COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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March 19, 2024

MEMORANDUM

TO: The Honorable Mark Sickles
Chair, House Appropriations Health and Human Resources Sub-Committee

The Honorable R. Creigh Deeds
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 2023 (Q4 FY2023)

This report is submitted in compliance with Item 304.III. of the 2023 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-June 2023

A Report to the Virginia General Assembly *March 19, 2024*

Report Mandate:

Item 304.III of the 2023 Appropriations 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 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 fee-for-service (FFS) 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.

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.

The Department has reviewed encounters identified by MCOs as readmissions and their associated payments as submitted by MCOs, and FFS claims. Because DMAS expects lag in claims reporting to undercount the number of readmissions reported, data are reported for July 2020 through June 2023. Data for July 2023 through December 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 were not correctly identified by MCOs or FFS system as readmissions, they will 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 are not flagged for purposes of this state policy (Item 304.III). As such, some claims which might reasonably be considered readmissions will 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 – June 2023

Month	Aetna	Anthem	Magellan	Optima	United	VA Premier	*All MCOs*	FFS	*Total*
2020-07	7	15		33	5	21	81	6	87
2020-08	9	5		42	11	29	96	14	110
2020-09	22	8		28	10	22	90	14	104
2020-10	17	7		36	13	25	98	14	112
2020-11	17	10		37	7	37	108	13	121
2020-12	25	11	1	37	7	35	116	14	130
2021-01	20	11		30	6	43	110	13	123
2021-02	17	17	1	28	4	62	129	10	139
2021-03	15	30	10	35	5	93	188	11	199
2021-04	11	41	14	40	5	70	181	17	198
2021-05	7	24	7	38	4	81	161	17	178
2021-06	7	29	13	36	6	71	162	23	185
2021-07		21	14	32	13	82	162	14	176
2021-08	2	42	17	30	8	108	207	17	224
2021-09		22	17	29	7	59	134	10	144
2021-10	2	39	10	33	11	65	160	14	174
2021-11	3	33	7	27	8	70	148	14	162
2021-12	2	45	7	36	17	82	189	12	201
2022-01		30	8	16	7	77	138	14	152
2022-02		33	7	25	10	93	168	18	186
2022-03		39	13	16	13	139	220	18	238
2022-04	2	34	16	9	7	171	239	12	251
2022-05	3	27	19	10	15	73	147	17	164
2022-06	1	37	11	15	10	74	148	9	157
2022-07	1	26		13	10	101	151	16	167
2022-08		45		11	19	110	185	17	202
2022-09	2	42		13	14	116	187	13	200
2022-10	3	38		18	14	100	173	8	181
2022-11		41		5	13	92	151	10	161
2022-12	2	45		2	11	89	149	10	159
2023-01	1	42		4	8	100	155	11	166
2023-02		41			10	174	225	15	240
2023-03		51		2	20	227	300	9	309
2023-04	1	32		6	16	143	198	12	210
2023-05		57		1	16	116	190	9	199
2023-06	7	39		8	12	153	212	4	216
Total	**199**	**1,109**	**192**	**781**	**372**	**3,203**	**5,856**	**469**	**6,325**

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. Payments and Estimated Savings, July 2020 – June 2023

MCO	(A) Dollars paid	(B) Counterfactual full payment amount	(C) Estimated savings
AETNA	$ 1,933,178	$ 3,866,357	$ 1,933,178
ANTHEM	7,759,644	15,519,288	7,759,644
OPTIMA	4,853,370	9,706,740	4,853,370
MAGELLAN	1,576,274	3,152,548	1,576,274
UNITEDHEALTHCARE	2,661,769	5,323,537	2,661,769
VIRGINIA PREMIER	15,308,492	30,616,985	15,308,492
FFS	3,512,156	7,024,311	3,512,156
Total	**$ 37,604,884**	**$ 75,209,767**	**$ 37,604,884**

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 – June 2023

Diagnosis	Count of Claims	Total Payment
Alcohol related disorders	629	$ 1,067,847
Opioid related disorders	550	259,943
Other sepsis	532	5,752,370
Type 1 diabetes mellitus	345	1,446,496
Hypertensive heart and chronic kidney disease	320	2,085,324
Sickle-cell disorders	316	1,689,527
Acute pancreatitis	199	756,658
Respiratory failure, not elsewhere classified	189	2,215,325
Schizoaffective disorders	175	835,014
Alcoholic liver disease	165	1,163,638
Type 2 diabetes mellitus	154	1,022,880
Hypertensive heart disease	137	863,564
Encounter for other aftercare and medical care	136	1,313,774
Major depressive disorder, recurrent	109	579,217
Cocaine related disorders	90	47,484
Bipolar disorder	80	378,147
Other chronic obstructive pulmonary disease	67	278,096
Acute kidney failure	62	281,121
Complications of genitourinary prosth dev/grft	57	375,216
Paralytic ileus and intestinal obstruction without hernia	55	320,238
Atrial fibrillation and flutter	54	241,532
Hepatic failure, not elsewhere classified	51	246,298
Other disorders of fluid, electrolyte and acid-base balance	50	203,753
Epilepsy and recurrent seizures	49	178,806
Complications of procedures, not elsewhere classified	44	318,178