



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

**As Required by
Government Code, Section 531.0862**

**Texas Health and Human Services
August 2023**



TEXAS
Health and Human
Services

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Executive Summary

[Texas Government Code, Section 531.0862\(b\)](#) requires the Texas Health and Human Services Commission (HHSC) to biannually submit a report on 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, including initiatives designed to improve recipients' access to and use of primary care providers, 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.

As discussed in the [March 2023 report](#), in 2021, there were approximately 1.3 million potentially preventable emergency room (or department)¹ visits (PPVs) in Texas Medicaid and CHIP programs, resulting in Medicaid expenditures of approximately \$559 million². If these visits had occurred in primary care settings instead of the emergency department (ED) or been prevented, it is assumed some of these expenditures could have been reduced or avoided. Overall, the top five medical reasons for PPVs in 2021 were the same as those in 2019 and 2020, but in different order and proportions. Upper respiratory infections and otitis media (ear infections) remained the top reason for PPVs.

This report includes information on current and upcoming initiatives for addressing potentially preventable ED 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:
 - ▶ Performance Indicator Dashboard; and
 - ▶ Medicaid Value-based Enrollment (VBE).

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

² DSRIP Report of PPE for 2013-2021 Medicaid+CHIP Data, Texas-EQRO Programming core.

- HHSC implemented or continued initiatives to encourage Medicaid providers and managed care organizations (MCOs) to continue effective interventions and best practices associated with improving Medicaid recipients' health outcomes accomplished under the DSRIP program, including:
 - ▶ Directed Payment Programs (DPPs);
 - ▶ Medicaid Benefits Changes;
 - ▶ Alternative Payment Model (APM) Requirements for MCOs;
 - ▶ Initiative to Increase Disease Management Participation;
 - ▶ Non-Medical Drivers of Health (NMDOH) Action Plan; and
 - ▶ Cross-Agency Coordination on Healthcare Strategies and Measures Project.

Initiatives discussed in previous reports without significant status changes at the time of writing this report are not included in this update.³

As described in the [August 2022 report](#), HHSC surveyed providers, including those that receive uncompensated care (UC) payments, and MCOs regarding initiatives that reduce ED visits that could have been managed in physician offices or clinics and improve access to primary care services. Survey results showed many organizations have already implemented initiatives designed to reduce ED visits. HHSC will work with providers that have not yet implemented initiatives impacting ED visits to determine what barriers they face or assistance they need to plan for new initiatives. HHSC will also work with providers to share information about current initiatives that appear to be effective.

This report describes updated data on factors contributing to PPVs and types of PPVs, current initiatives to reduce potentially preventable ED utilization by Medicaid recipients, and ongoing and new efforts to improve Medicaid recipients' health outcomes. Future reports will provide biannual updates on these programs and other new initiatives, as well as results of the work with stakeholders on challenges, sharing of effective solutions, and a description of next steps.

³ Initiatives without significant status changes: Medical Pay-for-Quality; Performance Improvement Projects; Emergency Triage, Treat, and Transport Demonstration Payment Model; Medicaid Teleservices Expansion; Accountable Health Communities Model; Improving Interoperability and Care Coordination in Behavioral Health Services; Tobacco Cessation Efforts; and Value-Based Purchasing Arrangements to Address NMDOH.

1. Introduction

In compliance with [Texas Government Code, Section 531.0862](#), 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 UC pool payments to identify and implement initiatives based on best practices and models designed to reduce ED visits that could have been managed in physician offices or clinics.

The report must also provide updates on HHSC's efforts to encourage Medicaid providers to continue effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were accomplished under the Delivery System Reform Incentive Payment (DSRIP) program. The statute 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, and other cost-effective measures.

In January 2021, the Centers for Medicare & Medicaid Services (CMS) approved a 10-year extension of the Texas Healthcare Transformation and Quality Improvement Program 1115 Demonstration Waiver to 2030. Through the extension, Texas worked to sustain the historical DSRIP program funding, approved with the initial waiver in December 2011. The terms of the waiver and an approved DSRIP Transition Plan led to the creation of four new state directed payment programs (DPPs). 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 are used to evaluate the programs' efficacy in advancing state quality goals.

The DSRIP program was designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers, and local health departments for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. Texas providers earned nearly \$24.5 billion in DSRIP funds

from 2012 to January 2023. DSRIP providers 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, through data analysis⁵ 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; and
- Care teams that include a care coordination role such as community health workers and social workers.

Key DSRIP quality measures for driving improvements in the health status of clients were related to maternal health, screenings for health promotion and disease prevention, chronic care management, especially diabetes, and follow-up after hospitalization for mental illness.

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

⁵ HHSC published analyses of DSRIP data in the *Provider Performance in the DSRIP Program, Demonstration Years 7 and 8 Report*, available at: <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf>, and the *DSRIP Transition Plan Milestone: Support Further Delivery System Reform*, 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. Data Analysis – Avoidable Use of Emergency Rooms in Medicaid

As discussed in previous versions of the *Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid*, HHSC operates several initiatives intended to reduce PPVs in Medicaid. This report describes updated data on types of PPVs from the [March 2023 report](#) and factors contributing to PPVs from the [March 2022 report](#).

Types of PPVs

The most common medical reasons for PPVs in Medicaid and CHIP from 2021 are shown in Table 1. Overall, the top five medical reasons for PPVs in 2021 were the same as those in 2019 and 2020, but in different order and proportions. Upper respiratory infections and otitis media (ear infections) remained the top reason for PPVs.

Table 1. Top Medical Reasons for PPVs in Texas Medicaid and CHIP, 2021⁶

Enhanced Ambulatory Patient Group Description	Number of PPVs	Percent of Total PPVs	Percent of Total PPV Weights	PPV Expenditures	Percent of Total PPV Expenditures
Infections of Upper Respiratory Tract & Otitis Media	277,384	21.6%	16.1%	\$72.91M	13.0%
Non-Bacterial Gastroenteritis, Nausea and Vomiting	105,834	8.3%	10.5%	\$52.42M	9.4%
Viral Illness	74,961	5.8%	7.3%	\$23.87M	4.3%
Abdominal Pain	72,113	5.6%	7.3%	\$59.45M	10.6%
Contusion, Open Wound and Other Trauma to Skin and Subcutaneous Tissue	70,792	5.5%	6.2%	\$25.11M	4.5%

⁶ Texas EQRO. *External Quality Review of Texas Medicaid and CHIP Managed Care Annual Technical Report, State Fiscal Year 2022*. Available at: <https://www.hhs.texas.gov/sites/default/files/documents/eqro-annual-tech-report-contract-yr-2022.pdf>

Factors Contributing to PPVs

Some patients use the ED for visits that could have been managed in physician offices or clinics.⁷ Some of these patients visit the ED because they cannot, or do not, access timely primary, dental, or behavioral health care for preventive services or to manage chronic conditions.⁸ Reasons for this may include health professional shortages, limited availability of appointments, and other challenges such as lack of transportation.⁹ Without preventative services and timely treatment, conditions can develop, worsen, or lead to additional complications that may have otherwise been avoided with routine care.

[MCOs are required](#) to maintain adequate networks with sufficient capacity to provide timely access to all covered services according to contract standards. HHSC monitors managed care network adequacy with distance and travel time standards and by using mystery shopper appointment availability studies.

Availability of timely appointments decreased for several types of providers from 2021 to 2022. Prenatal appointments, preventive and routine primary care appointments, and behavioral health appointments compliant with wait-time standards were less available in 2022 compared to prior years.¹⁰ HHSC met one-on-one with each MCO to discuss the root cause for continued noncompliance with prenatal appointment wait times. MCOs compliance appointment wait-time standards will continue to be monitored through the secret shopper calls and noncompliance will be addressed by HHSC through contract remedies.

The percentage of providers who offered weekend appointments decreased in STAR and STAR Health in state fiscal year 2022 compared to state fiscal year 2021. The

⁷ Weinick, et. al. *How Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics?* Health Affairs, September 2010. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0748>

⁸ U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. *Trends in the Utilization of Emergency Department Services, 2009-2018*. March 2021. Available at: <https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf>

⁹ For additional discussion and data analysis regarding factors contributing to PPVs, see the March 2022 report, available at: <https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf>

¹⁰ Texas EQRO. *External Quality Review of Texas Medicaid and CHIP Managed Care Annual Technical Report, State Fiscal Year 2022*. Available at: <https://www.hhs.texas.gov/sites/default/files/documents/eqro-annual-tech-report-contract-yr-2022.pdf>

percentage of providers that offered telehealth services or weekend behavioral health appointments decreased across all the programs in state fiscal year 2022 compared to state fiscal year 2021.

In [a March 2021 report to Congress on trends in ED utilization](#), the United States Department of Health and Human Services stated that research indicates “access and convenience play an important role in the choice to seek care in an ED.” The report also cited research showing that doctors sometimes refer their patients to the ED if they need care outside of office hours or if an appointment is not available when needed.

Even when patients access timely preventative care, they may still need urgent care for acute illness or injury. For some of these conditions, patients may have difficulty determining the severity without diagnostic procedures and medical expertise.¹¹ If they do not have convenient alternatives for urgent care or cannot distinguish whether a condition is urgent or emergent, they may visit an ED for treatment.

HHSC will continue to analyze data from MCO and provider performance reports and member surveys to understand the factors contributing to PPVs. HHSC also has several ongoing and new initiatives designed to reduce PPVs and improve health outcomes overall, which are discussed in the next section. HHSC will provide updates on these programs, progress on reducing PPVs, and other initiatives to improve member health outcomes in subsequent reports.

¹¹ U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. *Trends in the Utilization of Emergency Department Services, 2009-2018*. March 2021. Available at: <https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf>

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

[Texas Government Code, Section 531.085](#) requires HHSC to coordinate with hospitals and other providers that receive UC payments to identify and implement initiatives to reduce ED visits that could have been managed in physician offices or clinics, including initiatives to improve recipients' access to and use of primary care providers.

To meet these requirements, HHSC is leveraging available data and conducting stakeholder surveys to identify current issues that contribute to the preventable use of EDs and to identify effective solutions and potential next steps. In addition, HHSC has already implemented initiatives and plans to implement additional initiatives meant to incentivize and hold MCOs accountable for their management of non-emergent ED utilization.

The Medical Pay-for-Quality, Performance Improvement Projects, Emergency Triage, Treat, and Transport Demonstration Payment Model, Medicaid Teleservices Expansion, Accountable Health Communities Model, and Improving Interoperability and Care Coordination in Behavioral Health Services initiatives were included in previous reports and have not had significant status changes. Future reports will include any updates on the initiatives described below as well as initiatives included in past reports.

HHSC Performance Indicator Dashboard

The Performance Indicator Dashboard provides a comprehensive view of overall quality of healthcare provided to Medicaid members by MCOs. It includes a set of measures for each managed care program. The measures assess different aspects of healthcare quality that HHSC has determined to be of greatest importance.¹² An MCO whose per-program performance is below the minimum standard on more than 33.33 percent of the measures on the dashboard is subject to remedies under

¹² Additional background is included in the March 2022 report, available at: <https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf>

the contract, including placement on a corrective action plan (CAP).¹³ Measures for which the MCO has a low denominator are excluded from the CAP calculation. For 2020, nine STAR MCOs, four STAR+PLUS MCOs, and four STAR Kids MCOs did not meet the minimum standard on more than 33.33 percent of the dashboard measures and were placed on CAPs. For 2021, seven STAR MCOs, three STAR+PLUS MCOs, seven STAR Kids MCOs, and one STAR Health MCO were placed on CAPs. Compared to 2020, fewer MCOs received CAPs in STAR and STAR+PLUS. However, STAR Health was not subject to a CAP in 2020 but was in 2021. The Public Health Emergency may have impacted the 2021 dashboard results.

Medicaid Value-based Enrollment (VBE)

[Texas Government Code, Section 533.00511](#) directs HHSC to create an incentive program to automatically enroll a greater percentage of recipients who did not actively choose a managed care plan into a managed care plan based on:

- The quality of care provided through the MCO offering that managed care plan;
- The organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and
- The organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on potentially preventable events (PPEs).

When an individual enrolls in Medicaid, they are encouraged to select an MCO using MCO report cards and other information sent to the individual. If a Medicaid client does not select a health plan, HHSC uses a default assignment methodology to enroll the client in an MCO. Beginning in fiscal year 2021, HHSC began incorporating measures of quality and efficiency into this auto assignment process. Under the new VBE, MCOs with better performance than other MCOs on the factors listed in Table 2 receive a higher share of enrollment than under the current methodology.

¹³ For more information, see Chapter 10.1.14 of the Uniform Managed Care Manual, available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf>

Table 2. VBE Methodology Criteria

Dimension	Weight	VBE Enrollment Criteria
Cost and Efficiency	40%	Risk-adjusted actual to expected spending ratio
Cost and Quality	20%	Risk-adjusted actual to expected PPEs ratios: Potentially Preventable Admissions, Potentially Preventable 30-day Readmissions, and PPVs
Quality and Member Satisfaction	40%	Composite Report Card Scores (Quality and Member Satisfaction), which include: <ul style="list-style-type: none">• Member experience with doctors and the health plan – derived from results of member surveys;• Staying healthy – MCO performance on preventive care measures; and• Controlling chronic diseases – MCO performance on important quality measures regarding care for asthma, Attention Deficit Hyperactivity Disorder, Chronic Obstructive Pulmonary Disease, depression, or diabetes, depending on the program.¹⁴

HHSC updates the VBE dimensions each year for each combination of health plan, service area, and program.

Each month, MCOs see an increase or decrease in auto enrollment as a result of performance in the VBE model relative to what they would have received under the previous model that did not consider MCO performance. Across each program, MCOs currently experience the following impacts from VBE:

- STAR: The highest performing MCO gains 13.4 percent more auto enrolled members than they would have under the old non-value-based model. The lowest performing MCO loses 18.4 percent.
- STAR+PLUS: The highest performing MCO gains 4.3 percent, while the lowest performing plan loses 9.6 percent of its auto enrollments.
- STAR Kids: The highest performing plan gains 6.3 percent, while the lowest performing plan loses 12.5 percent.

Detailed information on VBE is available in the [Value-based Enrollment Incentive Program](#) report released in January 2021 and the [Annual Report on Quality Measures and Value-based Payments](#) released in December 2022.

¹⁴ The Composite Scores are included in the report cards.

4. Initiatives to Improve Medicaid Recipients' Health Outcomes

Texas [Government Code, Section 531.0862](#) 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 has many 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.

The Tobacco Cessation Efforts and Value-Based Purchasing Arrangements to Address NMDOH initiatives were included in previous reports and do not have significant status changes. Future reports will include any updates on the initiatives described below as well as initiatives included in past reports.

Directed Payment Programs (DPPs)

CMS, under federal regulations ([Code of Federal Regulations, Title 42. § 438.6\(c\)](#)), allows states to direct MCO expenditures “to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement”.¹⁵ The state develops the programs, specific to a class of provider, and directs MCOs to implement the associated provider payments. DPPs must help the state advance its [Managed Care Quality Strategy](#). HHSC uses its Managed Care Quality Strategy to assess and improve the quality of health care and services provided through the managed care system. Most DPPs require annual approval from CMS.

As introduced in the [March 2022 report](#), four new DPPs were developed as part of the goal to sustain DSRIP funding for the Texas health system and advance DSRIP best practices:

- Comprehensive Hospital Increased Reimbursement Program (CHIRP);
- Texas Incentives for Physician and Professional Services (TIPPS);
- Rural Access to Primary and Preventive Services (RAPPS); and

¹⁵ For more information, see the CMS State Medicaid Director Letter from January 8, 2021, available at: <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf>

- Directed Payment Program for Behavioral Health Services (DPP BHS).

In March 2023, HHSC sent an [evaluation of state fiscal year 2022 and 2023](#) to CMS and an [evaluation plan](#) for state fiscal year 2024. This evaluation plan included new performance targets for some measures, including some that may impact PPVs, such as tobacco screening and cessation and influenza immunization screening.

In June 2023, HHSC sent participants a new data visualization tool to help providers compare their performance to their peers' and to state fiscal year 2024 evaluation targets. HHSC wants this tool to incentivize providers that have not yet met the target to improve their performance. If providers have already exceeded the target, HHSC hopes to facilitate sharing of best practices to improve quality of care for all Medicaid clients. HHSC evaluates the DPPs each year and will continue to assess the programs' impact on the health outcomes and health delivery system.

Medicaid Benefits Changes

The 87th Legislature passed legislation, such as Senate Bill (S.B.) 672 and House Bill (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 (CoCM)

S.B. 672, 87th Legislature, Regular Session, 2021 required HHSC to provide Medicaid reimbursement for the provision of behavioral health services that are classified as collaborative care management services. To comply with S.B. 672, Texas Medicaid developed a new medical policy for collaborative care management services that implemented on June 1, 2022.

The CoCM is a systematic approach to the treatment of behavioral health conditions in primary care settings. The model integrates the services of behavioral health care managers and psychiatric consultants with primary care provider oversight to manage behavioral health conditions as chronic diseases. CoCM services include outreach and engagement, completion of an initial assessment, development of an individualized and person-centered plan of care, monitoring and tracking a client's progress using a registry that is used jointly with the electronic medical record, providing brief interventions, and conducting weekly caseload reviews with the psychiatric consults. There are many benefits to providing mental health treatment

in primary care settings including client convenience, reducing stigma associated with treatment for mental health disorders, and improving care for clients with both medical and mental disorders.

Prior to delivering CoCM services, providers must have an established CoCM program. Therefore, effective January 1, 2023, providers in fee-for-service (FFS) Medicaid must attest they have an established CoCM program and that they are actively providing CoCM services consistent with the core principles and specific functional requirements of the model, as described in the CoCM benefit in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) in the *Texas Medicaid Provider Procedures Manual*. Providers of CoCM services in FFS Medicaid must complete the "Attestation Form for Collaborative Care Model (CoCM) in Texas Medicaid" that is available on the Texas Medicaid & Healthcare Partnership website, at the start of every new episode of care and maintain the form in the client's medical record. The attestation form falls into the category of administrative procedures for which MCOs have flexibility to establish their own policies and processes. Therefore, MCOs may use or edit the form at their discretion. MCOs opting to implement the attestation form may choose whether completion of the form is required for each client receiving CoCM services or at the provider/practice level.

In addition, in January 2023, Texas Medicaid launched a computer-based training for CoCM services that is available to providers on the Texas Medicaid & Healthcare Partnership Learning Management System website.

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 DSMES and medical nutrition therapy (MNT) 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 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.

HHSC continues to examine the cost-effectiveness and feasibility of providing DSMES and MNT services to diabetic Medicaid clients. HHSC continues conducting research and analysis on improved health outcomes and cost effectiveness of both DSMES and MNT in Medicaid, which will result in a report detailing the findings.

Chronic care management was a focus area of the DSRIP Transition, and the Best Practices Workgroup¹⁶ 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.

Alternative Payment Model (APM) Requirements for MCOs

Since 2018, HHSC has required MCOs to shift an increasing proportion of provider reimbursement into APMs that link a portion of provider payments to metrics for quality and efficiency. These APMs may involve financial risk on providers or reward providers for meeting performance standards. Under current requirements, MCOs must make 50 percent of their provider payments through an APM with at least 25 percent through an APM involving financial risk for providers by calendar year 2022. MCOs are largely on track to meet these initial goals. For calendar year 2021, the most recent year for which data are complete, MCOs averaged 47 percent of payments through APMs in STAR, 49 percent in STAR+PLUS, and 46 percent in STAR Kids. Nearly all MCOs had implemented at least one APM with a metric to encourage lower emergency department utilization or rates of PPVs.

For calendar year 2023 data, HHSC will begin a transition to an APM Performance Framework that recognizes MCO efforts beyond just meeting these payment targets. Initial data collection, in September 2024, would be for the purpose of testing the updated data collection tool, with the new requirements fully in place for the 2024 data collected in September 2025. Under the updated approach, MCOs

¹⁶ In January 2020, HHSC established the DSRIP Transition Best Practices Workgroup, comprised of 84 DSRIP provider representatives, DSRIP anchor organization representatives, and Executive Committee Waiver members. 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. For more information, see the August 2022 report, available at: <https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-medicaid-aug-2022.pdf>

will be encouraged to develop and field innovative models that address specific quality improvement priorities, including models that encourage ambulance transports to alternative sites instead of emergency departments when appropriate, address non-medical drivers of health, and incentivize the integration of primary and behavioral healthcare services.

Initiative to Increase Disease Management Participation

H.B. 2658, 87th Legislature, Regular Session, 2021 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 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 found MCOs were including members who were initially in a disease management program and were getting services more tailored to their needs outside of the disease management program, such as case management, as continuing in that disease management program. This was artificially lowering active participation rates. HHSC made changes in the Uniform Managed Care Manual to clarify that these members receiving related services outside the disease management program should not be considered when calculating active participation in disease management programs. The EQRO will reassess active participation rates through administrative interviews starting in 2024 and make recommendations to MCOs and HHSC accordingly.

Non-Medical Drivers of Health (NMDOH) Action Plan

NMDOH are "the conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes."¹⁷ [The NMDOH Action Plan](#) sets out the priorities and goals that will guide Texas Medicaid and CHIP Services as new and ongoing NMDOH activities are coordinated and continue to progress. The

¹⁷ These are also known as social drivers of health and drivers of health. The definition is from the CDC. *Social Determinants of Health at CDC*. Available at: <https://www.cdc.gov/about/sdoh/index.html>

priority NMDOH for the action plan are food, housing, and transportation, and the goals are to:

- Build data infrastructure for statewide quality measurement and evaluation;
- Coordinate services and existing pathways throughout the delivery system;
- Develop policies and programs that encourage MCOs and providers to identify and address health-related social needs while containing costs; and
- Foster opportunities for collaboration with key partners.

The NMDOH Action Plan supports the continuation of best practices associated with improvements in the health outcomes of Medicaid recipients identified during the DSRIP program. The action plan also advances the [Texas Managed Care Quality Strategy](#) and strategically aligns with legislative direction from the 88th Legislature.

H.B. 113, 88th Legislature, Regular Session, 2023 allows Medicaid MCOs in STAR to categorize services provided by a community health worker as a quality improvement cost, as authorized by federal law, instead of as an administrative expense.

H.B. 1575, 88th Legislature, Regular Session, 2023 requires HHSC to adopt standardized assessment questions designed to screen for, identify, and aggregate data regarding the NMDOH needs of pregnant women eligible for benefits under a public benefits program administered by HHSC or another health and human services agency, including Medicaid. Additionally, H.B. 1575 requires MCOs in STAR to conduct a NMDOH needs screening for pregnant women, determine if the recipient needs a referral for services, and provide HHSC with the data collected during screenings.

In spring 2023, the NMDOH Action Plan was posted to the public HHSC website and HHSC staff began presenting the plan to stakeholders, including MCOs, providers, and community-based organizations.

Cross-Agency Coordination on Healthcare Strategies and Measures Project

The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Health Related Provisions, Section 10.06) authorizes the Cross-Agency Coordination on Healthcare Strategies and Measures project. This project, referred to as "The 5 Agencies Project," requires state agencies that pay for the health care of Texans to coordinate data to identify outliers and improvements for

efficiency and quality that can be implemented within each health care system. The five agencies participating in the collaborative include: HHSC, Department of State Health Services (DSHS), Employees Retirement System, Teacher Retirement System, and Texas Department of Criminal Justice.¹⁸ The project is now in its fourth year and was recently renewed through August 2025.

Representatives for each of the five participating agencies and the University of Texas Health Data Center meet at least quarterly to review analytic methods, discuss findings, and collaborate on project goals and objectives. The University of Texas Health Data Center has successfully built a multi-agency data system spanning millions of records, stood up secure data portals for four agencies (DSHS does not contribute data) and one portal to compare data across agencies, and published biennial reports in [2020](#) and [2022](#). The agencies have established two quality improvement projects. The first project focuses on reducing self-harm events¹⁹ which includes developing initiatives to integrate behavioral healthcare with primary care and promote early identification of mental health issues among patients. The second project focuses on improving maternal health outcomes including by identifying ways to support and promote the DSHS TexasAIM safety bundles. Secure data portals provide the agencies with access to dashboard data that includes utilization analyses on hospital admissions, ED visits, procedures, outpatient services, and prevalence rates.

¹⁸ Note: The Department of State Health Services is not required to provide data.

¹⁹ "Self-harm" is defined as non-suicidal self-injury and/or other self-harming behaviors.

5. Conclusion

HHSC implemented or continued progress on initiatives to reduce avoidable ED use, including the Performance Indicator Dashboard and Medicaid VBE. HHSC also developed or continued progress on 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 alternative payment models, and other cost-effective measures. Initiatives include DPPs, Medicaid Benefits Changes, APM Requirements for MCOs, Initiative to Increase Disease Management Participation, the NMDOH Action Plan, and the Cross-Agency Coordination on Healthcare Strategies and Measures Project.

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
CAP	Corrective Action Plan
CHIP	Children’s Health Insurance Program
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
DPP	Directed Payment Program
DPP BHS	Directed Payment Program for Behavioral Health Services
DSHS	Department of State Health Service
DSMES	Diabetes Self-Management Education and Support
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EQRO	External Quality Review Organization
FFS	Fee-for-service
H.B.	House Bill
HHSC	Health and Human Services Commission
MCO	Managed Care Organization
MNT	Medical Nutrition Therapy
NMDOH	Non-medical Drivers of Health
PPE	Potentially Preventable Event
PPV	Potentially Preventable Emergency Room Visit
RAPPS	Rural Access Primary and Preventive Services
S.B.	Senate Bill
SFY	State fiscal year
TIPPS	Texas Incentives for Physicians and Professional Services
UC	Uncompensated Care
VBE	Value-based Enrollment