DPP 101

Introduction to Directed Payment Program Quality Reporting

CHIRP, TIPPS, RAPPS, & DPP BHS

March 2024

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TEXAS
Health and Human Services

Contents

This document is a resource for people who are responsible for submitting quality reporting for CHIRP, TIPPS, RAPPS, and DPP BHS.

Quick Facts

What are Directed Payment Programs?

Directed Payment Programs (DPPs) are designed to help Medicaid managed care programs achieve delivery system and payment reform and performance improvement. Participating providers submit quality reporting and receive payments from MCOs as directed by HHSC.

HHSC currently operates five DPPs. The Quality Incentive Payment Program (QIPP) for nursing facilities began in State Fiscal Year (SFY) 2018. The four programs listed below began in SFY 2022.[1] This document provides guidance for these four DPPs.

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

Who participates in the DPPs?

Each DPP is limited to specific classes of providers and Medicaid managed care programs.

CHIRP

Children's hospitals, rural hospitals, mental health hospitals, state-owned hospitals, and urban hospitals that provide health care services to Texans enrolled in STAR and STAR+PLUS Medicaid programs.

DPP BHS

Certified Community Behavioral Health Clinics (CCBHCs) that provide behavioral health services to Texans enrolled in STAR, STAR+PLUS, and STAR Kids Medicaid programs.

RAPPS

Rural health clinics (RHCs) that provide primary care and long-term care services to Texans enrolled in STAR, STAR+PLUS, and STAR Kids Medicaid programs.

TIPPS

Health-related institutions, indirect medical education physician groups affiliated with hospitals and other physician groups that provide health care services to Texans enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs.

[1] You can find more information on QIPP on the Medicaid and CHIP Directed Payment Programs webpage: https://www.hhs.texas.gov/providers/medicaid-business-resources/medicaid-chip-directed-payment-programs.

Conditions of Participation

CHIRP, TIPPS, RAPPS, and DPP BHS require participants to submit quality reports to HHSC as a condition of participation in the program. If you do not meet the conditions of participation, you will be removed from the program, and payments you received will be recouped.

Pay-for-Performance (P4P)

Starting in SFY2025, CHIRP will include a P4P component for eligible hospitals where hospitals must improve on certain measures to earn a portion of their payment. Beginning in SFY2026, TIPPS will include a P4P component for some participants.

When do I submit quality reporting?

There are two rounds of reporting in each state fiscal year (SFY), followed by an opportunity to correct your reporting if needed. You must submit quality reporting in each quality reporting round. HHSC will share exact dates with participants prior to the reporting round.

- October – Quality Reporting Round 1
- April – Quality Reporting Round 2
- June/July – Corrections Round

I'm new to directed payment programs. How do I get up to speed?

1. Sign up for GovDelivery notices to receive alerts related to the DPPs. CHIRP DPP BHS TIPPS RAPPS
2. Sign up for the DPP Quality contact list and get reporting portal access by submitting the DPP Contact Form. Program contacts will receive monthly updates from HHSC's DPP Quality Team.
3. Review quality reporting resources
    - The Medicaid and CHIP Directed Payment Programs webpage is available to the public and includes current Reporting Requirements, Measure Specifications and FAQ, and program evaluation reports.
    - The Reporting portal bulletin board (requires login credentials) is available to current DPP program participants and includes technical resources like quality reporting templates and quality measurement trainings.
4. Send additional quality reporting questions to DPPQuality@hhs.texas.gov

Quality Goals & Objectives

Quality Goals

DPPs must advance the goals in the Texas Managed Care Quality Strategy. Each quality measure that you report for the DPPs aligns with one of Texas's quality strategy goals listed below.

Quality Strategy Goal	CHIRP	DPP BHS	RAPPS	TIPPS
Promoting optimal health for Texans	√	√	√	√
Providing the right care in the right place at the right time	√	√	√	√
Keeping patients free from harm	√			
Promoting effective practices for people with chronic, complex, and serious conditions	√	√	√	√
Attracting and retaining high-performing Medicaid providers to participate in team based, collaborative, and coordinate care	√	√	√	√

How do I contribute to the quality goals of the DPPs?

You contribute to the quality goals and objectives by tracking the required quality measures and improving your performance over time.

Quality reporting is made public so that you can compare your performance to your peers and to state and national benchmarks.

HHSC and MCOs may also use your performance data to provide technical assistance or develop possible policy or program changes to drive quality improvement.

Program Evaluation

Your quality reporting, as well as data from other sources, is used to assess the degree to which the programs are meeting their quality goals and objectives. Statewide program level evaluations are completed by HHSC as part of the annual program application and approval process.

Visit the Directed Payment Program Evaluation webpage for more information about the DPP evaluation plans.

Evaluation Targets

Beginning in the SFY2024 program year, HHSC set evaluation targets for some of the provider reported measures. These targets are an improvement in the median rate reported by participating providers. The targets will help Texas measure improvements in the program over time. Providers should monitor their performance relative to these targets and identify opportunities to improve their performance if needed.

Program Development

Program Approval

DPPs are approved by the federal Center for Medicaid and Medicare Services (CMS). Texas HHSC submits an application (also called a preprint) to CMS for annual approval of a program. The application includes the quality goals and objectives and the measures that participating providers must report, as well as an evaluation of statewide prior year performance.

CMS will use evaluation findings to make decisions about future program years. CMS expects states to demonstrate year over year improvement through annual evaluations.

HHSC publishes Texas Administrative Code rules that align with the application.

- Approved preprints and correspondence with CMS
- Proposed preprints
- Other states' approved state directed payment preprints.

How can I participate in program development?

You can participate in the development of the DPPs by:

- Participating in stakeholder workgroups. Targeted stakeholder engagement is held in the summer or fall preceding each program year. Workgroups may include existing program participants, representatives from MCOs, and other quality experts. Participation from clinical quality experts is strongly encouraged.

- Reviewing and submitting written comments on proposed changes to administrative rules. Rule changes are published in the Texas Register in the fall or winter preceding each program year, if needed.

- Reviewing and submitting written comments on proposed quality measures and requirements. Draft requirements are posted in December preceding each program year.

Program Cycle

Develop DPP

- Stakeholder engagement & public hearings
- HHSC updates rules
- HHSC submits preprint to CMS

Prepare for the Program Year

- HHSC finalizes quality measures and requirements
- Providers apply to participate
- HHSC collects Intergovernmental Transfers (IGT)

Implement

- CMS approves DPP
- Providers submit quality reporting
- HHSC drafts evaluation report

Program Enrollment

How do I enroll in a DPP?

The annual enrollment process is handled by the Provider Finance Department (PFD). Program enrollment announcements will go out through GovDelivery early in the calendar year. You must ensure that you are signed up for your program's GovDelivery notices to receive these announcements.

During the enrollment process, links to the applications and information on eligibility will be posted on each PFD program website:

- CHIRP
- DPP BHS
- RAPPS
- TIPPS

Am I automatically enrolled if I participated in the past?

No. You must apply for enrollment annually.

How do I know if I'm enrolled?

If you have questions about enrollment or provider eligibility, contact PFD. Financial modeling, intergovernmental transfers (IGT), and payments calculations (scorecards) are also handled by PFD:

- Email
  - CHIRP & RAPPS: PFD_Hospitals@hhsc.state.tx.us
  - DPP BHS: PFD_DPPBHS@hhs.texas.gov
  - TIPPS: PFD_TIPPS@hhs.texas.gov
- Website: PFD Supplemental Payments Information

Payment Eligibility & Performance

Are my payments impacted by my performance on quality measures?

At this time, your eligibility for DPP BHS, RAPPS and TIPPS payments are not impacted by your performance on quality measures or on meeting the evaluation targets. This may change in the future.

Starting in SFY 2025, a component of pay-for-performance (P4P) measures, referred to as Component 3, will be added to CHIRP. Urban and children's hospitals will be eligible to participate in this component. CHIRP payments for components 1 and 2 are not impacted by your performance on quality measures or on meeting the evaluation targets.

What is pay-for-performance (P4P)?

Pay-for-Performance (P4P) is a payment model in which you receive incentive payments for meeting quality goals and targets.

For example, you may have a goal meet or exceed a 10% gap closure over your baseline on a quality measure. You would receive funds for meeting or exceeding this goal. Some P4P programs may also offer partial payment for partially achieving your goal.

SFY 2025 CHIRP Component 3 uses a payment tier system where the percentage of total available points the hospital earns determines their payment tier. Providers who achieve 50% or more possible points will receive 100% of the possible Component 3 funding. You can find more information about P4P in CHIRP in the SFY 2025 CHIRP Requirements document.

Where can I find more information about CHIRP Component 3?

An overview of CHIRP Component 3 can be found in the SFY 2025 CHIRP Requirements document that is posted on the CHIRP quality website. It includes details on:

- Achievement Calculation and Payment Tiers
- Achievement Targets
- Urban Hospital P4P Measures
- Children's Hospital P4P Measures

An SFY 2025 CHIRP Component 3 Achievement Calculator is also available to help you determine your performance on CHIRP Component 3 measures. It can be found on the reporting portal's bulletin board and on the CHIRP quality website.

You can also get more information on CHIRP Component 3 measures, how achievement is calculated, and how payment is determined by watching the recording of the Getting Ready for CHIRP Component 3 Quality Reporting webinar, found on the CHIRP quality website.

What is the CHIRP Component 3 achievement calculator? This Excel file includes four tabs with achievement calculators, one for each goal calculation type (high benchmark, average benchmark, actual/expected ratio, and improvement over self). You can enter your baseline into the calculator to help calculate your performance goal. You can also enter performance data to help you determine whether you fully achieved, partially achieved or did not achieve your Component 3 measures.

The file also includes a tab with a points calculator that you can use to determine what payment tier you achieved. The payment tier will determine the percentage of total possible payment you will receive for Component 3.

The achievement calculator is a tool to use for planning purposes prior to reporting your baseline and performance data to HHSC and you do not need to submit the calculator to HHSC.

Quality Reporting Process

What types of quality data will I submit?

There are two types of quality data that you must track:

- Structure measures like Health Information Exchange participation. Structure measure reporting requires you to respond to qualitative questions. You do not have to implement the structure measures that are being tracked.
- Process or outcome measures, like rates of screening for food insecurity, diabetes control, or unintentional medication discrepancies. Process and outcome measure reporting requires you to submit a numeric performance rate for a specific time period and respond to qualitative questions.

Which measures do I have to report?

The measures you must report are determined by your provider class. The measures that each provider class must report are listed in the Reporting Requirements document.

The reporting template will also indicate the measures you must report based on your provider class.

If you are uncertain which measures you must report for a given program year, contact DPPQuality@hhs.texas.gov

How do I use the Measure Specifications file?

The measure specifications are a Microsoft Excel file with detailed instructions for how to report each structure, process, and outcome measure.

Make sure you are using the most recent version of the file for the program year for which you are reporting, which is posted to each program's quality website.

Tab Title	What key information is on each tab?
Introduction	- File version - Detailed description of each tab in the file and the definitions of all columns (data fields)
Measure Specifications	- Measurement periods - Information about the measure steward with links - Numerator and denominator inclusion and exclusion criteria for process and outcome measures, including what codes, as applicable, to look for in each step - Program-specific modifications and other helpful information for quality reporting
Specs Viewer	- Measure specifications information in a printer friendly version - Can be used to print specifications for individual measures by selecting Measure ID in cell E2
Change Log	- Changes made to the file since the prior file version
FAQs	- Frequently asked questions updated throughout the program year

How will I submit my quality reporting?

You will use an Excel-based reporting template to enter numerator and denominator data for process and outcome measures and to respond to qualitative questions.

You will upload your completed reporting template to the reporting portal.

How do I get the reporting template?

The reporting template will be made available on the reporting portal bulletin board approximately 30 days prior to the reporting submission deadline. HHSC will send an email to DPP quality contacts and send a GovDelivery notice when the reporting template is available. The reporting template is updated for each reporting period and cannot be re-submitted.

Will there be additional trainings to help me get ready for reporting?

HHSC hosts a webinar for program participants at the starts of each reporting period. Additional training opportunities may occur throughout the year.

Information about DPP participant quality reporting trainings will be sent to the DPP Quality contact list and will be posted to the online reporting portal bulletin board.

Can I see a copy of a reporting templates from prior years?

While reporting templates from prior years are no longer available, the reporting portal bulletin board typically includes a link to a webinar from the last reporting period where you will see a walk-through of the reporting template.

How long does it take to complete the reporting template?

The amount of time it takes to complete the quality reporting template will depend on a number of factors including how many measures you are reporting. In prior years, participants report that it takes them on average less than 2 hours to complete the reporting template.

Reporting Portal

You will use a reporting portal to upload your reporting template and to access reporting resources on the bulletin board.

In March 2024 the program will transition to a new reporting portal that is accessed through IAMOnline. If you are a user for the current reporting portal, your account will be added automatically to the new one. New users will need to register with IAMOnline for an account and request access to the new reporting portal. Additional guidance and training will be provided when the new reporting portal goes live.

We will continue to use the bulletin board feature on the old reporting portal until we officially switch to the new one for the SFY 2024 Round 2 reporting period. You can use the instructions below to access and navigate the old reporting portal.

How do I request access to the reporting portal?

If you need access to the reporting portal, submit a DPP Contact Form.

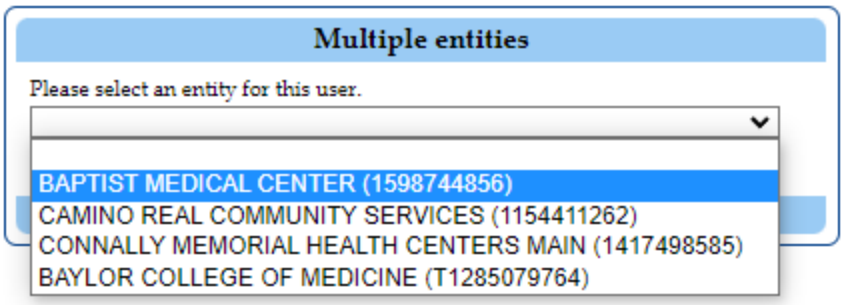
Once you are registered, you will receive two automated "Welcome to DSRIP and DPP Online Reporting System" emails from TXHealthcareTransformation_DoNotReply@hhsc.state.tx.us containing your login credentials and a link to the reporting portal. Check your junk folder if automated emails are not received.

How do I log into the reporting portal?

Navigate to the reporting portal and use the login credentials (i.e., Login ID and Password) provided in the automated "Welcome to the DSRIP and DPP Online Reporting System" email to access the reporting system.

There is a limit of **seven** login attempts. If you fail to login six times, you may want to reset your password through the **FORGOT PASSWORD/LOGIN?** link.

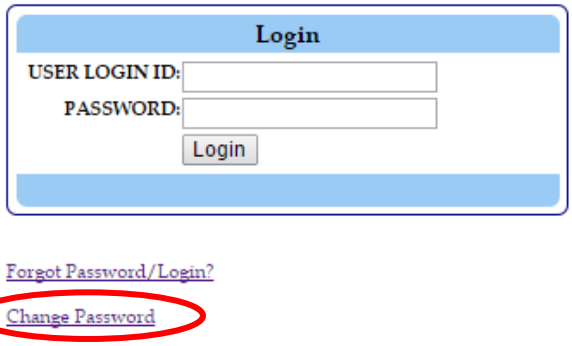
If your user account is affiliated with more than one participating provider and/or DPP (i.e., CHIRP, DPP BHS, RAPPS, and/or TIPPS), you will be prompted to select a provider when logging in, as shown in the screenshot below. CHIRP, DPP BHS, and RAPPS will have the provider's NPI next to the provider name, while TIPPS will have the Provider ID.



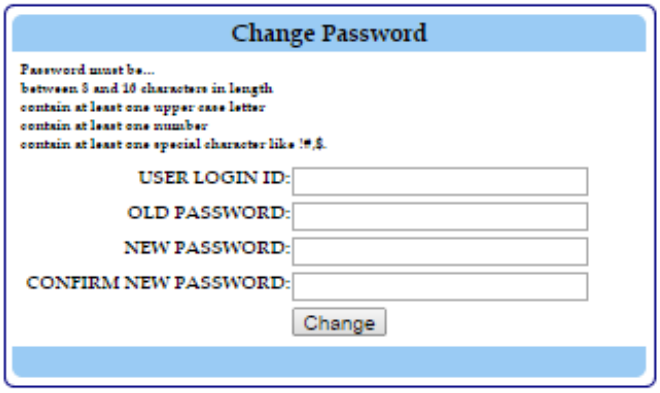
How do I change my password?

To change or personalize your password, follow these steps:

Step 1: On the reporting portal login screen, click the **CHANGE PASSWORD** link.



Step 2: Enter your Username, your temporary password (Old Password), and then your personalized password (New Password) twice. Click **CHANGE**.



Step 3: A message in green text should appear at the top of the page noting the "Password changed successfully." You can use the new password to log in as soon as you see this message.

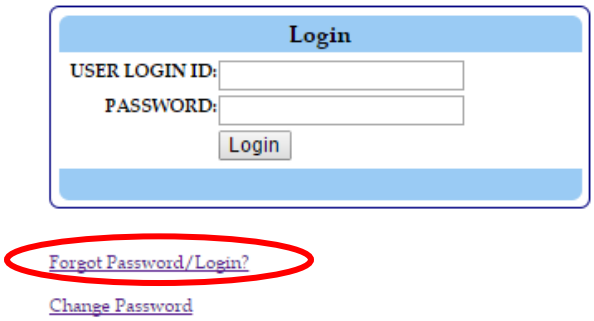
Reporting System Login Screen After Password Change

Shows "Password changed successfully" after a user changes their password.

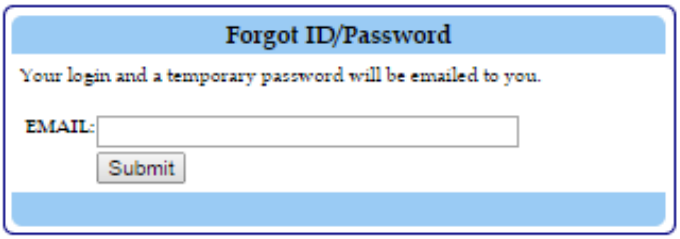
How do I reset my password?

To reset your password, follow these steps:

Step 1: On the Online Reporting Portal login screen, click the **FORGOT PASSWORD/LOGIN?** link.



Step 2: Enter your registered email address and click **SUBMIT**.

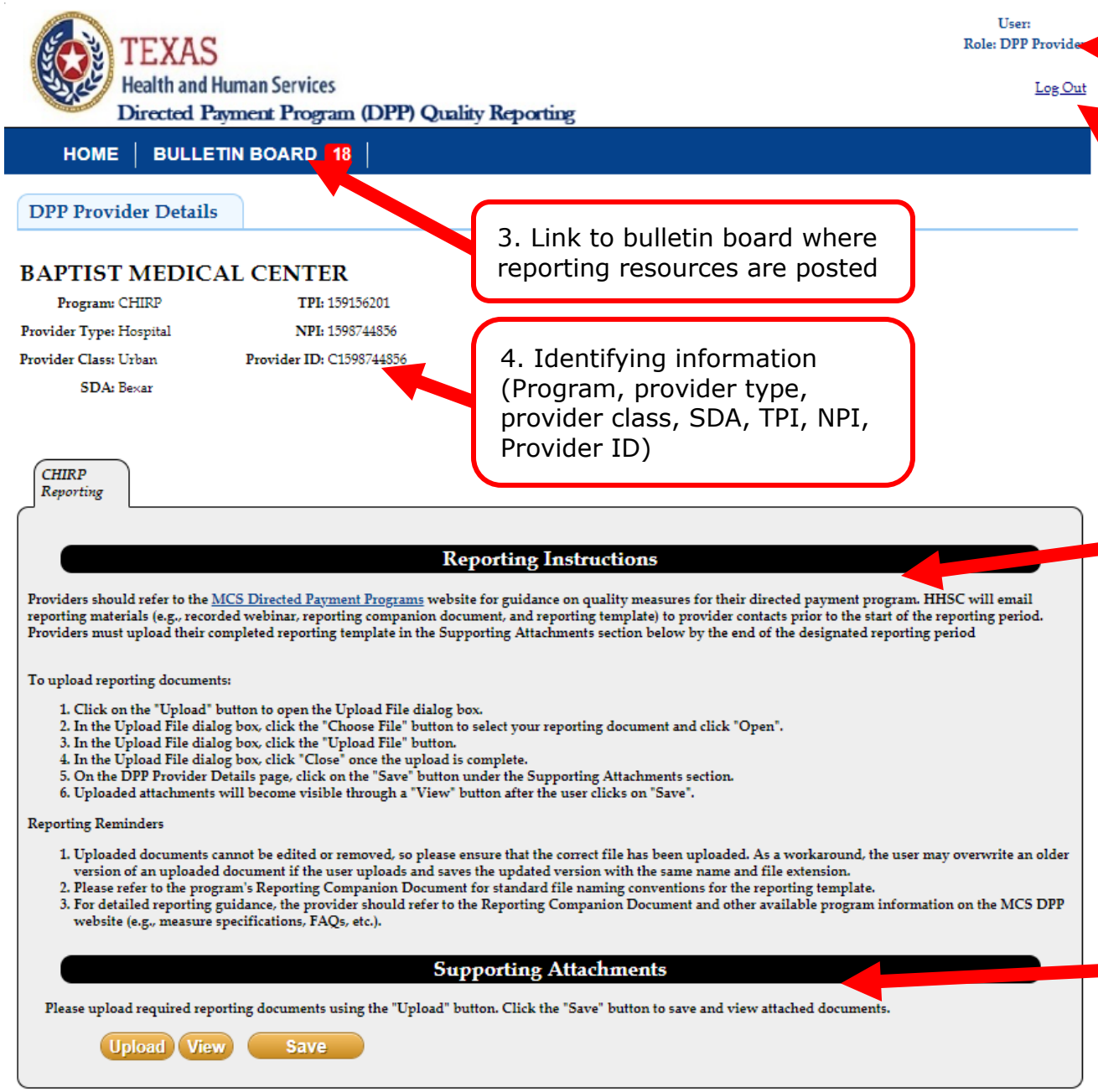


Step 3: You will receive an automated email containing a new temporary password shortly after you submit your email address. You can then use this "old password" to create a new personalized password in the **Change Password** process.

How do I unlock my user account?

If your account is locked due to too many login attempts, email DPPQuality@hhs.texas.gov and request that your account be unlocked. Account unlock requests are processed during HHSC business hours and may take up to two days.

How do I navigate the DPP Provider Homepage?



1. You Must be logged in as a **DPP Provider** to upload a template

2. Select **LOG OUT** to end your session

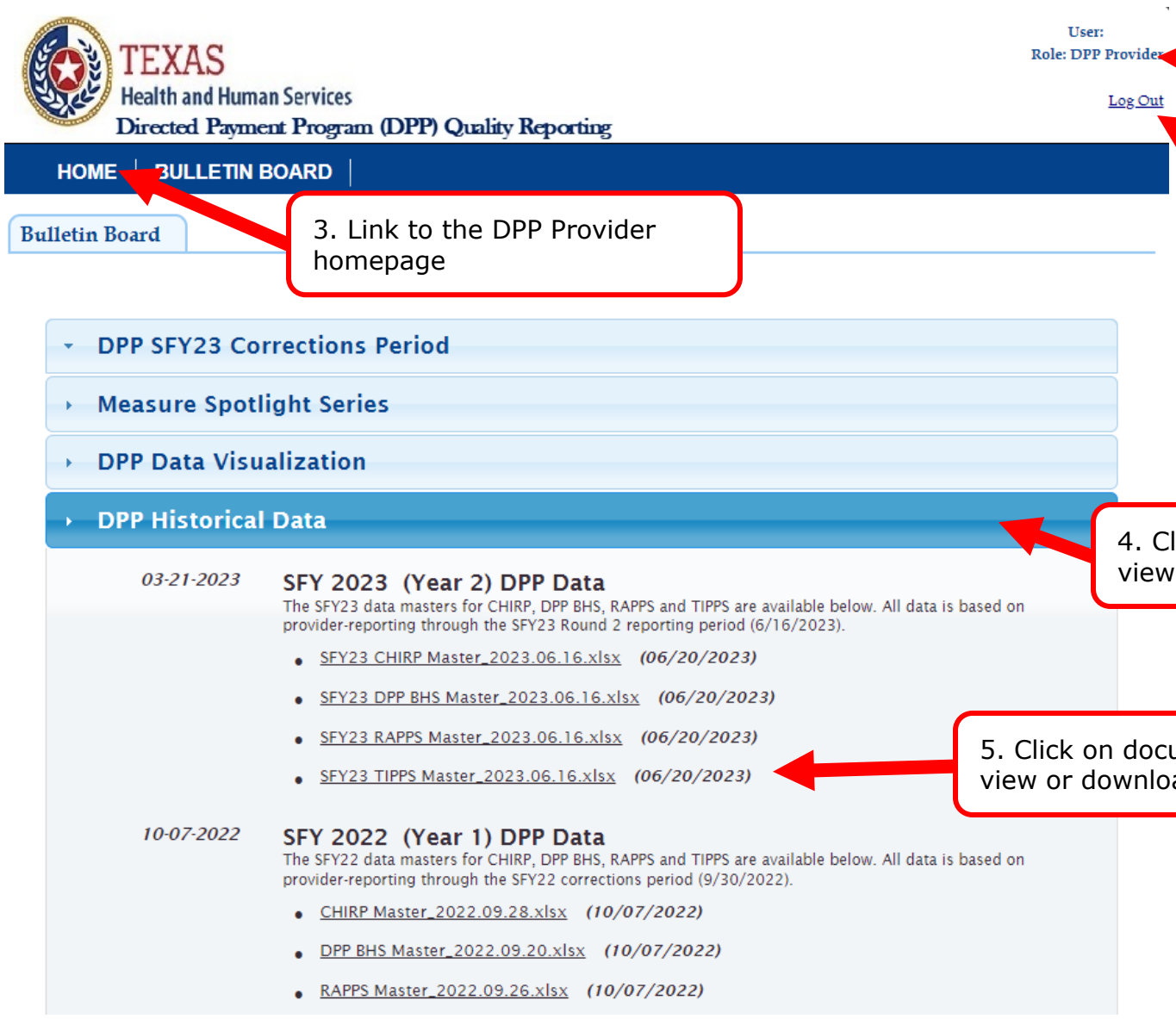
3. Link to bulletin board where reporting resources are posted

4. Identifying information (Program, provider type, provider class, SDA, TPI, NPI, Provider ID)

5. Guidance on how to upload your reporting template and other reminders

6. Provides options to upload, save, and view files

How do I navigate the bulletin board?



1. You must be logged in as a **DPP Provider** to view the bulletin board

2. Select **LOG OUT** to end your session

3. Link to the DPP Provider homepage

4. Click on a section header to view related posts

5. Click on document link to view or download

How can I tell if there is a new post on the bulletin board?

A red notification should appear next to "Bulletin Board" on the menu bar when something new has been posted.

HHSC will also notify participants through our DPP contact lists when new information and resources are posted on the bulletin board or when a file has been updated.

How do I remove a user?

If you are the lead contact for an organization, you can request to remove access for staff members who are no longer with the organization by emailing DPPQuality@hhs.texas.gov

You can also submit a DPP Contact Form if there are multiple changes to be made (e.g., the contact is being replaced). HHSC will deactivate the account so the user no longer has access to the reporting portal.

Reporting Portal Tips

- Uploaded documents cannot be edited or removed. However, the user can upload and save an updated version with the same name and file extension to overwrite the original version.
- The reporting portal will log you out if you are idle for more than 20 minutes and will prompt you to log in again.
- Temporary passwords will expire after two days but can still be used in the Change Password process.
- Temporary passwords are case sensitive.
- When copying and pasting a temporary password, make sure there are no extra spaces at the end of the password.

Common Terms & Acronyms

Common DPP Terms

Term	Definition
Application	Application that providers submit annually to be eligible for a specific DPP
Baseline	Is a set of data collected before any intervention or action is applied. It allows to assess effectiveness of the intervention after its implementation.
Baseline Period	HHSC-defined period in which a baseline is established. In P4P, the baseline period is used to determine achievement compared to the performance period.
Benchmark	A benchmark is a rate used as a point of comparison. It can be based on state or national data. In CHIRP, most P4P measures have a benchmark that is used to set goals.
Corrections Period	HHSC-defined period during which providers can submit corrections to previously submitted data
Evaluation	Analysis of the directed payment programs based on the review of provider reported data as well as data received from the external review organization that tells the state and federal government whether the program is achieving its goals
Performance Period	Time period in which a clinical or process action must be completed to achieve desired results. This period is used to measure performance.
Process and Outcome measures	Data measures that providers are required to report on
Provider ID	Unique ID assigned to a participating provider that includes the first letter of the program name and eligible billing NPI
Required Corrections	Corrections that providers must submit to remain eligible for program participation

Term	Definition
Reporting Period	HHSC-defined period during which providers submit required reporting
Reporting Portal	Web-based application used by providers to submit required reporting and access reporting resources and templates
Structure Measures	Measures that assess attributes of healthcare setting, including various resources (e.g. electronic health records and number of staff)
Template	Required file (Excel) that providers must populate to submit their reporting

Common Acronyms

Acronym	Definition
ACIA	Average Commercial Incentive Award is a uniform rate enhancement, based upon a percentage of the estimated average commercial reimbursement. ACIA is Component 2 in the Comprehensive Hospital Increase Reimbursement Program.
ACR	Average Commercial Reimbursement is an estimate of what average commercial payor would pay for the services
AHRQ	Agency for Healthcare Research and Quality is the lead federal agency charged with improving the safety and quality of healthcare
AIM	Alliance for Innovation on Maternal Health is a national data-driven maternal safety and quality improvement initiative with the goal of improving maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles.
APHRIQA	Alternate Participating Hospital Reimbursement for Improving Quality Award is Component 3 in the Comprehensive Hospital Increase Reimbursement Program. Its payments are based on achievement of P4P quality measures.
BHS	Behavioral Health Services includes a wide range of diagnostic, therapeutic, and rehabilitative services used in treatment of mental health, substance abuse and co-occurring disorders
CAHPS	Consumer Assessment of Healthcare Providers and Systems is an AHRQ program with the goal of understanding patient experience with healthcare.
CCBHC	Certified Community Behavioral Health Clinic is a clinic that provides a comprehensive range of mental health and substance use services
CHIP	Children's Health Insurance Program. CHIP covers children and youth who don't qualify for Medicaid due to family income. CHIP is not included in the directed payment programs.
CFR	Code of Federal Regulations codifies rules published in the Federal Register by various federal agencies.

Acronym	Definition
CHIRP	Comprehensive Hospital Increased Reimbursement Program is a Directed Payment Program administered by HHSC that provides increased Medicaid payments to hospitals for inpatient and outpatient services provided to persons enrolled in STAR and STAR+PLUS
CMHC	Community Mental Health Center is an entity that provides a variety of services including outpatient services, including specialized outpatient services for children, the elderly, and individuals who are chronically mentally ill. CMHCs participate in DPP BHS.
CMS	Centers for Medicare & Medicaid Services is a federal agency that oversees the Medicare and Medicaid programs
COP	Condition of Participation refers to requirements described in Texas Administrative Code for providers willing to participate in the directed payment programs
CQM	Clinical Quality Measures are used to assess observations, treatment, processes, experience, and outcomes of patient care
CY	Calendar Year
DPP	Directed Payment Program is designed to help managed care program achieve delivery system and payment reform and performance improvement under Medicaid managed care contracts. DPPs are governed by Medicaid managed care regulations at 42 C.F.R. §438
DPP BHS	Directed Payment Program for Behavioral Health Services is designed to promote and improve access to behavioral health services, care coordination, and successful care transitions for individuals enrolled in STAR, STAR+PLUS and STAR Kids. CMHCs and LBHAs are entities eligible to participate in the program.
EDEN	Emergency Department Encounter Notification system that provides a real-time notice of patient health care encounters from acute and post-acute care facilities across Texas.
EHR	Electronic Health Records

Acronym	Definition
EQRO	External Quality Review Organization provides an external quality review of Medicaid services delivered via managed care organizations. CMS requires states to have an EQRO.
FFS	Fee-for-Service reimbursement is a payment in which a provider is paid a fee for each service delivered to eligible individuals
HCPCS	Healthcare Common Procedure Coding System includes descriptive terms and identifying codes that are used to identify medical services
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission is a state agency that manages programs that help families with food, health care, safety and other services. HHSC manages Medicaid and CHIP programs
HIE	Electronic health information exchange allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically
HRI	Health-Related Institution is a network physician group owned or operated by an institution named in Texas Education Code §63.002. HRIs participate in TIPPS.
HRSN	Health-related social needs refer to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being.
ICHP	Institute for Child Health Policy is the external review organization for Texas Medicaid and CHIP
IGT	Intergovernmental Transfer is a transfer of local funds to Health and Human Services Commission for the purpose of federal match in Medicaid program
IME	Indirect Medical Education refers to 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 for which the hospital is assigned or retains billing rights for the physician group. IMEs participate in TIPPS.

Acronym	Definition
IOS	Improvement Over Self is a method of assessing changes in a provider's performance based on that specific provider reporting on the quality measure over multiple years
IP	Inpatient care is medical treatment administered to a patient whose condition requires treatment in a hospital or other health care facility, and the patient is formally admitted to the facility by a doctor
LBHA	Local Behavioral Health Authority is an entity responsible for planning, managing, and monitoring public behavioral health services at the local level. LBHAs participate in DPP BHS.
LOINC	Logical Observation Identifiers Names and Codes
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	A Medicaid managed care organization contracted with HHSC to provide health care services to Medicaid recipients
MCCO	Managed Care Compliance and Operations, a department within MCS
MCS	Medicaid & CHIP Services division within Texas Health and Human Services Commission
MLR	Medical Loss Ratio is a share of total health care premiums spent on medical claims and efforts to improve the quality of care provided
NCQA	National Committee for Quality Assurance is a private, not-for-profit organization dedicated to improving the quality of health care. NCQA is the measure steward or source for certain quality measures.
NMDOH	Non-medical drivers of health are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes.
NPI	National Provider Identifier is a 10-digit identifier from the National Plan and Provider Enumeration System that is required for Medicaid enrollment

Acronym	Definition
NQF	National Quality Forum is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare. NQF endorses quality measures.
OIG	Office of the Inspector General
OP	Outpatient care is a service that is administered with an overnight stay in a hospital
PCP	Primary Care Provider is a health care professional who practices general medicine
PFD	Provider Finance Department within Health and Human Services Commission that determines providers' eligibility for DPPs, provides scorecards to MCOs, and manages financial aspects of the DPPs
P4P	Pay for Performance is a payment model that rewards a healthcare provider for meeting pre-defined goals for quality measures
P4R	Pay for Reporting is a model that has a requirement to report quality measure data to be eligible for payment
PPA	Potentially Preventable Admissions is a hospital admission that might have been reasonably prevented with adequate access to ambulatory care
PPC	Potentially Preventable Complications are harmful events or negative outcomes that develop after hospital admission and may result from processes involved in care and treatment rather than from natural progression of the underlying illness
PPE	Potentially Preventable Events are encounters, which could be prevented, that lead to unnecessary services or contribute to poor quality of care
PPV	Potentially Preventable Emergency Department Visits are emergency treatment for a condition that could have been treated or prevented by a physician or another practitioner

Acronym	Definition
QIPP	Quality Incentive Payment Program is a directed payment program designed to help nursing facilities achieve transformation in care quality through innovation
RAPPS	Rural Access to Primary and Preventive Services Program is a directed payment program for rural health clinics that incentivizes the provision of primary and preventive services to individuals enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs
RHC	Rural health clinic is a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR 405 and 491. RHCs participate in RAPPS
SA	Service Area defines the counties included in any HHSC-defined geographic area as applicable to each MCO, formerly Service Delivery Area (SDA)
SDP	State Directed Payment programs allow states to direct plan expenditures in connection with provider payment initiatives under Medicaid managed care contracts. CMS uses this acronym while Texas uses DPP.
SFY	State Fiscal Year is the time period from September 1 through August 31
SIR	Standardized Infection Ratio is a statistic used to track healthcare associated infections over time, at a national, state, or facility level. It is a ratio of the actual number of infections a facility observes, and the number of infections that they would be predicted to observe based on their case mix (actual to expected ratio).
SMM	Severe Maternal Morbidity includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health
SNOMED CT	Systematized Nomenclature of Medicine -- Clinical Terms is a collection of medical terms providing codes, terms, synonyms, and definitions used in clinical documentation and reporting

Acronym	Definition
STAR	State of Texas Access Reform Medicaid Managed Care Program. STAR is a Medicaid Managed Care Program. STAR covers low-income children, pregnant women, and families. STAR is part of CHIRP, TIPPS, RAPPS, and DPP BHS.
STAR Kids	STAR Kids is a Medicaid Managed Care Program. STAR Kids covers children and adults 20 and younger who have disabilities. STAR Kids is part of TIPPS, RAPPS, and DPP BHS.
STAR Health	STAR Health is a Medicaid Managed Care Program. STAR Health covers children who get Medicaid through the Department of Family and Protective Services (DFPS) and young adults previously in foster care. STAR Health is not part of the DPPs at this time.
STAR+PLUS	STAR+PLUS is a Medicaid Managed Care program. STAR+PLUS covers adults with disabilities, people age 65 and older (including those dually eligible for Medicare and Medicaid), and women with breast or cervical cancer. STAR+PLUS is part of QIPP, CHIRP, TIPPS, RAPPS, and DPP BHS.
STC	Special Terms and Conditions is a set of rules, specifications and requirements included in the demonstration project/waiver
SUD	Substance Use Disorder is a mental health disorder that affects a person's brain and behavior, leading to their inability to control their use of substances (e.g. alcohol, illegal, drugs, etc.)
TAC	Texas Administrative Code is a compilation of all state agency rules in Texas
TIPPS	Texas Incentives for Physicians and Professional Services is a directed payment program for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid managed care programs. Eligible physician groups include health-related institutions (HRIs), indirect medical education (IME) physician groups affiliated with hospitals and other physician groups
TPI	Texas Provider Identifier is an identifier that Medicaid providers are required to have to be paid for any Medicaid service

Acronym	Definition
UHRIP	Uniform Hospital Rate Increase Program is the first component of the Comprehensive Hospital Increase Reimbursement Program that provides a uniform rate enhancement on all hospital inpatient and outpatient services claims
VBP	Value-Based Purchasing is a provider reward program with incentive payments for the quality of care provided to Medicaid clients