30-day Limitation on Reimbursement for Inpatient Hospital Care Provided to Medicaid Recipients Enrolled in STAR+PLUS Medicaid Managed Care

As Required by

House Bill 4533, 86th Legislature,

Regular Session, 2019

Texas Health and Human Services

Commission

December 2020

TEXAS
Health and Human Services

Table of Contents

Executive Summary

Texas is unique among Medicaid programs due to its 30-day spell of illness (SOI) rule, which limits payment once a client has had 30 days of inpatient care. After 30 days of inpatient hospital care is provided, additional inpatient care is not covered until the member has been out of an acute care facility for 60 consecutive days.

Since it was first introduced in the Medicaid Fee for Service program in 1977, the SOI policy has undergone many changes, some related to Texas Medicaid's transition from a Fee for Service (FFS) model to largely a managed care model. In 2013, the rule was extended to the STAR+PLUS program as a cost saving measure. Over the years, various populations potentially impacted by the SOI rule, such as clients with certain mental illnesses, have been carved in or out of the SOI rule. Currently, the rule only pertains to the FFS and STAR+PLUS Medicaid populations, with exceptions for certain diagnoses and health care procedures. Amid the changes to the SOI rule over the years, Section 29 of House Bill (HB) 4533, 86th Legislature, Regular Session, 2019, directs HHSC to examine its impact on members in managed care[1]. To the extent data is available on the subject, the bill calls for HHS to examine:

1) the number of Medicaid recipients affected by the limitation,
2) the clinical outcomes of Medicaid recipients affected by the limitation,
3) the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days, and
4) any cost savings achieved by the limitation under Medicaid.

HHSC generally relies on Medicaid and CHIP administrative data, including encounters and enrollment data, to analyze trends in service utilization among its members in managed care programs but HHSC determined that this data does not accurately identify clients who exceed the 30-day rule. After exploring all potential data sources, HHSC decided its best option was to collect data and estimates on the SOI rule's impact from the Managed Care Organizations (MCOs) themselves.

However, using the MCO administrative data for this report also presented challenges. MCOs were not able to submit all the data requested. In addition, their methods for estimating effects of the SOI varied, making comparisons across MCOs difficult. As a result, HHSC was only able to address reporting elements 1, 3, and 4 above to the extent that the MCOs submitted accurate data or estimates to HHSC for the study. HSHC was unable to address reporting element number 2, evaluation of the clinical outcomes of members impacted by the SOI rule, because it requires clinical and other information not captured by encounter data or the administrative data submitted by the MCOs.

[1] The Office of Inspector General (OIG) enforces the SOI rule for FFS claims.

The results of this study demonstrate the following:

- The number of clients affected by this rule has increased from about 2,800 to 3,500 from State Fiscal Year (SFY) 2015 to 2019.
- The number of hospitalizations that exceeded the SOI rule is nearly 9,000 in SFY2019, compared to 8,000 in SFY2015. These hospitalizations represent about 51,000 days over the limit in SFY2015, and approximately 54,000 in SFY2019.
- In comparison, during the same time period, enrollment for clients potentially impacted by the SOI rule decreased six percent, while their general hospitalizations remained relatively stable. Therefore, enrollment or general hospitalization trends for the population do not explain the increase in the number of clients impacted by the SOI rule and the rise in both the number of and length of hospitalizations over the SOI limit.
- The estimated amount of money the plans would have paid if days or admissions had not been denied range from an estimated $62.5 million in SFY2015 to $73.8 million in SFY2019.
- The different methods and abilities for health plans to estimate the number of clients affected creates a substantial range of affected dollars, from less than $1 million for United Healthcare to more than $50 million for Cigna-HealthSpring.
- HHSC, nor the health plans, had available data to adequately study any potential adverse impact of the SOI limit on clinical outcomes, which would include a more complete clinical picture of the members' health condition and acuity level, in addition to a way to exclude from the study members who subsequently received the services, just not paid for by Medicaid.

1. Introduction

Hospital inpatient services is one of the largest categories of costs for health spending. In Texas, acute care inpatient services account for nearly $4 billion dollars in managed care plans' expenditures. The STAR+PLUS program, which is mainly composed of the blind, disabled, and aged Medicaid populations, accounts for nearly 40% of these costs. To prevent unnecessary hospital stays and to temper expenses, the state of Texas has codified, in Texas Administrative Code (TAC) Section 354.1072(a)(1), the acceptable duration of care.

In addition, Texas Medicaid maintains a policy unique among Medicaid programs, the 30-day spell of illness (SOI) rule, which limits payment once a client has had 30 days of inpatient care. After 30 days of inpatient hospital care is provided, coverage for additional inpatient care is not covered until the member has been out of an acute care facility for 60 consecutive days.

Since it was first introduced in the Medicaid Fee for Service program in 1977, the SOI policy has undergone many changes, some related to Texas Medicaid's transition from a Fee for Service (FFS) model to largely a managed care model, often resulting in carve-ins or carve-outs of various populations. Currently, the rule only pertains to adults in the FFS and STAR+PLUS programs. Exceptions exist for enrollees receiving a prior-approved transplant medically necessary because of an emergent, life-threatening condition. The limit also does not apply to STAR+PLUS members admitted to an inpatient hospital due to a diagnosis of a severe and persistent mental illness (SPMI).

Amid the many changes to the SOI rule, particularly its extension to STAR+PLUS in 2013, which was intended as a cost saving measure, Section 29 of House Bill (HB) 4533, 86th Legislature, Regular Session, 2019, directs HHSC to examine the impact of the SOI rule on the STAR+PLUS program, including the number and length of client hospitalizations and associated costs averted:

> *Using available resources, the Health and Human Services Commission shall report available data on the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid managed care program under 1 T.A.C. Section 354.1072(a)(1) and other applicable law. To the extent data is available on the subject, the commission shall also report on:*
> *(1) the number of Medicaid recipients affected by the limitation and their clinical outcomes; and*
> *(2) the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.*
> *(b) Not later than December 1, 2020, the Health and Human Services Commission shall submit the report containing the data described by Subsection (a) of this section to the governor, the legislature, and the*

Legislative Budget Board. The report required under this subsection may be combined with any other report required by this Act or other law.

HHSC generally relies on Medicaid and CHIP administrative data, including encounters and enrollment data, to analyze trends in service utilization and associated costs among members in its managed care programs. Other available data sources comprise Managed Care Organization (MCO) self-reported contractually required deliverables, such as counts of hotline calls and complaints, usually submitted in aggregate form. Occasionally, HHSC requests the MCOs (or "health plans") for one-time data requests to fulfill the needs of specific projects or legislative reports.

To address the questions required by HB 4533, HHSC first analyzed claims and encounters data and determined that this data does not accurately identify clients who exceed the 30-day rule, chiefly because of the time required to adjudicate the claims/encounters and because provider awareness of the rule may reduce submission of claims/encounters that exceed 30 days. After consulting with other areas in HHSC, the Office of Inspector General, and the Internal Quality Review Organization for potential data, HHSC decided its best option was to collect data and estimates on the SOI rule's impact from the health plans. However, some MCOs were not able to submit all the data requested. In addition, their methods for estimating effects of the SOI varied, making comparisons across MCOs difficult. As a result, HHSC was only able to evaluate the following reporting elements to the extent that the MCOs submitted accurate data or estimates to HHSC for the study: 1) the number of Medicaid recipients affected by the limitation, 2) the impact on reducing inpatient hospital days, and 3) any cost savings achieved by the limitation under Medicaid.

Even with the data and estimates MCOs submitted, HSHC was unable evaluate the clinical outcomes of members impacted by the SOI rule as the MCOs reported that information to evaluate the clinical outcomes was not available. This reporting element is more complicated than the other measures because it requires information not included in encounter or other data submitted by the MCOs. First, encounters do not include the level of clinical detail required to determine if a member warranted extended days. Encounters also do not identify members who received extended hospital days, just not paid for by Medicaid. In addition, encounters do not capture members who needed additional hospital days but for whom claims were not submitted at all or only for the first 30 day stay because of provider awareness of the SOI rule.

This report examines:

1) The history of the 30-day SOI policy in Texas;
2) Data collection and limitations impacting the feasibility of fully answering all portions of Section 29 of HB 4533;
3) Broader enrollment and hospitalizations trends among the STAR PLUS members potentially impacted by the rule to provide context for the results of the SOI analysis, and

4) The estimated number of members affected, days of inpatient hospitalization, and their associated costs. These figures are limited in their validity by reliance on the health plans' self-reported data based on the plans' various estimation methodologies.

2. Background

Since it was first introduced in the Medicaid FFS program in 1977, the SOI policy has undergone many changes, some related to Texas Medicaid's transition from FFS model to largely a managed care model, resulting in various populations being carved in or out of SOI populations over time. HB 4533, 86th Legislature, Regular Session, 2019, directs HHSC to examine the impact of the SOI rule specifically on members in managed care. This section discusses these changes to the Medicaid program and the rule itself to place the current legislative request about impact to client services and cost savings in historic context.

Restrictions on inpatient stays vary significantly by insurer and state. Medicare continues to pay providers for all inpatient stays, but the coinsurance a member contributes increases as the number of hospital days increases, to the point of members paying all costs[1]. Medicaid inpatient limits range by state, from none, to prior authorization needed, to Texas' cutoffs based on days spent in the hospital[2].

Since 1977, a 30-day spell of illness and $200,000 (for facility charges only, not professional charges) acute care inpatient maximum policy has been in place for FFS Medicaid. Exceptions were added to limit the populations subject to this rule. The initial carveouts were for individuals under age 21 and for members with an approved organ transplant that is medically necessary because of an emergent condition[3].

In 1991, due to rising medical costs, HB 7, 72nd Legislature, Regular Session, 1991, was passed to establish managed care pilot programs to provide higher quality health care in select geographic areas. The Center for Medicare and Medicaid Services (CMS) approved the 1915(b) Waiver, allowing this pilot program to commence. This new LoneSTAR (State of Texas Access Reform) Health Initiative, later condensed to just STAR, had the additional change of not including the SOI rule that was present in the FFS model.

With the success of the STAR program, in January 1998 the State received CMS approval for 1915(b) and 1915(c) waivers to create a new managed care pilot. Its purpose is to integrate acute and long-term care services for aged, blind, and disabled Medicaid members. This new pilot began in Harris County and is known as STAR+PLUS. Like the STAR program, STAR+PLUS also omitted the SOI rule.

Enrollment in the STAR+PLUS program requires meeting the following eligibility criteria:

> *(1) be approved for Medicaid, and (2) be one or more of the following:*
>
> > *A) Age 21 or older, getting Supplemental Security Income (SSI) benefits, and able to get Medicaid due to low income.*
> > *B) Not getting SSI and able to get STAR+PLUS Home and Community-*

Based Services.
C) Age 21 or older, getting Medicaid through what are called "Social Security Exclusion programs" and meet program rules for income and asset levels.
D) Age 21 or over residing in a nursing home and receiving Medicaid while in the nursing home.
E) In the Medicaid for Breast and Cervical Cancer program.[4]

This policy remained relatively unchanged until the Texas Legislature, through the 2006-07 General Appropriations Act, Senate Bill (SB) 1, 79th Legislature, Regular Session, 2005, directed the implementation of the STAR+PLUS Hospital Carve-Out model in February 2007. Inpatient hospital services (excluding specific behavioral health services) were removed from MCO capitation rates and the services were to be paid through the traditional Medicaid FFS system. Reverting to the FFS system meant that the SOI was observed once again, except for the behavioral health hospital services that remained in the capitation rate.

September of 2011 saw the initial submission of Texas's 1115 Transformation Waiver for statewide expansion of managed care. Its approval in January 2012 altered the State Plan by waiving the $200,000 cap requirements for members in STAR and STAR+PLUS, carving inpatient hospitalizations back into the STAR+PLUS capitation rate (effective March 2012), and setting the end date of the SOI limitations for STAR+PLUS members for September 6, 2013, effectively removing the SOI requirement for many Medicaid-eligible adults[5].

Rider 51 from the 2014-15 General Appropriations Act, SB 1, 83rd Legislature, Regular Session, 2013, required HHSC to implement additional cost containment and reduction measures. One of the initiatives was to examine the effect of reestablishing the hospital 30-day SOI limitations in STAR+PLUS. A high-level fiscal analysis suggested that the initiative would result in a cost savings of $58 million general revenue ($140 million all funds) over the SFY14-15 biennium. The findings were sent to CMS in June 2013, with the recommendation to reinstate the limitation via a waiver amendment. This amendment was approved in September 2013.

Texas received approval from CMS in October 2015 for an amendment removing the SOI limitation for STAR+PLUS members who have a SPMI diagnosis in the top five diagnoses on admission[6]. SPMI is defined by the Diagnostic and Statistical Manual of Mental Disorders as a diagnosis of bipolar disorder, major depressive disorder, recurrent depressive disorder, schizophrenia, or schizoaffective disorder. Before approval of this amendment, some of these members with SPMI received general revenue-funded services at state hospitals after exhausting the 30-day spell of illness. Even though these clients would now receive lengthier inpatient care, these costs would possibly be offset by lower uncompensated care and by averting costlier future care.[7] By analyzing the average inpatient hospital costs for members with SPMI during SFY2013 (when behavioral health inpatient stays were in the capitated rate and no SOI existed) versus SFY2014 (when the SOI was reimplemented), HHSC identified cost differences, leading to an added capitation

rate increase totaling approximately $12.3 million in all funds for SFY2016 for all STAR+PLUS MCOs.

After receiving feedback from various stakeholders, HHSC submitted an amendment to the 1115 waiver in April 2016 to limit the STAR+PLUS SOI exemption to only those members who are admitted primarily due to a diagnosis of SPMI[8] (compared to the former policy of SPMI being listed in the top five admission diagnoses). HHSC officially withdrew its CMS request for this SPMI change[9], but the alteration was written into the STAR+PLUS expansion contract, effective September 1, 2016[10].

To assist members during the COVID-19 pandemic, HHSC submitted an amendment related to those affected by the disease, approved on September 3, 2020[11]. The amendment increased the 30-day spell an additional 30 days for anyone who has an inpatient stay associated with a COVID-19 diagnosis (not specifically a primary diagnosis of COVID-19), excluding presumptive positive cases. This amendment doubles the allowable days to 60, retroactive from March 13, 2020.

3. 30-Day Spell of Illness Analysis

3.1 Data Collection and Limitations

HHSC generally relies on Medicaid and CHIP administrative data, including encounters and enrollment data, to analyze trends in service utilization among its members in managed care programs. Other available data sources comprise MCO self-reported contractually required deliverables, such as counts of hotline calls and complaints, usually submitted in aggregate counts. Occasionally, HHSC requests the MCOs for one-time data requests to fulfill the needs of specific projects or legislative reports.

To address the questions required by HB 4533, HHSC first analyzed claims and encounters data and determined that this data does not accurately identify clients who exceed the 30-day rule, chiefly because it may take years for some hospital claims or encounters to be adjudicated, and because provider awareness of the rule may reduce submission of claims/encounters that exceed 30 days. After consulting with other areas in HHSC, the OIG, and the Internal Quality Review Organization for potential data, HHSC decided its best option was to collect data and estimates on the SOI rule's impact from the health plans.

Each MCO maintains its own internal algorithms and databases to identify clients who exceed the 30-day SOI rule. The health plans run quarterly, or more frequent, checks on STAR+PLUS members and flag hospitalizations that have exceeded the limit. If members are verified to have surpassed the allotted days, MCOs will recoup part or all the amount paid to the providers, so having the most accurate and up-to-date information is in their best interest. This incentive makes their data the most reliable source available for identifying the inpatient stays that exceed SOI limits.

However, using the MCO administrative data for this report also presented challenges. First, because the methods and algorithms for identifying SOI clients vary by MCO, comparisons between MCOs must be made with caution. Second, even though the MCO's administrative data are more final and detailed than HHSC's encounters, the data are still sometimes incomplete. For example, the MCO data allows them to identify which denials specifically related to the SOI rule, whereas HHSC's encounters do not include this information. However, claims may be submitted months after the service has occurred and possibly take years before being adjudicated. Therefore, in some cases, a health plan may not identify a violation of the rule until years later.

Additionally, like HHCS' encounter data, the health plan administrative data does not capture inpatient claims that were not submitted at all or only submitted for the first 30 day stay because of awareness of the rule. This limitation prevents the health plans from gathering information on how long the stay would have been,

how much the stay would have cost (thus how much money saved), and a wide range of other information readily available on claims.

An issue specific to United Healthcare (UHC) is that their historical SOI data has been segmented across several databases. This fact increases the difficulty for UHC to provide information for earlier years, specifically SFY2016 and SFY2017, for this report. These two years may exhibit fewer members exceeding the SOI, but the reduction is due to incomplete data.

Within the data limitations of the MCO submitted data, HHSC was able to answer the following reporting elements required by the legislation to the extent that the MCOs submitted accurate data or estimates to HHSC for the study: 1) the number of Medicaid recipients affected by the limitation, 2) the impact on reducing inpatient hospital days, and 3) any cost savings achieved by the limitation under Medicaid.

Even with the data and estimates MCOs submitted, HHSC was unable to address the remaining reporting element, evaluation of the clinical outcomes of members impacted by the SOI rule. The MCOs reported that information to answer the clinical outcomes was not available. This reporting element is more complicated than the other measures because it requires information not included on encounter or other data submitted by the MCOs. First, encounters do not include the level of clinical detail required to determine if a member warranted extended days. Encounters also do not identify members who received extended hospital days, just not paid for by Medicaid. In addition, encounters do not capture members who needed additional hospital days but for whom claims were not submitted at all or only for the first 30 day stay because of provider awareness of the SOI rule.

HHSC requested five fiscal years of data (SFY2015 to SFY2019) from each health plan for SOI information via the MCO Notices portion of the TexConnect Portal. The elements asked for were 1) the numbers of clients affected by the limitation, 2) the number of hospitalizations that partially or completely exceeded the rule, 3) the number of days of care that exceeded the 30-day limit, and 4) the amount of money the plan would have paid if days or admissions had not been denied. This data was aggregated at the health plan level. Data elements were chosen based on the conversations held with the MCOs to determine which information was feasible for them to provide. Nevertheless, in some cases, MCOs did not provide all requested data.

Health plans were advised to provide information on all stays exceeding the allowable 30 days that they had data for and to estimate the members and costs the plan would have paid if all claims were billed and prior authorizations were accepted. The total costs are approximations because each hospital facility has its own contracted reimbursement amount and the actual paid amounts are only calculated if the claim is processed. Several plans did not report these dollar figures for the report.

Ultimately, the study looked at two groups of clients impacted by the 30 day rule: 1) clients whose hospital stays surpass the allotted 30 days, for whom encounters

have been submitted after they are discharged, and who are relatively easy for the health plans to identify by running periodic encounter checks; and 2) clients whose hospital stays over 30 days were denied up front either because the provider did not submit the inpatient encounter or because the health plan denied the prior authorization. Identifying all the clients in the latter scenario is only estimated by the MCOs.

3.2. Medicaid Enrollment and Hospital Utilization Trends

The study results provided in Section 3.3 are examined across time (2015 through 2019) and across the five STAR+PLUS health plans. Because data patterns found in these results may, to some degree, reflect larger Medicaid enrollment or hospital utilization trends, the purpose of this section is to provide context for more accurate interpretation of the study results. To that end, Section 3.2 provides trends in Medicaid enrollment overall, and more specifically, the target population of the study, Medicaid-Only STAR+PLUS clients,[2] in addition to associated overall hospitalizations not limited to SOI rules.

The total number of Medicaid members in Texas saw minimal change from SFY2015 to SFY2019, from 5.4 million unique members to 5.3 million, a 2% total drop in unique members over the 5-year period. The decrease in STAR+PLUS members was more pronounced over this same period, at 6%, from about 646,000 members to roughly 605,000. A similar percentage drop is found among Medicaid-Only STAR-PLUS clients, the clients potentially impacted by the SOI rule.

In addition to these observed population trends across time, Medicaid-Only STAR+PLUS enrollment is not evenly distributed among the five major health plans. Superior HealthPlan (Superior) has the most members, closely followed by Amerigroup, while Cigna-HealthSpring has the lowest enrollment numbers among all health plans throughout the entire five years (Table 1). While Amerigroup, Cigna-HealthSpring, Molina, and Superior saw a decrease in enrollment over time, UHC saw a 10% increase in members from SFY2015 to SFY2019. The composition of members' demographic characteristics also varies as each MCO covers a different array of Service Delivery Areas (SDAs). These demographic differences may contribute to variation in SOI hospitalization patterns across MCOs.

[2] STAR+PLUS clients who are dually eligible in Medicaid and Medicare receive their hospital services and other acute care services through Medicare so are not impacted by the SOI rule.

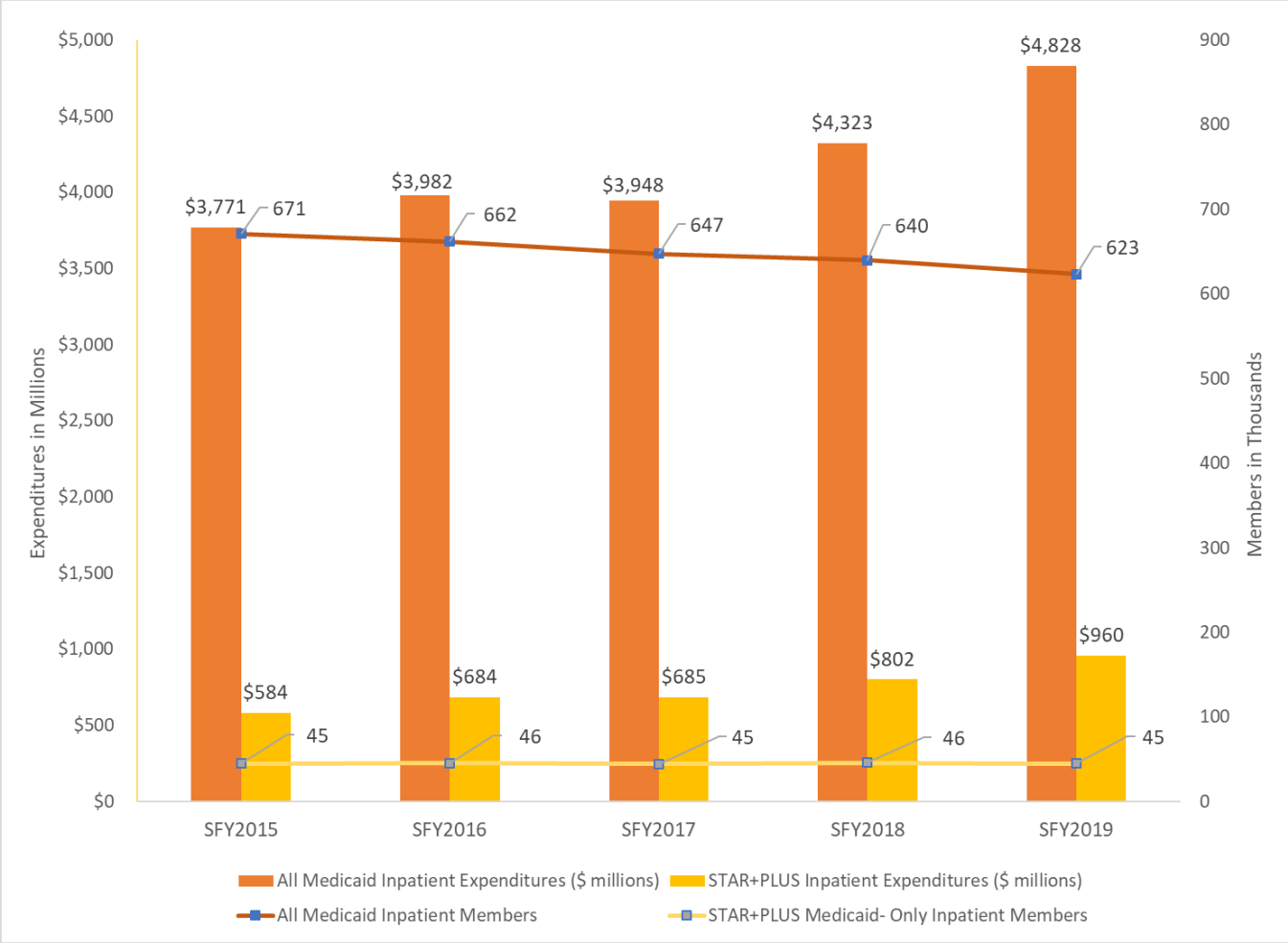
Table 1. Texas Medicaid-Only STAR+PLUS Enrolled Members by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup	79,689	77,790	76,201	70,421	69,246
Cigna-HealthSpring	26,179	24,886	24,736	24,298	23,710
Molina	46,905	45,785	45,120	43,255	42,106
Superior	87,253	85,262	83,446	77,952	76,698
United Healthcare	62,399	63,631	65,250	66,772	68,134
Unduplicated Texas Total	284,777	284,950	282,241	270,928	269,160

Source: Medicaid CHIP Data Analytics, Center for Analytics & Decision Support, HHSC.
Notes: Member counts are unduplicated, based on the PCN, within each year and MCO. Counts are not additive as a member may be in more than one MCO during the year, but the Texas Totals provide unduplicated counts across MCOs. Data includes Medicaid-Only STAR+PLUS members, excluding dual eligibles.

The number of all Medicaid members who had an inpatient hospital claim or encounter decreased from SFY2015 to SFY2019 by more than 7%, from approximately 671,000 to about 623,000 (Figure 1). In contrast to the overall Medicaid trend, Medicaid-Only STAR+PLUS members' hospital inpatient utilization slightly increased, by .3%, as about 100 more members utilized services in SFY2019 compared to SFY2015. Both groups saw large increases in inpatient expenditures, rising 28% for all of Medicaid and 64% for the STAR+PLUS population. Note that the managed care expenditures reflect the amount the health plans paid to providers, and not actual Medicaid outlays, as MCOs are paid on a capitation rate.

Figure 1. Texas Medicaid Inpatient Members and Medicaid-Only STAR+PLUS Members (in Thousands) and Associated Expenditures (in Millions), SFY2015-19 (See Appendix 1 for Table version)



Source: Medicaid CHIP Data Analytics, Center for Analytics & Decision Support, HHSC.
Notes: The data include FFS and managed care programs. Managed care health plans are paid on a capitation basis. Texas does not reimburse individual providers under contract with the health plans. Expenditures reflect client services only and do not include administrative, capitations, supplemental payments, DSH, or Upper Payment Levels (UPL) dollars.

One significant factor in these increased expenditures is the roll out of Uniform Hospital Rate Increase Program (UHRIP)[12]. UHRIP provides additional payments to hospitals that treat Medicaid members in STAR and STAR+PLUS. The program is financed using a combination of local funds and federal funds, so there is no increased expenditure of state general revenue. The goal of the program is to improve client satisfaction and access to care by decreasing the difference between service costs and actual reimbursements to hospitals serving Medicaid clients. UHRIP began on December 1, 2017 as a pilot program for just the Bexar and El Paso SDAs. The program rolled out throughout the entire state on March 1, 2018. The estimated total of UHRIP payments in SFY2019, the first full year of the program, is $1.6 billion[13].

3.3 Results

Combined MCO summary

The legislative intent of Section 29 of HB 4533 is to identify the effects the SOI rule has on Medicaid clients and associated expenditures. HHSC was asked to analyze, to the extent data is available on the subject, the number of Medicaid recipients affected by the limitation and their clinical outcomes, and the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved.

After determining that accurately estimating the SOI effects with the available claims administration data, HHSC consulted with the STAR+PLUS health plans to understand what information they collect and which parts of the request could be completed with available MCO administrative data. Four data elements (number of clients, number of hospitalizations, number of hospital days, and estimated paid amount recovered) were determined to best exhibit the SOI rule effects.

Each health plan used its own methods for identifying SOI clients and potential cost savings and were instructed to provide any estimated counts and costs that they could practically project. Four of the five STAR+PLUS health plans provided estimated information. Therefore, the indicators are typically a combination of MCO approximations and actual MCO administrative data. UHC did not provide the estimated data, only limited administrative data. Amerigroup did not provide estimated dollars.

The reported values for all four measures increased from SFY2015 to SFY2018 (Table 2). SFY2016 and SFY2017 would likely have been higher if UHC had provided full estimates. Investigations into the SOI limitation tend to occur after the stay and can last years, so these indicators, especially for SFY2018 and SFY2019, are probably incomplete and will increase.

The number of SOI hospitalizations increased over time, while client enrollment decreased six percent and the overall hospitalizations for Medicaid-Only STAR+PLUS clients remained relatively flat, as described in Section 3.2 above. Therefore, enrollment or general hospitalization trends for the population do not explain the increase in the number of clients impacted by the SOI rule and the rise in both the number of and length of hospitalizations over the SOI limit.

Likewise, the proportion of clients affected out of the total STAR+PLUS hospitalizations rises from about 6% in SFY2015 (2,775 SOI clients out of 44,811 total Medicaid-Only STAR+PLUS hospitalized clients) to about 8% in SFY2019 (3,480 SOI clients out of 44,959 total Medicaid-Only STAR+PLUS hospitalized clients). Even though the total STAR+PLUS and SOI hospitalizations increase in amount paid, the proportion of dollars associated with SOI decreases over time, from 11% of total amount paid in SFY2015 ($62.5 million out of $584.4 million) to 8% in SFY2019 ($73.8 million out of $960.2 million).

Table 2. Estimated Texas Medicaid STAR+PLUS 30-Day Spell of Illness Measures, SFY2015-19

Indicator	2015	2016	2017	2018	2019
Number of clients affected[a]	2,775	2,903	2,969	3,492	3,480
The number of hospitalizations that partially or completely exceeded the rule	8,011	8,407	8,485	9,625	8,888
Number of days of care that exceeded the 30-day limit	51,237	54,108	52,292	58,209	53,810
The amount of money the plan would have paid if days or admissions had not been denied ($ millions)[b]	$62.5	$70.8	$68.5	$75.8	$73.8

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Numbers of clients are added up across all health plans. A client may switch health plans during the year and may be counted more than once.

[b] Dollar amounts include estimated recoupments and overestimates the actual amounts associated with the hospitalizations.

Data from these four indicators do not resolve the issue of clinical outcomes for the SOI population. This reporting element is more complicated than the other measures because it requires information not included on encounter or other data submitted by the MCOs. Encounters only reveal if the client did not receive the additional service days from Medicaid, and do not reveal who needed additional services in Medicaid but did not receive them. Encounters also do not who needed additional hospital days but for whom claims were not submitted at all or only for the first 30 day stay because of provider awareness of the SOI rule.

MCO Specific Summary

The health plans can follow HHSC's rule about how to identify which clients have exceeded the 30-day SOI using the guidance laid out in the STAR+PLUS General Contract Terms & Conditions[10], but they employ different methods for estimating those clients who never had a claim submitted on their behalf. Although the numbers are not directly comparable, they offer insights into SOI rule impacts. Amerigroup and UHC's reporting figures do not include estimated dollars. Additionally, UHC submitted limited actual encounter data for SFY2016 and SFY2017.

Variation in the number of STAR+PLUS clients affected by the SOI between MCOs mostly reflects the uneven dispersal of members enrolled. For example, Superior enrolls the highest number of Medicaid-Only STAR+PLUS members and reports the highest number of members affected by the SOI rule (Table 3). UHC is an outlier as

the MCO has higher enrollment but the lowest number of members impacted. This discrepancy is likely due to the MCO missing two years of data and its difficulties identifying members denied services up-front.

Table 3. Estimated Number of Texas Medicaid STAR+PLUS Members[a] Affected by SOI by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup	594	439	422	414	415
Cigna-HealthSpring	136	218	208	219	236
Molina	512	492	498	490	448
Superior	1,418	1,753	1,840	2,253	2,254
United Healthcare[bc]	115	1	1	116	127

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] A client may switch health plans during the year and may be counted more than once.

[b] Client counts include estimates for all health plans except United.

[c] United reported missing data for SFY2016 and SFY2017.

On average over the five years, Superior reports the highest number of hospitalizations impacted by the SOI rule, which is in line with enrolling the highest number of Medicaid-Only STAR+PLUS members (Table 4). Across all the plans, the average member had multiple hospitalizations, ranging from one hospitalization per SOI member in UHC, up to 7 hospitalizations per SOI member in Cigna-HealthSpring in SFY2018.

Table 4. Estimated Number of Texas Medicaid STAR+PLUS Hospitalizations that Partially or Completely Exceeded the SOI Rule by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup	1,458	1,231	1,322	1,281	1,435
Cigna-HealthSpring	736	1,418	1,407	1,514	1,210
Molina	3,472	2,904	2,779	2,897	2,333
Superior	2,230	2,853	2,976	3,817	3,783
United Healthcare [ab]	115	1	1	116	127

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Hospitalizations include estimates for all health plans except United.

[b] United reported missing data for SFY2016 and 2017.

The number of days from the excess SOI inpatient stays varies widely by health plan and by fiscal year (Table 5). Because inpatient stays are estimated, calculating

the exact number of days the member would have been in the hospital is difficult, as there are many variables that factor into the length of stay: admission diagnosis, members' age, comorbidities, complications from procedures, and others.

Table 5. Estimated Number of Texas Medicaid STAR+PLUS Days of Care that Exceeded the 30-day Limit by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup	8,558	7,715	7,638	6,907	8,020
Cigna-HealthSpring	3,958	6,171	6,432	5,846	4,693
Molina	18,198	16,259	14,498	16,055	12,622
Superior	19,682	23,960	23,706	28,464	27,466
United Healthcare [ab]	841	3	18	937	1,009

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Excess hospitalization days include estimates for all health plans except United.

[b] United reported missing data for SFY2016 and 2017.

UHC reported the fewest average days of care per member that exceeded the 30-day limit in SFY2016 at three days (Table 6), although that data is incomplete. When UHC's incomplete years of data are excluded from the comparisons, Superior in SFY2019 reported the fewest excess days per hospitalization per client, at 12 days. Molina reported the highest average excess days per hospitalization per member at nearly 36 days in SFY2015.

Table 6. Estimated Number of Texas Medicaid STAR+PLUS Excess Hospitalization Days per Member by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup	14.4	17.6	18.1	16.7	19.3
Cigna-HealthSpring	29.1	28.3	30.9	26.7	19.9
Molina	35.5	33.0	29.1	32.8	28.2
Superior	13.9	13.7	12.9	12.6	12.2
United Healthcare [ab]	7.3	3.0	18.0	8.1	7.9

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Hospitalizations include estimates for all health plans except United.

[b] United reported missing data for SFY2016 and 2017.

The average excess days per hospitalization is more similar across MCOs than the average excess days per member (Table 7). Although the data is incomplete, UHC reported the lowest and highest number of excess days per hospitalization in SFY2016 and SFY2017, at 3 and 18 days, respectively. Excluding UHC, Cigna-

HealthSpring reported the lowest average excess days per hospitalization at four days in SFY2018 and SFY2019. Superior reported the highest average at roughly nine days in SFY2015.

Table 7. Estimated Number of Texas Medicaid STAR+PLUS Excess Hospitalization Days per Hospitalization by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup	5.9	6.3	5.8	5.4	5.6
Cigna-HealthSpring	5.4	4.4	4.6	3.9	3.9
Molina	5.2	5.6	5.2	5.5	5.4
Superior	8.8	8.4	8.0	7.5	7.3
United Healthcare [ab]	7.3	3.0	18.0	8.1	7.9

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Hospitalizations include estimates for all health plans except United.

[b] United reported missing data for SFY2016 and 2017.

The reader is cautioned to keep the data limitations from Section 3.1 in mind while considering the following discussion of cost estimates. The amount that would have been paid to providers, absent the 30-day SOI rule, increased over time for four of the five health plans, and stayed relatively constant for the fifth, UHC (Table 8). Cigna-HealthSpring had the largest estimated expenditures at $51.6 million in SFY2018, while Amerigroup and UHC (the plans without estimates) had the lowest amounts at $1 million, excluding UHC's two incomplete years. Even with analysis still underway for recent years, SFY2019 was the highest for Superior and Amerigroup.

Table 8. Estimated Amount of Texas Medicaid STAR+PLUS Money (in $ Millions) the Plan Would Have Paid if Days or Admissions Had Not Been Denied by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup[a]	$2.0	$1.3	$1.0	$1.4	$2.1
Cigna-HealthSpring	$43.4	$50.0	$45.8	$51.6	$49.0
Molina	$12.5	$13.4	$16.0	$14.0	$14.3
Superior	$3.5	$6.2	$5.7	$8.1	$8.3
United Healthcare [b]	$1.0	$0.0	$0.0	$0.7	$0.9

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Hospitalization expenditures include estimates for all health plans except Amerigroup and United.

[b] United reported missing data for SFY2016 and 2017.

Cigna-HealthSpring had the highest average estimated amount per client (Table 9) and hospitalization (Table 10), $319,400 and $59,000, respectively, in SFY2015. Amerigroup had the lowest average estimated amount per client and hospitalization, $2,300 and $700, respectively, in SFY2017. Amerigroup's numbers are skewed because they include estimated hospitalizations but do not include estimated expenditures for those clients.

Table 9. Estimated Average Amount of Texas Medicaid STAR+PLUS Money the Plan Would Have Paid per Member, Absent the SOI Rule, by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup[a]	$3,421	$2,941	$2,324	$3,282	$5,091
Cigna-HealthSpring	$319,449	$229,088	$220,184	$235,394	$207,453
Molina	$24,353	$27,184	$32,093	$28,659	$31,974
Superior	$2,477	$3,525	$3,087	$3,576	$3,665
United Healthcare[b]	$8,752	$3,407	$22,953	$6,388	$6,945

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Hospitalization expenditures include estimates for all health plans except Amerigroup and United.

[b] United reported missing data for SFY2016 and 2017.

Table 10. Estimated Average Amount of Texas Medicaid STAR+PLUS Money the Plan Would Have Paid per Hospitalization, Absent the SOI Rule, by MCO, SFY2015-19

MCO	2015	2016	2017	2018	2019
Amerigroup[a]	$1,394	$1,049	$742	$1,061	$1,472
Cigna-HealthSpring	$59,029	$35,220	$32,550	$34,050	$40,462
Molina	$3,591	$4,605	$5,751	$4,847	$6,141
Superior	$1,575	$2,166	$1,909	$2,111	$2,183
United Healthcare[b]	$8,752	$3,407	$22,953	$6,388	$6,945

Source: Data submissions from Molina Healthcare, Amerigroup, Superior, Cigna-HealthSpring, and United Healthcare.

[a] Hospitalization expenditures include estimates for all health plans except Amerigroup and United.

[b] United reported missing data for SFY2016 and 2017.

4. Conclusion

The 30-day SOI rule has undergone significant changes over time, and modifications continue with the current COVID-19 pandemic. The measures required by HB 4533 help capture the impact of SOI on the number of clients impacted by the rule, including the number and length of hospitalizations and associated costs, averted, in the past years. This report draws from MCO 30-day SOI administrative data, which represents estimates for 1) the number of clients affected by the SOI limitation, 2) the number of hospitalizations that partially or completely exceeded the rule, 3) the number of days of care that exceeded the 30-day limit, and 4) the amount of money the plan would have paid if days or admissions had not been denied.

This study looked at two groups of clients impacted by the 30 day rule: 1) clients whose hospital stays surpass the allotted 30 days, for whom encounters have been submitted after they are discharged, and who are relatively easy for the health plans to identify by running periodic encounter checks; and 2) clients whose hospital stays over 30 days were denied up front either because the provider did not submit the inpatient encounter or because the health plan denied the prior authorization. Identifying all the clients in the latter scenario is not possible; health plans are only able to provide rough estimates.

The results of this study suggest that:

- The number of members affected by this rule has increased from about 2,800 to 3,500 from SFY2015 to SFY2019 (Table 2).
- The number of hospitalizations that exceeded the SOI rule increased from 8,000 in SFY2015 to about 9,000 in SFY2019. These hospitalizations represent about 51,000 days over the limit in SFY2015 and about 54,000 in SFY2019 (Table 2).
- In comparison, during the same time period, enrollment for clients potentially impacted by the SOI rule decreased six percent, while their general hospitalizations remained relatively stable. Therefore, enrollment or general hospitalization trends for the population do not explain the increase in the number of clients impacted by the SOI rule and the rise in both the number of and length of hospitalizations over the SOI limit.
- Likewise, the number of clients affected by SOI out of the number of Medicaid-Only STAR+PLUS clients hospitalized in general rises from about 6% in SFY2015 (2,775 SOI clients of 44,811 total clients) to about 8% in SFY2019 (3,480 SOI clients of 44,959 total clients).
- Costs for both any Medicaid-Only STAR+PLUS and SOI related hospitalization increase over time, but the proportion of dollars associated with SOI decreases, from 11% of total amount paid in SFY2015 ($62.5 million out of $584.4 million) to 8% in SFY2019 ($73.8 million out of $960.2 million).

- The amount of money the plan would have paid, absent the SOI rule, ranges from an estimated $62.5 million in SFY2015 to $73.8 million in SFY2019 (Table 2).
- The different methods MCOs utilized to estimate the number of clients affected by the SOI rule creates a substantial range of affected dollars, from less than $1 million for United Healthcare to more than $50 million for Cigna-HealthSpring (Table 9). Cigna-HealthSpring also has the highest average cost per hospitalization at $59,029 in SFY2015. Amerigroup has the lowest average cost per hospitalization at $742 in SFY2017 (Table 10).
- HHSC, nor the health plans, had available data to adequately study any potential adverse impact of the SOI limit on clinical outcomes, which would include a more complete clinical picture of the members' health condition and acuity level, in addition to a way to exclude from the study members who subsequently received the services, just not paid for by Medicaid.

5. List of Acronyms

Acronym	Full Name
CMS	Center for Medicare and Medicaid Services
DRG	Diagnosis Related Group
FFS	Fee-For-Service
HB	House Bill
HHSC	Health and Human Services Commission
MCO	Managed Care Organization
MMC	Medicaid Managed Care
OIG	Texas Office of Inspector General
PCN	Patient Control Number
SB	Senate Bill
SDA	Service Delivery Area
SFY	State Fiscal Year
SOI	Spell of Illness
SPMI	Severe and Persistent Mental Illness
STAR	State of Texas Access Reform
TAC	Texas Administrative Code
UHC	UnitedHealthcare
UHRIP	Uniform Hospital Rate Increase Program
UPL	Upper Payment Limit

6. Appendix 1

Texas Medicaid Inpatient Members and Expenditures (in Millions), SFY2015-19

State Fiscal Year	All Medicaid Inpatient Members	All Medicaid Inpatient Expenditures ($ millions)	STAR+PLUS Medicaid-Only Inpatient Members	STAR+PLUS Inpatient Expenditures ($ millions)
2015	671,060	$3,770.6	44,811	$584.4
2016	661,567	$3,981.8	45,655	$684.1
2017	647,448	$3,948.4	44,645	$684.9
2018	639,927	$4,322.9	45,858	$802.2
2019	623,065	$4,828.5	44,959	$960.2

Source: Medicaid CHIP Data Analytics, Center for Analytics & Decision Support, HHSC.
Notes: The data include FFS and managed care programs. Managed care health plans are paid on a capitation basis. Texas does not reimburse individual providers under contract with the health plans. Expenditures reflect client services only and do not include administrative, capitations, supplemental payments, DSH, or Upper Payment Levels (UPL) dollars.

References

1. U.S. Centers for Medicare & Medicaid Services. (2020) *Inpatient hospital care*. https://www.medicare.gov/coverage/inpatient-hospital-care . Accessed on September 30, 2020.

2. Kaiser Family Foundation. (2019) *Medicaid Benefits: Inpatient Hospital Services, other than in an Institution for Mental Disease*. https://www.kff.org/medicaid/state-indicator/inpatient-hospital-services-other-than-in-an-institution-for-mental-diseases/ . Accessed on September 30, 2020.

3. Texas Administrative Code TITLE 1, PART 15, CHAPTER 354, SUBCHAPTER A, DIVISION 6, RULE §354.1072.

4. Texas Health and Human Services Commission. (2020) *STAR+PLUS.* https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/starPLUS. Accessed on September 30, 2020.

5. U.S. Centers for Medicare & Medicaid Services. (2011) *Texas Healthcare Transformation and Quality Improvement Program (11-W-00278/6).* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-stc-12112011-09302016.pdf. Accessed on September 30, 2020.

6. Wachino, Vikki. (2015). *CMS Amendment Approval-October 2015 (10/1/2015)*. U.S. Centers for Medicare & Medicaid Services.

7. Ghahremani, Kay (2015). *Amendment 11 - Spell of Illness (06/16/2015).* Texas Health and Human Services Commission.

8. Jessee, Gary (2016). *State Application - Amendment 13 (12/22/2016).* Texas Health and Human Services Commission.

9. Snyder, Jami (2017). *Amendment 13 Spell of Illness Request Withdrawal by Texas (5/15/2017).* Texas Health and Human Services Commission.

10. Texas Health and Human Services Commission. (2020). *Subject: Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions (Version 1.35).*

11. Costello, Ann M (2020). *Demonstration Approval - Texas COVID-19 Amendment.* U.S. Centers for Medicare & Medicaid Services.

12. Texas Health and Human Services Commission (2020). *Uniform Hospital Rate Increase Program.* https://rad.hhs.texas.gov/hospitals-clinic/hospital-

services/uniform-hospital-rate-increase-program. Accessed on September 30, 2020.

13. Texas Health and Human Services Commission (2020). *TX UC DSH UHRIP Payment Model Data Refresh.* https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/medicaid-1115-waiver-payments. Accessed on September 30, 2020.