Readmissions Review Quality Program Guide

The purpose of this document is to share details about the Florida Blue Readmissions Review Quality Program. The program is designed to foster better care as a path to reducing readmissions. It also aims to increase awareness of Florida Blue resources and assist facilities in identifying opportunities to help reduce preventable readmissions.

Readmissions Review Quality Program Overview
Preventable readmissions are a serious quality concern. Recently, the Centers for Medicare & Medicaid Services (CMS) reported 20 percent of Medicare patients were readmitted within 30 days after a hospital discharge. In Florida, 148 hospitals were penalized by CMS for hospital readmissions. For our Commercial and Medicare lines of business, readmission rates within 30 days averaged more than 10 percent in 2019.

The Florida Blue Readmissions Review Quality Program is designed to foster better care as a pathway to reducing certain readmissions that could have been prevented by the provision of care consistent with accepted standards during the prior admission discharge planning and post-discharge follow-up care period. Hospitals are expected to provide care consistent with accepted standards during a hospitalization which includes appropriate discharge planning. Additionally, hospitals have accountability for ensuring necessary follow-up care occurs.

This program, which is a Florida Blue quality-of-care review process, will determine (i) if an admission is for treatment of the same or a related condition, or a procedure occurring less than 15 days from a prior admission’s discharge and (ii) if the subsequent inpatient care could have been reasonably prevented by the provision of care consistent with accepted standards during the prior discharge planning and/or post discharge follow-up period. This will apply to subsequent admissions to the same hospital or a satellite of the hospital and to return transfers to the acute care hospital from the sub-acute care facility when the patient is returned to the originating hospital or satellite of the originating hospital.

Data sharing is a key aspect of this program. Understanding statewide readmission rates, and specific rates and data for your facility can help identify opportunities for improvement. Knowing where your facility stands when compared to others helps establish benchmarks and a path towards improvement. Florida Blue plans to partner with facilities and share available data to encourage the use of available resources and reduce readmission rates.

Additionally, consistent with our commitment to assist providers and improve the quality of the services provided to our members, the program also seeks to encourage collaboration between Florida Blue and providers. This collaboration is intended to improve patient outcomes by addressing gaps in discharge planning and follow-up care.

General Opportunities for Improvement
Members routinely return to the hospital for adverse drug event (ADE), inability to understand the importance of their medications and diagnoses, lack of proper follow-up care, and/or misdiagnosis. Unnecessary readmissions are disruptive to the member and family. They
increase the risk of infection and complications and can have negative physical, emotional and psychological effects. The following list includes examples of general areas that can be improved to prevent readmissions:

- Discharge planning
- Patient compliance with medication and care instructions
- Care coordination
- Engagement with Case Management
- Home health care and other resource support

**Florida Blue Resources**

Florida Blue has certain resources that may be helpful to hospitals in their efforts to reduce readmissions. Engaging these resources and connecting them to members might help increase member understanding and compliance with hospital discharge instructions, medication adherence, and ensure follow-up care is completed. These can also address social determinants of health that may affect patient compliance with instructions and medication adherence. Here’s a summary of some of those resources:

- **PopHealth Care**— In-Home Care Management and ARNP/Physician services that can serve members/patients. This is currently available in 17 counties covering about 80 percent of Florida Blue membership. Members are selected for this program based on readmission risk internally, but can be referred when the member has limited access to post-discharge follow-up visits on a case-by-case basis.

- **GuideWell Emergency Doctors and Crucial Care**— Free-standing, high-acuity care center with Board-certified emergency doctors who can see members for treatment of major and minor care and potentially avoid hospitalization. The providers work closely with the member’s treating physician(s). These are available at several locations: three in Orlando, and one in Jacksonville.

- **Value-Based Providers**— Florida Blue has developed relationships with many provider groups across the state to provide primary and specialty care, such as Sanitas and Diagnostic Clinic Medical Group (DCMG). We can assist the discharge planning team in locating a provider and make arrangements, if needed.

- **Regional Resources**— Florida Blue has registered nurses, pharmacists, social workers, dietitians and physicians focused on care coordination to support members and families in every region of the State.

- **Florida Blue Foundation Grantees**— Provides investments to reduce hospital readmission rates for community members who are uninsured, underinsured, low-income, senior citizens, have chronic conditions or have survived substance abuse and opioid overdoses. Programs provide training and education to peer-recovery specialists and home-based care using telehealth capabilities. It also supports training paramedics and providing transportation to follow-up appointments.
• **Member Incentive Gift Card Program (Commercial only)** – This program is designed to encourage member compliance with follow-up recommendations and applies to non-self-funded members.

  ❖ Offered to eligible members at high risk for readmission
  ❖ Rewards members for follow-up visits completed within 14 days ($50) or within 30 days ($25) after discharge
  ❖ No member paperwork required
  ❖ Gift cards mailed within 6 – 8 weeks after receiving doctor’s visit claim

• **Medicare Advantage Readmission Prevention Program** – A 30-day post discharge plan of care for Medicare members at risk of inpatient readmission. Care Managers may reach out to members via a home visit, video teleconferencing and by telephone every five business days. Members are identified for this program based on being discharged from the hospital AND predictive modeling for risk of readmission. The overall goal of this program is to provide self-management support to members at high risk for readmission ensuring the member/caregiver understands the discharge instructions, has a medication reconciliation, keeps their follow-up appointment post hospitalization, and can identify ‘red flags’ that indicate they need to contact their physician. Program services include:

  ❖ Readmission Prevention Assessment; including a Comprehensive Medication Reconciliation, Safety Survey or Home Visit Survey, and Patient Health Questionnaires (PHQ) 2 and 9 for depression.
  ❖ Home visit (if member agrees) or video teleconferencing visit with the member in their home (if member has a computer or smartphone);
  ❖ Individualized Care Plan that includes a focus on the following:
    ➢ Compliance with all discharge instructions;
    ➢ Compliance and adherence to medication and treatment regimen;
    ➢ Monitoring conditions as appropriate; and
    ➢ Description and compliance with a symptom response plan.
  ❖ Support and assistance from a Licensed Social Worker for transportation, financial, or other social needs; and
  ❖ Transfer to Complex Care or Health Management if continued self-management support is required.

• **Community Health Program (Medicare only)** – This program is designed to provide member and family support via in-person home visits or phone. A Community Health Specialist (CHS) reaches out with compassion and empathy to focus on the member’s social needs. Our goal is to build a trusting and caring relationship with our members while working with them, their families, and the local communities to resolve and overcome their social issues. Resource examples include:

  ❖ Safe and affordable housing
  ❖ Access to education, public safety
  ❖ Availability of and access to healthy foods
  ❖ Availability of and access to local emergency/health services
  ❖ Environments free of life-threatening toxins
How to Access Florida Blue Resources
Access to Florida Blue resources is supported by Florida Blue Care/Case Management and can be arranged by contacting the following:

- **Nurse Care Management/Single Point-of-Contact (Commercial)** – Access to Florida Blue resources is supported by a Florida Blue Care Management Nurse (CMN) who works with discharge teams to assist with planning for the patient. Each hospital has dedicated Florida Blue staff to support their discharge planning teams. CMN availability is Monday – Friday during business hours, and Saturdays before 4 p.m. After-hour voice messages are returned no later than the next business day. Hospitals can also request resource support by faxing or emailing the Care Management Referral Form for Florida Blue Clinical Resources. This form can be found at floridablue.com; select Providers (top of the page), Tools & Resources, Forms, Physician & Provider Forms, and then Care Management Referral Form for Florida Blue Clinical Resources.

  Florida Blue Care Management
  Dedicated Phone: 844-730-2583 (844-730-BLUE)
  Dedicated Fax: 904-997-5188
  Dedicated Email: CareMemberOutreach@bcbsfl.com

- **Medicare Case Management (Medicare)** – Individuals with Complex or Chronic Health Conditions may benefit from one of our Florida Blue Medicare Care Programs. The Florida Blue Medicare Case Management nurses assist members with serious health issues, and their families with access to health plan covered services and community resources. CMN availability is Monday – Friday, 8 a.m. to 5 p.m. An On-Call RN is available after-hours and on weekends. Hospitals can also request resource support by faxing or emailing the Medicare Clinical Care Programs Referral Form. This form can be found at floridablue.com; select Providers (top of the page), Tools & Resources, Forms, Physician & Provider Forms, and then Medicare Clinical Care Programs Referral Form.

  Florida Blue Medicare Case Management
  Dedicated Phone: 800-955-5692, opt 1, then opt 2
  Dedicated Fax: 904-565-4255
  Dedicated Email: medicare_casemanagement_vm@floridablue.com

Readmissions Review Quality Program Exclusions
The following are examples of exclusions from the Readmissions Review Quality Program. This applies to both Commercial and Medicare Advantage. This is not an all-inclusive list.

- Previous discharge against medical advice
- Repetitive treatments such as cancer chemotherapy and/or transfusions
- Readmissions greater than 15 days after date of discharge
- Staged/planned procedures
- Hospice care
- Obstetrical care
- Psychiatric admissions
- Sickle Cell crisis
• Transplants
• Conditions unrelated to the initial admission
• Critical Access Hospitals

What the Readmissions Review Quality Program Means for Florida Blue Members
Florida Blue will not provide additional reimbursement for same or related subsequent admissions which were reasonably preventable and within 15 days. Inpatient stays not approved for additional reimbursement under this readmissions program will be the sole liability of the hospital. Compensation for the original admission constitutes the full reimbursement payable for both the original admission and the preventable readmission. Florida Blue members are not to be held liable for these subsequent admissions. Specifically, hospitals are not allowed to bill members for the subsequent preventable admissions.

Appeals Process
Appeals may be submitted as outlined in the Manual for Physicians and Providers available on the Provider section of floridablue.com. Please complete the Provider Clinical Appeal Form and check the box for “Coding and Payment Rule.” Your formal appeal must be submitted within 365 days of the claim payment denial.