Texas DSRIP

Measure Bundle Protocol

2/6/18 - Category C Measure Updates

Contents

Introduction

The Delivery System Reform Incentive Payment (DSRIP) program is designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers and local health departments for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. This Measure Bundle Protocol for the DSRIP program is effective for Demonstration Years (DYs) 7-8 beginning October 1, 2017 [contingent on negotiations with the Centers for Medicare and Medicaid Services].

The DY7-8 Measure Bundle Protocol reflects the evolution of the DSRIP program from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system. In DY7-8, DSRIP Performing Providers will report on required reporting categories at their provider system level.

Category A

Required reporting for Category A in DY 7-8 includes progress on Core Activities, Alternative Payment Model (APM) arrangements, costs and savings, and collaborative activities. The Category A requirements were developed to serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of APMs to continue services for Medicaid and low-income or uninsured (MLIU) individuals after DSRIP ends. The listing of Core Activities in the Measure Bundle Protocol reflects those project areas that have been determined to be the most transformational and will support continuation of the work begun by Performing Providers during the first years of DSRIP. These Core Activities will be continued or implemented by a Performing Provider to support achievement of its Category C measure goals.

Category B

As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving the DSRIP target population: MLIU individuals. To that end, Category B will require each Performing Provider to report the total number of individuals and the number of MLIU individuals served by its system during each DY. The Measure Bundle Protocol sets out parameters for a Performing Provider to define its "system" to reflect the Performing Provider's current care landscape that is striving to advance the Triple Aim: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.

Category C

For Category C, targeted measure bundles have been developed for hospitals and physician practices, and lists of measures are available for community mental health centers and local health departments. Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures for DY7-8 allows for ease in measure selection and approval, increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.

The menu of available Measure Bundles for hospitals and physician practices and measures for community mental health centers and local health departments were built with measures from common

DY2-6 Category 3 pay-for-performance (P4P) measures; new P4P measures added from authoritative sources, with a preference for measures endorsed by the National Quality Forum; and innovative measures as needed, which will be pay-for-reporting (P4R) for DY7-8 and function as a measure testing process.

Measure Development Process

HHSC formed a DSRIP Clinical Champions stakeholder group in 2015 to provide clinical expertise for development of DSRIP processes. The Clinical Champions consist of clinical, health quality, and operational professionals in Texas. In 2015, the Clinical Champions reviewed provider-submitted Transformational Impact Summaries—brief, structured project descriptions and evaluations—and identified DSRIP projects' high impact practices. HHSC used these high impact practices to inform the initial selection of the Category C Measure Bundle topics. The Clinical Champions also helped HHSC refine the DSRIP project menu to include only the most transformational project areas.

In 2017, Texas HHSC began a new process with the Clinical Champions to seek their input on the meaningfulness, improvability and clinical appropriateness of proposed measures to include in the Hospital and Physician Practice Measure Bundles, as well as any identified gaps in measurement. HHSC implemented a multi-round process with the Clinical Champions to choose the draft measures for each of the Category C Measure Bundles. The process entailed three rounds of anonymous voting by Measure Bundle topic subgroups—termed Bundle Advisory Teams—via online surveys. Each round was followed by an advisory team conference call to discuss the survey results.

HHSC assigned Clinical Champions to 11 Bundle Advisory Teams based on their areas of clinical expertise and interest. Additionally, some Clinical Champions with operational expertise were assigned to a Technical Advisory Team, which provided feedback to the Bundle Advisory Teams and HHSC about the feasibility of implementing suggested quality measures in a variety of settings.

The Bundle Advisory Teams rated each potential measure using a 5-point Likert scale, based on the measure's importance according to the member's clinical judgement. During the second and third survey rounds, participants reviewed the anonymous results of previous rounds, including both numerical ratings for each measure and qualitative comments submitted on the surveys and during conference calls. Each round resulted in the exclusion of measures with limited support. Additionally, Bundle Advisory Team members had the opportunity to suggest new and innovative measures, and those were included in the last round of voting.

Community Mental Health Centers and the Texas Council of Community Centers provided recommendations for measures related to behavioral health, and Local Health Departments were engaged in the development of measures for those Performing Providers.

Points were assigned to measures as outlined in the Measure Bundle Protocol.

HHSC will submit an updated Measure Bundle Protocol for DY9-10 to CMS (including a review of innovative measures tested in DY7 and DY8 for possible inclusion as P4P in the DY9-10 menu) no later than July 31, 2019.

Category D

For DY7-8, the Category D Statewide Reporting Measure Bundles have replaced the former Category 4 reporting on population-focused measures. While Category 4 was only for hospitals, all provider types

will be able to report on Category D in DY7-8. The Statewide Reporting Measure Bundles align with the MLIU population, are identified as high priority given the health care needs and issues of the patient population served, and are viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system. These bundles refine the hospital measures from the former Category 4 and add measures for physician practices, community mental health centers and local health departments. The emphasis of Category D is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics.

Category A

Each performing provider is required to report on the following for Category A:

- Core Activities;
- Alternative Payment Models (APMs);
- Costs and Savings; and
- Collaborative Activities.

Category A is designed to support DSRIP sustainability through providers' reporting on progress on the four key areas outlined above. Performing providers will design the structure of their next step initiatives based on the foundation of quality improvements from DY2-6 projects. This approach will offer providers the flexibility to choose the elements for these four key areas with the goal to continue improvement in health care access and coordination. Category A reporting is required for all providers; its structure allows the flexibility for continuous quality improvement for the pay-for-performance in quality measurement in Category C.

Core Activities

With the transition from project-level to provider-level reporting, performing providers will no longer report on projects; instead they will report on achievement of the goals for the Category C measures they select. To understand what enables performing providers to achieve these goals, performing providers report the Core Activities they implement to achieve these goals.

As defined in the PFM, a Core Activity is an activity implemented by a performing provider to achieve its Category C measure goals. A Core Activity can be an activity implemented by a performing provider as part of a DY2-6 DSRIP project that the performing provider chooses to continue in DY7-8, or it can be a new activity that the performing provider is implementing in DY7-8.

Core Activities included in this Protocol are connected to the Transformational Extension Menu (TEM) that HHSC and Clinical Champions developed in 2015-2016. HHSC and Clinical Champions identified in the TEM the most transformative initiatives from the initial waiver period, many of which are based on effective models that can be implemented by providers in the transition from project-level reporting to provider-level quality-based reporting. In addition to activities learned through Texas DSRIP, providers can also propose activities from other national quality initiatives such as the MACRA Merit-based Incentive Payment System (MIPS).

There are certain activities that performing providers can incorporate in any Core Activity as a sub-activity if it contributes to improving quality of care; such as technology improvements (e.g., Electronic Medical Records or Health Information Exchange connectivity) and continuous quality improvement (CQI), but the technological advances activities or the CQI should not be the only activity that performing providers choose to report on.

Core Activities Selection and Reporting

A performing provider needs to select and report on at least one Core Activity that supports the achievement of its Category C measure goals for the selected Measure Bundle(s) or measures. There is no maximum number of Core Activities that the performing provider may select.

Performing providers can select Core Activities from the list created by HHSC and they can include their own Core Activity by using the *Other* option and providing a description. In addition to reporting on Core Activities supporting Category C measures, a performing provider may include a Core Activity tied to the mission of the performing provider's organization, even if the activity does not have a strong connection to the selected measures. Selection of a Core Activity not tied to the measure bundles or measures cannot be the only selection, but can be chosen as an additional core activity that the provider is reporting.

Requirement of at least one Core Activity was designed to increase the flexibility for performing providers and to lessen the reporting commitment by the providers. It is reasonable to assume that some performing providers will have just one main activity and requiring them to report on many initiatives would not benefit the performing provider or state and federal entities. However, providers with many initiatives can benefit from sharing what activities they are implementing. If some performing providers are successful at achieving the goals for the measures they are working on, understanding the main drivers for this success is beneficial to the state and federal government as well as other performing providers who are working on similar quality initiatives. In addition, sharing information on Core Activities can lead to further collaboration among providers within and across the regions.

Performing providers will indicate which DY2-6 projects will have Core Activities that continue in DY7-8 in the RHP Plan Update and which projects have been completed. The RHP Plan Update template will allow providers to select Core Activities that will continue from DY2-6 projects and new Core Activities that will be implemented.

For example, a performing provider that expanded its primary care clinic in DSRIP DY2-6 could indicate to HHSC whether they plan to continue that expansion in DY7-8 (e.g., space expansion, increase in hours that clinic is in operation, or additional staffing). The same provider may decide to select *Provision of coordinated services for patents under Patent Centered Medical Home (PCMH) model* as a Core Activity that will assist the provider in achieving the goals for Improved Chronic Disease Management: Diabetes Care measure bundle.

As another example, a provider who increased access to different types of specialty during DY2-6 and may decide to maintain the same level of specialty staff only in some areas but provide telemedicine services to other areas of specialty. This provider may select *Use telehealth to deliver specialty services* as a Core Activity.

In general, performing providers can select Core Activities from various groupings as long as it reflects what the provider is carrying out. Performing providers working on quality initiatives in the area of behavioral health are not limited to areas directly related to behavioral health Core Activities and can select items of other areas.

During the second reporting period of each DY, providers will report on all Core Activities selected, both continuing and those that are newly added. If adjustments are needed, performing providers can revise their strategies used in achieving Category C goals and update their selection of Core Activities at any time without HHSC approval. During the second reporting period of each DY, performing providers will provide a description of any newly selected Core Activity and the reason for selecting it along with reporting progress on previously selected Core Activities. If a provider has more than one Core Activity in the initial selection, and the provider needs to delete one of these activities due to the changes, they are not required to choose a replacement activity to report on. Providers may also add new core

activities and discontinue those that are not showing results. It is recommended that providers use continuous quality improvement to monitor their progress. Reporting for Core Activities will be done via a template developed by HHSC or entered directly into the DSRIP Online Reporting System.

Menu of Core Activities

Access to Primary Care Services

- Increase in utilization of mobile clinics
- Increase in capacity and access to services by utilizing Community Health Workers (CHWs)/promotoras, health coaches, peer specialists and other alternative clinical staff working in primary care
- Expanded Practice Access (e.g., increased hours, telemedicine, etc.)
- Establishment of care coordination and active referral management that integrates information from referrals into the plan of care
- Provision of screening and follow up services
- Provision of vaccinations to target population
- Integrated physical and behavioral health care services
- Use telemedicine/telehealth to deliver specialty services
- Provision of services to individuals that address social determinants of health.
- Other

Access to Specialty Care Services

- Improvement in access to specialty care services with the concentration on underserved areas, so providers can continue to increase access to specialty care in the areas with limited access to services.
- Use telemedicine/telehealth to deliver specialty services.
- Implementation of remote patient monitoring programs for diagnosis and/or management of care.
- Provision of services to individuals that address social determinants of health.
- Other

Expansion or Enhancement of Oral Health Services

- Utilization of targeted dental intervention for vulnerable and underserved population in alternate setting (e.g., mobile clinics, teledentistry, FQHC, etc.)
- Expanded use of existing dental clinics for underserved population
- Expansion of school based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.
- Other

Maternal and Infant Health Care

- Implementation of evidence-based strategies to reduce low birth weight and preterm birth (Evidence-based strategies include Nurse Family Partnership, Centering Pregnancy, IMPLICIT: Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques among others)
- Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (Early Elective Delivery, Hemorrhage, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans)
- Use telemedicine/telehealth to deliver specialty services.
- Provision of services to individuals that address social determinants of health.
- Other

Patient Centered Medical Home

- Provision of coordinated services for patients under Patent Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care
- Integration of care management and coordination for high-risk patients based on the best practices (AHRQ PCMH framework, Risk Stratified Care Management- High Risk, Rising Risk and Low Risk designations, ACP PCMH model Safety Net Medical Home Initiative- Change Concepts for Practice Transformation, etc.)
- Enhancement in data exchange between hospitals and affiliated medical home sites.
- Utilization of care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; etc.
- Provision of services to individuals that address social determinants of health.
- Other

Expansion of Patient Care Navigation and Transition Services

- Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others)
- Enhancement in coordination between primary care, urgent care, and Emergency Departments to increase communication and improve care transitions for patients
- Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program, which includes a connection of ED patients to primary and preventive care.
- Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
- Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients.
- Expansion of access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions.

- Provision of services to individuals that address social determinants of health.
- Other

Prevention and Wellness

- Self-management programs and wellness programs using evidence-based designs (e.g., Stanford Small-Group Self-Management Programs for people with arthritis, diabetes, HIV, cancer, chronic pain, and other chronic diseases; SAMHSA's Whole Health Action Management among others)
- Implementation of strategies to reduce tobacco use (Example of evidence based models: 5R's (Relevance, Risks, Rewards, Roadblocks, Repetition) for patients not ready to quit; Ottawa Model; Freedom From Smoking Curriculum- American Lung Association among others)
- Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (e.g., Technology Supported Multi Component Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss; Coordinated Approach to Child Health - CATCH; and SPARK among others)
- Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
- Utilization of whole health peer support, which could include conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g., hypertension, diabetes, and health risks such as obesity, tobacco use, and physical inactivity)
- Use of community health workers to improve prevention efforts
- Implementation of evidence based strategies to reduce sexually transmitted diseases.
- Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual.
- Other

Chronic Care Management

- Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care–integrated complex care management (CCM), Complex Patient Care Model Redesign- enhanced multidisciplinary care teams, The Transitional Care Model, etc.)
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management
- Management of targeted patient populations; e.g., chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services
- Implementation of a medication management program that serves patients across the continuum of care
- Utilization of pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers
- Utilization of enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and allows patients to enter health information and/or enables bidirectional communication about medication changes and adherence.

- Use telemedicine/telehealth to deliver specialty services.
- Education and alternatives designed to curb prescriptions of narcotic drugs to patients.
- Provision of services to individuals that address social determinants of health.
- Other

Availability of Appropriate Levels of Behavioral Health Care Services

- Utilization of mobile clinics that can provide access to BH care in very remote, inaccessible, or impoverished areas of Texas
- Utilization of telehealth/telemedicine in delivering behavioral services
- Increasing access to services by utilizing staff with the following qualifications: Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model
- Utilization of Care Management function that integrates primary and behavioral health needs of individuals
- Provision of services to individuals that address social determinants of health and/or family support services.
- Other

Substance Use Disorder

- Provision of Medication Assisted Treatment
- Education of primary care practitioners on preventive treatment option
- Utilization of telehealth/telemedicine in delivering behavioral health services
- Utilization of Prescription Drug Monitoring program (can include targeted communications campaign)
- Supported employment services for individuals in recovery
- Office-based additional treatment for uninsured individuals
- Peer recovery support
- Provision of services to individuals that address social determinants of health including housing navigation services.
- Utilization of telehealth/telemedicine in delivering behavioral services

Behavioral Health Crisis Stabilization Services

- Provision of crisis stabilization services based on the best practices (e.g., Critical Time Intervention, Critical Intervention Team, START model).
- Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients.
- Implement models supporting recovery of individuals with behavioral health needs.
- Provision of services to individuals that address social determinants of health.
- Other

Palliative Care

- Provision of coordinated palliative care to address patients with end-of-life decisions and care needs.
- Provision of palliative care services in outpatient setting.
- Transitioning of palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility and management of patients' needs.
- Provision of services to individuals that address social determinants of health.
- Utilization of services assisting individuals with pain management.
- Other

Other

If a Core Activity is not on this list, a provider can include a Core Activity and provide a description. As stated previously, providers may not add activities such as continuous quality improvement or a technology improvement as a stand-alone Core Activity. HHSC reserves the right to determine the appropriateness of "other" Core Activities chosen by a provider.

Alternative Payment Models (APMs)

Based on numerous studies and research articles related to categories of healthcare spending and opportunities for increased efficiencies, there is a widespread trend towards linking health care payments to measures of quality and/or efficiency (aka "value"). Texas Medicaid and CHIP programs are following this trend and have developed a Value-Based Purchasing Roadmap. Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved healthcare outcomes and efficiency.

Because the initial DSRIP program has been a very effective incubator for testing how alternative, value based payment models can support patient centered care and clinical innovation, HHSC continues to work closely with MCOs and DSRIP providers on ways to incorporate promising clinical models as VBP arrangements in the Medicaid MCO provision of care. Performing providers will report on progress in building the capacity to participate in a VBP model with MCOs through better utilization of Health Information Technologies and better measurement processes.

Costs and Savings

Based on the requirement included in the PFM, performing providers will submit information related to the costs of at least one Core Activity of their choice and the forecasted or generated savings of that Core Activity. Along with other required information, providers will submit a short narrative including Core Activity chosen, methodology and assumptions made for the analysis. Information related to costs and savings will be submitted in a template approved by HHSC or a comparable template. Performing Providers may use the *Return on Investment Forecasting Calculator for Quality Initiatives* by the Center for Health Care Strategies, Inc., or a comparable template that includes a description of the Core Activity, duration of the initiative, target population, costs, utilization changes and/or savings.

Performing providers will include costs and savings specific to their organization and other contracted providers if that information is available. If selected by the provider Core Activity is broad in scope,

provider can concentrate its analysis on a component of this Core Activity and provide an explanation for such selection during the reporting. A progress update will be submitted to HHSC during the second reporting period of DY7 and a final report of costs and savings will be submitted during the second reporting period of DY8. This information is key to assist performing providers to work with Medicaid Managed Care Organizations and other health care payers for sustainability.

Collaborative Activities

To continue to foster growth of collaboration within and among regions, all performing providers are required to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting each DY and report on participation during the second reporting period of each DY. Lessons learned from these meetings should be relevant at the provider level or applicable to some of the provider Core Activities. Providers will report on collaborative activities in the template prescribed by HHSC.

Category B

System Definition

DSRIP is shifting from project-based reporting to system-level reporting and a focus on system-wide changes and quality outcomes for DY7-8. As such, each performing provider will be required to define its system in the RHP Plan Update for its RHP.

In the broadest sense, the system is defined by the location(s) where patients are served by the performing provider and the types of services patients are receiving. The system definition will provide a broad structure in which performing providers work to improve care and transform the way healthcare is delivered in the state of Texas. While DSRIP will maintain its overall emphasis of improving care and access for the Medicaid and low-income or uninsured (MLIU) population in Texas, DSRIP reporting will no longer be limited by project-specific interventions or project-defined target populations.

A performing provider's system definition should capture all aspects of the performing provider's patient services. The Patient Population by Provider (PPP) (reported in Category B) is intended to reflect the universe of patients served by the performing provider's system, and therefore, the performing provider's system definition should incorporate all aspects of its organization that serve patients. The system definition may not exclude certain populations (with the exception of incarcerated populations served by hospital systems under contract with a government entity). The system definition should include all of a performing provider's service arenas that will be measured in its Category C measures, but may not be limited to those populations or locations if other services are provided by the performing provider.

Systems may be limited by geographic location. For example, a participating provider that operates one hospital in one RHP and another hospital in a separate RHP will have two systems if the separate hospitals were each DSRIP participating providers in DY2-6, though they are technically owned by the same company. System is not exclusively defined by ownership. Alternatively, the system may cross geographic locations. For example, a performing provider that operates a variety of clinics in one RHP and multiple clinics in another RHP may be one system. DSRIP participating providers with the same ownership may not combine two currently separate DSRIP providers into one system for DY7-8, unless this has been previously approved. A performing provider's delineation of system should consider data systems and the extent to which the various components are coordinating to improve health of the patients served.

There are required and optional components of a performing provider's system definition for each performing provider type. The required components are elements of a system that, through discussion with stakeholders and the technical advisory team, should be included as a performing provider's "base unit"; it has been determined that these components are essential functions and/or departments of the provider type. Therefore, the required components must be included in a performing provider's system definition if the performing provider's organization has that business component. A performing provider may then include optional components in its system definition and patient count, including contracted partners for certain services. Unless otherwise granted permission from HHSC, a performing provider should not count within its system definition or patient population another DSRIP performing provider's **required** components. There may be overlap in system definition for contracted partners; for example,

System A that contracts with FQHC A and System B that contracts with FQHC A may both count the FQHC A as part of their system definition.

As indicated in the PFM, performing providers may add contracted entities to their system definition. Certain options will be specified by HHSC, but performing providers will also have the option to add an "other" category. Performing providers will be required to explain any "other" optional component of the system definition. Inclusion of the population served in the optional components may be disallowed by HHSC. Performing providers should include optional components in their system definition only if the performing provider will have access to all data necessary for reporting. Performing providers should be mindful of data arrangements when contracting with entities that they intend to include in their system definition.

Required and Optional System Components

The following table displays the required and optional components of the system definition by performing provider type.

	Required*	**Optional**
Hospitals	Inpatient Services	Contracted Specialty Clinics
	Emergency Department	Contracted Primary Care Clinics
	Owned or Operated Outpatient Clinics	School-based Clinics
	Maternal Department	Contracted Palliative Care Programs
	Owned or Operated Urgent Care Clinics	Contracted Mobile Health Programs
		Other
Physician Practices	Owned or Operated Primary Care Clinics	Contracted Specialty Clinics
	Owned or Operated Specialty Care Clinics	Contracted Primary Care Clinics
	Owned or Operated Hospital	Contracted Community-based Programs
	Owned or Operated Urgent Care Clinics	Other
Community Mental Health Centers	Home-based services	Hospital
	Office/Clinic	Contracted Clinic

		School-based Clinic
		Contracted Inpatient Beds
		State-funded Community Hospital
		Community Institution for Mental Disease (IMD)
		General Medical Hospital
		State Mental Health Facility
		State Mental Retardation Facility
		Other
Local Health Departments	Clinics	Mobile Outreach
	Immunization Locations	Other

*Required only if the performing provider has this business component.

Once the performing provider has defined its system and the definition has been approved by HHSC, the provider will focus its reporting measure denominators in Category C. Denominators for Category C will be naturally limited by the setting of services or the measure specifications.

Category C

Each performing provider must select Category C Measure Bundles or measures from the following menus included in this section based on provider type: 1) the Hospital and Physician Practice Measure Bundle Menu; 2) the Local Health Department Measure Menu; or 3) the Community Mental Health Center Measure Menu. These menus include the number of points that each Measure Bundle or measure is worth.

Each performing provider is assigned a minimum point threshold (MPT) for Measure Bundle or measure selection as described in the Program Funding and Mechanics Protocol (PFM). Each performing provider must select Measure Bundles or measures worth enough points to meet its MPT in order to maintain its valuation for DY7 and DY8.

1. Measure Points

a. Each measure is assigned a point value based on the following classifications:
    i. Clinical Outcome: Patient clinical measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns are valued at 3 points.
    ii. Population Based Clinical Outcome (PBCO): Clinical Outcomes that measures ED utilization or admissions for selected conditions for all individuals in the target population of a Measure Bundle are valued at 4 points.
    iii. Cancer Screening: Cancer screening measures are valued at 2 points
    iv. Hospital Safety: hospital safety and infection measures are valued at 2 points.
    v. Process Measure: measures of clinical practice are valued at 1 point.
    vi. Immunization: immunization rates are valued at 1 point.
    vii. Quality of Life: measures related to quality of life or functional assessment are valued at 1 point.
    viii. Innovative Measure: Innovative measures are pay-for-reporting (P4R) and valued at 0 points.
    ix. Quality Improvement Collaborative Activity: participation in quality improvement activities is valued at 0 points.

b. Measure classification is specified for each measure in Appendix A Category C Specifications Document.

c. All measures are designated as Pay-for-Performance (P4P) except for Innovative Measures and Quality Improvement Collaborative Activities which are Pay-for-Reporting (P4R) in DY7 and DY8. Measures that are P4R are noted in Measure Bundles for Hospital & Physician Practices section.

2. Hospital and Physician Practice Measure Bundle Points & Selection Requirements

a. The base point value of a Measure Bundle is equal to the sum of the points for the required measures in the Measure Bundle. The base point value of a Measure Bundle designated as High State Priority is then multiplied by 2, and the base point value of a Measure Bundle designated as State Priority is then multiplied by 1.5.

i. High State Priority Measure Bundles (sum of the required measures' points multiplied by 2)
    1. E1: Improved Maternal Care
    2. E2: Maternal Safety
    3. H3: Chronic Non-Malignant Pain Management
ii. State Priority Measure Bundles (sum of the required measures' points multiplied by 1.5)
    1. A1: Chronic Disease Management: Diabetes
    2. A2: Chronic Disease Management: Heart Disease
    3. C1: Healthy Texans
    4. D1: Pediatric Primary Care
    5. D4: Pediatric Chronic Disease Management: Asthma
    6. D5: Pediatric Chronic Disease Management: Diabetes
    7. H1: Behavioral Health in a Primary Care Setting
    8. H2: Behavioral Health & Appropriate Utilization
    9. H4: Integrated Care for People with Serious Mental Illness

b. Optional measures in a Measure Bundle, if selected, add points to the Measure Bundle.
    i. Optional measures that add points, if selected, are not impacted by a high state priority or a state priority multiplier.

    EXAMPLE: Measure Bundle A1 - Chronic Disease Management: Diabetes is a State Priority Measure Bundle with required measures equaling 7 points and a multiplier of 1.5 for a base point value of 11 points. If a hospital selects Measure Bundle A1 and selects measures A1-500 Diabetes Composite and A1-508 Rate of ED Visits for Diabetes as P4P (A1-500 and A1-508 Population Based Clinical Outcomes worth an additional four points each and are required as P4P for providers with an MPT of 75, and optional as P4P for providers with an MPT less than 75), 8 points will be added to the Measure Bundle for a total of 19 points towards the hospital's MPT.

c. Limitations on Hospital and Physician Practice Measure Bundle Selections and Optional Measure Selections
    i. Measure Bundles K1 Rural Preventive Care and K2 Rural Emergency Care can only be selected by hospitals with a valuation less than or equal to $2,500,000 per DY. Providers that select measure bundle K1 cannot also select measure bundles A1, A2, B1, C1, D1, E1, or H1. Measure K2-285 cannot be selected if measure bundle K1 is selected.
    ii. Each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a Population Based Clinical Outcome.
    iii. For Measure Bundles A1, A2, B1, C1, D1, and H2, Population-based clinical outcomes are required for providers with an MPT of 75 and optional as P4P with 4 additional points for providers with an MPT below 75. Providers that do not opt to select a PBCO as P4P but have a measurable numerator greater than 0 are required to

report the PBCO as P4R following the requirements for a measure with insignificant volume.

iv. For Measure Bundles D4 and D5, the Population-based clinical outcome is a required measure for any provider that selects that Measure Bundle as the PBCO in each bundle is essential to the Measure Bundle objective.

v. Each hospital or physician practice with a valuation of more than $2,500,000 per DY must either: 1) select at least one Measure Bundle with at least one required 3 point clinical outcome measure; or 2) select at least one Measure Bundle with at least one optional 3 point clinical outcome measure selected. Three point clinical measures must have significant volume and be P4P to qualify as the required 3 point measure.

vi. If bundles D3 Pediatric Hospital Safety and J1 Hospital Safety are both selected, the points of each bundle will be reduced by 50%.

3. Community Mental Health Center and Local Health Department Measure Points & Selection Requirements

a. Certain measures designated as a state priority, if selected, add an additional point.

b. CMHCs and LHDs must select and report on at least two unique measures.

c. Each CMHC or LHD with a valuation of more than $2,500,000 per DY must select at least one 3 point clinical outcome measure.

d. If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 4 points will be counted towards the Performing Provider's MPT.

4. Minimum Volume Definitions & Requirements

a. Minimum Volume Definitions

i. *Significant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is greater than or equal to 30, unless an exception has been granted by HHSC to use an all-payer denominator as defined in the PFM.

ii. *Insignificant volume* is defined, for most outcome measures, as an MLIU denominator for the measurement period that is less than 30, but greater than 0, unless an exception has been granted by HHSC to use an all-payer denominator.

iii. *No volume* is defined as an MLIU denominator for the measurement period that is 0. For a PBCO, no volume is defined as a numerator for the 12 month measurement period that is 0.

b. Hospital and Physician Practice Minimum Volume Requirements

i. A hospital or physician practice may only select a Measure Bundle for which the hospital's or physician practice's MLIU denominator for the baseline measurement period for at least half of the required measures in the Measure Bundle has *significant volume*.

ii. A hospital or physician practice may only select an optional measure in a selected Measure Bundle for which the hospital or physician practice's MLIU denominator for the baseline measurement period has *significant volume*.

iii. **Insignificant Volume:** If a hospital or physician practice selects a Measure Bundle with a required measure for which the hospital or physician practice has *insignificant volume*, the valuations of the measure's reporting milestones will remain the same, but the valuations of the measure's achievement milestones will be redistributed proportionally among the achievement milestones for the other measures in the Measure Bundle with *significant volume*.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *insignificant volume* for one required measure. The selected Measure Bundle is assigned a valuation of $1,000,000. The milestone valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Measure Bundle Valuation: $1,000,000			DY8 Measure Bundle Valuation: $1,000,000	
		DY7 Baseline Milestone ($250,000)	DY7 PY1 Reporting Milestone ($250,000)	DY7 Achievement Milestone ($500,000)	DY8 PY2 Reporting Milestone ($250,000)	DY8 Achievement Milestone ($750,000)
1 (required)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000
2 (required)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000
3 (required)	Insignificant	$62,500	$62,500	-	$62,500	-
4 (optional)	Significant	$62,500	$62,500	$166,667	$62,500	$250,000

1. If a hospital or physician practice has *insignificant volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *insignificant volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *insignificant volume* for the measurement period, the measure's achievement milestone valuation may be redistributed as described in this subsection.

iv. **No Volume:** Required measures with *no volume* because the hospital or physician practice does not serve the population measured will be removed from the Measure Bundle and the valuations of the associated reporting and achievement milestones will be redistributed proportionally among the remaining measures in the Measure Bundle.

EXAMPLE: A physician practice selects a Measure Bundle with four required measures, selects one optional measure in the Measure Bundle, and has *no volume* for one required measure. The selected Measure Bundle is assigned a valuation of $1,000,000. The valuations for DY7 and DY8 are as follows:

Measure	Volume	DY7 Measure Bundle Valuation: $1,000,000			DY8 Measure Bundle Valuation: $1,000,000	
		DY7 Baseline Milestone ($250,000)	DY7 PY1 Reporting Milestone ($250,000)	DY7 Achievement Milestone ($500,000)	DY8 PY2 Reporting Milestone ($250,000)	DY8 Achievement Milestone ($750,000)
1 (required)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000
2 (required)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000
3 (required)	None	-	-	-	-	-
4 (optional)	Significant	$83,333	$83,333	$166,667	$83,333	$250,000

1. If a hospital or physician practice has *no volume* for the baseline measurement period for a required measure in a selected Measure Bundle at the time of RHP Plan Update submission, the hospital or physician practice will notify HHSC in the RHP Plan Update that it has *no volume* for the measure.
2. If a hospital or physician practice reports the baseline or performance for a required measure in a selected Measure Bundle with *no volume* for the measurement period, the measure's reporting and achievement milestone valuation may be redistributed as described in this subsection.

c. CMHC and LHD Minimum Volume Requirements

i. A CMHC or LHD may only select measures for which it has *significant volume*.

5. Eligible Denominator Population

All measure bundles will be based on the DSRIP attributed population defined below. Each measure bundle has a target population (or pool of people) for which the provider system is accountable for improvement under the DSRIP incentive arrangements. The target population identifies all individuals in the DSRIP attributed population for each provider system, which then serves as the starting point for all the measures within the measure bundle, and includes all individuals that would fall into the measure specifications for the included measure.

When reporting data for measures in a measure bundle, the eligible denominator population for each measure will be determined by the following process:

Step 1: Determine the DSRIP attributed population using the prescribed attribution methodology defined below.

Step 2: Determine the individuals from step one that are included in the measure bundle or measure target population

Step 3: Determine the individuals from the measure bundle target population that meet the measure specific denominator inclusion criteria.

Step 4: Determine payer type for individuals or encounters in the denominator following standardized specifications to determine the all payer, Medicaid, and uninsured rate for each

measure.

Step 1: Determine the DSRIP attributed population using the prescribed retroactive attribution methodology defined below based on the provider type indicated in the RHP Plan Submission:

1. For Hospital organizations and Physician Practices, the DSRIP attributed population includes individuals from the DSRIP system defined in Category B that meet at least one of the criteria below. Individuals do not need to meet all or multiple criteria to be included.
    a. Medicaid beneficiary attributed to the Performing Provider during the measurement period as determined by assignment to a primary care provider (PCP), medical home, or clinic in the performing providers DSRIP defined system OR
    b. Individuals enrolled in a local coverage program (for example, a county-based indigent care program) assigned to a PCP, medical home, or clinic in the performing providers DSRIP defined system OR
    c. One preventive service provided during the measurement period (Includes value sets of visit type codes for annual wellness visit, preventive care services - initial office visit, preventive care services - established office visit, preventive care individual counseling) OR
    d. One ambulatory encounter during the measurement year and one ambulatory encounter during the year prior to the measurement year OR
    e. Two ambulatory encounters during the measurement year OR
    f. Other populations managed with chronic disease in specialty care clinics in the performing providers DSRIP defined system
    g. One emergency department visit during the measurement year OR
    h. One admission for inpatient or observation status during the measurement year OR
    i. One prenatal or postnatal visit during the measurement year OR
    j. One delivery during the measurement year OR
    k. One dental encounter during the measurement year OR
    l. Enrolled in a palliative care or hospice program during the measurement year OR
    m. Other populations not included above that should be included in a measure bundle target population included in the RHP plan submission and approved by HHSC (for example, individuals enrolled in community based education programs)

2. For Community Mental Health Centers the DSRIP attributed population includes:
    a. All individuals from the DSRIP system defined in Category B that meet one of the following criteria during the measurement period:
        i. One encounter with the performing providers system during the measurement year and one encounter during the year prior to the measurement year OR
        ii. Two encounters with the performing providers system during the measurement year OR
        iii. Other populations defined by the CMHC in the RHP Plan Submission and approved by HHSC

3. For Local Health Departments the DSRIP attributed population includes:
    a. Individuals with one eligible encounter during the measurement period OR
    b. Other populations defined by the LHD in the RHP Plan Submission and approved by HHSC

4. Allowable Exclusions for all provider types:
    a. Performing providers may remove from the DSRIP attributed population any individual for which the provider has documentation of any one of the following during the measurement year:
        i. The individual that was previously assigned a PCP, medical home, or clinic with the provider but has changed their care to a PCP, medical home, or clinic that is not with the performing providers DSRIP system.
        ii. The patient has had a total time of incarceration during the measurement period that exceeded 45 days.

For Steps 2 - 4, refer to the introduction section of Appendix A Category C Measure Specifications.

6. Exceptions to MPTs and Measure Bundle Selection for Hospital and Physician Practices with a Limited Scope of Practice

a. Certain performing providers have a limited scope of practice. These performing providers may include children's hospitals and specialty hospitals such as infectious disease hospitals and Institutions for Mental Disease [IMDs].
    i. If such a performing provider is not able to reasonably report on enough bundles to meet its MPT based on its limited scope of practice and available community partnerships, the performing provider may request a lowered MPT equal to the sum of all Measure Bundles that the performing provider could reasonably report. The performing provider must request a lowered MPT prior to the RHP Plan Update submission, by a date determined by HHSC.
    ii. If such a performing provider is not able to reasonably report on at least half of the required measures in Measure Bundles needed to meet its MPT based on its limited scope of practice and available community partnerships, the performing provider may request approval to select measures outside of the Measure Bundle structure prior to the RHP Plan Update submission, by a date determined by HHSC.
        1. The hospital or physician practice must select measures from the Hospital and Physician Practice Measure Bundle Menu, the Local Health Department Measure Menu, or the Community Mental Health Center Measure Menu in accordance with the measure selection requirements for Local Health Departments and Community Mental Health Centers.
    iii. A hospital's or physician practice's request to lower the MPT or to select measures outside of the Measure Bundle structure may be subject to review by CMS. If HHSC and CMS, as appropriate, approve the request, the hospital's or physician practice's total valuation may be reduced.

7. Exceptions to Measure Selection for Local Health Departments

a. Local Health Departments may continue to report measures that an LHD reported for Category 3 in DY6 that are P4P in DY6 and not otherwise included in the L1 Local Health Department Menu.
    i. Grandfathered measures that are classified as standalone measures in DY2-6 will be valued at 3 points. Grandfathered measures that are non-standalone in DY2-6 will be valued at 1 point unless a measure has been given a categorization with a valuation of 2 points in the Measure Bundle Protocol.
    ii. Grandfathered measures will use DY6 (10/01/2016 - 09/30/2017) as the baseline measurement period for determining DY7 and DY8 goal achievement milestones, and standard performance measurement periods so that PY1 is CY2018, PY2 is CY2019, and PY3 is CY2020.
    iii. Duplicated measures will only count once towards a providers MPT. For example, if an LHD has two non-standalone measures that are the same measure selection in DY6 but report different rates for different facilities, the provider may continue to report both measures, but both measures will only contribute 3 points towards the MPT.
b. Local Health Departments may use a combination of grandfathered DY6 Category 3 measures and new measures selected from the L1 Local Health Department Menu in the Measure Bundle Protocol. New measures cannot duplicate grandfathered measures.

Measure Bundles for Hospitals & Physician Practices

Hospital & Physician Practice Measure Bundles	Any PBCO (4 points)	Any Clinical Outcome (3 points)	Base Points	Additional Points	Max Points
A1: Chronic Disease Management: Diabetes *[SP]*	*Required* [1]	Required	11	9	**20**
A2: Chronic Disease Management: Heart Disease *[SP]*	*Required* [1]	Required	8	11	**19**
B1: Care Transitions & Hospital Readmissions	None	Required	11	0	**11**
B2: Patient Navigation & ED Diversion	None	Required	3	9	**12**
C1: Primary Care Prevention - Healthy Texans *[SP]*	*Required* [1]	None	12	4	**16**
C2: Primary Care Prevention - Cancer Screening	None	None	6	0	**6**
C3: Hepatitis C	None	None	4	0	**4**
D1: Pediatric Primary Care *[SP]*	*Required* [1]	Required	14	6	**20**
D3: Pediatric Hospital Safety	None	None	10	0	**10**
D4: Pediatric Chronic Disease Management: Asthma *[SP]*	Required	None	9	0	**9**
D5: Pediatric Chronic Disease Management: Diabetes *[SP]*	Required	None	8	0	**8**
E1: Improved Maternal Care *[HSP]*	None	Required	10	1	**11**
E2: Maternal Safety *[HSP]*	None	Required	8	0	**8**
F1: Improved Access to Adult Dental Care	None	Required	7	0	**7**
F2: Preventive Pediatric Dental	None	None	2	0	**2**
G1: Palliative Care	None	*None* [2]	6	0	**6**
H1: Integration of Behavioral Health in a Primary or Specialty Care Setting *[SP]*	None	Required	12	0	**12**
H2: Behavioral Health and Appropriate Utilization *[SP]*	*Required* [1]	Optional	8	11	19
H3: Chronic Non-Malignant Pain Management *[HSP]*	None	None	10	0	**10**
H4: Integrated Care for People with Serious Mental Illness *[SP]*	None	None	5	0	**5**
I1: Specialty Care [3]	None	None	2	0	**2**
J1: Hospital Safety	None	None	10	0	**10**
K1: Rural Preventive Care [4]	Optional	None	3	10	**13**
K2: Rural Emergency Care [4]	None	None	3	1	**4**
Total Possible Points			187	62	244

[SP] Measure Bundle Designated as a State Priority
[HSP] Measure Bundle Designated as a High State Priority

[1] One or more PBCOs are required as P4P for providers with an MPT 0f 75 that select bundle, optional as P4P for others

[2] Clinical outcome included for cancer hospital only

[3] Requires prior authorization

[4] Can only be selected by hospitals with a valuation at or below $2,500,000 per DY

A1: Improved Chronic Disease Management: Diabetes Care

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

Target Population:
Adults with diabetes

Base Points: 7*1.5 (state priority) = 11
Possible Additional Points: 9
Maximum Total Possible Points: 20

ID	Measure	Steward	NQF #	Required	Measure Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	No	+1
A1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Yes	1
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Yes	3
A1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	Yes	3
A1-500	PQI 93 Diabetes Composite (Adult short-term complications, long-term complications, uncontrolled diabetes, lower-extremity amputation admission rates)	AHRQ	N/A	Yes*	+4/+0
A1-508	Reduce Rate of Emergency Department visits for Diabetes	N/A	N/A	Yes*	+4/+0

*For providers that select Measure Bundle A1:

- Measures A1-500 AND A1-508 are Population Based Clinical Outcomes and are required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measures as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

A2: Improved Chronic Disease Management: Heart Disease

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of heart disease and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization.

Target Population:
Adults with heart disease

Base Points: 5*1.5 (state priority) = 8
Possible Additional Points: 11
Maximum Total Possible Points: 19

ID	Measure	Steward	NQF #	Required	Measure Point Value
A2-103	Controlling High Blood Pressure	NCQA	0018	Yes	3
A2-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	Yes	1
A2-384	Risk Adjusted CHF 30-Day Readmission Rate	N/A	N/A	No	+3
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	N/A	Yes	1
A2-501	PQI 08 Heart Failure Admission Rate (Adult)	AHRQ	N/A	Yes*	+4/+0
A2-509	Reduce Rate of Emergency Department visits for CHF, Angina, and Hypertension	N/A	N/A	Yes*	+4/+0

*For providers that select Measure Bundle A2:

- Measures A2-501 and A2-509 are Population Based Clinical Outcomes and are required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measures as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

B1: Care Transitions & Hospital Readmissions

Objective:
Implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to improve health outcomes, and prevent increased health care costs and hospital readmissions.

Target Population:
Individuals transitioning out of inpatient care

Base Points: 11
Possible Additional Points: N/A
Maximum Total Possible Points: 11

ID	Measure	Steward	NQF #	Required	Measure Point Value
B1-124	Medication Reconciliation Post-Discharge	NCQA	0097	Yes	1
B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	N/A	N/A	Yes	3
B1-217	Risk Adjusted All-Cause 30-Day Readmission	N/A	N/A	Yes	3
B1-252	Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	AMA	0649	Yes	1
B1-253	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	AMA	0647	Yes	1
B1-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	1
B1-352	Post-Discharge Appointment	AHA/ASA, TJC	2455/ 2439	Yes	1

B2: Patient Navigation & ED Diversion

Objective:
Utilize patient navigators (community health workers, case managers, or other types of professionals) and/or develop other strategies to provide enhanced social support and culturally competent care to connect high risk patients to primary care or medical home sites, improve patient outcomes, and divert patients needing non-urgent care to appropriate settings.

Target Population:
Adults utilizing the emergency department

Base Points: 3
Possible Additional Points: 9
Maximum Total Possible Points: 12

ID	Measure	Steward	NQF #	Required	Measure Point Value
B2-242	Reduce Emergency Department (ED) visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes**	*(+3)*
B2-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes**	*(+3)*
B2-392	Reduce Emergency Department visits for Acute Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes	*3*
B2-393	Reduce Emergency Department visits for Dental Conditions	N/A	N/A	Yes**	*(+3)*
**Must select one of either B2-242, B2-387, B2-393 May select one or more additional from B2-242, B2-387, B2-393 for up to an additional 6 points.					

C1: Primary Care Prevention - Healthy Texans

This bundle is a State Priority.

Objective:
Provide comprehensive, integrated primary care services that are focused on person-centered preventive care and chronic disease screening.

Target Population:
Adults

Base Points: 8*1.5 (state priority) = 12
Possible Additional Points: 4
Maximum Total Possible Points: 16

ID	Measure	Steward	NQF #	Required	Possible Measure Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	1
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	Yes	1
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	Yes	1
C1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	1
C1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	Yes	1
C1-272	Adults (18+ years) Immunization status	ICSI	N/A	Yes	1
C1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	Yes	1
C1-389	Human Papillomavirus Vaccine (age 18 -26)	N/A	N/A	Yes	1
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	AHRQ	N/A	Yes*	+4/+0

*For providers that select Measure Bundle C1:

- Measure C1-502 is a Population Based Clinical Outcomes and is a required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measure as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

C2: Primary Care Prevention - Cancer Screening

Objective:
Increase access to cancer screening in the primary care setting.

Target Population:
Adults

Base Points: 6
Possible Additional Points: N/A
Maximum Total Possible Points: 6

ID	Measure	Steward	NQF #	Required	Measure Point Value
C2-106	Cervical Cancer Screening	NCQA	0032	Yes	2
C2-107	Colorectal Cancer Screening	NCQA	0034	Yes	2
C2-186	Breast Cancer Screening	NCQA	2372	Yes	2

C3: Hepatitis C

Objective:
Implement screening program in high risk populations to detect and treat Hepatitis C infections.

Target Population:
Adults

Base Points: 4
Possible Additional Points: N/A
Maximum Total Possible Points: 4

ID	Measure	Steward	NQF #	Required	Measure Point Value
C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	3059	Yes	1
C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	PCPI	3061	Yes	1
C3-368	Hepatitis C: Hepatitis A Vaccination	American Gastroenterological Association	0399	Yes	1
C3-369	Hepatitis C: Hepatitis B Vaccination	American Gastroenterological Association	0400	Yes	1

D1: Pediatric Primary Care

This bundle is a State Priority.

Objective:
Increase access to comprehensive, coordinated primary care & preventive services focused on accountable, child-centered care that improves quality of life and health outcomes.

Target Population:
Children

Base Points: 9*1.5 (state priority) = 14
Possible Additional Points: 5
Maximum Total Possible Points: 20

ID	Measure	Steward	NQF #	Required	Measure Point Value
D1-108	Childhood Immunization Status (CIS)	NCQA	0038	Yes	1
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity	NCQA	0024	Yes	1
D1-212	Appropriate Testing for Children With Pharyngitis	AHRQ	0002	Yes	3
D1-237	Well-Child Visits in the First 15 Months of Life	NCQA	1392	Yes	1
D1-271	Immunization for Adolescents	NCQA	1407	Yes	1
D1-284	Appropriate Treatment for Children with URI	NCQA	0069	Yes	1
D1-301	Maternal Depression Screening	NCQA	1401	No	+1
D1-389	Human Papillomavirus Vaccine (age 15-18)	N/A	N/A	No	+1
D1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	Yes	1
D1-503	PDI 97 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	AHRQ	N/A	Yes*	*+4/*+0
D1-T01	*Innovative Measure*: Behavioral Health Counselling for Childhood Obesity (P4R)	Meadows	N/A	No	0

*For providers that select Measure Bundle D1:

- Measure D-503 is a Population Based Clinical Outcomes and is a required P4P measures for providers with an MPT of 75.
- Providers with an MPT less than 75 may opt to report measure as P4P.
- Providers with an MPT below 75 that do not opt to report as P4P that have any numerator volume will report as P4R. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

D3: Pediatric Hospital Safety

Objective:
Reduce hospital errors, improve effectiveness of staff communication (both internally and with patients and their caregivers), improve medication management, and reduce the risk of health-care associated infections.

Target Population:
Children receiving inpatient care

Base Points: 10
Possible Additional Points: N/A
Maximum Total Possible Points: 10

If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.

ID	Measure	Steward	NQF #	Required	Measure Point Value
D3-330	Pediatric CLABSI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	2
D3-331	Pediatric CAUTI		N/A	Yes	2
D3-333	Pediatric Surgical site infections (SSI)		N/A	Yes	2
D3-334	Pediatric Adverse Drug Events		N/A	Yes	2
D3-335	Pediatric Pressure Injuries		N/A	Yes	2

D4: Pediatric Chronic Disease Management: Asthma

This bundle is a State Priority.

Objective:
Develop and implement chronic disease management interventions that are geared toward improving management of asthma to improve patient health outcomes and quality of life and reduce unnecessary acute and emergency care utilization.

Target Population:
Children with asthma

Base Points: 6*1.5 (state priority) = 9
Possible Additional Points: N/A
Maximum Total Possible Points: 9

ID	Measure	Steward	NQF #	Required	Possible Measure Points
D4-139	Asthma Admission Rate (PDI 14)	AHRQ	0728	Yes	4
D4-353	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	University Hospitals Cleveland Medical Center	3170	Yes	1
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	The American Academy of Asthma Allergy and Immunology	0047	Yes	1

D5: Pediatric Chronic Disease Management: Diabetes

Objective:
Develop and implement diabetes management interventions that improve patient health outcomes and quality of life, prevent onset or progression of comorbidities, and reduce unnecessary acute and emergency care utilization.

Target Population:
Children with Type 1 and Type 2 Diabetes

Base Points: 5*1.5 (state priority) = 8
Possible Additional Points: N/A
Maximum Total Possible Points: 8

ID	Measure	Steward	NQF #	Required	Measure Point Value
D5-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	NCQA	0024	Yes	1
D5-406	Diabetes Short-term Complications Admission Rate (PDI 15)	AHRQ	N/A	Yes	4
D5-T07	Innovative Measure: Diabetes Care Coordination (P4R)	TBD	N/A	No	0

E1: Improved Maternal Care

This bundle is a High State Priority.

Objective:
Improve maternal health outcomes by implementing evidence-based practices to provide pre-conception, prenatal and postpartum care including early detection and management of comorbidities like hypertension, diabetes, and depression.

Target Population:
Pregnant and postpartum women

Base Points: 5*2 (high state priority) = 10
Possible Additional Points: 1
Maximum Total Possible Points: 11

ID	Measure	Steward	NQF #	Required	Measure Point Value
E1-193	Contraceptive Care – Postpartum Women Ages 15–44	US Office of Population Affairs	2902	No	+1
E1-232	Timeliness of Prenatal Care	NCQA	1517	Yes	1
E1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	Yes	3
E1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	Yes	1

E2: Maternal Safety

This bundle is a High State Priority.

Objective: Improve maternal safety and reduce maternal morbidity through data driven interventions to prevent and manage obstetric hemorrhage.

Target Population:
Women with preterm or full-term deliveries

Base Points: 4*2 (high state priority) = 8
Possible Additional Points: N/A
Maximum Total Possible Points: 8

ID	Measure	Steward	NQF #	Required	Measure Point Value
E2-150	PC-02 Cesarean Section	The Joint Commission	0471	Yes	3
E2-151	PC-03 Antenatal Steroids	The Joint Commission	0476	Yes	1
E2-A01	Quality Improvement Collaborative Activity: Participation in OB Hemorrhage Safety Bundle Collaborative through the Texas Collaborative for Healthy Mothers and Babies *(P4R for participation in collaborative in DY7 and P4R for implementation of recommended practices in DY8)*	N/A	N/A	Yes	0

F1: Improved Access to Adult Dental Care

Objective:
Increase access to timely, appropriate dental care.

Target Population:
Adults

Base Points: 7
Possible Additional Points: N/A
Maximum Total Possible Points: 7

ID	Measure	Steward	NQF #	Required	Measure Point Value
F1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	1
F1-226	Chronic Disease Patients Accessing Dental Services	N/A	N/A	Yes	3
F1-227	Dental Caries: Adults	Healthy People 2020	N/A	Yes	3
F1-T03	*Innovative Measure*: Oral Cancer Screening (P4R)	A&M College of Dentistry	N/A	No	0

F2: Preventive Pediatric Dental Care

Objective:
Expand access to dental care including screening and preventive dental services to improve long term oral health and quality of life and reduce costs by preventing the need for more intensive treatments.

Target Population:
Children

Base Points: 2
Possible Additional Points: N/A
Maximum Total Possible Points: 2

ID	Measure	Steward	NQF #	Required	Measure Point Value
F2-224	Dental Sealant: Children	Healthy People 2020	N/A	Yes	1
F2-229	Oral Evaluation: Children	American Dental Association	2517	Yes	1

G1: Palliative Care

Objective:
Provide palliative care services to patients and their families and/or caregivers to improve patient outcomes and quality of life with a focus on relief from symptoms, stress, and pain related to serious, debilitating or terminal illness.

Target Population:
Individuals with serious or terminal illness enrolled in a hospice or palliative care program

Base Points: 6
Possible Additional Points: N/A or 6*
Maximum Total Possible Points: 6 or 12*

ID	Measure	Steward	NQF #	Required	Measure Point Value
G1-276	Hospice and Palliative Care – Pain assessment	University of North Carolina-Chapel Hill	1637	Yes	1
G1-277	Hospice and Palliative Care – Treatment Preferences	University of North Carolina-Chapel Hill	1641	Yes	1
G1-278	Beliefs and Values	University of North Carolina-Chapel Hill	1647	Yes	1
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation/UCLA	1617	Yes	1
G1-362	Hospice and Palliative Care -- Dyspnea Treatment	University of North Carolina-Chapel Hill	1638	Yes	1
G1-363	Hospice and Palliative Care -- Dyspnea Screening	University of North Carolina-Chapel Hill	1639	Yes	1
G1-505	Proportion Admitted to Hospice for less than 3 day	American Society of Clinical Oncology	0216	No*	+3
G1-507	Proportion not Admitted to Hospice	American Society of Clinical Oncology	0215	No*	+3
*Measures G1-505 and G1-507 may only be selected by a cancer hospital					

H1: Integration of Behavioral Health in a Primary or Specialty Care Setting

This bundle is a State Priority.

Objective:
Implement depression, substance use disorder, and behavioral health screening and multi-modal treatment in a primary or non-psychiatric specialty care setting.

Target Population:
Individuals receiving primary care services or specialty care services

Base Points: 8*1.5 (state priority) = 12
Additional Points: N/A
Maximum Total Possible Points: 12

ID	Measure	Steward	NQF #	Required	Measure Point Value
H1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	Yes	1
H1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	Yes	3
H1-286	Depression Remission at Six Months	MN Community Measurement	0711	Yes	3
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	Yes	1
H1-T04	*Innovative Measure:* Engagement in Integrated Behavioral Health (P4R)	Meadows	N/A	No	0

H2: Behavioral Health and Appropriate Utilization

This bundle is a State Priority.

Objective:
Provide specialized and coordinated services to individuals with serious mental illness and/or a combination of behavioral health and physical health issues to reduce emergency department utilization and avoidable inpatient admission and readmissions.

Target Population:
Individuals with serious mental illness

Base Points: 5*1.5 (state priority) = 8
Possible Additional Points: 11
Maximum Total Possible Points: 19

ID	Measure	Steward	NQF #	Required	Measure Point Value
H2-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	*(Yes)**	*+3*
H2-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	*(Yes)**	*+3*
H2-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	Yes	1
H2-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	No	+1
H2-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	Yes	1
H2-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	Yes	1
H2-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	Yes	1
H2-510	Reduce Rate of Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes * †	+4/+0
H2-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS	N/A	Y	1

† For providers that select Measure Bundle H2 and have an MPT of 75:
Measure H2-510 is a Population Based Clinical Outcome and is a required P4P measure for providers with an MPT of 75.

† * For providers that select Measure Bundle H2 and have an MPT of less than 75:
Providers with an MPT less than 75 must select one of either H2-160, H2-216, or H2-510 as P4P. Providers that do not opt to report H2-510 as P4P that have any numerator volume must report as P4R and select one of either H2-160 or H2-216. Measures reported as P4R will not count towards the measure bundle's point value and do not contribute towards a provider's MPT.

H3: Chronic Non-Malignant Pain Management

This bundle is a High State Priority.

Objective:
Improve individuals' quality of life and reduce pain through lifestyle modification, psychological approaches, interventional pain management, and/or pharmacotherapy while recognizing current or potential substance abuse disorders. Improve providers' ability to identify and manage chronic non-malignant pain using a function-based multimodal approach, and ability to screen for substance use disorder and connect individuals to appropriate treatment.

Target Population:
Adults with chronic pain or on long-term opioid therapy

Base Points: 5*2 (high state priority) = 10
Possible Additional Points: N/A
Maximum Total Possible Points: 10

ID	Measure	Steward	NQF #	Required	Measure Point Value
H3-144	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain	CMS	0418	Yes	1
H3-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	1
H3-288	Pain Assessment and Follow-up	CMS	0420	Yes	1
H3-401	Opioid Therapy Follow-up Evaluation	N/A	N/A	Yes	1
H3-403	Evaluation or Interview for Risk of Opioid Misuse	N/A	N/A	Yes	1
H3-T05	*Innovative Measure:* Treatment of Chronic Non-Malignant Pain Management with Multi-Modal Therapy (P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	0
H3-T06	*Innovative Measure:* Patients on long-term opioid therapy checked in prescription drug monitoring programs (PDMPs) (P4R)	AHRQ/ San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	0

H4: Integrated Care for People with Serious Mental Illness

This bundle is a State Priority.

Objective:
Improve physical health outcomes for individuals with serious mental illness.

Target Population:
Individuals with Serious Mental Illness

Base Points: 3*1.5 (state priority) = 5
Possible Additional Points: N/A
Maximum Total Possible Points: 5

ID	Measure	Steward	NQF #	Required	Possible Measure Points
H4-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	Yes	1
H4-258	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia	NCQA	1933	Yes	1
H4-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	Yes	1

I1: Specialty Care

Objective:
Improve quality of life and functional status for individuals with chronic and life impacting conditions receiving services in an outpatient specialty care setting.

Target Population:
Adults & Children with chronic and life impacting conditions

Base Points: 2
Possible Additional Points: N/A
Maximum Total Possible Points: 2

Requires prior authorization and can only be selected once by Hospital and Physician Practices with a specialty care project in DY6.

ID	Measure	Steward	NQF #	Required	Measure Point Value
I1-385	Assessment of Functional Status or QoL	N/A	N/A	Yes	1
I1-386	Improvement in Functional Status or QoL	N/A	N/A	Yes	1

J1: Hospital Safety

Objective:
Improve patient health outcomes and experience of care by reducing the risk of health-care associated infections, and reducing hospital errors.

Target Population:
Individuals receiving inpatient care

Base Points: 10
Possible Additional Points: N/A
Maximum Total Possible Points: 10

If D3 and J1 are both selected, the points of each bundle will be reduced by 50%.

ID	Measure	Steward	NQF #	Required	Measure Point Value
J1-218	Central line-associated bloodstream infections (CLABSI) rates	CDC	0139	Yes	2
J1-219	Catheter-associated Urinary Tract Infections (CAUTI) rates	CDC	0138	Yes	2
J1-220	Surgical site infections (SSI) rates	CDC	0299	Yes	2
J1-221	Patient Fall Rate	American Nurses Association	0141	Yes	2
J1-506	PSI 13 Post-Operative Sepsis Rate	AHRQ	N/A	Yes	2

K1: Rural Preventive Care

This bundle is only available to hospitals with a valuation less than or equal to $2,500,000 per DY.

Objective:
Improve provision of preventive care in rural and critical access hospitals to improve patient health.

Target Population:
Adults and Children in Rural Areas

Base Points: 3
Possible Additional Points: 10
Maximum Total Possible Points: 13

Measure Bundles A1, A2, C1, D1, E1, and H1 cannot be selected if Measure Bundle K1 is selected.

ID	Measure	Steward	NQF #	Required	Measure Point Value
K1-103	Controlling High Blood Pressure	NCQA	0018	No	+3
K1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	1
K1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	No	+1
K1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	No	+3
K1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	No	+1
K1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	1
K1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041/ 3070	No	+1
K1-285	Advance Care Plan	NCQA	0326	Yes	1
K1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	No	+1

K2: Rural Emergency Care

This bundle is only available to hospitals with a valuation less than or equal to $2,500,000 per DY.

Objective:
Improve quality of emergency care in rural and critical access hospital to improve patient health.

Target Population:
Adults and Children receiving emergency services in rural areas

Base Points: 3
Possible Additional Points: 1
Maximum Total Possible Points: 4

ID	Measure	Steward	NQF #	Required	Measure Point Value
K2-285	Advance Care Plan	NCQA	0326	No*	+1
K2-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	1
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	CMS	0497	Yes	1
K2-359	Emergency Transfer Communication Measure	University of Minnesota Rural Health Research Center	0291	Yes	1

*K2-285 cannot be selected if measure bundle K1 is selected.

Local Health Department Measures

LHD Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
L1-103	Controlling High Blood Pressure	NCQA	0018	3
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1
L1-107	Colorectal Cancer Screening	NCQA	0034	2
L1-108	Childhood Immunization Status (CIS)	NCQA	0038	1
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	1
L1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3
L1-186	Breast Cancer Screening	NCQA	2372	2
L1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1
L1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3
L1-210	317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1
L1-224	Dental Sealant: Children	Healthy People 2020	N/A	1
L1-225	Dental Caries - Children	Healthy People 2020	N/A	3
L1-227	Dental Caries - Adults	Healthy People 2020	N/A	3
L1-231	Preventive Services for Children at Elevated Caries Risk - Modified Denominator	American Dental Association	N/A	1
L1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	3
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	NCQA	1392	1
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3
L1-242	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)	None	N/A	3
L1-268	Pneumonia vaccination status for older adults	CMS	0043	1

LHD Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
L1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	1
L1-271	Immunization for Adolescents- Tdap/TD and MCV	NCQA	1407	1
L1-272	Adults (18+ years) Immunization status	Institute for Clinical Systems Improvement	N/A	1
L1-280	Chlamydia Screening in Women	NCQA	0033	1
L1-343	Syphilis positive screening rates	CDC	N/A	1
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	CDC	N/A	3
L1-345	Gonorrhea Positive Screening Rates	CDC	N/A	1
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	CDC	N/A	3
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	CDC	N/A	3
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3
L1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	1

Community Mental Health Center Measure Menu

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	3	+1
M1-103	Controlling High Blood Pressure	NCQA	0018	3	+1
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	1	+1
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	3	
M1-124	Medication Reconciliation Post-Discharge	NCQA	0097	1	
M1-125	Antidepressant Medication Management (AMM-AD)	NCQA	0105	3	
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	CMS	0418	1	
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828 eMeasure	1	
M1-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	3	
M1-165	Depression Remission at 12 Months	MN Community Measurement	0710	*(3)**	+1
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia	CMS	1879	3	
M1-181	Depression Response at Twelve Months-Progress Towards Remission	MN Community Measurement	1885	*(3)**	+1
M1-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	1	+1

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	N/A / 3059 eMeasure	1	+1
M1-205	Third next available appointment	Wisconsin Collaborative for Healthcare Quality	N/A	1	
M1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	3	
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	1	
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	1	+1
M1-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	3	
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3	
M1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	3	
M1-256	Initiation of Depression Treatment	CQAIMH	N/A	1	
M1-257	Care Planning for Dual Diagnosis	CQAIMH	N/A	1	
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	1	+1
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	CQAIMH	N/A	1	+1
M1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1	
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1	
M1-264	Vocational Rehabilitation for Schizophrenia	CQAIMH	N/A	1	

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	+1
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1	
M1-280	Chlamydia Screening in Women	NCQA	0033	1	+1
M1-286	Depression Remission at Six Months	MN Community Measurement	0711	*(3)**	+1
M1-287	Documentation of Current Medications in the Medical Record	CMS	0419	1	+1
M1-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	1	+1
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	2801	1	
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	1	+1
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	1	+1
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	The Joint Commission	1664	1	+1
M1-340	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	APA/ NCQA/ PCPI	N/A	1	+1
M1-341	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period	APA/ NCQA/ PCPI	N/A	1	+1
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	SAMHSA/ CCBHC	N/A	1	

CMHC Measures					
ID	**Measure**	**Steward**	**NQF #**	**Points**	**Additional Points for State Priority Measures**
M1-385	Assessment of Functional Status or QoL *Specific to IDD Services*	N/A	N/A	1	
M1-386	Improvement in Functional Status or QoL *Specific to IDD Services*	N/A	N/A	1	
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	3	+1
M1-390	Time to Initial Evaluation: Mean Days to Evaluation	SAMHSA/ CCBHC	NA	1	
M1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS		1	+1
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS/CQAIMH	NA	1	+1

**If more than one of M1-165, M1-181, and/or M1-286 are selected, only 4 points will be added to meet MPT.*

Category D

Category D represents a population health perspective for all DSRIP performing providers. Whereas the initial waiver period included Category 4 statewide reporting for hospitals, Category D includes measures for all DSRIP performing provider types including Hospitals, Community Mental Health Centers, Physician Practices, and Local Health Departments. This reporting is designed to assist providers, managed care organizations, Regional Healthcare Partnerships, and state and federal agencies to have regional and statewide views of important health care trends. The Category D reporting measure bundles are:

- Aligned with Medicaid, low-income, and uninsured populations;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

Category D Structure:

Required Statewide Reporting Measure Bundles for each of the performing provider types:

- Hospitals
- Community Mental Health Centers (CMHCs)
- Physician Practices
- Local Health Departments (LHDs)

The Category D emphasis is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics; therefore, performing providers will not be required to achieve improvement in Category D. All measures are required and may be reported in the first or second reporting period of each DY. Performing providers will also submit qualitative information describing providers' activities impacting measures. Measure reporting and qualitative information will be submitted in the form prescribed by HHSC.

Hospital Statewide Reporting Measure Bundle

As specified in the PFM hospital performing providers must report on all measures included in this bundle:

- Potentially preventable admissions (PPAs)
- Potentially Preventable 30-day readmissions (PPRs)
- Potentially preventable complications (PPCs)
- Potentially Preventable ED visits (PPVs)
- Patient satisfaction

Hospital performing providers report on the Category D Statewide Hospital Reporting Measure Bundle, including hospitals that were previously exempt from the reporting on population health measures during DY2-6. Each hospital performing provider subject to required Category D reporting must report on all measures.

For PPAs, PPRs, PPCs and PPVs, hospitals with low volume are still required to respond to qualitative questions.

Hospital Reporting Measures

Potentially Preventable Admissions (PPAs)

PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. Circumstances associated with PPAs are ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs may represent a failure of the ambulatory care provided to the patient. In addition to a significant quality problem, excess PPAs result in unnecessary increases in cost. From the perspective of care providers, one way to improve efficiency and quality and to generate greater value is to better identify and avoid unnecessary hospitalizations.

PPA by Category

CHF (Congestive Heart Failure)
DM (Diabetes)
BH/SA (Behavioral Health/Substance Abuse)
COPD (Chronic Obstructive Pulmonary Disease)
Adult Asthma
Pediatric Asthma
CP & CAD (Angina and Coronary Artery Disease)
HTN (Hypertension)
Cellulitis
Bacterial PNA (Respiratory Infection)
PE & RF (Pulmonary Edema and Respiratory Failure)
Others

Potentially Preventable Readmissions (PPRs)

Readmissions have potential value as an indicator of quality of care because they may reflect poor clinical care and poor coordination of services either during hospitalization or in the immediate post discharge period. A potentially preventable readmission is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. “Clinically related” is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. A readmission is defined as a return hospitalization to an acute care hospital that follows a prior acute care admission

within a specified time interval, called the readmission time interval. The readmission time interval is the maximum number of days allowed between the discharge date of a prior admission and the admitting date of a subsequent admission. If a subsequent admission occurs within the readmission time interval and is clinically related to a prior admission, it is considered a PPR. The hospitalization triggering a PPR is called an Initial Admission. Subsequent PPRs relate back to the care rendered during or following the Initial Admission.

PPR by Category

CHF (Congestive Heart Failure)
DM (Diabetes)
BH/SA (Behavioral Health or Substance Abuse)
COPD (Chronic Obstructive Pulmonary Disease)
CVA (Cerebrovascular Accident)
Adult Asthma
Pediatric Asthma
AMI (Acute Myocardial Infarction)
CP & CAD (Angina and Coronary Artery Disease)
HTN (Hypertension)
Cellulitis
Renal Failure
C Section (Cesarean delivery)
Sepsis
Others

Potentially Preventable Complications (PPCs)

PPCs are in-hospital complications that are not present on admission, but result from treatment during the inpatient stay. As indicators of quality of care, PPCs represent harmful events or negative outcomes that might result from processes of care and treatment rather than from natural progression of the underlying disease. Increased costs resulting from complications are passed on to payers because the diagnosis codes linked to complications frequently increase Diagnosis Related Group (DRG) payment.

The 3M PPC methodology identifies PPCs based on risk at admission, using information from inpatient encounters, such as diagnosis codes, procedure codes, procedure dates, present on admission (POA) indicators, patient age, sex and discharge status. Accurate coding of the POA indicators is particularly important as it serves two primary purposes: (1) to identify potentially preventable complications from

among diagnoses not present on admission, and (2) to allow only those diagnoses designated as present on admission to be used for assessing the risk of incurring complications.

PPC by Category

Renal Failure without Dialysis
Urinary Tract Infection
Clostridium Difficile Colitis
Encephalopathy
Shock
Pneumonia & Other Lung Infections
Acute Pulmonary Edema and Respiratory Failure without Ventilation
Stroke and Intracranial Hemorrhage
Post Hemorrhagic & Other Acute Anemia with Transfusion
Venous Thrombosis
Ventricular Fibrillation/Cardiac Arrest
Major Gastrointestinal Complications without Transfusion or Significant Bleeding
Other Complications of Medical Care
Moderate Infections
Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection
Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure
Septicemia & Severe Infections
Acute Pulmonary Edema and Respiratory Failure with Ventilation
Post-Operative Infection & Deep Wound Disruption without Procedure
Infections due to Central Venous Catheters

Potentially Preventable ED visits (PPVs)

A PPV is an emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting. Because some visits are preventable, they may indicate poor care management, inadequate access to care, or poor choices on the part of the patient. Emergency department visits for conditions that are preventable or treatable with appropriate primary care lower health system efficiency and raise costs.

PPV by Category

Skin and Integumentary System
Breast
Musculoskeletal System
Respiratory System
Cardiovascular System
Hematologic, Lymphatic and Endocrine
Gastrointestinal
Genitourinary System
Male Reproductive System
Female Reproductive System
Neurologic System
Ophthalmologic System
Otolaryngologic System
Radiologic Procedures
Rehabilitation
Mental Illness and Substance Abuse Therapies
Nuclear Medicine
Radiation Oncology
Dental Procedures

Patient Satisfaction

The reporting is limited to the inpatient setting.

For Patient Satisfaction, providers will report the percentage of survey respondents who choose the most positive, or "top-box" response for HCAHPS Reporting Measures:

- Percent of patients who reported that their nurses "Always" communicated well
- Percent of patients who reported that their pain was "Always" well controlled
- Percent of patients who reported that staff "Always" explained about medicines before giving it to them
- Percent of patients who reported that YES, they were given information about what to do during their recovery at home
- Percent of patients who reported that their room and bathroom were "Always" clean
- Percent of patients who reported that the area around their room was "Always" quiet at night
- Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Percent of patients who reported YES, they would definitely recommend the hospital.

Hospitals that do not report HCAHPS as part of Medicare Inpatient Prospective Payment System due to low volume or other exempt status may use an alternative hospital patient satisfaction survey and must include information in their RHP Plan Update that describes the method they will use for reporting.

Community Mental Health Center Statewide Reporting Measure Bundle

Community Mental Health Centers (CMHCs) will report on their activities being carried out to impact rates on the following measures and provide qualitative reporting as required by HHSC[1]:

1. **Effective Crisis Response**

   This measure is the percent of individuals receiving crisis services who avoid inpatient admission after the crisis episode.

2. **Crisis Follow up**

   This measure is the percent of individuals receiving crisis services who receive a crisis follow up services within a defined time period.

3. **Community Tenure (Adult and Child/Youth)**

   This measure is the percent of individuals who successfully avoid psychiatric inpatient care.

4. **Reduction in Juvenile Justice Involvement**

   This measure is the percent of children and youth who demonstrate improvement on indicators of juvenile justice involvement.

[1] These measures may be modified at the end of DY7-8. CMHCs will report based on the modified measure specifications once approved by HHSC.

5. Adult Jail Diversion

This measure is the percent adults who demonstrate improvement on indicators of criminal justice involvement.

Physician Practices Statewide Reporting Measure Bundle

Physician Practices will report on their activities being carried out to impact rates measured by Prevention Quality Indicators (PQIs). Based on the description by the Agency for Healthcare Research and Quality (AHRQ), PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

Based on the regional summary of the PQIs that HHSC will make available to the performing providers, each physician practice will provide qualitative information on their efforts to impact these rates.

1. Diabetes Short-term Complications Admission Rate
2. Perforated Appendix Admission Rate
3. Diabetes Long-term Complications Admission Rate
4. Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
5. Hypertension Admission Rate
6. Heart Failure Admission Rate
7. Low Birth Weight Rate
8. Dehydration Admission Rate
9. Bacterial Pneumonia Admission Rate
10. Urinary Tract Infection Admission Rate
11. Uncontrolled Diabetes Admission Rate
12. Asthma in Younger Adults Admission Rate
13. Lower-Extremity Amputation among Patients with Diabetes Rate

Local Health Departments Statewide Reporting Measure Bundle

Based on the information available via Texas Behavioral Risk Factor Surveillance System (BRFSS)[2], HHS agencies will provide a RHP specific summary for the following areas:

- Access to health care services
- Health status of the population:
- Selected immunizations
- Prevention of sexually transmitted diseases.

Each LHD will provide a qualitative description of what is carried out by that LHD in its region to impact the rates and trends of the following measures:

1. **Time Since Routine Checkup**
   - BRFSS Questionnaire: About how long has it been since you last visited a doctor for a routine checkup?
2. **High Blood Pressure Status**
   - BRFSS Calculated Variable: Doctor diagnosed high blood pressure
3. **Diabetes Status**
   - BRFSS Calculated Variable: Doctor diagnosed diabetes
4. **Overweight or Obese**
   - BRFSS Calculated Variable: Overweight or obese
5. **Smoker Status**
   - BRFSS Calculated Variable: Four-level smoker status (Current Smoker - Every Day; Current Smoker - Some Days; Former Smoker; and Never Smoker)
6. **Selected Immunizations**
   - **Flu Shot Past Year**
     - BRFSS Questionnaire: During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?
   - **Ever Had Pneumonia Shot**
     - BRFSS Questionnaire: Have you ever had a pneumonia shot?
   - **Received Tetanus Shot Since 2005**
     - BRFSS Questionnaire: Since 2005, have you had a tetanus shot? Was this Tdap, the tetanus shot that also has pertussis or whooping cough vaccine?
   - **Ever Had MMR Vaccine**
     - BRFSS Questionnaire: Have you ever received the MMR vaccine?
   - **Had All HPV Shots**
     - Calculated Variable: Received all 3 HPV shots
7. **Prevention of Sexually Transmitted Diseases**
   - **Ever Had HIV Test**
     - BRFSS Questionnaire: Have you ever been tested for HIV?

[2] Additional information on BRFSS is available in Appendix B

Appendix B

Regional summaries with selected health information are generated based on the data collected by the Department of State Health Services via Texas Behavioral Risk Factor Surveillance System (BRFSS). BRFSS, initiated in 1987, is a federally supported landline and cellular telephone survey that collects data about Texas residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Texas BRFSS is an important tool for decision-making throughout the Texas Health and Human Services, Texas Department of State Health Services and the public health community. Public and private health officials at the federal, state, and local levels rely on the BRFSS to identify public health problems, set priorities and goals, design policies and interventions, as well as evaluate the long term impact of these efforts.

This surveillance can be used to monitor the Healthy People 2020 Objectives for current smoking, obesity, high blood pressure, exercise and physical activity, flu and pneumonia vaccinations, cholesterol and cancer screenings, seat belt use, as well as other risk factors.
The BRFSS is administered under the direction of the Centers for Disease Control and Prevention (CDC) so that survey methods and much of the questionnaire are standardized across all BRFSS surveys in the 50 states, three territories, and the District of Columbia. As a result, comparisons can be made among states and to the nation.