COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 12, 2022

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Barry D. Knight
Chair, House Appropriations Committee

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

SUBJECT: Report on hospital readmissions, July 2020-September 2021

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 313.BBBBB, 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.

CR/wf

Enclosure

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

Report on hospital readmissions, July 2020-Sept. 2021

A Report to the Virginia General Assembly *April 15, 2022*

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

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 2 million Virginians. Members have access to primary and specialty health services, inpatient care, 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 400,000 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.

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 encounters identified by MCOs as readmissions and their associated payments as submitted by MCOs, and fee for service (FFS) claims. Findings based on these encounters and claims identified as readmissions 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 for some MCOs. In addition, one MCO shows reduced identification of readmissions in more recent months. 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

Table 1 shows the count of claims associated with readmissions, by month, for each MCO, all MCOs, fee-for-service, and overall. The Department finds a total of 2128 readmissions that meet policy criteria between July 1, 2020 and September 30, 2021. Monthly total reported readmissions increased over time, from a total of 77 readmissions in July 2020 for MCOs (excluding FFS) to a high of 201 in August 2021. Because DMAS expects lag in claims reporting to undercount the number of readmissions reported, data are reported for July 2020 through September 2021, and October 2021 through March 2022 are excluded at this time to allow data submission to be completed.

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

Month	Aetna	Anthem	Molina	Optima	United	VA Premier	All MCOs	FFS	Total
2020-07	7	16		32	5	17	77	6	*83*
2020-08	9	4		42	11	22	88	12	*100*
2020-09	22	10		28	11	16	87	14	*101*
2020-10	17	10		35	13	16	91	14	*105*
2020-11	17	9		34	7	26	93	11	*104*
2020-12	25	12	1	33	7	29	107	14	*121*
2021-01	20	11		28	6	40	105	13	*118*
2021-02	19	21	1	27	4	56	128	10	*138*
2021-03	15	36	2	28	5	93	179	11	*190*
2021-04	11	46	7	35	6	69	174	17	*191*
2021-05	7	27	2	30	4	80	150	17	*167*
2021-06	7	46	1	23	6	74	157	21	*178*
2021-07		39	4	22	13	86	164	13	*177*
2021-08	1	56	5	19	8	112	201	14	*215*
2021-09		37	7	24	8	55	131	9	*140*
Total	**177**	**380**	**30**	**440**	**114**	**791**	**1932**	**196**	***2128***

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 (shown in Table 2). 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. From July 2020 to September 2021, the total of reported readmissions by health plan ranges from 30 reported readmissions and an associated rate of 0.18 readmissions per 10,000 member months (Molina) to 791 reported readmissions with an associated rate of 1.66 readmissions per 10,000 member months (Virginia Premier). FFS shows a rate of 4.62 readmissions per 10,000 member months. Counts of readmissions using encounter data submitted by MCOs appear lower than might be reasonably expected for some MCOs.

Table 2. Readmission rates per 10,000 member months, July 2020 - Sept. 2021

Month	Aetna	Anthem	Molina	Optima	United	VA Premier	All MCOs	FFS	Total
2020-07	0.36	0.36		1.12	0.33	0.57	0.52	1.66	*0.55*
2020-08	0.46	0.09		1.46	0.73	0.73	0.59	3.09	*0.65*
2020-09	1.10	0.22		0.96	0.72	0.53	0.57	3.60	*0.65*
2020-10	0.83	0.21		1.19	0.83	0.52	0.59	3.60	*0.67*
2020-11	0.82	0.19		1.14	0.44	0.84	0.60	4.87	*0.66*
2020-12	1.18	0.25	0.09	1.09	0.43	0.92	0.68	6.25	*0.76*
2021-01	0.92	0.23		0.91	0.36	1.26	0.65	6.04	*0.73*
2021-02	0.87	0.43	0.09	0.87	0.24	1.75	0.79	4.20	*0.84*
2021-03	0.68	0.73	0.18	0.89	0.30	2.88	1.09	5.17	*1.15*
2021-04	0.49	0.92	0.61	1.11	0.35	2.12	1.05	7.13	*1.14*
2021-05	0.31	0.54	0.17	0.94	0.23	2.45	0.90	6.56	*0.99*
2021-06	0.31	0.91	0.09	0.72	0.34	2.25	0.94	8.43	*1.05*
2021-07		0.77	0.34	0.68	0.73	2.60	0.97	5.01	*1.03*
2021-08	0.04	1.09	0.42	0.58	0.44	3.36	1.18	4.63	*1.24*
2021-09		0.71	0.58	0.73	0.44	1.63	0.76	3.13	*0.80*
Total	**0.55**	**0.52**	**0.18**	**0.95**	**0.46**	**1.66**	**0.80**	**4.62**	***0.87***

Prior discussions with MCOs regarding these findings indicated that multiple plans 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 if all readmissions were included.

Cost of Readmissions and potential estimated savings

DMAS conducted an analysis of dollars associated with readmissions (shown in Table 3). As with the total number of readmissions, DMAS identified a number of inconsistencies in reporting 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 encounters correctly under this policy and that the reported dollar paid amount reflects accurate identification and payment; as such, it should be considered an upper bound on the potential reductions in hospital payments, rather than a precise estimate.

Table 3. Sum of dollars paid and estimated savings, July 2020 - Sept. 2021

MCO	(A) Dollars paid	(B) Counterfactual payment amount	(C) Estimated savings
Aetna	$1,669,249	$3,338,497.06	$1,669,249
Anthem	$3,384,272	$6,768,543.56	$3,384,272
Molina	$211,053	$422,105.84	$211,053
Optima	$2,653,047	$5,306,094.20	$2,653,047
United	$969,934	$1,939,867.28	$969,934
VA Premier	$5,116,410	$10,232,819.90	$5,116,410
FFS	$1,324,737	$2,649,473.88	$1,324,737
Grand Total	$15,328,701	$30,657,401.72	$15,328,701

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 4, along with the count of associated claims and total dollars paid for those claims.

Among the 2128 total readmissions identified above, the most frequent primary diagnosis for readmissions was sepsis (188 claims at $2,131,871). Other conditions associated with high frequencies of readmissions include alcohol abuse, diabetes mellitus, heart and kidney disease, sickle cell disorders, 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. It should be noted that COVID-19 was the primary diagnosis for 27 readmissions.

Table 4. Top 25 primary diagnoses associated with readmissions

Dx code	Dx description	Count of claims	Total payment
A41	Other sepsis	188	$2,131,871
F10	Alcohol abuse, uncomplicated	138	$425,998
E10	Diabetes mellitus without complications	133	$531,499
I13	Hypertensive heart and chronic kidney disease with heart failure	130	$847,981
D57	Sickle-cell disorders	125	$725,533
K85	Acute pancreatitis	89	$345,520
K70	Alcoholic liver disease	78	$589,539
J96	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia	59	$689,680
E11	Type 2 Diabetes Mellitus	54	$405,761
I11	Hypertensive heart disease	54	$291,054
F25	Schizoaffective disorders	46	$260,670
Z51	Encounter for other aftercare	40	$274,722
U07	COVID-19, virus identified (lab confirmed)	27	$294,191
K56	Paralytic ileus and intestinal obstruction without hernia	25	$159,029
L03	Cellulitis and acute lymphangitis	25	$103,393
T81	Complications of procedures, not elsewhere classified	24	$193,804
T83	Complications of genitourinary prosthetic devices, implants and grafts	24	$154,131
E87	Other disorders of fluid, electrolyte and acid-base balance	24	$102,721
F33	Recurrent depressive disorder, current episode severe with psychotic symptoms	24	$99,297
N17	Acute kidney failure	23	$128,641
J44	Other chronic obstructive pulmonary disease	23	$86,955
K72	Hepatic failure, not elsewhere classified	22	$75,066
F11	Opioid abuse/dependence	22	$11,992
T80	Complications following infusion, transfusion and therapeutic injection	21	$237,487
T82	Complications of cardiac and vascular prosthetic devices, implants and grafts	20	$226,949

Summary

Based on lower than expected volumes and rates for total readmissions, and MCO feedback, DMAS expects data to continue to improve 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 $15,328,701 in reduced payments due to readmissions meeting policy criteria between July 1, 2020 and September 30, 2021. Top diagnoses related to flagged readmissions include sepsis, alcohol abuse, diabetes mellitus, heart and kidney disease with heart failure, sickle-cell disorders, and pancreatitis.