MEDICAID PAYMENT POLICIES AND CARE COORDINATION WORKGROUP

Meeting 1

October 27, 2020

Meeting Agenda

- Welcome and Introductions
- Guidelines
- Workgroup Purpose, Strategy, Timeline
- Emergency Department Utilization and Hospital Readmissions Analyses
  - Presentations by DMAS, VHI, and VHHA
- Group Discussion
- Homework
- Adjourn

Disclaimer

The primary goal of this workgroup is to provide a report to the General Assembly highlighting data, findings, and policy options in the areas of emergency room utilization and hospital readmissions. As a reminder, this meeting is open to the public and all information shared and presented during workgroup activities, may be made public and/or included in this public report to the Virginia General Assembly.

Workgroup Member Guidelines

- ✓ Robust and meaningful discussion is encouraged, and should be based on a data-driven approach to presentations, findings, and policy options.
- ✓ Discussions should be solution-focused and provide actionable policy options to improve the future state of Virginia health care.
- ✓ The Workgroup must ultimately report policy options to the General Assembly for its consideration. DMAS will construct a report outlining Workgroup efforts, policies discussed, key information from those conversations, and policy options.

Overview of Workgroup Purpose, Strategy, Timeline

Overview of Workgroup Purpose

The Department of Medical Assistance Services shall convene a workgroup to evaluate and develop strategies and recommendations to improve payment policies and coordination of care in the Medicaid program to encourage the effective and efficient provision of care by providers and health care systems serving Medicaid members. The workgroup shall include representatives from the Virginia Hospital and Healthcare Association, hospitals, the Virginia Association of Health Plans, managed care organizations, emergency department and primary care physicians, and other stakeholders deemed necessary by the department. The workgroup shall:

(i) evaluate the appropriate coordination of services and cooperation among Medicaid managed care organizations (MCOs), hospitals, physicians, social services organizations, and nonprofit organizations to achieve a **reduction in hospital readmissions, improved health outcomes, and reduced overall costs of care** for conditions with high rates of hospital readmission in the Medicaid program;

(ii) **examine the role of hospital discharge planning and MCO care coordinators** in assisting Medicaid beneficiaries with access to appropriate care and services post-discharge and other factors that may contribute to higher rates of readmission such as social determinants of health that could impact a patient's readmission status;

(iii) assess the effectiveness of past and current mechanisms to **improve outcomes and readmission rates** by hospitals and health care systems and best practices and models from federal programs and other states;

(iv) assess how to prevent inappropriate utilization of emergency department services;

(v) examine the role of MCO care coordinators in assisting Medicaid beneficiaries **access to appropriate care, including Medicaid beneficiary access to and the availability and use of alternative non-emergency care options**, adequacy of MCO provider networks and reimbursement for primary care and alternative non-emergency care options, and the effectiveness of past and current mechanisms to improve the use of alternative non-emergent care by Medicaid beneficiaries;

(vi) evaluate the **impact of freestanding emergency departments and hospital emergency department marketing** on emergency department utilization along with lower-cost options for triage of non-emergency cases to alternative settings;

(vii) consider other states **efforts to address emergency department utilization**, including the use of medical and health homes, alternative primary care sites, and programs to coordinate the health needs of “super-utilizers"; and

(viii) consider strategies to engage **in value-based payment arrangements and other forms of financial incentives to encourage appropriate utilization of services and cooperation by health care providers and systems** in improving health care outcomes, including a review of designated Performance Withhold Program measures, Clinical Efficiency measures, and other existing or potential programs.

The department shall provide data on emergency room utilization and hospital readmissions of Medicaid beneficiaries to the workgroup to assist in its evaluation and analysis. The department shall report on the workgroup's findings and recommendations to the Joint Subcommittee for Health and Human Resources Oversight by December 15, 2020.

Proposed Workgroup Strategy to address Emergency Department Utilization, Hospital Readmissions, and Care Coordination

- ✓ Convene Workgroup **October 2020 – March 2021**
  - Review emergency department utilization and hospital readmissions data (October 2020)
  - Assess stakeholder care coordination activities, discharge practices, and appropriate sites of care to affect positive care outcomes (November 2020)
  - Review successful federal, state, and provider interventions to address ED utilization and hospital readmissions (December 2020)
  - Discuss value-based purchasing and other financial incentives for potential policy options in Medicaid (March 2021)
- ✓ Deliver report to General Assembly by **May 1, 2021**.

Workgroup Meeting Timeline

1 Meeting One: October 27, 2020

- ✓ Overview of workgroup purpose, strategy, and timeline
- ✓ Review ED utilization and hospital readmissions data in Virginia
- ✓ *Homework for Workgroup Members (VHHA/Hospitals, VAHP/MCOs, Primary Care Physicians, and Emergency Department Physicians): Care Coordination Presentations for meeting 2 addressing workgroup topics (i), (ii), and (v).*

2 Meeting Two: November 19, 2020

- ✓ Review of care coordination and discharge practices, as well as access to appropriate sites of care (presentations from workgroup members).
- ✓ *Homework for Workgroup Members:*
  - *All Members: Provide written feedback on any draft report content provided to date, including any draft policy options*
  - *VCHI and DMAS (with assistance from DMAS' Actuary): Prepare presentations on past and current efforts to address ED utilization and hospital readmissions nationally and in Virginia. (iii, iv, vii)*

3 Meeting Three: December 17, 2020

- ✓ Review successful federal, state, and provider interventions to address ED utilization and hospital readmissions (presentations from DMAS and VCHI).
- ✓ *Homework for Workgroup Members:*
  - *All Members: Provide written feedback on any draft report content provided to date, including any draft policy options*
  - *DMAS: Prepare presentation on existing value based purchasing and other financial incentives.*

4 Meeting Four: March 18, 2021

- ✓ Discuss value-based purchasing and other financial incentives for potential policy options in Medicaid (DMAS presentation).
- ✓ *Homework for Workgroup Members: Provide any written feedback on Meeting 4 content to DMAS.*

Overview of Emergency Department & Hospital Readmissions Utilization and Trends in Virginia

DMAS Clinical Efficiency Performance Measures

DMAS evaluates potentially preventable and/or medically unnecessary emergency department utilization, hospital admissions, and hospital readmissions through performance measures designed in consultation with its actuary (Mercer) to focus on managed care organizations. This suite of performance measures are typically referred to as DMAS' "Clinical Efficiency Measures."

Low-Acuity Non-Emergent (LANE) Emergency Room Utilization Clinical Efficiency

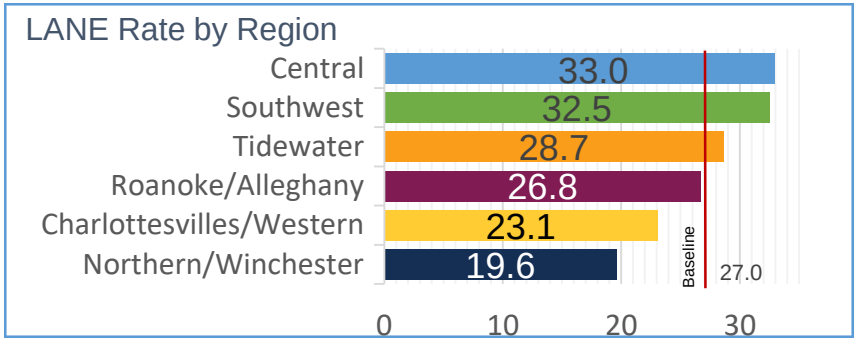
- ✓ The LANE analysis identifies ER visits that could have occurred in a lower-acuity setting or been avoided through the provision of consistent, evidence-based primary care, proactive care management and/or health education.
- ✓ The steps and criteria for the LANE ER utilization measure are as follows:
  - Identify ER visits associated with a list of ~790 potentially preventable diagnosis codes
  - Apply a percent preventable associated with each code using the NYU algorithm (i.e. all instances of a code are not necessarily deemed preventable/avoidable)
  - Apply exclusionary criteria for ER visits associated with any of the following:
    - Inpatient encounters or observation stays,
    - Trauma,
    - Delivery of a newborn,
    - Dually eligible members,
    - Members <1 or >64 years of age.
  - Adjust final output to track rate of LANE visits per 1,000 member months
- ✓ More information on the DMAS LANE ER utilization measure can be found on the DMAS website at https://www.dmas.virginia.gov/#/valuebasedpurchasing, including detailed technical specifications, value sets, and output

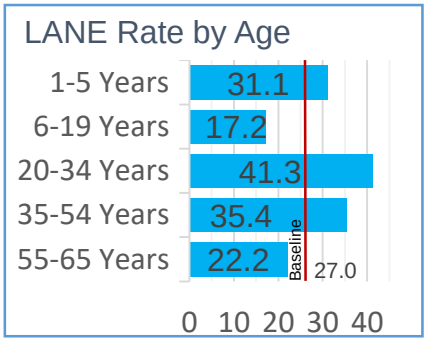
LANE Results for Medallion 4.0

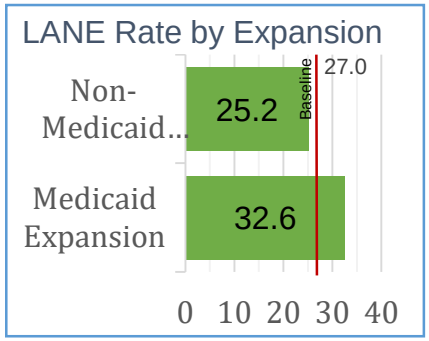
Low-Acuity Non-Emergent (LANE) Emergency Room Visits Demographics – Medallion 4.0

Medallion 4.0

LANE Visits Rate (Baseline)[3]	LANE ER Visits (Baseline)[1]	Member Months (Baseline)
27.0	**313,027**	**11,586,386**







Notes:
1. Total LANE ER visits with diagnosis code, after adjusting for preventability (%), and rounded to the nearest whole number.
2. Total LANE ER Visits with diagnosis code, after adjusting for preventability (%), and rounded to the nearest whole number.
3. Baseline rates reflect calendar year 2019 performance.

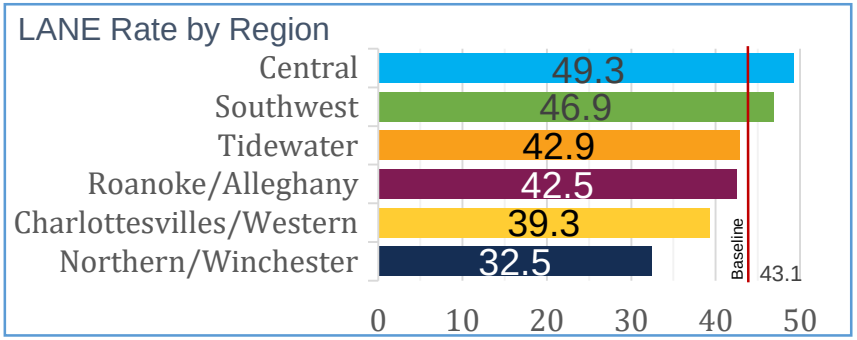
Rank	Diagnosis Code	Description	LANE ER Visits[2]
1	J06.9	Acute upper respiratory infection, unspecified	31,290
2	J02.9	Acute pharyngitis, unspecified	13,317
3	N39.0	Urinary tract infection, site not specified	10,907
4	R51	Headache	9,707
5	J02.0	Streptococcal pharyngitis	8,891
6	R11.2	Nausea with vomiting, unspecified	8,710
7	J10.1	Influenza due to other identified influenza virus with other respiratory manifestations	7,443
8	J20.9	Acute bronchitis, unspecified	6,729
9	R05	Cough	6,598
10	M54.5	Low back pain	5,944
11	K52.9	Noninfective gastroenteritis and colitis, unspecified	5,889
12	R10.9	Unspecified abdominal pain	5,403
13	J45.901	Unspecified asthma with (acute) exacerbation	4,993
14	J11.1	Influenza due to unidentified influenza virus with other respiratory manifestations	4,981
15	R11.10	Vomiting, unspecified	4,733
16	H66.91	Otitis media, unspecified, right ear	4,525
17	R21	Rash and other nonspecific skin eruption	4,302
18	H66.92	Otitis media, unspecified, left ear	4,030
19	N76.0	Acute vaginitis	3,961
20	K04.7	Periapical abscess without sinus	3,755
21	R19.7	Diarrhea, unspecified	3,576
22	J18.9	Pneumonia, unspecified organism	3,493
23	R10.84	Generalized abdominal pain	3,251
24	R42	Dizziness and giddiness	3,092
25	R1013	Epigastric pain	2,797
		Total LANE ER Visits from Top 25 Diagnoses	**172,317**
		Percent of Top 25 Diagnoses as a percentage of Total LANE ER Visits	**55%**

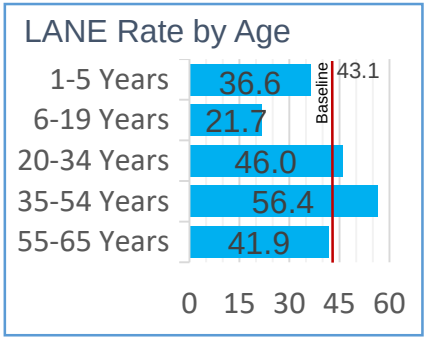
LANE Results for CCC+

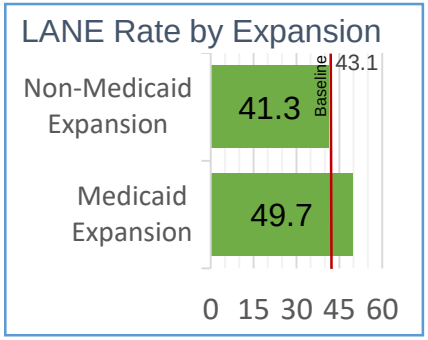
Low-Acuity Non-Emergent (LANE) Emergency Room Visits Demographics – CCC+

Commonwealth Coordinated Care Plus

LANE Visits Rate (Baseline)[3]	LANE ER Visits (Baseline)[1]	Member Months (Baseline)
43.1	**62,200**	**1,443,823**







Notes:
1. Total LANE ER visits with diagnosis code, after adjusting for preventability (%), and rounded to the nearest whole number.
2. Total LANE ER Visits with diagnosis code, after adjusting for preventability (%), and rounded to the nearest whole number.
3. Baseline rates reflect calendar year 2019 performance.

Rank	Diagnosis Code	Description	LANE ER Visits[2]
1	J06.9	Acute upper respiratory infection, unspecified	3,169
2	N390	Urinary tract infection, site not specified	2,654
3	R51	Headache	2,406
4	M545	Low back pain	2,284
5	J209	Acute bronchitis, unspecified	1,952
6	J441	Chronic obstructive pulmonary disease with (acute) exacerbation	1,719
7	R112	Nausea with vomiting, unspecified	1,673
8	R109	Unspecified abdominal pain	1,550
9	J029	Acute pharyngitis, unspecified	1,212
10	E1165	Type 2 diabetes mellitus with hyperglycemia	1,203
11	R05	Cough	1,117
12	R42	Dizziness and giddiness	973
13	J45901	Unspecified asthma with (acute) exacerbation	962
14	R1084	Generalized abdominal pain	922
15	K529	Noninfective gastroenteritis and colitis, unspecified	920
16	K047	Periapical abscess without sinus	884
17	J189	Pneumonia, unspecified organism	805
18	I10	Essential (primary) hypertension	756
19	M542	Cervicalgia	741
20	R1013	Epigastric pain	720
21	J40	Bronchitis, not specified as acute or chronic	659
22	M25561	Pain in left knee	647
23	M25562	Pain in right knee	620
24	R21	Rash and other nonspecific skin Eruption	616
25	N3000	Acute cystitis without hematuria	612
		Total LANE ER Visits from Top 25 Diagnoses	**31,777**
		Percent of Top 25 Diagnoses as a percentage of Total LANE ER Visits	**51%**

Hospital Readmissions Clinical Efficiency

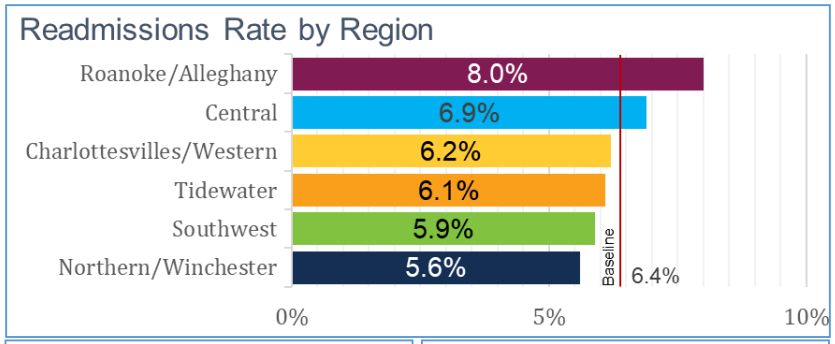
- ✓ The hospital readmissions CE analysis identifies hospital readmissions that could have been potentially prevented/avoided through improved patient follow up, care coordination, and discharge planning.
- ✓ The steps and criteria for the hospital readmissions CE PM are as follows:
  - Identify admissions to acute medical facilities.
  - Look for all readmissions occurring with 30 days of an anchor admission.
  - Apply exclusionary criteria associated with any of the following:
    - Cancer diagnoses,
    - Discharge disposition (leaving AMA, transferred, expired),
    - Dually eligible members,
    - Members <1 or >64 years of age,
    - Planned admissions and select pregnancy related admissions.
- ✓ More information on the DMAS Hospital Readmissions measure can be found on the DMAS website at https://www.dmas.virginia.gov/#/valuebasedpurchasing, including detailed technical specifications, value sets, and output.

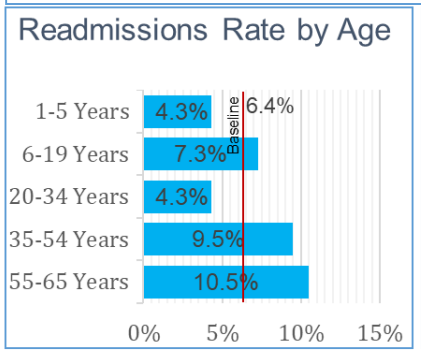
Hospital Readmissions Results for Medallion 4.0

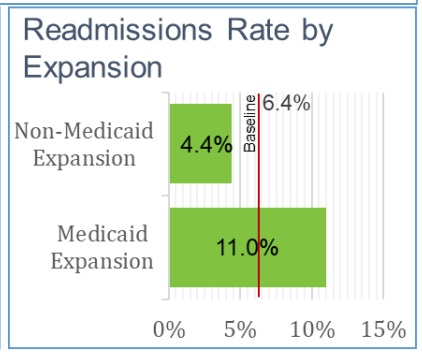
Hospital Readmissions Demographics – Medallion 4.0

Medallion 4.0

Readmissions Rate (Baseline)	Readmissions (Baseline)[1]	Admissions (Baseline)
6.4%	**3,942**	**61,290**







Notes:
1. Baseline rates reflect calendar year 2019 performance.

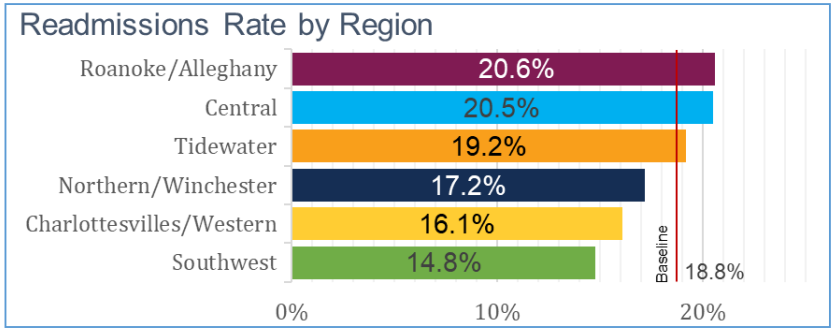
Rank	Diagnosis Code	Description	Readmissions	Percent of Readmissions
1	F33	Major depressive disorder, recurrent	462	12%
2	F31	Bipolar affective disorder	202	5%
3	F10	Alcohol related disorders	199	5%
4	E10	Type 1 diabetes mellitus	158	4%
5	F34	Persistent mood [affective] disorders	148	4%
6	F32	Major depressive disorder, single episode	147	4%
7	F25	Schizoaffective disorders	128	3%
8	A41	Other Sepsis	110	3%
9	O99	Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium	91	2%
10	T81	Complications of procedures, not elsewhere classified	89	2%
		Total from Top 10 Diagnoses	**1,734**	**44%**

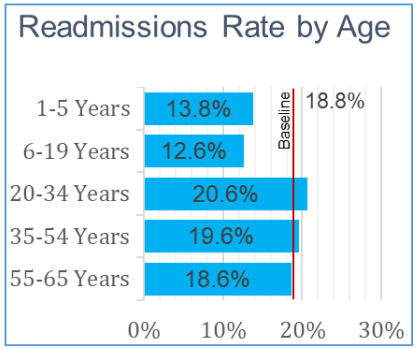
Hospital Readmissions Results for CCC+

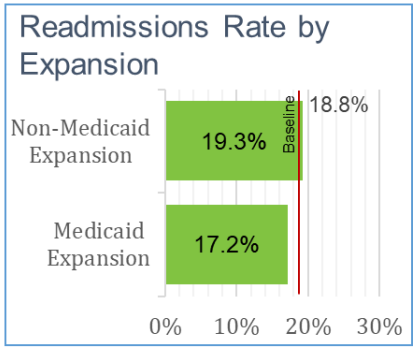
Hospital Readmissions Demographics – CCC+

Commonwealth Coordinated Care Plus

Readmissions Rate (Baseline)	Readmissions (Baseline)[1]	Admissions (Baseline)
18.8%	**5,209**	**27,747**







Notes:
1. Baseline rates reflect calendar year 2019 performance.

Rank	Diagnosis Code	Description	Readmissions	Percent of Readmissions
1	F25	Schizoaffective disorders	549	11%
2	F33	MDD recurrent moderate	411	8%
3	F31	Bipolar affective disorder	337	6%
4	A41	Other Sepsis	286	5%
5	F10	Alcohol abuse, uncomplicated	204	4%
6	F20	Schizophrenia	179	3%
7	I13	Hypertensive heart and chronic kidney disease	171	3%
8	E10	Type 1 diabetes mellitus	162	3%
9	E11	Type 2 diabetes mellitus	125	2%
10	J96	Respiratory Failure	114	2%
		Total from Top 10 Diagnoses	**2,538**	**49%**

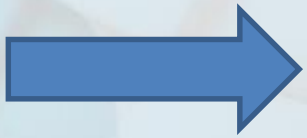
Commercial Market ED and Readmission Metrics

Slides prepared by VHI for October 27th meeting of Medicaid Payment Policies and Care Coordination Work Group

Virginia's All Payer Claims Database (APCD)

Participating Health Insurance Companies[1]

-Aetna/CVS/Innovation Health
-Anthem
-Carefirst
-Cigna
-CMS
-DMAS
-Humana
-Kaiser Permanente
-Magellan
-Optima Health
-Piedmont
-United Health Group Plans & Optum
-Virginia Premier



-40-60% of commercially insured individuals depending on the timeframe

-All individual and small group market, Self insured large group is based on Opt-In decision of employer

-COVA and VA municipalities must participate

Data is currently available through Q3 2019

[1] All plans with at least 1,000 eligible members must submit medical/pharmacy claims to APCD as of July 1, 2019 (via passage of VA Senate Bill 1216)

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Virginia Patient Level Data System (PLD)

- Includes patient demographic, administrative, clinical and financial information on every discharge that occurs in Virginia licensed hospitals

- Patient level data is produced for every calendar quarter since the third quarter of 1993 and is available approximately six months after the end of each calendar quarter.

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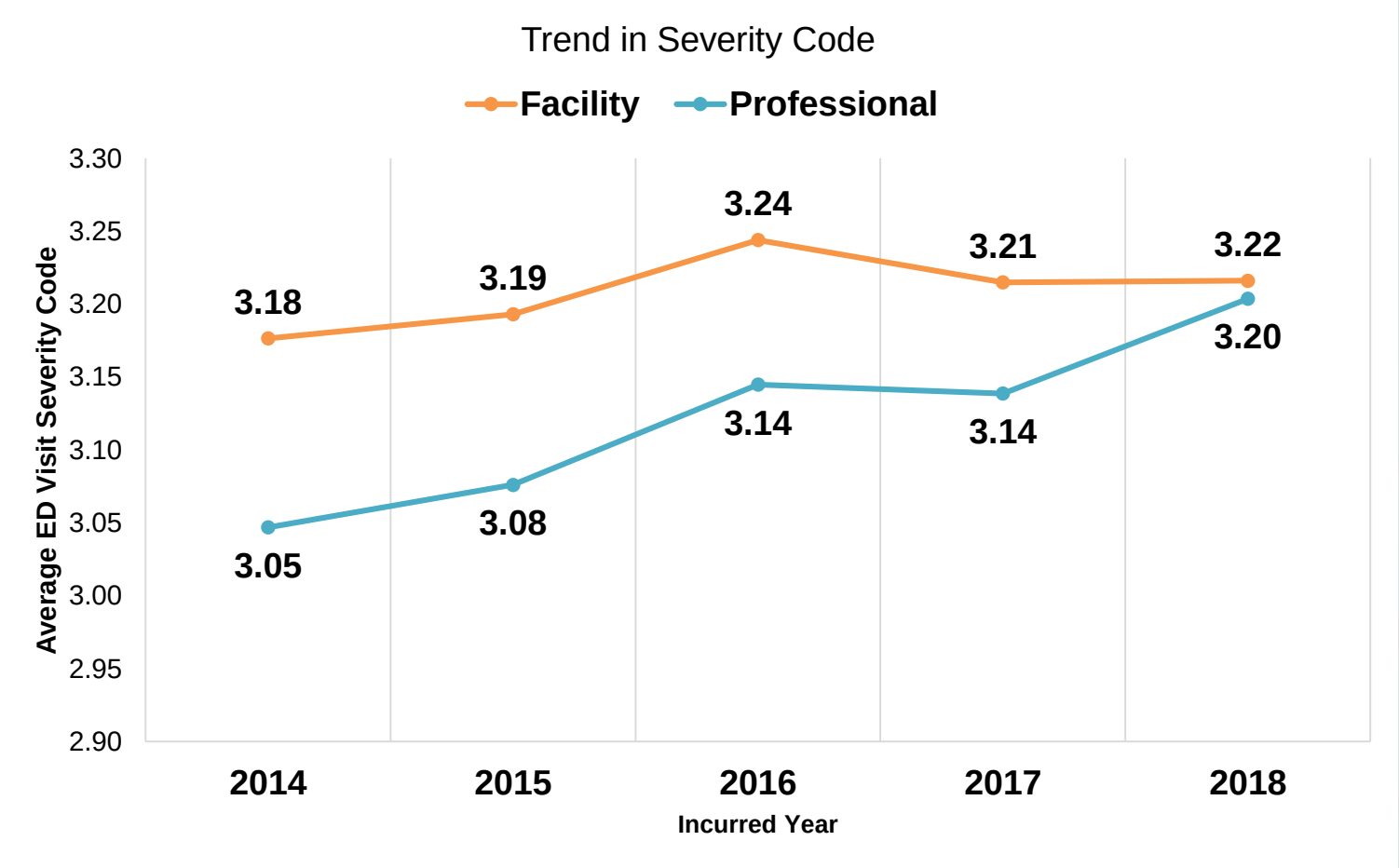
Distribution of ED Visit by Age and Region[1]

Member Age Band	Northwestern	Northern	Southwest	Central	Eastern	Statewide
[0-5]	7%	9%	6%	6%	5%	7%
[6-19]	14%	16%	12%	12%	11%	13%
[20-34]	**27%**	**25%**	**26%**	**29%**	**28%**	**27%**
[35-54]	**33%**	**32%**	**35%**	**35%**	**36%**	**34%**
[55-65]	17%	14%	19%	17%	18%	17%
[65+]	2%	3%	3%	2%	2%	2%

[1] Commercial Market within APCD for Q3 2018- Q2 2019, ED visit defined using 4 digit prefix 9928, Age based on DOS*

Trends in ED Visit Severity Code Level[1]



[1] *Commercial Market within APCD, ED visit defined using 4 digit prefix 9928**

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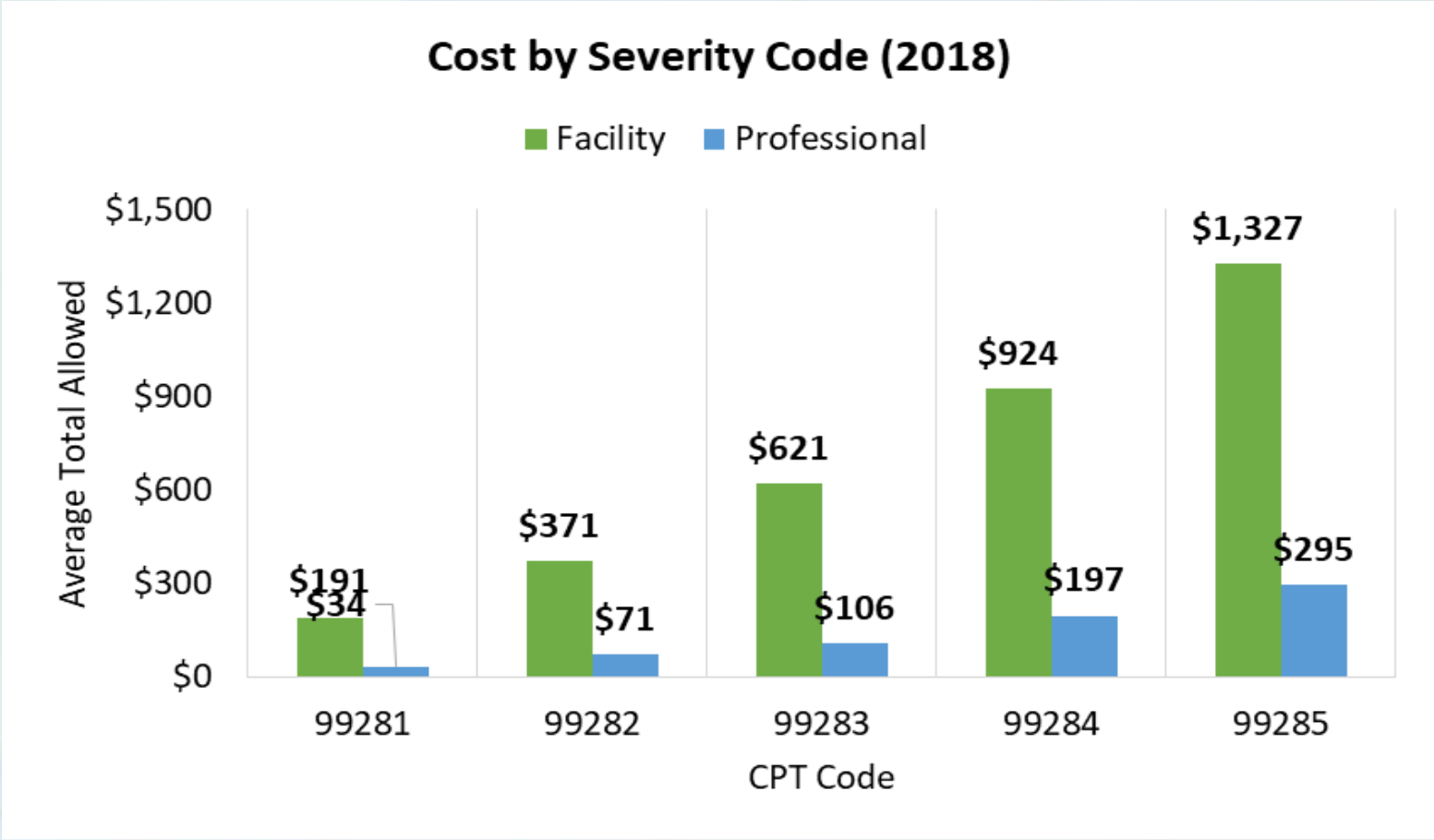
Average Commercial Reimbursement by ED Visit Severity Code[1]



[1] *Commercial Market within APCD for CY 2018- Q2 2019, commercial reimbursement displayed using standardized proxy reimbursement amount, more examples on the average commercial reimbursement for common healthcare services can be found at* http://vhi.org/HealthcarePricing/default.asp

Most Frequent ED DX Categories[1]

	2013		2018	
Diagnosis Category (Primary)	**% of Total ED Visits**	**Rank**	**% of Total ED Visits**	**Rank**
Abdominal pain	6%	1	5%	2
Sprains and strains	5%	2	4%	3
Superficial injury; contusion	5%	3	4%	5
Nonspecific chest pain	4%	4	5%	1
Other upper respiratory infections	4%	5	3%	6
Potentially Avoidable	**11%**	**-**	**10%**	**-**

[1] Commercial Market within APCD, DX categories based on AHRQ CCS groupings, Potentially Avoidable ED visits defined used California Dept of Health/OHA methodology, more data about rates of potentially avoidable ED visits can be found at http://vhi.org/Hospitals/avoidable-ed-visits.asp

Care Surrounding a Potentially Avoidable ED Visit[1]

At least 1 PCP or Urgent Care Visit

31%

30 Days Before

Total Number of Individuals that had a Potentially Avoidable ED Visit in 2018

31,387

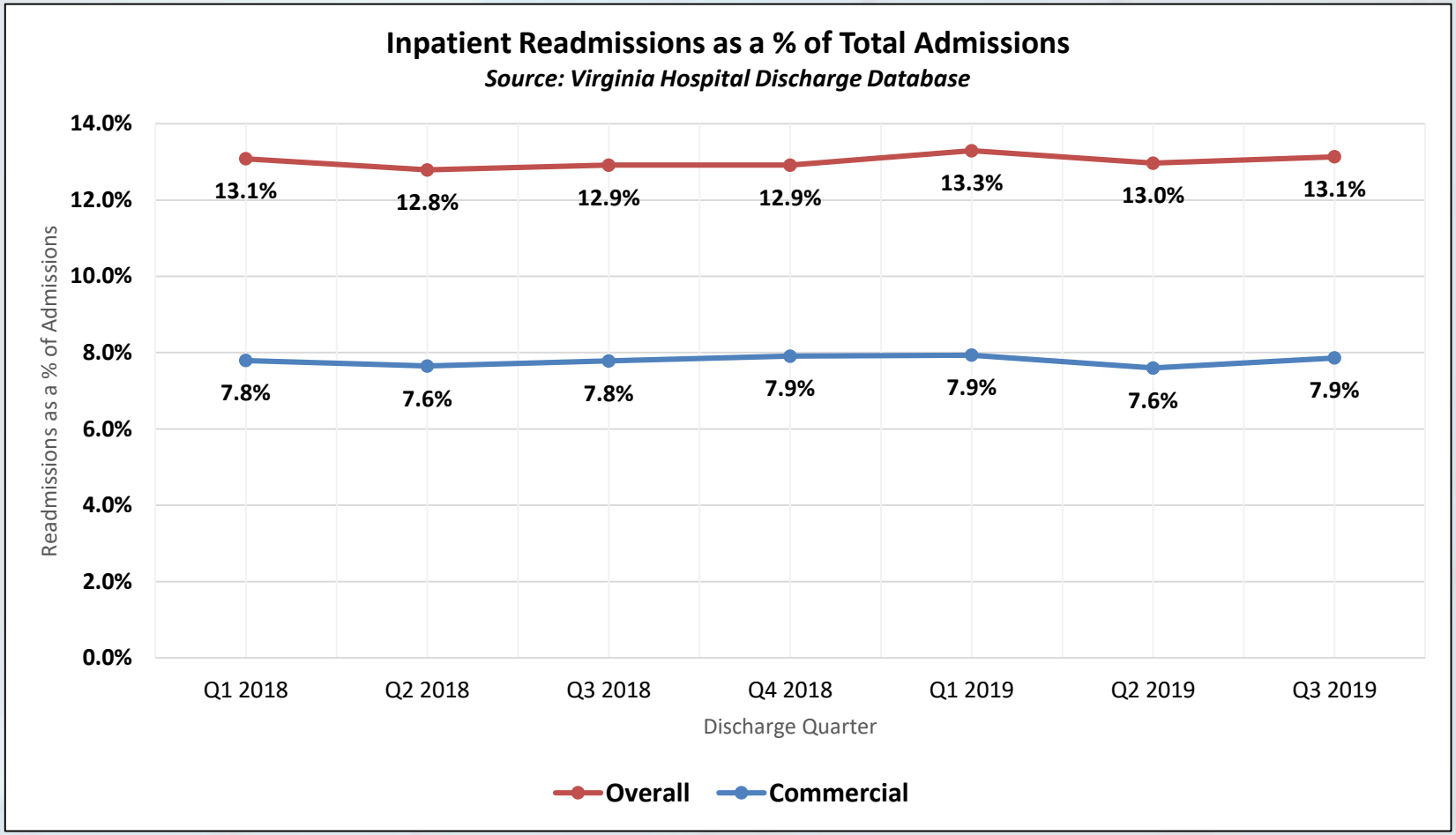
At least 1 other Potentially Avoidable ED Visit

11%

30 Days After

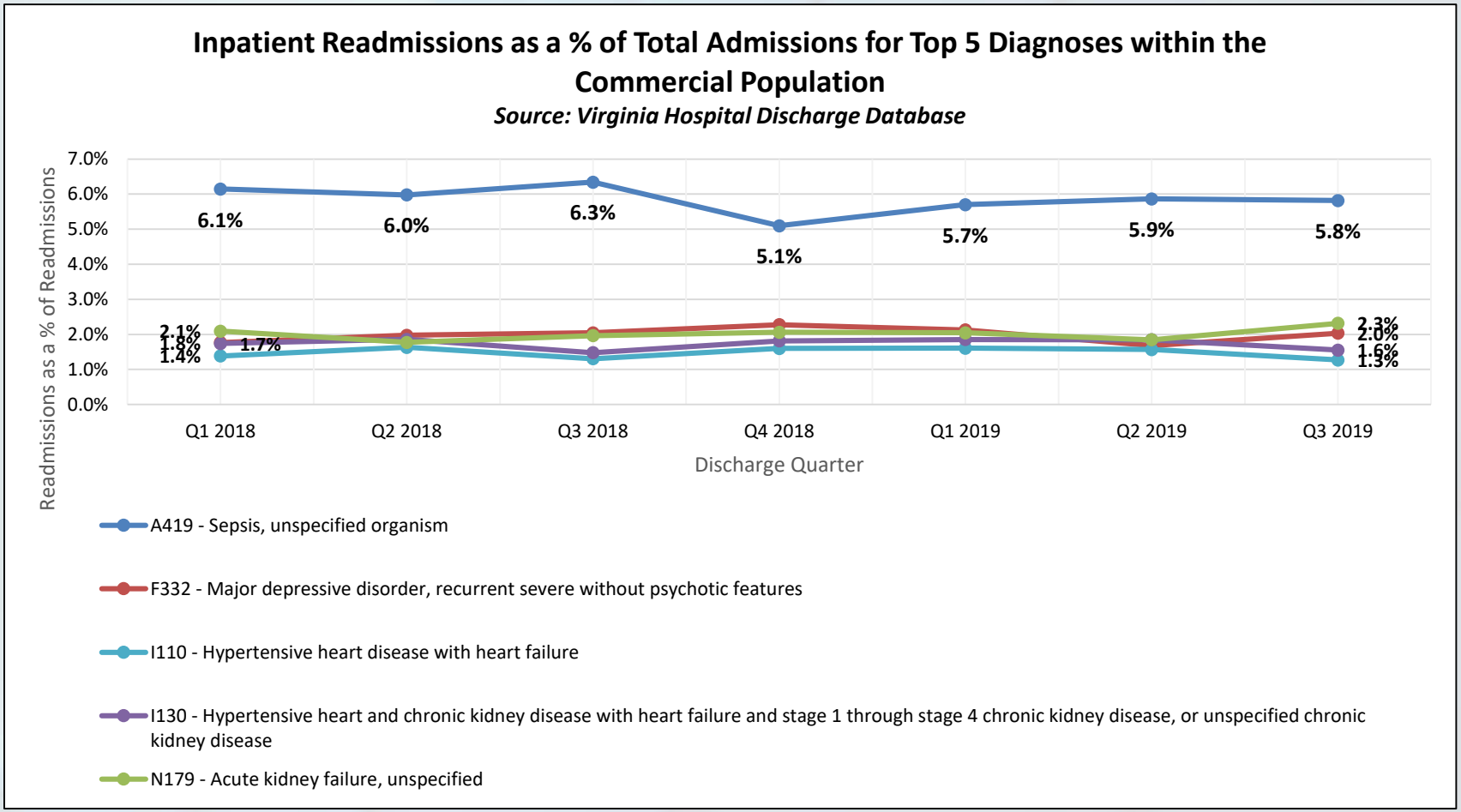
[1] Commercial Market within APCD, Potentially Avoidable ED visits defined used California Dept of Health/OHA methodology, more data about rates of potentially avoidable ED visits can be found at http://vhi.org/Hospitals/avoidable-ed-visits.asp

Inpatient Readmissions as a % of Total Admissions



Readmissions methodology based on DMAS Clinical Efficiency Performance Measure Technical Specifications

Inpatient Readmissions as a % of Total Readmissions for Top 5 Diagnoses within the Commercial Population



Readmissions methodology based on DMAS Clinical Efficiency Performance Measure Technical Specifications

Thank you

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Emergency Department Visits by Payer

An Exploratory Analysis

October 2020

Overview:

1. About the Data
2. Statewide Trends
3. Payer-Specific Statewide Trends
4. Statewide 30-day Readmission Trends

About the Data

Emergency Department

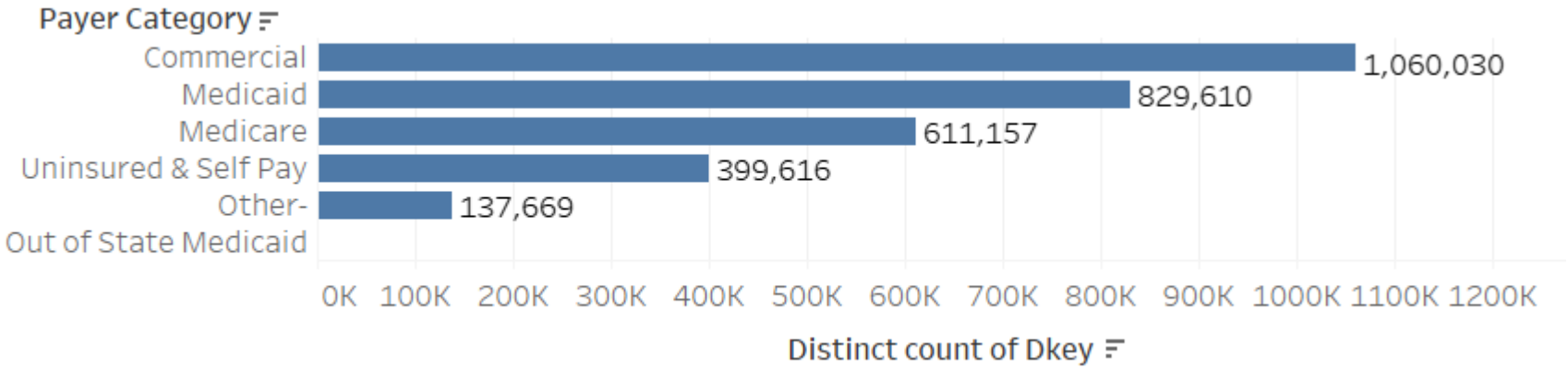
- VHHA ED Database
- Most Recent Year of Data (Q2 2019 to Q1 2020)
- Voluntary submission by hospitals
- VHHA estimates its capturing close to 90% of all ED visits in Virginia
- Includes 3,039,308 ED Visits

30-Day Readmissions

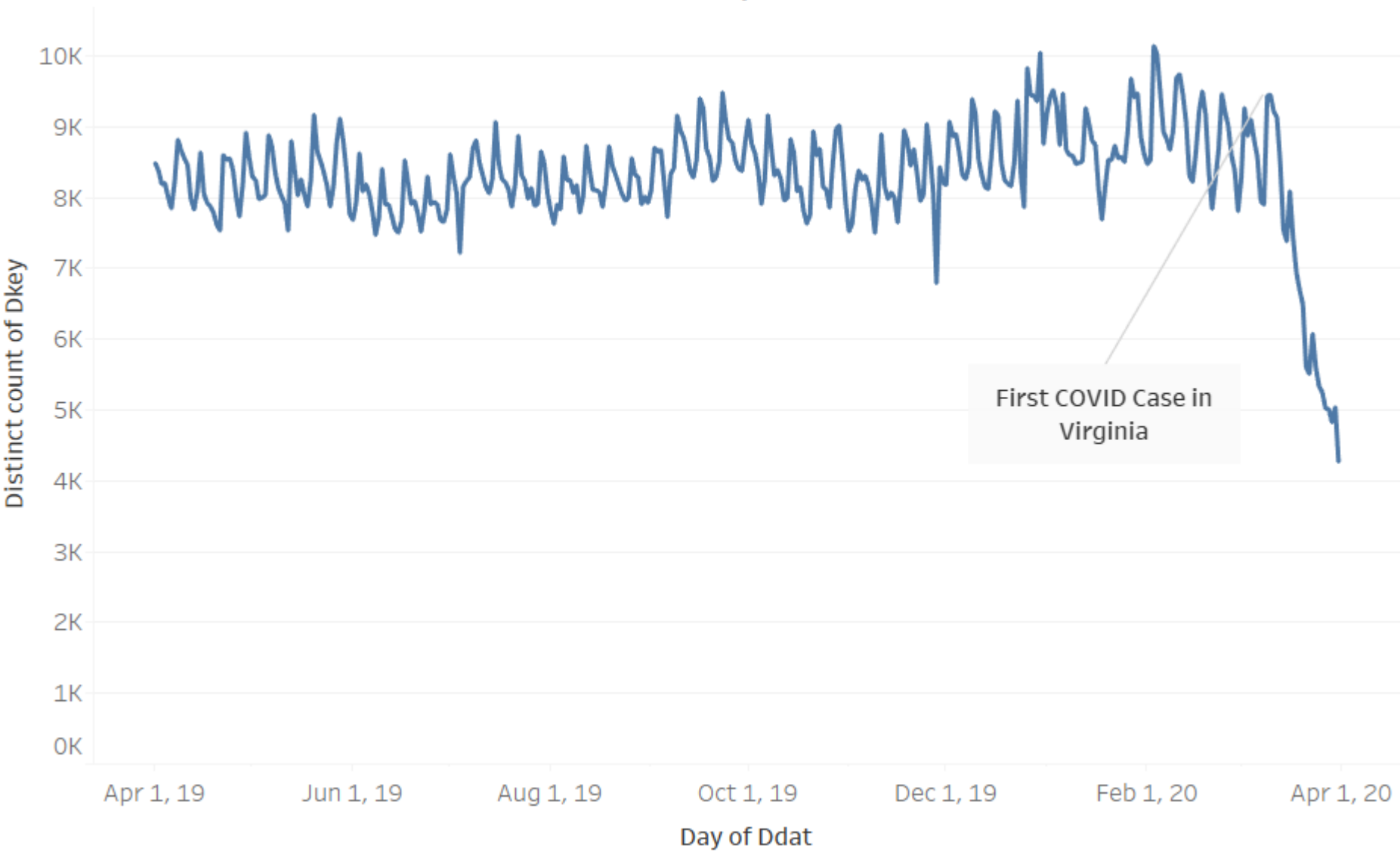
- VHHA Readmissions Database
- Timeframe: Q3 2018 to Q2 2020
- CMS-Yale Methodology applied to all payers
- 100% of all acute care hospitals

Statewide Emergency Department Trends

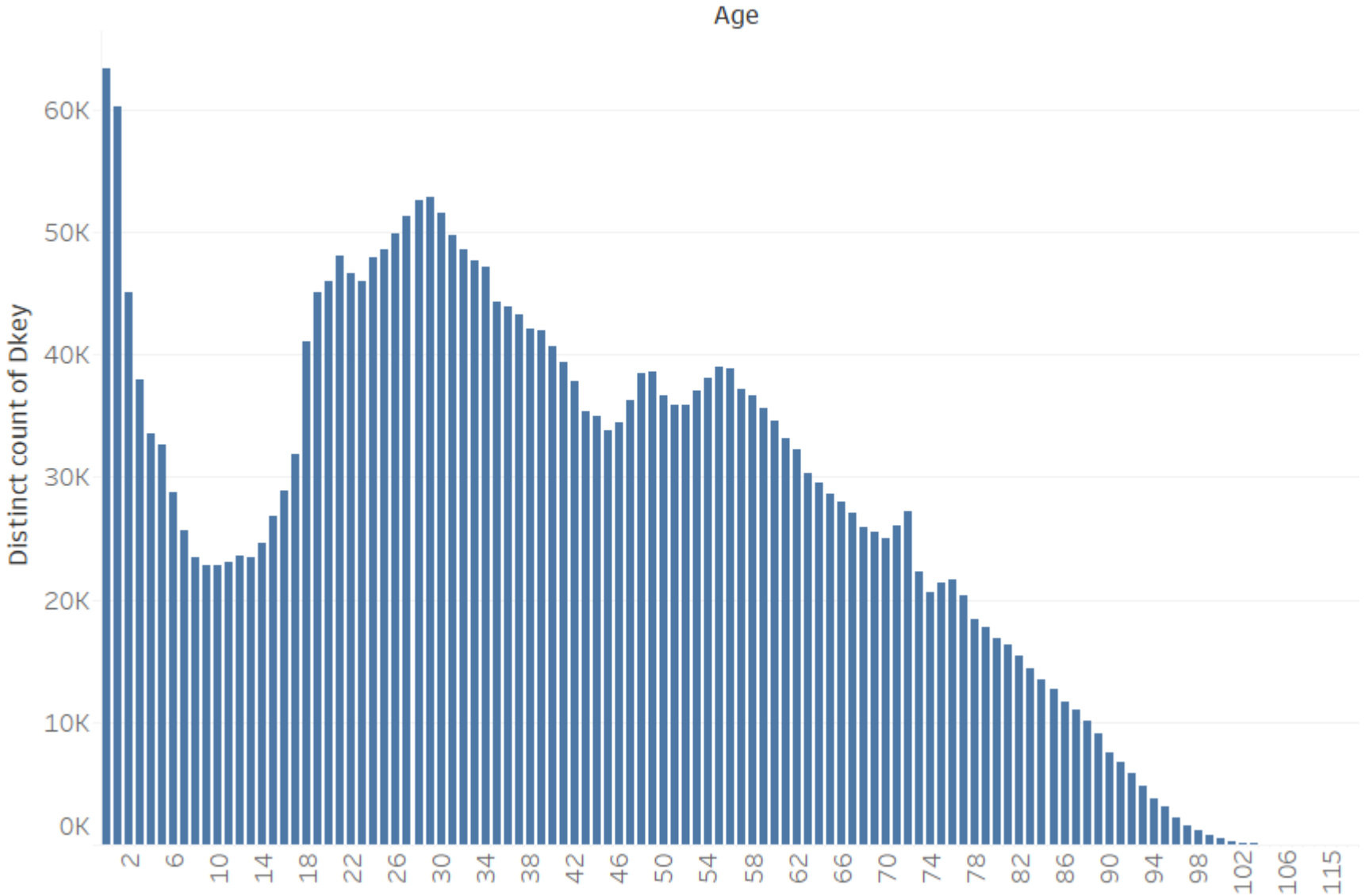
ED Visits by Payer Category



ED Visit Volumes



ED Visits by Age



ED Visits by Race

Race Desc	ED Visits	% of Total
American Indian	4,345	0.14%
Asian	60,017	1.97%
Black	1,030,525	33.91%
Hispanic - Black	3,534	0.12%
Hispanic - White	63,892	2.10%
Other, Specified	215,764	7.10%
Unknown, Not Recorded	64,096	2.11%
White	1,597,135	52.55%
Grand Total	3,039,308	100.00%

ED Visits by Top 20 Primary Diagnosis

Dxdesc	
ACUTE UPPER RESPIRATORY INFECTION, UNSPECIFIED	79,100
OTHER CHEST PAIN	78,737
CHEST PAIN, UNSPECIFIED	56,405
URINARY TRACT INFECTION, SITE NOT SPECIFIED	47,351
HEADACHE	46,144
NAUSEA WITH VOMITING, UNSPECIFIED	37,892
LOW BACK PAIN	34,209
UNSPECIFIED ABDOMINAL PAIN	32,811
VIRAL INFECTION, UNSPECIFIED	31,931
ACUTE PHARYNGITIS, UNSPECIFIED	30,250
SYNCOPE AND COLLAPSE	30,150
DIZZINESS AND GIDDINESS	29,565
FEVER, UNSPECIFIED	29,027
FLU DUE TO OTH IDENT INFLUENZA VIRUS W OTH RESP ..	28,232
ACUTE BRONCHITIS, UNSPECIFIED	27,758
UNSPECIFIED INJURY OF HEAD, INITIAL ENCOUNTER	26,371
NONINFECTIVE GASTROENTERITIS AND COLITIS, UNSPE..	24,279
COUGH	24,045
ESSENTIAL (PRIMARY) HYPERTENSION	20,833
CONSTIPATION, UNSPECIFIED	20,412

Top 20 Chronic Conditions

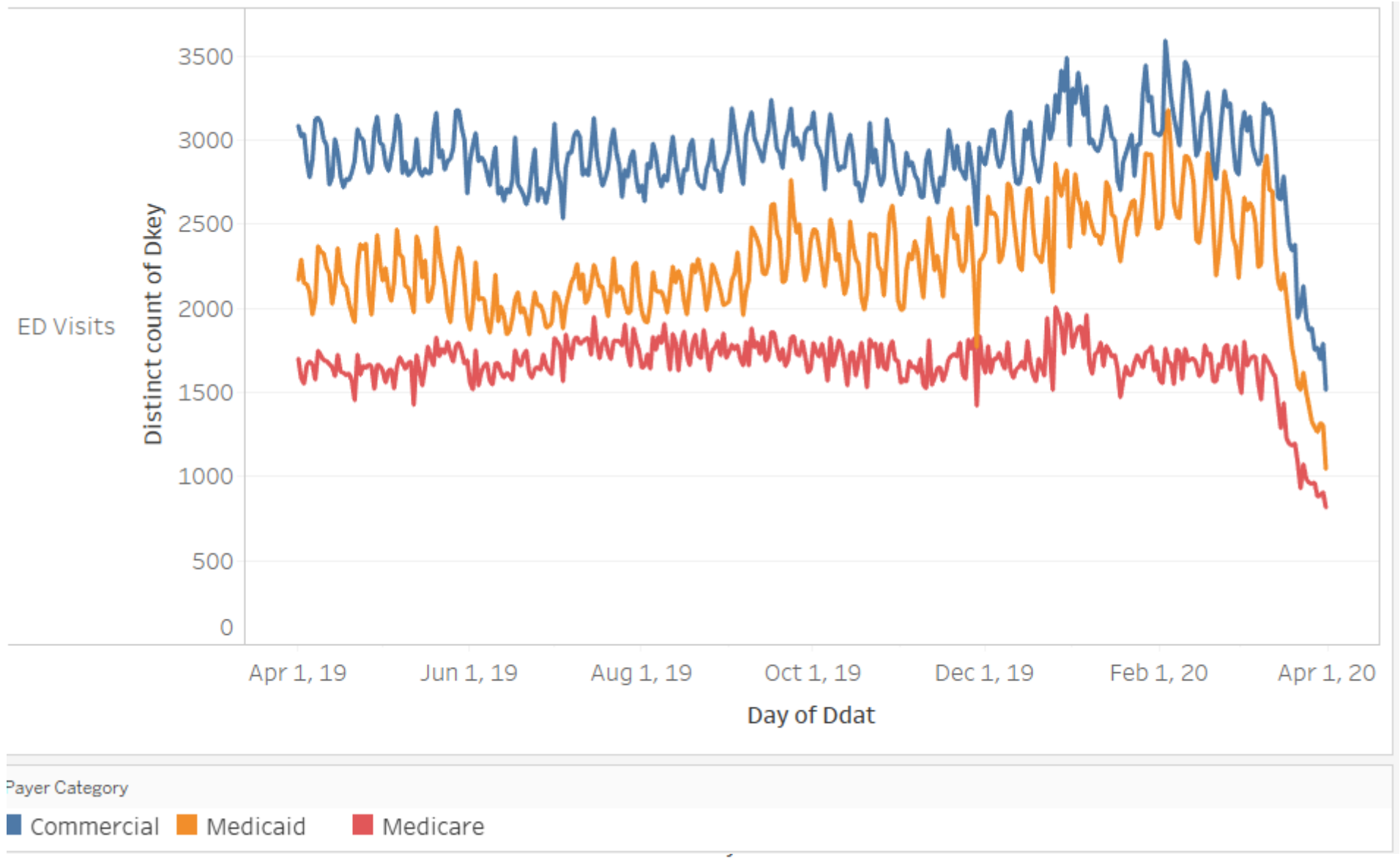
Ccwdesc	
HYPERTENSION	786,763
TOBACCO USE	534,424
DIABETES	355,398
HYPERLIPIDEMIA	269,290
ASTHMA	202,024
CHRONIC KIDNEY DISEASE	159,042
ISCHEMIC HEART DISEASE	153,016
ANXIETY DISORDERS	151,304
CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND ..	139,903
FIBROMYALGIA CHRONIC PAIN AND FATIGUE	124,430
DEPRESSION	115,119
DEPRESSIVE DISORDERS	112,394
OBESITY	93,378
HEART FAILURE	91,719
ACQUIRED HYPOTHYROIDISM	91,065
RA/OA (RHEUMATOID ARTHRITIS/OSTEOARTHRITIS)	83,497
ANEMIA	69,443
ALCOHOL USE DISORDERS	50,215
MIGRAINE AND CHRONIC HEADACHE	48,203
DRUG USE DISORDERS	47,521

Chronic condition categories grouped using the CCW algorithm:
https://www2.ccwdata.org/web/guest/home/

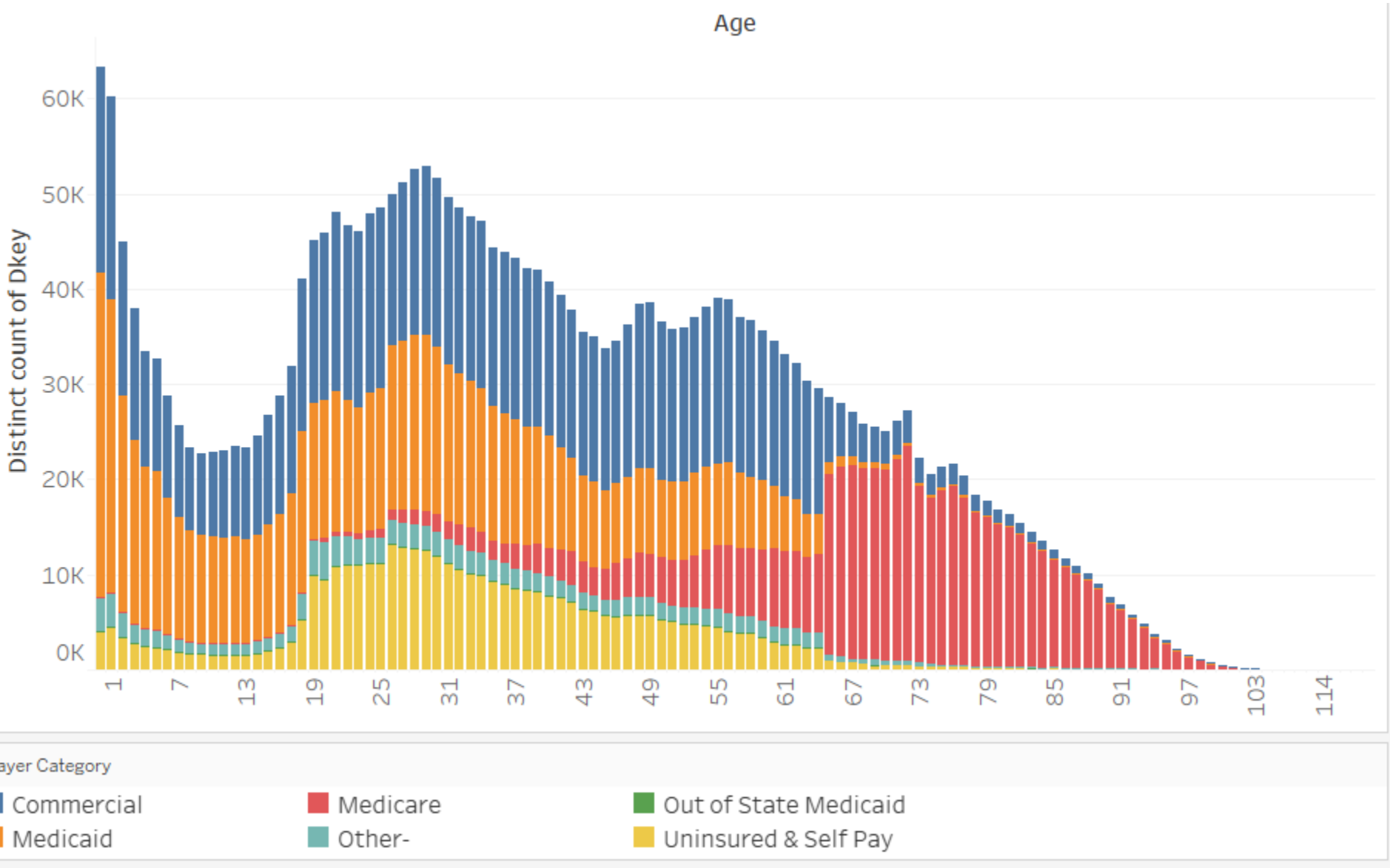
Payer-Specific Trends

- Medicare
- Medicaid
- Commercial

ED Visit Volumes by Payer



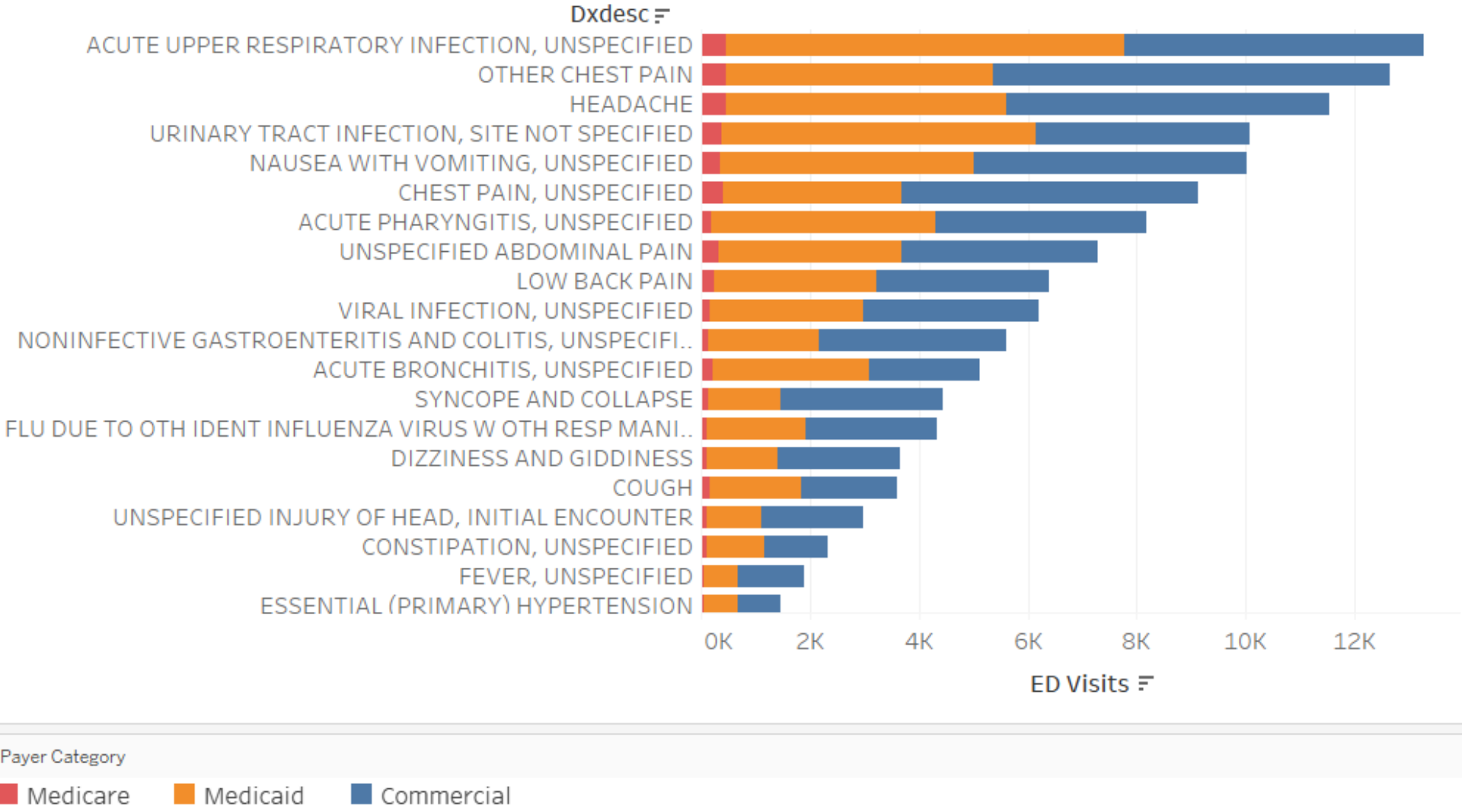
ED Visits by Age and Payer



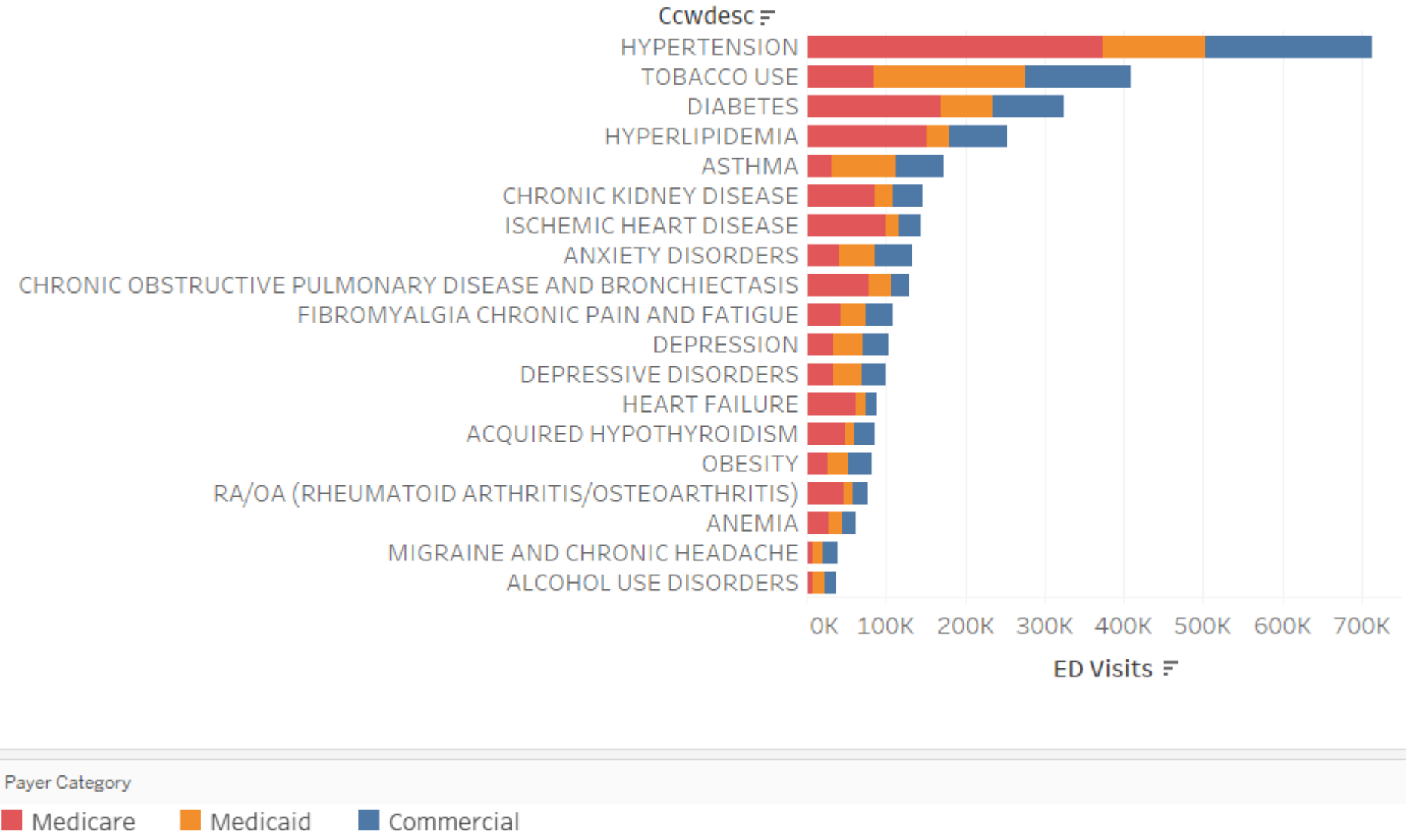
ED Visits by Race and Payer

Race Desc	Payer Category Commercial	Medicaid	Medicare	Grand Total
American Indian	1,623 (0.1%)	1,130 (0.0%)	782 (0.0%)	3,535 (0.1%)
Asian	35,016 (1.4%)	7,229 (0.3%)	9,423 (0.4%)	51,668 (2.1%)
Black	275,987 (11.0%)	390,595 (15.6%)	165,050 (6.6%)	831,632 (33.3%)
Hispanic - Black	874 (0.0%)	1,390 (0.1%)	257 (0.0%)	2,521 (0.1%)
Hispanic - White	28,323 (1.1%)	10,590 (0.4%)	3,757 (0.2%)	42,670 (1.7%)
Other, Specified	89,680 (3.6%)	51,075 (2.0%)	11,667 (0.5%)	152,422 (6.1%)
Unknown, Not Recorded	23,946 (1.0%)	18,424 (0.7%)	6,502 (0.3%)	48,872 (2.0%)
White	604,581 (24.2%)	349,177 (14.0%)	413,719 (16.5%)	1,367,477 (54.7%)
Grand Total	1,060,030 (42.4%)	829,610 (33.2%)	611,157 (24.4%)	2,500,797 (100.0%)

ED Visits by Top 20 Primary Diagnosis and Payer

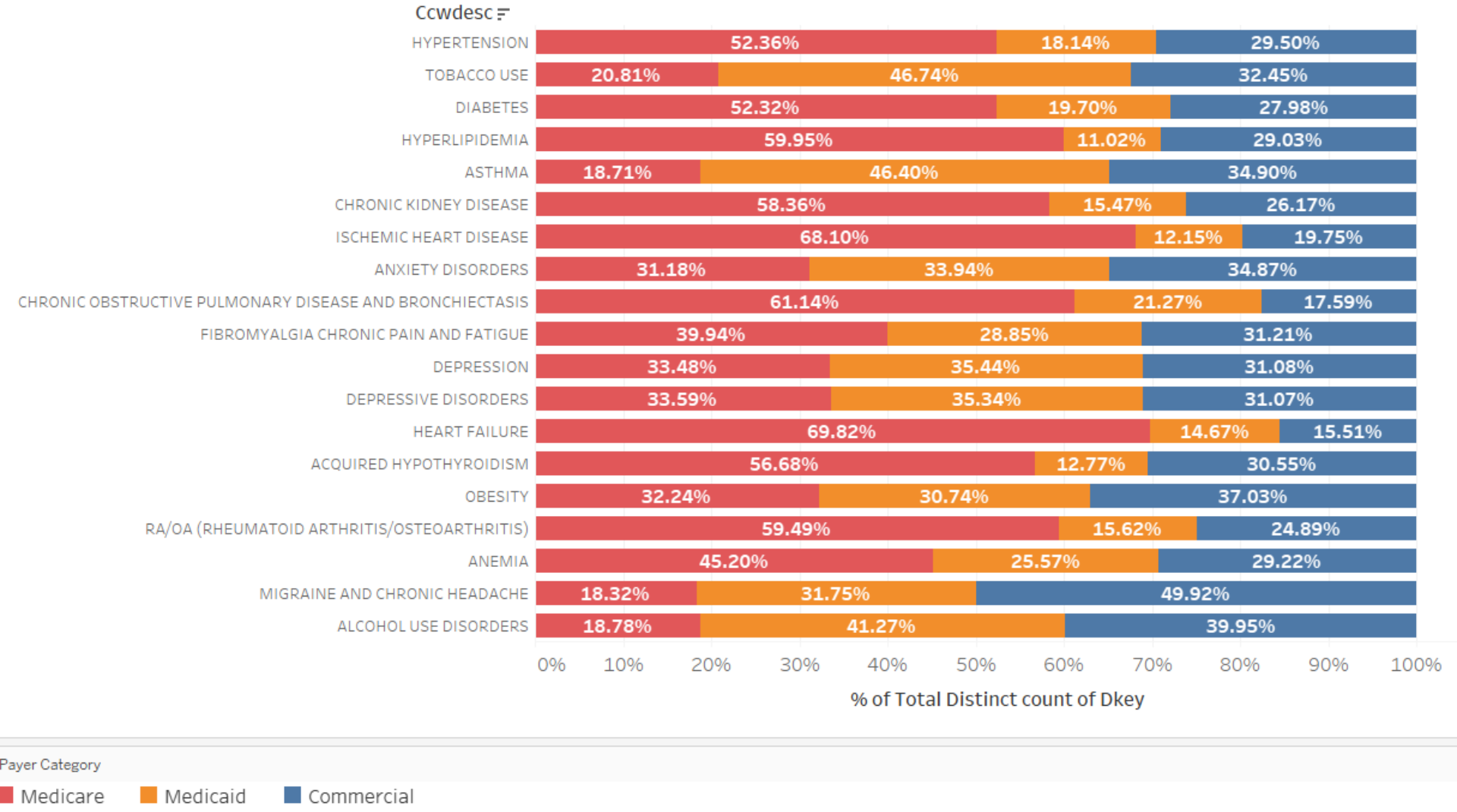


ED Visits by Top 20 Chronic Conditions and Payer



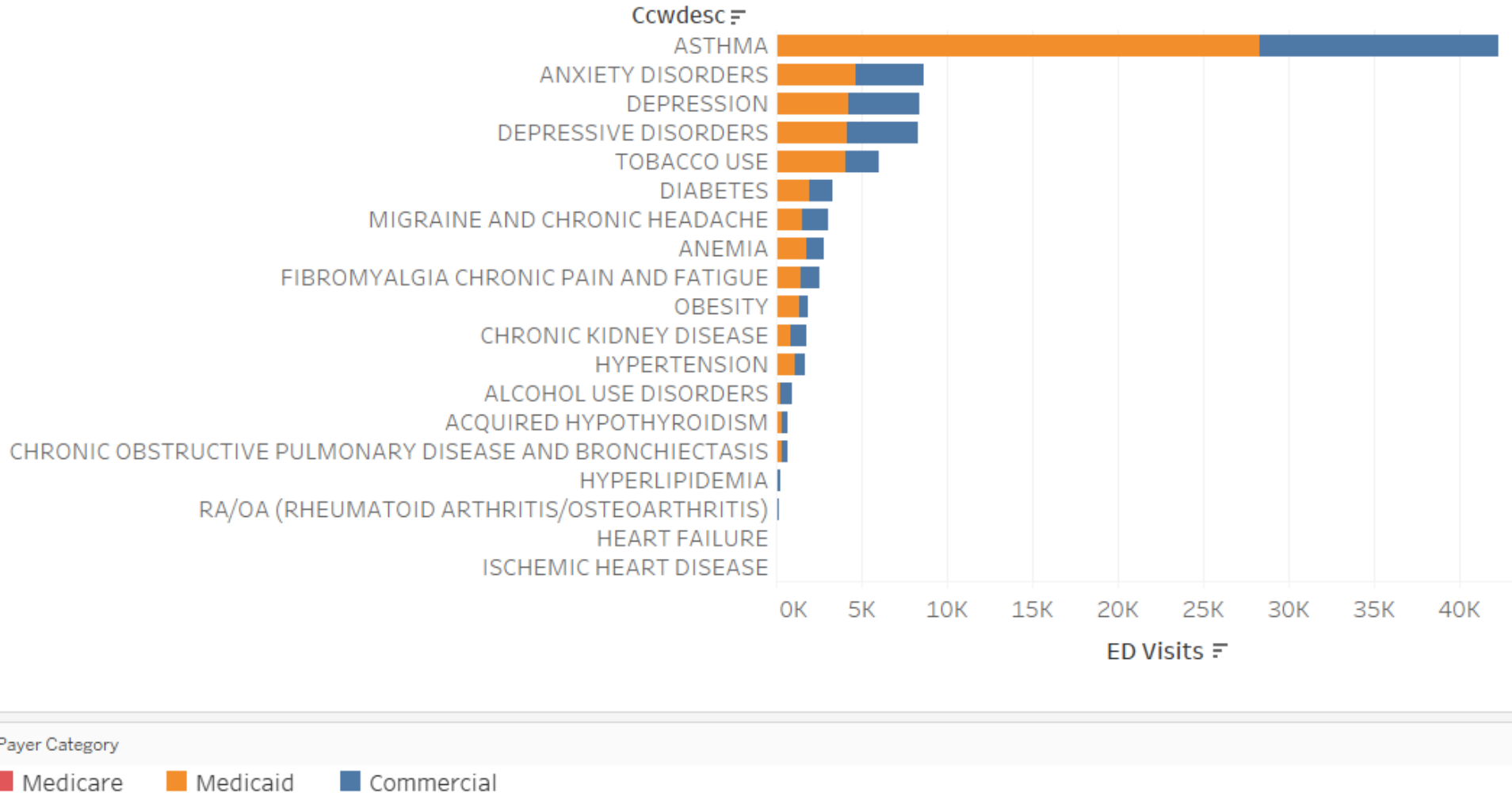
ED Visits by Top 20 Chronic Conditions and Payer

broken down by % of total



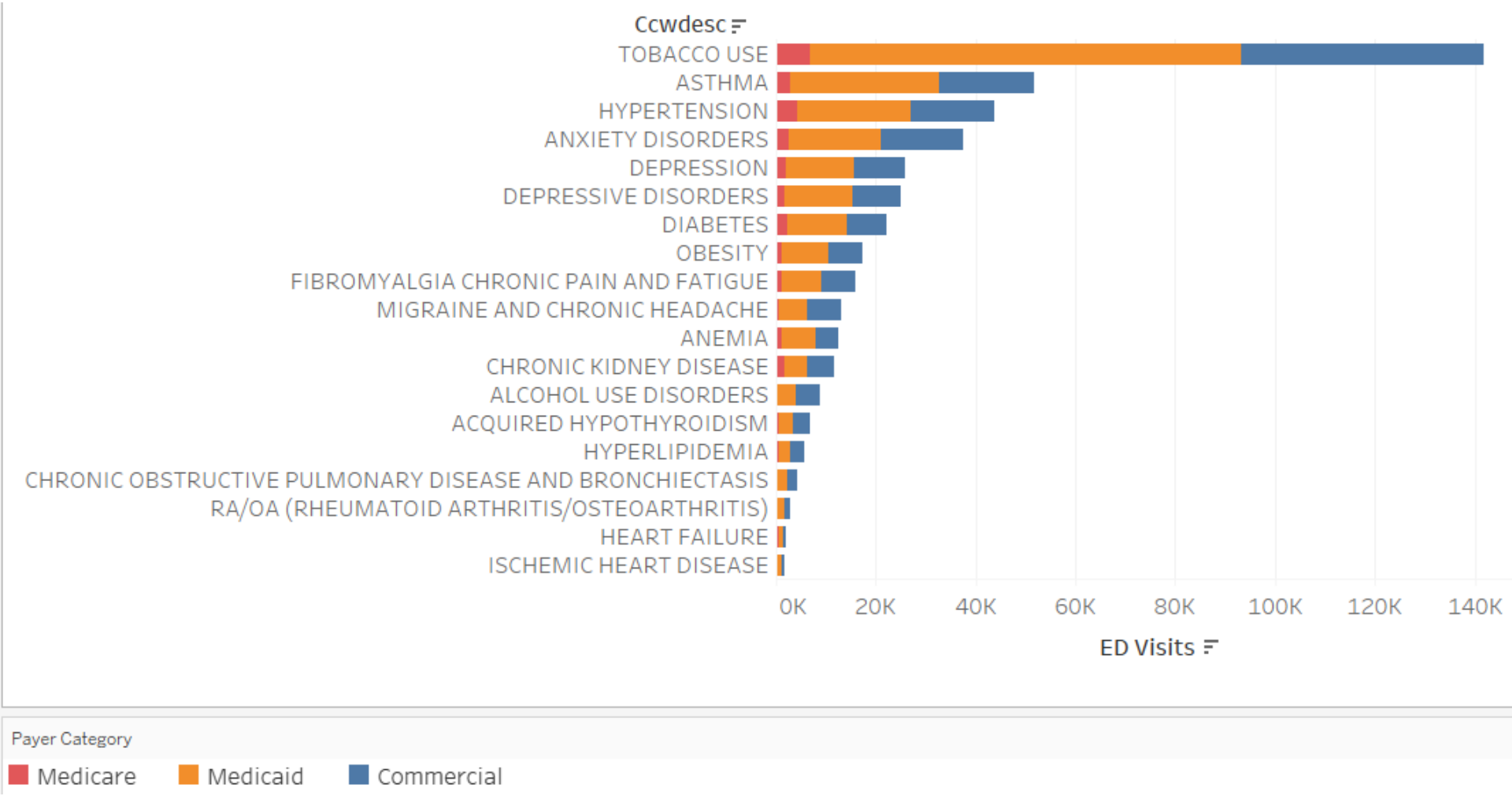
ED Visits by Top 20 Chronic Conditions and Payer

Broken down by ages 0 to 18

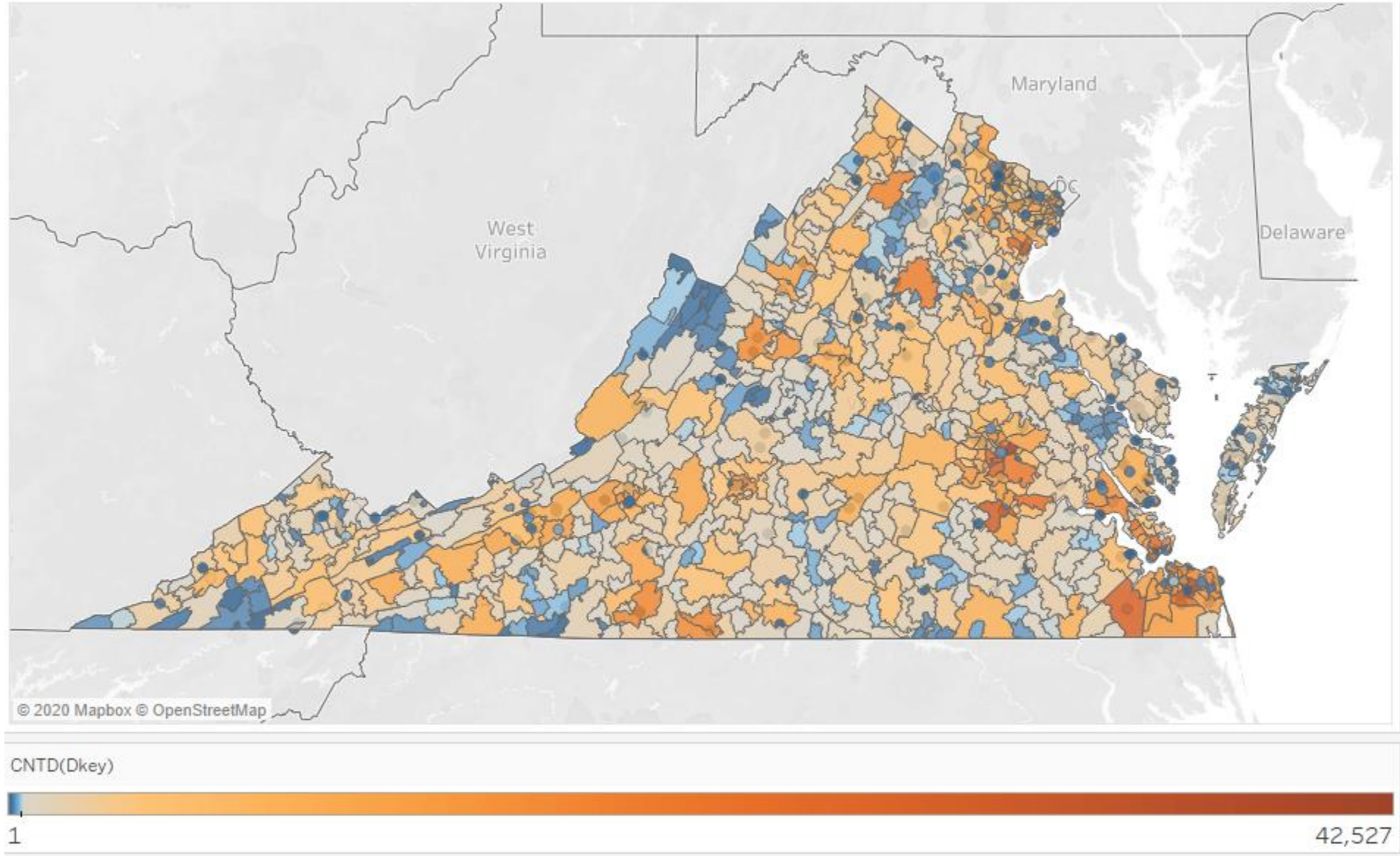


ED Visits by Top 20 Chronic Conditions and Payer

Broken down by ages 19 to 35

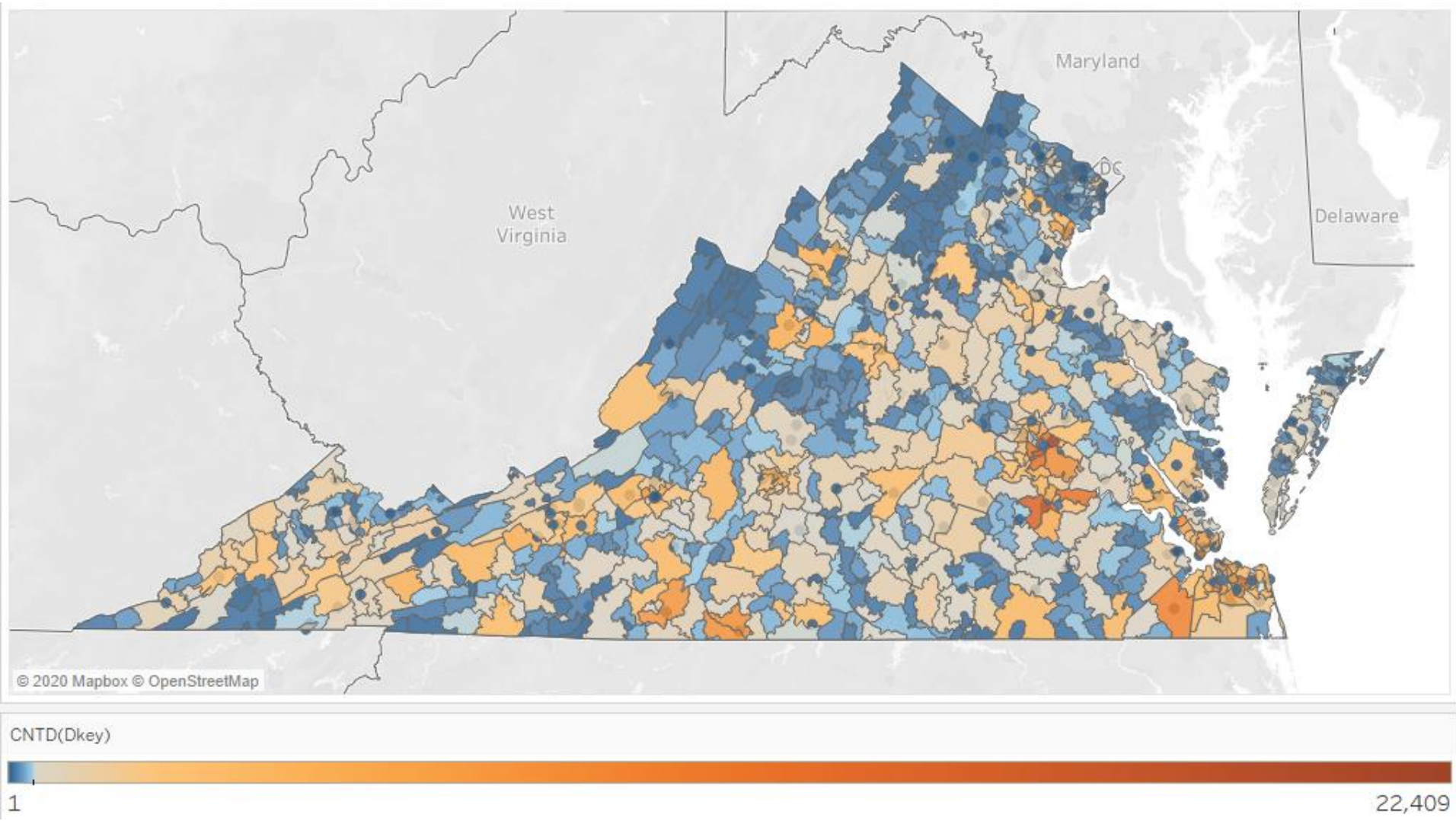


ED Visits by ZIP Code



ED Visits by Zip Code and Payer

Medicaid



Statewide 30-day Readmissions Trends

30-Day Readmissions by Payer (3-years)

	Commercial	Medicaid	Medicare	Other Ins	Uninsured	Grand Total
Eligible Volume	322,670	95,025	741,776	30,050	67,872	1,257,393
30-day Readmissions	26,090	13,099	97,438	2,602	5,495	144,724
Raw Readmission Rate	8.09%	13.78%	13.14%	8.66%	8.10%	11.51%

30-Day Readmissions by Top Readmission DRGs (3-years)

All Payers

DRG #	Readmission DRG	Readm30
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	10,630
291	HEART FAILURE AND SHOCK WITH MCC	9,995
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	3,473
683	RENAL FAILURE WITH CC	2,921
872	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	2,881

30-Day Readmissions by Top Readmission DRGs (3-years)

Medicare

DRG #	Readmission DRG	Readm30
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	8,018
291	HEART FAILURE AND SHOCK WITH MCC	7,977
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	2,586
683	RENAL FAILURE WITH CC	2,172
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	2,072

Medicaid

DRG #	Readmission DRG	Readm30
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	810
291	HEART FAILURE AND SHOCK WITH MCC	687
638	DIABETES WITH CC	400
812	RED BLOOD CELL DISORDERS WITHOUT MCC	381
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	343

Commercial

DRG #	Readmission DRG	Readm30
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	1,415
291	HEART FAILURE AND SHOCK WITH MCC	1,033
392	ESOPHAGITIS, GASTROENTERISTIS AND MISCELLANEOUS DIGESTIVE D..	685
872	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOU..	618
683	RENAL FAILURE WITH CC	393

Uninsured

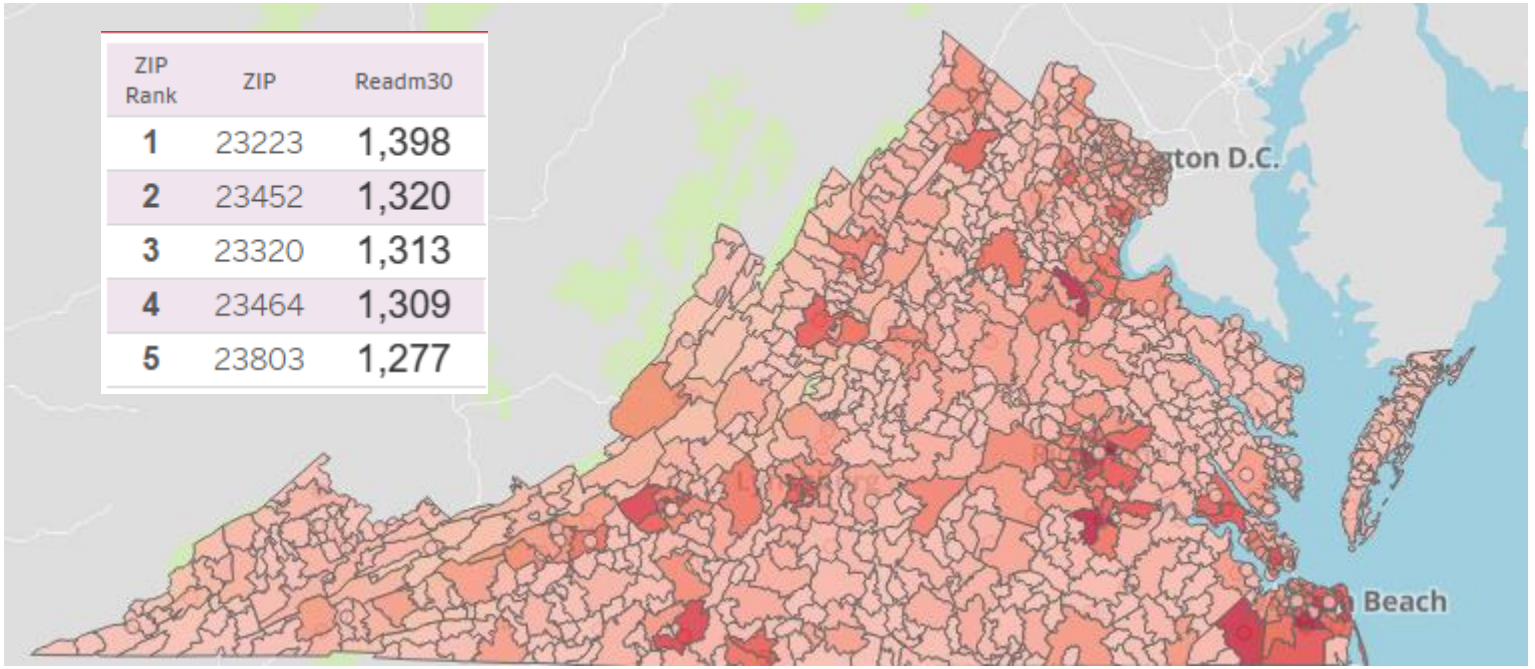
DRG #	Readmission DRG	Readm30
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	227
638	DIABETES WITH CC	225
291	HEART FAILURE AND SHOCK WITH MCC	194
392	ESOPHAGITIS, GASTROENTERISTIS AND MISCELLANEOUS DIGESTIVE D..	143
439	DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH CC	118

Other

DRG #	Readmission DRG	Readm30
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	160
291	HEART FAILURE AND SHOCK WITH MCC	104
872	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOU..	68
392	ESOPHAGITIS, GASTROENTERISTIS AND MISCELLANEOUS DIGESTIVE D..	66
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	52

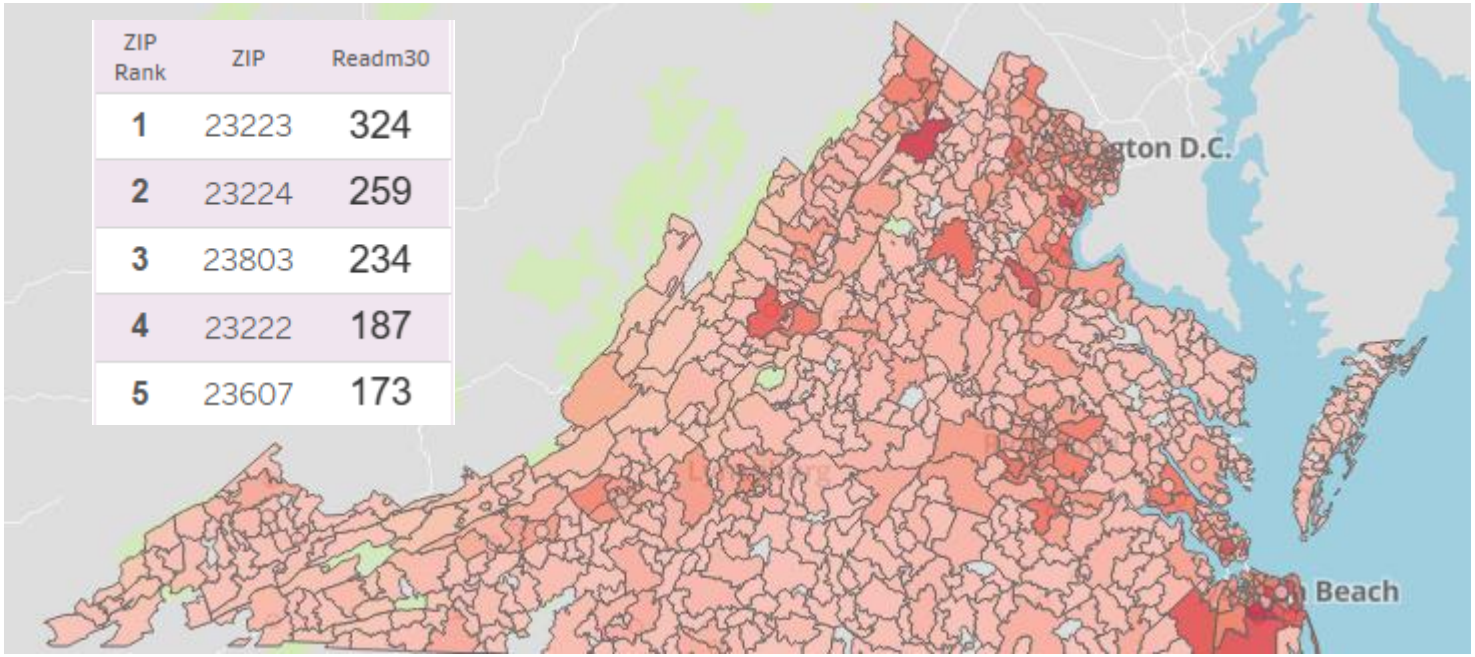
30-Day Readmissions by Patient ZIP (3-years)

All Payers



30-Day Readmissions by Patient ZIP (3-years)

Medicaid



Questions for Group Discussion

- ✓ What features of the analyses presented today stand out to you as most/least informative?
- ✓ What other data/information would be helpful to further inform this discussion?
- ✓ Given the data shared today, what types of health care or member engagement efforts seem promising to influence use of appropriate levels of care for members with diagnoses driving ER use and hospital readmissions?
- ✓ What questions are important to answer as we turn to a discussion of care coordination in the next meeting?
- ✓ Are there any policy options that appear appropriate to raise at this point?

Homework

- ✓ The purpose of meeting 2 is to establish a baseline understanding of **care coordination activities occurring across the health care system**.
- ✓ Designated workgroup members (i.e. Hospitals/VHHA, MCOs/VAHP, Emergency Physicians, and Primary Care) should prepare presentations related to the care coordination processes/activities from the point of view of their respective stakeholder groups for both emergency department utilization and hospital readmissions (addressing items i, ii, and v of the workgroup mandate). Below are questions to consider in crafting your presentation:
  - How does your group identify people for care coordination?
  - What are the key responsibilities for your group's care coordinators?
  - How would you describe your group's role in the care coordination and discharge planning process?
  - What is the timeframe for care coordination and/or discharge planning initiation? How long do patients receive support?
  - How do your care coordinators and discharge planners coordinate with others across the health system?
  - How does your group promote appropriate sites of care for patients?
  - What patient/member and family support do your care coordinators provide related to ER utilization, discharge planning, and seeking appropriate sites of care?
  - How do you know the patient/member support is successful?
  - Any additional information you wish to share with the group on this topic.
- ✓ Please note that presentations should be approximately 20 minutes in length and must be submitted to Rusty.walker@dmas.Virginia.gov by November 13, 2020.

Public Comment

Public comments should be submitted to Rusty Walker (rusty.walker@dmas.virginia.gov) and will be collected for distribution to workgroup members.

Next Meeting and Timelines

- ✓ **November 19, 2020**, 3:00-5:00 p.m.
- ✓ Send slides on care coordination to DMAS (rusty.walker@dmas.virginia.gov) by **November 13, 2020**.
  - Time limit of ~20 minutes per stakeholder group.