Attachment B

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The Texas Incentives for Physicians and Professional Services program (TIPPS) is comprised of three payment components payable to three classes of physician groups.

Component 1: Only applicable to Class 1 and Class 2 providers. It will consist of an incentive payment equal to 65% of the total program funds. The estimated value of the incentive payment for each provider will be based upon the proportion of historical counts of unique members served by the provider to the total number of members receiving services from participating providers. As a condition of participation, providers must report on quality improvement activities on a semi-annual basis and must serve at least one Medicaid member in the reporting period. Payment distribution will be reconciled to actual utilization during the program year if there is a statistically significant variance in the clients served between the historical data and the program period.

Component 2: Only applicable to Class 1 and Class 2 providers. It will consist of a performance incentive payment paid on a semi-annual basis triggered by achievement on specified performance measures. This component will be equal to 25% of the total program funds. The estimated value of the performance incentive payment for each provider will be based upon the proportion of a provider's historical paid claims to the total paid claims of participating providers. To qualify for Component 2 payments, providers must achieve quality improvement measures that will be reported on a semi-annual basis and must serve at least one Medicaid member in the reporting period.

Component 3: A targeted rate increase limited to professional encounters that is available to all provider classes. Applicable CPT codes would include 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215. To qualify for Component 3 payments, providers must achieve quality improvement measures that will be reported on a semi-annual basis and must serve at least one Medicaid member in the reporting period. If a provider demonstrates achievement of the quality measures, the provider will receive payments as a uniform rate increase on paid claims.

Component 1 consists of structure measures. Components 2 and 3 consist of process and outcome measures that are identified as either improvement over self (IOS) and benchmark quality measures. Providers are required to report baselines for IOS measures as a condition for participation in the program. For

benchmark measures, providers must meet or exceed national benchmarks to be eligible for payment. Only providers with the required minimum volume in measure denominators will earn payment for achievement on those measures. Funds that are non-disbursed due to failure of one or more physician groups to meet performance requirements will be distributed across all qualifying physician groups in the service delivery area based on each physician group's proportion of total earned TIPPS funds from Components One, Two, and Three combined at the end of the year.