COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)

May 22, 2023

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-September 2022 (Q1 FY2023)

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) 664-2660.

CR/wrf
Enclosure

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

Report on hospital readmissions, July 2020-Sept. 2022 (Q1 FY2023)

A Report to the Virginia General Assembly *May 22, 2023*

Report Mandate:

Per Item 304.III of the 2022 Appropriation Act: "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 Department has reviewed encounters identified by MCOs as readmissions and their associated payments as submitted by MCOs, and fee for service (FFS) claims. Since DMAS expects lag in claims reporting to undercount the number of

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 reported, data are reported for July 2020 through September 2022. Data for October 2022 through March 2023 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 are not correctly identified by MCOs or FFS system as readmissions, they will not be counted here.
3. MCOs may have 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). Therefore, 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 – September 2022

Month	Aetna	Anthem	Molina	Optima	United	VA Premier	*All MCOs*	FFS	*Total*
2020-07	7	15	33		5	18	*78*	6	*84*
2020-08	9	5	42		11	21	*88*	14	*102*
2020-09	22	8	28		11	17	*86*	14	*100*
2020-10	17	9	36		13	17	*92*	14	*106*
2020-11	17	11	37		7	28	*100*	13	*113*
2020-12	25	11	37	1	7	30	*111*	14	*125*
2021-01	20	12	30		6	39	*107*	13	*120*
2021-02	17	20	28	1	4	57	*127*	10	*137*
2021-03	15	36	34	10	5	93	*193*	11	*204*
2021-04	11	42	39	14	5	72	*183*	17	*200*
2021-05	7	27	34	7	4	81	*160*	17	*177*
2021-06	7	44	30	13	6	72	*172*	23	*195*
2021-07		34	25	14	13	81	*167*	14	*181*
2021-08	2	54	21	17	8	108	*210*	17	*227*
2021-09		35	26	17	7	59	*144*	10	*154*
2021-10	2	54	31	10	11	66	*174*	14	*188*
2021-11	3	54	25	7	8	70	*167*	14	*181*
2021-12	2	63	32	7	17	81	*202*	12	*214*
2022-01		46	12	8	7	77	*150*	15	*165*
2022-02		54	17	7	10	93	*181*	18	*199*
2022-03		66	8	14	13	139	*240*	17	*257*
2022-04	2	58		16	7	172	*255*	12	*267*
2022-05	4	41	1	20	15	68	*149*	17	*166*
2022-06	1	73	4	11	10	71	*170*	10	*180*
2022-07	2	47	3		9	92	*153*	15	*168*
2022-08		67	1		18	98	*184*	13	*197*
2022-09	2	61			16	97	*176*	13	*189*
Total	**194**	**1,047**	**614**	**194**	**253**	**1,917**	***4,219***	**377**	***4,596***

Cost of Readmissions and 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 penalty imposed 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 – September 2022

MCO	(A) Dollars paid	(B) Counterfactual full payment amount	(C) Estimated Penalty (B-A)
AETNA	$ 1,880,834	$ 3,761,668	$ 1,880,834
ANTHEM	7,973,132	15,946,263	7,973,132
OPTIMA	3,809,820	7,619,640	3,809,820
MAGELLAN	1,579,900	3,159,800	1,579,900
UNITEDHEALTHCARE	1,882,266	3,764,532	1,882,266
VIRGINIA PREMIER	10,925,493	21,850,986	10,925,493
FFS	3,065,684	6,131,367	3,065,684
Total	**$ 31,117,129**	**$ 62,234,258**	**$ 31,117,129**

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 – September 2022

Diagnosis	Count of Claims	Total Payment
Other sepsis	410	$ 4,616,432
Alcohol related disorders	348	741,920
Hypertensive heart and chronic kidney disease	253	1,838,399
Sickle-cell disorders	247	1,395,083
Type 1 diabetes mellitus	243	952,361
Opioid related disorders	242	116,736
Acute pancreatitis	167	623,574
Respiratory failure, not elsewhere classified	141	1,643,127
Alcoholic liver disease	131	911,724
Schizoaffective disorders	116	551,359
Type 2 diabetes mellitus	113	756,024
Hypertensive heart disease	104	654,449
Encounter for other aftercare and medical care	95	862,138
Major depressive disorder, recurrent	72	423,561
Acute kidney failure	60	282,971
Other chronic obstructive pulmonary disease	54	235,992
Hepatic failure, not elsewhere classified	54	259,810
Complications of procedures, not elsewhere classified	52	405,628
Complications of genitourinary prosth dev/grft	52	354,110
Bipolar disorder	51	234,282
Paralytic ileus and intestinal obstruction without hernia	47	271,753
Atrial fibrillation and flutter	44	199,385
Epilepsy and recurrent seizures	42	155,625
COVID-19, virus identified (lab confirmed)	42	426,585
Other disorders of fluid, electrolyte and acid-base balance	41	182,765