Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid

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Executive Summary

In compliance with Senate Bill (S.B.) 1136, 87th Legislature, Regular Session, 2021, this report provides an overview of the Health and Human Services Commission's (HHSC's) efforts to coordinate with hospitals and other providers to:

- Identify and implement initiatives designed to reduce Medicaid recipients' use of emergency room services as a primary means of receiving health care benefits, and
- Encourage Medicaid providers to continue implementing effective interventions and best practices that were developed and achieved under the Delivery System Reform Incentive Payment (DSRIP) program.

This report summarizes existing DSRIP data regarding hospitals' tracking of potentially preventable emergency room visits (PPVs), DSRIP providers' identification and use of best practices with a positive Return on Investment (ROI), and the DSRIP anchor annual report. HHSC will use DSRIP provider reported data as a starting place for identifying and developing new initiatives that reduce PPV rates or that improve Medicaid recipients' health outcomes.

This report includes information on current and proposed initiatives for addressing potentially preventable emergency department (ED)[1] utilization and for implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients:

- HHSC implemented or continued progress on initiatives designed to reduce ED utilization as a primary means of receiving healthcare by Medicaid recipients, including:
  - Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project
  - Medicaid Teleservices Expansion
- HHSC implemented or continued progress on initiatives to encourage Medicaid providers and managed care organizations (MCOs) to continue

[1] For the purposes of this report, emergency room and emergency department are used interchangeably.

implementing effective interventions and best practices associated with improving Medicaid recipients' health outcomes accomplished under the DSRIP program, including:

- Medicaid Benefits Changes
- Initiative to Increase Disease Management Participation
- Tobacco Cessation Efforts

The first *Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid*[2]*,* submitted March 2022, described the current scope of PPVs, existing initiatives to reduce potentially preventable ED utilization by Medicaid recipients, initial and proposed initiatives to improve Medicaid recipients' health outcomes, and HHSC's stakeholder engagement plan. Initiatives discussed in the first biannual report that do not have significant status changes at time of writing this report are not included in this update.[3]

S.B. 1136 requires HHSC to coordinate with hospitals and other providers to identify and implement initiatives to reduce ED utilization. This report includes discussion of the survey HHSC conducted in spring 2022 with providers receiving uncompensated care (UC) payments and MCOs. Respondents indicated they have observed patients seeking primary care services in an ED setting. However, the majority of organizations also indicated they had implemented initiatives designed to reduce ED visits for primary care services or improve access to primary care. Additional responses to the survey provide information on best practices and other recommendations to address barriers to implementation.

This report describes data analysis of DSRIP hospitals' tracking of PPVs, analysis of DSRIP providers' Costs and Savings interventions, a summary of the results of the DSRIP anchor annual report, current initiatives to reduce potentially preventable ED utilization by Medicaid recipients, ongoing efforts to improve Medicaid recipients' health outcomes, and HHSC's stakeholder engagement survey. Future reports,

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[2] https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf

[3] Initiatives without significant status changes: Medical Pay for Quality (P4Q) Program, Performance Improvement Projects (PIPs), HHSC Performance Indicator Dashboard, Medicaid Value-based Enrollment (VBE), Directed Payment Programs (DPPs), Alternative Payment Model Requirements for MCOs, and Proposed Value-based Purchasing Arrangements to Address SDOH.

required by S.B. 1136 to be submitted biannually, will provide updates on these programs and other new initiatives.

1. Introduction

In compliance with S.B. 1136, 87th Legislature, Regular Session, 2021, HHSC must report biannually on the agency's efforts to implement initiatives and measures designed to reduce costs and improve recipient health outcomes under Medicaid. The report must provide updates on the agency's efforts to coordinate with hospitals and other providers that receive uncompensated care (UC) pool payments to identify and implement initiatives based on best practices and models designed to reduce Medicaid recipients' use of hospital ED services as a primary means of receiving health care benefits. The report must also provide updates on HHSC's efforts to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were accomplished under the DSRIP program. The bill directs HHSC to encourage these best practices through existing provider incentive programs, the creation of new provider incentive programs, the terms of contracts with Medicaid MCOs, use of alternative payment models (APMs), and other cost-effective measures.

In December 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. When CMS renewed the Waiver in December 2017, it authorized DSRIP funding through September 30, 2021 with a Waiver end date of September 2022.

In January 2021, CMS approved a 10-year extension of the waiver to 2030, which is in effect. Through the extension, Texas worked to sustain the historical DSRIP funding through the terms of the waiver and a DSRIP Transition Plan, that led to the creation of four new state directed payment programs. Under the federal authority for DPPs, HHSC may direct MCOs to pay increased reimbursements to participating providers. Participating providers are required to report certain quality metrics as a condition of participation; the data will be used to evaluate the programs efficacy in advancing state quality goals. HHSC already operates the Quality Incentive Payment Program DPP for Nursing Facilities. The four new DPPs developed under the DSRIP Transition Plan include:

- Comprehensive Hospital Increased Reimbursement Program (CHIRP)

- Texas Incentives for Physicians and Professional Services (TIPPS)
- Rural Access Primary and Preventive Services (RAPPS)
- DPP for Behavioral Health Services (DPP BHS)

HHSC needs to apply to CMS for approval of these DPPs annually. HHSC submitted the fiscal year 2023 applications, or preprints, for these DPPs to CMS on March 1, 2022. CMS approved these DPPs for fiscal year 2023 on August 1, 2022.

The Waiver also authorized the UC pool. UC payments originated as a way for Texas to continue to expand managed care in Medicaid programs and continue making supplemental payments to hospitals. Texas UC payments may be used to reduce the actual uncompensated cost of medical services provided to uninsured individuals who meet a provider's charity care policy. The medical services must meet the definition of "medical assistance" defined in federal law. UC pool participating providers include public and private hospitals, public ambulance providers, government dental providers, and physician practice groups.

The DSRIP program is designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers (CMHCs), and local health departments (LHDs) for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. Texas providers earned over $22.7 billion in DSRIP funds from 2012 to January 2022, served 11.7 million people, and provided 29.4 million encounters from October 1, 2013 to September 30, 2017.[4]

Over the course of the DSRIP program, numerous best practices were identified. HHSC published analyses of DSRIP data in the *Provider Performance in the DSRIP Program, DYs 7 and 8 Report*[5] and the *DSRIP Transition Plan Milestone: Support*

[4] The number of people served and encounters provided are for Demonstration Years (DYs) 3-6 (October 1, 2013 to September 30, 2017) and are not unduplicated counts.

[5] Texas Health & Human Services Commission. *Provider Performance in the DSRIP Program, DYs 7 and 8 Report.* December 2020. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf

Further Delivery System Reform.[6] In January 2020, HHSC established the DSRIP Transition Best Practices Workgroup (BPW), comprised of 84 DSRIP provider representatives, DSRIP anchor organization representatives (public hospitals and local governmental entities who act as coordinators for providers in their regions), and Executive Committee Waiver members (a workgroup that provides HHSC with feedback on Waiver implementation). The workgroup 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 prioritized DSRIP outcome measures and practices, which were identified as key to driving improvements in the health status of clients.

Through data analysis and stakeholder engagement, the following DSRIP best practices were identified.

- Improving patient navigation and care coordination through practices such as pre-visit planning and providing culturally and linguistically appropriate care.
- Sustaining and expanding access to critical health care services, including through telehealth.
- Integration or co-location of primary care with specialty care and psychiatric services.
- Care teams that include a care coordination role such as community health workers (CHWs) and social workers.

Key DSRIP quality measures for driving improvements in the health status of clients included measures related to maternal health, screenings for health promotion and disease prevention, chronic care management, especially diabetes, and follow-up after hospitalization for mental illness. Appendix A includes an overview of the BPW results and the full list of key practices and measures.

[6] Texas Health & Human Services Commission. *DSRIP Transition Plan Milestone: Support Further Delivery System Reform.* December 2020. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-support-delivery-system-reform.pdf

2. Analysis of DSRIP Provider Reported Data

As discussed in the March 2022 *Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid*[7], HHSC operates several initiatives intended to reduce PPVs in Medicaid. The number of PPVs decreased significantly from 2013 to 2020 by over 15 percent, while the resource use or price of the remaining PPVs increased enough to increase total PPV expenditures. Data on PPV rates and expenditures is updated annually and will be published in time for inclusion in the next biannual report.

HHSC leveraged existing DSRIP data on initiatives to reduce PPVs, including for the Medicaid and Low-Income Uninsured (LIU) population, to round out the PPV data analysis provided in the first report. Hospitals reported annual qualitative data on PPVs and other potentially preventable events (PPEs) in DSRIP. This report includes a summary of trends in hospitals' PPV rates and of initiatives hospitals implemented to help address preventable ED visits.

HHSC also analyzed provider reported data regarding best practices to improve quality of care and health outcomes of patients. In October 2021, DSRIP providers submitted ROI analyses of one of their DSRIP interventions. Additionally, as part of the DSRIP Annual Report in December 2021, DSRIP providers submitted information regarding best practices developed and achieved under DSRIP. This report includes a summary of the results of the ROI analysis, a summary of the results of the annual report, and how provider reporting in both cases incorporated DSRIP best practices to improve the health outcomes of Medicaid recipients.

DSRIP Category D PPV Reporting

Category D reporting was designed to provide insights into regional and statewide health care trends for DSRIP performing providers, MCOs, Regional Healthcare Partnerships (RHPs), and state and federal agencies. The Category D reporting served as a valid health care indicator to inform and identify areas for improvement in population health within the health care system.

[7] https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf

To be eligible for payments under Category D, hospital providers were required to provide qualitative reporting on:

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

In the last year of Category D DSRIP reporting (Demonstration Year [DY] 10, October 1, 2020 – September 30, 2021), 68 out of 207 providers that submitted PPV information reported a decrease in either the PPV rate or the number of PPVs. At the same time, 77 providers reported observing an increase in either the rate or number of PPVs. Only 16 providers reported observing no change in PPVs.[8] This last reporting period for Category D took place during the COVID-19 Public Health Emergency (PHE), which could have impacted providers' ability to impact PPVs.

Although these data have certain limitations because they do not provide underlying patient-level detail and have a year-long data lag, the data provide valuable information that providers, hospital leadership, clinical teams, and case managers use to identify specific areas of interventions.

One hundred thirty-four (134) providers reporting on PPVs stated that they have initiatives that help address PPVs, and encourage patients visiting EDs for nonemergent issues to seek future primary care services in a different setting. The most commonly implemented initiatives were:

- Tracking patients with frequent visits and offering them resources to manage chronic illness in a primary care setting
- Referrals to primary care clinics and Federally Qualified Health Clinics (FQHCs)
- Referrals to specialty care clinics
- Opening and/or expanding primary care clinics

[8] Remaining providers did not provide an assessment of changes in the PPVs. Most of them were low volume providers without sufficient data.

- Establishing Patient Centered Medical Homes with the focus on preventive care
- Increasing hours of clinics' operation
- Education on proper use of ED and primary care services
- Establishing patient navigation and care coordination programs, and
- Follow up (phone calls) with individuals discharged from ED to answer questions

One hundred thirty-seven (137) providers reported that selected DSRIP Core Activities had an impact on PPVs and other PPEs. Core Activities are activities that providers implemented to achieve quality goals for their interventions. These Core Activities are complimentary to the initiatives described above and align with DSRIP focus areas:

- Chronic care management
- Navigation programs
- Care coordination
- Patient education
- Provision of vaccinations (e.g., pneumonia vaccine)
- Increase in access to primary care services
- Enhancement in coordination between primary care providers and hospital EDs

DSRIP Category D reporting provides important information on DSRIP hospitals' PPV trends and interventions providers implemented to reduce PPVs. Many of the interventions and activities of providers started as original DSRIP projects and became part of everyday operations. Some providers reported that these interventions will remain post-DSRIP.

DSRIP Provider Identified Best Practices

DSRIP Costs and Savings

DSRIP providers with a total valuation[9] greater than or equal to $1 million per DY were required to submit a Costs and Savings analysis in October 2019 for DYs 7-8, and in October 2021 for DYs 9-10.[10] The analyses were of an intervention connected to one of the provider's selected Core Activities. In DYs 7-10, providers were required to select and report on at least one Core Activity that supported the achievement of its quality measure goals. For analyses submitted in October 2021, providers were required to analyze a different intervention or different aspect of the intervention than was analyzed in October 2019.[11]

The Costs and Savings analysis included the costs associated with implementing the intervention and any forecasted or generated savings or losses associated with the intervention. In October 2021, providers used a tool developed by HHSC to conduct a ROI analysis to demonstrate the forecasted or generated savings, if any, of the selected intervention. 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.

The goal of the analysis was to serve as a tool for providers to better understand the sustainability of the chosen intervention or to use the ROI as a basis for entering into a value-based payment arrangement with payers.

While HHSC provided significant technical assistance to complete the analysis, the results are not verified or validated by HHSC. Providers relied heavily on

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[9] A provider's valuation is the total amount of money available for the provider to earn. Valuation by provider, measure, and milestone is available at: https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants

[10] DY 7 is October 1, 2017 to September 30, 2018. DY 8 is October 1, 2018 to September 30, 2019. DY 9 is October 1, 2019 to September 30, 2020. DY 10 is October 1, 2020 to September 30, 2021.

[11] A detailed summary of the Costs and Savings analyses submitted in October 2019 is available in the DSRIP transition milestone *Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8*. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf.

assumptions in their calculations. These assumptions included anticipated trends in utilization, costs, and enrollment. 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.

Of the 208 completed analyses submitted in October 2021:

- 166 (80 percent) showed that investment in the Core Activity produced a positive ROI to the healthcare system
- 41 (20 percent) showed that investment in the Core Activity did not produce a positive ROI

Providers analyzed a variety of types of interventions, with different target patient populations, intervention settings, and intervention sizes. The primary focus area of the interventions analyzed in providers' Costs and Savings analyses is shown in Table 1. These focus areas aligned with the major focus areas of the DSRIP program overall.

Table 1: Primary Focus Area of October 2021 Costs and Savings Analyses

Primary Focus Area	Count	Percentage
Chronic care management	60	29%
Behavioral health	40	19%
ED utilization	30	14%
Health promotion and disease prevention	29	14%
Patient navigation, care coordination, and care transitions	28	14%
Maternal health and birth outcomes	13	6%
SDOH	6	3%
Telemedicine and telehealth	2	1%
Total	208	100%

Following providers' submission of analyses in October 2021, HHSC reviewed the analyses and selected 3 – 5 exemplary submissions in each focus area. Exemplary analyses had a positive ROI, robust analysis, and reasonable assumptions and data sources. HHSC analyzed these exemplary interventions to better understand interventions with a positive ROI to the healthcare system, including the types of interventions, the types of costs associated with interventions, how interventions improved health outcomes for Medicaid recipients, positive effects beyond cost savings, and how interventions incorporated DSRIP best practices.

Most of the costs associated with the exemplary interventions were staffing costs, office or clinic costs, staff education, patient education or outreach, equipment costs, and purchasing and maintaining technology. Most providers indicated they would continue the intervention post-DSRIP, though a few indicated it would be difficult to maintain the same level of services without DSRIP funding.

Providers emphasized that in addition to reduced costs for themselves, these initiatives resulted in reduced costs to other providers (especially through reduced ED utilization and increased preventative care), such as state and local governments (including health care funding and through reduced jail stays), local employers, and Texas Medicaid. While providers were only required to analyze a minimum of three years for the Costs and Savings analyses, providers also emphasized that in the long-term, addressing chronic disease, behavioral health needs, substance abuse disorders, and SDOH needs results in improved health outcomes and additional savings to the healthcare system and to society.

Several interventions focused on decreasing PPVs and PPEs. Reducing PPEs, admissions, and readmissions keeps costs down for the provider and the overall health care system as care in the ED is generally more expensive than in other care settings such as clinics. Providers also discussed how the interventions helped decrease ED wait times and reduced strain on ED staff.

In addition to the cost savings, providers cited positive outcomes such as increased patient and family satisfaction, increased staff satisfaction, strengthened relationships with other providers and MCOs, improved overall quality of their practice, and improved performance on quality metrics. Additionally, interventions for all focus areas led to improved health outcomes for patients. For example, in the maternal health focus area, providers highlighted that early interventions improved health outcomes for both mothers and infants and led to reduced complications and length of stays in the hospital and lowered rates of pre-term births, low-weight births, and caesarian sections.

Analysis showed that the interventions included numerous DSRIP best practices, including interventions aimed at improving patient navigation and care coordination; education and use of self-management programs; inclusion of CHWs and social workers in care teams; and integration or co-location of primary care with specialty care including behavioral care.

The exemplary interventions analyzed as part of the costs and savings submissions illustrate that providers used DSRIP funding to implement and operate interventions

that incorporated DSRIP best practices and resulted in a positive ROI for the healthcare system, improved health outcomes for Medicaid recipients, and other positive outcomes. HHSC will continue to explore these interventions as potential models to implement in Medicaid and drive improvements in health outcomes.

DSRIP Regional Healthcare Partnership (RHP) Annual Report

The DSRIP program was organized by 20 RHP structures across the state. The regions were determined through a stakeholder input process and were required per the RHP Planning Protocol (Attachment I to the 1115 Waiver)[12] to be coordinated by a public hospital or local governmental entity, called an anchor. Each region's anchor was responsible for leading the community needs assessment process, RHP coordination, holding regional collaboratives to discuss lessons learned, and supporting providers participating in the program.

At the end of each calendar year, anchors were required to coordinate with providers in their region to complete the RHP Annual Report. All 20 anchors provided responses for the DY10 Annual Report by December 15, 2021, and the report was submitted to CMS on March 1, 2022.

The DY10 Annual Report included a question asking anchors to describe any best practices associated with improvements in the health status of Medicaid recipients that were developed and achieved under DSRIP in the RHP. The most indicated DSRIP best practices were:

- Telehealth, including for primary, behavioral health, and specialty care
- Creation or expansion of care coordination positions, including both personnel that do and do not require clinical licensure
- Integration and/or co-location of primary care psychiatric care in the outpatient setting
- Same day or walk-in appointments

[12] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf

Health promotion and disease prevention was a common category of DSRIP best practices. Anchors indicated that timely assessment (including screenings and well check-ups), treatment, and self-management and patient education (both materials and classes) were important best practices. These practices were used to make progress on a variety of quality metrics, including measures related to chronic disease management, particularly for patients with diabetes, body mass index (BMI) screenings, and tobacco cessation efforts.

Another frequently included category was improved processes and data collection. Anchors indicated key practices were implementation of automated reminders/flags within the electronic health record; improved data collection and staff training processes; pre-visit planning or standing order protocols; and increased data sharing through health information exchanges (HIEs).

Several SDOH related practices were included by anchors, including use of CHWs; addressing SDOH and family support needs by providing support services to minimize barriers to care; and culturally and linguistically appropriate care planning for patients.

HHSC will continue to explore best practices identified during data analysis and from engagement with DSRIP providers as potential practices to implement more broadly in Medicaid to drive improvements in health outcomes. HHSC has also begun to incorporate some of these best practices through new policies and benefits, as discussed below.

3. Initiatives to Reduce Potentially Preventable Emergency Department Utilization in Medicaid

Section 1 of S.B. 1136 requires HHSC to coordinate with hospitals and other providers that receive UC payments to identify and implement initiatives to reduce Medicaid recipients' use of hospital ED services as a primary means of receiving health care benefits, including initiatives to improve recipients' access to and use of primary care providers.

To meet these requirements, HHSC is leveraging available data, conducting surveys, and will convene a workgroup consisting of various external stakeholders to identify current issues that contribute to the preventable use of EDs and to identify effective solutions and potential next steps. Additional details related to this work are included in Section 5 of this report, Stakeholder Engagement.

In addition, HHSC has already implemented initiatives and plans to implement additional initiatives, which are meant to incentivize and hold MCOs accountable for their management of non-emergent ED utilization.

Initiatives included in the March 2022 *Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid*[13] that do not have significant status changes are the Medical Pay-for-Quality (P4Q) Program, Performance Improvement Projects (PIPs), HHSC Performance Indicator Dashboard, and Medicaid Value-based Enrollment (VBE). Future reports will include any updates on the initiatives described below as well as initiatives included in past reports.

Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project

The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 42) requires HHSC to implement the Emergency

[13] https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf

Triage, Treat, and Transport Model (ET3) in Medicaid to reimburse Medicaid-enrolled emergency medical services providers for:

- Transporting Medicaid clients to alternative destinations, other than an emergency department, as approved by HHSC;
- Facilitating appropriate treatment in place at the scene; and
- Facilitating appropriate treatment in place via telemedicine or telehealth.

The ET3 Program is a Medicare initiative designed to improve quality of care and lower costs by reducing avoidable emergency transports and unnecessary hospitalizations. This was a DSRIP project that was found to be successful.

To implement Rider 42, HHSC is updating policy to include billing guidance for providers. In alignment with guidelines provided by CMS, Texas Medicaid will reimburse ambulance providers for ET3 services using procedure codes included in current policy. In addition, five new modifiers will be added to the policy to allow reimbursement for transport to alternative destinations and treatment in place. The benefit will be implemented on September 1, 2022.

Medicaid Teleservices Expansion

To ensure continuity of care for Texas Medicaid clients during the COVID-19 Public Health Emergency (PHE), HHSC authorized the use of synchronous audio-visual telemedicine and telehealth, and audio-only, platforms to deliver a range of services. House Bill (H.B.) 4, 87th Legislature, Regular Session, 2021, required HHSC to expand services eligible to be delivered by telemedicine or telehealth in any program, benefit, or service HHSC determines to be cost effective and clinically appropriate. It also required HHSC to implement audio-only benefits for behavioral health services and authorized HHSC to implement audio-only benefits in any program or services, if determined to be clinically appropriate and cost effective.

H.B. 4 builds on S.B. 670, 86th Legislature, Regular Session, 2019, which authorized synchronous audio-visual telemedicine and telehealth services in Medicaid managed care. Prior to S.B. 670, Medicaid reimbursement was provided for a limited number of telehealth and telemedicine services. Under S.B. 670, MCOs have the responsibility to determine which services could be delivered through telemedicine, telehealth, and audio-only methods. MCOs cannot deny reimbursement to health care providers for a Medicaid service or procedure just because it was delivered via synchronous audio-visual telemedicine or telehealth.

MCOs also cannot deny or reduce reimbursement for a covered health care service or procedure based upon the network provider's choice of platform and must ensure that telemedicine and telehealth services promote and support patient-centered medical homes. In implementing H.B. 4, HHSC issued direction to Medicaid and Children's Health Insurance Program (CHIP) MCOs reminding them of these responsibilities and included behavioral health audio-only delivery within these requirements.

HHSC analyzed the clinical and cost effectiveness of Medicaid and CHIP telemedicine and telehealth PHE-related flexibilities to align with H.B. 4 requirements and transitioned many state plan and 1915(c) waiver services delivered in the fee-for-service system from temporary PHE flexibilities to ongoing policy through interim guidance. The interim guidance is in place until the policy is formally effective in the corresponding Texas Medicaid Provider Procedures Manual, Texas Administrative Code, and program handbooks.

Through interim guidance, HHSC authorized providers to submit claims for reimbursement for synchronous audio-visual delivery for several benefits and services including, but not limited to:

- Behavioral health services and benefits, and in some cases, this included reimbursement for audio-only delivery;
- Healthy Texas Women (HTW) and HTW Plus services and benefits;
- Many professional and specialized therapy services including speech therapy, occupational therapy, and physical therapy;
- Certain case management services.

HHSC also authorized telehealth and telemedicine reimbursement for rural health clinics and FQHCs, and reimbursement of patient site fees for telemedicine.

Teleservices policies require providers to defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience. When implementation of H.B. 4 is complete, HHSC is expecting increased access to care for Medicaid members, especially for members in rural areas, and continued access to services using telecommunications after the PHE ends.

The importance of teleservices to enhance access to care has been recognized throughout DSRIP, and the DSRIP program provided an opportunity to expand its

use. For example, of the 1,340 DSRIP projects implemented by participating providers during DSRIP DYs 2-6 (October 1, 2012 – September 30, 2017), approximately 6 percent (77 projects) had a teleservices component. By November 2019, 39 percent of providers reported implementing at least one of four teleservices Related Strategies[14] to some extent (101 of 256 providers). Based on the most recent DSRIP reporting in April 2021, 72 percent of providers reported implementing at least one of these teleservices Related Strategies to some extent (183 of 254 providers).

Additionally, the significance of these teleservices initiatives was highlighted by the BPW. The third top-rated key practice identified by the BPW was "Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist." In part because of DSRIP, the use of teleservices—for instance, to provide specialty care in remote areas—has been slowly increasing over the years, including in the Texas Medicaid program.[15] The COVID-19 PHE, however, significantly accelerated this upward trend in utilization. HHSC's implementation of H.B. 4 will maximize the use of teleservices beyond the COVID-19 PHE.

[14] DSRIP Related Strategies related to teleservices include: 1) Telehealth to provide virtual medical appointments and/or consultations with a primary care provider; 2) Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only); 3) Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist; and 4) Telehealth to provide virtual appointments and/or consultations with a dentist.

[15] Texas Health and Human Services Commission. *Telemedicine, Telehealth, and Home Telemonitoring Services in Texas Medicaid*. December 2020. Available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/sb-789-telemedicine-telehealth-hts-medicaid-dec-2020.pdf.

4. Initiatives to Improve Medicaid Recipients' Health Outcomes

Section 2 of S.B. 1136 requires HHSC to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were developed and achieved under DSRIP. HHSC is implementing initiatives to encourage Medicaid providers and MCOs to continue implementing these types of interventions and best practices. Many of these current and proposed initiatives are summarized in the first report, and additional initiatives are summarized below.

Initiatives included in the March 2022 *Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid*[16], that do not have significant status changes are Directed Payment Programs (DPPs), Alternative Payment Model Requirements for Medicaid MCOs, and Proposed Value Based Purchasing Arrangements to Address SDOH. Future reports will include any updates on the initiatives described below as well as initiatives included in past reports.

Medicaid Benefits Changes

The 87th Legislature passed additional legislation, such as S.B. 672 and H.B. 2658 described below, that will incorporate DSRIP best practices into the Medicaid program. The legislation provides the opportunity to advance frequently implemented and best practices of DSRIP, such as enhanced care coordination and chronic disease management. Based on the legislation, best practices, and additional research, HHSC is exploring other Medicaid benefit changes.

Collaborative Care Model

S.B. 672, 87th Legislature, Regular Session, 2021 requires HHSC to provide Medicaid reimbursement for the provision of behavioral health services that are classified as collaborative care management services. The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions in

[16] https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf

primary care settings. The model integrates the services of behavioral health care managers and psychiatric consultants with PCP oversight to proactively manage behavioral health conditions as chronic diseases. These services include care plans developed and driven by evidence-based practice guidelines. The use of a team that integrates physical and behavioral health care can improve care coordination and care transitions, and thereby improve health outcomes. CoCM services became a benefit in Texas Medicaid for persons of all ages who have a mental health or substance use condition, as determined by the PCP, on June 1, 2022.

The collaborative care management services benefit was chosen by DSRIP providers in a survey conducted by HHSC in May 2020 as one of the most effective interventions for positively impacting their clients' health. The addition of this benefit to the Medicaid program will facilitate the continuation of this best practice.

Diabetes Self-Management Education and Support (DSMES)

H.B. 2658, 87th Legislature, Regular Session, 2021, requires HHSC to study the cost-effectiveness and feasibility of providing diabetes self-management education and medical nutrition therapy services to people with diabetes in Medicaid. If these services are found to improve health outcomes and lower costs for Medicaid, the bill requires HHSC to develop a program to provide the benefits and seek prior approval from the Legislative Budget Board prior to an implementation. These evidence-based services could potentially reduce unnecessary ED use by supporting members with diabetes to self-manage their condition to prevent or delay diabetes complications.

Chronic care management is a focus area of the DSRIP Transition, and the BPW identified diabetes-related performance measures as the two most important key measures for driving improvements in health status for clients. Education in chronic disease self-management was one component of chronic care management services, which was one of the Core Activities most commonly associated with improvement on certain diabetes quality measures in DSRIP.[17]

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[17] Texas Health & Human Services Commission. *Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8*. December 2020. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf

Initiative to Increase Disease Management Participation

H.B. 2658 requires MCOs to identify reasons for low active participation rates in MCOs' disease management programs, and to develop approaches to increase active participation for high-risk participants.

HHSC has asked the Texas Medicaid External Quality Review Organization (EQRO) to conduct a study of factors contributing to active participation in disease management programs and participation by year, condition, and program. The EQRO is also studying if and how MCOs are screening for and implementing interventions for SDOH in their disease management programs. The study is anticipated to be completed by Fall 2022. Once the study is completed, HHSC will review the findings and determine what action to take to help increase active participation.

Tobacco Cessation Efforts

The EQRO found that the rate of adult smoking was significantly associated with higher ED utilization among STAR+PLUS adults.[18] The US Preventive Services Task Force recommends clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.[19] HHSC uses several measures track tobacco cessation efforts by providers and MCOs, as shown in Tables 2, 3, and 4. Overall, the rate of members using tobacco has declined from 2016 to 2020.

[18] External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/eqro-summary-of-activites-report-contract-yr-2020.pdf

[19] https://jamanetwork.com/journals/jama/fullarticle/2775287

Table 2: CMS Core Measures Related to Tobacco Cessation[20]

CMS Core Measures	2016	2017	2018	2019	2020
Advising Smokers and Tobacco Users to Quit (% of beneficiaries 18 and older who were current smokers or tobacco users who received advice to quit during the measurement year)	68.5	68.6	73.2	73.1	66.8
Discussing Cessation Medications (% of beneficiaries 18 and older who were current smokers or tobacco users who discussed or were recommended cessation medications during the measurement year)	45.2	45.2	38.7	38.8	44.1
Discussing Cessation Strategies (% of beneficiaries 18 and older who were current smokers or tobacco users who discussed or were recommended cessation methods or strategies during the measurement year)	28.1	28.1	35.0	35.2	33.2
Percentage of Current Smokers and Tobacco Users	32.0	31.9	26.4	26.2	20.1

Table 3: Tobacco Cessation Experience of Care Survey Measures: STAR+PLUS Members[21]

Experience of care Survey Measures: STAR+PLUS Member	2016	2018	2020
% Advised to Quit Smoking (% members who use tobacco at least some days responding "Always")	47.9	54.5	43.1
Ever advised to quit smoking or other tobacco use (% of members who use tobacco at least some days responding at least "Sometimes")	77.1	80.5	71.3
Discussed tobacco use cessation medication (% of members who use tobacco at least some days responding at least "Sometimes")	51.1	50.1	51.9
Discussed non-medication tobacco cessation strategies (% of members who use tobacco at least some days responding at least "Sometimes")	38.5	42.6	39.5

[20] https://thlcportal.com/measures/cmscoremeasuredashboard

[21] https://thlcportal.com/survey/expofcare/STARPLUS

Experience of care Survey Measures: STAR+PLUS Member	2016	2018	2020
Tobacco use (% responding at least "Some days")	37.7	37.9	32.0

Table 4: Tobacco Cessation Experience of Care Survey Measures: STAR Members[22]

Experience of care Survey Measures: STAR Member	2016	2018	2020
% Advised to Quit Smoking (% of members who use tobacco at least some days responding "Always")	32.6	35.4	34.6
Ever advised to quit smoking or other tobacco use (% of members who use tobacco at least some days responding at least "Sometimes")	59.6	61.3	59.2
Discussed tobacco use cessation medication (% of members who use tobacco at least some days responding at least "Sometimes")	27.9	25.4	27.7
Discussed non-medication tobacco cessation strategies (% of members who use tobacco at least some days responding at least "Sometimes")	28.9	27.5	24.0
Tobacco use (% responding at least "Some days")	17.4	16.8	14.6

While member tobacco usage rates have decreased, members report through survey responses that providers are not discussing tobacco cessation consistently, which could help decrease rates further. As part of the DSRIP program, some providers selected a pay for performance measure to incentivize these discussions. One measure, reported on by 112 providers in 2019, tracks the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user. Another measure, Tobacco Screening and Cessation Counseling for Adolescents, was used by 26 providers in DSRIP for 2019. Among the DSRIP BPW members, there was strong consensus that these measures were

[22] https://thlcportal.com/survey/expofcare/STARAdult

key to driving improvements in their clients' health status.[23] Appendix B shows the improvements in median rates for these measures from 2017 to 2019. These measures could be used by MCOs and providers in alternative payment models to increase screening and interventions. MCOs report their APMs to HHSC including the performance measures used. For the most recent report available, 2020, none of the MCOs reported using measures related to tobacco screening or interventions.[24]

Medicaid benefits include counseling for pregnant women who have a tobacco habit[25] and tobacco cessation counseling for anyone with a tobacco use disorder in Medicaid ages 10 and older.[26] Medicaid also covers nicotine replacement therapies, which can be administered with a skin patch, lozenges, gum, inhalers or nasal sprays. Some MCOs offer Value Added Services that include additional tobacco cessation resources and members can compare these benefits by plan.[27]

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[23] Texas Health & Human Services Commission. *Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8*. December 2020. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf.

[24] 2020 Medicaid Managed Care Health Plans Alternative Payment Models (APMs) with their Providers. Available at: https://www.hhs.texas.gov/sites/default/files/documents/2020-apm-summary.xlsx

[25] Section 4.1.17 of the Texas Medicaid Provider Procedures Manual (TMPPM)

[26] Section 9.2.58.3.3 of the TMPPM

[27] https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/choosing-a-health-plan/starplus-comparison-charts

5. Stakeholder Engagement

S.B. 1136 requires HHSC to coordinate with hospitals and other providers that receive UC payments to identify and implement initiatives to reduce ED utilization. In spring 2022, HHSC conducted a survey to collect information from providers that receive UC payments, as well as MCOs and other providers, regarding initiatives to reduce the use of the ED as a primary means of receiving healthcare and improve access to primary care services. A majority of organizations indicated observing individuals using the ED services for primary care services, and 74 percent of organizations that provided responses reported implementing initiatives designed to reduce ED visits or improve access to primary care.

Survey of Providers That Receive UC Pool Payments

To meet the requirements of S.B. 1136, HHSC conducted a survey to collect information from organizations on:

- initiatives that reduce ED utilization for primary care services;
- initiatives that improve access to and use of primary care providers;
- barriers that providers experience in improving Medicaid recipients' access to primary care services; and
- recommendations for initiatives that reduce Medicaid recipients' use of ER services as a primary means of receiving health care benefits.

Survey Background

HHSC sent a request to complete the survey to providers that currently participate in the UC program including public and private hospitals, public ambulance providers, government dental providers, and physician practice groups.

In addition to providers participating in the UC program, HHSC sent a request to complete the survey to providers eligible to participate in the Public Health Provider – Charity Care Program (PHP-CCP), which allows qualified providers to receive reimbursement for the cost of delivering healthcare services, when those costs are not reimbursed by another source. HHSC also solicited responses from Medicaid

MCOs since they play an important role in incentivizing initiatives that promote access to primary care services.

Providers and other stakeholders could complete the survey between April 26, 2022 and May 6, 2022. Survey questions can be found in Appendix C of this report.

Survey Considerations and Limitations

Before conducting the analysis of this survey, HHSC removed responses that did not respond to all sections of the survey and any duplicative responses. A response was kept in for analysis if there were responses to all sections of the survey, even if the organization did not respond to every question in each section. Additionally, this survey asked for initiatives that reduce ED utilization for primary care and improve access to and use of primary care providers. While questions were asked separately for each of these initiative categories, the responses cannot be tied to only one category as many of the initiatives can both reduce ED utilization for primary care and improve access to and use of primary care providers. Finally, because the survey is self-reported HHSC cannot confirm all responses.

HHSC received responses from 217 organizations, including:

- 117 hospitals
- 39 ambulance providers
- 31 Local Mental Health Authorities (LMHAs) and Local Behavioral Health Authorities (LBHAs)
- 11 MCOs
- 3 LHDs
- 5 CMHCs
- 4 Physician Practices
- 4 Public Health Districts
- 1 Rural Health Clinic (RHC)
- 1 State Owned Cancer Center

HHSC received an additional 15 survey responses; however, they were not sufficiently complete to be included in the analysis.

Of the 217 organizations that completed the survey for the analysis, 136 (63 percent) reported participating in DSRIP. Most of the responding organizations that do not participate in DSRIP are ambulance providers, MCOs, and select hospitals.

Use of Hospital ED Services as a Primary Means of Receiving Health Care Benefits

Based on the results, most organizations (87 percent) reported observing Medicaid and non-Medicaid individuals using EDs to receive primary care services. To incentivize delivery of services at the right place, many organizations report implementing initiatives designed to reduce ED visits. Table 5 shows that 74 percent of organizations that provided responses reported implementing initiatives designed to reduce ED visits or improve access to primary care.

Table 5: Implementation of Initiatives by Type of Organization

Type of Organization	Number of organizations with responses	Number of organizations observing use of ED for primary care services	Number of organizations implementing initiatives designed to reduce ED visits or improve access to primary care	Organizations implementing initiatives as a percent of those with responses
Hospital	117	105	93	79%
Ambulance Provider	39	32	12	31%
LMHA and LBHA	31	30	30	97%
MCO	11	9	10	91%
CMHC	5	5	5	100%
Public Health District	5	3	2	40%
Physician Group	4	1	4	100%
LHD	3	1	3	100%
RHC	1	1	1	100%
State Owned Cancer Center	1	1	0	0%
Total	**217**	**188**	**160**	**74%**

Description of the Interventions

Organizations were asked to select the category that best fit their initiative out of the choices included below. The category list was based on commonly implemented DSRIP activities:

- Care coordination;
- Follow-up appointments (e.g., follow-up after ED visit, hospitalization, etc.) with a primary care provider;
- Follow-up appointments (e.g., follow-up after ED visit, hospitalization, etc.) with a specialty care provider;
- Use of community health workers;
- Extended hours during weekends and evenings in outpatient setting; or
- Other.

Each organization was able to provide responses on multiple interventions. In total, 217 organizations provided information on 333 initiatives.

As seen in Table 6, care coordination was the most commonly selected category of initiative reported, followed by follow-up appointments (e.g., follow-up after ED visit, hospitalization, etc.) with a primary care provider, extended hours during weekends and evenings in outpatient setting, use of community health workers, and finally follow-up appointments (e.g., follow-up after ED visit, hospitalization, etc.) with a specialty care provider. Eighty-one (81) initiatives fell into the Other category, which commonly consisted of patient education and integration of various types of care. Of the initiatives reported by organizations, 329 of the initiatives were said to have impacted Medicaid recipients.

Table 6: Types of Initiatives Implemented by Organizations

Category	Count of initiatives
Care coordination	131
Follow-up appointments (e.g. follow-up after ED visit, hospitalization, etc.) with a primary care provider	59
Extended hours during weekends and evenings in outpatient setting	31
Use of community health workers	20
Follow-up appointments (e.g. follow-up after ED visit, hospitalization, etc.) with a specialty care provider	11
Other	81
Total	**333**

Individuals Impacted through Initiatives

Organizations implementing initiatives to reduce ED utilization and improve access to primary care estimate that, in total, interventions impact 2,326,861 individuals per year. This number represents all individuals, not just the Medicaid enrollees. This number is not an unduplicated count and populations in the interventions can overlap, since respondents could include the same number of individuals when describing multiple initiatives. Respondents provided estimates for 295 initiatives. Based on the reported data, the size of the interventions varies; more than 50 percent of the initiatives are serving 1,000 or fewer individuals per year. Table 7 below show the number of interventions and the corresponding impact of the intervention.

Table 7: Number of Individuals Served in the Initiatives

Number of individuals served per year	Count of initiatives reporting this number of individuals served per year
Under 100	33
100-500	96
501-1,000	35
1,001-5,000	84
5,001-10,000	21
10,000-40,000	26

Partnering with Other Organizations

Survey participants indicate that many initiatives are being implemented through partnerships with other organizations. Ninety organizations provided 180 responses with types of partnerships they establish when working on initiatives to reduce ED services used for primary care and improve access to and use of primary care providers. Based on the responses received, 49 percent of the interventions involved partnerships with other organizations to implement the initiative. The focus areas for the most common initiatives that involved partnering with other stakeholders were care coordination, use of CHWs, follow-up appointments (after ED visit, hospitalization), same-day or walk-in appointments, and extended hours – weekends and evenings.

Table 8: Number of Partnerships in Initiatives Designed to Reduce ED Visits or Improve Access to Primary Care

Type of Organization	Number of responses regarding partnering options with other providers when implementing initiatives	Most partnered organizations when implementing initiatives
Hospital	62	Community health clinics, other hospitals, and PCPs, and somewhat frequently with specialty care providers, community organizations including social services agencies, and academic institutions
LMHA and LBHA	59	Local governments, community health clinics, hospitals, PCPs, FQHCs, academic centers, community organizations, and the law enforcement and criminal justice system
Ambulance Provider	21	Community organizations including social services agencies, community health clinics, local government, hospitals, urgent care providers, behavioral health providers, and transportation providers
MCO	21	PCPs, some community health clinics and HIEs
CMHC	8	Hospitals, community health clinics, LHDs, FQHCs, law enforcement
Public Health District	5	Hospitals, local schools, community organizations
LHD	3	Hospitals, local schools, community organizations
Physician Group	1	Insurance payers
Rural Health Clinic	0	
Total	**180**	

Based on the reported data, some organizations are most often selected as partners. Table 9 shows that hospitals, PCPs and community health centers or clinics were the top organizations with which the respondents partnered. Overall, organizations shared 325 partnership examples.

Table 9: Most Commonly Selected Partners for Initiatives Designed to Reduce ED Visits or Improve Access to Primary Care

Type of Organization Selected as a Partner for the Initiatives	Number of Responses Indicating this Organization as a Partner in the Initiatives	Responses Indicating this Organization as a Partner in the Initiatives as a Percent of those with Responses
Hospitals/hospital systems	40	12%

Type of Organization Selected as a Partner for the Initiatives	Number of Responses Indicating this Organization as a Partner in the Initiatives	Responses Indicating this Organization as a Partner in the Initiatives as a Percent of those with Responses
Primary Care Providers	35	11%
Community health center/clinics	32	10%
FQHCs	22	7%
Non-profits/community organizations	22	7%
Local health district	18	6%
Specialty care providers	17	5%
Criminal justice system (law enforcement, local jails, TDCJ, TJJD)	14	4%
Local behavioral health providers	12	4%
Local social services system	12	4%
Academic institutions	8	2%
Home health agencies	7	2%
Other types	86	26%

Note: Other types included local governments, transportation companies, school districts, MCOs, fire departments/EMS, among others.

Use of DSRIP Best Practices in the Interventions

Organizations were also asked if their initiative(s) were based on a DSRIP best practice. Of the 136 organizations that stated that they participated in DSRIP, 79 respondents indicated that at least one of their initiatives involved interventions similar to DSRIP best practices. This resulted in a total of 154 initiatives from those 79 organizations, or approximately 2 interventions per organization. It should be noted that the providers could have responded to this survey question without referencing DSRIP Best Practices list. HHSC grouped responses received in the survey based on the connection to the Best Practices list. Appendix A provides additional details on identified Best Practices in DSRIP.

These initiatives were connected to a wide variety of DSRIP best practices, the most common being integration or co-location of primary care and psychiatric services in the outpatient setting, care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, CHW, medical assistant,

etc.), care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.), and same day and/or walk-in appointments in the outpatient setting.

Challenges and Barriers

The main barriers to reducing ED utilization for primary care services for Medicaid recipients and improving Medicaid recipients' access to primary care services that organizations identified in this survey fell into four categories: provider barriers, patient barriers, systemic barriers, and Medicaid barriers.

For provider-related barriers, funding and staffing issues were the most commonly reported, followed by lack of collaboration with other providers and MCOs, and lack of available data. These provider-related barriers were most frequently reported by hospitals, ambulance providers, and MCOs.

Patient-related barriers had a wider breadth of responses and most commonly included transportation and childcare barriers, patient refusals to use another provider type, low compliance during follow-up care and lack of health education. Patient refusals were most commonly reported by hospitals and ambulance providers, while transportation and childcare barriers were listed by local mental and behavioral health authorities, local and public health districts, and hospitals.

The most widely reported systemic barrier was limited number of providers in an area accepting Medicaid, followed by limited number of PCPs and specialty care providers in an area, and lack of PCP appointment availability and after-hours care. These systemic challenges were most commonly stated by providers that practice in rural areas.

Medicaid-specific barriers were related to reimbursement and difficulty providing care to patients with a different PCP listed as their medical home on their insurance.

Table 10: Common Barriers Faced by Organizations

Barrier Category	Barrier	Count of Providers
Provider-Related	Funding (providers)	19
	Staffing issues	19
	Lack of collaboration with other providers	4
	Lack of collaboration with MCOs	2
	Lack of available data	2
Patient-Related	Transportation issues	21
	Patient choice/refusal to utilize another provider type	12
	Patient compliance during follow-up care	6

Barrier Category	Barrier	Count of Providers
	Lack of health education	6
	Childcare issues	4
	Patient difficulties navigating healthcare system	4
	Difficulty contacting patients	4
	Financial (patient)	4
	Serious Mental Illness (SMI)/behavioral health needs	4
	SDOH considerations	4
Systemic	Limited providers in area accepting Medicaid	21
	Limited number of PCPs in area	16
	Lack of PCP appointment availability	9
	Lack of PCP after-hours care	9
	Limited number of specialty care providers in area	7
Medicaid-Specific	Medicaid reimbursement issues/barriers	5
	Difficulty providing care if patient has a different PCP on insurance	2

Recommended Initiatives for Reducing ED Services as a Primary Means of Receiving Health Care in Medicaid

Organizations were asked if they would recommend their initiatives to reduce ED use for the Medicaid population. Of the 160 organizations that stated they implemented at least one initiative, only 18 stated that they would not recommend their initiative for Medicaid recipients. The most common responses for why the organization would not recommend their initiative was a lack of patient interest or participation and their initiative was not appropriate for the Medicaid population. When asked why they would recommend their initiative for the Medicaid population, organizations most stated that their initiatives reduced the need for emergency care, increased emphasis on primary care (especially concerning preventative care and specialist visits), increased access to affordable care, increased outreach methods, integrated care services, improved patient outcomes, and/or reduced rates of readmissions which would positively impact the Medicaid population. While there was a wide variety of responses by provider type, physician groups, RHCs, and teaching hospitals recommended all of their initiatives for the Medicaid population.

Many of the initiatives recommended for Medicaid addressed multiple barriers listed above. For example, one ambulance provider recommended their initiative because it is a "cost effective solution for Medicaid recipients which 'steers' recipients back to primary care services and provides increased health literacy resulting in improved outcomes. [This initiative] improved community education and

coordination of care through partnerships with other agencies that have a focus to address the needs of the shared population."

Other Recommended Initiatives for Reducing ED Services as a Primary Means of Receiving Health Care

In addition to the details for the implemented initiatives, survey respondents had an opportunity to recommend other initiatives to reduce Medicaid recipients' use of ED services as a primary means of receiving health care benefits. HHSC received 78 recommendations for initiatives for the Medicaid population. Some Medicaid providers and MCOs have been implementing these initiatives independently.

- **New models for delivery of care** (23 responses)
  - Organizations recommended use of CHWs and social workers, paramedicine programs, mental health crisis centers, use of multi-disciplinary teams that address health and SDOH, integration of primary and behavioral health services, expansion of mobile models that can reach individuals in need of services, and use of Medicaid medical homes.
- **Care coordination, care navigation and chronic care management and specialty services** (14 responses)
  - To implement these initiatives, organizations also suggested changes in the reimbursement policies to use alternative payment models to incentivize care coordination models and care navigation, especially for high utilizers.
- **Changes in reimbursement policies** (9 responses)
  - Organizations suggested incorporating incentive models to increase number of PCPs participating in Medicaid, integration of primary and behavioral health services, altering reimbursement policies to include additional incentives for primary care models, new models of care delivery including CHW programs, SDOH, and telemedicine.
- **Increase number of PCPs participating in Medicaid** (6 responses)
  - Organizations suggested improving access to care by increasing the number of PCPs that are available to provide primary care services

- **Financial participation by an individual for primary care services received at ED** (5 responses)
  - Organizations suggested implementing incentives for receiving services within primary care locations or implementing a cost-sharing requirement for ER services.[28]
- **Other recommended initiatives** (21 responses)
  - These initiatives included public awareness and education on use of ED and primary care services, stronger MCO requirements for use of primary care services and expanded partnership with MCOs, access to transportation services, extended hours for primary care services and availability of same-day appointments.

Next Steps

HHSC will continue working with stakeholders to determine which initiatives can be considered for the Medicaid program. HHSC will convene a workgroup consisting of external stakeholders that participated in the survey to elicit their recommendations for potential next steps that would encourage providers to implement or sustain these initiatives. Future reports will provide updates on these efforts.

[28] Cost-sharing for ED services have been explored previously, but federal law prohibits cost-sharing requirements for emergency services, excludes all children from cost-sharing, and requires hospitals to meet certain requirements regarding the assessment of the ED visit and alternative non-emergency service providers in order to impose cost-sharing in an ED setting. It has been estimated that the costs of implementing systems to collect the potentially minimal amounts would be more than any amounts collected.

6. Conclusion

HHSC implemented initiatives to reduce avoidable ED use, including the ET3 Project and Medicaid teleservices expansion. HHSC also developed initiatives to improve Medicaid recipients' health outcomes and continue effective best practices achieved under the DSRIP program through provider incentive programs, the terms of contracts with MCOs, implementation of APMs, and other cost-effective measures. Initiatives include Medicaid benefit changes, the initiative to increase disease management participation, and tobacco cessation efforts.

HHSC will continue to leverage available data and assess current programs and other promising practices from the DSRIP program, Medicaid stakeholders, and national experts to determine additional options to reduce ED use as a primary means of health care. HHSC is committed to developing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were accomplished under the DSRIP program.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Model
BMI	Body Mass Index
BPW	Best Practices Workgroup
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CHW	Community Health Worker
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
DSHS	Department of State Health Services
DSMES	Diabetes Self-Management Education and Support
DSRIP	Delivery System Reform Incentive Payment
DPP	Directed Payment Program
DPP BHS	Directed Payment Program for Behavior Health Services
DY	Demonstration Year
ED	Emergency Department
EQRO	External Quality Review Organization
ER	Emergency Room
ET3	Emergency Triage, Treat, and Transport Model
EWC	Executive Waiver Committee
FQHC	Federally Qualified Health Clinic
HCP-LAN	Healthcare Payment Learning and Action Network
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HRSN	Health-related Social Need
HTW	Healthy Texas Women
LBHA	Local Behavioral Health Authority
LHD	Local Health Department

Acronym	Full Name
LIU	Low Income Uninsured
LMHA	Local Mental Health Authority
MCO	Managed Care Organization
MCS	Medicaid & CHIP Services
P4Q	Pay-for-Quality
PCP	Primary Care Physician/Provider
PHE	Public Health Emergency
PHP-CCP	Public Health Provider – Charity Care Program
PIP	Performance Improvement Project
PPA	Potentially Preventable Admission
PPC	Potentially Preventable Complications
PPE	Potentially Preventable Events
PPR	Potentially Preventable 30-day Readmissions
PPV	Potentially Preventable Emergency Room Visit
RAPPS	Rural Access Primary and Preventive Services
RHC	Rural Health Clinic
RHP	Regional Healthcare Partnership
ROI	Return on Investment
SDOH	Social Determinates of Health
SFY	State Fiscal Year
SMI	Serious Mental Illness
THLC	Texas Healthcare Learning Collaborative
THSteps	Texas Health Steps
TIPPS	Texas Incentives for Physicians and Professional Services
TMPPM	Texas Medicaid Provider Procedures Manual
UC	Uncompensated are
VBE	Value-based Enrollment
VBP	Value Based Payment

Appendix A. DSRIP Best Practices Workgroup Executive Overview: Prioritizing Key Measures and Key Practices

In January 2020, HHSC established the Best Practices Workgroup (BPW) of current DSRIP Performing Providers, DSRIP Anchors, and Executive Waiver Committee (EWC) members to support the sustainability of delivery system reform best practices, the successful completion of DSRIP Transition Plan milestone deliverables, and the development of the next phase of delivery system reform in Texas. There are 84 total BPW members[29], including 65 DSRIP Performing Providers, 14 DSRIP Anchors, and 5 EWC members.

Thus far, BPW members have completed Survey 1: Prioritizing Key Measures and Survey 2: Prioritizing Key Practices to provide input on the prioritization of measures and practices from DSRIP that have been key for driving improvements in the health status of clients, delivery system reform, quality improvement, and DSRIP Transition Focus Areas.

During DSRIP Demonstration Years (DYs) 1-9, over 500 Category 3 and Category C quality measures, 600 Core Activities, and 9,000 Related Strategies have been reported on, which represent the activities and strategies that DSRIP Performing Providers have implemented to meet their Category C quality measures. In Survey 1, BPW members were surveyed on a total of 41 measures (Table 13), representing DSRIP measures with higher priority measure classifications (e.g., clinical outcome measures as opposed to process measures) and higher priority focus areas for the state and/or CMS. In Survey 2, BPW members were surveyed on a total of 40 practices (Table 14), representing practices in DSRIP-reported data that were most commonly implemented by DSRIP Performing Providers and/or associated with the key measures identified from Survey 1 results.

Out of the 41 total surveyed measures and the 40 total surveyed practices, Table 11 and Table 12 show the top 10 prioritized key measures and key practices,

[29] The DSRIP Best Practices Workgroup membership list is available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/best-practices-workgroup-membership-list.pdf

respectively, for driving improvements in the health status of clients. Notably, these prioritized key measures do not involve tracking a client's utilization pattern in the ED or hospital setting (e.g., emergency visit, hospitalization, and readmission rates). Moreover, although these are not the only key practices that may be driving improvements in the health status of clients, these prioritized key practices, including strategic population health management; care teams with dedicated social and cultural expertise in addition to medical expertise; and virtual and co-located integration of behavioral health services with physical health services reflect the delivery system transformation that should be sustained even after the DSRIP program ends.

Lastly, detailed survey results including all of the additional qualitative responses submitted for Survey 1 and Survey 2 as well as detailed survey design and methodology information can be found in the respective "Final Results" documents, e.g., "BPW Survey 1 Final Results_20200710" and "BPW Survey 2 Final Results_20200710".

Table 11: Top 10 Prioritized Key Measures

Number	ID	Measure Title
1	4.1	Diabetes - HbA1c Poor Control
2	4.2	Diabetes - Blood Pressure Control
3	8.5	Cancer Screening
4	4.6	Cardiovascular Disease - High Blood Pressure Control
5	6.1	Follow-up after Hospitalization for Mental Illness
6	6.8	Age-Appropriate Screening for Clinical Depression/ Suicide Risk (Adult, Child, and Adolescent)
7	8.8	Pediatric and Adolescent Immunization Status
8	7.2	Post-Partum Follow-up Care Coordination
9	5.5	Medication Reconciliation
10	7.1	Maternal Screening for Behavioral Health Risks

Table 12: Top 10 Prioritized Key Practices

Number	ID	Practice Description
1	5.2	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
2	5.4	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
3	4.4	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist

Number	ID	Practice Description
4	5.3	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
5	4.1	Same-day and/or walk-in appointments in the outpatient setting
6	4.3	Integration or co-location of primary care and psychiatric services in the outpatient setting
7	5.5	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
8	5.1	Culturally and linguistically appropriate care planning for patients
9	4.2	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
10	6.1	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)

Table 13: Listing of 41 Measures included in Survey 1

ID	Measure Title
4.1	Diabetes - HbA1c Poor Control
4.2	Diabetes - Blood Pressure Control
4.3	Diabetes - Composite Admissions Rate
4.4	Pediatric Diabetes - Short Term Complications Admissions Rate
4.5	Diabetes - ED Visits Rate
4.6	Cardiovascular Disease - High Blood Pressure Control
4.7	Cardiovascular Disease - Admissions Rate
4.8	Cardiovascular Disease - 30-Day Readmissions Rate
4.9	Cardiovascular Disease - ED Visits Rate
4.10	Pediatric Asthma - Inpatient Admissions / ED Visits Rate
4.11	Post-Discharge Appointment for Heart Failure
5.1	ED Visits Rate for Acute Ambulatory Care Sensitive Conditions
5.2	Pediatric - Acute Conditions Admissions Rate
5.3	Emergency Transfer Communication
5.4	Median Departure Time for Patients Admitted from ED
5.5	Medication Reconciliation
6.1	Follow-up after Hospitalization for Mental Illness
6.2	Alcohol/Other Drug Dependence Treatment Initiation Rate
6.3	Depression Response at Twelve Months- Progress Towards Remission
6.4	Behavioral Health Conditions - ED Visits Rate
6.5	Behavioral Health Conditions - Criminal Justice Setting Admissions Rate
6.6	Housing Screening for Clients with Schizophrenia
6.7	Independent Living Skills Screening for Clients with Schizophrenia
6.8	Age-Appropriate Screening for Clinical Depression/ Suicide Risk (Adult, Child, and Adolescent)
7.1	Maternal Screening for Behavioral Health Risks
7.2	Post-Partum Follow-up Care Coordination
7.3	Cesarean Section Rate
7.4	Low Birth-Weight Birth Rate
7.5	Pre-Term Birth Rate

ID	Measure Title
8.1	Body Mass Index Screening and Follow-up Plan
8.2	Nutrition and Physical Activity Counseling for Pediatric and Adolescent Clients
8.3	Tobacco Screening and Cessation Counseling
8.4	Tobacco Screening and Cessation Counseling for Adolescents
8.5	Cancer Screening
8.6	Hepatitis Screening and Follow-up Plan
8.7	Adult Immunization Status
8.8	Pediatric and Adolescent Immunization Status
8.9	Latent Tuberculosis Infection Treatment Rate
8.10	Advanced Care Plan
8.11	Dental Caries Adults
8.12	Dental Caries/Dental Sealants Children

Table 14: Listing of 40 Practices included in Survey 2

ID	Practice Description
4.1	Same-day and/or walk-in appointments in the outpatient setting
4.2	Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
4.3	Integration or co-location of primary care and psychiatric services in the outpatient setting
4.4	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
4.5*	Integration or co-location of psychiatry and substance use disorder treatment services in the outpatient setting
4.6	Mobile clinic or other community-based delivery model to provide care outside of the traditional office (excludes home-based care)
4.7	Integration or co-location of primary care and dental services in the outpatient setting
5.1	Culturally and linguistically appropriate care planning for patients
5.2	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
5.3	Automated reminders/flags within the E.H.R. or other electronic care platform (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)
5.4	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
5.5	Care team includes personnel in a care coordination role requiring clinical licensure (e.g. registered nurse, licensed clinical social worker, etc.)
5.6	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.
5.7	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
5.8	Formal closed loop process for scheduling referral visits as needed
5.9*	Data sharing connectivity or arrangement with Medicaid Managed Care Organization(s) for patient claims data

ID	Practice Description
5.10	Data sharing connectivity across care settings within provider's integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
5.11*	Data sharing connectivity or Health Information Exchange (HIE) arrangement across care settings external to provider's office/integrated delivery system (includes inpatient, outpatient, post-acute, urgent care, pharmacy, etc.) for patient medical records
5.12*	Formal closed loop process for coordinating the transition from pediatric to adult care
6.1	Panel management and/or proactive outreach of patients using a gap analysis method (i.e. strategically targeting patients with missing or overdue screenings, immunizations, assessments, lab work, etc.)
6.2*	Panel management and/or proactive outreach of patients using a risk-stratification method (i.e. strategically targeting patients based on risk factors associated with worsening disease states)
6.3	Database or registry to track quality and clinical outcomes data on patients
6.4	Analysis of appointment "no-show" rates
7.1	Care team includes a behavioral health professional such as a psychologist, licensed clinical social worker, licensed counselor (LPC, LMHC), etc.
7.2	Care team includes a registered dietician(s)
7.3*	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
7.4	Home visit model of providing clinical services at a patient's residence (may be restricted to specific patient subpopulations)
7.5	Classes for patients focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)
7.6	Classes for patients focused on diet, nutrition counseling, and/or cooking
7.7	Peer-based programming (includes support groups, peer coaching/mentoring, etc.)
7.8	Patient educational materials or campaigns about preventive care (e.g. immunizations, preventive screenings, etc.)
7.10	SBIRT (Screening, Brief Intervention, Referral, and Treatment) workflow actively in place
7.11*	Care team includes a clinical pharmacist(s)
8.1	Screening patients for food insecurity
8.2	Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
8.3	Screening patients for housing needs
8.4	Formal partnership or arrangement with housing resources to support patient health status (e.g. affordable housing units, transitional housing, rental assistance, etc.)
8.5	Screening patients for housing quality needs
8.6	Screening patients for transportation needs
8.7	Formal partnership or arrangement with transportation resources to support patient access to care (e.g. public or private transit, etc.)

Note: Practice IDs with an asterisk indicate that while the practice was not reported as commonly implemented by providers in DSRIP-reported data, the practice was still included in Survey 2 since the practice was associated with at least one of the key measures identified in Survey 1: Prioritizing Key Measures.

Appendix B. Category C Performance Reporting 2019

Table 15: DSRIP Category C Measure Performance Reporting 2019 on Tobacco Use and Cessation Measures for All Payer, Medicaid, and Low Income Uninsured (LIU) Payer Types

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
K1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	36	0.63	↑ 0.83	0.59	↑ 0.78	0.58	↑ 0.75
M1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	33	0.51	↑ 0.85	0.61	↑ 0.88	0.48	↑ 0.84
C1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	30	0.78	↑ 0.92	0.79	↑ 0.93	0.64	↑ 0.91
L1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	9	0.71	↑ 0.91	0.50	↑ 0.94	0.58	↑ 0.91

Category C Measure ID and Title	Measures Reporting 2019 Data	All Payer 2017 Median Rate	All Payer 2019 Median Rate	Medicaid 2017 Median Rate	Medicaid 2019 Median Rate	LIU 2017 Median Rate	LIU 2019 Median Rate
F1-105: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	4	0.81	↑ 0.82	0.26	↑ 0.79	0.86	↑ 0.89
D1-400: Tobacco Use and Help with Quitting Among Adolescents	15	0.84	↑ 0.95	0.84	↑ 0.96	0.78	↑ 0.91
M1-400: Tobacco Use and Help with Quitting Among Adolescents	8	0.70	↑ 0.89	0.67	↑ 0.92	0.66	↑ 0.89
L1-400: Tobacco Use and Help with Quitting Among Adolescents	3	0.48	↑ 0.65	0.50	↑ 0.90	0.37	↑ 0.77

Note: The arrow symbol (↑) indicates the 2019 median rate was an increase compared the 2017 median rate for the payer type.

Appendix C. Senate Bill 1136 Uncompensated Care Survey

Senate Bill (S.B.) 1136, 87th Legislature, Regular Session, 2021, requires the Health and Human Services Commission (HHSC) to coordinate with hospitals and other providers that receive supplemental payments under the uncompensated care payment program (UC) to identify and implement initiatives based on best practices and models that are designed to reduce Medicaid recipients' use of hospital emergency room (ER) services as a primary means of receiving health care benefits. This could include initiatives designed to improve access to and use of primary care providers.

HHSC is conducting a survey to collect information from providers on:

- Initiatives that reduce ER utilization for primary care services;
- Initiatives that improve access to and use of primary care providers;
- Barriers that providers experience in improving Medicaid recipients' access to primary care services; and
- Recommendations for initiatives that reduce Medicaid recipients' use of ER services as a primary means of receiving health care benefits.

Results from this survey will be used to inform HHSC on provider's perspective and experience regarding the points above. Based on the information gathered in this survey, HHSC will utilize recommendations to form next steps toward developing and implementing interventions and best practices associated with improvements in the health outcomes of Medicaid recipients in Texas.

HHSC suggests that various departments or individuals within your organization work together to respond to the survey, including individuals involved in assessing quality of care delivered to Medicaid recipients.

Please complete this survey by May 6, 2022 at 11:59 PM. If you have any questions regarding the survey, direct your emails to TXHealthcareTransformation@hhsc.state.tx.us

Section I: Contact Information

1. **Name of organization**
   - Text

2. **Type of organization. If "Other" is selected, please describe.**
    - Hospital
    - Teaching Hospital
    - Ambulance Provider
    - Community Mental Health Clinic
    - Local Behavioral Health Authority
    - Local Mental Health Authority
    - Local Health Department
    - Public Health District
    - Managed Care Organization (branch to 2.c)
    - Rural Health Clinic
    - Physician Group
    - Other

2.a. NPI Number

- Number

2.b. TPI Number

- Number

2.c. Managed Care Organization's full name.

- Text

3. **Did your organization participate in the Delivery System Reform Incentive Payment (DSRIP) program?**
    - Yes
    - No
4. **Name (First and Last)**
    - Text
5. **Position**
    - Text
6. **Email Address**
    - Text
7. **Phone Number**

- Text

8. **Would you like to add another contact?**
   - Yes (branching questions 8 a-d, same options as questions 4 – 7)
   - No

Section II: Initiatives that reduce ER utilization for primary care services

9. **Has your organization observed any individuals, regardless of Medicaid status, utilizing the ER for primary care services?**
   - Yes
   - No

10. **Has your organization implemented or does your organization plan to implement any initiatives designed to reduce ER visits as a primary means of receiving health care benefits?**
   - Yes
   - No (branch to Section III)

10.a. Please select the number of initiatives your organization has implemented or plans to implement to reduce ER visits as a primary means of receiving health care benefits.
   - 1 initiative
   - 2 initiatives
   - 3 initiatives
   - 4 initiatives
   - 5 initiatives

The following questions (10.a.i – 10.a.xi.a) would be the same for each initiative selected by the providers in Q 10.a.

10.a.i. Name of initiative.
   - Text

10.a.ii. Please select the category that best fits this initiative. If "Other" is selected, please describe.
   - Care coordination

- Follow up appointments (e.g. follow up after ER visit, hospitalization, etc.) with a primary care provider
- Follow up appointments (e.g. follow up after ER visit, hospitalization, etc.) with a specialty care provider
- Use of community health workers
- Extended hours during weekends and evenings in outpatient setting
- Other

10.a.iii. Please provide a brief description of the initiative.

- Text

10.a.iv. Does this initiative impact Medicaid recipients?

- Yes
- No

10.a.v. Is this initiative based on a DSRIP best practice? If the provider did not participate in DSRIP please select "No".

- Yes (branching to 10.a.v.a)
- No

10.a.v.a Which DSRIP best practice(s) was this initiative based on? More information regarding DSRIP best practices can be found here: https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition

- Text

10.a.vi. When was this initiative first implemented? If it has not been implemented, when is it expected to be implemented?

- Date

10.a.vii. Is this initiative still ongoing?

- Yes
- No (branching to 10.a.vii.a and 10.a.vii.b)

10.a.vii.a. When did this initiative end?

- Date

10.a.vii.b. Please provide the reason(s) for ending this initiative.

- Text

10.a.viii. Does your organization partner with providers outside of your organization or other stakeholders on this initiative?

- Yes (branching to 10.a.viii.a)
- No

10.a.viii.a. Which providers or stakeholders does your organization partner with on this initiative?

- Text

10.a.ix. Approximately how many individuals receive services through this initiative per year?

- Number

10.a.x. What challenges did your organization encounter when implementing this initiative?

Select all that apply

- Lack of staff
- Lack of financial resources
- Low participation by patients
- Low participation by providers
- Other (please describe)

10.a.xi. Would you recommend this initiative to reduce ER visits as a primary means of receiving health care benefits for the Medicaid population?

- Yes (branch to 10.a.xi.a)
- No (branch to 10.a.xi.b)

10.a.xi.a Please describe why you would recommend this initiative to reduce ER visits as a primary means of receiving health care benefits for the Medicaid population.

- Text

10.a.xi.b Please describe why you would not recommend this initiative to reduce ER visits as a primary means of receiving health care benefits for the Medicaid population.

- Text

Section III: Initiatives that improve access to and use of primary care providers

11. Has your organization implemented or does your organization plan to implement any initiatives that improve access to and use of primary care providers?

- Yes, and I have at least one initiative that I have not filled out information about earlier in this survey
- Yes, but I have already listed information about all initiatives that fit this category earlier in the survey (Branch to section IV)
- No (Branch to section IV)

11.a. Please select the number of initiatives your organization has implemented or plans to implement to improve access to and use of primary care providers. If an initiative fits this criteria but was already described in the previous section, please omit it from your response below.

- 1 initiative
- 2 initiatives
- 3 initiatives
- 4 initiatives
- 5 initiatives

The following questions (11.a.i – 11.a.xi.a) would be the same for each initiative selected by the providers in Q11.a.

11.a.i. Name of initiative.

- Text

11.a.ii. Please select the category that best fits this initiative.

If "Other" is selected, please describe.

- Care coordination
- Follow up appointments (e.g. follow up after ER visit, hospitalization, etc.) with a primary care provider
- Follow up appointments (e.g. follow up after ER visit, hospitalization, etc.) with a specialty care provider

- Use of community health workers
- Extended hours during weekends and evenings in outpatient setting
- Other

11.a.iii. Please provide a brief description of the initiative.

- Text

11.a.iv. Does this initiative impact Medicaid recipients?

- Yes
- No

11.a.v. Is this initiative based on a DSRIP best practice? If the provider did not participate in DSRIP please select "No".

- Yes (branching to 11.a.v.a)
- No

11.a.v.a Which DSRIP best practice(s) was this initiative based on? More information regarding DSRIP best practices can be found here: https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition

- Text

11.a.vi. When was this initiative first implemented? If it has not been implemented, when is it expected to be implemented?

- Date

11.a.vii. Is this initiative still ongoing?

- Yes
- No (branching to 11.a.vii.a and 11.a.vii.b)

11.a.vii.a. When did this initiative end?

- Date

11.a.vii.b. Please provide the reason(s) for ending this initiative.

- Text

11.a.viii. Does your organization partner with providers outside of your organization or other stakeholders on this initiative?

- Yes (branching to 11.a.viii.a)
- No

11.a.viii.a. Which providers or stakeholders does your organization partner with on this initiative?

- Text

11.a.ix. Approximately how many individuals receive services through this initiative per year?

- Number

11.a.x. What challenges did your organization encounter when implementing this initiative?

Select all that apply

- Lack of staff
- Lack of financial resources
- Low participation by patients
- Low participation by providers
- Other (please describe)

11.a.xi. Would you recommend this initiative to improve access to and use of primary care providers for the Medicaid population?

- Yes (Branch to 11.a.xi.a)
- No (Branch to 11.a.xi.b)

11.a.xi.a Please describe why you would recommend this initiative to improve access to and use of primary care providers for the Medicaid population.

- Text

11.a.xi.b Please describe why you would not recommend this initiative to improve access to and use of primary care providers for the Medicaid population.

- Text

Section IV: Barriers to improving Medicaid recipients' access to primary care services

12. Does your organization experience any barriers to reducing ER utilization for primary care services for Medicaid recipients that were not listed in the prior section(s)?

- Yes (branching to 12.a)
- No

12.a Please explain any additional barriers.

- Text

13. Does your organization experience any barriers to improving Medicaid recipients' access to primary care services that were not listed in the prior section(s)?

- Yes (branching to 13.a)
- No

13.a Please explain any additional barriers.

- Text

Section V: Recommendations for initiatives to reduce use of ER services for primary care in Medicaid

14. Are there any initiatives that your organization has not implemented but would recommend to reduce Medicaid recipients' use of ER services as a primary means of receiving health care benefits?

- Yes (branching to 14.a)
- No

14.a Please describe the initiative(s) and why you would recommend it to reduce Medicaid recipients' use of ER services as a primary means of receiving health care benefits.

- Text