Non-Medical Health-Related Needs of Certain Pregnant Women Report

As Required by
House Bill 1575, 88th Legislature,
Regular Session, 2023

Texas Health and Human Services
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TEXAS
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Executive Summary

House Bill (H.B.) 1575, 88th Legislature, Regular Session, 2023, relates to health outcomes for pregnant women and their children under Medicaid and the Thriving Texas Families (TTF) program. The bill requires the Texas Health and Human Services Commission (HHSC) to:

- Add community health workers (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.
- Adopt standardized questions that Medicaid managed care organizations (MCOs) and TTF service providers and subcontractors must use to screen all pregnant women for non-medical health-related needs, coordinate services and referrals, and share the results with HHSC. MCOs and TTF service providers and subcontractors must obtain pregnant women's informed consent to perform the screening.
- 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.

In accordance with Texas Government Code, Section 531.014, HHSC consolidated the two required reports because they relate to the same subject matter. This consolidated report describes the status of implementation of CPW, including creating pathways for CHWs and doulas to become Medicaid providers of CPW services, and expanding CPW case management training. It also describes the status of finalizing the non-medical health-related needs screening questions and amending the Medicaid managed care and TTF contractual requirements to include the new screening and data reporting requirements.

Because screening for non-medical needs did not begin until September 1, 2024, complete screening data are not available for this report. This report includes implementation insights and screening data from a voluntary MCO pilot in summer 2024. To provide a portrait of Texas pregnancies prior to the implementation of H.B. 1575, this report presents population data on the demographic characteristics, prenatal risk factors, pregnancy outcomes, and birth outcomes for pregnant women and their newborns in Medicaid managed care and TTF in state fiscal year 2023.

1. Introduction

Texas Government Code, Section 531.653 requires certain qualifications for CPW providers, and Section 531.654 requires HHSC to revise the CPW standardized case management training. H.B. 1575 directed HHSC to submit a status report on the implementation of case management services provided to pregnant women under the CPW program during the preceding state fiscal year. The status report is to include de-identified information about the non-medical health-related needs of women receiving case management services, the number and types of referrals made for women to non-medical community assistance programs and providers, and birth outcomes for the women.

Additionally, Texas Government Code, Section 531.024183 requires HHSC to adopt standardized screening questions designed to screen for, identify, and aggregate data regarding the non-medical health-related needs of pregnant women enrolled in Medicaid and the TTF program. Texas Government Code, Section 531.655 requires MCOs and TTF service providers and subcontractors to use the standardized screening questions, obtain the woman's informed consent to perform the screening, determine if the woman is eligible for service coordination, CPW case management, non-covered services, community supports, and other resources, and provide the screening data to HHSC in the form and manner prescribed by HHSC. Additionally, HHSC is required to biennially submit a report that uses de-identified information to summarize the screening data collected by MCOs and TTF service providers and subcontractors during the previous biennium.

In this report, HHSC consolidated the two required reports described above, as allowed in Texas Government Code, Section 531.014.

2. Background

HHSC administers the Medicaid program, which provides health care to low-income children and their families, pregnant women, former foster care youth, individuals with disabilities and people aged 65 and older. Low-income pregnant women are enrolled in Medicaid during pregnancy and 12 months postpartum effective March 1, 2024.[1] CPW case management services are a Medicaid benefit for children from birth through 20 years of age and pregnant women of any age who have a health condition, health risk, or high-risk condition. Providers of CPW case management services, also known as CPW case managers, help members gain access to needed medical, social, educational, and other services. HHSC transitioned CPW services to a managed care delivery model in September 2022.[2]

HHSC also administers the TTF program. [Texas Health and Safety Code, Section 54] established the program as a continuation of the Alternatives to Abortion program.[3] The TTF program provides a statewide network of services that promote childbirth and support women and families through childbirth and early childhood. Services are delivered through contracted providers, including pregnancy centers, social service providers, adoption agencies, and maternity homes for pregnant women.

In February 2023, HHSC developed the [Non-Medical Drivers of Health (NMDOH) Action Plan], a set of guiding priorities and strategic goals to advance new and ongoing activities related to addressing NMDOH. NMDOH are "the conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes."[4] In the action plan, the three priority NMDOH are food, housing, and transportation needs. The four goals to address these priorities are to build data infrastructure; coordinate services and existing pathways throughout the delivery system; develop policies and programs; and support opportunities for collaboration across the agency and with key partners including the MCOs, Medicaid providers, and community-based organizations. The implementation of H.B. 1575 activities related to non-medical health-related aligns with the priorities and goals in the action plan.

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[1] Coverage was expanded to 12 months postpartum as directed by H.B. 12, 88th Legislature, Regular Session, 2023.
[2] CPW services were transitioned to a managed care delivery model as required by H.B. 133, 87th Legislature, Regular Session, 2021. Medicaid fee-for-services (FFS) clients still receive this benefit.
[3] The Alternatives to Abortion program was created by the 2006-07 General Appropriations Act, Senate Bill 1, 79th Legislature, Regular Session, 2005 (Article II, Special Provisions Relating to all Health and Human Services Agencies, Section 50).
[4] The definition of NMDOH is adapted from the Centers for Disease Control and Prevention. NMDOH are also known as social determinants of health or social drivers of health.

3. Children & Pregnant Women Case Management

Texas Government Code, Sections 531.653 and 531.654 require Medicaid CPW providers to meet certain qualifications and direct HHSC to revise the CPW standardized case management training. In addition, Texas Human Resources Code, Section 32.024(pp) and (qq) requires HHSC to add two new Medicaid provider types, CHWs and doulas, as eligible CPW providers.

This report provides a status update on implementation. A future report will include de-identified information about the non-medical health-related needs of women receiving case management services, the number and types of referrals made by MCOs for women to non-medical community assistance programs and providers, and birth outcomes for the women.

New Provider Types

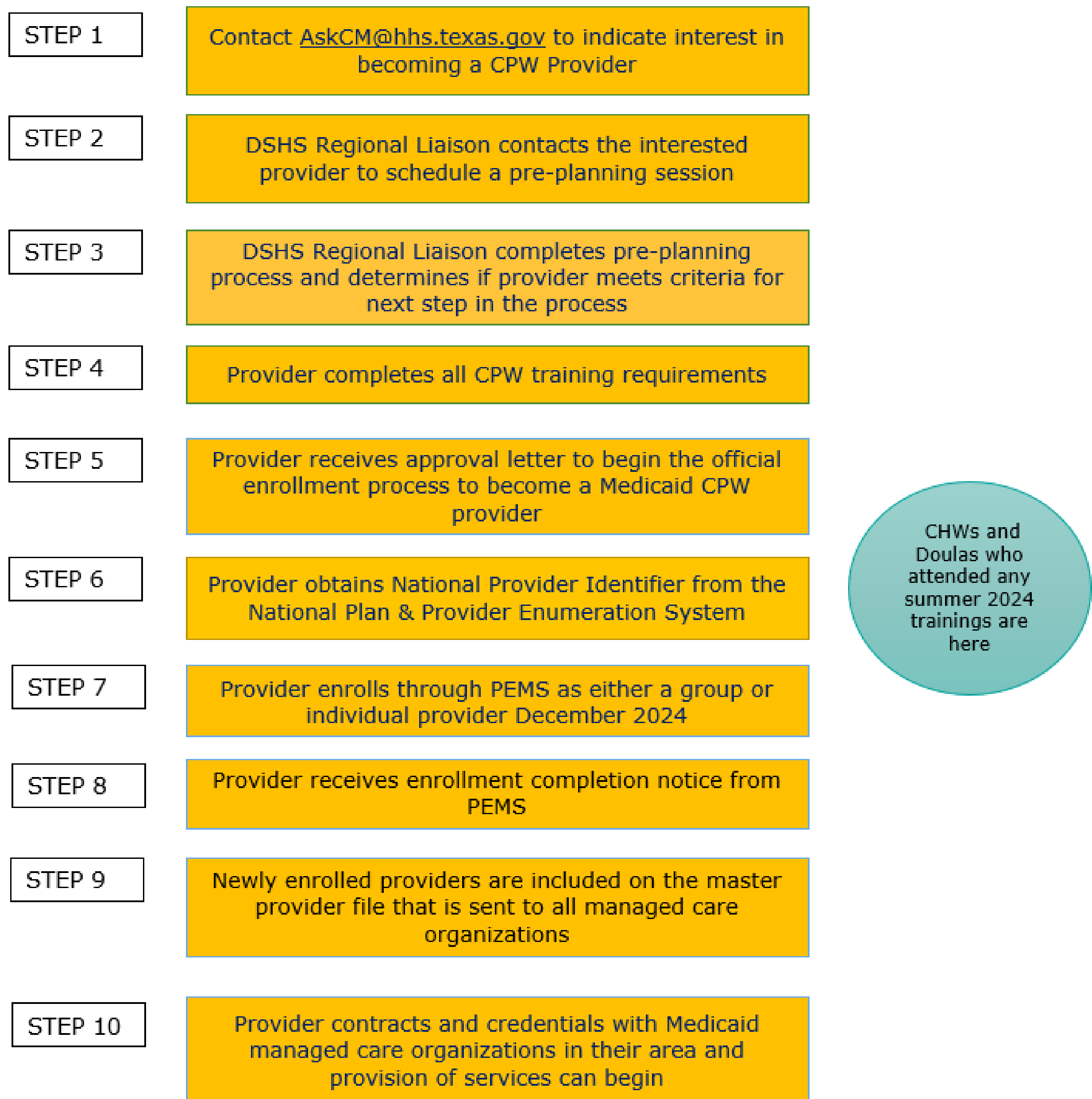
Nurses and social workers were previously eligible to enroll as CPW case managers. Texas Government Code, Section 531.653 added two new provider types, doulas and CHWs, as eligible CPW case managers.

The certification of CHWs, as defined by Texas Health and Safety Code, Section 48.001(7), is completed by the Department of State Health Services and provides a clear pathway for identifying those qualified for subsequent inclusion into the Medicaid case management network of CPW providers.

As there is not a single national certification program for doulas, HHSC identified criteria, incorporated feedback from stakeholders, and created pathways to confirm eligibility to provide Medicaid case management services through the provider enrollment process. Two pathways to qualification as a case manager for doulas were created – experience and training.

As of September 2024, there were 120 enrolled CPW case management providers. Additionally, 377 individuals started the pre-planning process to learn more about becoming a CPW case management provider. Figure 1 outlines the steps a provider interested in becoming a Medicaid CPW case management provider must take, which includes enrolling in the Provider Enrollment Management System (PEMS).

Figure 1. Steps to become a Provider of Case Management for Children and Pregnant Women Services



Expanded Standardized Case Management Training

HHSC conducted an extensive outreach and education campaign over summer 2024 to identify, train, and prepare prospective new Medicaid providers for the enrollment process.

In addition to the existing standardized case management training, Texas Government Code, Section 531.654 requires HHSC to create trauma-informed training. This new training includes instruction on social services, community assistance programs, nutrition and housing assistance, counseling and parenting services, substance use disorder (SUD) treatment, and domestic violence assistance and shelter.

HHSC completed the new training module and made it available to all CPW providers in June 2024. It is a one-hour, on demand course on the Texas Health Steps training website.

Figure 2. Training Module for CPW Providers

Virtual Instructor-Led Training

The existing case management training (virtual, but instructor-led) incorporated the new trauma-informed training for all providers to complete to become eligible for enrollment as a case management provider. In summer 2024, 311 total prospective new case managers completed the scheduled trainings which is the fourth step to becoming eligible for enrollment.

Informational Webinars

HHSC presented informational webinars to update existing CPW case managers (nurses and social workers already enrolled as CPW case managers) and new or

prospective CPW case managers (CHWs and doulas, as well as any new nurses and social workers) on progress towards implementation of the CPW program updates required by H.B. 1575. In total, 226 case managers (current and prospective) attended. This is not a step in the process of becoming a CPW case management provider.

System Enhancements

Medicaid providers are federally required to enroll with HHSC. Therefore, the two new provider types must be added to the Medicaid PEMS. The system changes needed to enroll doulas and CHWs as Medicaid CPW providers and to process their claims are scheduled for November 2024. Therefore, the system can begin accepting applications from doulas and CHWs to become Medicaid providers starting on December 1, 2024.

4. Non-Medical Needs Screening

Texas Government Code, Section 531.024183 requires HHSC to adopt standardized screening questions that MCOs and TTF service providers and subcontractors must use to screen all consenting pregnant women for non-medical needs, coordinate services and referrals, and report the results to HHSC. This report provides a status update on implementation of the finalized non-medical needs screening questions and requirements for the MCOs and TTF service providers and subcontractors, in addition to implementation insights and screening data from the voluntary MCO pilot, and a portrait of Texas pregnancies prior to the implementation of H.B. 1575. Future reports will include summaries of the data collected by MCOs and TTF during the previous biennium.

Final Non-Medical Needs Screening Questions

In spring 2024, HHSC finalized the standardized screening questions that MCOs and TTF service providers and subcontractors must use to screen all consenting pregnant women for the following types of non-medical health-related needs: food, transportation, housing (living situation and quality of housing), and child care.

The final non-medical needs screening questions are available in English and Spanish in Appendix A.

Screening Questions Development Process

H.B. 1575 does not prescribe which standardized screening questions HHSC must adopt or the non-medical needs that the MCOs and TTF service providers and subcontractors must screen. In summer 2023, HHSC created an interdisciplinary workgroup of experts from HHSC (including Medicaid and TTF staff), the Department of State Health Services, and the Department of Family and Protective Services to research and consider questions from a number of common non-medical needs screening tools.[5] The workgroup found there was limited alignment in screening questions used by MCOs and TTF service providers and subcontractors, and there was not an existing set of screening questions specifically designed for

[5] The workgroup reviewed the following screening tools: the Hunger Vital Sign; the Center for Medicare & Medicaid Accountable Health Communities Health-Related Social Needs; the American Academy of Family Physicians Social Determinants of Health; Boston Medical Center's We Care; the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences; the Health Leads Social Needs; and North Carolina's Medicaid 1115 Waiver Social Determinants of Health.

the non-medical needs of pregnant women. Therefore, the workgroup adapted screening questions from existing sources to meet the requirements of the bill and to better tailor questions to the needs of pregnant women.

In fall 2023 during the draft development phase, HHSC engaged key stakeholder groups for feedback on the draft screening questions. HHSC received feedback from all 16 MCOs and all four TTF service providers and subcontractors, as well as the Texas Medical Association, Texas Association of Community Health Centers, Texas Council on Family Violence, Every Body Texas, Texas Women's Healthcare Coalition, and committee members of the HHSC Value-Based Payment and Quality Improvement Advisory Committee. HHSC incorporated stakeholder feedback and finalized the screening questions in spring 2024.

MCO Screening and Data Reporting Requirements

In accordance with Texas Government Code, Sections 531.024183 and 531.655, HHSC amended Medicaid managed care contractual requirements to include the new MCO screening and data reporting requirements. Starting September 1, 2024, MCOs must make a best effort to initiate outreach activities to conduct the non-medical needs screening within 30 days of the member's enrollment with the MCO or after the MCO identifies a member is pregnant. The MCOs may perform the required screening in combination with other contractually required screenings, such as the initial health needs screening or the perinatal risk assessments. The MCOs must use the member's screening results to determine if the member needs a more comprehensive assessment for MCO service coordination, covered services, including CPW services, and non-covered services such as value-added services or community resources. Additionally, the MCOs must provide to HHSC the data the MCO collects using the standardized non-medical needs screening questions.

MCO Pilot

Complete screening data from the MCOs will not be available until 2025. In summer 2024, HHSC implemented a voluntary pilot with 11 of the 16 MCOs. MCOs used the finalized non-medical needs screening questions and collected data on a subset of consenting pregnant women in managed care during a pilot period of June 1, 2024, through July 31, 2024. The list of MCOs that volunteered to participate in the pilot with HHSC is available in Appendix B. MCOs that participated in the pilot were not expected to outreach and screen all pregnant women or complete the system updates needed to implement the MCO contractual requirements.

Table 1 outlines the key differences between the MCO pilot and the MCO contract requirements.

Table 1. Key Differences: MCO Pilot and MCO Contract Requirements

	MCO Pilot	MCO Contracts
Who Must Screen?	Voluntary MCOs (11 total)	All MCOs (16 total)
Who is Screened?	Subset of pregnant women in managed care who consented to be screened	All pregnant women in managed care who consent to be screened
When do Screenings Occur?	June 1, 2024 – July 31, 2024	September 1, 2024, onward
What Data are Reported to HHSC?	A subset of the required data fields	All required data fields

MCO Pilot Implementation Insights

To better understand how the MCOs identified pregnant members and administered the non-medical needs screening questions, HHSC analyzed meeting notes from discussions with each MCO and conducted a survey with the MCOs to ask questions about their implementation approach during the pilot. All MCO names have been de-identified from their feedback and respective data, and this section presents implementation insights from the pilot.

The MCOs described the following methods for identifying members who are pregnant:

- Enrollment data with a pregnancy code (“TP40”)
- Claims data (perinatal-related clinical encounters, hospitalizations, emergency department visits, and prescriptions)
- Hospital admission, discharge, and transfer data
- Notification of pregnancy by MCO staff (i.e., when service coordination or other care management staff learn about a member’s pregnancy status through other routine outreach processes)
- Notification of pregnancy by providers (i.e., when an obstetrics physician notifies the MCO about a member’s pregnancy status)
- Notification of pregnancy by the member (i.e., when a member self-reports or notifies the MCO about their pregnancy status)

For the pilot, most of the MCOs incorporated the non-medical needs screening questions into existing processes wherever possible. Each MCO had slightly

different existing processes, but the majority of MCOs administered the screening questions telephonically (i.e., a staff person asks the screening questions over the phone and documents the member's verbal responses) and incorporated the step into existing telephonic outreach workflows. The most common types of MCO staff to administer the screening questions over the phone were either CHWs or administrative staff. Most MCOs had workflows in which the screening staff were responsible for conducting outreach, administering the screening questions, and documenting the screening results, while different staff—including a mix of CHWs, social workers, and nurses—were assigned to members to follow-up with assistance.

Unlike the majority of MCOs who screened members telephonically, one MCO piloted the screening questions electronically through their existing care management digital application ("app"). Pregnant members completed the screening questions in the app on their own time, eliminating the need for MCO staff to conduct the screening questions.

As required by Texas Government Code, Section 531.024183(d), the MCOs may not perform a screening unless the MCO obtains informed consent to perform the screening. During the pilot, most MCOs described obtaining informed consent based on verbal or digital consent according to the method used to administer the screening questions.

Additionally, the pilot found that for members whose preferred language was Spanish or another language other than English, most MCOs administered the screening either using Spanish or bilingual speaking staff or an interpreter service.

MCO Pilot Population

For the pilot, HHSC allowed each MCO to determine the subset of pregnant women to screen (pilot population). Most MCOs limited the scope of their pilot population to some extent, such as only new members who are pregnant; members who are in service coordination or other types of care management; members in certain managed care programs; and members in certain counties. The pilot population size across the MCOs ranged from 59 to 1,610 pregnant women. There was a wide range in pilot population sizes because some MCOs only reported on completed screenings while others reported on their full pilot populations, including those who declined the screening or were not able to complete the screening for other reasons (e.g., outreach was still in progress, or the member could not be reached). Importantly, rates of completed and declined screenings should not be viewed as indicative of future rates due to the short pilot period and varying methods used by

MCOs for tracking and reporting pilot data to HHSC. Additionally, some MCOs were not able to conduct outreach to their full pilot populations during the short pilot period, resulting in artificially high rates of members who could not be reached or for whom outreach was still in progress. For additional information about the pilot population and participation rates by MCO, see Appendix B, Table B-1.

MCO Pilot Screening Results

MCOs completed a total of 1,159 screenings during the pilot period from June 1, 2024, through July 31, 2024. Members from all managed care programs completed the screening, with most pregnant members enrolled in the STAR managed care program and no more than five percent enrolled in the STAR Kids, STAR Health, or STAR+PLUS programs (results not shown in this report). Additionally, most screenings were completed in English, with Spanish being the next most common language. Fewer than five percent of screenings for any MCO were completed in a language other than English or Spanish (results not shown in this report).[6]

All MCOs reported some percentage of non-medical needs among pregnant women who were screened (see Appendix B, Table B-2). In fact, every type of non-medical need—food insecurity, transportation, housing, and child care—was identified by every MCO. Food insecurity was the most commonly identified non-medical need, followed by child care needs. Though a number of pregnant members were identified with housing and transportation needs, those with housing-related needs tended to report problems with utility bills and housing quality rather than homelessness or housing insecurity. Appendix B, Table B-2 shows the percentage of completed screenings indicating each type of non-medical need by MCO.

In cases where a non-medical need was identified, the member was asked whether they wanted help with the identified need. The pilot screening data suggest that though food insecurity was the most commonly identified non-medical need, members with identified child care needs were more likely to respond that they wanted help with that need, on average, than those who reported challenges related to food insecurity (see Appendix B, Table B-2).

MCO Pilot Limitations

The MCO pilot screening data should be interpreted alongside several key limitations. First, the MCO pilot data presented in this report are not representative of the entire target population of pregnant women in managed care during the pilot

[6] Other languages the screenings were completed in included Vietnamese, Russian, Arabic, Dari, Nepali, Pashto, Somali, Swahili, and Tamil.

period from June 1, 2024, through July 31, 2024. HHSC coordinated the MCO pilot using a convenience sample of 11 voluntary MCOs and did not require participating MCOs to include all pregnant women in the pilot. Therefore, the MCO pilot screening data should not be interpreted as a representative baseline for the prevalence of non-medical needs among all pregnant women in managed care. Instead, the MCO pilot screening data must be reviewed in the context of each MCO's pilot population. Future reports will include screening data for the full population of pregnant women in managed care.

Second, HHSC did not require participating MCOs to collect all data fields that are contractually required, such as Medicaid ID, date of birth, information about pregnancy, and the activities or referrals coordinated for the member for help with identified non-medical needs. Since the pilot data did not include any identifying information, HHSC will not be able to link any of the pilot screening data to Medicaid member-level quality outcomes, such as birth outcomes or referrals to CPW case management services. HHSC aims to include these types of analyses in a future legislative report.

Medicaid Pregnant Population Data, State Fiscal Year 2023

To provide a portrait of Medicaid pregnancies in Texas prior to the implementation of H.B. 1575, the HHSC Office of Data, Analytics, and Performance (DAP) used administrative claims and encounters data to describe the demographic characteristics, prenatal risk factors, and pregnancy and birth outcomes of 189,429 pregnant Medicaid managed care members and their newborns in state fiscal year 2023 (September 1, 2022, to August 31, 2023). For more information on the methods for this analysis, see Appendix C.

Demographic Characteristics

Table 2 shows the age, race, ethnicity, and rurality of pregnant Medicaid managed care members. Almost 80 percent of the pregnant population was between 20 and 34 years old, while 10 percent were under age 20 and another 10 percent were age 35 or older.

HHSC collects race and ethnicity data as separate fields. Over half of the pregnant population was of Hispanic or Latino ethnicity. The racial distribution shows White women comprised approximately 57 percent of pregnant members, followed by members of unknown race (20.7 percent) and Black or African American members

(18.5 percent). The remaining racial categories represented less than two percent each.

Approximately 83 percent of the pregnant population resided in Metro counties, followed by Rural counties (9.8 percent) and Micro counties (6.8 percent). For more information on the definition of county designations, refer to Appendix D.

Table 2. Demographic Characteristics of the Medicaid Managed Care Pregnant Population, SFY 2023[1]

Domain	Characteristic	n	%
Total	*Total*	*189,429*	
Age Group[2]	<20	19,292	10.2%
Age Group	20-24	58,983	31.1%
Age Group	25-34	91,364	48.2%
Age Group	35+	19,790	10.4%
Race	White	108,520	57.3%
Race	Black or African American	34,992	18.5%
Race	American Indian or Alaska Native	883	0.5%
Race	Asian	3,032	1.6%
Race	Native Hawaiian or Other Pacific Islander	504	0.3%
Race	Two or More Races	2,253	1.2%
Race	Unknown Race	39,245	20.7%
Ethnicity	Hispanic or Latino	105,621	55.8%
Ethnicity	Not Hispanic or Latino	77,302	40.8%
Ethnicity	Unknown Ethnicity	6,506	3.4%
Rurality[3]	Metro	157,883	83.3%
Rurality	Micro	12,890	6.8%
Rurality	Rural	18,635	9.8%
Rurality	Unknown	21	0.0%

Data Source: Medicaid FFS claims and Managed Care encounters; 8-month eligibility data; Texas Integrated Eligibility Redesign System (TIERS) Datamart Extract (see Appendix C for detail).

Analysis by HHSC-DAP.

1 The pregnant population for SFY 2023 is defined as members who were pregnant in SFY 2022/23; whose pregnancy ended between September 1, 2022 and August 31 2023, and; who were enrolled in a managed care plan at some point during their perinatal period. Excludes members with more than one pregnancy ending during SFY 2023.

2 Member age based on age on the date the pregnancy ended.

3 County is based on county of residence of the member.

Prenatal Risk Factors and Pregnancy Outcomes

Prior research has demonstrated a link between prenatal risk factors and adverse birth outcomes for women and their newborns, making the prenatal period a key focus for interventions aimed at improving overall birth outcomes. Table 3 shows the prevalence of prenatal risk factors and pregnancy outcomes among pregnant Medicaid managed care members in Texas. During their pregnancy, approximately 17 percent had a diagnosis of anemia; 20 percent were overweight or obese; and 12 percent were diagnosed with a mental health condition, such as a mood disorder, anxiety disorder, or psychotic disorder. Fewer than 10 percent of women received a diagnosis of gestational diabetes, gestational hypertension, hemorrhage, or preeclampsia. Four percent of the clients had a diagnosis of nicotine dependence during their pregnancy, while another four percent were diagnosed with SUD other than nicotine dependence.

Approximately 88 percent of pregnancies ended in a delivery (n = 166,127) and the remaining 12 percent resulted in a pregnancy loss. For additional information on the technical definitions and diagnosis codes used to determine prenatal risk factors and pregnancy outcomes, see Appendix C.

Table 3. Prenatal Risk Factors and Pregnancy Outcomes for the Medicaid Managed Care Pregnant Population, SFY 2023[1]

Domain	Outcome	n	%
Total	*Total*	*189,429*	
Prenatal Risk Factors[2]	Anemia	31,243	16.5%
Prenatal Risk Factors	Gestational diabetes	18,447	9.7%
Prenatal Risk Factors	Gestational hypertension	15,301	8.1%
Prenatal Risk Factors	Hemorrhage	16,846	8.9%
Prenatal Risk Factors	Overweight and obesity	37,343	19.7%
Prenatal Risk Factors	Preeclampsia	11,641	6.1%
Behavioral Health[2]	Mental health conditions	22,896	12.1%
Behavioral Health	Substance use disorders (SUD)	13,848	7.3%
Behavioral Health	SUD, excluding nicotine dependence	7,927	4.2%
Behavioral Health	Nicotine dependence	7,596	4.0%
Pregnancy Outcome[3]	Delivery	166,127	87.7%
Pregnancy Outcome	No delivery, pregnancy loss	23,302	12.3%

Data Source: Medicaid FFS claims and Managed Care encounters; 8-month eligibility data. Analysis by HHSC-DAP.

1 The pregnant population for SFY 2023 is defined as members who were pregnant in SFY 2022/23; whose pregnancy ended between September 1, 2022 and August 31 2023, and; who were enrolled in a managed care plan at some point during their perinatal period. Excludes members with more than one pregnancy ending during SFY 2023.

2 Prenatal risk factors and behavioral health outcomes are based on diagnoses that occurred up to 220 days before the date of the pregnancy outcome. Members in the "Nicotine dependence" and "SUD, excluding nicotine dependence" categories are not mutually exclusive and will not sum to the total number of members with SUD. Members in the "Nicotine dependence" category may also have SUD.

3 Definitions of pregnancy outcomes: Delivery - Identifies women with claims indicating that the pregnancy ended in a delivery. Approximately 98% of deliveries resulted in a live birth (n=163,068). A small number (n=878) resulted in a stillbirth, while the remaining delivery outcomes could not be determined from administrative data (n=2,181); No delivery, pregnancy loss - Identifies women with claims for non-delivery pregnancy ending events, such as spontaneous abortion (miscarriage) or other non-viable pregnancies, such as ectopic or molar pregnancies.

Newborn Outcomes

Table 4 shows the prevalence of adverse birth outcomes among newborns born to Medicaid managed care members. Specifically, 8.4 percent of newborns had a low birth weight (less than 2,500 grams); 10.9 percent were born preterm (less than 37 weeks gestation); and 13.1 percent were admitted to a neonatal intensive care unit (NICU) within their first 28 days of life. For additional information on the technical definitions and diagnosis codes used to determine newborn outcomes, see Appendix C.

Table 4. Birth Outcomes for Newborns of the Medicaid Managed Care Pregnant Population, SFY 2023[1]

Outcome[2]	n	%
Total[1]	*163,539*	
Low Birth Weight	13,818	8.4
Preterm Birth	17,831	10.9
NICU Utilization	21,503	13.1

Data Source: Medicaid FFS claims and Managed Care encounters. Analysis by HHSC-DAP.

1 The newborn population for SFY 2023 is defined as newborns who were born in SFY 2023 to Medicaid managed care members who were pregnant in SFYs 2022/23.

2 Newborn-related outcomes are based on claims and encounters up to 28 days after birth.

Discussion

Limitations

The data presented in this section rely on Medicaid administrative data, which are collected for billing rather than for research purposes. Since medical claims typically only include diagnoses relevant to specific visits rather than a complete medical history, some conditions and risk factors may be underrepresented in this report. In 2021, for example, other sources indicate the percentage of Texas mothers with a pre-pregnancy body mass index in the obese range was 31.5 percent compared to

20 percent of pregnant members identified as overweight or obese in Medicaid claims data, as shown in Table 3.

Moreover, determining accurate outcomes for some measures requires linking data between mother and infant claims, which may involve conflicting or missing data across member records. In a small number of cases, HHSC imputed missing end of pregnancy dates based on other available information. HHSC relied on validated and commonly used coding schemes wherever available to support the accuracy of results, but considerations related to data completeness (e.g., varying lengths of member enrollment, out of state treatment, pregnancy ending events without a Medicaid service visit) may impact the precision of estimates presented in this report.

Future Analyses

Future reports will analyze perinatal health outcomes among women screened for non-medical needs, allowing HHSC to better understand the role of non-medical factors in pregnancy-related outcomes. Additionally, HHSC will aim to examine whether referrals to community-based organizations and other social service providers help reduce adverse birth outcomes and certain postpartum conditions, such as severe maternal morbidity and postpartum depression.

Thriving Texas Families Screening and Data Reporting Requirements

HHSC worked collaboratively with TTF service providers and subcontractors to ensure that the finalized non-medical needs screening will be used to screen and document the results for all eligible pregnant clients who consent to be screened. Specifically, HHSC reviewed with TTF service providers and subcontractors the required use of the standardized screening questions to screen for non-medical needs of pregnant women and requirements to inform the woman:

- About the type of data that will be collected during the screening and the purposes for which the data will be used.
- The collected data will become part of the woman’s medical record or service plan.
- Service providers and subcontractors must obtain the woman’s informed consent to perform the screening.

Additionally, HHSC provided training to review the elements of the screening tool, and the requirements regarding consent. TTF service providers and subcontractors started screening pregnant women on September 1, 2024, and will submit monthly reports of required data to HHSC through a new database starting in fall 2024. HHSC is developing a data element guide to ensure continuity and compliance with the specified non-medical needs screening responses. HHSC will finalize contract amendments for the TTF program in fall 2024 to include the new requirements for the finalized screening and data reporting requirements for state fiscal year 2025.

Thriving Texas Families Target Population Data

While the eligible population for the TTF program includes other client types, H.B. 1575 requires TTF service providers and subcontractors to screen pregnant women. To provide a portrait of Texas pregnancies in the TTF program prior to the implementation of H.B. 1575, Table 5 describes the demographic characteristics, including age, ethnicity, race, and rurality, of 56,610 pregnant women who received TTF services in state fiscal year 2023.

Almost 94 percent of the pregnant women served by the program are between the ages of 18 and 39 years old. TTF collects race and ethnicity data as one field. Almost half of the pregnant population was of Hispanic or Latino ethnicity. The racial distribution shows Black or African American women comprised approximately 26 percent of pregnant members, followed by White women (20.4 percent). The remaining racial categories each represented less than three percent. Appendix E further breaks down by race and ethnicity the number of TTF services received by pregnant women in counseling or mentoring, educational materials, and classes. Approximately 88 percent of the pregnant population resided in Metro counties, followed by Rural counties (6.6 percent) and Micro counties (5.3 percent). For more information on the definition of county designations, refer to Appendix D.

Table 5. Demographic Characteristics of the TTF Pregnant Population, SFY 2023

Domain	Characteristic	n	%
Total	Total	56,610	
Age Group	<15	93	0.2
Age Group	15-17	1,781	3.1
Age Group	18-22	14,896	26.3
Age Group	23-29	22,865	40.4
Age Group	30-39	15,341	27.1
Age Group	40+	1,477	2.6

Domain	Characteristic	n	%
Age Group	Refused to Answer	157	0.3
Race/ Ethnicity	White	11,552	20.4
Race/ Ethnicity	Black or African American	14,901	26.3
Race/Ethnicity	American Indian or Alaska Native	272	0.5
Race/Ethnicity	Asian or Pacific Islander	1,436	2.5
Race/Ethnicity	Other	591	1.0
Race/Ethnicity	Refused to Answer	216	0.4
Race/Ethnicity	Hispanic or Latino	27,642	48.8
Rurality	Metro	49,870	88.1
Rurality	Micro	3,026	5.3
Rurality	Rural	3,714	6.6

Data Source: Excel Workbooks provided by TTF service providers and subcontractors. Analysis by HHSC-TTF.

Future Analyses

The TTF program intends to utilize the non-medical needs screening to improve personalized support for clients when assessing for services and referral needs. HHSC will use the data to assess trends among the TTF client population to better inform the needs of the program to better help Texas families thrive.

5. Conclusion

This report describes the status of implementation of requirements as directed by H.B. 1575 for new CPW provider types and training as well as the new non-medical needs screening and data reporting requirements for MCOs and TTF service providers and subcontractors. Additionally, this report includes implementation insights and screening data from a voluntary pilot with 11 MCOs in summer 2024, as well as population data to describe the demographic characteristics, prenatal risk factors, pregnancy, and birth outcomes of pregnant women in Medicaid managed care and TTF in state fiscal year 2023 before the implementation of H.B. 1575.

Future reports will include biennial summaries of the screening data collected by MCOs and TTF service providers and subcontractors, information about the non-medical health-related needs of women receiving CPW services, the number and types of referrals made to non-medical community assistance programs and providers, and perinatal health outcomes among women screened for non-medical needs. The implementation activities for H.B. 1575 and future data analyses will allow HHSC to better understand the role of non-medical needs in pregnancy-related outcomes for pregnant women served by Texas Medicaid and the TTF program.

List of Acronyms

Acronym	Full Name
CHW	Community health worker
CMS	Centers for Medicare and Medicaid Services
CPW	Children and Pregnant Women
DAP	Office of Data, Analytics, and Performance
FFS	Fee-for-service
H.B.	House Bill
HHSC	Health and Human Services Commission
HPOE	Health Program Outcomes and Epidemiology
MCO	Managed care organization
MDR	Master Data Repository
NICU	Neonatal intensive care unit
NMDOH	Non-medical drivers of health
PEMS	Provider enrollment management system
SFY	State fiscal year
SUD	Substance use disorder
TIERS	Texas Integrated Eligibility Redesign System
TTF	Thriving Texas Families

Appendix A. Final Non-Medical Needs Screening Questions in English and Spanish

HHSC Non-Medical Needs Screening

Food

For you and your household, please answer if the next two statements are often true, sometimes true, or never true.

1. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   A. Often true
   B. Sometimes true
   C. Never true
   D. Decline to answer
2. Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.
   A. Often true
   B. Sometimes true
   C. Never true
   D. Decline to answer

If the member answers “Never true” or “Decline to answer” for questions 1 and 2, skip question 3 and go to question 4.

3. Would you like help with your food needs?
   A. Yes
   B. No
   C. Decline to answer

Transportation

4. Within the past 12 months, has a lack of reliable transportation kept you from medical appointments or getting medications?

    A. Yes

    B. No

    C. Decline to answer

5. Within the past 12 months, has a lack of reliable transportation kept you from doing things you need to do, such as grocery shopping or getting to work or school?

    A. Yes

    B. No

    C. Decline to answer

If the member answers "No" or "Decline to answer" for questions 4 and 5, skip question 6 and go to question 7.

6. Would you like help with transportation?

    A. Yes

    B. No

    C. Decline to answer

Housing

7. What is your living situation today?

    A. I have a steady place to live.

    B. I have a steady place to live today, but I'm worried about losing it in the future.

    C. I don't have a steady place to live. I am temporarily staying in another person's home, in a hotel, shelter, car, abandoned building, bus or train station, or living outside on the street, in the woods, or in a park.

    D. Decline to answer

Think about where you live when answering the next six questions.

8. Do you have problems paying for utilities, such as electricity, gas, heat, air conditioning or water?
    A. Yes
    B. No
    C. Decline to answer
9. Do you have problems with utilities not working, such as electricity, gas, heat, air conditioning or water?
    A. Yes
    B. No
    C. Decline to answer
10. Do you have problems with pests like bugs or mice?
    A. Yes
    B. No
    C. Decline to answer
11. Do you have problems with mold?
    A. Yes
    B. No
    C. Decline to answer
12. Do you have problems with lead paint or pipes?
    A. Yes
    B. No
    C. Decline to answer
13. Do you have problems with smoke or carbon monoxide detectors missing or not working?
    A. Yes
    B. No
    C. Decline to answer

If the member answers "I have a steady place to live" or "Decline to answer" for question 7, and "No" or "Decline to answer" for all questions 8-13, skip question 14 and go to question 15.

14. Would you like help with your living situation?

   A. Yes

   B. No

   C. Decline to answer

Child Care

15. In the next 12 months, will you need help finding or paying for child care?

   A. Yes

   B. No

   C. Decline to answer

If the member answers "No" or "Decline to answer" for question 15, skip question 16.

16. Would you like help with child care?

   A. Yes

   B. No

   C. Decline to answer

Evaluación de necesidades no médicas de la HHSC

Alimentación

Con base en su situación personal y la de su hogar, indique si las siguientes afirmaciones son ciertas con frecuencia, a veces o nunca.

1. En los últimos 12 meses, le preocupaba que se acabaran los alimentos que tenía antes de obtener suficiente dinero para comprar más.

   A. Con frecuencia

   B. A veces

   C. Nunca

   D. Prefiero no contestar

2. En los últimos 12 meses, los alimentos que compraba no rendían lo suficiente y no tenía dinero para comprar más.

   A. Con frecuencia

   B. A veces

   C. Nunca

   D. Prefiero no contestar

Si la persona responde “nunca” o “prefiero no contestar” a las preguntas 1 y 2, omita la pregunta 3 y pase a la pregunta 4.

3. ¿Le gustaría recibir ayuda para cubrir sus necesidades de alimentación?

   A. Sí

   B. No

   C. Prefiero no contestar

Transporte

4. En los últimos 12 meses, ¿la falta de transporte confiable le impedía acudir a sus citas médicas o recoger sus medicamentos?

   A. Sí

   B. No

   C. Prefiero no contestar

5. En los últimos 12 meses, ¿la falta de transporte confiable le impedía hacer actividades necesarias, como ir a la tienda a comprar alimentos o acudir al trabajo o la escuela?

   A. Sí

   B. No

   C. Prefiero no contestar

Si la persona responde “no” o “prefiero no contestar” a las preguntas 4 y 5, omita la pregunta 6 y pase a la pregunta 7.

6. ¿Le gustaría recibir ayuda con el transporte?
   A. Sí
   B. No
   C. Prefiero no contestar

Vivienda

7. ¿Cuál es su situación de vivienda actual?
   A. Tengo un lugar estable para vivir.
   B. Tengo un lugar estable para vivir hoy, pero me preocupa perderlo en el futuro.
   C. No tengo un lugar estable donde vivir. Estoy quedándome temporalmente en el hogar de otra persona, un hotel, refugio, carro, edificio abandonado, estación de tren o de autobús, o vivo a la intemperie en la calle, bosque o parque.
   D. Prefiero no contestar

Responda a las siguientes seis preguntas en relación con su situación de vivienda.

8. ¿Tiene problemas para pagar los servicios públicos, como la electricidad, el gas, la calefacción, el aire acondicionado o el agua?
   A. Sí
   B. No
   C. Prefiero no contestar
9. ¿Tiene problemas de mal funcionamiento de servicios públicos, como la electricidad, el gas, la calefacción, el aire acondicionado o el agua?
   A. Sí
   B. No
   C. Prefiero no contestar
10. ¿Tiene problemas de plagas, como insectos o ratones?
   A. Sí
   B. No
   C. Prefiero no contestar

11. ¿Tiene problemas de moho?
    A. Sí
    B. No
    C. Prefiero no contestar
12. ¿Tiene problemas por pintura o tubería de plomo?
    A. Sí
    B. No
    C. Prefiero no contestar
13. ¿Tiene problemas de mal funcionamiento o ausencia de detectores de humo o de monóxido de carbono?
    A. Sí
    B. No
    C. Prefiero no contestar

Si la persona responde “tengo un lugar estable para vivir” o “prefiero no contestar” a la pregunta 7, y “no” o “prefiero no contestar” a las preguntas de la 8 a la 13, omita la pregunta 14 y pase a la pregunta 15.

14. ¿Le gustaría recibir ayuda con su situación de vivienda?
    A. Sí
    B. No
    C. Prefiero no contestar

Cuidado infantil

15. En los siguientes 12 meses, ¿necesitará ayuda para encontrar o pagar por un servicio de cuidado infantil?
    A. Sí
    B. No
    C. Prefiero no contestar

Si la persona responde “no” o “prefiero no contestar” a la pregunta 15, omita la pregunta 16.

16. ¿Le gustaría recibir ayuda para el cuidado infantil?

   A. Sí

   B. No

   C. Prefiero no contestar

Appendix B. MCO Pilot Population and Screening Data

Appendix B includes data from the Medicaid MCO pilot, which represents data collected from June 1, 2024, through July 31, 2024, by 11 participating MCOs. The following MCOs volunteered to participate in the pilot with HHSC:

1. Aetna Better Health of Texas
2. Blue Cross Blue Shield
3. Community Health Choice
4. Cook Children's Health Plan
5. Dell Children's Health Plan
6. El Paso Health
7. Parkland Community Health Plan
8. Superior HealthPlan
9. Texas Children's Health Plan
10. UnitedHealthcare
11. Wellpoint (formerly Amerigroup)

Table B-1 includes the pilot population description, pilot population size (number of distinct pregnant women), and the number of Medicaid pregnant women who completed, declined, or did not complete the screening for other reasons. Table B-2 shows the percentage of completed screenings indicating a food, transportation, housing, or child care need across the MCOs, including the percentage of pregnant women who wanted help when a non-medical need was identified.

Table B-1. Medicaid Pilot Population Description, Size, and Participation Rates

	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G	MCO H	MCO I	MCO J	MCO K
Pilot Population Definition	New members who are pregnant	New members who are pregnant in certain counties	Pregnant members participating in MCO Service Coordination phone call	New members who are pregnant	New members who are pregnant in certain managed care programs	All pregnant members	New members who are pregnant in certain managed care programs	New members who are pregnant	New members who are pregnant	Pregnant members in Service Coordination	Pregnant members with digital care management app
Pilot Population Size	226	1,610	197	419	67	165	59	259	62	904	543
Completed Screening	34 (15%)	145 (9%)	197 (100%)	70 (17%)	3 (4%)	163	59	259	37 (60%)	131 (14%)	61 (11%)
Declined Screening	44 (19%)	126 (8%)	0 (0%)	16 (4%)	6 (9%)	2	NR	NR	25 (40%)	27 (3%)	0 (0%)
Other[1,2]	148 (65%)	1,339 (83%)	NA	333 (79%)	58 (87%)	NR	NR	NR	NR	746 (83%)	482 (89%)

Data Source: MCO pilot data June-July, 2024. Analysis by HHSC-DAP.

Data Source: MCO pilot data June-July 2024. Analysis by HHSC-DAP.

Notes: NR=Not reported. Two MCOs only reported screening completions and did not report the number of members who declined or were otherwise unable to be screened. Two MCOs reported the number of members who completed or declined the screening but did not report on those unable to be screened.

NA=Not Applicable. One MCO only administered screenings to members they were already speaking with on the phone, so "Other" outcomes such as "unable to reach" or "outreach in progress" do not apply.

1 If a member had multiple records (e.g., was included in multiple months) and the member did not complete the screening in any month, HHSC used the record with the latest date to determine the reason not screened.

2 Other reasons member not screened include: MCO attempts to reach the member are still in progress, the MCO could not reach the member, or the member pregnancy ended for any reason. Additionally, several MCOs later communicated they could not initiate outreach to the full pilot population due to the short pilot period.

Table B-2. Percentage of Medicaid Pregnant Women with Positive Screening Results During the Pilot, Based on Non-Medical Need and Wanting Help with that Type of Need[1,2]

Type of Non-Medical Need	MCO A	MCO B	MCO C	MCO D	MCO E[3]	MCO F	MCO G	MCO H	MCO I	MCO J	MCO K
n	*34*	*145*	*197*	*70*	*3*	*163*	*59*	*259*	*37*	*131*	*61*
Food Insecurity	27%	48%	12%	31%	-	22%	44%	42%	38%	24%	69%
Want Help, Food?[4]	100%	91%	63%	36%	-	50%	46%	78%	57%	69%	67%
Transportation	24%	19%	4%	6%	-	8%	10%	14%	11%	8%	18%
Want Help, Transport?[4]	100%	93%	25%	0%	-	62%	33%	75%	50%	73%	64%
Experiencing Homelessness	0%	2%	2%	3%	-	13%	0%	4%	8%	2%	7%
Housing Insecurity	12%	6%	0%	0%	-	1%	2%	5%	5%	7%	15%
Paying Utilities	24%	7%	8%	6%	-	7%	15%	15%	5%	10%	31%
Housing Quality	3%	10%	4%	14%	-	20%	25%	13%	19%	5%	18%
Want Help, Housing?[4]	73%	57%	43%	0%	-	14%	6%	57%	56%	48%	43%
Child Care	18%	17%	25%	9%	-	17%	19%	26%	30%	18%	33%
Want Help, Child Care?[4]	100%	100%	70%	50%	-	86%	91%	90%	82%	87%	85%

Data Source: MCO pilot data June-July 2024. Analysis by HHSC-DAP.

Notes: Measure definitions for Non-Medical Needs presented in this table are included in Table B-3 below.

1 For the "Want Help" questions, some additional members asked for help but were not included in the results because the skip pattern in the non-medical needs screening questions was not enforced: for "Want Help, Food?", 17 additional members; for "Want Help, Transport?", 35 additional members; for "Want Help, Child Care?", 5 additional members.

2 If a member had multiple records (e.g., was included in multiple months) and the member completed the screening, HHSC kept the record with screening data. If a member had two screenings HHSC used the most recent one. Records that listed "Medicaid not Primary" as the reason screening was not completed were excluded.

3 Indicates data are suppressed due to small numbers.

4 The denominator for the "Want Help" questions reflects the number of people with a positive screening result for the relevant non-medical need and varies by non-medical need and MCO. Table B-3 below presents the measure definitions for each "Want Help" question.

Table B-3. Measure Definitions for Non-Medical Needs and Wanting Help

Type of Non-Medical Need	Numerator	Denominator
Food Insecurity	Members who responded, "Often true" or "Sometimes true" to "Within the past 12 months, you worried that your food would run out before you got money to buy more." or "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."	Number of members with a completed screening
Want Help, Food?	Members who responded "yes" to wanting help for food	Members who responded, "Often true" or "Sometimes true" to "Within the past 12 months, you worried that your food would run out before you got money to buy more." or "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."
Transportation	Members who responded "yes" to "Within the past 12 months, has a lack of reliable transportation kept you from medical appointments or getting medications?" or "Within the past 12 months, has a lack of reliable transportation kept you from doing things you need to do, such as grocery shopping or getting to work or school?"	Number of members with a completed screening
Want Help, Transport?	Members who responded "yes" to wanting help for transportation	Members who responded "yes" to "Within the past 12 months, has a lack of reliable transportation kept you from medical appointments or getting medications?" or "Within the past 12 months, has a lack of reliable transportation kept you from doing things you need to do, such as grocery shopping or getting to work or school?"

Type of Non-Medical Need	Numerator	Denominator
Experiencing Homelessness	Members who responded “I do not have a steady place to live. I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in the woods, in a car, abandoned building, bus or train station, or in a park” to “What is your living situation today?”	Number of members with a completed screening
Housing Insecurity	Members who responded, “I have a steady place to live today, but I’m worried about losing it in the future” to “What is your living situation today?”	Number of members with a completed screening
Paying Utilities	Members who responded “yes” to “Do you have problems paying for utilities, such as electricity, gas, heat, air conditioning or water?”	Number of members with a completed screening
Housing Quality	Members who responded “yes” to at least one of the questions about housing quality, including utilities not working (such as electricity, gas, heat, air conditioning or water), problems with pests like bugs or mice, problems with mold, problems with lead paint or pipes, or problems with smoke or carbon monoxide detectors missing or not working.	Number of members with a completed screening
Want Help, Housing?	Members who responded “yes” to wanting help for housing	Members who responded "I have a steady place to live today, but I’m worried about losing it in the future" or "I do not have a steady place to live. I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in the woods, in a car, abandoned building, bus or train station, or in a park." to "What is your living situation today?" or "yes" to any of the other housing-related questions in the housing section of the screening.
Child Care	Members who responded “yes” to “In the next 12 months, will you need help finding or paying for child care?”	Number of members with a completed screening

Type of Non-Medical Need	Numerator	Denominator
Want Help, Child Care?	Members who responded “yes” to wanting help for child care	Members who responded "yes" to "In the next 12 months, will you need help finding or paying for child care?"

Appendix C. Methods for Measuring Medicaid Target Population and Outcomes

Study Population

HHSC used guidelines developed by the Centers for Medicare and Medicaid Services (CMS) to identify pregnant Medicaid members. The CMS guidelines included diagnosis, revenue, and procedure code sets that were used to categorize pregnancy-related outcomes, such as live birth, stillbirth, or pregnancy loss (e.g., miscarriage or ectopic pregnancy). HHSC further processed these data to determine the number of pregnancy episodes ending during the state fiscal year. To obtain the most accurate date of the pregnancy outcome, pregnancy episodes were verified against infant dates of birth via linkages in the HHSC master data repository (MDR) relationships table. For pregnancy episodes that did not result in a live birth, the date of the pregnancy outcome is based on the date of service from the earliest claim or encounter indicating a pregnancy may have ended. The final sample includes Medicaid managed care members who were pregnant in either state fiscal year 2022 or 2023. Members were excluded if they had more than one pregnancy outcome in state fiscal year 2023; did not have pregnancy outcome in state fiscal year 2023; did not have an enrollment record during the month and year of the pregnancy outcome; were not enrolled in managed care during calendar year 2022-2023; were enrolled in partial benefit Medicaid (e.g. Emergency Medicaid [TP30]); or had conflicting or implausible pregnancy outcomes. Demographic characteristics, including age and county of residence, were based on the enrollment record for the month in which the pregnancy outcome occurred.

Race and ethnicity are optional fields on the eligibility application for state benefits and not all Medicaid members provide this information. Additionally, applicants are allowed to mark one or more race categories. This report uses race categories for pregnant Medicaid members that are based on definitions used by Texas's External Quality Review Organization for standardized federal reporting. These categories also align with race and ethnicity data reported by MCOs for the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set, as well as the required data fields in the text file layout for the non-medical needs screening questions.

The Medicaid newborn population for state fiscal year 2023 is defined as newborns who were born in state fiscal year 2023 to Medicaid managed care members who

were pregnant in either state fiscal year 2022 or 2023. The newborn population includes multiple births (e.g., twins). Newborn-related measures are based on Medicaid claims and encounters up to 28 days after birth.

Data Sources

Member-level Enrollment Files

TIERS is the HHSC system of record for member-level enrollment files. It utilizes an integrated application to determine the eligibility status of people applying for or currently receiving services through HHSC programs. Monthly member-level enrollment files contain information about the person's age, sex, race and ethnicity, county, health care service delivery model (i.e., FFS or managed care), MCO enrollment, and length of enrollment. These data are used to identify members and member-level subgroups. Member-level enrollment files are subject to an approximate eight-month time lag. For documentation describing the data sources and methodology used to pull TIERS-derived data, see Table C-1.

Medicaid Claims and Encounters

HHSC contracts with Texas Medicaid and Healthcare Partnership to maintain claims and encounters data for services provided to Texans participating in Medicaid. From these data, HHSC can identify people who were diagnosed with particular conditions.

Claims and encounter data have been processed by Texas Medicaid and Healthcare Partnership since January 1, 2004. Texas Medicaid and Healthcare Partnership performs internal edits for data quality and completeness. The member-level claims/encounter data contain the Current Procedural Terminology codes; the ICD-10-CM codes; place of service codes; and other information necessary to calculate outcome measures. Claims and encounter data are adjudicated on an approximate eight-month time lag. Prior analyses with Texas data have shown that, on average, over 96 percent of the claims and encounters are complete by that timeframe.

Master Data Repository

HHSC's Enterprise Data Governance team has developed a tool for matching and merging multiple member eligibility records from TIERS to determine the most accurate information for a person and storing that record in an MDR. The data mastering process uses identifiers such as a person's name, birth date, home

address, phone number, and social security number to create one individual record for members that may participate in different programs in the TIERS database. In addition, a person's relationship to another person (e.g., mother and infant relationship) in TIERS can be identified through the mastering process. The MDR was used to support the identification of mother-infant relationships and classify pregnancy-related outcomes, such as a live birth, to improve the validity of measures used in this report.

Table C-1. TIERS Documentation

Data Elements	TIERS Documentation
Members' County, Managed Care Plan, and Program	**Data Sources:** elig.E8Mnth_All_201101_202312 **Filters/Constraints:** elig_date >=202209 and elig_date <=202308 and sex = 'F' and (10 <= age <= 60); **Query date:** July 2024 **Prepared By:** Health Program Outcomes and Epidemiology (HPOE), DAP, HHSC, July 2024
Race and Ethnicity	**Data Sources:** dm.DM_MED_TF_Client_EOM_SFY23_27 **Filters/Constraints:** where 1962<=year(dob_dt)<=2013 and (gender_cd='F') **Query date:** July 2024 **Prepared By:** HPOE, DAP, HHSC, July 2024.
MDR	**Data Sources:** DC_INDV, DC_RELATIONSHIPS. **Filters/Constraints:** where (DC_INDV.FILE_CLEARANCE_SW = 'Y') and (DC_INDV.INACTIVE_IND = 'N') and (DC_INDV.DELETE_SW = 'N') and (CV_DC_MCI_INDV.INACTIVE_IND='N') and (DC_RELATIONSHIPS.EFF_END_DT is null) and child_birth_date between 01-Sep-2022 and 07-Jun-2024 **Query date:** July 2024 **Prepared By:** Master Data Management-Enterprise Information Management and HPOE, DAP, HHSC, July 2024.

Measure Definitions

Codes for Identifying Pregnancies and Pregnancy Outcomes

Pregnancy outcomes are based on claims or encounters for services provided to pregnant members in Medicaid managed care. Table C-2 contains the diagnosis, revenue, and procedure codes used to determine pregnancy outcomes. Diagnoses

were based on codes in the first five diagnosis positions on any paid inpatient or outpatient claim or encounter.

Table C-2. Pregnancy Outcomes

Codes	Description
ICD-10-CM diagnosis codes: O80, Z370, Z372, Z373*, Z375-Z376, Z38 Linkage to a Medicaid-enrolled infant having a birthdate matching the estimated date of delivery.	Delivery, live birth
ICD-10-CM diagnosis codes: Z371, Z373*, Z374, Z376*, Z377	Delivery, stillbirth
ICD-10-CM diagnosis codes: O1002-O165**, O2402-O2493**, O252-O2673**, O4200-O4212, O6010X0-O779, O82-O85, O860, O8611-O879, O8802-O899**, O900-O902, O904, O905-O906, O9081-O99892**, O9A12-O9A53**, Z379, Z390, Z392 Revenue codes: 720-724, 729 Procedure codes: 59160, 59200, 59300, 59350, 59400, 59409, 59410, 59414, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 ICD-10-PCS: 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10D17ZZ, 10D18ZZ, 10E0XZZ, 10S07ZZ, 10S0XZZ	Delivery, live/still unspecified
ICD-10-CM diagnosis codes: O0000-O089, O3100X0- O3133X9, O364XX0-O364XX9, Z332 Procedure codes: 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870 ICD-10-PCS: 10A00ZZ, 10A03ZZ, 10A04ZZ, 10A07Z6, 10A07ZW, 10A07ZX, 10A07ZZ, 10A08ZZ, 10D27ZZ, 10D28ZZ, 10J20ZZ, 10J23ZZ, 10J24ZZ, 10J27ZZ, 10J28ZZ, 10J2XZZ, 10S20ZZ, 10S23ZZ, 10S24ZZ, 10S27ZZ, 10S28ZZ, 10T20ZZ, 10T23ZZ, 10T24ZZ, 10T27ZZ, 10T28ZZ	No delivery, pregnancy loss

* ICD-10-CM codes Z373 and Z376 indicate a multiple pregnancy (e.g., twins, triplets, etc.) with different birth outcomes for infants in the same pregnancy (e.g., one live birth and one stillbirth). Medicaid members with one of these diagnosis codes will be categorized as having a live birth only if they have been matched to a Medicaid-enrolled infant.

** ICD-10-CM codes within these ranges include information on the timing of the condition or complication. The "Delivery, live/still unspecified" category only includes members with codes indicating the timing of the condition was during childbirth or the puerperium. In other words, if the condition occurred in the first, second, or third or unspecified trimester it would be excluded.

Codes for Prenatal Risk Factors

Risk factors during pregnancy are based on diagnoses that occurred up to 220 days before the date of pregnancy outcome. Table C-3 through Table C-5 contain the ICD-10 diagnosis codes used to identify prenatal risk factors, mental health conditions, and SUDs in the Medicaid pregnant population. Diagnoses were based on codes in any position on any paid inpatient or outpatient claim or encounter.

Table C-3. Prenatal Risk Factors

ICD-10-CM Codes	Description
D50-D64	Anemia
O240, O241, O243, O244	Gestational diabetes
O13	Gestational hypertension
O432, O441, O443, O445, O45, O46, O72	Hemorrhage
E66, Z6825-Z6839, Z6841-Z6845, Z6853, Z6854	Overweight and obesity
O11, O14	Preeclampsia

Table C-4. Mental Health Conditions

ICD-10-CM Codes	Description
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99-F99	Unspecified mental disorder

Table C-5. SUDs

ICD-10-CM Codes	Description
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F10	Alcohol related disorders
F11	Opioid related disorders
F12	Cannabis related disorders
F13	Sedative, hypnotic, or anxiolytic related disorders
F14	Cocaine related disorders
F15	Other stimulant related disorders
F16	Hallucinogen related disorders
F17	Nicotine dependence
F18	Inhalant related disorders
F19	Other psychoactive substance related disorders
F10-F16, F18-19	Mental and behavioral disorders due to psychoactive substance use, excluding nicotine dependence

Codes for Newborn Measures

Infant outcomes are based on claims or encounters with a date of service occurring within the first 28 days of life. Diagnoses were based on codes in any position on any paid inpatient or outpatient claim or encounter.

Table C-6. Codes for Newborn Conditions

Codes	Description
ICD-10-CM diagnosis codes: P0501-P0508, P0511-P0518, P0700-P0703, P0710-P0718 APR-DRG codes: 5881-5884, 5891-5894, 5911-5914, 5931-5934, 6021-6024, 6031-6034, 6071-6074, 6081-6084, 6091-6094, 6111-6114, 6121-6124, 6131-6134, 6141-6144, 6211-6214, 6221-6224, 6231-6234, 6251-6254, 6261-6264	Low Birth Weight
ICD-10-CM diagnosis codes: P0720-P0726, P0730-P0739 APR-DRG codes: 5891-5894 MS-DRG codes: 790, 791, 792	Preterm
Revenue codes: 174-175 Procedure codes: 99295-99300, 99468-99469, 99471-99472, 99477-99480	NICU

Appendix D. County Type Definitions

This report categorizes each Texas county into a metro, micro, or rural county type. Table D-1 lists the population and density parameters applied to determine county type designations. A county must meet both the population and density thresholds for inclusion in a given county type designation. Any of the population density combinations listed for a given county type designation may be met for inclusion within that county type designation. Annually, CMS applies these parameters to the most recently available U.S. Census Bureau population estimates to determine appropriate county type designations.

The county of residence was selected based on where the member resided at the time of the pregnancy outcome.

Table D-1. County Type Designations

County Type	Population	Density (persons per square mile)
Metro	≥ 1,000,000	≥ 1,000
Metro	500,000 – 999,999	≥ 1,500
Metro	Any	≥5,000
Metro	≥ 1,000,000	10 – 999.9
Metro	500,000 – 999,999	10 –1,499.9
Metro	200,000 – 499,999	10 – 4,999.9
Metro	50,000 – 199,999	100 – 4,999.9
Metro	10,000 – 49,999	1,000 – 4,999.9
Micro	50,000 – 199,999	10 – 99.9
Micro	10,000 – 49,999	50 – 999.9
Rural	10,000 – 49,999	10 – 49.9
Rural	<10,000	10 – 4,999.9
Rural	Any	<10

Source: Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (A CMS Rule on June 2, 2020).

Table D-2. County Names by County Type

County type	Counties
Metro	Angelina, Bell, Bexar, Bowie, Brazoria, Brazos, Cameron, Collin, Comal, Dallas, Denton, Ector, El Paso, Ellis, Fort Bend, Galveston, Grayson, Gregg, Guadalupe, Harris, Hays, Hidalgo, Hood, Hunt, Jefferson, Johnson, Kaufman, Lubbock, McLennan, Midland, Montgomery, Nueces, Orange, Parker, Potter, Randall, Rockwall, Smith, Tarrant, Taylor, Travis, Victoria, Webb, Wichita, Williamson
Micro	Anderson, Aransas, Bastrop, Caldwell, Camp, Chambers, Cherokee, Coryell, Hardin, Harrison, Henderson, Kendall, Kerr, Lamar, Liberty, Maverick, Morris, Nacogdoches, Rusk, San Patricio, Starr, Titus, Tom Green, Upshur, Van Zandt, Walker, Waller, Washington, Wilson, Wise, Wood
Rural	Andrews, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Baylor, Bee, Blanco, Borden, Bosque, Brewster, Briscoe, Brooks, Brown, Burleson, Burnet, Calhoun, Callahan, Carson, Cass, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Delta, DeWitt, Dickens, Dimmit, Donley, Duval, Eastland, Edwards, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Franklin, Freestone, Frio, Gaines, Garza, Gillespie, Glasscock, Goliad, Gonzales, Gray, Grimes, Hale, Hall, Hamilton, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hill, Hockley, Hopkins, Houston, Howard, Hudspeth, Hutchinson, Irion, Jack, Jackson, Jasper, Jeff Davis, Jim Hogg, Jim Wells, Jones, Karnes, Kennedy, Kent, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamb, Lampasas, Lavaca, Lee, Leon, Limestone, Lipscomb, Live Oak, Llano, Loving, Lynn, Madison, Marion, Martin, Mason, Matagorda, McCulloch, McMullen, Medina, Menard, Milam, Mills, Mitchell, Montague, Moore, Motley, Navarro, Newton, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Polk, Presidio, Rains, Reagan, Real, Red River, Reeves, Refugio, Roberts, Robertson, Runnels, Sabine, San Augustine, San Jacinto, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Terrell, Terry, Throckmorton, Trinity, Tyler, Upton, Uvalde, Val Verde, Ward, Wharton, Wheeler, Wilbarger, Willacy, Winkler, Yoakum, Young, Zapata, Zavala

Appendix E. Demographic Data for Pregnant Women Receiving TTF Services

Table E-1 through Table E-3 shows the number of TTF services pregnant women received through counseling or mentoring, educational materials, and classes.

Table E-1. Race/Ethnicity of Pregnant Women Receiving TTF Counseling/Mentoring Services, SFY 2023

Race/Ethnicity	Pregnancy	Parenting	Adoption	Life Skills	Employment Readiness
Total	**74,139**	**14,744**	**15,621**	**52,601**	**21,786**
White	15,770	2,788	2,956	12,097	4,416
Black or African American	21,241	4,261	4,030	12,550	5,747
American Indian or Alaska Native	417	57	105	291	115
Asian or Pacific Islander	2,031	444	431	1,224	516
Hispanic or Latino	33,074	6,837	7,891	26,329	10,946
Other	1,051	258	130	80	27
Refused to Answer	555	99	78	30	19

Data Source: Excel Workbooks provided by service providers and subcontractors. Analysis by HHSC-TTF.

Table E-2. Race/Ethnicity of Pregnant Women Receiving TTF Educational Materials, SFY 2023

Race/Ethnicity	Pregnancy	Parenting	Adoption	Life Skills	Employment Readiness
Total	**58,294**	**22,565**	**16,040**	**62,719**	**21,829**
White	13,111	3,872	3,024	13,617	4,419
Black or African American	14,676	5,727	4,208	14,473	5,683
American Indian or Alaska Native	339	92	106	338	117
Asian or Pacific Islander	1,509	629	452	1,472	514
Hispanic or Latino	28,221	11,934	8,017	32,745	11,076
Other	293	214	148	47	11
Refused to Answer	145	97	85	27	9

Data Source: Excel Workbooks provided by service providers and subcontractors. Analysis by HHSC-TTF.

Table E-3. Race/Ethnicity of Pregnant Women Receiving TTF Classes, SFY 2023

Race/Ethnicity	Pregnancy	Parenting	Adoption	Life Skills	Employment Readiness
Total	**3,781**	**9,044**	**13**	**11,587**	**432**
White	715	1,216	4	1,720	46
Black or African American	1,023	2,030	5	2,597	129
American Indian or Alaska Native	25	35	-	52	1
Asian or Pacific Islander	93	223	1	279	3
Hispanic or Latino	1,862	5,525	3	6,913	250
Other	57	12	-	21	3
Refused to Answer	6	3	-	5	-

Data Source: Excel Workbooks provided by service providers and subcontractors. Analysis by HHSC-TTF.