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.

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 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:
  - Medical Pay-for-Quality (P4Q) Program
  - Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project
  - Improving Interoperability and Care Coordination in Behavioral Health Services

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

[2] DSRIP Report of PPE for 2013-2022 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:
  - Alternative Payment Models (APMs) for MCOs
  - House Bill (H.B.) 1575 Implementation
  - Maternal Opioid Misuse (MOM) Model

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

Senate Bill (S.B.) 1136, 87th Legislature, Regular Session, 2021, 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 survey HHSC conducted in fall 2023. HHSC followed up with providers who indicated in spring 2022 that even though they observed individuals using the ED services for primary care services, they were not implementing initiatives designed to reduce ED visits or improve access to primary care. About half of respondents indicated that they implemented initiatives since spring 2022. Respondents still not implementing initiatives reported obstacles such as limited financial resources and lack of staff.

This report describes updated data on the current scope 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 survey. 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; HHSC Performance Indicator Dashboard; Medicaid Value-based Enrollment; Medicaid Teleservices Expansion; Accountable Health Communities Model; Directed Payment Programs; Medicaid Benefits; Value-Based Purchasing Arrangements to Address Non-medical Drivers of Health (NMDOH); Initiative to Increase Disease Management Participation; Tobacco Cessation Efforts; NMDOH Action-Plan; 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 uncompensated care (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. HHSC has proposed changes to the DPPs for state fiscal year 2025; the changes (currently pending CMS approval) will be covered in future reports.

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 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 (CHWs) 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 data on PPV rates from 2018 – 2022, which is an additional year of data since the March 2023 report. The August 2023 report describes data on types of PPVs and factors contributing to PPVs.

Potentially Preventable Emergency Department Visit (PPV) Rates

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.

HHSC operates several initiatives intended to reduce PPVs, as discussed in the next section.

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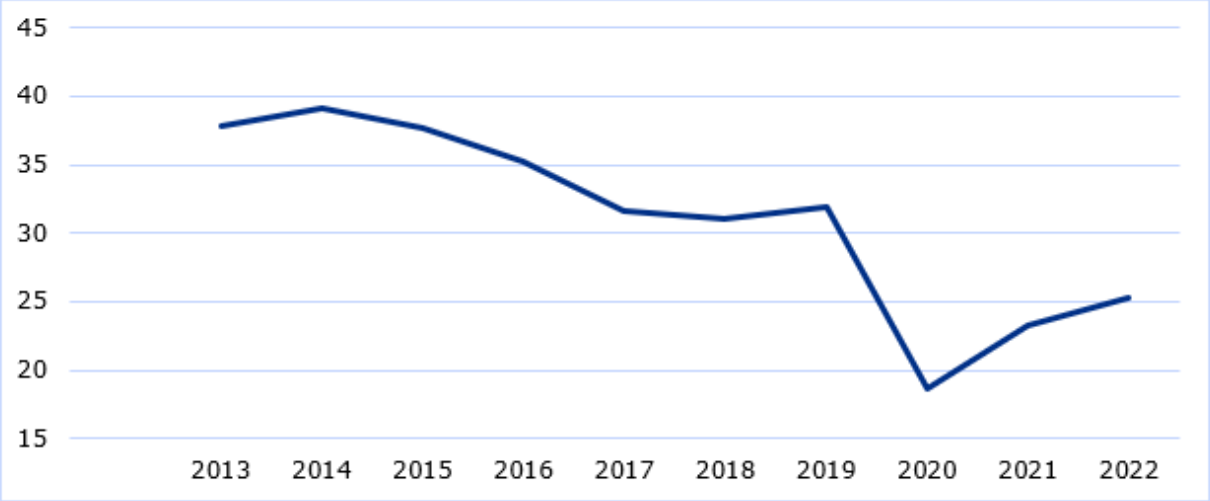
[6] There are various methodologies to determine and measure which ED visits could have been prevented. Texas Medicaid and its EQRO use the methodology from 3M to measure PPVs. See *Potentially Preventable Events*, available at: https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/potentially-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

PPV Rates 2013 - 2022

The number of PPVs per 1,000 member months[8] decreased from 37.8 in 2013 to 25.3 in 2022, as shown in Figure 1, indicating a 33.1 percent decrease in the rate when adjusted for caseload increase over the same time period. However, PPV rates have been increasing since 2020. The PPV weight per 1,000 member months stayed at 9.2 between 2013 and 2019, decreased to 5.4 in 2020, then increased to 7.4 in 2022, as shown in Figure 2.[9] 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.[10]

Figure 1: Number of PPVs Per 1,000 Member Months, All Programs, 2013-2022

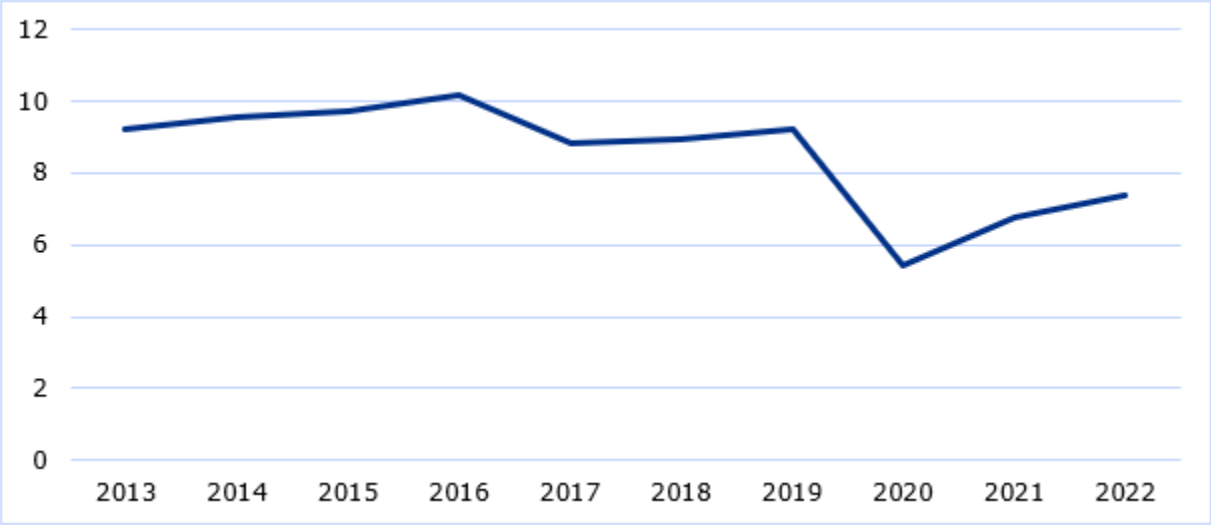


[8] Member months refers to the number of individuals enrolled in each Medicaid and CHIP program each month. The Texas EQRO calculates PPVs based on 1,000 member months.

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

[10] 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.

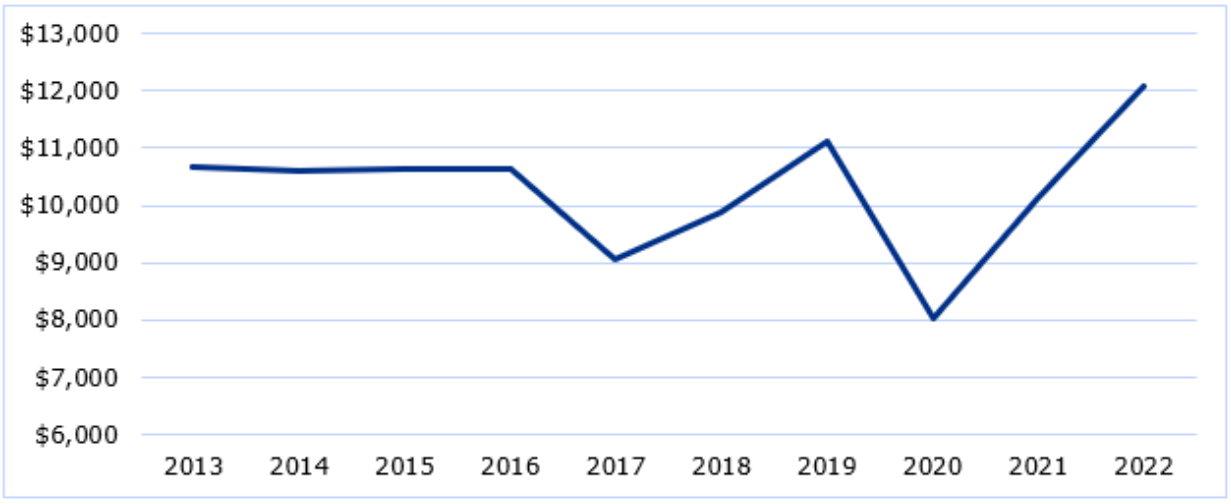
Figure 2: PPV Weight Per 1,000 Member Months, All Programs, 2013-2022



PPV Expenditures 2013 - 2022

PPV expenditures per 1,000 member months increased from $10,665 in 2013 to $12,093 in 2022, as shown in Figure 3. While the number of PPVs per 1,000 member months decreased, the resource use or prices of the remaining PPVs increased total PPV expenditures over this time period. PPV expenditures per 1,000 member months have been increasing since 2020.

Figure 3: PPV Expenditures Per 1,000 Member Months, All Programs, 2013-2022



Impact of the Public Health Emergency on PPVs

All three measures – PPV rates, weights, and expenditures – declined in 2020, which could represent impacts from the novel coronavirus (COVID-19) public health emergency (PHE).[11] The federal Families First Coronavirus Response Act (Public Law 116-127), passed in March 2020, required States to maintain continuous Medicaid coverage during the federal PHE period as a condition of receiving enhanced federal funding.[12] The Texas Medicaid caseload increased from 3.9 million members in March 2020 to 5.8 million in December 2022. Measures that are standardized by 1,000 member months may have decreased in part due to this increase in overall caseload volume. The federal PHE expired in May 2023, and future reports will look at PPV rates without continuous Medicaid coverage.

[11] For additional discussion regarding the impacts of the PHE on PPV measures, see the March 2023 report, available at: https://www.hhs.texas.gov/reports/2023/03/biannual-report-initiatives-reduce-avoidable-emergency-room-utilization-improve-health-outcomes.

[12] On December 29, 2022, Congress passed the 2023 Consolidated Appropriations Act which separated the continuous Medicaid coverage requirements established in the Families First Coronavirus Response Act from the federal COVID-19 PHE declaration. The requirement for continuous Medicaid coverage ended on March 31, 2023.

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 Performance Improvement Projects, HHSC Performance Indicator Dashboard, Medicaid Value-based Enrollment, Medicaid Teleservices Expansion, 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.

Medical Pay-for-Quality (P4Q) Program

The P4Q program is required for all MCOs and dental maintenance organizations and uses financial penalties and rewards, coupled with performance measures, to improve health outcomes. For the medical P4Q program, MCOs are evaluated based on their performance against benchmarks and on their performance improvement/decline from the prior year (performance against self). MCOs not meeting target performance thresholds for the P4Q measures could lose capitation dollars that are at-risk.[13] Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed to high-performing MCOs. Funds remaining after

[13] For more information on the Medical P4Q program, see the Annual Report on Quality Measures and Value Based Payments 2021, available at: https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2021.pdf.

the collection and redistribution process form a bonus pool to reward high-performing MCOs on specific measures.

Table 1 shows key at-risk measures related to avoidable ED utilization and how long each measure has been tracked in the medical P4Q Program. Table 1 also includes PPVs and Potentially Preventable Admissions (PPAs), which are hospital admissions that may have been prevented with access to ambulatory care or health care coordination.

HHSC suspended the medical P4Q program for measurement years 2020 and 2021 because of the PHE. The addition of STAR Kids was planned for January 2020; however, due to the PHE was delayed to 2022. CHIP medical P4Q is on hold for the 2024 and 2025 measurement years due to there not being enough members to yield valid data. It will be reconsidered for inclusion in the 2026 measurement year.

Table 1. Key At-Risk Measures for the Medical P4Q Program related to Avoidable ED Utilization, Including Access to and Use of Primary Care Providers

Measure	STAR+PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Emergency Department Visits (PPVs)	2018 - 2019 2022 - 2025	2018 - 2019 2022 - 2025	2022 - 2025	2018 - 2019 2022 - 2023
Potentially Preventable Admissions (PPAs)	-	2022 - 2025	-	-

Table 2 of Appendix A in the Annual Report on Quality Measures and Value Based Payments 2023 lists the bonus pool measures and effective years for the same period. Table 2 below includes the key bonus pool measures related to avoidable ED utilization, including access to and use of primary care providers.

Table 2. Key Bonus Pool Measures for the Medical P4Q Program related to Avoidable ED Utilization, Including Access to and Use of Primary Care Providers

Measure	STAR+PLUS	STAR	STAR Kids	CHIP
PPAs	-	2018 - 2019	-	-
Prevention Quality Indicator Composite	2018 - 2019 2022 - 2025	-	-	-
Access to Routine Care, adult survey	-	2022 - 2025	-	-

The Texas Healthcare Learning Collaborative (THLC) Portal was established to strengthen public reporting, increase transparency, and improve accountability of services and care provided under the Texas Medicaid system. The Medical P4Q Performance Dashboard on the THLC Portal shows rewards or losses the MCOs earned or incurred for 2019 for PPV performance by MCO and program.

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

The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 42) requires HHSC to implement the Emergency Triage, Treat, and Transport Model (ET3) in Medicaid to reimburse Medicaid-enrolled emergency medical services providers for:

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

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

HHSC implemented Rider 42 on September 1, 2022. HHSC updated policy to include billing guidance for providers. In alignment with guidelines provided by CMS, Texas Medicaid reimburses ambulance providers for ET3 services using procedure codes included in current policy. In addition, five new modifiers have been added to the policy to allow reimbursement for transport to alternative destinations and treatment in place.

Improving Interoperability and Care Coordination in Behavioral Health Services

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.

In 2022, HHSC created an Interoperability Center of Excellence (iCoE). The iCoE supports and aligns with the Health Information Exchange (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 is within the Performance Management & Analytics System (PMAS). The PMAS platform collects admission, discharge, and transfer alerts from the Texas Health Services Authority's Emergency Department Encounter Notification (EDEN) system and clinical information in the form of continuity of care documents for Medicaid clients received from HIEs participating in the HIE Connectivity Project. PMAS has developed 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 and expand upon what is currently submitted by participating health care organizations.

Working through the iCoE and in conjunction with initiatives related to S.B. 26, 88th Legislature, Regular Session, 2023, there is interest in using EDEN data to improve care coordination between primary care and mental health providers, LMHAs and MCOs. HHSC will be 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 and CHIP clients who also receive BH services. Currently, this only includes data for Medicaid and CHIP members.

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 non-medical drivers of health screening and referrals) that hospitals can adopt.

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, and additional initiatives are summarized below.

The DPPs, Medicaid Benefits, Value-Based Purchasing Arrangements to Address Non-Medical Drivers of Health (NMDOH), Initiative to Increase Disease Management Participation, Tobacco Cessation Efforts, NMDOH Action-Plan, and Cross-Agency Coordination on Healthcare Strategies and Measures Project 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.

Alternative Payment Models (APMs) 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 or reward to 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. More information on APM requirements and progress toward state goals is available in the 2023 Annual Report on Quality Measures and Value-Based Payments.

Reducing avoidable ED use is an area of focus for APMs for most MCOs. During calendar year 2022, nine out of the 16 MCOs reported at least one APM with ED utilization as a component of the model. Goals for these APMs span from reducing preventable ED utilization generally to targeting specific, underlying reasons for ED use, such as uncontrolled asthma or unmet behavioral health needs. The models incentivize efforts across a variety of provider types, including hospital, primary care, behavioral health, nursing facility, and home health care providers. An estimated 1.5 million unique members were impacted by APMs addressing ED

utilization in 2022. Through the review of the APM evaluations completed by MCOs that will take place in 2024, HHSC will learn more about the impact of these arrangements on ED utilization for services that can be delivered in primary care settings and will include this information in future reports.

Starting with calendar year 2024 reporting, HHSC will transition to an APM Performance Framework that recognizes MCO efforts beyond just meeting payment targets. Initial data collection, planned for September 2024, will test the updated data collection tool. The new requirements will be fully in place for 2024 data collected in September 2025. Under the updated approach, MCOs will be encouraged to develop and field innovative models that address specific quality improvement priorities, including models that encourage improvements in maternal health outcomes, address NMDOH, support home and community-based services workforce development, incentivize the integration of primary and behavioral healthcare services, and reduce potentially preventable ED visits.

House Bill (H.B.) 1575 Implementation

House Bill (H.B.) 1575, 88th Legislature, Regular Session, 2023, relates to improving health outcomes for pregnant women under Medicaid and certain other public benefits programs. The bill requires HHSC to:

- Adopt standardized questions that Medicaid MCOs and Thriving Texas Families (TTF) service providers and subcontractors must use to screen all pregnant women for NMDOH, coordinate services and referrals, and share the results with HHSC. Pregnant women must opt-in to the screening.
- Add CHWs and doulas as new Medicaid providers of case management for children and pregnant women (CPW) services and revise the CPW standardized case management training. Training must be trauma-informed with instruction on social services, community assistance programs, domestic violence, and consent policies.
- Submit reports back to the legislature, including a one-time status report by December 1, 2024, on implementation, and a report by December 1 of each even-numbered year that summarizes the data collected by MCOs and TTF during the previous biennium.

MCOs and TTF will start screening pregnant women using the standardized questions and sharing data with HHSC in fall 2024. Doulas and CHWs are anticipated to begin enrolling as providers summer to fall 2024 and submitting claims for CPW services beginning in winter 2024.

Maternal Opioid Misuse (MOM) Model

According to the Texas Maternal Mortality and Morbidity Review Committee's 2022 report, behavioral health conditions including drug overdose are the second leading cause of maternal deaths in Texas (17 percent of cases). S.B. 750, 86th Legislature, Regular Session, 2019 directed HHSC to apply for funding available through the Center for Medicare & Medicaid Innovation (CMMI) to implement a model of care that "improves the quality and accessibility of care for… pregnant women with opioid use disorder enrolled in Medicaid during the prenatal and postpartum periods". Texas was awarded funding to pilot the Maternal Opioid Misuse Model (MOM Model) in 2020. The Texas MOM Model demonstration period is currently in its fourth year and is set to end in December 2024.

The MOM Model is a service delivery model that aims to improve the quality of care and reduce costs for pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD). To enroll, individuals must be pregnant; enrolled in Medicaid; and have a current or previous history of opioid use. The Texas MOM Model operates as a partnership between Texas HHSC and three care delivery partners in Houston: Baylor College of Medicine, Santa Maria Hostel, and Harris Health, which operates a clinic dedicated to treating maternal substance use at Ben Taub Hospital. Services include extensive education, assessment and treatment planning, breastfeeding support, and care coordination to keep women engaged, both in postpartum care and medication assisted treatment for OUD.

In 2021, there were approximately 282,000 pregnant or postpartum Medicaid recipients.[14] Among them, 15,313 were identified as having substance use disorder (SUD) and 1,250 had a diagnosis of OUD.[15] Through Medicaid, these women are eligible for prenatal care and other preventive, primary, and behavioral health care

[14] Pregnant women were identified using claims and encounters with a pregnancy-related diagnosis code listed in the principal, admission, or in the first through fourth positions (see CMS, 2023, available at: https://www.medicaid.gov/sites/default/files/2023-05/mih_reference_codes.pdf). Counts were restricted to female beneficiaries between 15 and 44 as of December 31, 2021, and does not include women enrolled in Emergency Medicaid (TP30).

[15] Medicaid recipients were identified as having a substance use disorder if they had a SUD diagnosis in the first (primary/principal diagnosis), second, or third header diagnosis of a paid claim/encounter in 2021. SUD diagnoses include ICD-10 codes beginning with O9931, O9932, or F1 (excluding codes beginning with F17 [tobacco use]). Opioid use disorder was defined as ICD-10 codes beginning with F111, F112, or F119.

services. The MOM Model is designed to enhance the benefit and efficacy of services provided during this window of access.

Women enrolled in the MOM Model have access to a dedicated team of care professionals tasked with coordinating all aspects of their care—from managing chronic conditions, to screening for pregnancy complications and monitoring OUD treatment adherence—intended to reduce care crises and lower utilization of emergency care. The MOM Model has served 75 Texas women as of the end of 2023.

CMMI is considering a one year no-cost extension with unspent federal funds; however, no official information has been released. During the remaining period of the demonstration, HHSC staff will evaluate effectiveness of the program and the program's impact on ED utilization of the MOM Model enrollees and their babies after birth. Early results indicate that infants born to women in the MOM Model require less intensive care, have shorter hospital stays, and are less likely to be diagnosed with Neonatal Abstinence Syndrome. Additionally, their mothers are more likely to adhere to medications prescribed for OUD and engage in postpartum care.

5. Stakeholder Engagement

As described in the August 2022 report, in spring 2022 HHSC 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. In October 2023, HHSC sent a follow-up survey to 79 respondents who initially said they were not implementing any initiatives to reduce ED visits. The follow-up survey found that 55 percent of respondents had begun implementing initiatives designed to reduce ED visits or improve access to primary care.

Table 3. Summary of Intervention Implementation by Provider Type

Type of Organization	Number of respondents	Number of respondents implementing initiatives designed to reduce ED visits or improve access to primary care	Percent of respondents implementing initiatives
Hospitals	18	16	89%
Ambulance providers	18	2	11%
Local Health Departments	3	2	67%
Physician groups	3	2	67%
MCOs	1	1	100%
Local Mental Health Authority and Local Behavioral Health Authority	1	1	100%
Total	**44**	**24**	**55%**

Two-thirds of the organizations newly implementing initiatives to reduce avoidable ED use are hospitals. The newly implemented initiatives include care coordination, follow-up appointments, weekend and after hour outpatient visits, and use of CHWs. The initiatives varied in reach, from affecting five people to thousands of people. Some respondents reported partnering with other organizations, including local nonprofit organizations, Federally Qualified Health Centers, or primary care providers in the area. Most of the respondents that implemented initiatives said they experienced challenges such as low participation rates, lack of financial resources, and staff shortages.

Of the respondents, ambulance providers were least likely to implement initiatives to reduce avoidable ED use. All respondents reported obstacles such as limited

financial resources and lack of staff. Several respondents stated that they do not have a full understanding of the potential interventions to impact ED utilization. Two respondents stated that the federal Emergency Medical Treatment and Labor Act limits their ability to implement certain interventions. Respondents stated that learning about various initiatives implemented by a similar provider would be the most helpful resource for developing workable solutions.

HHSC is planning to facilitate a workgroup for providers to share experiences and best practices. Results from this workgroup will be included in future reports.

6. Conclusion

Since the last report submission in August 2023, HHSC implemented and continued progress on initiatives to reduce avoidable ED use, including the Medical P4Q Program, the ET3 Project, 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, implementation of alternative payment models, H.B. 1575 implementation, and the MOM Model.

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. Upcoming activities include evaluating APMs for ED utilization, convening a workgroup for UC recipients to identify best practices in reducing avoidable ED utilization, and studying the impact of the PHE unwinding on ED utilization. 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
BH	Behavioral health
CHIP	Children's Health Insurance Program
CHW	Community health workers
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPW	Children and pregnant women
DPP	Directed Payment Program
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EDEN	Emergency Department Encounter Notification
EQRO	External Quality Review Organization
ET3 Project	Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project
H.B.	House Bill
HHSC	Health and Human Services Commission
HIE	Health information exchange
iCoE	Interoperability Center of Excellence
MCO	Managed Care Organization
MOM Model	Maternal Opioid Misuse Model
NMDOH	Non-medical Drivers of Health
OUD	Opioid use disorder
P4Q	Pay-for-Quality
PHE	Public health emergency
PMAS	Performance Management & Analytics System
PPA	Potentially Preventable Admission
PPE	Potentially Preventable Event
PPV	Potentially Preventable Emergency Room Visit
S.B.	Senate Bill
SUD	Substance use disorder
THLC	Texas Healthcare Learning Collaborative
TTF	Thriving Texas Families
UC	Uncompensated Care