

7. Business Office Quality Process Improvement

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7.1 Accreditation and Patient Rights, Confidentiality, Privacy, and Safety Requirements

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or other accrediting body will query the staff, especially Registration, on patient rights, confidentiality, privacy, and life safety requirements for the facility. The following questions and positive responses address these key areas.

How do you explain patient rights?

- Staff provides a booklet that reviews their rights.
- If patient cannot understand, is developmentally disabled, or deaf, staff explains the patient's rights to the family member.
- Patient rights are posted within the facilities.

How do you maintain confidentiality?

- Staff uses private booths to accommodate patients.
- Staff speaks in hushed tones, to include reference to the patient name.
- Confidential information is *never* shared with colleagues or family members.
- The pre-certification desk is located away from mainstream of patients, because patients' names are given over the phone for insurance purposes.
- Staff shreds all documents that contain any patient names and keeps those discarded documents in a separate container.

How do you maintain privacy?

- Staff speaks in hushed tones.
- Information is not requested that is not pertinent to the admission or facility visit.
- Staff accommodates any patient who requests that their room number or phone number not be given out.
- Emergency room staff moves patient into emergency room bay or examination room if the triage room is occupied.
- Staff is aware of the privacy regulation.

How do you maintain life safety?

- Fire drills
- Disaster preparation and plans
- Hazardous spills
- Infection control

7.2 Quality Performance and Improvement

After each JCAHO and/or other accrediting body survey is completed, it is recommended that a Performance Improvement Summary be developed, updated, and maintained to demonstrate to JCAHO and its surveyors that improvements have been identified and monitored.

The following table provides examples of activities that would fall under a quality performance improvement activity. The objective is that once a deficiency is identified, a plan of action can be put in place to improve the deficiencies that were noted.

Example of a Performance Improvement Summary

Problems Identified	Action Taken or Recommended	Evidence of Improvement
Outpatient Bills	Verify provider order and notes or no payment.	Payments have increased.
Late filing of ancillary test in medical record	Staff given in-service on timely filing. Electronic health record enacted.	Reports readily available. Reports automatically posted in EHR once test results are received.
Timely Radiology reports	Identify inpatient versus outpatient.	Colored dots used. Radiologist reads inpatient x-rays before outpatient ones. Reports placed on chart as soon as possible. Electronic health record updates results immediately.

Accreditation/certification usually requires annual testing of competency that includes documentation maintained in personnel files that substantiates employee competency in their job duties.

7.3 Flow Charts for Process Improvement

A team-oriented approach with tangible department goals can serve as incentive for process improvement. By creating a series of goals and rewards for each department, each team is motivated to eliminate any lags in their particular department and a friendly competitive atmosphere can be created.

By documenting with charts and graphs the progress of the individual teams by department, the facility begins to create an overall team effort and a “continuous quality improvement” environment. This effort can then be acknowledged by management, which affirms a sense of appreciation to all departments and enhances the desired behavior.

Charting results can serve as an educational tool for the facility. By creating a flow chart of the various components and inviting members from Registration, Coding, Billing, and other appropriate ancillary departments to meet, there will be discussions regarding possible problems. This opens the door to create a tighter process improvement effort. Using this lag analysis process, delays can be discussed without blame and everyone can examine the results and work together to create improved workflow solutions.

7.4 Registration Performance Tracking

Incomplete or inaccurate registration information leads to billing and payment delays. Payment delays eventually impact the quality of care. The best way to improve the registration process is to track registration accuracy by implementing a performance improvement plan.

Tracking registration accuracy can be done in several ways. Registration can conduct a registration effectiveness audit. Billing and Collections can track the reasons for claim rejections, highlighting and documenting those caused by registration inaccuracies and deficiencies.

Tracking should reflect both an individual’s performance and the department’s overall performance. It is good information which the department can use to develop a teamwork approach to resolving and preventing the errors causing the denials.

By understanding the accuracy level and rejections due to poor registration information, the department can create a plan of action to improve and standardize the registration process.

For those facilities accepting non-beneficiaries, the department should

- Track its up-front collections success.
- Identify the number of patients who owe deductibles or coinsurance at the time of service.

It is also important to track how non-beneficiary patients pay; such as, by cash, check, or credit card.

7.4.1 Eliminating Registration Errors

A detailed-oriented Registration staff is a valuable asset to the facility. They are responsible not only for gathering complete and accurate information, but also for entering that information into RPMS.

It is extremely important to review and update the Insurer File so that your Registration Staff can appropriately identify the correct the insurer information in your system.

Some of the most common registration errors are not obvious and at times, an insurer will use even the slightest error to their advantage.

Examples of insurer-related errors and solutions

Error: Calculating ages when using the birthday rule for coordination of benefits (determining primary insurer)

Solution: Determine primary insurer based on who birth date falls first in the calendar year, not who is older. The birth year does not matter.

Error: Enter Medicare HIC number as they appear on the card, substituting slashes for hyphens and including numbers only

Solution: Check with the fiscal intermediary to learn their requirements for filing claims. Some require that hyphens and any other punctuation be omitted. In all cases, do not forget the suffix.

Error: Entering insured's identification number a group number

Solution: Double-check to make certain group numbers that are entered on the registration form matches the number listed under the group number heading on the card, not the patient identification number.

Error: Using abbreviations that are misinterpreted (e.g., "pat" means "patient" to some, "preadmission testing" to others)

Solution: Created a list of common abbreviations for all staff members to use. The list should be consulted when writing or reading abbreviations.

Error:	Failing to note useful information in the comments section of RPMS.
Solution:	Any relevant information from either the registration staff or the benefit coordinator needs to be entered into the "free text" section of the registration application. Any information is important in deciding whether to proceed with collections or wait for additional information from the patient or insurer.
Error:	Failing to include insurer address
Solution:	Be sure to copy the back of the insurance card. If the address is not entered at the time of registration, it can be tracked down by checking the card copy. In the case of regional carriers, be sure to note the address on the back of the insured's card. Claims most often must be sent where the patient is insured, not where the patient is treated.
Error:	Transposing first and last names
Solution:	Insurers rarely look for coincidences on claims (such as patient's first name matches the last name of the beneficiary and last name matches the beneficiary's first name). Insurers routinely reject flawed claims. Check on the card to see how names are labeled. Some put the first name last, and some do not. Be sure to record it accurately.
Error:	Using existing information in the system from a previous visit
Solution:	Update patient information at each visit. Insurances, addresses, and employment are all subject to change.
Error:	Failing to get provider's signature and proper date of service
Solution:	Clinics are more likely to fall prey to this problem. Providers may sign or stamp a batch of forms at once and sometimes blank forms. Expect claim denials if a form is signed and dated before the time of service.
Error:	Failing to get preauthorization
Solution:	Know which insurers require preauthorization for treatment. If in doubt, call. It is better to make the extra effort to avoid claim denials.

7.4.2 Steps to Improve Registration Quality

There are five basic steps to improving the quality of the Registration staff. Initially review the process for a couple of days with the staff. Once the accuracy has improved, then scale back to random surveys. The steps are:

1. Track errors.

Most clinical and accounting systems, as well as the RPMS registration application, include tracking by employee. Use this tool to identify and correct problems that stem from the front end.

2. Work with staff as soon as errors are identified.

Don't wait for an annual performance appraisal to review the number of errors. The consequences of multiple errors for the year becomes the burden of the facility

3. Recognize employees for what they do right.

Identifying errors is important, but praise is needed when things go right and the accuracy has improved.

4. Monitor quality daily.

Spot checking registration records daily helps keep staff on their toes and accuracy levels high. Again revert to random reviews once quality and accuracy have improved.

5. Provide ongoing training.

Training includes one-on-one review of problem areas as well as more formal full staff training sessions. Key is to address problems as they arise and craft solutions with staff. "With" is the operative word.

7.4.3 Checking Registration Performance for Quality Assurance

To check for compliance:

1. Pull a list of scheduled patients from a particular day.
2. Review the information in the RPMS Patient Registration application regarding insurance information, demographics, and other information; and review Page 8 to determine if the insurance information was updated during that visit and whether it was entered into RPMS.
 - Was only a primary insurance referenced?
 - Was a secondary insurance, pharmacy-only, or dental insurance listed?
 - Was the insurance billing address correctly reflected?
 - Was the identification number accurately reflected?
3. Review the billing information on the patient.
 - Was the same insurance information billed?
 - Was the same address used?
 - Was the account paid?
 - Were errors identified and if so what errors?

4. Determine a percentage for your facility that meets expectations and pass the review of the audit back to the staff.
5. Compute a level of compliance for each registration staff person.
6. Add the information to the Quality Assurance Statistic form.
7. Use this data as well as the staff person's improvement as part of the performance appraisal process

7.5 Benefit Coordinator Performance Tracking

- On a monthly basis, calculate the percent of patients referred to the Benefit Coordinator that qualify for alternate resources versus those that did not.
- Determine the percent increase by month of the number of patients that qualify, and perform a trend analysis over several months.
- Develop a monthly cumulative report listing the number of patients that were referred to the Benefit Coordinator for alternate resources, and calculate the reimbursement on those patients by month.
- Compare the increased reimbursement by alternate resource payor, month-to-month.

7.5.1 Checking Benefit Coordinator Performance for Quality Assurance

- Establish and staff a full time Benefit Coordinator position.
- Train the Benefit Coordinator on all aspects of alternate resources:
 - Benefits
 - Exclusions
 - Eligibility and qualifications
 - Application process
 - Documents needed to substantiate
 - Types of alternate resources available
- Cross train Registration staff regarding which potential patients may qualify for alternate resources.
- Assure there is an established process for referring “all” potential patients to the Benefit Coordinator from Registration.
- Follow up with Medicaid, Medicare, and other alternate resources to assure the coverage is approved.

- Document in the **RPMS Patient Registration** application all updates on conversations.
- Always inform Billing of new insurance coverage.

7.6 Billing Performance Tracking

The RPMS Third Party Billing application's **Pending Claims Status** report will reveal areas that need attention before the claim can be approved. Many incorrect components of the claim cannot be detected until billers attempt to approve the claim. If deficiencies are found the biller has the option to place the claim into a pending status, using the 3P Claim Pending Status table in RPMS.

The Pending Claims Status report will show if

- Claims are rejected due to incomplete or inaccurate information from registrations.
- Information on the patients provided at registration is correct and complete.
- Billing understands the correct format used to bill a particular insurer, and/or whether the biller incorrectly billed the account.

Building collaboration and more open lines of communication between Registration, Coding, and Billing will eliminate any finger-pointing and will improve the entire business process.

7.6.1 Chart Auditing

The medical record serves as a tool for patient care, medical research, and healthcare statistical measurements, and as a supporting tool for reimbursement. The medical record has been evolving for years to the development of the electronic medical record.

The patient's medical record, or patient chart, is a legal document that should not be tampered with, falsified, or altered in any manner that would cause the loss of or suppression of data. The chart should never be published or released to anyone without the patient's express consent.

The documentation in the medical record is required to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examination, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient.

The medical record often serves in many court cases for medical malpractice judgments as the final piece of definitive evidence.

In addition, the medical record facilitates:

- The ability of the physician and other health care professional to evaluate and plan patient's immediate treatment and to monitor their health care over time
- Communication and continuity of care between physicians and other health care professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for education
- Support to the claims processing

The process of chart auditing needs to be outlined by each facility compliance plan. The questions – how often, how many charts, when to audit – should be addressed in the plan. The Office of the Inspector General has published a variety of model compliance plans in its electronic reading room that can be referenced.

Internal auditing is done to verify that the facility is performing in good compliance. This practice also ensures good fiscal returns for cleanly coded claims. Chart auditing includes the process of verifying CPT and ICD-9-CM codes against the document for the encounter.

Evaluation and management services represent the foundation of the patient encounter and procedural coding. Guidelines and rules associated with the evaluation and management of coding present some of the most subjective coding conventions out of all sections in the CPT manual.

In addition to the internal auditing, the government audits records to a variety of different kinds of fraud and abuse. Therefore, it is important that each facility audit their records prior to any external audit review.

Stages and steps in an audit process are:

- **Criteria**

The first stage is to define “*what should be*” – basically a baseline for the audit, a best practice that you would like the facility to achieve, or what actually should be occurring.

- **Condition**

The second stage is to define “*what is*” – Document what is occurring and whether that meets the criteria

- **Cause**

When the condition does not meet the criteria, you need to document why – “*Why is this process falling short?*”

- **Effect**

“*What is the financial, resource, quality, or other impact of the condition?*” – It might mean, lost revenue; it might mean lost time in research; it might mean duplication of initiatives. In this stage, you look at the difference and significance between what is and what should be.

- **Recommendations**

This stage of the process is to define and implement a solution with an achievable action plan and follow-up review process. This stage also includes the establishment of performance targets and performance due dates.

7.6.2 Payment Analysis

One of the most important processes is submitting the bill in a timely manner to the insurance company. For the current inpatient and outpatient billing timeframes, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Party Revenue Accounts Management and Internal Controls” (5-1.3H), which is available at this website:

http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part5/pt5chpt1/part5c_hapt1.htm#3h)

An audit should be periodically conducted to sample the billing timeframe. For this process, simply review 25-to-50 recently paid accounts from each of your major payers.

1. Enter the discharge date or the date of the facility visit and then the date the bill was actually mailed or billed electronically to the insurer.

Then count the number of days between those times. This figure should not be more than ten days for inpatient claim, based on discharge date.

2. Enter the date paid and the number of days between the date billed and the date paid.

This figure should not be more than 30 days. If the figure is more than 45 days, there is an internal or system problem that needs to be reviewed.

The audit enables the facility to identify potential issues, bottlenecks in the process, system transmission issues, and business process workflow changes that can improve the day-to-day operations.

7.6.3 Electronic Billing Systems - Checks and Balances

With electronic submission of claims, you should ensure that a confirmation of receipt is received and the response reports are reviewed after each batch submission.

- Know the number of bills approved and ready for export by printing or displaying the Summary of Bills Ready for Submission option in RPMS Third Party Billing. Limit the number of bills you include in each batch to make the batch more manageable and to meet payer requirements.
- Ensure filename used to create the batch file complies with payer requirements.
- Create batch file using the Create EMC File option in RPMS Third Party Billing, and FTP from your RPMS file directory to prepare for export.
- After transmitting your batch file, compare the entries to the number of claims received by the payer. If they match, you are assured that the transfer mechanism you have in place is working. If they do not match, you could be omitting claims from your daily batch submission, and you will need to remedy this situation immediately.

- Your insurer or billing vendor (clearing house) should be transmitting confirmation reports to you regularly that reflect the claims they received from you in your last transmission batch. Compare these figures to the number of claims you transmitted. If the numbers match, you will know the claims have been routed to the insurance companies. If the numbers do not match, you will need to contact your insurer or billing vendor to resolve the discrepancies.

It is important to examine your confirmation reports daily upon receipt. Periodically you may find claims that have failed payer specifications. It is imperative to correct and resubmit these claims promptly. If allowed to accumulate, these claims will have an adverse effect on your receivables, thus defeating one of the major advantages of billing electronically.

For any attachments requested with electronic billing, it is advisable to ask your insurer if they prefer a hard-copy of the report, or if the report can be faxed directly.

7.6.4 Benchmarking the Billing Process

As part of an ongoing review process, six-to-eight designated individuals – from either the facility, from the Area office, or from a contracted entity – should form a review group. This review group would focus on analyzing and finding solutions to problems in the billing process, by examining and comparing existing processes to successes of peers. This is called benchmarking.

If a health care facility wants to be the best, it must know how others manage to be so good. Benchmarking involves finding best-class examples of product, service, or operational systems, and adjusting the existing facility to meet those standards. Benchmarking can be the foundation for any receivables improvement program.

Benchmarking steps involved in the billing process are:

1. Identify what is to be benchmarked.

It could be something tangible such as days, bad debt, or billing time or it could be something as intangible as patient satisfaction

2. Identify comparative facilities.

Expect to spend some time on researching, perhaps visiting, and definitely comparing, other entity's successes.

3. Determine data collection method and collect data.

The team that conducts the studies determines what measurements will be used.

4. Determine current performance levels.

Take the measurements of your own function and compare them with the measurements from the benchmarked facility. That usually produces a negative or positive performance gap.

5. Project future performance levels.

Use the measurements of the gap to figure out what the new performance goals should be if that gap is to be closed, and how long it will take.

6. Establish functional goals.

Write down your objectives.

7. Develop action plans.

These plans tell how you are going to achieve the objectives.

8. Implement the plans and monitor progress.

If the goals are not being met, problem-solving teams might be formed to figure out why.

9. Recalibrate measurements.

Keep abreast of industry standards and new best practices.

10. Communicate benchmarking findings and gain acceptance.

Present findings and recommendations to staff and to higher management for endorsement.

7.7 Monitoring Productivity

To just evaluate the productivity of a staff person from manual activities would be very hard to analyze. One of the ways where productivity could be tracked would be from a follow-up report that is generated for each financial category. The supervisor could review accounts randomly on the report for each follow-up person. Another way would be to have the follow-up staff turn in a weekly manual report on the number of accounts they have worked and the number of accounts paid.

Examples:

For...	Use...
Billing	Bills Listing Report, by approving official
A/R	Transaction report (TAR), by Accounts Receivable (A/R) entry clerk
Coding	Counts Report (RPMS PCC Application), by individual; also provides a summary report

7.7.1 Billing Productivity Standards

A recent survey demonstrates that billers average 53 bills per day or 6.6 bills per hour. The following guidelines provide an estimate for billing based on the electronic capabilities of the facility.

- **Fully Automated Facility**

95-to-100% of edits are done on the computer. For this type of facility, a typical biller should send out at least 2,500 bills per month or at least 120 bills per day. Factors that could affect this quantity are payer mix, quality of bills produced by your system, and size and location of the facility.

- **Semi-automated Facility**

Edits are made by hand, and an even number of electronic and paper claims are submitted. For this type of facility, a typical biller should send out at least 1,000-to-1,800 bills per month or around 86 claims per day.

- **Manual Facility**

All information is keyed into the system by data entry staff and is mailed manually. For this type of facility, a typical biller should send out at least 35 bills per day.

Factors that affect the productivity of billers include:

- **The number of telephone calls received by the billers**

Some billers are interrupted by incoming telephone calls all day. This can make a big difference in productivity.

Suggestion: Establish a separate position within the billing department to handle incoming phone calls.

- **The volume associated with follow-up on outstanding accounts**

Many billers have to follow up on their claims with third-party payers.

Suggestion: If the volume associated with follow-up is too high, then have either a separate individual or area do the follow-up, or reserve a few hours each day for the biller to follow-up. For the latter, this will enable the biller to concentrate on billing rather than periodically interrupting their day for follow-up.

- **Problems with data moving through RPMS in a timely manner**

Late charges are always an issue. The more late charges or orphan tests a biller gets, the bigger the billing backlog.

- **Billers also functioning as coders**

Performing the multi-task functions of coding and billing, or checking the coding of the coder and billing, slows down productivity.

Suggestion: Have a separate coding staff in the facility and have the biller focus only on billing.

- **Billing office setup**

If the Billing office is setup where billers are assigned by insurer, some billers may be processing more paper claims while others are processing more electronic claims.

Suggestion: Have your computer specialist or Area office work with the primary insurers that you are submitting paper claims, to determine whether these same claims can be submitted electronically.

- **Payer's requirements**

A percentage of the claims processed require a great deal of manual work.

Suggestion: Meet with the insurance company to discuss payment problems, requirements, and solutions.

7.7.2 Ways to Divide Billing Workload

There are several ways to divide the workload in the Billing Department – by payer, by alphabet, or by team.

Payer Split

The billing responsibilities are divided into the major payer groups – Medicare, Medicaid, and private insurance.

Benefits:

- Billers become specialists by payer types. Billers can keep abreast of the changing requirements and regulations.

Pitfalls:

- With the secondary billing, such as Medicare and Medicaid or Medicare and private insurance, the same claim will be handled by two billers and may go back and forth. In addition, telephone calls with the two insurers may not consistently be handled between the two billers.
- Patient revenue mix may change, causing uneven workload among the billers.

Alphabet Workload Split

The billing responsibilities are divided according to an alphabetical split, based on the patients' last name.

Benefits:

- Billers are responsible for billing all payers, and there is no controversy or back and forth between two billers with coordination of benefits.
- Billers become cross-trained with multiple insurers and can cover for other billers if they are on vacation or sick.

Pitfalls:

- With the third-party billing requirements changing rapidly, it may be difficult for billers to remain experts in all payers.
- Billers will need to be proficient with manual billing, as well as billing through the various insurer terminals.

Team Workload Split

A team is a combination of payer and alphabet billing processes. A team can be divided first by payer, and then further divided alphabetically.

- Benefits:**
- The Split promotes teamwork, rather than the “their job, not my job” mentality.
 - There is more flexibility when staff is on vacation or sick.
 - Team size can be shifted depending on work volume.
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- Pitfalls:**
- Shifting staff from one team to another can create resistance to change or stress.
 - Not everyone from the team can attend a meeting or a seminar, for no one would be available to work on the bills.

7.8 Training and Business Process Improvement

Constant change in health care rules, regulations, and guidelines makes training an imperative. The hazards of not taking the time to train, initially and at regular updates, can prove to be costly. Without proper training and leaving it up to the individual about where to go for information makes it difficult for the person to perform effectively.

For example, the results of improper training in Registration could result in (1) missing data elements that will slow the claims processing; (2) inaccurate data results in claim rejections and/or leads to rebilling; and (3) failure to obtain preauthorization within required time parameters leading to claims rejections and/or reimbursement denied in part or full.

The costs of improper training at the front-end show up in reduced reimbursements and/or increased staff effort as the back-end must duplicate tasks that should have been performed at the front-end.

Training Basics

Training Task	Description
Create Processes	This entails identifying job requirements and creating processes to meet those requirements
Develop Policies and Procedures	Processes to meet job requirements need to be backed up with set policies and procedures that serve as guideline that can be referred to after training.
Create a Training Manual	This can be combined with developing policies and procedures. What is important is that staff has a written resource to which they can refer to independently resolve issues as they occur while remaining within established guidelines. Training is just someone conveying what needs to be done; staff needs something to refer back to.
Train	Bring staff together in small groups during work hours. Explain job requirements and the processes to meet those requirements. Be specific and use detailed examples. The best trainer tries to demonstrate to staff how their work fits into the bigger picture, and how their work is interrelated.
Set Goals and Objectives	Establish measurable goals in key performance areas. For registration, these can include registration accuracy, number of registrations to complete in a day, etc.
Monitor Performance	Quality assurance is required to determine if training is adequate. Among the management tools in monitoring performance are reports from the business office on why claims' processing was delayed or why rejections occurred. These records will show if registration records are coming through incomplete or if information is inaccurate.
Provide Ongoing Training	Ongoing training can occur in refresher courses or informally one-on-one. Effective monitoring allows supervisors to provide training as needed. For example, if a staff person consistently fails to complete a certain field, the supervisor should speak with the staff person to review the problem and discuss why it is a problem.

7.9 Pay-for-Performance Demonstrations

Medicare has various initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive health care services, including physicians' offices and ambulatory care facilities, hospitals, nursing homes, home health care agencies, and dialysis facilities.

The foundation of effective pay-for-performance initiatives is collaboration with providers and other stakeholders to ensure that

- Valid quality measures are used.
- Providers are not being pulled in conflicting directions.
- Providers have support for achieving actual improvement.

Through collaborative initiatives with public agencies and private organizations, CMS is developing and implementing a set of pay-for-performance directives to support quality improvement.

There are three physician demonstrations:

(1) Physician Group Practice Demonstration (BIPA 2000)

Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), this demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. The demonstration seeks to encourage coordination of Part A and Part B services, promote efficiency through investment in administrative structure and process, and reward physicians for improving health outcomes.

(2) Medicare Care Management Performance Demonstration (MMA section 649)

Modeled on the "Bridges to Excellence" program, this is a three-year, pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards will receive bonus payments for managing these patients.

(3) Medicare Health Care Quality Demonstration (MMA section 646)

This demonstration, which was mandated by section 646 of the MMA, will be a five-year demonstration program under which projects enhance quality by improving patient safety; reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines, encouraging shared decision making, and using culturally and ethnically appropriate care.

7.10 Quality Improvement Organization

The Quality Improvement Organization (QIO) consists of local organizations that, by law, contract with the Centers for Medicare & Medicaid to provide quality improvement assistance to health care providers, such as physicians, hospitals, nursing homes, and home health agencies, and to health plans that contract with Medicare.

The QIO was established to redirect, simplify, and enhance the cost-effectiveness and efficiency of the medical peer review process. The three main functions of the QIO are to

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care.
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary and that are provided in the most economical setting.
- Protect beneficiaries by expeditiously addressing individual cases, such as beneficiary quality of care complaints, contested hospital issued notices of noncoverage (HINNs), alleged Emergency Medical Treatment and Labor Act (EMTALA) violations (e.g., patient dumping), and other statutory responsibilities.

7.10.1 Proposed 8th Scope of Work

To help the QIOs, CMS is proposing an **8th Scope of Work** - a plan that would include the following enhancements to the previous QIO contracts.

- It recognizes that although the U.S. Healthcare system has been leading the way in many improvements in health care, the full potential of our health care system to improve health is not being achieved. The plan aims to promote dramatic improvements in the quality of health care so that every person receives the right care every time.

- It proposes that the QIOs may need to build on their current efforts to involve other organizations and entities to provide the best possible expert assistance in increasingly specialized areas, and invites comments on options for accomplishing this through subcontracting and other partnerships.
- It indicates that the design of the program will be organized to better distinguish QIO impact from improvement that may occur without QIO assistance, such as increased awareness of clinical guidelines by physicians.

The 8th Scope of Work will guide the work of the QIOs for the three-year cycle beginning in August 2005. This proposal focuses on four settings:

- Nursing Homes
- Home Health Agencies
- Hospitals
- Physician Offices

It also includes the continuation of protecting beneficiaries and the Medicare Trust Fund through work on appeals, beneficiary complaints, payment error, and other case review activities.

The proposed work in the 8th Scope of Work moves beyond the current 7th Scope of Work in the following ways:

- QIOs will work to promote dramatic improvement, promoting the adoption and effective use of healthcare information technology (HIT), performance measurement, process redesign, and organizational culture change.

For example, working with partners in a pilot project, QIOs are assisting small-to-medium sized physician offices in California, Arkansas, Massachusetts, and Utah, in adopting office-based electronic health record (EHR) systems and using such systems to improve efficiency of care delivery, quality of care, and patient safety.

- When the Medicare prescription drug benefit becomes available in 2006, QIOs will work with prescription drug plans and providers to ensure quality care to people with Medicare on improvement projects, such as measures to detect inappropriately prescribed rugs and ways to identify patients who may be at risk for harmful interactions.

- QIOs will work to improve care for disadvantaged populations by focusing on physician office-based care to make sure all Medicare beneficiaries get the right preventive services and appropriate care for chronic diseases, such as diabetes.
- QIOs are expected to continue offering mediation as a service to Medicare beneficiaries. This service involves direct provider involvement in responding to beneficiary complaints, which often results in improved communication between provider and patient, in order to resolve quality of care issues.

This multi-pronged approach includes helping consumers make decisions using timely and accurate quality of care information, and urging providers to improve quality using free assistance from QIOs and through “pay-for-performance” demonstrations.