Partnering to Pay for MCH:

Part II, The Public Sector

September 13, 2006

AUDREY YOWELL: Good afternoon. And welcome to our webcast, Partnering to Pay for Maternal Public Health. I'm Audrey Yowell. I'll review the ways you can use your computer interface during the webcast. Slides will appear in the central window on your screen and should advance automatically. The slide changes are synchronized for the speaker's presentations. You don't need to do anything to move the slides forward. You may need to adjust the timing, though, and you can match the audio by using the slide delay control at the top of the messaging window.

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minutes to do the online survey. It will help us to improve the presentations and technical quality.

Next slide. The webcast emerged out of the concerns of the grantees to participate in the alliance for information on MCH, the collaborative we call Aim. It's national membership organizations whose members are decision makers in state and local government, MCH professions, foundations, advocates for family. The purpose of the collaborative is help members of those organizations make well informed decisions affecting public health policies and programs, for women, children and family, and to alert the MCHB to issues across the nation. The AIM collaborative -- it has grantee organizations whose members are focused on maternal and child health, and improving and understanding the maternal and child health including organizations whose members have decision making responsibilities for MCH. We have 16 grantee partners and MCHB is the 17th and equal partner.

Beyond the value of these grant programs alone, an added value in convening the two and this provides opportunities for these organizations with very different perspectives to share expertise and concerns, and to educate one another as well as the bureau about emerging issues and promising practices. During the first meeting of AIM in February of 2006, great concern was expressed by the grantees about how to continue to support and maintain essential MCH services in the current climate of fiscal austerity. This is the second of two designed to address the challenge, and each webcast features representatives of our AIM partners. The first on June 6 explored the business, health

insurance and philanthropy and it was archived and can be viewed like the one today, www.mchcom.com. Our webcast today will address the perspective of organizations representing public sector folks, state and local government officials. For more information you can contact me.

We'll have a slide available end of the broadcast, or you can reach me at email and by phone 301-443-4292. And now to begin our discussion of partnering to pay for MCH, I'm pleased to introduce our first presenter, Donna Brown.

DONNA BROWN: Thank you, Audrey. I'm delighted to be here with you to talk about a topic that is important, timely, and often difficult. What I'm going to do is set the stage for the rest of the discussion by giving you the briefest of overviews of why federal funds for health is shrinking, and how it translates into small program cuts which I think many of you have been experiencing for many years now. Next slide, please. It helps to divide the maternal and child health funding for the purposes of my discussion into two broad categories. Entitlement spending, predominantly Medicaid and SCHIP, and there is discretionary funding, HRSA and everything else. There are different congressional rules and procedures, different committee jurisdictions and there are different politics associated with each of them. They're both, of course, strained by increasing costs. I suspect I don't need to tell you which one is larger.

Next slide, please. This graph shows you just how much larger in the Department of Health and human services budget for FY 2006 domestic discretionary programs are

compared to, or entitlement programs are compared to domestic discretionary programs. The Medicare and Medicaid you see, the tall columns there, the skyscrapers, represent more than 80% of the federal Department of Health and human services budget. Discretionary programs encompasses a wide range of funding sources. Everything at the national institutes of health, food and drug administration, Centers for Disease Control and Prevention and so on, as well as many discretionary human services programs. They represent a little more than the 10% of the HSS budget.

Next slide, please. The question arises, which is easier for Congress to cut? The answer you see before you, and that is the much smaller pot of the domestic discretionary spending. There are a number of reasons for this. But I'll point out two of the most important ones. The first is that congressional appropriators who control the discretionary spending are bound by budget caps by a resolution. I will get into that topic a little more briefly because it's incredibly important. Secondly, Congress has to pass appropriations legislation every single year, if they didn't, the federal government would shut down. By contrast, entitlement programs tend to be revised far less frequently, they are more complex and we know they are politically more volatile.

Next slide, please. What's a budget resolution and why should we all care? A congressional budget resolution is essentially a rule that Congress sets for itself every year, and it sets caps on discretionary spending. The effect of a budget resolution is to determine the overall size of the pie from which all discretionary programs, of which all discretionary programs constitute a slice. The role of the congressional House and Senate

committees is to slice up the pie by the competing demands. The ability of the appropriators to add spending is limited and sometimes they have to make very painful cuts, as you all know. Many people at this table represent organizations that have spent a long time advocating for funding for maternal and child health at the federal level. The appropriators have told us their hands are tied by the budget resolution, no matter how good a case we make, how sympathetic the programs are, and there are few as sympathetic as health for mothers and children, there is really nothing they can do because of the caps imposed on them by the congressional budget resolution.

Next slide, please. A little history here is pertinent and I will not go through everything on the slide, but for years Congress actually never succeeded in passing a budget resolution and the caps to which I'm referring frankly had no practical effect what appropriators were able to do. Those are years in which the discretionary programs saw fairly consistent and sometimes generous increases. However, in 2005 Congress defied the predictions of almost every political pundant in Washington and passed a tight resolution the first time in a long time. This year the health, education and labor communities rose to the challenge that appropriaters had set for them and addressed the budget resolution. They mounted a very substantial joint effort to increase funding for the bill that funds the Departments of Labor, Health and Human services and Education, all lumped together under a single budget cap. That effort succeeded, gaining over 4 billion over the president's proposal in the House, and 7 billion in the Senate, 5 billion has materialized. The House and Senate have not agreed on a final budget resolution and we don't think they will but they will observe their own budget caps. A question many people ask, if budget caps are so tight,

how is it that we are paying for much needed relief for the victims of Hurricanes Katrina and Rita, as well as the expenses in Iraq and Afghanistan. Any time Congress wishes to exempt funding from budget caps they can do so by nominating it as emergency spending. So far in 2006, two large emergency spending bills have passed. Funding for pandemic influenza preparedness has fallen under this rubric.

This graph shows you in a way how funding for domestic discretionary programs has fallen as a share of the economy. You notice the slow downward has grown dramatic since the year 2003. Where are we now? The funding for the block grants and Dr. Sybinsky will be addressing that later, has followed a typical pattern. It was about level for four years, but it took a 3% or so cut in FY 2006, the current fiscal year. However, remember each year there is inflation and inflation in health care costs is higher than that in the general domestic economy. Moreover, each year, in order to meet budget caps or budget targets, Congress has taken, at the very last minute, small across the board cuts in all domestic discretionary programs. Very few have been exempt. Those cuts have ranged from .7% to 1.1% each year. If you do that, I'm sure you can see for a number of years that amounts to a big mouthful of cuts over a small -- over a period of time. For the next fiscal year, the president again proposed what I call level "funding of $693 million or so" for the maternal child and health block grant.

This is my final slide and it shows you I think quite dramatically what many of you may have experienced in programs if you work on the MCH block grant. This year we are, in fact, back to what the level of funding was about in fiscal year 1999. In other words, back

to where we were eight years ago. No wonder all of you and all of us are facing great challenges to continue services. With that I will turn you over to State Representative Melvin Neufeld.

MELVIN NEUFELD: Thank you. A pleasure to be here and I want to start out by thanking HRSA, it's my experience in the 20 years in the legislature, HRSA has done a great job of disseminating the information to local government officials and we appreciate what they do. I'm here on behalf of the conference of state legislators and I happen to be on the executive committee of that group. NCSL is a bipartisan membership group, composed of members of every state around the nation, and we have some goals to improve the quality and effectiveness of the state legislators, to promote policy, innovation and communication, and to ensure that state legislators have a strong voice in the federal system in Washington. We also work together with the national conference of governors and the other groups of leaders from state government that deal in Washington.

Next slide. The roles of the state legislature are to control the purse strings. And of course to control the purse strings it's incumbent upon us to make sure that we understand the state policies we are trying to implement. We establish or disestablish programs in order to keep that control of policy and money. We, of course, put the requirements as we can on state programs and provide oversight, but really determining the state policy of how programs are going to be implemented is really the main role of the state legislators and as we are trying to control the money.

Next slide. In the legislature we deal with everything. We have, of course, I'm from Kansas, we have a number of agricultural issues. Always on the front, and we currently are, for example, are looking at having to build some new prison space. Health and health-related issues are a big issue on our screen always in the legislature. A big percentage of our budget. And of course as you all know, zoning and eminent domain are also big issues of late in the state legislatures.

Next slide. Just On the issue of health issues, state legislators have many challenges and issues to set policies on and so we have a number of things, and some of those are there on your slide. Medicaid, big pots of money, but there are a lot of other issues there. The insurance policy of the state, thank goodness states still have some say on insurance policy and regulation of insurance. And it's not been taken over by the federal government yet, although some people like to do that. But we think that's real important for states to have control so that advocates for different programs have the opportunity, in fact, to come, lobby the local legislature and do things that will work in a particular state and keep that opportunity alive. Obviously long-term care is a major issue. It's really the deal breaker for both Medicaid and Medicare in the future. Unless we change how we look at that issue, Medicaid and long-term care in our state, within 20 years about 100% of our state budget will be in the two line items. So obviously we are all concerned about how we handle those issues. There's, on the whole list another things, and one of the little boxes I have there, it happens to be in red, maternal and child health.

Next slide. The states have numerous challenges following the 9/11 decline in the economy. States had a $235 billion drop in receipts as a result of that unfortunate situation. And we are still trying to recover and get back on level playing field. Some of the states are doing pretty well, some of us not quite so well. But that drop, in spite of the fact that the feds did come in and help us with a little extra funding on Medicaid, it's still made us do a lot of changes in the states and change policy because we simply did not have the money and unlike the federal governments, states need to have real money to spend, and so we did have to make adjustments in programs that we are trying to still make sense of. Nationwide health care spending is 31% of the average state's budget. Health care costs and I'll show you some charts on that later clearly outpace inflation and the growth of government income. And because of those factors, it's nearly impossible to maintain the status quo on coverage. At the same time, there's a lot of political pressure and a lot of political talk around the country of increasing eligibility for government health programs when we simply don't have, most states don't have the money to maintain what we currently have. And to face that off, we all have major competing demands for state resources.

Next slide. In distribution of state budget for health services, you'll see that 71% nationwide average of state spending is in Medicaid. So clearly that's an entitlement program brought to us by the federal government. We have very little flexibility that we can make the changes to the programs to make adjustments, to make the programs work in our states. But the legislatures across the states are pretty well restricted in the responses

that we have with our total dollar spending and we have to learn to be smarter in the future in order to avoid that collapse that I talked about earlier.

Next slide. This one kind of brings home a real problem. State revenues go from 01 experience, or a minus 7/10 of a percent, nationwide, and in 2005, 6.8% increase in revenue. But when you compare that to the growth rate of Medicaid in the states, you can see that it's a little less than a third that, in other words, Medicaid entitlement expenditures are growing three times as past as revenue increases in the state. Therefore, putting a tremendous crunch on programming. Next slide. To add to that wonderful news, Congress has continued because of things that were already mentioned. What it amounts to is leave the entitlements in place and so we have $75 billion of additional costs to the states that have been sent down because of changes in federal reimbursement and not changes in mandates. But on the other hand, the federal government has increased mandatory spending, from 27% of the budget in 1965 to 40 years later, 54% of the federal spending is on mandatory spending. And to further complicate our PROS in the states, 19 states, including Kansas, anticipate having a structural deficit. At the current budget levels and the growth rate of Medicaid, we will actually have a higher spending level than our receipts, and since we don't have the option of printing money, we will have to reduce programs in those 19 states.

Next slide. Is there a silver lining? We certainly hope so, and let's see what we can do to help y'all work with your states and your state legislators to try to make a purse out of this pig's ear.

Next slide. We need to think about how the decisions are made in your state in the legislature. So we need to identify what we really need to do. We need to review existing programs. Listening to constituents is very important component and of course you can't really identify your state needs and you can't really get a good review of what you are currently doing unless you do listen. And so I encourage you all to make sure that you develop communication with your legislators to do that. Then it's our job, of course, to determine what resources we have to put in it and establish those priorities with the budget to make things work the best we can.

Next slide. When you are working with legislators, remember that legislators really need the facts and they need your input. Legislators and every state legislator is this way. Everyone that's elected to be a representative of the people wants to be a good steward of the public purse and wants to take good care of their constituents. But we really do need good data and evidence-based logic and reasoning for program changes. And we need our program people to be accountable and our programs to be accountable. And most of all, our states want to be good partners with our partners in the state and providers and non-profit groups and everyone we deal with in the states.

Next slide. This is to the data, some of you may not be able to read what it says on the screen there, it says just a couple farm boys sitting at the cafe and they are saying are you just pissing or moaning or can you verify what you are saying with data? Sometimes we can.

Next slide. Containing health care costs. In light of the position where we are at in this country where the eminent collapse of Medicaid and Medicare if we don't make changes, and I believe, therefore, eminent catastrophe in the total health system, we need to change the way we think. Currently we have a Medicaid and Medicare system that's built on what do we do with the recipients when they show up in the emergency room, and it has to change. We need to quit talking about a health care system. We really need to move to a health system. And the emphasis should be what do we do to keep people healthy? To prevent them from going to the emergency room and to acute care? And only by doing that are we going to be able to address our long-term health needs in our states and the long-term care needs is we have to change the way we think, and the, and what the states fund and how we fund the Medicaid and Medicare flexibility to get us towards that change of thinking. The next item I have there on that is term you may not have thought of or seen before. This is in Kansas, we passed a bill a couple years ago setting up the Kansas health policy authority.

Policy authority is a board of regents concept. They have responsibility for the funding and the running of all of Medicaid, all state paid health insurance and control the data in order to have not much of a political decision on what happens in our health system, but move towards that health system versus the health care system and try to change our spending habits to make that happen. And under that, normally we talk a lot in the health care system about primary care. And in the public health sector we talk about preventive care. And well, that's all well and good, it's both wrong. What we need to be talking about is

primary preventive care. We need to combine those functions. We need to have one unit moving forward to keep people, to keep people healthy and to help people that have chronic disease to remain healthy. To do that, of course, it's important that we have data-driven programs, the state spending needs to be based on data-driven, and also need to improve our outcomes to find those things that help achieve our goals and of course, to contain health care costs we also have to set limits on what we are spending.

Next slide. I kind of like this little egg graph, I guess that's what you call this. Wrong colors for an egg but you get the picture. The total circle is health. And in the big part of the circle we have primary preventive care. We have newborn screening, early intervention, prenatal care. In the medical model, the little dot, what we think of as health care. We have acute care and emergency room.

Next slide. What the evidence supports. If we go to evidence-based systems, what do we do? For example, if the state wants to spend the money fast, to have children ready to learn when they enter school, where do you spend the money? The answer is simple. Prenatal care. Unless children are born healthy, they are not likely to enter school ready to learn. And so it's important that we put a lot of emphasis on prenatal care and make sure we take maximum use of the assets in our state to provide that. In early brain development we have learned and the data shows clearly the number one reason children after they're born fail to thrive to become ready to learn when they enter school is because of toxic stress in the home. Toxic stress is any major obstacle in that home that increases the adrenalin level of the mother and thereby the child and with high adrenalin levels and

disruption in the home the child will not develop normal communication brain links and therefore is not ready to enter school. So those early programs may be a home visitor program, or things we can do in the community to give support to single mothers to intervene and provide drug treatment where there's addiction problems, to control domestic abuse in the home, all will help our children to be better equipped and be healthier in the future. And, of course, newborn screening is all, evidence also says that's way at the top of our list of things that we need to do and make sure it's done if we are going to have healthy population in the future.

Next slide. The effects of toxic stress on early childhood, there's the whole list of things, like I said, that are -- this screen is kind of ironic because not only does it kind of tell you what the items we consider toxic stress are, but these are also the symptoms that children will display later in life if they are in this situation. So obviously it's critically important that we have mental health services, you know, to help mother with that depression early on, like I said, drug and alcohol treatment program, and also those chronic physical health issues if you address those in the mother, you are much less likely to have the child grow up and have the same problems.

Next slide. Challenges in decision making. I like to use a little cowboy logic, I'm from cow country, and cowboy logic is simply can't get there if you don't know where you are going. We need to set a policy in our states that says that we really do want to change the way we look at the system to move forward. And of course Albert Einstein told us that the

definition of insanity is doing the same thing over and over and expecting a different result. Generally that's kind of how we run government programs, both in our states and in the nation. And we simply have to break that cycle.

Next slide. This is a five-year history in Kansas and can you find the maternal child health expenditures? And if you are looking at the bar graph I have there, you'll have a little trouble finding it. On the left side of each year's data, at the bottom line is a little tiny mark. And that is the spending on maternal child health. Below I've got the dollars and kind of what's been brought out before. The -- in 2003, for example, we had a little over four million state money and 9.4 million federal money. And 2007 we have a little less than 4 million state money and a little over 9.2 million. So with inflation to account, it's a significant reduction in the program. The other thing you will notice is where the pressure is in Kansas, and number of other states. You'll see the tall bar there is education. We have had a lawsuit which has kind of been relieved now by the state Supreme Court, but they kind of insisted that the legislature add nearly a billion dollars additional funding to K-12 funding. That comes when we know we have a structural deficit in the budget anyway. It's going to be problematic to budget it, but it is going to mean that discretionary funding programs will have to be reduced in our state, and I think other states experience the same thing. There is a national association of school litigators suing trying to get the courts instead of the legislature to control the funding, and it means real problems for the health and social programs in the states.

Next slide. As Dilbert kind of understood, this explains where they are at in a lot of the PROS. The fellow being interviewed. You have three degrees and Ph.D. Yes, and it's impressive and I have no common sense whatsoever. Dilbert says it's not the sort of thing you should say on a job interview. And the guy says I don't see why not. That's what they think of in government sometimes and I would like to change that but I don't know if I'll be successful. What's our goal? I don't know about the rest of you, but my goal is to do away with the silos when it deals with children, particularly. We are putting in, and this pictures, this illustrated is not to scale, it will it would be higher. But I think our education spending, health care spending, prevention spending and I didn't butt it -- put it in here because it's insignificant in a graph as I showed you earlier, you cannot even show maternal and child health when you graph it with everything else, but those programs need to work together and be coordinated into one. Failure to acknowledge that the most money we spend in our states that will affect our children's population health in the future is K-12 spending. And yet we really don't coordinate those programs together. Don't work together. We leave them out in separate silos and like our recent lawsuit proved, there's no real attention paid to what the outcome is good for the kids and I think we need to concentrate on that.

Next slide. When you are working with your legislators, just a few hints on what you should do and not do. Don't wait 'til after your session is started. Be involved year around. Go meet with your local elected official. And remember, all politics is local, so meet with your local people. And when you meet with them, be accurate, reliable, honest, concise, and don't give up, don't -- be vigilant. Build relationships with individual members of the legislature. Reach out to new members, both in the legislature and of the total group of

people that work with children. In other words, try to see if you can actually get the educators on board for children. Offer to be a resource for the legislature. Most of our state legislators in the bigger states are citizen legislators. We don't really have a full-time staff. So any time you can bring accurate research to us is helpful and we appreciate it. Be sure and be inclusive of people involved in your issue. Have concise written materials. Do not bring me a ten-page thesis on what you want done. A one-pager with three bullet points is best because we are overwhelmed with the hundreds of issues we deal with, and we need the information quick and concise. And then be sure and thank people when they cooperate and work with you.

On the don't side, and I see a lot of this with children's advocates, don't assume that you don't count. I'm just amazed at the people that I have to pull into the process when they say we don't think it mattered when they are there or not. No, you need to be at the table, you need to make sure that your positions are being heard, and you need to make sure the legislators and the oat poll -- the other policy makers understand you do care about the future of children in your state. Never give misleading or false information. Because that leads you to the third point. That will make you enemies and you don't want that. And like I said before early, don't wait 'til the session to do it. Start meeting with them whenever you get an opportunity. Don't be too narrowly focused. Don't just -- don't go into the legislature and say my part of the program is the only thing that matters and you have to do this or you don't care about children. Be sure and learn to work with a broader group of advocates and you'll be more successful for everybody. And then don't give up on what you believe in. It's on my slide, don't refuse to compromise. But in a way, that's really

wrong. You should never compromise but you should be willing to come and negotiate and cooperate and get the best deal you can, but never ever back down from what the right position is, and that is the good of children and never compromise on what's good for the kids. And don't do what I've done, just go on and on and on and on and on and on, and never, never, never, never, never, never, never, never give up on the kids. Thank you. Our next speaker is Peter Sybinsky. Peter is the chief executive officer for the office of material and child health programs.

PETER SYBINSKY: Thank you very much, Representative Neufeld. My purpose is to give you a review of how federal cuts impact on state programs. The organization I represent, association of maternal and child health programs represents leaders of state programs for maternal and child health and children with special health care needs in the 50 states and nine jurisdictions. Our members use Title V as the key, the catalyst for constructing systems of care for women and children across the country. Each state, because of its differences and its own community standards will have a different program. So Title V allows each state to Taylor the programs to the needs of its own community. We fund -- Title V has existed a long time, the longest living public health program Congress has authorized at the national level. In 1936 it was originally developed and grew over time into a number of different programs, which were consolidated into a block grant in 1982. In this block grant the provisions that allow states a lot of flexibility in constructing their programs. They have to match the federal government three state dollars to every four federal dollars and the slide ratio is backwards, but it is three state dollars to four federal

dollars. And there's a required maintenance of effort. States are required to maintain a level of effort that they contributed in 1989.

Next slide, please. This is a very similar picture to the graph that Ms. Brown gave to you, but I want to point out a couple things about the graph. The first thing is that the block grant has enjoyed a period of very good solid growth from the time, about the time of its inception all the way through to 1995. This growth has been through three different national administration's of differing political parties so you have a bipartisan consensus that has led to the growth of the maternal and child health block. However, after 1995, you can see basic stasis in the program. $700 million has gone up or down a little bit, but by and large, the program has been static, and as Ms. Brown pointed out, when you have no growth in the funding for programs, inflation whittles away as what you can buy. And as Representative Neufeld said clearly, the impact of the shrinking dollar on health is exacerbated by the needs of direct care. The dollars mean less than in 1995. The second point is, there are only two cuts in the maternal and child health block grant. One was a minor cut back in the mid 1980s, due to a political issue and growth continued. However, the cut we received last year in the block grant, 2006, actually is a little more concerning and again reference to Miss Brown's presentation, there is a structural deficit at the federal level. A deficit which is sizeable and is squeezing out discretionary programs. So we are very concerned that this cut at the federal level will be not just a one-time event, but might mirror a larger picture and the larger squeezing that she talked about.

Next slide, please. One of my principle data sources here, the principle Satan source, Principle source, a survey. The association normally surveys the regions three times a year, and in this time especially after we had had a little bit of time for the states to evaluate the cuts in the block grant that they received in 2006, we thought an appropriate question about the impact of the cuts would be appropriate and so we asked that question this summer. As you can see, there are three major areas of reduction in those, in the reductions that were made. Direct services, administrative programs or administrative services, and payer and eligibility cuts.

Next slide, please. The cuts to direct services are pretty alarming. The significance of the slide, therefore, outlines a picture which is of great concern. Many states don't do large scale direct services, and so when direct services are cut, this is a sign, and you'll see later on in my presentation, this is one of the last things the programs that states do, whether you are a legislature or governor, you don't want to cut your programs. You see their value, you want to continue their success. And when you cut back on the direct services, you find a real problem, so there's a great reluctance to do that, but over a third of our states, 17, there were 40 states responding, so we have almost a total population of states, and over a third of those states cut back on program development. These are programs that would do the kinds of things that Representative Neufeld discussed. Doing reprogramming and development of efforts to take account of the new science about brain development, to look at early childhood, to develop systems of care that relate to new PROS, and that's the first thing that's getting snuffed out is the innovation. Looking at family planning children services, adolescent health, about a third of the states also have

made cuts in those programs. And most disturbing is that children with special health care needs, kids who really do have health problems, impact on the communities and the families and neighborhoods, in eight states they have cut the programs as well. Despite the reluctance of the states that had to do this, the second, next slide, please, the next impact is on administrative services. And as you can see, in 18 to 20 states staff have been eliminated or frozen. These are staff that basically do the development of the innovative programs. They support other programs in the community, they support the other MCH types of activity. And when they go thin, or when they do get filled, essentially important work that is, that helps with efficiency, that helps to deliver services, that helps to attune those services and plan those services for the future does not get done. Training and evaluation, as well as IT support and other kinds of technical support have been cut in the administrative services area. And eligibility is another category. By and large this is a direct service cut in many ways. In two states, or three states, rather, prior authorization and payer of last resort issues have been reduced. Essentially people have to work harder to get onto the roles of MCH in those states. And also eligibility standards have been tightened up in six to seven states. Still an additional cut on the top of direct services.

Next slide, please. Another survey question helps us to shed light on the results that we just saw. When asked about emerging issues in their states, which was another question, the three major factors noted by our members who are leaders of maternal and child health in their states were funding cutbacks outside of Title V, Medicaid changes and the cost of undocumented purposes. Funding cutbacks outside of Title V, there are a wide range of other programs, large programs in state government that represent health. There

are often state appropriations, either for Medicaid match or for those state programs that get cut back when the economic base for those programs is not there. Same is true at the local level. Many of our states share their federal funds with counties and cities and other local government units. Those states come up with their own match and often those matches have been cut because of a lack of local tax revenues. And other funding is an issue as well.

The federal block grant, a base for prevention services for women and children, in many states, has, because of its reduction of 20% -- 25% at the federal level has had a significant impact. Social Services black grant and mental health block grant and other federal funding sources have also been cut. People, because they have worked with systems often use a blend of funding to patch holes and to create new programs. When those other sources of funding outside of Title V dry up, their work is harder and the difficulty of creating this system is more difficult. Medicaid changes brought about by the deficit reduction act in eligibility and in, you know, for citizenship issues, are also seen as having a big impact. And certainly the state's restructuring of Medicaid is expected to have further impacts. And finally the cost of undocumented persons. We gave an example here of Florida that back in 1996 Florida spent 10.5 for health care for undocumented persons.

Five years, I'm sorry, ten years later the figure is 74.2 million. A seven-fold increase in the impact in the cost of undocumented persons. That $60 million of increased funding could have been put to preventive services, maternal and child health services, but it is going to undocumented persons. Not that the need is not there, and not that we don't have to deal

with it, but the fact is, that is a major factor that is impact I am -- impacting the maternal and child health landscape. So what do we do as state administrators to get to the legislature with a balanced budget so the legislature can evaluate the, and keep the, and keep health services going? What I'm doing is sort of giving you the least, or I should say probably the most common to the least common. Kinds of things that states do administratively to cut back. And as you can see, the first ones that I'm going to mention have relatively little impact on the public. Many of them should be done on a regular basis anyway. Reducing administrative expenses by consolidating unnecessary duplication. Bringing about less expensive aspects, sorry, less expensive ways of doing something. Buying cheaper paper is just a very simple example of reducing administrative expenses without really trying to, or without really impacting on the services that you develop. Changing the way a service is delivered. States often contract out to get cheaper services than they would have to deliver with state employees alone, or by putting in services to a bid process they can, you know, reduce costs. Resource sharing, working with other programs to share infrastructure and office space. And basically integrating services so they are more effectively delivered to a population and again, eliminating duplication in that way. Negotiating better contracts, being better managers, and that, of course, is -- is an important factor we do as is improved contract administration, making sure that contracts are out on time and effectively delivered, or to have an effective partnership with the private sector that manages them. Better employee oversight on one hand. If you cut back on your employees, you can watch them better. But by and large, employee oversight and better management is something we all should be doing. And a technique that is good over the short-term is often states, because of vacancies, because of

unanticipated savings, often have some carry-forward at the end of the year and to meet an emergency or to meet a limited term shortfall they can use the carry forward in the following year for short-term problems. And right here on this slide are the relatively easy things, the things we can all agree upon. The things that should not have an impact on the public service and maternal and child health service.

However, if you go to the next slide, point out some of the tougher things we do. And one is moving it to another symbol, underneath another symbol, cost shifting. Getting Medicaid to pay for something, or private insurance to pay for something, to get partners to bear a cost, or have families pay a bigger share of the cost. The costs are still there, but if the money is not there in the public sector to pay for it, someone has to -- money has to be brought in if we want to continue to deliver the services and states will try to cost shift where they can to get the most effective services for their recipients and their people. You can seek funds from reductions in other programs. This is not very wise in terms of long-term, just like not telling the truth or giving misinformation to a legislator, you have to work with people and seeking reductions from other programs is not something that enhances administrative working together. But it does happen occasionally, and it is an alternative that some people might want to -- might use, although as I said, it's rather unfortunate to do that. Replacing lost funds with new state funds is another technique, and when the state economy is booming, that is probably one of the first alternatives that we will try to do as administrators, to convince the legislators this need is significant, program is significant and the state can pick up the costs and states do frequently pick up the additional costs brought about by federal reductions, and but in many states and times

there are no funds to do this. So that cannot be an alternative in a good number of situations.

Then we get back to the second column over there, that's beginning to cut back on lower priority services. Usually administrative services are first for reductions. Then you move into other areas, such as reducing the number of geographic locations that people can use to access your services. Reduce the number of services, the number of staff, number of contract services delivered, or reduce the types of populations that are covered. These are regrettable and at the far end of the spectrum. It's what we don't want to do. But again, the data at the beginning of the survey shows that's beginning to happen now. Last alternative, cutting back on services and even perhaps eliminating lower priority services are becoming more frequent as a result of the fact that the federal cuts are there and the state financial situations have not been sufficient to allow enough states to pick up the slack.

Last slide, please. Importance, I think, of -- of the statements that Representative Neufeld said in terms of working over the long-term with the legislature are very important in this slide. We are saying the same basic things. We have to look at the long-term for our programs. We have to look at what is good for the people and the children that we serve. Note the business cycle. It's an economic reality that there are times of cut backs and we have to plan and be very prudent about what we do so that when these cycles come we can effectively deal with them. We need to plan ahead for the down periods. Need to seek compelling arguments and data, to justify the initiatives so when the money is there and

the urge is there and the enthusiasm is there for initiatives, that we can justify those initiatives when the money is available. It means planning and working with partners, and marketing our ideas effectively. And this is essentially the things that we can do over the long-term to weather and to prove the short-term cuts. How does the presentation or the latter part of the presentation shed light on the survey data? In short, as I'm saying in summary, the data identifies the states have gone through the easy cuts and disturbing, this is a disturbing fact, and the fact that the -- so many of the cuts are direct services relating to services to women and children are very concerning and need to be, I think, integrated into the arguments that we make to support the block grant and to support maternal and child health expenditures at the state and local level. Further cuts are very likely to result in deeper impacts in more states and we have to be very, very cognizant of that as we move forward in our, in both our planning and in working with others to make sure that there is resources for maternal and child health programs. Thank you. And next I would like to move to our next speaker who is Miss Zenobia Harris, the patient care leader for the central region of the Arkansas department of Department of Health. Representing CityMatCH and Zenobia.

ZENOBIA HARRIS: Thank you, Peter. It is really a pleasure to be able to participate in this web conference today and to talk about specifically things that we have experienced and are experiencing at the local public health department level in reference to and response to the shifts in funding available for maternal and child health and other services. I also would like to give reference to during the course of my talk, the CityMatCH joint web survey conducted this past August on the effects of diminishing federal funds on the local

department’s ability to provide maternal and child health services. 91 responded health departments, a very excellent view of how services, various services have been affected by these shrinking federal dollars. As far as local services in Arkansas are concerned, Arkansas has traditionally been a direct services state. In recent years we have had to really shift our ability to provide many direct services into local -- We have also looked at changes that have affected our ability to, our funding stream, narrowed or altered -- our state's restructure of the Medicaid program to include a family planning waiver and child health insurance company, our kids first, and we have experienced political motivation, particularly a movement toward emphasis on performance monitoring that has had a very concise -- on our ability to provide services. Also experienced some extreme population shifts in particular in northwest portions of our states, certainly here in central Arkansas as well where I'm located that have changed demographics in the way that we provide services in our local communities. We have experienced many immigrants and non-native clients seeking services and creating the need for enhancing the cultural and appropriate responses with little preparation of our local staff.

Next slide. Arkansas' story as it relates to the block grant changes, a strong emphasis on funding shifts. We have experienced in recent years strong emphasis on performance based. Each region is assigned a specific population base geographic targets that we must meet in providing public health services in order to be able to break even with the costs of operation. We have had to make adjustments to staff and standing based on our performance to meet these targets. Numerous monitoring tools have been utilized to assist our region in meeting these goals. Tools such as nursing utilization tools,

management utilization reviews, and specialized utilization tools have been developed to allow managers to more effectively assess the effectiveness of services provided by our full-time equivalent or staff, and to enable us to make adjustments either daily, weekly, monthly, quarterly, as needed, to be able to provide services in our local communities. Next slide, please. Arkansas has the fastest growing Hispanic population in this region of the United States. Due to this increase in population, our local public health responses have not always been rapid enough to respond to the demand of services. Our ability to respond has been stunted by a lack of adequate staff, and in addition, an increase in Medicaid eligibility in many of our clients has resulted in a shift to the private sector of some clients who have formerly been served by the public health sector. All family health services or MCH services have been affected by the shift.

Next slide, please. In response to this, we have instituted a concept that is known in the private sector as same day scheduling, whereby clients can call in and obtain an appointment often in a 24 to 48-hour of their call for various services provided by the local health departments. An exception to this would be some women's health services, which are dependent upon traveling, clinicians, or traveling nurse practitioners, whereby patients are given the next available appointments for the services. But most of the time we are certainly able to offer them within the timelines that have been established by the program. In addition, meeting franchise program targets for particularly in family planning and WIC have become an institutional part of how we provide services. Next slide, please.

Challenges that we have faced in providing WIC services include having to limit other services in order to reach our targets for WIC, we have decreased immunization and follow-up, and the staff in the larger health departments in the central region of the state to allow the staff to effectively serve larger numbers of clients. Next slide, please. In women's health, meeting our family planning target, we have experienced some alternative successes. In addition, our maternity case load targets have often, have in the past few years, we have experienced a decrease in the numbers of maternity clients we have served because of the excellent job we have done in outreaching to the private sector and enrolling clients in the Medicare programs, Medicaid programs which allow them to purchase their care, or have their care paid for through the private sector, utilizing Medicaid eligibility. Also in women's health we have experienced a limited ability to provide outreach services, and the methods of care that we provide have changed in our communities in terms of increasing our emphasis on performance and less emphasis on quality of care and follow-up of care, as well as a decreaseability to provide education services, which result in fewer services available for at risk women and teens. This experience is not unlike those listed in the web survey which we have recently undertaken.

Next slide, please. Maternity services enhanced access to private providers with the Medicaid expansion, and increased willingness of local physicians has resulted in some decrease in maternity clients who enter into care into local health departments. The Hispanic population increase has led to a shift in the type of client that we do see in maternity service, and so because of that shift we have had a decreased demand for

interpreter services, and increased demand to understand our cultural, or to develop our cultural competency skills in providing services to the exchanging population. In addition to maternity service, an increased emphasis on initial visit with the emphasis of referring women to primary care providers after that initial visit as a way of entering into the system to be able to connect them with a primary care provider. This slide is an example of several of the counties in the central district who had reproductive health targets, often unable to reach because of difficulty meeting staffing needs or shifts. When we I am -- implemented same day scheduling there was a dramatic improvement in the ability to meet client needs based upon being able to schedule services for clients based on the availability of staff on particular days.

Next slide, please. In the immunization area we have experienced decreased opportunities to provide immunization due to staffing issues. Often the inability to adequately staff the clinics has sometimes limited our ability to serve clients on the spot and results in missed opportunities. Next slide, please. Approximately six years ago Arkansas school health programs and adolescent health services were cut in the direct service area as a direct result of funding changes and losses of revenues in our state programs. We have made some changes in the support that we offer to schools by leveraging our state tobacco settlement funds through the school cooperatives which were established by the state department of education. Next slide, please. Well child clinics also experienced an unfortunate demise in that cut six years ago that we experienced. We eliminated our well baby and other clinic services, and these were services which is enable us a valuable opportunity to follow up on WIC and immunization status of infants

and preschool children. On the other hand, because of our kids or child health insurance program many children and infants have been able to access these services through the private sector. Next slide, please. Survival strategy and solutions to assistance of the local health department have been many and varied.

Next slide. Probably a strategy which we have most relied upon in recent months have been the monitoring strategy. Where we actually measured the goals, in -- the targets for the various programs and consequently develop improvement plans at least quarterly to address how problems meeting the goals and the targets will be addressing local health departments or local settings. Any consequences that were experienced such as physician cuts or physician shifts is shared by the local health department who operate in the same health district. These consequences include daily monitoring of staff utilization, monthly reporting of staff full-time equivalent utilization, and routine conferences with health district managers and regional directors as they work with their local staff in addressing issues that prevent them from meeting targets, or to celebrate opportunities that have been afforded to them that enable them to do the numerical targets. And the hometown health approach, using funding from local government where possible, have become a very important part of our approach to surviving in our local communities. Becoming more involved in local planning efforts and local health promotion activities at the local health department level have proved very valuable to keep the health department connected in the community and to continue to be seen as a positive resource for those at need in our community. Extremely helpful to us.

Next slide, please. Funding shifts have also been extremely valuable to us as we have worked to look at solutions to assist us in obtaining MCH services in our community. Utilizing private insurance sources, and local philanthropic groups, and other funds to enhance the health services are valuable ways in which we have tried to provide MCH services for the community. Next slide, please. Conserving our resources has also been a helpful strategy. The relationship in the Department of Health and service family has proved very valuable. Last year the Department of Health became the division of health within the Department of Health and human services after we merged after some, a long conferencing. The opportunity to improve our accounts receivables and the turn around time to promoting increased cash flow for our Medicaid billable services has proven to be very, very helpful, as we have tried to work on those issues that help us increase our opportunity to function. Limits on supplies and reducing staff and reducing services which are considered to be non-essential or non-priority have also been helpful strategies. Unfortunately, many health departments have had to give up some practices of assisting local community residents in obtaining services that are not necessarily directly related to maternal and child health, but which they considered to be very helpful to their own health and well-being, such as blood pressure checks and weight checks, have had to be reevaluated and in some instances eliminated also sharing and rotating staff in critical needs areas, and reducing non-essential travel are other strategies we have utilized in order to conserve our resources.

Other strategies we are considering to further advance the resources include further promoting billable services, training opportunities for the clinic staff, training providers to

maximize reI imbursement amounts they bill for. Another strategy is to enhance our cultural competency training so we are better able to provide services to immigrants and non-traditional public health clients. Still another strategy is the promotion of hiring of individuals from various immigrant groups to communicate cultural and health needs. And lastly, to continue to further our communications with our elected officials and the legislators, not only to just share our reports but to also involve them in our local community planning effort, invite them into our facility, visits to local gatherings, local health departments, to assist in furthering their understanding of local health needs, a very valuable strategy that we continue to promote in the Department of Health. Another strategy that had been recommended through the joint web survey includes utilizing federally funded community health centers to provide family planning services, implementing nurse practitioner programs in the communities and throughout the state, requesting MCH physicians to be funded via state budget, increasing participation in SCHIP, and things to be billed to SCHIP, increasing fees for immunization and service, reducing staff, restricting I implementation of new programs, and eliminating training budget items, expenses. Next I would like to introduce you to Gayle Lees Sandlin who is director of the bureau of children's health insurance in Alabama.

GAYLE LEES SANDLIN: Thank you Zenobia. It's good to be with y'all. I want to thank Audrey for helping us do this together today as well as for the National Governor Association folks who have made it possible for me to be with you today. As she said, I work with, and the director of the state children's health program in Alabama and I like to tell the story we were the first in the nation to have our plan approved. We consider it a

success story. Sometimes I have slides of my presentation that talk about how we usually do things in Alabama under court order. Unfortunately this is one thing we did right. It didn't require a court order to address us. We did it based on our looking and working together. There were folk in Alabama meeting before the legislation was actually passed at the federal level. I want to go through some of the points of discussion on the next slide and tell you the three areas I'm going to address today. I'm going to talk a little bit about some cost sharing measures that we have done in our SCHIP program and using some principles we have, our state health officer, Dr. Don Williams, one of the things he told us is he wanted our decisions to be made based on the program being administratively simple. Some examples of things and the thought process we went through with that.

Also talk about some of the collaboration efforts that we did among us as well as the other stakeholders, and talk more about that. Because I believe that particularly in this difficult time of restricted funding that collaboration is one of the most important things that you can do in working together to see where the mutual goals are. And then the Alabama Medicare program and another foundation I'll explain later. We did it through collaboration, through some pooling of funds that we put together and I think that's important enough for me to talk about that. I think it's important to talk about the next slide show you how our program is put together. This may be a little difficult to see over the Internet. Let me explain it to you and walk you through this. Along the bottom of the slide you see the numbers 1-18. SCHIP program could serve children up to the age of 19. This recognizes the children in Alabama between 0 and 19. Going up the left hand side of the chart,

percentages from 0 to 235%, represents the federal poverty level. We could go up to 200% of the federal poverty level for the SCHIP.

If you see the gray line across the bottom of the slide there, unfortunately Alabama is a state that has very, very few resources. Like some of our other states, certainly like Arkansas, we are right in there with you. We trade places periodically, I think. But we were funding our Medicaid for low income families program, assistance program that used to be associated with the aid to families with dependent children or AFDC or the welfare programs with that. We are at 13% of the federal poverty level. One of the lowest in the nation. Don't have a lot going on there. On top of that represented in the blue is the SOBRA program. It's a tool and the vehicle in which it was approved. But we were, unfortunately, again some of the national levels, we were at the minimum levels of what we had to do in order to receive the funding in our state. Set our SCHIP program, it's difficult to tell on this chart, but the SOBRA program ended at the age of 14. The feds said you have to roll it in one year at a time and we were doing that, but slow in being able to put the funding together.

Our first program that we did with our SCHIP dollars was to actually expand Medicaid coverage. We immediately gave assistance to those children who were 14-19 years old. They went in a Medicaid expansion, applied for Medicaid, received the Medicaid benefits, but used the SCHIP dollars behind the scenes to do that. What this enabled, instead of fazing the children in one year at a time, we were able to put them on immediately to Medicaid. Those dollars paying for the program now come from Medicaid and no longer

come from SCHIP. That would have happened but only one year at a time. In addition to that, we had a group who was looking, as I mentioned earlier, about how to implement SCHIP and the decision was made in Alabama to implement a separate chip program, something separate from the Medicaid agency. Chip comes up for reauthorization next year. I stress give us flexibility. It's important in some states to have expanded Medicaid. It was important in Alabama to have tried something different and stepped outside the Medicaid guide. So be sure and I hope if any of you have the opportunity to advocate for the SCHIP reauthorization, you'll advocate for having it to states.

We set it up to be on top of the Medicaid level and up to 200% of the federal poverty level. In addition to that, we were fortunate to have a program by Blue Cross and blue shield, it's where they will put in half the money, the rest is matched from private individuals or businesses, and they are able to deliver some limited services to children. Basically it pays for doctor's visit, no prescription medication, no vision, no dental. It's better than no insurance coverage for children.

Our Blue Cross/Blue Shield maintained their programs. A lot of states they shut the caring programs down when chip came along. In our state, they decided to lift up and sit on top of all kids so we think it's important to have the programs work together. There are some things we've done I'll talk about. We have the Medicaid for the low income families at the lowest level, and then SOBRA and the Alabama child caring foundation. I have listed some of the administratively simple program issues on the next slide I want to talk with you a little about. The state health officer said I want it as simple as possible. Be true to

finding children who are appropriate for the program but don't set up barriers, don't make big hoops or make it difficult for children to enroll in the program, all of our decision making is based on the guidance. It's a self-insurance model. We decided to step outside the Medicaid arena for a number of PROS. At -- the legislature was not able to pay the bills, and they said let's not start another group of children off with the same kinds of things, try something different, use the flexibility the chip legislation gives us. By doing this, we put out an RFP. We bought into the private insurance model in the state. We did not set up another network or reimbursement system. We had a commitment to use a three-program application. So when a child actually fills out the application they are applying for the Medicaid programs, they are applying for all kids and applying for the child caring foundation.

We know it's difficult for families to understand where the level cuts off and so what we are doing is we are saying don't worry about that. Get the application in, give us the information, let us figure out which program you are eligible for and how we can work with you. One of the things that is different in Alabama, our Medicaid workers are outstationed. They are based around the state. But we have centralized processing for the all-kids program. Also a mail-in application we have created so families don't have to come into the facility but they can mail the application in. In addition to that, we have developed a web-based application. I'm going to give you some statistics on that. We have had some surprising responses to that. We also do self-declaration of eligibility, different than the Medicaid program. They require complete documentation, we do self-declaration, again to keep it simple. We have done some testing of that. Rates very similar to those of

Medicaid. Philosophy is, why do we want to set up stringent administrative procedures to make it difficult for folks to get on the program when we will make about the same results by making it simple. Also yearly premiums and people who enroll in our program have ten months to pay those premiums. We did not want to set up a monthly premium because that would set up a pretty heavy administrative structure to keep up with that and how many months do you go off the program and what do have you to do to go back on the program. We decided our co-pays would be selected by the providers and one of the most innovative things the outreach strategy is designed to teach the people who reach the people.

A lot of other states have paid for people to find applicants for the programs. We did not have enough money to do that. What we decided to do is find places where the folks were in the community, and teach those folks about Medicaid and all kids and ask their assistance in helping us identify family. The next slide is the fee schedule. We have kept it simple. Three fee levels. One on the bottom indicates no fee. We follow the national guidelines. 200 of the 69,000 children enrolled who fit into the no fee category. And also the low fee and the fee category. Structure is the same, reimbursed the same. But in our low fee category, for families under 150% of federal poverty level, $50 for the first child, up to three children. Maximum those families will pay per year is $150. Per year. Co-pays range from 3 to $10. And then for the fee group which is above 150, majority of our children are in the low fee group, the split is about 70% of our children in the low fee and 30% in the fee group, their annual premium is $100 per child per year up to a maximum of three. The maximum they'll pay is 300.

I want to talk about the cost sharing procedures and the simple things we have done. We set up and use annual premiums instead of monthly programs. They have ten months to pay. We do send them quarterly notices about their premiums and what's due to remind them of that. But they do have the entire ten months until they come up for renewal in the program. They can make partial payments, and we now have folks on our staff who are what we call pay smart counselors. Some of the focus groups, families talk to us about their premiums and what they said to us is you know, many meant to pay that premium. I was going to do it. I knew in October I had to do it. Started the kids in school, had to get school clothes, I thought I would do it after we got them in school, and then Thanksgiving and Christmas, and pay it after the first of the year, additional expense, the car broke down. The story goes on. Like some of us we have intentions to do it by the end of the year as they face renewal they had not done that. So we have trained counselors on our staff to talk to folks to say you have $300 that's due. Think in terms what you might be able to pay this. How about three $100 payments. One in January, one in March and one in June, and that would get you there.

Anyway, helping folks think through let's plan for this, let's see what we need to do. As I mentioned, we do send out quarterly premium notices and it is the responsibility of the family to pay those premiums in order to renew for the following year. We now have the ability to use credit cards so that families are able to do that, if they do that, I think there's a $4 fee but the family pays that rather than us doing that. We do have kept our co-pays relatively small. Chip legislation indicates you can't charge families more than 5% of their

income in co-pays. We looked at that from a global perspective and set the co-pays at a level we would not have to monitor that on an ongoing basis and said co-pays will be collected by the providers, so none of that is anything we would do. I want to switch gears a little bit and the next slide talks about collaboration. Our SCHIP program has been founded on collaboration. Worked in state government for a number of years and have never seen folks get behind anything as purposefully as they did in implementing the SCHIP legislation in Alabama. We had a work group over 120, 150 people to came together, and I want to list some of the areas they came from. We certainly have providers there from the medical association, pediatrician organization was there, emergency room services were involved with us because an awful lot of the children when they are uninsured will seek treatment through the emergency rooms. Hospitals were extremely involved. They co-sponsored with us eight sites around the state to kick off our program and certainly the FQHCs were involved with us.

On the next slide you can see advocates that we had involved. There were advocates who represented children's health care access, anti-poverty, mental health access, business councils were involved because they knew what it would mean to their community. Another group extremely involved was the covering kids and families grant received from the Robert Wood Johnson foundation. Our legislators were involved and certainly advocates with us in the beginning of the program. And not only with our legislative branch involved, but the next slide I have listed some of the executive branches involved with us.

I don't think I actually put on the slide but the governor's office goes right up there, they were involved. I think I skipped that through the state but all of our state agencies who had some interest in having children insured were involved with us. That includes our public welfare agency, mental health retardation, rehab services were involved. Title V agency, and then within public health, we certainly had our MCH program. They were right there at the forefront with us. We had our regulatory folk, those who look at and guide, and then rural health, nursing, to name a few of those involved with us, as well as the state insurance department that actually does the regulation. They came together, met continuously for about six months and then even after the implementation of the program. They sat down and helped us look at some of the key issues. One of the examples I like to use, we could have use presumption. We had folks who sat down in a committee looking at eligibility standards who went to other states or called other states, didn't physically go but called other states to look at that research the advantages and disadvantages and then brought a recommendation back to us. So stakeholders became acutely involved in the decision making from the beginning. That helped us have a wide base of people who could contribute to the decision making so we could make those decisions that we needed to.

In addition to that, we have ongoing collaboration. Certainly kept all the partners and stakeholders involved, but something that I want to stress that's been extremely valuable to us is we have regular monthly meetings with our state Medicaid staff. We are separate agencies but we want to collaborate and work together. We do those meetings to problem solve. We actually keep a running agenda so be don't come back to the meeting and say I

thought you were going to do, no, left it with you. We keep something going. Write up what happened at the meetings. And they sit down and look at cases, look at cases that are not moving between the two systems so we can see where do we need to adjust policy. We have done an awful lot and we are really pleased with different grants from the Robert Wood Johnson foundation. We were the recipients of the implementation grant with that, and I'll talk more about how we used that grant to actually build some electronic interface between our agency and the Medicaid agency.

Another thing we do, we co-locate Medicaid staff in our chip office. The Medicaid staff are outbased around the state, chip is done in process centrally. We have three Medicaid workers and administrative support person who work in our office and process some of the applications that come through our office. It gives us the on-site ability if we have a problem case to go over to the workers, pull it up on the screen, help us find where that person is so we can get somebody enrolled in the program. And also professional social workers, master level on the staff and their job is to problem solve. Their job is to help families. As I mentioned earlier, difficult for families between the two programs to figure out where they need to go because we take information by declaration, Medicaid does it by complete documentation. There are sometimes when families appear to fall through the crack and do not appear to be eligible for either program. The social workers are the ones to identify where and when that happens and say stop the system, get this family into health care, need to go one place or another. We felt it was important to have professionally trained people in order to do that. We feel it's contributed to the collaboration and also making it family friendly. I mentioned the joint application.

On the next slide I have listed that is with all kids, Alabama child care foundation and Medicaid, and we have mail-in applications and a joint application distribution. Most of those mail-in applications come into our office and it's been interesting because prior to the implementation of chip, wasn't anybody saying can't you get more kids enrolled in Medicaid. Nobody was doing that. This has helped families see and helped constituents see that children's health care is important. We do need to get them enrolled in the program.

This next distribution on item number five on this slide shows that of the applications that come through the chip door, 40% of them are Medicaid eligible. The word is the woodwork effect. Folks did not know or did not apply for Medicaid or were not able to go through the process. About 40% of those turn out to be all kids eligible and another 20% we send to the Alabama child caring foundation. I did not put in this presentation but all of our programs you can see dramatic growth, not only in the all kids program but certainly in the Medicaid program. Med -- Medicaid has enrolled another 200,000 children in the program as a result of those efforts there. Now, that has advantages and disadvantages. It's a higher expense for Medicaid but they are cheap. We are getting them off to a healthy start, getting access to care. Also have a preprinted renewal form. We could do that within hours to make it easier for the families and make it administratively simple so when the form comes back in we don't have to start all over again with doing that. Another innovative thing we have done, we have regional staff that we have hired. There's about

17 of them around the state. And certainly their objective is to find folks in outreach in the local community.

The main thing they do, as I said earlier, to teach the people, to reach the people. Get in touch with the providers, particularly pediatrician's office. We are going to have children there uninsured. I know when I took my child in after the I implementation of SCHIP, five of the people at the front office staff said I think I'm eligible for chip. So you know, you don't know where you are going to touch folks. But we teach the pediatrician's front office staff when somebody comes in and they are not insured, give them an application packet, help them know about this. But these regional staff not only outreach but they also do something that I think is maybe more important. They are systems coordinators. They are there at the local level. They make regular contacts with those outstationed Medicaid workers. They get feedback. They are the eyes and ears in the community to find out what's working, what's not working, what do we need to do, what policies do we need to implement, what do we need to bring to the work group is the workers can help figure this out and how to do that.

The third area that begins on the next slide is the electronically connection, I don't think I've made that -- electronically connected the programs, to say those programs that provide services to children. We use the supporting families after welfare reform grant the Robert Wood Johnson grant. It was roughly $250,000, matched it with SCHIP dollars and turned it into $1.5 million. We were able to take a small amount of money and multiply that to use as our administrative costs. We didn't have many dollars, so what we did, we built

an ADI, or automated data integration system. Built something which the Medicaid system, an old one could talk to, and built something the SCHIP system could talk to. We knew we could not do a direct interface, because our systems were so far apart. Consultants spent a lot of time in Medicaid, as well as SCHIP, mapping, and look at our programming that undergirded all this, and built the ADI system. So when the applications come through the office, 40% are Medicaid eligible. We key them into our system. We toted them up the street. I wanted to name it the tote system. But we put the paper forms in the mail cartons and toted them up to the Medicaid agency. Now they are sent electronically. So when they get the physical application, it gets routed to the worker, the worker puts the application in front of them.

They key the Social Security number in. Their screen is prepopulated with the information so they do not have to rekey that again. It has saved a tremendous amount of time of us moving information between our agencies, and then our third component was being able -- we built a secondary phase with that. We also, in addition to the ADI system that connects Medicaid and the child caring foundation or the all kids, built a web-based application and I mentioned earlier I was going to give you some interesting statistics on that. We get approximately 1,000 applications a month. About 6,000 a month in our office there. So about 1,000 of them come into our office, about 48% of the applications that come through the Internet turn out to be Medicaid eligible. Now that surprised us. We were not expecting that. We really expected that it would be a much, much lower percentage because the children that are enrolled in SGI are mostly working families and felt like they were the ones that were going to be and have more access to the

applications. About 39% turn out to be the SCHIP eligible, 10% total to the Alabama child caring. It's a large percentage of applications coming in through the web, but also it's touching a lot of people you might not expect to touch with that. I'm not sure what other states have found, but we found it was real, really, really interesting with that. This electronic connection that we have done has certainly, as you can indicate, see on the next slide, has reduced the processing time, decreased keying errors and routed families to the right program.

Two other initiatives, there was another program in our state where they were developing a tool that could be used to communicate in Spanish. We have taken that project over and we are using chip dollars now to develop that. It's going to be a device given to the Medicaid outstationed workers. When they have someone that speaks Spanish, it will talk them through the application, things they are able to press and communicate in Spanish to the families so they can then communicate better with them in order to take those applications. In addition to that, a device -- we are excited about the possibilities. The last couple of slides I've got are just something that we are really, really proud of. We work with the University of Alabama, maternal and child health program in the school of public health and they have helped us by doing surveys of our enrollees. We have seven or eight different surveys that we do. But these surveys have given us some wonderful information that we have now sat down and looked at. It indicates a couple of things just from an overall perspective that our SCHIP program continues to have an impact in reducing the rate of uninsurance and low income children in the state.

Not only have we enrolled more children in Medicaid and the all kids foundation, but also increased in the Alabama child caring foundation. We think is phenomenal. 20% children enrolled turned out to be children who were undocumented citizens who would not be eligible for Medicaid or All Kids. And we are pleased to be able to do that. It's not a comprehensive plan but they can get to the doctor and get medications the doctor can administer to them. The children in All Kids show better access and utilization in health care services. And we believe this coordination we have done behind the scenes of working with Medicaid, meeting with them on a monthly basis, interfacing our two systems and getting involved with them has improved children staying enrolled in programs. I'm going to show you a couple of slides. Go through this real quickly. The next slide is access to medical care. You can see the blue line across the bottom may not be quite as clear, indicates the access to care that was reported prior to enrollment in chip and the red line shows the access to care that was reported after enrollment in chip. It's gone from an average of 64% to 94% showing improved access to care, which we think is just phenomenal. Really, really pleased with that. In addition to that, not only have all children seen improved access to care but a larger increase in children with special health care needs. They report an even larger increase to access to care. The blue line across the bottom shows before enrollment in chip, the red line is after enrollment in chip.

The third slide shows emergency room use, and again this goes in the other direction. The blue line shows emergency room use before chip, the red line shows after enrollment in chip. I want to point out to you that gap is narrowing at the right of our slide. We are finding that there are more and more children that are reporting and the last slide has the

statistics on this, that before enrolling in our program, 30% of the children enrolled lacked access to care and 23% now are reporting that. So we have decreased from 30 to 23%. These are children, these are families reporting the children did not have access to care. You may say Gayle, you are going in the wrong direction. We are actually not and don't believe it's a crowd-out issue. We are not drawing from private insurance. But what is happening, children are staying in the system when they come up for renewal, we are seeing a lot of what's called churning, children moving between the two programs, moving between Medicaid. Sometimes to private insurance and then back onto All Kids. We believe the electronic connectivity is keeping children insured, I hope I'm explaining this to where it will come through. We think this is one of our biggest and most exciting kinds of things we have done. More respondents are reporting that their insurance has proved. And the last says from 6% to 38%.

And finally we love this, I hope I don't offend anybody with it, but on our last slide it says we want to leave no child behind, that these are the children that we are out there to get, whether they are Medicaid, All Kids eligible, we believe some of the coordination, collaboration, all of those things have helped us improve access to children. And it's resulted in one of the lowest rates for the children in the nation. I sped through the slides. They say people from the south don't talk very fast, but I sped through them.

AUDREY YOWELL: Thanks to all of our presenters. Three quick points before we sign off. Number one, we'll be responding to your questions by email in the near future. Number two, don't forget to fill out your evaluations, we need them. Three, I apologize. I had

prepared slides before this and somehow they have evaporated. I apologize reading the contact information. 301-443-4292, email is Ayowell at HRSA.gov. And that information will be included among the slides when the webcast is archived. And it will be available by September 27 at the same web site you saw it at today, www.mchcom.com.

Thank you presenters, and I want to thank the viewers who cared enough about partnering to pay for MCH to join us today. Thanks and have a good afternoon.

MELVIN NEUFELD: Thank you, Audrey.