Report on hospital readmissions, July-December 2020

A Report to the Virginia General Assembly

July 15, 2021

Report Mandate:

313.BBBBB The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services under Title XIX to modify the definition of readmissions to include cases when patients are readmitted to a hospital for the same or a similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice. If the patient is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at 50 percent of the normal rate, except that a readmission within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. The department shall have the authority to implement this reimbursement change effective July 1, 2020, and prior to the completion of any regulatory process undertaken in order to effect such change. The department shall report quarterly on the number of hospital readmissions, the cost, and the primary diagnosis of such readmissions to the Joint Subcommittee for Health and Human Resources Oversight.

Background

The 2020 General Assembly required the Department of Medical Assistance Services (DMAS) to establish a reduced payment policy for hospital readmissions based on specifications in the 2020 Virginia Appropriations Act, Item 313.BBBBB. The policy defines readmissions that would trigger a reduced reimbursement from the Department as readmissions related to "the same or a similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice." Readmissions meeting this criteria are subject to a 50 percent reduction in reimbursement.

Reductions in payment were effective as of July 1, 2020 for services rendered through managed care and through fee-for-service delivery systems. Managed care organizations (MCOs) contracted with the state were required to implement system edits in their encounter data to identify readmissions as defined above, and to change their payments for such readmissions to half the usual rate. Similar system edits were required in fee-for-service systems. While the payment policy was implemented July 1, 2020, due to the COVID-19 public health emergency and complications with system edits, reporting of

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 500,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

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the policy and claims submissions were delayed by a year. MCOs were required to resubmit adjudicated claims retrospectively to capture all encounters associated with readmission since July 1, 2020 by June 1, 2021. The Department has reviewed initial claims submissions and readmissions as identified by MCOs, and their associated payments. Findings based on these resubmissions are summarized in this report.

Based on available secondary data sources used for validation, DMAS finds implementation or reporting of the readmissions policy may be incomplete. The Department continues to work with the MCOs and internal systems to improve reporting and expects that as MCOs gain experience, they will better identify readmissions and pay at adjusted rates.

Readmissions by MCO and Month

The Department finds a total of 459 readmissions that meet policy criteria between July 1 and December 31, 2020. Monthly total reported readmissions declined after September, from a total of 72 readmissions in September for MCOs (excluding FFS) to 61 in December. Because DMAS expects lag in claims reporting to undercount the number of readmissions reported, data are reported for July through December 2020, and January through June 2021 are excluded to allow data submission to be completed.

Count of claims, July – December 2020							
MCO	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
AETNA	7	9	25	19	18	25	**103**
ANTHEM				2	1	3	**6**
MAGELLAN						1	**1**
OPTIMA	30	41	23	20	4	2	**120**
UNITEDHEALTHCARE	4	7	11	14	7	7	**50**
VIRGINIA PREMIER	14	20	13	16	25	23	**111**
All MCOs	*55*	*77*	*72*	*71*	*55*	*61*	***391***
FFS	6	10	14	14	11	13	**68**
Total	**61**	**87**	**86**	**85**	**66**	**74**	**459**

In addition to analyzing raw counts of readmissions, DMAS also adjusted reported readmissions by population to compare reported rates across MCOs and fee-for-service. There is substantial variation in the population-adjusted readmissions rate between the MCOs and when comparing MCOs to FFS. Reporting varies by MCO beyond expected levels of variation due to member volume. Health plans range from 1 reported readmission and an associated rate of 0.02 readmissions per 10,000 members (Magellan) to 120 reported readmissions with an associated rate of 0.68 readmissions per 10,000 members (Optima). FFS shows a rate of 3.44 readmissions per 10,000 members, though lower FFS enrollment in November and December led to increased rates (3.6 in October to 5.8 per 10,000 in December). Counts of readmissions using encounter data submitted by MCOs appear lower than might be reasonably expected.

Reported readmissions rate per 10,000 members, July – December 2020							
MCO	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
AETNA	0.36	0.46	1.24	0.93	0.87	1.18	**0.85**
ANTHEM	-	-	-	0.04	0.02	0.06	**0.02**
MAGELLAN	-	-	-	-	-	0.09	**0.02**
OPTIMA	1.05	1.42	0.79	0.68	0.13	0.07	**0.68**
UNITEDHEALTHCARE	0.27	0.46	0.72	0.90	0.44	0.43	**0.54**
VIRGINIA PREMIER	0.47	0.66	0.43	0.52	0.81	0.73	**0.61**
All MCOs	*0.37*	*0.52*	*0.48*	*0.46*	*0.35*	*0.39*	***0.43***
FFS	1.66	2.57	3.60	3.60	4.87	5.80	**3.44**
Total	**0.40**	**0.57**	**0.55**	**0.54**	**0.42**	**0.46**	**0.49**

When these findings were presented to MCOs, multiple plans indicated that they found problems with the process they used to identify readmissions and would be revising the process and resubmitting historical readmission claims as they are identified. MCOs may also already have had readmissions policies in place with providers that more strictly limit their exposure than this state policy; as such, even if readmissions did occur, they might not receive the 50% adjustment and thus would not be flagged for purposes of this state policy. For MCOs for which such policies are active, reported readmission volume and rates may thus be lower than in the FFS system.

Cost of Readmissions and Potential Estimated Savings

DMAS conducted an analysis of dollars associated with readmissions. As with the total number of readmissions, DMAS identified a number of reporting inconsistencies and has been working with the health plans to revise their encounter submissions. To date, MCOs are unable to report both the original amount and the revised amount paid to DMAS. Without this information, DMAS is not able to verify that MCOs are paying a reduced rate of 50% of the usual rate. However, assuming that payments reported to DMAS (column A in the table below) are 50% of the usual payment amount, the usual cost of readmissions is estimated by doubling the payment amount of identified readmissions (B). The estimated amount in savings from the policy (C) is the cost of readmissions (B) less the reduced payment amount (A). Note that this approach assumes MCOs are correctly identifying and paying readmission-related claims correctly under this policy and that the reported dollar paid amount reflects accurate identification and payment; as such, it should be an illustrative estimate rather than what DMAS believes is the actual experience.

Sum of dollars paid and estimated savings, July – December 2020			
	(A)	(B)	(C)
MCO	Dollars paid	Counterfactual payment amount	Estimated savings
AETNA	$1,131,675	$2,263,349	$1,131,675
ANTHEM	$60,184	$120,369	$60,184
MAGELLAN	$4,041	$8,082	$4,041
OPTIMA	$574,237	$1,148,474	$574,237
UNITEDHEALTHCARE	$395,529	$791,057	$395,529
VIRGINIA PREMIER	$1,038,646	$2,077,293	$1,038,646
FFS	$575,425	$1,150,850	$575,425
Total	**$3,779,737**	**$7,559,474**	**$3,779,737**

Top 25 Diagnoses Associated with Readmissions

In addition to considering overall counts of readmissions and associated dollars, DMAS also examined readmissions by diagnosis codes to identify the most frequent primary diagnoses associated with readmissions and the spending on those readmissions.

Among the 459 total readmissions identified above, the most frequent primary diagnosis for readmissions was sepsis (33 claims at $485,376). Other conditions associated with high frequencies of readmissions include heart and kidney disease, sickle cell disorders, diabetes mellitus, and pancreatitis. Three of the top 10 diagnoses are related to conditions associated with alcohol dependence and abuse: alcohol abuse, alcoholic liver disease, and acute pancreatitis. Specific to 2020, it should be noted that COVID-19 was the primary diagnosis for 8 readmissions.

Diagnosis code	Diagnosis description	Count of claims	Total payment
A41	Other sepsis	33	$485,376
I13	Hypertensive heart and chronic kidney disease with heart failure	32	$160,599
D57	Sickle-cell disorders	27	$133,980
E10	Diabetes mellitus without complications	25	$106,557
K85	Acute pancreatitis	23	$73,474
F10	Alcohol abuse, uncomplicated	21	$59,415
K70	Alcoholic liver disease	16	$81,874
E11	Type 2 Diabetes Mellitus	13	$80,872
I11	Hypertensive heart disease	12	$55,892
J44	Chronic obstructive pulmonary disease with (acute) lower respiratory infection	10	$33,707
T80	Complications following infusion, transfusion and therapeutic injection	10	$126,493
Z51	Encounter for other aftercare	9	$74,691
U07	COVID-19, virus identified (lab confirmed)	8	$117,538
J96	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia	8	$73,197
N17	Acute kidney failure	7	$57,357
G40	Epilepsy and recurrent seizures	7	$22,950
I48	Atrial fibrillation and flutter	7	$24,459
T83	Complications of genitourinary prosthetic devices, implants and grafts	7	$52,865
E87	Other disorders of fluid, electrolyte and acid-base balance	6	$22,633
I63	Cerebral infarction, unspecified	6	$23,446
K57	Diverticular disease of intestine	6	$32,742
K50	Crohn’s disease	5	$24,876
L03	Cellulitis and acute lymphangitis	4	$13,393
I26	Pulmonary embolism	4	$60,116
C79	Secondary malignant neoplasm of other and unspecified sites	4	$19,602

Summary

Based on lower than expected volumes and rates for total readmissions, and MCO feedback, DMAS expects reported readmissions to increase for this reporting time period as a result of data improvement as MCOs gain experience with implementation of the updated readmissions definition. Based on reported readmissions and assumptions about MCO implementation of the readmissions policy outlined above, DMAS found that hospitals may have incurred $3,779,737 in reduced payments due to readmissions meeting policy criteria between July 1 and December 31, 2020. Top diagnoses

related to flagged readmissions include sepsis, heart and kidney disease with heart failure, diabetes mellitus, pancreatitis, and alcohol abuse and alcoholic liver disease.