ISSUE REVIEW

Iowa Legislative Fiscal Bureau

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History of Child Welfare Treatment Services Paid by the Medical Assistance Program

ISSUE

This is a review of the Rehabilitative Treatment and Support (RTS) services currently included in the Medical Assistance Program for Medicaid eligible children. The current draft Request for Proposal (RFP) for the Integrated Access Plan issued by the Department of Human Services (DHS) and the Department of Public Health proposes inclusion of these services in a mental health and substance abuse managed care contract.

AFFECTED AGENCIES

Department of Human Services
Department of Public Health

CODE AUTHORITY

Chapter 1241, Section 11, 1992 Iowa Acts
Chapter 172, Sections 11 (1) and (3), 1993 Iowa Acts

BACKGROUND

Rehabilitative Treatment and Support Services

In 1993, the State of Iowa initiated a process to maximize federal financial reimbursement for child welfare and juvenile justice services, by distinguishing the treatment portion of certain child welfare services from the supervision and maintenance portion of those services. This process sought Medicaid match, under the rehabilitative services option, for treatment services provided through four programs:

- Family Centered Services
- Family Preservation
- Family Foster Care
- Group Foster Care

The inclusion of Rehabilitative Treatment and Support (RTS) services in the Medicaid Program produced approximately $94.0 million in additional federal funds to Iowa since 1993. Iowa is one of many states to include payment for Rehabilitative Treatment and Support

(RTS) services in the Medicaid Program. As additional background information, **Appendix 1** details caseloads of various services provided in the child welfare and juvenile justice system, including Family and Group Foster Care.

Medicaid Federal Requirements

As a part of the rehabilitative services option, the State was obligated to comply with specific federal requirements that did not exist when the State assumed payment responsibility:

1. Determination of rehabilitative need by a "licensed practitioner of the healing arts", which Iowa achieves through the Clinical Assessment and Consultation Teams (CACT). This provision is also referred to as determination of medical necessity.

2. Service provision must be directed to a specific Medicaid-eligible child. Services can be provided to the family if directed specifically to the child's medical/remedial needs while general parenting skills or other treatment to address a parent's need is not reimbursable.

3. Services must meet the basic medical/remedial requirements of the Medicaid Program and be rehabilitative rather than habilitative (a skill must first be attained, then lost in order to qualify as rehabilitative.)

4. Services were required to be appropriately documented in provider records.

Rehabilitative Treatment and Support (RTS) State Plan

Iowa included detailed service definitions in the State's Title XIX Plan. The Plan defines the State's application of the Medicaid Program to Rehabilitative Treatment and Support (RTS) service provision in Iowa, and forms the rules upon which Iowa may be audited by the federal government. Many states including child welfare and juvenile justice services in Medicaid have service definitions that are less detailed. Iowa's DHS chose to submit a more detailed Plan as protection from federal challenges. The Plan definitions were a factor in the initial federal Health Care Financing Administration (HCFA) Program Review and provided a basis for maintaining federal reimbursement for skill building services, since HCFA approved the inclusion of these services in the Plan in 1993.

HCFA Program Review

In June 1994, the regional office of the HCFA initiated a program review of Iowa's system, which included some individual records review. The purpose of the review was to evaluate delivery of Rehabilitative Treatment and Support (RTS) services to ensure that:

- Only Medicaid-eligible children received the services
- The services were medical or remedial in nature
- The "medically necessary" standard was applied to service delivery
- Provided services were documented properly

The review was not as stringent or diligent as a financial audit. The HCFA conclusion, reported in July 1995, was that some of the provided services, although of benefit to families, would not be eligible for Medicaid reimbursement under Iowa's Title XIX Plan. This determination was in part due to the manner in which providers reported services, in part due to provision of services to persons who were not Medicaid eligible, and in part due to provision of some ineligible services. Based on the 1995 review, HCFA requested a $1.8 million disallowance from the DHS for the

quarter covered by the review. The disallowance was lifted based upon a plan of correction implemented by the Department. If extrapolated to an entire year and assuming no impact from the plan of correction, the annual fiscal impact would have been $7.2 million. It is impossible to determine, without a specific and comprehensive review of Department and provider records, if this fiscal estimate would apply to current service delivery.

Managed Care of Behavioral Health Services

In 1994, Iowa issued a managed care contract for behavioral health services under a federal "freedom of choice" waiver, which allows a state to require Medicaid beneficiaries to receive services through a managed care organization. Inherent in the waiver is the right to create a much more flexible set of services and financing. All mental health services funded for Medicaid beneficiaries, with the exception of Psychiatric Medical Institutions for Children (PMICs), were included in the Iowa Mental Health Access Plan (MHAP) implemented in March 1995. A similar plan for substance abuse services was implemented in September 1995. Medicaid beneficiaries under the age of 65 receive mental health and substance abuse services through these two Plans. Children receiving Rehabilitative Treatment and Support (RTS) services are enrolled in the Plans and subsequently receive mental health and substance abuse treatment.

The Medicaid managed mental health care plan, and the Medicaid portion of the managed substance abuse care plan, are both operated in a capitated at-risk environment. The contractors receive a designated amount of money each month per enrollee, regardless of whether the enrollee receives services. In both the mental health and substance abuse managed care plans, the amount of the capitation payment for an individual varies according to their eligibility category. Based on historical fee-for-service expenditures, different capitation rates were developed by an actuarial firm for five categories of Medicaid beneficiaries:

- Family Investment Plan (FIP) eligibles under 19 years of age
- FIP eligibles ages 19-64
- Supplemental Security Income (SSI) eligibles under 19 years of age
- SSI eligibles ages 19-64
- Adults ages 19-64 dually eligible for Medicaid and Medicare

The amount of capitation received by the contractors varies each month according to the number of persons enrolled for that month and the eligibility categories into which the enrollees fall. The mental health and substance abuse contractors use those capitation payments to reimburse providers for services provided to enrollees accessing care. The contractors are required to pay for all services needed by all enrollees, even if the service costs exceed the capitation payments received. In a risk-bearing contract, the State and federal government are assured that the cost for each enrollee will not exceed the amount of the monthly capitation payment. The capitated payment includes funds for both services and administrative costs borne by the contractor.

Managed Care Expenditures

The Mental Health Access Plan (MHAP) is anticipated to expend $48.0 million in Medicaid appropriations (combined state and federal funds) for FY 1998. Approximately one-third of the total expenditure will provide services for Medicaid eligible children. The Medicaid portion of the Iowa

Managed Substance Abuse Care Plan (IMSACP) will total an estimated $8.0 million. It is unknown at this time what portion of the $8.0 million will be spent on services for children.

Psychiatric Medical Institutions for Children (PMICs)

Not included in current behavioral health services are the Psychiatric Medical Institutions for Children (PMICs). Currently, the State spends an estimated $16.0-$18.0 million in providing PMIC services, and an additional $4.0-$6.0 million providing ancillary services to children while in PMICs. A significant portion of the additional service cost is for inpatient care.

CURRENT SITUATION

Integrated Access Plan Issues

There are a variety of issues involved in the current debate over the Integrated Access Plan. Some of the major areas of discussion since release of the second draft RFP include:

- A possible federal financial audit and the potential resulting loss of federal funds for treatment services, if any, found to be ineligible for Medicaid match.
- Inflexibility with respect to current rehabilitation treatment services (the restrictions which currently apply to service provision included in the State plan.)
- The lack of integration between behavior health services and child welfare/juvenile justice services, including existing incentives for cost-shift among entities responsible for payment.
- The value of community-based decision-making and impact on service design and delivery, particularly the impact on the efforts of decategorization at the county level.

The second draft of the Integrated Access Plan addresses these issues, but raises questions particularly since the level of detail in a draft RFP leaves room for negotiation with the bidder eventually awarded the contract. As written, the draft neither includes nor excludes services for families as a group, as opposed to services for individual eligible clients. The impact upon decategorization and community-based decision-making is also unknown.

Training Efforts

Since the HCFA review, key personnel including Clinical Assessment and Consultation Team (CACT) members and social workers have been trained to properly categorize Rehabilitative Treatment and Support (RTS) services. Subsequent to training, it is unknown how many Rehabilitative Treatment and Support (RTS) services currently provided are not eligible for Medicaid funds, but representatives from HCFA and from the DHS agree that some ineligible services are potentially still provided.

Potential Audit and Subsequent Decrease of Federal Funds

If HCFA requires a financial audit, a detailed review of documents might reveal the inappropriate use of federal Medicaid funds for services not specifically included in the federal regulations. The HCFA would then have the authority to ask for reimbursement of the improperly allocated federal funds (a disallowance or return of funds previously spent.) The audit would also reduce the annual estimate of federal Medicaid funds available for Rehabilitative Treatment and Support (RTS) services by a like amount in the future. According to the DHS, the likely range of impact is between $2.0 and $8.0 million annually.

HCFA Recommends Managed Care

Representatives from HCFA believe the DHS has made a good faith effort to correct deficiencies found in the 1995 review. However, HCFA also believes that expenditures continue which would not be allowable if audited. The HCFA regional representative has also indicated that, should Iowa incorporate these child welfare/juvenile justice services within an Integrated Access Plan, the concerns requiring an audit would no longer exist. The HCFA would allow the DHS to base the capitation payment upon expenditure history since implementation of the plan of correction. The concerns expressed in the 1995 HCFA review would be addressed to HCFA's satisfaction under a managed care waiver, because:

- The HCFA allows reimbursable services to be defined and determined by the State and the contractor so long as access to services covered in the Medicaid State Plan is maintained.
- The HCFA changes oversight to focus on access to appropriate services and quality assurance, no longer focusing on documentation, service definitions, or rehabilitative need.
- Inclusion of Rehabilitative Treatment and Support (RTS) services in the Integrated Access Plan consolidates the Medicaid funding stream, removing HCFA concerns about duplication, overlap, and coordination between Medicaid-funded programs.

Timetable for Decision Making

A specific timetable has not been established concerning implementation of managed care or when HCFA might initiate a financial audit absent inclusion of Rehabilitative Treatment and Support (RTS) services in managed care. Several discussions including the DHS, HCFA, and legislators or staff have suggested a three to six month window for decision-making, provided that HCFA is assured of Iowa's commitment to the managed care provision of the treatment portion of child welfare services for Medicaid-eligible clients. Any such audit is subject to State appeal and negotiation.

Federal IV-E Funding

The issue of Title IV-E federal funding, as it relates to Rehabilitative Treatment and Support (RTS) services, has relevance for policy makers. The federal government matches state funds for the "maintenance" (room and board) costs for FIP-eligible children in out-of-home care through Title IV-E funding. Total expenditures, including State and federal funds, have averaged $16.4 million annually for Iowa's foster care system over the last three years. The federal funds match State expenditures and are considered an entitlement. Many of the children receiving Rehabilitative Treatment and Support (RTS) services under Medicaid also receive Title IV-E funding. If a child leaves an out-of-home placement, Title IV-E funds no longer may be accessed for aftercare services. There is some safeguard in the draft RFP, requiring that a contractor must honor court orders for out-of-home child welfare and juvenile justice placements. If the State seeks to develop a more integrated system, the relationship of Rehabilitative Treatment and Support (RTS) services and Title IV-E funding should be examined. Currently, the federal government is authorized to provide waivers to a small number of states regarding Title IV-E funding, which would be a potential option for Iowa.

Work Group Appointed

The Child Welfare Services Work Group of various stakeholders in the child welfare and juvenile justice service system has been appointed by Legislative Leadership to consider the various options and make recommendations concerning inclusion of Rehabilitative Treatment and Support (RTS) services in the Integrated Access Plan, and other recommendations for future service delivery. A letter sent to the members, including a suggested goal and principles for decision making, a meeting agenda, and a list of the Work Group members is included in **Appendix 2**.

ALTERNATIVES

There are a variety of options the State can pursue to change the current service system to address concerns. Many options would require waivers from the federal Department of Health and Human Services (either through the Health Care Financing Administration for Medicaid, or through the Administration on Children, Youth, and Families for Title IV-E, or both). Following are some options available to the State which may be considered by the Work Group:

1. **Continue Rehabilitative Treatment and Support (RTS) services under Medicaid Fee-for-Service.** Continue to administer Rehabilitative Treatment and Support (RTS) services separately from the managed care contract, seeking to address federal concerns and exploring the options to reduce paperwork and administrative costs and increased service flexibility. Exact budget impact is unknown, but is estimated to be a decrease in federal funds in a range of $2.0-$8.0 million.
2. **Maintain Rehabilitative Treatment and Support (RTS) services in the Integrated Access Plan.** Refine the second draft RFP with child welfare and juvenile justice services included as part of the Plan. Budget impact must consider weighing the administrative costs specified in the contract, not to exceed 15.0% in the draft RFP, potential loss of federal funds should Rehabilitative Treatment and Support (RTS) services not be included in the Plan, and potential administrative and cost-shift savings due to integration of services.
3. **Managed Care for Rehabilitative Treatment and Support (RTS) services distinct from the Integrated Access Plan.** The State could seek a freedom of choice (1915b) Medicaid waiver to cover Rehabilitative Treatment and Support (RTS) services, either managing those services directly, through a quasi-public entity, through a single managed care provider, or through a

number of managed care providers (and potentially through decategorization or other local governing boards). Budget impact is unknown at this time.

4. **Managed Care for the Entire Child Welfare/Juvenile Justice System.** Iowa could seek to establish an integrated behavioral health and child welfare/juvenile justice managed care structure, with an overall capitation on State and federal funding, either managing those services directly, through a quasi-public entity designed for that purpose, through a single managed care provider, through decategorization of other local governing boards, or through a managed care contract. Budget impact is unknown at this time.

5. **Title IV-E Waiver.** Restructure the full range of child welfare services through a IV-E waiver (federal foster care funds) and a freedom of choice (1915b) Medicaid Waiver. Recent federal legislation (passed during the week of November 10, 1997) now authorizes ten new demonstration waivers annually through the Year 2002. The waiver process would most likely base federal Title IV-E funds on a specified base year and allow flexibility in services provision, specified though a State Plan. Budget impact is unknown at this time.

6. **Explore Other Options.** The State could seek a new relationship with the federal government, as Oregon has done with the Oregon Progress Board, in order to provide maximum flexibility in the use of federal funding under Title IV-E and Title XIX (and potentially other federal sources) to achieve Iowa's goals in the child welfare/juvenile justice and behavioral health arenas.

STAFF CONTACT: Margaret Buckton (Ext. 17942) Deb Anderson (Ext. 16764)

Appendix 1

Child and Family Services Programs in Iowa
FY 1996 - FY 1998 Caseloads

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998 (estimate)
Founded Cases of Child Abuse/Neglect	6,400	6,700	6,944	7,472	7,837	7,800	8,767	9,825	10,119	9,435	9,435
Family Foster Care (average monthly)	1,806	1,855	1,975	1,989	2,024	2,058	2,221	2,534	2,715	2,686	2,769
Group Foster Care (average monthly)	1,480	1,547	1,531	1,656	*1,576	1,393	1,096	1,109	1,028	968	994
Independent Living (average monthly)	43	49	53	61	80	103	117	129	131	115	139
Psychiatric Medical Institutions for Children (PMIC) (average monthly)										383	336
Children in Mental Health Institutes(MHI) (average monthly)	95	89	99	87	74	75	83	74	63	52	52
Juvenile Institutions (average monthly)	323	319	323	287	266	267	277	277	286	280	279
Shelter Care (average monthly)	504	546	624	650	650	542	484	**277	283	299	303
Acute Psychiatric Hospitalizations									***386	***266	***61 as of 10/97
Substance Abuse Treatment of Children	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	****71	****13	****7 as of 10/97
Subsidized Adoptions (average monthly)	591	699	786	921	1,238	1,323	1,438	1,584	1,880	2,218	2,554

* Group Foster Care cap was first legislated as a bed cap in 1992. In 1996, the bed cap was changed to an expenditure cap. Also, beginning in FY 1992, daily averages are used rather than monthly averages for Group Care.

** Shelter care averages, beginning in FY 1995, are daily averages rather than monthly averages.

*** Number of children under age 19 who received psychiatric hospitalization and were not enrolled in MHAP. Figures may include children also included in the PMIC count.

**** Number of children under age 19 who received substance abuse treatment and were not enrolled in MHAP. The Program began mid-FY 1996, and FY 1996 figures may be inflated due to case backlog.

Appendix 2

Dear _____

Thank you for agreeing to serve on the legislature's Treatment Component of Child Welfare Services Work Group. We realize your participation in the Work Group will require a significant demand on your time, and we thank you for that commitment. The work of this Work Group will be very important in establishing recommendations to the legislature for the long-term and short-term financing of services to Iowa's vulnerable children and families.

At our request Arlene Dayhoff, former chair of the Council on Human Services, and Charles Bruner, executive director of the Child and Family Policy Center, have agreed to co-chair this Work Group.

We have scheduled the first meeting of the Work Group to begin at 1:30 PM, on Monday, November 17, 1997. The meeting is scheduled to adjourn at noon, on Wednesday, November 19, 1997. The meeting will be held in Des Moines, at the Hotel Fort Des Moines.

Enclosed you will find a meeting response form. Please complete and return it to the Child and Family Policy Center as soon as possible to facilitate logistics for the meeting.

Also enclosed you will find a document setting out the goal for the Work Group, and suggested principles for operation of the Work Group. The document also includes a listing of the Work Group's membership.

Because Iowa is in the procurement process for a managed care contract we expect Work Group members to sign statements regarding confidentiality and potential conflicts of interest. We are in the process of discussing these, and any other, membership participation issues with the Attorney General's Office. We will share that information with you as soon as possible.

In the near future you will be receiving a complete agenda for the November 17-19 meeting, along with background materials, and any confidentiality and conflict of interest assurances that may be necessary.

Thank you again for agreeing to participate in this Work Group. It provides an excellent opportunity to improve our system of services for Iowa's children and families. We look forward to receiving your recommendations.

Sincerely,

/s/ Ron Corbett, Speaker of the Iowa House of Representatives
/s/ Mary Kramer, President of the Iowa Senate
/s/ Hubert Houser, House Co-Chair, Joint Human Services Appropriations Subcommittee
/s/ Maggie Tinsman, Senate Co-Chair, Joint Human Services Appropriations Subcommittee

Treatment Component of Child Welfare Services
Work Group Retreat
Hotel Fort Des Moines

Monday, November 17, 1997

The goal of the first day is to set a base for all future work by getting participants to better know one another, to accept and agree to the charge given to the work group, and to set out for themselves a set of principles by which to assess different options. It also will provide a primer in some of the underlying issues and options (global vs. individual capitation, types of waivers possible in Medicaid and IV-E, ability to use family vs. individual as service unit, etc.).

12:30--12:40	Welcome -- Statement of Work Group Primary Goal -- Legislative Leadership
12:40--1:00	Participants Introduce Selves and State One Hope for Meeting
1:00--2:00	Legislative Panel -- Discussion of Charge to the Work Group
2:00--2:15	Break
2:15--2:30	Confidentiality and Conflict of Interest Requirements -- Office of the Attorney General
2:30--4:00	• Presentation of Initial Draft of Principles to Guide Exploration of Options. • Small Group Discussion of Principles (Groups are charged to make recommendations for modifications and additions. Individuals will rank their top three principles)
4:00--5:00	Overview of Current Status of Financing Child Welfare and Juvenile Justice Services; Underlying Issues, Concepts and Options -- LSB and LFB
5:00--7:00	Reception and Dinner
7:00--8:30	• Finalization of Amended Principles to Guide Work Group Activities • Organization of Work Group's Work Including Need for Full Work Group vs. Sub-Group Meetings • Schedule Future Meetings

Tuesday, November 18, 1997

The purpose of day two is to provide participants much more detail on the options available to the state and their potential ramifications, including the reflections of experts in the field from outside the state. It also is designed to raise questions requiring further research and information and to surface any other options that might be worth pursuing. At the conclusion of the day the Work Group will set the direction for future work that assures the primary goal of the Work Group is achieved.

8:30--8:45	Outline of Long-Term and Short-Term Options -- Co-Chairs
8:45--9:45	History and Rationale for Second Draft of the RFP, Including Time for Questions and Answers -- DHS
9:45--10:45	Federal Requirements and Federal Perspective on Iowa's Options, Including Time for Questions and Answers -- HCFA and DHHS
10:45--11:00	Break
11:00--12:15	Small Group Discussions (participants can raise questions and answers and discuss and explore options, with participants encouraged to identify additional information needs)
12:15--1:15	Lunch
1:15--1:45	Reports from Small Groups (reports will describe any additional options and define additional information needs)
1:45--3:30	• Panel: Reflections from National Experts on Title XIX, IV-E, and Managed Care on What They Have Heard and on Important Issues and Next Steps • Large Group Discussion with National Experts
3:30--4:00	Discussion of Next Steps and Decision Points Including the Process for Reaching Them: • Linking or De-Linking • Specific Options to Directly Pursued • Schedule for Obtaining Needed Additional Information
4:00	Adjourn

Treatment Component of Child Welfare Services Work Group

In response to the concerns raised about the placement of portions of Iowa's Juvenile Justice/Child Welfare Services in the second draft of the Managed Care RFP, the leadership of the Legislature has created a Treatment Component of Child Welfare Services Work Group.

Goal:

The goal of the Work Group is to recommend a strategy, or strategy options to the Iowa General Assembly by February 1, 1998 regarding the manner in which Iowa can develop a more flexible and holistic system for child welfare and juvenile justice services, in particular services funded through Medicaid as rehabilitative treatment services. One responsibility of the Work Group is to make a recommendation on whether to "de-link" child welfare/juvenile justice services from the Iowa Plan. The Work Group will make a recommendation to the Legislature on the linkage issue by January 12, 1998.

Principles:

The Work Group will agree to its own set of principles by which to assess and distinguish among different options and strategies for achieving the goals, but these principles are expected to include principles similar to the following:

1. Developing a flexible service delivery system that responds holistically to children and families, and is contoured to child, family, and community needs and assets;

2. Providing for quality review based upon performance objectives;

3. Supporting local design and decision-making through decategorization boards;

4. Reinvesting savings resulting from more efficient delivery of services (particularly as it applies to reducing lengths of stay in residential treatment) to enhance other elements of the service system;

5. Creating a delivery system across behavioral health and substance abuse treatment and child welfare, and also across child welfare and education and special education, other health services, and community systems of support to children and families which is seamless for those who use services and coordinated by those who provide and fund services;

6. Creating a system that reduces or eliminates incentives for cost-shifting based upon payment responsibility;

7. Fostering innovation and experimentation in developing cost-effective services;

8. Insuring that, whenever possible, families are preserved and, when placement is necessary, that permanency plan goals are achieved in a timely fashion, with minimal disruptions to the child;

9. Simplifying paperwork and reporting mechanisms which still maintain accountability standards over expenditures. Meet worker needs to provide appropriate care and treatment, and meets the needs of the quality assurance and performance accountability systems; and

10. Providing a strong data system, available at the state and community level. For continued oversight and quality improvement.

Reporting to the Legislature:

The co-chairs of the Work Group shall regularly report to the legislative leadership, and to the chairs and ranking members of the Human Resources committees and the Joint Human Services Appropriations Subcommittee. The Work Group will submit regular reports to the Human Services Restructuring Task Force, and to the Joint Human Services Appropriations Subcommittee. The final report will be submitted to the Legislature and the Governor.

Membership:

Charles Bruner, Des Moines Co-Chair (Child and Family Policy Center)
Arlene Dayhoff, Cedar Rapids Co-Chair (Public Citizen)
Dr. James Austin, Sioux City (Superintendent, Sioux City Community Schools)
Marc Baty, Cedar Rapids (Linn/Jones County DHS Area Administrator)
Julie Beckett, Iowa City (Public Citizen)
John Calhoun, Sioux City (Juvenile Court Officer, 3rd Judicial District)
Beth Crowell, (CPC, Harrison, Monona, and Shelby Counties)
Mary Dubert, Davenport (Director, Scott County Community Services)
Carol Finkel, Kansas City MO (Health Care Financing Administration Liaison)
Roger Gutmann, Des Moines (President, Lutheran Social Services of Iowa)
Patricia Hendrickson, Davenport (Chief Juvenile Court Officer, 7th Judicial District)
Don Herman, Des Moines (Division Administrator, Department of Human Services)
Steve Huston, Eldora (Superintendent, State Training School)
Mary Nelson, Des Moines (Division Administrator, Department of Human Services)
Diane Dethmers Paca, Garner (Vice-Chair, Iowa Council on Human Services)
Charles Palmer, Des Moines (Director, Department of Human Services)
Sara Petersen, Waterloo (North Iowa Juvenile Services)
Mike Riepe, Mt. Pleasant (Henry County Attorney)
Ralph Rosenberg, Ames (Coalition for Family and Children's Services in Iowa)
Julie Schmidt, Atlantic (Cass County Supervisor)
Dr. Edward Schor, Des Moines (Medical Director, Division of Family and Community Health, Department of Public Health)
Ted Stilwill, Des Moines (Director, Department of Education)
Sally Stutsman, Iowa City (Johnson County Supervisor)
Gretchen Tegeler, Des Moines (Director, Department of Management)
Tom Wilson, Davenport (President, Family Resources, Inc.)
Representative of the Foster Parents Association
Administration for Children, Youth, and Families Liaison, Chicago, IL

Health Care Financing Administration, Washington, DC
Administration for Children, Youth, and Families, Washington, DC

Meetings:

This work group will meet at least twice between now and the first of the year. The first meeting will be a 3 day retreat, in Des Moines, on November 17-19. It is tentatively set for the Hotel Fort Des Moines.