Quality Assessment of
A Health Care Organization
(Medicare extension)

Managerial & other problems in extending the current
Medicare system to a general customer population

TEAM 8
BRIAN DORMAN

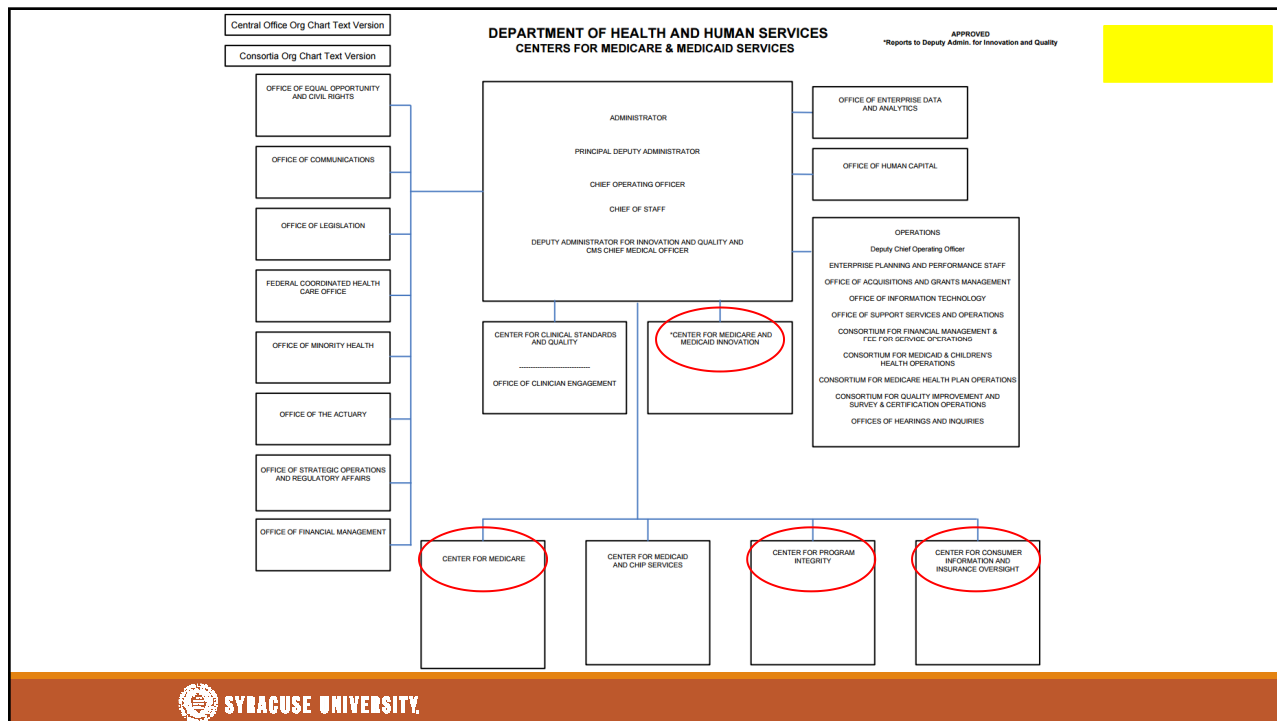YANQING HU

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List of Concerns Derived from COPQ

❑ Funding for Medicare

❑ Under staffed do to increased customer base

❑ Poor training

❑ Available service providers

❑ Cost of medical expenses

❑ Increased documentation and paperwork

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Organizational Chart

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Central Office Org Chart Text Version

Consortia Org Chart Text Version

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED
*Reports to Deputy Admin. for Innovation and Quality

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS

OFFICE OF COMMUNICATIONS

OFFICE OF LEGISLATION

FEDERAL COORDINATED HEALTH CARE OFFICE

OFFICE OF MINORITY HEALTH

OFFICE OF THE ACTUARY

OFFICE OF STRATEGIC OPERATIONS AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL MANAGEMENT

ADMINISTRATOR

PRINCIPAL DEPUTY ADMINISTRATOR

CHIEF OPERATING OFFICER

CHIEF OF STAFF

DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY AND CMS CHIEF MEDICAL OFFICER

OFFICE OF ENTERPRISE DATA AND ANALYTICS

OFFICE OF HUMAN CAPITAL

OPERATIONS
Deputy Chief Operating Officer
ENTERPRISE PLANNING AND PERFORMANCE STAFF
OFFICE OF ACQUISITIONS AND GRANTS MANAGEMENT
OFFICE OF INFORMATION TECHNOLOGY
OFFICE OF SUPPORT SERVICES AND OPERATIONS
CONSORTIUM FOR FINANCIAL MANAGEMENT & FEE FOR SERVICE OPERATIONS
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS
CONSORTIUM FOR MEDICARE HEALTH PLAN OPERATIONS
CONSORTIUM FOR QUALITY IMPROVEMENT AND SURVEY & CERTIFICATION OPERATIONS
OFFICES OF HEARINGS AND INQUIRIES

CENTER FOR CLINICAL STANDARDS AND QUALITY

OFFICE OF CLINICIAN ENGAGEMENT

*CENTER FOR MEDICARE AND MEDICAID INNOVATION

CENTER FOR MEDICARE

CENTER FOR MEDICAID AND CHIP SERVICES

CENTER FOR PROGRAM INTEGRITY

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

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Important Organizational Areas

❑Center for Medicare and Medicaid Innovation

  ❑Designs, Evaluates, Implements and Distributes Information About Effective & Innovative Payment and Service Delivery Models With a Goal of Enhancing the Quality of Healthcare and Reducing Costs while Carrying Out Core Business Functions

  ❑Amy Bassano, Acting Director

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Important Organizational Areas

❑Center for Medicare

  ❑The Epicenter for National Medicare Program Policies and Operations that Identifies and Proposes Modifications to Current Medicare Programs and Policies
  ❑Main Group for Management, Oversight, Budget and Performance of Medicare Plans that Carries Our Missions and Goals to Position the Organization to Meet Future Challenges

  ❑Cheri Rice, Acting Deputy Center Director

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Important Organizational Areas

❑Center for Program Integrity

❑The Epicenter for All Medicare and Medicaid Fraud and Abuse Issues that Promotes Integrity of the Systems through Audits and Policy Reviews, Identifying and Resolving Program Vulnerabilities

❑George Mills, Jr., Deputy Operations Director

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Important Organizational Areas

❑Center for Consumer Information and Insurance Oversight

❑Sets and Enforces Standards for Health Insurance to Promote Fair, Affordable and Quality Health Coverage is Available and Provides Information on Insurance Coverage Options to the General Consumers
❑Collects Data to Maintain, Implement and Monitor Compliance With Insurance Market Rules

❑Jeff Wu, Acting Associate Deputy Director for Policy

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Questions

1) What issues do you currently face within the Medicare system?
2) Walk me through the current process of applying for Medicare?
   a) How long does the current process take?
   b) Is it a difficult process?
3) Where do you feel the system is lacking support?
4) Do you have a training processes for employees?
5) How many errors are reported each week?
   a) What are the majority of these errors?

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Question 1

❑ What issues do you currently face within the Medicare system?

❑ Billions of dollars being wasted
❑ Avoidable harm to patients
❑ Higher Volume of Chronic Diseases
❑ Enrollment/Miss-understanding by Patients

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Question 2

❑Walk me through the current process of applying for Medicare?
    a)   How long does the current process take?
    b)   Is it a difficult process?

❑ Medicare cards should arrive within 30 days after individuals complete the Medicare Part A or B application during the Initial Enrollment Period. The Initial Enrollment Period begins three months before individuals turn 65 and lasts for seven months.
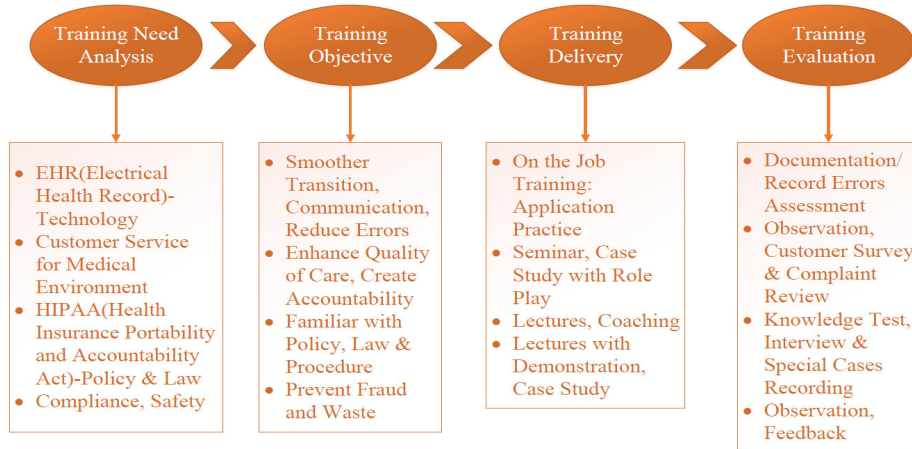
❑ You can sign up for Part A and/or Part B during the General Enrollment Period between January 1–March 31 each year if both of these apply:
    ❑ You didn't sign up when you were first eligible.
    ❑ You aren't eligible for a Special Enrollment Period.

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Question 3

❑ Where do you feel the system is lacking support?

    ❑ Lack of support for family caregivers of elderly Medicare recipients
    ❑ Payment process for services, medical equipment
        ❑ Stringent supporting documentation requirements
        ❑ Claims service lacking information for adjudication
    ❑ Human Resource:
        ❑ Well-trained employees, general doctors and specialists resource.
    ❑ Communication:
        ❑ Payment support and tools for different medical care providers to communicate and work together.
    ❑ Screenings & Vaccines
        ❑ Only certain screenings and vaccines are covered under part A or B.

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Question 4

☐ Do you have a training process for employees?

Training Need Analysis ➤ Training Objective ➤ Training Delivery ➤ Training Evaluation

Training Need Analysis	Training Objective	Training Delivery	Training Evaluation
• EHR(Electrical Health Record)-Technology • Customer Service for Medical Environment • HIPAA(Health Insurance Portability and Accountability Act)-Policy & Law • Compliance, Safety	• Smoother Transition, Communication, Reduce Errors • Enhance Quality of Care, Create Accountability • Familiar with Policy, Law & Procedure • Prevent Fraud and Waste	• On the Job Training: Application Practice • Seminar, Case Study with Role Play • Lectures, Coaching • Lectures with Demonstration, Case Study	• Documentation/ Record Errors Assessment • Observation, Customer Survey & Complaint Review • Knowledge Test, Interview & Special Cases Recording • Observation, Feedback

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Question 5

☐ How many errors are reported each week?

☐ Comprehensive Error Rate Testing (CERT)
☐ Improper Payment Categories
  ☐   No Documentation
  ☐   Insufficient Documentation
  ☐   Medical Necessity
  ☐   Incorrect Coding
  ☐   Other

Service Type	Improper Payment Rate	Improper Payment Amount (2)
Inpatient Hospitals	6.20%	$7.0B
Durable Medical Equipment	39.90%	$3.2B
Physician/Lab/Ambulance	12.70%	$11.5B
Non-Inpatient Hospital Facilities	14.70%	$21.7B
Overall	12.10%	$43.3B

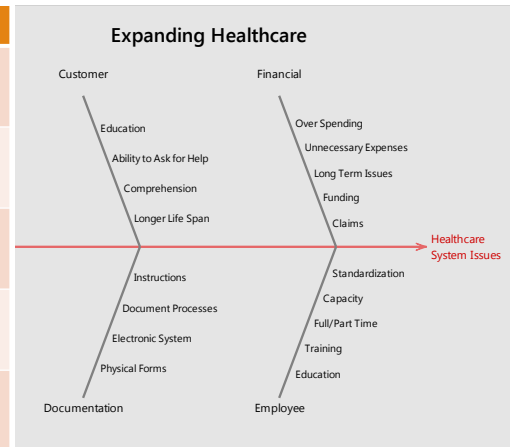*2015 Improper Payment rates & amounts.*

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Diagnostic of Issues

❑The lack of information is leading to unnecessary spending

❑ Long gap between filing application and acceptance into the program.

❑Inefficient processes and training
  ❑ Lack of training in the required billing procedures creates problems and denied or rejected claims.

❑Missing proper documentation for processes
  ❑ Incorrect documentation leads to excess time & money spent to verify claims.

❑Employees unable to answer customer questions

❑Not utilizing available resources

❑Lack of funding sources to keep up with the growing demand of new enrollees, and the increasing number of Medicare patients with severe illness & high medical costs.

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Root Cause Analysis

Financial	Employee	Customer	Documentation
Over Spending	Education	Education	Physical Forms
Unnecessary Medical Expenses	Training	Ability to Ask For Help	Electronic System
Long Term Health Issues	Full/Part Time	Comprehension	Documents Processes
Funding	Capacity	Longer Life Spans	Instructions
Claim Service	Standardization		

Expanding Healthcare

Customer
- Education
- Ability to Ask for Help
- Comprehension
- Longer Life Span

Financial
- Over Spending
- Unnecessary Expenses
- Long Term Issues
- Funding
- Claims

Healthcare System Issues

Documentation
- Instructions
- Document Processes
- Electronic System
- Physical Forms

Employee
- Standardization
- Capacity
- Full/Part Time
- Training
- Education

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Results from Diagnostics and Root Cause Analysis

❑ Medicare's current status of high enrollment vs. the low number of taxpayers supporting the system cannot sustain the increasing costs associated with fraud and waste.
   ❑ Are fraud/waste being prevented and have we eliminated the opportunity for overbilling.

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Solutions for Quality Issues

❑ Monitoring and auditing reporting
   ❑ Implement compliance and practice standards
   ❑ Designate a compliance officer

❑ Conduct appropriate training and education

❑ Respond appropriately to detected offenses and develop corrective action
   ❑ Develop open lines of communication with employees
   ❑ Enforce disciplinary standards through well-publicized guidelines

❑ Create a better process for evaluating medical needs and requirements

❑ Standardize operations

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Assess Improvements and How-to Sustain

❑ Do our auditing reports indicate an increase/decrease in the total number of errors
  ❑ If errors continue, increase, What specific area is affected most
  ❑ Have employees been successfully trained in their specific area of expertise as it relates to the Medicare process.
  ❑ Have disciplinary standards been enforced on violators, have previous violators conformed to the new standards.

❑ Questionnaires for employees and doctors

❑ Training videos that are required on a regular basis

❑ Hold Kiasens to evaluate processes

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References

www.CMS.gov

Various information regarding Healthcare operations

Bipartisan Policy Center (BPC) report: Improving quality and value in the U.S health care system, August, 2009

http://medassureservice.com

Greenbox: Employee Training and Development

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