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Submitted via email to [RAD 1115 Waiver Finance@hhsc.state.tx.us](mailto:RAD_1115_Waiver_Finance@hhsc.state.tx.us)

Dear Ms. Grady:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the proposed rule on the Texas Incentives for Physicians and Professional Services Program. For select hospitals, and their associated physician groups, the proposed TIPPS Program will help lessen the funding shortfall attributable to the DSRIP transition. Although we are supportive of HHSC's proposed TIPPS Program, we have several questions/comments on the following issues:

- Program Classes
- Program Funding
- Program Eligibility- IME Groups
- Quality Measures (Note: additional comments will be provided by the Feb. 2 deadline)

Background

The proposed rule describes the circumstances under which HHSC will direct a Medicaid managed care organization 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 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. The proposed Texas Incentives for Physician and Professional Services Program is a physician-directed payment program that may serve as a transition for Network Access Improvement Program and Delivery System Reform Incentive Payment for physician practice groups. The program is intended to serve as a performance incentive and value-based payment arrangement, with a small component of a uniform rate increase. 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.

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.

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.

Issue # 1 – Program Classes-Eligibility

As proposed, Section 353.1309 identifies three physician practice group classes eligible to participate in TIPPS: (1) Health Related Institution (HRI) groups; (2) Indirect Medical Education (IME) groups; and (3) Other groups. The proposed definition of an HRI physician practice group indicates it must be “associated with an institution” named in the Texas Education Code §63.002. However, the rule and preamble fail to explain what is meant by “associated with” for purposes of determining eligibility to participate in this class. Does a written contract between a physician group and an HRI named in the Education Code to provide resident training meet the requirement? Or is HHSC’s intent that only the physician groups owned and operated by the HRI are eligible?

Recommendation:

- HHSC revise the definition of HRI physician practice group prior to adopting the rule to clarify eligibility to participate in the program as a member of this class.

Issue # 2 – Program Funding

As proposed, the TIPPS Program has three classes, HRI, IME and Other. It assumes that HRIs and IME can provide IGT. Subsection (f)(2) of the proposed rule appears to require all sponsoring governmental entities to submit a declaration of intent to transfer IGT to HHSC for the entire program period. However, Subsection (f)(1) only requires that HHSC provide notice of “suggested IGT responsibilities for the program period” to eligible and enrolled HRI and IME physician groups prior to the IGT declaration of intent deadline. The notice to those entities would include the “estimated utilization for eligible and enrolled other physician practice groups within the same service delivery area.”

Based on this language, it is unclear whether HHSC intends to provide notice to sponsoring governmental entities of the “other” group; or whether it intends for the sponsoring governmental entities of the HRI and IME physician groups to fund the non-federal share of the TIPPS rate increases to the “other” class.

Recommendation:

- HHSC revise the rule before adoption to clarify whether the “other” class members will be required to identify a sponsoring governmental entity to be notified of suggested IGT amounts.

Issue # 3 – Program Eligibility-IME Groups

The definition of “Indirect Medical Education (IME) physician practice group” at proposed 1 TAC §353.1309(b)(2) only captures physician practice groups that are “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.”. We are unsure why HHSC put the billing requirement in the IME definition in the rule.

In order to comply with the state’s corporate practice of medicine requirements, hospitals have established legal structures that do not result in the assignment of those billing rights to the hospital but rather to a separate legal entity related to the hospital. We understand that many physician groups contracted with IME hospitals do not assign the hospital their billing rights, instead use an affiliated nonprofit entity associated with the hospital to fulfill those functions. Eligibility to join the IME component is contingent on the hospital receiving the “billing rights”. Under these arrangements the hospital is the member, but the billing rights for the group remains at the nonprofit entity level. Other hospitals may utilize “friendly” captive physician practice group models where the hospital or a hospital-affiliated management company manages a third-party physician practice group entity, such as a PLLC or professional association with the billing rights for the group maintained by the physician entity instead of the hospital.

Recommendation:

- HHSC amend, before adoption, the proposed rule to clarify that physician groups are eligible to participate as a member of this class if they are contracted with, owned, or operated by, and assign billing rights to, “a hospital receiving the medical education or teaching medical education add-on.”

Other verbiage that may potentially achieve a similar outcome include the following:

- HHSC modify the definition of IME Practice Groups to consider related legal entities to meet the hospital assignment requirement as long the legal entity meets the Medicare definition of a “related organization” under 42 CFR §413.17.
- HHSC modify the definition of IME Practice Groups by deleting the reference to “assigned billing rights” a hospital receiving the indirect medical education add-on ~~for which the hospital is assigned billing rights for the physician practice group.~~
- HHSC modify the definition of IME Practice Groups to “ A network physician group contracted with, owned or operated by a hospital receiving the indirect medical education add-on for which the hospital (or an entity that meets the Medicare definition of a related organization as defined under 42 CFR §413.17) is assigned billing rights for the physician practice group.”

- HHSC modify the definition of IME Practice Groups to include those IME hospitals in which the “billing rights” were assigned to the entity that’s related to the hospital

Additional IME Group Comments

- The definition of an IME physician practice group indicates it must be contracted with, owned, or operated by a hospital receiving the IME add-on and that has billing rights for the group. However, the inpatient reimbursement rule does not describe an “IME add-on,” but instead describes two separate medical education add-ons -- one for urban hospitals and one for children’s hospitals. The use of the term “IME add-on” therefore leaves room for multiple interpretations of physician practice groups eligible to participate in the program as a member of this class. HHSC should clarify this definitional issue.
- The IME Group definition states that only those physician groups affiliated with a hospital “receiving the indirect medical education add-on” will qualify as an IME physician practice group. This language could be construed to limit participation based on the timing of when a hospital receives the IME add-on. Therefore, we recommend that the definition be amended to make clear that a group will qualify as an IME physician practice group if it is affiliated with a hospital that has an approved teaching program during the applicable TIPPS program period, which thereby makes such hospital eligible to receive the IME add-on—regardless of the timing of the hospital’s actual receipt of the IME add-on.
- HHSC include explanatory language in its proposed definition of IME physician practice groups that explains that rationale as to why the proposed definition cites 42 C.F.R. §413.17.

Issue # 4 - Quality Measures

Pay-for-Performance Conditions – HHSC explicitly proposes to condition TIPPS Components Two and Three, which together comprise 35% of the total TIPPS payment opportunity, on provider achievement of certain quality metrics. This pay-for-performance requirement under TIPPS is significantly more onerous than what CMS requires, and what HHSC is proposing for CHIRP, which only includes reporting requirements. We do not know what HHSC's rationale is for distinguishing between the two programs.

Quality Specifications – Providers’ clinical and quality teams review the proposed measure specifications to assess both the feasibility of complying with the reporting requirements and the likelihood of achievement, as necessary for the pay-for-performance components. For example, providers may find it impractical or costly to comply with HHSC’s proposed requirement that providers report on measures separately by payor (i.e., stratifying reporting for each Medicaid managed care product, “Other Medicaid,” “Uninsured,” and “Other payor types”).

Carryforward Opportunity - HHSC should allow participating providers to carry forward reporting and payment opportunities, to the extent a participating provider fails to achieve a metric at the first reporting opportunity.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions, please do not hesitate to contact me at rschirmer@tha.org or 512/465-1056.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "Richard Schirmer".

RICHARD SCHIRMER, FACHE, FHFMA
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