Centers for Medicare & Medicaid Services

FY 2005 GPRA Annual Performance Plan

FY 2004 Revised Final GPRA Annual Performance Plan

FY 2003 GPRA Annual Performance Report

January 2004

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

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2005 Annual Performance Plan (APP) and FY 2003 Annual Performance Report (APR), as required by the Government Performance and Results Act of 1993 (GPRA). CMS takes great pride in the many achievements we are about to report on our programs and on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. Our approach to performance measurement under GPRA has been to develop an APP with goals that are representative of CMS' vast responsibilities.

CMS has become the largest purchaser of health care in the United States, serving nearly 82 million Medicare and Medicaid beneficiaries, including those covered by the State Children's Health Insurance Program (SCHIP). When the Medicare and Medicaid 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.

CMS' mission is to assure health care security for beneficiaries. For CMS, this has resulted in a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. To ensure that CMS remains a responsive, dynamic, and relevant government Agency that serves the American public, we are continuing to focus our attention on citizen-centered governance in FY 2005 and beyond. Both the APP and APR emphasize this focus by identifying our significant processes and services; by helping us expand our resources in a way that enhances service to the public; by being accountable stewards of Agency resources; and, by enabling us to monitor and evaluate our effectiveness. We will be communicating, collaborating, and cooperating with key customers and partners, both public and private, to help us achieve the desired outcomes stated in this plan.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law by the President on December 8, provides immediate help to the most needy beneficiaries in the Medicare program, adds new prescription drug and preventative benefits and provides extensive help to low income seniors. Starting this year, seniors will be able to see the impact of the legislation through expanded benefits in Medicare Advantage plans and, in May, seniors will be able to enroll in the Medicare-Approved Drug Discount Card Program for immediate help with the cost of prescription drugs. This is an exciting time for CMS and there is much work to be done implementing the many provisions of this new law. In fact, we have added three new performance goals to our APP tracking our efforts implementing the prescription drug benefit, the discount card and Medicare contractor reform.

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The 2001 President's Management Agenda gave CMS an opportunity to develop 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. Of the 32 total performance goals represented in FY 2005, forty-one percent of the goals are focused on the President's Management Agenda. Also, within the context of the Department's Strategic Plan goals and objectives, and in keeping with the Secretary's guidance, our FY 2005 GPRA goals are represented in seven of the nine priority areas. Over the years, CMS has increased its number of outcome goals, while balancing its plan with a mix of output goals and reducing the overall number of measures. And, consistent with OMB direction, we have developed "full cost" estimates for our FY 2005 GPRA goals.

We have made progress in reducing the Medicare fee-for-service payment error rate, and look forward to continuous improvements and measurement utilizing data from the Comprehensive Error Rate Testing (CERT) program. CERT has allowed CMS to look at more specialized areas of payment, thus enabling us to correct specific problems and further protect the Medicare Trust Funds.

Through the SCHIP and Medicaid programs, we continue to make progress in improving access to health care and in addressing health care quality issues for the population covered by these programs. Similarly, one of our priorities is to ensure that our Medicare beneficiaries receive quality health care. In fact, several performance goals in our APP/APR reflect successful efforts in the areas of preventive care. Our performance goal to improve already high beneficiary satisfaction ratings will show further success for the Medicare program.

We have accomplished much in the past year and look forward to success in this fiscal year and beyond. CMS is confident that performance measurement under GPRA will substantially improve CMS' programmatic and administrative performance and I am also pleased to report that the data measuring CMS' performance contained in this report are complete and reliable.

Sincerely,

Dennis G. Smith
Acting Administrator

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I. EXECUTIVE SUMMARY

A. AGENCY MISSION

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services. The creation of CMS in 1977 brought together, under one leadership, the two largest Federal health care programs--Medicare and Medicaid. In 1997, the State Children's Health Insurance Program (SCHIP) was established to address the health care needs of uninsured children. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act provided sweeping changes to the Medicare program along with expanded responsibilities for CMS. CMS has become the largest purchaser of health care in the United States, serving nearly 82 million Medicare and Medicaid beneficiaries, including those covered under the State Children's Health Insurance Program.

CMS' mission is to assure health care security for beneficiaries. To ensure that CMS remains a responsive, dynamic, and relevant government agency that serves its citizens, we are continuing to focus our attention on citizen-centered governance in FY 2005 and beyond. This Annual Performance Plan (APP) and Report (APR) emphasizes this focus by identifying our significant processes and services, by helping us expand our resources in a way that enhances service to the public, by being accountable stewards of Agency resources, and by enabling us to monitor and evaluate our effectiveness

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 a steward of taxpayer dollars. Our performance goals are linked to the HHS Strategic Plan goals and CMS' strategic goals. The Agency is confident that performance measurement under GPRA will substantially improve CMS'programmatic and administrative performance.

B. OVERVIEW OF PLAN AND PERFORMANCE REPORT

CMS' total number of FY 2005 goals is 32. We carried over the majority of the goals in the FY 2004 plan, with new targets appropriate for FY 2005 focusing on meaningful outcomes, and introduced new goals that reflect the Agency's new responsibilities.

The 2001 President's Management Agenda gave CMS an opportunity to develop 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. As in previous years, many of our performance goals are consistent with these objectives. In fact, of the 32 total performance goals represented in FY 2005, many of the goals are focused on the President's Management Agenda. Also, within the context of the Department's Strategic Plan goals and objectives and in keeping with the Secretary's guidance, our FY 2005 GPRA goals are represented in seven of the nine priority areas. Over the years, CMS has increased its number of

outcome goals, while balancing its plan with a mix of output goals and reducing the overall number of measures. And, consistent with OMB direction, we have developed "full cost" estimates for our FY 2005 GPRA goals.

Summary of FY 2003 Successes

Overall, CMS experienced positive results in FY 2003. Of the 61 targets (36 goals) being reported for FY 2003, we have 11 targets for which we do not have complete data. We have met or exceeded expectations for 42 of the 51 targets for which we have complete data.

Summary of FY 2003 Performance Challenges

Although we are not reporting success in meeting the following 7 goals in their entirety, we have made significant progress:

Medicare Fee-For-Service Error Rate (MIP1-03)
Improve the Provider Enrollment Process (MIP7-03)
Increase the use of Electronic Commerce/Standards in Medicare (MO3-03)
Increase Referral of Eligible Delinquent Debt for Cross Servicing (MO6-03)
Decrease the Prevalence of Pressure Ulcers in Nursing Homes (QSC2-03)
Develop and Implement an Information Technology Architecture (FAC2-03)
Improve CMS' Information Systems Security (RP1-03)

Pending FY 2002 Performance Goals

Results are now available for the following previously unreported FY 2002 goals:

Goals Met

- Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.
- Decrease the prevalence of restraints in nursing homes.
- Increase the percentage of women 65 and over who receive a mammogram
- Sustain improved laboratory testing accuracy.

Goals Not Met

- Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal.
- Decrease the prevalence of pressure ulcers in nursing homes.
- Improve CMS' information systems security.

Performance Goals Removed from the APP

The following goals have been removed from the plan:

- Improve CMS oversight of Medicare Fee-for-Service Contractors (MO5-05)
  This goal is being replaced by a new contractor reform goal resulting from the new Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

- Increase Referral of Eligible Delinquent Debt for Cross Servicing (MO6-05)
  This goal was removed in order to make room for new, equally compelling goals resulting from the new Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

- Program Integrity Customer Service (MIP6-04)
  Although the customer service project was initiated in FY 2001 and continues today, this project is in transition. CMS is developing an overall customer service plan that may encompass the program integrity customer service project. The development of an alternative evaluation method is being discussed, therefore, this goal is being discontinued beginning in FY 2004 until a scope and method are established and clarified.

- Develop New Medicare Payment Systems in Fee for Service and Medicare + Choice (FAC4-05)
  CMS has achieved great success with this goal and will continue improving these areas.

- Improve CMS' Workforce Planning (FAC6-04)
  This goal is being removed because HHS is developing a workforce planning system that all Department components will be required to use. Workforce planning remains a priority; however, we need to reevaluate and adjust our approach in light of these recent changes and additional requirements.

- Improve CMS' Management Structure (FAC7-04)
  While this activity will continue in the future, this goal is being removed after FY 2004. The goal of constructing an automated system to capture data will be completed in 2003 and data collection will be completed in 2004.

- Increase Awareness About the Opportunity to Enroll in the Medicare Savings Programs (FAC9-04)
  We will continue our efforts to increase awareness of these programs to eligible beneficiaries, measuring our progress; however, this goal will be discontinued beginning with the FY 2005 Annual Performance Plan.

- Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization (FAC10-03)
  This goal is being removed after FY 2003 because we have completed the targets. CMS will continue to monitor staffing levels in the future while FTE levels will be tracked and set by DHHS beginning in 2004.

Highlights

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law by the President on December 8, preserves and strengthens the current Medicare program, adds new prescription drug and preventative benefits and provides extensive

help to low income seniors. Starting in 2004, seniors will be able to see the impact of the legislation through expanded benefits in Medicare Advantage plans and, in June, seniors will be able to enroll in the Medicare-Approved Drug Discount Card Program for immediate help with the cost of prescription drugs. This is an exciting time for CMS and there is much work to be done implementing the many provisions of this new law.

In Fall 2003, CMS continued its national ad campaign, which assists beneficiaries and their caregivers to become active and informed participants in their health care decisions. As a result of the new Medicare legislation, seniors and people living with disabilities will need to understand their choices and select the best option for them. For those reasons, outreach, education and appropriate testing of messages to beneficiaries has never been so important. We will want to ensure that we reach individuals eligible for the benefit and encourage them to apply. The focus of the 2003 ad campaign was to continue to increase target audience recognition of 1-800-MEDICARE and its purpose. In addition to promotion of 1-800-MEDICARE as a resource for Medicare, in FY 2004 we plan to use the media campaign to support the introduction of the new Medicare-endorsed prescription drug card.

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 working 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.

Program Assessment Rating Tool (PART)

CMS has taken an active role in the PART process. In 2002, OMB evaluated CMS on the Medicare Integrity Program (MIP) and SCHIP and in 2003 on the Medicare program. All programs received positive results, with MIP receiving one of the highest scores of all the programs reviewed by OMB in 2002. As a result of the PART process, we added two new MIP goals measuring the contractor error rate and the Medicare provider compliance error rate. The PART effort provided an opportunity for CMS to improve our GPRA plan and establish a more meaningful, systematic link between GPRA and the budget process.

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

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II. PERFORMANCE PLAN AND REPORT/BUDGET LINKAGES

A. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services. The creation of CMS 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. CMS has become the largest purchaser of health care in the United States, serving nearly 82 million Medicare and Medicaid beneficiaries, including those covered under the State Children's Health Insurance Program (SCHIP).

CMS' mission is to assure health care security for beneficiaries. CMS' strategic goals and objectives are developed in conjunction with the Strategic Plan of the Department of Health and Human Services (HHS) and outline our goals for achieving this mission. The CMS strategic plan, the HHS Strategic Plan, the enactment of the Government Performance and Results Act (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. To ensure that CMS remains a responsive, dynamic and relevant government agency that serves its citizens, we are focusing our attention on citizen-centered governance in fiscal year (FY) 2005 and beyond. This Annual Performance Plan (APP) and Report (APR) emphasize this focus by identifying our significant processes and services, by helping us expand our resources in a way that enhances service to the public, by being accountable stewards of Agency resources, and by enabling us to monitor and evaluate our effectiveness. We will be communicating, collaborating, and cooperating with key customers, both public and private, to help us achieve the desired outcomes stated in this plan.

The President's Management Agenda of 2001 announced several reform initiatives with the primary objectives of making the Government more citizen-centered, results-oriented, and market-based. In response, CMS has 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. Many of our performance goals are consistent with these objectives, as illustrated later in the Plan.

Consistent with the President's Management Agenda, CMS initiatives include process reengineering efforts, improved methods of working and management initiatives that will enable the Agency to implement its long-term goals and objectives. For example:

- In order to expand e-government, we continue to improve our popular "Medicare.gov" website to make the most of technology for the growing number of beneficiaries who have access to the Internet. It is a critical tool for our GPRA goals to improve the dissemination and understanding of Medicare information. Also, CMS makes use of computer based training (CBT) to educate our workforce on systems security issues and other subjects. This training enhances productivity by allowing employees the flexibility of scheduling training based on their individual schedule and makes a better use of time for both the employee and the Agency. It also provides a way for the employee to refer back to familiar training tools if necessary.

- Improving financial management is a key initiative in the President's Management Agenda and has been a long-term focus in achieving CMS mission. With establishment of the Medicare Integrity Program through the Health Insurance Portability and Accountability Act (HIPAA), CMS began to focus on paying the right amount to legitimate providers for covered, reasonable and necessary services. CMS has been a pioneer in the field of identifying, quantifying, and reducing payment errors in the Medicare fee-for-service program. Through our efforts to reduce national fee-for-service payment errors, we have developed a method for determining a Medicare provider compliance error rate, as well as a contractor error rate. We are also expanding our experience with a similar pilot effort under the Medicaid and SCHIP programs. Our commitment to the fiscal integrity of our programs and to being accountable stewards of public funds also bolsters the Department's strategic goal to achieve excellence in management practices.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law by the President on December 8, preserves and strengthens the current Medicare program, adds new prescription drug and preventative benefits and provides extensive help to low income seniors. Starting this year, seniors will be able to see the impact of the legislation through expanded benefits in Medicare Advantage plans and, in June, seniors will be able to enroll in the Medicare-Approved Drug Discount Card Program for immediate help with the cost of prescription drugs.

We continue our national ad campaign, which assists beneficiaries and their caregivers in becoming active and informed participants in their health care decisions. In 2001 and 2002, 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 access to customer service representatives at 1-800-MEDICARE, improvements to www.Medicare.gov, expanded web-based capabilities to help consumers compare health plan choices, and a national ad campaign on the new choices and new ways to get information on CMS programs. In Fall 2003, we continued the national ad campaign. The focus of the 2003 media campaign was to continue to increase target audience

recognition of 1-800-MEDICARE and its purpose. In addition to promotion of 1-800-MEDICARE as a resource for Medicare, in FY 2004 we plan to use the media campaign to support the introduction of the new Medicare-endorsed prescription drug card. 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.

Summary of Plan and Report

This Annual Performance Plan (APP) for CMS sets out specific performance goals for the Agency for FY 2005. It builds on previous APPs submitted to Congress and contains many enhancements. The CMS APP complements and supports the Agency's FY 2005 budget, and is an integral part to achieve budget and performance integration. The total number of FY 2005 goals in this APP is 32. We carried over the majority of the goals in the FY 2004 plan, with new targets appropriate for FY 2005 focusing on meaningful outcomes. This year we will be reporting on the status of 36 FY 2003 performance goals

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 a steward of taxpayer dollars. Our performance goals are linked to the HHS Strategic Plan goals and the CMS strategic goals and objectives. The Agency is confident that performance measurement under GPRA will substantially improve CMS' programmatic and administrative performance.

The chart below shows the number of performance goals and targets within those performance goals from the beginning of the GPRA process to the present submission, and it includes reporting tallies as appropriate.

Program Performance Report Summary

	Goals	Total Measures In Plan	Outcome Measures	Output Measures	Efficiency Measures*	Results Reported	Results Met	Results Not Met
1999	**18**	**22**	**7**	**15**	**0**	**22**	**20**	**2**
2000	**30**	**40**	**13**	**27**	**0**	**40**	**31**	**9**
2001	**33**	**54**	**16**	**38**	**0**	**54**	**40**	**14**
2002	**35**	**59**	**16**	**43**	**0**	**58**	**45**	**13**
2003	**36**	**61**	**29**	**32**	**0**	**51**	**42**	**9**
2004	**36**	**54**	**36**	**18**	**0**	**N/A**	**N/A**	**N/A**
2005	**32**	**47**	**32**	**15**	**4**	**N/A**	**N/A**	**N/A**

* Efficiency measures are determined based on the intended outcomes resulting in a better run program.

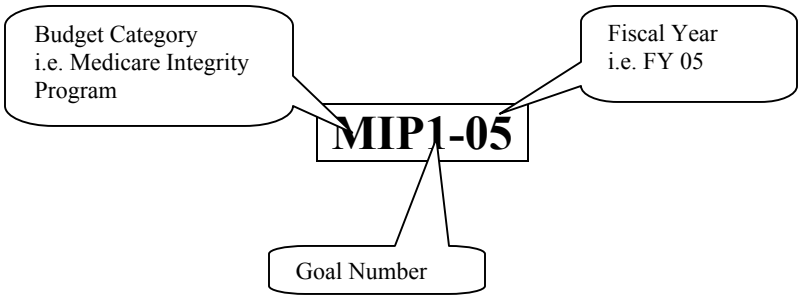
The Agency's APP is divided by budget category as a means of integrating budget and performance. The Table of Contents provides an easy-to-read road map indicating how the programs and performance goals are organized in the plan. The GPRA goals identified under each of our 11 budget categories are representative of the vital activities CMS performs to fulfill its mission. Thus, the APP does not reflect every activity and challenge encountered by the Agency. Using a representative approach is consistent with guidance from GAO based on the nature of the Agency's work.

In accordance with a directive from OMB, we have included full cost estimates for our FY 2005 performance goals. All Program Management resources have been allocated to program areas via CMS' FY 2002 cost allocation factors. Full costs are then allocated to individual groups of performance goals through a combination of both specific identification and the allocation of Program Management resources. As many of CMS' goals are outcome oriented, we have based these costs on activities that are representative of each of the goals. We believe this gives us the best available information to indicate the proper cost estimates. The process is comprehensively discussed in the Appendix, Section F.

Performance measurement results provide a wealth of information about the success of CMS programs and activities, and CMS uses 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 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.

An improvement in this year's plan is the indication in the reporting charts of linkage between our plan and the Department's Strategic Plan goals and Healthy People 2010 initiative. In the reference section of the reporting charts, a numeral has been added to indicate to which goal(s) in the Department's Strategic Plan our FY 2005 GPRA **outcome** goals are linked. Goals associated with the President's Management Agenda are identified by the  icon. Goals associated with Healthy People 2010 are indicated by "HP-xx"", with the "xx" indicating the corresponding chapter of the initiative. These icons are also found in the reference section. The reference column also includes an individual number tied to each goal. This number (example: MIP1-05) corresponds to the budget category (example: **MIP**1-05) in which the goal resides, a number for the goal (example: MIP**1**-05) and the latest year in which the goal appears in the Plan (example: MIP1-**05**). Finally, in this section, as appropriate, we note "See FY 04 Revised Final" for changes in FY 2004 goals.



CMS' FY 2005 plan reflects our continued efforts to strengthen our coordination with other organizations and to ensure that our performance data are reliable. We continue to cite and describe data sources for each individual goal, including data verification, data validation, and data limitations and concerns. Data issues are explored further in the Appendix, Section D.

Each of our GPRA goals 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.

B. DISCUSSION AND PERFORMANCE ANALYSIS

In this section, we present our report on CMS' performance for FY 2003, and goals planned for FY 2004 and FY 2005. The report and goals are organized by budget category. We begin by describing the category and presenting a table summarizing our FY 2003 performance and FY 2004 and FY 2005 targets. 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.

The 32 individual goal narratives for FY 2005 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).

Medicare Benefits

Medicare Benefits	FY 2002 Actual	FY 2003 Actual	FY 2004 Current Estimate	FY 2005 Estimate
Medicare Benefits	**$252.2 B**	**$272.6 B**	**$296.4 B**	**$324.6 B**
Medicare Modernization	**$0.0 B**	**$0.0 B**	**$0.4 B**	**$0.3 B**
Total	**$252.2 B**	**$272.6 B**	**$296.8 B**	**$324.9 B**

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the Nation's largest health insurance program, which covers approximately 41 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For nearly four decades, this program has helped pay medical bills for millions of Americans, providing them with comprehensive health benefits they can count on. 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 some key measures to represent the Medicare benefits budget category. We strive to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high-quality care and ensuring fairness of the program to its beneficiaries.

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

- Protect the Health of Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal (QIO2-05)
- Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram (QIO3-05)
- Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams (QIO4-05)
- Protect the Health of Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection (QIO5-05)
- Improve Beneficiary Telephone Customer Service (MO1-05)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-05)
- Improve Beneficiary Understanding of Basic Features of the Medicare Program (MO9-05)

Performance Goals	Targets	Actual Performance	Ref.
Improve satisfaction of Medicare beneficiaries with the health care services they receive **[outcome goal]**			MB1 **3, 5**
--Managed care access to care	**FY 05:** 93% of beneficiaries **FY 04:** Collect (& share) data **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop new baselines/ targets to include disenrollee data **FY 00:** See below	**FY 05:** 7/05 **FY 04:** **FY 03:** Data collected (Goal met) **FY 02:** Data collected (Goal met) **FY 01:** 90.5% of beneficiaries **(Baseline*)** (Goal met) **FY 00:** See below	See FY 04 Revised Final
--Managed care access to specialist	**FY 05:** 86% of beneficiaries **FY 04:** Collect (& share) data **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop new baselines/ targets to include disenrollee data **FY 00:** See below	**FY 05:** 7/05 **FY 04:** **FY 03:** Data collected (Goal met) **FY 02:** Data collected (Goal met) **FY 01:** 83.7% of beneficiaries **(Baseline*)** (Goal met) **FY 00:** See below	
--Fee-for-service access to care	**FY 05:** 95% of beneficiaries **FY 04:** Collect (& share) data **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop baselines/ targets **FY 00:** Same as FY 1999 **FY 99:** Continue to develop measurement and reporting methodology	**FY 05:** 7/05 **FY 04:** **FY 03:** Data collected (Goal met) **FY 02:** Data collected (Goal met) **FY 01:** 92.8% of beneficiaries (**Baseline***) (Goal met) **FY 00:** Survey fielded in FY 2001 with baseline data available fall 2001 (Goal met) **FY 99:** Development continuing (Goal met)	
--Fee-for-service access to specialist *CAHPS 2000 data % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 85% of beneficiaries **FY 04:** Collect (& share) data **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop baselines/targets	**FY 05:** 7/05 **FY 04:** **FY 03:** Data collected (Goal met) **FY 02:** Data collected (Goal met) **FY 01:** 82.8% **(Baseline*)** (Goal met)	

Performance Goals	Targets	Actual Performance	Ref.
Improve satisfaction of Medicare beneficiaries with the health care services they receive			MB1
--Managed care access to care	**FY 00:** Collect/share data to achieve 79% of plans by CY 2003 **FY 99:** Develop target	**FY 00:** Data collected (Goal met) **FY 99:** Target dev. (Goal met) **FY 98:** 74% of plans* **(Baseline)**	
--Managed care access to specialist Shaded portion is prior to inclusion of disenrollee data.	**FY 00:** Collect/share data to achieve 75% of plans by CY 2003 **FY 99:** Develop target	**FY 00:** Data collected (Goal met) **FY 99:** Target developed (Goal met) **FY 98:** 70% of plans **(Baseline)**	
Improve Medicare's administration of the beneficiary appeal process (Developmental) **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** --Medicare Advantage: Analyze the data collected and develop a reporting format --FFS: Developmental **FY 04:** --Medicare Advantage: Begin data collection --FFS: Developmental **FY 03:** --Medicare Advantage: Enhance data collection --FFS: Developmental **FY 02**: --Medicare Advantage: Issue OPL with reporting instructions --FFS: Evaluate data needs & capabilities **FY 01**: --Publish Operational Policy Letter (OPL) --Begin collecting baseline data **FY 00:** Have system in place for collection of managed care appeal data	**FY 05:** --Medicare Advantage: --FFS: **FY 04**: --Medicare Advantage: --FFS: **FY 03**: --Medicare Advantage: The data workgroup has developed new reporting formats for the IRE. The IRE will begin submitting reports under the new format as of January 2004. (Goal met) --FFS: The project team has selected a contractor to develop the MAS. (Goal met) **FY 02**: --Medicare Advantage: Reassessed data collection (Goal not met) --FFS: Evaluation complete (Goal met) **FY 01**: --OPL132 04/27/01 (Goal met) --Collection delayed (Goal not met) **FY 00**: Delayed due to burden to Medicare Advantage (Goal not met.) (Baseline developmental)	MB4 **5**

Performance Goals	Targets	Actual Performance	Ref.
Implement the new Medicare-endorsed prescription drug Card	**FY 04:** Implement the new Medicare-Endorsed Prescription Drug Discount Card program **FY 05:** Continue providing information to people with Medicare about the program through written materials, the www.medicare.gov website and 1-800-MEDICARE.	**FY 04:** **FY 05:**	MB 6 **3** See FY 04 Revised Final
Implement the new Medicare prescription drug benefit	**FY 04:** Develop and publish a Notice of Proposed Rulemaking **FY 05:** 1. Develop and publish the Final Rule in the Federal Register 2. Develop baselines and targets	**FY 04:** **FY 05:**	MB 7 **3,5** See FY 04 Revised Final

Performance Results Discussion

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).
In an effort to capture more complete information for the managed care portion, data from a managed care disenrollee survey is combined with survey data from current managed care enrollees. Baselines and targets have been recalculated to reflect this change.

Our efforts to improve beneficiary satisfaction are ongoing by continuing to collect and share Consumer Assessment of Health Plans (CAHPS) information from beneficiaries. Specific presentations on the CAHPS surveys, from which these measures are developed, have been made to individual Medicare managed care (MMC) plans, to Quality Improvement Organizations (QIOs) at meetings of the American Health Quality Association, and to beneficiaries on the Medicare Health Plan Compare website. In addition, we have established a website to provide access to QIOs on issues related to FFS. As for managed care, an interactive version of the MMC-CAHPS report is available to health plans on the Health Plan Management System, or HPMS. This web-based report allows health plans to "drill down" and examine their CAHPS results by demographic factors such as age, race, and health status. This website is also available to CMS staff and QIOs as long as they have a password to the site.

In order for the increases over the baseline to be statistically significant, these are long-term targets with reporting due at the end of the 5-year period; however, we are monitoring the data as it becomes available each cycle.

Beneficiary Appeals - It is important that we address beneficiary appeals for both managed care and FFS programs in Medicare. In FY 2002 the Medicare+Choice (now called Medicare Advantage) Organization (M+COs) appeals target was to send data

collection instructions to the M+CO (Medicare Advantage) plans. However, the industry voiced concern about imposing additional workload burdens on Medicare Advantage plans. CMS refocused its approach; data collection will now be obtained through the Independent Review Entity (IRE), thereby alleviating any burdens on the Medicare Advantage plans. The FFS FY 2002 target was met by having the appeals data re-evaluated to determine future needs for improving the administration of this essential beneficiary protection. After evaluating future needs, CMS decided that its data needs would best be served by a unified system (the Medicare Appeals System) that can incorporate and utilize both FFS and Medicare Advantage appeals data.

Prescription Drug Card/ Drug Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law by the President on December 8, preserves and strengthens the current Medicare program, adds new prescription drug and preventative benefits and provides extensive help to low income seniors. Starting in 2004, seniors will be able to see the impact of the legislation through expanded benefits in Medicare Advantage plans and, in June, seniors will be able to enroll in the Medicare-Approved Drug Discount Card Program for immediate help with the cost of prescription drugs.

People with Medicare without drug coverage will be eligible for the Medicare-endorsed Prescription Drug Discount Card, which will begin operation six months after enactment and continue until the full benefit is implemented. Beginning in 2006, Medicare beneficiaries will have access to the standard benefit that includes the following: a modest monthly premium; a deductible of $250; coinsurance of 25 percent up to an initial coverage limit of $2,250; protection against high out-of-pocket prescription drug costs, with co-pays of $2 for generics and preferred multiple source drugs and $5 for all other drugs, or 5 percent of the price, once an enrollee's out-of-pocket spending reaches a limit of $3,600.

Performance Goal MB1-05

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

Baselines (FY 2001-2005 Goals [1]): CY 2000 Managed care - (a) Getting needed care for illness or injury: 90.5 percent of beneficiaries enrolled in a Medicare managed care (MMC) plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: 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. CY 2000 Fee-for-service (FFS) - (a) Getting needed care for illness or injury: 92.8 percent of beneficiaries enrolled in the original Medicare FFS (MFFS) 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: 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 2005 Targets: Achieve by the end of CY 2004 targets set for managed care and FFS.
FY 2004 Targets: Same as FY 2002/2003.
FY 2003 Targets: Same as FY 2002. **Performance:** Goal met. We continue to collect CAHPS data and assist in quality improvement initiatives by sharing data with plans, QIOs and beneficiaries toward meeting our ultimate target by the end of CY 2004.
FY 2002 Targets: Managed Care - Direct efforts to achieve by the end of CY 2004 for (a) getting needed care for illness or injury: 93 percent of beneficiaries, and (b) Access to a specialist: 86 percent of beneficiaries. These efforts include: (1) continue to collect MMC-CAHPS and Disenrollee data and make available to Medicare managed care plans, and Medicare beneficiaries, to assist in quality improvement initiatives and beneficiary plan choice, respectively. FFS - Direct efforts to achieve by the end of CY 2004 for (a) Getting needed care for illness or injury: 95 percent of beneficiaries, and (b) Access to a specialist: 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 beneficiariesto assist in beneficiary plan choice. **Performance:** Goal met. We continue to collect CAHPS data and assist in quality improvement initiatives by sharing data with plans, QIOs and beneficiaries toward meeting our ultimate target by the end of CY 2004.

[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.

(Continued from previous page) **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 - Goal met. 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. FFS – Goal met. 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.
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 - Goal met. Baseline and target developed. FFS - Goal met. Development continuing with survey to be fielded in FY 2001.

Discussion: A fundamental goal 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 Quality Improvement Organizations (QIOs), health plans, and beneficiaries through various means, including the National *Medicare & You* Education Program (NMEP).

Provision of CAHPS performance information assists 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 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. The CMS 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 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 are 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.

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 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 (FY 2001) 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 MB4-05

Improve Medicare's Administration of the Beneficiary Appeals Process

Baseline: Developmental. Baseline data collection for Medicare + Choice (now called Medicare Advantage) Organizations (M+CO) appeals will begin in FY 2002 and continue through FY 2003.
FY 2005 Target: **Medicare Advantage:** Analyze the IRE data collected and determine a reporting format for the IRE. **FFS**: Develop the second phase of the Medicare Appeals System (MAS)
FY 2004 Target: **Medicare Advantage:** Begin collection of Independent Review Entity (IRE) data. **FFS**: Develop the first phase of the Medicare Appeals System (MAS)
FY 2003 Target: Developmental. **Medicare Advantage:** Enhance data collection at the Independent Review Entity (IRE) level. **FFS:** Developmental **Performance:** Goal Met
FY 2002 Target: Developmental. **Medicare Advantage:** Issue OPL with reporting instructions. **Performance:** Goal Not Met **FFS:** Evaluate CMS's FFS appeal data needs and capabilities. **Performance:** Goal Met
FY 2001 Target: Publish Operational Policy Letter (OPL) and begin collecting baseline data for Medicare Advantage. **Performance:** OPL published 04/27/2001, collection delayed.
FY 2000 Target: Implement system for collection of Medicare Advantage appeal data. **Performance:** Goal not met due to added burden to Medicare Advantage.

Discussion: The appeals process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. Under fee-for-service (FFS) Medicare, beneficiaries and providers have the right to appeal a denial of payment by a Medicare fiscal intermediary (FI) or carrier. This appeal usually comes after the service has been provided. The appeals process takes on added significance under the Medicare Advantage program because these appeals may also involve pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

Medicare Advantage Data Collection:
Starting in FY 1999, CMS required Medicare Advantage to collect aggregate level appeals data and report it out to beneficiaries. Now beneficiaries are able to make more informed choices when selecting a managed care plan. CMS captures data on appeals activities not resolved at the Medicare Advantage level and that have proceeded to a higher level of review by an independent CMS contractor. CMS does not yet capture data on Medicare Advantage plans' internal appeals activity, due to concerns regarding burdening Medicare Advantage plans with increased reporting requirements.

Various methods of data collection have been discussed and abandoned in light of Medicare Advantage industry concerns that these methods would be too burdensome. In

FY 2002, CMS decided to enhance the data collection at the Independent Review Entity (IRE) level. CMS met with representatives of the IRE to review enhanced data elements and finalize a report on CMS data needs. The IRE would report to CMS via a new system that would incorporate both the FFS and Medicare Advantage systems. The IRE is also working with CMS to determine whether additional data elements are needed to assist them in their monitoring of Medicare Advantage activities.

FFS Data Collection: In FY 2001, CMS awarded a contract to analyze FFS data and to provide options for the Medicare appeals system. These evaluative efforts were undertaken to determine FFS future data needs. The contractor's initial findings were submitted to CMS in FY 2002. Late in FY 2002, the contractor submitted a draft business case analysis, which outlined both user and system requirements. CMS staff reviewed the requirements and provided comments that were incorporated into a refined document. This document would serve as a base on which future business and systems requirements would be built upon.

Combined Medicare Advantage/FFS Data Collection
In FY 2002, CMS reassessed its data needs and system/business requirements for both FFS and Medicare Advantage. The same contractor that analyzed the requirements for individual Medicare Advantage and FFS systems performed a Business Case Analysis (BCA) of the benefits of a combined system. The contractor has met with CMS representatives within CBC to discuss modifications to the BCA and to determine the best method for developing a combined FFS/Medicare Advantage system.

During the summer of 2002, CMS met with the IRE to discuss enhanced Medicare Advantage data that was being collected. CMS has developed a team tasked with analyzing the enhanced data elements and determining the best reporting format to be used by the IRE.

CMS has moved forward with recommendations made by the BCA: both FFS and Medicare Advantage information technology were combined into the Medicare Appeals System (MAS). CMS then began to assess a variety of "Commercial Off The Shelf" (COTS) and "Government Off The Shelf" (GOTS) software solutions. The selected solution will interface with databases such as the Medicare Beneficiary Database, Medicare Managed Care System, and the National Medicare Utilization Database. In this way, the Qualified Independent Contractors, for FFS and the IRE, for managed care, will process and adjudicate Medicare appeals in one system.

During the summer of 2003, a CMS panel reviewed responses to its Request For Proposals (RFP) on integration of system hardware with COTS and GOTS software solutions, and reviewed oral presentations from prospective contractors on development of the MAS. On September 29, 2003, a contract was awarded. The contractor submitted a draft System Development Plan (SDMP) on October 13, 2003, which provided a detailed explanation of development activities, project milestones, and schedules for development of the MAS.

During the week of October 20, 2003, CMS held a week-long session to develop business requirements for the MAS. Several CMS components met with the contractor responsible for developing the system to discuss the needs to be addressed by the MAS.

Coordination: The CMS has worked closely with the Center for Health Dispute Resolution, 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. 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 Medicare Advantage appeals data will be reported by the Medicare Advantage to the IRE. The IRE will maintain data in its system and provide reports to CMS. The IRE ultimately will report data into the MAS. Aggregate FFS data are entered into the Contractor Reporting of Operational Workload Data (CROWD) system by FIs and carriers.

Verification and Validation: CMS utilizes the Contractor Performance Evaluation (CPE) process to evaluate the performance of FIs and carriers.

Performance Goal MB6-05

Implement the New Medicare-Endorsed Prescription Drug Card

Baseline: Prior to enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, most people with Medicare did not have access to prescription drug coverage through the Medicare program.
FY 2005 Target: Continue providing information to people with Medicare about the program through written materials, the www.medicare.gov website and 1-800-MEDICARE.
FY 2004 Target: Implement the new Medicare-Endorsed Prescription Drug Discount Card program through the development and publication of the requirements for the Medicare-Endorsed Prescription Drug Discount Card program, solicitation and approval of applications from prescription drug discount card program sponsors, and provision of information to people with Medicare about the program.

Discussion: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as signed by the President on December 8, 2003, will give all Medicare beneficiaries access to prescription drug coverage and the buying power to reduce the prices they pay for drugs. The Act provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all people with Medicare until the full plan is available nationwide.

People with Medicare without drug coverage will be eligible for the Medicare-endorsed Prescription Drug Discount Card, which will begin operation six months after enactment and continue until the full benefit is implemented. The card program is estimated to save beneficiaries between 10 to 25 percent on most drugs. Those with incomes below 135 percent of poverty will be given immediate assistance through a Medicare-endorsed prescription drug discount care with $600 annually to apply toward purchasing their medicines.

Coordination: CMS will work closely with the Internal Revenue Service, Social Security Administration, and various governmental agencies in implementing this program.

Data Source(s): Required regulations and/or notices must be published in final in time to implement this program six months after enactment of the Act. CMS must sign contracts with card sponsors and must provide information about the program through written materials, the website, and 1-800-MEDICARE.

Verification and Validation: We intend to monitor whether we are meeting the information needs of people with Medicare about the program. For example, we will monitor the questions coming into the 1-800-MEDICARE call center to ensure that the customer service representatives have the information needed to answer specific questions. When additional information needs are identified, we will modify print materials and the website as needed.

Performance Goal MB7-05

Implement the New Medicare Prescription Drug Benefit

Baseline: Prior to enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, most people with Medicare did not have access to prescription drug coverage through the Medicare program.
FY 2005 Target: 1) Develop and publish the Final Rule in the Federal Register with requirements for the new benefit. 2) Developmental. Baselines and future targets will be developed to measure Medicare's informational activities, including beneficiary awareness of different features of the new benefit.
FY 2004 Target: Develop and publish a Notice of Proposed Rulemaking in the Federal Register with requirements for the new benefit.

Discussion: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as signed by the President on December 8, 2003, will give all Medicare beneficiaries access to prescription drug coverage and the buying power to reduce the prices they pay for drugs. The Act provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all people with Medicare until the full plan is available nationwide.

Beginning in 2006, Medicare beneficiaries will have access to the standard benefit that includes the following: a monthly premium of about $35; a deductible of $250; coinsurance of 25 percent up to an initial coverage limit of $2,250; protection against high out-of-pocket prescription drug costs, with co-pays of $2 for generics and preferred multiple source drugs and $5 for all other drugs, or 5 percent of the price, once an enrollee's out-of-pocket spending reaches a limit of $3,600. Although drug plan sponsors may change some of the specifications, the benefit offered must at least be equal in value to the standard benefit. People with Medicare with limited savings and low incomes will receive a more generous benefit package.

In 2006 data will be collected to monitor the implementation of the new benefit.

Coordination: CMS will work closely with the Internal Revenue Service, Social Security Administration, and various governmental agencies in implementing this program.

Data Source(s): To be identified as part of the developmental work.

Verification and Validation: This will depend on the data source identified as part of the developmental work.

Quality of Care:
Quality Improvement Organizations

Quality Improvement Organizations	FY 2002 Actual	FY 2003 Actual	FY 2004 Current Estimate	FY 2005 Estimate
Total Obligations	**$314.6 M**	**$703.0 M**	**$106.6 M**	**$344.6 M**

Under the Quality Improvement Organization (QIO) program, formerly known as the Peer Review Organization (PRO) program, 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. The QIO 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 QIOs perform. Funding patterns tend to vary substantially from year to year. The QIO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

The following goals from the Survey & Certification Quality of Care budget section of our Plan are related to this budget category but are not listed in the report below:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-05)
- Decrease the Prevalence of Restraints in Nursing Homes (QSC1-05)
- Decrease the Prevalence of Pressure Ulcers in Nursing Homes (QSC2-05)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-05)

Performance Goal	Targets	Actual Performance	Ref.
Increase annual influenza (flu) and lifetime pneumococcal vaccinations (MCBS) **[outcome goal]** -- Flu	**FY 05:** 72.5% **FY 04:** 72.5% **FY 03:** 72.5% **FY 02:** 72 % **FY 01:** 72 % **FY 00:** N/A	**FY 05:** Expect data 12/06 **FY 04:** Expect data 12/05 **FY 03:** Expect data 12/04 **FY 02:** 69.0% (Goal not met) **(NEW DATA)** **FY 01:** 67.4% (Goal not met) **FY 00:** 70.4% **FY 99:** 69.3% * **FY 98:** 68.5 %* **FY 97:** 67.1 %* **FY 96**: 65 % **FY 95:** 61 % **FY 94:** 59% (MCBS) **(Baseline)**	QIO2 HP-14 **1, 3**
-- Pneumococcal % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 69% **FY 04:** 69% **FY 03:** 67% **FY 02:** 66% **FY 01:** 63% **FY 00:** N/A	**FY 05:** Expect data 12/06 **FY 04:** Expect data 12/05 **FY 03:** Expect data 12/04 **FY 02:** 64.6% (Goal not met) **(NEW DATA)** **FY 01:** 63.3% (Goal met) **FY 00:** 62.7% **FY 99:** 61.7 %* **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 rate of annual influenza (flu) vaccination (NHIS) **** Shaded area indicates goal based on previous data source.**	**FY 01:** Switched to new data source. (see above) **FY 00:** 60% **FY 99:** 59%	**FY 00:** 64% (Goal met) **FY 99:** 66% (Goal met) **FY 98:** 64% **FY 97:** 63% **FY 95:** 58% **FY 94:** 55% (NHIS) **(Baseline)**	
Increase biennial mammography rates (National Claims History file) **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 52.5%♦ **FY 04:** 52%♦ **FY 03:** 51.5%♦ **♦ Measure based on 2002 HEDIS®**	**04-05:** **03-04:** Expect data 8/05 **02-03:** Expect data 8/04 **01-02:** 51.6% **00-01:** 51% **(Baseline)**	QIO3 HP-3 **1, 3**

Performance Goal	Targets	Actual Performance	Ref.
	FY 03: See Above **FY 02:** 52%* **FY 01:** 51%* ***Measure based on 1999 HEDIS®**	 **01-02:** 52.2% (Goal met) **(NEW DATA)** **00-01:** 51.6% (Goal met) **99-00:** 50.5% **98-99:** 49% **97-98:** 45% **(Baseline)**	
Increase biennial mammography rates (NHIS) **** Shaded area indicates goal based on previous data source.**	**FY 01:** Switched to new data source (see above) **FY 00:** 60% **FY 99:** 59%	**FY 01:** N/A **FY 00:** 68.1% (Goal met) **FY 99**: 66.8% (Goal met) **FY 98**: 63.8% **FY 94:** 55% (NHIS) **(Baseline)**	
Improve the rate of biennial diabetic eye exams **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 70.1% **FY 04:** 69.9% **FY 03:** 68.9% **FY 02:** 68.6 % **FY 01:** 68.3 %	**03-05:** **02-04:** **01-03:** Expect data 12/04 **00-02:** 69.6% (Goal met) **(NEW DATA)** **99-01:** 69.2% (Goal met) **98-00:** 68.1% **97-99:** 67.8% **(Baseline)**	QIO4 HP-5 **1, 5** See FY 04 Revised Final
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 72.5% **FY 04:** 66.6% **FY 03:** 60.5%	**FY 05:** **FY 04:** **FY 03:** 06/04 **FY 02:** 60%* **FY 01:** 57.6% **(Baseline)** *9 month period	QIO5 **1, 5** See FY 04 Revised Final
Improve heart attack survival rates --Lower the 1-year mortality rate for Medicare beneficiaries following hospital admissions for heart attack	**FY 03:** Goal discontinued **FY 02**: 27.4% **FY 01**: 27.4% **FY 00**: 27.4 %	**01-02:** Expect data 9/04 **00-01:** 33.3%◆ (Goal not met) **(NEW DATA)** **99-00:** 33.2%◆ (Goal not met) **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	QIO1

Performance Results Discussion

Improving the quality of care for Medicare beneficiaries is one of our primary objectives. CMS' GPRA goals reflect quality priorities both in prevention and adhering to quality standards and support the Department's strategic plan goals. Several of the QIOs' 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, an estimated 780,000 surgeries are complicated by infection each year resulting in longer hospital stays, increased morbidity, mortality, and health care costs. Therefore, our goal to prevent surgical site infections focuses on administering antibiotics in a timely manner before a surgical procedure.

Adult Immunizations - We fell short of our FY 2002 adult immunization targets of 72 percent for influenza and 66 percent for pneumococcal vaccinations; and achieved rates of 69 percent and 64.6 percent, respectively. While we increased our influenza rate over the previous year's 67.4 percent, continued manufacturing and distribution delays of vaccine during the 2001-2002 influenza season, coupled with another mild flu season, may have contributed to some beneficiaries not receiving their flu immunization. Secondary data sources (some preliminary) support this trend.

In FY 2001, 67.4 percent of all Medicare beneficiaries age 65 years and older reported receipt of an annual flu vaccine, and 63.3 percent reported receipt of a pneumococcal vaccine in their lifetime. While we exceeded our target to achieve a 63 percent lifetime pneumococcal vaccination rate, we did not meet our target to achieve an annual flu vaccination rate of 72 percent. This decrease in the influenza immunization rate reflects the temporary shortage and distribution delays that affected vaccine distribution in 2000 and 2001 which were beyond our control.

Recent challenges with the vaccine supply and distribution as well as other challenges make it difficult to establish accurate goals for FY 2005 at this time. For example, in 2003, only two companies will be manufacturing the injectable flu vaccine that is recommended for older adults; and there has been reported public concern about side effects of the general safety of immunizations. Complicating the supply side, the 2003-2004 flu season has been impacted by a strain of influenza virus which differs slightly from the components of the available vaccine. Because of these factors, we have decided to adopt the FY 2004 goals for FY 2005. We will continue to evaluate environmental factors affecting the supply and demand for flu vaccine in setting future targets.

CMS continues to promote the receipt of annual influenza and lifetime pneumococcal vaccinations through its partnership with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization (NCAI). CMS sponsors many information campaigns aimed at providers and Medicare beneficiaries, including racially and ethnically diverse adult populations. We hope that the recent establishment of standing orders for flu and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies as well as increased reimbursement for related vaccination will help to overcome some of the barriers that prevent patients from being immunized.

Additionally, in order to remove administrative barriers to immunization, CMS on August 15, 2003 published a ruling that exempts paper roster billing claims for Medicare covered vaccinations from the Health Insurance Portability and Accountability Act (HIPAA) rules.

Mammography – CMS' performance goal to increase the percentage of women Medicare beneficiaries age 65 and older who receive a mammogram is another illustration of our Agency's promotion of secondary prevention and increasing cancer survival through early detection. Performance measurement of mammography rates has served to focus resources within CMS for ongoing monitoring and improved performance.

CMS' FY 2001 and FY 2002 mammography targets are based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised their technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 Technical Specifications. The revised indicator reflects changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.

CMS' revised mammography indicator is a more restrictive definition than the previous indicator. Reanalysis of biennial 2000-01 mammography data with this "HEDIS® 2002" mammography measure suggest a decrease of 0.6 percent of eligible female beneficiaries age 65 years or older with mammography services paid by Medicare. Consequently, targets for CMS' mammography goal were revised, beginning with FY 2003, to account for the more conservative estimates from the HEDIS® 2002 measure. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

In late 2001-early 2002, there was a great deal of controversy in the press regarding mammography, along with press releases from governmental agencies affirming the recommendations for regular mammography screening. For example, the US Preventive Services Task Force (USPSTF) and the National Cancer Institute (NCI) continue to recommend mammography for early detection. Additionally, the Department of Health and Human Services (HHS) issued a press release affirming the need for mammography screening. Continued outreach and education may be especially important at this time to ensure that women with Medicare get screening mammograms on a regular basis. CMS remains committed to its mammography efforts through the National Medicare Mammography Campaign, which involves CMS contractors and QIOs, as well as other agencies in HHS to include NCI. Activities of this campaign target beneficiaries and providers and involve private partnership efforts, to include a national partnership with Wal-Mart Stores, Inc. through its pharmacies.

We have met our targets through FY 2002, and current projections, based on analysis of the most recent interim NCH data, indicate we are on track for our FY 2003 target

(January 2002-December 2003) of 51.5 percent as well as future targets of 52.0 percent for FY 2004, and 52.5 percent for FY 2005.

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. CMS' quality goal to increase special eye exams for our diabetic beneficiaries reflects our commitment to improve diabetes care.

We surpassed our FY 2001 goal to increase the rate of biennial diabetic eye exams to 68.3 percent by increasing the rate to 69.2 percent. (The 2001 data were originally calculated with the managed care beneficiaries included in the rate with a resulting rate of 68.9 percent. With recalculation of the year 2001 with only Medicare fee-for-service beneficiaries included, the eye exam rate moved up to 69.2 percent.) We also met and exceeded our FY 2002 target (of 68.6 percent) at 69.6 percent.

Quality Improvement Organizations continue to work with the physicians in their State to increase the rate of eye examinations. Our FY 2002 performance has already exceeded our FY 2003 target of 68.9 percent. Although these increases have occurred slowly with great effort, we feel it is appropriate to revise our FY 2004 target to 69.9 percent (from 69.2 percent), and are setting our FY 2005 target at 70.1 percent.

Surgical Site Infections – Optimizing the timing of antibiotic administration has been demonstrated to decrease the incidence of surgical site infection. The addition of this goal in our performance plan is another example of our commitment to preventive health and increasing healthy outcomes for our beneficiaries.

The Medicare Surgical Site Infection Prevention Project (SIP) has been expanded from 19 States to all 50 States as of February 1, 2003. While the SIP Project focuses on the five highest volume surgeries, CMS will only be targeting the total percentage increase in frequency from all the cases followed. Baseline data from 2001 demonstrated that antibiotics were only administered within the recommended timeframe in just over half (57.6 percent) the cases. With national expansion and continued QIO commitment our targets for FY 2003, FY 2004, and FY 2005 increase to 60.5 percent. 66.6 percent, and 72.5 percent, respectively, significantly reducing the number of complications our beneficiaries will experience**.**

Data collection for years following the initial baseline will use methods that reflect the evolution of CMS quality improvement activities toward reporting at the hospital level. As a result, data reflects a percentage of 60 percent for FY 2002, which includes a period of 9 months, and is included for tracking purposes. Data for subsequent years will be available approximately 9 months after the period of interest.

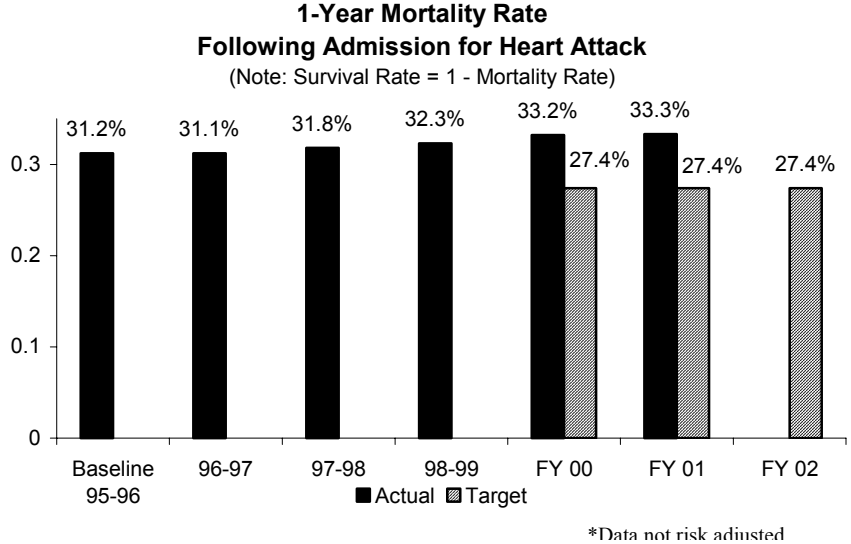
Heart Attack Survival - We did not meet our FY 2001 goal to decrease the one-year mortality rate to 27.4 percent among Medicare beneficiaries following hospital admissions for heart attack. The one-year mortality rate for heart attacks that occurred between August 1, 2000 and July 31, 2000 was 33.3 percent. Based on this data and

other recent trends, we do not expect to meet the FY 2002 target. Data for our FY 2002 target is expected September 2004.

There are a number of interventions that have been proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002, but we discontinued this goal beginning in FY 2003. CMS will continue to encourage and monitor research in this area to determine what may be contributing to these disappointing trends.

Performance Goal QIO1-02

Improve Heart Attack Survival Rates By Decreasing Mortality *(Discontinued after FY 2002)*



The 1995-96 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 has been working to 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 1995-96 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 were appropriate candidates for all or some of the treatments listed

above, CMS anticipated that patient survival following a heart attack could be improved by more widespread use of these proven therapies. The American College of Cardiology and the American Heart Association 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 were derived from data generated in a four-State pilot quality improvement effort conducted by 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 QIOs nationwide began to phase in quality improvement activities related to heart attack treatment. In 1999, CMS began writing performance-based contracts with QIOs, 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 were to continue, the expected change after 5 years would be 3.0 percentage points. Therefore, the target assumed that this trend would continue; though this was 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 had been widely adopted; all QIOs 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 would translate into about 3,000 lives saved.

There are a number of interventions that have been proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

Coordination: 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. CMS will also continue its ongoing collaboration around HCQIP with the QIOs.

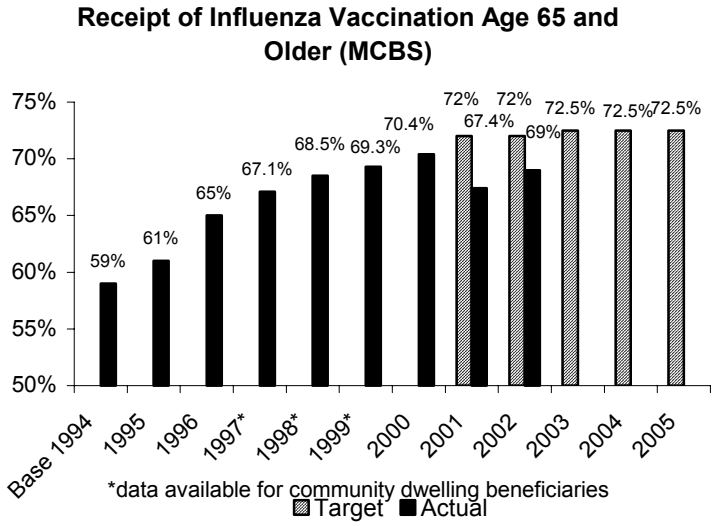
Data Source(s): The mortality rates are calculated from Medicare Part A hospital claims and the Medicare Enrollment Database. Since mortality data for the year following hospitalization are needed, there will be a lag in reporting results. For example, in order to know the 1-year mortality rate for patients hospitalized in August 2000 through

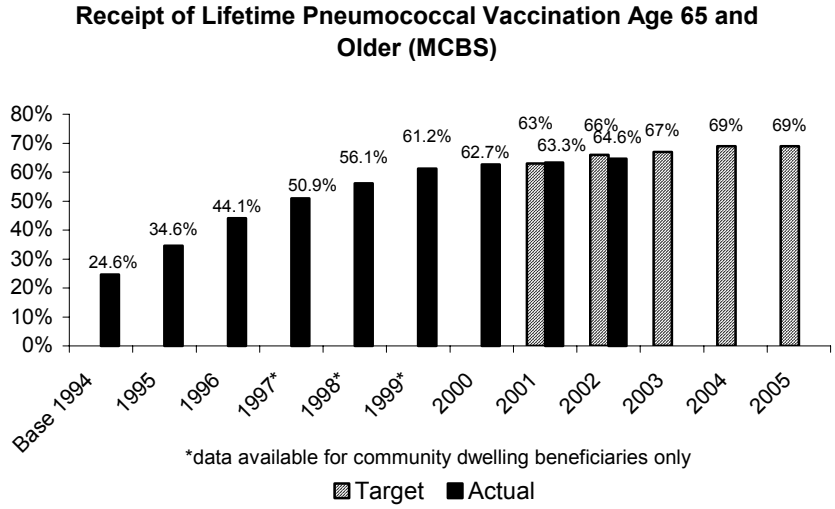
July 2001, deaths occurring during August 2001 through July 2002 would need to be assessed. After updating the enrollment database, linking to the claims data, and performing the analysis, results would be expected in FY 2003. Neither the actual nor target rates have been adjusted for age or co-morbidity, 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 QIO2-05

Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal





Discussion: An average of 36,000 Americans die from influenza or its complications each year. In 2000 and 2001 the National Center for Health Statistics reported influenza and pneumonia to be the primary causes of death for more than 58,000 and 55,000 older adults respectively. 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. Consistent with the Department's strategic plan goals and through the collaborative efforts of the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease

Control and Prevention (CDC) and the National Coalition for Adult Immunization (NCAI), we are working to improve adult immunization rates in the Medicare population.

In recent years, there have been flu vaccine shortages and distribution delays, which have impacted the delivery of immunizations. MCBS data from the 2000 – 2001 vaccination season indicated that one of the leading reasons cited by Medicare beneficiaries for not getting a flu shot was that the vaccine was unavailable or in short supply. This was the first year in which the MCBS recorded this response in significant numbers. Continued manufacturing and distribution delays of vaccine during the 2001-2002 influenza immunization season, coupled with another mild flu season, may have contributed to some beneficiaries not receiving their flu immunization. Also, data analyses from different sources point to an apparent leveling off of flu vaccination rates, and most recent data for pneumococcal vaccinations indicate that these rates are slowing down as well.

Traditionally, pneumococcal immunizations are given by health care providers along with the flu immunization. According to the American Medical Association, over 70% of pneumococcal vaccine sales in 2002 occurred in the four-month period of August through November. It is possible that disruptions of influenza vaccine supply may have impacted the pneumococcal vaccination rates also. In addition, a study published in the May 1, 2003 edition of the *New England Journal of Medicine* found limited protection from the vaccine for developing community-related pneumonia. Instead, the report found the vaccine to be highly effective in preventing blood infections due to pneumococcal bacteria. Such reports may dissuade some health care professionals from offering the pneumococcal vaccine for their older patients.

Other challenges CMS faces in achieving our adult immunization goal include the following:

- While efforts have been made recently to increase the administration fee and vaccine reimbursement rates for influenza and pneumocccocal immunizations, some providers still consider the reimbursement too low;
- One of the largest manufacturers of influenza vaccines has recently dropped out of the market, with as yet unknown impact on production levels;
- Public concern about the general safety of immunizations, with unknown consequences on compliance levels in our target population; and
- Pneumococcal vaccinations are still not universally accepted by providers.

The most effective strategy noted in current literature for improving patient access to adult immunizations is the implementation of standing orders. This occurs when non-physician personnel vaccinate according to a physician-approved protocol without direct physician involvement at the time of immunization. To support this evidence-based intervention, CMS and CDC have been working together to develop a strategy to increase the use of standing orders for influenza and pneumococcal vaccinations. In October 2002, standing orders were established for influenza and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies that serve Medicare and Medicaid

beneficiaries. Additionally, CMS raised the reimbursement rates for influenza and pneumococcal vaccination and its administration in 2003. In order to remove administrative barriers to immunization, CMS published on August 15, 2003 a ruling that exempts paper roster billing claims for Medicare covered vaccinations from the Health Insurance Portability and Accountability Act (HIPAA) rules.

Our targets for FYs 2003 - 2004 are set based on the recent trends. In light of recent trends for pneumococcal, we revised our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older.

Recent challenges with influenza vaccine supply and distribution as well as other challenges make it difficult to establish accurate goals for FY 2005 at this time. For example, in 2003, only two companies manufactured flu vaccine. During the early 2002-2003 flu season, all 50 States experienced early outbreaks of influenza and many cases of the flu, which created great demand from the public to seek immunizations. Complicating the supply side, the 2003-2004 flu season has been impacted by a strain of influenza virus which differs slightly from the components of the available vaccine. As a result of the public's demand for flu vaccine and concerns of vaccine shortage during the 2003-2004 flu season, the CDC in December 2003 changed its public health recommendation from offering vaccine to all people to targeting high-risk individuals for immunization. For the 2004-2005 flu season, there is a high potential for a change in at least one strain of the influenza vaccine, which may once again impact manufacturing, availability and distribution. Because of these factors, we have decided to adopt the FY 2004 goals for FY 2005. We will continue to evaluate environmental factors affecting the supply and demand for flu vaccine in setting future targets.

Coordination: The CMS, CDC and 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.

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 influenza and pneumococcal vaccines.

Data Source(s): In FY 2001, the Medicare Current Beneficiary Survey (MCBS) was 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-institutionalized 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.

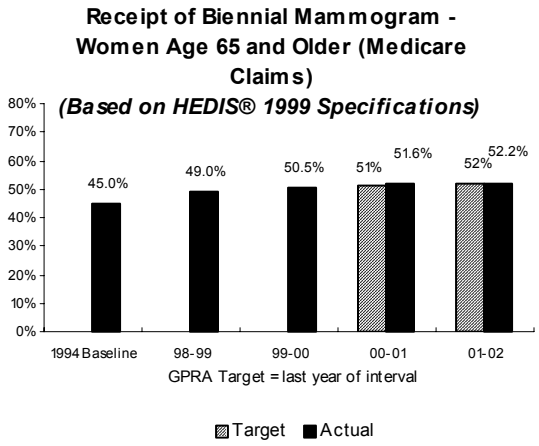
The NHIS and the Behavioral Risk Factor Surveillance System (BRFSS) provide comparable data to the MCBS, for community-dwelling persons age 65 or older, and will be used as secondary data sources

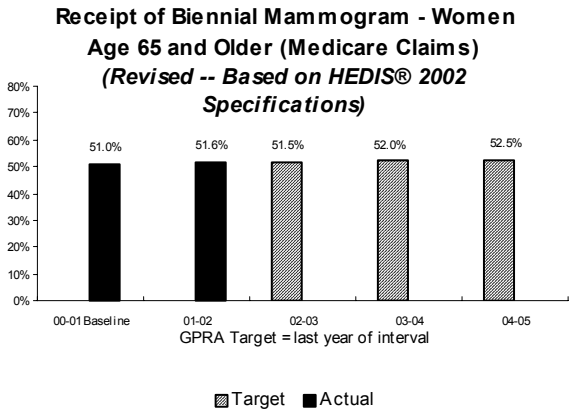
Medicare claims data (National Claims History file) provide another supplementary source of data but are likely to under-report vaccinations because the data exclude Medicare beneficiaries enrolled in managed care plans and beneficiaries who receive vaccinations outside the Medicare payment system (e.g.,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

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 QIO3-05

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





Discussion: CMS's National Medicare Mammography Campaign is directed at improving women beneficiaries' knowledge of breast cancer screening and awareness of Medicare's annual screening mammography benefit. Health care providers are also targeted to improve their recommendation of breast cancer screening.

In support of the Mammography Campaign, CMS's goal is 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 those 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.

The CMS's FY 2001 and FY 2002 mammography targets are based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised their technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 Technical Specifications. Based on these recent revisions, we have modified our baseline and future targets, beginning with FY 2003, to attain consistency with the 2002 HEDIS® measure and to reflect changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.

The CMS's revised mammography indicator is a more restrictive definition than the current indicator. Analysis of the HEDIS® 2002 measure yields a mammography rate that is 0.6 percent lower for FY 2001 than our previous HEDIS® 1999 measure of eligible female beneficiaries age 65 or older with mammography services paid by Medicare. Consequently, future targets for CMS's mammography goal have been revised, beginning with FY 2003, to account for the more conservative estimates from the HEDIS® 2002 measure. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01. Current projections based on analysis for the most recent interim data indicate we are on track to meet future targets; as a result, we have set our FY 2005 target at 52.5 percent.

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.

CMS's Mammography Campaign involves a number of components within the Agency as well as the Quality Improvement organizations (QIOs). In addition, the Campaign partners with a number of sister agencies within the Department of Health and Human Services including the National Cancer Institute (NCI), the Centers for Disease Control and Prevention and the Public Health Service (PHS) Office of Women's Health. Researchers, physicians, and nurses are also consulted on a number of the mammography campaign activities.

The CMS's QIOs are charged with monitoring and improving quality of care for Medicare beneficiaries, and are directed to improve mammography rates among female Medicare beneficiaries (in their respective States). The QIOs' contract performance will be evaluated, in part, on measured improvements in their statewide mammography rates. Among many of the mammography campaign activities, CMS and the QIOs have worked

with Wal-Mart Stores, Inc. to distribute mammography educational materials to its pharmacy customers across the country. These educational materials-which include a Medicare message – are produced by CMS in partnership with the National Cancer Institute.

Data Source(s): The National Claims History (NCH) file is the data source used to track the mammography goal. The percentage of women age 65 and older with paid Medicare claims for mammography services during a biennial period will be calculated. The denominator consists of women who are enrolled in both Parts A and B on 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 rate calculation. 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 actor Surveillance System (BRFSS). The NHIS served as the primary data source for CMS's mammography goal through FY 2000.

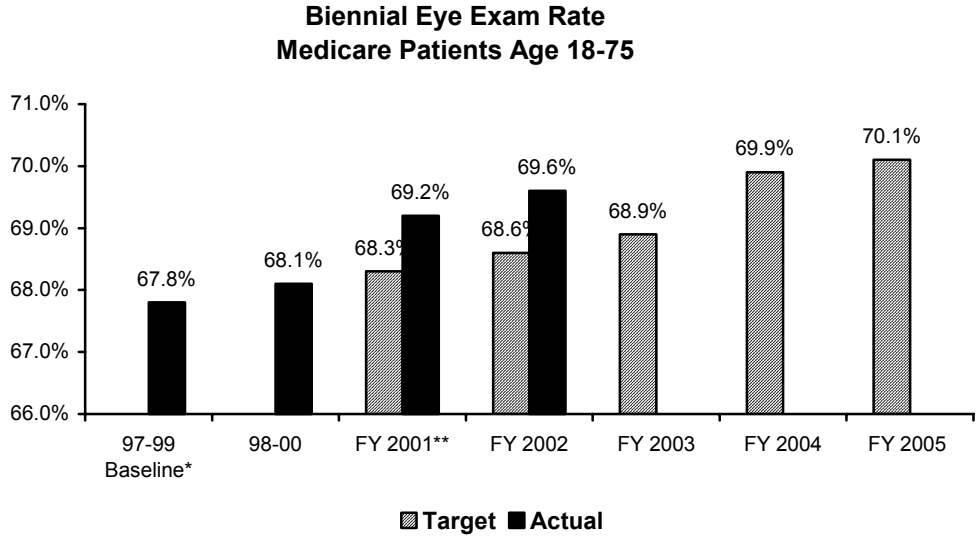
The CMS will continue to monitor recommendations by leading authorities such as the U.S. Preventive Service Task Force regarding the frequency of mammography and targeted age groups. As new developments dictate, CMS's staff will Consider modifications to this goal to ensure consistency with evidence-based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

Verification and Validation: The 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. The self-reported rates of mammography screening have historically been higher when based on these survey sources. Therefore, we cannot directly compare the rates from the secondary data sources with the reported rate based on claims data, but will compare year-to-year changes observed in each data source, to determine if equivalent rates of improvement are seen.

Performance Goal QIO4-05

Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams



* Baseline Revised from 68.5%
** FY 2001 target recalculated from 69.0%
***Target to be set pending additional data.

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). According to CDC, prevalence of diagnosed diabetes increased in all age groups between 1980 and 1999 with people ages 65-74 years having the highest prevalence rate (14.51 per 100 population). That rate was 13 times higher than people less than 45 years of age (1.10 per 100 population). Among U.S. adults, diagnosed diabetes increased 40 percent from 1990 to 2000.

The National Eye Institute reports diabetes affects approximately 14 million Americans, and about 40 percent of all people with diabetes have at least mild signs of diabetic retinopathy, the most common ocular complication of diabetes. Diabetic retinopathy is the leading cause of blindness in adults 25-74 years of age. People with diabetes are at significantly higher risk of blindness than the general population. Up to 21 percent of newly diagnosed patients with Type 2 diabetes have retinopathy, and many develop some retinopathy over time. Screening and care can prevent up to 90 percent of diabetes-related blindness.

Coordination: 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. CMS has directed the Quality Improvement Organizations (QIOs) to improve the diabetic eye exam rate among Medicare beneficiaries in their respective States.

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 QIOs have also contributed to the national campaign.

Data Source(s): The National Claims History (NCH) file 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 QIO contract cycle. Each State fell into one of three measurement periods. The following are the cycles for each of the three rounds of QIOs using the 2001 reporting year as an example. Round one remeasurement period runs from April 1, 1999 to March 30, 2001. Round two remeasurement period runs from July 1, 1999 to June 30, 2001. Round 3 remeasurement runs from October 1, 1999 to September 30, 2001. Subsequent biennial rates are calculated in a similar manner. A programming error required a revision of the 1997-99 baseline from 68.5 percent to 67.8 percent. The 2001 data were originally calculated with the managed care beneficiaries included in the rate with a resulting rate of 68.9 percent. With recalculation of the year 2001 with only Medicare fee-for-service beneficiaries included, the eye exam rate moved up to 69.2 percent. The final rate for 2002 is 69.6 percent, and considering past performance, we have revised our FY 2004 target to 69.9 percent (from 69.2 percent), and set our FY 2005 target at 70.1 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 Advantage 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. CMS will use these alternate data sources to verify and validate trends.

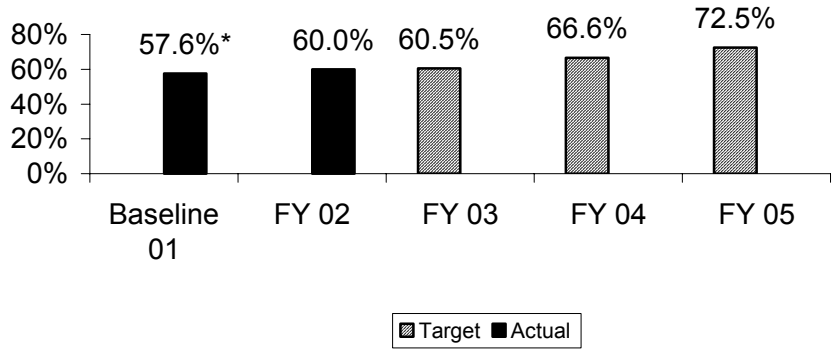
Verification and Validation: The NCH is a 100 percent sample of Medicare claims submitted by providers to Medicare and is checked for completeness and consistency. Utilization rates for age groups, race and gender are calculated and compared to previous years' data to check for any unusual changes in data values.

Medicare Advantage 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.

Performance Goal QIO5-05

Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection

Percentage of Patients Who Received Preventive Antibiotics within the Recommended Timeframe



*Due to a data error, the original baseline has been changed. These data were corrected, and the targets recalculated at the same rate of improvement previously targeted.

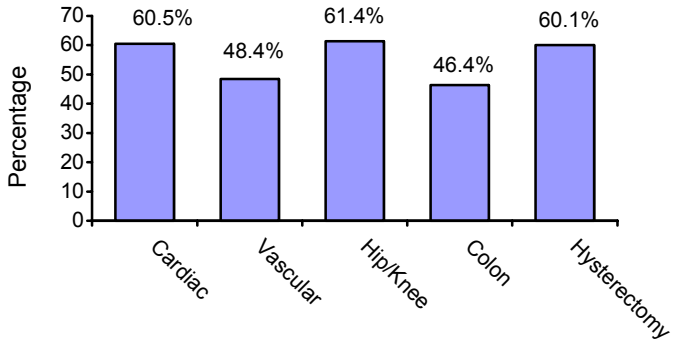
Discussion: Postoperative surgical site infection (SSI) is a major cause of patient morbidity, mortality, and health care cost. SSI complicates an estimated 780,000 of nearly 30 million operations in the United States each year. For certain types of operation, rates of infection are reported as high as 20 percent. Each infection is estimated to increase a hospital stay by an average of 7 days and add an average of over $3,000 in hospital costs (1992 data). The incidence of infection increases intensive care unit admission by 60 percent, the risk of hospital readmission five-fold, and doubles the risk of death. Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection. The reduction in the incidence of surgical site infection that is expected to result from improvement in the timing of antibiotic prophylaxis will primarily benefit Medicare beneficiaries through reduced morbidity and mortality. It will benefit CMS and Medicare secondarily through the reduced need for and cost of rehospitalization for treatment of infections.

The goal of administering the antibiotic before surgery is to establish an effective level of the antibiotic in the body to prevent the establishment of infection during the time that the surgical incision is open. Studies performed in the 1960's and 1970's demonstrated that a common reason why the prevention failed was because the antibiotics were administered too far ahead of surgery (resulting in diminished antibiotic levels towards the end of surgery) or after the operation began (resulting in an absence of antibiotics towards the beginning of surgery). In a study of 2,847 surgery patients at The Latter Day Saints (LDS) Hospital in Salt Lake City, Classen, et al. found that the lowest incidence of

post-operative infection was associated with antibiotic administration within one hour prior to surgery. The risk of infection increased progressively with greater time intervals between administration and skin incision. This relationship was observed whether antibiotics preceded or followed skin incision.
Opportunities to improve postoperative care have been demonstrated. The actual systems within hospitals are often the cause of improper antibiotic timing. For example, at LDS Hospital, administration of the first antibiotic dose "on call" to the operating room was frequently associated with the antibiotic being administered too early. Restructuring the system resulted in an increase in appropriate timing from 40 percent of cases in 1985 to 99 percent of cases in 1998.

The Centers for Medicare & Medicaid Services (CMS) has been developing the national Medicare Surgical Infection Prevention (SIP) Project, www.surgicalinfectionprevention.org, since 1999. The SIP Project measures the frequency of antibiotic administration within the hour prior to five common types of major surgery where infection is the most likely to occur (see below). The chart below shows the percentage of specific surgeries where antibiotics were administered within the hour prior to surgery. The data from FY 01 will be the baseline from which future years will be measured. While the data being collected have specific targets for the individual surgeries, CMS will only be reporting on the percentage of proper administration for the total of all five types of surgery.

Percentage of Patients in 2001 who Received Preventive Antibiotics within the Recommended Timeframe by Surgery



Coordination: The Centers for Disease Control and Prevention (CDC) has been a major partner in this project. The project is being implemented by the Medicare quality improvement organizations (QIOs) during the seventh contract cycle. All 53 QIOs were engaged in the project as of February 1, 2003.

CMS and CDC have formed partnerships with 13 outside organizations to support the project. These include the American Academy of Orthopedic Surgeons, the American College of Surgeons, the American Geriatrics Society, the American Hospital Association, the American Society of Anesthesiologists, the American Society of Health Systems Pharmacists, the Association of Perioperative Registered Nurses, the

Association for Professionals in Infection Control and Epidemiology, the Infectious Diseases Society of America, the Joint Commission on Accreditation of Healthcare Organizations, the Society for Healthcare Epidemiology, the Surgical Infections Society, the Voluntary Hospital Association, the Society of Thoracic Surgeons, and Premier, Inc. The Oklahoma Foundation for Medical Quality was contracted as the support QIO for the project. A SIP collaborative that applied the quality improvement methods of the Institute for Healthcare Improvement was recently completed at selected hospitals in all 50 States. Results of that collaborative indicated that substantial improvement in the delivery of prophylactic antibiotic is possible and that the incidence of surgical site infection can probably be reduced as a result.

In addition, Federal and private organizations are developing an expanded version of the SIP Project with a goal of reducing the incidence of surgical site infection plus other complications such as pneumonia, myocardial infarction, venous thrombosis, and pulmonary embolism. Pilot projects are now active in three States, with the new project to become operational in August 2005.

Data Source: Baseline State-level performance rates are calculated using data abstracted from up to 870 medical records sampled randomly in each State. Data collection for years following the initial baseline will use methods that reflect the evolution of CMS quality improvement activities toward reporting at the hospital level. Each successive year will include an increasing proportion of data that are collected by individual hospitals. A sample of these data will be validated by the Medicare quality improvement organization in each State. Ongoing surveillance sampling will continue through the entire QIO contract period. Data are collected by two clinical data abstraction centers that have been under contract with CMS for 7 years. An abstraction tool designed specifically for that purpose supports data collection by hospitals.

Verification and Validation: The accuracy and reliability of data from the abstraction centers are monitored constantly through reabstraction of a sample of medical records. If the data collected by hospitals are used by CMS, the data will then be validated by each State's QIO and/or the clinical data abstraction centers. It was during this process that a flaw in the original abstraction was discovered. The original data were corrected, and targets recalculated at the same rates originally targeted.

Quality of Care: Survey and Certification

Survey and Certification Program	FY 2002 Actual	FY 2003 Actual	FY 2004 Final Conference	FY 2005 Estimate
Total	**$252.5 M**	**$252.1 M**	**$251.3 M**	**$270.4 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. CMS' investment in quality oversight includes initial inspections of providers who request participation in the Medicare program, periodic 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' 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' 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 **[outcome goal]** Measure based on QM % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 6.6% **FY 04:** 7.2%	**FY 05:** **FY 04:** **FY 03**: 7.8%** **FY 02:** 9.3% **(Baseline)**** ** Measure based on MDS-QM	QSC1 **3,5** See revised FY 04 Final
Decrease the Prevalence of Restraints in Nursing Homes **(outcome goal)** *Measure based on OSCAR Shaded area indicates goal based on previous data	**FY 04:** Switched to new data source (see above) **FY 03:** 10% **FY 02:** 10% **FY 01:** 10% **FY 00:** 10% **FY 99:** 14%	 **FY 03:** 03/04 **FY 02:** 9.6% (Goal met)* **FY 01:** 10.0% (Goal met)* **FY 00:** 10.0% (Goal met) * **FY 99:** 11.9% (Goal met)* **FY 96:** 17.2% **(Baseline)*** *Measure based on OSCAR	
Decrease the Prevalence of Pressure Ulcers in Nursing Homes **(outcome goal)** % of full cost (FY 2003-2005): See	**FY 05:** 8.7% **FY 04:** 8.9%	**FY 05:** **FY 04:** **FY 03:** 8.9% ** **FY 02:** 8.6% ** **Measure based on MDS-QM	QSC2 HP-1 **3,5** See

Performance Goals	Targets	Actual Performance	Ref.
Section F in Appendix A			Revised 04 Final
Decrease the Prevalence of Pressure Ulcers in Nursing Homes **[outcome goal]** *Shaded area indicates goal based on previous data source.	**FY 03:** 9.5% **FY 02:** 9.5% **FY 01:** 9.6 % **FY 00:** Establish baseline/targets	**FY 03:** 03/04 **FY 02:** 9.8% (Goal not met)* **FY 01:** 10.5% (Goal not met)* **FY 00:** 9.8% (Goal met)* **(Baseline)** *Measure based on MDS-QI	
Assure the Purchase of Quality, Value, and Performance in State Survey and Certification Activities.			QSC4 
-- Develop and implement a measure to allocate State survey and certification funding in a manner that links value to quality performance.	**FY 05:** Develop a FY 2005 State Survey and Certification budget allocation method that allocates available increases in the budgets for state agencies in a manner that promotes high levels of state performance and value-based purchasing of survey activities on the part of CMS.	**FY 05:** (Developmental)	See FY 04 Revised Final
% of full cost (FY 2003-2005): See Section F in Appendix A	**FY 04:** Develop a FY 2004 State Survey and Certification budget allocation method that allocates available increases in the budgets for state agencies in a manner that promotes high levels of state performance and value-based purchasing of survey activities on the part of CMS.	**FY 04:** (Developmental)	

Performance Goals	Targets	Actual Performance	Ref.
Improve the Management of the Survey and Certification Budget Development and Execution Process -- Use price based methodology to allocate survey and certification appropriation	**FY 03:** Allocate FY 2003 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC and/or NLTC surveys. **FY 02:** Allocate FY 2002 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC surveys. **FY 01:** Allocate FY 2001 budget increases to those States within the 15% threshold for unit survey hours **FY 05:** Assure FY 04 standards are met and identify appropriate corrective action plans **FY 04:** Assure FY 03 standards are met and identify appropriate corrective action plans **FY 03:** Assure FY 02 standards are met and identify appropriate corrective action plans **FY 02:** Evaluate FY 01 performance results **FY 01:** Develop measures	**FY 03:** (Goal met) **FY 02:** (Goal met) **FY 01:** (Goal met) **FY 05:** **FY 04:** **FY 03:** (Goal met) **FY 02:** (Goal met) **FY 01:** Measures developed (Goal met)	QSC3  See FY 04 Revised Final
-- Use performance measures and baselines to measure quality of survey work performed.			

Performance Results Discussion

The core of the nursing home survey process is a 4-5 day onsite visit that checks to see that a nursing home is meeting Federal health and safety requirements. The standard survey takes a "snapshot" of beneficiary care. They are unannounced and, by legislation, must take place based on a statewide average of once every 12 - 15 months. Also, States must conduct complaint surveys within proscribed time frames any time a serious problem is alleged.

CMS monitors specific data reported by nursing homes such as the Minimum Data Set (MDS) and the administrative data from the Online Survey Certification and Reporting System (OSCAR) and uses these aggregate data sets to provide a comprehensive view of the individual receiving care in the nursing home. Starting in FY 2004, CMS will use the MDS Quality Measure (MDS-QM) for both the reporting of physical restraints and pressure ulcers. State Survey and Certification Agencies focus on quality of care furnished to residents as measured by indicators of medical, nursing and rehabilitative

care, dietary and nutrition services, activities and social participation, sanitation, infection control, and the physical environment. Our performance goals to improve the rates of physical restraints and pressure ulcers in nursing homes represent the Agency's commitment to protect its beneficiaries.

We know that targeted quality improvement initiatives improve the quality of care and Medicare Quality Improvement Organizations (QIOs) are leaders in these efforts. Quality improvement in nursing homes is a major focus of the QIOs under the 7th Scope of Work (SOW). In fact, the QIOs will be supporting CMS' efforts to publicly report the quality of care in nursing homes. The Nursing Home Quality Initiative is a multi-pronged effort that consists of 1) CMS' continuing regulatory and enforcement initiatives conducted by State survey agencies; 2) new and better consumer information on the quality of care in nursing homes; 3) community-based quality improvement programs offered by QIOs; and 4) collaboration and partnership to leverage knowledge and resources. QIOs will work with nursing home providers to improve performance on agreed upon measures and to implement quality improvement projects and will work with the stakeholders, including the State Survey & Certification agencies to improve care. Together, these activities will help us achieve our annual nursing home performance goals.

Physical Restraints - CMS' 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 9.6 percent in 2002. Data for FY 2003 will be available in March 2004. Starting in FY 04, CMS will use MDS-QM scores to report the prevalence of physical restraints.

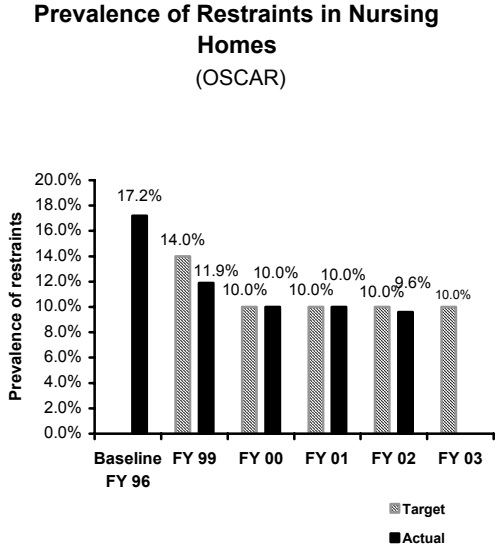
Pressure Ulcers – CMS is concerned about not meeting the Pressure Ulcer target in 2002 and about the gap between the target and the measured rate. We believe that this gap may stem, in part, from a number of factors: an artifactual effect due to facilities' change in coding behavior resulting in reporting of pressure ulcers that would not previously have been reported; and an increase in case-mix (severity of illness) of the nursing home population. We are working to better understand and address these variables. Also, we are developing a program to educate providers about more accurate assessment and coding, as well as new protocols aimed at onsite audit procedures that will verify the accuracy of nursing homes' Minimum Data Set (MDS) assessments. Data for FY 2003 will be available in March 2004. Starting in FY 04, CMS will use MDS-QM scores to report the prevalence of pressure ulcers.

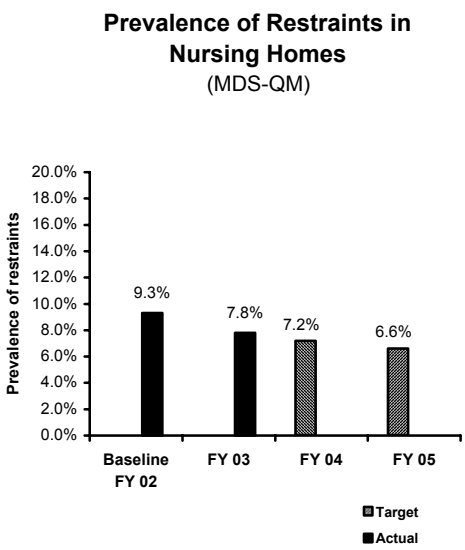
Survey and Certification Budget – Our goal to improve the survey and certification budget process moved CMS from the "cost" based approach to a "price" based methodology, which uses national standard measures of workload and costs to project individual State workloads and budgets. CMS met its FY 2003 target to allocate the FY 2003 budget increase to the State Survey and Certification budget using a price-based methodology. CMS 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 2003 base budget that assumed the FY 2002 funding level. All other States received a FY 2003 base budget increase proportionate to each State's FY 2002 budget. In FY 2003, CMS will assess State survey agency performance based on the quality of survey work performed. CMS regional offices are currently working with States to review and assess State survey agency performance according to the seven State performance standards established by CMS. In FY 2004 and FY 2005, CMS will use available performance data to develop and implement a measure that moves toward the linking of value to quality State survey agency performance.

Performance Goal QSC1-05

Decrease the Prevalence of Restraints in Nursing Homes





Discussion: "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. According to the law, restraints may only be imposed to treat the resident's medical symptoms or to ensure safety and only upon the written order of a physician (except in emergency situations). Restraints should never be used for staff convenience or to punish the resident.

The two charts above present target and actual rates derived from two different data sources. From FY 1996 through FY 2002, the mean facility restraint prevalence was calculated from data reported by the nursing homes at the annual survey. These data were collected in CMS's survey and certification database known as the Online Survey and Certification and Reporting (OSCAR). Beginning in FY 2002, pressure ulcer prevalence measures were also calculated using the Minimum Data Set Quality Measure (MDS-QM) scores used on Nursing Home Compare. Starting in FY 2004, CMS will report the prevalence of restraints in nursing homes using the MDS-QM scores. The purpose of this change is to use a set of measurements that are more consistent with those used in CMS's public reporting initiative.

The prevalence of restraints in nursing homes has decreased steadily since FY 1996. Final performance results for the FY 2002 restraints target shows the prevalence at 9.6 percent using OSCAR. FY 2003 OSCAR data will not be available until March 2004. Performance results for the FY 2002 prevalence of physical restraints is 9.3 percent using the MDS-QM score.

The reduction in the use of physical restraints has been one of CMS's major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care and may be 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 has promoted the reduced use of physical restraints is through the annual survey process. 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. In addition, the Quality Improvement Organizations (QIOs), which are dedicated to working directly with individual providers to improve the quality of care delivered, play an important role in helping nursing homes reduce the use of physical restraints in their facilities.

In establishing quality of care performance goals, 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, CMS places considerable importance on nursing home quality measures. A significant portion of both Medicare and Medicaid benefit dollars pay for care in nursing homes. Although not yet updated for FY 2003, 19 percent of benefit dollars under Medicaid and nearly 6 percent for Medicare were expended for nursing home care in FY 2002. In FY 2004, CMS is proposing a target restraint rate of 7.2 and a target restraint rate of 6.5 percent for FY 2005. We are evaluating several new interventions to achieve these rate reductions.

Coordination: CMS's coordination includes State survey agencies, QIOs, and CMS Regional Offices.

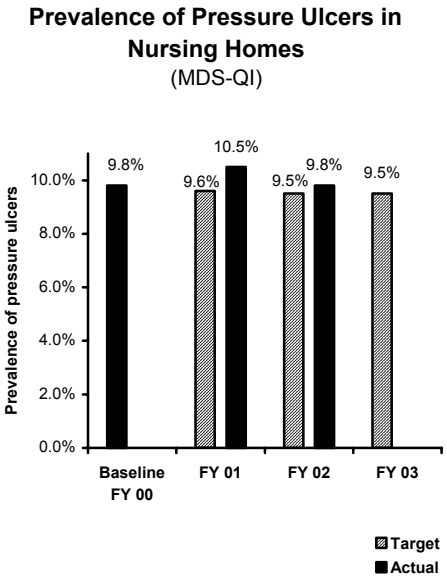
Data Source(s): Previously, data on the use of physical restraints were obtained from the Online Survey and Certification and Reporting (OSCAR) database. With this GPRA update, CMS is reporting on the physical restraints using the publicly-reported Quality Measures derived from the the Minimum Data Set (MDS-QM). The physical restraints quality measure being used is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison (CHSRA). We report the prevalence of physical restraints—excluding side rails—in the last three months of the fiscal year. If the year is not complete, we report the most recent data available.

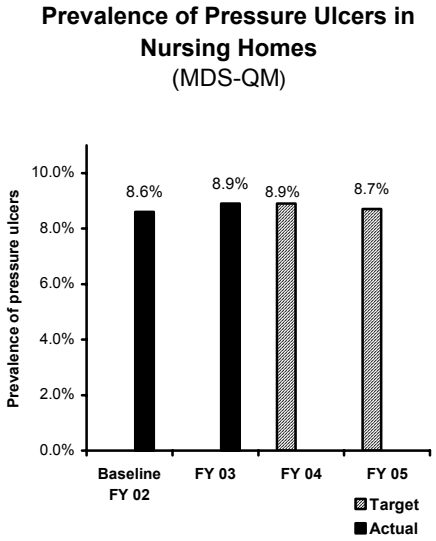
Verification and Validation: The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self reported by the nursing home.

MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

Performance Goal QSC2-05

Decrease the Prevalence of Pressure Ulcers in Nursing Homes





Discussion: "Pressure ulcer" refers to any lesion caused by unrelieved pressure resulting in damage to underlying tissues. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents except in those whose clinical condition impedes the prevention of pressure ulcer development.

The two charts above present target and actual rates derived from two different data sources. From FY 2000 through FY 2002, the mean pressure ulcer prevalence was calculated using the Minimum Data Set Quality Indicator (MDS-QI) scores. Beginning in FY 2002, pressure ulcer prevalence measures were also calculated using the Minimum Data Set Quality Measure (MDS-QM) scores used on Nursing Home Compare. Beginning in FY 2004, CMS will only report the prevalence of pressure ulcers in nursing homes using MDS-QM scores. The purpose of this change is to use a set of measurements that are more consistent with those used in CMS's public reporting initiative.

Using MDS-QI measures, the prevalence of pressure ulcers in nursing homes decreased slightly from FY 2001 to 2002. Final performance results for the FY 2002 pressure ulcer target shows the prevalence at 9.8 percent using the MDS-QI measures and 8.6 percent using the MDS-QM. FY 2003 MDS-QI data will not be available until March 2004.

CMS believes that the increase in the reported prevalence of pressure ulcer prevalence stems from 1) a change in facilities' coding behavior leading to their reporting pressure ulcers that would not previously have been reported and 2) an increase in case-mix

(severity of illness) of the nursing home population. The small increase from FY 2002 to FY 2003 may also reflect normal random variation.

Reduction of facility-acquired pressure sores remains a high priority of the agency. CMS has tasked the Quality Improvement Organizations (QIOs) with assisting nursing homes in creating quality improvement protocols directed toward preventing and treating pressure ulcers.

Additionally, CMS has convened a panel of national clinical experts in pressure sore treatment and prevention. These experts have helped CMS revise the interpretive guidelines and investigative protocols used by surveyors and to improve surveyor training. Changes to the protocols include: adding information about the location of current clinical practice guidelines; enhancing the definitions related to pressure ulcer identification; providing an overview of current processes and practices for the prevention and treatment of pressure ulcers; and revising the investigative protocol for determining if pressure ulcer development was avoidable by the facility. In addition, it is planned that educational opportunities regarding the final products will be provided to both surveyors and providers, utilizing nationally recognized clinical experts in pressure ulcer care. CMS anticipates that the guidance will be finalized in the Spring of 2004. CMS plans to offer training via satellite broadcast on that guidance during the summer of 2004.

Coordination: CMS is working with provider organizations, States, and consumer advocates on an ongoing basis in developing survey instruments and guidelines. In addition, we have invited nationally recognized pressure ulcer experts from the National Pressure Ulcer Advisory Panel to help us develop consistent nursing home survey protocols.

Data Source(s): CMS will solely use the quality measures derived from the Minimum Data Set (MDS) to measure the prevalence of pressure ulcers in long term care facilities from FY 2004 forward. Prior to FY 2004, CMS will report using MDS-QI scores. Nursing homes submit this information to the State MDS database, which is linked to the national MDS database. The measure being used for the pressure ulcer goal is adapted from one developed by the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin, Madison. For this goal we report the prevalence of pressure ulcers measured in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. The numerator consists of all residents with a pressure ulcer, stages 1-4, on the most recent assessment and the denominator is all residents. Pressure ulcers counted on admission assessments are excluded.

Verification and Validation: The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self reported by the nursing home.

MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

Performance Goal QSC3-03

Improve the Management of the Survey and Certification Budget Development and Execution Process
(Discontinued after FY 2003)

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/or non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed. **Performance:** FY 2003 Target met for allocating FY 2003 Survey and Certification budget. The results of the FY 2003 state survey Performance Standards were submitted to CMS by the state survey agencies in July 2003. Consolidated data report is pending.
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. **Performance:** FY 2002 Target met for allocating FY 2002 Survey and Certification budget. CMS finalized the consolidated data report of the FY 2002 State Survey Performance Standards that will be sent back to the regions and states. The final FY 2002 National Performance Standards Report is currently pending.
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: 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, CMS moved from a cost-based budget development and execution model to a price-based model. A price-based methodology for developing and allocating survey and certification funding uses national standard measures of workload and costs to project individual State workloads and budgets, in order to move States towards more uniformity and efficiency.

To accomplish these objectives and to help ensure national consistency in the survey and certification budget process, CMS continues to review and analyze State reported OSCAR 670 data in the area of survey hours reported for long term care facilities.

For example, budget policy decisions for FY 2003 were dependent upon three different key factors: (1) original FY 2003 State budget requests, (2) accompanying regional budget recommendations, and (3) internal budget and data analysis.

Specifically, for FY 2003 the FY 2002 State funding levels were assumed as the budget baseline for all States. CMS then analyzed combined national average survey times for skilled nursing facilities (SNFs) and SNF/Nursing Facilities (NFs). Any State that exceeded the combined national average survey time for SNF and SNF/NFs, by 15 percent or more, was provided a FY 2003 budget that assumed the FY 2002 funding level. All other States received a share of the overall State funding increase from FY 2002 to FY 2003 that was proportionate to each State's FY 2002 budget, and subject to regional office recommendations.

CMS will continue to update historical data with state reported Online Survey and Certification and Reporting (OSCAR) data. In FY 2004 and FY 2005, CMS will work towards a goal that focuses more on assuring the purchase of quality, value, and performance in State survey and certification activities.

CMS finalized the consolidated data report of the FY 2002 State Survey Performance Standards that will be distributed to the CMS regional offices and states. The FY 2002 National Performance Standards Report final analysis is currently pending. FY 2003 performance standards for State survey agencies were completed by the State survey agencies in July 2003, and State data consolidation efforts are currently pending.

CMS anticipates that updates to the performance standards will occur on an annual basis.

Coordination: CMS's coordination includes CMS Regional Offices (ROs) and State survey agencies.

Data Source(s): Workload data obtained from state reported OSCAR 670 data and State Survey and Certification Workload Reports (Form HCFA-434). The budget, expenditures, and baseline data are obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.

Verification and Validation: OSCAR 670 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.

Performance Goal QSC4-05
Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities

Baseline: Developmental
FY 2005 Target: Develop a FY 2005 State Survey and Certification budget allocation method that allocates available increases in the budgets for state agencies in a manner that promotes high levels of state performance and value-based purchasing of survey activities on the part of CMS.
FY 2004 Target: Develop a FY 2004 State Survey and Certification budget allocation method that allocates available increases in the budgets for state agencies in a manner that promotes high levels of state performance and value-based purchasing of survey activities on the part of CMS.

Discussion: The primary mission of CMS's survey and certification program is to ensure that the nation's elderly and disabled receive high quality care and adequate protections. 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 the above objectives, CMS has begun to move from a cost-based budget development and execution model to a value-based model. In 2001, 2002, and 2003 increases to the state survey and certification budget were allocated using price-based boundaries: states only received a budget increase if their average hours per survey were within 115% of the national average.

Moreover, CMS has designed and implemented a system of state performance indicators for survey and certification activities. Seven (7) performance measures were implemented in FY 2001 on a test basis, were fully deployed in 2002, and further refined in 2003. The performance standards include:

- Standard 1: Surveys are planned, scheduled and conducted timely.

- Standard 2: The State Survey Agency effectively communicates noncompliance on the CMS form 2567, Statement of Deficiencies.

- Standard 3: Certifications are fully documented, and consistent with applicable law, regulations and general instructions.

- Standard 4: When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to.

- Standard 5: All expenditures and charges to the program are substantiated to the Secretary's satisfaction.

- Standard 6: The conduct and reporting of complaint investigations are timely and accurate, and comply with CMS general instructions for complaint handling.

- Standard 7: Accurate and timely data is entered into online survey and certification data systems.

CMS is committed to move forward in its ongoing efforts to focus on the assurance of purchasing quality, value, and performance in State survey and certification activities. The foundation of this commitment and focus is based on the recent development and implementation by CMS of the 7 State performance measures, as well as the successful CMS efforts (since FY 2001) in meeting Performance Goal QSC3-03.

Actual performance data have been collected for 2002 and 2003 activities. Those data are currently being analyzed. We will use all such available performance data to develop and implement a measure that moves toward the linking of value and performance to bolster the importance of the quality of surveys; the overall state performance in completing the required number and frequency of surveys; and the effective performance of State survey agencies in taking remedial action on complaints and deficiencies. The measure will then be incorporated in the allocations of any available budget increases for survey and certification in FY 2004 and FY 2005.

Coordination: CMS's coordination includes CMS Regional Offices (ROs) and State survey agencies.

Data Source(s): Information on State performance reviews are obtained from the CMS/CMSO National Performance Standards Report. Workload data obtained from state reported OSCAR 670 data and State Survey and Certification Workload Reports (Form HCFA-434). The budget,-expenditures, and baseline data are obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.

Verification and Validation: OSCAR 670 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. State Agency performance reviews are conducted by CMS each fiscal year.

Grants to States for Medicaid/Medicaid Agencies

Medicaid Activity	FY 2002 Actual	FY 2003 Actual	FY 2004 Current Estimate	FY 2005 Estimate
Total	**$151.6 B**	**$169.0 B**	**$177.3 B**	**$183.2 B**

Medicaid is a means tested health care entitlement program financed by States and the Federal Government. Approximately 43 percent of the funding came from the States and 57 percent from the Federal Government in FY 2002. 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 not listed in the chart below is:

- Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and Increase Enrollment of Eligible Children in Medicaid (SCHIP1-05)

Performance Goal	Targets	Actual Performance	Ref.
Increase the Percentage of Medicaid Two-Year Old Children Who are Fully Immunized **[outcome goal]**		**(See Appendix B for performance details.)**	MMA2
-- Group I	**FY 05:** 3-year reporting period complete	**FY 05:** N/A	HP-14
	FY 04: 3-year reporting period complete	**FY 04:** N/A	**1, 7**
	FY 03: Measure State-specific immunization rate- Achieve State target	**FY 03:** 6 of 16 States have reported third and final remeasurement	
	FY 02: Measure State-specific immunization rates	**FY 02:** 16 of 16 States have reported second remeasurement.	
	FY 01: Measure State-specific immunization rates	**FY 01:** All methodologies, baselines and targets set. 16 of 16 States report first remeasurement.	
	FY 00: Complete development of State-specific methodologies and baselines	**FY 00:** 16 of 16 States completed methodologies and baselines.	
		FY 99: Identified Group I States and began developing State-specific methodology and baselines.	

Performance Goal	Targets	Actual Performance	Ref.
--Group II	**FY 05:** 3-year reporting period complete **FY 04:** Measure State-specific immunization rate **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 05:** N/A **FY 04:** **FY 03:** 4 of 10 States have reported second remeasurement. **FY 02:** 8 of 10 States have reported first remeasurement. **FY 01:** 10 of 10 States complete methodologies and all have reported baselines and targets **FY 00:** Identified Group II States and began developing State-specific methodology and baselines	
-- Group III % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Measure State-specific immunization rate. **FY 04:** Measure State-specific immunization rate. **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 05:** **FY 04:** **FY 03:** 12 of 24 States have reported first remeasurement. **FY 02:** 21 of 24 States complete methodologies and have developed baselines and/or targets. **FY 01:** Group III States identified; began developing State-specific methodologies and baselines **FY 00:** N/A	

Performance Goal	Targets	Actual Performance	Ref.
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates. **[outcome & efficiency goal]** % of full cost (FY 2003-2005): See Section F in Appendix A.	**FY 05:** Publish a proposed rule, scheduled for April 2004. **FY 04:** Pilot test the finalized CMS PAM Model in both Title XIX Medicaid and Title XXI SCHIP programs in up to 25 States and develop final specifications for the model. **FY 03:** Expand the project to 12 States; pilot test the CMS PAM Model in all 12 States. Assess the results of the FY 02 pilot study; develop draft final specifications for the CMS PAM Model to be pilot tested in FY 04. **FY 02:** Pilot study in 9 States. **FY 01:** Pilot study in 2 States.	**FY 05:** **FY 04:** 27 States are participating **FY 03**: (Goal Met) 12 States participating **FY 02:** (Goal met) **FY 01:** (Goal not met) **Baseline:** To be determined	MMA4 See FY 04 Revised Final **8**
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) **[outcome goal]** (Developmental) -- Medicaid	**FY 05:** **(a)** Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States. **FY 04:** **(a)** Continue to work with State representatives and update the timeline for implementing recommendations; **(b)** Continue to identify a strategy for improving health care delivery and **(c)** Initiate action steps for implementing recommendations.	**FY 05:** **FY 04:**	MMA5 See FY 04 Revised Final **5**

Performance Goal	Targets	Actual Performance	Ref.
	FY 03: **(a)** Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and **(c)** Initiate action steps for implementing recommendations.	**FY 03:** (Goal partially met) **(a)** Goal Met **(b)** Goal Partially met/ Partially delayed. Data expected 6/04. **(c)** Goal Not met/ Delayed	
-- SCHIP	**FY 05:** **(a)** Continue to collect core performance measurement data from States through the State annual reports; **(b)** Use the new automated State Annual Report Template System (SARTS) to analyze and evaluate performance measurement data; **(c)** Provide technical assistance to States on establishing baselines, measurement methodologies, and targets for SCHIP core measures. **FY 04:** **(a)** Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format; and **(c)** Collect 2003 data (baseline) from States.	**FY 05:** **FY 04:** Data expected early CY 05.	
% of full cost (FY 2003-2005): See Section F in Appendix A	**FY 03:** To begin working with States on the PMPP. **(a)** Report on results of the meeting with States and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging	**FY 03:** (Goal met)	

Performance Goal	Targets	Actual Performance	Ref.
	improvement; **(c)** Initiate action steps for implementing recommendations; and **(d)** Begin to implement core SCHIP performance measures.		

Performance Results Discussion

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

Fifty of the fifty-one States eligible to participate in this project continue to work actively to increase the immunization rates of Medicaid two-year old beneficiaries. Maintaining the parameters of the project over five years, as established by each State, is not easily accomplished. Many States have encountered difficulty in continuing their methodologies and have had to find ways to resolve these issues to stay in the project. However, we believe that measuring States' performance through this project has affected immunization rates by providing an opportunity to draw attention to poor immunization rates in some States and focus them on improvement. In States where immunization rates are high, this project validates and highlights their current efforts and gives them an opportunity to continue successful interventions and plan additional interventions to maintain or improve their rate.

Data for FY 2003 indicate 38 percent of Group I States reported their third and final remeasurement, 40 percent of Group II States reported second remeasurement and 50 percent of Group III States reported their baselines and/or targets. Details on Group I, II and III States can be found in Appendix B. This Appendix summarizes each State's methodology, relevant definitions, numerical baselines, 3-year targets, and interim remeasurements.

Medicaid Payment Error Rate – We met the FY 2003 goal to assist States in conducting Medicaid payment accuracy studies seeks to measure and ultimately reduce Medicaid payment error rates. Twelve states participated in the second year of the pilot (FY 2003) Medicaid Payment Accuracy Measurement (PAM) Project; seven of these States pilot tested the CMS PAM Model in their fee for service program, four States tested the model in both their fee for service and managed care programs, and one State tested the model specifically in their managed care program. Notably, eight of these twelve States participated in the first year (FY 2002) of the PAM Project. During the second year (FY 2003), the CMS PAM model was modified for compliance with the Improper Payments Information Act of 2002 to measure the rate of improper payments attributable to overpayments, underpayments, and payments to ineligible beneficiaries. The model was also modified for application to the Title XXI SCHIP program. Therefore, in FY 2004, the project will be expanded to include twenty-seven states that

will pilot test the CMS PAM Model in their Title XIX Medicaid and/or Title XXI SCHIP programs. Final PAM Project report data for the second year (FY 2003) will be available 04/30/04.

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) – 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. In FY 2003, CMS met its SCHIP targets for this goal: (a) CMS reported on results of the meeting with State representatives (identified proposed measures) and are proceeding towards implementing recommendations; (b) CMS and States are identifying a strategy for improving health care delivery and/or quality and have already specified measures; (c) CMS is initiating action steps for implementing recommendations by asking States to begin reporting on the core measures in the FY 2003 annual reports, to the extent data is available; and (d) CMS and States are beginning to implement core SCHIP performance measures.

In FY 2003, CMS partially met its Medicaid targets for this goal: (a) (Met) Identified proposed measures and are identifying a timeline for implementing recommendations; (b) (Partially met/ Partially delayed) Identifying a strategy for improving health care delivery and/or quality and have already specified measures for gauging improvement; (c) (Not met/ Delayed) Initiating action steps for implementing recommendations by requesting states to report available data on the core set of performance measures as a pilot test.

Medicaid targets have been delayed because CMS received OMB clearance for the data collection tool in September 2003. Following notification of the form's clearance, CMS convened a teleconference with State representatives in September 2003 to discuss the data collection tool and a preliminary timeline for data reporting. A "Dear State Health Official" letter requesting States to report available data on the core set of performance measures as a pilot test also will be sent to the States by the middle of CY 2004.

CMS is also planning to establish a formal process to develop evidence-based Medicaid health improvement priorities (including performance measure specifications and targeted improvement models). Also in FY 2003, we are planning to implement performance measures in the Medicaid programs and begin a process to collect baseline data for those measures. In FY 2004, CMS and the States will begin to refine data submission, methodological processes and reporting, and CMS will initiate a process to collect baseline data from the States to begin measuring progress.

Performance Goal MMA2-05

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

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Group I	Develop Baseline	Report 1st Year	Report 2nd Year	Report 3rd Year	Project Complete	
Group II		Develop Baseline	Report 1st Year	Report 2nd Year	Report 3rd Year	Project Complete
Group III			Develop Baseline	Report 1st Year	Report 2nd Year	Report 3rd Year

Figure 1: Timeline for State Activities

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 worked 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 is 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 is not useful or meaningful.

The methodologies chosen by individual States depended 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 defined 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: CMS has worked closely with States, the CDC, and the American Public Human Services Association (APHSA) to develop a strategy for this goal. 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 MMA4-05

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

Baseline: Prior to FY 2001**,** Illinois, Texas, and Kansas have independently developed methodologies to conduct State level Medicaid payment accuracy studies; no suitable methodology to produce national level estimates has been developed.
FY 2005 Target: Publish a proposed rule, scheduled for April 2004, that requires States to estimate payment error in Medicaid and SCHIP using the methodology developed in the PAM Project.
FY 2004 Target: Pilot test the CMS Payment Accuracy Measurement (PAM) Model in both Title XIX Medicaid and Title XXI SCHIP programs in up to twenty-five States and develop the final specifications for the model. The CMS PAM Model is expected to produce both State specific and national level payment accuracy estimates. This model was developed as a result of FY 2002 experiences and initially pilot tested with twelve States during FY 2003.
FY 2003 Target: Expand the PAM Program to twelve States. Pilot test the CMS PAM Model in all twelve of these States. Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to develop draft final specifications for the CMS PAM Model. **Performance:** Goal met. Twelve States are participating in FY 2003.
FY 2002 Target: Nine pilot States will conduct payment accuracy measurement studies. The 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 FY 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). **Performance:** Goal met. Nine States have developed payment accuracy methodologies as part of their participation in the pilot study; final reports will be reviewed as part of the FY 2003 Target.
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 would 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 Improper Payments Information Act of 2002 (Public Law 107-300) directs each executive agency, in accordance with the Office of Management and Budget (OMB) guidance, to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments, and submit those estimates to Congress before March 31 of the following applicable year.

In Exhibit 57B of OMB Circular A-11, programs for which improper payment information is requested within the Department of Health and Human Services include: Head Start, Medicare, Medicaid, Temporary Aid to Needy Families (TANF), Foster Care Title IV-E, State Children's Health Insurance Program (SCHIP), and the Child Care and Development Fund.

In FY 2000 CMS adopted a Government Performance Reporting Act (GPRA) goal to explore the feasibility of developing a methodology to estimate improper payments for the Medicaid program. During the year, CMS established the Medicaid Payment Accuracy Measurement (PAM) Project. Prior to the Medicaid PAM Project only three States, Illinois, Texas, and Kansas, had attempted to estimate payment accuracy for the Medicaid program at the State level and no model had been developed to estimate payment accuracy at the national level.

In July of 2001, CMS formally solicited States to participate in the first year of the Medicaid PAM Project (FY 2002). Using a combination of Federal Financial Participation (FFP) and Health Care Fraud and Abuse Control (HCFAC) grant funds, nine States were awarded grants to develop and pilot test various methods for measuring the accuracy of Medicaid payments. These nine States were Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming. These States each received 100 percent reimbursement for their first year PAM project costs.

During the first year of the project, CMS also contracted with The Lewin Group as the technical consultant to the Medicaid PAM Project in order to work with the States and to help develop a single methodology that can be used by all States. Working collaboratively with the nine States, CMS and The Lewin Group developed the CMS PAM Model. The CMS PAM Model has been designed to estimate a State-specific payment accuracy rate that is within +/- 3 percent of the true population accuracy rate with 95 percent confidence. Moreover, through weighted aggregation, the State-specific estimates can be used to make national level payment accuracy estimates for the Medicaid program.

In May 2002, CMS solicited States to participate in the second year of the Medicaid PAM Project (FY 2003). Twelve States were awarded PAM grants to pilot test the CMS PAM Model. These twelve States are: Florida, Indiana, Louisiana, Mississippi, Nebraska, New York, North Carolina, North Dakota, Oklahoma, Texas, Washington, and Wyoming. Notably, eight of these twelve States also participated in the first year of the project. Each of the twelve States will pilot test the CMS PAM Model and, as in the first year of the project, each of these States will receive 100 percent reimbursement for all project costs.

In June 2003, CMS solicited states to participate in the third year of the PAM Project (FY 2004). In the solicitation, CMS encouraged states to pilot test the CMS PAM Model in both Medicaid and SCHIP. Twenty-seven States were awarded PAM grants to pilot test

the model in their Title XIX Medicaid program and/or Title XXI SCHIP program. As in the previous two years, using a combination of FFP and HCFAC funds, States will receive 100 percent reimbursement for all PAM Project expenditures. In order to accommodate the diversity among States, provide maximum flexibility, and expand participation, CMS offered each State the opportunity to participate in any or all aspects of the PAM Project that are relevant to the State. As such, States chose to pilot test the model in either their Medicaid or SCHIP programs, or in both programs. Furthermore, within Medicaid, States chose to pilot test the FFS component, the MC component, or both. Similarly, in SCHIP, States chose to pilot test the model in either their Medicaid expansion, stand alone, or both components of their program. Although, CMS encouraged States to participate in all relevant areas, some States prefer selective participation. However, to maintain consistency, all States are required to adhere to the procedures and guidelines detailed in the CMS PAM Model. At the conclusion of the third year of pilot testing, the final specifications for the CMS PAM Model will be produced in anticipation of nationwide implementation, known as Payment Error Rate Measurement (PERM).

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. The CMS will work closely with the pilot States, as well as with States collectively through the National Association of State Medicaid Directors. During the second year, The Lewin Group will be providing technical assistance to all twelve States pilot testing the CMS PAM Model. The Lewin Group will be providing similar technical assistance during the third year of the project to a potentially greater number of States that will be pilot testing the CMS PAM Model in their Medicaid, SCHIP, or both programs.

Data Source(s): The nine pilot States in the first year used their own Medicaid paid claims, encounter data, and related medical records, and tested differing PAM methodologies. During the second year, each of the twelve States will continue to use their own paid claims and medical records; however, all twelve States will be pilot testing the CMS PAM Model. Similarly, during the third year, all States will be pilot testing the CMS PAM Model in their Medicaid and/or SCHIP programs and each State will use their own paid claims and medical records to conduct the study.

Verification and Validation: The CMS and The Lewin Group will work with the pilot States, Medicare, and the Inspector General to evaluate the PAM Project, including the data sources and validation techniques. During the second year, CMS and The Lewin Group will work closely with all twelve States pilot testing the CMS PAM Model to ensure that implementation was consistent across the participating States. Similar efforts will be conducted during the third year; in addition, a cost analysis of the second year of the project will be conducted to identify major cost drivers and to develop recommendations for improving cost efficiency.

Performance Goal MMA5-05

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP)

Baseline: Developmental.

FY 2005 Target:

--Medicaid

(a) Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States.

--SCHIP

(a) Continue to collect core performance measurement data from States through the State annual reports; **(b)** Use the new automated State Annual Report Template System (SARTS) to analyze and evaluate performance measurement data; **(c)** Provide technical assistance to States on establishing baselines, measurement methodologies, and targets for SCHIP core measures.

FY 2004 Target:

--Medicaid

(a) Continue to work with State representatives and update the timeline for implementing recommendations; **(b)** Continue to identify a strategy for improving health care delivery and/or quality; and **(c)** Initiate action steps for implementing recommendations.

-- SCHIP

(a) Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States.

FY 2003 Target: To begin working with States on the Performance Measurement Partnership Project (PMPP).

--Medicaid

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and **(c)** Initiate action steps for implementing recommendations

-- SCHIP

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; **(c)** Initiate action steps for implementing recommendations; and **(d)** Begin to implement core SCHIP performance measures.

Performance:

-- Medicaid: Goal partially met. (a) (Met) Identified proposed measures and are identifying a timeline for implementing recommendations; (b) (Partially met/ Partially delayed) Identifying a strategy for improving health care delivery and/or quality and have already specified measures for gauging improvement; (c) (Not met/ Delayed) Initiating action steps for implementing recommendations by requesting states to report available data on the core set of performance measures as a pilot test.

--SCHIP: Goal met. (a) Identified proposed measures and are identifying a timeline for implementing recommendations; (b) Identifying a strategy for improving health care delivery and/or quality and have already specified measures for gauging improvement;

(c) Initiating action steps for implementing recommendations by asking states to begin reporting on the core measures in the FY 2003 annual reports, to the extent data is available; and (d) Beginning 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 are only beginning to collect and analyze information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. Since we are still far from having a complete picture of the quality of care that the Medicaid population receives on a national basis, the Medicaid program's ability to 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 is not yet realized.

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 (MMA2-05).

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 began working with States to jointly explore a strategy for State and Federal use of performance measures. CMS asked 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 Performance Measurement Partnership Project (PMPP) is Medicaid's first effort to develop performance measures based on consensus and voluntary State participation. As part of this effort, seven HEDIS® measures were proposed by a workgroup of State Medicaid and SCHIP officials as performance indicators that States would report annually on a voluntary basis. The following are the seven proposed performance measures (SCHIP-related measures in bold):

- Adult access to preventive/ambulatory health services
- **Children's access to primary care practitioners**
- Comprehensive diabetes care (HbA1c tests)
- Prenatal and postpartum care (prenatal visits)

- **Use of appropriate medications for children with asthma**
- **Well child visits for children in the first 15 months of life**
- **Well child visits in the 3rd, 4th, 5th, and 6th years of life**

CMS convened a teleconference with the States in September 2003 to discuss a timeline for implementing recommendations. A "Dear State Health Official" letter requesting States to report available data on the core set of performance measures as a pilot test also will be sent to the states by the middle of CY 2004. Results from the pilot test will support continued work with the States to develop the technical specifications for the measures that have been selected.

CMS and States are planning a strategy for the coordinated use of performance measures for 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

It will take time and additional work to develop specifications for reporting the performance measures for FFS delivery systems. States will report their values (on a voluntary basis) for the seven HEDIS® measures to CMS until such time as a unified data system can be used to calculate measures on behalf of States. SCHIP performance measures will be collected through the SCHIP annual report process, beginning in FY 2003. CMS has revised the SCHIP State annual report template to include the core measures for States to begin reporting, to the extent they have data available. Annual reports are due from States on January 1 of each year.

Coordination: CMS is working 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. CMS plans eventually to use the Medicaid Statistical Information System (MSIS) to collect administrative data from State Medicaid and possibly SCHIP agencies and calculate performance measures, but in the meantime States will submit data to CMS independently from MSIS until such time as a unified data system can be used to calculate measures on behalf of States. The current vehicle for SCHIP programs to report PMPP measures to CMS will be the SCHIP Annual Report, which is due on January 1 of every year. Beginning with the FY 2003 reports, States will be directed to submit their PMPP measure results under the performance measure and quality improvement sections of the SCHIP Annual Report.

Verification and Validation: Developmental.

State Children's Health Insurance Program

State Children's Health Insurance Program	FY 2002 Actual	FY 2003 Actual	FY 2004 Current Estimate	FY 2005 Estimate
Budget Authority	**$3.1 B**	**$3.2 B**	**$3.2 B**	**$4.1 B**
Redistribution Funding	**$2.8 B**	**$2.2 B**	**$0.0 B**	**$0.0 B**
Total	**$5.9 B**	**$5.4 B**	**$3.2 B**	**$4.1 B**

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. Some States are continuing to submit plan amendments and section 1115 waivers to further expand insurance coverage under SCHIP.

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

- Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) (MMA5-05)

Performance Goal	Targets	Actual Performance	Ref.
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid **[efficiency and outcome goal]** -- Increase the number of children enrolled in regular Medicaid or SCHIP % of full cost FY 2003: 96.7% FY 2004: 94.6% FY 2005: 95.5%	**FY 05:** Maintain enrollment at FY 2004 levels **FY 04:** Maintain enrollment at FY 2003 levels **FY 03:** + 5% over 2002 **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 05:** **FY 04:** Expected late 1/05 **FY 03:** Expected late 1/04 **FY 02:** Additional 2,750,000 (updated) children enrolled in SCHIP and Medicaid (Goal met) **FY 01:** Additional 2,800,000 children enrolled in SCHIP and Medicaid (Goal met) **FY 00:** Additional 1,870,000 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 HP-1 **3** See FY 04 Revised Final

Performance Results Discussion

Decrease Uninsured Children - The implementation of SCHIP has enhanced the availability of health care coverage for children. 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. While the main goal of the SCHIP program still remains to provide health assistance to uninsured, low-income children and to increase enrollment, the current economic conditions have made it difficult for CMS to achieve its enrollment targets for SCHIP. Therefore, CMS is revising its GPRA enrollment targets for FYs 2004 and 2005 to maintain enrollment of children in SCHIP and Medicaid. Based on enrollment trends for FY 2002 and interim data for FY 2003, we anticipate meeting the FY 2003 target. We will have the 2003 data by late January 2004.

Performance Goal SCHIP1-05

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

Baseline: In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid, and none in SCHIP.
FY 2005 Target: Maintain enrollment at FY 2004 levels.
FY 2004 Target: Maintain enrollment at FY 2003 levels.
FY 2003 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 5% over the previous year.
FY 2002 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 2,750,000 from the previous year.
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 2,800,000 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 1,870,000 from the previous year.
FY 1999 Target: Develop a goal; set baseline and targets. **Performance:** Goal met.

Discussion: The purpose of SCHIP as stated in Title XXI of the Social Security Act is, "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children." Consistent with this purpose, and to affirm our commitment to decreasing the number of uninsured children, CMS has established this goal to increase the number of children enrolled in SCHIP and Medicaid.

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. This program represents the largest single expansion of health insurance coverage for children in more than 30 years and aims to improve the quality of life for millions of vulnerable children less than 19 years of age. As of September 1999, all States, territories and the District of Columbia had approved SCHIP plans in place.

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

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.

In order to address some of the barriers applicants face in enrolling in SCHIP and Medicaid, States have altered and even simplified the application process by doing such things as allowing applicants to use mail-in applications and significantly reducing the paperwork requirements imposed on families applying for coverage. A number of States have also made SCHIP and Medicaid applications available on the Internet, to simplify the application process and address the distance barrier that a number of families face in applying for these programs. According to the Statistical Enrollment Data System (SEDS), more than 5.3 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2002, and many more were enrolled in "regular" Title XIX Medicaid through outreach efforts and application simplification strategies undertaken as a result of SCHIP.

Although States have simplified the application process for children, many States have not yet made efforts to streamline and simplify practices for Medicaid families to the same extent; 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.

CMS monitors State progress through our review of State enrollment data reported to CMS through SEDS. This data, along with information collected through monitoring visits and State annual reports, is used to provide technical assistance to the States and identify model practices, resulting in improved program performance.

While the main goal of the SCHIP program still remains to provide health assistance to uninsured, low-income children and to increase enrollment, the current economic conditions have made it difficult for CMS to achieve its enrollment targets for SCHIP. Therefore, CMS is revising its GPRA enrollment targets for FYs 2004 and 2005 to maintain enrollment of children in SCHIP and Medicaid.

In the face of the recent fiscal challenges, a number of States may be reversing some of their simplification efforts and reducing outreach to try to maintain enrollment. States are using their flexibility to impose waiting lists on SCHIP potential enrollees and reducing eligibility levels while trying to maintain their programs. It is also important to note, however, that some States are increasing eligibility and other States are reaching mature, stable enrollment under SCHIP.

Given the current economic conditions and potential reductions in State programs, CMS feels that maintaining enrollment should be a priority.

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	*20,500,000*	*22,480,000*	*1,300,000*	
2000	3,350,000	*21,000,000*	*24,350,000*	*1,870,000*	1,000,000
2001	4,450,000	*22,700,000*	*27,150,000*	*2,800,000*	1,000,000
2002	5,340,000	*24,600,000*	*29,900,000*	*2,750,000*	1,000,000
2003	--	--	--	--	5%
2004	--	--	--	--	Maintain FY 2003 Enrollment Levels
2005	--	--	--	--	Maintain FY 2004 Enrollment Levels

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 has worked with States, various operating divisions within HHS, other Federal Government agencies, and the private sector on a broad array of outreach activities. These activities included 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.

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 report quarterly on unduplicated counts

[3] Ku, Leighton and Brian Bruen, "The Continuing Decline in Medicaid Coverage," December 1999.

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. 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 http://www.cms.hhs.gov/schip/sho-letters/mpr12301.asp).

The 1998-2002 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.Capturing enrollment data for Medicaid children is also a challenge, because States do not always report Medicaid data as timely in SEDS as they do their SCHIP enrollment data.

Verification and Validation: The program enrollment data that States submit through SEDS are reviewed by CMS 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 2002 Actual	FY 2003 Actual	FY 2004 Final Conference	FY 2005 Estimate
Total	**$35.3 M**	**$36.2 M**	**$43.0 M**	**$43.0 M**
Full-Time Equivalents	**80**	**80**	**78**	**72**

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. There are approximately 183,537 CLIA certified laboratories. Approximately 78.9 percent (144,991) 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). Under CLIA, CMS will continue its partnership with the States to certify and inspect approximately 21,350 laboratories during the FY 2005 - 2006 survey cycle. This is the number of non-accredited laboratories to be surveyed every two years.

Performance Goal	Targets	Actual Performance	Ref.
Sustain improved laboratory testing accuracy			CLIA1
-- Percentage of laboratories enrolled in proficiency testing (PT) with no failures	**CY 04:** Goal Discontinued **CY 03:** 90% **CY 02:** 90% **CY 01:** 90% **CY 00:** 90% **CY 99:** 90%	**CY 04:** N/A **CY 03:** Expect data 3/04 **CY 02:** 92.3% (Goal met) **NEW DATA** **CY 01:** 92.5% (Goal met) **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 04:** Goal Discontinued **CY 03:** 95% **CY 02:** 95% **CY 01:** 95% **CY 00:** 95% **CY 99:** 95%	**CY 04:** N/A **CY 03:** Expect data 3/04 **CY 02:** 96.8% (Goal met) **NEW DATA** **CY 01:** 96.4% (Goal met) **CY 00:** 96.4% (Goal met) **CY 99:** 95.4% (Goal met) **CY 98:** 94.8% **CY 97:** 94.4% **CY 96:** 93.2%	

Performance Goal	Targets	Actual Performance	Ref.
		CY 95: 89.6% **(Baseline)**	
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver **[efficiency goal]** -- Increase the percentage of laboratories adhering to manufacturer's instructions % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** TBD **FY 04:** TBD **FY 03:** New in FY 2004	**FY 05:** **FY 04:** Expect data Spring 2005	CLIA2

Performance Results Discussion

Proficiency Testing -- Success in our PT program increases patient and physician confidence by producing a snapshot of a 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 exceeded our 2002 targets to sustain improved testing accuracy with 92.3 percent of laboratories having no failures and 96.8 percent of laboratories properly enrolled in PT. As a result of recent regulatory changes, the grading of proficiency testing results has been made more stringent. More samples will now be graded by the proficiency testing programs as previously-excluded programs are brought under the measurement system. This has the potential to lower overall statistical results absent continued vigilance. We will not be able to determine the impact of these changes until March 2004, as final data is due at this time. Preliminary data now indicates that 2003 targets to sustain improved testing accuracy will be met.

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. We recognize that it is important to maintain these levels of laboratory testing accuracy and to continue to monitor performance in these target areas. However, we see a new opportunity to positively impact laboratory testing, by focusing on waived laboratory procedures (See CLIA2-05).

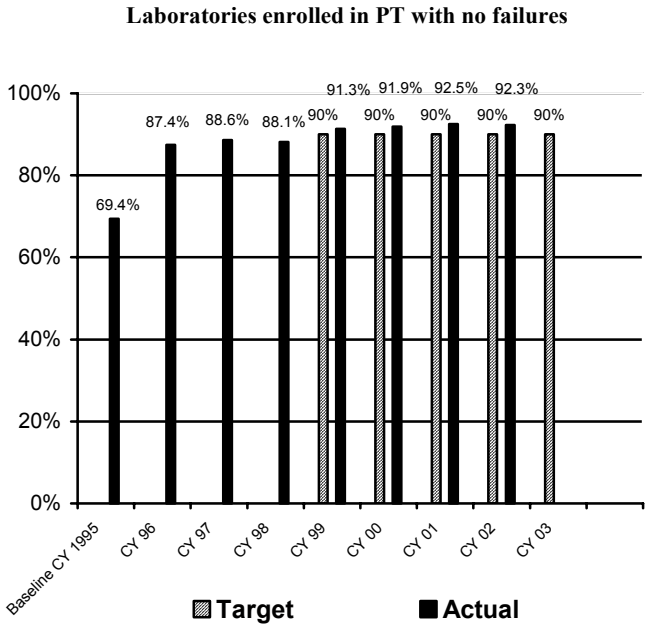
We will continue to report on our current PT goal through FY 2003, while gathering baseline data for our new goal. In FY 2004 we will report our new baseline and begin measuring improvement in the percentage of laboratories having/following manufacturer's instructions.

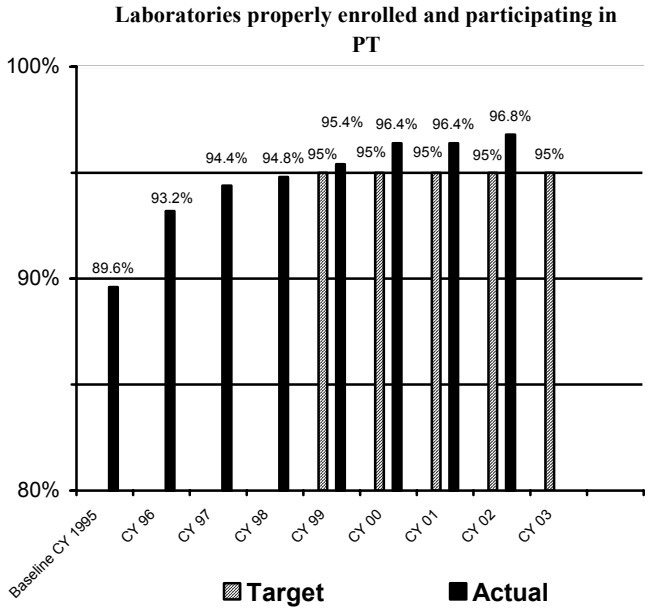
Waived Laboratory Testing -- Beginning in FY 2004, CMS will measure the percentage of laboratories performing waived tests (not subject to proficiency testing) that have/follow manufacturer's instructions. Currently, 78.9 percent of CLIA certified laboratories perform test methodologies that are so simple that the likelihood of erroneous results is negligible and, therefore, are not subject to PT.

CMS is conducting surveys on a nationwide sample to assess the number of laboratories performing waived tests that do not have manufacturer's instructions or do not follow manufacturer's instructions. In FY 2003, we revised the original surveyor questionnaire to facilitate uniform data collection, and to expand the questions in order to gather test-specific information. A national baseline will be determined from this data, and in FY 2004, we will begin measuring improvement.

Performance Goal CLIA1-03

Sustain Improved Laboratory Testing Accuracy
(Discontinued after FY 2003)





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 183,537 CLIA certified laboratories. Approximately 78.9 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. (There are approximately two percent of laboratories that are CLIA-exempt; that is, they are located within States with CMS approved State licensure programs.) The remaining 21.1 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.

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. It is important to maintain these levels of laboratory testing accuracy and to continue to monitor performance in these target areas. However, we see a new opportunity to positively impact laboratory testing, by focusing on waived laboratory procedures (See CLIA2-04).

We will continue to report on this goal through FY 2003, while gathering baseline data for our new goal. In FY 2004 we will report our new baseline and begin measuring improvement in the percentage of laboratories having/following manufacturers instructions.

Coordination: 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 Certification and 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.

Performance Goal CLIA2-05

Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver

Baseline: Developmental. In FY 2003, baseline data will be collected on a national scale for the number of laboratories holding a certificate of waiver that do not have manufacturer's instructions or do not follow manufacturer's instructions.
FY 2005 Target: To be determined.
FY 2004 Target: To be determined. We will determine our FY 2004 target once we have reviewed baseline data.

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. Certificates are issued to laboratories based on the complexity of testing that they perform. Laboratories are issued a certificate of waiver if they perform only waived tests. A waived test is defined as a simple laboratory test that has been determined by the Secretary of the Department of Health and Human Services to have an insignificant risk of erroneous results. Laboratories performing waived tests are required to follow manufacturer's instructions for performing the test, but they are not routinely surveyed.

In two independent studies, State surveyors in Colorado and Ohio found that about half of waived and provider-performed microscopy laboratories were not following manufacturer's instructions, did not have manufacturer's instructions onsite, or were conducting tests they were not authorized to perform. If this percentage was found to be representative of the nation as a whole, it would mean that as many as 60,000 laboratories may not be following manufacturers' testing instructions and/or may be performing tests incorrectly. Waived tests are determined by the FDA to have "an insignificant risk of erroneous result" (if performed correctly), "or pose no reasonable risk of harm to the patient if performed correctly." We do not know the level of potential harm for any of those tests whose waived status presumes proper compliance with manufacturers' instructions but which are performed incorrectly.

The above results were cited in an August 2001 report from the Office of the Inspector General (OIG) titled "Enrollment and Certification Processes in the Clinical Laboratory Improvement Amendments Program". These findings led to CMS initiating a pilot study in eight other states. The findings of the pilot mirror those of previous studies conducted by the States of Colorado, Ohio, and New York. The pilots found that only 52 percent of laboratories performing waived tests had manufacturer's instructions or followed manufacturer's instructions (if they had them). It does not automatically follow that patients are harmed if, for these types of simpler tests, the laboratory fails to follow fully the manufacturer's instructions. However, these initial indications are troublesome. They merit further research and both testing and measurement of intervention strategies that would lead to higher levels of conformance with manufacturers' instructions.

Based on data collected in the above studies, during revisits to waived laboratories that received education during and after the initial survey, there is some indication that awareness of, and adherence to, manufacturer's instructions improved.

In FY 2002, CMS conducted educational and information gathering visits on a nationwide sample to assess the number of laboratories performing waived tests that do not have manufacturer's instructions or do not follow manufacturer's instructions. This effort is to ensure quality testing i.e., accuracy, reliability, and timeliness of patient test results regardless of where the test is performed for the benefit of public health.

We intend to set our FY 2004 target in late 2004, after reviewing FY 2003 and FY 2004 baseline data. In FY 2004, we will pre-test measures of improvement and implement them in 2005.

Coordination: CMS will work closely with State surveyors, our federal partners and CMS-approved accreditation organizations to further evaluate waived laboratories and to develop and implement strategies to improve the compliance of laboratories performing waived testing with the CLIA requirement of following manufacturer's instructions.

Data Source(s): The universe of laboratories to be surveyed is selected from the Online Survey Certification and Reporting System (OSCAR). The surveyors enter information collected during the surveys directly into the State Surveyors Information System (SSIS). The data in the SSIS is used to generate reports of findings for the analysis of laboratory compliance, trends and improvement. For FY 2003, the SSIS will be the primary source for data collection and reporting improvement. The data is collected during the survey via a standard questionnaire. The surveyor uses the answers on that questionnaire to input data into the SSIS.

Verification and Validation: Surveyors collect information on the questionnaire while on site and in contact with the laboratory. Surveyors enter the findings they have recorded into the SSIS so that national data can be gathered and analyzed. The SSIS system contains edits that prevent surveyors from entering data that is inappropriate or is inconsistent with other information on the questionnaire. A follow-up visit is performed on 10 percent of the laboratories to validate the initial findings and improvements made by the laboratory as a result of the survey.

Medicare Integrity Program

Medicare Integrity Program	FY 2002 Actual	FY 2003 Actual	FY 2004 Current Estimate	FY 2005 Estimate
Total	**$699.6 M**	**$719.7 M**	**$720.0 M**	**$720.0 M**

The CMS' 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' program integrity activities are primarily funded through the Medicare Integrity Program (MIP), established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The MIP includes medical review and benefit integrity activities, provider education and training, Medicare Secondary Payer, and provider audits. The CMS' overall program integrity efforts are supplemented by funding from CMS' program management account and other funds made available from the Health Care Fraud and Abuse Control Account (HCFAC).

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

- Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates (MMA4-05)

Performance Goals	Targets	Actual Performance	Ref.
Reduce the percentage of improper payments made under the Medicare fee-for-service program **[outcome & efficiency goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 4.6% **FY 04**: 4.8% **FY 03:** 5% **FY 02:** 5% **FY 01:** 6% **FY 00:** 7% **FY 99:** 9%	**FY 05:** **FY 04:** **FY 03:** 5.8%* (Goal not met) **FY 02:** 6.3% (Goal not met) **FY 01:** 6.3% (Goal not met) **FY 00:** 6.8% (Goal met) **FY 99:** 7.97% (Goal met) **FY 98:** 7.1% **FY 97:** 11% **FY 96:** 14% **(Baseline)** * Does not include non-response claims	MIP1 **3,8**
Develop and implement methods for measuring program integrity outcomes: -- Implement the Provider Compliance Rate prepay medical review -- Implement the refined Comprehensive Error Rate Testing (CERT) program to produce subnational error rates -- Develop a fraud rate among providers in a contractor's service area	 **FY 03:** Subsumed in MIP1 **FY 02:** Goal not continued. **FY 01:** Implement program **FY 03:** Subsumed in MIP1 **FY 02:** Goal not continued. **FY 01:** Implement program **FY 03:** Goal not continued. **FY 02:** Implement program **FY 01:** Develop requirements	 **FY 03:** Goal met. **FY 02:** N/A **FY 01:** Implementation complete (Goal met) **FY 03:** Goal met. **FY 02:** N/A **FY 01:** Implementation complete (Goal met) **FY 03:** Goal not continued **FY 02:** Progress dependent on HCFAC funding (Goal not met) **FY 01:** Progress dependent on HCFAC funding (Goal not met)	MIP2

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 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. Reduce the 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 02:** N/A **FY 01:** See status below 1a. Guidelines in use (Goal met) 1b. See goal MIP2 2. PSC operational models implemented (Goal met) 3a. Pending funds availability 3b. Available 07/2003 4. (Goal not met) 5. (Goal met) 6. 2.79 percent. (Goal not met.) 7. CMS contract with NHIC. (Goal met.) 8. (Goal met) 9. Ten point plan implemented. Pending funds availability. 10. See goals QSC1 and QSC2 **(Baseline)** All new activities	

Performance Goals	Targets	Actual Performance	Ref.
Improve the Process of Credit Balance Recoveries	**FY 04:** Goal not continued **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 04:** Goal not continued **FY 03:** Implementation complete August 2003. (Goal met.) **FY 02:** Developed processes (Goal met) **FY 01:** See Final Review Summary Report and Final Management Overview Report (Goal met) **FY 00:** Incomplete information regarding credit balance reporting process **(Baseline)**	MIP5
Increase Medicare Secondary Payer liability and no-fault dollar recoveries **** Shaded area indicates version of the goal before the change in focus**	**FY 01:** Goal carried over with new focus (see above) **FY 00:** 5% increase over baseline	**FY 01:** N/A **FY 00:** 29.1% (Goal met**)** **FY 99:** 20% **FY 98:** $364 million **(Baseline)**	
Assess program integrity customer service	**FY 04:** Goal discontinued **FY 03:** Conduct survey and develop a CAP **FY 02:** Conduct and analyze surveys. Develop baseline and targets.	**FY 04:** **FY 03:** Survey completed from February to April (Goal met) **FY 02:** Surveys are complete and a CAP has been developed (Goal met**)**	MIP6 See FY 04 Revised Final

Performance Goals	Targets	Actual Performance	Ref.
Improve the provider enrollment process % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05** Revalidate 20% of Part A/Part B providers/suppliers **FY 04:** Develop web-enabled enrollment process via PECOS for both Part A and Part B providers/suppliers. **FY 03**: Implement PECOS, revalidate 20% of Part A providers **FY 02:** Develop PECOS, revise CMS-855, publish regulation	**FY 05:** **FY 04:** **FY 03:** Regulation not published. Target pushed back to FY 05. (Goal not met.) **FY 02:** PECOS implemented 7/29/02 (Goal met) Regulation and revised form are in clearance (Goal not met)	MIP7 See FY 04 Revised Final
Improve effectiveness of Medicare Secondary Payer (MSP) provisions by increasing number of voluntary data sharing agreements (VDSA) with insurers or employers **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05**: 4 additional VDSAs **FY 04:** 2 additional VDSAs	**FY 05:** **FY 04:** **FY 02**: 6 VDSAs (Baseline)	MIP8 See FY 04 Revised Final **8**
Reduce the Contractor Error Rate **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** 25 Percent of claims processed by contractors with error rate* less than or equal to FY 2004 unadjusted paid claims error rate. **FY 04:** Develop baseline. *including non-response claims	**FY 05:** **FY 04:** **FY 03:** New in FY 04	MIP9 **3,8**
Decrease the Provider Compliance Error Rate (PCER) **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Decrease Provider Compliance Error Rate 20% below FY 2004 level. **FY 04:** Develop baseline.	**FY 05:** **FY 04:** **FY 03:** New in FY 04	MIP10 **3,8** See FY 04 Revised Final

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. Although we did not meet our target of a 5 percent error rate in FY 2003, we were successful in reducing the rate to 5.8[4] percent. We believe there is still important work to be done and expect to achieve our goal of further reducing the error rate. This goal to reduce the Medicare error rate is determined to be an efficiency measure because we believe the outcome of this goal will ultimately result in a better run Medicare program.

With implementation of the Comprehensive Plan for Program Integrity in FY 2001, CMS focused 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 CERT program was fully implemented in 2002, therefore, CMS produced a fee-for-service error rate for Durable Medical Equipment Regional Carriers (DMERCs) in FY 2002; for all carriers for FY 2002; and for fiscal intermediaries for FY 2003. To provide further quality assurance over the error rate estimate, CMS has produced the FY 2003 national error rate with oversight provided by the OIG. For FY 2004 and beyond, CMS will assume the substantive testing portion of the CFO audit.

CMS has also implemented the Provider Compliance Error Rate, which is produced as a product of CERT medical record reviews. In fact, in keeping with our commitment to OMB during the Program Assessment Rating Tool (PART) process, CMS developed two new FY 2004 goals measuring the provider compliance error rate and the contractor error rate.

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 we assessed our performance throughout the implementation process, it was also critical to monitor the overall effectiveness of each initiative in the plan throughout FY 2001. We continue to monitor many of these programs as we collect final data.

Medicare Secondary Payer/Credit Balance Recoveries - Medicare Secondary Payer (MSP) dollar recovery activities ensure that the appropriate primary payer makes payments for health care services for beneficiaries. 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. In FY 2002, instead of focusing on no-fault dollar recoveries, we concentrated on the mandatory Medicare credit balance reporting requirements for providers and thus revised the name of the goal. The intent of these requirements is to ensure that Medicare properly recovers

[4] This figure has been adjusted to account for the high provider non-response experienced in FY 2003. Had the adjustment not been made, the national paid claims error rate would have been 9.8 percent.

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. CMS met its FY 2003 target by implementing improved processes for contractors to ensure consistency and timely recoveries of credit balances.

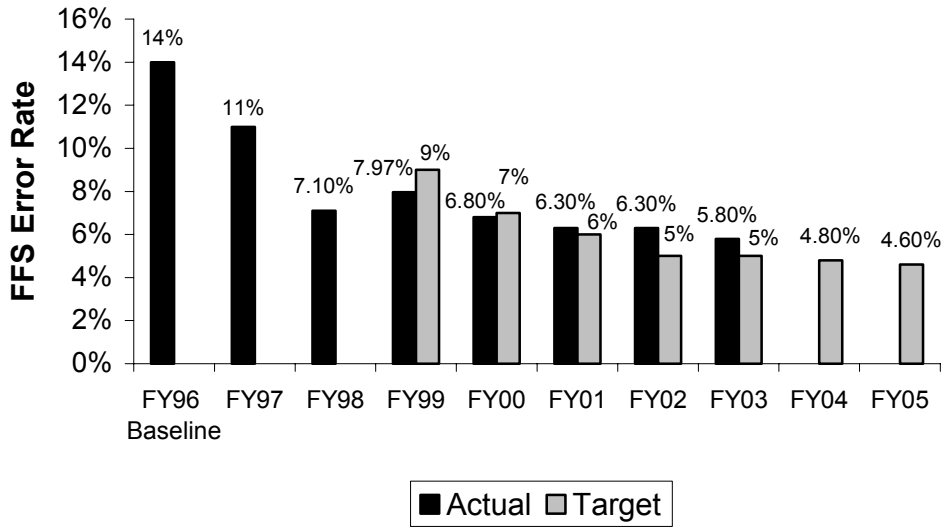
Program Integrity Customer Service – The goal to assess customer service behaviors in handling fraud and abuse cases would ultimately result in contractors developing a plan to assess customer service behaviors in the program integrity area. In FY 2002, as a result of the survey, CMS formed a PI Customer Service Action Planning Team which developed a nine point plan to improve program integrity customer service. Part of the plan included training for contractors which was conducted during the summer of 2002. A second customer service survey was conducted between February and April 2003. Most of the ratings calculated in this year's survey indicate improvements over last year's ratings. CMS is currently discussing the development of an overall customer service plan that may encompass the PI customer service project and which may entail a different evaluation method. Therefore, this goal is being discontinued in FY 2004 and beyond. In the future, we may take another look at developing targets when a scope and method are established.

Improve the Provider Enrollment Process - The goal to improve the provider enrollment process is an effort to continue the spirit of the Comprehensive Plan of paying claims properly to legitimate providers and suppliers. CMS intends to have a streamlined and more uniform process for revalidating applications from providers of Medicare. To that end, CMS made the Provider Enrollment Chain Ownership System (PECOS) available to fiscal intermediaries on July 29, 2002 and to the carriers on November 3, 2003. The fiscal intermediaries and carriers will continue to populate the system with data from new provider/supplier applications. In April 2003, the proposed regulation in regards to establishing and maintaining billing privileges and the revised CMS-855 form was published in the Federal Register. All targets for this goal have been pushed back to FY 2005 in order to allow time for publication of the final regulation and the web-enabled enrollment process.

MSP Voluntary Data Sharing Agreements - We have introduced this goal to further improve the effectiveness of the administration of the Medicare Secondary Payer provisions by increasing the number of Voluntary Data Sharing Agreements (VDSA) with insurers or employers. As we increase the number of VDSAs with large employers or insurers, we should be able to significantly decrease erroneous payments made by Medicare as the primary insurer when it should have been secondary.

Performance Goal MIP1-05

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. CMS has implemented an Error Rate Reduction Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

CMS exceeded its GPRA targets for 1999 and 2000. In general, the substantial reduction in the error rate demonstrates that the Medicare contractor claims processing system is working well. Furthermore, during 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 corrective action plan that was in place at that time. CMS agreed to continue these corrective actions in response to both the FY 1998 and 1999 audits.

In FY 2003, CMS did not reach the target of 5 percent, however we were successful in reducing the error rate from the FY 2002 rate of 6.3 percent to 5.8[5] percent. 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 will continue to be successful in reducing the fee-for-service error rate.

The Comprehensive Error Rate Testing (CERT) program was fully implemented in FY 2003; as such, the CERT program produced a Medicare fee-for-service error rate for FY 2003. To provide further quality assurance over the error rate estimate, CMS originally intended to run the CERT program in parallel with the CFO Audit for at least one year; therefore, during FY 2003 both programs were to be used to produce national fee-for-service error rates. However, meetings with the Office of Inspector General (OIG) prompted an agreement that CMS would produce the FY 2003 error rate with oversight by the OIG. For FY 2004 and beyond, CMS will be assuming the substantive testing portion of the CFO audit.

In addition to the national error rate, CERT outcomes include contractor-specific error rates, as well as two additional rates used to help measure provider compliance with Medicare payment and billing requirements, and the accuracy of the contractor's claims payments and processing activities. These rates known respectively as the provider compliance error rate and the services processed error rate, allow CMS to quickly identify emerging trends in managing Medicare contractor performance.

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. CMS and OIG entered into an agreement stipulating that the OIG would act as CMS's agent to measure the Medicare fee-for-service error rate in FYs 2000, 2001 and 2002. CMS assumed responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG.

Verification and Validation: CMS replicated OIG's methods as much as possible for FY 2003 to ensure consistent and equal comparisons across fiscal years. The CERT program was awarded to the Program Safeguard Contractor AdvanceMed a CSC company (formerly known as DynCorp) in FY 2000. The CERT program is monitored for compliance by CMS through monthly reports from the contractor.

[5] These figures have been adjusted to account for the high provider non-response experienced in 2003. Had the adjustment not been made, the national paid claims error rate would have been 9.8 percent.

Performance Goal MIP2-03
Develop and Implement Methods for Measuring
Program Integrity Outcomes
(Discontinued after FY 2003)

Baseline: The three proposed methods are new and currently in development and testing phases. Therefore, baseline data do not exist.
FY 2003 Target: Methods to be subsumed in MIP1-04. **Performance:** Goal met.
FY 2002 Target: To implement a model fraud rate program. **Performance:** Goal not met.
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: 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 was 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. CMS awarded a contract to implement the **Comprehensive Error Rate Testing (CERT)** program. CERT will produce a paid claims error rate, processed claims error rate, and a contractor error rate. 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 at the carriers in April 2001. Phase 3 was implemented at the intermediaries in January 2002.

The CERT program was 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 will produce the FY 2003 error rate with

oversight by the OIG. For FY 2004 and beyond, CMS will be assuming the substantive testing portion of the CFO audit.

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. We did not meet our FY 2002 target to develop a model fraud rate program under CERT because we did not receive the funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.

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 were published in January 2002. These same reports were 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: CMS verifies contractor performance and data through its Contractor Performance Evaluation program.

Performance Goal MIP5-03

Improve the Process of Credit Balance Recoveries
(Discontinued after FY 2003)

Baseline: Incomplete information regarding credit balance-reporting process.
FY 2003 Target: To fully implement revised processes and controls in contractor credit balance activities. **Performance:** Goal met. Revised processes implemented August 2003.
FY 2002 Target: Develop improved processes and controls to be utilized by all contractors to ensure consistency and timely recoveries. **Performance:** Goal met. Developed improved processes. These processes are going through internal clearance prior to full implementation in FY 2003.
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: Studies performed by CMS and the Office of Inspector General (OIG) indicate that approximately 90 percent of credit balances are mainly attributable to provider billing practices. 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. 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. The CMS-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.

Providers who 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 the recovery of any reported credit balances.

CMS's initial review of the FI quarterly credit balance reports indicated that a high percentage of providers submit the CMS-838 with a zero dollar credit balance. This is possible because the CMS-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 CMS-838 represents a very tightly run system or a provider that cleans up its credit balance accounts immediately before submitting the CMS-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 CMS-838 timely and identified a credit balance, but did not submit adjustment bills 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 credit balance recoveries. This includes a lack of data on the timeframe within which reported credit balances are recovered through adjustment bills or payment by check.

Approaches 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 2003 target, processes identified in FY 2002 to be enhanced were fully implemented in August 2003.

Coordination: The CMS, and the FIs will coordinate and monitor the efforts on this GPRA goal.

Data Source(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.

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 and SAS-70 reviews.

Performance Goal MIP6-03

Assess Program Integrity Customer Service
(Discontinued after FY 2003)

Baseline: Program integrity customer service surveys are new; therefore baseline data do not exist.
FY 2004 Target: Goal not continued.
FY 2003 Target: A survey of providers and beneficiaries will be conducted. Data from the survey will be used to identify weaknesses and develop a corrective action plan to deal with those weaknesses. **Performance:** Goal met. Survey was conducted from February to April 2003.
FY 2002 Target: A survey of providers and beneficiaries will be conducted. Targets and a baseline will be developed from these data. **Performance:** Goal met. A corrective action plan has been developed.

Discussion: CMS developed this 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.

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.

Although the customer service project was initiated in FY 2001 and continues today, this project is in transition. CMS is developing an overall customer service plan that may encompass the program integrity customer service project and the development of an alternative evaluation method is being discussed. Therefore, this goal is being discontinued beginning in FY 2004 until a scope and method are established and clarified.

Coordination: 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 and 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 MIP7-05

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 2005 Target: Revalidate 20 percent of Part A and Part B providers/suppliers currently enrolled in the Medicare program using the web-enabled enrollment process. This revalidation target will help capture those providers/suppliers that entered Medicare using the CMS-855 enrollment form or that entered Medicare prior to the use of the CMS-855 enrollment form.
FY 2004 Target: Develop a web-enabled enrollment process via PECOS for both Part A and Part B providers/suppliers.
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 CMS-855 enrollment form or that entered Medicare prior to the use of the CMS-855 enrollment form. **Performance:** Goal not met. Regulation was not published, therefore, this target has been pushed back to FY 2005.
FY 2002 Target: Develop PECOS, implement the revised CMS-855 enrollment form and the regulation pertaining to establishing and maintaining billing privileges. **Performance:** PECOS was made available on July 29, 2002, for the fiscal intermediaries to begin populating the system with data from new applications (Goal met). The regulation is in the final stages of the clearance process and the revised CMS-855 forms are pending the release of the regulation. (Goal not met.)

Discussion: This goal is aimed at improving the 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 2005, 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 CMS-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 of information from the enrollment process are dispersed among the Medicare carriers, which is why we developed a national enrollment system. PECOS has been implemented for the fiscal intermediaries and carriers. Currently, all provider/supplier enrollment data received via a revised CMS-855 Form (Provider/Supplier Enrollment Application) is input into PECOS. As all new enrollments are entered into PECOS, PECOS will track the workflow from data entry to final disposition.

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

Performance Goal MIP8-05

Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers

Baseline: As of FY 2002, CMS had negotiated six (6) Voluntary Data Sharing Agreements (VDSAs) with employers and insurers
FY 2005 Target: Sign 4 additional VDSAs
FY 2004 Target: Sign two (2) additional VDSAs.

Discussion: The purpose of this goal is to increase the number of VDSAs that CMS has with large employers and insurers for the purpose of exchanging employer or insurer health plan enrollment information for Medicare eligibility information. These data exchanges allow CMS to identify those Medicare beneficiaries who have group health coverage via their employment or via their spouse's employment. Medicare pays secondary in those situations where the beneficiary has group health plan coverage based on his/her own, or a family member's current employment. The VDSA allows CMS to receive this health plan coverage information from employers or insurers on a current (quarterly) basis, which enables Medicare to correctly process Medicare claims for primary or secondary payment. For employers, a VDSA can be used to satisfy their statutory obligation, under 42 U.S.C. § 1395y(b)(5)(c), to complete questionnaires resulting from the Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match process; and to provide that information to CMS on a more current basis.

Employers and insurers often do not know if their non-working enrollees under the age of 65 also have Medicare coverage, so they continue to make primary payments for individuals for whom Medicare is primary. The VDSA also allows employers and insurers to receive Medicare eligibility information for their insured that are not currently working. As part of the VDSA process, employers/insurers can send CMS basic identifying information on an individual they insure and CMS can identify those people entitled to Medicare including basic entitlement information such as periods of entitlement and the beneficiary's Health Insurance Claim Number.

The quarterly, mutual exchange of employee/insurer coverage information for Medicare eligibility information enables all parties to correctly process claims for primary and secondary payment. Additional benefits to CMS include: (1) a significant reduction in costs and administrative efforts associated with dispute resolution and recovery of mistaken primary payments, (2) lower long term operating costs for collection and storage of employer coverage data than via the IRS/SSA/CMS Data Match Project, (3) more accurate coverage data on a current basis and (4) increased customer service to beneficiaries and our Medicare partners.

Many of the advantages of VDSAs to CMS also apply to employers/insurers. An additional significant advantage for employers is that, if they sign a VDSA, they are

excused from completing the annual IRS/SSA/CMS Data Match Questionnaire. Employers complain that the IRS/SSA/CMS Data Match can be costly, is difficult to plan and budget for, and requires them to retrieve archived coverage information. Many employers have asked if there is a better way they could provide CMS with employee and spousal coverage information. The alternative is signing a VDSA. The CMS also benefits from having the employer submit employee coverage information via the VDSA. Rather than waiting the up to two and a half years it takes to identify potential working beneficiaries and their spouses via the IRS/SSA/CMS Data Match, CMS gets current coverage data every quarter directly from the employer/insurer. As previously stated, more timely coordination of benefits reduces expense and hassle to CMS, our partners and Medicare beneficiaries associated with CMS's attempts to recover mistaken Medicare primary payments by enabling Medicare to pay correctly the first time a claim is submitted for payment.

The CMS has made great strides to sign VDSAs with large employers/insurers and has included the expansion of this initiative as part of CMS's goal to reduce the incidences of mistaken payments under the FY 2004 MSP comprehensive plan. The resources required to electronically exchange information with CMS on a cost effective basis limit the potential market for VDSAs to large employers and insurers. As of December 11, 2003, including the 40 Plans under the BCBSA VDSA, CMS has signed 60 VDSAs with large insurers and large employers. Negotiations continue with numerous other interested employers and insurers. As predicted, with the FY 2002 signing of the BCBSA Agreements, which cover a large enrollee population, inquiries have increased from other large insurers, which represent significant sources of MSP information. Of note, Cigna, with an enrollee population of 14 million, signed a VDSA in late FY 2003.

In addition to numerous print, mail and website promotions of VDSAs, CMS and the Coordination of Benefits (COB) Contractor have hosted or participated in numerous employer conferences and outreach programs. Due to these marketing efforts and word of mouth from current participants, requests for information about VDSAs continues to increase.

Coordination: The CMS will continue to work with its COB Contractor and other private and public partners to develop new ways of marketing VDSAs. The mutual benefits of these agreements help VDSAs to sell themselves to larger employers and insurers. However, given the size of the entities CMS seeks for this effort and the systems changes they must make to participate in this electronic data exchange, these negotiations are usually protracted, with many internal and external variables affecting how many can be finalized in a given period.

Of significance is the current impact of the Health Insurance Portability and Accountability Act (HIPAA) requirements on employers' and insurers' ability to allocate resources to the VDSA process. The burden of implementing HIPAA provisions has resulted in some interested parties suspending interest in a VDSA with CMS at this time. CMS was able to quickly address HIPAA impacts on the VDSA process with little interruption to the negotiation and implementation of new agreements. Software and

procedures developed by CMS mitigated the impact of HIPAA on the VDSA process for employers and insurers, thus allowing some interested entities to sign agreements that might have otherwise been put on hold. Still, many interested participants have had to put off signing and implementing a VDSA due to HIPAA's impact on other parts of their operations. Despite these roadblocks, the CMS will continue to supervise the COB Contractor's promotion of VDSAs to employers/insurers as an alternative to the IRS/SSA/CMS Data Match and will monitor and actively support the efforts toward achieving this GPRA goal.

One positive trend seen in FY 2003, is that more new potential participants are approaching CMS with prior knowledge of how these agreements work. This shortened learning curve, whether the result of CMS outreach activities or the rapidly growing number of current participants has resulted in some recent agreements being negotiated and implemented fairly quickly.

Data Source(s): The CMS receives the Medicare Secondary Payer (MSP) data from those entities, identified above, that currently have a VDSA with CMS. The employer/insurer sends its files to the COB Contractor for processing in the prescribed CMS format, and files containing information on covered working individuals are transferred to CMS. The COB Contractor also processes the separate eligibility inquiry file sent by employers/insurers through the Enrollment Data Base to obtain the necessary Medicare entitlement information. The CMS does not use any of the data submitted in the employers eligibility inquiry file to update any of Medicare's records. Each file submission results in its own separate response file being sent back to the employer.

Verification and Validation: The COB Contractor edits and validates the data received by the employers/insurers through multiple independent processes before uploading any new MSP information to the Common Working File, a CMS database used in the claims adjudication process. All records with an error are identified and sent back to the employer/plan indicating why the record could not be processed. Records that do not contain errors are processed accordingly.

Performance Goal MIP9-05

Reduce the Medicare Contractor Error Rate

Baseline: Developmental.
FY 2005: 25 percent of Medicare claims will be processed by contractors who have an error rate (including non-response claims) less than or equal to the FY 2004 actual unadjusted national paid claims error rate.
FY 2004: Set Baseline.

Discussion: CMS implemented the Comprehensive Error Rate Testing (CERT) program in 2002 and is using the CERT methodology to develop the national fee-for-service error rate with greater precision than the previous OIG audit method. In addition, CERT will produce paid claims error rates, provider compliance error rates, and services processed error rates. The CERT program will provide substantially greater detail and analysis of vulnerabilities in the current system, which will help focus corrective actions.

CERT is a tool that CMS wants contractors to use to develop their medical review and provider education and training strategies. Contractors receive a quarterly error rate update from the CERT contractor and can use the information on a quarterly basis to look for trends and outliers. Using 2003 rates as a baseline, CMS can begin to track whether the corrective actions undertaken by the contractor are affecting their error rates. CERT is being used in the contractor performance based contracting pilots as a metric.

For each Medicare contractor, Medicare conducts reviews for a statistically valid sample of claims and determines whether the contractor paid the claim accurately. The reviews determine whether health care providers were underpaid or overpaid for the sampled claims. The results reflect not only the contractor's performance, but also the billing practices of the health care providers in their region.

The results lead to a contractor-specific error rate that Medicare tracks to promote improvements. Contractors then develop targeted error rate reduction plans to reduce payment errors through provider education, claims review and other activities.

By FY 2008, CMS intends to have all Medicare claims processed by contractors that have an error rate less than or equal to the previous year's actual unadjusted national paid claims error rate. Critically important in reducing the contractor error rate is determining the root causes of error. Some errors may be caused by claims processing systems, unclear policies or CMS technical requirements. The CMS will use the information obtained through this process to revise policies and instructions, and institute systems changes, as well as use CERT as a measure of performance.

We are proposing the following annual targets:

FY 2005: 25 percent of Medicare claims will be processed by contractors who have an error rate* less than or equal to the FY 2004 actual unadjusted national paid claims error rate;

FY 2006: 50 percent of Medicare claims will be processed by contractors who have an error rate* less than or equal to the FY 2005 actual unadjusted national paid claims error rate;

FY 2007: 75 percent of Medicare claims will be processed by contractors who have an error rate* less than or equal to the FY 2006 actual unadjusted national paid claims error rate.

* Including non-response claims

Once baseline data is received, CMS will evaluate these targets and modify as necessary to meet the primary goal.

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

Data Source: Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers.

Verification and Validation: CMS verifies contractor performance and data through its Statement of Auditing Standards Number 70 (SAS 70) program. In addition, the OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

Performance Goal MIP10-05

Decrease the Medicare Provider Compliance Error Rate

Baseline: Developmental
FY 2005: Decrease the Provider Compliance Error Rate 20 percent over the 2004 level.
FY 2004: Set baseline.

Discussion: The Provider Compliance Error Rate is a method of determining a "compliance error rate" among providers based upon a random sample of submitted claims. The sampled claims are subjected to detailed medical review and a compliance error rate is calculated based upon the dollar value ratio of invalid claims submitted to total claims. The Provider Compliance Error Rate is expected to enhance medical review effectiveness and promote provider compliance.

CMS wants contractors to use findings from the CERT contractor to develop their medical review and provider education and training strategies. Beginning in January 2004, contractors will receive a quarterly error rate update from the CERT contractor and can use the information to look for trends and outliers. CERT will be used to establish the baseline provider compliance error rates. Once a baseline is created, CMS will be able to track whether or not the corrective actions undertaken by the contractor are affecting their provider compliance error rate.

Our goal by 2008 is to significantly improve the provider compliance error rate. We are proposing the following annual targets:

2005: Decrease the Provider Compliance Error Rate 20 percent over the 2004 level.
2006: Decrease the Provider Compliance Error Rate 20 percent over the 2005 level.
2007: Decrease the Provider Compliance Error Rate 20 percent over the 2006 level.

Once baseline data is received, CMS will evaluate these targets and modify as necessary to meet the primary goal.

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: Contractors receive a quarterly error rate update from the CERT contractor and can use the information to look for trends and outliers.

Verification and Validation: The CMS verifies contractor performance and data through its Statement of Auditing Standards Number 70 (SAS 70) program. In addition, the OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

Medicare Operations

Medicare Operations	FY 2002 Actual	FY 2003 Actual	FY 2004 Final Conference	FY 2005 Estimate
Medicare Operations	**$1,521.4 M**	**$1,665.0 M**	**$1,701.0 M**	**$1,793.9 M**
Medicare Modernization	**$0.0 M**	**$0.0 M**	**$210.5 M**	**$209.0 M**
Total	**$1,521.4 M**	**$1,665.0 M**	**$1,911.5 M**	**$2,002.9 M**
Full-Time Equivalents	**N/A**	**N/A**	**10**	**10**

The Medicare Operations line item primarily funds the traditional Medicare fee-for-service program, mainly through the activities of CMS' 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 responsible for making timely, accurate, and fiscally responsible payments to Medicare providers and suppliers for covered health care services. In FY 2005, they will process more than 1.1 billion Medicare claims; handle approximately 8 million appeals; respond to more than 50 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 Beneficiary Improvement and Protection Act of 2000, and 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 that educates Medicare beneficiaries so they can make informed health decisions based on accurate, reliable, relevant and understandable information. The Medicare Operations activity funds the major portion of NMEP activities which include: a Medicare handbook with area-specific information on managed care plans, a toll-free number (1-800-MEDICARE), an Internet site (www.medicare.gov), counseling and outreach, and a national ad campaign. Other sources of funding include the Medicare+Choice user fee and Quality Improvement Organization funds.

The CMS' 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 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 (MB1-05)
- Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (MIP1-05)
- Improve the Provider Enrollment Process (MIP7-05)

Performance Goal	Targets	Actual Performance	Ref.
Improve Beneficiary Telephone Customer Service (Developmental) --Quality of Response	**FY 05:** --Minimum of 90% pass rate for Adherence to Privacy Act --Minimum of 90% meets expectations for Customer Skills Assessment --Minimum of 90% meets expectations for Knowledge Skills Assessment **FY 04:** --Minimum of 90% pass rate for Adherence to Privacy Act --Minimum of 90% meets expectations for Customer Skills Assessment --Minimum of 90% meets expectations for Knowledge Skills Assessment **FY 03**: --Minimum of 85% pass rate for Adherence to Privacy Act --Minimum of 90% meets expectations for Customer Skills Assessment --Minimum of 85% meets expectations for Knowledge Skills Assessment	**FY 05:** **FY 04:** **FY 03**: --95.08% pass rate for Adherence to Privacy Act (Goal met) --98.75% meets expectations for Customer Skills Assessment (Goal met) --93.60% meets expectations for Knowledge Skills Assessment (Goal met)	MO1 See FY 04 Revised Final
-- Expansion of 1-800-MEDICARE number and desktop rollout % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05**: Continue expansion efforts **FY 04**: Continue expansion efforts **FY 03**: Begin expansion efforts	**FY 05:** **FY 04**: **FY 03**: Expansion efforts have begun (Goal met)	

Performance Goal	Targets	Actual Performance	Ref.
Improve Beneficiary Telephone Customer Service (Developmental) -- Accessibility * Busy rate * Answer time	**FY 03:** Not continued **FY 02:** Set baselines/future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** N/A **FY 02:** (Goal not met) **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 See FY 03 Revised Final
-- Accuracy of Response	**FY 02:** Set baselines/future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 02:** See above (Goal met) **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:** Not continued **FY 02:** Set baselines/future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** N/A **FY 02:** (Goal not met) **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)	
****Shading indicates the goal's targets prior to the current revision.**			

Performance Goal	Targets	Actual Performance	Ref.
Medicare Payment Timeliness Consistent w/Statutory Floor and Ceiling Requirements **[efficiency goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Same as FY 2004 **FY 04:** Same as FY 2003 **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 05:** **FY 04**: **FY 03: Intermediaries** 99.2% (Goal met); **Carriers** 99.6% (Goal met) **FY 02: Intermediaries** 99.7% (Goal met); **Carriers** 99.5% (Goal met) **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 05:** 97% **FY 04:** 97% **FY 03:** 97% **FY 02:** 97% **FY 01:** 97% **FY 00:** 97% **FY 99:** 97%	**FY 05:** **FY 04:** **FY 03:** 98.2% (Goal met) **FY 02:** 98% (Goal met) **FY 01:** 97.7% (Goal met) **FY 00:** 97.4% (Goal met) **FY 99:** 97.1%	
-- Maintain high percentage of EMC for carriers	**FY 05:** 80% **FY 04**: 80% **FY 03:** 80% **FY 02:** 80% **FY 01:** 80% **FY 00:** 80% **FY 99:** 80%	**FY 05:** **FY 04**: **FY 03:** 84.5% (Goal met) **FY 02:** 83.7% (Goal met) **FY 01:** 83.0% (Goal met) **FY 00:** 81.9% (Goal met) **FY 99:** 80.9%	
-- Implement HIPAA standards	**FY 05:** TBD **FY 04**: Complete eligibility inquiry and response and retail drug standards implementation and testing. Initiate enhancements for previously implemented EDI transactions including COB. **FY 03:** Complete claim status, eligibility inquiry, prior authorization, and retail drug standards implementation and testing. **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 05:** **FY 04**: Final data due October 2004. **FY 03:** Completed Medicare implementation of HIPAA EDI standards for claims status inquiry and response. Implementation of retail drug standards and the eligibility inquiry and response started. (Goal partially met) **FY 02:** Completed Medicare implementation of HIPAA EDI standards for claims, COB, and ERA. Implementation for claims status and eligibility inquiries started. (Goal met) **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)	

Performance Goal	Targets	Actual Performance	Ref.
Develop baseline data for electronic claims status, electronic eligibility queries, ERA, EFT and COB transactions % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 04:** Complete baseline data collection for intermediaries. **FY 03:** Complete Baseline **FY 02:** Continue to develop Baseline. **FY 01:** Develop Baseline.	**FY 04:** Final data due October 2004. **FY 03:** Baseline data collection for carriers has started. Intermediary data collection to begin in FY 2004. (Goal partially met) **FY 02:** Baseline data collection to begin for carriers effective 04/1/03. Intermediary collection to be scheduled. **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.	
Improve CMS' Rating on Financial Statements % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Maintain a "clean" opinion on the FY 2005 financial statements. **FY 04:** Maintain a "clean" opinion on the FY 2004 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 05:** **FY 04:** **FY 03:** (Goal met) **FY 02:** (Goal met) **FY 01:** (Goal met) **FY 00:** (Goal met) **FY 99:** (Goal met) **FY 98:** Qualified opinion **(Baseline)** **FY 97:** Qualified opinion **FY 96:** Disclaimer on audit	MO4

Performance Goal	Targets	Actual Performance	Ref.
Improve CMS oversight of Medicare Fee-for-Service contractors (Developmental) **[outcome goal]**	**FY 05:** Developmental **FY 04:** Developmental **FY 03:** Building on prior year's experience. **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 05**: Goal discontinued **FY 04:** **FY 03:** (Goal met) **FY 02:** (Goal met) **FY 01:** (Goal met) **FY 00:** Inconsistency in reporting **(Baseline)**	MO5 **5, 8** 
Increase eligible delinquent debt referred for cross servicing to the Program Support Center	**FY 05:** Goal discontinued **FY 04:** Continue to refer 100% of eligible delinquent CMS receivables to Treasury. **FY 03:** --Continue to refer 100% of eligible delinquent CMS receivables to Treasury. --Improve the 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 05:** Goal discontinued **FY 04:** **FY 03:** --Actual eligible debt referred was approximately 96%. Additional system changes will be required to implement improved written procedures to refer eligible Claims Accounts Receivable debts (Goal not met) --Established improved procedures for referring the debt for cross servicing. (Goal met) **FY 02:** Referred 90% of eligible debt. Remaining debt to be referred first part of FY 2003. (Goal not met) **FY 01:** $2.1 billion delinquent debt referred **FY 00:** We referred approximately $2 billion in delinquent debt. This equals about 25% of eligible debt **(Baseline)**	MO6 

Performance Goal	Targets	Actual Performance	Ref.
Improve effectiveness of dissemination of Medicare information to beneficiaries (5-year targets): **[outcome goal]**			MO8 **3, 5**
--Accessibility of Information Collect and monitor data to achieve by FY 2004 percentage of beneficiaries who sought Medicare information from Medicare sources and reported the information received answered their question(s).	**FY 05:** Maintain FY 04 target **FY 04:** 77% **FY 03:** Collect/monitor data **FY 02**: Collect/monitor data **FY 01**: Collect/monitor data **FY 00**: Collect/monitor data	**FY 05:** **FY 04:** Fall 05 **FY 03:** Data collected/monitored (Goal met) **FY 02**: Data collected/monitored (Goal met) **FY 01**: Data collected/monitored (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)**	
--Awareness of Messages Collect and monitor data to achieve by FY 2004 percentage of beneficiaries who knew that most people covered by Medicare may select from among different health plan options within Medicare. % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Maintain FY 04 target **FY 04:** 57% **FY 03:** Collect/monitor data **FY 02**: Collect/monitor data **FY 01**: Collect/monitor data **FY 00**: Collect/monitor data	**FY 05:** **FY 04:** Fall 05 **FY 03:** Data collected/monitored (Goal met) **FY 02**: Data collected/monitored (Goal met) **FY 01**: Data collected/monitored (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 Goal	Targets	Actual Performance	Ref.
Improve beneficiary understanding of basic features of the Medicare program by: **[outcome goal]** (1) Increasing number of questions correctly answered by beneficiaries to measure understanding of different components of Medicare (2) Increasing percentage of beneficiaries aware of 1-800 MEDICARE number % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Maintain FY 04 targets **FY 04**: (1) 3.50 out of 6 questions (2) 65% of beneficiaries **FY 03:** Continue to collect & monitor data **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 05:** **FY 04:** Fall 05 **FY 03:** Data collected/monitored (Goal met) **FY 02:** Baselines/targets developed (Goal met) **FY 01**: Steps 1-5 completed. Survey fielded (Goal met) **CY 00:** (1) 2.75 out of 6 questions (2) 53% of beneficiaries **(Baselines)**	MO9 **3, 5**
Implement Medicare Contracting Reform % of full cost (FY 2003-2005): See Section F in Appendix A	**FY05:** Developmental	**FY05:** **Baseline:** All Medicare claims processed by 27 FI and 19 Carriers	MO10 **5, 8**

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 quality standards to keep up with industry norms and customer expectations. Initially for FY 2000-2002, our intent was to measure beneficiary customer service in three areas: accessibility, accuracy of response, and caller satisfaction. Once consistent standards were developed for all contractors, CMS was able to continue to collect data for these measures, meeting our FY 2001 goal. However, due to technical difficulties, our FY 2001 conversion to the FTS-2001 long distance service provider (WorldCom) took longer than expected requiring an extension of the future data collection period for the accessibility measure. A change in Agency priorities and the strategy for telephone customer service required a redirection of funding for the national caller satisfaction survey to a pilot operation in Pennsylvania (beneficiaries calling a single 800 number), in early FY 2002. This important pilot is a model for how CMS will handle calls in the future, and the future focus of this goal will track the nationwide implementation of this toll free number.

CMS also made the development and implementation of a standard desktop for customer service representatives (CSRs) at contractor call centers one of its highest priorities in telephone delivery. This desktop, Next Generation Desktop, has now been deployed at 1-

800-MEDICARE and in three Part A, three Part B, and two Durable Medical Equipment Regional Carrier call centers. The desktop will continue to be rolled out to the remaining call centers over the next couple of years. It will result in significant improvements in the call centers, by increasing the consistency and accuracy of responses to beneficiary inquiries, ultimately increasing their satisfaction with the telephone interaction. However, given the lack of baseline data and the anticipated initial impact of the new desktop tool, CMS cannot establish realistic performance targets for caller satisfaction for several years to come. Although we met our targets for FY 2003, this lack of baseline data, along with the change in Agency priorities has resulted in the discontinuation of the caller satisfaction and accessibility measures at this time.

Fee-for-Service Medicare Payment Timeliness – For FY 2003, we were successful in achieving payment timeliness of electronic claims at 99.2 percent for intermediaries and 99.6 percent for carriers. This goal is determined to be an efficiency measure because we believe the outcome will ultimately result in a better run Medicare program. We will continue to maintain payment timeliness performance at a level that meets the statutory requirement for payment of electronic claims.

Electronic Commerce – In FY 2003, we were successful in maintaining high percentages of electronic media claims. At the end of FY 2003, 98.2 percent and 84.5 percent of the claims for fiscal intermediaries and carriers, respectively, were submitted electronically. We are on track to maintain those same levels of success in FY 2004. 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 (EDI) standards, and continued the work in FY 2002 and FY 2003. We will continue our work on developing, and implementing other goals (e.g., data collection and reporting of electronic claim status, electronic eligibility inquiries, ERA, EFT, and COB transactions) in FY 2004.

Programming and preliminary testing for implementation of the HIPAA claim standard was completed in FY 2003. Programming hours and funding to enable completion of implementation and testing for each of the HIPAA standards were unavailable in FY 2001 and FY 2002 because of changes in agency project prioritization. As a result, some of the work was deferred to FY 2003, and FY 2004

HIPAA requires that the Secretary adopt national health care EDI standards for at least the nine transaction types specified in the legislation. Due to contractor over runs, it was not possible to schedule implementation and testing of the transaction for retail drug and the eligibility query and response until late FY 2003. The retail drug standard and eligibility standard implementation will be completed in FY 2004. We are on target to reach our FY 2004 targets.

Chief Financial Officer's Report – The CMS financial statements are a material element 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). The CMS met its goal to maintain a "clean" unqualified opinion on FY 2003 financial statement for the fifth consecutive year. We also accelerated the financial reporting and auditing process and issued our audited financial report on November 14, 2003. This was over 2 months earlier than last year.

During FY 2003, we strengthened Medicare contractor financial management oversight through four workgroups addressing four key areas identified by auditors: follow up on corrective action plans, reconciliation of funds expended to paid claims, trend analysis, and internal controls. 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 is to implement an integrated general ledger accounting system.

Fee-for-Service Contractor Oversight - In an effort to improve performance and oversight of carriers and fiscal intermediaries that interact directly with CMS' customers, CMS established several performance goals in this area. CMS can provide better oversight of our contractors by using a standardized, uniform evaluation process. In FY 2001 national teams using standardized review protocols conducted 171 onsite reviews. In FY 2002, national teams using standardized evaluation protocols conducted 132 onsite reviews. In FY 2003, national teams using standardized evaluation protocols conducted 56 onsite reviews in nine business functions handled by the carriers and fiscal intermediaries. Additionally, three reviews that were not originally scheduled were conducted in accordance with special requests received from CMS' Regional Offices. Reviews of many of the payment safeguard business functions (e.g., overpayments and debt collection, medical review, and Medicare Secondary Payer) were carried out through contracts with public accounting firms that conducted Statement of Auditing Standards (SAS) 70 reviews.

CMS has achieved greater review consistency through:

- the increased use of national (regional office/central office) review teams,
- by developing and using standardized review protocols,
- by training reviewers in general performance auditing techniques, lessons learned from the prior year's reviews, and the standard protocols,
- by reviewing all team evaluation reports in advance of sending them to the contractor, and
- by reviewing a sample of CPE review teams' workpapers.

Due to the changes introduced in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, this successful goal will be discontinued after FY 2004 in order to highlight new Agency responsibilities (see new goal MO10-05). CMS looks forward to continued improvement through the use of prior years' performance information to modify some parts of our evaluation guidelines and to provide better training to the reviewers.

Delinquent Debt – CMS worked hard to meet its goal of referring 100 percent of all eligible delinquent debt. However, due to the various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated. During FY 2003, CMS developed improved written procedures to refer eligible Claims Accounts Receivable debts to Treasury, however system changes are required to fully implement those written instructions. Therefore, CMS managed to refer approximately 96 percent of its eligible delinquent debt by the end of the fiscal year. The balance of eligible debt will be referred in FY 2004.

Beneficiary Information - With clear baselines in place, we continue to track our beneficiary education efforts toward our ultimate 5-year target for beneficiary accessibility to Medicare information and understanding of basic messages promoted through the educational efforts. Feedback from surveys of beneficiaries receiving the *Medicare & You* handbook continues to be positive, and the number of beneficiaries calling CMS' 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. These efforts, along with other national and local programs, strive to raise beneficiary awareness of the information provided by Medicare; e.g., through the Quality Improvement Organizations' public nursing home campaigns.

In Fall 2001 and 2002, CMS embarked on a national ad campaign, which has helped beneficiaries and their caregivers become more aware of the services provided by the Medicare program to help them become more 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 included:

- expanding customer service representative 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 (Medicare Advantage 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 national ad campaign on the new choices and new ways to get information.

In Fall 2003, we continued the national ad campaign. The focus of the campaign was to continue to increase target audience recognition of 1-800-MEDICARE and its purpose. In addition to promotion of 1-800-MEDICARE as a resource for Medicare, in FY 2004 we plan to use the media campaign to support the introduction of the new Medicare-endorsed prescription drug card.

Interim data shows progress toward our targets. The strategies above 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 (MO9-

05) and to increase adult immunization (QIO2-05) and mammography rates (QIO3-05). We continue to measure and monitor progress on this goal. We plan to conduct another national media campaign in Fall 2003 to continue our promotion of the Medicare program, and for FY 2005 plan to maintain the high performance levels set for FY 2004.

Beneficiary Understanding - To promote beneficiary and public understanding of CMS and its programs, we have developed a goal to improve and measure 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. We will measure beneficiary awareness and understanding of the Medicare program using the Medicare Current Beneficiary Survey. The first measure is to improve the number of questions about the Medicare program answered correctly out of six questions on a knowledge quiz. The second measure is to improve beneficiary awareness of the 1-800-MEDICARE information number. We continue to measure and monitor efforts on this goal, and we plan to maintain in FY 2005 the high performance levels set for FY 2004.

Implement Medicare Contracting Reform - On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Section 911 of the Act establishes the Medicare FFS Contracting Reform Initiative (MCRI) that will be implemented over the next several years. Under this provision, CMS is to replace the current Medicare FI and Carrier contracts, using competitive procedures, with new MAC contracts by October 2011. The new MAC contracts may be renewed annually based on performance for a period of 5 years, but they must be re-competed every 5 years.

In accordance with the new legislation, CMS plans to transition 100% of the Medicare FFS claims workload to the new MACs over the course of FYs 2006 through 2011. CMS has commenced developing its implementation plan for MCRI. Near-term activities include drafting an acquisition plan, a procurement strategy, and a MAC Statement of Work. CMS will also continue to conduct a FFS Incentive Pilot with three of its current contractors to test concepts for possible incorporation into the new MAC contracts. During the course of FY 2004, CMS will develop a timeline and funding strategy for all its activities under MCRI.

Performance Goal MO1-05

Improve Beneficiary Telephone Customer Service

Baseline: National quality targets defined. Currently no standardization of telephone call centers; 1 pilot underway.
FY 2005 Target: (1) Quality Standards: --Minimum of 90 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 90 percent meets expectations for Knowledge Skills Assessment (2) Continue national expansion of 1-800-MEDICARE.
FY 2004 Target: (1) Quality Standards: --Minimum of 90 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 90 percent meets expectations for Knowledge Skills Assessment (2) Continue national expansion of 1-800-MEDICARE.
FY 2003 Target: (1) Quality Standards: --Minimum of 85 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 85 percent meets expectations for Knowledge Skills Assessment (2) Begin national expansion of 1-800-MEDICARE. **Performance:** Goal met
FY 2002: New in FY 2003

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 2002 Target: Complete data collection and set baselines/future targets. **Performance:** Goal partially met. Accuracy standards were set (see Quality Standards, above). Accessibility and caller satisfaction measures discontinued due to shift in focus in the delivery of beneficiary telephone customer service.
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 18 million telephone beneficiary inquiries annually. Beneficiary telephone customer service is a central part of CMS's customer service function, and we are developing a long-term and comprehensive strategy to deliver efficient, informative and customer-focused telephone service for our beneficiaries.

Although our previous goal (FY 2000-02) focused on measuring improvements in accessibility, accuracy of response, and caller satisfaction, our new goal focuses on the nationwide implementation of a single 800 number for beneficiary inquiries. This shift reflects a significant systems change that will enhance contractor efficiency and also improve

responsiveness to our beneficiaries. We will continue to measure the quality standards that we have built over the last few years while we introduce improvements in telephone customer service via the 1-800-MEDICARE line nationwide.

Currently, the 1-800-MEDICARE number is a helpline for general Medicare questions unrelated to specific claims or individual beneficiaries; our planned expansion will allow personalized customer service via the 800 number. This goal focuses on improvements at the carrier and fiscal intermediary level; these services will ultimately be rolled into a single 800 number that will route customers to the appropriate Medicare contractor call centers. CMS presently allows each Medicare contractor to have numerous toll-free numbers for managing their Medicare telephone inquiries. This has proven to be confusing to the public and prevents us from managing our call volumes in an orderly and efficient manner. In addition, based on statistics, we answer over 18 million calls a year; however, we receive almost 30 million call attempts a year to all of our toll-free numbers. This means that a large percentage of our calls go unanswered each year. A single 800 number will provide one point of contact for the calling public.

Our long-term strategy will be to make this 800 number a single entry point into the network, providing economies of scale, and to utilize resources by seamlessly shifting from over utilized to underutilized call centers. This will: (1) capture many of the calls that were not getting through, and (2) reduce the number of callers who dial one number and are referred to another (currently, 25 percent of the callers to the 1-800-MEDICARE are referred to their carrier's 800 number). All call centers will have access to the systems housing beneficiary information and will be equipped with scripts to enable the customer service representatives to handle any question, regardless of which call center is being used. The 800 number pilot project in Pennsylvania is a model for how CMS will handle calls in the future.

Another critical strategy is the development and implementation of a standard desktop for customer service representatives at the contractor call centers. This Next Generation Desktop has now been deployed at 1-800-MEDICARE, and in three Part A, three Part B, and two Durable Medical Equipment Regional Carrier call centers. The desktop will continue to be rolled out to the remaining call centers over the next couple of years. The new desktop tool is designed to increase the consistency and accuracy of all responses to beneficiary inquiries and thus will ultimately increase the customers' satisfaction with the telephone interaction.

Coordination: CMS will work closely with its contractors during the data collection process for our quality measures and implementation of the desktop toward national implementation of 1-800-MEDICARE.

Data Source(s): 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 CMS's Customer Service Assessment and Management System using scorecard totals.

Verification and Validation: Data reported by Medicare contractors 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. CMS plans to validate the data on accuracy of response by having an independent third party sample a minimum of calls.

Performance Goal MO2-05

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 2005 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
FY 2004 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
FY 2003 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims. **Performance:** Goal met
FY 2002 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims. **Performance:** Goal Met
FY 2001 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims. **Performance:** Goal Met
FY 2000 Target: Maintain payment timeliness at the statutory requirement of 95 percent 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) establishes as the 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' bill/claim processing timeliness requirements. The final data for FY 2003 showed a payment rate for intermediaries of 99.2 percent and 99.6 percent for carriers.

Coordination: CMS is committed to being a reliable business partner for the provider community. 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: CMS routinely utilizes Contractor Performance Evaluation (CPE) for determining whether intermediaries and carriers are meeting claims processing timeliness requirements. 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 MO3-05

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 2005 Target: (a) The FY 2005 target EMC rates will remain at 97 percent and 80 percent for intermediaries and carriers, respectively, as we do not anticipate the EMC share to go up until after FY 2005. (b) Begin implementation of the HIPAA transaction standard for attachments.
FY 2004 Target: (a) The FY 2004 target EMC rates will remain at 97 percent and 80 percent for intermediaries and carriers, respectively. (b) Complete baseline data for fiscal intermediaries for electronic claims status, electronic eligibility queries, electronic remittance advice (ERA), electronic funds transfer (EFT), and coordination of benefits (COB) transactions; for carriers for electronic eligibility queries, and for durable medical equipment regional carriers for retail drug claims.
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 2005*, when initial Health Insurance Portability and Accountability Act (HIPAA) standards should have been implemented throughout the industry. (b) Complete baseline data for carriers for electronic claims status, electronic eligibility queries, electronic remittance advice, electronic funds transfer, and coordination of benefits 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. *Delayed from FY 2004 **Performance:** Goal Partially Met (See FY 2004 Target)
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 2005* when Health Insurance Portability and Accountability Act (HIPAA) standards are implemented throughout the industry, and the resulting issues have been satisfactorily resolved. (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. *Delayed from FY 2003 **Performance:** Goal Met
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 maintain, and, in the long-run, increase the percentage of 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 was further delayed due to the passing of Public Law 107-105 in December 2001. The Administrative Simplification Compliance Act (ASCA) gave covered entities the option to obtain an extension for compliance to October 16, 2003 from October 16, 2002, giving the Medicare program an additional year to become HIPAA compliant. Medicare filed for an extension as required under ASCA. In addition, due to widespread inability of the majority of providers to fully comply with the HIPAA standards as of the end of FY 2003, a contingency plan was implemented by Medicare to assure continuation of health care payments and services while providers complete their implementation activities. This will result in continued support of pre-HIPAA electronic formats as well as the HIPAA formats into FY 2004.

Over the last decade, CMS has placed a great emphasis on the use of electronic claims transmissions. The final data for FY 2003 showed an electronic claims submission rate of 98.2 percent for intermediaries and 84.5 percent for carriers. These rates are at or near a natural saturation point. We believe maintenance of EMC will be challenging in FY 2004 and FY 2005 given the HIPAA implementation environment across the health care industry. However, the requirement for electronic claim submission under ASCA will help in maintaining and eventually increase the high level of EMC reached in previous years.

As Medicare providers 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 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. The target of establishing baseline data for electronic claim status, electronic eligibility inquiries, Electronic Remittance Advice and Electronic Funds Transfer in the third quarter of FY 2001 and in FY 2002 was delayed due to lack of funding. Collection of baseline data for carriers began April 1, 2003. Intermediary collection has been scheduled for FY 2004.

Coordination: The CMS works closely with Medicare contractors in the development of EMC payment rates, and with Medicare contractors and Standard Developing Organizations (e.g., X12) in developing HIPAA standards.

Data Source(s): The data source for tracking EMC is CMS's Contractor Reporting of Operational and Workload Data (CROWD) system. Medicare contractors started to separately report to CMS on status of HIPAA standards implementation and testing in FY 2002. In FY 2003, collection of baseline data for carriers began being collected through the CROWD system for EDI transactions in addition to claims and collection of intermediary data, which began in FY 2004.

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 contracted 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 ended in early FY 2003.

Performance Goal MO4-05

Maintain CMS's Improved Rating on Financial Statements

Baseline: In the FY 1998 financial statements, one item totaling $3.6 billion was questioned by the auditors, resulting in a qualified opinion.
FY 2005 Target: Maintain an unqualified opinion on CMS' FY 2005 financial statements.
FY 2004 Target: Maintain an unqualified opinion on CMS's FY 2004 financial statements.
FY 2003 Target: Maintain an unqualified opinion on CMS's FY 2003 financial statements. **Performance:** Goal met.
FY 2002 Target: Maintain a "clean" unqualified opinion on CMS's FY 2002 financial statements. **Performance:** Goal met.
FY 2001 Target: Maintain a "clean" unqualified opinion on CMS's FY 2001 financial statements. **Performance:** Goal met.
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: Our goal is to maintain an unqualified opinion, which indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and financing of CMS. Auditors review the financial operations, internal controls, and compliance with laws and regulations at CMS and its Medicare contractors.

Since FY 1998, we have made significant improvements on our financial statements. On the FY 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.

The CMS has received unqualified audit opinions since FY 1999, including for FY 2003 on November 7, 2003. During FY 2003, we tested financial management internal controls and reviewed accounts receivable balances at 15 Medicare contractors using Certified Public Accounting (CPA) firms. In addition, we continued to use workgroups comprised of Central Office (CO) and Regional Office (RO) consortia staff responsible for addressing four key areas identified by auditors: follow up on corrective action plans (CAPs), reconciliations of funds expended to paid claims, trend analysis, and internal controls. The objectives of each workgroup are to clearly define CO and RO roles and responsibilities, as well as develop the national strategic plans to strengthen our Medicare

contractor financial management oversight in these areas. Our long-term plan is to implement 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 statements is issued by a CPA firm with oversight by the OIG.

Verification and Validation: The CMS works closely with the OIG and 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 83 percent.

Performance Goal MO5-04
Improve CMS Oversight of Medicare Fee-for-Service Contractors
(Discontinued after FY 2004)

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 2005 Target: Goal discontinued.
FY 2004 Target: Developmental.
FY 2003 Target: Building on program achievement in prior years, CMS will move still further toward its goal of national uniform contractor evaluation. **Performance:** Goal Met
FY 2002 Target: Building on experience of FY 2001 and continuing towards goal of national uniform contractor evaluation. **Performance:** Goal Met
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 931 million claims and administer benefit outlays of approximately $197 billion. In FY 2003, they processed an estimated 1 billion Medicare claims; handled more than 6.4 million appeals; responded to over 40 million inquiries from providers and beneficiaries; enrolled, educated, and trained providers and suppliers; educated and assisted beneficiaries; and performed other responsibilities on behalf of CMS. In FY 2004, it is estimated that the contractors will handle more than 6.4 million appeals, respond to over 51 million inquiries from providers and beneficiaries, as well as enroll, educate and train providers and suppliers and perform other responsibilities on the part of CMS.

Beginning in FY 1999 and continuing in FY 2000, FY 2001, FY 2002, and FY 2003, 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 were conducted by national teams using standardized review protocols, under the guidance of the same project leaders assigned to each business function. Several contractor activities, such as accounts receivable, computer systems security, and the effectiveness of contractor financial internal controls, were evaluated through contracts with consulting or accounting firms, which used a standard review program.

In 2002, national (RO/CO) teams conducted evaluations using standardized protocols on which they had received training. Project Leaders, each assigned to a single business function, provided guidance to the teams evaluating the function and were responsible for approving the final evaluation reports issued to contractors.

In FY 2002, we achieved greater review consistency through the increased use of national (RO/CO) review teams trained to evaluate functions performed by the Medicare contractors. Additional steps were taken to foster greater consistency including: standardizing review protocols, conducting national training on the protocols, participating in training by USDA's Government Audit Training Institute on approaches to performance audits, standardizing CPE review reports and management reports, performing a quality review in central office of each report concurrent with the Project Leader's review of the draft, and reviewing evaluators' work papers for a limited number of reviews in each business function. Finally, through contracts with consulting or accounting firms, some contractor activities such as accounts receivable and the effectiveness of contractor financial internal controls were evaluated through reviews conducted by consulting CPA firms.

During FY 2003, CMS conducted 56 contractor performance evaluations of nine different business functions performed by fee-for-service contractors. Teams of central and regional office CMS staff conducted the evaluations, using standardized protocols on which they all were trained. Project Leaders, each assigned to a single business function, provided guidance to the teams evaluating the function and were responsible for approving the final evaluation reports issued to contractors. In addition, during FY 2003, CMS also has teams conducting 38 reviews in eight different business functions at three contractors that participated in a Medicare Incentive Pilot. There were two review periods during the year and each contractor was evaluated in all business functions each time.

Finally, in FY 2003, CMS contracted out for SAS 70 reviews as the means to evaluate contractor performance in most of the business functions that are either financial or considered a payment safeguard. Specifically, SAS 70 reviews were conducted by certified public accountants in such contractor activities as financial operations, medical review, Medicare Secondary Payer, debt collection, provider audit, and overpayments.

While data will be reported in FY 2004, this goal will be discontinued after FY 2004.

Coordination: The annual CPE strategy is coordinated with management and staff from CMS's central and regional offices. Working with the regions, CO managers with responsibility for the various business functions set annual evaluation priorities and develop standard review protocols utilized by the review teams. These same CO components name technical assistants who helped by training the reviewers on the evaluation protocols and providing any needed technical guidance throughout the evaluation period. We will continue to coordinate within CMS because of the plan of the Financial Management component to continue using contracted SAS-70 reviews as the means to evaluate most of the business functions for which it is responsible.

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

Verification and Validation: CMS staff reviewed the reports cited under data sources to assess performance and report on progress. In addition, at least one review team in each business function had its work papers reviewed by CMS staff.

Performance Goal MO6-05

Increase Referral of Eligible Delinquent Debt for Cross Servicing
(Discontinued after FY 2004)

Baseline: Prior to fiscal year (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 2005 Target: Goal discontinued.
FY 2004 Target: Continue to refer 100 percent of eligible delinquent CMS receivables to Treasury. Improve the procedures for identifying, monitoring and tracking these debts.
FY 2003 Target: Continue to refer 100 percent of eligible delinquent CMS receivables to Treasury. Improve the procedures for identifying, monitoring and tracking these debts. **Performance:** Goal not met. CMS referred approximately 96 percent of its eligible delinquent debt at the end of the fiscal year. The balance of eligible debt will be referred in FY 2004. CMS implemented improved instructions during FY 2003, however additional system changes are required and will be programmed during FY 2004 to fully implement those instructions.
FY 2002 Target: Increase the dollar amount of debt referred for cross servicing to 100 percent of eligible delinquent debt. **Performance:** Goal not met. Due to various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated. The CMS referred approximately 90 percent of its eligible delinquent debt by the end of the fiscal year. The balance of eligible debt will be referred in FY 2003.

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 2002, CMS referred approximately $4 billion in delinquent debt to Treasury for cross servicing and offset. By the end of FY 2002, CMS's original goal was to refer 100 percent of eligible delinquent debt. CMS is working hard in order to meet its goal of referring 100 percent of all eligible delinquent debt. The debt referral process was more labor intensive than we originally projected based on our pilot implementation efforts. This is because our remaining unreferred debt contains numerous debts of relatively small amounts consisting primarily of beneficiary debt, fiscal intermediary Claims Accounts receivables, and other MSP debt. As of FY 2003, CMS referred approximately 96 percent of its eligible delinquent debt. CMS continues to streamline its debt referral processes and strive for a 100 percent referral goal.

CMS initially targeted only Medicare Part A and Part B overpayments for referral for cross servicing. However to meet our goal to refer 100 percent of eligible delinquent debt, 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, certifying that the debt is valid and legally enforceable, sending a notice which apprises the debtors of their rights, and notifying the debtor of the intent to refer the debt for cross servicing. Medicare Secondary Payer (MSP) debt, which is a large percentage of CMS's delinquent debt, was added to the referral process in FY 2001. In FY 2002, CMS began to focus on other types of debts in its accounts receivable balance, many of which reside in various databases internal to CMS. In FY 2003, CMS continued to refer additional types of delinquent debt, including defaulted Health Maintenance Organization (HMO) loan debts, fiscal intermediary Medicare Claims Account receivables, remaining types of MSP debt, and small dollar amounts of Non-MSP Part B overpayments. CMS also revised its eligibility criteria to include debts under fraud investigation that are still eligible for internal Medicare offset/recoupment. Also, during FY 2003, CMS developed improved instructions to refer eligible Claim Account receivable debts, however additional system changes are required to fully implement those instructions.

Coordination: CMS, its Regional Offices 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. During FY 2003, periodic meetings were held with various employer organizations, Treasury representatives and CMS staff to clarify and streamline the debt referral processes.

Data Sources: 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. MSP debt information is housed in the Medicare contractor locations. Central Office debt resides on various databases, including the accounting system. Medicare contractors and CMS enter debt information into the Debt Collection System (DCS) prior to referral.

During FY 2003, CMS developed and implemented new financial reporting instructions for the Medicare contractors to further improve financial reporting and identification of eligible and non-eligible delinquent debt.

CMS's Healthcare Integrated General Ledger Accounting System (HIGLAS), which will include an accounts receivable system, is in the pilot design, development and implementation 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. It is expected that HIGLAS will also produce a download report to DCS. This automation will greatly enhance data integrity and timely referral of eligible debt.

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. CMS will verify that the information in the DCS system is consistent with the data reported in the POR/PSOR systems and contractor 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.
CMS has developed a good working relationship with Treasury personnel so that individual discrepancies and issues are resolved expeditiously.

Performance Goal MO8-05

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries

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 2005 Targets: Maintain performance levels set for FY 2004.
FY 2004: Achieve (1) 77 percent of beneficiaries who reported the information they received answered their question(s), and (2) 57 percent of beneficiaries who knew that most people covered by Medicare can select from among different health plan options within Medicare.
FY 2003: Same as FY 2002/2001. **Performance:** Goal met. Data being collected and monitored.
FY 2002: Same as FY 2001. **Performance:** Goal met. Data being collected and monitored.
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, (1) 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 Advantage. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the "right information at the right time."

The National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information through a variety of channels in order 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. In FY 2004, we plan to use the media campaign to support the introduction of the new Medicare-endorsed prescription drug card.

The NMEP, along with other national and local programs strive to raise beneficiary awareness from different perspectives; e.g., through public nursing home campaigns through the Quality Improvement Organizations. All programs are evaluated and assessed to determine their effectiveness and to implement further improvements.

In developing our targets, we assumed an average 2 percentage point increase per year; thus, 10 percentage points over the 5-year period. We figured that this was achievable given the emphasis on the education program. The targets are set for FY 2004, in order for the percentage increases to be large enough to be statistically detected.

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. These organizations have the ability to assist us in the development and dissemination of Medicare information on a much broader basis at regional and local levels.

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. Over a 5-year period, CMS will track changes in the ability to access information and beneficiary awareness.

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.

Performance Goal MO9-05

Improve Beneficiary Understanding of Basic Features of the Medicare Program

Baselines (CY 2000): (1) Fifty-three percent of Medicare beneficiaries were aware that Medicare has a 1-800-MEDICARE toll-free number. (2) Beneficiaries were able to answer correctly 2.75 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
FY 2005 Targets: Maintain performance levels set for FY 2004.
FY 2004 Targets: (1) Sixty-five percent of Medicare beneficiaries are aware that Medicare has a 1-800 number. (2) Beneficiaries are able to answer correctly 3.50 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
FY 2003 Target: Continue collecting and monitoring the Medicare Current Beneficiary survey (MCBS) data for reporting on CY 2004 data. **Performance:** Goal met. Baselines and targets developed.
FY 2002 Target: Developmental. Baselines and future targets will be developed. **Performance:** Goal met. Baselines and targets 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:** Goal met. Steps 1-5 completed. Survey fielded.

Discussion:
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.

As part of this goal, there are two measures. The first measure is the number of questions answered correctly out of six questions on a knowledge quiz. The quiz includes the following true/false questions:

(1) Most people covered by Medicare can select among different kinds of health plan options;
(2) Medicare without a supplemental insurance policy pays for all of your healthcare expenses;

(3) People can report complaints to Medicare about their Medicare managed care plans (HMOs) or supplemental plans if they are not satisfied with them;
(4) If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they have limited choices about what doctors they can see;
(5) If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they can change or drop the plan and still be covered by Medicare; and
(6) Medicare managed care plans (HMOs) that cover people on Medicare often cover more health services, like prescribed medicines, than Medicare without a supplemental policy.

The second measure is how many beneficiaries are aware of the CMS 1-800 MEDICARE toll-free number.

The CMS employs a variety of strategies to ensure that targeted audiences are reached with "the right information at the right time" to make informed health care decisions in order to accomplish these objectives. Ongoing formative research and consumer testing is conducted as part of all programs to ensure the development of products and information that will be understandable and delivered through the most appropriate, maximum number of information channels to reach the broadest audiences. These audiences include vulnerable populations who have problems with access to information. The CMS works across the organization to ensure maximum and efficient use of existing infrastructures to carry key Medicare messages and information to beneficiaries; e.g., expanding an existing information channel to provide new information to beneficiaries rather than building a new infrastructure. The CMS has begun to promote and publicize information channels and resources for many of our programs to further raise the awareness levels of Medicare beneficiaries.

The CMS's National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information to improve awareness of Medicare core features and sources. This program uses a variety of information channels to raise awareness including a handbook in print, toll-free telephone services through 1-800-MEDICARE, information via www.medicare.gov, and direct counseling support through the State Health Insurance & Assistance Program. NMEP along with other national and local programs strive to raise beneficiary awareness from different perspectives; e.g., public nursing home campaigns through the Quality Improvement Organizations. All programs are evaluated and assessed to determine their effectiveness and to implement further improvements.

Coordination: All CMS beneficiary-centered programs emphasize partnerships with Federal, State, local agencies, and beneficiary advocacy groups. These organizations have the ability to assist us in the development and dissemination of Medicare information on a much broader basis at regional and local levels. As an example, CMS has built an alliance network of over 120 national organizations and has formed a National Advisory Panel on Medicare Education that consists of national experts in consumer education. This panel 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 ongoing 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 included questions asking beneficiaries about their awareness of basic features of the Medicare program.

Questions were in a "true," "false," or "not sure" format. For ethical reasons, after asking questions, MCBS interviewers made 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: 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. 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 MO10-05

Implement Medicare Contracting Reform

Baseline: All Medicare claims processing work is currently conducted by 27 Medicare Fiscal Intermediaries and 19 Carriers [None (0%) of Medicare Fee-For-Service (FFS) claims workload has been transitioned to Medicare Administrative Contractors (MACs)].
FY 2005 Target: Developmental

Discussion: Since the inception of Medicare, the Centers for Medicare & Medicaid Services (CMS) has contracted out vital program operational functions (i.e., claims processing, provider and beneficiary services, appeals, etc.) to a set of contractors known as Medicare Fiscal Intermediaries (FIs) and Carriers. In Fiscal Year (FY) 2003, these contractors processed approximately one billion claims and performed their other responsibilities within a total contractor budget of approximately $1.6 billion.

Most of the FI and Carrier contracts were initiated on a non-competitive basis, and CMS renews most of these contracts each year based on satisfactory performance. An exception may occur when a contractor decides to leave the program. For example, CMS teamed with the Blue Cross Blue Shield (BCBS) Association to compete BCBS of Rhode Island's workload when that company chose to end its FI and carrier contracts in FY 2003.

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Section 911 of the Act establishes the Medicare FFS Contracting Reform Initiative (MCRI) that will be implemented over the next several years. Under this provision, CMS is to replace the current Medicare FI and Carrier contracts, using competitive procedures, with new MAC contracts by October 2011. The new MAC contracts may be renewed annually based on performance for a period of 5 years, but they must be re-competed every 5 years. The Federal Acquisition Regulations (FAR) will apply to the new MAC contracts except to the extent that any provisions in them are inconsistent with a specific Medicare requirement, and the new MAC contracts may provide for performance incentives.

In accordance with the new legislation, CMS plans to transition 100% of the Medicare FFS claims workload to the new MACs over the course of FYs 2006 through 2011. CMS has commenced developing its implementation plan for MCRI. Near-term activities include drafting an acquisition plan, a procurement strategy, and a MAC Statement of Work. CMS will also continue to conduct a FFS Incentive Pilot with three of its current contractors to test concepts for possible incorporation into the new MAC contracts. During the course of FY 2004, CMS will develop a timeline and funding strategy for all its activities under MCRI.

Coordination: CMS will work with the Consortium Contractor Management Officers and Regional Offices to ensure the correct reporting of contractor workload data. During the transition to the MAC contractors, CMS will coordinate closely with HHS

components and contractors to ensure that the mandated procurements are conducted effectively and that claims processing operations are transferred with minimal effect on providers and beneficiaries.

In addition, CMS will develop a website to communicate with and obtain feedback from current and potential contractors and stakeholders. CMS will continue to engage select contractors in a pilot study to test concepts for possible coordination into the new MAC contracts.

Data Source(s): Data on contractor workload is available through CMS' current reporting systems. Furthermore, CMS will present progress reports on MCRI to the Department of Health & Human Services, the Office of Management & Budget, and Congress on a regular basis. CMS' contract office will notify the public of MAC contract opportunities and awards in accordance with FAR.

Verification and Validation: CMS staff will review all reports with cited data to ensure that the reports are accurate, complete and understandable.

Federal Administrative Costs

Federal Administrative Costs	FY 2002 Actual	FY 2003 Actual	FY 2004 Final Conference	FY 2005 Estimate
Total	**$530.4 M**	**$567.3 M**	**$577.1 M**	**$589.2 M**
Full-Time Equivalents*	**4,417**	**4,561**	**4398**	**4398**

*FTEs in all years are now shown with their associated fund source.

Funding for Federal Administrative Costs provides roughly 4,398 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.

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:

- Improve Medicare's Administration of the Beneficiary Appeals Process (MB4-05)
- Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements (MO2-05)
- Increase the Use of Electronic Commerce in Medicare (MO3-05)
- Maintain CMS' Improved Rating on Financial Statements (MO4-05)
- Improve the Management of the Survey and Certification Budget Development and Execution Process (QSC3-03)
- Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities (QSC4-05)
- Improve CMS' Information Systems Security (RP1-05)

Performance Goals	Targets	Actual Performance	Ref.
Develop and Implement an Information Technology (Enterprise) Architecture % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** --Continue maturing the EA **FY 04:** --Continue maturing the EA **FY 03:** --Continue maturing the ITA --Complete development and promulgation of remaining IT policies **FY 02:** --Continue policy and procedure development --Complete development of System Design Reference Models & integration into SDLC activities -- Monitor ITA (Enterprise Architecture) 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 05:** **FY 04:** **FY 03:** --Continued maturing the ITA (Goal met) -- IT policy structure redesigned. 3 IT policies being drafted, 2 guides finalized and in use. Additional necessary subordinate guides are being developed. (Goal not met) **FY 02:** --Established IT policy and procedure development teams. Developed and promulgated 2 policies, 15 remaining policies being drafted (Goal met) -- Development of all (8 in total) SDRMs completed 2/13/02 & projects have begun using the SDRMs in their SDLC activities. (Goal met) -- Monitoring Enterprise Architecture conformance as part of the IT Investment Management Review Process. Established baseline Products and Standards Profile. (Goal met) **FY 01:** -- Being developed; Completion of 6 templates expected 3/1/02 (Goal not met) --Integrated (Goal met) **FY 00:** All standards approved (Goal met)	FAC2 See FY 04 Revised Final

Performance Goals	Targets	Actual Performance	Ref.
Develop New Medicare Payment Systems in Fee-for-Service and Medicare Advantage: % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Goal not continued. **FY 04:** -- Implement PPS system for Inpatient Psychiatric Hospital services -- Implement revised risk-adjusted payments for Managed Care **FY 03:** -- Continue design of PPS system for Inpatient Psychiatric Hospital services -- Begin combined collection of data for risk adjusted payments for Managed Care **FY 02:** -- Implement Inpatient Rehabilitation Facilities PPS -- Improved risk-adjustment model for Medicare+Choice **FY 01:** -- Implement Home Health Agency PPS -- Make risk-adjusted payments based on PIP-DCG model **FY 00:** -- Implement Hospital Outpatient PPS -- Publish final HHA PPS Regulation -- Make Risk-adjusted payments **FY 99:** -- Establish SNF PPS -- Make Risk Adjusted payments	**FY 05:** N/A **FY04:** **FY 03:** -- Proposed rule published 11/19/2003. (Goal met.) -- Revised data collection process began 10/02. (Goal met.) **FY 02:** -- IRF PPS rule published 8/7/01. Implemented 1/1/02 (Goal met) -- Inpatient/ambulatory risk-adjustment model selected (Goal met) **FY 01:** -- HHA PPS implemented 10/1/00 (Goal met) -- (Goal met) **FY 00:** -- Outpatient PPS implemented 8/1/00 (Goal met) -- Rule published 7/3/00 (Goal met) -- Risk adjusted payments began 1/1/2000 (Goal met) **FY 99:** -- (Goal met) -- (Goal met) **Baseline:** Cost reimbursement for HHA, SNF, inpatient rehab, outpatient hospital and psychiatric hospitals. Payments to managed care plans not risk-adjusted.	FAC4 **8**

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS' Workforce Planning **[outcome goal]**	**FY 04** Goal discontinued **FY 03:** Complete development of and implement automated workforce planning modules **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 03:** Delay in workforce planning modules being developed and implemented. Retirement projections module developed and implemented in a small group in CMS. (Goal partially met.) **FY 02:** Developed work roles and assigned CMS positions to work roles. Determined future skills and knowledge requirements. (Goal met)	FAC6 **8**  See FY 04 Revised Final
Improve CMS' Management Structure **[outcome goal]**	**FY 05:** Goal discontinued **FY 04:** Establish a baseline using data from the automated management competency system. **FY 03:** (a) Implementation of a competency-based performance management (planning and appraisal) program for managers; (b) Implementation of an awards and recognition program for managers; and (c) Exploration of data sources	**FY 05: N/A** **FY 04:** **FY 03**: Both performance management (a) and awards and recognition (b) systems for non-SES managers are fully operational. We are developing a system (c) to interpret raw data from (a) and (b). (Goal met)	FAC7 **8** 
Strengthen and Maintain Diversity at all Levels of CMS **[outcome goal]** % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Same as FY 2003/2004 **FY 04:** Same as FY 2003 **FY 03:** Increase representation of EEO groups in areas where they demonstrate underrepresentation	**FY 05:** **FY 04:** **FY 03:** Progress made (Goal met) **FY 02:** Progress made (Goal met) **FY 01:** Progress made (Goal met) **FY 00:** EEO groups representing manifest imbalances in CMS workforce **(Baseline)**	FAC8 **8** 
Increase awareness about the opportunity to enroll in the Medicare Savings Programs **[outcome goal]**	**FY 05:** Goal discontinued **FY 04:** Increase awareness of Medicare Savings Programs to 20% **FY 03:** Increase awareness of Medicare Savings Programs to 13% **FY 02**: Develop baseline and set future targets	**FY 05:** **FY 04:** **FY 03:** **FY 02:** 11% (Goal met) **(Baseline)**	FAC9 **3**

Performance Goals	Targets	Actual Performance	Ref.
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization	**FY 04:** Goal discontinued **FY 03**: -- Achieve greater administrative efficiency through consolidation of administrative functions and reduction of FTEs by 93 FTE's -- Achieve a more citizen-centered focus through organizational delayering to 4 layers	**FY 04:** N/A **FY 03:** --114 administrative position incumbents deployed and 8 administrative positions abolished. All CMS administrative functions consolidated at the OPDIV level, except where sound business reasons dictate otherwise. (Goal met) --For all 16 components where the number of managerial layers exceeded four, delaying efforts are completed. (Goal met) **FY 02:** **--**4632 FTE Ceiling **(Baseline** 1/1/02**)** --5 layers (**Baseline** 1/1/02)	FAC10  See FY 04 Revised Final

Performance Results Discussion

The CMS' 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' 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' 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 Advantage measures our progress towards implementing prospective payment systems (PPS) 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 implemented PPS for inpatient rehabilitation facilities in FY 2002. Additionally, CMS began developing a psychiatric hospital PPS in FY 2002 and published a proposed regulation on November 19, 2003. Risk-adjusted payments for Medicare Advantage plans were implemented January 1, 2000 and we continue to improve the collection of data. In fact, we have a revised data collection process implemented in October 2002 for hospital inpatient, hospital outpatient and

physician data. The new approach for data collection has significantly reduced the burden of data collection for Medicare Advantage organizations.

Information Technology Architecture (EA)- In FY 2002, workgroups were established to develop IT policies and procedures. Two policies were issued, 5 more policies were awaiting approval, and the remaining policies were to be in solid draft by September 2003. Necessary subordinate documents were also being developed. In FY2003, CMS reconsidered this activity and decided to redesign its IT policy development structure. CMS aligned this structure to the select/control/evaluate model presented in GAO's February 1997 guidance, *Assessing Risks and Returns: A Guide for Evaluating Federal Agencies' IT Investment Decision-Making.* CMS is developing three policies: one for IT selection management, one for IT implementation management, and one for IT evaluation management. These policies are being drafted and approved. Process guides and best practice guides have been or will be developed to support each of the three policy areas. The guides will become part of an asset library that will be used by project owners for managing their projects. There has also been a transition in thought that these activities are part of the everyday activities of "maturing the architecture." Therefore, in FY2004 and beyond they will be included in the "Continue maturing the EA" goal.

Workforce Planning – To meet the rising challenge of maintaining a workforce with the specific skills necessary to accomplish our goals, and consistent 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 (Knowledge and Skills Inventory – KSI). Currently, the Department is developing a workforce planning system that will be used by all Department components, and although workforce planning remains a priority, this goal is being removed from the annual performance plan.

Management Structure – CMS is developing an automated system to track competency areas and 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' 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 March of 2002, CMS fully implemented a competency-based recruitment and selection process. In FY 2003, we developed an automated system (form and database) that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports. This information will allow us to measure the improvement in management competency as a result of CMS' Leadership and Management Development Strategy (LMDS) activities. A system will be developed in FY 2004 to collect and interpret the raw data collected from the LMDS system described

above in order to establish baselines and future targets for these activities. While this activity will continue in the future, this goal is being removed after FY 2004.

Workforce Diversity – We are pleased to report progress in our goal to increase representation in the CMS workforce of Equal Employment Opportunity (EEO) groups in areas where they demonstrate under representation. In FY 2001, we realized increases for individuals with disabilities, American Indians/Alaskan Natives and Hispanics. In FY 2002, we realized an increase in the workforce representatation of Hispanics as well as other previously underrepresented EO groups (most notably American Indian females) within certain occupational series.

In FY 2003, we again realized an increase in the workforce representation of Hispanics, up from 4.4 percent in FY 2002 to 4.6 percent. In addition, we successfully increased representation for previously under represented EO groups within certain occupational series as follows:

--Auditing – Individuals with targeted disabilities (3.2 to 3.6 percent)
--General Health Sciences (Professional) – Hispanic females (no representation to 0.8 percent) and black males (1.7 to 2.5 percent)
--Health Insurance Specialist – Hispanic males (1.3 to 1.5 percent)
--Program Adminstration/Management – Black males (8.9 to 10.7 percent), individuals with disabilities in general (10.2 TO 10.3 percent), and individuals with targeted disabilities (1.8 to 1.9 percent)
--Administrative/Program Management – Hispanic females (0.9 to 2.1 percent)
--Financial Program Management – Black females (15.3 to 16.5 percent) and black males (7.6 to 8.7 percent)
--Inspector General/Investigator – Individuals with disabilities (7.8 to 8.1 percent), Hispanic females and Asian/Pacific Islander females, both (4.7 to 5.7 percent), and Asian/Pacific Islander males (2.3 to 3.3 percent).

CMS utilizes various initiatives and hiring authorities to address the under representation of certain EO groups in the Agency. For example, we encourage managers and supervisors with hiring authority to take advantage of such programs as the Federal Career Intern Program (Presidential Executive Order 13162), which is designed to help federal agencies recruit and attract exceptional individuals into a variety of occupations. We also reference public sector and private industry reports to replicate successful practices of other Federal agencies in addressing EEO group under representation.

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. This goal focused on individuals who are eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs.

In FY 2003, CMS provided a variety of activities to increase awareness of Medicare Savings Programs. Some of the activities include:

- Revising the Medicare Savings Programs Outreach Kit. The kit contains training materials for professionals and beneficiaries about the Medicare Savings Programs. This kit is available on the CMS.hhs.gov website;
- Providing information to the Medicare Helpline Customer Service Representatives. This information is provided to beneficiaries about the Medicare Savings Programs and provides them with a telephone number to call in their state on how and where to apply;
- Updating the State Health Insurance Program (SHIP) Training Manual for Dual Eligible Programs. The kit is available on the SHIP.org website.

The FY 2003 target was to increase awareness to 13 percent; we revised our FY 2004 target to 20 percent due to excellent interim progress. Final FY 2003 data will be available in in early 2004. While we intend to continue our efforts to increase awareness of Medicare Savings Programs to eligible beneficiaries, this goal will be discontinued beginning after FY 2004.

Implement CMS Restructuring Plan – In support of the President's Management Agenda, we made significant progress toward our FY 2003 goal to achieve greater administrative efficiency through consolidation of administrative functions and a reduction in staffing, and to achieve a more citizen-centered focus through organizational delayering.

In support of our target to consolidate administrative functions, we awarded the Consolidated Information Technology Infrastructure Contract (CITIC) in May 2002 under which CMS has combined multiple information technology support contracts into a consolidated contract. In addition, we have exceeded our target (of 93) at 114 to reduce our administrative FTEs using a combination of attrition and re-deployment of incumbents to non-administrative, citizen-centered service positions and 8 administrative positions were abolished. We also completed a reorganization of the human resources (HR) function to facilitate potential consolidation at the Department of Health and Human Services (HHS) level and/or cross servicing with other Operating Divisions within HHS. This reorganization aligned CMS HR functions with consolidation objectives. As of April 2003, all 16 CMS-identified vertical delayering action items were completed, and a majority of the agency's double deputies had been eliminated. Utilizing the expanded scope of the Voluntary Early Retirement Authority, we were able to exceed our FY 2003 goal of greater administrative efficiency and achieving a more citizen-centered focus.

This goal is being removed after FY 2003 because we have completed the targets. CMS will continue to monitor staffing levels in the future while FTE levels will be tracked and set by HHS beginning in 2004.

Performance Goal FAC2-05

Develop and Implement an Information Technology (Enterprise) 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 2005 Target: Continue maturing the Enterprise Architecture (EA) by performing activities such as: making relational architectural data available CMS-wide via the intranet; more robustly applying the Architecture to enterprise-wide strategic and tactical planning activities; and issuing and revising IT policies and subordinate documents, as needed.
FY 2004 Target: Continue maturing the Enterprise Architecture (EA) by performing activities such as: making relational architectural data available CMS-wide via the intranet; more robustly applying the Architecture to enterprise-wide strategic and tactical planning activities; and issuing and revising IT policies and subordinate documents, as needed.
FY 2003 Target: Continue to develop the ITA (Enterprise Architecture), including further expansion of both breadth and depth using a segmented approach, with specific segments determined as opportunities and needs arise. Complete development and promulgation of remaining IT policies. **Performance:** Goal Partially Met – Development of Architecture progressing. Integrated repository structured and populated at high level. Medicare Fee-for-Service Claims segment documented in repository. Policy structure redefined. Three policies being drafted. Two guides finalized and in use. Additional guides will be developed, as needed.
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. **Performance:** Goal Met
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 architecture that is aligned with CMS's strategic business objectives. The EA 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 EA, and has appointed an architect to oversee its development and implementation.

The CMS has developed an IT vision on which the target EA 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.

An IT modernization effort in CMS is planned that will result in maturing portions of the architecture. 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.

CMS has developed an EA 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) EA maturity; 2) awareness/ compliance relative to the EA; and 3) organizational impact of the EA. Selected goal-based metrics will be used for GPRA reporting. The process-based metrics will be used by CMS for internal improvements to the EA and related processes.

In FY 2003, CMS partially met its goal. However, in order to meet its first FY 2003 target, CMS developed an IT Modernization Plan that is serving as the guide for capital investment decisions in modernizing CMS's systems environment to effectively support business needs. In addition, CMS acquired Popkin Software's System Architect (SA) licenses for reposing and modeling the EA data. Existing EA and Medicare fee-for-service data were loaded into the repository and the segment models were integrated with the enterprise-wide models. Popkin Software was hired to complete the customization of the tool. CMS has populated SA with the Technical Reference Model data and the Enterprise System Inventory Database data, and will make it available to staff via the intranet in FY 2004.

In addition, CMS's IT policy development structure was redefined. As a result, CMS partially met its second target. The structure is now more closely aligned to the select/control/evaluate model presented in GAO's February 1997 guidance, *Assessing Risks and Returns: A Guide for Evaluating Federal Agencies' IT Investment Decision-Making.* CMS is developing three policies: one for IT selection management, one for IT implementation management, and one for IT evaluation management. These policies are being drafted and approved. Process guides and best practice guides have been or will be developed to support each of the three policy areas. The guides will become part of an asset library that will be used by project owners for managing their projects. In the future, the policy development activities will become part of CMS's regular architecture maturity activities and will be reported as such.

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 the HHS Enterprise Architecture Program Team. CMS is also adjusting and/or mapping its architecture to the Federal Reference Models developed by OMB.

Data Source(s): Approved standards and preferred IT products are 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. We are publishing all IT policies and subordinate documents in a single asset library. Also, System Design Reference Models or system design patterns will be integrated into the EA. A mechanism for measuring architecture maturity will be the depth and breadth of data in the System Architect Repository.

Verification and Validation: The CMS Technical Advisory Board verifies and validates that project designs comply with: IT Standards Profile database, the System Design Reference Models, and other Enterprise Architecture conformance criteria.

Performance Goal FAC4-04

Develop New Medicare Payment Systems in Fee-for-Service and Medicare Advantage
(Discontinued after FY 2004)

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 2005 Target: Goal not continued
FY 2004 Target: Implement PPS system for inpatient psychiatric hospital services**.** A new risk adjustment model for payments to Medicare Advantage organizations that incorporates inpatient and ambulatory data will be implemented in CY 2004 and the collection of inpatient and ambulatory data will continue.
FY 2003 Target: Continue design of PPS system for inpatient psychiatric hospital services. Begin the combined collection of both inpatient and ambulatory data for the implementation of an improved Medicare Advantage risk adjustment methodology in CY 2004. **Performance:** Goal met. Inpatient psychiatric hospital proposed regulation was published November 19, 2003. Revised data collection process for Medicare Advantage began October 2002.
FY 2002 Target: Implement PPS systems for inpatient rehabilitation services during FY 2002. Design PPS systems for psychiatric hospitals. An improved risk adjustment model for payments to Medicare Advantage organizations will be developed for implementation in CY 2004 and data systems will be implemented to capture both inpatient and ambulatory data. **Performance:** Goal met. The inpatient rehabilitation facilities (IRF) PPS rule was published in the Federal Register on August 7, 2001. IRF PPS was successfully implemented on January 1, 2002. A risk adjustment model for payments to Medicare Advantage organizations has been selected that incorporates both inpatient and ambulatory data.
FY 2001 Target: Implement PPS systems for HHA services October 1, 2000. Risk adjusted payments to Medicare Advantage organizations 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 Advantage. 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 Advantage. **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 Advantage (formerly 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 Advantage 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 phase in of the risk adjustment methodology, 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: 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. 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' Workforce Planning
(Discontinued after FY 2003)

Baseline: Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2004.
FY 2004 Target: Goal not continued.
FY 2003 Target: Complete development of and implement automated workforce planning modules. **Performance:** Goal partially met. The Retirement Projections Module was installed onto the personal computers of a small group in CMS. Unanticipated contractor challenges delayed development and implementation of the other workforce planning modules which are being developed in house.
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. **Performance:** Goal met.

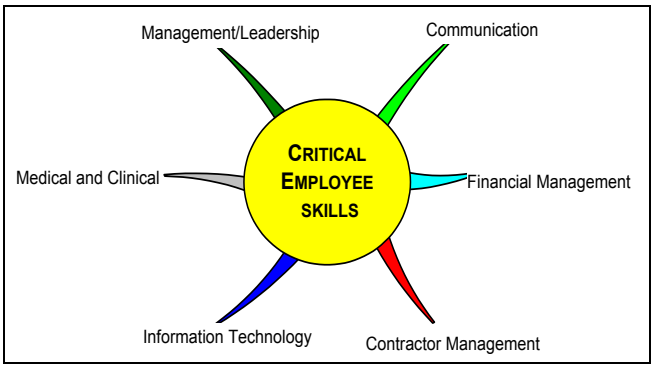
Discussion: Over the years, CMS' programs, structures, and workforce have changed significantly. Today, the organization faces a series of unprecedented business and environmental challenges, which have major implications for CMS's workforce. These challenges demonstrate a need to determine and address 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 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: CMS' 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 Agenda, CMS is creating a dynamic workforce planning system to help managers make strategic plans and decisions for hiring/staffing, retention, and human resources development.

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. Agency management ranked skill and knowledge gaps identified through this one-time data collection initiative based on breadth, depth, and criticality for accomplishing CMS' 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 at least one crosscutting skill (e.g., project management).

In FYs 2002 through 2005, we are 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, a prototype system was developed. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. In FY 2003, a "proof of concept" model was built which included three workforce planning modules (supply, demand, gap analysis). Modules were delivered in FY 2003. Full implementation, in FY 2004, 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. 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 developed the design and a "proof of concept model" for the automated workforce planning system through the Office of Personnel Management's training management assistance services. Within CMS, we will be converting and implementing the model to meet internal CMS standards, developing supplemental modules, and coordinating with the Office of Information Services to implement the system.

Data Source(s): Beginning in the third quarter of FY 2004, the first in a series of intranet-based workforce planning modules will house data on the number of full-time equivalents (FTEs) performing each of CMS' 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. When fully operational, employees and managers will be able to access and update information on themselves or their organizations. These modules are 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 modules 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 FAC7-04

Improve CMS' Management Structure
(Discontinued after FY 2004)

Baseline: Developmental.
FY 2004 Target: Performance Management: Establish a data baseline using information from the automated management competency system. (Though this activity will be ongoing at CMS, this goal will be discontinued in the APP after FY 2004.
FY 2003 Target: (a) Performance Management: Full implementation of a competency-based performance management (planning and appraisal) program for non-Senior Executive Service (non-SES) managers; **(b)** Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and **(c)** 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. **Performance:** Goal met. Steps a, b, and c completed.

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 5 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.

We wanted to reflect in the APP our efforts to improve leadership at CMS, and we expect the foundation and measurement capability to be accomplished by FY 2004. These activities will continue at CMS; however, since this effort has been implemented, we will discontinue this goal in our APP.

<u>Recruitment and Selection</u>

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 was fully implemented effective March 4, 2002.

Performance Management

Performance management (planning and appraisal) programs 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 program for non-SES managers that will encourage managers to discuss, develop and apply the managerial competencies. The performance management program was implemented in October 2003.

In line with the Performance Management Program for managers (i.e. appraisal and awards and recognition systems), in FY 2003, CMS developed an automated system (form and database) that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports. This information will allow us to determine the management competencies most used in CMS and to track ratings from year to year. The theory is if the human resources processes consistently support these core management competencies; that is, we recruit and select based on these competencies, managers are rated against these competencies, our management training focuses on these competencies and managers are rewarded for demonstrating these competencies, the current culture will change and CMS managers will become better leaders.

We will gather baseline data from the automated system in FY 2004 to begin measuring improvement in the leadership competencies.

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 and hiring and performance management, CMS developed 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 revised 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.

Coordination: The goal to improve CMS' 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): In FY 2003, CMS developed an automated system that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports.

Verification and Validation: Developmental. The selected CMS managerial competencies were validated in the Agency under contract with Wilson Learning. All management evaluations, including competency information to be entered into the automated system, are reviewed at the Office/Center Director and Regional Administrator level through the management reporting feature of the automated system.

Performance Goal FAC8-05

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 that exhibited manifest imbalance in the CMS workforce.
FY 2005 Target: Increase the representation of EEO groups in areas where they demonstrate under representation.
FY 2004 Target: Increase the representation of EEO groups in areas where they demonstrate under representation.
FY 2003 Target: Increase the representation of EEO groups in areas where they demonstrate under representation. **Performance:** Goal met. Representation increased in certain under represented EEO groups and in certain job series.

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"[6] with the Civilian Labor Force. By doing so, we ensure the diversity we seek, since the Civilian Labor Force is comprised of persons 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.[7] 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 figures[8]
- 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)
- The CMS Workforce Profiles (prepared using (WIPS)

[6] Parity exists when an EEO group's Agency workforce representation is equal to the Civilian Labor Force.
[7] Conspicuous Absence occurs when an EEO group's Agency workforce representation is between 0 and 20% of the Civilian Labor Force.
[8] 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.

Verification 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.

The CMS Workforce Profiles - Validated and verified by CMS.

Performance Goal FAC9-04

Increase Awareness of the Opportunity to Enroll in the Medicare Savings Programs
(Discontinued after FY 2004)

Baseline: Based on data collected in 2000, 11 percent of Medicare beneficiaries were aware of Medicare Savings Programs.
FY 2005 Target: Goal not continued.
FY 2004 Target: Increase awareness of Medicare Savings Programs to 20 percent.
FY 2003 Target: Increase awareness of Medicare Savings Programs to 13 percent.
FY 2002 Target: Develop baseline and set future targets. **Performance**: Goal met

Discussion: Although Medicare provides beneficiaries with a basic set of health benefits; the beneficiaries are still 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 Medicare Savings 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 (e.g. 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 providing awareness of the programs. These efforts include development of a variety of educational materials for targeted populations such as: African American, Hispanic, Asian American Pacific Islander, American Indian/Alaskan Native, caregivers, and the disabled. These materials are available on the cms.hhs.gov website. Information regarding the Medicare Savings Programs is available in CMS publications such as: the *Medicare & You* handbook and the Guide to Health Insurance for People with Medicare. Additionally, the Regional Education About Choices in Health (REACH) Campaign through community-based outreach activities and

regional materials continues to educate Medicare beneficiaries on the Medicare Savings Programs. The State Health Insurance Assistance Programs (SHIPS) provides assistance through individual counseling and group education activities to educate Medicare beneficiaries about the programs are kept abreast of any changes. In addition, CMS is working with the Social Security Administration (SSA) in conducting a legislatively mandated outreach project based on Section 1144 of the Beneficiary Improvement Protection Act. The objective of this outreach project is to provide information about the Medicare Savings Programs and is geared toward potentially eligible Medicare beneficiaries who appear to meet the income criteria of the QMB/SLMB, QI and QDWI programs. Also, CMS routinely provides alerts and other information on these mailings to Regional Offices and to SHIPS.

CMS also provides 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 continue to work with States, the advocacy community, and other interested parties to increase awareness about Medicare Savings Programs.

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 and grants to State Health Insurance Assistance Programs (SHIPs), States, ombudsman and information intermediaries for outreach. 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.

Data Source(s): The primary source of data on beneficiary awareness of the Medicare Savings Programs will be the Medicare Current Beneficiary Survey (MCBS). CMS will track progress for this goal using MCBS data. 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.

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 *(Discontinued after FY 2003)*

Baseline: CMS FY 2002 FTE Ceiling of 4632 and up to five management levels in the organization as of January 01, 2002.
FY 2004 Target: Goal not continued. This activity will be tracked by the Department of Health and Human Services (HHS) beginning in FY 2004.
FY 2003 Target: 1. Achieve greater administrative efficiency through consolidation of administrative functions and enhance the delivery of citizen-centered services by developing strategies that will enable the reduction of administrative FTE by 93 without substantially reducing the level of administrative services necessary to maintain CMS's operational efficiency. 2. Achieve a more citizen-centered focus through organizational de-layering, from five layers to four, in 16 CMS components. **Performance:** Goal met. 1. Reduced administrative FTEs by 114 and abolished 8 administrative positions. 2. Delayering completed in all 16 components.

Discussion: In support of the President's Management Agenda, the Secretary directed the Department of Health and Human Services (HHS) to consolidate administrative functions for all Operating Divisions (OPDIV) to achieve greater administrative efficiency. The resultant improvements in administrative efficiency will enable OPDIVs to significantly reduce the FTE required to perform administrative functions, and will thus allow OPDIVs to transfer these FTE resources into positions responsible for the direct provision of citizen-centered services. Along these lines, by the end of FY 2003, CMS reduced administrative (e.g., human resources, facilities management, budget and finance, information technology (IT), general administration and public affairs) FTE usage by 114 (from the projected FY 2002 usage). These reductions were achieved using a combination of strategies including attrition (with vacant FTE transferred to direct citizen-centered service positions) or the re-deployment of incumbents into direct citizen-centered service positions. Voluntary Early Retirement Authority (VERA) was approved for CMS in August 2002 to assist in reducing the targeted administrative function FTEs via attrition. CMS requested and was granted a 90-day extension (through September 2003) in this authority, which contributed to a further reduction of administrative FTE and a corresponding re-deployment of staff to line positions. CMS achieved the administrative efficiencies necessary to allow for reduction of 23 FTEs in the human resources (HR) area without compromising requisite levels of internal administrative support by working closely with HHS to maximize consolidation of HR functions and intra-Departmental cross-servicing arrangements to establish significantly improved "economies of scale." CMS has implemented enhancements to its HR automation environment to help facilitate HR FTE reduction. In June 2002, we implemented a major restructuring of CMS' Human Resources Management Group to separate the HR strategic consulting function from the classification and staffing operations to position ourselves to better evaluate competitive sourcing, shared servicing, and automation opportunities. Again, we believe that this initiative enabled us to better absorb the loss of administrative FTE targeted for the HR function.

CMS 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 de-layering. CMS will continue its efforts to maintain strong adherence to restructuring and de-layering principles. Through these plans, we hope to further our goal of creating a more citizen-centered, diverse, high quality workforce at all levels of the Agency. Further restructuring activities for FY 2004 and FY 2005 will be targeted pending additional guidance.

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, 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 Deputy Administrator and Chief Operating Officer, has financial oversight responsibility. In the area of IT, CMS awarded the Consolidated Information Technology Infrastructure Contract (CITIC) in May 2002. Under CITIC, CMS has combined multiple IT infrastructure support contracts (data center, network services, telecommunications, etc.) into a consolidated contract managed by the Office of Information Services.

We identified 16 components in which we have more than the target level of four management layers. De-layering efforts in all 16 components were completed in FY 2003. Moreover, we have identified and eliminated many of the double deputies that existed 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.

Coordination: This goal was coordinated with the Office of the Assistant Secretary for Administration and Management, HHS.

Data Source(s): CMS's Employment Status Report, which tracks FTE ceiling, gains and losses, is used to measure FTE reduction. CMS Organizational charts determined targets for organizational de-layering.

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

Research, Demonstration, and Evaluation

Research, Demonstration, and Evaluation	FY 2002 Actual	FY 2003 Actual	FY 2004 Final Conference	FY 2005 Estimate
Total	**$117.0 M**	**$73.6 M**	**$77.8 M**	**$68.3 M**

The Research, Demonstration and Evaluation program supports CMS' role as a beneficiary-centered purchaser of the highest quality health care at the lowest possible cost. 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' 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' 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 are related to this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-05)
- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice (FAC4-05)

Performance Goal	Targets	Actual Performance	Ref.
Assess the relationship between CMS research investments and program improvements % of full cost (FY 2003-2005): See Section F in Appendix A	**FY 05:** Conduct internal and external assessments **FY 04:** Conduct internal assessment **FY 03:** Conduct internal assessment **FY 02:** Repeat 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 05:** **FY 04:** **FY 03:** Internal assessment completed (Goal met) **FY 02:** Internal assessment and external review completed (Goal met) **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 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.

In response to the recommendation of the FY 2002 external reviewers regarding annual assessments, we conducted only an internal assessment for FY 2003. The internal assessment process continues to evolve as we integrate it into the work planning and budgeting processes. We met our FY 2003 goal by, increasing staff involvement through the use of topical workgroups. An outside consultant assisted management in reviewing the workgroup process with the aim of improving it in the future. The next external assessment is planned for FY 2005.

Performance Goal R1-05

Assess the Relationship between CMS Research Investments and Program Improvements

FY 2005 Target: Conduct internal and external assessments.
FY 2004 Target: Conduct internal assessment.
FY 2003 Target: Conduct internal assessment. **Performance:** Goal met – internal assessment completed.
FY 2002 Target: Repeat internal and external assessments. **Performance:** Goal met – internal assessment and external review completed.
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, Medicaid, and State Children's Health Insurance 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.

We have found that annual internal assessments are a useful way to monitor our ongoing R&D activities. However, the external review benefits from a broad multiyear

perspective, and we believe that the external process can more effectively be conducted every 3 years. Therefore, beginning in FY 2003, internal assessments will be conducted on an annually, but we will only perform external assessments every three years. After the FY 2002 external assessment, the next external assessment will not occur until FY 2005.

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): 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.

Revitalization Plan

Revitalization Plan	FY 2002 Actual	FY 2003 Actual	FY 2004 Final Conference	FY 2005 Estimate
Total	**N/A**	**N/A**	**$29.6 M**	**$24.4 M**

CMS' Revitalization Plan is a multi-year investment initially proposed in the FY 2004 President's Budget to fund fundamental infrastructure improvements, modernize systems and operations, and bring Medicare and Medicaid operations into the modern era.

The FY 2005 budget includes $24.4 million in 2-year budget authority to continue efforts to address long-term IT challenges. In FY 2005, the focus will be on the continued redesign of the Common Working File (CWF) and the overall Medicare claims processing redesign (MCPR). The budget also provides funds to continue modernizing CMS' antiquated data environment and CMS' IT infrastructure to effectively support a secure e-gov/e-commerce environment. Collectively, these modernization activities will reduce CMS' security perimeter and improve systems security at CMS and our Medicare contractors.

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

- Increase the Use of Electronic Commerce/Standards in Medicare (MO3-05)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-05)
- Improve Beneficiary Understanding of Basic Features of the Medicare Program (MO9-05)

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS' Information Systems Security **[outcome goal]**	**FY 05:** --Achieve zero material weaknesses --Accredit security plans **--**Fund security modernization activities	**FY 05:**	RP1 Formerly FAC3
	FY 04: --Achieve zero material weaknesses --Accredit security plans --Fund safeguards for security gaps at the Medicare contractors --Publish acceptable risk safeguards in CMS ITA --Establish policies for automation of paper-based processes	**FY 04:**	See FY 04 Revised Final **2**
	FY 03: -- Eliminate all material weaknesses -- Implement access control management system	**FY 03:** **--** One weakness (Goal not met) **--** CMS is testing new system; if successful, contract for system completed Jan.-Feb. 2004 (Goal not met)	
	FY 02: -- Eliminate all material weaknesses -- Evaluate Medicare contractors' security profile and apply baseline to CMS' business partners -- Implement intrusion detection & response procedure	**FY 02:** --One weakness (Goal not met) **(NEW DATA)** **--**Evaluation complete (Goal met) **--**Implemented April 02 (Goal met)	
	FY 01: -- Eliminate all material weaknesses -- Increase percent of employees receiving security training to 95% -- Increase proportion of Medicare contractor sites receiving security review	**FY 01:** -- One weakness (Goal not met) -- 20% CBT delayed (Goal not met in FY01, but it was achieved in FY02.) --One-third (Goal met)	
	FY 00: -- Eliminate all material weaknesses	**FY 00:** **--** One weakness (Goal not met) **FY 99:** two weaknesses **FY 97:** five weaknesses **(Baseline)**	
% of full cost (FY 2003-2005): See Section F in Appendix A			

Performance Results Discussion

Information Systems Security – CMS has created a goal to improve its information systems security policies and practices enterprise-wide. CMS' response toward meeting

this goal directly supports the Security Modernization program area of the CMS IT Modernization initiative. Through efforts to close security gaps identified at the Medicare contractors, reduce the number of material weaknesses involving both CMS internal information security and CMS external business partner security, and establish new security safeguards, CMS is moving forward in preparing for future security challenges.

Evaluations have been completed on high-risk Medicare contractors and CMS has begun funding projects to close the gaps between the security profiles and core security requirements. A corrective action plan was created to address the material weakness of the Electronic Data Process (EDP) portion cited in CMS' FY 2001 CFO report for both Central Office and Medicare contractor systems. The 2003 CFO audit results indicated one material weakness – an aggregation of findings across the Medicare contractors. A computer-based training (CBT) package was deployed to all personnel to increase the number of employees receiving training. This program was prolonged due to a major rewrite to include section 508 of the Americans with Disabilities Act, therefore the FY2001 target to have 95 percent of CMS employees receive security awareness training carried over into 2002.

In FY 2003, contractors made progress in implementing 683 safeguards funded in late 2002. They managed to complete 554 safeguards. In addition, under a contract awarded in FY 2002, a new system has been developed and CMS is in the process of testing this system. The contract will reach completion in 2004 granted that the test is successful.

We are confident the program will result in continued improvement in CMS' security posture and are optimistic that future goals will be met.

Performance Goal RP1-05

Improve CMS' Information Systems Security

Baseline: The 1997 OIG electronic data processing (EDP) audit for CMS' 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 2005: Achieve zero material weaknesses in the CFO EDP Controls Audit. Security plans accredited for front-end systems. Fund security modernization activities and risk mitigation activities at selected Medicare contractors to the extent of available resources.
FY 2004: Achieve zero material weaknesses in the CFO EDP Controls Audit. Security plans accredited for CMS General Support Systems. Fund corrective actions of critical weaknesses at Medicare contractors to the extent of available resources. Implement host-based Intrusion Detection System (IDS) on mission-critical CMS systems. Acceptable risk safeguards for CMS systems are formally published in the CMS IT Architecture.
FY 2003: Achieve zero material weaknesses in the EDP portion of the FY 2003 CFO audit. Implement improved access control management system. **Performance:** Goal not met, one material weakness.
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' business partners. Implement an intrusion detection capability and document an incident response procedure. **Performance:** Goal not met, one material weakness.
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. As part of this commitment, CMS' response toward meeting the goal of improving Information Security directly supports the Security Modernization program area of the CMS IT Modernization initiative. Through efforts to close security gaps identified at the Medicare contractors, reduce the number of material weaknesses involving both CMS internal information security and CMS external business partner security, and establish new security safeguards, CMS is moving forward in preparing for future security challenges.

In the FY 2001 CFO audit, one material weakness was cited. A corrective action plan was created to address this weakness. Under this plan, a mitigating protocol establishing strict controls over local program changes has been created and field-tested. Beginning in 2002, all data centers running Fiscal Intermediary Standard System (FISS) became subject to review using this protocol. The results of the 2003 CFO audit indicated one material weakness – an aggregation of findings across the Medicare contractors.

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.

In FY 2002, CMS completed evaluation of the highest risk Medicare contractors' security profiles against the comprehensive baseline of security requirements. Medicare contractors proposed 1,602 needed safeguards in the 2001 CAST security assessment to comply with CMS' baseline security requirements at a cost of $70 million. In March 2002, CMS funded proposed safeguards at a cost of $5.0 million. In August 2002, CMS funded additional safeguards and system security plans (SSPs) at a cost of $9.7 million. Many of these safeguards have recurring costs that will be absorbed in the regular Medicare contractor budget. The total number of safeguards and SSPs funded is 683. In FY 2003, contractors made progress in implementing the safeguards, completing 554 of them. In addition, under a contract awarded in FY 2002, a new system has been developed and CMS plans to test this system. The contract will reach completion in 2004 granted that test is successful.

CMS' strategy is to complete the evaluation process of all other Medicare contractors and to close critical security gaps. 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.

CMS also implemented an intrusion detection capability on the first of three ingress points on the network in 2002. In addition, CMS recently decided to migrate to the Managed Security Services contract awarded to the Department of Health and Human Services for IDS implementation, which will provide cost savings as well as effective IDS coverage and expansion of current deployment.

In accomplishing the goals outlined above, CMS is ensuring that we are in compliance with the Federal Information Security Management Act (FISMA), which 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' business areas. We have formulated a systems security management framework to achieve the systems security improvement goals systematically. CMS' 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): 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' 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: Attendance records will be retained for security training and may be validated. 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.

IV. APPENDIX TO THE PERFORMANCE PLAN

A. 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 2005 Annual Performance Plan goals to the draft FY 2003-2008 HHS Strategic Plan and CMS' strategic goals.

LINK OF FY 2005 CMS PERFORMANCE GOALS AND THE DRAFT FY 2003-2008 HHS STRATEGIC PLAN

FY 2005 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Medicare Benefits								
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services			✓		✓			
Improved Medicare's Administration of the Beneficiary Appeals Process					✓			
Implement the New Medicare Endorsed Prescription Drug Card			✓					
Implement the New Medicare Prescription Drug Benefit			✓		✓			
Quality of Care: Quality Improvement Organizations								
Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal	✓		✓					
Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram	✓		✓					
Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams	✓				✓			
Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection	✓				✓			
Quality of Care: Survey & Certification								
Decrease the Prevalence of Restraints in Nursing Homes			✓		✓			
Decrease the Prevalence of Pressure Ulcers in Nursing Homes			✓		✓			
Assure the Purchase of Quality, Value, and Performance in State Survey and Certification Activities					✓			✓
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								✓
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP)					✓			

FY 2005 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
State Children's Health Insurance Program								
Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid			✓					
Clinical Laboratory Improvement Amendments (CLIA)								
Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver					✓			
Medicare Integrity Program								
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Services Program			✓					✓
Improve the Provider Enrollment Process			✓					✓
Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers								✓
Reduce the Medicare Contractor Error Rate			✓					✓
Improve the Medicare Provider Compliance Rate			✓					✓
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			✓		✓			
Maintain CMS' Improved Rating on Financial Statements								✓
Implement Medicare Contracting Reform					✓			✓
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries			✓		✓			
Improve Beneficiary Understanding of Basic Features of the Medicare Program			✓		✓			
Federal Administrative Costs								
Develop and Implement an IT (Enterprise) Architecture					✓			
Strengthen and Maintain Diversity at all Levels of CMS								✓
Research, Demonstration, and Evaluation								
Assess the Relationship between CMS Research Investments and Program Improvements				✓				

FY 2005 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Revitalization Plan								
Improved CMS' Information Systems Security		✓						

* DHHS Strategic Goals

Goal 1 – Reduce the major threats to the health and well-being of Americans.

Goal 2 – Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges.

Goal 3 – Increase the percentage of the Nation's children and adults who have access to regular health care services and expand consumer choices.

Goal 4 – Enhance the capacity and productivity of the Nation's health science research Enterprise.

Goal 5 – Improve the quality of health care services.

Goal 6 – Improve the economic and social well-being of individuals, families, and communities, especially those most in need.

Goal 7 – Improve the stability and healthy development of our Nation's children and youth.

Goal 8 – Achieve excellence in management practices.

Linking CMS' FY 2005 Performance Goals to CMS' Strategic Goals*

Protect and improve beneficiary health and satisfaction.

- Improve satisfaction of Medicare beneficiaries with health care services they receive.
- Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal.
- Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women 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 enroll children in SCHIP & Medicaid.
- Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.
- Protect the health of Medicare beneficiaries by optimizing the timing of administration of antibiotics to reduce the frequency of surgical site infection.
- Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP).
- Decrease the prevalence of restraints in nursing homes.
- Decrease the prevalence of pressure ulcers in nursing homes.
- Implement the New Medicare Endorsed Prescription Drug Card.
- Implement the New Medicare Prescription Drug Benefit.

Foster appropriate and predictable payments and high quality care.

- Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.

Promote understanding of CMS programs among beneficiaries, the health care community, and the public.

- Improve effectiveness of dissemination of Medicare information to beneficiaries
- Improve Medicare's administration of the beneficiary appeals process.
- Improve beneficiary understanding of basic features of the Medicare program.

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

- Maintain CMS' improved rating on financial statements.
- Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program.
- Reduce the Medicare contractor error rate.
- Improve the Medicare provider compliance rate.
- Improve the effectiveness of the administration of the Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data sharing agreements with insurers or employers.
- Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring & ultimately reducing Medicaid payment error rates.
- Improve the provider enrollment process.
- Assure the purchase of quality, value, and performance in State Survey and Certification activities.

Foster excellence in the design and administration of CMS programs.

- Improved beneficiary telephone customer service.
- Implement Medicare contracting reform.
- Develop and implement information technology (enterprise) architecture.
- Improve CMS' information systems security.
- Increase the use of electronic commerce/standards in Medicare.
- Strengthen and maintain diversity at all levels of CMS.

Provide leadership in the broader health care marketplace to improve health.

- Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.
- Assess the relationship between CMS research investments & program improvements.

***Please note:** A performance goal may be linked to more than one strategic goal. Primary linkages are represented here.

B.1. Changes In Annual Performance Plan (APP) Goals

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
Medicare Benefits							
Improve satisfaction of Medicare beneficiaries with the health care services they receive. (Beginning FY 2001: the goal includes data from disenrollees.)	● ✓	● ✓	● ✓	● ✓	● ✓	✓	✓
Enroll beneficiaries into managed care plans timely. FY 2002-2003: Process Medicare Advantage Organization elections in compliance with the BBA beneficiary election provisions.	○ ✓	● ✓	● ✓	○ ✓			
Improve Medicare's administration of the beneficiary appeal process.		○ ✓	Ⓟ ✓	Ⓟ ✓	● ✓	✓	✓
Implement the new Medicare endorsed prescription drug card.						✓	✓
Implement the New Medicare Prescription Drug Benefit.						✓	✓
Increase health plan choices available to Medicare beneficiaries removed in FY 2001 to focus on areas under CMS' control.	○ ✓	● ✓					
Quality of Care: Quality Improvement Organizations							
Improve heart attack survival rates.		○ ✓	○ ✓	🕓 ✓			
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal. (Beginning FY 2001: Lifetime pneumococcal vaccination included and data source changed from NHIS to Medicare Current Beneficiary Survey to include institutional based beneficiaries.)	● ✓	● ✓	Ⓟ ✓	○ ✓	🕓 ✓	✓	✓
Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram. (Beginning FY 2001: Data source changed from NHIS to Medicare claims data to include institutional based beneficiaries.)	● ✓	● ✓	● ✓	● ✓	🕓 ✓	✓	✓
Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.			● ✓	● ✓	🕓 ✓	✓	✓
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection.					🕓 ✓	✓	✓
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.			● ✓	● ✓	● ✓		
Assure the purchase of quality, value, and performance in State Survey and Certification activities.						✓	✓
Grants to States for Medicaid/Medicaid Agencies							
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.	● ✓	● ✓	● ✓	● ✓			

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
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 Medicaid and the State Children's Health Insurance Program (SCHIP).					Ⓟ ✓	✓	✓
Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance.	● ✓	● ✓	Ⓟ ✓				
State Children's Health Insurance Program							
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid.	● ✓	● ✓	● ✓	● ✓	🕓 ✓	✓	✓
Clinical Laboratory Improvement Amendments (CLIA)							
Improve laboratory testing accuracy. (Beginning FY 2000 sustain improved laboratory testing accuracy.)	● ✓	● ✓	● ✓	● ✓	🕓 ✓		
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.						✓	✓
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 was completed in FY 2001.			🕓 ✓				
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. FY 2003: Improve the process of credit balance recoveries.		● ✓	● ✓	● ✓	● ✓		
Assess program integrity customer service.				● ✓	● ✓		
Improve the provider enrollment process.				Ⓟ ✓	Ⓟ ✓	✓	✓
Improve the effectiveness of the administration of Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data sharing agreements with insurers or employers.						✓	✓
Reduce the Medicare contractor error rate.						✓	✓
Improve the Medicare provider compliance rate.						✓	✓
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.	● ✓	○ ✓					
Increase the ratio of recoveries identified to audit dollars spent. (Discontinued after FY 2000 due to data source concerns.)		● ✓					
Medicare Operations		○ ✓	● ✓	Ⓟ ✓	● ✓	✓	✓
Improve beneficiary telephone customer service.							

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.		● ✓	● ✓	● ✓	● ✓	✓	✓
Increase the use of electronic commerce/standards in Medicare.	● ✓	● ✓	Ⓟ ✓	● ✓	Ⓟ ✓	✓	✓
Maintain CMS' 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, combined with the National *Medicare & You* Education Program beneficiary information goal, below.)		● ✓	● ✓	● ✓			
Improve effectiveness of dissemination of Medicare information to beneficiaries (Beginning FY 2001: fee-for-service component split as a new goal under Medicare Operations)		● ✓	● ✓	● ✓	● ✓	✓	✓
Improve beneficiary understanding of basic features of the Medicare program.			● ✓	● ✓	● ✓	✓	✓
Implement Medicare contracting reform.							✓
Ensure millennium compliance (readiness) of CMS computer systems.	● ✓	● ✓					
Federal Administrative Costs							
Develop and implement an information technology (enterprise) architecture.		● ✓	Ⓟ ✓	● ✓	Ⓟ ✓	✓	✓
Develop new Medicare payment systems in fee-for-service and Medicare Advantage.	● ✓	● ✓	● ✓	● ✓	● ✓	✓	
Improve CMS' workforce planning.				● ✓	Ⓟ ✓		
Improve CMS' 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.					● ✓		
Ensure compliance with HIPAA requirements through the use of policy form reviews.		● ✓	● ✓				
Research, Demonstration, and Evaluation							
Assess the relationship between CMS research investments and program improvements.	● ✓	Ⓟ ✓	● ✓	● ✓	● ✓	✓	✓
Revitalization Plan							
Improve CMS' information systems security. (FY 2000 – FY 2003 in Federal Administrative Costs budget category)		○ ✓	Ⓟ ✓	Ⓟ ✓	○ ✓	✓	✓

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

B.2. Revised Final FY 2004 GPRA Annual Performance Plan Goals

Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive MB1-04

Original FY 2004 Target
Achieve by the end of CY 2004 targets as set for managed care and FFS.

Revised Final FY 2004 Target
Managed Care - Direct efforts to achieve by the end of CY 2004 for (a) getting needed care for illness or injury: 93 percent of beneficiaries, and (b) access to a specialist: 86 percent of beneficiaries. 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) (formerly known as PROs) and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice.

FFS - Direct efforts to achieve by the end of calendar year (CY) 2004 for (a) getting needed care for illness or injury: 95 percent of beneficiaries, and (b) access to a specialist: 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
The target period is by the end of CY 2004, which is in FY 2005. This target was inadvertently shown as an FY 2004 target, which does not allow for a five-year measurement period. The FY 2004 target is included along with FYs 2002-2003 in the measurement and monitoring/information sharing phase of this goal.

Implement the New Medicare-Endorsed Prescription Drug Card MB6-04

Original Baseline and FY 2004 Target
Not included in the FY 2004 Annual Performance Plan.

Baseline
Prior to enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, most people with Medicare did not have access to prescription drug coverage through the Medicare program.

Revised Final FY 2004 Target
Implement the new Medicare-Endorsed Prescription Drug Discount Card program through the development and publication of the requirements for the Medicare-Endorsed Prescription Drug Discount Card program, solicitation and approval of applications from

prescription drug discount card program sponsors, and provision of information to people with Medicare about the program.

Rationale
This performance goal is added to the Revised Final FY 2004 Annual Performance Plan to reflect a major provision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Implement the New Medicare Prescription Drug Benefit MB7-04

Original Baseline and FY 2004 Target
Not included in the FY 2004 Annual Performance Plan.

Baseline
Prior to enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, most people with Medicare did not have access to prescription drug coverage through the Medicare program.

Revised Final FY 2004 Target
Develop and publish a Notice of Proposed Rulemaking in the Federal Register with requirements for the new benefit.

Rationale
This performance goal is added to the Revised Final FY 2004 Annual Performance Plan to reflect a major provision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams QIO4-04

Original FY 2004 Target
Increase the diabetic eye exam rate in Medicare diabetic population (18-75) to 69.2 percent.

Revised Final FY 2004 Target
Increase the diabetic eye exam rate in Medicare diabetic population (18-75) to 69.9 percent.

Rationale
The final rate for FY 2002 is 69.6 percent. Although these increases have occurred slowly with great effort, we feel it is appropriate to revise our FY 2004 target to 69.9 percent based on past performance.

Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection QIO5-05

Original FY 2004 Target
54.8 percent based on an FY 2001 baseline of 47.4 percent.

Revised Final FY 2004 Target
66.6 percent based on a corrected FY 2001 baseline of 57.6 percent.

Rationale
The original baseline was developed using data later found to be flawed. These data were corrected, and the revised baseline and targets were calculated at the same rate of improvement as previously projected.

Decrease the Prevalence of Restraints in Nursing Homes QSC1-05

Original FY 2004 Target
Maintain the prevalence of restraints in nursing homes at 10 percent.

Revised FY 2004 Target
Decrease the prevalence of restraints in nursing homes to 7.2 percent.

Rationale
Methodology was improved for the data collected on restraints in nursing homes. A new target was set to reflect the improved methodology.

Decrease the Prevalence of Pressure Ulcers in Nursing Homes QSC2-05

Original FY 2004 Target
Maintain the prevalence of pressure ulcers in nursing homes at 9.5 percent.

Revised FY 2004 Target
Decrease the prevalence of pressure ulcers in nursing homes to 8.9 percent.

Rationale
Methodology was improved for the data collected on pressure ulcers in nursing homes. A new target was set to reflect the improved methodology.

Improve the Management of the Survey and Certification Budget Development and Execution Process QSC3-03

Original FY 2004 Target
Allocate FY 2004 State Survey and Certification budget using the price-based budget methodology to distribute, at minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and/or non long-term care survey. Use performance measures and associated baselines to measure the quality of the survey work performed

Revised FY 2004 Target
Removed and Revised Goal and Target.
Develop an FY 2004 State Survey and Certification budget allocation method that allocates available increases in the budgets for State agencies in a manner that promotes high levels of State performance and value-based purchasing of survey activities on the part of CMS.

Rationale
CMS has the responsibility to purchase high value survey services, verify that the survey services were preformed as contracted, and assess the quality of the survey services performed. To accomplish these objectives, CMS has begun to move from a cost-based budget development and execution model to a value-based model.

Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates MMA4-04

Original FY 2004 Target
Pilot test the CMS Payment Accuracy Measurement (PAM) Model in up to twenty-five States and develop the final specifications for the model; this model is expected to produce both State specific and national level estimates. This model was developed as a result of FY 2002 experiences and initially pilot tested with twelve States during FY 2003.

Revised Final FY 2004 Target
Pilot test the CMS PAM Model **in both Title XIX Medicaid and Title XXI SCHIP programs** in up to twenty-five States and develop the final specifications for the model. The CMS PAM is expected to produce both State specific and national level payment accuracy estimates. This model was developed as a result of FY 2002 experiences and initially pilot tested with twelve States during FY 2003.

Rationale
Because of the new requirements resulting from the Improper Payments Information Act of 2002, the model has been modified to measure the rate of improper payments attributable to overpayments, underpayments, and payments made to ineligible beneficiaries for both the Medicaid and SCHIP programs.

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) MMA5-04

Original FY 2004 Target:

--Medicaid

(a) Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States.

-- SCHIP

(a) Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States.

Revised Final FY 2004 Target:

--Medicaid

(a) Continue to work with State representatives and update the timeline for implementing recommendations; **(b)** Continue to identify a strategy for improving health care delivery and/or quality; and **(c)** Initiate action steps for implementing recommendations.

-- SCHIP

(b) Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States.

Rationale:

The Medicaid targets have been delayed due to because CMS received OMB clearance for the data collection tool in September 2003.

Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP or Medicaid SCHIP1-04

Original FY 2004 Target

Increase the number of children who are enrolled in regular Medicaid or SCHIP by 5 percent over the previous year.

Revised Final FY 2004 Target

Maintain enrollment at FY 2003 levels.

Rationale

The main goal of the SCHIP program still remains to provide health assistance to uninsured, low-income children and to increase enrollment, the current economic conditions have made it difficult for CMS to achieve its enrollment targets for SCHIP. Therefore, CMS is revising its GPRA enrollment targets for FYs 2004 and 2005 to maintain enrollment of children in SCHIP and Medicaid.

Assess Program Integrity Customer Service MIP6-04

Original FY 2004 Target
A survey of providers and beneficiaries will be conducted. Data from the survey will be used to identify weaknesses and develop a corrective action plan to deal with those weaknesses.

Revised Final FY 2004 Target
This goal has been discontinued and is removed from the FY 2004 Revised Final APP.

Rationale
Although the customer service project was initiated in FY 2001 and continues today, this project is in transition. CMS is developing an overall customer service plan that may encompass the program integrity customer service project. The development of an alternative evaluation method is being discussed, therefore, this goal is being discontinued beginning in FY2004 until a scope and method are established and clarified.

Improve the Provider Enrollment Process MIP7-04

Original FY 2004 Target
Continued implementation of PECOS and revalidating 25 percent of Part A and Part B providers/suppliers currently enrolled in the Medicare program using the new streamlined process.

Revised Final FY 2004 Target
Implementation of PECOS and revalidating 20 percent of Part A and Part B providers/suppliers currently enrolled in the Medicare program using a new streamlined process. This revalidation target will help capture those providers that entered Medicare using the CMS-855 enrollment form or that entered Medicare prior to the use of the CMS-855 enrollment form.

Rationale
CMS did not publish the regulation implementing the revised CMS-855 enrollment form in FY 2003; therefore the FY 2003 target was pushed back to FY 2004.

Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers MIP8-04

Original FY 2004 Target
Sign two (2) additional VD**M**As.

Revised Final FY 2004 Target
Sign two (2) additional VD**S**As.

Rationale
We have changed the name Voluntary Data Matching Agreements (VDMAs) to Voluntary Data Sharing Agreements (VDSAs) to better describe our process.

Decrease the Medicare Provider Compliance Error Rate MIP10-04

Original FY 2004 Title
Improve the Medicare Provider Compliance Rate.

Revised FY 2004 Title
Decrease the Medicare Provider Compliance Error Rate.

Rationale
We have changed the title to indicate we will be calculating an error rate rather than a compliance rate.

Improve Beneficiary Telephone Customer Service MO1-04

Original FY 2004 Target
(1) Quality Standards:
--Minimum of 87 percent pass rate for Adherence to Privacy Act
--Minimum of 90 percent meets expectations for Customer Skills Assessment
--Minimum of 87 percent meets expectations for Knowledge Skills Assessment
(2) Continue national expansion of 1-800-MEDICARE.

Revised Final FY 2004 Target
(1) Quality Standards:
--Minimum of 90 percent pass rate for Adherence to Privacy Act
--Minimum of 90 percent meets expectations for Customer Skills Assessment
--Minimum of 90 percent meets expectations for Knowledge Skills Assessment
(2) Continue national expansion of 1-800-MEDICARE.

Rationale
CMS has monitored the contractors' performance in FY 03 to date and based on the contractors' ability to meet the FY 03 targets for quality service, CMS has modified the targets to further improve customer service to the beneficiaries in FY 04 and FY 05. The revised targets are achievable within the proposed fiscal year budgets.

Develop and Implement an Information Technology Enterprise Architecture FAC2-04

Original FY 2004 Target

Continue maturing the ITA (Enterprise Architecture). Revise and update promulgated policies to ensure continued compliance with Federal and legislative requirements and to address lessons learned from implementation of these promulgated policies.

Revised Final FY 2004 Target
Continue maturing the Enterprise Architecture (EA) by performing activities such as: making relational architectural data available CMS-wide via the intranet; more robustly applying the Architecture to enterprise-wide strategic and tactical planning activities; and issuing and revising IT policies and subordinate documents, as needed.

Rationale
The target and title for this goal has been revised to more accurately reflect CMS priorities.

Improve CMS' Workforce Planning FAC6-04

Original FY 2004 Target
Update workforce planning data and establish a knowledge skill level baseline.

Revised Final 2004 Target
This goal is removed from the FY 2004 Revised Final Annual Performance Plan.

Rationale
Recent HHS consolidation of human resource (HR) functions has significantly altered the way we perform and deliver HR services and human capital planning. This, together with new requirements for reporting (e.g., A-76 studies), has impacted the vision and outcome of this goal, which was developed in 2001. In addition, HHS is developing a workforce planning system that all OPDIVs will be required to use. Workforce planning remains a priority; however, we need to reevaluate and adjust our approach in light of these recent changes and additional requirements.

Increase Awareness of the Opportunity to Enroll in the Medicare Savings Program FAC9-04

Original FY 2004 Target
Increase awareness of Medicare Savings Program to 14 percent.

Revised Final 2004 Target
Increase awareness of Medicare Savings Program to 20 percent.

Rationale
The target for this goal has been revised so that CMS' target will be an increase in awareness, above previous years.

Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization FAC10-04

Original FY 2004 Target
To be determined

Revised Final 2004 Target
None. This goal has been discontinued and removed from the FY 2004 Revised Final Annual Performance Plan.

Rationale
This goal is scheduled to become an HHS target once the Department decides on new administrative FTE levels for all of HHS for 2004. HHS will take the lead in tracking this goal.

Improve CMS' Information Systems Security RP1-05

Original FY 2004 Target
Achieve zero material weaknesses in the CFO EDP Controls Audit. Security plans accredited for CMS General Support Systems. Fund corrective actions at Medicare contractors to the extent of available resources. Implement host-based Intrusion Detection System (IDS) on mission-critical CMS systems. Acceptable risk safeguards for CMS systems are formally published in the CMS IT Architecture. Establish digital signature and encryption policies to enable automation of paper-based administrative processes.

Revised Final 2004 Target
Achieve zero material weaknesses in the CFO EDP Controls Audit. Security plans accredited for CMS General Support Systems. Fund corrective actions of critical weaknesses at Medicare contractors to the extent of available resources. Implement host-based Intrusion Detection System (IDS) on mission-critical CMS systems. Acceptable risk safeguards for CMS systems are formally published in the CMS IT Architecture.

Rationale
Establish digital signature and encryption policies to enable automation of paper-based administrative processes -- We are deleting this sub-target because as yet there is no DHHS or government-wide standard to follow.

C. Partnerships and Coordination

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 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 nearly 82 million Medicare and Medicaid beneficiaries including those covered by the State Children's Health Insurance Program.

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.

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

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

- CMS partners with many other Federal and private entities in its goal to reduce surgical site infection by optimizing the timing of antibiotic administration.

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

- 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.

- 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.

D. Data Issues – Data Verification and Validation

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.

CMS conducts comparisons across similar data systems where practical to ensure validity and reliability of data sources. For example, under performance goal MB1-05 (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' APP relies on survey data, evaluations, and special studies conducted by other Federal agencies. 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' 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.

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.

E. 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. To represent the activity brought about by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, two new performance goals have been added.

Linking Performance Measurement to Cost Accounting

We select the performance goals in CMS' APP based on the fact that, collectively, they broadly represent the work of the Agency. The CFO clean opinion goal shows our commitment to clear and complete accounting for funds across the Agency. CMS' APP is divided into 11 budget categories showing the budget requests for FY 2003-2005 and including representative performance goals included in each. To address full cost estimate requirements, we have shown full costs by program and related GPRA performance goals in Section F.

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

Capital investment, primarily in the form of technology, supports all of CMS' goals. CMS technology investments are funded through the Agency's annual Information Technology (IT) budget, which in turn is funded from several of CMS' accounts. We have continued to include information technology planning in the FY 2005 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' 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

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' programs on beneficiaries, providers, States, Tribes, and other customers and partners. The scope of CMS' research, demonstration, and evaluation activities embrace all areas of health care relevant to CMS programs: costs, access, quality, service delivery models, and financing approaches. CMS has planned several program and demonstration evaluations over the next five 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 assesses 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.

CMS strongly emphasizes its priorities in its performance plans. Going into our fifth year of reporting, the process is already having an effect on the management of our programs as indicated in the reports. Reporting over time will reveal trends, which will increase the usefulness of the GPRA process in the management of CMS' programs.

F. Summary Full Cost of Performance Program Areas

The full cost estimates included in this appendix show the funds expended by CMS to support agency GPRA goals. The estimates below display the allocation of CMS' budgetary resources among its GPRA goals. The information in this appendix is part of a multi-year effort to improve the integration of budget and program performance information. As the performance plan evolves and HHS gains more experience with full cost estimates, the allocation of funds among goals may change.

MEDICARE

Dollars in Millions

FY 2005 OMB Req. GPRA Performance Goals	Program Category	FY 2003	FY 2004	FY 2005
Medicare: Program. Level		**$278,063.7**	**$302,583.3**	**$330,804.9**
Medicare: Full Cost		**$278,063.7**	**$302,583.3**	**$330,804.9**
Improve satisfaction of Medicare beneficiaries with the health care services they receive (MB1-05) Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal. (QIO2-05) Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram. (QIO3-05) Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams. (QIO4-05) Implement the Medicare the Medicare Endorsed Prescription Drug Card (MB5-05) Implement the New Medicare Prescription Drug Benefit (MB6-05)	**Benefits 1/**	**$272,598.4**	**$296,427.0**	**$324,597.0**

FY 2005 OMB Req. GPRA Performance Goals	Program Category	FY 2003	FY 2004	FY 2005
Reduce the percentage of improper payments made under the Medicare fee-for-service program (MIP1-05) Improve Medicare's administration of the beneficiary appeal process. (MB4-05) Assure the purchase of quality, value, and performance in State Survey and Certification activities (QSC4-05) Reduce the Medicare contractor error rate (MIP9-05) Improve the provider enrollment process (MIP7-05) Improve the effectiveness of the administration of Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data exchange agreements with insurers or employers. (MIP8-05) Improve the Medicare provider compliance rate. (MIP10-05) Maintain CMS' improved rating on financial statements. (MO4-05)	Financial Mgt. 2/	**$2,783.9**	**$3,749.4**	**$3,415.6**
Decrease the prevalence of restraints in nursing homes. (QSC1-05) Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection. (QIO5-05) Decrease the prevalence of pressure ulcers in nursing homes. (QSC2-05) Assess the relationship between CMS research investments and program improvements. (R1-05)	**Quality 3/**	**$968.4**	**$526.5**	**$792.9**

FY 2005 OMB Req. GPRA Performance Goals	Program Category	FY 2003	FY 2004	FY 2005
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements. (MO2-05) Improve beneficiary telephone customer service. (MO1-05) Increase the use of electronic commerce/standards in Medicare. (MO3-05) Improve effectiveness of dissemination of Medicare information to beneficiaries. (MO8-05) Improve beneficiary understanding of basic features of the Medicare program. (MO9-05) Implement Medicare contracting reform (MO10-05) Develop and implement an information technology architecture. (FAC2-05) Strengthen and maintain diversity at all levels of CMS. (FAC8-05) Improve CMS' information systems security. (RP1-05)	**Other Admin. 4/**	**$1,713.0**	**$1,880.5**	**$1,999.5**

1/ Benefits dollars derived from the sum of HI Benefits outlays + SMI Benefits outlays + ESRD Networks outlays + Transitional Benefits outlays.

2/ Financial Management dollars derived from the sum of Medicare HCFAC obligations + Treasury obligations + MMA low-income determinations (incl. SSA MMA obligations) + allocated Program Management (100% Medicare Operations,73% PM MMA) obligations.

3/ Quality dollars derived from the sum of QIO obligations + allocated Program Management (100%Survey & Cert. + 50% of Medicare Related R,D&E, 10% PM MMA) obligations.

4/ Other Administration dollars derived from the sum of 100% Federal Admin. Obligations + 50% of Medicare Related R,D&E + 100% Revitalization Plan obligations + 17% of PM MMA obligations. This amount also includes the transfer to SSA + other Non-CMS Administration (excl. SSA, Treasury) + M+C User Fees.

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MEDICAID
Dollars in Millions

FY 2005 OMB Req. GPRA Performance Goals	Program Category	FY 2003	FY 2004	FY 2005
Medicaid: Program. Level		**$169,117.5**	**$177,406.5**	**$183,214.0**
Medicaid: Full Cost		**$169,117.5**	**$177,406.5**	**$183,214.0**
Increase the percentage of Medicaid two-year old children who are fully immunized. (MMA2-05)	**Benefits 1+-/**	**$160,035.0**	**$168,364.3**	**$173,878.4**
Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates. (MMA4-05)	**Financial Mgt. 2/**	**$4,517.5**	**$4,474.2**	**$4,623.4**
Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP). (MMA5-05)	**Quality 3/**	**$4,565.0**	**$4,568.0**	**$4,712.3**

1/ Benefits dollars derived from the sum of Net MAP obligations (including effects of new legislation) + VFC obligations. Includes the Medicare Part B transfer, as the obligation benefits Medicaid beneficiaries (pays Medicare premiums).

2/ Financial Management dollars derived from the sum of Fraud Control Units obligations + Medicaid HCFAC obligations + 50% allocation of S&L Administration obligations + 50% of allocated Medicaid Related Program Management obligations.

3/ Quality dollars derived from the sum of Medicaid Survey & Certification obligations + 50% allocation of S&L Administration obligations + 50% of allocated Medicaid Related Program Management obligations. Note, 4% of S&L Administration allocated to quality functions has been transferred to the SCHIP program for the shared "Partnership" goal.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)
Dollars in Millions

FY 2005 OMB Req. GPRA Performance Goals	Program Category	FY 2003	FY 2004	FY 2005
SCHIP: Prgm. Level		**$5,563.1**	**$3,354.4**	**$4,267.3**
SCHIP: Full Cost		**$5,563.1**	**$3,354.4**	**$4,267.3**
Decrease the number of uninsured children by working with States to implement SCHIP and increase enrollment of eligible children in Medicaid. (SCHIP1-05)	**Benefits 1/**	**$5,381.6**	**$3,175.2**	**$4,082.4**
Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP). (MMA5-05)	**Quality 2/**	**$181.4**	**$179.2**	**$184.9**

1/ Benefits dollars derived from SCHIP benefits obligations.

2/ Quality dollars derived from the sum of allocated Program Management obligations + 4% of Medicaid S&L Administration allocated to SCHIP quality functions for the shared "Partnership" goal.

OTHER BUDGET (INCLUDES CLIA)
Dollars in Millions

FY 2005 OMB Req. GPRA Performance Goals	Program Category	FY 2003	FY 2004	FY 2005
Other: Prgm. Level		**$72.6**	**$132.0**	**$381.8**
Other: Full Cost		**$72.6**	**$132.0**	**$381.8**
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver. (CLIA2-05)	**Quality 1/**	**$36.2**	**$43.0**	**$43.0**

1/ Quality dollars assume 100% of the budgeted CLIA obligations, only. The other items are left unallocated, since CMS presents a single CLIA goal to reflect this program category.

Performance Program Summary Table
Estimated Full Cost by Program
($ in Millions)

Program Line	FY 2003	FY 2004	FY 2005
Medicare	$278,071.0	$302,583.3	$330,804.9
Medicaid	$169,117.5	$177,406.5	$183,214.0
SCHIP	$5,563.1	$3,354.4	$4,267.3
Other	$72.6	$132.0	$381.8
CMS Full Cost	**$452,824.3**	**$483,476.2**	**$518,668.1**
CMS Program Level	**$452,824.3**	**$483,476.2**	**$518,668.1**

Allocation Methodology:

- Allocated Program Management budgetary resources consist of funds appropriated to CMS' Program Management account, plus no-year carryforward attributable to the Managed Care Redesign and Standard Systems Transitions activities. With the exception of the Sale of Data user fee, all Program Management user fees are specifically included within the program level of the programs they benefit. The Sale of Data user fee has been allocated across all programs, utilizing the same methodology as CMS' Program Management appropriation.
- CMS full cost display reflects estimated obligations related to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

- When not specifically identified, all Program Management resources have been allocated to program areas via CMS' FY 2003 cost allocation factors. Under this approach, actual FY 2003 obligations by Program Management line item are split by program and compared to the total level of actual Program Management obligations. The resulting percentage factors are then applied to out-year (FY 2004 – FY 2005) budgetary resources, yielding program-based allocations of Program Management resources.

- All remaining administrative costs (i.e., HCFAC, QIO, Medicare Non-CMS Administration, Medicaid State and Local Administration, etc.) have been specifically identified to the programs they benefit, and are included in each program's overall program level.

- The methodology described above has been applied consistently across all years reflected in this exercise (FY 2003 – FY 2005).

- As stated in Departmental guidance, full cost is assumed to equal each program's individual program level. For mandatory elements of our programs, budgetary resources are defined as the level of obligations needed to fund all outlays. For discretionary elements of our programs, budgetary resources are assumed to equal the sum of appropriated funds + estimated user fee obligations + available carryforward.

- CMS's full cost display reflects estimated obligations related to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

- Full costs are allocated to individual groups of performance goals through a combination of both specific identification and the allocation of Program Management resources as described above.

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. All 16 Group I States have reported their first and second re-measurement rates.

Six of 16 States have reported their third and final re-measurement rate. Arkansas and Connecticut have had a number of personnel changes that have resulted in a delay in reporting. They expect to be caught up in 2004. Idaho, as a result of other Governor's initiatives early in the project, is delayed in reporting the current year re-measure rate. Early in the project, Kansas reporting is delayed due to problems in data collection and staff turnover. Both states are plagued by budget and personnel cuts as well as personnel turnover that result in delays in reporting. Oklahoma, Oregon, Rhode Island and Utah report on the calendar year and will have results in 2004. Washington has completed the report and expects to send it soon.

Group II States

Group II States actively participated in the project, but also experienced delays. All Group II States submitted their State-specific methodologies, baseline and three-year target rates.

Eight of 10 Group II States have reported their first re-measurement rate. Delaware is expected to report by the end of 2003. New Hampshire has had some frustration in obtaining the data according to the methodology and has hired new contractors to move this project back on schedule.

Group III States

The third and final group of States have prepared their baseline methodologies. Twenty-one of the 24 Group III States have reported their baseline and target rates. Georgia asked for an extension due to difficulty verifying the data. Pennsylvania ran into some problems obtaining a final rate for their baseline measures. Texas determined the National Immunization Survey (NIS) to be the source of its rate and must wait for CDC to release the Medicaid rates. Twelve states have not submitted their re-measure rates. In addition to the states listed above, Indiana, Missouri, Nebraska, New Mexico, New York, South Carolina, and West Virginia plan to report in 2004 due to their data collection cycles. All States indicated they plan to be up to date in 2004.

Appendix B

Baseline Measurement Methodologies for the GPRA Medicaid Childhood Immunization Goal

Group I States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Arizona	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(a)	4(a, b, c)	FY 1999	75%	78%	78%	75%	80%
Arkansas	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(b, c)	7/1/97 – 6/30/98	65%	74%	67%	Pending	90%
California	MCP & FFS 2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4 (c)	CY 1998	54%	54%	57%	62%	65%
Connecticut	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(a)	CY 1998	77%	75%	76%	Pending	80%
Idaho	2-year old 1(b) Medicaid enrollment 2(b) Fully immunized 3(a)	4(c, d)	1/1/01 sample selection date	66%	65%	66%	Pending	76%
Iowa	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(h)	4(b, c)	CY 1998	58%	68%	68%	71%	90%
Kansas	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(c)	FY 2000	42%	50%	51%	Pending	90%
Maine	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(i)	4(c, a)	7/1/98 – 6/30/99	24%	32%	71%	77%	70%
Massachusetts	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(j)	4(b)	CY 1997	64%	69%	69%	74%	80%
Michigan	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(k)	4(b)	CY 1997	49%	57%	65%	Pending	90%
Mississippi	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(a)	4(a, d)	7/97 – 6/98	85%	85%	88%	81%	85%

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Oklahoma	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(d)	4(a, b, d)	CY 1998	65%	76%	68%	Pending	90%
Oregon	2-year old 1(a) Medicaid enrollment 2(e) Fully immunized 3(a)	4(a, b)	CY 1998	63%	67%	70%	Pending	67%
Rhode Island	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(k)	4(a, c, d)	CY 1998	75%	72%	67%	Pending	79%
Utah	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(f)	4(a, b, c)	FY 1999	19%	27%	31%	Pending	65%
Washington	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4(b)	CY 1998	58%	77%	80%	Pending	58%

Group II States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Alaska	2-year old 1(b) Medicaid enrollment 2(p) Fully immunized 3(f)	4(c, e, d)	7/1/99 – 6/30/00	85%	88%	Pending	2004	88%
Colorado	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(i)	4(c)	CY 2000	48%	44%	Pending	2004	52%
Delaware	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(a, c)	CY 1998	43%	Pending	Pending	2004	60%
District of Columbia	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(l)	4(a, c)	CY 1998	61%	61%	68%	2004	72%
Florida	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(a)	4(d)	01/98	82%	81%	84%	79%	90%
Louisiana	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(b)	CY 1998	82%	82%	Pending	2004	84%
New Hampshire	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(j)	4(b, c, d)	CY 2000	67%	Pending	Pending	2004	80%
North Carolina	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(e)	4(c)	CY 2000	34%	42%	Pending	2004	60%
North Dakota	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(j)	4(a, c)	CY 2000	43%	45%	65%	2004	90%
South Dakota	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(a)	9/30/01	52%	62%	65%	2004	90%

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third re-measure	Target Rate
Alabama	2-yr Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(l)	4(a)	7/1/01 - 6/30/02	75%	78%	2004	2005	80%
Georgia	2-yr Old 1(b) Medicaid Enrollment 2(d) Fully Immunized 3(l)	4(d)	2/01 – 2/02	Pending	Pending	2004	2005	pending
Hawaii	2-yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(g)	4(c)	7/1/01 - 6/30/02	67%	69%	2004	2005	85%
Illinois	2-yr. Old 1(b) Medicaid Enrollment 2(a) Fully Immunized 3(l)	4(a, c)	Jan. 02	38%	50%	2004	2005	70%
Indiana	2-yr. Old 1(a) & 1(b) Medicaid Enrollment 2(d) Fully Immunized 3(g) & 3(f)	4(b, c)	CY 2000	8%	Pending	2004	2005	57%
Maryland	2-yr. Old 1(b) Medicaid Enrollment 2(a) Fully Immunized 3(g)	4(a, b, c)	CY 2001	52%	58%	2004	2005	56%
Minnesota	2-yr. Old 1(a) Medicaid Enrollment 2(f) Fully Immunized 3(e)	4(c)	CY 2000	11%	12%	2004	2005	20%
Missouri	2-yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(a, c)	CY 2001	47%	Pending	2004	2005	53%
Montana	2-yr. Old 1(b) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(a, b, c, d)	CY 2001	81%	88%	2004	2005	85%
Nebraska	2-yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(a, b, c)	CY2001	58%	Pending	2004	2005	70%

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Nevada	2 yr. Old 1(b) Medicaid Enrollment 2(c) Fully Immunized 3(a)	4(c, a)	FY 2001	66%	66%	2004	2005	80%
New Jersey	2 yr. Old 1(a) Medicaid Enrollment 2(c) Fully Immunized 3(f)	4(c)	CY 1999	44%	45%	2004	2005	60%
New Mexico	2 yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(c)	CY 2001	41%	Pending	2004	2005	80%
New York	2 yr. Old 1(a) Medicaid Enrollment 2(f), (a) Fully Immunized 3(c)	FFS - 4(c, b) MCO - 4(b, c)	Born Oct 1, 1998 - Dec 31, 1998	56%	Pending	2004	2005	61%
Ohio	2 yr. Old 1(a) Medicaid Enrollment 2(c) Fully Immunized 3(g)	4 (a, c, b, d)	SFY 2001	49%	53%	2004	2005	70%
Pennsylvania	2 yr. Old 1(e) Medicaid Enrollment -2(c) Fully Immunized 3(h)	4(a, c)	7/1/98 - 6/30/99	Pending	Pending	2004	2005	Pending
South Carolina	2 yr. Old 1(k) Medicaid Enrollment 2 (o) Fully Immunized 3 (l)	4 (a, b, c, d)	CY2000	84%	Pending	2004	2005	85%
Tennessee	2 yr. Old 1(a) Medicaid Enrollment 2(d) Fully Immunized 3(a)	4(a, b, d)	Jan 1, 2002	60%	Pending	2004	2005	80%
Texas	2 yr. Old 1(b) Medicaid Enrollment 2(b) Fully Immunized 3(a)	4(c)	7/01 – 6/02	Pending	Pending	2004	2005	Pending
Vermont	2 yr. Old 1(b) Medicaid Enrollment 2(b) Fully Immunized 3(m)	4(b, c)	6/02	80%	Pending	2004	2005	85%

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Virginia	2 yr. Old 1(a) Medicaid Enrollment 2(c) Fully Immunized 3(a)	4(b)	7/99 – 6/00	69%	84%	2004	2005	85%
West Virginia	2 yr. Old 1(a) Medicaid Enrollment 2(d) Fully Immunized 3(l)	4(a, c)	CY2000	75%	Pending	2004	2005	80%
Wisconsin	2 yr. Old 1(a) Medicaid Enrollment 2(f) Fully Immunized 3(f)	4(a, b, c, d)	CY2001	41%	55%	2004	2005	80%
Wyoming	2 yr. Old 1(b) Medicaid Enrollment 2(c) Fully Immunized 3(a)	4(b)	6/15/00	55%	38%	93%	2005	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) Immunization registry

4(b) Chart review

4(c) Administrative data

4(d) Survey

4(e) Alaska Permanent Fund

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