Federal/State Partnership Meeting

Plenary Presentation Rising Health Pressures in the Current Economic Environment

October 25-27, 2009

JON NELSON: If everybody could take your seats so we can get this session underway, particularly, the MCHB staff over here, which are kind of rowdy.

Good morning, everyone. This morning's program addresses some of the most salient issues facing states today and a sub-theme that is running through virtually every session we've had over the last two days. How do the states contain to meet the needs of their most needy populations, and in some cases, what are the services that will no longer be able to be supported?

We've assembled a panel that I think is uniquely positioned to address the economic circumstances that we all face today. We have representatives from the NGA, the National Governors Association, ASTHO, which is the Association of State and Territorial Health Officials, Title V, of course. And I'm looking forward to an interactive session here. First though, one housekeeping matter, as I think you're all aware. Following this panel, we have the honor of having Secretary Sebelius join us and present to the group. Because of the vagaries of Washington traffic and the Secretary's -- her own schedule that may have some impact on the -- at the end of this session. So, if I start looking frantic up here, it's only because I'm getting the high sign at the back to

either stretch the program out or cut it because the secretary is on her way. So, bear with me on that. Also, this is, you know, I was going to get a BlackBerry message here, but there's not much reception here, so it will have to be by sight.

Let me introduce our speaker and panelists. We're going to do it in the same way that we did the sessions earlier in the program. And that is, I'm going to introduce the panelists first. We have three panelists. We have a moderator and a speaker. And I'll introduce the panelists and then the moderator and finally the speaker. The panelists are Kathleen Nolan, Sharon Moffatt and Deliana Fuddy, our own, very own. The moderator, of course, is Melita Jordan, a Philadelphia Eagles fan, very sad. And our speaker is Robin Rudowitz.

Kathleen Nolan recently joined the National Governors Association in the Center for Best Practices where she is charged with public health issues spanning a wide range of topics. Ms. Nolan's major policy areas include health promotion and disease prevention, disease management, leadership issues and public health preparedness. She joined the NGA after several years with Association of State and Territory -- State and Territorial Health Officials where she was a senior director for prevention policy. Previously, she worked as a research associate at the Institute of Medicine where she conducted policy research in bioethics, disability policy, funding of government health programs, managed care and quality improvement. Before moving to Washington D.C., Ms. Nolan received -- served as program specialist in the Colorado Department of Public Health and Environment with various legislative regulatory and policy duties. She

received her MPH from George Washington University School of Public Health and Health Service, and her BA in Psychology from Carleton College in Northfield, Minnesota.

Sharon Moffatt is the Chief of Health Promotion and Disease Prevention for ASTHO. Sharon is the chief, Health – prevent -- Promotion and Disease Prevention with the National Association of State and Territorial Health Officials prior to her work at the national level. She served for two years as Commissioner of Health for the Vermont Department of Health. In addition, she served for two governors as the Deputy Commissioner of Health. As health commissioner, Sharon has led the State Public Private Executive Committee in the strategic development and the implementation of Vermont's chronic disease system of care. As a public health leader, Ms. Moffatt has been a program planner in the areas of public health, nursing, environmental health, refugee health, maternal-child health, school health and children's mental health. Throughout her public health career, she has worked closely with a wide variety of public health and healthcare professionals and key community partners to systematically improve the health of our citizens. She has worked as a public health nurse for over 25 years, serving for seven years as Vermont State director of Public Health Nursing. Since 1997, she has been an adjunct assistant professor at the University of Vermont College of Nursing and Allied Health. She has had leadership roles at the national level including past president of the Association of State and Territorial Directors of Nursing, as a member of the State Health Officials Management Committee and is a member of the ASTHO Prevention Policy Committee.

Deliana Fuddy. Ms. Fuddy holds degrees in sociology and social work. You've heard all of these, because she's already received many accolades. But she's -- holds degrees in sociology, social work and public health from the University of Hawaii and Johns Hopkins University. She is currently the chief of Family Health Services Division, Hawaii Department of Health. Her area of expertise for 30 years has been in the promotion of health and social services for women and children throughout the state of Hawaii. As a division chief, Ms. Fuddy provides administrative oversight to the maternal and child health early intervention, children and special health and -- with special health needs, women, Infant and children -- child -- children nutrition, primary care and women's health services for the state of Hawaii. She has been involved with several interdepartmental and private sector collaboratives that address the issues of vulnerable population including young children and the uninsured. Ms. Fuddy has made numerous national and international professional presentations regarding the subject of maternal and child health prevention programs. She serves as the principal investigator for Hawaii's early childhood coordinating systems grant, Title V Block Grants, safe state systems development grant, Healthy Start's disparities grant, Primary Care Office grant and the Perinatal Risks Assessment Monitoring Systems grant, Evidence-Based home visitation grants as well. She also serves as the treasurer for the Association of Maternal and Child Health Programs, AMCHP.

Melita Jordan is the Director of the Bureau of Family Health. And she was appointed as the Director of the Bureau of Family Health with the Pennsylvania Department of Health

in September of 2004. She also serves as an adjunct professor at Drexel University of Public Health and Region III director and board member of the Association of Maternal and Child Health Programs. Ms. Jordan received her Bachelor of Science Degree in Nursing from Seton Hall University, and completed her nursing and midwifery education at the University of Mississippi Medical Center School of Nursing and Midwifery, and her Master of Science in Nursing Degree from the University of Medicine and Dentistry of New Jersey. Some of the programs/areas Ms. Jordan oversees include the Federal Title V, Maternal and Child Health programs. The select Special Supplemental Nutrition Program for women, infants and children. And her current interests and activities send her on reducing disparities and improving access to healthcare services for all persons regardless of race, age, sex or special needs.

And finally, our speaker this morning is Robin Rudowitz. Robin is a principal policy analyst for the Kaiser Commission on Medicaid and the Uninsured, a major initiative of the Kaiser Family Foundation. The Commission functions as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. Ms. Rudowitz has been commission -- at the commission since August of 2004, identifies policy opportunities for the commission, develops and oversees some of the commission's research, and develops and writes commission publications. Her work focuses on Medicaid financing issues. Prior to coming to the commission, she was a senior manager at The Lewin Group, a health policy and management consulting firm, where she worked on a wide variety of health policy and delivery issues related to safety-net providers, Medicaid payments and the uninsured.

Ms. Rudowitz has also spent time working on budget and health policy issues at the federal, state and local levels of government. From 1999 to 2001, she served as the Medicaid director in the Office of Legislation at the Centers for Medicare & Medicaid Services. And prior to that, she worked at the District of Columbia's chief financial officer, overseeing funding for the district's Medicaid, temporary assistance of needy families and public health programs. She's also worked at the CBO, the Congressional Budget Office, preparing estimates for Medicaid in the Children's Health Insurance Program through the Balanced Budget Act of 1997. And before that -- it's a long career, longer than the rest of us. And before that, for the Ways and Means Committee of the New York State Assembly, Ms. Rudowitz was educated at Cornell University where she earned her undergraduate degree and a Master's in public health administration. Thank you. Robin?

ROBIN RUDOWITZ: Good morning, everyone. Thank you so much for having me here. I'm not 90. I just had a lot of jobs. Oh, let me just get these set up, a set of slides. That works fine. There we go. Okay.

Thanks so much for inviting me to participate in this conference, and I am going to be talking about really the ripple effects of the recession and how it's affected families, communities, states, providers and really also focus a little bit on the Medicaid program because it is so critical to serving the MCH populations that you all serve. So, I think, my goal is really to provide some context on Medicaid and the recession and what's happening with the economy and really set up a larger discussion for the panel. We did,

at Kaiser, release a bunch of reports in August and we had an event that turns out to be quite depressing focusing on the recession. So, while these are challenging times, I also hope that everyone realizes that Medicaid in particular is functioning the way it is designed to function in really serving as a safety net, particularly for these populations in these very, very challenging and difficult economic times.

So just to start with -- and I'm sure that this is overview and background and repetition for many of you, but Medicaid is so important to the MCH populations. Well, it only really serves 15 percent of the people in the United States. It disproportionately affects kids and pregnant women, covering over half of all low-income children and over or about 4 in 10 of all the births in the country are paid for by the Medicaid Program. Although kids represent about half of the enrollees on the program, they are really only a small fraction of the cost. So kids and adults represent about 75 percent of the enrollees on the program but about 30 percent of the cost, and Medicaid really also serves elderly and people with disabilities. And they represent a much smaller fraction of the enrollees but a much larger share of the cost. And of course, when we look at children and adults, these are the populations that are being primarily affected by the recession.

While states or the federal government sets the minimum levels for eligibility for the Medicaid programs, states have the opportunity to expand eligibility to kids and people who are eligible for the program. So there is quite a variation across states but all but seven states now cover kids in their Medicaid or CHIP programs at or above 200 percent of the federal poverty level. So that's about $44,000 for a family of four per year.

Also, about 40 states cover pregnant women through Medicaid at income levels at 185 percent to the poverty level or above. Because of these higher eligibility levels for children in conjunction with many efforts by the states to help streamline the application process for Medicaid and do outreach also through working again, in conjunction with MCH programs, it has been a huge success story in reducing the uninsurance rate for children by about half over the last decade.

While there has been great success for kids, and again, a covering and expanding coverage, Medicaid eligibility for parents of the children who were enrolled lags quite far behind. And coverage for parents is just much more limited. So, about half the states or over half the states had eligibility levels and Medicaid for the parents of the kids in the program that is at 50 percent of the poverty or below 50 percent of the poverty level. We know that coverage, of course, is important in providing access to care on the services that kids, pregnant women and the parents need.

So just turning quickly to what we're seeing now with the effect of the recession. Of course, as you all know, we're seeing unemployment continue to rise. State revenues are dropping to record levels and record declines and state revenue declines. States are facing really severe budget shortfalls which is putting pressure on all programs across the states. Medicaid programs are under stress, and families, of course, are struggling. And many have lost health coverage and are becoming uninsured as part of this recession. When you look at what's happening with unemployment, the recession officially started in December 2007 when unemployment was at 4.9 percent. The latest

data that we have available was showing that unemployment has now hit 9.8 percent. That means about 7.5 million people have lost their jobs since the start of the recession, and we're hitting about 15 million people who are currently unemployed. And that staggering number is even an undercount because other people have taken part time jobs so they're not counted as unemployed. And many people have stopped looking for a job, which also means they're not counted in these figures.

The recession in this downturn has really affected all states and all state programs. But the unemployment rate does vary across states but we do see 15 states including the district have unemployment rates that are above 10 percent. When we look at what's happening with state revenue, you see this yellow line going way down. And for the second quarter of 2009, states faced a decline in state tax revenue of 16.3 percent. This is the largest we -- for the first quarter, it was the largest record -- the largest decline on record and that was over 11 percent, and now it's declined even further to 16.3 percent. So, this combination of unemployment and declining state tax revenue, of course, these states facing major budget shortfalls and that figure is something like $350 billion for the rest of 2010 and through 2011. So it's bad for states in terms of what they're facing, what they're dealing with this fiscal challenge.

At Kaiser, we've done a lot of research on what the unemployment rate means to affecting coverage. So what we see is that for every one percentage point increase in this national unemployment rate, you're going to see an increasing case load on Medicaid and also an increase in the uninsured of about 1.1 million. To put that in

perspective, we've seen an increase in the national unemployment rate of about five percent, we can expect that case loads for Medicaid have increased by about five million and we're expecting to see an increase of over five million people without insurance. Of course, all of this happens at the time when states are facing these revenue shortfalls so it really does create a crunch for states and facing the high demands and needs for public programs at the same time that states are really least able to afford it.

We see from the recent census data that just came out and this is for 2008, so this is really capturing just what happened at the beginning of the recession. But we're seeing a continuation of people losing their employer-sponsored coverage and we're seeing an increase in Medicaid and CHIP enrollment. That has actually translated into a decrease in the number of uninsured kids. So, again, that's part of a little bit of a success story of how these programs are really working as effective safety net for kids. However, again, because the coverage levels are so much more limited for adults, and some adults are not eligible for the program at all, we are seeing an increase in the number of uninsured adults.

Congress and the president, of course, tried to respond to this dire fiscal situation by passing the American Recovery and Reinvestment Act. And one of the key pieces of the ARRA was really this increase in the Medicaid map trade. So, an increase in what the federal government would pay in terms of Medicaid because that financing is shared between the states and the federal government. It amounts to an estimated $87 to $90

billion over the period from October 1, 2008 through the end of 2010, which is important. So all states are getting additional help from the federal government and states that are experiencing very high increases in their unemployment are getting some extra help. But there is a condition that states cannot reduce their eligibility levels and they also cannot make it harder for people to apply for the program in order to get that additional funding. There's also additional help, so some people can continue to afford their employer coverage through the cover program. However, many people are finding, even with this significant subsidy, that coverage is still too expensive through that program.

We know from a survey that we just put out last month that these funds are -- have been critically helpful for states. So they've helped states close both Medicaid and general fund budget shortfalls. So what that means is that money from the federal government has really relieved these shortfalls and freed up money for other programs coming in through, you know, so it's helping Medicaid but it's also freeing up local and state dollars for other, other things. It's also helped avoid or reduce the impact of provider cuts and benefit cuts that states, otherwise, would have been looking at had it not been for this increase in federal funding.

We also know that states did experience much higher levels of spending and enrollment growth in 2009 than they had anticipated at the start of their fiscal years for 2009. And almost all states really attributed that additional growth to what's happening with the recession. So, again, more kids and adults are coming in to enroll and that's really

pushing up spending for the program. And despite the increase in what's happening, or the federal government's help in financing the Medicaid program, states are still looking at cutting back. So they're looking at cutting back on provider payments or cutting back on benefits for their populations through the Medicaid program but, again, eligibility has been largely protected.

When you look at what's happening with the recession in terms of how it's affecting families and communities, we know we've done a bunch of focus groups. We were just out in the spring in four different communities. And it's really a, you know, as no one, it's not a surprise to anyone, the financial crisis for families is quite severe. There's no jobs there, families are facing foreclosure. They've depleted a lot of their savings, they're facing medical debt. And for many of these people, they had jobs so it's the first time that they're really navigating some of these public assistance programs. And I'm sure that you may be seeing that, too, where it's a new population coming in that has not been -- never needed to use public assistance programs, which is creating more challenges. Employers are also struggling. We've talked to some small employers so they're, you know, struggling between layoffs and cutting coverage. And we're also seeing, as we already knew, but it's really highlighting some of the wide gaps in our health care system. So, again, kids are sometimes or most often eligible for Medicaid or CHIP but the adults aren't. So, it's really -- you see very clearly the gaps in coverage in our health care system. We know that if you're underinsured or uninsured, you're going to delay or postpone care that you really need. So, individuals aren't getting the prescriptions that they need. And we're talking about for serious conditions like

hypertension, seizures, asthma, so things that can have really significant longer term consequences. And the safety net is really being stressed and strained as more people are coming to clinics and to programs that are already under-funded or at their capacity.

So just to wrap up, when we look forward, we really see that states are -- it's not over yet for states. And we -- when we talk to states, they'll say that the lag from a recession is about one to two years. So even if the recession is declared over and there's a turnaround in the economy, it's really going to take a while for that to filter through and for states to start to recover. States are also quite worried about the end of these additional Medicaid funds from ARRA that are scheduled to expire at the end of -- oh it's -- they end in 2011, so at the end of 2010, which is halfway through state fiscal year 2011. And then I'm sure you'll hear more about health reform, but states are anticipating health reform but also have concerns about any new additional fiscal responsibilities as well as capacity both in terms of providers and administrative capacity and how they're going to handle additional applications and fitting into that system. And for individuals, and I'm -- again, I'm sure you're seeing this as well, there's -- well, health reform has a promise to cover more people. There are a lot of people who need help right now, and health reform is not going to help them right now. So, we seem to need more and better efforts to help connect families with existing programs that are out there if health reform passes and there's still time in between the implementation of health reform. So with that sort of set up, I think I'll turn it over to the panel to talk about more detail of the MCH programs. Thank you, Robin.

MELITA JORDAN: Good morning. Again, I'm Melita Jordan. I appreciate this opportunity to serve as a moderator for this distinguished panel. And I'm going to start first with my friend and colleague Loretta.

LORETTA FUDDY: Aloha. I must apologize for my voice. I woke up this morning with a scratchy throat and that's a clear indication that the Pacific Islands are calling me home and I need to get back to my tropical sun. So, hopefully my voice will hold out.

Hawaii, like the rest of the nation is really struggling with the downturn in the economy. We really have a bad mixture of declining revenues. Our last council of revenues was at a -nine percent. Our unemployment rate was at a 50-year high, which is 7.6 but that's not, you know -- that's -- it may not seem bad when you compare to other states but it is at 50 percent high and we were down to under three percent of unemployment. And, of course, when people are cautious about the economy, they're not spending. And Hawaii is so heavily dependent on tourism, that means that our revenues are even less in that respect. And, of course we have, just to give you a picture of Hawaii's environment, we have a Republican Governor . So, there has been a lot of tax incentives. So, the incentives almost equal, at the beginning of this period, our budget deficit so, I mean, that tells you a little bit about our revenues as well. And the mantra has been no new taxes.

Just to give you a sense of our Department of Health, we're very different than most of the states. We're a centralized system. We have State Department of Health. We don't

have any county or local department of healths. At our district or at our neighbor islands, there are county offices but they are all run by state government employees. And we roughly have about 3,000 Department of Health employees but we're very large. We include environmental health as well as behavioral health and the other core public health functions, to give you just a little sense of that. And we've gone through two rounds of budget restrictions and I'm hearing that there may be a third. And sad to say that the field of family health and maternal and child health are usually the first to go. I've heard my deputy director say, [inaudible], the Governor is looking for a restriction. The three largest pots of money are Department of Education, Department of Human Services, and the Department of Health. The Governor doesn't have control over the Department of Education. It has its own board. She can issue a restriction but how they apply it is up to the Board of Education. And so, the heaviest restrictions have come to those individuals that need services the most, Department of Health, Department of Human Services. When you look at the Department of Health, unfortunately, we have, in our arena, been dubbed as nice-to-have programs, not as essential. So that's a critical philosophical issue that we need to deal with. Now, that being said, the family health division has very good advocates within the community. We've built years of good partnerships and we have received lots of dollars in the past. So our budgets have grown over time. So when they look at within family health and they say you've had a large increase, let's cut you back.

At this point in time, it calls into question really what are core public health functions. We have strong community support. We have strong legislative support. But from the

Governor ’s level, she's looking at a bottom line of the budget and not programs. As I said, in normal times, there is always a good balance between the Governor ’s perspective and the legislative perspective. And under a Republican administration, there’s always been the issues of cutting government. But the legislature has been very generous to the type of programs within family health. But at this point in time, there’s nowhere to go. We have been cut. Well, we have experienced 35 percent reduction in our staff and a 55 percent reduction in our contract services. Now, our mix of funds before all of these restriction was about 50 percent state funds and 50 percent federal and other funds. At this point in time, it’s a 25-75 percent mix. And if we go into future budget restrictions, it will look like it will be state funds 15 percent and 85 percent other funds. And that’s not because it rises is in the other half of [inaudible] but decreases.

And I think it really points out the kinds of tensions that most of us in the states experience. When you’re looking at budgets, you look at what’s essential, and we often have state mandates and we often have court ordered services. And at this point in time, those are being prioritized. There’s also the tension between what should be government function and what should be privatized. We do heavily contracting out to many of our community health centers and other health and human services agencies. But again, when they talk about privatization, it is not those contracting piece but what can the private sector pick up on its own at this point in time. There’s also, I pointed out, the tension between what is a safety net. You’ve heard about them -- the good work within Medicaid. And Medicaid is viewed as a safety net. And if Medicaid, Department of Human Services is a safety net, then we can cut any road these other programs that are

within the Department of Health because they clearly are not the safety net. When you look at early childhood programs, when you look at parenting support, when you look at some mental health services, again, they're not viewed as critical.

And at this point in time, we are also looking at our Governor coming -- she will end her term limit next year. So she's looking for what can be her legacy. And our tobacco dollars really have gone to look at what kind of new initiative can she highlight to feature her administration. So at this point in time, we're having discussions within the Department of Health about a new Department of Health and a skinnied down Department of Health. And we're talking about functions limiting to regulatory enforcement preparedness, vital records, those kinds of things that no one else can do.

We're looking at redefining the safety net. We're looking at our state mandates and saying, are there some state mandates that we can change? We're looking at eligibility requirements and shifting that so that we can have less services for our families coming in the door. So, again, there is that cost shifting to the private sector to the counties. So how do we survive in this environment? These have been my strategies. I think we really have to make the case for prevention and we have made that case over and over again but we always make the case for the long term benefits. We are in a situation where everybody is short term. And we need to look at not the long term benefits of prevention but the short term benefits and really making that case. We need to present the science behind it. We need to get the data out and we need to really define again, as I said, what are those core safety net functions. And I think here, the federal

government can really play a critical role in helping us define that and making the case for maternal and child health. But again, we are doing a lot of cranking out our data and making that case. We're using our plans data. We're using our behavioral health re-survey data and really showcasing that more than ever before.

At this point in time, family health was, kind of, within other than behavioral health, environmental health, the big area that was cut. But we are entering a phase where the whole department will be affected and the playing field is being leveled. And we're talking about creating new partnerships and breaking down those silos, which I think are very good. And we need to make that connection between chronic disease and maternal and child health. Partnerships has showed us very well in the past but we're looking at forging new partnerships. We're really looking at partnering not only with health and human services and those private agencies that deliver that but really working not only with physician community but with the early childhood community with the business sectors and with judiciary because they are also now seeing the value of early childhood programs. Also looking where we can have fee-driven services, we now have fees for our newborn metabolic screening program. We charge for the lab slips to the hospitals. That's created a stream of funds for us with our special funds. We need to really push our third party reimbursement. We do well capturing Medicaid but we are also looking at changing some of our statutes so we can go after our Blue Shield and Kaiser to get reimbursement for our services. Looking at developing dedicated funding stream. Our community health centers, fortunately, two years ago went in to say that they would get a quarter of a cent on tobacco tax, and that eventually will increase to

1.25 cent and that will fund their whole system of care. And that cannot be touched by the Governor nor by the legislature, so dedicated funding streams. I'm beginning to look at, you know, tobacco has been taxed quite a bit but what about alcohol tax? We haven't had a raise in that in many years, so.

The last thing I want to say is that I've tried to pay a great deal of attention to staff morale. This has been very, very hard on staff. And the state government employees have been in the political football between the union, the legislature and the Governor. And originally, we are -- we're in contract negotiations. And the Governor said, if you do not take furloughs -- three-day furloughs is what she was promoting -- then I'm going to lay off staff. And the unions challenged and there was a delay in that. So, we had a layoff of 1,100 employees. But there was always the hope that the union would settle and the layoffs will go away. Revenues has worsened, so now we're in a situation where the unions have agreed to two days of furlough but we're still eliminating 1,100 positions. So the staff had hoped and now they are really struggling with -- now I'm facing layoffs in addition to furloughs. And there'll be maybe more coming.

So, again, the rapidity of change is really staggering. It, you know, it used to be every couple of years, there is change. Then, you know, once a year, then every six months. But we are experiencing change upon change upon change. And it's coming every month, every two weeks and this is staggering for staff. So, as you heard about resiliency, that's my big focus right now, is looking at our staff and trying to give them the skills they need to be more resilient in this ever-changing environment, and to help

them to be part of the restructuring discussion and to help them help -- include them in the redesign and the diversification of our efforts. So, I will end right there. Thank you.

SHARON MOFFATT: Thank you. That was -- that was excellent. I want to suggest to you that our title for this session and overall for the meeting and making change is critical as we think through our opportunities but also the multiple challenges and suggest to you that this is also the worst of times but perhaps the best of times if we're smart. So, let's take a moment to look at the worst of times. And you've already heard that several different places. Well, let me give you some more numbers to solidify the worst in times. Seventy six percent of our state health agencies actually have made cuts in fiscal year 2009. Thirty eight percent expect cuts in the coming next fiscal round. Fifty percent expect to lose staff through layoffs or attrition in the next fiscal year. It gets worse. States are actually responding and many of you know this. You're experienced yourself. Loretta just reinforced that for us, but states are using things such as layoffs, 29 percent of states have had layoffs, 39 percent of states are actually eliminating programs, 74 percent have lost staff through attrition, and 74 percent of states are actually reducing services. This is just in our state health departments.

In addition, if we look even closer and take an examination of what's happening to our maternal-child health programs, it continues to be even more doom and gloom, if you will. We have states that have had program cuts or eliminations in such areas as family planning, oral health, immunization, family health and nutrition even in the area of WIC, early intervention for developmental delays, teen pregnancy prevention and school

health services. I would also suggest to you that if you look at NASHIA's recent analysis report in September that they are also seeing the same trends at the local level. And, again, I know many of us are both centralized and work very closely, obviously, in many areas throughout our country with our local partners. But 55 percent of local health departments have had to make cuts in services. So, if that's the worst of times, let me try and be a bit optimistic in the opportunities that we have, perhaps, before us, if we really use our public health enterprise and our public health spirit to make the best of these times and really make change happen. So, we have -- and I'm going to be talking about in a little bit more detail the American Recovery and Reinvestment Act. We have National Health Reform. In particular, many of you, I think, are following the home visiting funding, that's potential there. And also key in that national health reform are those public health trust dollars.

I want to give you some perspectives from our colleagues in the room and our leadership that we have heard from over the last several days to help us frame our thinking as we look at the opportunities before us. One of my long-time colleagues out of Vermont who's here with us, Stephen Brooks, who's actually been head of our maternal-child health program in the area of children with special health needs, when I asked, "How are we doing?" And his comment were, "Well, these trends are really forcing us to examine what we like to do and what we need to do." And I think Loretta was pointing to that. Some of our colleagues from the Pacific Islands of Hawaii were speaking earlier and how they actually bring resources together in the schools. And not only do they do assessments on immunizations but they're also doing mental health

assessments and really looking at what the social and mental health challenges are for the schools. So they're bringing that whole person perspective together. Dr. Kotelchuck actually challenged us to look at the lessons of continuous quality improvement. If we are flatlining, if you will, in the area of infant mortality, what's happening? What do we need to do different? Really challenges to think about our evidence and how we're enforcing and using our evidence to inform those critical decisions that are needing to be made.

In our very first opening, Vijaya Hogan actually asked us to really look at our lack of progress in the area of health disparities. Why haven't we budged? Why haven't we brought those lines together? But are we really taking a moment to look back at our history at those times where maybe the interceptions between the two disparity areas are actually something that we can learn from. Have we really gone back to learn from our own history? Dr. Van Dyck very eloquently yesterday laid out for us the life course and our lifespan. And really, are we looking at only one, kind of, point in time in the lifespan or the whole lifespan and where are the leverages? And again, Loretta just pointed out to looking at the chronic disease and the prevention aspect of it. Dr. Wakefield set out three important priority areas for us to think about. And I would suggest just that maybe a pillar of the way we think about these opportunities in the area of collaboration, performance and public health. And then Loretta was just speaking to me in terms of Pennsylvania and some of the really creative ways they're working together. They took ARRA funding around housing and they're really doing some very focused work in the area of rebatement for land. So, they're partnering with

those other dollars. In another area, they've actually been receiving their dollars for WIC and looking at the eHealth and the technology. And we really thought about that coordination between the funding coming in for WIC and that technology, the funding coming into our community health centers and putting those systems together just even in the area of immunization so that we knew every child was immunized, and if not, how do we target those resources? And that gets us back to maybe addressing some of those health equity areas that we need to so desperately take a look at.

So, in summary, I want to just, kind of, close my statements with really challenging us as a public health community to really look at are we willing and able to make the change? Are we willing to take these very desperate times and turn those into opportunities? Have we creatively thought of all the opportunities within the ARRA funding? Have we partnered on all the possible levels? Are we out there verbalizing very vocally our support in health reform, of the public health trust fund, of the workforce development work, of the home visiting work? Are we making our voices heard on the Hill in this critical time where we have critical funding available to our states possibly in play here? Have we leveraged all our partners? Have we leveraged transportation, Medicaid? And Robin was speaking to that earlier. WIC, child care, what about housing? What about parks and recs? What about our community health centers? What about our academic partners in terms of building a workforce? In the area of measuring our performance, I challenge us to really look very seriously at the evidence base. The good news are the home visiting language actually supports the use of that evidence base. But are we using that wisely? Are we using the community preventive services

guide, which has over 99 recommendations? Many of them are ones that we could apply immediately.

And then the last area I mentioned you to really think about is the policy levers. Very difficult times right now to propose taxes in states, but there are many other policies that impact the lives of individuals. From car seats to indoor air, clean air to manual labeling that really can make a difference that can be low cost or no cost policies in this environment. So with that, I think it's our collective will that we really can make a change and make a difference in the lives of those individuals we touch every day. Thank you.

KATHLEEN NOLAN: Well, we're going to keep backing up in contacts. So now, we're all the way at the top, again, one more time. You know, at NGA, we have an executive director who is an economist. So it's not like we ever have cheery meetings. But right now, there -- I think he's actually reveling in coming in and depressing everybody every time we get together. I am going to give you one more number and I apologize for doing that, but I do think it's important and is part of my key message here.

The number comes from the Rockefeller Institute, which recently released a number of studies and said that in their best case fiscal scenario, it will be 2014 before states reach their pre-recession general revenues levels of 2007 and 2008. So, this is not hunker down and get through it time. This is truly the creativity and reinvention piece is really going to have to be the way that we come at this. What this 2014 number means is that, that is going to be years that we are foregoing investments. We are foregoing

investments and returns into our rainy day funds. We are not putting the pieces back together, but just hanging on as close as we can. So, though the picture looks particularly bleak for the next two years or so, it's not going to bounce back into this glorious new time, and I think that that's a really critical component. And it is now, the conversations we are having at NGA about all issues, not just health, are how are we going to do less with less, not more with less. It is about reinventing and re-establishing what our priorities are as government in all of our programs. The safety net, and I mean the safety net with large, not just health safety net, but housing, food stamps, all of the other components of the safety net. We are looking at every single component of that to see where we are going to go as state government in these issues. And so I think that that is really important.

So, one key message is, don't hunker down. We're not just going to pull out of this in two years and be right back where we were. The other key message is, it's about a holistic approach to setting goals and making your value well understood. And I'm going to come back to that in a little bit more. But that's the other key message from me.

So some specifics on the health care reforms items from other issues. Depending on what happens, and I'm not on the lobbyists side, so you can ask me if there's going to be a health bill and I have no idea anymore than anybody else does. But one of the possible outcomes of whatever is happening is that Medicaid itself could look quite different than it does right now. And, you know, the representation of how kids are already a big proportion in the numbers but already not on the spending side, that's --

could even get more skewed. I think there's a lot of differences that may come across in how Medicaid is a safety net for children. It may be a different picture in a few years. And so I think that's one of the things I'm hearing a lot of some of the tension that exists about that as a Medicaid -- Medicaid as a children safety net. Maybe that changes. Maybe that shifts in the new -- potentially the new Medicaid. So I think that's one of the things to think about.

And then where Medicaid leaves off is going to drift for a while potentially. And so, those gaps between whatever exists in Medicaid and whatever may exists in other insurance reforms et cetera is also going to be a critical component and a place where this community may have some need to step in and figure out what happens to kids if CHIP changes, if Medicaid changes, if there's other kinds of arrangements or something else to think about going forward.

I mentioned the issues around all of the safety net programs. Obviously, we are going to see the continuation of furloughs of staff and cuts of budget cuts, of downsizing, privatizing, outsourcing, who knows what else. Every single tool that's available is going to be used. I throw into that context another number, 38 elections for governors . We have right now, I believe, the last count I heard was 24 guaranteed turnover, either term limits or have just decided not to run again. I can't imagine why they don't want to be governors. But we are seeing that as well. And I think that that's another thing to consider. Am I about to get the hook? Well, I'll keep talking until somebody --

JON NELSON: No, keep talking.

KATHLEEN NOLAN: Okay. So I do think that one of the issues that's coming up -- and every governor, I don't care what party they're coming from, is going to be running on the economy and is going to be running on efficient government. And I guarantee that one of the things you're going to have to do is show where you sit on those things going forward and how it is you're able to demonstrate your value. And I do stress that it's not just the health safety net. It really is the issues around the entire safety net programs and how we take care of vulnerable populations in our communities. So those are some of the difficulties. And I'm going to try to jump real quickly to a couple of specifics about how we can go forward and how we can do this. But I think the bottom line for me, what I do want to make clear is we can do a lot and we have done a lot, and we continue to do a lot to show our value in meeting our goals. We are constantly showing, look, where we spent this money is the right thing, and what we were trying to do in this program, we achieved. But I think there's a different context and it may be a nuance, but it's different now because we have to show our value to some broader goals, not just our own. And I think that that's some of the things you've been hearing from the examples here is not just was the program successful internal to what its goals were, but how did it fit in an overall approach to moving forward in being a good safety net program. And so I think some of those issues will be your balancing against not just did you meet your immunization goals, but how does that work in the overall context. And I think that's really particularly true in the health care reform conversation. We are going to be doing a lot of work on this issue at the Governors Association. Part of that is going to be

implementing whatever does come through at the federal level. But there's another facet of this conversation that is simply not occurring a lot, which is how do we control the cost of the system as they exist right now. And that is a reliance on primary care and a reliance on prevention to help us contain the cost going forward. And this group of people and programs is a real key component to that. And so it's not just do you accomplish your goals, but how do you help move that cost containment primary care and prevention focus conversation in the health care reform. What's your contribution to that so that there's a real sense of value to these programs outside of just the programs themselves. I do think we're going to have a lot of conversations in our health care reform debate about how public health and clinical care programs come into mutual understanding and progress with the populations that we're talking about. And I think that that's -- it's a conversation we haven't really gotten our feet or our hands around it. But I think we're really going to have to do a lot better on showing how those are -- those can contribute to each other. So that's something from the health care reform conversation that I think this group in particular has a real handle on.

I wanted to talk about one other thing that we're doing at NGA that I think is relevant to this group, and that is around -- I don't -- we call it integration, but I know that that's got a lot of pitfalls to it. But we've been looking at -- we held a summit last month where we got together the early childhood focus from the education community with the MCH and early childhood folks on the health community along with the social services folks as well. And that was about trying to put this program together where you have a sense that we're all serving the same people. We're serving the same people and we're trying

to come at them with different ways and different goals, and how can we get more coherent and really try to pull of those strings together from education, from human services and from health so that we are better serving children. And we were looking particularly at the early childhood population of zero to five.

So I encourage you to kind of follow both of those conversations as you're thinking of ways to follow the previous panelist's advice on being creative. Those are two key components where both in the sense of reinventing government in different times and then reinventing the health care system where this community, I think, can really try to make their name understood and keep the investments going in the difficult times ahead.

So, with that, I will stop and we'll see where it goes from here.

JON NELSON: Thank you.

KATHLEEN NOLAN: Thank you.

JON NELSON: Let me just welcome the people who joined us here from another HRSA bureau, HWH bureau, and there is a simultaneous meeting going on at the hotel, and we're fortunate. Welcome and I'm glad you're able to join us, and the secretary will be joining us shortly.

But what we're talking about here is some of the economic pressures the states face in maternal and child health bureau in the Title V program, which provides services to the women, children and their families.

MELITA JORDAN: Thanks, Jon. Not to be redundant and I want to make sure that we have the opportunity to engage the audience. And so, I'm going to open the mic up for questions to the panelists. We've had a substantive discussion here in presentation. So I would like to open it up for you to ask questions of the experts up here. Please, join us at the microphone.

UNKNOWN SPEAKER: You can't make --

MELITA JORDAN: Now, I know this was a sobering presentation. However -- well, again, as many of you know, most states, as Robin had mentioned and was also, Dr. Fraser mentioned yesterday that, again, property sales and income tax is the structure where most states generate their revenue. And as Loretta was mentioning, again, how they're looking for dedicated streams to support their newborn screening program, as most of us know, that many states use different funding methodologies to fund a core public health program such as our newborn screening program in the various states. But as states really face severe budget shortfalls, it does create a profound and negative impact on our local communities. When states are struggling to collect revenue that's needed for either education, for police, for health and other essential services, it risks local and state communities or state governments to then raise property taxes

and/or income taxes within their states. And again, with the high and rising unemployment rate that we current have, as I look at, again, Pennsylvania where I'm from and 2000 -- Pennsylvania 2009 unemployment rate was nine point -- I'm sorry -- 8.8 percent as compared to last year, it was only 5.6 percent in September of 2008. And so, again, as Robin mentioned as well, is that the unemployment rate continues to rise. And again, the economists, as you know, as was just recently stated, is forecasting in some places to be 10.5 percent that we already have in some of our states currently. So the demands on our resources are certainly increasing with the new constituency, as well as the constituency that we're serving already. And so the challenges are there, but I think also, as Sharon mentioned, this is an opportunity, it's an opportunity to leverage our resources to be extremely efficient with our resources and continue to try to serve with the amount of support with the collaboration in our other partners to provide for the services of our constituents and the families within this country.

So again, if there's no further questions -- I can't imagine no one has a question.

JON NELSON: Are there no economists in the --

UNKNOWN SPEAKER: They don't ever have questions.

MELITA JORDAN: I know Rhode Island wasn't going to let me down.

PETER SIMON: Hi. I'm Peter Simon from Rhode Island. I was a little distracted because I was sending an e-mail to Kathleen's mother, telling her how proud she should be. It's all right. I outed you.

I do have a question, though, and I asked this before, and I'm going to ask it of you all because I think you've helped us approach this from a macro issue. I have a very micro kind of issue, though. We can't get money into the community if there's no cash. And the Federal assistance that we already have isn't getting out. So if that is broken, how are we supposed to get out the additional moneys that are coming in, unless the Federal Government figures out a different way to allow states to spend their money? I'm sure you're going to answer that, Kathleen, huh?

KATHLEEN NOLAN: No. You know, we've been -- it's interesting how quickly in some ways we move beyond the recovery conversation, but this is where the states are really struggling. And it isn't just in the health issues. We've had a tremendous focus on what's going on with those dollars overall in every aspect of the programs. I think there's always the issues around no replacement dollars. We got to keep them going forward, and that's -- it's a constant struggle. In fact, I think at one point we had a conversation, this was in a different context with some of the folks on the Hill saying, you know, I don't know if you know this but states can't actually print money and only one state is allowed to have a deficit by the Constitution. Then we're like, "Yeah, we got budget problems, too." We're like, "Okay." So, I think -- unfortunately, I think that there's just a dichotomy of thinking between what happens at the Federal level and what happens in the states

that it all goes all the way back to the Federalist Papers. So I think, unfortunately, we've got to continue to work on it. I do think in all of our recovery conversations, there's the desire to make this work. And so where we can find those particular points where we can make changes, hopefully we can keep working on it. It's not done. From our perspective, we're not done. We haven't figured this whole thing out. We got to keep working and we got to keep finding specific places we can make some changes. But, no, I do not have an answer for you. And thanks for outing me, by the way.

UNKNOWN SPEAKER: I have a question for the two at the end.

UNKNOWN SPEAKER: Go ahead.

UNKNOWN SPEAKER: I'm not sure whether we can say there is an optimistic view or a pessimistic view. But there was some comment on sources of revenues, largely sales taxes, property taxes and income taxes tend to probably form a large part of state revenues. Do you see adjustments going on at the states of that mix in the face of -- I guess you would argue that the states are reluctant and the governors are reluctant to raise taxes, but are some more palatable than others?

KATHLEEN NOLAN: My read would be actually the fee basis being a more politically palatable approach to raising revenues than any tax basis, followed potentially only by sales taxes or other things as revenue like the tobacco or other opportunities for that kind of tax. I think, overall, we're not going to see from anybody right now major tax

increases on anything. And I do think -- you know, I said that these governors are running. And it is important, and I encourage you to tune into the elections and what they're saying as this goes forward, because, you know, the elections, like, already started. But it is important to get a sense about where this is coming down so that when you are offering new opportunities, knowing what they promised in the campaigns, knowing what some of their approaches will be, will be important as you go on shaping your agenda for after they take over in January 11, 2011. That's my read. Fees are a possibility in some political dynamics much more than any tax increases. I don't know if you had a different opinion, Sharon.

SHARON MOFFATT: I would agree. But, okay, let me give you a couple of examples. Let's use a user fee as a possibility of around sugar sweetened beverages, again, an area where we could get some revenue, could actually, significantly impact obesity and particularly childhood obesity. So that would be an area I would ask you to do some close looking at. And is it more palatable to package it as a user fee than a tax? I'll point to Arkansas, which, just actually last year, came up with a tobacco tax. But one of the reasons they got their tobacco tax through was they had significant issues around their trauma system and did they not have a fully built trauma system. So that was their issue, then they had to raise the money, so they got the tobacco dollars. But again, to the leadership of the state health commissioner, Dr. Paul Halverson, he actually parlayed those dollars even further to really look at injury prevention for children, actually and adults, focused a lot on motor vehicle crash, quickly tied it back to the cost of trauma and the trauma system and then actually moved almost 10 state policies in

the area of injury through -- gradually to driver license, several others. So there's several different opportunities, I think, in that area that would challenge us to say, "We can't give up on how we impact the health of our people." And there are other levers beyond just the dollar levers to go forward.

MELITA JORDAN: If I could just add to that, though. I would -- again, many of you may recall that Pennsylvania was the last state to pass a budget and 111 days went by before we finally had a budget. And one of the things the Governor had put on the table was to raise taxes. He was adamant about raising taxes to make sure that he could fund the public health -- the public education as well as child care. And he would not change his position on child care funds as well as public education recognizing that scores were rising for a number of inner city children who were in public schools and in some of the other areas that was receiving less funds. And so that it was a long discussion between the two philosophical differences in the House and the Senate. But finally, Pennsylvania did pass a budget just recently as well as raising the tax that took 111 days to get to. But he was determined that he was going to hold on to some core issues that he was concerned about which was education and child care. And so I think, again, and he -- there will be -- you know, Pennsylvania will be, you know, looking for a new governor in the next 18 months, but again, sometimes those things are taken into consideration, but I do believe that raising taxes is on the agenda. But it is a fight. It is a tremendous fight within a state.

JON NELSON: Question. Yes?

LISA WALKER: Hi. I'm Lisa Walker from Texas. And I just had a quick comment. It seemed like with the work being done on the Healthy People 2010 and at -- yeah, well, we had Healthy People 2010 but the Healthy People 2020, they were setting the stage for goals and objectives for the nation that will be very critical. We're trying to establish a mechanism for evidence to feed up from that, to that and support that from the grassroots up. It seems like we're having this great initiative for national goals and objectives and yet, obviously, financing that and the progress toward those are starting to deteriorate to some degree. I was wondering if there is some effort. It'd be nice to see, sort of, buy-in from Governor , public health associations, and how all that ties together so that we can create that value across states and link it together and so that evidence base is coming up and is established in a common way, in a linked way so the value can feed up back and forth between the Healthy People 2020 and therefore have a lot of power to hopefully stand again sometimes these budget cut areas, if all states have and agree upon common goals, set of criteria and maybe some sort of report carding issue of where states have decided to prioritize relative to the Healthy People 2010. So you can tell where a state maybe is unable to move in one direction or another because of finances. But it's evident across the board and maybe some evidence from other states can feed in to support that.

JON NELSON: I don't know who would like to address that. But it's an interesting question and that is directly addressing the -- really the conflict between the expectations established under Healthy People 2020 and the current environment which

seems to not look at that, but put them both on the table at the same time. So there -- the governors and the states are addressing those simultaneously. What are the demands on the system and what are the expectations to provide services to the people in the populations in their states in the same time they're addressing the short falls and the shortcomings they have of the nation's -- sort of the economics of it?

KATHLEEN NOLAN: I don't know if I -- it's an interesting concept. I think that the -- well, maybe the challenge is back to the Healthy People 2020 process in being able to identify that contribution of how those things truly should be expectations of the health system. I think one of the challenges is that sometimes those don't always come across. They come across as everything under the sun that could possibly be important and it's very hard to prioritize within that process of what is truly going to make the value statements sing. So I think that -- and I know there was a process of years ago to do the top 10 or something like that, the sentinel pieces. If that were a direction with the Healthy People process, it might make more sense in that context of being able to say, "Okay, yes, ultimately, I like my health department to be able to do everything. But when I've got to figure out what the top three things I've got to protect, help me make that decision," then I think it could be useful in the political and budgeting process in a way that it hasn't been to date.

UNKNOWN SPEAKER: Loretta.

LORETTA FUDDY: I think, you know, as we talk about the social determinants of health, we really need to look at whole community solutions. I mean, I think given the economy, we need to look at whole community solutions. For Hawaii, really clearly we have to look at diversifying our economy. We can't be dependent upon tourism forever. It's not our silver bullet. And so we have to look at how do we crack new businesses? How do we develop new streams of revenues? And when we look at these health issues, as we talked about the social determinants of health. I mean, the in-rows are going to be made with our, you know, with housing and with labor. And we really need to make those kinds of connections. And we're beginning to do that. We're beginning to call to the table our housing people, or looking at judiciary because that's one area that we overlap considerably, especially with the young children in foster care. And so, how do we connect those dots? And I think it needs to be whole community solutions and not departmental solutions.

SHARON MOFFATT: If I could build on the community concept -- I actually have a question for the audience. We're going to flip this around a little bit. How many of you are actually involved right now in helping to write the grant applications for the [inaudible] dollars that are going out under ARRA? Not a lot of hands. Okay. What if I told you there is a -- almost a half a billion dollars available right now for people in our states and our territories and our tribal communities to impact on prevention. So, I challenge you to think about -- I know sometimes those grants are being written over in another part of our silo by chronic disease or whatever. If the prevention dollars and we and the Maternal and Child Health community are part of helping guide, craft, support,

affect those dollars then, you know, we have a half a billion dollars that we can help influence. So, I would ask you today actually for the community grants as the day for the letters of intent to go in, there's state dollars, some of those will be dedicated dollars to states and some of them are competitive dollars. I would encourage you to go home and find out where those applications are and what part of that your expertise can be brought to bear in the application process.

LORETTA FUDDY: And I would just dovetail with that. We're finding our niche in how to work together with these other parts of the department that we haven't previously as it relates to these new funding streams. And the niche is that within our arena, Maternal and Child Health, we have a lot of the data and those outcome measures are really being required for those grant applications. And so, we are now a valued partner because we help with those grant applications because we have the data that's going to make the case and also to measure the impact. And I think that's going to be our niche.

MELITA JORDAN: I'd like to thank our speaker as well as our panelists for today and thank you the audience for participating. I would like to ask -- I will take a few minutes to stand and stretch but I'd like to ask you not to leave the room. Thank you.