State Efforts to Address Postpartum Depression, Maternal Mortality and Morbidity in Texas

As Required by

Health and Safety Code, Sections

34.0155 and 34.0158

Texas Health and Human Services

Commission

December 2020

TEXAS
Health and Human Services

Table of Contents

Executive Summary

The *State Efforts to Address Postpartum Depression, Maternal Mortality and Morbidity in Texas* report is submitted in accordance with Senate Bill (S.B.) 17, 85th Legislature, First Called Session, 2017, and S.B. 748, 86th Legislature, Regular Session, 2019.

S.B. 17 requires the Health and Human Services Commission (HHSC), to evaluate options for reducing pregnancy-related deaths and for treating postpartum depression (PPD) in economically disadvantaged women. HHSC, in coordination with the Department of State Health Services (DSHS) and the Texas Maternal Mortality and Morbidity Review Committee (MMMRC), is required to identify strategies to lower the costs of providing medical assistance in the state's Medicaid program related to severe maternal morbidity and chronic illness, and to improve quality outcomes related to the underlying causes of severe maternal morbidity and chronic illness.

S.B. 748 requires HHSC to report on actions taken to address maternal morbidity and reduce maternal mortality rates, including information from various programs and initiatives, including Medicaid, the children's health insurance program, the perinatal program, the Healthy Texas Women (HTW) program, the Family Planning Program, the program under the Maternal and Child Health Services Block Grant Act (42 U.S.C. Section 701 et seq.), the Perinatal Advisory Council, and the Healthy Texas Babies program. The report must also include a summary of the initiatives of state health plans, which includes efforts administered through the Employee Retirement System (ERS), the Teachers Retirement System (TRS), and the Texas Department of Criminal Justice (TDCJ).

Improving maternal health and addressing the causes of maternal mortality and morbidity are a priority for HHS. To provide a comprehensive picture of efforts across the Texas Health and Human Services (HHS) system, this report presents an all-encompassing overview of HHS strategies, programs, and initiatives to reduce maternal mortality and morbidity, outlining efforts responsive to both S.B. 17 and S.B. 748 coordinated across programs and agencies. In accordance with Health and Safety Code Sections 34.0155 and 34.0158, this report summarizes HHS strategies to reduce pregnancy-related deaths, address PPD, lower Medicaid costs related to severe maternal morbidity, and improve quality outcomes related to the underlying causes of maternal mortality and morbidity.

A review of current data in this report demonstrates key areas where Texas needs to focus efforts to improve maternal health outcomes. Medicaid pays for more than half of Texas births. The 2018 Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report (Joint Report) noted 68.5 percent of cases of maternal mortality in 2012 were women with Medicaid coverage at delivery. The same report also found that depression was the most frequently identified mental health condition contributing to pregnancy-related death. According to a DSHS analysis of Texas Pregnancy Risk Assessment Monitoring System combined 2014-2016 data, the prevalence of PPD within six months of delivery in Texas was approximately 14 percent, which is higher than the national average of 12.5 percent. The 2019 Healthy Texas Mothers and Babies Data Book noted the following:

- Substantial race and ethnic disparities exist for maternal health indicators, including rates of preterm birth, maternal mortality, and severe maternal morbidity, and Non-Hispanic Black mothers have significantly higher rates of each of these adverse health outcomes than do other race and ethnic groups;
- The risk of maternal death due to drug overdose was higher for White mothers and for mothers aged 40 years or older;
- The most common causes of death among mothers during pregnancy or within 365 days postpartum were drug overdoses, cardiac events, homicides, suicides, and infections/sepsis; and
- Hypertension/eclampsia is both a leading diagnosis of severe maternal morbidity and a leading cause of maternal death for Black women.

The 2018 Joint Report concluded that most maternal deaths occur more than 60 days after delivery, emphasizing the critical need for continuity of care. This report provides an overview of state-administered programs and benefits that play a role in serving women of child-bearing age, from pre-conception health through to postpartum and inter-conception care. The report also highlights pilot programs, flexibilities leveraged for remote service delivery during the novel coronavirus disease 2019 (COVID-19) public health emergency, and advances within those programs that focus on addressing access to care to improve maternal health outcomes. Additionally, HHS has worked to implement targeted efforts to reduce pregnancy-related deaths, treat PPD, and improve quality outcomes related to the causes of maternal morbidity and chronic illness. These initiatives include:

- The implementation of the HTW Medicaid 1115 Demonstration Waiver, providing approximately $350 million in federal funding for women's health services over the five-year waiver period, ensuring that auto-enrollment into available services will continue to be an automatic process;

- The launch of an enhanced limited postpartum care services package for eligible women enrolled in Healthy Texas Women, in accordance with S.B. 750, 86th Legislature, Regular Session, 2019;
- Expedited processes for determining Medicaid eligibility for pregnant women and enrolling them in Medicaid managed care organizations (MCOs), where they have access to a comprehensive benefit package;
- Expanded services to women who are pregnant or have dependent children, and have been diagnosed with a substance use disorder;
- Participation in a five-year project that facilitates integrating prenatal and behavioral health care for women enrolled in Medicaid with opioid use disorder.
- Collaboration with Medicaid MCOs and HTW providers to develop and implement a PPD treatment network;
- Public health efforts that incorporate individual public awareness and knowledge, professional education, community empowerment, community improvement, and a network of partnerships that coordinate to drive adoption and diffusion of health care quality improvements for maternal and infant health and safety; and
- The recruitment of 219 hospitals, representing more than 98 percent of all hospitals with obstetric services in Texas, to participate in the Texas Alliance for Innovation on Maternal Health Obstetric Hemorrhage Bundle programming, supporting the implementation of evidence-based strategies to improve maternal safety and health care.

HHS will continue to coordinate and collaborate across programs and agencies to ensure a holistic, systematic approach in advancing state efforts to address PPD and maternal mortality and morbidity in Texas.

Introduction

S.B. 17 amended the Texas Health and Safety Code to add Section 34.0155, which requires HHSC to submit a written report summarizing HHS efforts to evaluate options for reducing pregnancy-related deaths and for treating PPD among economically disadvantaged women.[1] The report must focus on the most prevalent causes of pregnancy-related deaths as identified in the joint biennial report written by the MMMRC and DSHS. It must also identify strategies to:

- lower Medicaid costs related to severe maternal morbidity and chronic illness; and
- improve quality outcomes related to the underlying causes of severe maternal morbidity and chronic illness.

This report provides information on the MMMRC's activities and on DSHS' maternal health and safety initiatives. Reports on these activities are published on the DSHS Legislative Reports webpage.

S.B. 748 amends the Health and Safety Code by adding Section 34.0158, which requires HHSC to produce a written report by December 1 of each even-numbered year summarizing the actions taken to address maternal morbidity and reduce maternal mortality rates. The report must describe programs and initiatives created to address maternal morbidity and reduce maternal mortality rates Texas, including information about:

- Medicaid;
- Children's Health Insurance Program (CHIP), including CHIP Perinatal;
- The HTW program;
- The Family Planning Program (FPP);
- Texas' program under the Maternal and Child Health Services Block Grant Act;
- The Perinatal Advisory Council;
- The Healthy Texas Mothers and Babies programs; and
- State health plans managed by ERS, the TRS, and TDCJ.

Texas' efforts to address maternal mortality and morbidity involve coordinated, strategic approaches spanning multiple programs and agencies. While S.B. 17 and S.B. 748 include specific requirements, HHS' efforts while individually responsive to

[1] A "pregnancy-related death" is a death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

each statute, are inextricably linked. This combined report meets the requirements of Health and Safety Code Sections 34.0155 and 34.0158 and provides a comprehensive view of the Texas HHS initiatives and programs to support maternal health and safety, address PPD, and reduce pregnancy-related deaths and severe maternal morbidity.

Background

Addressing maternal mortality and morbidity is a critical priority of Texas HHS and the state health plans administered by the ERS, TRS, and TDCJ.

Statewide data in this report on the prevalence and causes of maternal mortality and morbidity come primarily from the following DSHS published reports.

- 2019 Healthy Texas Mothers and Babies Data Book (2019 HTMB Data Book)
- 2018 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report (2018 Joint Report)
- Texas 2017 Pregnancy Risk Assessment Monitoring System Data Book Summary (2017 PRAMS Data Book Summary)
- Texas 2016 Pregnancy Risk Assessment Monitoring System Data Book Summary (2016 PRAMS Data Book Summary)
- DSHS Legislative Brief: Investigating Maternal Mortality in Texas November 2017—Revised (DSHS 2017 Legislative Brief)
- The Role of Opioid Overdoses in Confirmed Maternal Deaths, 2012-2015 (2017 DSHS Opioid Brief)

"Maternal morbidity" is defined under Chapter 34 of the Health and Safety Code to mean a pregnancy-related health condition occurring during pregnancy, labor, or delivery or within one year of delivery or the end of a pregnancy. "Severe maternal morbidity" (SMM) is defined within the same section of the Health and Safety Code to mean maternal morbidity that constitutes a life-threatening condition.[2] SMM is closely related to maternal mortality, because it involves conditions that, if left untreated, can result in maternal mortality. Within the last decade, SMM rates across the United States have been rising, while the SMM rates in Texas have remained relatively stable from 2009 to 2018.[3]

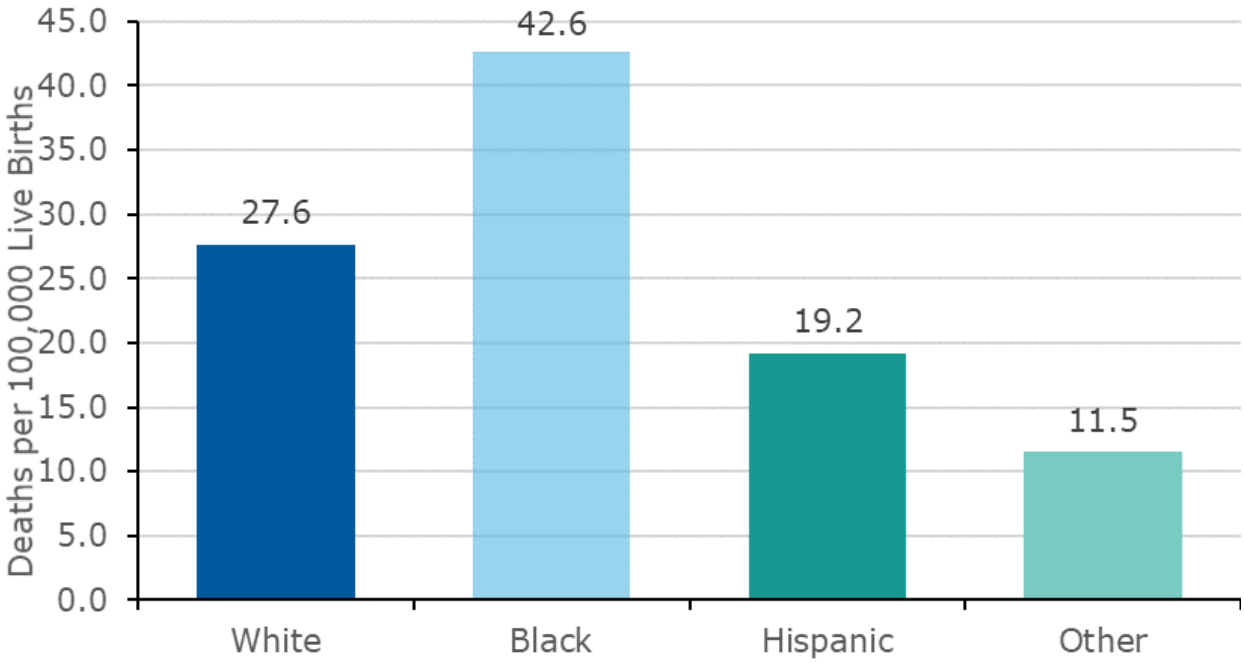
In 2018, the MMMRC (previously known as the Maternal Mortality and Morbidity Task Force) published findings that almost 80 percent of pregnancy-related deaths in Texas were determined to be preventable. As stated in the 2018 Joint Report, a death was considered "preventable" if the Review Committee found that there was at least some chance of the death being avoided by one or more reasonable

[2] Texas Health and Safety Code, Section 34.001, related to Texas Maternal Mortality and Morbidity Review Committee definitions.
[3] 2019 Healthy Texas Mothers and Babies Data Book, p. 50.

changes to the circumstances of the patient, provider, facility, systems, or community factors.[4]

The 2019 HTMB Data Book also noted that substantial race and ethnic disparities exist for maternal health indicators, including rates of preterm birth, maternal mortality, and severe maternal morbidity. Non-Hispanic Black mothers have significantly higher rates of each of these adverse health outcomes than do other race and ethnic groups.[5] The risk of maternal death due to drug overdose was higher for White mothers and for mothers aged 40 years or older.[6] In addition, geographic and regional differences were observed throughout Texas, such as the prevalence of smoking during pregnancy.

Figure 1: Rate of Confirmed Maternal Death in Texas by Race/Ethnicity, 2012-2015.[7]



Source: 2012-2015 Linked Birth, Fetal Death, and Maternal Death Files
Prepared by: Maternal & Child Health Epidemiology Unit
Dec 2018

[4] 2018 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, p. 6.
[5] 2019 Healthy Texas Mothers and Babies Data Book, p. 56.
[6] Ibid, p. 49.
[7] Ibid, p. 48.

Causes of Maternal Mortality and Morbidity

According to the 2018 Joint Report, the leading causes of pregnancy-related death in 2012, as identified by the MMMRC through comprehensive case review, included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.

According to the 2019 HTMB Data Book, between 2012 and 2015, the most common causes of death among mothers during pregnancy or within 365 days postpartum were drug overdoses (16.8 percent), cardiac events (14.4 percent), homicides (11.0 percent), suicides (8.6 percent), and infections/sepsis (8.4 percent).[8]

Almost 80 percent of maternal deaths occurred after seven days postpartum. Of these, drug overdoses were the most frequent cause of death, followed by cardiac events, homicides, and suicides. Twenty-one percent of deaths occurred during pregnancy or within seven days postpartum. Of these, the most common causes were hemorrhages, cardiac events, and amniotic embolisms.[9]

Table 1. Confirmed Maternal Deaths by Timing and Cause of Death, Texas, Over a Four-Year Period, 2012-2015.[10,11]

Cause of Death	While Pregnant	0-7 Days Postpartum	8-42 Days Postpartum	43-60 Days Postpartum	61+ Days Postpartum	Total
Drug Overdose	0	3	7	5	49	**64**
Other Causes	5	5	6	3	44	**63**

[8] 2019 Healthy Texas Mothers and Babies Data Book, p. 49
[9] DSHS Legislative Brief: Investigating Maternal Mortality in Texas November 2017—Revised, p. 2.
[10] 2018 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, p. C-1.
[11] DSHS focused data analysis on numbers and rates of maternal death while pregnant or within 365 days postpartum. To accurately identify cases of maternal death for this analysis, DSHS used only the cases where a death certificate matched either a birth or a fetal death record within one year of the woman's death (except for deaths due to motor vehicle accidents). DSHS did not review medical and autopsy records to find additional cases for this analysis, and therefore, maternal deaths identified through this method underestimate the true number of maternal deaths in Texas during this timeframe. Maternal deaths in the first half of pregnancy that are not identified by birth or fetal death certificate were not captured. Based on this process, DSHS identified 382 maternal death cases for the years 2012-2015.

Cause of Death	While Pregnant	0-7 Days Postpartum	8-42 Days Postpartum	43-60 Days Postpartum	61+ Days Postpartum	Total
Cardiac Event	2	12	9	5	27	**55**
Homicide	2	1	5	2	32	**42**
Infection/ Sepsis	1	3	14	3	11	**32**
Suicide	0	1	2	2	28	**33**
Cerebrovascular Event	0	8	9	1	9	**27**
Hemorrhage	3	12	2	0	3	**20**
Hypertension/ Eclampsia	0	7	4	0	7	**18**
Pulmonary Embolism	2	3	4	2	2	**13**
Amniotic Embolism	1	9	0	0	0	**10**
Substance Use Sequelae (e.g., liver cirrhosis)	0	0	2	0	3	**5**
Total	**16**	**64**	**64**	**23**	**215**	**382**

Substance Use

DSHS's Investigations of maternal deaths between 2012-2015 as seen in the 2017 DSHS opioid brief determined that 64 of 382 confirmed maternal deaths were due to drug overdoses. Drug overdoses accounted for the most frequent accidental cause of maternal death in Texas during the period, with almost 80 percent of these deaths occurring 60 days or more postpartum.

According to the 2017 DSHS Opioid Brief, death certificate narrative analysis revealed key facts about specific drugs involved in maternal deaths. While opioids played a significant role in confirmed maternal deaths involving drug overdoses, most deaths involved more than one drug, regardless of whether opioids were involved. Of the 64 drug overdose maternal deaths, 42 (66 percent) involved a

combination of drugs. Based on a search of death certificate narratives, opioids were detected in more than half of these maternal drug overdose deaths.[12]

Comorbidities

Women with diabetes and their infants have increased risks of a variety of complications, including infant and fetal death. While a relatively small proportion (fewer than 8 percent) of women who deliver in Texas each year have some form of hypertension, these women experience about 11 percent of all fetal and infant deaths. Additionally, these women experience a high rate of severe maternal morbidity. Hypertension/eclampsia is both a leading diagnosis within SMM and a leading cause of maternal death for Black women.[13] Obesity is a well-known risk factor for developing hypertension, diabetes, and a variety of other medical problems during pregnancy, and the proportion of mothers with a pre-pregnancy body mass index (BMI) in the obese range increased from 21.9 percent in 2009 to 28 percent in 2018.[14]

Mental Health

The 2020 Centers for Disease Control and Prevention (CDC) data brief, Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017, found mental health conditions to be a leading underlying cause of pregnancy-related death, accounting for 8.8 percent of pregnancy-related deaths.[15,16] For the purposes of this CDC maternal mortality review, mental health conditions included deaths due to suicide, overdose/poisoning, and unintentional injuries determined by a Maternal Mortality Review Committee to be related to a mental health condition.[17]

The 2018 Joint Report noted that depression was the most identified mental health condition contributing to pregnancy-related death.[18] According to a DSHS analysis of Texas PRAMS 2014-2016 data, the prevalence of PPD within six months of

---

[12] The Role of Opioid Overdoses in Confirmed Maternal Deaths, 2012-2015, p. 1

[13] 2019 Healthy Texas Mothers and Babies Data Book, p. 47.
[14] 2019 Healthy Texas Mothers and Babies Data Book, p. 42.
[15] Mental health conditions include deaths to suicide, overdose/poisoning, and unintentional injuries determined by a MMRC to be related to a mental health condition.
[16] Davis NL, Smoots AN, Goodman DA. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019.
[17] Ibid.
[18] 2018 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, p. B-5

delivery in Texas was approximately 14 percent, which is higher than the national average of 12.5 percent.

Texas Initiatives

HHS is committed to improving maternal health and preventing maternal mortality and SMM in Texas. Since the 2018 edition of this report was published, HHS has worked to implement initiatives to reduce pregnancy-related deaths, treat PPD, and improve quality outcomes related to the causes of SMM and chronic illness. These initiatives include:

- **DSHS-HHSC Women's & Children's Health Collaborative:** This is a bi-agency workgroup to guide and coordinate initiatives related to women and children. Its goal is to inform and coordinate efforts including implementation of legislation and existing programs.
- **HTW Plus:** HHSC launched an enhanced, limited postpartum care services package called HTW Plus for eligible women enrolled in HTW.
- **PPD Strategic Plan:** In collaboration with DSHS, HHSC issued a five-year strategic plan to improve access to PPD screening, referral, treatment, and support services, as required by House Bill (H.B.) 253, 86th Legislature, Regular Session, 2019.
- **Maternal Opioid Misuse Model:** Texas was one of 10 states chosen to participate in the Maternal Opioid Misuse (MOM) Model, a five-year project through the Center for Medicare and Medicaid Innovation (CMMI) that facilitates integrating prenatal and behavioral health care for women enrolled in Medicaid with opioid use disorder.
- **PPD Treatment Network:** HHSC is collaborating with Medicaid MCOs and HTW providers to develop and implement a PPD treatment network for women enrolled in Medicaid or HTW, as required by S.B. 750.
- **Public health efforts:** The DSHS HTMB Framework incorporates: 1) Individual Public Awareness and Knowledge, 2) Professional Education, 3) Community Empowerment, 4) Community Improvement, and 5) Perinatal Quality Improvement Network.

State health plan programs and initiatives include:

- **ERS HealthSelect of Texas high-risk pregnancy management:** Maternity specialists provide ongoing telephone support for pregnant women, including care coordination and management of comorbid conditions.

- **TRS Ovia Health maternal and family benefit**: Provides daily support and access to maternal health experts seven days a week. Ovia Health has an app that includes symptom tracking, clinical programs, coaching, and return to work planning.

- **TDCJ Baby and Mother Bonding Initiative**: Focuses on the bond between a mother and her baby by providing information on attachment, socialization, and psychological development. The program also aims to prepare the mother for real-life circumstances and reduce recidivism.

Efforts to Reduce Pregnancy-related Deaths and Maternal Morbidity

Medicaid

The 2018 Joint Report found that women with Medicaid coverage at delivery accounted for 68.5 percent of cases of the maternal mortality cases in 2012. Medicaid pays for more than half (53 percent) of Texas births and plays a critical role in reducing rates of maternal mortality and morbidity.[19] Medicaid has several initiatives to address maternal health throughout the pregnancy and postpartum periods.

Medicaid provides health care and long-term services and supports to low-income children and their families, pregnant women, former foster care youth, individuals with disabilities, and people age 65 and older. The majority of Medicaid in Texas (94 percent) is provided through a managed care service delivery model. The State of Texas Access Reform (STAR) managed care program serves pregnant women, low- income children, and some families. STAR constitutes 68 percent of Medicaid managed care enrollment in Texas.

To be eligible for Medicaid, individuals must:

- Live and intend to remain in Texas,
- Have a Social Security Number or apply for one,
- Be a U.S. citizen or meet alien status requirements, and
- Meet other specific requirements, which vary by program.

To be eligible for Medicaid, pregnant women must have a household income at or below 198 percent of the federal poverty level (FPL). Women who are already covered by Medicaid when they become pregnant do not need to re-apply to receive maternal care.

Medicaid covers 4.3 million Texans, and 33 percent are in the 15-64 age groups that include women of childbearing ages. In fiscal year 2019, almost 70 percent of the pregnant women in the Texas Medicaid program were between age 19 and age 29. Reflective of the overall Medicaid population, just more than half (52 percent)

[19] HHSC Financial Services Analysis 2020. Data is state fiscal year 2019.

of pregnant women receiving Medicaid are Hispanic, 23 percent are Caucasian, 19 percent are Black, and 5 percent other/unknown.[20]

In accordance with Texas Government Code Section 533.0075(4), HHSC has expedited processes for determining eligibility for pregnant women and enrolling them in Medicaid MCOs. A review of fiscal year 2018 and 2019 eligibility and enrollment data found that:

- Approximately 70 percent of pregnant women were certified as eligible within one day of application. The average waiting time is three days from application to certification.
- The average enrollment time to managed care for retroactive enrollment is 11 days and 24 days for prospective enrollment.[21]
- On average, women applied for Medicaid in their 12th week of pregnancy, or near the end of their first trimester. However, the greatest frequency (median) of applications was at six weeks gestational age.

Pregnant women maintain continuous coverage from the first day of the month in which eligibility is certified through the last day of the month in which the 60-day postpartum period ends, regardless of the birth outcome. Most changes in circumstance, such as income or household composition, do not affect their eligibility, and the women remain eligible through the end of their certification period. [22]

Texas Medicaid provides a comprehensive benefit package for pregnant clients, including an array of perinatal services aligning with the American College of Obstetricians and Gynecologists' standard practice guidelines for prenatal and postpartum care, in addition to the continuum of non-pregnancy-related benefits available to all Medicaid clients. This includes coverage of drugs needed to treat women with high-risk pregnancies or women at risk of premature delivery. The Medicaid drug formulary, which MCOs must comply with, also contains some vitamins, minerals, and home health supply products.

[20] HHSC Financial Services Analysis 2020.

[21] If eligibility is certified on or before the 10th day of the month, the managed care effective date is retroactive to the 1st of the certification month. If eligibility is certified after the 10th of the month, the managed care effective date is prospective to the 1st of the month after the certification month. Women enrolled prospectively may access services through traditional, fee-for-service Medicaid until managed care enrollment begins.

[22] Title 42 Code of Federal Regulations (CFR) Sections 435.116 and 435.170

Enhanced Prenatal Services

Prenatal care is a critical component of both maternal and child health. Over the past 10 years, timeliness in prenatal care has increased by 14 percent as managed care has become the predominant service delivery model in Texas.[23] Prenatal care identifies known correlates of maternal morbidity and mortality such as diabetes and hypertension and allows providers to educate pregnant women on how to manage their chronic diseases while pregnant. Prenatal care also allows providers to prepare for and treat high risk pregnancies as well as arrange deliveries at the appropriate level of maternal and neonatal care.

In accordance with S.B. 750, HHSC is collaborating with Medicaid MCOs to "develop and implement cost-effective, evidence-based, and enhanced prenatal services for high-risk pregnant women covered under Medicaid."

Group Prenatal Care

Texas Medicaid provides coverage for group prenatal care, which is an evidence-based model that brings pregnant women of similar gestational age together as a cohort for prenatal care with their obstetric provider. Women receive a private physical assessment with their provider and, during group sessions, women learn how to take and record their own vital signs, support each other, and gain knowledge and skills related to pregnancy, birth, and infant care.

HHSC has educated stakeholders with group care models, such as the Centering Healthcare Institute and the March of Dimes, about the Medicaid benefit. HHSC is also updating the Texas Medicaid Provider Procedures Manual obstetrics services policy to clarify coverage of group prenatal care. Currently information about the benefit resides solely in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook.* To increase provider awareness and expand access to this service for Texas Medicaid clients, policy language specific to the group prenatal care benefit will be moved to the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook*. The expected timeframe for the completion of the obstetrics services policy is spring 2021. HHSC will continue to work with stakeholders to increase awareness of group prenatal care.

Care Coordination

The first step in effective care coordination is identifying the individuals in need of services. By contract, STAR and CHIP MCOs must make a best effort to conduct an

[23] HHSC analysis comparing EQRO Quality of Care reports from 2008 and 2018.

initial health needs screening for pregnant members within 30 days of enrollment. This screening must be used to prioritize members for service management.[24] MCOs must also develop and maintain a system and procedures for identifying members with special health care needs (MSHCN), including women with high-risk pregnancies. HHSC requires MCOs to provide service management to pregnant women who:

- Are age 35 and older or 15 and younger;
- Have a diagnosis of preeclampsia, high blood pressure, or diabetes;
- Have a mental health condition or substance use disorder (SUD); or
- Had a previous pre-term birth.

As part of STAR service management, the MCOs must work with MSHCN, their health care providers, their families and, if applicable, legal guardians to develop a person-centered service plan – a seamless package of care in which primary, acute care, and specialty service needs are met, ensuring access to treatment by a multidisciplinary team when necessary.

In fiscal year 2019, there were 288,962 unique STAR members in the pregnant women risk group. Of those, 28,862 were identified by the MCOs as MSHCN.[25] From state fiscal year 2018 Quarter 1 through state fiscal year 2020 Quarter 2, pregnant MSHCN were more likely to have a service plan than other MSHCN, and more likely to have their service plan completed within a month of being identified as MSHCN.

HHSC is working to improve service management for pregnant women, including developing maternity-specific service management requirements.

Prenatal Best Practices in Medicaid Managed Care

In February 2020, HHSC surveyed the STAR MCOs to identify best practices for increasing access to and participation in prenatal care. Survey results documented that at the time of survey, every STAR MCO was communicating with pregnant members in multiple ways, including the distribution of welcome packets, making phone calls, sending letters, texts, and postcards, and through apps to educate them about the importance of scheduling and attending prenatal visits. Every MCO also has a care coordinator/case management team to work with pregnant members.

[24] Service management is the service performed or arranged by the MCO to facilitate development of a person-centered service plan and coordination of services among a member's primary care provider, specialty providers, and non-medical providers to ensure appropriate access to covered services and community supports.
[25] HHSC Center for Analytics and Decision Support, July 2020.

Individual MCOs reported some specific strategies that worked for them to increase participation in prenatal care, and these were shared with all STAR and CHIP MCOs to encourage adoption of best practices:

- Calling members when notified a member is pregnant to help them find an obstetrician if they don't already have one.
- Providing pre-authorizations to providers for ultrasounds.
- Participating in the Nurse-Family Partnership, where they review previous prenatal appointments and help women prepare for their next appointment.[26]
- Partnering with community organizations such as the March of Dimes for high-risk members needing care.
- Providing materials such as a prenatal schedule, questions for providers, notes from visits, dates of follow-up or specialist appointments, as well as a tracking log giving the mother the ability to keep track of key measures such as weight and blood pressure.
- Prompting case managers to assist members with obtaining transportation.
- Rewarding members, usually with gift cards, for attending specific prenatal appointments (some MCOs require attendance at all visits, some specify the appointments).
- Hosting baby showers for new moms to teach them about health for the mom and baby during pregnancy, the importance of dental exams and physicals, and the availability of community resources such as car seat safety and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Reviewing claims data to ensure members are attending appointments.

Maternal Health Pilot Programs

HHSC is engaged in several legislatively-directed initiatives designed to improve maternal health in Medicaid.

Maternal Teleservices

In addition to this report on efforts to reduce maternal mortality and morbidity, S.B. 748 directs HHSC to:

- evaluate the use of telemedicine services for women during pregnancy and the postpartum period,[27]

[26] Nurse-Family Partnership is a program that connects first-time mothers with nurses who specialize in maternal and child health. These nurses provide the care and support that new moms need to have healthy pregnancies and strong families.
[27] Texas Health and Safety Code Section 34.0159(8)

- conduct a study on permitting Medicaid reimbursement for prenatal and postpartum care delivered through telemedicine and telehealth,[28] and
- develop a maternal teleservices pilot program to deliver prenatal and postpartum care through teleservices for women with low-risk pregnancies.[29]

Results from HHSC analysis using data from fiscal years 2017 through 2019 demonstrate that while most pregnant women are not using teleservices to access prenatal and postpartum care, the rate of telehealth use increased, and pregnant and postpartum women are using telehealth services at higher rates than ever. In fiscal year 2019, pregnant and postpartum women used teleservices mostly for physical health, while in 2017 most women used teleservices for behavioral health only.

Teleservices have been recognized as an important tool to increase appointment attendance. The maternal teleservices pilot program will focus on increasing participation in prenatal and postpartum care and will help quantify and document adherence to regularly scheduled pregnancy-related care. Transportation and taking time away from work are two barriers cited that prevent women from keeping pregnancy-related appointments.

Teleservices can alleviate those barriers. Consistent care can prevent or catch possible health risks early in the pregnancy and during the postpartum period that are essential in reducing maternal mortality and morbidity. In accordance with S.B. 748, HHSC will publish a report on this pilot project by January 1, 2021.

Pregnancy Medical Homes

S.B. 748 also directed HHSC to implement a pregnancy medical home pilot program to provide coordinated, evidence-based maternity care management.[30]

Under the Patient-Centered Medical Home, medical practices provide ongoing, team-based, coordinated care for the health, maintenance, and acute and chronic health care needs of their patients. [31] This model emphasizes the need for effective care coordination through a team-based, patient-centered approach, with a focus

[28] Texas Government Code Section 531.02163
[29] Texas Health and Safety Code Section 34.020
[30] Texas Government Code Section 531.0996

[31] American College of Obstetricians and Gynecologists. (2018, August). *Committee Opinion Number 744: Value-based payments in obstetrics and gynecology*. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/08/value-based-payments-in-obstetrics-and-gynecology

on patient engagement in self-management, collaboration with community support, and population health management.

Patient-centered medical homes operate in a variety of practice models, including multispecialty group practices, integrated health care systems, and community practice centers, but are most frequently led by a physician team.[32] In recent years, this model has been adapted for use in the perinatal population and classified as the pregnancy medical home (PMH), with obstetric care provided by physicians, nurse practitioners, physician assistants, and midwives. Integrated additional services are provided by a variety of specialists, with pediatric, behavioral health, dental, optometry, pharmacy and laboratory, and maternal-fetal medicine services embedded in the clinic. PMH models have shown improved perinatal outcomes demonstrated by decreased emergency department utilization, and lower rates of cesarean deliveries and neonatal intensive care unit admissions.

Texas Medicaid's Pregnancy Medical Home Pilot seeks to provide coordinated, evidence-based maternity care through maternity management teams consisting of physicians, physician assistants, certified nurse midwives, nurse practitioners, and social workers. The maternity management team will conduct a pregnancy risk assessment for each woman in the pilot, develop an individual pregnancy care plan, and follow the woman throughout her pregnancy to reduce poor maternal and infant health outcomes. In accordance with S.B. 748, HHSC will publish a report on this pilot program by January 1, 2021.

Transportation

Medicaid clients, providers, and MCOs cite lack of transportation as the biggest barrier to keeping medical appointments, especially given the volume and frequency of medical appointments needed for prenatal and postpartum care. The number of medical appointments increases for high risk women with complications during the pregnancy and postpartum period.

H.B. 25, 86th Legislature, Regular Session, 2019 directs HHSC to develop and implement a pilot program for providing medical transportation program services to pregnant women and new mothers.[33] The pilot program allows a pregnant woman enrolled in STAR to bring her children with her when using nonemergency medical transportation (NEMT) services, a flexibility which is not currently permitted. In accordance with federal regulations, Medicaid reimbursement is only available for NEMT services provided to an individual traveling to a health care service, with

[32] Ibid.
[33] Texas Government Code Section 531.024141

limited exceptions such as a medically necessary attendant or a parent accompanying a child.[34] For some women, this creates a barrier to accessing needed healthcare while pregnant and after delivery.

The pilot's purpose is to determine whether a woman's ability to bring her children with her when using NEMT services decreases the rate of missed appointments for covered health services. HHSC's evaluation of the pilot will seek to identify any increases in access to prenatal and postpartum health care services and reductions in pregnancy-related complications.

Using data beginning September 1, 2020, HHSC will evaluate the pilot for cost-effectiveness and whether it improves the efficiency and quality of services provided under the Medical Transportation Program.

Maternal Opioid Misuse Model

The 2018 Joint Report recommends integrated care models combining physical and behavioral health services for women and families, while also identifying the need for models of integrated maternal healthcare services and services for women with SUDs and mental health conditions that have insurance coverage for these services.

S.B. 750 directed HHSC to apply to the Centers for Medicare and Medicaid Services (CMS) for available federal money to implement a model that improves quality and accessibility of care for pregnant women with opioid use disorder (OUD) enrolled in Medicaid during the prenatal and postpartum periods and their children after birth. In May 2019, HHSC applied for the MOM Model, a five-year project through the CMS Center for Medicare and Medicaid Innovation that facilitates integrating prenatal and behavioral health care for women with OUD who are enrolled in Medicaid.

Texas was one of 10 states selected by CMS to receive MOM Model funding, with the goal to improve quality of care for pregnant and postpartum women with OUD while reducing costs, expanding access to and service-delivery capacity of integrated care, and creating sustainable coverage and payment strategies that support integration of care.

The five-year cooperative funding agreement will allow Texas to receive up to $5 million in federal funds over the project period, based on performance and availability of funding to combat the opioid crisis. HHSC partnered with Houston's Harris Health System, Baylor College of Medicine, and the Santa Maria Hostel chemical dependency treatment facility to implement the MOM Model. These

[34] 42 CFR 431.53 Assurance of transportation.

providers will begin enrolling women into the MOM Model in July 2021. The MOM Model will be housed within an existing clinic at Harris Health's Ben Taub Hospital, where a multidisciplinary clinic will provide integration of obstetrics and neonatology, anesthesia, psychiatry, addiction medicine, and peer support into a singular setting.

Children's Health Insurance Program (CHIP)

CHIP provides health care to children, teenagers, and young adults who are not eligible for Medicaid based on their family's income but whose family cannot afford to buy private health insurance. Texans who apply for benefits and do not qualify for Medicaid are automatically evaluated for CHIP eligibility. CHIP constitutes 9 percent of the enrollment in managed care programs in Texas.

CHIP Perinatal services are for the unborn children of uninsured pregnant women who do not qualify for Medicaid due to income or immigration status. Additionally, to qualify for CHIP Perinatal, pregnant women must have an income at or below 202 percent of the FPL. About 99 percent of CHIP Perinatal members are at or below 198 percent of the FPL.[35] In 2017, CHIP Perinatal constituted 10 percent of pregnant women served by Medicaid and CHIP. CHIP Perinatal covers prenatal visits and related services for the unborn child and two postpartum visits conducted within 60 days after the end of the pregnancy.

For CHIP Perinatal clients at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid, which covers only her labor and delivery. If the mother's labor and delivery are covered by Emergency Medicaid, her CHIP Perinatal newborn receives 12 months of continuous Medicaid coverage from the date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL and at or below 202 percent of the FPL remain in CHIP Perinatal and receive comprehensive CHIP benefits from their date of birth through the remainder of the 12-month coverage period.

Healthy Texas Women Program

HHSC implemented HTW in 2016 to provide access to core women's health and family planning services at no cost to low-income women, with the goal of positively impacting women's health, including maternal and reproductive health. HTW accomplishes this by offering a robust array of services including family

[35] HHSC Financial Services Analysis 2020. Data is state fiscal year 2019.

planning services, screenings and pharmaceutical treatment for hypertension, diabetes, high cholesterol, and postpartum depression, providing immunizations, and providing breast and cervical cancer screenings and diagnostic services.

Reproductive health benefits include preconception counseling, pregnancy tests, pelvic examinations, and Pap tests, contraceptive services including long-acting reversible contraceptive (LARC) products and sterilization, screening and treatment for sexually transmitted infections, and cervical dysplasia treatment.

These services are foundational to unintended pregnancy prevention, early cancer detection, and maternal mortality reduction.

To qualify for HTW, a woman must be between the ages of 15 and 45, not be eligible for other program benefits, not be pregnant, not have any other health care coverage, and have a household income at or below 200 percent of the FPL. Women ages 15 through 17 must have a parent or legal guardian apply, renew, and report changes on their behalf.

The 2018 Joint Report's conclusion that a majority of maternal deaths occur more than 60 days after delivery makes continuity of care crucial. Eligible women are automatically enrolled into HTW when their Medicaid for Pregnant Women coverage ends. Continuous care provides for the management of chronic conditions like diabetes and hypertension, ensures treatment for identified or emergent postpartum complications, and maintains critical mental health services at a vulnerable time, with the ultimate goal of achieving better health outcomes for both the mother and child.

During fiscal year 2019, a total of 83,805 women were auto-enrolled into HTW from Medicaid for Pregnant Women. Total client enrollment grew 16.2 percent in fiscal year 2019, from 255,571 women in September 2018 to 296,959 women in August 2019. In fiscal year 2019, the average monthly enrollment in HTW was 279,671.

1115 Demonstration Waiver

On January 22, 2020, CMS approved the HTW Medicaid 1115 Demonstration Waiver for a five-year period ending December 31, 2024. The waiver approval does not change the HTW program, but it allows Texas to receive federal funding for women ages 18-44 at a 90 percent matching rate for HTW family planning services and at the regular Medicaid match rate for other pre-conception services such as preventive health screenings. Texas will receive approximately $350 million in federal funding for women's health services over the five-year waiver period. Previously the HTW program was funded solely through state general revenue.

Teens 15-17 years old who have a parent or guardian apply on their behalf are still covered for the same benefit package with state general revenue.

Most eligibility criteria for HTW remains the same. However, the HTW Medicaid 1115 Demonstration Waiver requires the use of Modified Adjusted Gross Income (MAGI) methodologies to determine the woman's household composition and financial eligibility for the program. MAGI methodologies are the same procedures used to determine financial eligibility for Medicaid for children, pregnant women, and parents and caretaker relatives. Additionally, women applying for HTW will now need to be determined ineligible for full Medicaid and CHIP before being determined eligible for HTW. This eligibility determination will be similar to what currently happens when a child is determined ineligible for Medicaid before being determined eligible for CHIP.

The HTW Medicaid 1115 Waiver also slightly changes the enrollment process for women transitioning from Medicaid for Pregnant Women to HTW. When the waiver is fully implemented, financial eligibility will be reviewed before the woman is enrolled into HTW. It is not anticipated that reviewing financial eligibility will cause challenges for women transitioning from Medicaid for Pregnant Women to HTW or reduce enrollment. From the woman's perspective, enrollment into HTW when Medicaid for Pregnant Women ends will continue to be an automatic process. Women will not need to complete a new application and will only be contacted if HHSC cannot verify eligibility criteria through electronic data sources.

Improved Communications

S.B. 2132, 86th Legislature, Regular Session, 2019, required HHSC to provide more information about HTW, including services provided, when women are auto-enrolled in HTW.[36] HHSC mails two letters to women auto-enrolling in HTW:

- Enrollment notification; and
- Information about how to withdraw from the HTW program and how to provide a confidential mailing address to HHSC for HTW correspondence.

In June 2020, HHSC added standard language to the letters about HTW, why a woman was enrolled, the services provided at no cost, how to find a provider or see if her current provider accepts HTW, and directions to the HealthyTexasWomen.org website for additional information.

[36] Government Code Section 531.0995

Continuity of Care

S.B. 750 directs HHSC to implement strategies to ensure continuity of care for women who transition from Medicaid to the HTW program.[37]

HHSC is working to identify HTW providers on the list of enrolled providers sent to Medicaid and CHIP MCOs. This will enable MCOs to connect members with HTW providers in their network so women can continue seeing those same providers after Medicaid and CHIP coverage ends, including for women auto-enrolled into HTW.

Based on findings and recommendations from Year 1 of the Texas Collaborative for Healthy Mothers and Babies (TCHMB) Postpartum Access to Healthcare (PATH) project,[38] HHSC is working with the TCHMB to create a worksheet for providers to clarify eligibility criteria and covered services in the Medicaid, CHIP, HTW, and the FPP,[39] as well as when and how women transition among those programs. This reference guide is intended for providers to help women navigate program transitions and improve continuity of care.

In addition, HHSC issued a request for information (RFI) to solicit feedback to identify and inform how best to ensure continuity of care from stakeholders such as people delivering or receiving care. The RFI was posted on the Electronic State Business Daily for 30 days from September 28, 2020 to October 28, 2020. HHSC is currently analyzing RFI responses to identify additional continuity of care strategies.

Healthy Texas Women Plus

S.B. 750 directed HHSC to evaluate postpartum care services provided to women enrolled in the HTW program after the first 60 days of the postpartum period and develop and implement an enhanced, cost-effective, focused postpartum services package.[40] HTW Plus implemented September 1, 2020 and provides enhanced postpartum services to women enrolled in HTW who were pregnant in the past year.

---

[37] Health and Safety Code Section 32.153
[38] Nehme E, Patel D, Cortez D, Gulbas L, Lakey D. (2020) Increasing Access to Healthcare Coverage for Uninsured, Postpartum Women in Texas: A Report from the Postpartum Access to Healthcare (PATH) Project. Austin, TX: The University of Texas System/Texas Collaborative for Healthy Mothers and Babies. https://static1.squarespace.com/static/595a4df159cc68d0978dfb9e/t/5ed6ac0c1e04677c30183e03/1591127056689/TCHMB-PATH-report-May2020.pdf
[39] The Family Planning Program is explained in detail on p. 23.
[40] Health and Safety Code Section 32.153

To qualify for HTW Plus services, a woman must meet all HTW eligibility requirements, have been pregnant in the 12 months prior to enrollment, and be between the ages of 18-44. This includes women who were automatically enrolled following Medicaid for Pregnant Women coverage, as well as women who apply for HTW coverage and indicate on the application that they were pregnant in the past year. Eligible women whose automatic enrollment into HTW has been delayed due to extended Medicaid for Pregnant Women coverage during the COVID-19 public health emergency will be able to receive HTW Plus services for the first 12 months of HTW coverage after the public health emergency ends. See section on COVID-19 public health emergency for additional information.

HTW Plus benefits target the contributors to maternal morbidity and mortality as identified in the 2018 Joint Report, including:

- PPD and other mental health conditions
  - Services include individual, family and group psychotherapy services; and peer specialist services.
- Cardiovascular and coronary conditions, asthma, and diabetes
  - Services include imaging studies; blood pressure monitoring; diabetes testing; and asthma, anticoagulant, antiplatelet, and antihypertensive medications.
- SUD, including drug, alcohol, and tobacco use
  - Services include screening, brief intervention, and referral for treatment; outpatient substance use counseling; smoking cessation services; medication-assisted treatment (MAT); and peer specialist services.

HHSC is preparing a request to amend the HTW 1115 demonstration waiver to include HTW Plus services. HHSC plans to submit the amendment to CMS in December 2020 with a requested effective date of April 1, 2021.

The COVID-19 Public Health Emergency

HHSC has continued to promote maternal health during the COVID-19 public health emergency.

HHSC required Medicaid and CHIP MCOs to conduct outreach and provide education to their pregnant members. HHSC directed MCOs to prioritize outreach for members identified as high risk, including members with comorbidities that put them at higher risk of severe illness or adverse birth outcomes due to COVID-19.[41] Topics

[41] Delahoy MJ, Whitaker M, O'Halloran A, et al. Characteristics and Maternal and Birth Outcomes of Hospitalized Pregnant Women with Laboratory-Confirmed COVID-19 — COVID-NET, 13 States, March 1–August 22, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1347–1354. DOI: http://dx.doi.org/10.15585/mmwr.mm6938e1

for MCO outreach and education to pregnant members included COVID-19 screening, making a backup labor plan if their local hospital capacity changes, telehealth and telemedicine options, access to Medicaid benefits, and availability of social support services including nutrition during the public health emergency.

In addition, HHSC implemented flexibilities to allow remote delivery of care to support social distancing while ensuring individuals, including pregnant women, got needed services including prenatal care, mental health, and substance use services. HHSC made claims payable for teleservices and telephone (audio only) delivery of evaluation and treatment services, as appropriate.

HHSC, in compliance with Federal House Resolution (H.R.) 6201 (2020), the Families First Coronavirus Response Act, is sustaining Medicaid and HTW eligibility for individuals who were enrolled by March 18, 2020, and those determined eligible after this date, until the last day of the month in which the COVID-19 public health emergency ends. Because of the requirements of H.R. 6201, women certified for Medicaid for Pregnant Women remain enrolled in this program and are not auto enrolled in HTW during the public health emergency.

Family Planning Program

FPP provides contraceptive and family planning services to assess physical and mental health, including screenings and referrals for prenatal services and community resources. The goal of FPP is to ensure the best outcome for every pregnancy and every new mother. Men and women age 64 and younger who are at or below 250 percent of the FPL are eligible for services through FPP.

Preconception health benefits in FPP include screening and education about high-risk conditions, such as hypertension, diabetes, and obesity, in order to improve health prior to pregnancy. Preconception health benefits in FPP also include prevention, screenings, referrals, and treatment for tobacco and alcohol use; sexually transmitted infections; and occupational and environmental exposures. Additionally, FPP provides education, screening, and referral for substance use and domestic violence, which can increase during pregnancy and the postpartum period.

Initial and follow-up pregnancy visits include: a complete and interval history; physical examination; risk assessment; planning; treatment; counseling (nutritional, psychosocial, and family planning) and education (maternal health and child topics); laboratory and diagnostic tests, as indicated; and referral, as indicated. Women who are eligible are referred to Medicaid and CHIP Perinatal.

Screening for PPD, a serious and sometimes life-threatening condition, is conducted for all new mothers. The provider discusses the screen with the woman and asks

questions to evaluate her risk of PPD. Women in need of treatment for postpartum depression are referred to a mental health provider.

Title V Maternal and Child Health Fee-for-Service Program (Prenatal Medical and Dental)

This program serves pregnant women with income at or below 185 percent FPL who do not have access to care for the available services. As part of eligibility screening process, applicants are screened for eligibility for other health care programs. Prenatal services for pregnant women are provided for up to 60 days while the applicant is awaiting Medicaid or CHIP Perinatal coverage, and 30 days for postpartum services. This program provides a safety net for any gap in coverage, as Title V eligibility can be granted the same day a patient seeks services at a clinic.

Services include physical examination and clinical assessment, family planning, counseling and education services, referrals as indicated by medical history, prenatal laboratory and diagnostic testing, and case management for high risk pregnant women. Dental services are provided until three months postpartum and include comprehensive and periodic oral evaluation, radiographs, preventive and therapeutic dental care.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC is a nutrition program that helps low-income pregnant women, postpartum and breastfeeding women, infants, and young children up to age 5 receive tailored nutrition education, breastfeeding and infant feeding support, referrals to essential health and community resources, and supplemental nutritious foods to improve health outcomes. National studies show WIC may lead to savings in the Texas Medicaid program by promoting better nutrition and health among low-income pregnant women and infants.[42,43]

A key component of the WIC program is counseling aimed at identifying nutrition-related health and wellness concerns during pregnancy and in the postpartum period. Women can talk with public health, nutrition, and breastfeeding

[42] Devaney, Barbara, Linda T. Bilheimer, and Jennifer Schore. The Savings in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program, Volume 1. Alexandria, Virginia: U.S. Department of Agriculture, October 1990.
[43] Devaney, Barbara, Linda T. Bilheimer, and Jennifer Schore. The Savings in Medicaid Costs for Newborns and Their Mothers from Prenatal Participation in the WIC Program, Volume 2. Alexandria, Virginia: U.S. Department of Agriculture, April 1991.

professionals and establish individualized goals for behavior change. Breastfeeding peer counselors are available to provide mom-to-mom support to help promote and support a mother to meet her breastfeeding goals. These individual interactions provide key opportunities for program staff to share resources and referrals to information and programs that promote improved health outcomes.

WIC provides clients with a variety of print and digital resources on women's health and pregnancy. Educational publications such as "Your Guide to Women's Health" and "Your Guide to Pregnancy" cover healthy habits during and after pregnancy. Online resources including online classes and articles are available on WIC's client-facing website, TexasWIC.org. The website contains "Click & Learn" online lessons for clients such as "Healthy Eating, Healthy Pregnancy," "Thinking of You and a Healthy Pregnancy Too," "Nutrition and Self-Care for the New Mom," and "Baby Blues." In 2020 WIC debuted live online classes for clients including a live pregnancy discussion. Overall, WIC print and digital materials cover a range of topics that support physical and mental health during and after pregnancy, such as the importance of good nutrition, staying active, prenatal care and waiting 39 weeks to deliver, avoiding smoking and alcohol, baby blues and mental health, and accessing resources and support.

Substance Use Prevention and Treatment Services

Based on the 2018 Joint Report indicating drug overdose was a leading cause of maternal death between 2012 and 2015, there is a clear need for substance use intervention and treatment services. Pregnant women diagnosed with a SUD are a priority population in the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment block grant (Title XIX, Part B, Subpart II, Sec.1922(c)). SAMHSA has "set-aside" funds which may only be spent on female-specific services. These set-aside funds ensure the availability of substance use intervention, treatment, and recovery support services for pregnant women and women with dependent children. The set-aside also underscores both the importance of prenatal care and treatment for pregnant women who have been diagnosed with a SUD and the critical periods of early development in children.

The following priority populations have been established for admission into SUD services:

- Based on federal and state guidelines, pregnant injecting individuals must be admitted within 48 hours.
- Based on federal and state guidelines, pregnant individuals must be admitted within 48 hours.

- Based on federal and state guidelines, injecting drug users must be admitted within 14 days.
- Based on state guidelines, Department of Family and Protective Services-referred individuals must be admitted within 72 hours.
- Based on state guidelines, individuals identified as being at high risk for overdose must be admitted within 72 hours.[44]

Treatment and Intervention Services

Availability of services funded by block grant treatment funds is based on individual clinical and financial eligibility. Services for pregnant and parenting women who meet clinical and financial eligibility requirements include withdrawal management (detoxification), residential treatment, outpatient, and MAT. To provide further gender-specific treatment, Women and Children Intensive Residential and Supportive Residential Services were established to provide effective treatment and offer parenting education, reproductive health education, and gender-specific groups. Women and Children programs allow women to enter and remain in treatment with their children, which helps reduce interference in critical bonding and attachment between mothers and children in infancy and early childhood.

Pregnant and Parenting Intervention (PPI) programs provide community-based, gender-specific outreach and intervention services for women. PPI services are available to pregnant women with a current or past substance-exposed pregnancy and women who are parenting a child younger than 6 and who have a SUD or are at risk of developing a SUD. PPI programs are intended to reduce the impact, severity, and cost associated with a substance-exposed pregnancy to the mother and child dyad. Services include intensive case management, motivational interviewing, home visitation, and education. Program goals include improving birth outcomes, reducing risk of parental substance misuse, promoting parent/child bonding, improving parenting skills, improving safety of relationships and home environment, increasing access to community resources, and promoting engagement in reproductive health and well-child visits. In fiscal year 2021, PPI programs were redesigned to focus on pregnant and parenting women with higher acuity needs. There are seven PPI providers throughout the state. PPI programs are located in counties with the highest percentage of newborn neonatal abstinence syndrome (NAS) cases, as determined by Medicaid claims and encounter data in fiscal year 2016.

[44] A priority designation is required in all HHSC Substance Use provider contracts related to implementation of the Texas Targeted Opioid Response.

Parenting and Drug Risk Education Services (PADRES) programs also provide community-based services to pregnant women or parenting men and women. PADRES programs provide community-based intervention and outreach services and evidenced-based education to men and women of childbearing age. PADRES programs seek to decrease the effects of substance use within the family and to increase access to community resources and evidenced-based education. PADRES programs also focus on behavior change and lowering risky substance use behavior. In fiscal years prior to 2021, only men who were fathers, or expectant fathers, were eligible to participate in PADRE programs. In fiscal year 2021, PADRE programs were renamed to PADRES and redesigned to also serve pregnant and parenting women whose intervention and education needs are not acute enough to rise to the level of the services provided by PPI programs. As of October 2020, there are 11 PADRES providers throughout the state.

Expansion of Substance Use Disorder Treatment

Efforts to expand services provided to pregnant women and women with dependent children spans multiple substance use intervention and treatment programs. In August 2016, the Statewide Pregnancy Stabilization Center in San Antonio, also known as the Restoration Center, became operational. The Restoration Center allows pregnant women to enter a single SUD treatment and recovery program that provides a full continuum of care for them and their children. This program serves pregnant women and women with dependent children from across the state, including women who reside in areas of the state that may not offer the care opioid-dependent pregnant women require. Participation by region and county varies each month and year. In fiscal year 2018, the Restoration Center served 92 women in treatment and 57 enrolled in recovery services. In fiscal year 2019, the Restoration Center served 92 women in treatment and 62 enrolled in recovery services.

Treatment slots designated for pregnant and postpartum women who have exhausted their pregnancy-related Medicaid benefits have also been expanded to provide a seamless transition and to avoid any disruption in Neonatal Abstinence Syndrome-Opioid Treatment Services (NAS-OTS). In fiscal year 2021, for consistency with other MAT services, NAS-OTS services have been renamed to NAS-MAT. In fiscal year 2021, there are 27 NAS-MAT providers, an increase from 15 NAS-OTS providers in fiscal year 2020 and 13 NAS-OTS providers in fiscal year 2019. In fiscal year 2018, 222 slots (75 percent) were filled for MAT in the NAS-OTS program. In fiscal year 2019, NAS-OTS served 225 clients.

The 2019-2020 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 64) appropriated $23,634,844 in general

revenue funds for fiscal year 2020 to reduce the substance use treatment waitlist for pregnant women and women with dependent children. Approximately $5.3 million of Rider 64 funding was used by HHSC to amend contracts with approximately 80 percent of substance use disorder treatment providers serving pregnant women and women with dependent children to expand the state-funded treatment capacity for pregnant women and women with dependent children.

In fiscal year 2020, $3 million of Rider 64 funds was designated to create a new substance use intervention service, known as Comprehensive Continuum of Care (CCC). This service includes comprehensive case management, community-based linkages, and retention services through pre-admission service coordination. CCC is designed to reduce barriers to treatment, enhance motivation, stabilize life situations, and facilitate engagement in SUD treatment.

In fiscal year 2020, to further expand services to women who are pregnant or have dependent children, and have been diagnosed with a SUD, HHSC used Rider 64 funds to establish the Casa Mia program. Casa Mia used Rider 64 funds to help build physical infrastructure for a recovery residence with a specialized nursery for pregnant and postpartum women and their infants. This startup capital was used to support the recovery residence and nursery while the facility explored further licensing. By June of 2021, Casa Mia hopes to add a neonatal pediatric care facility to its recovery residence and specialized nursery. At this neonatal pediatric care facility, infants born to women with a SUD (primarily an opioid use disorder) will receive continued care from hospital staff as medication tapering continues. Although Rider 64 funds have been used to help grow Casa Mia, Casa Mia expects to become self-sustaining through Medicaid reimbursements and alternate funding sources by the end of calendar year 2021.

Neonatal Abstinence Syndrome Programs

Substance use during pregnancy is associated with significant adverse pregnancy outcomes, such as prematurity, low birth weight, and NAS. NAS is a group of conditions that can occur in newborns who were exposed to certain substances, including opioids, during their mother's pregnancy. NAS most commonly occurs following in utero exposure to opioids (both prescription medications and "street drugs") but may also be caused by maternal use of other substances, such as certain antidepressants, sedatives, and medications used to treat anxiety.

The 2016-17 and 2018-19 General Appropriations Acts each appropriated $11.2 million in general revenue funds over each biennium to reduce the incidence and severity of NAS in Texas. The funds created and expanded new and existing services aimed at reducing the incidence, severity, and costs associated with NAS.

- Fiscal year 2016: A return-on-investment analysis for NAS-OTS showed that 95 women were served, with an average savings of $15,981 per birth compared to costs for women not enrolled in NAS-OTS. Women entered 4.1 months prior to delivery and remained for 10.1 months after delivery. For these women, the NAS-OTS birth costs were $13,108 per individual, compared to $29,089 per individual for Medicaid NAS non-OTS birth costs.

- Fiscal year 2018: The return-on-investment analysis indicated women entered 3.2 months prior to delivery and remained in NAS-OTS services for 13.4 months after delivery. The average cost per newborn with Medicaid delivery was $4,302. Following birth, the average cost associated with an NAS birth was $12,500 if the mother was enrolled in an NAS-OTS program. For mothers not enrolled in an NAS-OTS programs, the average cost associated with an NAS birth, primarily inpatient hospital costs, was $22,102.

These NAS funds helped fund the Statewide Pregnancy Stabilization Center as well as the recovery residence and recovery support services discussed above.

Mommies Program and Intervention Services Expansion

The Mommies program is an integrated and collaborative model of care shown to reduce expensive newborn hospital stays and support family preservation. The program is designed to eliminate as many potential barriers as possible to maximize a woman's chances for a successful recovery. Care is delivered in a collaborative, non-punitive, and therapeutic manner that aims to support women who seek treatment. The Mommies program provides education, collaboration, and coordination to obstetric care providers to integrate SUD treatment, screening, and education for pregnant and postpartum women and their infants. The Mommies program has also made available NAS response teams in the local community, which are designed to increase education, understanding, and awareness to address the problem of opioid use in pregnant and postpartum women. In fiscal year 2019, the Mommies program had 165 participants and 619 women delivering.

Since 2016, the PPI programs were funded to expand services to provide OTS support to target outreach efforts through enhancing education and services to women at risk for having a child with NAS. The goal is to help these women gain an earlier entrance into prenatal care, SUD treatment, and increased access to health care information. Outreach strategies include reaching high-risk women to access OB/GYN care and SUD treatment, women who would not traditionally engage with the health care system. In fiscal year 2019, PPI programs screened 4,749 women and 10,757 individuals in targeted outreach across Texas. In fiscal year 2021, PPI programs were redesigned as described above.

Training and Research Initiatives

HHSC funds training and research initiatives at the University of Texas related to NAS. Training concerning NAS is supported by continued online training modules, Mommies Regional Training to hospital personnel and community partners, Department of Family and Protective Services' regional trainings, a statewide annual symposium, and intensive technical assistance. Additionally, overdose prevention trainings are offered in areas identified as having high rates of maternal opioid use.

NAS research supports key initiatives for better understanding health care for women with an OUD. The University of Texas Health Science Center at San Antonio began researching the biopsychosocial factors surrounding maternal relapse and overdose for people using and in recovery from OUD through the Maternal Opioid Morbidity Study. Preliminary results show that participants experienced high rates of exposure to multiple stressful and traumatic life events beginning early in life and extending into adulthood. The most common of these events were loss of a loved one to an accident, homicide, or suicide; and having experienced sexual, physical, or emotional abuse. The circumstances surrounding return to opioid use or overdose involved removal of an infant or child by Child Protective Services, isolation, unaddressed trauma, mental health symptoms, and stress. These social determinants of health can be addressed with new and innovative models of care and access to needed services.

The University of Texas Health Science Center at San Antonio is also conducting the Kangaroo Mother study to build further evidence for non-pharmacological management strategies for infants. Study results show that participants indicated an alteration in their parental role (e.g., separation from their infant, not being the primary caregiver, not having alone time) was the most stressful aspect of their infants' hospitalization for NAS. During Kangaroo Mother Care (KMC) researchers found a significant reduction in both maternal and infant heart rate, fewer infant withdrawal symptoms, and greater maternal engagement in infant care.[45] Further, because of KMC, mothers reported: (a) they and their infants could relax, (b) they had "alone" time with their infants; and (c) their infants had "forgiven" them for their drug use. Due to these findings, two large neonatal intensive care units in San Antonio have redesigned their care model to include KMC and mother-infant rooming-in, which has resulted in a decreased length and cost of hospital stay.

[45] KMC is a method of caring for premature babies in which the infants are held skin-to-skin with a parent, usually the mother, for as many hours as possible every day. The KMC Study attempts to determine is KMC is effective for infant experiencing NAS symptoms.

Finally, Seeking Safety is an evidence-based and trauma-informed curriculum frequently used when working with women who are pregnant, or have dependent children, and have a SUD. As of November 2020, HHSC funded SUD providers' access to a virtual Seeking Safety training. In the spring of 2021, HHSC will offer a statewide Seeking Safety training to all HHSC SUD providers who serve pregnant women and women with dependent children.

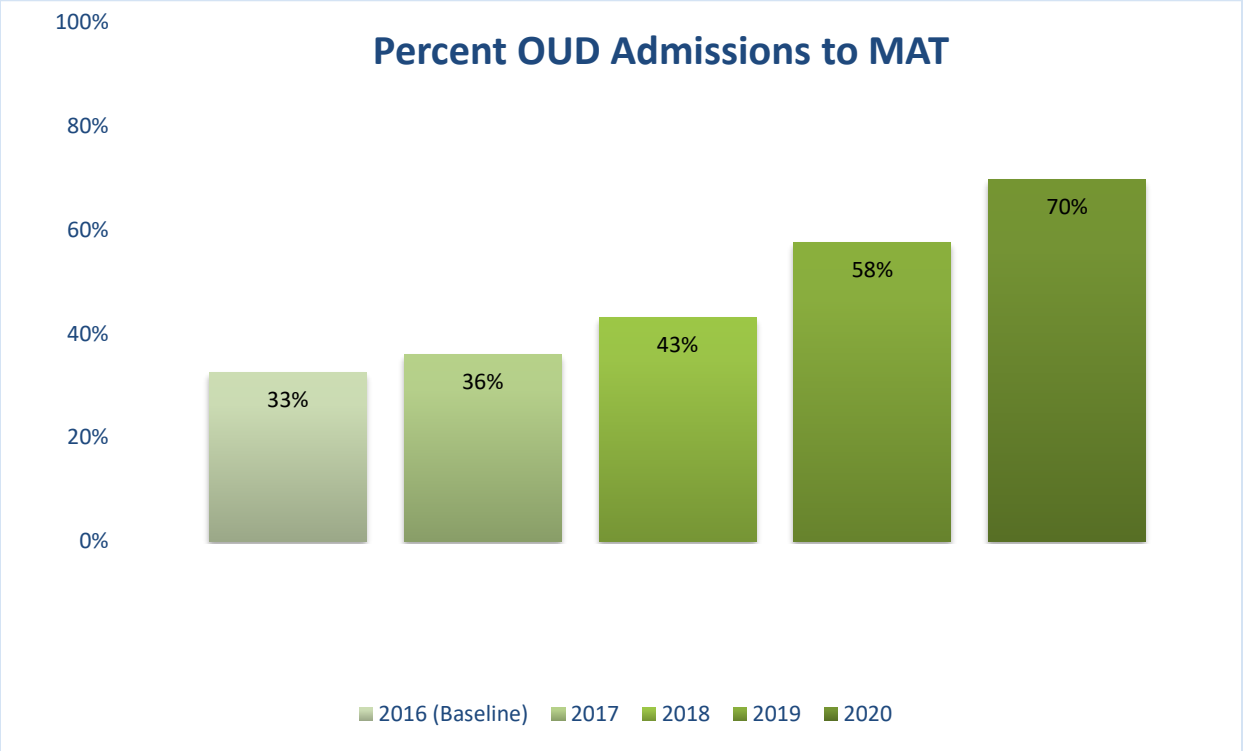
The University of Texas' "Operation Naloxone" provides a professional resource for Texas-specific data and information about opioid use, overdose, reversals, and trends.

Texas Targeted Opioid Response

Since May 2017, Texas has received more than $280 million in federal funding to fight the opioid crisis under the Texas Targeted Opioid Response (TTOR) program. To date, more than 600,000 people have received prevention, treatment, and/or recovery support services including MAT, peer recovery coaching, disposal of prescription drugs, and overdose-related emergency response services. Those who benefit from TTOR services include people with opioid use disorder, their family members, significant others, and supportive allies affected by opioid use.

The TTOR program aims to address the opioid crisis by reducing unmet treatment need and opioid overdose-related deaths through its evidence-based programming.

Figure 1. Percent Opioid Use Disorder Admissions to MAT



Treatment outcomes of this program include increased access to evidence-based treatment for OUD. After TTOR funding was awarded, the percentage of persons receiving evidence-based MAT increased by 112 percent (See Figure 1). Prevention outcomes of this program include decreased opioid-related overdose deaths in Texas. As of August 2020, a total of 6,251 people were trained in overdose prevention, and 318,263 two-dose kits of naloxone were distributed to both traditional and non-traditional first responders, resulting in 2,807 confirmed lives saved.

TTOR is partnering with FPP through the Integrated Family Planning Opioid Response project. This project aims to provide family planning clinic patients who are identified as being at risk for opioid overdose or opioid use disorder with initial treatment induction, recovery support, primary care follow-up and support, and overdose prevention services when and where they need it. The overall goal of the project is to reduce overdose death, increase access to low-threshold healthcare services, and improve quality of life.

Medicaid Services

Medicaid covers the following SUD treatment services: assessment, individual and group SUD counseling, MAT, residential treatment, residential withdrawal management, and outpatient withdrawal management.

In 2019, HHSC updated the Medicaid SUD treatment policy. The following policy changes expand access to Medicaid SUD treatment for all Medicaid recipients:

- Consistent with the federal Comprehensive Addiction and Recovery Act of 2016, qualified advanced practice registered nurses and physician assistants can be reimbursed for delivering MAT with buprenorphine-containing products.[46]
- Consistent with the federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, qualified clinical nurse specialists, nurse midwives and nurse anesthetists may be reimbursed for delivering MAT with buprenorphine-containing products.[47]
- Injectable and implantable buprenorphine are now covered in Medicaid.
- Existing service limits on outpatient SUD individual and group counseling, as well as residential treatment, can be exceeded with documentation explaining the need for continued services.

In addition to the Medicaid SUD treatment policy updates, peer specialist services for persons with a mental illness and/or a SUD were added as a separate Medicaid benefit in 2019 as directed by Human Resources Code Section 32.024(kk).

Additionally, effective September 1, 2020, HHSC implemented new managed care contract requirements related to SUD treatment:

- MCOs are prohibited from requiring prior authorization for MAT as a condition for provider reimbursement, as required Human Resources Code Section 32.03115(b).[48]
- MCOs must ensure access to at least two outpatient mental health providers, two chemical dependency treatment facilities, and two opioid treatment programs, in each managed care service area.

[46] Public Law 114-198, Title III- Treatment and Recovery, Section 303
[47] SUPPORT Act, Public Law 115-271, Title III – FDA and Controlled Substance Provisions-Section 3201.
[48] Texas Medicaid SUD policy has not required prior authorization for MAT since it was added as a benefit in 2010.

- MCOs must also meet time and distance standards for access to chemical dependency treatment facilities and opioid treatment programs, in each service area.
- MCOs must provide out-of-network reports for SUD residential treatment services to facilitate HHSC's monitoring of access to residential SUD treatment.

Maternal Opioid Misuse (MOM) Model

The MOM Model cooperative funding agreement described earlier in this report seeks to improve quality of care and expand access to integrated maternal and behavioral health care. The MOM Model will use universal SUD screenings, outpatient and residential treatment, and peer specialist services as part of a comprehensive care package for MOM Model enrollees.

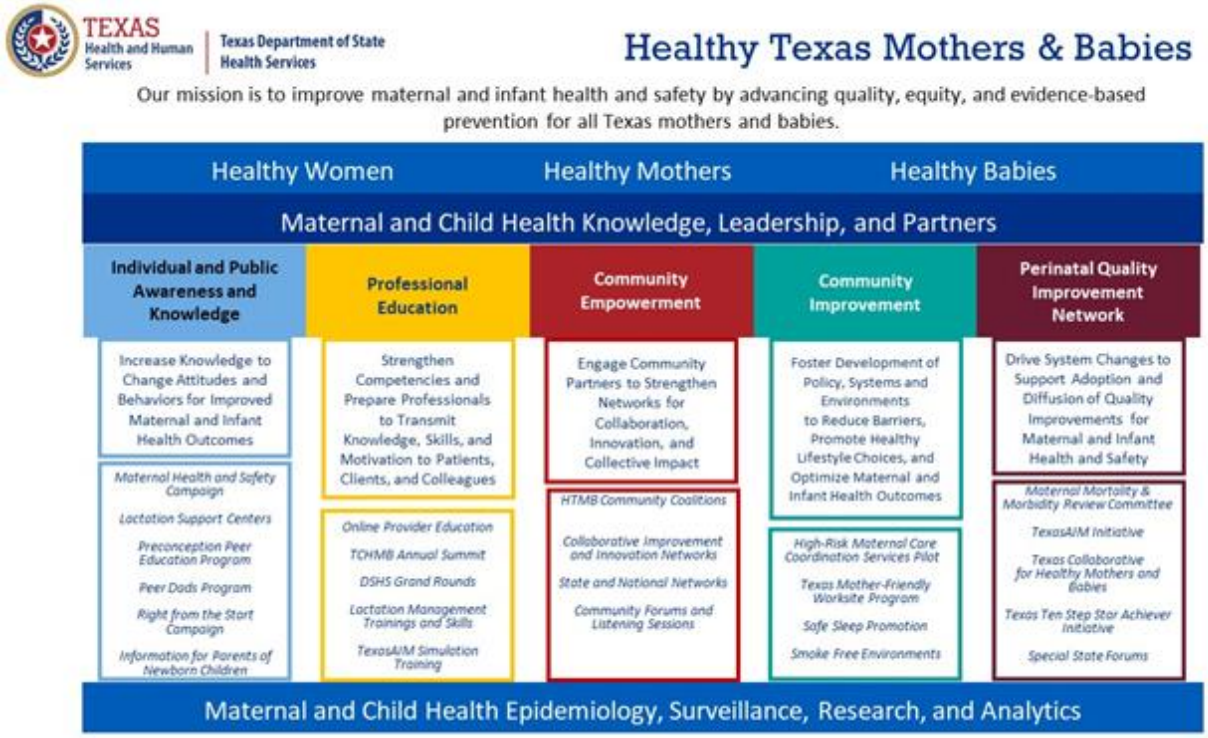
Public Health Efforts

Healthy Texas Mothers and Babies Framework

DSHS implements multiple public health initiatives to support safer pregnancy, postpartum, and interpregnancy periods for Texas mothers and their babies. These initiatives are organized within a framework called Healthy Texas Mothers and Babies (HTMB), which is funded by the Title V Block Grant (Figure 2).[49]

[49] As part of the Social Security Act of 1935, Title V is the nation's longest running public health program. Title V is a partnership between the federal government and the states/territories in which funding is used to implement programs to improve the health & well-being of our nation's mothers, children and families.

Figure 2. Healthy Texas Mothers and Babies Framework



The core components of the HTMB Framework fall within five categories:

1. Individual public awareness and knowledge,
2. Professional education,
3. Community empowerment,
4. Community improvement, and
5. Perinatal Quality Improvement Network.[50]

The HTMB framework includes the following activities to support maternal health and safety:

- Facilitating and supporting the Texas Maternal Mortality and Morbidity Review Committee.
- Implementing the TexasAIM Initiative.
- Analyzing trends, rates, and disparities in pregnancy-related deaths.
- Developing the High-Risk Maternal Care Coordination Services Program (HRMCCSP) Pilot study to provide support, resources, technical assistance,

[50] The Perinatal Quality Improvement Network is a network of partnerships that coordinate to drive adoption and diffusion of health care quality improvements for maternal and infant health and safety.

training, and guidance to a pilot site to integrate community health worker services for women with high-risk pregnancies.
- Developing a Maternal Health and Safety Awareness, Education, and Communication Campaign to increase public awareness and maternal mortality and morbidity prevention activities.
- Promoting online provider education modules and providing other continuing education and skills development activities that provide health care professionals with knowledge and resources to improve the health of women before, during, and after pregnancy.
- Providing preconception health and life planning tools through activities including the HTMB Community Coalitions and the Preconception Peer Education program
- Providing funding and support to the Texas Collaborative for Healthy Mothers and Babies (TCHMB).

Additional information for key activities is provided below. DSHS public health initiatives related to perinatal mood and anxiety disorders are highlighted in the HHSC PPD Strategic Plan, described elsewhere in this report.

Texas Maternal Mortality and Morbidity Review Committee (MMMRC)

Administered by DSHS, the MMMRC is a 17-member multidisciplinary committee established by Health and Safety Code Section 34.002. The MMMRC studies cases of identified pregnancy-associated death to determine if deaths were related to pregnancy or preventable, and what factors contributed to death. Findings from MMMRC case review and statewide trend analyses are used to develop and prioritize MMMRC recommendations for preventing maternal mortality and morbidity. Multidisciplinary maternal mortality case review is part of a cycle of continuous quality improvement for health systems and is an integral part of Texas' Perinatal Quality Improvement Network. The 2020 MMMRC and DSHS Joint Biennial Report is scheduled to be published on concurrently with this report and is available on the DSHS Legislative Reports webpage.

Texas Collaborative of Healthy Mothers and Babies (TCHMB)

DSHS funds and supports the TCHMB, the state's perinatal quality collaborative. TCHMB is a collaboration of more than 150 healthcare providers, scientists, hospitals, state agencies, advocates and insurers whose goals are:

- Reducing preterm birth and infant mortality
- Reducing disparities in the health outcomes of mothers and babies
- Reducing maternal mortality and severe maternal morbidity

- Improving the health outcomes of mothers and babies
- Increasing the involvement of fathers / families
- Improving women's health throughout the life cycle

TCHMB seeks to advance health care quality and patient safety for all Texas mothers and babies, through the collaboration of health and community stakeholders in the development of joint quality improvement initiatives, the advancement of data-driven best practices, and the promotion of education and training.

Maternal Health and Safety Activities

The TexasAIM Initiative was developed in response to the MMMRC's recommendation to promote a culture of safety and high reliability in Texas birthing facilities and uses maternal patient safety bundles from the Alliance for Innovation on Maternal Health (AIM) Program to improve maternal health and safety in hospitals throughout Texas. AIM bundles are proven, evidence-based strategies used to improve maternal safety and health care quality. Each AIM bundle focuses on a specific maternal health and safety topic.

DSHS partners with the American College of Obstetricians and Gynecologists-AIM National, the Texas Hospital Association, the TCHMB, and other key partners to implement the TexasAIM Initiative. The TexasAIM Initiative supports participating hospital obstetric units with implementing AIM bundles to address the leading causes of preventable maternal mortality in Texas including obstetric hemorrhage, severe hypertension in pregnancy, and maternal opioid use disorder.

As of September 2020, DSHS has recruited 219 hospitals to participate in the TexasAIM Obstetric Hemorrhage Bundle programming, representing more than 98 percent of all hospitals with obstetric services in Texas (approximately 99 percent of state births, and 10 percent of national births).

DSHS is scheduled to publish the DSHS Maternal Health and Safety Initiatives report on December 1, 2020, concurrent to this report, to provide updates on maternal health and safety activities including the TexasAIM Initiative, the HRMCCSP Pilot, and the Maternal Health and Safety Awareness, Education, and Communication Campaign.[51] The report is available on the DSHS Legislative Reports webpage.

[51] DSHS Maternal Health and Safety Initiatives report is described in Health and Safety Code Sec. 34.0156.

Perinatal Advisory Council

The Perinatal Advisory Council (PAC), established by Health and Safety Code Section 241.187, provides clinical and non-clinical recommendations to improve neonatal and maternal outcomes. As an advisory committee, the PAC is supported by HHSC and makes recommendations to DSHS. Physicians, nurses, hospital administrators and representatives are on the council.

Initially, the PAC worked with its many stakeholders to shape rules guiding state designations for neonatal and maternal hospital levels of care, helping to ensure that pregnant women and newborns receive the right care at the right time in the right place. With those rules now in place, the PAC has turned its focus on highlighting best practices, policies, and key trends affecting the care and outcomes of mothers and newborns. As part of this charge, PAC members provided input to the MMMRC in June 2020. During the open forum, PAC members:

1. Identified improving access to care, both prenatal and postnatal, as a major priority for reducing maternal mortality and morbidity.
2. Explained the benefits of providing a full continuum of care to women after discharge for childbirth.
3. Recommended additional state support to promote access by low-income, uninsured Texas mothers to comprehensive postpartum care, including consideration of extending Medicaid coverage for postpartum care from a 60-day period to 1-year.
4. Recommended more research on outcomes related to demographics, funding, geography, and other factors that influence maternal health, as well as the further development of an appropriate data infrastructure to support this research.
5. Highlighted training and resources related to implicit bias and health equity available through the American Medical Association and American Academy of Family Physicians task forces and other organizations.
6. Advocated extending the long-acting reversible contraception benefit coverage period.
7. Supported the continuation of the statewide implementation of AIM Maternal Safety bundles, including by augmenting payment for hospitals that adopt AIM and AIM Plus bundles.
8. Recommended that maternal safety and quality improvement initiatives make a greater effort to include certified professional midwives, due to a resurgence of home births, particularly in rural areas.
9. Recommended additional education to reduce the stigmatization of women who have SUD.

Education and Awareness

Texas Health Steps Online Provider Education Program

Given the substantial racial and ethnic disparities in maternal mortality rates across Texas, HHS is committed to increasing health equity through providing culturally responsive care. One HHS resource is the Texas Health Steps Online Provider Education program (OPE). Many of the courses offer free continuing education credit for physicians, nurses, social workers, and other health professionals. In its effort to decrease racial and ethnic disparities in maternal mortality rates, HHS offers the following courses through OPE:

- *Advancing Health Equity in Texas through Culturally Responsive Care* provides physicians and other health care professionals with practical guidance about how to advance health equity by adopting and implementing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.
- *Culturally Effective Health Care* equips Texas Health Steps providers and others to meet legal requirements and employ best practices and medical ethics to serve the health care needs of culturally diverse children, adolescents and their families. In addition to addressing the health of patients and clients, the course addresses the disparities and risk factors in healthcare systems.

In conjunction with these courses, OPE offers providers additional courses to combat mortality and morbidity during the preconception and prenatal periods:

- *Preconception Health: Screening and Intervention* focuses on promoting good health for women, interpreting health risks and conditions that can adversely affect maternal and infant health, and the integration of preconception health care and counseling into routine clinical encounters.
- *Prenatal Health: Screening and Intervention* focuses on the leading causes of maternal mortality and morbidity in Texas and the integration of prenatal screening, treatment, and counseling protocols that promote maternal health and safety.

Family Violence Program

In fiscal year 2020, the HHSC Family Violence Program served 40,477 adult women through 71 centers across the state. HHSC-funded family violence centers offer 24-hour emergency shelter and/or supportive services including but not limited to crisis intervention, safety planning, access to emergency medical care, legal

advocacy and information and referrals. HHSC also collaborates with the Texas Council on Family Violence on key program initiatives, including program enhancement services, education and outreach, and statewide stakeholder workgroups that help improve services to survivors of family violence. Through prevention work in community outreach efforts and relationships with other community-based organizations, HHSC-funded family violence centers help survivors break the cycle of abuse and educate the public on the dynamics of family violence and healthy relationship boundaries. Their work is critical in ensuring survivors in Texas feel safe and supported and help to reduce maternal mortality related to intimate partner violence.

Prenatal Screening Webpage

As directed by Health and Safety Code Section 34.0055, HHSC maintains a prenatal screening webpage to connect health care providers to resources, screening, and educational materials for substance use and domestic violence. The webpage includes screening tools for providers, referral resources for Substance Use Program centers and Family Violence Program centers, and outreach materials available for professionals to use in their clinics. The webpage also provides contact information for the National Domestic Violence Hotline, HHSC Family Violence Centers and the Substance Abuse hotline for those who have experienced domestic violence or need help with substance use.

Efforts to Treat Postpartum Depression

Addressing PPD has been a significant focus of HHS for several years. HHSC and DSHS are pursuing a wide variety of legislatively mandated and agency-driven initiatives to better understand PPD, improve PPD screenings and referrals, and expand treatment for women with PPD.

In February 2019, HHS submitted a report, *Postpartum Depression Among Women Utilizing Texas Medicaid*, to the Legislature in accordance with 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 85). The report examined Medicaid claims and encounter data to study the frequency of pregnancy-related depression (PRD) among women with a Medicaid-paid delivery, the frequency of PRD screening by Medicaid and women's health providers, utilization of services and onset of treatment for PRD, and Medicaid costs.

The results of this analysis reflect how pregnancy-related depression symptoms become apparent throughout pregnancy and beyond, rather than solely after delivery:

- In fiscal year 2016, more than half of women with Medicaid-paid deliveries diagnosed with PRD had a diagnosis that occurred before delivery;
- Almost half (48.3 percent) of the 7,269 women with a Medicaid-paid delivery seeking care for PRD had at least one visit with a physician or other non-institutional Medicaid provider prior to delivery; and
- Over one fourth (28.7 percent) of women who used LMHA services for pregnancy-related depression were treated both during pregnancy and after delivery, and 16.2 percent were only treated during pregnancy.

PPD Coverage, Screening, Referrals and Treatment

Several HHS programs provide screening, referrals, and treatment for PPD. Below is a short summary of PPD coverage in HHS programs, followed by more detailed information about each program as detailed in Table 2.

Table 2: Summary of PPD coverage in HHS programs

Program	PPD Coverage
Medicaid for Pregnant Women	Covers all Medicaid State Plan services, including prenatal and postpartum office visits as well as psychotherapy and medications for treating PPD.
CHIP Perinatal (CHIP-P)	Covers two postpartum visits, which include PPD screening.
Medicaid & CHIP (infant coverage)	Covers PPD screening at the infant's checkup through 12 months of age, regardless of the mother's coverage.
Healthy Texas Women	Covers diagnostic evaluation, antidepressant medications, and unlimited office visits, including follow-up visits for women with a diagnosis of PPD.
HTW Plus	Covers a focused service package for eligible women for 12 months following the end of pregnancy-related Medicaid coverage. Behavioral health benefits include psychotherapy and peer specialist services for women diagnosed with PPD and other mood disorders.
Family Planning Program	Covers screening and diagnosis of PPD for women who meet income eligibility requirements and do not qualify for other similar coverage. Providers are required to refer women who screen positive for PPD to a provider who can perform further evaluation and determine a course of treatment.
Primary Health Care Program	Covers screening, diagnosis, and medication for PPD.
Title V Maternal and Child Health Fee-for-Service Program (Prenatal Medical and Dental)	Covers screening and diagnosis of PPD for women who meet eligibility requirements and do not qualify for other similar coverage. Providers are required to refer women who screen positive for PPD to a provider who can perform further evaluation and determine a course of treatment.

Medicaid and CHIP

Pregnant and postpartum women with Medicaid coverage can access a broad range of mental health services that are available to screen for and treat PPD. Services include:

- Individual, family, and group psychotherapy
- Psychiatric diagnostic evaluation
- Psychological neurobehavioral and neuropsychological testing
- Mental health targeted case management
- Mental health rehabilitation
- Peer-specialist services
- Psychiatric hospital care

Effective July 1, 2020, HHSC added Medicaid coverage for Zulresso, a new clinician-administered drug to treat severe PPD and the only FDA-approved drug for PPD. It is administered under observation with a 60-hour intravenous infusion.

CHIP Perinatal

The CHIP Perinatal program provides services for the unborn children of pregnant women who are uninsured, do not qualify for Medicaid due to income or immigration status, and whose household income is at or below 202 percent of the federal poverty level. Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and two postpartum visits.

Infant Coverage

As directed by Health and Safety Code Section 62.1511,[52] HHSC Medicaid and CHIP cover a PPD screening for the child's mother as part of the infant's coverage, regardless of whether the mother is also enrolled in Medicaid or CHIP. The screening is performed during a covered visit for the infant that occurs before the infant's first birthday.

Additional reimbursement is available for one PPD screening that takes place during a checkup for Texas Health Steps, Texas Medicaid's comprehensive preventive child health service that includes medical, dental, and case management services.

When a mother is screened for PPD through Texas Health Steps, providers must discuss the screening results with the mother, as well as the possibility of depression and the impact depression may have on the mother, family, and the

[52] H.B. 2466, 85th Legislature, Regular Session, 2017.

health of the infant. The Texas Health Steps provider and mother discuss the mother's options, so the provider can refer her to an appropriate provider for further evaluation and treatment. Screening and referral are not contingent upon a mother's Medicaid eligibility.

Healthy Texas Women

Under HTW, coverage is provided for PPD screening, diagnostic evaluation and medication, and follow-up care. HTW Plus, which launched in September 2020, includes the HTW PPD coverage in addition to individual and family psychotherapy services, group psychotherapy services, and peer specialist services.

Telehealth and Telemedicine

In accordance with Texas Government Code Section 531.0216:[53]

- MCOs are prohibited from denying reimbursement for a covered health care service or procedure to a network provider solely because the service or procedure was delivered remotely as a telemedicine (physician-delivered) or telehealth (non-physician delivered) service.
- An MCO may not limit, deny, or reduce reimbursement for a covered health care service or procedure delivered remotely by a network provider based upon the provider's choice of platform for providing the covered health care service or procedure.
- An MCO must ensure that the use of telemedicine and telehealth services promotes and supports patient-centered medical homes through the sharing of a summary of the service(s), exam findings, prescribed medications, and patient instructions between telemedicine and telehealth services providers and members' primary care providers.
- Federally Qualified Health Care Centers can be reimbursed for providing teleservices.

The expanded availability to telemedicine/telehealth provided by this law opens new avenues in Medicaid managed care for PPD screening and services to be provided to women in need.

[53] S.B. 670, 86th Legislature, Regular Session, 2019

Other HHS Programs

Family Planning Program

FPP covers screening and diagnoses of PPD for women who meet income eligibility requirements and do not qualify for other similar coverage. FPP providers are required to refer women who screen positive for PPD to a provider who can perform further evaluation and determine a course of treatment.

Primary Health Care Program

The Primary Health Care Services Program works with clinic sites across Texas to ensure that eligible Texans can access comprehensive primary health care services to prevent, detect, and treat health problems. PPD screening, diagnosis, and medication are covered in this program.

Title V Maternal and Child Health Fee-for-Service Program (Prenatal Medical and Dental)

The Title V Maternal and Child Health Fee-for-Service Program (Prenatal Medical and Dental) is a gap coverage program available to low-income women who are ineligible or awaiting approval for other health care assistance programs The program provides two postpartum visits in addition to the two postpartum visits allowed by CHIP Perinatal and covers screening and diagnosis of PPD. Providers are required to refer women who screen positive for PPD to a provider who can perform further evaluation and determine a course of treatment.

Local Mental Health Authorities and Local Behavioral Health Authorities

HHSC contracts with 37 local mental health authorities (LMHAs) and two local behavioral health authorities (LBHAs) to deliver mental health services in communities across Texas. HHSC sends annual reminders to LMHAs and LBHAs of the requirements in Health and Safety Code Chapter 62 and Human Resources Code Chapter 32 related to coverage of services for PPD under Medicaid and CHIP. When a woman who is not eligible for Medicaid screens positive for PPD, the Medicaid provider may refer her to a community resource, including an LMHA/LBHA. The LMHA/LBHA provides diagnostic and clinical assessments to determine her eligibility for services while also noting the PPD flag in her electronic health record.

A range of basic services are available for women who are referred to LMHAs/LBHAs and who meet the identified needs threshold (an automatic calculation derived during the assessment process):

- Case management
- Pharmacological management
- Counseling
- Medication training and support
- Psychosocial rehabilitative services
- Skills training and development
- Supported employment
- Supportive housing
- Assertive community treatment
- Peer support

Peer Support Services

Medicaid Peer Specialists

Peer support services are important in helping identify and address PPD. As mentioned above, Medicaid added coverage for peer specialist services effective January 1, 2019. A peer specialist uses personal experience to support another person with skills development, a person-centered recovery plan and problem-solving strategies. Peer specialist services encompass recovery and wellness-support services, mentoring, and advocacy.

Informal Peer Support

DSHS and WIC promote peer support through lactation support activities. Some lactation support centers provide mother-to-mother breastfeeding support groups under the Maternal and Child Health Section's Healthy Texas Mothers and Babies Lactation Support Center Services-Strategic Expansion Program. WIC also oversees the breastfeeding peer counselor program, providing mother-to-mother support in WIC clinics, hospitals, and other community settings.

Texas Clinician's Postpartum Depression Toolkit

HHSC's Texas Clinician's Postpartum Depression Toolkit, which was launched in 2017, is an evidence-based resource that provides clinical decision support for diagnosis and treatment of PPD. The toolkit, which is geared toward all clinicians who provide care to women and their infants in the postpartum period, also includes links to patient and provider resources and information on state programs that provide coverage for related services.

PPD Treatment Network

In accordance with Health and Safety Code Section 32.154, HHSC is collaborating with Medicaid MCOs and HTW providers to develop and implement a PPD treatment network for women enrolled in Medicaid or HTW.[54] HHSC has been researching best practices in other states for treating PPD and identifying elements for the PPD treatment network in Texas. Core components identified so far include:

- **Provider networks:** HHSC is working to build a network of providers for perinatal mental health which encompasses treatment during pregnancy and after, not just the postpartum period. Early diagnosis and treatment of maternal mood disorders improves maternal health during and after pregnancy. HHSC has solicited feedback from Medicaid MCOs and HTW providers on how best to identify treatment providers and strengthen the referral system, including ways to use teleservices to increase access to treatment. HHSC is evaluating how to best recruit providers, including perinatal psychiatrists, to provide services in-person and through telemedicine and telehealth.
- **Continuity of care:** Efforts to improve continuity of care between Medicaid and HTW will help prevent gaps in treatment when transitioning between programs.
- **Teleconsultations:** HHSC research identified teleconsultation as a best practice in numerous states and it has also been recommended by stakeholders. HHSC is exploring how the Child Psychiatry Access Network (CPAN) could be used for provider-to-provider teleconsultation for PPD, as has been done in other states.[55]

Postpartum Depression Strategic Plan

As required by Health and Safety Code 32.046,[56] HHSC developed a five-year strategic plan to improve access to PPD screening, referral, treatment, and support services. The PPD strategic plan, which was issued in September 2020, includes a variety of strategies, including:

- **Opportunities for telehealth and telemedicine in Medicaid and CHIP.** HHS will continue to explore ways to support and expand telehealth and

[54] S.B. 750, 86th Legislature, Regular Session, 2019
[55] Implemented as part of S.B. 10, 86th Legislature, Regular Session, 2019, CPAN is an initiative of the Texas Child Mental Health Care Consortium. CPAN provides pediatricians and primary care providers of children with behavioral health with teleconsultation and training through a network of academic settings to increase their capacity to identify and treat mental health issues.
[56] H.B. 253, 86th Legislature, Regular Session, 2019

telemedicine for PPD through Medicaid and CHIP services in fiscal year 2021 and beyond.

- **Opportunities for telehealth and telemedicine in HTW and HTW Plus.** HHS will continue to explore ways to support and expand telehealth and telemedicine for PPD in the HTW and HTW Plus programs in fiscal year 2021 and beyond.
- **Understand provider needs and challenges.** HHSC will create and distribute a survey on PPD to LMHAs/LBHAs in fiscal year 2021. The survey results will establish a baseline of provider knowledge of PPD and current challenges providers face in diagnosing and treating PPD.
- **Increase awareness of PPD and treatment options among HTW providers and increase access to postpartum care, including PPD care.** Outreach and training will be conducted on new postpartum benefits in HTW Plus in fiscal year 2021.
- **Increase awareness of PPD among WIC clients**. WIC will develop materials that include information on PPD, including a healthcare provider website with a page on PPD, as well as additional client-facing web lessons. The materials will be available in fiscal year 2021.
- **Increase awareness of PPD among healthcare professionals.** DSHS will host a series of continuing education presentations on perinatal mood and anxiety disorders in fiscal year 2021. Lectures will include information about the prevalence and effects of perinatal mood and anxiety disorders on outcomes for women and children, as well as PPD signs, symptoms, screening, diagnosis, treatment, and referral.
- **Improve network of providers.** HHS will continue to collaborate with Medicaid health plans and HTW providers throughout fiscal year 2021 to determine how to best identify treatment providers for maternal mood disorders and to develop a workflow process for health plans to assist in the referral of members. HHSC will explore options to recruit providers, including perinatal psychiatrists, to provide services in-person and through telemedicine and telehealth. HHSC aims to implement this strategy in fiscal year 2022.
- **Expand provider referral network.** HHSC will create and disseminate an LMHA training/webinar in fiscal year 2021. This training/webinar will educate providers and referral networks on the role of LMHAs in the community and how to best access their services.
- **Enhance provider resources.** HHS will revise and publish an updated version of the Texas Clinician's Postpartum Depression Toolkit in fiscal year 2021. Updates will address: the PPD treatment network for women enrolled in Medicaid or HTW; managed care and fee-for-service referral networks; screening options in neonatal intensive care units; updated information on Medicaid-covered services, including Zulresso; and updated information

regarding HTW and HTW Plus mental health services. HHSC has a goal of publishing the revised toolkit before September 1, 2021.

- **Evaluate access to peer support services.** Based on the results of post-implementation utilization review, HHS staff will consider whether policy changes are necessary to increase access to the Medicaid peer-specialist benefit in fiscal year 2021.
- **Increase PPD awareness and access to treatment to reduce stigma.** Psychotherapy and peer support services are included as benefits of HTW Plus starting in fiscal year 2021. This will increase PPD awareness and access to treatment, help normalize the diagnosis, decrease stigma, and help prevent maternal morbidity and mortality.
- **Increase PPD outreach to providers to reduce stigma.** In fiscal year 2021, the DSHS TexasAIM Initiative will make available an Obstetric Care for Women with Opioid Use Disorder Bundle for select hospitals that focuses on addressing stigma and bias in the care of women with opioid use disorder and comorbidities, which include PPD and other perinatal mood and anxiety disorders.

Strategies to Lower Costs and Improve Quality Outcomes

Medical Pay-for-Quality Program

Texas Government Code Chapter 536 requires the use of payment systems to hold Medicaid and CHIP MCOs accountable for the quality of services they provide with focus on the use of quality-based outcome and process measures, including measuring potentially preventable events.[57] In the medical Pay for Quality (P4Q) program, three percent of MCOs' capitation is at-risk for performance on quality measures. MCO performance is evaluated in three ways:

- Performance against self (comparison of an MCO's performance to its prior year performance)
- Performance against benchmarks (comparison of an MCO's performance against Texas and national peers)
- Bonus pool measures

Using performance against self and performance against benchmarks allows HHSC to reward high performing plans while still incentivizing plans to improve, regardless of their current level of performance. Plans can earn or lose money based on their performance against self and against benchmarks. Any money remaining after recoupments and distributions are calculated is placed in a bonus pool where MCOs can earn rewards if they meet a separate set of bonus pool measures. Bonus pool measures allow HHSC to encourage improvement with no financial risk to the health plans.[58]

The medical P4Q program measures were selected to focus on prevention, chronic disease management including behavioral health, and maternal and infant health. HHSC staff included MCOs, provider organizations, and advisory committees in the development of the P4Q program and the selection of measures. Maternal health measures at-risk in P4Q are prenatal and postpartum care which is the percentage of deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment and postpartum visit between 21-56 days after delivery for STAR in measurement years 2018 and 2021, and cervical cancer screening for STAR+PLUS

[57] S.B. 7, 82nd Legislature, First Called Session, 2011
[58] Additional information about P4Q program methodology and measures can be accessed at https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program

in measurement years 2018, 2019, and 2021.[59] STAR+PLUS is a statewide managed care program for adults with disabilities and those age 65 and older.

Low birth weight, which is the percentage of live births that weighed less than 2,500 grams, is a bonus pool measure for STAR in measurement years 2018, 2019, and 2021. HHSC suspended the P4Q program for 2020 because of the COVID-19 public health emergency.

Due to multiple quality initiatives addressing maternal health, it is difficult to quantify the effect of the P4Q program on plan performance. Program rates improved on prenatal and postpartum care and cervical cancer screening while the low birth weight rate remained the same as the 2017 rate.[60]

Healthcare Effectiveness Data and Information Set Quality Measures

The National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) is a nationally recognized and validated set of measures used to gauge quality of care provided to members. Texas MCOs consistently perform above the national median for Medicaid prenatal care visits in the first trimester or within 42 days of enrollment.

HHSC developed a group of maternal health performance measures that will be available to the public on the Texas Healthcare Learning Collaborative portal in late 2020. These measures are a mix of nationally recognized measures that capture maternal care, and some Texas-specific measures developed to address important areas of maternal health in the state.

Table 1. Maternal Health Measures

Name	Description
Pregnancy-Associated Outcome Measures	The proportion of severe maternal morbidity (SMM) among Medicaid births, specifically: • The proportion of SMM cases among all deliveries. • The proportion of SMM cases among deliveries having hemorrhage.

[59] For 2021, only the postpartum care submeasure is used.

[60] Detailed measurement year 2018 P4Q results can be accessed at https://thlcportal.com/dashboards/p4qperformancedashboard

Name	Description
	• The proportion of SMM cases among deliveries with preeclampsia.
Prenatal and Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Timeliness of Prenatal Care - The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization • Postpartum Care - The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
Contraceptive Care - Postpartum Women	Among women ages 15 to 44 who had a live birth, the percentage that: 1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery. 2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two Age groups, Ages 15-20 and Ages 21-44, are reported for Child and Adult respectively.
Live Births Weighing Less Than 2,500 Grams	Percentage of live births that weighed less than 2,500 grams during the reporting period.
Cervical Cancer Screening	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years.

Name	Description
	• Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.
Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Contraceptive Care - All Women	Among women ages 15 to 44 at risk of unintended pregnancy, the percentage that: 1. Were provided a most effective or moderately effective method of contraception. 2. Were provided a long-acting reversible method of contraception (LARC). Two Age groups, Ages 15-20 and Ages 21-44, are reported for Child and Adult respectively.
C-Section Rates	C-section rates among all Medicaid births: • Overall • Without complications • With complications

Value-Based Payment

HHSC has adopted the principles of value-based payment (VBP) for Medicaid and CHIP managed care programs. Through its managed care contracting model with the MCOs, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume-based (i.e. fee-for-service) toward models structured to reward increased patient access, care coordination and/or integration, and improved health care outcomes and efficiency.

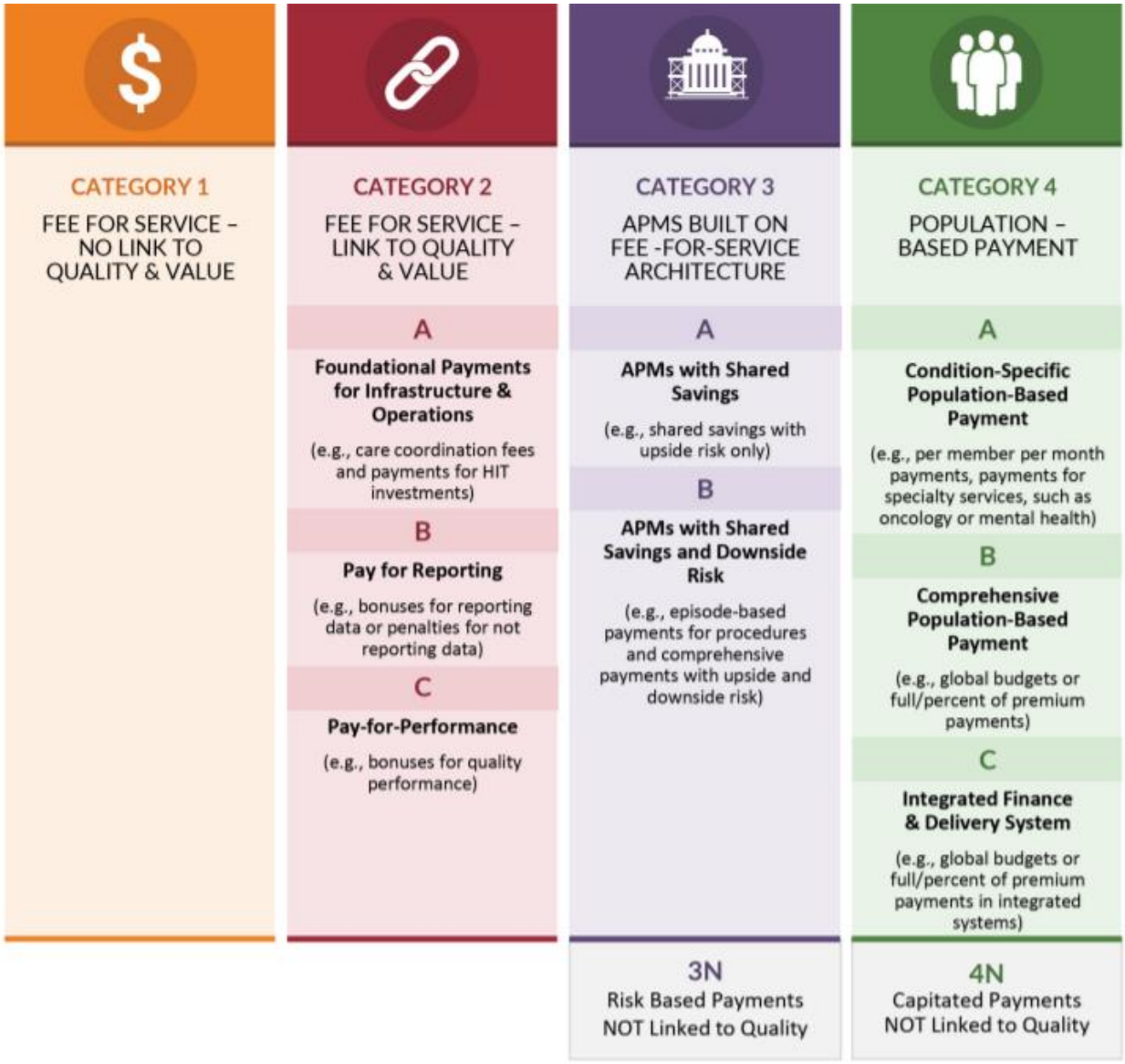
Beginning in 2018, HHSC implemented managed care contract provisions that require MCOs to meet targets for establishing alternative payment models (APMs) with providers. APMs are the specific payment arrangements and methods used in

VBP programs. These MCO requirements increase over four years. By 2021, half of MCO payments to providers for medical services are expected to be in an APM. Examples of APMs include providers receiving bonuses for achieving quality or reaching goals on performance measures, sharing savings for delivering services at lower cost, or incurring financial losses for not meeting specified quality and cost benchmarks.

HHSC has adopted the APM Framework developed by the Health Care Payment Learning & Action Network (HCP LAN).[61] Figure 3 shows the framework from HCP LAN and the various categories of APMs.

[61] https://hcp-lan.org/apm-refresh-white-paper/

Figure 3. HCP LAN APM Framework



Note: This framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in distinct categories, the Framework captures a continuum of clinical and financial risk for provider organizations. Source: HCP LAN.

In 2018, 11 MCOs, mainly in the STAR and CHIP programs, implemented 52 APMs in contracts with their providers that included performance criteria related to improving maternal outcomes. According to the LAN framework, the majority of these APMs were in Category 2, specifically "Pay for Performance", with a few in

Category 3 using a "Shared Savings" model, and a smaller number in Category 4 associated with a level of downside risk. Most of the providers involved in the APMs were OB/GYNs, followed by primary care physicians. Through the APM initiative, MCOs paid about $15 million in net incentives (typically above contracted rates) to providers participating in APMs with a maternal quality component.

Though HHSC does not require the use of specific metrics in the APM initiative, generally MCOs implement APMs and associated performance measures that address priorities identified by HHSC. These measures focus on increasing access to services and care coordination (including after-hours availability), reducing cesarean sections, and improving postpartum care.

S.B. 750 requires HHSC to develop or enhance statewide initiatives to improve the quality of maternal health care services and outcomes for women in Texas.[62] HHSC must specify the initiatives that each contracted MCO must incorporate in the organizations' managed care operations. In coordination with DSHS partners, external partners and stakeholders, and informed by participation in the CMS Medicaid Innovation Accelerator Program, staff are implementing the following initiatives to fulfill S.B. 750.

Delivery System Reform Incentive Payment

On December 21, 2017, CMS approved Texas' request for the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver for the next five years. One of the main components of the waiver is the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP is 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. The target population of DSRIP includes children and adults enrolled in Medicaid or CHIP, as well as children and adults that are low-income, uninsured, or both.

The DSRIP program developed targeted measure bundles that group clinical and process measures into common themes/ objectives, such as behavioral health or diabetes care. Participating hospitals selected measure bundles to improve, and then earned DSRIP incentive payments for improving rates for their selected measures for the DSRIP target population. Two measure bundles were developed for maternal care, and two preventive care measure bundles include maternal care measures.

[62] Health and Safety Code Section 32.155

Table 2. DSRIP Measure Bundles with Measures of Maternal Care

Measure Bundle	Measure Bundle Objective
E1 Improved Maternal Care	Improve maternal health outcomes by implementing evidence-based practices to provide pre-conception, prenatal, and postpartum care including early detection and management of comorbidities such as hypertension, diabetes, and depression.
E2 Maternal Safety	Improve maternal safety and reduce maternal morbidity through data driven interventions to prevent and manage obstetric hemorrhage.
D1 Pediatric Primary Care	Increase access to comprehensive, coordinated primary care & preventive services focused on accountable, child-centered care that improves quality of life and health outcomes.
K1 Rural Preventive Care	Improve provision of preventive care in rural and critical access hospitals to improve patient health.

For each selected measure, providers reported a baseline rate that derived from data from calendar year 2017, and then reported performance for each measure in subsequent years. In calendar year 2019, the majority of providers reported improvement in the median rate for each measure of maternal care, indicating improvement in outcomes for the population measured.

Table 3. DSRIP Pay-for-Performance Measure Reporting CY2017 – CY2019

Measure ID	Measure Title	Providers Reporting Measure	Median Baseline Rate (CY2017)	Median PY2 Rate (CY2019)
E2-150	Cesarean Section (lower rates are better)	25	31%	27%
E2-151	Antenatal Steroids	17	97%	100%
E1-232	Timeliness of Prenatal Care	19	72%	82%
E1-235	Post-Partum Follow-Up and Care Coordination	19	64%	83%
E1-300	Behavioral Health Risk Assessment	20	29%	67%
K1-300	Behavioral Health Risk Assessment (Rural Hospital)	1	35%	67%
D1-301	Maternal Depression Screening	6	67%	86%

Hospital Levels of Care Designations

Maternal and neonatal level of care (LOC) designations improve health outcomes by promoting care in the most appropriate setting and facilitating transfers through regional coordination. H.B. 15, 83rd Legislature, Regular Session, 2013, and H.B. 3433, 84th Legislature, Regular Session, 2015, required DSHS to assign LOC designations to hospitals based on the neonatal and maternal services provided. Criteria for the LOC designations was recommended and approved by the Perinatal Advisory Committee.

The neonatal LOC designation rules adopted by HHSC became effective in June 2016 and the initial onsite surveys began in October 2016. The maternal LOC designation rules became effective in March 2018 and the initial onsite surveys began in July 2018. The neonatal LOC designation became a requirement for Medicaid reimbursement in 2018. S.B. 749, 86th Legislature, Regular Session, 2019, extended the time frame for the maternal LOC designation as a requirement for Medicaid reimbursement of maternal care services to September 1, 2021.

DSHS assigns a level of care designation to individual hospitals based on compliance with administrative code requirements. The Level I hospitals submit documented evidence of facility compliance with the administrative requirements. Level II, III, and IV hospitals are evaluated for compliance through an on-site survey conducted by an independent third-party organization. Hospital processes and patient care are evaluated to ensure appropriate services are available for the patient population served, and continuously monitored and evaluated for opportunities to improve care and potentially improve health outcomes.

Maternal designation awards began in April 2019, with 14 hospitals receiving designations. Texas has approximately 226 hospitals currently providing maternal services. DSHS received 75 maternal designation applications, accounting for only 33 percent of facilities currently providing maternal services. The declaration of a state of disaster in Texas due to the COVID-19 pandemic required survey organizations to suspend onsite visits to evaluate facility compliance with the rule requirements. This interruption in survey services and postponement of facility onsite visits delayed and reduced the submission of maternal designation applications for over seven months. Virtual Survey Guidelines were developed to assist survey organizations in resuming surveys through a virtual platform. Survey organizations have conducted 91 surveys to date with 10 virtual surveys occurring since September.

The designation awards are ongoing and increasing monthly with a deadline for all designations to be completed by August 31, 2021, to be eligible for Medicaid

reimbursement. An updated listing of designated maternal facilities is available at https://dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx#IV.

Texas currently has 230 neonatal designated hospitals eligible for Medicaid reimbursement. A list of hospitals is available at:

https://dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx#IV.

State Health Plans

Employees Retirement System (ERS)

ERS administers benefits to help the State of Texas attract and retain a qualified workforce for 117 state agencies, 46 public universities and 19 junior/community and technical colleges. These benefits include both health insurance, optional add-on benefits, and an employee/employer-funded pension. The health insurance program is a core benefit for current and retired state and higher education employees who provide or have provided essential services for a growing state.

ERS administers various health insurance benefits for more than a half-million Texans through the Texas Employees Group Benefits Program (GBP). The State offers several self-funded plans for employees, retirees, and their families: HealthSelect of Texas®, Consumer Directed HealthSelect℠, and the HealthSelect℠ of Texas and Consumer Directed HealthSelect Prescription Drug Programs. Eight out of 10 health plan participants are enrolled in the HealthSelect of Texas point-of-service medical plan.

ERS uses a competitive bidding process to contract with third-party plan administrators (TPAs) to process medical claims and provide a network of health care providers with a very high standard for network adequacy. Pharmacy Benefits Managers (PBMs) are used in the administration of ERS' prescription drug programs. TPAs and PBMs are responsible for establishing robust networks, contracting for provider/pharmacy reimbursement rates, managing the plan formularies, and collecting drug manufacturer rebates. The current TPA for the self-funded HealthSelect medical plans is Blue Cross and Blue Shield of Texas (BCBSTX).

HealthSelect supports expectant mothers with various programs and plan benefits to help them have a healthy pregnancy, birth and, ultimately, a healthy baby. Specifically, HealthSelect provides holistic high-risk pregnancy management using dedicated medical and mental health clinicians.

BCBSTX maternity specialists conduct telephone outreach and provide ongoing support to expectant mothers identified with high-risk pregnancies, through claims data, utilization, provider or self-referrals. The clinician engages with the participant throughout the pregnancy and post-delivery, providing support to help coordinate care for the mother and her baby. The clinician supports the participant by coordinating with the providers, addressing co-morbid conditions, and connecting

the mother with resources (such as dedicated licensed social workers, who are able to provide support, encouragement, and other identified needs.)

HealthSelect also provides integrated mental health clinical support for participants enrolled in a care management program. These participants receive a mental health/depression screening and are connected with a licensed mental health clinician when appropriate. Through a seamless approach, participants receive holistic support for their medical and mental health needs.

WellonTarget®, accessible in the HealthSelect Blue Access for Members personal portal, offers self-guided courses about pregnancy that participants can take online at their convenience on topics such as healthy foods, body changes and labor. These educational and support tools help expectant mothers have healthy pregnancies through every stage.

These services provide critical care and support to the maternal health of the ERS HealthSelect participants. Ensuring healthy pregnancies, births, and babies is important to provide support for the participants and also prevents more costly and preventable critical care services for the plan.

Teacher Retirement System (TRS)

TRS has a long history of delivering health benefits to public education affiliated participants. Since 1986, TRS has provided health coverage to retirees through TRS-Care. Starting in 2002, TRS has also offered coverage to public education employees through TRS-ActiveCare. In FY 2019, TRS provided health coverage to 712,888 people, including 483,113 public education employees and their families and 229,775 retirees and their families. TRS is composed of a predominantly female population; 65.1 percent of all members are female and in fiscal year 2019 there were 5,394 newborns.

TRS recently completed a medical procurement and awarded both the TRS-ActiveCare and TRS-Care Standard, the plan for retirees without Medicare, to BCBSTX. Prior to the procurement, TRS-ActiveCare and TRS-Care Standard were administered by Aetna. TRS-ActiveCare switched to BCBSTX effective September 1, 2020, and TRS-Care Standard will change administrators on January 1, 2021.

TRS partnered with both Aetna and BCBSTX to provide maternity programs aimed at reducing child bearing risk and maternal mortality rates.

Blue Cross and Blue Shield of Texas

TRS-ActiveCare and TRS-Care Standard members have access to Ovia Health through BCBSTX. Ovia Health is a maternity and family benefit, offering daily personalized support. Ovia Health supports tracking for fertility, pregnancy, and early years of parenting. Ovia Health provides access to registered nurses, midwives, lactation counselors, and reproductive health coaches seven days a week.

The Ovia Health app includes the following features:

- Health assessment and symptom tracking.
- Over 50 physician-developed clinical programs.
- Unlimited one-on-one coaching (registered nurse health coaches).
- Career and return-to-work programs.

Ovia Health follows the American College of Obstetricians and Gynecologists clinical guidelines and uses Patient Health Questionnaire-9 and Edinburgh Postnatal Depression Scale, a validated screening for postpartum support.

BCBSTX's Clinical High-Risk Maternity Management focuses on women identified as high-risk maternity cases but is available for all members. BCBSTX identifies TRS members for High-Risk Maternity Management by combining Ovia Health assessments, 14-sonogram claims, disease codes impacting pregnancy, and member self-referrals. Member-level data of women who are at increased risk of adverse outcomes is given to case managers who proactively reach out. There are 67 high-risk triggers including age, BMI, gestational diabetes, ulcerative colitis, and previous pregnancy complications.

Aetna

TRS-ActiveCare and TRS-Care Standard members have access to the Aetna Maternity Program through Aetna. The nurses and staff of the Aetna Maternity Program provide helpful facts on prenatal care, labor and delivery, and more. Each participant will get a personal nurse if they have health conditions that could affect their pregnancy.

The Aetna Maternity Program supports the entire continuum of the pregnancy:

- Getting ready for a healthy pregnancy (including a smoking cessation program).
- Understanding high-risk pregnancy.
- What to expect each trimester.
- Preeclampsia, what it is and how to prevent it.

- Understanding the difference between Baby Blues and PPD.
- Post-delivery recovery.

Texas Department of Criminal Justice (TDCJ)

The University of Texas Medical Branch – Correctional Managed Care (UTMB-CMC) provides exceptional maternal care to TDCJ's pregnant offender population. Programs and initiatives in maternal healthcare are designed to achieve the best possible outcomes. UTMB-CMC focuses on the well-being of the pregnant mother and her baby before and after delivery. Pregnant offenders receive comprehensive health care such as diet counseling, vitamins, routine obstetrical care, lab testing, and mental health counseling. The following data for fiscal years 2019-2020 confirm the success of maternal care for incarcerated mothers and babies.

Current Number of Pregnant Offenders: 15 as of October 29, 2020
Fiscal year 2019 Number of Live Births - 153
Fiscal year 2020 Number of Live Births - 123
Fiscal year 2019 Number of Miscarriages - 0
Fiscal year 2020 Number of Miscarriages - 1
Fiscal year 2019 Infant Mortality Rate – 0 percent
Fiscal year 2020 Infant Mortality Rate - 0.81 percent
Fiscal year 2019 Maternal Mortality Rate - 0 percent
Fiscal year 2020 Maternal Mortality Rate - 0 percent

TDCJ and UTMB-CMC collaborate with UTMB School of Nursing (UTMB-SON) and the local community in Houston with the Santa Maria Hostel on programs focused on bonding, parenting, building healthy relationships, substance abuse issues, learning to make good life choices, and overall maternal/baby well-being. Each program is described briefly in the following paragraphs.

Baby and Mother Bonding Initiative

The Baby and Mother Bonding Initiative (BAMBI) program offers multiple classes and individual programs to help foster a healthy mother-child bond, prepare the offender for real-life situations, address substance use concerns, and adhere to TDCJ-Rehabilitation Programs Division mission of providing an opportunity for mother and child bonding and attachment. Bonding and attachment are vitally important to healthy growth and development, socialization, and psychological development during the infant's formative years. This initiative is achieved while in a safe and secure environment. BAMBI is structured with treatment goals that include rehabilitation, recovery, and reduction of recidivism. Program participants (offenders) receive 20 hours of programming each week.

Love Me Tender

The Love Me Tender program provides mother and infant visitation for TDCJ postpartum women who are housed at Hospital Galveston after delivery. The program supports the BAMBI mission and evidenced-based practices that benefit mother/infant bonding.

BAMBI/School of Nursing (SON) Collaborative Project

The BAMBI/UTMB-SON Collaborative Project is an innovative, service-learning project created by the UTMB-SON faculty members and leadership teams from TDCJ and the UTMB Health System. This project supports the mission of BAMBI to improve maternal bonding and meet breastfeeding objectives while impressing the importance of advocacy for vulnerable populations on nursing students.

Conclusion

The State of Texas has many programs and initiatives aimed at improving maternal health outcomes, improving quality of care, addressing PPD, and reducing costs associated with maternal mortality and morbidities. Texas HHS will continue coordination and collaboration across agencies and among these programs and initiatives for a holistic, systematic approach to achieving these goals and furthering the Texas HHS mission of improving the health, safety, and well-being of Texans through good stewardship of public resources.

List of Acronyms

Acronym	Full Name
AIM	Alliance for Innovation on Maternal Health
APM	Alternative Payment Model
BAMBI	Baby and Mother Bonding Initiative
BCBSTX	Blue Cross and Blue Shield of Texas
BMI	Body Mass Index
CCC	Comprehensive Continuum of Care
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus Disease 2019
CPAN	Child Psychiatry Access Network
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
ERS	Employee Retirement System
FPL	Federal Poverty Level
FPP	Family Planning Program
GBP	Group Benefits Program
H.B.	House Bill
H.R.	House Resolution
HCP LAN	Health Care Payment Learning & Action Network
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HRMCCSP	High-Risk Maternal Care Coordination Services Program
HTMB	Healthy Texas Mothers and Babies
HTW	Healthy Texas Women
KMC	Kangaroo Mother Care
LARC	Long-Acting Reversible Contraceptive
LBHA	Local Behavioral Health Authority

LMHA	Local Mental Health Authority
LOC	Level of Care
MAGI	Modified Adjusted Gross Income
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MMMRC	Texas Maternal Mortality and Morbidity Review Committee
MOM	Maternal Opioid Misuse
MSHCN	Members with Special Health Care Needs
NAS	Neonatal Abstinence Syndrome
NAS-OTS	Neonatal Abstinence Syndrome-Opioid Treatment Services
NEMT	Nonemergency Medical Transportation
OPE	Online Provider Education
OUD	Opioid Use Disorder
P4Q	Pay for Quality
PAC	Perinatal Advisory Council
PADRES	Parenting and Drug Risk Education Services
PATH	Postpartum Access to Healthcare
PBM	Pharmacy Benefits Manager
PMH	Pregnancy Medical Home
PPC	Prenatal and Postpartum Care
PPD	Postpartum Depression
PPI	Pregnant and Parenting Intervention
PRD	Pregnancy-related Depression
RFI	Request for Information
S.B.	Senate Bill
SAMHSA	Substance Abuse and Mental Health Services Administration
SMM	Severe Maternal Morbidity
STAR	State of Texas Access Reform
SUD	Substance Use Disorder
TCHMB	Texas Collaborative for Healthy Mothers and Babies
TDCJ	Texas Department of Criminal Justice
TPA	Third-party Plan Administrator

TRS	Teachers Retirement System
TTOR	Texas Targeted Opioid Response
UTMB-CMC	University of Texas Medical Branch – Correctional Managed Care
UTMB-SON	University of Texas Medical Branch – School of Nursing
VBP	Value-Based Payment
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children