DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

SEP 17 2019

Stephanie Muth
State Medicaid Director
Texas Health and Human Services Commission
4900 North Lamar Blvd
P.O. Box 13247
Austin, Texas 78711

Dear Ms. Muth:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving the Program Funding and Mechanics Protocol, and the Measure Bundle Protocol, for Texas' section 1115(a) demonstration (11-W-00278/6), entitled "Texas Healthcare Transformation and Quality Improvement Program." These protocols govern the operation of Texas' Delivery System Incentive Payment (DSRIP) for the next two demonstration years. CMS appreciates the collaborative effort between Texas and CMS in working to address the complicated and technical issues associated with the protocols.

Your project officer for this demonstration is Mr. Eli Greenfield. He is available to answer any questions concerning your section 1115 demonstration. Mr. Greenfield's contact information is:

Center for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6157
E-mail: Eli.Greenfield@cms.hhs.gov

Official communications regarding official matters should be sent simultaneously to Mr. Greenfield and Bill Brooks, Director of Medicaid Field Operations South in our Dallas office. Mr. Brook's contact information is as follows:

Mr. Bill Brooks
Director, Medicaid Field Operations South
Dallas Regional Office
1301 Young Street, Room 714
Dallas, TX 75202

If you have any questions regarding this approval, please contact your project officer.

Sincerely,

[redacted]

Angela D. Garner
Director, Division of System Reform Demonstrations

Enclosure

cc: Bill Brooks, Director, Division of Medicaid Field Operations (DMFO) South, Regional Operations Group (ROG)
Jeoffrey Branch, State Lead, DMFO South, ROG
Linda Huynh, Texas Health and Human Services (HHSC)
Andy Vasquez, Texas HHSC

Attachment J
Program Funding and Mechanics Protocol

TEXAS
Health and Human Services

I. PREFACE

On December 12, 2011, the Centers for Medicare and Medicaid Services (CMS) approved Texas' request for a new Medicaid demonstration waiver ("Demonstration") entitled "Texas Healthcare Transformation and Quality Improvement Program" (Project # 11-W-00278/6) in accordance with section 1115 of the Social Security Act. This waiver authorized the establishment of the Delivery System Reform Incentive Payment (DSRIP) program. The initial waiver was approved through September 30, 2016, and an initial extension was granted through December 31, 2017. An additional 5 year extension was granted on December 21, 2017. This section of the DSRIP Program Funding and Mechanics Protocol applies to demonstration years (DY) 7 through 10. Policies for DY 1 through 6 are provided in the Addendum.

1. Delivery System Reform Incentive Payment (DSRIP) Program

Special Terms and Conditions (STC) 34 of the Demonstration authorizes Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program is designed to provide incentive payments to hospitals and other Performing Providers 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.

Activities funded by DSRIP shall be based on Regional Healthcare Partnerships (RHPs). Each RHP shall have geographic boundaries and will be coordinated by a public hospital or local governmental entity (the Anchoring Entity). The Anchoring Entity shall collaborate with Performing Providers and other stakeholders in the RHP on the RHP Plan Updates (updates of the RHP Plan that was originally developed in 2012 to accelerate meaningful delivery system reforms that improve patient care for low-income populations in the RHP). The RHP Plan Updates must be consistent with the RHP's mission and quality goals, as well as CMS's triple aims to: improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

RHP Plan Updates for DY7-8 will reflect the evolution of the DSRIP program from project-level reporting to provider Core Activities supporting Performing Provider-level outcomes that measure continued transformation of the Texas healthcare system. RHP Plan Updates for DY9-10 will give Performing Providers an opportunity to update their selections of outcomes and Core Activities.

DY7-10 will serve as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of Alternative Payment Models (APMs) to continue services for Medicaid and low-income or uninsured (MLIU) individuals after the waiver ends.

To that end, Performing Providers will define and update the system they will utilize in DY7-10 for Category B and Category C measurements in the RHP Plan Updates. As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that Performing Providers maintain a focus on serving the target population: MLIU patients. Because DSRIP reporting will no longer be project-specific, HHSC requires that Performing Providers demonstrate that they are maintaining a certain level of service to the MLIU target population. In addition, HHSC does not want Performing Providers to stop serving the MLIU population in an effort to enhance achievement of Category C measures. The Category B system definition and Patient Population by Provider (PPP) is meant to define the universe of patients that will be served by a Performing Provider; Category C measure denominators will naturally be limited by settings of services or measure specifications.

A Performing Provider's system definition should capture all aspects of the Performing Provider's patient services. There are required and optional components of a Performing Provider's system definition for each Performing Provider type. The required components must be included in a Performing Provider's system definition if the Performing Provider's organization has that business component. Optional components are less common among a provider type, but with the exception of contracted providers, should be included if they are a prominent component of a Performing Provider's system of care. Performing Providers may also add contracted partners to their system definition. Please refer to the Measure Bundle Protocol for the optional and required components of the system definition. Performing Providers will define and update their system in the RHP Plan Updates.

Categories 1-4 in DY2-6 are transitioned to the following Categories in DY7-10:

- Category A - Required reporting that includes progress on Core Activities, Alternative Payment Model (APM) arrangements, costs and savings, and collaborative activities as described in paragraph 17.
- Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)
- Category C - Measure Bundles and Measures
- Category D - Statewide Reporting Measure Bundle, similar to hospital Category 4 reporting during the initial demonstration period and DY6, expanded to include all Performing Providers.

2. Measure Bundle Protocol and Program Funding and Mechanics Protocol

In accordance with STC 34, the Measure Bundle Protocol (Attachment R) defines the Performing Provider system-level measures that are bundled to align closely with transformative DSRIP project areas from the Initial Demonstration Period and includes an appendix for measure specifications. The Program Funding and Mechanics Protocol (Attachment J) describes the State review process for RHP Plans and RHP Plan Updates, incentive payment methodologies, RHP and State reporting requirements, and penalties for missed milestones.

Following CMS approval of Attachment R and Attachment J, each RHP must submit an RHP Plan Update that identifies the selected Measure Bundles and measures for each Performing Provider for DY7-8 and later for DY9-10 in accordance with these attachments and the STCs.

This version of the Program Funding and Mechanics Protocol is approved as of TBD 2019.

3. Organization of "Attachment J: Program Funding and Mechanics Protocol"

Attachment J has been organized into the following sections:

I. Preface
II. DSRIP Eligibility Criteria
III. Key Elements of RHP Plan Updates
IV. Review and Approval Process of RHP Plan Updates
V. RHP Plan Update Modifications for DY7-10
VI. Performing Provider Requirements for DY7-10
VII. Disbursement of DSRIP Funds for DY7-10
VIII. RHP and State Reporting Requirements
IX. Data Quality Assurance

4. Definitions

a. Core Activity - An activity implemented by a Performing Provider to achieve the Performing Provider's Category C measure goals. A Core Activity may include an activity implemented by a Performing Provider as part of a DY2-6 DSRIP project that the Performing Provider continues in DY7-10, or a new activity implemented by a Performing Provider in DY7-10.

b. Demonstration Year (DY) 6 - The initial 15-month period of time, as approved by the Centers for Medicare & Medicaid Services (CMS), for which the waiver is extended beyond the Initial Demonstration Period, or October 1, 2016 - December 31, 2017.

    i. Demonstration Year (DY) 6A - Federal fiscal year (FFY) 2017, or the first 12 months of DY6 (October 1, 2016 - September 30, 2017).

    ii. Demonstration Year (DY) 6B - The last three months of DY6 (October 1, 2017 - December 31, 2017).

c. Demonstration Year (DY) 7 - Federal fiscal year (FFY) 2018, which includes DY6B (October 1, 2017 - September 30, 2018). This is also reporting year (RY) 1.

d. Demonstration Year (DY) 8 - Federal fiscal year (FFY) 2019 (October 1, 2018 - September 30, 2019). This is also reporting year (RY) 2.

e. Demonstration Year (DY) 9 - Federal fiscal year (FFY) 2020 (October 1, 2019 - September 30, 2020). This is also reporting year (RY) 3.

f. Demonstration Year (DY) 10 - Federal fiscal year (FFY) 2021 (October 1, 2020 - September 30, 2021). This is also reporting year (RY) 4.

g. Demonstration Year (DY) 11 - Federal fiscal year (FFY) 2022 (October 1, 2021 - September 30, 2022).

h. Initial Demonstration Period - The first five demonstration years (DY) of the waiver, or December 12, 2011, through September 30, 2016.

i. Measure Bundle - A grouping of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Measure Bundles are selected by hospitals and physician practices. Each Measure Bundle may include required measures and optional measures that may be selected by hospitals and physician practices in addition to the required measures.

j. Medicaid and Low-income or Uninsured (MLIU)

    i. To qualify as a Medicaid individual for purposes of MLIU Patient Population by Provider (PPP), the individual must be enrolled in Medicaid or Children's Health Insurance Program (CHIP) at the time of at least one encounter during the applicable DY.

    ii. To qualify as a low-income or uninsured individual for purposes of MLIU PPP, the individual must either be below 200 percent of the federal poverty level (FPL) or must not have health insurance at the time of at least one encounter during the applicable DY.

    iii. If an individual was enrolled in Medicaid at the time of one encounter during the applicable DY, and was low-income or uninsured at the time of a separate encounter during the applicable DY, that individual is classified as a Medicaid individual for purposes of MLIU PPP.

k. Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) - The number of MLIU individuals served by the Performing Provider during an applicable DY.

l. Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) Goal - The number of MLIU individuals that a Performing Provider must serve in accordance with paragraph 16, during an applicable DY. The goal is based on the average of the number of MLIU individuals served in DY5 and the number of MLIU individuals served in DY6.

m. Performance Year (PY) - The measurement period used for achievement of a Category C measure. Each performance year corresponds to a calendar year. PY1 is CY 2018, PY2 is CY 2019, PY3 is CY 2020, and PY4 is CY 2021.

n. System - A Performing Provider's patient care landscape, as defined by the Performing Provider. The system should include all required components, if the Performing Provider has that business component. The system definition may also include optional components, including contracted providers. Optional components should be included if they are a prominent component of a Performing Provider's system of care. The system may not be limited by patient type, payer or diagnosis.

o. Total Patient Population by Provider (PPP) - The total number of individuals served by the Performing Provider during an applicable DY. The Total PPP shall include all individuals provided a service during the applicable DY within the Performing Provider's defined system.

p. Uncompensated Care (UC) Only Hospital - A hospital eligible to be a Performing Provider that is not a Performing Provider but receives UC payments.

II. DSRIP ELIGIBILITY CRITERIA

5. RHP Regions

a. RHP Composition

Texas has approved 20 Regional Healthcare Partnerships (RHPs) whose members may participate in the DSRIP program. The approved RHPs share the following characteristics:

- The RHPs are based on distinct geographic boundaries that generally reflect patient flow patterns for the region;
- The RHPs have identified local funding sources to help finance the non-federal share of DSRIP payments for Performing Providers; and
- The RHPs have identified an Anchoring Entity to help coordinate RHP activities.

The approved RHPs include the following counties:

- RHP 1: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, Wood
- RHP 2: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler

- RHP 3: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, Wharton
- RHP 4: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, Victoria
- RHP 5: Cameron, Hidalgo, Starr, Willacy
- RHP 6: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, Zavala
- RHP 7: Bastrop, Caldwell, Fayette, Hays, Lee, Travis
- RHP 8: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, Williamson
- RHP 9: Dallas, Denton, Kaufman
- RHP 10: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, Wise
- RHP 11: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, Taylor
- RHP 12: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley 0, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, Yoakum
- RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green
- RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, Winkler
- RHP 15: El Paso, Hudspeth
- RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, McLennan
- RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, Washington
- RHP 18: Collin, Grayson, Rockwall
- RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, Young
- RHP 20: Jim Hogg, Maverick, Webb, Zapata

b. RHP Tier Definition

i. Tier 1 RHP
An RHP that contains more than 15 percent share of the statewide population under 200 percent of the federal poverty level (FPL) as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

ii. Tier 2 RHP

An RHP that contains at least 7 percent and less than 15 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iii. Tier 3 RHP
An RHP that contains at least 3 percent and less than 7 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS).

iv. Tier 4 RHP
An RHP is classified in Tier 4 if one of the following three criteria are met: (1) the RHP contains less than 3 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS); (2) the RHP does not have a public hospital; or (3) the RHP has public hospitals that provide less than 1 percent of the region's uncompensated care.

6. RHP Anchoring Entity

The Texas Health and Human Services Commission (HHSC) delegates to the Anchoring Entity the responsibility of coordination with the RHP participants on the RHP Plan Updates for that RHP. Each RHP shall have one Anchoring Entity that coordinates the RHP Plan Updates for that RHP. In RHPs that have a public hospital, a public hospital shall serve as the Anchoring Entity. In RHPs without a public hospital, the following entities may serve as Anchoring Entities: (1) a hospital district; (2) a hospital authority; (3) a county; or (4) a State university with a health science center or medical school. RHP Anchoring Entities shall be responsible for coordinating RHP activities and assisting HHSC in performing key oversight and reporting responsibilities.

Anchoring Entities' activities shall include:

- Coordinating the community needs assessment update for the RHP as needed;
- Engaging stakeholders in the RHP, including the public and through the learning collaborative plan (as required in paragraph 38);
- Coordinating the RHP Plan Updates that best meet community needs in collaboration with RHP participants;
- Ensuring that the RHP Plan Updates are consistent with Attachment R, Attachment J, and all other State/waiver requirements;
- Transmitting the RHP Plan Updates to HHSC on behalf of the RHP;
- Ongoing monitoring and annual reporting (as required in paragraphs 37 and 41) on status of activities and performance of Performing Providers in the RHP; and
- Ongoing communication with HHSC on behalf of the RHP.

7. IGT Entities

Intergovernmental transfer (IGT) Entities are entities that fund the non-federal share of DSRIP payments for an RHP. They include Anchoring Entities, government-owned Performing Providers, community mental health centers (CMHCs), local health departments (LHDs), academic health science centers, and other government entities such as counties.

An IGT Entity may fund DSRIP, Uncompensated Care (UC), or both DSRIP and UC as long as requirements described herein are met and the IGT funding source comports with federal requirements outlined in STC 46.

IGT Entities may fund Performing Providers outside of their RHP. Such funding must be documented in the RHP Plan Updates for the RHP in which the Performing Provider is participating.

8. Performing Providers

"Performing Providers" are providers that are responsible for: 1) implementing Core Activities to achieve the Category C measure goals in the RHP Plan Updates; and 2) measuring, reporting, and improving performance on the Category C measure goals in the RHP Plan Updates, among other reporting requirements outlined in this protocol. All Performing Providers must have a current Medicaid provider identification number. Performing Providers that complete milestones and measures as specified in Attachment R, "Measure Bundle Protocol" are the only entities that are eligible to receive DSRIP incentive payments in DY7-10. Performing Providers will primarily be hospitals, but CMHCs, LHDs, and physician practices may also receive DSRIP payments.

A Performing Provider may only participate in the RHP Plan Updates for the RHP where it is physically located except that physician practices affiliated with an academic health science center, major cancer hospitals, or children's hospitals may perform DSRIP outside of the RHP where the Performing Provider's institution is physically located. Performing Providers participating in multiple RHPs may be assigned to a single "home" RHP.

9. DSRIP Requirements for Uncompensated Care (UC) Only Hospitals

In DY7-8, a UC only hospital must participate annually in a regional learning collaborative and/or smaller, targeted learning collaborative or stakeholder meeting and report on mandatory Category D measures identified in Attachment R, "Measure Bundle Protocol."

III. KEY ELEMENTS OF RHP PLAN UPDATES

10. RHP Plan Updates for DY7-8

Each RHP Anchoring Entity must submit an RHP Plan Update for its RHP for DY7-8 using a State-approved template that identifies the participants, objectives, Measure Bundles, measures, milestones, and associated DSRIP values adopted from Attachment R, "Measure Bundle Protocol," and meets all requirements pursuant to the STCs and described herein.

The RHP Plan Updates shall include the following sections:

- RHP Organization including collaborating organizations
- Community Needs Assessment
- Stakeholder Engagement
- The Performing Provider's system definition
- Category A reporting including: 1) the Performing Provider's description of the transition of its DY2-6 projects to its selected Category C Measure Bundles or measures; and 2) the Performing Provider's Core Activities for DY7-8
- Category B MLIU Patient Population by Provider (PPP) baselines
- Category C Measure Bundles and measures for each Performing Provider
- Category D Statewide Reporting Measure Bundles for each Performing Provider
- DSRIP valuation amounts
- Signed certifications from the leadership of Performing Providers and their affiliated IGT Entities

11. RHP Plan Updates for DY9-10

Each RHP Anchoring Entity must submit an RHP Plan Update for its RHP for DY9-10 using a State-approved template that identifies the participants, objectives, Measure Bundles, measures, milestones, and associated DSRIP values adopted from Attachment R, "Measure Bundle Protocol," and meets all requirements pursuant to the STCs and described herein.

The RHP Plan Updates shall include the following sections:

- RHP Organization.
- Updates to Community Needs Assessment, if needed.
- Stakeholder Engagement.
- Anchor hosts at least one public meeting prior to submission of the RHP Plan Update for DY9-10.
- Updates to each Performing Provider's system definition, if needed.
- Category A reporting, including updates to the Performing Provider’s Core Activities for DY9-10.

- Updates to Category B MLIU Patient Population by Provider (PPP), if needed. Forecasted breakout of Medicaid individuals and LIU individuals served in DY9-10 based on MLIU individuals served in DY7-8.
- Category C Measure Bundles and measures for each Performing Provider including:
  - Optional addition or discontinuation of Measure Bundles or measures to meet the updated Minimum Point Threshold (MPT) for DY9-10. This includes allowing Performing Providers with an MPT of less than 75 to update population-based clinical outcomes as pay-for-performance (P4P) or pay-for-reporting (P4R). Providers may replace Measure Bundles and measures up to a maximum of 20 points of a provider's assigned MPT for DY9-10 with good cause limited to significant system changes such as a hospital merger or significant change in a measure bundle's required system component of outpatient services or hospital services as identified in Attachment R, "Measure Bundle Protocol".
  - Related Strategies reporting associated with DY9-10 Measure Bundle selections for hospitals and physician practices or DY9-10 measure selections for CMHCs and LHDs.
  - Justification for any Category C changes from DY7-8 and requested exceptions for new selections in DY9-10.
- Category D Statewide Reporting Measure Bundles for each Performing Provider.
- DSRIP valuation amounts.
- Certifications from the leadership of Performing Providers and their affiliated IGT Entities.

IV. REVIEW AND APPROVAL PROCESS OF RHP PLAN UPDATES

12. HHSC Review and Approval Process for DY7-8

a. Submission of RHP Plan Updates

By January 31, 2018, or 90 days after the approval of Attachment R, "Measure Bundle Protocol," and Attachment J, "Program Funding and Mechanics Protocol" (whichever is later), each RHP Anchoring Entity will submit the completed RHP Plan Update for DY7-8 for HHSC review.

b. Anchoring Entity Review of RHP Plan Updates

To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of each Performing Provider's submission for the RHP Plan Update for DY7-8 to ensure compliance with elements described in 12.c. below prior to submitting the RHP Plan Update to HHSC.

c. HHSC Review of RHP Plan Updates

i. HHSC shall review and assess each RHP Plan Update according to the following criteria:
   A. The RHP Plan Update is in the prescribed format.
   B. The RHP Plan Update contains and completes all required elements described herein and is consistent with the STCs.
   C. The RHP Plan Update conforms to the requirements for Category A Required reporting, Category B MLIU Patient Population by Provider (PPP), Category C Measure Bundles and measures, and Category D Statewide Reporting Measure Bundles as described herein, as well as in Attachment R, "Measure Bundle Protocol."
   D. The amount and distribution of funding is in accordance with Section VI "Performing Provider Requirements for DY7-8" and Section VII "Disbursement of DSRIP Funds for DY7-8" of this protocol.
   E. The RHP Plan Update is consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. By February 28, 2018, or 30 days following the due date for submission of the RHP Plan Updates, HHSC will complete its review of each RHP Plan Update and will notify the RHP Anchoring Entity in writing of any questions, concerns, or problems identified.

iii. The RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions, concerns, and problems by the date specified in the aforementioned notification.

iv. By March 31, 2018, or 60 days following the due date for submission of the RHP Plan Updates, HHSC will approve or disapprove each RHP Plan Update.

13. HHSC Review and Approval Process for DY9-10

a. Submission of RHP Plan Updates

By November 30, 2019, or 60 days after the approval of Attachment R, "Measure Bundle Protocol," and Attachment J, "Program Funding and Mechanics Protocol" (whichever is later), each RHP Anchoring Entity will submit the completed RHP Plan Update for DY9-10 for HHSC review.

b. Anchoring Entity Review of RHP Plan Updates

To support HHSC's review process, the RHP Anchoring Entity shall perform an initial review of each Performing Provider's submission for the RHP Plan Update for DY9-10 to ensure compliance with elements described in 13.c. below prior to submitting the RHP Plan Update to HHSC.

c. HHSC Review of RHP Plan Updates

i. HHSC shall review and assess each RHP Plan Update according to the following criteria:

A. The RHP Plan Update is in the prescribed format.
B. The RHP Plan Update contains and completes all required elements described herein and is consistent with the STCs.
C. The RHP Plan Update conforms to the requirements for Category A Required reporting, Category B MLIU Patient Population by Provider (PPP), Category C Measure Bundles and measures, and Category D Statewide Reporting Measure Bundles as described herein, as well as in Attachment R, "Measure Bundle Protocol."
D. The amount and distribution of funding is in accordance with Section VI "Performing Provider Requirements for DY7-10" and Section VII "Disbursement of DSRIP Funds for DY7-10" of this protocol.
E. The RHP Plan Update is consistent with the overall goals of the DSRIP program and the objectives of the Medicaid program.

ii. By January 15, 2020, or 45 days following the due date for submission of the RHP Plan Updates, HHSC will complete its review of each RHP Plan Update and will notify the RHP Anchoring Entity in writing of any questions, concerns, or problems identified.
iii. The RHP Anchoring Entity shall respond in writing to any notification by HHSC of questions, concerns, and problems by the date specified in the aforementioned notification.
iv. By February 28, 2020, or 90 days following the due date for submission of the RHP Plan Updates, HHSC will approve or disapprove each RHP Plan Update.

V. RHP PLAN UPDATE MODIFICATIONS FOR DY7-10

Consistent with the recognized need to provide RHPs with flexibility to modify their RHP Plan Updates over time and take into account evidence and learning from their own experience over time, as well as for unforeseen circumstances or other good cause, a Performing Provider may request prospective changes to the RHP Plan Update for the RHP(s) in which it participates through an RHP Plan Update modification process.

14. RHP Plan Update Modification Process

A Performing Provider may request to modify the RHP Plan Update for the RHP(s) in which it participates under the following circumstances:

a. Requests to Modify a Performing Provider's System Definition

A Performing Provider may submit a request to HHSC to change its system definition with good cause. The Performing Provider must submit the request to HHSC no later than 30 days prior to the first day of the semi-annual reporting period. HHSC will evaluate how the change to the Performing Provider's system definition impacts Category B and/or Category C.

b. Requests to Modify MLIU Patient Population by Provider (PPP)

A Performing Provider may submit a request to HHSC to change its MLIU PPP baseline and goals with good cause. Good cause may include:

i. A significant change to the Performing Provider's system definition as approved under paragraph 12.a.;
ii. An error in the data uncovered subsequent to baseline reporting;
iii. A significant policy change at the state or federal level that redefines eligibility for Medicaid or other eligibility-based programs that would be captured in the MLIU population; or
iv. A significant shift in the demographic served by the Performing Provider.

The Performing Provider must submit the request to HHSC no later than 30 days prior to the first day of the semi-annual reporting period.

c. Requests to Modify Category C Measures

i. Category C Measure Payer Types for Reporting Milestones

A Performing Provider may submit a request to HHSC to be exempted from reporting its performance on the Medicaid-only payer type and/or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations or low volume. The Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and the first day of the second reporting period of DY7 for DY7-10 measures and the first day of the second reporting period of DY9 for DY9-10 new measures.

ii. Category C P4P Measure Payer Type for Goal Achievement Milestones

A Performing Provider may submit a request to HHSC to change the payer a measure's goal achievement milestone is based with good cause, such as a small denominator or data limitations. The Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

iii. Category C Optional Measures for Hospitals and Physician Practices

A hospital or physician practice may submit a request to HHSC to delete an optional measure from a selected Category C Measure Bundle. The hospital or physician practice must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures. Optional measures that add point(s) to a Category C

Measure Bundle may only be deleted if a hospital's or physician practice's MPT is still met without the deleted optional measure's point(s). The funds associated with the deleted optional measure will be reallocated to the remaining measures in the Measure Bundle such that the remaining measures' valuations are equal.

iv. Category C Measures for CMHCs and LHDs

A CMHC or LHD may submit a request to HHSC to replace a selected Category C measure with one or more other Category C measures with point values greater than or equal to the point value of the measure being replaced. This request is based on good cause, such as a low volume or data limitations. The CMHC or LHD must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

d. Submission, Review, and Approval Process

A Performing Provider must submit an RHP Plan Update modification request in writing to HHSC. HHSC will review the RHP Plan Update modification request and notify the Performing Provider in writing of any questions or concerns identified. HHSC will then notify the Performing Provider in writing of its decision on the RHP Plan Update modification request. Substantial changes to system definitions, Category C Measure Bundles or measures, or Category B MLIU PPP, may be subject to a secondary review and ongoing compliance monitoring by the independent assessor.

VI. PERFORMING PROVIDER REQUIREMENTS FOR DY7-10

15. DY7-11 Pool Allocation

a. The DSRIP pool allocation for DY7-11 comports with STC 35.

DSRIP Pool Allocation According to Demonstration Year (total computable)

DY7	DY8	DY9	DY10	DY11
3,100,000,000	3,100,000,000	2,910,000,000	2,490,000,000	0

b. No later than March 31, 2019, HHSC will submit an updated PFM Protocol to CMS that includes DSRIP requirements for DY9-10.

c. CMS will aim to approve the updated PFM protocol no later than 45 days after its submission.

d. No later than July 31, 2019, HHSC will submit an updated Measure Bundle Protocol to CMS that includes revised measures and changes to innovative measures for DY9-10.

e. CMS and Texas will collaborate together and aim to approve the updated Measure Bundle Protocol within 60 days after its submission.

16. Performing Provider Valuation

a. A Performing Provider's total valuation for each demonstration year of DY7 and DY8 is equal to its total valuation for DY6A with the following exceptions:

   i. If HHSC determined that a DSRIP project was ineligible to continue in DY6A, the Performing Provider affected by such a determination may use the funds associated with the DSRIP project beginning in DY7; or

   ii. If a Performing Provider withdrew a DSRIP project between June 30, 2014, and June 30, 2016, the Performing Provider may use the funds associated with the DSRIP project beginning in DY7.

   iii. Performing Providers beginning DSRIP participation in DY7 with a total valuation less than $250,000 for DY7 may increase their total valuation to up to $250,000 per each subsequent DY beginning in DY7. Performing Providers eligible for this option must make this choice in the RHP Plan Update.

b. A Performing Provider’s total valuation for each demonstration year of DY9 and DY10 is calculated as follows:

   i. If a Performing Provider has a DY8 total valuation that is less than or equal to $1 million, its total valuation for each demonstration year of DY9 and DY10 is equal to its total valuation for DY8. These valuations are subtracted from the DY9 and DY10 pool amounts.

   ii. If a Performing Provider has a DY8 total valuation that is greater than $1 million, its total valuation for each demonstration year of DY9 and DY10 is calculated as follows:

      A. The remaining DY9 and DY10 pool amounts are divided by the DY8 valuation for all Performing Providers with a DY8 total valuation greater than $1 million to determine the percentage reductions for DY9 and DY10;
      B. The Performing Provider’s DY8 valuation is multiplied by the percentage reduction in valuation from DY8 for the applicable DY to determine the total valuation for each demonstration year of DY9 and DY10; and
      C. The Performing Provider’s total valuation for each demonstration year of DY9 and DY10 is not reduced to less than $1 million.

iii. If a Performing Provider withdrew from participating in DSRIP during DY8 or withdraws during the RHP Plan Update for DY9-10, the Performing Provider's valuation is proportionately distributed among the remaining Performing Providers in the RHP based on each Performing Provider's percent share of DY8 valuation in the RHP.

c. Each Performing Provider's valuation must comport with the following funding distribution in DY7-10.

DSRIP Funding Distribution

	DY7*	**DY8***	**DY9**	**DY10**
RHP Plan Update Submission	20%	NA	NA	NA
Category A - required reporting	0%	0%	0%	0%
Category B - MLIU PPP	10%	10%	10%	10%
Category C- Measure Bundles and Measures	55 or 65%	75 or 85%	75%	75%
Category D - Statewide Reporting Measure Bundle	15 or 5%	15 or 5%	15%	15%

*If an RHP's private hospital participation minimums are met, as described in paragraph 25, then Performing Providers in the RHP may increase the Statewide Reporting Measure Bundle funding distribution to 15% in DY7-8.

17. Category A - Eligibility for DY7-10 Payments

Each Performing Provider is required to complete the following for Category A to be eligible for payment of Categories B-D.

a. Core Activities

Each Performing Provider must report on progress and updates to one or more Core Activities as indicated in the RHP Plan Updates during the second reporting period of each DY.

b. Alternative Payment Models

Each Performing Provider must report on any progress toward, or implementation of, Alternative Payment Model (APM) arrangements with Medicaid managed care organizations (MCOs) or other payers during the second reporting period of each DY.

c. Costs and Savings

Performing Providers who have a total valuation of $1 million or more per DY are required to submit the costs of at least one Core Activity of choice and the

forecasted or generated savings of that Core Activity. Performing Providers must analyze: 1) a different Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis in DY9-10 than was used for the Costs and Savings analysis in DY7-8. Performing Providers must submit this information in a template approved by HHSC or a comparable template. Performing Providers should include costs and savings specific to their organization and other contracted providers if that information is available. A progress update must be submitted during the second reporting period of DY7 and DY9, and a final report of costs and savings must be submitted during the second reporting period of DY8 and DY10.

d. Collaborative Activities

Each Performing Provider is 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.

18. Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP)

a. Each Performing Provider is required to report for each DY the total number of individuals served by their system, as well as the number of MLIU individuals served by their system, to be eligible for up to 10 percent of the Performing Provider's total valuation.

For purposes of PPP, an individual is a patient receiving a face-to-face or virtual encounter (a service, billable or not) that is the equivalent of a service that would be provided within the physical confines of the defined system. This could include home-visits or other venue-based services that are documented. The service should be billable or charted. Providers are not allowed to count phone calls, text messages, or undocumented encounters.

b. Each Performing Provider is required to submit the baseline total number of individuals served by their system, as well as the baseline number of MLIU individuals served by their system, in the RHP Plan Update for DY7-8 and revise as needed in the RHP Plan Update for DY9-10. Each Performing Provider is required to submit the forecasted breakout of the total Medicaid individuals and LIU individuals that will be served in DY9-10 based on the MLIU individuals served in DY7-8.

c. To calculate the MLIU PPP baseline, the Performing Provider will include in their RHP Plan Update the Total PPP in DY5 and DY6 and the MLIU PPP in DY5 and DY6. HHSC will calculate the average of the DYs and set the MLIU PPP maintenance goal. These are new baselines and are not tied to the QPI reported during DY3-6. The reported baselines will be subject to compliance monitoring.

d. The Performing Provider is required to report the total number of MLIU individuals served each DY and in DY9-10, provide a breakout of the total Medicaid individuals and LIU individuals served during each DY. The number of MLIU individuals served must be maintained or increased each DY with an allowable variation. The allowable variation from the goal will not be more than 5% below the 100% goal and is meant to account for natural fluctuation that may occur from one year to the next in the number of patients seeking services at a provider. The allowable variation is to be determined by HHSC once Performing Providers have submitted their baselines, and calculation of allowable variance will consider Performing Provider size, type, and the MLIU percentage of Total PPP served in the baseline years. The Performing Provider is also required to report the Total PPP numeric value. The Performing Provider is not required to maintain the ratio of MLIU PPP to Total PPP from the baseline year to earn a Category B payment, but must provide an explanation for any changes in the ratio.

e. The numbers of MLIU individuals served and total individuals served may be reported in the second reporting period of the DY being reported. Performing Providers may request to carry-forward reporting of MLIU PPP until the first round of reporting following the end of the DY being reported if they need additional time to compile or clean up data. If MLIU PPP reporting is not submitted on time or does not meet the requirements of the reporting, future DSRIP payments may be withheld until the complete report is submitted.

19. Category C - Measure Bundle Requirements for Hospitals and Physician Practices

a. The Category C Measure Bundle topics for hospitals and physician practices include the following and are described in Attachment R, "Measure Bundle Protocol."

i. Chronic Disease Management: Diabetes Care
ii. Chronic Disease Management: Heart Disease
iii. Care Transitions & Hospital Readmissions
iv. Patient Navigation & Emergency Department Diversion
v. Primary Care Prevention - Healthy Texans
vi. Primary Care Prevention - Cancer Screening
vii. Hepatitis C
viii. Pediatric Primary Care
ix. Pediatric Hospital Safety
x. Pediatric Chronic Disease Management: Asthma
xi. Pediatric Chronic Disease Management: Diabetes
xii. Improved Maternal Care
xiii. Maternal Safety
xiv. Improved Access to Adult Dental Care

xv. Preventive Pediatric Dental
xvi. Palliative Care
xvii. Integration of Behavioral Health in a Primary or Specialty Care Setting
xviii. Behavioral Health and Appropriate Utilization
xix. Chronic Non-Malignant Pain Management
xx. Integrated Care for People with Serious Mental Illness
xxi. Specialty Care
xxii. Hospital Safety
xxiii. Rural Preventive Care
xxiv. Rural Emergency Care

b. Each hospital and physician practice must determine a DSRIP attributed population to apply to its selected Measure Bundles as described in Attachment R, "Measure Bundle Protocol".

c. Each Measure Bundle includes required measures and may include optional measures.

d. Each measure within a Measure Bundle will be pay-for-performance (P4P) or pay-for-reporting (P4R).

e. Each Measure Bundle and measure is assigned a point value as described in Attachment R, "Measure Bundle Protocol."

f. Each hospital and physician practice is assigned a Minimum Point Threshold (MPT) for Measure Bundle selection.

g. Each hospital and physician practice must select Measure Bundles worth enough points to meet its MPT in order to maintain its valuation for DY7-10.

    i. If a hospital or physician practice does not select Measure Bundles worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of Measure Bundle points selected, and its total DY8-10 valuation will be reduced proportionately across its Categories B-D based on the number of Measure Bundle points selected.

    Example: A hospital's DY7 valuation is $5 million and its MPT is 50. The RHP's private participation requirements are met, so if it were to select Measure Bundles worth 50 points, its DY7 valuation would be allocated as follows: $1 million for the RHP Plan Update (20%); $500,000 for Category B (10%); $2.75 million for Category C (55%); and $750,000 for Category D (15%).

    However, the hospital selects Measure Bundles worth only 40 points, so its DY7 valuation is decreased to $4 million and is allocated as follows:

$800,000 for the RHP Plan Update (20%), $400,000 for Category B (10%), $2.2 million for Category C (55%), and $600,000 for Category D (15%).

h. Each hospital or physician practice with a valuation greater than $2,500,000 per DY in DY7-8 or greater than $2 million in DY10 must: 1) select at least one Measure Bundle with at least one required 3 point measure; or 2) select at least one Measure Bundle with at least one optional 3 point measure, and select an optional 3 point measure in that Measure Bundle. The 3 point measure must have significant volume to meet the requirement.

i. Certain Measure Bundles may include population based clinical outcomes that are required as P4P or P4R based on the measure and a provider's MPT as described in Attachment R, "Measure Bundle Protocol."

j. Each hospital or physician practice with an MPT of 75 must report at least two population-based clinical outcomes as P4P, as specified in Attachment R, "Measure Bundle Protocol."

k. Only hospitals with a valuation equal to or less than $2,500,000 per DY may select the rural Measure Bundles in DY7-8 as identified in Attachment R, "Measure Bundle Protocol."

    i. If a rural Measure Bundle is selected, then certain Measure Bundles and duplicate measures may not be selected as specified in Attachment R, "Measure Bundle Protocol."

l. 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 as defined in Attachment R, "Measure Bundle Protocol," unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume for one or more required measures.

m. 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 as defined in Attachment R, "Measure Bundle Protocol," unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume.

n. Each hospital or physician practice must indicate required measures with an MLIU denominator with less than significant volume in the RHP Plan Update. HHSC may identify measures with less than significant volume during reporting review and adjust valuation as described in paragraph 19.q.

o. Each hospital and physician practice may allocate its Category C valuation among its DY7-8 selected Measure Bundles as it wishes, so long as: 1) no single

Measure Bundle is allocated a percentage of the Category C valuation that is less than seventy-five percent of its point value as a percentage of all the selected Measure Bundles' point values; 2) no Measure Bundle without any required or selected optional 3 point measures is allocated a higher percentage of the hospital's or physician's Category C allocation than the Measure Bundle's point value as a percentage of all its selected Measure Bundles' point values; and 3) no Measure Bundle with at least one required or selected optional 3 point measure is allocated a higher percentage of the hospital's or physician practice's Category C allocation than the Measure Bundle's point value multiplied by 1.25 as a percentage of all its selected Measure Bundles' point values.

The minimum Measure Bundle valuation is calculated using the following formula:

(Measure Bundle point value/ all selected Measure Bundles' point values) * .75 * Category C valuation

The maximum Measure Bundle valuation for a Measure Bundle without any required or selected optional 3-point measures is calculated using the following formula:

(Measure Bundle point value/ all selected Measure Bundles' point values) * Category C valuation

The maximum Measure Bundle valuation for a Measure Bundle with at least one required or selected optional 3 point measure is calculated using the following formula:

(Measure Bundle point value/ all selected Measure Bundles' point values) * 1.25 * Category C valuation

Example:

- A hospital has selected four Measure Bundles. Measure Bundle A is worth 4 points, Measure Bundles B-C are each worth 10 points, and Measure Bundle D is worth 6 points, for a total of 30 selected points.
- Measure Bundle A has no required or selected optional 3-point measures. Measure Bundles B-D have required 3 point measures.
- The hospital or physician practice may not allocate to Measure Bundle A less than 10% [(4/ 30) * .75] of its Category C valuation, Measure Bundles B-C less than 25% [(10/ 30) * .75] of its Category C valuation, and Measure Bundle D less than 15% [(6/ 30) * .75] of its Category C valuation.
- The hospital or physician practice may not allocate to Measure Bundle A more than 13.33% (4/30) of its Category C valuation, Measure Bundle B-C more than 41.67% [(10/30)* 1.25] of its Category C valuation, and Measure Bundle D more than 25.00% [(6/30)* 1.25] of its Category C valuation.

For valuation changes greater than one percent of a Measure Bundle's point value as a percentage of all the selected Measure Bundles' point values, a justification is required addressing amount of improvement required, level of effort required for improvement, and population impacted. HHSC will review and approve or deny these changes in the RHP Plan Update.

p. For DY9-10, each Measure Bundle selected by the hospital or physician practice is allocated a percentage of the hospital's or physician practice's Category C valuation that is equal to the Measure Bundle's point value as a percentage of all of the hospital's or physician practice's selected Measure Bundles' point values.

q. The valuation for each measure in a Measure Bundle selected by the hospital or physician practice is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle, so that the measures' valuations are equal with the exception of Measure Bundles with innovative measures. Innovative measures are 50 percent of the value of a measure that is not an innovative measure.

    i. The valuation for each innovative measure in a Measure Bundle with innovative measures is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle subtracted by .5 for each innovative measure and divided by 2. The valuation for the remaining measures in a Measure Bundle with innovative measures is determined by dividing the Measure Bundle valuation by the number of measures in the Measure Bundle subtracted by .5.

    ii. If a hospital or physician practice selects a Measure Bundle with a required measure with an MLIU denominator with no volume as defined in Attachment R, "Measure Bundle Protocol", the measure is removed from the Measure Bundle, and its valuation for the DY is redistributed equally among the remaining measures in the Measure Bundle with significant volume as defined in Attachment R, "Measure Bundle Protocol". This measure valuation also applies to population based clinical outcomes that are approved with no numerator volume.

    iii. If a hospital or physician practice selects a Measure Bundle with a required measure with an MLIU denominator with insignificant volume as defined in Attachment R, "Measure Bundle Protocol", the valuation for the measure's baseline reporting milestone and reporting milestones is maintained, unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume. The valuation for the measure's goal achievement milestone for the DY is redistributed equally among the goal achievement milestones for the remaining measures in the Measure Bundle with significant volume as defined in Attachment R, "Measure Bundle Protocol." This measure valuation also applies to population based clinical outcomes that are approved to be reported as pay-for-reporting.

r. The standard point valuation (or value per point) is $500,000.

s. Minimum Point Thresholds for Hospitals.

i. A hospital's MPT is based on the following factors:

A. The hospital's DY7 valuation.
B. The hospital's DY7 valuation as a percentage of the DY7 valuations for all hospitals.
C. The hospital MPT cap of 75.
D. The hospital's size and its role in serving Medicaid and uninsured individuals, which is measured by:
I. The hospital's Medicaid and uninsured inpatient days as a percentage of all hospitals' Medicaid and uninsured inpatient days as reported in the Texas Hospital Uncompensated Care Tool (TXHUC) for FFY 2016 weighted at .64.
II. The hospital's outpatient Medicaid and uninsured costs as a percentage of all hospitals' Medicaid and uninsured outpatient costs as reported in the TXHUC for FFY 2016 weighted at .36.

ii. A hospital's MPT is calculated as follows:

A. First, the hospital's Statewide Hospital Factor (SHF) is determined as follows:

Statewide Hospital Factor (SHF) =

.64 multiplied by (the hospital's Medicaid and uninsured inpatient days divided by all hospitals' Medicaid and uninsured inpatient days) plus

.36 multiplied by (the hospital's outpatient Medicaid and uninsured costs divided by all hospitals' Medicaid and uninsured outpatient costs)

B. Second, the hospital's Statewide Hospital Ratio (SHR) is determined as follows:

Statewide Hospital Ratio (SHR) =

(DY7 valuation divided by all hospitals' DY7 valuations) divided by SHF

C. Third, the hospital's MPT is determined as follows:

- If SHR ≤ 3:

MPT = the lesser of:
a) DY7 valuation divided by standard point valuation ($500,000); or
b) MPT cap (75 points)

- If SHR > 3 but ≤ 10:

  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) MPT cap (75 points)

- If SHR > 10 and DY7 valuation ≤ $15 million:

  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) 40 points

- If SHR > 10 and DY7 valuation > $15 million:

  MPT = the lesser of:
  a) (DY7 valuation divided by standard point valuation [$500,000]) multiplied by (SHR divided by 3); or
  b) MPT cap (75 points)

iii. If a hospital does not have data for the factors under paragraph 19.s.i.D, is a specialty hospital with a limited scope of practice, or has system overlap with a physician practice Performing Provider, its MPT will be determined using an alternate methodology to be determined by HHSC.

iv. For DY9-10, a hospital's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

t. Minimum Point Thresholds for Physician Practices

i. A physician practice's MPT is the lesser of:

A. DY7 valuation divided by standard point valuation ($500,000); or
B. MPT cap (75 points)

ii. If a physician practice is a specialty physician practice with a limited scope of practice, its MPT will be determined using an alternate methodology to be determined by HHSC.

iii. For DY9-10, a physician practice's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

20. Category C - Measure Selection Requirements for CMHCs and LHDs

a. The Category C measures for CMHCs and LHDs are described in Attachment R, "Measure Bundle Protocol".

b. Each CMHC and LHD must determine a DSRIP attributed population to apply to its selected measures as described in Attachment R, "Measure Bundle Protocol".

c. Each measure is assigned a point value as described in Attachment R, "Measure Bundle Protocol".

d. Each CMHC and LHD is assigned a Minimum Point Threshold (MPT) for selection of measures.

e. Each CMHC and LHD must select a measure or a combination of measures worth enough points to meet its MPT in order to maintain its valuation for DY7-10.

    i. If a CMHC or an LHD does not select measures worth enough points to meet its MPT, its total DY7 valuation will be reduced proportionately across its RHP Plan Update funds and Categories B-D based on the number of measure points selected, and its total DY8-10 valuation will be reduced proportionately across its Categories B-D based on the number of measure points selected.

f. A CMHC or LHD must select and report on at least two unique measures.

g. Each CMHC or LHD with a valuation of more than $2,500,000 per DY in DY7-8 and more than $2,000,000 in DY10 must select at least one 3 point measure.

h. An LHD may select P4P measures that the LHD reported for Category 3 in DY6 to meet their DY7-8 MPT as described in Attachment R, "Measure Bundle Protocol."

i. A CMHC or LHD may only select a measure for which the CMHC's or LHD's MLIU denominator for the baseline measurement period has significant volume as defined in Attachment R, "Measure Bundle Protocol", unless an exception is granted by HHSC to use an all-payer, Medicaid-only, or LIU-only denominator with significant volume.

j. All measures selected by a CMHC or LHD are valued equally; however, a CMHC or an LHD may allocate its Category C valuation among its selected measures in DY7-8 as long as: 1) no single measure is allocated a valuation that is less than 75 percent of its initial measure valuation ((total Category C valuation/number of measures selected) /2); 2) no single 1-point or 2-point measure is allocated a valuation that exceeds its initial measure valuation (total valuation/number of measures selected); and 3) no single 3-point or 4-point measure is allocated a valuation that exceeds its initial measure valuation (total valuation/number of measures) multiplied by 1.25.

Example:

- A CMHC selected four measures.
- Measures A and B are 3-point measures. Measures C and D are 1-point measures.
- The total Category C valuation for the CMHC is $400,000 with each measure initially valued at $100,000 ($400,000 /4).
- The CMHC may not allocate to Measures A-D less than $75,000 ($100,000 * .75).
- The CMHC may not allocate to Measures A-B more than $125,000 ($100,000 * 1.25) and Measures C and D more than $100,000 ($400,000 /4).

For valuation changes greater than one percent of initial measure valuation, a justification is required addressing amount of improvement required, level of effort required for improvement, and population impacted. HHSC will review and approve or deny these changes in the RHP Plan Update.

For DY9-10, all measures selected by a CMHC or LHD are valued equally.

k. The standard point valuation (or value per point) is $500,000.

l. Minimum Point Thresholds for CMHCs and LHDs

   i. A CMHC's MPT is the lesser of:

      A. DY7 valuation/ standard point valuation ($500,000); or
      B. The CMHC MPT cap of 40.

   ii. An LHD's MPT is the lesser of:

      A. DY7 valuation/ standard point valuation ($500,000); or
      B. The LHD MPT cap of 20.

   iii. For DY9-10, a CMHC's or LHD's MPT is recalculated using the DY10 valuation in place of the DY7 valuation, with a maximum reduction of 10 points from the MPT used in DY7-8.

21. Category C - Measurement Periods for P4P Measures

a. The baseline measurement period is calendar year (CY) 2017 (January 1, 2017 - December 31, 2017) for measures selected for DY7-10. The baseline measurement period is CY 2019 (January 1, 2019 - December 31, 2019) for measures newly-selected for DY9-10.

   i. A measure may be eligible for a shorter baseline measurement period consisting of no fewer than six months if it: 1) has a denominator or eligible cases greater than or equal to 30 for the requested baseline measurement period; and 2) would not be compromised by a shorter baseline

measurement period. Examples of measures that would be compromised by a shorter baseline measurement period include blood pressure control (for which the denominator is individuals diagnosed with hypertension in the first six months of the measurement period), outcomes sensitive to flu season or other seasonal variation, and numerators with a low frequency of probability of occurrence. A Performing Provider may request HHSC approval to use a shorter baseline measurement period for an eligible measure in the RHP Plan Update submission.

ii. A P4P measure may be eligible for a delayed baseline measurement period that ends no later than September 30, 2018 for measures selected for DY7-10 and no later than September 30, 2020 for measures newly-selected for DY9-10. In cases where a provider has no or insufficient volume to establish a baseline that ends by December 31, 2017 for measures selected for DY7-10 or December 31, 2019 for measures newly-selected for DY9-10, a Performing Provider may request HHSC approval to use a delayed baseline measurement period for a measure. If HHSC approves the Performing Provider's request, the Performance Year (PY) measurement periods do not change. The measure's goal achievement will begin with PY2 for measures selected for DY7-10 and PY4 for measures newly-selected for DY9-10. A Performing Provider must report PY1 and PY2 for a measure with a delayed baseline measurement period for measures selected for DY7-10. A Performing Provider must report PY3 and PY4 for a measure with a delayed baseline measurement period for measures newly-selected for DY9-10.

iii. For LHD P4P measures that were reported in Category 3 in DY6 and selected for DY7-10, the baseline measurement period is DY6 (October 1, 2016 - September 30, 2017).

b. PY1 is CY 2018 (January 1, 2018 - December 31, 2018).

c. PY2 is CY 2019 (January 1, 2019 - December 31, 2019).

d. PY3 is CY 2020 (January 1, 2020 - December 31, 2020).

e. PY4 is CY 2021 (January 1, 2021 - December 31, 2021).

f. Exceptions to measurement periods may be indicated in Attachment R, "Measure Bundle Protocol" for P4P measures for which a CY measurement period would impact the continuity of data reported (example: NQF 0041 Influenza Immunization, where the measure steward specifies a denominator inclusion period of visits between October 1 and March 31 to align with the flu season).

22. Category C - Measure Milestones

a. The Category C measure milestone structure and valuation for DY7-10 is as follows:

	DY7	DY8	DY9	DY10
Innovative Measure or Quality Improvement Collaborative Activity	100% Reporting Year (RY) 1 reporting milestone	100% RY2 reporting milestone	100% RY3 reporting milestone	25% RY4 reporting milestone 75% achievement milestone
P4P Measure - Baseline Reporting Milestone	25%	NA	NA	NA
P4P Measure - Reporting Milestone	PY1 25%	PY2 25%	PY3 25%	PY4 25%
P4P Measure - Achievement Milestone	DY7 Goal 50%	DY8 Goal 75%	DY9 Goal 75%	DY10 Goal 75%
New DY9-10 P4P Measure - Baseline Reporting Milestone	NA	NA	12.5%	NA
New DY9-10 P4P Measure - Reporting Milestone	NA	NA	PY3 12.5%	PY4 25%
New DY9-10 P4P Measure - Achievement Milestone	NA	NA	DY9 Goal 75%	DY10 Goal 75%

b. A Performing Provider must report a baseline for a measure, and HHSC must approve the reported baseline for reporting purposes, before a Performing Provider can report PY1 (or PY2 for measures with a delayed baseline measurement period or PY3 for measures newly-selected for DY9-10).

   i. Performing Providers must adhere to measure specifications and maintain a record of any variances that were approved by HHSC prior to reporting a baseline for a measure.

ii. HHSC's approval of a reported baseline for reporting purposes does not constitute approval for a Performing Provider to report a measure outside measure specifications. If at any point HHSC or the independent assessor identifies that a Performing Provider is reporting a measure outside measure specifications, reporting and goal achievement milestone payment may be withheld or recouped while the Performing Provider works to bring reporting into compliance with specifications.

c. Performing Providers must report the reporting and goal achievement milestones for a P4P measure for a given PY during the same reporting period with some exceptions for measures with a delayed measurement period.

d. As part of the DY9 and DY10 reporting milestones, Performing Providers are required to update Related Strategies reporting, as indicated in Attachment R, "Measure Bundle Protocol."

e. Some measures have multiple parts as outlined in Attachment R, "Measure Bundle Protocol."

i. A measure with multiple parts has one baseline reporting milestone, one PY reporting milestone for each DY, and multiple goal achievement milestones for each DY.

ii. The valuation for each measure part's goal achievement milestone is determined by dividing the measure's total goal achievement milestone valuation by the number of measure parts, so that each measure part's goal achievement milestone is valued equally.

iii. All measure parts for a given baseline or achievement for a PY must be reported in the same reporting period.

iv. Each measure part's goal achievement milestone will be measured independently to determine percent of goal achieved as defined in paragraph 29.

23. Category C - Measure Denominator Population

a. Each Category C measure's eligible denominator population must include all individuals served by the Performing Provider system during a given measurement period that are included in the Measure Bundle target population as defined in Attachment R "Measure Bundle Protocol."

b. Performing Providers may not select Performing Provider specific facility, co-morbid condition, age, gender, and race/ethnicity subsets not otherwise specified in Attachment R "Measure Bundle Protocol."

c. In order to be eligible for payment for a measure's reporting milestone, the Performing Provider must report its performance on the all-payer, Medicaid-only, and LIU-only payer types.

    i. A Performing Provider may request in the RHP Plan Update submission to be exempted from reporting its performance on the Medicaid-only payer type or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations.

    ii. A Performing Provider may also submit an RHP Plan Update modification request to HHSC to be exempted from reporting its performance on the Medicaid-only payer type or the LIU-only payer type for a measure's reporting milestone with good cause, such as data limitations, prior to reporting a baseline for the measure and no later than the first day of the second reporting period of DY7 for DY7-10 measures and the first day of the second reporting period of DY9 for DY9-10 new measures.

d. Payment for a P4P measure's goal achievement milestone is based on the Performing Provider's performance on the MLIU payer type.

    i. A Performing Provider may request in the RHP Plan Update submission that payment for a P4P measure's goal achievement milestone be based on the Performing Provider's performance on the all-payer, Medicaid-only, or LIU-only payer type with good cause, such as a small denominator or data limitations.

    ii. A Performing Provider may also submit an RHP Plan Update modification request to HHSC to change the payer type on which payment for a measure's goal achievement milestone is based with good cause, such as a small denominator or data limitations; the Performing Provider must submit the request to HHSC prior to reporting a baseline for the measure and no later than 30 days prior to the first day of the second reporting period of DY7 for DY7-10 measures and no later than 30 days prior to the first day of the second reporting period of DY9 for DY9-10 new measures.

24. Category C - Methodology for Setting P4P Measure Goals

a. Category C P4P measure goals are set as an improvement over the baseline. Each P4P measure will be designated in Attachment R, "Measure Bundle Protocol" as either Quality Improvement System for Managed Care (QISMC) or Improvement over Self (IOS). QISMC measures will have a defined High Performance Level (HPL) and Minimum Performance Level (MPL) based on state or national benchmarks.

P4P Measure Goals for Measures Selected for DY7-10

	QISMC - Baseline below MPL	**QISMC -** Baseline equal to or greater than the MPL and lower than the HPL	**QISMC -** Baseline equal to or greater than the HPL	**IOS**
DY7	MPL	The greater absolute value of improvement between: 5% gap closure towards HPL, or baseline plus (minus) 2% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 2% of the difference between the HPL and MPL or the IOS goal	2.5% gap closure
DY8	10% gap closure between the MPL and HPL	The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 8% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal	10% gap closure
DY9	MPL plus 12% gap closure between the MPL and HPL	The greater absolute value of improvement between: 22.5% gap closure towards HPL, or baseline plus (minus) 9% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 9% of the difference between the HPL and MPL or the IOS goal	11.75% gap closure
DY10	MPL plus 15% gap closure between the MPL and HPL	The greater absolute value of improvement between: 25% gap closure towards HPL, or baseline plus (minus) 10% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 10% of the difference between the HPL and MPL or the IOS goal	12.5% gap closure*

* Innovative Measure F1-T03 continued in DY9-10 will be treated as an IOS measure in DY10 and will have a gap closure of 12.5% over baseline unless an alternate goal based on benchmark data is recommended by the measure steward as part of the measure validation process.

P4P Measure Goals for Measures Newly-Selected for DY9-10

	QISMC - Baseline below MPL	**QISMC** - Baseline equal to or greater than the MPL and lower than the HPL	**QISMC** - Baseline equal to or greater than the HPL	**IOS**
DY9	MPL plus 2.5% gap closure between the MPL and HPL	The greater absolute value of improvement between: 10% gap closure towards HPL, or baseline plus (minus) 4% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 4% of the difference between the HPL and MPL or the IOS goal	5% gap closure
DY10	MPL plus 10% gap closure between the MPL and HPL	The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 8% of the difference between the HPL and MPL	The lesser absolute value of improvement of baseline plus (minus) 8% of the difference between the HPL and MPL or the IOS goal	10% gap closure*

*Innovative Measure FI-T03 newly selected in DY9-10 will be treated as an IOS measure in DY10 and will have a gap closure of 10% over baseline unless an alternate goal based on benchmark data is recommended by the measure steward as part of the measure validation process.

b. In cases where a Performing Provider has significant denominator volume and no measurable numerator because required numerator inclusions and exclusions are not tracked during the baseline measurement period, a Performing Provider may request in the RHP Plan Update for DY7-8 to use a baseline numerator of 0 for certain measures designated as process measures and QISMC. Measures that are eligible for a numerator of 0 are indicated in Attachment R, "Measure Bundle Protocol."

    i. If a provider is approved by HHSC to report a baseline numerator of 0, the goal for the DY7 goal achievement milestone will be equal to the 75th percentile as indicated in Attachment R, "Measure Bundle Protocol" and the goal for the DY8 goal achievement milestone will be equal to a 10% gap closure between the 75th percentile and the HPL. For measures approved for a baseline numerator of 0 that are continuing in DY9-10, the DY9-10 goals are determined according to the table in paragraph 24.a. using an updated baseline that is set at the PY1 rate. Measures approved to report with a numerator of 0 in DY7-8 will have standard baseline and PY measurement periods as described in paragraph 21.

25. Category D - Statewide Reporting Measure Bundle

a. Each Performing Provider is required to report on the Statewide Reporting Measure Bundle specific to the type of Performing Provider (hospital, physician practice, CMHC, or LHD) as described in Attachment R, "Measure Bundle Protocol."

b. Category D is valued at 5 percent of a Performing Provider's total valuation for DY7-8. Category D may be increased to 15 percent of a Performing Provider's total valuation if the requirements under paragraph 25.c. are met.

c. An RHP must maintain the following total private hospital valuation amounts at submission of the RHP Plan Update for DY7-8. A 3 percent decrease may be allowed in each RHP and considered maintenance.

Private Hospital Participation

RHP	Private Hospital Valuation	Minimum Private Hospital Valuation in each DY
1	$38,856,709	$37,691,007
2	$12,933,175	$12,545,180
3	$133,630,962	$129,622,034
4	$64,989,767	$63,040,074
5	$108,996,712	$105,726,810
6	$68,777,524	$66,714,199
7	$84,513,275	$81,977,876
8	$9,607,121	$9,318,907
9	$120,556,063	$116,939,381
10	$50,540,564	$49,024,347
11	$21,345,261	$20,704,903
12	$40,896,051	$39,669,169
13	$14,111,711	$13,688,360
14	$13,799,933	$13,385,935
15	$39,491,671	$38,306,921
16	$8,476,165	$8,221,880
17	$12,637,136	$12,258,022
18	$5,311,040	$5,151,709
19	$5,832,483	$5,657,509
20	$11,173,926	$10,838,708
TOTAL	$870,343,929	$844,233,611

d. Category D is valued at 15 percent of a Performing Provider's total valuation for DY9-10.

e. Each measure within the Category D Statewide Reporting Measure Bundle is valued equally.

VII. DISBURSEMENT OF DSRIP FUNDS FOR DY7-10

26. RHP Plan Update Submission for Payment in DY 7

Submission of a State-approved RHP Plan Update shall serve as the basis for payment of 20 percent of a Performing Provider's DY7 total valuation.

27. Category A - Eligibility for DY7-10 Payments

Each Performing Provider is required to complete Category A to be eligible for payment of Categories B-D.

a. Category A must be reported in the second reporting period of each demonstration year to be eligible for payment of Categories B-D of the applicable demonstration year.

b. If Category A is not reported in the second reporting period of each demonstration year, then previous payments for the RHP Plan Update submission and Categories B-D for the applicable demonstration year may be recouped and prospective payments including those in the next reporting period may be withheld until Category A is completed.

28. Basis for Payment of Category B - MLIU PPP

The number of MLIU individuals served by the Performing Provider must be maintained or increased each DY with an allowable variation below the baseline, as described in paragraph 18.d. to be eligible for payment of the MLIU PPP milestone. The allowable variation below the maintenance goal (baseline) will be determined by HHSC and is to be based on the size and type of Performing Provider and will also account for the baseline MLIU percentage of Total PPP.

If a Performing Provider is unable to maintain the MLIU PPP number within the allowable variation, then the payment associated with the number will be reduced. Partial payment will be tiered in the following manner: 100% valuation for achievement at 100% of goal (with allowable variation); 90% of valuation for achievement of 90% to 99% (or 100% less allowable variation as the upper limit); 75% of valuation for achievement of 75% - 89% of goal; or 50% of valuation for achievement of 50% - 74% of goal. A Performing Provider will not earn any payment for maintaining less than 50% of its MLIU patient population.

29. Basis for Payment of Category C - Measure Bundles and Measures

a. P4P and P4R Measure Reporting Milestones

A Performing Provider must fully achieve reporting milestones to qualify for a DSRIP payment related to these milestones.

b. P4P Measure Goal Achievement Milestones

Partial payment for P4P measure goal achievement milestones is available in quartiles for partial achievement measured over baseline in PY1, PY2, PY3, and PY4. The achievement value is multiplied by the milestone valuation to determine payment. P4P measures with a baseline above the HPL are not eligible for partial achievement.

i. Each P4P measure has an associated goal achievement milestone that is assigned an achievement value based on the Performing Provider's achievement of the measure's goal as follows:

- If 100 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 1.0;
- If at least 75 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.75;
- If at least 50 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.5;
- If at least 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.25; or
- If less than 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.

ii. For DY9-10, hospital safety measures as identified in Attachment R, "Measure Bundle Protocol" with perfect performance at baseline are eligible for full payment based on maintenance of high performance. If maintenance of high performance is achieved, the achievement milestone is assigned an achievement value of 1.0. Perfect performance at baseline is one in which no numerator cases are reported during the baseline measurement period with one or more eligible denominator cases. Maintenance of high performance is defined as an increase of one numerator case that was not preventable during a performance year. Each provider eligible for maintenance of high performance may determine a valid definition for a numerator case that is not preventable and will submit documentation to HHSC if reporting maintenance of high performance in a performance year.

iii. The percent of the goal achieved for DY7-10 milestones is determined as follows:

- Measures with a positive directionality where higher scores indicate improvement in measure:
  - DY7 achievement = (PY1 Achieved - Baseline)/(DY7 Goal - Baseline)
  - Carryforward of DY7 achievement = (PY2 Achieved - Baseline)/(DY7 Goal - Baseline)
  - DY8 achievement = (PY2 Achieved - Baseline)/(DY8 Goal - Baseline)
  - Carryforward of DY8 achievement = (PY3 Achieved - Baseline)/(DY8 Goal - Baseline)
  - DY9 achievement = (PY3 Achieved - Baseline)/(DY9 Goal - Baseline)
  - Carryforward of DY9 achievement = (PY4 Achieved - Baseline)/(DY9 Goal - Baseline)
  - DY10 achievement = (PY4 Achieved - Baseline)/(DY10 Goal - Baseline)
- Measures with a negative directionality where lower scores indicate improvement in a measure:
  - DY7 achievement = (Baseline - PY1 Achieved)/(Baseline - DY7 Goal)
  - Carryforward of DY7 achievement = (Baseline - PY2 Achieved)/(Baseline - DY7 Goal)
  - DY8 achievement = (Baseline - PY2 Achieved)/(Baseline - DY8 Goal)
  - Carryforward of DY8 achievement = (Baseline - PY3 Achieved)/(Baseline - DY8 Goal)
  - DY9 achievement = (Baseline - PY3 Achieved)/(Baseline - DY9 Goal)
  - Carryforward of DY9 achievement = (Baseline - PY4 Achieved)/(Baseline - DY9 Goal)
  - DY10 achievement = (Baseline - PY4 Achieved)/(Baseline - DY10 Goal)

30. Basis for Payment of Category D - Statewide Reporting Measure Bundle

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made in successfully reporting measures included in the Statewide Reporting Measure Bundle specific to the type of Performing Provider. A Performing Provider must complete reporting on a Category D measure to be eligible for Category D payment for the measure.

31. Carry-forward Policy

Carry forward is allowed for Category B and C. Carry forward is not allowed for Category A or D.

If a Performing Provider is unable to report a Category B MLIU PPP and Total PPP in the second reporting period of the achievement DY, the Performing Provider may request to carry forward reporting of the Category B milestone to the first reporting round of the following DY. The measurement period will not change.

If a Performing Provider does not report a baseline or performance year in the first reporting period after the end of the measurement period, the Performing Provider may request to carry forward reporting of the associated Category C milestone to the next reporting round. For measures with a delayed baseline measurement

period, a Performing Provider may request to carry forward reporting of the baseline until the first reporting period of DY8 for DY7-10 measures and until the first reporting period of DY10 for DY9-10 new measures. Carrying forward reporting does not change baseline or performance measurement periods.

Performing Providers may carry forward achievement of the Category C goal achievement milestones so that the DY7 goal achievement milestone can be achieved in PY1 or PY2, the DY8 goal achievement milestone can be achieved in PY2 or PY3, the DY9 goal achievement can be achieved in PY3 or PY4, and the DY10 goal achievement can be achieved in PY4. For DY7-10 measures with a delayed baseline measurement period, DY7 goal achievement can only be achieved in PY2 and the DY8 goal achievement milestone can be achieved in PY2 or PY3. For new DY9-10 measures with a delayed baseline measurement period, the DY9 goal achievement and DY10 goal achievement can only be achieved in PY4. The carried forward achievement must be reported in the first reporting period after the end of the carried forward measurement period.

Incentive funding that is carried forward still remains associated with the original DY for all accounting purposes (including calculation of the annual DSRIP payment limits). Carried forward DSRIP funding is subject to all Medicaid claiming requirements and may be paid no later than two years after the end of a DY in which it was to have been completed (e.g., for DY7, which ends September 30, 2018, payments may be made no later than September 30, 2020). Although authority for DSRIP funding expires September 30, 2021, DSRIP payment may be claimed after this point, subject to the carry-forward provisions in this section (e.g. final DSRIP payments will be made in January 2023).

32. Penalties for Missed Milestones

If a Performing Provider does not report the milestones during the carry-forward period or the reporting year with respect to Category D - Statewide Reporting Measure Bundle, funding for the incentive payment shall be forfeited by the Performing Provider.

33. Remaining DY7-8 DSRIP Funds

a. Available DY7-8 DSRIP Funds

The funds remaining from each demonstration year for DY7 and DY8 is based on the difference between the available pool allocation as described in paragraph 13 and all Performing Providers' valuation as described in paragraph 14.a.

b. Regional Allocation

The remaining DY7-8 DSRIP funds are allocated to RHPs that did not fully utilize their original regional DY5 allocation based on the regional DY6 valuation and

the valuation available to the region according to paragraph 14.a, excluding regional changes due to DY6 combined projects and DY7 assignment of "home" regions.

Regional Allocation of Additional DSRIP Funds from Remaining DY7-8 DSRIP Funds

RHP	Additional Regional Allocation per DY
RHP 1	$866,635
RHP 2	$2,308,000
RHP 3	$0
RHP 4	$522,345
RHP 5	$4,797,112
RHP 6	$0
RHP 7	$0
RHP 8	$5,739,571
RHP 9	$0
RHP 10	$0
RHP 11	$0
RHP 12	$0
RHP 13	$0
RHP 14	$0
RHP 15	$0
RHP 16	$0
RHP 17	$9,284,861
RHP 18	$1,318,286
RHP 19	$0
RHP 20	$4,062,821
TOTAL	**$28,899,632**

c. Allocation Requirements

The RHP may determine how to allocate the additional DY7-8 DSRIP funds among Performing Providers based on the community needs assessment. New Performing Providers that did not participate in DSRIP in DY2-6 and are an eligible Performing Provider type may be allocated funds to begin participation in DY7-8.

i. Each RHP must conduct at least two public stakeholder meetings to determine the uses for the additional funding.

ii. Each Performing Provider must certify that there is a source of IGT for the additional funding.

iii. The RHP Plan Update must include a description of the process to determine the uses for the additional funding and indicate the interested Performing Providers that were or were not allocated additional funding.

iv. Existing and new Performing Providers allocated additional funds must follow all DSRIP requirements.

34. Withdrawal of a Performing Provider

If a Performing Provider withdraws from DSRIP during the RHP Plan Update submission for DY7-8 or in DY7, DY8, DY9, or DY10, then the funding may not be transferred to other Performing Providers or to the RHP.

If a Performing Provider withdraws after the RHP Plan Update submission for DY9-10, then all DY9-10 DSRIP payments received prior to the withdrawal are recouped and the provider forfeits any remaining DY9-10 DSRIP payments.

VIII. RHP AND STATE REPORTING REQUIREMENTS

35. RHP Reporting in DY7-10

Two times per year, Performing Providers seeking payment under the DSRIP program shall submit reports to HHSC demonstrating progress achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by HHSC. IGT Entities will review the submission of the reported performance. Based on the reports, HHSC will calculate the incentive payments for the progress achieved in accordance with Section VII "Disbursement of DSRIP Funds for DY7-10." The Performing Provider shall have available for review by HHSC or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of October 1 through March 31: the reporting and request for payment is due April 30.
- Reporting period of April 1 through September 30: the reporting and request for payment is due October 31.

These reports will serve as the basis for authorizing incentive payments to Performing Providers in an RHP for achievement of DSRIP milestones. HHSC shall have 30 days to review and approve or request additional information regarding the data reported for each milestone. If additional information is requested, the Performing Provider shall respond to the request within 15 days and HHSC shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. HHSC shall schedule the payment transaction for each

RHP Performing Provider within 30 days following HHSC approval of the Performing Provider's RHP report.

36. Intergovernmental Transfer Process

HHSC will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider in accordance with paragraph 35 and approved by the IGT Entity and the State. Within 14 days after notification by HHSC of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider.

At the time that HHSC requests IGT funding for DSRIP incentive payments, the State may also require the IGT Entity to transfer additional funds to provide a portion of the non-federal share of the state's administrative costs related to waiver monitoring activities.

37. RHP Annual Year End Report

Each RHP Anchoring Entity shall submit an annual report by December 15 following the end of each demonstration year during DY7-10. The annual report shall be prepared and submitted using the standardized reporting form approved by HHSC. The report will include information provided in the interim reports previously submitted for the DY. Additionally, the RHP will provide a narrative description of the progress made, lessons learned, challenges faced, stakeholder engagement, and other pertinent findings.

38. Learning Collaborative Plans

Recognizing the importance of learning collaboratives in supporting continuous quality improvement, RHPs will submit learning collaborative plans with the RHP Plan Updates, to reflect opportunities and requirements for shared learning among the DSRIP Performing Providers in the region. The DY7-8 and DY9-10 learning collaborative plans may include an annual regional learning collaborative and/or smaller, targeted learning collaboratives or stakeholder meetings. Two or more regions may work together to submit a cross-regional DY7-8 or DY9-10 learning collaborative plan. HHSC will develop a template for submission of RHP learning collaborative plans.

39. Texas Reporting to CMS

a. Quarterly and Annual Reporting

DSRIP will be a component of the State's quarterly operational reports and annual reports related to the Demonstration. These reports will include:

i. All DSRIP payments made to Performing Providers that occurred in the quarter as required in the quarterly payment report pursuant to STC 42(c);

ii. Expenditure projections reflecting the expected pace of future disbursements for each RHP and Performing Providers; and

iii. A summary assessment of each RHP's DSRIP activities during the given period including progress on milestones.

b. Claiming Federal Financial Participation

Texas will claim federal financial participation (FFP) for DSRIP incentive payments on the CMS 64.9 waiver form. FFP will be available only for DSRIP payments made in accordance with all pertinent STCs and Attachment R, "Measure Bundle Protocol" and Attachment J, "Program Funding and Mechanics Protocol."

IX. DATA QUALITY ASSURANCE

40. Data validation and alignment with managed care

Data and milestones that form the basis of incentive payments in DSRIP should have a high degree of accuracy and validity. The state must require that each Performing Provider certify that data received to demonstrate DSRIP achievement is accurate and complete. Data accuracy and validity also will be subject to review by the independent assessor.

41. Compliance Monitoring of DSRIP

All RHP Plan Updates are subject to potential audits, including review by the independent assessor. Upon request, Performing Providers must have available for review by the independent assessor, HHSC, and CMS, all supporting data and back-up documentation demonstrating performance of a milestone as described under an RHP Plan Update for DSRIP payments.

Failure of a Performing Provider to provide supporting documentation of performance of a milestone to the independent assessor or HHSC within the defined period of time may result in recoupment of DSRIP payments.

HHSC may recoup payments for milestones when a Performing Provider's documentation does not support the information reported.

Texas DSRIP Measure Bundle Protocol Demonstration Years 7-10

TEXAS
Health and Human Services

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Introduction

The Delivery System Reform Incentive Payment (DSRIP) program is designed to provide incentive payments to Texas hospitals, physician practices, Community Mental Health Centers (CMHCs), and Local Health Departments (LHDs) 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) 7-10 beginning October 1, 2017 [contingent on negotiations with the Centers for Medicare and Medicaid Services (CMS)].

The DY7-10 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 DY7-10, DSRIP Performing Providers will report on required reporting categories at their provider system level.

Category A

Required reporting for Category A in DY7-10 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, the Texas Health and Human Services Commission (HHSC) wants to ensure that Performing 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. In addition, Performing Providers will also report a breakout of MLIU individuals served by its system during DY9-10. 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 CMHCs and LHDs. Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures for DY7-10 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 CMHCs and LHDs 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.

Additionally, in DY9-10, Category C includes required reporting on Lists of Related Strategies as determined by Measure Bundle selection for hospitals and physician practices or measure selection for CMHCs and LHDs. The individual Related Strategies within a List represent strategies Performing Providers may have implemented that impact the Category C Measure Bundle or measure target population. HHSC aims to examine the relationship between Related Strategies reporting and Performing Providers demonstrating higher Category C performance achievement among shared Measure Bundles or measures.

Related Strategies (Category C) and Core Activities (Category A) are similar in that they both involve better understanding what kinds of strategies Performing Providers are implementing to meet Category C achievement goals. In fact, the individual Related Strategy descriptions were informed by, but not limited to, Core Activity descriptions.

However, there are key differences between Related Strategies and Core Activities. First, the Lists of Related Strategies include strategies a Performing Provider may have implemented, even apart from DSRIP, which may not be included in Core Activities reporting. Second, unlike Core Activities reporting, Related Strategies reporting does not include a qualitative reporting component. Moreover, even if multiple Category C measures are selected, Performing Providers are only required to report on at least one Core Activity, leaving a gap in understanding what strategies were implemented across all selected Measure Bundles/measures for a given Performing Provider or across Performing Providers selecting shared Measure Bundles/measures.

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 Performing 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.

CMHCs and the Texas Council of Community Centers provided recommendations for measures related to behavioral health, and LHDs 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 DY7-10 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 DY7-10, 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 Performing Provider types can report on Category D in DY7-10. 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, CMHCs, and LHDs. 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;
- APMs;
- Costs and Savings; and
- Collaborative Activities.

Category A is designed to support DSRIP sustainability through Performing Providers' reporting on progress on the four key areas outlined above. Performing Providers design the structure of their next-step initiatives based on the foundation of quality improvements from DY2-6 projects and the experience from implementing Core Activities in DY7-8. This approach offers Performing 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 Performing Providers; its structure allows the flexibility for continuous quality improvement for the P4P in quality measurement in Category C.

Core Activities

With the transition from project-level to Performing Provider-level reporting, Performing Providers no longer report on projects; instead, they 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 meet their Category C goals.

As defined in the Program Funding and Mechanics Protocol (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 DY7-10, or it can be a new activity that the Performing Provider is implementing in DY7-10.

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

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 Performing 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 Performing 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, Performing 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 Performing Providers within and across the regions.

In the RHP Plan Update for DY7-8, Performing Providers indicated which DY2-6 projects had Core Activities that continued in DY7-8 and which projects have been completed. The template for the RHP Plan Update for DY7-8 allowed Performing Providers to select Core Activities that continued from DY2-6 projects and new Core Activities that Performing Providers selected for implementation. In DY9-10, Performing Providers can continue working on the Core Activities from DY7-8 if they contribute to the Performing Providers' goals, or new Core Activities can be selected if Performing Providers need to adjust their initiatives based on their experience.

For example, a Performing Provider that expanded its primary care clinic in DSRIP DY2-6 decided to continue that expansion in DY7-8 (e.g., space expansion, increase in hours that clinic is in operation, or additional staffing) and selected *Provision of coordinated services for patents under Patent Centered Medical Home (PCMH) model* as a Core Activity that assisted the Performing Provider in achieving the goals for Improved Chronic Disease Management: Diabetes Care Measure Bundle in DY7-8. This Performing Provider can continue with the same Core Activity in DY9-10 but adjust it if needed. The Performing Provider may also decide to add a new Core Activity to reflect additional work that currently takes place or will be done in DY9-10.

As another example, a Performing Provider who increased access to different types of specialty care during DY2-6 could then decide in DY7-8 to maintain the same level of specialty care only in some areas but provide telemedicine services to other areas of specialty care. This Performing Provider may have selected *Use telehealth to deliver specialty services* as a Core Activity for DY7-8. In DY9-10, this Performing Provider may decide to continue with the existing Core Activity and adjust it as needed and select a new Core Activity, *Implementation of remote patient monitoring programs for diagnosis and/or management of care,* that will reflect additional plans that the Performing Provider is selecting to further promote its goals tied to quality measures selected under Category C.

In general, Performing Providers can select Core Activities from various groupings as long as it reflects what the Performing 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 in other areas.

During the second reporting period of each DY, Performing Providers 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 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 Performing Provider has more than one Core Activity in the initial selection, and the Performing Provider needs to delete one of these activities due to the changes, then the Performing Provider is not required to choose a replacement activity to report on. Performing Providers may also add new Core Activities and discontinue those that are not showing results. It is recommended that Performing Providers use continuous quality improvement to monitor their progress. Providers report on Core Activities using 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)/promotors, 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 Performing 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, Federally Qualified Health Centers (FQHCs), 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, LHDs, 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)
- Provision of coordinated prenatal and postpartum care
- 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 (Agency for Healthcare Research and Quality (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 Service

- 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 Emergency Department (ED), and others)
- Enhancement in coordination between primary care, urgent care, and EDs 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 ED 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; and 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 CHWs 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 behavioral health 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

Hospital Safety and Quality

- Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)
- Implementation of evidence-based practices to improve quality of care (e.g., Quality Departments, monitoring and evaluation, etc.)
- Other

Other

If a Core Activity is not on this list, a Performing Provider can include a Core Activity and provide a description. As stated previously, Performing 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 Performing Provider.

Alternative Payment Models

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 Children's Health Insurance Program 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 with Managed Care Organizations (MCOs) and DSRIP Performing Providers on ways to incorporate promising clinical models as Value-Based Purchasing (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 Analysis

Based on the requirement included in the PFM for DY7-8, Performing Providers with a total valuation of $1 million or more per DY are required to 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. In DY9-10, Performing Providers will continue with the Costs and Savings review and must analyze: 1) a different Core Activity than was used for the Costs and Savings analysis in DY7-8; or 2) a different aspect of the same Core Activity for the Costs and Savings analysis than was used for the Costs and Savings analysis in DY7-8. Along with other required information, Performing Providers will submit a short narrative including Core Activity chosen, methodologies, and assumptions made for the analysis. Information related to Costs and Savings analysis 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 information such as the 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 the Core Activity selected for the analysis is broad in scope, Performing Providers can concentrate their analysis on a component of this Core Activity and provide an explanation for such selection during reporting. In DY7-8, Performing Providers submitted a progress update on the analysis during the second reporting period of DY7, and the final report of costs and savings will be submitted during the second reporting period of DY8. For DY9-10, Performing Providers will submit a progress update for the new analysis to HHSC during the second reporting period of DY9, and a final report of costs and savings will be submitted during the second reporting period of DY10. This information is key to assist Performing Providers to work with Medicaid MCOs 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. A Performing Provider's participation in the learning collaborative, stakeholder forum, or other stakeholder meeting in DY7-10 can be done in person, via conference call, or via other telecommunications applications, and these meetings should include individuals from other entities in this region or other regions. Lessons learned from these meetings should be relevant at the Performing Provider level or applicable to some of the Performing Provider's Core Activities. Performing Providers will report on Collaborative Activities via the DSRIP online reporting system.

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 DY7-10. 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 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 areas 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. In DY9-10, Performing Providers report a breakout of Medicaid and low-income or uninsured (LIU) served by their systems. In DY7-8 MLIU was reported as one number.

Systems may be limited by geographic location. For example, a Performing 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 Performing 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 Performing Providers with the same ownership may not combine two currently separate DSRIP Performing Providers into one system for DY7-10, 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 Performing 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 tables display the required and optional components of the system definition by Performing Provider type.

Hospitals

Required*	Optional
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

*Required only if the Performing Provider has this business component.

Physician Practices

Required*	Optional
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

*Required only if the Performing Provider has this business component.

Community Mental Health Centers

Required*	Optional
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

*Required only if the Performing Provider has this business component.

Local Health Departments

Required*	Optional
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, then the Performing Provider will focus its system population according to the measure denominators for Category C reporting. Denominators for Category C will be naturally limited by the encounter types defined in 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 Performing Provider type: 1) Hospital and Physician Practice Measure Bundle Menu; 2) Local Health Department Measure Menu; or 3) 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 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, and in DY9 and DY10.

Additionally, in DY9-10, Performing Providers will report on Lists of Related Strategies as determined by Measure Bundle selection for hospitals and physician practices or by measure selection for LHDs and CMHCs. For each Related Strategy within a required List, Performing Providers will make two reporting indications regarding the strategy's implementation (e.g., Implementation Date and Implementation Status). Performing Providers are required to report on Related Strategies in the DY9-10 RHP Plan Update and required to update Related Strategies reporting as part of the DY9 and DY10 Category C reporting milestones.

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 P4R in DY7-8 and valued at 0 points; The Innovative measure for DY9-1 is P4P in DY10 and valued at 1 point for DY9-10.
   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 P4P except for Innovative Measures and Quality Improvement Collaborative Activities which are P4R in DY7 and DY8 and P4P if selected or continued in DY9 and DY10. 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 during the initial selection period. 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 PBCOs worth an additional four points each and are required as P4P for Performing Providers with an MPT of 75 and optional as P4P for Performing 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 in DY7-8 by hospitals with a valuation less than or equal to $2,500,000 per DY. Performing 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. In DY7 and DY8, each hospital or physician practice with an MPT of 75 must select at least one Measure Bundle with a PBCO. In DY9 and DY10, each hospital or physician practice with an MPT of 75 must select Measure Bundles that result in a minimum of two PBCOs.
   iii. For Measure Bundles A1, A2, B1, C1, D1, and H2, Population Based Clinical Outcomes are required for Performing Providers with an MPT of 75 and optional as P4P with 4 additional points for Performing 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 PBCO is a required measure for any Performing Provider that selects that Measure Bundle as the PBCO in each Measure 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 in DY7-8 or $2,000,000 in DY10 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 in DY7-8 or $2,000,000 in DY10 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 for DY7 and $1,000,000 for DY8. The milestone valuations for DY7 and DY8 are as follows:

Measure	Volume	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	$0	$62,500	$0
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 in DY7 and $1,000,000 in DY8. The valuations for DY7 and DY8 are as follows:

Measure	Volume	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	$0	$0	$0	$0	$0
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 Performing Provider system is accountable for improvement under the DSRIP incentive arrangements. The target population identifies all individuals in the DSRIP attributed population for each Performing 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 LIU rate for each measure.

Step 1: Determine the DSRIP attributed population using the prescribed retroactive attribution methodology defined below based on the Performing 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, and 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 ED 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 CMHCs, 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 LHDs, 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 Performing Provider types:
   a. Performing Providers may remove from the DSRIP attributed population any individual for which the Performing 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 Performing 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.
   i. If such a Performing Provider is not able to reasonably report on enough Measure 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 LHDs and CMHCs.

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 Department

a. LHDs 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 Performing 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 Performing Provider may continue to report both measures, but both measures will only contribute 3 points towards the MPT.
b. LHDs 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.
c. LHDs may continue to report grandfathered measures that were approved for use in DY7 and DY8 as P4P in DY9 and DY10.
d. LHDs may not select new grandfathered measures for use in DY9 and DY10.

Hospital & Physician Practice Measure Bundle Menu

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]* DY7/8	*Required* [1]	Required	14	6	**20**
D1: Pediatric Primary Care *[SP]* DY9/10	*Required* [1]	Required	12	6	**18**
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]* DY7/8	None	Required	10	1	**11**
E1: Improved Maternal Care *[HSP]* DY9/10	None	Required	10	0	**10**
E2: Maternal Safety *[HSP]* DY7/8	None	Required	8	0	**8**
E2: Maternal Safety *[HSP]* DY9/10	None	Required	12	0	**12**
F1: Improved Access to Adult Dental Care DY7/8	None	Required	7	0	**7**
F1 Improved Access to Adult Dental Care DY9/10	None	Required	7	1	**8**
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 & 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]	None	Optional	3	10	**13**
K2: Rural Emergency Care [4]	None	None	3	1	**4**
Total Possible Points DY7/8	N/A	N/A	182	62	244
Total Possible Points DY9/10	N/A	N/A	184	63	247

[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 Performing Providers with an MPT 0f 75 that select bundle, optional as P4P for others.
[2]Clinical outcomes included for cancer hospital only (optional 6 additional points).
[3]Requires prior authorization.
[4]Can only be selected in DY7-8 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 in DY7/8	Required in DY9/10	Measure Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	No	No	+1
A1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Yes	Yes	1
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Yes	Yes	3
A1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	Yes	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*	Yes*	+4 if P4P +0 if P4R
A1-508	Reduce Rate of Emergency Department visits for Diabetes	N/A	N/A	Yes*	Yes*	+4 if P4P +0 if P4R

*For Performing Providers that select Measure Bundle A1:

- Measures A1-500 AND A1-508 are PBCOs and are required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measures as P4P.
  Performing 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 Performing 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 in DY7/8	Required in DY9/10	Measure Points
A2-103	Controlling High Blood Pressure	NCQA	0018	Yes	Yes	3
A2-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	Yes	Yes	1
A2-384	Risk Adjusted CHF 30-Day Readmission Rate	N/A	N/A	No	No	+3
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	N/A	Yes	Yes	1
A2-501	PQI 08 Heart Failure Admission Rate (Adult)	AHRQ	N/A	Yes*	Yes*	+4 if P4P +0 if P4R
A2-509	Reduce Rate of Emergency Department visits for CHF, Angina, and Hypertension	N/A	N/A	Yes*	Yes*	+4 if P4P +0 if P4R

*For Performing Providers that select Measure Bundle A2:

- Measures A2-501 and A2-509 are PBCOs and are required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measures as P4P.
- Performing 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 Performing 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 in DY7/8	Required in DY9/10	Measure Points
B1-124	Medication Reconciliation Post-Discharge	NCQA	0097	Yes	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	Yes	3
B1-217	Risk Adjusted All-Cause 30-Day Readmission	N/A	N/A	Yes	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	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	Yes	1
B1-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	1
B1-352	Post-Discharge Appointment	AHA/ASA, TJC	2455/ 2439	Yes	Yes	1

B2: Patient Navigation & ED Diversion

Objective:
Utilize patient navigators (CHWs, 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 in DY7/8	Required in DY9/10	Measure Points
B2-242	Reduce Emergency Department (ED) visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes**	Yes**	*(+3)*
B2-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes**	Yes**	*(+3)*
B2-392	Reduce Emergency Department visits for Acute Ambulatory Care Sensitive Conditions (ACSC)	N/A	N/A	Yes	Yes	*3*
B2-393	Reduce Emergency Department visits for Dental Conditions	N/A	N/A	Yes**	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 in DY7/8	Required in DY9/10	Measure Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	1
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	Yes	Yes	1
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828	Yes	Yes	1
C1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	Yes	1
C1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070	Yes	Yes	1
C1-272	Adults (18+ years) Immunization status	ICSI	N/A	Yes	Yes	1
C1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	Yes	Yes	1
C1-389	Human Papillomavirus Vaccine (age 18 -26)	N/A	N/A	Yes	Yes	1
C1-502	PQI 91 Acute Composite (Adult Dehydration, Bacterial Pneumonia, Urinary Tract Infection Admission Rates)	AHRQ	N/A	Yes*	Yes*	+4 if P4P +0 if P4R

*For Performing Providers that select Measure Bundle C1:

- Measure C1-502 is a PBCOs and is a required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measure as P4P.
- Performing 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 Performing 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 in DY7/8	Required in DY9/10	Measure Points
C2-106	Cervical Cancer Screening	NCQA	0032	Yes	Yes	2
C2-107	Colorectal Cancer Screening	NCQA	0034	Yes	Yes	2
C2-186	Breast Cancer Screening	NCQA	2372	Yes	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 in DY7/8	Required in DY9/10	Measure Points
C3-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	3059	Yes	Yes	1
C3-328	Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	PCPI	3061	Yes	Yes	1
C3-368	Hepatitis C: Hepatitis A Vaccination	American Gastroenterological Association	0399	Yes	Yes	1
C3-369	Hepatitis C: Hepatitis B Vaccination	American Gastroenterological Association	0400	Yes	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:

DY7/8: 9*1.5 (high state priority) = 14

DY9/10: 8*1.5 (high state priority) = 12

Possible Additional Points: 6

Maximum Total Possible Points: 20 for DY7/8, 18 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
D1-108	Childhood Immunization Status (CIS)	NCQA	0038	Yes	Yes	1
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity	NCQA	0024	Yes	Yes	1
D1-212	Appropriate Testing for Children With Pharyngitis	AHRQ	0002	Yes	Yes	3
D1-237	Well-Child Visits in the First 15 Months of Life	NCQA	1392	Yes	Discontinued	DY7/8: 1 DY9/10: 0
D1-271	Immunization for Adolescents	NCQA	1407	Yes	Yes	1
D1-284	Appropriate Treatment for Children with URI	NCQA	0069	Yes	Yes	1
D1-301	Maternal Depression Screening	NCQA	1401	No	No	+1
D1-389	Human Papillomavirus Vaccine (age 15-18)	N/A	N/A	No	No	+1
D1-400	Tobacco Use and Help with Quitting Among Adolescents	CMS	N/A	Yes	Yes	1
D1-503	PDI 97 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	AHRQ	N/A	Yes*	Yes*	*+4 if P4P +0 if P4R
D1-T01	*Innovative Measure:* Behavioral Health Counselling for Childhood Obesity	Meadows	N/A	No	Discontinued	0

*For Performing Providers that select Measure Bundle D1:

- Measure D-503 is a PBCOs and is a required P4P measures for Performing Providers with an MPT of 75.
- Performing Providers with an MPT less than 75 may opt to report measure as P4P.
- Performing 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 Performing 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 in DY7/8	Required in DY9/10	Measure Points
D3-330	Pediatric CLABSI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-331	Pediatric CAUTI	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-333	Pediatric Surgical site infections (SSI)	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-334	Pediatric Adverse Drug Events	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	Yes	2
D3-335	Pediatric Pressure Injuries	Children's Hospitals' Solutions for Patient Safety National Children's Network	N/A	Yes	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 in DY7/8	Required in DY9/10	Measure Points
D4-139	Asthma Admission Rate (PDI 14)	AHRQ	07228	Yes	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	Yes	1
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	The American Academy of Asthma Allergy and Immunology	0047	Yes	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 in DY7/8	Required in DY9/10	Measure Points
D5-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	NCQA	0024	Yes	Yes	1
D5-406	Diabetes Short-term Complications Admission Rate (PDI 15)	AHRQ	N/A	Yes	Yes	4
D5-T07	*Innovative Measure:* Diabetes Care Coordination	TBD	N/A	No	Discontinued	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 for DY7/8

Maximum Total Possible Points: 11 for DY7/8, 10 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
E1-193	Contraceptive Care – Postpartum Women Ages 15–44	US Office of Population Affairs	2902	No	Discontinued	DY7/8: +1
E1-232	Timeliness of Prenatal Care	NCQA	1517	Yes	Yes	1
E1-235	Post-Partum Follow-Up and Care Coordination	CMS	N/A	Yes	Yes	3
E1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA-PCPI	N/A	Yes	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:

DY7/8: 4*2 (high state priority) = 8

DY9/10: 6*2 (high state priority) = 12

Possible Additional Points: N/A

Maximum Total Possible Points: 8 for DY7/8, 12 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
E2-150	PC-02 Cesarean Section	The Joint Commission	0471	Yes	Yes	3
E2-151	PC-03 Antenatal Steroids	The Joint Commission	0476	Yes	Yes	1
E2-A01	Quality Improvement Collaborative Activity: Participation in OB Hemorrhage Safety Bundle Collaborative (TexasAIM Plus) through the Texas Department of State Health Services *(P4R for participation in collaborative and implementation of recommended practices in DY7-8)*	N/A	N/A	Yes	Discontinued	0
E2-601	Hemorrhage Risk Assessment *(Requires participating in TexasAIM Plus)*	Alliance for Innovation in Maternal Care	N/A	N/A	Yes	1
E2-602	Quantified Blood Loss *(Requires participating in TexasAIM Plus)*	Alliance for Innovation in Maternal Care	N/A	N/A	Yes	1

F1: Improved Access to Adult Dental Care

Objective:
Increase access to timely, appropriate dental care.

Target Population:
Adults

Base Points: 7

Possible Additional Points: DY9/10: 1

Maximum Total Possible Points: 7 for DY7/8, 8 for DY9/10

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
F1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	1
F1-226	Chronic Disease Patients Accessing Dental Services	N/A	N/A	Yes	Yes	3
F1-227	Dental Caries: Adults	Healthy People 2020	N/A	Yes	Yes	3
F1-T03	*Innovative Measure:* Oral Cancer Screening (DY7/8: P4R, DY9: P4R, DY10: P4P)	A&M College of Dentistry	N/A	No	No	DY7-8: 0 DY9-10: +1

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 in DY7/8	Required in DY9/10	Measure Points
F2-224	Dental Sealant: Children	Healthy People 2020	N/A	Yes	Yes	1
F2-229	Oral Evaluation: Children	American Dental Association	2517	Yes	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 in DY7/8	Required in DY9/10	Measure Points
G1-276	Hospice and Palliative Care – Pain assessment	University of North Carolina-Chapel Hill	1637	Yes	Yes	1
G1-277	Hospice and Palliative Care – Treatment Preferences	University of North Carolina-Chapel Hill	1614	Yes	Yes	1
G1-278	Beliefs and Values	University of North Carolina-Chapel Hill	1647	Yes	Yes	1
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation/UCLA	1617	Yes	Yes	1
G1-362	Hospice and Palliative Care -- Dyspnea Treatment	University of North Carolina-Chapel Hill	1638	Yes	Yes	1
G1-363	Hospice and Palliative Care -- Dyspnea Screening	University of North Carolina-Chapel Hill	1639	Yes	Yes	1
G1-505	Proportion Admitted to Hospice for less than 3 days	American Society of Clinical Oncology	0216	No*	No*	+3
G1-507	Proportion not Admitted to Hospice	American Society of Clinical Oncology	0215	No*	No*	+3

*Measures G1-505 and G1-507 may only be selected by a cancer hospital in DY7/8 but may be selected by any performing provider with a cancer hospital as a part of their system definition in DY9/10.

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 in DY7/8	Required in DY9/10	Measure Points
H1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	Yes	Yes	1
H1-255	Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	Yes	Yes	3
H1-286	Depression Remission at Six Months	MN Community Measurement	0711	Yes	Yes	3
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-PCPI	2152	Yes	Yes	1
H1-T04	*Innovative Measure:* Engagement in Integrated Behavioral Health	Meadows	N/A	No	Discontinued	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 in DY7/8	Required in DY9/10	Measure Points
H2-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	*(Yes)**	*(Yes)**	*+3*
H2-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	*(Yes)**	*(Yes)**	*+3*
H2-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	CQAIMH	N/A	Yes	Yes	1
H2-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	No	No	+1
H2-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	Yes	Yes	1
H2-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	AMA-PCPI	1365	Yes	Yes	1
H2-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	0104	Yes	Yes	1
H2-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	CMS	N/A	Yes	Yes	1
H2-510	Reduce Rate of Emergency Department visits for Behavioral Health and Substance Abuse	N/A	N/A	Yes * †	Yes * †	+4 if P4P +0 if P4R

† For Performing Providers that select Measure Bundle H2 and have an MPT of 75:Measure H2-510 is a PBCO and is a required P4P measure for Performing Providers with an MPT of 75.

† * For Performing Providers that select Measure Bundle H2 and have an MPT of less than 75: Performing Providers with an MPT less than 75 must select one of either H2-160, H2-216, or H2-510 as P4P.

Performing 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 Performing 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 in DY7/8	Required in DY9/10	Measure Points
H3-144	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain	CMS	0418	Yes	Yes	1
H3-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	1
H3-288	Pain Assessment and Follow-up	CMS	0420	Yes	Yes	1
H3-401	Opioid Therapy Follow-up Evaluation	N/A	N/A	Yes	Yes	1
H3-403	Evaluation or Interview for Risk of Opioid Misuse	N/A	N/A	Yes	Yes	1
H3-T05	*Innovative Measure:* Treatment of Chronic Non-Malignant Pain Management with Multi-Modal Therapy (DY7/8: P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	Discontinued	0
H3-T06	*Innovative Measure:* Patients on long-term opioid therapy checked in prescription drug monitoring programs (PDMPs) (DY7/8: P4R)	San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	No	Discontinued	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 in DY7/8	Required in DY9/10	Measure Points
H4-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	1932	Yes	Yes	1
H4-258	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NCQA	1933	Yes	Yes	1
H4-260	Annual Physical Exam for Persons with Mental Illness	CQAIMH	N/A	Yes	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. Cannot be selected for the first time in DY9/10.

ID	Measure	Steward	NQF #	Required in DY7/8	Required in DY9/10	Measure Points
I1-385	Assessment of Functional Status or QoL	N/A	N/A	Yes	Yes	1
I1-386	Improvement in Functional Status or QoL	N/A	N/A	Yes	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 in DY7/8	Required in DY9/10	Measure Points
J1-218	Central line-associated bloodstream infections (CLABSI) rates	CDC	0139	Yes	Yes	2
J1-219	Catheter-associated Urinary Tract Infections (CAUTI) rates	CDC	0138	Yes	Yes	2
J1-220	Surgical site infections (SSI) rates	CDC	0299	Yes	Yes	2
J1-221	Patient Fall Rate	American Nurses Association	0141	Yes	Yes	2
J1-506	PSI 13 Post-Operative Sepsis Rate	AHRQ	N/A	Yes	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 in DY7-8. This bundle may not be selected for the first time in DY9-10.

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 in DY7/8	Required in DY9/10	Measure Points
K1-103	Controlling High Blood Pressure	NCQA	0018	No	No	+3
K1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	NCQA	0028	Yes	Yes	1
K1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	No	No	+1
K1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	No	No	+3
K1-146	Screening for Clinical Depression and Follow-Up Plan	CMS	0418	No	No	+1
K1-268	Pneumonia vaccination status for older adults	CMS	0043	Yes	Yes	1
K1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041/ 3070	No	No	+1
K1-285	Advance Care Plan	NCQA	0326	Yes	Yes	1
K1-300	Behavioral Health Risk Assessment for Pregnant Women	AMA / PCPI	N/A	No	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 in DY7-8. This bundle may not be selected for the first time in DY9-10.

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 in DY7/8	Required in DY9/10	Measure Points
K2-285	Advance Care Plan	NCQA	0326	No*	No*	+1
K2-287	Documentation of Current Medications in the Medical Record	CMS	0419	Yes	Yes	1
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	CMS	0497	Yes	Yes	1
K2-359	Emergency Transfer Communication Measure	University of Minnesota Rural Health Research Center	0291	Yes	Yes	1

*K2-285 cannot be selected if Measure Bundle K1 is selected.

Local Health Department Measure Menu

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
L1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1
L1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1
L1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1
L1-268	Pneumonia vaccination status for older adults	CMS	0043	1

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
L1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	SAMHSA/ CCBHC	N/A	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

Measures L1-262, L1-263, L1-265, and L1-342 are added for new selection in DY9-DY10 only.

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
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

ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
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	
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

ID	Measure	Steward	NQF #	Points	Additional Points for State Priority Measures
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	
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	N/A	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	N/A	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.*

Related Strategies Reporting for Hospitals & Physician Practices

In DY9-10, as determined by Measure Bundle selection, hospitals and physician practices will report on one or more Related Strategies Lists. As identified in the table below, Measure Bundles with similar interventions, service settings, and/or populations may be associated with a single Related Strategies List.

Within each Related Strategies List, there are multiple individual Related Strategies organized by Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health.* Individual Related Strategies may be limited to specific Related Strategies Lists.

Hospitals & Physician Practices Measure Bundles and associated Related Strategies Lists

Adult Primary Care and Chronic Disease Management

ID	Measure Bundle
A1	Chronic Disease Management: Diabetes
A2	Chronic Disease Management: Heart Disease
C1	Primary Care Prevention - Healthy Texans
C2	Primary Care Prevention - Cancer Screening
C3	Hepatitis C

Hospital Readmissions and Emergency Department Utilization

ID	Measure Bundle
B1	Care Transitions and Hospital Readmissions
B2	Patient Navigation & ED Diversion

Pediatric Primary Care and Chronic Disease Management

ID	Measure Bundle
D1	Pediatric Primary Care
D4	Pediatric Chronic Disease Management: Asthma
D5	Pediatric Chronic Disease Management: Diabetes

Maternal Care and Safety

ID	Measure Bundle
E1	Improved Maternal Care
E2	Maternal Safety

Dental Care

ID	Measure Bundle
F1	Improved Access to Adult Dental Care
F2	Preventive Pediatric Dental

Palliative Care and Specialty Care (Chronic and Life Impacting Conditions)

ID	Measure Bundle
G1	Palliative Care
I1	Specialty Care

Behavioral Health Integration

ID	Measure Bundle
H1	Mental Health Comorbidities
H2	Behavioral Health and Appropriate Utilization
H3	Chronic Non-Malignant Pain Management
H4	Integrated Care for People with Serious Mental Illness

Hospital Safety

ID	Measure Bundle
J1	Hospital Safety
D3	Pediatric Hospital Safety

Rural Primary Care

ID	Measure Bundle
K1	Rural Primary Care

Rural Emergency Care

ID	Measure Bundle
K2	Rural Emergency Care

Example:
In DY9-10, a hospital or physician practice selects seven Measure Bundles: A1, A2, C1, C2, D1, F2, and J1.

The Performing Provider will report on the following four Related Strategies Lists associated with those seven Measure Bundle selections:

- *Adult Primary Care Prevention and Chronic Disease Management (A1, A2, C1, C2)*
- *Pediatric Primary Care Prevention and Chronic Disease Management (D1)*
- *Dental Care (F1)*
- *Hospital Safety (J1)*

H/PP Theme: Access to Care

Related Strategies in the *Access to Care* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Behavioral Health Integration
- Rural Primary Care

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)
1.40	Integration or co-location of primary care and dental services in the outpatient setting *(Limited to: Hospital Readmissions and ED Utilization; Dental Care)*
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist *(Limited to: Hospital Readmissions and ED Utilization; Dental Care)*

H/PP Theme: Care Coordination

Related Strategies in the *Care Coordination* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care *(Limited to: Pediatric Primary Care and Chronic Disease Management)*

H/PP Theme: Data Analytics

Related Strategies in the *Data Analytics* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as *"Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Hospital Safety**
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. *(Limited to: Hospital Readmissions and ED Utilization; Palliative/Specialty Care; Rural Emergency Care)*
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

**Within this Theme, the Hospital Safety List only includes RS-IDs 3.00, 3.01, and 3.10.

H/PP Theme: Disease Management

Related Strategies in the *Disease Management* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Palliative/Specialty Care
- Behavioral Health Integration
- Hospital Safety**
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
4.61	Patient educational materials or campaigns about advance care planning/directives *(Limited to: Adult Primary Care and Chronic Disease Management; Palliative/Specialty Care; Rural Primary Care; Rural Emergency Care)*
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place *(Limited to: Maternal Care and Safety; Palliative/Specialty Care; Behavioral Health Integration; Rural Primary Care)*
4.71	Medication-Assisted Treatment (MAT) services actively offered *(Limited to: Behavioral Health Integration)*
4.80	Hospital hand hygiene protocol/programming (Limited to: Hospital Safety)
4.81	Checklist(s) (or similar standardized protocol) tailored to prevent hospital safety-related events *(Limited to: Hospital Safety*)
4.82	Formal process for monitoring compliance with hospital safety-related protocols (includes reviews, "secret shopper" approaches, etc.) *(Limited to: Hospital Safety)*
4.83	Formal process for analyzing and addressing hospital safety-related events (includes root-cause analyses, remediation policies, etc.) *(Limited to: Hospital Safety)*

**Within this Theme, the Hospital Safety List only includes RS-IDs 4.80, 4.81, 4.82, and 4.83.

H/PP Theme: Social Determinants of Health

Related Strategies in the *Social Determinants of Health* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Behavioral Health Integration
- Rural Primary Care
- Rural Emergency Care

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

Related Strategies Reporting for Local Health Departments

In DY9-10, as determined by measure selection, Local Health Departments will report on one or more Related Strategies Lists. As identified in the table below, measures with similar interventions, service settings, and/or populations may be associated with a single Related Strategies List.

Within each Related Strategies List, there are multiple individual Related Strategies organized by Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health.* Individual Related Strategies may be limited to specific Related Strategies Lists.

Local Health Department Measures and associated Related Strategies Lists

Adult Primary Care Prevention and Chronic Disease Management

ID	Measure
L1-103	Controlling High Blood Pressure
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
L1-107	Colorectal Cancer Screening
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
L1-186	Breast Cancer Screening
L1-268	Pneumonia vaccination status for older adults
L1-269	Preventive Care and Screening: Influenza Immunization
L1-272	Adults (18+ years) Immunization status
L1-280	Chlamydia Screening in Women (CHL)
L1-343	Syphilis positive screening rates
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis
L1-345	Gonorrhea Positive Screening Rates
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate
L1-207	Diabetes care: BP control (<140/90mm Hg)

Hospital Readmissions and Emergency Department Utilization

ID	Measure
L1-160	Follow-Up After Hospitalization for Mental Illness
L1-242	Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Pediatric Primary Care

ID	Measure
L1-108	Childhood Immunization Status (CIS)
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)
L1-271	Immunization for Adolescents
L1-400	Tobacco Use and Help with Quitting Among Adolescents

Maternal Care and Safety

ID	Measure
L1-235	Post-Partum Follow-Up and Care Coordination

Dental Care

ID	Measure
L1-224	Dental Sealant: Children
L1-225	Dental Caries: Children
L1-227	Dental Caries: Adults
L1-231	Preventive Services for Children at Elevated Caries Risk

Access to Care

ID	Measure
L1-205	Third next available appointment
L1-342	Time to Initial Evaluation: Evaluation within 10 Business Days

Criminal Justice

ID	Measure
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Serious Mental Illness

ID	Measure
L1-262	Assessment of Risk to Self/ Others
L1-263	Assessment for Psychosocial Issues of Psychiatric Patients
L1-265	Housing Assessment for Individuals with Schizophrenia

Example:
In DY9-10, an LHD selects five measures: L1-103 Controlling High Blood Pressure, L1-105 Tobacco Screening & Cessation, L1-115 HbA1C Poor Control, L1-225 Dental Caries: Children, and L1-227 Dental Caries: Adult.

The Performing Provider will report on the following two Related Strategies Lists associated with those five measure selections:

- *Primary Care Prevention and Chronic Disease Management (L1-103, L1-105, L1-115)*
- *Dental Care (L1-225, L1-227)*

LHD Theme: Access to Care

Related Strategies in the *Access to Care* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.22	Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting *(Limited to: Serious Mental Illness)*
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)
1.40	Integration or co-location of primary care and dental services in the outpatient setting *(Limited to: Dental Care)*
1.41	Telehealth to provide virtual appointments and/or consultations with a dentist *(Limited to: Dental Care)*

LHD Theme: Care Coordination

Related Strategies in the *Care Coordination* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care *(Limited to: Pediatric Primary Care and Chronic Disease Management)*

LHD Theme: Data Analytics

Related Strategies in the *Data Analytics* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as *"Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. *(Limited to: Hospital Readmissions and ED Utilization)*
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

LHD Theme: Disease Management

Related Strategies in the *Disease Management* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place *(Limited to: Maternal Care and Safety; Criminal Justice; Serious Mental Illness)*
4.71	Medication-Assisted Treatment (MAT) services actively offered *(Limited to: Criminal Justice)*

LHD Theme: Social Determinants of Health

Related Strategies in the *Social Determinants of Health* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Adult Primary Care and Chronic Disease Management
- Hospital Readmissions and ED Utilization
- Pediatric Primary Care and Chronic Disease Management
- Maternal Care and Safety
- Dental Care
- Access to Care**
- Criminal Justice
- Serious Mental Illness

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) *(Limited to: Pediatric Primary Care and Chronic Disease Management; Dental Care)*

**Within this Theme, the Access to Care List only includes RS-IDs 5.20 and 5.21.

Related Strategies Reporting for Community Mental Health Centers

In DY9-10, as determined by measure selection, Community Mental Health Centers will report on one or more Related Strategies Lists. As identified in the table below, measures with similar interventions, service settings, and/or populations may be associated with a single Related Strategies List.

Within each Related Strategies List, there are multiple individual Related Strategies organized by Themes: *Access to Care, Care Coordination, Data Analytics, Disease Management, and Social Determinants of Health.* Individual Related Strategies may be limited to specific Related Strategies Lists.

Community Mental Health Centers Measures and associated Related Strategies Lists

Physical Health Comorbidities

ID	Measure
M1-103	Controlling High Blood Pressure
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
M1-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk
M1-207	Diabetes care: BP control (<140/90mm Hg)
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia
M1-260	Annual Physical Exam for Persons with Mental Illness
M1-280	Chlamydia Screening in Women (CHL)

Hospital Readmissions and Emergency Department Utilization

ID	Measure
M1-124	Medication Reconciliation Post-Discharge
M1-160	Follow-Up After Hospitalization for Mental Illness
M1-216	Risk Adjusted Behavioral Health/ Substance Abuse 30-Day Readmission Rate
M1-287	Documentation of Current Medications in the Medical Record
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)

Children and Adolescents

ID	Measure
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
M1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)
M1-305	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*
M1-400	Tobacco Use and Help with Quitting Among Adolescents

Specialty Care (Chronic and Life Impacting Conditions)

ID	Measure
M1-385	Assessment of Functional Status or QoL (Modified from NQF# 0260/2624)
M1-386	Improvement in Functional Status or QoL (Modified from PQRS #435)

Serious Mental Illness (SMI): Depression

ID	Measure
M1-125	Antidepressant Medication Management (AMM-AD)
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)
M1-165	Depression Remission at Twelve Months
M1-181	Depression Response at Twelve Months- Progress Towards Remission
M1-256	Initiation of Depression Treatment
M1-262	Assessment of Risk to Self/ Others
M1-286	Depression Remission at Six Months
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)

Serious Mental Illness: Schizophrenia

ID	Measure
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients
M1-264	Vocational Rehabilitation for Schizophrenia
M1-265	Housing Assessment for Individuals with Schizophrenia
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia

Dual Diagnosis and Substance Use Disorder (SUD) Treatment

ID	Measure
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
M1-257	Care Planning for Dual Diagnosis
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
M1-339	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3 / Alcohol and Other Drug Use Disorder Treatment at Discharge SUB-3a
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
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
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

Access to Care

ID	Measure
M1-205	Third next available appointment
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days
M1-390	Time to Initial Evaluation: Mean Days to Evaluation

Criminal Justice

ID	Measure
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Example:
In DY9-10, a CMHC selects five measures: M1-103 Controlling High Blood Pressure, M1-115 HbA1c Poor Control, M1-147 BMI Screening and Follow-Up, M1-125 Antidepressant Medication Management, and M1-146 Screening for Clinical Depression and Follow Up Plan.

The Performing Provider will report on the following two Related Strategies Lists associated with those five measure selections:

- *Physical Health Comorbidities (M1-103, M1-115, M1-147)*
- *Serious Mental Illness: Depression (M1-125, M1-146)*

CMHC Theme: Access to Care

Related Strategies in the *Access to Care* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
1.00	Same-day and/or walk-in appointments in the outpatient setting
1.01	Night and/or weekend appointments in the outpatient setting
1.10	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
1.11	Telehealth to provide virtual medical appointments and/or consultations with a primary care provider
1.12	Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)
1.20	Integration or co-location of primary care and psychiatric services in the outpatient setting
1.21	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
1.22	Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting
1.30	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)

CMHC Theme: Care Coordination

Related Strategies in the *Care Coordination* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Criminal Justice

RS-ID	Related Strategies Description
2.00	Culturally and linguistically appropriate care planning for patients
2.01	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.02	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2.10	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
2.11	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
2.12	Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.
2.20	Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified
2.30	Formal closed loop process for scheduling referral visits as needed
2.40	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data
2.50	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.51	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
2.60	Formal closed loop process for coordinating the transition from pediatric to adult care *(Limited to: Children and Adolescents)*

CMHC Theme: Data Analytics

Related Strategies in the *Data Analytics* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care
- Criminal Justice

RS-ID	Related Strategies Description
3.00	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
3.01	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
3.10	Database or registry to track quality and clinical outcomes data on patients
3.20	Analysis of appointment "no-show" rates
3.30	Formal partnership or arrangement with post-acute care facilities (e.g. skilled nursing facility, inpatient rehabilitation facility, long-term acute care hospital, home health agency, hospice, etc.) to track/share quality measures such as length of stay and readmission rates, etc. *(Limited to: Hospital Readmissions & ED Utilization; Specialty Care)*
3.40	Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc. *(Limited to: Children and Adolescents)*

CMHC Theme: Disease Management

Related Strategies in the *Disease Management* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Criminal Justice

RS-ID	Related Strategies Description
4.00	Care team includes a clinical pharmacist(s)
4.01	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
4.02	Care team includes a registered dietician(s)
4.10	Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences
4.20	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
4.30	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
4.31	Classes for patients focused on diet, nutrition counseling, and/or cooking
4.32	Classes for patients focused on physical activity
4.40	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
4.50	Telehealth to provide remote monitoring of patient biometric data (e.g. HbA1c levels, blood pressure, etc.) and/or medication adherence
4.60	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
4.70	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place
4.71	Medication-Assisted Treatment (MAT) services actively offered *(Limited to: Dual Diagnosis/SUD Treatment; Criminal Justice)*

CMHC Theme: Social Determinants of Health

Related Strategies in the *Social Determinants of Health* Theme shown in the table below are included in all of the following Related Strategies Lists unless the individual Related Strategy is separately noted as "*Limited to"* a specific List:

- Physical Health Comorbidities
- Hospital Readmissions and ED Utilization
- Children and Adolescents
- Specialty Care
- SMI: Depression
- SMI: Schizophrenia
- Dual Diagnosis/SUD Treatment
- Access to Care**
- Criminal Justice

RS-ID	Related Strategies Description
5.00	Screening patients for food insecurity
5.01	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
5.10	Screening patients for housing needs
5.11	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
5.12	Screening patients for housing quality needs
5.13	Formal partnership or arrangement with housing quality resources to support patient health status (e.g. housing inspections, pest control management, heating and other utility services, etc.)
5.20	Screening patients for transportation needs
5.21	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)
5.30	Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives (e.g. addressing environmental triggers, healthy lunch options, field day activities, etc.) *(Limited to: Children and Adolescents)*

** Within this Theme, the Access to Care List only includes RS-IDs 5.20 and 5.21.

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, CMHCs, physician practices, and LHDs. This reporting is designed to assist Performing Providers, MCOs, Regional Healthcare Partnerships (RHP), 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 and LIU 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
- CMHCs
- Physician practices
- 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 Performing 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. ED 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

Reporting on Patient Satisfaction is limited to the inpatient setting.

For Patient Satisfaction, Performing Providers will report the percentage of survey respondents who choose the most positive, or "top-box," response for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Reporting Measures:

- Percent of patients who reported that their doctors "Always" communicated well
- Percent of patients who reported that their nurses "Always" communicated well
- Percent of patients who reported that their pain was "Always" well controlled[1]
- 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.

[1] This question will most likely be substituted for DY9-10 reporting.

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.

Community Mental Health Center Statewide Reporting Measure Bundle

CMHCs will report on their activities being carried out to impact rates on the following measures and provide qualitative reporting as required by HHSC:[2]

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.

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 report on their activities being carried out to impact rates measured by Prevention Quality Indicators (PQIs). Based on the description by the 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.

[2] Some measures may be modified at the end of DY9-10. CMHCs will report based on the modified measure specifications once approved by HHSC.

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)[3], 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?

[3] Additional information on BRFSS is available in Appendix B.

- **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?

Appendix A

Category C Measure Specifications

Appendix B

Regional summaries with selected health information are generated based on the data collected by the Department of State Health Services via 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.