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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 6:
AR - LA - NM - OK - TX

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

REGION 6

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INTRODUCTION

Acentra Health is the designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 6, which includes: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. 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	8,203	14.48%
Medicare FFS Post-Acute Appeals	3,267	5.77%
Medicare Advantage Post-Acute Appeals	42,435	74.93%
Hospital Issued Notice of Non-Coverage Appeals	6	0.01%
Hospital Requested Review Appeals	7	0.01%
Quality of Care	553	0.98%
Immediate Advocacy	1,969	3.48%
EMTALA	193	0.34%
Total	**56,633**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, unspecific organism	33,108	28.30%
2. J189 – Pneumonia, unspecific organism	12,603	10.77%
3. N179 – Acute kidney failure, unspecified	12,402	10.60%
4. N390 – Urinary tract infection, site not specified	11,061	9.45%
5. I110 – Hypertensive heart disease with heart failure	9,824	8.40%
6. I130 – Hypertensive heart and chronic kidney disease with heart failure and Stage 1-4 chronic kidney disease or unspecified chronic kidney disease	9,283	7.93%
7. I214 – Non-ST elevation myocardial infarction	7,645	6.53%
8. U071 – COVID-19	7,435	6.35%
9. J9601 – Acute respiratory failure with hypoxia	7,084	6.05%
10. I480 – Paroxysmal atrial fibrillation	6,563	5.61%
Total	**117,008**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	5,511	9.95%
1: Distinct Psychiatric Facility	44	0.08%
2: Distinct Rehabilitation Facility	2,944	5.31%
3: Distinct Skilled Nursing Facility	45,355	81.86%
5: Clinic	0	
6: Distinct Dialysis Center Facility	1	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	
8: Independent-Based Rural Health Clinic	0	
9: Provider-Based Rural Health Clinic	21	0.04%
C: Freestanding Ambulatory Surgery Center	3	0.01%
G: End-Stage Renal Disease Unit	12	0.02%
H: Home Health Agency	127	0.23%
N: Critical Access Hospital	507	0.92%
O: Setting Does Not Fit Into Any Other Existing Setting Code	257	0.46%
Q: Long-Term Care Facility	217	0.39%
R: Hospice	182	0.33%
S: Psychiatric Unit of an Inpatient Facility	7	0.01%
T: Rehabilitation Unit of an Inpatient Facility	25	0.05%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.00%
Y: Federally Qualified Health Centers	3	0.01%
Z: Swing Bed Designation for Critical Access Hospitals	0	
Other	186	0.34%
Total	**55,405**	**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	9	3	33.33%
C02: Apparently did not make appropriate diagnoses and/or assessments	77	18	23.38%
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)]	314	29	9.24%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	109	24	22.02%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	29	4	13.79%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	15	5	33.33%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	24	12	50.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	23	1	4.35%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	5	1	20.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	47	16	34.04%
C11: Apparently did not demonstrate that the patient was ready for discharge	78	21	26.92%
C12: Apparently did not provide appropriate personnel and/or resources	12	0	0.00%
C13: Apparently did not order appropriate specialty consultations	10	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	5	1	20.00%
C15: Apparently did not effectively coordinate across disciplines	7	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	66	21	31.82%
C17: Apparently did not order/follow evidence-based practices	8	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	13	10	76.92%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	128	30	23.44%
Total	**979**	**196**	**20.02%**

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	8,203	14.60%	85.40%
Medicare FFS Post-Acute Appeals	3,267	52.00%	48.00%
Medicare Advantage Post-Acute Appeals	42,435	54.05%	45.95%
Hospital Issued Notice of Non-Coverage Appeals	6	50.00%	50.00%
Hospital Requested Review Appeals	7	42.86%	57.14%
Total	**53,918**	**47.92%**	**52.08%**

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	41,425	74.56%
Rural	5,437	9.79%
Unknown	8,696	15.65%
Total	**55,558**	**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	565	54.64%
Rural	120	11.61%
Unknown	349	33.75%
Total	**1,034**	**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 Dallas 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 6 staff, targeting a wide array of healthcare associations in their states. Additional highlights include contributing to the National Medicare Training Program and co-presenting with CMS regional staff during a quarterly meeting for Medical Society personnel with representation from five state medical associations.

Presentations in Region 6 also took place at State Health Insurance Assistance Program trainings for state directors in Louisiana, New Mexico, and Arkansas, reaching 50 attendees whose organizations serve about

20,000 Medicare beneficiaries. A connection with the office of Veterans Affairs provided an opportunity to speak directly to 460 veterans during a presentation at a Veterans Affairs Supportive Housing meeting in Texas. This group serves a large number of rural veterans in its area.

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
2,103	1,881	89.44%

10) EXAMPLE/SUCCESS STORY

A Medicare beneficiary was at a skilled nursing facility for physical therapy. The representative met with the administrator, who stated her father was progressing, and therapy would continue. Just a few days later, however, the beneficiary was discharged from therapy without notification when he went to the emergency department. The family then received a bill from the facility. Unable to resolve the issue with the facility, the representative requested assistance from Acentra Health.

The Clinical Reviewer (CR) contacted the business office at the facility. It was determined a case manager inappropriately gave a Notice of Medicare Non-coverage to the beneficiary, who had dementia. The representative from the business office stated the financial liability would be resolved and the social worker

who gave the inappropriate notice was no longer on staff. The CR followed up with the beneficiary's representative, who expressed how much she appreciated Acentra Health advocating for her father.

11) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	50,623	63.32%
Male	29,331	36.68%
Unknown	0	0.00%
Total	**79,954**	**100.00%**
Race		
Asian	173	0.22%
Black	17,522	21.92%
Hispanic	598	0.75%
North American Native	1,046	1.31%
Other	432	0.54%
Unknown	405	0.51%
White	59,778	74.77%
Total	**79,954**	**100.00%**
Age		
Under 65	14,370	17.97%
65-70	12,553	15.70%
71-80	26,265	32.85%
81-90	21,195	26.51%
91+	5,571	6.97%
Total	**79,954**	**100.00%**

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	116,181
Total Number of Calls Answered	114,324
Total Number of Abandoned Calls	1,393
Average Length of Call Wait Times	00:00:26
Number of Calls Transferred by 1-800-Medicare	1,494

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 6 – STATE OF ARKANSAS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	387	9.44%
Medicare FFS Post-Acute Appeals	90	2.20%
Medicare Advantage Post-Acute Appeals	3,501	85.39%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	29	0.71%
Immediate Advocacy	84	2.05%
EMTALA	9	0.22%
Total	**4,100**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	7,459	63.99%
Male	4,198	36.01%
Unknown	0	0.00%
Total	**11,657**	**100%**
Race		
Asian	16	0.14%
Black	2,869	24.61%
Hispanic	30	0.26%
North American Native	71	0.61%
Other	27	0.23%
Unknown	30	0.26%
White	8,614	73.90%
Total	**11,657**	**100.00%**
Age		
Under 65	2,400	20.59%
65-70	1,988	17.05%
71-80	3,645	31.27%
81-90	2,881	24.71%
91+	743	6.37%
Total	**11,657**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	176	4.49%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	193	4.92%
3: Distinct Skilled Nursing Facility	3,458	88.15%
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	1	0.03%
H: Home Health Agency	7	0.18%
N: Critical Access Hospital	56	1.43%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	27	0.69%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	2	0.05%
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	3	0.08%
Total	**3,923**	**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.

Provide the number of concerns by quality of care QRD Category Code and the number that were confirmed at the highest level of review, for completed quality of care reviews.

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	1	0	0.0%
C02: Apparently did not make appropriate diagnoses and/or assessments	6	1	16.67%
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)]	27	2	7.41%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	2	50.0%
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	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	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	2	50.00%
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	1	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	8	2	25.00%
Total	**59**	**9**	**15.25%**

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	387	9.73%
Medicare FFS Post-Acute Appeals	90	2.26%
Medicare Advantage Post-Acute Appeals	3,501	88.01%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**3,978**	**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	3,501	85.66%
Rural	397	9.71%
Unknown	189	4.62%
Total	**4,087**	**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	53	81.54%
Rural	2	3.08%
Unknown	10	15.38%
Total	**65**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
96	80	83.33%

ACENTRA BFCC-QIO REGION 6 – STATE OF LOUISIANA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	682	17.84%
Medicare FFS Post-Acute Appeals	113	2.96%
Medicare Advantage Post-Acute Appeals	2,771	72.50%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	2	0.05%
Quality of Care	61	1.60%
Immediate Advocacy	164	4.29%
EMTALA	29	0.76%
Total	**3,822**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	6,124	59.20%
Male	4,221	40.80%
Unknown	0	0.00%%
Total	**10,345**	**100.00%**
Race		
Asian	16	0.15%
Black	4,267	41.25%
Hispanic	65	0.63%
North American Native	11	0.11%
Other	29	0.28%
Unknown	69	0.67%
White	5,888	56.92%
Total	**10,345**	**100.00%**
Age		
Under 65	1,798	17.38%
65-70	1,687	16.31%
71-80	3,546	34.28%
81-90	2,534	24.49%
91+	780	7.54%
Total	**10,345**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	495	14.21%
1: Distinct Psychiatric Facility	1	0.03%
2: Distinct Rehabilitation Facility	152	4.36%
3: Distinct Skilled Nursing Facility	2,706	77.69%
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	1	0.03%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	7	0.20%
N: Critical Access Hospital	43	1.23%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	53	1.52%
R: Hospice	19	0.55%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	5	0.14%
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	0.03%
Total	**3,483**	**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	8	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)]	37	3	8.11%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	8	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)	3	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	13	9	69.23%
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	1	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)	5	1	20.00%
C17: Apparently did not order/follow evidence-based practices	5	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	30	7	23.33%
Total	**128**	**20**	**15.63%**

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	682	19.11%
Medicare FFS Post-Acute Appeals	113	3.17%
Medicare Advantage Post-Acute Appeals	2,771	77.66%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	2	0.06%
Total	**3,568**	**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	66	1.80%
Rural	3,336	91.05%
Unknown	262	7.15%
Total	**3,664**	**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	0	0.00%
Rural	107	81.06%
Unknown	25	18.94%
Total	**132**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
181	156	86.19%

ACENTRA BFCC-QIO REGION 6 – STATE OF NEW MEXICO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	313	16.06%
Medicare FFS Post-Acute Appeals	126	6.46%
Medicare Advantage Post-Acute Appeals	1,359	69.73%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	23	1.18%
Immediate Advocacy	114	5.85%
EMTALA	14	0.72%
Total	**1,949**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,152	57.91%
Male	2,291	42.09%
Unknown	0	0.00%
Total	**5,443**	**100.00%**
Race		
Asian	12	0.22%
Black	203	3.73%
Hispanic	283	5.20%
North American Native	133	2.44%
Other	95	1.75%
Unknown	65	1.19%
White	4,652	85.47%
Total	**5,443**	**100.00%**
Age		
Under 65	885	16.26%
65-70	755	13.87%
71-80	1,852	34.03%
81-90	1,496	27.48%
91+	455	8.36%
Total	**5,443**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	210	11.99%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	89	5.08%
3: Distinct Skilled Nursing Facility	1,427	81.45%
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	16	0.91%
N: Critical Access Hospital	2	0.11%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	6	0.34%
S: Psychiatric Unit of an Inpatient Facility	1	0.06%
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	0.06%
Total	**1,752**	**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	5	3	60.00%
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)]	24	4	16.67%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	1	33.33%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	1	100.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	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	2	1	50.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	2	50.00%
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	1	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	1	100.00%
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	6	5	83.33%
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	**60**	**19**	**31.67%**

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	313	17.41%
Medicare FFS Post-Acute Appeals	126	7.01%
Medicare Advantage Post-Acute Appeals	1,359	75.58%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**1,798**	**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	1,448	77.31%
Rural	125	6.67%
Unknown	300	16.02%
Total	**1,873**	**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	25	40.32%
Rural	1	1.61%
Unknown	36	58.06%
Total	**62**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
122	112	91.80%

ACENTRA BFCC-QIO REGION 6 – STATE OF OKLAHOMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	267	6.15%
Medicare FFS Post-Acute Appeals	258	5.94%
Medicare Advantage Post-Acute Appeals	3,603	83.02%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	58	1.34%
Immediate Advocacy	138	3.18%
EMTALA	16	0.37%
Total	**4,340**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	7,769	64.66%
Male	4,247	35.34%
Unknown	0	0.00%
Total	**12,016**	**100.00%**
Race		
Asian	49	0.41%
Black	1,442	12.00%
Hispanic	87	0.72%
North American Native	794	6.61%
Other	124	1.03%
Unknown	43	0.36%
White	9,477	78.87%
Total	**12,016**	**100.00%**
Age		
Under 65	2,267	18.87%
65-70	1,862	15.50%
71-80	3,799	31.62%
81-90	3,264	27.16%
91+	824	6.86%
Total	**12,016**	**100.0**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	196	4.71%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	45	1.08%
3: Distinct Skilled Nursing Facility	3,716	89.26%
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	16	0.38%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	28	0.67%
N: Critical Access Hospital	135	3.24%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	5	0.12%
R: Hospice	20	0.48%
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	2	0.05%
Total	**4,163**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

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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	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	11	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)]	28	2	7.14%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	11	1	9.09%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	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	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	3	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	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	7	1	14.29%
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)	8	3	37.50%
C17: Apparently did not order/follow evidence-based practices	1	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	3	0	0.00%
Total	**77**	**7**	**9.09%**

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	267	6.47%
Medicare FFS Post-Acute Appeals	258	6.25%
Medicare Advantage Post-Acute Appeals	3,603	87.28%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**4,128**	**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	3,614	85.74%
Rural	202	4.79%
Unknown	399	9.47%
Total	**4,215**	**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	54	67.50%
Rural	3	3.75%
Unknown	23	28.75%
Total	**80**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
156	133	85.26%

ACENTRA BFCC-QIO REGION 6 – STATE OF TEXAS

8) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	6,558	15.47%
Medicare FFS Post-Acute Appeals	2,677	6.31%
Medicare Advantage Post-Acute Appeals	31,181	73.53%
Hospital Issued Notice of Non-Coverage Appeals	6	0.01%
Hospital Requested Review Appeals	5	0.01%
Quality of Care	384	0.91%
Immediate Advocacy	1,468	3.46%
EMTALA	125	0.29%
Total	**42,404**	**100.00%**

9) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	26,322	64.54%
Male	14,459	35.46%
Unknown	0	0.00%
Total	**40,781**	**100.00%**
Race		
Asian	81	0.20%
Black	8,770	21.51%
Hispanic	135	0.33%
North American Native	39	0.10%
Other	157	0.38%
Unknown	201	0.49%
White	31,398	76.99%
Total	**40,781**	**100.00%**
Age		
Under 65	7,053	17.29%
65-70	6,184	15.16%
71-80	13,588	33.32%
81-90	11,141	27.32%
91+	2,815	6.90%
Total	**40,781**	**100.00%**

10) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	3,949	9.73%
1: Distinct Psychiatric Facility	14	0.03%
2: Distinct Rehabilitation Facility	2,411	5.94%
3: Distinct Skilled Nursing Facility	33,592	82.75%
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	4	0.01%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	10	0.02%
H: Home Health Agency	57	0.14%
N: Critical Access Hospital	254	0.63%
O: Setting Does Not Fit Into Any Other Existing Setting Code	4	0.01%
Q: Long-Term Care Facility	154	0.38%
R: Hospice	96	0.24%
S: Psychiatric Unit of an Inpatient Facility	7	0.02%
T: Rehabilitation Unit of an Inpatient Facility	18	0.04%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	2	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	21	0.05%
Total	**40,593**	**100.00%**

11) 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	7	3	42.86%
C02: Apparently did not make appropriate diagnoses and/or assessments	48	15	31.25%
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)]	203	22	10.84%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	83	20	24.10%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	15	4	26.67%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	12	4	33.33%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	23	12	52.17%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	16	1	6.25%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	5	1	20.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	30	6	20.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	53	16	30.19%
C12: Apparently did not provide appropriate personnel and/or resources	12	0	0.00%
C13: Apparently did not order appropriate specialty consultations	9	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	4	1	25.00%
C15: Apparently did not effectively coordinate across disciplines	5	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	51	16	31.37%
C17: Apparently did not order/follow evidence-based practices	1	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	7	5	71.43%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	34	4	11.76%
Total	**618**	**130**	**21.04%**

12) 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	6,558	16.22%
Medicare FFS Post-Acute Appeals	2,677	6.62%
Medicare Advantage Post-Acute Appeals	31,181	77.13%
Hospital Issued Notice of Non-Coverage Appeals	6	0.01%
Hospital Requested Review Appeals	5	0.01%
Total	**40,427**	**100.00%**

13) 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	32,796	78.61%
Rural	1,377	3.30%
Unknown	7,546	18.09%
Total	**41,719**	**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	433	62.30%
Rural	7	1.01%
Unknown	255	36.69%
Total	**695**	**100.00%**

14) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
1,548	1,400	90.44%

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