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CENTERS FOR MEDICARE & MEDICAID SERVICES

Acentra HEALTH

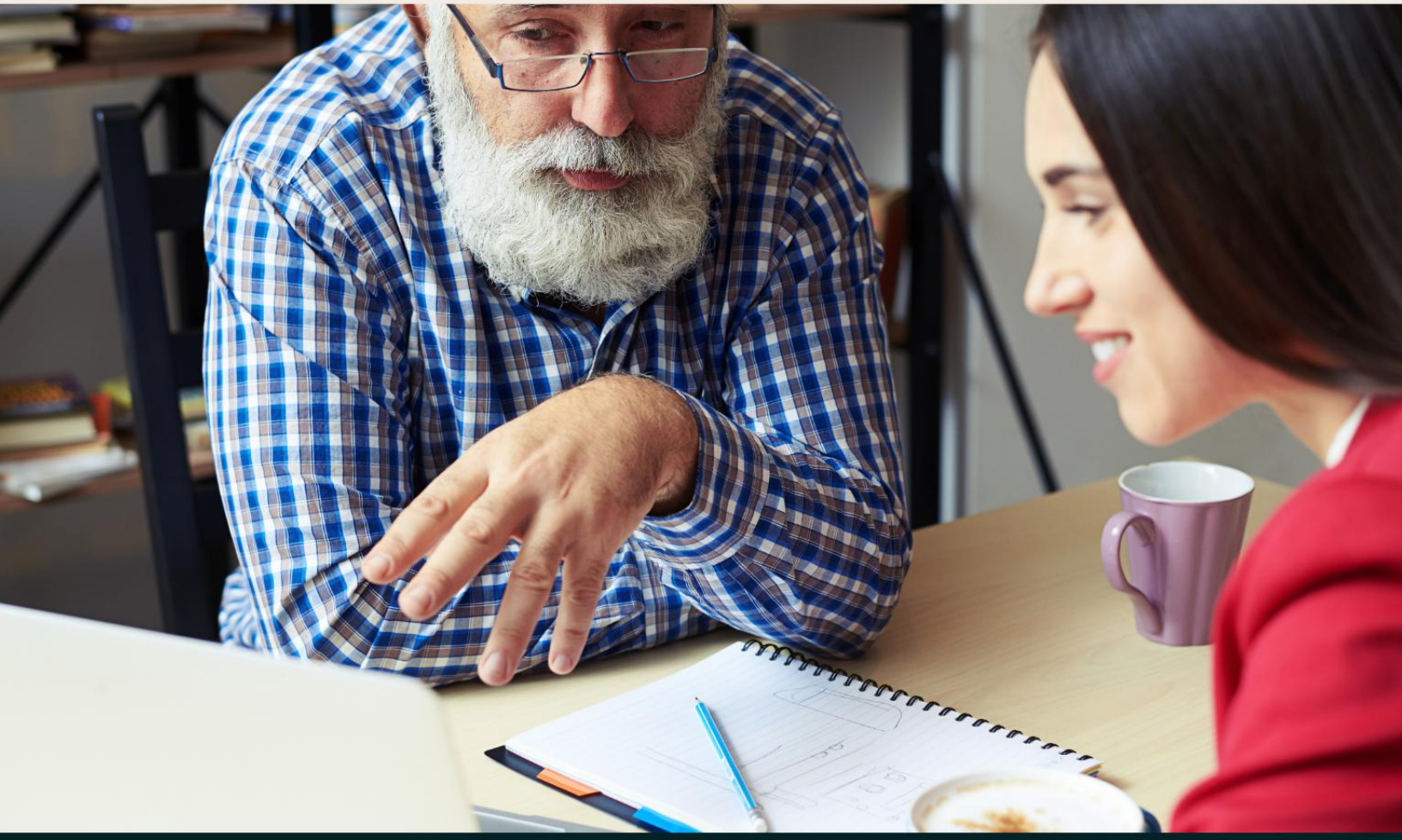
Annual Medical Review Services

Review Report

Reporting Year 2024

BFCC-QIO 13TH SOW
January 1 - December 31 2024

Region 8:
CO - MT - ND - SC - UT - WY



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BFCC-QIO ANNUAL MEDICAL REVIEW SERVICES REVIEW REPORT REPORTING YEAR 2024

REGION 8

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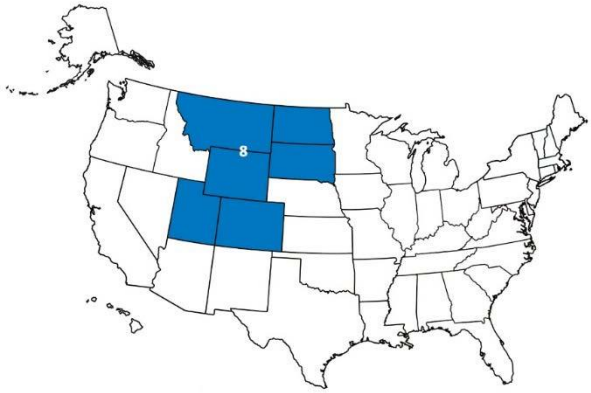
INTRODUCTION

Acentra Health is the designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 8, which includes: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. Under its contract with CMS, Acentra Health performs critical functions on behalf of Medicare beneficiaries, their families, providers, and CMS itself. The QIO Program is one of the largest federal programs dedicated to improving health quality and is a cornerstone of the U.S. Department of Health and Human Services' National Quality Strategy. The program's goal is to provide better care outcomes and overall health while assisting in lowering costs.



The QIO Program's mission is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. CMS has identified three core functions that guide the work of BFCC-QIOs such as Acentra Health:

- Improving the quality of care for beneficiaries.
- Protecting the integrity of the Medicare Trust Fund by ensuring Medicare pays only for services and goods that are reasonable, necessary, and provided in the most appropriate setting.
- Safeguarding beneficiaries by promptly addressing individual complaints, including Quality of Care concerns, provider-based notice appeals, violations of the Emergency Medical Treatment and Labor Act (EMTALA), and other related matters as defined in QIO-related law.

As a BFCC-QIO, Acentra Health conducts reviews of complaints about the quality of medical care received by beneficiaries. The organization also provides an appeal process for Medicare beneficiaries who are being discharged from hospitals or whose services are being terminated – such as care provided by skilled nursing facilities, home health agencies, hospices, and rehabilitation settings.

To help resolve concerns rapidly, Acentra Health offers a service called Immediate Advocacy, which allows beneficiaries to work with healthcare providers to resolve issues quickly and without requiring a formal review of medical records. These services are designed to protect the rights of beneficiaries while promoting responsiveness and fairness in the healthcare system.

In addition to beneficiary appeals and complaints, Acentra Health performs other mandatory reviews, such as EMTALA reviews and general quality reviews referred by a variety of state and federal agencies and organizations. This review work supports CMS's goals of quality improvement and program integrity while ensuring consistency in decision-making and consideration of local needs.

Understanding individual medical rights and healthcare literacy are central to Acentra Health's approach to protecting beneficiaries and ensuring access to quality care. Through targeted outreach and a commitment to addressing barriers, Acentra Health works to improve access to quality care and promote positive healthcare outcomes.

As part of its reporting responsibilities, Acentra Health provides data on case reviews and other services completed within the designated time period. These reports present both regional information in the report body and state-specific data in the appendix – reflecting the organization's commitment to transparency and accountability. By aligning its operations with CMS's goals and focusing on effective, patient-centered processes, Acentra Health plays a vital role in improving healthcare quality, protecting beneficiaries, and ensuring Medicare resources are used wisely.

ANNUAL REPORT BODY

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	979	8.87%
Medicare FFS Post-Acute Appeals	788	7.14%
Medicare Advantage Post-Acute Appeals	8,698	78.79%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	141	1.28%
Immediate Advocacy	343	3.11%
EMTALA	91	0.82%
Total	**11,040**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, unspecific organism	59,526	29.38%
2. J189 – Pneumonia, unspecific organism	20,557	10.15%
3. N179 – Acute kidney failure, unspecified	18,992	9.37%
4. N390 – Urinary tract infection, site not specified	17,380	8.58%
5. I130 – Hypertensive heart and chronic kidney disease with heart failure and Stage 1-4 chronic kidney disease or unspecified chronic kidney disease	17,042	8.41%
6. I110 – Hypertensive heart disease with heart failure	16,649	8.22%
7. J9601 – Acute respiratory failure with hypoxia	13,632	6.73%
8. U071 – COVID-19	13,562	6.69%
9. I214 – Non-ST elevation myocardial infarction	13,226	6.53%
10 .I480 – Paroxysmal atrial fibrillation	12,029	5.94%
Total	**202,595**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	818	7.51%
1: Distinct Psychiatric Facility	7	0.06%
2: Distinct Rehabilitation Facility	249	2.29%
3: Distinct Skilled Nursing Facility	9,347	85.80%
5: Clinic	0	
6: Distinct Dialysis Center Facility	0	
7: Dialysis Center Unit of Inpatient Facility	0	
8: Independent-Based Rural Health Clinic	0	
9: Provider-Based Rural Health Clinic	0	
C: Freestanding Ambulatory Surgery Center	0	
G: End-Stage Renal Disease Unit	0	
H: Home Health Agency	92	0.84%
N: Critical Access Hospital	165	1.51%
O: Setting Does Not Fit Into Any Other Existing Setting Code	55	0.50%
Q: Long-Term Care Facility	20	0.18%
R: Hospice	89	0.82%
S: Psychiatric Unit of an Inpatient Facility	0	
T: Rehabilitation Unit of an Inpatient Facility	0	
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	
Y: Federally Qualified Health Centers	0	
Z: Swing Bed Designation for Critical Access Hospitals	1	0.01%
Other	51	0.47%
Total	**10,894**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	26	2	7.69%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	81	19	23.46%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	22	3	13.64%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	1	25.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	1	33.33%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	7	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	4	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	11	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	1	50.00%
C15: Apparently did not effectively coordinate across disciplines	3	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	9	1	11.11%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	4	3	75.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	51	3	5.88%
Total	**230**	**34**	**14.78%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Acute Appeals, FFS & Managed Care	979	12.87%	87.13%
Medicare FFS Post-Acute Appeals	788	41.88%	58.12%
Medicare Advantage Post-Acute Appeals	8,698	47.94%	52.06%
Hospital Issued Notice of Non-Coverage Appeals	0	N/A	N/A
Hospital Requested Review Appeals	0		
Total	**10,465**	**44.20%**	**55.80%**

6) Evidence Used in Decision-Making

The table that follows describes the common types of evidence or standard of care used to support Acentra Health Review Coordinators and independent Peer Reviewer decisions for Appeals. For the Quality of Care reviews, we have provided the most highly utilized types of evidence/standards of care to support Acentra Health's Review Coordinator and independent Peer Reviewer decisions for the specific list of diagnostic categories provided in the table.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	UpToDate (*uptodate.com*); Centers for Disease Control and Prevention (CDC) (*cdc.org*); American Medical Association (AMA) (*ama-assn.org*); American Lung Association (*lung.org*)	UpToDate provides standards of care relevant to the concern. The standards are updated as new information is obtained. The CDC is also used as an official resource for accessing guidelines and clinical standards, including detailed treatment regimens and follow-up.
	Heart Failure	UpToDate (*uptodate.com*); American Heart Association (AHA) (*heart.org*); AMA (*www.ama-assn.org*)	UpToDate is used for updated information on current standards of care. AHA and AMA information is used to supplement clinical information.
	Pressure Ulcers	UpToDate (*uptodate.com*); Agency for Healthcare Research and Quality (AHRQ) (*ahrq.gov*);	UpToDate and AHRQ remain excellent online resources for identifying standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		Wound, Ostomy and Continence Nursing Society (WOCN) (*WOCN.org*)	
	Acute Myocardial Infarction	UpToDate (*uptodate.com*); AHA (*heart.org*); AMA (*www.ama-assn.org*)	UpToDate is used for updated information on current standards of care. AHA and AMA information are used to supplement clinical information.
	Urinary Tract Infection	UpToDate (*uptodate.com*); American Society of Nephrology (*asn-online.org*)	UpToDate and the American Society of Nephrology provide current standards for renal-related concerns and care.
	Sepsis	UpToDate (*uptodate.com*); Sepsis Alliance (*sepsis.org*); AMA (*ama-assn.org)*	UpToDate provides current standards of care related to the treatment of sepsis. Additional references provide further information for review.
	Adverse Drug Events	UpToDate (*uptodate.com*); CDC (*cdc.gov*); National Institutes of Health (NIH); (*ncbi.nim.hih.gov*); AHRQ *(ahrq.gov)*	UpToDate provides current standards of care. The CDC, NIH, and AHRQ provide additional references related to specific medications and interactions/ reactions associated with the medications.
	Falls	UpToDate (*uptodate.com*); American Geriatrics Society (*americangeriatrics.org*)	UpToDate provides current standards of care to prevent falls. The Geriatric Society provides additional information on preventing falls in the elderly population as well as follow-up treatments.
	Surgical Complications	UpToDate (*uptodate.com*); American College of Surgeons (*facs.org*); NIH (*ncbi.nim.nih.gov*)	UpToDate provides current standards of care related to various surgical procedures. The American College of Surgeons and NIH provide additional insights into various procedures, potential complications (expected and unexpected), and follow-up care.
Appeals		Appeals National Coverage Determination Guidelines, including language and provisions from the JIMMO v. Sebelius settlement	Medicare coverage is limited to services that are: • Reasonable and necessary for the diagnosis or treatment of an illness or injury • Within the scope of a defined Medicare benefit category

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
			• Consistent with professionally recognized standards of care • Appropriately delivered in the most suitable and safe setting.

7) Reviews by Geographic Area

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	11,437	84.00%
Rural	906	6.65%
Unknown	1,272	9.34%
Total	**13,615**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	214	72.05%
Rural	14	4.71%
Unknown	69	23.23%
Total	**297**	**100.00%**

8) Outreach and Collaboration with Beneficiaries

Strengthening Outreach Through Strategic Stakeholder Engagement

Building strong relationships with diverse stakeholder organizations is a central part of Acentra Health's outreach strategy. Across the regions it serves, Acentra Health actively cultivates and sustains professional partnerships that help extend the reach and impact of the BFCC-QIO program. Whether through one-on-one calls or structured virtual meetings, its direct engagement approach ensures timely and effective communication of program information and updates to stakeholders who serve Medicare beneficiaries.

Acentra Health continues to maintain a productive, collaborative relationship with CMS's Denver office. It regularly shares BFCC-QIO updates, participates in quarterly/annual meetings, and collaborates through joint conference calls with our shared audiences. During the 2024 Medicare open enrollment period, Acentra Health's Outreach team co-hosted multiple webinars with CMS's Region 8 staff, targeting a wide array of healthcare associations in their states.

Relationships with State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) partners in the region were keys. Acentra Health presented at the 2024 Colorado SHIP and SMP conference, attended by statewide staff and volunteers who serve about 10,000 beneficiaries. Through established relationships with rural health associations in Montana, Wyoming, and South Dakota, The Outreach team

disseminated information to more than 700 rural hospitals and clinics that collectively serve more than 21,000 Medicare beneficiaries.

Acentra Health's Chief Medical Officer, Jessica Whitley, MD, presented to regional Medical Societies at the CMS Region 8 Office quarterly meeting. More than 35 physicians responsible for the care of an estimated 5,000 Medicare beneficiaries in three states attended.

Multi-Channel Communication and Content Distribution

Outreach and communications efforts at Acentra Health employ multiple channels to inform stakeholders and beneficiaries about the BFCC-QIO program. These include:

- Newsletters – Acentra Health produces two newsletters: "Case Review Connections," a quarterly publication for providers and stakeholders, and "On the Healthcare Front," a monthly publication for beneficiaries. Combined, they reach more than 6,500 subscribers. The stakeholder newsletter has received a Gold MarCom Award and consistently exceeds industry open rate benchmarks.
- Video and Audio Platforms – Acentra Health maintains a YouTube channel and produces the podcast "Aging Health Matters" to broaden outreach to the Medicare population. The Case Status Tool video averages about 700 views per month and leads visitors to an interactive web page that draws more than 300,000 visits per month. Spanish-language videos are available to support the Spanish-speaking population. The podcast has surpassed 1,000 downloads and features guest experts discussing Medicare-related topics.
- Website and Accessibility – The Acentra Health website includes dedicated sections for beneficiaries, offering downloadable resources and program tools available in multiple languages via a page translator and several areas of Spanish-specific web content. The website is continuously monitored for compliance with Section 508 of the Americans with Disabilities Act to ensure accessibility for users with disabilities. A downloadable screen reader is available to support inclusive access.

9) IMMEDIATE ADVOCACY CASES

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
387	330	85.27%

10) EXAMPLE/SUCCESS STORY

A Medicare beneficiary's representative contacted Acentra Health with concerns about her mother's recent discharge from a healthcare facility. She stated the facility sent her mother home without a transitional care plan, therapy arrangements, or access to essential services. During the stay, the representative also stated, her mother experienced neglect and developed a pressure wound that required skilled nursing care, but the facility did not arrange for services before discharge. Additionally, the representative reported the facility failed to advocate for continued care and did not set up home health services. The representative voiced concerns that

these issues placed her mother at a serious risk of rehospitalization. Seeking help to resolve these issues, she reached out to Acentra Health.

The Clinical Reviewer (CR) reached out to the facility and initially spoke with the administrator, who acknowledged the concerns and directed the case to the director of nursing (DON). The DON stated the facility's case management team would re-engage with a home health provider to arrange for proper care and assess if it would accept the beneficiary back into the service.

The CR's follow-up call with the beneficiary's representative confirmed the DON had reached out and the case manager was actively collaborating with the family to secure home health services. The representative expressed satisfaction that case management was now involved and appreciated the support from Acentra Health, stating, "Thank you for helping and for escalating things for us."

11) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	100,402	62.58%
Male	60,025	37.42%
Unknown	0	0.00%
Total	**160,427**	**100.00%**
Race		
Asian	1,305	0.81%
Black	30,304	18.89%
Hispanic	3,584	2.23%
North American Native	334	0.21%
Other	1,427	0.89%
Unknown	1,095	0.68%
White	122,378	76.28%
Total	**160,427**	**100.00%**
Age		
Under 65	23,661	14.75%
65-70	22,903	14.28%
71-80	51,774	32.27%
81-90	47,947	29.89%
91+	14,142	8.82%
Total	**160,427**	**100.00%**

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	21,527
Total Number of Calls Answered	21,187
Total Number of Abandoned Calls	257
Average Length of Call Wait Times	00:00:23
Number of Calls Transferred by 1-800-Medicare	268

CONCLUSION

Acentra Health's outcomes and findings for this reporting period reflect the daily work performed to improve the quality of care delivered to Medicare beneficiaries. These case reviews not only support each beneficiary's experience and rights, but generate valuable data that can be used to enhance provider performance system-wide. Individual case insights help identify patterns and opportunities for broader quality improvement across the Medicare landscape. In addition, the data presented in this report reveal most Quality of Care reviews are initiated by concerns raised directly by beneficiaries or their representatives. This reinforces the central role that patient voices play in shaping the review process and driving significant improvements in care.

Acentra Health brings meaningful value to the Medicare program, its beneficiaries, their families and caregivers, and the healthcare providers who serve them. With a strong focus on safeguarding the rights of beneficiaries, Acentra Health partners with healthcare organizations to deliver education about quality standards, medically necessary care, and Medicare compliance. Its services support patients throughout the continuum of care; from early discharge concerns to urgent appeals and communication challenges.

- The complaints and appeals processes Acentra Health offers ensure beneficiaries have access to compassionate, expert advocates who listen and communicate the unique needs of each individual to providers. These concerns are addressed using nationally recognized care standards, helping providers enhance the quality of care delivered to future patients.
- The Immediate Advocacy program provides rapid, real-time solutions to healthcare concerns, often resolving communication breakdowns, language barriers, logistical issues, or challenges with access to equipment or services.
- When a concern about quality of care is confirmed through a medical record review, Acentra Health provides educational feedback to the provider, explaining how similar situations can be improved in the future. If a broader, systemic issue is identified, the case may be referred to the state's QIN-QIO for further support. These organizations provide technical assistance and may initiate a Quality Improvement Initiative to address the root cause of the issue.
- Acentra Health protects both Medicare beneficiaries and the Medicare Trust Fund by ensuring payments are made only for healthcare services that are reasonable, medically necessary, and delivered in the most appropriate setting.
- Acentra Health provides timely and clinically sound physician opinions for required 5- and 60-day reviews under Section 1867(d)(3) of EMTALA for potential violations, helping ensure emergency care standards are upheld.
- Through direct engagement with beneficiaries, families, providers, and community stakeholders, Acentra Health promotes patient-centered care and supports CMS's goals for equitable, high-quality healthcare. Educational outreach and engagement efforts are designed to empower beneficiaries to understand their rights, advocate for themselves, and make informed decisions about their care – regardless of geographic location, language, ability, or other barriers.

Acentra Health incorporates CMS's strategic goals throughout its operations. The work is essential to the Medicare program and makes a lasting impact on the lives of beneficiaries, caregivers, and families. By combining advocacy, education, review services, and a commitment to health equality, Acentra Health ensures quality healthcare is both protected and improved for those it serves.

APPENDIX

ACENTRA BFCC-QIO REGION 8 – STATE OF COLORADO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	461	6.81%
Medicare FFS Post-Acute Appeals	308	4.55%
Medicare Advantage Post-Acute Appeals	5,681	83.91%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	90	1.33%
Immediate Advocacy	205	3.03%
EMTALA	25	0.37%
Total	**6,770**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	10,847	62.11%
Male	6,617	37.89%
Unknown	0	0.00%
Total	**17,464**	**100.00%**
Race		
Asian	116	0.66%
Black	887	5.08%
Hispanic	458	2.62%
North American Native	50	0.29%
Other	126	0.72%
Unknown	140	0.80%
White	15,687	89.82%
Total	**17,464**	**100.00%**
Age		
Under 65	1,812	10.38%
65-70	1,815	10.39%
71-80	5,844	33.46%
81-90	6,030	34.53%
91+	1,963	11.24%
Total	**17,464**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	304	4.73%
1: Distinct Psychiatric Facility	3	0.05%
2: Distinct Rehabilitation Facility	117	1.82%
3: Distinct Skilled Nursing Facility	5,803	90.26%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	61	0.95%
N: Critical Access Hospital	64	1.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	8	0.12%
R: Hospice	64	1.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	5	0.08%
Total	**6,429**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

*Beginning on January 1, 2021, CMS began testing the inclusion of the Part A Hospice Benefit within the MA benefits package through the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	19	2	10.53%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	67	17	25.37%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	19	2	10.53%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	5	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	4	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	10	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	1	50.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	5	1	20.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	3	2	66.67%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	17	1	5.88%
Total	**159**	**26**	**16.35%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	461	7.15%
Medicare FFS Post-Acute Appeals	308	4.78%
Medicare Advantage Post-Acute Appeals	5,681	88.08%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**6,450**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	5,586	85.06%
Rural	129	1.96%
Unknown	852	12.97%
Total	**6,567**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	127	73.84%
Rural	0	0.00%
Unknown	45	26.16%
Total	**172**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
235	197	83.83%

ACENTRA BFCC-QIO REGION 8 – STATE OF MONTANA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	36	4.69%
Medicare FFS Post-Acute Appeals	69	8.98%
Medicare Advantage Post-Acute Appeals	570	74.22%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	9	1.17%
Immediate Advocacy	26	3.39%
EMTALA	58	7.55%
Total	**768**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,321	61.44%
Male	829	38.56%
Unknown	0	0.00%
Total	**2,150**	**100**
Race		
Asian	1,979	92.05%
Black	58	2.70%
Hispanic	57	2.65%
North American Native	23	1.07%
Other	21	0.98%
Unknown	7	0.33%
White	5	0.23%
Total	**2,150**	**100.00%**
Age		
Under 65	798	37.12%
65-70	638	29.67%
71-80	261	12.14%
81-90	261	12.14%
91+	192	8.93%
Total	**2,150**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	30	4.52%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	0.30%
3: Distinct Skilled Nursing Facility	589	88.70%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	4	0.60%
N: Critical Access Hospital	30	4.52%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	9	1.36%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**664**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	3	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices			
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	10	1	10.00%
Total	**18**	**1**	**5.56%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	36	5.33%
Medicare FFS Post-Acute Appeals	69	10.22%
Medicare Advantage Post-Acute Appeals	570	84.44%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**675**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	580	85.80%
Rural	83	12.28%
Unknown	13	1.92%
Total	**676**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	13	72.22%
Rural	3	16.67%
Unknown	2	11.11%
Total	**18**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
32	26	81.25%

ACENTRA BFCC-QIO REGION 8 – STATE OF NORTH DAKOTA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	81	12.68%
Medicare FFS Post-Acute Appeals	154	24.10%
Medicare Advantage Post-Acute Appeals	370	57.90%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	8	1.25%
Immediate Advocacy	21	3.29%
EMTALA	5	0.78%
Total	**639**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	725	55.13%
Male	590	44.87%
Unknown	0	0.00%
Total	**1,315**	**100.00%**
Race		
Asian	5	0.38%
Black	18	1.37%
Hispanic	0	0.00%
North American Native	39	2.97%
Other	14	1.06%
Unknown	10	0.76%
White	1,229	93.46%
Total	**1,315**	**100.00%**
Age		
Under 65	145	11.03%
65-70	132	10.04%
71-80	292	22.21%
81-90	477	36.27%
91+	269	20.46%
Total	**1,315**	**100.0%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	44	7.55%
1: Distinct Psychiatric Facility	1	0.17%
2: Distinct Rehabilitation Facility	27	4.63%
3: Distinct Skilled Nursing Facility	488	83.70%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	4	0.69%
N: Critical Access Hospital	13	2.23%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	4	0.69%
R: Hospice	2	0.34%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**583**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	3	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	3	1	33.33%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	1	100.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	1	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	6	0	0.00%
Total	**16**	**2**	**12.50%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	81	13.39%
Medicare FFS Post-Acute Appeals	154	25.45%
Medicare Advantage Post-Acute Appeals	370	61.16%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**605**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	485	79.90%
Rural	50	8.24%
Unknown	72	11.86%
Total	**607**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	15	93.75%
Rural	1	6.25%
Unknown	0	0.00%
Total	**16**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
22	21	95.45%

ACENTRA BFCC-QIO REGION 8 – STATE OF SOUTH DAKOTA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	79	17.79%
Medicare FFS Post-Acute Appeals	59	13.29%
Medicare Advantage Post-Acute Appeals	278	62.61%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	8	1.80%
Immediate Advocacy	20	4.50%
EMTALA	0	0.00%
Total	**444**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	13,412	62.78%
Male	7,952	37.22%
Unknown	0	0.00%
Total	**21,364**	**100.00%**
Race		
Asian	59	0.28%
Black	6,944	32.5%
Hispanic	27	0.13%
North American Native	22	0.10%
Other	110	0.51%
Unknown	137	0.64%
White	14,065	65.84%
Total	**21,364**	**100.00%**
Age		
Under 65	3,669	17.17%
65-70	3,282	15.36%
71-80	7,416	34.71%
81-90	5,479	25.65%
91+	1,518	7.11%
Total	**21,364**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	67	16.88%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	9	2.27%
3: Distinct Skilled Nursing Facility	307	77.33%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	0.50%
N: Critical Access Hospital	10	2.52%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	2	0.50%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**397**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

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Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	12	0	0.00%
Total	**12**	**0**	**0.00%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	79	18.99%
Medicare FFS Post-Acute Appeals	59	14.18%
Medicare Advantage Post-Acute Appeals	278	66.83%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**416**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	361	86.16%
Rural	28	6.68%
Unknown	30	7.16%
Total	**419**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	11	68.75%
Rural	2	12.50%
Unknown	3	18.75%
Total	**16**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
20	16	80.00%

ACENTRA BFCC-QIO REGION 8 – STATE OF UTAH

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	260	12.64%
Medicare FFS Post-Acute Appeals	185	8.99%
Medicare Advantage Post-Acute Appeals	1,532	74.48%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	17	0.83%
Immediate Advocacy	62	3.01%
EMTALA	1	0.05%
Total	**2,057**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	64,156	62.65%
Male	38,252	37.35%
Unknown	0	0.00%
Total	**102,408**	**100.00%**
Race		
Asian	1,104	1.08%
Black	21,586	21.08%
Hispanic	3,053	2.98%
North American Native	166	0.16%
Other	1,119	1.09%
Unknown	718	0.70%
White	74,662	72.91%
Total	**102,408**	**100.00%**
Age		
Under 65	15,400	15.04%
65-70	15,368	15.01%
71-80	32,467	31.70%
81-90	30,306	29.59%
91+	8,867	8.66%
Total	**102,408**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	191	9.79%
1: Distinct Psychiatric Facility	2	0.10%
2: Distinct Rehabilitation Facility	57	2.92%
3: Distinct Skilled Nursing Facility	1,663	85.24%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	19	0.97%
N: Critical Access Hospital	0	0.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	9	0.46%
R: Hospice	9	0.46%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	1	0.05%
Total	**1,951**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	8	1	12.50%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	1	100.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	1	100.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	1	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	6	1	16.67%
Total	**19**	**5**	**26.32%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	260	13.15%
Medicare FFS Post-Acute Appeals	185	9.36%
Medicare Advantage Post-Acute Appeals	1,532	77.49%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**1,977**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	1,667	81.64%
Rural	247	12.10%
Unknown	128	6.27%
Total	**2,042**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	21	84.00%
Rural	0	0.00%
Unknown	4	16.00%
Total	**25**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
67	61	91.04%

ACENTRA BFCC-QIO REGION 8 – STATE OF WYOMING

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	61	17.38%
Medicare FFS Post-Acute Appeals	11	3.13%
Medicare Advantage Post-Acute Appeals	262	74.64%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	6	1.71%
Immediate Advocacy	9	2.56%
EMTALA	2	0.57%
Total	**351**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	202	66.67%
Male	101	33.33%
Unknown	0	0.00%
Total	**303**	**100.00%**
Race		
Asian	3	0.99%
Black	234	77.23%
Hispanic	19	6.27%
North American Native	0	0.00%
Other	5	1.65%
Unknown	0	0.00%
White	42	13.86%
Total	**303**	**100.00%**
Age		
Under 65	42	13.86%
65-70	22	7.26%
71-80	140	46.20%
81-90	75	24.75%
91+	24	7.92%
Total	**303**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	38	11.55%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	29	8.81%
3: Distinct Skilled Nursing Facility	256	77.81%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	1	0.30%
N: Critical Access Hospital	5	1.52%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**329**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	**6**	**0**	**0.00%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	61	18.26%
Medicare FFS Post-Acute Appeals	11	3.29%
Medicare Advantage Post-Acute Appeals	262	78.44%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**334**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	301	88.01%
Rural	26	7.60%
Unknown	15	4.39%
Total	**342**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	6	75.00%
Rural	0	0.00%
Unknown	2	25.00%
Total	**8**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
11	9	81.82%

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