Texas Incentives for Physician and Professional Services (TIPPS) Requirements
State Fiscal Year (SFY) 2025

Program Overview

TIPPS is a directed payment program that provides for increased Medicaid payments to certain physician groups providing health care services to adults and children enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.

Quality Goals

TIPPS aims to advance the goals of the Texas Managed Care Quality Strategy. Participating providers will report quality measures that tie to the following quality strategy goals.

1. Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health.
2. Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate.
3. Promoting effective practices for people with chronic, complex and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs.
4. Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team-based, collaborative, and coordinated care.

Program Structure

TIPPS includes three components. Physician groups must apply annually for participation in TIPPS.

1. Component 1: Uniform percentage increase paid at time of claim adjudication that includes measures focused on primary care and chronic care. Component One will be 90 percent of the total program value for SFY 2025.
2. Component 2: There is no Component 2 for SFY 2025.
3. Component 3: Uniform rate increase for certain outpatient services that includes measures focused on maternal health, behavioral health, and non-medical drivers of health (NMDOH). Component 3 will be 10 percent of the total program value for SFYs 2025.

Component 3 rate enhancements will be applied to the following nine CPT codes that align with the measures: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

Three classes of physician groups are eligible to participate in TIPPS:

1. Physician groups owned or operated by a health-related institution (HRI) named in Section 63.002 of the Texas Education Code;
2. Physician groups contracted with, owned, or operated by a hospital receiving the indirect medical education add-on (IME) for which the hospital is assigned or retains billing rights for the physician group; and
3. Other physician groups that are not an HRI or IME (Other) physician groups and are managed care organization network physician groups.

Component 1

Component 1 includes process and outcome measures. Component 1 requires annual submission of data for the process and outcome measures.

HRI and IME physician groups are eligible for Component 1 and must report all Component 1 measures as a condition of participation.

Component 3

Component 3 includes structure, process, and outcome measures. Component 3 requires annual submission of status updates for the structure measure and data for the process and outcome measures.

HRI, IME, and other physician groups are eligible for Component 3 and must report all Component 3 measures as a condition of participation.

Reporting Requirements

As a condition of participation in the program, physician groups must report data for all measures in the components for which they are eligible. Failure to meet any conditions of participation will result in removal of a physician group from TIPPS and recoupment of all funds previously paid to the physician group during the program period.

SFY 2025 semiannual reporting is planned to take place during Reporting Period 1 (October 2024) and Reporting Period 2 (April 2025).

- Reporting Period 1 (October 2024): Physician groups will report progress on structure measures.
- Reporting Period 2 (April 2025): Physician groups will report data for outcome and process measures for January 1, 2024 to December 31, 2024.

Reporting must follow the detailed specifications for each measure as included in the SFY 2025 Measure Specifications.

For structure measures, physician groups must submit responses to qualitative reporting questions that summarize their progress toward implementing the structure measure. Physician groups are not required to implement structure measures as a condition of participation.

For outcome and process measures, a physician group must submit specified numerators and denominators and respond to qualitative reporting questions as specified by HHSC. Physician groups must report rates for measures stratified by Medicaid Managed Care, Other Medicaid, Uninsured, and All-Payer.

Reported qualitative and numeric data will be used to monitor physician group-level progress toward state quality objectives.

Component 1 & 3 Physician Group-Reported Measures

Component 1

Physician Group Classes: HRI and IME physician groups

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward[1]	Reporting Payer Type
T1-102	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome (Intermediate)	0059	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T1-103	Preventive Care and Screening: Influenza Immunization	Process	0041e	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T1-104	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	0028	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T1-113	Childhood Immunization Status	Process	0038	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer

[1] See Appendix B for a list of acronyms for measure stewards.

T1-114	Immunization for Adolescents	Process	1407	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T1-119	Controlling High Blood Pressure	Outcome	0018	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer

Component 3

Physician Group Classes: HRI, IME, and Other physician groups

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
T3-105	Health Information Exchange (HIE) Participation	Structure	NA	NA	NA
T3-115	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	0418	CMS	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T3-124	Depression Response at Twelve Months	Outcome	1885	MNCM	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T3-161	Food Insecurity Screening and Follow-up Plan	Process	NA	HHSC	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
T3-162	Prenatal Depression Screening and Follow-up on Positive Screen	Outcome (Intermediate)	NA	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer

Attribution Methodology

Physician groups must follow these steps to identify the specific population that should be included in the numerator and denominator for physician group-reported process and outcome measures.

Step 1: Determine the TIPPS-attributed population

Step 2: Determine the measure-specific denominator population

Step 3: Stratify the measure-specific denominator population by required reporting payer type

Attribution Step	**Details**
Step 1: Attributed Population Definition	Using a retrospective attribution methodology, the TIPPS-attributed population includes the individuals that a participating provider, as indicated in the enrollment application, must include in accordance with the "Attributed Population Inclusion Criteria."
Step 1: Attributed Population Inclusion Criteria	The provider's attributed population includes any individual who 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 Primary care service CPT/HCPCS codes, preventive care service value sets, and ambulatory encounter value sets and CPT/HCPCS codes are provided in Appendix A.
Step 1: Allowable Exclusions	Encounters with an individual incarcerated in a state or federal facility during the measurement period

Attribution Step	Details
Step 2: Measure-Specific Denominator Population Definition	The measure-specific denominator population (Step 2) includes the individuals or encounters from the TIPPS attributed population (Step 1) that meet all criteria under the "Eligible Physician Specialties and Other Clinicians", "Denominator Inclusions", and "Denominator Exclusions" as applicable for each quality measure, as defined in the Measure Specifications tab. Participating providers may refer to the most recent NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, physician subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). The NUCC provider taxonomy definitions and codes for physician subspecialties that are 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.
Step 3: Reporting Payer Types	Measures must be stratified by the required reporting payer as outlined below. • Medicaid Managed Care: exclusive to STAR, STAR+PLUS, and STAR Kids • Other Medicaid: STAR Health and Medicaid Fee-For-Service • Uninsured: includes No insurance; County-based or other public medical assistance • All Payer: includes Medicaid Managed Care, Other Medicaid, Uninsured, and all other payer types such as CHIP, Medicare, Medicare/Medicaid Dual Eligibles, Commercial Insurance, Qualified Medicare Beneficiaries, and Non-Texas Medicaid individuals/encounters

Attribution Step	Details
Step 3: Payer-Type Assignment Methodology	The assignment methodology depends on the unit of measurement for the denominator. The unit of measurement is defined in the Measure Specifications file. 1. Individual: If a person can be counted once in the denominator, then the unit of measurement is an individual. The payer type assignment will be determined by either the most recent payer type on record at the end of the measurement period OR as any individual with a Medicaid Managed Care-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid Managed Care. The same assignment methodology for determining Medicaid Managed Care must be applied consistently across the measurement period. 2. Encounter: If a person can be counted in the denominator more than once, then the unit of measurement is an encounter. The payer type assignment will be determined by the payer type on record for the qualifying encounter (e.g., visit or admission).

Additional Reporting Information

Data Sources and Data Elements

Depending on the measure steward and the publicly available measure specifications source, the measure specifications may have been written based on electronic health record (E.H.R.) and claims data sources available to healthcare providers or health plans. For any measures where the measure specifications were originally written based on data sources available to health plans, HHSC has adapted the measure specifications for DPP participating providers.

For DPP reporting purposes, DPP participating providers are responsible for complying with measure specifications and should use the most complete data available to ensure that the data reported are representative of the entire population served. In cases where a variance from a designated measure specification is required due to variances in data sources, DPP participating providers may opt to use local or proprietary data elements (codes or values) mapped to the standard data elements (codes or values) included in the measure specifications.

DPP participating providers that use local or proprietary data elements must maintain documentation of the relevant clinical concepts, definitions, or other information as applicable that crosswalks to the standard data elements. DPP participating providers should keep a record

of such variances to make note of and ensure consistency of such variances when reporting each measurement year.

Data Measurement Periods

The data measurement period required for a given reporting period is identified under Measurement Period in the Measure Specifications file. Additionally, measure-specific denominator specifications may place additional limitations on the measurement period used for denominator inclusion. This may include using only a portion of the measurement period for denominator inclusion or identifying encounters and/or diagnosis that occur before the measurement period for denominator inclusion (a lookback period).

All measures are specified for a 12-month data Measurement Period, unless otherwise specified under Measurement Period.

Sampling Methodology Requirements

DPP participating providers should use the most complete data available to ensure that the rates reported are representative of the entire population served. All cases that meet the eligible population requirements for the measure must be included.

For measures where all required data elements are not available electronically (E.H.R., claims data, or registry) or are of poor quality, providers may conduct a sample to determine rate for a given measurement year. DPP participating providers should follow the sampling methodology included in the measure specifications, or if no sampling methodology is specified, providers should follow the HHSC sampling methodology identified below:

HHSC Sampling Methodology

DPP participating providers should use available administrative data to determine the denominator population. Sampling should be systematic and random to ensure that all eligible individuals have an equal chance of inclusion. The resulting sample should be representative of the entire eligible population for the measure. At the time of reporting, DPP participating providers will indicate if a sampling methodology is used. DPP participating providers should maintain records of sampling methodology and random selection.

HHSC Minimum Sample Size for All-Payer

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases.

- For a measurement period where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 411 cases.

It is recommended to select an oversample of 10-15% of the sample size for substitution in the event that cases in the original sample are excluded from the measure

Appendix A – Primary Care Service, Preventive Care Service, and Ambulatory Encounter Value Sets and CPT/HCPCS Codes

Primary Care Service – CPT/HCPCS Codes

99202–99205: New patient, office or other outpatient visit

99211–99215: Established patient, office or other outpatient visit

99304–99306: Initial nursing facility visit

99307–99310: Subsequent nursing facility visit

99315–99316: Nursing facility discharge day management

99318: Nursing facility annual assessment

99324–99328: New patient, domiciliary or rest home visit

99334–99337: Established patient, domiciliary or rest home visit

99339–99340: Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home

99341–99345: New patient, home visit

99347–99350: Established patient, home visit

Preventive Care Service - Value Sets

Annual Wellness Visit: 2.16.840.1.113883.3.526.2.1363

Preventive Care Services - Initial Office Visit, 0 to 17:
2.16.840.1.113883.3.464.1003.101.12.1022.

Preventive Care Services - Established Office Visit, 0 to 17:
2.16.840.1.113883.3.464.1003.101.12.1024

Preventive Care Services - Initial Office Visit, 18 and Up:
2.16.840.1.113883.3.464.1003.101.12.1023

Preventive Care Services - Established Office Visit, 18 and Up:
2.16.840.1.113883.3.464.1003.101.12.1025

Preventive Care Services - Individual Counseling: 2.16.840.1.113883.3.464.1003.101.12.1026

Ambulatory Encounter – Value Sets and CPT/HCPCS Codes

Office Visit: 2.16.840.1.113883.3.464.1003.101.12.1001

Face-to-Face Interaction: 2.16.840.1.113883.3.464.1003.101.12.1048

Ophthalmological Services: 2.16.840.1.113883.3.526.3.1285

Outpatient Consultation: 2.16.840.1.113883.3.464.1003.101.12.1008

Psych Visit - Psychotherapy: 2.16.840.1.113883.3.526.3.1496

Ambulatory/ED Visit: 2.16.840.1.113883.3.464.1003.101.12.1061

Psych Visit - Diagnostic Evaluation: 2.16.840.1.113883.3.526.3.1492

Psychoanalysis: 2.16.840.1.113883.3.526.3.1141

Occupational Therapy Evaluation: 2.16.840.1.113883.3.526.3.1011

Hemodialysis: 2.16.840.1.113883.3.526.3.1083

Peritoneal Dialysis: 2.16.840.1.113883.3.526.3.1084

Preventive Care Services - Other: 2.16.840.1.113883.3.464.1003.101.12.1030

Speech and Hearing Evaluation: 2.16.840.1.113883.3.526.3.1530

Outpatient Encounters for Preventive Care: 2.16.840.1.113762.1.4.1047.9

96156: Health behavior assessment, or re-assessment

96158–96159: Health behavior intervention, individual, face-to-face

96160: Administration and interpretation of patient-focused health risk assessment

96161: Administration and interpretation of caregiver-focused health risk assessment

Appendix B: List of Acronyms for Measure Stewards

Acronym	Full Name
CMS	Centers for Medicare & Medicaid Services
MNCM	MN Community Measurement
NCQA	National Committee for Quality Assurance

Appendix C: Summary of Program Changes

The requirements document now includes technical instructions that were previously included in the measure specifications Excel file including the attribution methodology and additional reporting information. This content was not changed as compared to SFY 2024, unless otherwise noted below.

Component 2 measures for SFY 2024 have been moved to Component 1 for SFY 2025. Measure IDs for the following measures have changed.

SFY 2024 Measure ID	SFY 2025 Measure ID
T2-102 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	T1-102 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
T2-113 Childhood Immunization Status	T1-113 Childhood Immunization Status
T2-114 Immunization for Adolescents	T1-114 Immunization for Adolescents
T2-119 Controlling High Blood Pressure	T1-119 Controlling High Blood Pressure

In addition, HHSC removed T1-117 Tobacco Use and Help with Quitting Among Adolescents from the TIPPS SFY 2025 measures based on feedback from stakeholders that this measure was redundant to T1-104 Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention.