Texas Policy Evaluation Project

RESEARCH BRIEF

MARCH 12, 2015

Family Planning and Primary Health Care Programs in Texas: How Well Are They Working?

In 2013, the Texas state legislature allocated $100 million to provide health care for Texas resident women ages 18 and over with incomes ≤200% of the federal poverty level under the new Expanded Primary Health Care (EPHC) program. Primary and preventive care services are the program's central focus, with a stated goal that 60% of women served receive contraceptive services. Program funds can also be used to cover the cost of a range of other services, such as diagnostic screening for reproductive cancers and testing and treatment for chronic diseases.

Between September and December 2013, more than 50 organizations throughout the state received EPHC funding. This new program is intended to serve as a payer of last resort for women who need services that are not covered by other programs, namely the Texas Women's Health Program and the Department of State Health Services Family Planning program.

To evaluate organizations' experiences using EPHC and other family planning funds to deliver services to women in their community, researchers with the Texas Policy Evaluation Project interviewed executive directors and program administrators at 31 oganizations between November 2014 and January 2015. These organizations included federally qualified health centers, county health departments, hospital districts, academic medical centers, and family planning and primary health care providers in all health regions in Texas.

In this research brief, we highlight what health care providers see as the major strengths and limitations of the EPHC program and their thoughts about the Sunset Advisory Commission's recommendations regarding consolidating existing women's health programs.

Strength #1: Coverage for Broader Scope of Services Was Valued

- Providers are very **happy to be able to provide an expanded scope of service** for their clients. Funding is now available to cover the cost of follow-up for abnormal cancer screenings, as well as diagnosis and treatment for chronic diseases such as hypertension and diabetes.

  "We can make sure that we are giving the patient a holistic approach to care and making sure that when they come and see us for preventative service that the buck doesn't stop with us and they are able to continue care."

Strength #2: The Additional Funding Provided by EPHC

- Some but not all of the providers we interviewed said EPHC funding **greatly increased their capacity** to serve the women in need in their communities, by enabling them to offer highly effective family planning methods to more women than in the previous biennium.

  "We use it a lot. I don't know where we'd be without EPHC."

Limitation #1: Family Planning Was Not Always Successfully Integrated into Primary Care

- At some organizations, **primary care services are prioritized over family planning** given their service model and client population's extensive health needs.

- Some primary care providers **lack the training and confidence to discuss family planning** with clients.

  "Primary care doctors [think they] know how to do family planning, but they do not really; unlike a nurse practitioner who has been doing it for years at a family planning clinic."

Limitation #2: Administrative Barriers Common

- At many organizations, **billing was onerous and required enormous amounts of staff time** to integrate EPHC into existing accounting systems and charge services that were not covered by other programs.

- **Reporting requirements are burdensome**. Providers found it very difficult to use existing infrastructure (e.g., electronic medical records systems) to track the number of clients served since not all eligible services can be coded in a patient's record.

  "It has been a huge challenge…we've spent more hours backing dollars out and moving them around and changing patients over and all of that stuff than we've probably spent [on services]."

- Many organizations often **fell short of the 60% program target**, even when administrators developed systems proactive strategies to recruit women and to regularly monitor the number of women served.

  "I think we are one of the few, at the state level, that is close to the 60%. … I think we were maybe just under 50%. So I think we did everything we could, working closely with our staff with outreach, focusing their attention on women 18 to 44, primarily, anyone needing family planning services, trying to find them."

Limitation #3: Funding Mechanisms Do Not Cover the Cost of Care

- The **fee-for-service model does not cover the cost of offering services**. Some services are reimbursed below the cost it takes to provide the services, and there are no funds to build or support infrastructure and community outreach.

- The **cost per client calculation does not accurately assess program effectiveness** because providing women with the most effective methods, such as female sterilization and long-acting reversible contraceptives, increases program costs. Also, **funding allocations based on cost per client is inadequate** for clients with extensive primary health care needs, particularly those needing prescriptions for chronic diseases.

  "Once you build out that wide open door to your pharmaceuticals, your ancillaries and everything else, there's just no way that $300 per patient covers that … when they have multiple chronic diseases. These are not healthy women at the end of the day that we're working with. So that's the piece that is going to make this not sustainable going forward."

Provider Recommendations: Sunset Family Planning Consolidation

- Providers would **welcome a consolidation of TWHP and EPHC if it would reduce the administrative burdens** that currently exist. However, they expressed concerns about losing coverage for Texas residents and women who are sterilized, as well as point-of-service eligibility.

  "If all this money goes into one pot, and undocumented patients are no longer covered … we will still have them in our system, and we still deliver their babies. But if they are no longer eligible for services under this combined program, then we have a problem."

  "Most [problematic] of all is offsite eligibility. You have to be able to provide services at the time she arrives at the window... you cannot say go to the Medicaid office and come back in six weeks."

- Providers want to **expand age eligibility for women**. Including teens is important, particularly in areas with high rates of teen pregnancy. Women older than age 44 continue to need cancer screening services and protection from unintended pregnancy.

  "I think with dropping the age down to 15 you are going to see a tremendous impact on unintended births in the state of Texas because of the simple fact that you are starting to hit a population where they are becoming most sexually active."

- **Coverage for men is essential**. Expanding program eligibility or establishing a dedicated men's health program will facilitate partner treatment for sexually transmitted infections. Funds could also be used for health education and contraceptive services (e.g., vasectomy).

  "If it's a women's-only program and there's nothing for male STD treatment, I mean, there's no point. They come back multiple times…unless you treat them [both at the clinic] together."

CONCLUSIONS

Based on these interviews, we believe there is a great opportunity to increase the efficiency of the provision of family planning and related primary health care services for low-income women in Texas, and to realize greater reach and quality with the funds allocated for this purpose.

RECOMMENDATIONS

Provider input should be included in the development of a consolidated program. Because of their experience offering care through different funding mechanisms, providers are knowledgeable about the specific family planning and primary care services that take place in a clinical encounter and how these are (or are not) captured in electronic medical records and claim forms. This intimate understanding of the challenges of billing for services and reporting about participants in multiple programs can be used to develop more streamlined processes in a future consolidated women's health program.

Providers also understand their clients' complex life circumstances and health needs and how these can be effectively addressed in their communities to reduce barriers to care. Therefore, they are uniquely positioned to help create a new program that effectively and efficiently meets the needs of women and men in Texas.

To ensure that providers are fully involved in resolving issues that will inevitably arise while implementing a new state state-run health program, **legislation to create a consolidated program should include a permanent advisory committee composed of experienced women's health providers**, as well as consumers of reproductive health services who are likely to be affected by these changes.

TxPEP is a five-year comprehensive effort to document and analyze the impact of the measures affecting reproductive health passed by the 82nd and 83rd Texas Legislatures. The project team includes researchers at the University of Texas Population Research Center, Ibis Reproductive Health, and the University of Alabama-Birmingham.

www.utexas.edu/cola/orgs/txpep