	QUESTIONS	RESPONSE
1	HHSC is allowing "a 3-month run-out period for encounters." However, a three month run out may not be enough time to allow for all required steps. a. 90 days for provider to submit claims b. 30 days for MCO to process claim c. 30 days to submit encounter record after claim is paid d. 120 days for provider to appeal a claim We recommend 6 months of runout to allow for more complete reporting and prevent rework.	**We will review this information.**
2	[MCO] administers UHRIP based on admission date of inpatient claims. The proposed changes suggest that HHSC will administer based on discharge date. This change may cause for duplicative payment to hospitals in the period when this reporting transition occurs.	**Researching**
3	Currently, hospitals are eligible for UHRIP from MCO if they are contracted with the MCO and if they are geographically located within the MCO's service delivery area. Please confirm these requirements will continue under the proposed changes. Without these requirements the administrative effort for MCOs will be substantially increased.	**Confirmed**
4	Will the encounter flag (noting whether the claims line is eligible for a UHRIP increase) continue to be a requirement under the proposed changes? The proposed changes should specify the encounter submission requirements for the MCO.	**Yes, the encounter flag will continue to be a requirement.**
5	The Proposed changes should specify which lines of business are eligible for UHRIP. Currently, STAR and STAR Plus are eligibility. Will other lines such as STAR Kids, be included under the proposed changes.	**HHSC is proposing to add the STAR Kids line of business to be eligible for UHRIP.**
6	Please confirm that the MCO's will continue to receive a 2.5% administrative fee under the proposed changes.	**This topic is under evaluation.**
7	Will HHSC determine Hospitals performance in the quality outcome criteria or will the MCO determine? The Proposed Changes should clarify who has this responsibility.	**HHSC intends to determine quality performance.**
8	If claim run out occurs six months after a quarter ends, but claim adjustments can occur with 24 months of a paid date, how will those claims be assessed?	**HHSC is evaluating how adjustments that impact final payment may need to be handled. However, since the proposal is for a uniform dollar based on an encounter, adjustments affecting only the paid amount would not have an impact. If entire claims are denied, then there might be an adjustment.**

	QUESTIONS	RESPONSE
9	Will the UHRIP reimbursement be built into the MCO's monthly capitation rates or will there will be a separate funding mechanism? If built into the MCO monthly capitation rates, will there be an opportunity to reconcile payments versus premiums?	**The UHRIP reimbursement will not be built into the MCO's monthly capitation rates. A proxy rate will be developed for the rate certifications, but no payments will be made based on them. Rate Analysis will calculate the payments to MCOs based on submitted encounters and those payments will be made through a separate funding mechanism. After all payments have been made, the rate certifications will be amended to reflect actual payments.**
10	Will UHRIP apply only to hospitals that are contracted with the MCOs in question? Hospitals located in SDAs in which the MCO is contracted, or without those restrictions?	**UHRIP will apply only to in-network encounters.**
11	We have a question about HHSC's proposed basis for calculating hospitals' uniform dollar increase under UHRIP 2.0. The attachment HHSC provided indicates that the uniform dollar increase will be applied to encounters, with inpatient encounters based on discharge date. Assuming a patient is discharged after a 5 day inpatient stay and the uniform dollar increase is $100, will HHSC apply the uniform dollar increase to each day of the five-day stay (resulting in a $500 UHRIP payment) or will HHSC apply the uniform dollar increase on the encounter without regard to the length of the stay (resulting in a $100 UHRIP payment)?	**HHSC proposes that the increase be based on encounter, regardless of length of stay.**
12	We have worked with several providers who have undergone changes of ownerships (CHOW's) in which they accepted the Medicare contract assignment and retained their Medicare provider number; however, it has taken up to 7 months to obtain their new Medicaid TPI due to delays in TMHP processing. In both cases, we have seen Medicaid Managed Care payors either not honor/pay on claims effective on the CHOW date or delay claims processing until the new owner TPI's are assigned. Some Medicaid Managed Care payors only honor claims with service dates as of the date the CHOW was approved by TMHP (and not back to the effective date of the CHOW)! These delays and/or non-payments by Medicaid Managed Care payors threaten to significantly harm provider UHRIP payments for providers who undergo CHOW's.	**We will attempt to take this scenario under advisement.**
13	Will there be any special consideration or assistance given to hospitals who are experiencing CHOW's so as to prevent a loss of UHRIP payments? Given that Medicaid Managed Care payors are not bound by any TAC regulations to honor CHOW effective dates and quickly onboard providers, I believe special consideration should be given to providers who undergo CHOW's. These significant delays or outright non-payments of Medicaid Managed Care payments are difficult enough for small, rural providers; additional penalties in the form of UHRIP underpayments would simply add insult to injury for hospitals trying to survive in an already difficult environment.	**We will attempt to take this scenario under advisement.**
14	The change to a lump-sum retroactive based payment and the IGT at the time of payment should be well accepted and great for the industry as a whole to follow historical supplemental payment methods. Can the pay-to-play be avoided, if a public does not IGT? Will all payments be required to be haircut if all IGT is not received within the SDA?	**HHSC anticipates that a lack of IGT will result in a decrease across the SDA.**
15	This will require the use of relative weights of the claims to calculate the acuity of the service provided, will the state assign the relative weight or have the MCO include?	**Through the proposed method, HHSC does not anticipate taking into account acuity.**

	QUESTIONS	RESPONSE
16	Does the state intend to run MCO claims through TMHP to have the correct DRG applied? How will the various MCO payment methods be converted to an SDA (i.e. Per diem, RCC, contracted rate, etc.)	**The dollar increase is a flat amount; it does not require or use DRG or relative weight for the calculation of payments. To illustrate, if the provider has 10 claims and the increase is $5.00 per claim then there will be UHRIP payment of $50.00.**
17	This dollar increase appears to be related to inpatient claims, how will the outpatient claims be accounted for with the dollars amount increase? The outpatient claims payments are derived in a RCC or a specific rate for the service? Will the outpatient claims still be based on a percentage increase?	**Outpatient claims will be based on encounters by date of service.**
18	"Medicaid managed care shortfall is defined as using only the managed care portion of the Medicaid shortfall to allocate the pool to hospital classes" – This method appears to be a reduction of payments potentially for the hospitals that have a substantial amount of traditional Medicaid claims due to the patient becoming Medicaid eligible during the admission. This would seem to harm large publics that may have a significant first admission as low income or indigent. This may reduce the overall dollars available to all hospitals, correct?	**If the overall pool size is linked directly to the allocation method, then the supposition is correct.**
19	"Payment methodology shortfall" – Will this method be based on SDAs or based on the individual TEFRA rate to determine the cost? Will there be an inflation factor be applied to the cost based on the last rebasing or is the cost considered flat? Will the current payment rate be determined based on the current SDA?	**This methodology would be based upon the SDA, which is limited by available appropriations and is not updated to account for cost growth. We would calculate the SDA as though it were not appropriation limited and included cost growth since the last time rates were established. Inflation can and should be applied. Yes, the current payment rate will be based on the current SDA.**
20	The dollar amount appears to potentially have a positive impact for rural hospitals, since there cost based rates have the oldest rebasing time-frame. Will their cost based rates be adjusted for the hospitals that were held to a floor and cap? Many of the rurals are held to outdated contracts that pay the lesser of SDA or cost to charges, how will dollar difference be determined if the MCO are holding them to a cost of charges and not paying the full SDA?	**The additional payment is a flat dollar increase and is a payment based on the number of encounters, not the contract rate payment.**
21	The dollar amount appears to harm the children's hospitals, since the majority of the hospitals received an SDA greater than their actual TEFRA rate. Will the TEFRA rate be used to determine their individual cost? IF TEFRA Rate is used how will the payments received above this rate be accounted for to avoid a false shortfall calculation?	**This methodology would be based upon the SDA, which is limited by available appropriations and is not updated to account for cost growth. We would calculate the SDA as though it were not appropriation limited and included cost growth since the last time rates were established. We won't use the current TEFRA rate, we will follow the method mentioned previously.**
22	Achieve a quality outcome or positive policy change by linking it to a portion of the pool – Although the use of quality outcomes to increase payment follows the legislative direction for quality based payment, will there be any reduction to payments for low performers?	**HHSC doe not anticipate reductions for low performers, but the overall structure will depend on the quality outcome. For instance, HHSC could say that there would be a regular UHRIP pool that everyone can access, but an amount for high performers may be set aside. Alternatively, there could be an eligibility requirement that hospitals that are able to transmit ADT data must do so to receive any UHRIP funds.**
23	PPC / PPR is already used within the payments as a rate reduction and could be considered a duplicative measure.	**Understood, thank you.**

	QUESTIONS	RESPONSE
24	The remaining 2 quality measure may have merit, these should be address from clinical experts within the hospitals. The primary concern will be the increased HHSC administrative time to apply a quality payment structure which will likely have to be based on historical information versus live data. How will HHSC allow for appeals for negative outcomes? Has HHSC determine the overall percentage of the total UHRIP payments will be at risk for the quality measures?	**At this time, HHSC is not considering appeals for negative outcomes. However, HHSC is willing to listen to alternatives. As to the overall percentage attributable to the quality measures, it largely depends on the measure itself.**
25	HHSC's announcement states to follow a strict payment schedule, challenges to the accuracy of the MCO encounter data can't be submitted to HHSC. What are the plans to ensure MCOs are providing accurate data to HHSC throughout the quarter?	**HHSC's contracts with MCOs require accurate and timely reporting of encounter data, and we now have a UHRIP indicator that MCOs can use to flag eligible claims. In addition to the contract requirement to submit timely and accurate encounter data, HHSC has and continues to implement business edits that validates identified data elements to ensure submitted encounter data meets key state and federal program requirements. HHSC will also implement metrics and data analysis to ensure encounter data meets program requirements.**
26	What are the specific criteria for cases to be included in the UHRIP payment period? How will patients who had an encounter during the program period but whose claims have not yet been paid be handled?	**In-network encounters submitted by MCOs, that are not related to non-emergent ED use, and within the payment period, will be included.**
27	a. For the HIE proposal: What limitations would be in place for use of the data by the network, MCOs, and others?	**HHSC would not anticipate placing any further limitations on the use of data beyond that which the individual HIEs utilize.**
	1. Is there funding available to establish interconnectivity in areas without a HIE?	**If the questioner means to ask if there is funding for a hospital to connect to an HIE because of this program, the answer is no. However, HHSC is open to staggering payments to ensure that a payment occurs prior to a connection becoming functional. If the questioner means to ask if there is funding for a region to develop an HIE, Hospital Payments and Waiver Programs is currently unaware of such funding but will attempt to determine funding availability.**
	2.. How would this proposal overlap with HHSC's Emergency Department Encounter Notifications (EDEN) project?	**HHSC anticipates that it would coincide with the EDEN project.**
	b. For the antibiotic stewardship proposal, would the requirement be to have a program or something beyond that?	**HHSC is still reviewing the exact structure of such a program but anticipates that it would be modeled after the CDC's Core Elements of Antibiotic Stewardship.**
28	With the uniform dollar amount…will the dollar amount be the same for both inpatient and outpatient claims or will you do a dollar amount for Inpatient and a separate dollar amount for outpatient?	**HHSC proposes to determine a uniform dollar that is equal to both inpatient and outpatient.**
29	Can HHSC provide more information about the data sources and methodologies for each of the two proposed allocation methodologies?	**HHSC anticipates DSH/UC application template and 2018 claim and encounter data, to determine cost. That cost will be used to calculate a "proxy" state wide standard dollar amount with add-ons with inflation. These "proxy" rates will not be scaled for budget neutrality. Payments will be estimated based on the "proxy" rates and compared to payments estimated using current 2020 rates. The difference in the payments estimated using the unscaled rates and the payments estimated using the current rates will be the estimated SDA shortfall. The shortfall amount will be used as the basis for allocation.**
30	What time period is HHSC considering using for the calculation of the shortfall for the purposes of allocations?	**2018 claim and encounter data will be used, with inflation in the estimated rates described above.**

	QUESTIONS	RESPONSE
31	For the Payment methodology shortfall/Medicaid reimbursement methodology proposal, how would HHSC calculate what a payment "should be" (as referenced in the webinar slides) and how does this relate to the hospital's cost as determined the last time HHSC rebased (as referenced in the word document proposal)?	**Please see question / answer 19**
32	Will this (UHRIP reforms) apply only to hospitals that are contracted with the MCOs in question? Hospitals located in SDAs in which the MCO is contracted, or without those restrictions?	**HHSC proposes that only in-network encounters would be considered for UHRIP.**
33	HHSC has stated that it plans to use 2018 claim and encounter data to determine cost for both proposed shortfall methodologies. Will HHSC use adjudicated claims data from 2018, as it does for DSH? Or claims with discharge dates in the 2018 federal fiscal year? Or something else?	**The Medicaid shortfall allocation will use the Medicaid shortfalls from the recently completed 2020 DSH/UC Application with the PGY3 UHRIP adjustment removed. The rate shortfall calculation will be based on discharge date in SFY 2018.**
34	If a hospital appealed the prepopulated 2018 MCO data in the 2020 DSH application, and if HHSC grants the appeal, can HHSC confirm that it will use the resulting corrected data for purposes of the UHRIP shortfall calculation?	**The results of the appeals will not be incorporated in the data used for modeling both scenarios due to timing. However, in theory, appeals would be incorporated into the shortfalls used in an actual allocation calculation.**
35	If HHSC decides to use the Medicaid Managed-care-only shortfall calculation, will data from all MCOs be used? Or only data from the in-network MCOs from which the hospital will receive the UHRIP reimbursement increase?	**Currently HHSC is calculating the Managed-care-only shortfall using data from all MCOs because the only means to calculate the shortfall is using the MMIS data in the DSH/UC Applications. HHSC has no means of distinguishing what is in-network from what is not in the MMIS data.**
36	Will HHSC use data from all lines of service? Or only those eligible for UHRIP increases (*i.e* ., STAR, STAR Plus, proposed STAR Kids)?	**If this is in relation to the Medicaid MCO Shortfall calculation or the rate shortfall, HHSC currently plans to use data from all lines of service. Star-Health encounters could be carved out of the data if that is requested.**
37	Eligible encounters: HHSC has indicated that in-network encounters "submitted by MCOs . . . and within the payment period" will be included in the payment calculations for that period. Does that mean that the encounter: a. Must be for: (1) An IP claim with a discharge date in the payment period; or (2)) An OP claim with dates of service in the payment period; AND b. Must have been adjudicated by the MCO and submitted to HHSC/TMHP by the end of the run-out period If that is not correct, please explain how eligible encounters will be identified.	**This is correct.**

	QUESTIONS	RESPONSE
38	UHRIP in its current form is subject to specific federal rules and specific questions on the CMS "preprint" applicable to directed payment uniform dollar or rate increases authorized under 42 C.F.R. 438.6(c)(1)(iii). The following questions relate to HHSC's proposal to add a quality component to UHRIP. Has HHSC explored whether federal law permits a state to limit uniform dollar or percentage increase expenditures by its contracted MCOs in such a way that would effectively prohibit the MCOs from paying increases to certain providers in a class of network providers that fail to meet the designated quality performance threshold and/or quality-based eligibility requirement?	**HHSC has previously discussed the issue with CMS who indicated that such a model was possible. However, HHSC will continue to engage with its federal partners.**
39	Under HHSC's interpretation of applicable federal law, does adding a quality component to UHRIP morph the program into a value-based purchasing, delivery system reform, or performance improvement initiative regulated under 42 C.F.R.438.6(c)(1)(i) or (ii), thereby necessitating compliance with other federal rules and standards not currently applicable to UHRIP?	**HHSC's understanding is that the reformed UHRIP would qualify as both a value-based purchasing and state directed uniform dollar. However, HHSC will continue to engage with its federal partners.**
40	Does HHSC believe that adding a quality component to UHRIP will require HHSC to submit responses to different or additional sections of the CMS "preprint" when seeking approval from CMS, such as sections 4, 5, 16, 17, and/or 18?	**It is likely that HHSC will have to submit responses to additional sections of the CMS pre-print.**