COUNCIL ON HUMAN SERVICES

PUBLIC HEARING

JULY 11, 2007

1)	Dr. Robert Russell	Iowa Dental Association/Delta Dental of Iowa
2)	Doug Johnson	Iowa Health Care Association
3)	Pat Giorgio	Iowa Center for Assisted Living
4)	Maja Rater	Citizen
5)	Shelly Chandler	Iowa Association of Community Providers
6)	Di Findley	Iowa Caregivers Association
7)	Judge Connie Cohen	5th Judicial District (Des Moines)
8)	Marilyn Pierce	Child Care Resource & Referral
9)	Lynhon Stout	Iowa Foster & Adoptive Parents
10)	Shanell Wagler	Iowa Community Empowerment
11)	Tom Southard Candice Bennett	Chief Juvenile Court Officer (Ames) & Chief Juvenile Court Officer (Cedar Rapids)
12)	Bob Welsh	Citizen
13)	Jodi Tomlonovic	Family Planning Council
14)	Karen & Dave Honold	Day Care for Exceptional Children
15)	Julie Fidler Dixon	Advisory Council on Brain Injuries
16)	Heather Hulscher	Iowa Hospital Association
17)	Erica Fuchs	Citizen
18)	Kim Schmett	Coalition for Family & Children Services
19)	Sheila Hansen	Child & Family Policy Center

20)	**Kelli Soyer**	**National Association of Social Workers (NASW)**
21)	**Kristine Burnett**	**Citizen**
22)	**Dana Petrowsky**	**Iowa Association of Homes & Services for the Aging**
23)	**Mary O'Brien**	**Visiting Nurse Services**

Comments Submitted in Writing (Did not present)

- **Iowa State Association of Counties**
- **Becky Harker, Governor's Developmental Disabilities Council**
- **Linda Goeldner, Iowa Nurses Association**
- **Planned Parenthood of Greater Iowa**

Testified but did not Submit Written Comments

- **Joy Harris, Day Care for Exceptional Children**

Statement of Dr. Bob Russell, DDS, MPH
On behalf of the Delta Dental of Iowa, Iowa Dental Association and
The Iowa Department of Public Health
before the
Iowa Department of Human Services
Public Hearing on: SFY 2009 budget process
July 11, 2007

Good morning, I am Dr. Bob Russell, the Iowa Department of Public Health Dental Director and Oral Health Bureau Chief. I am pleased to submit testimony for the record on behalf of a collaboration between Delta Dental of Iowa, Iowa Dental Association and the Iowa Department of Public Health.

The focus of our collaboration embodies the goal of improving the oral health of Iowans. I am here today to speak to you about a project that addresses oral health care access for underserved Medicaid enrolled young Iowans.

On May 12, 2005, the Iowa Legislature passed a bold Medicaid reform initiative called Iowa Care Act, which was signed into law by Governor Vilsack. Included within the Iowa Care Act legislation was the following mandate: *"By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the early and periodic screening, diagnostic, and treatment program."*

As I hope you can imagine, this is a daunting task to accomplish given the number of barriers that must be surmounted including:

1. An insufficient number of practicing dentists in Iowa, particularly in lower-income and rural parts of the state.
2. An aging dental workforce –median age 54

3. Most dental practices are nearly saturated with higher income insured or paying patients
4. Low overall Medicaid participation rates and most not taking on new Medicaid clients
5. Complaints of low Medicaid patient compliance, high appointment "no-shows" and low Medicaid reimbursement rates (not competitive in private markets)
6. Over half of Iowa's general dentist are uncomfortable or unwilling to provide services to children under age 3

In response to this legislation, the Iowa Department of Human Services partnered with the Iowa Department of Public Health, the Iowa Dental Association, the Iowa Dental Hygienists' Association, Delta Dental of Iowa, and the University of Iowa College of Dentistry to develop a proposal that would fulfill the dental home mandate. The result is called the I-Smile Dental Home Project.

The I-Smile program objectives are to improve the dental support system for children, especially Iowa's underserved children; improve the dental Medicaid system; implement dentist recruitment and retention strategies to increase access in underserved area, and integrate dental services into rural and critical access hospitals. A "dental home" means that Iowa would ensure regular access and professional oral healthcare at critical times during a child's growth and development and defined under federal Early Periodic Screening Diagnosis and treatment (EPSDT) requirements.

Beginning strategies to address accessing a dental home for Medicaid-enrolled children through the I-Smile proposal have been initiated thanks to an interagency agreement between the Iowa Department of Human Services and the Iowa Dept. of Public Health. This funding allows strengthening the dental infrastructure of local Title V Child Health agencies to focus on children's oral health and provide oral health care coordination through I-Smile Coordinators utilizing prevention focused dental hygienists. Recently, Iowa Department of Public Health designated all 99 Iowa counties into 23 service areas for I-Smile coordinators – please see the map attached. The I-Smile coordinators are also responsible for increasing oral health education and promotion for

families; and partnering with WIC, Head Start, Migrant and Community Health Centers, Iowa hospital health systems and programs. Other components that have been implemented include trainings to non dental healthcare providers, such as physicians and nurses, to provide screenings, fluoride varnish applications, education and referrals to dentists; providing trainings for dental providers about care for children under age three; and strengthened the state Title V Child Health database system for tracking patient care coordination and appointments.

This early component of the I-Smile plan targets improvements in patient compliance and education via care coordination activities; however, we still lack the level of dentist's participation in Medicaid to achieve dental home for all enrolled children without improvements in the Medicaid reimbursement system itself.

How can we improve the access to care problem in the dental Medicaid program through the I-Smile proposal? We have only to look at another nearby Midwestern state that has seen a significant positive change to their dental Medicaid program – Michigan. What did they do? They utilized a familiar dental insurance carrier to create a network of dentists willing to see Medicaid-enrolled children with increased reimbursement rates. Michigan leaders also initiated reimbursing non-dental providers for providing screening and fluoride varnish to children in settings beyond a dental office. According to the Journal of American Dental Association study on the *Michigan Medicaid's Healthy Kids Dental program, An assessment of the first 12 months* by Stephen A. Eklund, D.D.S., Dr. P.H, James L. Pittman, D.D.S., M.S. and Sarah J. Clark, M.P.H (J Am Dent Assoc, Vol 134, No 11, 1509-1515. © 2003) dental care utilization increased 31.4 percent overall and 39 percent among children continuously enrolled for 12 months, compared with the previous year under Medicaid. Dentists' participation increased substantially, and the distance traveled by patients for appointments was cut in half.

While increasing provider reimbursement rates alone can improve the willingness of many providers to serve Medicaid children, we believe that the addition of other dental home improvements initiated in the I-Smile plan will produce even greater willingness since the program addresses other issues providers have listed as barriers to participation.

Iowa must initiate a similar insurance-based benefit plan – much like our current *Hawk-I* program; but for Medicaid enrolled children. The combined state/federal cost may range from $15 to $40 million depending on the age range of children covered. Two plans are currently pending – one for ages 6 and under as seen in the 2007 Appropriations bill- HF 909 or the original 2005 IowaCare Act ages 12 and under.

According to policy brief produced by the Children's Dental Health Project in Washington DC, the estimated cost savings of getting children into a dental home and providing early prevention services results in 40% in cost savings over a five year period. For Medicaid programs, early dental care can save up to ten times the costs currently observed if a child ends up in a hospital emergency room. The recent death of a Maryland Child-Deamonte Driver due to a dental infection that went to the child's brain illustrates the importance of avoiding delays in dental care.

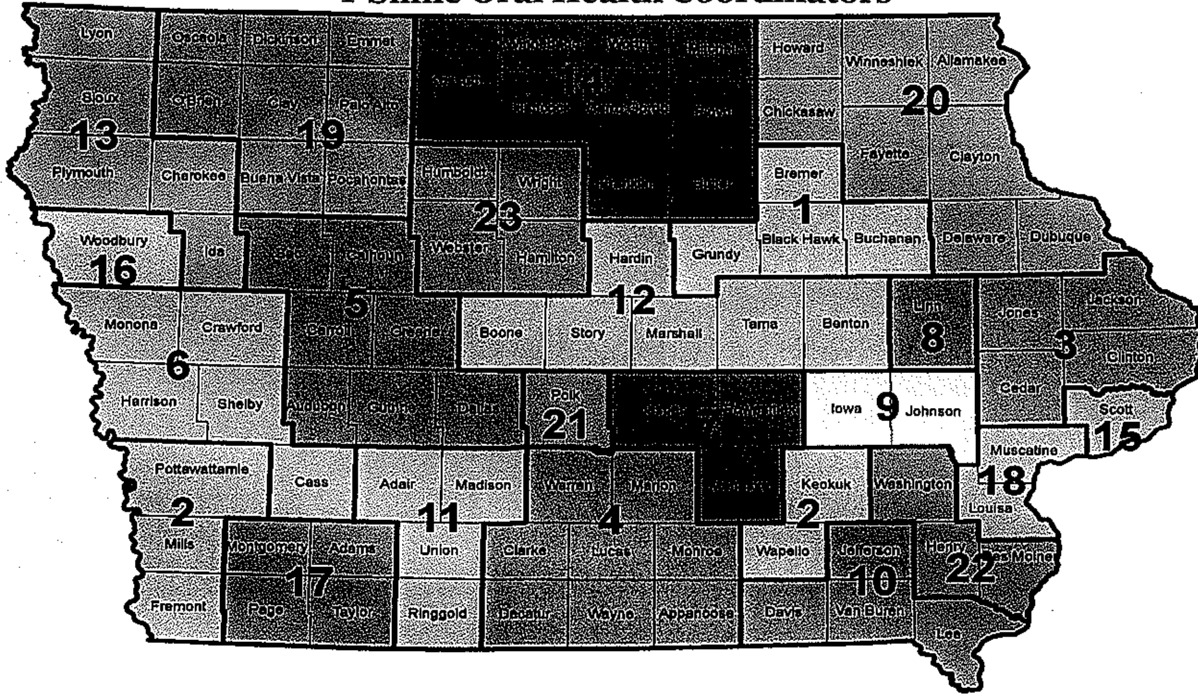
Additional provisions requested for inclusion within the I-Smile proposal address issues such as the need to reinstate periodontal (gum treatment) for pregnant women and adults to decrease the potential of transmitting oral decay causing bacteria to young children. Another component is a targeted student loan repayment plan similar to the Delta Dental Public Benefit pilot student loan repayment plan that requires as a condition of repayment a dentist placed in an underserved rural community to include Medicaid patients in their practices. This will require another estimated $350,000 in additional costs.

The overall goal for the I-Smile project is to provide Iowa's children with quality oral health care that is accessible, assures adequate identification of disease risk and prevention through education and monitoring, strengthens the parental involvement and education of their child's oral health. But just as important, the I-Smile proposal addresses the oral health professional recruitment and retention needs and increases provider willingness to serve Medicaid enrolled children throughout the state. We believe that a multi-discipline approach is required for achieving dental home that involves both primary care and dental providers whom interact with a child at different stages of

development. However, an adequate Medicaid reimbursement system must be available before access to essential dental home services can be obtained.

On behalf of the Iowa Dental Association, Delta Dental of Iowa and the Iowa Department of Public Health, I urge you to address the access to care issues that are affecting young Iowans by supporting the complete I-Smile Dental Home budget proposal and meeting the legislative mandate of the Iowa Care Act. Thank you for your time.

I-Smile Oral Health Coordinators



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Updated March 2007

CDHP **Policy Brief**

Cost Effectiveness of Preventive Dental Services

Preventive Dental Interventions Reduce Disease Burden and Save Money

Preventive dental interventions, including early and routine preventive care, fluoridation, and sealants are cost-effective in reducing disease burden and associated expenditures.[i,ii,iii,iv] While millions of children in the United States benefit from routine preventive dental care, there are still millions of additional children who needlessly suffer from avoidable dental disease. As a result, tooth decay continues to remain the single most common chronic disease of childhood, causing untold misery for children and their families.

Preventive Care: Low-income children who have their first preventive dental visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dentally related costs are almost 40% lower ($263 compared to $447) over a five year period than children who receive their first preventive visit after age one.[i]

Fluoridation: The Centers for Disease Control and Prevention reports that for every $1 invested in fluoridation, $38 in dental treatment costs is saved.[ii] In addition, Medicaid dental programs costs as much as 50% less in fluoridated communities compared to non-fluoridated communities.[iii]

Sealants: Sealants prevent cavities and reduce associated dental treatment costs, especially among high-risk children, where sealants applied to permanent molars have been shown to avert tooth decay over an average of 5-7 years.[iv,v,vi]

Lack of Dental Care Leads to Costly Emergency Department Visits and Temporary Solutions

Without access to regular preventive dental services, dental care for many children is postponed until symptoms, such as toothache and facial abscess, become so acute that care is sought in hospital emergency departments.[vii] This frequent consequence of failed prevention is not only wasteful and costly to the health care system, but it rarely addresses the problem, as few emergency departments deliver definitive dental services. As a result, patients typically receive only temporary relief of pain through medication and in some acute cases, highly costly, but inefficient surgical care. A three-year aggregate comparison of Medicaid reimbursement for inpatient emergency department treatment ($6,498) versus preventive treatment ($660) revealed that on average, the cost to manage symptoms related to dental caries on an inpatient basis is approximately 10 times more than to provide dental care for these same patients in a dental office.[vii]

The Connection Between Access and Preventive Care

Multiple interrelated social and demographic factors, including income, race, and education can limit children's access to preventive dental care.[viii,ix] Low-income children are only half as likely to access preventive dental services as middle or high-income children, despite their higher occurrence of dental problems. They are also two to three times more likely to suffer from untreated dental disease.[viii, ix] Minority children are less likely to have access to dental services than their white counterparts, as are children whose primary caregivers have limited education.[viii, ix,x]

Dental insurance coverage plays an integral role in accessing preventive care. Children with private or public dental coverage are 30 percentage points more likely than low-income uninsured children to have a preventive dental visit in the previous year.[x] Children with Medicaid coverage are significantly more likely to have a usual source of care.[xi]

For many low-income children, Medicaid's EPSDT program provides public coverage and access to dental care, including routine preventive services, such as sealants and fluoride treatments. Parents of children covered by Medicaid are 3.5 times less likely to report that their child has an unmet dental need than uninsured children.[xii] In addition, cost-estimation modeling of preventive interventions predict cost savings of $66-$73 per tooth surface prevented from needing repair among young Medicaid-enrolled children.[xiii] Further estimates reveal a savings of 7.3 percent from regular screening and early intervention.[xiv]

The Consequence: Untreated Dental Disease Affects General Health

The progressive nature of dental diseases coupled with lack of access to preventive care can significantly diminish the general health and quality of life for affected children. Failure to prevent dental problems has long-term adverse effects that are consequential and costly. In particular, unchecked dental disease compromises children's growth and function (including their ability to attend to learning, to develop positive self-esteem, to eat and to speak), thereby making the cost of preventive dental care low compared to alternatives of suffering, dysfunction, and expensive repair.[viii,xv]

Despite historic achievements in oral health, such as community water fluoridation and other preventive measures, millions of children are still without basic dental care. Oral health promotion and prevention is critical to reducing disease burden and increasing quality of life. Failure to provide access to preventive dental care almost always results in quick fixes that are short-lived and high-priced, especially among low-income children and their families who are without the resources necessary to access dental services. Recognizing that dental insurance, including Medicaid coverage, is an essential part of accessing care may be the first step to reducing barriers to care and eliminating oral health disparities by ensuring that low-income children gain access to the preventive dental services they need.

Credits: Shelly-Ann Sinclair MPH, Burton Edelstein DDS MPH
February 23, 2005

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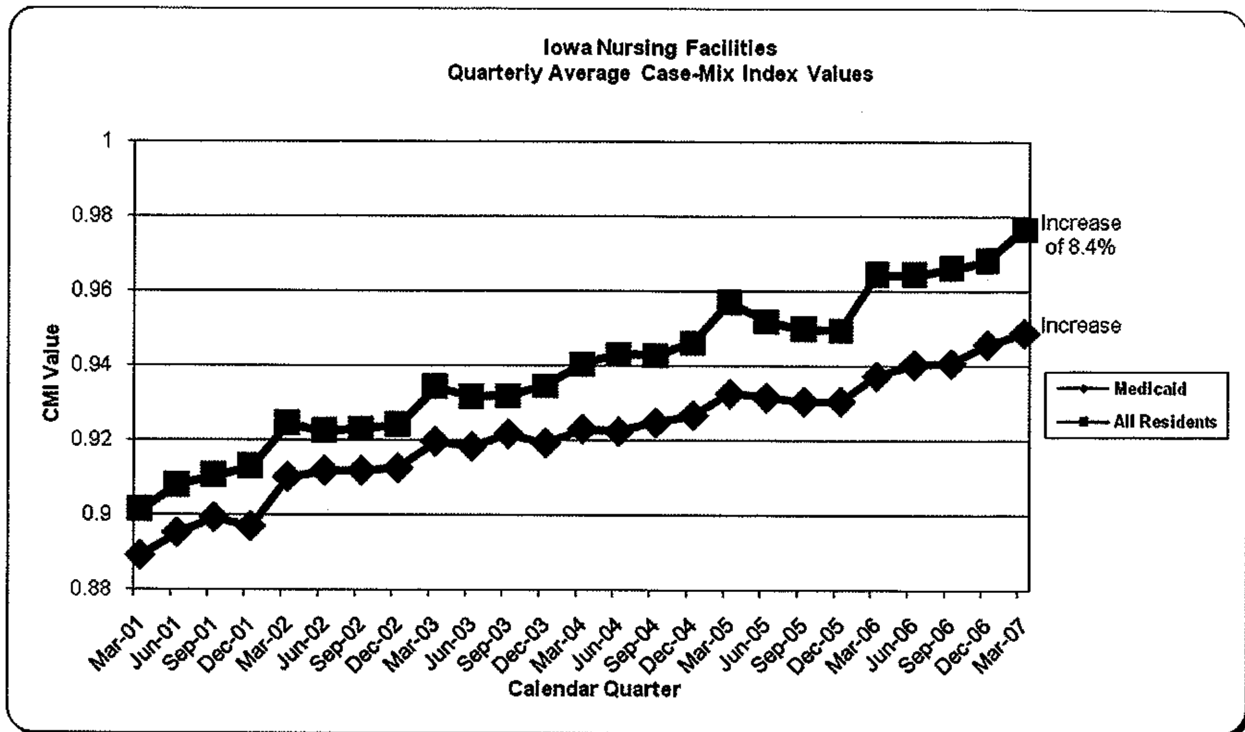
[i] Savage Matthew, Lee Jessica, Kotch Jonathan, and Vann Jr. William. *"Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs"*. Pediatrics 2004; 114 pp.418-423
[ii] Centers for Disease Control and Prevention. Oral Health Resources Fact Sheet. *"Cost Savings of Community Water Fluoridation"* Accessed 12/31/04 at http://www.cdc.gov/OralHealth/factsheets/fl-cwf.htm
[iii] Centers for Disease Control and Prevention. *"Water Fluoridation and Costs of Medicaid Treatment for Dental Decay –Louisiana, 1995-1996"*. MMWR Weekly. September 03, 1999/48(34), pp.753-757.
[iv] Quinonez, Downs, Shugars, et al. *"Assessing Cost-Effectiveness of Sealant Placement in Children"*. Accepted for publication: Journal of Public Health Dentistry.
[v] Werner C, Pereira A, Eklund S. *"Cost-effectiveness study of a school-based sealant program. Journal of Dentistry for Children"*. March-April 2000.
[vi] Weintraub J, Stearns S, Rozier G, Huang C. *"Treatment Outcomes and Costs of Dental Sealants Among Children Enrolled in Medicaid"*. American Journal of Public Health. November 2001. (91) 11, pp. 1877-1881.
[vii] Pettinato Erika, Webb Michael, Seale N. Sue. *"A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care"*. Pediatric Dentistry 2000: 22(6), pp.463-468
[viii] Edelstein, Burton. *"Disparities in Oral Health and Access to Care: Findings of National Surveys. Ambulatory Pediatrics"*. March-April 2002: 2(2) Supplement.
[ix] Kenney Genevieve, Ko Grace, Ormond Barbara. *"Gaps in Prevention and Treatment: Dental Care for Low-Income Children"*. The Urban Institute. Series B. No. B-15. April 2000.
[x] Kenney, Genevieve; McFeeters, Joshua; Yee, Justin. *Preventive Dental Care and Unmet Dental Needs Among Low-Income Children.* The Urban Institute. Accepted for publication: American Journal of Public Health.
xi Slifkin RT, Silberman P, Freeman V. *"Moving from Medicaid to North Carolina Health Choice: Changes in Access to Dental Care for NC Children"*. North Carolina Medical Journal. 2004 Jan-Feb 65(1), pp. 6-11.
xii Newacheck, P.W., Peraly, M. and Hughes, D.C. *"The Role of Medicaid in ensuring children's access to care. Journal of the American Medical Association"*. 280(20), pp.1789-93, 1998.
[xiii] Ramos-Gomez FJ, Shepard DS. *"Cost-effectiveness Model for Prevention of Early Childhood Caries"*. J Calif Dent Association. 1999 Volume 27, pp. 539-44
[xiv] Zavras AI, Edelstein BL, Vamvakidis A. *"Health Care Savings from Microbiological Caries Risk Screening of Toddlers: a Cost Estimation Model"*. Journal of Public Health Dentistry. Summer 2000. 60(3) pp. 182-8.
[xv] US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General– Executive Summary.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

DHS Council Presentation
July 2007

The members of the Iowa Health Care Association (IHCA) thank you for the opportunity to present concerns and recommendations for FY 2009. Our comments today do not specifically address appropriation requests; however, we have updated information presented in previous years. We will also present an issue brief that—with your support—will continue the efforts of providers and multiple state agencies to address appropriate long term care capacity across Iowa.

IHCA represents 322 of the 430 nursing facilities (75 percent) in Iowa and 215 assisted living centers, residential care facilities and senior housing units. Many of these providers offer a wide range of home and community based services.

In 2000 the transition to the current nursing facility (NF) reimbursement system began. We have worked as a close partner with both the Department and Legislative branch throughout this process. The chart below illustrates the increase in the average acuity of residents in Iowa's NFs since the implementation of the new system. The current system is responsive to this increase in care needs, and we appreciate your support toward full funding of this system.



Increasing acuity is a significant pressure that providers face. Other continuing pressures providers experience include census declines and staffing shortages. The recent increase in mandatory minimum wage is trickling up through the system and will push up entry level wages. We estimate this could push up wages across the system by $10-$12 million.

The average NF payment for Medicaid beneficiaries in Iowa was approximately $114 per-patient-day compared to a national average of nearly $148. This means that the State's share of NF payments is less than $30 per day for room, board, supplies and 24-hour nursing care. NFs in Iowa continue to experience real losses on every day of service to Medicaid patients. We project this loss will be approximately $9.50 for FY 2006 or nearly $50 million per year. Fully funding the Case-Mix Reimbursement System is critical to minimize these losses.

We encourage the Council to work toward a fully funded case-mix payment system. We ask that your planning include an increase to the SNF Market Basket July 1, 2008. We estimate this to be 3 percent or $6.2 million state dollars and very important to maintain a stable and predictable funding stream.

Various agencies have documented that Iowa has some of the oldest nursing facilities in the nation. Renovation and replacement of these facilities is critical to meet the upcoming demand of the growing elderly population. IHCA members are very pleased with the passage of HF 911 that includes the introduction of the Nursing Facility Renovation and Replacement Fund.

A key issue for the Council is effective utilization of limited resources. Future spending should to be directed toward programs that can do the most for beneficiaries without disrupting access to services. Nursing facility services are clearly the most effective with the State's cost at roughly $30 per-patient-day for nearly 13,000 beneficiaries. This buys room, board and 24-hour nursing care at more than 430 locations across Iowa. We believe that enhancements and incentives for alternatives need to be considered carefully. The payment systems need to be designed to promote acceptance and streamline efficiencies.

In addition, monitoring capacity across the system will help determine if changes are needed to gain savings. IHCA has developed an issue brief to address specific areas where high vacancies of nursing facility beds exist. Simply stated, this is a bed buy-back program funded with State dollars that would pay target facilities to close and, as a result, create efficiencies across the system. The case studies in the issue brief use specific facility data from areas in Iowa. The potential savings to the State is substantial and, with fewer provider locations, these savings would become permanent. Using model data from 2004 and 2005, spending approximately $2.5 million would produce an annual savings of $750,000. The payback period is less than four years and future savings after that become permanent. Other states, including New York and North Dakota, are implementing similar programs to varying degrees. We encourage you to consider of this proposal and would be glad to discuss it further with you or DHS representatives.

Thank you again for the opportunity to make this presentation. Please contact the Iowa Health Care Association if you have questions or need additional information.

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About IHCA and ICAL

Iowa Health Care Association (IHCA) and the Iowa Center for Assisted Living (ICAL) are nonprofit trade associations, whose nearly 550 facility members and 108 associate members span the continuum of long term care. IHCA·ICAL members provide services to Iowa's frail and elderly served through nursing facilities, residential care facilities, assisted living programs, senior housing, and elder group homes. Both organizations are dedicated to enhancing long term care in Iowa by providing leadership, advocacy, information, and education to a broad range of providers, consumers, government agencies, and others comprising the long term care community.

IHCA·ICAL continuously strives to improve the quality of care provided to Iowa's frail and elderly and is dedicated to professionalism, ethical behavior, and integrity among all long term health care providers. The variety of services provided by our members ensures the availability of the right care at the right time.

Who IHCA·ICAL serves

IHCA·ICAL's nearly 550 members represent approximately 80 percent of Iowa's nursing home providers. ICAL represents 65 percent of Iowa's certified assisted living programs. Our members serve more than 42,000 residents in the long term care continuum. These organizations employ more than 30,000 people who provide quality care to Iowa's frail and elderly. We represent more than 83 percent of residents served through Iowa's Medicaid program.

Our mission

IHCA and ICAL are dedicated to promoting quality long term care through professional development and shaping public and private policy through effective advocacy.

Our vision

IHCA and ICAL strive to be Iowa's most trusted, respected, and influential leader in long term care policy and advocacy and a valued resource for information and education.

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DHS Council Presentation
July 2007

The members of the Iowa Center for Assisted Living (ICAL) thank you for the opportunity to present our concerns and recommendations for FY 2009. ICAL represents about 230 assisted living facilities, residential care facilities, elder group homes, and senior housing communities. Our members also provide Medicaid home and community based long term care services to the elderly when they meet the nursing home level of care.

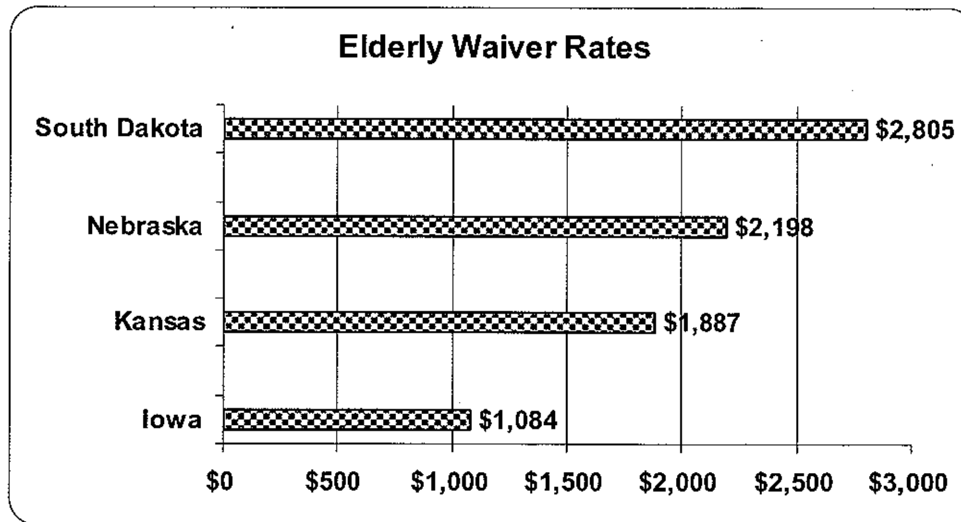
Our comments today address concerns regarding the low cap for the HCBS elderly waiver and the ability to provide access to affordable health care in alternative long term care settings.

Assisted Living Services

Many of our members continue to seek ways to provide assisted living services to the elderly in their community, but continue to find it difficult to provide services to those on Medicaid. Currently tenants on Medicaid can receive assistance with services by using the HCBS elderly waiver and SSA in-home health related care programs, but accessibility is limited by low reimbursement levels.

We ask that consideration be given to increasing the HCBS elderly waiver cap. Currently, the HCBS elderly waiver cap is $1,084, which is only 40 percent of the average nursing facility reimbursement rate in Iowa. In surrounding states, the HCBS elderly waiver ranges from $1,877 to $2,805. (See Figure 1.)

Figure 1



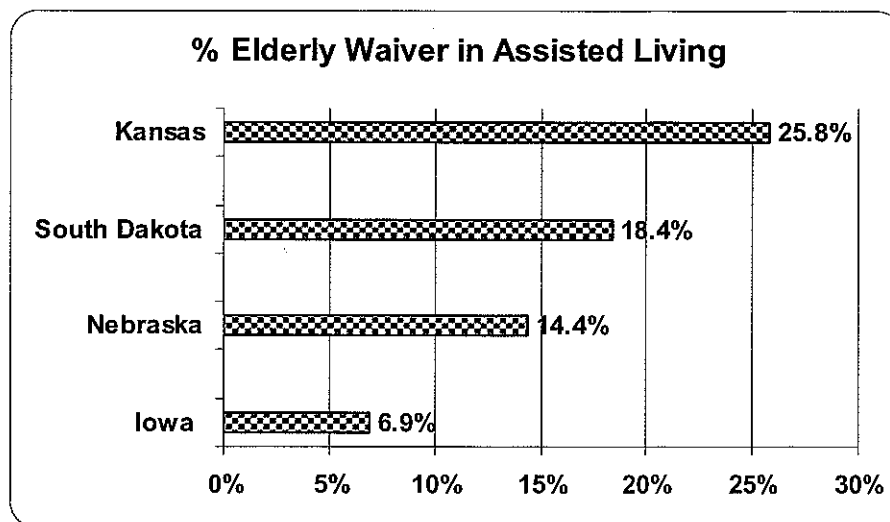
The low payment ceiling of $1,084 discourages providers and tenants from actively participating in the elderly waiver and greatly decreases access to this service for Medicaid clients. Tenants on Medicaid transfer from assisted living to a nursing facility much sooner because $1,084 is not sufficient to cover the cost of their increasing care needs.

The Iowa Finance Authority (IFA) developed an affordable assisted living model for urban Iowa settings (Des Moines, Ames, and Iowa City) with an average monthly cost in 2005 of $1,800 that was reimbursed not only by Medicaid through the elderly waiver, but also through the Medicaid home health care benefit. These models have managed to bring in an average of 60 percent more in reimbursement than traditional assisted living

programs. However, in the past five years IFA has not been able to replicate these results in rural settings. Rural providers found it not feasible to develop a home health agency to serve a small population.

The access to assisted living for Iowans on Medicaid is extremely limited with only 560 of 8,075 elderly waiver clients residing in assisted living programs. This is less than 6.9 percent of the assisted living population. This percentage is very low compared to neighboring states. (See Figure 2.) In April 2007, Assisted Living Concepts, the owner of multiple assisted living facilities in Iowa, sent 30-day discharge notices informing their elderly waiver clients that they could no long offer them services due to low reimbursement rates. More and more Iowa providers are having to make the tough decision to either limit the number of or no longer accept elderly waiver clients. These actions are affecting both existing and potential tenants.

Figure 2



Residential Care Facilities

The State Supplementary Assistance (SSA) reimbursement rate of $26.50 per day for services in residential care facilities (RCF) is significantly lower than the cost of providing services. Today's estimated average per-day cost of providing services is $65 for 24-hour supervision, three meals a day, medication administration, financial management, housekeeping, laundry, activities and psycho-social intervention. Looking back to FY 2005, the Department reported the average per-day cost for RCF care at $56.05 and providers' losses then were nearly $30 per day. Some RCF elderly tenants utilize the elderly waiver program to assist them with paying for services instead of the SSA program, which has a similar type of reimbursement level.

The current reimbursement rate of $26.50 per patient day seriously limits access to alternative long term care services for low-income Iowans. We ask that the SSA funding for RCF services be increased to $35 per day. Increasing SSA funding would require funding of approximately $2 million and improve access to this long term care alternative for Medicaid clients.

6750 Westown Parkway, Suite 100, West Des Moines, IA 50266-7726

phone 515.327.5020 ▪ toll-free 800.422.3106 ▪ fax 515.327.5019

www.iowahealthcare.org ▪ ical@iowahealthcare.org

About the Iowa Center for Assisted Living

Your source for leadership in the assisted living profession, serving our members through consumer education, networking opportunities, public affairs, professional development and a respected voice in public policy advocacy.

The Iowa Center for Assisted Living (ICAL) is the assisted living voice of the Iowa Health Care Association, Iowa's largest organization representing long term care. ICAL represents nearly 230 facility members and 108 associate members who provide services to Iowa's frail and elderly served through assisted living programs, residential care facilities, senior housing and elder group homes. ICAL is dedicated to enhancing long term care in Iowa by providing leadership, advocacy, information, and education to a broad range of providers, consumers, government agencies, and others comprising the long term care community.

ICAL continuously strives to improve the quality of care provided to Iowa's frail and elderly and is dedicated to professionalism, ethical behavior, and integrity among all long term health care providers. The variety of services provided by our members ensures the availability of the right care at the right time.

Who ICAL serves

ICAL's nearly 230 members represent 65 percent of Iowa's certified assisted living programs. Our members serve more than 7,000 tenants and residents in the long term care continuum. These organizations employ more than 4,000 people who provide quality care to Iowa's elderly.

Our mission

ICAL is dedicated to promoting quality long term care through professional development and shaping public and private policy through effective advocacy.

Our vision

ICAL strives to be Iowa's most trusted, respected, and influential leader in long term care policy and advocacy and a valued resource for information and education.

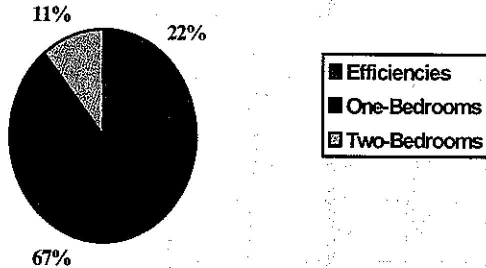
ICAL professional staff

Steve Ackerson, *Executive Director*, steve@iowahealthcare.org
Cindy Baddeloo, *Deputy Director*, cindy@iowahealthcare.org
Lisa Uhlenkamp, *Director of ICAL*, lisa@iowahealthcare.org
Kelly Verwers Meyers, *Director of Regulatory Affairs*, kelly@iowahealthcare.org
Claire Seely, *Director of Communications*, claire@iowahealthcare.org
Dave Tomlin, *Director of Education and Convention*, dave@iowahealthcare.org
Marcia Hewitt, *Director of Membership Services*, marcia@iowahealthcare.org

ICAL
IOWA CENTER FOR ASSISTED LIVING

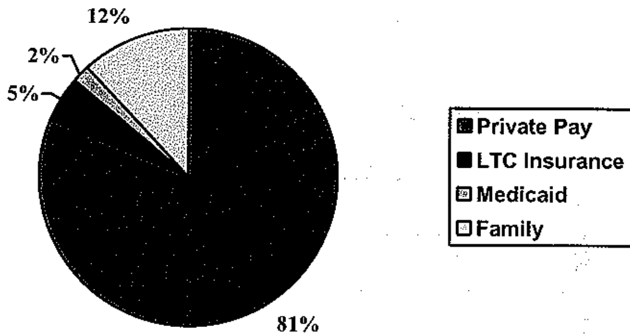
ICAL 2006 Assisted Living Survey

Units

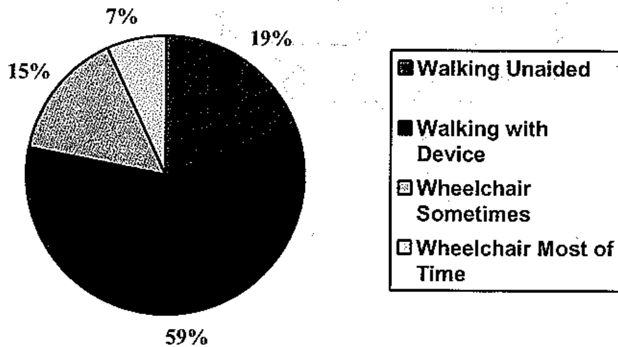


Average cost of one-bedroom unit = $2,649
Average occupancy = 93%
Location = 68% Rural, 32% Urban
Average number of units = 31
Total Assisted Living Programs = 235

Finances: How tenants pay



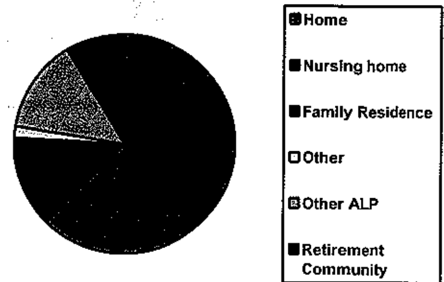
Mobility



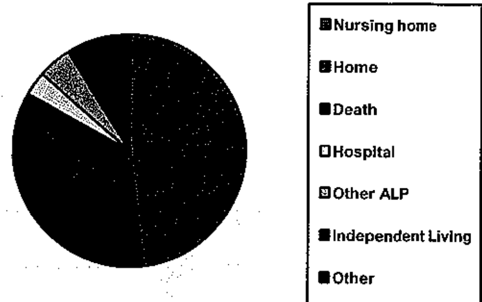
Tenants

Average age: 87 years
Female: 84.5%
Male: 15.5%

Where they come from:

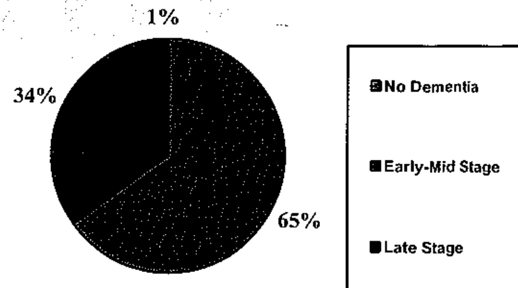


Where they leave to:

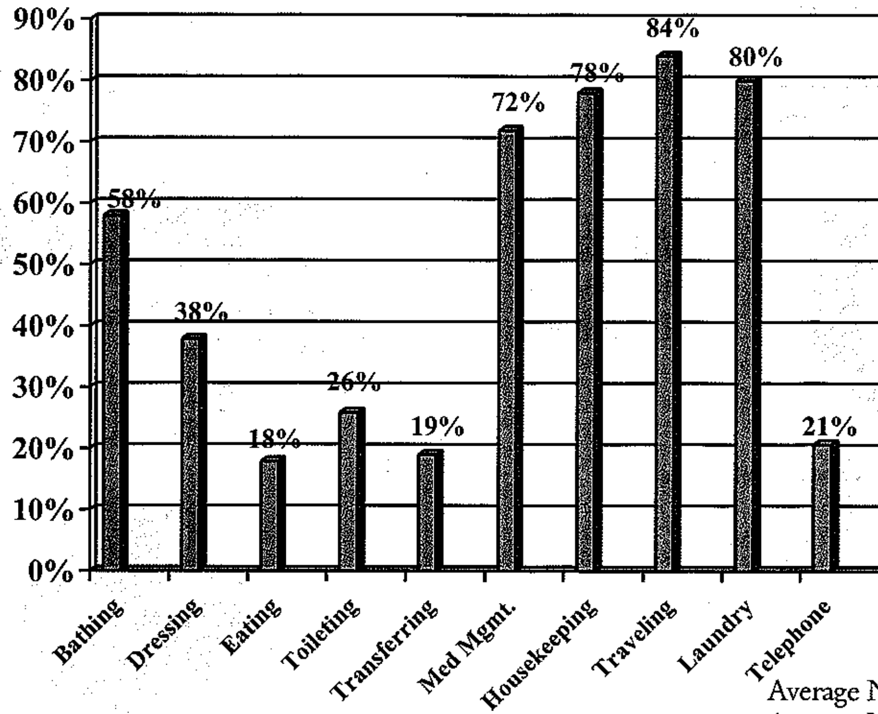


Average Length of Stay = 24 months

Cognitive profile:

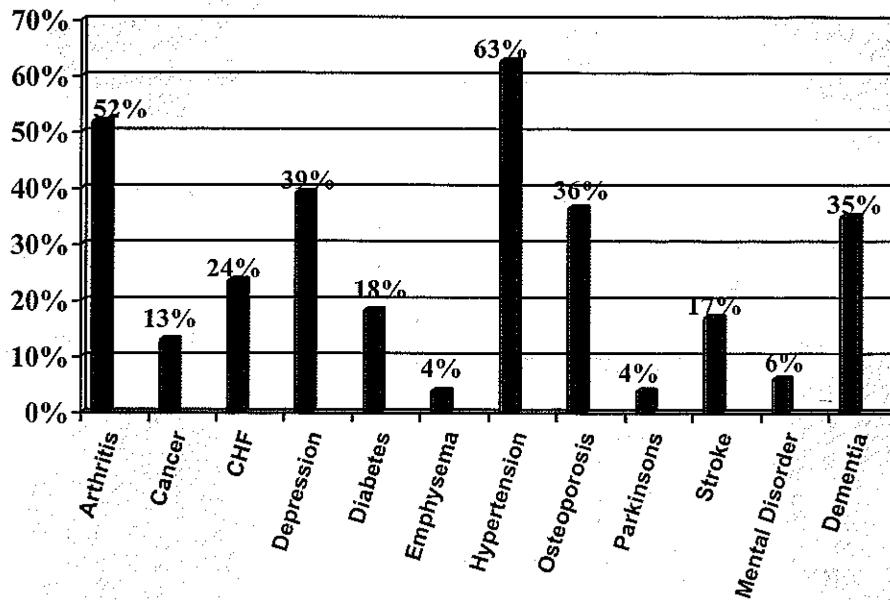


Tenants accessing services



Average Number of ADLs is 1.6
Average Number of IADLs is 3.4

Health Conditions Present



Maja Rater

702 Baker Street
Casey, Iowa 50048
Phone/Fax: 641-746-2692
Email: children@netins.net

My name is Maja Rater. I am a mother of 7 children.

After 23 years of marriage my former husband tried to kill me in front of the children. I left with them and filed for divorce.
His last words were "I won't send you a dime."

I knew that he would try not to pay any support. But at that point in time, I had faith in our government and believed they would make sure he supported his children. . I knew that in Iowa the law states that parents must support their children.

I quickly learned that the child support enforcement system was not working (willfully), and that very few people are concerned with the welfare of children and mothers in this nation

It took me many years to finally get the monthly court ordered child support payments he had agreed to pay on a regular, reliable bases. As a matter of fact, it took me so many years that my youngest daughter, who was 4 years old when we were divorced, was a junior in college and now we were only dealing with back support.

To get that support I have had to put up the fight of my life. I was thwarted at every turn by the agency which was instituted to aid me in enforcing the orders and collecting the support (the Child Support recovery Unit) as well as the courts.

Since I began my fight for support many more laws have been passed by congress, such as, the Deadbeat Parent Punishment Act, which was applied to my case.

When my former husband got off parole after spending 14 months of a 5 year prison sentence in state prison for criminal nonsupport, the judge purged an old contempt order which was keeping him paying. Then he quit his job and left the state for the state of Kansas.

Welfare reform laws pulled the rug out from under moms like me who had been abandoned by a deadbeat former husband, and deceived by a nation ("community") which refused to deliver on its obligations to the families and the laws. We basically

were on our own with nowhere to turn.

Had I been "lucky" enough to be a widow we would have received Survivor Benefits and I would have been punished if seeking work outside the home. For us who are divorced (or never married) there is nothing unless the fathers willingly pay the court ordered support in spite of the laws of the land. If we turn to welfare, what is left of it, we have to seek work or our benefits will be cut (while dads get a free ride).

This is the richest country in the world and the most lawless when it comes to family law!!

When I spoke to Rep Lynn Woolsey a few weeks ago asking her to reintroduce the bill to move child support collection to IRS, I reminded her how lucky we were that we at least had Aid to Dependent Children which today's mothers don't have (I at least had that while my kids were very young). Today's mothers have to do it all by themselves unless dads willingly pay support, while the agency in charge of enforcing the court ordered child support collects payments only on 63 % of the cases while over one billion dollars is owed to children in Iowa. CSRU tells those of us who get some payments "something is better than nothing."

What would CSRU attorneys do if their wages were cut in half and then told "something is better than nothing?" They tell us they represent the state while they intimidate and order mothers to accept less than the full amount of court ordered support. A few weeks ago I asked a CSRU attorney where she got the authority from to demand that, as well as how it was in the state's interest that moms receive less than the full court ordered child support amount. I was told to shut up. Often when dads don't pay the full amount the states have to pick up the difference in various benefits.

For every dollars spent $4.58 dollars are collected in court ordered child support as well as the federal government pays 66 percent of allowable administrative expenditures and 90 percent for laboratory paternity costs, so why is CSRU so unwilling to use the tools available to collect on theses orders for children and liberate these families from the strangle hold of welfare?

President Ronald Reagan's favorite phrase was that "government is not the solution. It is the problem". He must have had CSRU in mind when he sad that.

Because of my very public fight for justice and support I hear from mothers on a dally bases begging for help with their child support cases. I have included a few copies of those letters. One mother has been on welfare for years. Her child is 9 years old and CSRU never has contacted the father. They have now and are proceeding with a paternity test.

We need public policy and law enforcement which ensures that parents meet their moral

and legal obligations to their children

In spite of all the laws handed down by congress since I began my fight for support in 1991 nothing much has changed. According to an article by David Yepsen of the Des Moines Register in 1964 "only" $500 million was owed to thousands of children in court ordered child support. Now it is over one billion dollars. In the year 2000 when Reps Lynn Woolsey and Henry Hyde introduced a bill in congress to move child support collections to IRS, $50 billion dollars were owed to children nationwide. Now it is over $107 billion.

Every day we hear from past or present public officials how they care about the poor and the children. Yet they did nothing about their plight then (or now) while in office when they not only could but were obligated to.

As Ronald Reagan said the government is the problem not the solution. And it is true when it comes to CSRU, but it does not have to be that way.

It is long time past for this nation to deliver more than words to the children abandoned by parents and deceived by a society which will not deliver on it obligations to these families. It is time for this nation to be more of what it claims to be: A country of laws. But in order to be that we have to overhaul CSRU and replace the people with employees whose mindset it is to deliver to the people they serve: the children and families owed support and the tax payers paying the bills, often one and the same.

The richest country in the world works the hardest at keeping millions of children living in poverty!!

It is time to take care of our most precious natural resource: our children.

May 29, 2007

TO: Ms. Mia Rodder

FROM: Gina Greubel

RE: Child Support

Dear Mia:

Thank you for taking the time to talk with me on Friday. Having had the opportunity to talk with another mother that you were able to help, made me realize that there are people out there who are fighting for our rights, and that something in fact can be done about deadbeat dads.

My child support recovery case number is #430436. My ex-husband, Raul M. Moreno, SS #461-61-0810, owes me over $27,000 in back child support. This amount continues to grow as each month passes. I have received no payments since December 7, 2006.

Raul currently resides with his wife and stepchild at 11708 Imperial Gem in El Paso, Texas 79936. He just recently filed for a child support modification. Our court date was May 1, 2007. The judge decided to uphold the original order and that there should not be a modification in the support.

On numerous occasions my ex-husband has stated that he cannot afford the amount he owes and that he will continue to switch jobs when they find him because it takes child support recovery awhile to enforce the judgment at the next job since he lives and works in another state. He in fact admitted to this during our court hearing. He also stated that he has a new family to take care of now and that he can't take care of them when he is paying me child support. I also have a new family now and my new husband and I have primary custody of all of our five children.

I have asked the child support recovery unit on several occasions to hold my ex-husband in contempt of court, revoke his driving privileges or even put him in jail. I am continually informed that we need to wait longer and that they only do that as a last resort. My other fear is that since my ex-husband lives in El Paso, which is a border town to Juarez, Mexico, is that he will go across the border to work. He has threatened to do this in the past. I have asked the child support recovery representative what I could do in the event this happens, and she said that the USA

11840 Letch's Lane
Delton, MI 49046
March 21, 2005

Dear Ms. Rater,

I contacted you in 2002 regarding child support for my children. I had asked you for advice regarding my rights and possible actions as my children's father Danny was not making his obligated payments. At that time, he had ceased all payments. Child Support Recovery (CSR) was not much help.

You had offered to help me in researching my case and determining what actions were possible. Before I had a chance to respond to you, I began making some headway with CSR. Danny was found in contemp of court, had his driver's license suspended, and was offered a payment plan.

Our original court order from 1997 requires Danny to pay just $352 per month for support of our four children plus half of any remaining health and dental costs after insurance. His new payment plan requires him to pay just $225 per month. He has arrearages over $10,000. He is accruing a larger debt each month as he is $127 short of his obligation, which is then added to his arrearages.

He claims to be self-employed. He is not required to prove that he is self-employed or to provide financial records showing that he has an income. He may also be working "under the table" based on comments made by my children after visiting him. He has no medical reason for which he can not work. He simply chooses not to work so that he doesn't have to fulfill his support obligation.

CSR has ceased pursuing him. I was told that as long as he is "making an attempt," CSR can not take any further action against him. They advised me that I should hire a private attorney if I want further action taken. I would like to, if possible, avoid the expense of a private attorney. Likewise, private agencies that specialize in collecting child support want a substantial percentage of any collections. Many of these agencies won't offer support unless the arrearages are twice the amount of my current arrearages.

I am writing to you today seeking advice. Can you please let me know what my options are without hiring an attorney, or do you feel that hiring an attorney would be my best recourse at this point? Should I contact someone other than you for advice? You had told me, when I initially spoke with you, that you have been through this system. I know you understand the frustration of trying to work "within the system."

One of the problems I have encountered is the fact that I live in Michigan and he lives in Iowa. I have been told that, since the case originated in Iowa, I can not have the case transferred to Michigan without Danny's consent. He would, most likely be unwilling to allow the case to be transferred as he knows that I would be more able to pursue the case locally.

I would appreciate any insight you could provide. I can be reached at the above address or by email at smth0927@aol.com or by phone at (269) 671-4678 (home) or (269) 979-7053 (work).

Thank you so much for your consideration,

Dena S. Haffner

The New York Times
nytimes.com

August 22, 2006

How We Ended Welfare, Together

By BILL CLINTON

TEN years ago today I signed the Personal Responsibility and Work Opportunity Reconciliation Act. By then I had long been committed to welfare reform. As a governor, I oversaw a workfare experiment in Arkansas in 1980 and represented the National Governors Association in working with Congress and the Reagan administration to draft the welfare reform bill enacted in 1988.

Yet when I ran for president in 1992, our system still was not working for the taxpayers or for those it was intended to help. In my first State of the Union address, I promised to "end welfare as we know it," to make welfare a second chance, not a way of life, exactly the change most welfare recipients wanted it to be.

Most Democrats and Republicans wanted to pass welfare legislation shifting the emphasis from dependence to empowerment. Because I had already given 45 states waivers to institute their own reform plans, we had a good idea of what would work. Still, there were philosophical gaps to bridge. The Republicans wanted to require able-bodied people to work, but were opposed to continuing the federal guarantees of food and medical care to their children and to spending enough on education, training, transportation and child care to enable people to go to work in lower-wage jobs without hurting their children.

On Aug. 22, 1996, after vetoing two earlier versions, I signed welfare reform into law. At the time, I was widely criticized by liberals who thought the work requirements too harsh and conservatives who thought the work incentives too generous. Three members of my administration ultimately resigned in protest. Thankfully, a majority of both Democrats and Republicans voted for the bill because they shouldn't be satisfied with a system that had led to intergenerational dependency.

The last 10 years have shown that we did in fact end welfare as we knew it, creating a new beginning for millions of Americans.

In the past decade, welfare rolls have dropped substantially, from 12.2 million in 1996 to 4.5 million today. At the same time, caseloads declined by 54 percent. Sixty percent of mothers who left welfare found work, far surpassing predictions of experts. Through the Welfare to Work Partnership, which my administration started to speed the transition to employment, more than 20,000 businesses hired 1.1 million former welfare recipients. Welfare reform has proved a great success, and I am grateful to the Democrats and Republicans who had the courage to work together to take bold action.

The success of welfare reform was bolstered by other anti-poverty initiatives, including the doubling of the earned-income tax credit in 1993 for lower-income workers; the 1997 Balanced Budget Act, which included $3 billion to move long-term welfare recipients and low-income, noncustodial fathers into jobs; the Access to Jobs initiative, which helped communities create innovative transportation services to enable former welfare recipients and other low-income workers to get to their new jobs; and the welfare-to-work tax credit, which provided tax incentives to encourage businesses to hire long-term

welfare recipients.

I also signed into law the toughest child-support enforcement in history, doubling collections; an increase in the minimum wage in 1997; a doubling of federal financing for child care, helping parents look after 1.5 million children in 1998; and a near doubling of financing for Head Start programs.

The results: child poverty dropped to 16.2 percent in 2000, the lowest rate since 1979, and in 2000, the percentage of Americans on welfare reached its lowest level in four decades. Overall, 100 times as many people moved out of poverty and into the middle class during our eight years as in the previous 12. Of course the booming economy helped, but the empowerment policies made a big difference.

Regarding the politics of welfare reform, there is a great lesson to be learned, particularly in today's hyper-partisan environment, where the Republican leadership forces bills through Congress without even a hint of bipartisanship. Simply put, welfare reform worked because we all worked together. The 1996 Welfare Act shows us how much we can achieve when both parties bring their best ideas to the negotiating table and focus on doing what is best for the country.

The recent welfare reform amendments, largely Republican-only initiatives, cut back on states' ability to devise their own programs. They also disallowed hours spent pursuing an education from counting against required weekly work hours. I doubt they will have the positive impact of the original legislation.

We should address the inadequacies of the latest welfare reauthorization in a bipartisan manner, by giving states the flexibility to consider higher education as a category of "work," and by doing more to help people get the education they need and the jobs they deserve. And perhaps even more than additional welfare reform, we need to raise the minimum wage, create more good jobs through a commitment to a clean energy future and enact tax and other policies to support families in work and child-rearing.

Ten years ago, neither side got exactly what it had hoped for. While we compromised to reach an agreement, we never betrayed our principles and we passed a bill that worked and stood the test of time. This style of cooperative governing is anything but a sign of weakness. It is a measure of strength, deeply rooted in our Constitution and history, and essential to the better future that all Americans deserve, Republicans and Democrats alike.

Bill Clinton, the 42nd president, heads the Clinton Foundation.

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EIGHT MAJOR FEDERAL CHILD SUPPORT LAWS

*

1975 - Social Security Act, Title IV, Section D

*

1984 - Child Support Amendments - Public Law 98-378

*

1988 - Family Support Act - Public Law 100-485

*

1992 - Child Support Recovery Act, P.L. 102-521, 18 USC Chapter 11A

*

1993 - Omnibus Budget Reconciliation Act

*

1994 - Full Faith and Credit Act P. L. 103-383

*

1996 - Personal Responsibility and Work Opportunities Reconciliation Act of 1996, PRA

*

1998 - Dead Beat Parents Punishment Act

www.childsupport-aces.

Child Support Automated Enforcement Tools
Delinquency Triggers

Enforcement Tool	Statute	Administrative Rules	Triggers
Income Withholding (IWO)	252D—effective date of order; amount equal to payment of one month	98.21 - same as 252D	Mandatory IWO—delinquency of at least one mo.; Immediate IWO—establishment of support obligation
Administrative Levy	252I – delinquency in an amount equal to the support payment for one month	98.91 – same as 252I	Delinquency of at least one month
License Sanctions	252J – delinquent in an amt. equal to the support payment for 3 months	98.101 – same as 252J	3 months delinquent; no seek employment order; no income withholding in place
Seek Employment	252B.21 – obligor failed to make support payments	98.71 – same as 252B.21	3 months delinquent; no income withholding in place
Contempt	598.23 – willingly fails to make support payments as provided in the order	None	Failure to comply with seek employment; worker/attorney assessment
State Tax	252B.5 Revenue 421.17(21)	95.6 – $50 delinquency & no payment on current & delinq. support in each of past 12 mos.	$50 delinquency & no payment on current & delinq. support in each of past 12 mos.
Federal Tax and Non-tax Offset	252B.5	95.7 – PA $150 delinq. & delinquent for three months; NPA - $500.	PA $150 delinq. & delinquent for three months; NPA - $500 & per federal regulations, child must be a minor
Vendor Offset	252B.5 and 421.17(29)	98.81 refers to 421.17(29)—delinq. at least $50	Same as state tax
Credit Reporting	252B 42 USC 666(a)(7)	95.12 – overdue support exceeds $1,000	Overdue support exceeds $1,000 (IV-D)
Passport Sanctions	252B.5 – over $5,000 delinquency	None	Over $5,000 delinquency

Commander in chief. SEC. 7. The governor shall be commander in chief of the militia, the army, and navy of this state.

Duties of governor. SEC. 8. He shall transact all executive business with the officers of government, civil and military, and may require information in writing from the officers of the executive department upon any subject relating to the duties of their respective offices.
Duty as to state accounts, §70A.8 of the Code

Execution of laws. SEC. 9. He shall take care that the laws are faithfully executed.

"The duty of parents to provide for the maintenance of their children, is a principle of natural law: an obligation... laid on them not only by nature herself but by their own proper acts, in bringing them into the world; for they would be in the highest manner injurious to their issue, if they only gave their children life that they might afterwards see them perish.

Sir Williams Blackstone
Commentaries on the Law of England in Four Books

726.5 Nonsupport.

A person, who being able to do so, fails or refuses to provide support for the person's child or ward under the age of eighteen years commits nonsupport; provided that no person shall be held to have violated this section who fails to support any child or ward under the age of eighteen who has left the home of the parent or other person having legal custody of the child or ward without the consent of that parent or person having legal custody of the child or ward. Support, for the purposes of this section, means any support which has been fixed by court order, or, in the absence of any such order or decree, the minimal requirements of food, clothing or shelter. Nonsupport is a class "D" felony.
Section History: Early form

[S13, § 4775-a; C24, 27, 31, 35, 39, § 13230; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, § 731.1; C79, 81, § 726.5]

Table H: The Current Support Collection Rate for Five Fiscal Years

Return to: Preliminary Data Report FY 2004

THE CURRENT SUPPORT COLLECTION RATE FOR FOR FIVE FISCAL YEARS

STATES	2000	2001	2002	2003	2004
ALABAMA	35.15	46.30	47.77	49.95	51.26
ALASKA	49.18	51.22	53.84	55.70	55.49
ARIZONA	44.65	46.73	44.48	43.15	42.68
ARKANSAS	47.39	48.10	50.32	58.28	55.34
CALIFORNIA	40.02	41.03	42.40	45.20	47.96
COLORADO	50.72	52.82	54.97	55.16	55.51
CONNECTICUT	53.48	55.55	55.04	54.76	54.54
DELAWARE	58.19	NR	60.74	60.66	60.29
DIST. OF COL.	44.35	NR	47.96	49.71	51.22
FLORIDA	49.88	52.11	56.40	56.40	56.75
GEORGIA	47.51	48.18	49.73	51.01	51.88
GUAM	40.20	42.75	43.16	44.60	46.66
HAWAII	49.94	51.03	51.13	51.27	53.09
IDAHO	52.68	53.80	55.43	53.87	55.68
ILLINOIS	36.48	37.64	39.11	47.04	49.25
INDIANA	NR	46.80	48.52	50.54	51.04
IOWA	62.37	57.65	59.10	60.02	62.18
KANSAS	NR	54.66	55.06	55.30	54.38
KENTUCKY	50.91	53.52	52.80	53.63	54.70
LOUISIANA	52.39	53.83	56.44	56.87	55.93
MAINE	57.30	59.57	57.76	55.67	56.57
MARYLAND	58.52	60.29	62.02	63.18	61.79
MASSACHUSETTS	58.72	63.55	59.68	60.90	62.64
MICHIGAN	67.25	60.27	59.36	55.70	60.21
MINNESOTA	68.25	67.35	72.96	69.87	69.53
MISSISSIPPI	49.09	50.02	49.55	51.98	52.79
MISSOURI	47.83	49.24	50.74	52.67	53.33

MONTANA	56.80	56.71	58.50	59.05	58.40
NEBRASKA	60.63	62.69	66.49	66.15	67.37
NEVADA	NR	45.80	46.99	40.90	51.11
NEW HAMPSHIRE	65.03	65.94	65.51	64.27	64.54
NEW JERSEY	63.14	64.60	65.00	65.01	64.92
NEW MEXICO	40.36	43.90	46.75	48.96	49.42
NEW YORK	NR	NR	65.12	64.75	64.75
NORTH CAROLINA	59.21	60.38	61.26	61.79	62.72
NORTH DAKOTA	67.13	69.15	71.55	71.35	72.02
OHIO	NR	68.01	66.77	67.25	67.88
OKLAHOMA	44.32	45.10	46.46	48.44	48.60
OREGON	59.65	59.57	60.41	59.86	59.29
PENNSYLVANIA	66.57	71.56	74.70	74.81	74.37
PUERTO RICO	44.87	46.55	48.67	52.59	53.84
RHODE ISLAND	53.70	61.33	61.11	61.76	61.92
SOUTH CAROLINA	37.82	NR	49.51	49.22	48.39
SOUTH DAKOTA	67.67	67.01	67.70	67.11	68.29
TENNESSEE	44.91	48.34	50.44	53.75	54.71
TEXAS	65.10	61.98	59.93	57.65	58.54
UTAH	55.49	56.20	58.60	58.65	59.82
VERMONT	65.60	67.32	66.34	65.78	66.12
VIRGIN ISLANDS	NA	NA	47.02	53.07	53.24
VIRGINIA	56.50	58.16	58.97	59.72	60.04
WASHINGTON	60.29	61.88	63.98	64.33	62.87
WEST VIRGINIA	NR	60.97	62.07	62.81	62.85
WISCONSIN	NR	NR	72.68	67.73	67.64
WYOMING	55.81	58.33	60.05	60.86	60.79
AVERAGES	53.89	55.93	57.55	58.04	58.99

Source: OCSE-157; line 25/24

NR - Not reliable; NA - Not available.

No determination has been made regarding data reliability in FY 2004.

Public assistance rolls increase despite reductions in welfare

By Stephen Ohlemacher, Associated Press Writer
Monday, February 26, 2007 12:59 PM PST

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WASHINGTON - The welfare state is bigger than ever despite a decade of policies designed to wean poor people from public aid.

The number of families receiving cash benefits from welfare has plummeted since the government imposed time limits on the payments a decade ago. But other programs for the poor, including Medicaid, food stamps and disability benefits, are bursting with new enrollees.

The result, according to an Associated Press analysis: Nearly one in six people rely on some form of public assistance, a larger share than at any time since the government started measuring two decades ago.

Critics of the welfare overhaul say the numbers offer fresh evidence that few former recipients have become self-sufficient, even though millions have moved from welfare to work. They say the vast majority have been forced into low-paying jobs without benefits and few opportunities to advance.

"If the goal of welfare reform was to get people off the welfare rolls, bravo," said Vivyan Adair, a former welfare recipient who is now an assistant professor of women's studies at Hamilton College in upstate New York. "If the goal was to reduce poverty and give people economic and job stability, it was not a success."

Proponents of the changes in welfare say programs that once discouraged work now offer support to people in low-paying jobs. They point to expanded eligibility rules for food stamps and Medicaid, the health insurance program for the poor, that enable people to keep getting benefits even after they start working.

"I don't have any problems with those programs growing, and indeed, they were intended to grow," said Ron Haskins, a former adviser to President Bush on welfare policy.

"We've taken the step of getting way more people into the labor force and they have taken a huge step toward self-sufficiency. What is the other choice?" he asked.

In the early 1990s, critics contended the welfare system encouraged unemployment and promotec Welfare recipients, mostly single mothers, could lose benefits if they earned too much money or if of their children.

Major changes in welfare were enacted in 1996, requiring most recipients to work but allowing thei benefits after they started jobs. The law imposed a five-year limit on cash payments for most peop Assistance for Needy Families program, or TANF. Some states have shorter time limits.

Nia Foster fits the pattern of dependence on government programs. She stopped getting cash wel 1990s and has moved from one clerical job to another. None provided medical benefits.

The 32-year-old mother of two from Cincinnati said she supports her family with help from food sta

Foster said she did not get any job training when she left welfare. She earned her high-school equ community college.

"If you want to get educated or want to succeed, the welfare office don't care," Foster said. "I don't what you do once the benefits are gone."

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Foster now works in a tax office, a seasonal job that will end after April 15. She hopes to enroll at t this spring and would like to study accounting. She is waiting to find out if she qualifies for enough tuition.

Shannon Stanfield took a different, less-traveled path from welfare, thanks to a generous program to get a college education.

Stanfield, 36, was cleaning houses to support her two young children four years ago when she lea welfare recipients at nearby Hamilton College, a private liberal arts school in Clinton, N.Y.

"At the time I was living in a pretty run-down apartment," said Stanfield, who was getting welfare pa food stamps. "It wasn't healthy."

The program, called the Access Project, accepts about 25 welfare-eligible parents a year. Hamilto first-year students and the program supplements financial aid in later years. Students get a host of services, including help finding internships and jobs and financial assistance in times of crisis.

About 140 former welfare recipients have completed the program and none still relies on governm said Adair, the Hamilton professor who started the Access Project in 2001.

Stanfield, who still gets Medicaid and food stamps, plans to graduate in May with a bachelor's deg to be a teacher.

"I slowly built up my confidence through education," Stanfield said. "I can't honestly tell you how mu life."

Programs such as Access are not cheap, which is one reason they are rare. Tuition and fees run a Hamilton, and the program's annual budget is between $250,000 and $500,000, Adair said.

In 2005, about 5.1 million people received monthly welfare payments from TANF and similar state drop from a decade before.

But other government programs grew, offsetting the declines.

About 44 million people - nearly one in six in the country - relied on government services for the pc the most recent statistics compiled by the Census Bureau. That compares with about 39 million in

Also, the number of people getting government aid continues to increase, according to more recer individual programs.

Medicaid rolls alone topped 45 million people in 2005, pushed up in part by rising health care costs offering benefits. Nearly 26 million people a month received food stamps that year.

Cash welfare recipients, by comparison, peaked at 14.2 million people in 1994.

There is much debate over whether those leaving welfare for work should be offered more opportu education, so they do not have to settle for low-paying jobs that keep them dependent on governm

"We said get a job, any job," said Rep. Jim McDermott, chairman of the House subcommittee that "And now we expect them to be making it on these minimum-wage jobs."

McDermott, D-Wash., said stricter work requirements enacted last year, when Congress renewed will make it even more difficult for welfare recipients to get sufficient training to land good-paying jc

But people who support the welfare changes say former recipients often fare better economically i in low-paying jobs, before entering education programs.

"What many people on TANF need first is the confidence that they can succeed in the workplace a

of work," said Wade Horn, the Bush administration's point man on welfare overhaul.

"Also, many TANF recipients didn't have a lot of success in the classroom," Horn said. "If you war
confidence of a TANF recipient, putting them in the classroom, where they failed in the past, that i:
their confidence."

Horn, however, said he would like to see local welfare agencies provide more education and traini
already moved from welfare to work.

"The true goal of welfare to work programs should be self-sufficiency," Horn said.

—

On the Net:

Welfare State:
http://hosted.ap.org/dynamic/files/specials/interactives/wdc/public_assistance/index.html?SITE=OI

Temporary Assistance for Needy Families: http://www.acf.hhs.gov/acf-services.htmlwalia

Medicaid: http://www.cms.hhs.gov/home/medicaid.asp

Food stamp program: http://www.fns.usda.gov/fsp/

Supplemental Security Income:

http://www.ssa.gov/notices/supplemental-security-income/

The Access Project: http://www.hamilton.edu/college/access/index.html

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Survey finds spike in Iowa homelessness

Problem has hit poor moms with kids especially hard since '99

RODNEY WHITE THE REGISTER

Struggling: Shuianda Ross, 30, shown with three of her four children, is living at the Des Moines YWCA, but she hopes to find a job and a new home for her family. African-Americans make up 2 percent of Iowa's population but 24 percent of its homeless population.

By LEE ROOD
REGISTER STAFF WRITER

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Homelessness among poor women with children in Iowa rose

IOWA'S HOMELESS POPULATION

The 2005 Iowa Statewide Homeless Survey is based on "conservative" reporting by 1,675 agencies and schools statewide that served people who

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Survey finds spike in Iowa homelessness

Rood Lee
Staff

Problem has hit poor moms with kids especially hard since `99

By LEE ROOD
REGISTER STAFF WRITER

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Homelessness among poor women with children in Iowa rose dramatically from 1999 to 2005, with that group now making up more than three out of five of all homeless households, a new study has found.
The study shows a 14.5 percent overall leap in homelessness, an increase based on "conservative" reporting by public and private agencies.
The yearlong study commissioned by the Iowa Council on Homelessness cost $76,000 and paints the most accurate demographic picture ever of the estimated 21,280 Iowans believed to be without permanent homes in 2005. It includes the first specific information about public school children who are homeless.
The findings are stark: 550 schoolchildren lived on the streets or "doubled up" with others in Cedar Rapids, 523 in Des Moines, 447 in Council Bluffs, 317 in Davenport and 223 in Sioux City.
"It has gone from bad to worse, it really has," said Kittie Weston-Knauer, principal of Scavo Alternative School in Des Moines. "And the thing is, if we really wanted to stop this, we could find a way."
Those who work with homeless populations say several factors -a lackluster economy, growing family dysfunction and drug problems, demographic shifts and less government help -have collided to worsen living conditions, especially for single mothers. Affordable housing and employment were two top concerns among homeless people surveyed for the research, as 32 percent could not find an affordable place to live, 26 percent had been evicted or foreclosed upon, and 20 percent had lost jobs.
"I think it's really hard to put a firm picture on any homeless community because they're invisible," said Mike Peterson, outreach coordinator for Iowa Homeless Youth Centers in Des Moines, an agency that helps homeless people ages 16 to 22. "But it's clear we are seeing more females than males now."
Like other nonprofit groups, Iowa Homeless Youth Centers is seeing many more new faces in its fluid population. Thirty to 40 people each month seek help at its downtown Des Moines service center for the first time; there they can get food from a pantry and hot

meals. The agency serves 400 to 500 people a month. In coming weeks, the pantry may have to further ration food -the current limit is 16 items a month -to meet greater demand.
A policy team from around the state met Thursday and today at the Des Moines Botanical Center to use the new research to hone a two-year-old statewide plan to deal with homelessness, said Lyle Schwery, homeless programs coordinator for the Iowa Finance Authority.
That group is expected to make recommendations to the homeless council, a group with 30 voting members representing nonprofit agencies, businesses, religious groups, and homeless or formerly homeless adults.
"We just got the study last Friday," Schwery said. "We are struggling to get it analyzed ourselves."
The research by the Iowa Policy Project in Mount Vernon suggests that more people are being turned away from shelters, while homelessness is increasing at a greater rate among some groups. African-Americans make up 2 percent of the population, but they now make up 24 percent of the homeless population.
Ninety-four percent of homeless households with children are headed by single women.
Linda Williams-Moore, executive director of the YWCA in Des Moines, and staff members said the growing number of women and children seeking assistance are in more desperate situations than in years past.
Some have reached the federal government's five-year limit on welfare benefits but show no hope of ever being able to hold a job that pays enough to support their children. Others are victims of domestic violence. Some come out of prison and have nowhere to go.
Many made their way through school systems but are barely literate.
"One of our moms here has four kids and an IQ of 58," said Cathi VaNote, a YWCA residence hall director.
Said Williams-Moore: "For a segment of our population, the standards are unreachable. It's not that they don't want out of here. But for some, this is going to be it."
Shuianda Ross, a 30-year-old YWCA resident, is typical of some of Iowa's new homeless.
A former nursing student in Louisiana, she was forced to quit school last year after learning she was pregnant with her fourth child. Her relationship with her boyfriend failed. Her welfare checks amounted to $250 a month.
Deciding Louisiana had nothing to offer her, Ross packed up her children last June and took a train to Iowa. Here, she receives more welfare money from the state -$495 a month plus food stamps. Most of that money -$310 -goes toward the small, low-income apartment she rents at the YWCA; the rest goes for food.
After giving birth a month ago, Ross said, she is already looking for work.
"I want to be independent -to work, buy a car, eventually get a bigger place and set an example for my children," she said. "I just want to have a simple life and be happy. That's all."
But it's not easy.
Those who determine public policy should walk in a single mother's shoes to understand her need for job training and a better-paying job, she said.
"I think they need to see the things we go through," she said.
While the 2005 homeless study excluded individuals who live temporarily with relatives and friends, it did include some families who were living together, according to one

school that officials surveyed.
That's why the West Sioux Community School District, on the western edge of the state between Sioux City and Sioux Falls, S.D., was found to have the highest proportion of homeless schoolchildren in the state -12.8 percent. Superintendent Paul Olson said many Hispanic families there make the most of lower-paying jobs by "doubling up."
In Olson's opinion, many are poor, but they are not necessarily desperate.
"In some cases, we have four to five families living in one place," he said. "Part of this is cultural, but every once in a while it concerns us. We had one family living in another family's garage with no insulation."
IOWA'S HOMELESS POPULATION
The 2005 Iowa Statewide Homeless Survey is based on "conservative" reporting by 1,675 agencies and schools statewide that served people who were homeless at some time during 2005. The numbers exclude individuals who were temporarily living with relatives or friends. The numbers include people living on the streets, in pup tents or in their cars, as well as those living in shelters and transitional housing.
21,280: The number of Iowans who were homeless in 2005, a 14.5 percent increase from 1995.
523: The number of homeless students in the Des Moines school district, which is 1.6% of total enrollment.
HOW YOU CAN HELP THE HOMELESS
Call the Des Moines Area Religious Council, (515) 277-6969, to find out how and what you can contribute to area pantries. In Des Moines, three main shelters are Churches United Shelter, (515) 284-5719; Bethel Mission, (515) 244-5445; and Door of Faith, (515) 974-0545. The YWCA constantly needs towels, blankets and sheets. For more information, call (515) 244-8961.
EVERY SCHOOL DISTRICT IN IOWA
See how many homeless children were reported in each Iowa school district at DesMoinesRegister.com.
Photo_By: RODNEY WHITE/THE REGISTER: In Des Moines: This encampment, seen from the Southwest Ninth Street bridge, is along the Raccoon River. Those who work with homeless populations say several economic and social factors have combined to worsen living conditions for many people.
Photo_By: RODNEY WHITE/THE REGISTER: Struggling: Shuianda Ross, 30, shown with three of her four children, is living at the Des Moines YWCA, but she hopes to find a job and a new home for her family. African-Americans make up 2 percent of Iowa's population but 24 percent of its homeless population.

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The Child Support Program: An Investment That Works

By Vicki Turetsky

April 2005

The child support program enforces the responsibility of parents to support their children when they live apart. The child support program is jointly funded by federal and state governments under title IV-D of the Social Security Act. The program collects child support for families, establishes the legal relationship between children and their unmarried fathers, and obtains private health care coverage. Families receiving Temporary Assistance for Needy Families (TANF) cash assistance or Medicaid must participate in the child support program, while other families may apply for child support services. Any child is eligible for state child support services, regardless of income.[1]

Child Support Makes a Difference to Children.

- **Child support dollars matter to families.** In 2003, the child support program served 17.6 million children and collected $20.1 billion in private child support dollars.[2] Next to the mothers' earnings, child support is the second largest income source for poor families receiving child support. Among families receiving support in 2001, families below poverty received an average of $2,500 in support, or 30 percent of total family income. Families between 100 and 200 percent of poverty received nearly $4,000, or 15 percent of family income. Thirty-six percent of children with family incomes below the federal poverty level received child support, while 50 percent of families with incomes between 100 and 200 percent of poverty received support.[3] Almost two-thirds of low-income families with child support receive steady payments.[4]

- **Child support helps connect children to their fathers.** Fathers who pay regular child support are more involved with their children, providing them with emotional as well as financial support.[5] Reliable child support has a positive effect on children's achievement in school, and appears to have a greater impact on children dollar for dollar than other types of income.[6] Strengthened child support enforcement reduces divorce rates, especially for couples in which the mother is likely to go on welfare. Child support also appears to deter non-marital births.[7] There is also evidence that regular child support payments may reduce severe conflict between the parents.[8]

- **Child support touches the lives of many working families.** Sixty percent of all single parent families participate in the child support program. The vast majority of program participants are former welfare families or other working families with modest incomes. Sixty percent of program participants receive some form of public assistance, such as TANF, Medicaid, Food Stamps, Supplemental Security Income (SSI), or subsidized housing.[9] Low-income families are significantly more likely to receive child support if they participated in the child support program at some point.[10]

Child Support Increases Self-Sufficiency.

- **Child support reduces welfare use.** Families who receive child support are more likely to leave welfare and less likely to return.[11] There is evidence that child support is an alternative to cash assistance—families are less likely to use cash assistance when child support is available.[12] One-fourth of the welfare caseload decline between 1994 and 1996 may have been attributable to child support enforcement.[13] After 1996, the number of TANF cases closed with child support has increased steadily.[14] Receipt of child support is especially important to help families stabilize their incomes after leaving welfare.[15]

- **Parents with regular child support hold jobs longer.** Parents with regular child support payments are more likely to find work faster and to stay employed longer than those who do not. Child support supplements low earnings and helps families weather a job loss or other financial crisis.

The Child Support Program Works.

- **Program performance has improved dramatically.** Child support collection rates have more than doubled since 1996, when Congress overhauled the program as a part of welfare reform. In 2003, 50 percent of families in the child support program received child support, up from 20 percent in 1996. Collected dollars increased by more than 75 percent since 1996, to $21 billion from $12 billion.[16]

- **The program has especially benefited former welfare families.** Child support collections have increased, even though the child support caseload has declined. Collections for former TANF families have increased the most. Between 1999 and 2003, the number of former TANF cases remained unchanged. Yet collections for former TANF families increased 75 percent. By comparison, the number of families who never received welfare declined 7 percent, while collections for these families increased 14 percent.

The Child Support Program is Cost-Effective.

- **For every dollar spent, the child support program collects $4.33 in child support payments.**[17] Public dollars invested in the child support program yield more than a four-fold return in child support dollars. In 2003, the child support

program collected $21.2 billion in child support.[18] Federal and state costs were $5.2 billion. The federal government pays 66 percent of program costs, with states paying the rest.

- **Ninety percent of these dollars were paid to families.** Of the $21 billion collected each year by the child support program, $19 billion is paid directly to families. In addition, the government holds back $2 billion to help repay TANF and foster care costs.

- **The child support program pays for itself.** The child support program directly decreases the costs of other public assistance programs by increasing family self-sufficiency. A study conducted by the Urban Institute found that the child support program cost $4 billion in 1999, but saved more than $4.9 billion in direct budgetary reductions in federal and state outlays in public assistance programs. The child support program avoided more than $2.6 billion in other programs, including TANF, Medicaid, Food Stamps, SSI, and subsidized housing. In addition, the child support program saved $2.3 billion in recouped TANF and foster care costs.[19]

You Get What You Pay For.

- **Improved performance is related to improved funding.** The research shows that child support performance and funding levels are directly related. Increased investment of federal and state dollars since 1996 has contributed to improved performance.[20] The more effective the child support program, the higher the savings in public assistance costs.[21]

- **If the federal government cut back on its funding commitment, families will receive less child support.** State experience with budget cuts suggests that when funding for the child support program declines, performance declines quickly follow.[22] If the federal government shifts costs to states, state are ill-equipped to make up the difference. The result is likely to be less child support for families and an increase in public assistance use.

For additional information, contact Vicki Turetsky, vturet@clasp.org (202) 906-8012.

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[1] 42 U.S.C. 654(4).

[2] U.S. Department of Health and Human Services, Office of Child Support Enforcement. (2004). *Child Support Enforcement FY 2003 Preliminary Data Report,* table 6. Washington, DC: Author. Retrieved April 20, 2005 from www.acf.hhs.gov/programs/cse/.

[3] Sorensen, E. (2003). *Child Support Gains Some Ground.* Washington, DC: Urban Institute. Retrieved April 20, 2005 from www.urban.org.

[4] In an analysis of several research samples, between 35-39 percent of current and former welfare recipients did not receive payments for more than 5 consecutive months. Miller, C., Farrell, M, Cancian, M. &

[1] 42 U.S.C. 654(4).

[2] U.S. Department of Health and Human Services, Office of Child Support Enforcement. (2004). *Child Support Enforcement FY 2003 Preliminary Data Report,* table 6. Washington, DC: Author. Retrieved April 20, 2005 from www.acf.hhs.gov/programs/cse/.

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[4] In an analysis of several research samples, between 35-39 percent of current and former welfare recipients did not receive payments for more than 5 consecutive months. Miller, C., Farrell, M, Cancian, M. & Meyer, D. (2005). *The Interaction of Child Support and TANF: Evidence from Samples of Current and Former Welfare Recipients.* Report prepared for U.S. Health and Human Services. Washington, DC. Retrieved April 20, 2005 from www.aspe.hhs.gov.

[5] Seltzer, J., McLanahan, S., & Hanson, T. (1998). "Will Child Support Enforcement Increase Father-Child Contact and Parental Conflict After Separation?" In I. Garfinkel, S. McLanahan, D. Meyer, & J. Seltzer (Eds.), *Fathers Under Fire.* New York, NY: Russell Sage Foundation.

[6] Barnow, B., Dall, T., Nowak, M. & Dannhausen, B. (2000). . *The Potential of the Child Support Enforcement Program to Avoid Costs to Public Programs: A Review and Synthesis of the Literature.* Report prepared for the U.S. Department of Health and Human Services. Washington, DC. Retrieved April 20, 2005 from www.acf.hhs.gov/programs/cse/.

[7] Barnow, et al, 2000.

[8] Meyer & Cancian, 2001.

[9] Mellgren, L., Burnszynski, J., Douglas, S. & Sinclair-James, B. (2004). *Characteristics of Families Using Title IV-D Services in 2001.* Washington, DC: Office of Assistant Secretary of Policy and Evaluation, U.S. Health and Human Services. Retrieved April 20, 2005 from www.aspe.hhs.gov. Sorensen, 2003. In 2001, 60 percent of families participating in the child support program had incomes below 200 percent of the poverty line, while only 30 percent of non-participating families had incomes that low. One-third of participating families were poor, compared to 10 percent of non-participating families. Almost 80 percent of participating families had incomes below 300 percent of poverty, or $43, 890 for a parent and two children.

[10] Sorensen, E. & Zibman, C. (2000). *To What Extent Do Children Benefit from Child Support?* Washington, DC: Urban Institute; Sorensen, E. & Zibman, C. (2000). *Child Support Offers Some Protection Against Poverty.* Washington, DC: Urban Institute.

[11] Miller et al., 2005; Sorensen & Zibman, 2000; Garfinkel, I., Heintze, T., & Huang, C. (2001). "Child Support Enforcement: Incentives and Well-being," In B. Meyer & G. Duncan (Eds.), *The Incentives of Government Programs and the Well-Being of Families.* Chicago, IL: Joint Center for Poverty Research. Retrieved April 20, 2005 from www.jcpr.org.

[12] Barnow, et al., 2000; Sorensen & Zibman, 2000.

[13] Garfinkel, et al., 2001.

[14] U.S. Department of Health and Human Services, Office of Child Support Enforcement, *FY 2004 Preliminary Report,* table 11, and preceding reports. In the five-year period between 1996 and 2000, the number of TANF cases closed with child support payments increased 56 percent.

[15] Formoso, C. (1999). *The Effect of Child Support and Self-Sufficiency Programs on Reducing Direct Support Public Costs.* Olympia, WA: Washington State Division of Child Support.

[16] Office of Child Support Enforcement, *FY 2004 Preliminary Report,* tables 1 and 2, and preceding reports.

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] Wheaton, L. (2003). *Child Support Cost Avoidance in 1999.* Report prepared for the U.S. Department of Health and Human Services by the Urban Institute. Washington, DC. Retrieved on April 20, 2005 from www.acf.hhs.gov/programs/cse/.

[21] Garfinkel et al., 2000; Fishman, M., Tapogna, J., Dybdal, K., & Laud, S. (2000). *Preliminary Assessment of the Associations between State Child Support Enforcement Performance and Financing Structure.* Falls Church, VA: Lewin Group; Turetsky, V. (1998). *You Get What You Pay For: How Federal and State*

Iowa
Association of
Community
Providers

Shelly Chandler
Executive Director

Funding Concerns and Requests

Members of Iowa Association of Community Providers

I. During the 2005 legislative session a bill was passed to increase the personal needs allowance for individuals residing in long term care facilities from $30 to $50. At the end of the session, a statement was inserted into the language stating that this bill excluded residents of intermediate care facilities (ICF).

During the 2006 legislative session no less than 10 bills were filed to rectify this to increase the personal needs allowance for these individuals. The bill was passed as part of HF909 and included residents of ICF/MR, ICF/MI and PMIC. During the May Administrative Rules Review Committee the DHS rules indicated that a supplemental had been authorized for fiscal year '08. Just last week new rules were introduced indicating the supplemental was only for nursing facilities, leading us exactly where we were prior to the 2005 session.

We request this be finally funded by the Department. It does not benefit anyone but children and adults whose needs are such that they require this level of care.

II. During the 2006 legislative session the minimum wage was increased from $5.15 to $6.20 in April, then $7.25 in January. Members of the Association support a living wage for our clients with whom we work to get and maintain employment and for our 15,000 employees across the state. While members of the Association pay above minimum, they are highly conscientious of maintaining a gap between their employees and the service industry. The increase in the minimum wage closed that gap for many of the members. The current rate setting process does not allow for increasing rates to reflect the change in minimum wage, and providers are very concerned about employee retention.

The Association requests an exception to the current rules to off-set the minimum wage increase by rebasing in 2008 for waiver services and ICF. The current rules state that the Department "may" do this for ICF providers, but does not state it "will." The rebasing year for waiver providers was in 2006, so there is no current methodology to correct this until 2009. Providers simply cannot carry the burden of wage increased to retain staff without the benefit of rate increases.

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III. While the 2006 legislative session was very positive, and we were pleased with the additional $12 million for allowable growth, this new money did not address rate increases for wages, as other funds did for teachers and employees of nursing facilities, who saw double digit percentage wage increases. The Association requests a cost of living increase for the MH/DD provider community that faces the same concerns as teachers and nursing home employees such as increased insurance premiums, gas prices, energy costs, etc.

IV. HCBS allows providers a 2 ½% "profit margin". However, the rate is set retrospectively and does not take into considerations increased costs throughout the year, such as those mentioned above (cost of living, staff raises, insurance, etc.). Further, if a provider does in fact see a small profit, the rate for the next fiscal year is cut by that amount, essentially penalizing the provider for the allowed profit. The claims payment system lags behind several months, forcing providers into difficulties with cash flow, at times being forced to take loans to continue daily operations. Payment of net 30 is requested to improve cash flow rather than continuing the practice of "lending" to the state. Unlike the corporate business world, throughout this period of "floating loans," our members do not suspend service; rather continue to provide services to individuals with disabilities and mental illness.

V. Rate setting for ICF/MR providers based upon 80% cap does not address the rising cost of doing business (increased wages for staff to meet cost of living, double digit insurance premiums, inflationary increases of supplies and equipment). Providers have had rates reduced with this cap while costs that are not within their direct control continue to increase. Staff of these services are paid wages that are at or below the poverty level. ICF/MR provides one component necessary in the continuum of care for individuals.

The acuity of individuals served in ICF/MR settings requires focus of care 24 hours a day/seven days a week. This need does not align with the effort to move to a case-mix reimbursement based upon a menu of services as found in HCBS.

Thank you for this opportunity to provide comment to the Iowa Human Services Council to assist in the continued improvement of system care for individuals with disabilities and mental illness.

Iowa Council on Human Services Budget Hearing
Submitted by
Iowa CareGivers Association
Fiscal Year 2008

IOWA CAREGIVERS ASSOCIATION FISCAL NEEDS

History: The Iowa CareGivers Association (ICA), founded in 1992, is the first nonprofit independent direct care worker association in Iowa. The ICA's mission is to enhance the quality of care by providing education, recognition, advocacy and research in support of DCWs. Its sole purpose is the recruitment and retention of Certified Nurse Aides (CNAs), Home Care Aides (HCAs), and other DCWs in response to the DCW shortage and high turnover rates that compromise the quality of and limit access to care and supportive services.

Problem: Without DCWs children with special needs, persons with disabilities and older Iowans are placed at great risk for not having their most basic care needs met. Many DCWs leave the field due to: 1) short staffing; 2) poor wages and benefits (25% of CNAs in Iowa's nursing homes have no health care coverage from any source); 3) lack of respect/status; and 4) lack of adequate education, training, and opportunities for advancement within the field of direct care. It is incumbent upon us to invest in an infrastructure that will ensure a stable direct care workforce to meet the growing demand for services resulting from the increasing number of Iowans reaching retirement age and in need of care or services, and the movement toward more home and community based services.

The public's health and welfare are dependent upon a stable health and long term care workforce. Access to care at any level is not possible without those providing the care.

What ICA Brings to the Partnership:
Many strides have been made in addressing these very important and complex issues but more must be done. The ICA is eager to continue to partner with the IDHS and other state entities to build upon the incredible momentum that currently exists.

The ICA has been a leader at the state and national levels in the areas of DCW recruitment and retention and the DCW Association movement.

- 186 direct care workers have completed Leadership training. 94% of the graduates report that taking the course increases the likelihood that they will remain in the fields of direct care.
- ICA has been asked to host the first National Direct Care Worker Association Convention in August here in Des Moines.
- 2000 members (map) but each member represents another 300 that we do not have the capacity to reach.

State Funding Will Enable ICA To:

- Build our capacity to reach more direct care workers with more of our programs

But because much of the work we do is in pushing for systems changes and because our own ability to demonstrate effectiveness and respond to various needs of direct care workers is contingent upon public system's infrastructure...

RECOMMENDATION FOR DHS TO BETTER SERVE IOWANS

Our best estimates of costs associated with Certified Nurse Aide (CNA) turnover in Iowa's nursing homes is estimated at approximately $42 million annually. Unfortunately, they are just that...estimates! There is no mechanism within the state's system for accurate and consistent tracking of DCW or other long term care worker rates of turnover. In addition, there is no standardized formula for measuring turnover in our state or the country for that matter.

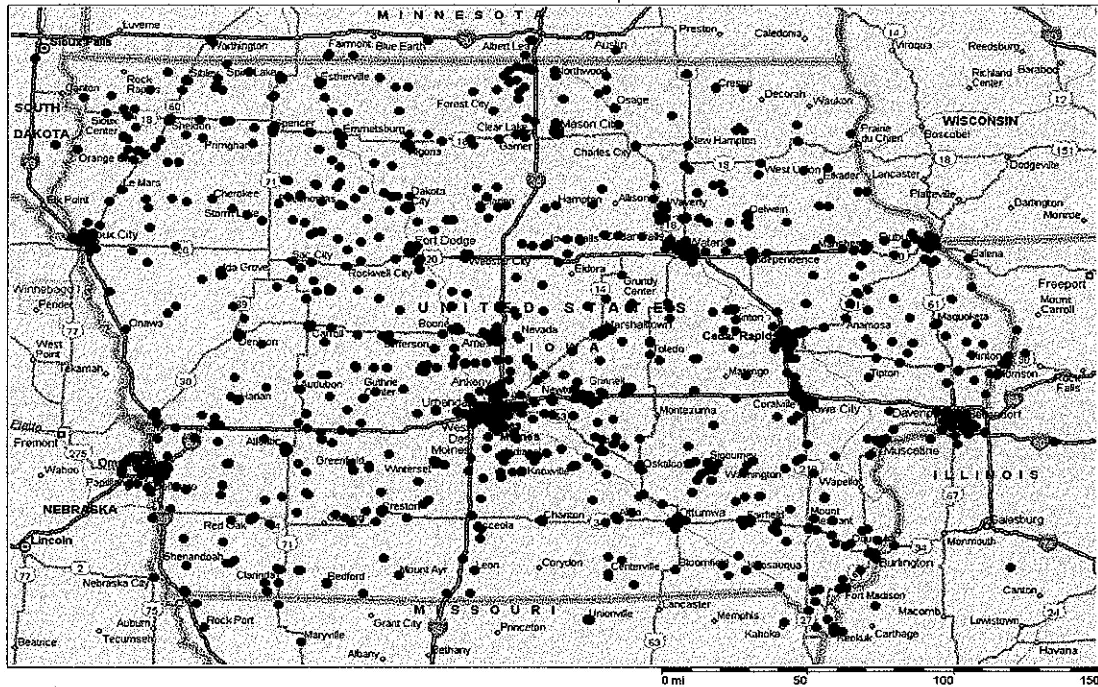
Iowa's nursing homes, through the case mix payment system are eligible for an incentive payment if they meet certain accountability measures, one of which is staff retention. Unfortunately, the turnover of ALL staff is lumped together (administrators, maintenance staff, accountant, CNAs, Directors of Nursing, Social Workers, etc.). One would assume that the turnover of those providing the most basic hands on care might have a greater direct impact on the "quality" of care being delivered than the turnover of the accountant or lawn maintenance crew.

The system should contain a mechanism for tracking turnover of staff by worker classification using **one standard formula.** With better turnover data we can in partnership: 1) more accurately assess the costs associated with staff turnover; 2) provide important information to consumers and family members making decisions about nursing home or other forms of long term care; and 3) identify program and education gaps.

Recommendations:

- Continue current efforts to assess the effectiveness of the case mix payment system and accountability measures
    - Collect staff retention measures from nursing facilities by worker classification
    - Correlate the staff retention of various worker classifications to the facilities' standing with the state/citations/inspections.
    - Make the turnover information public
    - Provide incentives for providers to encourage DCW involvement in the ICA programs and services
- Ensure that the department has the resources it needs to conduct ongoing evaluation and analysis of the pay for performance program

ICAMembership



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Iowa CareGivers Association
Direct Care Worker Members
Each member represents another 300 direct care workers that we do not have the capacity to reach.

IOWA DISTRICT COURT
FIFTH JUDICIAL DISTRICE
Polk County Courthouse
500 Mulberry
Des Moines, Iowa 50309-4241
(515) 286-3037

CONSTANCE COHEN
JUVENILE COURT JUDGE

July 11, 2007

TO: Iowa Council on Human Resources
FROM: Constance Cohen, Juvenile Court Judge
RE: Recommendations

Thank you for the opportunity to share recommendations for the SFY 2009 Department of Human Services budget process. As chair of the Juvenile Court Committee of the Iowa Judges Association, I have consulted with members of the Committee for their ideas. While I cannot guarantee complete consensus among our members, these are the issues about which most members agree.

Maximize Interdisciplinary Training Opportunities

Continue to collaborate with the Iowa Children's Justice Initiative, Model Court, Court Teams for Change, Middleton Center for Children's Rights, and other agencies / projects to stretch training dollars and promote best practices. Piecemeal grants and other resources are available. Stakeholders need to communicate effectively to maximize these precious resources. Only with training can we work together to apply the science of effective interventions to practice.

Assure Funding for Essential Court Ordered Services

There must be adequate funding for psychological and substance abuse evaluations for parents and children; for substance abuse treatment for indigent parents; and psychotropic medications for indigent parents and children. DHS should collaborate with the Department of Health to maximize resources to fulfill this joint responsibility. Without adequate evaluations and treatment, recidivism and re-abuse will continue to increase and frustrate compliance with program improvement plans designed to maintain maximum Title IV reimbursements.

Adequately Support P.L. 109-239: ICPC

The new Safe and Timely Interstate Placement of Children Act of 2006 requires interstate compact home studies to be completed within sixty days in most cases.

Compliance with P.L. 109-239: Records

Foster children who age out of the foster system must be provided their health and education records by DHS at no cost.

Caseloads

Establishing caseloads for social workers at national standards levels will foster longevity, save time and money, and enhance services to families. Current caseloads are "penny wise, pound foolish".

Adequately Fund the Children's Mental Health Waiver

The addition of 389 beds was most welcome, but will still not meet immediate needs. No child who needs the waiver should have to wait. Unaddressed problems only cost more in the long run. Many judges support reinstating "unable" language back into Iowa Code Section 232.2(6)(f) if the waiver is not expanded to meet needs. Children who are waiting and are not subject to Court jurisdiction have no access to services.

Subsidized Guardianships

Fully funding subsidized guardianships will allow CINA cases to close in situations where guardians have no other funding source that would enable them to maintain the children.

Family Team Meetings

Implementation of family team meetings has been a success story system wide. It should be supported and expanded.

Parents As Partners

This is an outstanding initiative that deserves continued support and the opportunity to expand statewide.

Pre-Removal Conferences

Pre-removal conferences have effectively reduced trauma for children and enabled parents to engage in reunification services at a very early stage in legal proceedings. In many cases, parents can be valuable resources in helping children make the transition if they are part of the plan. In Polk County, adding a registered nurse to the team of professionals at pre-removal conferences and removals has helped to maintain the focus on child well-being during an otherwise chaotic and disruptive event.

Early Access Services

Fully employ the Part C of the IDEA to ensure each child, zero to three, receives the assessments and follow-up services to which he/she is entitled under federal law to reduce developmental delays and other problems. There is absolutely no cost for these important early interventions.

Family Drug Court / Court Teams for Change (ZeroToThree)

There is a pending grant application ($500,000 for each of five years) that will enable these proven programs in Polk and Wapello Counties to continue and to support expansion to Linn, Scott, and Cherokee Counties. We urge DHS to continue to contribute to the collaborative successes existing programs have enjoyed and to support Children's Justice Initiatives (formerly Court Improvement Project).

Child Care Resource & Referral of Northeast Iowa

Ensuring quality services that make child care successful for all children and their families through community partnerships.

Regional Office:

Waterloo Office
3675 University Avenue
P.O. Box 4090
Waterloo, Iowa 50704-4090
(319) 233-0804
(800) 475-0804
childcare@episervice.org

Community Offices:

Allison Office
101 Cherry Street
P.O. Box 624
Allison, Iowa 50602-0624
(319) 267-2644
(877) 635-9455

Dubuque Office
3505 Stoneman Road
Suite 5
Dubuque, Iowa 52002
(563) 557-1628
(866) 296-5331

Forest City Office
1144 Hwy 69 North
P.O. Box 253
Forest City, Iowa 50436-0253
(641) 585-1720

Independence Office
1009 1st St. West
Independence, Iowa 50644
(319) 334-5900
(866) 655-7420

Mason City Office
202 1st Street SE
Suite 205
Mason City, Iowa 50401
(641) 424-9559
(866) 424-9559

New Hampton Office
910 East Main Street
New Hampton, Iowa 50659
(641) 394-4854
(866) 394-4854

TO: Council on Human Services
FROM: Iowa Child Care Resource & Referral Agency Directors
Submitted by: MariLynn Pierce, Director – Region 2
SUBJECT: SFY '09 Budget - Public Comment

Background / History

Iowa Child Care Resource & Referral (CCR&R), comprised of five regional offices, is a statewide service delivery system established in legislation in 1992. CCR&R services are designed to:

- support FAMILIES with a menu of services including:
  -- help finding child care to meet unique family needs
  -- consumer education on the indicators of high-quality child care
  -- information about child development, brain development, early learning
  -- information about child care subsidy programs
  -- links to other community services
- support CHILD CARE PROVIDERS through:
  -- child care specific training, at little or no cost
  -- guidance related to policies and practices when starting a new child care business
  -- information on state registration and licensing requirements
  -- technical assistance directed at quality improvements, including the state's Quality Rating System
  -- recruitment and retention activities to increase the number and quality of child care programs.
- support COMMUNITIES through:
  -- providing reliable data on availability of child care supply and demand data
  -- on-going data gathering from providers for market rate and fee structure information
  -- support of coordinated early care and education efforts at the local, community level.

CCR&R agencies are the critical, first level community contact point with all child care providers; enabling effective service delivery, communication, and quality improvement through the development of consistent, trusted relationships.

Meeting the Challenge / Setting a Course for Enhancing Quality

If a child is not cared for, loved, nurtured, stimulated … from birth, they grow into an incomplete adult, having failed to learn such things as the give and take of human relationships, confidence in their problem-solving abilities, respect for others, a knowledge that there are others in the world upon whom they can depend. We've come to understand that the quality of a child's early experiences are immensely important, providing for the child the momentum needed to enter school ready to succeed. The CCR&R system is designed to meet the needs of parents and of providers in assuring high quality child care settings are available for *all* of Iowa's children.

The CCR&R system has grown to become a trusted and reliable support for not only parents and providers, but as a delivery mechanism for other funders interested in increasing the quality of care (i.e., Empowerment, United Way, etc.). However, as other early childhood systems have seen significant state investment in the past several years, CCR&R has not. It's direct state funding has remained stable for the past decade. As the very infrastructure parents, providers, and funders rely on to deliver many of the quality improvement initiatives underway in our state, it is critical that the ongoing support for CCR&R maintain pace with those expectations – not just funding specific projects, or moving funding in a myriad of indirect and administratively burdensome ways into the CCR&R system -- but direct appropriation to DHS to support and expand the many quality services we deliver in our statewide system efforts.

On behalf of Iowa Child Care Resource & Referral, we request the Iowa Department of Human Services give consideration *and* request state funding to support the following issues:
(note: there are many ways in which Iowa's child care system can be improved and strengthened. The following list is a blending of activities that would be primarily the responsibility of the Department and those that might be the responsibility of CCR&R. Those items clearly requiring additional funding are indicated by **)

- **Regulation** – Raising the Floor for Minimum Quality
  1. Require all child care providers, caring for 3 or more unrelated children on a regular basis for a fee, to be regulated. This is an issue being considered now by an interim legislative study committee. Critical to the implementation success of this increased regulation is:
     ** Increase funding for CCR&R employed Child Care Home Consultants, with an ultimate goal of 1 consultant for every 75 registered Child Development Homes.
  2. Require 40 hours of pre-service training for all regulated child care providers, with implementation in SFY '10, allowing for a one year implementation planning period.
  3. Increase required annual training hours to 24, again with a targeted implementation in SFY '10, allowing for a one year implementation planning period.
  4. Link child care regulatory requirements to Iowa's Early Learning Standards

- **Skill Building** – Helping Providers Create a Vision for Change
  1. ** Iowa's Quality Rating System – increase funding support in sfy09 for the cooperative work of DHS and CCR&R.
  2. Create, in partnership with other state entities, a high-quality community-based training system for all child care providers, with implementation and delivery managed through CCR&R. This would continue the work that has begun through an Empowerment contract with the Department of Education.
     ** funding would be required to continue this effort
  3. Develop a state-wide structure to support the training, credentialing, and skill enhancement of trainers/instructors; a process requiring study, implementation planning, and funding.

- **<u>Translating Knowledge to Practice</u>**
  1. Link on-site child care provider consultation with attendance at training to assist providers in implementation of newly learned skills.
     ** sufficient funding required for continued enhancement of the consultation skills of CCR&R staff

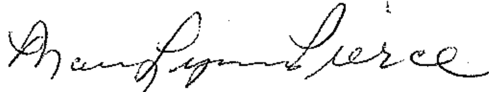
  2. ** Fund one "Business Development Consultant" per CCR&R region (total: 5.0 FTE) for the purpose of improving the business practices of child care providers promoting greater sustainability and accountability in the delivery of child care services.

- **<u>Strengthening the System</u>**
  1. ** Formalize Iowa's CCR&R structure as a "State Managed System", recognized as such by the National Association of Child Care Resource & Referral Agencies, with at least one full time DHS position dedicated to managing the work of CCR&R within the larger arena of early care and education, and serving as a state-level representative of that system.

  2. ** Create a state recognized position of "Child Care Inclusion Specialist", with funding sufficient for 5.0 FTE (one position per CCR&R Region). Goal: develop and expand the number of child care providers who can provide services, in the least restrictive environment, for preschool children identified as having special needs, increasing the capacity of providers to care for all children.

The quality of care ultimately depends upon the interaction and relationship between the child care provider and the child. "Care" and "Education" cannot be separated into distinct categories. The skill and stability of adults in a child's life matters most. Our resources and efforts must be directed at increasing the skills and stability of the child care workforce. With your continued support, the CCR&R system is prepared to deliver on that effort.

Respectfully Submitted:



MariLynn Pierce

Iowa Foster & Adoptive Parents Association

Empowering, supporting and advocating for foster, adoptive and kinship families across Iowa

Council on Human Services Presentation

July 11, 2007

Overview

For more than 30 years the Iowa Foster and Adoptive Parents Association (IFAPA) has been a voice for Iowa's children through the supports provided to foster and adoptive families.

The Iowa Foster and Adoptive Parent Association's mission is to recruit and retain quality foster and adoptive families by providing 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.

The Iowa Foster and Adoptive Parents Association's vision is to provide leadership in Iowa to ensure that every child has a secure, loving and stable family. IFAPA provides ongoing support, resources and training to more than 5500 foster and adoptive families across Iowa. IFAPA continues to focus on and address the constant and emerging issues facing families.

IFAPA appreciates the continued support and affirmation the Department of Human Services (DHS) has shown Iowa foster and adoptive parents and the children in their care.

Iowa Key Foster Care and Adoption Facts

In Fiscal Year 2006:

- Number of Children in Foster Family Care - 2905
- Number of licensed foster parents across Iowa - 3006
- Number of Children in Out of Home Care - 6048
- Number of Children Adopted from Foster Family Care - 956
- Percent of Special Needs Adoptions completed by Foster Parents - 78%
- Percent of Children adopted through DHS that receive adoption subsidy - 90%
- Number of Children in Iowa's Foster Care system waiting to be adopted - 125
- Percent of Children in Family Foster Care placed with a Relative - 36%

DHS System Changes: The Impact on Foster & Adoptive Families in Iowa

Iowa KidsNet replaced KidSake, which had been administered through IFAPA. This has been a major change for all the partners in the Child Welfare System, changing the role of DHS and private agency workers. Foster parents may experience a change in their licensing worker and now have a KidsNet support worker to provide assistance to alleviate disruptions and assist the family in providing care for the children. In addition, matching of foster children to foster homes is the responsibility of KidsNet. KidsNet staff have not had the opportunity to establish a relationship with the foster families and are just learning where foster children are placed and what the skills of the foster parents are. Families are very confused with the changes in the system, the loss of some relationships with workers, and how placements matches will be made. They are receiving numerous calls from KidsNet staff for information, for placements, and for support. IFAPA will continue to provide peer support to the foster and adoptive parents through the Foster and Adoptive Parent Liaison Program. These peer supporters will be one connection that has not changed.

Through the IFAPA Liaison Program, IFAPA has learned of the growing number of adoptive families who are experiencing major issues with the children they adopted years ago. Some families are experiencing disrupted adoptions and/or divorce. Some families are seeking assistance through PMICs and extensive individual and family therapy. These services are limited and these families may not meet the service requirements for Better Results for Children. There are over 2,700 subsidized adoptive families in Iowa.

DHS workers still exceed the Child Welfare League of America's ratio of cases to worker (1-17 cases.) Foster and adoptive parents are struggling to meet the challenging needs of the children in care. They need support and services to be able to provide for these children. Greater and more consistent access to workers and the services that the children need is required. Adequate funding needs to be directed to workers and services to support the foster and adoptive parents, which in turn will lead to greater retention of foster/adoptive parents and less disrupted placements.

The proposed Dual Licensing –Resource Family Model will have a major effect on the families who are interested in providing foster and adoptive services. This model has been used in other states with success. It will require new rules, regulations, significant changes within the system, and training for workers, agencies and foster/adoptive parents. If this model is well designed in Iowa, it could be an effective means of providing services to foster and adoptive families.

The establishment of the Mental Health Division is another positive step in Iowa. This has been an area where leadership, creativity, planning, and coordination with all partners has been sorely lacking. IFAPA strongly supports a 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.

Sibling Visitation Law

Many children and youth in care are not placed with their siblings. For some, this is one of the most difficult aspects of removal from their home and placement in foster care. This new law directs DHS to place siblings together when possible; document in the case plan and to the Court efforts made to keep sibling together and a visitation plan if they are not together; document ongoing efforts to reunite siblings; and provide training to foster and adoptive parents about the importance of sibling relationships.

Recognizing the value of the sibling relationship, IFAPA has already begun providing training to Iowa parents. This training reinforces the importance of sibling bonds and teaches ways to maintain relationships between siblings who are not placed together.

Iowa Foster Care Education and Training Program

The Iowa Foster Care Education and Training Program demonstrates our state's commitment to children and youth in care. This program will be administered through the College Student Aid Commission to provide financial assistance for postsecondary education or training for young adults age 18 through 23 who were involved with the state's foster care or juvenile justice programs. Youth in care will have the opportunity to achieve an education that they could previously only dream about and the opportunity to grow into contributing members of their communities.

The IV-E Waiver for Funding of Subsidized Guardianship

The IV-E Waiver for funding of subsidized guardianship is seen as a positive option for many older youth in care. The IV-E Waiver provides an opportunity for caretakers to receive financial assistance and the youth to receive Medicaid without having to remain in the foster care or court system.

The IV-E Waiver program has a few drawbacks. Since the federal waiver requires a control group and random assignment to this program, all youth who may benefit from subsidized guardianship will not be eligible to receive it. Also, children who enter subsidized guardianship may lose benefits from the Preparation for Adult Living Program (PAL) and other funding designed to assist older youth in care. IFAPA has continued to seek out information on the interfacing of this program with other programs to assist families and youth to make informed decisions on what is the best option in their situation.

Iowa Foster and Adoptive Family Concerns and Issues

Iowa continues to have fiscal constraints that limit resources for additional programming and emphasizes the importance of collaboration among all private and public groups working with families and children. On behalf of foster and adoptive families and children, 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%.

- Medicaid to continue to fund the health, mental health and dental services needed by the foster/adoptive children. Families have reported they have limited access to dentists, orthodontists and mental health providers who are skilled in the issues of foster/adoptive care and who will accept Title XIX payment.

- Continued development and payment of Post-Adoption Supports to families and children who have limited access to services through DHS.

- Adequate number of DHS social workers to provide services and supports to their families. Workers must have manageable caseloads that allow planning time, allow workers to be trained, make the required visits with the children and their families and have time to put in place best practices for foster and adoptive services, and time for Family Team Meetings for each child in care.

Additional issues of concern for foster and adoptive families:

- Working with the school system on the special needs of children in care. Our publications and *Building Bridges* program are assisting individual teachers and school personnel to have a better understanding of the educational needs and issues involving foster and adoptive parents and the children in their care.

- The IV-E Waiver and the subsidized guardianship program does not allow children placed into the subsidized guardianship program to access the Preparation of Adult Living program or other funding sources available to older children who age out of foster care.

- Relative caregivers need resources and information that address their unique parenting and family issues.
- Foster families need to be heard. They need to be encouraged to participate in court hearings and to be recognized as a valued team member on the child's case. Foster families have a wealth of information and first-hand experience of parenting the child daily. We can not underestimate the value foster families bring to a child's team.

IFAPA Resources: Addressing the Ongoing Needs of Foster and Adoptive Families

IFAPA Publications

IFAPA staff have developed and made available to foster and adoptive parents the following publications:

- *Navigating Iowa's Adoption Subsidy Program*
- *The Child Abuse Assessment: A Guide for Foster Parents*
- *Confidentiality: A Guide for Foster Parents*
- *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*
- *Raising Relative's Children*
- *News and Views of Iowa* – bi-monthly newsletter for foster and adoptive parents

IFAPA Parent Training

Each year IFAPA offers foster and adoptive parents across Iowa a variety of training as well as an annual conference. Training allows a family to enhance the skills necessary to parent children with histories of abuse, neglect, mental health issues, and additional complex issues. Foster and adoptive parents often need to teach children how to cope and manage emotional and behavioral disorders that can span a lifetime. Training provides every family the opportunity to gain the knowledge and skills needed to help children heal. Training helps families build the skill set and knowledge base to parent children in care. The following is a list of trainings offered by IFAPA:

- **Six Hour Trainings**

IFAPA offered 115 six-hour trainings to foster and adoptive parents from July 2006 – June 2007. Of these 115, five were cancelled due to weather and eleven were cancelled due to low enrollment.

Advanced Topics in Transracial Adoption & Foster Care
Love and Logic
More Than My File
My Brother, My Sister: Sibling Relations in Adoption and Foster Care
Family Team Meetings
Creating Sexual Safety in Foster Care & Adoption
Preventative Practices
Managing Your Risk
Teaching Life Skills
Helping Everybody in the Family Deal with Grief & Loss
Life Long Connections
Fostering Positive Relationships
Working with Birth Families
For Better or Worse...Couples Who Foster- Strategies for Success
Anger De-Escalation
Drug Awareness

- **Mandatory Abuse Reporter Training**

IFAPA offered Mandatory Child Abuse Reporting to foster parents over the ICN to sites across the state in November 2006 and June 2007. This was also offered in March, 2007 at the IFAPA conference. The course offering was cancelled at the conference due to inclement weather, and the trainer not able to make it to Des Moines.

- **Support Group Training**

Support Groups for foster and adoptive parents were offered training opportunities of: Aging Out; Meth-Exposed Children; 14 DVD topics specific to parenting children in foster and adoptive families; 9 Preventative Practice Modules; Confidentiality; Public Policy Training; Building Bridges: Helping Your Adopted or Foster Child Succeed in School; Confidentiality; and Working with the Courts

- **Life Long Connections Training**

IFAPA partnered with DHS and Independent Living staff to bring in the National Child Welfare Resource Center for Youth Development to create and provide a Training of the Trainers on the topic of Teen Permanency. The focus on this training is to identify, build and maintain relationships with important people in their lives (such as relatives, siblings, teachers, friends, neighbors, coaches, and other role models and peer supports). IFAPA trainers were trained on this topic, and it is a 6-hour training held across the state.

Connections Booklet - IFAPA is creating a publication that can be shared with all foster and adoptive parents to facilitate the process of identifying and building connections in the lives of the children in their care.

- **Siblings Training**

IFAPA has launched a new training on the importance of sibling connections in foster and adoptive families. This training was developed thanks to a grant from the Cummins Filtration Foundation in Lake Mills, Iowa. It is offered as a 6-hour training, or a 2-hour support group training.

- **Love and Logic Initiative**

IFAPA recognizes the importance of teaching parents how to best help children in their care heal from the effects of trauma and abuse. Specialized training for parents is an on-going need, and IFAPA hopes to implement an on-going Love and Logic curriculum to meet this need.

IFAPA Events

- Foster Care and Adoption Month Event at Adventureland: a thank you and fun day for foster and adoptive families.
- Adoption Saturday: a celebration and special day for adoptive families and an opportunity to inform the public about adoption.
- Legislative Breakfast held March 13, 2007: an opportunity for parents and Legislators from across the state to discuss foster and adoptive care issues.
- Journey Home Bus Tour in May 2006: a collaboration and awareness raising event for Polk County Community Leaders to understand a day in a life of a child in care. IFAPA partnered with Polk County Decategorization to offer this event.

IFAPA: Supporting Families

- Through the FAIR (Foster Allegation Information Resource) Program foster and adoptive parents who face an allegation of abuse are provided ongoing support as well as information on the assessment process, time frames, and appeal rights.
- Eighteen Foster and Adoptive Parent Liaisons who are independent contractors of IFAPA provided peer support to foster and adoptive parents in their assigned areas. They contact newly licensed foster homes to provide information and are available as an on going source of information and support.
- The three IFAPA Adoption Information Specialists (AIS staff) have developed resources, training curriculums, and materials on the issues facing foster and adoptive families. The AIS staff answers questions and provides support, information, referrals and resources to Iowa adoptive families.
- The Subsidized Adoption Respite Program provides information to adoptive families on the respite program and pays respite providers for up to 5 days of respite per child per year.
- The *Building Bridges* curriculum was developed by IFAPA to improve communication and collaboration between school personnel, foster and adoptive parents, and youth in out-of-home care.

- IFAPA staff continue to serve on committees for Dual Licensing, Iowa Plan Advisory Committee, Mental Health Forum, DHS Kinship Committee, KidsNet Area teams, KidsNet Oversight Committee, Stakeholder's Panel, Merit Roundtable for Consumers, Families, and Advocates, and Children's Justice Initiative.

- *Medication Management in Foster and Adoptive Homes* is a booklet compiled by IFAPA staff to help foster and adoptive families appropriately and safely manage the medication needs of the children in their homes. Completion of the booklet and a quiz over the material will be required of all foster and adoptive families.

IFAPA: Forming Family Connections

IFAPA recognizes the need for foster and adoptive families to connect with other similar families to share knowledge and experiences and offer mutual support, as well as for families to receive ongoing information to help them parent the children entering their homes. IFAPA has established a variety of ways to help meet those needs for connections:

News and Views Newsletter

IFAPA publishes a print newsletter six times per year that is distributed to all licensed foster families and subsidized adoptive families in the state. Each issue contains a variety of informational and educational articles on topics of interest to foster and adoptive families. Current and past issues are always available on our website.

E-Newsletter

Each month, IFAPA send an electronic newsletter to all families who have shared their email addresses with us. This e-newsletter contains links to the best child welfare-related articles and current IFAPA information and updates.

Listserv Discussion Group

During the past year IFAPA established a listserv that is available to any of our members. This listserv is an online discussion group that gives members the opportunity to discuss issues, ask questions, share resources, and connect with families who have similar interests or concerns. Anyone who is a member of the listserv can post a question or share information which can then be sent to all members of the listserv. The listserv is moderated by an IFAPA staff person who reviews all messages before they are posted. There are currently 168 members and in recent months we have had 30-40 posts to the listserv monthly. It is proving to be a popular and valuable resource for our families.

IFAPA Website

The IFAPA website at www.ifapa.org serves as a repository for an enormous amount of information and resources on foster care and adoption. By going to this one source, families can access the following information and much more:

- Upcoming trainings
- Upcoming events
- Legislative news
- Contact information for Foster and Adoptive Liaisons
- Support groups available throughout the state
- Scholarship information for foster/adoptive children
- Foster Parent Handbook & DHS forms important to foster/adoptive families
- Free printable lifebook pages
- Tax information for foster/adoptive families
- Copies of all IFAPA publications, including copies of current and previous IFAPA newsletters
- Links to other helpful websites

Some of the resources available on the IFAPA website, such as the printable lifebook pages and our educational publications, have received national recognition.

IFAPA Support Groups

IFAPA recognizes that one of the sources of support and connection our families most depend upon is the foster and adoptive parent support groups that are located throughout the state. These support groups offer parents with similar needs and concerns the opportunity to come together to share and provide mutual support. Most groups also offer opportunities for foster parents to obtain their required training hours each year. IFAPA offers a small monetary stipend yearly to new or ongoing support groups who choose to affiliate with IFAPA to help with some of the expenses of operating a support group. There are currently 44 IFAPA-affiliated support groups throughout the state. Many of these groups are facilitated by IFAPA liaisons or other IFAPA staff members. IFAPA staff and board members are committed to attending the meetings of each affiliate group a minimum of twice per year and to making at least one visit to non-affiliated groups. One IFAPA staff member who has extensive experience in organizing and operating support groups serves as a resource for support group leaders who have questions or concerns about support group leadership. IFAPA has a moderated listserv specifically for support group leaders to share information and answer questions related to support group leadership. We have also developed a support group manual that has been distributed to each group in the state, and we have traditionally held a free retreat for support group leaders each year to help them develop and hone their leadership skills. IFAPA also supplies support groups with a variety of free two-hour trainings that are available for their regular meetings and works with support group leaders to help meet the training needs of the support groups.

IFAPA: Addressing the Needs of Kinship Families

IFAPA recognizes the growing trend of relatives and other significant adults caring for children in the Child Welfare system.

Kinship Information, resources and referrals

IFAPA developed *Raising Relatives' Children*, a 32-page booklet to address the needs of kinship caregivers. The booklet shares resources on education, children's mental health issues, and financial resources, among other topics. The booklet is available free and has been widely distributed to kinship caregivers in Iowa through support groups, trainings, DHS offices, and Area Agencies on Aging.

Kinship Committee work

IFAPA staff members participate in the DHS Kinship Committee. This committee makes recommendations to DHS regarding policies, services and finding for kinship caregivers. Through this committee, IFAPA staff helped develop the *Kinship Guide to Child Welfare Services in Iowa* booklet, which will be distributed to all relative caregivers through DHS.

Kinship Creative Programming

IFAPA is looking at creating a new program to address the unique needs of kinship caregivers. One option is to offer an 800-number for families to call for information, resources, and referrals. IFAPA hopes to start a kinship caregiver listserv and expand to offer support groups for kinship caregivers in some parts of the state.

Educating families and policymakers on Kinship issues

IFAPA partnered with Generations United, a national intergenerational organization, to educate the public and policymakers about the importance of subsidized guardianship as a funding option for relatives raising children in the child welfare system. IFAPA held two forums – one in Muscatine with a Grandparents Raising Grandchildren support group and one in Des Moines with the Middleton Center for Children's Rights.

IFAPA: Forming Community Partnerships

The Iowa Foster and Adoptive Parents Association is striving to work collaboratively with the Iowa Department of Human Services and other child-welfare agencies to address the needs of children in care and Iowa's foster and adoptive families.

IFAPA has formed partnerships with Iowa KidsNet, Children and Families of Iowa - Elevate, Every Child Matters, Every Child Counts, Des Moines Child Guidance Center, the Middleton Center for Children's Rights, Iowa Association of Adoption Agencies, Polk County Community Betterment, Polk County Decategorization, Magellan, and the Greater Des Moines Community Foundation.

IFAPA: Looking Forward

What can we do better? With limited funding it is imperative that DHS effectively manage and prioritize children's issues. Focusing on in-home services to prevent removal and maintain safety in the family of origin is the beginning. When a child's safety and well being can not be protected in the birth family, services and resources need to be targeted to assist the child, birth family and foster family to be successful. For children unable to return safely to their birth family, support and assistance must be available to allow children permanency options of adoption or subsidized guardianship. Additional resources and information that address the unique needs of relative caregivers should also be considered. Cooperation and partnership among all agencies working with families and children is critical. IFAPA will continue to bring innovative and established good practice ideas to the child welfare table.

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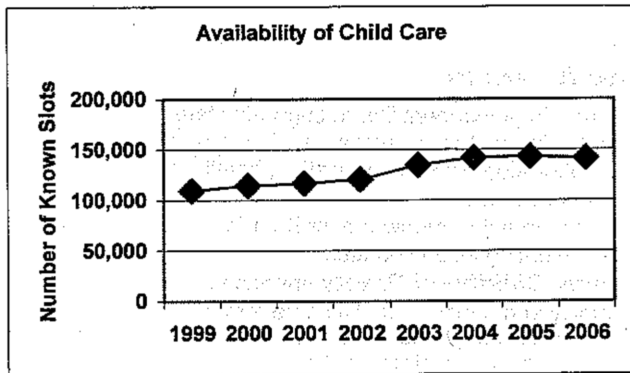
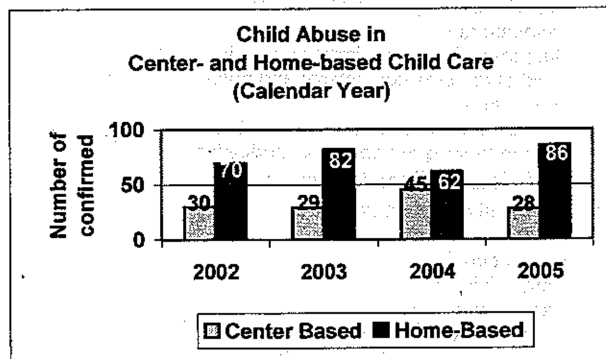
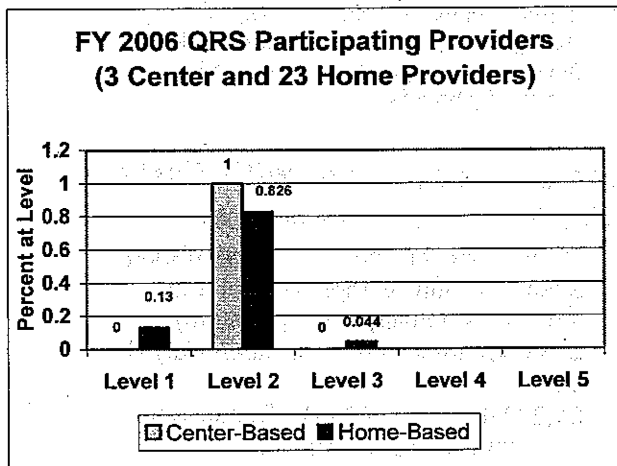
Secure and Nurturing Child Care Environments







Also Note:

- Iowa ranks 3rd in the nation at 71% for the percent of children under age 6 with all parents in the workforce. (UC Census – 2004 Community Survey)
- 19.66% of Iowa's 3 and 4 year olds attended an accredited preschool or one meeting Head Start performance standards in 2004-2005. This was in increase from 18.55% the previous year. (Iowa Department of Education)

State Indicators:

- Child Abuse in a Child Care Setting
- Availability of Child Care
- Quality Child Care Ratings

Research shows that high quality early care environments are positively related to children's later language, math, and behavior skills. Empowerment early childhood funds are targeted for specific quality enhancement activities. Technical assistance through training and mentoring helps child care providers deliver better care and education. Through Community Empowerment efforts, the numbers of centers, teachers, and family child care providers who participate in quality improvement activities have increased.

A Local Example of Quality Improvement

Harrison, Monona, Shelby Empowerment - Quality Improvement Project

The Harrison, Monona, Shelby (HMS) Counties Empowerment Area identified the improvement of quality childcare as one of their priorities based on their community plan and are specifically working on reaching the goal of 80% of early care environments participating in the QRS or achieving national accreditation. With the support of a Child Care Specialist (CCR&R), ECERS-R observations & assessments (ISU Extension), and incentives to early education providers, HMS Empowerment has been able to produce the following outcomes in FY'06:

- 2 programs received QRS ratings in FY '06; 4 centers are nationally accredited
- 30% increase of child care slots in registered homes or centers
- 53% of registered home providers enrolled in Step Up to Quality (incentives) Project. 83% completed requirements of program.
- 460 children served by these environments.
- 11 classrooms participated in ERS assessments and 100% developed quarterly plans to improve the quality based on the scales' guidelines.
- 169 children receive early learning experiences in these classrooms.
- 3 centers enrolled in Infant incentive program. 46% of caregivers completed 100% of the 20 PITC classes

A partnership between communities and the state to improve the well-being of families with young children.

Purpose

Community Empowerment is to empower individuals and their communities to achieve desired results to improve the quality of life for children, 0-5, and their families.

Achieving Results and Key Indicators

Every Empowerment Area in Iowa will have the capacity and commitment for achieving these results as measured by these indicators:

Healthy Children
- Low Birth Weight
- Rate of Immunization by age 2

Children Ready for School
- Pre-literacy skills
- Children in Quality Preschools

Safe and Nurturing Families
- Incidence of Child Abuse
- Teen Birth Rate

Safe and Supportive Communities
- Serious Crime
- Juvenile Arrests
- Employment Rate

Secure and Nurturing Child Care Environments
- Child Abuse in a Child Care Setting
- Availability of Child Care
- Quality Child Care Ratings

Statewide Collaborations

- Early Care, Health and Education Congress
- Early Childhood Iowa Stakeholders
- Promoting Early Learning Standards and Quality Child Care Rating System
- Collaborative training opportunities with Prevent Child Abuse Iowa and Community Partnerships to Protect Children

DHS Investments

(Early Childhood Grants)

FY 2004	$7,261,647
FY 2005	$7,259,000
FY 2006	$7,250,000
FY 2007	$7,246,000
FY 2008	$7,250,000

How it works

- State Empowerment Board supports state and community partnerships and promotes collaboration between education, health and human services
- 58 community Empowerment Boards representing all 99 counties
- ***Early Childhood Grants*** enhance the quality and capacity of child care through:
  - Regular child care and provider recruitment
  - Child care for mildly ill children
  - 2nd and 3rd shift child care
  - Provider training and professional development
  - Support child care registration and licensure
  - Child care home consultants and nurse consultants
  - Support providers to improve quality rating system ranking or seeking accreditation
- ***School Ready Grants*** provide comprehensive services for:
  - Preschool and child care
  - Parent support
  - Home visitation
  - Parent education
  - Professional Development
- An interagency team from the Departments of Economic Development, Education, Human Rights, Human Services, Management, Public Health, and Workforce Development supports the state and community boards

Local Investments with Early Childhood Grants *(FY 2007)*

- $2,084,429 child care capacity building
- $884,372 Quality Improvement and Incentives (Quality Rating System)
- $686,064 Infant/ext. hour care/mildly ill care
- $1,272,418 Home/Center Consultants
- $602,638 Nurse Consultant
- $525,527 Professional Development including TEACH and PITC support

Ruth L. Mosher, Chair
Council on Human Services

Kevin W. Concannon
Director

Testimony – Chief Juvenile Court Officers
Human Services Council
July 11, 2007

We would like to thank you for the opportunity to share with you some of the exciting things happening in Juvenile Court Services with delinquent youth in the state of Iowa. The ability to implement these changes is due in large part to our cooperative relationship with the Department of Human Services. We also need to raise the concern of substantial service cuts in the face of higher service needs for delinquents.

For the past several years, Juvenile Court Services has engaged in an intensive effort to implement programs recommended by the U.S. Dept. of Justice, Model Program Guide for our clientele and their families. Best Practice programs are programs that work, over time, to reduce delinquent behavior and improve client functioning in our society.

One Best Practice program that has been implemented for many of our delinquent youth around the state is a program called "Aggression Replacement Training" or ART. In the last two years, over 250 people in Iowa have been trained in facilitating Aggression Replacement. Hundreds of Iowa youth have successfully completed Aggression Replacement Training. ART has been enthusiastically adopted and proven effective in urban, rural, school, community and residential care settings in improving the social functioning of "at risk" youth.

Juvenile Court Services, two years ago, began implementation of a second Best Practice program in Iowa called Functional Family Therapy. Functional Family Therapy or FFT is a short-term, family-based program that has proven effective for a range of adolescent problems; including violence, conduct disorder, and family conflict.

FFT is considered to be one of the best programs available in the United States for reducing recidivism in a cost-effective manner. FFT is up and operating in four judicial districts in Iowa. Plans are under way for its implementation in two of the other eight judicial districts.

Of 109 youth and families who have completed FFT in the Sixth Judicial District in the last two years, 105 of those youth were able to remain in their home following treatment. Only 4 were discharged to out-of-home placements.

Juvenile Court Services implemented a state-wide, evidence-based risk and needs assessment tool called the Iowa Delinquency Assessment Tool or IDA on January 2, 2007. Use of the IDA will allow JCS to describe in detail the types of youth we are serving; assess the youth's level of risk and their need for services; direct the youth to appropriate services; and evaluate the effectiveness of the services our youth are receiving.

Juvenile Court Services has also implemented a research-based tool for assessing the risk level of juvenile sex offenders the JSORRAT II. JCS is currently working with Iowa State University to validate the tool for youth here in Iowa.

Juvenile Drug Courts are up and running in four Judicial Districts. Those courts have proven successful in addressing substance abuse behaviors for young people in our state. Youth who are successful in those programs do not have to be placed out of the home.

Other innovative programs occurring across the state include a Hispanic Life Skills program, week-end violators programs, gender-specific programs, and disproportionate minority contact programs.

You have been provided a set of charts and graphs to show the history of funding for delinquent services in Iowa over the past 10 years. The attached charts show the decrease in Federal and State monies for services to delinquent youth. Since 2001, funding for services to delinquent youth has decreased by over 35%. These cuts have resulted in the closing of day treatment programs, limiting services to many clients, fewer treatment alternatives and difficulty in getting thorough client evaluations. The slight increase seen in the last year was an increase to providers and did not increase the amount of services available.

1) Expenses, also, continue to increase. Much of the funding for Court Ordered Services fund goes to cover the costs for transporting youth. With the increasing transportation costs, <u>we would request an increase of six per cent (6%) in COS to maintain our current level of service.</u>

2) The graduated sanctions funding supports school liaisons, day treatment programming, tracking and monitoring, lifeskills training and treatment programs. We need to begin to restore lost services to our communities as well as supporting the progressive new programming. Functional Family Therapy is provided through Graduated Sanctions Funding. The cost of FFT (approximately $2000 per family in urban areas and higher in rural areas) is not currently reimbursed by Medicaid or insurance. To continue this cost-effective program and other programs proven to effectively keep youth out of group care, JCS would request a six per cent (6%) increase in graduated sanctions. This does not restore the 35% loss, but we believe it to be a workable and reasonable first step.

3) As part of the changes in the Medicaid funding to Child Welfare Services, the Chief JCO and SAMs agreed to separate the services money for delinquent and CHINA cases this year. Delinquency services monies have been carved out of family centered services. To help clarify what monies are being provided to serve delinquent youth, we would ask that all delinquency funding be incorporated in the Department's budget as part of a delinquency services line-item.

4) JCS would like to expand juvenile drug courts to two additional Judicial Districts. We are requesting that funding for juvenile drug courts be increased by $300,000 ($150,000 per jurisdiction) to cover the cost of that expansion. We believe that these increases will have the long-term effects of continuing the current reduction in the number of young people in Iowa who need out-of-home care, while at the same time, providing increased safety to the communities of Iowa because of delinquent behavior.

Again we want to thank the Council on Human Services and Director Concannon for their past support and also thank Department administrative team for their efforts in helping us to facilitate the cost-effective and progressive programs that will help Iowa move to the forefront in the care of delinquent youth.

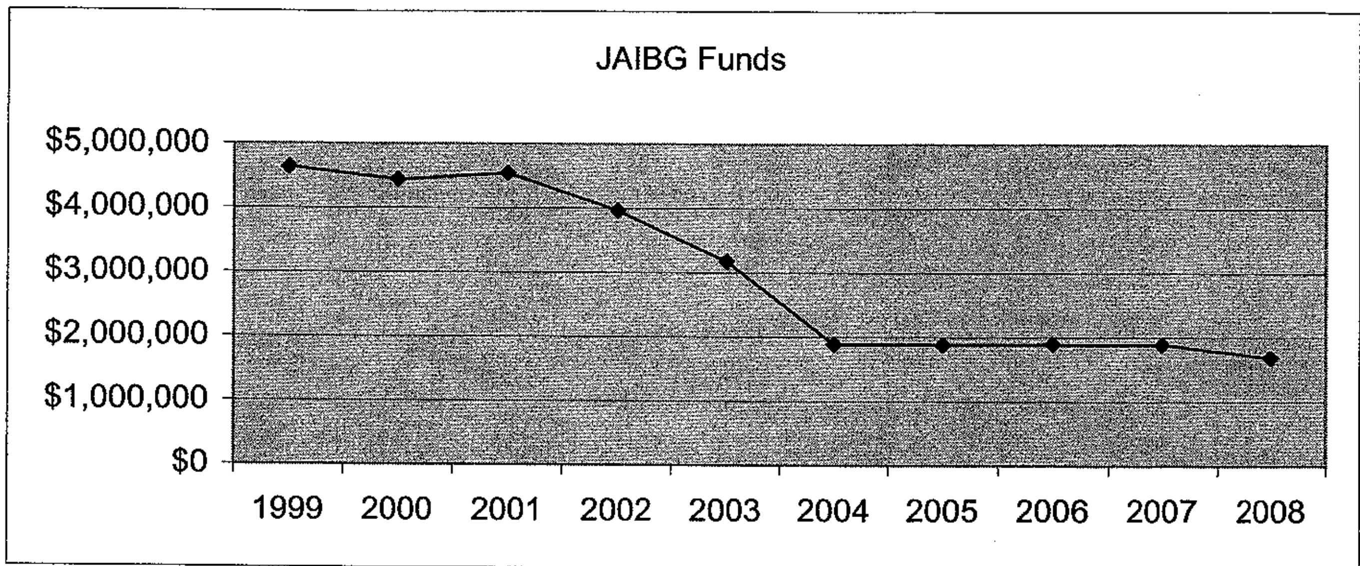
On behalf of the Chief Juvenile Court Officers of the State of Iowa,

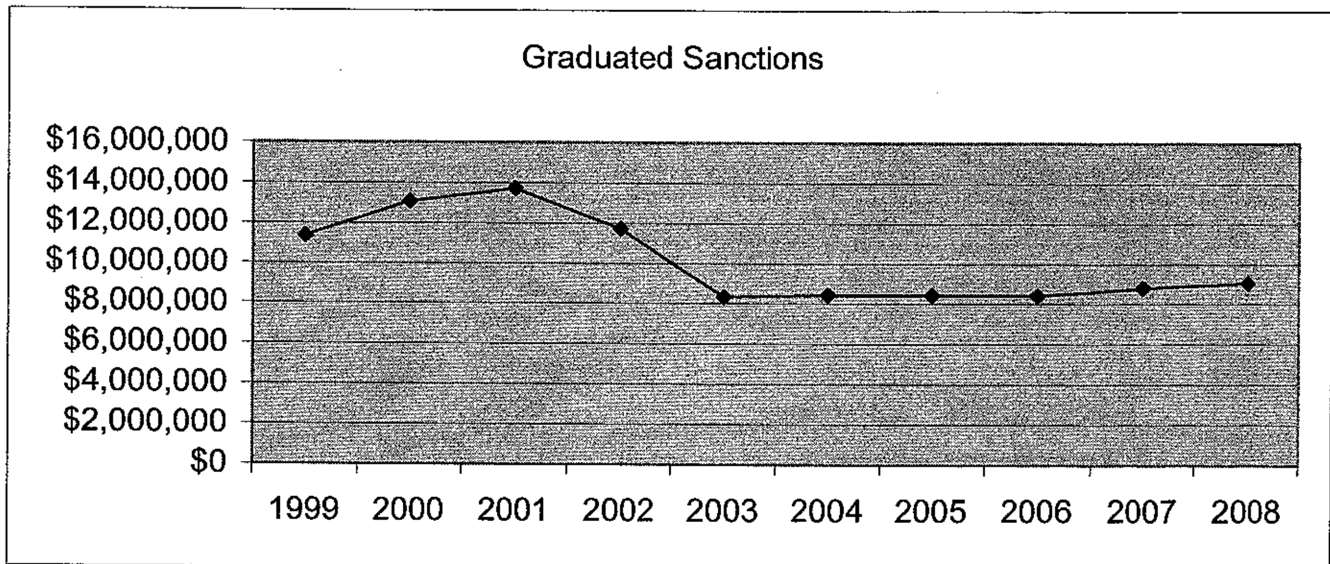
1st Judicial District	Ruth Frush
2nd Judicial District	Tom Southard
3rd Judicial District	Gary Niles
4th Judicial District	Keith Pick
5th Judicial District	Marilyn Lantz
6th Judicial District	Candice Bennett
7th Judicial District	Pat Hendrickson
8th Judicial District	John Wauters

State of Iowa Juvenile Justice Funds

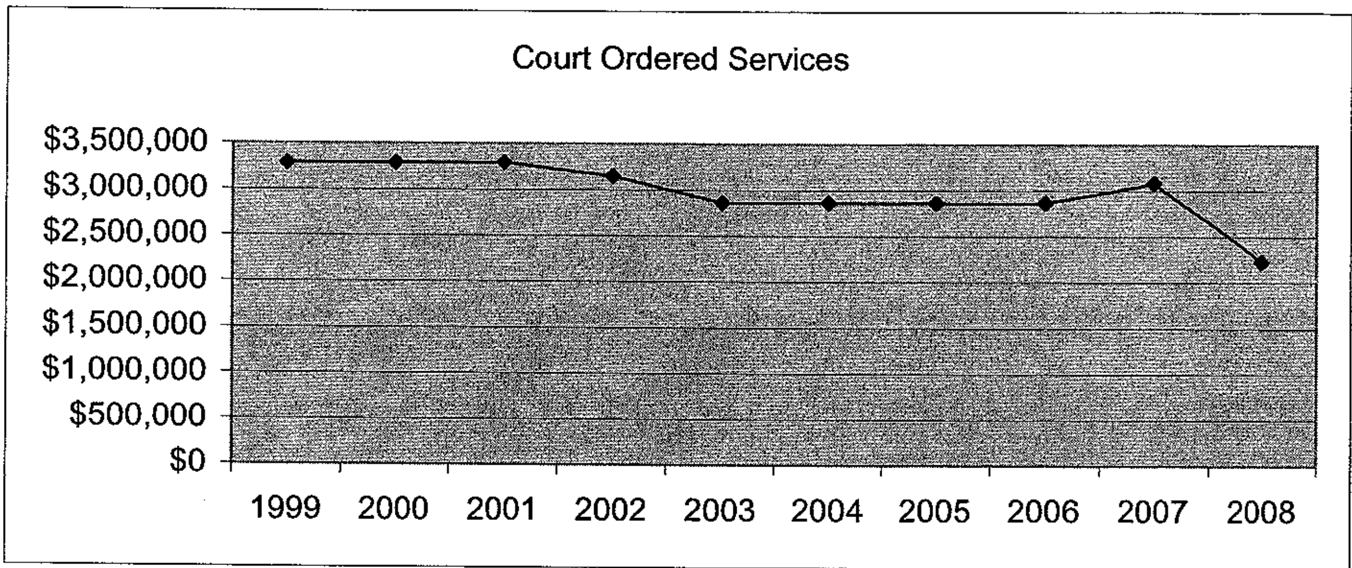
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
JAIBG Funds	$4,641,700	$4,438,300	$4,541,508	$3,955,100	$3,174,000	$1,887,100	$1,887,100	$1,887,100	$1,887,100	$1,675,438
Graduated Sanctions	$11,354,870	$13,061,370	$13,711,370	$11,701,297	$8,319,417	$8,419,141	$8,409,509	$8,396,641	$8,781,642	$9,052,732
Court Ordered Services	$3,290,000	$3,290,000	$3,290,000	$3,148,530	$2,859,851	$2,859,851	$2,859,851	$2,859,851	$3,078,000	$2,229,963
Juvenile Drug Court									$1,000,000	$830,000
Total Funds	$19,286,570	$20,789,670	$21,542,878	$18,804,927	$14,353,268	$13,166,092	$13,156,460	$13,143,592	$14,746,742	$13,788,133
				-12.80%	-33.40%	-38.80%	-38.80%	-39%	-31.60%	
									Carve-out from Family Centered Services	$2,912,418

JUVENILE DELIQUENCY FUNDING IN IOWA

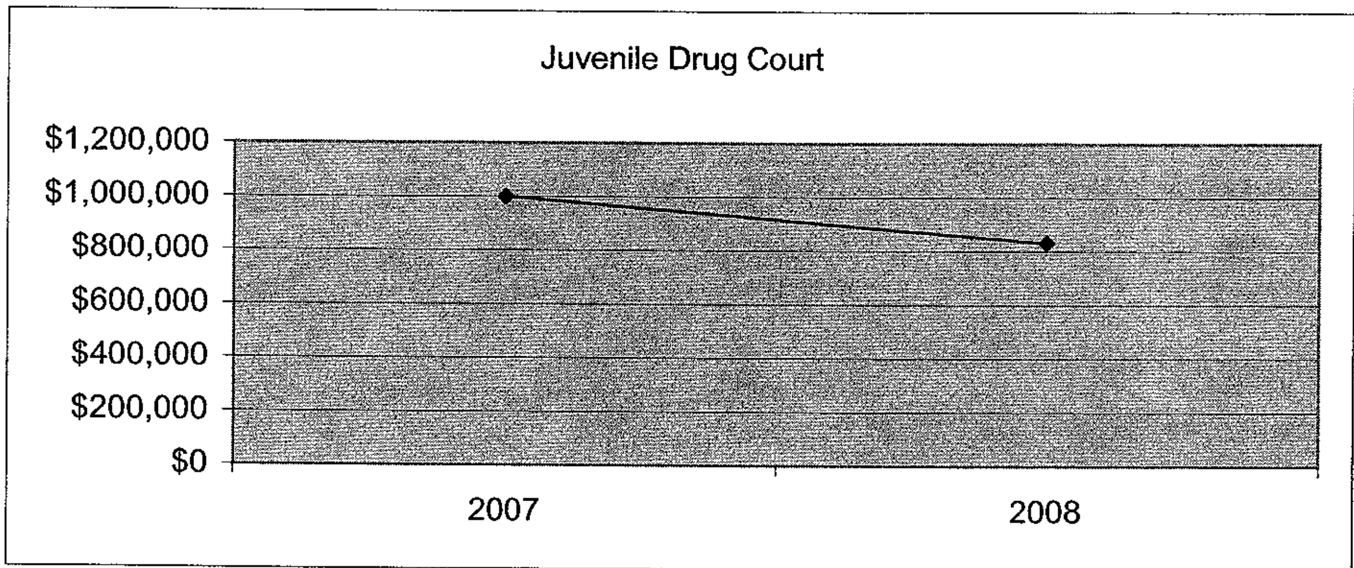




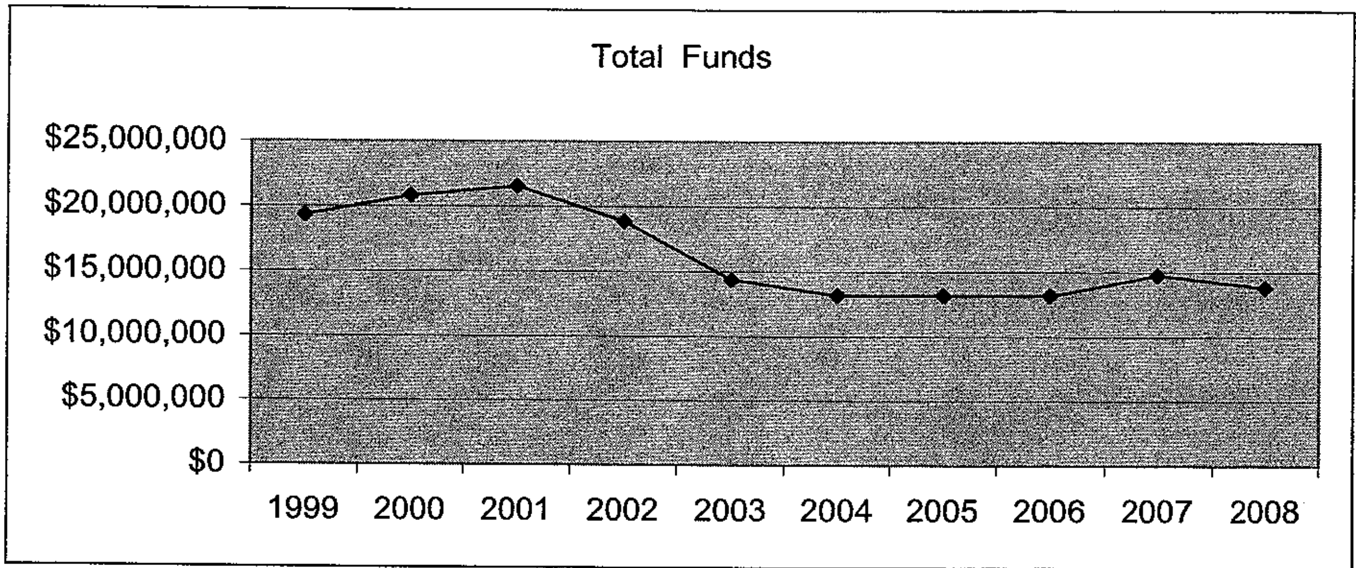
JUVENILE DELIQUENCY FUNDING IN IOWA



**For 2008: Reflects carve out of DHS portion of Court Ordered Services Funding.



JUVENILE DELIQUENCY FUNDING IN IOWA



MEMORANDUM

To: Council on Human Services
From: Bob Welsh, Citizen
Re: Child Care
Date: July 11, 2007

I come today to express again to you my personal concerns about the child care in the state of Iowa and to share again with you my concerns about the co-pay fee scale.

Some positive steps have been taken but there are many issues that need to be addressed.

The state is not in a position to insure the safety of all children in child care settings.

There is probably no one solution to this problem. My own personal view is that it will require increasing the safety standards for all child care settings, the development of a training and monitoring program, and mandatory registration.

The state child care reimbursement rates are driving quality providers out of the profession and denying low income families quality child care.

My personal view is that the market rate survey should be done annually and that the reimbursement rate should be adjusted annually to keep pace with the market rate. I believe Iowa needs to examine increasing the reimbursement level of the market rate survey to the 85th percentile, rather than the 75th percentile that is now used. There are many providers who do not accept state child care assistance because the rates are so far below their actual cost that they cannot afford to accept state child care funds. This is compounded by the fact that Iowa does not allow the provider to accept funds to supplement the child care payment. I personally believe this rule should be changed.

The downside of this is that it will require more dollars. The benefit, however, is that it will provide greater access to quality care for low income families, increase the retention of providers and, most importantly, provide positive outcome for our children.

Now, let me share with you my concern that the July 13, 2005, recommendations of the State Child Care Advisory Council have been misunderstood or ignored. Let me remind you that SCCAC recommended a change in the co-payment schedule that basically cut in half the steps and added a variable relating to the number of children receiving state child care assistance. We further recommended that the state move to a formula-based fee scale when the new computer system was operational.

You will recall that the reason given for not moving to a change in the co-payment schedule was that it would be too confusing to make this change and then make the changes that would be involved in the new computer system.

meeting, I and others were advised that the child care co-payment schedule that was recommended for implementation in 2005 will be implemented in 2007 even though the new computer system is not going to be operational. We lost two years.

The good news about all of this is that your new bureau chief in Child Care is now looking into the formula-based fee scale.

At the June 14, 2007, meeting a fiscal analysis of the formula-based fee scale was presented. The problem, however, was that the analysis included assumptions that were not a part of the recommendation. Hopefully this is being addressed.

Why, then, am I bringing this to your attention? It is because I believe it is important that you be reminded of the values of the formula-based fee scale and to emphasize to you that I recognize that the exact formula which we recommended, based on staff data, might need to be slightly adjusted to make it budget neutral.

As one of you stated at an earlier meeting, when I first shared my concerns on this issue with you, prior to being on the SCCAC, I was a young man. It is too bad that steps were not taken, as was recommended, to move to the formula-based fee scale when the new computer system was operational--a recommendation, I would remind you, which you approved. My hope is that by next year DHS will have in place a formula-based fee scale. I merely hope that you as a Council will make sure that staff moves forth on this issue.

In closing, please take steps to insure the safety of all children in all child care settings, and to make sure that the reimbursement rates are adequate to assure quality care to all children, regardless of their family income.

Thank you!

FAMILY PLANNING COUNCIL OF IOWA
TESTIMONY TO THE
COUNCIL ON HUMAN SERVICES
JULY 2007

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 FY2009 budget process.

The value of providing voluntary family planning services is well documented. The saving of public dollars is obvious. Those savings are $3.00 of Medicaid prenatal and delivery costs for every $1.00 spent on family planning. And, that figure is just the prenatal and delivery costs – it does not include the further costs of children who are then on Medicaid and who may need other services provided by the Department of Human Services.

The need for providing voluntary family planning services is clear. The "Iowa Barriers to Prenatal Care Study, 2006" examines the intendedness of pregnancies of Iowa women delivering births in Iowa hospitals. The study shows that in 2006 for women with family incomes less than $10,000 a year, 60% of the pregnancies were unintended. For women with family incomes between $10,000 and $19,999 a year, 58.9% of the births were unintended.

So, I would like to thank the Council on Human Services and the Department of Human Services for their understanding of the importance of family planning services and for the Medicaid Family Planning Waiver. The waiver went into effect February 1, 2006.

The waiver has helped many Iowa women. But, unfortunately, far more women than we anticipated do not meet the eligibility criteria for the waiver and thus are still facing the difficulty of being able to afford family planning services. One of the most significant problems relates to health care coverage. Under the Iowa waiver, if a woman has any type of health insurance she is not eligible for the waiver. This applies even if the health insurance does not cover family planning. For example, a woman with only catastrophic health care coverage, which definitely would not cover family planning services, is ruled ineligible because she has health insurance. There are a number of women who are impacted by this rule.

Another problem that women are facing is the new Medicaid rule requiring proof of citizenship for Medicaid enrollment. This has decreased the number of women applying for the waiver. For women born out of state, it has caused considerable difficulties and delay in coverage. I am certain that this issue is a concern for all of the Medicaid programs. I hope that the Council will work with others to have this rule changed.

The effect of the issues identified previously has placed new burdens on women and the family planning clinics. We are asking that the Department of Human Services appropriate state funds for family planning services in order to provide coverage for those women who are income eligible but unable to enroll because they have health insurance which does not cover family planning.

An additional issue for the family planning waiver is the timeliness of requests to the federal government for changes to the waiver. As issues are identified and changes needed for the waiver, it is imperative that IDHS moves quickly to develop the necessary requests, responses, etc. I ask that the Council designate plan revisions for the family planning waiver as a high priority for DHS and encourage the prompt submission of needed documents.

Another important mechanism for prevention is to provide good, factual information and education about preventing unintended pregnancies. It is especially important that teens receive honest, age appropriate, medically accurate, 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 ask that this program continue to be funded.

A further health care issue for women is cervical cancer. Two types of human papillomavirus (HPV) cause 70% of all cases of cervical cancer. In the United States death from cervical cancer is relatively low because of the system in place for detecting and treating precancerous conditions. However, there are significant costs associated with treating the precancerous conditions.

In June of 2006, the Food and Drug Administration (FDA) approved a vaccine for cervical cancer. This vaccine has been found to be 100% effective in the two HPV types that cause 70% of cervical cancer cases. The vaccine is administered in a three dose regiment over a six month period. The vaccine is approved for females ages 9 - 26. The vaccine is very expensive. It costs $120 per dose for a total vaccine acquisition cost of $360 for the series. This amount does not cover the cost of administering the vaccine. Adding in those expenses raises the cost to over $500.00. For many low income women and women without adequate health insurance, this cost is a significant obstacle which means that they will be unable to obtain this vaccine.

The vaccine would not only reduce the number of deaths from cervical cancer, it will also reduce the number of abnormal Pap smears which cause millions of women nationwide to need follow up care. This care ranges from additional Pap tests to more invasive procedures such as colposcopies, biopsies, and other procedures. In 2006,

8.13% of the Pap tests conducted through the Family Planning Council of Iowa's program were abnormal and required follow up care.

The Vaccine for Children program will help make the vaccine available for girls age 11-18. However, for those women ages 19-26 there are obstacles which will affect their ability to obtain the vaccine. For the uninsured women, there are very few options available. The federal Medicaid program will not cover the HPV vaccine as part of the family planning waiver. But the state could add it as a covered service that is paid for with state dollars. We ask that the Council add this as a covered service to family planning waiver for women ages 19-26.

Recommendations:

State funding for family planning for women whose health insurance status does not allow them to enroll in the Medicaid Family Planning Waiver Program:

Women who would qualify for the Medicaid family planning waiver but have health insurance that does not cover family planning have an identified need for services. We ask the Council to support providing assistance to these women.

Support for the proof of citizenship requirement for Medicaid services:

This is a requirement that places additional burdens on those least able to afford it. We ask the Council to work with other states and organizations to have this requirement changed.

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.

Addition of HPV Vaccine as a covered service under the Medicaid Family Planning Waiver Program:

The cost savings of reducing cervical cancer and treatment for precancerous conditions make this an important health care option. We ask the Council to support using state funds to provide this vaccine to women covered by the Medicaid Family Planning Waiver.

For more information contact: Jodi Tomlonovic, Executive Director
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(515) 288-9028
jtomlonovic@fpcouncil.com

FAMILY PLANNING COUNCIL OF IOWA

ADDENDUM TO TESTIMONY TO THE IOWA COUNCIL ON HUMAN SERVICES

Value of Family Planning:
Savings from Every $1.00 Spent on Voluntary Family Planning Services:

Nationally: $3.00 saved in Medicaid prenatal and delivery costs (Guttmacher Institute, *Facts in Brief–Contraceptive Services*, Mar 2005)

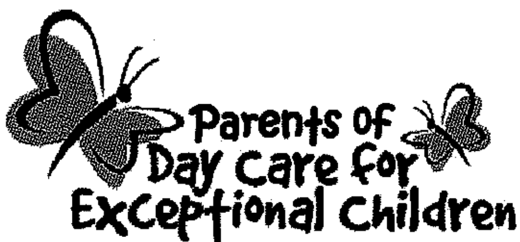
Iowa: $8.07 saved in future Medicaid and Iowa human services program costs (*Benefit/Costs Analysis of Publicly Funded Family Planning Services*, Center for Health Services Research, University of Iowa. 1992)

Need for Family Planning:
Of every 100 women who are sexually active and not using contraceptives – 85 will become pregnant over a one year period. (Contraceptive Technologies, 17th ed. 1998, pg. 216)

Desirability of Services:
Measurement of desirability of pregnancy among Iowa women giving birth in Iowa hospitals

	2006
Women with incomes below $10,000 who did not desire the pregnancy	**69%**
Women with incomes between $10,000-$19,999 who did not desire the pregnancy	**59.8%**
Women with incomes below $10,000 who did not desire the pregnancy and did not use contraceptives	**67.3%**
Women with incomes between $10,000-$19,999 who did not desire the pregnancy and did not use contraceptives	**63.3%**

Source: *Iowa Barriers to Prenatal Care Survey.* 2006



We would like you to meet Paul and Joey Honold. Paul and Joey are two children who attend Day Care for Exceptional Children. If the FULL amount of $19M is not funded for County MH/DD Services, Polk County will cut funds to Day Care for Exceptional Children and the Day Care may close.

Joey is 16 and is mentally retarded and Autistic. Joey has a very limited vocabulary and is still in diapers. Paul, who is also mentally retarded and Autistic is 11 and is high functioning; however, he has behavioral, academic, and social issues.

We, Karen and Dave Honold, their parents, both have careers. Karen is a training manager at Nationwide Insurance and Dave is an account manager at CDS. We both really enjoy our jobs and it helps to have something normal in our lives while raising two special needs children. As you know, to be able to work we need day care. We have attended several day cares over the years and have been kicked out of all of them. We found Day Care for Exceptional Children nine years ago. Day Care for Exceptional Children is the only day care in Des Moines and Johnston that will accept and care for our children. The day care has talented staff and great programming that gives us the peace of mind to be able to go to our jobs and not worry.

We were informed that Day Care for Exceptional Children may close in July if the funding from the County is cut. Daycare for Exceptional Children is more than just a day care. They have developed curriculum designed to help integrate these children into society. If they can learn living skills before they are adults they will require less public assistance once they become adults. Polk County has done a good job of funding many programs that help disabled people and their families get by. Polk County has informed us if the full amount is not funded Day Care for Exceptional Children is the first program to be cut.

THANK you for all your efforts so far. But we need more for the Day Care to survive. Please help us. Please let us know how we can help.

Karen and Dave Honold
4210 51st Street, Des Moines, IA 50310
Home phone number 253-0924 (Karen work: 508-4608, Dave work: 280-4118)
e-mail: kdhonold@yahoo.com

Iowa Department of Public Health
Advancing Health Through the Generations

Chester J. Culver	Patty Judge	Thomas Newton, MPP, REHS
Governor	Lt. Governor	Director

Advisory Council on Brain Injuries
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Program Manager
Kory Schnoor
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MISSION OF THE COUNCIL
• Study the Needs of Individuals with Brain Injuries and Their Families.
• Promote and Implement Injury Prevention Strategies.
• Make Recommendations Regarding the Planning, Development, and Administration of a Comprehensive Statewide Service Delivery System.

July 11, 2007

To: Members of the Iowa Council on Human Services

Re: SFY 2009 Budget Hearing Process

The Iowa Department of Public Health (IDPH) reports that over 2,500 Iowans are injured and hospitalized annually resulting from traumatic brain injury. The Centers for Disease Control and Prevention estimates that at least 55,000 Iowans live with long-term disability because of brain injury; with 745 experiencing the onset of long-term disability each year.

The Advisory Council on Brain Injuries would like to thank the Iowa Department of Human Services for its continued commitment in providing services and supports for Iowans with disabilities, specifically those with brain injury. The Medicaid Home and Community Based Services Brain Injury Waiver provides approximately 1000 slots to eligible Iowans. The IDPH partnered with DHS in SFY 2007, providing the non-federal share to make available 200 slots through the IDPH Brain Injury Services Program, with an additional 200 slots approved for SFY 2008.

Increasing the number of slots available for eligible Iowans with brain injury greatly assists those individuals in receiving the appropriate supports and services, thereby reducing the risk of institutionalization. Even with the increased assistance, there remains much need. The HCBS Brain Injury Waiver waiting list is currently over 340, and continues to grow.

We ask that DHS request an adequate appropriation that will fund all HCBS Brain Injury Waiver slots, including 100 of those currently funded by IDPH. Additionally, we ask that DHS fully utilize the 1272 slots approved by the Center for Medicare and Medicaid Services.

By increasing availability and maximizing Brain Injury Waiver Services, all of our efforts will help improve the lives of Iowans with brain injuries and their families.

Respectfully Submitted,

Julie Fidler Dixon, Member
Advisory Council on Brain Injuries

On behalf of its 117 member hospitals, the Iowa Hospital Association (IHA) appreciates this opportunity to address the Council on Human Services as it begins its deliberations on the FY 2009 Department of Human Services (DHS) budget priorities.

The June 13 Commonwealth Fund report – "Aiming Higher; Results from a State Scorecard on Health System Performance" – underscores Iowa hospitals' commitment to ensuring Iowans continue to receive high quality, low cost health care. The state scorecard ranks Iowa second in the country across key dimensions of health system performance, **and Iowa was the only state to rank in the highest quartile with all five of the primary dimensions measured in the report:** assessing access, quality, avoidable hospital use and costs, equity and healthy lives.

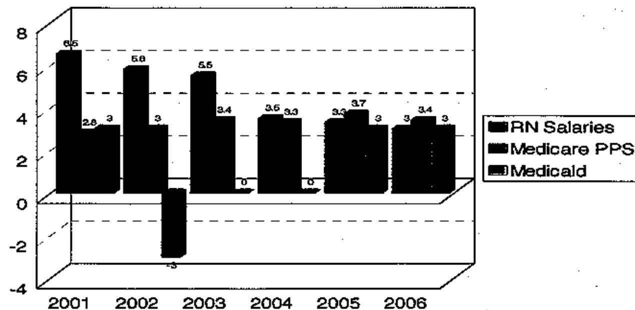
The state of Iowa must recognize that not only does Iowa arguably have the best health care system in the nation, but that this system in and of itself should be a valued resource that at present is not supported economically by the state with adequate Medicaid funding. Not only are Iowa hospitals committed to serving the health care needs of their communities on a moment's notice, they are the backbone of the community in response to any emergency – 24 hours a day – seven days a week. Late February of this year, that readiness was tested as a result of a massive ice storm that rolled its way through much of the east–central part of the state. People without power found food and shelter at Iowa hospitals, and some of the state's most vulnerable population continued to receive the necessary health care services they rely upon each day.

The ability for Iowa's hospitals to continue performing at this level is in jeopardy as a result of the legislature providing only two 3 percent inflationary payment increases since FY 2001. This in effect **results in payment cuts from the state.** Each year, Iowa hospitals face the same operational pressures as any other business; for instance, the costs of increasing salaries, utilities and replacing and updating aging facilities. Unlike other businesses, hospitals must purchase expensive medical technology and equipment, fund medical education programs and recruit and retain qualified health care professionals that deliver the high quality and efficient care documented in the Commonwealth Fund report.

The following chart illustrates the rate of registered nurse (RN) salary increases in comparison to the inflation updates provided by the Centers for Medicare & Medicaid Services for the Medicare program, and by the Iowa legislature for the Medicaid program. It clearly depicts the state's failure to keep pace with cost of inflation. In

response, highly skilled health care professionals are making an exodus from Iowa because Iowa hospitals, often the largest employers in the state, cannot afford to provide competitive wages and salaries when Medicaid services at hospitals are not fully funded. Nurses and psychiatrists in particular, are leaving the state for better pay. It is hospital employees that come together and sacrifice their own comforts to ensure the needs of Iowans are met at their most vulnerable moments. It is the employees that provide the high quality and efficient care 24 hours a day, seven days a week. It is the employees and ultimately Medicaid recipients that are impacted when the legislature fails to adequately fund Medicaid services in Iowa hospitals.

Comparison of Iowa Hospitals Salary Increases vs. Increases in Medicare PPS & Medicaid Payments
2001-2006



Compounding the employment pressures, hospitals are the only providers that never turn away Medicaid patients. Other providers may elect to no longer accept Medicaid patients as their reimbursements rates decline. Hospitals do not have this choice. For example, not only are psychiatrists leaving the state, but they who remain are refusing to accept Medicaid patients. This places hospitals in an even more precarious position because they cannot turn Medicaid patients away, yet when patients need inpatient psychiatric care there are not nearly enough professionals to provide that service.

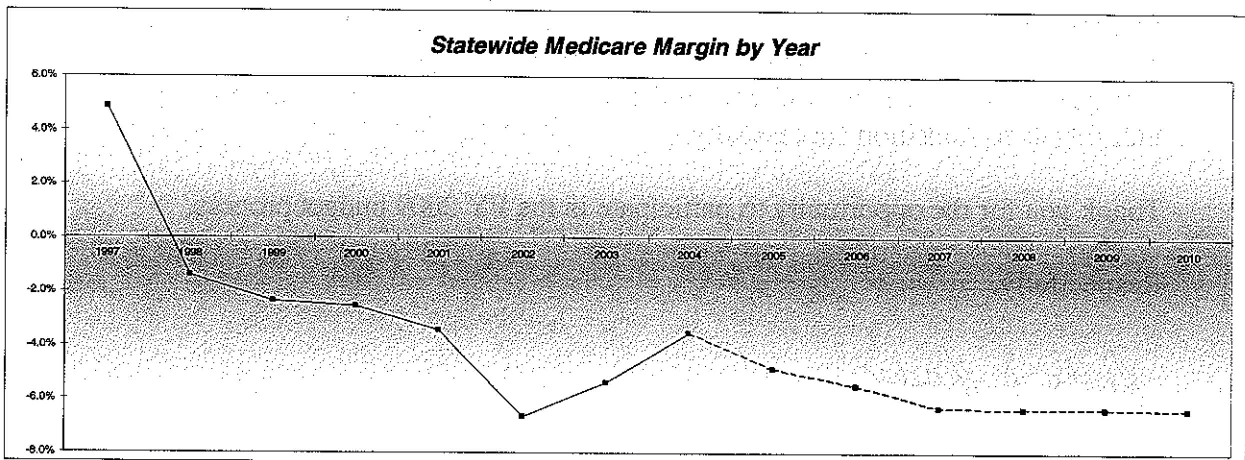
The Council has asked that presenters focus their remarks on "ideas and strategies that will maximize the positive impact on Iowans." As stated previously, Iowa has a premier health care system already in place. The state now must fund this valuable resource to protect and ensure access to this level of care to Iowans for years into the future.

During the 2007 General Assembly, lawmakers secured a $1 per pack increase in the tobacco sales tax. Included in the bill, a health care trust fund will be established in FY 2008 to target these funds for health care priorities. While there is a perception of limited state resources, the Council must remember this fund will be available.
Equally important for the Council to understand as it undertakes its FY 2009 budget deliberations is that for every dollar the state invests into the Medicaid program, the federal government invests an additional two. Medicaid is the only program within the state budget with this financial relationship.

The following are IHA's specific recommendations.

Bring Medicaid Payments to Medicare Levels

This chart illustrates the negative Medicare margins of all Iowa hospitals, and provides a forecast on the impact of these margins through 2010 based on current law. Collectively, Medicare and Medicaid comprise about 60 percent of all Iowa hospital revenue. In 2006 Iowa hospitals are projected to lose $100 million providing care to Medicare beneficiaries alone. In that same year, Iowa's hospitals lost $118 million from providing services to Medicaid recipients. And as you are all aware, by law, Medicaid cannot pay more than the Medicare program for similar services. By bridging this gap between the two funding streams, the Council has an opportunity to positively influence the delivery of health care in this state by alleviating the financial pressures on Iowa hospitals to hire and retain highly skilled professionals, and thus expanding access to care to all Iowans.



To bring Medicaid payments to the level of Medicare, the state would need a $27 million (2007 Fiscal Note) investment which would then be matched nearly 2-to-1 by the federal government, resulting in $50-70 million for Iowa hospitals. Given the increasing numbers of Medicaid patients, it is the responsibility of Iowa's government to bridge the gap which in turn will help hospitals provide adequate salaries and benefits to the nearly 70,000 hospital employees across the state. This investment will further expand access to care for Iowa's citizens.

Expand Cost Reimbursement to Hospital Outpatient Behavioral Health Services

Just two years ago, the legislature adopted a cost reimbursement system for community mental health centers and distinct part hospital psychiatric units. By expanding cost reimbursement to hospital outpatient behavioral health departments, not only will the Medicaid program be enhancing access to services across the state for Medicaid recipients, but will be saving the state money at the same time. It is much more cost effective for the state to pay for prevention and maintenance of behavioral health care for Medicaid recipients than it is to pay for an emergency room visit followed by a lengthy inpatient hospital acute care stay. By preventing the more costly inpatient admissions, some of the capacity issues both hospitals and mental health institutes (MHIs) face would be lessened, and individuals in need of inpatient acute psychiatric services could more readily access this care.

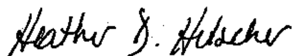
Invest in Sub-Acute Level of Care for Behavioral Health Patients

Community hospital inpatient psychiatric units are the appropriate setting for patients needing **short-term** acute inpatient psychiatric care. IHA supports a system that provides a continuum of care that is currently missing from Iowa's behavioral health system: sub-acute care. Sub-acute care is the level between inpatient acute psychiatric care and community residential care. Sub-acute care provides supports and services to individuals that are not ready for residential care, and would fail in the residential setting if placed prematurely.

DHS should invest in building the capacity and resources to provide sub-acute care for both children and adults to assist in the difficult transition for many individuals with significant needs. Expanding upon this level of care will decrease recidivism and decrease overall costs for the state and its 99 counties. Additionally, this plan would allow both hospital distinct part units and MHIs the ability to transition patients to a lower level of care more efficiently while providing the necessary supports for individuals to transition successfully.

Thank you for the opportunity to participate in the FY 2009 budget process.

Respectfully,



Heather Hulscher
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July 11, 2007

End Medicaid Coverage of Routine Infant Circumcision

I'm here today as a private citizen to urge DHS to eliminate Medicaid funding for routine infant circumcision. Medicaid was designed to provide for the medical needs of the poor. Since routine infant circumcision is widely acknowledged to be an elective, medically unnecessary procedure, Medicaid has no business funding it.

Routine circumcision of newborn boys is a surgical procedure that destroys the foreskin and causes the certain loss of its protective, sensory, and sexual functions. (A baby boy's intact foreskin, which is almost always fused to the glans at birth, protects it from urine and fecal matter during the diaper phase, contains numerous erogenous, fine-touch sensory receptors, similar to those in the lips, and matures into a natural sliding and gliding mechanism that enables non-abrasive, self-lubricating sexual activity.) Recent research has found that circumcision removes the most sensitive parts of the penis (Sorrells, ML, *et al.* (2007) "Fine-touch pressure thresholds in the adult penis," *BJU International*, 99:865-869). Infant circumcision subjects babies not only to these permanent lifetime losses, but also to numerous complications including infection, hemorrhage, disfigurement, amputation, and even occasionally death.

Unfortunately, every year more than $600,000 in Iowa Medicaid funds are used to pay for routine circumcision of approximately 5000 healthy baby boys. (The Iowa DHS director, Mr. Kevin Concannon, has reported to me that Iowa Medicaid paid $857,299 in 2005, $642,389 in 2004, and $525,776 in 2003 for routine male circumcisions of 5110, 4020, and 3452 infants, respectively.) This expenditure occurs despite the "requirement under applicable law and regulations, both state and federal, that Medicaid funding is only available for 'medically necessary' services" (quoted from a letter Mr. Concannon wrote to me).

Those who think that routine infant circumcision is medically necessary or advised need to know that the Centers for Medicare & Medicaid Services list "routine or ritual circumcision" (diagnosis code ICD-9-CM V50.2) as an "elective surgery for purposes other than remedying health states," and include it among the ICD-9-CM codes that are never covered because they are "services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury" (from "Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report, January 2006).

Furthermore, numerous medical organizations do not recommend routine infant circumcision. The American Academy of Pediatrics, representing 60,000 pediatricians, states that "data are not sufficient to recommend routine neonatal circumcision" (1999 Circumcision Policy Statement). The American Medical Association and the American College of Obstetricians and Gynecologists also do not recommend routine infant circumcision because of the lack of medical value.

People who claim that some Iowa doctors feel routine circumcision is medically necessary should be informed that even Iowa's main medical centers, including Mercy Medical

Center, Iowa Methodist Medical Center, Iowa Lutheran, and Blank Children's Hospital, state in their on-line health information that "there is NOT a compelling medical rationale for the procedure in healthy boys" (www.mercydesmoines.org and www.ihsdesmoines.org).

Recently, the effects of adult male circumcision on HIV infection rates in several African studies have made the headlines. These studies, however, cannot be used to support the practice of routine circumcision of infants since baby boys do not engage in sexual intercourse and so are not subject to sexually-transmitted infection. The American Medical Association states that "behavioral factors are far more important risk factors for acquisition of HIV and other sexually transmissible diseases than circumcision status, and circumcision cannot be reasonably viewed as 'protecting' against such infections" (1999 Report on non-therapeutic circumcision). Furthermore, studies in the United States have found that intact males do not have an increased risk of STD infection, including HIV (Laumann *et al.* (1997) *JAMA*, 277:1052-1057 and Thomas, AG, *et al.* (2004) *International AIDS Society*).

Personally speaking, I have one child and he is intact. I know first-hand that circumcision is unnecessary and is based strictly on whether or not the parents want it done. As is written in a recent *Family Urology* article, "The decision for or against elective circumcision is usually made for religious or cultural reasons. Clearly, based on the European experience where fewer boys are circumcised, there is no overwhelming medical indication for circumcision" ("What's New in Pediatric Urology," *Family Urology*, June 2002). Medicaid should not be supplying the funds for such whimsical choices. Medicaid is intended solely for necessary medical services, not for cultural preferences.

Sixteen states have already discontinued coverage of non-therapeutic circumcision. (These include Arizona, California, Florida, Idaho, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota Oregon, Utah, and Washington.) There is, therefore, ample precedent for discontinuing Medicaid coverage of non-therapeutic infant circumcision in Iowa. In the western states the circumcision rate is approximately 35 percent. Nationally the rate has fallen to 55 percent. Even in the Midwest where the circumcision rate is highest, Minnesota, Missouri, and North Dakota have eliminated coverage.

The 16 states that have stopped paying for non-therapeutic circumcision are in compliance with the law. The 34 states that have not yet changed their policies, including Iowa, are out of compliance. You can help correct this situation. Please eliminate funding for non-therapeutic circumcision from the Iowa Medicaid budget. Continuing Medicaid coverage for a procedure deemed to have no significant medical value displays fiscal irresponsibility with taxpayer money.

Coalition for Family and Children's Services in Iowa

Kim D. Schmett, *Executive Director*
Ann Harrmann, *Associate Director*

Iowa Council on Human Services
July 11, 2007
Comments from Kim D. Schmett
Executive Director
Coalition for Family and Children's Services in Iowa

I. Transfer of the Rehabilitative Treatment Services program to Medicaid

This program has been a model of cooperation between Iowa Medicaid Enterprises and providers as they continue to work together to resolve the numerous problems involved with such a large programmatic change.

II. Saving Iowa's Children's Shelters

Two years ago the Department created a monthly system of paying Children's Shelters for a contracted number of beds. This system has worked admirably to stabilize our protective system of shelter and prevent further closings. Prior to the implementation of this system a number of Shelters had been forced to close. This stabilization was attained by estimating the Department's needs for service at individual shelters. The numbers were remarkably accurate state-wide., When the unpaid last day of use is calculated there is approximately one available bed per shelter. However,. six of the current 22 existing shelters did not receive a contract for at least ten beds. Due to staffing requirements, this is the minimum fiscally necessary for their operating costs.

The Coalition wants to work with the Department to create a long term Shelter policy that will meet the future needs of Iowa's children.

III. Department RFPs.

The Department is issuing a series of RFPs that will recreate Iowa's child welfare system. The two most recent (Drug testing and Family Centered) have received a very limited number of responses, despite the fact that not

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submitting a bid will prohibit an agency from continuing to provide its current services in its community.

The Coalition would like to ask the Human Services Council to conduct a comprehensive review of the policy directing the issuance of these RFPs to assure they are in the long term best interests of Iowa and its children. We would urge the Council to work with the Child Welfare Advisory Committee created by the Legislature last session to assure the terms of future RFPs are realistic for successful implementation.

IV. Cost of Living Legislation

The Legislature has provided a three percent cost of living adjustment for child welfare providers during each of the last three sessions. The Coalition would like to request the Human Services Council to include this language in its formal budget request.

Financing Child Care in Iowa: How Far Is Too Far Behind?

Charles Bruner, Sheila Hansen, and Kelli Soyer
Every Child Counts Network
Child and Family Policy Center
December, 2004 (updated July, 2007)

Nationally, parents pay the majority of the costs for child care, estimated at 59% of all costs. The costs that families are economically able to pay for child care often are far from sufficient to guarantee quality care.

Families with young children generally are at the start of their careers and earn less than do families with older children. According to the 2000 census, 81,123 of the 223,045 Iowa children under the age of six (36.4% of all children under six) lived in families with incomes below 200% of the federal poverty level ($28,296 for a family of three). These families have very limited discretionary income and even modest child care expenses place financial hardships upon them.

Also according to the 2000 census, Iowa ranks third among states in the proportion of families with young children where both parents (or the only parent) worked outside the home (71.4%). Therefore, Iowa has a very high demand for child care.

While Iowa is a national leader in the number of working families, Iowa's support for ~~early~~ child care and ~~education~~ lags behind many other states and falls far short of what is needed to ensure child care quality, affordability, and availability. Improving the quality, availability, and affordability of care is needed for two important reasons:

- To ensure that parents can economically support their families through work and be dependable employees, and
- To ensure that children receive the developmental supports they need while in care to start school able to meet school expectations – across cognitive, social and emotional, and health dimensions.

The following provides a picture of child care in Iowa, with an emphasis upon Iowa's child care subsidy program in comparison with other states. It examines issues of affordability, quality, and public funding, and suggests what needs to occur to improve both quality and affordability.

AFFORDABILITY

The child care subsidy program is designed to make child care more affordable to working Iowans. Iowa's income cut-off level for the child care subsidy, however, is among the lowest in the nation. At 145% of poverty, Iowa's eligibility level ranked 44th among states in absolute dollars and 46th as a percentage of the state median income. The comparisons are shown in Table One.

Table One **Iowa's Child Care Subsidy Eligibility Cut-Off and 50-State Averages**		
	Eligibility Cut-Off for Family of Three (2005 Data)	Eligibility Cut-Off for Family of Three (2005 Data) % of Median Income
Iowa	$23,328	43%
50-State Average	$28,722	56%
Iowa Ranking Among States	44th	46th
Iowa % of 50-State Average	81.2%	76.8%

Source: National Women's Law Center

As a result of the low eligibility cut-off, when families receiving the child care subsidy move above the income cut-off level in Iowa, they often face huge increases in their child care costs, known as the "cliff effect." This is shown in Table Two:

Table Two **Cliff Effect in Child Care**					
% Poverty and Income for Family of Three (2006)	Parent Co-Payment	Daily State Subsidy Payment per Child in Basic, Full-Time Care (2004 market rate)			
		Reg. Home Toddler	Reg. Home Pre-School	Center Toddler	Center Pre-School
100% ($17,170)	None	$24	$22.50	$31	$25
145% ($23,328)	$7 day	$17	$15.50	$24	$18
Above 145%	$18+ day	$0	$0	$0	$0

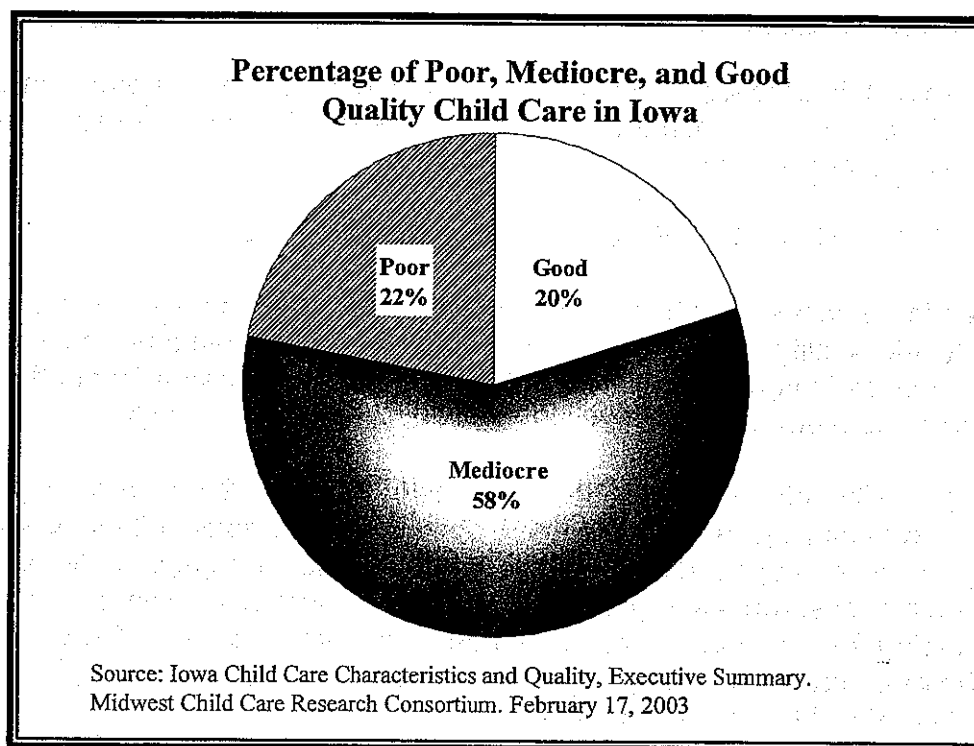
The following is an example of the "cliff effect." A working family of three, with a toddler in a child care center, receives a $0.50 hourly wage increase at its full time job (40 hours per week), equivalent to an additional gross weekly income of $20. This wage increase puts the family over the eligibility limit for receiving help from the state child care subsidy program because its income is now above the 145% poverty level. According to Table Two, the family now is responsible for the entire $29.00 in daily child care expenses, $22.00 more than they had been paying on a daily and $110.00 on a weekly basis. Over a full year of work, the additional child care costs to the family are $5,500, while the $0.50 hourly wage increase provides only an additional $1,040 in annual income. The result is that the family is worse off by $4,460 after the raise, a financial "cliff" that they have fallen off. Families have to receive more than a $2 .60 per

hour pay increase simply to keep from falling over this cliff, if they want to retain their children in this arrangement.
In short, Iowa's child care subsidy program's low eligibility cut-off level leaves many families in situations where they must struggle to find very inexpensive child care arrangements, ones which are unlikely to ensure quality.

Expanding eligibility levels under the child care subsidy program is necessary both for reasons of parental affordability and to enable the state to improve child care quality through a rating and reimbursement system.

♦ *QUALITY*

Providing quality child care requires skilled and consistent child care providers in appropriate child care settings who have few enough children under their care to give the attention those children need. Child care quality can be assessed directly through a variety of tools that require observation of the child care setting and the care provider interactions with children. The most recent survey of Iowa registered and licensed child care settings was the Midwest Child Care Research Consortium. It showed only a minority of child care provided could be considered of good quality, while a significant share could be considered poor, as represented in the chart below.



Source: Iowa Child Care Characteristics and Quality, Executive Summary. Midwest Child Care Research Consortium. February 17, 2003

WAGES AND PROVIDER SUBSIDY SUPPORT

An important indirect measure of quality is the compensation that providers of child care receive. The wages child care providers receive help determine who can be recruited to

serve as providers and how long they will stay. Both qualifications and continuity of care provision (low turnover rates) have been shown to be strong predictors of child care quality. These are affected by what subsidy rates are offered through the state child care subsidy program. Table Three shows how Iowa's wages compare with those of other states for both child care workers and pre-school teachers and how Iowa's subsidy rates compare.

TABLE THREE
Iowa Wages for Child Care Workers and Pre-School Teachers and Iowa Child Care Subsidy Rates Compared with Other States

	Child Care Workers Avg Hourly Wage	Pre-School Teachers Avg Hourly Wage
Iowa	$7.71	$9.78
50-State Average	$8.28	$10.75
Iowa Rank	34th	35th
Iowa as % of 50-State Average	93.1%	91.0%

Source: May, 2004 US Bureau of Labor Statistics occupational employment wage data.

Clearly, Iowa's child care worker wages are well below the average provided among the fifty states. The skill and continuity of the child care workforce is severely compromised by these low average wages.

TAKING STEPS TO IMPROVE QUALITY AND AFFORDABILITY

Iowa, even in comparison with other states, has a long way to go to ensure child care affordability and quality. Tiered rating and reimbursement systems represent one way to provide incentives to improve quality, but they must be built upon a foundation that already begins to meet minimum levels of availability and affordability.

A voluntary quality rating system is set to launch in February 2006. A quality rating system supports families' awareness and access to quality early childhood settings. The system must be adequately funded at the onset and then grow as demand for participation by consumers and providers increases. Currently, Iowa does not regulate all adults caring for children. Of those providers who are registered, DHS is challenged to meet the demands of licensing, registration and monitoring. Iowa needs to improve the regulation of child care settings by:

- Improving the quality of registered child care providers by completing pre-registration visits and conducting annual monitoring.

- Improving the quality of licensed child care centers by providing adequate pre-licensing consultation, timely completion of licensing reviews, completion of annual unannounced visits.

Another key component of the QRS is professional development. Iowa needs

- Increased funding for T.E.A.C.H. to support providers in post-secondary education.
- Increased funding to support training opportunities offered through CCR&R's, ISU Extension, AEA's, community colleges and Empowerment areas.
- Increased funding to expand and improve consultation to child care home providers

To develop a reimbursement structure in the Child Care Subsidy Program, the eligibility cut-off level to address affordability issues for parents will have to be raised. Additionally reimbursement incentives must be offered to providers. Iowa's current rates are far from sufficient in ensuring *adequate* care, let alone providing supports to move to *higher quality care.* In the end, at least $15 to $20 million is needed in "catch-up" investments in Iowa's child care subsidy system to put it in a position to implement a quality rating and reimbursement system.

National Association of Social Workers – Iowa Chapter
July 11, 2007

Thank you for the opportunity to address the Department of Human Service management and Council. There are many concerns and visions for service that are shared by the NASW Iowa Chapter and the Iowa Department of Human Services. We both care deeply about disadvantaged persons and vulnerable populations in our State. We both want to reduce and eliminate the effects of poverty on Iowans, prevent and address the abuse of vulnerable people like children and the elderly, and provide quality accessible services to those with mental health issues and disabilities.

NASW is the largest association of professional Social Workers in the world with over 500,000 members. The Iowa Chapter has over 1,100 members who are policy makers, therapists, caseworkers, and organizers. NASW members work in medical, school, criminal justice, mental heath, and child welfare settings. In Iowa, Social Workers provide 60% of all mental health services. And we are a shrinking profession with an average age of 45 and, according to a study by the Department of Public Health, 28% of our profession over 57 years of age.

The NASW Iowa Chapter has deep concerns regarding the new policy implemented eight months ago in November 2006 by DHS and Magellan as it pertains to assessment, diagnosis, and treatment provided by a Licensed Practitioner of the Healing Arts (LPHA). The new policy drastically limits who can provide mental health services to Medicaid and Medicare clients. The policy is far more restrictive than prior policy and Iowa law. It negatively affects your clients, your budget, and the Social Work field.

NASW Iowa Chapter requests that DHS and Magellan reconsider and amend the definitions of "Mental Health Professional" (MHP) in the Iowa Administrative Rules Code and "Licensed Practitioner of the Healing Arts" (LPHA) in the Magellan Provider Criteria. These definitions ignore the Iowa Social Work Licensing statute, which establishes the practice authority and limitations for Social Workers. The definitions eliminate qualified Social Workers licensed at the Masters Level (LMSW) level from reimbursement for providing assessment, diagnosis, and treatment services to DHS clients.

The Iowa Code qualifies both the Licensed Master Social Worker (LMSW) and Licensed Independent Social Worker (LISW) to perform the same services. The only exception is that an LISW can work as a private or sole practitioner. Both LMSW and LISW practitioners are legally authorized to perform psychosocial assessment, diagnosis, and treatment. Assessment includes, but is not limited to, psychosocial histories, problem identification, and evaluation of symptoms and behavior. Diagnosis includes, but is not limited to, assessment of psychosocial and behavioral strengths and weaknesses as well as effects of the environment on behavior. And treatment includes psychosocial therapy with individuals, couples, families, and groups, establishing treatment goals and monitoring progress, differential treatment planning, and interdisciplinary consultation and collaboration.

DHS Administrative Rule Code Chapter 441 requires an MHP to be licensed, have at least a master's degree and at least two years (4,000 hours) of post-degree supervised experience. Magellan's Provider Criteria requires an LPHA Social Worker to have a MSW degree, 3,000 hours of post-degree experience, and licensure at the highest level for independent practice (an LISW).

The policies go far beyond the requirement of Iowa law. They disadvantage clients from choosing from all competent therapists. They also disadvantage qualified Social Workers in provision of services for which they are trained, tested, and ready. NASW disputes the assumption that quality mental health Social Work services require licensure at the independent level (LISW). This assumption

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limits client access, creates artificial qualification criteria for clinical Social Workers, and adds unnecessary cost to DHS services.

NASW members report that clients drop needed services, travel long distances to an approved provider, and sometimes receive services from an LPHA with little experience in their issues. Client service and choice should be limited only on empirical data and recognized qualifications in Iowa law. State agencies should not implement policy that is more restrictive than statute and disadvantage client accessibility and choice. Rules that disadvantage qualified professionals from practice are not appropriate unless there is empirical consumer data supporting such a rule. We ask that the Department and Magellan change the rule or conduct a customer and provider study to show why the rule should be kept.

A newly licensed MSW has undergone a rigorous course of instruction and internship. The 60+ academic hours are 15 hours more than preparation required for other graduate counseling degrees. An LMSW receives a minimum of two semesters of supervised family and individual counseling practice prior to entering the field. The MSW degree prepares a Social Worker to competently practice immediately upon graduation and licensure.

Multi-service agencies in Iowa undergo thorough professional and government oversight. These agencies have provided competent quality services to DHS clients through LMSW Social Workers for a long time. Standards of supervision in the agencies are client centered and high quality. DHS and Magellan have the capability to assure that both LISWs in private practice and agencies with supervised LMSW employees provide quality service to clients.

An LISW Social Worker in private practice has mental health counseling skills, business skills, and ongoing case consultation available. An LMSW Social Worker in agency practice has mental health counseling skills, experienced supervision, collaboration capabilities, and case consultation available. The Magellan and DHS rules are based on artificial difference and severely limit a client's choices for service. Limitation of client services is beyond the limitations of the licensing law and without good reason.

Excluding supervised LMSW services for DHS mental health clients is not a necessary or good use of limited resources. Quality service and the hourly rate of a private practice LISW are sometimes necessary for specialized services and client preference. However, some clients may prefer services from an agency for convenience or comfort. The human service agencies in Iowa have the expertise to provide supervised quality service. It is fiscally inappropriate to limit services to more costly practitioners when quality supervised LMSW services are available.

Finally, and this is really a post-script, Social Workers in Iowa are increasingly in short supply. Like other caring fields, Social Workers depend on education, internship, supervision, and experience to develop our skills and enhance our services. Social Workers have rigorous ethics, rules, standards, and law to assure quality practice. LMSW supervision is a model of case consultation that contributes the wisdom and experience of a mentor to a Social Worker. An LMSW is fully trained and tested for practice and is in the next generation of LISW practitioners.

We are proud to partner with the DHS to address the issues of disadvantaged and vulnerable Iowans. We offer our support to your often-daunting mission. NASW trusts that you will give thoughtful consideration to this issue. We ask that DHS and Magellan change their policies to recognize qualified LMSW practitioners in the mental health service field.

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IN IOWA, THE LAW SAYS THAT PARENTS MUST SUPPORT THEIR CHILDREN!

For the last five years I have been raising my three children by myself, physically, mentally and financially, despite my ex-husband being ordered to pay child support for our three children, to keep medical insurance on the children and myself, which has not happened in the last 5 years. I am not on welfare, but I am a disabled mother of three making $948.00 a month on SSDI. I am one step away from being homeless and living in a van with my three children.

I used to believe that our country was a land of laws. I believed in our court systems, our government system, and I believed that our State was there to see to it that these laws were enforced. I believed that if you committed a crime, you would be punished for your actions. That the state would enforce that punishment that was on the books regarding the criminal activity. It didn't matter who you were, everyone was punished by the laws of the land.

I have learned differently in the past 5 years while dealing with Child Support Recovery here in Iowa and the general perception by their representatives. I had not taken into account that I lived in a state/nation which ignored the laws of the land when it comes to the welfare of the children. Despite hearing so much lip service paid to the subjects of children, poverty and single mothers, the system that we have in place now regarding court ordered child support and the agency which have been designated to enforce it, is nothing more then a sham. How can I say that? Because I have lived in the system and experienced it for the past 5 years since divorcing my husband of 10 years.

Here is my personal story. I was separated in 2001, and divorced on July 2, 2002. My ex-husband never paid one single penny of any order for child support, any bills, or anything regarding the temporary order despite my attorney assuring me he would. After the divorce became final, my ex-husband once again never made any payment to his court ordered child support. Finally, a few months from the divorce date of July 2nd, in September I started to receive child support because I continually called Child Support Recovery asking them what they were doing about my order. Finally, a Mandatory Income Withholding order was presented to my ex-husband's work. Collection of the child support for my children started to come in, but was not what was ordered in the decree. I could not understand it. I spoke with my attorney at the time and her response was I needed to contact CSRU. They were in charge now. So I called CSRU over and over, asking for an explanation. I could not believe what I was hearing when I placed calls. Responses from their customer service line were: "Why do you even count on your support?", "Have you ever thought of applying for welfare?", "There is nothing we can do for you, be glad your getting something!". These were the answers and the contempt in the customer service department was astonishing to me. I could not believe that the people that were

hired to collect and distribute my children's child support were so hostile.

I started talking to other custodial parents about their child support orders. I could not believe that they were telling me the same responses when they called about their cases. Finally, I had enough. I made contact with a supervisor in CSRU who sat down with me, told me that child support was not equipped with handling a situation like mine. That new laws needed to be added to legislature to make it a criminal crime not to pay child support and then they could help me. Now remember, this was a supervisor. At no time did she explain that Iowa already had a Felony Non-support law on file. Iowa Code 726.5 Unknowing of this, I started speaking to Senators about getting a law into effect that would make it a felony charge of criminal child neglect/child endangerment not to support your children. I spent two years working on that. Finally, one Senator figured out I was not going away and sat down with his staff and helped draft the new law that I wanted on the books. We were turned down in legislation the first time, but I would not give up and on July 1, 2006, House File 2332 went into effect. It added to the already existing Iowa Code 726.5. I still was not aware of this Felony charge we already had on the book, and neither were my Senators that I had spoken to or worked with!

I went back to child support armed and ready to do battle. I was now not receiving a dime of child support. The Child Support Recovery System blamed it on the fact that because they were in Florida, they could not do anything. Did they bother telling me about the Interstate Collection Law? Did they bother telling me that their office could transfer my case over to the Federal authorities to press charges? No, No and No.

It wasn't until I started to study our laws did I realize that Child Support Recovery was not doing their job. When I called CSRU about taking my ex-husbands driver's license away, they told me they could not do that, when I questioned their ability to take his registration away, they would not do that either. When I questioned them on contempt actions for willful non-payment, they told me the system was to bogged down to do that and it would take 18 months to 2 years for anyone to even start looking at my case. I was appalled. In 2003 after nearly a year of non-support, I started contempt charges against my ex-husband. He showed up for the first date, but after that, would not come to court. Finally, a year after my initial hearing, the Judge ordered that we were going to have the trial no matter what. Once again, his 4th lawyer at the time, tried to get the trial continued, but the Judge would not allow it. He resigned as counsel and we had our trial. Finally, my children had their day in court. It was eventually handed down by the Judge that my ex-husband was in contempt of court for willful non-payment of his child support and an arrest warrant was issued for him. I personally walked up to the Sheriff of Warren County with the Order and had them send it to Florida, which they did. My ex-husband was picked up within the week, but posted bond and took off again. I transferred this Order of Contempt to CSRU and expected them to do something with it. Did they? No. Once again I was treated indifferently and with disrespect. I could not believe the attitudes of the people that were working in an office that was supposed to be representing my children.

Currently, my ex-husband, Benjamin David Burnett is $28,000 behind in his child support, has not honored the agreement to keep medical insurance on the children and myself, and has done everything he can to get out of paying anything to help raise our three children. And, the saddest

part of all this? Is that CSRU has been bending over backwards to protect my ex-husband's rights and not the rights of our children.
My personal story could total 50 or more pages if I went into detail about every single meeting I have had with CSRU. Suffice it to say, at every single turn, they have thwarted me in trying to help me enforce my children's court ordered support. A change is needed. The offices of CSRU are not doing the job that they need to be doing. They are great as a bank, taking in the MIW orders that come to them and disbursing them, as long as there is no work that goes along with them. People like myself (there is more than 1 billion dollars in non-collected child support in Iowa alone) are at a loss what to do. They turn to the system that was established to help them, and they are shunned.

I sat in a meeting with Child Support Recovery in the middle of June about my case. At this meeting, our Governor's office was represented, two Attorney Generals for Child Support were there, Senator Staci Apple, Barbara Lucina a supervisor for CSRU, and Maja Rater were present. During this meeting, one Attorney General proceeded to tell me, that "if I did not like what CSRU was doing, I could go elsewhere to have my child support enforced! Where am I to go? Why is the office that is regulated by our government and state not willing to do the job that they were entrusted to do? This same Attorney General also proceeded to tell me that I could take the case to Warren County Attorney's and have them prosecute, despite having the US Attorney's office monitoring my case. The sole objective of that meeting was to get rid of me.

I don't know what the solution to this problem we have in Iowa is with CSRU, but I do know that a thorough investigation should be done on why we are 1 billion dollars behind in collecting child support and enforcing the laws that are on the books. Maybe it is time to disband this office and turn it over to the IRS for collection. It is time that the children of Iowa receive their dignity back. For all the lip service our Governor, Senators, Representatives, and Child Support Recovery do, it is time for action. It is time for our state to make a decision and have an office that actually honors their job. One that is dedicated to enforcing the court ordered child support cases (whether hard or easy). One that does not have the attitude of attacking the custodial parent when they question why their case is not going the way it should. One that does not bend over backwards to protect the Non-Custodial parent, but instead, bends over backwards to protect the children.

They say that the US is a place of dreams. Well, despite living in poverty, my children have dreams also and I am willing to do whatever it takes to see that those dreams are found. I am asking the same of the State of Iowa. The enforcement of child support is mandatory. It is needed. It is a measure of dignity to be given to the children. I have been in the fight of my life with CSRU and I am hoping that maybe just hearing what I have had to go through will help this counsel understand that a change needs to be made. Maybe someday, custodial parents will not have to go through the loops that I have. Maybe someday, CSRU will start to actually do their job of enforcing the child support orders that the court hands down.

726.5 NONSUPPORT.

A person, who being able to do so, fails or refuses to provide support for the person's child or ward under the age of eighteen years for a period longer than one year or in an amount greater than five thousand dollars commits nonsupport; provided that no person shall be held to have violated this section who fails to support any child or ward under the age of eighteen who has left the home of the parent or other person having legal custody of the child or ward without the consent of that parent or person having legal custody of the child or ward. "Support", for the purposes of this section, means any support which has been fixed by court order, or, in the absence of any such order or decree, the minimal requirements of food, clothing or shelter. Nonsupport is a class "D" felony.

[S13, § 4775-a; C24, 27, 31, 35, 39, § 13230; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, § 731.1; C79, 81, § 726.5]

2006 Acts, ch 1119, §8

Referred to in § 252B.7, 600B.29, 726.4

Previous Section 726.4 *Next Section 726.6*

Statement
By Dana Petrowsky, President/CEO

Iowa Council on Human Services
Wednesday, July 11th, 2007
Des Moines, IA

The Iowa Association of Homes and Services for the Aging (IAHSA) is a 501 (c) (6) trade association founded in 1964. Our members are not-for-profit nursing homes, retirement communities, hospital long-term care, assisted living programs, residential care communities, and senior housing and community services providers throughout the state. IAHSA's 148 members spring from diverse heritage of religious, civil, and fraternal organizations. Together they serve over 20,000 Iowans and their families.

IAHSA and its members are leaders in the movement to transform facility-based long-term care from "institutions" to the new person directed care models:

- That embody an atmosphere of home and facility connection to the community;
- Where elders in need of skilled nursing care continue to make decisions about how to live their everyday lives; and
- Where hands-on caregivers are empowered to provide outstanding care…and to help elders live meaningful lives.

We ask each of you as members of the Iowa Council on Human Services to:

Provide Adequate Funding for Long-Term Care for the Poor Elderly

Medicaid is the safety net for poor, frail elders who need long-term care. Primary cost drivers in the Medicaid Nursing Facility program include:

- ever increasing costs for regulatory compliance,
- increased staffing and wages for hands-on caregivers,
- rising acuity of residents, and
- increased indirect costs such as insurance premiums and utilities.

Iowa Association of Homes & Services for the Aging
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Our analysis shows that 65 percent of all skilled nursing facility costs in the 2005 cost reports were directed to wages, benefits and other employment costs.

The introduction of the case-mix system has had positive impact on long-term care facilities in Iowa. The system does a better job of recognizing direct care costs, which are the costs that have the most impact on the quality of care needed by the frail elderly residents. However, for the case-mix reimbursement system to work well, it is essential that rebasing occur and the rebasing is adequately funded.

We commend the Department of Human Services for working with the long-term care profession to help fund the case-mix reimbursement system. However, current payments have been artificially reduced by DHS budget limitations. A skilled nursing facility's per-patient day loss for Medicaid services increases each year.

The need of Iowa's elderly poor are great. Adequately funding the case-mix reimbursement system will assure that resources are used for services that are needed by some of the state's most vulnerable citizens.

Provide Adequate Funding for Home and Community-Based Service Providers
Polls indicate that people would prefer to age in their homes, communities or in an assisted living program. The continuation of "rebalancing" long-term care should not inadequately fund or harm any Medicaid provider of long-term care services.

IAHSA agrees with the DEA Director John McCalley when he stated in ***Aging in Iowa*** "We need to increase the reimbursement levels for home and community-based services to keep pace with their true costs."

Statement
By Dana Petrowsky, President/CEO

Iowa Council on Human Services
Wednesday, July 11th, 2007
Des Moines, IA

In 2005, the Iowa Legislature approved adding assisted living as a waiver service. We request that the DHS act on this legislation and submit a plan to CMS this year.

Serious consideration needs to be given to increasing the HCBS elderly waiver cap. The limited Medicaid funding provided by the current $1,084 cap forces Medicaid-recipient tenants to leave their assisted living and enter nursing facilities oftentimes earlier than their acuity level requires.

The State of Iowa should provide appropriate and high quality long-term care services based on the consumer's needs and an adequate payment system for the entire continuum of care.

Provide Adequate Funding for Residential Care Facilities (RCF)
Residential care facility reimbursement rates are well below the cost of providing services. $26.50 provides room, board, supplies, personal assistance and other essential daily living activities.

At $26.50 per day, RCFs are being reimbursed a mere $1.08 per hour for a room, three meals a day, medication administration, assistance with bathing, laundry services, scheduled activities and 24-hour staffing. The residents living in RCFs are closer in care level to what used to be nursing facility residents. Costs are closer to $3.75-$4.00 per hour or about $90 per day for one RCF.

An additional $200 - $400 a month is available to RCFs through the Medicaid Elderly Waiver, for Medicaid eligible residents. However, this is bottom dollar care. Iowa has a

goal to reduce the occupancy in nursing facilities, and prolong the time before entering a nursing facility. While assisted living programs are an alternative to nursing facility placement, RCFs are another viable option.

RCFs have only seen $1.50 increase in rate during the last 3 years. Without an increase, RCFs do not know how they will break even. IAHSA proposes an incremental increase over the next couple of years.

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

Thank you!

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What Medicaid Means to Bishop Drumm Retirement Center

Bishop Drumm Retirement Center is a Continuing Care Retirement Center located in Johnston. In total, about 290 elderly people live on the campus, including 150 residents of the Skilled Nursing Facility (Bishop Drumm Care Center).

Bishop Drumm was originally established by the Religious Sisters of Mercy in 1939. When operations first began, there was no Medicaid program. The Sisters managed to provide quality services with operational revenue from privately paying residents and philanthropic support from the community. At that time, very little support was obtained from publicly funded programs.

When the Medicare and Medicaid programs were established in the mid-sixties, the Bishop Drumm Home became certified for Title XIX, and increased governmental support was obtained. At that time, most of the residents had minimal care needs that could now be handled in a Residential Care Facility or an Assisted Living Program.

Sr. Beatrice Marie Costello became administrator of the Bishop Drumm Home in 1974, and she still lives on the campus. According to Sr. Bea, costs were kept very low, but the Medicaid program was helpful in providing reimbursement for indigent residents, however, the support amounted to only 76% of the cost of care. Bishop Drumm had regular cash flow problems, and on some occasions, the Sisters would have to borrow money to make payroll. Nevertheless, the Sisters had faith, and they always managed to pay the bills

In 2002, Bishop Drumm became certified for Medicare and additional public funding became available.

Today, the payer-mix at Bishop Drumm Care Center is as follows:

- 49.4% privately paying
- 47.6% Medicaid-eligible
- 3.0% Medicare.

Current operational revenue by pay type is as follows:

- 48.1% - Privately-paying residents
- 7.2% - Donations for operations
- 39.3% - Medicaid-eligible residents
- 4.4% - Medicare

Source of revenue for Bishop Drumm Care Center:

- 66.2% Private (includes donations and client participation portion of Medicaid)
- 24.0% Federal (includes Medicare and Federal portion of Medicaid funding)
- 9.8% State (state portion of Medicaid funding)

The implementation of the Case Mix Reimbursement System has had a very positive impact on Bishop Drumm Care Center. Under the previous system where reimbursement was capped at the 75 percentile, the reimbursement for Bishop Drumm was always far below costs. Although Medicaid reimbursement is still below costs, the gap has narrowed from what it would have been under the old system. Currently, Medicaid reimbursement is equal to about 87% of costs:

Average per diem costs	$148.48
Current Medicaid rate	$128.57
Current per diem gap	$ 19.91
Projected Medicaid census for FY07	26,162 resident days
Projected Medicaid gap for FY07	$520,885

(based on 1/31/07 YTD financials)

Bishop Drumm Care Center – Summary of Statement of Operations

Overall financial performance (FY 07 – Jan 31, 2007 YTD annualized):

Net revenue on operations	$ 7,905,300	
Operating expenses	$ 8,131,300	
Gain (Loss)	$ (226,000)	
Operating margin		(2.9%)
Philanthropic Support	$ 500,000	
Gain (Loss)	$ 274,000	
Margin		3.5%

The introduction of the case mix reimbursement system has had another positive impact on long-term care facilities in Iowa. The system does a much better job of recognizing direct care costs, which are the costs that have the most impact on the quality of care needed by the elderly residents.

However, for the case mix reimbursement system to work well, it is essential that rebasing occur on a regular basis. The original legislative intent of the system was that rebasing occurs every two years. The last time it was rebased was December 31. 2004. We urge the legislature to rebase the case mix reimbursement system again this year.

The needs of Iowa's elderly poor are great. Rebasing the case mix reimbursement system will assure that resources are used for services that are most needy by some of the state's most vulnerable citizens.

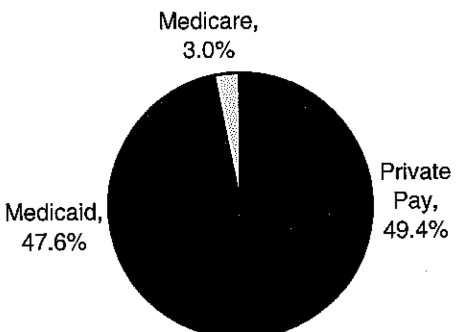
Bishop Drumm Care Center
November 2006

Census by Payer Type	
Private Pay	49.4%
Medicaid	47.6%
Medicare	3.0%

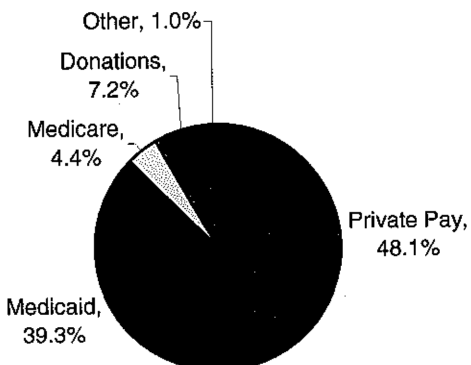
% Revenue By Payer-Type	
Private Pay	48.1%
Medicaid	39.3%
Medicare	4.4%
Donations	7.2%
Other	1.0%

Source of Revenue	
Private	66.2%
Federal	24.0%
State	9.8%

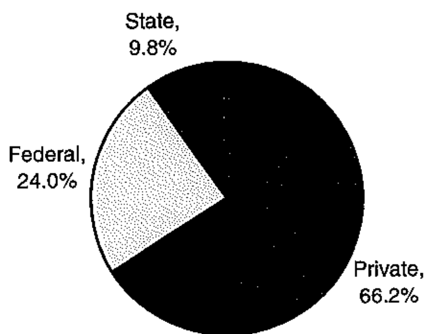
Census by Pay Type



Revenue By Pay Type



Source of Revenue



July 10, 2007

Ladies and Gentlemen of the Council:

I come before you today with a very brief presentation.
I am here representing Visiting Nurse Services in Polk County.

We have numerous programs and multiple funding streams that we utilize to provide services to our clients. We are the recipient of Title V funding for women and children and Local Public Health dollars that provide services for chronically ill adults.. We have several programs and staff members dedicated to programming that we operate in conjunction with DHS such as the EPSDT program and outreach for *hawk-i*.

We have built a working relationship with DHS over the years and it is long term and cordial. Today I am asking for your political endorsement.

As an agency we have recognized the vital role that the Certified Child Care Nurse Consultant (CCNC) makes within the early childhood care arena. (I have passed out to you an advocacy brief to explain this position in more detail). We had used some of our limited Maternal Child Health dollars to have a nurse function in this capacity. We have cobbled together funding sources to create a small CCNC team who currently work with 78 homes and 110 childcare centers on critical health and safety issues. Other regions in the state find themselves in similar situations.

Because the operation of the Child Care Nurse Consultant program is divided between DHS and IDPH it really has not risen on the priority list of either department. I believe in order to advance this issue and receive an appropriation to IDPH to add to the program to begin to meet community needs it needs political endorsement to advance in the legislature. Today I am requesting political support to advance this issue. I hope to glean your support as a Board, and hope to work with Director Concannon, and the new DHS legislative liaison to advance this issue.

Thank you for giving me the opportunity to bring this topic before you.

Mary C. O'Brien
Community Policy Liaison
Visiting Nurse Services
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Child Care Nurse Consultants

2008 Advocacy Statement

Discussion:

Iowa children are in child care.
On any given day, nearly 80 percent of Iowa's young children are in some form of child care outside of their own home. Many studies show that the quality of child care affects a child's development. Inferior child care is associated with poor outcomes for children. Health and safety are crucial aspects of quality care. The highest risks of physical harm to children in group care settings are from injury and infectious disease. Children exposed to a poor quality child care are less likely to be prepared for the demands of school and more likely to have their social-emotional development derailed.

Improvements are needed in Iowa child care.
A 2002 study by the Midwest Consortium including Iowa, Nebraska, Missouri and Kansas, found that almost 80 percent of Iowa child care rated poor or mediocre quality at best. The quality of infant care in Iowa was poorer than the quality of child care in other Midwestern states.

Nurses are needed to improve child care in Iowa
Community health nurses credentialed as Child Care Nurse Consultants have the expertise needed to assist child care businesses improve the health and safety in daily practice. Iowa child care businesses call upon nurses' expertise related to the following:

- preventing infectious diseases
- preventing child injuries
- developing asthma and other health emergency protocols
- helping with medication
- caring for children with special health needs

Iowa has Child Care Nurse Consultants but not enough funds.
A variety of funding sources are used to support Child Care Nurse Consultants. Currently, most funding sources are variable and allocated on a year-to-year basis. This does not allow communities to meet the needs of child care businesses and the families they serve.

Policy recommendation for state funding:
Local community health advocates are asking for state funding at $1,200,000 to be allocated to the Iowa Department of Public Health. $1,100,000 would be assigned to local Maternal and Child Health (MCH) agencies to support a CCNC. $80,000 would be retained by IDPH for 1 FTE to provide technical assistance and training to local MCH agencies. The remaining $20,000 would be used for products, training, and printing health materials for child care businesses.

For more information contact: Mary O'Brien
Visiting Nurse Services
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IOWA STATE ASSOCIATION OF COUNTIES

Budget and Legislative Recommendations for
Department of Human Services

Fiscal Year 2008-2009

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 2008–2009 DHS budget and legislative package. This effort toward cooperation is greatly appreciated. Counties understand that the underfunding of DHS programs creates major issues that must be addressed by county resources if an acceptable quality-of-life is going to be maintained for local citizens. Our recommendations are broken into the following categories:

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES FUNDING AND SERVICES

In order for the State of Iowa to realize either the system redesign proposed by the MH/DD Commission or the Mental Health Systems Improvement currently being developed, there must be adequate state funding to support system change. ISAC supports the following improvements to the disability service system:

- Allowed growth that takes into account inflation, growth in the numbers served and investments in improvements in the service delivery system;
- A state-county cooperative effort to manage increased Medicaid costs including the adoption of a uniform cost report for services funded by both counties and the state;
- Maintenance of Medicaid-funded case management services for persons with disabilities;
- Continued sufficient funding of the state payment program to allow the county of residence to provide the same services at the same reimbursement rate to persons with no county of legal settlement;
- Development of a timeline for moving the management of Medicaid and institutional state cases along with the associated funding to the county of residence; and
- Adequate funding of technical assistance and oversight of the Medicaid program, most critically the Habilitation Services and Home and Community Based Services (HCBS) in congregate living settings.

The county-managed MH/DD system has experienced a significant problem in prior budget years with ensuring that its budget needs are forwarded in a timely manner to the Governor. The DHS Council could alleviate this problem by addressing this issue in their budget recommendation this year. The growth allocation for FY '09 is 3%; the Council can compare this with the projected Medicaid budget increases to determine whether this will be enough to keep counties from having to cut services.

ISAC has aggressively pursued redesign of the Iowa MH/DD/BI system. This pursuit is an attempt to create a quality system for Iowans with disabilities by enhancing their quality of life and self-sufficiency. To help facilitate this system redesign, ISAC adopted a proposal that includes the following interdependent components:

- Standardization of clinical and financial eligibility;
- A defined set of core community-based services;
- Transition from the concept of legal settlement to one of residency;
- Increased utilization of federal funding for disability services;
- Creation of a funding formula that is directly linked to the individual receiving services;
- Expansion of the state-operated risk pool and creation of local risk pools; and
- Define/redefine roles of the state and counties in the management of the system

DISPUTED BILLINGS

For many services provided to persons with disabilities, the Department charges all or part of the cost back to the county. DHS does not have an adequate system to resolve bills which a county disputes. In 2001, the Legislature ordered DHS to forgive all bills for services prior to July 1, 1997, if the county had properly disputed the bill. Unless dramatic improvements are made in the DHS processes, ISAC supports the development of a process to move the date for writing off bills from July 1, 1997, to July 1, 2002. In addition, ISAC supports legislative changes which would require DHS to respond to disputed billings in a timely manner, to allow credits from one institution to be used against charges at another institution, and to clarify that any offset process only be used within a specific county fund (e.g. MH/DD Services Fund, General Fund, etc.).

ISAC has offered to work with the Department to improve the accuracy of the Medicaid billings.

CHAPTER 812 COMMITMENTS

The lack of clarity as to responsibility for the costs of Chapter 812 commitments continue to add to the disputed billings concerns. ISAC supports legislation clarifying that the cost of evaluation and restoration of competence to stand trial pursuant to Iowa Code chapter 812 is a state funding responsibility. Many counties refuse to pay these costs out of their MH/DD funds and the state is collecting less than $1M per year while the rest remains on the books in dispute.

INSTITUTIONAL PLACEMENT OF CHILDREN

The placement by the Department of Human Services of children in institutional settings creates problems for counties when those children reach majority. Since they are already placed and families are comfortable with those placements, moving to more community-based options is problematic. It would be very helpful if the department used those placements much more sparingly and encouraged more use of home and community based services for children.

Preparation, Participation and Power.

July 6, 2007

TO: Iowa Council on Human Services Members

FROM: Becky Harker, Executive Director

RE: SFY 2009 Budget Testimony

Thank you for the opportunity to offer suggestions as you develop your budget recommendations for FY 2009. The Governor's DD Council is a federally funded state agency designed 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 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 Council continues in the areas of self-determination and community inclusion with an emphasis on increasing the capacity of all Iowans affected by disability to effectively advocate for policy and funding that promote empowerment, choice and inclusion in natural community settings.

Current circumstances are especially challenging for many Iowans with disabilities and their families. The demand for State Medicaid waiver services is at an all-time high. Inadequate funding has resulted in growing waiting lists that severely limit access to needed home and community based services. Many Iowans with disabilities and their families, having exhausted all their community-based options are forced to consider institutional care. Meanwhile the county-managed mental health and disability services system has been squeezed financially. State law limits the amount of county funds for the services system; state funding for growth in that system was reduced in 2001 and allowed growth appropriations in recent years have failed to keep up with inflation and increasing numbers of new individuals seeking services. The result has been more county waiting lists and fewer choices for people with disabilities and families. The General Assembly tackled this issue during their 2007 session and restored a significant portion of the $23 million shortfall in Mental Health and Disability Services growth funds needed to avoid significant reductions in

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services and eligible populations. Their action relieved the immediate stress on county budgets and the lives of those most immediately affected by the crisis but the remaining gaps underscore the extent of both the problem and the need. We look to you and to the Department to lead the effort to fill those gaps with budget and policy recommendations that:

- Continue the effort to refocus Iowa's MH/MR/DD/BI system by shifting policy and funding toward a more equitable community-based system that is more focused on consumer choice and results.

- Fully fund and target MH/MR/DD Allowed Growth to ensure that funds are directed where they are most needed – to consumers living in counties that use their money each year and maximize local resources.

- Create access to needed services and supports by fully funding the state's Medicaid waiver waiting lists.

This crisis wasn't created overnight and most Iowans with disabilities don't expect an overnight "fix". What they do expect is responsible public policy that respects individual choice and promotes opportunities for independence. We sincerely appreciate your contributions to the effort and hope that you'll join us in supporting the development of policy and budgeting that reduces institutional bias and creates real choice for and access to community-based service alternatives.

Iowa Nurses Association
100 Years of Nursing Advocacy
1904-2004

STATEMENT TO THE IOWA COUNCIL ON HUMAN SERVICES
Fiscal Year 2009 Budget Recommendations and Legislative Package

July 11, 2007

1. 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 certain medications to be used under certain conditions that in an alternate setting would be able 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.

2. Evaluate time devoted to certify and recertify changes in dosages for psych-mental health clients.
This requirement adds to the cost of doing business for private practitioners and is a deterrent to provision of services to Medicaid clients. We encourage an analysis of the time spent and the administrative costs of such requirements.

3. Dental care access
Dental health is an important aspect of total physical health. We were pleased for children that dental screening will occur in schools. Preventive care is important to preserving total physical health and saves money in the long run.

We strongly encourage funds be set aside for school nurses to access to assist children who need screening and services.

4. Accurate Identification and Analysis of Medicaid Claims Data submitted by ARNPs
It has been four 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.**

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.

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 which under represents the care and services ARNPs are providing to the Medicaid population already.

July 11, 2007

Mr. Kevin Concannon
Director of Iowa Department of Human Services
Hoover State Office Building
1305 E. Walnut
Des Moines, IA 50319

RE: Family Planning Services

Dear Director Concannon:

Thank you for providing Planned Parenthood of Greater Iowa (PPGI) the opportunity to present strategies to improve access to family planning services in Iowa. It is our hope that Iowa can assist women in need of family planning services in the coming budget year by expanding funds for family planning services in your annual budget proposal for the reasons set forth in this letter. We are proposing an increase in the rate of Medicaid reimbursement for family planning services only and we are proposing a new initiative to establish a bridge fund to close the gap created by the federal citizenship documentation requirements in the Medicaid family planning program.

Medicaid Family Planning Rate Increase

The federal share of family planning services provided in the Iowa Medicaid Program is 90%. The current levels of reimbursement are a disincentive to service provision. We propose a 25% increase to expand provider participation and enhance service availability throughout the state. The Iowa share of this increase is 10% of the effort, and translates into only a 2.5% increase in state cost of supplying the limited range of services defined as family planning. There is no better return on state dollar investment than the 90/10 federal state match to assure access to unintended pregnancy prevention.

Medicaid Bridge Funding

Another significant deterrent to accessing health care services for low income families comes from the current federal citizenship documentation requirements. These requirements are restricting, and in many cases denying, access to services for minors and low-income Iowa women. It often has the effect of driving the patient away entirely. We recommend the state allocate funds so that a rotating fund – a bridge – can be established to allow family planning clinics to provide services to an individual with incomplete documentation until such time as that documentation can be procured and Medicaid reimbursement can begin. Once Medicaid approval is granted to the client through the existing mechanisms, the family planning clinics would reimburse the fund using those same existing mechanisms.

The Center on Budget and Policy Priorities (CBPP) estimates that this citizenship documentation policy has resulted in loss of a wide variety of health care services to hundreds of thousands of

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American citizens. This group undoubtedly includes a significant number of teens and low-income Iowa women who go without family planning services, and thus at increased risk of unintended pregnancy. PPGI's goal is to continue to provide those services without delay while the application process can be completed.

The negative consequences of unintended pregnancy, especially among teens and low-income women, are severe for the parents, the children, and the state. Parents in these circumstances are far less likely to find ways out of poverty, and teen parents often find themselves with serious obstacles to continuing their education. Children born into these circumstances are often unable to escape this cycle of poverty, and face increased risk of criminal behavior, substance abuse, and other social problems.

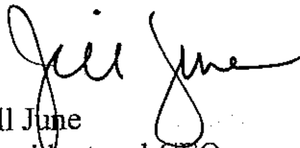
For the state, significant funds will be expended through Medicaid and other entitlement programs to care for both the expectant mothers and their new children. According to data from a number of studies, including data cited in the findings of pending federal legislation, government saves at least $3 for every dollar spent on family planning. Put another way, the State of Iowa is going to spend money on this group one way or another. The state will simply be spending a smaller amount by providing immediate access to preventative measures now, rather than spending far more for years to come in subsidies for the care of children of teen and low-income mothers.

This fits directly into the Governor's health care proposal, and its intent of responsible, preventive health care to decrease costs and increase quality. The Governor states as a goal the desire to reduce our health care costs through preventive care so that less medical care will be required overall. He expresses concern over the shifting of health care costs and its drag on the Iowa economy. PPGI shares those concerns, and as a result urges action that will allow its clinics to provide the necessary family planning services that will allow at-risk women to avoid unintended pregnancy.

Again, it is our hope that DHS can assist Iowa's family planning clinics with this initiative by including it in the annual budget proposal to the Governor. There are many citizens in this state that depend on this action for quality health care.

Thank you for your time and your serious consideration.

Sincerely,



Jill June
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How a Family Planning Bridge Fund Could Function

BACKGROUND

The State of Iowa currently spends $0.00 in state funds for family planning services, other than the federally required match for Medicaid. This means that there is no state supported alternative to federal programs like Medicaid that can cover all or part of the cost of family planning services for low-income Iowans. This leaves Medicaid as the essential program in Iowa for providing the kinds of services that will keep rates of unintended pregnancy down, especially among teens and those at or near the poverty line.

Currently, the responsibility to establish the federal citizenship requirements for Medicaid rests with the various health care providers. We see about a third of our clients completing the necessary paperwork within the first month of service and successfully enroll in the Medicaid program. The rest of our clients, who are valid US citizens, struggle with producing the documentation. This struggle exists for a variety of reasons, but we've found that it takes about three months of our staff working with the clients to gather all the necessary documentation and provide this to Medicaid. So, for three months, clients who want access to birth control are charged full price for services which they cannot afford. (This is in accord with the requirement of Title X clinic status that you must charge full price if a person doesn't qualify. In this instance they do not qualify because they have access to a source of third party payment – Medicaid – and because of incomplete paperwork they are not able to use that source.)

The consequence of this is that these patients can't afford birth control services, don't pay the provider, and don't return for ongoing birth control services. This puts the woman at greater risk for an unwanted pregnancy, leaves the provider with a loss of reimbursement for services already provided, and impedes the ability of the State to fulfill the goals set out in the Medicaid Waiver application. In non-Title X sites services may be deferred until the necessary paperwork is received. This protects the provider from incurring expenses that will never be reimbursed, however the patient is at risk for an unwanted pregnancy.

HOW THE BRIDGE FUND COULD WORK

The "bridge fund" concept would use existing systems in place for processing Medicaid reimbursement by allowing clinics to use state dollars for three to four months to provide the services, while working with the clients to establish the federal citizenship requirements. It is in everyone's best interest to qualify these patients, as this will help at the clinic level, the state level, and at the level of the greater good of our society. Once qualified with Medicaid, the clinic will get the Medicaid dollars to cover those costs and reimburse the state fund, so those dollars are available to aid the next client who comes in and struggles with the citizenship requirements.

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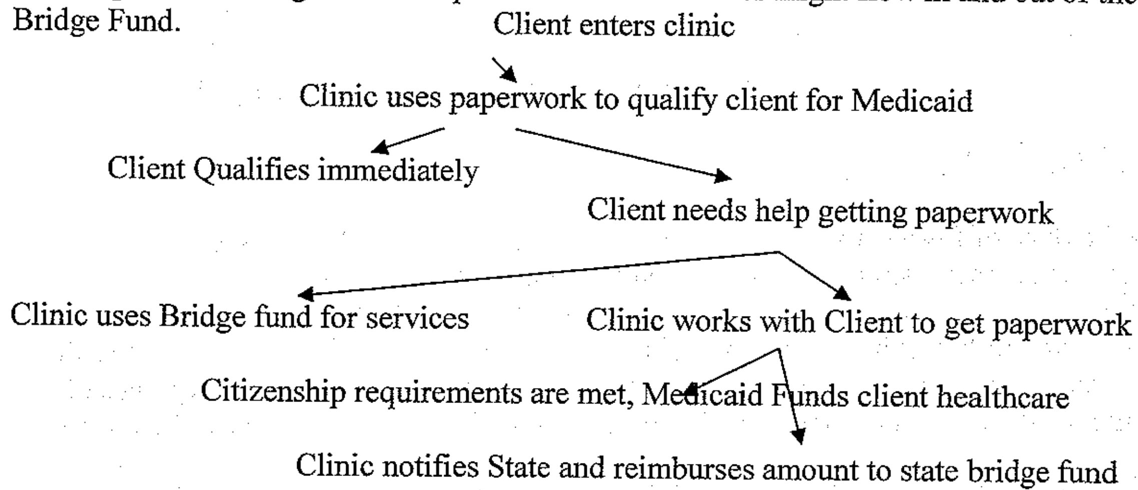
The diagram following is an example of how the resources might flow in and out of the Bridge Fund.



SUMMARY

By establishing a Bridge Fund for the purpose of securing documentation for those clients who qualify for the Medicaid Family Planning Waiver, the State of Iowa will meet the agreed upon goal of assisting low income women and their families in reducing unwanted pregnancies. As a consequence, the State will also reduce greater costs to the State and to Medicaid for the children born to low income women.

Testimony submitted to
The Iowa Council on Human Services, July 2007
by FutureNet, The Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health

Community Adolescent Pregnancy Prevention

Between 1991 and 2004, the teen birth rate in Iowa declined 26 percent. The progress Iowa has made in reducing teen childbearing saved taxpayers an estimated $40 million in 2004 alone. Even so, a recent analysis* from the National Campaign to Prevent Teen Pregnancy shows that teen childbearing (teens 19 and younger) in Iowa cost taxpayers (federal, state, and local) at least $82 million in 2004 in services to these young families.

Of the total 2004 costs in services to families parented by teens, 42% were federal costs and 58% were state and local costs. Most of these service costs reflect the tremendous social, educational, and healthcare burdens born to young families who live in communities that not only fail to fully invest in proven effective prevention programs, but that also fail to adequately invest in programs that will ensure the ultimate success of teen parents and their children. In 2004, Iowa taxpayer costs for services to children of teen mothers (whose male partners may be teen or adult men) included: $14 million for public health care (Medicaid and hawk-i); $32 million for child welfare; $13 million for incarceration; and $22 million in lost tax revenue due to decreased earnings and spending.

In 2004, Iowa invested $1,379,134 ($1,065,450 federal dollars through Temporary Assistance for Needy Families (TANF) / $313,684 local match) in community-based teen pregnancy prevention through its Community Adolescent Pregnancy Prevention (CAPP) grant program, administered through the Iowa Department of Human Services. Since 1988, CAPP grantees have worked collaboratively in their communities to design and deliver teen pregnancy prevention programs and services. In 2004-2005, over 50,800 teens were served. Further, sixteen years of program evaluation by the University of Iowa consistently show evidence of a decline in teen pregnancy rates in those counties served by CAPP programs. Still, only 54 of Iowa's 99 counties were served at least partially by that program, leaving 45 counties and even more communities with no state funding for teen pregnancy prevention. Moreover, there is no requirement that CAPP grantees use science-based strategies in their teen pregnancy prevention efforts or discuss contraception and abstinence, as recommended by several leading medical associations.

We know that the greatest return on our investment in adolescent pregnancy prevention comes when teens participate in programs that have a proven effective impact based on accepted standards of evaluation. Increased and ongoing investment in science-based strategies for teen pregnancy prevention programs will result in further declines in teen pregnancy as well as further reduce the costs of teen childbearing. In addition, sustained investment in family planning services to teens will continue to play an important role in the decline of Iowa's teen birth rate.

With this in mind, FutureNet requests your support to allow the Community Adolescent Pregnancy Prevention Grant program to have a greater impact in reducing and eventually eliminating teen pregnancy in our state.

1. **Support an increase in funding to the Community Adolescent Pregnancy Prevention Grant program so that proven effective prevention and intervention programs can serve teens in all 99 Iowa counties.**
2. **Participate in a consortium of key players in our state's field of adolescent sexual health, convened by FutureNet, who will establish reasonable basic standards of science-based practices that can be accomplished by all providers of sexual health education in Iowa, including CAPP grantees and Iowa schools.**

For further information, contact Rhonda Chittenden, Executive Director
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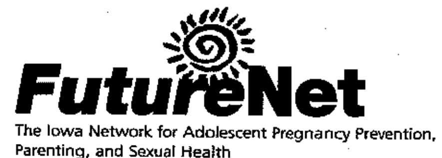

*To read the full report, "By the Numbers: The Public Costs of Teen Childbearing in Iowa, November 2006" by the National Campaign to Prevent Teen Pregnancy, go to www.teenpregnancy.org or contact FutureNet.