QIO Program
BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 2
(January 1 - December 31, 2020)

Region 1
CT – MA – ME – NH – RI – VT

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

Kepro™

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INTRODUCTION:

Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 1, which covers the following states: Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont. The Quality Improvement Organization (QIO) Program is an integral part of the U.S. Department of Health and Human Services National Quality Strategy and the CMS Quality Strategy. Within this report, you will find data which reflects the work completed by Kepro within the second year of its BFCC-QIO contract. The first section of this report contains regional data followed by an Appendix with state-specific data.

The QIO Program is all about improving the quality, safety, and value of the care the Medicare beneficiary receives through the Medicare program. CMS identifies the core functions of the QIO Program as:

- 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 expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

BFCC-QIOs, such as Kepro, review complaints about the quality of medical care. They also provide an appeal process for Medicare beneficiaries when a healthcare provider wants to discontinue services or discharge the beneficiary from the hospital. Kepro provides a service called Immediate Advocacy for beneficiaries who want to quickly resolve a Medicare situation with a provider, which does not require a medical record review. By providing these services, the rights of Medicare beneficiaries are protected while also protecting the Medicare Trust Fund.

ANNUAL REPORT:

1) TOTAL NUMBER OF REVIEWS

The data below reflects the total number of medical record reviews completed for Region 1.

The BFCC-QIO has review authority for a number of different situations. These include:

- Beneficiaries or their appointed representatives who have concerns related to the quality of provided healthcare services by either a facility or physician.
- Beneficiaries or their representatives who are appealing a pending hospital discharge or the discontinuation of skilled services such as physical therapy.
- Potential Emergency Medical Treatment & Labor Act (EMTALA) violations – In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	92	1.05%
Quality of Care Review (All Other Selection Reasons)	34	0.39%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	65	0.74%
Notice of Non-coverage (BIPA)	2,631	30.15%
Notice of Non-coverage (Grijalva)	4,226	48.43%
Notice of Non-coverage (Weichardt)	1,673	19.17%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	5	0.06%
Emergency Medical Treatment & Labor Act (EMTALA) 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**8,726**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	24,765	26.90%
2. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	10,133	11.01%
3. U071 - COVID-19	9,493	10.31%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	8,574	9.31%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	8,510	9.24%
6. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	7,716	8.38%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	6,501	7.06%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
8. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	6,424	6.98%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	5,225	5.68%
10. J690 - PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	4,721	5.13%
Total	**92,062**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	135	14.27%
1: Distinct Psychiatric Facility	8	0.85%
2: Distinct Rehabilitation Facility	12	1.27%
3: Distinct Skilled Nursing Facility	644	68.08%
5: Clinic	2	0.21%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	1	0.11%
8: Independent Based Rural Health Clinic (RHC)	1	0.11%
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	3	0.32%
H: Home Health Agency	57	6.03%
N: Critical Access Hospital	19	2.01%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	15	1.59%
R: Hospice	39	4.12%
S: Psychiatric Unit of an Inpatient Facility	3	0.32%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.11%
Y: Federally Qualified Health Centers	3	0.32%
Z: Swing Bed Designation for Critical Access Hospitals	3	0.32%
Other	0	0.00%
Total	**946**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflects the category of quality of care concerns identified during medical record reviews along with the corresponding outcome.

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

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the healthcare provider and/or practitioner.

4.A. QUALITY OF CARE CONCERNS CONFIRMED

The below data reflects the total number of confirmed concerns.

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	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	27	7	25.93%
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)]	62	4	6.45%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	40	13	32.50%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	1	25.00%
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	3	1	33.33%
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	5	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	15	8	53.33%
C11: Apparently did not demonstrate that the patient was ready for discharge	25	2	8.00%
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	5	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	25	4	16.00%
C17: Apparently did not order/follow evidence-based practices	6	5	83.33%
C18: Apparently did not provide medical record documentation that impacts patient care	12	5	41.67%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	38	6	15.79%
Total	**279**	**56**	**20.07%**

4.B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up.

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**
24	42.86%
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	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	4
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 provision of patient education, ensuring stability for discharge and providing discharge planning	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner test/procedure/surgery technique	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	5
Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	1
Provider-Patient Care by Staff - Improvement needed in staff assessments	1
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1

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 anesthesia complications	1
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 medication errors	3

5) DISCHARGE/SERVICE TERMINATIONS

The data below reflects the discharge location of beneficiaries linked to discharge/service termination reviews for Request for BFCC-QIO Concurrence and Weichardt Reviews completed in Region 1. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self care (routine discharge)	19	14.07%
02: Discharged/transferred to another short-term general hospital for inpatient care	4	2.96%
03: Discharged/transferred to skilled nursing facility (SNF)	50	37.04%
04: Discharged/transferred to intermediate care facility (ICF)	4	2.96%
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	48	35.56%
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)	2	1.48%
21: Discharged/transferred to court/law enforcement	0	0.00%
30: Still a patient	1	0.74%
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	2	1.48%
51: Hospice - medical facility	1	0.74%
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	3	2.22%
63: Discharged/transferred to a long-term care hospital	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
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	1	0.74%
Other	0	0.00%
Total	**135**	**100.00%**

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

The data below reflect the number of appeal reviews and the percentage of reviews, for each outcome, in which the physician reviewer either agreed or disagreed with the hospital discharge or discontinuation of skilled services decision.

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/Admission - (Admission and Preadmission/HINN 1)	65	20.00%	80.00%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	4	100.00%	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	3,184	31.78%	68.22%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	2,277	22.27%	77.73%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	953	5.56%	94.44%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (MA Weichardt)	396	8.84%	91.16%
Total	**6,879**	**23.61%**	**76.39%**

7) Evidence Used in Decision-Making

The table that follows describes the most common types of evidence or standards of care used to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions for medical necessity/utilization review and appeals.

For the Quality of Care reviews, Kepro has provided one to three of the most highly utilized types of evidence/standards of care to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions. A brief statement of the rationale for selecting the specific evidence or standards of care is also included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
Quality of Care	Pneumonia	CMS' Pneumonia indicators (PN 2-7) UpToDate®	CMS' guidelines for the management of patients with Community Acquired Pneumonia (CAP) address basic aspects of preventive care and treatment. The guidelines emphasize the importance of vaccination as well as the need for appropriate and timely antimicrobial therapy. Adherence to guidelines is associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Heart Failure	American College of Cardiology (ACC); CMS' Heart Failure indicators (HF 1-3) UpToDate®	ACC's guidelines for the management of patients with heart failure address aspects of care that when followed are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers. CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.

			UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Acute Myocardial Infarction	American College of Cardiology (ACC) Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10) UpToDate®	ACC's guidelines for the management of patients with acute myocardial infarction address aspects of care that when followed are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7) UpToDate®	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Sepsis	Institute for Healthcare Improvement (IHI) UpToDate®	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way

			clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Adverse Drug Events	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.
	Falls	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.
	Patient Trauma	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events or serious medical errors.
	Surgical Complications	Surgical complications	Kepro's Generic Quality Screening Tool
Appeals		National Coverage Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria	Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) are made through an evidence-based process.

8) Reviews by Geographic Area

In tables 8A-B, Kepro has provided the count and percent by rural vs. urban geographical locations for Health Service Providers (HSPs) associated with a completed BFCC-QIO review.

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

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	786	88.71%
Rural	92	10.38%
Unknown	8	0.90%
Total	**886**	**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	61	91.04%
Rural	5	7.46%
Unknown	1	1.49%
Total	**67**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro has developed a valuable partnership with the Massachusetts Senior Medicare Patrol (MA SMP) program, which educates Medicare beneficiaries, family members, and professionals on the importance of being engaged healthcare consumers. Kepro has been a participating member of the MA SMP program's Statewide Advisory Committee, which is comprised of diverse representatives that aim to educate all Medicare and Medicaid beneficiaries. Kepro has been able to connect with organizations such as the Region 1 CMS office, MA Office for Refugees and Immigrants (ORI), and MA Healthy Aging Collaborative. While exploring partnerships in the Statewide Advisory Committee meetings, Kepro was introduced to the MA SMP initiative to provide virtual group education sessions to senior centers throughout the state of Massachusetts. Kepro has participated in several sessions, and Kepro contact information has been included in the MA SMP slide presentations. The MA SMP program conducted approximately 40 education sessions, reaching roughly 8,000 Medicare beneficiaries. The MA SMP has also provided a testimony of their experience and collaboration efforts with Kepro, which was included in Kepro's quarterly newsletter.

10) Immediate Advocacy Cases

The data below reflects the number of beneficiary complaints resolved through the use of Immediate Advocacy.

Based on the nature of the concern(s) raised by the beneficiary, Kepro staff members may recommend the use of Immediate Advocacy. Immediate Advocacy is an informal process used to quickly resolve an oral or verbal complaint. In this process, Kepro makes immediate/direct contact with a provider and/or practitioner for the beneficiary. The Kepro staff member will summarize what Immediate Advocacy involves for the beneficiary and obtain the beneficiary's oral consent to participate in Immediate Advocacy before proceeding.

During Contract Year 2 and due to the COVID-19 impact, Kepro has made a strategic plan to highly encourage Medicare beneficiaries and/or family members to take advantage of the advocacy benefits. As a result, a high

percentage of beneficiary-initiated quality of care complaints are being resolved through the use of Immediate Advocacy.

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
310	256	82.58%

11) EXAMPLE/SUCCESS STORY

A Medicare beneficiary was admitted to the hospital for COVID-19 symptoms. After being unable to return to the assisted living facility, the beneficiary was transferred to a skilled nursing facility (SNF) for therapies. It was determined that the beneficiary was positive for COVID-19.

The beneficiary's son called Kepro to discuss concerns with the beneficiary's SNF stay, which included how there was no psychiatric evaluation given, he was never informed that the beneficiary refused therapy, and was informed that the 100th skilled day would be approaching in days. The Immediate Advocacy process and limitations were discussed by the clinical reviewer (CR), including an option of either a 3-way call or the CR could advocate on the beneficiary representative's behalf. The representative was agreeable to Immediate Advocacy and provided permission to disclose identity. The representative requested that the CR call the SNF, to advocate on his behalf.

The CR was able to speak to the Case Manager and the Assistant Facility Administrator regarding the representative's concerns and discussed a COVID-19 waiver for SNFs.

As a result, the SNF coverage was renewed, the psychiatric evaluation was scheduled to be completed, and the beneficiary would be re-evaluated by physical therapy.

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	50,584
Total Number of Calls Answered	43,387
Total Number of Abandoned Calls	5,652
Average Length of Call Wait Times	00:03:11 (191 Secs)
Number of Calls Transferred by 1-800-Medicare	155

CONCLUSION:

Kepro's outcomes and findings for year two of this CMS contract outline the daily work performed during the pursuit of care improvements provided to the individual Medicare beneficiary. These reviews provide solid data that can be extrapolated to improve the quality of provider care throughout the system based upon these individual's experiences as a part of the overall system. COVID-19 presented unique challenges throughout year, but Kepro was able to adapt to the circumstances and assist Medicare beneficiaries, their families, and healthcare providers and practitioners as they coped with the pandemic.

APPENDIX

KEPRO BFCC-QIO REGION 1 – STATE OF CONNECTICUT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	34	0.96%
Quality of Care Review (All Other Selection Reasons)	5	0.14%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	2	0.06%
Notice of Non-coverage (BIPA)	1,055	29.64%
Notice of Non-coverage (Grijalva)	2,019	56.73%
Notice of Non-coverage (Weichardt)	443	12.45%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.03%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**3,559**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	5,867	30.17%
2. U071 - COVID-19	2,407	12.38%
3. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	1,930	9.92%
4. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	1,912	9.83%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	1,744	8.97%
6. A4189 - OTHER SPECIFIED SEPSIS	1,429	7.35%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	1,251	6.43%
8. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	1,091	5.61%
9. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	979	5.03%
10. J690 - PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	838	4.31%
Total	**19,448**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,239	60.53%
Male	808	39.47%
Unknown	0	0.00%
Total	**2,047**	**100.00%**
Race		

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Asian	19	0.93%
Black	183	8.94%
Hispanic	18	0.88%
North American Native	1	0.05%
Other	23	1.12%
Unknown	24	1.17%
White	1,779	86.91%
Total	**2,047**	**100.00%**
Age		
Under 65	149	7.28%
65-70	213	10.41%
71-80	624	30.48%
81-90	715	34.93%
91+	346	16.90%
Total	**2,047**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	29	11.37%
1: Distinct Psychiatric Facility	1	0.39%
2: Distinct Rehabilitation Facility	2	0.78%
3: Distinct Skilled Nursing Facility	190	74.51%
5: Clinic	1	0.39%
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	20	7.84%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	0.39%
R: Hospice	9	3.53%
S: Psychiatric Unit of an Inpatient Facility	2	0.78%
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	**255**	**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 beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the healthcare provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

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	11	1	9.09%
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)]	18	3	16.67%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	12	5	41.67%
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	1	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	2	1	50.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	2	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	3	2	66.67%
C11: Apparently did not demonstrate that the patient was ready for discharge	10	1	10.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	3	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	2	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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)	9	1	11.11%
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	5	1	20.00%
Total	**80**	**15**	**18.75%**

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**
11	73.33%
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	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner medication management	4
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner monitoring of patient response/changes and adjusting treatment	1
Provider-Continuity of Care - Improvement needed in staff assessment completion/reporting	1
Provider-Patient Care by Staff - Improvement needed in staff assessments	1
Provider-Patient Care by Staff - Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Patient Rights - Improvement needed in notice of noncoverage issuance	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	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)	3	0.10%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.03%

MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	1,576	54.80%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	920	31.99%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	242	8.41%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	134	4.66%
Total	**2,876**	**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	233	95.49%	88.71%
Rural	7	2.87%	10.38%
Unknown	4	1.64%	0.90%
Total	**244**	**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	17	94.44%	91.04%
Rural	0	0.00%	7.46%
Unknown	1	5.56%	1.49%
Total	**18**	**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
100	80	80.00%

KEPRO BFCC-QIO REGION 1 – STATE OF MAINE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	11	1.78%
Quality of Care Review (All Other Selection Reasons)	2	0.32%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	9	1.45%
Notice of Non-coverage (BIPA)	77	12.44%
Notice of Non-coverage (Grijalva)	346	55.90%
Notice of Non-coverage (Weichardt)	173	27.95%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.16%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**619**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	2,114	31.24%
2. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	729	10.77%
3. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	726	10.73%
4. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	621	9.18%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	575	8.50%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	544	8.04%
7. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	425	6.28%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	406	6.00%
9. J690 - PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	344	5.08%
10. I480 - PAROXYSMAL ATRIAL FIBRILLATION	282	4.17%
Total	**6,766**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	187	52.82%
Male	167	47.18%
Unknown	0	0.00%
Total	**354**	**100.00%**
Race		
Asian	0	0.00%
Black	4	1.13%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	1	0.28%
North American Native	0	0.00%
Other	0	0.00%
Unknown	5	1.41%
White	344	97.18%
Total	**354**	**100.00%**
Age		
Under 65	51	14.41%
65-70	46	12.99%
71-80	104	29.38%
81-90	123	34.75%
91+	30	8.47%
Total	**354**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	13	15.12%
1: Distinct Psychiatric Facility	1	1.16%
2: Distinct Rehabilitation Facility	1	1.16%
3: Distinct Skilled Nursing Facility	57	66.28%
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	1	1.16%
N: Critical Access Hospital	8	9.30%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	3.49%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	1.16%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	1	1.16%
Other	0	0.00%
Total	**86**	**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 beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

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	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	5	0	0.00%
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	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)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	3	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	0	0.00%
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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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	1	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	1	0	0.00%
Total	**21**	**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**
N/A	N/A
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)	7	1.55%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	1	0.22%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	266	58.72%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	65	14.35%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	68	15.01%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	46	10.15%
Total	**453**	**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	41	51.25%	88.71%
Rural	37	46.25%	10.38%
Unknown	2	2.50%	0.90%
Total	**80**	**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	4	57.14%	91.04%
Rural	3	42.86%	7.46%
Unknown	0	0.00%	1.49%
Total	**7**	**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
28	23	82.14%

KEPRO BFCC-QIO REGION 1 – STATE OF MASSACHUSETTS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	31	1.17%
Quality of Care Review (All Other Selection Reasons)	21	0.79%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	10	0.38%
Notice of Non-coverage (BIPA)	1,165	43.81%
Notice of Non-coverage (Grijalva)	910	34.22%
Notice of Non-coverage (Weichardt)	521	19.59%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.04%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**2,659**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	12,673	25.27%
2. U071 - COVID-19	6,054	12.07%
3. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	5,571	11.11%
4. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	4,662	9.29%
5. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	4,468	8.91%
6. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	4,434	8.84%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	3,605	7.19%
8. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	2,934	5.85%
9. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	2,926	5.83%
10. J690 - PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	2,830	5.64%
Total	**50,157**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,009	60.82%
Male	650	39.18%
Unknown	0	0.00%
Total	**1,659**	**100.00%**
Race		
Asian	12	0.72%
Black	66	3.98%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	7	0.42%
North American Native	0	0.00%
Other	19	1.15%
Unknown	19	1.15%
White	1,536	92.59%
Total	**1,659**	**100.00%**
Age		
Under 65	145	8.74%
65-70	181	10.91%
71-80	428	25.80%
81-90	586	35.32%
91+	319	19.23%
Total	**1,659**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	63	16.03%
1: Distinct Psychiatric Facility	4	1.02%
2: Distinct Rehabilitation Facility	8	2.04%
3: Distinct Skilled Nursing Facility	261	66.41%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	1	0.25%
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	0.25%
H: Home Health Agency	23	5.85%
N: Critical Access Hospital	1	0.25%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	11	2.80%
R: Hospice	18	4.58%
S: Psychiatric Unit of an Inpatient Facility	1	0.25%
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	1	0.25%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**393**	**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 beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

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	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	13	5	38.46%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	24	1	4.17%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	17	8	47.06%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	1	33.33%
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)	3	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	4	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	7	5	71.43%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	1	16.67%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty 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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	13	2	15.38%
C17: Apparently did not order/follow evidence-based practices	5	5	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	11	5	45.45%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	26	5	19.23%
Total	**135**	**38**	**28.15%**

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	26.32%
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 provision of patient education, ensuring stability for discharge and providing discharge planning	1
Practitioner-Patient Care by Practitioner - Improvement needed in practitioner test/procedure/surgery technique	1
Provider-Continuity of Care - Improvement needed in case management/discharge planning	4
Provider-Patient Care by Staff - Improvement needed in staff following provider established care protocols	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of anesthesia complications	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of medication errors	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)	13	0.61%
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)	682	32.26%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	994	47.02%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	339	16.04%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	86	4.07%
Total	**2,114**	**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	357	98.62%	88.71%
Rural	5	1.38%	10.38%
Unknown	0	0.00%	0.90%
Total	**362**	**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	30	100.00%	91.04%
Rural	0	0.00%	7.46%
Unknown	0	0.00%	1.49%
Total	**30**	**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
131	112	85.50%

KEPRO BFCC-QIO REGION 1 – STATE OF NEW HAMPSHIRE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	4	0.88%
Quality of Care Review (All Other Selection Reasons)	4	0.88%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	17	3.73%
Notice of Non-coverage (BIPA)	86	18.86%
Notice of Non-coverage (Grijalva)	172	37.72%
Notice of Non-coverage (Weichardt)	173	37.94%
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	**456**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	2,256	26.62%
2. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	1,036	12.22%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	962	11.35%
4. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	807	9.52%
5. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	807	9.52%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	735	8.67%
7. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	594	7.01%
8. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	517	6.10%
9. I480 - PAROXYSMAL ATRIAL FIBRILLATION	398	4.70%
10. J690 - PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT	364	4.29%
Total	**8,476**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	173	59.25%
Male	119	40.75%
Unknown	0	0.00%
Total	**292**	**100.00%**
Race		
Asian	2	0.68%
Black	4	1.37%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	0	0.00%
North American Native	0	0.00%
Other	1	0.34%
Unknown	2	0.68%
White	283	96.92%
Total	**292**	**100.00%**
Age		
Under 65	44	15.07%
65-70	36	12.33%
71-80	80	27.40%
81-90	93	31.85%
91+	39	13.36%
Total	**292**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	13	17.11%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	1.32%
3: Distinct Skilled Nursing Facility	47	61.84%
5: Clinic	1	1.32%
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)	1	1.32%
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	1.32%
H: Home Health Agency	2	2.63%
N: Critical Access Hospital	6	7.89%
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	2.63%
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	2	2.63%
Other	0	0.00%
Total	**76**	**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 beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED.

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	1	1	100.00%
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)]	5	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	6	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	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	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%
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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	1	50.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	3	0	0.00%
Total	**19**	**2**	**10.53%**

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**
2	100%
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 monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Safety of the Environment in Patient Care - Improvement needed in prevention of decubiti or worsening of existing decubiti	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)	19	5.43%
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)	124	35.43%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	76	21.71%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	115	32.86%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	16	4.57%
Total	**350**	**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	51	70.83%	88.71%
Rural	19	26.39%	10.38%
Unknown	2	2.78%	0.90%
Total	**72**	**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	4	80.00%	91.04%
Rural	1	20.00%	7.46%
Unknown	0	0.00%	1.49%
Total	**5**	**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
16	14	87.50%

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KEPRO BFCC-QIO REGION 1 – STATE OF RHODE ISLAND

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	10	0.81%
Quality of Care Review (All Other Selection Reasons)	2	0.16%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	22	1.78%
Notice of Non-coverage (BIPA)	201	16.24%
Notice of Non-coverage (Grijalva)	706	57.03%
Notice of Non-coverage (Weichardt)	297	23.99%
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	**1,238**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	1,112	22.88%
2. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	584	12.01%
3. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	578	11.89%
4. U071 - COVID-19	530	10.90%
5. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	420	8.64%
6. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	406	8.35%
7. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	350	7.20%
8. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	330	6.79%
9. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	320	6.58%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	231	4.75%
Total	**4,861**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	424	60.74%
Male	274	39.26%
Unknown	0	0.00%
Total	**698**	**100.00%**
Race		
Asian	5	0.72%
Black	23	3.30%
Hispanic	2	0.29%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
North American Native	0	0.00%
Other	10	1.43%
Unknown	10	1.43%
White	648	92.84%
Total	**698**	**100.00%**
Age		
Under 65	79	11.32%
65-70	77	11.03%
71-80	175	25.07%
81-90	246	35.24%
91+	121	17.34%
Total	**698**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	11	11.00%
1: Distinct Psychiatric Facility	1	1.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	69	69.00%
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	9	9.00%
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	3	3.00%
R: Hospice	5	5.00%
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	2	2.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**100**	**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 beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

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	1	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	9	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	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	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	4	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	2	0	0.00%
Total	**20**	**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**
N/A	N/A
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)	18	1.97%
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)	486	53.29%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	178	19.52%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	127	13.93%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	103	11.29%
Total	**912**	**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	94	100.00%	88.71%
Rural	0	0.00%	10.38%
Unknown	0	0.00%	0.90%
Total	**94**	**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	6	100.00%	91.04%
Rural	0	0.00%	7.46%
Unknown	0	0.00%	1.49%
Total	**6**	**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
27	20	74.07%

KEPRO BFCC-QIO REGION 1 – STATE OF VERMONT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	2	0.90%
Quality of Care Review (All Other Selection Reasons)	0	0.00%
Utilization/Medical Necessity (All Selection Reasons)	N/A	N/A
Notice of Non-coverage (Admission and Preadmission/HINN 1)	5	2.25%
Notice of Non-coverage (BIPA)	47	21.17%
Notice of Non-coverage (Grijalva)	73	32.88%
Notice of Non-coverage (Weichardt)	93	41.89%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.90%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
Total	**222**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 - SEPSIS, UNSPECIFIED ORGANISM	743	21.10%
2. J189 - PNEUMONIA, UNSPECIFIED ORGANISM	413	11.73%
3. I214 - NON-ST ELEVATION (NSTEMI) MYOCARDIAL INFARCTION	408	11.59%
4. I110 - HYPERTENSIVE HEART DISEASE WITH HEART FAILURE	338	9.60%
5. N390 - URINARY TRACT INFECTION, SITE NOT SPECIFIED	315	8.95%
6. I130 - HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY	304	8.63%
7. N179 - ACUTE KIDNEY FAILURE, UNSPECIFIED	297	8.44%
8. J441 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W (ACUTE) EXACERBATION	272	7.73%
9. M1711 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE	222	6.31%
10. M1712 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE	209	5.94%
Total	**3,521**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	71	49.31%
Male	73	50.69%
Unknown	0	0.00%
Total	**144**	**100.00%**
Race		
Asian	3	2.08%
Black	2	1.39%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Hispanic	0	0.00%
North American Native	0	0.00%
Other	1	0.69%
Unknown	1	0.69%
White	137	95.14%
Total	**144**	**100.00%**
Age		
Under 65	20	13.89%
65-70	14	9.72%
71-80	46	31.94%
81-90	38	26.39%
91+	26	18.06%
Total	**144**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	6	16.67%
1: Distinct Psychiatric Facility	1	2.78%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	20	55.56%
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	2.78%
H: Home Health Agency	2	5.56%
N: Critical Access Hospital	4	11.11%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	2	5.56%
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	**36**	**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 beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro would retain those concerns and work directly with the health care provider and/or practitioner.

5.A. QUALITY OF CARE CONCERNS CONFIRMED

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)]	1	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	1	1	100.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty 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%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
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**	**1**	**25.00%**

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**
1	100%
Category and Type Assigned to QIIs	**Number of QIIs Referred to a QIN-QIO for Each Category Type**
Provider-Continuity of Care - Improvement needed in case management/discharge planning	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)	5	2.87%
Notice of Non-coverage Request for BFCC-QIO Concurrence - (Request for BFCC-QIO Concurrence/HINN 10)	2	1.15%
MA Appeal Review (CORF, HHA, SNF) - (Grijalva)	50	28.74%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) - (BIPA)	44	25.29%
Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs - (FFS Weichardt)	62	35.63%
MA Notice of Non-coverage Hospital Discharge Notice - Attending Physician Concurs – (MA Weichardt)	11	6.32%
Total	**174**	**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	10	29.41%	88.71%
Rural	24	70.59%	10.38%
Unknown	0	0.00%	0.90%
Total	**34**	**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%	91.04%
Rural	1	100.00%	7.46%
Unknown	0	0.00%	1.49%
Total	**1**	**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
8	7	87.50%

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