Texas Incentives for Physician and Professional Services (TIPPS) Year 2 Application

The Texas Health and Human Services Commission (HHSC) announces enrollment for the Texas Incentives for Physician and Professional Services (TIPPS) program for the eligibility period covering September 1, 2022-August 31, 2023.

TIPPS is a physician-directed payment program (DPP) to serve as a transition from Network Access Improvement Program (NAIP) and Delivery System Reform Incentive Payment (DSRIP) program for certain physician groups. TIPPS is designed to 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 and 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.

Participation

To qualify to participate in TIPPS, a physician group must meet the requirements of one of the three eligible classes. The three classes eligible to participate are:

1) Health Related Institution (HRI) Physician group: Network physician group owned or operated by an institution named in Texas Education Code Section 63.002;
2) Indirect Medical Education (IME) group: Network physician group contracted with, owned, or operated by a hospital receiving either a medical education add-on or a teaching medical education add-on as described in 1 Texas Administrative Code Section 355.8052 (relating to Inpatient Hospital Reimbursement) for which the hospital is assigned or retains billing rights for the physician group; and
3) Other physician group: A physician group that is not a HRI or IME, is enrolled with a Managed Care Organization (MCO) for the delivery of Medicaid covered benefits, is located in a service delivery area with at least one sponsoring governmental entity, and has served at least 250 unique Medicaid managed care clients in the prior state fiscal year.

Payment Methodology Components:

1) Component 1 is a uniform dollar increase paid monthly that includes structure measures on quality improvement activities (65 percent of total program value). HRIs and IMEs are eligible to participate in Component 1.
2) Component 2 is a uniform rate enhancement paid semiannually that includes measures focused on primary care and chronic care (25 percent of total program value). HRIs and IMEs are eligible to participate in Component 2.
3) Component 3 is a uniform rate enhancement for certain outpatient services that includes measures focused on maternal health, chronic care, behavioral health, and social determinates of health (10

percent of total program value). 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. All physician groups otherwise eligible to participate in TIPPS and enrolled with an MCO for the delivery of Medicaid covered benefits are eligible to participate in Component 3.

Apply for TIPPS

The application is comprised of the following sections: (1) Physician Group Information; (2) Measure Denominator Eligibility Questions; and (3) Certification and should take about 10 minutes to complete. Only one application should be submitted for each entity. The application must be submitted by 11:59 PM on March 22nd, 2022.

The contact information provided within this application will be used for further communications. Once the application period is complete, the applications will be processed and follow-up communication will be sent. For questions about TIPPS, please visit the HHSC website. For questions regarding the content of the application, please email the question(s) to PFD_TIPPS@hhs.texas.gov (mailto:PFD_TIPPS@hhs.texas.gov) with "TIPPS Year 2 Application" in the subject line.

A confirmation email will NOT be sent at the time of survey completion. After survey submission, please print the confirmation page for your records.

* Required

Section 1 - Physician Group Information

In this section, please enter physician group and contact information.

A taxonomy code is a unique 10-character code that identifies your provider type and specialization.

The application will be limited for Class 1, Class 2, and Class 3 physician groups who bill with the following taxonomy codes:

https://pfd.hhs.texas.gov/sites/rad/files/documents/acute-care/2021/2021-tipps-taxonomy-year-2-changes.pdf (https://pfd.hhs.texas.gov/sites/rad/files/documents/acute-care/2021/2021-tipps-taxonomy-year-2-changes.pdf)

Use these taxonomy codes to determine the billing National Provider Identifiers (NPIs) relevant to the TIPPS program.

NOTE: In a a single application, if more than one billing NPI is submitted, HHSC will group all submitted NPIs under one TIPPS Physician Group Name for quality reporting purposes.

1. Physician Group Name: *

2. Doing Business As (DBA):

3. Physician Group 9-digit Billing Taxpayer Identification Number (TIN) WITHOUT Hyphen. Please list all that apply separated by commas. *

   Example - 123456789, 987654321, 012345678, etc.

4. Physician Group 10-digit Billing National Provider Identifier (NPI).
   Please list all that apply separated by commas.
   NOTE: In a single application, if more than one billing NPI is submitted, HHSC will group all submitted NPIs under one TIPPS Physician Group Name for quality reporting purposes. *

   Example - 1234567890, 9876543210, 0123456789, etc.

5. Did the provider enroll in TIPPS Year 1? *

   ◯ Yes

   ◯ No

6. If yes, then enter the 11-digit TIPPS Year 1 Provider ID. This is the TIPPS Year 1 identifier the provider used for TIPPS Year 1 quality reporting and is composed of the first initial of the DPP ("T") and the provider NPI.

   A list of the TIPPS Year 1 Provider IDs can be found on the PFD TIPPS webpage under "Enrollment" and at the link below:

   https://pfd.hhs.texas.gov/sites/rad/files/documents/acute-care/y1-tipps-provider-id.pdf (https://pfd.hhs.texas.gov/sites/rad/files/documents/acute-care/y1-tipps-provider-id.pdf)

7. Select the class of Physician Group for which you are applying: *

- ◯ HRI Group
- ◯ IME Group
- ◯ Other Physician Group

8. Primary Contact Name: *

9. Primary Contact Title: *

10. Primary Contact Phone Number Without Special Characters: *

Example - 1234567890

The value must be a number

11. Primary Contact Email Address: *

12. Add a secondary contact? *

- ◯ Yes
- ◯ No

13. Secondary Contact Name:

14. Secondary Contact Title:

15. Secondary Contact Phone Number Without Special Characters:

Example - 1234567890

The value must be a number

16. Secondary Contact Email Address:

17. Preparer Contact Name: *

- ◯ Primary Contact
- ◯ Secondary Contact
- ◯ Other

18. Preparer Contact Title: *

19. Preparer Contact Phone Number Without Special Characters: *

Example - 1234567890

The value must be a number

20. Preparer Contact Email Address: *

Measure Denominator Eligibility Questions

Physician practice groups must have a minimum denominator volume of 30 Medicaid managed care patients ((includes STAR, STAR+PLUS, and STAR Kids) in at least 50 percent of the measures in calendar year 2022 for Components 2 and 3 to be eligible to participate in each Component.

TIPPS Measure Specifications for additional information on denominator inclusions and exclusions:

https://www.hhs.texas.gov/sites/default/files/documents/dpp-measure-specifications-sfy23-v1-tipps.xlsm (https://www.hhs.texas.gov/sites/default/files/documents/dpp-measure-specifications-sfy23-v1-tipps.xlsm)

TIPPS program requirements for reporting requirements:

https://www.hhs.texas.gov/sites/default/files/documents/tipps-requirements-sfy23-year-2.pdf (https://www.hhs.texas.gov/sites/default/files/documents/tipps-requirements-sfy23-year-2.pdf)

21. If participating as an HRI or IME, please certify you expect to have a minimum denominator volume of 30 Medicaid managed care patients (includes STAR, STAR+PLUS, and STAR Kids) in CY2022 in at least 5 of the following Component 2 measures. In other words, for each measure selected below, provider certifies to have an expected minimum denominator volume of 30 Medicaid managed care patients (includes STAR, STAR+PLUS, and STAR Kids). HHSC will verify minimum denominator volume requirements during reporting review. *

- [ ] Not applicable
- [ ] Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- [ ] Cervical Cancer Screening
- [ ] Childhood Immunization Status
- [ ] Immunization for Adolescents
- [ ] Preventive Care and Screening: Screening for Depression and Follow-up Plan
- [ ] Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing
- [ ] Preventive Care and Screening: Influenza Immunization
- [ ] Tobacco Use and Help with Quitting Among Adolescents
- [ ] Chlamydia Screening in Women
- [ ] Controlling High Blood Pressure

22. Please certify you expect to have a minimum denominator volume of 30 Medicaid managed care patients (includes STAR, STAR+PLUS, and STAR Kids) in CY2022 in at least 3 of the following Component 3 measures. In other words, for each measure selected below, provider certifies to have an expected minimum denominator volume of 30 Medicaid managed care patients (includes STAR, STAR+PLUS, and STAR Kids). HHSC will verify minimum denominator volume requirements during reporting review. *

- [ ] Food Insecurity Screening
- [ ] Maternity Care: Post-Partum Follow-up and Care Coordination
- [ ] Behavioral Health Risk Assessment for Pregnant Women
- [ ] Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- [ ] Depression Response at Twelve Months
- [ ] Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Section 3 - Certification

23. By checking this box, I certify that I understand that as a condition of participation in TIPPS, an enrolled provider must report data for all measures in the component(s) for which it is eligible by deadlines communicated by HHSC. Failure to meet any conditions of participation will result in removal of the provider from the program and recoupment of all funds previously paid during State Fiscal Year 2023 (Year 2). *

- [ ] Certify

24. By checking this box, I certify that I understand that for Component 2 and Component 3 process and outcome measures, providers must report data stratified by the following payer types: Medicaid Managed Care (STAR, STAR+PLUS, and STAR Kids), Other Medicaid, Uninsured, and All Payer. *

- [ ] Certify

25. By checking this box, I certify that I understand that information I provide may be published at the provider level in interim or final reports to CMS or the public about this program. This information may include the Average Commercial Reimbursement (ACR) gap or the ACR Upper Payment Limit (UPL). *

- [ ] Certify

26. By checking this box, I certify that I understand that I must serve at least 250 unique Medicaid managed care clients (includes STAR, STAR+PLUS, and STAR Kids) in each program period in order to be eligible for payment. *

- [ ] Certify

27. By checking this box, I certify that no part of any payment made under TIPPS will be used to pay a contingent fee nor does any agreement with the physician practice group use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the physician group's receipt of TIPPS funds. *

- [ ] Certify

28. By checking this box, I certify that the physician group will submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from TIPPS. *

- [ ] Certify