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)

July 15, 2024

MEMORANDUM

TO: The Honorable Mark D. Sickles
Chair, Joint Subcommittee on Health and Human Resources Oversight

The Honorable R. Creigh Deeds
Vice Chair, Joint Subcommittee on Health and Human Resources Oversight

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

SUBJECT: Report on hospital readmissions, July 2020-December 2023

This report is submitted in compliance with item 288.AA. of the *2024 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.

CJR/wrf

Enclosure

Pc: The Honorable Janet Kelly, Secretary of Health and Human Resources

Report on hospital readmissions, July 2020-December 2023

A Report to the Virginia General Assembly *July 15, 2024*

Report Mandate:

288.AA. 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 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 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% 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 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 2023, and January 2024 through June 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 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.

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 – December 2023

Month	Aetna	Anthem	Magellan	Optima	United	VA Premier	*All MCOs*	FFS	*Total*
2020-07	7	15		33	5	35	95	6	101
2020-08	9	5		42	11	55	122	14	136
2020-09	22	8		28	10	39	107	14	121
2020-10	17	7		36	13	43	116	14	130
2020-11	17	10		37	7	50	121	13	134
2020-12	25	12	1	37	7	43	125	14	139
2021-01	20	13		30	6	52	121	13	134
2021-02	17	17	1	28	4	71	138	10	148
2021-03	15	30	10	35	5	95	190	11	201
2021-04	11	40	14	40	5	77	187	17	204
2021-05	7	23	7	38	4	83	162	17	179
2021-06	7	28	13	36	6	74	164	23	187
2021-07		19	14	32	13	84	162	14	176
2021-08	2	41	17	32	8	110	210	17	227
2021-09		22	17	30	7	63	139	10	149
2021-10	2	40	10	33	11	65	161	14	175
2021-11	3	33	7	28	8	70	149	14	163
2021-12	2	46	7	36	17	85	193	12	205
2022-01		31	8	18	7	77	141	14	155
2022-02		33	7	26	10	94	170	18	188
2022-03		40	13	19	13	141	226	18	244
2022-04	2	35	16	12	7	173	245	12	257
2022-05	3	29	19	13	15	74	153	17	170
2022-06	1	36	11	20	10	75	153	9	162
2022-07	1	25		24	10	101	161	16	177
2022-08		47		24	19	111	201	17	218
2022-09	2	40		24	14	116	196	13	209
2022-10	3	41		29	14	102	189	8	197
2022-11		45		18	13	93	169	10	179
2022-12	2	50		24	12	95	183	10	193
2023-01	1	47		18	9	101	176	11	187
2023-02		41		17	10	176	244	14	258
2023-03		54		19	21	229	323	9	332
2023-04	1	41		20	17	146	225	12	237
2023-05	1	57		15	18	120	211	12	223
2023-06		42		13	12	158	225	5	230
2023-07		32		181	16		229	17	246
2023-08		33		187	18		238	12	250
2023-09		47		158	17		222	11	233
2023-10		35		234	17		286	12	298
2023-11		42		350	12		404	14	418
2023-12		39		204	17		260	14	274
Total	**200**	**1,371**	**192**	**2,278**	**475**	**3,376**	**7,892**	**552**	**8,444**

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. Sum of dollars paid and estimated savings, July 2020 – December 2023

MCO	(A) Dollars paid	(B) Counterfactual full payment amount	(C) Estimated savings
AETNA	$1,954,242	$3,908,483	$1,954,242
ANTHEM	$9,361,675	$18,723,350	$9,361,675
OPTIMA	$10,073,102	$20,146,204	$10,073,102
MAGELLAN	$1,576,274	$3,152,548	$1,576,274
UNITEDHEALTHCARE	$3,188,105	$6,376,211	$3,188,105
VIRGINIA PREMIER	$16,910,844	$33,821,688	$16,910,844
FFS	$4,371,561	$8,743,122	$4,371,561
Total	**$47,435,803**	**$94,871,606**	**$47,435,803**

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 – December 2023

Diagnosis	Count of Claims	Total Payment
Alcohol related disorders	1181	$1,470,092
Opioid related disorders	765	$339,683
Other sepsis	664	$7,151,860
Type 1 diabetes mellitus	421	$1,712,987
Sickle-cell disorders	421	$2,153,377
Hypertensive heart and chronic kidney disease	390	$2,515,530
Acute pancreatitis	244	$937,781
Respiratory failure, not elsewhere classified	221	$2,652,253
Schizoaffective disorders	221	$1,059,350
Alcoholic liver disease	194	$1,401,814
Type 2 diabetes mellitus	192	$1,254,478
Encounter for other aftercare and medical care	177	$1,798,623
Hypertensive heart disease	171	$1,011,618
Major depressive disorder, recurrent	130	$705,978
Bipolar disorder	106	$497,891
Cocaine related disorders	101	$54,857
Other chronic obstructive pulmonary disease	98	$518,305
Other stimulant related disorders	95	$112,065
Complications of genitourinary prosth dev/grft	81	$491,052
Acute kidney failure	77	$365,745
Other disorders of fluid, electrolyte and acid-base balance	70	$298,106
Paralytic ileus and intestinal obstruction without hernia	70	$457,248
Epilepsy and recurrent seizures	63	$275,533
Atrial fibrillation and flutter	61	$316,661
Cannabis related disorders	59	$11,616