

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Quality Improvement Organizations: Next Steps towards Transforming  
Beneficiary Protection  
Thursday, July 16, 2009  
3:30 – 5:00 p.m. EST  
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host this Special Open Door Forum (ODF) to discuss improvements to the Quality Improvement Organization (QIO) Beneficiary Protection Program (BPP).

The BPP incorporates several QIO functions, including quality of care reviews, reviews of beneficiary complaints, higher-weighted Diagnostic Related Group reviews, utilization reviews, early readmission reviews, EMTALA reviews, appeals of discharges from various provider settings (fee for service and Medicare Advantage), and hospital preadmission reviews.

This Special ODF will serve as a follow-up to our ODF last October, during which we received valuable feedback from participants about the current state of the BPP as well as suggestions for moving the program forward on its mission to protect the rights of beneficiaries to receive high-value, high-quality health care.

In particular, this Special ODF will address:

- CMS activities since the last ODF call of October 2008;
- Key concerns that providers and beneficiaries have about the current BPP processes;
- What CMS is doing to improve the BPP, particularly the beneficiary complaint and complaint review process;
- How CMS plans to accomplish these improvements; and
- CMS' next steps in transforming the BPP.
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As CMS moves forward on BPP transformation, additional Forums may be scheduled based on need.

We look forward to your participation.

Special Open Door Participation Instructions:

Dial: 1-800-837-1935 & Reference Conference ID: 19705106. Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at [http://www.cms.hhs.gov/OpenDoorForums/05\\_ODF\\_SpecialODF.asp](http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp) and will be accessible for downloading beginning Monday, July 27, 2009.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.hhs.gov/opendoorforums/> .

Thank you for your interest in CMS Open Door Forums.

Audio file for this transcript: [http://media.cms.hhs.gov/audio/QIO\\_Bene\\_Protection\\_Program.mp3](http://media.cms.hhs.gov/audio/QIO_Bene_Protection_Program.mp3) .

## CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:  
Quality Improvement Organizations: Next Steps towards  
Transforming Beneficiary Protection  
Moderator: Natalie Highsmith  
Thursday, July 16, 2009  
3:30 pm ET

Operator: Good afternoon, my name is (Amy) and I'll be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services special open door forum on quality improvement organization next step towards transforming beneficiary protection.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session.

If you would like to ask a question during this time simply press star then the number 1 on your telephone keypad.

If you would like to withdraw your question press the pound key. Thank you, Miss Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you Amy and good day to everyone and thank you for joining us for this Special Open Door Forum on the Quality Improvement Organization Beneficiary Protection Program.

This Special Open Door serves as a follow up to the initial Open Door back in October 2008 during which you provided CMS with valuable feedback about the current state of the Beneficiary Protection Program as well as suggestions on moving the program forward on its mission.

During this Open Door today, staff will address CMS activities since the last call in October, key concerns that providers and beneficiaries have about the current beneficiary protection process, what CMS is doing to improve the beneficiary

protection, particularly the beneficiary complaint and complaint review process, how CMS plans to accomplish these improvements and CMS's next steps towards transforming the beneficiary protection program.

As always there will be time left over for Q&A. I will now turn the call over to Miss Jean Moody-Williams who is the Director of the Quality Improvement Group. Jean?

Jean Moody-Williams: Thank you very much and welcome everyone. We appreciate your taking the opportunity to join us. We understand we have a large number of participants and we are very happy to hear that.

You should have hopefully the slides in front of you which the second slide includes our agenda for the afternoon. You'll note that I'll start with a few introductory remarks.

And after that we'll move right in to discussing improvements to the beneficiary complaint process and that will be done by Tom Kessler who many of you are probably familiar with .

And following Tom, Linda will talk about plans for future improvement and the next steps. We also really wanted to have time left to hear from you, to take your questions and your comments.

We are aware that on the phone we have beneficiaries, beneficiary advocates, we have providers on the phone. We probably even have some QIOs on the phone, so I think we will have quite a lively discussion and hopefully a good use of your afternoon.

This is very important as we begin or continue I should say to transform the beneficiary protection program. We are very committed to making this a program that works for our Medicare beneficiaries.

You know I was just thinking that I started my position as the Director of the Quality Improvement Group in October which was just about the time of the last Open Door Forum.

So while I was new to the position I had the opportunity to really come in and hear many of your concerns as well as the ideas that you raised at the time.

Well, since that time several months have passed and there's really been a great deal of work done internally within CMS as well as by the QIOs which included - what we really tried to do over this period of time, was focus on getting a good understanding of the processes that lead to the concerns that you expressed, any ideas that you had during the last call.

We felt that this was necessary because we heard and we knew that processes do vary from locality to locality. And I do believe that we achieved the goal of getting a very good understanding of how the program is operating throughout the country.

And while we'll probably never know it all, I think this - we have sufficient information to begin our efforts to decrease some of the unnecessary variability and to move toward improving the process.

We don't want a program that's one-size-fits-all which is why I highlight the word unnecessary variability.

In addition to the comments that we received from you during the open door forum, I did just want to mention that we've been busy evaluating recommendations from various other reports that we have including those from the Institute of Medicine.

We had some work done by various CMS contractors and I also spent some time talking with beneficiaries to know what they are experiencing first hand as well as meeting with QIOs and hearing from them the challenges that they face as they try to do the job that we have charged them to do.

So after hearing from everyone we began to prioritize the recommendations that we wanted to move forward and to determine basically which one of those recommendations required regulatory changes and which ones did not.

Quite frankly, there were a number of changes that would require some regulatory changes or even changes in the law that governs our review.

And we're looking at those and moving forward with recommendations in those areas but as you're probably aware with the legislative process or regulatory process, some of those items take longer than others to enact.

But we are looking at that and coming up with our plan for how to continue to move forward. But not wanting to be stagnant we are proceeding to move forward the improvements that don't necessarily require changes in regulations.

And we're making changes to our CMS manual which is used of course to provide directions to the quality improvement organizations.

In many cases these revisions are being made to reflect what really is current practice but may not be adequately reflected in the manual. Usually this would result because we provided communications via various CMS directives.

But we've taken the time to make sure that they all get in to one place. This was one of our key recommendations that we received from our evaluators. Other changes have been recommended to standardize the process.

What we want to ensure is that beneficiaries have the same high quality review process regardless of where they happen to reside in the country. We are considering changes to make the process more efficient relative to the way that information is collected as well as the timeliness and the quality of the review process.

We are formally seeking comments on our intake form that Tom will tell you about in just a bit, about how you can participate in that activity. I just want to set some expectations for today's meeting and just to note up front that it's not really to provide solutions to the issues that you've raised.

But we wanted to let you know that the work continues, to let you know - we wanted to give you an idea of those issues that did rise as far as priority level and those are the items that are really guiding our work at the current time.

But then there's also the opportunity for you after you hear what we heard and those things that are guiding our work for you to say well that's good and that's important but you still didn't really address the area of concern that I have.

And so we'll have some time at the end for you to say you know what about this or what about that? And we really do solicit your feedback in that regard.

I'll just end so as not to spend a lot of time talking here but leave some time for review by saying that it is very, very easy in many of the meetings that we have to get engrossed in the technical issues of the regulation or the information system or the process that we use.

And while it is very necessary that we focus on these things in order to make meaningful change I always stop and encourage the participants to never forget that the reason we are making this change is for the beneficiary.

So as we have our discussion today that should continue to be our focus and as we talk today and you provide comments I would request that you please couch your comments in that frame of reference.

You know, what are the changes that will make this process work for the beneficiary? So at this point I can take any general questions and then I will turn it over to Tom who's going to kind of go through what some of the key concerns that we heard, how we prioritize that and how we're working on that.

Before I turn it over to Tom, I will take any questions that you might have just in general.

Natalie Highsmith: Okay Amy, if you can just remind everyone on how to get into the queue to ask a question and everyone please remember when it is your turn to restate your name, what state you are calling from and what provider or organization you're representing today.

And please remember that this is for general questions, not for things that are left to be discussed in the agenda.

Operator: At this time I would like to remind everyone if you would like to ask a question press star, the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Again if you would like to ask a general question please press star then the number 1 on your telephone keypad.

Jean Moody-Williams: Okay, well that's fine. I think probably once we get a little bit more specific information people will have more to react to.

And with that said I will now turn it over to Tom.

Tom Kessler: Thank you, Jean. As was referenced earlier we held a special open door forum in October 2008. There were 348 participants on the Open Door Forum including provider, physician and beneficiary representatives as well as CMS staff and contractor staff.

And just for reference I am picking up on Slide 3 to begin with. The ODF was actually designed to address concerns with regulations and CMS received a number of helpful comments.

Some of the comments represented broader concerns with the overall QIO program. As a first step I'll go over some of the broad concerns we received during the last ODF and then I'll address some of the changes we are considering as improvements which we do not believe require regulatory change and for which we're requesting your comments on.

One of the key points of feedback we received related to the QIOs' use of medical record reviews to complete quality of care reviews such as beneficiary complaints. It was noted that the focus on the medical record results in quality of care concerns being missed entirely or places the QIO in a position where they cannot confirm the concerns if evidence is not contained in the medical record.

In addition, we received comments last year at the open door forum that there is a need to shorten the overall time frame to complete the quality of care reviews.

And of particular note it was pointed out that the 30 days given to providers and physicians to submit medical records needs to be shortened considerably.

It was also mentioned that there should be financial ramifications for the failure to submit the medical records in a timely manner. Go on to Slide 4.

We also received several comments regarding the need to share additional information with beneficiaries. And this included advising the beneficiary of the specific facts so - and which are finding that the care provided did not meet professionally recognized standards of care.

But also a desire to know that specific steps that the physician and/or the provider took to improve the care in response to the QIOs findings.

In addition, it was suggested that beneficiaries should be advised of quality of care concerns that the QIOs find in the course of completing the review even if the concern had not been raised by the beneficiary in their complaints.

There was a general request that data associated with the beneficiary protection program be shared with beneficiaries and beneficiary advocacy groups.

It was also suggested that the time frame during which a beneficiary can file a complaint be limited since currently a beneficiary can file a complaint regarding core care that occurred several years or perhaps even decades ago.

In addition, it was suggested that the QIOs be required to advise physicians and providers up front that medical records are being requested as a result of a beneficiary complaint since this is currently not a requirement.

Slide 5, there were also several comments related to the physician's role or more precisely physician's control over the complaint process.

In particular it was noted that the physicians' control, whether a beneficiary receives the results of a review and that this should be eliminated. In addition, the general authority a physician has to withhold results if they believe a beneficiary may harm themselves should be eliminated.

There were similar comments related to bringing equity to the complaint process from a beneficiary's perspective.

A concern was also expressed that in some instances only care that is gross and flagrant is seemed to violate the standard of care and it was stated that there are

numerous instances where poor care was given that must be corrected even though the care was not gross and flagrant.

It was also discussed that beneficiaries should have input into information contained in their medical records and that poor care should be linked to the conditions of participation providers must fulfill regarding the Medicare program.

These represent the main points of feedback we received on the call that we have been working to evaluate. Others were obtained that we hope to address through the broader modifications to the program requirements.

These include clearly delineating the roles and responsibilities of the QIOs compared to other CMS contractors such as the FIs and MACs.

In addition we received a few email comments covering issues such as the value of limiting the disclosure of information found during the course of reviews so that physicians and providers are more willing to work together to address substandard care.

We received a recommendation that beneficiaries be required to resolve complaints with their Medicare health plans before they can file complaints with the QIOs.

And we received the suggestion that other perspectives be obtained in completing reviews such as the primary care physician's perspective and the Medicare health plan's perspective.

We have continued to consider all these comments in redesigning the beneficiary protection program. Slide 6, while the prior Open Door Forum addressed the regulations associated with all beneficiary protection program functions, we have attempted to look beyond the regulations and address all aspects of the program.

Most of our initial focus has been on beneficiary complaints and during the last nine to ten months, we have begun assessing process improvements with particular focus on potential decreases to the time frames for processing complaints.

We continue to consider other improvements to the program with considerable emphasis on standardization across the QIOs.

Through standardization we intend to facilitate beneficiary awareness of the complaint program, simplify beneficiaries' ability to file complaints, and improve our evaluation of the effectiveness of the program.

Next slide, one minor process change we've identified that we believe could greatly enhance the beneficiary complaint program is the development of a standardized quality of care complaint form.

Currently every QIO has developed their own unique form and process through which beneficiary complaints are received. The length, form, content of these forms varies across the program.

In addition, there are process variations that exist as a result of the use of the different forms. On June 26, 2009, notice was published in the Federal Register regarding our intent to implement a standardized complaint form that contains uniform instructions all beneficiaries will follow in submitting complaints.

Our major emphasis in creating the form was to simplify the process for a beneficiary who wants to file a complaint. In the future, rather than having a multiple page form to complete in order to initiate a complaint, a beneficiary will merely complete a one-paged form.

In addition, we have coupled this with basic process changes all QIOs will follow to ensure consistency. In particular, we will limit the amount of information QIOs initially send to beneficiaries outside of the complaint form.

So that the focus is on the beneficiary complaint. One last aspect is that we will be able to maintain the form on CMS' Web site which obviously we can not currently do since every QIO has a different form.

Next slide. As indicated in the Federal Register notice, formal comments on the Medicare quality of care complaint form are due August 25, 2009.

If you have comments regarding policy related issues associated with the form, you can call me, Tom Kessler, at 410-786-1991. However, please note that formal comments may only be submitted by following the instructions in the Federal Register notice.

Formal comments must be submitted by utilizing the [www.regulations.gov](http://www.regulations.gov) Web page or by sending them via regular mail to the following address; CMS Office of Strategic Operations and Regulatory Affairs, Division of Regulations Management Development, attention Document Identifier/OMB Control Number, Room C4-26-05, 7500 Security Boulevard, Baltimore Maryland, 21244-1850.

And I'll give that same address again later in the presentation. All right, the next slide, as you may know some QIOs have offered alternative dispute resolutions to beneficiaries over the last several years.

ADR has offered to beneficiaries for complaints where no quality of care concern has been identified after review of the medical records. The types of ADR include mediation, facilitated resolution and a third type called external resolution.

We are currently considering other approaches to the use of ADR to resolve beneficiary complaints and welcome comments regarding these alternative approaches including the timing of the offer during the processing of the complaint such as before completing the review of the medical record or the use of actual other types of ADR.

Please note that comments related to ADR are not part of the formal comments to be submitted regarding the Medicare quality of care complaint form and should be submitted using the following email address; cms [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) . That's cms [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) .

Just to repeat-- comments regarding the Medicare quality of care complaint form should not be submitted to this email address to be formally considered.

Next slide, as part of our efforts to evaluate changes to the manner in which QIOs complete quality of care reviews including beneficiary complaints, we are contemplating the utilization of evidence-based standards of care to increase the level or amount of standardization amongst the QIOs and improve the reliability of findings.

In addition, we are considering the viability of conveying the standards of care to beneficiaries when rendering decisions on complaints to increase the transparency of the QIOs' decisions.

We are requesting input on these issues as well as recommendations for other changes to this aspect of the program. Again the cms [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) email address should be used to forward your suggestions and input on this issue.

Next slide, we are also considering methods to improve the manner in which physicians and/or providers are afforded the opportunity to discuss initial QIO findings regarding potential quality of care concerns.

Currently 20 days are given to fulfill the opportunity for discussion. We are exploring the possibility of decreasing this time frame and are requesting your feedback regarding this.

In addition we are requesting input regarding the types of information that should be submitted during this opportunity for discussion period.

Should the opportunity for discussion be limited to a discussion or should information not originally in the medical record be eligible for submission as part of the opportunity for discussion.

Again the cms [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) email address should be used to forward your suggestions and input on this issue.

Next slide, we are also considering reducing the time frame for requesting a re-review of the initial decision the QIO renders on a quality of care review which includes beneficiary complaint reviews.

Currently 30 days are provided. However in light of time frame associated with other QIO functions and appeal processes, for instance the expedited appeal processes which actually occur within 24 hours, it appears that the 30 days could be reduced, perhaps significantly.

In addition, with regard to the beneficiary complaint quality of care reviews, we are considering whether the right to request a re-review could be given to beneficiaries.

We are requesting your feedback on these issues and other recommendations you might have regarding the re-review process.

Again the cms [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) email address should be used to forward your suggestions and input on this issue.

Next slide, we have also identified other aspects of the beneficiary complaint process that are subject to wide variation across the QIOs and we are currently considering these to improve the process.

In particular, we have attempted to better define the next step every QIO must complete in carrying out a beneficiary complaint review.

And then we've attempted to definite the time necessary to complete each of these steps. In several instances, we identified unaccounted-for steps in the process and also potential decreases to the current time frames and we believe we could implement these at some point in the near future.

In completing this work, we have considered input from the QIOs so that we can take advantage of best practices in existence. Our objective is to ensure we provide beneficiaries with a timely response to complaints that convey as much information as feasible in the resolution of these complaints.

We welcome your comments as we consider the proposed changes and welcome your comments on any aspect of the program.

And one final time, for comments regarding the draft Medicare quality of care complaint form, please submit these comments via the [www.regulations.gov](http://www.regulations.gov) Web page to ensure that they are considered.

Or you may submit them via regular mail to the address CMS Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, attention Document Identifier/OMB Control Number, Room C4-26-05, 7500 Security Boulevard, Baltimore Maryland, 21244-1850.

And I would recommend that you actually consult the actual Federal Register notification to confirm the address.

In addition, for recommendations on all other items that we had discussed including alternative dispute resolution, the use of evidence-based standards of care, the

opportunity for discussion and the re-review right, please submit your comments to the following email address, cms [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) .

And now I'm going to throw it back for potential questions regarding the specific issues that I've gone over.

Natalie Highsmith: Okay Amy, if you could just remind everyone on how to get into the queue to ask their question and everyone please remember when it is your turn to restate your name, what state you are calling from and what provider or organization you are representing today.

Operator: At this time I would like to remind everyone if you would like to ask a question press star and the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Our first question comes from the line of (Cheryl Kevinger) from Pennsylvania, your line is open.

(Cheryl Kettinger): Yes hi, my name is (Cheryl), I'm from Magee Rehabilitation Hospital. I'm actually curious to ask a question to Tom about something that we've experienced and would like some clarification about the QIO's role.

We are a freestanding acute inpatient rehab facility in the Philadelphia area and often we have been utilizing I guess a preadmission assessment of course for whether a patient's appropriate for admission to acute inpatient rehab when referred from an acute care hospital.

We've recently experienced some discrepancy and have gone to extensive lengths to discuss it with the Quality Insights of Pennsylvania as well as we had a representative from CMS, Dr. David Russo and Dr. David Wenner were the two representatives that we spoke with.

That basically stated that the beneficiaries do not have the right to appeal if we were to issue a hand to them that they're not appropriate for admission to acute inpatient rehab.

That beneficiaries do not have the right to appeal to the QIO, it would not constitute a review based on the fact that they're going from an acute care setting to an acute rehab setting, that that's not an alternative level of care.

We beg to differ on that and they have advised us to bring it to your attention and to the attention - because it just basically eliminated a beneficiary's right to appeal.

How can we get that to be considered for revision?

Tom Kessler: Well, I think on this issue what I'd like to do frankly - collect more information not only from you but from David Russo and others. So if you want to give me a buzz at the 410-786-1991 number we can discuss that issue.

(Cheryl Kettinger): That would be great. I will do that, thank you.

Tom Kessler: Sure.

Operator: Our next question comes from the line of Gerry Craynard from California, your line is open.

Natalie Highsmith: Hi, Gerry? Okay, let's move to the next question please.

Operator: Our next question comes from the line of Linda Powell, Alabama, your line is open.

Linda Powell: Yes, I am currently the utilization review coordinator for the Callahan Eye Foundation Hospital, but for 14 years, I worked for the QIO in this state handling beneficiary complaints.

And I wanted to know if the standardized form takes into consideration beneficiary's complaints not being appropriate for this type of review.

The majority of beneficiary complaints over my 14 years of doing this related more to wanting payment to be taken back from physicians or hospitals that didn't do things the way the beneficiary felt it should be.

It was not - they wanted to see some punitive damage for the facility or the provider of care in some way. And most of the time the things that they complained about were more personality related with the staff.

So rather than true beneficiary concerns that would be a medical issue. And it was very difficult to find any of their concerns documented in a medical record.

Tom Kessler: Okay, and that's certainly something that we are considering as we look at the program overall, the beneficiary complaint form is specific to fulfilling the requirements that we need to get these complaints received in a written form.

But certainly the QIOs, their authority and what they look at goes beyond just beneficiary complaints and you know they currently actually will review issues such as let's say billing issues, the other CMS contractors, etcetera.

So this form only is supposed to be specific to the beneficiary complaint process and we're certainly looking though at all functions performed by the QIOs within the beneficiary protection program you know to ensure that we account for the best processes related to those functions.

Jean Moody-Williams: I'll also add that you know the beneficiary can send in the complaint, that would be up to them to send it what they would want to bring to our attention. But we are looking at how we could appropriately triage the various activities much like other organizations whereby we would look at the nature of the complaint.

The system complaints are important to them although they may not be a quality of care concern. So then we can triage and send those kinds of complaints to maybe our partner in survey and certification.

So we don't want to lose items, I understand your point that not all of them may be clinical issues. But they are you know indeed important to the person that sent them in so we're trying to figure out a way to have appropriate triage.

Linda Powell: I agree with you that it is important to the beneficiary and they are concerned that many times they aren't concerns that can be even identified by what the QIO does in reviewing the medical records or even discussing the issues with the provider of care, whether it be the physician or the hospital.

Jean Moody-Williams: Right.

Linda Powell: Thank you for listening.

Operator: Our next question comes from the line of Jackie Birmingham from Connecticut, your line is open.

Jackie Birmingham: First, thank you for taking my call. I hope this is related to the intent of the session this afternoon and I'm curious about the relationship of a complaint versus an appeal.

And - for instance a patient's in the hospital and they've received the Important Message from Medicare about their discharge appeal rights.

And they appeal to the QIO for review. What is the relationship of the complaint form to the appeal form? I think it's probably extremely basic but understanding a patient in the hospital has the right to complain about the quality of the discharge.

They also have the right to appeal and there is growing confusion over how to deal with - not growing confusion but I am very concerned now about how these two issues are related.

Tom Kessler: The two issues are not related. The notices with regard to I think what you're referencing are the discharge appeal processes, the expedited appeal processes that exist in a different setting.

Sometimes they're referred to the BIPA or the (Grijalva) or the Weichardt appeal processes, those relate to whether or not the individual should be discharged from that setting.

The Medicare quality of care complaint form is not related to whether or not the individual should be discharged or remain in the provider setting, it relates to any care that the beneficiary received, whether inpatient or not.

So it's actually really broader and it's not related to CMS coverage issues. So they are two entirely separate processes.

Jackie Birmingham: Do we know if a patient who has requested a review of the discharge who is - and the QIO agrees the discharge is ready, the patient is ready, do we know if they turn into complaints?

Tom Kessler: Well, they may not turn into complaints; however, the QIOs in reviewing those discharge decisions, they do consider them in terms of general quality of care issues.

But it may not be that the beneficiary filed a complaint in addition to filing a request for you know an expedited appeal of that discharge decision being made by the provider.

So while there's not necessarily a direct link, there could conceivably be a link at some point in the process, but it isn't necessarily through the beneficiary filing a complaint.

Jackie Birmingham: Very good, I appreciate that explanation. And what I'll do is think more about how to word my question and get back to you off line.

I'm very interested in how discharge appeals trigger patients' satisfaction and patient complaints and are we really doing the right thing for the beneficiary, and just for the record, I happen to be a Medicare beneficiary so I'm filling two roles.

Thank you very much.

Operator: Again if you would like to ask a question, please press star then the number 1 on your telephone keypad.

Jean Moody-Williams: And I'll just mention it doesn't have to be a question, it could be a comment you'd like us to consider as we move forward with our redesigning our process as well.

Operator: The next question comes from the line of Susan Bowman from Florida, your line is open.

Winnie Grove: Hi, yes, this is Winnie Grove, the compliance nurse. My question is how are you foreseeing this form and this process - the form getting into the beneficiary's hands so that if they do have a quality concern they can get that to the QIO expeditiously?

Tom Kessler: Currently we're still in development but for the most part many of the calls actually come in to the QIOs through 1-800-Medicare. As those calls are actually handled by the QIOs, the QIOs will then be conversing with the beneficiaries.

And the QIOs will actually be able to mail the form out to the beneficiary or it's actually - the form is going to be located on CMS's email or - excuse me - Web site.

And so the beneficiary could actually print the form off and they could then forward it to the QIO. So there's going to be a couple of different ways, it ultimately could get to the QIO.

We think at this point based upon the historical methods through which the forms are given to the QIOs that aspect will not change drastically in that the beneficiaries will be mailing it in at some point to the QIOs.

Winnie Grove: Do you see a similar process to the hospital district appeal where the hospitals are required to you know give some sort of a notice to the beneficiary while they're in here to let them know of that appeal process?

Will there be something similar implemented by CMS or required to where the hospitals will need to have a process in place to give the beneficiaries some kind of notice during their stay?

Tom Kessler: As far as I know right now that is not something that we are specifically considering. But certainly that is an option, a comment that you know we can look in to.

Winnie Grove: Thank you.

Operator: Our next question comes from the line of Cathy Hamblen in Ohio, your line is open.

Cathy Hamblen: Hi, my name is Cathy Hamblen, I'm with Carespring Healthcare Management. We have several nursing home facilities. I guess my concern is that many times we have families who appeal the QIO or our decision to cut someone from their Medicare benefit even though from admission and throughout their stay we inform them on what the guidelines are for Medicare stay.

The expedited claims many times are 24-hour turnaround, the medical records person then has to copy a record which can be a rather large volume of paper and get it to you.

So I'm really concerned about the volume of paper and the way that those claims are being reviewed.

My other concern is that now we have a complaint form for - to go to the QIO and I think a previous caller had said that many times the QIO complaints are not really geared towards a medical record issue.

And medical - as it is right now Medicare beneficiaries can call on the ombudsman local and - or they can call the facility, they can call the ombudsman, they can call the state.

And then you have the QIO, are we not doing some replication and do people really know who's the appropriate person for what kind of complaint?

Tom Kessler: Well in terms of the state authority, you did mention the state, to the extent that there's a different entity within the state that handles quality of care complaints, we are not addressing that nor can we trump that state authority to resolve complaints that are submitted to their agencies.

And I know for a fact the same type of dynamic exists within the state of Maryland. We're merely addressing complaints as it's an outgrowth of CMS' authority as the regulatory agency over top of Medicare.

Jean Moody-Williams: Linda will address that.

Linda Smith: This is Linda Smith, I think this is a good time to share with you some of the additional activities that we're planning to improve the beneficiary complaint process.

Many of the comments and questions that you have raised are very good ones, and we have identified these. I want to start by acknowledging the fact that we recognize that education plays a big role in helping the beneficiaries and providers and other partners to really understand the role of the QIO in complaint investigations and how we identify quality of care concerns.

One of the divisions we have for further redesign to this program is to make this program more patient-centered and to actually improve the efficiencies in the beneficiary complaint process.

We have been working collaboratively with our partners across CMS, which includes 1-800-Medicare, it includes our ombudsman's office, it includes our CPC who addresses appeals cases and refers some of those to the QIOs.

So within CMS we are working as a team to look to see how we can really improve this process from intake to triage and to refer it to the appropriate entities.

We are evaluating a triage structure, really looking at levels of priority for the QIOs. We're hoping to make the QIO process time frame shortened and more outcome oriented.

This will require us to really collaborate with our state survey agencies and our state ombudsmen programs as well to really meet the needs of the beneficiary.

And I would just like to reiterate a statement that Jean Moody-Williams made during her introductory statement and that is the beneficiary is the true focus of our redesign effort.

We want to be more responsive, we want to ensure that we identify quality of care problems, we want to make sure we are very responsive especially when those problems that have been identified causes serious harm and consequences to the beneficiary.

So, these are some of the activities we are undertaking with the redesign effort. In addition to that, we have been working with the QIOs and with CMS departments at Joint Application Development meetings.

Actually thoroughly revealed in this complaint process and looking for ways that we can improve. We plan, in the future, to conduct stakeholder meetings. We want to come to the table to you with ideas for you to react to.

We ask for your response to these ideas. That is forthcoming and we would appreciate your support and participation with that effort.

Cathy Hamblen: That's the only thing and I agree the beneficiary's quality of care issues do need to be addressed. I just think many times you know that the surveyors trying to maintain their survey and certification calendars.

And the ombudsman is getting around to all of the residents, periodically you'll have one resident who complains every week and the surveyors are in and out of the building you know every other week surveying some issues.

So I do think there has to be a way as you call triaging it but I also think the beneficiaries need to know what's the appropriate organization to review the complaints so that the QIO is not reviewing a fall that happened at the same time the ombudsman's not reviewing it.

And the state survey and certification is not reviewing it. Do you follow me?

Linda Smith: Yes I do, and that is one of the reasons we really do feel we need to have the educational focus to help beneficiaries to really understand how we define quality of care concerns and the type of concerns that the QIO can assist them with.

Cathy Hamblen: Okay. I thank you.

Linda Smith: Thank you.

Operator: Our next question comes from the line of Robin Jordan in Arizona, your line is open.

Robin Jordan: Thank you. I was just wondering if there are any plans to take this from a paper process to a online Web-based process.

Linda Smith: Yes, we are actually working with our Information Systems Group and we are trying to develop a Web-based process to make this form and other information available through Internet and other areas.

Operator: Our next question comes from the line of Linda Powell in Alabama, your line is open.

Linda Powell: Yes, I have one other question. You mentioned earlier or someone did about the concerns that had been discussed on a previous call, the concern about the physician control over whether the beneficiary gets the results of the review or not.

In my past experience of having reviewed beneficiary complaints having to respond to beneficiaries, for the majority of the cases even if the results are okay, they do find - well that they don't find a problem, physicians will not allow you to communicate that result to the beneficiary if it's regarding the physician.

If it is negative toward the physician, they definitely will not allow you to communicate that to the physician. Is that being worked on at present? Is that going to go away where the physician doesn't have the control of what goes back to the beneficiary?

Tom Kessler: It's certainly a comment that we have had discussions about it in terms of an exact course of action. At this time, I really can't say that. But yes, it is something - a comment that we've heard multiple times and certainly are considering improvements to that.

Linda Powell: Thank you.

Operator: Again if you would like to ask a question please press star then the number 1 on the telephone keypad. At this time we have no questions in queue.

Natalie Highsmith: Okay, I guess I'll go ahead and turn the call over to Tom Kessler for any closing remarks.

Tom Kessler: Well actually, I'm going to make one statement before I turn it over to Linda Smith for the last piece of this. Oh, actually apparently Linda has done it, so I apologize.

I do want to correct - apparently I put a CMS on the beginning of the email address. And that was not correct, so in submitting comments please just send the comments to [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) . My apologies, that CMS is extraneous.

Kelly Anderson: And that is the address that's in your slide deck.

Tom Kessler: And then with that we appreciate you, you know, listening in and we look forward to having additional discussions with you as we move forward in the future. Thank you.

Natalie Highsmith: Okay Amy can you tell us how many people joined us on the phone lines?

Operator: Our largest number was 327.

Natalie Highsmith: Three twenty seven. Thank you everyone.

Jean Moody-Williams: Thanks.

Operator: You're welcome, this concludes today's conference call, you may now disconnect.

END