COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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May 1, 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 – September 2023 (Q1 FY2024)

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-September 2023

A Report to the Virginia General Assembly *May 1, 2024*

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 Department of Medical Assistance Services (DMAS) has a reduced payment policy for hospital readmissions based on specifications in the 2023 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 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.

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 fee-for-service (FFS) claims and encounters identified by MCOs as readmissions and their associated payments as submitted by MCOs. Since DMAS expects lag in claims reporting to undercount the number of readmissions reported, data are reported for July 2020 through September 2023, and October 2023 through March 2024 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 already have had readmissions policies in place with providers that more strictly limit their exposure than this DMAS policy; as such, even if readmissions did occur, they might not receive the 50% adjustment and thus will not be flagged for purposes of this report. As such, some claims which might reasonably be considered readmissions will 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 2023

Month	Aetna	Anthem	Magellan	Optima	United	VA Premier	*All MCOs*	FFS	*Total*
2020-07	7	15		33	5	16	76	6	82
2020-08	9	5		42	11	28	95	14	109
2020-09	22	8		28	10	19	87	14	101
2020-10	17	7		36	13	18	91	14	105
2020-11	17	10		37	7	25	96	13	109
2020-12	25	11	1	37	7	28	109	14	123
2021-01	20	11		30	6	33	100	13	113
2021-02	17	17	1	28	4	52	119	10	129
2021-03	15	30	10	35	5	70	165	11	176
2021-04	11	41	14	40	5	59	170	17	187
2021-05	7	24	7	38	4	79	159	17	176
2021-06	7	29	13	36	6	66	157	23	180
2021-07		21	14	32	13	80	160	14	174
2021-08	2	42	17	30	8	105	204	17	221
2021-09		22	17	29	7	57	132	10	142
2021-10	2	39	10	33	11	63	158	14	172
2021-11	3	33	7	27	8	66	144	14	158
2021-12	2	45	7	36	17	79	186	12	198
2022-01		30	8	16	7	77	138	14	152
2022-02		33	7	25	10	93	168	18	186
2022-03		39	13	15	13	138	218	18	236
2022-04	2	34	16	9	7	169	237	12	249
2022-05	3	27	19	10	15	73	147	17	164
2022-06	1	37	11	14	10	73	146	9	155
2022-07	1	26		12	10	99	148	16	164
2022-08		45		10	19	110	184	17	201
2022-09	2	42		7	14	115	180	13	193
2022-10	3	38		14	13	100	168	8	176
2022-11		40		5	13	92	150	10	160
2022-12	2	44		2	11	89	148	10	158
2023-01	1	41		4	8	99	153	11	164
2023-02		39		-	10	171	220	14	234
2023-03		47		1	19	223	290	9	299
2023-04	1	29		6	14	137	187	12	199
2023-05		56		-	15	112	183	12	195
2023-06		36		7	12	147	202	4	206
2023-07		29		97	12		138	17	155
2023-08		8		121	12		141	11	152
2023-09		2		42	8		52	10	62
Total	**199**	**1,132**	**192**	**1,024**	**399**	**3,060**	**6,006**	**509**	**6,515**

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 2, below), DMAS has calculated the full cost of readmissions by doubling the payment amount of readmissions claims submitted by the MCOs (column B). The estimated amount in savings from the policy (column 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 Savings for July 2020 – September 2023

MCO	(A) Dollars paid	(B) Counterfactual full payment amount	(C) Estimated savings
AETNA	$ 1,954,242	$ 3,908,483	$ 1,954,241
ANTHEM	8,509,695	17,019,391	8,509,696
OPTIMA	7,462,338	14,924,676	7,462,338
MAGELLAN	1,576,274	3,152,548	1,576,274
UNITED HEALTHCARE	2,804,667	5,609,334	2,804,667
VIRGINIA PREMIER	14,370,330	28,740,660	14,370,330
FFS	3,931,687	7,863,373	3,931,686
Total	**$ 40,609,233**	**$ 81,218,465**	**$ 40,609,232**

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 are shown in Table 3, along with the count of associated claims and total amount paid for those claims.

Table 3. Top 25 Primary Diagnoses Associated with Readmissions for July 2020 – September 2023

Diagnosis	Claim Count	Total Payment
Alcohol related disorders	784	$ 1,149,280
Opioid related disorders	676	300,165
Other sepsis	563	6,156,272
Sickle-cell disorders	363	1,897,464
Type 1 diabetes mellitus	352	1,378,046
Hypertensive heart and chronic kidney disease	335	2,190,478
Acute pancreatitis	211	779,871
Respiratory failure, not elsewhere classified	200	2,299,205
Schizoaffective disorders	188	932,611
Alcoholic liver disease	167	1,172,466
Type 2 diabetes mellitus	161	1,048,311
Hypertensive heart disease	148	901,606
Encounter for other aftercare and medical care	131	1,370,844
Major depressive disorder, recurrent	117	623,466
Cocaine related disorders	100	52,829
Bipolar disorder	95	459,162
Other chronic obstructive pulmonary disease	72	306,400
Complications of genitourinary prosth dev/grft	65	395,990
Acute kidney failure	64	307,372
Other disorders of fluid, electrolyte and acid-base balance	63	256,078
Paralytic ileus and intestinal obstruction without hernia	57	297,583
Atrial fibrillation and flutter	56	285,816
Epilepsy and recurrent seizures	55	225,101
Other stimulant related disorders	53	95,529
Hepatic failure, not elsewhere classified	51	246,298