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
Co-Chair, Senate Finance and Appropriations Committee
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-March 2022 (Q3 FY2022)

This report is submitted in compliance with item 304.III. of the 2022 Appropriations Act, 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) 786-8099.

CR
Enclosure

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

Report on Hospital Readmissions, July 2020-March 2022

A Report to the Virginia General Assembly

November 14, 2022

Report Mandate:

Item 304.III of the 2022 Appropriation Act 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."

Background

The Department has reviewed encounters identified by managed care organizations (MCOs) as readmissions and their associated payments as submitted by MCOs, and fee for service (FFS) claims. To avoid undercounting due to a lag in claims reporting, this report covers data from July 2020 through March 2022. April 2022 through September 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 will not be included in the report.
3. MCOs may already have had readmissions policies in place with providers that more strictly limit their exposure than this state policy; meaning that 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 will not be included in the report.

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 an approximate 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.

Readmissions by MCO and Month

Table 1 shows the count of claims associated with readmissions per Item 304.III by month, for each MCO, FFS, and overall.

Table 1. Count of claims, July 2020 – March 2022

Month	Aetna	Anthem	Molina	Optima	United	VA Premier	All MCOs	FFS	Total MCO + FFS
2020-07	7	15		32	5	18	77	6	*83*
2020-08	9	5		42	11	21	88	14	*102*
2020-09	22	9		27	11	17	86	14	*100*
2020-10	17	10		35	13	17	92	14	*106*
2020-11	17	9		34	7	29	96	13	*109*
2020-12	25	12	1	33	7	30	108	14	*122*
2021-01	20	11		29	6	39	105	13	*118*
2021-02	17	21	1	27	4	57	127	10	*137*
2021-03	15	34	10	29	5	93	186	11	*197*
2021-04	11	43	14	35	5	71	179	17	*196*
2021-05	7	27	7	31	4	81	157	17	*174*
2021-06	7	44	13	24	6	73	167	21	*188*
2021-07		38	14	20	13	81	166	14	*180*
2021-08	2	55	17	17	8	109	208	17	*225*
2021-09		35	17	23	7	56	138	10	*148*
2021-10	2	53	10	21	11	65	162	14	*176*
2021-11	3	53	7	16	8	69	156	14	*170*
2021-12	3	66	7	25	17	83	201	12	*213*
2022-01		47	8	8	7	75	145	14	*159*
2022-02		53	7	7	10	92	169	18	*187*
2022-03		66	14	6	13	135	234	17	*251*
Total	**184**	**706**	**147**	**521**	**178**	**1,311**	**3,047**	**294**	***3,341***

Cost of Readmissions and Difference in Spending

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 difference 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. Dollars paid and estimated spending difference, July 2020 – March 2022

MCO	(A) Amount Paid	(B) Counterfactual Full Payment Amount	(C) Estimated Savings
Aetna	$1,810,184	$3,620,368	$1,810,184
Anthem	$5,471,181	$10,942,361	$5,471,181
Molina	$1,358,201	$2,716,402	$1,358,201
Optima	$3,432,860	$6,865,720	$3,432,860
United	$1,353,069	$2,706,137	$1,353,069
VA Premier	$7,392,703	$14,785,405	$7,392,703
FFS	$2,261,864	$4,523,728	$2,261,864
Total	**$23,080,061**	**$46,160,121**	**$23,080,061**

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, July 2020 – March 2022

Diagnosis	Count of claims	Total payment
Other sepsis	290	$3,262,058
Alcohol related disorders	264	$619,588
Hypertensive heart and chronic kidney disease	201	$1,442,649
Type 1 diabetes mellitus	194	$755,597
Sickle-cell disorders	191	$1,093,816
Acute pancreatitis	135	$491,705
Opioid related disorders	99	$45,792
Alcoholic liver disease	97	$654,516
Respiratory failure, not elsewhere classified	88	$952,676
Type 2 diabetes mellitus	81	$567,196
Schizoaffective disorders	80	$326,290
Hypertensive heart disease	79	$487,417
Encounter for other aftercare and medical care	69	$556,802
Major depressive disorder, recurrent	44	$257,278
Other chronic obstructive pulmonary disease	43	$178,588
Hepatic failure, not elsewhere classified	40	$176,652
COVID-19	39	$439,781
Complications of procedures, not elsewhere classified	38	$289,130
Acute kidney failure	37	$185,685
Paralytic ileus and intestinal obstruction without hernia	36	$233,621
Complications of genitourinary prosth dev/grft	34	$204,383
Atrial fibrillation and flutter	33	$159,883
Epilepsy and recurrent seizures	32	$131,004
Cellulitis and acute lymphangitis	31	$164,590
Other disorders of fluid, electrolyte and acid-base balance	30	$130,084