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

Quality Goals

1. Promote 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. Promote 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 health care costs.

Program Overview

- The TIPPS program is a directed payment program (DPP). The program includes three components:
  - Component 1: Uniform dollar increase paid monthly that includes structure measures on quality improvement activities.
  - Component 2: Uniform rate enhancement paid semiannually that includes measures focused on primary care and chronic care.
  - Component 3: Uniform rate enhancement for certain outpatient services that includes measures focused on maternal health, chronic care, behavioral health, and SDOH.
- 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, and 92215.
- 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).
- HRI and IME physician practice groups are eligible for Components 1-3, while Other physician practice groups are eligible for Component 3 only.
- Physician practice groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 50 percent of the measures in CY2021 in each Component 2 and 3 to be eligible to participate in the Component.
- Eligibility for the program is determined through an application process.

Reporting Requirements

- As a condition of participation in the program, an enrolled provider must report data for all measures in the components for which it is eligible. A provider that fails to submit the required data by deadlines communicated by HHSC will be determined to be not in compliance with program eligibility requirements, will be removed from the program, and will have all funds that it received recouped.
- State fiscal year (SFY) 2022 (Year [Y] 1) reporting will begin on April 29, 2022, and will be on data for calendar year 2021.
- For structure measures, a provider must submit responses to qualitative reporting questions that summarize progress towards implementing a structure measure. Providers are not required to implement structure measures as a condition of reporting or program participation.

- For outcome and process measures, a provider must submit specified numerator and denominator rates and respond to qualitative reporting questions as specified by HHSC.
- For Component 2 and Component 3 process and outcome measures, physician practice groups must report rates stratified by the following payer types: Medicaid Managed Care, Other Medicaid, Uninsured, and All Payer.[1]
- Reported qualitative and numeric data will be used to monitor provider-level progress toward state quality objectives.

TIPPS Measures by Program Component

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
T1 - Uniform Dollar Increase	T1-101	Care team includes personnel in a care coordination role not requiring clinical licensure	Structure	NA	NA
	T1-105	Health Information Exchange (HIE) participation	Structure	NA	NA
	T1-106	Patient-Centered Medical Home (PCMH) accreditation or recognition status	Structure	NA	NA
	T1-107	Same-day, walk-in, or after-hours appointments in the outpatient setting	Structure	NA	NA
	T1-108	Pre-visit planning and/or standing order protocols	Structure	NA	NA
	T1-109	Patient education focused on disease self-management	Structure	NA	NA
	T1-110	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	Structure	NA	NA
	T1-111	Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services	Structure	NA	NA
T2 – Uniform Rate Enhancement	T2-103	Preventive Care and Screening: Influenza Immunization	Process	0041e	NCQA
	T2-104	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	00283	NCQA
	T2-112	Cervical Cancer Screening	Process	0032	NCQA
	T2-113	Childhood Immunization Status	Process	0038	NCQA

[1] In the reporting template, providers will indicate whether the provider's system can report the required reporting payer type of "Medicaid Managed Care" as outlined above to include STAR, STAR+PLUS, and STAR Kids. If provider's system cannot report "Medicaid Managed Care" as outlined above, then the provider may alternatively report the "Medicaid Managed Care" payer type as "Medicaid" (includes all Medicaid Managed Care programs and Medicaid FFS). This alternative will only be available during Y1 of the DPP. As a result of using this alternative, the required reporting payer types would be: Medicaid, Uninsured, and All Payer.

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
	T2-114	Immunization for Adolescents	Process	0407	NCQA
	T2-115	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	0418	CMS
	T2-116	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Process	0057	NCQA
	T2-117	Tobacco Use and Help with Quitting Among Adolescents	Process	2803	NCQA
	T2-118	Chlamydia Screening in Women	Process	0033	NCQA
	T2-119	Controlling High Blood Pressure	Outcome	0018	NCQA
T3 - Rate Enhancement	T3-102	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	0059	NCQA
	T3-121	Food Insecurity Screening	Process	NA	TX HHSC
	T3-122	Maternity Care: Post-Partum Follow-Up and Care Coordination	Process	NA	CMS
	T3-123	Behavioral Health Risk Assessment for Pregnant Women	Process	NA	TX HHSC
	T3-124	Depression Response at Twelve Months	Outcome	1885	MNCM
	T3-125	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Process	0024	NCQA