

## **Federal/State Partnership Meeting**

### **The Nitty Gritty on Health Reform and its Impact on MCH Programs and Populations**

October 25-27, 2009

JAMES RESNICK: -- on MCH programs and populations. I'm James Resnick, and I'm with the Office of Data and Program Development in the Maternal and Child Health Bureau, and it's a real pleasure to be here today.

I want to take a minute to reflect. Earlier during lunch my Michael Fraser talked about what was it that brought us in our careers or what brought us to the field. I reflect back to about 1994. I was an undergraduate, first year in college at the University of Massachusetts, and I knew I wanted to go into political science, but that's such a broad area. I mean, that can mean anything.

But I took a class. It was on healthcare. It was called "Healthcare For All, Why and How," and it was at that point that I got really passionate about it, because at the time that the class took place there was also another national discussion taking place, and it was on healthcare reform. It was a different proposal. Healthcare delivery was a bit different. But

the one thing that I remember is that there's almost nothing that is more political than healthcare. Healthcare is political.

And it's really interesting, as we read the media, we can talk about public option, no public option, we can talk about mandate, no mandate, fees, no fees. I mean, we're really having a real political science discussion. I mean, we're talking about the role of the federal government in healthcare delivery and insurance.

So it's an exciting time. It's exciting to be in Washington for this kind of conference as all this stuff is materializing and being debated.

So when I thought about -- I really felt that it was so important to have a session on healthcare reform for our conference, and when I went around and thought about all the people that really needed to be here to have this discussion, I really wanted to bring in the heavy hitters, as I call them, the A Team, because this is the second session. They are incredible and they are really on top of the healthcare debate. They know the issues in and out. Some were even around during the first healthcare debates. So it's exciting.

I want to start off with Kay Johnson. Kay is somebody that we all know well and really appreciate her hard work she has done on many, many different projects with the bureau over the years. She has been a leader in child health policy for 25 years. She's been active in Medicaid, Children's Health Policy at the federal and state levels since 1984, and served as an advisor to more than 40 state health and Medicaid agencies. Her expertise encompasses a wide range of maternal and child health issues.

Ms. Johnson is a research assistant professor of pediatric at Dartmouth Medical School and a lecturer in Health Policy at George Washington University. She's also president of the Johnson Group Consulting. Formerly, she worked as the national policy director for the March of Dimes and as senior staff at the Children's Defense Fund. And, Kay, interestingly, provided direct service to low-income families and child care and child development programs in the 1970s.

I just also want to say that the reason I really enjoy working with Kay is she's really one of the few people nationally that knows Medicaid and knows public health, and she can speak the lingo on both sides of the aisle, and we've had an opportunity to work with many states and really try to bridge those partnerships, and I really am happy that she can be here today.

I also want to introduce Jocelyn Guyer. She is the co-executive director at the Center for Children and Families, and a senior researcher at Georgetown University Health Policy Institute. At CCF she has worked extensively on child and family health issues, including the reauthorization of CHIP and the role of Medicaid in covering children and families.

She joined CCF from the Kaiser Commission on Medicaid and the Uninsured where she served most recently as associate director. At the commission, she led analysis in several emerging issues in healthcare for vulnerable Americans, including the implications of the Part D Medicare drug benefit for impoverished seniors and people with disabilities and major proposals to restructure Medicaid.

I really wanted Jocelyn here because about three or four years ago she came to this same conference, and at that time there was another major debate about the restructuring of the Medicaid program, and she spoke at the meeting, and I really felt that she'd be beneficial for the discussion taking place today.

But I also want know that whenever there is really a national health policy discussion taking place nationwide, especially around Medicaid and CHIP, I look to the research for

the analysis that you do, and you really help move the field and help people really take complicated legislative issues and really understand how it works in their daily programs on the state and local levels, so thank you.

And, finally, Brent Ewig. Brent joined AMCHP, the Association of Maternal and Child Health Programs, in 2007 as the director of Public Policy and Government Affairs. In this role he works to advance MCH programs by assisting in the development and implementation of AMCHP's public policy in government affair strategies and promotes policies, education and advocacy among AMCHP's members.

Prior to this position Brent served for two years as the senior program associate at Grantmakers in Health where he advised health foundations and corporate funders on health issues and synthesized lessons learned from their work. He also spend over eight years at the Association of State and Territorial Health Officials, ASTHO, where he served as the principal director for prevention and public health.

Prior to ASTHO, Brent served three years in the government relations office of InterHealth, a national association of non-for-profit religiously-affiliated hospitals and health systems.

I also want to say that I've had the opportunity to work with Brent over the last two years, and as I said earlier this afternoon, really, it's interesting. He has made such a strong impact in just two short years, but he really -- I really look to him when trying to see how national policy changes specifically impact Title V programs, and he's really developed a very great policy analysis group over at AMCHP. So I'm glad to have him here as well.

So, Kay, why don't you start off.

KAY JOHNSON: Well, I just want to say we had a nice, big, half-filled room in the first round and there are lots of good seats up front. For those of you who aren't coming and going, or even if [you are|your], it's fine. Just come on up and have a seat for the time that you're here. Adult-learning principles say that you'll be better able to listen if you're seated.

Okay. So I am going to talk about this from the point of view of a brand new taxonomy. And as I said to the folks earlier, I had to sort of -- at the end of last week I had these eight different side-by-sides. I had the AMCHP in the first focus and the Kaiser and the Commonwealth and the Georgetown and some that had been prepared by the

committees themselves and one on oral health over here and one from the Trust For America's Future just on public health aspects. So I have all these side-by-sides on my desk.

And in from George Washington University comes this new taxonomy. I said, Just what I needed, a new taxonomy. So I got so enthusiastic about this, I took the text of the taxonomy and turned it into a presentation for you over the weekend.

It really helped me make sense of all the information that I had, and I think it will help you make sense of it also, and my thanks to Sara Rosenbaum and her colleagues for giving me an opportunity to share this with you. She said share it widely, everybody use it. You can go to this long website or you can go to [www.gwhealthpolicy.org](http://www.gwhealthpolicy.org), which is the shorter way to get to their website.

So here's the taxonomy. It has ten elements. And in the excruciating detail that the lawyers and policy analysts at GW have put together, it really does cover the whole wide array of aspects of what we really ought to care about. And as we're going to talk later today, we often just talk about sort of this No. 1, and maybe if we're us, because of the

Title V thing, we kind of care about No. 7, and then maybe some of the other people really are looking to the bills about how they cover people for disparities.

But in fact there are things across all of these ten elements that affect the health of women and children, that affect MCH. So I'm going to kind of go through them one at a time and talk a little bit about what I saw and give some examples of how they might affect maternal and child health.

So the first one is easy. It's health insurance accessibility and affordability. And that's really about access to the coverage itself, issues about discrimination based on age and race and gender and health status and residential legal status, as well as the subsidies and premiums that have to do with affordability.

So what does this mean in terms of maternal and child health? Well, first and most importantly, if some combination of the bills that are there is passed, it seems almost certain that millions of women and children will gain access to coverage. If you have a mandated universal approach, which is what everyone is talking about, basically something that I think we all know but I like to remind us of is that four out of ten low-income women, four out of ten women living below 200 percent of the poverty level

are uninsured. They're uninsured unless they get pregnant. They're uninsured unless they get disabled, they're uninsured unless they turn 65 or their income falls to 20 percent of poverty or something, or they have kids, and then their income falls to 20 percent of poverty and they can't feed their kids, but they might qualify for Medicaid then.

So it really would be an enormous change and it would enable us to do things like the kind of lifespan approach, thinking about what it means to do preconception and interconception health for those women. It's absolutely fundamental. And Jocelyn will tell you more later about the kids who would also gain access. But there are millions of them, too.

The protection against gender discrimination. Barbara Mikulski and Patty Murray in the senate about a week or so ago had a hearing on gender discrimination, all the ways that even women who have coverage, they pay more because they have to pay more because they might have maternity -- they might need maternity coverage, because they might get breast cancer. Clearly gender discrimination, clearly going on widely across the system, and a very important issue.

Prohibiting discrimination on the basis of health status related to preexisting conditions, mental health parity, issues for everybody but particularly, I think, for children with special healthcare needs, and then setting affordability benchmarks. They are not everything that we would like them to be, but wouldn't it be nice to know what they are? Wouldn't it be nice to have somebody say this is what affordable coverage is, this is what proportion of your income would be reasonable for you to spend on healthcare instead of just having it be at the mercy of whatever plan that you're on? There would be subsidies for more people and there would be Medicaid coverage for those who have lowest income. And I'll talk more about that in a minute.

So then the second area of the taxonomy is around choice of coverage, empowerment and marketing. How do you choose your plan, how do you get enrolled into your plan, what are the safeguards that you have related to that enrollment, and here, obviously, the advantage of guaranteed issue of a policy, that you can't just be turned down because you are who [you are|your].

That there would be more choice of plans for many families, not for every family, but for many there would be more choice, and then that it would be, I am assuming in virtually every case, a better informed choice.

And I gave you just some examples. I did not give preference to any particular bills here. I just pulled examples of the kinds of things the bills might do. So, for example, in the House bill, this sort of tri-committee bill that they put together called H.R. 3200, they're talking about fair marketing principles, required outreach to vulnerable populations such as children, those with disabilities, mental illness or cognitive impairments, and more uniform marketing materials.

We learned from our experience with Medicaid managed care, not to mention the whole general way that you get information about signing up for a health plan, that you can't read what they give you, that there is deceptive marketing, particularly to low-income and vulnerable populations, and so just having the guideline that these things have to -- they have to be principled, they have to be fair and that there's a regulatory handle for the government to make sure that there are.

In the Finance Committee bill they talk, for example, about that many of the plans and states would be covered, that the secretary would define and develop standard definitions of common insurance terms, common medical terms, create some scenarios so that you could see how would this -- if you're a person with asthma, how would you be covered under Plan A or Plan B; if you're a person with breast cancer, how would you be

covered; if you wanted to have a baby, how would you be covered under Plan A or Plan B.

And they generally call for more uniform application processes. And I think Jocelyn's work, the work that many people did in the Medicaid expansions for pregnant women and then again in CHIP, thinking about more uniform enrollment, common applications, common forms; all of that actually literally has fed into these discussions.

The third area is the coverage. Really this is about benefits. So there's way too many words on this slide, but I really did want to put up the two examples, and I'm just going to go through and take a moment with this.

Six months ago we were feeling like we were afraid to say EPSDT. And a lot has moved toward more like the EPSDT gold standard. And I was reminded that I did not put in the health -- the committee that Senator Kennedy formally chaired actually has Bright Futures in their benefits language and the push toward preventive services for adults, not just people on Medicare but adults under 65. Again, an opportunity for preconception and care and health across the lifespan.

The benefits as defined -- described right now under the House language would be hospitalization, clinics, physicians and others, equipment -- in a variety of settings, not just when you're in a health facility -- prescription drugs, rehabilitative and habilitative, mental health and substance abuse, preventive services, vaccines, maternity care, and No. 10, well baby and well child care and oral health, vision, and hearing services, equipment, and supplies at least for children under age 21. That would be a good thing.

In the Finance bill it's a slightly different, slightly more constrained list. Again, very similar on the opening part, and then you get down to maternity and newborn care, pediatric services, including dental and vision, and so and so forth. I like the House bill language better. Both of them could be more specific. But in fact Congress is not going to define all the vagaries of the benefit package, but we'll be likely to have a board, kind of the way they do Medicare today, that would actually do the oversight and keep up with changes and clinical guidelines and practice and evidence.

The fourth area of the taxonomy is around consumer protections. Particularly things like fair hearing and grievance procedures, obligations to tell people if they're about to lose their benefits, or if they've had a utilization review which says they're denied the service,

that they would actually have to tell you and give you an opportunity to have a hearing, and to have internal and external review of the decisions.

There are protections intended to protect your confidentiality around your own personal health information. Some of us believe that's possible, some of us don't, but there's at least an effort in the language of the of bill.

And then just, for example, in the consumer information area, the Finance bill authorizes \$30 million to establish a new competitive grant program to support consumer-assisted organizations in each state that would help people with these processes.

The fifth area of the taxonomy is around disparities and whether or not people who are medically underserved, people who have language or cultural access issues that they need to be addressed, data collection, civil rights, those things are all in this category.

The biggest piece here, particularly in the House bill, is an increase investment in safety net clinics, billions of dollars and a virtual tripling of the number of communities health centers.

Then there are little safety net boosts. These two examples, one about extending the Public Health Service Act drug pricing program to children's hospitals and Title V agencies, another about having the emphasis on primary care services and primary care training. There is emphasis on effective and appropriate communication. In the House bill they actually require effective cultural and linguistically appropriate communication, and there are a number of provisions that describe what that is and how you would follow up on getting it or not, what to do if you didn't get it.

The Finance bill extends the Family-to-Family Health Information Centers with about \$5 million in that provision. Investments in research. I pulled this one up here. There's a lot of quality research, and there's a lot of research throughout the whole bill. But what I really liked about this one is that it actually moves the conversation toward community-based research and participatory-action research. If you read that last sentence, members of such subpopulations would be included in the research. That would be a good thing to have in federal law.

It also has the -- the bills have a Medicaid option for Family Planning services, which would essentially replace the need for states to have Family Planning waivers, and the

Medicaid option to include freestanding birth centers as providers because some states have claimed that they are not.

No. 6 is about other forms of insurance and different kinds of arrangements. There are lots and lots of provisions about Medicare that I'm not going to talk about in this category. There are veterans provisions, other -- working with a variety of it.

But just to talk about Medicaid and CHIP here for a moment, there is Medicaid equalization that both the House bill and the Finance bill would propose to expand Medicaid to all non-elderly individuals with incomes up to 133 percent of poverty, including all those adults who don't qualify today.

In the Health bill, the Kennedy-Dodd Committee work goes up to 150 percent of poverty. Jocelyn is going to talk more about that. They try to address CHIP in the new system. In Finance, they would require states to maintain children in CHIP and Medicaid until 2019. In the House bill they would move them into something called the Health Insurance Exchange. And again, Jocelyn is going to tell you more about that.

There are maintenance of efforts provisions for Medicaid so states just don't go backwards. And it provides increased federal support for Medicaid, especially in high-need states. There are lots of questions about whether it's enough, but it does move in that direction.

And No. 7, integration with public health and making public health investments. I'm just going to touch briefly on several items here that I think are prime examples, both in the Senate Finance Committee and the House bill there are major provisions to expand a federal home visiting program. Brent is going to talk more about that.

The establishment of school-based health clinic program is another favorite example of mine. Having grants that are core public health infrastructure for states, localities and tribal health departments. And then at Prevention and Wellness Trust Fund, in the House bill it starts around \$2 billion and goes up from there. Again, Brent's going to tell you a little bit more about that. But major investments.

And No. 8, administering the new system and assuring accountability, who's the role of the government in assuring accountability, what are their enforcement tools, what about

fraud and abuse; lots of provisions there. I just wanted to point out a couple of things that I think really have meaning for us in terms of MCH.

Administrative simplification. Again, really building on the work that MCH leaders have done. Issues around portability and whether or not plans can market themselves in multiple states. Administrative structures are under this area. Would there be a big, new agency that would administer this or would existing agencies administer this. A lot about technology, health information technology, electronic health records, standardizing transactions, very long sections on those kind of provisions.

One little example that's MCH specific that I like in terms of accountability, in the Finance bill they would establish demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost savings. So there are lots of place where MCH advocates have tucked things in that would make a difference for families.

And No. 9 is about quality. Basically the bills would each create a quality board center institute. Some of them would create two or three such entities, large national entities.

Some of them -- basically some of those entities would have responsibility for setting a national quality strategy.

Not entirely sure what that is. The language is vague. It could be a very positive aggressive approach. It could just be about measurement. So whether there are some provisions which point to things like the improvement partnerships, like UPIC and VCHIP and the work that (inaudible) does and so on. But we're not sure how far they would go in that direction.

Quality measures, we're specifically talking about maternity measures and adult health measures, and there's provisions both for patient-centered and population measures. There is a lot of attention given to medical home, particularly pilots. Whether these would be the sort of watered-down adult versions or there would actually be resources going into more what we think as good pediatric medical home approaches with sort of more stringent standards that the American Academy of Pediatrics and MCHP have promoted, not clear, but an opportunity and money there. Work force investments and actually community prevention and wellness grants.

Last but not least, paying for reform. I've given you just the two examples here. The Finance bill would be a combination of savings from Medicare and Medicaid and new taxes and fees, and the largest source of new revenue would come from an excise tax on high-cost, if you will, fancy insurance plans.

And then in the House bill, about half of the cost is financed through Medicare and Medicaid. Much of the remaining costs are financed through a surcharge. You've probably, if you follow this in the news, heard about these surcharges on people, families with incomes over \$350,000 or individuals with incomes over \$280,000. And I note to you that includes everybody on Wall Street who have their pay capped last week.

So what does all this mean really in terms of MCH? Well, I think that we don't know what all of the impact of health reform will be, but my feeling and my belief is that it will very much affect the way that we draw the pyramid and affect what is written in the pyramid.

And so just thinking about examples, you know, what does it mean if they triple the number of community health centers? A lot of health departments and Title V agencies have pulled back from direct services. What more would that mean if there was this dramatic expansion in clinics?

What does it mean in terms of enabling services if we have a lot of new legal obligations around translation services or cultural linguistic competency, both what is your role and what you might not have to do, what you might have to do.

What does it mean in terms of it's not that you wouldn't do newborn screening, but are there different ways to finance newborn screening if everyone is insured or there's a new wellness and prevention trust fund? Are there different ways to do business?

It's not that you wouldn't do needs assessment evaluation and planning, but you might do it of different things. You might give your attention to different things.

So I just see increased roles in quality, things like improvement partnerships and measurement, a focus on getting family coverage and enrollment, not just the children we've often focused on in CHIP. Thinking about how you assure those benefits. What a challenge it's been to even try to assure EPSDT very clearly spelled out.

Implementing a big new home visiting program, hopefully in every state, boosting access to the primary care services that exist, and last but not least, making sure that prevention

is not just about chronic disease prevention and obesity, that it's also about Early Intervention for children, developmental services and a whole array of other things that I know all of you care about.

So I'm going to stop there and turn it over to Jocelyn, who's going to give you a lot more detail about these plans.

JOCELYN GUYER: Good afternoon, everybody. I just want you to know I'm looking at my Blackberry. I'm not doing personal shopping. I am actually looking for -- there is, as we speak and have this meeting, Senator Reid is having a major press conference on what the Senate bill will look like. So I will try to incorporate what I just read off the Blackberry a little bit into the conversation, but I didn't want you to think I was shopping for holiday presents or something.

I think it's helpful to start with a little bit of backdrop on where we are on the coverage issues for kids. In part because there's good news and bad news.

I think the good news is we've made extraordinary progress. The bad news is that part of what that means is in healthcare reform there's some risks that we could move

backwards, and so we really need to look at where we are and figure out how to build on what works and move forward.

In part because of the strong reauthorization of the Children's Health Insurance Program last fall, I think one of the risks we face is that there's a sense that we're done with kids. We did the Children's Health Insurance Program in February. Great job. We had the signing ceremony. We're done. And so part of what we faced in the healthcare reform debate is raising the profile of children's issues, and it's something that I think we all need to continue to work on.

That said, part of why people feel like kids are done is we actually have made some good progress. People probably remember earlier this month the Census Bureau came out with its data on where we are with the uninsured, and it was genuinely awful. It was an abysmal day. The number of uninsured was rising, poverty was rising, unemployment was through the roof.

But the one silver lining was that we have actually reduced the percentage and number of uninsured kids to the lowest level in over 20 years. And I think that reflects the very hard work that's been done by people in this room and across the country making sure that

Medicaid and CHIP in particular are there to cover kids when they do lose their employer-based insurance.

In light of that signing ceremony in February -- and we had done a lot of work on that bill, and it took many, many years, it went through two vetoes with President Bush, and so we were still happy it was signed, but then we also were like, oh, my God, could you have picked a worse time? State budgets are in complete chaos. What state is looking to move forward on covering more kids when they're already having enough of a hard time handling what they have now?

So we recently finished an analysis looking at how states responded to the Children's Health Insurance renewal in February, and we're very pleasantly surprised that actually 48 states, including D.C., have maintained their coverage for kids through Medicaid and CHIP. And 23 have actually moved forward to expand eligibility. The one I like to pick out is Arkansas, because it tends to be kind of an unusual suspect. It's not the Vermont.

But they did an expansion for kids this year from 200 percent to 300 percent of the federal poverty level. And I think that that reflects the strong political support for children.

It also, to be realistic, reflects that congress did give states a significant chunk of funding for their Medicaid programs in the fiscal (inaudible) earlier this year.

Kay, I think was very eloquent about what kids have to gain from reform. I think one of the things we're most looking at is the family-based coverage, that we could finally have families as an entire unit covered with tremendous gains for the fiscal stability of families. And then also we know that when parents are healthier and feeling better, their kids to do better as well.

I said in the earlier session, I used to have quite a few slides on the schedule for health reform, and I just deleted them because whatever you put in, within five minutes [it's]its] outdated. So I'll give you what we think is happening now. And if you've gotten anything on your Blackberry that's more recent, let us know so we're all up to date.

So people probably know, there's two bills in the Senate, the Senate Finance Committee, which is generally considered the bill that is most likely to be drawn from because it does have the vote of Senator Snow, the one Republican who is supporting any of the existing bills so far, and then former Senator Kennedy had a bill through the Health Committee

and right now the name of the game is merging those two bills so that it can go to the Senate floor.

And what Senator Reid was doing his press conference on is that he feels like he's apparently this afternoon struck a deal on how to handle the very controversial issue of whether or not there will be a public option. And it sounds like there will be, that states could opt out of.

So that -- once they kind of nail that down, we're expecting to see the legislative language on that in the next couple of days. They have promised that they will give people some time to read that language, so if you weren't planning to do anything else this week, here's your opportunity, and also get the Congressional Budget Office score on that language before they take it to the floor. So we think it will be next week before they would bring that bill to the floor. And then we're expecting a number of weeks of debate. This isn't going to be in and out. We're expecting this will go on probably at least through Thanksgiving, if not later.

On the House side, they have the three bills that I think people know about. There were three committees there, and they're now merging those bills at this point as week.

They're also trying to figure out their public option strategy and we're also expecting that they will go to the floor in early November.

After that, I think it's really just a wild card as to what's going to happen. There's people certainly setting a deadline of Christmas to get everything signed, but creeping into the news coverage recently has been discussion of January and February, which I was sort of hoping it would be over. But we may be at this next year as well.

UNKNOWN SPEAKER: Is there an election next year?

JOCELYN GUYER: So I think Kay has really nicely outlined the basic structure of the bills, so I won't go through those, other than I'm just curious, does everyone -- when the word "exchange" comes up, do you think like you're bringing something back to Target our do you think -- does everyone know what exchange is, what the exchange is?

UNKNOWN SPEAKER: No.

JOCELYN GUYER: Okay. So our basic structure is that we're going to build on what works. So people who are employer-based coverage are still going to be able to keep it. Hopefully it will be somewhat better.

Very low-income people will be covered through programs through the kinds of expansions that we'll talk about in a little bit. Mostly financed by the federal government.

And then everyone else, if you can't get into your employer coverage and you make too much money to qualify for Medicaid, they're creating something called an exchange, which is basically a marketplace for selling health insurance plans. It will be regulated, so those plans can't keep you out because you're sick and all those good things.

And then there will be subsidies that will go with those plans so if you need help buying your coverage, the subsidies will be available for people. The details vary dramatically, but up to 400 percent of the federal poverty line. And as I'll talk about in a couple minutes. One of the big issues with reform is whether or not those subsidies are adequate.

So in terms of kids, the good news is between the Medicaid, between the exchange program and employer-based insurance we should have pathways to coverage for almost all children in America. And the very notable exception is undocumented immigrant children are clearly not going to be covered. Not a single bill directly touches them. In fact, they go out of their way to say under no circumstances will we ever spend a single federal cent on coverage for undocumented immigrants. And I'm talking about coverage. There's other public health initiatives that they could hopefully access.

There are other kids, though, that could also remain uninsured. As I think everyone in this room probably knows, most children are actually already eligible for Medicaid and CHIP, and so one of the questions about health reform is will it make it possible for some of them who are kept out by red tape to get in. They're actually not going as far as I would like to see them do in terms of addressing red tape barriers to signing up for Medicaid and CHIP. So I think we will still see some families that are just daunted by the paperwork or have a hard time, probably in some specific states that make it pretty tough getting into coverage.

And then the other issue that I'll talk about in detail later is that even with these exchanges and the subsidies to help you buy coverage, there's deep concerns that those

subsidies are inadequate and that many families will still be unable to afford the insurance.

In terms of how kids will get the coverage, so it will be 133 probably, we think, for kids in Medicaid, and then the exchange coverage and the employer-based coverage on top of that.

The piece that I want to kind of delve into a little bit more detail on is what happens to the Children's Health Insurance Program, which is -- it's a small program, but it's done a lot of work in part by rejuvenating Medicaid and making -- just sort of bringing new attention to children's health issues. And so it's been really interesting to watch what's happening to it in healthcare reform.

Just so people have the backdrop, CHIP was renewed for five years by President Obama in February, and so it's slated to expire September 30th of 2013. That happens to be exactly when everything is supposed to go on board for health reform. They're supposed to set up the exchanges, they're supposed to start running the subsidies. It's all in 2013. So it's kind of dramatic timing.

What we're seeing the bills do with CHIP is actually very different in the House and the Senate. Both say that states have to continue their current CHIP coverage for kids through at least 2013. But then they diverge pretty sharply. The House has basically made the call that we don't need CHIP program anymore, that children will be better off in federally funded exchange plans, and so we should move -- we think it's going to be about 14 million kids who would otherwise have been on CHIP in 2013. And under the House, those kids will move from CHIP, so from the public program of CHIP, into these private exchange plans.

This created a fair amount of consternation, I think it's fair to say, among children's advocates who've spent many, many years working on CHIP and Medicaid and making sure it's good, decent coverage. And so alarm bells were raised that the exchange might not work as well for kids. In response, the House added a provision that says children are only supposed to be moved if the coverage in the exchange plan is comparable to what they have in CHIP.

Now, the glitch -- which is our new favorite word, the glitch -- the glitch is they didn't actually provide any conditional funding for CHIP if the coverage isn't as good, and they didn't directly say the coverage must be as good for children. So they kind of set up the

principle, but they've stopped a little bit short of directly guaranteeing that the coverage is as strong.

In the Senate, they've gone a different route. I think this is basically single-handedly due to J.D. Rockefeller from West Virginia, who feels strongly that the exchange plans will not work for children, and he wants to keep the CHIP program. So at the very last minute at the Senate Finance Committee markup, literally after midnight, two hours before they finished, he offered an amendment that keeps children in CHIP. It says states must continue their Medicaid and CHIP coverage at least through 2019, so a good decade into the future. It gives them some enhanced match for that. And here the glitch is he didn't actually fund the CHIP program. So he said on paper states must continue it, we're going to reauthorize it, we're going to do it, but he actually didn't put the money in the healthcare reform bill into financing the CHIP program that would be needed to be really secure and competent that that's in good shape.

I just want to add -- Kay talked a bunch about benefits, but I want to add kind of a backdrop caveat. As she said, they clearly have decided that they're not going to specify everything in great detail in statute on benefits. They have some good, decent categories of coverage. You might see increasing attention to this issue of -- they're saying that the

benefits can't have an actuarial value above a certain amount. And that's a very complicated word, but it basically means that if you were an actuary, and, God help us, I don't know any personally.

UNKNOWN SPEAKER: I know one.

JOCELYN GUYER: Oh, you do? Apparently they're very mathematical.

If you were to look at the benefits being offered to a population, on average the health insurance plan offering those benefits would pick up, say, 70 percent of the cost or 80 percent of the cost. So it's kind of a measure of the generosity of the benefit package.

One of the issues with all of these bills, especially with the Senate bill, is they're generally using very restrictive actuarial values. So in general, insurers are only supposed to pick up 65 percent of health insurance costs or 70 percent. It varies depending on your income.

So we may have the very best list of benefits in the world, but if there isn't some attention paid to this actuarial value, which is basically capping the generosity of the benefits, we

may something that looks good on paper, but families may have a really hard time getting the services. The way they'll do that is they'll impose significant cost sharing. So it's worth keeping an eye on that.

I want to spend a minute on this next slide, because it really goes back to this overarching issue of affordability of the plans that we're talking about.

And there's a lot of different pieces to what makes coverage affordable. Just one piece is how much it costs to sign up to the premiums, and that's what I'm going to focus on here. But once you sign up for coverage, you also need to be able to use services without overly expensive cost sharing, and that's also an issue in the bill, but it's not reflected in this slide.

So we wanted to take a look at, because there was so much consternation about would kids be better off in the exchange, better off in CHIP, what we did was take a look at the premiums for children in Medicaid and CHIP right now. So for a low-income family, and every single state except for just a few are at least at 200 percent of the poverty. So for a family at 200 percent of the poverty, what are you expected to pay to sign your children up for coverage.

In the average state right now it's less than one percent of your income. It's .7 percentage points to sign your kids up. All the reform bills are providing family-based coverage, so they're covering parents as well as kids, so you would think it should definitely cost more to cover an entire family as opposed to just kids. I think most people were thinking three or four times as much. The amounts they are looking at expecting families to pay are on the order of ten or more times as much in some of the bills. So specifically the Finance Committee is looking at charging families eight percent of their income at 200 percent of the poverty line to buy coverage.

And that's just the premiums. The out-of-pocket costs on top of that are expected to be several thousand dollars. So you can see why even though it kind of seems like a good idea to have kids in an exchange that's federally funded and a clear guarantee, it makes people nervous to move children from very strong CHIP and Medicaid programs into the exchange, unless you can really delve in and deal with these portability issues in the exchange, which there is some pressure to do. And obviously this is unaffordable not if you have kids, it's unaffordable if you don't have kids as well.

The other issue that I wanted to focus a little bit in on is how families are going to get signed up for coverage, because this is another area where I think they could maybe push it further and do more on the simplifications. I think there are a lot of proven strategies for making it easier for families to sign their kids up and keep coverage. There's 12-month continuous eligibility, there's presumptive eligibility, there's express lane, and they originally had all those ideas in their bill.

And then they started running out of money and they started dropping them. So all of those improvements to the Medicaid program that would have made it better for families have been dropped out of the bills. So it's just to say -- and it's purely for money reasons. They know it's a good idea, they like it; they just don't have the money for it. So there's not as much left as I think would be really good for families with kids.

Instead what they've generally done is focused on making the exchanges so that when you apply for the exchange, they will also evaluate you for Medicaid eligibility. So if you happen to go through the door of the exchange, they will check out whether or not you could also qualify for Medicaid and CHIP. And that will definitely be important and helpful, but they could have been a little bit stronger on the simplification.

The other kind of complexity I think we'll end up seeing and where families really may need some help navigating things is this new exchange and subsidy program is likely to be -- the subsidy will be administered by the IRS, and so a lot of families aren't really used to getting tax credits as the way that they get help with different things. And so I think it's going to be an adjustment for families, and then it will make it quite challenging for us to make sure that there's good coordination between the IRS and Medicaid and CHIP.

So to close out, I'll go through the challenges, and then we can end up hopefully on a more positive note.

So this is now like two weeks old, this slide. We used to worry it would fall apart entirely. I think at this point it clearly is going forward. I think that health reform will pass. There's such a political imperative by President Obama, by the Democratic party, they need this to pass. As someone who supports health reform, I think that's great. The only risk to it is they so desperately need it to pass that some of the issues you'd really like a hard stand on, like making sure coverage is affordable, they may need to let go of in their interest of getting it passed. So it just means we need to be extra vigilant.

The other, I think, risk is that we may see some backwards progress that we gained as a result of the Medicaid and CHIP moving forward and covering lots of kids. And we really need to keep an eye on that.

And then the third is that we don't address the red tape barriers to coverage for especially the lowest income kids who qualify for Medicaid.

So going forward in terms of at Georgetown, the top properties we've identified, the first is making sure that coverage truly is affordable for families. If we're going to get some coverage, we need better subsidies. We need to make sure that when they're signed up, they can use services without excessive cost sharing.

We also -- I sort of philosophically don't have a position on whether you should keep CHIP forever, not keep CHIP. I do philosophically have a position that we probably don't want to take that program down the day that we're setting up a vast new health insurance system. We should at least have a transitional period, and then we should be committed to making sure that children continue to receive the decent coverage and cost sharing protections they have now, and whether that's in CHIP or the exchange, I don't feel

strongly about it. I just feel strongly that we do need the affordability and the benefits and the access to care.

And then the last thing is that we clearly need to keep an eye on what happens to children in immigrant families. They're very much at risk under the reform bill, and it will be important to see how they fare.

So with that, why don't I close out and turn it over to Brent.

BRENT EWIG: -- I had all this hair then. If it does fall apart and it takes another 14 years, I shoulder to think what -- you know, the condition.

And then Jay also -- he also mentioned that the panel was heavy hitters and I kind of took that personally. I know I haven't been to the gym in about a year, but I have a good reason, because my daughter was born a year ago October 15th. I can just quickly show -- you can't see this, but I took her to her first Bob Dylan concert this last summer.

And then tying that to something Jocelyn said very mathematical, that actuaries -- I was actually an English major, and that reminded me of a story when we went in for delivery.

She was actually breach, so it was a scheduled C section, and we were going to the hospital, and this other family was, it was kind of a young family, you know, we waited a little while, but this young family comes in. And the woman is on the gurney, and she's in active labor, and she just screams out, "Don't! Can't! Won't! Couldn't! Shouldn't! Wouldn't!" And the father looks at the doctor, he's freaked out, he says, "Doc, Doc, what's the matter?" And the doctor says, "It's okay. She's just going through some contractions." Don't. Can't. Won't. I thought we needed a little story to start this afternoon. English majors love that kind of stuff, so I apologize. And I know some of it's a rerun to some of you. I can see you going, oh, no, not that one. And my wife's going to kill me for telling it.

So anyway, the three things I would like to do, again, building on the great presentations, really just try to highlight three things quickly.

One, share perspective on what some of AMCHP's priorities have been, what we've been doing and saying on your behalf here in D.C., what you can do to echo that message, understanding some of the restrictions and sensitivities there. And then, finally, to pick up on Kay's final essential point was what does this mean for Title V, your day-to-day work, the future of Title V.

So real quick on AMCHP's priorities, our board met here in D.C. last November right after the election, and like every one of the other hundreds of health associations in town, came up with our principles for health reform, and we really made it simple. I think Kay's taxonomy was brilliant with the ten. We kind of boiled it into three and said three things.

One, that all women, children, families should have access to health insurance. Two, that the benefits package should be adequate to meet the needs of women, children, and particularly children with special healthcare needs, and then three is that health reform should explicitly -- because healthcare is essential but insufficient to improve health, health reform should make investments in prevention and public health and should explicitly consider the future of Title V. So you kind of see where we succeeded there.

And what I say in the first two, we have been really lucky to have just a tremendous group of partners, a kind of ad hoc coalition that kind of came together a few month ago of all the kind of usual suspects that you would expect in MCH advocacy. So there's Academy of Pediatrics, children's hospitals, March of Dimes, First Focus, Children's Defense Fund, and began doing some regular meetings with key staff on the hill just on kind of think through in anticipation of what Jocelyn said, that there wasn't going to be the prioritization of children, but with March of Dimes and NCOG at the table, making sure

that there was a voice for women too and making the kind of primary message that healthy kids begin with healthy moms and healthy families, so really trying to get that preconception message in some of our advocacy. And it sort of worked.

So a lot of what I would say about access and benefits is there's a lot of good groups that are working on this. And I think you heard the highlights. And with access, the bottom line is that millions of women and children that don't have affordable options for insurance now should gain it when this bill passes.

So there's glitches there certainly. We can talk a little bit about that. And it particularly kind of relates to benefits, but on benefits, you know, Kay put up what the categories that each bill included. And we were sort of surprised to see that even included in that, it was friendly to some -- many MCH issues. So having no cost sharing for preventive services, referencing that all evidence-based clinical preventive services from the CDC guidelines should be included, having well child care, immunizations, mental health and substance abuse services and even oral health in those bills we think is a great start. That promise needs to be fulfilled in the details that will be written after the legislation passes.

But I think the biggest glitch that we have highlighted and heard about so far, and Jocelyn did a good job of raising the issue, is what happens to those kids with CHIP right now. The bottom line concern is then if they move into the exchange, they may lose some benefits protections that they currently have, at least on paper now, and they would certainly lose some of the cost sharing protections. So Jocelyn's slide was great on the percentage increase for premiums, and I just wanted to add First Focus has just put out some information showing that what children with special healthcare needs, their out of pocket costs might increase under exchange plans. And it's pretty eye-opening, and it wouldn't be good.

And I think, you know, again, it's hard to kind of analyze. A lot of this is coming out. The reality is probably most kids that are pretty healthy would do okay in an exchange plan, but particularly for those children with special healthcare needs, they could really stand to take a step backwards, and that's very concerning.

The trick for AMCHP is we are a stake group. So not only is health policy difficult enough, but we also have to deal with kind of state federalism and politics and know that many of you work for health directors that are appointed by their governors. And so to be cognizant about what governors feel about certain provisions, and again, I think the

bottom line is a lot of things that would fix these issues that we would all agree are good policy have an implication on state costs where they either would lock in states to a maintenance of effort or perhaps in some way shift costs to the states. And so that's made us be much more, unfortunately, cautious on the kinds of things, amendments, that we could support that have a cost implication to the states.

And as a kind of concrete example on this, the House bill includes a provision that says Medicaid rates are important to access, and so Medicaid rates should come up to at least close to where Medicare rates are. And again, I think we all know that. You know that kids on Medicaid have a hard time finding docs that will accept Medicaid. So bringing those rates up would help a lot.

But the National Governors Association has said that provision alone, without even any expansion, would cost states tens of billions of dollars. So unless it's fully federally financed, it's not acceptable. And, again, I think in other times we could have a good policy discussion of these issues.

What I'm trying to pass along to our colleagues is it doesn't behoove any of us to be supporting a plan right now that just would be unsustainable to states in the long term. So

adding those costs if states don't have the dollars to borrow, and you can't borrow like the federal government can, it's just not going to be sustainable. And we'd hate to see things unravel, because they're good policy, but it just doesn't take into account that state-federal mix of financing.

So it's a glitch that we have at AMCHP that a lot of partners don't have, and so we watch what they're saying. I think a lot of good work is being done.

So what are we doing on your behalf? We have been working with these groups, we've been supporting things we can, and -- oh, I skipped ahead. So access benefits, and, again, really good introduction and grounding on a lot of that.

The third piece that we said the principle of investing in prevention and public health and Title V, that's a somewhat more unique niche. And I think what we see and what you all know is that any health reform debate really focuses 97 percent of the money is in accessing healthcare, and that's where the debate is focused. And so we've really tried to focus on an AMCHP niche in talking about prevention and public health.

And so illustrate that, this is just one example. One of our talking points on the hill has been, yes, indeed, we've made great success in covering kids through CHIP and through other state innovations, and as Jocelyn pointed out, we are at this historic low in the number of uninsured kids at this point. And that's great. But childhood obesity hasn't been affected at all and in fact has risen unabated.

And so for those of you that didn't go to public health school might think, well, that must mean that insurance causes obesity, but as you all know, the correlation of that causation, or however that saying goes.

So the point here is not anyway to undermine the need for coverage. We say that that's essential and fundamental, and those investments need to be made. But we'd simply like to point out that billions of dollars are annually invested in the coverage question, and if we're not investing at least some adequate amount in prevention and using childhood obesity because that gets people's attention, all we're going to do is provide coverage that will then cover those exploding chronic disease costs that are going to be inevitable as these obese kids move into middle adulthood.

And we know that there's going to be a link in poor birth outcomes as well. So that's our point there. And again, it's not in any way to undermine the importance of coverage but to talk about why we need public health and healthcare moving forward together.

And so the good news is there's traction there. In both the House and Senate bills there are investment funds, public health investment funds, that would start at about \$2 billion a year and in the fifth year they would gear up to about \$10 billion a year in mandatory funding that would be -- it's specified to be above current appropriations level. So they couldn't just shift stuff around.

And this is, I think, as good as we could hope for, that they finally recognize we need to strengthen state and local public health systems. The glitches here, there's differences between the way the House and the Senate proposes it. The Senate -- well, first let me start with the House.

The House sets it up, and they really specify, there's about eight programs or areas that they would fund. So they set aside off the top about \$4 billion of the 10 billion for community health centers. They make investments to the tune of hundreds of millions of dollars in work force, both clinical and public health, and then they set up some new

programs. A \$1.2 billion program to support state and local had you been infrastructure and a \$1.3 billion grant program called State and Community Wellness Grants.

And we went to them early on and said we would love for your bill to explicitly address infant mortality, disparities in infant mortality, and we'd like to see it go through Title V. And they said we love your ideas, we'd like to do that, we want to invest in it, but probably not through Title V. We don't want to do a specific body part or disease, so we're going to create this kind of bigger fund, and your people will be eligible for it.

So that's not ideal, but it I think is the best that could be hoped for. They didn't want to set up here's the fund for infectious disease, here's the fund for chronic disease, here's the fund for injury and all that. They basically put it all in one fund.

I would argue it's not nearly enough, but it's a good start. It's new money on the table, and it's ours to lose. It's there, and we need to make sure it stays there.

The Senate, in contrast, sets up the situation where it's about \$10 billion in the fifth year, and they say it's for any program authorized under the Public Health Service Act. So much more flexibility. Great. But a glitch. As you all know, Title V is under the Social

Security Act. So from day one we put together a one-pager saying we would like an eight-sentence amendment, very specific, you know, on line 42 of page 382 it should say and title programs under Title V of the Social Security Act.

We shared that with Senator Harkin, Senator Baucus and Senator Dodd as kind of champions of these issues. They've all said they're aware of the issue, but I'll be honest that I think it's about 107th on their to-do list, and at this point with the melding that's going on and the timeframe, it may be that they only get to the top 20 things on their list.

So it may be something that we would need to come back in a future year to get a technical amendment correction on. But even if we can't get it fixed, what I would argue is that having that money going into the public health system, even if it won't go directly into Title V, it will benefit MCH. We'll have to fight for it, and it won't be easy, but as you all know now, we're all friendly competitors for the same small crumbs of public health. If we added \$10 billion to that pie, we could be a little more friendlier in the way we come around the table to compete for that money. So that's the investment fund.

The other key investment in both bills is home visiting. So if you were coming to this session just because you wanted to wait to hear about home visiting, I'm sorry you had to wait so long. But here it is.

So in both bills there are really strong proposals for home visiting programs. Again, there's differences between the House and the Senate. The House sets it up in Title IV of the Social Security Act, meaning that -- implying that it would go through the Administration For Children and Families and would have sort of a child welfare focus. Maybe those agencies would be the leads in the state.

The Senate, in contrast, sets it up as a new section of Title V, and specifies it would go through HRSA in coordination with ACF. And here's three great things about the Senate bill that are the talking points.

First of all, let me say the lead talking point right now is both on the investment fund and home visiting. Job number one is to make sure that they stay in the final bills. And so with this melding going on, they're deciding what can we afford, and this stuff is really, really, really vulnerable. So I'll talk about what you can do to help support it. But it could easily be pulled. It's just too expensive, adding to the cost of the bill.

So job number one is that we're asking that they keep those two provisions in as essential investments for public health and MCH.

And then here's the great things about the Senate bill. It builds on the success of Title V. So all the focus on accountability and state partnerships and all that we think is brilliant, and so that's our lead.

Second, it has twice as much money proposed as the House. It's \$1.5 billion in the Senate proposal, and half of that in the House.

And then, third, there's no match requirement in the Senate, and there's a small, I think it's 10 percent, match in the House. And under normal circumstances we would say we understand the importance of a match to show the buy-in, but under these circumstances it would really possibly block implementation for the states.

So that's our three lead talking points, and we'll be ready to circulate that as we get to conference if possible. But again, job number one is to keep it in.

However -- and it's coming around now -- you have the summary of the Senate provisions. There are some real red flags here that I think you should be aware of, and the very first one regards timing. And this says right off the bat that within 6 months of passage of the act, states would have to do a supplementary needs assessment in addition to the one you're doing for your Title V Block Grant, and get that in within 6 months, so in lightening speed. And the kicker is if you don't get it in, the federal government could withhold your Title V Block Grant. So there's a carrot and a stick.

UNKNOWN SPEAKER: Are you listening?

BRENT EWIG: Yeah.

UNKNOWN SPEAKER: Do we have your attention now?

BRENT EWIG: And so, I mean, I think the thinking here is they want to get these investment out there quickly. It's a priority for the President. And so Jocelyn was bold enough to make a few predictions there that something would pass. But the timing is the hard one. I stopped making predictions because every one I said all summer long was always two weeks to four weeks later that I said it might happen. So I don't know when

this would pass, but let's say it passed in December. That would mean that by next June a needs assessment would be due.

I think the good news is they're specific about what they would want states to report, and for most of those there is a data source. I think you would have the data at your fingertips or easy to get, but it would be a burden, and you know how these things happen. It's a paragraph in law and then the guidance could come out as 60 pages of what you need to do.

So that's glitch number one.

Glitch number two is on the model. And I would hope you could look in here. This has been a big food fight in D.C. I'll just acknowledge about. If we're going to do investments in home visiting, which models would it support. And the debate has been around evidence-based. And I think it's real important to know that the way the Senate writes it, it could be interpreted as somewhat -- very limiting of the models or model that would be eligible.

I think it's unclear right now to a lot of people reading it that it doesn't limit it to one model, although it looks like there might be some flexibility in there. We obviously have said all along that since states are using many different models to meet different needs, that that needs to be built in, and the House has better language on that. So I would just let you know that that is a glitch, the way they talk about the evidence standard for the model there.

And then there are benchmarks for progress. And again, we understand accountability, and we want to be held accountable. But these are in the summary, and I urge you to look closely at them. There's six benchmarks for progress that states would be asked to report on within three years to demonstrate progress, and states would choose four. And I think -- I'm doing this a little bit from memory, but I think there's some of them that are slam dunk.

The first one is, you know, demonstrate improved maternal and newborn health. The second is -- I think the second is reduce crime and domestic abuse. The third is school readiness, and the fourth, and this should get your attention, is demonstrate priorities in improving families' economic self-sufficiency. And I'm missing one. I can't remember. But then the fifth is reduced injury, and then there's show coordination with other services.

And so the way I'm looking at this, and it fits the theme of this meeting, is we talk so much about the importance of social determinants of health, and obviously education and income and economics are key to that. This is really the federal government saying we've heard you, we want to put -- make you accountable for that and we'll invest in it. And the question is, you know, would these modest investments -- in the fifth year it would be \$400 million a year -- be able to allow states to show those demonstrated improvement in those areas.

I don't want to say this out loud, and especially because the videotape is on, but I think one way to push back on that would say we're going to spend 20 times that much on Medicaid, at least -- we'll spend probably 40 times that much -- and nobody asks the Medicaid managed care plan at the end of the month to demonstrate that those Medicaid kids have better school readiness or improve their family economics, self-sufficiency. It's just a different standard of outcomes and accountability.

But I don't want to say that out loud because we don't want to sound like we're complaining about what -- and the bottom line for us is a wonderful investment in moms and kids, and if we create noise like that I think they could easily say, well, if you guys

don't know if you want it, we're just going to pull it or give it to somebody else. So that's why these things are sensitive, but I probably shouldn't say that on camera. Don't post this until after it's written and passed into law.

And then, finally, is there another glitch? Oh, yes, there's another glitch in there, or just a red flag, that says that if states don't have a successful advocacy after two years, that the feds could directly fund a national non-profit group with experience in home visiting to run the program. And so it's basically an escape valve run-around around the states, and I don't think that's the best way to handle that. If there's a need for technical assistance or a problem in the state implementing, let's work with that state rather than give the money to someone else.

So those are some of the glitches. But again, the bottom line for us is that in health reform there's a lot of these good things. And I mentioned this earlier, I just came across a quote that was said about Eleanor Roosevelt that she would rather light a candle than curse the darkness. And so I think we want to highlight what the candles are in this bill, knowing that we do need to curse the things -- the glitches and get them fixed, but I think there's a lot to like in there. And, again, my colleagues have highlighted a lot of those good things. So I didn't spend an a whole lot of time on that.

And then, finally, what it means for the future of Title V. I think the bottom line and case showed that the pyramid -- and when our board met last year, we already said this, that we're worried that if a bill passes and every mom and child has health insurance, Congress could easily turn to us and say why do we need the MCH Block Grant anymore, and we would show them the pyramid and they would look at the top with the gap filling in and say, well, your data here says that you're spending 52 percent of your allocation on direct gap filling services so can we cut you in half at least.

And we wanted to anticipate that sort of situation happening. And what the board directed us is let's talk about the uniqueness of Title V to do those other parts of the pyramid, the other levels. And so we've been going up to the hill as part of our regular appropriations visits to be preemptive and talk about people. Here's how we envision Title V thriving and why additional investment will be needed in the future.

And I'll be honest, we're getting push-backs specifically on the population-based piece. And what people do is they look at that, and every issue in MCH that we would want to address there, if you say infant mortality, they say, well, we're going to cover prenatal care and we have Healthy Start, and if it's obesity they say, you know, we have the whole

chronic disease center. If it's injury, similarly, there's injury center at CDC. If it nutrition, you know, they say we spend billions of dollars on WIC. If it's family planning there's Title X. And so you kind of see what the issue is that they feel they've put a categorical out there for just about every other program. And then how that relates to the infrastructure pieces they say each one of those programs has its own administrative funds and so we're not going to fund you to make sure that other programs are working well. Each of those programs certainly has its own administrative dollars.

So we're needing to adapt that message. And I think you heard a lot of good excitement about the energy to do that with Peter talking about some of that.

What we tried to do -- thank you, Kay. That was brilliant -- in anticipation of this, the story behind this, it's called the power of prevention for mothers and children, and it came out of a held meeting that we were doing where a staffer said to us, she said, you know, I used to work in NFRA (phonetic) so I know off the back of my hand that a dollar invested in family planning saves \$4 in Medicaid costs, but you must have that for all the MCH prevention services that you all do, right?

And we said, yes, of course. We'll get that to you right away, and then went back to the office and scrambled for weeks to say, okay, well -- no, I'm breast feeding, and just down the line, prenatal care, nutrition -- and started pulling it together. And we wanted to have a very brief document that highlighted, that kind of consolidated the most recent data that we have on the cost effectiveness of MCH common, MCH preventive services.

And what happened as we were going through this, it kind of got to that issue where we would say to the states, you know, tell us your data on nutrition, and they would say, well, we don't do as much because WIC does, and we supervise WIC in this decision.

So it raised some of those issues. But what we were able to do is not only do the data on cost effectiveness or return on investment -- not necessarily return on investment. I forget how we framed it -- but we talk about what Title V does to support each of these issues.

And so this has been helpful to us on the hill, and it's on our website. I don't know that we've done a direct mailing, and I was an idiot for not bringing a pile today to share with you all. But it's available on our website, and we'll make sure that you have copies available. And it's really been the piece we've used to underscore our message about why investing in Title V, why it's unique. And so that is available.

And then to kind of conclude it all, I think the big question we'll have in the future is if reform passes, everyone has insurance, we're going to have to figure out how we talk about Title V and its uniqueness and its effectiveness in that new system. And I think -- I'm freaked out, but I think we do have a little bit of a window of time because it's going to take a number of years to implement this, that maybe not next year is when the question gets asked, but I think it's on their mind now. And we're watching closely what their doing with the DSCH payments in Medicaid, and they're saying we can scale those back and save billions of dollars over time because there will be less uninsured people. And I think eventually they're going to go through the rest of the health budget and say do we still need this and where can we get some savings.

So we're trying to be proactive and thinking through questions and getting a message together, and we need your help.

And where we need your help most immediately -- and, again, I know the sensitivities around this. I should have prefaced this that whenever I talk about AMCHP's advocacy, that we of course never use any federal funding to do that. We're very careful. We've had our lawyers advise us on making sure we're in compliance with all IRS and federal rules.

And so we take that very seriously at AMCHP that we don't want to step across that line, and understand also that many of you have restrictions on what you can do.

But for those of you who are able, we sent out an alert last week really saying as they're melding these bills, now is the time to weigh in on a number of issues of importance to MCH, but specifically saying that the investment fund and the home visiting are two key pieces that are investments in MCH and need to stay in the final bill. So hopefully you saw that.

And going forward, we really try not to, you know, send out an action alert every other day because we know how limited you are, and if there's too many you just can't respond. So we really try to keep our powder dry for when it makes the most difference.

I think the next step, there will be some amendments on the floor, we'll probably maybe be engaged in some of that. And then if both bodies pass the bill and they get to conference, that will be our time to weigh and to say this is why we like the Senate or House language better. So keep an eye out for those, and those action alerts will be forthcoming.

JAMES RESNICK: Wow. A lot of information.

Why don't we start with some -- we have time for some questions. Please.

UNKNOWN SPEAKER: Could you just introduce yourself?

JAMES RESNICK: Yes, please.

UNKNOWN SPEAKER: (Inaudible) from South Dakota. You talked about the home visiting and the fact that that needs assessment. Well, as you guys know, we're in the middle of doing our five-year needs assessment. Do you have any guidance on how we can incorporate that old visiting needs assessment into what we're already doing, or does it have to be a separate needs assessment?

BRENT EWIG: It does specify separate. But that's a great question and idea that as you go through it I think we can pull out the specifics of what the Senate is asking. They very clearly specified they want to know the communities that are at risk for higher infant mortality rates, low birth weight, prematurity, poverty. They specified the kind of data

points that they would want to see, and that is the current level of home visiting across the state.

So I think that's a great idea. We could do a one-pager and --

UNKNOWN SPEAKER: (Inaudible).

BRENT EWIG: Yeah. Yeah. This week. Next week. Within a week, yeah.

JAMES RESNICK: Okay. An additional question. Yes, please. And you need to introduce yourself.

UNKNOWN SPEAKER: (Inaudible).

UNKNOWN SPEAKER: Richard, your voice doesn't travel very well in here. Thank you.

UNKNOWN SPEAKER: My name is Richard Roberts. I direct at Center for Children With Special Healthcare Needs and (inaudible). One of the things I was looking for (inaudible)

fathers. It was not mentioned once in the presentation. And we do actually contribute to this --

KAY JOHNSON: I didn't say men, but I actually include them whenever I talk about adults.

UNKNOWN SPEAKER: But I'm just saying that the conversation really needs to (inaudible).

BRENT EWIG: That's a good point. Thank you.

JAMES RESNICK: Okay. Amy Fein, please.

AMY FEIN: Hi. Amy Fein. I'm a consultant to (inaudible) and a couple other places. A couple of questions. One is having heard all the presentations earlier in this set of meetings and having worked on integrating services across sectors, is there anything in the current legislation, current talk about what's going to happen (inaudible). And the second question has to do with evidence-based. It makes me extremely nervous the way it's being interpreted. I'm wondering if you see any kind of coalition starting or work

starting to kind of begin to build a case for how do you look at this so that we can include the kinds of interventions the industry has been talking about that go well beyond a one on one doctor-patient relationship.

KAY JOHNSON: Amy, let me just take a crack at those. Both of those first -- I guess because we're taping. We sat last time and talked.

I think I did not see, and you and I have talked a lot and been sort of co-writing things around linkages and care coordination. You could build that into the money that's out there around the medical home. I could see it there. I could see it in some of the community prevention and wellness work. But it's not explicit in the way that you've written about it eloquently or that I know we've talked about.

On the evidence-based, I guess I didn't do this in the earlier one, but this is really at the heart of the issue for me around home visiting, that what we're doing is just wrong, and that what we're saying and people are driving language toward one model or another model, and Deb Darrow (phonetic) and I have been trying to talk and talk and talk, and Chapin Hall has a nice webinar we did about two weeks ago just to say, you know, when we had the peri-preschool data, we built a head start system. When we knew about the

early community health centers, we built a community health center system. And if we took the evidence that we have and applied it to the thousands and thousands of home visiting programs that exist to build a quality system for all of those home visiting programs, applying the evidence, we would be not throwing the baby out with the bath water.

JAMES RESNICK: Brent?

BRENT EWIG: And I think that the demonstration projects for medical home, and I think they're to the tune of over like \$1.2 billion, there's a chance to build on that and help. And so that's a bright side. I think, conversely, there are probably -- I've been worried about this too, that rather than make it easier for people to access programs, we're creating additional programs within here, and in the end will that hurt more that we're creating additional challenges to integration than rather taking the opportunity to do some of that.

At the same time, if it's new money, we're in a place where we don't want to complain about it. That's just Congress's inclination is to create new things rather than fully fund the things that we think work.

On the evidence-based -- and Kay did a good job -- and within the home visiting provision there is a lot of talk about funding evaluation, continuous evaluation. On a broader sense, in both the House and the Senate talk about expanding the funding to the tune of millions of dollars for both the clinical preventive services and the community-based preventive services guide.

And I think why we have said that's so essential is when you look at an issue like obesity -- again, I don't want to just talk about obesity -- in the CDC's community guide right now there's ten interventions they looked at, and only two of them are recommended. Eight of them have insufficient evidence for what is a national epidemic. So obviously we need to do what we think makes common sense now to address the problem, but we also need those investments to build that evidence base. It's not, we need to admit, as far along as we would like.

JAMES RESNICK: Please. And please introduce yourself.

DEBBIE GILMORE: Debbie Gilmore from Healthy and Ready to Work National Resource Center.

Nobody's talked about the fact that kids with special healthcare needs grow up and become adults. And in many states once you turn 18 or 21, depending on the state Medicaid rules, kids that need long-term care supports end up in nursing homes or living at home with parents continuing to provide that role. What provisions do any of the plans have for long-term care supports?

KAY JOHNSON: There's a lot in these bills about long-term care, a huge amount about long-term care that I didn't touch on. And I ran by everything so fast. But I think particularly the provisions that say you can't discriminate on the basis of health status, the idea that you'd have these basic benefits at one age or another --

DEBBIE GILMORE: -- the acute healthcare pieces --

KAY JOHNSON: The long-term care pieces likewise. And, again, there's a little bit of a bright line, particularly around the well services, you know, for the under 21. But for everybody the protections against discrimination because you have a disability and the boosts I think to long-term care are really there. What I would urge you to do is go to the GW website and look in that section. What I didn't say that the GW website does with all -- it's all text of these things. It will actually give you a link to the page number in the

bill. You can see the exact language. You can go through and just look under those sections and find language.

JAMES RESNICK: Thank you. I think we have time for about one more question.

Any other questions?

KAY JOHNSON: Can I do my plug?

JAMES RESNICK: Yeah, I'm going to let you do one plug. One other plug.

The one thing is that David Heppel and Audrey Yo who are in the back of the room, are looking to -- have asked me to make a quick announcement that if you have any models around home visiting or if you have an a program that you have evaluated on the state or community level, if you can please see them at the end of the session.

Kay?

JAMES RESNICK: I just want to plug, because she didn't, I want to plug Jocelyn's blog. It's called "Just Say Ah" as in just say ah, you know, that kind of just say ah. Okay. So if you go there, it's a really good way to keep up. It's a tool that I use. There are lots of things out there. If you want broad websites, Kaiser's really there for the broad issues as well as Commonwealth Fund.

But if you really want to think about the kids and families issues and you want to get a political angle on it, that's from Jocelyn.

(Cell phone ringing)

And that's a reminder to call my niece.

(Laughter)

JAMES RESNICK: Okay. Well I want to thank everybody for coming to this session.

(Applause)

I especially want to thank the speakers for doing a double session. It's one thing to call someone and say can you do a session, and then ask them to repeat it. So I'd like to especially thank them for that. And have a great rest of your conference and enjoy D.C.

Thank you.