# Engaging Medicaid Members

## Identifying the Non-Medical Needs of Pregnant Members

Baylor Scott & White Health Plan
Community Health Choice — Community Cares
Episcopal Health Foundation
Methodist Healthcare Ministries — Serving Humanity to Honor God
Michael & Susan Dell Foundation
Molina Healthcare
St. David's Foundation
superior healthplan
Treaty Oak Strategies
United Healthcare

# INTRODUCTION & OVERVIEW

## BACKGROUND

Recent conversations on health in Texas have gone beyond improving access to health care to address the non-medical, root causes of poor health. Access to affordable medical care is vitally important, but it is only 20% of what contributes to a person's overall health. The remaining 80% is determined by social and economic status, health behaviors, community safety, physical environment, and much more.

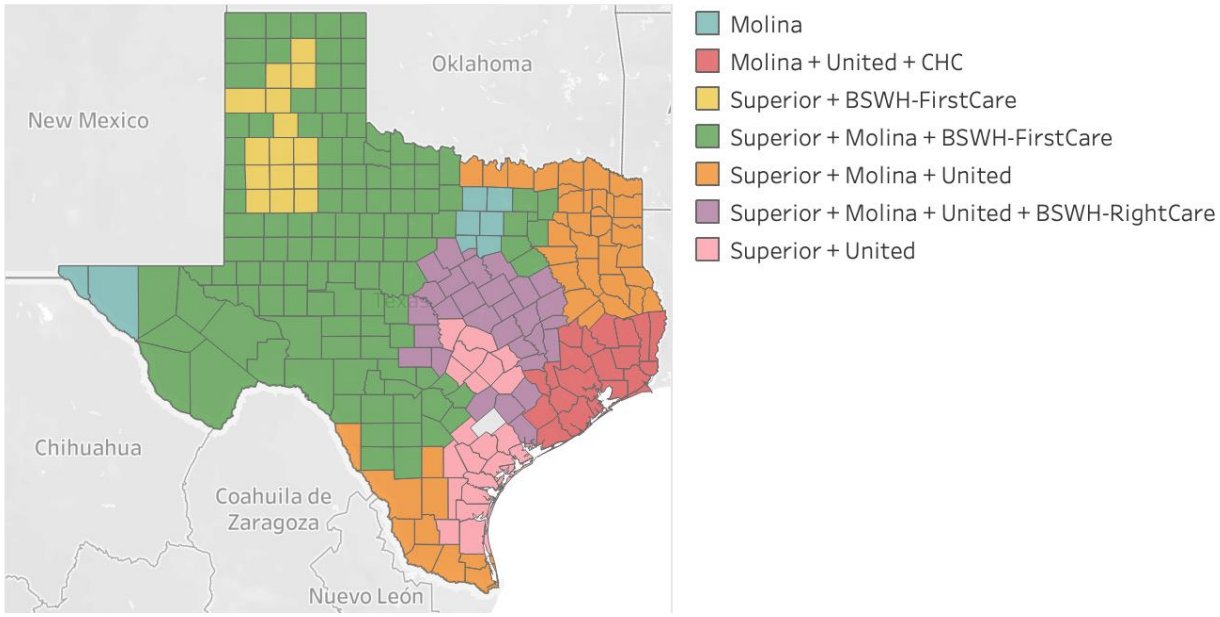
These conversations have led to several initiatives:

- Episcopal Health Foundation and the Michael & Susan Dell Foundation provided support for the Texas Health and Human Services Commission (HHSC) and Managed Care Organizations (MCOs) in their efforts to address non-medical drivers of health (NMDOH) needs of more than 5 million Medicaid beneficiaries across the state via a five-year Texas MCO NMDOH learning collaborative, a collaboration between EHF, HHSC, the Texas Association of Health Plans (TAHP), and the Texas Association of Community Health Plans (TACHP).
- In 2023, HHSC released a groundbreaking policy document called the Texas Medicaid and CHIP Services Non-Medical Drivers of Health Action Plan — the first major policy document released by the state relating to NMDOH policy. The plan found three major non-medical needs in Texas: food insecurity, housing, and transportation.
- In June 2023, Texas Governor Greg Abbott signed HB 1575 by Representative Hull and Chairwoman Kolkhorst, a bill that requires HHSC to develop standardized screening questions related to non-medical needs and allows community health workers and doulas to become billable provider types under case management for HHSC's children and pregnant women's program.
- In 2024, HHSC is expected to release a new alternative payment model framework that will incentivize MCOs to enter payment models that include NMDOH interventions and relationships with community-based organizations.

As the state, health care organizations, Medicaid providers, and other stakeholders continue to address non-medical needs, Medicaid enrollees remain absent from many conversations. In light of the recent policy momentum created by the release of HHSC NMDOH Action Plan and the passage of HB 1575, Episcopal Health Foundation (EHF), the Dell Foundation, Methodist Health Ministries (MHM), and St. David's Foundation partnered with five Medicaid MCOs (Community Health Choice, Baylor Scott & White Health Plan, Molina Healthcare, Superior, and United Healthcare) to establish

discussion group sessions to ensure the voices of pregnant Medicaid beneficiaries are included in conversations. This report summarizes key findings about their perspectives and thoughts on non-medical needs and supports by subject area: Employment and Housing, Transportation, and Food.

FIGURE 1: PARTICIPATING MCO COVERAGE AREAS




## METHODOLOGY

To facilitate the focus groups, each MCO was responsible for recruiting pregnant women who were or recently had been pregnant and were enrolled in their health plan. Participants included first-time mothers and mothers with other children. Workgroups were conducted in cities throughout the state, including Austin, Houston, San Antonio, Waco, and El Paso. Questions were developed jointly between the funders and the consultants. Participation was voluntary, responses have been anonymized to maintain confidentiality, and no names are included in the final report. Funding from EHF reimbursed each participant for their time with a $50 gift card.

- Baylor Scott and White Health Plan conducted two virtual discussions with 10 participants.
- Community Health Choice conducted two virtual discussions with 14 participants.
- Molina Health Plan conducted interviews with five participants.

- Superior conducted four in-person discussions after baby shower events with a total of 10 participants.
- United Health Plan conducted two virtual discussions which included 10 members.

## KEY FINDINGS

**Besides housing, employment, transportation, and food needs outlined in the report, participants defined additional NMDOH during and after pregnancy, including:**

### DOMESTIC VIOLENCE

This and other traumatic experiences created instability and posed health threats to mothers.

### CHILDCARE

Many mothers did not have family, friends, neighbors, or community institutions who could provide childcare to make medical appointments during pregnancy or to return to work after pregnancy.

### MATERNITY CLOTHING AND BABY ESSENTIALS

Mothers relied on garage sales and second-hand stores for maternity clothing but worried how they would get to stores and afford baby essentials two months after delivery.

### ENGLISH PROFICIENCY

Accessing services was more difficult for women who did not speak fluent English.

**Participants also identified the following critical health care barriers they faced:**

### CONTINUOUS INSURANCE COVERAGE

It was difficult for many participants to get Medicaid coverage (much harder with “more hoops to jump through” than for the Supplemental Nutrition Program for Women, Infants, and Children or WIC), and many lost coverage before they could obtain coverage or even afford a new insurance plan 60 days after delivery (current time frame when pregnant women’s Medicaid coverage ends).

### ACCESS TO OTC MEDICATION

Unless over-the-counter (OTC) medications are on the Medicaid prescription drug formulary and prescribed by a doctor, MCOs are not reimbursed for OTC medications bought by pregnant enrollees; several mothers had difficulty affording common OTC medications.

### PREGNANCY EDUCATION

Most of pregnancy education for first-time moms came through word of mouth and could be unreliable.

**Many of these women said that the greatest non-medical support came from their social networks.**

### SOCIAL NETWORKS PROVIDED SUPPORT

Family, friends, and neighbors often helped them get to appointments, provided money and transportation for groceries, and helped cover bills and rent. Some were also able to find help from churches and community resources but found that community-based organizations had limited resources and wait times for resources were long**. Social networks were so important to these women during pregnancy that many cited social networks as an anticipated need after pregnancy.** They also wanted to be connected to social networks of other new moms to not feel so alone postpartum and said they would continue to rely on family for emotional and other support

### SUPPORT FROM HEALTH CARE PROVIDERS

Participants reported lack of support related to non-medical needs came from their health care providers, including primary care providers (PCPs) and OBGYNs. One mother even remarked that a specialist was supposed to manage her pregnancy, but she was not allowed to bring her young children to appointments and did not have childcare or reliable transportation to make weekly or biweekly appointments. PCPs and OBGYNs reportedly provided good medical care and support on medical needs, but appointments were short, and providers almost never asked about non-medical needs. Though participants said that information on NMDOH resources were available from providers, it was upon request and participants were either too embarrassed to bring up their non-medical needs or would never have thought to ask their provider about non-medical needs. **Participants said that they would like information on NMDOH resources to be available at a kiosk in waiting rooms, crisis centers, and post offices so as not to need to ask for information.** They also said they would like providers to offer more virtual appointments in consideration of non-medical needs.

### APPRECIATION FOR HEALTH PLAN SUPPORT

When asked, “What role do you see for a health plan when we talk about non-medical needs,” no participant discussed surveying or asking questions. Instead, **they saw the role of health plans in addressing NMDOH as providing resources and information for assistance.** In other questions, some participants noted that no one asked them about non-medical needs and felt that it would be helpful for someone to ask them questions up front**.**

**Nonetheless, participants across the board reported that their Medicaid MCO provided significant non-medical support to enrollees.** One MCO’s enrollees all said that they received excellent care from their assigned case managers, who reached out weekly and provided information on value-added benefits that were useful during and after pregnancy. Requests for better non-medical care from MCOs included expanding networks (as covered dentists did not accept pregnant women and adults), prioritizing childcare services, and providing more postnatal support and resource connections.

# EMPLOYMENT

Without safe, secure employment and housing, people are more susceptible to negative health outcomes. The U.S. Department of Health and Human Services reports that "harmful workplace conditions…can increase the risk for negative health outcomes." A harmful workplace may directly result in fatalities, injury, or illness due to physical over-exertion or exposure to harmful chemicals. Certain workplace behavior, like discrimination and sexual harassment, can worsen those poor working conditions and negatively impact mental health.

A primary concern among mothers who struggled to afford safe and stable housing was making ends meet to afford housing, food, and childcare during and after pregnancy. Aside from lack of childcare, some found it difficult or impossible to work during pregnancy due to physically demanding and uncomfortable jobs, pregnancy-related health complications, and workplace discrimination. Others may have held secure employment throughout pregnancy, but their spouse or partner struggled with secure employment due to uncontrollable factors like weather.

Postpartum, when mothers were physically less able to work or did not have childcare to look after a newborn, unpaid maternity leave and unemployment required spouses and partners to make ends meet on a single-family income, which was sometimes an impossible task. Several mothers were also concerned that they or their spouse or partner would have to take on a second job to make ends meet postpartum.

Participants said they received good support finding employment from MCOs. Several mothers said that their MCO provided job-hunting services but that additional support and services are needed to improve employment security. One mother said it would be very helpful to have childcare assistance set up before delivery so that they could go back to work as soon as possible. Another mother said advocating for paternity leave would help split the burden of childcare postpartum without compromising income or risking employment security.

Several participants from each health plan asked for some form of advocacy for pregnancy-friendly employment. One mother specified help finding secure, comfortable, and preferred employment — not physically-demanding, pregnancy-risking jobs like construction, for example. Another specified help finding jobs that accommodate working from home and are not high stress. Yet another specified needing to educate employers on the rights of pregnant workers to end workplace discrimination.

# HOUSING

Quality housing is healthier housing; living in poor conditions can directly affect health outcomes. However, many people may have no choice but to live in substandard or overcrowded housing. Those in unstable housing situations — including being unable to afford rent — may move frequently, move to more affordable but dangerous places, or become homeless. Such housing instability has been shown to negatively impact children's' health. Additionally, chronic disease and premature death is much more common among adults who are homeless than those who are not, and the mortality rate for women who are homeless is ten times higher than for the general population. Pregnant women who are homeless are also more likely to deliver preterm and low-birthweight babies.

Several participants in these conversations said they were worried about having safe and stable housing; existing insecurity was predominantly due to unemployment or a lack of secure employment. Existing housing support came predominantly from mothers' MCOs. A couple of mothers said that their MCO helped them find safe, affordable housing, and most said that additional support and services were needed to reduce housing insecurity.

# TRANSPORTATION

While transportation is a covered Medicaid benefit, the Texas Medicaid program only covers non-emergency medical transportation services that include rides to doctor's offices, dentist's offices, hospitals, drug stores, or location that provides Medicaid-covered health care services. Reliable transportation also plays a vital role in accessing other interventions that can impact health outcomes. Other state Medicaid programs allow additional locations to help ensure access to services that can address NMDOH, such as transportation to community-based organizations like food banks and churches, education or training, employment search, grocery stores and other essential shopping, community events, and more.

Transportation to medical appointments, stores for groceries and household essentials, work, and school was commonly cited as a difficulty faced during pregnancy by single mothers without a car or mothers who shared a car with their partner. One mother found it especially hard to find transportation support in rural areas. Those who had full access to their own car cited no transportation issues. Those who shared a car with a partner were often unable to use the car because it would cause their partner to miss work.

When public transportation was available, the last mile problem made it difficult for pregnant mothers to use; bus stops were either too far away from home, the destination, or both to be useable. Additionally, lack of seating, shading from sun, and other accessibility features made it physically difficult to wait for a bus.

Even when Medicaid covered non-emergency medical transportation benefits to medical appointments were available, some mothers said that they could not use the service because they did not have childcare to leave their children at home.

Participants received transportation support from several sources, including:

- Family members and neighbors who were willing to drive patients to medical appointments and grocery stores,
- School busses for school-aged children,
- Facebook groups for rideshares, and
- MCO transportation benefits.

Those who struggled to find adequate transportation during pregnancy remained concerned about having transportation after pregnancy. Though walking would eventually be easier, they either had no access to public transportation or feared they would still have difficulty using it to get to farther-away necessities. Several pregnant mothers said they were unsure how to find transportation support once their Medicaid coverage ends.

# FOOD

Pregnant women and children are at risk for malnutrition when they can't access healthy, high-quality foods like fresh fruits and vegetables. But many low-income children and pregnant women in Texas do not have easy access to a store that stocks nutritious food. Almost 2.5 million low-income Texans have low access to grocery stores. Many have no access to public transportation, and more than 135,000 Texas households do not have a personal vehicle and live more than one mile from a supermarket or large grocery store. Closer stores that sell food, like drug stores and convenience stores, do not carry the same nutritious foods available at supermarkets and large grocers. Even when they can access healthy foods, many low-income mothers need financial support to afford those foods.

Though a handful of participants cited no concerns about food security during pregnancy, several others struggled to access affordable, healthy food. Some cited low income as a driver of food insecurity and worried about food running out before there was money to buy more (one mother noted that she often had to prioritize buying food overpaying bills). Another noted that she had limited transportation to get to the grocery store and had to rely on her neighbor to drive her. Several mothers said that it is hard to get healthy foods through food banks and that nutritional food is more expensive, takes more time to prepare, and spoils faster than packaged food; even if nutritional foods were more affordable or readily available through food banks, they are more inconvenient than less nutritious, prepared foods.

Almost every participant received help from WIC, yet most still needed additional food assistance; one mother said that applying for WIC was easier than applying for Medicaid, and a few noted that MCOs provided support getting WIC and SNAP benefits. However, women who qualified for WIC did not always qualify for SNAP. One focus group documented that all five participants qualified and benefitted from WIC and yet four participants said they still needed additional assistance to feed their families, only one qualified for SNAP. Women from other focus groups indicated that having access to SNAP benefits would alleviate food insecurity. Even for those mothers who were ineligible or unable to get SNAP, WIC increased access to fresh fruits and vegetables. Churches and food banks were additional sources of food for food-insecure mothers. Free school lunches eased food insecurity for pregnant mothers with school-aged children.

Looking to the future, several participants said they were concerned about continued WIC assistance to make sure they would have the financial means to provide nutrition for their babies. One was concerned with post-pregnancy travel to the grocery store

after transportation benefits lapsed. Several were concerned with getting food right before and after delivery — one suggestion included a food delivery service that would help to stock food for after delivery.

# CONCLUSION

Ensuring the voice of Medicaid beneficiaries is a part of the conversation is an important step in addressing health disparities and improving access to care. The Centers for Medicare and Medicaid Services (CMS) has also highlighted the need to ensure Medicaid beneficiaries are engaged in a meaningful way and are drafting rules that will reshape states' Medical Care Advisory Committee and will create a Beneficiary Advisory Group.

The information received through the recent workgroups held by the MCOs with support from EHF, MSDF, MHM and St. David's Foundation, provide insight to the direct needs of pregnant women in Texas and re-enforces the need for policies like House Bill 1575 to screen and provide navigation support to pregnant women and HHSC's NMDOH Action Plan which was created to guide HHSC in advancing quality while demonstrating cost containment. Furthermore, the testimonials demonstrate that MCO investments in interventions to address food, transportation, housing and employment insecurity provide much needed support to pregnant women in the Medicaid program.

Information shared also helps identify additional support that could be provided to help improve maternal outcomes and policies that could be explored including:

- Developing partnerships between providers, MCOs and social service organizations to identify ways to provide NMDOH resources to pregnant women.
- Identifying ways to better connect pregnant women to community supports and resources.
- Improving education about the Medicaid non-emergency transportation benefit and exploring Medicaid coverage of transport to additional locations.
- Ensuring providers, MCOs, and other entities working with pregnant women are using a trauma-informed approach to care.
- Providing a flag on MCO files indicating members receiving SNAP and/or WIC benefits to allow MCOs to identify and conduct outreach to their members.
- Allowing greater Medicaid coverage of over-the-counter medications.

The women included in these workgroups also highlighted a major need that Texas is addressing – access to health care coverage. House Bill 12, which provides 12 months postpartum coverage, was recently approved by CMS and the state and MCOs are working to implement it on March 1, 2024. More than 50 percent of all births in Texas are covered by the Medicaid program and extending coverage by an additional 10 months will allow pregnant women to receive much needed health care and non-medical support to ensure healthier moms and babies.