Directed Payment Programs: CHIRP, TIPPS, RAPPS and BHS

Frequently Asked Questions

Superior HealthPlan's Directed Payment Programs (DPP) reimburse providers for certain services by utilizing the following payers:

- Comprehensive Hospital Increase Reimbursement Program (CHIRP)
- Texas Incentives for Physicians and Professional Services (TIPPS)
- Rural Access to Primary and Preventive Services (RAPPS)
- Directed Payment Program for Behavioral Health Services (DPP BHS)

Please review the Frequently Asked Questions (FAQs) outlined below.

Comprehensive Hospital Increase Reimbursement Program (CHIRP)

What is CHIRP?
Effective September 1, 2021, the Comprehensive Hospital Increase Reimbursement Program (CHIRP) replaced the Uniform Hospital Rate Increase Program (UHRIP). CHIRP provides increased payments to hospitals for inpatient and outpatient services to members enrolled in the Superior HealthPlan Medicaid (**STAR** and **STAR+PLUS**) programs.

Who is eligible for CHIRP?
Children's hospitals, rural hospitals, state-owned hospitals that are not Institutions for Mental Diseases (IMDs), urban hospitals, non-state owned IMDs and state-owned IMDs. Providers must be in network with Superior to be eligible for CHIRP.

How are CHIRP rates determined?
Funds will be paid through two components of the managed care capitation rates:

- **Component 1:** The total value of the UHRIP component will be equal to a percentage of the estimated Medicare gap on a per-class basis, not to exceed 100% of the Medicare UPL gap at the Service Delivery Area (SDA)and class level, capped at the Average Commercial Rate (ACR) UPL gap to avoid exceeding 100% for the payment analysis.
    - The Medicare gap is calculated separately for STAR inpatient, STAR+PLUS inpatient, STAR outpatient, and STAR+PLUS outpatient services and is aggregated by SDA and class.
- **Component 2:** The Average Commercial Incentive Award (ACIA) component will be equal to a percentage of the ACR gap, less payments received under UHRIP.
    - The ACIA rate increase percentage is calculated separately for STAR inpatient, STAR+PLUS inpatient, STAR outpatient, and STAR+PLUS outpatient services at the individual hospital level not to exceed 90% of the SDA/class aggregate ACR. Allocation of funds across hospitals will be a uniform percentage of each participating hospital's individually calculated ACR gap.
- **Component 3**: The total value of the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) component will be equal to the sum of a percentage of the Medicare gap, not to exceed 100 percent, on a per class basis, capped at the ACR UPL gap to avoid exceeding 100% of the applicable average commercial rate for the total payment rate analysis less the amount received in the UHRIP component, and a percentage of the total estimated ACR UPL, not to exceed 90 percent, on a per class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA.

How are claims calculated for CHIRP?

- **Inpatient:** Inpatient claims are calculated based on discharge date. If there is no discharge date, then date of admission is used.
- **Outpatient:** Claims are calculated based on date of service and is applied at the service line level.

Texas Incentives for Physicians and Professional Services (TIPPS)

What is TIPPS?
The TIPPS program provides increased payments to certain physician groups providing health care services to members enrolled in the Superior Medicaid (**STAR**, **STAR Kids** and **STAR+PLUS**) programs.

Which providers are eligible for TIPPS?
Health-related institution physician groups, physician groups affiliated with hospitals that receive indirect medical education funds and other physician groups.

How will TIPP funds be paid for State Fiscal Year (SFY) 2025?
TIPPS funds are paid through three components of the managed care capitation rates:

- **Component 1:** Is equal to 90% of the total program value paid as a uniform percentage increase at the time of claim adjudication.
- **Component 2**: Is equal to 0% of the total program value.
- **Component 3:** Is equal to: remain 10 percent of the total program value; will be paid as a uniform percentage increase at the time of claim adjudication; will be limited to professional encounters available to all eligible physician groups; and will apply to Current Procedural Terminology (CPT) codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

Rural Access to Primary and Preventive Services (RAPPS)

What is RAPPS?
The RAPPS program is designed to incentivize rural health clinics (RHCs) that provide primary and preventive care services to persons in rural areas of the state enrolled in Superior Medicaid (**STAR**, **STAR+PLUS** and **STAR Kids**) programs.

Who is eligible for RAPPS?
Hospital-based RHCs, which include non-state government-owned and private RHCs and free-standing RHCs.

How will RAPPS funds be paid?
RAPPS funds are paid through one component of the managed care capitation rate:

- **Component 1**: Is a uniform dollar increase by class. Freestanding and hospital-based rural health clinics will receive a uniform dollar increase for the All-Inclusive Clinic Visit, (billing code T1015), and office visit codes 99201-99205 (new patients) and 99211-99215 (established patients).

Additional Payment Questions

Will there be a specific remit code for these payments?
Yes, see remit codes below:

- CHIRP payments can be identified for medical claims with **EXcx** and for behavioral health claims with **EXcX**.
- RAPP payments can be identified with **EXrP**.
- TIPPS payments can be identified with **EXdP**.

If not paid timely or correctly, will penalty/interest be applied?
No, Superior does not pay penalties or interest on pass-through payments.

Do we have the payment rates?

For CHIRP, providers may reference the **Texas Health and Human Services Commission (HHSC) Comprehensive Hospital Increase Reimbursement Program Provider Finance Department** webpage.

- For TIPPS, providers may reference the HHSC Texas Incentives for Physicians and Professional Services webpage.
- For RAPPS, providers may reference the HHSC Rural Access to Primary and Preventive Service webpage.

Will the CHIRP program require a Letter of Offer and Acceptance (LOA) and amendment like UHRIP?
Yes. There will be both LOAs and amendments to existing UHRIP LOAs that will be going out to those who are part of the CHIRP program. There will be no contractual action extended for any other-directed payment program.

Will providers have to analyze what they are receiving based on individual service rates to see if they are being paid the updated rate or retro payments?
Yes. Providers will have to analyze the reimbursement rates based on service lines processed with the EX codes identified below.

Will there be an identifier on claims so that we can track and differentiate the funding from contract rate, timing, etc.?
Yes. See remit codes that can be utilized as an identifier below:

- CHIRP payments can be identified for medical claims with **EXcx** and for behavioral health claims with **EXcX**.
- RAPP payments can be identified with **EXrP**.
- TIPPS payments can be identified with **EXdP**.

Is there a breakdown of the UHRIP and ACIA payments?
The UHRIP and ACIA payments have been combined. To determine their individual UHRIP and ACIA rates, providers can refer to the HHSC Uniform Managed Care Terms & Conditions (UMCC).

Can DPPs include COVID-19 claims?
DPPs may direct uniform rate increases on certain Superior claims. As of September 1, 2021, DPP payments cannot be made on COVID-19 claims. Pursuant to CFR 438.6 (c), Texas Medicaid is seeking Centers for Medicare and Medicaid Services (CMS) approval to use additional DPPs and apply uniform rate increases on certain claims. With the new rating period that began on September 1, 2021, rate increases through DPPs are no longer made on COVID-19 claims.

Directed Payment Program for Behavioral Health Services (DPP BHS)

What is the DPP BHS?
The DPP BHS is designed to promote and improve access to behavioral health services, care coordination, and successful care transitions for individuals enrolled in STAR, STAR+PLUS and STAR Kids. Two classes of providers are eligible to participate: (1) Community Mental Health Centers (CMHCs) and Local Behavioral Health Authority (LBHAs) with the Certified Community Behavioral Health Center (CCBHC) certification, and (2) CMHCs and LBHAs without CCBHC certification. Eligible Providers must enroll with HHSC to participate.

How will DPP BHS funds be paid?
Component 1 will comprise 100% of the DPP BHS funding in SFY 2025. Component 1 is a uniform dollar increase paid prospectively on a monthly basis. CMHCs and LBHAs with CCBHC certification are eligible to participate in Component 1. Centene is the parent company of Superior. All Component 1 funds dispersed will be issued by Centene in accordance with the Scorecards posted on the DPP BHS website.

Please note in previous years payments were split:

- **Component 1:** (65% of the DPP BHS funding): Uniform dollar increase paid prospectively on a monthly basis.
- **Component 2**: (35% of the DPP BHS funding): Uniform rate increase applied to specific CPT codes.

To access scorecards, and obtain details on methodology for each year, providers can visit the HHSC Directed Payment Program for Behavioral Health Services webpage.

I have been receiving Paper checks for Component 1. Can Component 1 payments be issued electronically?
Component 1 payments are issued through our Accounts Payable department, and not through Superior's claims system. Providers can request an Automated Clearing House (ACH) set up. An ACH is a U.S. financial network used for electronic payments and money transfers. ACH payments are a way to transfer money from one bank account to another.

To start the process, please reach out to the Behavioral Health Provider Representative at AM.BH@SuperiorHealthPlan.com. It is important you specify you are requesting ACH set-up for Component 1 payments. As part of the process, you will be asked to provide the following:

- Bank account number
- Routing number
- Voided check, bank letter or deposit slip to confirm the account number

An authorized representative from your company will be asked to sign and complete the ACH request form. Superior may require additional information throughout the set-up process. You will continue to receive paper checks while you wait for your ACH set-up to be completed.

Who can I reach out to with questions?
For questions, please reach out to your Provider Representative. To access their contact information visit Find My Provider Representative.