Uniform Hospital Rate Increase Program (UHRIP) Issues and Responses

Issue: Clarification on treatment of non-emergent Emergency Department (ED) claims and ancillary services related to those claims, specifically:

Response: A non-emergent ED claim is a claim that: 1) does not have a CPT code of 99284, 99285, 99291, or 99292; and 2) has a revenue code of 450, 452, 456, or 459.

Note: The exclusion of non-emergent ED claims does not apply to rural hospitals.

Note: Revenue codes such as observation, surgery, or inpatient when billed in addition to ED revenue codes are not exempt from UHRIP increases.

Issue: Breakdown of the UHRIP per Member per Month (PMPM) increase by component in dollars, e.g. hospital payments, HIP, premium tax, administrative fee, risk margin.

Response: Dollar values of components will be provided once PMPMs are calculated. The UHRIP administrative fee will be equal to 2.5% (note: not cumulative upon administrative fee provided for non-UHRIP); the risk margin will equal 5.0%, and the premium tax will equal 1.75%. The ACA Health Insurance Provider Fee (including Federal Income Tax and State premium tax impacts), for those MCOs subject to the fee will range between approximately 3% and 3.5.

Note: The administrative fee is not cumulative upon the administrative fee provided for the non-UHRIP per of the PMPM.

Issue: How will the administrative fee and Quality Incentive Funds (QIF) distributions/assessments, be treated for purposes of financial statistical reporting (including the administrative expense cap) and Experience Rebate.

Response: The UHRIP administrative fee should be treated in the same fashion as the non-UHRIP administrative fee when completing the Financial Statistical Report (FSR) and will be used in developing the administrative expense cap and the Experience Rebate.

QIF distributions/assessments are not part of the Medicaid program and, as result, are not to be reported on the FSR and will have no impact on the Experience Rebate.

Issue: Clarification on how UHRIP components and any QIF distributions/assessments will impact future rate-setting.

Response: The UHRIP component of reported costs will be removed from future rating experience. Actuaries will remove the costs reported through encounters, using the UHRIP percent increases by provider to rebase back to the “base” hospital costs, excluding UHRIP.

QIF distributions/assessments are not Medicaid payments and/or recoupments and should not be included in any MCO reporting to HHSC.

Issue: Impact of UHRIP on TDI Risk-Based Capital requirements.

Response: HHSC does not play a role regarding TDI Risk-Based Capital requirements and so cannot comment on this item.

Issue: Clarification of how and whether UHRIP will apply to beneficiaries dually eligible for Medicaid and Medicare, i.e. excluding services to all dually eligible beneficiaries or only those enrolled in Medicare-Medicaid Plans (MMP) under the six-county demonstration waiver.

Response: UHRIP does not apply to Dual-Eligible clients.

Issue: Confirm UHRIP will not require additional quality or other reporting obligations.

Response: UHRIP will not require additional quality or other reporting obligations at this point in time.

Issue: Clarification regarding whether HHSC will consider QIF distributions or assessments to qualify as Value Based Payments (VBP) or part of the Alternative Payment Model (APM).

Response: QIF distributions/assessments will not qualify as VBP or APM.

Issue: How should the MCOs report the base rate payment and the UHRIP payments on Encounters; Remittance and Status (R&S) reports; and remittances to hospitals?

Response: For each Encounter, the base rate payment and the UHRIP payment should be reported as a single figure. Content of R&S reports is a matter to be negotiated between MCOs and their contracted hospitals; HHSC does not play a role in these negotiations.

Issue: Will HHSC require MCOs to report UHRIP payments as an aggregated sum for all hospitals or a single hospital, separate from base rate payments?

Response: Currently, HHSC does not intend to require such reporting.

Issue: Should the UHRIP increases apply to Out-of-Network (OON) claims?

Response: The Texas Administrative Code (TAC) requires MCOs to reimburse OON, in-area service providers 95 percent the Medicaid FFS rate in effect on the date of service, and OON, out-of-area service providers at 100 percent of the Medicaid FFS rate in effect on the date of service. Given the requirements of these rules, the UHRIP increases should not be applied to non-single case OON payments.

Issue: When will HHSC provide a list of each hospital in each SDA, the UHRIP percent increase to be applied to each hospital and the hospital class (e.g., large public, private, rural, children's, etc.,) to which each hospital belongs?

Response: HHSC will provide this information to the MCOs in early September, 2017.

Issue: Will UHRIP revenues be subject to the 4 percent Pay for Quality (P4Q) holdback?

Response: No.

Issue: Are MCOs required to participate in a QIF?

Response: No. Participation in a QIF is negotiated between an MCO and its contracted hospitals.