Texas Incentives for Physicians and Professional Services Stakeholder Feedback on Measures and Performance Requirements

As Required by

Texas Administrative Code

§353.1311

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Contents

1. Overview

On January 12, 2021, HHSC released the draft measures and performance requirements for Texas Incentives for Physicians and Professional Services (TIPPS) for stakeholder feedback. The documents included measure specifications, attribution methodology, reporting requirements, achievement goals, and CPT codes for focused rate enhancements. HHSC hosted a webinar on January 20, 2021 to provide an overview of the proposed measures and performance requirements and answer questions. Stakeholders submitted feedback through an online survey that closed on February 2, 2021.

This document summarizes the stakeholder feedback HHSC received through the 32 respondents to the survey. HHSC staff reviewed stakeholder comments, grouped similar comments together, drafted responses, and determined changes through internal discussion and guidance from leadership. Changes made based on stakeholder feedback are reflected in the updated *TIPPS Measure Specifications*, *TIPPS Requirements,* and are noted in the responses herein.

HHSC will include the measures and performance requirements in the TIPPS state directed payment preprint submitted to the Centers for Medicare & Medicaid Services (CMS) in March 2021. All TIPPS requirements are subject to CMS approval. HHSC will post any changes requested by CMS as required in TAC §353.1311.

2. Component 1 Measures

T1-101: Patient-Centered Medical Home (PCMH) Accreditation and Recognition Status

1. Multiple stakeholders asked if PCMH accreditation is required and if so, by which agency.

   HHSC Response: No, PCHM accreditation is not required for T1-101. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for PCMH capacity (T1-101), physician groups will report on questions regarding the PCMH model; however, physician groups are not required to have obtained or be working towards PCMH accreditation and recognition.

T1: Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) Patient-Centered Medical Home (PCMH) item set

2. Multiple stakeholders asked what are the requirements of CG-CAHPS PCMH item set and if different assessments can be used to meet the measure.

   HHSC Response: Based on stakeholder feedback to reduce the number of measures in Component 1, HHSC has removed CG-CAHPS PCMH item set as a structure measure.

T1-102: Same-day, walk-in, or after-hours appointments in the outpatient setting

3. A respondent asked what is defined as "outpatient setting" and are urgent care visits included?

   HHSC Response: The outpatient setting is a setting that does not require hospitalization, observation, or an emergency department visit. Urgent care visits may be included in the outpatient setting.

4. Multiple stakeholders asked what are the requirements for these appointments, if there are expected hours or minimum expansion.

   HHSC Response: There are not any prescribed requirements for T1-103. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering

evidence-based best practices for high quality care. For example, to get a sense for same-day, walk-in, or after-hours appointment capacity (T1-103), physician groups will report on questions regarding the outpatient care model; however, physician groups are not required to have implemented or be working towards implementing same-day, walk-in, or after-hours appointments in the outpatient setting.

T1-103: Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)

5. Multiple stakeholders asked what are the requirements for the care team, what types of encounters are included, and whether these specific encounters must be tracked.

   HHSC Response: There are not any prescribed requirements for T1-104. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for multidisciplinary care team strategy (T1-104), physician groups will report on questions regarding care coordination staff; however, physician groups are not required to have implemented or be working towards implementing a care team with a non-clinically licensed staff member.

T1-104: Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)

6. Multiple stakeholders asked what are the requirements for pre-visit planning and/or standing order protocols, can electronic clinical decision support be used.

   HHSC Response: There are not any prescribed requirements for T1-105. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for pre-visit planning and standing order protocol strategy (T1-105), physician groups will report on questions regarding such population health best practices; however, physician groups are not required to have implemented or be working towards implementing pre-visit planning and standing order protocols.

Although pre-visit planning and standing order protocols are commonly automated into electronic health records (EHRs) or other care management platforms, pre-visit planning and standing order protocols (T1-105) are not necessarily the same as electronic clinical decision support (i.e., medical decision-making software that help clinicians determine a diagnosis and/or treatment plan). Rather T1-105 involves the manual or automated systems and workflows implemented to coordinate a patient's screenings, vaccinations, lab tests, prescription changes, and other scheduling needs during a visit.

T1-105: Patient education focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)

7. Multiple stakeholders asked what are the requirements for patient education, will encounters need to be tracked, is it limited to specific diseases, and must it be provided by certain personnel.

   HHSC Response: There are not any prescribed requirements for T1-106. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for patient education strategy (T1-106), physician groups will report on questions regarding disease self-management classes and resources; however, physician groups are not required to have implemented or be working towards implementing patient education focused on disease self-management.

T1: Social Determinants of Health (SDOH) data infrastructure: screening for SDOH

8. Multiple stakeholders asked what are the requirements for SDOH data infrastructure and which SDOH or survey.

   HHSC Response: Based on stakeholder feedback to reduce the number of measures in Component 1, HHSC has removed SDOH data infrastructure: screening for SDOH as a structure measure.

T1-106: Identification of pregnant women at-risk for Hypertension, Preeclampsia, or Eclampsia; treatment based on best practices; and follow-up with postpartum women diagnosed with Hypertension, Preeclampsia, or Eclampsia

9. Multiple stakeholders asked what are the requirements for identification, treatment, and follow-up of these women, what clinics does this apply to.

HHSC Response: There are not any prescribed requirements for T1-108. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for capacity to identify and treat high risk maternal health cases (T1-108), physician groups will report on questions regarding best practices for pregnant women at risk for hypertension, preeclampsia, or eclampsia; however, physician groups are not required to have implemented or be working towards implementing maternal health best practices.

T1-107: Connectivity to/participation in health information exchange (HIE)

10. Multiple stakeholders asked what are the requirements for connectivity to/participation in HIE, alignment with the measure in Comprehensive Hospital Increased Reimbursement Program (CHIRP), what is the level of required participation.

    HHSC Response: There are not any prescribed requirements for T1-109. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for health information exchange (HIE) capacity, infrastructure, and strategy (T1-109), physician groups will report on questions regarding HIE connectivity and participation; however, physician groups are not required to have implemented or be working towards implementing HIE connectivity and participation.

    Based on stakeholder feedback, HHSC has renamed the measure *Health Information Exchange (HIE) Participation* and measure description to "Reporting on status with enrollment in a public HIE" to align with the CHIRP measure.

T1-108: Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist or a psychologist

11. Multiple stakeholders asked what are the requirements for telehealth, is it limited to specific clinics/specialties.

    HHSC Response: There are not any prescribed requirements for T1-110. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a

sense for integrating behavioral health care access through telehealth capacity and infrastructure (T1-110), physician groups will report on questions regarding such telehealth best practices for behavioral health needs; however, physician groups are not required to have implemented or be working towards implementing telehealth with behavioral health practitioners.

12. One stakeholder requested that a new measure be added to expand telehealth services to specialty care.

    HHSC Response: Based on stakeholder feedback, HHSC has broadened measure T1-110 to include virtual specialty care provided by both behavioral health practitioners and physical health specialists: *Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services.*

General Component 1 feedback

13. Stakeholders requested that the number of measures be reduced or stream-lined and additional details be provided.

    HHSC Response: HHSC has removed two measures from Component 1: *Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) Patient-Centered Medical Home (PCMH) item set* and *Social Determinants of Health (SDOH) data infrastructure: screening for SDOH*.

    The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments.. The types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. Reporting for Component 1 measures will primarily be formatted as multiple-choice selections. HHSC will provide additional information regarding reporting once the reporting questions/template have been developed.

3. Component 2 Measures

T2-109: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

14. Several stakeholders requested that the measure be limited to reporting only on c. *Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user*.

    HHSC Response: Based on stakeholder feedback, the measure specifications for T2-111 have been updated. For TIPPS reporting purposes, only one rate will be reported as the "Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user."

15. One stakeholder indicated that this measure should be limited to providers with electronic health records.

    HHSC Response: Although the measure specifications refer to electronic Clinical Quality Measures (eCQMs), physician groups without electronic health records as the data source may use existing paper records as the data source. In cases where a variance from a designated data source is required, providers should keep a record of such variances to ensure consistency or changes in reporting future performance years. Providers may also opt to use local or proprietary codes or values mapped to the standard codes included in the TIPPS measure specifications. Providers that opt to use local or proprietary codes or values must maintain documentation that includes a crosswalk of relevant codes, values, descriptions, and clinical information if applicable.

16. One stakeholder requested that the measure's eligible physician specialties/clinicians be limited to primary care providers.

    HHSC Response: Per measure specifications, the denominator inclusion criteria are not limited only to primary care visits or primary care provider types. The eligible physician specialties/clinicians are adopted from the eligible clinicians for a given measure in CMS' Merit-based Incentive Program (MIPS).

T2-110: Cervical Cancer Screening

17. One stakeholder asked if the cervical cytology and HPV testing need to be resulted.

HHSC Response: Yes, per measure specifications, numerator inclusion criteria state that if using cervical cytology, then "CervicalCytology.result is not null" and if using HPV testing, then "HPVTest.result is not null".

18. One stakeholder asked whether the cervical cytology and HPV testing may be performed by an external provider.

    HHSC Response: Yes, the cervical cytology and HPV testing may be performed by an external provider. However, per measure specifications, the testing and result must be documented in the physician group's medical record for each patient to meet numerator inclusion criteria.

19. Two stakeholders stated that the recommendations for the measure are changing and flexibility should be given to how physician groups choose to measure. For instance, the American Cancer Society recommends HPV screening to begin at age 25 instead of 21.

    HHSC Response: Per the measure specifications source, cervical cancer screening may be determined using either of the following criteria:

    "* Women age 21-64 who had cervical cytology performed within the last 3 years; OR

    * Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years."

    Thus, if a physician group chooses to use the criteria involving HPV testing, the denominator criteria would be "Women 23-64 years of age with a visit during the measurement period" and the numerator criteria would be "Women with one or more screenings for cervical cancer as determined by human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women who are 30 years or older at the time of the test".

    These measure specifications, as defined by the measure steward, are in agreement with the stakeholders' feedback. Electronic clinical quality improvement (eCQI) provides common standards and shared technologies to monitor and analyze the quality of healthcare provided to patients and patient outcomes. Measure specifications for this measure are defined by eCQI and updated annually and this process is overseen by The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC).

T2-111: Childhood Immunization Status

20. Some stakeholders asked whether the immunizations may be administered by an external provider, if data from Immtrac2 may be used, if self-reported data may be used, and if the specifications can include these allowances.

HHSC Response: Yes, childhood immunizations may be administered by an external provider, obtained through Immtrac2, or through self-report. However, the information required in the measure specifications must be documented in the patient's clinical record, including test dates and codes for procedures. Per measure specifications, the numerator description states "children who have evidence showing…" and does not indicate who must administer the vaccinations.

21. Multiple stakeholders asked if patient refusals can be excluded from the denominator.

    HHSC Response: No, physician groups may not exclude patients who refuse vaccination from the denominator. Per measure specifications, the denominator only excludes patients whose hospice care overlaps the measurement period.

22. One stakeholder asked what is the definition of "Pediatric Medicine" for eligible physician specialties/clinicians; is this limited to pediatricians or does this include pediatric specialists (e.g. endocrinology, orthopedic surgery, urology) and primary care clinics that see pediatric patients.

    HHSC Response: HHSC has updated "Pediatrics" and "Family Medicine" into the "Eligible Physician Specialties and Other Clinicians" for childhood immunizations.

    HHSC has also updated Step 2 of the Attribution Methodology in the Measure Specifications to clarify the criteria under the "Eligible Physician Specialties and Other Clinicians". The update provides reference to the NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). Additionally, the update clarifies that NUCC provider taxonomy definitions and codes for physician subspecialties nested within an eligible physician specialty may be included if these subspecialists perform the quality actions described in the measure based on the services provided and the measure specific-denominator coding. Nurse Practitioners and Physician Assistants, as defined by NUCC, practicing under the listed eligible physician specialties or practicing equivalent services may also be included.

T2-112: Immunization for Adolescents

23. Some stakeholders asked whether the immunizations may be administered by an external provider, if data from Immtrac2 may be used, and if self-reported data may be used.

    HHSC Response: Yes, adolescent immunizations may be administered by an external provider, obtained through Immtrac2, or through self-report. However, the information required in the measure specifications must be

documented in the patient's clinical record, including test dates and codes for procedures.

24. Multiple stakeholders asked if patient refusals can be excluded from the denominator.

    HHSC Response: No, per measure specifications, physician groups may not exclude patients who refuse vaccination from the denominator. Denominator exclusion criteria are stated in the measure specifications.

25. Two stakeholders requested that only one rate be reported rather than all four rates.

    HHSC Response: Based on stakeholder feedback, the measure specifications for T2-114 have been updated. For TIPPS reporting purposes, only one rate will be reported as the "All patients who are compliant for Meningococcal, Tdap and HPV during the specified timeframes."

T2-113: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

26. Two stakeholders requested that the denominator be limited to a certain population, similar to DSRIP measure H3-144 that allowed use of a subset of individuals with a diagnosis of moderate to severe chronic pain.

    HHSC Response: Component 2 is focused on primary care and chronic care which is a broader population than the intended DSRIP measure bundle H3 Chronic Non-Malignant Pain Management.

27. Stakeholders had feedback on eligible physician specialties/clinicians for this measure. Two requested that "orthopedic surgery" be removed. One suggested limiting to primary care, neurology, and adding obstetrics/gynecology. Two broadly suggested limiting the clinicians/locations according to physician group.

    HHSC Response: The eligible physician specialties/clinicians are adopted from the eligible clinicians for a given measure as determined in CMS' Merit-based Incentive Program (MIPS).

    HHSC has also updated Step 2 of the Attribution Methodology in the Measure Specifications to clarify the criteria under the "Eligible Physician Specialties and Other Clinicians". The update provides reference to the NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). Additionally, the update clarifies that NUCC provider taxonomy definitions and codes for physician subspecialties nested within an eligible physician specialty may be included if these subspecialists perform the quality actions described in the measure based on the services provided and

the measure specific-denominator coding. Nurse Practitioners and Physician Assistants, as defined by NUCC, practicing under the listed eligible physician specialties or practicing equivalent services may also be included.

28. Two stakeholders asked if there were recommended screening tools and definitions of appropriate follow-up plans.

    HHSC Response: The measure steward specifications include definitions and examples of screening tools and follow-up plans that have been added to the TIPPS measure specifications.

T2-114: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing

29. One stakeholder requested that eye exam should be added.

    HHSC Response: Due to challenges during DSRIP reporting, HHSC has chosen not to include diabetic eye exams in TIPPS.

30. One stakeholder requested that the measure's eligible physician specialties/clinicians be limited to primary care providers.

    HHSC Response: The measure steward's specifications do not limit the denominator to preventive visits. The eligible physician specialties/clinicians are aligned to CMS' Merit-based Incentive Program (MIPS) quality measures.

T2-115: Preventive Care and Screening: Influenza Immunization

31. Some stakeholders asked whether the immunizations may be administered by an external provider and if data from Immtrac2 may be used.

    HHSC Response: Yes, influenza immunizations may be administered by an external provider and obtained through Immtrac2. However, the information required in the measure specifications must be documented in the patient's clinical record, including test dates and codes for procedures.

32. One stakeholder asked if patient refusals can be excluded from the denominator.

    HHSC Response: Per measure specifications, patients who decline to receive the influenza immunization may be excluded from the denominator.

33. One stakeholder requested that the measure's eligible physician specialties/clinicians be limited to primary care providers.

    HHSC Response: Per measure specifications, the denominator inclusion criteria are not limited only to primary care visits or primary care provider types. The eligible physician specialties/clinicians are adopted from the eligible clinicians for a given measure as determined in CMS' Merit-based Incentive Program (MIPS).

34. One stakeholder requested that flu vaccinations that begin in August should be included in the numerator.

    HHSC Response: Per measure specifications, the numerator includes "Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization." Therefore, per numerator inclusion criteria, patients who receive an influenza immunization during influenza season OR patients who reported previous receipt of an influenza immunization during August and September of the prior year would be included in the numerator.

    These measure specifications, as defined by the measure steward, are in agreement with the stakeholders' feedback.

T2-116: Tobacco Use and Help with Quitting Among Adolescents

35. One stakeholder asked whether screenings provided in the emergency department or urgent care clinics could be included.

    HHSC Response: Urgent care is listed under eligible physician specialties/clinicians. The denominator is limited to the CPT codes listed under denominator inclusions which does not include ED visits.

36. One stakeholder requested that the measure's eligible physician specialties/clinicians be limited to primary care providers.

    HHSC Response: Although the measure description refers to "primary care visit", the denominator inclusion criteria include codes beyond a primary care visit, such as 90791 – psychiatric diagnostic evaluations. HHSC has updated the "Additional Information" section of the Measure Specifications to clarify.

    The eligible physician specialties/clinicians are adopted from the eligible clinicians as determined in CMS' Merit-based Incentive Program (MIPS). HHSC has also updated Step 2 of the Attribution Methodology in the Measure Specifications to clarify the criteria under the "Eligible Physician Specialties and Other Clinicians". The update provides reference to the NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). Additionally, the update clarifies that NUCC provider taxonomy definitions and codes for physician subspecialties nested within an eligible physician specialty may be included if these subspecialists perform the quality actions described in the measure based on the services provided and the measure specific-denominator coding. Nurse Practitioners and Physician Assistants, as defined by NUCC, practicing under the listed eligible physician specialties or practicing equivalent services may also be included.

37. One stakeholder asked if patient refusals can be excluded from the denominator.

HHSC Response: No, physician groups may not exclude patients who refuse to be screened and refuse assistance with tobacco cessation from the denominator. Per the measure specifications, there are not any denominator exclusion criteria.

T2-118: Controlling High Blood Pressure

38. Two stakeholders requested that the numerator specifications be changed to an average over time or multiple readings instead of the most recent blood pressure reading.

    HHSC Response: Per the measure specifications, the numerator inclusion criteria states use of the most recent blood pressure reading. The measure steward (National Committee for Quality Assurance) provides guidance "If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading."

39. Two stakeholders asked if there is a value set or list of diagnoses for the denominator exclusion of patients who have advanced frailty and illness.

    HHSC Response: Additional details on definitions, including value sets, can be found in the measure source: https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS165v9.html

40. One stakeholder requested that the measure's eligible physician specialties/clinicians be limited to primary care providers.

    HHSC Response: Per measure specifications, the denominator inclusion criteria are not limited only to primary care visits or primary care provider types. The eligible physician specialties/clinicians are adopted from the eligible clinicians for a given measure as determined in CMS' Merit-based Incentive Program (MIPS).

41. One stakeholder asked if patient refusals can be excluded from the denominator.

    HHSC Response: No, per measure specifications, physician groups may not exclude patient refusals from the denominator. Denominator exclusion criteria are stated in the measure specifications.

General Component 2 Feedback

42. Two stakeholders asked if telehealth is eligible for inclusion.

    HHSC Response: Telehealth eligible modalities are allowed dependent on the measure and indicated in the specifications.

43. Two stakeholders asked if the same version of value sets is used through the measurement period.

HHSC Response: Yes, the same value sets should be used during the measurement period. HHSC will update measures annually based on measure stewards, including any changes in value sets.

44. One stakeholder suggested adding four measures: Weight Assessment and Counseling for Nutrition and Physical Activity (HEDIS WCC), Appropriate Treatment for Upper Respiratory Tract Infection (HEDIS URI), Diabetic Nephropathy Screening, and Diabetic Retinopathy Screening.

    HHSC Response: HHSC has not included additional measures in Component 2 based on stakeholders' request for fewer measures. Weight Assessment and Counseling for Nutrition and Physical Activity will be added to Component 3 as a replacement measure. Appropriate Treatment for URI was discussed with the stakeholder workgroup in fall 2020 and there was not much interest in its inclusion. The workgroup also focused on HbA1c testing for diabetes. HHSC may consider these measures for TIPPS Year 2 and will begin stakeholder engagement in fall 2021.

45. One stakeholder suggesting adding contraceptive care as a measure.

    HHSC Response: During the stakeholder workgroup meetings in fall 2020, contraceptive care was not prioritized as a focus area. HHSC may consider such a measure for TIPPS Year 2 and will begin stakeholder engagement in fall 2021.

4. Component 3 Measures

T3-119: Food Insecurity Screening

46. One stakeholder asked whether the screening needs to occur at every patient visit or recommended frequency.

    HHSC Response: The measure specifications for T3-121 have been updated. Per updated numerator inclusion criteria, the numerator includes patients screened for food insecurity using the Hunger Vital Sign (HVS) two questions with the screening results documented during the current encounter or during the previous twelve months.

47. One stakeholder asked to what age group the screening needs to be administered.

    HHSC Response: The measure specifications for T3-121 have been updated. Per updated denominator specifications, there are not any age restrictions for denominator inclusion. Per updated numerator specifications, while there are not any age restrictions for numerator inclusion, parents, guardians, and caregivers screened using the HVS 2 questions on behalf of the patient's household may be included in the numerator.

48. Two stakeholders indicated that they use a different tool and requested to continue using them.

    HHSC Response: The Hunger Vital Sign™ (HVS) is a validated 2-question food insecurity screening tool (sensitivity of 97% and specificity of 83%) based on the U.S. Household Food Security Survey Module to identify households (youth, adolescents, and adults) at risk for food insecurity if they answer that either or both of the following two statements is 'Often True' or 'Sometimes True' (vs. 'Never True'):

    • "Within the past 12 months we worried whether our food would run out before we got money to buy more."

    • "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

    Additionally, there are 11 language translations readily available of the Hunger Vital Sign™ and according to the sponsoring organization (Children's HealthWatch), "There is no fee or license required to use the Hunger Vital Sign™. We only ask that parties properly cite the tool as follows":

    > Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item

Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

Moreover, according to the University of California San Francisco SIREN (Social Interventions Research & Evaluation Network) SDOH Screening Tool Comparison Table, the HVS two questions are the most commonly used screening questions for food insecurity in existing SDOH assessment tools, including North Carolina Medicaid SDOH Tool; CMS Accountable Health Communities (AHC) Tool; American Academy of Family Physicians (AAFP) Tool; Boston Medical Center (BMC) Thrive Screening Tool; Income, Housing, Education, Legal Status, Literacy, Personal Safety (IHELLP) Questionnaire; and Safe Environment for Every Kid (SEEK) Tool, to name a few.

If these two questions are already included in a screening tool that the provider uses, then it is acceptable for this measure.

49. Some stakeholders stated that a new screening and EMR development will take time and resources to implement so do not recommend the measure be included.

HHSC Response: For any new quality measure and quality improvement effort, HHSC acknowledges the time and resource investment that is required to implement data collection infrastructure and change clinical workflows. For T3-121, the initial reporting requirements (e.g., Q1 reporting period) involve a status update regarding the development of such data collection infrastructure and any clinical workflows to report on food insecurity screenings. Data reporting (e.g., numerator, denominator, and resulting rate) for T3-121 will not be required until Q3 (2022) and the associated measurement period will be 01/01/2022 - 02/28/2022. Please note that a physician group may report a rate of 0% for this measurement period, if it is accurate that the physician group has not yet implemented any food insecurity screenings during the measurement period.

Additionally, multiple resources respective to the Hunger Vital Sign™, including academic publications, toolkits, and other technical assistance, are available: https://childrenshealthwatch.org/public-policy/hunger-vital-sign/

50. A few stakeholders requested that the screening be broadened to additional SDOH such as homelessness, tobacco use, interpersonal violence.

HHSC Response: HHSC agrees there are many SDOH domains that are relevant to improving the health status of individuals. However, only food insecurity was selected since it is one of the few SDOH domains with a validated screening question (e.g., Hunger Vital Sign). HHSC will continue to assess effective opportunities to expand quality improvement across additional SDOH domains.

51. Two stakeholders requested that the use of z codes be incentivized.

HHSC Response: For TIPPS reporting purposes in the first program year, documentation of ICD-10 diagnosis codes for SDOH ("Z codes") are not required per numerator specifications. However, HHSC may consider opportunities to incentivize the documentation of Z59.4 (Lack of adequate food and safe drinking water) and other relevant codes in future program years.

T3-120: Maternity Care: Post-Partum Follow-Up and Care Coordination

52. One stakeholder asked if telehealth visits will be allowed for numerator inclusion in the first eight weeks after giving birth.

    HHSC Response: No, the measure steward has not updated the specifications to include telehealth. The specifications will be updated annually.

53. Two stakeholders did not recommend the measure due to complexity.

    HHSC Response: The stakeholder workgroup in fall 2020 prioritized maternal health as a focus area for TIPPS. HHSC may consider other evidence-based measures related to maternal health for Year 2 and will begin stakeholder engagement in fall 2021.

54. Two stakeholders asked if the denominator includes women who gave birth anywhere, including outside the physician group.

    HHSC Response: Yes, the denominator does not exclude women who gave birth elsewhere. The denominator specifications indicate inclusions and exclusions.

55. One stakeholder asked if patient refusals can be excluded from the denominator.

    HHSC Response: No, per measure specifications, physician groups may not exclude patient refusals from the denominator. There are not any denominator exclusion criteria stated in the measure specifications.

56. One stakeholder asked about demonstrating achievement of the healthy lifestyle behavioral advice and immunization review update.

    HHSC Response: Per measure specifications, additional details on definitions for each numerator inclusion component are available in the measure source: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_336_MIPSCQM.pdf

T3-121: Behavioral Health Risk Assessment for Pregnant Women

57. Two stakeholders asked if the denominator includes women who gave birth anywhere, including outside the physician group.

    HHSC Response: Yes, the denominator does not exclude women who gave birth elsewhere. The denominator specifications indicate inclusions and exclusions.

T3-122: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

58. Three stakeholders indicated that the TIPPS specifications do not align with the measure source, specifically the measure name and denominator exclusions.

    HHSC Response: HHSC has updated the measure specifications to refer to the correct measure name and include the missing denominator exclusions.

59. One stakeholder requested that the measure's eligible physician specialties/clinicians be limited to primary care providers.

    HHSC Response: Per measure specifications, the denominator inclusion criteria are not limited only to visits with primary care provider types. The eligible physician specialties/clinicians are adopted from the eligible clinicians for a given measure as determined in CMS' Merit-based Incentive Program (MIPS).

60. One stakeholder asked if patient refusals can be excluded from the denominator.

    HHSC Response: No, per measure specifications, physician groups may not exclude patient refusals from the denominator. Per measure specifications, the only denominator exclusion criterion is patients using hospice.

61. One stakeholder group requested that the measure be replaced with screening for nephropathy based on the American College of Physicians recommendation.

    HHSC Response: The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure is evidence-based, endorsed by NCQA, and aligns with the CMS Adult Core Set. HHSC may consider the screening for nephropathy measure for TIPPS Year 2 and will begin stakeholder engagement in fall 2021.

T3-123: Depression Response at Twelve Months

62. Three stakeholders recommended this measure be removed from Component 3 stating that PHQ-9 is not necessary if a patient's depression is controlled and factors outside of physician group's control leading to depression.

HHSC Response: The stakeholder workgroup in fall 2020 prioritized behavioral health as a focus area. Depression is a common and treatable mental disorder, and the Depression Response at Twelve Months measure (NQF 1885), as opposed to the Depression Remission at Twelve Months measure (NQF 0710), allows measurement of clinically meaningful improvement and progress towards remission.

63. Two stakeholders asked to clarify the denominator inclusion for the measurement period and index year.

    HHSC Response: HHSC has updated the measure specifications with additional information to describe the index period and assessment period for each performance measurement year.

64. One stakeholder recommended adjusting the measure to include encounters within two months of the index event.

    HHSC Response: HHSC has updated the measure specifications with additional information to describe the index period and assessment period for each performance measurement year.

65. One stakeholder group suggested substituting the measure for adult populations with preventative care and screening: screening for depression and follow-up plan.

    HHSC Response: The Screening for Depression and Follow-Up Plan measure is already included in TIPPS Component 2; measures cannot be included in multiple Components since the same physician groups may participate in more than one Component. The current Depression Response at Twelve Months measure includes adults as well as adolescents.

T3: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

66. Multiple stakeholders requested that the measure be removed from Component 3 due to limited volume, complexity to document and track.

    HHSC Response: HHSC has removed the measure and replaced it with a benchmark measure of T3-124: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI documentation.

General Component 3 Feedback

67. Stakeholders suggested adding more appropriate pediatric measures, measures beyond maternal health.

    HHSC Response: HHSC will consider other measures for Year 2 and will begin stakeholder engagement in fall 2021.

68. Two stakeholder groups recommended that the structure of Component 3 be changed to either allowing proxy credit for achieving measures under existing MCO VBP arrangements or replacing all the measures with measures from Component 1 and 2 for private physicians and rural providers.

    HHSC Response: CMS requires that all providers within a class in a DPP report on the same measures. HHSC does not have detailed information on the various APM arrangements to include as measures in Component 3. Given that physician groups in Components 1 and 2 will participate in Component 3, the measures cannot be duplicated.

5. Quality Requirements

Attribution Methodology

69. One stakeholder requested that TIPPS include all Medicaid patients and not limit to those in managed care.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

70. One stakeholder asked if urgent and emergent care services will be considered primary care visits.

    HHSC Response: In Step 1 of the TIPPS Attribution Methodology, the list of primary care service codes, preventive service value sets, and ambulatory care value sets are included for determining the first step of attribution. Emergency department visits are included within the ambulatory encounter value sets. Urgent care is not considered a type of service; rather, it may be that primary care services or preventive services are provided in an urgent care setting, in which case the list of codes and value sets in Step 1 are still applicable.

71. One stakeholder suggested that a minimum of two visits be required while another stakeholder suggested one ambulatory encounter be included in the attribution. One stakeholder requested that express walk-in clinics be excluded from primary care services and limiting ambulatory encounters to specialties such as the MSSP ACO attribution. Another stakeholder recommended using a risk adjusted methodology within SDAs.

    HHSC Response: HHSC has updated the criteria under Step 1 of the TIPPS Attribution Methodology such that criterion b) is defined as one ambulatory encounter during the measurement period.

    The Physician Practice's Group's attributed population includes any individual that meets at least one of the criteria below:

    a) One primary care service or preventive service provided during the measurement period; OR

    b) One ambulatory encounter during the measurement period; OR

    c) One prenatal or postnatal visit during the measurement period

72. Two stakeholders stated that the attribution methodology does not account for a managed care member visiting different physician groups during the measurement year.

HHSC Response: The TIPPS Attribution Methodology is retrospective, not prospective. The retrospective attribution methodology determines the population of individuals that the physician group had a qualifying encounter or visit with that should be included in the denominator for the respective quality measure per Component. HHSC understands that managed care members that visit different physician groups during the measurement year may be included in the denominator of multiple providers.

73. Three stakeholders requested that Medicaid managed care patients include those who had Medicaid managed care at any point during the measurement year instead of the most recent payer type.

HHSC Response:

HHSC has updated the Payer Type Assignment Methodology under Step 3 of the TIPPS Attribution Methodology. Providers must apply the same methodology for determining Medicaid across the measurement period.

The payer type is determined based on the unit of measurement (e.g., "individual" or "encounter") of the measure-specific denominator (Step 2) as defined in the TIPPS Measure Specifications.

1. Individual: A unit of measurement is an "individual" if a person can only be counted once in the denominator in a given measurement period. Physician groups may choose to determine payer type by the most recent payer type on record for the individual at the end of the measurement period OR any individual with a Medicaid-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid.

2. Encounter: A unit of measurement is an "encounter" if a person can be counted in the denominator more than once in a given measurement period. Payer type will be determined by the payer type on record for the qualifying encounter (visit or admission).

74. One stakeholder asked if the HCPCS codes will be updated annually.

HHSC Response: The measure specifications will be updated in January 2022.

75. One stakeholder asked how the attribution is applied for Component 1.

HHSC Response: The attribution methodology is not applicable to Component 1 since Component 1 only includes reporting on measures that are "structure measures". As a reminder, "structure measures" help provide

a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. Reporting for Component 1 measures will primarily be formatted as multiple-choice selections. HHSC will provide additional information regarding reporting once the reporting questions/template have been developed.

Improvement Over Self (IOS) Measures

76. Multiple stakeholders commented on allowing maintenance of high performance, suggested goals for IOS measures, proposed future years include pay-for-reporting.

    HHSC Response: In Year 1, TIPPS IOS measures are reporting on baselines. Goals for future years have not been determined. HHSC will begin engaging stakeholders in fall 2021 on measures and goals for Year 2.

Benchmark Measures

77. A few stakeholders expressed concern that there are not enough benchmark measures to achieve full payment or recommend adjusting the calculation to allow partial payment.

    HHSC Response: HHSC has replaced Component 3 IOS measure *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* with benchmark measure *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. HHSC may consider different methodologies for calculating payment for Year 2 and will begin engaging stakeholders in fall 2021.

78. Two stakeholders requested that measures with benchmark goals be changed to improvement over self goals.

    HHSC Response: IOS measures are reporting baselines in Year 1. To ensure pay-for-performance for the TIPPS value-based directed payment program, benchmark measures were included.

79. Three stakeholders asked how the COVID-19 pandemic will be taken into account.

    HHSC Response: HHSC will continue to work with CMS to align COVID-19 impacts on quality measurement and will inform stakeholders of any changes.

80. One stakeholder requested that Component 3 goals be changed from the 25th percentile of national benchmarks to the 50th percentile.

    HHSC Response: HHSC finds that the 25th percentile is achievable for the wide range of physician groups participating in Component 3.

81. One stakeholder expressed concern that payment is based on achievement with six months of data during Quarter 1.

    HHSC Response: Quarter 1 reporting and payment is based on submitting data for January – June 2021. Achievement above the benchmark will be determined only in Quarter 3 based on January – December 2021 data.

82. Two stakeholders recommended that measurement not begin until after measures have been finalized.

    HHSC Response: HHSC intends to align measurement periods with other programs including MCO reporting to calendar years. A delay of the measurement period to calendar year 2022 would result in no pay-for-performance in Year 1.

Minimum Denominator Volume

83. One stakeholder requested that TIPPS include all Medicaid patients and not limit to those in managed care. Two stakeholders requested that achievement be based on all-payer or LIU in some cases.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

84. Two stakeholders requested that eligible physician specialties/clinicians be defined, including age ranges for General Practice, Family Practice, Pediatrics, subspecialists.

    HHSC Response: The eligible physician specialties/clinicians are adopted from the eligible clinicians as determined in CMS' Merit-based Incentive Program (MIPS). HHSC has also updated Step 2 of the Attribution Methodology in the Measure Specifications to clarify the criteria under the "Eligible Physician Specialties and Other Clinicians". The update provides reference to the NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). Additionally, the update clarifies that NUCC provider taxonomy definitions and codes for physician subspecialties nested within an eligible physician specialty may be included if these subspecialists perform the quality actions described in the measure based on the services provided and the measure specific-denominator coding. Nurse Practitioners and Physician Assistants, as defined by NUCC, practicing under the listed eligible physician specialties or practicing equivalent services may also be included. NUCC does not specify age ranges for each taxonomy code.

Three stakeholders expressed concern about determining eligibility based on historical services in CY2019 or CY2020.

HHSC Response: HHSC has removed the requirement that minimum volume be met in previous years and will apply the requirement to when data is reported, starting with CY2021.

85. Three stakeholders expressed concern about determining eligibility based on historical services in CY2019 or CY2020.

    HHSC Response: HHSC has removed the requirement that minimum volume be met in previous years and will apply the requirement to when data is reported, starting with CY2021.

86. wo stakeholders requested changing the threshold from 60% of measures meeting minimum denominator volume requirements and clarify that the minimum is applied across all managed care plans.

    HHSC Response: HHSC will update the rules §353.1309 to specify 50% of measures instead of 60%. The minimum volume was intended to apply across all managed care plans; however, HHSC has broadened the requirement to all Medicaid rather than only Medicaid managed care.

Reporting Requirements

87. Multiple stakeholders requested that stratified reporting by payer type be streamlined or removed. Suggestions included reporting on Medicaid managed care, Other Medicaid, LIU; Medicaid managed care, Medicaid fee-for-service, Other payers; Medicaid managed care, Medicaid, Uninsured, Other; all Medicaid only.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

88. One stakeholder requested that reporting for TIPPS, CHIRP, and DSRIP occur at different times.

    HHSC Response: HHSC is aligning reporting to allow at least three months of data lag and ensure consistency in reporting.

89. One stakeholder requested that reporting be once a year to reduce administrative burden.

    HHSC Response: Payments are triggered based on reporting. Annual reporting would limit ability to make semi-annual payments under Component 2 and delay Component 3 monthly payments.

Payment Eligibility

90. A few stakeholders expressed concern that there is only one benchmark measure in Component 3.

HHSC Response: HHSC has replaced Component 3 IOS measure *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* with benchmark measure *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. HHSC may consider different methodologies for calculating payment for Year 2 and will begin engaging stakeholders in fall 2021.

HHSC also updated the rules to account for payment based on the number of measures with minimum volume. Requirements were revised in §353.1309(h)(1)(D) and (E) to:

"(D) For purposes of the calculation described in subparagraph (B) of this paragraph, a physician group must achieve a minimum of 75 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients to be eligible for full payment of the benchmark measures. If a physician group achieves 50 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients, it is eligible for 75 percent payment. If a physician group achieves 25 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients, it is eligible for 50 percent payment.

(E) For purposes of the calculation described in subparagraph (C) of this paragraph, a physician group must achieve a minimum of 50 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients to be eligible for full payment."

Based on the number of measures with minimum denominator volume, payments based on benchmark achievement are included below.

	# 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%

	# 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
	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.

91. Multiple stakeholders asked how redistribution will be calculated and funding maximized.

    HHSC Response: Unearned funds will be proportionately distributed among physician groups based on each physician's groups payments in Components 1-3 out of total payments for Components 1-3 within the SDA.

92. Some stakeholders asked for the ability to carryforward achievement.

    HHSC Response: Payments must be distributed within the program year. HHSC will consider providers' lack of achievement in setting Year 2 measures, goals, and reporting timing.

Targeted CPT Codes for Component 3

93. Multiple stakeholders indicated that CPT code 99201 has been discontinued for CY2021.

    HHSC Response: HHSC has removed 99201 from the list of targeted CPT codes for rate enhancements.

94. Two stakeholders requested adding additional codes such as those under the Component 3 measures or annual wellness exams codes.

    HHSC Response: HHSC has targeted a few, commonly used CPT codes used in primary care. HHSC will consider additional CPT codes for Year 2 and will begin stakeholder engagement in fall 2021.

6. General Comments

95. One provider requested that measures be limited by clinic location/type instead of provider type due to staffing changes throughout the measurement period.

    HHSC Response: The eligible physician specialties/clinicians are adopted from the eligible clinicians as determined in CMS' Merit-based Incentive Program (MIPS). HHSC has also updated Step 2 of the Attribution Methodology in the Measure Specifications to clarify the criteria under the "Eligible Physician Specialties and Other Clinicians". The update provides reference to the NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). Additionally, the update clarifies that NUCC provider taxonomy definitions and codes for physician subspecialties nested within an eligible physician specialty may be included if these subspecialists perform the quality actions described in the measure based on the services provided and the measure specific-denominator coding. Nurse Practitioners and Physician Assistants, as defined by NUCC, practicing under the listed eligible physician specialties or practicing equivalent services may also be included.

96. A few stakeholders asked if measures would be reported for specific practices or physicians.

    HHSC Response: Physician groups may apply as a grouping of practices in the application based on billing NPIs. Reporting on each measure will be submitted in aggregate for the grouping of practices rather than individual rates for each billing NPI included in the application.

97. Some stakeholders requested that measures be finalized before the measurement period and more time be given for stakeholder feedback.

    HHSC Response: HHSC will begin engaging stakeholder in fall 2021 on measures and performance requirements for TIPPS Year 2. HHSC expects that most of the measures from Year 1 will continue.

98. Some stakeholders requested that Year 1 exclude pay-for-performance requirements or allow payment for preparing to report.

    HHSC Response: TIPPS is being submitted as a value-based DPP instead of a rate enhancement so pay-for-performance is key. In addition, most measures are already reported by HRIs in DSRIP, HHSC believes the goals are appropriate, and only some of the measures need to be achieved to be eligible for full payment, which is an opportunity for providers to focus their efforts.