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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 1:
CT – MA – ME – NH – RI – VT

www.acentraqio.com

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

REGION 1

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Introduction

Acentra Health is the designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 1, which includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. 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	3,506	12.33%
Medicare FFS Post-Acute Appeals	3,181	11.19%
Medicare Advantage Post-Acute Appeals	20,572	72.35%
Hospital Issued Notice of Non-Coverage Appeals	91	0.32%
Hospital Requested Review Appeals	3	0.01%
Quality of Care	176	0.62%
Immediate Advocacy	890	3.13%
EMTALA	14	0.05%
Total	**28,433**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, unspecific organism	23,216	27.36%
2. J189 – Pneumonia, unspecific organism	8,898	10.49%
3. I130 – Hypertensive heart and chronic kidney disease with heart failure and Stage 1-4 chronic kidney disease or unspecified chronic kidney disease	8,230	9.70%
4. U071 – COVID-19	7,848	9.25%
5. N390 – Urinary tract infection, site not specified	7,730	9.11%
6. N179 – Acute kidney failure, unspecified	7,555	8.90%
7. I110 – Hypertensive heart disease with heart failure	7,474	8.81%
8. I214 – Non-ST elevation myocardial infarction	5,425	6.39%
9. J9601 – Acute respiratory failure with hypoxia	4,976	5.86%
10. I480 – Paroxysmal atrial fibrillation	3,509	4.13%
Total	**84,861**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	3,418	12.07%
1: Distinct Psychiatric Facility	11	0.04%
2: Distinct Rehabilitation Facility	198	0.70%
3: Distinct Skilled Nursing Facility	24,067	84.98%
5: Clinic	0	
6: Distinct Dialysis Center Facility	0	
7: Dialysis Center Unit of Inpatient Facility	0	
8: Independent-Based Rural Health Clinic	0	
9: Provider-Based Rural Health Clinic	0	
C: Freestanding Ambulatory Surgery Center	3	0.01%
G: End-Stage Renal Disease Unit	13	0.05%
H: Home Health Agency	202	0.71%
N: Critical Access Hospital	154	0.54%
O: Setting Does Not Fit Into Any Other Existing Setting Code	95	0.34%
Q: Long-Term Care Facility	38	0.13%
R: Hospice	100	0.35%
S: Psychiatric Unit of an Inpatient Facility	0	
T: Rehabilitation Unit of an Inpatient Facility	1	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.00%
Y: Federally Qualified Health Centers	12	0.04%
Z: Swing Bed Designation for Critical Access Hospitals	9	0.03%
Other	0	
Total	**28,322**	**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	40	3	7.50%
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)]	118	12	10.17%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	45	14	31.11%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	9	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	1	50.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	5	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	4	1	25.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	14	2	14.29%
C11: Apparently did not demonstrate that the patient was ready for Discharge	27	1	3.70%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultations	2	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	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)	16	3	18.75%
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	5	3	60.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	10	0	0.00%
Total	**307**	**40**	**13.03%**

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	3,506	9.33%	90.67%
Medicare FFS Post-Acute Appeals	3,181	42.31%	57.69%
Medicare Advantage Post-Acute Appeals	20,572	48.88%	51.12%
Hospital Issued Notice of Non-Coverage Appeals	91	27.47%	72.53%
Hospital Requested Review Appeals	3	0.00%	100.00%
Total	**27,353**	**42.97%**	**57.03%**

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.
Quality of Care	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	27,074	96.45%
Rural	675	2.40%
Unknown	322	1.15%
Total	**28,071**	**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	307	**84.34%**
Rural	10	2.75%
Unknown	47	12.91%
Total	**364**	**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.

The Outreach team conducted numerous meetings and webinars with key staff and stakeholders in Region 1, including sessions for the Massachusetts State Health Insurance Assistance Program, a skilled nursing facility in Connecticut, and the Massachusetts Serving the Health Insurance Needs of Everyone program. The Outreach team actively engages with stakeholders across the state by regularly participating in the Massachusetts Senior Medicare Patrol (SMP) Statewide Advisory Committee meetings, supporting SMP's mission to educate Medicare and Medicaid beneficiaries on the importance of informed healthcare decisions. These partnership efforts reach approximately 11,000 Medicare beneficiaries.

Acentra Health maintained a collaborative relationship with the CMS Region 1 office in Boston throughout 2024, including participation in the CMS Social Security Administration Quarterly Congressional Caseworker Briefing. The Outreach team co-presented with CMS Region 1 staff during open enrollment events, ensuring

key staff and stakeholders received relevant program information. In addition, the Outreach team participated in a Region 1 Rural Health Town Hall, presenting in collaboration with CMS staff and other critical stakeholders.

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
914	836	91.47%

10) EXAMPLE/SUCCESS STORY

A Medicare beneficiary's representative raised concerns about the care her mother was receiving at a skilled nursing facility. The representative, who was also the beneficiary's daughter and held Power of Attorney, requested a conference call with the facility to address discrepancies between her mother's stated desire to regain strength and therapy documentation indicating she had been refusing treatment.

The representative expressed frustration over the facility's lack of clear communication, noting her family had received only two of the promised weekly progress update emails. Due to concerns about gaps in the coordination of care, the beneficiary's family had begun paying for private physical therapy. She emphasized that her mother's goals were to get stronger and return home, which her family had discussed directly with the beneficiary. She requested an intervention by Acentra Health to help resolve the concerns.

The Clinical Reviewer (CR) arranged a conference call that included the beneficiary's family and facility representatives. During the hour-long call, they discussed several concerns, including:

- Inconsistent progress updates: Weekly emails stopped after only two weeks.
- Conflicting reports of therapy participation: Documentation suggested refusal, but the beneficiary told her family she was participating.
- Ongoing behavioral and communication challenges: The beneficiary frequently called family members and staff multiple times during shifts, seeking continual attention and support.

The facility clarified that the beneficiary had been determined to be at a custodial level of care since October 2024 and had recently been hospitalized. Therefore, the agreed-upon plan would take effect upon her return to the facility. Resolutions and action items were established:

- Communication protocol: The representative will be the primary point of contact for the facility with other family members as secondary.
- Therapy observation: The family will be allowed to observe therapy sessions to verify the beneficiary's participation and offer encouragement.
- Resumption of updates: Weekly progress update emails will resume to keep the beneficiary's family informed and involved.

The beneficiary representative thanked the CR for coordinating the call and requested the option to include her in future discussions. She also expressed her satisfaction with the outcome of the case.

11) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	36,715	60.16%
Male	24,309	39.84%
Unknown	0	0.00%
Total	**61,024**	**100.00%**
Race		
Asian	393	0.64%
Black	5,136	8.42%
Hispanic	1,170	1.92%
North American Native	70	0.11%
Other	615	1.01%
Unknown	749	1.23%
White	52,891	86.67%
Total	**61,024**	**100%**
Age		
Under 65	8,149	13.35%
65-70	7,693	12.61%
71-80	17,792	29.16%
81-90	19,501	31.96%
91+	7,889	12.93%
Total	**61,024**	**100%**

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	58,560
Total Number of Calls Answered	57,660
Total Number of Abandoned Calls	679
Average Length of Call Wait Times	00:00:27
Number of Calls Transferred by 1-800-Medicare	695

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 to 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 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 1 – STATE OF CONNECTICUT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	820	6.91%
Medicare FFS Post-Acute Appeals	980	8.25%
Medicare Advantage Post-Acute Appeals	9,790	82.46%
Hospital Issued Notice of Non-Coverage Appeals	12	0.10%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	45	0.38%
Immediate Advocacy	224	1.89%
EMTALA	1	0.01%
Total	**11,872**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	15,175	59.72%
Male	10,234	40.28%
Unknown	0	0.00%
Total	**25,409**	**100.00%**
Race		
Asian	143	0.56%
Black	3,651	14.37%
Hispanic	435	1.71%
North American Native	17	0.07%
Other	245	0.96%
Unknown	338	1.33%
White	20,580	80.99%
Total	**25,409**	**100.00%**
Age		
Under 65	2,887	11.36%
65-70	3,247	12.78%
71-80	7,187	28.29%
81-90	8,429	33.17%
91+	3,659	14.40%
Total	**25,409**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	853	7.18%
1: Distinct Psychiatric Facility	1	0.01%
2: Distinct Rehabilitation Facility	6	0.05%
3: Distinct Skilled Nursing Facility	10,871	91.49%
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	111	0.93%
N: Critical Access Hospital	0	0.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	11	0.09%
R: Hospice	25	0.21%
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	4	0.03%
Total	**11,882**	**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	7	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)]	25	1	4.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	21	10	47.62%
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	1	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	5	2	40.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	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	2	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)	7	1	14.29%
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	2	2	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	10	0	0.00%
Total	**94**	**16**	**17.02%**

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	820	7.07%
Medicare FFS Post-Acute Appeals	980	8.45%
Medicare Advantage Post-Acute Appeals	9,790	84.38%
Hospital Issued Notice of Non-Coverage Appeals	12	0.10%
Hospital Requested Review Appeals	0	0.00%
Total	**11,602**	**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	11,535	99.34%
Rural	21	0.18%
Unknown	56	0.48%
Total	**11,612**	**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	82	97.23%
Rural	0	0.00%
Unknown	12	12.77%
Total	**94**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
241	218	90.46%

ACENTRA BFCC-QIO REGION 1 – STATE OF MASSACHUSETTS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	1,288	16.72%
Medicare FFS Post-Acute Appeals	1,613	20.93%
Medicare Advantage Post-Acute Appeals	4,242	55.06%
Hospital Issued Notice of Non-Coverage Appeals	27	0.35%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	90	1.17%
Immediate Advocacy	441	5.72%
EMTALA	4	0.05%
Total	**7,705**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	9,997	57.85%
Male	7,283	42.15%
Unknown	0	0.00%
Total	**17,280**	**100.00%**
Race		
Asian	143	0.83%
Black	1,296	7.50%
Hispanic	286	1.66%
North American Native	12	0.07%
Other	166	0.96%
Unknown	260	1.50%
White	15,117	87.48%
Total	**17,280**	**100.00%**
Age		
Under 65	2,124	12.29%
65-70	2,207	12.77%
71-80	4,868	28.17%
81-90	5,658	32.74%
91+	2,423	14.02%
Total	**17,280**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	1,106	15.33%
1: Distinct Psychiatric Facility	7	0.10%
2: Distinct Rehabilitation Facility	148	2.05%
3: Distinct Skilled Nursing Facility	5,828	80.78%
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 Unit1	1	0.01%
H: Home Health Agency	51	0.71%
N: Critical Access Hospital	8	0.11%
O: Setting Does Not Fit Into Any Other Existing Setting Dode	0	0.00%
Q: Long-Term Care Facility	24	0.33%
R: Hospice	36	0.50%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.01%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	5	0.07%
Total	**7,215**	**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	20	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)]	71	9	12.68%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	14	3	21.43%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	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	1	1	100.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	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	5	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	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)	6	2	33.33%
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	3	1	33.33%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	18	2	11.11%
Total	**156**	**18**	**11.54%**

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	1,288	17.96%
Medicare FFS Post-Acute Appeals	1,613	22.50%
Medicare Advantage Post-Acute Appeals	4,242	59.16%
Hospital Issued Notice of Non-Coverage Appeals	27	0.38%
Hospital Requested Review Appeals	0	0.00%
Total	**7,170**	**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	7,636	97.42%
Rural	2	0.03%
Unknown	200	2.55%
Total	**7,838**	**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	177	86.76%
Rural	4	1.96%
Unknown	23	11.27%
Total	**204**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
453	414	91.39%

ACENTRA BFCC-QIO REGION 1 – STATE OF MAINE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	353	14.91%
Medicare FFS Post-Acute Appeals	105	4.44%
Medicare Advantage Post-Acute Appeals	1,828	77.23%
Hospital Issued Notice of Non-Coverage Appeals	4	0.17%
Hospital Requested Review Appeals	1	0.04%
Quality of Care	22	0.93%
Immediate Advocacy	53	2.24%
EMTALA	1	0.04%
Total	**2,367**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,690	60.09%
Male	2,451	39.91%
Unknown	0	0.00%
Total	**6,141**	**100.00%**
Race		
Asian	0	0.00%
Black	31	0.50%
Hispanic	2	0.03%
North American Native	8	0.13%
Other	43	0.70%
Unknown	50	0.81%
White	6,007	97.82%
Total	**6,141**	**100.00%**
Age		
Under 65	1,018	16.58%
65-70	763	12.42%
71-80	1,980	32.24%
81-90	1,729	28.16%
91+	651	10.60%
Total	**6,141**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	314	14.06%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	11	0.49%
3: Distinct Skilled Nursing Facility	1,820	81.50%
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	8	0.36%
N: Critical Access Hospital	69	3.09%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	5	0.22%
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	5	0.22%
Other	1	0.04%
Total	**2,233**	**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	2	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	3	23.08%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	1	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	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	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	**29**	**4**	**13.79%**

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	353	15.41%
Medicare FFS Post-Acute Appeals	105	4.58%
Medicare Advantage Post-Acute Appeals	1,828	79.79%
Hospital Issued Notice of Non-Coverage Appeals	4	0.17%
Hospital Requested Review Appeals	1	0.04%
Total	**2,291**	**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	1,811	78.47%
Rural	474	20.54%
Unknown	23	1.00%
Total	**2,308**	**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	83.33%
Rural	3	10.00%
Unknown	2	6.67%
Total	**30**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
57	47	82.46%

ACENTRA BFCC-QIO REGION 1 – STATE OF NEW HAMPSHIRE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	334	15.34%
Medicare FFS Post-Acute Appeals	186	8.60%
Medicare Advantage Post-Acute Appeals	1,555	71.86%
Hospital Issued Notice of Non-Coverage Appeals	7	0.32%
Hospital Requested Review Appeals	2	0.09%
Quality of Care	3	0.14%
Immediate Advocacy	70	3.23%
EMTALA	7	0.32%
Total	**2,164**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,469	63.07%
Male	2,031	36.93%
Unknown	0	0.00%
Total	**5,500**	**100.00%**
Race		
Asian	23	0.42%
Black	30	0.55%
Hispanic	13	0.24%
North American Native	11	0.20%
Other	30	0.55%
Unknown	67	1.22%
White	5,326	96.84%
Total	**5,500**	**100.00%**
Age		
Under 65	967	17.58%
65-70	648	11.78%
71-80	1,581	28.75%
81-90	1,685	30.64%
91+	619	11.25%
Total	**5,500**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	302	14.04%
1: Distinct Psychiatric Facility	1	0.05%
2: Distinct Rehabilitation Facility	20	0.93%
3: Distinct Skilled Nursing Facility	1,788	83.12%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	0.09%
N: Critical Access Hospital	31	1.44%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	0.14%
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	3	0.14%
Other	1	0.05%
Total	**2,151**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

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

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

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	334	16.03%
Medicare FFS Post-Acute Appeals	186	8.93%
Medicare Advantage Post-Acute Appeals	1,555	74.62%
Hospital Issued Notice of Non-Coverage Appeals	7	0.34%
Hospital Requested Review Appeals	2	0.10%
Total	**2,084**	**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	2,054	98.00%
Rural	30	1.43%
Unknown	12	0.57%
Total	**2,096**	**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	8	100.00%
Rural	0	0.00%
Unknown	0	0.00%
Total	**8**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
64	63	98.44%

ACENTRA BFCC-QIO REGION 1 – STATE OF RHODE ISLAND

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	517	14.92%
Medicare FFS Post-Acute Appeals	207	5.97%
Medicare Advantage Post-Acute Appeals	2,630	75.90%
Hospital Issued Notice of Non-Coverage Appeals	33	0.95%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	10	0.29%
Immediate Advocacy	68	1.96%
EMTALA	0	0.00%
Total	**3,465**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,277	67.42%
Male	617	32.58%
Unknown	0	0.00%
Total	**1,894**	**100.00%**
Race		
Asian	2	0.11%
Black	66	3.48%
Hispanic	352	18.59%
North American Native	0	0.00%
Other	96	5.07%
Unknown	2	0.11%
White	1,376	72.65%
Total	**1,894**	**100.00%**
Age		
Under 65	224	11.83%
65-70	144	7.60%
71-80	635	33.53%
81-90	619	32.68%
91+	272	14.36%
Total	**1,894**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	545	16.02%
1: Distinct Psychiatric Facility	1	0.03%
2: Distinct Rehabilitation Facility	5	0.15%
3: Distinct Skilled Nursing Facility	2,829	83.18%
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	13	0.38%
N: Critical Access Hospital	0	0.00%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	0.03%
R: Hospice	6	0.18%
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	0.03%
Total	**3,401**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

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

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Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	3	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	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	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	1	50.00%
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	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	2	0	0.00%
Total	**18**	**1**	**5.56%**

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	517	15.26%
Medicare FFS Post-Acute Appeals	207	6.11%
Medicare Advantage Post-Acute Appeals	2,630	77.65%
Hospital Issued Notice of Non-Coverage Appeals	33	0.97%
Hospital Requested Review Appeals	0	0.00%
Total	**3,387**	**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	3,382	99.76%
Rural	0	0.00%
Unknown	8	0.24%
Total	**3,390**	**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	12	66.67%
Rural	0	0.00%
Unknown	6	33.33%
Total	**18**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
69	64	92.75%

ACENTRA BFCC-QIO REGION 1 – STATE OF VERMONT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	195	22.78%
Medicare FFS Post-Acute Appeals	83	9.70%
Medicare Advantage Post-Acute Appeals	529	61.80%
Hospital Issued Notice of Non-Coverage Appeals	8	0.93%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	7	0.82%
Immediate Advocacy	32	3.74%
EMTALA	2	0.23%
Total	**856**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,318	64.79%
Male	1,803	35.21%
Unknown	0	0.00%
Total	**5,121**	**100.00%**
Race		
Asian	83	1.62%
Black	75	1.46%
Hispanic	83	1.62%
North American Native	23	0.45%
Other	44	0.86%
Unknown	34	0.66%
White	4,779	93.32%
Total	**5,121**	**100.00%**
Age		
Under 65	933	18.22%
65-70	693	13.53%
71-80	1,618	31.60%
81-90	1,534	29.96%
91+	343	6.70%
Total	**5,121**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	174	22.25%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	548	70.08%
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	12	1.53%
H: Home Health Agency	5	0.64%
N: Critical Access Hospital	26	3.32%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	4	0.51%
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	12	1.53%
Z: Swing Bed Designation for Critical Access Hospitals	1	0.13%
Other	0	0.00%
Total	**782**	**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	2	1	50.00%
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)]	2	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	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	4	4	100.00%
Total	**10**	**5**	**50.00%**

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

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	195	23.93%
Medicare FFS Post-Acute Appeals	83	10.18%
Medicare Advantage Post-Acute Appeals	529	64.91%
Hospital Issued Notice of Non-Coverage Appeals	8	0.98%
Hospital Requested Review Appeals	0	0.00%
Total	**815**	**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	656	79.32%
Rural	148	17.90%
Unknown	23	2.78%
Total	**827**	**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	3	30.00%
Rural	3	30.00%
Unknown	4	40.00%
Total	**10**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
30	30	100.00%

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