Program	Texas Incentives for Physician and Professional Services (TIPPS)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids

Intended Quality Outcomes

1. Support access and improve outpatient care for Medicaid managed care members.
2. Expand successful innovations from DSRIP to a broader base of physician practice groups across the state to improve primary care, chronic care, maternal health, behavioral health, and social drivers of health (SDOH).

Program Overview

- The TIPPS program is a new value-based directed payment program (DPP). The program is intended to span 3 years. In Year 1, the program would include the three components described below.
- Three classes of physician practice groups are eligible to participate: 1) physician groups affiliated with a health-related institution (HRI) as defined by Section 63.002 of the Texas Education Code; 2) physician groups affiliated with a hospital receiving the indirect medical education add-on (IME); and 3) other physician practice groups that are not HRI or IME (Other).
- Component 1: Paid as a per-member-per-month (PMPM) payment, triggered by reporting on quality improvement activities. HRIs and IMEs are eligible for Component 1.
- Component 2: Serves as a performance incentive payment based on achievement of quality metrics focused on primary care and chronic care. HRIs and IMEs are eligible for Component 2.
- Component 3: Serves as a rate enhancement for certain outpatient services based on achievement of quality metrics focused on maternal health, chronic care, behavioral health, and SDOH. All physician practice groups are eligible for Component 3.
- Physician practice groups must have a minimum denominator volume of 30 Medicaid patients in at least 50 percent of the quality metrics in CY2021 in each Component 2 and 3 to be eligible to participate in the Component.

Reporting Requirements

- Component 1 includes structure measures and requires semi-annual reporting of status/progress for all Component 1 measures.
- Components 2 and 3 include Improvement Over Self (IOS) and benchmark measures and require semi-annual reporting.
- Reporting is tentatively planned to take place during Quarter 1 (Sep-Nov 2021) and Quarter 3 (Mar-May 2022).
    - Quarter 1: report data for all Component 2 and 3 measures for January to June 2021.
    - Quarter 3: report data for all Component 2 and 3 measures for January to December 2021.
- Physician practice groups must report Component 2 and 3 measures stratified by Medicaid, Uninsured, and Other payer types.

Achievement Requirements

- All measures must be reported for a provider to be eligible for payment. If a measure does not have a minimum denominator volume of 30, then the measure is not included in calculating achievement.
- For Year 1, IOS measures are reporting CY2021 as baseline as a condition of participation in the program. IOS measures will be pay-for-performance in later years.
- Year 1 goals for benchmark measures for reported CY2021 are meeting or exceeding the:
    - 50th percentile of national HEDIS benchmarks for Component 2
    - 25th percentile of national HEDIS benchmarks for Component 3.
- Component 2:
    - 100% payment based on achieving at least 75% of benchmark measures with minimum denominator volume;
    - 75% payment for achieving 50% of benchmark measures with minimum denominator volume; OR
    - 50% payment for achieving 25% of benchmark measures with minimum denominator volume.
- Component 3: 100% payment based on achieving at least 50% of benchmark measures with minimum denominator volume.

Component 3 rate enhancements will be applied to the following 9 CPT codes that align with the measures.

99202	99203	99204	99205	99211	99212	99213	99214	99215

	# of Benchmarks Achieved	# of Benchmarks with Minimum Denominator Volume	Eligible for % of Payment	# of Benchmarks Achieved	# of Benchmarks with Minimum Denominator Volume	Eligible for % of Payment
Component 2	6	6	100%	4	4	100%
	5	6	100%	3	4	100%
	4*	6	100%	2	4	75%
	3	6	75%	1	4	50%
	2	6	50%	0	4	0%
	1	6	0%	3	3	100%
	0	6	0%	2	3	75%
	5	5	100%	1	3	50%
	4	5	100%	0	3	0%
	3	5	75%	2	2	100%
	2	5	50%	1	2	75%
	1	5	0%	0	2	0%
	0	5	0%	1	1	100%
	0	0	NA**	0	1	0%
Component 3	2	2	100%	1	1	100%
	1	2	100%	0	1	0%
	0	2	0%	0	0	100%

* Although achievement is less than 75%, the original intention of at least 4 benchmark measures achieved is met and eligible for full payment.

**Component 2 has 10 measures with 6 benchmark measures. Physician groups must have minimum denominator volume of 30 Medicaid managed care members in at least one benchmark measure to meet the requirement that 50% of measures in a Component meet minimum denominator volume requirements.

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
T1 - PMPM	T1-101	Patient-Centered Medical Home (PCMH) Accreditation and Recognition Status	Structure	NA	NA
	T1-102	Same-day, walk-in, or after-hours appointments in the outpatient setting	Structure	NA	NA
	T1-103	Care team includes personnel in a care coordination role not requiring clinical licensure	Structure	NA	NA
	T1-104	Pre-visit planning and/or standing order protocols	Structure	NA	NA
	T1-105	Patient education focused on disease self-management	Structure	NA	NA
	T1-106	Identification of pregnant women at-risk for Hypertension, Preeclampsia, or Eclampsia; treatment based and follow-up	Structure	NA	NA
	T1-107	Health Information Exchange (HIE) participation	Structure	NA	NA
	T1-108	Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services	Structure	NA	NA
T2 - P4P	T2-109	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	0028e	PCPI
	T2-110	Cervical Cancer Screening	Process	0032	NCQA
	T2-111	Childhood Immunization Status	Process	0038	NCQA
	T2-112	Immunization for Adolescents	Process	1407	NCQA
	T2-113	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	0418e	CMS
	T2-114	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Process	0057	NCQA
	T2-115	Preventive Care and Screening: Influenza Immunization	Process	0041	AMA-PCPI
	T2-116	Tobacco Use and Help with Quitting Among Adolescents	Process	2803	NCQA
	T2-117	Chlamydia Screening in Women	Process	0033	NCQA
	T2-118	Controlling High Blood Pressure	Outcome	0018	NCQA
T3 - P4P	T3-119	Food Insecurity Screening	Process	NA	Texas HHSC
	T3-120	Maternity Care: Post-Partum Follow-Up and Care Coordination	Process	NA	CMS
	T3-121	Behavioral Health Risk Assessment for Pregnant Women	Process	NA	CMS
	T3-122	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	0059	NCQA
	T3-123	Depression Response at Twelve Months	Outcome	1885	MN CM
	T3-124	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Process	0024	NCQA