Texas CHIP Coalition & Eligibility Work Group Minutes
Friday, July 25th, 2008 11:00 a.m. – 1:30 p.m.
May Owen Conference Room, 10th Floor
Texas Medical Association

Attendees: Anne Dunkelberg, *CPPP*; Stacey Warren, *Texas Medical Association*; Morgan Walthall, *March of Dimes*; Emily Shelton, *Texas Impact;* Tanya Vargas, *Superior Health Plans;* Chris Yanis, *TAPNH;* Chuck Gurard, *Texas Association of OB/GYNs* Kevin Denmark, *Maximus*; Abby Williamson, *Peoples Community Clinic;* Maria Huemmer, *Texas Catholic Conference*; Candise Spikes, *Catholic Health Association of Texas*, Jan Hudson, *Seton Health Plan*; Scott McAninch, *San Antonio Non-Profit Council*; Nelda Cruz, *HHSC External Relations;* Shane Brewington, *Texas Health & Human Services*; Helen Davis, *Texas Medical Association*; Ivy Goldstein, *Medicaid Access Project*; E. Rex Ann Shotwell, *Insure-a-Kid;* Melissa Shannon, *CPPP*.

Via conference call: Julia Easley, *Children's Medical Center*; Laura Guerra-Cardus, *Children's Defense Fund*; Lisa Rhodes, *Catholic Charities*; Becky Pastner, *St David's Community Health Foundation*; Brittney Manor, *YWCA Dallas*; Jodie Smith, *Texans Care for Children*.

Guests: Dr Janet Realini, *Project WORTH;* Dr Mary Dale Peterson, *Driscoll Children's Health Plan*

Anne Dunkelberg called the meeting to order at 11:05AM

Presentations

Dr Janet P Realini of Project WORTH

Ms Dunkelberg introduced Dr Janet P Realini of the Project WORTH to provide information on reducing unplanned pregnancies and various funding streams for women's and maternal health in Texas. In addition to her work at Project WORTH, Dr Realini has also established the Healthy Futures Alliance and created the BIG DECISIONS curriculum on sexual health.

Unplanned Pregnancies in Texas Risks & Costs

Unplanned pregnancies in Texas are very common, with nearly half of all pregnancies being unintended, and 70 percent of pregnancies for unmarried women in their twenties. Disparities in health care have prevented greater gains in reducing unplanned pregnancies, the rate for women without insurance jumps to 58 percent. The costs of these unplanned pregnancies are high - Texas spent 1.1 billion in 2006 on Medicaid births alone.

The risks to the mother and child are greater for unintended pregnancies; women are more likely to delay medical treatment and less aware of the benefits of prenatal vitamins and nutrition. Other high risks include maternal depression, domestic abuse and fetal substance exposure. Women experiencing an unplanned pregnancy are also more likely to have their children too close together, which also increase the risks to both the mother and child.

Family planning (contraceptives plus educational construct) and preventive care can do a great deal to reduce unintended pregnancies. For every $1 spent on family planning initiatives nearly $4 is saved in Medicaid costs. Family planning initiatives in Texas do not provide access to abortion or primary care - women do have access to some forms of contraceptives and screenings, but state spending on programs amounts to $175 per woman annually. The

patchwork of funding streams and eligibility requirements creates confusion for service users, physicians, and outreach workers. The numbers served are also decreasing because health care costs are more expensive, but the block grants are not adjusted to reflect this. The Texas programs serve fewer than 20 percent of women estimated to be in need.

Dr. R's Policy Recommendations

- Prevent the reduction in Titles V, X, and XX and encourage policy makers to allocate funds to providers who can best serve women in need.
- Increase outreach and education programs for clients and providers to increase the number of women served and to allow women to better time their pregnancies. Currently more than 84,000 women are enrolled in programs with only 54,000 served.
- Include teen mothers under the age of 18 in the Women's Health Program to prevent a short interval second birth.
- Allow physicians and pharmacies to dispense a year's supply of birth control to minimize the risk of unplanned pregnancies.
- Increase tech support (improve TIERS) to increase enrollment and ease transition from Medicaid to the Women's Health Program.

Reducing Teen Pregnancies in Texas

Teen pregnancies are also a costly problem in Texas, the state currently holds the rank for both the highest rate of both first and second births for teen mothers. Texan teens have a higher rate of sexual activity - with 1 in 5 young people under the age 15 engage in intercourse. Just over one third of girls become pregnant before the age of 20 and for Latinas the rate increases to over half. Teen pregnancies in Texas cost at least $1 billion annually and they experience greater risks in childbearing.

Sex education can be helpful in reducing teen pregnancies and other health risks associated with sexual activity. Currently sex education in Texas is not required, and some abstinence only programs have used teaching methods that exaggerate negative info on contraceptives (failure rates, etc). There is a demonstrated need and desire from parents for "abstinence plus" programs in public schools, (which also include information on contraceptives and condoms). Such programs have resulted in delaying sexual experiences and increased the use of contraceptives.

Policy Options for Texas on Teen Pregnancy

- Increase access to abstinence plus programs that emphasize the importance of birth sequencing and planning a positive future. Such programs often reduce teen pregnancies and high school drop-out rates.
- Include accurate info on contraceptives in sex education programs. Information distributed to young people must be medically accurate and not encourage sexually active teens to stop using contraceptives.
- Permit teen mothers to consent to contraceptives, currently mothers under the age of 18 must gain parental consent to access contraceptives.

Ms Dunkelberg expressed concern over automatic referral to WHP defeating the cause-neutrality clause and was curious to know if anyone had investigated the issue. Dr Realini explained that she hoped this would be addressed in a conference call with HHSC. She invited members to participate in the call.

Items for Follow-Up

The details of the HHSC conference call and Dr Realini will be distributed on the Coalition listserv.

Dr Mary Dale Peterson of Driscoll Children's Health Plan

Ms Dunkelberg introduced Dr Mary Dale Peterson from Driscoll Children's Health Plan to provide information on the Women's Health Program (WHP) and Medicaid maternity coverage in Texas.

Accessing the Women's Health Program

The Women's Health Program is increasingly difficult to access - many inconsistencies create unnecessary barriers to care. The application process is redundant - the information necessary for the application had already been completed when applying for Medicaid Maternity coverage, which is frustrating for applicants. Some of the questions included on the form that create confusion and also prevent complete applications, for instance applicants are expected to report "gifts," but application does not specify monetary limits for these gifts.

The drug and treatment options available are very limited - doctors must complete screenings for high blood pressure, STDs, diabetes and obesity but cannot treat these problems. This creates an ethical dilemma for office-based doctors(i.e., providers other than Family Planning clinics) and reduces their willingness to treat clients in WHP. The system currently does not allow payments for nutritional courses or counseling for overweight or obese women. Obesity rates are increasing among pregnant women, causing these women to deliver bigger babies, which also leads to a greater number of C-sections and increased costs. Obesity also increases the risk of pre-existing or gestational diabetes, which leads to poor infant organ development and other congenital anomalies. We want individual dieticians to work with these women one-to-one. The Driscoll Children's Health Plan is providing this care in the hopes of reducing costs by having healthier mothers having healthier babies.

There are also some concerns regarding the time limits for Medicaid, it currently only allows 60 days of treatment after delivery, but 30 percent of our mothers at risk are often still unstable after the expiration of the time frame. They could also do more to educate women about the benefits of birth spacing and focus on the pre-conception phase – this would be more cost effective in the long-term.

Ms Dunkelberg asked for clarification on the plans to focus on. Dr Peterson explained that it should be Medicaid, WHP and perinatal program because it is a really cheap way to improve the births of our babies. She explained that there have been a number of programs that Driscoll has implemented in an effort to improve health and cut costs. One such initiative was the Cadena de las Madres Program, which is similar to the Nurse-Family Partnership, but uses lay-health care workers to keep costs low. They have educational baby showers and a support group which offers peer mentoring. It started because all of the birthing classes in the area had been dropped and there need to be some way of educating women on the benefits of breast feeding, making doctor's appointments and basic nutrition. The sessions are very well attended and received a lot of positive feedback.

Driscoll is also offering basic dental care for pregnant women, offering preventive care and simple extractions. Women also receive a dental discount card to help with anything that would require a dentist outside the hospital service. It's very basic but very cost effective.

Dr Petersons' Policy Recommendations

- Make a better effort to identify high risk women - this could be achieved by starting with a small percentage of those targeted and focus on encouraging appropriate spacing between births.
- Upon enrollment in Medicaid, prior birth histories should be available for doctors upon request.
- Continue Medicaid coverage past the 60 days after delivery to allow continuity of care – this is especially important for women with risky pregnancies.
- Implement a better pregnancy prevention strategy for teens and unmarried women.

Ms Dunkelberg asked if it was federal rules that set the 60 day requirement. Dr Peterson acknowledged this might be the case but a number of other states are able to work around it and provide better care for women in Medicaid. It was noted that the first step would be to make sure that all eligible women get referred to the WHP and this would be addressed at the August meeting when creating the upcoming principles.

With no other agenda items the CHIP Coalition meeting adjourned at 12:34 p.m.