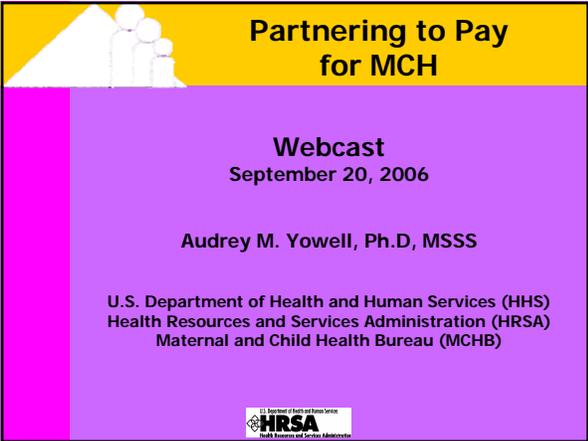


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**Partnering to Pay for
MCH: Part II, The
Public Sector**

Webcast
**Wednesday, September 20, 2006
1:00-3:30pm Eastern**



**Partnering to Pay
for MCH**

Webcast
September 20, 2006

Audrey M. Yowell, Ph.D, MSSS

U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau (MCHB)



The AIM Program

- Alliance for Information on MCH
- Grantee collaborative



Participants

- National membership organizations
- Members include decision-makers in:
 - State and local government
 - MCH professions
 - Foundations
 - Health insurance industry
 - Business
 - Family advocates



Purpose

- Help members make well informed decisions
- Public health policies and programs for women, children and families.
- Alert the MCHB to emerging issues





The Collaborative

Grantees under two MCHB programs

- Partnerships to Promote Maternal and Child Health (PPMCH)
 - Members focused on MCH
- Improving Understanding of Maternal and Child Health (IUMCH)
 - MCH as one of many areas of concern





AIM Partners

- American Academy of Pediatrics (AAP)
- American Academy of Pediatric Dentistry (AAPD)
- American Bar Association (ABA)
- Association of Maternal and Child Health Programs (AMCHP)
- Association of State and Territorial Health Officials (ASTHO)
- CityMatch (University of Nebraska)
- Grantmakers for Children, Youth & Families (GCYF)
- Family Voices
- Grantmakers in Health (GIH)
- National Association of County and City Health Officials (NACCHO)
- National Business Group on Health (NBGH)
- National Conference of State Legislators (NCSL)
- National Conference of State Legislators Consortium (with NGA, ASTHO, AMCHP)
- National Governors Association (NGA)
- National Healthy Start Association
- National Institute for Health Care Management (NIHCM)
- Today's Child Communications
- -----
- MCHB





Value Added

- Different perspectives
- Share expertise
- Educate each other and MCHB about MCH issues and practices



The Challenge

- Climate of fiscal austerity
- How to support essential MCH programs and services?



Two AIM Webcasts

- Varied perspectives:
 - Business, health insurance, philanthropy (June 6, 2006)
 - State and local government (today)



For more information:

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Shrinking Federal Funds for Public Health: What and Why

Donna L Brown, JD, MPH
Government Affairs Counsel
Senior Advisor for Public Affairs

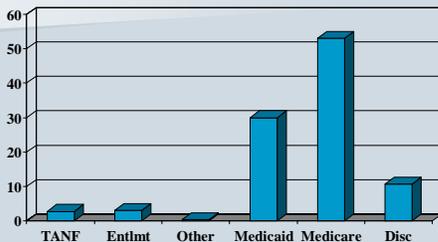


Two Categories of Funding for Maternal and Child Health

- **Entitlement** (Medicaid, SCHIP)
 - Cuts are made by changing the rules of the programs
- **Domestic discretionary** (HRSA and everything that is not an entitlement)
 - Cuts are made by reducing Congressional appropriations
- Both are strained by increasing costs

HHS Budget FY2006: \$642 B

Discretionary Total: \$67 B



Which do you think is easier for Congress to cut:
Domestic discretionary spending or entitlement spending?

Answer: Cutting domestic discretionary spending.

Why?

- Congressional appropriators are bound by budget caps which are set annually by a Congressional budget resolution.
- Appropriations legislation is an annual event. Entitlement programs are revised far less frequently because they are more complex and politically volatile.

What's a Budget Resolution and Why Does it Matter?

- Congressional budget resolutions set caps on discretionary (non-entitlement) spending. They determine the overall size of the fiscal "pie".
- The Appropriations Committees have the job of slicing up the pie. If the pie contracts in size, their ability to add spending is limited.
- Appropriators have told public health advocates to pay attention to the budget resolution because it ties their hands, no matter how sympathetic they are.



A little history:

- For years, Congress never succeeded in passing a budget resolution. The budget process had no practical effect.
- In 2005, Congress defied all predictions and passed a tight budget resolution for the first time in a very long time.
- This year, a massive effort by the health, public health, education and labor communities to add funding for these programs succeeded -- \$4 billion over the President's proposal in the House and \$5 billion in the Senate. House and Senate have not agreed on a final version and they won't this year, but both chambers will observe their own caps.

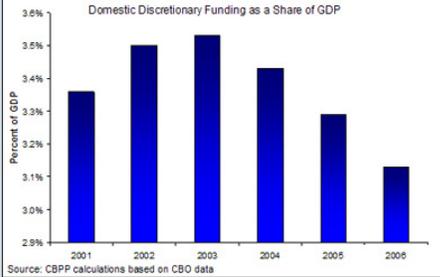
Question: If budget caps are so tight, how are we paying for continuing Katrina relief (and Iraq and Afghanistan?)

Answer: "Emergency spending."

If the House or Senate agree to designate spending as "emergency", it doesn't count. Pandemic influenza funding has fallen under this rubric, for instance.

Declining Domestic Spending

Since 2001, Funding for Domestic Discretionary Programs Has Fallen as a Share of the Economy



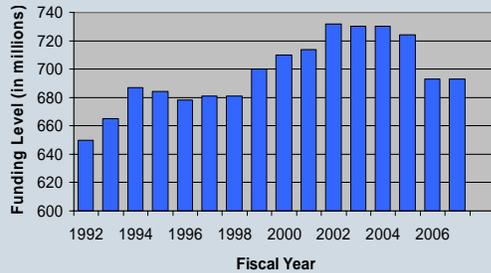
Where are we now?

- Funding for the maternal and child health block grant has followed a typical pattern. It was "level" for 4 years and took a 3% cut in FY 2006. However, each year there has been inflation. And each year Congress has imposed an across-the-board cut, which takes small "bites" out of every single federal discretionary program.
- For FY 2007, the President proposed "level" funding of \$693 million....less than FY 1999.
- Small bites add up to a big mouthful of cuts over time.



Changes in MCH Funding

MCH Block Grant Appropriations



Data sources:
<http://www.amchp.org/aboutamchp/publications/title%20%20%20Funding.pdf>
http://www.whitehouse.gov/omb/expectmore/detail_10000268_2005.html

State Legislators & Spending Priorities

MCHB Webcast "Partnering to Pay for MCH"

Kansas State Representative Melvin Neufeld
for the
National Conference of State Legislatures (NCSL)
September 20, 2006

National Conference of State Legislatures (NCSL)

NCSL is a bi-partisan national membership organization of all the state legislatures

Goals:

- ← To improve the quality & effectiveness of state legislatures.
- ← To promote policy innovation & communication among state legislatures.
- ← To ensure state legislatures a strong, cohesive voice in the federal system.



State Legislative Roles

- ← Control the purse strings: \$\$\$\$\$\$
- ← Determine state policy
- ← Establish programs
- ← Enact requirements
- ← Provide oversight



Legislators Deal with DOZENS of topics and competing demands

- ← From A to Z:
 - ← Agriculture
 - ← Corrections
 - ← Education
 - ← **Health**
 - ← Housing
 - ← Human Services
 - ← Labor
 - ← Transportation
 - ← Zoning . . .
- ← Hundreds or thousands of bills
- ← Can't do everything for everybody or fund everything people want



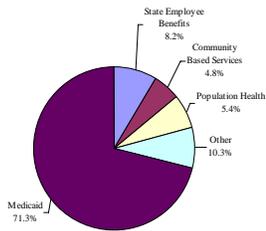
Health Issues by the Dozens

- ⊗ Medicaid
- ⊗ Insurance/mg'd care
- ⊗ Pharmaceuticals
- ⊗ Long-term Care
- ⊗ Uninsured
- ⊗ Professional licensure
- ⊗ **MCH**
- ⊗ Environmental
- ⊗ Public Health
- ⊗ Bioterrorism/avian flu
- ⊗ SCHIP
- ⊗ Prenatal Care
- ⊗ End-of-life
- ⊗ Obesity
- ⊗ Oral health
- ⊗ Injury Prevention
- ⊗ Mental Health
- ⊗ Disabilities
- ⊗ Substance Abuse
- ⊗ etc. ...

State Budget Pressures

- States: still rebounding from a \$235 billion gap since FY 2002
- Health spending accounts for 31% of the average state's budget
- Health costs far outpace inflation
- With rising health costs, simply maintaining current health programs is a challenge
- Legislatures face MANY competing demands

Distribution of the Average State's Budget for Health Services (2003)



Source: Milbank Memorial Fund, National Association of State Budget Officers and The Reforming States Group, 2002-2003 State Health Expenditure Report (New York: Milbank Memorial Fund, 2005). <http://www.milbank.org/reports/OSNASBO/index.html>

State Budgets & Health Costs

Source: NCSL, survey of legislative fiscal offices, 2001-2006

Year	State Revenues	Medicaid
2001	-0.7%	8.1%
2002	2.1%	8.6%
2004	4.3%	12.8%
2005	6.8%	14.6%
2006	2.7%	8.2%

More Bad Budget News ...

- Congress shifted \$75 billion in costs to states between FY 2004 & 2006
- Federal mandatory spending:
 - 1965: 27% of the budget
 - 2005: 54% of the budget
- FY 2008, 19 states anticipate structural deficits

Sources: U.S. Comptroller General David Walker at NCSL's 2006 Spring Forum; and NCSL's Fiscal Program

Is there a Silver Lining?



How Appropriations Decisions Are Made

- Identify state needs
- Review existing programs
- Listen to constituents
- Determine resources
- Establish priorities

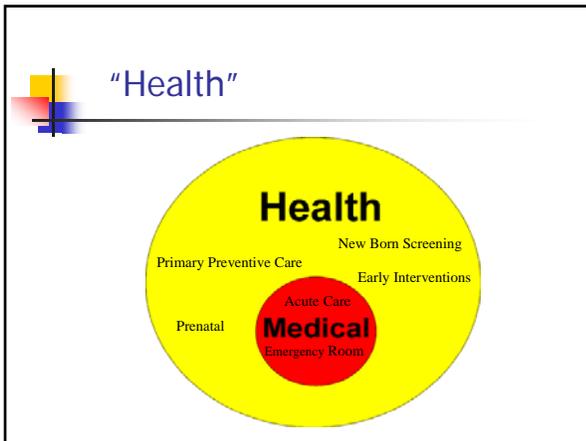
Legislators Need Facts & Input

- We want to be good stewards of the public purse
- We need good data and evidence
- We need programs to be accountable
- We want to be good partners with others to meet state needs



Containing Health Costs

- Health vs. "Health Care"
- Primary Preventive Care
- Buy Smart (data-driven)
- Improve Outcomes (data-driven)
- Set Limits



- ## Evidence Supports:
- Prenatal care
 - Highest return on investment
 - Early brain development
 - Toxic Stress in the home is a major obstacle to early development
 - Newborn screening
 - Early identification of problems

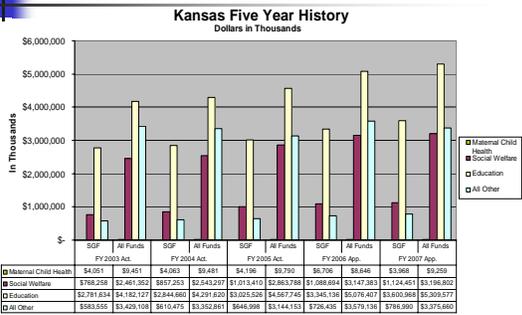
- ## Effects of Toxic Stress During Early Childhood
- | | |
|--|--|
| Mental Health: <ul style="list-style-type: none"> ■ Depression ■ Anxiety disorders ■ Alcoholism ■ Drug abuse ■ Learning & Memory | Physical Health: <ul style="list-style-type: none"> ■ Cardiovascular disease ■ Diabetes ■ Stroke |
|--|--|
- Source: National Scientific Council on the Developing Child*

State Challenges: Decision-Making

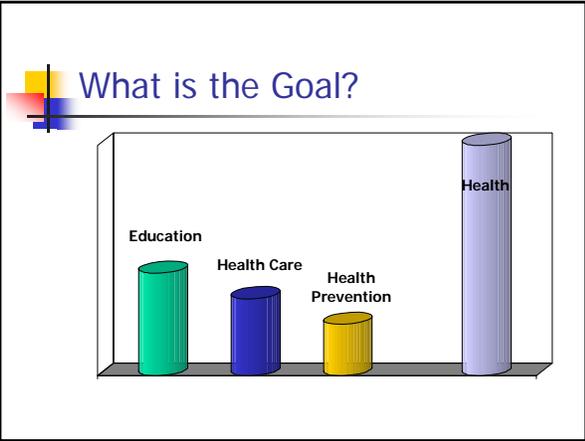
Cowboy Logic: You can't get there if you don't know where you're going.

"The definition of insanity is doing the same thing over and over again and expecting a different result." - Albert Einstein

Can You Find the MCH Expenditures?







- ### Dos and Don'ts: Working with Legislators
- | | |
|---|---|
| <p>DO:</p> <ul style="list-style-type: none"> o Get involved (year round) o Be accurate, reliable, honest, concise, and vigilant o Build relationships early o Reach out to new members (broaden network) o Offer to be a resource o Be inclusive of others o Have concise written materials o Personalize the issue/take a field trip o Work with education and health care advocates o Thank your audience | <p>Don't:</p> <ul style="list-style-type: none"> o Assume you don't count o Mislead or give false information o Make enemies o Wait until the session o Be too narrowly focused o Exclude other child advocates o Refuse to compromise o Go on and on . . . o Give up |
|---|---|

Partnering to Pay for MCH

State MCH Programs

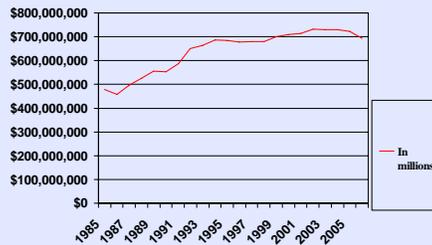


Partnering to Pay for MCH:
Title V: A Federal-State

- Title V of the Social Security Act authorizes federal funds for State MCH
- Funds converted to MCH Block Grant in 1982
- State to Federal match 4:3
- Maintenance of effort (1989)



Partnering to Pay for MCH:
MCH Block Grant Funding 1985-2006





Partnering to Pay for MCH:
Impact of FY2006 Cuts to MCHBGH

- Survey of States Conducted by AMCHP's Regional Directors
- 3 Surveys Per Year
- Question Focused on Impact of Title V 2006 Reductions by Congress
- Data from Summer 2006 Survey



Partnering to Pay for MCH:

Impact of Title V Reductions

- Direct Services
- Administrative
- Payer/eligibility



Partnering to Pay for MCH:

Impact of Title V Reductions

<u>Services</u>	<u># of States Affected</u>
■ Family Planning	14
■ Children's Services	14
■ Adolescent Health	13
■ CSHCN	8
■ Program Development	17



Partnering to Pay for MCH:

Impact of Title V Reductions

Reductions in Admin and Eligibility

<u>Administration</u>	<u># of States Affected</u>
Training/Evaluation	9
TA/IT support	8
Staff Eliminated/Frozen	18-20
<u>Eligibility</u>	
Prior Auth/Payer of Last Resort	3
Stricter Eligibility	6-7



Partnering to Pay for MCH:

Impact of Other Factors

Issues Impacting Funding Solutions:

- > Funding Cutbacks Outside Title V
 - > State
 - > Local
 - > Other Federal funding
- > Medicaid Changes
 - > Deficit Reduction Act (citizenship, eligibility, etc.)
 - > State restructuring of Medicaid
- > Cost of Undocumented Persons
 - FL Experience: \$10.5 mil. in 1996;
 - \$74.2 mil. in 2005



Partnering to Pay for MCH:

Problem-solving during Cutbacks: I

- Reduction of administrative expenses
 - Consolidation
 - Less expensive alternatives
- Changing the way services are delivered
 - Contracts
 - Resource sharing
 - Service integration
- Negotiating better Contracts
- Improving Contract Administration
- Better employee oversight
- Use "carry forward" funds for short-term problems



Partnering to Pay for MCH:

Problem-solving during Cutbacks: II

- Cost-Shifting
 - Medicaid
 - Insurance
 - Partners
 - Families
- Seek funds from reductions in other programs.
- Replace lost funds with new state funds
- Cut back lower priority services
 - Administrative services usually first for reductions
 - Geographic locations
 - Services delivered
 - Populations covered
- Eliminate lower priority services



Partnering to Pay for MCH:

Problem-solving during Cutbacks: III

- Importance of planning, working for **long term**
 - Business cycle important
 - Plan ahead for the “down” periods
 - Seek compelling arguments, data to justify **initiatives** for “up” periods
 - **Plan, work with partners**
 - **Market ideas effectively**

Local MCH Services In Arkansas

Zenobia Harris, BSN, RNP, MPH
Patient Care Manager
Arkansas Department of Health
and Human Services
Division of Health

Changes in the MCH Landscape

- Funding stream narrowed/altered
- Political motivations
- Population shifts

Arkansas' Story

- Funding shifts



Performance based Franchise targets



- Each Public Health Region assigned them
- Adjustments to staff and funding made based on performance
- Numerous monitoring tools developed and utilized to assist Regions

Population shifts

- Increasing Hispanic population in some areas of the state
- Local public health response not always rapid enough to serve demand
- Increased medicaid eligibility of clients resulted in shift to private sector of some former public sector clients

All Family Health Services

- Same Day Scheduling
- "Franchise" Program targets

WIC

- Limit other services to reach targets
- Specialization of staff

Women's Health

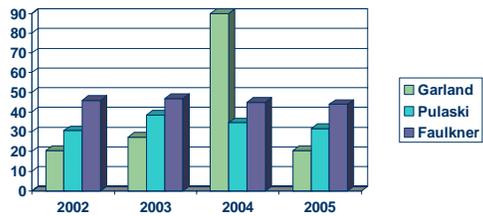
- Family Planning caseload Targets
- Maternity caseload targets
- Reduction in some areas
- Limited outreach
- Methods of care changing



Maternity Services

- Enhanced access to Private providers
- Hispanic population increase
- Initial visit emphasis

Reproductive Health Targets



Immunizations

- Decreased opportunities



School health

- Programs Cut



Well Child Clinics

- Eliminated



Survival Strategies

Monitoring

- Measuring Franchise goals closely
- Improvement plans
- Consequences shared

Hometown Health Approach

- Local partnerships to leverage services for the community



Funding shifts

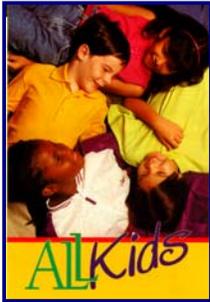
- Using other funds to pay for MCH staff



Conserving resources

- Leveraging relationship within DHHS family
- Limits on supplies
- Sharing /Rotating staff in critical need areas

Alabama Children's Health Insurance Program

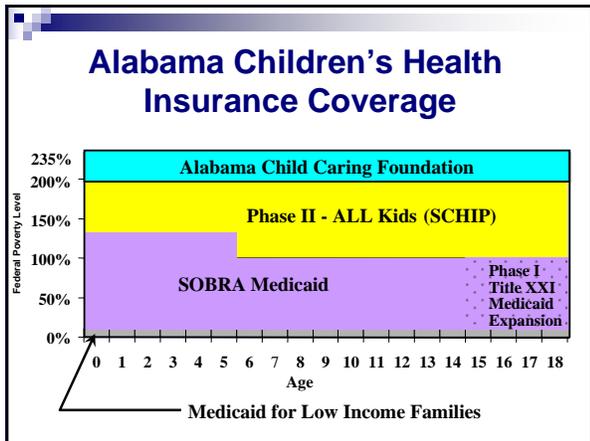


National Governors Association
"Partnering to Pay for MCH: Part II,
The Public Sector"
September 20, 2006

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Points of Discussion

- SCHIP Cost Sharing using "Administratively Simple" processes
- Collaboration to accomplish SCHIP goals
- Building electronic interface with SCHIP, Medicaid and Alabama Child Caring Foundation (ACCF)



- ### ALL Kids – “Administratively Simple” (Program Issues)
1. Self insured, private insurance model
 2. Bought into existing “private” insurance systems
 3. 3 program application
 4. Centralized processing
 5. Mail-in application
 6. Web-based application
 7. Self declaration of eligibility criteria
 8. Yearly premiums with 10 months to pay
 9. Co-pays collected by providers
 10. Outreach designed to “Teach the People Who Reach the People”

All Kids Parents

<p>Low Fee</p> <ul style="list-style-type: none"> ▪ Annual Premium \$50/ child for the first 3 children. ▪ Co-pays \$3.00 - \$10.00 	<p>Fee</p> <ul style="list-style-type: none"> ▪ Annual Premium \$100/ child for the first 3 children. ▪ Co-pays \$5.00 - \$20.00
--	---

•No fee – (Native American children only) no co-pays or premiums

“Administratively Simple” Cost Sharing Procedures

- Annual Premiums vs. Monthly Premiums
- 10 months to pay premium
- May make partial payments
- Pay Smart - 
- Quarterly premium notices
- Must pay premiums to renew for following year
- May use credit cards
- Small co-pays
- Co-pays collected by provider

Collaboration

SCHIP Implementation through workgroups

- Providers
 - Medical Association
 - Pediatricians
 - Emergency Room Physicians
 - Hospitals
 - Federally Qualified Health Centers (FQHC)

Collaboration (Continued)

- Advocates
 - Children Health Care Access
 - Anti-Poverty
 - Mental Health Access
 - Business Councils
 - Covering Kids & Families – Robert Wood Johnson Foundation (RWJ)
- Legislative Branch
 - Legislators

Collaboration (Continued)

- Executive
- State Agencies
 - Public Welfare
 - Mental Health/Mental Retardation
 - Rehabilitation Services
 - Title V – CSHCN
 - Public Health
 - MCH
 - Regulatory
 - Social Work
 - Nursing
 - Minority Health
 - Rural Health
 - Insurance Department

Collaboration (Continued)

- Children's Insurance Programs (ALL Kids, Medicaid, Alabama Child Caring Foundation)
 - Regular monthly meetings to problem solve
 - Problem research using Robert Wood Johnson – Supporting Families After Welfare Reform and Covering Kids & Families Grant
 - Co- location of Medicaid & ALL Kids Staff
 - Social Workers on staff – problem solve and identify policy differences

Joint Application

1. ALL Kids
2. Alabama Child Caring Foundation (ACCF)
3. Medicaid
 1. SOBRA
 2. Medicaid for Low Income Families (MLIF)
 3. Family Planning Waiver
4. Mail-in applications
5. Joint application Distribution
 1. 40% Medicaid 40% ALL Kids 20% ACCF
6. Pre-Printed Renewals

Regional Staff

- Located around the state
- “Teach The People Who Reach the People”
 - Outreach – Collaborate with local entities
 - Systems coordination

Electronically Connect Children’s Insurance Programs

- Use RWJ – Supporting Families After Welfare Reform grant with CHIP matching dollars
- Built electronic interface between ALL Kids, Medicaid and ACCF system – ALL Kids and Medicaid can communicate with it.
 - Automated Data Integration
 - Web-based application
 - Approximately 1,000 web applications per month
 - Medicaid – 48%
 - ALL Kids (SCHIP) 39%
 - ACCF – 10%
 - Not eligible – 3%

Electronically Connect Children’s Insurance Programs (Continued)

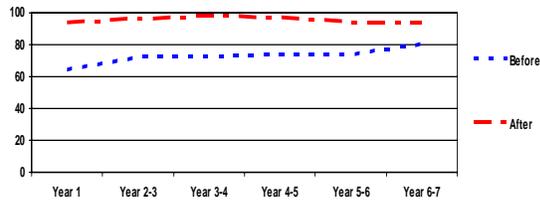
- Reduce processing time
- Decrease keying errors
- More effective routing of families to appropriate program

Accomplishments

As documented by the University of Alabama @ Birmingham, School of Public Health, through ALL Kids First year retrospective, New enrollees, and Continuous Enrollee surveys

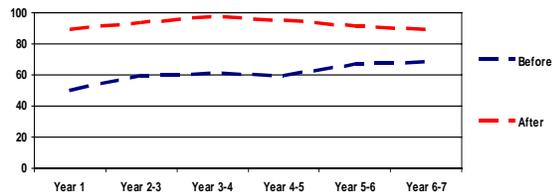
- Alabama's SCHIP program continues to have an impact on reducing the rate of uninsurance in low-income children in the state
- Children in ALL Kids show better access and utilization of healthcare services after enrollment
- Systems of coordination and administration of children's health insurance programs have been improved

Access to Medical Care



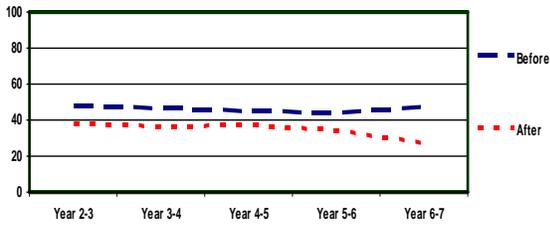
- Respondents report more access to medical care when needed, with the most significant change in the first year from 64 to 94 percent
- The gap between the before and after has narrowed; more children are coming into ALL Kids with prior access to medical care many through the Medicaid system; the whole system of providing care for children has shown improvement and collaboration

Children with Special Needs Access to Care



- After enrollment, the number of respondents with children with special health care needs who were able to get needed medical care increased in every year of the program
- An average of 61% before and 92% after enrollment were able to get medical care needed for their children

Emergency Room



- Respondents also reported fewer children utilizing the emergency room for care: the average over three years was 46% before enrollment and 34 % after enrollment
- The before and after enrollment in ALL Kids' picture continues the trend of improvement as the system insures more children and ER usage has declined

The System Works

- Since ALL Kids the systems that cover children's health have improved
- Fewer children come onto the program uninsured
 - Before the program, about 30% of children enrolling in ALL Kids lacked health insurance; 2005, the percentage was about 23%. Therefore, children are moving between programs to stay insured. Not a "crowd-out" issue.
- More children have continued access to care
 - More respondents reported their children always having health insurance, which greatly improved from 6 percent in 1998 to over 38 percent in 2005; parents often consider Medicaid coverage as a kind of health insurance



Leave no child behind

Contact Information

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Questions & Answers

Please complete the evaluation at the end of the webcast.

Please visit <http://www.mchcom.com> for an archive of this event and others.
