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
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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 2024 report, in 2022, there were approximately 1.58 million potentially preventable emergency room (or department)[1] visits (PPVs) in Texas Medicaid and Children's Health Insurance Program (CHIP) programs, resulting in Medicaid and CHIP expenditures of approximately $754 million.[2] If these visits were prevented or occurred in a primary care setting, some of these expenditures could have been reduced or avoided.

This report includes information on current and upcoming initiatives for addressing potentially preventable emergency department (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:
  - HHSC Performance Indicator Dashboard
  - Medicaid Value-Based Enrollment (VBE)
- HHSC implemented or continued initiatives to encourage Medicaid providers and managed care organizations (MCOs) to continue effective interventions

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

[2] See the DSRIP Report of PPE for 2013-2022 Medicaid+CHIP Data, Texas-EQRO Programming core.

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

- Collaborative Care Model
- Diabetes Self-Management Education and Support
- Directed Payment Programs Quality Measures

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

Texas Government Code, Section 531.0862(b), requires HHSC to coordinate with hospitals and other providers to identify and implement initiatives to reduce ED utilization as a primary means of receiving health care benefits. This report includes discussion of the HHSC workgroup on best practices to reduce ED utilization among providers receiving uncompensated care (UC) compensation.

This report describes updated data on types of PPVs, current initiatives to reduce potentially preventable ED utilization by Medicaid recipients, ongoing and new efforts to improve Medicaid recipients' health outcomes and HHSC's stakeholder engagement workgroup. 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: Performance Improvement Projects; Medicaid Teleservices Expansion; Accountable Health Communities Model; Value-Based Purchasing Arrangements to Address Non-medical Drivers of Health (NMDOH); Tobacco Cessation Efforts; NMDOH Action-Plan; Medicaid Pay-for-Quality (P4Q) Program; Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project; Improving Interoperability and Care Coordination in Behavioral Health Services; House Bill (H.B.) 1575 Implementation; Maternal Opioid Misuse Model; and Cross-Agency Coordination on Healthcare Strategies and Measures Project.

1. Introduction

In compliance with Texas Government Code, Section 531.0862(b), 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 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]

[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.

During the DSRIP program, through data analysis[5] 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.

[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. 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 top reasons for PPVs in 2022, which is an additional year of data since the August 2023 report. The March 2024 report describes data on PPV rates from 2013 – 2022.

Potentially Preventable Emergency Department Visits (PPVs)

Some people go to hospital EDs for conditions that are not emergencies, and others go for conditions that are emergencies at the time of the visit but could have been treated before becoming emergent with appropriate primary or urgent care. A PPV is emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting.[6] PPVs can result in avoidable healthcare costs, as ED visits are generally more expensive than primary care visits for comparable conditions.[7] According to Texas' contracted External Quality Review Organization (EQRO), there were approximately 1.58 million PPVs in Texas Medicaid and CHIP programs in 2022, costing approximately $754 million. If these visits were prevented or occurred in a primary care setting, some of these expenditures could have been reduced or avoided.

Types of PPVs

The most common medical reasons for PPVs across all Medicaid and CHIP programs from 2022 are shown in Table 1. Overall, the top five medical reasons for PPVs in 2022 are consistent with 2019 – 2021, although the order has changed throughout

[6] There are various methodologies to determine and measure which ED visits could have been prevented. Texas Medicaid and its EQRO use the methodology from 3M to measure PPVs. See *Potentially Preventable Events*, available at: https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events.

[7] See *Trends in the Utilization of Emergency Department Services, 2009-2018* by the U.S. Department of Health & Human Services. Available at https://aspe.hhs.gov/reports/trends-utilization-emergency-department-services-2009-2018.

that period. The top five medical reasons in 2022 were the same as those in 2021. 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, 2022[8]

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 and Otitis Media	358,478	22.7%	17.0%	$107.26M	14.2%
Non-Bacterial Gastroenteritis, Nausea and Vomiting	121,493	7.7%	9.8%	$68.14M	9.0%
Viral Illness	111,925	7.1%	9.0%	$40.22M	5.3%
Abdominal Pain	87,511	5.6%	7.3%	$79.21M	10.5%
Contusion, Open Wound and Other Trauma to Skin and Subcutaneous Tissue	83,500	5.3%	6.0%	$33.98M	4.5%

Factors Contributing to PPVs

Some patients use the ED for visits that could have been managed in physician offices or clinics.[9] 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.[10] Reasons for this may include health professional shortages, limited availability of appointments and other challenges such as lack of transportation.[11] Without preventive services and timely treatment, conditions can

[8] See *External Quality Review of Texas Medicaid & CHIP Managed Care Annual Technical Report, State Fiscal Year 2023* by the Texas EQRO. Available at: https://www.hhs.texas.gov/sites/default/files/documents/eqro-annual-technical-report-contract-sfy-2023.pdf

[9] See *How Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics?* Health Affairs by Weinick, et. al. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0748

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

[11] For additional discussion and data analysis regarding factors contributing to PPVs, see the August 2023 report, available at: https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-medicaid-aug-2023.pdf

develop, worsen, or lead to additional complications that may have otherwise been avoided with routine care.

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 will be 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.

Evaluation of Alternative Payment Models Impacting ED Utilization

Since 2018, HHSC has required MCOs to shift more provider reimbursement into alternative payment models (APMs). These arrangements must link a portion of provider payments to metrics for quality and efficiency, meaning providers have a greater risk for financial losses and a greater chance for financial rewards for meeting performance standards. Under current requirements, MCOs must make a minimum of 50 percent of their provider payments through an APM and at least 25 percent through an APM involving financial risk for providers. MCOs design APMs considering HHSC's APM priority areas, such as the reduction of preventable ED visits.

In April and May of 2024, HHSC surveyed MCOs to determine how many MCOs implemented APMs to reduce preventable ED utilization. Of the 16 MCOs that responded:

- Thirteen MCOs reported using an APM to reduce preventable ED visits;
- Two MCOs reported plans to implement a similar APM in the future; and
- One MCO reported working with providers to reduce preventable ED visits unrelated to an APM arrangement.

To understand how APMs affect ED utilization, HHSC staff requested MCOs share their evaluation of APMs' impact on utilization, quality, cost, and return on investment (ROI). In May 2024, MCOs provided evaluations for 75 APM arrangements aiming to impact ED utilization.

While HHSC staff continue to review details of the evaluations, this report provides a high-level summary of APMs.

APM Arrangements and Provider Types

The majority of evaluations submitted were on APMs with primary care providers. These arrangements enhance payments and supports for clinicians and incentivize improvement of patients' health outcomes. Many of the APM arrangements prioritize preventive care quality measures, such as nutrition and well-child visits, while tracking ED utilization.

The public health emergency (PHE) impacted PPV rates overall, as well as many of the APMs in these evaluations. According to MCO evaluations, the number of Medicaid members increased during the PHE due to continuous eligibility requirements, while the number of providers did not grow at the same rate. Some MCOs noted that limited provider availability may have resulted in Medicaid members using the ED more often than usual.

Due to PPV fluctuations during and following the PHE, many evaluations did not include estimates of savings for the APM arrangements with primary care providers. A few evaluations reported savings from their arrangements with this type of provider.

Evaluations highlighted that providers participating in APM arrangements have better results than non-participating providers when comparing ED visits and costs. However, evaluations indicated that some providers are reluctant to participate in APMs.

APMs and Behavioral Health

Evaluations included several APMs related to behavioral health aimed at impacting ED utilization. Highlights from these evaluations included:

- These APMs achieved savings and reduced preventable ED visits.
- MCOs that conducted ROI analyses on these APMs indicated positive ROIs.
- Initiatives that reported results observed more than a 20 percent reduction in ED utilization overall.
- Evaluations noted that providers participating in APMs related to behavioral health performed better than non-participating providers on various quality measures, including the reduction of ED visits.

APMs and Services Delivered at Members' Homes

Evaluations highlighted that several APMs provide services to Medicaid members at their homes to reduce unnecessary ED visits. These APMs include private duty nursing, personal attendant care, and home health services.

Highlights from these evaluations included:

- Providing services at home reduced unnecessary ED visits.
- Medicaid members eligible for these services generally have higher health needs compared to average Medicaid enrollees.

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 and workgroups 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 Performance Improvement Projects, Medicaid Teleservices Expansion, Medical Pay for Quality (P4Q) Program, Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project, Improving Interoperability and Care Coordination in Behavioral Health Sciences, and Accountable Health Communities Model 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 HHSC Performance Indicator Dashboard provides a comprehensive view of the overall quality of healthcare MCOs deliver to Medicaid members. It comprises a set of measures for each managed care program, assessing various aspects of healthcare quality HHSC has determined to be of utmost importance. HHSC subjects an MCO to remedies under the contract, including placement on a corrective action plan (CAP) if the MCO's per-program performance falls below the minimum standard on more than 33.33 percent of the dashboard measures. Measures with a low denominator for the MCO are excluded from the CAP calculation.

In 2022, several MCOs were placed on a CAP including the below:

- STAR - 14 MCOs
- STAR+PLUS - 4 MCOs
- STAR Kids - 8 MCOs

Medicaid Value-Based Enrollment

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.

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 automatic assignment process. Under the new value-based enrollment (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.

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 potentially preventable events 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: • Member experience with doctors and the health plan – derived from results of member surveys and complaints data; • 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.[12]

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 automatic enrollment due to 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 at the service area level, MCOs experience the following impacts from the latest VBE update:

- STAR: The highest performing MCO gains 5.5 percent more automatically enrolled members than they would have under the old non-value-based model. The lowest performing MCO loses 18.5 percent.
- STAR+PLUS: The highest performing MCO gains 5.7 percent, while the lowest performing plan loses 13.4 percent of automatic enrollments. VBE for STAR+PLUS will be paused in many service areas on September 1, 2024 until sufficient data is available for health plans new to the area.
- STAR Kids: The highest performing plan gains 11.6 percent, while the lowest performing plan loses 7.5 percent.

Detailed information on VBE is available in the *Annual Report on Quality Measures and Value-based Payments* released in December 2023.

[12] The Composite Scores are included in the report cards.

4. Initiatives to Improve Medicaid Recipients' Health Outcomes

Texas Government Code, Section 531.0862(b) 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 released in March 2022, and additional initiatives are summarized below.

Value-Based Purchasing Arrangements to Address Non-Medical Drivers of Health (NMDOH), APM Requirements for MCOs, Tobacco Cessation Efforts, House Bill (H.B.) 1575, 88th Legislature, Regular Session, 2023 Implementation, Maternal Opioid Misuse Model, and NMDOH Action-Plan 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

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."[13] The state develops the programs, which may be specific to a class or classes of provider or a particular Medicaid managed care service, and directs MCOs to implement the associated provider payments. Directed payment programs (DPPs) must help the state advance the Managed Care Quality Strategy. HHSC uses the 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.

[13] 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

HHSC administers the Quality Incentive Payment Program (QIPP). QIPP, implemented in fiscal year 2018, is a DPP designed to help nursing facilities achieve transformation in care quality through innovation.

As introduced in the March 2022 report, the following four DPPs were developed as part of the state's DSRIP Transition Plan to sustain key DSRIP initiative areas:

- Comprehensive Hospital Increased Reimbursement Program (CHIRP);
- Texas Incentives for Physician and Professional Services (TIPPS);
- Rural Access to Primary and Preventive Services (RAPPS); and
- Directed Payment Program for Behavioral Health Services (DPP BHS).

Evaluation

In March 2024, HHSC sent evaluations of fiscal years 2022 – 2024 for all DPPs to CMS. HHSC also sent CMS DPP evaluation plans for fiscal year 2025. These evaluation plans included new performance targets for existing measures, including targets that may impact PPVs, such as tobacco cessation interventions and immunizations.

The evaluations for fiscal years 2022-2024 provide a picture of the baseline health of the population visiting DPP providers.

- In 2022, Medicaid clients who saw TIPPS, DPP BHS, and RAPPS providers went to the ED for preventable conditions more often than expected when compared to other Medicaid clients.
- In 2022, Medicaid clients who saw DPP BHS and RAPPS providers across all Medicaid managed care programs went to the ED for preventable conditions less often than in 2021. However, this group still had more ED visits for preventable conditions than expected.
- In 2022, Medicaid clients in STAR and STAR Kids who saw TIPPS providers went to the ED for preventable conditions less often than in 2021.
- In 2022, the rates for DPP measure Follow-Up After Emergency Department Visit for Mental Illness Age 6+ increased compared to 2021 for TIPPS, stayed about the same for DPP BHS, and decreased for RAPPS in all programs except for STAR.

HHSC evaluates the DPPs each year and will continue to assess the programs' impact on the health outcomes and health delivery system.

Best Practices Learning Series

In April 2024, HHSC began the DPP Best Practices Learning Series, a webinar series for providers and MCOs in which HHSC staff share best practices for quality improvement during the fiscal year 2025 performance period (calendar year 2024) for certain DPP quality measures and focus areas. Several of these focus areas may impact PPVs, such as non-medical drivers of health and hospital readmissions.

Proposed DPP Changes in Fiscal Year 2025

HHSC submits an annual application for each DPP program. In the application for CHIRP for fiscal year 2025, HHSC proposed to shift a portion of program payment to pay-for-performance for CHIRP in fiscal year 2025. This includes a new component of six measures that will be known as Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA). The current proposal includes six measures, one of which is the continuing Follow-Up After ED Visit for Mental Illness: Ages 6-17 measure reported by the Texas EQRO. By changing this measure to pay-for-performance, HHSC is further incentivizing providers to improve performance on this quality measure. CHIRP pay-for-performance in fiscal year 2025 is pending CMS' approval.

Medicaid Benefits Changes

The 87th Legislature passed legislation, including Senate Bill (S.B.) 672 and House Bill (H.B.) 2658, that 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. To comply with S.B. 672, Texas Medicaid developed a new medical policy for collaborative care model (CoCM) 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 services of a behavioral health care managers and psychiatric consultant 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 consultant. 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.

Effective January 1, 2023, providers in fee-for-service Medicaid must attest they have an established CoCM program and are actively providing CoCM services consistent with the core principles and specific functional requirements of the model.[14]

In 2023, Texas Medicaid also launched a computer-based training and billing case study video series adapted from the University of Washington Advancing Integrated Mental Health Solutions Center training. The case study describes how various combinations of billing codes can be used for a client who is undergoing treatment for depression in the CoCM over several calendar months.

The CoCM 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

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

[14] The core principles and specific functional requirements of the Collaborative Care Model can be found in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) in the *Texas Medicaid Provider Procedures Manual*.

Texas Medicaid conducted extensive research and analysis over the past year on improved health outcomes and cost effectiveness of both DSMES and medical nutrition therapy. Texas Medicaid is currently developing the benefits and will seek approval from the Legislative Budget Board prior to implementation, as directed by the legislation.

5. Stakeholder Engagement

Best Practices Workgroup for Initiatives to Reduce ED Utilization

As described in the August 2022 and March 2024 reports, HHSC previously surveyed providers, including those that receive 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. Of those responses, care coordination was the most common initiative respondents were using to reduce potentially preventable ED visits. Providers that have not implemented any initiatives cited lack of funding, staffing, lack of available data and collaboration with other providers or MCOs, and lack of understanding of how to select an initiative to implement.

In June 2024, HHSC invited representatives of providers and MCOs to the first workgroup meeting dedicated to sharing care coordination best practices for reducing ED visits. Twelve representatives from 10 organizations joined the first workgroup meeting to discuss care coordination initiatives, challenges they face in implementing these initiatives, and their next steps. HHSC will continue to engage with providers and gather their feedback on best practices to reduce preventable ED visits.

6. Conclusion

Since the last report submission in March 2024, HHSC implemented and continued progress on initiatives to reduce avoidable ED use, including the HHSC 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 DPPs, and Medicaid benefits changes.

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 will continue sharing best practices, studying the impact of the PHE unwinding on ED utilization, analyzing APM evaluations, and updating continuing HHSC initiatives. HHSC is committed to developing effective interventions and implementing best practices associated with improvements in Medicaid recipients' health outcomes.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Model
CAP	Corrective Action Plan
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increase 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
DSMES	Diabetes Self-Management Education and Support
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EQRO	External Quality Review Organization
H.B.	House Bill
HHSC	Health and Human Services Commission
MCO	Managed Care Organization
PHE	Public Health Emergency
PPV	Potentially Preventable Emergency Room Visit
QIPP	Quality Incentive Payment Program
RAPPS	Rural Access to Primary and Preventive Services Program
ROI	Return on Investment
S.B.	Senate Bill
TIPPS	Texas Incentives for Physicians and Professional Services
UC	Uncompensated Care
VBE	Value-Based Enrollment