Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8

As Required by House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 38)

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Executive Summary

In compliance with the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 38), this report provides an overview of data and performance by performing providers in the Delivery System Reform and Incentive Payment (DSRIP) program.

The DSRIP program is authorized under the 1115 Texas Healthcare Transformation and Quality Improvement Program waiver. It provides incentive payments to providers to support enhanced access to healthcare, quality of care, and the health of patients and families served.

For the initial demonstration period or demonstration years (DYs) 1-5 (December 12, 2011 through September 30, 2016) of the waiver, a total of $11.4 billion was made available to approximately 300 providers. They included:

- Public and private hospitals;
- Physician groups, primarily affiliated with academic health science centers;
- Community mental health centers (CMHCs); and,
- Local health departments (LHDs).

For DYs 6-10 (October 1, 2016 through September 30, 2021), an additional $14.7 billion dollars was made available to providers.

The following sections describe high-level findings for each component of the Rider 38:

- ***Category C Measure Bundles and Measures Selected by Performing Providers for DYs 7-8.*** The measures most commonly selected by DSRIP providers for DYs 7-8 were:
  - Tobacco screening and cessation intervention;
  - Diabetes foot exam;
  - Diabetes hemoglobin A1c (HbA1c) poor control;
  - Body Mass Index (BMI) screening and follow-up;
  - Diabetes blood pressure control;
  - Pneumonia vaccination status for older adults; and,

- Documentation of current medications in the medical record.

- ***DSRIP Performing Provider Core Activities.*** Core Activities are activity implemented by providers to achieve their measure goals. The most commonly selected core activities were:
  - Access to Primary Care Services - Provision of screening and follow-up services (56 selections);
  - Chronic Care Management - Management of targeted patient populations with high risk for developing complications (45 selections); and,
  - Chronic Care Management - Utilization of care management and/or chronic care management services (43 selections).

- ***DSRIP Performing Provider Performance on Selected Measure Bundles and Measures for DY8.*** Providers reported data for 2,364 pay-for-performance (P4P) measures for calendar year 2019 (CY19). Of these 2,364 measures, providers reported:
  - 100 percent achievement of the DY 8 goal for 77 percent of measures;
  - Partial achievement for 9 percent of measures; and,
  - No achievement for 14 percent of measures.
  - In CY19, most P4P measures showed an increase in the median performance rate as compared to, the baseline year 2017, which indicates overall improvement in provider performance on their reported measures.

- ***Core Activities and Related Strategies Associated with Successful Category C Measure Performance.*** The 5 Core Activities associated with the greatest number of high-performing P4P measures are:
  - Availability of Appropriate Levels of Behavioral Health Care Services - Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model;
  - Access to Primary Care Services - Provision of screening and follow-up services;
  - Chronic Care Management – Utilization of care management and/or chronic care management services, including education in chronic disease self-management;
  - Chronic Care 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; and,

- Access to Primary Care Services - Provision of services to individuals that address social determinants of health.

- ***Summary of Final Costs and Savings Analyses.*** In October 2019, providers with a valuation of $1 million or more submitted their Cost and Savings analyses as required under Category A reporting. Of the 203 completed analyses[1]:
  - 174 (86 percent) showed that investment in Core Activities produced a positive return on investment (ROI) to the healthcare system;
  - 26 (13 percent) showed that investment in Core Activities did not produce a positive ROI; and,
  - Three (1 percent) showed that the savings generated by Core Activities were equal to the costs associated with implementing it.

- ***Core Activities with a Positive ROI.*** The types of Core Activities that reported a positive ROI varied significantly among providers.
  - At least 35 percent of Core Activities with a positive ROI provided care management and other services to individuals with chronic conditions, predominately diabetes;
  - At a minimum, 16 percent of Core Activities with a positive ROI addressed individuals' behavioral health service needs; and,
  - 13 percent managed the care of individuals who had frequent visits to emergency departments (EDs).

- ***DSRIP Valuation, Funds Earned and Paid for DYs 7-8.*** As of July 2020, DSRIP providers received a total of approximately:
  - $3.0 billion in DSRIP funds for DY 7, and,
  - $2.6 billion for DY 8.

Overall, the data indicate that the DSRIP program has laid a solid foundation of quality improvement, upon which Texas may continue to pursue healthcare delivery reform and advance value in the Medicaid program.

[1] This report only includes the 203 submissions that were complete and met all HHSC requirements.

1. Introduction

In compliance with the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 38), HHSC must report on outcomes achieved by performing providers in the DSRIP program. The report must provide the following for DYs 7 and 8[2]:

1. Describe the Measure Bundles and measures selected by performing providers;
2. Describe the Core Activities associated with the selected Measure Bundles and measures;
3. Describe performing providers' performance on their selected Measure Bundles and measures;
4. Identify the Core Activities that are associated with successful performing provider performance;
5. Include a summary of the final Costs and Savings;
6. Identify Core Activities with a positive ROI based on final Costs and Savings; and,
7. Identify the amount of DSRIP funds earned by each type of performing provider.

HHSC must submit the report to the Governor, Legislative Budget Board, and permanent committees in the House of Representatives and Senate with jurisdiction over health and human services by December 1, 2020.

HHSC conducted analyses of DSRIP data for DYs 7-8 to meet the requirements of the Rider. Measure Bundles and measure performance reflect data reported to HHSC by performing providers as of July 2020.

[2] Federal Fiscal Years 2018 and 2019.

2. Background

On December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) approved Texas' request for a new Medicaid demonstration waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" in accordance with section 1115 of the Social Security Act.

This waiver authorized the establishment of the DSRIP program. The DSRIP program provides incentive payments to performing providers to support enhanced access to healthcare, quality of care, and the health of patients and families served.

The initial waiver was approved through September 30, 2016. An initial extension was granted through December 31, 2017. On December 21, 2017, CMS granted a five-year extension of the waiver through September 30, 2022, including a four-year extension of the DSRIP program through September 30, 2021.

For the initial demonstration period, or DYs 1-5 (December 12, 2011 through September 30, 2016), a total of $11.4 billion was made available to approximately 300 DSRIP providers. The following types of providers participate in the program:

- Public and private hospitals;
- Physician groups, primarily affiliated with academic health science centers;
- CMHCs; and,
- LHDs.

DSRIP providers are organized across the state into 20 Regional Healthcare Partnerships (RHPs). The RHPs are based on distinct geographic boundaries that generally reflect patient flow patterns for the region. Appendix A provides a map of the RHPs.

Each RHP has an anchoring entity (or "anchor") that serves as an administrative liaison to HHSC, provides technical assistance to DSRIP providers in the region, and helps coordinate RHP activities.

DSRIP payments to providers are funded by federal funds matched to intergovernmental transfers (IGTs) from providers or partnering entities. IGTs must be public funds, such as tax revenue from a county or hospital district or General Revenue appropriated to a governmental entity.

For DYs 1-5, providers implemented approximately 1,450 projects from 4 categories:

- infrastructure development;
- program innovation and redesign;
- quality improvements; and,
- population-based improvements.

Providers earned payments primarily based on their achievement of project metrics.

For DYs 6-10 (October 1, 2016 through September 30, 2021), CMS made an additional $14.7 billion dollars available to providers. Beginning in DY 7, DSRIP fundamentally changed from payment based on providers' achievement of project metrics to payment based on providers' performance on selected outcome measures.

In DYs 7-8, a provider's valuation (the total amount of money available for the provider to earn) was equal to its DY 6 valuation with a small number of exceptions. Providers were required to report data, demonstrate achievement, and provide qualitative information across the following four DSRIP categories to earn their valuation:

- Category A - Required reporting that includes progress on Core Activities, Alternative Payment Model (APM) arrangements, costs and savings, and collaborative activities;
- Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP);
- Category C - Measure Bundles and Measures; and,
- Category D - Statewide Reporting Measure Bundle (population health measures)

Table 1 shows the funding distribution for each category.

Table 1. DSRIP Funding and Basis for Payment by Category for DYs 7-10

	DY 7	DY 8	DYs 9-10	Basis for Payment
RHP Plan Update	20%	0%	0%	Submission of the RHP Plan Update, which includes providers' Category C Measure Bundle and measures selections, Category A Core Activity selections, and associated payment amounts.
Category A - Required Reporting	0%	0%	0%	Category A reporting is required for a provider to be eligible for payment for Categories B-D but has no payment tied directly to the reporting.
Category B - MLIU PPP	10%	10%	10%	Maintaining or increasing the number of MLIU individuals served by the provider's system.
Category C - Measure Bundles and Measures	55%	75%	75%	Reporting and performance on selected health outcome measures.
Category D - Statewide Reporting Measure Bundle	15%	15%	15%	Reporting on certain population health measures.

3. Category C Measure Bundles and Measures Selected by Performing Providers

For DYs 7-8, DSRIP performing providers specified their planned areas of improvement by selecting Category C Measure Bundles or measures from a menu based on their provider type. Hospitals and physician practices primarily selected Measure Bundles, and CMHCs and LHDs selected individual measures.

For hospitals and physician practices, Measure Bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Each Measure Bundle has a target population (or pool of people) for which the provider system is accountable for improvement under the DSRIP incentive arrangements. For example, the target population for Measure Bundle A1 Diabetes Care is adults with diabetes within the provider's system.

Each measure has a Measure Class that helps identify the focus of improvement:

- Clinical Outcome: Measures of improvement in patient health status or utilization patterns;
- Population Based Clinical Outcome (PBCO): Rates of ED utilization or hospital admissions for a population;
- Process: Measures of clinical practice including how a provider delivers care;
- Hospital Safety: Rates of hospital infection and safety issues;
- Quality of Life: Measures of improvement in an individual's quality of life or functioning;
- Cancer Screening: Measures of adherence to cancer screening guidelines; and,
- Immunization: Measures of adherence to immunization guidelines.

Appendix B provides a complete list of DSRIP Category C Measure Bundles and measures for DYs 7-8 and the number of providers that selected each Measure Bundle and measure. The individual measures most commonly selected by providers were:

- Tobacco screening and cessation intervention;
- Diabetes foot exam;
- Diabetes HbA1c poor control;
- BMI screening and follow-up;

- Diabetes blood pressure control;
- Pneumonia vaccination status for older adults; and,
- Documentation of current medications in the medical record.

Best Practices Workgroup: Key Category C Measures

In January 2020, a Best Practices Workgroup consisting of more than 80 DSRIP provider representatives, DSRIP anchor representatives, and other stakeholders convened to support the sustainability of delivery system reform best practices and the development of the next phase of delivery system reform in Texas. The Workgroup's first task was to prioritize DSRIP Category C measures identified as key to driving improvements in the health status of clients. Workgroup members were surveyed on 41 measures that aligned with priority focus areas from HHSC's DSRIP Transition Plan[3].

Workgroup members prioritized measures as key drivers of improvements in the health status of clients and ranked the priority of key measures. The top 10 key measures were:

1. Diabetes HbA1c poor control;
2. Diabetes blood pressure control;
3. Cancer screening;
4. Cardiovascular disease blood pressure control;
5. Follow-up after hospitalization for mental illness;
6. Age appropriate screening for clinical depression or suicide risk;
7. Pediatric and adolescent immunization status;
8. Post-partum follow-up and care coordination;
9. Medication reconciliation; and,
10. Maternal screening for behavioral health risks.

Additionally, members ranked the top 3 key measures by various focus areas. Different key measures were prioritized for each focus area. Across all focus areas, the most frequently ranked key measures were:

[3] The CMS approved DSRIP Transition Plan can be found at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf

- Diabetes HbA1c poor control;
- Diabetes blood pressure control; and,
- Cardiovascular disease high blood pressure control.

The full list of the 41 measures and the degree of consensus on their priority can be found in Appendix C. Performance on these measures can be found in Appendix F.

4. DSRIP Performing Provider Core Activities

Core Activities are activity implemented by DSRIP performing providers to achieve Category C measure goals. A provider must select and report on at least one Core Activity that supports the achievement of its Category C measure goals. Providers may, but are not required to, select Core Activities from the menu developed by HHSC. There is no maximum number of Core Activities that providers may select. A provider must connect each Category C measure bundle or measure to a Core Activity.

HHSC worked with providers to update reported Core Activities in Fall 2019. The DY 9 Core Activities information is the most up-to-date and was used for this report. Table 2 shows the number of Core Activities selected by provider type in DY 9.

Table 2. Number of Active Core Activities in DY 9 by Provider Type

Provider Type	Number of Active Core Activities
Hospitals	443
CMHCs	89
Physician Practices	67
LHDs	60
Total	659

Table 3 shows the number of Core Activities selected by Core Activity Grouping (from the Measure Bundle Protocol). As shown, 62 percent of all Core Activities selected are from 4 Core Activity Groupings:

- Access to Primary Care Services;
- Chronic Care Management;
- Expansion of Patient Care Navigation and Transition Services; and,
- Behavioral Health Care Services.

Table 3. Number of Core Activities Selected in DY 9 by Core Activity Grouping

Core Activity Grouping	Number of Core Activities Selected
Access to Primary Care Services	131
Chronic Care Management	129
Expansion of Patient Care Navigation and Transition Services	88
Behavioral Health Care Services	62
Prevention and Wellness	61
Hospital Safety and Quality	52
Maternal and Infant Health Care	47
Behavioral Health Crisis Stabilization Services	21
Palliative Care	20
Patient Centered Medical Home	19
Access to Specialty Care Services	16
All Other including Oral Health Services, Substance Use Disorder and Other	13
Total	659

Appendix D includes a list of all 54 core activities selected by providers for DY 9. The 11 core activities in Table 4 represent more than 50 percent of all selected core activities.

Table 4. Most Commonly Selected Core Activities

Core Activity Grouping	Core Activity	Number of Core Activity Selections	Percent of All Core Activities Selected
Access to Primary Care Services	Provision of screening and follow up services	56	8%
Chronic Care Management	Management of targeted patient populations with high risk for developing complications	45	7%
Chronic Care Management	Utilization of care management and/or chronic care management services	43	7%
Multiple Groupings[4]	Provision of services to individuals that address social determinants of health	34	5%
Access to Primary Care Services	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)	26	4%
Hospital Safety and Quality	Implementation of evidence-based practices to improve quality of care	26	4%
Hospital Safety and Quality	Implementation of standard protocols to address leading cause of hospital infections and injuries	26	4%
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes	25	4%
Maternal and Infant Health Care	Implement standard protocols for the leading causes of preventable death and complications for mothers and infants	24	4%
Access to Primary Care Services	Provision of vaccinations to target population	24	4%

[4] Reflected in 7 Core Activity Groupings including Chronic Care Management, Availability of Appropriate Levels of Behavioral Health, Maternal and Infant Health Care among others.

Core Activity Grouping	Core Activity	Number of Core Activity Selections	Percent of All Core Activities Selected
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of care aligned with CCBHC model	22	3%

Core Activities by Provider Type in DY 9

Hospitals

Hospitals are reporting on 443 Core Activities, or 67 percent of all Core Activities. While hospitals' Core Activities are from 13 Core Activity Groupings, 70 percent of all hospitals' Core Activities are from the following 4 Core Activity Groupings:

- ***Chronic Care Management*** – 110 Core Activities, including:
  - Management of targeted populations with chronic diseases, which could incorporate utilization of patient portals and medication management; and,
  - Provision of services to individuals that address social determinants of health.
- ***Expansion of Patient Care Navigation and Transition Services*** – 77 Core Activities, including:
  - Coordination between primary care, urgent care, and EDs;
  - Implementation of care transition and/or a discharge planning programs; and,
  - Provision of navigation services to targeted patients, such as individuals with high ED utilization.
- ***Access to Primary Care Services*** – 73 Core Activities, including:
  - Provision of preventive services such as screening and vaccinations; and,
  - Increasing access to services through increasing available hours, use of telemedicine, or provision of services by alternative clinical staff.
- ***Hospital Safety and Quality*** - 52 Core Activities, including:
  - Implementation of protocols to address leading causes of hospital infections and injuries; and,
  - Implementation of evidence-based practices to improve quality of care.

Hospitals are also conducting 24 behavioral health-related Core Activities that:

- Integrate primary and behavioral health services;
- Provide crisis stabilization services, including community-based alternatives; and,
- Use telemedicine services.

Community Mental Health Centers (CMHCs)

CMHCs are reporting on 89 Core Activities, or 14 percent of all Core Activities. While CMHCs' Core Activities are from 8 Core Activity Groupings, 87 percent of all CMHCs' Core Activities are from the following 4 Core Activity Groupings:

- ***Availability of Appropriate Levels of Behavioral Health Care Services*** – 40 Core Activities, including:
  - Provision of care aligned with the CCBHC model;
  - Utilization of telehealth/telemedicine to deliver behavioral health services; and,
  - Utilization of care management function.
- ***Access to Primary Care Services*** – 14 Core Activities, including:
  - Integration of behavioral and primary care services; and,
  - Provision of screening and follow up services.
- ***Prevention and Wellness*** - 14 Core Activities, including:
  - Education and use of self-management programs;
  - Implementation of strategies to empower patients to make lifestyle changes including strategies to reduce tobacco use;
  - Utilization of whole health peer support; and,
  - Provision of services that address social determinants of health.
- ***Behavioral Health Crisis Stabilization Services*** - 9 Core Activities, including:
  - Implementation of community-based crisis stabilization alternatives; and,
  - Implementation of models supporting recovery of individuals in need of behavioral health services.

Other Core Activities that CMHCs are reporting on include patient care navigation services and office-based treatment for individuals with substance use disorder.

Physician Practices

Physician practices are reporting on 67 Core Activities, or 10 percent of all Core Activities. While physician practices' Core Activities are from 11 Core Activity

Groupings, 63 percent of all physician practices' Core Activities are from the following 4 Core Activity Groupings:

- ***Access to Primary Care Services*** – 18 Core Activities, including:
  - Provision of preventive services such as screening and vaccinations;
  - Increase in access to services through increase of available hours, use of telemedicine, and provision of services by alternative clinical staff; and
  - Integrated physical and behavioral health care services.
- ***Chronic Care Management*** – 10 Core Activities, including:
  - Management of targeted populations with chronic diseases, which could include medication management; and
  - Provision of services to address social determinants of health.
- ***Prevention and Wellness*** - 7 Core Activities, including:
  - Education and use of self-management programs;
  - Implementation of strategies to empower patients to make lifestyle changes;
  - Utilization of whole health peer support; and,
  - Utilization of community health workers.
- ***Maternal and Infant Health Care*** - 7 Core Activities, including:
  - Implementation of protocols for the leading causes of preventable death and complications;
  - Implementation of strategies to reduce low birth weight and preterm birth; and,
  - Provision of services to address social determinants of health.

Local Health Departments (LHDs)

LHDs are reporting on 60 Core Activities, or nine percent of all Core Activities. While LHDs' Core Activities are from 9 Core Activity Groupings, 67 percent of all LHDs' Core Activities are from the following 2 Core Activity Groupings:

- ***Access to Primary Care Services*** – 26 Core Activities, including:
  - Provision of preventive services such as screening and vaccinations;
  - Increasing access to services through increasing available hours, use of telemedicine and mobile clinics, and provision of services by alternative clinical staff; and
  - Utilization of care coordination and referral management.
- ***Prevention and Wellness*** - 14 Core Activities, including:
  - Implementation of strategies to empower patients to make lifestyle changes programs, including strategies to reduce tobacco use;

- Implementation of wellness and self-management programs;
- Implementation of evidence-based strategies to reduce sexually transmitted diseases; and,
- Utilization of whole health peer support.

Best Practices Workgroup: Key Practices

In addition to prioritizing DSRIP Category C measures key to driving improvements in the health status of clients, the Best Practices Workgroup was also tasked with prioritizing practices from DSRIP that have been key to driving improvements in the health status of clients within focus areas and populations for continued delivery system reform and quality improvement.

Best Practices Workgroup members were surveyed on a total of 40 practices that were most commonly implemented by DSRIP providers or associated with measures that the workgroup identified as key measures.[5] The top 10 prioritized key practices are:

1. Pre-visit planning and/or standing order protocols;
2. Care team includes personnel in a care coordination role not requiring clinical licensure;
3. Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist;
4. Automated reminders/flags within the electronic health record or other electronic care platform;
5. Same-day and/or walk-in appointments in the outpatient setting;
6. Integration or co-location of primary care and psychiatric services in the outpatient setting;
7. Care team includes personnel in a care coordination role requiring clinical licensure;
8. Culturally and linguistically appropriate care planning for patients;
9. Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting; and,

[5] The 40 practices reviewed by the Best Practices Workgroup were taken from Related Strategy reporting submitted in 2019. Related Strategy reporting is described in a later section in this report: Core Activities and Related Strategies Associated with Successful Category C Measure Performance - Related Strategies and Category C Successful Performance.

10. Panel management and/or proactive outreach of patients using a gap analysis method.

5. DSRIP Performing Provider Performance on Selected Measure Bundles and Measures for Demonstration Years 7-8

DSRIP performing providers earn incentive payments by achieving their goals for their selected Category C P4P measures. Providers establish their baseline performance with one calendar year of data for each measure. The measure goal for each program year is set as an improvement over the baseline. Each year, the percentage of improvement required to meet the goal increases. The exact percentages required for improvement by year can be found in the DSRIP Program Funding and Mechanics Protocol.[6]

Providers earn incentive payments for either full or partial achievement of a measure's goal. Full, or 100 percent, achievement is when a measure meets or exceeds its goal for a performance year (PY).[7] If a provider does not achieve 100 percent of a measure's goal, they can earn partial achievement at 25 percent, 50 percent, or 75 percent increments.

Category C Pay-for-Performance Measure Goal Achievement

As indicated in Table 16 of Appendix E, of the 2,364 measures with data reported for PY 2, (calendar year 2019), providers reported 100 percent achievement of the DY 8 goal for 77 percent of measures, partial achievement for 9 percent of measures, and no achievement for 14 percent of measures.

The table also shows variance in achievement by measure class. The Process, Cancer Screening, and Immunization measure classes had the highest rates of

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[6] The DSRIP Program Funding and Mechanics Protocol is available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/final-attachment-j-pfm-protocol-dy9-10.pdf

[7] A performance year is the calendar year of data used to demonstrate achievement of a goal for a DY. Performance Year (PY) 1 is January 1, 2018 – December 31, 2018 and is used to measure DY7 goal achievement. PY2 is January 1, 2019 – December 31, 2019 and is used to measure DY8 goal achievement.

measures fully achieving their goal, with over 75 percent of measures in each class demonstrating 100 percent achievement of the goal. The Hospital Safety and PBCO measure classes had the lowest rate of measures fully achieving their DY 8 goal, but had over 50 percent of measures with full goal achievement.

Performance varied between provider type, as indicated in Table 17 in Appendix E. CMHCs reported full achievement of 88 percent of measures, physician practices reported full achievement of 83 percent of measures, LHDs reported full achievement of 79 percent of measures, and hospitals reported full achievement of 72 percent of measures.

As Table 18 in Appendix E shows, there was also variation in performance between hospitals based on the type of ownership (public or private) and location (rural or non-rural). Public hospitals (both rural and non-rural) reported full achievement of the greatest percentage of measures (76 percent), while private rural hospitals reported full achievement of the lowest percentage of measures (68 percent).

Combining measure class and provider type provides more insight on the differences observed in goal achievement, as shown in Table 19 in Appendix E. Among all provider types, LHDs reported the highest rate of full goal achievement of Clinical Outcome measures (88 percent), but also reported the lowest rate of full goal achievement of Immunization measures (57 percent). CMHCs reported the highest rate of full goal achievement of Process measures. Hospitals and physician practices reported the highest rate of full goal achievement of Cancer Screening measures (79 percent and 78 percent).

Table 20 in Appendix E shows the differences in goal achievement among hospitals by measure class, and hospital ownership and location. Non-rural hospitals reported higher rates of full goal achievement of Cancer Screening measures (85 percent), while rural hospitals reported lower rates of full goal achievement of Cancer Screening measures (62 percent). Immunization measures also showed significant variation, with public rural hospitals reporting the highest rate of full goal achievement (83 percent) and private rural hospitals reporting the lowest rate of full goal achievement (63 percent). There was no difference in rates of full goal achievement for Immunization measures between public and private non-rural hospitals (77 percent).

Table 21 in Appendix E shows the goal achievement levels across the 20 RHPs.

Category C Performance Improvement from 2017 to 2019

In 2019, most Category C P4P measures showed an increase in the median performance rate reported by providers as compared to 2017, the baseline year, which indicates improvement overall in provider performance on their reported measures. Of the 188 measures that have one or more providers reporting 2019 data, 177 measures showed an improvement in the median rate, while 11 measures showed a worsening in the median rate. Median rates by measure for each reported payer type are shown in Table 22 (Appendix F).

Of the most commonly selected measures, process measures reported by CMHCs showed the greatest amount of improvement in the median rate between 2017 and 2019. Process measures may commonly show a significant amount of improvement in a short period of time, particularly for providers that have no prior experience with implementing or documenting a measured screening or clinical practice. Measures with the greatest amount of improvement in the median reported rate between 2017 and 2019 are:

- Assessment for psychosocial issues of psychiatric patients;
- Independent living skills assessment for individuals with schizophrenia;
- Documentation of current medications in the medical record;
- Unhealthy alcohol use screening & brief counseling; and,
- Counseling for psychosocial and pharmacologic treatment options for opioid addiction.

Clinical Outcome measures showing the greatest improvement were more likely to be related to behavioral health; 3 measures focus exclusively on behavioral health outcomes, one measure includes a component of post-partum depression screening, and one measure focuses on diabetes outcomes for adults served by CMHCs. The commonly selected Clinical Outcome measures with the greatest amount of improvement in the median reported achievement rate between 2017 and 2019 are:

- Post-partum follow-up and care coordination;
- Depression remission at six months;
- Initiation and engagement of alcohol and other drug dependence treatment;
- Diabetes HbA1c poor control (>9.0%); and,
- Follow-up after hospitalization for mental illness.

DSRIP Population and Category C Performance Measurement

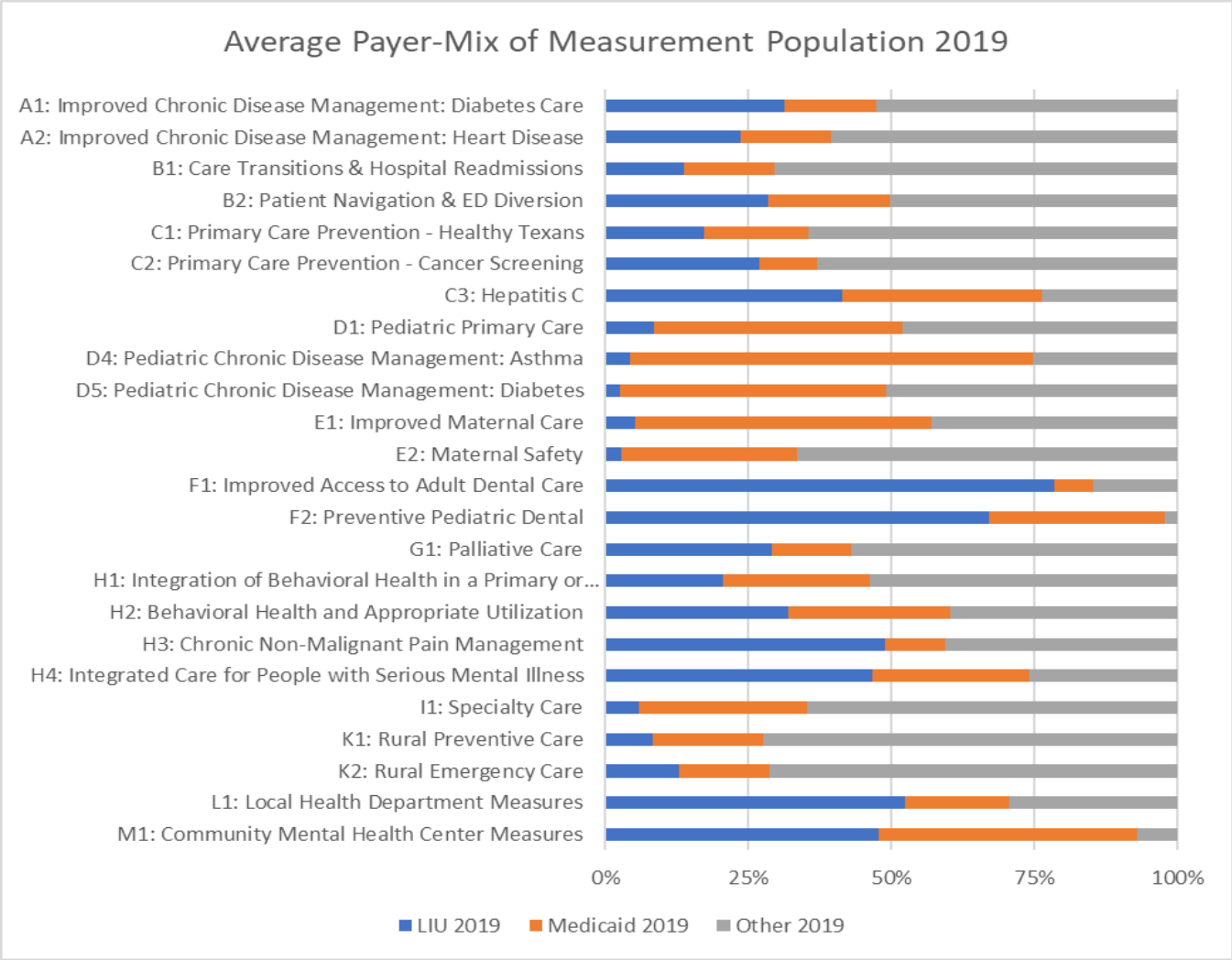
DSRIP providers report separate Category C measure rates for the clients they serve that are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), clients that are low-income or uninsured (LIU), as well as a rate for all clients regardless of payer type. The "Other" payer type includes Medicare and commercial insurance. For most measures, data for other payer types is reported for informational purposes only and is not included in the calculations to determine incentive payments. Figure 1 shows the percentage distribution by payer type of the measured Category C population by Measure Bundle.

Measures focused on care for children show a higher rate of the measured population is enrolled in Medicaid or CHIP. Measures focused on care for adults show a higher rate of the measured population is LIU.

As shown in Table 23 (Appendix G), Measure Bundle F1 Improved Access to Adult Dental Care has the highest rate of clients that are LIU (79 percent), while Measure Bundle D4 Pediatric Chronic Disease Management: Asthma has the highest rate of clients that are enrolled in Medicaid or CHIP (71 percent).

CMHC measures and Measure Bundle F2 Preventive Pediatric Dental report the lowest rate of people enrolled with a payer other than Medicaid or CHIP, and Measure Bundles K1 Rural Preventive Care and K2 Rural Emergency Care report the highest rate of people enrolled with a payer other than Medicaid or CHIP.

Figure 1. Payer Type of Measured Category C Population by Measure Bundle



Note: See Appendix G for data.

6. Core Activities and Related Strategies Associated with Successful Category C Measure Performance

Core Activities Most Commonly Associated with High Performance on Category C Pay-for-Performance (P4P) Measures

Table 5 shows the 5 Core Activities associated with the greatest number of high-performing Category C P4P measures. Appendix H describes the methodology for determining high performing Category C P4P measures.

Table 5. Core Activities Associated with the Greatest Number of High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Number of High Performing Measures with Core Activity
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of care aligned with CCBHC model	206
Access to Primary Care Services	Provision of screening and follow up services	162
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	151
Chronic Care 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	121
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	102

Core Activities Associated with High Performance on the Most Commonly Selected Category C Pay-for-Performance Measures

Diabetes Care Measures

Three of the most commonly selected Category C P4P measures are related to Diabetes Care: "Foot Exam," "Hemoglobin A1c (HbA1c) Poor Control (>9.0%)," and "Blood Pressure (BP) control (<140/90mm Hg)". The following 3 Core Activities are the most commonly associated with high performance on these 3 measures[8]:

- Management of targeted patient populations;
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management; and,
- Provision of services to individuals that address social determinants of health.

Tobacco Screening Measures

For another of the most commonly selected Category C P4P measures, "Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention," the most common Core Activities associated with high performance are:

- Provision of care aligned with CCBHC model;
- Provision of screening and follow up services;
- Implementation of strategies to reduce tobacco use;
- Implementation of evidence-based practices to improve hospital quality & safety of care;
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management; and,
- Provision of vaccinations to target population.

Measures of Care for Older Adults

For both the "Pneumonia vaccination status for older adults" and "Advance Care Plan" Category C outcome measures, the most common Core Activities associated with high performance are:

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[8] The definition of high performance on Category C P4P measures is available in Appendix H.

- Implementation of evidence-based practices to improve hospital safety and quality of care;
- Provision of screening and follow up services; and,
- Provision of vaccinations to target population.

The Core Activities associated with the greatest number of high-performing[9] Category C P4P measures by Measure Bundle can be found in Appendix I.[10]

Related Strategies and Category C Successful Performance

In addition to reporting on Core Activities, providers also report their progress on implementing a standardized set of "Related Strategies," which are interventions or practices that impact the Category C measurement population. This reporting provides uniform data and more specific descriptions of strategies providers may be implementing than the Core Activities reporting.

Related Strategies and Core Activities are similar in that they both describe approaches providers are using to meet Category C achievement goals. In fact, the individual Related Strategy descriptions were informed by, but not limited to, Core Activity descriptions. However, Related Strategies include approaches a provider may have implemented, even apart from DSRIP, which may not be included in Core Activities reporting. Related Strategies were added because providers are only required to report on one Core Activity (even if multiple Category C measures are selected), leaving a gap in understanding what strategies were implemented to achieve their goals.

Many of the most frequently implemented Related Strategies were implemented equally by both successful and non-successful measures. As shown in Table 45 in Appendix J, the Related Strategies most commonly implemented by providers with successful measures are:

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[9] The definition of high performance on Category C P4P measures is available in Appendix H.

[10] The following Measure Bundles selected by few providers had no Core Activities associated with Category C P4P measures meeting the definition of high-performance: D4 Pediatric Chronic Disease Management: Asthma; D5 Pediatric Chronic Disease Management: Diabetes; F1 Improved Access to Adult Dental Care; F2 Preventive Pediatric Dental; and H4 Integrated Care for People with Serious Mental Illness.

- Same-day and/or walk-in appointments in the outpatient setting;
- Culturally and linguistically appropriate care planning for patients;
- Pre-visit planning and/or standing order protocols;
- Care team includes personnel in a care coordination role requiring clinical licensure; and,
- Database or registry to track quality and clinical outcomes data on patients.

Certain Related Strategies were more likely to be implemented by providers with successful measures as compared to other measures. Comparison of successful and non-successful measures can identify Related Strategies that are correlated with success but does not identify which Related Strategies directly lead to successful Category C measure performance.

Related Strategies may also be associated with other factors that influence performance like financial resources, community factors, and demographics. One common finding is that measures associated with service delivery outside of the traditional clinic-based visits are more likely to have demonstrated goal achievement. A second finding is that different Related Strategies are associated with high performance for a Medicaid population as compared to a LIU population.

As shown in Table 46 in Appendix J, providers with successful measures are more likely to have implemented the following Related Strategies:

- Screening patients for housing needs;
- Home visit model of providing clinical services at a patient's residence; and,
- Screening patients for housing quality needs.

Variation in Related Strategies Associated with Successful Category C Measure Performance by Payer Type

Since providers report performance rates by payer type, Related Strategies associated with better rates for a given population can also be identified. As shown in Table 47 in Appendix J, providers that reported measures with the highest performance rates for Medicaid and CHIP clients are more likely to have implemented the following Related Strategies:

- Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting;
- Panel management and/or proactive outreach of patients using a gap analysis method;

- Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences;
- Screening patients for food insecurity; and,
- Screening patients for housing needs.

As shown in Table 48 in Appendix J, providers that reported measures with the highest performance rates for LIU clients are more likely to have implemented the following Related Strategies:

- Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.;
- Formal closed loop process for coordinating the transition from pediatric to adult care;
- Panel management and/or proactive outreach of patients using a gap analysis method;
- Formal partnership or arrangement with food resources to support patient health status; and,
- Formal partnership or arrangement with housing resources to support patient health status.

Appendix K shows the Related Strategies more likely to be associated with successful performance for each of the DSRIP provider types.

Associations between Related Strategies and Goal Achievement by Theme

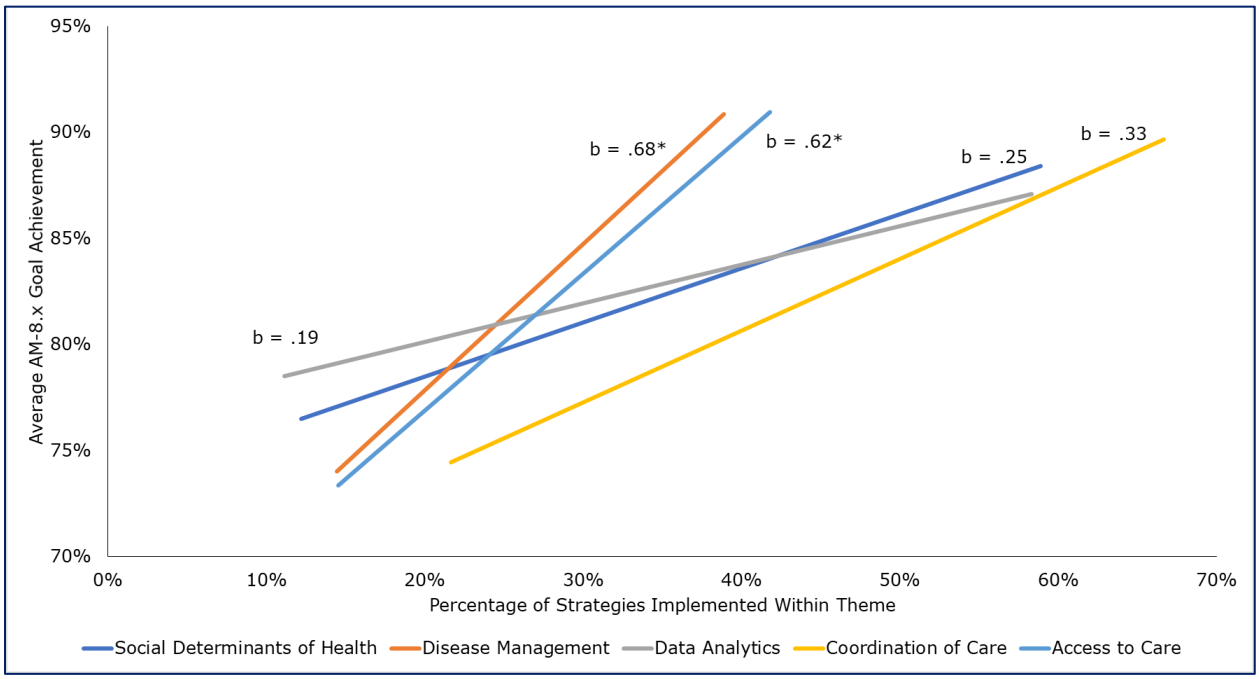
Each Related Strategy is grouped into 5 themes:

- Access to Care;
- Care Coordination;
- Data Analytics;
- Disease Management; or
- Social Determinants of Health.

Figure 2 displays the associations between Related Strategies implementation and Category C goal achievement by each of these five themes. Of the five themes, the results for Figure 2 suggest that the Related Strategies grouped into the themes of Disease Management and Access to Care may be promising strategies for achieving higher performance goals. In other words, the coefficients for the Disease

Management theme ($b = 0.68$, $p < .05$) and Access to Care theme ($b = 0.62$, $p < .05$) are statistically significant, indicating that higher implementation of Related Strategies within these themes is significantly associated with higher goal achievement. However, higher implementation of Related Strategies within the themes of Care Coordination, Data Analytics, and Social Determinants of Health are not necessarily significantly associated with higher goal achievement.

Figure 2. Associations between the Percentage of Related Strategies Implemented and Average Category C Goal Achievement, by Related Strategies Theme[11]



[11] The strength of the associations can be identified by the coefficient (b), and the associations with statistical significance ($p < 0.5$) can be identified by the asterisk (*).

For example, every additional percentage point of Related Strategies implemented within the Disease Management theme is associated with 0.68% better goal achievement, on average. Implementation of two of the 18 possible Related Strategies within this theme (11.1%) is associated with 71.6% goal achievement, whereas implementation of three Related Strategies within this theme (16.7%) is associated with 75.4% goal achievement.

For example, every additional percentage point of Related Strategies implemented within the Access to Care theme is associated with 0.62% better goal achievement, on average. Implementation of two of the 11 possible Related Strategies within this theme (18.2%) is associated with 75.2% goal achievement, whereas implementation of three Related Strategies within this theme (27.3%) is associated with 80.9% goal achievement.

Prepared by: Center for Analytics and Decision Support, Texas Health and Human Services Commission (JP). DRROC #922818

7. Summary of Final Costs and Savings Analyses

In DYs 7-8, DSRIP providers with a total valuation greater than or equal to $1 million per DY were required to submit a Costs and Savings analysis for at least one of their selected Category A Core Activities. The Costs and Savings analysis must include the costs associated with implementing the Core Activity and any forecasted or generated savings or losses associated with implementing that Core Activity. Some provider's Core Activities were very broad and used multiple interventions serving different patient populations; therefore, providers had the option to analyze only a portion of the Core Activity.

Providers used an ROI analysis to demonstrate the forecasted or generated savings, if any, of the selected Core Activity. Most providers used one of two tools recommended by HHSC to conduct their analyses, the forecasting tool to show projected or anticipated savings and the retrospective tool to show generated savings.

Providers using a forecasting analysis had to rely on assumptions about the effects of their intervention on the patient population's health care utilization. Providers using a forecasting analysis could reflect uncertainty associated with the assumptions/forecast parameters used to complete the analysis by using a sensitivity range in the forecasting tool to calculate the upper and lower bounds of the ROI.

Providers included data specific to their organization, such as start-up and operating costs to develop and maintain the intervention, and cost data representing savings and/or benefits attributable to the intervention. To arrive at cost savings attributable to the intervention, some providers had to make assumptions about changes in health care utilization of the patient population affected by the intervention, as they rarely had access to system-wide utilization data.

In the analysis, providers could reflect an impact from the intervention on other providers. For example, interventions implemented by CMHCs could have impacted inpatient utilization at the neighboring hospitals. In other words, the ROI could not accrue to the provider who invested and implemented the intervention being measured, but rather to the health care system. The goal of the analysis was to serve as a tool for providers to better understand the sustainability of the chosen

intervention or to utilize the ROI as a basis for entering into a value-based payment arrangement with payers.

In October 2019, providers submitted their Costs and Savings analyses as required under Category A reporting. Of the 297 providers in DYs 7-8 DSRIP, 212 providers were required to submit a Costs and Savings analysis. In addition, 3 providers that were not required to submit a report on cost and savings submitted an optional Costs and Savings analysis.

Of the 203 completed analyses[12]:

- 174 (86 percent) showed that investment in the Core Activity produced a positive ROI to the healthcare system;
- 26 (13 percent) showed that investment in the Core Activity did not produce a positive ROI; and,
- Three (1 percent) showed that the savings generated by the Core Activity were equal to the costs associated with implementing it.

Providers analyzed interventions that varied in terms of size (number of individuals served) and program costs to implement the intervention (start-up and operating costs). The intervention that required the least in terms of investment and operation costs was $721, while the average program costs were $4.2 million; the intervention that required the most investment was $347.4 million. The average number of individuals served in the first year of the intervention was 1,600, while the smallest intervention provided services to 5 individuals and the largest to 47,508 individuals.

While HHSC provided significant technical assistance to complete the analysis, the results are not verified or validated. Providers relied heavily on assumptions in their calculations. In addition, providers could complete the Costs and Savings analysis on any intervention associated with one of their Core Activities, which could have led providers to select interventions that were known or anticipated to result in positive ROIs.

Table 6 below describes the results of the analyses by provider type.

[12] This report only includes the 203 submissions that were complete and met all HHSC requirements.

Table 6. Costs and Savings Analyses by Provider Type

Provider type	Number of Analyses Submitted	Number with Positive ROI	Number with Negative ROI	Number with ROI of 0
Hospitals	136	117	17	2
CMHCs	38	31	7	0
Physician Practices	16	15	1	0
LHDs	13	11	1	1
Total	**203**	**174**	**26**	**3**

The most frequently selected Core Activity groupings for the analysis were:

- management of individuals with chronic conditions;
- improving access to primary and preventive services;
- expansion of patient care navigation and transition services; and,
- availability of the behavioral health services.

Analyses submitted in these 4 groupings represented 70 percent of all submissions to HHSC. Table 7 has additional information on the Core Activity groupings analyzed by providers.

Table 7. Core Activity Groupings in Costs and Savings Analyses

Core Activity Grouping	Number of Analyses and (Percent of Total)	Number of Positive ROIs	Number of Negative ROIs	Number of ROIs of 0
Chronic Care Management	46 (23%)	42	4	0
Access to Primary Care Services	40 (20%)	33	7	0
Expansion of Patient Care Navigation and Transition Services	29 (14%)	24	3	2

Core Activity Grouping	Number of Analyses and (Percent of Total)	Number of Positive ROIs	Number of Negative ROIs	Number of ROIs of 0
Availability of Appropriate Levels of Behavioral Health Care Services	27 (13%)	22	5	0
Prevention and Wellness	19 (9%)	18	1	0
Maternal and Infant Health Care	11 (5%)	10	0	1
Hospital Safety and Quality	8 (4%)	8	0	0
Behavioral Health Crisis Stabilization Services	7 (3%)	7	0	0
Access to Specialty Care Services	4 (2%)	4	0	0
Patient Centered Medical Home	6 (3%)	3	3	0
Other	4 (2%)	2	2	0
Palliative Care	1 (0.5%)	1	0	0
Substance Use Disorder	1 (0.5%)	0	1	0

While providers could select any of their Core Activities for the analysis, many providers analyzed costs and benefits related to one of the following:

- chronic disease management and care coordination;
- provision of behavioral health services in various settings;
- access to primary and preventive services, including vaccinations; and,
- availability of enhanced maternal care.

The analyzed interventions delivered a variety of services to different groups of individuals. Of the 203 interventions analyzed:

- 66 analyzed interventions (33 percent) provided services to individuals with chronic conditions regardless of the Core Activity grouping. The majority of these interventions (68 percent) provided care to individuals with diabetes;
- 36 analyzed interventions (18 percent) concentrated on services provided to individuals needing behavioral health services;
- 28 analyzed interventions (14 percent) provided services to ED frequent users and high-risk individuals;
- 15 analyzed interventions (7 percent) delivered services to pregnant and postpartum women; and,
- Six analyzed interventions (3 percent) specifically targeted the pediatric population.

The ROI varied significantly by the type of intervention. Hospital safety and quality, palliative care, and models supporting recovery of individuals with behavioral health needs were interventions that reported consistently high ROIs.

8. Core Activities with a Positive Return on Investment

Most of the Core Activities analyzed by providers (86 percent) had a positive ROI, and the specific activities that make up the interventions varied significantly between providers. At least 35 percent of Core Activities with a positive ROI provided care management and other services to individuals with chronic conditions, predominately with diabetes. At a minimum, 16 percent of Core Activities with a positive ROI were addressing the needs of individuals in need of behavioral health services; and 13 percent were managing the care of individuals who had frequent visits to EDs.

The analysis did not show a single Core Activity grouping that had all interventions with positive ROI for all provider types participating in DSRIP, but successful types of activities were identified for each provider type participating in the program. As indicated in Table 8 below, physician practices had the highest percentage of ROIs that were positive (94 percent).

Table 8. Positive ROIs by Provider Type

Provider Type	Number of Positive ROIs	Positive ROIs as a % of All ROIs
Hospitals	117	86%
CMHCs	31	82%
Physician Practices	15	94%
LHDs	11	85%
Total	**174**	**86%**

All Costs and Savings analyses in the following Core Activity groupings had positive ROIs, regardless of provider type:

- Maternal and Infant Health Care (10 analyses);
- Hospital Safety and Quality (8 analyses);
- Behavioral Health Crisis Stabilization Services (7 analyses);
- Access to Specialty Care Services (4 analyses); and,
- Palliative Care (1 analysis).

Results of the analysis submitted by hospital providers indicate that all DSRIP interventions in the areas of maternal and infant health care, hospital safety and quality, prevention and wellness initiatives, and palliative care have a positive ROI.

Results of the analysis submitted by CMHCs indicate that all DSRIP interventions in the areas of crisis stabilization services, prevention and wellness initiatives, patient care navigation and transition services, and specialty care services for individuals with serious mental illness have a positive ROI.

Results of the analysis submitted by physician practices and LHDs indicate that almost all DSRIP interventions have a positive ROI.

Additional detail about interventions with a positive ROI by provider type can be found in Appendix L.

9. DSRIP Valuation, Funds Earned and Paid

Table 9 shows that as of July 2020, DSRIP providers received approximately $3.0 billion in DSRIP funds for DY 7 and $2.6 billion for DY 8. The DY 8 data is not yet complete as providers have until July 2021 to earn and receive payment for certain DY 8 milestones.

Table 9. DSRIP Funds Paid for DYs 7-8 by Provider Type (as of July 2020)

Provider Type	# Providers in DYs 7-8	DY 7 Paid	DY 8 Paid
Hospitals	218	$1,949,665,382	$1,646,540,767
Physician Practices	19	$424,981,044	$396,492,269
CMHCs	39	$486,719,290	$466,390,358
LHDs	21	$128,561,841	$113,981,826
Total	**297**	**$2,989,927,556**	**$2,623,405,220**

Table 10 shows the amount of funds available, earned, and paid to DSRIP providers, by provider type, for DYs 7-8 as of July 2020. DSRIP providers earned about 97 percent of DY 7 funds available and 86 percent of DY 8 funds available. Providers have until July 2021 to earn and receive payment for certain DY 8 milestones.

Table 10 also shows that DSRIP providers were paid nearly 100 percent of the funds earned for DY 7 and nearly 99 percent of funds earned for DY 8. Providers were not paid all the funds earned because the nonfederal share of payments is funded with IGTs from local governmental entities. If local governmental entities do not have sufficient IGT to fund the full nonfederal share of earned funds, payments to providers will be less than the funds earned.

Table 10. DSRIP Funds Available, Earned and Paid for DYs 7-8, by Provider Type, as of July 2020 (*All dollar amounts in millions*)

Provider Type	# Providers DYs 7-8	DY 7 Available [13]	DY 7 Earned	DY 7 Paid	DY 8 Available [14]	DY 8 Earned	DY 8 Paid
Hospitals[15]	218	$2,033	$1,960	$1,950	$2,021	$1,675	$1,647
Public, non-rural	*17*	$1,030	$1,005	$1,004	$1,030	$907	$898
Public, rural	*67*	$130	$126	$125	$130	$106	$102
Private, non-rural	*95*	$821	$780	$771	$817	$621	$609
Private, rural	*39*	$53	$50	$49	$53	$40	$38

[13] "DY 7 Available" represents the sum of all providers' DY 7 valuations.

[14] "DY 8 Available" represents the sum of all providers' DY 8 valuations.

[15] A rural hospital is defined as per 1 TAC §355.8201(b)(20) as a hospital enrolled as a Medicaid provider that is: (A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or (C) designated by Medicare as a Rural Referral Center) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

Provider Type	# Providers DYs 7-8	DY 7 Available [13]	DY 7 Earned	DY 7 Paid	DY 8 Available [14]	DY 8 Earned	DY 8 Paid
Physician Practices	19	$434	$425	$425	$434	$396	$396
CMHCs	39	$492	$487	$487	$492	$466	$466
LHDs	21	$132	$129	$129	$132	$116	$114
Total	**297**	**$3,091**	**$3,000**	**$2,990**	**$3,088**	**$2,654**	**$2,623**

10. Conclusion

As the data analyzed in the report demonstrate, there are many successes in DSRIP. Most DSRIP providers achieved 100 percent of their goals for their selected health outcome measures using a wide variety of Core Activities and Related Strategies.

Provider performance on most measures improved over the two-year period, particularly performance on process measures and clinical outcome measures related to behavioral health. Most Core Activities for which providers conducted a costs and savings analysis reflect a positive ROI to the healthcare system.

As of July 2020, DSRIP providers received approximately $3.0 billion for DY 7 and $2.6 billion for DY 8 primarily for reporting and performance on their selected health outcome measures.

The report also demonstrates the magnitude of the DSRIP program and the variation across the state of interventions implemented to achieve quality improvements. This variety is borne of the regional focus, the diverse populations served, and the range of provider types and capacity in the DSRIP program. The conclusions drawn from the data analysis provide a rich array of possibilities to further improve the Texas healthcare delivery system.

The current DSRIP program funding ends September 30, 2021. The 1115 Waiver approval required that HHSC submit a Transition Plan to CMS specifying how Texas would continue healthcare delivery reform once DSRIP ends.[16]

The DSRIP Transition Plan outlines the steps HHSC will take to develop new policies, potential programs, and innovative financing mechanisms, among other activities, to continue to advance healthcare system reform and APMs that emphasize value in Texas Medicaid. Analysis of the data outlined in the report is a key step in determining the next phase of healthcare transformation.

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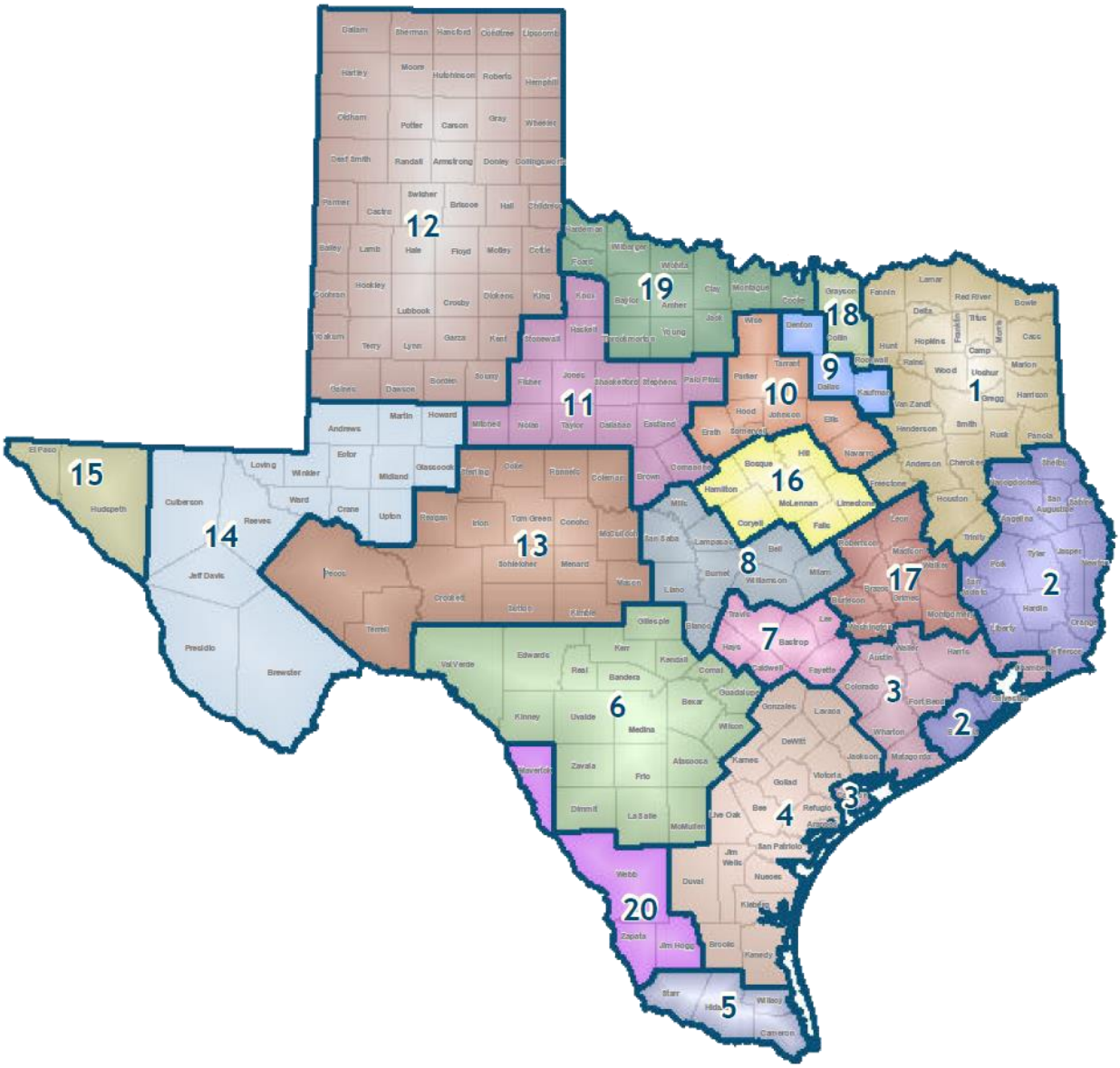
[16] The CMS approved DSRIP Transition Plan can be found at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Model
BP	Blood pressure
BMI	Body mass index
CCBHC	Certified Community Behavioral Health Clinic
CHF	Congestive heart failure
CHIP	Children's Health Insurance Program
CMHC	Community mental health center
CMS	Centers for Medicare and Medicaid Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration year
ED	Emergency department
IGT	Intergovernmental transfer
HbA1c	Hemoglobin A1c
HHSC	Health and Human Services Commission
LHD	Local health department
LIU	Low-income or uninsured
MLIU	Medicaid and low-income or uninsured
PBCO	Population Based Clinical Outcome
PCMH	Patient Centered Medical Home
PPP	Patient Population by Provider
PY	Performance year
P4P	Pay-for-performance
RHP	Regional Healthcare Partnership
ROI	Return on investment
SDOH	Social determinants of health

Appendix A. Texas Regional Healthcare Partnership (RHP) Regions



RHP 1

1. Anderson
2. Bowie
3. Camp
4. Cass
5. Cherokee

6. Delta
7. Fannin
8. Franklin
9. Freestone
10. Gregg
11. Harrison
12. Henderson
13. Hopkins
14. Houston
15. Hunt
16. Lamar
17. Marion
18. Morris
19. Panola
20. Rains
21. Red River
22. Rusk
23. Smith
24. Titus
25. Trinity
26. Upshur
27. Van Zandt
28. Wood

RHP 2

1. Angelina
2. Brazoria
3. Galveston
4. Hardin
5. Jasper
6. Jefferson
7. Liberty
8. Nacogdoches
9. Newton
10. Orange
11. Polk
12. Sabine

13. San Augustine
14. San Jacinto
15. Shelby
16. Tyler

RHP 3

1. Austin
2. Calhoun
3. Chambers
4. Colorado
5. Fort Bend
6. Harris
7. Matagorda
8. Waller
9. Wharton

RHP 4

1. Aransas
2. Bee
3. Brooks
4. DeWitt
5. Duval
6. Goliad
7. Gonzales
8. Jackson
9. Jim Wells
10. Karnes
11. Kenedy
12. Kleberg
13. Lavaca
14. Live Oak
15. Nueces
16. Refugio
17. San Patricio
18. Victoria

RHP 5

1. Cameron
2. Hidalgo
3. Starr
4. Willacy

RHP 6

1. Atascosa
2. Bandera
3. Bexar
4. Comal
5. Dimmit
6. Edwards
7. Frio
8. Gillespie
9. Guadalupe
10. Kendall
11. Kerr
12. Kinney
13. La Salle
14. McMullen
15. Medina
16. Real
17. Uvalde
18. Val Verde
19. Wilson
20. Zavala

RHP 7

1. Bastrop
2. Caldwell
3. Fayette
4. Hays
5. Lee
6. Travis

RHP 8

1. Bell
2. Blanco
3. Burnet
4. Lampasas
5. Llano
6. Milam
7. Mills
8. San Saba
9. Williamson

RHP 9

1. Dallas
2. Denton
3. Kaufman

RHP 10

1. Ellis
2. Erath
3. Hood
4. Johnson
5. Navarro
6. Parker
7. Somervell
8. Tarrant
9. Wise

RHP 11

1. Brown
2. Callahan
3. Comanche
4. Eastland
5. Fisher
6. Haskell

7. Jones
8. Knox
9. Mitchell
10. Nolan
11. Palo Pinto
12. Shackelford
13. Stephens
14. Stonewall
15. Taylor

RHP 12

1. Armstrong
2. Bailey
3. Borden
4. Briscoe
5. Carson
6. Castro
7. Childress
8. Cochran
9. Collingsworth
10. Cottle
11. Crosby
12. Dallam
13. Dawson
14. Deaf Smith
15. Dickens
16. Donley
17. Floyd
18. Gaines
19. Garza
20. Gray
21. Hale
22. Hall
23. Hansford
24. Hartley
25. Hemphill
26. Hockley
27. Hutchinson

28. Kent
29. King
30. Lamb
31. Lipscomb
32. Lubbock
33. Lynn
34. Moore
35. Motley
36. Ochiltree
37. Oldham
38. Parmer
39. Potter
40. Randall
41. Roberts
42. Scurry
43. Sherman
44. Swisher
45. Terry
46. Wheeler
47. Yoakum

RHP 13

1. Coke
2. Coleman
3. Concho
4. Crockett
5. Irion
6. Kimble
7. Mason
8. McCulloch
9. Menard
10. Pecos
11. Reagan
12. Runnels
13. Schleicher
14. Sterling
15. Sutton
16. Terrell

17. Tom Green

RHP 14

1. Andrews
2. Brewster
3. Crane
4. Culberson
5. Ector
6. Glasscock
7. Howard
8. Jeff Davis
9. Loving
10. Martin
11. Midland
12. Presidio
13. Reeves
14. Upton
15. Ward
16. Winkler

RHP 15

1. El Paso
2. Hudspeth

RHP 16

1. Bosque
2. Coryell
3. Falls
4. Hamilton
5. Hill
6. Limestone
7. McLennan

RHP 17

1. Brazos

2. Burleson
3. Grimes
4. Leon
5. Madison
6. Montgomery
7. Robertson
8. Walker
9. Washington

RHP 18

1. Collin
2. Grayson
3. Rockwall

RHP 19

1. Archer
2. Baylor
3. Clay
4. Cooke
5. Foard
6. Hardeman
7. Jack
8. Montague
9. Throckmorton
10. Wichita
11. Wilbarger
12. Young

RHP 20

1. Jim Hogg
2. Maverick
3. Webb
4. Zapata

Appendix B. Category C Measure Bundle Selections by Provider Type for Demonstration Years 7-8

Table 11. Category C Measure Bundle Selections by Provider Type for Demonstration Years 7-8[17,18]

MB ID	Measure Bundle Title	Hospitals & Physician Practices Selecting Measure Bundle	Public Non-Rural Hospitals Selecting Measure Bundle	Public Rural Hospitals Selecting Measure Bundle	Private Non-Rural Hospitals Selecting Measure Bundle	Private Rural Hospitals Selecting Measure Bundle	Physician Practices Selecting Measure Bundle
A1	**Improved Chronic Disease Management: Diabetes Care**	73	11	10	35	5	12
A2	**Improved Chronic Disease Management: Heart Disease**	37	8	3	19	4	6
B1	**Care Transitions & Hospital Readmissions**	22	7	2	12	2	1

[17] Only hospitals and physician practices select Measure Bundles.

[18] A rural hospital is defined as per 1 TAC §355.8201(b)(20) as a hospital enrolled as a Medicaid provider that is: (A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or (C) designated by Medicare as a Rural Referral Center) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

MB ID	Measure Bundle Title	Hospitals & Physician Practices Selecting Measure Bundle	Public Non-Rural Hospitals Selecting Measure Bundle	Public Rural Hospitals Selecting Measure Bundle	Private Non-Rural Hospitals Selecting Measure Bundle	Private Rural Hospitals Selecting Measure Bundle	Physician Practices Selecting Measure Bundle
B2	**Patient Navigation & ED Diversion**	26	1	2	19	6	0
C1	**Primary Care Prevention - Healthy Texans**	33	7	4	8	9	9
C2	**Primary Care Prevention - Cancer Screening**	35	8	4	11	7	9
C3	**Hepatitis C**	7	3	0	3	0	1
D1	**Pediatric Primary Care**	16	6	1	5	1	4
D3	**Pediatric Hospital Safety**	8	0	0	8	0	0
D4	**Pediatric Chronic Disease Management: Asthma**	9	0	0	7	0	2
D5	**Pediatric Chronic Disease Management: Diabetes**	4	0	0	4	0	0

MB ID	Measure Bundle Title	Hospitals & Physician Practices Selecting Measure Bundle	Public Non-Rural Hospitals Selecting Measure Bundle	Public Rural Hospitals Selecting Measure Bundle	Private Non-Rural Hospitals Selecting Measure Bundle	Private Rural Hospitals Selecting Measure Bundle	Physician Practices Selecting Measure Bundle
E1	**Improved Maternal Care**	21	2	3	8	5	6
E2	**Maternal Safety**	28	3	1	20	2	3
F1	**Improved Access to Adult Dental Care**	4	1	0	0	0	3
F2	**Preventive Pediatric Dental**	4	0	0	2	0	2
G1	**Palliative Care**	15	6	0	5	1	3
H1	**Integration of Behavioral Health in a Primary or Specialty Care Setting**	14	2	0	4	1	7
H2	**Behavioral Health and Appropriate Utilization**	11	3	0	8	0	0
H3	**Chronic Non-Malignant Pain Management**	4	1	0	2	0	1
H4	**Integrated Care for People with Serious Mental Illness**	3	3	0	0	0	0

MB ID	Measure Bundle Title	Hospitals & Physician Practices Selecting Measure Bundle	Public Non-Rural Hospitals Selecting Measure Bundle	Public Rural Hospitals Selecting Measure Bundle	Private Non-Rural Hospitals Selecting Measure Bundle	Private Rural Hospitals Selecting Measure Bundle	Physician Practices Selecting Measure Bundle
I1	**Specialty Care**	5	1	0	3	0	1
J1	**Hospital Safety**	39	4	2	32	3	0
K1	**Rural Preventive Care**	45	0	25	0	43	2
K2	**Rural Emergency Care**	28	0	19	3	25	0

Table 12. Category C Local Health Department Measure Selections for Demonstration Years 7-8[19]

Measure Bundle ID	Measure Title	Measure Class	Providers Selecting Measure	LHDs Selecting Measure	Hospitals & Physician Practices Selecting Measure
L1-103	Controlling High Blood Pressure	Clinical Outcome	1	1	0

[19] Local health departments (LHDs) selected measures from the LHD Measure Menu. Under limited circumstances, hospitals and physician practices received approval to select measures from the LHD Measure Menu.

Measure Bundle ID	Measure Title	Measure Class	Providers Selecting Measure	LHDs Selecting Measure	Hospitals & Physician Practices Selecting Measure
L1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	10	9	1
L1-107	Colorectal Cancer Screening	Cancer Screening	3	3	0
L1-108	Childhood Immunization Status (CIS)	Immunization	2	2	0
L1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Clinical Outcome	6	6	0
L1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	6	6	0
L1-160	Follow-Up After Hospitalization for Mental Illness	Clinical Outcome	2	2	0
L1-186	Breast Cancer Screening	Cancer Screening	3	3	0
L1-205	Third next available appointment	Process	1	1	0

Measure Bundle ID	Measure Title	Measure Class	Providers Selecting Measure	LHDs Selecting Measure	Hospitals & Physician Practices Selecting Measure
L1-207	Diabetes care: BP control (<140/90mm Hg)	Clinical Outcome	5	5	0
L1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	3	3	0
L1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Process	1	1	0
L1-224	Dental Sealant: Children	Process	2	2	0
L1-225	Dental Caries: Children	Clinical Outcome	3	2	1
L1-231	Preventive Services for Children at Elevated Caries Risk	Process	3	2	1
L1-235	Post-Partum Follow-Up and Care Coordination	Clinical Outcome	2	2	0
L1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Clinical Outcome	4	4	0

Measure Bundle ID	Measure Title	Measure Class	Providers Selecting Measure	LHDs Selecting Measure	Hospitals & Physician Practices Selecting Measure
L1-268	Pneumonia vaccination status for older adults	Immunization	4	4	0
L1-269	Preventive Care and Screening: Influenza Immunization	Immunization	7	6	1
L1-271	Immunization for Adolescents	Immunization	4	4	0
L1-272	Adults (18+ years) Immunization status	Immunization	4	4	0
L1-280	Chlamydia Screening in Women (CHL)	Process	6	6	0
L1-343	Syphilis positive screening rates	Process	3	3	0
L1-344	Follow-up after Treatment for Primary or Secondary Syphilis	Clinical Outcome	4	4	0
L1-345	Gonorrhea Positive Screening Rates	Process	3	3	0
L1-346	Follow-up testing for N. gonorrhoeae among recently infected men and women	Clinical Outcome	4	4	0

Measure Bundle ID	Measure Title	Measure Class	Providers Selecting Measure	LHDs Selecting Measure	Hospitals & Physician Practices Selecting Measure
L1-347	Latent Tuberculosis Infection (LTBI) treatment rate	Clinical Outcome	8	7	1
L1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	3	3	0

Table 13. Category C Community Mental Health Center (CMHC) Measure Selections for Demonstration Years 7-8[20]

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-100	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Clinical Outcome	5	5	0

[20] Community mental health centers (CMHCs) selected measures from the CMHC Measure Menu. Under limited circumstances, hospitals and physician practices received approval to select measures from the CMHC Measure Menu.

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-103	Controlling High Blood Pressure	Clinical Outcome	10	10	0
M1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	34	33	1
M1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Clinical Outcome	7	7	0
M1-124	Medication Reconciliation Post-Discharge	Process	3	3	0
M1-125	Antidepressant Medication Management (AMM-AD)	Clinical Outcome	3	3	0
M1-146	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	Process	20	19	1
M1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	31	31	0
M1-160	Follow-Up After Hospitalization for Mental Illness	Clinical Outcome	23	22	1
M1-165	Depression Remission at Twelve Months	Clinical Outcome	4	4	0

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-180	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)	Clinical Outcome	4	4	0
M1-181	Depression Response at Twelve Months-Progress Towards Remission	Clinical Outcome	5	5	0
M1-182	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Process	6	6	0
M1-203	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	Process	2	2	0
M1-207	Diabetes care: BP control (<140/90mm Hg)	Clinical Outcome	5	5	0
M1-210	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	7	7	0
M1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Process	12	12	0

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-241	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Clinical Outcome	2	2	0
M1-255	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Clinical Outcome	4	4	0
M1-256	Initiation of Depression Treatment	Process	2	2	0
M1-257	Care Planning for Dual Diagnosis	Process	13	13	0
M1-259	Assignment of Primary Care Physician to Individuals with Schizophrenia	Process	11	11	0
M1-260	Annual Physical Exam for Persons with Mental Illness	Process	7	7	0
M1-261	Assessment for Substance Abuse Problems of Psychiatric Patients	Process	18	18	0
M1-262	Assessment of Risk to Self/ Others	Process	12	12	0
M1-263	Assessment for Psychosocial Issues of Psychiatric Patients	Process	7	7	0

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-264	Vocational Rehabilitation for Schizophrenia	Process	7	7	0
M1-265	Housing Assessment for Individuals with Schizophrenia	Process	11	11	0
M1-266	Independent Living Skills Assessment for Individuals with Schizophrenia	Process	10	10	0
M1-286	Depression Remission at Six Months	Clinical Outcome	3	3	0
M1-287	Documentation of Current Medications in the Medical Record	Process	10	10	0
M1-305	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)	Process	17	17	0
M1-306	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*	Process	1	1	0
M1-317	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	23	22	1

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-319	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)	Process	25	25	0
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	Process	6	6	0
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	Process	6	6	0
M1-342	Time to Initial Evaluation: Evaluation within 10 Business Days	Process	8	8	0
M1-385	Assessment of Functional Status or QoL (Modified from NQF# 0260/2624)	Quality of Life	5	5	0

Bundle-Measure ID	Measure Title	Measure Class	Providers Selecting Measure	CMHCs Selecting Measure	Hospitals & Physician Practices Selecting Measure
M1-386	Improvement in Functional Status or QoL (Modified from PQRS #435)	Quality of Life	4	4	0
M1-390	Time to Initial Evaluation: Mean Days to Evaluation	Process	13	12	1
M1-400	Tobacco Use and Help with Quitting Among Adolescents	Process	8	8	0
M1-405	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Process	8	8	0

Appendix C. Best Practices Workgroup Prioritization of Category C Outcome Measures

Table 14. Category C Outcome Measures Included in Best Practices Workgroup (BPW) Surveys and Degree of Consensus among BPW Members that the Measure is Key to Driving Improvements in Clients' Health Status

Measure Title	Category C Measure IDs	BPW Consensus
Adult Immunization Status	C1-268, K1-268, L1-268, C1-269, K1-269, L1-269, C1-272, L1-272	Strong
Advanced Care Plan	K1-285, K2-285	Strong
Age-Appropriate Screening for Clinical Depression/ Suicide Risk (Adult, Child, and Adolescent)	H1-146, K1-146, M1-146, H2-319, M1-319, H2-305, M1-305	Strong
Body Mass Index Screening and Follow-up Plan	C1-147, L1-147, M1-147	Strong
Cancer Screening	C2-106, C2-107, L1-107, C2-186, L1-186	Strong
Cardiovascular Disease - High Blood Pressure Control	A2-103, K1-103, L1-103, M1-103	Strong
Dental Caries/Dental Sealants Children	F2-224, L1-224, L1-225	Strong
Diabetes - Blood Pressure Control	A1-207, L1-207, M1-207	Strong
Diabetes - HbA1c Poor Control	A1-115, K1-115, L1-115, M1-115	Strong
Follow-up after Hospitalization for Mental Illness	H2-160, L1-160, M1-160	Strong

Measure Title	Category C Measure IDs	BPW Consensus
Hepatitis Screening and Follow-up Plan	C3-203, M1-203, C3-328	Strong
Maternal Screening for Behavioral Health Risks	D1-301, E1-300	Strong
Medication Reconciliation	B1-287, H3-387, K2-287, M1-287	Strong
Nutrition and Physical Activity Counseling for Pediatric and Adolescent Clients	D1-211, D5-211, L1-211, M1-211,	Strong
Pediatric and Adolescent Immunization Status	D1-108, L1-108, D1-271, L1-271	Strong
Post-Partum Follow-up Care Coordination	E1-235, L1-235	Strong
Tobacco Screening and Cessation Counseling	C1-105, F1-105, K1-105, L1-105, M1-105,	Strong
Tobacco Screening and Cessation Counseling for Adolescents	D1-400, L1-400, M1-400	Strong
Alcohol/Other Drug Dependence Treatment Initiation Rate	M1-100	Weak
Behavioral Health Conditions - Criminal Justice Setting Admissions Rate	L2-241, M1-241	Weak
Cesarean Section Rate	E2-150	Weak
Dental Caries Adults	F1-227, L1-227	Weak

Measure Title	Category C Measure IDs	BPW Consensus
Depression Response at Twelve Months- Progress Towards Remission	M1-181	Weak
Housing Screening for Clients with Schizophrenia	H2-265, M1-265	Weak
Independent Living Skills Screening for Clients with Schizophrenia	H2-266, M1-266	Weak
Latent Tuberculosis Infection Treatment Rate	L1-347	Weak
Low Birth-Weight Birth Rate	NA	Weak
Pediatric Asthma - Inpatient Admissions / ED Visits Rate	D4-139, D4-353	Weak
Post-Discharge Appointment for Heart Failure	B1-352	Weak
Pre-Term Birth Rate	NA	Weak

Appendix D. Core Activities and Number of Selections for Demonstration Year 9

Table 15. Core Activities and Number of Selections for Demonstration Year 9

Core Activity Grouping	Core Activity	Number Selected
Access to Primary Care Services	Increase in utilization of mobile clinics	1
Access to Primary Care Services	Increase in capacity and access to services by utilizing Community Health Workers (CHWs)/promotors, health coaches, peer specialists and other alternative clinical staff working in primary care	6
Access to Primary Care Services	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)	26
Access to Primary Care Services	Establishment of care coordination and active referral management that integrates information from referrals into the plan of care	3
Access to Primary Care Services	Provision of screening and follow up services	56
Access to Primary Care Services	Provision of vaccinations to target population	24
Access to Primary Care Services	Integrated physical and behavioral health care services	13
Access to Primary Care Services	Use telemedicine/telehealth to deliver specialty services	1
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	1

Core Activity Grouping	Core Activity	Number Selected
Access to Primary Care Services	Other	0
Access to Specialty Care Services	Improvement in access to specialty care services with the concentration on underserved areas, so Performing Providers can continue to increase access to specialty care in the areas with limited access to services	12
Access to Specialty Care Services	Use telemedicine/telehealth to deliver specialty services	3
Access to Specialty Care Services	Implementation of remote patient monitoring programs for diagnosis and/or management of care	1
Access to Specialty Care Services	Provision of services to individuals that address social determinants of health	0
Access to Specialty Care Services	Other	0
Expansion or Enhancement of Oral Health Services	Utilization of targeted dental intervention for vulnerable and underserved population in alternate setting (e.g., mobile clinics, tele-dentistry, Federally Qualified Health Centers (FQHCs), etc.)	1
Expansion or Enhancement of Oral Health Services	Expanded use of existing dental clinics for underserved population	4
Expansion or Enhancement of Oral Health Services	Expansion of school-based sealant and/or fluoride varnish initiatives to otherwise unserved school-aged children by enhancing dental workforce capacity through partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers	2
Expansion or Enhancement of Oral Health Services	Other	1

Core Activity Grouping	Core Activity	Number Selected
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)	9
Maternal and Infant Health Care	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)	24
Maternal and Infant Health Care	Provision of coordinated prenatal and postpartum care	9
Maternal and Infant Health Care	Use telemedicine/telehealth to deliver specialty services	0
Maternal and Infant Health Care	Provision of services to individuals that address social determinants of health	5
Maternal and Infant Health Care	Other	0
Patient Centered Medical Home	Provision of coordinated services for patients under Patient Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care	12
Patient Centered Medical Home	Integration of care management and coordination for high-risk patients based on the best practices (Agency for Healthcare Research and Quality (AHRQ) PCMH framework; Risk Stratified Care Management — High Risk, Rising Risk, and Low Risk designations; ACP PCMH model Safety Net Medical Home Initiative — Change Concepts for Practice Transformation, etc.)	1
Patient Centered Medical Home	Enhancement in data exchange between hospitals and affiliated medical home sites	0

Core Activity Grouping	Core Activity	Number Selected
Patient Centered Medical Home	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.	6
Patient Centered Medical Home	Provision of services to individuals that address social determinants of health	0
Patient Centered Medical Home	Other	0
Expansion of Patient Care Navigation and Transition Service	Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the Emergency Department (ED), and others)	22
Expansion of Patient Care Navigation and Transition Service	Enhancement in coordination between primary care, urgent care, and EDs to increase communication and improve care transitions for patients	22
Expansion of Patient Care Navigation and Transition Service	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	13
Expansion of Patient Care Navigation and Transition Service	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	20
Expansion of Patient Care Navigation and Transition Service	Utilization of a comprehensive, multidisciplinary intervention to address the needs of high- risk patients	2

Core Activity Grouping	Core Activity	Number Selected
Expansion of Patient Care Navigation and Transition Service	Expansion of access to medical advice and direction to the appropriate level of care to reduce ED use for non-emergent conditions	8
Expansion of Patient Care Navigation and Transition Service	Provision of services to individuals that address social determinants of health	1
Expansion of Patient Care Navigation and Transition Service	Other	0
Prevention and Wellness	Self-management programs and wellness programs using evidence-based designs (e.g., Stanford Small-Group Self-Management Programs for people with arthritis, diabetes, HIV, cancer, chronic pain, and other chronic diseases; and SAMHSA's Whole Health Action Management among others)	6
Prevention and Wellness	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)	12
Prevention and Wellness	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)	0
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions	25

Core Activity Grouping	Core Activity	Number Selected
Prevention and Wellness	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)	4
Prevention and Wellness	Use of CHWs to improve prevention efforts	4
Prevention and Wellness	Implementation of evidence-based strategies to reduce sexually transmitted diseases	4
Prevention and Wellness	Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual	4
Prevention and Wellness	Other	2
Chronic Care Management	Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care– integrated complex care management (CCM), Complex Patient Care Model Redesign enhanced multidisciplinary care teams, The Transitional Care Model, etc.)	8
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	43
Chronic Care 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)	45
Chronic Care Management	Implementation of a medication management program that serves patients across the continuum of care	4

Core Activity Grouping	Core Activity	Number Selected
Chronic Care Management	Utilization of pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers	1
Chronic Care Management	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	13
Chronic Care Management	Use telemedicine/telehealth to deliver specialty services	0
Chronic Care Management	Education and alternatives designed to curb prescriptions of narcotic drugs to patients	0
Chronic Care Management	Provision of services to individuals that address social determinants of health	15
Chronic Care Management	Other	0
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of mobile clinics that can provide access to behavioral health care in very remote, inaccessible, or impoverished areas of Texas	1
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of telehealth/telemedicine in delivering behavioral services	8
Availability of Appropriate Levels of Behavioral Health Care 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	3

Core Activity Grouping	Core Activity	Number Selected
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model	22
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of Care Management function that integrates primary and behavioral health needs of individuals	17
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of services to individuals that address social determinants of health and/or family support services	9
Availability of Appropriate Levels of Behavioral Health Care Services	Other	2
Substance Use Disorder	Provision of Medication Assisted Treatment	0
Substance Use Disorder	Provision of Medication Assisted Treatment	0
Substance Use Disorder	Education of primary care practitioners on preventive treatment option	0
Substance Use Disorder	Utilization of telehealth/telemedicine in delivering behavioral health services	0
Substance Use Disorder	Utilization of Prescription Drug Monitoring program (can include targeted communications campaign)	0
Substance Use Disorder	Supported employment services for individuals in recovery	0

Core Activity Grouping	Core Activity	Number Selected
Substance Use Disorder	Office-based additional treatment for uninsured individuals	4
Substance Use Disorder	Peer recovery support	0
Substance Use Disorder	Provision of services to individuals that address social determinants of health including housing navigation services	0
Substance Use Disorder	Utilization of telehealth/telemedicine in delivering behavioral services	0
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)	2
Behavioral Health Crisis Stabilization Services	Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients	7
Behavioral Health Crisis Stabilization Services	Implement models supporting recovery of individuals with behavioral health needs	10
Behavioral Health Crisis Stabilization Services	Provision of services to individuals that address social determinants of health	2
Behavioral Health Crisis Stabilization Services	Other	0
Palliative Care	Provision of coordinated palliative care to address patients with end-of-life decisions and care needs	12
Palliative Care	Provision of palliative care services in outpatient setting	0

Core Activity Grouping	Core Activity	Number Selected
Palliative Care	Transitioning of palliative care patients from acute hospital care into home care, hospice, or a skilled nursing facility and management of patients' needs	3
Palliative Care	Provision of services to individuals that address social determinants of health	1
Palliative Care	Utilization of services assisting individuals with pain management	4
Palliative Care	Other	0
Hospital Safety and Quality	Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)	26
Hospital Safety and Quality	Implementation of evidence-based practices to improve quality of care (e.g., Quality Departments, monitoring and evaluation, etc.)	26
Hospital Safety and Quality	Other	0
Other	Other	1

Appendix E. Demonstration Years (DYs) 7-8 Category C Pay-for-Performance (P4P) Measure DY 8 Goal Achievement by Measure Class, Provider Type, and Regional Healthcare Partnership (RHP)

Table 16. Category C Pay-for-Performance Measure DY 8 Goal Achievement by Measure Class[21,22] (DYs 7-8)

Measure Class	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Cancer Screening	111	98.0%	77.1%	11.9%	11.0%
Clinical Outcome	507	93.1%	69.5%	10.8%	19.7%
Hospital Safety	226	79.2%	54.7%	6.1%	39.1%
Immunization	254	91.3%	75.0%	15.1%	9.9%
Population Based Clinical Outcome	112	90.2%	56.4%	7.9%	35.6%
Process	1337	92.6%	84.8%	7.4%	7.8%
Quality of Life	19	100.0%	63.2%	21.1%	15.8%
All Measures	**2581**	**91.6%**	**76.8%**	**9.1%**	**14.1%**

[21] The percentages in the last three columns of the table represent the percentage of DYs 7-8 P4P measures that have reported PY 2 (CY 19).

[22] While providers have reported PY 2 data for most measures, providers have through February 2021 to report final data for PY 2.

Table 17. Category C Pay-for-Performance Measure DY 8 Goal Achievement by Provider Type[23] (DYs 7-8)

Provider Type	DYs 7-8 Providers	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Hospital (All)	216	1743	88%	72.42%	10.12%	17.46%
Physician Practice	21	314	100%	82.75%	7.99%	9.27%
Community Mental Health Center (CMHC)	39	412	100%	88.32%	5.60%	6.08%
Local Health Department (LHD)	21	112	88%	78.57%	11.22%	10.20%

[23] The percentages in the last three columns of the table represent the percentage of DYs 7-8 P4P measures that have reported PY 2 (CY 19).

Table 18. Hospital Category C Pay-for-Performance Measure DY 8 Goal Achievement by Hospital Ownership (Public or Private) and Location (Non-rural or Rural)[24]

Hospital Ownership (Public or Private) and Location (Non-rural or Rural)[25]	DYs 7-8 Hospitals	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Hospital - Public Non-Rural	17	385	97%	76.47%	12.30%	11.23%
Hospital - Public Rural	66	298	84%	76.49%	5.98%	17.53%
Hospital - Private Non-Rural	94	877	86%	70.16%	8.75%	21.09%
Hospital - Private Rural	**39**	**181**	**88%**	**66.88%**	**17.50%**	**15.63%**

[24] The percentages in the last three columns of the table represent the percentage of DYs 7-8 P4P measures that have reported PY 2 (CY 19).

[25] A rural hospital is defined as per 1 TAC §355.8201(b)(20) as a hospital enrolled as a Medicaid provider that is: (A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or (C) designated by Medicare as a Rural Referral Center) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

Table 19. Category C Pay-for-Performance Measure DY 8 Goal Achievement by Provider Type and Measure Class[26]

Provider Type	Measure Class	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Hospital	Cancer Screening	78	97.4%	78.9%	13.2%	7.9%
Physician practice	Cancer Screening	27	100.0%	77.8%	7.4%	14.8%
LHD	Cancer Screening	6	100.0%	50.0%	16.7%	33.3%
Hospital	Clinical Outcome	339	90.9%	65.6%	10.4%	24.0%
Physician practice	Clinical Outcome	58	98.3%	80.7%	10.5%	8.8%
CMHC	Clinical Outcome	74	100.0%	68.9%	13.5%	17.6%
LHD	Clinical Outcome	36	91.7%	87.9%	9.1%	3.0%
Hospital	Hospital Safety	226	79.2%	54.7%	6.7%	38.5%
Hospital	Immunization	186	90.9%	75.1%	17.2%	7.7%
Physician practice	Immunization	49	100.0%	79.6%	8.2%	12.2%

[26] The percentages in the last three columns of the table represent the percentage of DYs 7-8 P4P measures that have reported PY 2 (CY 19).

Provider Type	Measure Class	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
LHD	Immunization	19	73.7%	57.1%	14.3%	28.6%
Hospital	Population Based Clinical Outcome	93	88.2%	51.2%	9.8%	39.0%
Physician practice	Population Based Clinical Outcome	19	100.0%	78.9%	0.0%	21.1%
Hospital	Process	813	88.4%	80.9%	8.9%	10.2%
Physician practice	Process	159	100.0%	85.5%	8.2%	6.3%
CMHC	Process	329	99.7%	93.6%	3.0%	3.4%
LHD	Process	36	88.9%	78.1%	12.5%	9.4%
Hospital	Quality of Life	8	100.0%	62.5%	12.5%	25.0%
Physician practice	Quality of Life	2	100.0%	100.0%	0.0%	0.0%
CMHC	Quality of Life	9	100.0%	55.6%	33.3%	11.1%
LHD	Grandfathered LHD Measure	15	86.7%	92.3%	7.7%	0.0%

Table 20. Hospitals' Category C Pay-for-Performance Measure Goal Achievement for Performance Year (PY) 2 (Calendar Year 2019) by Hospital Ownership Type (Public or Private), Location (Non-rural or Rural,) and Measure Class

Hospital Ownership Type (Public or Private) and Location (Non-rural or Rural)[27]	Measure Class	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Public Non-Rural	Cancer Screening	24	95.8%	82.6%	17.4%	0.0%
Public Rural	Cancer Screening	12	100.0%	66.7%	16.7%	16.7%
Private Non-Rural	Cancer Screening	33	97.0%	87.5%	6.3%	6.3%
Private Rural	Cancer Screening	9	100.0%	55.6%	22.2%	22.2%
Public Non-Rural	Clinical Outcome	64	98.4%	73.0%	15.9%	11.1%
Public Rural	Clinical Outcome	42	88.1%	70.3%	2.7%	27.0%
Private Non-Rural	Clinical Outcome	203	89.2%	61.9%	9.4%	28.7%
Private Rural	Clinical Outcome	28	89.3%	64.0%	16.0%	20.0%
Public Non-Rural	Hospital Safety	20	100.0%	55.0%	0.0%	45.0%
Public Rural	Hospital Safety	10	100.0%	90.0%	0.0%	10.0%

[27] A rural hospital is defined, per 1 TAC §355.8201(b)(20), as a hospital enrolled as a Medicaid provider that is: (A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or (C) designated by Medicare as a Rural Referral Center) and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget, or is located in an MSA but has 100 or fewer beds.

Hospital Ownership Type (Public or Private) and Location (Non-rural or Rural)[27]	Measure Class	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Private Non-Rural	Hospital Safety	193	75.6%	52.1%	7.5%	40.4%
Private Rural	Hospital Safety	3	100.0%	66.7%	33.3%	0.0%
Public Non-Rural	Immunization	48	97.9%	76.6%	21.3%	2.1%
Public Rural	Immunization	49	83.7%	85.4%	0.0%	14.6%
Private Non-Rural	Immunization	50	94.0%	76.6%	19.1%	4.3%
Private Rural	Immunization	39	87.2%	58.8%	29.4%	11.8%
Public Non-Rural	Population Based Clinical Outcome	35	97.1%	64.7%	11.8%	23.5%
Public Rural	Population Based Clinical Outcome	8	100.0%	50.0%	0.0%	50.0%
Private Non-Rural	Population Based Clinical Outcome	46	80.4%	43.2%	10.8%	45.9%
Private Rural	Population Based Clinical Outcome	4	75.0%	0.0%	0.0%	100.0%
Public Non-Rural	Process	192	96.4%	81.6%	9.2%	9.2%

Hospital Ownership Type (Public or Private) and Location (Non-rural or Rural)[27]	Measure Class	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
Public Rural	Process	177	80.8%	76.9%	8.4%	14.7%
Private Non-Rural	Process	346	88.2%	84.3%	7.9%	7.9%
Private Rural	Process	98	87.8%	74.4%	12.8%	12.8%
Public Non-Rural	Quality of Life	2	100.0%	50.0%	50.0%	0.0%
Public Rural	Quality of Life	0				
Private Non-Rural	Quality of Life	6	100.0%	66.7%	0.0%	33.3%
Private Rural	Quality of Life	0				

Table 21. Demonstration Years (DYs) 7-8 Category C Pay-for-Performance (P4P) Measure DY 8 Goal Achievement by Regional Healthcare Partnership (RHP)[28]

RHP	Providers in RHP	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
1	20	165	96%	79%	15%	6%
2	15	114	97%	82%	8%	10%
3	25	354	90%	72%	11%	17%
4	17	159	94%	74%	7%	19%
5	10	142	99%	71%	12%	16%
6	23	218	99%	84%	6%	10%
7	7	113	81%	76%	13%	11%
8	13	70	99%	78%	7%	14%
9	23	269	82%	79%	7%	14%
10	24	223	95%	79%	6%	15%

[28] The percentages in the last three columns of the table represent the percentage of DYs 7-8 P4P measures that have reported PY 2 (CY 19).

RHP	Providers in RHP	DYs 7-8 P4P Measures	Measures that have Reported PY 2 (CY 19)	Measures with 100% Achievement of DY 8 Goal in PY 2	Measures with Partial Achievement of DY 8 Goal in PY 2	Measures with 0% Achievement of DY 8 Goal in PY 2
11	15	68	85%	66%	9%	26%
12	36	190	92%	77%	10%	14%
13	13	52	100%	71%	13%	15%
14	10	79	92%	73%	10%	18%
15	8	123	90%	75%	13%	13%
16	7	64	81%	63%	10%	27%
17	12	48	96%	78%	9%	13%
18	6	35	100%	89%	3%	9%
19	12	66	95%	83%	6%	11%
20	**4**	**29**	**45%**	**85%**	**0%**	**15%**

Appendix F. Category C Measure Performance Reporting 2019

Table 22. Category C Measure Performance by Payer Type in 2019

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
A1-111: Comprehensive Diabetes Care: Eye Exam (retinal) performed	19	0.32	↑ 0.49	0.25	↑ 0.52	0.21	↑ 0.42
A1-112: Comprehensive Diabetes Care: Foot Exam	72	0.36	↑ 0.62	0.28	↑ 0.62	0.35	↑ 0.59
A1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	72	0.33	↑ 0.28	0.34	↑ 0.31	0.42	↑ 0.34
A1-207: Diabetes care: BP control (<140/90mm Hg)	72	0.65	↑ 0.70	0.64	↑ 0.73	0.62	↑ 0.70
A1-500: PQI 93 Diabetes Admissions Composite	18	0.02	↓ 0.03	0.03	↓ 0.04	0.03	↓ 0.03
A1-508: Reduce Rate of Emergency Department visits for Diabetes	21	0.22	↑ 0.22	0.34	↑ 0.25	0.23	↓ 0.24
A2-103: Controlling High Blood Pressure	36	0.62	↑ 0.68	0.61	↑ 0.69	0.59	↑ 0.66
A2-210: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	36	0.41	↑ 0.50	0.46	↑ 0.64	0.41	↑ 0.55

[29] ↑The median reported rate was an improvement in performance over the median reported baseline rate, regardless of the direction of improvement required of a given measure. For some measures, lower rates indicate an improvement in performance.

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
A2-384: Risk Adjusted CHF 30-Day Readmission Rate	2	1.25	↓ 1.26	1.63	↑ 1.43	1.00	↓ 1.49
A2-404: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	34	0.63	↑ 0.75	0.66	↑ 0.79	0.61	↑ 0.71
A2-501: PQI 08 Heart Failure Admission Rate (Adult)	9	0.01	↑ 0.01	0.02	↓ 0.03	0.01	↓ 0.01
A2-509: Reduce Rate of Emergency Department visits for CHF, Angina, and Hypertension	10	0.25	↑ 0.18	0.35	↑ 0.30	0.23	↑ 0.13
B1-124: Medication Reconciliation Post-Discharge	14	0.86	↑ 0.92	0.85	↑ 0.93	0.86	↑ 0.91
B1-141: Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions	17	1.01	↑ 0.84	1.00	↑ 0.76	0.65	↑ 0.46
B1-217: Risk Adjusted All-Cause 30-Day Readmission	17	1.06	↑ 0.93	1.25	↑ 1.03	0.82	↑ 0.66
B1-252: Transition Record with Specified Elements Received by Discharged Patients - Emergency Department Discharges	19	0.84	↑ 0.95	0.85	↑ 0.95	0.83	↑ 0.94
B1-253: Transition Record with Specified Elements Received by Discharged Patients - Discharges from Inpatient Facility	20	0.47	↑ 0.64	0.49	↑ 0.63	0.40	↑ 0.72
B1-287: Documentation of Current Medications in the Medical Record	16	0.62	↑ 0.87	0.62	↑ 0.85	0.77	↑ 0.89

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
B1-352-1: Post-Discharge Appointment Rate – Appointment scheduled prior to discharge	18	0.35	↑ 0.49	0.31	↑ 0.56	0.28	↑ 0.55
B1-352-2: Post-Discharge Appointment Rate – Appointment scheduled within 7 days post-discharge	18	0.12	↑ 0.27	0.07	↑ 0.38	0.09	↑ 0.34
B2-242: Reduce Emergency Department visits for Chronic Ambulatory Care Sensitive Conditions (ACSC)	18	0.06	↑ 0.05	0.06	↑ 0.05	0.05	↑ 0.05
B2-387-1: Reduce Emergency Department visits for Behavioral Health	8	0.08	↓ 0.11	0.08	↓ 0.13	0.04	↓ 0.08
B2-387-2: Reduce Emergency Department visits for Substance Abuse	8	0.03	↓ 0.03	0.02	↓ 0.03	0.04	↓ 0.05
B2-392: Reduce Emergency Department visits for Acute Ambulatory Care Sensitive Conditions (ACSC)	22	0.08	↑ 0.08	0.08	↓ 0.08	0.09	↓ 0.09
B2-393: Reduce Emergency Department visits for Dental Conditions	6	0.01	↑ 0.01	0.01	↑ 0.01	0.02	↑ 0.01
C1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	30	0.78	↑ 0.92	0.79	↑ 0.93	0.64	↑ 0.91
C1-113: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	32	0.85	↑ 0.89	0.83	↑ 0.90	0.78	↑ 0.86
C1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	29	0.38	↑ 0.77	0.40	↑ 0.82	0.31	↑ 0.80

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
C1-268: Pneumonia vaccination status for older adults	31	0.55	↑ 0.69	0.47	↑ 0.75	0.40	↑ 0.50
C1-269: Preventive Care and Screening: Influenza Immunization	31	0.35	↑ 0.46	0.31	↑ 0.58	0.16	↑ 0.30
C1-272: Adults (18+ years) Immunization status	33	0.03	↑ 0.13	0.03	↑ 0.15	0.01	↑ 0.09
C1-280: Chlamydia Screening in Women (CHL)	32	0.32	↑ 0.51	0.29	↑ 0.62	0.23	↑ 0.40
C1-389: Human Papillomavirus Vaccine (age 18 -26)	33	0.06	↑ 0.15	0.08	↑ 0.20	0.04	↑ 0.14
C1-502: PQI 91 Acute Admissions Composite	16	0.01	↑ 0.01	0.01	↑ 0.01	0.01	↑ 0.00
C2-106: Cervical Cancer Screening	35	0.48	↑ 0.65	0.41	↑ 0.66	0.47	↑ 0.60
C2-107: Colorectal Cancer Screening	33	0.45	↑ 0.55	0.42	↑ 0.54	0.31	↑ 0.42
C2-186: Breast Cancer Screening	35	0.61	↑ 0.70	0.57	↑ 0.69	0.47	↑ 0.58
C3-203: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	7	0.51	↑ 0.85	0.53	↑ 0.79	0.51	↑ 0.86
C3-328: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	6	0.36	↑ 0.60	0.35	↑ 0.52	0.36	↑ 0.71
C3-368: Hepatitis C: Hepatitis A Vaccination	7	0.13	↑ 0.40	0.12	↑ 0.43	0.09	↑ 0.50

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
C3-369: Hepatitis C: Hepatitis B Vaccination	7	0.21	↑ 0.59	0.19	↑ 0.56	0.22	↑ 0.64
D1-108: Childhood Immunization Status (CIS)	13	0.38	↑ 0.44	0.36	↑ 0.41	0.30	↑ 0.32
D1-211-1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Height/Weight Documentation	14	0.95	↑ 0.98	0.94	↑ 0.98	0.93	↑ 0.98
D1-211-2: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Nutrition	14	0.63	↑ 0.87	0.69	↑ 0.89	0.58	↑ 0.82
D1-211-3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Physical Activity	14	0.59	↑ 0.85	0.64	↑ 0.87	0.55	↑ 0.81
D1-212: Appropriate Testing for Children with Pharyngitis	14	0.82	↑ 0.90	0.82	↑ 0.91	0.80	↑ 0.88
D1-237: Well-Child Visits in the First 15 Months of Life (6 or more visits)	12	0.41	↑ 0.56	0.40	↑ 0.56	0.30	↑ 0.40
D1-271: Immunization for Adolescents	13	0.42	↑ 0.52	0.45	↑ 0.55	0.37	↑ 0.40
D1-284: Appropriate Treatment for Children with Upper Respiratory Infection (URI)	15	0.93	↑ 0.98	0.95	↑ 0.98	0.91	↑ 0.98
D1-301: Maternal Depression Screening	6	0.65	↑ 0.86	0.68	↑ 0.86	0.50	↑ 0.82

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
D1-389: Human Papillomavirus Vaccine (age 15-18)	7	0.32	↑ 0.56	0.37	↑ 0.62	0.31	↑ 0.47
D1-400: Tobacco Use and Help with Quitting Among Adolescents	15	0.84	↑ 0.95	0.84	↑ 0.96	0.78	↑ 0.91
D1-503: PDI 91 Pediatric Acute Admissions Composite	9	0.00	↑ 0.00	0.00	↑ 0.00	0.00	↑ 0.00
D3-330: Pediatric CLABSI	6	0.90	↑ 0.72	NA	NA	NA	NA
D3-331: Pediatric CAUTI	5	0.50	↓ 0.79	NA	NA	NA	NA
D3-333: Pediatric Surgical site infections (SSI)	4	14.85	↓ 25.5	NA	NA	NA	NA
D3-334: Pediatric Adverse Drug Events	5	0.14	↑ 0.05	NA	NA	NA	NA
D3-335-1: Pediatric Pressure Injuries – All Harm	4	0.48	↑ 0.37	NA	NA	NA	NA
D3-335-2: Pediatric Pressure Injuries – Serious Harm	4	0.08	↑ 0.05	NA	NA	NA	NA
D4-139: Asthma Admission Rate (PDI14)	7	0.02	↑ 0.01	0.02	↑ 0.01	0.00	↓ 0.00
D4-353: Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	5	0.42	↑ 0.59	0.53	↑ 0.87	0.36	↑ 0.50
D4-375: Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	7	0.93	↑ 0.98	0.96	↑ 0.98	0.88	↑ 0.92

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
D5-211-1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Height/Weight Documentation	3	1.00	↑ 1.00	1.00	↑ 1.00	1.00	↑ 1.00
D5-211-2: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Nutrition	3	0.86	↑ 0.96	0.87	↑ 0.95	0.89	↑ 1.00
D5-211-3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Physical Activity	3	0.86	↑ 0.94	0.87	↑ 0.95	0.89	↑ 1.00
D5-406: Diabetes Short-term Complications Admission Rate (PDI 15)	4	0.06	↓ 0.07	0.07	↓ 0.07	0.02	↓ 0.02
E1-235: Post-Partum Follow-Up and Care Coordination	18	0.66	↑ 0.80	0.63	↑ 0.84	0.43	↑ 0.92
E1-300: Behavioral Health Risk Assessment for Pregnant Women	19	0.29	↑ 0.70	0.25	↑ 0.67	0.25	↑ 0.67
E2-150: PC-02 Cesarean Section	24	0.33	↑ 0.29	0.31	↑ 0.27	0.35	↑ 0.28
E2-151: PC-03 Antenatal Steroids	15	0.98	↑ 1.00	0.97	↑ 1.00	1.00	↓ 1.00
F1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	4	0.81	↑ 0.82	0.26	↑ 0.79	0.86	↑ 0.89
F1-226: Chronic Disease Patients Accessing Dental Services	4	0.67	↑ 0.72	0.24	↑ 0.67	0.69	↑ 0.70

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
F1-227: Dental Caries: Adults	4	0.59	↑ 0.48	0.35	↓ 0.64	0.60	↑ 0.45
F2-224: Dental Sealant: Children	4	0.26	↑ 0.48	0.29	↑ 0.50	0.38	↓ 0.32
F2-229: Oral Evaluation: Children	3	0.54	↑ 0.89	0.54	↑ 0.85	0.88	↑ 0.94
G1-276: Hospice and Palliative Care – Pain Assessment	14	0.43	↑ 0.86	0.33	↑ 0.84	0.63	↑ 0.84
G1-277: Hospice and Palliative Care – Treatment Preferences	16	0.75	↑ 0.93	0.65	↑ 0.92	0.72	↑ 0.92
G1-278: Beliefs and Values - Discussion of Spiritual/Religious Concerns	15	0.75	↑ 0.90	0.70	↑ 0.89	0.82	↑ 0.90
G1-361: Patients Treated with an Opioid who are Given a Bowel Regimen	13	0.58	↑ 0.80	0.33	↑ 0.80	0.67	↑ 0.83
G1-362: Hospice and Palliative Care - Dyspnea Treatment	14	0.68	↑ 0.91	0.73	↑ 0.91	0.67	↑ 0.95
G1-363: Hospice and Palliative Care - Dyspnea Screening	16	0.69	↑ 0.87	0.67	↑ 0.86	0.72	↑ 0.90
G1-505: Proportion Admitted to Hospice for less than 3 days	1	0.24	↓ 0.26	0.28	↑ 0.19	0.14	↓ 0.50
G1-507: Proportion Not Admitted to Hospice	1	0.55	↑ 0.35	0.61	↑ 0.60	0.53	↑ 0.32
H1-146: Screening for Clinical Depression and Follow-Up Plan	13	0.57	↑ 0.74	0.47	↑ 0.67	0.49	↑ 0.74

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
H1-255: Follow-up Care for Children Prescribed ADHD Medication (ADD)	3	0.30	↑ 0.44	0.31	↑ 0.57	0.33	NA
H1-286: Depression Remission at Six Months	10	0.03	↑ 0.14	0.00	↑ 0.21	0.02	↑ 0.15
H1-317: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	13	0.20	↑ 0.65	0.24	↑ 0.76	0.21	↑ 0.62
H2-160-1: Follow-Up After Hospitalization for Mental Illness – Follow-up within 30 Days	5	0.13	↑ 0.25	0.11	↑ 0.27	0.10	↑ 0.27
H2-160-2: Follow-Up After Hospitalization for Mental Illness – Follow-up within 7 Days	5	0.06	↑ 0.15	0.05	↑ 0.16	0.06	↑ 0.24
H2-216: Risk Adjusted Behavioral Health/ Substance Abuse 30-Day Readmission Rate	2	0.73	↑ 0.66	0.93	↑ 0.66	0.60	↑ 0.46
H2-259: Assignment of Primary Care Physician to Individuals with Schizophrenia	9	0.21	↑ 0.42	0.20	↑ 0.64	0.15	↑ 0.34
H2-265: Housing Assessment for Individuals with Schizophrenia	3	0.01	↑ 0.09	0.01	↑ 0.07	0.04	↑ 0.19
H2-266: Independent Living Skills Assessment for Individuals with Schizophrenia	9	0.28	↑ 0.63	0.31	↑ 0.60	0.26	↑ 0.63

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
H2-305: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)	7	0.62	↑ 0.94	0.51	↑ 0.92	0.65	↑ 0.90
H2-319: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)	9	0.79	↑ 0.93	0.76	↑ 0.90	0.84	↑ 0.95
H2-405: Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	9	0.85	↑ 0.90	0.85	↑ 0.94	0.85	↑ 0.92
H2-510-1: Reduce Rate of Emergency Department visits for Behavioral Health	7	0.33	↓ 0.37	0.47	↓ 0.49	0.63	↑ 0.51
H2-510-2: Reduce Rate of Emergency Department visits for Substance Abuse	7	0.10	↓ 0.12	0.14	↑ 0.14	0.13	↓ 0.16
H3-144: Screening for Clinical Depression and Follow-Up Plan (CDF-AD) for individuals with a diagnosis of chronic pain	5	0.65	↑ 0.82	0.57	↑ 0.75	0.72	↑ 0.90
H3-287: Documentation of Current Medications in the Medical Record	5	0.73	↑ 0.82	0.06	↑ 0.57	0.73	↑ 0.82
H3-288: Pain Assessment and Follow-up	4	0.36	↑ 0.61	0.20	↑ 0.48	0.45	↑ 0.67
H3-401: Opioid Therapy Follow-up Evaluation	4	0.22	↑ 0.27	0.21	↓ 0.13	0.22	↑ 0.49
H3-403: Evaluation or Interview for Risk of Opioid Misuse	4	0.05	↑ 0.21	0.07	↑ 0.24	0.18	↑ 0.45

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
H4-182: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	3	0.67	↑ 0.87	0.65	↑ 0.88	0.68	↑ 0.88
H4-258: Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)	1	0.19	↑ 1.00	0.16	↑ 0.99	0.38	↑ 0.99
H4-260: Annual Physical Exam for Persons with Mental Illness	2	0.83	↑ 0.96	0.82	↑ 0.96	0.89	↑ 0.96
I1-385: Assessment of Functional Status or QoL	5	0.40	↑ 0.54	0.33	↑ 0.57	0.54	↓ 0.50
I1-386: Improvement in Functional Status or QoL	5	0.66	↑ 0.72	0.68	↑ 0.75	0.06	↑ 0.94
J1-218: Central line-associated bloodstream infections (CLABSI) rates	30	0.94	↑ 0.64	NA	NA	NA	NA
J1-219: Catheter-associated Urinary Tract Infections (CAUTI) rates	29	0.84	↑ 0.56	NA	NA	NA	NA
J1-220: Surgical site infections (SSI) rates	28	0.86	↑ 0.67	NA	NA	NA	NA
J1-221: Patient Fall Rate	34	2.65	↑ 2.49	NA	NA	NA	NA
K1-103: Controlling High Blood Pressure	4	0.61	↑ 0.69	0.61	↑ 0.66	0.54	↑ 0.57
K1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	36	0.63	↑ 0.83	0.59	↑ 0.78	0.58	↑ 0.75

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
K1-112: Comprehensive Diabetes Care: Foot Exam	5	0.17	↑ 0.26	0.18	↑ 0.33	0.14	↑ 0.32
K1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	2	0.25	↓ 0.31	0.32	↑ 0.27	0.58	↑ 0.57
K1-268: Pneumonia vaccination status for older adults	37	0.27	↑ 0.45	0.33	↑ 0.49	0.14	↑ 0.18
K1-269: Preventive Care and Screening: Influenza Immunization	5	0.18	↑ 0.39	0.20	↑ 0.39	0.12	↑ 0.22
K1-285: Advance Care Plan	37	0.11	↑ 0.33	0.14	↑ 0.33	0.05	↑ 0.23
K1-300: Behavioral Health Risk Assessment for Pregnant Women	1	0.33	↑ 0.66	0.34	↑ 0.67	0.38	↑ 0.71
K2-285: Advance Care Plan	1	0.32	↑ 0.67	0.31	↑ 0.71	0.28	↑ 0.69
K2-287: Documentation of Current Medications in the Medical Record	24	0.72	↑ 0.84	0.63	↑ 0.83	0.72	↑ 0.80
K2-355: Admit Decision Time to ED Departure Time for Admitted Patients	24	55.15	↑ 47.1	60.60	↑ 44.5	0.00	↓ 73.3
K2-359: Emergency Transfer Communication Measure	23	0.55	↑ 0.83	0.58	↑ 0.86	0.62	↑ 0.84
L1-103: Controlling High Blood Pressure	1	0.34	↑ 0.40	0.44	↑ 0.70	0.32	↑ 0.49

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
L1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	9	0.71	↑ 0.91	0.50	↑ 0.94	0.58	↑ 0.91
L1-107: Colorectal Cancer Screening	3	0.17	↑ 0.37	0.14	↑ 0.33	0.18	↑ 0.37
L1-108: Childhood Immunization Status (CIS)	2	0.14	↑ 0.22	0.13	↑ 0.21	0.15	↑ 0.23
L1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	5	0.38	↑ 0.31	0.34	↑ 0.25	0.36	↑ 0.29
L1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	6	0.45	↑ 0.82	0.50	↑ 0.86	0.32	↑ 0.84
L1-160: Follow-Up After Hospitalization for Mental Illness	2	0.58	↑ 0.82	0.53	↑ 1.00	0.53	↑ 0.86
L1-1602: Follow-Up After Hospitalization for Mental Illness	2	0.41	↑ 0.77	0.20	↑ 0.50	0.17	↑ 0.86
L1-186: Breast Cancer Screening	3	0.16	↑ 0.25	0.16	↑ 0.26	0.16	↑ 0.26
L1-207: Diabetes care: BP control (<140/90mm Hg)	5	0.51	↑ 0.66	0.52	↑ 0.68	0.60	↑ 0.74
L1-210: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	3	0.39	↑ 0.82	0.46	↑ 0.60	0.41	↑ 0.77

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
L1-211-1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Height/Weight Documentation	1	0.21	↑ 0.78	0.27	↑ 0.80	0.15	↑ 0.76
L1-211-2: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Nutrition	1	0.05	↑ 0.51	0.06	↑ 0.51	0.02	↑ 0.48
L1-211-3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Physical Activity	1	0.05	↑ 0.51	0.06	↑ 0.51	0.02	↑ 0.48
L1-224: Dental Sealant: Children	2	0.43	↑ 0.53	0.45	↑ 0.57	0.45	↑ 0.53
L1-225: Dental Caries: Children	3	0.32	↑ 0.26	0.28	↑ 0.21	0.37	↑ 0.28
L1-231: Preventive Services for Children at Elevated Caries Risk	2	0.69	↑ 0.91	0.70	↑ 0.92	0.48	↑ 0.91
L1-235: Post-Partum Follow-Up and Care Coordination	1	0.42	↑ 0.84	0.53	↑ 0.84	0.52	↑ 1.00
L1-241: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	3	0.08	↑ 0.07	0.06	↑ 0.03	0.07	↓ 0.07
L1-268: Pneumonia vaccination status for older adults	3	0.12	↑ 0.19	0.47	↑ 0.52	0.24	↑ 0.40
L1-269: Preventive Care and Screening: Influenza Immunization	5	0.16	↑ 0.33	0.23	↑ 0.37	0.19	↑ 0.34

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
L1-271: Immunization for Adolescents	3	0.18	↑ 0.18	0.20	↑ 0.24	0.15	↑ 0.18
L1-272: Adults (18+ years) Immunization status	2	0.10	↑ 0.25	0.00	↑ 0.02	0.23	↑ 0.26
L1-280: Chlamydia Screening in Women (CHL)	5	0.77	↓ 0.63	0.58	↓ 0.45	0.73	↓ 0.54
L1-343: Syphilis positive screening rates	1	0.01	↑ 0.00	NA	NA	NA	NA
L1-344: Follow-up after Treatment for Primary or Secondary Syphilis	4	0.12	↑ 0.31	0.50	↑ 0.55	0.12	↑ 0.20
L1-345: Gonorrhea Positive Screening Rates	1	0.02	↓ 0.03	0.00	↓ 0.03	0.02	↓ 0.03
L1-346: Follow-up testing for N. gonorrhoeae among recently infected men and women	4	0.14	↑ 0.22	0.00	↑ 0.20	0.06	↑ 0.12
L1-347: Latent Tuberculosis Infection (LTBI) treatment rate	7	0.64	↑ 0.76	0.76	↓ 0.73	0.68	↑ 0.74
L1-400: Tobacco Use and Help with Quitting Among Adolescents	3	0.48	↑ 0.65	0.50	↑ 0.90	0.37	↑ 0.77
M1-100-1: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Treatment within 14 Days of Diagnosis	5	0.22	↑ 0.43	0.22	↑ 0.39	0.23	↑ 0.45
M1-100-2: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Two or More Additional Services within 30 Days of Initiation Visit	5	0.10	↑ 0.20	0.05	↑ 0.16	0.12	↑ 0.20

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
M1-103: Controlling High Blood Pressure	10	0.52	↑ 0.63	0.56	↑ 0.64	0.49	↑ 0.61
M1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	33	0.51	↑ 0.85	0.61	↑ 0.88	0.48	↑ 0.84
M1-115: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	7	0.55	↑ 0.37	0.57	↑ 0.34	0.55	↑ 0.36
M1-124: Medication Reconciliation Post-Discharge	3	0.13	↑ 0.47	0.12	↑ 0.42	0.13	↑ 0.47
M1-125: Antidepressant Medication Management (AMM-AD)	3	0.75	↓ 0.69	0.70	↓ 0.69	0.73	↓ 0.66
M1-1252: Antidepressant Medication Management (AMM-AD)	3	0.54	↓ 0.41	0.48	↓ 0.42	0.51	↓ 0.45
M1-146: Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	20	0.40	↑ 0.65	0.36	↑ 0.60	0.37	↑ 0.66
M1-147: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	31	0.53	↑ 0.86	0.56	↑ 0.89	0.48	↑ 0.85
M1-160-1: Follow-Up After Hospitalization for Mental Illness – Follow-up within 30 Days	23	0.63	↑ 0.84	0.71	↑ 0.86	0.63	↑ 0.84
M1-160-2: Follow-Up After Hospitalization for Mental Illness – Follow-up within 7 Days	23	0.43	↑ 0.75	0.46	↑ 0.73	0.50	↑ 0.71

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
M1-165: Depression Remission at Twelve Months	4	0.06	↑ 0.09	0.05	↑ 0.08	0.06	↑ 0.09
M1-180: Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)	4	0.49	↑ 0.56	0.56	↑ 0.63	0.47	↑ 0.55
M1-181: Depression Response at Twelve Months- Progress Towards Remission	5	0.10	↑ 0.12	0.10	↑ 0.14	0.13	↓ 0.12
M1-182: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	6	0.57	↑ 0.82	0.59	↑ 0.84	0.54	↑ 0.78
M1-203: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	2	0.09	↑ 0.46	0.07	↑ 0.45	0.11	↑ 0.48
M1-207: Diabetes care: BP control (<140/90mm Hg)	5	0.64	↑ 0.71	0.81	↓ 0.71	0.60	↑ 0.72
M1-210: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	7	0.27	↑ 0.63	0.29	↑ 0.63	0.28	↑ 0.63
M1-211-1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Height/Weight Documentation	12	0.66	↑ 0.99	0.69	↑ 0.99	0.38	↑ 0.99
M1-211-2: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Nutrition	12	0.09	↑ 0.86	0.10	↑ 0.86	0.03	↑ 0.92

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
M1-211-3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – Counseling for Physical Activity	12	0.08	↑ 0.85	0.09	↑ 0.86	0.00	↑ 0.83
M1-241: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	2	0.05	↑ 0.02	0.03	↑ 0.01	0.06	↑ 0.02
M1-255: Follow-up Care for Children Prescribed ADHD Medication (ADD)	4	0.25	↑ 0.31	0.25	↑ 0.32	0.68	↓ 0.16
M1-2552: Follow-up Care for Children Prescribed ADHD Medication (ADD)	4	0.31	↑ 0.38	0.32	↑ 0.40	0.42	↓ 0.25
M1-256: Initiation of Depression Treatment	2	0.59	↑ 0.68	0.42	↑ 0.52	0.68	↑ 0.81
M1-257: Care Planning for Dual Diagnosis	13	0.26	↑ 0.46	0.21	↑ 0.49	0.22	↑ 0.46
M1-259: Assignment of Primary Care Physician to Individuals with Schizophrenia	11	0.35	↑ 0.53	0.36	↑ 0.59	0.31	↑ 0.44
M1-260: Annual Physical Exam for Persons with Mental Illness	6	0.09	↑ 0.24	0.06	↑ 0.23	0.11	↑ 0.24
M1-261: Assessment for Substance Abuse Problems of Psychiatric Patients	18	0.73	↑ 0.92	0.71	↑ 0.91	0.81	↑ 0.95
M1-262: Assessment of Risk to Self/ Others	10	0.55	↑ 0.80	0.64	↑ 0.83	0.49	↑ 0.81

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
M1-263: Assessment for Psychosocial Issues of Psychiatric Patients	7	0.38	↑ 0.95	0.26	↑ 0.83	0.43	↑ 0.96
M1-264: Vocational Rehabilitation for Schizophrenia	7	0.17	↑ 0.42	0.21	↑ 0.41	0.16	↑ 0.41
M1-265: Housing Assessment for Individuals with Schizophrenia	11	0.05	↑ 0.24	0.05	↑ 0.27	0.05	↑ 0.18
M1-266: Independent Living Skills Assessment for Individuals with Schizophrenia	10	0.17	↑ 0.65	0.17	↑ 0.69	0.17	↑ 0.61
M1-286: Depression Remission at Six Months	3	0.03	↑ 0.06	0.05	↑ 0.06	0.04	↑ 0.05
M1-287: Documentation of Current Medications in the Medical Record	10	0.12	↑ 0.56	0.11	↑ 0.58	0.12	↑ 0.56
M1-305: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)	16	0.32	↑ 0.80	0.29	↑ 0.80	0.31	↑ 0.80
M1-306: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	1	0.70	↑ 0.74	0.71	↑ 0.74	0.59	↑ 0.69
M1-317: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	23	0.35	↑ 0.88	0.52	↑ 0.88	0.33	↑ 0.88
M1-319: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	25	0.48	↑ 0.81	0.44	↑ 0.83	0.49	↑ 0.81

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate29	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
M1-340: Substance use disorders: Counseling regarding psychosocial AND pharmacologic treatment options for opioid addiction	6	0.06	↑ 0.51	0.06	↑ 0.35	0.15	↑ 0.48
M1-341: Substance use disorders: Counseling regarding psychosocial AND pharmacologic treatment options for alcohol dependence	6	0.06	↑ 0.37	0.07	↑ 0.37	0.05	↑ 0.38
M1-342: Time to Initial Evaluation: Evaluation within 10 Business Days	8	0.61	↑ 0.68	0.57	↑ 0.68	0.63	↑ 0.67
M1-385: Assessment of Functional Status or QoL	5	0.15	↑ 0.27	0.16	↑ 0.26	0.19	↑ 0.53
M1-386: Improvement in Functional Status or QoL	4	0.71	↑ 0.85	0.80	↑ 0.85	0.01	↑ 0.81
M1-390: Time to Initial Evaluation: Mean Days to Evaluation	12	14.50	↑ 10.5	16.09	↑ 11.28	16.16	↑ 10.09
M1-400: Tobacco Use and Help with Quitting Among Adolescents	8	0.70	↑ 0.89	0.67	↑ 0.92	0.66	↑ 0.89
M1-405: Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	7	0.51	↑ 0.82	0.49	↑ 0.78	0.51	↑ 0.83

Appendix G. Category C Measurement Population by Payer Type

Table 23. Measure Population and Payer Type Distribution by Measure Bundle for 2019

Measure Bundle	Population Measured	% LIU	% Medicaid or CHIP	% Other
A1: Improved Chronic Disease Management: Diabetes Care	Adults	31%	16%	53%
A2: Improved Chronic Disease Management: Heart Disease	Adults	24%	16%	61%
B1: Care Transitions & Hospital Readmissions	All	14%	16%	70%
B2: Patient Navigation & ED Diversion	All	28%	21%	50%
C1: Primary Care Prevention - Healthy Texans	Adults	17%	18%	65%
C2: Primary Care Prevention - Cancer Screening	Adults	27%	10%	63%
C3: Hepatitis C	Adults	41%	35%	24%
D1: Pediatric Primary Care	Children	8%	43%	48%
D4: Pediatric Chronic Disease Management: Asthma	Children	4%	71%	25%
D5: Pediatric Chronic Disease Management: Diabetes	Children	3%	46%	51%
E1: Improved Maternal Care	All	5%	52%	43%
E2: Maternal Safety	All	3%	31%	66%
F1: Improved Access to Adult Dental Care	Adults	79%	7%	15%
F2: Preventive Pediatric Dental	Children	67%	31%	2%
G1: Palliative Care	All	29%	14%	57%
H1: Integration of Behavioral Health in a Primary or Specialty Care Setting	All	21%	26%	54%
H2: Behavioral Health and Appropriate Utilization	All	32%	28%	40%
H3: Chronic Non-Malignant Pain Management	All	49%	11%	40%
H4: Integrated Care for People with Serious Mental Illness	All	47%	27%	26%

Measure Bundle	Population Measured	% LIU	% Medicaid or CHIP	% Other
I1: Specialty Care	All	6%	29%	65%
K1: Rural Preventive Care	Adults	8%	20%	72%
K2: Rural Emergency Care	Adults	13%	16%	71%
L1: Local Health Department Measures	All	52%	18%	29%
M1: Community Mental Health Center Measures	All	48%	45%	7%

Appendix H. Measuring High Performance for Category C Pay-for-Performance (P4P) Measures

High performance on a Category C pay-for-performance (P4P) measure is defined as PY 2 performance that meets at least one of the following three criteria:

1. PY 2 (2019) performance is an improvement over baseline (2017) performance;
2. PY 2 performance is higher than the median PY 2 performance for the measure; or
3. PY 2 performance is higher than the 90th percentile national benchmark for the measure, if available.

Successful Category C pay-for-performance (P4P) measures are defined as PY 2 performance that meets at least one of the following four criteria:

1. The measure achieved 100% of the DY 8 goal in PY 2;
2. The PY 2 performance rate was greater than the median performance rate in PY 2 for either:
   a. The Medicaid population;
   b. The Low-Income Uninsured (LIU) population; or
   c. The achievement payer type population (could be MLIU or all-payer).

Each P4P measure is designated in the DSRIP Measure Bundle Protocol as either Improvement over Self (IOS) or Quality Improvement System for Managed Care (QISMC). For both types, performing providers establish a baseline performance level with one calendar year of data for each measure. The measure goal for each performance year is set as an improvement over the baseline.

The performance year goals for IOS measures are gap closures. The gap is the difference between a measure's baseline and perfect achievement. A gap closure is when the performance year rate is closer to perfect achievement than to the baseline rate. Each performance year, the percentage for the gap closure goal

increases. The exact percentages by year can be found in the DSRIP Program Funding and Mechanics Protocol (PFM).[30]

QISMC measures have a defined High-Performance Level (HPL) and Minimum Performance Level (MPL). The HPL is the 90th percentile based on national benchmarks, and the MPL is the 25th percentile based on national benchmarks. For measures with a baseline below the MPL, the goal for DY 7 was to meet the MPL. Each subsequent year, the goal is a progressively larger gap closure. For measures with a baseline between the MPL and HPL, each year the goal is the greater absolute value of improvement between a specific gap closure towards the HPL, or baseline plus (minus) a specific percentage difference between the HPL and MPL. The percentage and gap closure goals increase for each subsequent year. For measures with a baseline greater than or equal to the HPL, the goal for each year is the lesser absolute value of improvement of baseline plus (minus) a specific percentage difference between the HPL and MPL, or the IOS goal. The percentages for each subsequent year's goals increase each year. The exact percentages for each year can be found in the DSRIP PFM.

[30] The DSRIP Program Funding and Mechanics Protocol (PFM) is available on the HHSC 1115 waiver website here: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/final-attachment-j-pfm-protocol-dy9-10.pdf.

Appendix I. Core Activities Most Commonly Associated with High-Performing Category C Pay-for-Performance (P4P) Measures for Demonstration Years 7-8 by Measure Bundle

Table 24. Measure Bundle A1: Chronic Disease Management: Diabetes Care – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle A1 Measures with High Performance31
Chronic Care 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	65
Chronic Care Management	Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care–integrated complex care management (CCM), Complex Patient Care Model Redesign- enhanced multidisciplinary care teams, The Transitional Care Model, etc.)	46
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	31
Chronic Care Management	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.	25

[31] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle A1 Measures with High Performance31
Access to Primary Care Services	Provision of screening and follow up services	23

Table 25. Measure Bundle A2: Improved Chronic Disease Management: Heart Disease – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle A2 Measures with High Performance[32]
Chronic Care 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	40
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	38
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	29
Chronic Care Management	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.	26
Access to Primary Care Services	Provision of screening and follow up services	6

[32] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle A2 Measures with High Performance[32]
Patient Centered Medical Home	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.	6

Table 26. Measure Bundle B1: Care Transitions & Hospital Readmissions – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle B1 Measures with High Performance[33]
Expansion of Patient Care Navigation and Transition Services	Enhancement in coordination between primary care, urgent care, and Emergency Departments to increase communication and improve care transitions for patients	15
Expansion of Patient Care Navigation and Transition Services	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	13
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	9
Access to Primary Care Services	Provision of screening and follow up services	7

[33] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle B1 Measures with High Performance[33]
Patient Centered Medical Home	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.)	7

Table 27. Measure Bundle B2: Patient Navigation & ED Diversion – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle B2 Measures with High Performance[34]
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	5
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions	5
Expansion of Patient Care Navigation and Transition Services	Expansion of access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions	5
Chronic Care Management	Utilization of evidence-based care management models for patients identified as having high-risk health care needs and/or individuals with complex needs (e.g., Primary care–integrated complex care management (CCM), Complex Patient Care Model Redesign- enhanced multidisciplinary care teams, The Transitional Care Model, etc.)	4

[34] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle B2 Measures with High Performance[34]
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)	3
Expansion of Patient Care Navigation and Transition Services	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	3

Table 28. Measure Bundle C1: Primary Care Prevention – Healthy Texans – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle C1 Measures with High Performance[35]
Access to Primary Care Services	Provision of vaccinations to target population	31
Access to Primary Care Services	Provision of screening and follow up services	29
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	13
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)	9

[35] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle C1 Measures with High Performance[35]
Patient Centered Medical Home	Provision of coordinated services for patients under Patient Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care	8
Patient Centered Medical Home	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.)	8
Prevention and Wellness	Use of community health workers to improve prevention efforts	8

Table 29. Measure Bundle C2: Primary Care Prevention: Cancer Screening – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle C2 Measures with High Performance[36]
Access to Primary Care Services	Provision of screening and follow up services	15
Patient Centered Medical Home	Provision of coordinated services for patients under Patient Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care	5

[36] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle C2 Measures with High Performance[36]
Expansion of Patient Care Navigation and Transition Services	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	5
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	4
Patient Centered Medical Home	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.	3

Table 30. Measure Bundle C3: Hepatitis C - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle C3 Measures with High Performance[37]
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions	4

[37] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle C3 Measures with High Performance[37]
Patient Centered Medical Home	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.	3

Table 31. Measure Bundle D1: Pediatric Primary Care Measures – Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle D1 Measures with High Performance[38]
Access to Primary Care Services	Provision of vaccinations to target population	23
Patient Centered Medical Home	Provision of coordinated services for patients under Patient Centered Medical Home (PCMH) model, which incorporates empanelment of patients to physicians, and management or chronic conditions and preventive care	9
Prevention and Wellness	Use of community health workers to improve prevention efforts	9
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	7

[38] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle D1 Measures with High Performance[38]
Patient Centered Medical Home	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.	6

Table 32. Measure Bundle D3: Pediatric Hospital Safety - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle D3 Measures with High Performance[39]
Hospital Safety and Quality	Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)	7

[39] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 33. Measure Bundle E1: Improved Maternal Care - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle E1 Measures with High Performance[40]
Maternal and Infant Health Care	Provision of coordinated prenatal and postpartum care	12
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)	10
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	6
Access to Primary Care Services	Provision of screening and follow up services	4
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)	4

[40] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 34. Measure Bundle E2: Maternal Safety - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle E2 Measures with High Performance[41]
Maternal and Infant Health Care	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)	6
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)	5
Access to Primary Care Services	Provision of screening and follow up services	2
Hospital Safety and Quality	Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)	2

[41] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 35. Measure Bundle G1: Palliative Care - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle G1 Measures with High Performance[42]
Palliative Care	Provision of coordinated palliative care to address patients with end-of-life decisions and care needs	30
Palliative Care	Utilization of services assisting individuals with pain management	18
Palliative Care	Transitioning of palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility and management of patients' needs	12
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	6
Access to Primary Care Services	Other	6

[42] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 36. Measure Bundle H1: Integration of Behavioral Health in a Primary or Specialty Care Setting- Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle H1 Measures with High Performance[43]
Patient Centered Medical Home	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.	4
Access to Primary Care Services	Provision of screening and follow up services	3
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of telehealth/telemedicine in delivering behavioral services	3

Table 37. Measure Bundle H2: Behavioral Health and Appropriate Utilization- Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle H2 Measures with High Performance[44]
Access to Primary Care Services	Provision of screening and follow up services	6

[43] The definition of high performance on Category C P4P measures is available in Appendix H.

[44] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle H2 Measures with High Performance[44]
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of Care Management function that integrates primary and behavioral health needs of individuals	6
Chronic Care Management	Implementation of a medication management program that serves patients across the continuum of care	1

Table 38. Measure Bundle H3: Chronic Non-Malignant Pain Management - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle H3 Measures with High Performance[45]
Access to Primary Care Services	Provision of screening and follow up services	4
Patient Centered Medical Home	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.	4
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	4
Behavioral Health Crisis Stabilization Services	Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients	4

[45] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	Measure Bundle H3 Measures with High Performance[45]
Behavioral Health Crisis Stabilization Services	Implement models supporting recovery of individuals with behavioral health needs	4
Prevention and Wellness	Implementation of interventions focusing on social determinants of health that can lead to improvement in well-being of an individual	4
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)	4

Table 39. Measure Bundle I1: Specialty Care- Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle I1 Measures with High Performance[46]
Access to Primary Care Services	Provision of screening and follow up services	2

[46] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 40. Measure Bundle J1: Hospital Safety- Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle J1 Measures with High Performance[47]
Hospital Safety and Quality	Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (e.g., CLABSI, CAUTI, SSI, Sepsis, and Falls)	19
Hospital Safety and Quality	Implementation of evidence-based practices to improve quality of care (e.g., Quality Departments, monitoring and evaluation, etc.)	17
Access to Primary Care Services	Provision of screening and follow up services	5
Expansion of Patient Care Navigation and Transition Services	Enhancement in coordination between primary care, urgent care, and Emergency Departments to increase communication and improve care transitions for patients	4
Chronic Care 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	4

[47] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 41. Measure Bundle K1: Rural Preventive Care- Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle K1 Measures with High Performance[48]
Hospital Safety and Quality	Implementation of evidence-based practices to improve quality of care (e.g., Quality Departments, monitoring and evaluation, etc.)	21
Access to Primary Care Services	Provision of screening and follow up services	16
Access to Primary Care Services	Provision of vaccinations to target population	14
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management	14
Access to Primary Care Services	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)	12

[48] The definition of high performance on Category C P4P measures is available in Appendix H.

Table 42. Measure Bundle K2: Rural Emergency Care- Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	Measure Bundle K2 Measures with High Performance[49]
Expansion of Patient Care Navigation and Transition Services	Enhancement in coordination between primary care, urgent care, and Emergency Departments to increase communication and improve care transitions for patients	19
Access to Primary Care Services	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)	6
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	6

Table 43. Local Health Departments (LHD) Measures - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	LHD Measures with High Performance[50]
Access to Primary Care Services	Provision of screening and follow up services	24
Access to Primary Care Services	Provision of vaccinations to target population	11

[49] The definition of high performance on Category C P4P measures is available in Appendix H.

[50] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	LHD Measures with High Performance[50]
Access to Primary Care Services	Expanded Practice Access (e.g., increased hours, telemedicine, etc.)	7
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions	7
Access to Primary Care Services	Provision of services to individuals that address social determinants of health	6

Table 44. Community Mental Health Centers (CMHC) Measures - Core Activities Most Commonly Associated with High-Performing Category C P4P Measures

Core Activity Grouping	Core Activity Title	CMHC Measures with High Performance51
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of care aligned with Certified Community Behavioral Health Clinic (CCBHC) model	206
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of telehealth/telemedicine in delivering behavioral services	63

[51] The definition of high performance on Category C P4P measures is available in Appendix H.

Core Activity Grouping	Core Activity Title	CMHC Measures with High Performance51
Access to Primary Care Services	Integrated physical and behavioral health care services	54
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of services to individuals that address social determinants of health and/or family support services	43
Access to Primary Care Services	Other	36

Appendix J. Related Strategies and Category C Successful Performance in Demonstration Years 7-8

Table 45. Frequently-implemented Related Strategies Associated with Percent of Measures that Fully Achieved the DY 8 Goal as compared to the Percent of Measures that did not Fully Achieve the DY 8 Goal

Related Strategy	Percent of Measures that Fully Achieved the DY 8 Goal with the Related Strategy (Measures with Implemented Related Strategy/ Measures that Achieved 100% of the DY 8 Goal)	Percent of Measures that did not Fully Achieve the DY 8 Goal with the Related Strategy (Measures with Implemented Related Strategy/ Measures that did not Achieve 100% of the DY 8 Goal)
Same-day and/or walk-in appointments in the outpatient setting	80% (1241/1544)	81% (347/431)
Culturally and linguistically appropriate care planning for patients	76% (1271/1681)	74% (334/451)
Pre-visit planning and/or standing order protocols	76% (1273/1681)	78% (353/451)
Care team includes personnel in a care coordination role requiring clinical licensure	79% (1328/1681)	84% (378/451)
Database or registry to track quality and clinical outcomes data on patients	69% (1231/1793)	69% (370/538)

Table 46. Related Strategies with the Greatest Difference in Implementation Status between Category C Pay-for-Performance (P4P) Measures that Fully Achieved the DY 8 Goal and Category C P4P Measures that did not Fully Achieve the DY 8 Goal

Related Strategy	Percent of Measures that Fully Achieved the DY 8 Goal with the Related Strategy (Measures with Implemented Related Strategy/ Measures that Achieved 100% of the DY 8 Goal)	Percent of Measures that did not Fully Achieve the DY 8 Goal with the Related Strategy (Measures with Implemented Related Strategy/ Measures that did not Achieve 100% of the DY 8 Goal)
Screening patients for housing needs	60% (955/1591)	45% (198/441)
Home visit model of providing clinical services at a patient's residence	44% (675/1544)	32% (119/376)
Screening patients for housing quality needs	41% (654/1591)	31% (137/441)

Table 47. Related Strategies with the Greatest Difference in Implementation Status between Category C Pay-for-Performance (P4P) Measures that were High Performing for the Medicaid Population and Category C P4P Measures that were not High Performing for the Medicaid Population

Related Strategy	Percent of Successful Measures with the Related Strategy (Measures with Implemented Related Strategy/ Measures with Medicaid Performance Rate greater than the Median Medicaid Performance Rate)	Percent of Non-Successful Measures with the Related Strategy (Measures with Implemented Related Strategy/ Measures with Medicaid Performance Rate at or below the Median Medicaid Performance Rate)
Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting	62% (119/191)	55% (115/211)
Panel management and/or proactive outreach of patients using a gap analysis method	55% (560/1013)	49% (525/1075)
Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences	33% (298/902)	28% (268/961)
Screening patients for food insecurity	50% (480/961)	45% (463/1020)
Screening patients for housing needs	59% (571/961)	54% (554/1020)

Table 48. Related Strategies with the Greatest Difference in Implementation Status between Category C Pay-for-Performance (P4P) Measures that were High Performing for the Low-income or Uninsured (LIU) Population and Category C P4P Measures that were not High Performing for the LIU Population

Related Strategy	Percent of Successful Measures with the Related Strategy (Measures with Implemented Related Strategy/ Measures with LIU Performance Rate greater than the Median LIU Performance Rate)	Percent of Non-Successful Measures with the Related Strategy (Measures with Implemented Related Strategy/ Measures with LIU Performance Rate at or below the Median LIU Performance Rate)
Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients	43% (424/976)	36% (390/1076)
Formal closed loop process for coordinating the transition from pediatric to adult care	46% (41/90)	39% (39/101)
Panel management and/or proactive outreach of patients using a gap analysis method	55% (546/986)	49% (530/1086)
Formal partnership or arrangement with food resources to support patient health status	31% (294/935)	24% (243/1030)
Formal partnership or arrangement with housing resources to support patient health status	28% (262/935)	21% (220/1030)

Appendix K. Related Strategies More Likely to be Associated with Successful Performance on Category C Pay-for-Performance (P4P) Measures for Demonstration Years 7-8 by Provider Type

Table 49. Related Strategies More Likely to be Associated with Successful Performance on Category C Pay-for-Performance Measures by Provider Type[52]

Related Strategy	Public Non-Rural Hospital	Public Rural Hospital	Private Non-Rural Hospital	Private Rural Hospital	Physician Practice	CMHC	LHD
Panel management and/or proactive outreach of patients using a gap analysis method	Yes		Yes			Yes	Yes
Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data		Yes	Yes			Yes	
Screening patients for housing needs		Yes	Yes				Yes
Screening patients for housing quality needs		Yes	Yes				Yes

[52] To determine Related Strategies more likely to be associated with successful measure performance, HHSC identified the Related Strategies with the greatest difference in selection between successful measures and non-successful measures. The definition of successful performance for Category C P4P measures is available in Appendix H. For each provider type, HHSC identified the five Related Strategies with the greatest difference in Related Strategy implementation between successful and non-successful measures in each category. Strategies marked with a "Yes" indicate a strategy for a provider type were ranked in the top strategies more likely to be implemented in one or more categories of a successful measure. Related Strategies with insignificant selection volume were excluded, as well as Related Strategies with no measurable positive difference between successful and non-successful measures.

Related Strategy	Public Non-Rural Hospital	Public Rural Hospital	Private Non-Rural Hospital	Private Rural Hospital	Physician Practice	CMHC	LHD
Home visit model of providing clinical services at a patient's residence		Yes			Yes		Yes
Classes for patients focused on physical activity					Yes	Yes	Yes
Group visit model or similar non-traditional appointment format that includes at least one provider and a group of patients with shared clinical and/or social experiences	Yes		Yes				
Care team includes a registered dietician(s)	Yes				Yes		
Formal partnership or arrangement with food resources to support patient health status	Yes				Yes		
Medication-Assisted Treatment (MAT) services actively offered	Yes				Yes		
Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only)	Yes				Yes		
Formal closed loop process for coordinating the transition from pediatric to adult care	Yes					Yes	
Analysis of appointment "no-show" rates		Yes	Yes				

Related Strategy	Public Non-Rural Hospital	Public Rural Hospital	Private Non-Rural Hospital	Private Rural Hospital	Physician Practice	CMHC	LHD
Care team includes personnel in a care coordination role not requiring clinical licensure		Yes		Yes			
Patient educational materials or campaigns about advance care planning/directives			Yes	Yes			
Care team includes a clinical pharmacist(s)			Yes			Yes	
Formal closed loop process for scheduling referral visits as needed			Yes				Yes
Hotline, call center, or other similar programming staffed by personnel with clinical licensure to answer questions for patients (and their families) related to medications, clinical triage, care transitions, etc.				Yes		Yes	
Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting				Yes			Yes
Night and/or weekend appointments in the outpatient setting					Yes		Yes
Panel management and/or proactive outreach of patients using a risk-stratification method					Yes		Yes

Related Strategy	Public Non-Rural Hospital	Public Rural Hospital	Private Non-Rural Hospital	Private Rural Hospital	Physician Practice	CMHC	LHD
Telehealth to provide remote monitoring of patient biometric data and/or medication adherence					Yes		Yes
Formal partnership or arrangement with transportation resources to support patient access to care						Yes	Yes
Screening patients for transportation needs						Yes	Yes
Formal partnership or arrangement with schools/school districts to collaborate on health-promoting initiatives	Yes						
Formal partnership or arrangement with schools/school districts to track/share data such as absenteeism, classroom behaviors, etc.	Yes						
Integration or co-location of primary care and psychiatric services in the outpatient setting	Yes						
Data sharing connectivity across care settings within provider's integrated delivery system for patient medical records		Yes					
Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system for patient medical records		Yes					

Related Strategy	Public Non-Rural Hospital	Public Rural Hospital	Private Non-Rural Hospital	Private Rural Hospital	Physician Practice	CMHC	LHD
Telehealth to provide virtual medical appointments and/or consultations with a primary care provider		Yes					
Integration or co-location of primary care and dental services in the outpatient setting			Yes				
SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place			Yes				
Classes for patients focused on disease self-management				Yes			
Culturally and linguistically appropriate care planning for patients				Yes			
Formal partnership or arrangement with post-acute care facilities to track/share quality measures such as length of stay and readmission rates, etc.				Yes			
Patient educational materials or campaigns about preventive care				Yes			
Classes for patients focused on diet, nutrition counseling, and/or cooking						Yes	
Formal closed loop process for scheduling a follow-up visit with a primary care provider and/or assigning a primary care provider when none is identified							Yes

Related Strategy	Public Non-Rural Hospital	Public Rural Hospital	Private Non-Rural Hospital	Private Rural Hospital	Physician Practice	CMHC	LHD
Screening patients for food insecurity							Yes

Appendix L. Return on Investment (ROI) by Provider Type and Core Activity Grouping

Table 50. Hospital Provider Type – ROIs by Core Activity Grouping

Core Activity Grouping	Description and the Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Chronic Care Management	Management of targeted patient populations (25); Utilization of evidence-based care management models for patients identified as having high-risk health care needs (9); and Implementation of a medication management program (1).	35	3
Access to Primary Care Services	Provision of screening and follow up services (15); Expanded Practice Access (e.g., increased hours, telemedicine, etc.) (5); Establishment of care coordination and active referral management (2); Provision of vaccinations (1); Increase in capacity and access to services by utilizing Community Health Workers (1); Provision of services to individuals that address social determinants of health (SDOH) (1); and Provider collaboration (1).	26	4
Expansion of Patient Care Navigation and Transition Services	Provision of navigation services to targeted patients (8); Identification of frequent ED users and use of care navigators as part of a preventable ED reduction program (5); Enhancement in coordination between primary care, urgent care, and EDs (3); Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients (2); and Implementation of a care transition and/or a discharge planning program (2).	20	3
Maternal and Infant Health Care	Develop and implement standard protocols for the leading causes of preventable death and complications for mothers and infants (4); Implementation of evidence-based strategies to reduce low birth weight and preterm birth (2); Reduction in variation in post-partum follow up care (2); Education related to Cesarean Sections (1); and Provision of services to individuals that address SDOH (1).	10	0

Core Activity Grouping	Description and the Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions (3); and Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (2); educational campaigns (tobacco cessation, vaccination, advance care planning) (3).	8	0
Hospital Safety and Quality	Development and implementation of standard protocols and/or evidence-based practices to address leading causes of hospital infections and injuries (6); and Implementation of evidence-based practices to improve quality of care (2).	8	0
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of Care Management function that integrates primary and behavioral health needs of individuals (2); Increasing access to services by utilizing staff with the following qualifications: Wellness and Health Navigation: peer specialists (1); and Behavioral health crisis stabilization services (1).	4	3
Access to Specialty Care Services	Use telemedicine/telehealth to deliver specialty services (1); and Improvement in access to specialty care services with the concentration on underserved areas (1).	2	0
Patient Centered Medical Home	Utilization of care teams that are tailored to the patient's health care needs, including non-physician health professionals (1); and Patient Centered Medical Home (PCMH) model (1).	2	3
Palliative Care	Utilization of services assisting individuals with pain management (1).	1	0
Improvement in Internal Processes	Decrease the time between first patient contact and initial evaluation for services (1).	1	1

Table 51. CMHC Provider Type – ROIs by Core Activity Grouping

Core Activity Grouping	Description and Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of telehealth/telemedicine in delivering behavioral services (5); Provision of care aligned with CCBHC model (5); Provision of services to individuals that address SDOH (3); Utilization of Care Management function that integrates primary and behavioral health needs of individuals (1); Increasing access to services by utilizing peer specialists (1); Other- follow up with individuals discharged from a psychiatric facility (1); and Other - psychiatric triage (1)	17	2
Behavioral Health Crisis Stabilization Services	Implementation of community-based crisis stabilization alternatives that meet the behavioral health needs of the patients (3); Implement models supporting recovery of individuals with behavioral health needs (1); and Other - crisis respite (1)	5	0
Prevention and Wellness	Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions (2); Implementation of evidence-based strategies to reduce and prevent obesity in children and adolescents (1); and Utilization of whole health peer support (1)	4	0
Access to Primary Care Services	Integrated physical and behavioral health care services (2)	2	2
Expansion of Patient Care Navigation and Transition Services	Expansion of access to medical advice and direction to the appropriate level of care to reduce ED use for non-emergent conditions (1)	1	0

Core Activity Grouping	Description and Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Access to Specialty Care Services	Improvement in access to specialty care services with the concentration on underserved areas (1)	1	0
Chronic Care Management	Implementation of a medication management program that serves patients across the continuum of care (1)	1	1
Substance Use Disorder	There are no Core Activities with positive ROIs in this grouping	0	1
Other	There are no Core Activities with positive ROIs in this grouping	0	1

Table 52. Physician Practices' ROIs by Core Activity Grouping

Core Activity Grouping	Description and Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management (4); and Management of targeted patient populations (1)	5	0
Access to Primary Care Services	Provision of vaccinations to target population (2); Provision of screening and follow up services (1); and Provision of services to individuals that address SDOH (1)	4	0
Expansion of Patient Care Navigation and Transition Services	Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients (1); and Implementation of a care transition and/or a discharge planning program and post discharge support program (1)	2	0

Core Activity Grouping	Description and Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Prevention and Wellness	Self-management programs and wellness programs using evidence-based designs (1)	1	0
Patient Centered Medical Home	Utilization of care teams that are tailored to the patient's health care needs, including non-physician health professionals (1)	1	0
Access to Specialty Care Services	Improvement in access to specialty care services with the concentration on underserved areas (1)	1	0
Availability of Appropriate Levels of Behavioral Health Care Services	Utilization of mobile clinics that can provide access to behavioral health care in very remote, inaccessible, or impoverished areas of Texas (1)	1	0
Prevention and Wellness	There are no Core Activities with positive ROIs in this grouping	0	1

Table 53. LHDs' ROIs by Core Activity Grouping

Core Activity Grouping	Description and Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Prevention and Wellness	Implementation of interventions focusing on SDOH (2); Implementation of evidence-based strategies to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions (1); Implementation of strategies to reduce tobacco use (1); and Utilization of whole health peer support (1)	5	0

Core Activity Grouping	Description and Number of Core Activities with Positive ROI	Number of Positive ROIs	Number of Negative ROIs
Expansion of Patient Care Navigation and Transition Services	Expansion of access to medical advice and direction to the appropriate level of care to reduce ED use for non-emergent conditions (1); and Provision of services to individuals that address SDOH (1)	2	0
Chronic Care Management	Utilization of care management and/or chronic care management services, including education in chronic disease self-management (1)	1	0
Availability of Appropriate Levels of Behavioral Health Care Services	Provision of services to individuals that address SDOH (1)	1	0
Access to Primary Care Services	Provision of screening and follow up services (1)	1	1
Behavioral Health Crisis Stabilization Services	Implement models supporting recovery of individuals with behavioral health needs (1)	1	0
Maternal and Infant Health Care	A Core Activity with an ROI of 0 (1)	0	0