Annual Medical Services Review Report

Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO)

12th Statement of Work (SOW)
January 1, 2022 – December 31, 2022

Region 2

Quality Improvement Organizations
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This material was prepared by Livanta LLC, the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) that provides claim review services nationwide and case review services for Medicare Regions 2, 3, 5, 7, and 9, 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. 12-SOW-MD-2023-QIOBFCC-CP279

INTRODUCTION

Livanta LLC is the designated Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) for the Centers for Medicare & Medicaid Services (CMS) Regions 2, 3, 5, 7, and 9. Region 2 includes New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands. The QIO Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human Services' (HHS) National Quality Strategy for providing better care and better health at lower cost. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

CMS identifies the following as the core functions of the QIO Program: improving quality of care for beneficiaries; protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and protecting beneficiaries by swiftly addressing individual complaints, such as beneficiary complaints, provider-based notice appeals, violations of the Emergency Medical Treatment and Active Labor Act (EMTALA), and other related responsibilities as articulated in QIO-related law.

BFCC-QIOs improve healthcare services and protect beneficiaries through efficient statutory review functions, including quality of care reviews for Medicare beneficiaries. The BFCC-QIO ensures consistency in the case review process while considering local factors and local needs for general quality of care, medical necessity, and readmissions. In addition to the statutory beneficiary protections preserved in Medicare law and the QIO Manual, Livanta's case review activities align with CMS's overarching goals. For example, health equity and health literacy are central to protecting beneficiary rights and ensuring quality care. Through its outreach activities and dedication to reducing and removing real and perceived barriers to access, Livanta works each day to support Medicare beneficiaries through equitable access to high-quality healthcare.

As part of the annual report series for the 12th Statement of Work (SOW), this document provides data regarding case reviews completed on behalf of Medicare beneficiaries and their representatives from January 1, 2022 through December 31, 2022. Readers will find the overall regional data in the first sections of this report and state-specific data in the report's Appendix. This report underscores Livanta's commitment to transparency by providing key performance metrics from the current reporting period. Livanta understands and respects beneficiaries' rights and concerns and remains dedicated to protecting patients by reviewing appeals and quality complaints in an effective and efficient patient-centered manner. Additional performance metric information is available in Livanta's online dashboard.

Livanta would like to acknowledge the continuing sacrifice and dedication of healthcare providers across the nation as they have tirelessly supported their patients and staff throughout the novel Coronavirus 2019 (COVID-19) pandemic.

ANNUAL REPORT

1) TOTAL NUMBER OF REVIEWS

Livanta completed reviews on behalf of Medicare beneficiaries receiving care in Region 2. This table breaks out the number of reviews by the different types of reviews conducted by Livanta.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	296	0.68%
Quality of Care Review (All Other Selection Reasons)	55	0.13%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	165	0.38%
Notice of Non-coverage (BIPA)	7,055	16.30%
Notice of Non-coverage (Grijalva)	26,576	61.41%
Notice of Non-coverage (Hospital Discharge/Weichardt)	9,099	21.03%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	25	0.06%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	4	0.01%
EMTALA 60 Day	0	0.00%
TOTAL	43,275	100.00%

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

This table provides information regarding the top ten medical diagnoses for inpatient claims billed during the annual reporting period for Medicare beneficiaries in Region 2.

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Sepsis, Unspecified Organism (A419)	48,348	27.26%
2. Covid-19 (U071)	33,399	18.83%
3. Hypertensive Heart Disease With Heart Failure (I110)	15,332	8.64%
4. Hypertensive Heart and Chronic Kidney Disease With Heart Failure And Stage 1-4/Unspecified Chronic Kidney Disease (I130)	14,900	8.40%
5. Acute Kidney Failure, Unspecified (N179)	13,861	7.82%
6. Urinary Tract Infection, Site Not Specified (N390)	12,776	7.20%
7. Pneumonia, Unspecified Organism (J189)	11,160	6.29%
8. Non-St Elevation (NSTEMI) Myocardial Infarction (I214)	10,432	5.88%
9. Other Specified Sepsis (A4189)	10,319	5.82%
10. Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation (J441)	6,836	3.85%
TOTAL	177,363	100%

3) Provider Reviews Settings

This table provides information on the count and percent by setting for Health Service Providers (HSPs) associated with a completed BFCC-QIO review in Region 2.

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	255	17.01%
1: Distinct Psychiatric Facility	10	0.67%
2: Distinct Rehabilitation Facility	17	1.13%
3: Distinct Skilled Nursing Facility	926	61.77%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.07%
7: Dialysis Center Unit of Inpatient Facility	2	0.13%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	2	0.13%
G: End Stage Renal Disease Unit	12	0.80%
H: Home Health Agency	96	6.40%
N: Critical Access Hospital	11	0.73%
O: Setting does not fit into any other existing setting code	5	0.33%
Q: Long-Term Care Facility	13	0.87%
R: Hospice	75	5.00%
S: Psychiatric Unit of an Inpatient Facility	35	2.33%
T: Rehabilitation Unit of an Inpatient Facility	21	1.40%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	6	0.40%
Y: Federally Qualified Health Centers	3	0.20%
Z: Swing Bed Designation for Critical Access Hospitals	8	0.53%
Other	1	0.07%
TOTAL	1,499	100.00%

4) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to Medicare beneficiaries was consistent with professionally recognized standards of healthcare. 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, Congress, etc.

In keeping with CMS directions, Livanta referred all confirmed quality of care concerns that appeared to be systemic in nature and/or appropriate for monitored quality improvement activities to the respective Quality Innovation Network (QIN)-QIO for follow-up. For confirmed concerns that may

have been amenable to a different clinical approach or related to documentation, Livanta retained the concerns and worked directly with the healthcare provider and/or practitioner. The below data reflects the total number of concerns referred to the QIN-QIO to provide technical assistance and not those retained by Livanta.

4.A. QUALITY OF CARE CONCERNS CONFIRMED

This table provides the number of confirmed quality of care concerns as identified by Physician Reviewer Assessment Form (PRAF) category codes within the CMS case review systems. These quality of care concerns are confirmed by Livanta's independent physician reviewers as care that did not meet the professionally recognized standards of medical care. Confirmed quality of care concerns commonly result in provider education and are referred, as appropriate, to CMS-designated QIN-QIO contractors who work with providers to improve patient care.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	1	100.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	66	29	43.94%
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)]	585	72	12.31%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	114	30	26.32%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	16	4	25.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	1	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	7	2	28.57%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	23	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	32	3	9.38%
C11: Apparently did not demonstrate that the patient was ready for discharge	16	2	12.50%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C13: Apparently did not order appropriate specialty consultation	8	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)	29	7	24.14%
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	2	40.00%
C40: Apparently did not follow up on patient's non-compliance	1	0	0.00%
C99: Other quality concern not elsewhere classified	314	12	3.82%
TOTAL	1,224	166	13.56%

4.B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Quality of Care Concerns Referred for QIIs

Number of Confirmed QoC Concerns Referred for QII	Percent (%) of Confirmed QoC Concerns Referred for QII
163	98.19%

QII Referral Details

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in other patient care by practitioner area	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	35
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	45

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	11
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	13
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner safety precautions	5
Provider-Continuity of Care - Improvement needed in case management/discharge planning	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	5
Provider-Patient Care by Staff - Improvement needed in other patient care by staff area	2
Provider-Patient Care by Staff - Improvement needed in staff assessments	3
Provider-Patient Care by Staff - Improvement needed in staff care planning	15
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	12
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	4
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	1

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	1

5) Discharge/Service Terminations

This table provides information regarding the discharge status of Medicare beneficiaries linked to appeals conducted by Livanta for provider-issued notices of Medicare non-coverage. Data contained in this table represent discharge or termination of service reviews from January 1, 2022 to December 31, 2022. The discharge status reported may be incomplete because of the inability to link the status with the claim data.

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self care (routine discharge)	3	25.00%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	6	50.00%
04: Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	2	16.67%
07: Left against medical advice or discontinued care	0	0.00%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	0	0.00%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	0	0.00%
40: Expired at home (Hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, or free standing Hospice)	0	0.00%
42: Expired – place unknown (Hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice – home	0	0.00%
51: Hospice – medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	1	8.33%
63: Discharged/transferred to a long-term care hospital	0	0.00%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	0	0.00%
TOTAL	12	100.00%

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

This table provides the number of appeal reviews by notification type and the percentage of physician reviews, specifically for each outcome, in which Livanta's independent physician reviewer agreed or disagreed with the discharge.

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Notice (%)	Physician Reviewer Agreed with Notice (%)
Notice of Non-coverage FFS Preadmission/ Admission (Admission and Preadmission/HINN 1)	165	16.36%	83.64%
Notice of Non-coverage Request for BFCC-QIO Concurrence (Request for BFCC-QIO Concurrence/ HINN 10)	25	24.00%	76.00%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	26,436	19.70%	80.30%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	7,007	19.20%	80.80%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Hospital Discharge/Weichardt)	5,665	10.03%	89.97%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Hospital Discharge/Weichardt)	3,401	11.20%	88.80%
TOTAL	42,699	17.64%	82.36%

7) Evidence Used in Decision-Making

The following tables provide examples of common types of evidence or standards of care used to support Livanta review coordinators and independent peer reviewer decisions. In completing Quality of Care reviews, Livanta's review coordinators and peer reviewers refer to available evidence and standards of care to support case review decisions. Several examples of these standards are includedbelow, along with a brief statement of the rationale for selecting the specific evidence or standards of care and the date of the most recently published guidelines.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	Risk factors and prevention of hospital-acquired and ventilator-associated pneumonia in adults (UpToDate) Last updated January 24, 2023	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.
Quality of Care	Heart Failure	Heart failure: Clinical manifestations and diagnosis in adults (UpToDate) Last updated April 20, 2022	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pressure Ulcers	Clinical staging and management of pressure-induced skin and soft tissue injury (UpToDate) Last updated April 1, 2022	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.
Quality of Care	Acute Myocardial Infarction	Overview of the acute management of ST-elevation myocardial infarction (UpToDate) Last updated May 16, 2022	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.
Quality of Care	Urinary Tract Infection	Acute complicated urinary tract infection (including pyelonephritis) in adults (UpToDate) Last updated June 26, 2023	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Sepsis	Sepsis syndromes in adults: Epidemiology, definitions, clinical presentation, diagnosis, and prognosis (UpToDate) Last updated June 13, 2023	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.
Quality of Care	Adverse Drug Events	Drug prescribing for older adults (UpToDate) Last updated July 12, 2023	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.
Quality of Care	Falls	Falls: Prevention in nursing care facilities and the hospital setting (UpToDate) Last updated July 1, 2022	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Patient Trauma	Initial management of trauma in adults (UpToDate) Last updated February 7, 2023	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.
Quality of Care	Surgical Complications	Overview of control measures for prevention of surgical site infection in adults (UpToDate) Last updated December 5, 2022	UpToDate is a comprehensive resource consisting of peer-reviewed, physician-authored articles on thousands of clinical topics. Its review articles are continuously updated by incorporating new evidence from hundreds of medical journals, and cited evidence is graded on its strength and quality. Unlike similar repositories that are designed to be used quickly at the point of care, UpToDate articles generally include more thorough explanations of both the foundations and nuances of their topics.

For Appeals reviews, Livanta's review coordinators and peer reviewers refer to authoritative Medicare references and standards to support case review decisions; several examples of these standards and guidelines are also included below.

Review Type	Evidence/Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Appeals	Medicare Benefit Policy Manual	According to the Medicare Benefit Policy Manual, Chapter 8, care in a skilled nursing facility (SNF) is covered if four factors are met. Physician reviewers apply those four requirements to each case reviewed. If ANY ONE of those four factors is not met, a stay in a SNF, even though it might include delivery of some skilled services, is not covered.
Appeals	Medicare Managed Care Guidelines, Chapter 13	Reconsideration Timing: "If the QIO upholds a Medicare health plan's decision to terminate services in whole or in part, the enrollee may request, no later than 60 days after notification that the QIO has upheld the decision, that the QIO reconsider its original decision."
Appeals	CMS Beneficiary Notices Initiative (BNI) website	Forms, model letter template language, and instructions for providers: "The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed."
Appeals	CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30: Financial Liability Protections	Instructions regarding hospital interactions with QIOs: "Before Medicare can pay for post-hospital extended care services, it must determine whether the beneficiary had a prior qualifying hospital stay of at least three consecutive calendar days."
Appeals	The Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7- Denials, Reconsiderations, & Appeals	This manual includes related instructions for the Quality Improvement Organization (QIO) processing of appeals.
Appeals	Local Coverage Determinations (LCDs)	These are coverage determinations for specific situations, and they are published by Medicare Administrative Contractors (MACs) for cases within their own respective jurisdiction.

Reviews by Geographic Area

The following tables show the number of Health Service Providers (HSPs) that completed a BFCC-QIO review for Appeal and Quality of Care by geographic area - rural versus urban for Region 2.

Table 8A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	1,303	94.01%
Rural	83	5.99%
Unknown	0	0.00%
TOTAL	1,386	100.00%

Table 8B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	171	94.48%
Rural	10	5.52%
Unknown	0	0.00%
TOTAL	181	100.00%

8) Outreach and Collaboration with Beneficiaries

Livanta's broad outreach and educational efforts help ensure that Medicare partners and provider organizations have up-to-date information about the BFCC-QIO Program. These activities empower stakeholders and individuals with knowledge and awareness of Medicare protections available through the BFCC-QIO Program. Livanta maintains a large subscriber base and regularly emails updates and BFCC-QIO information and materials to a range of stakeholders and also educates diverse audiences regarding the role and purpose of the BFCC-QIO. Providing Medicare beneficiaries, caregivers, and advocates access and exposure to this information is an important aspect of Livanta's outreach and collaboration efforts. Due to safety protocols restricting in-person events throughout the COVID-19 public health emergency, Livanta continued to conduct web-based educational programs and other virtual collaboration activities.

Digital Publications

Throughout 2022, Livanta expanded and grew its stakeholder publications. With its flagship publication, *The Livanta Compass*, Livanta educated a range of Medicare stakeholders by highlighting an array of ongoing and emergent topics. Since its inception in 2019, *The Livanta Compass* weekly e-publication has grown to over 1,700 subscribers, with double-digit growth year-over-year. Additionally, this publication has sustained higher-than-industry-average open rates. Topics from 2022 that yielded high open rates included the CMS hospital-at-home program, health equity, sepsis, family caregivers, and Medicare's annual Open Enrollment.

During this reporting period, *The Livanta Compass* earned a Gold MarCom award for its series on improving health equity. The health equity campaign included the following *Compass* issues: "Improving Access and Health Equity: The Critical Role of Critical Access Hospitals," "Supporting

Health Equity with a Focus on Communication," "Observing Mental Health Awareness Month Through a Health Equity Lens," and "Advancing Health Equity: National Minority Health Month." Livanta's partners have consistently praised this e-publication, and many partners routinely use the materials to supplement their internal training for their respective staff and volunteers.

Livanta's beneficiary-facing publication, *The Livanta Beacon*, which launched in August 2021, also demonstrated high levels of reader engagement throughout 2022. With a bi-weekly production schedule, *The Livanta Beacon* e-publication is written for Medicare patients, families, caregivers, and patient advocates. This publication educates readers about the value of the BFCC-QIO immediate advocacy service and related healthcare topics. Each short, de-identified, true-to-life story aims to shine a light on the healthcare journey in a way that readers can readily understand. *Beacon* has also enjoyed double-digit subscriber growth each year and continues to receive praise from stakeholders.

Social Media

Social media provides a unique opportunity for BFCC-QIOs like Livanta to engage beneficiaries, their families, and other caregivers in a medium that is already familiar to this audience. Livanta's engagement strategy for beneficiaries, caregivers, and healthcare providers includes maintaining an active presence across several social media platforms, including Facebook, Twitter, Instagram, and LinkedIn. During this reporting period, Livanta published more than 1,100 posts across these platforms, reaching hundreds of individuals each week, and its social media following grew by 18 percent.

To coincide with National Family Caregivers Month in November 2021, Livanta created and launched #MyRoleCounts, a new social media toolkit. Throughout 2022, the Livanta team promoted this toolkit as a campaign to raise awareness of family caregivers and to empower caregivers of Medicare beneficiaries to use available resources. The toolkit enabled partners and stakeholders to assist in raising awareness of family caregivers by providing a ready-to-use social media campaign. In creating the toolkit and its unique hashtag, Livanta considered the RAISE Family Caregiving Advisory Council's "Initial Report to Congress." That report notes that many individuals who provide care for a relative or another person may not self-identify as a caregiver and, therefore, may not be aware of available resources. The report noted that a lack of self-identification leads to inaccurate or incomplete research, making it hard for policymakers to understand caregivers' needs. The toolkit garnered several awards in 2022, including Gold Awards from MarCom and Hermes Creative and an impressive Platinum Award from AVA Digital.

Website

The Livanta BFCC-QIO website continues to serve as a robust information hub for Livanta's outreach and education efforts. With an average of more than 200,000 page views per month, the website is viewed by beneficiaries and their representatives, healthcare providers, and other Medicare stakeholders. To ensure that content is accurate, up-to-date, and accessible to those with disabilities, Livanta continuously reviews the website and makes revisions where necessary. This constant attention is critical to keep the website's information and functionality intact. In 2022, Livanta added a Reference Guide to the website as a resource for advocates who assist Medicare beneficiaries in accessing BFCC-

QIO services. Additionally, a portal was added to the website during this reporting period specifically designed for beneficiaries to upload files securely to Livanta.

Partnerships and Education

Throughout 2022, Livanta continued its outreach to a variety of external partners, including the State Health Insurance Program (SHIP) offices, Senior Medicare Patrol (SMP) agencies, and State Long-Term Care Ombudsman Programs (SLTCOPs). In addition to extensive email and telephone outreach, Livanta conducted virtual meetings and training programs as requested by stakeholder organizations, further developing and strengthening relationships with these important partners. Educational programs described in Livanta's Course Catalog highlight important details about Livanta's services for Medicare beneficiaries through the BFCC-QIO Program. Livanta's opportunity to engage with SHIPs, in particular, is significant because SHIP counselors and volunteers work directly with Medicare beneficiaries, their families, and caregivers in the local community. Partnerships with these organizations afford Livanta a unique opportunity to reach more individuals with important BFCC-QIO information. In addition to working with many state- and regional-level offices and programs, Livanta conducted outreach to identify new partners, offering virtual "meet-and-greet" opportunities and educational webinars for new audiences.

Livanta's outreach includes a focus on healthcare providers, and the communications team maintains an extensive database of nearly 6,000 provider contacts, enabling Livanta to reach out to providers when necessary. Additionally, provider bulletins and other communications are published when important changes occur in BFCC-QIO case review processes or when other critical program information must be disseminated. For example, the team prepares and distributes email blasts to hospital contacts in Livanta's BFCC-QIO regions each year. These email blasts remind hospital personnel to complete annual physician attestation and acknowledgment reporting requirements.

Livanta participates in regularly scheduled collaboration calls with the CMS Regional Offices in Region 2 and the CMS Field Office in Puerto Rico. Individuals participating in these calls represent Medicare partners and stakeholders in New York City, New Jersey, and the U.S. territories of Puerto Rico and the Virgin Islands. Attendees of these monthly Medicare partner calls include representatives from state and local government agencies on aging and insurance, representatives from elected officials' offices, community organizations, cultural and ethnic support organizations, and Medicare-certified healthcare provider organizations. By providing regular updates and information about the BFCC-QIO Program, Livanta educates and informs these local stakeholders, whose primary roles include disseminating information directly to Medicare beneficiaries, their caregivers, and families. With New Jersey and New York City representing some of the most densely populated parts of the country, partnering with these CMS offices provides access to over six million Medicare beneficiaries.

9) Immediate Advocacy Cases

Immediate Advocacy is an informal, voluntary process used by Livanta to resolve complaints quickly. This process begins when the Medicare beneficiary or his or her representative contacts Livanta and gives verbal consent to proceed with the complaint. Once consent is given, Livanta contacts the provider and/or practitioner on behalf of the Medicare beneficiary. Immediate Advocacy does not

include a review of the patient's medical records and is not appropriate when a beneficiary wants to remain anonymous. This table provides the number of Medicare beneficiary complaints and the number of Immediate Advocacy cases facilitated by Livanta for Region 2, along with the percentage of total Medicare beneficiary complaints that were resolved by Immediate Advocacy.

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
1,899	1,605	84.52%

10) Example/Success Story

Clarifying Discharge Plans to Resolve Communication Breakdowns

The beneficiary called Livanta after being admitted to the hospital for ankle surgery and experiencing significant pain. The beneficiary had been receiving extended-release morphine and immediate-release morphine every four hours. However, the beneficiary stated that the physician had stopped the extended-release morphine completely and changed the immediate-release morphine from every four hours to every six hours. The beneficiary stated that the dose changes led to increased pain and requested assistance communicating with the physician.

After listening to the beneficiary's concerns empathetically, Livanta's review coordinator explained Immediate Advocacy, and the beneficiary consented to the process. Livanta's review coordinator then contacted the hospital and spoke with the social worker, who also consented to participate in Immediate Advocacy. The review coordinator expressed the beneficiary's concerns about the pain medication regimen to the social worker. Upon reviewing the physician's notes, the social worker informed Livanta's review coordinator that the extended-release morphine had not been stopped but that the beneficiary was upset that the physician had stopped the intravenous (IV) morphine in favor of oral morphine tablets. Additionally, the social worker explained that she had been present in the room when the physician explained to the beneficiary that the IV morphine would be stopped so that the beneficiary could be discharged with the oral tablets. However, the beneficiary had wanted the IV morphine to continue until the time of the actual discharge. The social worker told the Livanta review coordinator that she would inform the physician that the beneficiary had contacted Livanta about the medication.

Livanta's review coordinator called the beneficiary to relay a summary of the conversation with the social worker. The beneficiary stated that the physician and social worker had stopped by to speak about stopping the IV morphine. The beneficiary explained that they thought the IV morphine would continue pending the outcome of a separate discharge appeal they had filed with Livanta. The review coordinator learned that although the beneficiary would have liked the IV morphine to continue, they now understood why switching to an oral medication was important.

This case illustrates how communication between healthcare professionals and beneficiaries can sometimes be confusing. In some cases, such as this one, beneficiaries may not fully understand their discharge plan, medication regimens, or other treatment plans, creating confusion and tension. As a BFCC-QIO, Livanta supports Medicare beneficiaries by identifying and resolving communication breakdowns.

11) Beneficiary Helpline Statistics

This table provides statistics concerning the Medicare beneficiary Helpline for this reporting period for Region 2.

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	137,141
Total Number of Calls Answered	132,304
Total Number of Abandoned Calls	4,802
Average Length of Call Wait Times	15 seconds
Number of Calls Transferred by 1-800-Medicare	397

CONCLUSION

Livanta contributes significant value to the Medicare program, Medicare beneficiaries, their families and caregivers, and healthcare providers. Each day, Livanta puts beneficiaries and their families first to safeguard their Medicare rights. Leveraging its unique position, Livanta partners with healthcare organizations and providers to offer education about quality care, medically necessary services, and compliance with Medicare regulations and requirements. Through innovative services, Livanta offers patient support along the entire continuum of care.

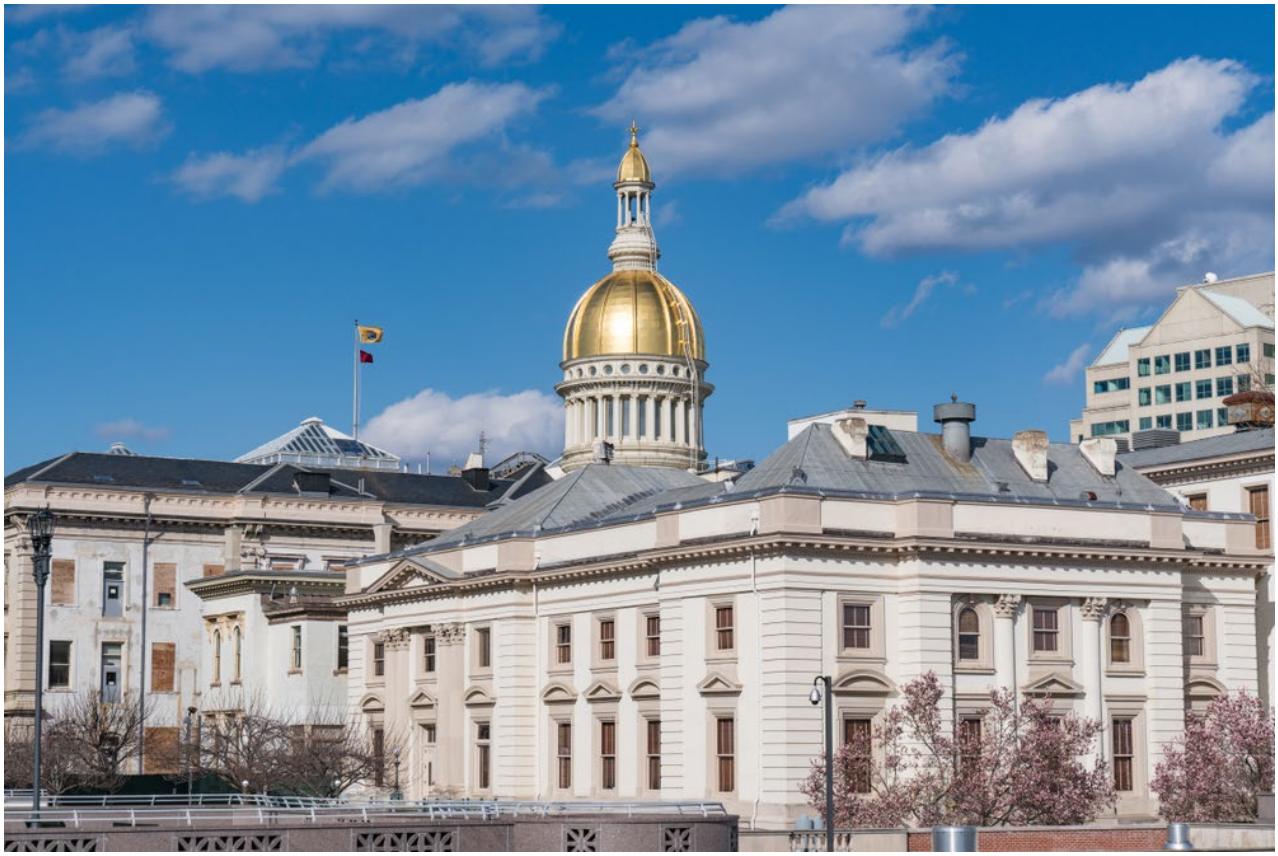
- The Medicare beneficiary complaints and appeals processes provide beneficiaries with a caring and empathetic advocate who contributes their expertise while conveying the beneficiaries' unique needs to healthcare providers. In addition, Livanta addresses these concerns with nationally recognized standards of care to empower providers to improve future care for all patients.
- Livanta's Immediate Advocacy program provides a rapid resolution to problems with real-time care. For example, this service can help resolve communication gaps, language barriers, logistical issues such as access to supplies or equipment, or similar barriers to care.
- When a quality of care concern is confirmed through medical record review, educational feedback is delivered to the provider outlining how care can be improved in future cases. When a systemic issue is identified, cases are referred to the state's Quality Innovation Network (QIN)-QIO. The QIN-QIO provides technical assistance to the healthcare provider organization to address underlying issues that may have led to the failure in care.
- Livanta protects Medicare beneficiary rights and the integrity of the Medicare Trust Fund through the handling of appeals and EMTALA cases by ensuring that Medicare pays only for reasonable and medically necessary healthcare services and that quality care is provided in the most appropriate setting.
- Livanta demonstrates its agility, innovative and entrepreneurial spirit, and deep commitment to patient-centered care by directly engaging Medicare beneficiaries, families, advocates, providers, and a broad array of other stakeholders. With its innovative and unique outreach publications, such as *The Livanta Compass* and *The Livanta Beacon*, webinars, and outreach materials, Livanta enables Medicare beneficiaries to take control of their health outcomes. Livanta reaches out to urban and rural areas to ensure that the protection of Medicare beneficiaries is prioritized across all 27 U.S. states and territories in which it serves as the BFCC-QIO.
- Livanta incorporates the goals and values of CMS's strategic aims throughout its operations and corporate philosophy. Livanta's outreach and education efforts affirm its commitment to advancing health equity by ensuring that all Medicare beneficiaries are empowered to know their rights, self-advocate, and collaboratively improve their own health regardless of location, language, disability, or other real or perceived barriers.

Livanta supports CMS's goal to ensure that Medicare beneficiaries receive quality healthcare by guaranteeing that their care is medically necessary and meets the standards of care set by the medical community. Livanta's work to support Medicare beneficiaries and healthcare providers is essential to the Medicare program but, most importantly, to the beneficiaries, families, and caregivers whose right to quality healthcare is protected and assured.

APPENDIX

LIVANTA | BFCC-QIO REGION 2

STATE OF NEW JERSEY



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	96	0.68%
Quality of Care Review (All Other Selection Reasons)	30	0.21%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	2,993	21.08%
Notice of Non-coverage (Grijalva)	8,414	59.26%
Notice of Non-coverage (Hospital Discharge/Weichardt)	2,659	18.73%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	5	0.04%
EMTALA 5 Day	1	0.01%
EMTALA 60 Day	0	0.00%
TOTAL	14,198	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Sepsis, Unspecified Organism (A419)	15,459	24.25%
2. COVID-19 (U071)	12,162	19.08%
3. Hypertensive Heart Disease With Heart Failure (I110)	5,975	9.37%
4. Hypertensive Heart and Chronic Kidney Disease With Heart Failure And Stage 1-4/Unspecified Chronic Kidney Disease (I130)	5,948	9.33%
5. Acute Kidney Failure, Unspecified (N179)	5,276	8.28%
6. Urinary Tract Infection, Site Not Specified (N390)	4,791	7.51%
7. Pneumonia, Unspecified Organism (J189)	4,315	6.77%
8. Non-ST Elevation (NSTEMI) Myocardial Infarction (I214)	3,923	6.15%
9. Other Specified Sepsis (A4189)	3,195	5.01%
10. Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation (J441)	2,711	4.25%
TOTAL	63,755	100.00%

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	7,174	60.69%
Sex/Gender	Male	4,647	39.31%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	11,821	100.00%
Race	Asian	174	1.47%
Race	Black	1,925	16.28%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	Hispanic	214	1.81%
Race	North American Native	3	0.03%
Race	Other	186	1.57%
Race	Unknown	156	1.32%
Race	White	9,163	77.51%
Race	**TOTAL**	11,821	100.00%
Age	Under 65	943	7.98%
Age	65-70	1,373	11.61%
Age	71-80	3,768	31.88%
Age	81-90	4,123	34.88%
Age	91+	1,614	13.65%
Age	**TOTAL**	11,821	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	67	13.09%
1: Distinct Psychiatric Facility	3	0.59%
2: Distinct Rehabilitation Facility	10	1.95%
3: Distinct Skilled Nursing Facility	337	65.82%
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 (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	2	0.39%
G: End Stage Renal Disease Unit	1	0.20%
H: Home Health Agency	27	5.27%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	1	0.20%
Q: Long-Term Care Facility	8	1.56%
R: Hospice	41	8.01%
S: Psychiatric Unit of an Inpatient Facility	9	1.76%
T: Rehabilitation Unit of an Inpatient Facility	4	0.78%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	2	0.39%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
TOTAL	512	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to Medicare 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 or her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen, Congress, etc.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Livanta, in keeping with CMS directions, referred all confirmed quality of care concerns that appeared to be systemic in nature and appropriate for quality improvement activities to the respective QIN-QIO for follow-up. For confirmed concerns that may have been amenable to a different approach to health care or related to documentation, Livanta retained the concerns and worked directly with the healthcare provider and/or practitioner. The below data reflects the total number of concerns referred to the QIN-QIO and not those retained by Livanta in order to provide technical assistance.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	29	15	51.72%
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)]	190	29	15.26%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	37	10	27.03%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	10	2	20.00%
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)	17	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	8	1	12.50%
C11: Apparently did not demonstrate that the patient was ready for discharge	5	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	10	3	30.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	3	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	106	3	2.83%
TOTAL	417	65	15.59%

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives

Number of Confirmed QoC Concerns Referred for QII	Percent (%) of Confirmed QoC Concerns Referred for QII
64	98.46%

QII Referral Details

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	17
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	16
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	9
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	4

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner obtaining patient history and performing physical examination	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner ordering of/coordination with/completion of practitioner specialty consultation	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner safety precautions	2
Provider-Patient Care by Staff - Improvement needed in staff assessments	2
Provider-Patient Care by Staff - Improvement needed in staff care planning	3
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	3
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of falls	1

6) 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
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	5	0.04%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	8,353	59.73%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	2,974	21.27%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	1,801	12.88%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	852	6.09%
TOTAL	13,985	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	492	100.00%	94.01%
Rural	0	0.00%	5.99%
Unknown	0	0.00%	0.00%
TOTAL	492	100.00%	100.00%

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

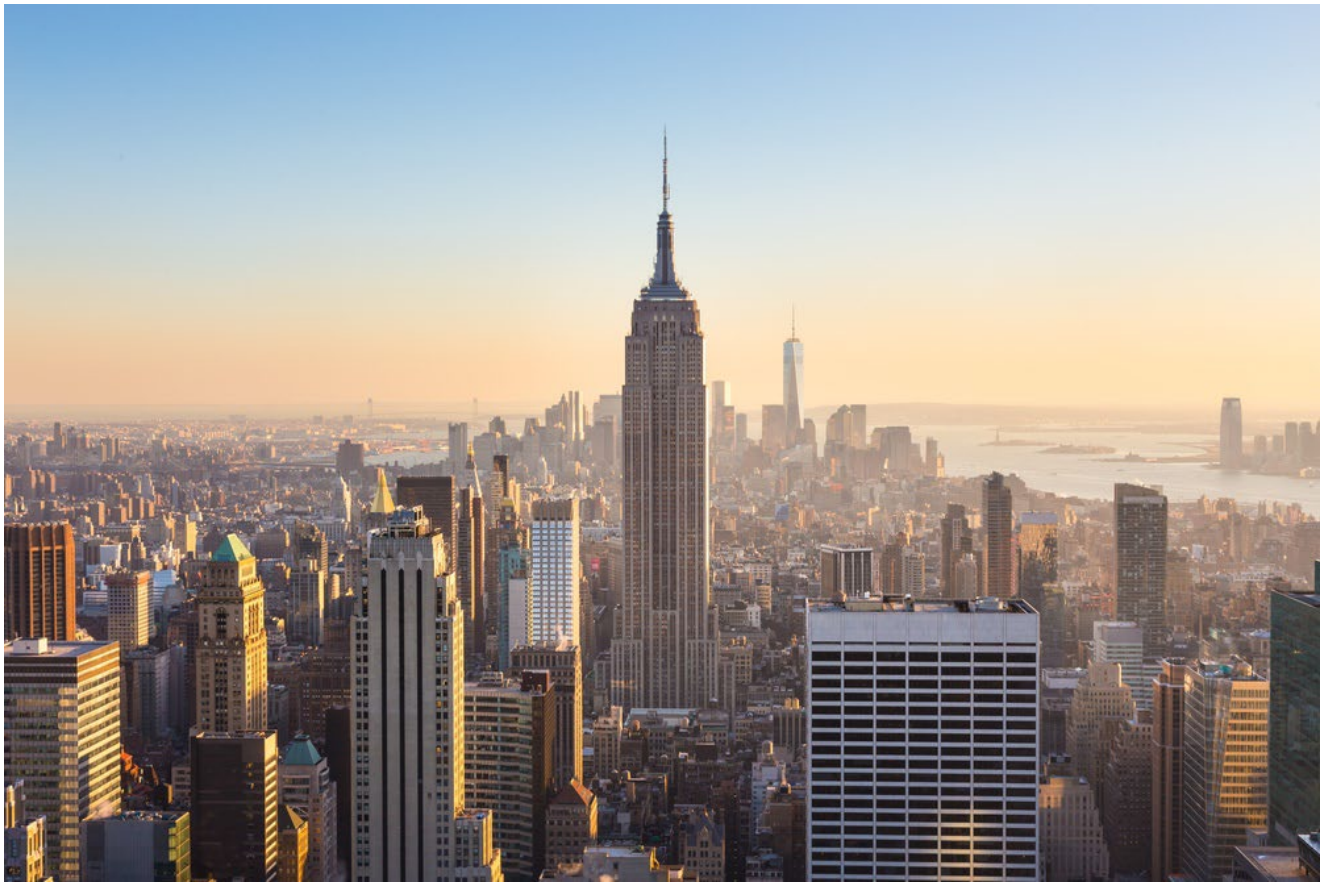
Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	60	100.00%	94.48%
Rural	0	0.00%	5.52%
Unknown	0	0.00%	0.00%
TOTAL	60	100.00%	100.00%

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
560	463	82.68%

LIVANTA | BFCC-QIO REGION 2

STATE OF NEW YORK



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	183	0.63%
Quality of Care Review (All Other Selection Reasons)	25	0.09%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	165	0.57%
Notice of Non-coverage (BIPA)	4,049	14.01%
Notice of Non-coverage (Grijalva)	18,151	62.79%
Notice of Non-coverage (Hospital Discharge/Weichardt)	6,312	21.83%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	20	0.07%
EMTALA 5 Day	3	0.01%
EMTALA 60 Day	0	0.00%
TOTAL	28,908	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Sepsis, Unspecified Organism (A419)	32,408	29.55%
2. COVID-19 (U071)	20,647	18.82%
3. Hypertensive Heart Disease With Heart Failure (I110)	8,888	8.10%
4. Hypertensive Heart and Chronic Kidney Disease With Heart Failure And Stage 1-4/Unspecified Chronic Kidney Disease (I130)	8,780	8.00%
5. Acute Kidney Failure, Unspecified (N179)	8,289	7.56%
6. Urinary Tract Infection, Site Not Specified (N390)	7,529	6.86%
7. Other Specified Sepsis (A4189)	6,939	6.33%
8. Pneumonia, Unspecified Organism (J189)	6,469	5.90%
9. Non-ST Elevation (NSTEMI) Myocardial Infarction (I214)	5,821	5.31%
10. Chronic Obstructive Pulmonary Disease W (Acute) Exacerbation (J441)	3,917	3.57%
TOTAL	109,687	100.00%

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	14,556	60.89%
Sex/Gender	Male	9,350	39.11%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	23,906	100.00%
Race	Asian	475	1.99%
Race	Black	4,024	16.83%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	Hispanic	598	2.50%
Race	North American Native	27	0.11%
Race	Other	498	2.08%
Race	Unknown	350	1.46%
Race	White	17,934	75.02%
Race	**TOTAL**	23,906	100.00%
Age	Under 65	1,894	7.92%
Age	65-70	2,823	11.81%
Age	71-80	7,479	31.29%
Age	81-90	8,220	34.38%
Age	91+	3,490	14.60%
Age	**TOTAL**	23,906	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	146	15.87%
1: Distinct Psychiatric Facility	5	0.54%
2: Distinct Rehabilitation Facility	4	0.43%
3: Distinct Skilled Nursing Facility	587	63.80%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.11%
7: Dialysis Center Unit of Inpatient Facility	2	0.22%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	11	1.20%
H: Home Health Agency	63	6.85%
N: Critical Access Hospital	11	1.20%
O: Setting does not fit into any other existing setting code	4	0.43%
Q: Long-Term Care Facility	5	0.54%
R: Hospice	22	2.39%
S: Psychiatric Unit of an Inpatient Facility	26	2.83%
T: Rehabilitation Unit of an Inpatient Facility	17	1.85%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	6	0.65%
Y: Federally Qualified Health Centers	1	0.11%
Z: Swing Bed Designation for Critical Access Hospitals	8	0.87%
Other	1	0.11%
TOTAL	920	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to Medicare 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 or her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen, Congress, etc.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Livanta, in keeping with CMS directions, referred all confirmed quality of care concerns that appeared to be systemic in nature and appropriate for quality improvement activities to the respective QIN-QIO for follow-up. For confirmed concerns that may have been amenable to a different approach to health care or related to documentation, Livanta retained the concerns and worked directly with the healthcare provider and/or practitioner. The below data reflects the total number of concerns referred to the QIN-QIO and not those retained by Livanta in order to provide technical assistance.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	1	1	100.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	35	14	40.00%
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)]	354	34	9.60%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	72	20	27.78%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	5	2	40.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	1	50.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	6	1	16.67%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	6	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	23	2	8.70%
C11: Apparently did not demonstrate that the patient was ready for discharge	11	2	18.18%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C13: Apparently did not order appropriate specialty consultation	6	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)	13	3	23.08%
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	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	1	0	0.00%
C99: Other quality concern not elsewhere classified	192	9	4.69%
TOTAL	734	91	12.40%

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives

Number of Confirmed QoC Concerns Referred for QII	Percent (%) of Confirmed QoC Concerns Referred for QII
89	97.80%

QII Referral Details

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in other patient care by practitioner area	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	18
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	25
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	9

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner safety precautions	3
Provider-Continuity of Care - Improvement needed in case management/discharge planning	1
Provider-Continuity of Care - Improvement needed in medical record documentation that impacts patient care	5
Provider-Patient Care by Staff - Improvement needed in staff assessments	1
Provider-Patient Care by Staff - Improvement needed in staff care planning	9
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	9
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	2
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of complications due to equipment unavailability/failure/misuse/unmaintained	1

6) 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
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	165	0.58%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	20	0.07%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	18,072	63.27%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	4,020	14.07%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	3,838	13.44%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	2,447	8.57%
TOTAL	28,562	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	809	95.06%	94.01%
Rural	42	4.94%	5.99%
Unknown	0	0.00%	0.00%
TOTAL	851	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	109	99.09%	94.48%
Rural	1	0.91%	5.52%
Unknown	0	0.00%	0.00%
TOTAL	110	100.00%	100.00%

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
1,225	1,044	85.22%

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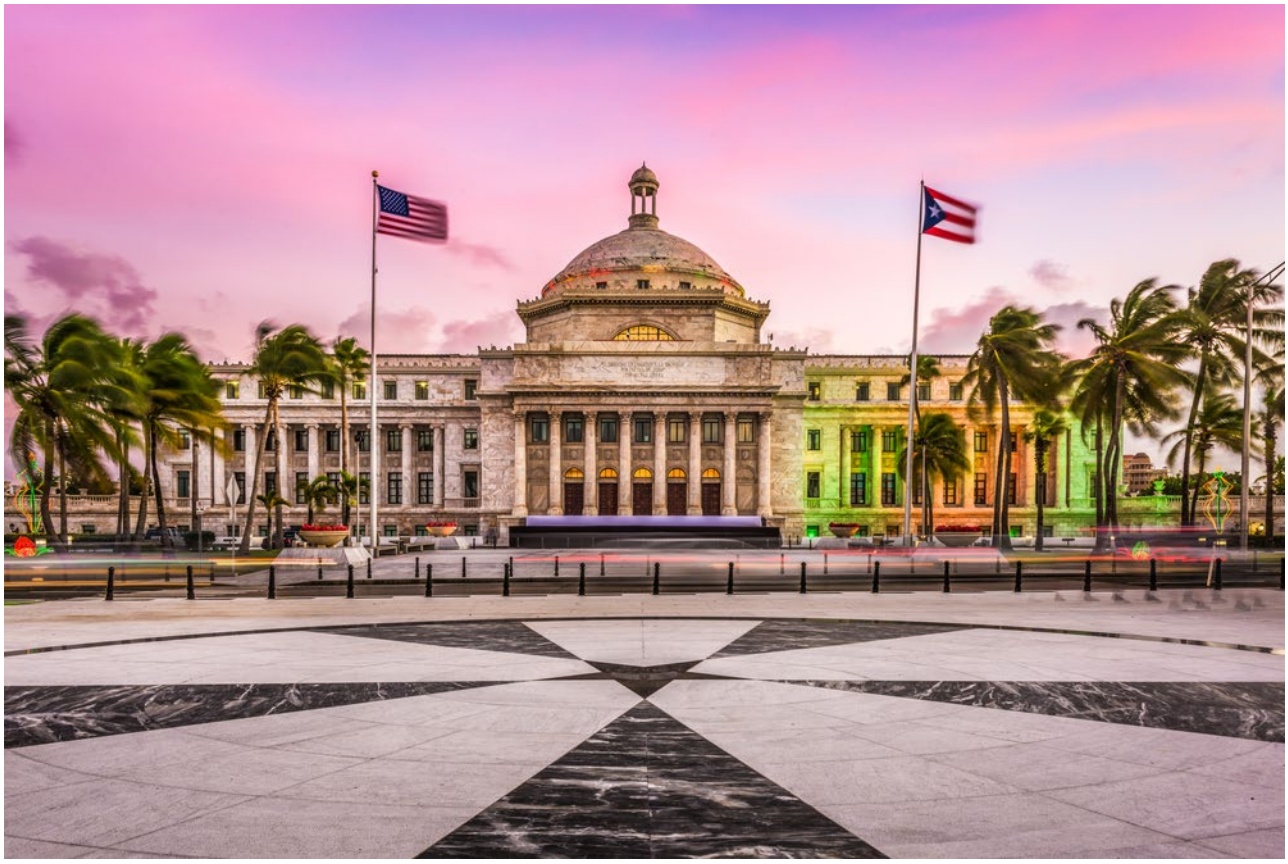
U.S. TERRITORY OF PUERTO RICO



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	16	10.32%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	10	6.45%
Notice of Non-coverage (Grijalva)	11	7.10%
Notice of Non-coverage (Hospital Discharge/Weichardt)	118	76.13%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
TOTAL	155	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Non-ST Elevation (NSTEMI) Myocardial Infarction (I214)	701	17.65%
2. COVID-19 (U071)	576	14.50%
3. Sepsis, Unspecified Organism (A419)	490	12.34%
4. Hypertensive Heart Disease With Heart Failure (I110)	451	11.35%
5. Urinary Tract Infection, Site Not Specified (N390)	422	10.62%
6. Pneumonia, Unspecified Organism (J189)	349	8.79%
7. Acute Kidney Failure, Unspecified (N179)	275	6.92%
8. Acute Ischemic Heart Disease, Unspecified (I249)	249	6.27%
9. Anemia, Unspecified (D649)	244	6.14%
10. Unilateral Primary Osteoarthritis, Left Knee (M1712)	215	5.41%
TOTAL	3,972	100.00%

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	124	53.45%
Sex/Gender	Male	108	46.55%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	232	100.00%
Race	Asian	0	0.00%
Race	Black	14	6.03%
Race	Hispanic	35	15.09%
Race	North American Native	0	0.00%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	Other	13	5.60%
Race	Unknown	2	0.86%
Race	White	168	72.41%
Race	**TOTAL**	232	100.00%
Age	Under 65	32	13.79%
Age	65-70	26	11.21%
Age	71-80	87	37.50%
Age	81-90	69	29.74%
Age	91+	18	7.76%
Age	**TOTAL**	232	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	40	63.49%
1: Distinct Psychiatric Facility	2	3.17%
2: Distinct Rehabilitation Facility	3	4.76%
3: Distinct Skilled Nursing Facility	2	3.17%
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 (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	6	9.52%
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	0	0.00%
R: Hospice	10	15.87%
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	63	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to Medicare 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 or her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen, Congress, etc.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Livanta, in keeping with CMS directions, referred all confirmed quality of care concerns that appeared to be systemic in nature and appropriate for quality improvement activities to the respective QIN-QIO for follow-up. For confirmed concerns that may have been amenable to a different approach to health care or related to documentation, Livanta retained the concerns and worked directly with the healthcare provider and/or practitioner. The below data reflects the total number of concerns referred to the QIN-QIO and not those retained by Livanta in order to provide technical assistance.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from 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)]	39	9	23.08%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	4	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	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	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	6	1	16.67%
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	15	0	0.00%
TOTAL	69	10	14.49%

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives

Number of Confirmed QoC Concerns Referred for QII	Percent (%) of Confirmed QoC Concerns Referred for QII
10	100.00%

QII Referral Details

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	1
Provider-Patient Care by Staff - Improvement needed in other patient care by staff area	2
Provider-Patient Care by Staff - Improvement needed in staff care planning	3

6) 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
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	11	7.91%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	10	7.19%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	19	13.67%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	99	71.22%
TOTAL	139	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	2	5.13%	94.01%
Rural	37	94.87%	5.99%
Unknown	0	0.00%	0.00%
TOTAL	39	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	2	18.18%	94.48%
Rural	9	81.82%	5.52%
Unknown	0	0.00%	0.00%
TOTAL	11	100.00%	100.00%

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
110	95	86.36%

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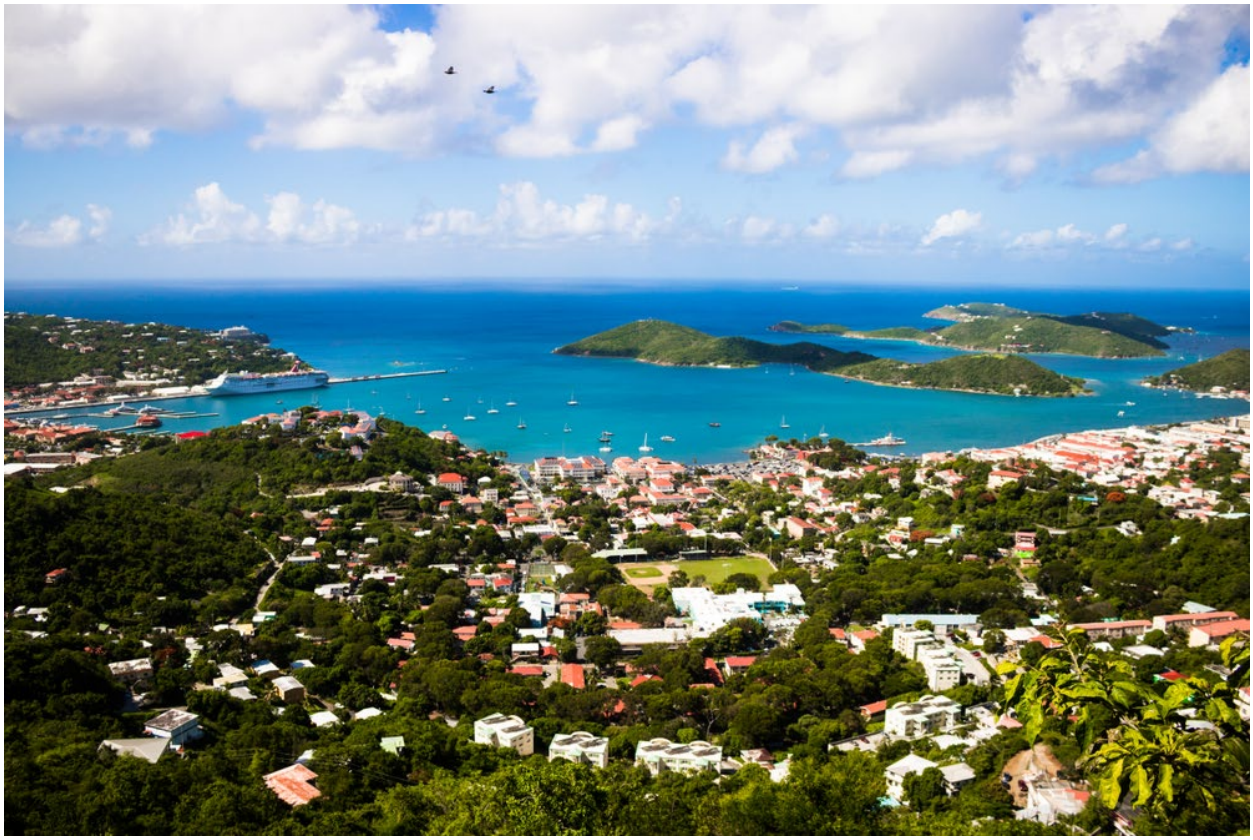
U.S. TERRITORY OF VIRGIN ISLANDS



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	1	7.14%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage (BIPA)	3	21.43%
Notice of Non-coverage (Grijalva)	0	0.00%
Notice of Non-coverage (Hospital Discharge/Weichardt)	10	71.43%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
TOTAL	14	100.00%

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Urinary Tract Infection, Site Not Specified (N390)	41	15.02%
2. COVID-19 (U071)	36	13.19%
3. Cerebral Infarction, Unspecified (I639)	35	12.82%
4. Pneumonia, Unspecified Organism (J189)	32	11.72%
5. Sepsis, Unspecified Organism (A419)	32	11.72%
6. Hypertensive Heart Disease With Heart Failure (I110)	29	10.62%
7. Acute Kidney Failure, Unspecified (N179)	24	8.79%
8. Other Pulmonary Embolism Without Acute Cor Pulmonale (I2699)	18	6.59%
9. Unspecified Intestinal Obstruction, Unspecified as to Partial Versus Complete Obstruction (K56609)	13	4.76%
10. Hypo-Osmolality And Hyponatremia (E871)	13	4.76%
TOTAL	273	100.00%

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	8	53.33%
Sex/Gender	Male	7	46.67%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	15	100.00%
Race	Asian	0	0.00%
Race	Black	11	73.33%
Race	Hispanic	1	6.67%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	North American Native	0	0.00%
Race	Other	0	0.00%
Race	Unknown	0	0.00%
Race	White	3	20.00%
Race	**TOTAL**	15	100.00%
Age	Under 65	1	6.67%
Age	65-70	2	13.33%
Age	71-80	4	26.67%
Age	81-90	6	40.00%
Age	91+	2	13.33%
Age	**TOTAL**	15	100.00%

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	2	50.00%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	0	0.00%
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 (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Free Standing Ambulatory Surgery Center	0	0.00%
G: End Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
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	0	0.00%
R: Hospice	2	50.00%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
TOTAL	4	100.00%

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to Medicare 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 or her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen, Congress, etc.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

Livanta, in keeping with CMS directions, referred all confirmed quality of care concerns that appeared to be systemic in nature and appropriate for quality improvement activities to the respective QIN-QIO for follow-up. For confirmed concerns that may have been amenable to a different approach to health care or related to documentation, Livanta retained the concerns and worked directly with the healthcare provider and/or practitioner. The below data reflects the total number of concerns referred to the QIN-QIO and not those retained by Livanta in order to provide technical assistance.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	2	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	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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)	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	1	0	0.00%
TOTAL	4	0	0.00%

5.B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives

Number of Confirmed QoC Concerns Referred for QII	Percent (%) of Confirmed QoC Concerns Referred for QII
0	0.00%

QII Referral Details

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
N/A	N/A

6) 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
Notice of Non-coverage FFS Preadmission/Admission Notice - (Admission and Preadmission/HINN 1)	0	0.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	0	0.00%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	3	23.08%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	7	53.85%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	3	23.08%
TOTAL	13	100.00%

7) Reviews by Geographic Area – Urban and Rural

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	0	0.00%	94.01%
Rural	4	100.00%	5.99%
Unknown	0	0.00%	0.00%
TOTAL	4	100.00%	100.00%

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

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	0	0.00%	94.48%
Rural	0	0.00%	5.52%
Unknown	0	0.00%	0.00%
TOTAL	0	0.00%	100.00%

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
4	3	75.00%