COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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September 12, 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-June 2022 (Q2 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) 786-8099.

CR
Enclosure

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

Report on Hospital Readmissions, July 2020-Dec. 2023 (Q2 FY23)

A Report to the Virginia General Assembly *September 12, 2023*

Report Mandate:

304.III 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.

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. Because DMAS expects lag in claims reporting to undercount the number of readmissions reported, data are reported for July 2020 through December 2022, and January 2023 through June 2023 are excluded at this time to allow data submission to be completed. Items to note regarding interpretation of numbers presented in this report:

About DMAS and Medicaid

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.

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.

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

Table 1. Top 25 Primary Diagnoses Associated with Readmissions, July 2020 – December 2022

Diagnosis	Count of Claims	Total Payment
Other sepsis	482	$ 5,497,631
Alcohol related disorders	394	822,194
Opioid related disorders	326	147,786
Type 1 diabetes mellitus	291	1,141,875
Hypertensive heart and chronic kidney disease	277	1,997,914
Sickle-cell disorders	274	1,517,070
Acute pancreatitis	183	701,326
Respiratory failure, not elsewhere classified	175	1,995,625
Alcoholic liver disease	145	1,012,056
Schizoaffective disorders	137	685,216
Type 2 diabetes mellitus	132	900,775
Hypertensive heart disease	119	763,469
Encounter for other aftercare and medical care	118	1,116,668
Major depressive disorder, recurrent	85	471,522
Acute kidney failure	68	323,015
Bipolar disorder	59	288,621
Complications of genitourinary prosth dev/grft	59	385,908
Complications of procedures, not elsewhere classified	59	464,049
Other chronic obstructive pulmonary disease	58	255,985
Hepatic failure, not elsewhere classified	55	274,845
Atrial fibrillation and flutter	49	211,903
Other disorders of fluid, electrolyte and acid-base balance	47	204,437
Paralytic ileus and intestinal obstruction without hernia	47	270,707
Epilepsy and recurrent seizures	44	160,918
COVID-19, virus identified (lab confirmed)	44	432,234

Readmissions by MCO and month

Table 2 shows the count of claims associated with readmissions per Item 304.III, by month, for each MCO, all MCOs, fee-for-service, and overall. The Department monitors MCO hospital readmission policies to ensure compliance.

Table 2. Count of claims, July 2020 – December 2022

Month	Aetna	Anthem	Molina	Optima	United	VA Premier	*All MCOs*	FFS	*Total*
2020-07	7	15		33	5	21	81	6	87
2020-08	9	5		42	11	27	94	14	108
2020-09	22	8		28	11	21	90	14	104
2020-10	17	9		36	13	20	95	14	109
2020-11	17	11		37	7	34	106	13	119
2020-12	25	11	1	37	7	34	115	14	129
2021-01	20	12		30	6	42	110	13	123
2021-02	17	20	1	28	4	61	131	10	141
2021-03	15	35	10	35	5	94	194	11	205
2021-04	11	42	14	40	5	72	184	17	201
2021-05	7	27	7	38	4	82	165	17	182
2021-06	7	44	13	35	6	72	177	23	200
2021-07		34	14	32	13	82	175	14	189
2021-08	2	54	17	28	8	108	217	17	234
2021-09		36	17	29	7	60	149	10	159
2021-10	2	54	10	32	11	65	174	14	188
2021-11	3	54	7	26	8	70	168	14	182
2021-12	2	63	7	36	17	82	207	12	219
2022-01		46	8	16	7	77	154	14	168
2022-02		54	7	24	10	93	188	18	206
2022-03		66	14	15	13	139	247	18	265
2022-04	2	57	16	9	7	170	261	12	273
2022-05	4	41	20	9	15	71	160	17	177
2022-06	1	70	11	13	10	73	178	9	187
2022-07	2	47		10	9	101	169	14	183
2022-08		68		3	19	110	200	18	218
2022-09	2	64			15	114	195	13	208
2022-10	3	62		2	16	100	183	8	191
2022-11		59		3	12	95	169	9	178
2022-12	2	69		2	12	89	174	10	184
Total	**199**	**1,237**	**194**	**708**	**293**	**2,279**	**4,910**	**407**	**5,317**

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 3. Dollars Paid and Estimated Savings, July 2020 – December 2022

MCO	(A) Dollars Paid	(B) Counterfactual Full Payment Amount	(C) Estimated Savings
AETNA	$ 1,944,608	$ 3,889,216	$ 1,944,608
ANTHEM	9,366,780	18,733,561	9,366,780
OPTIMA	4,489,313	8,978,626	4,489,313
MOLINA	1,579,900	3,159,801	1,579,900
UNITEDHEALTHCARE	2,170,345	4,340,690	2,170,345
VIRGINIA PREMIER	12,644,632	25,289,264	12,644,632
FFS	3,037,912	6,075,823	3,037,912
Total	**$ 35,233,490**	**$ 70,466,981**	**$ 35,233,490**