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 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, 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.

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 million[2]. 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. The number of PPVs per 1,000 member months decreased significantly from 37.8 in 2013 to 23.2 in 2021, a 38.6 percent decrease in the rate when adjusted for caseload increase over the same period. However, caseload increases and the resource use or prices of the remaining PPVs increased total PPV expenditures over this time.

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 Improvement Projects (PIPs)
    - Performance Indicator Dashboard

[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.

    - Medicaid Teleservices Expansion
    - Accountable Health Communities Model (AHCM)
    - Improving Interoperability and Care Coordination in Behavioral Health Services
- HHSC implemented or continued progress on 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
    - Non-Medical Drivers of Health (NMDOH) Action Plan
    - Continuing DSRIP Core Activities

Initiatives discussed in the first and second 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 collected information via survey from providers, including those that receive uncompensated care (UC) payments, and MCOs regarding initiatives that reduce the use of the ED as a primary means of receiving healthcare and improve access to primary care services. Survey results showed many organizations are already implementing 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 the current scope 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, required by code to be submitted biannually, will provide 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 Program, Medicaid Value-based Enrollment, Emergency Triage, Treat, and Transport Demonstration Payment Model, Value-based Purchasing Arrangements to Address Social Determinates of Health, Initiative to Increase Disease Management Participation, and Tobacco Cessation Efforts.

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 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 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, 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 Delivery System Reform Incentive Payment (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 will be 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 (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 nearly $24.5 billion in DSRIP funds from 2012 to January 2023, 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 (DYs) 3-6 (October 1, 2013 to September 30, 2017) and are not unduplicated counts.

Over the course of 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.
- 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 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.

[5] HHSC published analyses of DSRIP data in the *Provider Performance in the DSRIP Program, DYs 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 the March 2022 and August 2022 *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 PPV rates and expenditures from the March 2022 report.

Potentially Preventable Emergency Department Visit (PPV) Rates

Some patients 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), approximately 1.3 million PPVs in Texas Medicaid and Children's Health Insurance Program (CHIP) programs occurred in 2021, costing approximately $559 million. If these visits had occurred in primary care settings instead of the emergency department or been prevented, it is assumed some of these expenditures could have been reduced or avoided.

HHSC operates several initiatives intended to reduce PPVs, as discussed in the next section. The number of PPVs per 1,000 member months decreased significantly from 37.8 in 2013 to 23.2 in 2021, as shown in Figure 1, indicating a 38.6 percent decrease in the rate when adjusted for caseload increase over the same time period. The PPV weight per 1,000 member months stayed at 9.2 between 2013 and

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

2019, then decreased to 6.8 in 2021, as shown in Figure 2.[8] PPV weight is assigned to ED visits based on the estimated intensity of resource costs needed to provide effective treatment, based on national data. Total PPV weight reported is the sum of weights for a measurement period and thus accounts for both volume and resource use.[9]

Figure 1: Number of PPVs Per 1,000 Member Months, All Programs, 2013-2021

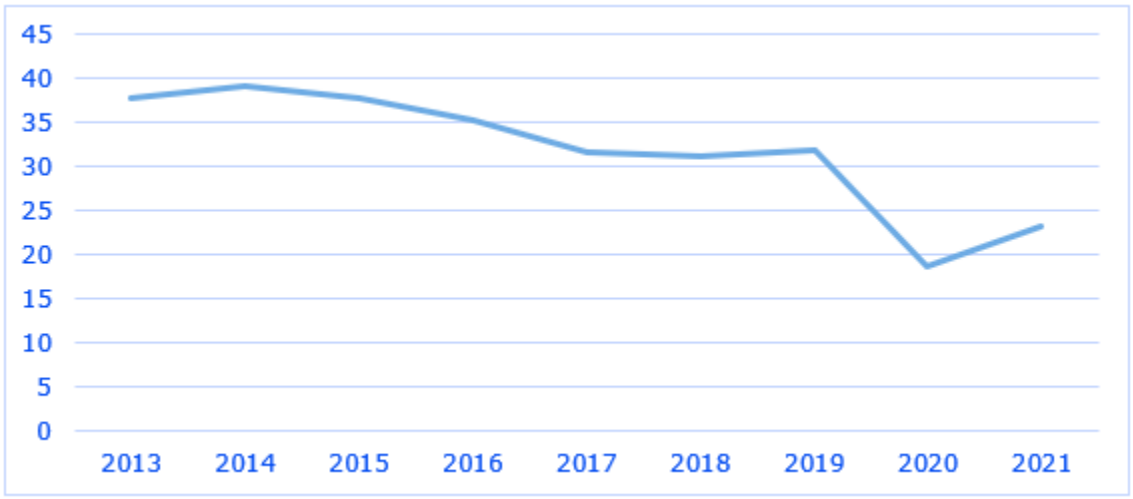
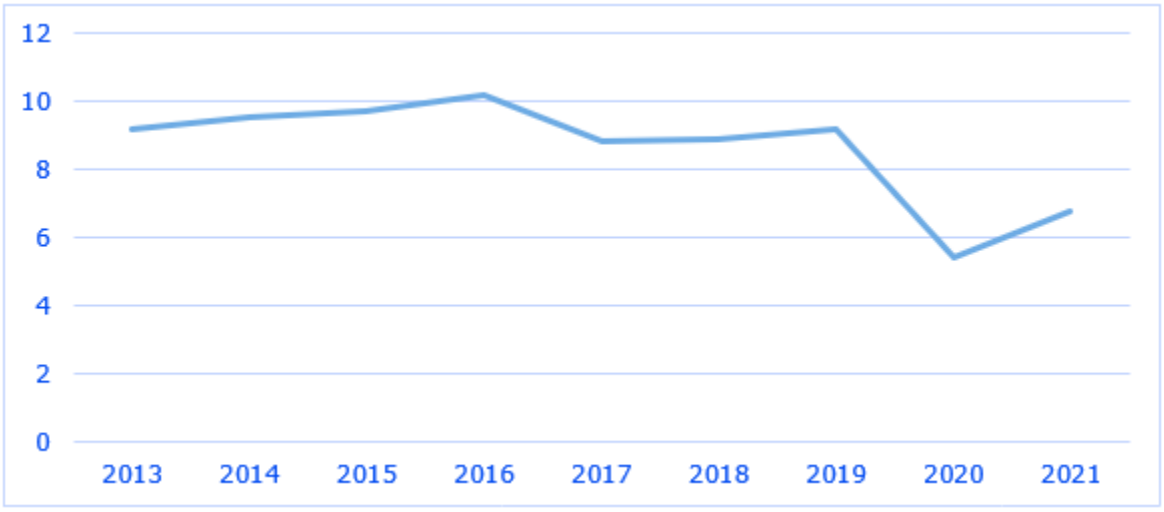


Figure 2: PPV Weight Per 1,000 Member Months, All Programs, 2013-2021

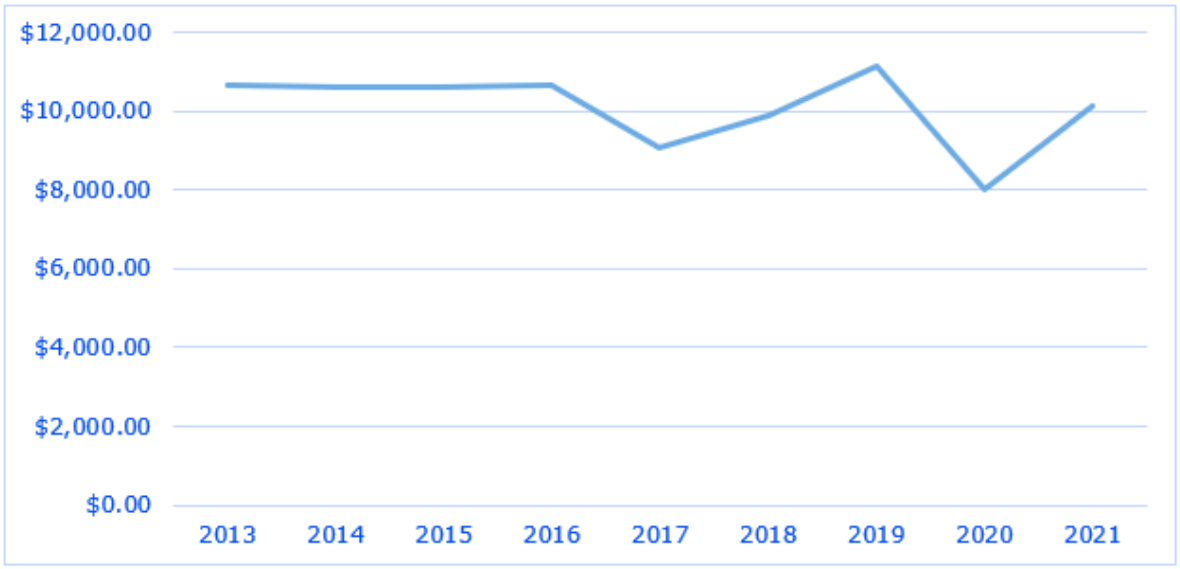


[8] DSRIP Report of PPE for 2013-2021 Medicaid+CHIP Data, Texas-EQRO Programming core.

[9] For additional detail on how PPV weights are calculated, see *DSRIP PPV CY2017 Technical Notes*, available at: https://dsrip.hhsc.texas.gov/bbDocuments/message-78/DSRIP%20PPV%20CY2017%20Technical%20Notes_EQRO.docx

PPV expenditures per 1,000 member months increased from $10,665 in 2013 to $11,120 in 2019, then fell to $10,115 in 2021 as shown in Figure 3. Total expenditures associated with PPVs in Medicaid and CHIP increased from approximately $444 million in 2013 to $559 million in 2021. To summarize, while the number of PPVs per 1,000 member months decreased, caseload increases and the resource use or prices of the remaining PPVs increased total PPV expenditures over this time period.

Figure 3: PPV Expenditures Per 1,000 Member Months, All Programs, 2013-2021



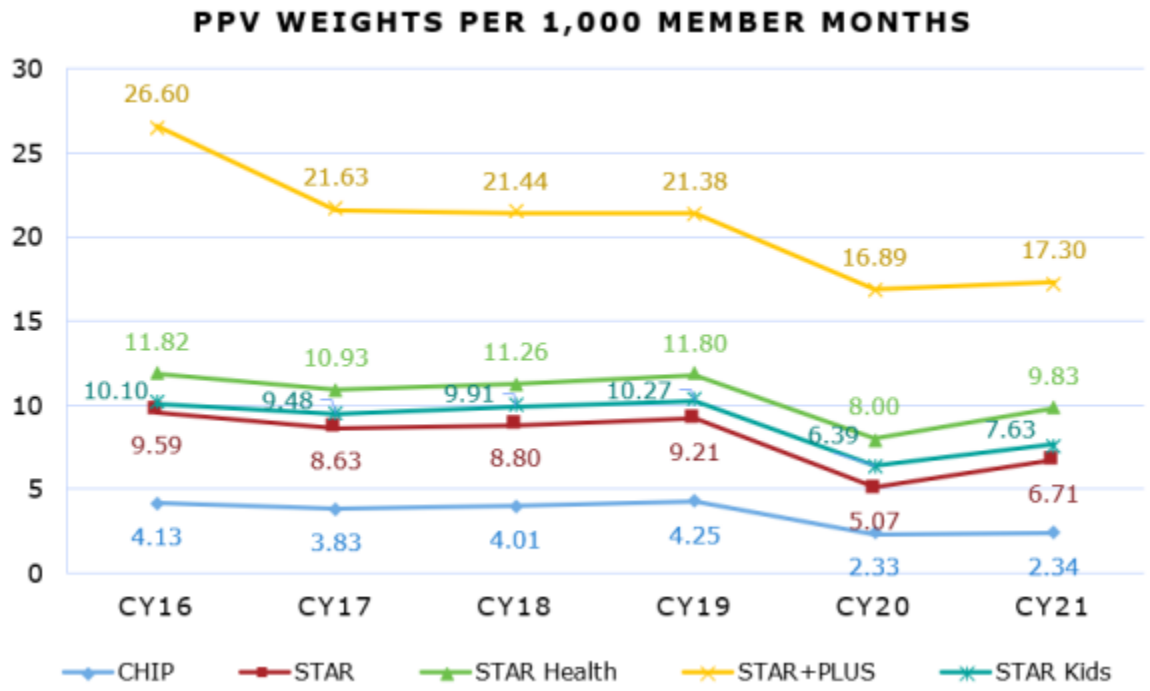
All three measures declined in 2020, which could represent changes from the novel coronavirus (COVID-19) public health emergency (PHE). Research suggests the decrease in ED visits was likely caused by several factors related to the PHE: restricting social interactions except for essential activities, fear of exposure to COVID-19 at hospitals, hospital policy changes, and concerns about long wait times. The increase in telehealth availability may have also diverted some inappropriate ED visits; however, the reduction in face-to-face urgent care may also have prevented some patients from receiving appropriate recommendations to go to the ED for evaluation. The federal Families First Coronavirus Response Act (Public Law 116-127), passed in March 2020, requires States to maintain continuous Medicaid coverage during the federal PHE period as a condition of receiving enhanced federal funding.[10] The Texas Medicaid caseload increased from

[10] On December 29, 2022, Congress passed the 2023 Consolidated Appropriations Act which separated the continuous Medicaid coverage requirements established in FFCRA from the federal COVID-19 public health emergency declaration. The requirement for continuous Medicaid coverage ends on March 31, 2023.

3.9 million members in March 2020 to 5.4 million in May 2022. Measures that are standardized by 1,000 member months may have decreased in part due to this increase in overall caseload volume.

The PPV weights vary by program within Medicaid. The PPV weight in STAR+PLUS was more than twice as high as the overall rate across other programs, as shown in Figure 4. While the population in STAR+PLUS is generally older than in other programs and more likely to have complex healthcare needs, STAR Kids also serves a population with complex healthcare needs but has about half the rate of PPVs.

Figure 4: Six-Year Trends of PPV Weights per 1,000 Member Months - All Programs[11]



While HHSC does not know the cause of these differences, they could reflect differences between the populations in health-related social needs, behavioral health conditions, tobacco use, or in age leading to more disabilities and comorbidities. For example, the EQRO found that the rate of adult smoking was significantly associated with higher ED utilization among STAR+PLUS adults.

[11] Texas HHSC. *Annual Report on Quality Measures and Value-Based Payments.* December 2022. Available at: https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2022.pdf

Types of PPVs

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

Table 1: Top Medical Reasons for PPVs in Texas Medicaid and CHIP, 2020[12]

Enhanced Ambulatory Patient Group (EAPG) 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	170,868	19.4%	14.5%	$45.48M	12.0%
Abdominal Pain	48,725	5.5%	7.3%	$37.02M	9.8%
Contusion, Open Wound and Other Trauma to Skin and Subcutaneous Tissue	55,271	6.3%	7.1%	$19.14M	5.1%
Non-Bacterial Gastroenteritis, Nausea and Vomiting	48,273	5.5%	7.0%	$25.06M	6.6%
Viral Illness	43,955	5.0%	6.3%	$13.88M	3.7%

In STAR+PLUS, the EQRO found that co-occurring behavioral health and physical health conditions accounted for the vast majority of all potentially preventable events in 2018. Additionally, about one percent of Medicaid and CHIP pediatric ED visits from 2013 to 2017 were related to Non-Traumatic Dental Conditions and resulted in expenditures of approximately $44 million.

Several factors may contribute to PPVs, including that patients cannot or do not access timely health care for preventative services or to manage chronic conditions. Reasons for this may include health professional shortages, limited availability of appointments, and other challenges such as lack of transportation.[13]

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[12] Texas EQRO. *EQRO Summary of Activities Report, State Fiscal Year 2020*. June 2021. 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

[13] 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

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 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 convening a stakeholder workgroup 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, which are meant to incentivize and hold MCOs accountable for their management of non-emergent ED utilization.

The Medical Pay-for-Quality (P4Q) and Medicaid Value-based Enrollment (VBE) initiatives were included in the March 2022 and August 2022 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.

Performance Improvement Projects (PIPs)

The Texas EQRO evaluates PIPs from each MCO and Dental Maintenance Organization (DMO) in accordance with state and federal regulations. PIPs are projects that MCOs and DMOs are required to implement that must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

To select the PIP topics, HHSC works with the EQRO to review MCO and DMO performance on quality measures and identify areas needing improvement. MCOs and DMOs are required to begin a two-year PIP each year for each Medicaid managed care and CHIP program. MCOs and DMOs must submit a PIP plan, annual progress reports, and a final report, all of which are evaluated by the EQRO.

For 2019, all MCOs focused on the statewide PIP topic, improving care for beneficiaries with complex needs. Specifically, the focus was on ED utilization or preventable admissions for this population. Many of these individuals have co-

occurring behavioral and physical health conditions, as discussed in the Types of PPVs section. As a result, selected measures for the PIP included the following.

- The percentage of members with depression and/or anxiety who had high utilization, defined by three or more ED visits or two or more inpatient stays in one measurement year.
- The rate of members with anxiety and/or depression who had any PPV during the measurement year.
- The rate of members with anxiety and/or depression who had any Potentially Preventable Admission (PPA) during the measurement year.

Due to the PHE, 2019 PIPs were extended to a third year. The EQRO will include final and overall results for the 2019 PIPs in the state fiscal year 2023 Summary of Activities report anticipated to be released by April 30, 2024. The two DMOs established a collaborative data-sharing agreement with an MCO with the aim of reducing dental-related PPVs as their 2019 PIP topics. For 2021, both DMOs have PIP topics to reduce dental-related PPVs.

The 2023 PIPs for all MCOs have the topic to reduce PPAs for behavioral health-related diagnoses. The final report for 2023 PIPs is tentatively due in October 2025.

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.[14] 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 the contract. Remedies include placement on a corrective action plan (CAP).[15] 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. Compared to 2019, improvements

[14] 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

[15] 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

were made in STAR and STAR Kids. However, dashboard performance declined for all STAR+PLUS MCOs in 2020. The PHE may have impacted the 2020 dashboard results.

Medicaid Teleservices Expansion

To ensure continuity of care for Texas Medicaid clients during the 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, requires 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.

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 permanent policy.

Accountable Health Communities Model

The AHCM, a five-year CMS funded initiative, tests whether systematically identifying and addressing health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization. Since 2016, HHSC has partnered with three Texas Bridge Organizations selected as participants for the AHCM. The organizations include: CHRISTUS Santa Rosa in San Antonio, the University of Texas Health Science Center in Houston, and the Parkland Center for Clinical Innovation (PCCI) in Dallas. Evaluation of the initiative at the national level is ongoing; however, PCCI commissioned a study on the effectiveness of services at their specific site. The results, published in the New England Journal of Medicine Catalyst, show that active navigation to address non-medical drivers of health was associated with a statistically significant reduction in ED utilization both during the period of navigation and for the following 12 months.

Improving Interoperability and Care Coordination in Behavioral Health Services

Senate Bill (S.B.) 640, 87th Legislature, Regular Session, 2021, requires HHSC to conduct a study to assess the technical resources available to behavioral health

(BH) providers and their capability to exchange clinical information. The *Interoperability Needs and Technology Readiness of Behavioral Health Service Providers* report describes the survey tool development and findings, presents the state implementation plan and timeline, and offers recommendations. Survey results identified gaps in the use of electronic health records and health information exchanges (HIEs) by some BH providers. Concerns related to costs, inefficiencies, patient consent, and confusion relating to requirements of federal and state laws were also identified. Recommendations included technology-related initiatives to address interoperability needs and challenges and standardize the use of NMDOH.

In 2022, HHSC created an Interoperability Center of Excellence (iCoE). The iCoE supports and aligns with the HIE Connectivity Project, funded through HHSC's HIE Implementation Advanced Planning Document. The HIE Connectivity Project is a collaborative pilot between HHSC programs and contracted HIE services to assess the quality of data collected via HIEs to coordinate the care of clients and provide real-time information and insights to the Medicaid programs. The HIE Connectivity Project promotes the use of local HIEs by Texas Medicaid providers by offering funds to offset connection costs. Additionally, it creates and maintains infrastructure to support HIE services statewide. The iCoE is intended to be the primary point for data exchange between HHS agencies, healthcare providers, MCOs, and other entities. The iCoE supports the exchange and integration of select health data and will evolve to support the incorporation of data for a broad range of HHS programs.

The HIE Connectivity Project is within the Performance Management & Analytics System (PMAS). The PMAS platform will collect Admission, Discharge, Transfer alerts and clinical information for Medicaid clients. PMAS also plans to develop implementation guides to improve the usability and consistency of data received. Working with community stakeholders, implementation guides will target improvements necessary to enable interoperability of health information. HHSC is working to integrate HIE data with data from Clinical Management for Behavioral Health Services to develop a report on hospital admissions and ED visits of Medicaid BHS clients to improve coordination of care.

Research indicates hospital care transition processes, such as post-discharge phone calls, or providing enhanced services to high-risk patients, can improve follow-up after hospitalization rates. HHSC expects these follow-up rates to increase as HIE is more widely adopted by hospitals and community providers. Preliminary hospital level data shows high variability in follow-up rates, further supporting that there are best practices in care coordination (such as HIE adoption and NMDOH screening and referrals) that hospitals can adopt.

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 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.

The Initiative to Increase Disease Management Participation, Tobacco Cessation Efforts, Collaborative Care Model, and Value-Based Purchasing Arrangements to Address NMDOH were included in the March 2022 and August 2022 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".[16] 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.

Four new DPPs were developed as part of the goal to sustain DSRIP funding for the Texas health system and advance DSRIP best practices. HHSC received approval for the four new DPPs for state fiscal year 2022:

- Comprehensive Hospital Increased Reimbursement Program (CHIRP),
- Texas Incentives for Physician and Professional Services (TIPPS),

[16] 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

- Rural Access to Primary and Preventive Services (RAPPS), and
- Directed Payment Program for Behavioral Health Services (DPP BHS).

On August 1, 2022, HHSC received approval for state fiscal year 2023 for all four DPPs. In March 2023, HHSC sent an evaluation of state fiscal year 2022 and 2023 to CMS. The evaluation gives a better picture of the baseline health of the population that visits DPP providers.

- In 2021, 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.
- STAR+PLUS clients seen by DPP BHS providers and STAR Kids clients seen by RAPPS providers were admitted to the hospital for preventable conditions less often than expected.
- For TIPPS, DPP BHS, and RAPPS, the program population rates were better than the statewide rate for the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure. The FUM measure reflects the percentage of ED visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Of note, the evaluation also shows that hospitals that took part in CHIRP had a 12 percent increase in use of a public HIE or an Electronic Health Record with HIE capabilities between the first and second years of the program. 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 additional legislation, such as 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.

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.

HHSC is examining the cost-effectiveness and feasibility of providing diabetes self-management education (DSMES) and medical nutrition therapy (MNT) services to diabetic Medicaid clients. HHSC is conducting research and analysis to determine if both DSMES and MNT services demonstrate improved health outcomes and cost effectiveness in Medicaid.

Chronic care management was a focus area of the DSRIP Transition, and the Best Practices Workgroup (BPW)[17] 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] In January 2020, HHSC established the DSRIP Transition BPW, 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

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."[18] Within NMDOH, there are health-related social needs (HRSNs), which are "the individual-level, adverse social conditions that can negatively impact a person's health or health care."[19]

A goal of the Texas Managed Care Quality Strategy is to promote optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health, and one of the objectives for meeting this goal is to address NMDOH.

In March 2021, HHSC submitted the *Assessment of Social Factors impacting Health Care Quality in Texas Medicaid* as a DSRIP Transition deliverable to CMS. The results found statistically significant associations between key Medicaid health care quality measures and county-level NMDOH variables, including but not limited to Race/Ethnicity, Food Insecurity, Access to Exercise Opportunities, and Rate of Violent Crime. Based on the Assessment results, DSRIP provider-reported data, and MCO feedback, the most common HRSNs observed in the Medicaid population are food insecurity, housing, and transportation.

The NMDOH Action Plan outlines four goals and associated actions to guide HHSC and contracted MCOs in advancing the Texas Managed Care Quality Strategy while demonstrating cost containment. The priority HRSNs are food insecurity, housing, and transportation. Actions will initially focus on food insecurity to leverage existing food insecurity projects in progress within the agency and with stakeholder partners and will expand to focus on housing and transportation in future years.

The goals of the NMDOH Action Plan are:

- Build Medicaid NMDOH data infrastructure for statewide quality measurement and evaluation of priority HRSNs among Texas Medicaid beneficiaries;

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[18] These are also known as social drivers of health and drivers of health. The definition is from the CDC. *Social Determinants of Health (SDOH).* March 2021. Available at: https://www.cdc.gov/about/sdoh/index.html

[19] *CMS Guide to Using the Accountable Health Communities HRSN Screening Tool: Promising Practices and Key Insights*. August 2022. Available at: https://innovation.cms.gov/media/document/ahcm-screeningtool-companion

- Coordinate services and existing pathways throughout the delivery system to address priority HRSNs for Texas Medicaid beneficiaries;
- Develop policies and/or programs to incentivize MCOs and providers to identify and address priority HRSNs for Medicaid beneficiaries while demonstrating cost containment; and
- Foster opportunities for collaboration with key partners internal and external to HHS to advance the NMDOH Action Plan Goals.

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. In addition to the DSRIP Transition deliverable described above, an analysis of DSRIP provider performance found that DSRIP providers that reported quality measures with the highest performance rates for Medicaid and CHIP beneficiaries were more likely to have implemented screening for food insecurity and screening for housing needs. Additionally, the BPW identified the inclusion of community health workers or promotor(a)s in a care coordination role on care teams as the second most impactful key practice from the DSRIP program.

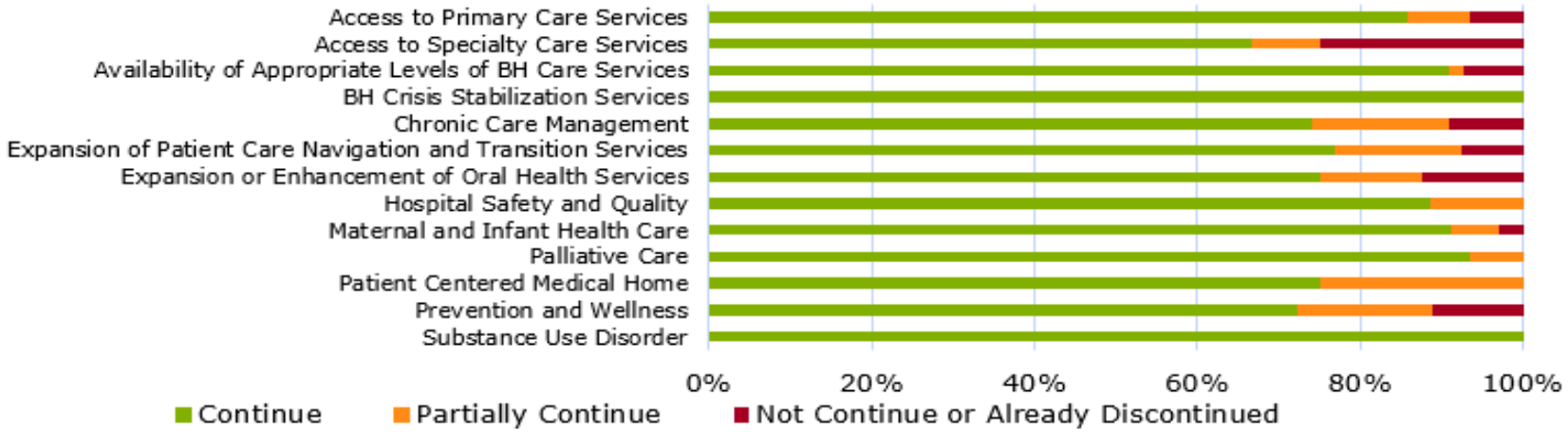
Continuing DSRIP Core Activities

In June 2022, HHSC requested information from DSRIP providers to identify DSRIP activities that may continue after the end of DSRIP funding. The authority for DSRIP ended on September 30, 2021. Out of 290 DSRIP providers, there were 188 survey respondents, a 65 percent response rate.

Core Activities are activities that providers implemented to achieve quality goals and align with DSRIP focus areas. Out of 664 active core activities as of DY10, providers responded on 487 core activities and reported that a large majority (93 percent) are planned for continuation. Hospitals and CMHCs reported the highest proportion of planned continuation of core activities.

Providers indicated all core activities related to *Behavioral Health Crisis Stabilization Services* and *Substance Use Disorder* are planned to continue. Figure 6 shows the portion of each core activity grouping providers report will continue, partially continue, and not continue or already discontinued, and the exact percentages are shown in Appendix A. The largest number of core activities reported as continuing by provider type were: *Chronic Care Management* for hospitals; *Access to Primary Care Services* for physician practices; *Availability of Appropriate Levels of Behavioral Health Care Services* for CMHCs; and *Access to Primary Care Services* for LHDs.

Figure 6: Status of Core Activities by Grouping



Many of these DSRIP initiatives increase access to services or improve quality of services that Medicaid individuals receive, which can have an impact on PPVs.

5. Conclusion

HHSC implemented or continued progress on initiatives to reduce avoidable ED use, including Performance Improvement Projects, the Performance Indicator Dashboard, the Medicaid Teleservices Expansion, the AHCM, and Improving Interoperability and Care Coordination in Behavioral Health Services. 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 Directed Payment Programs, Medicaid Benefits Changes, the NMDOH Action Plan, and Continuing DSRIP Core Activities.

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
AHCM	Accountable Health Communities Model
BH	Behavioral Health
BHS	Behavioral Health Services
BPW	Best Practices Workgroup
CAP	Corrective Action Plan
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
DMO	Dental Maintenance Organization
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
DY	Demonstration Year
EAPG	Enhanced Ambulance Payment Grouping
ED	Emergency Department
EQRO	External Quality Review Organization
ER	Emergency Room
FUM	Follow-up After Emergency Department Visit for Mental Illness
H.B.	House Bill
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HRSN	Health-Related Social Need
iCoE	Interoperability Center of Excellence
LHD	Local Health Department
MCO	Managed Care Organization
MNT	Medical Nutrition Therapy
NMDOH	Non-medical Drivers of Health
P4Q	Pay-for-Quality
PCCI	Parkland Center for Clinical Innovation
PCP	Primary Care Physician/Provider
PHE	Public Health Emergency
PIP	Performance Improvement Project
PPA	Potentially Preventable Admission
PPV	Potentially Preventable Emergency Room Visit
RAPPS	Rural Access Primary and Preventive Services
S.B.	Senate Bill
SDOH	Social Determinates of Health
TIPPS	Texas Incentives for Physicians and Professional Services
UC	Uncompensated Care

Acronym	Full Name
VBE	Value-based Enrollment
VBP	Value Based Purchasing

Appendix A. Post-DSRIP Status of Core Activities by Grouping

Core Activity Grouping	Continue	Partially Continue	Not Continue or Already Discontinued
Access to Primary Care Services	85.87%	7.61%	6.52%
Access to Specialty Care Services	66.67%	8.33%	25%
Availability of Appropriate Levels of BH Services	90.91%	1.82%	7.27%
BH Crisis Stabilization Services	100%	0%	0%
Chronic Care Management	74.03%	16.88%	9.09%
Expansion of Patient Care Navigation and Transition Services	76.92%	15.38%	7.69%
Expansion or Enhancement of Oral Health Services	75%	12.5%	12.5%
Hospital Safety and Quality	88.57%	11.43%	0%
Maternal and Infant Health Care	91.18%	5.88%	2.94%
Palliative Care	93.33%	6.67%	0%
Patient Centered Medical Home	75%	25%	0%
Prevention and Wellness	72.22%	16.67%	11.11%
Substance Use Disorder	100%	0%	0%
Total	82.34%	10.88%	6.78%