DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

December 9, 2025

Emily Zalkovsky
State Medicaid Director
Texas Health and Human Services Commission
4601 W. Guadalupe Street MC:H100
Austin, Texas 78751

Dear Director Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Texas' Final Report for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project Number: 11-W-002786), approved on September 3, 2020. This report covers the demonstration period from March 1, 2020, through July 10, 2023. CMS determined that the Final Report, submitted on May 10, 2024 and finalized on June 2, 2025, is in alignment with the CMS-approved Evaluation Design, and therefore approves the state's Final Report.

The approved Final Report may now be posted on the state's Medicaid website. CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
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Date: 2025.12.09 10:53:01 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Enclosure
cc: Ford Blunt, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

COVID-19 1115(a) Demonstration Evaluation: Inpatient Hospitalization Limitations

As Required by
Centers for Medicare and Medicaid Services

Texas Health and Human Services Commission

Office of Data, Analytics, and Performance
May 10, 2024

TEXAS
Health and Human Services

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Executive Summary

To assist states with addressing the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) created an 1115(a) demonstration opportunity that provided states flexibility and assistance enrolling and covering Medicaid members during the COVID-19 pandemic. CMS approved Texas' COVID-19 1115(a) demonstration on September 3, 2020, with a retroactive effective date of March 1, 2020. The demonstration allowed individuals subject to inpatient hospitalization limitations additional Medicaid coverage for COVID-19-related admissions[a]. This report summarizes findings from an evaluation which assessed how the approved COVID-19 1115(a) demonstration affected Texas' response to the public health emergency (PHE).

The evaluation relied on a descriptive case study design, in which Medicaid members who received coverage extensions through the COVID-19 1115(a) demonstration were identified and described in order to understand the impact of the amendment. The evaluation used administrative data to identify coverage extensions approved through the amendment, as well as interviews with a Medicaid Administrator and Managed Care Organization (MCO) representatives to obtain additional information about the administrative and financial impacts of the amendment.

Key findings identified through the evaluation include:

- Hospitalization coverage limits were of particular concern during the PHE due to increased hospitalizations and longer hospital stays associated with COVID-19, especially for those with complex medical conditions.

[a] The 30-day spell of illness limitation for hospital inpatient services described in the state plan does not apply to STAR enrollees, certain approved transplants, children age 20 and younger, or to individuals with severe and persistent mental illness. In addition, for inpatient hospital stays related to COVID-19 (i.e. a stay for which the COVID-19 diagnosis is not limited to the primary diagnosis and can be listed in any position on the claim, and excluding presumptive positive cases where a COVID-19 diagnosis has not yet been confirmed), Texas will extend the 30-day spell of illness limitation described in the state plan for an additional 30 days to allow an individual to stay up to 60 days in a hospital for the period of the COVID-19 Public Health Emergency (PHE).The state will also allow an individual to exceed the $200,000 inpatient hospital benefit limitation for COVID-19 related stays during the PHE.

- In total, 906 inpatient admissions (across 904 individuals) received a 30-day spell-of-illness (SOI) extension, and 10 individuals exceeded the $200,000 annual benefit limit.
- On average, the COVID-19 1115(a) demonstration provided approximately 10 additional days of coverage per inpatient admission among those who received a 30-day SOI extension, and $47,657.37 additional inpatient coverage per year among those who exceeded their annual benefit limit.
- The COVID-19 1115(a) demonstration provided greater flexibility to treat individuals, increased financial support to MCOs and hospitals, and may have reduced stress related to coverage uncertainty among hospitalized individuals.

The results of the evaluation should be interpreted alongside several key limitations, including challenges common to administrative data, and threats to validity associated with the qualitative methods used in this report. However, despite these limitations, findings from this evaluation confirm there was an increased need to suspend hospitalization limits due to COVID-19-related complications. The COVID-19 1115(a) demonstration amendment helped Texas address these challenges by providing greater flexibility to treat complex cases in hospital settings, improving client care, and reducing the financial burden on hospitals.

1. Introduction

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 pandemic constituted a national emergency. In response to the proclamation, the Secretary of Health and Human Services invoked their authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Social Security Act (Act) to the extent necessary, as determined by CMS.

To assist states with addressing the COVID-19 pandemic, CMS created an 1115(a) demonstration opportunity to waive or modify requirements of Title XIX of the Act. The 1115(a) demonstration opportunity allowed states flexibility and assistance enrolling and covering Medicaid clients during the COVID-19 pandemic. CMS announced the new COVID 1115(a) demonstration opportunity on March 22, 2020. All approved demonstrations received a retroactive effective date of March 1, 2020, and expired no later than 60 days after the end of the PHE (May 11, 2023), including any extensions.

Texas Health and Human Services Commission (HHSC) submitted a request for an COVID-19 1115(a) demonstration to CMS on July 7, 2020. The amendment proposed to extend the 30-day SOI limitation, and the $200,000 annual hospital benefit limitation. The 30-day SOI limitation described in the state plan limits Medicaid coverage for inpatient hospital admissions to 30 days per each SOI (each SOI resets after 60 consecutive days without an inpatient admission). The 30-day SOI limitation only applies to clients 21 and older[b] receiving services through Fee-for-Service (FFS), STAR+PLUS, or STAR Health. The $200,000 annual inpatient hospital benefit limitation described in the state plan limits Medicaid coverage for inpatient hospital admissions to less than $200,000 per benefit year (November 1 through October 31). The $200,000 annual hospital benefit limit only applies to clients 21 and older receiving services through FFS or STAR Health. Under existing policy, these limitations do not apply to certain approved transplants and STAR+PLUS clients with a severe and persistent mental illness.

The Medicaid programs subject to these limitations serve vulnerable populations, such as individuals with physical, intellectual, or developmental disabilities (STAR+PLUS or FFS), or children or young adults previously in foster care (STAR

[b] In compliance with H.R. 6201–116th Congress (2019-2020), for the duration of the public health emergency, these limitations do not apply to clients who turned 21 on or after March 18, 2020.

Health; Texas Health and Human Services Commission, 2022). To help assist these clients in light of challenges presented by the PHE, the COVID-19 1115(a) demonstration proposed to extend the 30-day SOI limitation for an additional 30 days, and extend the $200,000 annual inpatient hospital benefit limitation for COVID-19-related inpatient hospital stays.

CMS determined that the COVID-19 1115(a) demonstration was necessary to assist Texas in delivering the most effective care to its members in light of the COVID-19 PHE and approved the state's demonstration on September 3, 2020, with a retroactive effective date of March 1, 2020. HHSC's COVID-19 1115(a) demonstration expired with the end of the PHE on May 11, 2023.

CMS required states with approved COVID-19 1115(a) demonstrations to conduct an evaluation. Evaluations must test whether and how the approved expenditure authority affected states' response to the PHE, and the connection between the expenditures and the cost-effectiveness of states' response to the PHE. This report presents results of the COVID-19 1115(a) demonstration evaluation by HHSC's Office of Data, Analytics, and Performance (DAP).[c] This evaluation summarizes information for all clients subject to the 30-day SOI or $200,000 annual inpatient hospital benefit limitations, including those not covered under the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 demonstration (FFS and STAR Health).

[c] The use of DAP, previously known as the Center for Analytics and Decision Support, to conduct the evaluation was discussed with CMS during a call on August 27, 2020.

2. Study Methods

This evaluation is guided by two evaluation questions and four hypotheses that examine how the amendment affected the state's response to the PHE (see Table 1). This section provides an overview of the evaluation design, study populations, data sources, and analytic methods. Please refer to the full evaluation design for additional information. [d]

Table 1. Evaluation Questions and Hypotheses

Evaluation Question	Corresponding Hypotheses
Evaluation Question 1. What challenges did the public health emergency pose to Medicaid policies regarding hospitalization limits?	**Hypothesis 1.1.** Due to COVID-19-related complications, some Medicaid clients required hospital stays that exceeded the 30-day SOI limitation. **Hypothesis 1.2.** Due to COVID-19-related complications, some Medicaid clients required care that exceeded the $200,000 inpatient hospital benefit limitation.
Evaluation Question 2. How did the COVID-19 1115(a) demonstration help the state address challenges to hospitalization limits posed by the public health emergency?	**Hypothesis 2.1**. The COVID-19 1115(a) demonstration allowed the state greater flexibility in providing services to Medicaid clients with a COVID-19 diagnosis. **Hypothesis 2.2.** The COVID-19 1115(a) demonstration reduced the financial burden on hospitals during the PHE by reimbursing hospital stays that exceeded the 30-day SOI or $200,000 inpatient hospital benefit limitations.

Study Design Overview

The evaluation relied on a descriptive case study design, in which Medicaid clients who received coverage extensions through the amendment were identified and described in order to understand how the amendment helped the state address challenges to hospitalization limits posed by the PHE. The primary study populations include clients who received a 30-day SOI or $200,000 annual benefit limit extension through the amendment. The study also identified all clients subject to the 30-day SOI or $200,000 annual benefit limit (clients in FFS, STAR Health, or STAR+PLUS, aged 21 and older) who had an inpatient admission associated with COVID-19 during the PHE to determine rates of extensions provided through the 1115(a) demonstration. Lastly, DAP interviewed a Texas Medicaid administrator and

[d] A copy of the evaluation design for this COVID-19 1115(a) demonstration is available via (refer to Appendix F): https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-appvd-eval-des-03162022.pdf

MCO staff to obtain information about the administrative and financial aspects of the amendment.

Data Sources

The evaluation leveraged several administrative data sources, including:

- **FFS claims data**. The Texas Medicaid and Healthcare Partnership (TMHP) developed a flag for FFS clients that automatically determined inpatient admissions that were eligible for a 30-day SOI extension. DAP used TMHP's flag to identify FFS clients who exceeded the 30-day SOI limit. Additionally, DAP used FFS claims to identify clients who exceeded the $200,00 annual benefit limit, and all inpatient admissions subject to the 30-day SOI or $200,000 annual benefit limitation.
- **HHSC administrative data**. TMHP did not develop a flag that identified Medicaid managed care (MMC) clients who received a 30-day SOI extension. Instead, MCOs and HHSC coordinated to approve 30-day SOI extensions for MMC members. MCOs submitted requests for 30-day SOI extensions to HHSC. HHSC reviewed the cases to ensure they were subject to the 30-day SOI limit and eligible for an extension under the COVID-19 1115(a) demonstration. HHSC developed an internal HHSC SOI Tracker that noted approved inpatient admissions for MMC members that exceeded the 30-day SOI limit. DAP used the HHSC SOI Tracker to identify MMC members who exceeded the 30-day SOI limit.
- **Medicaid Managed Care encounter data**. DAP used MMC encounters to identify MMC members who exceeded the $200,00 annual benefit limit, and all inpatient admissions subject to the 30-day SOI or $200,000 annual benefit limitation.
- **Member enrollment files.** DAP used member enrollment files to obtain information about the member's age, sex, race/ethnicity, and county of residence.

In addition to administrative data, DAP conducted a virtual one-on-one interview with an HHSC Medicaid Administrator in December 2021, and virtual group interviews with four MCOs (ranging from 3-16 individuals per MCO) between February and March 2022. Additional details on the interview process are provided in Appendix A.

Analytic Methods

Hypotheses were tested using quantitative and qualitative methods. Descriptive statistics, such as estimates of central tendency and dispersion, were used to describe COVID-19-related inpatient hospital stays during the PHE, such as number of admissions, total days and costs per admission, as well as demographic characteristics of clients whose extended inpatient stays were covered under the COVID-19 1115(a) demonstration. Additionally, Chi-Square Tests of Independence and Kruskal-Wallis tests were used to examine differences in rates of 30-day SOI and $200,000 annual benefit limit extensions, as well as differences across demographic subgroups. Lastly, interviews with the Medicaid Administrator and MCOs were coded and examined using thematic analysis.

3. Results

The following section presents information about extensions approved under the 1115 (a) demonstration amendment, as well as qualitative data on perceived flexibilities provided through the amendment. Supplemental findings are provided in Appendix B.

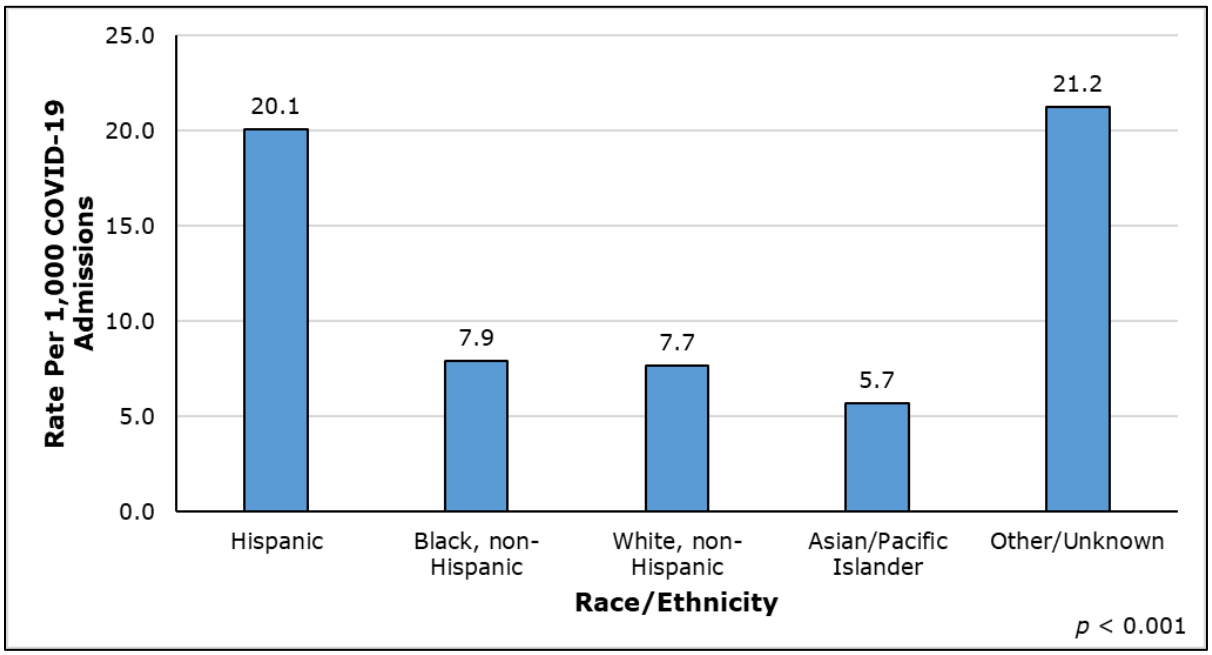
Extensions of the 30-Day Limitation

Number of Extensions (Measure 1.1.1)

There were 51,873 Medicaid clients subject to the 30-day SOI limitation who had an inpatient admission associated with COVID-19 during the PHE. Of those, 904 (1.7%) Medicaid clients received a 30-day SOI extension under the 1115 (a) demonstration amendment. However, many clients had more than one inpatient admission associated with COVID-19 during the PHE. In total, there were 59,149 COVID-19-related inpatient admissions subject to the 30-day SOI limitation during the PHE. Of those, 906 admissions (1.5%, or 15.3 per 1,000 COVID-19 related admissions) received an SOI extension. The remainder of results on the 30-day SOI extensions are summarized per admission, rather than per individual, as extensions were granted at the admission level.

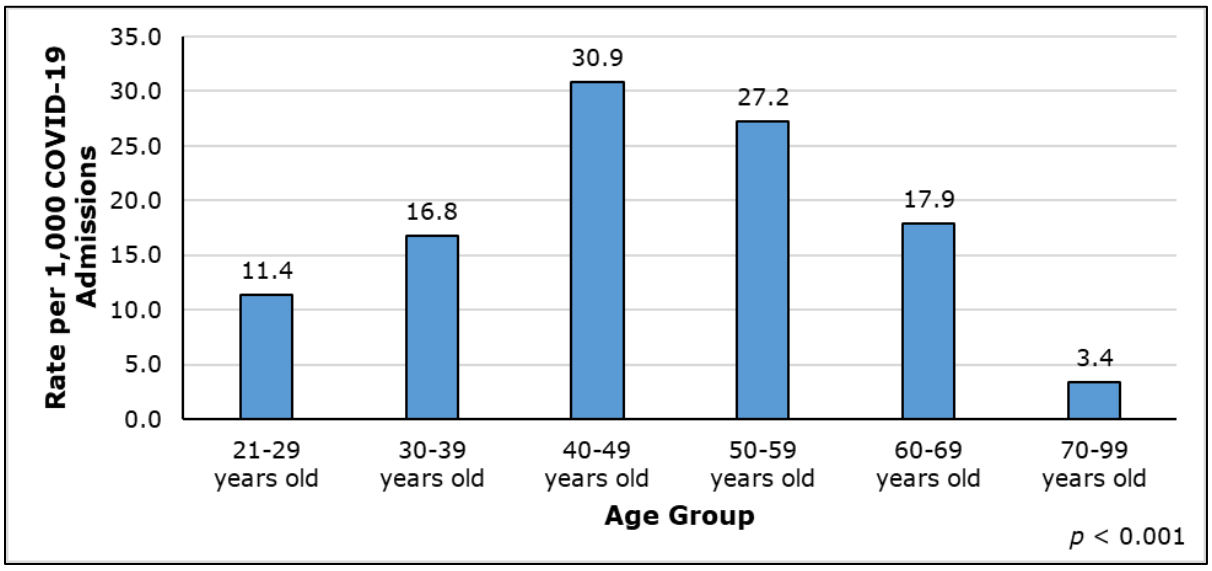
Inpatient admissions that received a 30-day SOI extension were most common among males between the ages of 50 and 69 years old receiving services through FFS. However, these findings primarily reflect the underlying population of clients who had an inpatient hospitalization for COVID-19 during the PHE. Admission rates also differed across race/ethnicity and age. Clients whose race/ethnicity was Hispanic or Other/Unknown were almost three times more likely to receive a 30-day SOI extension than other racial/ethnic groups (see Figure 1). Further, clients between the ages of 40 to 49, or 50 to 59, were more than twice as likely to receive an SOI extension than clients of other age groups (see Figure 2**Error! Reference source not found.**).

Figure 1. 30-Day SOI Extension Rate Per 1,000 Inpatient Admissions, by Race/Ethnicity



Notes: Rates are standardized within specific racial/ethnic groups (i.e., for every 1,000 inpatient admissions for Hispanic clients, 20.1 of those inpatient admissions received a 30-day SOI extension). Rates only include admissions subject to the 30-day SOI limitation (admission for clients in FFS, STAR Health, or STAR+PLUS, aged 21 and older). Figure reflects client demographic characteristics during the month and year of the inpatient admission.
Source: 8-Month Eligibility File (Office of Data Analytics and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).
Prepared by the Office of Data, Analytics, and Performance, HHSC.

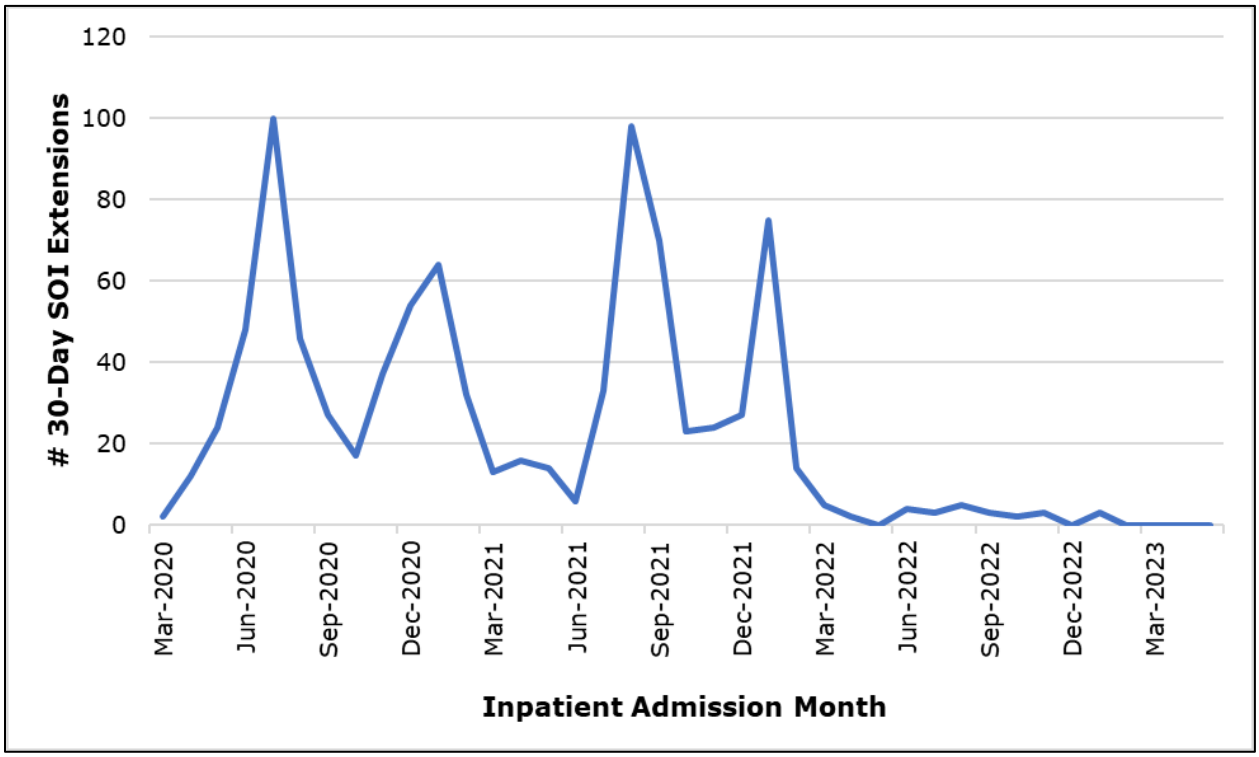
Figure 2. 30-Day SOI Extension Rate Per 1,000 Inpatient Admissions, by Age Group



Notes: Rates are standardized within specific age groups (i.e., for every 1,000 inpatient admissions for clients aged 21 to 29 years old, 11.4 of those inpatient admissions received a 30-day SOI extension). Rates only include admissions subject to the 30-day SOI limitation (admission for clients in FFS, STAR Health, or STAR+PLUS, aged 21 and older). Figure reflects member demographic characteristics during the month and year of the inpatient admission.
Source: 8-Month Eligibility File (Office of Data Analytics and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).
Prepared by the Office of Data, Analytics, and Performance, HHSC.

The number of inpatient admissions that received an SOI extension varied over time, and generally corresponded with the waves of the pandemic, as shown in Figure 3. More specifically, the number of admissions receiving an SOI extension peaked during COVID-19 summer surges in 2020 and 2021, and again during flu seasons. Very few SOI extensions occurred after March 2022, and the last SOI extension was issued in January 2023. The number and percentage of 30-Day SOI extensions per month are provided in Appendix B.

Figure 3. Number of 30-Day SOI Extensions per Month, March 2020 to May 2023



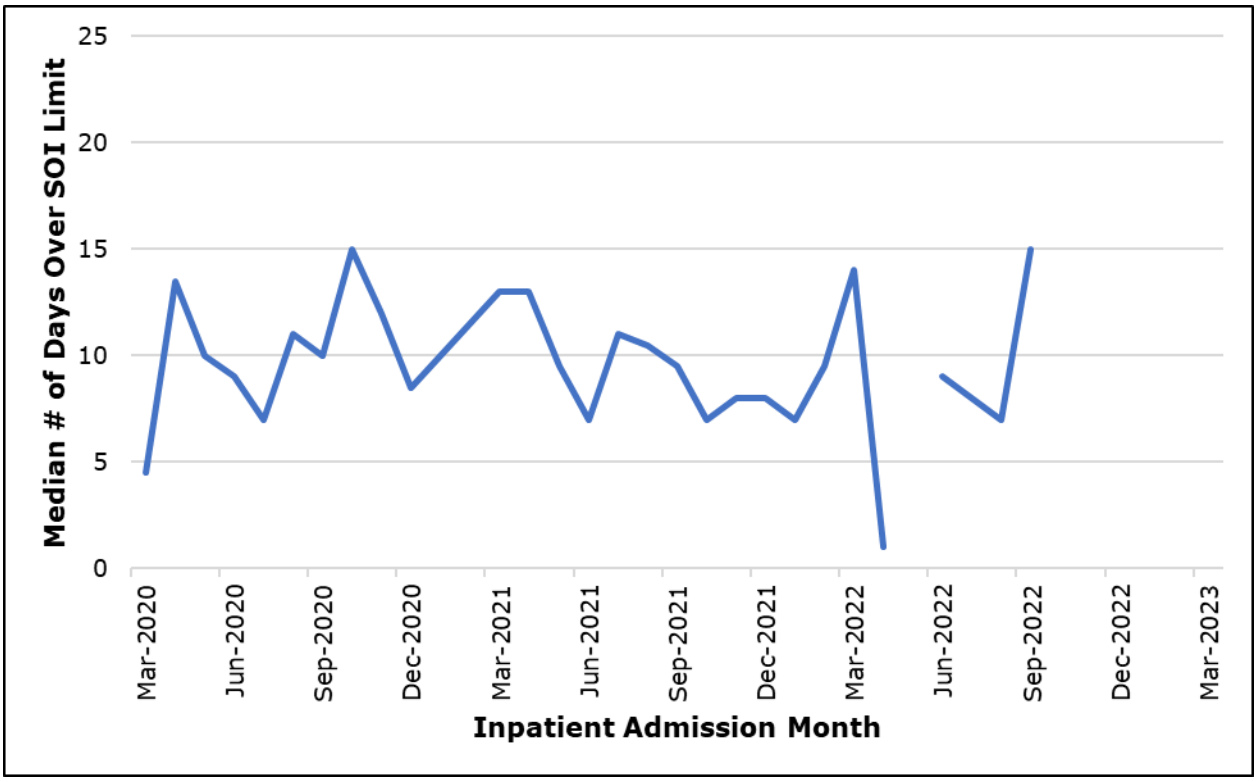
Notes: Figure reflects month and year of the inpatient admission for the 906 inpatient admissions that exceeded the 30-day SOI limitation. The last SOI extension was approved January 2023.
Source: 8-Month Eligibility File (Office of Data Analytics and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).
Prepared by the Office of Data, Analytics, and Performance, HHSC.

Length of Extensions (Measure 2.1.1)

Among the 906 inpatient admissions exceeding the 30-day SOI limitation, the median number of additional inpatient days paid was 10.0.[e] The median number of additional inpatient days paid remained relatively consistent across the PHE, as shown in Figure 4. No differences were found in the number of additional days paid across key subgroups. Additional information can be found in Appendix B.

[e] The evaluation design specified that Measure 2.1.1 summarize total days across all admissions within the SOI episode that exceeded the 30-day limit. However, not all admissions within a single SOI episode may have been subject to, or eligible under, the 1115(a) demonstration. As a result, counts across all admissions within a single SOI episode are not an accurate reflection of the flexibility provided by this amendment. Instead, DAP summarized the additional number of inpatient admission days granted through the 1115(a) demonstration.

Figure 4. Median Number of Days Over SOI Limit by Month of Admission, March 2020 to March 2023



Notes: Figure reflects median number of additional inpatient days paid across entire SOI episode, per month of admission. Month of admission reflects the month during which there was in inpatient admission that exceeded the 30-day SOI limit. Inpatient admissions during prior months may have contributed to 30-day SOI limit. Except for October 2022, months without data reflect months during which there was no inpatient admission that exceeded the 30-day SOI limit. Data for October 2022 was excluded because the median value for that admission month was highly influenced by a single outlier (SOI episode spanning approximately 200 days).
Source: 8-Month Eligibility File (Office of Data, Analytics, and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).
Prepared by the Office of Data, Analytics, and Performance, HHSC.

Extensions of the $200,000 Annual Limitation

Number of Extensions (Measure 1.2.1)

There were 37,413 Medicaid clients subject to the $200,000 annual inpatient hospital benefit limit who had an inpatient admission associated with COVID-19 during the PHE. Of those, only 10 Medicaid clients (<0.5%) exceeded the $200,000 annual benefit limit. The number of $200,000 annual inpatient benefit limit extensions per month are provided in Appendix B.

Clients that exceeded the $200,000 annual benefit limit were most commonly male, Hispanic, and between the ages of 40 and 49 years old. Additionally, all clients who exceeded the $200,000 annual benefit limit were enrolled in FFS. Additional demographic breakdowns are not provided due to the limited number of clients who exceeded the annual benefit limit.

Cost of Extensions (Measure 2.1.2)

The average (median) paid amount for all billed services per inpatient admissions among clients who exceeded the $200,000 annual benefit limit was $247,657.37.[f] This reflects $47,657.37 additional inpatient coverage per year, on average. The highest amount paid in a single year among clients who exceeded the benefit limit was $473,148.08 ($273,147.08 additional coverage). The lowest annual amount paid was $204,772.79 ($4,772.79 additional coverage). The total paid amount among most clients who exceeded the $200,000 annual benefit limit (8 out of 10) was between $200,000 and $300,000. A summary of annual amounts paid per month are provided in Appendix B.[g]

[f] Inpatient admissions that exceeded the $200,000 annual benefit limit must have been associated with COVID-19 to be approved under the 1115 (a) demonstration. However, all inpatient admissions during the year, including those not associated with COVID-19, counted towards the annual benefit limit. As such, total annual costs reflect all qualifying inpatient admissions, not just those associated with COVID-19.

[g] The evaluation design specified that Measure 2.1.2 summarize trends in annual costs for clients who exceeded the $200,000 annual benefit limit. However, given that only 10 members exceeded the $200,000 annual benefit limit, occurring during eight non-consecutive months, descriptive trend analysis was not feasible.

Administrative Impact of the Amendment

Key findings from interviews with MCOs and a Medicaid Administrator are provided below. Appendix B also provides an extended summary of feedback, summarized across the main themes.

Impact of Extensions on Client Care (Measures 2.1.3 and 2.1.4)

MCO representatives indicated that extending the 30-day SOI limitation benefitted members. They reported that the amendment supported the capacity of hospitals and providers to provide needed medical care and reduced members' anxiety about losing inpatient coverage due to extended treatment for COVID-19. MCOs did not report that the amendment impacted members' access to medically needed care, but one MCO explained that the amendment improved members' access to rehabilitation services and transplants. Rehabilitation might be needed after being on ventilators or intubated for many days due to COVID-19, and the amendment allowed for access to rehabilitation without a risk of non-payment to providers. This representative discussed their observations:

"Because we know that these members who had COVID that were on ventilators and intubated for a week or two weeks, that their bodies had severely deconditioned and needed intensive therapy, so I think it allowed members to be able to receive acute inpatient rehab treatment at their hospital setting without the risk of non-payment, so I think that was a huge impact to those members."

A representative from an MCO discussed how the amendment may have allowed for more thorough attention to the care and services members needed:

"I think it helped the relationship between the health plans that are trying to pay for the care, the facilities that are trying to provide the care, in making sure the member has the best possible outcome and appropriate time for discharge planning. Because some of these members required a lot of intense outpatient follow-up – nebulizers, oxygen – and I think it helped give folks breathing room to make sure they had everything in place."

Another representative from an MCO suggested that the amendment's coverage of care could have reduced anxiety among members:

"When you're not covered and your benefits are exhausted, there is still a lot of anxiety, all of that I think just dissipates because you're covered, your stay is covered. I feel like from a member perspective, this has to be a significant relief to them."

Only one MCO interviewed served STAR Health members, for whom the amendment also waived the $200,000 inpatient hospital benefit limitation. The representative from this MCO noted that the impact of waiving the $200,000 inpatient hospital benefit was limited because the STAR Health population is less medically complex, and therefore had less need for the extension.

Process-Related Changes (Measure 2.1.5)

HHSC's Process for Implementing the Amendment

The most prominent change required by HHSC to implement the amendment was the development of an internal review process to evaluate requests to extend SOI limitations, which are determined on a case-by-case basis. HHSC developed the following process for all requests to extend SOI limits:

1. MCOs submitted SOI extension requests to HHSC's Medical Benefits Team, who completed the initial review and collected required information from MCOs.
2. Extension requests were then reviewed by experts across three units: the Office of the Medical Director, Office of Policy, and Managed Care Compliance and Operations to determine whether COVID-19 is a contributing factor to the prolonged hospital admission.
3. Based on internal reviews, HHSC determined whether to approve the request to exceed the SOI limitations.
4. HHSC informed MCOs of the determination reached.

MCO Process for Implementing the Amendment

MCO representatives indicated they already had processes to track members exceeding SOI limitations prior to the amendment. As a result, minimal process adjustments were needed.

A minor adjustment in MCO processes was tracking which members had COVID-19 diagnoses. An MCO representative said that they maintain a list of diagnostic codes that are eligible for exemption or extension of the typical SOI limits, and they simply added COVID-19 codes to this list and then followed their procedures that were already in place to determine whether to submit a request for an extension of the inpatient stay. An MCO representative stated:

> *"When we get a request for an authorization for an inpatient stay, we are generally looking at driving diagnosis to see what the member is being admitted for as we review for medical necessity. That part didn't really change."*

Another process change was the submission of extensions to HHSC for review. MCOs were required to identify members approaching SOI limitations and submit extensions, when applicable, to HHSC for review on a case-by-case basis. Additionally, MCOs developed processes to ensure that approved extensions of SOI limitations were tracked in their system and shared with the hospital or provider requesting the inpatient stay.

MCO representatives were not aware of any impact of the amendment on hospital processes. All MCO representatives reported that the adjustments they made to implement this amendment were successful and that the process to receive determinations for SOI limit extensions from HHSC was smooth and efficient.

Impact of the Amendment on Costs (Measure 2.2.1)

All interviewees agreed that the amendment increased Medicaid funding available for MCOs to reimburse hospitals and providers for inpatient admissions related to COVID-19.

The Medicaid Administrator indicated that due to the amendment, HHSC paid more to MCOs for medical care for the patients who would have otherwise exceeded SOI limitations. The MCO representatives confirmed this, noting that the cost of member care increased during the PHE and the amendment resulted in greater payments to providers and hospitals for patients who had their SOI limitations extended due treatment for COVID-19. In the absence of the amendment, these claims would not have been covered by Medicaid. According to one MCO representative:

"The cost for some of these long-term hospital admissions…did increase. … [I]n the way the SOI limits the exposure to the health plan for really long stays, with the extension, this resulted in longer stays being approved, some of that would trigger outlier costs…. So, we did see more, higher cost cases come through for members as a result of the extension."

Some MCO representatives discussed the amount that was paid out for members whose length of stay was approved for an extension. For example, one MCO reported that they had 71 patients whose SOI limitation extensions were approved to exceed 30 days, resulting in an additional $1.7 million in payments to providers for the time spent beyond 30 days.

Although MCO representatives were not able to speak to the impact of the amendment on hospital finances, they reported that hospitals and providers also benefitted from increased Medicaid reimbursement available through the amendment. Prior to the amendment, providers were at risk of incurring the costs of long-term COVID-19 care without payment. An MCO representative said:

"I would say it helped hospitals… I knew hospitals were filling up with people on ventilators, and if there wasn't some type of an exception for them, they [hospitals] would be incurring a lot of costs and expense without an opportunity to recoup any of that. I think it helped avoid that additional cost for them."

Another MCO representative said:

"[W]hen they [hospitals/providers] were working with very sick members like this and the days were added, they didn't have to worry about, oh what are we going to do, we aren't going to get payment, these members are still very sick and coming up on the 30 day limit, we're needing to plan for their transition of care, things like that. It just helped on the provider side to have these additional days added."

The representative from the MCO that served both STAR+PLUS and STAR Health members noted that the increases in length of stay and member care costs were most evident among STAR+PLUS members, who are more medically complex than STAR Health members.

4. Limitations

The results of the evaluation should be interpreted alongside several key limitations. First, DAP had to rely on several administrative data sources to identify COVID-19-related inpatient admissions, including those that received an extension through the COVID-19 1115(a) demonstration. These data were designed for billing or policy tracking purposes rather than the purposes of this study, and therefore are subject to several drawbacks, such as data lags, data errors, and reporting inconsistencies. For example, demographic characteristics slightly varied across files, creating discrepancies when exploring subgroup differences in rates of 30-day SOI extensions.

Second, very few individuals exceeded the $200,000 annual benefit limit. DAP provided an overview of these individuals, but significance testing and subgroup analyses could not be performed on these measures.

Third, interviews were held virtually via Microsoft Teams due to ongoing impacts of the PHE, and cameras were not used. A limitation of this format is that non-verbal signals such as facial expressions and body language are missed (Saarijärvi & Bratt, 2021). Furthermore, interviewees only included one Medicaid Administrator at HHSC and MCO representatives. Feedback on downstream impacts to hospitals and Medicaid members was thus speculative or secondhand based on what was communicated to the interviewees.

Lastly, findings on administrative impacts may be susceptible to common threats to validity among qualitative methods, such as recall bias and social desirability bias. Interviewees' accounts of both past and current events may have been biased due to mood or emotional state at time of interview, inaccurate memories, or priming by interviewers (Polkinghorne, 2005). Additionally, DAP asked interviewees to recall experiences during the six-month period of the PHE before the amendment was approved (and retroactively implemented). The validity of conclusions drawn from this analysis are dependent on interviewees' abilities to accurately remember details prior to the amendment's approval, which was nearly a year and a half before the interviews. DAP attempted to reduce potential biases by using contextual reminders where appropriate and standardizing interview protocols.

Despite these limitations, the evaluation provides insight into the scope and impact of the COVID-19 flexibilities granted under this amendment.

5. Conclusion

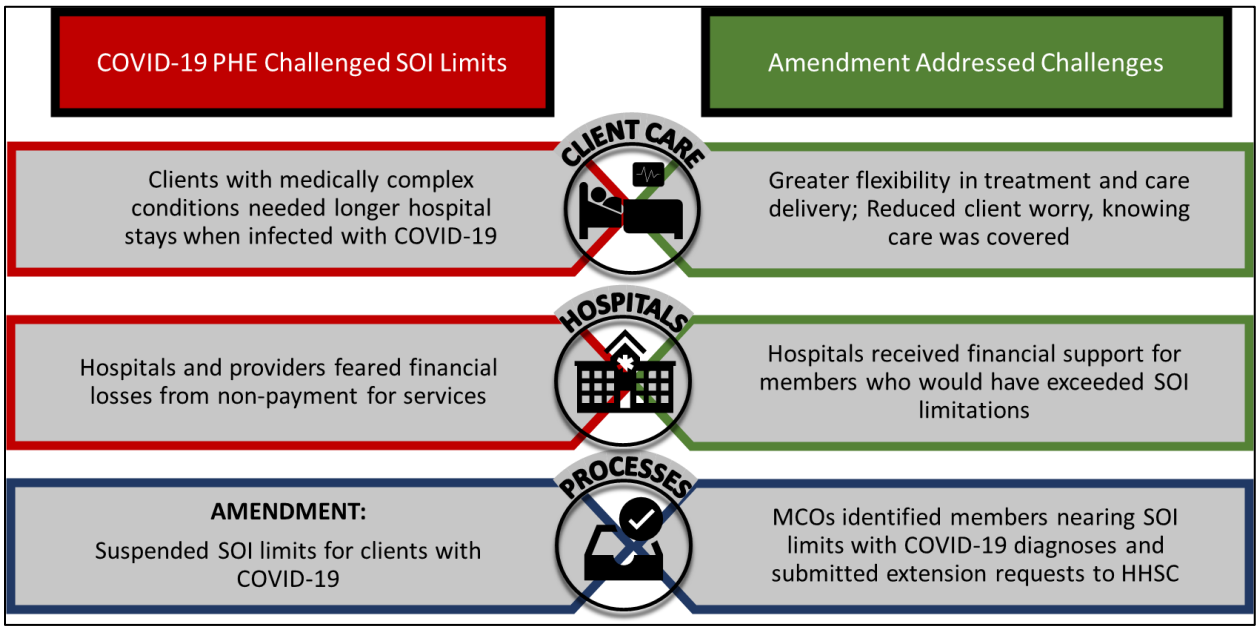
The evaluation of the COVID-19 1115(a) demonstration addressed two overarching questions: 1) What challenges did the PHE pose to hospitalization limits, and 2) How did the amendment help address those challenges?

According to HHSC and MCO staff, hospitalization limits were of particular concern during the PHE due to increased hospitalizations and longer hospital stays associated with COVID-19 complications, especially for those with complex medical conditions. Collectively, these challenges resulted in fewer available hospital beds, concerns about quality of care, and fears of financial losses for hospitals providing additional care to the Medicaid and low-income uninsured populations.

The COVID-19 1115(a) demonstration addressed these concerns by providing additional Medicaid coverage for inpatient admissions associated with COVID-19. In total, 906 inpatient admissions (across 904 individuals) received a 30-day SOI extension, and 10 individuals exceeded the $200,000 annual benefit limit. On average, these extensions provided approximately 10 additional days of coverage per admission, and $47,657.37 additional inpatient coverage per year, respectively.

HHSC and MCO staff indicated that the COVID-19 1115(a) demonstration provided greater flexibility to treat individuals, increased financial support to MCOs and hospitals, and may have reduced stress related to coverage uncertainty among hospitalized individuals. Figure 5 provides an overview of challenges faced by the hospitalization limits during the PHE, as well as how this amendment addressed those challenges.

Figure 5. Summary of Challenges Addressed by the COVID-19 1115(a) Demonstration



Collectively, these findings support the hypotheses that there was an increased need to exceed hospitalization limits due to COVID-19 related complications, and the COVID-19 1115(a) demonstration helped address those challenges by providing greater flexibility to treat complex cases in hospital settings, improving client care, and reducing the financial burden on hospitals.

Appendix A. Administrative Interviews

Interview Process

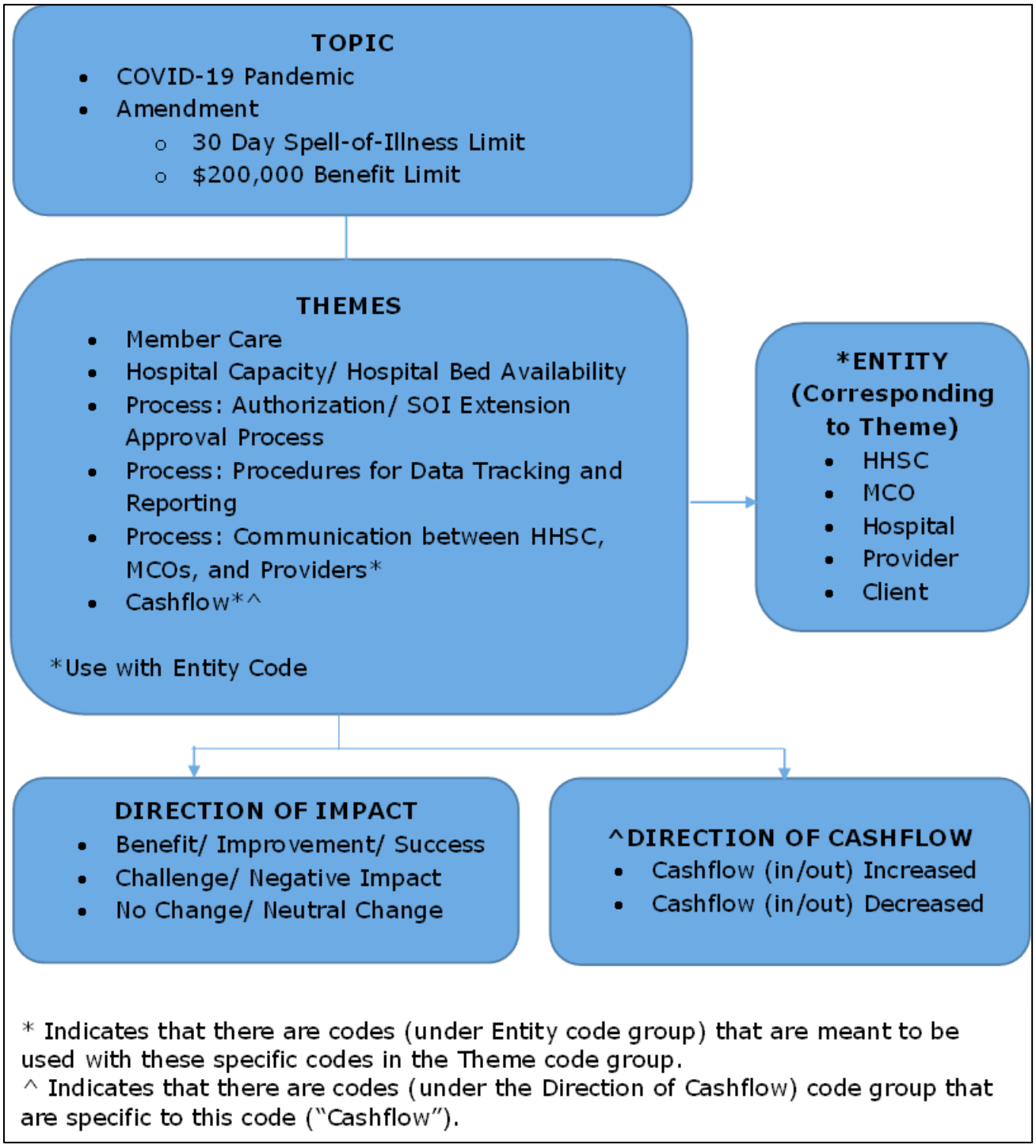
DAP conducted a virtual one-on-one interview with an HHSC Medicaid Administrator in December 2021, and virtual group interviews with four MCOs (ranging from 3-16 individuals per MCO) between February and March 2022. The HHSC Medicaid Administrator was selected based on their knowledge and familiarity with the administrative and financial aspects of Medicaid inpatient hospital stays. The MCOs selected represented large organizations that covered members in several managed care service areas, providing sufficient representation of STAR+PLUS and/or STAR Health members across the state. MCO selections were reviewed internally by the Managed Care Contracts and Oversight (MCCO) unit within HHSC Medicaid & CHIP Services (MCS).

Each interview was held for approximately 30-45 minutes. Three DAP staff attended each interview, one interviewer and two note takers. The interviewer was the same across all sessions, and the two note taking roles rotated among three individuals. Individual notes were collated into a single document for each interview. DAP coded interview notes using thematic analysis, which is a qualitative method used to identify themes and patterns across interviews while capturing the richness and complexity of the data (Vaismoradi, Turunen, & Bondas, 2013). This analytical method was used to identify patterns in how interviewees discussed impacts of the PHE and amendment on member care, processes and procedures, and distributions of costs.

Coding Structure

DAP developed codes to categorize the context (e.g., PHE, SOI Limitations, and the amendment), theme (e.g., member care, process changes, cashflow), entity, and direction of impacts, if any, of feedback provided. Further details on the coding structure can be found in Figure 6.

Figure 6. Final Coding Structure for HHSC and MCO Interviews



Appendix B. Supplemental Findings

Extensions of the 30-Day Limitation

Table 2. Inpatient Admissions with SOI Extension (Measure 1.1.1)

Demographic Characteristic	Inpatient Admissions Subject to Limitation[1]	% of Inpatient Admissions Subject to Limitation	Inpatient Admissions with SOI Extension	% of Inpatient Admissions with SOI Extension	Rate Per 1,000 COVID-19 Admissions
Sex*[2]	--	--	--	--	--
Male	34,114	57.7%	485	53.5%	14.2
Female	25,023	42.3%	417	46.0%	16.7
Not Reported	12	0.02%	4	0.4%	N/A[3]
Race/ Ethnicity* **	--	--	--	--	--
Hispanic	26,628	45.0%	534	58.9%	20.1
White, non-Hispanic	12,900	21.8%	99	10.9%	7.7
Black, non-Hispanic	9,121	15.4%	71	8.0%	7.9
Asian/Pacific Islander	1,404	2.4%	8	0.9%	5.7
Other/Not Reported	9,096	15.4%	193	21.3%	21.2
Age* **	--	--	--	--	--
21-29 years old	4,298	7.3%	49	5.4%	11.4
30-39 years old	5,609	9.5%	94	10.9%	16.8
40-49 years old	5,831	9.9%	180	19.9%	30.9
50-59 years old	10,296	17.4%	280	30.9%	27.2
60-69 years old	12,949	21.9%	232	25.6%	17.9
70-99 years old	20,166	34.1%	68	7.5%	3.4
Unknown	N/A	N/A	3	0.3%	N/A[3]
Medicaid Program*[2]**	--	--	--	--	--
FFS	42,414	71.7%	587	64.8%	13.8
MMC	16,735	28.3%	319	35.2%	19.0
TOTAL	**59,149**	**100%**	**906**	**100%**	**15.3**

Notes. Table reflects member demographic characteristics during the month and year of the inpatient admission. Differences in rates of admissions with an SOI extension were examined across subgroups using Chi-Square Tests of Independence. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

[1] Inpatient admissions subject to limitation and admissions with SOI extension were derived from different data sources, so there may be discrepancies in counts, especially among smaller subgroups (such as unknown age). [2] Statistically significant difference is likely driven by large sample size, as the effect size (Cramer's V) was small, suggesting differences offer limited practical application. [3] Rates per 1,000 admissions were not produced for subgroups with sample sizes too small to produce reliable estimates (less than 100 inpatient admissions subject to limitation).

Source: 8-Month Eligibility File (Office of Data Analytics and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).
Prepared by the Office of Data, Analytics, and Performance, HHSC.

Table 3. Number and Percentage of 30-Day SOI Extensions by Month of Admission (Measure 1.1.1)

Month of Admission[1]	# of Inpatient Admissions with SOI Extension	# of COVID-19-Related Admissions	% of Admissions with SOI Extension
March 2020	2	786	0.3%
April 2020	12	649	1.8%
May 2020	24	678	3.5%
June 2020	48	1,831	2.6%
July 2020	100	4,834	2.1%
August 2020	46	2,829	1.6%
September 2020	27	1,614	1.7%
October 2020	17	1,970	0.9%
November 2020	37	2,829	1.3%
December 2020	54	4,002	1.3%
January 2021	64	4,452	1.4%
February 2021	32	1,907	1.7%
March 2021	13	967	1.3%
April 2021	16	772	2.1%
May 2021	14	572	2.4%
June 2021	6	373	1.6%
July 2021	33	1,114	3.0%
August 2021	98	3,311	3.0%
September 2021	70	2,587	2.7%
October 2021	23	1,083	2.1%
November 2021	24	649	3.7%
December 2021	27	1,675	1.6%
January 2022	75	5,843	1.3%
February 2022	14	1,820	0.8%
March 2022	5	462	1.1%
April 2022	2	182	1.1%
May 2022	0	271	0.0%
June 2022	4	843	0.5%
July 2022	3	1,663	0.2%
August 2022	5	1,363	0.4%
September 2022	3	792	0.4%
October 2022	2	353	0.6%
November 2022	3	485	0.6%
December 2022	0	1,098	0.0%
January 2023	3	1,074	0.3%
February 2023	0	622	0.0%
March 2023	0	438	0.0%
April 2023	0	317	0.0%

Month of Admission[1]	# of Inpatient Admissions with SOI Extension	# of COVID-19-Related Admissions	% of Admissions with SOI Extension
May 2023	0	39	0.0%
Total Admissions	**906**	**59,149**	**1.5%[2]**

Notes. Table reflects month and year of the inpatient admission for the 906 inpatient admissions that exceeded the 30-day SOI limitation

[1] Month of admission reflects the month during which there was in inpatient admission that exceeded the 30-day SOI limit. Inpatient admissions during prior months may have contributed to 30-day SOI limit. [2] The percentage reflects the total number of admissions with an SOI extension among all COVID-19 related admissions.

Source: 8-Month Eligibility File (Office of Data, Analytics, and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).

Prepared by the Office of Data, Analytics, and Performance, HHSC.

Table 4. Average Days per SOI Extension (Measure 2.1.1)

Demographic Characteristic	# of Inpatient Admissions with SOI Extension	Mean Additional Days Needed	Median Additional Days Needed	Standard Deviation
Sex	--	--	--	--
Male	485	13.9	10.0	18.8
Female	417	12.9	10.0	15.1
Not Reported	4	13.8	14.5	9.3
Race/Ethnicity	--	--	--	--
Hispanic	534	12.0	9.0	11.4
White, non-Hispanic	99	15.6	8.0	23.4
Black, non-Hispanic	72	15.6	10.0	24.7
Asian/Pacific Islander	8	10.6	12.5	6.7
Other/Not Reported	193	15.8	12.0	22.3
Age	--	--	--	--
21-29 years old	49	14.1	11.0	18.0
30-39 years old	94	15.2	11.5	16.5
40-49 years old	180	13.7	10.0	15.4
50-59 years old	280	13.2	10.0	15.4
60-69 years old	232	13.3	8.0	21.8
70-99 years old	68	11.1	8.5	9.0
Unknown	3	12.7	12.0	11.0
Medicaid Program	--	--	--	--
FFS	587	12.1	10.0	10.7
MMC	319	16.0	9.0	24.8
TOTAL	**906**	**13.5**	**10.0**	**17.1**

Notes. Table reflects member demographic during the month and year of the inpatient admission. Differences in additional days needed were examined across subgroups using the Kruskal-Wallis test. No subgroup differences were statistically significant ($p > 0.05$).

Source: Source: 8-Month Eligibility File (Office of Data Analytics and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).

Prepared by the Office of Data, Analytics, and Performance, HHSC.

Extensions of the $200,000 Annual Limitation

Table 5. Number of, and Median Annual Costs for, $200,000 Annual Benefit Limit Extensions, by Month of Admission (Measure 1.2.1 and 2.1.2)

Month of Admission[1,2]	Number of Members	Median Paid Amount
November 2020	1	$274,745.03
April 2021	1	$302,746.99
August 2021	1	$226,959.97
September 2021	1	$260,981.57
October 2021	1	$269,848.43
December 2021	1	$204,772.79
January 2022	3	$234,333.17
December 2022	1	$214,738.32
Total	**10**	**$247,657.37**

Notes: Table reflects month and year of the inpatient admission for the 10 Medicaid clients that exceeded the $200,000 annual benefit limit. The percentage of members exceeding the $200,000 annual benefit limit per month was not calculated due to the small sample size.

[1] Only months with admissions that resulted in extensions to the $200,000 limit are included.

[2] Month of admission reflects the month during which there was in inpatient admission that exceeded the $200,000 annual benefit limit. Inpatient admissions during prior months may have contributed to the annual benefit limit.

Source: 8-Month Eligibility File (Office of Data, Analytics, and Performance Data Repository); FFS Claims (TMHP); HHSC SOI Request Tracker; MMC Encounters (TMHP).

Prepared by the Office of Data, Analytics, and Performance, HHSC.

Administrative Impact of the Amendment

Table 6. Summary of Feedback Provided by a Medicaid Administrator and MCO Staff During Interviews

Themes	Impact of COVID-19	Impact of Amendment

Member Care	• More members, particularly those with complex medical conditions, were at risk of exceeding the SOI limitations.
	• Exceeding SOI limitations was of particular concern for members needing rehabilitation services after a COVID-19-related illness and for patients needing to be evaluated for transplants.
		• The amendment did not impact delivery of medically needed care to members, but extending the 30-day SOI limit did support:
		  ○ Greater flexibility in treatment, planning, and delivery.
		  ○ Improved access to enhanced services, such as transplants or rehabilitation services.
		• Extending the 30-day SOI limit reduced worry and anxiety among members from knowing the costs of their care would be covered.
		• Waiving the $200,000 inpatient hospital benefit limit had little impact to clients subject to limitation (FFS and STAR Health), who are generally less medically complex than STAR+PLUS members (not subject to $200,000 annual benefit limit).

Themes	Impact of COVID-19	Impact of Amendment
Approval Process	N/A	• MCOs had to develop procedures for identifying members close to exceeding SOI limits so requests for extensions could be submitted to HHSC in a timely manner. • HHSC had to develop processes for receiving and reviewing requests for extending SOI limitations on a case-by-case basis, including establishing guidelines to determine whether COVID-19 was a contributing factor. • Extension requests were reviewed by three units within HHSC: the Office of the Medical Director, Office of Policy, and Managed Care Compliance and Operations. • After receiving approval from HHSC, MCOs had to indicate in their system that the individual received an extension to their SOI limits. This was one of the main process changes for MCOs.

Themes	Impact of COVID-19	Impact of Amendment
Data Tracking and Reporting	N/A	• Clinical experts at HHSC reviewed member records to determine if a member qualified for an extension based on whether a COVID-19 diagnosis contributed to the need for an extension. • MCOs already had processes in place for tracking members exceeding SOI limitations, but minor adjustments were made to identify members with COVID-19 diagnoses. • Hospitals sent MCOs member data related to SOI limitations daily. • Hospitals were not always aware of when members were approaching or exceeded SOI limitations since members may have transferred between facilities.
Communication	N/A	• The amendment increased communication between HHSC and MCOs regarding members exceeding SOI limitations. • MCOs informed hospitals of the determination made on requests for extending SOI limitations. • When a member was close to exceeding the SOI limit, MCOs submitted requests for extensions to HHSC with information such as the diagnosis and an explanation of the situation.

Themes	Impact of COVID-19	Impact of Amendment
Cashflow	• Hospitals risked not being able to recover payments for services rendered. Providers were providing services with fear of non-payment, and there was concern over the financial losses that hospitals might sustain. • Members were faced with the potential of incurring medical bills for claims that were not covered after SOI limitations were reached.	• HHSC distributed more reimbursement to MCOs for care to members who received SOI extensions. • MCOs distributed more money to providers for care to members who received SOI extensions. • Increased financial support helped hospitals and providers manage the strain of the PHE. • Members benefitted from not incurring costs of care if they exceeded SOI limitations. • MCOs did not identify any financial impacts of the amendment other than the additional cost of medical claims.

Source: HHSC and MCO Virtual Interviews (December 2021 to March 2022).
Prepared by the Office of Data, Analytics, and Performance, HHSC.

List of Acronyms

Acronym	Full Name
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus disease
DAP	Office of Data, Analytics, and Performance
FFS	Fee-for-Service
HHSC	Health and Human Services Commission
MCO	Managed Care Organization
MCCO	Managed Care Contracts and Oversight
MCS	Medicaid & CHIP Services
MMC	Medicaid Managed Care
PHE	Public Health Emergency
SOI	Spell of Illness
STAR	State of Texas Access Reform
TMHP	Texas Medicaid and Healthcare Partnership

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