TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Victoria Grady, Director of Provider Finance

SUBJECT: Physician Directed Payment Program

Agenda Item No.: 12

New Rules: §353.1309, Texas Incentives for Physicians and Professional Services; and §353.1311, Quality Metrics for Texas Incentives for Physicians and Professional Services

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: (e.g., Program Initiative)

The Texas Health and Human Services Commission (HHSC) proposes new §353.1309, concerning Texas Incentives for Physicians and Professional Services, and new §353.1311, concerning Quality Metrics for Texas Incentives for Physician and Professional Services, in Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter O.

The proposed rules describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform per member per month payment, certain incentivize payments, and a uniform percentage rate increase to physician practice groups in the MCO's network in a participating service delivery area (SDA) for the provision of physician and professional services. The rules also describe the methodology used by HHSC to determine the amounts of the payments or rate increase.

Currently, Texas' Medicaid physician payments, made through either the fee-for-service (FFS) or managed care models, do not always cover all Medicaid allowable costs for physician and professional services. HHSC is proposing these new rules to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment program (DSRIP) and the Network Access Improvement Program (NAIP).

Healthcare policy experts believe that increasing reimbursements in a value- or incentive-based manner may result in improved health outcomes for clients. HHSC anticipates that the increased payments to certain practice groups will support access to services, promote better health outcomes, and increase focus on improving quality goals that are established as part of the Texas Medicaid program.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with an MCO under certain limited circumstances. Under the federal rule, a state may direct an MCO to

raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's managed care quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These proposed rules authorize HHSC to use IGTs from governmental entities or from other state agencies to support capitation payment increases in one or more SDAs. Each MCO within the SDA would be contractually required by the state to increase payments by a per member per month payment, a performance incentive payment, or a uniform percentage for one or more classes of physician practice groups that provide services within the SDA.

Conceptual Framework

Eligibility

HHSC determines eligibility for payments by physician practice group class. The SDA must have at least one governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a physician practice group must be within a class designated by HHSC to receive the increase.

HHSC proposes classifying physician practice groups into three groups: health-related institution physician practice groups, indirect medical education physician practice groups, and other physician practice groups. The classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. The reimbursement increase will be uniform for all providers within each class; but if HHSC directs rate increases to more than one class within an SDA, the reimbursement increase may vary between classes.

Services subject to rate increase

HHSC may direct rate increases for all or a subset of physician and professional services based on advancing the goals and objectives of HHSC's managed care quality strategy.

Determination of rate increase

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or more classes of hospital within an SDA, including the amount of available funding; the class or classes of physician practice groups eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment

HHSC will follow the methodology described in Texas Administrative Code Title 1 §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

ISSUES AND ALTERNATIVES:

HHSC currently operates two programs that provide enhanced funding for physician reimbursement in Medicaid managed care: NAIP and DSRIP. Funding under both programs is ending. At the request of external stakeholders, HHSC convened a workgroup to discuss the scope and design of a potential physician directed payment program to align with ongoing efforts to transition from DSRIP and NAIP.

Topics discussed in the workgroup include: payment allocation methodology, class structure, participation requirements, IGT frequency, and potential quality measures. When discussing potential options for each topic, the workgroup considered the design of the current NAIP and DSRIP programs. Stakeholders agreed on a physician group class structure that comprises three classes and that a provider must be within one of the designated classes to be eligible for a payment increase. The workgroup discussed different options for a payment methodology and agreed on a three-component structure to allocate funds across qualifying providers.

The workgroup also discussed quality metrics that would be associated with the program, including possible metrics that could be designated for each funding component. Stakeholders generally agreed with including quality metrics and that some provider payments will be triggered by the achievement of certain performance requirements. HHSC will publish a notice of the proposed metrics and their associated performance requirements for public comment on the HHSC web site.

STAKEHOLDER INVOLVEMENT:

As mentioned above, HHSC convened a workgroup with external stakeholders that consisted of representatives from physician groups participating in either the NAIP or DSRIP programs. Stakeholders that participated in the workgroup include:

Texas Medical Association
University of Texas System
Texas A&M System
Texas Hospital Association
Teaching Hospitals of Texas
University of Texas Health Science Center at Tyler
University of Texas Medical Branch Galveston
University of Texas Health Science Center at Houston
University of Texas MD Anderson Cancer Center
University of Texas Health Science Center San Antonio
University of Texas Rio Grande Valley
University of Texas Southwestern Medical Center at Dallas
University of North Texas Health Science Center at Fort Worth

Texas Tech University Health Science Center
Texas Tech University Health Science Center El Paso
Texas Tech University Health Science Center Odesa
Texas Tech University Health Science Center AMA
Texas A&M University System Health Science Center
Baylor College of Medicine
University of Texas Austin Dell Medical School

The workgroup was broken up into two subcommittees: one focused on financing and one focused on quality. Over the seven-week period, stakeholders were asked to provide feedback on proposals presented by HHSC. Additionally, stakeholders participating in the quality subcommittee were asked to provide written feedback to help inform potential proposals presented by HHSC. Although the proposed rules were drafted after the workgroup concluded, HHSC considered stakeholders' feedback and recommendations when drafting the rules.

The proposed rules were presented to the Hospital Payment Advisory Committee on February 4, 2021, as an informational item. The proposal will be presented to the HHSC Executive Council meeting on February 18, 2021. Additionally, HHSC held a public hearing to receive public comments following the publication of the proposed rules.

FISCAL IMPACT:

HHSC anticipates there may be a fiscal impact to state government for reimbursement increases to state-owned physician practice groups, but there is insufficient information to provide an estimate. HHSC does not know which state-owned physician practice groups or state agencies will choose to sponsor increases under the program or at what level of funding.

There will be no fiscal impact to state government for reimbursement increases to non-state-owned physician practice groups because the non-federal share of the increase in capitation payments will be funded with IGTs from non-state governmental entities.

HHSC anticipates there may also be a fiscal impact to local governments, but there is insufficient information to provide an estimate. HHSC does not know which governmental entities will choose to sponsor rate increases under the program or at what level of funding.

RULE DEVELOPMENT SCHEDULE:

January 2021	Publish proposed rules in *Texas Register*
February 4, 2021	Present to the Hospital Payment Advisory Committee
February 11, 2021	Present to the Medical Care Advisory Committee
February 18, 2021	Present to HHSC Executive Council
March 2021	Publish adopted rules in *Texas Register*
March 2021	Effective date

REQUESTED ACTION: (Check appropriate box)

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §353.1309, concerning Texas Incentives for Physicians and Professional Services; and new §353.1311, concerning Quality Metrics for the Texas Incentives for Physician and Professional Services Program.

BACKGROUND AND PURPOSE

The purpose of the proposed new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform per member per month payment, certain incentive payments, and a uniform percentage rate increase to physician practice groups in the MCO's network in a participating service delivery area (SDA) for the provision of physician and professional services. The rules also describe the methodology used by HHSC to determine the amounts of the payments or rate increase.

Currently, Texas' Medicaid physician payments, made through either the fee-for-service (FFS) or managed care models, do not always cover all Medicaid allowable costs for physician and professional services. HHSC is proposing these new rules to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment program and the Network Access Improvement Program.

Healthcare policy experts believe that increasing reimbursements in a value- or incentive-based manner may result in improved health outcomes for clients. HHSC anticipates that the increased payments to certain practice groups will support access to services, promote better health outcomes, and increase focus on improving quality goals that are established as part of the Texas Medicaid program.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with an MCO under certain limited circumstances. Under the federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's managed care quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an IGT; and not be automatically renewed.

These proposed rules authorize HHSC to use IGTs from governmental entities or from other state agencies to support capitation payment increases in one or more SDAs. Each MCO within the SDA would be contractually required by the state to increase payments by a per member per month payment, a performance incentive payment, or a uniform percentage for one or more classes of physician practice groups that provide services within the SDA.

Conceptual Framework

Eligibility:

HHSC determines eligibility for payments by physician practice group class. The SDA must have at least one governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a physician practice group must be within a class designated by HHSC to receive the increase.

HHSC proposes classifying physician practice groups into three groups: health-related institution physician practice groups, indirect medical education physician practice groups, and other physician practice groups. The classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. The reimbursement increase will be uniform for all providers within each class; but if HHSC directs rate increases to more than one class within an SDA, the reimbursement increase may vary between classes.

Services subject to rate increase:

HHSC may direct rate increases for all or a subset of physician and professional services based on advancing the goals and objectives of HHSC's managed care quality strategy.

Determination of rate increase:

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or more classes of hospital within an SDA, including the amount of available funding; the class or classes of physician practice groups eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment:

HHSC will follow the methodology described in Texas Administrative Code Title 1 §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayments or disallowed amounts.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1309(a) establishes the TIPPS program and describes the goals of the program. Subsection (b) defines key terms used in the section. Subsection (c) describes the physician practice groups eligible for reimbursement increases. Subsection (d) describes the data sources that will be used in the program. Subsection (e) describes the participation requirements of the physician practice groups that wish to participate in the program, including the application process. Subsection (f) describes the process for collecting the non-federal share of the program funding. No state general revenue funds are available for the program and the non-federal share will be comprised of intergovernmental transfers. Subsection (g) describes the value and allocation of TIPPS capitation rate components. Subsection (h) describes the timing and basis for the distribution of TIPPS payments. Subsection (i) describes the notice requirements if there are changes in operation of the physician practice group. Subsection (j) refers to §353.1301(g) of this subchapter for the description of the reconciliation authority. Subsection (k) refers to §353.1301(j) and (k) of this subchapter for the description of the recoupment authority.

Proposed new §353.1311 describes the quality metrics associated with the TIPPS program. Subsection (a) establishes the purpose of the section. Subsection (b) defines key terms used in the section. Subsection (c) describes the quality metrics HHSC can designate for each TIPPS capitation rate component. Possible metrics include structure, improvement over self (IOS), or benchmark measures and will be evidence-based and presented for public comment. Subsection (d) discusses the performance requirements that will be associated with the designated quality metrics. Achievement of performance requirements will trigger payments for the TIPPS capitation rate components as described in §353.1309 of this subchapter. Subsection (e) provides for publication of the proposed metrics and their associated performance requirements. The notice will be published on HHSC's Internet website. Subsection (f) provides that final quality metrics and performance requirements will be provided on HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years the proposed rules are in effect, there may be a fiscal impact to state government for reimbursement increases to state-owned physician practice groups, but there is insufficient information to provide an estimate at this time because HHSC does not know what state-owned physician practice groups or state agencies will choose to sponsor increases under this section or at what level of funding.

There will be no fiscal impact to state government for reimbursement increases to non-state-owned physician practice groups because the non-federal share of the increase in capitation payments will be funded with IGTs from non-state governmental entities.

There may be a fiscal impact to local governments, but there is insufficient information to provide an estimate because HHSC does not know which governmental entities will choose to sponsor rate increases under this section or at what level of funding.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will create a government program;
(2) implementation of the proposed rules will not affect the number of HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create a new rule;
(6) the proposed rules will not expand, limit, or repeal existing rules
(7) the proposed rules will not change the number of individuals subject to the rules; and
(8) the proposed rules will positively affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, or micro businesses, or rural communities to comply with the proposed rule because participation in the program is optional.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be improved health outcomes as a result of flowing funding through the managed care organizations.

Trey Woods has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not impose any additional fees or costs on those who are required to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing is scheduled for January 11, 2021, at 11:30 a.m. (Central Standard Time) to receive public comments on the proposal. Persons requiring further information, special assistance, or accommodations should email RAD_1115_Waiver_Finance@hhsc.state.tx.us.

Due to the declared state of disaster stemming from COVID-19, the hearing will be conducted online only. No physical entry to the hearing will be permitted.

Persons interested in attending may register for the public hearing at:

https://attendee.gotowebinar.com/register/6921856016915791632

After registering, a confirmation email will be sent with information about joining the webinar.

HHSC will broadcast the public hearing. The broadcast will be archived for access on demand and can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code H400, P.O. Box 13247, Austin, Texas 78711-3247, or by email to RAD_1115_Waiver_Finance@hhsc.state.tx.us.

During the current state of disaster due to COVID-19, physical forms of communication are checked with less frequency than during normal business operations. Therefore, please submit comments by email if possible.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the Texas Register. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be post-marked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R028" in the subject line.

STATUTORY AUTHORITY

The new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code, Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The proposed new rules implement Texas Government Code, Chapter 531; Texas Government Code, Chapter 533; and Texas Human Resources Code, Chapter 32. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 424-6637 or (512) 462-6223.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1309. Texas Incentives for Physicians and Professional Services.

(a) Introduction. This section establishes the Texas Incentives for Physicians and Professional Services (TIPPS) program. TIPPS is designed to incentivize physicians and certain medical professionals to improve quality, access, and innovation in the provision of medical services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1311 of this subchapter (relating to Quality Metrics for the Texas Incentives for Physicians and Professional Services Program).

(1) Health Related Institution (HRI) physician practice group--A network physician practice group associated with an institution named in Texas Education Code §63.002.

(2) Indirect Medical Education (IME) physician practice group – A network physician practice group contracted with, owned, or operated by a hospital receiving the indirect medical education add-on for which the hospital is assigned billing rights for the physician practice group.

(3) Network physician practice group--A physician practice group located in the state of Texas that has a contract with a Managed Care Organization (MCO) for the delivery of Medicaid covered benefits to the MCO's enrollees.

(4) Other physician practice group--A network physician practice group other than those specified under paragraphs (1) and (2) of this subsection.

(5) Program period--A period of time for which an eligible and enrolled physician practice group may receive the TIPPS amounts described in this section. Each TIPPS program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

(6) Total program value--The maximum amount available under the TIPPS

program for a program period, as determined by HHSC.

(c) Eligibility for participation in TIPPS. A physician practice group is eligible to participate in TIPPS if it complies with the requirements described in this subsection.

(1) Physician group composition. A physician group must indicate the eligible physicians, clinics, and other locations to be considered for payment and quality measurement purposes in the application process.

(2) Minimum volume. Physician groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 60 percent of the quality metrics in each Component to be eligible to participate in the Component.

(3) The physician group is:

(A) an HRI physician practice group;

(B) an IME physician practice group; or

(C) any other physician practice group that:

(i) can achieve the minimum volume as described in subparagraph (2) of this subsection;

(ii) is located in a service delivery area with at least one sponsoring governmental entity; and

(iii) served at least 250 unique Medicaid managed care clients in the prior state fiscal year.

(d) Data sources for historical units of service and clients served. Historical units of service are used to determine a physician practice group's eligibility status and the estimated distribution of TIPPS funds across enrolled physician practice groups.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's national provider identification (NPI) number and taxonomy code combination that are billed as a professional encounter only.

(2) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine eligibility status of other physician practice groups.

(3) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine distribution of TIPPS funds across eligible and enrolled physician practice groups.

(4) In the event of a disaster, HHSC may use data from a different state fiscal year at HHSC's discretion.

(5) The data used to estimate eligibility and distribution of funds will align with the data used for purposes of setting the capitated rates for managed care organizations for the same period.

(6) HHSC will calculate the estimated rate that an average commercial payor would have paid for the same services using either data that HHSC obtains independently or data that is collected from providers through the application process described in subsection (c) of this section.

(e) Participation requirements. As a condition of participation, all physician practice groups participating in TIPPS must allow for the following.

(1) The physician practice group must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period will be no less than 21 calendar days, and the final date of the enrollment period will be at least nine days prior to the intergovernmental transfer (IGT) notification.

(2) The entity that bills on behalf of the physician practice group must certify, on a form prescribed by HHSC, that no part of any TIPPS payment will be used to pay a contingent fee, consulting fee, or legal fee associated with the physician practice group's receipt of TIPPS funds, and the certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) The entity that bills on behalf of the physician practice group must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, TIPPS.

(f) Non-federal share of TIPPS payments. The non-federal share of all TIPPS payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support TIPPS.

(1) HHSC will communicate suggested IGT responsibilities for the program period with all TIPPS eligible and enrolled HRI physician practice groups and IME physician practice groups at least 10 days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under the TIPPS program for the program period as determined by HHSC, plus eight percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across HRI physician practice groups and IME physician practice groups, plus estimated utilization for eligible and enrolled other physician practice groups within the same service delivery area, for the program period. HHSC will also communicate estimated maximum revenues each eligible and enrolled physician practice group could earn under TIPPS for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled practice groups will meet 100 percent of their quality metrics.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 15 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website by March 15 of each year.

(4) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(g) TIPPS capitation rate components. TIPPS funds will be paid to Managed Care Organizations (MCOs) through three components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of TIPPS funds to the enrolled practice groups will be based on each practice group's performance related to the quality metrics as described in §353.1311 of this subchapter. The practice group must have provided at least one Medicaid service to a Medicaid client in each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 65 percent of total program value.

(B) Allocation of funds across qualifying HRI and IME physician practice groups will be proportional, based upon historical Medicaid clients served.

(C) Monthly payments to HRI and IME physician practice groups will be triggered by performance requirements as described in §353.1311 of this subchapter.

(D) Other physician practice groups are not eligible for payments from Component One.

(E) HHSC will reconcile the interim allocation of funds across qualifying HRI and IME physician groups to the actual distribution of Medicaid clients served across these physician groups during the program period as captured by Medicaid MCOs contracted with HHSC for managed care 180 days after the last day of the program period. This reconciliation will only be performed if the weighted average (weighted by Medicaid clients served during the program period) of the absolute values of percentage changes between each practice group's proportion of historical Medicaid clients served and actual Medicaid clients served is greater than 18 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 25 percent of total program value.

(B) Allocation of funds across qualifying HRI and IME practice groups will be proportional, based upon historical Medicaid utilization.

(C) Payments to practice groups will be triggered by achievement of performance requirements as described in §353.1311 of this subchapter.

(D) Other physician practice groups are not eligible for payments from Component Two.

(3) Component Three.

(A) The total value of Component Three will be equal to 10 percent of total program value.

(B) Allocation of funds across practice groups will be proportional, based upon actual Medicaid utilization of specific procedure codes as identified in the final quality metrics or performance requirements described in §353.1311 of this subchapter.

(C) Payments to practice groups will be triggered by achievement of performance requirements as described in §353.1311 of this subchapter during the reporting period prior to the payment period.

(4) Funds that are non-disbursed due to failure of one or more practice groups to meet performance requirements will be distributed across all qualifying practice groups in the service delivery area based on each practice group's proportion of total earned TIPPS funds from Components One, Two and Three combined at the end of the year.

(h) Distribution of TIPPS payments.

(1) Before the beginning of the program period, HHSC will calculate the portion of each PMPM associated with each TIPPS enrolled practice group broken down by

TIPPS capitation rate component, quality metric, and payment period. For example, for a practice group, HHSC will calculate the portion of each PMPM associated with that practice that would be paid from the MCO to the practice group as follows.

(A) Monthly payments from Component One as performance requirements are met will be equal to the total value of Component One for the practice group divided by twelve.

(B) Semi-annual payments from Component Two associated with each quality metric will be equal to the total value of Component Two associated with the quality metric divided by 2.

(C) Payments from Component Three associated with each quality metric will be equal to the total value of Component Three attributed as a uniform rate increase based upon historical utilization.

(D) For purposes of the calculation described in subparagraph (B) of this paragraph, a physician group must achieve a minimum of four benchmark measures to be eligible for full payment of the benchmark measures. If a physician group achieves three benchmark measures, it is eligible for 75 percent payment. If a physician group achieves two benchmark measures, it is eligible for 50 percent payment.

(E) For purposes of the calculation described in subparagraph (C) of this paragraph, a physician group must achieve a minimum of one benchmark measure to be eligible for full payment.

(F) In situations where a practice does not have minimum denominator volume of 30 Medicaid managed care patients for a quality metric to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics within the component.

(2) MCOs will distribute payments to enrolled practice groups as they meet their reporting and quality metric requirements. Payments will be equal to the portion of the TIPPS PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the TIPPS PMPM.

(i) Changes in operation. If an enrolled practice group closes voluntarily or ceases to provide Medicaid services, the practice group must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(j) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period

using the methodology described in §353.1301(g) of this subchapter and, as applicable, subsection (g)(1)(E) of this section.

(k) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

§353.1311. Quality Metrics for the Texas Incentives for Physicians and Professional Services Program.

(a) Introduction. This section establishes the quality metrics that may be used in the Texas Incentives for Physician and Professional Services (TIPPS) program.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1309 of this subchapter (relating to the Texas Incentives for Physicians and Professional Services).

(1) Baseline--An initial standard used as a comparison against performance in each metric throughout the program period to determine progress in the quality metrics.

(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparison against a physician practice group's progress throughout the program period.

(3) Measurement Period (MP)--The time period used to measure achievement of a quality metric.

(c) Quality metrics. For each program period, HHSC will designate one or more metrics for each TIPPS capitation rate component.

(1) Each quality metric will be identified as a structure measure, improvement over self (IOS) measure, or benchmark measure.

(2) Any metric developed for inclusion in TIPPS will be evidence-based.

(d) Performance requirements. For each program period, HHSC will specify the performance requirement that will be associated with the designated quality metric. Achievement of performance requirements will trigger payments for the TIPPS capitation rate components as described in §353.1309 of this subchapter. The following performance requirements are associated with the quality metrics described in subsection (c) of this section.

(1) A physician practice group must report all quality metrics to be eligible for payment.

(2) Achievement of quality metrics.

(A) To achieve a structure measure, providers must report their progress on associated activities for each MP.

(B) Achievement of an IOS measure is based on reporting of the baseline for each MP. For each program period except the one beginning September 1, 2021, achievement is based on meeting or exceeding during the MP the benchmark set prior to the start of the program period.

(C) Achievement of a benchmark measure is based on reporting for each MP and meeting or exceeding during the MP the benchmark set prior to the start of the program period.

(3) Reporting frequency. Achievement will be reported semi-annually unless otherwise specified by the quality metric.

(e) Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 preceding the first month of the program period. The notice must be published either by publication on HHSC's website or in the *Texas Register*. The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted for 15 business days following publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(f) Publication of Final Metrics and Performance Requirements. Final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 of the calendar year but before the first month of the program period, HHSC will provide notice of the changes through HHSC’s website.