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

ADOPTION PREAMBLE

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §353.1309, relating to Texas Incentives for Physicians and Professional Services. The amendment to §353.1309 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6683). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the amendment is to pursue modifications to the Texas Incentives for Physicians and Professional Services (TIPPS) program to simplify the program structure, provide additional details concerning certain enrollment-related processes and procedures, and reduce the administrative burden of operating the program for HHSC and participating providers.

HHSC sought and received authorization from the Centers for Medicare & Medicaid Services (CMS) to create TIPPS for state fiscal year (SFY) 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment (DSRIP) program. HHSC has not made significant modifications to TIPPS since its inception in SFY 2022.

Directed payment programs authorized under 42 C.F.R. §438.6(c), including TIPPS, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

HHSC determined that TIPPS contains certain provisions that pose administrative complexity that may impede HHSC's and the participating providers' ability to use the program to advance a quality goal or strategy. HHSC, therefore, amends and modifies the program rule to reduce administrative complexity and advance the program toward improved quality of services provided to Medicaid clients by participating providers.

Beginning in SFY 2025, the rule amendment will shift the program structure. For SFY 2025, Component One will be 90 percent of the total program value paid as a uniform rate increase at the time of claim adjudication, and Component Two will be equal to 0 percent of the total program value. For SFY 2026, Component One will be 55 percent of the total program value paid as a uniform rate increase at the time of claim adjudication; and Component Two will be equal to 35 percent of the total program value, based on a pay-for-performance model based on achievement of quality measures and paid through a scorecard. Component Three will remain as it is currently for all future years, comprising 10 percent of the total program value,

based on a uniform rate increase percentage paid at the time of claim adjudication for an identified set of procedure codes.

HHSC met with participating providers and discussed multiple options. HHSC considered moving the program to a majority pay-for-performance component in SFY 2025. Some providers were in support of this change, while others requested more time. Those opposed to a SFY 2025 shift to pay-for-performance requested more time so providers would be aware of the quality measures that would be used in the pay-for-performance model before implementation. HHSC is interested in feedback on the proposed option and may consider modifying the rules in subsequent program periods.

HHSC will determine the network status of an enrolling provider for an entire program period based on the submission of supporting documentation through the enrollment process.

HHSC included other minor clarifying or grammatical revisions to improve the accuracy and readability of the rule text.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC received feedback regarding the proposed rule from nine commenters at seven organizations: The University of North Texas Health Science Center at Fort Worth, Texas Tech University Health Science Center Lubbock, Texas Children's Hospital, The University of Texas Medical Branch, The University of Texas Health Science Center at Houston, Teaching Hospitals of Texas, and Texas A&M University Health Science Center. A summary of the comments relating to the rule and HHSC's responses follows.

Comment: Multiple commenters suggested that HHSC require Managed Care Organizations (MCOs) to include visibility for TIPPS payments in the processing of adjudicated claims to enable providers to track TIPPS payments from MCOs.

Response: HHSC acknowledges the comment. While HHSC supports transparency between MCOs and providers, the content of contracts between MCOs and providers is outside the scope of the rule being amended. Therefore, it is not relevant to the proposed rule change. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters requested that HHSC clarify whether network status for enrollment purposes will be determined using the National Provider Indicator (NPI) assigned to the parent or umbrella network physician group, the NPI assigned to a clinic location of a network physician group, or another criteria such as documentation from an MCO that the network physician group is in the MCO's network.

Response: HHSC disagrees that the text of the rule requires clarification and declines to revise the rule in response to the comment. HHSC encourages all network physician groups to include all eligible NPIs, including those assigned to a parent or umbrella network group and those assigned to a clinic location, on enrollment applications so that HHSC can most fully evaluate the network status and eligibility of each network physician group. HHSC will verify network status at the time of enrollment, and HHSC staff will be available to answer specific questions regarding NPIs at that time.

Comment: Multiple commenters asked HHSC to calculate TIPPS Component add-on amounts on a level specific to each Service Delivery Area (SDA).

Response: HHSC acknowledges the comment and is taking these suggestions into consideration for future program operations. However, HHSC did not propose modifications related to this topic in the current rule proposal; consequently, other program participants and the public did not have an opportunity to comment on such a change. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters asked HHSC to clarify the methodology for determining eligibility each program year.

Response: HHSC acknowledges the comment. HHSC encourages all providers to include all eligible NPIs on enrollment applications, including NPIs assigned to a parent or umbrella network physician group and those assigned to a clinic location, so that HHSC can evaluate the network status and eligibility of each provider. HHSC will verify network status at the time of enrollment, and HHSC staff will be available to answer specific questions at that time. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters suggest reconciliation should be based on the number of unique Medicaid clients served by a network physician group and should not be tied to billing NPI where a single, enrolled Medicaid member may be counted multiple times within the same parent or umbrella network physician group. Some commenters recommend that clauses 353.1309(g)(1)(A)(vi) and (vii), as well as 353.1309(g)(2)(B) and (C), be struck accordingly.

Response: HHSC acknowledges the comment and is taking these suggestions into consideration for future program operations. However, HHSC did not propose modifications related to this topic in the current rule proposal; consequently, other program participants and the public did not have an opportunity to comment on such a change. No revision to the rule text was made in response to this comment.

Comment: One commenter suggested that HHSC implement a formal network status validation process that includes MCOs submitting a point of contact for network status validation, a standard reporting template or other system, and mediation services provided by HHSC.

Response: HHSC acknowledges the comment. Beginning in SFY 2025, the TIPPS enrollment process will include network status validation from both MCOs and providers. HHSC staff will remain available to assist providers with questions regarding network status. No revision to the rule text was made in response to this comment.

Comment: One commenter asked HHSC to require MCOs to track and verify group NPIs instead of individual provider NPIs.

Response: HHSC acknowledges the comment. HHSC encourages all network physician groups to include all eligible NPIs, including those assigned to a parent or umbrella network group and those assigned to a clinic location, on enrollment applications so that HHSC can most fully evaluate the network status and eligibility of each network physician group.

Comment: One commenter expressed concern about moving Components One and Two to uniform rate increases paid at the time a claim is adjudicated, citing a delayed payment timeline for Component Three rate increases in the current TIPPS program. The commenter disagrees with the change and requests that HHSC update contracts between HHSC and MCOs to include payment timelines and penalties for non-compliance.

Response: HHSC acknowledges the comment. HHSC supports the timely adjudication of claims and payment of rate increases. Please refer to Chapter 2 of the Uniform Managed Care Manual for processes and procedures related to claim adjudication. No revision to the rule text was made in response to this comment.

Comment: One commenter asked what codes will be receiving the Component One enhanced payments and whether the uniform enhanced rate has been determined.

Response: HHSC acknowledges the comment. All payable codes to providers, excluding certain services that are outside the scope of TIPPS, will receive a uniform rate increase. Payable taxonomy codes will be published on the Provider Finance Department website for TIPPS (https://pfd.hhs.texas.gov/acute-care/texas-incentives-physicians-and-professional-services) prior to the beginning of each applicable program period. No revision to the rule text was made in response to this comment.

Comment: One commenter requested clarification regarding whether care provided outside of the SDA for which an MCO has a contract with HHSC may qualify for TIPPS reimbursement.

Response: HHSC acknowledges the comment. TIPPS payments are made to in-network providers even if the care delivered is outside of the service delivery area in which the MCO operates. HHSC did not propose modifications related to this topic in the current rule proposal; consequently, other program participants and the public did not have an opportunity to comment on such a change. Should an MCO and provider disagree regarding whether a claim is reimbursable within the

provider/MCO network agreement, the provider and MCO should work through the typical and already established provider/MCO complaint processes. No revision to the rule text was made in response to this comment.

Comment: One commenter supports the proposed elimination of minimum volume requirements for eligibility purposes.

Response: HHSC acknowledges the comment and appreciates the support. No revision to the rule text was made in response to this comment.

Comment: One commenter requests clarification on whether the terms "physician group" or "provider group" have the same meaning.

Response: HHSC acknowledges the comment. HHSC appreciates the suggestion for clarification and is amending "provider group" to read "physician group" in the rule in two instances under Section 353.1309(e)(2), to ensure consistency of terms.

Comment: Multiple commenters believe there is a drafting error in multiple places within the proposed version of the rule, and that HHSC intended to propose: "[P]rogram periods beginning on or before September 1, 2023, but on or after September 1, 2021" instead of "[P]rogram periods beginning on or after September 1, 2023, but on or after September 1, 2021."

Response: HHSC agrees with the suggested edits and made changes to the rule accordingly.

Comment: Multiple commenters ask HHSC to revert to the previous methodology for assigning NPIs to an SDA in which the NPI bills the most claims.

Response: HHSC acknowledges the comment and will evaluate the methodology during the SFY 2025 model preparation. No revision to the rule text was made in response to this comment.

Comment: One commenter asks HHSC to include advanced practice providers in HHSC's list of eligible taxonomy codes for each component of the TIPPS program.

Response: HHSC acknowledges the comment and will evaluate the inclusion of advanced practice providers during the SFY 2025 model preparation. No revision to the rule text was made in response to this comment.

Comment: One commenter requests HHSC to explain if the proposed performance-based Component 2 in SFY 2026 will require a reconciliation or how the agency intends to avoid a reconciliation under the proposed process while also meeting the CMS regulatory requirement for all directed payment programs to be based on the utilization and delivery of services.

Response: HHSC acknowledges the comment. For program periods prior to SFY 2026, HHSC will continue to work with providers as well as CMS on actuarially sound reconciliations and meeting regulatory requirements. The intent of updating this portion of the rule is to eliminate the need for a reconciliation in program years that coincide with, and are subsequent to, SFY 2026. No revision to the rule text was made in response to this comment.

Comment: One commenter wants confirmation on whether HHSC intended for proposed §1309.353(g)(2)(B) and (g)(2)(C) to be at a consistent sub-order as (g)(1)(A)(vi) and (g)(1)(A)(vii), respectively. If so, they ask that HHSC confirm and correct the sub-order, or otherwise explain why identical provisions under Component Two apply to different program years than those under Component One.

Response: HHSC agrees with the suggested changes in the comment and made language updates to the rule text under Section 353.1309(g).

Comment: One commenter asks that the agency remain open to considering separate payment terms for TIPPS if CMS issues favorable regulations or guidance.

Response: HHSC acknowledges the comment and will consider program changes in response to updated CMS guidance, should CMS issue an update. No revision to the rule text was made in response to this comment.

Comment: One commenter supports HHSC's goal of simplifying the program structure.

Response: HHSC acknowledges the comment and appreciates the support. No revision to the rule text was made in response to this comment.

Comment: One commenter recommends that HHSC publish and disseminate the plan codes to enrolled providers once developed and assigned.

Response: HHSC acknowledges the comment. HHSC will disseminate any updates to plan code information to providers once developed and assigned. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters recommend amending "For program periods beginning on or after September 1, 2023, but on or after September 1, 2021" to read, "For program periods beginning on or after September 1, 2021," as those same clauses clearly call out and reference the changes specific to FY25 with the language "periods beginning on or after September 1, 2024." The commenter believes the labeling of the program periods covered under the initial rules is confusing as written and recommends amending "For program periods beginning on or after September 1, 2023, but on or after September 1, 2021" to read, "For program periods beginning on or after September 1, 2021, but prior to September 1, 2024."

Response: HHSC disagrees with the edit language suggested. HHSC made edits that more accurately reflect the rule's intended language, which is being corrected from "on or after September 1, 2023," to "on or before September 1, 2023," throughout the rule text. No revision to the rule text was made in response to this comment.

Comment: One commenter recommends that any minimum window for changes to enrollment information be at least 10 business days instead of 9 calendar days.

Response: HHSC acknowledges the comment and will consider the commenter's suggestion regarding changes to enrollment information for future program operations. No revision to the rule text was made in response to this comment.

Comment: One commenter requests clarification and guidance from HHSC on what "documentation" qualifies as proof of a network agreement. The commenter asked if only fully executed contracts with MCOs are acceptable or if the ability to demonstrate current contract negotiations with an MCO is sufficient for submission and network status credit at the time of TIPPS enrollment.

Response: HHSC acknowledges the comment. Beginning in SFY 2025, the TIPPS enrollment process will include network status validation from both MCOs and providers. HHSC will verify network status at the time of enrollment, and HHSC staff will be available to answer specific questions at that time. No revision to the rule text was made in response to this comment.

HHSC made minor editorial changes in subsections (b)(5), (b)(7), (d)(2), (d)(10), (e)(7), (f)(1), (g)(1)(A)(i), (g)(1)(A)(vi), (g)(1)(B)(ii), (g)(1)(C)(ii), and (g)(2)(A)(vi), (g)(2)(C)(ii), and (g)(3)(A) to correct grammar and improve readability.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner 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 medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment implements Texas Government Code Chapter 531, Texas Government Code, Chapter 533, and Texas Human Resources Code Chapter 32.

This agency hereby certifies that the adoption 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) 707-6071.

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§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 group--A network physician group owned or operated by an institution named in Texas Education Code §63.002.

(2) Indirect Medical Education (IME) physician group--A network physician group contracted with, owned, or operated by a hospital receiving either a medical education add-on or a teaching medical education add-on as described in §355.8052 of this title (relating to Inpatient Hospital Reimbursement) for which the hospital is assigned or retains billing rights for the physician group.

(3) Intergovernmental Transfer (IGT) Notification--Notice and directions regarding how and when IGTs should be made in support of the program.

(4) Network physician group--A physician 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.

(5) Network Status--A provider's network status with a contracted MCO, as determined by the national provider identification (NPI) number and Plan Code combination.

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

(7) Plan code--A unique 2-digit alphanumeric code established by HHSC denoting the individual managed care organization, program, and service delivery area.

(8) Program period--A period of time for which an eligible and enrolled physician 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.

(9) Suggested IGT responsibility--Notice of potential amounts that a governmental entity may wish to consider transferring in support of the program.

(10) 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 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. For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, physician groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 50 percent of the quality metrics in each component to be eligible to participate in the component. For program periods beginning on or after September 1, 2024, no minimum denominator volume is required.

(3) The physician group is:

(A) an HRI physician group;

(B) an IME physician group; or

(C) any other physician group that:

(i) can achieve the minimum volume during program periods beginning on or before September 1, 2023, but on or after September 1, 2021, as described in paragraph (2) of this subsection;

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

(iii) for program periods beginning on or before September 1, 2023, but on or after September 1, 2021, served at least 250 unique Medicaid managed care clients in the prior state fiscal year. For program periods beginning on or after September 1, 2024, no minimum volume is required.

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

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's 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 the eligibility status of other physician groups for program periods beginning on or before September 1, 2023, but on or

after September 1, 2021.

(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 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.

(7) If HHSC is unable to compute an actuarially sound payment rate based on private payor information described in paragraph (6) of this subsection for any services, then those services will be removed from consideration from the TIPPS program.

(8) All services billed and delivered at a Federally Qualified Health Center, dental services, and ambulance services are excluded from the scope of the TIPPS program.

(9) Encounter data used to calculate payments for this program must be designated as paid status. Encounters reported as a paid status, but with zero or negative dollars as a reported paid amount will not be included in the data used to calculate payments for the TIPPS program.

(10) If a provider with the same Tax Identification Number as the payor is being paid more than 200 percent of the Medicaid reimbursement on average for the same services in a one-year period, then a related-party-adjustment will be applied to the encounter data for those encounters. This adjustment will apply a calculated average payment rate from the rest of the provider pool to the related parties paid units of service.

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

(1) The physician 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 release of suggested IGT responsibilities.

(2) Enrollment is conducted annually, and participants may not join the program after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the suggested IGT responsibilities under subsection (f)(1) of this section. For each program period, a physician group must

be located in a Service Delivery Area (SDA) in which at least one sponsoring governmental entity that agrees to transfer to HHSC some or all of the non-federal share under this section is also located. An SDA is designated by HHSC for each provider, or physician group with multiple locations, based on the SDA in which the majority of a physician group's claims are billed. Services that are provided outside of a designated SDA may be included in the designated SDA.

(3) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(4) The entity that bills on behalf of the physician group must certify, on a form prescribed by HHSC, that no part of any TIPPS payment will be used to pay a contingent fee nor may the entity's agreement with the physician group use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the physician group's receipt of TIPPS funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(5) If a provider has changed ownership in the past five years in a way that impacts eligibility for the TIPPS program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, the TIPPS program.

(6) Report all quality data denoted as required as a condition of participation in §353.1311(d)(1) of this subchapter.

(7) Failure to meet any conditions of participation described in this subsection will result in the removal of the provider from the program and recoupment of all funds previously paid during the program period.

(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 groups and IME physician groups at least 10 calendar 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 groups and IME physician groups, plus estimated utilization for eligible and enrolled other physician groups within the same service delivery area, for the program period. HHSC will also communicate the estimated maximum revenues each eligible and enrolled physician 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 physician 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 21 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) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. 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 physician groups will be based on each physician group's performance related to the quality metrics as described in §353.1311 of this subchapter. The physician 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) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, the total value of Component One will be equal to 65 percent of the total program value.

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

(ii) Monthly payments to HRI and IME physician groups will be a uniform rate increase.

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

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(v) 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 120 days after the last day of the program period.

(vi) Redistribution resulting from the reconciliation will be based on the actual utilization of enrolled NPIs.

(vii) If a provider eligible for TIPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(B) For the program period beginning on September 1, 2024, the total value of Component One will be equal to 90 percent of the total program value.

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

(ii) Payments to physician groups will be a uniform rate increase paid at the time of claim adjudication.

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

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(C) For program periods beginning on or after September 1, 2025, the total value of component one will be equal to 55 percent of the total program value.

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

(ii) Payments to physician groups will be a uniform rate increase paid at the time of claim adjudication.

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

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, the total value of Component Two will be equal to 25 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will

be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be a uniform rate increase.

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

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(v) 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 120 days after the last day of the program period.

(vi) Redistribution resulting from the reconciliation will be based on the actual utilization of enrolled NPIs.

(vii) If a provider eligible for TIPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(B) For the program period beginning September 1, 2024, Component Two will be equal to 0 percent of the program.

(C) For program periods beginning on or after September 1, 2025, the total value of Component Two will be equal to 35 percent of the total program value.

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

(ii) Payments to physician groups will be made through a pay-for-performance model based on their achievement of quality measures and paid through a scorecard.

(iii) Other physician 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 the total program value.

(B) Allocation of funds across physician 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 physician groups will be a uniform rate increase.

(D) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(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 and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs and the MCO network status at the time of the application under subsection (e)(1) of this section. For example, for a physician group, HHSC will calculate the portion of each PMPM associated with that group that would be paid from the MCO to the physician group as follows.

(A) Payments from Component One.

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, payments will be monthly and will be equal to the total value of Component One for the physician group divided by twelve.

(ii) For program periods beginning on or after September 1, 2024, payments will be made as a uniform percentage increase paid at the time of claim adjudication.

(B) Payments from Component Two.

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, payments will be semi-annual and will be equal to the total value of Component Two for the physician group divided by 2.

(ii) For the program period beginning on September 1, 2024, no payments will be made for Component Two.

(iii) For program periods beginning on or after September 1, 2025, payment will be made on a scorecard basis at payments based on the reporting of quality measures and paid through a scorecard at the time of achievement.

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

(2) MCOs will distribute payments to enrolled physician groups as directed by HHSC. 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 physician group closes voluntarily or ceases to provide Medicaid services, the physician 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.

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