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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TEXAS
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Executive Summary

Texas Government Code, Section 531.0862(b) requires the Texas Health and Human Services Commission (HHSC) to biannually prepare and submit to the legislature 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.

According to Texas' contracted External Quality Review Organization (EQRO), there were approximately 1.6 million potentially preventable emergency room (or department)[1] visits (PPVs) in Texas Medicaid and Children's Health Insurance Program (CHIP) in calendar year 2023, resulting in Medicaid and CHIP expenditures of approximately $905 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:
  - Performance Improvement Projects
  - Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project

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

[2] See the DSRIP Report of PPE for 2013-2023 Medicaid+CHIP Data, Texas-EQRO Programming core.

- Improving Interoperability and Care Coordination in Behavioral Health Services
- Engagement with Stakeholders through *Best Practices to Reduce ED Utilization* Workgroup

- 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:
  - House Bill (H.B.) 1575 Implementation
  - Maternal Opioid Misuse (MOM) Model
  - Aligning Technology by Linking Interoperable Systems (ATLIS) for Client Health Outcomes Program
  - Alternative Payment Models (APMs) for Medicaid MCOs

Initiatives discussed in previous reports without significant status changes at the time of writing this report are not included in this update.[3] 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: Medicaid Teleservices Expansion; Performance Indicator Dashboard; 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 Program; Directed Payment Programs; Value-Based Enrollment; Collaborative Care Model; Diabetes Self-Management Education and Support; Initiative to Increase Disease Management Participation; 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 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 APMs 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. Under the federal authority for state directed payment programs, 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*, and the *DSRIP Transition Plan Milestone: Support Further Delivery System Reform*.

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

Potentially Preventable Emergency Department Visits (PPVs)

Some people go to hospital EDs for conditions that are not emergencies or 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. Both scenarios describe PPVs. 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 EQRO, there were approximately 1.6 million PPVs in Texas Medicaid and CHIP programs in calendar year 2023, costing approximately $905 million. If these visits were prevented or occurred in a primary care setting, some of these expenditures could have been reduced or avoided.

PPV Rates 2013 - 2023

The rate of PPVs and associated costs adjusted for Medicaid caseload for calendar year 2023 are lower than 2013 rates. These rates have been on the rise since 2020 but remain lower than prior to the federal Public Health Emergency (PHE).

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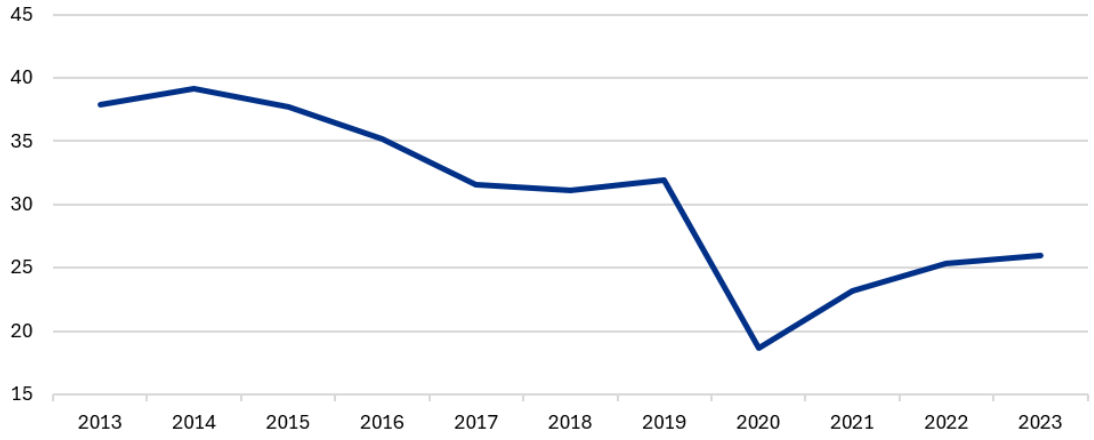
[6] There are various methodologies to determine and measure which ED visits could have been prevented. Texas Medicaid and its EQRO use the methodology from 3M to measure PPVs. See *Potentially Preventable Events*.

[7] See *Trends in the Utilization of Emergency Department Services, 2009-2018* by the U.S. Department of Health & Human Services.

The number of PPVs per 1,000 member months[8] decreased over the last ten years, from 37.8 in 2013 to 26.0 in 2023, as shown in Figure 1, indicating a 31.2 percent rate reduction when adjusted for the caseload increase over the same time period. PPV rates have been increasing since 2020, although the rate of increase slowed between 2022 and 2023.

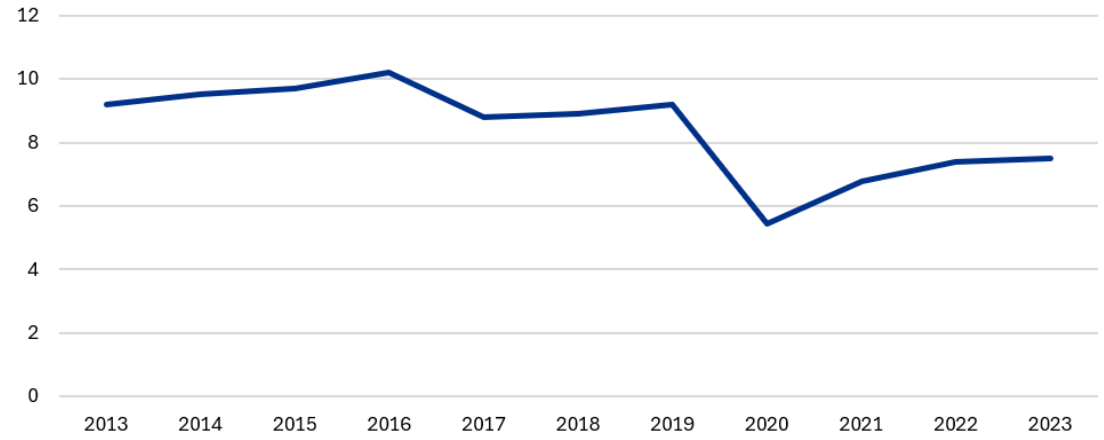
Figure 1: Number of PPVs Per 1,000 Member Months, All Programs, 2013-2023



PPV weight is assigned to ED visits based on the estimated intensity of resource costs utilized to provide effective treatment.[9] Total PPV weight reported is the sum of relative weights for each PPV for a measurement period and thus accounts for both volume and resource use. 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 7.5 in 2023, as shown in Figure 2.[10]

[8] Member months refer 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] Texas' EQRO assigns a national 3M™ PPV weight to each PPV based on the ED visit's primary Enhanced Ambulatory Patient Group.
[10] DSRIP Report of PPE for 2013-2022 Medicaid+CHIP Data, Texas-EQRO Programming core.

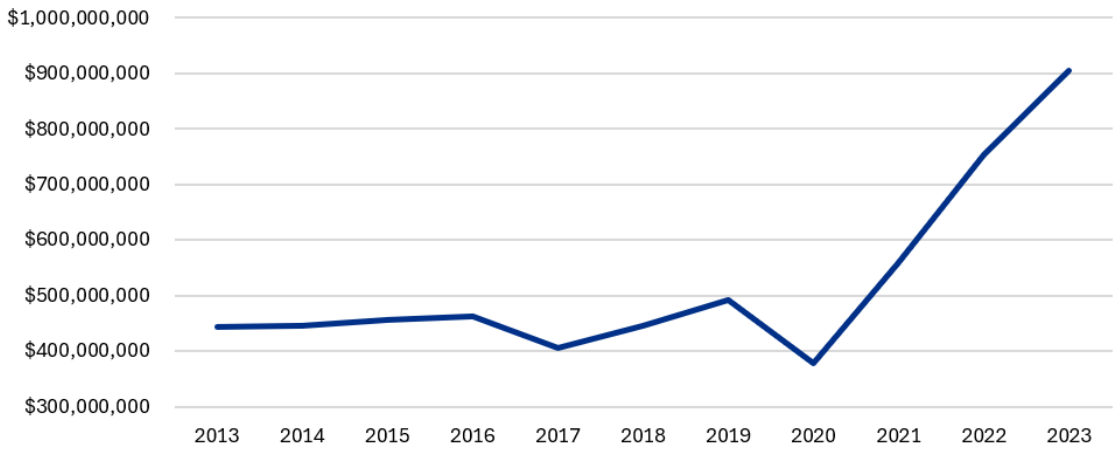
Figure 2: PPV Weight Per 1,000 Member Months, All Programs, 2013-2023



PPV Expenditures 2013 - 2023

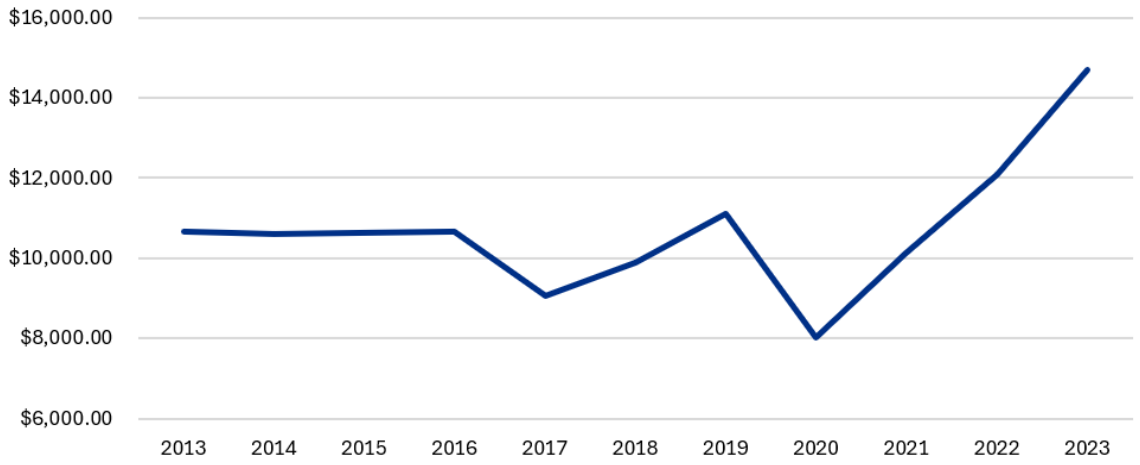
Overall PPV expenditures across all Medicaid programs have increased over the past ten years, from $444,143,856 in 2013 to $905,260,214 in 2023, as shown in Figure 3.

Figure 3: PPV Expenditures, All Programs, 2013-2023



PPV expenditures per 1,000 member months increased from $10,665 in 2013 to $14,703 in 2023, as shown in Figure 4. While the number of PPVs per 1,000 member months are lower in 2023 than 2013, the resource use or costs of the PPVs increased total PPV expenditures over this time period. These increases in PPV expenditures per 1,000 member months and total PPV expenditures primarily occurred from 2020 through 2023.

Figure 4: PPV Expenditures Per 1,000 Member Months, All Programs, 2013-2023



All 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.

Impact of the Public Health Emergency Expiration

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.[11] The requirement for continuous Medicaid coverage ended in March 2023, and the federal PHE expired in May 2023. The March 2024 report discussed the trends of PPV rates and expenditures during and following the federal PHE.

Following the 2023 Consolidated Appropriations Act, HHSC initiated Medicaid eligibility renewals from April 2023 through April 2024. The Texas Medicaid

[11] 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 PHE declaration.

caseload increased from 3.9 million members in March 2020 to 5.9 million in April 2023, at the beginning of the renewal process.

By December 2023 after several months of reprocessing Medicaid eligibility renewals, the caseload was 4.3 million members.

Despite the overall decrease in the Medicaid caseload, the EQRO observed increases in PPV expenditures per 1,000 member months and expenditures overall disproportionate to the increase in PPVs and PPV weights per 1,000 member months since 2020. HHSC will continue to analyze data from MCO and provider performance reports to understand the factors contributing to PPVs and the impact of the PHE expiring on PPVs.

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. 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.

Performance Improvement Projects

The Texas EQRO evaluates performance improvement projects (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 people with complex needs have co-occurring behavioral and physical health conditions. Final and overall results for the 2019 PIPs are in the state fiscal year 2023 Annual Technical report. 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.

The 2023 PIP topic for all MCOs is to reduce potentially preventable admissions for behavioral health-related diagnoses. The final report for 2023 PIPs is tentatively due in October 2025.

Emergency Triage, Treat, and Transport Demonstration Payment Model Project

The 2022-23 General Appropriations Act, Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 42) requires HHSC to implement the 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 also 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 CMS guidelines, Texas Medicaid reimburses ambulance providers for ET3 services using procedure codes included in current policy. As part of the rider, five new modifiers were added to the policy to allow reimbursement for transport to alternative destinations and treatment in place.

The federal PHE impacted Medicaid utilization. HHSC will analyze ET3 utilization during the 12 months following the end of the federal PHE's continuous Medicaid enrollment requirements. HHSC expects to provide utilization analysis data in 2026.

Improving Interoperability and Care Coordination in Behavioral Health Services

S.B. 640, 87th Legislature, Regular Session, 2021, required HHSC to conduct a study to assess the technical resources available to behavioral health 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. One of the interoperability goals discussed in this report is "expanding health information exchange (HIE) capabilities in the state, with focus on Medicaid and public health services."

In accordance with HHSC's interoperability goals, HHSC began receiving data through the HIE Connectivity Project in 2020, funded through HHSC's HIE Implementation Advanced Planning Document. This project consists of three strategies.

- Strategy one assists three of the state's five local HIEs with connecting to Medicaid ambulatory providers and hospitals by offering funds to offset the costs of establishing new connectivity.
- Strategy two develops and maintains HIE infrastructure to support connectivity with Texas Medicaid via the Texas Health Services Authority's shared services platform, allowing local HIEs and hospitals to send data to HHSC.
- Strategy three is the Emergency Department Encounter Notification (EDEN) system. EDEN provides near real-time Admission, Discharge, and Transfer alerts via the Texas Health Services Authority's platform, allowing for patients' care transitions to be smoother and providers to offer more timely and appropriate follow-up services.

Additionally, a collaborative pilot between HHSC programs created a data repository to house incoming data from the HIE Connectivity Project, assess its quality, and make it available to HHSC programs. These programs can use the data to coordinate the care of clients and provide real-time information and insights.

HHSC also created a data model and a cloud-based database for analytics using clinical data. The platform collects EDEN Admission, Discharge, and Transfer alerts and clinical information in the form of continuity of care documents for Medicaid clients via the HIE Connectivity Project. HHSC developed implementation guides to improve the usability and consistency of data received and is working with community stakeholders to target improvements necessary to enable interoperability of health information and expand upon what participating health care organizations currently submit.

In conjunction with initiatives related to S.B. 26, 88th Legislature, Regular Session, 2023, HHSC is using EDEN data to improve care coordination between primary care and behavioral health providers, local mental health authorities and MCOs. To achieve this, HHSC is working to integrate HIE data with data from Clinical Management for Behavioral Health Services to develop a comprehensive report on

hospital admissions and ED visits of Medicaid and CHIP clients who also receive behavioral health services.

Research conducted by the Agency for Healthcare Research and Quality 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.[12] 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 implement to improve follow-up rates.

[12] Agency for Healthcare Research and Quality (2014). Hospital Guide to Reducing Medicaid Readmissions.

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 NMDOH, Tobacco Cessation Efforts, Directed Payment Programs, Medicaid Benefits, 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.

H.B. 1575 Implementation

House Bill (H.B.) 1575, 88th Legislature, Regular Session, 2023, relates to improving health outcomes for pregnant women and their children under Medicaid and the Thriving Texas Families program.

The bill requires HHSC to add doulas and community health workers as new Medicaid providers of case management for children and pregnant women (CPW) services and revise the training requirements for CPW providers. The bill also requires HHSC to adopt standardized screening questions that MCOs and Thriving Texas Families service providers must use to screen all pregnant women for non-medical health-related needs with informed consent, coordinate services and referrals, and share the results with HHSC.

HHSC finalized the non-medical needs screening and data sharing contractual requirements, effective September 1, 2024. MCOs and Thriving Texas Families began screening pregnant women using the standardized questions and sharing data with HHSC in fall 2024. Beginning on December 1, 2024, the Medicaid provider enrollment system began accepting applications for doulas and community health workers as Medicaid CPW provider, and systems are ready for claims submission by these new provider types for CPW services. Some community health workers and

doulas have begun engaging with the enrollment process. For more information on H.B. 1575 implementation and pilot data, see the published legislative report, Non-Medical Health-Related Needs of Certain Pregnant Women Report (December 2024).

Maternal Opioid Misuse Model

According to the Texas Maternal Mortality and Morbidity Review Committee's 2024 report, mental health conditions were one of the top six underlying causes of maternal deaths in Texas in 2020 (seven percent of cases). The report found that mental health and substance use disorders contributed to pregnancy-related death and were often co-occurring. 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 and their children after birth." Texas was awarded funding to pilot the MOM Model in 2020. In December 2024, CMMI approved a one year no-cost extension with unspent federal funds through December 2025. The model is currently in its sixth year of implementation.

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). 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. As of December 2024, the MOM Model has served 111 Texas women.

In 2021, there were approximately 282,000 pregnant or postpartum Medicaid recipients.[13] Among them, 15,313 were identified as having substance use disorder and 1,250 had a diagnosis of OUD.[14] Through Medicaid, these women are eligible

[13] 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. 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).

[14] Medicaid recipients were identified as having a substance use disorder if they had a substance use disorder diagnosis in the first (primary/principal diagnosis), second, or third

for prenatal care and other preventive, primary, and behavioral health care services. The MOM Model is designed to enhance the benefit and efficacy of services provided during this window of access.

Starting in calendar year 2025, a third party-evaluator will evaluate the MOM Model. The evaluation will include a utilization review of MOM Model services, including birth outcomes for mothers with a substance use disorder, and length of hospitalization for mother and baby at time of delivery, among other metrics. This analysis will provide information about the effectiveness of the MOM Model for Texas Medicaid pregnant women.

Aligning Technology by Linking Interoperable Systems for Client Health Outcomes Program

HHSC launched the Aligning Technology by Linking Interoperable Systems (ATLIS) for Client Health Outcomes program (the ATLIS program) as a new Medicaid managed care incentive program, effective September 1, 2024. ATLIS streamlines data sharing between providers and MCOs to enhance care coordination, and ultimately, improve health outcomes for Medicaid recipients.

42 Code of Federal Regulations, Section 438.6(b)(2) authorizes ATLIS as an incentive arrangement for MCOs and requires ATLIS further the program initiatives identified in the state Managed Care Quality Strategy. Per federal requirements, the aggregate of all incentive payments paid to an MCO by the state may not exceed five percent of the MCO's approved capitation. The regulation applicable to incentive arrangements does not allow states to direct MCO payments to providers.

HHSC will assess MCOs' performance based on MCO achievement of certain milestones related to the interoperability and connectivity of the MCOs' network providers. The incentive payments will be funded through intergovernmental transfers from non-state governmental entities and federal matching funds.

In the first year of ATLIS, each participating MCO will report the status of connectivity to the EDEN[15] system and exchange of Consolidated Clinical Document Architecture data, for the MCO and for the MCO's in-network providers. MCOs will

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header diagnosis of a paid claim/encounter in 2021. Substance use disorder 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.

[15] Described on page 11 of this report.

be required to identify barriers to interoperability and how MCOs and their in-network providers are using electronic health information to support quality improvement and value-based care. MCOs will earn incentive payments for achieving certain milestones on a semi-annual basis.[16] Through these processes, the ATLIS program aims to improve MCOs' ability to respond to Admission, Discharge, and Transfer alerts in a timely manner, and ultimately reduce preventable ED visits.

Alternative Payment Models 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 to providers for not meeting performance standards but also reward them if they achieve high performance. Under previous APM requirements, MCOs had to make 50 percent of their provider payments through an APM with at least 25 percent through an APM involving financial risk for providers. Beginning in calendar year 2024, the MCOs are required to maintain these minimum payment requirements as their baseline and are held accountable for meeting additional APM requirements in the newly designed APM approach. More information on APM new requirements, the MCO's progress toward meeting state goals, and HHSC's new APM approach is available in the 2024 Annual Report on Quality Measures and Value-Based Payments.

Initial data collection under the new framework was completed in December 2024, and will be used to test the updated data collection tool. The new requirements will be fully in place for data collected in 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, and incentivize the integration of primary and behavioral healthcare services.

Reducing avoidable ED use is also an area of focus for APMs for most MCOs. 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

[16] The January and July deadlines may change as required for program implementation and operation.

home health care providers. An estimated 1.7 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 2025, 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.

5. Stakeholder Engagement

HHSC received stakeholder feedback from various provider types about the potential impact of emergency medical services departments and community paramedicine in reducing low-acuity ED visits, which many providers regard as PPVs. This feedback has highlighted the roles of EMS and paramedicine in patient transport, home health visits, and redirecting non-emergent cases towards alternative resources. Due to the consistency of this feedback across providers, HHSC has focused on and will continue to investigate the role that EMS departments and community paramedicine can play in reducing PPVs in Texas.

Best Practices to Reduce ED Utilization Workgroup

In September 2024, HHSC invited representatives of providers and MCOs to the second meeting of the *Best Practices to Reduce ED Utilization* workgroup. This meeting had 78 attendees and focused on the role of interagency collaboration in reducing PPVs. Two providers, one local mental health authority and one county-level EMS department, presented on their best practices for interagency collaboration. Both providers cited relationships and collaboration with other local agencies as a key component of their impact in reducing PPVs.

HHSC will hold additional Best Practices to Reduce ED Utilization workgroup meetings to engage with providers and gather feedback. Increasing participation of hospitals, other providers receiving UC funds, and their partner organizations could be an effective way to share best practices among stakeholders. However, the workgroup is voluntary and information sharing is limited to providers who participate in workgroup sessions.

Community Paramedicine

In November 2024, HHSC participated in the Texas Community Paramedicine Roundtable, hosted by Department of State Health Services. This roundtable brought together more than 50 representatives from HHSC, the Department of State Health Services, the Department of Agriculture Office of Rural Health, emergency medical service providers, medical and health centers, and foundations, among other stakeholders. During the roundtable, participants defined community paramedicine focus areas, including decreasing the number of visits for individuals

with high ED utilization.[17] Participants noted that existing community paramedicine programs show improvement in individuals' health outcomes and can produce savings. They identified challenges, such as planning program implementation, funding, and billing community paramedics for services.

Several MCOs recognize partnerships with community paramedicine providers as an innovative strategy to engage with individuals that have frequent visits to the ED. One MCO observed a 25 percent decrease in avoidable ED visits, a 51 percent decrease in inpatient behavioral health admissions, and a 26 percent decrease in inpatient admissions, while members' utilization of primary care providers and prescription medication increased by 13 percent between their program implementation in 2021 through July 2024.

[17] Additional focus areas included reducing hospital readmissions and working with individuals with behavioral health and substance use disorders.

6. Conclusion

Since the last report submission in August 2024, HHSC implemented and continued progress on initiatives to reduce avoidable ED use, including PIPs, 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 H.B. 1575 implementation, the MOM Model, the ATLIS program, APMs, and through stakeholder engagement such as hosting the *Best Practices to Reduce ED Utilization* workgroup.

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, 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 Abbreviations

Abbreviation	Full Name
APM	Alternative Payment Model
ATLIS	Aligning Technology by Linking Interoperable Systems
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPW	Children and Pregnant Women
DMO	Dental Maintenance Organization
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EDEN	Emergency Department Encounter Notification
EQRO	External Quality Review Organization
ET3	Emergency Triage, Treat, and Transport Demonstration Payment Model
H.B.	House Bill
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
MCO	Managed Care Organization
MOM	Maternal Opioid Misuse (Model)
NMDOH	Non-Medical Drivers of Health
OUD	Opioid Use Disorder
PHE	Public Health Emergency
PIP	Performance Improvement Project
PPV	Potentially Preventable Emergency Room Visit
S.B.	Senate Bill
UC	Uncompensated Care