in SCHIP at another point, making it difficult to establish an accurate unduplicated count across all programs. Similarly, the SCHIP counts include some double counting of children in States that have combination programs. To the extent our data allow, we will closely monitor this issue.

Clinical Laboratory Improvement Amendments (CLIA)

Clinical Laboratory Improvement Amendments	FY 2000 Actual	FY 2001 Enacted	FY 2002 Appropriation	FY 2003 Estimate
Total Budget Authority	**$42.3 M**	**$43.4 M**	**$43.4 M**	**$43.4 M**

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) strengthen quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens for health purposes. Currently 174,500 laboratories are registered with the CLIA program. Approximately 77 percent of these laboratories perform test methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and, therefore, are not subject to proficiency testing (PT) or routine inspections. Workloads projected for FY 2004 include a five percent sample review of all 16,300 accredited laboratories and surveys of 20,800 non-accredited laboratories, State validation surveys of 800 accredited laboratories, and approximately 1,600 follow-up surveys and complaint investigations.

Performance Goal	Targets	Actual Performance	Ref.
Sustain improved laboratory testing accuracy			CLIA1
-- Percentage of laboratories enrolled in proficiency testing (PT) with no failures	**CY 03:** 90% **CY 02:** 90% **CY 01:** 90% **CY 00:** 90% **CY 99:** 90%	**CY 03:** **CY 02:** **CY 01:** 91.7% (interim); Final data expected 3/02 **CY 00:** 91.9% (Goal met) **CY 99:** 91.3% (Goal met) **CY 98:** 88.1% **CY 97:** 88.6% **CY 96:** 87.4% **CY 95:** 69.4% **(Baseline)**	
-- Laboratories properly enrolled and participating in PT	**CY 03:** 95% **CY 02:** 95% **CY 01:** 95% **CY 00:** 95% **CY 99:** 95%	**CY 03:** **CY 02:** **CY 01:** 95.5% (interim); Final data expected 3/02 **CY 00:** 96.4% (Goal met) **CY 99:** 95.4% (Goal met) **CY 98:** 94.8% **CY 97:** 94.4% **CY 96:** 93.2% **CY 95:** 89.6% **(Baseline)**	

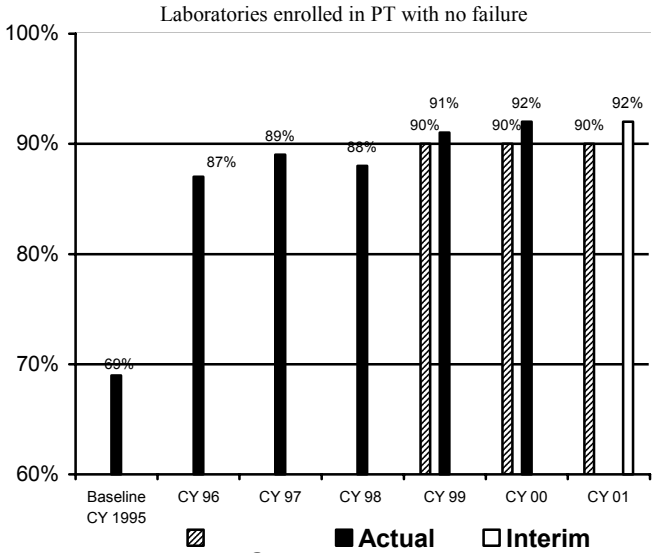
Performance Results Discussion

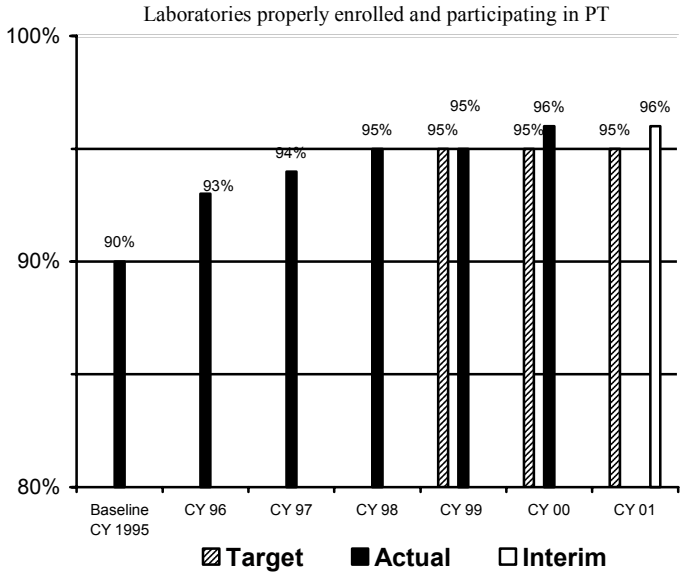
Success in our PT program increases patient and physician confidence by producing a snapshot of laboratory's ability to perform tests accurately. It also reduces the need for repetitive testing, which will reduce overall costs of medical care related to diagnostic testing. We have exceeded our targets in FYs 1999 and 2000 to sustain improved testing accuracy with 91.9 percent of laboratories having no failures and 96.4 percent of laboratories properly enrolled in PT. We expect to receive final CY 2001 performance data for our CLIA goal in the first quarter of CY 2002, and based on the performance we have seen thus far, we anticipate continued success.

The CMS feels that we have reached peak performance with the percentage of laboratories enrolled in PT with no failures and with the percentage of laboratories properly enrolled and participating in PT. However, we feel that it is important to maintain these levels of laboratory testing accuracy and to continue to monitor and report on performance in these target areas. Documented experiences with previously regulated and voluntarily accredited laboratories indicate that PT performance can achieve these high levels, and our data now reflect that the previously unregulated laboratories can also accomplish this. The experiences also maintain that PT performance can be monitored and sustained to guarantee accurate and reliable testing and timely PT problem resolution.

Performance Goal CLIA1-03

Sustain Improved Laboratory Testing Accuracy





Discussion: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. CLIA specifies quality standards for proficiency testing (PT), which provides CMS with a means of measuring laboratory performance. A laboratory's performance of PT provides CMS surveyors, CLIA surveyors, inspectors of approved accreditation organizations, and surveyors of approved State licensure programs with an excellent overview of the laboratory's current ability to produce accurate patient test results. Because of the continuous monitoring of PT by these individuals and the value of PT in general, we decided to use PT enrollment and successful PT performance as our target areas for improvement for this goal.

PT involves sending sample specimens with known properties to each laboratory three times per year, the results of which are not known to the laboratory. Laboratories' PT results are then evaluated for accuracy by CMS-approved private and State operated PT programs, following CLIA PT requirements. The PT testing is "blind," in that the laboratory staff members are not given any information about what they are expected to find. The CLIA regulation requires that the PT samples be tested in the same manner and by the same individuals as those performing patient testing.

Laboratory personnel, tests offered, and even laboratory size, location and environment are never constant. Because each can have a significant impact on test performance, we decided to set our initial goals at the highest realistic levels possible, taking into consideration that many laboratories had never been regulated before CLIA. Setting

high initial targets (what we believed to be a maximum expectation for 38,000 laboratories, with no assurance they could be met) gave us true goals to strive for in our ever-changing health care environment, and we believed anything less stringent would not have been acceptable, considering the clinical impact of laboratory results on the beneficiaries of Medicare and Medicaid, as well as all other patients.

PT increases patient and physician confidence in a particular laboratory by producing a snapshot of the laboratory's ability to perform tests accurately according to objective standards. This enhanced confidence in laboratory test accuracy reduces the need or inclination for repetitive laboratory testing and thereby reduces the overall costs of medical care related to diagnostic testing. Typically, a laboratory that performs well on PT also provides accurate testing results for clinicians, which aids in rapid and appropriate patient diagnoses and therefore contributes to effective treatment. There is a well-documented educational value for the laboratory from PT because of the opportunity and incentive for the laboratory to learn from its PT performance.

There are approximately 174,500 CLIA certified laboratories. Seventy-seven percent of these laboratories perform test methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and, therefore, are not subject to PT. The remaining 23 percent of the laboratories must perform PT on the required tests or analytes and are overseen directly by CMS, the State survey agencies, or private accrediting organizations. There are currently 86 tests or analytes (i.e., cholesterol, glucose, white blood cell count, etc.) for which laboratories must perform PT under CLIA. This list of 86 analytes is largely made up of diagnostic tests, which are commonly performed and whose results are important to health care treatment decisions. Each laboratory performs PT on the required analytes that are a part of its specific test menu.

Since PT data is only collected by calendar year, we are reporting in terms of calendar years. It is more accurate to report information for the same time frame, as opposed to having some information in calendar years and other information in fiscal years.

Coordination: The CMS works closely with State surveyors, CMS-approved accreditation organizations, PT programs, CMS-approved State laboratory licensure programs (CLIA-exempt laboratories) and professional advocacy groups in carrying out its CLIA activities.

Data Source(s): The primary data source is the Online Survey and Certification Reporting System (OSCAR). The PT enrollment rate is calculated using: (1) the number of laboratories in the OSCAR database that were subject to on-site survey and PT testing for at least one analyte, and (2) the number of laboratories cited as deficient for failing to be appropriately enrolled in PT. The rate at which enrolled labs perform successfully on PT is calculated using totals from the OSCAR database for: (1) the total number of tests performed for the year; and (2) the total number of failed scores received for the year.

Verification and Validation: Surveyors verify this data through ongoing monitoring of PT information, communicating with the laboratories and PT programs and by conducting biennial on-site surveys. The PT programs that provide the samples undergo an annual and ongoing review process coordinated by CMS with assistance from the Centers for Disease Control and Prevention. For example, the PT data system and PT programs are monitored to ensure that PT data transmitted to CMS is accurate, complete and timely.

Medicare Integrity Program

Medicare Integrity Program	FY 2000 Actual	FY 2001 Actual	FY 2002 Current Estimate	FY 2003 Estimate
Total Budget Authority	**$630.0 M**	**$680.0 M**	**$700.0 M**	**$720.0 M**

The CMS's program integrity efforts ensure the Medicare program pays the right amount, to a legitimate provider, for covered, reasonable and necessary services that are provided to an eligible beneficiary. The CMS's program integrity activities are primarily funded through the Medicare Integrity Program (MIP), established by the Health Insurance Portability and Accountability Act of 1996. The MIP includes medical review and benefit integrity activities, provider education and training, Medicare Secondary Payer, and provider audits. The CMS's overall program integrity efforts are supplemented by funding from CMS's program management account and funds made available from the Health Care Fraud and Abuse Control Account (HCFAC).

Other representative goals that are related to this budget category but are not listed in the chart include:

- Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates (MMA4-03)

Performance Goals	Targets	Actual Performance	Ref.
Reduce the percentage of improper payments made under the Medicare fee-for-service program	**FY 03:** 5% **FY 02:** 5% **FY 01:** 6% **FY 00:** 7% **FY 99:** 9%	**FY 03:** **FY 02:** **FY 01:** Available 2/02 **FY 00:** 6.8% (Goal met) **FY 99:** 7.97% (Goal met) **FY 98:** 7.1% **FY 97:** 11% **FY 96:** 14% **(Baseline)**	MIP1
Develop and implement methods for measuring program integrity outcomes:			MIP2
-- Implement the Provider Compliance Rate prepay medical review	**FY 03:** Subsumed in MIP1 **FY 02:** Goal not continued. **FY 01:** Implement program **FY 00:** New in FY 2001	**FY 03:** **FY 02:** **FY 01:** All three phases currently being implemented. Implementation to be complete in 2002. (Goal met.) **FY 00:** N/A	
-- Implement the refined Comprehensive Error Rate Testing (CERT) program to produce subnational error rates	**FY 03:** Subsumed in MIP1 **FY 02:** Goal not continued. **FY 01:** Implement program **FY 00:** New in FY 2001	**FY 03:** **FY 02:** **FY 01:** All three phases currently being implemented. Implementation to be complete in 2002. (Goal met.) **FY 00:** N/A	
-- Develop a fraud rate among providers in a contractor's service area	**FY 03:** Subsumed in MIP1 **FY 02:** Implement program **FY 01:** Develop requirements **FY 00:** New in FY 2001	**FY 03:** **FY 02:** **FY 01:** Goal not met. Progress dependent on HCFAC funding **FY 00:** N/A	

Performance Goals	Targets	Actual Performance	Ref.
Improve the effectiveness of program integrity activities through successful implementation of the Comprehensive Plan for Program Integrity:			MIP3
-- Successfully implement the Comprehensive Plan	**FY 02:** Goal not continued **FY 01:** 100% **FY 00:** New in FY 2001	**FY 02:** N/A **FY 01:** Goal met. **FY 00:** N/A **FY 99:** Plan initiated **(Baseline)**	
-- Measure effectiveness by achieving a significant portion of the performance measures for each of the ten Comprehensive Plan activities	**FY 02:** Goal not continued **FY 01:** Meet 90% of measures for each of the activities: 1a. Develop Carrier/FI performance standards 1b. Implement PCR, CERT; and develop fraud rate 2. Implement program safeguard contractor (PSC) models 3a. Non-physician practitioner error rate 3b. Therapy services error rate 4. Improve the provider enrollment process 5. Assure Millennium contingency planning 6. Inpatient hospital error rate 7. Data exchange to monitor care in congregate care settings 8. Implement managed care PSC and managed care payment validation 9. Community mental health centers error rate 10. Improve quality of care in nursing homes **FY 00:** New in FY 2001	**FY 02:** N/A **FY 01:** See status below. 1a. Goal met. Guidelines in use. 1b. See goal MIP2 2. Goal met. PSC operational models implemented. 3a. Available mid-2002 3b. Available mid-2002 4. Goal not met. Regulation implementing provider enrollment form not published. 5. Goal met. 6. FY 2001 error rate available late 2002 7. CMS contract with NHIC. Data available mid-2002. 8. Goal met 9. Ten point plan implemented 10. See goals QSC1 and QSC2. **FY 00:** N/A **Baseline:** All new activities	

Performance Goals	Targets	Actual Performance	Ref.
Increase Medicare Secondary Payer liability and no-fault dollar recoveries	**FY 01:** Goal carried over with new focus (see below) **FY 00:** 5% increase over baseline **FY 99:** New in FY 2000	**FY 01:** N/A **FY 00:** 29.1% (Goal met) **FY 99:** 20% **FY 98:** $364 million **(Baseline)**	MIP5
Increase Medicare Secondary Payer (MSP) credit balance recoveries and/or decrease recovery time to recoup dollar recoveries	**FY 03:** Fully implement revised processes and controls in contractor credit balance activities **FY 02:** Develop improved processes and controls to be utilized by contractors to ensure consistency and timely recoveries **FY 01:** Gather information on 1) provider credit balance identification, submission and resolution processes; and 2) contractor monitoring and resolution of credit balances **FY 00:** New in FY 2001	**FY 03:** **FY 02:** **FY 01:** Goal met. See Final Review Summary Report and Final Management Overview Report. **FY 00:** Incomplete information regarding credit balance reporting process **(Baseline)**	
Assess program integrity customer service (Developmental)	**FY 03:** Developmental **FY 02:** Conduct and analyze surveys. Develop baseline and targets. **FY 01:** New in FY 2002	**FY 03:** **FY 02:** **FY 01:** New in FY 2002 (Baseline developmental)	MIP6
Improve the provider enrollment process	**FY 03:** Implement PECOS, revalidate 20% of Part A providers **FY 02:** Develop PECOS, revise HCFA-855, publish regulation **FY 01:** New in FY 2002	**FY 03:** **FY 02:** **FY 01:** N/A	MIP7
Decrease improper payment rate for home health services	**FY 01:** Goal not continued **FY 00:** 10% **FY 99:** 35%	**FY 01:** N/A **FY 00:** Data available April 2002 **FY 99:** 19% (Goal met) **1995-1996:** 40% **(Baseline)**	27-00

Performance Results Discussion

Medicare Error Rate - We have achieved extremely positive results in our effort to reduce improper payments. We have virtually cut the Medicare fee-for-service error rate in half over the past few years.

With expected achievement of the implementation of the Comprehensive Plan for Program Integrity in FY 2001, CMS will focus its efforts on the Comprehensive Error Rate Testing (CERT) program. The purpose of CERT is to stratify the Medicare payment error rate to strengthen our ability to target problem areas.

The CMS has met the FY 2001 target for the implementation of CERT for Part B carriers and Durable Medical Equipment Regional Carriers (DMERCs); Part A fiscal intermediaries are scheduled for implementation in FY 2002. Following this implementation schedule, CMS will produce a fee-for-service error rate for DMERCs for FY 2002; for all Part B carriers for FY 2002; and for Part A contractors for FY 2003. To provide further quality assurance over the error rate estimate, CMS intends to run the CERT program in parallel with the Chief Financial Officer (CFO) Audit for at least one year; therefore, during FY 2003 both programs will produce national fee-for-service error rates.

The Provider Compliance Rate (PCR) is on the same implementation schedule as the CERT program and will be produced as a product of CERT medical records reviews.

The Comprehensive Plan for Program Integrity – Through implementation of the Comprehensive Plan for Program Integrity, CMS has evaluated various initiatives in order to target high risk areas and better focus our resources to address problem areas. While performance is being assessed throughout the implementation process, it has been critical to monitor the overall effectiveness of each initiative in the plan throughout FY 2001. Based on information we have received to this date, we expect to meet the target for this goal.

New Program Integrity Goals - The CMS is continuing to develop two program integrity goals. The first goal is to assess customer service behaviors in handling fraud and abuse cases (MIP6). The second goal is to improve the provider enrollment process in an effort to continue the spirit of the Comprehensive Plan of paying claims properly to legitimate providers and suppliers (MIP7).

Medicare Secondary Payer - Medicare Secondary Payer (MSP) dollar recovery activities ensure that payment for health care services for beneficiaries is made by the appropriate primary payer. The MSP activity attempts to collect timely and accurate information on the proper order of payers and to make sure that Medicare pays only for those claims where it has primary responsibility. Final data for our FY 2000 target indicated that we met our goal by achieving a 29.1 percent increase over the 1998 baseline of $364 million. This increase was reflective of increased educational/outreach efforts among contractors, attorneys, insurers, beneficiaries and providers.

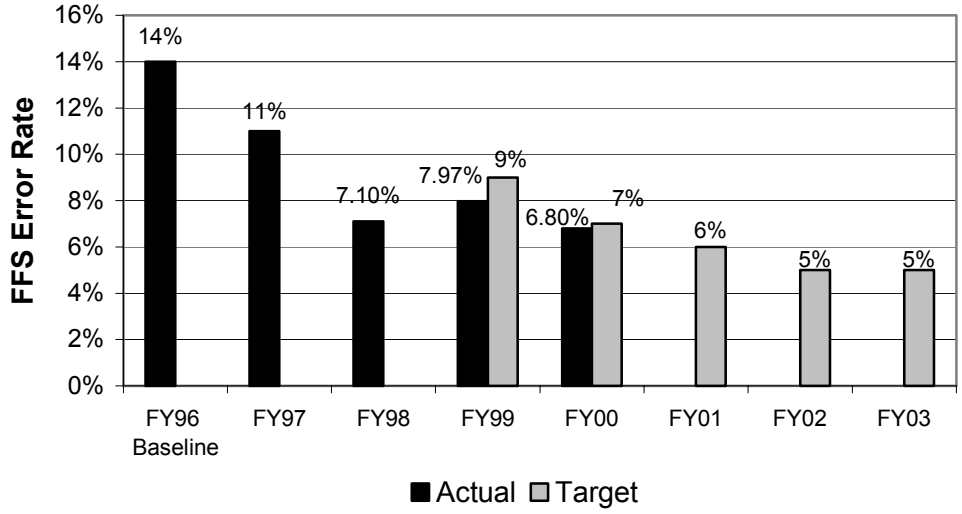
In FY 2001, instead of focusing on no-fault dollar recoveries, we concentrated on the mandatory Medicare credit balance reporting requirements. The intent of these requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. Approximately 90 percent of credit balances are mainly attributable to provider billing practices and over 50 percent are MSP-related. Currently, we are developing revised procedures and controls in contractor credit balance activities. In fact, a final Review Summary Report and Final Summary Management Overview Report are now available. In order to meet the goals for FY 2002, CMS plans to revise the current credit balance instructions for the regional office, fiscal intermediary and provider levels based on the observations and recommendations issued in the reports. The revised instructions will be implemented and monitored by FY 2003.

Home Health Error Rate - Our efforts to reduce improper home health service payments have paid off based on the repeat sampling of home health claims in California, Illinois, New York and Texas as part of an Office of Inspector General Operation Restore Trust study. This figure decreased from 40 percent in 1996 to 19 percent in 1999 and is expected to go down further. We are optimistic we will meet our FY 2000 goal of 10 percent. The OIG studies indicated a trend toward meeting the target for this goal, therefore this goal was discontinued in order for CMS to focus on other equally compelling fraud and abuse areas. However, in FY 2001 and following years, CMS will also continue to focus on reducing improper home health payments.

Medical Review - As we begin to apply our experience with the performance plan and use performance results to manage our programs, we begin to adjust our goals accordingly. With respect to the medical review program, we initially developed the medical review goal at a time when CMS intended to do more medical review. Although we missed our goal to medically review 100 million claims, this goal has been revised with a new focus. Improving the quality of our medical review by making accurate and appropriate medical review determinations has become a priority over simply increasing the number of reviews we perform. Since that time, we have changed our focus from quantity to quality. Improving the quality of our medical review is the first activity in the Comprehensive Plan for Program Integrity (MIP3) and it has changed our medical review operations. We are now taking steps, such as implementing the CERT program (MIP2) to ensure that we are making accurate and appropriate medical review determinations rather than simply increasing the number of reviews we perform.

Performance Goal MIP1-03

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



Discussion: The purpose of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program. One of CMS's key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. The CMS has implemented a Corrective Action Plan (CAP) designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate. Examples of the positive effects of our corrective actions on reducing improper payments are illustrated in both the 1998 and 1999 Office of Inspector General (OIG) reports.

The CMS exceeded its GPRA targets for 1999 and 2000. In general, the substantial reduction in the error rate over the past 4 years demonstrates that the Medicare contractor claims processing system is working well. Furthermore, during the two previous audits, a significant portion of improper payments reported were attributable to documentation errors. However, in FY 1998, documentation errors accounted for only $2.1 billion, a substantial decline from the $8.7 billion reported in FY 1996. The OIG attributed much of the substantial improvement in this category to the CMS CAP. The CMS agreed to continue these corrective actions in response to both the FY 1998 and 1999 audits. We will further reduce the error rate by continuing to focus our corrective

actions on areas of vulnerability identified by the OIG. We believe that by aggressively addressing specific high risk areas we can meet our GPRA goal of further reducing the error rate to five percent by FY 2002.

The Comprehensive Error Rate Testing (CERT) program will be fully implemented in FY 2003; as such, the CERT program will produce a Medicare fee-for-service error rate for FY 2003. To provide further quality assurance over the error rate estimate, CMS intends to run the CERT program in parallel with the CFO Audit for at least one year; therefore, depending on funding, both programs may be used to produce national fee-for-service error rates for FY 2003.

Coordination: We will continue to work with our partners in conducting our everyday business of ensuring Medicare claims are paid properly. We will build on the successes of Operation Restore Trust by continuing to work with the OIG, Department of Justice, and State survey agencies.

Data Source(s): The payment error rate has been computed by the OIG in Fiscal Years 1996 through 1999 as part of their Chief Financial Officer's Act audit. The CMS and OIG have entered into an agreement stipulating that the OIG will act as CMS's agent to measure the Medicare fee-for-service error rate in FYs 2000 and 2001. The CMS will assume responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2002. The CMS will continue its agreement with the OIG to produce a fee-for-service error rate until the CERT program is fully implemented and quality assurance testing has been completed.

Verification and Validation: The CMS plans to continue the OIG methods for computing the error rate for FY 2000 and 2001. The CMS will replicate OIG's methods as much as possible for FY 2002 to ensure consistent and equal comparisons across fiscal years. The CERT program was awarded to the Program Safeguard Contractor DynCorp in FY 2000. The CERT program is monitored for compliance by CMS through monthly reports from the contractor and a PSC evaluation team.

Performance Goal MIP2-03

Develop and Implement Methods for Measuring Program Integrity Outcomes

Baseline: Developmental. The three proposed methods are new and currently in development and testing phases. Therefore, baseline data does not exist. The first year of full implementation in FY 2002 will be used to develop baseline data.
FY 2003 Target: Methods to be subsumed in MIP1-03.
FY 2002 Target: To implement a model fraud rate program. (This project is contingent upon funding from HCFAC.)
FY 2001 Target: To implement the Provider Compliance Rate (PCR); the Comprehensive Error Rate Testing (CERT) program; and develop requirements for a model fraud rate program. **Performance:** Goal met (model fraud rate development dependent on HCFAC funding).

Discussion: The CMS is developing better methods to measure fraud, waste, and abuse in the Medicare program. This performance goal measures our progress in developing and implementing these methods.

The **Provider Compliance Rate (PCR)** is a method of determining a "compliance rate" among providers based upon a random sample of submitted claims. Essentially, the sampled claims are subjected to detailed medical review and a compliance rate is calculated based upon the dollar value ratio of valid claims to total claims. As such, the PCR provides a very useful measure of the appropriateness of claims submitted prior to payment. The PCR has been pilot tested over a two-year period at three contractor sites and is ready for full implementation. PCR will be implemented during FY 2001 as part of the CERT program at all Medicare contractors. PCR is expected to both further enhance medical review effectiveness and promote provider compliance.

The Office of Inspector General (OIG) currently administers the CFO Audit, which provides CMS with a national fee-for-service claims payment error rate. However, the CFO audit does not provide a usable measure of improper payments at subnational levels. The CMS awarded a contract to implement the **Comprehensive Error Rate Testing (CERT)** program. CERT will produce contractor, provider and benefit specific error rates. These rates can also be aggregated to produce national level estimates similar to the CFO audit but with greater precision. The CERT program will provide substantially greater detail and analysis of vulnerabilities in the current system which will help focus corrective actions. The CERT program will be implemented in three phases. Phase 1 began in August 2000 at the four Durable Medical Equipment Regional Carriers (DMERCs). Phase 2 began in October 2000 at the carriers on the VIPS Medicare System (VMS). Phase 3 began in April 2001 at the carriers on the Electronic Data System Medicare Contractor System (EDS MCS). The remainder of the carriers are scheduled to be implemented in FY 2002. CERT will be implemented at the intermediaries in the beginning of CY 2002.

The CMS tasked a Medicare contractor to develop and pilot test a method for estimating a **fraud rate** among providers in a contractor's service area. The pilot program includes drawing a random sample of claims using the CERT platform, contacting beneficiaries, and conducting interviews. The beneficiary interviews are considered critical in determining whether the provider actually delivered the stated services on the claim. However, due to the complexity of measuring fraud, numerous other indicators are required in order to produce a reliable estimate. The CMS has been examining alternative proposals for nationwide feasibility and a model fraud rate program will be implemented in FY 2002, contingent upon funding from the Health Care Fraud and Abuse Control (HCFAC) account.

Coordination: We will continue to work with OIG, our PSC contractors, and our Medicare contractors to develop the projects identified in this goal.

Data Source(s): Monthly reports are received from the Contractor to verify that they have complied with the phases proposed in the CERT implementation timetable for the Medicare contractors. The first CERT error rate and PCR reports for the four DMERCs are to be published in January 2002. These same reports will be published for the carriers on the VMS system in April 2002 and in August 2002 for the carriers on the EDS MCS system. The first national error and PCR rates will be published for FY 2003.

Verification and Validation: The CMS verifies Contractor performance and data through its Contractor Performance Evaluation program.

Performance Goal MIP3-01

Improve the Effectiveness of Program Integrity Activities through the Successful Implementation of the Comprehensive Plan for Program Integrity

This goal was designed to monitor the implementation and measure the effectiveness of CMS's Comprehensive Plan for Program Integrity. The Comprehensive Plan outlined CMS's overall program integrity strategy, as well as ten specific 6 to 18 month initiatives that were to improve the effectiveness of our program integrity efforts. Five of these initiatives addressed program management issues and the other five initiatives addressed specific benefit areas that we suspected were high program vulnerabilities.

PI Comprehensive Plan Performance Sub-goal	Target	Actual Performance
1(a). Increase the effectiveness of medical review and benefit integrity activities: Improve quality of medical review and benefit integrity outcomes	Develop and implement Medicare Carrier and FI program integrity performance standards that measure quality and desired outcomes.	Goal met. Guidelines were tested in 1999, refined in 2000 and further streamlined for use in FY 2001
1(b). Increase the effectiveness of medical review and benefit integrity activities: Develop new methods to reduce the percentage of improper payments made under the Medicare fee-for-service program.	Implement the Provider Compliance Rate (PCR); implement the refined CFO audit methodology to produce a subnational error rate; implement a fraud rate program.	See goal MIP2-03.
2. Implement the Medicare Integrity Program	Implement four program safeguard contractor (PSC) operational models: functional, data analysis, benefit and full PSC.	Goal met. We have implemented the three PSC operational models and have awarded the contract for the fourth PSC model.
3(a). Implement Program Safeguards for BBA provisions: Establish (1) a national database of State statutes concerning non-physician practitioner licensure requirements, and (2) a process to measure the non-physician practitioner error rate.	Implement a national database of State licensure requirements for non-physician practitioners and to pay 90 percent of non-physician practitioner claims correctly.	CMS has a database of State licensure requirements for non-physician practitioners and is in the process of making this information available to interested parties. Non-physician practitioner error rate available mid-2002.
3(b). Implement Program safeguards for BBA provisions: Create a therapy service program safeguards contractor (PSC)	Develop error rate for therapy services claims	DynCorp, the Comprehensive Error Rate Testing PSC, will produce an error rate for therapy services for years 1998, 1999, 2000. These error rates will be available in mid-2002.
4. Promote Provider Integrity	Reduce the rate of return in the provider enrollment process by 30 percent.	Goal not met. Regulation implementing new enrollment form not published.
5. Assure millennium contingency planning	Form contingency planning workgroups for Y2K	Goal met.
6. Inpatient hospital care	Reduce the payment error rate for inpatient hospital claims	FY 2001: Data available late 2002 Baseline: 3.4% (1998)

PI Comprehensive Plan Performance Sub-goal	Target	Actual Performance
7. Congregate Care	Develop a data exchange analysis project with Medicare contractors and Medicaid State agencies to allow the coordinated monitoring of services provided to Medicare and Medicaid beneficiaries in congregate care settings	CMS contract with NHIC. Data available mid-2002.
8. Managed Care	Implement the Enrollment Certification Contractor (ECC) and the Managed Care Program Safeguards Contractors (MCPSC)	Goal met. A PSC contract awarded to CMRI on 11/22/00 to perform managed care payment validation. A full and open competition was sponsored by CMS to create a schedule of Medicare Managed Care Program Integrity Contractors. Eight of these contracts were awarded earlier this year. ECC functions will be assumed by these new managed care contractors.
9. Community Mental Health Centers (CMHCs)	Reduce the payment error rate for CMHCs to 39 percent	10 point plan to address abuses implemented . Fully expect to meet target.
10. Nursing Homes	Decrease the prevalence of pressure ulcers and restraints in nursing homes	See goals QSC1-03 and QSC2-03.

Performance Discussion

By developing and publicly distributing the Comprehensive Plan, CMS reinforced its commitment to fighting fraud and abuse in the Medicare and Medicaid programs. Promoting the integrity of Medicare and Medicaid is a top priority for CMS. As these programs have grown in size and complexity, so have the importance and challenges of that responsibility.

Achieving program integrity now requires the active involvement of every component of CMS, and effective coordination with our partners, including contractors, providers, beneficiaries, law enforcement, and others. Our overarching program integrity goal is straightforward. We strive in every case to pay the right amount, to a legitimate provider, for covered, reasonable, and necessary services, provided to an eligible beneficiary: to pay it right the first time.

In order to achieve this overarching goal, CMS's Comprehensive Plan addressed ten areas. Five of the initiatives in the Comprehensive Plan addressed program management vulnerabilities and the other five addressed specific service areas that we believed were vulnerable to fraud and abuse. The CMS began work on these initiatives in October 1999 and we expect to have these initiatives fully implemented in FY 2001. While performance is being assessed throughout the implementation process, it is critical to monitor the overall effectiveness of each initiative throughout FY 2001. To

assist us in evaluating the effectiveness of our efforts, we developed specific performance measures for each of the ten Comprehensive Plan initiatives.

Comprehensive Plan Sub-Goal Updates

(1) Increase the Effectiveness of Medical Review and Benefit Integrity Activities -- Plans for improvement in this area include increasing the overall level of medical review; hiring outside contractors to evaluate medical review practices and workloads across contractors; developing improved performance standards for contractor program integrity activities; and, conducting training for CMS and contractor staff to enhance the quality of fraud case referrals.

Goal (1a): Improve quality of medical review and benefit integrity outcomes

Baseline: Current quantitative Medicare carrier and fiscal intermediary program integrity performance measurement process

FY 2001 Target: To develop and fully implement Medicare carrier and fiscal intermediary program integrity performance standards that measure quality and desired outcomes

Update Information: New Contractor Performance Evaluation (CPE) guidelines that focus on measuring quality outcomes have been developed and fully implemented. These guidelines were first tested during FY 1999. They were revised in FY 2000 and further streamlined for use in FY 2001. **Goal Met.**

Goal (1b): Develop new methods to reduce the percentage of improper payments made under the Medicare fee-for-service program.

Baseline: The three proposed methods described in the target are new.

FY 2001 Target: To implement the Provider Compliance Rate (PCR); to implement the refined CFO audit methodology to produce a subnational error rate; and to implement a fraud rate program.

Update Information: See goal MIP2-03 update.

(2) Implement the Medicare Integrity Program – The CMS is using its more flexible contracting authority to begin contracting with new entities called Program Safeguard Contractors (PSCs). The CMS has awarded 13 PSC contracts and between September and November of 1999 CMS awarded six program integrity task orders to these new contractors.

Goal: Implement a fully functioning Program Safeguard Contractor (PSC)

Baseline: Currently none of the three PSC modes are fully implemented. Additionally, there is no awarded contract for the full PSC model.

FY 2001 Target: To fully implement the following three PSC operational models: a functional model, data analysis model, and a benefit model. In addition, our goal is to award a PSC contract for the fourth PSC operational model, a full PSC model.

Update Information: We have implemented the three PSC operational models and have awarded the contract for the fourth PSC model. **Goal Met.**

Functional model:
Western Integrity Center: awarded to CSC 7/14/00 - fully operational
Benefit Integrity Support Center: awarded to EDS 11/24/99 - fully operational

Data Analysis Model:
Statistical Analysis Center: awarded to DYNCorp. 3/14/00 - fully operational

Benefit Model:
Therapy Service PSC: awarded to DYNCorp. 8/14/00 - fully operational

Full PSC Model:
DME PSC: awarded to TriCenturion 11/18/00 – fully operational 10/01

(3) Implement Program Safeguards for BBA Provisions -- The Balanced Budget Act of 1997 (BBA), created several new programs, benefits, and payment systems. Payment safeguards must be built into each of these prior to implementation. A variety of efforts are underway within CMS to prevent fraud in these new programs before it happens.

Goal (3a): Establish (1) a national database of State statutes concerning non-physician practitioner licensure requirements, and (2) a process to measure the non-physician practitioner error rate.

Baseline: Currently, there is no national database of State non-physician practitioner licensure requirements, nor is there a claims payment error rate for these services.

FY 2001 Target: Fully implement a national database of State licensure requirements for non-physician practitioners and to pay 90% of non-physician practitioner claims correctly.

Update Information: We have created a database of State licensure requirements. We plan to roll this information out to the Medicare carriers and fiscal intermediaries no later than March 2002. Additionally, with the implementation of the Comprehensive Error Rate Testing program we will create a non-physician practitioner paid claims error rate. We expect to be able to estimate this error rate with FY 2001 data no later than July 2002.

Goal (3b): Create a therapy service Program Safeguards Contractor (PSC)

Baseline: Currently, no therapy service PSCs exist, nor is there an established error rate for therapy service claims.

FY 2001 Target: To develop an error rate for therapy service claims.

Update Information: The Therapy PSC contract was awarded to DYNCorp on August 14, 2000. This contract will end in early 2002 and the Comprehensive Error Rate Testing program PSC will produce the first therapy paid claims error rate for years 1998, 1999 and 2000 by mid-2002.

(4) Promote Provider Integrity -- Enrolling only high quality providers is key to assuring program integrity. Plans are underway to develop stricter standards and stronger conditions of participation, conduct on-site visits to verify legitimacy and compliance with standards, increase the frequency of re-enrollment, create a national provider enrollment database, establish surety bond requirements, collect Social Security numbers to improve accountability, and collect better ownership and financial solvency information.

Goal: Improve the provider enrollment process
Baseline: 70% rate of return
FY 2001 Target: Reduce the rate of return by 30 percentage points to 40%
Update Information: We are at risk of not meeting this goal because we have not been able to take a number of the steps necessary to improve the enrollment process. First and foremost, the regulation and the new provider enrollment form have not yet been published in the Federal Register. Due to funding constraints, the Provider Enrollment Chain Ownership System (PECOS) has not been implemented. (See goal MIP7-03)

(5) Assure Millennium Contingency Planning -- With the advent of the new millennium, Medicare and Medicaid must continue to maintain fiscal integrity. We formed contingency planning workgroups and conducted extensive millennium related business analysis and risk analysis. We spent Summer 1999 testing our contingency plans. **Goal met.**

(6) Inpatient Hospital Care -- Inpatient hospital claims comprised at least 20 percent of the errors identified in the FY 1996, FY 1997, and FY 1998 CFO audits. These errors are particularly significant because they tend to be large claims. The CMS has developed a multi-faceted corrective action plan to reduce these errors, including the development of an inpatient claim Payment Error Prevention Program.

Goal: Reduce the payment error rate for inpatient hospital claims
Baseline: 3.4 percent (FY 1998)
FY 2001 Target: Data available late 2002
Update Information: The FY 1998 baseline has been established. The total inpatient hospital paid claims error rate is 3.4 percent. The total error rate for FY 2001 will be available at the end of 2002. We fully expect the FY 2001 error rate to be lower than the FY 1998 baseline.

(7) Congregate Care -- Groups of beneficiaries gathered in one place, such as a skilled nursing facility, assisted living facility, or adult day care program, become easy targets for unscrupulous providers. Combating this type of fraud requires action on a range of fronts, and a series of proposals is being evaluated. These include assessments of CMS

data and systems requirements necessary to understand these types of abuses, adjusting performance measures, and education efforts targeting congregate care facilities.

Goal: Develop a data exchange and analysis strategy to monitor the services provided to Medicare/Medicaid beneficiaries in congregate care settings.

Baseline: System does not currently exist.

FY 2001 Target: Develop and complete a data exchange analysis project with Medicare contractors and Medicaid State agencies to allow the coordinated monitoring of services provided to Medicare/Medicaid beneficiaries in congregate care settings.

Update Information: The CMS is contracting with National Heritage Insurance Corporation (NHIC) to conduct data matching and associated fraud and abuse review programs operating in the State of California. The computer matching agreement has been drafted and is under review. We have drafted the congregate care project proposal and will work with NHIC to complete the project using FY 2001 data no later than six months after the end of the fiscal year.

(8) Managed Care – This initiative consists of three types of tasks: 1) implementation of Medicare+Choice (M+C) program integrity provisions as required under the Balanced Budget Act of 1997, 2) ongoing monitoring of M+C contractors, and 3) development of a Statement of Work (SOW) for one or more managed care program safeguard contractors (PSCs). The purpose of this goal is to fully implement two new types of contractors--the Enrollment Certification Contractor and the Managed Care PSC(s)--to assist us in accomplishing the three tasks defined in the Managed Care Program Integrity initiative.

Goal: Creating Additional Contractors for Managed Care

Baseline: Currently there is no Enrollment Certification Contractor (ECC) and there are no Managed Care PSCs

FY 2001 Target: Fully implement the Enrollment Certification Contractor and the Managed Care PSCs.

Update Information: **Goal met.** On November 22, 2000 CMS awarded a contract to CMRI, a PSC contractor, to perform managed care payment validation work. Additionally, CMS sponsored a full and open competition to create a schedule of Medicare Managed Care Program Integrity Contractors. CMS met its goal and awarded eight of these managed care contracts earlier this year. There will not be a separate procurement for an Enrollment Certification Contractor. Instead, this work will be assumed by the Medicare Managed Care PIC contractors.

(9) Community Mental Health Centers – The CMS plans a series of actions to strengthen oversight over this benefit. We have already begun a site-visit program to

assess the compliance of CMHCs with Medicare rules, and plan to continue this effort. We will be issuing a clarification of the requirements applicable to CMHCs entering the program and subjecting new applicants to increased scrutiny, intensifying medical review for partial hospitalization claims, and increasing our audits of CMHC cost reports.

Goal: Reduce the payment error rate for Community Mental Health Center (CMHC) Partial hospitalization Claims

Baseline: 90 percent error rate in 1996

FY 2001 Target: 39 percent error rate

Update Information: The CMS has fully implemented its 10-point plan to address the abuses identified in the CMHC setting. Based on the success of these efforts we expect to meet our error rate reduction target for FY 2001. A PSC will re-evaluate the CMHC error rate at the end of FY 2001. This error rate information will be available no later than July 2002.

(10) Nursing Homes – The CMS plans several steps to improve the quality of care in the nursing home setting. We will impose sanctions more swiftly and increase the number of site inspections for repeat offenders, enhance Federal review and training for State inspection agencies, and continue building our national automated data system. Survey results will be posted on the Internet to increase accountability and flag problem providers for families and the public.

Goal: Decrease the prevalence of pressure ulcers in nursing homes. (For additional information, see goal QSC2-03)

Baseline: 9.8 percent.

FY 2001 Target: 9.6 percent prevalence of pressure ulcers in nursing homes.

Update Information: See QSC2-03.

Goal: Decrease the prevalence of restraints in nursing homes. (For additional information, see goal QSC1-03)

Baseline: 1996 - The mean prevalence of the use of physical restraints among all nursing homes in CY 1996 was 17.2 percent.

FY 2001 Target: Maintain a prevalence of the use of physical restraints at less than 10 percent.

Update Information: See QSC1-03.

Performance Goal MIP5-03

Increase Medicare Secondary Payer Credit Balance Recoveries and/or Decrease Recovery Time to Recoup Dollar Recoveries

Baseline: Incomplete information regarding credit balance-reporting process.
FY 2003 Target: To fully implement revised processes and controls in contractor credit balance activities.
FY 2002 Target: Develop improved processes and controls to be utilized by all contractors to ensure consistency and timely recoveries.
FY 2001 Target: Gather information on 1) provider credit balance identification, submission and resolution process; and 2) contractor monitoring and resolution of credit balances. **Performance:** Goal met. A Final Review Summary Report and a Final Summary Management Overview Report are now available.

Discussion: The intent of the Medicare Secondary Payer (MSP) provisions of the Social Security Act is to ensure that payment for health care services for beneficiaries is made by the appropriate primary payer for those beneficiaries with more than one source of insurance. MSP program activities attempt to collect timely and accurate information on the proper order of payers and to make sure that Medicare pays primary only for those claims where it has primary responsibility.

The intent of the mandatory Medicare credit balance reporting requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. The HCFA-838 report must be completed quarterly by all hospitals and other health care facilities participating in the Medicare program to help ensure that monies owed to the Medicare program are repaid in a timely manner.

Studies performed by CMS and the Office of Inspector General indicate that approximately 90 percent of credit balances are mainly attributable to provider billing practices and that over 50 percent are MSP-related. Providers must: 1) maintain, during the admission process, a system that identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented; 2) bill other primary payers before billing Medicare except in certain liability situations; and 3) reimburse Medicare within 60 days if the provider receives payment for the same services from another payer.

Providers that fail to follow these requirements risk losing participation in the Medicare program. Additionally, CMS instructions, in combination with regulations, furnish fiscal intermediaries (FIs) with the authority to sanction providers by suspending program payments if providers do not report credit balances on a quarterly basis. Medicare instructions require providers to follow specific procedures for credit balance reporting in order to guarantee recovery of any reported credit balances.

The CMS's initial review of the FI quarterly credit balance reports indicated that a high percentage of providers submit the HCFA-838 with a zero dollar credit balance. This is possible because the HCFA-838 provides a "snapshot" of the provider's credit balance activities rather than an ongoing view. However, CMS is vulnerable under this snapshot approach because it has no way to determine whether or not a zero balance on the HCFA-838 represents a very tightly run system or a provider that cleans up its credit balance accounts immediately before submitting the HCFA-838 each quarter (including situations where a provider zeroes out its credit balances, but does not make appropriate refunds to the Medicare program). The CMS has identified instances where providers received two payments for the same service, but the provider reported a zero dollar credit balance during that period. Additionally, we identified providers that submitted the HCFA-838 timely and identified a credit balance, but did not submit adjustment requests or send in a check as repayment.

Providers that do not adhere to the reporting requirements of the credit balance report reduce potential savings to the Trust Funds. Due to limited resources and funding available to CMS, only a small percentage of providers can be audited each year. Credit balance reports may not be audited or reviewed for several years because they are only audited during onsite reviews.

Currently, CMS has no database with information specific to MSP credit balance recoveries. This includes a lack of data on the timeframe within which reported credit balances are recovered through adjustment or payment by check.

Approaches under consideration include: 1) provider education (as well as attorney and insurer education); 2) instructions to the FIs to strengthen their analysis of the credit balance reporting overall and to specifically look at providers with a continuous zero dollar credit balance; 3) an increase in field audits with a strengthened review of credit balance reporting overall, including special emphasis on those providers with continuous zero dollar credit balance reporting; and 4) use of an independent contractor for data collection and analysis.

To reach our FY 2001 target, a consulting firm was used for data collection and analysis of six regional offices, six fiscal intermediaries and 24 providers. The methodology, observations, summaries and recommendations are now available in a Final Review Summary Report and a Final Summary Management Overview Report.

We are currently developing "best practices" associated with current procedures that will be used in reaching our FY 2002 goal of developing revised processes and controls. Once improved processes are in place, we plan to implement them in FY 2003.

Coordination: The CMS Central Office (CO), CMS Regional Offices (ROs), and the FIs will coordinate and monitor the efforts on this GPRA goal.

Data Sources(s): Any increased recoveries will be reflected within financial statements as well as savings reports. A Final Review Summary Report and Final

Summary Management Overview Report prepared by an independent contractor are now available. We will investigate the possibility of implementing tracking requirements specific to credit balance recoveries.

Verification and Validation: We rely on our contractors to report on their progress with credit balance activities. Their performance and data are evaluated through our Contractor Performance Evaluation Program.

Performance Goal MIP6-03

Assess Program Integrity Customer Service

Baseline: Developmental.
FY 2003 Target: Developmental.
FY 2002 Target: A survey of providers and beneficiaries will be conducted. Targets and a baseline will be developed from these data.

Discussion: The CMS is developing a goal to measure and ultimately improve customer satisfaction with the manner in which our program integrity (PI) activities are conducted. This goal focuses on CMS's PI activities with respect to two distinct groups: the provider community and the beneficiary community.

The provider community interacts with CMS and its contractors in many ways. The enrollment process is viewed as burdensome by many providers due to the amount of information that must be supplied. Providers have voiced concern that they do not receive consistent feedback from CMS and its contractors regarding billing issues. They have expressed concern that simple billing errors can result in criminal findings. With respect to the provider community, the aim of this goal is to ensure that the subject of a PI-related review is satisfied with the manner in which their case was handled, even though they may not be satisfied with the outcome.

The CMS, in partnership with the American Association for Retired Persons (AARP), has encouraged beneficiaries to be aware of services billed on their behalf and to report any instances of suspected fraud. In many cases the beneficiary is reluctant to contact CMS or the contractor about a provider. They may fear retaliation or have loyalties, which create ambivalence. With respect to the beneficiary community, this goal will strive to ensure that their contacts are handled in a courteous, professional and attentive manner.

In pursuit of this goal, a contractor will coordinate focus groups, develop and perform surveys, and assist Medicare contractors in the development of customer service plans. The surveys will include, but not be limited to, provider enrollment activities, providers who have been the subject of medical reviews and cost report audits, and beneficiaries who have reported Medicare fraud complaints.

Once the survey and focus group data collection is complete, we will analyze the results and develop specific measures for this goal. The measures will quantify and track responses to survey questions and issues raised in focus groups. The results will help us determine the areas in which we should improve our service delivery.

Coordination: The CMS will work closely with its contractors and other stakeholders (e.g., AARP, American Medical Association, American Hospital Association) in carrying out this goal.

Data Source: Information collected from focus groups and surveys will be the primary data source for this goal.

Verification/Validation: The contractor carrying out the surveys and focus groups will be responsible for implementing quality assurance and standard protocols to ensure reliability of the data.

Performance Goal MIP7-03

Improve the Provider Enrollment Process

Baseline: Current data sources for information on the enrollment process are limited, which is why we are developing a national enrollment system.
FY 2003 Target: Implementation of PECOS and revalidating 20 percent of Part A providers currently enrolled in the Medicare program using a new streamlined process. This revalidation target will help capture those providers that entered Medicare using the HCFA-855 enrollment form or that entered Medicare prior to the use of the HCFA-855 enrollment form.
FY 2002 Target: Develop PECOS, implement the revised HCFA-855 enrollment form and the regulation pertaining to establishing and maintaining billing privileges.

Discussion: This goal is aimed at improving the certified provider enrollment process at the Medicare contractors. One of our key program integrity goals is to ensure we make payments to legitimate providers. This reduces the resources necessary to chase after improper payments. The goal of provider/supplier enrollment is to ensure that only qualified and legitimate individuals and entities receive the right to participate in the Medicare program.

By the end of FY 2002, we intend to have a streamlined and more uniform process of revalidating applications from certified providers for Medicare that will continue to promote the type of payment safeguards we implemented in 1996-1997 with the first nationally standardized enrollment application process.

With the implementation of the new HCFA-855s, the Provider Enrollment Chain Ownership System (PECOS), and the "Enrollment Regulation," CMS and its contractors will have the ability to obtain a complete nationally formulated online standard history of any provider or supplier that has or had a business relationship with the Medicare program and the role or roles the individual or organization played in that relationship (e.g., physician, owner, manager, billing agent, etc.).

Coordination: The CMS will work closely with its Medicare payment contractors in carrying out the activities associated with this goal.

Data Source(s): Current data sources for information on the enrollment process are limited, which is why we are developing a national enrollment system. For this goal, we will extract data from the System for Tracking Audit and Reimbursement (STAR). PECOS will house all data via the revised HCFA-855 forms. PECOS will retain the data elements that will identify those certified providers who are currently known to the Medicare program. Once the centralized enrollment system is implemented for certified provider data, we will be able to use that information in assessing our performance.

Verification/Validation: Annually, we use contractor performance evaluation protocol to assess Medicare contractor provider enrollment activities. PECOS data will be verified during annual, onsite surveys of contractors.

Performance Goal 27-00

Reduce the Percentage of Medicare Home Health Services Provided for which Improper Payment is Made

Baseline: A 1997 report by the HHS Office of the Inspector General (OIG) on home health agencies revealed that, in four of the five States reviewed by the OIG as part of Operation Restore Trust (ORT), payments for 40 percent of Medicare home health services should not have been made. In generating this report, the OIG reviewed a sample of 1995 and 1996 paid claims data collected over a 15 month period which ended March 31, 1996.
FY 2000 Target: Reduce the home health error rate from 35 to 10 percent in California, Illinois, New York, and Texas by taking specific corrective actions, including implementing the home health provisions of the Balanced Budget Act of 1997. **Performance:** Data available April 2002.
FY 1999 Target: Reduce the home health error rate from 40 percent to 35 percent. **Performance:** Goal met.

Discussion: In 1997, the OIG of the Department of Health and Human Services (HHS) reported that nearly 40 percent of home health services provided in California, Illinois, New York, and Texas (which in 1995 represented nearly 28 percent of all nationwide home health agency reimbursements) did not meet the Medicare requirements for payment. Further, the report examined paid home health claims to determine whether services were delivered and if they met Medicare's criteria for payment. A random sample of claims during the 15-month period ending March 31, 1996 was reviewed, indicating specifically from on-site OIG staff reviews, that claims were improperly paid.

In FY 1999, the OIG repeated its evaluation of home health claims, using a sample of paid home health claims from January 1, 1998 to September 30, 1998 in the same four States, and determined that CMS's activities successfully reduced the home health claims payment error rate from 40 percent to 19 percent, exceeding the CMS goal of reducing the error rate in 1998 to 35 percent.

In FY 2001, CMS is replicating the OIG evaluation of home health claims for a third and final time, using a sample of paid home health claims from January 1, 1999 to September 30, 1999 in the same four States, to determine if CMS's activities have reduced the rate of improper payment from 19 percent to 10 percent for 1999.

To accomplish this goal, CMS developed and implemented tools to fight fraud and abuse in the Medicare home health program that: strengthened the Agency's ability to identify problem home health agencies; prevented them from entering into the program; reduced losses to the Medicare program due to problem home health agencies; and, prevented inappropriate payments to providers by restructuring coverage and payment for home health services.

The OIG studies indicated a trend toward meeting the target for this goal, therefore this goal was discontinued in order for CMS to focus on other equally compelling fraud and

abuse areas. However, in FY 2001 and following years, CMS will also continue to focus on reducing improper home health payments.

Coordination: Success at reducing home health fraud depends heavily on coordination both within and outside CMS. The partnership demonstrated through ORT has become the way we do business.

Data Source(s): Independent audit of a statistical sample of paid claims to be conducted by CMS or its agent.

Verification/Validation: This will be an independent audit conducted by CMS or its agent.

Medicare Operations

Medicare Operations	FY 2000 Actual	FY 2001 Enacted	FY 2002 Appropriation	FY 2003 Estimate
Total Budget Authority*	**$1,237.1 M**	**$1,356.4 M**	**$1,534.0 M**	**$1,675.1 M**

The Medicare Operations line item primarily funds the traditional Medicare fee-for-service program, mainly through the activities of CMS's Medicare contractors. There are two basic types of contractors: Fiscal Intermediaries, who process mainly Part A claims (e.g., hospital bills) and Carriers who process Part B claims (e.g., physician bills). These contractors are charged with making timely, accurate, and fiscally responsible payments to Medicare providers and suppliers for covered health care services. In FY 2003, they will process almost one billion Medicare claims; handle more than 7 million appeals; respond to over 40 million inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS.

The Medicare Operations activity also includes Information Technology funding for critical claims processing functions, such as telecommunications, systems maintenance, and data center support. It funds a variety of projects that enhance the Medicare program and make it more efficient, such as a new accounting and financial management system for the contractors. It also supports major provisions of the Health Insurance Portability and Accountability Act of 1996, including Administrative Simplification and the Privacy Regulation. In addition, it funds the National *Medicare&You* Education Program (NMEP), an initiative designed to educate the public about Medicare and to increase beneficiaries' understanding of their choices within the program. The Medicare Operations activity funds the major portion of NMEP activities which include: a Medicare handbook with area-specific information on Medicare+Choice plans; a toll-free number (1-800-MEDICARE); an Internet site (www.medicare.gov); and counseling and outreach. Other sources of funding include Medicare+Choice user fee and Peer Review Organization (soon to be known as Quality Improvement Organization) funds.

The CMS's Medicare contractors also serve as the front line in safeguarding the Medicare trust funds against fraud, waste, and abuse. These benefit integrity activities are funded separately through the Medicare Integrity Program budget and are not included in the totals shown in the chart above.

Other representative goal(s) that fit under this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-02)
- Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (MIP1-03)

- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice (FAC4-03)
- Improve the Provider Enrollment Process (MIP7-03)

Performance Goal	Targets	Actual Performance	Ref.
Improve Beneficiary Telephone Customer Service (Developmental) -- Accessibility * Busy rate * Answer time	**FY 03:** Will be developed in FY 2002 **FY 02:** Set baselines/ future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** **FY 02:** **FY 01:** Data being collected (Goal met) **FY 00:** Data necessary to determine baselines/targets are expected by the end of FY 2002. (Goal not met)	MO1
-- Accuracy of Response	**FY 03:** Will be developed in FY 2002 **FY 02:** Set baselines/ future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** **FY 02:** **FY 01:** Data being collected. (Goal met) **FY 00:** Data necessary to determine baseline/target are expected by the end of FY 2002. (Goal not met)	
-- Caller Satisfaction	**FY 03:** Will be developed in FY 2002 **FY 02:** Set baselines/ future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** **FY 02:** **FY 01:** Data being collected. (Goal met) **FY 00:** Data necessary to determine baseline/target are expected by the end of FY 2002. (Goal not met)	
Medicare Payment Timeliness Consistent w/Statutory Floor and Ceiling Requirements	**FY 03:** Same as FY 2002 **FY 02:** Same as FY 2001 **FY 01:** Maintain payment timeliness at the statutory requirement for electronic bills/claims **FY 00:** Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment	**FY 03:** **FY 02:** **FY 01: Intermediaries** 99.2% (Goal met); **Carriers** 98.7% (Goal met) **FY 00: Intermediaries** 99.4% (Goal met); **Carriers** 99.6% (Goal met) **FY 99: Intermediaries** – 99.6%; **Carriers** – 99.4% **FY 98:** 95 percent of both **Part A** clean, electronically submitted non-Periodic Interim Payment bills and **Part B** clean electronically submitted claims are processed within 14-30 days of receipt **(Baseline)**	MO2

Performance Goal	Targets	Actual Performance	Ref.
Increase Use of Electronic Commerce/ Standards in Medicare			MO3
-- Maintain high percentage of electronic media claims (EMC) for Fiscal Intermediaries (FIs)	**FY 03:** 97% **FY 02:** 97% **FY 01:** 97% **FY 00:** 97% **FY 99:** 97%	**FY 03:** **FY 02:** **FY 01:** 97.7% (Goal met) **FY 00:** 97.4% (Goal met) **FY 99:** 97.1%	
-- Maintain high percentage of EMC for Carriers	**FY 03:** 80% **FY 02:** 80% **FY 01:** 80% **FY 00:** 80% **FY 99:** 80%	**FY 03:** **FY 02:** **FY 01:** 83.0% (Goal met) **FY 00:** 81.9% (Goal met) **FY 99:** 80.9%	
-- Implement HIPAA standards	**FY 03:** Complete claim status, eligibility inquiry, prior authorization, and retail drug standards implementation and testing. Begin implementation of the attachment standard. **FY 02:** Complete implementation of HIPAA EDI standards for claims, COB and ERA. Begin implementation for claims status and eligibility inquiries. **FY 01:** Begin testing and implementation of HIPAA EDI standards **FY 00:** New in 2001	**FY 03:** **FY 02:** **FY 01:** Instructions for testing and implementation of the HIPAA EDI standards were issued in FY 2001 (except for the eligibility inquiry and response transaction). Due to competing project priorities, implementation and testing of other HIPAA EDI standards needed to be delayed until FY 2002. (Goal not met) **FY 00:** N/A	
Develop Baseline data for electronic claims	**FY 03:** Complete Baseline **FY 02:** Continue to develop Baseline **FY 01:** Develop Baseline	**FY 03:** **FY 02:** **FY 01:** Funding was requested for this work for FY 01 and FY 02 but not available as needed for higher priority projects. As a result, system changes to enable baseline data to be collected was deferred to FY 03.	

Performance Goal	Targets	Actual Performance	Ref.
Improve CMS's Rating on Financial Statements	**FY 03:** Maintain a "clean" opinion on the FY 2003 financial statement **FY 02:** Maintain a "clean" opinion on the FY 2002 financial statement **FY 01:** Maintain a "clean" opinion on the FY 2001 financial statement **FY 00:** Maintain a "clean" opinion on the FY 2000 financial statement **FY 99:** Achieve a "clean" opinion on the FY 1999 financial statement	**FY 03:** **FY 02:** **FY 01:** Data available 02/02 **FY 00:** Goal met **FY 99:** Goal met **FY 98:** Qualified opinion **(Baseline)** **FY 97:** Qualified opinion **FY 96:** Disclaimer on audit	MO4
Improve CMS oversight of Medicare Fee-for-Service contractors (Developmental)	**FY 03:** Developmental **FY 02:** Building on experience of FY 2001 **FY 01:** Building on progress achieved in FY 1999 and FY 2000 CMS will move further toward its goal of national, uniform contractor evaluation. **FY 00:** New in 2001	**FY 03:** **FY 02:** **FY 01:** Goal met **FY 00:** Inconsistency in reporting **(Baseline)**	MO5
Increase eligible delinquent debt referred for cross servicing to the Program Support Center	**FY 03:** Continue to refer all eligible delinquent CMS receivables for cross servicing and improve procedures for identifying, monitoring, and tracking these debts **FY 02:** Increase dollar amount of debt referred for cross servicing to 100% of eligible delinquent debt **FY 01:** New in FY 2002	**FY 03:** **FY 02:** **FY 01:** $2.1 billion delinquent debt referred **FY 00:** We referred approximately $2 billion in delinquent debt. This equates to about 25% of eligible debt **(Baseline)**	MO6

Performance Goal	Targets	Actual Performance	Ref.
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service through implementation of the Medicare Summary Notice (MSN)	**FY 03:** Goal discontinued due to completion of implementation **FY 02:** Complete national implementation **FY 01:** Same as FY 2000 **FY 00:** Support MSN efforts, aiming toward full implementation FY 2002 **FY 99:** New in FY 2000	**FY 03:** N/A **FY 02:** **FY 01:** Carrier/FI MSN implementation at 81%. Contractor support ongoing. (Goal met) **FY 00:** Carrier/FI MSN implementation at 81% (Goal met) **FY 99:** Carrier/FI MSN implementation at 75% **FY 97:** Beneficiaries received various notices indicating claims activity for most Part A and Part B services **(Baseline)**	MO7
Improve effectiveness of dissemination of Medicare information to beneficiaries through the National Medicare Education Program (NMEP) (5-year targets): * Accessibility of Information Percentage of beneficiaries who sought Medicare information from Medicare sources & reported that the information received answered their question(s).	**FY 03:** Same as FY 2002 **FY 02**: Same as FY 2001 **FY 01**: Continue collecting and monitoring MCBS data for final reporting in FY 2004 **FY 00**: 77% by FY 2004 **FY 99**: New in FY 2000	**FY 03:** **FY 02**: **FY 01**: Data being collected. (Goal met) **FY 00**: Though single-year MCBS data are not statistically meaningful for this goal, we are on track to meet our target by FY 2004 **FY 99**: 67% **(Baseline)**	MO8 **Moved from M+C User Fee budget category**
* Awareness of Messages Percentage of beneficiaries who knew that most people covered by Medicare can select from among different health plan options within Medicare.	**FY 03:** Same as FY 2002 **FY 02**: Same as FY 2001 **FY 01**: Continue collecting and monitoring MCBS data for final reporting in FY 2004 **FY 00**: 57% by FY 2004 **FY 99**: New in FY 2000	**FY 03:** **FY 02**: **FY 01**: Data being collected. (Goal met) **FY 00**: Though single-year MCBS data are not statistically meaningful for this goal, we are on track to meet our target by FY 2004 **FY 99**: 47% **(Baseline)**	

Performance Results Discussion

Fee-for-Service Telephone Customer Service - To improve fee-for-service (FFS) telephone customer service, CMS is "raising the bar" with respect to accessibility standards to keep up with industry norms and customer expectations. As important as it

is to be accessible to beneficiaries, the quality of the communication is also being addressed through the accuracy and caller satisfaction measures.

While we have made substantial progress in the area of FFS telephone customer service, we did not meet our goal to develop baselines in order to set targets by FY 2000. Standardized processes were implemented at the start of FY 2000 and data collection began. During the first quarter startup, it became evident that additional work was needed with individual contractors concerning the processes and the data input procedures before the accuracy of the data could be ensured. Significant telephone customer service improvements were undertaken in FY 2000 and FY 2001 and will continue in FY 2002, which will have an impact on the performance data being collected. These improvements included beginning to standardize the customer service representative training, conversion from local telephone service to FTS-2001 government long distance, and preliminary implementation of standardized interactive voice response services for callers. For these reasons, it was necessary to expand the baseline collection period from 1 to 3 years.

We continue to collect performance data via CMS's Customer Service Assessment and Management System (CSAMS). We have also begun to evaluate the performance metrics currently collected via CSAMS. Effective FY 2001, CMS replaced individual contractor surveys and self reporting with a national survey conducted by an independent third party on a quarterly basis. Since the second quarter of FY 2001, access to data from the FTS-2001 long distance carrier (MCIWorldCom) has been available on external busy rates for the individual call centers. These data are input to CSAMS for tracking on a monthly basis.

Fee-for-Service Payment Timeliness - For our FY 2001 Medicare Payment Timeliness goal, we were successful in achieving payment timeliness of electronic claims at 99.2 percent for intermediaries and at 98.7 percent for carriers. We will continue to maintain payment timeliness performance at a level that meets the statutory requirement for payment of electronic claims.

Electronic Commerce – For our FY 2001 Electronic Commerce goal, we were successful in maintaining high percentages of electronic media claims of 97.7 percent and 83.0 percent for fiscal intermediaries and carriers, respectively. The CMS is performing ongoing work with Health Insurance Portability & Accountability Act (HIPAA) electronic standards development for the health care environment. In FY 2001, we began implementing HIPAA Electronic Data Interchange standards.

Programming and preliminary testing for implementation of the HIPAA claim standard was completed in FY 2001. As a result of changes in agency project prioritization, programming hours and funding were unavailable for this project in FY 2001 to enable completion of implementation and testing for each of the HIPAA standards. As a result, some of the work was deferred until FY 2002. In addition, due to the complexity of implementation of these standards, contractor programming hour estimates increased resulting in completion of less work, but at a higher cost than initially anticipated.

HIPAA requires that the Secretary adopt national health care EDI standards for at least the nine transaction types specified in the legislation. As a result of a redirection of funding and available programming hours, it was not possible to schedule implementation and testing of the transactions for prior authorization and retail drugs until FY 03. Those standards, as well as work deferred from FY 01 and FY 02 as described above, are now included in the targets established for FY 03, and we expect to achieve those targets then.

Chief Financial Officer's Report - The CMS financial statements are a building block of both the Department of Health and Human Services financial statements and the government-wide financial statements required by the CFO Act of 1990 and the Government Management and Reform Act (GMRA). In FY 1999, CMS worked with the auditors to clarify exactly what documentation is available and necessary to support the Medicare Receivables. As a result, we issued revised financial reporting instructions to clarify receivables reporting policy and to ensure more consistent contractor operations. During FY 2001, we tested financial management internal controls at 13 Medicare contractors using Certified Public Accounting (CPA) firms, conduct contractor performance evaluation reviews of financial management issues at 6 Medicare contractors, and review accounts receivable balances at 12 Medicare contractors using CPA firms. In addition, we continued to develop the analytical tools necessary to perform more expansive trend analysis of critical financial data to identify potential errors or misstatements. Our long-term plan involves the implementation of an integrated general ledger accounting system.

Fee-for-Service Contractor Oversight - In an effort to improve performance and oversight of carriers and fiscal intermediaries (FIs) that interact directly with CMS's customers, CMS established several performance goals in this area. The CMS can provide better oversight of our contractors by using a standardized, uniform evaluation process. In 2001, national teams using standardized review protocols conducted 160 onsite reviews. The FY 2001 findings will be discussed at the FY 2002 Lessons Learned conferences to make improvements in the process. The CMS has highlighted best practices and applied lessons learned more globally to foster enhanced review consistency. Through the use of performance information to guide our contractor oversight activities, we are looking forward to continued improvement.

Delinquent Debt - The CMS plans to improve debt collection procedures and continues to refer all eligible delinquent CMS receivables for cross servicing by the Department of Treasury. Prior to FY 2001, CMS referred $2 billion in delinquent debt for cross servicing. In FY 2001, CMS referred an additional $2.1 billion. The referral process was delayed the first half of this fiscal year in order to implement system edits in CMS's Debt Collection System (DCS) to ensure more accurate debt referral.

Beneficiary Information/Fee-for-Service (Medicare Summary Notice--MSN) - National implementation of the MSN is expected to improve effectiveness of information for beneficiaries enrolled in the fee-for-service program. Because this

monthly information will be in a more understandable, clear format than previous multiple notices, it is also expected to be easier for beneficiaries to spot inconsistencies or instances of fraud. In FY 2001, we supported, and will continue to support, the Medicare contractors that have already implemented the MSN by answering questions, solving problems, considering suggestions, etc. We will also continue to handle Congressional, beneficiary, contractor, and beneficiary advocacy group inquiries relating to the MSN in general and to the resulting confusion beneficiaries may feel due to receiving the MSN in some instances and different benefit notices (EOMBs, NOUs, EOBs) in other instances.

Beneficiary Information through the National *Medicare&You* Education Program (NMEP) - With clear baselines in place, we continue to track efforts of the NMEP toward our eventual 5-year target for beneficiary accessibility and understanding of educational efforts in the area of the Medicare+Choice program.

Overall, we are pleased with the results so far. Beneficiary feedback from the *Medicare&You* handbook has been overwhelmingly positive as indicated on the completed postcards included in the handbook. The number of beneficiaries calling CMS's toll-free number (1-800-MEDICARE) continues to increase with positive feedback. The beneficiary-centered website (www.medicare.gov) also continues to be popular, and data collected from the website's feedback form demonstrate high user satisfaction.

In the Fall of 2001, CMS embarked on a National Media Campaign which will help beneficiaries and their caregivers become active and informed participants in their health care decisions. We implemented a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. This includes:

- expanding phone service availability at 1-800-MEDICARE to 24 hours a day, 7 days a week;
- introducing a web-based Medicare Personal Plan Finder on www.medicare.gov to help consumers compare their health plan choices (M+C plans, Medicare Fee-for-Service, and Medigap plans);
- enabling customer service representatives at 1-800-MEDICARE to provide more in-depth help to callers on finding the health plan choice that is best for them; and
- conducting a publicity campaign on the new choices and new ways to get information.

These strategies will contribute to many important Agency efforts and will support several performance goals, including our goals to improve beneficiary understanding of basic features of the Medicare program (MB5-03) and to increase adult immunization (QP2-03) and mammography rates (QP3-03).

Performance Goal MO1-03

Improve Beneficiary Telephone Customer Service

Baseline: Developmental. Baseline data on accessibility, accuracy of response, and caller satisfaction are being collected and will be available by the end of FY 2002.
FY 2003 Target: Using baseline data, establish call center performance targets for accessibility, accuracy of response, and caller satisfaction. Collect monthly data from each call center and compare performance against targets, identify where improvements are needed on national and regional levels. Take necessary actions and/or conduct training to bring about improved performance. Specific target goals to be determined.
FY 2002 Target: Complete data collection and set baselines/future targets.
FY 2001 Target: Continue data collection for accessibility, accuracy of response, and caller satisfaction measures (revised due to unavailability of accurate data until FY 2002). **Performance:** Goal met. Data collection continuing.
FY 2000 Target: Develop baselines and targets by the end of FY 2000 in areas of accessibility, accuracy of response, and caller satisfaction. **Performance:** Goal not met.

Discussion: Medicare carriers handle nearly 15 million telephone beneficiary inquiries annually. Beneficiary telephone customer service is a central part of CMS's customer service function. This goal focuses on improving the service that the carriers provide by measuring and assessing performance in three areas: accessibility of the service, accuracy of response, and caller satisfaction.

There are no historical data that are comparable across carriers. For FY 2000, CMS developed standard definitions, calculating methodology, quality call monitoring process and tools, and a caller satisfaction survey process to be used by all the carriers (and potentially by third parties independent of CMS) in collecting the data. Carriers began utilizing the new definitions, processes and tools in October 1999. Consistent and normalized baseline data on accessibility and contractor service levels, accuracy of response, and caller satisfaction are being collected and will be available by the end of FY 2002. The FY 2002 baseline data will enable CMS to set specific targets for accuracy of response beginning in FY 2003 and for future years. The CMS intends to adopt a long-term view in measuring and improving carrier telephone customer service. We will initiate a number of interventions to promote improved performance, including:

- establishing higher standards through changes to the contractor performance requirements;
- collecting and sharing information on best practices, through mechanisms such as annual conferences, monthly contractor call center user group conference calls and a bimonthly newsletter; and
- monitoring contractor performance and using our legal authority as appropriate when contractors fail to meet CMS standards.

The FY 2001 goal was met, as CMS continues to collect data for accessibility, accuracy of response, and caller satisfaction measures.

Coordination: The CMS will work closely with its contractors during the data collection process for these measures.

Data Source(s): Data on busy rates will be obtained from FTS-2001 (MCI WorldCom), the Federal Government's long distance telephone service provider. Data on the percent of calls answered within a specified time frame are available from the automatic call distributor equipment used by each carrier. These data are reported to CMS each month via CMS's Customer Service Assessment and Management System (CSAMS).

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 are reported monthly to CSAMS using scorecard totals.

During FY 2000, data on caller satisfaction were determined by tabulating the standardized survey forms completed each month and collected via CSAMS. Effective FY 2001 CMS replaced individual contractor surveys and self reporting with a national survey conducted by an independent third party on a quarterly basis to reduce costs and achieve more objective, uniform results. The national survey utilizes the same standardized survey forms previously used by the contractors.

Verification and Validation: For FY 2000, CMS developed standard definitions and a calculating methodology to be used by all the carriers (and potentially by independent third parties) in collecting the data. Data reported by carriers are routinely reviewed by CMS Regional Offices as part of the contractor performance evaluation process. In addition, contractor reporting is reviewed on a regular basis by CMS for compliance with established standards. The CMS plans to validate the data on accuracy of response by having an independent third party sample a minimum of calls.

Performance Goal MO2-03

Sustain Medicare Payment Timeliness
Consistent with Statutory Floor and Ceiling Requirements

Baseline: In the baseline year FY 1998, intermediaries and carriers, respectively, met statutory requirements that 95 percent of clean, electronically submitted non-Periodic Interim Payment electronic bills and 95 percent of clean, electronically submitted claims are processed between 14-30 days of receipt.
FY 2003 Target: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims.
FY 2002 Target: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims.
FY 2001 Target: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims. **Performance:** Goal Met
FY 2000 Target: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment. **Performance:** Goal Met

Discussion: The Social Security Act, sections 1816 (c)(2) and 1842 (c)(2) establish mandatory timeliness requirements for Medicare claims payment to providers of services. As a result, Medicare intermediaries and carriers are required to pay 95 percent of clean electronic media bills/claims between 14 to 30 days from the date of receipt. This requirement does not include Periodic Interim Payment bills.

Medicare contractors have traditionally satisfied CMS's bill/claim processing timeliness requirements. Medicare contractors are under added pressure to sustain performance with increased efforts directed at decreasing the number of Medicare payments that are attributed to fraudulent or abusive billing. However, CMS has identified bill/claim-processing timeliness as a priority area. To that end, Medicare contractors are required to maintain the statutory level of bill/claim processing timeliness performance while strengthening their ability to deter fraud and abuse in the Medicare program.

Coordination: The CMS is committed to being a reliable business partner for the provider community. The CMS works closely with its contractors to ensure that payment timeliness requirements are met.

Data Source(s): 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.

Verification and Validation: The CMS routinely utilizes Contractor Performance Evaluation (CPE) for determining claims processing timeliness. Through CPE, 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.

Performance Goal MO3-03

Increase the Use of Electronic Commerce/Standards in Medicare

Baseline: In the baseline year FY 1999, intermediaries and carriers, respectively, reached Electronic Media Claim (EMC) rates of 97.1 percent and 80.9 percent.
FY 2003 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after FY 2004, when initial Health Insurance Portability and Accountability Act (HIPAA) standards should have been implemented throughout the industry. (b) Complete baseline data for electronic claims status, electronic eligibility queries, electronic remittance advice (ERA), electronic funds transfer (EFT), and coordination of benefits (COB) transactions. (c) Complete implementation and testing of the HIPAA electronic transaction standards for: claims status and response, eligibility inquiry and response, prior authorization, and retail drugs claims, payments and inquiries. (d) Begin implementation of the HIPAA transaction standard for attachments.
FY 2002 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after FY 2003 when Health Insurance Portability and Accountability Act (HIPAA) standards are implemented throughout the industry. (b) Complete implementation and testing, at Medicare contractor sites of the HIPAA Electronic Data Interchange (EDI) standards for the following Medicare transactions: electronic claims and COB, and the ERA. Begin implementation activities for the eligibility inquiries and response, and claims status inquiry and response transactions.
FY 2001 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. (b) In the third quarter of FY 2001 begin to establish baseline data for electronic claims status, electronic eligibility inquiries, Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) transactions. (c) Begin implementation and testing, at Medicare contractor sites, the HIPAA EDI standards for the following Medicare transactions: electronic claims and coordination of benefits, ERA, eligibility inquiries and response, and claims status inquiry and response. **Performance:** Goal Partially Met
FY 2000 Target: Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers through FY 2000. **Performance:** Goal Met

Discussion: The objective of this performance goal is to increase the percentage of these activities accomplished electronically, rather than on paper form, on the telephone, or through other manual means. Increasing standardization and increasing the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars.

HIPAA requires that the Secretary of HHS adopt, at a minimum, standardized electronic formats and data contents for claims, COB, ERA, claims status inquiry/response, eligibility inquiry/response, prior authorization, retail drugs processing, and attachments for use by the entire U.S. health care payment industry. The Secretary is encouraged to adopt further standards as warranted, and is also required to periodically adopt updates to or replacements for the previously published standards. As a result, HIPAA transaction standards implementation and maintenance will be an ongoing project for Medicare.

Within two years of publication of the final rule for each standard, health care plans and providers of service that engage in electronic health care commerce are required to utilize the standards required under HIPAA (small plans have three years), and are prohibited from use of similar but non-compliant EDI transaction formats. The initial HIPAA transactions final rule was published in August 2000, but most Medicare contractor implementation activities could not begin until FY 2002 due to the need to assign available contractor programming hours and funds to projects determined to be a higher priority. This led to the deferral of a number of HIPAA implementation activities from FY 2001 to FY 2002 or FY 2003. This has been further delayed due to recent legislation (PL 107-105). The target for FY 2003 now also includes three of the HIPAA standards that we had not previously planned to implement in prior years: for prior authorization, retail drugs, and attachments.

The CMS has, over the last decade, placed a great emphasis on the use of electronic claims transmissions. The final data for FY 2001 showed an electronic claims submission rate of 97.7 percent for intermediaries and 83.0 percent for carriers. These rates are at or near a natural saturation point. We believe maintenance of EMC will be challenging in FY 2002 and FY 2003 given the HIPAA pre-implementation environment across the health care industry.

As Medicare providers begin to focus on the standards under HIPAA, we believe they will slow their EDI investments as they prepare for the new standards. This could result in at best, no increase in use of electronic transactions during the transition period to full use of the HIPAA standards. At worst, this could result in a temporary reduction of provider use of EDI if they wait for the industry to complete HIPAA implementation and work out any resulting problems. It is not realistic to expect any increase in provider EDI use during this period of health care industry EDI transaction flux.

Our approach, therefore, has been to set targets on maintenance of electronic claims levels during this transition, implementation and testing of HIPAA standards, development of baseline measurements for other EDI transactions, and establishment of targets for these transactions.

Coordination: The CMS works closely with Medicare contractors in the development of HIPAA standards and EMC payment rates.

Data Source(s): The data source for tracking EMC is CMS's Contractor Reporting of Operational and Workload Data (CROWD) system. Medicare contractors will begin to separately report to CMS on status of HIPAA standards implementation and testing in FY 2002. In FY 2003, performance statistics should begin to be collected through the CROWD system for EDI transactions in addition to claims.

Verification and Validation: The CMS routinely utilizes the Contractor Performance Evaluation (CPE) for evaluating the accuracy of contractor data reporting, including CROWD. 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. In addition, CMS is in the process of contracting with an IV & V company to conduct HIPAA-specific evaluations to validate Medicare contractor compliance with the adopted EDI standards. These verification and validation activities should be in effect in FY 2002 and later.

Performance Goal MO4-03

Maintain CMS's Improved Rating on Financial Statements

Baseline: In the FY 1996 financial statement, four items totaling $60.7 billion were questioned by the auditors, resulting in a disclaimer on the audit. Two items totaling nearly $6 billion were questioned in the FY 1997 financial statement resulting in a qualified opinion. One item totaling $3.6 billion was questioned in the FY 1998 financial statement resulting in a qualified opinion.
FY 2003 Target: Maintain a "clean" (unqualified) opinion on CMS's FY 2003 financial statements.
FY 2002 Target: Maintain a "clean" (unqualified) opinion on CMS's FY 2002 financial statements.
FY 2001 Target: Maintain a "clean" (unqualified) opinion on CMS's FY 2001 financial statements.
FY 2000 Target: Maintain a "clean" (unqualified) opinion on CMS's FY 2000 financial statements. **Performance:** Goal met.
FY 1999 Target: Achieve a "clean" (unqualified) opinion on CMS's FY 1999 financial statements. **Performance:** Goal met.

Discussion: As an Agency with one of the largest budgets in the Federal Government, CMS has a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. The CMS takes its financial management responsibilities seriously, and is committed to improving financial systems, accounting procedures, and reporting processes.

The Chief Financial Officers Act 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.

The purpose of an audit is to ensure that the financial statements are reasonable. This is accomplished by reviewing the full spectrum of financial operations, internal controls, and compliance with laws and regulations at CMS and with its agents. It is the Agency's goal to maintain a "clean" unqualified opinion. A clean opinion indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and financing of CMS.

Since FY 1996, we have made significant improvements on our financial statements. On the FY 1997 and 1998 statements, we obtained a qualified opinion because the auditors found deficiencies in several aspects of the Medicare contractors' accounts receivable: (1) inadequate supporting documents to validate accounts receivable balances, and (2) inability to reconcile subsidiary financial records to the accounting reports submitted to CMS.

In FY 1999 and FY 2000, CMS received clean audit opinions. During FY 2001, we tested financial management internal controls at 13 Medicare contractors using Certified Public Accounting (CPA) firms, conducted contractor performance evaluation reviews of financial management issues at six Medicare contractors, and reviewed accounts receivable balances at 12 Medicare contractors using CPA firms. In addition, we continued to develop the analytical tools necessary to perform more expansive trend analysis of critical financial data to identify potential errors or misstatements. Our long-term plan involves the implementation of an integrated general ledger accounting system.

Coordination: This goal requires coordination with the Office of Inspector General (OIG), CMS internal financial components, CMS regional offices, Medicare contractors, and Medicaid State Agencies.

Data Source(s): The audit report of CMS's financial statement is issued by a contract CPA firm with oversight by the OIG.

Verification and Validation: The CMS works closely with the OIG and contract CPA firms during the audit and has the opportunity to review, discuss, and/or clarify the "Findings and Conclusions" presented. The General Accounting Office (GAO) has responsibility for the opinion on the consolidated government-wide financial statements, which includes oversight for the audit of the Department of Health and Human Services, of which CMS's outlays are approximately 82 percent.

Performance Goal MO5-03

Improve CMS Oversight of Medicare Fee-for-Service Contractors

Baseline: Developmental. There was extensive variation in the format of reports and review protocols and timeliness of report submission during the period from FY 1995 to FY 1998.
FY 2003 Target: Developmental.
FY 2002 Target: Building on experience of FY 2001 and continuing towards goal of national uniform contractor evaluation.
FY 2001 Target: Building on progress achieved in FY 1999 and FY 2000, CMS will move further toward its goal of national, uniform contractor evaluation. **Performance:** Goal Met

Discussion: In FY 2001, Medicare fee-for-service payment contractors received approximately $1.45 billion in program management and Medicare Integrity Program funding to process nearly 915 million claims and administer benefit outlays of approximately $197 billion. In FY 2003, they will process an estimated 1 billion Medicare claims; handle more than 7 million appeals; respond to 40 million inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS.

In FY 1995, CMS decentralized its approach to evaluating these contractors and afforded considerable flexibility to CMS regional offices in planning and conducting evaluations of contractors within each region. Decentralization of these reviews produced inconsistency from region to region, and difficulty in assessing national contractor performance.

Beginning in FY 1999 and continuing in FY 2000 and FY 2001, CMS focused on contractor performance evaluation (CPE) through a risk-based, consistent national approach to contractor review that allocates resources to evaluating high-risk contractors and/or program benefits. The criteria for selecting additional contractors for more intensive review include: claims volume, administrative costs, benefit payout, integrity issues and past performance.

In 2001, all onsite reviews are being conducted by national teams using standardized review protocols, under the guidance of the same project leaders assigned to each business function. Approximately 160 onsite regional office/central office (RO/CO) and multi-regional team reviews have been scheduled in 15 business functions. An estimated 600 additional reviews based on contractor operational data are in progress. We will achieve greater review consistency through the increased use of national (RO/CO) review teams trained to evaluate functions performed by these high-risk contractors. Additional steps toward greater consistency include increased use of multi-regional review teams, as well as increasing the number of and standardizing review protocols, providing national training on the protocols, providing training on approaches to performance audits, and standardizing CPE review reports and management reports. Finally, some contractor activities, such as accounts receivable, computer systems

security, and the effectiveness of contractor financial internal controls, will be evaluated through contracts with consulting or accounting firms, which will use a standard review program.

Coordination: CPE is closely coordinated with management and staff from CMS's central and regional offices. Working with the regions, central office program managers with responsibility for contractor business functions set annual evaluation priorities and develop the standard review protocols utilized by the review teams.

Data Source(s): Data on the extent of use of contractor review teams and the timeliness of issuance of each Report of Contractor Performance will be available through internal management reporting.

Verification and Validation: The CMS staff will review the reports cited under data sources to assess performance and report on progress.

Performance Goal MO6-03

Increase Referral of Eligible Delinquent Debt for Cross Servicing

Baseline: Prior to FY 2001, CMS referred over $2 billion in eligible delinquent debt for cross servicing. This is approximately 25 percent of CMS's eligible delinquent debt.
FY 2003 Target: Continue to refer all eligible delinquent CMS receivables for cross servicing and to improve the procedures for identifying, monitoring and tracking these debts.
FY 2002 Target: Increase the dollar amount of debt referred for cross servicing to 100% of eligible delinquent debt.

Discussion: The Debt Collection Improvement Act of 1996 (DCIA) is intended to facilitate collections by the Federal Government and to encourage the streamlining of procedures and coordination of information within and among Federal agencies. The DCIA mandates Federal agencies to refer eligible delinquent debt (180 days past due) to the Department of Treasury or a Treasury designated Debt Collection Center (DCC) for cross servicing. Debts not eligible for referral include debts: (1) in bankruptcy status, (2) with an appeal pending at any level, (3) in active litigation, or (4) where the debtor is deceased.

Prior to FY 2001, CMS referred over $2 billion in delinquent debt for cross servicing. This is approximately 25 percent of CMS's eligible delinquent debt and was CMS's debt referral goal for FY 2000. In FY 2001, CMS referred an additional $2.1 billion of eligible debt. By the end of FY 2002, CMS's goal is to refer 100 percent of eligible delinquent debt.

To meet this goal, CMS revised its debt referral procedures to utilize resources at the Medicare Contractor and Regional Office locations. These referral procedures include identifying debt eligible for referral, verifying the status and balance of the debt and certifying that the debt is valid and legally enforceable. A notice must be sent to the debtor regarding the indebtedness and the intent to refer the debt for cross servicing.

The notice must provide the debtor with specific information regarding the DCIA and outline the debtor's rights. Sixty days after the notice is sent to the debtor, if no response or payment is received, the debt is entered into a CMS developed database for internal tracking and transfer to DCC.

The CMS initially targeted only Medicare Part A and Part B overpayments for referral for cross servicing. Medicare Secondary Payor (MSP) debt, which is a large percentage of CMS's delinquent debt, was added to the referral process. For FY 2002, CMS will also refer other types of debts in its accounts receivable balance.

Coordination: The CMS and the Medicare Payment Contractors maintain ongoing coordination to monitor and track the debts selected for referral, debts referred, and collections received as a result of referrals. Referral efforts are coordinated with the

Department of Treasury and the Program Support Center (PSC) of the Department of Health and Human Services.

Data Sources: The CMS tracks its non-MSP overpayments through the Provider Overpayment Reporting (POR) system, the Physician/Supplier Overpayment Reporting (PSOR) system, and Medicare Contractor internal systems. Medicare contractors and CMS enter debt information into the Debt Collection System (DCS) prior to referral.

The CMS Healthcare Integrated General Ledger Accounting System (HIGLAS), which will include an accounts receivable system, is in the pilot design, development and implementation phase. This is an 18 month phase. Once implemented HIGLAS will interface with Medicare Contractor selected systems and will further streamline the current debt referral process. The implementation of this new system is expected to be completed in FY 2006.

Other types of accounts receivable, which are not housed in CMS contractor's systems, are being identified and tracked for referral to cross servicing.

Verification and Validation: Data systems outlined above will be used to track and monitor progress. At this time, the present system has limited edits to ensure data integrity. Until an integrated system is developed and implemented, CMS will monitor the data in the various systems used to ensure data integrity and consistency. The CMS will verify that the information in the DCS system is consistent with the data reported in the POR/PSOR systems. Contractor data will be verified using the Contractor Financial Reports, Statement of Financial Position (HCFA Form 750) and Status of Accounts Receivable (HCFA Form 751). In addition, CMS will request reports from the PSC on the status of debt that was referred to Treasury and other debt.

Performance Goal MO7-02

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries in Fee-for-Service

Baseline: In FY 1997, beneficiaries received various notices indicating claims activity for most Part A and Part B services.
FY 2002: CMS plans to complete national implementation of the Medicare Summary Notice (MSN).
FY 2001: Same as FY 2000. (To better reflect budget linkage, this goal was moved from the Medicare+Choice User Fee budget category.) **Performance:** Carrier/FI implementation at 81 percent and contractor support ongoing. Goal met.
FY 2000: Support MSN efforts, aiming toward full implementation in FY 2002. **Performance:** Carrier/FI implementation at 81 percent. Goal met.

Discussion: To enhance beneficiary understanding of their Medicare benefits and reduce confusion over what Medicare covered for their services, CMS is continuing and, in FY 2002, completing its nationwide implementation of the MSN. The MSN combines information sent to Medicare beneficiaries on benefits received under Medicare Part A and Part B into easy-to-read monthly statements.

The MSN reduces beneficiary confusion and paperwork by providing a monthly summary of services delivered under Part A, and separate summaries for services under Part B, and durable medical equipment--like monthly credit card statements. The MSN also reduces confusion by providing claim information in a consistent format that is clearer, more concise, and easier to understand than current notices. MSN pilot test results show that beneficiaries can better understand what Medicare paid or denied and what they may owe. The MSN also contains important information regarding Medicare fraud and abuse detection, including new "Help Stop Fraud" messages to help beneficiaries identify potential fraud.

In FY 2002, we will modify the Part A MSN format to incorporate the Balanced Budget Act (BBA) requirement to list the amount Medicare paid to the provider (already included in the Part B MSN). Modifications to the existing beneficiary/provider outreach and education materials will be made as a result of these changes to the MSN.

Coordination: Teleconferences between CMS and fiscal intermediaries, carriers, and standard system representatives will play a critical role as CMS grows closer to national implementation of the MSN. Feedback on the MSN comes from a variety of organizations, including beneficiary advocacy groups; Medicare Peer Review Organizations; State Health Insurance Assistance Programs; and Beneficiary Advisory Councils.

Data Source(s): Successful completion of the MSN will rely on the Medicare Part A, Part B, and Durable Medical Equipment Regional Carrier (DMERC) contractor systems.

Verification and Validation: CMS oversees the performance of contractors through routinely scheduled site visits and performance reviews.

Performance Goal MO8-03

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries through the National Medicare & You Education Program (NMEP)

Baseline: (1) In 1999, 67 percent of beneficiaries who sought Medicare information from Medicare sources reported that the information they received answered their question(s). (2) In 1999, 47 percent of beneficiaries knew that most people covered by Medicare could select from among different health plan options within Medicare.
FY 2003: Same as FY 2002/2001.
FY 2002: Same as FY 2001.
FY 2001: Continue collecting and monitoring Medicare Current Beneficiary Survey (MCBS) data for final reporting in FY 2004. **Performance:** MCBS data being collected for the 5-year period. We are on track toward meeting the goal by FY 2004.
FY 2000: By 2004, 77 percent of beneficiaries will report that the information they received answered their question(s), and (2) 57 percent will know that most people covered by Medicare can select from among different health plan options within Medicare. **Performance:** MCBS data being collected for the 5-year period. We are on track toward meeting the goal by FY 2004.

Discussion: The Balanced Budget Act (BBA) of 1997 mandated the greatest changes to Medicare since its inception. One of these changes was the expansion of health insurance options under Medicare+Choice. To support the new program and help Medicare beneficiaries make more informed health care decisions, CMS initiated the National *Medicare&You* Education Program (NMEP). The NMEP employs numerous communication vehicles to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; rights, responsibilities and protections; and health behaviors. The primary objectives of the education efforts are to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the Federal Government and its private sector partners) as trusted and credible sources of information. We assumed an average 2 percentage point increase per year with our targets; thus, 10 percentage points over the 5 year period. We figured that this was achievable given the emphasis on the education program.

Coordination: The CMS is continuing the process of building alliances with other consumer centered organizations to improve the dissemination of information to educate Medicare beneficiaries and those that act on their behalf.

Data Source(s): The Medicare Current Beneficiary Survey (MCBS) is the primary data source. Over a 5-year period, CMS will track changes in the ability to access

information and beneficiary awareness. The target of a 10-percentage point increase is set for FY 2004, because this is a multi-year education campaign and the percentage increase needs to be large enough to statistically detect it.

Verification and Validation: The MCBS is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device.

Federal Administrative Costs

Federal Administrative Costs	FY 2000 Actual	FY 2001 Enacted	FY 2002 Appropriation	FY 2003 Estimate
Total Budget Authority	**$485.9 M**	**$527.8 M**	**$555.2 M**	**$587.2 M**
Full-Time Equivalents	**4,446**	**4,520**	**4,569**	**4,476**

Funding for Federal Administrative Costs provides roughly 4,476* CMS employees the ability to execute the Government's responsibilities in continuing Medicare and Medicaid services. These responsibilities include providing direct program services to beneficiaries, providers, Medicare contractors, and State agencies, as well as the general public. In addition, these responsibilities include combating fraud, waste, and abuse; overseeing safety and quality of health care; promoting managed care; responding to data requests; implementing legislation; and developing efficient payment and operating systems.

* Includes 80 Full Time Equivalents (FTEs) funded by non-appropriated funds.

In addition to the fact that Federal Administrative Costs provide the "backbone" for most of the GPRA goals, other representative goals related to this budget category but not listed in the chart are:

- Process Beneficiary Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions (MB3-03)
- Improve Medicare Managed Care Plans' Administration of Appeal Process (MB4-03)
- Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements (MO2-03)
- Increase the Use of Electronic Commerce in Medicare (MO3-03)
- Improve CMS's Rating on Financial Statements (MO4-03)
- Improve CMS's Oversight of Contractors (MO5-03)
- Increase Referral of Eligible Delinquent Debt for Cross Servicing (MO6-03)
- Improve the Management of the Survey and Certification Budget Development and Execution Process (QSC3-03)

Performance Goals	Targets	Actual Performance	Ref.
Ensure Compliance with HIPAA Requirements Through the Use of Policy Form Reviews: -- Percent of forms utilized by issuers reviewed in direct enforcement States	**FY 02:** Goal not continued **FY 01:** 60% **FY 00:** 30% **FY 99:** New in 2000	**FY 02:** N/A **FY 01:** 60% (Goal met) **FY 00:** 30% (Goal met) **FY 99:** N/A **FY 98:** 0 **(Baseline)**	FAC1
Develop and Implement an Information Technology Architecture	**FY 03:** --Continue maturing the ITA --Develop architectural support services **FY 02:** --Continue policy and procedure development --Complete development of System Design Reference Models & integration into SDLC activities -- Monitor ITA conformance as part of Investment Process **FY 01:** -- Develop template configuration for major system development -- Integrate ITA into investment review process **FY 00:** Approve standards and policies for basic services (target unchanged, language was modified) **FY 99:** New in 2000	**FY 03:** **FY 02:** **FY 01:** -- Being developed; Completion of 6 templates expected 3/1/02 --Integrated (Goal Partially Met) **FY 00:** All standards approved (Goal met) **FY 99:** N/A	FAC2

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS's Information Systems Security:			FAC3
-- Eliminate all material weaknesses	**FY 03:** Zero weaknesses **FY 02:** Zero weaknesses **FY 01:** Zero weaknesses **FY 00:** Zero weaknesses	**FY 03:** **FY 02:** **FY 01** one weakness (Goal not met) **FY 00:** one weakness (Goal not met) **FY 99:** two weaknesses **FY 97:** five weaknesses **(Baseline)**	
-- Implement access control management system	**FY 03:** Implement	**FY 03:**	
-- Increase percent of employees receiving security training	**FY 01:** 95% **FY 00:** New in 2001	**FY 01**: 20% CBT delayed **FY 00:** N/A	
Contractor Security Evaluation: -- Add system security reviews to CPEs -- Evaluate Medicare contractors' security profile and apply baseline to CMS's business partners	**FY 03:** Add reviews **FY 02:** Apply baseline	**FY 03:** **FY 02:**	
-- Increase proportion of Medicare contractor sites receiving security review	**FY 01:** One-third **FY 00:** New in 2001	**FY 01:** One-third (Goal met) **FY 00:** N/A	
Intrusion detection: -- Conduct penetration testing -- Implement intrusion detection & response procedure	**FY 03:** Test **FY 02:** Implement	**FY 03:** **FY 02:**	

Performance Goals	Targets	Actual Performance	Ref.
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice:			FAC4
-- Design PPS systems for psychiatric hospitals	**FY 03:** Continue to develop system **FY 02:** Initiate design of system	**FY:03** **FY 02:**	
-- Implement PPS for Inpatient Rehabilitation Facilities	**FY 02:** Implement system	**FY 02:**	
-- Implement PPS for HHAs	**FY 01**: Implement system **FY 00:** Publish rule	**FY 01:** HHA PPS implemented 10/1/00 (Goal met) **FY 00:** Rule published 7/3/00 (Goal met.)	
-- Implement PPS for hospital outpatient services	**FY 00:** Implement system	**FY 00:** Outpatient PPS implemented 8/1/00. (Goal met.)	
-- Risk-adjusted payments for managed care	**FY 01:** Make risk-adjusted payments **FY 00:** Make risk-adjusted payments **FY 99:** Establish risk-adjustment methodology	**FY 01:** Goal met. **FY 00:** Risk adjusted payments began 1/1/2000 (Goal met). **FY 99:** Goal met.	
-- Establish methodology for SNF PPS	**FY 99:** Complete implementation started in 7/98	**FY 99:** Goal met. **Baseline:** Cost reimbursement for HHA, SNF, inpatient rehab, outpatient hospital and psychiatric hospitals. Payments to managed care plans not risk-adjusted.	

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS's Workforce Planning	**FY 03:** Fully implement automated workforce planning system **FY 02:** Build and populate an automated workforce planning system based on work roles. - Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role. - Determine future skill and knowledge requirements. **FY 01:** New in 2002	**FY 03:** **FY 02:** **FY 01:** N/A	FAC6
Improve CMS's Management Structure	**FY 03:** (1) Implementation of a competency-based performance management system for managers (2) Implementation of an awards and recognition program for managers (3) Exploration of data sources **FY 02:** New in 2003	**FY 03:** **FY 02:** New in 2003	FAC7
Strengthen and Maintain Diversity at all Levels of CMS	**FY 03:** Increase representation of EEO groups in areas where they demonstrate underrepresentation **FY 02:** New in 2003	**FY 03:** **FY 02:** New in 2003 **FY 00:** EEO groups representing manifest imbalances in CMS workforce **(Baseline)**	FAC8
Increase awareness about the opportunity to enroll in the Medicare Savings Programs	**FY 03:** To be determined. We will increase awareness about Medicare Savings Program and set target based on FY 2002 baseline information **FY 02**: Develop baseline and set future targets	**FY 03:** **FY 02:**	FAC9

Performance Goals	Targets	Actual Performance	Ref.
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization			FAC10
Achieve greater administrative efficiency through consolidation of administrative function and reduction by of FTEs	**FY 03**: reduce by 93 FTE's	**FY 03:** **FY 02:** 4632 FTE Ceiling **(Baseline** 1/1/02**)**	
Achieve a more citizen-centered focus throurh organizational delayering.	**FY 03**: 4 layers	**FY 03:** **FY 02**: 5 layers **(Baseline, 1/1/02)**	

Performance Results Discussion

The CMS's Federal Administrative Budget funds a wide range of activities. Five key areas that fall under this category are: implementing the provisions of the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA); modernizing and strengthening CMS's information technology (IT) systems; improving systems security and workforce planning.

The provisions of the BBA, Balanced Budget Refinement Act (BBRA), and HIPAA made significant changes in CMS's programs. These changes were the largest the agency has seen since its inception. Two goals that support these provisions are to develop new Medicare payment systems and to ensure compliance with HIPAA.

Medicare Payment Systems - The goal to develop new payment systems in fee-for-service and Medicare+Choice measures our progress towards implementing prospective payment systems (PPSs) for skilled nursing facilities, home health agencies, hospital outpatient departments, inpatient rehabilitation facilities and psychiatric hospitals. Prospective payment for these services is expected to result in more efficient provision of care and lower costs to the Medicare program.

In FY 1998, CMS began implementing a PPS for skilled nursing facilities. In FY 2000 a PPS was implemented for hospital outpatient departments. On October 1, 2000, CMS implemented a PPS for home health and we expect to implement PPS for inpatient rehabilitation facilities in FY 2002. Additionally, CMS will begin developing a psychiatric hospital PPS in FY 2002. Risk-adjusted payments for Medicare+Choice plans were implemented January 1, 2000.

HIPAA Policy Form Reviews - Our FY 2001 goal to ensure compliance with HIPAA access, portability, and renewability requirements measures our progress towards reviewing insurance policy forms in those States that do not guarantee renewal of insurance coverage, have not passed appropriate laws, or do not substantially enforce them ("direct enforcement" States). These reviews determine if the contractual wording of the forms discloses certain protections mandated by HIPAA. We met our FY 2001

target of 60 percent. Since at this time only one State continues to rely on CMS for implementation of the original HIPAA law, and our workload has diminished, we are not continuing this goal in the future. The CMS continues to enforce amendments to HIPAA in several States.

Information Systems Security - The CMS has created a goal to improve its information systems security policies and practices enterprise-wide. An aggressive program involving updated policies, and increased oversight was initiated. The FY 2001 target was to achieve zero material weaknesses on the Electronic Data Process (EDP) portion of CMS's FY 2000 CFO report for both Central Office and Medicare contractor systems. The 2001 CFO audit reported one material weakness, CMS has developed and approved a protocol for this oversight, however it has not been fully implemented. At this time, training has been provided to approximately 20 percent of CMS employees through security conferences. A computer-based training (CBT) package will be deployed to all personnel. This program was prolonged due to a major rewrite to include section 508 of the Americans with Disabilities Act, therefore the FY 2001 target to have 95 percent of CMS employees receive security awareness training will carry over into 2002. In FY 2002 CMS will implement an intrusion detection capability and document an incident response procedure. We are confident the program will result in continued improvement in the security posture of CMS and are optimistic that future goals will be met.

Information Technology Architecture - Another critical IT area in addition to security is architecture. The information technology architecture goal is designed to track the development and implementation of an IT architecture framework. We made substantial progress toward reaching our FY 2001 targets to integrate ITA requirements into our internal project review process and develop standard configuration templates. These goals were not fully met due to staffing and budget shortfalls. The ITA has been integrated into the investment review process through CMS's Integrated IT Investment Management Roadmap effort. Architecture review checkpoints throughout the Roadmap are being used to support ITA decisions. The CIO Technical Advisory Board is already performing this review role (FY 2002 Target). The CMS has begun efforts to develop configuration templates (now being called "System Design Reference Models") for major systems and is expecting to complete six templates by March 2002. Use of these models will facilitate required System Development Life Cycle activities.

Workforce Planning - To meet the rising challenge of maintaining a workforce with the specific skills necessary to accomplish our goals, and in accordance with the President's Management priorities, CMS is instituting a systematic approach to assessing and addressing skills and knowledge needs. In FY 2000 CMS developed a competency catalogue of skills and knowledge required to accomplish Agency functions. This catalogue was used in FY 2001 to inventory current employee competencies.

Skill and knowledge gaps identified through this one-time data collection initiative were ranked by agency management, resulting in the identification of gaps in specific

knowledge and skills. In FY 2002, we will be implementing strategies to address the gaps in each of the seven knowledge and skill areas.

Design of an intranet-based system to house workforce planning data was also initiated in FY 2001. During FY 2002, the system is being built, populated, and brought on-line. Full implementation, expected in FY 2003, will give CMS data on knowledge and skill gaps that can be tracked over time.

Management Structure – CMS is developing a performance goal to improve our management structure. Through workforce planning, we have identified specific competency areas across the Agency that need to be targeted for improvement, including CMS's management and leadership. We will be focusing on activities such as recruitment and selection, performance management, awards and recognition, and continuous learning, to strengthen the leadership skills of our management. In FY 2003 we will explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of CMS's Leadership and Management Development Strategy (LMDS) activities.

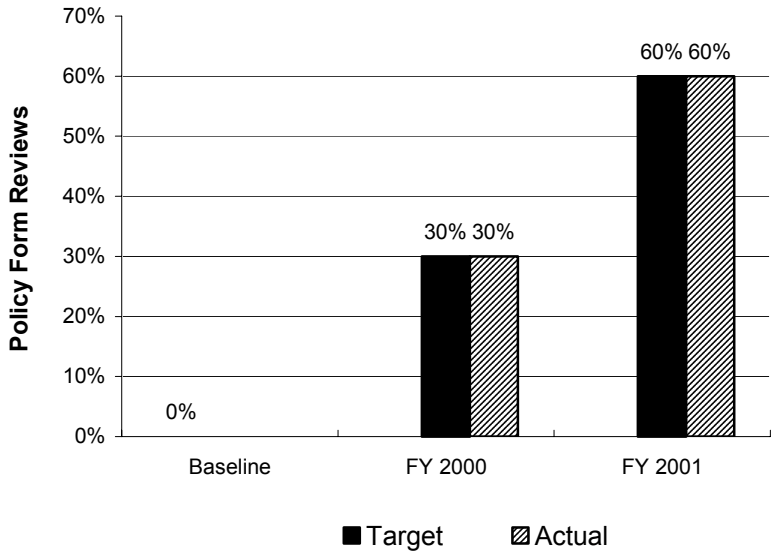
Workforce Diversity – We are committed to strengthening and maintaining a diverse workforce at all levels in CMS. To that end, we have developed a performance goal that captures ongoing efforts to reduce disparities among equal employment opportunity groups and foster an atmosphere that values diversity in the workplace.

Medicare Savings Programs - In the past CMS focused its efforts on increasing enrollment of dual eligible beneficiaries. Dual eligible beneficiaries are eligible for both the Medicare and the Medicaid programs. The goal to increase awareness about the opportunity to enroll in the Medicare Savings Programs will target the low-income Medicare beneficiary population. Initially this goal will focus on individuals who are eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs. In FY 2002 we will develop the baseline and set future targets to increase awareness. By FY 2003 we will increase awareness based on the target set in FY 2002.

Implement CMS Restructuring Plan – In support of the President's Management Agenda, CMS has developed a hiring plan and a restructuring plan. These priorities are reflected in a new goal focused on achieving greater administrative efficiency through consolidation of administrative functions and achieving a more citizen-centered focus through organizational delayering.

Performance Goal FAC1-01

Ensure Compliance with HIPAA Requirements through the Use of Policy Form Reviews



Discussion: Title I of the Health Insurance Portability and Accountability Act (HIPAA) contains the health insurance access, portability, and renewability standards which apply to self-funded and fully-insured group coverage, as well as to individual market coverage. HIPAA was enacted to promote access to health insurance coverage to people who had lost their insurance, often through job dislocation, or who were previously uninsurable because of their health status.

Some of HIPAA's standards, such as guaranteed renewal of insurance coverage, apply equally to coverage sold in all markets, while other standards do not. The Department of Health and Human Services (HHS), through CMS, is responsible for ensuring that States enforce HIPAA provisions with respect to issuers of coverage in the group and individual markets. If States do not have similar protections in place, do not pass appropriate laws, or do not substantially enforce them, CMS is required to take enforcement actions. In FY 2000 three States (Missouri, Rhode Island and California) failed to pass or substantially enforce appropriate laws regarding group and/or individual insurance. Therefore, CMS has been directly enforcing the HIPAA requirements in Missouri and Rhode Island in the individual and group markets; and enforced the HIPAA requirements in the individual market in California.

The policy form is a written document that represents the binding agreement of insurance between two or more parties. State insurance departments traditionally reviewed policy forms to ensure the contracts complied with appropriate laws and did not fail to disclose required benefits and rights afforded to the consumer. Since CMS has now assumed enforcement in several States, we must take on certain

responsibilities, which were previously conducted by the State including the review of policy forms. The policy form reviews will determine if the contractual wording of the forms fail to disclose certain protections afforded by HIPAA. If a policy form document fails to disclose certain rights to the consumer or excludes eligibility or benefits as required by HIPAA, CMS will advise the issuer to amend the contracts.

This goal was revised for FY 2001. Rhode Island and California enacted into law the protections set forth in HIPAA so CMS will no longer be reviewing policy forms in those States. Furthermore, by the end of Calendar Year 2000, CMS had determined that five States were not adequately enforcing amendments to HIPAA. Therefore, CMS began enforcing the Women's Health and Cancer Rights Act (WHCRA) in: Colorado, Massachusetts, North Dakota and Delaware; and the Newborns' and Mothers' Health Protection Act in Wisconsin. However, by the end of July 2001, North Dakota and Delaware enacted into law the protections set forth in WHCRA. Therefore, CMS's policy form review enforcement efforts are limited to Missouri, Colorado, Massachusetts, and Wisconsin.

WHCRA provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health insurance coverage and individual health insurance coverage. However, WHCRA does not require issuers to pay for mastectomies. If a health insurance issuer chooses to cover mastectomies, then the issuer is generally subject to the WHCRA requirements.) The Newborns' and Mothers' Health Protection Act of 1996 was signed into law on September 26, 1996. The law includes important new protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth.

The CMS Regional Offices will request issuers, which represent 60 percent (80 percent in FY 2002) of the market in both the group and individual market to submit their forms to them for review. If a company chooses not to correct its forms, we can take enforcement action, which includes imposing civil monetary penalties. At the end of FY 2001, CMS accomplished the 60 percent target in Colorado, Massachusetts and Wisconsin. The CMS had already exceeded the goal for Missouri, with a completion of over 90 percent of the market share. Since at this time only one State (Missouri) continues to rely on CMS for implementation of the original HIPAA law, and our workload has diminished, we are not continuing this goal past FY 2001.

Coordination: This goal requires significant coordination with the State insurance departments and the issuers. Achievement of the targets depends upon the cooperation of the State insurance departments to confirm premium volume in order to identify issuers that maintain a significant market share in the State. In addition, completing a policy form review will depend upon the timeliness of the submission of forms by the issuer and the attention given by the issuer to making the required revisions.

Data Source(s): The policy forms were submitted by the issuers. The primary data source to identify target issuers from whom to request such forms will be State

insurance departments and other State insurance regulatory agencies which confirm premium volume and market share. A second data source to confirm market share was the Statistical Compilation and Market Share Reports for Accident and Health Insurance Companies and Health Maintenance Organizations published by the National Association of Insurance Commissioners (NAIC).

Verification and Validation: The review of inquiries and complaints and the implementation of market conduct examinations was used to identify other policy forms that are being used by a target issuer and were not submitted for CMS's review.

Performance Goal FAC2-03

Develop and Implement an Information Technology Architecture

Baseline: The CMS use of Information Technology (IT) could not adequately support the future business needs of the Agency. We determined that the development of an improved Information Technology Architecture (ITA) was needed.
FY 2003 Target: Continue maturing the ITA, including further expansion of both breadth and depth, as opportunities and needs arise. Develop architectural support services for enterprise-wide use, for example, business process modeling or technology assessment.
FY 2002 Target: Continue development of policies and procedures required for implementation of the HCFA ITA and migration strategy. Complete development and integrate use of standard configuration templates, a.k.a., "System Design Reference Models," with major system development life cycle activities. Monitor ITA conformance as part of the IT Investment Review Process.
FY 2001 Target: Develop standard configuration templates for use in major system design efforts. Integrate the ITA conformance criteria into the IT Investment Review Process. **Performance:** Goal Partially Met-*First set of templates near completion, conformance criteria integrated into IT Investment Review Process.*
FY 2000 Target: Approve standards and policies for each of the 66 basic service areas identified in the HCFA ITA technical reference model. **Performance:** Goal Met - *All basic service areas approved, policies addressed as needed.*

Discussion: The CMS, as required by the Clinger-Cohen Act of 1996, is developing an integrated, enterprise-wide ITA that is aligned with CMS's strategic business objectives. The ITA will document the relationships between CMS's business and management processes and the technology that supports those processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support CMS's mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS's IT systems. The CMS's Chief Information Officer (CIO) has overall responsibility for the ITA, and has appointed an architect to oversee its development and implementation.

The CMS has developed an IT vision on which the target ITA will be based. Key elements of this vision are:

- a central "core" of well-managed databases;
- modular applications systems accessing the databases; and
- structured interfaces to facilitate access to the data in the core databases.

The CMS has completed the preliminary target architecture and migration strategy. As CMS continues to implement and mature this architecture and migration strategy, the Agency will begin to replace current, system-specific databases with new databases that have broad applicability across many systems. It will also redesign antiquated data systems and technology to take advantage of modern, more flexible programming languages. The result will be a systems environment that is more responsive to current

and future business demands, less expensive to maintain, and better able to support program operations and policy decision-making.

The CMS has developed an ITA metrics program to measure the implementation and effectiveness of the architecture. It includes two types of metrics: goal-based and process-based. The goal-based metrics relate to 1) ITA maturity; 2) awareness/compliance relative to the ITA; and 3) organizational impact of the ITA. Selected goal-based metrics will be used for GPRA reporting. The process-based metrics will be used by CMS for internal improvements to the ITA and related processes.

The CMS has begun its metrics program for GPRA reporting by measuring ITA maturity using the number of standards and preferred IT products the have been approved by the IT Council. Once a set of standards and preferred products has been established, it must be kept up to date. In order to ensure a periodic update, we will implement a process in which all standards and products will be reviewed on an 18-month cycle. In each fiscal year, then, two-thirds of the standards and products will undergo review and update. We will also be measuring the percent of completeness of activities designed to mature and implement the target ITA and migration strategy – activities such as: development of criteria to determine architecture compliance, creation of standard templates for use in establishing configurations of platforms and tools for software development projects, and integration of models and processes developed as part of the architecture into CMS's day –to-day activities.

Coordination: The CMS is coordinating the ongoing evolution of its architecture and migration strategy with other Department of Health and Human Services (HHS) representatives. This coordination occurs through regular meetings of the HHS CIO Council and its ITA Group.

Data Source(s): Approved standards and preferred IT products will be documented in the IT standards profile database, which is accessible through CMS's Intranet. Current work is underway to document all IT policies in a standard manner. Plans are to capture all these documented IT policies in a single repository. Procedures are in miscellaneous releases of guides and handbooks produced by the IT committees and CMS components. These will be accessible as part of the Roadmap activities. New procedures will be developed to accompany newly documented policies. Also, System Design Reference Models will be integrated into the Roadmap activities.

Verification and Validation: The ITA Committees, the CIO's Technical Advisory Board, and responsible CMS components will review the contents of the IT Standards Profile database and System Design Reference Models (once they are available) for accuracy.

Performance Goal FAC3-03

Improve CMS' Information Systems Security

Baseline: The 1997 OIG electronic data processing (EDP) audit for CMS's Central Office showed one material weakness and 31 reportable conditions; and four material weaknesses and 102 reportable conditions for Medicare contractor systems. In Central Office, there was a material weakness in the control of access to production data. In the contractor area, there was one material weakness in physical access and three in the control of local modifications or overrides to shared system applications and edits programs. Reportable conditions were found in all seven categories of evaluation.
FY 2003: Achieve zero material weaknesses in the EDP portion of the FY 2003 CFO audit. Implement improved access control management system. Conduct penetration testing and vulnerability assessments at a subset of Medicare contractors and CMS service providers. Include systems security reviews in Contractor Performance Evaluations (CPEs).
FY 2002: Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Evaluate the highest risk Medicare contractors' security profiles against a comprehensive baseline of security requirements. Begin to apply the comprehensive baseline of security requirements to CMS's business partners. Implement an intrusion detection capability and document an incident response procedure.
FY 2001: Achieve zero material weaknesses in EDP portion of the FY 2001 CFO audits. In addition, 95 percent of CMS employees will receive security awareness training; and CMS will complete site security reviews for its Medicare payment contractors. (Each contractor will be reviewed once every 3 years.) **Performance:** Goal not met, one material weakness.
FY 2000: Achieve, for both Central Office and Medicare payment contractor systems, zero material weaknesses in the EDP portion of the FY 2000 CFO audit. **Performance:** Goal not met, one material weakness being explored for closure.

Discussion: As CMS moves further into on-line activity, with increased business partners and technological complexity, the protection of confidential information becomes even more critical. The CMS is fully committed to fulfilling its stewardship responsibilities for the information contained in its data systems and transported across its networks.

The CMS developed a multiple year Medicare Contractor Systems Security Plan for FY 2000. This plan requires contractors to have comprehensive security programs covering administrative, physical and technical safeguards based on a current specific set of core requirements which include security requirements from OMB, GAO, IRS, Presidential Decision Directives (PDD) 63, and HIPAA. The CMS's strategy is to require Medicare payment contractors to implement policies, procedures, hardware and software in compliance with CMS core requirements and to develop security plans for each of their systems, conduct risk assessments and conduct annual compliance audits. Medicare payment contractors will also be required to certify systems security compliance as part of their annual internal controls certification and to develop and test business continuity and contingency plans.

In September 2000 a national security conference was held with all Medicare payment contractors to discuss the multiple year goals and objectives. This discussion provided contractors with the current core set of security requirements. In FY 2001, an analysis of the gap between the external systems security posture of the contractors and the core requirements will be completed. The CMS awarded an intrusion detection contract September 2001. An incident response procedure is in development.

The CMS's strategy is to complete the evaluation process of all other Medicare contractors over the next three to four years and to close the gaps identified. The evaluation process will be accomplished through Statement of Auditing Standards (SAS70) and Chief Financial Officers (CFO) reviews and CMS will then begin a comprehensive evaluation of the effectiveness of all contractor security activities.

In accomplishing the goals outlined above, CMS is ensuring that we are in compliance with the Government Information Security Reform Act (GISRA). GISRA underscores the activities of the agency.

Coordination: The scope of enterprise systems security spans across the data, applications, and infrastructure services supporting all of CMS's business areas. We have formulated a systems security management framework to achieve the systems security improvement goals systematically. The CMS's Office of Information Services will work with CMS internal/external business managers and data owners to assess current security posture, establish target positions, and formulate transition plans.

Data Source(s): The CMS will retain training documents, to include computerized documentation in support of Computer Based Training (CBT) for all CMS users, and copies of public service announcements. For the remaining portions of the target, OIG audit findings, CMS's review findings and associated corrective actions tracking database (under development) will be the primary data sources for the CFO audit portion of this goal.

Verification and Validation: Regarding security training, attendance records will be retained. Validation may be performed through checks of sign-in-sheets. Audit and review findings are reviewed by information security personnel and verified by systems owners.

Performance Goal FAC4-03

Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice

Baseline: Prior to the enactment of the BBA of 1997, SNFs, HHAs, hospital outpatient services, inpatient rehabilitation services and psychiatric hospitals were paid on a cost reimbursement basis (although certain limits applied). Payments to managed care plans were not risk-adjusted (did not reflect variations in per capita costs based on health status of beneficiaries).
FY 2003 Target: Continue design of PPS system for psychiatric hospitals. Begin the combined collection of both inpatient and ambulatory data for the implementation of an improved Medicare+Choice risk adjustment methodology in CY 2004.
FY 2002 Target: Implement PPS systems for inpatient rehabilitation services during FY 2002. Design PPS systems for psychiatric hospitals. An improved risk adjustment model will be developed for implementation in CY 2004 and data systems will be implemented to capture both inpatient and ambulatory data.
FY 2001 Target: Implement PPS systems for HHA services October 1, 2000. Risk adjusted payments to M+COs will continue to be made based on the PIP-DCG model; and the collection of inpatient data will continue in FY 2001. **Performance:** Goal met. The HHA PPS final rule was effective October 1, 2000.
FY 2000 Target: Implement PPS for hospital outpatient services. Make risk adjusted payments under Medicare+Choice. Publish final PPS regulation for HHA. **Performance:** Goal met. Risk adjusted payments began January 1, 2000 and hospital outpatient department PPS was implemented August 1, 2000. HHA PPS final rule published July 3, 2000.
FY 1999 Target: Establish methodology for SNF PPS and establish risk adjuster methodology for Medicare+Choice. **Performance:** Goal met.

Discussion: The Balanced Budget Act (BBA) of 1997 requires the development of a number of prospective payment systems (PPS) in traditional Medicare and a risk adjustment methodology for payments to Medicare+Choice plans. The categories of providers or services that are to be paid on a prospective basis include skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation hospital services, and services provided in hospital outpatient departments. The Balanced Budget Refinement Act (BBRA) of 1999 requires the development of a PPS for psychiatric hospitals.

Prior to enactment of the BBA, SNFs, HHAs, hospital outpatient services, and inpatient rehabilitation hospital services were paid on a cost reimbursement basis (though certain limits applied). Prior to enactment of the BBRA, psychiatric hospitals also were paid on a cost reimbursement basis. Prospective payment for these services is expected to result in more efficient provision of care, and lower costs to the Medicare program. With regard to payments to Medicare+Choice plans, CMS, the Congressional Budget Office, and numerous researchers have found that, because of the relatively better health of Medicare Health Maintenance Organization (HMO) enrollees, the pre-BBA payment

methodology can result in higher costs than fee-for-service Medicare. Based on BBA requirements, the Secretary implemented a risk adjustment methodology, on January 1, 2000, that accounts for variations in per capita costs based on health status. The Medicare, Medicaid and SCHIP Benefits Improvement Protection Act (BIPA) of 2000 further mandates that the risk adjustment methodology starting in 2004 should be based on data from inpatient hospital and ambulatory settings (Section 603).

Coordination: The CMS will work closely with its payment contractors in carrying out this goal.

Data Source(s): Required regulations and/or notices must be published in final in time to implement each provision.

Verification and Validation: We intend to further refine and improve the payment methodologies on a continuous basis. The CMS will use data and studies to determine appropriateness of the payment systems with a view towards continuous refinement.

Performance Goal FAC6-03

Improve CMS's Workforce Planning

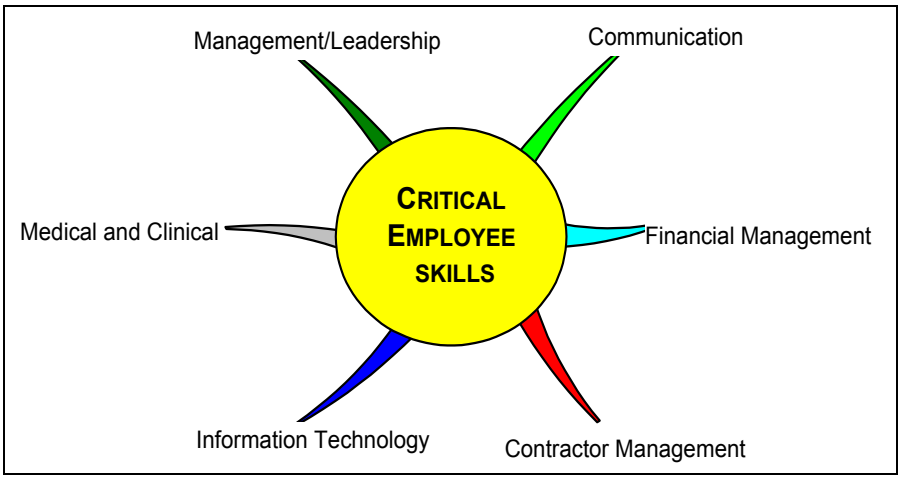
Baseline: Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2003.
FY 2003 Target: Fully implement automated workforce planning system, including updating previously collected data and establishing a knowledge and skill level baseline.
FY 2002 Target: Build and populate an automated workforce planning system based on work roles. - Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role. - Determine future skill and knowledge requirements.

Discussion: Over the years, CMS's programs, structures, and workforce have changed significantly. Today, the organization faces a series of unprecedented business and environmental challenges, which have major implications for CMS's workforce. These challenges demonstrate a need to determine and address gaps in necessary skills and knowledge. The challenges are listed below:

(1) Financial Resources: Increased accountability for programmatic outcomes more closely linked to the budget;
(2) Legislation: Major modifications to our programs as a result of legislation;
(3) Human Resources: Aging workforce and increased competition for skilled workers;
(4) Agency-wide Restructuring: New skills are required as CMS restructures itself to become more responsive to citizens and other stakeholders.
(5) Increased Stakeholders: Increased program support to partners and stakeholders as beneficiary demographics change and demands grow;
(6) Customers: The CMS's transition from a traditional role as payer and regulator into a broader role as an active market presence;
(7) Technology: Rapid advancements in technology resulting in difficulty obtaining, developing, and retaining technology-related skills; and
(8) Health Care Delivery: Rapid changes in medical practices and technology, requiring new and dynamic methods of oversight and regulation.

Given these challenges, and in accordance with the President's Management Plan, CMS is creating a dynamic workforce planning system to help managers make strategic plans and decisions for hiring/staffing, retention, and human resources development. The CMS workforce planning model will: (1) analyze current and future work; (2) develop a current and future competency framework; (3) identify existing workforce competencies; and (4) conduct an analysis of gaps between current and future requirements and existing workforce skills and knowledge. This four-phase process will be supplemented with retirement, retention, and demographic analyses. This data serves as the basis for several action plans, including recruitment plans, succession plans, learning plans, and staffing/redeployment plans.

A gap is defined as the level of a skill or knowledge required in carrying out the agency's mission now or in the future, minus the level of that skill or knowledge available in the current workforce. During FY 2000, CMS leadership identified the following six broad competency areas as long-term priority workforce planning needs:



During FY 2001, CMS employees completed a Knowledge and Skills Inventory, identifying their current level of skills and knowledge as well as the levels required in their current positions. Skill and knowledge gaps identified through this one-time data collection initiative were ranked by agency management based on breadth, depth, and criticality for accomplishing CMS's strategic goals. This ranking resulted in the identification of gaps in specific knowledge and skills in each of the six areas listed above, as well as one cross-cutting skill (project management).

In FY 2002, we will be implementing strategies to address the gaps in each of the seven knowledge and skill areas. The level of skill or knowledge in these targeted areas will be increased by strategic activities to recruit, develop, retain, and/or redeploy employees. These activities will be evaluated to determine their effectiveness in increasing knowledge or skills. In future years, the automated workforce planning system will be used to determine changes in workforce knowledge and skills.

Design of an intranet-based system to house workforce planning data was initiated in FY 2001. During FY 2002, the system is being built, populated, and brought on-line. Full implementation, expected in FY 2003, will give CMS data on knowledge and skill gaps that can be tracked over time.

Coordination: Workforce planning is being done in accordance with guidelines and standards of the Department of Health and Human Services, the Office of Management and Budget, the Office of Personnel Management, and the General Accounting Office. The CMS is working with the American Federation of Government Employees, Local 1923, which represents staff.

C^2 Technologies, Inc. and the American Institutes for Research are developing the automated workforce planning system through the Office of Personnel Management's

training management assistance services. Within CMS, the Office of Internal Customer Support is coordinating with the Office of Information Services to implement the system.

Data Source(s): Beginning in FY 2003, an intranet-based workforce planning system will house data on the number of full-time equivalents (FTEs) performing each of CMS's business functions and roles, the skills and knowledge required to carry out the functions and roles, and the skills and knowledge of current CMS staff. Employees and managers will be able to access and update information on themselves or their organizations. This system, when operational, is expected to provide the data for periodic reports on the status of the agency's skill and knowledge requirements.

Verification and Validation: All CMS staff will be expected to provide data on skill and knowledge levels; sampling will not be used. The automated workforce planning system will allow for managerial validation of skill and knowledge data and employee validation of data provided by managers. The data for the automated system is being collected using standard job analysis and other behavioral science techniques, which include validation procedures.

Performance Goal FAC7-03

Improve CMS's Management Structure

Baseline: Developmental.
FY 2003 Target: **(1)** Performance Management: Full implementation of a competency-based performance management system for non-Senior Executive Service (non-SES) managers. **(2)** Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results. **(3)** Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Discussion: The CMS faces a number of human resource challenges in the next several years, including the increasing number of managers eligible for retirement. In order to address this challenge, we have had to reevaluate the development and growth of our managers. Like many other Federal agencies, CMS has often chosen managers based upon their technical expertise with little emphasis on their leadership skills. The CMS has initiated a Leadership and Management Development Strategy (LMDS) to build proficiency in the disciplines of leadership and management by developing systems and practices that promote a high standard of leadership throughout the Agency.

The LMDS is based on a set of five competencies, encompassing 28 related skills. The five competencies are based on those used by the Office of Personnel Management for members of the Senior Executive Service. The intent is to build proficiency throughout the Agency in the disciplines of management and leadership by developing systems and practices that promote a high standard of leadership that is both results-oriented and customer-focused. These proficiencies will enable CMS managers to become better stewards of the programs entrusted to the Agency by the public. The LMDS addresses a wide range of activities, including performance management and awards and recognition, which comprise our FY 2003 targets, along with recruitment and selection and continuous learning, which are efforts that are already in progress.

Recruitment and Selection

Many Government managers are often selected on the basis of their personal technical expertise, without emphasis on demonstrated leadership skills. Novice managers who do not receive timely training and mentoring for their new roles often continue to function as technical leads with a few added administrative duties.

In 1999, CMS introduced a new process, on a pilot basis, for recruiting and selecting managers based on the five managerial competencies—managing change, leading people, producing results, managing resources, and partnering/building coalitions. Working from the list of 28 competency-related Knowledge Skills and Abilities (KSAs), selecting officials chose the KSAs that were most important for the position being filled, with all five managerial competencies being represented, in addition to technical KSAs, specific to a CMS program or function. In this way, a balance was maintained between the desired technical and managerial selection criteria. Full

implementation of the competency-based recruitment and selection process for non-SES managers is targeted to occur in February 2002.

Performance Management

Performance management (planning and appraisal) systems fulfill five organizational purposes: 1) linking individual performance to the organization's mission and objectives; 2) defining what constitutes acceptable performance; 3) measuring and evaluating individual performance; 4) relaying information about current performance back to individuals to shape their future performance; and 5) providing information to related management systems (such as compensation or succession planning).

The CMS is working to introduce a performance planning and appraisal system for non-SES managers that will encourage managers to discuss, develop and apply the managerial competencies. One of our targets is to have this performance management system fully developed in FY 2003.

Awards and Recognition

Any attempt to implement a competency-based approach to management must recognize all competencies, both programmatic and managerial. To support competency-based recruitment & hiring and performance management, CMS will develop an awards and recognition program for non-SES managers in FY 2003.

Continuous Learning

Using a managerial competency-based model for management is the foundation for improved recruitment and selection, performance management, and awards and recognition for CMS managers.

To that end, CMS has identified a core set of classroom learning opportunities that will help managers, both new and established, acquire and become proficient in basic management skills. The initial set of courses was first offered in FY 2001, and we continue to identify additional courses and other learning opportunities. In FY 2002 we will revise requirements to make the core management learning opportunities mandatory for probationary managers, and to make a reasonable number of continuing management education classes mandatory in each year after completion of probation for all managers.

Once we have implemented the various pieces of the LMDS, we will explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of these activities.

Coordination: The goal to Improve CMS's management structure is being conducted in accordance with a modified approach used by the Office of Personnel Management for members of the Senior Executive Service. All activities in this regard are undertaken with the concurrence of the LMDS Advisory Panel and the CMS Leadership Development and Recognition Board.

Data Source(s): Developmental. CMS will explore data sources to develop a baseline and targets in FY 2003.

Verification and Validation: Developmental. The selected CMS managerial competencies were validated in the Agency under contract with Wilson Learning.

Performance Goal FAC8-03

Strengthen and Maintain Diversity at all Levels of CMS

Baseline: Comparing the CMS Workforce with the National Civilian Labor Force (CLF), in FY 2000, there were Equal Employment Opportunity (EEO) groups which exhibited manifest imbalance in the CMS workforce.
FY 2003 Target: Increase the representation of EEO groups in areas where they demonstrate underrepresentation.

Discussion: Workforce diversity has evolved from sound public policy to a strategic business imperative. Federal diversity initiatives have historically focused on equal employment opportunity (EEO) and affirmative employment. The Federal Government must now broaden its view of diversity. We must embrace the business, cultural, and demographic dimensions of diversity as well as the legal dimension. Focusing on diversity and looking for more ways to be a truly inclusive organization--one that makes full use of the contributions of all employees--is not just a nice idea; it is good business sense that yields greater productivity and competitive advantage. Diversity management programs are recognized as being a critical link in achieving the agency's specific mission or business needs, relative to employees, customers, suppliers, and other stakeholders. This is the business case for valuing diversity.

The business case for diversity has two significant elements. First, the labor market has become increasingly competitive. We must use every available source of candidates to ensure that we have the high-quality workforce needed to deliver our mission to the American public. It is an intangible asset for an organization to have a good public perception. Being recognized as an organization that values diversity contributes to a positive image which in turn will attract the best and the brightest employees. As the value of diversity continues to grow in the business community and elsewhere, recruiting and retaining talented employees who are diverse is becoming even more important to an organization's success. Second, the changing demographics of America mean that the public served by CMS is also changing. When we recruit and retain an inclusive workforce--one that looks like the America we serve--and when individual differences are respected, appreciated, and valued, diversity becomes an organizational strength that contributes to achieving results. A byproduct of capitalizing on differences is creativity. Historically, some of the most creative periods in civilization have emerged when people of different backgrounds had contact. Employees from varied backgrounds can bring different perspectives, ideas and solutions to use in strategic planning, problem solving, and decision making. It enables us to better serve the taxpayer by reflecting the customers and communities we serve.

All Federal agencies strive for "parity"4 with the Civilian Labor Force. By doing so, we ensure the diversity we seek, since the Civilian Labor Force is comprised of persons

4 Parity exists when an EEO group's Agency workforce representation is equal to the Civilian Labor Force.

age 16 and over, excluding those in the armed Forces, who are employed or seeking employment.

Workforce diversity is characterized along a continuum of 1) parity, 2) near parity, 3) manifest imbalance and 4) conspicuous absence.5 On the road to achieving parity in its workforce, CMS must first reduce the manifest imbalances that currently exist.

Federal agencies are required by regulation to monitor the representation of all EEO groups each year and to report Agency activities and accomplishments to the Equal Employment Opportunity Commission and the Office of Personnel Management (OPM). Strategies that will bring improvement include: communicating the Agency leadership's strong commitment to diversity, workforce planning, conducting effective outreach and recruitment, utilizing hiring flexibilities, maintaining a supportive work environment, providing development and training opportunities (upward mobility programs), monitoring activities and making adjustments as needed, establishing accountability, reward success and continuously educate and communicate the value of diversity.

Coordination: Department of Health and Human Services; Equal Employment Opportunity Commission; OPM (Federal Equal Opportunity Recruitment Program (FEORP)); Department of Labor, Office of Disability Employment Policy; State Vocational Rehabilitation Agencies; national colleges and universities (including Historically Black Colleges and Universities, Hispanic Serving Institutions, and Tribal Colleges and Universities); Federal Asian Pacific American Council; Organization of Chinese Americans; National IMAGE; League of United Latin American Citizens, National Council of LaRaza; National Hispanic Leadership Conference; National Society of Hispanic MBAs; Blacks in Government; National Association for the Advancement of Colored People; National Congress of American Indians; and Association of American Health Plans, Minority Management Development Program.

Data Source(s):

- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 1990 official decennial census figures6
- The 1990 official decennial census figures
- OPM's Central Personnel Data File (updated every pay period)
- HHS' Workforce Inventory Profile System (WIPS) (updated every pay period)
- CMS Workforce Profiles (prepared using (WIPS)

5 Conspicuous Absence occurs when an EEO group's Agency workforce representation is between 0 and 20% of the Civilian Labor Force.

6 EEOC Office of Public Sector Programs requires agencies to use current, official Census Bureau Civilian Labor Force data to calculate under-representation indices. The Census Bureau is in the process of analyzing 2000 census data by occupation category and code. The Census Bureau estimates that verification and validation will be completed in 2003 and that official figures will be available in late 2003.

Verfication and Validation:

- 1990 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 1990 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.
- CMS Workforce Profiles - Validated and verified by CMS.

Performance Goal FAC9-03

Increase Awareness of the Opportunity to Enroll in the Medicare Savings Programs

Baseline: To be determined.
FY 2003 Target: To be determined. We will increase awareness of Medicare Savings Programs and set target based on the FY 2002 baseline.
FY 2002 Target: Develop baseline and set future targets.

Discussion: Although Medicare provides beneficiaries with a basic set of health benefits, the beneficiaries still are required to pay a significant amount out-of-pocket for premiums, deductibles and co-insurance. These costs can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance. This performance goal will seek to increase awareness of State programs that can assist low-income Medicare beneficiaries with their Medicare cost-sharing expenses.

The State programs enacted to help Medicare beneficiaries with their cost-sharing expenses include, among others, Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), and Qualifying Individual (QI).

In the initial years of this endeavor, we will emphasize awareness to individuals who are eligible for the QMB and SLMB programs. These programs were enacted to help low-income Medicare beneficiaries with their Medicare cost-sharing expenses. States are required to pay for the premiums, deductibles, and cost sharing for QMBs. For SLMBs, they are required to pay for the Part B premium. Despite the existence of these programs, a substantial proportion of individuals eligible for these programs are not enrolled (two recent studies estimated non-participation rates for QMB to range from 40-60 percent).

Since enactment of the QMB and SLMB provisions, CMS has undertaken a number of outreach initiatives directed at identifying and enrolling potential eligibles. These efforts include publishing and distributing an information brochure. These brochures are distributed to local senior centers and other community organizations through the State Health Insurance Assistance Programs (SHIPs). The *Medicare&You* handbook includes information about the programs, and provides a toll-free telephone number for beneficiaries to call for more information. In addition, CMS has conducted special targeted mailings to new Medicare beneficiaries who appear to meet the income criteria of the QMB program.

CMS also has provided interested States with identifying information about newly eligible Medicare beneficiaries who are potential candidates for the State programs. In order to achieve our goal we are working with States, the advocacy community, and other interested parties to develop a comprehensive strategy to increase awareness about

Medicare Savings Programs. This strategy will include an analysis of the effectiveness of these current activities as well as identification of new interventions that will be implemented as part of the FY 2003 performance plan.

Coordination: CMS has conducted a number of activities in the area of outreach in partnership with other Federal agencies, States, providers, and community organizations. These activities included: direct mailings to beneficiaries; grants to State Health Insurance Assistance Programs (SHIPs); States; and ombudsman and information intermediaries for outreach. In FY 2002, CMS will continue to use various channels of communications and information intermediaries to increase Medicare beneficiary awareness about the opportunity to enroll in programs that might be able to assist them with their Medicare cost-sharing expenses. Outreach strategies will only be able to be fully realized through the continuation of the partnerships that have been formed with other Federal agencies, such as the Social Security Administration and the Health Resources and Services Administration.

Data Source(s): The primary source of data on beneficiary awareness of the Medicare Savings Programs will be the Medicare Current Beneficiary Survey (MCBS). The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. The MCBS includes questions that ask beneficiaries about their awareness of programs that are open to seniors and persons with disabilities who have limited financial resources and need help paying Medicare-related costs. The measure will only include low-income beneficiaries. Current MCBS data are being analyzed to establish a baseline and to determine targets.

The questions are in a "yes," "no," and "don't know" format. For ethical reasons, after asking questions, MCBS interviewers will make the correct answers to the questions available to the respondents (beneficiaries cannot inadvertently be left with any misperceptions about the program). Therefore, the act of surveying these respondents would confound subsequent measurement of their awareness of the program features. Sampled beneficiaries remain in the MCBS for 3 years and then rotate out of the survey. Thus, each year about one-third of the overall MCBS sample is new and two-thirds are returning. To avoid instrumentation bias, the measure will only include new MCBS members. This new part of the MCBS sample is itself nationally representative of the Medicare population.

Verification and Validation: All data from the MCBS are carefully edited and cleaned prior to the creation of analytic data files. Sample weights will be prepared that allow adjustments to survey estimates to account for differential probabilities of selection in the MCBS sample, under-coverage, and differential patterns of survey non-response. Statistical precision will be calculated and presented with the estimates.

Performance Goal FAC10-03

Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization

Baseline: CMS FY 2002 FTE Ceiling of 4632 and up to five management levels in the organization as of January 01, 2002.
FY 2003 Target: 1. Achieve greater administrative efficiency through consolidation of administrative functions and reduction by 93 FTEs. 2. Achieve a more citizen-centered focus through organizational delayering, from five layers to four, in nine CMS groups.

Discussion: In support of the President's Management Agenda, the Secretary has directed Department of Health and Human Services (DHHS) to consolidate administrative functions (e.g., budget & finance; information technology; procurement & grants management; public affairs; and legislative affairs) for all Operating Divisions (OPDIV) to achieve greater administrative efficiency. The CMS is supporting the consolidation of public affairs and legislative functions within DHHS, resulting in a transfer of 63 full-time equivalents (FTEs) from CMS to the Office of the Secretary. Additionally, CMS will reduce FTE usage by 93 in FY 2003 (from the projected FY 2002 usage) through other miscellaneous initiatives designed to increase administrative efficiency.

In response to the Assistant Secretary for Administration and Management directive of November 8, 2001, CMS has developed and submitted to DHHS a Hiring Plan for Fiscal Year 2002, and a Restructuring Action Plan to achieve the restructuring objectives for administrative efficiency and delayering. Through these plans, we plan to further our goal of creating a more citizen-centered, diverse, high quality workforce at all levels of the Agency.

In general, all CMS administrative functions, such as budget and financial management, human resource management, public affairs, and legislative affairs are already consolidated at the OPDIV level, except where sound business reasons dictate otherwise. Many of the specific steps detailed in the Action Plan refine current business operations of consolidated functions to improve efficiency and service delivery. For example, we will create an effective Agency-wide information technology (IT) project review and IT investment system with centralized IT policies and oversight by the Chief Information Officer (CIO) that will govern all IT initiatives. Where financial operations occur outside the direct line authority of the Chief Financial Officer (CFO), the Agency's Financial Management and Investment Board (FMIB), which reports directly to the Chief Operating Officer and Deputy Administrator, has financial oversight responsibility. Also, we will restructure the CMS Human Resources Management Group in FY 2002 to separate the HR strategic consulting function from the classification and staffing operations to better evaluate competitive sourcing, shared servicing, and automation options.

We have identified all organizations in which we have more than the target level of four management layers for the Agency, and have developed plans and organization charts for achieving the goal of four management levels. Moreover, we have identified and plan to eliminate many of the double deputies that presently exist in the Agency. We are confident this will help us achieve a more citizen-centered focus and will complement many of the other citizen-centered initiatives already in place within CMS.

The number of FTEs reduced through streamlining/consolidation activities will be measured. The CMS organization structure will be used to determine the target of four management levels. We will compare the difference between CMS's FY 2002 baseline FTE ceiling of 4632 and the number of management levels in the organization as of January 1, 2002 to the actual levels achieved for both of these data sources by the end of FY 2003.

Coordination: The goal to implement a CMS Restructuring Plan to create a more citizen-centered organization is being coordinated with the Office of the Assistant Secretary for Administration and Management, in support of the President's Management Agenda.

Data Source(s): The CMS Employment Status Report, which tracks FTE ceiling, gains and losses will be used to measure FTE reduction. The CMS Organizational charts will determine the target for organizational delayering.

Verification and Validation: Internal checks of the information are regularly performed.

Research, Demonstration, and Evaluation

Research, Demonstration, and Evaluation	FY 2000 Actual	FY 2001 Enacted	FY 2002 Appropriation	FY 2003 Estimate
Total Budget Authority	**$61.8 M**	**$138.3 M**	**$117.2 M**	**$28.4 M**

The Research, Demonstration and Evaluation program supports CMS's role as a beneficiary-centered purchaser of the highest quality health care at the lowest possible cost. The CMS performs, coordinates, and supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of CMS's programs on its beneficiaries, providers, States, and other customers. This role requires the development, implementation and evaluation of a variety of innovative, new demonstration projects as well as expanded efforts to evaluate the effectiveness of CMS's current programs. These research responsibilities include evaluations of the Medicare and Medicaid programs and the State Children's Health Insurance Program.

Other representative goals that fit under this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-03)
- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice (FAC4-03)

Performance Goal	Targets	Actual Performance	Ref.
Assess the relationship between CMS research investments and program improvements	**FY 03:** Conduct internal and external assessments **FY 02:** Conduct internal and external assessments **FY 01:** Repeat internal assessment; conduct initial external review **FY 00:** Conduct internal and external assessments **FY 99:** Develop goal for FY 2000	**FY 03:** **FY 02:** **FY 01:** Internal assessment and external review completed (Goal met) **FY 00:** First internal assessment conducted; External review delayed **FY 99:** Goal developed (Goal met)	R1

Performance Results Discussion

Research - Assessing the impact of research and demonstration activities is challenging. In many cases the anticipated effects of such efforts are long-term outcomes. In addition, proving a direct correlation between a research intervention and

a given result can be very difficult, particularly in the field of health care where multiple variables can cloud the analysis.

Many lessons were learned as we conducted our first internal assessment of CMS's research in FY 2000. Due to some important issues that were raised during the baseline assessment, we chose to make some improvements to our internal methodology before having our assessment reviewed by an external panel. While this delay meant that the first external assessment was not conducted during FY 2000, we have learned valuable lessons for improving the goal for the future.

The FY 2001 Internal Assessment Report was completed in August 2001, and the first external review was conducted during September 2001. All agency components with projects funded through the R&D budget contributed to the Internal Assessment Report, which was compiled into a 27-page report and a 70-page appendix. Four prominent external researchers reviewed the Internal Assessment. They provided comments on the overall composition of the R&D agenda and made recommendations for improving future assessments.

Overall, the reviewers found our characterization of the accomplishments and limitations in each research area to be accurate. One reviewer described it as "a systematic, thoughtful effort that balances taking credit where credit is due with acknowledging limitations and distinguishing between internal and external barriers to effectiveness." Another reviewer found it "a methodical review of CMS research – useful in understanding how CMS has approached its research responsibilities and for assessing future research needs."

We are planning to continue the same cycle in FYs 2002 and 2003. We will take the recommendations of the external reviewers into account as we proceed with the next round of internal and external assessments.

Performance Goal R1-03

Assess the Relationship between CMS Research Investments and Program Improvements

FY 2003 Target: Repeat internal and external assessments.
FY 2002 Target: Repeat internal and external assessments.
FY 2001 Target: Repeat internal assessment. Conduct initial external review. **Performance:** Goal met – internal assessment and external review completed.
FY 2000 Target: The baseline internal performance assessment will be conducted between August 1999 and February 2000. For this initial year, the external review of the internal assessment will be carried out between February and August 2000. **Performance**: Goal partially met - internal assessment conducted; first external review delayed.
FY 1999 Target: Develop a goal. **Performance:** Goal met.

Discussion: The purpose of CMS's research program is to provide CMS and the health care policy community with objective analyses and information to foster improvement in CMS programs and to guide the Agency in its future direction. The CMS's research and development (R&D) functions are to develop, test and implement new health care financing policies and to monitor and evaluate the impact of CMS's programs on its beneficiaries, providers, States, and other customers and partners. In addition, CMS's research program produces a body of knowledge that is used by Congress, the Executive Branch, and the States to improve the efficiency, quality, and effectiveness of the Medicare and Medicaid programs.

A regular systematic review and assessment of CMS's research program is important to ensure that CMS's beneficiaries obtain maximum benefits from R&D spending. The CMS's performance on this goal is measured using a formal annual internal assessment that is reviewed and evaluated by external experts. The internal assessment is dovetailed with the development of the 2-year research plan and budget, which involves consultation with all CMS components regarding their research needs. In turn, each CMS component with projects in the research budget will be responsible for performing the internal assessment of their projects.

An initial internal assessment was completed in March 2000. This assessment was organized in terms of the six themes of the FY 2000 CMS Research Plan (Medicare Health Plans: Enrollment, Delivery, and Payment; Provider Payment and Delivery Innovations in Traditional FFS Medicare; Future of Medicare; Outcomes, Quality, and Performance; Vulnerable Populations, Medicaid, and Dual Eligibles; and Cross-Cutting R&D activities). The key product of the assessment was a theme-by-theme list of accomplishments and limitations that provides a snapshot of CMS's portfolio of research projects -- including projects CMS has discretion over and those that are

mandated by Congress. During FY 2001, the internal review process was refined to involve all agency components with R&D projects funded through the R&D budget. The 2001 Internal Assessment was completed in August 2001.

We did not conduct an external review during FY 2000, but elected to postpone the initial external review pending refinement of the internal review process. The first external review was conducted during September 2001. Four prominent external researchers reviewed the Internal Assessment Report. They provided comments on the overall composition of the R&D agenda and made recommendations for improving future assessments.

Overall, the reviewers found our characterization of the accomplishments and limitations in each research area to be accurate. One reviewer described it as "a systematic, thoughtful effort that balances taking credit where credit is due with acknowledging limitations and distinguishing between internal and external barriers to effectiveness." Another reviewer found it "a methodical review of CMS research – useful in understanding how CMS has approached its research responsibilities and for assessing future research needs."

Coordination: Coordination of CMS R&D activities with other Federal and State organizations, non-profit research foundations, colleges and universities, private research firms, research components of trade organizations, and advocacy groups takes place regularly on a variety of levels. The CMS staff regularly participates in the annual conferences of groups such as the American Public Health Association and the Association for Health Services Research, as well as professional meetings of social science associations. These contacts are important in defining CMS's R&D agenda, avoiding duplication of effort, stimulating research on CMS issues by researchers outside of CMS, and generally increasing the productivity of CMS R&D.

Data Source(s): The CMS developed an assessment report for evaluating its research efforts. Data sources used for this report include the CMS R&D Plan, legislation that mandates CMS research activities, and other documents produced under CMS research, demonstration, and evaluation projects.

Verification and Validation: The application of research effectiveness criteria combines internal self-assessment and review by external experts. All CMS components responsible for research and demonstration projects are involved in the self-assessment process. The external experts are drawn from highly credible researchers familiar with both CMS programs and the national scope of health care research.

PART III – APPENDIX TO THE PERFORMANCE PLAN

A.1 Approach to Performance Measurement

CMS's Performance Measurement Philosophy

The CMS performance measurement philosophy grows out of its overriding commitment to secure high quality, high value health care for its beneficiaries. Given the nature and size of CMS's programs, its approach to performance measurement includes a strategy of selecting performance goals that are significant and representative of program performance. All goals align with the new (FY 2001-2006) HHS and CMS Strategic Plans. The CMS Annual Performance Plan (APP) includes a mix of outcome, output, and process goals, although all goals are closely tied to program outcomes.

Data Issues

The CMS uses many data systems to measure its performance on GPRA goals. Each goal in the APP contains a section on data verification and validation and describes any limitations of the data sources. Relying on a number of administrative and survey data systems presents certain difficulties and vulnerabilities. For example, there are inherent time lags between the actual data submission, data compilation, and the due dates for report submissions. Goals for which data are not yet available will be included in a subsequent Annual Performance Report.

The CMS conducts comparisons across similar data systems where practical to ensure validity and reliability of data sources. For example, under performance goal MB1-03 (a goal to improve Medicare beneficiary satisfaction with services), the Medicare Consumer Assessment of Health Plans Study (CAHPS) is used to assess beneficiary satisfaction with health plans. We will check the consistency of CAHPS data with similar data from the Medicare Current Beneficiary Survey. Another approach we employ to ensure data quality is the use of consistency edits. For example, the On-line Survey and Certification and Reporting (OSCAR) data system (used to measure the prevalence of restraints in nursing homes) measures State-to-State and facility-to-facility variation within data elements. Our experience has shown that these variations have been relatively constant, resulting in national measurements with high reliability.

In addition to data already available through CMS systems, CMS's APP relies on survey data, evaluations, and special studies conducted by other Federal agencies. The CMS relies on these agencies to verify and validate their data. External data sources enable us to conserve resources by minimizing duplication of effort. Since most of these surveys, studies, and audits are conducted for multiple purposes, refinements of methods and definitions that strengthen data collection for one purpose may weaken the usefulness of the information of CMS's performance measurement under GPRA. If a data source changes in a manner that diminishes its appropriateness for our performance measure or a better data source is identified, we will evaluate our approach. For

instance, in our mammography goal, we are now using Medicare claims data since the National Health Interview Survey did not include institutional-based beneficiaries.

A.2.a Changes In Annual Performance Plan (APP) Goals

GPRA Performance Goals by Budget Category	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Medicare Benefits					
Improve satisfaction of Medicare beneficiaries with the health care services they receive. (Beginning FY 2001: the goal includes data from disenrollees.)	● ✓	● ✓	● ✓	✓	✓
Increase health plan choices available to Medicare beneficiaries removed in FY 2001 to focus on areas under CMS's control.	○ ✓	● ✓			
Enroll beneficiaries into managed care plans timely. FY 2002-2003: Process Medicare+Choice Organization elections in compliance with the BBA beneficiary election provisions.	○ ✓	● ✓	● ✓	✓	✓
Improve Medicare's administration of the beneficiary appeal process.		○ ✓	○ ✓	✓	✓
Improve beneficiary understanding of basic features of the Medicare program.			● ✓	✓	✓
Quality of Care: Peer Review Organizations					
Improve heart attack survival rates.		Ⓟ ✓	Ⓟ ✓	✓	✓
Increase the percentage of Medicare beneficiaries age 65 & older who receive an influenza vaccination. (Beginning FY 2001: lifetime pneumococcal vaccination included and data source changed from NHIS to Medicare Current Beneficiary Survey to include institutional based beneficiaries.)	● ✓	● ✓	Ⓟ ✓	✓	✓
Increase the percentage of Medicare beneficiaries age 65 & older who receive a mammogram. (Beginning FY 2001: data source changed from NHIS to Medicare claims data to include institutional based beneficiaries.)	● ✓	Ⓟ ✓	Ⓟ ✓	✓	✓
Increase the rate of diabetic eye exams.			Ⓟ ✓	✓	✓
Quality of Care: Survey & Certification					
Decrease the prevalence of restraints in nursing homes.	● ✓	● ✓	Ⓟ ✓	✓	✓
Decrease the prevalence of pressure ulcers in nursing homes.		● ✓	Ⓟ ✓	✓	✓
Improve the management of the Survey and Certification budget development and execution process.			● ✓	✓	✓
Grants to States for Medicaid/Medicaid Agencies					
Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance.	● ✓	● ✓	○ ✓		
Work with States to develop Medicaid program performance goals. (Beginning FY 2000 increase the percentage of Medicaid two-year old children who are fully immunized.)	● ✓	● ✓	● ✓	✓	✓
Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.	● ✓	● ✓	● ✓	✓	
Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.			○ ✓	✓	✓
Improve health care quality across the Medicaid and State Children's Health Insurance Program (SCHIP) through the CMS/State Performance Measurement Partnership Project.					✓
State Children's Health Insurance Program					
Decrease the number of uninsured children by working with States to implement SCHIP and increase enrollment of eligible children in Medicaid.	● ✓	● ✓	● ✓	✓	✓

GPRA Performance Goals by Budget Category	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Clinical Laboratory Improvement Amendments (CLIA)					
Improve laboratory-testing accuracy. (Beginning FY 2000 sustain improved laboratory testing accuracy.)	● ✓	● ✓	Ⓟ ✓	✓	✓
Medicare Integrity Program					
Reduce the percentage of improper payments made under the Medicare fee-for-service program.	● ✓	● ✓	Ⓟ ✓	✓	✓
Develop and implement methods for measuring program integrity outcomes.			● ✓	✓	✓
Improve the effectiveness of program integrity activities through the successful implementation of the Comprehensive Plan for Program Integrity. Goal will be completed in FY 2001.			Ⓟ ✓		
Increase the ratio of recoveries identified to audit dollars spent. (Discontinued after FY 2000 due to data source concerns.)		● ✓			
Increase Medicare Secondary Payer liability & no-fault dollar recoveries. Focus changed beginning FY 2001 to increase Medicare Secondary Payer credit balance recoveries and/or decrease recovery time.		● ✓	● ✓	✓	✓
Assess program integrity customer service.				✓	✓
Improve the provider enrollment process.				✓	✓
Improve the efficiency of the medical review of claims. Goal discontinued, focus change from quantity to quality.		○ ✓			
Reduce the percentage of Medicare home health services provided for which improper payment is made.	● ✓	Ⓟ ✓			
Medicare Operations					
Improve beneficiary telephone customer service.		○ ✓	● ✓	✓	✓
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.		● ✓	● ✓	✓	✓
Increase the use of electronic commerce/standards in Medicare.	● ✓	● ✓	○ ✓	✓	✓
Maintain CMS's improved rating on financial statements.	● ✓	● ✓	Ⓟ ✓	✓	✓
Improve CMS oversight of Medicare fee-for-service contractors.			● ✓	✓	✓
Increase referral of eligible delinquent debt for cross servicing.				✓	✓
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service. (In FY 2000, represented under M+C User Fee)			● ✓	✓	
Ensure millennium compliance (readiness) of CMS computer systems.	● ✓	● ✓			
Improve effectiveness of dissemination of Medicare information to beneficiaries through the National *Medicare&You* Education Program. (Beginning FY 2001: fee-for-service component split as a new goal under Medicare Operations) **(Moved from the Medicare+Choice User Fee budget category)**		● ✓	● ✓	✓	✓
Federal Administrative Costs					
Ensure compliance with HIPAA requirements through the use of policy form reviews.		● ✓	● ✓		
Develop and implement an information technology architecture.		● ✓	○ ✓	✓	✓

GPRA Performance Goals by Budget Category	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Improve CMS's information systems security.		○ ✓	○ ✓	✓	✓
Develop new Medicare payment systems in fee-for-service and Medicare+Choice.	● ✓	● ✓	● ✓	✓	✓
Improve CMS's workforce planning.				✓	✓
Improve CMS's management structure.					✓
Strengthen and maintain diversity at all levels of CMS.					✓
Increase awareness about the opportunity to enroll in the Medicare Savings Programs.				✓	✓
Implement CMS Restructuring Plan to create a more citizen-centered organization.					✓
Research, Demonstration, and Evaluation					
Assess the relationship between CMS research investments and program improvements.	● ✓	○ ✓	● ✓	✓	✓

✓ **Goal in identified year**
○ **Goal not met or partially met**
Ⓟ **Final data pending**
● **Goal met**

A.2.b Revised Final FY 2002 GPRA Annual Performance Plan Goals

Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive MB1-02

Original Baseline

Developmental. Managed Care: Baseline data for beneficiaries disenrolled from their managed care plan will become available in FY 2001 (this survey was fielded in Fall 2000). These data will be combined with Consumer Assessment of Health Plans Survey (CAHPS) data for current enrollees to get a complete picture of plan performance.
Fee-for-Service: Baseline data will become available in FY 2001. The CAHPS FFS survey was fielded in Fall 2000.

Revised Final Baseline

FY 2001 Managed care - (a) Getting needed care for illness or injury: In 2000, about 90.5 percent of beneficiaries enrolled in a Medicare managed care plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: In 2000, about 83.7 percent of beneficiaries enrolled in a managed care plan reported that it was not a problem to see a specialist that they needed to see.

FY 2001 Fee-for-service (FFS) - (a) Getting needed care for illness or injury: In 2000, about 92.8 percent of beneficiaries enrolled in the Original Medicare FFS health plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: In 2000, about 82.8 percent of beneficiaries enrolled in the Original Medicare FFS health plan reported that it was not a problem to see a specialist that they needed to see.

Original FY 2002 Target

Developmental. Managed care: Develop new baselines/future targets including data from disenrollee survey.
FFS: Develop baselines/future targets based on survey results.

Revised Final FY 2002 Target

Managed Care - Continue efforts to achieve by the end of CY 2004, (a) 93 percent of beneficiaries enrolled in a Medicare managed care plan will report that they could usually or always get care for illness or injury as soon as they wanted. (b) 86 percent of beneficiaries enrolled in a managed care plan will report that it was not a problem to see a specialist that they needed to see. These efforts include: (1) continue to collect MMC-CAHPS and Disenrollee data and make available to Medicare managed care plans, Medicare Quality Improvement Organizations (QIOs), and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice.
FFS - Continue efforts to achieve by the end of CY 2004, (a) about 95 percent of beneficiaries enrolled in the Original Medicare FFS health plan will report that they could usually or always get care for illness or injury as soon as they wanted. (b) 85

percent of beneficiaries enrolled in the Original Medicare FFS health plan will report that it was not a problem to see a specialist that they needed to see. These efforts include: (1) continue to collect MFFS-CAHPS data and make available to Medicare QIOs and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice.

Rationale
With regard to the managed care portion of this goal, disenrollee data, available in FY 2001, was added to the population of managed care enrollees in order to get a more accurate picture of plan satisfaction. Survey data for FFS beneficiaries also just became available in FY 2001 so that baselines could be set and targets developed. The goal was revised accordingly.

Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions MB3-02

Original FY 2002 Target
Developmental. Develop a target that measures CMS system performance for processing enrollments/disenrollments in compliance with the lock-in provisions of the BBA.

Revised Final FY 2002 Target
Develop a target that measures performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA.

Rationale
To better measure performance, we will not only measure enrollments and disenrollments with respect to the lock-in period, we will also measure plan benefit package election data, which also must comply with the lock-in period mandated by BBA.

Improve Medicare's Administration of the Beneficiary Appeals Process MB4-02

Original Baseline: Developmental. Baseline data collection for M+CO appeals will begin in FY 2001 and continue through FY 2002. Baseline data collection for FFS will begin in FY 2001.

Revised Final Baseline
Developmental. Baseline data collection for M+CO appeals will begin in FY 2002 and continue through FY 2003.

Original FY 2002 Target: Developmental.
M+CO: Begin collecting data to establish baseline.
FFS: A pilot program is under consideration to analyze FFS appeal data already collected from fiscal intermediaries and carriers.

Revised Final FY 2002 Target
Developmental.
M+CO: Issue OPL with reporting instructions.
FFS: Evaluate CMS's FFS appeal data needs and capabilities
Rationale
M+CO data collection will not begin until January 2003 due to a delay in developing the data collection system.
The Benefits Improvement and Protection Act (BIPA) mandates new appeals process which will change the requirements for FFS data collection.

Increase the Percentage of Medicare Beneficiaries Age 65 Years and Older Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal QP2-02

Original FY 2002 Targets
The original FY 2002 target for receipt of annual vaccination for influenza was 73. The original target for receipt of lifetime vaccination for pneumococcal pneumonia was 65 percent.

Revised Final FY 2002 Targets
The revised FY 2002 target for receipt of annual influenza vaccination is 72 percent. The revised FY 2002 target for receipt of lifetime vaccination for pneumococcal pneumonia is 66 percent.

Rationale
Both these revisions are based on updated projections to our data-based model for these immunizations from the latest data (2000) from the Medicare Current Beneficiary Survey (MCBS). In the case of influenza vaccination, we adjusted our FY 2002 target downward, while the pneumococcal projections informed an increase in our FY 2002 target.

Increase the Rate of Diabetic Eye Exams QP4-02

Original FY 2002 Goal
Increase the diabetic eye exam rate in Medicare diabetic population (18-75) to 69.5 percent (original 1997-1999 baseline = 68.5 percent).

Revised Final FY 2002 Baseline and Target
Revise the 1997-99 baseline from 68.5 to 67.8 percent. Revise FY 2002 target to 68.6 percent.

Rationale
Due to a recently discovered programming error we have adjusted the baseline from 68.5 to 67.8 percent. This error affected approximately one-third of the States and

derived a biennial eye exam rate on an incomplete cohort of beneficiaries. The FY 2002 target was adjusted accordingly.

Improve the Management of the Survey and Certification Budget Development and Execution Process QSC3-02

Original FY 2002 Target
To be determined.

Revised Final FY 2002 Target
Allocate the FY 2002 State Survey and Certification budget using the price based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.

Rationale
This goal is no longer developmental, and the FY 2002 target was set.

Improve Access to Care for Elderly & Disabled Medicare Beneficiaries who do not have Public or Private Supplemental Insurance MMA1-02

Original FY 2002 Goal
To be determined.

Goal Refocused - Rationale
Overall CMS has been successful in increasing enrollment of elderly and disabled beneficiaries who do not have public or private supplemental insurance known as "dual eligibles". In FY 2002 we will replace this goal with a goal, to "Increase awareness about the opportunity to enroll in the Medicare Savings Programs" (FAC9-02). The goal will target the low-income Medicare beneficiary population and initially focus on individuals who are eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs. In FY 2002 we will develop the baseline and set future targets to increase awareness.

Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates MMA4-02

Original FY 2002 Target
Developmental. We will assess the pilot studies initiated by two States in FY 2001 to determine the target for FY 2003.

Revised Final FY 2002 Target
The initial pilot studies will occur during FY 2002 and FY 2003. We will work with five or six pilot States to construct and conduct payment accuracy measurement studies. The preliminary data gathered from these five or six States will be used to begin refining payment accuracy methodologies and assess the feasibility of constructing a single methodology that could be used by all States and to construct a method of estimating a national rate.

Rationale
Funding was not available for implementation of the pilot, however CMS would like to begin this effort.

Increase the Use of Electronic Commerce/Standards in Medicare MO3-02

Original FY 2002 Target
(a)Maintain FY 2001 EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after October 2002 when Health Insurance Portability and Accountability Act (HIPAA) standards are implemented throughout the industry. (b) Complete baseline data for electronic claims status, electronic eligibility inquiries, ERA and EFT transactions. (c) Complete implementation and testing, at Medicare contractor sites of the HIPAA Electronic Data Interchange (EDI) standards for the following Medicare transactions: electronic claims and coordination of benefits, ERA, eligibility inquiries and response, and claims status inquiry and response.

Revised Final FY 2002 Target
(a) Maintain EMC level of 97 percent for intermediaries and 81 percent for carriers. We anticipate that EMC levels will not rise until after FY 2003 when Health Insurance Portability and Accountability Act (HIPAA) standards are implemented throughout the industry. (b) Complete implementation and testing, at Medicare contractor sites of the HIPAA Electronic Data Interchange (EDI) standards for the following Medicare transactions: electronic claims and COB, and the ERA. Begin implementation activities for the eligibility inquiries and response, and claims status inquiry and response transactions.

Rationale
The Secretary is encouraged to adopt further standards as warranted, and is also required to periodically adopt updates to or replacements for the previously published standards.

Improve CMS Oversight of Medicare Fee-for-Service Contractors MO5-02

Original FY 2002 Target
Developmental

Revised Final FY 2002 Target
Building on experience of FY 2001 and continuing towards goal of National uniform contractor evaluation.

Rationale
This is a developmental goal following a timeline to reach a National uniform contractor evaluation.

Ensure Compliance with HIPAA Requirements through the Use of Policy Form Reviews FAC1-02

Original FY 2002 Goal
Ensure Compliance with HIPAA Requirements Through the Use of Policy Form Reviews: Percent of insurers which have had their policy forms reviewed in direct enforcement States (Target: 80 percent).

Goal Discontinued - Rationale
Since the inception of this goal, only one State continues to rely on CMS for implementation of the original HIPAA law. Because this workload has diminished so significantly, we are no longer retaining it as a GPRA goal.

Develop and Implement an Information Technology Architecture FAC2-02

Original FY 2002 Target
Continue development of policies and procedures required for implementation of the CMS ITA and migration strategy. Complete developing and begin integrating the use of standard configuration templates with major system development life cycle activities. Monitor ITA conformance as part of the IT Investment Review Process.

Revised Final FY 2002 Target
Continue development of policies and procedures required for implementation of the CMS ITA and migration strategy. Complete developing and begin integrating the use of standard configuration templates, a.k.a., "System Design Reference Model," with major system development life cycle activities. Monitor ITA conformance as part of the IT Investment Review Process.

Rationale
Standard configuration templates have been named System Design Reference Model.

Increase CMS's Information Systems Security FAC3-02

Original FY 2002 Target
Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Evaluate the highest risk Medicare contractors' security profiles against a comprehensive baseline of security requirements. Begin to apply the comprehensive baseline of security requirements to CMS's business partners.

Revised Final FY 2002 Target
Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Evaluate the highest risk Medicare contractors' security profiles against a comprehensive baseline of security requirements. Begin to apply the comprehensive baseline of security requirements to CMS's business partners. Implement an intrusion detection capability and document an incident response procedure.

Rationale
Intrusion detection capability and document response procedure added.

Improve CMS's Workforce Planning FAC6-02

Original FY 2002 Target
Developmental. Our target will be to reduce the gap between the current and targeted levels of skills and knowledge.

Revised Final FY 2002 Target
Build and populate an automated workforce planning system based on work roles.

- Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role.
- Determine current and future skill and knowledge requirements.

Rationale
In FY 2001 we had initially intended to determine baselines and targets for FY 2002 using the FY 2001 Knowledge and Skills Inventory data. However, the Internet survey instrument was too time-consuming to repeat on a regular basis. We will reassess the knowledge and skill levels of CMS employees using a new Intranet inventory based on work roles. This automated workforce planning system will enable us to collect data for baselines and targets more consistently and efficiently.

Meanwhile, CMS has taken actions to increase skills in areas targeted for improvement via recruitment, development, retention, and/or redeployment. We have also initiated plans to evaluate skill increases resulting from these interventions.

Increase Awareness About the Opportunity to Enroll in the Medicare Savings Program FAC9-02

New FY 2002 Goal

The goal to increase awareness about the opportunity to enroll in the Medicare Savings Programs will target the low-income Medicare beneficiary population and initially focus on individuals who are eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs. In FY 2002 we will develop the baseline and set future targets to increase awareness.

Rationale

Overall CMS has been successful in increasing enrollment of elderly and disabled beneficiaries who do not have public or private supplemental insurance.

A.3 Linkage to HHS and CMS Strategic Plans

A key concept underpinning the GPRA law is the close linkage of an agency's strategic plan, performance plan, and its budget. The next few pages illustrate the linkages of the FY 2003 Annual Performance Plan goals to the new FY 2001-2006 DHHS Strategic Plan and the CMS Strategic Goals.

LINK OF FY 2003 CMS PERFORMANCE GOALS AND THE FY 2001-2006 HHS STRATEGIC PLAN

FY 2003 APP Performance Goal	DHHS Strategic Plan Goal*					
	1	2	3	4	5	6
Medicare Benefits						
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services			✓	✓		
Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions			✓			
Improved Medicare's Administration of the Beneficiary Appeals Process			✓	✓		
Improve Beneficiary Understanding of Basic Features of the Medicare Program			✓			
Quality of Care: Peer Review Organizations						
Improve Heart Attack Survival Rates			✓	✓		
Increase Percentage of Beneficiaries Age 65+ Years Who Receive Annual Vaccinations for Flu and Lifetime Pneumococcal	✓	✓	✓	✓		
Increase the Percentage of Beneficiaries Age 65+ Who Receive a Mammogram		✓	✓	✓		
Increase the Rate of Diabetic Eye Exams		✓	✓	✓		
Quality of Care: Survey & Certification						
Decrease the Prevalence of Restraints in Nursing Homes		✓	✓	✓		
Decrease the Prevalence of Pressure Ulcers in Nursing Homes		✓	✓	✓		
Improve the Management of the Survey and Certification Budget Development and Execution Process		✓	✓	✓		
Grants to States for Medicaid/Medicaid Agencies						
Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized	✓	✓	✓	✓		
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates			✓			

FY 2003 APP Performance Goal	DHHS Strategic Plan Goal*					
	1	2	3	4	5	6
Improve Health Care Quality Across the Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project			✓	✓		
State Children's Health Insurance Program						
Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid		✓	✓			
Clinical Laboratory Improvement Amendments (CLIA)						
Sustain Improved Laboratory Testing Accuracy				✓		
Medicare Integrity Program						
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Services Program			✓			
Develop and Implement Methods for Measuring Program Integrity Outcomes			✓			
Increase Medicare Secondary Payer Credit Balance Recoveries and/or Decrease Recovery Time to Recoup Dollar Recoveries			✓			
Assess Program Integrity Customer Service			✓			
Improve the Provider Enrollment Process			✓			
Medicare Operations						
Improve Beneficiary Telephone Customer Service			✓			
Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements			✓			
Increase the Use of Electronic Commerce/Standards in Medicare			✓			
Improve CMS's Rating on Financial Statements			✓			
Improve CMS Oversight of Medicare Fee-for-Service Contractors			✓			
Increase Referral of Eligible Delinquent Debt for Cross Servicing			✓			
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries through the National *Medicare&You* Education Program			✓	✓		
Federal Administrative Costs						
Develop and Implement an IT Architecture			✓			
Improved CMS's Information Systems Security			✓			
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice			✓			
Improve CMS's Workforce Planning			✓			

FY 2003 APP Performance Goal	DHHS Strategic Plan Goal*					
	1	2	3	4	5	6
Improve CMS's Management Structure			✓			
Strengthen and Maintain Diversity at all Levels of CMS			✓			
Increase Awareness About the Opportunity to Enroll in the Medicare Savings Programs			✓	✓		
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization			✓			
Research, Demonstration, and Evaluation						
Assess the Relationship between CMS Research Investments and Program Improvements			✓			✓

* DHHS Strategic Goals
Goal 1 -- Reduce the Major Threats to the Health and Productivity of All Americans
Goal 2 -- Improve the Economic and Social Well-being of Individuals, Families and Communities in the United States
Goal 3 -- Improve Access to Health Services and Assure Integrity of the Nation's Health Entitlement and Safety Net Programs
Goal 4 -- Improve the Quality of Health Care and Human Services
Goal 5 -- Improve the Nation's Public Health Systems
Goal 6 -- Strengthen the Nation's Health Sciences Research Enterprise

Linking CMS's Performance Goals to CMS's Strategic Goals

Protect and improve beneficiary health and satisfaction.

- Improve satisfaction of Medicare beneficiaries with health care services they receive.
- Improve heart attack survival rates.
- Increase the percentage of Medicare beneficiaries age 65 years & older who receive an annual influenza vaccination & lifetime vaccination for pneumococcal.
- Increase the percentage of Medicare beneficiaries age 65 years & older who receive a mammogram.
- Increase the percentage of Medicaid two-year-old children who are fully immunized.
- Decrease the number of uninsured children by working with States to implement SCHIP & by enrolling children in Medicaid.
- Increase the rate of diabetic eye exams.
- Improve health care quality across the Medicaid and State Children's Health Insurance Program (SCHIP) through the CMS/State Performance Measurement Partnership Project

Promote the fiscal integrity of CMS programs and be an accountable steward of public funds.

- Improve CMS's rating on financial statements.
- Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program.
- Develop & implement methods for measuring program integrity outcomes.
- Increase Medicare Secondary Payer credit balance recoveries and/or decrease recovery time to recoup dollar recoveries.
- Increase referral of eligible delinquent debt for cross servicing.
- Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring & ultimately reducing Medicaid payment error rates.
- Assess program integrity customer service.
- Improve the provider enrollment process.

Purchase the best value health care for beneficiaries.

- Decrease the prevalence of restraints in nursing homes.
- Decrease the prevalence of pressure ulcers in nursing homes.
- Improve management of Survey & Certification budget development & execution process.

Promote beneficiary and public understanding of CMS and its programs.

- Improve effectiveness of dissemination of Medicare information to beneficiaries through the National *Medicare&You* Education Program.
- Improve Medicare's administration of the beneficiary appeal process.
- Improve beneficiary understanding of basic features of the Medicare program.
- Increase awareness about the opportunity to enroll in the Medicare Savings Programs.

Provide leadership in the broader public interest to improve health.

- Sustain improved laboratory testing accuracy.
- Assess the relationship between CMS research investments & program improvements.

Foster excellence in the design and administration of CMS's programs.

- Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions.
- Improved beneficiary telephone customer service.
- Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.
- Improve CMS's oversight of Medicare fee-for-service contractors.
- Develop & implement information technology architecture.
- Improve CMS's information systems security.
- Increase the use of electronic commerce/standards in Medicare.
- Develop new Medicare payment systems in FFS & Medicare+Choice.
- Improve CMS's workforce planning.
- Improve CMS's management structure.
- Strengthen and maintain diversity at all levels of CMS.
- Implement CMS Restructuring Plan to create a more citizen-centered organization.

A.4 Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning, and Program Evaluation

Linking Performance Measurement to the CMS Budget

We have taken care to ensure that major budget categories, including both program benefits and program administration funds, have adequate coverage in the APP. Our performance plan and report are organized by budget category to provide a linkage of performance goals, program activities and dollar amounts. These linkages ensure that in setting performance goals, CMS selects goals that are representative of the full range of Agency activities and resources.

Linking Performance Measurement to Cost Accounting

We select the performance goals in CMS's APP based on the fact that, collectively, they broadly represent the work of the Agency. Where appropriate, explicit cost linkages exist. In other cases explicit cost linkages are not made, but activities are linked to budget categories as explained above. The CFO clean opinion goal shows our commitment to clear and complete accounting for funds across the Agency.

Linking Performance Measurement to Information Technology (IT) and Capital Planning

Capital investment, primarily in the form of technology, supports all of CMS's strategic goals. The CMS technology investments are funded through the Agency's annual Information Technology (IT) budget, which in turn is funded from several of CMS's accounts.

We have continued to include information technology planning in the FY 2003 APP in our goal to develop and implement an information technology architecture, as required by the Clinger-Cohen Act of 1996 and in alignment with CMS's strategic business objectives. We believe implementation of the full process must be phased to be fully successful, and our performance goal reflects that approach.

Performance Measurement Linkages with Program Evaluation

The CMS performs, coordinates, and supports research and demonstration projects (through studies, contracts, grants, and waivers) to develop and implement new health care financing policies and to evaluate the impact of CMS's programs on beneficiaries, providers, States, Tribes, and other customers and partners. The scope of CMS's research, demonstration, and evaluation activities embrace all areas of health care relevant to CMS programs: costs, access, quality, service delivery models, and financing approaches.

The CMS has planned several program and demonstration evaluations over the next 5 years and beyond to assess our strategies for improving our programs. Findings from

our demonstration evaluations will be used to help CMS plan for the future of our programs and modify strategies for accomplishing our APP and strategic goals. We have included in our APPs a performance goal, which directly assessed our research and demonstration activities.

We consider the evaluation work of others, such as the Office of Inspector General, the General Accounting Office, and the Medicare Payment Advisory Commission, in developing our performance plan. Findings from evaluation by these entities have influenced our choice of performance measures, including the Medicare fee-for-service error rate goal and our goal to stratify the Medicare payment error rate to strengthen our ability to target problem areas.

The CMS strongly emphasizes its priorities in its performance plans. Though CMS is still in the early stages of GPRA reporting, the process is already having an effect on the management of our programs as indicated in the reports. Future reporting, which over time will reveal trends, will increase the usefulness of the GPRA process in the management of CMS's programs.

A.5 Developmental Goals Timeline

Some of our goals are labeled "developmental" goals. We include these goals in our plan to show our commitment to certain priorities while acknowledging the challenges of developing a specific, measurable goal.

Process Beneficiary Medicare+Choice Organization Elections in Compliance with the BBA Lock-in Provisions (MB3-03)

FY 2001
- Complete systems requirements for BBA lock-in provisions.
- Develop design for implementing lock-in provisions into managed care systems.

FY 2002 (last quarter)
- Begin GPRA goal data collection
- Develop methodology for calculating GPRA goal target and supporting data.

Improve Medicare's Administration of the Beneficiary Appeal Process (MB4-03)

FY 2000
- Clearance process developed for collecting appeals data from Medicare+Choice organizations due to additional burden.
- Have a system in place for collection of managed care appeal data.
- Operational Policy Letter (OPL) requiring appeals data.

FY 2001
- OPL published April 27, 2001.

FY 2002
- Issue OPL with reporting instructions for M+COs.
- Evaluate CMS's FFS appeal data needs and capabilities.

FY 2003
- Begin data collection of appeals for Medicare+Choice organizations.

Improve Beneficiary Understanding of Basic Feature of the Medicare Program (MB5-03)

FY 2001
- Incorporated questions into the Medicare Current Beneficiary Survey to measure this area.

FY 2002
- Future targets will be developed pending the availability of baseline data in early CY 2002.

Increase the Percentage of Medicaid Two-Year-Old Children who are Fully Immunized (MMA2-03)

FY 1999
- Goal did not exist. This was an FY 1999 goal to work with States to develop a Medicaid performance goal, which resulted in this goal.
- First group of States (Group I) identified.
- Group I States worked with CMS, along with technical assistance from CDC, to begin developing State-specific definitions and methodologies for measuring fully immunized Medicaid two-year-olds.
- The CMS and CDC provided ongoing guidance and technical assistance to the first wave of States, including conference calls, site visits and meetings.

FY 2000
- Group I States established baselines by end of FY 2000.
- Group II States identified.
- Group II States began to work with CMS (with technical assistance from CDC) to develop State-specific definitions and methodologies.

FY 2001
- Group I States will measure their immunization rate for the first time at the end of FY 2001 using the same methodology they used for their baseline in FY 2000.
- Group II States will continue to develop methods and will establish their baseline for immunization of two-year-old Medicaid children by end of FY 2001.
- Group III States will be identified for participation.
- Group III will begin work together with CMS (with technical assistance from CDC) to develop State-specific definitions and methodologies.

FY 2002
- Group I States will measure their immunization rate for the second time using the same methodology they used for their baseline in FY 2000.
- Group II States will measure their immunization rate for the first time using the same methodology they used for their baseline in FY 2001.
- Group III States will continue to develop methods and will establish their baselines.

FY 2003
- All groups scheduled to report.
- Group I States to report on their 3-year targets.

A CMS/State Performance Measurement Project to Improve Health Care Quality Across Medicaid and State Children's Health Insurance Program (MMA5-03)

FY 2003
- CMS and States will identify initiatives for improving health care delivery and/or quality, and an accompanying GPRA goal(s).

- For each GPRA goal, CMS and States will design their quality improvement strategies and specify the measures for gauging improvement.

FY 2004
- Baseline data will be collected from States; data reporting and methodological processes will be refined.
- Implementation of the targeted quality improvement programs will commence.

FY 2005-06
- Re-measurement will occur.
- New quality improvement cycle begins.

FY 2007
- Evaluation and Final Report.

Assess Program Integrity Customer Service (MIP6-03)

FY 2002
- Conduct survey of beneficiary and provider customer service satisfaction. Surveys will be mailed to participants in October 2001.
- Analyze data from surveys to develop targets and baselines. Baseline projections will be used to develop a training curriculum. Training will be provided in FY 2002.

FY 2003
- Conduct an assessment of the effectiveness of the training provided in FY 2002.

Improve Beneficiary Telephone Customer Service (MO1-03)

FY 1999-FY 2000
- The CMS developed standard definitions, calculating methodology, quality call monitoring process and tools, and a caller satisfaction survey process to be used by all the carriers in collecting data to set baselines and targets for accessibility, quality, and satisfaction standards.

FY 2000
- Carriers began using new definitions, processes and tools.
- Based on lessons learned, refined quality reporting tool.

FY 2000-FY 2002
- Data are being collected on accessibility, quality, and satisfaction measures to be available by the end of FY 2002.
- Baselines and future targets will be set by the end of FY 2002.

Improve CMS Oversight of Medicare Fee-For-Service Contractors (MO5-03)

FY 2000

- To improve accountability within the regional offices for contractor management and oversight, and to strengthen the reporting relationship between Central Office and the regions, CMS consolidated the leadership responsibility for the regional office management of contractors within each Consortium by establishing the Consortium Contractor Management Officer.
- Completed conforming organizational changes for the Central Office management and oversight components.
- Retained an outside consultant to assist in the development of a CPE Continuous Improvement Program, an operational framework for improving CPE. This framework reflects distinct CPE planning and execution cycles.
- Developed, pilot tested and implemented a structured, documented risk assessment protocol to assure that limited evaluation resources are applied to CMS priorities.
- Conducted a CPE Lessons Learned Conference for Regional and Central Office staff to share the FY 1999 CPE experience and plan future improvements. More than 80 regional office and 30 Central Office staff participated in this conference.
- Increased the number of national team reviews to 74.
- Issued the national review strategy 3 months earlier than in previous year.
- Increased the number of national standardized CPE review protocols developed from 7 to 13.
- Trained CPE reviewers on each of the protocols; videotaped the training and provided copies to each regional office.
- Issued 39 annual Reports of Contractor Performance, covering all contractors, 4 months earlier than in the previous year.
- Conducted in-depth internal control reviews at 25 contractors.
- Increased the intensity and frequency of follow-up in Corrective Action Plans and Performance Improvement Plans.
- Increased oversight of Accounts Receivable; every contractor was reviewed during FY 2000.
- Improved CPE management reporting through the development of a national CPE management information database.
- Undertook a comprehensive updating to CPE guidance contained in the Regional Office Manual (ROM).

FY 2001

- Evaluated and further refined the risk analysis methodology.
- Evaluated, further improved and continued to develop national review protocols.
- Developed a comprehensive set of clear and measurable contractor performance standards.
- Completed development of and implemented a national CPE database to provide management information on the progress of CPE 2001.

- Performing pre-issuance quality assessment of review reports to ensure greater consistency.
- Started reviews in the first quarter of FY 2001.
- Conducted a national Lessons Learned Conference for over 150 reviewers.
- Performed pre-issuance quality assessment of review reports to ensure greater consistency.
- Completed and issued rewrite of CPE portion of the Regional Office Manual.
- Issued eleven CPRstras providing real time CPE operational policy guidance.
- Implemented a contractor rebuttal process.
- Began development of a training curriculum for CPE reviewers.
- Provided feedback on performance by business function to Central Office program managers.
- Issued 37 annual FY 2000 Reports of Contractor Performance to the CEO's of each corporation serving as a Medicare contractor.

FY 2002

- Incorporating further improvements to the risk assessment process to adopt a 3-year review cycle.
- Will conduct basic auditing training to over 200 reviewers.
- Will conduct a national Lessons Learned Conference.
- Planning further improvements to national review protocols.
- Planning training on all CPE review protocols. (October – December)
- Planning to begin reviews earlier in the year.
- Subject to funding and staff, increase the number of RO-CO/ Multi-Regional Teams.
- Planning further enhancements to the CPE national database.
- Plan to issue thirty-six FY 2001 Reports of Contractor Performance on an earlier schedule than the FY 2000 reports.
- Planing to keep a core of RO-CO review team members together (where feasible) on all reviews they conduct.
- Changed terminology used to classify negative CPE findings to be in line with terminology of the Federal Acquisition Regulations.

Improve CMS's Workforce Planning (FAC6-03)

FY 2000

- CMS developed a competency catalogue of skills and knowledge required to accomplish Agency functions.

FY 2001

- Using this catalogue, CMS inventoried current employee competencies.
- We intended to determine baselines and targets for FY 2002 using the inventory data. However, the inventory was too cumbersome to ask staff to complete in the same format in the future. Instead, CMS:

- Identified several specific gaps critical to meeting strategic goals.
- Began actions to increase skills in these areas – via recruitment, development, and/or redeployment.
- Initiated design of a dynamic, Intranet-based system to house workforce planning data.

FY 2002

- CMS will build, populate, and install an Intranet-based system to house and track workforce planning data.
- CMS will monitor and evaluate actions taken to increase targeted skill areas.
- CMS will determine future knowledge and skill requirements.
- CMS will define work roles and assign each position in the agency to a work role.

FY 2003

- CMS will fully implement an automated workforce planning system, including updating data collected in FY 2000 through 2002.
- CMS will continue to monitor and evaluate actions taken to increase targeted skill areas.
- CMS will determine baselines and targets for FY 2004.

Increase Awareness about the opportunity to enroll in the Medicare Savings Programs (FAC9-03)

FY 2002

- Analyze Medicare Current Beneficiary Survey (MCBS) data to develop targets and baselines.

FY 2003

- Track progress using MCBS data.
- Provide brochures on the Medicare Savings Programs to SSA, AoA, SHIPs, Senior Centers, Hospitals, PROs, partners, etc.
- Provide training materials on the CMS website.
- Provide information about the Medicare Savings Programs in various publications such as *Medicare&You*, *Guide to Health Insurance for People with Medicare*, etc
- Develop language to be used in all correspondence from beneficiaries requesting assistance with medical expenses.
- Establish partnerships with organizations that interact with potentially eligible low income Medicare beneficiaries to distribute information.
- State Health Insurance Assistance Programs (SHIPs) will continue to use individual counseling and group education activities as opportunities to inform potential eligibles about the Medicare Savings Programs. In addition, best practice outreach methods developed as pilots will continue to be promoted for wider use by all SHIPs.

- The Regional Education About Choices in Health (REACH) Campaign through community-based outreach activities and regional materials will continue to educate Medicare beneficiaries on the Medicare Savings Programs.

Appendix B

State Methodologies and Reporting for the GPRA Medicaid Childhood Immunization Goal (MMA2-03)

Due to the various data collection and reporting methodologies used by individual States, immunization coverage levels are not directly comparable across States. Each State will measure its own progress, using a consistent measurement methodology.

The following Appendix summarizes State-specific methodologies and includes relevant definitions, and presents each State's baseline and three-year targets for increasing childhood immunization rates.

Group I States

Although all Group I States have actively participated, there have been problems and barriers that have delayed reporting. Eleven of the 16 Group I States have reported their first remeasurement rate.

California reports a change in personnel and reduced program funds as the cause for their delay in reporting. Oklahoma reports at the end of each calendar year. In Oklahoma and Kansas, the report is delayed for signatures at the State level. Rhode Island also reports a shortage of funds and personnel as cause for their delay in reporting. Idaho, which had a delay last year, intends to report its first and second remeasurement rates by August 2002.

Group II States

Group II States actively participated in the project, but also experienced delays. All Group II States submitted their State-specific methodologies, and six of 10 Group II States reported their baseline and three-year target rates.

Alaska has reported a delay in reporting due to a re-organization of the State office physical locations. Colorado, North Carolina and North Dakota have had a change in personnel assigned to this program and have asked to report in early 2002 to give them time to review the plan and analyze the data. North Dakota has reported problems obtaining all the signatures needed for clearance.

Group III States

The third and final Group of this project is preparing their baseline methodologies and will report the baseline measures and target rates at the end of FY 2002.

Appendix B
Group I & II States
Baseline Measurement Methodologies for the GPRA Medicaid Childhood Immunization Goal

Group I States:

State	Baseline Definitions	Data Source/s	Covered by Baseline	Baseline Rate	measure	Second Re-measure	Third Re-measure	Target Rate
Arizona	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(a, b, c)	FY 1999	62%	65%	2/02	2/03	80%
Arkansas	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(d, e)	7/1/97 – 6/30/98	65%	74%	8/02	8/03	90%
California	MCP & FFS 2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4 (f) MCP 4 (h) FFS	CY 1998	MCP – 52% FFS 54%	Pending	9/02	9/03	65%
Connecticut	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(i)	CY 1998	77%	77%	6/02	6/03	80%
Idaho	2-year old 1(b) Medicaid enrollment 2(b) Fully immunized 3(a)	4(h, j)	1/1/01 sample selection date	66%	Pending	6/02	6/03	76%
Iowa	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(h)	4(b, d, e)	CY 1998	58%	60%	6/02	6/03	90%
Kansas	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(e)	FY 2000	42%	Pending	12/02	12/03	90%
Maine	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(i)	4(e, i)	7/1/98 – 6/30/99	24%	32%	11/02	11/03	70%
Massachusetts	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(j)	4(f)	CY 1997	64%	69%	12/02	12/03	80%

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Michigan	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(k)	4(m)	CY 1997	79%	75%	6/02	6/03	90%
Mississippi	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(a)	4(a, g)	7/97 – 6/98	85%	85%	10/02	10/03	85%
Oklahoma	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(d)	4(a, b, n)	CY 1998	65%	Pending	12/02	12/03	90%
Oregon	2-year old 1(a) Medicaid enrollment 2(e) Fully immunized 3(a)	4(a, d)	CY 1998	63%	67%	8/02	8/03	67%
Rhode Island	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(k)	4(a, c, e, g)	CY 1998	75%	Pending	11/02	11/03	79%
Utah	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(f)	4(a, b, e)	FY 1999	19%	27%	4/02	4/03	65%
Washington	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4(d)	CY 1998	58%	77%	10/02	10/03	58%

Group II States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Rate	First Re-measure	Second Re-measure	Third Re-measure	
Alaska	2-year old 1(b) Medicaid enrollment 2(p) Fully immunized 3(f)	4(r, s, t)	7/1/99 – 6/30/00	Pending	9/02	9/03	9/04	Pending
Colorado	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(u)	CY 2000	Pending	7/02	7/03	7/04	Pending
Delaware	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(a, r)	CY 1998	43%	12/02	12/03	12/04	60%
District of Columbia	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(l)	4(h, a)	CY 1998	50%	10/02	10/03	10/04	74%
Florida	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(a)	4(v)	01/98	82%	10/02	10/03	10/04	90%
Louisiana	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(w, b)	CY 1998	82%	12/02	12/03	12/04	84%
New Hampshire	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(j)	4(h, p, q)	CY 2000	67%	9/02	9/03	9/04	90%
North Carolina	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(e)	4(c, x)	CY 2000	Pending	12/02	12/03	12/04	Pending
North Dakota	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(j)	4(a, e)	CY 2000	Pending	12/02	12/03	12.04	Pending
South Dakota	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(a)	9/30/01	52%	9/02	9/03	9/04	90%

APPENDIX B

Definition of two-year old:

1(a) States choosing to measure number of two-year olds over a period of time (i.e. using State or Federal fiscal year, calendar year, or a point in time such as January 1).

1(b) States measuring by age (i.e. 24 - 35 months of age, between 19 and 35 months of age or 0 to 24 months of age).

Medicaid enrollment:

2(a) Twelve months enrollment and have no more than 30 - 45 days gap in enrollment.
2(b) Enrolled for at sample date selected.
2(c) Enrolled at least 6 months
2(d) Ever enrolled.
2(e) Enrolled in Medicaid managed care
2(f) Enrolled at least 10 months with no more than 45 day gap in enrollment

Fully immunized:

3(a) 4 DTP, 3 OPV, 1 MMR
3(b) 4 DTP, 3 OPV, 1 MMR, 1 Hib
3(c) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 3 HBV; HEDIS (2001 & 2000, Comb 1; 1999, Comb 2)
3(d) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 2 HBV; HEDIS (1999, Comb 1; 1998, Comb 2)
3(e) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 3 HBV, 1 VZV; HEDIS (2001 & 2000, Comb 2; 1999, Comb 3)
3(f) 4 DTP, 3 OPV, 1 MMR, 3 Hib, 3 HBV; HEDIS (2002, Comb 1)
3(g) 4 DTP, 3 OPV, 1 MMR, 3 Hib, 3 HBV, 1 VZV; HEDIS (2002 & 1, Comb 2)
3(h) 4 DTP, 3 OPV, 1 MMR, 4 Hib, 3 HBV, 1 VZV (ACIP schedule 1998)
3(i) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 2 HBV; HEDIS (1998, Comb 1)
3(j) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 3 HBV
3(k) 4 DTP, 3 OPV, 1 MMR, 4 Hib, 3 HBV (ACIP/AAP recommendations)
3(l) 4 DTP, 3 OPV, 1 MMR, 3 Hib (NIS)
3(m) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 3 HBV, 1 VZV
3(n) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 2 HBV, 1 VZV; HEDIS (1998, Comb 3)

Data Sources:

4(a) State Immunization registry,
4(b) Medical records abstraction,
4(c) Health plan administrative data
4(d) Medicaid MCO plan chart review
4(e) Claims database
4(f) HEDIS® like specifications modified by the State
4(g) State survey data
4(h) Medicaid Management Information System/Decision Support System (MMIS/DSS)
4(i) State Immunization Registry and Tracking System
4(j) Provider survey
4(k) Medicaid enrollment data
4(l) Immunization program record reviews
4(m) Independent-EQR meeting CMS standards based on medical record review
4(n) Parental documentation of immunization record
4(o) Medical Assistance Management Information System (MAMIS)
4(p) CASA
4(q) reports from MCO's
4(r) Medicaid Eligiblity Information System (MEIS)
4(s) Alaska Permanent Fund Dividend
4(t) Random Sample Resource Patient Management System (RPMS)
4(u) HEDIS
4(v) birth Cohort Survey

4(x) encounter data
4(y) private sector voluntary registry

GLOSSARY OF TERMS

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
CASA	Clinic Assessment and Software Application
CY	Calendar year
DTP/DTaP	Diptheria, Tetanus, Pertussis/ Diptheria, Tetanus, acellular Pertussis
EQR	External Quality Review
FFS	Fee-For-Service
GPRA	Government Performance and Results Act
HBV	Hepatitis B Vaccine
HEDIS	Health Plan Employer Data Information Set
HEDIS Hybrid	Hybrid - Using the above set along with other available data systems
Hib	Haemophilus Influenza type b
MCO	Managed Care Organization
MCP	Managed Care Program
MIS/DSS	Management Information System
MMR	Measles, Mumps, Rubella
OPV/IPV	Oral Polio Vaccine/Intramuscular Polio Vaccine
PCCMP	Primary Care Case Management Program
VZV	Varicella Zoster Vaccine