COUNCIL ON HUMAN SERVICES PUBLIC HEARING
JULY 13, 2005

Presenter	Organization
#1 Tonya Diehn	March of Dimes
#2 Jule Reynolds	ASK Resource Center
#3 Dana Holland	Iowa Health Care Association
#3 Dana Holland	Iowa Council for Health Care Centers
#4 Jay Brewer	Iowa Respite and Crisis Care Coalition
#5 Ellen Failor	Iowa Juvenile Home Foundation
#6 Tracy Warner	Iowa Hospital Association
#7 Tom Klaus	Future Net
#8 Ben Woodworth	Advisory Council on Brain Injuries
#9 Brice Oakley	Iowa Alliance of Boys and Girls Clubs of America
#10 Dana Petrowsky	Iowa Association of Homes and Services for the Aging
#11 Bob Welsh	State Child Care Advisory Council
#12 Frank Severino	Iowa Osteopathic Medical Association
#13 Mikelle	Youth Policy Institute
#14 Dan Homan	AFSCME
#15 Linda Hinton	Iowa State Association of Counties

#16 Di Findley	Iowa Caregivers Association
#17 Julie Beckett	Family Voices
#18 Fred Leviton	Delta Dental of Iowa
#18 Fred Leviton	Iowa Dental Association
#19 Karla Fultz McHenry	Iowa Medical Society
#20 Pat Crosley	Mental Health Planning and Advisory Council
#21 Lynhon Stout	Iowa Foster and Adoptive Parents
#22 P.J. West	Human Rights – FaDSS Program
#23 Linda Goeldner	Iowa Nurses Association
#24 Dr. Dave Carlyle	Iowa Academy of Family Physicians

Did Not Testify but Submitted Written Comments:

- **Jodi Tomlonovic, Family Planning Council**
- **Planned Parenthood**
- **Rik, Shannon, Governor's Developmental Disabilities Council**
- **Tom Temple, Iowa Pharmacy Association**

Testified but Did Not Provide Written Comments:

- **Kim Schmett, Coalition for Family and Children Services**
- **Shanelle Wagler, Empowerment**
- **Angie Plager, Gov's Personal Assistance Services and Comprehensive Family Support Council**

Statement of Tonya Diehn

before the

Iowa Department of Human Services

Public Hearing on: SFY 2007 budget process

July 13, 2005

Mr. Chairman, I am Tonya Diehn, the chairwoman of the State Program Services & Public Affairs Committee for the Iowa Chapter of the March of Dimes Birth Defects Foundation. I am pleased to submit testimony for the record as you and your colleagues from the Council on Human Services move through the SFY 2007 budget process.

The mission of the March of Dimes is to improve the health of children by preventing birth defects and infant mortality. As you might expect, providing adequate health care coverage to women of childbearing age and infants and children is one of our primary advocacy priorities and is especially pertinent to the advancement of our mission.

Adequate health coverage of metabolic formula and medical foods through Medicaid and the hawk-I program will improve the health for individuals with metabolic disorders, particularly Phenylketonuria, and will reduce the number of individuals with mental retardation, cognitive disorders, and birth defects.

Phenylketonuria or PKU arises from the absence of a single enzyme (phenylalanine hydroxylase). This enzyme normally converts the essential amino acid, phenylalanine, to another amino acid, tyrosine. Failure of the conversion to take place results in a buildup of phenylalanine. Excess phenylalanine is toxic to the central nervous system and causes severe neurological problems including mental retardation when treatment is not started within the first few weeks of life. Treatment requires strict dietary modifications, a prescribed metabolic formula, and, depending on the individual's age and severity, low protein medical foods. Not every individual has the same degree of enzyme deficiency. Only an experienced metabolic program can determine the appropriate treatment for an individual and perform the necessary monitoring to keep them in metabolic control.

In 2000, the National Institute of Health Consensus Development Conference Statement determined that metabolic control is essential with PKU patients and treatment is "for life". Dietary food modification is not sufficient to prevent adverse outcomes to the PKU patient. Life long treatment with medical formula and foods is critical to preserve cognitive and behavioral function in all individuals with PKU and other metabolic disorders.

In addition, according to the Center for Disease Control (CDC), we know that female PKU patients in their reproductive years who have discontinued medical formula and diet have a 100% chance of having children with a birth

defect such as a heart defect, microcephaly, and even mental retardation. This risk is significantly reduced by being on the diet and in good metabolic control prior to conception and throughout the duration of the pregnancy.

Currently, according to University of Iowa Medical Genetics Clinic, there are 17 Medicaid patients and 3 *hawk-i* patients that seek metabolic control in Iowa. Metabolic formula is covered under the Iowa Administrative Rules for Medicaid, oral supplementation section. For fiscal '04 and to date for '05, Medicaid contract insurers have not paid their claims. Medicaid does not cover low protein medical foods. Neither metabolic formula nor the low protein medical foods are covered by *hawk-I*.

How can the Iowa Department of Human Services and the March of Dimes help people with PKU prevent further birth defects? The March of Dimes has successfully led legislative action to provide a grant through the Department of Public Health to the University of Iowa Medical Genetics Clinic to assist every PKU patient in the cost of the low protein medical foods. An example of the high pricing of the foods, a box of spaghetti we buy at the store costs $1.00, but the low protein medical box of spaghetti costs $10.00 and is only available online or at the Hy-Vee food store in Iowa City. The March of Dimes is also working with the Department of Human Services to rectify the error in nonpayment of metabolic formula for the current Medicaid patients.

We are asking the Department of Human Services to expedite the claims issue regarding the nonpayment for the metabolic formula for Medicaid patients. This is an issue that clearly needs to be resolved forthwith. The call for Medicaid coverage for low protein medical foods needs to be examined by the Council with appropriate action. Also, we ask the Council to strongly encourage the *hawk-i* board to initiate coverage for PKU patients under their program for metabolic formula and foods.

On behalf of the Iowa Chapter of the March of Dimes, thank you for your leadership on Medicaid, the State Children's Health Insurance Program (*hawk-i*), IowaCares Act and other health benefits for mothers and children who often have difficulty obtaining the care they need when they need it.

Again, thank you for your time and for your commitment to Iowa families and their children.

DHS Budget Hearing

July 13, 2005

Access for Special Kids: ASK Resource Center, is pleased to contribute to this hearing. ASK Resource Center is a family driven non-profit organization dedicated to assuring that kids with disabilities and their families have good information the support they need. The ASK vision is: Access for all Iowans. As Director I want to thank this Council and particularly DHS Director Kevin Concannon and his staff, as they has demonstrated their dedication to family centered practices and system's change as it relates to kids with disabilities. We specifically are proud of the new legislation that supports kids with severe emotional disturbance through a new waiver program. The impact is yet to be seen but I commend the Department for taking the lead towards community based programs.

ASK Resource Center also supports the Governor's recent Executive Order that directs DHS to work with health care providers to provide more effective and efficient in-home care services for people with disabilities. All people deserve nurturing, safe, and supportive educational, living, recreational and employment environments where they and their families are valued and treated with respect and dignity. High expectations supported by continuing quality services lead to best outcome for people with disabilities. Persons with disabilities with long term care needs and their family caregivers should be supported across the lifespan in ways that respond to their individual needs and promote self-determination. Reverse Iowa's current institutional bias by fully supporting The Olmstead decision and the Governor's Executive Order with systems change designed to mandate a priority for programming and funding that support choice, flexibility and individualized support and services for persons with disabilities and their families

Policy Recommendations

- Fully fund and expand the *Children at Home Program.* This program is progressive and efficient in its approach to meeting the needs for children with disabilities at the very local level. This program has been piloted in Iowa but needs to expand statewide. This hidden treasure has been evaluated and found to be efficient and effective. This program slogan is: "Home Grown Kids". It allows flexibility yet accountability through local stakeholders who care about the families in their community and want them to stay and be successful and require accountability in spending as funds are limited. Please support the Children at Home Program.

- *Establish individual, annual budget funding*-ensuring that dollars follow the individual, not the institution, that they be served in the Least Restricted Environment (LRE) of their choice.

- Support the restructure efforts of the Mental Health, Developmental Disabilities, Mental Retardation and Brain Injury (MH/DD/MR/BI) Commissions Children's redesign. Work hard at broad stakeholder input whenever possible.

- In conclusion: Continue to include families at every level of evaluation, implementation and monitoring of programs that effect children with disabilities. We are competent and dedicated to family support and education to improve the outcomes of our children.

Submitted by Jule Reynolds, Director ASK Resource Center: jule@askresource.org

IHCA and ICHCC presentation to DHS Council

Iowa Health Care Association (IHCA) and the Iowa Council of Health Care Centers (ICHCC) come together to present concerns and recommendations for FY 2007 appropriation requests. Together IHCA and ICHCC represent nearly 360 nursing facilities (81 percent) in Iowa and more than 215 assisted living and senior living programs and residential care facilities. Many of these providers offer a wide range of home and community based services, as well.

In 2000 the transition to the current nursing facility reimbursement system began. IHCA and ICHCC worked closely with DHS and legislators throughout the transition. The charts below illustrate how funding needs are closely tied to the increasing acuity needs of residents. Chart 1 shows the growth in acuity since the implementation of the new system. Chart 2 shows the growth in Medicaid beneficiaries in nursing facilities. These significant pressures are the primary reasons to fully fund the payment system.

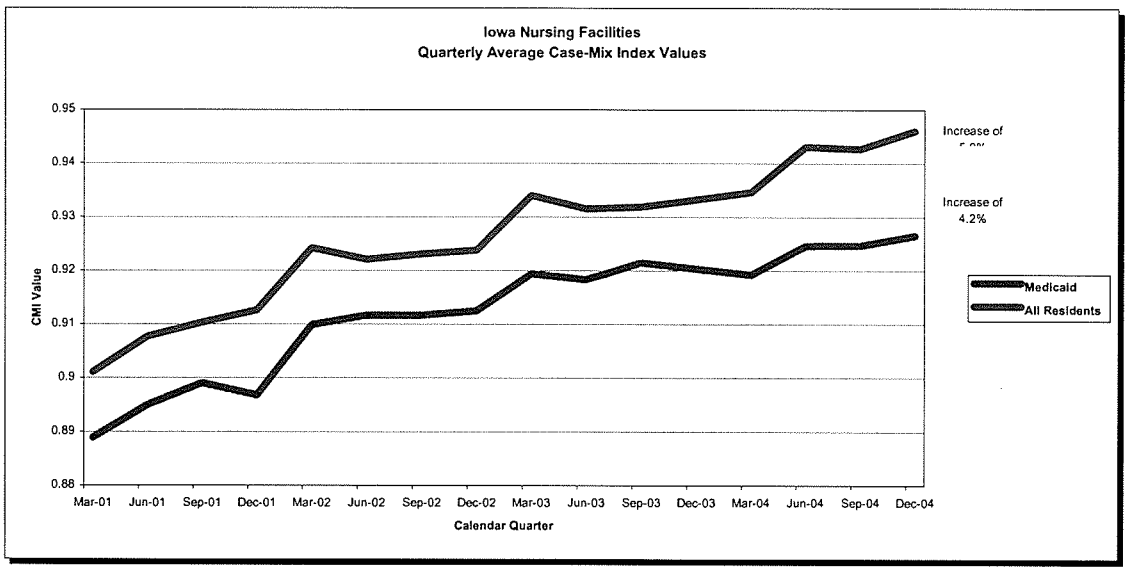

Chart 1

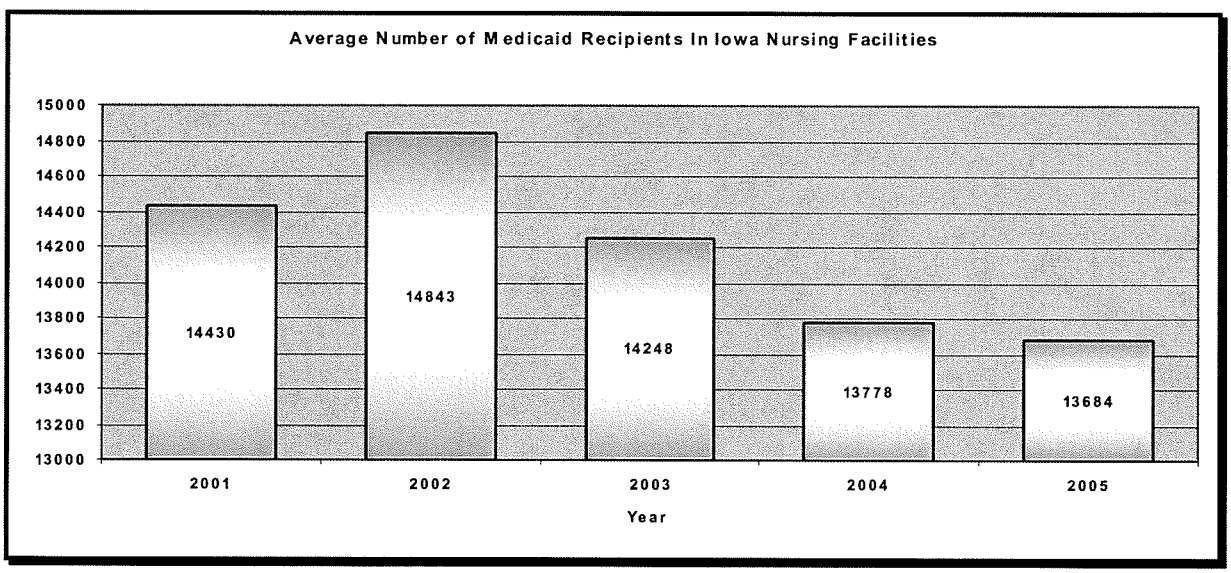

Chart 2

The numbers below illustrate how utilization rates in Iowa are unique compared to the rest of the country. Iowa is significantly below the national average in the percentage of Medicaid residents in nursing facilities and the payment rates received by nursing facilities. Nursing facilities in Iowa provide cost-efficient services compared to the national averages. For example, the State share of Medicaid PPD of $35 includes room, board, supplies, therapies and 24-hour nursing care.

	Iowa average	National average
Medicaid utilization	50%	75%
Average Medicaid PPD	$103	$135
State share Medicaid PPD	$30 (FMAP @ 36%)	$67 (FMAP @ 50%)

Nursing facility providers have done their part to help control Medicaid expenditures over the past several years. Nursing facilities have accepted payment system changes including:

- Removal of hold harmless payments
- Increase of the occupancy penalty from 80 to 85 percent
- Limits applied to the SNF Market Basket Index adjustment
- Decrease in bed hold payments from 75 to 42 percent
- Elimination of Medicare cross-over payments
- Reduction in the excess payment calculations (completely removed in FY 2006)

In addition, assisted living programs have had no increase in reimbursement rates since 2000. Residential care facility reimbursement rates are well below the cost of providing services. These cuts—many of which are permanent—resulted in nearly $30 million in Medicaid program annual savings. The 2005 state fiscal analysis will show nursing facilities' spending growth at approximately one percent—significantly less than the initial projections.

Also, through conversion grants and elderly waiver services, nursing facilities, assisted living programs and residential care facilities have actively participated in increasing the availability of home and community based services by developing a broader continuum of care within their service offerings. Nursing facilities also actively participated in funding the Senior Living Trust Fund. Iowa nursing facilities, assisted living programs and residential care facilities have played a significant role in strategically slowing the growth in Medicaid funding needs and accessing federal funding sources.

Recommendations

The reforms in HF 841 limit admissions to nursing facilities by increasing the level of care criteria required for admission. The impact of this change will be seen in the coming months. While we understand the need for alternative services, we also believe in developing more efficient and streamline payment reforms that adequately compensate providers of Elderly Waiver Services within assisted living, residential care and adult day care.

In 2004, the long term care profession worked with DHS to develop a tiered payment system for assisted living and residential care. We recommend that this plan be submitted to the State Legislature and for CMS approval. Medicaid assisted living tiered payment systems are currently being utilized in 13 other states. Of the 6,000 Elderly Waiver Program participants in Iowa, fewer than 500 reside in assisted living programs. Chart 3 shows the growth in Elderly Waiver Program beneficiaries.

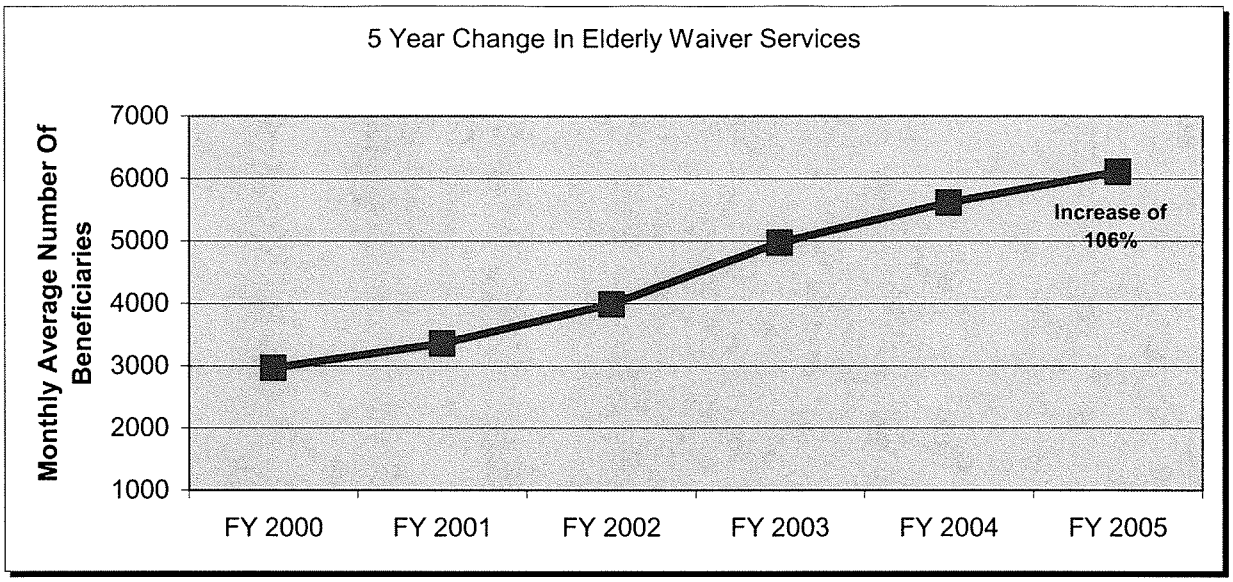

Chart 3

We encourage the DHS Council to work toward a fully funded nursing facility, assisted living and residential care payment system, recognizing the influence of acuity levels, utilization rates and the high regulatory standards. Because the state, through DHS, is providing enhancements to encourage the availability and utilization of alternative service options—which is resulting in a decrease census in nursing facilities—we are requesting the nursing facility Occupancy Penalty be eliminated. In addition, we believe Iowa should consider a bed banking or set-aside program to encourage further licensed bed capacity reduction and protect future capacity concerns.

It is documented that Iowa is home to some of the oldest nursing facility structures in the nation. Renovation and replacement of these structures is critical to meeting the demand of the growing elderly population and its changing needs. With the shift to alternative services, the demand for services may very likely outpace the existing capacity and infrastructure of the current long term care facilities. A proactive fair rental payment system will help nursing homes and residential care facilities better prepare for the changing needs and acuity of Iowa's frail, elderly citizens.

We support the goal to provide appropriate and high quality long term care services based on the consumer's needs and an adequate payment system for all levels of care. Nursing facilities are a key component in the State's efforts to provide effective utilization with limited resources. We encourage you to direct future spending toward programs that can do the most for Medicaid beneficiaries without disrupting access to services. Enhancements and incentives for alternative service providers need to be considered carefully. A more streamline payment system should be designed that will promote provider participation.

Summary

Dennis Smith, CMS Director for Medicaid and State Operations recently told American Health Care Association representatives that CMS supports state reforms promoting home and community based waiver services. In his comments, he said these objectives should not be designed to harm nursing facility providers and residents, but to foster cooperation and access along the continuum of care.

Long term care utilization is steadily changing and the State's initiative to expand alternatives is in line with the demands of Iowa's current and future elderly. The further expansion of alternatives should be carefully considered by placing the focus on the overall cost and quality of care provided by these programs. Employment issues and staffing shortages in the long term care continuum must be addressed by developing and implementing strategies to encourage entry into the profession's workforce.

Recent history has shown how successful a cooperative working relationship can be between DHS and the long term care profession. The profession has supported many recent changes and will continue to actively promote new ideas to reduce the burden of long term care funding needs on the General Fund.

IOWA RESPITE & CRISIS CARE COALITION

Supporting Families Across Iowa and the Lifespan

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July 12, 2005

Christine G. Louscher, Chair
Council on Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

Dear Chair Louscher:

The Iowa Respite and Crisis Care Coalition appreciates the opportunity to present these comments to the Council on Human Services.

We realize these are difficult times for the Department of Human Services. There are likely not enough resources available to cover all of the human service needs within the state of Iowa. This is equally true for families with family members with special needs and those families that experience emergencies or crisis in their lives. They are also seeing resources from a variety of sources disappear. As always, they are also struggling to make do with less than ideal.

I recently received an application for emergency care for a family with 3 children who folks felt were at risk of abuse and or neglect. I realize that I received some of the information 2nd & 3rd hand but the applicant was directed to IRCCC because she was told that **imminent risk of abuse is not a population DHS is currently serving.**

I don't know if that is true (I hope it isn't). if it is, I think it needs to be rethought. Have we come to the point that we tell children – wait until you have been abused, then we can help? We are concerned that there needs to be a strong and viable safety net throughout the state for children at risk of injury and abuse.

We encourage the Council to continue to look for ways of making services more flexible and responsive to families. You need to continually dialogue with families to see what they need and how they need it. Sometimes increased flexibility in how services are provided can help make up for fewer dollars to fund those services.

Our Direct Family Access Respite program which we began in 2001, awards respite funds directly to families, allows them great latitude in who provides and where the respite service takes place. Even though the funds are very limited, families love it because they can tailor it to their needs.

We encourage the Department of Human Services to support efforts throughout the system to allow funding for services to follow the individual to secure services in the least restrictive setting of choice. Artificial restrictions on where services and by whom should be reviewed and as much as possible removed to facilitate the efficient provision of services in settings of choice.

Sincerely,

Jay W. Brewer
Executive Director

Iowa Juvenile Home Foundation

"Established 1996"

701 South Church *Toledo, Iowa 52342* *Ph. 515-484-2560*

July 13, 2005

Good morning. I am Ellen Failor, the secretary/treasurer for the Iowa Juvenile Home Foundation board of directors.

The 1920 college campus in Toledo that now houses the state's commitment to delinquent girls and CINA girls or boys is in need of multiple repairs. The Iowa Juvenile Home (IJH) will begin the process so work can commence on the geo-thermal heating and cooling system this summer with the appropriated $1.3 million infrastructure funds this year and $1.5 million next year for the geo-thermal system, plus an all new maintenance building in order to replace the existing building before it falls down. Skow Cottage, as well as the school/administration building, will be getting new roofs.

This, however, is not enough. IJH is aging "ungracefully." Overcrowding and inadequate physical space cultivate a climate of disrespect and humiliation. We would like to have the support of the Department of Human Services for $12 million more infrastructure funds for the Iowa Juvenile Home in Toledo.

In fiscal year 2004, IJH staff served 229 youth. Most (79%) arrive below where they should be educationally, which is not a surprise since most (70%) were not attending school before arriving. IJH cottage staff coordinate with the educational staff for each student, and fiscal year 2004 statistics show how much better these students do when allowed to attend classes and focus on their studies:

- 51% get back in step with public school and society
- 15% of the 17% designated as seniors graduated or received GED preparation
- 39 students had honor roll achievements
- 126 received vocational certificates for formal training, and
- 143 received on-the-job training.

For every month at IJH, each student gained two months in education. These are our children who most likely will remain in Iowa and be our future work force if we can prevent them from entering prison as an adult. This intervention in their life and a turnaround in their education are vital for all of us.

The IJH staff in Toledo have made abundant opportunities for changes in the lives of these teenagers whom they serve. We need the Department of Human Services to help them continue by insuring the physical safety issues on the campus along with the new vocational education school building.

IJH currently teaches vocational classes (separate for boys and girls) in food preparation, photography, career exploration and retail merchandising. There is a waiting list for vocational classes. Students have expressed an interest in training and employment opportunities that go beyond what can be offered in an already crowded school building. We need construction of a new vocational school building.

Plans also call for the relocation of the security department and the medical staff currently in the 1923 infirmary building to the lower level of the new vocational school building. Continued work on the cottages includes remodeling bathrooms and replacing drafty windows.

Further infrastructure funding will positively impact the education, treatment, health and safety of the youngsters at IJH. We hope that the Iowa Council on Human Services will give every consideration to supporting this request with the Governor's Office and with members of the General Assembly.

Iowa Juvenile Home Foundation Mission Statement

Enhance the IJH's ability to enable youth to become contributing members of society through:

- *Advocating for youth and the programs that serve them;*
- *Educating people about the abilities and needs of the IJH;*
- *Supporting the accomplishments of youth and staff; and*
- *Pursuing auxiliary funding.*

Iowa Juvenile Home Foundation Board of Directors

Alice Campbell, William Christensen, Robert Eppler, Ellen Failor, Dr. Kathy Fejes, Ron Ferrin, William Skow, Carol Thompson, Dr. Paul Vance, Kenn Vinson, and Dr. Rachel Williams.

IOWA HOSPITAL ASSOCIATION

Council on Human Services
SFY 2007 Public Hearing
July 13, 2005

We've all heard the saying "the more things change, the more they stay the same". As the Iowa Medicaid program stands on the threshold of implementing historic reform with the recent approval of waiver from the federal government to expand limited Medicaid coverage to individuals under 200 percent of the federal poverty guidelines, the fact remains that this significant transformation provides care to the same population as its precursor, the Indigent Patient Care Program, also known as state papers. However, the source of funding for this population changes, moving from state funding and local property tax revenue to dollars designed to maximize federal funding for Iowa's Medicaid program.

But regardless of the source of funding, the need to adequately pay providers for the provision of these services still exists and the ability of Iowa hospitals to provide high quality, comprehensive health care services is being threatened by insufficient government payments. Although the legislature approved a 3% payment increase for Medicaid providers for FY 2006, this action represents the first payment update for hospitals since FY 2000. While we're appreciative of this increase, it falls far short of the growing gap that was created first by setting payment levels below the actual cost of providing care, and then by not recognizing the annual cost increases that have occurred in pharmaceuticals, technology, utilities, and other factors, such as salaries, essential to hospital operations.

Therefore, IHA's testimony this year to the Council is no different than it has been in past years, despite the radical change facing the Medicaid program. Ninety of 116 Iowa hospitals lost money in 2003 treating Medicaid patients. Unfortunately, when hospitals are only paid 87% of their costs to provide care to Medicaid patients, other parties who pay for health care services subsidize the program. Businesses and individuals who purchase insurance pay higher premiums or buy policies with higher deductibles or co-payments in an effort to deflect some of the increases due to cost-shifting of Medicaid payment shortfalls to other patients. This cost shift compounds the problem by increasing the number of people who can no longer afford health insurance or who cannot afford to pay the larger out-of-pocket costs when they need care. A recent report from Families USA shows that the cost of health insurance premiums for Iowa families in 2005 is $518 higher due to the unpaid cost of health care for the uninsured. Premiums for Iowans with individual health insurance coverage are $200 higher this year. This dilemma creates a situation that relies on local hospitals to provide more charity care as part of their community benefit. Community benefits are activities designed to improve health status and increase access to health care. Along with uncompensated care, which is made up of both charity care and bad debt, community benefits include such services

and programs as health screenings, support groups, counseling, immunizations, nutritional services, and transportation programs. An IHA statewide survey released earlier this year shows that Iowa hospitals provided more than $417 million in community benefits in 2003. That figure includes $353 million in uncompensated care and over $64 million in free or discounted programs and services that hospitals offered to help the communities they serve.

The programs and services identified in the community benefits survey were implemented in direct response to the needs of individual communities, as well as entire counties and regions.

Unfortunately, the ability of Iowa hospitals to respond to such needs is being hindered by the enormous financial losses caused by Medicare and Medicaid. While these government programs combined represent about 60 percent of all hospital revenue in Iowa, providing services to patients covered by the two programs created approximately $84 million in additional losses for hospitals.

When community benefit programs are threatened, then so is the access to health care for thousands of Iowans since these kinds of programs are not likely to be offered by any entity other than the community hospital. And that access is vital to our state's economic climate.

Iowa's hospitals, and the more than 68,000 employees who provide care in them, applaud our state's economic growth. You may be aware of the recent *Des Moines Register* story and editorial urging state leaders to prioritize "the basics" for ensuring continued economic success. That list must surely include access to high-quality health care.

The Register noted some indications of Iowa's past economic struggles, including low population growth, lack of job diversity, low wages and a poor record for holding onto college graduates and young people in general. Prioritizing health care addresses these issues through a broad array of lifelong career opportunities in well-paying, high-tech jobs in all parts of Iowa - a state that happens to rank sixth in the nation for quality of health care.

If we are to maintain that kind of quality and keep working to make Iowa a better place to live, then we must protect the essential assets - "the basics" - that not only support economic growth but are at the foundation of our quality of life. This is not a long list, and good health care - and access to it - must certainly be at or near the top.

The lack of an annual Medicaid payment update jeopardizes this access by making it more difficult for hospitals to compete with other states for quality health care workers, to provide community benefit programs, and to account for the growing number of uninsured in the state. Policymakers can ensure continued economic growth through an investment in Iowa's hospitals which are major contributors to the Iowa economy. A comprehensive study by IHA of the economic impact of health care shows that Iowa hospitals generate nearly 147,000 jobs and an annual payroll just under $5 billion. In addition, Iowa hospital employees spend more than $1.7 billion on retail sales and contribute more than $84 million in state sales tax revenue.

This is the third year IHA has collected this data which examines the jobs, income retail sales and sales tax produced by hospitals and the rest of the state's health care sector. As in the previous reports, this year's data underscores the tremendous economic impact of hospitals and health care in Iowa.

This data is vital in pointing out that the provision of quality health care services is a cornerstone to the infrastructure of Iowa's communities and an essential force in the state's economic development.

IHA and Iowa's hospitals remain committed to seeking collaborative solutions toward maintaining quality health care services for all Iowans. The goals in this regard are no different than legislators who are elected to serve their districts, DHS staff who are employed to respond to Medicaid members, and hospitals that exist to serve their patients and community. In the end, it's the same population.

Presented by:
Tracy Warner
Vice President, Finance Policy
Iowa Hospital Association

Iowa Hospital Association
2004 Community Benefit Survey Program Report Summary

Surveys representing 116 hospitals

Traditional Community Benefits

Uncompensated Care (Charity and Bad Debt) $353,120,493

Non-Traditional Community Benefits Summary

Unprofitable/Subsidized Services	Addresses a Community Need	Provided At a Loss	Provided in Partnership
Unprofitable/Subsidized Inpatient Clinics/Services	116	133	32
Unprofitable/Subsidized Outpatient Clinics/Services	170	227	32
Total Unprofitable/Subsidized	**286**	**360**	**64**

	Participants or Units	Financial Loss
Non-Billed/Sliding Scale/Free Services		
Community Education and Outreach	1,319,245	$ 7,250,052
Health Screening	105,721	$ 1,533,487
Support Groups	39,872	$ 536,032
Counseling	155,536	$ 3,184,500
Self-Help	102,245	$ 1,889,059
Immunization	47,355	$ 203,840
Non-Billed/Reduced Fee Clinics	570,784	$ 5,964,353
Other Non-Billed:		
Family Support Services	119,817	$ 2,235,825
Free or Discounted Prescriptions/Supplies	8,626	$ 713,951
In-Home Services	70,435	$ 1,880,360
Meals/Nutritional Services	677,988	$ 1,370,799
Transportation Services	49,345	$ 2,216,953
All Other Non-Billed Community Programs	221;517	$ 1,717,239
Total Non-Billed Community Benefits Programs	3,488,486	$ 30,696,450
Cash or In-Kind Donations		$ 9,355,912
All Other Community Benefits Not Included Elsewhere		$ 2,805,582
Loss on Medical Education and Research		$ 21,494,868
Total Non-Traditional Community Benefits*		$ 64,352,812

Community Benefits Total $417,473,305

Medicare Losses (estimated) $70,000,000
Medicaid Losses (estimated) $14,000,000

FutureNet
The Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health

Planning For Success
2005 Annual Conference
October 4, 2005
Stoney Creek Inn
Johnston, Iowa

Testimony to the Council on Human Services

July 13, 2005

Community Adolescent Pregnancy Prevention Grant Program – Iowa DHS

On behalf of the Community Adolescent Pregnancy Prevention (CAPP) grantees, including FutureNet, Inc., *The Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health*, thank you for the opportunity to speak briefly to the Council on Human Services this morning.

Since last appearing before this Council a little over a year ago, FutureNet has moved quickly to lead CAPP grantees in the process of establishing standards of practice statewide for sexual health educators. Whether comprehensive sexuality education, abstinence education, STI/HIV education, or teen parent classes, our innovative initiative, *Touchstones: Sexual Health Measures That Matter*, clearly establishes a baseline for providing science-based practices in sexual health education.

The Touchstones Project grew out of the convergence of several indicators of need, some positive and some negative, which came to light during the past twelve months.

On the positive side, *The Touchstones Project* hopes to continue the momentum of the excellent work already being done.

- Community Adolescent Pregnancy Prevention programs, funded by the Iowa Department of Human Services, now serve over 50,000 Iowa students each year in 54 counties.
- Fifteen years of evaluation on these programs by The University of Iowa consistently show clear evidence of positive impact on student participants.
- Most significantly, since 1989 the number of births to Iowa teenagers has decreased from 4,017 per year to 3,420 in 2002.

Ironically, the CAPP grant program, despite clear evidence of success, has been "flat funded" (received no increase) since 1998 from the Iowa Legislature.

On the negative side, *The Touchstones Project* hopes to reverse some disturbing trends that have come to light.

- Iowa schools have produced no valid data for the Centers for Disease Control and Prevention's Youth Risk Behavior Survey since 1997. The absence of this data makes it extremely difficult for prevention specialists, in *any* field, to get a clear picture of the health risk behaviors of Iowa youth.
- The Iowa Youth Survey, also conducted in Iowa schools, has an extraordinarily weak section related to youth sexual risk behavior making it virtually useless to prevention programs and specialists.
- Finally, there is no legislative requirement that sexual health education provided to Iowa students reflect science-based practices, which includes providing medically accurate sexual health information. Sadly, legislation introduced by Rep. Mary Mascher, and eleven co-sponsors, to correct this loophole never made it out of the Iowa House Education Committee this spring.

Remarkably, these three trends can all be easily and inexpensively reversed if schools, citizens, and the legislature will simply exercise the will to do so.

The Touchstones Project has caught the attention and imagination of a wide variety of health professionals within the state of Iowa and nationwide. Recently FutureNet submitted an application to become one of a handful of state coalitions nationwide to partner with the Centers For Disease Control and Prevention and other national organizations to more effectively promote science-based practices in sexual health education and adolescent pregnancy prevention. Over thirty letters of support for *The Touchstones Project*, from a variety of governmental, university, educational, business, and private not-for-profit organizations, were included with

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that application to demonstrate broad-based, statewide support. Additionally, FutureNet has been invited to present *Touchstones: Sexual Health Measures That Matter*, to state health planners in Oklahoma; to an invitation-only gathering of state teen pregnancy prevention coalitions leaders in North Carolina; at the annual national conference of the Healthy Teen Network in Chicago; and at the annual meeting of the American Public Health Association in New Orleans. *The Touchstones Project*, which is funded in part by the CAPP grant program, has already helped Iowa regain some of the leadership role it enjoyed when the field of teen pregnancy prevention was still young nearly 20 years ago.

Now that the momentum, in terms of both the teen birth rate and the leadership position of our state, is shifting, we request your support to allow the Community Adolescent Pregnancy Prevention grant programs to do more. Here's how:

- **Support an increase in funding to the Community Adolescent Pregnancy Prevention Grant program using TANF money that will become available when the Iowa family planning Medicaid waiver is approved.**
  - CAPP programs currently receive $1.3 million dollars and serve over 50,000 youth each year in 54 counties. However, the CAPP program hasn't received an increase in funding since 1998.
  - With the pending
  - Iowa's investment in Community Adolescent Pregnancy Prevention (CAPP) is saving taxpayers millions of dollars, with the reduction in teen pregnancies, while better preparing kids for the future.
  - A new crop of kids becomes teenagers each year, therefore our prevention efforts must continue.
  - Over half the families on public assistance were started by teen parents. Since 1998 Community Adolescent Pregnancy Prevention programs have contributed to reducing the teen birth rate by 18%, thus lowering the number of families receiving FIP.
- **Support legislation requiring Iowa's schools to provide youth with age appropriate, medically accurate, science-based instruction related to health, human growth and development and family life education.**
  - An article in the Sunday, July 10, 2005 Des Moines Register (*Anti-drug program financing questioned, page 1-A by Clarke Kauffman*) illustrates the need for science-based practices in ALL fields of prevention, including sexual health education.
  - After more than 25 years of research, development, testing, tweaking, and testing again, we know what works to prevent teen pregnancy and reduce the risk of sexually transmitted infections among our youth. What we have learned, and what *The Touchstones Project* asserts, is: "The truth is the single most effective tool we can use to teach adolescents about sexual health, responsibility, and risk."
  - Healthy Iowans 2010 (Goal 7-6) calls for action that would *"Assure that all abstinence education, teen pregnancy prevention, and adolescent sexual health programs in Iowa are science-based and medically accurate as defined by the standards developed by the Centers for Disease Control and Prevention (CDC) by 2010."* This new collaborative project – *Touchstones: Sexual Health Measures That Matter* – can make this call a reality.

Thank you for your time and for your consideration. I'm delighted to answer questions now or later if you will contact me at the phone number, email, or address listed below:

Respectfully,

Tom Klaus, Executive Director
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SEXUAL HEALTH

Touchstones

MEASURES THAT MATTER

A project of

FutureNet

The Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health

On January 10, 2005 the FutureNet Board of Directors unanimously and enthusiastically embraced a proposal from Executive Director Tom Klaus for a five-year project that will facilitate the implementation of strategies for the adoption and use of science-based practices in the design, development, and implementation of all adolescent pregnancy prevention, abstinence education, teen parent, and sexual health education programs offered in Iowa. The project is ***Touchstones—Sexual Health Measures that Matter.*** *This paper describes The Touchstones Project and invites individuals and organizations to join with FutureNet to work toward its success for the sake of Iowa kids.*

What is meant by "science-based practices?"

Over the past twenty years researchers and leaders in the fields of adolescent pregnancy prevention, services to adolescent parents, and adolescent sexual health have attempted to identify "what works," "best practices," "characteristics of effectiveness," and "proven effective" programming. Today the term "science-based practices" has emerged to describe the whole range of these strategies.

"Science-based practices" refers not just to the content or type of program but also to the process used to develop programs. The Touchstones Project has adopted the definition of "science-based practices" jointly developed by the Centers for Disease Control and Prevention, Advocates For Youth, The National Campaign to Prevent Teen Pregnancy, and the National Organization on Adolescent Pregnancy, Parenting, and Prevention (now known as the Healthy Teen Network):

"More comprehensively, the term science-based practices refers not only to the ***type*** *of program (for example, a teen pregnancy prevention program based on social science research) but also to the* ***process*** *for developing a program (such as creating a logic model and evaluating the program with process, outcome, and/or impact studies). Science-based practices in preventing teen pregnancy, sexually transmitted infections (STIs), and HIV include, but are not limited to, the following –*

- *Relying on interventions that have been evaluated and found to be effective in preventing or reducing sexual risk behaviors and/or in reducing the incidence of pregnancy and/or HIV/STIs*
- *Relying on evaluations that have been rigorous enough to be accepted by a peer-reviewed journal and/or by a panel of* ***independent*** *experts who are conducting an* ***objective*** *review*
- *Using social science research that identifies risk and protective factors*
- *Using a logic model – a framework for linking risk and protective factors with effective program strategies and anticipated outcomes*
- *Relying on programs that are grounded in behavioral and social science theory and that clearly define and document activities, curricula, and protocols*
- *Conducting evaluation and using the findings to change programs so as to enhance their effectiveness.*

In sum, relying on science-based practices means using evaluation findings, social science research, survey data, and empirical findings to establish effective strategies and reject ineffective ones."[1]

Why The Touchstones Project?

When adolescent pregnancy became a national issue nearly thirty years ago, little was known about the best ways to address it, either in preventing future adolescent pregnancies and in providing support for pregnant and parenting adolescents. With the adoption of Title IX, schools were required to provide equal access to educational opportunities for adolescent mothers and thus the issue of adolescent pregnancy was elevated to a new level in the public consciousness.

Iowa schools were among some of the first in the country to open their doors to pregnant and parenting adolescents. Several Iowa agencies were among the first to offer support programs for adolescent mothers. With the adoption of a comprehensive Human Growth & Development plan and establishment of the adolescent pregnancy prevention grant program under the Iowa Department of Human Services, Iowa became a respected pioneer in the field of adolescent pregnancy.

Over the years Iowa's pioneering role has been eclipsed by the innovative efforts of other states; new research that has advanced the field; and local and national policies that have effectively slowed, even stalled, the implementation of the effective and best practices that have emerged from theory, practice, and research.

- The state Human Growth & Development plan developed several years ago has not been regularly updated to reflect the most recent research.
- Neither has the Human Growth & Development plan been adopted and implemented as completely or widely as intended.
- Since 1997 no weighted data (valid data that can be generalized to the whole state) has been generated from the Iowa Youth Risk Behavior Survey (YRBS). The validity of the YRBS, conducted every other year on odd years, is dependent upon the participation of the school districts that are randomly selected and the students within those schools who are randomly selected. Beginning with the 1999 YRBS there have been insufficient numbers of participants, either schools or students, for the Iowa data to be usable across the state.

(Continued on page 2)

The Vision of The Touchstones Project

By 2010, all adolescent pregnancy prevention, abstinence education, teen parent, and sexual health education programs in Iowa are designed, developed, and implemented according to accepted standards for science-based practice.

(Continued from page 1)

- Similarly, the Iowa Youth Survey provides very limited information related to sexual risk behavior. This limited information is not generally useful for gaining an accurate understanding of the needs of Iowa youth with regard to sexual health education.
- The absence of such critical information about sexual risk behavior of Iowa youth seriously undermines the efforts of service providers to design, develop, and implement programs that can address the behaviors and ensure the health of Iowa youth.
- Presently there is no legislation requiring any state, county, or local government departments; public or private educational institutions; or other community agencies and organizations delivering abstinence education, comprehensive sexuality education, services to pregnant and parenting adolescents, and sexual health education to provide programming that is consistent with "science-based practices."

Overall there has been an insufficient, if not altogether absent, commitment to using "science-based practices" in sexual health education in our state today. The Touchstones Project seeks to strengthen this commitment in a positive, collaborative, and voluntary way.

The Touchstones Project: Why now?

There have been a number of developments, at the national and state levels, that indicate the time is right to create a higher standard in sexual health education for Iowa's youth.

- Research conducted over the past three decades have given us an unprecedented understanding of "what works" in our fields.
- Through a project overseen by the Centers for Disease Control and Prevention (CDC) the research findings have been distilled into models of "science-based practices" for our field by the National Campaign to Prevent Teen Pregnancy, Advocates For Youth, and Healthy Teen Network.
- In a recent report that considered the content of the thirteen most popular federally funded abstinence education curriculum, eleven were found to contain significant errors and misleading public health information. At least three of the eleven curriculum are used by abstinence education grantees in the state of Iowa.
- In response to this report, newspaper editorials in Iowa's two largest cities, Des Moines and Cedar Rapids, called for changes and emphasized the need for kids to receive truthful information about sex.
- During the mid-term review of Healthy Iowans 2010, the state's health plan, the need for science-based practices was affirmed by the adoption of Goal 7-6: *Assure that all abstinence education, teen pregnancy prevention, and adolescent sexual health programs in Iowa are science-based and medically accurate as defined by the standards developed by the Centers for Disease Control and Prevention (CDC) by 2010.*

*Future*Net will not be undertaking this project alone. There are numerous other organizations within the state of Iowa that share the concern for science-based practices in sexual health and they are expected to become close collaborators on The Touchstones Project. Nonetheless, *Future*Net is uniquely qualified to provide key leadership:

- *Future*Net is the only organization in the state that has the mission of "supporting" a leadership network concerned with all three major areas to be addressed: adolescent pregnancy prevention, sexual health, and adolescent parenting.
- Many of the events and activities currently conducted by *Future*Net already promote the goals of The Touchstones Project.
- As a "grassroots" organization, *Future*Net already has access to many of the professionals who have the ability to implement science-based practices directly with Iowa's children and youth. Just among the Iowa Department of Human Service's Community Adolescent Pregnancy Prevention grantees served by *Future*Net, over 50,000 youth were served in FY 2004.

The Touchstones Project Outcomes:

- Conduct and publish a study identifying levels of understanding of and use of science based practices in sexual health education statewide
- Adoption of legislation to ensure medically accurate sexual health education that is informed by science-based practices
- Train 1,000 professionals statewide, working at all levels in the field of adolescent sexual health, in the use of science-based practices
- Establish a consortium, consisting of individuals, organizations, educational institutions, and state agencies, that will work together to establish clear standards of practice and lists of recommended programs
- Sponsor an annual institute on adolescent sexual health to provide continuing education opportunities to public and private school educators and counselors
- Monitor, continuously with project partners, the implementation of science-based practices in sexual health education statewide
- Reestablish Iowa as a national leader in sexual health education for our youth
- Ensure the availability of youth risk behavior data and use of rigorous evaluation strategies to inform the development of sexual health curricula and programs

How do I support The Touchstones Project?

- ***Join*** *Future*Net at www.iowafuturenet.org: Your ***FREE*** membership is the key to receiving regular updates and additional invitations to action.
- ***Share*** this paper with your colleagues and others who care about sexual health education in our state.
- ***Learn*** more about the content and quality of the sexual health education being provided to youth in your community.

SEXUAL HEALTH Touchstones MEASURES THAT MATTER

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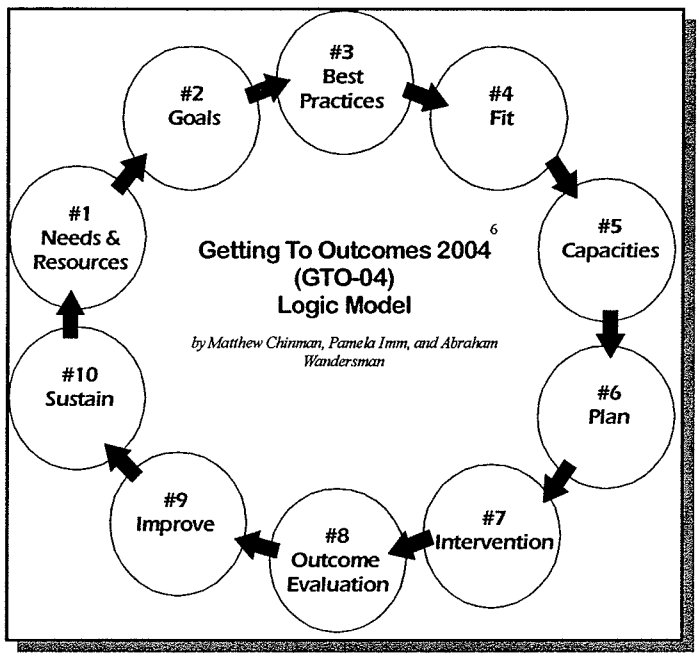
How will *Future*Net achieve the vision of The Touchstones Project?

- ***Persistently advocating*** for a professional culture that embraces a common definition of "science-based practices" for sexual health education.
- ***Effectively building*** a diverse statewide consortium of partners that will identify, establish, promote, and adhere to standards of excellence for Iowa sexual health education.
- ***Continuously encouraging*** the Iowa Legislature to require that all health education, and especially sexual health education – which includes abstinence-only education and adolescent pregnancy prevention – to be medically accurate[2] and consistent with science-based practices in both its process of development and program content.
- ***Assertively encouraging*** the development of curriculum and programs that not only reflect science-based practices but also facilitate the development of positive personal sexual ethics.
- ***Consistently training*** in and requiring use of the Getting To Outcomes 2004 logic model as a structure for designing, describing, and delivering programs.
- ***Thoughtfully establishing*** the following criteria to ensure that science-based practices become the expected norm while still being within reach for all of Iowa's sexual health education programs:
  - ***Gold Standard:*** *Implementation, with integrity, of an evidence-based, proven effective program and a detailed GTO-04 logic model to describe the replication effort.*
  - ***Silver Standard:*** *Implementation, with adaptations approved by the program developer(s), of an evidence-based, proven effective program and a detailed GTO-04 logic model to describe the replication effort.*
  - ***Bronze Standard:*** *Implementation of prevention programs that are based upon all ten of the "10 Characteristics of Effective Sex and HIV Education Programs;"[3] or implementation of community-based adolescent parent programs based upon the Child Welfare League of America's "Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents;"[4] or implementation of school-based adolescent parent programs based upon the Center for Assessment and Policy Development's 'Providing Critical Services and Supports to Teen Parents and Their Children."[5] Must also include a detailed GTO-04 logic model to describe the implementation effort.*
  - ***Innovation Stage:*** *If the program being used or being developed is innovative to the point that it doesn't quite fit any of the above standards, the GTO-04 logic still must be used to describe:*
    1. *How the best available research supports the theory and implementation strategy for the program;*
    2. *How the program's strategies link to specific outcomes;*
    3. *How Continuous Quality Improvement will be used to move the program from the Innovation Stage toward the next level.*



- ***Relentlessly asserting*** that ALL Iowa sexual health education programs can embrace the values of The Touchstones Project without compromising their distinctive messages or missions.

Touchstones of Excellence:

Accuracy: Any sexual health education provided to Iowa children and youth needs to be factual, truthful, medically accurate, and informed by the weight of available peer-reviewed research.

Accountability: All providers of sexual health education in Iowa need to voluntarily adhere to a set of standards and be willing to accept a periodic peer review of practices and program content.

Authenticity: Providers of sexual health education in Iowa will bring an integrity to their work by voluntarily utilizing science-based practices in the development of programming, employing the highest ethical standards when delivering programming, and thoughtfully promote positive sexual ethics among youth served.

Advocacy: Providers of sexual health education in Iowa will actively advocate for:

- abstinence first from any form of risky intimate sexual activity;
- age appropriate, medically accurate sexuality education for all;
- access and referral to reproductive health care and services for sexually active youth; and,
- the efficacy of contraception and condoms in reducing the risk of pregnancy and STI/HIV infection.

About *Future*Net:

*Future*Net, Inc. is the Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health. The roots of the organization are traced back to 1989, with the formation of the Pregnant and Parenting Teen Task Force by the United Way of Central Iowa. Over the next ten years, the organization, which is now *Future*Net, began to take shape ideologically, programmatically, and structurally. In 1999, ten years later, *Future*Net filed articles of incorporation as a not-for-profit organization in the State of Iowa.

Today *Future*Net has a statewide membership of nearly 200 individuals and agencies. The activities and functions of *Future*Net are various but all relate directly to its mission ***"to support within Iowa a leadership network concerned with issues of adolescent pregnancy prevention, sexual health, and parenting."*** Among those activities are:

- Publication of a quarterly newsletter, news releases, periodic email alerts, and materials related to its various programs.
- Collaboration with Solutions, Inc., a private advertising agency that is also an Iowa Department of Human Services Media Campaign grantee, in the development, promotion, dissemination, and implementation of a statewide adolescent pregnancy prevention and sexual health promotion media campaign.
- Sponsorship of an annual statewide conference that brings nationally known speakers and experts to Iowa for direct and personal interaction with health educators, case managers, social workers, and other professionals working in our fields of interest. The annual conference also provides an opportunity for local professionals and agencies to showcase innovative and successful programs and strategies.
- Participation in two national initiatives – *"Teen Pregnancy Prevention Day & Month"* (May) and *"Let's Talk Month"* (October). *Future*Net participates by encouraging members to plan special events and activities during these times to highlight the need to focus on adolescent pregnancy prevention and the importance of parent/child communication about sex. *Future*Net also identifies materials that have been developed, both locally and nationally, and helps members and friends gain access to those materials.
- Sponsorship of an annual Legislative Day to give local providers an opportunity to showcase their work at the Iowa Statehouse, meet their legislators, and give voice to issues that are critical to success in our field.
- A statewide poster and pamphlet contest for junior high and senior high age youth. Youth are invited to develop a poster and/or a pamphlet that provides positive messages to other Iowa youth about sexual responsibility, sexual health, or adolescent pregnancy prevention. Each year a winner is selected in each category and is given a gift certificate and recognition in the newsletter.
- Distribution of educational materials that have particular significance to youth and a variety of other items related to the statewide media campaign.
- Support for regional activities as coordinated by members meeting in one of five regional groups throughout the state of Iowa.

For More Information:

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FutureNet
The Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health

References

[1] Alford S., Leon J., Sugland BW. *Science-Based Practices: A Guide for State Teen Pregnancy Prevention Organizations.* Washington, DC: Advocates For Youth, 2004.

[2] The Touchstones Project defines medically accurate as, "Complete information that is verified or supported by the weight of research conducted in compliance with scientific methods, recognized as accurate, and objective by leading professional organizations and agencies with relevant expertise in the field, such as the American College of Obstetrics and Gynecologists, American Public Health Association, American Academy of Pediatrics, and published in peer-reviewed journals where appropriate; and information that is free of racial, ethnic, sexual orientation, and gender biases."

[3] Kirby, D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy.* Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2001. Kirby argues that that "the ten characteristics appear to be necessary characteristics – that is, when evaluated programs lacked one or more of these characteristics, they were typically found to be ineffective at changing behavior." (p. 91-92). The "10 Characteristics of Effective Sex and HIV Education Programs" are:

1. Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
2. Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important sexual antecedents to be targeted.
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. This appears to be one of the most important characteristics that distinguishes effective from ineffective programs.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STDs.
5. Include activities that address social pressures that influence sexual behavior.
6. Provide examples of and practice with communication, negotiation, and refusal skills.
7. Employ teaching methods designed to involve participants and have them personalize the information.
8. Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.
9. Last sufficient length of time. (Kirby stated at the 2004 NOAPPP conference that further research shows that is a minimum of 15 classroom sessions in schools and a minimum of 5 hours in community settings. Community settings can accomplish more in less time IF participation is voluntary, participants are fresh [e. g., Saturday program vs. school day], and if the program is conducted in small groups of six or less.)
10. Select teachers or peer leaders who believe in the program and then provide them with adequate training.

[4] Available from Child Welfare League of America at http://www.cwla.org/pubs/pubdetails.asp?PUBID=6894.

[5] Available from the Healthy Teen Network (NOAPPP) website at http://www.noappp.org/downloads/capd16.pdf. Also available from the Center for Assessment and Policy Development are two slightly older publications that would be useful for program developers focused on providing services to adolescent parents in a school setting: *School-Based Programs for Adolescent Parents and Their Young Children: Guidelines for Quality and Best Practice* and update overview of that publication by the same name. Both can also be downloaded from the Healthy Teen Network (NOAPPP) website.

[6] Chinman, C., Imm, P., Wandersman, A. Getting to Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation. Santa Monica, CA: The RAND Corporation, 2004. Available to download at: http://www.rand.org/publications/TR/TR101/.

Iowa

Department of Public Health

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To: Members of the Iowa Council on Human Services – July 13, 2005

Re: SFY 2007 Budget Hearing Process

The Iowa Department of Public Health reports that over 2000 Iowans, more than five each day, are injured and hospitalized annually resultant of traumatic brain injury. The Centers for Disease Control and Prevention estimates that as many as 700 each year will need ongoing or recurrent services and supports, with their current estimate being at least 55,000 Iowans living with long-term disability from brain injury.

Although Iowa's service delivery system offers a variety of options for some of these survivors, the services are often fragmented and difficult to access. While the Advisory Council on Brain Injuries recognizes the great strides that have been made in recent years to address these gaps in service, Iowa still has a long way to go before we can recognize a statewide, coordinated system of care for Iowan's with brain injury.

The Advisory Council on Brain Injuries would like to thank the Iowa DHS for its continued commitment to developing services and supports for Iowans with disability, to include those with brain injury. The Medicaid Home and Community Based Services Brain Injury Waiver utilizes almost 700 approved providers and has 972 slots available for eligible Iowans. Effective October 1, 2005 the cap for the waiver is expected to increase by 150 slots. It is hoped the $6,000,000 appropriated to eliminate the waiting lists will cover this increase. If it does not a $905,760 supplemental appropriation would be necessary to cover this. With another 150 slots available effective October 1, 2006 there will be a need for increased appropriations in SFY 2007 of approximately $905,760. Fully funding these slots will increase access to needed services and will further Iowa's compliance with the Americans with Disabilities Act, Olmstead Decision.

We request your support in legislation to be submitted this year supporting brain injury prevention efforts, making brain injury information and advocacy services more readily available, and increasing the amount of BI funded waiver slots.

The Advisory Council looks forward to working collaboratively with Iowa DHS in the next year on developing language mandated in HF 882 for implementation of county-based brain injury services. The Advisory council also looks forward to playing an active role in reconfiguring the brain injury waiver to offer enhanced access to services as dictated in HF 841.

Respectfully submitted,

Patricia Crawford
Chair, Advisory Council on Brain Injuries

THE IOWA ALLIANCE OF BOYS & GIRLS CLUBS OF AMERICA

Hearings before the Council on Human Services

July 13, 2005

INTRODUCTION

My name is Brice Oakley and I am here representing the Iowa Alliance of Boys & Girls Clubs of America. Our purpose in testifying is to suggest ways in which the Boys & Girls Clubs throughout the state can help Iowa meet its goals under the Federal Temporary Assistance for Needy Families (TANF) program.

This testimony will have served its purpose if some of you make a note during this presentation to follow-up on the ideas we can only briefly touch on today.

BOYS & GIRLS CLUBS HAVE BEEN SERVING KIDS FOR 100 YEARS

For over 100 years Boys & Girls Clubs have been places where kids age 6-18 can go every afternoon after school lets out, and throughout the summer. In our Clubs, kids enjoy guidance and mentorship from caring, trained professionals and volunteers, operating programs.

Membership in our Clubs averages $5 a year – affordable for every family.

The Iowa Alliance of local Boys & Girls Clubs is chartered by the Boys & Girls Clubs of America, itself a federally charted nonprofit organization by Act of Congress since 1906. Last year, our Clubs operated sixteen centers in communities across the state, serving nearly 6,000 regular members, and an additional 10,000 youth who came into our Clubs for special events. I have met some alumni from these programs --- names you'd recognize --- and the most often heard testimonial is "It changed my life."

Under the charter, local Clubs offer national-caliber programming developed by BGCA, and operate to the high standards of effectiveness and accountability set by the national organization. For a number of years BGCA has been nationally recognized for the high accountability for results in its programs as their low administrative cost.

BOYS & GIRLS CLUBS ARE A GOOD TANF INVESTMENT

I'd like to now focus on why we're a good investment for Iowa's TANF dollars.

Because the Boys & Girls Clubs offer life-changing opportunities and proven-effective programming to thousands of Iowa's lowest income youngsters, the Clubs are a natural vehicle for helping the Department of Human Services to make a lasting, positive impact on particularly high-need populations.

The Charitable Choice Provision of TANF allows charitable organizations such as Boys & Girls Clubs to compete as service providers if a state chooses to contract with the private sector for delivery of welfare services. In fact, more than a dozen states around the country have chosen to invest a significant portion of their TANF allocation into specific Boys & Girls Club programs. These states include North Carolina, $1,000,000; Mississippi, $1,800,000; California, $1,500,000; and Ohio, $600,000. We can provide specifics as to the effectiveness of those programs in other states. Our outcomes-based accountability standards and reports are second to none.

BOYS & GIRLS CLUBS AS AN IMPORTANT TANF PARTNER

As you structure the TANF budget for FY 2007, please consider including a line item for investment in the Iowa Alliance of Boys & Girls Clubs of America. We would propose a program designed to address five key areas of concern in Iowa:

1. Preventing teen pregnancy and out-of-wedlock births. BGCA's SMART Moves, Passport to Manhood, SMART Girls, and Keystone Club Leadership programs, have been proven to give young people the skills they need to avoid premature sexual activity. TANF could be used to fund those programs in Clubs throughout the State.

2. Job and College Readiness. BGCA's education and career training programs have been demonstrated to help kids stay in school, get better grades, and move with confidence and skills into their post-secondary education or career. Specifically, TANF could be used to fund Project Learn – BGCA's educational enhancement program, the TEENSupreme Career Prep Program, technology training through CLUBTech and Operation Connect, and a new College Prep program designed in partnership with the College Board, the company that administers the SAT.

3. Drug and alcohol abuse. Early use of drugs and alcohol are leading contributors long-term welfare dependency, as well as a host of behavioral and emotional problems. TANF could be used to fund SMART Moves, which has been proven effective in reducing drug and alcohol use. The Iowa Alliance has just applied to the Iowa Department of Public Health for a grant under legislation approved this past session to bring substance abuse prevention skills to over 1,000 kids across Iowa.

4. Feeding and nutrition. Every Iowa Alliance Club offers members a snack in the afternoons, and many provide full meals in their own kitchens. TANF could be used to fund the creation or enhancement of food service programs, allowing Clubs to reach out to those kids in their communities that are not eating, enroll them into the Club and feed them.

5. Providing opportunity in underserved communities. Despite being the largest provider of after-school youth development services in Iowa, the Boys & Girls Clubs serve only a fraction of the kids who could benefit from our services. TANF could be used to fund outreach programs to enroll new members in existing Clubs, and create new Club branches and organizations in communities where they do not currently exist. And it can be used to help provide transportation, giving more kids access to our Clubs. The more youth we serve, the fewer will find their way onto Iowa's welfare rolls.

BOYS & GIRLS CLUBS ARE READY TO TAKE THOSE NEXT STEPS

Although our professional staff and volunteers have worked in the field for many years with the department's staff, this is the first time the Iowa Alliance has asked to become an important statewide partner with the Department of Human Services. If you would like to explore further these and other opportunities, please ask Director Concannon and his staff to sit down with us, examine the possibilities, and then design the appropriate criteria needed to extend the reach of TANF funding into our communities.

Iowa has a rare window of opportunity right now to take some innovative steps. It is time we joined hands in that effort.

Brice Oakley
Avenson, Oakley & Cope Consulting
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Iowa Association of
Homes & Services
for the Aging

Statement
By Dana Petrowsky, President/CEO
Iowa Association of Homes & Services for the Aging

Iowa Council on Human Services
Wednesday, July 13th, 2005
Des Moines, IA

Since 1964, the Iowa Association of Homes and Services for the Aging has represented providers of high quality healthcare, housing and services for seniors. Our faith-based, mission-oriented and community-sponsored members number 183 nonprofit nursing facilities, continuing care retirement communities, senior housing, residential care facilities, assisted living facilities, and community service providers. Our mission is to inspire leadership and benevolence in our members through networking, education, information and advocacy.

Supporting the DHS Mission

The State of Iowa has committed to assure care for low-income frail and elderly through the Medicaid program. Our members are committed to providing quality care. For years, residents who pay for their care privately have had to take on some of the burden of caring for the Medicaid residents to ensure the level of quality care demanded by federal regulations was provided.

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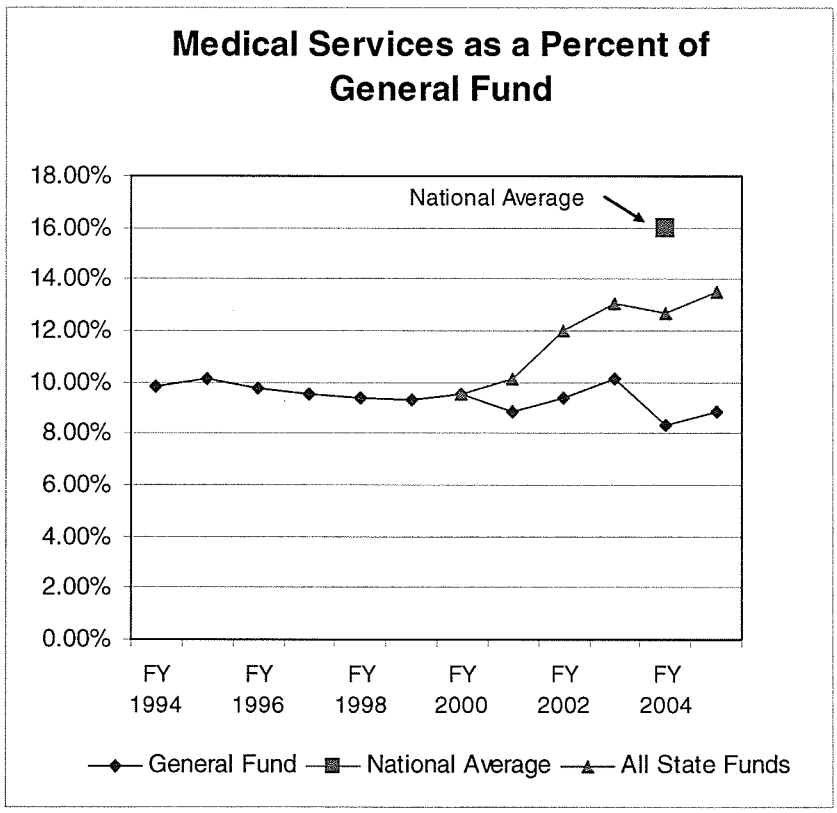
In state fiscal year 2004, Iowa spent only 8% of general fund revenue on Medicaid services versus the national average of 16%. This is problematic in that the State of Iowa has the highest percentage of people over 85 years of in the United States, the second-highest percentage of residents 65 and over. As a result the State of Iowa faces an increased demand for elderly care services. Provider rate cuts this next fiscal year would have a disastrous effect on long-term care services for Iowa's 14,000 + frail and elderly Medicaid nursing residents.



Prepared by the Legislative Service Agency

Funding the System

- **Tobacco Tax.**

We support an increase in the tobacco tax to help alleviate the strain of the Medicaid budget.

- **Assisted Living Support.**

Iowa needs a Medicaid Waiver for Assisted Living services which is simple, easy to access and offers adequate reimbursement to encourage providers to offer the service. House File 617 as signed by the Governor requires that DHS request from CMS a waiver to add assisted living service to the HCBS elderly waiver. We support the development of an assisted living vendor payment based on a **"tiered rate"** structure which would more accurately reflect the costs of care to fairly reimburse assisted living programs for the services.

- **Home and Community-Based Services Support.**

A payment system which reflects more closely actual costs for all home and community-based alternatives and services would facilitate more services being provided in less expensive settings. We support a plan that puts money into the continuum of services, including assisted living and adult day programs, in addition, Continuing Care Retirement Community (CCRC) type services, and demonstrations of such programs as PACE and "cash and counseling" should be expanded to Medicaid recipients.

Preserve the "Safety Net"

However, in funding home and community based services, the Department must not compromise the safety net provided by nursing homes for the most needy and vulnerable population. Iowans currently have access to nursing home services within access to their homes through out Iowa. This allows continued contacts with family and friends.

We support full implementation of the case mix reimbursement methodology for nursing facilities without reductions as is currently the case with no inflation allowance. It has created and supported the safety net for the frail elderly while assuring the dollars went for care.

Funding the "Safety Net"

According to the 2004 International Journal of Health Care Finance and Economics, *"A Longitudinal Study of Medicaid Payment, Private-Pay Price and Nursing Home Quality"* any further reduction in the nursing facility case-mix reimbursement rate would have a detrimental effect on the frail elderly population that is served. The Medicaid rate is an important policy instrument towards addressing the quality of care in nursing facilities. The results of recent studies imply that cuts in Medicaid nursing home spending will come at the expense of lower quality. It is essential that the Council on Human Services not forget the most vulnerable frail population served in a nursing facility.

Medicaid recipients who reside in skilled nursing facilities must continue to receive financial assistance which is reflective of costs. The modified price-based case-mix

reimbursement system (case-mix) enacted by the Iowa General Assembly in 2001 has never been fully implemented. The Iowa General Assembly used a phase-in period of three years; a view of the history shows the nursing facility rate under the case-mix payment system has not been realized.

The attachment will show the history of the phase-in of the case-mix reimbursement. It shows the Medicaid payment for nursing facilities was not allowed to be fully rebased and full implementation of the case-mix system for nursing facilities never occurred.

Furthermore, by design, the case-mix system only allows just over one-half of nursing facilities to receive its costs. Under the case-mix system, nursing facilities receive 120% of median of case-mix adjusted costs for the direct-care component and 110% of median of non-case-mix adjusted costs for nondirect care.

The case-mix reimbursement system has two important features. It encourages nursing facilities to spend the limited resources in the areas that benefit residents, while also promoting economy and efficiency. It also provides incentives to encourage quality of care, enhance quality of life for residents and increase access to appropriate care.

Unfortunately, due to the State of Iowa budget the case-mix system has not been fully implemented. Obviously the nursing facilities have not seen lower costs. The costs of care is increasing significantly, including "big-ticket" costs such as pharmaceutical and

other medical supplies, general and professional liability insurance, natural gas and employee health insurance. Other demands are proposed increased fines, proposed requirement of sprinkler systems in all nursing facilities and a potential increase in property taxes.

We stand ready to work with you and the Department as we move forward together to serve Iowa dependent elderly population.

Thank you!

Iowa Association of Homes & Services for the Aging

ATTACHMENT TO:

Statement
By Dana Petrowsky, President/CEO
Iowa Association of Homes & Services for the Aging
Iowa Council on Human Services
Wednesday, July 13th, 2005
Des Moines, IA

HISTORY OF PHASE IN NURSING FACILITY CASE-MIX REIMBURSEMENT SYSTEM

Historically, the State match for the Medicaid Program was funded by the State General Fund. Economic conditions over the past four years have resulted in a large increase in the Medicaid caseload nationally, and in Iowa. In addition, increases in medical costs, particularly prescription drugs, have increased expenditures in the Program.

Beginning in FY 2001, other State funding sources were used to offset the State General Fund cost (see **Table 1 –** created by the Legislative Service Agency). The shift has grown over time; in FY 2005, the total State appropriation is $568.2 million, of which $361.4 million is from the General Fund and $206.8 million is from other funds.

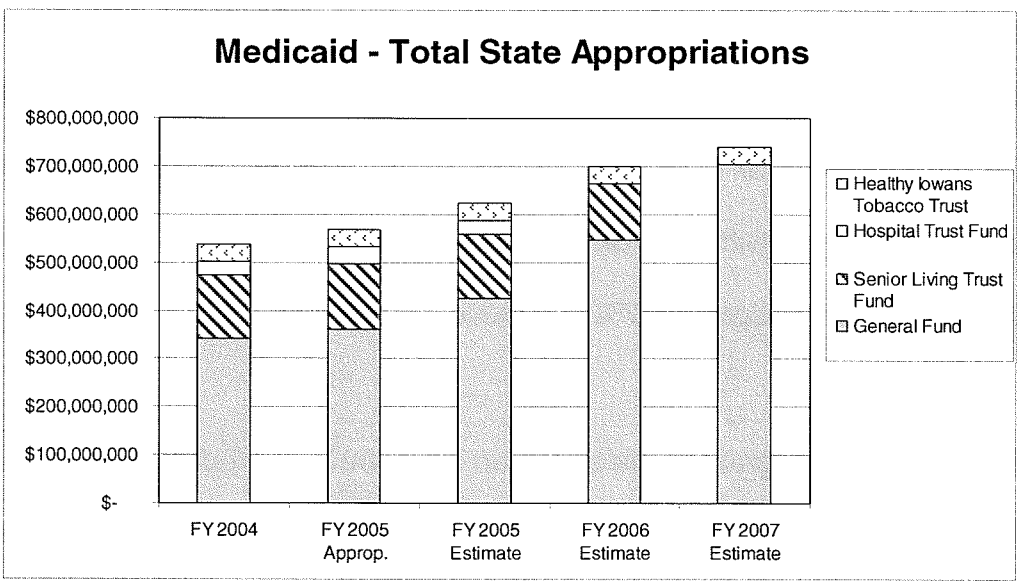


Table 1

1701 48th Street, Suite 203, West Des Moines, Iowa 50266-6723
515/440-4630 Fax 515/440-4631 website: www.ageiowa.org email: iahsa@ageiowa.org

Representing not-for-profit health care, housing and service providers

State Fiscal Year 2001.

Also in 2001, SF 2193, the Iowa Senior Living Program Act, passed directing the Department of Human Services to implement a case-mix reimbursement methodology for Iowa's nursing facilities and skilled nursing facilities beginning July 1, 2001.

State Fiscal Year 2002.

The first year of a phase-in 66.67% of Nursing Facility Rate was based on the "old flat rate" system and 33.33% was computed using the new case-mix system

State Fiscal Year 2003.

The second year of the phase-in 33.33% of Nursing Facility Rate was based on the old system and 66.67% was computed using the case-mix system.

State Fiscal Year 2004.

Full implementation of the case-mix reimbursement methodology was to occur. However, House File 619 capped the Medicaid nursing facility budget at **$147,252,856.** The DHS projected nursing home expenditures after the required bi-annual rebasing and accounting for the HCFA/SNF inflation index for SFY 2004 would be $159,761,234 resulting in a shortfall of funds. Therefore, in order to comply with HF 619, the DHS adjusted the inflation factor of the case-mix rate calculation for each provider by -6.7% to remove the shortfall.

However, the US Congress granted the states an increase in the federal matching payments of 2.95% for the last two quarters of Federal Fiscal Year (FFY) and the first three quarters of FFY 2004. This one time money which has been made available to the state amounted to around

$47,000,000 in savings of state dollars from the Medicaid budget. The DHS calculations for SFY 2004 were based on the old federal matching rate and do not recognize the new rate. Therefore, the $47,000,000 was available to DHS to "fill" any Medicaid shortfall.

The nursing home profession worked with the DHS to show how the projected expenditures, because of the increased federal matching rate, would not be as much as projected. The DHS compromised and cut the reduction in the inflation factor of nursing facilities by -3.44% instead of -6.7 %.

The actual state dollars spent in State Fiscal Year 2004 was **$140,782,975.** If it were not for the federal fiscal relief of the increase in FMAP, according to the Legislative Services Agency, the state spending on the Medicaid nursing facility budget would have been **$149,003,919.**
The DHS also initiated "Savings Options" for the Medicaid nursing facility budget in SFY 2004:

1. The "hold harmless" provision was phased out. The "hold harmless" provision provided that a facility in SFY 2002 and 2003 received a lower daily rate under the new system than they received under the old flat rate system, plus they received an inflation adjustment. This was done to give those facilities time to adjust their business to the new system which pays on the basis of the acuity of the residents.
2. The required minimum occupancy under the case mix was increased from 80% to 85%.
3. DHS eliminated the co-payment made by DHS for Medicare beneficiaries who are also eligible for Medicaid for services received as a Skilled Nursing patient.
4. DHS reduced the bed-hold payment factor from 75% to 42% of the established Medicaid rate for all nursing facilities eligible for bed hold payments.

5. DHS eliminated the payment of services for dual eligibles for skilled nursing services; therefore nursing facilities had to become Medicare certified, not get payment for services, or not admit dual eligibles.

State Fiscal Year 2005.

House File 2298 capped the Medicaid nursing facility budget at **$156,013,248.** According to the Legislative Service Agency, based on data through May, 2004 the estimated State Medicaid Nursing Facility expenditures are at $155,468,422.

House File 2298 also implemented another "savings option" by adjusting the ceilings for the excess payment allowance from 100% to 50% on the direct care side and from 65% to 32.5% on the non-direct care side.

State Fiscal Year 2006.

The Case-Mix Reimbursement System includes a provision to rebase the Medicaid rates using the most current cost data every other year. The next rebase is scheduled to occur in State Fiscal Year 2006 for the nursing facility Medicaid rates effective July 1, 2005.

House File 825 capped the Medicaid nursing facility budget at **$161.6 Million.** The Legislative Service Agency estimates rebasing would increase the nursing facility line-item by 5.3%. The cap is a 3.5% increase. House File 825 provides another "savings option" by eliminating the remaining "excess payment allowance" from for both direct care and non-direct care.

MEMORANDUM

To: The Council on Human Services
From: State Child Care Advisory Council
Re: Recommendations to Redesign the Child Care Subsidy Co-payment schedule
Date: July 13, 2005

I am here today representing the State Child Care Advisory Council. Our chair has her Corporate Board meeting today and thus is unable to be present. This statement has been reviewed and approved by members of the Executive Committee of SCCAC.

There are two items we wish to bring to your attention.

First, we wish to express our appreciation to the General Assembly, to you and the Department's staff for the progress that was made on child care issues in the 2005 General Assembly:

Increasing the eligibility level for child care assistance,
Increasing child care provider's rates,
Funding a Quality Rating System.

These are all positive steps. But along with our thanks we present a challenge. More needs to be done. SCCAC is looking into how best to address a number of barriers to increasing the quality of child care that providers and policy makers on the council have identified. These barriers include:

Excessive Red Tape
Lack of Trained Providers
Lack of Mandatory Registration
Low Regulations
Low Reimbursement Rates
A clear understanding of what high quality child care looks like.

Secondly, is our recommendation to redesign the child care subsidy co-payment schedule. The State Child Care Advisory Council on February 10, 2005, unanimously approved five recommendations:

1. Continue the current policy to start co-payments at 100% of poverty.

2. Make adjustments in co-payments in light of the number of children receiving care.
   - Base family co-payment will be calculated for two children in care.
   - Family co-payment will be reduced for a family with one child in care and increased for families with three or more children in care.
   - The maximum family co-payment will be based on three children receiving care.

3. Reduce current sliding fee scale minimum from 50 cents per unit to 20 cents per unit.
    - Full-time care for a family with one child equals $8.00 per month.

4. Certify per unit co-payment every twelve months rather than every six months. This means that payments will not change within a 12-month period, regardless of changes in family income.
    - A right of review within this period may be requested by the household.

5. Adopt the attached fee schedule.
    - Move to a formula based fee when DHS has the computer system needed. (Note: DHS feels they cannot use a formula based fee scale at this time since it causes too much disruption in their network when it is shared across servers.)

Attached you will find the attached fee schedule which we recommend you adopt. You will also find a copy of the statement concerning our rationale which was submitted to the department staff. It includes moving to a percentage based formula when your new computer system is in place. We have been told that the department cannot administer this formula until then. We accept that position, but feel that the implementation of our recommendations should not wait until the new system is in place.

We trust that at one of your near future meetings, you will place this item on your agenda and hopefully at that time adopt these recommendations.

	HH size										Number of kids in care						
											Unit	Unit	Unit	Monthly	Monthly	Monthly	
	1	2	3	4	5	6	7	8	9	10	fee	fee	fee	fee	fee	fee	
	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1	2	3+	1	2	3+	
A	$737	$989	$1,241	$1,492	$1,744	$1,996	$2,248	$2,499	$2,751	$3,003	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
	1%	2%	2%	2%	2%	1%	1%	1%	1%	1%							
B	$776	$1,041	$1,306	$1,571	$1,836	$2,101	$2,366	$2,631	$2,896	$3,161	$0.20	$0.45	$0.70	$8.00	$18.00	$28.00	
	2%	3%	3%	2%	2%	2%	2%	1%	1%	1%							
	$798	$1,070	$1,343	$1,615	$1,887	$2,160	$2,432	$2,705	$2,977	$3,250	$0.45	$0.70	$0.95	$18.00	$28.00	$38.00	
	3%	3%	3%	3%	2%	2%	2%	2%	2%	1%							
C	$819	$1,099	$1,379	$1,659	$1,939	$2,219	$2,498	$2,778	$3,058	$3,338	$0.70	$0.95	$1.20	$28.00	$38.00	$48.00	
	5%	4%	4%	3%	3%	3%	2%	2%	2%	2%							
	$842	$1,130	$1,418	$1,705	$1,993	$2,281	$2,568	$2,856	$3,144	$3,431	$0.95	$1.20	$1.45	$38.00	$48.00	$58.00	
	6%	5%	5%	4%	3%	3%	3%	2%	2%	2%							
D	$865	$1,161	$1,456	$1,752	$2,047	$2,343	$2,638	$2,934	$3,229	$3,525	$1.20	$1.45	$1.70	$48.00	$58.00	$68.00	
	7%	6%	5%	4%	4%	3%	3%	3%	2%	2%							
	$890	$1,193	$1,497	$1,801	$2,105	$2,409	$2,712	$3,016	$3,320	$3,624	$1.45	$1.70	$1.95	$58.00	$68.00	$78.00	
	7%	6%	6%	5%	4%	4%	3%	3%	3%	2%							
E	$914	$1,226	$1,538	$1,850	$2,162	$2,474	$2,786	$3,098	$3,410	$3,722	$1.70	$1.95	$2.20	$68.00	$78.00	$88.00	
	8%	7%	6%	5%	4%	4%	3%	3%	3%	3%							
	$939	$1,260	$1,581	$1,902	$2,223	$2,543	$2,864	$3,185	$3,506	$3,827	$1.95	$2.20	$2.45	$78.00	$88.00	$98.00	
	9%	8%	7%	6%	5%	4%	4%	3%	3%	3%							
F	$965	$1,295	$1,624	$1,954	$2,283	$2,613	$2,942	$3,272	$3,601	$3,931	$2.20	$2.45	$2.70	$88.00	$98.00	$108.00	
	10%	8%	7%	6%	5%	4%	4%	4%	3%	3%							
	$992	$1,331	$1,670	$2,008	$2,347	$2,686	$3,025	$3,363	$3,702	$4,041	$2.45	$2.70	$2.95	$98.00	$108.00	$118.00	
	11%	9%	7%	6%	5%	5%	4%	4%	3%	3%							
G	$1,019	$1,367	$1,715	$2,063	$2,411	$2,759	$3,107	$3,455	$3,803	$4,151	$2.70	$2.95	$3.20	$108.00	$118.00	$128.00	
	11%	9%	8%	7%	6%	5%	4%	4%	4%	3%							
	$1,048	$1,405	$1,763	$2,121	$2,478	$2,836	$3,194	$3,552	$3,909	$4,267	$2.95	$3.20	$3.45	$118.00	$128.00	$138.00	
	12%	10%	8%	7%	6%	5%	5%	4%	4%	3%							
H	$1,076	$1,444	$1,811	$2,179	$2,546	$2,913	$3,281	$3,648	$4,016	$4,383	$3.20	$3.45	$3.70	$128.00	$138.00	$148.00	140%Max
	12%	10%	8%	7%	6%	5%	5%	4%	4%	4%							
	$1,106	$1,484	$1,862	$2,240	$2,617	$2,995	$3,373	$3,751	$4,128	$4,506	$3.45	$3.70	$3.95	$138.00	$148.00	$158.00	
	13%	10%	9%	7%	6%	5%	5%	4%	4%	4%							
I	$1,136	$1,524	$1,912	$2,301	$2,689	$3,077	$3,465	$3,853	$4,241	$4,629	$3.70	$3.95	$4.20	$148.00	$158.00	$168.00	
	14%	11%	9%	8%	6%	6%	5%	4%	4%	4%							
	$1,168	$1,567	$1,966	$2,365	$2,764	$3,163	$3,562	$3,961	$4,360	$4,758	$3.95	$4.20	$4.45	$158.00	$168.00	$178.00	
	14%	11%	9%	8%	7%	6%	5%	5%	4%	4%							
J	$1,200	$1,610	$2,020	$2,429	$2,839	$3,249	$3,659	$4,068	$4,478	$4,888	$4.20	$4.45	$4.70	$168.00	$178.00	$188.00	
	14%	11%	10%	8%	7%	6%	5%	5%	4%	4%							
	$1,234	$1,655	$2,076	$2,497	$2,919	$3,340	$3,761	$4,182	$4,604	$5,025	$4.45	$4.70	$4.95	$178.00	$188.00	$198.00	
	15%	12%	10%	8%	7%	6%	5%	5%	4%	4%							
K	$1,267	$1,700	$2,133	$2,565	$2,998	$3,431	$3,864	$4,296	$4,729	$5,162	$4.70	$4.95	$5.20	$188.00	$198.00	$208.00	
	15%	12%	10%	8%	7%	6%	5%	5%	4%	4%							
	$1,303	$1,748	$2,192	$2,637	$3,082	$3,527	$3,972	$4,417	$4,861	$5,306	$4.95	$5.20	$5.45	$198.00	$208.00	$218.00	
	16%	12%	10%	8%	7%	6%	6%	5%	5%	4%							
L	$1,338	$1,795	$2,252	$2,709	$3,166	$3,623	$4,080	$4,537	$4,994	$5,451	$5.20	$5.45	$5.70	$208.00	$218.00	$228.00	175% Max
	15%	12%	10%	8%	7%	6%	6%	5%	5%	4%							
M	$1,438	$1,895	$2,352	$2,809	$3,266	$3,723	$4,180	$4,637	$5,094	$5,551	$5.45	$5.70	$5.95	$218.00	$228.00	$238.00	

MEMORANDUM

To: Julie Ingersoll
From: Sliding Fee Scale Committee
Re: Rationale
Date: March 22, 2005

The Committee recommendations, which were unanimously approved by the State Child Care Advisory Council, were based on (a need) or (our desire) to improve the current child care subsidy and the need to address problems in the current system.

The problems identified by subsidy participants and programs, as well as an analysis by the ad hoc "process committee" included:

1. The current child care co-payment structure does not provide a fair cost to households with different numbers of children. Households with one child pay as much as households with two or more children receiving child care.
2. The child care subsidy procedure of verifying income every six months does not match some other programs that serve low income households.
3. The current subsidy rate structure includes three "cliffs" that created *de facto* disincentives for households using child care subsidy when their salaries push them off the cliff. The first cliff occurs when a small increase in income triggers the payment of co-payments. The second cliff occurs when an increase in income triggers a rise in the co-payment resulting in a net decrease in income. The third cliff occurs when a small increase in income makes one ineligible for child care assistance. We were able to address the first two cliffs. Seeking to be budget neutral we were unable to address the third cliff.

Background:
At the August 12, 2004 meeting of the State Child Care Advisory Council (SCCAC) council chair, Kathy Sorrell reported that the Council on Human Services had requested that the SCCAC report back to them after the sliding fee scale had been reviewed by staff and the SCCAC.

At the August meeting a "process committee" was appointed to develop a formal proposal to address the issues above and then make recommendations back to the Council. The first issue the committee addressed was how big a problem the beginning cliff and the small cliff factors were. It was the feeling of the committee, based on what they had heard from consumers, that the present system could be improved.

In its deliberations, a number of options for adjusting the variables of the subsidy system were enumerated. The committee sought feedback from the rest of the Council on these issues through a survey and had an extended conversation with Council members during the October 14th Council meeting.

In subsequent meetings, the committee drafted five recommendations based on the input from the Council members and with the data provided to us, we developed a set of recommendations that we believe will enhance the current system. These recommendations were submitted to the Council at its February 10, 2005 meeting. The Council unanimously approved these recommendations.

The committee is most appreciative of the assistance that Mark Adams provided. All on the committee felt a real partnership as we worked together.

In our report you find our rationale for each of our recommendations.

Recommendation # 5 was to use the chart developed by Mark Adams and move to a formula based fee when DHS has the computer system needed. The formula basis would allow for a DHS worker to enter the number of persons in the household and the household income and the computer program would then generate a per unit cost based on the number of children receiving care. The formula developed by Mark Adams was:

Poverty Level	One child	Two	Three Plus
100 – 109	16%	18%	20%
110 – 119	18%	20%	22%
120 – 129	20%	22%	24%
130 – 139	22%	24%	26%
140 – 149	24%	26%	28%
150 – 159	25%	27%	29%
160 – 169	26%	28%	30%
170 - 175	27%	29%	31%

All of our recommendations were based on the desire to enhance the present system. We believe that these recommendations connect to make the system fairer and more user-friendly.

Iowa Osteopathic Medical Association

IOMA

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July 13, 2005

Ruth L. Mosher, Chair
Council on Human Services
1305 E. Walnut Street
Des Moines, IA 50309

Dear Ms Mosher:

The Iowa Osteopathic Medical Association wishes to thank you on behalf of its members for the invitation to participate in the SFY 2007 budget process.

True solutions to Medicaid funding will require imagination, innovation and cooperation. While the funding of the coming fiscal year looms large, it is important to look at solutions that address the fundamental problems of the program. In many cases, focusing on only the next fiscal year actually compounds the problems that will need to be addressed in the long term.

Ultimately, every solution proposed must be evaluated in the light of two questions; "What will be the impact on the health of the patient?" and "What will be the future financial impact on the program?" Again this requires a long-term view of the problem at hand. While some solutions may decrease immediate expenditures, they may also decrease the health of the individual patient. This will ultimately mean spending even more money in the following years.

It is with these thoughts in mind that we respectfully submit the following discussion and recommendations for your consideration.

#1- Significantly expand the OTC formulary which recipients may directly purchase, and encourage the use of these remedies prior to any ER and /or office visits for minor illnesses.

#2- Work with the Federal authorities to obtain a waiver to reduce the frequency of ICF nursing home visits from every other month to four times per year (quarterly). This would cut two nursing home visits per year, and still provide safe and responsible care to this population.

#3- Pay for all appropriate medications without a formulary, which ultimately increases long-term costs. In order to control pharmaceutical costs, payment should be limited to the cost of the medication to the pharmacy, plus an appropriate handling or dispensing fee.

#4- Reduce emergency room utilization by implementing any or all of the following:

a) allow physicians and/or hospitals to charge an immediate co-pay if any patient presents to the ER for a non-emergent condition
b) create an incentive program for physicians to expand office hours and, therefore, reduce reliance on the ER for after hours care
c) reimburse physicians ER visits at the office visit rate for any non-emergent visit
d) encourage adherence to the MediPass guidelines and not allow any ER visit without the pre-approval of the personal physician
e) reduce the threat of EMTALA violations when physicians are trying to appropriately manage patients care

#5- Make recipients responsible for their health care choices. It is well documented that a first dollar or "cart blanche" health care system is prone to abuse. The Medicaid system should explore the possibility of establishing a medical savings account program for all primary health care and make the patient the beneficiary of the program when well managed.

In addition to the above cost saving measures, IOMA wishes to submit some additional ideas, which we feel ultimately need attention. While we realize that many of these items will require an upfront investment, we feel that the long term gain and efficiency will be worth the upfront costs. We feel it is only right to provide you with our suggestions on long-term solutions to eliminate future funding crises.

Of course, this Association stands ready to provide representation to any task force, or working group, which the Department of Human Services, Governor, or Legislature establishes to address long term Medicaid solutions.

Sincerely,

Leah J. McWilliams, CAE
Executive Director

Executive Summary

The Iowa Osteopathic Medical Association, on behalf of the over 800 osteopathic physicians practicing in Iowa, is pleased to have the opportunity to offer these comments on the current Medicaid crisis.

We respectfully submit the following recommendations. Please see full document for discussion and rationale for these recommendations.

- We recommend that Title XIX eligibility carry mandatory training in consumer economics.
- We recommend that the State explore innovative solutions to this issue.
- We recommend the State study the financial and health impact of providing economic incentives for clinics, particularly those in rural areas, to offer extended office hours.
- We recommend that the State streamline procedures for signing up for the various programs.
- We recommend additional training for DHS staff so that they may better match patients with the programs that will be of the most benefit.
- We recommend that the State explore ways to make DHS services more available.
- We recommend that treatment of mental illness and substance abuse be reimbursed at a level that is on parity with all other Title XIX reimbursement services.
- We recommend that the PDL being developed have considerable physician input to avoid increasing total cost of care and utilization.
- We recommend that the primary factor in the selection of pharmaceutical agents being placed on the PDL be the beneficial affect they have on the patient's health.
- We recommend that the State develop systems and programs designed to maximize the use of out-patient facilities and minimize the inappropriate use of the emergency department.
- We recommend that the State consider the impact on access to care when setting provider reimbursement rates.
- We recommend that the State continue to provide access to diagnostic services and that the State consider the impact on access to these services when setting reimbursement rates.
- We recommend that dental care continue to be a covered service.
- We recommend that the process for becoming a Medicaid DME supplier be streamlined
- We recommend that payment rates for DME supplies provided through the physicians office be adequately and fairly reimbursed.
- We recommend that hospital reimbursement be set at a level that is at least equal to Medicare reimbursement.
- We recommend that the State set long term care facility reimbursement rates at a level that adequately and fairly compensates facilities for the cost of providing services.
- We recommend that the Elderly Waiver Program be expanded in an effort to provide lower cost patient preferred care.
- We recommend that the State continue its efforts to enroll all eligible patients in this program.

- We recommend the Spend-Down Program be reviewed with an eye toward more realistic calculation of expected spend-down requirements.
- We recommend that the State, through the Iowa DHS and our elected representatives actively participate in the House Task Force on Medicaid Reform review process.
- We support the implementation of an additional tax on cigarettes with all proceeds going to offset the healthcare costs related to the use of tobacco.
- We recommend that the State engage **all** stakeholders in an **ongoing** dialog to find solutions to the funding and operational challenges facing the Medicaid program.
- We recommend that the State work with our elected officials in Washington to allow expansion of the use of co-pays.
- We recommend the State work with providers to implement on-line real-time eligibility checking.
- We recommend the State explore the use of magnetic encoded eligibility cards similar to what is currently being done with food stamps.
- We recommend the State develop policies that encourage patients to utilize appropriate self-care.
- We recommend that the term "fraud" be used only to describe activity where there was a clear intent to obtain payment for a service or product that was not provided or medically necessary.
- We recommend that coding requirements be simplified and that the State adopt coding policies and practices that are in compliance with industry standards.
- We recommend that those providers who truly commit fraud be prosecuted to the full extent of the law.
- We recommend that the contract with Iowa Health Solutions be terminated.
- We recommend the State fully adopt CPT and ICD-9 coding and avoid the use of "local codes" and exceptions to standard coding.
- We recommend that the State require the Title XIX fiscal intermediary to process and pay claims in compliance with Iowa insurance regulations.
- We recommend that the State continue to expand the use of Medicaid HMOs.
- We recommend that provider reimbursement rates be set in compliance with the Code of Iowa Section 249A.20.
- We recommend that payments be made to providers not less than twice monthly.
- We recommend that the State work with our elected officials in Washington DC to make changes to the EMTALA to end this abuse.
- We recommend that the State recognize the growing medical liability insurance crisis in Iowa.
- We recommend that the legislature enact and the Governor sign meaningful tort reform during the next legislative session.
- We recommend that the State indemnify physicians for any claims arising from the treatment of Medicaid patients.
- We recommend that the State view Medicaid reform as an ongoing process rather than a one time fix.
- We recommend that the State evaluate the impact of all proposed solutions on the global cost of care.

- We recommend that the State work with providers and the federal government to develop, implement and fund information sharing technologies.

We recognize that some of these recommendations may not have the immediate desired fiscal impact. However, we believe that in the long term, each of these recommendations will have a positive effect on the health of Iowans receiving Medicaid assistance. Clearly this is in the best interest of the patient, the physician, and the State. A healthier population requires less money to care for and that will improve the financial health of the Medicaid system.

ELIGIBILITY

Eligibility reform is needed. Our physicians regularly report treating patients on Medicaid who from all outward appearances have jobs and sufficient financial resources to provide for their own care. Conversely, physicians also report extreme frustration in trying to provide care to patients who have been denied Medicaid coverage but appear to qualify. Many Title XIX patients make poor economic decisions that deepen their dependence on Title XIX care. While we recognize that in many respects the federal government sets eligibility criteria, the State should evaluate eligibility criteria as well.

- We recommend that Title XIX eligibility carry mandatory training in consumer economics.

ACCESS TO SERVICES

Medical

Generally in Iowa, medical services are available. In some rural areas, shortages still exist. Lack of transportation continues to be a major impediment to patients trying to access healthcare services. This leads to increased utilization of ER services because patients either wait too long to seek care or because they must rely on others who are only available after normal clinic hours for transportation

- We recommend that the State explore innovative solutions to this issue.
- We recommend the State study the financial and health impact of providing economic incentives for clinics, particularly those in rural areas, to offer extended office hours.

DHS Offices

DHS offices are at times difficult to locate and particularly in rural areas difficult for some people to get to. While some forms and services are available on-line, many Medicaid patients lack computer equipment or access to the world-wide-web. Patients often report getting conflicting information from DHS staff. Many patients have commented to our physicians on the limited county DHS office hours. Rules for various programs are confusing and difficult for many patients to understand. DHS staff themselves seems confused as to which program is best for a particular patient. Our physicians report patients with specific needs being signed up for a program that doesn't provide access to the very care they need.

- We recommend that the State streamline procedures for signing up for the various programs.
- We recommend additional training for DHS staff so that they may better match patients with the programs that will be of the most benefit.
- We recommend that the State explore ways to make DHS services more accessible.

SERVICES

Mental Health/Substance Abuse

Finding timely psychiatric care for Title XIX patients is extremely difficult. While family physicians provide significant amounts of psychiatric care, many Title XIX patients require the expertise of a trained psychiatrist. When psychiatric services are available, the doctor is often located a significant distance away from the patient. We have recently learned that a major central Iowa mental health facility is no longer accepting Title XIX patients. Clearly this creates a serious access problem. The driving issue in this area is the grossly inadequate reimbursement. While mental health and substance abuse patients consume considerable healthcare resources, failing to appropriately treat these patients has even greater consequences including increased rates of suicide, crime, domestic violence, and healthcare costs.

- We recommend that treatment of mental illness and substance abuse be reimbursed at a level that is on parity with all other Title XIX reimbursement services.

Pharmaceuticals/Drug Prior Authorization

The current Drug Prior Authorization Program is inefficient. The cost of administration plus repeat clinic visits and hospitalizations clearly exceeds any savings derived from the program. We applaud the efforts of the State to address this through the development of a Preferred Drug List (PDL). While this approach to curbing pharmaceutical costs may decrease drug acquisition costs, the potential exist to increase costs due to drug failures.

- We recommend that the PDL being developed have considerable physician input to avoid increasing total cost of care and utilization.
- We recommend that the primary factor in the selection of pharmaceutical agents being placed on the PDL be the beneficial affect they have on the patient's health.

Outpatient/Clinic Services

Clinic based primary care is the most efficient care delivery system. The Title XIX Program should utilize programs and strategies that maximize the use of outpatient primary care clinics. Unfortunately, the current system does nothing to encourage the use of outpatient clinics or discourage the inappropriate use of the emergency department. Unnecessary ER visits should actively be discouraged.

The current Title XIX reimbursement rates fail to cover the cost of providing services. Reasonable reimbursement rates are essential to maintaining an adequate number of physicians willing to serve the Title XIX population. Physicians are no longer able to cost shift the losses incurred in caring for Title XIX patients. Inadequate Title XIX payment rates threaten the financial viability of many clinics. While physicians want to help ALL patients, inadequate Title XIX payments lead clinics to limit or stop seeing Title XIX patients.

- We recommend that the State develop systems and programs designed to maximize the use of outpatient facilities and minimize the inappropriate use of the emergency department.
- We recommend that the State consider the impact on access to care when setting provider reimbursement rates.

Lab/X-ray

Access to diagnostic services is essential for the establishment of a diagnosis and the initiation of treatment. No physical or economic barriers should exist to inhibit or discourage the appropriate use of diagnostic testing.

- We recommend that the State continue to provide access to diagnostic services and that the State consider the impact on access to these services when setting reimbursement rates.

Dental

While considered an optional service, dental care is essential to the health and well being of patients. Solutions must be found that encourage dentist to participate in the Title XIX program.

- We recommend that dental care continue to be a covered service.

Durable Medical Equipment

Access to durable medical equipment (DME) is essential for the proper treatment of many conditions. Many rural communities have no local DME supplier other than the physician's office. While most physicians have no desire to supply such things as hospital beds and commodes, they do need to be able to provide patients with items such as splints, crutches, bracing devices, etc. The process for physicians to become DME suppliers is cumbersome and time consuming and therefore effectively eliminates the ability of some patients to obtain needed durable medical supplies.

- We recommend that the process for becoming a Medicaid DME supplier be streamlined.
- We recommend that payment rates for DME supplies provided through the physicians office be adequately and fairly reimbursed.

Hospital

Community hospitals provide needed in-patient and out-patient services. The current Title XIX reimbursement rates fail to cover the cost of providing services. Reasonable reimbursement rates are essential in maintaining an adequate number of hospitals able to serve the Title XIX population. Hospitals are no longer able to cost shift the losses incurred in caring for Title XIX patients. Inadequate Title XIX payment rates threaten the financial viability of our hospitals.

- We recommend that hospital reimbursement be set at a level that is at least equal to Medicare reimbursement.

Long Term Care

Long term care is a significant problem in Iowa. With a large elderly population, the number of patients needing long term care is growing. Additionally, increased societal mobility means that many patients have no nearby family to assist them in their homes. Clearly

maintaining people in their homes is less costly than nursing home placement. When nursing home placement is required, payment rates must realistically meet the cost of providing services.

- We recommend that the State set long term care facility reimbursement rates at a level that adequately and fairly compensates facilities for the cost of providing services.

PROGRAMS

Elderly Waiver

As noted above, it is less costly to maintain a patient in their home than to pay for nursing home care. Further, given the choice, patients would prefer to remain in their own homes.

- We recommend that the Elderly Waiver Program be expanded in an effort to provide lower cost patient preferred care.

SCHIP

Infants and children are an especially vulnerable patient population. As a result, minimal health interventions made during this time can have a tremendous beneficial impact on a patient's life-long health. Every effort should be made to enroll all eligible patients in this program.

- We recommend that the State continue its efforts to enroll all eligible patients in this program.

Spend-down Program

In theory, this program allows those who don't meet Title XIX eligibility criteria to still receive assistance; the reality is that the spend-down calculated for many patients is unreasonable. Many patients are unable to meet basic living expenses and afford their monthly spend-down effectively leaving them with no benefits at all.

- We recommend this program be reviewed with an eye toward more realistic calculation of expected spend-down requirements.

FUNDING

Federal

It is clear that federal funding of the Title XIX program is inadequate for the mandated services. Rep. Heather Wilson (R-NM), chair of the Republican House Task Force on Medicaid Reform has begun hearings on this issue as well as broader issues facing the Title XIX program.

- We recommend that the State, through the Iowa DHS and our elected representatives actively participate in the House Task Force on Medicaid Reform review process.

State

With the anticipated shortfall in revenue projected for the program, great energy has been focused on cutting services. Attention should be given for opportunities to increase funding and for methods to more efficiently utilize existing funds. There are many opportunities to reduce costs without decreasing provider reimbursement.

- We support the implementation of an additional tax on cigarettes with all proceeds going to offset the cost healthcare costs related to the use of tobacco.
- We recommend that the State engage **all** stakeholders in an **ongoing** dialog to find solutions to the funding and operational challenges facing the Medicaid program.

Recipient

In SFY 2004, the Legislature implemented a system of co-pays for Medicaid recipients. We think this is a good start and this concept should be expanded. One of the problems that drives the funding issue is a lack of recipient accountability for utilization. We recognize that many Title XIX patients have extremely limited financial resources and that federal law limits the ability to use co-pays as a funding mechanism. However, physicians frequently observe patients finding ways to afford unnecessary and even health threatening expenses.

- We recommend that the State work with our elected officials in Washington to allow expansion of the use of co-pays.

FRAUD AND ABUSE

Where money is involved, the potential for fraud and abuse exists. We would be remiss if we did not acknowledge that a small number of both patients and providers are guilty of fraud and abuse.

Recipients

Probably the largest area of fraud is in the area of eligibility. Adequate systems must be in place to insure that only those truly eligible for services receive them. Another area of abuse engaged in by patients is the inappropriate use of the ER simply for convenience and repeated visits to clinics for minor problems that patients who have to pay for the visit would care for at home. While providers continually educate patients on what needs to be seen and what can be cared for at home, there are no incentives for patients to do so. Coverage of certain non-prescription drugs has helped, but further efforts in this area are needed.

- We recommend the State work with providers to implement on-line real-time eligibility checking.
- We recommend the State explore the use of magnetic encoded eligibility cards similar to what is currently being done with food stamps.
- We recommend the State develop policies that encourage patients to utilize appropriate self-care.

Providers

We believe that the incidence of true provider fraud is extremely low. We recognize that durable medical equipment is an area that requires close scrutiny. Often what is termed fraud is the result of complicated coding requirements rather than an attempt to defraud.

- We recommend that the term "fraud" be used only to describe activity where there was a clear intent to obtain payment for a service or product that was not provided or medically necessary.
- We recommend that coding requirements be simplified and that the State adopt coding policies and practices that are in compliance with industry standards.
- We recommend that those providers who truly commit fraud be prosecuted to the full extent of the law.

PAYMENT ISSUES

Iowa Health Solutions

Iowa Health Solutions is roundly regarded in the provider community as an abysmal failure. Particularly frustrating to physicians is the lack of availability of local specialists. Rigidly applied program rules and an unwillingness to consider the patient's need for care have endangered patients' health. Claims processing has been poor with claims being regularly rejected for no reason and payment failing to meet the Iowa Division of Insurance's rules on timely payment.

- We recommend that the contract with Iowa Health Solutions be terminated.

Coding

Common Procedural Terminology (CPT) and International Classification of Disease 9th edition (ICD-9) coding are the standard methodologies for communicating to fiscal agents what was done for a patient and why. Complicated exception rules to this coding standard should be avoided.

- We recommend the State fully adopt CPT and ICD-9 coding and avoid the use of "local codes" and exceptions to standard coding.

Fiscal Intermediary

The Title XIX fiscal intermediary should perform two essential functions. One, it should process and pay provider claims in a timely and efficient manner. Secondly, the FI should provide the State with timely information on utilization patterns and provide other data needed by the State to operate the program. While we can not comment on the latter, we do not feel that the current FI adequately performs the former function. Physicians regularly report rejected and denied claims that when resubmitted without any change are then paid. The average length of time from claim submission to payment is more than double the average insurers' time frame.

- We recommend that the State require the Title XIX fiscal intermediary to process and pay claims in compliance with Iowa insurance regulations.

Medicaid HMO

In general, we applaud the use of Medicaid HMO products to provide services to patients and encourage the expansion of their use. These programs should be allowed broad leeway to provide the same services, under the same terms as they provide to non-Medicaid patients.

- We recommend that the State continue to expand the use of Medicaid HMOs.

Physician/Provider reimbursement

Adequate physician/provider reimbursement is essential to maintaining access to care. Current Title XIX payments do not cover the cost of providing care. As noted above providers can no longer cost shift under-reimbursed expense to commercial insurers. Further reductions in physician/provider reimbursement rates will result in large numbers of providers limiting the number of Medicaid patients they treat or withdrawing from the program all together. It is unreasonable to expect providers to finance the Title XIX program by providing services at payment rates below their cost of providing service.

We are also troubled by proposals to reduce the frequency of provider payments. Such a proposal would be contrary to the industry norms and would create a significant cash flow problem for small physician offices.

- We recommend that provider reimbursement rates be set in compliance with the Code of Iowa 249A.20.
- We recommend that payments be made to providers not less than twice monthly.

LEGAL/REGULATORY ISSUES

Emergency Medical Treatment And Labor Act

The federal Emergency Medical Treatment and Labor Act (EMTALA) while well intentioned have expanded to the point where it has placed onerous requirements on hospitals and physicians. Patients know that as a result of this law, they can present to an emergency room at any time for any problem and they will be evaluated. This is a large area of abuse that significantly increases costs. Physicians report that they have had patients who are offered a same day appointment but because it doesn't fit the patient's schedule they will present to the emergency room with a simple cold.

- We recommend that the State work with our elected officials in Washington D.C. to make changes to the EMTALA to end this abuse.

Tort Reform

Rising medical malpractice insurance premiums are having a significant impact on the ability of physicians to continue to practice in Iowa. The Title XIX population is disproportionately affected by this problem because as physicians struggle to meet premium increases, they must fill their appointment schedule with patients that have insurance plans that provide better payment for services. Surveys have shown that the tort liability crisis is causing as many as 45% of Iowa physicians to consider leaving the state, retiring early, or to change

specialties. Iowa must enact significant tort reform or it will risk losing physicians to care for all patients.

- We recommend that the State recognize the growing medical liability insurance crisis in Iowa.
- We recommend that the legislature enact and the Governor sign meaningful tort reform during the next legislative session.
- We recommend that the State indemnify physicians for any claims arising from the treatment of Medicaid patients.

COST CUTTING MEASURES

Any proposed cost cutting measures must be evaluated in the context of the proposed change's impact on the global cost of care. Many times, cost savings in one area predictably drive patient and or physician behavior that increases the cost of care in another area. Further, administrative costs associated with any proposed program must be realistically evaluated and considered prior to implementation.

Many of the suggestions made here may actually increase spending initially. It must be recognized that improving the health of the Medicaid population will ultimately reduce the total cost of that care. This requires a view that exceeds one fiscal year.

- We recommend that the State view Medicaid reform as an ongoing process rather than a one time fix.
- We recommend that the State evaluate the impact of all proposed solutions on the global cost of care.

INFORMATION SHARING/INFORMATION TECHNOLOGY USE

Technologies such as electronic medical records, electronic prescribing, information sharing technologies, and handheld computers and personal digital assistants all have the potential to enhance healthcare and lower the cost of providing healthcare. Caution must be taken, however, to fully study emerging technologies before implementation. In the past, technologies have been implemented without fully understanding the cost, the impact on existing care systems, or the time required to become proficient in their use. Further, while some technologies have resulted in global cost savings, physicians have been forced to absorb the cost of the technology while the operational cost savings have been seen elsewhere in the system. Physicians do not have the financial resources to absorb the cost of further technologies. Funding mechanisms that match the benefactor of the technologies cost savings with payment for the technology must be found.

- We recommend that the State work with providers and the federal government to develop, implement and fund information sharing technologies.

YOUTH POLICY
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POLICY CHANGE: Extending the age of foster care from 18 to 21

Youth making the transition to adulthood from foster care fare worse than their same-age peers, and in many cases much worse. Many approach the age of majority with significant educational deficits and relatively few appear to be on a path that will provide them with the skills necessary to thrive in today's economy. They are less likely to be employed than their peers, and earnings from employment provide few of them with the means to make ends meet. This is reflected in the economic hardships many of the youth face and the need that many have for government assistance. A large number continue to struggle with health and mental health problems. Too many of the youth have children for who they cannot provide a home and they are much more likely than their peers to be involved with the criminal justice system.

Studies, including the Chapin-Hall Discussion paper, have shown that allowing foster youth the option of remaining under the care and supervision of the child welfare system past the age of 18 offers significant advantages to them as they make the transition to adulthood.

Foster youth who remain in care can receive independent living services to help them with the transition. Many then can progress further in their education and they are more likely to have access to health and mental health services. Females are less likely to become pregnant and remaining in care has also been associated with a decreased risk of economic hardship and criminal justice system involvement.

It's possible that the availability of stable housing allows young people to better cope with other responsibilities associated with this period of their lives. Alternatively, remaining in care can help keep young people in contact with child welfare services professionals who provide access to services and supports that they need as they move towards adulthood.

Iowa allows youth who turn 18 while in care, to remain in care voluntarily until they graduate from high school. In addition, in a regulatory change made in 2004, youth that leave care after turning 18 who have not graduated from high school, may return to foster care voluntarily in order to complete their high school education.

Many other states provide services for their young adults up to the age of 21 or in some cases 23 (Alaska, Arizona, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Michigan, Missouri, New Hampshire, New Mexico, New York, South Carolina, Tennessee, Texas, Vermont, Washington, Wisconsin). Many of these states provide housing, education assistance, job training, case management and/or counseling.

The Chafee Foster Care Independence Program provides federal funds to states to help prepare their current and former foster youth for the transition to independent living. Youth may receive services in six domains – educational services, vocational training or employment services, budgeting and financial management services, health education services, housing services or services to promote their development. Case managers, out-of-home care providers or social service agencies can provide these services. Iowa receives approximately $1.3 million in these Chafee funds.

Iowa is beginning to provide services to young adults. The Department of Human Services is currently funding a statewide aftercare network (in addition to $600,000 of Chafee funds, $200,000 of Iowa's Community Mental Health Services Block Grant is used to fund the network) to address the needs of young adults who have aged-out of foster care. Eight Iowa human service agencies are collaborating so that services can be delivered to local young adults. These agencies provide support, services and links to additional resources such as transitional living services, employment training and counseling across Iowa. The young people who are eligible for this support need to be currently living anywhere in Iowa, a former foster care recipient, at least 18 years old but not yet 21 and left foster care at age 17 ½ or older.

The Iowa College Student Aid Commission administers the Education and Training Voucher program. Grants of up to $5,000 per year are available to eligible Iowa students who have been in Iowa foster care. The Iowa Finance Authority is seeking to assist youth with transitional apartment subsidy for agencies that provide housing and life skills training. $150,000 of Chaffee funds supports this program. Iowa has opted to not expand Medicaid to provide services to youth ages 18-20 years old who have aged out of foster care.

Youth leaving child welfare services are an especially vulnerable group of young adults. Although some programs and services are available to aid them in their quest for independence, there is considerable room for improvement. Many of the services offered are inflexible because they are still largely defined by age, rather than by an individual's need for services. These programs cost can be quite substantial. However, one thing is certain - the cost of doing nothing is even greater. When a child with emotional, physical, learning or behavioral problems is adrift, the cost to society in homelessness, crime, joblessness and other outcomes is substantial and enduring.

AFSCME

Our Vanishing Budgets

Iowa's Response to the Fiscal Crisis in the States

Iowa Fiscal Partnership

www.iowafiscal.org

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February 2005

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The Iowa Fiscal Partnership is a joint initiative of the Iowa Policy Project and the Child & Family Policy Center, two nonprofit, nonpartisan Iowa-based organizations that cooperate in analysis of tax policy and budget issues facing Iowans.

IFP reports are available on the web at http://www.iowafiscal.org.

Acknowledgements

This was a big study, and we sought advice and suggestions from a large number of people in several state agencies in gathering information for all five parts of the series on which this volume is based. We want to specifically thank the following for their assistance, although they are not responsible for the findings or recommendations in these reports: Officials from the three Regents universities, the community college system, the Iowa Department of Management, the Iowa Department of Education, and the Iowa Association of School Boards; Michael Morrison, President of North Iowa Area Community College; Rob Denson, President of Des Moines Area Community College; Aaron Podolefsky, Vice President of Academic Affairs at the University of Northern Iowa; Warren Madden at ISU; Keith Greiner at the Iowa College Student Aid Commission; Lisa Oakley and Steve Hill at the Iowa Department of Management; Michelle Wendel of the Iowa Department of Education; Gene Gardner of the Iowa Association of Community College Trustees; Barbara Boose at the Board of Regents; Steve Parrott and Don Sceszycki at the University of Iowa; Lana Dettbarn and Jeff Armstrong at Eastern Iowa Community College; Jon Studer and Brad Hudson from the Iowa State Education Association; Larry Sigel from the Iowa Association of School Boards; Jim Nervig and Steve Ford of the Iowa Department of Management; Susan Judkins of the League of Iowa Cities; William Peterson and Jay Syverson of the Iowa State Association of Counties; officials of the cities and counties chosen for detailed analysis; the Iowa Department of Human Services; Sally Cunningham; Jan Clausen; Jeff Robinson and Dave Reynolds of the Iowa Legislative Services Agency; and the American Federation of State, County and Municipal Employees.

We also are particularly grateful to the Annie E. Casey Foundation and the Stoneman Family Foundation.

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Iowa's Response to the Fiscal Crisis in the States

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Introduction

A brief but deep recession in 2001 caught almost all states by surprise. A booming economy and rising state revenues in the 1990s had encouraged them to both increase general fund spending and cut taxes substantially. In a more difficult economy, states found new and severe budget problems, widely referred to as a "fiscal crisis in the states."

The Iowa Fiscal Partnership analyzed in detail Iowa's response to that fiscal crisis. Before the recession, Iowa had been slower than most states to expand spending. At the same time, it had been quicker than most to cut taxes and did not assure an adequate investment in its rainy day fund to cover the inevitable downturn of a business cycle. Confronted with deficits each year since 2001, Iowa balanced the budget by cutting services and borrowing from trust funds.

Iowa now is left with a chronic or "structural" deficit. As Iowa looks to the future, its government faces the challenge of restoring services and replenishing borrowed funds at the same time that a changing economy and outdated tax system will further strain the state's finances. This volume of reports explains in detail how Iowa has arrived at a state of chronic budget crisis; analyzes the impact of the resulting state cuts on education, local governments and human services; and finally, offers recommendations to put Iowa back on the road to recovery.

The first chapter, ***Out of Step,*** shows that Iowa's response to the fiscal crisis differed dramatically from that of most other states. From 2001 to 2004, most states increased taxes or rolled back unsustainable tax cuts to cope with budget deficits. While the average state raised taxes by 4.3 percent, Iowa continued to cut taxes by 2.2 percent. While most states could still afford some minor increases in general fund spending, Iowa was forced to dramatically cut spending by 8 percent. Iowa's response to the fiscal crisis clearly was out of the mainstream.

The second chapter, ***Eroding Support for Education,*** shows that Iowa reduced state funding for education at all levels — at the state universities, at the community colleges, and for primary and secondary education. Real (inflation-adjusted) cuts of over 20 percent to state universities caused tuition and fees to increase 70 percent between 2001 and 2004, making higher education less affordable. Support for community colleges declined by 30 percent, forcing them to increase tuition by over one-third. This raised Iowa's community college tuition rates to among the highest in the country, 39 percent higher than the national average. In effect, Iowa balanced the state budget on the backs of college and university students.

Across-the-board cuts and meager "allowable growth" resulted in real cuts to K-12 education, which is the largest part of the state budget. Moreover, Iowa's ranking slipped in 50-state comparisons of per-pupil spending and average teacher salaries.

The third chapter, ***Holes in the Safety Net,*** describes the impact of Iowa's response to the fiscal crisis on the Department of Human Services (DHS) budget and services. Despite increased demand for human services during a recession, Iowa cut funding or held it steady for DHS programs, and eliminated a number of discretionary programs. While Iowa retained its commitment to Medicaid and kept up with increased health-care costs, the state severely curtailed other services. One-third of all mental health institute beds closed; child welfare funding declined despite a 20 percent increase in confirmed child-abuse cases; and emergency assistance funding was eliminated. The result: Many important aspects of the safety net are substantially weaker, and others (particularly those provided through Medicaid) face severe budget challenges in future years.

The fourth chapter, ***Passing the Buck,*** shows that city and county governments in Iowa have made tough choices as they struggled to deal with cuts in state support, a stagnant property tax base, and rising health insurance costs for their employees. State support was cut by 42 percent and heath insurance costs increased substantially (78 percent for counties). At the same time, state assessment rules severely limited the capacity of local governments to generate property tax revenue. Local governments had to take drastic measures. The City of Keokuk eliminated nine jobs, Cedar Rapids eliminated 23 jobs, and Des Moines eliminated 140 jobs. Growing numbers of cities and counties also increased fees and property tax rates, turning to special levies when general fund levies were maxed out. Cities and counties also spent down reserve funds that will need to be replenished. Local governments face new challenges if they are to maintain the same level of public services in future years. Clearly, one impact of the state fiscal crisis has been an increase in property taxes.

The fifth chapter, ***A Chronic Crisis,*** shows that Iowa's actions have deepened the fiscal crisis for two reasons. First, state government borrowed $2 billion from trust funds and one-time revenue sources to finance continuing services. Permanent sources of revenue will be required to sustain services in future years and trust funds will also need to be replenished. Second, the state failed to address the underlying cause of the fiscal crisis — inadequate revenue for meeting ongoing budget needs. Budget deficits will persist until state leaders modernize the tax system to reflect dramatic changes in Iowa's economy. Changes in the economy that demand tax modernization include: the move toward a more service- and information-based economy from a physical goods economy, the broadened boundaries of business, the growth of the internet and e-commerce, the aging of society and growth in retirement income, recent but major trends toward the concentration of wealth and income, the growth in tax expenditures, and federal and other actions that place more responsibilities on state government. Tax reform and modernization, based upon widely recognized tax principles, is needed to provide an adequate and sustainable funding base for essential public services.

Each chapter of this volume is taken from a five-part series from the Iowa Fiscal Partnership (IFP), "Our Vanishing Budgets: Iowa's Response to the Fiscal Crisis in the States." Full reports are available on the IFP website, www.iowafiscal.org <http://www.iowafiscal.org>. The Iowa Fiscal Partnership is a joint initiative of two Iowa-based nonprofit policy analysis organizations, the Child & Family Policy Center in Des Moines and the Iowa Policy Project in Mount Vernon.

Chapter 1.

Out of Step

The State Fiscal Crisis, 2001-2004:

Comparing Responses of Iowa and Other States

By Charles Bruner and Mike Crawford

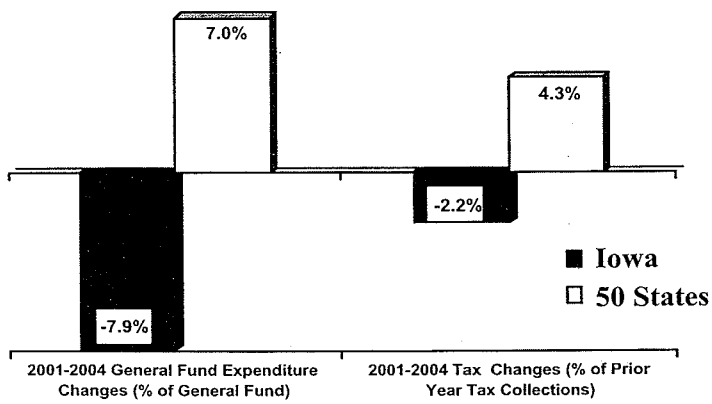
Like most states in the country, the recent economic recession has put severe strains on Iowa's budget and ability to fund services. The last three years (fiscal years 2002 through 2004) have often been referred to as years of "fiscal crisis in the states." After an eight-year economic boom in which states generally were able both to cut taxes and increase general fund spending, the abrupt economic slowdown sharply reduced most states' revenues for the last three fiscal years, requiring major budget adjustments such as:

- cutting spending.
- tapping reserve funds, including rainy day funds, or other non-general funds.
- raising taxes.

This report compares Iowa's response to that of other states, in terms of general fund expenditures, K-12 expenditures, and tax changes. It shows conclusively that Iowa has been at the extremes of state policy, cutting spending more than all but two other states and actually cutting taxes at a time when most states raised taxes. How far Iowa has been out of the mainstream is depicted in Figure 1.1, which shows the percentage change in general fund spending and tax law changes for Iowa and for the 50 states as a whole from 2001 (which we take as the base year) through the fiscal crisis years of 2002-2004.[1]

While Iowa is often perceived as "about average" among states, Figure 1.1 shows that the responses to the state fiscal crisis in terms of tax and expenditure policies in Iowa have been far from the mainstream. For all states in the aggregate, fiscal 2004 general fund spending was 7 percent higher than it had been in 2001, but Iowa actually cut spending almost 8 percent during that period. Similarly, the states as a whole raised taxes 4.3 percent between 2001 and 2004, while Iowa cut taxes 2.2 percent.

Figure 1.1. Iowa Changes in Taxes and Expenditures Compared with Changes in the 50 States, 2001-2004



[1] The National Association of State Budget Officers, in conjunction with the National Governors Association, does an annual report of state general fund and other expenditures for the 50 states. The National Conference of State Legislatures does a similar report on enacted tax policies and their impacts upon state tax collections.

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Mike Crawford *is senior research and administrative associate for CFPC. He directs the Iowa Kids Count Initiative and works in data collection and analysis.*

Since overall 50-state and Iowa data was available for general fund expenditures back to 1995 and for tax changes back to 1996, this report also provides a longer term perspective on Iowa taxing and spending in comparison with other states. Over the longer period, the same differences in taxing and spending remain, with Iowa enacting substantially greater tax cuts over this period while constraining spending substantially more than almost all other states.

State General Fund Expenditure Changes

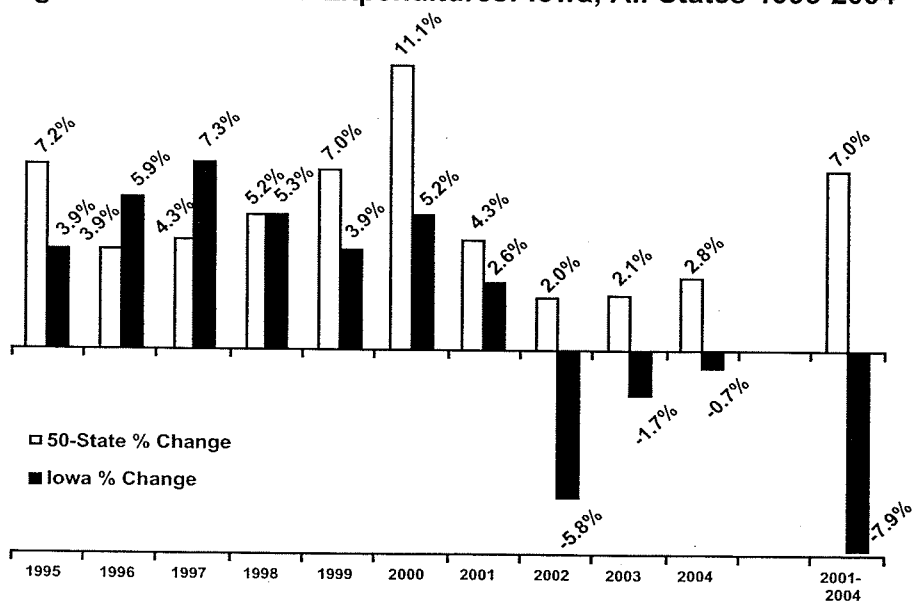
The National Association of State Budget Officers and the National Governors Association produce an annual report on state general fund expenditures.[2] This report is recognized as the best source for comparative state budget information across the 50 states. While different state general funds may include different state expenditures, these data are the best available for comparing state budget responses over time.[3]

Figure 1.2 shows, for both Iowa general fund expenditures and the aggregate of all state government general fund expenditures, the year-to-year percentage changes in spending over the last decade (1995-2004). Iowa's general fund expenditures, like those in states across the country, increased every year between 1995 and 2001. Iowa increased spending by 39.5 percent over this seven-year period, but this amount was much less than the 51.6 percent increase for all states combined. [See full data in Table A-1 in Appendix.]

In fiscal years 2002, 2003 and 2004, however, Iowa's general fund expenditures actually declined each year, while for the 50 states, spending rose over 2 percent each year. If Iowa had been able to keep pace with other states in its overall general fund expenditure growth in the past three years, its 2004 expenditures would have been $730 million greater.

Table A-2 in the Appendix provides state-by-state figures for the period from FY2001-2004. During this period, Iowa was one of

Figure 1.2. Gen. Fund Expenditures: Iowa, All States 1995-2004



Source: National Association of State Budget Officers

[2] The information provided in this section of the report is from annual reports from the National Association of State Budget Officers. All figures except the 2004 figures are actual final reported figures; figures for fiscal 2004 are estimated figures, based upon enacted state budgets, but not on audited state expenditures (which will not be available for a number of months).

[3] States establish different non-general funds in addition to the general fund. In Iowa, for instance, transportation expenditures are largely through the road use tax fund, which is not part of the state general fund. Similarly, the tobacco trust fund, the senior living trust fund, and the rainy day funds all constitute trust funds outside the

only 10 states with actual reductions in state general fund spending. At 7.9 percent, Iowa's decline was exceeded by only two states, Michigan (10.6 percent) and South Carolina (9.6 percent).

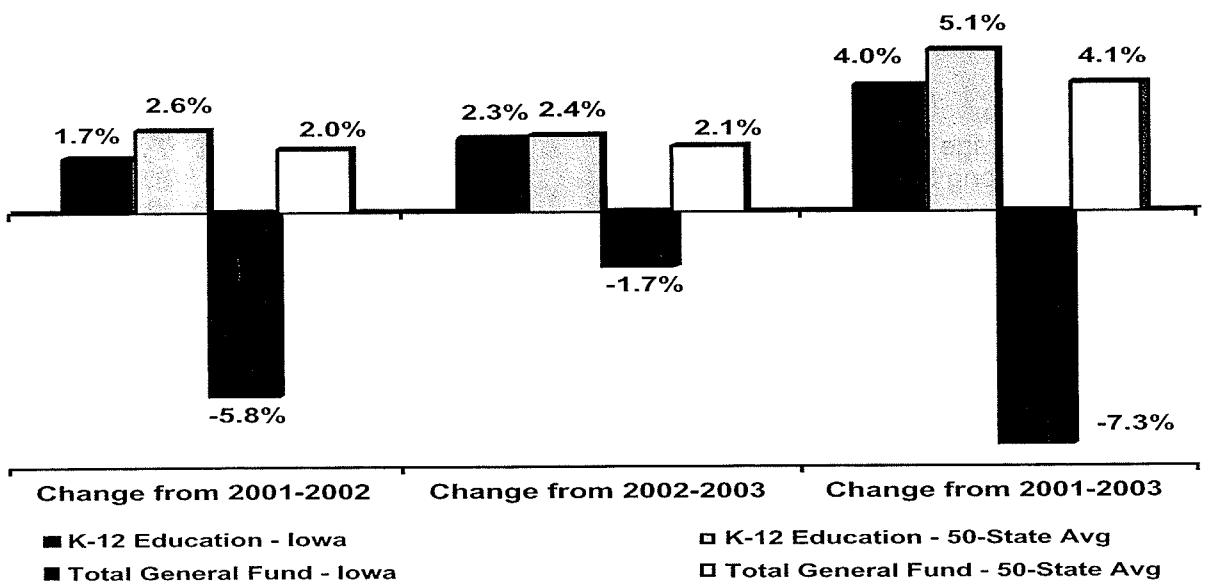
State K-12 Education Expenditures

Expenditures on public primary and secondary (K-12) education constitute the largest single part of most state general fund budgets. Comparative state data also are available on state general fund K-12 expenditures through the National Association of State Budget Officers, but only through FY2003.

Figure 1.3 shows changes in K-12 general fund expenditures over the 2001-2003 period for Iowa and the total of all 50 states. Education expenditures are contrasted with overall general fund expenditures (overall state-by-state data are provided in Table A-3 in the Appendix).

As Figure 1.3 shows, while Iowa's K-12 general fund expenditure growth was lower than that for the country, K-12 expenditures fared significantly better than the general fund expenditures as a whole. Overall, states made generally greater commitments to K-12 education than to

Figure 1.3. K-12 Education and Total General Fund Expenditures FY 2001-2003: Iowa and 50-State Total



Source: National Association of State Budget Officers

general fund. Some states rely more heavily than Iowa, and some rely less heavily, on non-general funds to support services. This report only addresses general fund expenditures, but these should be largely comparable within a state, over time, unless the state made major changes to its non-general fund expenditures. Further, state general fund expenditures only cover state expenditures, and not federal funds (including funds matching state general fund expenditures under Medicaid or Title IV-e) or local expenditures such as those covered for schools and community colleges to match state aid formulas. Differences in the manner in which states fund education, and K-12 education in particular, mean that state-only general fund comparisons do not necessarily reflect state commitments to K-12 education, although they can generally give a good indication of relative changes in funding commitments over time.

other parts of the budget, but the spread between general fund and K-12 expenditures was most pronounced in Iowa.

While Figure 1.3 shows that Iowa protected K-12 education from reductions in general fund expenditures, Iowa's overall K-12 growth still fell below that of other states. In addition to comparisons by general fund expenditures, the National Education Association reports on state public education programs in terms of per-pupil spending and in terms of average teacher salaries, two measures of public commitment to education.[4] Table 1.1 shows changes over this period both in Iowa's actual per pupil expenditures and average teacher salaries, as well as Iowa's ranking among the 50 states on each.

Table 1.1. Iowa Per Pupil Education Expenditures (based on Fall enrollments) and Average Teacher Salaries, with National Average and Iowa State Rank

	2001-2002	2003-2004
Per Pupil Expenditure		
Iowa	$ 6,819	$ 7,098
National Average	$ 7,548	$ 8,156
Iowa Below Average By	$ 729	$ 1,058
Iowa's Rank Among States	33rd	36th
Average Teacher Salary		
Iowa	$ 38,230	$ 39,432
National Average	$ 44,683	$ 46,826
Iowa Below Average By	$ 6,453	$ 7,394
Iowa's Rank Among States	34th	37th

Source: National Education Association. Rankings of the States and Estimates of School Statistics, 2001-2 and 2003-4

Table 1.1 indicates that, while Iowa has increased its overall per pupil expenditures and salaries have risen, its increases have not kept pace with those in the country as a whole over these "fiscal crisis" years. Iowa remained well below the national average in both categories, and the gap between Iowa spending and the national average spending, and between Iowa salaries and national salaries, actually widened substantially. As a result, Iowa's rank slipped three places on both measures.

State Tax Actions

As stated at the beginning of this report, states have taken a variety of actions to respond to the state fiscal crisis – cutting programs and expenditures, tapping reserve funds and other sources outside the general fund, and making changes in tax and revenue structures.

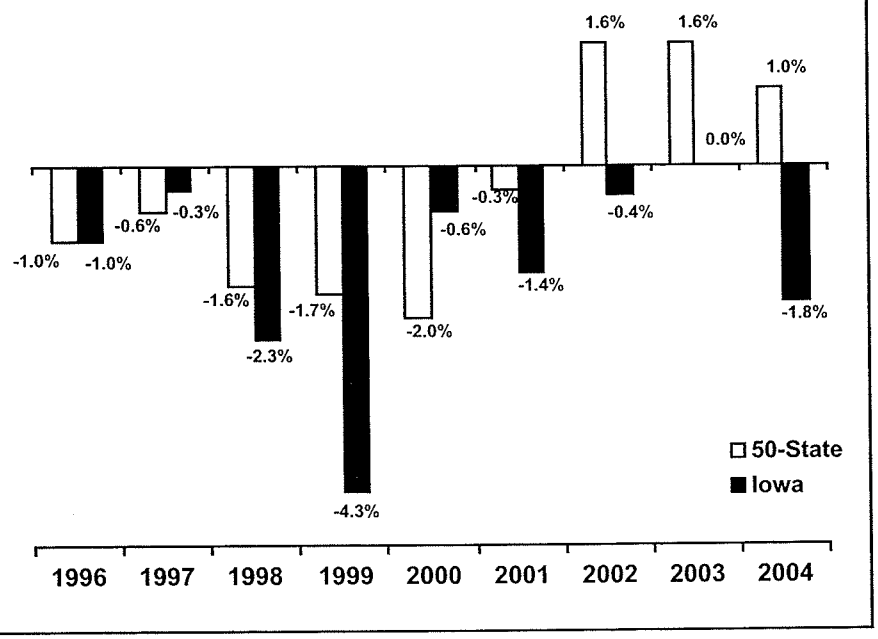
The National Conference of State Legislatures annually provides a special fiscal report on *State Tax Actions* that represents the best source for current information on tax law changes

[4] National Education Association. *Rankings of the States and Estimates of School Statistics, 2001-2002 and 2003-2004.*

by each state. Complete reports are available for tax actions taken in 2002 and 2003, and a preliminary report is available for 2004.[5] Tax actions taken in a particular year generally have their impact in the next fiscal year, with the percentages used by NCSL based upon the prior year's overall tax collections.

Figure 1.4 shows the changes in state taxes as a percentage of overall tax collections for the years 1996 through 2003, for both Iowa and the composite of all 50 states.[6] Both Iowa and other states enacted a substantial number of tax cuts over the period from 1996 through 2001, though Iowa cut taxes to a significantly greater degree than the average state. The cumulative effect of these tax cuts was to reduce tax collections by 8.9 percent for Iowa over this period and by 7.0 percent for states as a whole, compared to what they would have been had there been no change in tax law. Despite the cuts in taxes and tax rates, general fund revenue still grew because of the robust economy. [See Table A-4 in Appendix for complete Iowa information.]

Figure 1.4. Changes in State Taxes as a Percent of Overall Tax Collections 1996-2003, Iowa and 50-State



The figures for 2002 and 2003 (and preliminary figures for 2004) show Iowa at much greater variance with other states, however. Iowa reduced its overall taxes at the same time that states, as a whole, were enacting quite significant tax increases. States raised taxes in these years so as to nearly offset the tax cuts in the earlier period, while Iowa continued to cut taxes. Between 1995 and 2004, the cumulative effect of all tax changes was to reduce taxes by just 2.3 percent across all states, but by 10.9 percent in Iowa.

Table A-5 in the Appendix provides summary data for the 50 states on net tax changes for 2002 and 2003, both in millions of dollars and as a percentage of tax collections. Sixteen states enacted tax increases in 2002 in excess of 1.0 percent of prior tax collections and 19 states enacted such tax increases in 2003. When the tax changes of the two years are combined, 42 states showed overall tax increases, while only four states showed tax declines, with Iowa in the latter category. The majority of states enacted significant tax increases over this

[5] Rabol, M. (January, 2003). *State Tax Actions 2002.* Denver, CO: National Conference of State Legislatures. Rabol, M. (March, 2004). *State Tax Actions 2003.* Denver, CO: National Conference of State Legislatures. National Conference of State Legislatures (July, 2004). *State Budget and Tax Actions 2004: Preliminary Report.*

[6] Iowa data in this instance were not available through the National Conference of State Legislatures for all the years, so was adapted from an Iowa Department of Management report on tax cuts enacted since 1996. Iowa figures are shown in fiscal years, as shown in that report. These data are provided in a table in the Appendix.

period. Nationally, the average increase was 3.2 percent of tax collections. Overall, $17.9 billion in net state tax increases occurred over this period.

While there is only preliminary data on 2004, with reports from 40 of the 50 states, Iowa was identified as the only state with a tax reduction of 1 percent or more, and seven states raised taxes by 1 percent or more.[7] Among the reporting 40 states, over $2.8 billion in revenue was raised by tax increases. Clearly, between 2001 and 2004, Iowa not only failed to raise taxes to address the state fiscal crisis, as the vast majority of states did, but actually stood as one of a very few states reducing taxes over this period.

The National Conference of State Legislatures' reports also show the locus of the tax changes by type of tax. These are shown in Table 1.2, by both total dollar amount and percent of total, for each of the three years (with 2004 still preliminary).

Table 1.2. Net Tax Increases Enacted in the 50 States by Type of Tax

Type of Tax	2002		2003		2004	
	Millions of $	% of Total	Millions of $	% of Total	Millions of $	% of Total
Personal Income	$ 1,603.3	18%	$ 2,720.2	31%	$ 833.1	30%
Corporate Income	$ 2,315.6	25%	$ 958.0	11%	$ 214.0	8%
Sales and Use	$ 969.5	11%	$ 2,715.1	31%	$ 525.8	19%
Health Care	$ 338.7	4%	$ 400.7	5%	$ 487.1	17%
Cigarette/Tobacco	$ 3,018.1	33%	$ 891.3	10%	$ 330.4	12%
Motor Fuel	$ 136.6	2%	$ 338.7	4%	$ -3.0	0%
Alcohol	$ 7.0	0%	$ 35.6	0%	$ 0.0	0%
Other	$ 708.7	8%	$ 702.8	8%	$ 413.2	15%
Total Net Increase	$ 9,097.7	100%	$ 8,762.8	100%	$ 2,800.6	100%

Source: National Conference of State Legislatures

As Table 1.2 shows, states made use of a variety of tax sources to address their fiscal crises. Over the three-year period, increases in state personal income taxes represented the largest source of additional revenue, with cigarette and tobacco taxes next, followed by sales and use and corporate income taxes. States used no single source of tax revenue, nor did states fail to tap any available tax sources.

[7] *Preliminary Report, op.cit.* The seven states raising taxes by more than one percent were: Alabama, Arkansas, Louisiana, Maine, New Jersey, Rhode Island, and Virginia. The ten states not yet reporting were: California, Delaware, Illinois, Massachusetts, Michigan, New York, North Carolina, Ohio, Oklahoma, and Tennessee.

Discussion and Implications

The data presented here clearly show that states experienced fiscal crises in the last three fiscal years and responded by containing overall general fund expenditures and, in most instances, raising taxes. These actions occurred in sharp contrast to the previous seven years, during which states cut taxes significantly and concertedly and still experienced significant general fund revenue growth.

Iowa had already contained its general fund growth more than other states during the period from 1995 through 2001, enacting tax cuts from 1996 to 2001 that were somewhat larger than those in other states in the country as a whole.

Between 2001 and 2004, however, Iowa was at the extreme end among states both in:
- reducing general fund expenditures
- reducing (rather than raising) taxes.

Other states tackled their fiscal crises in an overall different manner and re-examined their tax systems and made tax changes. These involved increases in a variety of tax areas.

The result has been a near decade-long combination of tax cuts and expenditure containment in Iowa that has put Iowa well out of step with other states.

While this report clearly shows that Iowa's actions were out of step with those in other states, it does not go into the specific merits of the actions Iowa took. It does suggest, however, that Iowa has a great deal of room to adjust and raise taxes as a means to respond to state general fund expenditure needs, if those needs represent state services and obligations important to Iowa residents.

Chapter 2.

Eroding Support for Education

Iowa's State Fiscal Crisis and Its Impact on Education

By Jeremy Varner and Elaine Ditsler

A detailed examination of the fiscal situation of state and local government in Iowa appropriately begins with education. Education – the Board of Regents institutions, community colleges and K-12 school districts – accounts for 60 percent of the state general fund budget. Furthermore, public school systems are the single largest local entity in terms of property taxes.

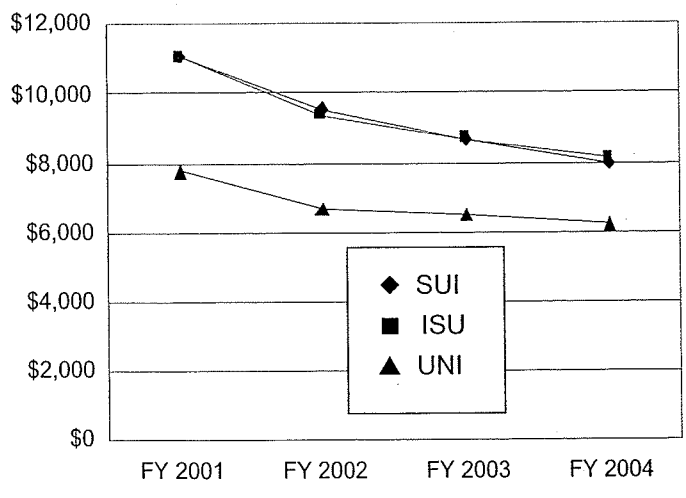
This report examines how the lingering state fiscal crisis has affected the Regent universities (University of Iowa, Iowa State University and University of Northern Iowa), the community college system, and Iowa's K-12 public school districts. We look at the period from fiscal year 2000-01 (FY2001), before the major drop-off in state revenues, through fiscal year 2003-04 and, in some cases, through fiscal 2004-05 budgets. We find that the fiscal crisis has weakened state support at all levels.

The Regent Universities

The Regent universities pay for the lion's share of faculty/staff salaries, benefits, and other core activities out of the general operating fund. More than 90 percent of general operating fund revenue comes from two sources: (1) state general fund appropriations and (2) tuition and fees.

Between FY2001 and FY2004, state funding of the Regent universities declined 14 percent at the University of Iowa (SUI), 16 percent at Iowa State (ISU), and 15 percent at Northern Iowa (UNI). These reductions totaled nearly $94 million (in nominal dollars). In FY2001, state funding accounted for two-thirds of Iowa Regent universities' general operating revenue; by FY2004, this proportion had fallen to just over half. The three public universities have struggled to adjust to fewer funds and to unpredictable revenue streams. Often the cuts in state funding have not only been severe, but have come in the middle of fiscal years, creating a host of problems for university administrators.

Figure 2.1. Per Pupil State Operating Funds at Regents Universities, FY2001-04, Constant Dollars



Source: Iowa State Board of Regents

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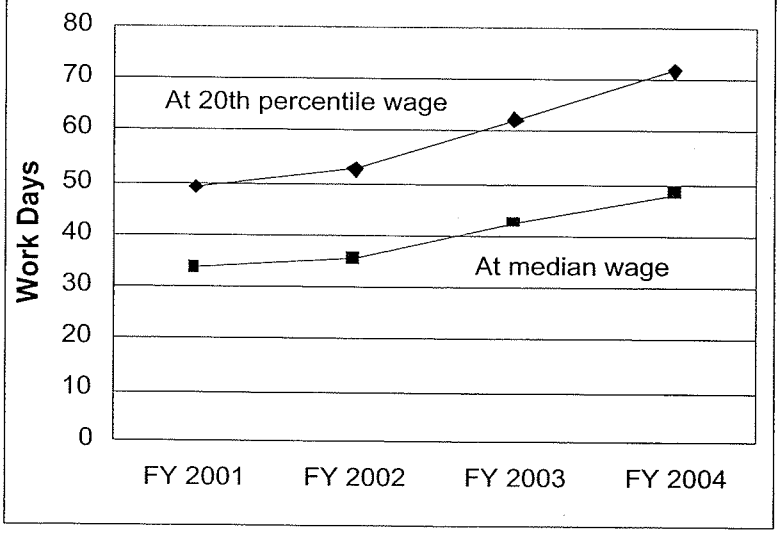
Elaine Ditsler *is a Research Associate for the IPP. She specializes in economic and budget analysis.*

The real impact of these cuts becomes apparent only after adjusting for inflation. The Higher Education Price Index (HEPI) is typically used to adjust for inflation in university expenses. Since 1999, the HEPI has outpaced the Consumer Price Index (CPI) nearly two to one. In 2001 HEPI-adjusted dollars, state appropriations actually declined 22 percent at SUI, 24 percent at ISU, and 23 percent at UNI between FY2001 and FY2004. Per pupil funding declined by about a quarter in just three years as a result of cuts in state appropriations.

Since FY2001, the state has consistently under-funded salary increases, forcing the universities to take funds from elsewhere to pay for those increases. Compounding the problem has been the rapid rise in the cost of fringe benefits, which has consumed much of the institutions' salary funds. In response to funding cuts, the universities have relied increasingly on temporary staff (ISU), part-time staff (UNI), or both (SUI). Student/faculty ratios have risen as well.

To replace state revenue cut from their budgets, the Regent universities raised tuition and fees at unprecedented rates. From FY2001 to FY2005, resident undergraduate tuition at Iowa's Regent universities rose 62 percent, from $2,906 to $4,702. Fees, which vary by institution, rose even more rapidly, with the result that resident tuition and fees together rose 68 percent at SUI, 73 percent at ISU, and 72 percent at UNI in just four years. Non-resident tuition and fees over this same period rose 40 percent at SUI, 52 percent at ISU, and 57 percent at UNI. Tuition and fees rose from 27.9 percent of total operating funds in FY2001 to 41.3 percent in FY2005.

Figure 2.2. Work Days Needed to Pay Average Tuition and Fees at Regents Universities



Sources: Iowa College Student Aid Commission, Legislative Services Agency, U.S. Bureau of the Census

Both resident and nonresident tuition rates at SUI and ISU historically have compared favorably to national and peer group averages. In FY2001, Regent institution tuition and fees were less than 79 percent of the national average. Since then, tuition and fees have risen more rapidly in Iowa than nationally. Resident undergraduate tuition and fees grew to 89 percent of the national average in FY2003. In FY2004, undergraduate tuition and fees at SUI were 85.1 percent of its peer group average for residents and 87.5 percent for non-residents. At ISU, resident tuition and fees were 87.5 percent of its peer group average and nonresident tuition and fees were 85.7 percent of the group average. UNI's tuition rates were even higher – resident undergraduate tuition was 102.7 percent of the peer group average, and nonresident tuition was 91.3 percent of the peer group average.

University officials cite rising tuition as the major reason for the decline in enrollments in recent years, particularly at UNI. A public university education has, indeed, become significantly less affordable in the past four years. Between FY2001 and FY2004, the median wage in Iowa (half

of workers earn less, half earn more) rose just 9.4 percent, while average tuition and fees at the Regent universities rose almost 58 percent. As a result, a person earning the median wage would have had to work 48 days to pay tuition and fees in FY2004, 44 percent longer than in FY2001. By FY2005, it is likely that, for a person with the median annual earnings of about $27,000, the burden of financing a public university education for one of his or her children will have increased over 50 percent in just the four years since FY2001.

State funding for financial assistance has not increased to mitigate problems of college affordability. General fund appropriations for the Iowa College Student Aid Commission (ICSAC) and its grant and scholarship programs have been reduced 10 percent from FY2001 to FY2004 (without adjusting for inflation).

In FY2001, the Iowa Work Study Program was appropriated $2.75 million and served more than 4,000 needy students. In FY2002, funding for this program was eliminated altogether. Other smaller ICSAC grant programs including the Iowa Grant (similar to the Pell Grant) have also been reduced in recent years despite tuition inflation.

While federal financial aid increased FY2001 to FY2005, it has not kept up with rising tuition. In particular, the federal Pell Grant Program, which is critical for low-income students, has not grown fast enough to keep pace with the increasing cost of post-secondary education. The cap on individual Pell Grants increased just 8 percent – from $3,750 to $4,050 – between FY2001 and FY2004. The maximum Pell grant fell from about 120 percent of tuition and fees at Iowa Regent universities in 2001 to about 75 percent in 2004. Similarly, loan limits in the Federal Direct Stafford loan program have not increased during the past 10 years, leading to a greater reliance on alternative loans. As a result of all these factors, the total financial need of all those undergraduates who file the Free Application for Federal Student Aid (FAFSA) that was *not* met by grant aid grew 23 percent from FY2001 to FY2003 at Iowa Regent universities, from $159.1 million to $195.8 million. Average student indebtedness at graduation also rose over that two-year period, by 10.7 percent at SUI, 14.5 percent at ISU, and 11.9 percent at UNI.

In summary, the budget crisis of the past four years has reduced services at Iowa's public universities while drastically increasing its cost. The affordability of a university education has been seriously eroded, as financial aid resources (including tax benefits) have not increased sufficiently to offset the large increases in tuition and fees. Iowa's universities are no longer a good deal for many out-of-state students, reducing nonresident enrollment and cutting into the surplus tuition those students generate.

The Community Colleges

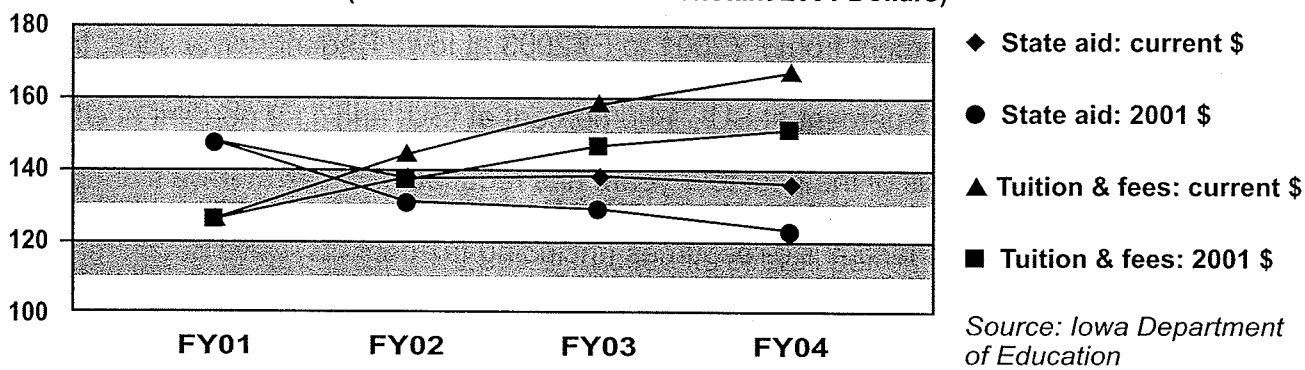
The State of Iowa is divided into 15 multicounty merged areas, each served by a single community college. These two-year comprehensive community colleges each serve from four to 12 counties; enrollment ranges from just over 1,000 full-time students at Northwest Iowa Community College to more than 15 times that number at Kirkwood Community College. The State Board of Education sets standards for the community college system and approves each of the institutions' budgets. The operating budgets of the community colleges are funded through a combination of student tuition and fees, state aid, federal funds, local property taxes, and other income. Together, state funding and tuition and fees account for over 80 percent of community colleges' unrestricted general fund revenue.

In current dollars, state funding was reduced in fiscal years 2002 and 2004, and rose a little in

2003. (For the community colleges, fiscal year 2004 figures are budget figures, adjusted for the state aid cuts; re-estimated figures were not available, and actual figures will be available in late 2004 or early 2005). In FY2004, however, state appropriations were $11.5 million less than they were in 2001. In constant dollars (adjusted using the HEPI), funding was reduced each fiscal year from 2001-2004, leaving state aid in FY2004 $24.6 milion lower (almost a 17 percent reduction) than it was in FY2001. Facing a decline in state revenue coupled with increasing enrollment and limited funding options, community colleges opted to raise tuition to balance their budgets. Tuition and fee revenue exceeded state aid for the first time in FY2002, and the gap has widened ever since. As a proportion of total unrestricted general operating fund revenues, state general aid slipped from 46 percent in FY2001 to 38 percent in FY2004, while tuition and fees rose from 39 percent to 46 percent.

While state and local funding has been falling off, community college enrollments increased 19 percent from FY2001 to FY2004, and are expected to increase again in FY2005. The result has been sharply reduced per-pupil state appropriations. Between FY2001 and FY2004, state funding per pupil sank 30 percent, from $1,909 to $1,342. One of the state's largest community colleges, Des Moines Area Community College, has faced particularly difficult challenges managing rapid growth coupled with reduced revenue from the state. The cuts have been sharp — state general aid is down 8 percent from FY2001 to FY2004. Adjusted for inflation (HEPI), it slipped 17 percent. With enrollment up 19 percent during the same time period, per-pupil state general aid slid 30 percent when adjusted for inflation.

Figure 2.3. Community College State Aid and Tuition, FY2001-04
(Millions of Current and Constant 2001 Dollars)



Source: Iowa Department of Education

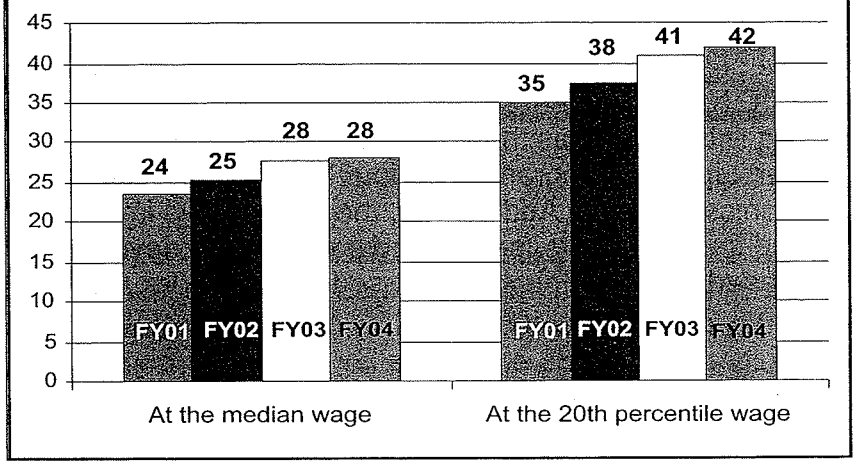
Local support, in the form of property taxes, accounts for just 6 percent of total unrestricted general fund revenue for Iowa's community colleges. Several property tax levies are allowed under Iowa law, some of which require voter approval. The Iowa Code caps the larger levies and significantly restricts the use of the remaining levies. Most of the colleges have exhausted their ability to raise levies or impose new ones. All 15 colleges are at the 20.25-cent limit for the general operating levy. Most of the remaining levies cannot be increased without voter approval. Furthermore, the property tax base has been growing slowly in recent years for all local governments, as the rollback on residential property continues to reduce residential valuation growth.

The average tuition at Iowa community colleges has risen by a third (in current dollars) from $1,937 in FY2001 to $2,571 in FY2004 (and rose again to $2,754 for FY2005). The cost of

attending Iowa's community colleges last year was 39 percent higher than the national average. The College Board reported that the national average resident tuition and fees (based on 30 credit hours, nine month semester) was $2,097 in FY2004. By comparison, Iowa's average tuition and fees were $2,919. A study by the Midwest Higher Education Compact found Iowa's tuition and fees to be third highest in the region (behind Minnesota and Wisconsin), and $875 (43 percent) above the average of 11 Midwestern states ($2,044). The MHEC also found that in 2002, Iowa had a higher proportion of its revenue generated from tuition and fees, and thus a lower proportion from state appropriations, than any adjacent state except South Dakota.

As average tuition and fees at Iowa community colleges climbed 30 percent from FY2001 to FY2004, the median hourly wage for Iowa workers rose only 9.4 percent (to $13.01). An individual at the median hourly wage would need to work about 28 days to pay tuition and fees in FY2004, 19 percent longer than in FY2001. For those with wages in the 20th percentile (20 percent of workers earn less than this wage, 80 percent earn more), wages rose only 8.3 percent, to $8.72. At the 20th percentile, an individual would need to work about 42 days to pay tuition and fees in FY2004, 20 percent longer than in FY2001.

Figure 2.4. Number of Work Days Needed to Pay Average Tuition & Fees at Iowa Community Colleges, FY2001-04



Source: Iowa Department of Education, U.S. Bureau of the Census

Financial aid has not kept pace with rising tuition. Funding for the Vocational Technical Tuition Grant Program, which provides access to vocational programs at community colleges, was $2.48 million in FY2001 but slipped to $2.32 million in FY2004 despite the rapidly increasing cost of tuition. While over 16,000 students with financial need applied for Vocational Technical Tuition Grant help in FY2004, only 2,800 were projected to receive assistance.

Federal Pell Grants, the cornerstone of aid for low-income students, have not risen fast enough to keep pace with the increasing cost of post-secondary education. The average Pell Grant covers only about a third of tuition and commuter room and board at the average public two-year college nationally. While total federal financial aid (including increasingly popular tax credits that disproportionately help those with less need) increased 23 percent between FY2001 and FY2003, it has fallen well short of meeting the rising cost of two-year public education in Iowa.

As a consequence of tuition hikes and insufficient increases in grant assistance, student indebtedness has grown substantially. The number of Stafford loan borrowers at Iowa colleges rose dramatically, from 35,567 to 48,787, between FY2001 and FY2003 – up 37 percent, far ahead of increased enrollment. In 2001, the average indebtedness of graduating community college students was already $4,521. While no later figures are available, community colleges are reporting higher borrowing levels and increased student indebtedness.

From FY2001 to FY2003, community colleges attempted to cut costs by shifting from full-time faculty to adjunct faculty when possible. The number of full time instructional positions fell 2.3 percent during this period, from 2,024 to 1,977, despite rapidly increasing enrollment. Meanwhile, the total number of adjunct instructional positions grew 10.8 percent, from 4,088 to 4,528. Nearly half of part-time instructional positions have been cut. In the aggregate, the number of instructional positions was reduced 6 percent, from 7,416 to 6,985. At Eastern Iowa Community College (EICC), for example, 62 full-time positions have been cut or replaced by part-time or adjunct staff since FY2001. North Iowa Area Community College (NIACC) reduced 33 positions, representing about 12 percent of the college's total faculty and staff. This shift to adjunct faculty and the cuts in positions amounts to a reduction in the level of services provided to students. While no measure of full-time equivalent instructors is available, the number of full time equivalent students per full-time instructional position grew from 32 to nearly 43.

Budget constraints have also impacted academic programming. At EICC, for example, two AA degree programs and one high school program were eliminated between FY2001 and FY2004. DMACC has closed several programs and others have not been expanded and now have waiting lists as long as three years. At NIACC, several programs have been reduced, including partnerships and programs with four high schools, the optometric assistant program, and an electronics program. Additionally, the college has implemented periodic hiring freezes, restricted travel budgets, scrutinized professional development requests, reduced supply orders, decreased security hours, decreased library hours, and discontinued federal depository library services.

At the same time, salary increases have been held below the rate of inflation. The average base salary rose only about 1 percent from FY2001 to FY2003, from $39,454 to $40,028, while the CPI-U rose approximately 4 percent. The average faculty salary at two-year public colleges in Iowa is 13 percent lower than in other states in the region.

Community college enrollment is growing rapidly, yet state funding has not kept pace. If state appropriations continue to wane and short-term cuts become long-term realities, Iowa's community college students will continue to pay more for less and many may be priced out of the market, at a time when the economy is demanding an increasingly educated workforce.

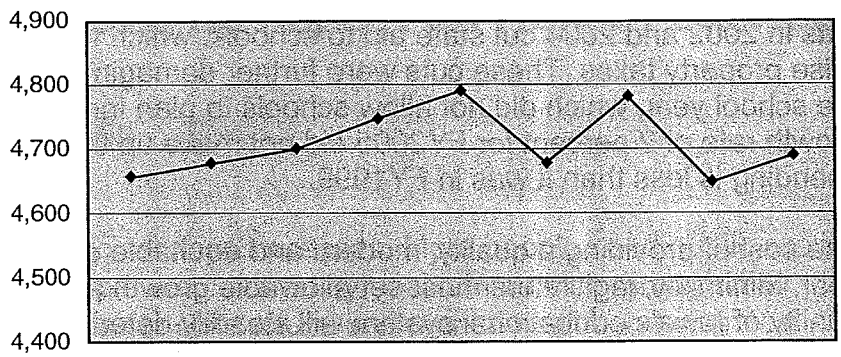
Iowa's K-12 School System

K-12 education accounts for about 46 percent of Iowa's General Fund budget. Like most states, Iowa relies on a combination of property taxes and state aid to finance elementary and secondary education. The foundation aid formula is the principal mechanism for allocating costs between state aid and property taxes, and for determining the regular program budget for all school districts. The regular program budget must cover the cost of salaries, benefits, utilities, maintenance, school supplies and other purchases that keep the school district operational on a daily basis.

Recent state budget problems have reduced funding to Iowa's K-12 public schools. Between 1996-97 and 2000-01, real spending on regular K-12 programs rose 1.6 percent, or 2.8 percent on a per-pupil basis. In the fiscal crisis years since then, however, spending decreased 4.8 percent, or 2.1 percent on a per-pupil basis. In real (constant) dollars, the state budget crisis has forced per-pupil spending lower than it was in 1998-99.

Each year, the Legislature determines the amount of allowable per-pupil spending through the "allowable growth" rate. For the 2001-02 school year, legislators set allowable growth at 4 percent. However, a 4.3 percent across-the-board cut in the middle of the school year forced schools to cut spending or to shift $74.1 million to property taxes. For the 2002-03 school year, legislators revised allowable growth downward from 4 percent to 1 percent due to revenue problems. In FY2004, allowable growth was set at 2 percent, but a 2.5 percent across the board cut forced schools to cut spending or to shift $43.6 million to property taxes. In total, schools received about $161 million less than the Legislature originally committed. The state has also faltered on another commitment to the K-12 education. The state is only funding about 11 percent of the Instructional Support Program instead of the 25 percent originally promised.

Figure 2.5 Per Pupil Regular Program Budget Spending in Iowa's K-12 Schools (Constant 2004 Dollars)



Source: Iowa Department of Management

School districts are also being hit by sluggish or even negative growth in taxable property valuations. This forces schools to raise property tax rates in order to generate the same amount of revenue. Additional sources of financing for schools, such as the Local Option Sales Tax and the Physical Plant and Equipment Levy, are primarily only available for capital expenditures or have other strict limitations.

Some schools have been able to spend more than the amount authorized by allowable growth because of a special provision called the budget guarantee. The budget guarantee allows schools with declining enrollments to maintain the same regular program budget as the previous year by levying additional property taxes. The guarantee was put in place in recognition that schools have costs that do not decline at the same rate as enrollment. The number of school districts utilizing the budget guarantee increased from 68 in FY1996 to 242 in FY2005.[1]

Beginning in the current school year, 2004-05, the budget guarantee is being phased out. As a result, 170 school districts received cuts in regular program funding and 52 school districts received cuts in per pupil regular program funding.[2] With the phaseout of the budget guarantee, all 242 schools lose the funding allotted by the guarantee and will have to cope with smaller budgets. Cost-cutting measures could include whole-grade sharing, increased class sizes, reduced course offerings and decreased instruction time.

[1] State of Iowa, Legislative Services Agency.
[2] Author's calculations based on data from the Iowa Association of School Boards

Iowans value their education system and Iowa students achieve high marks as a result. However, the recent years of state budget problems have taken their toll on K-12 education. Since FY2001, per pupil spending increases have not even kept pace with inflation. The 2003 allowable growth factor was set at the lowest level in history (1 percent), and the across-the-board cuts in 2002 and 2004 cut state aid to schools, which forced schools to cut spending and/or raise property taxes. These cuts were further damaging because they came in the middle of the school year, which did not allow schools to plan for how to absorb the cuts. The allowable growth rate of 2 percent for FY2005 did not make up the ground already lost: Real per-pupil spending is less than it was in FY1999.

The cost of providing a quality, modern and equitable education for each student rises each year. Minimally, legislators must set allowable growth above the rate of inflation. Otherwise, the quality of Iowa's educational system will steadily deteriorate and with it so will the quality of life of all Iowans.

Chapter 3.

Holes in the Safety Net

Iowa's State Fiscal Crisis and Its Impact on Human Services

By Charles Bruner and Victor Elias

Overview

During a recession, the demand for public services increases. More people need public assistance to support their families; fewer people are covered by health insurance through their employer; family stress causes an increase in child abuse and mental health and chemical dependency problems. Most of the state programs and services that address these needs are provided through funding that goes to the Iowa Department of Human Services (DHS).

This report analyzes how both state and overall appropriations for programs under the supervision of the Iowa Department of Human Services changed between state fiscal year 2001 and state fiscal year 2004. Outside of education, the DHS budget is the largest share of the state budget and its appropriations, but state appropriations tell only a part of the story. State general fund appropriations in FY2004 of $707.3 million for the DHS covered only 25 percent of the funding used by the department, with non-general fund expenditures totaling $2.835 billion, primarily from federal funds administered by the department.

Table 3.1 (page 20) shows the changes in general fund appropriations and non-general fund expenditures and authorized FTEs (full-time equivalent workers) for the DHS for fiscal years 2001 and 2004, by major department category (with the exception that state expenditures for child care have been moved from the child and family services section to the economic assistance section).

As Table 3.1 shows, overall general fund appropriations declined dramatically during this period (by 9.7 percent), while non-general fund expenditures rose even more dramatically (by 51.9 percent). Despite increased demand, the department's workforce declined substantially during the period.

Total general fund appropriations and non-general fund expenditures rose by 29.8 percent over the three-year period, which would appear as a healthy overall growth, well above the rate of inflation. This figure is deceptive, however, as it includes substantial new state expenditures established to draw down additional federal funding. As will be discussed later, the major reason for the increase in overall expenditures was the state's Medicaid program.

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Victor Elias *is a senior associate at the CFPC, where his responsibilities include research, budget and policy analysis on various issues.*

Table 3.1. Iowa Department of Human Services
General Fund Appropriations and Non-General Fund Expenditures and FTEs
FY2001 and FY2004, by Major Categories

	Actual 2001	Estimated Net 2004	% Change FY01-04
GENERAL FUND APPROPRIATIONS			
Economic Assistance and Child Care	$ 47,424,192	$ 49,123,135	3.6%
Medical Services	433,610,949	373,711,547	-13.8%
Child and Family Services	128,440,386	114,892,580	-10.6%
Mental Health, Mental Retardation, Developmental Disability, and Brain Injury (MH/MR/DD/BI)	104,631,003	105,222,096	0.6%
Managing and Delivering	68,909,400	64,318,185	-6.7%
Total General Fund Human Services	**$ 783,015,930**	**$ 707,267,543**	**-9.7%**
NON-GENERAL FUND EXPENDITURES			
Economic Assistance and Child Care	$ 142,410,580	150,969,095	6.0%
Medical Services	70,734,333	228,891,521	223.6%
Child and Family Services	29,935,270	34,565,543	15.5%
MH/MR/DD/BI Total	9,692,376	8,108,843	-16.3%
Managing and Delivering Services	18,290,783	19,556,433	-6.9%
Other DHS Federal (Grants and Match)	1,153,395,820	1,713,018,158	48.5%
Total Non-General Fund Human Services	**$ 1,424,459,162**	**$2,155,109,593**	**51.3%**
TOTAL HUMAN SERVICES EXPENDITURES (General and Non-General Funds)			
Economic Assistance and Child Care	$ 189,834,772	$ 200,092,230	5.4%
Medical Services	504,345,282	602,603,068	19.5%
Children and Family Services	158,375,656	149,458,123	-5.6%
MH/MR/DD/BI	114,323,379	113,330,939	-0.9%
Managing and Delivering Services	87,200,183	83,874,618	-3.8%
Other DHS Federal	1,153,395,820	1,713,018,158	48.5%
Total Human Service Expenditures	**$ 2,207,475,092**	**$ 2,862,377,136**	**29.7%**
TOTAL AUTHORIZED FTEs[1]			
Economic Assistance and Child Care	339.00	437.00	28.9%
Medical Services	21.00	21.00	0.0%
Child and Family Services	366.07	349.07	-4.6%
MH/MR/DD/BI	2,420.06	2,367.30	-2.2%
Managing and Delivering Services	2,457.66	2,094.00	-14.80%
Total Human Services Authorized FTEs	**5,603.79**	**5,268.37**	**-6.0%**

[1] These are Iowa Department of Human Services figures, and differ somewhat from those from the Legislative Fiscal Bureau figures. The Department also has provided information on actually funded and filled positions, which are shown in the Appendix. While the authorized figures are somewhat higher than the filled figures, the relationships across the years are consistent across most categories, except for Child and Family Services, which will be discussed later.

Source: Legislative Services Agency, Fiscal Division, unless noted otherwise

Over this period there were significant cutbacks in certain discretionary and often more preventive services, and there were major transfers of funds and uses of time-limited funding sources to meet ongoing program needs. The result has placed strains on most parts of the DHS budget and on the workers and providers who deliver services to those in need.

Summary of Impacts by Department of Human Services Appropriations Areas

The following summarizes what the report found for each of the service areas.

Economic Assistance and Child Care Summary

Over the last three years, while the state's economic position has worsened and Iowans generally have greater needs for economic assistance:-

- Overall state general fund expenditures have remained virtually unchanged over the three-year period (although non-general fund expenditures have increased).
- Two state-supported efforts to help families – emergency assistance and individual development accounts – have been eliminated.
- Iowa has not raised its payment benefits under TANF to reflect the impacts of inflation. Additionally, although Iowa has adopted standards for FIP hardship exemptions, a number of TANF recipients have reached their five-year eligibility limits and no longer quality for assistance at all.
- Iowa's child-care subsidy program remains among the least well-funded in the country, with major cliff effects due to the low eligibility limits for participation, and Iowa has done the minimum in meeting its maintenance of efforts requirements for child care.
- A declining share of state funding has been devoted to economically supporting families with children, when child care subsidies and payment benefits are combined, a trend that has continued from 1980 to the present.

Medical Services

Iowa is a major source of medical care for Iowa's children and for the elderly and persons with disabilities and must contend with the same medical cost issues that affect private employers and insurers. Medical services:

- represent the largest and fastest growing part of the DHS overall budget;
- have become the source for medical coverage for a large share of children from Iowa's working families whose health coverage needs are not being met by the private, employer-based health care system, yet are needed to enable those families to work;
- increasingly have been funded by resources that will not be there in the future;
- in some places (dental care and EPSDT services, in particular) do not provide sufficient financial incentives for comprehensive or accessible care; and
- will require significant and ongoing new general fund expenditures if needs are to be met.

Child and Family Services

While Iowa's child welfare system is generally considered to be underfunded and to face challenges in meeting federal expectations related to protecting children and achieving permanency and well-being goals:

- Overall child welfare expenditures declined, even though demand increased;
- Specific elements of the system were cut back, with the decategorization reserve funding eliminated, and the adoption subsidy program subject to new restrictions;
- Support for both purchase-of-service providers and institutions has forced real cuts in services and availability; and
- Federal funding under Title IV-E and particularly under Medicaid, and the flexibility of that funding, remained a major, unresolved issue with the federal government.

Mental Health, Retardation, Developmental Disability, and Behavioral Services

Over the last two decades, the state has taken increasing financial responsibility for financing mental health, retardation, developmental disability, and behavioral services. Between 2001 and 2004, however,

- Mental health services have not received increased funding to reflect inflation nor to address unmet need or increased demand as exists during recessions;
- Mental health institutes have been able to cope with reduced funding only by instituting major reductions in bed capacity;
- Several small and more discretionary services have been eliminated; and
- Services remain fragmented and of variable availability and quality throughout the state.

Managing and Delivering Services

The department needs staff to administer and manage the $2.3 billion budget and its many programs. Generally, demand increased for most DHS programs from 2001 to 2004, but the managing and delivering services component of the Department of Human Services has:

- been dramatically reduced at the general administration level;
- experienced reductions in administrative staff at the local level; and
- not kept pace at the direct field operations level with increases in caseloads, with caseload levels far above recommended levels in child welfare services, in particular.

Conclusion

DHS clients have felt the impact of the state fiscal crisis from 2001 to 2004 as resources have been held constant or reduced while service needs have increased. The resource reductions would be even greater if the figures were expressed in inflation-adjusted terms.

Overall state general fund expenditures have declined, but non-general fund expenditures have increased dramatically, almost exclusively the result of medical services expenditures and largely due to increased federal funding. A good share of this federal funding increase, however, is from time-limited funding sources or is under federal review and challenge.

There has been elimination of a number of small, discretionary services, such as emergency assistance and family assistance, and some cutbacks in others, such as adoption assistance, and a departmental reorganization has very significantly reduced general administration. Decategorization reserves were eliminated in order to address the budget crisis, removing one incentive to more community-based and prevention-focused service delivery. The state's commitment to more prevention-oriented services represents a very small part of the overall department's budget, but it has experienced very real cutbacks.

Most of the Department of Human Services budget is involved in administering services that are supported, at least in part, by federal funding, with attendant federal regulations and requirements with which the state must comply. The state has been successful in leveraging significant additional federal funding, particularly under Medicaid (through RTS services, the Senior Living Trust Fund, and the Hospital Trust Fund), but these have come with restrictions and with challenges. Maintaining the existing funding base, particularly related to intergovernmental transfers (the Senior Living Trust Fund and the Hospital Trust Fund) and RTS, will be a challenge in subsequent years.

While Iowans experienced significant cutbacks in certain services through the 2001 to 2004 fiscal years, and found others to be simply unavailable (such as dental care under Medicaid), the next few years will be critical in determining how much the state will commit to meeting child, family and senior health care and social needs, and how much support can be secured from the federal government to this end. The enhanced federal Medicaid match has expired, and no salary adjustments were built into the department's budget, effectively resulting in future staff cutbacks or other reductions in program.

At the same time that Iowans were affected by the recession and in greater need of the services the Iowa Department of Human Services provides, the state effectively cut back on many of the services being provided. Much repair and restoration work needs to be done if the Iowa Department of Human Services is to meet its mandates over the next several years.

Chapter 4.

Passing the Buck

Iowa's State Fiscal Crisis and Its Impact on Local Government

By Peter S. Fisher, Victor Elias and Jeremy Varner

The State of Iowa has experienced severe revenue shortfalls every year since fiscal 2001, creating budget problems that have impacted Iowa's local governments as well as state government. The capacity of Iowa's 99 counties and 949 towns and cities to provide basic local public services — police and fire protection, parks and recreation, planning and zoning, street and secondary road maintenance, and public health services — has been compromised. Cities and counties have been forced to lay off workers and increase service fees. They have spent down fund balances and increased property tax levies, in many instances to the maximum levy allowed by law.

One of the reasons that local governments have struggled is that the State of Iowa has passed them its own financial problems. The state has cut support for local governments by 42 percent — or $119 million — since FY2001. The financial troubles of cities and counties were compounded by another problem: sluggish growth in the property tax base. Total non-TIF valuation rose just 6.5 percent between FY2001 and FY2005 (1.6 percent per year), while inflation in the cost of state and local government services was 9.4 percent (2.3 percent per year). With a stagnant tax base, rising costs, and reduced revenue from the state, many cities and counties increased property tax rates to maintain services. Between FY2001 and FY2005, the number of counties that had reached or exceeded their general fund levy limit increased from 70 to 97, and the percent of cities at the general fund limit rose from 71 percent to 78 percent. Seventeen counties now exercise their authority to exceed levy limits due to unusual circumstances, while only one county did so in FY2001.

The spiraling cost of heath insurance has increased the cost of doing business for all employers, and local governments are no exception. From FY2001 to FY2004, the cost for county health insurance premiums increased by 78.4 percent. With general fund levies constrained, cities and counties turned to special levies to finance the rapidly increasing cost of health insurance. While other city property tax rates changed very little between FY2001 and FY2005, the average tax rate for employee benefits grew 32 percent. Meanwhile, the number of counties using the general supplemental levy rose from 72 to 92. On average, about three-fourths of the increase in overall city property tax rates is attributable to employee benefit levies.

More cities and counties have adopted local option sales taxes. This has not solved the financial problems facing local governments. Sales tax revenue has grown much more slowly than property taxes over the past four years. The local option sales tax, like the state tax, suffers from an eroding base due to the rising share of untaxed services and the shift to untaxed internet sales.

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Jeremy Varner *is a University of Northern Iowa student who interned at the IPP.*

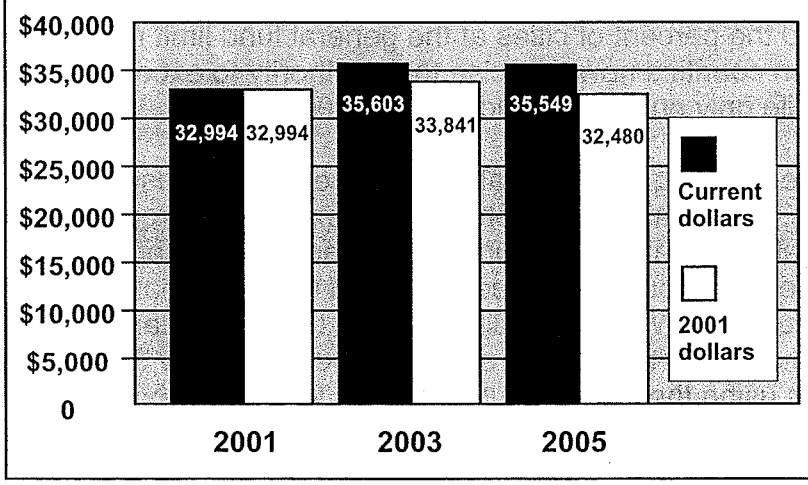
The Property Tax Base

Real property (land and buildings) remains the principal tax base for local governments in Iowa, despite the growth in local option sales taxes. While population and income growth drives increased demands for city and county services, and more revenue is needed to keep up with higher costs, the property tax base has not generally grown proportionately. This is primarily due to the state system of rollbacks, which has had the effect of reducing residential valuation to less than half its market value, and to the system of agricultural valuation (based on productivity rather than market value).

Overall gross taxable valuation in the state increased 8.3 percent between FY2001 and FY2005. Residential taxable value increased 16.4 percent over this period despite the rollback, and commercial and industrial property value grew almost 28 percent. Other classes of property — primarily agricultural land and buildings, and utility property — decreased. The fastest growing component of gross valuation was Tax Increment Financing (TIF) valuation, which grew in part because of the creation and expansion of TIF areas. TIF valuation grew by almost 50 percent over the four-year period (though it still accounted for just 5.7 percent of total value). Much of TIF valuation is dedicated to economic development or rebated to the property owner. Non-TIF valuation, which is a better measure of the tax base available to local governments to fund general city and county services, grew more slowly than total gross valuation — just 1.6 percent per year. The growth in total non-TIF valuation — 6.5 percent for the four years — is well below the rate of inflation as measured by the federal government's index for the cost of state and local government purchases, which increased 9.4 percent over that four-year period.

Combined with the tax rate limits, this slow growth in taxable valuation has clearly constrained the ability of cities and counties to finance services. For tax rates to remain constant while costs rise and population expands, taxable property values must increase enough to maintain a constant valuation per capita, after adjusting for inflation. Real (inflation-adjusted) per capita taxable valuation statewide did increase from FY2001 to FY2003, but has declined each year since, and in FY2005 was 3.6 percent below its 2001 level.

Figure 4.1. Per Capita Property Tax Base, Statewide

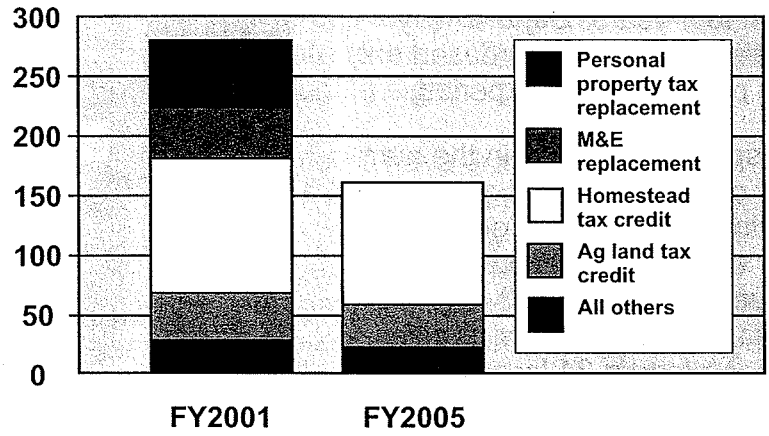


Property Tax Replacement Funds

All local governments, including cities, counties, school districts and community colleges, rely to a significant extent on state property tax replacement funds as a source of revenue. These replacement funds represent state revenue provided to local governments to compensate them for the state eliminating a local source of revenue (such as the property tax on machinery and equipment, livestock, or personal property) or to compensate for state mandated property

tax breaks (homestead credit, military credit, and elderly and disabled credit). In FY2001 these property tax replacement funds accounted for $280 million in revenue to all of Iowa's local governments. By FY2005 these replacement funds from the state had been reduced by 42.4 percent to $161 million, a loss of $119 million in revenues to Iowa's local governments. By FY2005, the only remaining property tax replacement money provided to local governments was to compensate for state-mandated property tax breaks. The state addressed its revenue shortfalls by transferring the problem to local governments.

Figure 4.2. Total Property Tax Replacement Funds to Local Governments ($ millions)



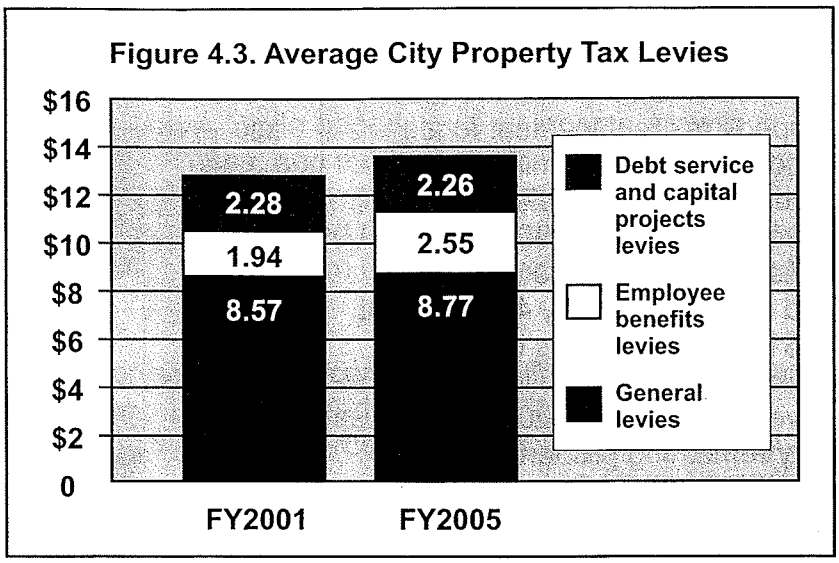
The City of Keokuk was probably the hardest hit by the elimination of machinery and equipment from the property tax base (and now the elimination of the reimbursement), losing over 10 percent of total valuation. This contributed to budget problems that led Keokuk to eliminate 10 full-time positions, or 9 percent of the city's workforce. Among counties, Clinton lost 12 percent of its property tax revenue (second only to Monroe County's 26 percent loss). Scott County lost $3.1 million in state tax replacements between FY03 and FY05, making up for the lost revenue by increasing property taxes $3.2 million.

City Revenues

One measure of the stress that the fiscal crisis has put on city governments is the actions that cities have taken to raise additional revenue. In Iowa, the property tax levy used to support the bulk of services, which are financed out of the city's "general fund," is effectively limited to $8.37 per thousand dollars of assessed valuation (the general fund levy of $8.10 plus the 27-cent emergency levy). In FY2001, 71 percent of Iowa municipalities were at the $8.10 limit, and 23 percent also levied all, or nearly all, of the allowable emergency levy. By FY2005, those proportions had increased; 78 percent of cities are now at the $8.10 limit, and 31 percent use at least 90 percent of the emergency levy.

Most cities have had little room to raise tax rates to offset the declining real per capita tax base, since most have been at the general fund levy limit for some time and many are using the entire emergency levy as well. Still, average property tax rates increased 6.2 percent from FY2001 through FY2005. However, 78 percent of that increase was attributable to the employee benefits levies, which are not subject to limit. These levies fund health insurance coverage and pension fund contributions. The City of Guttenberg, for example, has experienced increases in health insurance costs of 12 percent to 14 percent every year for the past several years, and has had to increase employee contributions, in addition to raising the property tax rate, to pay for these increases. Employee benefit costs have increased in Council Bluffs by 24 percent to 35 percent each of the past four years. Other cities have also passed on part of the cost increase to employees in the past two years: Cedar Rapids and Mason City are two examples.

On average for all cities, the employee benefits levy was raised almost 32 percent over the past four years. General levy rates, in contrast, increased only 2.3 percent over this period.



Despite an increase in the number of cities employing the local option sales tax, budgeted real per capita local option tax revenue increased just 3 percent from 2001 to 2005 for all cities. Among Iowa's 34 largest cities, local option tax revenue actually grew more slowly than the cost of producing services, so that actual real per capita revenues declined from FY2001 to FY2003, and were expected to decline further in the next two years. These trends reflect two factors: (1) the long-term decline in the sales tax base as purchases shift from goods to services (which are less likely to be subject to the sales tax) and as consumers rely more on mail order and internet purchases, on which state sales tax is rarely paid; and (2) the effects of the recession, which reduced consumer spending, particularly on goods subject to the local sales tax.

Intergovernmental aid also fell during the past four years. As a result, cities turned to increases in property tax rates and increases in fees, fines and charges to make up for the lost revenue. In percentage terms, the largest revenue growth was in fees, which increased 41 percent per person from FY2001 to FY2005. The City of Des Moines, for example, raised every one of the nearly 50 fees it charges.

City Expenditures and Fund Balances

In the face of declining revenues and a declining property tax base, cities have generally tried to preserve the most essential public services, such as police and fire protection. Cuts have been concentrated on public works and cultural and recreational programs. Overall, city government spending increased $10 in real per capita terms, a 1.8 percent increase, from 2002 to 2005. Most of this increase is attributable to the $14 increase in per capita spending for public safety, an area that accounts for about a third of city operating budgets. Because of rising costs, particularly of employee benefits, increased spending has often been accompanied by program cuts and elimination of positions, and many cities over this period reduced spending. Cedar Rapids cut over $3 million from its budget in the past two years, and eliminated 22.5 full-time-equivalent positions. Des Moines has eliminated 140 positions since FY2002.

One means of maintaining services as much as possible and minimizing layoffs is to draw down fund balances. This is a one-time source of money and cannot be relied upon for more than two or three years in succession. When and if revenues recover, some of the increased revenue may be needed to restore fund balances as well as restore services. While cities are wary of digging too large a hole for themselves, many in the past two years have decided to deplete fund balances rather than lay off more city employees and cut services further. Council

Bluffs, however, had to spend down its general fund balance from $6.8 million in FY2001 to $4.6 million by the end of FY2003, leaving little flexibility to deal with revenue shortfalls in FY2004. As a result, the city eliminated eight positions that year in the fire and police departments, and cut one of the four ambulances, and then was forced to lay off eight additional workers mid-year when it was hit with $754,000 in cuts in state revenue. The city followed with further cuts in FY05: 12 more positions were eliminated, including eight in public safety.

Of the 34 cities with populations over 10,000, increasing numbers have drawn down fund balances to make up for revenue shortfalls. By FY2004 and FY2005, about three-fourths of these cities had dipped into their fund balances. Twenty-nine had declining general fund balances in FY2004, and the median change during that fiscal year among the 34 was -7.6 percent. Twenty-three of the cities project balances to decline again in FY2005. During this period, the median city among the 34 largest saw its general fund balance at the start of the fiscal year decline from 27.0 percent of fiscal year expenditures in FY2003 to 25.6 percent in FY2004 and a projected 22.7 percent in FY2005.

County Revenues

As is the case with cities, the recent economic recession has impacted the capacity of county governments to meet the needs of their residents. During an economic contraction, there is a continued demand on county services, but not a commensurate growth in property values, which is the primary source of county revenue. As a result, counties have struggled with a mismatch between revenue and services demands over the last few years.

As with city governments, state actions have exacerbated county financial troubles. Cuts in state tax replacements have put pressures on counties to draw upon their reserves or to increase property taxes. From FY2001 to FY2005, state tax replacement payments to counties declined by $38.6 million, or 25.4 percent. With this decline in county revenue, counties were forced to look at their major revenue source, the property tax, in order to meet continued need for county services including public safety, human services, elections and recording mortgage transactions. County property taxes increased by 19.4 percent from FY2001 to FY2005. In FY2001, 29 counties were below their general fund levy limit of $3.50 per $1,000 valuation. Currently only two counties are below that limit. In FY2001, 72 counties used their general supplemental levy. Currently, 92 of Iowa's 99 counties are using that levy. Currently 17 counties are exercising their authority to exceed levy limits due to unusual circumstances, while only one county did so in FY2001.

County Expenditures and Fund Balances

Counties have worked to hold the line on county expenditures as they have dealt with declining state tax replacements and an increasing demand and cost for services. County total expenditures increased by a modest 8.8 percent between FY2001 and FY2005, below the 9.4 percent inflation rate as measured by the index for the costs of state and local government services. Even while trying to hold the line on expenditures, counties still saw an increase in the cost of public safety services, including law enforcement, jails, and criminal prosecution from FY2001 to FY2005. Over this period, county public safety costs increased by 22.9 percent, or $7.6 million. A significant portion of the increase in county cost is the increase in health insurance. From FY2001 to FY2004, the cost for county health insurance premiums increased on average

by 78.4 percent. Winneshiek County saw its health insurance premiums for single coverage rise 240 percent between FY2001 and FY2004.

In an attempt to limit the need for property tax revenue, counties have spent down their balances by $31.7 million, so that in FY2005 those balances are expected to be below 25 percent of county expenditures. Maintaining at least a 25 percent balance to avoid cash flow problems is considered important for good fiscal management, since county expenses occur throughout the year, while property tax revenues come in during the spring and fall.

Conclusion

Both city and county governments faced budget challenges from FY2001 to FY2005 that stemmed from common sources:

- An overall tax base (primarily property taxes) in which growth has not kept pace with the economy or demands upon local governments;
- Rapidly expanding health care costs for employees that represent an increasingly large part of local expenditures; and
- Declines in state property tax replacement funding, as a result of state efforts to deal with the state fiscal crisis.

While different city and county governments acted differently, in general city and county governments acted to maintain essential services, particularly police and fire protection, through:

- Raising property tax levies to the maximum rate allowed and, when necessary, adopting emergency levies;
- Spending down their budget reserves; and
- Raising fines, permit fees and charges for services.

Even with these actions, city and county budgets grew more slowly than the inflation rate, and the result has been some elimination of services and laying off of local government employees. The loss of state property tax replacement funds, totaling over $110 million, produced particular challenges. In many instances, these state actions had the effect of raising local property tax levies.

As cities and counties look into the future, many must replenish their budget reserves and seek sustainable funding bases for local services, with the current property tax base unlikely to be able to fully play that role.

Chapter 5.
A Chronic Crisis

Can Iowa Keep Its Promises?

By Elaine Ditsler, Charles Bruner and Peter S. Fisher

For state legislators, there is no more important responsibility than passing a yearly budget. The budget determines the investments that Iowa will make in education, health care, public safety, infrastructure, the justice system and the workforce, all of which underpin a healthy economy. Iowans are rightly proud of the quality of life in this state, and understand that it depends in no small part on the quality of our public education system, our roads, and other public services. Yet Iowa is now at a crossroads; the state's ability to keep its promises in the coming years will depend crucially on how clearly we recognize the problems we face and take responsibility for solving them.

From 1996 until 2001, Iowa and the entire country experienced an economic boom, which increased personal income and caused state tax collections to swell. During this period, Iowa was quicker than most states to enact tax cuts and slower than most to expand spending. In fact, tax cuts enacted during that time – when fully phased in – will reduce general fund revenue by $700 million annually.

Since the economy routinely cycles between periods of growth and retraction, budget discipline must apply equally to tax cuts and to spending increases. In the late 1990s, legislators enacted unsustainable tax cuts based on temporary surges in revenue. This failure to budget over the full economic cycle is the primary reason for the state's shaky financial situation over the last several years. The tax cuts, combined with Iowa's changing economy and demographics, have resulted in a mismatch between revenues and expenditures, which the recent recession has only amplified.

As this and other reports in this budget series show, Iowa's response to the financial crisis – cutting services, adopting new tax cuts, and raiding special funds – has likely extended the state's financial problems into the future. Few, if any, government services were left unscathed by the budget cuts and the severely curtailed spending deepened the recession by pushing up unemployment. Cuts in state spending caused layoffs in the public sector, in the companies that operate under contracts with the state, and in other companies due to the multiplier effect of more unemployed Iowans with less income to spend. As Nobel Laureate economist Joseph Stiglitz has noted, reductions in state spending during a recession can be more harmful than tax increases. By enacting additional tax cuts *during the recession*, Iowa worsened its own financial position.

Instead of seeking permanent sources of revenue, Iowa turned to finite revenue sources. The Senior Living Trust Fund, the Healthy Iowans Tobacco Trust, the Endowment for Iowa's Health Account and 38 other funds, most of which were intended for vastly different purposes, were raided to shore up general fund budget gaps. These dollars are no longer available for their intended purposes, and many funds – most notably the Senior Living Trust Fund – are precariously close to broke.

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As we look to the future, we face the challenge of replenishing the funds that were raided, at the same time that shifting demographics, a changing economy, and an outdated tax system are likely to put further strains on the state's finances. Iowa's sales tax has not adjusted to the new economy, corporate income tax collections have declined substantially, and we may well face declining federal revenue in the near future. Furthermore, as Iowa's population ages, a greater share of Iowans will be drawing primarily on income from pensions and Social Security, which already is taxed at a substantially lower rate than the same amount of earned income, reducing revenues at the same time that strains on the Medicaid system increase. Seniors account for a large share of total Medicaid expenditures, primarily because of nursing facility costs, and Iowa's population over age 65 is projected to grow 57 percent between 2000 and 2025.

These trends suggest that the state will continue to be hobbled by budget deficits in the future unless Iowa takes corrective action now. In order to meet its responsibilities to all Iowans, the state needs to modernize its tax system by closing tax loopholes, broadening the sales tax base and fixing the personal income tax.

How Iowa Balanced the Budget: FY2001- FY2005

Like a family, state government must live within its means. As with almost all states, the Iowa Constitution prohibits deficit spending. A projected deficit requires that Iowa increase revenues, reduce spending or take other measures before it adopts a budget. The general fund is the primary operating budget for state government. In addition, there are other funds that are typically dedicated for specific purposes. For example, the Road Use Tax Fund collects gasoline tax revenues, which, according to the Iowa Constitution, can only be spent for road construction, maintenance, and related purposes. Other non-general funds, such as the Senior Living Trust Fund, the Rebuild Iowa Infrastructure Fund and the Endowment for Iowa's Health Account were established for specific purposes, but the General Assembly can depart from those original intentions.

Faced with cumulative general fund budget gaps of over $3 billion between fiscal 2001 and 2005, the state cut $1.4 billion in services and made $2 billion in transfers from sources outside of the general fund (see Figure 1).[1] In turn, services that were funded by these other (non-general fund) sources had to be scaled back. In Figure 1, Iowa's fully funded budget for 2001 is based on fiscal 2000 appropriations plus built-in costs for 2001, as estimated by the Legislative Services Agency.[2] Following the same methodology, each year's fully funded budget is estimated based on the previous year's actual appropriations plus built-in costs and an amount sufficient to pay for all of the services that were shifted to non-general funds during the previous year.[3] This method provides a conservative estimate, since it automatically ratchets down the base if there are cuts in the previous year. This is why a "fully funded budget" required fewer dollars in 2004 and 2005.

During this period, the state permanently eliminated some of its responsibilities, including part of the Educational Excellence program and two property tax replacement credits, which cut a com-

[1] About $657 million of the $2 billion were revenue transfers, which are transfers of money from a special fund to the general fund (see Figure A-3 in the Appendix). The rest were expenditure transfers, which are transfers of funding responsibilities (programs and services) from the general fund to special funds (see Figure A-1 in the Appendix).The state also de-appropriated $85.2 million from the general fund for the Endowment for Iowa's Health Account, which is not counted as a transfer but has the same effect as a revenue transfer.

[2] Built-ins are estimated by the Legislative Services Agency. They are a standing appropriation required by the Code of Iowa, an entitlement program, or an appropriation for a future fiscal year that increases or decreases compared to the prior year.

[3] Programs and services shifted to non-general funds are known as expenditure transfers. The authors took care to ensure that some expenditure transfers were not double counted as built-ins.

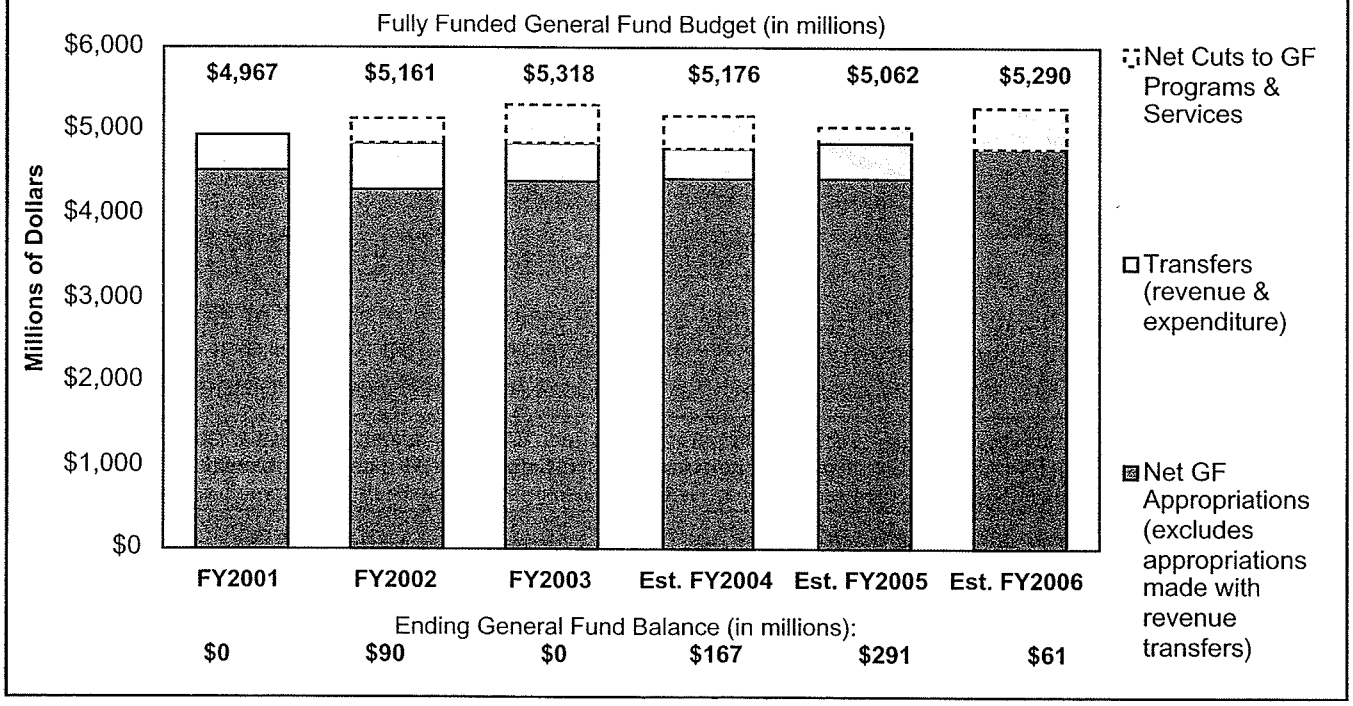
bined total of $119 million from the budget.[4] The number of full-time state workers decreased by 1,585 employees between FY2001 and FY2003, and additional workers were laid off by private contractors and providers due to the state budget crisis.

By 2005, cuts to key programs and services were still not fully restored in such areas as education and child and family services:

- Higher education spending is $124 million short of its 2001 level;
- The state match for the K-12 Instructional Support Program continues to be capped at $14 million, forcing property taxpayers to pick up the balance;
- Over one-third of the state's mental health institutes' beds have been closed;
- The state ended its long-time emergency assistance program;
- Despite a 20 percent increase in child abuse cases, the child welfare budget remained flat.

Furthermore, of the money that was borrowed from special funds (represented by the "transfers" in Figure 5.1), none has been replaced. State law requires that a portion ($118 million) be reimbursed

Figure 5.1. How Iowa Balanced the Budget, FY2001-FY2005 (and a projection for FY2006)



Source: Legislative Services Agency, Fiscal Services Division

Notes: Revenues are based on December 2004 Revenue Estimating Conference projections. A fully funded budget is equal to the previous fiscal year's GF appropriations (before reversions) + net built-in increases + an amount to pay for all of the GF services that were shifted to non-general funds during the previous year. Since a "fully funded budget" is based on the previous year's actual GF appropriation, cuts in one year can reduce the base budget in the next year. School aid and other standing appropriations and entitlement programs are automatically added back as built-ins. However, other cuts, such as the across the board cuts, and cuts to higher education and property tax credits ratchet down the base, and therefore reduce the amount that constitutes a fully funded budget in the next year.

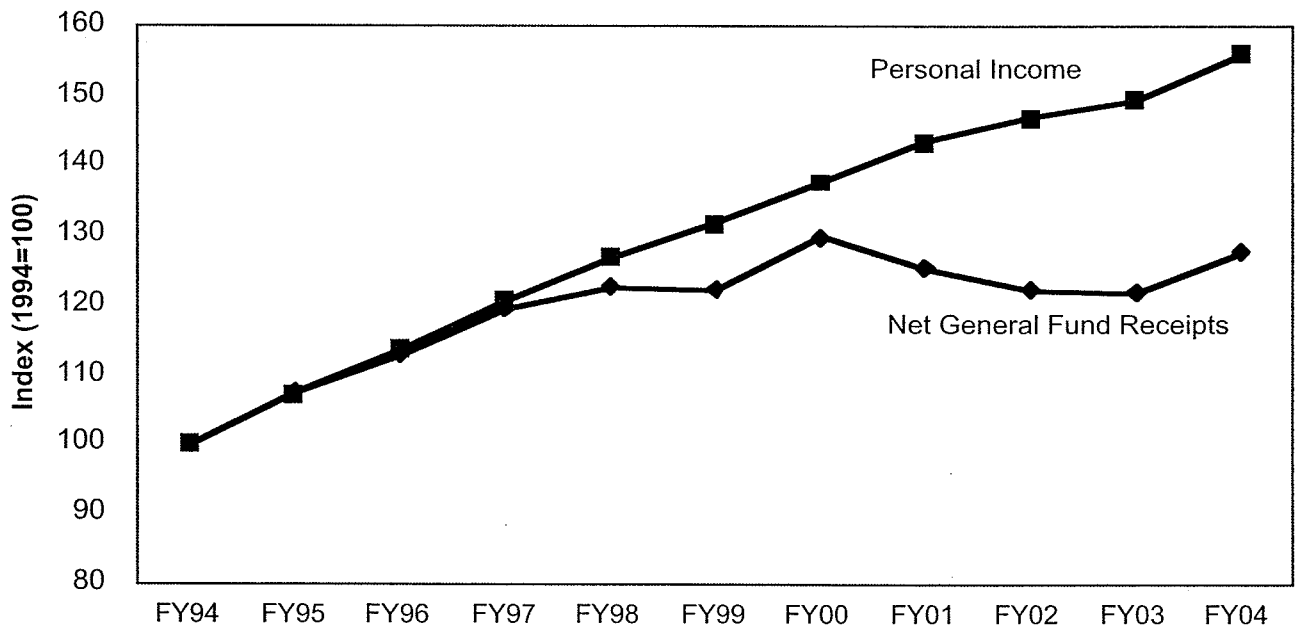
[4] The Machinery & Equipment Property tax credit replacement was permanently eliminated, cutting about $42 million from the budget between 2001 and 2005. The Property Tax Replacement credit was also permanently eliminated- cutting $52 million from the budget between 2001 and 2004.

to the Senior Living Trust Fund and $172 million be reimbursed to the Endowment for Iowa's Health Account. With the state already facing a projected shortfall for 2006, revenues will be insufficient to repay these amounts in 2006.

What Happened to Revenues?

A comparison of personal income growth with revenue growth shows that tax cuts, rather than a weak economy, are the main culprit for the fall-off in revenues in the last several years. Between 1994 and 1997, personal income and general fund receipts grew together. However, since 1997, personal income has continued to climb while general fund revenues declined (see Figure 2).

Figure 5.2. The Divergence of Personal Income Growth and General Fund Revenue Growth



Source: Legislative Services Agency, Fiscal Services Division, State of Iowa; Bureau of Economic Analysis.

Notes: Numbers are indexed to 100 in order to provide relevant units of comparison. General fund receipts are on an accrual basis. In order to make comparisons over time, the FY2001-FY2004 figures do not include revenue transfers into the general fund from non-general fund sources.

After suffering through three of the toughest budget years since the 1980s, revenues have begun to recover slightly. However, revenues are growing from the depressed level they reached in the depths of the fiscal crisis. Despite the moderate turnaround, Iowa still is projected to have a budget shortfall for 2006.

Ideally, the tax system should generate excess revenue during economic boom times, with the excess placed in reserves – a rainy day fund. This fund should be sufficient to sustain government services during a recession. Demand for many government services is actually higher during a recession, due to increased need for so-called "safety net" services. When the tax system does not generate sufficient revenue over the course of the business cycle to maintain public services in good times and bad, a state is said to have a "structural deficit." Iowa's tax system and rainy day

fund did not permit the state to maintain services and local government support during the current prolonged downturn, and they will not do so in the future without reform.

As it stands now, Iowa needs to collect about $514 million more than is currently projected by the Revenue Estimating Conference in order to afford a fully funded budget in FY2006. The state must replenish its two rainy day funds with $292 million and reimburse $290 million to the Senior Living Trust Fund and the Endowment for Iowa's Health Account. Ideally, the state should also, but is not required to, reimburse all special funds for the $2 billion taken since 2001.

The raiding of the Senior Living Trust Fund will be particularly damaging in future years. The Senior Living Trust Fund was established in 2001 and was originally intended as a source of funding to help the elderly to stay in their homes instead of going into nursing facilities. With the fiscal crisis, it has become a popular source of money for programs that previously had been funded by the general fund. Between FY2001 and the end of FY2005, the trust fund will have paid for $490 million in general fund programs, the vast majority of which ($448 million) was for Medicaid. About 88 percent of total trust fund expenditures were spent on Medicaid, while only 3 percent were spent on conversion grants for in-home care (which was the original purpose of the trust fund).

The trust fund was capitalized with deposits from the federal government. However, the federal government is discontinuing these transfers, and the trust fund will no longer receive deposits. As a result, the fund is likely to be depleted by FY2006. Going forward, the important funding that the Senior Living Trust Fund has provided to the Department of Human Services (over $485 million, primarily for Medicaid) and the Department of Elder Affairs (over $31 million between FY2001 and FY2005) will have to be replaced with general fund money.

Outlook and Policy Recommendations

Iowa's response to the state fiscal crisis over the last four years has not addressed the underlying cause of that crisis – the structural deficit that in large measure was the result of large tax cuts enacted from 1995 to 2000 (and exacerbated by further cuts since 2001, despite the recession and budget shortfalls). This structural deficit will worsen, as previously enacted tax cuts continue to be phased in, while service needs and costs continue to rise. Iowa must address this structural deficit and, in doing so, must also recognize that changing demographics and a changing economy require tax modernization. The following is a very broad-brush description of these changes and their implications for tax policy.

1. Changes toward a more service- and information-based economy

The country has moved from a goods-based manufacturing economy to a much more service-based economy. One of the consequences has been that a sales tax based upon goods no longer collects revenue in an amount that reflects consumer spending. Extending the sales tax to a much broader range of consumer purchasing activities is needed to sustain the sales tax as a revenue source that reflects such purchasing.

2. The broadened boundaries for business

In recent years, multi-state businesses have found new and very effective ways of exploiting loopholes in state tax codes. These loopholes allow them to shift taxable income from one state to another to minimize their corporate income tax bill. Moving to combined reporting is one necessary way to ensure that firms conducting business in Iowa are subject to taxation here.

3. The internet and its impact

The growth of the internet as a means for handling commerce has been huge and is expanding. Iowa has taken steps to collect sales taxes on internet sales to Iowans, and this is an important first step. Other forms of commerce, such as telephone service, will also increasingly be handled through the internet. It is critical that states have the authority to tax internet commerce simply for reasons of tax equity, since traditional Main Street retailers must continue to collect the tax from their customers. Failure to do so, moreover, is likely to have significant impacts upon state tax collections.

4. The aging of society and the growth in retirement income

Iowa is continuing to age. In 2000, there were four working-age people (18-64) for every person over 65; by 2020, that figure will decline to fewer than three working-age people. Not only does that put a greater responsibility on those working to support their families, it also places challenges on the state tax system. Those over 65 receive most of their income through Social Security and pension fund benefits. However, this income is taxed at a lower rate than income from work. Iowa law currently exempts from taxes the first $6,000 of pension income ($12,000 if married filing jointly). And because of generous exemptions for Social Security income, over two-thirds of Social Security recipients pay no tax on their benefits, and the remaining recipients pay tax on, at most, 50 percent of their benefits. Tax policies should not exempt more of this income from ever being taxed, at the risk of severely eroding Iowa's income tax base as the population ages. The same holds for a total repeal of the inheritance tax, as, in many inheritances, much of the wealth has never been taxed. Like the situation for the tax on Social Security and pension income, there is a wide misunderstanding of the actual impact of the existing inheritance tax and about who would benefit from repeal.

5. Trends toward the concentration of wealth and income.

Those who have benefited most from economic growth over the last 20 years have been individuals at the very top of the income and wealth scale. Because Iowa's overall state and local tax system is regressive, taking a smaller share of income from those at the top of the scale, most of the income gains have gone to those paying the smallest share of their income in taxes. A flat (proportional) or progressive overall tax system is needed to ensure that state government continues to collect the revenues needed to support basic services. The individual income tax remains the only progressive tax in Iowa's overall tax structure. If the goal is an overall proportional system, the income tax needs to be more progressive in order to compensate for the much larger regressive parts (sales and property) of the tax code.

6. The growth in tax expenditures as a tool for economic development

Particularly when there was strong state revenue growth, the state enacted a number of tax "incentives" marketed as supporting economic growth and development. Unlike appropriations, these tax expenditures are not reviewed annually and do not require re-enactment, nor are they limited in terms of their overall expense to the treasury. Some of the estimates of their cost to the treasury were far below what they eventually cost. Additionally, it has been hard to track their overall costs, let alone determine whether they achieved their economic development justification. The decline in corporate tax revenues is one sign that these tax expenditures have reduced tax collections substantially. These expenditures need to be reviewed on a periodic basis and held up to much greater public scrutiny. They need to be much more transparent than they are currently, with required disclosures of the tax filers who make use of them and the size of their benefits. They should receive at least as much scrutiny as line item expenditures in the state budget.

7. *Other trends that will reduce revenues or increase spending needs*

- Nationally, the federal deficit is creating new calls to restrict domestic spending and take such actions as block granting Medicaid and Title IV-E (foster care), which is likely to translate into reduced revenues to state governments.
- Federal actions may be taken to restrict state authority to tax – from e-commerce to definitions of taxable connection (nexus) to determinations of taxable income under corporate and individual income taxes.[5]
- The rapid rise in health insurance costs will continue to drive inflation in the cost of state and local government well above increases in the general cost of living and require government to take a larger share of personal income just to maintain services.
- The "sin tax" revenues that Iowa has counted on to balance budgets are not likely to grow with the economy, as tobacco consumption declines and the state reaches the saturation point in gambling revenues.
- The continuing rise in prison populations due to sentencing legislation in the 1990s will continue to drive up corrections expenditures.
- City, county and school budgets will continue to be strained by the urbanization of the population combined with urban sprawl, which leaves rural areas with an aging and expensive infrastructure with excess capacity, while demands for urban services in developing suburbs continue and the fiscal capacity of central cities and older suburbs declines.

It's time for a long-range look at Iowa taxes. The current Iowa tax system requires modernization to reflect dramatic changes in the economy if it is to continue to provide the revenues, in a fair and competitive manner, that state government needs to fulfill its responsibilities. If we do not confront our long-term budgetary problems now, state and local governments will not be able to keep their promises to the citizens of Iowa to maintain the quality of life that they cherish, for themselves and their children.

[5] While Iowa can choose not to couple with federal tax changes regarding deductions and taxable income, this complicates tax filing and is often difficult to achieve politically. Further, it places additional responsibilities on sole state enforcement rather than adherence both to state and IRS regulations and laws.

Appendix

Table A-1
Net Tax Increases Enacted in the 50 States by Type of Tax

	United States		Iowa	
	General Fund Expenditures ($ in millions)	Yearly Change	General Fund Expenditures ($ in millions)	Yearly Change
1994	$322,162		$3,503	
1995	$345,216	7.2%	$3,641	3.9%
1996	$358,664	3.9%	$3,855	5.9%
1997	$374,099	4.3%	$4,138	7.3%
1998	$393,736	5.2%	$4,359	5.3%
1999	$421,470	7.0%	$4,529	3.9%
2000	$468,216	11.1%	$4,763	5.2%
2001	$488,458	4.3%	$4,887	2.6%
2002	$497,997	2.0%	$4,605	-5.8%
2003	$508,450	2.1%	$4,529	-1.7%
2004	$522,492	2.8%	$4,499	-0.7%
Change from 1994 - 2001	51.6%		39.5%	
Change from 2001-2004	7.0%		-7.9%	
Change from 1994-2004	62.2%		28.4%	

Source: National Association of State Budget Officers

Table A-2

General Fund Expenditures in the 50 States, 2001-2005 ($ millions)

	2001 Actual Expenditures	2002 Actual Expenditures	2003 Actual Expenditures	2004 Est. Expenditures	2005 Rec. Expenditures	2001-04 %Change	2001-05 %Change
NEW ENGLAND							
Connecticut	$11,883	$12,187	$12,120	$12,562	$13,154	5.7%	10.7%
Maine	2,571	2,584	2,533	2,556	2,662	-0.6%	3.5%
Massachusetts	22,133	22,800	22,439	21,930	22,979	-0.9%	3.8%
New Hampshire	1,070	1,174	1,336	1,376	1,390	28.6%	29.9%
Rhode Island	2,483	2,650	2,682	2,796	2,899	12.6%	16.8%
Vermont	867	881	888	905	939	4.4%	8.3%
MID-ATLANTIC							
Delaware	2,429	2,454	2,454	2,650	2,785	9.1%	14.7%
Maryland	10,238	10,572	10,347	10,262	11,234	0.2%	9.7%
New Jersey	20,811	21,997	23,568	23,854	25,708	14.6%	23.5%
New York	36,840	38,324	37,613	42,071	41,896	14.2%	13.7%
Pennsylvania	19,862	20,429	20,400	21,462	22,334	8.1%	12.4%
GREAT LAKES							
Illinois	17,961	17,831	21,893	22,766	23,416	26.8%	30.4%
Indiana	10,018	9,708	10,309	11,437	11,357	14.2%	13.4%
Michigan	9,859	9,298	8,735	8,813	8,655	-10.6%	12.2%
Ohio	21,143	21,627	22,653	23,778	24,752	12.5%	17.1%
Wisconsin	11,078	11,259	11,033	10,566	11,563	4.6%	4.4%
PLAINS							
Iowa	4,887	4,605	4,529	4,499	4,759	-7.9%	2.6%
Kansas	4,429	4,466	4,138	4,332	4,615	-2.2%	4.2%
Minnesota	12,755	12,333	13,894	13,966	14,108	9.5%	10.6%
Missouri	6,610	6,626	6,382	6,597	7,097	-0.2%	7.4%
Nebraska	2,479	2,599	2,619	2,603	2,757	5.0%	11.2%
North Dakota	819	862	860	884	920	7.9%	12.3%
South Dakota	793	848	884	934	976	17.8%	23.1%
SOUTHEAST							
Alabama	5,213	5,325	5,473	5,566	5,699	6.8%	9.3%
Arkansas	3,242	3,213	3,251	3,526	3,652	8.8%	12.6%
Florida	19,779	19,044	20,514	21,260	23,785	7.5%	20.3%
Georgia	14,644	15,014	16,025	16,175	16,125	10.5%	10.1%
Kentucky	6,969	7,082	7,179	7,281	7,418	4.5%	6.4%
Louisiana	6,280	6,484	6,617	6,505	6,711	3.6%	6.9%
Mississippi	3,398	3,304	3,458	3,591	3,540	5.7%	4.2%
North Carolina	13,446	13,741	13,856	14,799	15,505	10.1%	15.3%
South Carolina	5,422	5,179	4,995	4,901	4,996	-9.6%	7.9%
Tennessee	7,293	7,779	7,914	8,295	8,955	13.7%	22.8%
Virginia	11,270	11,129	12,118	12,301	13,148	9.1%	16.7%
West Virginia	2,547	2,817	2,933	3,226	3,078	26.7%	20.8%
SOUTHWEST							
Arizona	6,372	6,339	6,026	6,541	7,165	2.7%	12.4%
New Mexico	3,595	3,918	4,051	4,503	4,384	25.3%	21.9%
Oklahoma	4,770	4,882	4,653	4,699	4,716	-1.5%	1.1%
Texas	28,427	29,890	30,656	29,434	29,460	3.5%	3.6%
ROCKY MOUNTAIN							
Colorado	5,641	5,742	5,913	5,662	5,916	0.4%	4.9%
Idaho	1,829	1,980	1,926	1,994	2,084	9.0%	13.9%
Montana	1,268	1,353	1,283	1,290	1,323	1.7%	4.3%
Utah	3,906	3,625	3,536	3,614	3,770	-7.5%	3.5%
Wyoming	368	390	788	788	1,023	114.1%	178.0%
FAR WEST							
Alaska	NA	2,392	2,496	2,301	2,252	-3.8%	*5.9%
California	78,053	76,752	77,482	78,028	76,062	0.0%	2.6%
Hawaii	3,365	3,656	3,806	3,823	4,058	13.6%	20.6%
Nevada	1,691	1,817	2,037	2,320	2,545	37.2%	50.5%
Oregon	4,825	5,822	3,825	5,251	4,945	8.8%	2.5%
Washington	10,827	11,214	11,330	11,219	11,700	3.6%	8.1%
TOTAL	$488,458	$497,997	$508,450	$522,492	$536,970	7.0%	9.9%

* Alaska's Percent Change is from 2002

Source: National Association of State Budget Officers

Table A-3

Actual, Estimated Education Expenditures in the 50 States, 2001-2003 ($ millions)

	2001 Actual Expenditures	2002 Actual Expenditures	2003 Est. Expenditures	2001-03 %Change
NEW ENGLAND				
Connecticut	$2,173	$2,002	$1,994	-8.2%
Maine	954	926	956	0.2%
Massachusetts	3,884	4,155	4,085	5.2%
New Hampshire	883	949	988	11.9%
Rhode Island	670	708	746	11.3%
Vermont	735	784	NA	6.7%
MID-ATLANTIC				
Delaware	1,130	1,202	1,245	10.2%
Maryland	3,026	3,172	3,395	12.2%
New Jersey	6,787	7,234	7,832	15.4%
New York	14,219	15,145	15,626	9.9%
Pennsylvania	6,482	6,714	6,995	7.9%
GREAT LAKES				
Illinois	6,035	6,025	6,397	6.0%
Indiana	4,210	3,891	4,231	0.5%
Michigan	11,297	11,268	11,399	0.9%
Ohio	6,669	7,164	7,378	10.6%
Wisconsin	4,948	5,125	5,359	8.3%
PLAINS				
Iowa	2,048	2,082	2,129	4.0%
Kansas	2,307	2,361	2,363	2.4%
Minnesota	4,382	4,478	5,647	28.9%
Missouri	3,522	3,614	3,699	5.0%
Nebraska	781	866	870	11.4%
North Dakota	313	321	343	9.6%
South Dakota	327	343	342	4.6%
SOUTHEAST				
Alabama	3,155	3,314	3,391	7.5%
Arkansas	1,770	1,790	1,894	7.0%
Florida	7,944	7,654	8,229	3.6%
Georgia	6,034	6,238	6,331	4.9%
Kentucky	2,952	2,990	3,061	3.7%
Louisiana	2,558	2,784	2,865	12.0%
Mississippi	1,756	1,772	1,891	7.7%
North Carolina	5,732	5,880	5,904	3.0%
South Carolina	2,459	2,432	2,505	1.9%
Tennessee	2,557	2,607	2,733	6.9%
Virginia	4,363	4,447	4,399	0.8%
West Virginia	1,448	1,491	1,587	9.6%
SOUTHWEST				
Arizona	2,557	2,955	3,002	17.4%
New Mexico	1,668	1,870	1,821	9.2%
Oklahoma	2,504	2,482	2,431	-2.9%
Texas	13,508	13,166	13,966	3.4%
ROCKY MOUNTAIN				
Colorado	2,278	2,553	2,763	21.3%
Idaho	974	1,005	1,020	4.7%
Montana	515	566	579	12.4%
Utah	1,637	1,735	1,699	3.8%
Wyoming	493	497	501	1.6%
FAR WEST				
Alaska	NA	NA	NA	NA
California	28,548	28,515	27,744	-2.8%
Hawaii	1,310	1,545	1,467	12.0%
Nevada	719	816	883	22.8%
Oregon	2,293	2,737	2,373	3.5%
Washington	4,845	5,077	5,197	7.3%
TOTAL	$194,359	$199,447	$204,255	5.1%

* Vermont's Percent Change is 2001-2002

Source: National Association of State Budget Officers

Table A-4

Iowa Tax Cuts in Millions of Dollars and as a Percentage of Previous Year's Tax Collections Contrasted with Percentage Changes as the Result of Tax Law Changes in the 50 States

	1996	1997	1998	1999	2000	2001	2002	2003	2004
10% Income Tax Cut			$103.0	$102.0					
Insurance Premium									$12.2
Pension Tax	$ 22.2			$ 24.4					
Inheritance/Estate								$15.2	$12.5
Personal Exemption				$ 28.8					
Capital Gains Increase				$ 18.0					
Dependent Credit	$ 16.5								
Health Ins. Deduct		$11.8							
Chapter S				$ 9.8					
Index Brackets	$ 6.0								
Tuition/Textbook				$ 3.8		$ 7.9			
IPERS Pretax			$ 4.4	$ 4.4					
Other *		$ 0.6	$ 1.2	$ 8.0		$ 3.0			
Sales Tax on Utilities						$ 45.0			
Sales Tax Holiday					$ 5.8				
Hospitals Exemption				$ 15.0	$ 15.0	$ 15.0			
Internet Sales					$ 5.8				
M & E			$ 4.0		$ 1.4				
Other **	$ 2.0	$ 0.4	$ 0.5	$ 1.4	$ 0.5				
New Cuts in Year	$ 46.7	$ 12.8	$113.1	$215.6	$ 28.5	$ 70.9		$ 15.2	$ 24.7
Iowa Calculations									
Pvs Year Tax Coll.	$4,193.1	$4,424.2	$4.683.8	$4,894.4	$4,946.0	$5,213.9	$5,315.9	$5,127.3	$5,208.7
Cuts as % Pvs Year	98.9%	99.7%	97.6%	95.6%	99.4%	98.6%	99.6%	100.0%	98.2%
Cumulative % Red.	98.9%	98.6%	96.2%	92.0%	91.5%	90.2%	89.8%	89.8%	88.2%
Reduction 01-04									-2.2 %
50-State Calculations									
Cuts as % Pvs. Year	99.0%	99.4%	98.4%	98.3%	98.0%	99.7%	101.6%	101.6%	101.0%
Cumulative % Red.	99.0%	98.4%	96.8%	95.2%	93.3%	93.0%	94.5%	96.0%	97.0%
Increase 01-04									4.3 %

Notes on Table: The Iowa tax reductions are based upon an Iowa Department of Management report and are used to calculate the percentage tax reductions for the years 1996 through 2001. The gross tax collection data is taken from an Iowa Department of Revenue Report. While the tax changes from the Iowa Department of Management report are shown for 2002-04, the % changes are drawn from the National Conference of State Legislatures' report and are slightly different as to timing. The federal data are taken from the National Conference of State Legislatures' report, with the 2004 data only representing 40 of the 50 states. These figures do not reflect a legislative change that occured after FY2004 in a special session to allow a bonus depreciation for certain business purchases.

Table A-5

State Tax Changes, 2002-2004 ($ millions)

	2002 Actions		2003 Actions		2004 Actions
	Net Tax Change	% of 2001 Taxes	Net Tax Change	% of 2001 Taxes	% State Tax Change
NEW ENGLAND					
Connecticut	$ 73.6	0.7%	$ 613.0	6.8%	No Change
Maine	25.7	1.0%	57.2	2.2%	+ 1 - 5%
Massachusetts	962.0	5.6%	140.0	0.9%	Not Applicable
New Hampshire	0.0	0.0%	- 58.2	- 3.1%	No Change
Rhode Island	30.1	1.3%	37.7	1.8%	+ > 5%
Vermont	39.8	2.6%	42.2	2.8%	No Change
MID-ATLANTIC					
Delaware	0.0	0.0%	119.6	5.5%	Not Applicable
Maryland	93.9	0.9%	52.3	0.5%	No Change
New Jersey	1,073.0	5.6%	452.4	2.5%	+ > 5%
New York	279.8	0.6%	2,979.9	6.9%	Not Applicable
Pennsylvania	729.6	3.2%	747.5	3.4%	No Change
GREAT LAKES					
Illinois	372.0	1.6%	453.0	2.0%	Not Applicable
Indiana	925.1	9.1%	-11.7	-0.1%	No Change
Michigan	231.4	1.0%	17.1	0.1%	Not Applicable
Ohio	404.0	2.1%	1,516.6	7.7%	Not Applicable
Wisconsin	-9.0	-0.1%	3.8	0.0%	No Change
PLAINS					
Iowa	-18.9	-0.4%	1.3	0.0%	- 1% or More
Kansas	270.0	5.4%	6.5	0.1%	No Change
Minnesota	16.2	0.1%	27.2	0.2%	No Change
Missouri	60.0	0.7%	8.6	0.1%	No Change
Nebraska	107.1	3.5%	29.4	1.0%	No Change
North Dakota	0.0	0.0%	1.5	0.1%	No Change
South Dakota	0.0	0.0%	6.4	0.7%	No Change
SOUTHEAST					
Alabama	126.5	2.0%	0.0	0.0%	+ 1 - 5%
Arkansas	0.0	0.0%	120.9	2.4%	+ > 5%
Florida	141.4	0.6%	-51.0	-0.2%	No Change
Georgia	-12.2	-0.1%	122.9	0.9%	No Change
Kentucky	0.0	0.0%	2.6	0.0%	No Change
Louisiana	-3.0	0.0%	0.0	0.0%	+ 1 - 5%
Mississippi	0.0	0.0%	-1.0	0.0%	No Change
North Carolina	129.6	0.8%	81.8	0.5%	Not Applicable
South Carolina	10.0	0.2%	-1.0	0.0%	No Change
Tennessee	755.6	9.7%	0.0	0.0%	Not Applicable
Virginia	1.0	0.0%	10.5	0.1%	+ 1 - 5%
West Virginia	-18.0	-0.5%	99.0	2.8%	No Change
SOUTHWEST					
Arizona	101.4	1.2%	69.7	0.8%	No Change
New Mexico	-5.6	-0.1%	45.3	1.2%	No Change
Oklahoma	101.0	1.6%	68.0	1.1%	Not Applicable
Texas	0.0	0.0%	15.0	0.1%	No Change
ROCKY MOUNTAIN					
Colorado	0.0	0.0%	0.0	0.0%	No Change
Idaho	0.0	0.0%	174.5	7.7%	No Change
Montana	0.0	0.0%	43.1	3.0%	No Change
Utah	11.9	0.3%	19.2	0.5%	No Change
Wyoming	0.0	0.0%	20.0	1.8%	No Change
FAR WEST					
Alaska	2.7	0.2%	0.9	0.1%	No Change
California	1,995.0	2.2%	100.0	0.1%	Not Applicable
Hawaii	-65.1	-1.9%	-16.0	-0.5%	No Change
Nevada	0.0	0.0%	413.0	10.5%	No Change
Oregon	176.0	3.0%	37.0	0.7%	No Change
Washington	-15.9	-0.1%	145.1	1.1%	No Change
TOTAL	$9,097.7	1.6%	$8,762.8	1.6%	0.5%

Source: National Conference of State Legislatures

Reports from the Iowa Fiscal Partnership

The Iowa Fiscal Partnership produced several papers examining Iowa budget policy in recent months. They are available as free downloads from the IFP website, http://www.iowafiscal.org.

- ***Everything You Wanted to Know About Closing Tax Loopholes and Balancing Iowa's Budget ... But Were Afraid to Ask.*** 40 pages.

- ***Iowa Voters and Taxes: Strong Public Support for Selective Taxes to Maintain Services.*** 6 pages.

- ***Property Tax Assessment in Iowa: Changes With HF692.***
  By Thomas Pogue. 31 pages.

- ***Rethinking Iowa's Personal Income Tax: Tax Reform Based Upon Recognized Tax Principles.***
  By Charles Bruner. 10 pages.

- ***Iowa Taxes on Social Security Benefits – The Facts.*** 2 pages.

- ***Whose Bonus? No Rationale for Iowa Adopting Federal Depreciation Options.***
  By Charles Bruner and Peter S. Fisher. 2 pages.

- ***Average by Any Measure: State and Local Taxes in Iowa.***
  By Peter S. Fisher. 6 pages.

Our Vanishing Budgets: Iowa's Response to the Fiscal Crisis in the States

(5-part series)

- ***The State Fiscal Crisis, 2001-2004: Comparing Responses of Iowa and Other States.***
  By Charles Bruner and Michael Crawford. 14 pages.

- ***Iowa's State Fiscal Crisis and Its Impact on Education: Erosion of Support at All Levels.***
  By Jeremy Varner and Elaine Ditsler. 63 pages.

- ***Iowa's State Fiscal Crisis and Its Impact on Human Services: New Holes in the Safety Net.***
  By Charles Bruner and Victor Elias. 32 pages.

- ***Iowa's State Fiscal Crisis and Its Impact on Local Government: Cities and Counties Face Tough Choices and Diminished State Support.***
  By Peter Fisher, Victor Elias and Jeremy Varner. 48 pages.

- ***A Chronic Budget Crisis: Can Iowa Keep Its Promises?***
  By Elaine Ditsler, Charles Bruner and Peter S. Fisher. 23 pages.

IOWA STATE ASSOCIATION OF COUNTIES

Budget and Legislative Recommendations for
Department of Human Services
Fiscal Year 2006–2007

ISAC's Mission Statement:
To promote effective and responsible county government for the people of Iowa.

The Iowa State Association of Counties (ISAC) would like to thank the Council on Human Services for the invitation to provide input into the development of the FY 2006–2007 DHS budget and legislative package. Counties understand that one of the major quality-of-life/local funding issues they face is the ongoing underfunding of DHS programs and the ensuing ramifications at the local level.

That said, we have been working with the Department and the Legislature for a number of years on the Mental Health and Developmental Disabilities service system in Iowa. ISAC has aggressively pursued redesign of the Iowa MH/MR/DD/BI system. This pursuit is an attempt to create a quality system for Iowans with disabilities by enhancing their quality of life and increasing their self-sufficiency.

In order for the State of Iowa to realize the system redesign proposed by the MH/MR/DD/BI Commission, there must be adequate state funding to support this system change. SF 69, the beginning of MH/DD system redesign was based on the premise that the service system should NOT be funded primarily with property taxes. SF 69 capped the amount that counties can raise through property taxes to fund the system. Additional funds have to come from the state.

During the last session two system redesign elements were proposed which stepped away from this premise and would have put additional pressure on local property tax dollars to fund MH/DD services. One proposal was to devolve the state case program to the counties with the counties at risk for at least some portion of any increased costs. The other proposal was for the development of a new service for persons with brain injury with the costs shared by the state and the counties.

Whether the cases of persons without legal settlement in a county in Iowa are managed by the state or the counties, those individuals must have access to the same services menu at the same rates as the person's county of residence. Until this is done, system redesign will be at an impasse. Having the counties financially at risk for additional populations without adequate state funding, puts the whole system at risk of collapse.

As it relates to brain injury services, the legislature expressed concern that the counties will not manage brain injury services responsibly without having county dollars invested. There is a simple resolution to this issue – the state can design, fund and manage any new services added to the brain injury service delivery system.

ISAC supports the following improvements to the disability service system:

- Maintenance of Medicaid-funded case management services for persons with disabilities and the addition of this service for persons with state case status;
- Adequate funding of the state payment program, along with necessary statutory changes, to allow the state to provide the same services at the same reimbursement rate as the person's county of residence;
- Adequate funding of technical assistance and oversight of the Medicaid program, most critically the Adult Rehabilitation Option (ARO) and the expansion of Home and Community Based Services (HCBS) in congregate living settings.

Due to the lack of resources to support adequate training, technical assistance, and oversight for the ARO program, the State of Iowa now faces a $6.2M payback to the federal government following an audit of the program. While the counties fund the local match for this program, they have no control over it. Counties took an $18M cut in MH/DD allowed growth in the FY 2002 as part of the state's efforts to balance the state budget. Several reasons were cited for the amount of this cut including the projected savings to the counties through the new Adult Rehabilitation Option (ARO) to be implemented July 1, 2001. As the state looks for sources to funds the payback, it is important to remember that the ARO "savings" to counties have already been "scooped" by the legislature.

It is also important to understand that counties have consistently called for more stringent monitoring of the program since its inception. The following policy statement was included in ISAC's FY 2003 Policy Statements and Legislative Objectives book:

> "It has become increasingly apparent that the state needs to develop a better method of providing technical assistance and oversight of the Adult Rehabilitation Options (ARO) services. The Medicaid program currently does not have the resources to provide this service and there is some risk that the way the services are provided and the way that costs are allocated might not be in compliance with Medicaid regulations. ISAC supports funding for quality assurance reviews of ARO providers by the Iowa Department of Human Services (DHS) to assure that persons served are eligible for the services and that the documentation meets state and federal requirements."

This policy statement was edited in the FY 2004 book to include concern about the Home and Community Based Waiver Services (HCBS). ISAC continues its offer to work with the Department to improve the training and monitoring of the program as well as the accuracy of the Adult Rehabilitation Option billings.

July 9, 2005

Ruth L. Mosher, Chair
Council on Human Services
1224 25th Street
West Des Moines, Iowa 50266

Dear Ms. Mosher:

Thank you for the opportunity to testify at the Iowa Department of Human Services 2007 budget hearing.

We hope you will give consideration to our suggestions on how to meet the growing demand for care and supportive services for Iowans by ensuring a stable direct care workforce. We look forward to working with you to find ways to foster public and private partnerships by leveraging private foundation funding to help augment funding shortfalls and ensure that Iowa's needs are met.

Please extend our appreciation to the council members.

Sincerely,

Di Findley
Executive Director
Iowa CareGivers Association
515-241-8697

Iowa Council on Human Services
Recommendations Submitted by
Iowa CareGivers Association
For 2007 DHS Budget Hearing

Recommendations/Requests
Support Direct Care Retention and Recruitment by:

1) **Considering Direct Care Workers in any targeted awareness campaign related to eligibility for Iowa's expanded health care coverage**
2) **Allocating $350,000 a year to the ICA over the next two years to build capacity around the proven effective DCW Leadership and Mentor programs in order to reduce staff turnover rather than subsidizing turnover**
3) **Continue to support the ICA's DCW annual educational conference scholarship program**
4) **Build upon the vast body of work on DCW Recruitment and Retention that already exists through the Iowa Better Jobs Better Care Program, Iowa CareGivers Association, the Center for Health Workforce Planning within the Department of Public Health, and others when creating new initiatives such as the expansion of home and community based services**

Rationale
Most Iowans who receive nursing home or home care prefer developing a special personal relationship with one or two direct care workers and a recent focus group discussion with Iowa family members of those who have used home care services or a nursing home to provide care or services for a loved one also said that they believe high turnover in Certified Nurse Aides and Home Care Aides diminishes the quality of care that their loved ones receive. Worker shortages are due, in part, to workers leaving the field at alarming rates and most often within the first three months of employment.

Studies conducted by the Iowa CareGivers Association and the Iowa Better Jobs Better Care Program, a $1.3 million grant program funded by The Robert Wood Johnson Foundation and the Atlantic Philanthropies, and for which the ICA is the lead agency, reveal that Direct Care Workers leave the field due to:

- Poor wages
- Lack of benefits (25% CNAs in nursing homes have no health care coverage from any source) (Explain: some may be part time.... Ultimately – uninsured caring for or assisting the uninsured! Poster kids for the issue. The state's ability to negotiate funding to expand coverage

to the uninsured is great...but this segment of the uninsured should also be targeted.
- Lack of educational and advancement opportunities within the field of direct care
- Lack of respect
- Short Staffing

A recent report conducted by Dorie Seavey, PhD, labor economist of the Paraprofessional Healthcare Institute for BJBC found that the cost for every direct care worker who leaves is between $3000 and $3500. There are approximately 18,000 CNAs alone employed in Iowa, and as many as 60% of them turn over annually. Thus the estimated annual cost of turnover for Iowa's Certified Nurse Aides who work in nursing homes is: $35,100,000
18,000 x .60% = 10,800 x $3,000 = $32,400,000 - $37,800,000

That $35 million could go a long way toward health care coverage or an educational scholarship or program to stop the high rates of turnover.

Iowa Climate
Direct care worker recruitment and retention issues are now on the federal and state level radar screens. They are on the agendas for the National Governor's Association and the White House Conference on Aging. The Quality Improvement Organizations in all states are now required by Centers for Medicare and Medicaid Services to focus on CNA Recruitment and Retention. Our state team headed up by Iowa's QIO, IFMC, has formed a Person Directed Care Coalition. In addition, the IFMC has convened a DCW recruitment and retention subgroup which also met recently and identified 3 priorities: Direct Care Worker Mentoring, Direct Care Worker Leadership, and Supervisory Coaching. All of these activities present opportunities to partner and to leverage private foundation dollars to help augment state and nonprofit association budgets to address these serious issues. The ICA and BJBC project bring the DCW Leadership Training, and DCW Mentor Training, a curriculum that was originally developed through initial funding for the CNA Recruitment and Retention pilot project. Over the years, through the project and our various activities we have demonstrated positive retention outcomes. Unfortunately, we have not had the resources to build capacity around these programs so that we can be of greater assistance to Iowa's long term care providers, workers, advocates, consumers, and their families.

The Iowa Better Jobs Better Care Program is a 3 ½ year program that allows us to work with 14 long term care providers to implement direct care worker leadership training, mentoring, and person directed care training. It is the first time that two major private foundations have earmarked significant funding for DCW R/R. Iowa was one of 5 states in the country to be awarded.

In addition, a BJBC Coalition of approximately 15 different agencies and organizations was formed. They achieved a great deal in the area of policy with two pieces of legislation passing during the last legislative session:
With $124,000 of the BJBC funding we contracted with DIA to make the necessary technological changes within the Registry so that it will accommodate all classifications of direct care workers. Currently only those CNAs working in nursing home are required by federal law to be on the Registry. HF810 appropriates $80,000 for the maintenance of these major Registry expansion changes.

The Governor signed Executive Order 43 last week calling for an expansion of home and community based services. The EO will help to facilitate consumer directed care and cash and counseling models currently being pursued in Iowa. There is language in the Order that calls for the creation of yet another Registry. I would urge the department and those working with the disability community to view the work that has been done by the ICA and the Iowa BJBC as a benefit and something to build upon rather than spending additional dollars to create a new registry.

HF781 calls for a DCW Education Task Force to be administered by the Iowa Department of Public Health. The BJBC Coalition conducted a statewide DCW Education survey of workers, long term care administrators, and long term care licensed nurses. This data is in the process of being tabbed. It is our hopes that this group will serve in some capacity to inform the DCW Ed Task Force.

And finally, we know that DCWs leave the field due to a lack of health care coverage. The state's ability to negotiate with the feds, the funding to expand health care coverage to more Iowans should consider this segment of the uninsured population to conduct any targeted eligibility awareness programs. And we would be happy to help in that effort.

Recommendations/Requests
Subsidize Direct Care Worker retention rather than turnover:

1) **Consider Direct Care Workers in any targeted awareness campaign related to eligibility for Iowa's expanded health care coverage**
2) **Allocate $350,000 a year to the ICA over the next two years to build capacity around the DCW Recruitment/Retention efforts**
3) **Continue to support the ICA's DCW scholarship program**
4) **Build upon the vast body of work on DCW Recruitment and Retention that already exists through the Iowa Better Jobs Better Care Program, Iowa CareGivers Association, the Center for Health Workforce Planning within the Department of Public Health, and others when creating new initiatives such as the expansion of home and community based services**

Initial Estimated Budget

○ Train the Trainer/Hire 2 additional trainers	$200,000
○ Benefits $50,000 x .20% - $10,000 x 2	$ 40,000
○ Other staff (Director/Support/Program Director	$100,000
○ Benefits	$ 20,000
○ Travel state	$ 40,000
○ Meeting/Program Costs	$ 70,850
○ Supplies	$ 39,000
○ Contractors/Consultants	$ 100,000
▪ Program Planning/Assessment	
▪ Evaluation	
○ Admin 15%	$ 90,150
TOTAL	$700,000

TOTAL Year One: $350,000
TOTAL Year Two: $350,000

Testimony: the Council on Human Services :July 13, 2005
By Julianne O'Connell Beckett, National Director of Policy
Family Voices, Inc.

Members of the Council I am pleased to have this opportunity to speak before you today. Let me begin by introducing Family Voices. We are a grassroots network of families and friends speaking on behalf of children with special health care needs. Our current membership includes 50,000 families across this country many of whom are currently enrolled in Medicaid and SCHIP programs. It is my responsibility to help them understand the policy implications for such programs and to assist states in developing programs that can best serve our children. It is in that capacity that I come here today.

While State Medicaid programs are facing an increase in the population roles and thus in the cost of service delivery to this population it is advocates such as yourself who must speak up to the concerns of how services are delivered and at what cost do we face should we not provide a comprehensive service package to our most vulnerable population in the most cost effective and efficient way possible.

My experience tells me that having those most knowledgable in coordination of such services is critical. In 1984 I joined the University of Iowa Hospital and Clinics staff as a paid parent consultant. Working closely with Dr. John MacQueen, then Director of the Child Health Specialty Clinics we developed a program that assisted families of children with special health care needs whose children needed access to the home and community-based waiver program. We developed a case management tool that trained DHS social workers to utilize this program in the most effective and efficient manner while allowing children who would normally be institutionalized to stay at home with their families and actively participate in community life.

Along with Pediatric Nurse Practitioner Brenda Rae Moore we traveled around this state to assist nurses working in CHSC's

regional centers to develop the required plan of care, with their DHS social work partners, by identifying services, who was responsible for payment of those services and who would be delivering those services.

It did not take long for the Department to recognize the importance of having such a comprehensive look at community based systems of care to support these vulnerable families and so a contract was developed between CHSC's and the Regional nursing staff and DHS.

Here I must emphasize that children with special health care needs are not just little adults-they get sicker quicker, the systems that serve them are necessary to their growth and development and their families must be provided the supports they need to maintain these very vulnerable children in as natural a setting as possible so that they may become active citizens in their community. These families do require family-to-family support but even more so they need to know that this system that has helped them will be there should a crisis occur.

John MacQueen was a visionary who recognized the importance of the expertise families have to offer in developing and guiding the system in creating the best outcomes for these children and their families. The Regional Centers were developed to assure that no family had to travel more than 45 minutes to receive the kind of medical expertise only found at the University of Iowa Hospitals and Clinics in the early 1970's. That meant that if a child needed to be seen at clinic the family had to travel 2-6 hours to wait in an all-day clinic and then return home. Families from Council Bluffs, Sioux City, Spencer, Creston and even Dubuque would often have to take one day off work to travel to Iowa City spend the evening in a hotel, sit the next day in clinic, spend another night in a hotel and drive home the next day. Many parents were losing three work days every few months so their children could receive adequate care or they had the choice of leaving their children at the University for months at a time to receive such care-not exactly the most family friendly system.

Why am I telling you this? Well as of July 1st CHSC has had to reduce their nursing staff from nine nurses to three. The contract that CHSC had to assist the Department of Human Services with these children in disease management has been awarded to the Iowa Foundation for Medical Care. IFMC while I am sure is a wonderful organization, my question is, will have they have the expertise that CHSC has developed over these many years to serve these families? Who will train those at IFMC to know how best to work with these families and these community systems?

I am assured that currently no centers will be closing but who can say in these turbulent times. These centers are funded under the MCHB block grant but we all know how vulnerable a block grant program can be at the federal level. Will CHSC centers have the funds to sustain the caseload especially with an increase in slots on the waiver program without this contract?

Won't there be a duplication of services if IFMC does the assessment of this population and decide level of care but the "parent consultants" working at 18 hours a week help with the plan of care? Both functions used to occur at the same time under the CHSC program. Why did someone not ask about the impact of these decisions? In many instances these parent consultants, I emphasize again, who will work part time (18 hours a week) will have an increase in their caseload by 100-150%. Will IFMC nurses be doing site visits? If they need to do 5 assessments a day clearly they will not be doing home visits as currently occurs for most of the waiver clients on initial assessment?

It is my understanding that the current Director of CHSC was not even informed that contract renewal would not be forthcoming. He should have been involved in the discussions that would ultimately undermine this important program for children and their families.

I am asking that due diligence be paid to this vulnerable population. I have been assured by Kevin Concannon that he and others on his staff are looking at assisting CHSC as they identify ways to continue support. I applaud those efforts but again

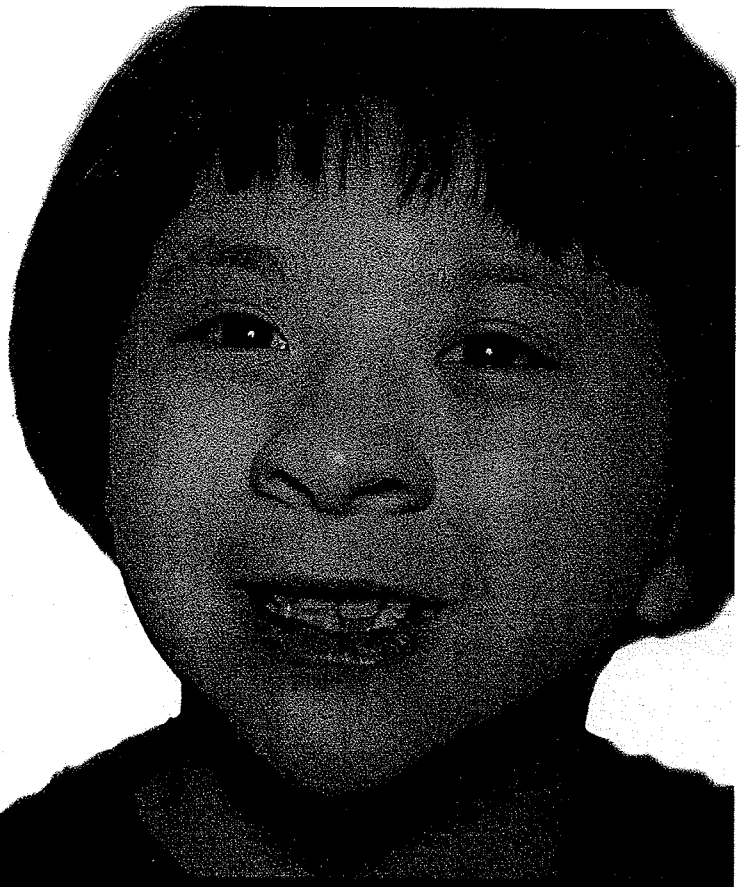
emphasize that decisions like this that have far flung consequences should never be made internally without first receiving all of the information necessary to prevent a disaster from occurring. You can only achieve that goal by communication with all parties involved. I will be glad to help in anyway to assist the Department but urge you to take measures that such incidence like this do not occur again. I urge you to request a complete review of training opportunities for IFMC staff who will be working with this population. As a part of the new Medicaid commission I will push for a better understanding of the role of care coordination and disease management and will defend and promote the CHSC model as the most cost effective, efficient and safe system for children with special health care needs.

Serving People with Disabilities

NFDH

National Foundation of Dentistry for the Handicapped

A charitable affiliate of the American Dental Association



Annual Report 2003-2004

28,000 disabled, elderly, and other vulnerable individuals received $13 million of dental services during the year through the Foundation's three direct-service programs: **Donated Dental Services (DDS), BRIDGE,** *and* **HouseCalls.** *The 5,648 people assisted through DDS received $12.2 million in free comprehensive treatment.*

Direct-care program services accounted for 93% of the Foundation's expenses. An additional 7% involved general management while fund raising accounted for 2%.

Imagine if you didn't have any fillings, only large cavities and throbbing toothaches. Imagine not having any teeth or dentures. Imagine your teeth literally crumbling as you chew. Imagine the pain, the embarrassment, the difficulty eating. Imagine being helpless to do anything about the dilemma because disabilities prevent you from working and being able to afford needed care. Such imaginings are regrettable realities for many people.

"The inherent dignity of every person is reflected through a healthy smile."

Imagine your relief and gratitude when a simple request for help results in pain-relieving and dignity-restoring care. That, too, is fortunately a reality for many.

The National Foundation of Dentistry for the Handicapped, a charitable nonprofit organization, has created and is expanding humanitarian projects that help vulnerable individuals enjoy the comfort, function, and dignity of dental health. That work is supported through service and monetary contributions from a large and growing coalition of dentists, laboratories, dental companies and organizations, foundations and government. They are acknowledged by group in this report since each cannot be personally recognized and thanked.

11,600 Volunteer Dentists

Dentists, using their own offices, donate comprehensive care for individuals referred through the **Donated Dental Services (DDS)** program. Projects are operational in 34 states and the Foundation's national DDS Program helped people in 16 more states and the District of Columbia. Volunteers donated $12.2 million in treatment to 5,648 people during the fiscal year, a 6% increase from the previous year. Since DDS began as a pilot project in Colorado in 1985, more than 60,000 disabled or elderly people have received over $72 million of treatment.

Continued from front

Several dentists also participate in the **Dental HouseCall** project. Equipment is transported to private residences, long-term care facilities, inner city schools, and mental health centers. Individuals unable to go to dental offices are provided comprehensive care at those sites. Approximately 3,900 individuals in New Jersey and metropolitan Chicago were assisted with $720,000 in treatment. Twenty-three percent (23%) was contributed.

The Dental HouseCall unit in New Jersey serving patients.

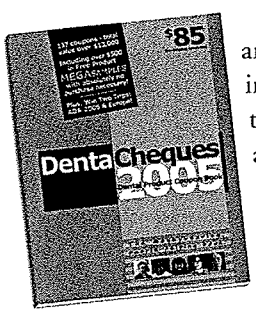
2,836 Volunteer Dental Laboratories

Many people assisted through the DDS program need crowns, bridges, and full or partial dentures, the fabrication of which involves dental laboratories. Participating labs donated over $935,000 in services during the year.

Darla DeKoster, a Certified Dental Technician with Davis Dental Laboratory in Wyoming, MI, one of the generous labs volunteering in the DDS program.

Dental Companies

Several companies provide free replacement of materials used by volunteer labs for DDS cases, thereby enabling the labs to contribute more than they otherwise could. **Dentsply International** donates teeth used in dentures, and **Argen**, **Heraeus Kulzer**, and **Ivoclar Vivadent** replace metal alloys used in crowns and bridges. **Implant Innovations, Inc.** donates materials for patients requiring implants.



These companies, and 64 others, contribute in another important way through their discount and rebate offers in the **DentaCheque** dental product coupon book, a unique fund-raising project benefiting the Foundation. Annual development of DentaCheques is sponsored by the **Colgate Palmolive Company** and the **American Dental Trade Association**. The current edition includes 134 money-saving offers for dentists. DentaCheque sales provided $405,545 in general support for the Foundation during the fiscal year.

Hundreds of sales representatives with participating supply companies volunteer to promote DentaCheque, accounting for more than half of all sales. Many also distribute information about the Donated Dental Services program to their dentist customers.

Teachers and Counselors

BRIDGE is a preventive dental health outreach project to reduce the amount and severity of disease among developmentally disabled individuals. Program hygienists work in schools, vocational training centers, and group homes. Information from oral screenings is used to prioritize referrals for treatment, and guide teachers in providing oral health instruction. Over 18,000 individuals in Colorado, New Jersey, and Oregon were served.

Ronnie Calem, a BRIDGE program hygienist in New Jersey, with special education students.

Dental Organizations

The following national dental organizations are assisting with the expansion of DDS by encouraging members to participate. Many of their state and local units additionally help in various ways, including providing office space for DDS program coordinators, publicizing the project, offering financial support, and/or having representatives on boards of NFDH state affiliates.

State Governments

State governments provide most of the operating support for the **DDS**, **HouseCall**, and **BRIDGE** projects. The value of that public support is substantially compounded through the charitable work of dentists and laboratories, and the preventive intervention of hygienists, teachers, and counselors.

Delta Dental Plans / Foundations

Additional operating support for the direct-service programs in several states is provided by **Delta Dental Plans** and foundations. Benefactors for each project are listed in the DDS Services & Supporters green shaded area.

Subsequent to the September 11, 2001 atrocities, most state governments plummeted into difficult deficits. Funding was reduced for health and human service programs assisting vulnerable individuals, increasing the need for charitable dental care. The Foundation responded with a commitment to promptly expand Donated Dental Services (DDS) throughout the country. The **xélan Foundation** (San Diego, CA) provided a significant grant in support of the initiative. Additional funding was provided by the **Daniels Fund** (Denver, CO) and **Great-West Life and Annuity Insurance Company**.

American Dental Association

Academy of General Dentistry

American Academy of Periodontology

American College of Dentists

American Association of Endodontists

American Association of Oral and Maxillofacial Surgeons

American College of Prosthodontists

American Academy of Implant Dentistry

American Association of Women Dentists

Hispanic Dental Association

National Association of Dental Laboratories

American Dental Assistants Association

American Association of Orthodontists

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Combined Statement of Support, Revenue and Expenses and Changes in Fund Balances

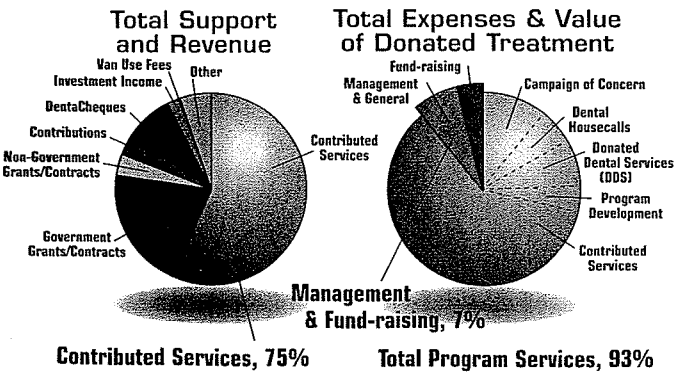
Year Ending June 2004

Copy of complete audited financial statements available on request.
Audited by Gelfond Hochstadt Pangburn P.C.

	Year Ending June 2004
PUBLIC SUPPORT	
Grants and contracts,	
Governmental agencies:	1,768,876
Non-governmental agencies:	428,661
Contributions	339,299
	2,536,836
Contributed services:	9,130,111[1]
Total public support	11,666,947
REVENUE:	
Special events:	
Revenues	45,600
Cost of special events	-6,255
DentaCheques revenue	405,545
Investment income	93,706
Other revenue	24,969
	563,565
Total public support & revenue	**12,230,512**
EXPENSES:	
Program services:	
Campaign of Concern	698,636
Dental Housecalls	73,532
Donated Dental Services	1,315,234
Program Development	128,095
	2,215,497
Contributed services	9,130,111
	11,345,608
Support services:	
Management and General	630,055
Fund-raising, DentaCheques expenses	209,872
Total supporting services	839,927
Total expenses	**12,185,535**
Net assets at beginning of year	2,992,738
Net assets at end of year	3,037,715[2]

[1] DDS licensees reported an additional $3,077,980 in donated dental treatment.

[2] Includes $941,058 temporarily and permanently restricted for program operations.



DDS Services & Supporters

***Licensee program **Also includes funding for Dental HouseCalls and/or BRIDGE**

ALABAMA DDS Mr. Wayne McMahan, Alabama Dental Association • 247 dentists and 75 laboratories • $255,925 in donated services to 169 people • Sponsors/Funders: Alabama Dental Association, Alabama Medicaid Agency, and National Foundation of Dentistry for the Handicapped

ALASKA DDS Dr. Julie Robinson, Chair • 76 dentists and 34 laboratories • $121,069 in donated services to 34 people • Sponsors/ Funders: Alaska Dental Society, Alaska Division of Mental and Developmental Disabilities, Division of Senior and Disabilities Services, Governor's Council on Disabilities and Special Education, and Mental Health Trust Authority

***ARIZONA DDS** Mr. Rick Murray, Arizona Dental Association • 93 dentists and 33 laboratories • $2,114 in donated services to 2 people • Sponsors/Funders: Arizona Dental Association, Arizona Department of Health Services, Office of Oral Health, and The Robert Wood Johnson Foundation

***ARKANSAS DDS-Arkansas Health Care Access Foundation** 115 dentists and 23 laboratories • $112,64 in donated services to 49 people • Sponsors/ Funders: Arkansas Dental Association, Arkansas Department of Human Services, and Rebsamen Insurance Foundation

CALIFORNIA DDS (Sacramento, Bay Area and Los Angeles) 644 dentists and 191 laboratories • $76,996 in donated services to 43 people • Sponsors/ Funders: California Dental Association, Delta Dental Plan of California, and National Foundation of Dentistry for the Handicapped

****COLORADO Foundation of Dentistry for the Handicapped** Dr. Paul Bottone, President • 700 dentists and 220 laboratories • $955,186 in donated services to 367 people • Sponsors/ Funders: Chamberlain Foundation, Colorado Dental Association, Colorado Dental Association Charity Fund, Colorado Department of Public Health and Environment, Colorado Division of Developmental Disabilities, Colorado Trust, Delta Dental Plan of Colorado, Denver Foundation – Lowe Fund, Hil Foundation, A. V. Hunter Trust, Mile High United Way, and Pacificare Foundation

FLORIDA DDS Dr. Samuel Dorn, Chair • 338 dentists and 107 laboratories • $370,408 in donated services to 147 people • Sponsors/ Funders: Florida Dental Association, National Foundation of Dentistry for the Handicapped, Retirement Research Foundation, South Florida Dental Foundation, and South Florida District Dental Association

HAWAII DDS Dr. Mel Choy, Chair • 62 dentists and 16 laboratories • $62,110 in donated services to 25 people • Sponsors/ Funders: Hawaii Council on Developmental Disabilities, Hawaii Dental Association, and Hawaii Department of Health

****ILLINOIS Foundation of Dentistry for the Handicapped** Dr. Gerald Ciebien, President • 639 dentists and 134 laboratories • $781,149 in donated services to 383 people • Sponsors/ Funders: Chicago Dental Society, Cuneo Foundation, Delta Plan of Illinois, Glenkirk, Illinois Central College, Illinois Department of Public Health, Illinois State Dental Society, Otto W. Lehmann Foundation, and Retirement Research Foundation

INDIANA Foundation of Dentistry for the Handicapped Dr. W. Randall Long, President • 614 dentists and 138 laboratories • $516,595 in donated services to 236 people • Sponsors/ Funders: John W. Anderson Foundation, Indiana Dental Association, Indian State Department of Health, and Indiana University School of Dentistry.

KANSAS Foundation of Dentistry for the Handicapped Dr. Wayne Thompson, President • 284 dentists and 67 laboratories • $452,427 in donated services to 20 people • Sponsors/ Funders: Kansas Dental Association and Kansas Department of Social and Rehabilitation Services

LOUISIANA Foundation of Dentistry for the Handicapped Dr. Raymond Unland, Jr., President • 383 dentists and 107 laboratories • $276,473 in donated services to 204 people • Sponsors/ Funders: Louisiana Dental Association, Louisiana Office for Citizens with Developmental Disabilities, LSU School of Dentistry, and United Way for the Greater New Orleans Area

MAINE DDS Drs. Michael Bufo and James Helmkamp, Co-Chairs • 119 dentists and 16 laboratories • $174,034 in donated services to 88 people • Sponsors/ Funders: Division of Community and Family Health of the Maine Department of Human Services, Maine Dental Association, Maine Primary Care Association, and Northeast Delta Dental Foundation

Serving People with Disabilities

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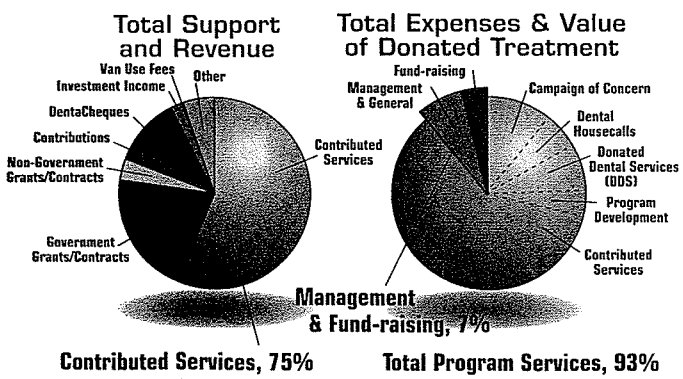

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***TEXAS DDS-Texas Dentists for Healthy Smiles** Dr. William H. Gerlach, Chairman • 763 dentists and 18(laboratories • $1,095,012 in donated services to 428 people • Sponsors/ Funders: Texas Dental Association, Gil and Dody Weaver Foundation, and Lola Wright Foundation

***VIRGINIA DDS-Virginia Dental Association** 489 dentists and 117 laboratories • $556,095 in donated serv ices to 275 patients • Sponsors/ Funders: Community Foundation (Annabelle Jenkins) and the Virginia Dental Association

WASHINGTON SEATTLE-KING COUNTY DDS Dr. Cheryl Townsend, Chair • 132 dentists and 58 laboratories • $325,865 in donated services to 91 people • Sponsors/ Funders: Glaser Foundation, Lynn Foundation, National Foundation of Dentistry for the Handicapped, Seattle Foundation, Seattle-King County Dental Founda tion, and Seattle-King County Dental Society

WEST VIRGINIA DDS Dr. Jerry Bouquot, Chair • 74 dentists and 26 laboratories • $98,281 in donated serv ices to 70 people • Sponsors/ Funders: National Founda tion of Dentistry for the Handicapped and West Virginia Dental Association

WISCONSIN Foundation of Dentistry for the Handicapped Dr. Paul P. Conrardy, President • 484 dentists and 100 laboratories • $506,706 in donated serv ices to 203 people • Sponsors/ Funders: Delta Dental Plan of Wisconsin, Wisconsin Dental Association, and Wisconsin Department of Health and Family Services

WYOMING DDS Dr. Jim Barber, Chair • 97 dentists an 56 laboratories • $81,652 in donated services to 56 people • Sponsors/ Funders: Wyoming Dental Associa tion and Wyoming Department of Health

NATIONAL DDS program served individuals in the following states: Connecticut, Delaware, District of Columbia, Georgia, Idaho, Iowa, Kentucky, Massachu setts, Missouri, Nebraska, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Utah, and Wash ington (outside King County)

National Donated Dental Services

CONNECTICUT • 20 dentists and 0 laboratories • $2,365 in donated services to 2 people

DELAWARE • 4 dentists and 2 laboratories • $1,725 in donated services to 1 person

DISTRICT OF COLUMBIA • 2 dentists and 0 laborat ries • $5,954 in donated services to 2 people

GEORGIA • 21 dentists and 4 laboratories • $1,181 in donated services to 8 people

IDAHO • 11 dentists and 6 laboratories • $4,233 in donated services to 2 people

IOWA • 5 dentists and 1 laboratory • Donated services to 12 people

KENTUCKY • 6 dentists and 2 laboratories • Donated services to 5 people

MASSACHUSETTS • 21 dentists and 2 laboratories • $2,424 in donated services to 7 people

MISSOURI • 149 dentists and 18 laboratories • $30,67 in donated services to 12 people

NEBRASKA • 7 dentists and 2 laboratories • $3,532 ir donated services to 1 person

NEW YORK • 185 dentists and 15 laboratories • $31,034 in donated services to 21 people

NORTH CAROLINA • 29 dentists and 8 laboratories • $63,257 in donated services to 5 people

OKLAHOMA • 14 dentists and 7 laboratories • $5,630 in donated services to 5 people

SOUTH CAROLINA • 12 dentists and 1 laboratory • $660 in donated services to 4 people

TENNESSEE • 32 dentists and 5 laboratories • $3,732 in donated services to 10 people

UTAH • 12 dentists and 1 laboratory • $160 in donatec services to 3 people

VERMONT • 1 dentist and 0 laboratories • $0 in donated services to 0 people

WASHINGTON (outside King County) • 13 dentists ar 4 laboratories • $14,854 in donated services to 6 peopl

"The inherent dignity of every person is reflected through a healthy smile."

Catherine Kruczek endured burns over 46% of her body during a 1985 fire. Scar tissue limits mobility of her arms and the fingers on one hand had to be amputated. Unable to work and living on very limited Social Security Disability checks, she had extensive dental disease because she was unable to pay for needed treatment. Dr. Philip Harwood, a volunteer dentist in Boulder, Colorado, fabricated dentures for Ms. Kruczek after removing several of her severely decayed teeth and completing root canals on others. Ms. Kruczek wrote, **"I wish I had a photograph of how I looked before because now I look twenty years younger. I can't tell you how glad I am to smile now. Before I got help I only had 15 teeth left, and my front tooth had fallen out. Getting help changed my attitude, and now I can smile again."**

Scott Foley has Down Syndrome and some related medical problems. He lives with his mother in Alabama. Their only income is from Social Security, which is barely enough to cover routine expenses. The cost of the extensive dental treatment that he needed was unaffordable. Dr. Jason Northcutt, assisted by Rohling Dental Lab, donated the care, which included crowning four teeth.

Joan Golding is functionally disabled by neurofibromatosis, a condition producing tumors of the skin and nerves as well as deformities of bone. Most of her teeth were severely decayed, many rotted to just the remains of roots. She endured pain and difficulty eating because the comprehensive dental treatment that she needed was financially unattainable. Dr. Charles Fisher resolved that dilemma by fully donating the care. Her teeth were too diseased to be saved, and were removed after which dentures were made. Ms. Golding wrote, **"I cried when I first got my teeth because I felt beautiful...I'm not shy about smiling anymore. So many people have beautiful smiles and, guess what, so do I now."**

William Glaefke had worked throughout his adult life until liver disease forced retirement. He needs a liver transplant; however, a prerequisite of the procedure is that dental and other infections must be treated. Many of his teeth were severely decayed and had to be removed. Yet, with no income and limited government assistance, he couldn't afford the treatment standing in the way of being placed on a transplant waiting list. Dr. William Colwell, a volunteer oral surgeon in Seattle, donated the surgery and Dr. Leah Worstman, assisted by Thorn Ford Dental Lab, donated full dentures.

Sonya Rouse with her dentist, Dr. Larry Bowers of Washington, DC. Ms. Rouse had her first stroke at the age of three. Her last stroke occurred three years ago. Among other limitations, she is unable to use her left hand. Living on limited and fixed income from Social Security, she was unable to afford needed dental treatment, including a couple of crowns and a partial denture.

Madeline, an eleven year-old developmentally disabled youngster, is one of the individuals served during the year through NFDH's three direct-service projects: BRIDGE, HouseCalls, and Donated Dental Services (DDS). She was evaluated at a Jersey City, New Jersey special education school by a dental hygienist with the BRIDGE project. Most of her teeth were severely decayed, and a couple had abscesses. Her mother is a factory worker earning modest wages. The family's income was insufficient to pay for the dental care that she needed, but too much to qualify for Medicaid or other public health financing programs.

Madeline was referred to Dr. Justin Stone, a dentist volunteering in the Donated Dental Services (DDS) program. She required sedation in addition to $6,800 of treatment, including several root canals procedures, extractions, numerous fillings, and crowns placed on some teeth.

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TESTIMONY FOR IOWA COUNCIL ON HUMAN SERVICES

July 13, 2005

Members of the Council:

My name is Fred Leviton and I am the Vice President of the National Foundation of Dentistry for the Handicapped. I am here today to talk with about an exciting new program we are starting in Iowa to help disabled or elderly people who cannot afford comprehensive treatment, nor get public aid: Donated Dental Services (DDS). Joining me are representatives of our partner organizations: Dr. Ed Schooley, Vice President of Delta Dental of Iowa and Mr. Larry Carl, Executive Director of the Iowa Dental Association.

Delta Dental is providing the monies to start the program, is donating office space for the program's referral coordinator, and will promote DDS to dentists throughout the state. The Iowa Dental Association has endorsed this program and will help recruit dentists to volunteer among its members and recognize those dentists that do participate. Our success will be based on the participation of dentists and with the dental association's help, we expect many dentists will give back to their communities through this program.

Before I talk about what we are doing with the DDS program, let me first briefly describe the problem we are trying to address.

Many aged or disabled Iowans have seriously-neglected dental problems because they cannot afford needed treatment and public assistance is generally unavailable.

With limited incomes and restricted government help, hundreds of elderly and disabled people suffer from neglected dental problems. They cannot afford food and rent, let alone hundreds of dollars worth of dental care. Though many are eligible for Medicaid, Iowa's Medicaid program only provides emergency and basic dental benefits for adult recipients. And numerous disabled or elderly individuals do not qualify for Medicaid, yet are still indigent and cannot afford care. Several clinics help, but focus on emergency services, not extensive treatment. As a result, dental diseases fester though they cause pain, suffering, and a host of related health problems.

DONATED DENTAL SERVICES (DDS) PROGRAM

Delta Dental of Iowa has generously provided a two-year grant to start a DDS program in Iowa. Dentists and laboratories throughout the state will donate comprehensive treatment to one or two disabled or elderly people each year. In the next few weeks, we will start recruiting Iowa dentists and expect that 175 will volunteer by the end of the first year; eventually, over 250 will participate as will many labs.

Donated Dental Services (DDS)
a national humanitarian program

developed and coordinated by NFDH

in collaboration with

12,000 volunteer dentists

2,900 volunteer laboratories

American Dental Association

Academy of General Dentistry

American Academy of Periodontology

American College of Dentists

American Association of Endodontists

American Association of Oral and Maxillofacial Surgeons

American College of Prosthodontists

American Academy of Implant Dentistry

American Association of Women Dentists

American Dental Assistants Association

Hispanic Dental Association

National Association of Dental Laboratories

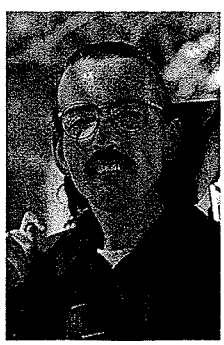
American Association of Orthodontists

Financial support provided by

- xélan Foundation
- Leslie and Linda Buck Foundation
- Donald and Julie Gardner Foundation
- L. Donald Guess Foundation
- John F. Philips Foundation
- Michael L. Quick Foundation
- The Daniels Fund
- Delta Dental
- Great-West Life and Annuity Insurance Company

with assistance from

- Dentsply
- Argen
- Heraeus Kulzer
- Ivoclar
- Implant Innovations Inc.
- Nobel Biocare
- Patterson Dental Company
- Sullivan-Schein Dental

The inherent dignity of every person is reflected through a happy and healthy smile

DDS targets indigent adults who are also mentally or physically disabled, mentally or chronically ill (including the homeless), or aged. The program is a last resort for people with seriously neglected problems who have no where else to turn to for needed care.

We started the first DDS program in Colorado in 1985 and have since developed similar initiatives with state dental associations in 34 other states. This last year alone, some of nearly 12,000 dentists and 3,000 labs that volunteer donated over $13.5 million worth of services for 6,500 vulnerable people.

THE REQUEST

We are here to request the Council's help in several ways.

First, help get the word out to the agencies serving the disabled or aged people we want to help. We have already sent applications to about 120 health and social services agencies throughout Iowa and will meet tomorrow with Des Moines area agencies at United Way. We know the people needing our help are out there, but many may not know of this service. Attached to your copy of this testimony is an application. Please feel free to copy it and distribute it.

Second, while Delta Dental is generously providing startup funding, in several years we will need approximately $45,000 per year to sustain the program and are looking to the State of Iowa for help. DDS has three major cost areas: Salary for a half-time referral coordinator who qualifies applicants, matches them with volunteer dentists, and monitors each patient's progress to identify and resolve problems; Laboratory bills for dentures, crowns, and bridges (while dental laboratories also donate, the amount of needed lab work will exceed what volunteers contribute); and, telephone, postage, computer and other administrative costs associated with operating a statewide referral system. Once the program is operational, we expect to generate $350,000 worth of care each year for 175 people, or almost $8 in care for every dollar spent.

Dentists alone cannot shoulder the burden of treating indigent disabled or aged people with severely neglected problems. Volunteerism is becoming increasingly important because government cannot afford all of our diverse and complex problems, including health care for all elderly or disabled individuals. But government can help enormously by allocating its limited funds to support private sector partnerships, such as the DDS Program.

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Hello:

In response to your recent inquiry about the availability of free or low-cost dental care, we are pleased to provide the following information about the Donated Dental Services (DDS) program.

ELIGIBILITY: Dentists in Iowa have volunteered to provide comprehensive dental care at no charge to people of all ages who, because of a serious disability, advanced age, or medical problems, lack adequate income to pay for needed dental care. There are no rigid financial eligibility requirements. Applicants must need more than routine care in order to qualify.

COST: There is generally no cost to qualifying individuals; occasionally, people in a position to pay for part of their care may be encouraged to do so, especially when laboratory work is involved.

APPLICATION PROCEDURES:

Step One — please complete, sign, and return the enclosed application,

Step Two — when your application comes up for review, a referral coordinator will call to obtain additional information (those who don't qualify will be told so during the call),

Step Three — the referral coordinator will share the information about a person tentatively accepted with a volunteer dentist,

Step Four — you will be notified of the dentist's name and phone number and you will be responsible for scheduling an appointment for an examination. Final acceptance into the program will only be made after the clinical examination when the specific treatment needs are established.

Upon receipt, your application will be placed on our waiting list. Please be patient; due to program limitations, we are not able to process each application as soon as it is received. The referral coordinator will contact you when your application comes up for review.

We are sorry you are experiencing a dental problem and we hope the Donated Dental Services (DDS) program may be a source of some help.

Sincerely,

DDS Program Coordinator

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a national humanitarian program

developed and coordinated by NFDH

in collaboration with

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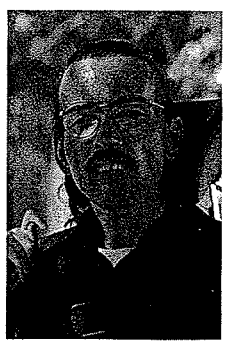
- Patterson Dental Company
- Sullivan-Schein Dental

The inherent dignity of every person is reflected through a happy and healthy smile

APPLICATION FOR DONATED DENTAL SERVICES (DDS) PROGRAM

IOWA DONATED DENTAL SERVICES
C/O NFDH
1800 15TH STREET, SUITE 100
DENVER, CO 80202
(303) 534-5360
(888) 471-6334

DATE OF APPLICATION:_____

HAVE YOU APPLIED BEFORE?_____

APPLICANT

NAME:_____ PHONE:_____

ADDRESS:_____ PLEASE CIRCLE: MALE FEMALE

CITY, STATE, ZIP:_____ COUNTY:_____

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY #:_____

MARITAL STATUS: ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED

HOW DID YOU HEAR ABOUT THE DDS PROGRAM? _____

CONTACT PERSON (RELATIVE, FRIEND, ETC.):

NAME: _____ PHONE: _____

RELATIONSHIP TO YOU: _____

NUMBER OF PEOPLE IN YOUR HOUSEHOLD:_____

NAME OF EACH PERSON AGE RELATIONSHIP TO YOU

_____

_____

_____

_____

MAJOR DISABILITIES OR HEALTH PROBLEMS (EXPLAIN IN AS MUCH DETAIL AS POSSIBLE):

_____

_____

_____

DO YOU REQUIRE WHEELCHAIR ACCESS? ____YES ____NO

PHYSICIAN'S NAME:_____ PHYSICIAN'S PHONE #:_____

FINANCIAL INFORMATION

MONTHLY INCOME:

ARE YOU ABLE TO WORK? ____YES ____NO

IF NO, PLEASE EXPLAIN:_____

_____

ARE YOU EMPLOYED? ___YES ____NO PLACE OF EMPLOYMENT:_____

YOUR MONTHLY WAGES: $_____

IS YOUR SPOUSE EMPLOYED? ____YES ____NO PLACE OF EMPLOYMENT:_____

SPOUSE'S MONTHLY WAGES: $_____

IF SPOUSE IS UNEMPLOYED, WHY?_____

PUBLIC ASSISTANCE:

PROGRAM MONTHLY AMOUNT HOW LONG HAVE YOU RECEIVED BENEFITS?

SSI:_____

SOCIAL SECURITY DISABILITY:_____

AFDC:_____

SOCIAL SECURITY:_____

UNEMPLOYMENT:_____

OTHER:_____

OTHER:_____

TOTAL MONTHLY HOUSEHOLD INCOME: $_____

TOTAL VALUE OF SAVINGS:_____

TOTAL VALUE OF INVESTMENTS:_____

TYPE OF INVESTMENTS:_____

FOOD STAMPS? ____YES ____NO MONTHLY AMOUNT:$_____

MONTHLY EXPENSES:

HOUSING: $_____ PHONE: $_____ FOOD(NOT INCL. FOOD STAMPS): $_____

GAS/ELECTRICITY: $_____ WATER/SEWER: $_____ CAR PAYMENT: $_____

CAR INSURANCE: $_____ GAS/CAR EXP: $_____ HEALTH INSURANCE: $_____

LIFE/BURIAL INS.:$_____ MEDICATIONS: $_____ MEDICAL COSTS: $_____

OTHER:_____

OTHER:_____

OTHER:_____

TOTAL MONTHLY HOUSEHOLD EXPENSES: $_____

DENTAL NEEDS

BRIEFLY DESCRIBE YOUR DENTAL NEEDS: _____

_____

NAME OF LAST DENTIST: _____ PHONE#: _____

DATE OF LAST DENTAL VISIT: _____

HOW WILL YOU GET TO DENTAL APPOINTMENTS? _____

PLEASE LIST OTHER TOWNS YOU CAN GET TO: _____, _____,

_____, _____

DO YOU RECEIVE MEDICAID BENEFITS? ____YES ____NO MEDICAID # _____

DO YOU HAVE DENTAL INSURANCE? ____YES ____NO

Are any family members able to contribute to costs of your dental treatment?

____yes ____no If yes, please explain: _____

_____

Are any other sources available to help pay for dental care (i.e. churches, service organizations, other agencies, etc.)? ____yes ____no

If yes, please explain: _____

Do you own a car? ____ yes ____ no

Make, model, and year of car: _____

REFERRING AGENCY

AGENCY NAME: _____ PHONE: _____

NAME OF CASEWORKER: _____

ADDRESS: _____

CITY, STATE ZIP: _____

ADDITIONAL INFORMATION

Use this space to elaborate on any information not sufficiently explained in other areas.

_____

_____

_____

_____

_____

Please read the following statements. If you understand and agree to the conditions, please sign and date the form at the bottom.

I understand that I will need to provide personal information that includes but is not limited to medical, dental, and financial condition.

I give my consent for the referral coordinator to obtain information, relevant to my eligibility for the DDS program, from my physician, dentist, individuals who know me and/or government or private agencies.

I give permission for the referral coordinator to share pertinent information, about my eligibility, with one or more volunteer dentist in the DDS program. If my disability is AIDS or HIV related, I give the Foundation of Dentistry for the Handicapped (FDH) permission to release information about my medical condition and hold FDH harmless for doing so.

I realize that application to the DDS program does not assure I will be referred for an examination or that I will be accepted as a patient following an examination.

I understand that the Foundation of Dentistry for the Handicapped, which coordinates the DDS program, will determine whether I am eligible for the program and, if so, will seek to refer me to a participating volunteer dentist. I further understand that the dentist, not the Foundation, is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

I understand that the dentist(s) have volunteered to treat my existing dental condition only and are not obligated to provide donated care in the future or to maintain me as a patient.

I understand that importance of keeping all scheduled appointments. Failure to do so, without at least 24 hour notice to the dentist, can and will disqualify me from obtaining further treatment through the program.

To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current physical, mental and financial status.

Signature of client:_____ Date:_____

Signature of client's guardian:_____ Date:_____
(if necessary)

Signature of person referring (if applicable):_____ Date:_____

IOWA MEDICAL SOCIETY

Working for Iowa physicians and their patients

Testimony of the Iowa Medical Society
Before the Council on Human Services
Regarding the Iowa Medicaid Budget and Physician Reimbursement

July 13, 2005

The Iowa Medical Society (IMS), representing over 4,600 physician members, thanks the Council on Human Services (Council) for this opportunity to appear before you to discuss the Iowa Medicaid program.

In our role as physician and patient advocate, we realize the difficult challenges facing the Council when the state has limited funds available to meet its ongoing obligations for programs such as Medicaid. We appreciate your dedication to providing quality services to those Iowans who are most in need. Iowa physicians have a long history of partnering with the Iowa Department of Human Services (Department) to provide this care and do not want to impede Iowans' access to medical care. To that end, IMS continues to advocate at the federal level to protect the financial stability of the state Medicaid program and to advocate for ongoing funding for those most in need of health care.

Federal Medicaid Reform

The federal budget resolution calls for $10B in Medicaid reductions for FY 2006 and a long-range plan to assure the sustainability of the program. IMS and its physician members are acutely aware of the impact that such cuts could have on our most vulnerable populations here in Iowa. This reform comes at a time when the Centers for Medicare and Medicaid Services (CMS) have moved forward with their charge to strengthen the program integrity and the financial management activities of the Medicaid program. The best evidence of this is the recently approved 1115a demonstration project IowaCare. The IowaCare program, as you know, is the result of year-long negotiations with CMS regarding the use of intergovernmental transfers which were deemed unacceptable as a way to finance Medicaid in Iowa. IMS supports the Council and the Department in their efforts to move forward with the IowaCare program.

IMS is also advocating with the Iowa Congressional Delegation on the need for caution regarding significant changes to the structure of Medicaid that would lead to potential caps on eligibility or additional cost sharing by Medicaid recipients. In addition, any changes in the program that could impact the ability to access services must be closely scrutinized for the impact on both the providers of the service and the patients for whom they provide care. Additional administrative burdens that could result from increased activities regarding financial management of the program cannot be sustained by physician practices without adequate reimbursement. A good example of this is the movement towards the use of electronic health records (EHR) within the next ten years. Last year, the Iowa Medical Society began a joint health information technology (HIT) initiative and that work continues with our health care

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partners and stakeholders. What will stand in the way of progress regarding this new technology will be the necessary funding to assure interoperability of electronic health records. The use of an electronic health record cannot become another unfunded mandate, e.g., HIPAA, for physician practices. IMS will be pushing our delegation to assure that necessary funding in the form of grants or incentive payments is available as the federal health care programs push forward on EHR.

State Medicaid Funding Issues

IMS welcomes the opportunity to join with other stakeholders and help make the tough choices necessary for Iowa to be able to continue to provide quality medical services to those Iowans who are most in need. While IMS is extremely concerned about continued Medicaid funding, we remain committed to protecting the quality of the Iowa health care system, for which Iowa is ranked sixth in the nation. To that end, we respectfully ask the Council to entertain the following requests:

Fully fund Iowa Medicaid and *hawk-i*. IMS remains committed to fully funding the Iowa Medicaid and ***hawk-i*** programs. Providing adequate funding for these programs would permit the state to comply with Iowa Code section 249A.20, which requires that Iowa physicians be reimbursed on par with state Medicare reimbursement levels. These Medicare rates are established yearly by CMS and are set according to the Resource Based Relative Value Scale (RBRVS). While this payment requirement has been in the Iowa Code since November of 2000, Medicaid rates have not kept pace with Medicare rates since July 1, 2001. The 3% rate reduction in fiscal year 2002 and continued rate freezes in fiscal years 2003, 2004, and 2005 have underfunded reimbursements to physicians.

IMS appreciates the 3% increase for reimbursements to all providers allowed for in the appropriation for FY 2006, but the fact remains that even with this modest increase, physician payments for Iowa Medicaid remain approximately 5% below current RBRVS Medicare levels. Medicare payments for Iowa physicians are some of the lowest in the nation and not keeping pace in Medicaid reimbursement only exacerbates an underfunded health care system in Iowa.

IMS requests that the Department of Human Services and the legislature fulfill the obligation to meet the requirement of Iowa Code section 249A.20 and reimburse Iowa physicians for Medicaid according to Medicare rates. IMS also asks the Council to safeguard the Medicaid budget and avert future cuts to physician reimbursement.

Reduce the administrative burden on physicians. Low reimbursements, coupled with excessive administrative burdens, hamper Iowa physicians' ability to care for their patients. The state should examine and take steps to reduce the administrative work load placed on physicians and their practices by:

- **Rescinding the $3.00 Medicaid co-pay.** In FY 2004, the General Assembly passed legislation, which included short-term savings in the form of a $3.00 Medicaid co-pay. The collection of this nominal fee generates substantial paperwork for physicians. If one considers the limited population groups who are required to pay this fee, due to federal

exemptions, the co-pay increases physicians' administrative burden without generating substantial revenue for the state. Especially in smaller offices, the time and staff required for processing the fee often costs physicians more than the $3.00 fee that is collected. In reality, the co-pay becomes a reduction in their already low reimbursement rate.

IMS requests the Council to rescind the $3.00 co-payment that was enacted in 2004 in order to reduce this administrative burden on providers.

- **Including physicians in the process of establishing the Health Promotion Partnerships.** The IowaCare program establishes a number of practice and clinical management programs that will impact the practice of medicine in Iowa. IMS requests the Council to recognize the expertise that the Iowa HIT Initiative, coordinated by IMS, can bring to the establishment of a practical strategy for the use of electronic health records in Medicaid and IowaCare.

  Also of particular interest is the requirement for the design and implementation of a provider incentive payment program for Medicaid and IowaCare. Provider incentive payment programs or pay for performance programs are hotly debated and are a primary issue in health care management. IMS requests that the Council again recognize the design of such programs, including the potential for increased administrative burdens and data collection that will financially impact physician practices. Iowa physicians should not be required to participate in yet another unfunded mandate without adequate reimbursement and financial assistance to implement electronic health records and/or a provider incentive payment system.

Conclusion

During these difficult times, it is important that health care providers advocate and provide care to those Iowans in need. The full funding of Medicaid, ***hawk-i*** and the new IowaCare program is necessary to assure adequate care to those served by these safety net programs. However, additional burdens to physician practices, such as the implementation of electronic health records and a provider incentive payment system on top of the co-pay requirements and a low provider reimbursement, jeopardize physician participation in the Medicaid program. We urge the Council to consider addressing these issues in the FY 2007 Department of Human Services budget.

The Iowa Medical Society and the physicians it represents are committed to remaining partners with the Medicaid program. Physicians recognize that all Iowans have a role in making Iowa a safer, healthier and better place to live; and we look forward to continuing our work with the Council on Human Services and the Department as it moves forward on these new initiatives. We thank you for your consideration of these issues and would urge you to take the lead in ensuring access and quality health care for all Iowans.

Authority of Iowa's Mental Health Planning & Advisory Council:

Public Law 102-321, enacted by the U.S. Congress in 1992, (and codified at 42 U.S.C. Chp. 6A(XVII)(B)) requires each state to plan and implement a comprehensive, community-based system of care for adults with serious mental illness and for children and adolescents with serious emotional disorders. The same federal statue requires the State's mental health authority to submit an annual report on the progress that has been made to improve community services as a condition of receiving federal Mental Health Block Grant funds. A further condition of the receipt of federal funds, is the assurance that the State "will establish and maintain a mental health planning council".

Duties of Iowa's Mental Health Planning & Advisory Council:

1. **Review plans provided to the Council pursuant to section 1915(a) by the State and submit to the State any recommendations of the Council for modifications to the plans;**

2. **Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;**

3. **Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.**

Current Members: (50% Families and Consumers)

Families/Consumers:
Alice Book, Des Moines
Barry Buchanan, Atlantic
Patricia Crosley, Des Moines (Chair)
Alice Holdiman, Decorah
Brenda Hollingsworth, Iowa City
Mary Hughes, Kalona
June Lackore, Mason City
Ronda Swolley, Waterloo
Jerry Mayes, Waterloo (V.C.)
Lori Reynolds, Anamosa
Tammy Riley, Prescott
Margaret Stout, Des Moines
Candy Taylor, W. Des Moines
Terri Zirkelbach, Scotch Grove

Providers/Advocates:
Connie Fanselow, Legal Advocate
Ro Foege, Legislator
Jack Holveck, P&A
Donna Meck, Judicial Advocate
Karen Shurke, CMHC-Adult
Scott Shafer, (Past Chair) CMHC - Children

State Agencies:
Sue Bakker, Mental Health
Micheleen Maher, DE, DVRS (Secretary)
Richard Moore, DHR, CJJP
Sally Nadolsky, DHS, Medical
Carla Pope, Iowa Finance Auth.
John Spence, DOC
Suana Wessendorf, Dept. Education
Cheryl Whitney, Social Services

Current Projects

38 Community Mental Health Providers implementing 75 Evidence Based Projects

Children	
22	School Based Projects
10	Home and Community Based Projects
5	Developing EBP's Projects

Adults	
13	Wellness Management and Recovery Projects
9	Co-occurring Disorders (SA/MH)
16	Developing EBP's Projects

Ongoing Statewide Projects

- Technical Assistance for Implementing Evidence Based Practices
- Children/Adult Mental Health Advocacy, Support and Training
- Respite for Caregivers of Children with SED and Adults with SMI
- Office of Consumer Affairs
- Stipends for Consumers and Family members to attend training conferences

Enhancing Iowa's Capacity to Provide Evidence-Based Mental Health Practices - Phase II

Contract between Iowa DHS (Iowa's Federal Mental Health Block Grant)
and the Iowa Consortium for Mental Health
Oct. 1, 2004 through Sept. 30, 2005

This project is best viewed as a continuation of work completed in the fall of 2004: Enhancing Iowa's Capacity to Provide Evidence-Based Mental Health Practices. The current project (Phase II) builds off the original effort and delineates the steps for activities.

Task I. Implement Evidenced Based Practices into Iowa's Community Mental Health Block Grant Providers

Background:

SF2288 (passed in the '04 session) stipulates that Community Mental Health Block Grant monies be used for "evidence-based practices" (EBP's).

Activities:

1. Assisted DHS in establishing an Implementation Workgroup that has met regularly since September 2004.

2. Facilitated the Workgroup in the development of a consensus as to what constitutes evidence-based practice.

3. Documented and disseminated the concept to potential contractors (i.e., CMHC directors), through presentations, and web-based dissemination methods.

4. Assisted DHS in creating the Request For Applications (RFA), based on the group's consensus on definitions and constructs of EBP's.

5. Collaborated with the workgroup and Mental Health Planning Council in developing a plan for initial implementation of this process.

6. Provided direct TA to potential applicants, by phone, letter or e-mail or teleconferences.

7. Developed a review process and committee to review the proposals, approved by DHS, with input from the EBP workgroup and Mental Health Planning Council (MHPC).

8. Developed a process to collect quarterly reports, monitor adherence to contracts and effectiveness of programs.

Task 2: Create a Database of Community Mental Health Providers to measure outcomes of the Evidence-Based Practices they are Implementing.

Background:

In the first proposal, a case was made for the long-term value of a database that tracked the utilization/implementation of EBPs in Iowa's CMHCs. In addition to providing information to SAMSHA and others (such as NRI, NAMI) on Iowa's utilization of EBPs, such a database can become a source for comparison across programs, resources, geographies, and clients.

Activities:

A survey was distributed to all providers designated as county mental health community centers on their utilization of EBPs for adults with SMI and children with SED.
Administrators received hard copy notification of the survey's URL at their monthly meeting and an email with the link: the survey instrument was a web capture form.
Results incorporated in the CMHC Block grant application (tables 16-17) due September 2005.

Task 3: Share accumulated and learned information with key stakeholders

Background:

An ongoing forum for interaction has been established between ICMH and CMHC directors – via the monthly meetings of the Community Mental Health Advisory Committee. These interactions have and will continue to foster an ongoing discussion of EBP's, implementation strategies, barriers, funding, etc. An important focus will be on TA, on monitoring and reporting outcome data as an EBP activity.

Activities:

ICMH staff including Dr. Michael Flaum has attended monthly meetings of the executive directors of the MHCs to discuss various aspects of EBP's. Strategies to monitor and record outcomes using a standardized approach have been encouraged and TA provided. Presentations to CMHC directors at monthly MH advisory council meeting throughout the length of the project will continue. Michael Flaum has presented to the MHPC at their regularly scheduled meetings.

Task 4: Provide ICN Training Series on EBP's

Activities:

A statewide ICN series on EBPs for Children and Adolescents with Serious Emotional Disorders has been scheduled for August/September 2005. Information will be disseminated during July.

Iowa Foster and Adoptive Parents Association

6864 Northeast 14th Street, Suite 5 • Ankeny, IA 50023-9525 • 1-800-277-8145 • 515-289-4567 • fax 515-289-2080 • e-mail IFAPA@ifapa.org

Council on Human Service Presentation
July 13, 2005

The Iowa Foster and Adoptive Parent Association's mission is to "recruit and retain quality foster and adoptive families by promoting support, training and public awareness in conjunction with other public and private organizations. The Iowa Foster and Adoptive Parents Association (IFAPA) advocates for foster and adoptive children and families."

IFAPA appreciates the support and cooperation shown by the Department of Human Services toward the foster and adoptive parents of Iowa and the special needs children they provide homes for.

As requested from the invitation, the fiscal needs for the services and support of the foster and adoptive parents is being shared in this document.

We realize next year will require extensive planning with limited resources. Our association is asking for the following:

- At a minimum maintain the foster family and adoption subsidy maintenance rates at 65% of the USDA standard for raising a child in the Midwest. Ideally the rates should be increased to 70%
  Iowa complete 1077 adoptions for children in the child welfare system. This has substantially increased the adoption subsidy assistance payments, while allowing for a saving for these children in foster care and also providing them with a permanent home.
- Fund a subsidized guardianship program. This would allow relative caregivers to provide a permanency option for youth who are not adopted.
- Medicaid to continue to fund the health, mental health and dental services needed by the foster/adoptive children. Families have been reporting that they have limited access to dentists who will accept Title XIX payment. We are now hearing that many doctors are also not accepting Title XIX patients.
- Development and payment of Post-Adoption Supports.
- Develop a post-secondary educational tuition payment program for foster and adoptive children.
- Adequate numbers of DHS social workers to provide services and supports to a manageable size caseload, allow planning time, allow workers to be trained and have time to put in place best practices for foster and adoptive services, and time for Family Team Conferencing for each child in care.

During the 2003 Federal Review of Iowa's Foster Care System, an area of weakness was the quantity of social worker contract with troubled families.

The foster parents in the *2000 Iowa Foster Family Satisfaction Survey – Retention* Analysis and in additional limited services identified several areas of concern that would assist with retention of foster parents. Those include:

1. Being valued as a member of the team, by joint training opportunities, by regular contact with the workers (calls being returned), being listened to as they have the children 24/7 and having ideas and their recommendations considered in the planning for the children, and having accurate information on the children shared with the families.
2. Increased training in the area of specific behavior disorders and how to parent children with them, more information on how the system works and the teamwork approach, plus working with birth families.
3. Joint training of social workers and foster parents.
4. Better representation by the GAL's in meeting the mandated requirements.

These are other issues that are of major concern to the foster and adoptive parents:

- Mental health needs of foster and adoptive children. IFAPA strongly supports children's mental health system. Most of the children who come into foster care/adoptive care have mental health issues that require outpatient therapy for child and family, medications, and many times hospitalization, PMIC, or residential treatment.
- Working with the schools on the special needs of these children. Our publications and Building Bridges program are working with individual teachers and groups in the schools for a better understanding of the needs and issues with the foster and adoptive parents.

Within IFAPA's Personal Service Contract with DHS, the association has accomplished the following:

Publications

- Publication of *The Child Abuse Assessment: A Guide for Foster Parents*
- Publication of *Confidentiality: A Guide for Foster Parents*
- Publication: *Foster Parents and the Courts*
- *Adoption Basics for Educators: How Adoption Impacts Children and How Educators Can Help*

- *Helping Your Adopted Child Succeed in School* – parents' booklet
- *Raising Relative's Children*
- *News and Views of Iowa* – bi-monthly newsletter for foster and adoptive parents

Training

- Offered 46 – six hour trainings to foster and adoptive parents from February through June 2005. (Preventative Practices, Managing your Risks, Drug Awareness, Living with Foster or Adoptive Adolescent, Teaching Life Skills, Parenting with Pizzazz, and Crisis De-Escalation.
- Offered Mandatory Child Abuse Reporting to foster parents over the ICN
- State Conference held March 4,5,and 6th, 2005
- Support Groups for foster and adoptive parents were offered training opportunities of: 9 Preventative Practice Modules, Confidentiality, FAIR, Public Policy Training, and Working with the Courts

Events

- Foster Care and Adoption Month Event at Adventureland in September.
- Adoption Saturday
- Spring Fling
- Legislative Breakfast in March 2005 where 80 plus Legislators attended to learn about foster and adoptive care issues.
- Booth at Iowa State Fair for the 10 days to recruit foster and adoptive parents

Supports

- Through the FAIR (Foster Allegation Information Resource) Program, foster parents who had an allegation of abuse were provided information of the assessment process, time frames, and appeal rights.
- The 18 Independent Contractors of Foster and Adoptive Parent Liaisons provided peer support to foster and adoptive parents in their assigned areas. They contact newly licensed foster homes to provide information and contact foster homes exiting foster care to determine the reasons for the families leaving.
- The IFAPA part-time Adoption Information Specialists have contacted the new adoptive subsidized families to provide support, information and referral, resources.
- Subsidized Adoption Respite – IFAPA completes mailings to adoptive families on the respite program and pays providers for up to 5 days of respite.

- "Building Bridges" – Training of trainers to go into the schools systems and provide training for staff on the dynamics of foster and adoptive care.

We will continue to serve on committees for Transitioning Youth from foster care to independence, Iowa Youth Development, Supreme Court Improvement Project, Program Improvement Committees, Iowa Plan Advisory Committee, Mental Health Forum, Merit Roundtable for Consumers, Families, and Advocates, and Healthy and Safe Families.

As you can see, the Iowa Foster and Adoptive Parents Association collaborates and is in a partnership with the Iowa Department of Human Services and the other child-welfare agencies and associations to meet the needs of the foster and adoptive parents who are providing a home to Iowa's special needs children.

Family Development & Self Sufficiency
FaDSS

Hello, my name is P.J. West, from MATURA Action Corp. I am a FaDSS Coordinator for the Family Development and Self-sufficiency Program (FaDSS). I am here representing the Iowa Family Development Alliance to talk about the FaDSS Program.

FaDSS is a holistic, strength based, in home family program that focuses on preventative services, and facilitates long term family change and self sufficiency for families who receive FIP (Family Investment Program) benefits. FaDSS works closely with PROMISE JOBS, Iowa's JOBS program, one that assists families to become employed.

FaDSS is a program administered by the Iowa Department of Human Rights Division of Community Action Agencies under contract with the Department of Human Services. For fiscal year 2005, FaDSS received funding in the amount of $5,133,042.

FaDSS provides services to Iowa's most fragile families with multiple barriers. In Fiscal Year 2004, FaDSS served 3489 families, which included 6,600 children. Half of those children were between the ages of 0 and 5. In FY04, 30% of families enrolled in the FaDSS program were of an ethnic minority.

FaDSS is provided in all of Iowa's 99 counties through a network of eighteen agencies with Certified Family Development Specialists. Each specialist is also a Mandatory Child Abuse Reporter.

FaDSS addresses many barriers that families face. These include but are not limited to domestic violence, substance abuse, and mental health.

FaDSS provides a variety of services to families, which can include such things as parenting skill development that assists families at risk to provide a safe and healthy environment for their children, providing protection for children and linking families to informal and formal connections within their community.

The FaDSS program prides itself in the way it collaborates with the community. All of the 18 FaDSS programs are unique in the way that they attain this collaboration, however, there is a common theme among all counties in the importance of building strong working relationships with PROMISE JOBS and the Department of Human Services, including both Income Maintenance and the service side of DHS. Collaboration is ongoing, each year, each month, each day, the FaDSS Program is developing new relationships with programs, agencies and services in the community that can assist families with their goal of self sufficiency and family stability. Some of the strong bonds that the MATURA FaDSS program has developed have been with the numerous Community Action programs, such as Heads Start, WIC, Child Care Resource and Referral and Weatherization, others include the low income housing agency SIRHA, Vocational Rehabilitation, the local Community College and many more.

FaDSS is a program focused on results. These results center on self-sufficiency and family stability. They include results in the areas of employment, education, income, and reduction of barriers.

Some of the FaDSS Program results for Fiscal Year 2004 include the Return On Investment, with every dollar invested in FaDSS resulting in an annual return of $1.48 in wages earned and FIP saved. The total amount of FIP savings for FY04 was $1,444,462.

In regards to employment, FaDSS families exceeded the state target for average hourly wages for FIP households, with the average hourly wage of head of households in FaDSS being $7.57. The state target rate was $7.00 in FY04.

67% of FaDSS families made progress on their education goals.

More than 73% of families who received transitional services with the FaDSS program were still off of FIP one year later.

83% of households that had an individual with identified mental health issues received treatment while participating in FaDSS. 72% of individuals enrolled in the FaDSS program in FY04, with substantiated substance abuse issues, are now receiving treatment.

For more information on the FaDSS program, please check out the website!

www.iowafadss.org

In closing, it is important for resources to be utilized to their fullest potential. Investing in programs that achieve results is important for all Iowans, but most importantly for the families who receive these services. FaDSS is a community asset that has shown that it gets results for families and is a good investment for Iowa. Thank you for your time and we look forward to continuing our relationship with the Department to achieve the best results for Iowa's families.

Iowa Nurses' Association
100 Years of Nursing Advocacy
1904 - 2004

STATEMENT TO THE IOWA COUNCIL ON HUMAN SERVICES
Fiscal Year 2007 Budget Recommendations and Legislative Package

July 13, 2005

1. **Accurate Identification and Analysis of Medicaid Claims Data submitted by ARNPs**
It has been two years since our request of Commissioner Concannon for programming the computer software to collect claims data submitted by advanced registered nurse practitioners (ARNPs) pursuant to implementation of House File 479 passed in 2003. **We believe it would be innovative for the Iowa Medicaid program to implement the data collection technology to follow the episode of care rather than just paying units of services.**

With all the changes of the Medicaid program in structuring of the Iowa Medicaid Enterprise into one location, we hope that our request is being taken into consideration. Until such data is compiled in such a manner that it can be analyzed and compared, it is difficult to demonstrate that cost savings can occur with the use of advanced registered nurse practitioners.

As we have noted in past years, a 1992 study in the *Yale Journal of Medicine* looked at two decades of research and evidence was that advanced registered nurse practitioners (ARNPs) provide care of comparable quality and at a lower cost than physicians since ARNPs prescribe fewer drugs, use less expensive tests and select lower cost treatments than physicians do. In the findings, it was determined that patients of nurse practitioners experienced fewer hospitalizations than patients of physicians, and the average cost per visit for patients of nurse practitioners was $12.36 compared to $20.11 for physician patients. (These results are impacted by NP and physician salary differentials.) NP ordered more laboratory tests than physicians, although the laboratory cost per NP patient was less than for the physician patient (likely less costly tests are ordered with greater frequency).

The Office of Technology Assessment (OTA) Study (1979) published in MEDICAL CARE, February 1982 noted that "...the episode is a "more appropriate unit for measuring differences in effectiveness of care, since the outcome of the care process may be causally related not only to a service received at a single visit, but to any services received over the course of the episode." Measured this way, costs-per-episode were found to be at least 20% less when nurse practitioners provided the initial care than when physicians did.

The Iowa Nurses Association lobbied this issue 2001 to 2003 by stating that that the Association believed that utilizing ARNPs could save the Medicaid program dollars, both from the already established reduction in payment as compared to physicians, for their monitoring an "episode of care" and for deferring or delaying hospitalizations and nursing home stays. We would very much like to see with your Medicaid data, a replication of the professional literature that demonstrated that patients of nurse practitioners experienced fewer hospitalizations than patients of physicians and the average cost per visit was lower adjusting for salary differentials.

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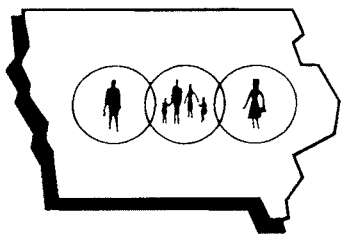
There would be the added benefit of ensuring that ARNPs are billing under their own number and being reimbursed at the ARNP rate for Medicaid services. We continue to have concerns that many physician offices continue to bill ARNP services under the physician billing rate for Medicaid and thereby increased costs to the Medicaid program and under representing the care and services ARNPs are providing to the Medicaid population.

2. **Placement for aggressive and abusive individuals.**
Admitting aggressive and abusive patients to long term care facilities is not appropriate. Long term care regulations will not allow for medications to be used. The association membership believes there has been an increase in the use of expensive emergency services and an increased number of acute hospitalizations. The lack of long-term housing and services cause unnecessary suffering and stress on clients, families and an increase in direct and indirect costs for society. **We recommend consideration of community based congregate housing with on-site professional services for those who are severely ill and continued policy work to develop a cost-effective alternative solution.**

3. **Dental care access**
Dental health is an important aspect of total physical health. The payment levels are so low that it is de facto non-provision of dental care.

It is our understanding that for adults, the only service Medicaid will pay for, is to pull the tooth, rather than to restore health to the tooth. This is extremely unfortunate for the patient and the dentist to be limited to this option. We also understand that while there are 1000 dentists that continue to see children who are Medicaid recipients, there are challenges to accommodate the increased volume of new patients. Preventive care is important to preserving total physical health.

We strongly encourage improvement of both payment and service availability since these services as a preventive health measure.



IOWA ACADEMY OF FAMILY PHYSICIANS

Iowa Academy of Family Physicians Testimony to the Iowa Department of Council of Human Services

July 13, 2005

The Iowa Academy of Family Physicians (IAFP) is pleased to present testimony to the Iowa Department of Human Services Council. The IAFP represents over 1800 family physicians that provide quality health care throughout the state to Iowans.

The IAFP is especially proud of the care we provide Iowans enrolled in the state's health care programs including the state Medicaid program and the Healthy and Well Kids in Iowa ***hawk-i*** program. As we look towards the future we are eager to learn more about Iowa's new Medicaid expansion program, IowaCare. IowaCare presents a number of challenges and opportunities that IAFP is eager to participate in and address. As we plan for the 2006 legislative session, we are also aware of the continuing budget challenges that the Department faces, particularly those related to future funding for all of the Department's health care programs.

As many did, the IAFP spent the 2004 legislative interim attending the Medical Assistance Crisis Intervention Team (MACIT) meetings held throughout the state. Members of MACIT faced the enormous challenge of determining how to cut over $130 million from the Medicaid budget. The IAFP was pleased when the body recommended in its' final report no cuts in eligibles or services provided by the Medicaid program. We were also extremely pleased when the MACIT recommended increasing Iowa's tobacco tax by up to $1 in order to fund the Medicaid program.

The IAFP is a long time champion of the anti-tobacco movement and believes strongly in increasing Iowa's tobacco tax in order to improve health. Unfortunately while a comprehensive lobbying effort was waged during the session, the tobacco tax was ultimately not increased.

Iowa's cigarette tax has not been increased since 1991 and is currently 36 cents per pack. Iowa's stagnancy on the issue has placed our state 42nd lowest in the nation. At this level Iowa is tied with Louisiana, and only Florida, Kentucky, Mississippi, Missouri, North Carolina, South Carolina, Tennessee and Virginia have lower cigarette taxes. (Keep in mind Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and Virginia are all tobacco producing states).

The impact of Iowa's low tobacco tax should not be lost on this body, as Medicaid recipients have some of the highest tobacco utilization numbers nationally. According to the Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Report* (January 30, 2004) in 2000, of approximately 32 million persons who received health insurance coverage through Medicaid program, an estimated 11.5 million (36%) smoked. Scientific research shows that even a 10 percent increase in the price of cigarettes reduces youth smoking rates by roughly 7% and overall cigarette consumption by about 4%.

According to information from the CDC's Tobacco Control 2002 State Highlights, in 1998, Iowa spent about 14% ($235,000,000 or $745.39 per recipient) of all Medicaid expenditures on smoking-related illnesses and diseases. Advocates will be going back to the drawing board on this issue in 2006 and looks forward to partnering with the

Executive Branch on this issue. We continue to feel that it is appropriate that an increase in the tobacco tax be approved, and be used to fund health care programs.

Partnering with the Department on tobacco issues is important for another reason, as work in this area also supports new goals outlined in the IowaCare Act. As approved by the legislature Division IV "Health Promotion Partnerships" of the IowaCare Act includes language related to smoking cessation. The language reads:

> "The Department shall implement a program with the goal of reducing smoking among recipients of medical assistance who are children to less than one percent and among recipients of medical assistance and expansion population members who are adults to less than ten percent by July 1, 2007."

The IAFP applauds these lofty goals. While Iowa does not have specific Medicaid youth or adult use figures, according to the *Iowa 2004 Adult Tobacco Use Survey* Iowa's current adult smoking rate is 20.3%, and according to a preliminary information released from the *2004 Iowa Youth Tobacco Survey* the youth smoking rates are 20% for high school youth and 7% for middle school youth. Based on the CDC's national figures it can be assumed that the rates or tobacco use amongst the Medicaid population are even higher.

While the state's smoking reduction goals for Medicaid recipients are set high, there is some good news. This past session the legislature approved language we believe will provide Medicaid with a major tool to help meet the challenge. House File 875, the 2005 Health & Human Services Appropriations bill, includes language that directs the Medicaid program to provide cessation drug coverage to recipients beginning this fiscal year.

Prior to this legislative change, the state had primarily limited tobacco use prevention efforts to youth through funding provided to the Iowa Department of Public Health Tobacco Use Prevention & Control Division. While the Division is able to provide Quitline Iowa (a 1-800 number accessible to any Iowan) and $75,000 to free health care clinics to provide cessation products, overall the Division's funds cannot be used for adult cessation efforts.

In addition to smoking cessation, House File 875 also directs the Medicaid program to cover weight reduction treatments & drugs. IAFP is eager to work with the Department on establishing these new components of the Medicaid program. We urge the Council to support Department efforts to implement coverage of these products as soon as possible through emergency rules.

IAFP is also looking forward to the opportunity to engage in discussions and activities related to the implementation of the IowaCare Act. With IowaCare having received approval July 1, 2005 from CMS, Iowa's indigent care will be provided differently, and it is up to all of us involved in the health care community to ensure that those most vulnerable Iowans continue to access health care.

When IAFP first read about IowaCare, our members raised many questions about the program as well as concerns related to elimination of the State Papers Program, a program that had been in place for 100 years. While State Papers was not a fail proof health care system, the program's familiarity and structure of county patient quotas was comforting to family physicians who were often the first point of entry for qualified recipients.

In our opinion, a short coming of the State Papers Program was that, for the most part, it did not allow for primary care to be provided locally, nor did it do a good job of providing preventive care.

We feel the new IowaCare program shares this same shortcoming, as patients will (at least initially) have to access care at Broadlawns Medical Center, the University of Iowa Hospitals and Clinics, or one of the four state mental health institutions. The program also has some unique features that may provide additional challenges for the patient, as well as provide new responsibilities.

Of key concern to the IAFP is the potential for money appropriated to the program to be utilized before the end of the fiscal year, causing enrollees to be "cut-off" from the program. We understand this same scenario could have also occurred with the State Papers Program. And that, just as with State Papers, IowaCare will expect that health care institutions such as the University of Iowa, Broadlawns Medical Center, and Iowa hospitals continue to provide indigent or charity care when program funding is depleted. These institutions are proud of the indigent care they provide the state, and no doubt they will continue to step up to the plate.

However a change may be participants' expectations for care under IowaCare may be higher than they were under State Papers, as participants will be required to pay a monthly premium and co-pay. With think this payment responsibility coupled with the fact that IowaCare has no provisions for county quotas may change the access of care across the state, and that does concern us. Obviously, only time will provide the impact of the program.

We are therefore pleased that issues related to the impact of IowaCare on indigent care will be studied this fiscal year by a task force assigned the purpose of identifying any growth in uncompensated care due to the implementation of IowaCare. We are also pleased that during the July 2005 Medical Assistance Advisory Council Meeting Director Gessow informed Medicaid providers that access to information pertaining to IowaCare utilization will be available to the public.

Now that IowaCare is officially underway, IAFP looks forward to learning from this first year of implementation. We are eager to begin participating in conversations related to the number of program aspects that will have a major impact on the Medicaid and IowaCare programs that are outlined in the legislation, which are to be implemented in the coming year & years. These provisions include:

Provision from Division II Medicaid Expansion

- Direction that "beginning no later than March 1, 2006, within 90 days of enrolling in IowaCare, each IowaCare population member shall participate in conjunction with receiving a single comprehensive medical examination and completing a personal health improvement plan...." The single comprehensive medical examination may be provided by an IowaCare network physician, advanced registered nurse practitioner (ARNP), or physician assistant (PA), or any other physician, ARNP, or PA, available to any full benefit recipient.

Provisions from Division IV Health Promotion Partnerships

- Dietary Counseling – By July 1, 2006 the Department shall design and begin implementation of a strategy to provide dietary counseling to children and adult recipients of the Medicaid and IowaCare;
- Electronic Medical Records – By October 1, 2006 the Department shall develop a practical strategy for expanding utilization of electronic medical recordkeeping by providers under Medicaid and the IowaCare provider network;
- Provider Incentive Payment Programs – By January 1, 2007 the Department shall design and implement a provider incentive payment program for providers under Medicaid and providers included in the IowaCare network;
- Smoking Cessation – By July 1, 2007 the Department shall implement a program with the goal of reducing smoking recipients of Medicaid who are children to less than 1% and among adult recipients of Medicaid and Iowa Care to less than 10%

Provision from Division V Iowa Medicaid Enterprise

- Clinicians Advisory Panel – Clinical Management – By July 1, 2005, the medical director of the Iowa Medicaid enterprise, with approval from the Medicaid Administrator, shall assemble and act as chairperson for a clinicians advisory panel to recommend to the Department clinically appropriate health care utilization management and coverage decisions for the Medicaid program and for IowaCare which are not otherwise addressed by the Iowa Medicaid Drug Utilization Review Commission or the Medicaid Pharmaceutical and Therapeutics Committee.

The IAFP views the Medicaid, ***hawk-i*** and IowaCare programs as partnerships between the state, providers and patients. Our members are committed to providing quality care and access to the state's health care programs and we look forward to dialoguing with the Department and the Council about Medicaid tobacco cessation coverage; increasing Iowa's tobacco tax for health care; and implementation of the IowaCare program and policies.

FAMILY PLANNING COUNCIL OF IOWA
TESTIMONY TO THE
COUNCIL ON HUMAN SERVICES
JULY 2005

The Family Planning Council of Iowa is a private non-profit organization dedicated to promoting access to family planning and reproductive health care for all Iowans through direct services, public education and advocacy, professional training, and collaboration.

Thank you for the opportunity to provide testimony to the Council on Human Services regarding the FY2007 budget process.

First, I would like to thank the Council on Human Services and the Department of Human Services for moving forward on the Medicaid Waiver for family planning services. The Department's commitment to and work on pursuing the waiver and developing the implementation has been laudable. Known as the Iowa Family Planning Network, the waiver will help the women of Iowa as well as the State itself. Prevention of unintended pregnancies provides many positive benefits for individuals and society. So, thank you again for your strong support of obtaining a Medicaid waiver for family planning.

This waiver project will help Iowa capitalize on the value of voluntary family planning services. DHS's investment in a family planning waiver project will provide the anticipated results and savings only if all DHS programs support the project. This means that other programs provide their clients with information about and access to the Iowa Family Planning Network. The cooperation of other DHS programs is important to the success of the waiver project.

Providing clinical services is one mechanism for helping avert unintended pregnancies. Another important mechanism is to provide good, factual information and education about preventing unintended pregnancies. It is especially important that teens receive honest, age appropriate, evidence based information about preventing pregnancies. It is also important that teens are provided with the lessons and life skills to enable them to make good decisions regarding avoiding unintended pregnancies. Over the years, the Department of Human Services has funded the Community Adolescent Pregnancy Prevention Program (CAPPP). This program, using Temporary Assistance to Needy Families (TANF) funds, requires that communities come together to develop programs for their area to work with teens on preventing pregnancy. This required collaboration of various types of providers assures that the funded programs reflect the needs of the community.

We are anticipating that the Medicaid family planning waiver will soon be approved. If the family planning waiver is approved it would free up some TANF funds that could be used for increasing funding for the Community Adolescent Pregnancy Prevention Program.

Recommendations:

Continued Support of Funding for the Community Adolescent Pregnancy Prevention Programs:

Education and information to young people is an additional means of helping avoid unintended pregnancies. The Community Adolescent Pregnancy Prevention funds community developed programs focusing on this issue. We ask the Council to continue to support this program and to increase the funding level.

Encourage Information about Voluntary Family Planning Services:

Having state and private agencies that provide human services programs furnish information about voluntary family planning services to their interested clients helps clients avoid unintended pregnancies and the attendant future costs. We ask the Council to encourage the provision of information and the provision of referrals to the Iowa Family Planning Network for interested clients.

For more information contact: Jodi Tomlonovic, Executive Director
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Planned Parenthood®
Iowa Planned Parenthood Affiliate League

THE IOWA COUNCIL ON HUMAN SERVICES
FY 2007 Budget Hearing

Submitted July 2005 by Jill June
Representing the Iowa Planned Parenthood Affiliate League

Community Adolescent Pregnancy Prevention

An important component of preventing unintended pregnancy among adolescents is through the Community Adolescent Pregnancy Prevention programs (CAPP). Although the rate of teenage pregnancy in the United States has been declining, it remains the highest in the developed world. Much work still needs to be done.

> Teen mothers are less likely to graduate from high school and more likely than their peers who delay childbearing to live in poverty and to rely on welfare.
>
> The children of teenage mothers are often born at low birth-weight and experience health and developmental problems.
>
> Teenage pregnancy poses a substantial financial burden to society in lost tax revenues, public assistance, child health care, foster care, and involvement with the criminal justice system.

In Iowa in 2003, 3326 babies were born to teen mothers. The annual cost associated with supporting each teen family is an estimated $17,000 per year. Iowa's investment of $4.1 million in CAPP programs from 1998 to 2002 created an estimated savings of $31 million as a result of the decrease in teen birth rates and the costs associated with teenage parenting. (1) Clearly investing in the CAPP programs is cost-effective.

CAPP programs are currently funded through TANF at $1.3 million dollars and haven't received an increase in funding since 1998. These programs fund efforts in 50 Iowa counties to strengthen families and prevent negative outcomes for children. In 2003, over 62,000 teens were reached in those 50 counties, however, 49 counties went un-served.

Recommendations:

With the anticipated approval of the Iowa family planning Medicaid waiver and a decrease in the need for TANF family planning funding, we recommend your consideration of a much needed increase in the Community Adolescent Pregnancy Prevention funding.

(continued on back)

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In addition, regardless of strategies used to reduce the incidence of teen pregnancy in the state, we urge your support of age-appropriate, medically accurate, science-based instruction related to health, human growth and development and family life education.

Sources: 1. FutureNet (2004) based on figures from the Iowa Department of Public Health, Teen Birth Rate 2002 and the Robin Hood Foundation (2000)

The Iowa Planned Parenthood Affiliate League is a coalition of reproductive health care providers advocating for access to voluntary family planning services and adolescent pregnancy prevention programs as key components of public policy to protect the health and well-being of women and children in Iowa.

For additional information contact: Judith Rutledge, Iowa Planned Parenthood Affiliate League, 515/280-7004, ext 114 or jrutledge@ppgi.org

Governor's Developmental Disabilities Council

People, Possibilities, Progress

July 12, 2005

TO: Iowa Council on Human Services Members

FROM: Rik Shannon, Public Policy Manager

RE: SFY 2007 Budget Testimony

Thank you for this opportunity to offer suggestions as you develop your budget recommendations for the FY 2007. The Governor's DD Council is a federally funded state agency with a responsibility to work to influence systems change that promotes the independence, productivity and inclusion of the more than 450,000 Iowans with disabilities. The Council works with direction from our funder, the federal Administration on Developmental Disabilities (ADD), to identify needs and to plan initiatives that address outcomes in specific emphasis areas for people with disabilities. The focus of the Iowa DD Council has been in the areas of self-determination and community inclusion, areas in which success will be determined, in part, by the extent of efforts to develop systems of service delivery that promote empowerment, individual choice and inclusion in natural community settings.

The Medicaid program in Iowa retains a distinct "institutional bias", meaning that too often seniors and individuals with disabilities are disproportionately served in higher-cost institutions, instead of receiving lower cost home- and community-based care. When compared with other states for FY 2002, Iowa spent 49% of all MR/DD spending on community services, defined as those delivered in settings of 1-6 individuals, ranking the state 49th in the nation, well below the national average of 68%. The ranking does not mean Iowa is choosing not to fund services for persons with disabilities but it does suggest that, rather than shifting away from funding institutions as many states have, Iowa is continuing to fund a dual system that supports both institutional and community-based services at a higher cost to the state.

The DD Council has long supported the development of policy and budgeting that reduces the institutional bias and rebalances the long-term care system by creating choices for and access to community-

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based service alternatives. Progress was made in this area during the 2005 session of the Iowa Legislature and we applaud your part in that effort. The decision to fully fund the current waiting lists for Home and Community Based Waiver Services was a significant one and consistent with policy decisions intended to move the long-term care system in a direction that improves services and streamlines administrative procedures while simultaneously creating efficiencies that contain costs and may in fact lead to long-term cost savings. The sweeping Medicaid reforms in HF 841, in addition to increasing access to critical health care, include key elements critical to the rebalancing of the long-term care system in Iowa.

We trust that your budget recommendations will capture the commitment to systems change articulated in HF 841 and more recently in Executive Order 43. In signing the Executive Order supporting efforts to increase access to home and community-based service options, Governor Vilsack acknowledged the progress made during the past legislative session and continued saying, "Without in-home assistance, individuals who otherwise would be able to thrive in the community could be forced to seek institutionalization in order to receive the care and services they need. Folks who need assistance should have options to stay in their own home." We couldn't agree more and we look forward to a budget that builds our state's capacity to offer options that use our limited resources wisely and which enhance the quality of life for all Iowans with disabilities and their families. We thank you for your time and attention and hope that you will consider the Governor's DD Council as a resource as you move forward.

Date: July 12, 2005

To: Council on Human Services

From: Thomas R. Temple, R.Ph., M.S.
Executive Vice President & CEO
Iowa Pharmacy Association

Subject: 2006-2007 Budget Recommendations and Legislative Package

We appreciate the opportunity to provide input into the Department's budget development process. Our recommendations, outlined below, focus on the medical assistance and medical contracts components of the budget, with particular emphasis on the Medicaid drug program.

In developing the Department's recommended budget and legislative package for 2005-2006, the Iowa Pharmacy Association (IPA) would offer to the Council, the following recommendations:

1. The Council should seek full funding for the prescription drug program. In addition, the Council should encourage reasonable, prudent and creative strategies to address the escalating costs of prescription drug products while assuring access to core patient care services.

Comment: The rational and appropriate use of medication remains the most cost effective form of therapy available to the Medicaid program and to Medicaid recipients. Failure to provide adequate funding to the prescription drug program would jeopardize patient access to medications from pharmacy providers across the state. Limiting access to medications places Medicaid recipients at risk for avoidable expenditures. Without access to preventative medication, patients may require more expensive forms of acute care and therapy (e.g. primary care and specialty physician visits, surgical procedures, hospitalizations, and nursing home care). Patients, pharmacists and prescribers working cooperatively can identify cost-effective appropriate therapeutic options.

A cooperative relationship between the patient, pharmacist, and prescriber grows in importance as the Medicaid program must use limited health care dollars wisely, recognizing the increasing costs of pharmaceuticals, including the introduction of new and more expensive agents. Efforts should be enhanced to allow pharmacists to work with the Department of Human Services and physicians and other prescribers to better understand the relative cost of therapeutic decisions regarding medication. Efforts of the Drug Utilization Review Commission and appropriate implementation of the proposed preferred drug list are important tools in this effort.

However, implementation and expansion of these programs place increased administrative responsibilities on the provider pharmacists. Pharmacists are pleased to work with the Department and their patients to optimize cost effective care. However, pharmacists should be adequately compensated both for the delivery of professional services and management of the medication regimen.

2. The Council should continue to support the Pharmaceutical Case Management service for selected at-risk Iowa Medicaid recipients. This important program allows pharmacists and physicians to jointly provide specialized services for Medicaid recipients at high risk for medication related problems.

Comment: The traditional prescription reimbursement system provides payment for drug product and an associated dispensing fee. While distribution of the appropriate medication to the patient is important and maintaining access to care for all Iowans is critical, the traditional system does not reward efforts to ensure appropriate drug therapy and positive outcomes.

In October 2000, Iowa Medicaid Pharmaceutical Case Management (PCM) services were initiated through an amendment to the State Plan. The Department of Human Services, researchers at the University of Iowa, and the professions of pharmacy and medicine designed and implemented a program to optimize patient care. PCM services involve physicians and pharmacists, working in teams, providing care for eligible Medicaid recipients identified as being at high risk for having trouble taking their medications safely and effectively. Physicians prescribe and establish treatment goals, while pharmacist team members provide additional follow-up and feedback between physician visits about the effectiveness of medication therapy and occurrence of side effects. The service has been recognized nationally and is being replicated in other states as a key component of

providing quality cost effective patient care. Continued support of the Council on Human Services for this important service is requested.

3. The Council should recommend adequate funding for the Iowa Medicaid drug utilization review program.

Comment: The Iowa Medicaid drug utilization review program is recognized as one of the leading Medicaid quality assurance programs nationally. Administered by IPA through a subcontract with the Iowa Foundation for Medical Care, the program has consistently demonstrated a cost savings ratio of over 2.5 to 1. The S. Y. E. 2003 report indicated direct savings of $2.98 for each dollar appropriated. The Iowa DUR contract qualifies for 75% federal matching funds. Since the federal government matches state expenditures at a 3:1 ratio, the cost savings per state dollar spent is $11.91.

IPA recognizes the expertise of the DUR Commission and encourages the Council to continue funding to support the activities of the Commission. IPA also encourages the Council to coordinate the actions of the P&T Committee with the DUR Commission to best utilize resources for the Iowa Medicaid prescription drug program

4. The Council should recommend a modification in the reimbursement policy for home infusion pharmacy services to adequately compensate for the services provided.

Comment: The current system of reimbursing drug cost plus an associated dispensing fee is not appropriate to compensate the services provided for home infusion therapy. Unlike traditional pharmacy services, home infusion therapy is a very specialized service that has expenses associated with unique patient education and monitoring, delivery, and nursing care, as well as expensive equipment necessary for the preparation and administration of infusion therapy. A new reimbursement methodology that reflects the costs involved in the delivery of these services is needed to encourage the utilization of home infusion therapy. Home infusion therapy allows patients to go home from the hospital or nursing home earlier, or to choose to receive their infusion drug therapy at home, saving significant dollars in institutional care expenses.

IPA is pleased to have the opportunity to work with DHS staff on the development of budget details relative to each of the above-mentioned recommendations. Again, thank you for the opportunity to provide input into the budget development process.