12th Statement of Work (SOW) | January 1, 2023 – October 31, 2023

ANNUAL MEDICAL SERVICES REVIEW REPORT

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

Region 2

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 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.

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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, 2023 through October 31, 2023. 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.

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)	641	1.57%
Quality of Care Review (All Other Selection Reasons)	56	0.14%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	175	0.43%
Notice of Non-coverage (BIPA)	6,062	14.86%
Notice of Non-coverage (Grijalva)	25,462	62.43%
Notice of Non-coverage (Hospital Discharge/Weichardt)	8,345	20.46%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	20	0.05%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	26	0.06%
EMTALA 60 Day	0	0.00%
TOTAL	**40,787**	**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)	43,069	31.20%
2. Covid-19 (U071)	14,656	10.62%
3. Hypertensive Heart Disease with Heart Failure (I110)	13,107	9.50%
4. Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease (I130)	12,971	9.40%
5. Acute Kidney Failure, Unspecified (N179)	11,556	8.37%
6. Urinary Tract Infection, Site Not Specified (N390)	11,394	8.26%
7. Pneumonia, Unspecified Organism (J189)	10,621	7.70%
8. Non-ST Elevation (NSTEMI) Myocardial Infarction (I214)	8,439	6.11%
9. Other Specified Sepsis (A4189)	6,450	4.67%
10. Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (J441)	5,760	4.17%
TOTAL	**138,023**	**100.00%**

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	249	16.97%
1: Distinct Psychiatric Facility	8	0.55%
2: Distinct Rehabilitation Facility	15	1.02%
3: Distinct Skilled Nursing Facility	909	61.96%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.07%
7: Dialysis Center Unit of Inpatient Facility	3	0.20%
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	1	0.07%
G: End Stage Renal Disease Unit	19	1.30%
H: Home Health Agency	92	6.27%
N: Critical Access Hospital	12	0.82%
O: Setting does not fit into any other existing setting code	4	0.27%
Q: Long-Term Care Facility	17	1.16%
R: Hospice	77	5.25%
S: Psychiatric Unit of an Inpatient Facility	28	1.91%
T: Rehabilitation Unit of an Inpatient Facility	14	0.95%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	8	0.55%
Y: Federally Qualified Health Centers	1	0.07%
Z: Swing Bed Designation for Critical Access Hospitals	9	0.61%
Other	0	0.00%
TOTAL	**1,467**	**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 suitable for different clinical approaches, are minor, or represent isolated occurrences, Livanta retained the cases 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 by Livanta and are referred, as appropriate, to CMS-designated QIN-QIO contractors who work with providers to develop Quality Improvement Initiatives 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	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	35	6	17.14%
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)]	270	42	15.56%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	57	8	14.04%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	10	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	1	33.33%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	6	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	39	7	17.95%
C11: Apparently did not demonstrate that the patient was ready for discharge	12	1	8.33%

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	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	23	3	13.04%
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	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	233	9	3.86%
TOTAL	**697**	**78**	**11.19%**

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
77	98.72%

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 acting on laboratory and imaging test results	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	7
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	42

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	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	8
Provider-Patient Care by Staff - Improvement needed in staff care planning	7
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	1
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	2
Provider-Patient Rights - Improvement needed in other patient rights area	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 (NOMNCs). Data contained in this table represent discharge or termination of service reviews from January 1, 2023 to October 31, 2023. 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)	0	0.00%
02: Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03: Discharged/transferred to skilled nursing facility (SNF)	0	0.00%
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	0	0.00%
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%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
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	0	0.00%
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%
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	**0**	**0.00%**

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)	174	18.97%	81.03%
Notice of Non-coverage Request for BFCC-QIO Concurrence (Request for BFCC-QIO Concurrence/ HINN 10)	20	15.00%	85.00%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	25,408	24.36%	75.64%

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Notice (%)	Physician Reviewer Agreed with Notice (%)
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	6,036	25.36%	74.64%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Hospital Discharge/Weichardt)	5,106	9.64%	90.36%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Hospital Discharge/Weichardt)	3,225	10.64%	89.36%
TOTAL	**39,969**	**21.50%**	**78.50%**

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 included below, 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.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
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.
Quality of Care	Pressure Ulcers	Clinical staging and management of pressure-induced skin and soft tissue injury (UpToDate) Last updated August 16, 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	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.
Quality of Care	Sepsis	Sepsis syndromes in adults: Epidemiology, definitions, clinical presentation, diagnosis, and prognosis (UpToDate)	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

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		Last updated September 15, 2023	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 September 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

Review Type	Evidence/Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		Administrative Contractors (MACs) for cases within their own respective jurisdiction.
Appeals	Regulations promulgated at 42 CFR §§422.624 and 626	These regulations provide authorization and describe the procedure for appeals from Medicare Advantage (MA) plan members in post-acute settings.
Appeals	Regulations promulgated at 42 C.F.R. 405.1200-1206 (see especially 42 CFR §405.1202)	These regulations provide authorization and describe the procedure for appeals from Medicare Fee-For-Service (FFS) beneficiaries in in post-acute settings.
Appeals	Regulations promulgated at 42 C.F.R. 405.1205 and 42 C.F.R. 422.620	These regulations provide authorization and describe the procedure for hospital appeals (not including Hospital-Issued Notices of Noncoverage [HINN] and Notice of Hospital Requested Review [HRR]).

8) 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	1,282	93.78%
Rural	85	6.22%
Unknown	0	0.00%
TOTAL	**1,367**	**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	141	94.00%
Rural	9	6.00%
Unknown	0	0.00%
TOTAL	**150**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Livanta's outreach and educational programming helps keep the Medicare community up to date with information about the BFCC-QIO Program. Aiming to empower stakeholders and individuals with knowledge and awareness of Medicare protections available through the BFCC-QIO Program, Livanta regularly emails updates and BFCC-QIO information to a range of stakeholders and diverse audiences. A significant aspect of Livanta's outreach and collaboration efforts includes educating Medicare beneficiaries, caregivers, and advocates about the role and purpose of the BFCC-QIO Program. Due to safety protocols initiated during the COVID-19 public health emergency that restricted in-person events, Livanta continued to conduct web-based educational programs and other virtual collaboration activities.

Digital Publications

During the reporting period, Livanta's stakeholder publications continued growing. The team emphasized several critical topics and educated Medicare stakeholders through Livanta's flagship publication, *The Livanta Compass*. Since its inception in 2019, *The Livanta Compass* weekly e-publication has grown to over 1,800 subscribers, with double-digit growth year-over-year. Additionally, this publication has sustained higher-than-industry-average open rates. Topics from 2023 that yielded high open rates included health equity, minority mental health awareness, Medicare's quality improvement contractors, and a series about quality of care concerns.

The Livanta Compass earned a Gold MarCom award for its series on quality health care. The series spanned four weeks of the e-publication and addressed these topics: Exploring Quality of Care Concerns, Pressure Injuries and Preventable Patient Harm, Medication Management, and Pain Management. Through this campaign, Livanta educated Medicare beneficiaries, healthcare providers, and other stakeholders about important care issues identified by Livanta's physician reviewers. 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, continued to demonstrate high levels of reader engagement throughout 2023 and has grown to include over 800 subscribers. With a bi-weekly production schedule, *The Livanta Beacon* e-publication is written for Medicare beneficiaries, 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* also continues to receive praise from stakeholders. *The Livanta Beacon* earned an honorable mention in the 2023 MarCom Awards in the healthcare category.

Social Media

In addition to its robust publications, Livanta leveraged social media to further engage beneficiaries, their families, and other caregivers. Livanta maintains an active presence across social media platforms that are most familiar to the general public, including Facebook, Twitter, Instagram, and LinkedIn. During this reporting period, Livanta published more than 1,159 posts across these platforms, reaching hundreds of individuals each week, and its social media following gained 102 followers.

To coincide with National Minority Health Month in April 2023, Livanta launched #BeAwareForBetterCare, a new social media toolkit. Throughout 2023, the Livanta team promoted this toolkit as a campaign to raise awareness of health equity and literacy and to encourage healthcare providers to share available resources with Medicare beneficiaries. The toolkit enabled partners and stakeholders to assist in raising awareness of health equity and literacy by providing a ready-to-use social media campaign. In creating the toolkit and its unique hashtag, Livanta considered CMS's Strategic Plan, which includes advancing equity and expanding access. The pillar of advancing health equity focuses on addressing the health disparities that underlie the nation's health system, and expanding access focuses on access to quality, affordable health coverage and care. The toolkit received recognition from partners and other federal organizations such as Health.gov and also garnered an impressive Platinum Award in the 2023 MarCom competition.

Website

During the reporting period, Livanta's BFCC-QIO website served as a knowledge portal for Livanta's outreach and education efforts. With more than 200,000 website hits per month, the website provides essential information for 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 2023, Livanta added FAQ documents to the website as a resource for advocates who assist Medicare beneficiaries in accessing BFCC-QIO services. Additionally, Livanta added a new page to the website during this reporting period that contains two social media toolkits for people to access on one page and share easily.

Partnerships and Education

Developing relationships with various stakeholder organizations is an important component of an effective outreach strategy, and Livanta works diligently to maintain relationships with a number of stakeholder organizations across the region. Through these efforts, Livanta establishes professional connections and forms and fosters these relationships over time. Speaking directly with stakeholders via telephone calls or more formally through a virtual platform helps Livanta disseminate BFCC-QIO Program information and essential updates rapidly and effectively.

Over several months in 2023, Livanta leveraged existing relationships to disseminate information about Livanta's forthcoming e-Appeal system. The communications team conducted dozens of meetings and webinars with key staff and stakeholders in Livanta's Medicare BFCC-QIO Regions. For example, the team contacted the State Health Insurance Program (SHIP) offices and State Long-Term Care Ombudsman Program (SLTCOP) offices in all regions to ensure that those who work directly with vulnerable populations daily were also informed about Livanta's soon-to-be-launched e-Appeal system.

Medicare's Region 2, comprised of New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands, is home to more than six million Medicare beneficiaries. New York City, the most densely populated city in the country, is directly adjacent to New Jersey, the nation's most densely populated state. During the reporting period, the Livanta communications team engaged in a targeted outreach campaign to

Medicare community stakeholders in this region regarding the forthcoming launch of Livanta's e-Appeals system. Livanta's e-Appeals system became available on its website in October 2023, giving Medicare beneficiaries and their caregivers the ability to file discharge and service termination appeals online.

As a part of this campaign, Livanta's communications team conducted outreach to several stakeholder organizations across Region 2. These organizations included the State Long-Term Care Ombudsman Program (SLTCOP) offices for New York, New York City, and New Jersey, the State Health Insurance Program (SHIP) offices for New York and New Jersey, a family resource center in New Jersey, and the Senior Medicare Patrol (SMP) office of New Jersey. Livanta's communications team also met with participants from several other stakeholder forums, including New York Medicare Partners, New Jersey Medicare Partners, and the Puerto Rico-Virgin Islands Medicare Stakeholders group, to announce the planned e-Appeals system. During these calls, more than 40 different patient advocacy groups were in attendance. This effort augmented Livanta's long-standing participation in community and stakeholder engagement forums for New York City, New Jersey, Puerto Rico, and the U.S. Virgin Islands.

10) Immediate Advocacy Cases

Immediate Advocacy is an informal, voluntary process used by Livanta to resolve complaints quickly. These complaints typically involve issues like communication gaps, language barriers, logistical issues such as access to supplies or equipment, or similar barriers to care. The Immediate Advocacy 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
1,420	1,193	84.01%

11) Example/Success Story

Eliminating Confusion Through Improved Communication

The beneficiary reported to a Livanta representative that he had been admitted to the hospital for knee surgery. He was informed by the hospital staff that he was being discharged, but no one had discussed a discharge plan with him. He was concerned that there was no plan in place and did not know where or if he would be going to a facility for rehabilitation.

After hearing the beneficiary's concern, Livanta's review coordinator explained the Immediate Advocacy process, to which he consented. The review coordinator called the provider and spoke with the social work manager, who referred the review coordinator to a specific social worker. Upon contacting the social worker and explaining the Immediate Advocacy process, the social worker agreed to participate. After hearing the beneficiary's concerns, the social worker explained that she was pursuing different facilities and sent referrals to them. Additionally, the beneficiary had filed a discharge appeal, which the social worker was waiting for the decision before addressing the discharge plan further. However, at the request of Livanta's review coordinator, the social worker agreed to discuss the discharge plan with the beneficiary.

The review coordinator followed up with the beneficiary to confirm the social worker had spoken with him, which she had. The beneficiary was satisfied that his concerns had been communicated and he now understood his options.

This case illustrates how unclear communication between healthcare professionals and beneficiaries can create confusion. In some cases, such as this one, beneficiaries may not fully understand their discharge plan, creating fear and tension. As a BFCC-QIO, Livanta supports Medicare beneficiaries by identifying and resolving communication breakdowns.

12) 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	171,692
Total Number of Calls Answered	114,456
Total Number of Abandoned Calls	1,784
Average Length of Call Wait Times	12.6 seconds
Number of Calls Transferred by 1-800-Medicare	565

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.

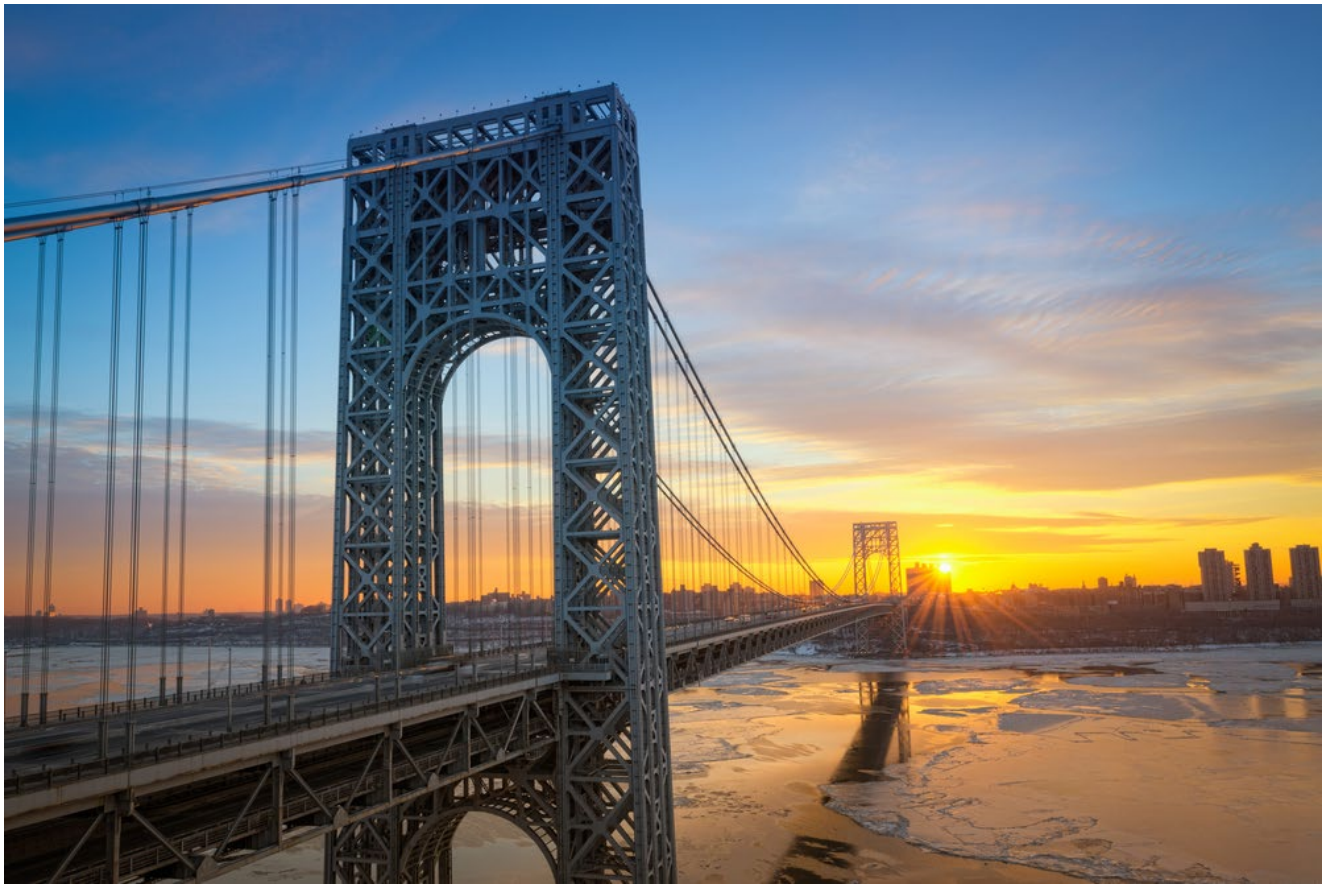
- The Medicare beneficiary complaints and appeals processes provide beneficiaries with a caring and empathetic advocate who contributes their expertise while conveying the beneficiaries' unique needs to healthcare providers. In addition, Livanta addresses these concerns with nationally recognized standards 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 and may request a Quality Improvement Initiative 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 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 provides timely, complete, and clinically sound physician opinions for 5-day and 60-day reviews described in EMTALA Section 1867(d)(3) for cases involving potential violations.
- 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)	249	1.74%
Quality of Care Review (All Other Selection Reasons)	6	0.04%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	7	0.05%
Notice of Non-coverage (BIPA)	2,421	16.96%
Notice of Non-coverage (Grijalva)	8,779	61.49%
Notice of Non-coverage (Hospital Discharge/Weichardt)	2,804	19.64%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.01%
EMTALA 5 Day	8	0.06%
EMTALA 60 Day	0	0.00%
TOTAL	**14,276**	**100.00%**

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Sepsis, Unspecified Organism (A419)	13,331	27.71%
2. Covid-19 (U071)	5,243	10.90%
3. Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease (I130)	5,032	10.46%
4. Hypertensive Heart Disease with Heart Failure (I110)	4,987	10.37%
5. Acute Kidney Failure, Unspecified (N179)	4,338	9.02%
6. Urinary Tract Infection, Site Not Specified (N390)	4,056	8.43%
7. Pneumonia, Unspecified Organism (J189)	3,918	8.14%
8. Non-St Elevation (NSTEMI) Myocardial Infarction (I214)	3,006	6.25%
9. Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (J441)	2,222	4.62%
10. Paroxysmal Atrial Fibrillation (I480)	1,976	4.11%
TOTAL	**48,109**	**100.00%**

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	7,135	60.36%
Sex/Gender	Male	4,686	39.64%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	**11,821**	**100.00%**
Race	Asian	185	1.57%
Race	Black	2,037	17.23%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	Hispanic	241	2.04%
Race	North American Native	2	0.02%
Race	Other	203	1.72%
Race	Unknown	160	1.35%
Race	White	8,993	76.08%
Race	**TOTAL**	**11,821**	**100.00%**
Age	Under 65	913	7.72%
Age	65-70	1,448	12.25%
Age	71-80	3,869	32.73%
Age	81-90	4,029	34.08%
Age	91+	1,562	13.21%
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	63	12.60%
1: Distinct Psychiatric Facility	4	0.80%
2: Distinct Rehabilitation Facility	9	1.80%
3: Distinct Skilled Nursing Facility	330	66.00%
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	1	0.20%
G: End Stage Renal Disease Unit	4	0.80%
H: Home Health Agency	25	5.00%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	2	0.40%
Q: Long-Term Care Facility	10	2.00%
R: Hospice	40	8.00%
S: Psychiatric Unit of an Inpatient Facility	8	1.60%
T: Rehabilitation Unit of an Inpatient Facility	4	0.80%
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	**500**	**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, was medically necessary, and provided in the correct setting. 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 suitable for different approaches to health care or related to documentation, Livanta retained the cases 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.

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	9	2	22.22%
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)]	110	17	15.45%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	17	2	11.76%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	6	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	12	3	25.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	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	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)	12	1	8.33%
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	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	80	2	2.50%
TOTAL	**255**	**27**	**10.59%**

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
26	96.30%

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	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	18
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 provision of patient education,	4

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
ensuring stability for discharge and providing discharge planning	
Provider-Patient Care by Staff - Improvement needed in staff care planning	2

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)	7	0.05%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	2	0.01%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	8,765	62.69%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	2,409	17.23%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	1,892	13.53%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	907	6.49%
TOTAL	**13,982**	**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	480	100.00%	93.78%
Rural	0	0.00%	6.22%
Unknown	0	0.00%	0.00%
TOTAL	**480**	**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	53	100.00%	94.00%
Rural	0	0.00%	6.00%

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Unknown	0	0.00%	0.00%
TOTAL	**53**	**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
441	357	80.95%

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)	355	1.35%
Quality of Care Review (All Other Selection Reasons)	50	0.19%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	168	0.64%
Notice of Non-coverage (BIPA)	3,623	13.75%
Notice of Non-coverage (Grijalva)	16,675	63.29%
Notice of Non-coverage (Hospital Discharge/Weichardt)	5,441	20.65%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	18	0.07%
EMTALA 5 Day	18	0.07%
EMTALA 60 Day	0	0.00%
TOTAL	**26,348**	**100.00%**

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Sepsis, Unspecified Organism (A419)	29,325	33.82%
2. Covid-19 (U071)	9,007	10.39%
3. Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease (I130)	7,785	8.98%
4. Hypertensive Heart Disease With Heart Failure (I110)	7,716	8.90%
5. Acute Kidney Failure, Unspecified (N179)	6,938	8.00%
6. Urinary Tract Infection, Site Not Specified (N390)	6,894	7.95%
7. Pneumonia, Unspecified Organism (J189)	6,219	7.17%
8. Non-St Elevation (NSTEMI) Myocardial Infarction (I214)	4,849	5.59%
9. Other Specified Sepsis (A4189)	4,365	5.03%
10. Paroxysmal Atrial Fibrillation (I480)	3,604	4.16%
TOTAL	**86,702**	**100.00%**

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	12,981	60.63%
Sex/Gender	Male	8,428	39.37%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	**21,409**	**100.00%**
Race	Asian	472	2.20%
Race	Black	3,561	16.63%
Race	Hispanic	555	2.59%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	North American Native	25	0.12%
Race	Other	458	2.14%
Race	Unknown	377	1.76%
Race	White	15,961	74.55%
Race	**TOTAL**	**21,409**	**100.00%**
Age	Under 65	1,699	7.94%
Age	65-70	2,616	12.22%
Age	71-80	6,823	31.87%
Age	81-90	7,306	34.13%
Age	91+	2,965	13.85%
Age	**TOTAL**	**21,409**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	146	16.22%
1: Distinct Psychiatric Facility	2	0.22%
2: Distinct Rehabilitation Facility	4	0.44%
3: Distinct Skilled Nursing Facility	576	64.00%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	1	0.11%
7: Dialysis Center Unit of Inpatient Facility	3	0.33%
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	13	1.44%
H: Home Health Agency	64	7.11%
N: Critical Access Hospital	12	1.33%
O: Setting does not fit into any other existing setting code	2	0.22%
Q: Long-Term Care Facility	7	0.78%
R: Hospice	22	2.44%
S: Psychiatric Unit of an Inpatient Facility	20	2.22%
T: Rehabilitation Unit of an Inpatient Facility	10	1.11%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	8	0.89%
Y: Federally Qualified Health Centers	1	0.11%
Z: Swing Bed Designation for Critical Access Hospitals	9	1.00%
Other	0	0.00%
TOTAL	**900**	**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, was medically necessary and provided in the correct setting. 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 suitable for different approaches to health care or related to documentation, Livanta retained the cases 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.

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	21	3	14.29%
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)]	147	22	14.97%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	38	5	13.16%
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	2	1	50.00%
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)	6	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	27	4	14.81%
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%

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	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	10	1	10.00%
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	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	140	6	4.29%
TOTAL	**405**	**43**	**10.62%**

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
43	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 acting on laboratory and imaging test results	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner diagnosis and evaluation of patients	5
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	22
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medical record documentation that impacts patient care	3
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	2

Category and Type Assigned to QIIs	Number of QIIs referred to a QIN-QIO for each Category Type
Provider-Patient Care by Staff - Improvement needed in staff care planning	2
Provider-Patient Care by Staff - Improvement needed in staff carrying out plan of care	1
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	2
Provider-Patient Rights - Improvement needed in other patient rights area	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)	167	0.65%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	18	0.07%
MA Appeal Review (CORF, HHA, SNF)/(Grijalva)	16,635	64.32%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	3,609	13.96%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	3,195	12.35%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	2,237	8.65%
TOTAL	**25,861**	**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	801	95.47%	93.78%
Rural	38	4.53%	6.22%
Unknown	0	0.00%	0.00%
TOTAL	**839**	**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	87	98.86%	94.00%
Rural	1	1.14%	6.00%
Unknown	0	0.00%	0.00%
TOTAL	**88**	**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
888	759	85.47%

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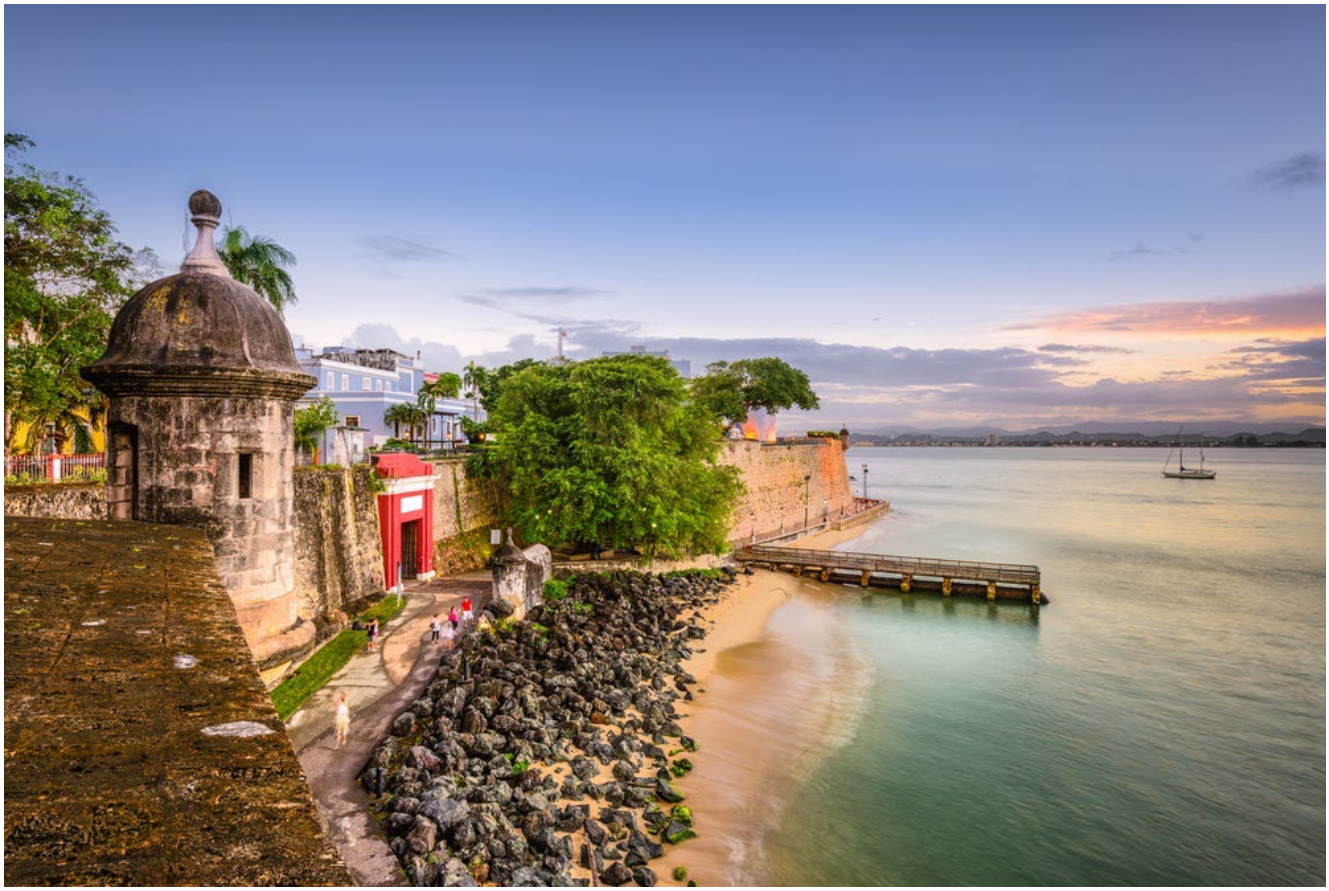
U.S. TERRITORY OF PUERTO RICO



1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	37	24.18%
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)	15	9.80%
Notice of Non-coverage (Grijalva)	7	4.58%
Notice of Non-coverage (Hospital Discharge/Weichardt)	94	61.44%
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	**153**	**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)	594	16.81%
2. Pneumonia, Unspecified Organism (J189)	439	12.43%
3. Urinary Tract Infection, Site Not Specified (N390)	420	11.89%
4. Sepsis, Unspecified Organism (A419)	416	11.77%
5. Hypertensive Heart Disease With Heart Failure (I110)	388	10.98%
6. Covid-19 (U071)	385	10.90%
7. Acute Kidney Failure, Unspecified (N179)	262	7.42%
8. Anemia, Unspecified (D649)	227	6.43%
9. Acute Ischemic Heart Disease, Unspecified (I249)	205	5.80%
10. Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation (J441)	197	5.58%
TOTAL	**3,533**	**100.00%**

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	100	58.14%
Sex/Gender	Male	72	41.86%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	**172**	**100.00%**
Race	Asian	0	0.00%
Race	Black	8	4.65%
Race	Hispanic	25	14.53%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	North American Native	0	0.00%
Race	Other	3	1.74%
Race	Unknown	0	0.00%
Race	White	136	79.07%
Race	**TOTAL**	**172**	**100.00%**
Age	Under 65	29	16.86%
Age	65-70	25	14.53%
Age	71-80	56	32.56%
Age	81-90	48	27.91%
Age	91+	14	8.14%
Age	**TOTAL**	**172**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	38	62.30%
1: Distinct Psychiatric Facility	2	3.28%
2: Distinct Rehabilitation Facility	2	3.28%
3: Distinct Skilled Nursing Facility	3	4.92%
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	1	1.64%
H: Home Health Agency	2	3.28%
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	13	21.31%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
TOTAL	**61**	**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, was medically necessary and provided in the correct setting. 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 suitable for different approaches to health care or related to documentation, Livanta retained the cases 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.

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	5	1	20.00%
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	2	1	50.00%
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	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	2	1	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%

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)	1	1	100.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	13	1	7.69%
TOTAL	**37**	**8**	**21.62%**

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
8	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 diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner general treatment planning/administration	2
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner provision of patient education, ensuring stability for discharge and providing discharge planning	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)	7	6.03%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	15	12.93%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	14	12.07%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	80	68.97%
TOTAL	**116**	**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	1	2.27%	93.78%
Rural	43	97.73%	6.22%
Unknown	0	0.00%	0.00%
TOTAL	**44**	**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	1	11.11%	94.00%
Rural	8	88.89%	6.00%
Unknown	0	0.00%	0.00%
TOTAL	**9**	**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
76	62	81.58%

LIVANTA | BFCC-QIO REGION 2

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)	0	0.00%
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	30.00%
Notice of Non-coverage (Grijalva)	1	10.00%
Notice of Non-coverage (Hospital Discharge/Weichardt)	6	60.00%
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	**10**	**100.00%**

2) Top 10 Principal Medical Diagnoses

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. Pneumonia, Unspecified Organism (J189)	46	16.97%
2. Sepsis, Unspecified Organism (A419)	37	13.65%
3. Cerebral Infarction, Unspecified (I639)	35	12.92%
4. Hypertensive Heart Disease With Heart Failure (I110)	32	11.81%
5. Covid-19 (U071)	31	11.44%
6. Urinary Tract Infection, Site Not Specified (N390)	28	10.33%
7. Acute Kidney Failure, Unspecified (N179)	23	8.49%
8. Type 2 Diabetes W Diabetic Peripheral Angiopathy W Gangrene (E1152)	13	4.80%
9. Hypertensive Chronic Kidney Disease with Stage 5 Chronic Kidney Disease or End Stage Renal Disease (ESRD) (I120)	13	4.80%
10. Unspecified Atrial Fibrillation (I4891)	13	4.80%
TOTAL	**271**	**100.00%**

3) Beneficiary Demographics Possible Data Source

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender	Female	8	80.00%
Sex/Gender	Male	2	20.00%
Sex/Gender	Unknown	0	0.00%
Sex/Gender	**TOTAL**	**10**	**100.00%**
Race	Asian	0	0.00%
Race	Black	6	60.00%

Category	Demographic	Number of Beneficiaries	Percent of Beneficiaries
Race	Hispanic	1	10.00%
Race	North American Native	0	0.00%
Race	Other	0	0.00%
Race	Unknown	0	0.00%
Race	White	3	30.00%
Race	**TOTAL**	**10**	**100.00%**
Age	Under 65	0	0.00%
Age	65-70	2	20.00%
Age	71-80	2	20.00%
Age	81-90	4	40.00%
Age	91+	2	20.00%
Age	**TOTAL**	**10**	**100.00%**

4) Provider Reviews Settings

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	2	33.33%
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	1	16.67%
H: Home Health Agency	1	16.67%
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	33.33%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
TOTAL	**6**	**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, was medically necessary and provided in the correct setting. 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 suitable for different approaches to health care or related to documentation, Livanta retained the cases 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.

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)]	0	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%

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	0	0	0.00%
TOTAL	**0**	**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)	1	10.00%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF)/(BIPA)	3	30.00%

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (FFS Weichardt)	5	50.00%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs (MA Weichardt)	1	10.00%
TOTAL	**10**	**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%	93.78%
Rural	4	100.00%	6.22%
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%	94.00%
Rural	0	0.00%	6.00%
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
15	15	100.00%