

INPATIENT READMISSION PROGRAM PROTOCOLS

Effective January 1, 2012, CenCal Health is launching a quality initiative to reduce the thirty (30) day inpatient hospital readmission rate for its Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) membership.

Reducing avoidable readmissions is an opportunity for CenCal Health and its contracted providers to collaborate to improve the quality of patient care while reducing health care costs. The primary goal of this program is to ensure a timely follow-up visit is completed by a member's Primary Care Provider (PCP) after an inpatient hospital stay.

DEFINITIONS

“CenCal Health Care Managers” are plan staff who assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs of members across the care continuum. The essential functions of the Care Manager include assessment, planning, facilitation, and advocacy as defined by the current standards of practice for care management.

“CenCal Health Utilization Management Coordinators” are plan staff who evaluate and determine coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or member, in cooperation with other parties, to promote appropriate use of resources.

“Follow-up Visit” is a timely visit completed by a contracted PCP after a SBHI or SLOHI member is discharged from an acute care hospital. Follow-up visit timelines are indicated in the section below.

“Inpatient Stay” is an admission to a hospital for treatment that requires at least one overnight stay.

“Readmission” is an inpatient hospital stay that occurs within thirty (30) days of an inpatient hospital discharge.

“Risk Stratification” is a classification strategy to determine a member's risk for suffering a particular condition or need for preventive intervention on the basis of one or more chosen criteria.

MEMBER RISK STRATIFICATION

The Inpatient Readmission Initiative only applies to SBHI and SLOHI members who are non-obstetric and dual eligible (Medicare primary Part B only).

Members included in the Inpatient Readmission Initiative will be classified based on their risk of readmission being either high or low as determined by clinical and

socio-economic factors. Conditions that have been identified in the literature as leading to a high risk for readmission include, but are not limited to, mental health issues, substance abuse, cancer, cirrhosis, anemia, heart failure with COPD, HIV, and diabetes.

Members will initially be determined to be high risk if they meet one or more of the following criteria:

- Are disabled (by eligibility aid category)
- Are 50 years of age or older with one or more high risk conditions
- Have greater than three (3) high risk conditions
- Are admitted to a hospital four (4) or more times in the previous twelve (12) months
- Have six (6) days or more in the hospital

Any member who does not meet the criteria above will be classified as low risk for hospital readmission. Low risk members should receive a follow-up visit from their PCP on a routine basis, usually within fourteen (14) to twenty-one (21) days after a hospital discharge.

FOLLOW-UP VISIT TIMEFRAMES

As the goal of the program is a timely follow-up visit after an inpatient hospital stay, members are to be seen within specific timeframes of discharge from the hospital. Special emphasis on medication reconciliation is an important component during the post-discharge visits as confusion over medication regimes is cited in the literature as a major cause of hospital readmissions.

- For high risk members, the follow-up visit should occur within forty-eight (48) to seventy-two (72) hours after discharge. PCPs may perform up to two (2) readmission follow-up visits for a high risk member in a nine (9) day period for each hospital admission per member to receive additional reimbursement.

Follow-up visits completed for high risk members will be reimbursed a flat rate for each visit as indicated in the Incentive Payments section below.

CenCal Health will be contacting the PCP office to assist with the scheduling of visits for high risk members. If a PCP knows of patients being discharged from the hospital and believes them to be high risk for readmission and in need of expedited follow up visit(s), CenCal Health will reimburse for follow up visit(s) as long as it meets the time frames noted above.

- For low risk members, the follow-up visit should occur on a routine basis, usually within fourteen (14) to twenty-one (21) calendar days after a hospital discharge. No additional reimbursement will be made for routine follow up care for low risk members.

UTILIZATION & CARE MANAGEMENT

CenCal Health understands that typical office scheduling will not always accommodate post-hospitalization visits on short notice. CenCal Health staff will assist by tracking members who are discharged from the hospital and may contact the PCP practice to request a follow-up visit post-hospitalization.

In addition, Utilization Management (UM) nurses will be assisting members with follow-up care by acting as a liaison with hospital case managers and discharge planners, calling members upon discharge, arranging for services such as home health and evaluating the need for additional in home support services like In Home Supportive Services (IHSS). UM nurses can also refer members evaluated to be high risk for readmission to CenCal Health's care managers who will follow members more intensively and work more closely with the member's PCP to ensure efficient coordination of outpatient care.

CLAIM REPORTING

For each follow-up visit completed for high risk members that meet the time frames outlined above, the PCP will submit a Claim form to CenCal Health using one of the following CPT procedure codes with a TS modifier (which indicates a Follow-Up Visit).

CPT Code	Description	Modifier
99202	Office Visit, New, Level 2	TS
99203	Office Visit, New, Level 3	TS
99204	Office Visit, New, Level 4	TS
99204	Office Visit, New, Level 5	TS
99212	Office Visit, Established, Level 2	TS
99213	Office Visit, Established, Level 3	TS
99214	Office Visit, Established, Level 4	TS
99215	Office Visit, Established, Level 5	TS

The Follow-Up Visit is payable to contracted PCPs only. In addition, the service can be rendered and is payable to a PCP for his/her assigned members as well as for members that are unassigned to that PCP's practice. For those members seen that are not assigned, Referral Authorization Forms (RAFs) will be waived for readmission follow-up visits. Waiving the RAF requirement will relieve the referring PCP from initiating a referral as well as relieve the PCP who is providing the service from completing this authorization.

INCENTIVE PAYMENTS

There are two payment options available under the program: Direct Reimbursement or Deferred At-Risk Reimbursement.

Direct Reimbursement (Option 1):

In addition to monthly capitation, PCPs who submit Claims for readmission follow-up visits will be paid a flat rate of \$50.00 per qualified visit. Though reported through a Claim form as described above, the Claim will be paid at \$0.00 because reimbursement will be issued through a separate payment to be provided on a monthly basis for services rendered in the prior month. The payment timeframe will be the 15th of each month.

Deferred Reimbursement to an At Risk Pool (Option 2):

PCPs may select not to accept direct reimbursement under Option 1 above for submitted Claims and to instead defer the reimbursement amounts into an at-risk pool. PCP practices that have a minimum of 2,500 assigned members in their practice qualify for the deferred reimbursement option. For PCPs that have multiple locations, the 2,500 member minimum requirement can be across all sites for qualification for selection of the deferred reimbursement option.

The deferred reimbursement option utilizes a comparison of the PCP's baseline readmission rate to their current readmission rate for assigned members to determine whether an improvement has been made. Readmission rate thresholds, as indicated below, will determine the percentage of the at risk pool the PCP can earn under this option. Though reported through a Claim form, the Claim will be paid at \$0.00 because reimbursement will be provided through this separate payment mechanism. The pool is comprised of the total amount of follow-up visits that are reported as described above valued at \$50 per qualified visit.

Change to Baseline Readmission Rate	Percent of Pool Earned
No change or increase	25%
Decrease of 10% or less	100%
Decrease of 10% or more	200%

Readmission Calculation

The program will use a six (6) month time frame to calculate changes to a PCP's baseline readmission rate and use the same timeframe between calendar year. For example, the first six (6) months of the current calendar year will be compared to data from the first six (6) months of the prior calendar year, i.e., 1/1/12 – 6/30/12 and 1/1/11 – 6/30/11. The last six (6) months of the current calendar year will be compared to data from the same period of the prior calendar year, i.e., 7/1/11 – 12/31/11 and 7/1/12 – 12/31/12.

Initially, obtaining timely discharge data from out-of-area acute care hospitals can

be a challenge. For the first six (6) months of the program, only discharges from “in-network” hospitals will be tracked by CenCal Health. Subsequent six (6) month periods will include members assigned to the PCP who are discharged from both in-network and out-of-network hospitals. Note that an admission will then be considered a readmission if the member is readmitted to any hospital during the thirty (30) day period following discharge.

Incentive Payments

PCPs that choose the deferral option will be paid within five (5) months of the biannual reporting cycle. For the first half of the calendar year ending June 30th, PCPs can expect payment in November of that same calendar year whereas for the second half of the calendar year ending December 31st, PCPs can expect payment in May of the following calendar year.

Reports

Upon the determination of the six (6) month readmission calculation, PCPs will be mailed a performance report indicating their prior and current readmission rates, the size of the incentive pool and the amount of the pool that will be distributed based upon the change to the readmission rate.

Appeal Process

CenCal Health acknowledges that the data received from acute care hospitals is not perfect. If any member is not captured in the reimbursement options, Options 1 or 2 above, providers may appeal to have the Follow-Up Visit(s) included for payment by contacting the Provider Services Department at (805) 562-1674. Provider appeals must be received within 180 days from the date of service of the readmission Follow-Up Visit for consideration.