Texas DSRIP

Measure Bundle Protocol

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Contents

Introduction

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

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

Category A

Required reporting for Category A in DY 7-8 includes progress on Core Activities, Alternative Payment Model (APM) arrangements, cost 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 alternative payment models to continue services for Medicaid and low-income or uninsured individuals after the waiver ends. The listing of Core Activities in the Measure Bundle Protocol reflect those project areas that have been determined to be most transformational and will support continuation of the work begun by providers during the first years of the waiver. These Core Activities will be continued or implemented by a performing provider to support achievement of its Category C measure goals.

Category B

As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving the DSRIP target population: Medicaid and low-income uninsured (MLIU) patients. To that end, Category B will require each Performing Provider to report the total number of individuals and number of MLIU individuals served by their system each DY. The Measure Bundle Protocol sets out parameters for a provider to define its "system" to reflect the 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 Measure Bundles, targeted measure bundles have been developed for hospitals and physician practices, and lists of measures are available for community mental health centers and local health departments. Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures for DY7-8 allows for ease in measure selection and approval, increases standardization of measures across the state for providers with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.

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

DY2-6 Category 3 Pay for Performance (P4P) Measures; new P4P measures added from authoritative sources, with a preference for NQF endorsed measures; and innovative measures as needed, which will be Pay for Reporting (P4R) for DY7-8 and function as a measure testing process.

Measure Development Process

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

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

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

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

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

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

Category D

For DY7-8, the Category D Statewide Reporting Measure Bundles have replaced the former Category 4 reporting on population-focused measures. While Category 4 was only for hospitals, all provider types will be able to report on Category D in DY7-8. The Statewide Reporting Measure Bundles align with the MLIU population, are identified as high priority given the health care needs and issues of the patient population served, and are viewed as valid health care indicators to inform and identify areas for

improvement in population health within the health care system. These bundles refine the hospital measures from the former Category 4 and add measures for physician practices, community mental health centers and local health departments. The emphasis of Category D is on the reporting of population health measures to gain information on and understanding of the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics.

Category A

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

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

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

Core Activities

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

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

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

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

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

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

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

During the second reporting period of each DY, providers will report on all Core Activities selected, both continuing and those that are newly added. If adjustments are needed, performing providers can revise their strategies used in achieving Category C goals and update their selection of Core Activities at any time without HHSC approval. During the second reporting period of each DY, performing providers will provide a description of any newly selected Core Activity and the reason for selecting it along with reporting progress on previously selected Core Activities. If a provider has more than one Core Activity in the initial selection, and the provider needs to delete one of these activities due to the changes, they are not required to choose a replacement activity to report on. Providers may also add new core activities and discontinue those that are not showing results. It is recommended that providers use continuous quality improvement to monitor their progress. Reporting for Core Activities will be done via a template developed by HHSC or entered directly into the DSRIP Online Reporting System.

Examples of Core Activities

Access to Primary Care Services

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

Access to Specialty Care Services

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

Expansion or Enhancement of Oral Health Services

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

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)

Patient Centered Medical Home

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

Expansion of Patient Care Navigation and Transition Services

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

Prevention and Wellness

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

Chronic Care Management

- Utilization of evidence-based care management models for patients identified as having high-risk health care 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

Availability of Appropriate Levels of Behavioral Health Care Services

- Utilization of mobile clinics that can provide access to BH care in very remote, inaccessible, or impoverished areas of Texas
- Utilization of telehealth/telemedicine in delivering behavioral services
- Increasing access to services by utilizing staff with the following qualifications: Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists
- Utilization of Care Management function that integrates primary and behavioral health needs of individuals

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

Palliative Care

- Provision of coordinated palliative care to address patients with end-of-life decisions and care needs
- Transitioning of palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility and management of patients' needs

Other

If nothing on the list above applies to what is being implemented, a provider can include his or her own Core Activity and provide a description.

Alternative Payment Models (APMs)

Based on numerous studies and research articles related to categories of healthcare spending and opportunities for increased efficiencies, there is a widespread trend towards linking health care

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

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

Costs and Savings

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

Performing providers will include costs and savings specific to their organization and other contracted providers if that information is available. A progress update will be submitted to HHSC during the second reporting period of DY7 and a final report of costs and savings will be submitted during the second reporting period of DY8. This information is key to assist performing providers to work with Medicaid Managed Care Organizations and other health care payers for sustainability.

Collaborative Activities

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

Category B: System Definition

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

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

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

Systems may be limited by geographic location. For example, a provider that operates one hospital on one RHP and another hospital in a separate RHP may have two systems, 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. A performing provider's delineation of system should consider data systems and the extent to which the various components are coordinating to improve health of the patients served.

There are required and optional components of a performing provider's system definition for each performing provider type. The required components are elements of a system that, through discussion with stakeholders and the technical advisory team, should be included as a performing provider's "base unit"; it has been determined that these components are essential functions and/or departments of the provider type. Therefore, the required components must be included in a performing provider's system definition if the performing provider's organization has that business component. A performing provider may then include optional components in its system definition and patient count, including contracted partners for certain services. Unless otherwise granted permission from HHSC, a performing provider should not count within its system definition or patient population a component that is already included as part of another performing provider's system definition or patient population. However, HHSC is considering how to treat system definition when there is overlap between physician practices and hospitals where they practice.

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 additional 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.

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

	Required*	Optional
Hospitals	Inpatient Services	Contracted Specialty Clinics
	Emergency Department	Contracted Primary Care Clinics
	Owned Outpatient Clinics	School-based Clinics
	Maternal Department	Contracted Palliative Care Programs
	Homeless Program	Contracted Mobile Health Programs
	Urgent Care Clinics	Other
Physician Practices	Owned or Operated Primary Care Clinics	Contracted Specialty Clinics
	Owned or Operated Specialty Care Clinics	Contracted Primary Care Clinics
	Owned or Operated Hospital	Contracted Community-based Programs
		Other
Community Mental Health Centers	State-funded Community Hospital	Home-based services
	Community Institution for Mental Disease (IMD)	Contracted Clinic
	General Medical Hospital	School-based Clinic
	Hospital	Other
	Office/Clinic	
	State Mental Health Facility	

	State Mental Retardation Facility	
Local Health Departments	Clinics	Mobile Outreach
	Immunization Locations	Other

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

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

Category C

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

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

1. Measure Points

a. Each measure is assigned a point value based on the following criteria:
    i. 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. Cancer screening measures and hospital safety and infection measures are valued at 2 points.
    iii. Measures of clinical practice, immunization rates, and measures related to quality of life or functional assessment are valued at 1 point.
    iv. Measures that are pay-for-reporting (P4R) are valued at 0 points. Innovative measures are the only measures that are P4R in the Hospital and Physician Practice Measure Bundle Menu. These innovative measures are still under consideration.
b. Not all measures in the Hospital and Physician Practice Measure Bundle Menu will contribute points to the bundle.

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

a. The base point value of a Measure Bundle is equal to the sum of the points for the required measures in the Measure Bundle. The base point value of a Measure Bundle designated as High State Priority is then multiplied by 2, and the base point value of a Measure Bundle designated as State Priority is then multiplied by 1.5.
    i. High State Priority Measure Bundles (sum of the required measures' points multiplied by 2)
        1. E1: Maternal Care
        2. 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. H1: Behavioral Health in a Primary Care Setting
7. H2: Behavioral Health & Appropriate Utilization
8. H4: Integrated Care for People with Serious Mental Illness

b. Certain 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 8 points and a multiplier of 1.5 for a base point value of 12 points. If a hospital selects Measure Bundle A1 and the optional measure A1-247 Reduce ED Visits for Diabetes, 3 points will be added to the Measure Bundle for a total of 15 points towards the hospital's MPT.

c. Limitations on Hospital and Physician Practice Measure Bundle Selections and Optional Measure Selections
    i. Measure Bundles K2 Rural Preventative Care and K2 Rural Emergency Care can only be selected by hospitals with a valuation less than or equal to $2,000,000 per DY.
    ii. Each hospital or physician practice with a valuation of more than $2,000,000 per DY must either: 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.
    iii. An optional measure within a Measure Bundle that adds points to the Measure Bundle, if selected, cannot add points if it duplicates a measure in another selected Measure bundle that is counted towards the bundle point value (either a required measure or an optional measure that adds points). Duplicative measures can be identified by the last three digits of the program ID.

3. Community Mental Health Center and Local Health Department Selection Requirements

a. A CMHC and LHD must select at least one 3-point measure
b. If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 3 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 all-payer denominator for the measurement period that is greater than or equal to 30.
    ii. *Insignificant volume* is defined, for most outcome measures, as an all-payer denominator for the measurement period that is less than 30, but greater than 0.
    iii. *No volume* is defined as an all-payer denominator for the 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 all-payer 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 all-payer denominator for the baseline measurement period has *significant volume*.

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

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

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

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

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

Bundle.

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

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

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

c. CMHC and LHD Minimum Volume Requirements

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

5. Eligible Denominator Population

a. The eligible denominator population for each measure will be determined by: 1) measure setting; 2) active patient definition, if applicable within the measure setting, and 3) denominator specifications.

b. Each measure has a defined measure setting. The eligible denominator population should be limited to the defined measure setting as indicated in the Measure Specifications. Measure settings may include:

i. Primary Care
ii. Urgent Care
iii. Outpatient Specialty Care (can be further refined for applicable measures)
iv. Behavioral Health Inpatient
v. Behavioral Health Outpatient
vi. Emergency Department
vii. Hospice
viii. Hospital
ix. OB
x. Dental Clinic

c. The denominator for a measure with a primary care setting should be limited to active patients. An active patient for a primary care setting is defined as an individual who meets one or more of the following criteria:
    i. Had two visits in the 12-month measurement period.
    ii. Had one visit in the measurement period and one visit in the 12 months prior to the measurement period.
    iii. Assigned to a primary care physician.
d. The denominator for a measure with an outpatient specialty care setting should be limited to active patients. An active patient for an outpatient specialty care setting will be defined by a Performing Provider in the RHP Plan Update.
e. The denominator for measures with a setting other than a primary care setting or an outpatient specialty care setting may not be limited to active patients.

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

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

Measure Bundles for Hospitals & Physician Practices

Bundle ID	Hospital & Physician Practice Measure Bundles	Base Points	Possible Additional Points	Maximum Possible Points
A1	Improved Chronic Disease Management: Diabetes Care	12	3	15
A2	Improved Chronic Disease Management: Heart Disease	12	3	15
B1	Care Transitions & Hospital Readmissions	6	N/A	6
B2	Patient Navigation & ED Diversion	4	3	7
C1	Primary Care Prevention - Healthy Texans**	9	N/A	9
C2	Primary Care Prevention - Cancer Screening & Follow-Up**	6	3	9
C3	Hepatitis C**	3	N/A	3
D1	Pediatric Primary Care	12	1	13
D3	Pediatric Hospital Safety**	6	N/A	6
D4	Pediatric Chronic Disease Management: Asthma	11	3	14
E1	Improved Maternal Care	12	1	13
F1	Improved Access to Adult Dental Care	6	N/A	6
F2	Preventive Pediatric Dental**	2	N/A	2
G1	Palliative Care**	6	N/A	6
H1	Integration of Behavioral Health in a Primary or Specialty Care Setting	8	N/A	8
H2	Behavioral Health and Appropriate Utilization	9	6	15
H3	Chronic Non-Malignant Pain Management**	4	3	7
H4	Integrated Care for People with Serious Mental Illness**	3	N/A	3
I1	Specialty Care**	2	N/A	2
J1	Hospital Safety**	8	N/A	8
K1	Rural Preventative Care*	3	4	7
K2	Rural Emergency Care*	3	N/A	3
Total Possible Points		147	30	177

*Can only be selected by hospitals with a valuation at or below $2,000,000 per DY
**Measure Bundles with no required 3 point measures

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 Medicaid/CHIP and Low Income Uninsured Population:
Adults with diabetes

Base Points: 8*1.5 (state priority) = 12
Possible Additional Points: 3
Maximum Total Possible Points: 15

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	N		
A1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Y	1	
A1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	N		
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Y	3	
A1-116	Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA	0062	N		
A1-207	Diabetes care: BP control (<140/90mm Hg)	NCQA	0061	Y	3	
A1-208	Comprehensive Diabetes Care LDL-C Screening	NCQA	0063	Y	1	
A1-247	Reduce Emergency Department visits for Diabetes	N/A	N/A	N		+3
A1-321	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation (eMeasure)	American Podiatric Medical Association	0417	N		

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 Medicaid/CHIP and Low Income Uninsured Population:
Adults with heart disease

Base Points: 8*1.5 (state priority) = 12
Possible Additional Points: A maximum of 3 additional points may be added to this bundle
Maximum Total Possible Points: 15

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
A2-103	Controlling High Blood Pressure *(BAT Recommendation to allow follow-up home blood pressure readings recorded in EHR/medical record)*	NCQA	0018	Y	3	
A2-104	Medical Assistance with Smoking and Tobacco Use Cessation (MSC) - Modified Denominator	NCQA	0027	Y	1	
A2-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828 eMeasure	N		
A2-206	Cholesterol management for patients with cardiovascular conditions	NCQA	N/A	Y	3	
A2-208	Comprehensive Diabetes Care LDL-C Screening	NCQA	0063	N		
A2-210	PQRS #317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS	N/A	Y	1	
A2-246	Reduce Emergency Department visits for Selected Condition or Conditions: CHF, Diabetes, Angina/Hypertension,	None	N/A	N		+3

	Behavioral Health & 3Substance Abuse, COPD, or Dental					
A2-384	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization	CMS	1891	N		+3

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 Medicaid/CHIP and Low Income Uninsured Population:
Individuals transitioning out of inpatient care

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

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
B1-124	Medication Reconciliation Post-Discharge	NCQA	0097	N		
B1-141	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) for selected conditions: heart failure hospitalization, coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use *(BAT Recommends a Standardized Risk Adjusting Methodology for all providers in DY7 - DY8)*	CMS / other	0330 / 2515 / other	N		
B1-217	Risk Adjusted All-Cause Readmission *(BAT Recommends a Standardized Risk Adjusting Methodology for all providers in DY7 - DY8)*	N/A	N/A	Y	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	Y	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	Y	1	
B1-287	Documentation of Current Medications in the Medical Record	CMS	0419	Y	1	
B1-351	INR Monitoring for individuals on warfarin after hospital discharge,	CMS	2732	N	P4R	

B2: Patient Navigation & ED Diversion

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Individuals without a PCP or otherwise at high risk of disconnect from institutionalized health care

Base Points: 4
Possible Additional Points: 3
Maximum Total Possible Points: 7

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
B2-242	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)	None	N/A	N		+3
B2-246	Reduce Emergency Department visits for Selected Condition or Conditions: CHF, Diabetes, Angina/Hypertension, Behavioral Health & Substance Abuse, COPD, or Dental	None	N/A	Y	3	
B2-250	Reduce low acuity ED visits	AHRQ	N/A	N		
B2-251	Emergency department (ED) visits where patients left without being seen	Australian Council on Healthcare Standards	N/A	N		
B2-352	Post-Discharge Appointment *(BAT recommendation to expand to principle diagnosis of Heart Failure, Diabetic Ketoacidosis, CAD, COPD, and to specify post-discharge appointment scheduled prior to discharge or the end of the next business day if discharge was completed outside of business hours)*	2455: AHA/ASA, 2439: TJC	2455 & 2439	Y	1	
B2-353	Proportion of Children with ED Visits for Asthma with	University Hospitals	3170 (Under	N		

	Evidence of Primary Care Connection Before the ED Visit	Cleveland Medical Center	Review by NQF)			
B2-354	Post-Discharge Evaluation *(BAT recommendation to expand to principle diagnosis of Heart Failure, Diabetic Ketoacidosis, CAD, and COPD)*	TJC	2443	N		

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 Medicaid/CHIP and Low Income Uninsured Population:
Adults

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

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	NCQA	0028	Y	1	
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA	0057	Y	1	
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421 / 2828 eMeasure	Y	1	
C1-268	Pneumonia vaccination status for older adults	CMS	0043	Y	1	
C1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070 eMeasure	Y	1	
C1-272	Adults (18+ years) Immunization status	Institute for Clinical Systems Improvement	N/A	Y	1	
C1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	N		
C1-285	Advance Care Plan	NCQA	0326	N		
C1-389	Human Papillomavirus Vaccine (age 14 -26)	N/A	N/A	N		

C2: Primary Care Prevention - Cancer Screening & Follow-Up

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Adults

Base Points: 6
Possible Additional Points: 3
Maximum Total Possible Points: 9

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
C2-106	Cervical Cancer Screening	NCQA	0032	Y	2	
C2-107	Colorectal Cancer Screening	NCQA	0034	Y	2	
C2-162	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	American Gastroenterological Association	0658	N		
C2-186	Breast Cancer Screening	NCQA	2372	Y	2	
C2-199	PQRS #439: Age Appropriate Screening Colonoscopy	American Gastroenterological Association	N/A	N		
C2-274	Mammography follow-up rate	CMS	N/A	N		+3
C2-275	Abnormal Pap test follow-up rate	American College of Obstetrics and Gynecology	N/A	N		

C3: Hepatitis C

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Adults with undiagnosed chronic Hepatitis C Infection.

Base Points: 3
Possible Additional Points: N/A
Maximum Total Possible Points: 3

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
C3-202	PQRS #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis *(BAT recommendation that denominator is limited to individuals managing treatment for HCV in the primary care setting)*	American Gastroenterological Association	N/A	N		
C3-203	PQRS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	N/A / 3059 eMeasure	Y	1	
C3-311	PQRS #390 Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options	American Gastroenterological Association	N/A	N		
C3-328	Appropriate Screening Follow-up for Patients Identified with	PCPI	3061 eMeasure	Y	1	

	Hepatitis C Virus (HCV) Infection					
C3-368	Hepatitis C: Hepatitis A Vaccination	American Gastroenterological Association	0399	N		
C3-369	Hepatitis C: Hepatitis B Vaccination	AMA-convened Physician Consortium for Performance Improvement	0400	Y	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 Medicaid/CHIP and Low Income Uninsured Population:
Children

Base Points: 8*1.5 (state priority) = 12
Possible Additional Points: 1
Maximum Total Possible Points: 13

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
D1-108	Childhood Immunization Status (CIS)	NCQA	0038	Y	1	
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	0024	Y	1	
D1-212	Appropriate Testing for Children With Pharyngitis	AHRQ	0002	Y	3	
D1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	NCQA	1392	Y	1	
D1-238	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA	1516	N		
D1-240	Adolescent Well-Care Visits (AWC)	NCQA	N/A	N		
D1-271	Immunization for Adolescents-Tdap/TD and MCV (Updated to include HPV)	NCQA	1407	Y	1	
D1-284	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	NCQA	0069	Y	1	
D1-301	Maternal Depression Screening	NCQA	1401	N		+1
TBD	*Innovative Measure Under Consideration*: Behavioral Health Counselling for Childhood Obesity	TBD	N/A	N	P4R	

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 Medicaid/CHIP and Low Income Uninsured Population:
Children receiving inpatient care

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

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

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 Medicaid/CHIP and Low Income Uninsured Population:
Children with asthma

Base Points: 7*1.5 (state priority) = 11
Possible Additional Points: 3
Maximum Total Possible Points: 14

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
D4-139	Asthma Admission Rate (PQI15-AD) *(Admissions for ages 5 - 18)*	AHRQ	0728	N		+3
D4-173	Medication Management for People with Asthma	NCQA	1799	Y	3	
D4-209	Asthma Percent of Opportunity Achieved	N/A	N/A	N		
D4-249	Pediatric/Young Adult Asthma Emergency Department Visits	Alabama Medicaid Agency	1381	Y	3	
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	The American Academy of Asthma Allergy and Immunology	0047	Y	1	
D4-376	Asthma Quality of Life Assessment Tool	N/A	N/A	N		

E1: Improved Maternal Care

This bundle is a High State Priority.

Objective:
Improve maternal and infant 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 Medicaid/CHIP and Low Income Uninsured Population:
Women from preconception through the post-partum period

Base Points: 6*2 (high state priority) = 12
Possible Additional Points: 1
Maximum Total Possible Points: 13

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
E1-148	PC-01 Elective Delivery (Patients with elective vaginal deliveries or elective cesarean)	The Joint Commission	0469 / 2829 eMeasure	N		
E1-150	PC-02 Cesarean Section (Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section)	The Joint Commission	0471	Y	1	
E1-151	PC-03 Antenatal Steroids	The Joint Commission	0476	N		
E1-193	Contraceptive Care – Postpartum Women Ages 15–44 (CCP-AD)	US Office of Population Affairs	2902	N		+1
E1-232	Timeliness of Prenatal/Postnatal Care *(Rate 1 only, HHSC is discussing reporting rate for Medicaid only with possible alignment with MCOs)*	NCQA	1517	Y	1	
E1-235	Post-Partum Follow-Up and Care Coordination (PQRS #336)	CMS	N/A	Y	3	
E1-300	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)	AMA-PCPI	N/A	Y	1	
E1-378	Appropriate Prophylactic Antibiotic	Massachusetts General	0472	N		

	Received Within One Hour Prior to Surgical Incision – Cesarean section.	Hospital/ Partners Health Care System				
TBD	*Innovative Measure Under Consideration:* Preeclampsia measure	TBD	N/A	N	P4R	

F1: Improved Access to Adult Dental Care

Objective:
Increase access to timely, appropriate dental care.

Target Medicaid/CHIP and Low Income Uninsured Population:
Adults

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

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
F1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	NCQA	0028	N		
F1-226	Chronic Disease Patients Accessing Dental Services	N/A	N/A	Y	3	
F1-227	Dental Caries: Adults	Healthy People 2020	N/A	Y	3	
TBD	*Innovative Measure Under Consideration*: Oral Cancer Screening	TBD	N/A	N	P4R	

F2: Preventive Pediatric Dental Care

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Otherwise unserved children

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

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
F2-224	Dental Sealant: Children	Healthy People 2020	N/A	Y	1	
F2-225	Dental Caries: Children	Healthy People 2020	N/A	N		
F2-229	Oral Evaluation: Children - Modified Denominator	American Dental Association	2517 (Modified)	Y	1	
F2-231	Preventive Services for Children at Elevated Caries Risk - Modified Denominator	American Dental Association	N/A	N		

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 Medicaid/CHIP and Low Income Uninsured Population:
Individuals with serious or terminal illness.

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

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
G1-276	Hospice and Palliative Care – Pain assessment	University of North Carolina-Chapel Hill	1637	Y	1	
G1-277	Hospice and Palliative Care – Treatment Preferences	University of North Carolina-Chapel Hill	1641	Y	1	
G1-278	Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.	University of North Carolina-Chapel Hill	1647	Y	1	
G1-285	Advance Care Plan	NCQA	0326	N		
G1-361	Patients Treated with an Opioid who are Given a Bowel Regimen	RAND Corporation/UCLA	1617	Y	1	
G1-362	Hospice and Palliative Care -- Dyspnea Treatment	University of North Carolina-Chapel Hill	1638	Y	1	
G1-363	Hospice and Palliative Care -- Dyspnea Screening	University of North Carolina-Chapel Hill	1639	Y	1	
G1-364	Patients with Advanced Cancer	RAND Corporation	1628	N		

	Screened for Pain at Outpatient Visits					

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 Medicaid/CHIP and Low Income Uninsured Population:
Individuals receiving primary care services or specialty care services

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

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
H1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	NCQA	0028	N		
H1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17 and to expand to screening for general behavioral health concerns including anxiety)*	CMS	0418	Y	1	
H1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)	NCQA	0108	N		
H1-286	Depression Remission at Six Months *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	MN Community Measurement	0711	Y	3	
H1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	AMA-convened Physician Consortium	2152	Y	1	

	(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)	for Performance Improvement				
TBD	*Innovative Measure Under Consideration:* Engagement in Integrated Behavioral Health	TBD	N/A	N	P4R	

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 Medicaid/CHIP and Low Income Uninsured Population:
Individuals with mental illness, high utilization, and complex needs

Base Points: 6*1.5 (state priority) = 9
Possible Additional Points: A maximum of 6 additional points may be added to this bundle
Maximum Total Possible Points: 15

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
H2-160	Follow-Up After Hospitalization for Mental Illness	NCQA	0576	*(Y)**	*(3)*	+3
H2-216	Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	N/A	N/A	*(Y)**	*(3)*	+3
H2-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)	N/A	N		
H2-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	N		+1
H2-266	Independent Living Skills Assessment for Individuals with Schizophrenia	CQAIMH	N/A	N		+1
H2-305	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)	AMA-PCPI	1365	Y	1	
H2-316	Alcohol Screening and Follow-up for	NCQA	2599	Y	1	

	People with Serious Mental Illness					
H2-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)	AMA-convened Physician Consortium for Performance Improvement	0104	Y	1	
H2-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	N/A	N/A	*(Y)**	*(3)*	+3
*Must select one of either H2-160, H2-216, or H2-387 May select one or more additional from H2-160, H2-216, or H2-387 for an additional 3 points.						

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 Medicaid/CHIP and Low Income Uninsured Population:
Adults with chronic pain

Base Points: 2*2 (high state priority) = 4
Possible Additional Points: 3
Maximum Total Possible Points: 7

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
H3-144	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain *(Denominator subset of chronic pain)*	CMS	0418	N		
H3-197	Use of Opioids at High Dosage - modified denominator	Pharmacy Quality Alliance	2940 (Modified)	N		+3
H3-257	Care Planning for Dual Diagnosis	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)	N/A	N		
H3-287	Documentation of Current Medications in the Medical Record	CMS	0419	Y	1	
H3-288	Pain Assessment and Follow-up	CMS	0420	Y	1	
TBD	*Under Consideration:* Treatment of Chronic Non-Malignant Pain	San Francisco Health Network, Alameda	N/A	N	P4R	

	Management with Multi-Modal Therapy	Health Systems, UC San Diego			
TBD	*Under Consideration:* Patients on long-term opioid therapy checked in prescription drug monitoring programs (PDMPs)	AHRQ/ San Francisco Health Network, Alameda Health Systems, UC San Diego	N/A	N	P4R

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 Medicaid/CHIP and Low Income Uninsured Population:
Individuals with Serious Mental Illness

Base Points: 2*1.5 (state priority) = 3
Possible Additional Points: 0
Maximum Total Possible Points: 3

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
H4-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	NCQA	1932	Y	1	
H4-258	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)	NCQA	1933	N		
H4-260	Annual Physical Exam for Persons with Mental Illness	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)	N/A	Y	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 Medicaid/CHIP and Low Income Uninsured Population:
Adults & Children with chronic and life impacting conditions

Base Points: 2
Possible Additional Points: 0
Maximum Total Possible Points: 2

This bundle can be chosen for different specialties utilizing different tools up to 3 times (for a maximum of 6 points).

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
I1-385	Assessment of Functional Status or QoL (Modified from NQF# 0260/2624)	N/A	N/A	Y	1	
I1-386	Improvement in Functional Status or QoL (Modified from PQRS #435)	N/A	N/A	Y	1	

J1: Hospital Safety

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Individuals receiving inpatient care

Base Points: 8
Possible Additional Points: N/A
Maximum Total Possible Points: 8

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
J1-218	Central line-associated bloodstream infections (CLABSI) rates	CDC	0139	Y	2	
J1-219	Catheter-associated Urinary Tract Infections (CAUTI) rates	CDC	0138	Y	2	
J1-220	Surgical site infections (SSI) rates	CDC	0299	Y	2	
J1-221	Patient Fall Rate	American Nurses Association	0141	Y	2	
J1-222	Severe Sepsis and Septic Shock: Management Bundle	Henry Ford Hospital	0500	N		
J1-372	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Centers for Disease Control and Prevention	1716	N		

K1: Rural Preventative Care

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

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Adults and Children in Rural Areas

Base Points: 3
Possible Additional Points: 4
Maximum Total Possible Points: 7

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
K1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(BAT recommendation to stratify as two rates, ages 18+ and 12 – 17)*	NCQA	0028	Y	1	
K1-112	Comprehensive Diabetes Care: Foot Exam	NCQA	0056	N		
K1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	N		+3
K1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD) *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17 and to expand to screening for general behavioral health concerns including anxiety)*	CMS	0418	N		
K1-268	Pneumonia vaccination status for older adults	CMS	0043	Y	1	
K1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041/ 3070 eMeasure	N		
K1-285	Advance Care Plan	NCQA	0326	Y	1	
K1-287	Documentation of Current Medications in the Medical Record	CMS	0419	N		

K1-300	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)	AMA-PCPI	N/A	N		+1
K1-358	*Under Consideration*: Health literacy measure derived from the health literacy domain of the C-CAT	American Medical Association	1898	N	P4R	

K2: Rural Emergency Care

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

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

Target Medicaid/CHIP and Low Income Uninsured Population:
Adults and Children in Rural Areas

Base Points: 3
Possible Additional Points: N/A
Maximum Total Possible Points: 3

ID	Measure	Steward	NQF #	Required	Required Measures Points	Additional Points
K2-223	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	NCQA	0101	N		
K2-285	Advance Care Plan	NCQA	0326	N		
K2-287	Documentation of Current Medications in the Medical Record	CMS	0419	Y	1	
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	CMS	0497	Y	1	
K2-359	Emergency Transfer Communication Measure	University of Minnesota Rural Health Research Center	0291	Y	1	

Example of a Hospital's Measure Bundle Selection

Please refer to the PFM for details regarding how measure bundle and the measure bundle valuations are determined.

Assumptions for this example:
Hospital's MPT: 40 points
Category C Valuation in DY7: $11,000,000
Performing Provider Type: Hospital, with inpatient

Measure Bundle and Measure Valuation Calculation:

(i) Minimum Measure Bundle Valuation - The valuation for each selected Measure Bundle must be greater than or equal to:

*(Measure Bundle point value/ the sum of all selected Measure Bundles' point values)/ 2 * Category C Valuation*

(ii) Maximum Measure Bundle Valuation - The valuation for each selected Measure Bundle without a 3-point measure must be less than or equal to:

*(Measure Bundle point value/ the sum of all selected Measure Bundles' point values) * Category C Valuation*

There is no maximum valuation for Measure Bundles with at least one 3-point measure.

(iii) Measure Valuation - All measures within a Measure Bundle are valued equally (required measures and any selected optional measures) with the exceptions described in 6(f) and (g).

Bundle Selections	Selected Bundle Required Points + Additional Points	Minimum DY7 Valuation for Each Bundle	Maximum DY7 Valuation for Bundle
A1 Improved Chronic Disease Management: Diabetes Care	12	(12 / 40) / 2 *$11,000,000 = $1,650,000	N/A
B1 Care Transitions & Hospital Readmissions	6	(6 / 40) / 2 * $11,000,000 = $825,000	N/A
C1 Primary Care Prevention - Healthy Texans ***(no 3-point measures)***	9	(9 / 40) / 2 * 11,000,000 = $1,237,500	(9 / 40) * $11,000,000 = $2,475,000
E1 Improved Maternal Care	12 + 1	(13 / 40) / 2 * $11,000,000 = $1,787,500	N/A
Total	40 points (meets MPT)		

Example Measure Bundle and Measure Selections:

Bundle Selections	Measure Selections	Required	Required Measure Points	Additional Points	DY7 Valuation
A1 Measure Selection Summary: 4 required measures; 1 of 5 optional measures selected					
A1 Improved Chronic Disease Management: Diabetes Care	A1-112: Comprehensive Diabetes Care: Foot Exam	Y	1	N/A	$970,000
	A1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Y	3	N/A	$970,000
	A1-116: Comprehensive Diabetes Care: Medical Attention for Nephropathy	N	N/A	N/A	$970,000
	A1-207: Diabetes care: BP control (<140/90mm Hg)	Y	3	N/A	$970,000
	A1-208: Comprehensive Diabetes Care LDL-C Screening	Y	1	N/A	$970,000
	TOTAL A1 Bundle Points *(State Priority)*:		12	Total Selected Valuation:	$4,850,000
B1 Measure Selection Summary: 4 required measures; no optional measures selected					
B1 Care Transitions & Hospitals Readmissions	B1-217 Risk Adjusted All-Cause Readmission	Y	3	N/A	$206,250
	B1-252 Care Transition: Transition Record with Specified Elements Received by Discharged Patients	Y	1	N/A	$206,250
	B1-253 Transition Record with Specified Elements Received by Discharged Patients	Y	1	N/A	$206,250
	B1-287 Documentation of Current Medications in the Medical Record	Y	1	N/A	$206,250
	TOTAL B1 Bundle Points		6	Total Selected Valuation:	$825,000
C1 Measure Selection Summary: 6 required measures; no optional measures selected					
C1 Primary Care Prevention - Healthy Texans	C1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Y	1	N/A	$300,000
	C1-113: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Y	1	N/A	$300,000

	C1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Y	1	N/A	$300,000
	C1-268: Pneumonia vaccination status for older adults	Y	1	N/A	$300,000
	C1-269: Preventive Care and Screening: Influenza Immunization	Y	1	N/A	$300,000
	C1-272: Adults (18+ years) Immunization status	Y	1	N/A	$300,000
	TOTAL C1 Bundle Points *(State Priority):*		9	Total Selected Valuation:	$1,800,000
E1 Measure Selection Summary: 4 required measures; 2 of 5 optional measures selected					
E1 Improved Maternal Care	E1-148: PC-01 Elective Delivery	N	N/A	N/A	$587,500
	E1-150 PC-02 Cesarean Section	Y	1	N/A	$587,500
	E1-193: Contraceptive Care – Postpartum Women Ages 15–44	N	N/A	+1	$587,500
	E1-232: Timeliness of Prenatal/Postnatal Care	Y	1	N/A	$587,500
	E1-235: Post-Partum Follow-Up and Care Coordination	Y	3	N/A	$587,500
	E1-300: Behavioral Health Risk Assessment	Y	1	N/A	$587,500
	TOTAL E1 Bundle Points *(High State Priority)*		12 + 1 (additional points) = 13	Total Selected Valuation:	$3,525,000
Total:			**40 points**		**$11,000,000**

Local Health Department Measures

LHD Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
L1-103	Controlling High Blood Pressure *(BAT Recommendation to allow follow-up home blood pressure readings recorded in E H R/medical record)*	NCQA	0018	3
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	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 eMeasure	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	PQRS #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 (PQRS #336)	CMS	N/A	3
L1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	NCQA	1392	1

LHD Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	None	N/A	3
L1-242	Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)	None	N/A	3
L1-268	Pneumonia vaccination status for older adults	CMS	0043	1
L1-269	Preventive Care and Screening: Influenza Immunization	AMA / PCPI	0041 / 3070 eMeasure	1
L1-271	Immunization for Adolescents- Tdap/TD and MCV (Updated to include HPV)	NCQA	1407	1
L1-272	Adults (18+ years) Immunization status	Institute for Clinical Systems Improvement	N/A	1
L1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	1
L1-343	Syphilis positive screening rates	CDC	N/A	1
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	CDC	N/A	3
L1-345	Gonorrhea Positive Screening Rates	CDC	N/A	1
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	CDC	N/A	3
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	CDC	N/A	3
L1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	N/A	N/A	3

Community Mental Health Center Measure Menu

CMHC Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	3
M1-103	Controlling High Blood Pressure *(BAT Recommendation to allow follow-up home blood pressure readings recorded in E H R/medical record)*	NCQA	0018	3
M1-104	Medical Assistance with Smoking and Tobacco Use Cessation (MSC) - Modified Denominator	NCQA	0027 (Modified)	1
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	NCQA	0028	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) *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17 and to expand to screening for general behavioral health concerns including anxiety)*	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)**
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)	CMS	1879	3
M1-181	Depression Response at Twelve Months- Progress Towards Remission	MN Community Measurement	1885	*(3)**
M1-182	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	NCQA	1932	1

CMHC Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
M1-203	PQRS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	N/A / 3059 eMeasure	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
M1-208	Comprehensive Diabetes Care LDL-C Screening	NCQA	0063	1
M1-210	PQRS #317 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
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 (ADD)	NCQA	0108	3
M1-256	Initiation of Depression Treatment	Center for Quality Assessment and Improvement in Mental Health (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
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	CQAIMH	N/A	1
M1-262	Assessment of Risk to Self/Others	CQAIMH	N/A	1
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients	CQAIMH	N/A	1
M1-264	Vocational Rehabilitation for Schizophrenia	CQAIMH	N/A	1

CMHC Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
M1-265	Housing Assessment for Individuals with Schizophrenia	CQAIMH	N/A	1
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia	C CQAIMH	N/A	1
M1-280	Chlamydia Screening in Women (CHL)	NCQA	0033	1
M1-286	Depression Remission at Six Months *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	MN Community Measurement	0711	*(3)**
M1-287	Documentation of Current Medications in the Medical Record	CMS	0419	1
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	2801	1
M1-316	Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA	2599	1
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling *(BAT recommendation to stratify as two rates, ages 18+ and 12 - 17)*	AMA-convened Physician Consortium for Performance Improvement	2152	1
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)	AMA-convened Physician Consortium for Performance Improvement	0104	1
M1-339	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	The Joint Commission	1664	1
M1-340	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.	APA/ NCQA/ PCPI	N/A	1

CMHC Measures				
ID	**Measure**	**Steward**	**NQF #**	**Points**
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
M1-342	Time to Initial Evaluation	SAMHSA/ CCBHC	N/A	1
M1-385	Assessment of Functional Status or QoL (Modified from NQF# 0260/2624) *Specific to IDD Services*	N/A	N/A	1
M1-386	Improvement in Functional Status or QoL (Modified from PQRS #435) *Specific to IDD Services*	N/A	N/A	1
M1-387	Reduce Emergency Department visits for Behavioral Health and Substance Abuse (Reported as two rates)	N/A	N/A	3

**If more than one of M1-165, M1-181, and/or M1-286 are selected, only 3 points will be added to meet MPT.*

Example of a CMHC's Measure Bundle Selection

Please refer to the PFM for details regarding how measure bundle and the measure bundle valuations are determined.

Assumptions for this example:
CMHC's MPT: 15 points
Category C Valuation in DY7: $4,125,000
Performing Provider Type: Community Mental Health Center

Measure Valuation Calculation:

(i) Minimum Measure Valuation - no single measure is allocated a valuation that is less than half of its initial measure valuation

((Total Category C valuation/Number of measures selected) /2)

(ii) Maximum Measure Valuation - no single non-3 point measure is allocated a valuation that exceeds its initial measure valuation:

(Total valuation/Number of measures selected)

There is no maximum valuation for 3-point Measures.

Measure Selection	Measure Points	Minimum DY7 Valuation	Max DY7 valuation	Selected DY7 Valuation
M1-165: Depression Remission at 12 Months	3	($4,125,000/10)/2 =$206,250	N/A	$450,000
M1-181: Depression Response at Twelve Months- Progress Towards Remission	(3)*		N/A	$650,000
M1-241: Decrease in MH admissions and readmissions to criminal justice settings	3		N/A	$550,000
M1-257: Care Planning for Dual Diagnosis	1		($4,125,000/10) =$412,500	$300,000
M1-259: Assignment of Primary Care Physician to Individuals with Schizophrenia	1			$250,000
M1-260: Annual Physical Exam for Persons with Mental Illness	1			$362,500
M1-265: Housing Assessment for Individuals with Schizophrenia	1			$206,250
M1-340: Substance use disorders	1			$343,750
M1-342: Time to Initial Evaluation	1			$412,500
M1-387: Reduce ED visits for Behavioral Health and Substance Abuse	3		N/A	$600,000
TOTAL	**15 points**			**$4,125,000**

*M1-181 functions as 3-point measures for valuation, but does not count towards meeting the MPT.

Category D: Population-Focused Improvements

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

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

Category D Structure:

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

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

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

Statewide Reporting Measure Bundles

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

All hospital performing providers must report on the Category D Statewide Hospitals Reporting Measure Bundle 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, unless for certain measures the provider does not have statistically valid data.

Certain hospital performing providers may report 0 if they do not have statistically valid data for the required measures as defined by the measure. Hospitals will need to describe a reason for reporting 0 on the required measures.

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

4. Potentially Preventable ED visits (PPVs)

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

PPV by Category

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

5. Patient Satisfaction

The reporting of the measures must be limited to the inpatient setting only.

Each HCAHPS theme includes a standard set of questions. The following HCAHPS themes will be reported on:

- Your care from doctors;
- Your care from nurses;
- The hospital environment; when you left the hospital.
  Data Source: HCAHPS296

Community Mental Health Center Statewide Reporting Measure Bundle

Community Mental Health Centers (CMHCs) must report on the following measures and provide qualitative reporting as required by HHSC:

1. Effective Crisis Response

a. The percentage of individuals receiving crisis services who avoid admission to a HHS Operated or Contracted Inpatient Bed within 30 days of the start of the crisis episode.
b. Calculation: (Numerator/Denominator)*100
    i. Numerator: The number of persons with crisis episodes that avoid admission into HHS Operated or Contracted Inpatient Beds within 30 days of the first day of the crisis episode
    ii. Denominator: The number of crisis episodes
c. Exclusion(s)/Exception(s):
    i. Crisis Stabilization Units (CSU), Extended Observation Units (EOU), Crisis Respite, Crisis Residential and Rusk and Vernon forensic locations.
    ii. Children in a Level of Care (LOC)-Y (YES Waiver).
    Data Source: CARE, CMBHS and MBOW

2. Crisis Follow up

a. The percentage of persons with a mental health community LOC-A = 5 who receive a Crisis Follow-Up service encounter within 30 days.
b. Calculation: (Numerator/Denominator)*100
    i. Numerator: The number of persons with a mental health community Level of Care (LOC)-A = 5, who receive an authorized service encounter or are authorized to a Full Level of Care (FLOC) within 30 days
    ii. Denominator: The number of persons with a mental health community LOC-A = 5
c. Exclusion(s)/Exception(s): N/A
    Data Source: CARE system and MBOW (MBOW report found in the Contract Performance Measures)

3. Adult Community Tenure

a. The percentage of adults in a FLOC that avoid hospitalization in a HHS Operated or Contracted Inpatient Bed after authorization into Full Level of Care (FLOC)

b. Calculation: (Numerator/Denominator)*100
    i. Numerator: All adults authorized in a FLOC during the measurement period who avoid hospitalization in a HHS Operated or Contracted Inpatient Bed after authorization into a FLOC
    ii. Denominator: All adults authorized in a FLOC during the measurement period
c. Exclusion(s)/Exception(s):
    i. Crisis Stabilization Units (CSU) -including Hill Country, Extended Observation Units (EOU), Crisis Respite, Crisis Residential and Rusk and Vernon forensic locations
    ii. Measurement period is six months.

Data Source: CARE, CMBHS and MBOW.

4. Child and Youth Community Tenure

a. The percentage of children and youth in a FLOC avoiding psychiatric hospitalization in a HHS Purchased Inpatient Bed after authorization into a FLOC
b. Calculation: The percentage of children/youth authorized in a FLOC who avoid hospitalization in a HHS Purchased Inpatient Bed Day after authorization into a FLOC
    i. Numerator: The number of children and youth authorized in a FLOC who avoided hospitalization in a HHS Purchased Inpatient Bed after authorization into a FLOC
    ii. Denominator: All children and youth authorized in a FLOC during the measurement period

    Data Source: CMBHS and MBOW

5. Juvenile Justice Avoidance

a. Percent of children/youth enrolled in a FLOC showing no arrests (acceptable) or a reduction of arrests (improving) from time of first assessment to time of last assessment within the measurement period (with assessments occurring at least 75 days apart)
b. Calculation: (Numerator/Denominator)*100
    i. Acceptable Juvenile Justice Involvement Avoidance
        1. Numerator: The number of children and youth recommended and authorized for a FLOC, whose latest number of arrests is 0 and whose previous number of arrests is 0
        2. Denominator: All children and youth recommended and authorized for a FLOC who have at least two number of arrests ratings.
    ii. Improving Juvenile Justice Involvement Avoidance
        1. Numerator: The number of children and youth recommended and authorized for a FLOC, whose latest number of arrests rating is less than their previous number of arrests rating.
        2. Denominator: All children and youth recommended and authorized for a FLOC who have at least two number of arrests ratings.

    Data Source: This measure utilizes the Arrests Item from the community data section of the Uniform Assessment.

6. Adult Jail Diversion[1]

a. Calculation: (Numerator/Denominator)*100

[1] This measure maybe modified at the end of DY7-8. CMHCs will report based on the modified measure specification once approved by HHSC.

i. Numerator: The number of valid TLETS bookings in the local service area with a CARE match multiplied by the LMHA's equity factor. The match criterion is 5 of the 6 elements must match. Elements include: first name; last name; date of birth; race; gender; and social security number. If the unmatched element is the social security number at least 7 of the 9 digits in the social security number must match. Additionally, matched consumers must have an associated Continuity of Care Match.
ii. Denominator: The number of valid TLETS bookings in the local service area. A valid booking is one that includes all 6 of the elements.
iii. Equity factor: The LMHA's per capita funding rate (excluding funding for hospital beds and Hospitality House) divided by the per capita funding rate of the LMHA with the highest per capita funding rate.
iv. Exclusion(s)/Exception(s): N/A

Data Source: Texas Law Enforcement Telecommunications System (TLETS), CARE, CMBHS, and MBOW.

Physician Practices Statewide Reporting Measure Bundle

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

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

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

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

Local Health Departments Statewide Reporting Measure Bundle

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

- Access to health care services: time since routine check up
- Health status of the population: high blood pressure status, diabetes status, overweight or obese, smoker status
- Selected vaccinations: flu shot past year

Additional information on BRFSS is available in Appendix A.

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

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. 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?

Appendix A

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

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