Q&A Session for RHP 9, 10, & 18 Learning Collaborative: 1115 Waiver Updates

Date: Wednesday, July 07, 2021

Q: The STAR programs seem to be the focus in the informational materials distributed but the specifications have "Reporting Payer Type Stratification" as Medicaid, Uninsured, Other Insurance. What is the recommended approach to defining the targeted population?

A:
From the Spec Document Columns J-L Header:
Step 3: Attribution Methodology: Stratify the measure-specific denominator population by payer type. *Quality measures data must be stratified by the required reporting payer types unless otherwise specified under "Reporting Payer Type Stratification" in the Measure Specifications. (See Column K) in the Specs Excel Spreadsheet.

For most Quality Measures:

- Medicaid (e.g., STAR, STAR+PLUS, STAR Kids, STAR Health; Medicaid fee-for-service; Medicaid/Medicare dual eligible)
- Uninsured (e.g., No insurance; County-based or other public medical assistance)
- Other Insurance (e.g., CHIP; Medicare; Commercial insurance)

Q: Is there any IGT related to LHD-CCP?

A:
If you are referring to the PHP-CCP (Public Health Plan – Charity Care Program? The PHP-CCP will be funded: "The non-federal share of funding for payments under this section is limited to certified public expenditures from governmental entities." So no, not an IGT. Certified public expenditures basically is that you certify that you spent the money on allowable Medicaid expenditures and that CMS will provide the Federal portion related to what you already spent.

Q: Has there been information about the specific reporting process.? Report directly to HHSC or report to MCOs and then when MCOs determine scores in each SDA , send info to HHSC?

A:
No specific details at this time. However, providers will report to HHSC and the state will inform the MCO's of the rates that need to be adjusted, based on aggregate data at the state level across the specific programs providers. Based on conversation with the Anchor's it sounds like they are looking at some type of portal, kind of like the DSRIP portal. HHSC is currently working with MCO's to iron out the details.

Q: How are discrepancies between our data and the MCO data going to be reconciled? Hopefully, the numbers will be the same, but I suspect there will be instances there they won't match.

A:
I don't know that there is a specific answer for this at this time. However, as the reporting for the DPPs is to HHSC and not to the MCO's I am not sure that there would be a discrepancy because what is reported to the state will be at an organizational/system level, while what is reported to MCO's is MCO specific.

Q: Do we have any idea of how the funding valuation for CHIRP and TIPPS is going to be allocated across participants and how the funding (enhanced rates) relate to service volume; for example, is there a volume cap at a participant's total funded amount? The rules mention a reconciliation process 2 years after reporting, but not much else (unless I missed it). I did see the updated valuation model, but was curious if that was the final version

A:
The program values are subject to changes based on actual enrollment, data changes and approval issued by the Centers for Medicare and Medicaid Services (CMS). There has not yet been an updated modeling document uploaded since April 2021 on the Provider Finance Page. Allocation of the funds will follow the rules outlines for each DPP.

As far as the reconciliation process, we have not received any additional detail, however, I would expect it to follow the same type of patterns as existing programs such as the current UHRIP or QIPP programs.

Existing Financial Models for the DPPs and an Estimated Hospital Program Payments for Federal Fiscal Year 2021 and 2022 can be downloaded from:
https://pfd.hhs.texas.gov/provider-finance-communications

Q: Another question, on the funding that is redistributed when a performance goal is missed, do we have details on how that redistribution works? Where it goes? Who gets it?

A:
We do not have details on this at this time.

Q: I am confused on the timing of CHIRP report, the rates are effective Sept 1 not Oct 1 so we won't get paid in Sept? HHSC mentioned payments being distributed in December, I think, from October reporting?

A:
Distribution of CHIRP payments. CHIRP payments will be based upon actual utilization and will be paid as a percentage increase above the contracted rate between the MCO and the hospital.

I read this to mean, whatever rates that are contracted with MCO's will start September 1 and these payments will be added after the reporting periods are done.

Q: Did HHSC commit to an answer about whether or not the annual programs' measures would remain the same or if they were considering adding new measures potentially each year?

A:
No, however we anticipate they will keep those they can keep consistent but adjustments will be based on requirements from CMS guidance and state initiatives. As you will remember, they had quite a few more measures before the final specs were distributed for year 1. Some of them were the SDOHs. I would anticipate that over time, the SDOHs will added as better measurement standards are identified.