COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 14, 2022

MEMORANDUM

TO: The Honorable Matthew Farris
Chair, House Appropriations Health and Human Resources Sub-Committee

The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee Health and Human Resources Subcommittee

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on hospital readmissions, July 2020-December 2021 (Q2 FY2022)

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 304.III, which states:

> *"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."*

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

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Enclosure

Pc: The Honorable John Little, Secretary of Health and Human Resources

Report on Hospital Readmissions, July 2020-Dec. 2021

A Report to the Virginia General Assembly

November 14, 2022

Report Mandate:

Item 304.III, stated, "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 2022 General Assembly required the Department of Medical Assistance Services (DMAS) to establish a reduced payment policy for hospital readmissions based on specifications in the 2022 Virginia Appropriations Act, Item 304.III. 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.

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 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 600,000 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% for newly eligible adults, generating cost savings that benefit the overall state budget.

The Department has reviewed encounters identified by MCOs as readmissions and their associated payments as submitted by MCOs, and fee for service (FFS) claims. Because DMAS expects lag in claims reporting to undercount the number of readmissions reported, data are reported for July 2020 through December 2021, and January 2022 through June 2022 are excluded at this time to allow data submission to be completed.

Items to note regarding interpretation of numbers presented in this report:

1. Readmissions identified in this report are not necessarily comparable to those identified using other definitions of readmissions or other external data sources.
2. If claims were not correctly identified by MCOs or FFS system as readmissions, they would not be counted here.
3. MCOs may 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 (Item 304.III). As such, some claims which might reasonably be considered readmissions would still not be counted herein

Readmissions by MCO and month

Table 1 shows the count of claims associated with readmissions per Item 304.III, by month, for each MCO, all MCOs, fee-for-service, and overall.

Table 1. Count of claims, July 2020 - Dec. 2021

Month	Aetna	Anthem	Molina	Optima	United	VA Premier	All MCOs	FFS	Total
2020-07	7	16		32	5	18	78	6	*84*
2020-08	9	5		42	11	21	88	14	*102*
2020-09	22	10		27	11	15	85	14	*99*
2020-10	17	10		35	13	17	92	14	*106*
2020-11	17	9		34	7	28	95	11	*106*
2020-12	25	12	1	33	7	30	108	14	*122*
2021-01	20	11		28	6	39	104	13	*117*
2021-02	17	21	1	27	4	57	127	10	*137*
2021-03	15	34	2	27	5	93	176	11	*187*
2021-04	11	44	7	35	5	71	173	17	*190*
2021-05	7	27	2	30	4	78	148	17	*165*
2021-06	7	44	1	24	6	73	155	21	*176*
2021-07		37	4	21	13	84	159	14	*173*
2021-08	1	55	5	17	7	111	196	16	*212*
2020-11		36	6	23	8	57	130	10	*140*
2020-12	2	54	2	19	11	66	154	13	*167*
2021-01	3	55	3	16	8	71	156	14	*170*
2021-02	2	62	5	22	16	83	190	12	*202*
Total	**182**	**542**	**39**	**492**	**147**	**1012**	**2414**	**241**	***2655***

Cost of Readmissions and potential estimated savings

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 MCOs are reporting the reduced readmission payments per this policy (column A in the table below), DMAS has calculated the full cost of readmissions by doubling the payment amount of readmissions claims submitted by the MCOs (B). The estimated amount in savings from the policy (C) is the full cost of readmissions (B) less the reduced payment amount (A). Note that this approach assumes MCOs are correctly identifying and paying readmission-related encounters under this policy and that the reported dollar paid amount reflects accurate identification and payment.

Table 2. Sum of dollars paid and estimated savings, July 2020 - Dec. 2021

MCO	(A) Dollars paid	(B) Counterfactual full payment amount	(C) Estimated savings
Aetna	$1,744,590	$3,489,179	$1,744,590
Anthem	$4,403,994	$8,807,987	$4,403,994
Molina	$267,237	$534,473	$267,237
Optima	$2,978,532	$5,957,064	$2,978,532
United	$1,179,240	$2,358,479	$1,179,240
VA Premier	$5,996,259	$11,992,518	$5,996,259
FFS	$1,722,911	$3,445,822	$1,722,911
Total	**$18,292,762**	**$36,585,524**	**$18,292,762**

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. The top 25 diagnoses (by claim count) are shown in

Table ***3***, along with the count of associated claims and total dollars paid for those claims.

Table 3. Top 25 primary diagnoses associated with readmissions

Diagnosis	Count of claims	Total payment
Other sepsis	230	$2,647,042
Alcohol related disorders	182	$541,895
Hypertensive heart and chronic kidney disease	172	$1,253,310
Type 1 diabetes mellitus	157	$605,997
Sickle-cell disorders	152	$924,675
Acute pancreatitis	115	$420,941
Alcoholic liver disease	85	$590,958
Respiratory failure, not elsewhere classified	75	$763,944
Type 2 diabetes mellitus	71	$530,100
Hypertensive heart disease	64	$333,785
Schizoaffective disorders	64	$231,031
Encounter for other aftercare and medical care	55	$422,661
Paralytic ileus and intestinal obstruction without hernia	32	$211,460
Major depressive disorder, recurrent	32	$158,478
COVID-19	31	$316,704
Other chronic obstructive pulmonary disease	31	$112,972
Opioid related disorders	31	$15,983
Hepatic failure, not elsewhere classified	31	$115,377
Acute kidney failure	30	$149,531
Complications of procedures, not elsewhere classified	29	$223,030
Cellulitis and acute lymphangitis	29	$133,634
Other disorders of fluid, electrolyte and acid-base balance	28	$130,313
Complications of genitourinary prosth dev/grft	28	$178,913
Bipolar disorder	26	$125,818
Atrial fibrillation and flutter	26	$122,751