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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 4:
AL – FL – GA – KY – MS – NC – SC – TN

www.acentraqio.com

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

REGION 4

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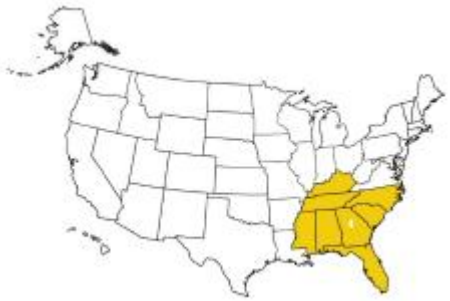
INTRODUCTION

Acentra Health is the designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 4, which includes: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. 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	22,844	17.05%
Medicare FFS Post-Acute Appeals	6,624	4.94%
Medicare Advantage Post-Acute Appeals	97,900	73.08%
Hospital Issued Notice of Non-Coverage Appeals	18	0.01%
Hospital Requested Review Appeals	89	0.07%
Quality of Care	1,220	0.91%
Immediate Advocacy	4,973	3.71%
EMTALA	286	0.21%
Total	**133,954**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, unspecific organism	84,807	27.90%
2. N390 – Urinary tract infection, site not specified	31,157	10.25%
3. J189 – Pneumonia, unspecific organism	31,014	10.20%
4. N179 – Acute kidney failure, unspecified	28,371	9.33%
5. I130 – Hypertensive heart and chronic kidney disease with heart failure and Stage 1-4 chronic kidney disease or unspecified chronic kidney disease	26,548	8.73%
6. I110 – Hypertensive heart disease with heart failure	25,028	8.23%
7. U071 – COVID-19	22,887	7.53%
8. I480 – Paroxysmal atrial fibrillation	19,173	6.31%
9. I214 – Non-ST elevation myocardial infarction	19,091	6.28%
10. J9601 – Acute respiratory failure with hypoxia	15,920	5.24%
Total	**303,996**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	20,296	15.53%
1: Distinct Psychiatric Facility	148	0.11%
2: Distinct Rehabilitation Facility	3,056	2.34%
3: Distinct Skilled Nursing Facility	103,443	79.17%
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	18	0.01%
9: Provider-Based Rural Health Clinic	2	0.00%
C: Freestanding Ambulatory Surgery Center	11	0.01%
G: End-Stage Renal Disease Unit	4	0.00%
H: Home Health Agency	1,119	0.86%
N: Critical Access Hospital	887	0.68%
O: Setting Does Not Fit Into Any Other Existing Setting Code	544	0.42%
Q: Long-Term Care Facility	332	0.25%
R: Hospice	771	0.59%
S: Psychiatric Unit of an Inpatient Facility	0	
T: Rehabilitation Unit of an Inpatient Facility	22	0.02%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	
Y: Federally Qualified Health Centers	1	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	
Other	5	0.00%
Total	**130,660**	**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	18	3	16.67%
C02: Apparently did not make appropriate diagnoses and/or Assessments	204	26	12.75%
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)]	717	107	14.92%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	312	43	13.78%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	40	10	25.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	14	3	21.43%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	44	15	34.09%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	54	2	3.70%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	28	8	28.57%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	66	12	18.18%
C11: Apparently did not demonstrate that the patient was ready for Discharge	118	18	15.25%
C12: Apparently did not provide appropriate personnel and/or resources	3	1	33.33%
C13: Apparently did not order appropriate specialty consultations	11	3	27.27%
C14: Apparently specialty consultation process was not completed in a timely manner	16	2	12.50%
C15: Apparently did not effectively coordinate across disciplines	10	3	30.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	259	44	16.99%
C17: Apparently did not order/follow evidence-based practices	28	9	32.14%
C18: Apparently did not provide medical record documentation that impacts patient care	34	21	61.76%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	182	10	5.49%
Total	**2,158**	**340**	**15.76%**

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	22,844	10.86%	89.14%
Medicare FFS Post-Acute Appeals	6,624	46.97%	53.03%
Medicare Advantage Post-Acute Appeals	97,900	54.13%	45.87%
Hospital Issued Notice of Non-Coverage Appeals	18	33.33%	66.67%
Hospital Requested Review Appeals	89	30.34%	69.66%
Total	**127,475**	**45.98%**	**54.02%**

6) Evidence Used in Decision-Making

The table that follows describes the one to two most common types of evidence or standards 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 one to three of the most highly utilized types of evidence/standards of care to support Acentra Health Review Coordinators and the independent Peer Reviewers decisions for the specific list of diagnostic categories provided in the table. A brief statement of the rationale for selecting the specific evidence or standards of care is also included.

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*);	UpToDate and AHRQ remain excellent online resources for identifying standards of care and practice guidelines. WOCN provides

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		Agency for Healthcare Research and Quality (AHRQ) (*ahrq.gov*); Wound, Ostomy and Continence Nursing Society (WOCN) (*WOCN.org*)	nursing guidelines for staging and care of pressure ulcers.
	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	Medicare coverage is limited to services that are:

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		from the JIMMO v. Sebelius settlement	• Reasonable and necessary for the diagnosis or treatment of an illness or injury • Within the scope of a defined Medicare benefit category • 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	116,971	89.10%
Rural	5,445	4.15%
Unknown	8,859	6.75%
Total	**131,275**	**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	1,470	**58.87%**
Rural	60	2.40%
Unknown	967	38.73%
Total	**2,497**	**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 Atlanta office. It regularly shares key BFCC-QIO updates, participates in quarterly/annual meetings, and collaborates through joint conference calls to our shared audiences. During the 2024 Medicare open enrollment period, Acentra Health's Outreach team co-hosted multiple webinars with CMS's Region 4 staff, targeting a wide array of healthcare associations in the eight states.

These included:

- Home health, hospice, and palliative care organizations
- Rural health departments and associations
- Nursing home associations
- Hospital associations

Collectively, these organizations represent more than 50,000 healthcare professionals involved in direct contact with the Medicare population. More than 250 staff members participated in the webinars, ultimately supporting outreach to an estimated 10,000 Medicare beneficiaries across the region.

Partnerships with SHIP and SMP Organizations

Acentra Health has built strong partnerships with State Health Insurance Assistance Programs (SHIP) and Senior Medicare Patrol (SMP) organizations throughout its service area. It proudly supports the GeorgiaCares program, including its Medicare Improvements for Patients and Providers Act grant application. GeorgiaCares serves as both the SHIP and SMP organization in the state and has counseled more than 56,000 individuals on Medicare-related topics. During open enrollment, the Outreach team conducted an educational presentation for GeorgiaCares staffers, helping them better understand offerings to support the 90,000 Medicare beneficiaries they serve.

Acentra Health also continues to share timely announcements and updates with GeorgiaCares and the Georgia Aging and Disability Network. Additionally, Acentra Health presented at four SHIP/SMP trainings in South Carolina in 2024. Attendees received educational resources, key contact information, and a follow-up survey link to provide feedback and measure impact for continuous improvement.

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
5,208	4,736	90.94%

10) Example/Success Story

The beneficiary was referred to a gastroenterologist for assistance with digestive issues. Sadly, he was continuously losing weight. A representative for the beneficiary had been unable to get an appointment with the doctor and was concerned because the beneficiary was not doing well. She did not know this was the same office the beneficiary had been seen in several years prior with a different doctor. The doctor's office manager did not want to schedule the appointment because the beneficiary had previously left the practice. His representative reached out to Acentra Health for assistance with reaching out to the doctor's office.

The Clinical Reviewer (CR) from Acentra Health reached out to the practice manager. The practice manager explained that staff were trying to review all new patients with a care history over the previous three years to limit transfers. Also, the doctor was not sure he could help the beneficiary. The practice manager stated she would call the beneficiary's wife to better explain the office policy.

The CR then followed up with the beneficiary's representative to provide a case update. The representative was happy because the doctor's office agreed to set up an appointment. She asked if she could call or write a letter to Acentra Health to explain her satisfaction with the outcome of the intervention.

11) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	178,550	62.18%
Male	108,585	37.82%
Unknown	0	0.00%
Total	**287,135**	**100.00%**
Race		
Asian	1,030	0.36%
Black	69,493	24.20%
Hispanic	4,167	1.45%
North American Native	582	0.20%
Other	1,980	0.69%
Unknown	2,101	0.73%
White	207,782	72.36%
Total	**287,135**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Age		
Under 65	44,963	15.66%
65-70	39,714	13.83%
71-80	92,255	32.13%
81-90	83,162	28.96%
91+	27,041	9.42%
Total	**287,135**	**100.00%**

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	292,668
Total Number of Calls Answered	287,434
Total Number of Abandoned Calls	4,016
Average Length of Call Wait Times	00:00:26
Number of Calls Transferred by 1-800-Medicare	3,418

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 also 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 that 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 beneficiaries and the Medicare Trust Fund by ensuring payments are made only for 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 HEALTH BFCC-QIO REGION 4 – STATE OF ALABAMA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	1,025	14.25%
Medicare FFS Post-Acute Appeals	221	3.07%
Medicare Advantage Post-Acute Appeals	5,642	78.43%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	2	0.03%
Quality of Care	46	0.64%
Immediate Advocacy	239	3.32%
EMTALA	19	0.26%
Total	**7,194**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	11,328	62.47%
Male	6,806	37.53%
Unknown	0	0.00%
Total	**18,134**	**100.00%**
Race		
Asian	17	0.09%
Black	6,052	33.37%
Hispanic	26	0.14%
North American Native	26	0.14%
Other	40	0.22%
Unknown	59	0.33%
White	11,914	65.70%
Total	**18,134**	**100.00%**
Age		
Under 65	3,396	18.73%
65-70	2,793	15.40%
71-80	6,149	33.91%
81-90	4,512	24.88%
91+	1,284	7.08%
Total	**18,134**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	733	10.77%
1: Distinct Psychiatric Facility	1	0.01%
2: Distinct Rehabilitation Facility	306	4.50%
3: Distinct Skilled Nursing Facility	5,700	83.76%
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	0.01%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	20	0.29%
N: Critical Access Hospital	14	0.21%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	9	0.13%
R: Hospice	21	0.31%
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	**6,805**	**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	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or Assessments	9	1	11.11%
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)]	35	3	8.57%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	6	0	0.00%
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	2	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)	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	5	2	40.00%
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	1	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)	10	2	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	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	9	1	11.11%
Total	**89**	**11**	**12.36%**

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	1,025	14.88%
Medicare FFS Post-Acute Appeals	221	3.21%
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Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	2	0.03%
Total	**6,890**	**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	5,993	86.78%
Rural	317	4.59%
Unknown	596	8.63%
Total	**6,906**	**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	71	78.02%
Rural	3	3.30%
Unknown	17	18.68%
Total	**91**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
247	225	91.09%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF FLORIDA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	13,019	30.89%
Medicare FFS Post-Acute Appeals	2,644	6.27%
Medicare Advantage Post-Acute Appeals	23,459	55.65%
Hospital Issued Notice of Non-Coverage Appeals	2	0.00%
Hospital Requested Review Appeals	3	0.01%
Quality of Care	493	1.17%
Immediate Advocacy	2,477	5.88%
EMTALA	54	0.13%
Total	**42,151**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	71,382	60.86%
Male	45,899	39.14%
Unknown	0	0.00%
Total	**117,281**	**100.00%**
Race		
Asian	552	0.47%
Black	18,572	15.84%
Hispanic	3,654	3.12%
North American Native	153	0.13%
Other	1,162	0.99%
Unknown	1,068	0.91%
White	92,120	78.55%
Total	**117,281**	**100.00%**
Age		
Under 65	17,884	15.25%
65-70	14,447	12.32%
71-80	35,306	30.10%
81-90	36,024	30.72%
91+	13,620	11.61%
Total	**117,281**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	11,078	27.90%
1: Distinct Psychiatric Facility	118	0.30%
2: Distinct Rehabilitation Facility	1,662	4.19%
3: Distinct Skilled Nursing Facility	25,470	64.15%
5: Clinic	1	0.00%
6: Distinct Dialysis Center Facility	1	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	90	0.23%
N: Critical Access Hospital	57	0.14%
O: Setting Does Not Fit Into Any Other Existing Setting Code	692	1.74%
Q: Long-Term Care Facility	145	0.37%
R: Hospice	373	0.94%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	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	17	0.04%
Total	**39,705**	**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	10	1	10.00%
C02: Apparently did not make appropriate diagnoses and/or Assessments	92	12	13.04%
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)]	309	37	11.97%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	105	20	19.05%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	16	3	18.75%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	5	1	20.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	14	1	7.14%
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	17	6	35.29%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	30	8	26.67%
C11: Apparently did not demonstrate that the patient was ready for discharge	54	8	14.81%
C12: Apparently did not provide appropriate personnel and/or resources	2	1	50.00%
C13: Apparently did not order appropriate specialty consultations	5	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	2	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	78	20	25.64%
C17: Apparently did not order/follow evidence-based practices	10	4	40.00%
C18: Apparently did not provide medical record documentation that impacts patient care	10	7	70.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	141	23	16.31%
Total	**928**	**154**	**16.59%**

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	13,019	33.27%
Medicare FFS Post-Acute Appeals	2,644	6.76%
Medicare Advantage Post-Acute Appeals	23,459	59.96%
Hospital Issued Notice of Non-Coverage Appeals	2	0.01%
Hospital Requested Review Appeals	3	0.01%
Total	**39,127**	**10.00%**

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	38,248	91.55%
Rural	370	0.89%
Unknown	3,159	7.56%
Total	**41,777**	**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	648	63.22%
Rural	0	0.00%
Unknown	377	36.78%
Total	**1,025**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
2,560	2,340	91.41%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF GEORGIA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	3,153	21.69%
Medicare FFS Post-Acute Appeals	665	4.57%
Medicare Advantage Post-Acute Appeals	9,873	67.91%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	4	0.03%
Quality of Care	155	1.07%
Immediate Advocacy	637	4.38%
EMTALA	51	0.35%
Total	**14,538**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	24,288	62.24%
Male	14,736	37.76%
Unknown	0	0.00%
Total	**39,024**	**100.00%**
Race		
Asian	196	0.50%
Black	16,210	41.54%
Hispanic	170	0.44%
North American Native	7	0.02%
Other	206	0.53%
Unknown	285	0.73%
White	21,950	56.25%
Total	**39,024**	**100.00%**
Age		
Under 65	7,064	18.10%
65-70	5,680	14.56%
71-80	13,379	34.28%
81-90	10,407	26.67%
91+	2,494	6.39%
Total	**39,024**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	2,826	21.08%
1: Distinct Psychiatric Facility	4	0.03%
2: Distinct Rehabilitation Facility	268	2.00%
3: Distinct Skilled Nursing Facility	9,484	70.76%
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	322	2.40%
N: Critical Access Hospital	338	2.52%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	35	0.26%
R: Hospice	118	0.88%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.01%
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	7	0.05%
Total	**13,403**	**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	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or Assessments	23	3	13.04%
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)]	123	35	28.46%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	28	3	10.71%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	7	2	28.57%
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	17	13	76.47%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	13	1	7.69%
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	5	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for Discharge	12	1	8.33%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	3	1	33.33%
C14: Apparently specialty consultation process was not completed in a timely manner	4	1	25.00%
C15: Apparently did not effectively coordinate across disciplines	2	1	50.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	17	7	41.18%
C17: Apparently did not order/follow evidence-based practices	10	4	40.00%
C18: Apparently did not provide medical record documentation that impacts patient care	8	7	87.50%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	24	5	20.83%
Total	**304**	**85**	**27.96%**

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	3,153	23.02%
Medicare FFS Post-Acute Appeals	665	4.86%
Medicare Advantage Post-Acute Appeal	9,873	72.09%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	4	0.03%
Total	**13,695**	**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	12,698	91.76%
Rural	675	4.88%
Unknown	466	3.37%
Total	**13,839**	**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	161	52.96%
Rural	13	4.28%
Unknown	130	42.76%
Total	**304**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
664	612	92.17%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF KENTUCKY

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	548	4.23%
Medicare FFS Post-Acute Appeals	554	4.27%
Medicare Advantage Post-Acute Appeals	11,532	88.97%
Hospital Issued Notice of Non-Coverage Appeals	1	0.01%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	160	1.23%
Immediate Advocacy	163	1.26%
EMTALA	4	0.03%
Total	**12,962**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	19,898	65.22%
Male	10,612	34.78%
Unknown	0	0.00%
Total	**30,510**	**100.00%**
Race		
Asian	63	0.21%
Black	3,574	11.71%
Hispanic	42	0.14%
North American Native	25	0.08%
Other	61	0.20%
Unknown	110	0.36%
White	26,635	87.30%
Total	**30,510**	**100.00%**
Age		
Under 65	4,280	14.03%
65-70	4,630	15.18%
71-80	10,653	34.92%
81-90	8,543	28.00%
91+	2,404	7.88%
Total	**30,510**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	478	3.82%
1: Distinct Psychiatric Facility	2	0.02%
2: Distinct Rehabilitation Facility	143	1.14%
3: Distinct Skilled Nursing Facility	11,493	91.94%
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	19	0.15%
9: Provider Based Rural Health Clinic	1	0.01%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	40	0.32%
N: Critical Access Hospital	244	1.95%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	14	0.11%
R: Hospice	61	0.49%
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	6	0.05%
Total	**12,501**	**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	19	1	5.26%
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)]	44	6	13.64%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	93	2	2.15%
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	1	100.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	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	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for Discharge	12	2	16.67%
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)	100	2	2.00%
C17: Apparently did not order/follow evidence-based practices	3	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	102	4	3.92%
Total	**386**	**19**	**4.92%**

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	548	4.34%
Medicare FFS Post-Acute Appeals	554	4.38%
Medicare Advantage Post-Acute Appeals	11,532	91.27%
Hospital Issued Notice of Non-Coverage Appeals	1	0.01%
Hospital Requested Review Appeals	0	0.00%
Total	**12,635**	**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	9,580	75.34%
Rural	1,785	14.04%
Unknown	1,351	10.62%
Total	**12,716**	**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	106	26.70%
Rural	23	5.79%
Unknown	268	67.51%
Total	**397**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
180	162	90.00%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF MISSISSIPPI

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	472	17.80%
Medicare FFS Post-Acute Appeals	86	3.24%
Medicare Advantage Post-Acute Appeals	1,912	72.10%
Hospital Issued Notice of Non-Coverage Appeals	15	0.57%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	22	0.83%
Immediate Advocacy	122	4.60%
EMTALA	23	0.87%
Total	**2,652**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,930	62.48%
Male	2,960	37.52%
Unknown	0	0.00%
Total	**7,890**	**100.00%**
Race		
Asian	35	0.44%
Black	3,569	45.23%
Hispanic	13	0.16%
North American Native	21	0.27%
Other	19	0.24%
Unknown	17	0.22%
White	4,216	53.43%
Total	**7,890**	**100.00%**
Age		
Under 65	1,825	23.13%
65-70	1,295	16.41%
71-80	2,499	31.67%
81-90	1,845	23.38%
91+	426	5.40%
Total	**7,890**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	437	17.55%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	66	2.65%
3: Distinct Skilled Nursing Facility	1,856	74.54%
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	6	0.24%
N: Critical Access Hospital	99	3.98%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	9	0.36%
R: Hospice	16	0.64%
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	0.04%
Total	**2,490**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

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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	1	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)]	13	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	7	1	14.29%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	7	4	57.14%
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	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	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	2	1	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	1	1	100.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	1	50.00%
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	13	5	38.46%
Total	**49**	**13**	**26.53%**

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	472	18.99%
Medicare FFS Post-Acute Appeals	86	3.46%
Medicare Advantage Post-Acute Appeals	1,912	76.94%
Hospital Issued Notice of Non-Coverage Appeals	15	0.60%
Hospital Requested Review Appeals	0	0.00%
Total	**2,485**	**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	2,210	87.77%
Rural	159	6.31%
Unknown	149	5.92%
Total	**2,518**	**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	28	57.14%
Rural	2	4.08%
Unknown	19	38.78%
Total	**49**	**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	114	93.44%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF NORTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	2,054	6.99%
Medicare FFS Post-Acute Appeals	1,377	4.69%
Medicare Advantage Post-Acute Appeals	25,093	85.45%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	80	0.27%
Quality of Care	128	0.44%
Immediate Advocacy	562	1.91%
EMTALA	72	0.25%
Total	**29,366**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	41,809	62.90%
Male	24,659	37.10%
Unknown	0	0.00%
Total	**66,468**	**100.00%**
Race		
Asian	148	0.22%
Black	21,301	32.05%
Hispanic	194	0.29%
North American Native	250	0.38%
Other	426	0.64%
Unknown	473	0.71%
White	43,676	65.71%
Total	**66,468**	**100.00%**
Age		
Under 65	9,430	14.19%
65-70	9,854	14.83%
71-80	21,726	32.69%
81-90	19,570	29.44%
91+	5,888	8.86%
Total	**66,468**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	1,971	6.90%
1: Distinct Psychiatric Facility	2	0.01%
2: Distinct Rehabilitation Facility	87	0.30%
3: Distinct Skilled Nursing Facility	25,961	90.93%
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	3	0.01%
H: Home Health Agency	319	1.12%
N: Critical Access Hospital	66	0.23%
O: Setting Does Not Fit Into Any Other Existing Setting Code	20	0.07%
Q: Long-Term Care Facility	19	0.07%
R: Hospice	71	0.25%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	19	0.07%
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	13	0.05%
Total	**28,551**	**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	4	2	50.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	34	3	8.82%
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)]	66	3	4.55%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	28	2	7.14%
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	0	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)	8	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	13	2	15.38%
C11: Apparently did not demonstrate that the patient was ready for Discharge	13	1	7.69%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultations	1	1	100.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	17	1	5.88%
C17: Apparently did not order/follow evidence-based practices	3	1	33.33%
C18: Apparently did not provide medical record documentation that impacts patient care	7	2	28.57%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	16	0	0.00%
Total	**216**	**18**	**8.33%**

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	2,054	7.18%
Medicare FFS Post-Acute Appeal	1,377	4.81%
Medicare Advantage Post-Acute Appeals	25,093	87.73%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	80	0.28%
Total	**28,604**	**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	26,617	92.57%
Rural	980	3.41%
Unknown	1,157	4.02%
Total	**28,754**	**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	210	80.46%
Rural	1	0.38%
Unknown	50	19.16%
Total	**261**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
589	535	90.83%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF SOUTH CAROLINA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	1,205	14.83%
Medicare FFS Post-Acute Appeals	500	6.15%
Medicare Advantage Post-Acute Appeals	6,066	74.65%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	55	0.68%
Immediate Advocacy	290	3.57%
EMTALA	10	0.12%
Total	**8,126**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	4,699	63.16%
Male	2,741	36.84%
Unknown	0	0.00%
Total	**7,440**	**100.00%**
Race		
Asian	24	0.32%
Black	356	4.78%
Hispanic	73	0.98%
North American Native	34	0.46%
Other	59	0.79%
Unknown	73	0.98%
White	6,821	91.68%
Total	**7,440**	**100.00%**
Age		
Under 65	821	11.03%
65-70	906	12.18%
71-80	2,441	32.81%
81-90	2,270	30.51%
91+	1,002	13.47%
Total	**7,440**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	968	12.69%
1: Distinct Psychiatric Facility	1	0.01%
2: Distinct Rehabilitation Facility	215	2.82%
3: Distinct Skilled Nursing Facility	6,212	81.43%
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	0.01%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	164	2.15%
N: Critical Access Hospital	9	0.12%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	35	0.46%
R: Hospice	21	0.28%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.01%
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	0.03%
Total	**7,629**	**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	9	1	11.11%
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	5	18.52%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	9	1	11.11%
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	2	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	1	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 consultation	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)	4	1	25.00%
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	11	2	18.18%
Total	**69**	**12**	**17.39%**

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	1,205	15.51%
Medicare FFS Post-Acute Appeals	500	6.43%
Medicare Advantage Post-Acute Appeals	6,066	78.06%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**7,771**	**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	7,327	91.64%
Rural	166	2.08%
Unknown	502	6.28%
Total	**7,995**	**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	46	65.71%
Rural	0	0.00%
Unknown	24	34.29%
Total	**70**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
300	279	93.00%

ACENTRA HEALTH BFCC-QIO REGION 4 – STATE OF TENNESSEE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	1,367	8.03%
Medicare FFS Post-Acute Appeals	593	3.48%
Medicare Advantage Post-Acute Appeals	14,354	84.34%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	162	0.95%
Immediate Advocacy	482	2.83%
EMTALA	61	0.36%
Total	**17,019**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	896	63.01%
Male	526	36.99%
Unknown	0	0.00%
Total	**1,422**	**100.00%**
Race		
Asian	2	0.14%
Black	51	3.59%
Hispanic	5	0.35%
North American Native	67	4.71%
Other	14	0.98%
Unknown	8	0.56%
White	1,275	89.66%
Total	**1,422**	**100.00%**
Age		
Under 65	149	10.48%
65-70	274	19.27%
71-80	342	24.05%
81-90	445	31.29%
91+	212	14.91%
Total	**1,422**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	1,013	6.18%
1: Distinct Psychiatric Facility	5	0.03%
2: Distinct Rehabilitation Facility	354	2.16%
3: Distinct Skilled Nursing Facility	14,852	90.61%
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	65	0.40%
N: Critical Access Hospital	19	0.12%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	56	0.34%
R: Hospice	0	0.00%
S: Psychiatric Unit of an Inpatient Facility	23	0.14%
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	0.03%
Total	**16,392**	**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	18	5	27.78%
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)]	101	18	17.82%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	36	14	38.89%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	6	1	16.67%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	5	1	20.00%
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)	9	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	4	1	25.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	9	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	14	2	14.29%
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	3	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	5	2	40.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	31	10	32.26%
C17: Apparently did not order/follow evidence-based practices	2	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	7	4	57.14%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	24	0	0.00%
Total	**277**	**58**	**20.94%**

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	1,367	8.38%
Medicare FFS Post-Acute Appeals	593	3.63%
Medicare Advantage Post-Acute Appeals	14,354	87.99%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**16,314**	**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	14,298	85.26%
Rural	993	5.92%
Unknown	1,479	8.82%
Total	**16,770**	**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	200	66.67%
Rural	18	6.00%
Unknown	82	27.33%
Total	**300**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
546	469	85.90%

Publication No. R4-147-06/2025. This material was prepared by Acentra Health, a Medicare Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.