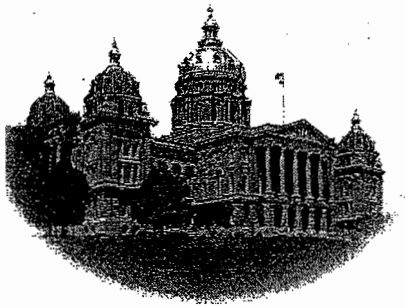
Legislative Services Agency

HANDOUTS

Long-Term Care System Task Force

September 16, 2004

Background Information on Long-Term Care
Compiled by Patty Funaro, Senior Legal Cousel, Legislative Services Agency



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September 7, 2004

TO: MEMBERS OF THE LONG-TERM CARE SYSTEM TASK FORCE

FROM: PATTY FUNARO, SENIOR LEGAL COUNSEL, LEGISLATIVE SERVICES AGENCY

RE: LONG-TERM CARE SYSTEM TASK FORCE INFORMATION

I. Background of Long-Term Care Task Force.

Senate File 2190 (**attachment 1**) established goals and benchmarks for the Iowa long-term care system. Senate File 2190 also established a long-term care task force to provide recommendations and strategies in developing the long-term care system. The Governor vetoed the bill, and in his veto message (**attachment 2**) directed the Departments of Elder Affairs, Human Services and Inspections and Appeals to make recommendations for improvements in the long-term care system to be submitted in a written report no later than October 1, 2004.

The Legislative Council authorized the establishment of a Long-Term Care Task Force. The Task Force is authorized to have three meetings and has the following charge:

Charge: Develop a list or priorities to realize the goal of the long-term care system in Iowa, recommend strategies to implement the list of measurable priorities, recommend immediate and long-range steps to be taken in realizing the system goal, recommend any legislation needed to implement the task force report and system goal, and recommend strategies regarding the use of a universal assessment and counseling tool to assist individuals in making appropriate use of long-term care options.

II. Recent History of Long-Term Care Legislation in Iowa.

During the 2003 and 2004 Sessions of the 80th Iowa General Assembly, the following legislation was approved relating to long-term care and services for elders:

2003 SESSION:

SENATE FILE 416 - Dependent Adult Abuse - Facilities, Services, and Information

This Act relates to dependent adult abuse, including elder abuse, emergency shelter, and support services projects.

The Act directs the Department of Elder Affairs (DEA) to identify area agencies on aging to implement the projects. The target population of the projects is elders who are subjects of reports of suspected dependent adult abuse and who are not receiving assistance under a county management plan. The Act directs DEA to award funds for the projects in accordance with the state's service contract process.

The Act also includes provisions relating to reports of dependent adult abuse. The Act allows an agency approved by the Department of Human Services (DHS), not solely the department, to complete assessments of necessary services and make appropriate referrals following a report of suspected dependent adult abuse. The Act authorizes access to founded and unfounded dependent adult abuse information to an employee of an agency requested by DHS to provide case management or other services to the dependent adult and to the Long-Term Care Resident's Advocate when the dependent adult resides in a long-term care facility or when the alleged perpetrator is an employee of a long-term care facility.

The Act provides that dependent adult abuse information determined by a preponderance of the evidence to be founded is to be sealed 10 years after the receipt of the initial report, unless good cause is shown why the information should remain available. Current law provides that information relating to particular cases of suspected dependent adult abuse is subject to the 10-year time frame. Additionally, under current law, if a subsequent report of a suspected case of dependent adult abuse involving the same dependent adult or alleged perpetrator is received by the registry within the 10-year period, the information in both reports is then to be sealed 10 years after receipt of the subsequent report unless good cause is shown. Under the Act, this timeframe relates only to a subsequent report of founded dependent adult abuse.

The Act eliminates the provision that dependent adult abuse information which cannot be determined by a preponderance of the evidence to be founded or unfounded is to be expunged one year from the date of the initial report. The Act provides instead that dependent adult abuse information which is determined by a preponderance of the evidence to be unfounded is to be expunged one year from the date it is determined to be unfounded, rather than immediately upon determining that it is unfounded.

The Act also provides that if a correction of dependent adult abuse information is requested and the information is determined to be unfounded, the information is to be expunged one year from the date it is determined to be unfounded, rather than immediately.

HOUSE FILE 386 - Policy and Services for the Elderly

This Act relates to the Department of Elder Affairs (DEA) and the Elder Iowans Act. The Act amends definitions and other provisions to be consistent with the federal Older Americans Act and specifies the programs and services that DEA is to provide or administer.

The Act specifies that the Long-Term Care Resident's Advocate is to advocate for residents of long-term care facilities excluding those facilities licensed primarily to serve persons with mental retardation or mental illness. The Act decreases the number of times that the Commission on Elder Affairs is required to meet from six to four times annually. The Act eliminates the Elder Law Education Program, which ended operation in FY 1992-1993 due to discontinuation of the appropriation; eliminates the role of DEA in the representative payee program, which is currently sponsored locally; eliminates the directive to DEA to develop and disseminate information regarding Medicare supplemental insurance policies as this function is performed by the Insurance Division of the Department of Commerce; and makes conforming changes.

HOUSE FILE 558 - Disclosure of Information to Subjects of Child or Dependent Adult Abuse Reports

This Act authorizes the Department of Human Services to disclose information regarding the listing of an individual in the Child or Dependent Adult Abuse Registry or the Sex Offender Registry when the disclosure is necessary for the protection of a child or dependent adult. The disclosure is limited, as applicable, to persons who are the subject of a child abuse report (the child, child's parent, guardian, or legal custodian, person named in the report as having committed the abuse, and attorneys for these persons) or the subject of a dependent adult abuse report (the dependent adult, adult's guardian, custodian, or guardian ad litem, person named in the report as having committed the abuse, and attorneys for these persons).

HOUSE FILE 560 - Medical Assistance - Home and Community-Based Services

This Act relates to home and community-based services (HCBS) waivers under the Medical Assistance (Medicaid) Program.

The Act, in part, provides that a case manager for an HCBS waiver may terminate the contract of a person providing consumer-directed attendant care services if the case manager determines that the person has breached the contract by not providing the services agreed to under the contract.

HOUSE FILE 672 - Adult Day Services

This Act establishes regulatory provisions for adult day services.

Under prior law, provisions relating to regulation of adult day services consisted of development of a system of oversight by affected state agencies, industry representatives, and consumers under the Department of Elder Affairs (DEA).

Under the Act, new Code Chapter 231D is created to provide for the regulation of adult day services under DEA with enforcement provided by the Department of Inspections and Appeals (DIA). The Act directs DEA to establish a program for certification and monitoring of, and complaint investigations related to, adult day services. The rules and standards are to be formulated in consultation with DIA and affected industry, professional, and consumer groups. In addition to rules, interpretive guidelines are also to be issued. The Act requires all adult day services programs to be certified by DIA. The Act establishes application and fee requirements; provides a procedure for denial, suspension, or revocation of certification; provides an appeals process, emergency provisions, and for conditional operation of a program; provides for DIA to be notified of casualties relative to an adult day services program; provides a complaint process; provides for disclosure of final findings by DIA related to monitoring evaluations or complaint investigations; provides penalties for noncompliance with certification requirements and enforcement of the provisions of the chapter; prohibits retaliation by an adult day services program; provides for nursing assistants and medication aides to claim work within adult day services programs as credit toward certification; and provides for fire and safety standards.

The Act also requires DIA, in consultation with DEA and the Department of Public Safety, to submit a written report to the General Assembly and the Joint Appropriations Subcommittee on Health and Human Services regarding implementation of the Act. The Act also provides that if an adult day services program for persons with mental retardation is voluntarily accredited prior to July 1, 2003, DIA is to accept the voluntary accreditation as the basis for certification for the period beginning July 1, 2003, and ending June 30, 2004. This provision takes effect May 30, 2003.

HOUSE FILE 675 - Regulation of Elder Family Homes, Elder Group Homes, and Assisted Living Programs Fire and Safety Standards

This Act provides for regulation of elder group homes and assisted living programs and eliminates the Code chapter relating to elder family homes.

The Act provides for regulation of elder group homes by the Department of Elder Affairs (DEA) and for inspection and certification of elder group homes by the Department of Inspections and Appeals (DIA). The Act changes the definition of "elder group home" to mean a single-family residence operated by a person, rather than being the residence of the person providing the room, board, and personal care to elders. The Act also provides that rather than being owner-occupied or owned by a nonprofit corporation and occupied by a resident manager, the elder group home is required only to be staffed by an on-site manager 24 hours per day, seven days per week.

The Act provides for regulation of assisted living programs. The Act requires DEA to establish policy and DIA to provide enforcement with regard to assisted living programs. The Act defines assisted living programs as those programs providing housing with services to three or more tenants, rather than to six or more tenants as under prior law. Division III of H.F. 683 revised provisions of this Act relating to continuing care retirement communities as follows: Language enacted in this Act, H.F. 675, relating to continuing care retirement communities (CCRCs), provides that a CCRC that complied with the chapter of the Code relating to retirement facilities (Code Chapter 523D) would

not be held in violation of the assisted living program chapter if the CCRC provides services to independent living residents. The provision in H.F. 683 provides instead that a CCRC may provide limited personal care and emergency response services to its independent living tenants under certain conditions.

The Act directs DEA to establish, by rule, a program for certification and monitoring of assisted living programs. The rules are to be formulated in consultation with DIA and affected industry, professional, and consumer groups. In addition to the adoption of rules, DEA is also to issue interpretive guidelines. Each assisted living program in the state is to be certified by DIA. If an assisted living program is voluntarily accredited by a recognized accrediting entity, DIA is to certify the program based upon the voluntary accreditation. The Act provides that DEA may establish, by rule, a special classification for affordable assisted living programs and is to adopt rules regarding the conducting or operating of another business or activity in the distinct part of the physical structure in which the assisted living program is provided.

The Act specifies requirements for written occupancy agreements and provides a process for involuntary transfer of a tenant. The Act provides for filing and disposition of complaints; provides for an informal review of contests to the results of a monitoring evaluation or complaint investigation; provides for public disclosure of the final findings of a monitoring evaluation or complaint investigation; provides the bases for denial, suspension, or revocation of certification and for conditional operation of a program; provides for notice, appeal, and emergency provisions relating to a denial, suspension, or revocation of certification; provides for notification of DIA of any casualties at an assisted living program; prohibits retaliation by the program; provides for application of civil and criminal penalties for certain violations and for injunctive relief; provides for nursing assistants and medication aides to claim work within an assisted living program as credit toward their certification; provides transitional provisions; establishes certification and related fees; provides that the Uniform Residential Landlord and Tenant Act applies to assisted living programs; and provides for transition of departmental staff.

2004 SESSION:

SENATE RESOLUTION 180 - This resolution requests the Senate leadership to establish a blue ribbon elder services planning group to develop a plan for unifying the state administration of services utilized by elderly Iowans who are age 60 or older. **(attachment 3)**

SENATE FILE 2183 - Long-Term Care Asset Disregard Incentive Program - VETOED BY THE GOVERNOR

This bill would have established an Iowa Long-Term Care Asset Disregard Incentive Program administered by the Department of Human Services and the Insurance Division of the Department of Commerce.

HOUSE FILE 2146 - Sex Offender Registration Requirements - Incest Committed Against Dependent Adult

This Act requires a person who is convicted of incest against a dependent adult as defined in Code Section 235B.2 to register as a sex offender. Under current law, only a person who commits incest against a minor has to register as a sex offender.

HOUSE FILE 2378 - Medical Assistance Trusts - Payment Rates

This Act relates to the income limits for medical assistance income trusts, also known as Miller Trusts. In order to qualify for payment of nursing facility care under the Medical Assistance (Medicaid) Program, a person must have income that is less than three times the federal Supplemental Security Income Program's benefit level. Many individuals have too much income to qualify for Medicaid payment of facility care, but have too little income to pay for the care. Federal law requires states to cover nursing facility care for individuals with income over the income limit by allowing for the establishment of a specific type of trust (medical assistance income trust in Iowa) to allow for the diversion of income. Because monthly income paid into the trust is not counted in determining the individual's income, the individual can then meet Medicaid Program eligibility requirements.

Medical assistance income trusts have requirements as to the disposition of payments made from the trust. In determining the disposition of payments from the trust, the average statewide charge for certain types of care is utilized. Under current law, the levels of care referenced do not reflect recent changes made in the Medicaid reimbursement system. Under this Act, the levels of care are changed to reflect the current reimbursement system and to allow higher rates for special types of care to be taken into consideration in determining disposition of payments from the trust. The Act eliminates two levels of care related to skilled nursing facility care and provides for a determination of the charge for care or specialized care provided in a nursing facility. Specialized care includes such care as Alzheimer's care received by an adult, skilled nursing facility care received by a child, or skilled nursing facility care for neurological disorders received by a child or an adult.

HOUSE FILE 2514 - Dementia-Specific Alternative Living - VETOED BY THE GOVERNOR

This bill related to the implementation of a pilot project for dementia-specific alternative living.

SENATE FILE 2298 - Government Funding, Administration, and Regulation - Appropriations and Miscellaneous Changes

Division VI of this Act, Senior Living and Hospital Trust Funds, provides, in part, for a new Code provision creating a Senior Living Revolving Loan Program Fund to provide financing for the construction of affordable assisted living and service-enriched affordable housing for seniors and persons with disabilities and creates a Home and Community-Based Services Revolving Loan Program Fund to further the goals of DEA, adult day services, respite services, and congregate meals by expanding facilities and infrastructure that provide adult day services, respite services, and congregate meals that address the needs of persons with low incomes. **(attachment 4)**

III. Attachments.

The following documents are attached to this background statement:

- Attachment 1: Senate File 2190: Establishing a Long-Term Care Task Force.
- Attachment 2: Governor's veto message for Senate File 2190.
- Attachment 3: Senate Resolution 180: Requesting the Senate leadership to establish a blue ribbon elder services planning group.
- Attachment 4: Senate File 2298, Division VI, establishing Code section 16.183, Home and Community-Based Services Revolving Loan Program Fund.
- Attachment 5: Listing of the types and capacity of long-term care options for elders regulated by the Iowa Department of Inspections and Appeals.
- Attachment 6: A Profile of Older Americans: 2003, compiled by the U.S. Department of Health and Human Services, Administration on Aging.
- Attachment 7: Long-Term Care in Iowa Long-Range Plan materials, provided by the Iowa Department of Elder Affairs.
- Attachment 8: Materials provided by the Iowa Department of Human Services.
- Attachment 9: Materials provided by the Iowa Department of Public Health.
- Attachment 10: Materials provided by the Iowa Department of Inspections and Appeals.

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Senate File 2190

PAG LIN

SENATE FILE 2190

AN ACT

RELATING TO THE DEVELOPMENT OF THE LONG=TERM CARE SYSTEM IN IOWA.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. GOAL OF IOWA'S LONG=TERM CARE SYSTEM. The general assembly finds and declares that the goal of Iowa's long=term care system is to ensure residents access to an extensive range of high=quality long=term care options that maximize independence, choice, and dignity through the development of a comprehensive system of community=based and institutional long=term care options that provide affordable, high=quality, cost=effective services and other supports delivered in the most integrated, life=enhancing setting. The general assembly finds and declares that information regarding all components of the long=term care system must be effectively communicated to all those potentially impacted by the need for long=term care in order to empower consumers to make decisions about how best to meet their own long=term care needs.

Sec. 2. BENCHMARKS. The following benchmarks shall be used in measuring the state's progress in realizing its goal for the long=term care system:

1. Reducing the number of nursing home beds from the current ninety=one per one thousand persons for individuals sixty=five years of age or older.

2. Increasing the percentage of Medicaid long=term care dollars expended on community=based services.

3. Increasing the proportion of Medicaid long=term care dollars expended on consumer=directed care.

4. Increasing the percent of providers having and using consumer satisfaction surveys.

5. Reducing the use of nursing homes for individuals sixty=five years of age and older who have relatively few disabilities.

6. Improving satisfaction with the long=term care system by both providers and consumers.

7. Increasing the proportion of frail elders receiving assistance from family caregivers.

8. Increasing the proportion of Iowans with private long=term care insurance coverage.

Sec. 3. LONG=TERM CARE SYSTEM TASK FORCE.

1. A long=term care system task force is created consisting of the following members:

a. Five members of the senate and five members of the house of representatives, serving as voting members. The legislative members shall be appointed by the majority leader of the senate, after consultation with the president of the senate and the minority leader of the senate, and by the speaker of the house, after consultation with the majority leader and the minority leader of the house of representatives. Appointments shall comply with sections

69.16 and 69.16A. Vacancies shall be filled by the original appointing authority and in the manner of the original appointment.

b. A representative of the governor's office, serving as an ex officio, nonvoting member.

c. An individual with expertise in long=term care, selected by the legislative council, serving as an ex officio, nonvoting member.

d. The director of human services, the director of public health, the director of the department of elder affairs, and the director of the department of inspections and appeals, or the directors' designees, serving as ex officio, nonvoting members.

2. Nonlegislative members shall receive actual expenses incurred while serving in their official capacity. Legislative members shall receive per diem compensation and expenses pursuant to section 2.12.

3. The individual with expertise in long=term care, selected by the legislative council, shall act as chairperson of the task force. A majority of the voting members of the task force shall constitute a quorum.

4. The task force shall submit a report to the general assembly by December 15, 2004, which includes all of the following:

a. A list of priorities developed by the task force to realize the stated goal of the long=term care system in Iowa.

b. Strategies recommended by the task force to implement the priorities listed that are measurable utilizing the benchmarks established.

c. Recommendations of immediate and long=range steps to be taken in realizing the goal of the long=term care system.

d. Any recommendations of legislation necessary to implement the work of the task force and to realize the goal of the long=term care system in Iowa.

e. Strategies recommended by the task force regarding the use of a universal assessment and counseling tool to assist individuals in making appropriate use of long=term care options.

JEFFREY M. LAMBERTI
President of the Senate

CHRISTOPHER C. RANTS
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 2190, Eightieth General Assembly.

MICHAEL E. MARSHALL
Secretary of the Senate

Approved _____, 2004

4 11 THOMAS J. VILSACK
4 12 Governor

The Iowa Legislature
General Assembly

Veto Message

May 14, 2004

The Honorable Chester Culver
Secretary of State
State Capitol Building
L O C A L

Dear Mr. Secretary:

I hereby transmit Senate File 2190, an Act relating to the development of the long-term care system in Iowa.

With the establishment of the Senior Living Trust, Iowa began the formation of a three pronged long-term care system Today, in-home care, assisted living, and skilled nursing care are available to Iowans. Iowa must continue the course begun with the Senior Living Trust.

Another task force, especially one that does not draw on the expertise of those providing care or the executive branch department employees involved in elder care, will not improve our current system. The legislation establishes a task force, which is not designed to make meaningful recommendations; and for that reason, I cannot and will not approve Senate File 2190.

What is needed is continued evaluations between the Department of Elder Affairs, Department of Human Services, ar Department of Inspections and Appeals with the assistance of experts in the field of long-term care to make recommendations as to how Iowa could build upon the system already in place. With this veto message, I am directing the department heads from the aforementioned agencies to prepare a joint and agreed upon report with recommendations for improvements to our current long-term care system. I expect that report no later than October 1, 2004. The directors should seek to comply with the spirit of Senate File 2190 by outlining

practices and benchmarks by which to gauge short-term and long-term success.

For the above reasons, I hereby respectfully disapprove Senate File 2190.

Sincerely,

Thomas J. Vilsack
Governor

TJV:jmc

cc: Secretary of the Senate
Chief Clerk of the House

Attachment 3

Senate Resolution 180

Concurrent and Simple Resolutions, and

Conference Committee Reports do not have a Title page

PAG LIN

SENATE RESOLUTION NO.
BY TINSMAN

A Resolution requesting the Senate leadership to establish a blue ribbon elder services planning group to develop a plan for unifying the state administration of services utilized by elderly Iowans who are age sixty or older.

WHEREAS, Iowa's services for persons who are elderly provide an important element in the community life of the state; and

WHEREAS, Iowa's services for these populations, while of high quality, are amenable to improvement through consideration of the state's role in administering the services; NOW THEREFORE,

BE IT RESOLVED BY THE SENATE, That the Senate leadership is requested to establish a blue ribbon elder services planning group to develop a plan for unifying the state administration of services utilized by elderly Iowans who are age sixty or older and the plan should address options for implementing the unification through legislation, funding changes, or other appropriate means and shall address the services paid for or provided to elderly Iowans by the departments of elder affairs, human services, and public health; and

BE IT FURTHER RESOLVED, That the departments that are the focus of the planning process are requested to provide staffing services for the planning group and the plan should be submitted to the Senate when it is completed; and

BE IT FURTHER RESOLVED, That the unification plan should be designed to achieve the following goals:

1. Provide for a more effective delivery of services to persons who are elderly.
2. Create financial efficiencies.
3. Create more accountability; and

BE IT FURTHER RESOLVED, That the appointments necessary for the planning group be made by the Senate Majority Leader in consultation with the Senate Minority Leader and that the membership of the planning group should include the following:

1. The directors of the three departments or the directors' designees.
2. A director of an area agency on aging.
3. A representative of the governor.
4. A representative of the banking industry in this state who has significant experience with reorganization or restructuring of agencies.
5. The chief executive officer of a united way organization located in Iowa.

6. The president of an Iowa resource center for nonprofit organizations.

7. The president of the university of northern Iowa.

8. The chairman of the board of the largest private employer in the state.

9. An individual retired as president of the state's largest private health insurer who has served as mayor of Iowa's largest city.

10. The head of the AARP Iowa chapter.

11. The chief executive officer of an Iowa=based financial services company ranked by Fortune Magazine as sixth among life and health companies.

12. Two members of the senate.

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Attachment 4

Sec. 171. NEW SECTION. 16.183 HOME AND COMMUNITY=BASED SERVICES REVOLVING LOAN PROGRAM FUND.

1. A home and community=based services revolving loan program fund is created within the authority to further the goals specified in section 231.3, adult day services, respite services, and congregate meals. The moneys in the home and community=based services revolving loan program fund shall be used by the authority for the development and operation of a revolving loan program to develop and expand facilities and infrastructure that provide adult day services, respite services, and congregate meals that address the needs of persons with low incomes.

2. Moneys received by the authority from the senior living trust fund, transferred by the authority for deposit in the home and community=based services revolving loan program fund, moneys appropriated to the home and community=based services revolving loan program, and any other moneys available to and obtained or accepted by the authority for placement in the home and community=based services revolving loan program fund shall be deposited in the fund. Additionally, payment of interest, recaptures of awards, and other repayments to the senior living revolving loan program fund shall be deposited in the fund. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys in the home and community=based services revolving loan program fund shall be credited to the fund. Notwithstanding section 8.33, moneys that remain unencumbered or unobligated at the end of the fiscal year shall not revert but shall remain available for the same purpose in the succeeding fiscal year.

3. The authority, in cooperation with the department of elder affairs, shall annually allocate moneys available in the home and community=based services revolving loan program fund to develop and expand facilities and infrastructure that provide adult day services, respite services, and congregate meals that address the needs of persons with low incomes.

4. The authority shall adopt rules pursuant to chapter 17A to administer this section.

Attachment 5

Types and capacity of long-term care options for elders regulated by the Department of Inspections and Appeals
(as provided by DIA health facilities website: https://dia-hfd.iowa.gov/DIA_HFD/Home.do)

NF
"Nursing Facilities" are institutions or distinct parts of institutions housing three of more individuals for a period exceeding 24 consecutive hours, whose primary purpose is to provide health-related care and services, including rehabilitation, for individuals who because of mental or physical condition, require nursing care and other services in addition to room and board. Nursing facilities do not engage primarily in providing treatment or care for mental illness or mental retardation. Definition is found in Chapter 135C of the Code of Iowa.
TOTAL NF = 440
TOTAL CAPACITY OF NF = 32898

CCDI
"Chronic Confusion or Dementing Illness" is a special license classification for nursing facilities or a special unit within such a facility providing care to persons who suffer from chronic confusion or dementing Illness. Reference to Chronic Confusion of Dementing Illness Units is made in the acts and joint resolutions of the 1990 regular session of the Seventy-Third General Assembly of the State of Iowa
TOTAL CCDI = 107
TOTAL CAPACITY OF CCDI = 2143

RCF
"Residential Care Facilities" are institutions, places, buildings, or agencies providing accommodation, board, personal assistance and other essential daily living activities for a period exceeding 24 consecutive hours. Individuals living in a residential care facility are unable to sufficiently or properly care for themselves because of illness, disease, or physical or mental infirmity, but do not require the services of a registered or licensed practical nurse, except for emergencies.
Definition is found in Chapter 135C of the Code of Iowa.
TOTAL RCF = 162
TOTAL CAPACITY OF RCF = 5445

ALP (Assisted Living Program)
ALP-provision of housing with services, which may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living, to three or more tenants in a physical structure, which provides a homelike environment. Includes encouragement of family involvement, tenant self-direction and tenant participation in decisions.
TOTAL ALP = 182
TOTAL CAPACITY OF ALP = 7811

EGH (Elder Group Home)
EGH-a single family residence that is operated by a person who is providing room, board, and personal care to three to five elders who are not related to the person providing the service within the third degree of consanguinity or affinity.
TOTAL EGH = 13
TOTAL CAPACITY OF EGH = 8

HHA

"Home Health Agencies" provide skilled nursing services and at least one of the following other therapeutic services: physical, speech or occupational therapy, medical social services of home health aide services to patients in their residences. The services must follow a written plan of treatment established by each patients attending physician in conjunction with agency staff. Definition is found in Title 42 in the Code of Federal Regulations.

TOTAL HHA = 237

TOTAL CAPACITY OF HHA = 0

HOSPICE

"Hospice" care is an alternative way of caring for terminally ill individuals which stresses palliative care (medical relief of pain) as opposed to curative or restorative care. Hospice care is not limited to medical aspects, but addresses all physical, psychological and spiritual needs of the patient and emotional needs of the patient's family. The emphasis of the hospice program is in keeping the hospice patient at home with his or her family and friends as much as possible. Definition is found in Title 42 in the Code of Federal Regulations and 135J of the Iowa Administrative Code. Hospice licensure is a voluntary licensure program.

TOTAL HOSPICE = 75

TOTAL CAPACITY OF HOSPICE = 58

HOSPITAL

A "swing-bed hospital" is a hospital which has a Medicare provider agreement and meets the following requirements to be granted approval from the Health Care Financing Administration of the U. S. Department of Health and Human Services to provide posthospital extended-care services.

The hospital must have fewer than 100 hospitals beds, excluding beds for newborns; intensive-care beds; certified nursing facility/skilled nursing facility distinct parts; and distinct-part psychiatric and rehabilitation units excluded from the medicare prospective payment plan.

Hospitals with 50-99 hospital beds must have transfer agreements with all skilled nursing facilities within a 50 mile radius of the hospital.

The hospital must be located in a rural area. Rural areas are all areas not delineated as "urban" by the U.S Census Bureau, based on the most recent census.

The hospital has not had swing-bed approval terminated within the two years previous to application.

The hospital Is substantially in compliance with the following skilled nursing facility requirements:

type='a' resident rights;
admission, transfer and discharge rights;
resident behavior and facility practice;
patient activities;
social services;
discharge planning;
Specialized rehabilitative services; and
dental services.

Definition is found in Title 42 in the Code of Federal Regulations.

TOTAL HOSPITAL = 62

TOTAL CAPACITY OF HOSPITAL = 9936

ADS (Adult Day Services)

ADS-an organized program providing a variety of health, social, and related support services for 16 hours or less in a 24-hour period to two or more persons with a functional impairment on a regularly scheduled contractual basis.

TOTAL ADS = 33
TOTAL CAPACITY OF ADS = 0

HSP-NF
A hospital based distinct part nursing facility is a designation of beds by floor, wing or contiguous room designation that denotes an organizational and physical
TOTAL HSP-NF = 18
TOTAL CAPACITY OF HSP-NF = 1041

HSP-SNF
A hospital based distinct part nursing facility is a designation of beds by floor, wing or contiguous room designation that denotes an organizational and physical
TOTAL HSP-SNF = 11
TOTAL CAPACITY OF HSP-SNF = 187

HSP-SNF/NF
A hospital based distinct part nursing facility is a designation of beds by floor, wing or contiguous room designation that denotes an organizational and physical
TOTAL HSP-SNF/NF = 21
TOTAL CAPACITY OF HSP-SNF/NF = 750

ALPD (Assisted living program—dementia specific)
Dementia-specific assisted living program- a program that serves five or more tenants with dementia between Stages 4 and 7 on the Global Deterioration Scale and hold itself out as providing specialized care for persons with dementia in a dedicated setting.
TOTAL ALPD = 13
TOTAL CAPACITY OF ALPD = 663

Attachment 6

A Profile of Older Americans: 2003

Administration on Aging

U.S. Department of Health and Human Services

Table of Contents

Highlights *

- The older population (65+) numbered 35.6 million in 2002, an increase of 3.3 million or 10.2% since 1992.
- The number of Americans aged 45-64 – who will reach 65 over the next two decades – increased by 38% during this decade.
- About one in every eight, or 12.3 percent, of the population is an older American.
- Over 2.0 million persons celebrated their 65th birthday in 2002.
- Persons reaching age 65 have an average life expectancy of an additional 18.1 years (19.4 years for females and 16.4 years for males).
- Older women outnumber older men at 20.8 million older women to 14.8 million older men.
- Older men were much more likely to be married than older women--73% of men vs. 41% of women (Figure 2). Almost half of all older women in 2002 were widows (46%).
- About 31 percent (10.5 million) of noninstitutionalized older persons live alone (7.9 million women, 2.6 million men).
- Half of older women age 75+ live alone.
- Almost 400,000 grandparents aged 65 or more had the primary responsibility for their grandchildren who lived with them.
- By the year 2030, the older population will more than double to 71.5 million.
- The 85+ population is projected to increase from 4.6 million in 2002 to 9.6 million in 2030.
- Members of minority groups are projected to represent 26.4 percent of the older population in 2030, up from 16.4 percent in 2000.
- The median income of older persons in 2002 was $19,436 for males and $11,406 for females. Median money income of all households headed by older people (after adjusting for inflation) fell by –1.4% from 2001 to 2002; however, this difference was not statistically significant.
- The Social Security Administration reported that the major sources of income for older people was:
    - Social Security (reported by 91 percent of older persons),
    - Income from assets (reported by 58 percent),
    - Public and private pensions (reported by 40 percent), and
    - Earnings (reported by 22 percent).
- About 3.6 million older persons lived below the poverty level in 2002. The poverty rate for older persons was 10.4% in 2002 which is not statistically different from the rate in 2001. Another 2.2 million or 6.4% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level).

*Principal sources of data for the Profile are the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics. The Profile incorporates the latest data available but not all items are updated on an annual basis.

The Older Population

The older population--persons 65 years or older--numbered 35.6 million in 2002 (the most recent year for which data are available). They represented 12.3% of the U.S. population, about one in every eight Americans. The number of older Americans increased by 3.3 million or 10.2% since 1992, compared to an increase of 13.5% for the under-65 population. However, the number of Americans aged 45-64 – who will reach 65 over the next two decades – increased by 38% during this period.

In 2002, there were 20.8 million older women and 14.8 million older men, or a sex ratio of 141 women for every 100 men. The female to male sex ratio increases with age, ranging from 116 for the 65-69 age group to a high of 230 for persons 85 and over.

Since 1900, the percentage of Americans 65+ has tripled (from 4.1% in 1900 to 12.3% in 2002), and the number has increased eleven times (from 3.1 million to 35.6 million). The older population itself is getting older. In 2002, the 65-74 age group (18.3 million) was eight times larger than in 1900, but the 75-84 group (12.7 million) was more than 16 times larger and the 85+ group (4.6 million) was almost 38 times larger.

In 2001, persons reaching age 65 had an average life expectancy of an additional 18.1 years (19.4 years for females and 16.4 years for males).

A child born in 2001 could expect to live 77.2 years, about 30 years longer than a child born in 1900. Much of this increase occurred because of reduced death rates for children and young adults. However, the past two decades have also seen reduced death rates for the population aged 65-84, especially for men – by 29.0% for men aged 65-74 and by 22.5% for men aged 75-84. Life expectancy at age 65 increased by only 2.5 years between 1900 and 1960, but has increased by 3.8 years from 1960 to 2001.

Over 2.0 million persons celebrated their 65th birthday in 2002. In the same year, about 1.8 million persons 65 or older died. Census estimates showed an annual net increase of approximately 249,000.

There were 50,364 persons aged 100 or more in 2002 (0.02% of the total population). This is a 35% increase from the 1990 figure of 37,306.

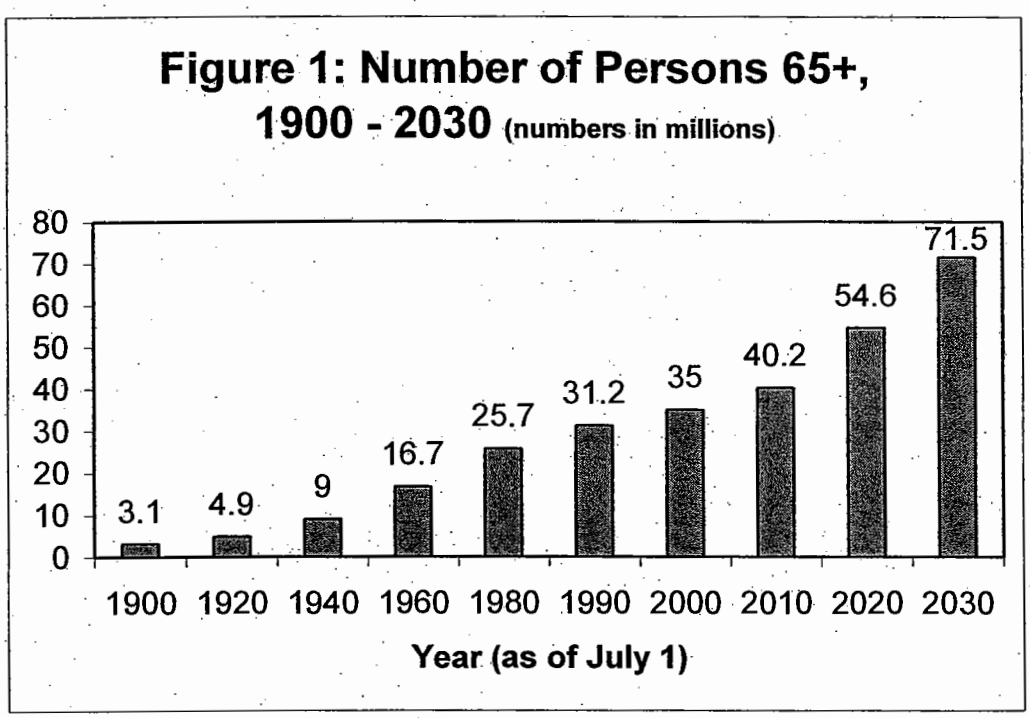
(Data for this section were compiled primarily from Internet releases of the U.S. Bureau of the Census and the National Center for Health Statistics).

Future Growth

The older population will continue to grow significantly in the future (see Figure 1). This growth slowed somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. But the older population will burgeon between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

By 2030, there will be about 71.5 million older persons, more than twice their number in 2000. People 65+ represented 12.4% of the population in the year 2000 but are expected to grow to be 20% of the population by 2030. The 85+ population is projected to increase from 4.6 million in 2002 to 9.6 million in 2030.

Minority populations are projected to represent 26.4% of the elderly population in 2030, up from 17.2% in 2002. Between 2000 and 2030, the white** population 65+ is projected to increase by 77% compared with 223% for older minorities, including Hispanics (342%), African-Americans** (164%), American Indians, Eskimos, and Aleuts** (207%), and Asians and Pacific Islanders** (302%).

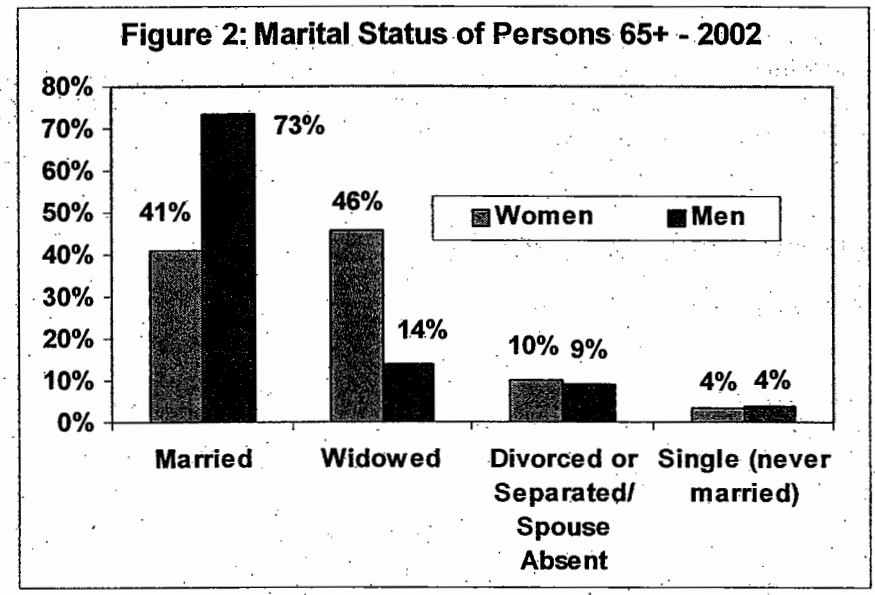


Note: Increments in years are uneven.
(Sources: Projections of the Population by Age are taken from the January 2004 Census Internet Release. Historical data are taken from "65+ in the United States," Current Population Reports, Special Studies, P23-190. Data for 2000 are from the 2000 Census and 2002 data are taken from the Census estimates for 2002.)

Marital Status

In 2002, older men were much more likely to be married than older women--73% of men, 41% of women (Figure 2). Almost half of all older women in 2002 were widows (46%). There were over four times as many widows (8.9 million) as widowers (2.0 million).

Divorced and separated (including married/spouse absent) older persons represented only 10% of all older persons in 2002. However, this percentage has increased since 1980, when approximately 5.3% of the older population were divorced or separated/spouse absent.



(Based on Internet releases of data from the 2002 Current Population Survey of the U.S. Bureau of the Census)

Living Arrangements

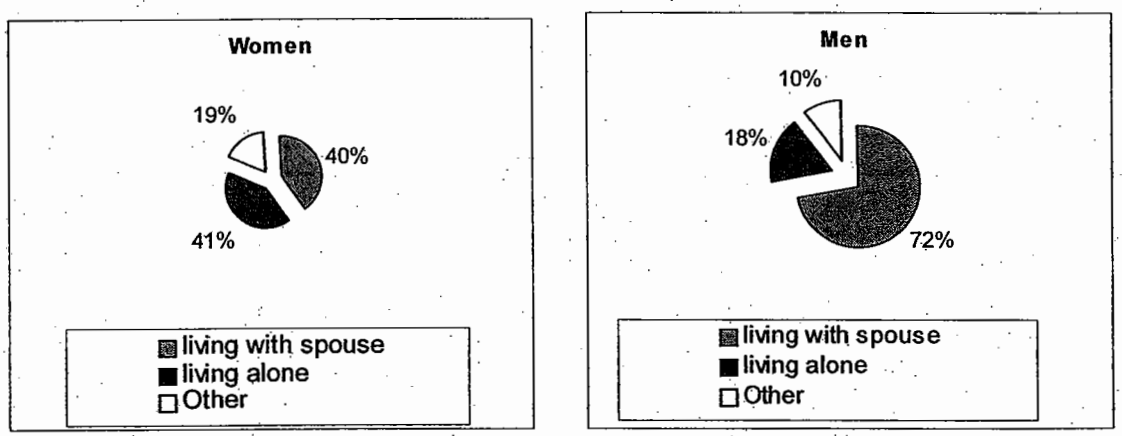
Over half (53.6%) the older noninstitutionalized persons lived with their spouse in 2002. Approximately 10.2 million or 72% of older men, and 7.8 million or 40% of older women, lived with their spouse (Figure 3). The proportion living with their spouse decreased with age, especially for women. Only 28.8% of women 75+ years old lived with a spouse.****

About 30% (10.5 million) of all noninstitutionalized older persons in 2002 lived alone (7.9 million women, 2.6 million men). They represented 41% of older women and 18% of older men. The proportion living alone increases with advanced age. Among women aged 75 and over, for example, half (49.4%) lived alone (in 2000).

About 633,000 grandparents aged 65 or over maintained households in which grandchildren were present in 1997. In addition, 510,000 grandparents over 65 years lived in parent- maintained households in which their grandchildren were present. In 2000, almost 400,000 grandparents over 65 years old were the persons with primary responsibility for their grandchildren who lived with them.

While a relatively small number (1.56 million) and percentage (4.5%) of the 65+ population lived in nursing homes in 2000, the percentage increases dramatically with age, ranging from 1.1% for persons 65-74 years to 4.7% for persons 75-84 years and 18.2% for persons 85+. In addition, approximately 5% of the elderly lived in self-described senior housing of various types, many of which have supportive services available to their residents.

Figure 3: Living Arrangements of Persons 65+: 2002



(Based on data from U.S. Bureau of the Census. See: March 2002 Current Population Survey Internet releases. See also: "America's Families and Living Arrangements; Population Characteristics: June, 2001, Current Population Reports, P20-537" and "The 65 Years and Over Population: 2000, Census 2000 Brief, October, 2001" as well as other Census 2000 data and unpublished data from the Centers for Medicare and Medicaid Services.)

Racial and Ethnic Composition

In 2002, 17.24% of persons 65+ were minorities--8.1% were African-Americans,** 2.7% were Asian or Pacific Islander,** and less than 1% were American Indian or Native Alaskan.** Persons of Hispanic origin (who may be of any race) represented 5.5% of the older population. In addition, 0.5% of persons 65+ identified themselves as being of two or more races.

Only 6.7% of minority race and Hispanic populations were 65+ in 2002 (8.2% of African-Americans,** 8.18% of Asians and Pacific Islanders,** 6.6% of American Indians and Native Alaskans,** 5.1% of Hispanics), compared with 15.0% of whites.**

(Data for this section were compiled from Internet releases of the Census 2002 Estimates).

Geographic Distribution

In 2002, about half (52%) of persons 65+ lived in nine states. California had over 3.7 million; Florida 2.9 million; New York 2.5 million; Texas 2.2 million; and Pennsylvania 1.9 million. Ohio, Illinois, Michigan, and New Jersey each had well over 1 million (Figure 6).

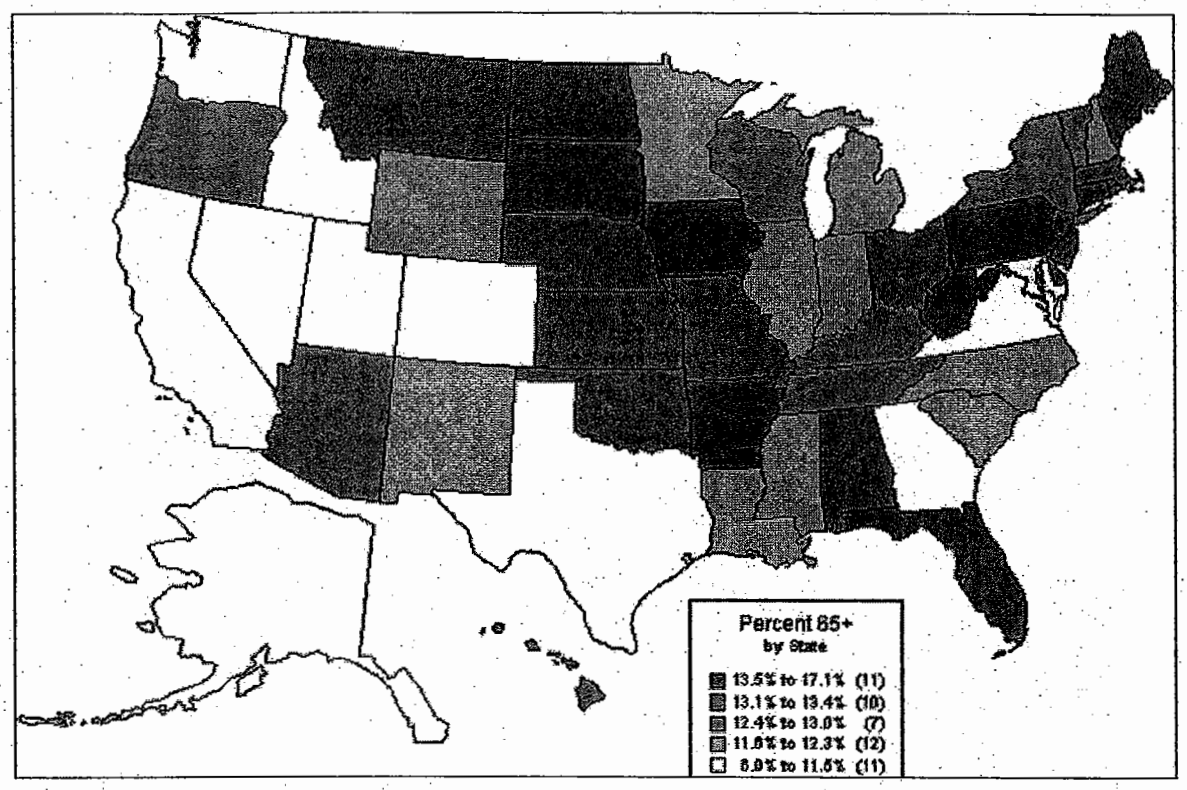
Person 65+ constituted approximately 14% or more of the total population in 9 states in 2002 (Figure 6): Florida (17.1%); Pennsylvania (15.5%); West Virginia (15.3%); North Dakota (14.8%); Iowa (14.7%); Rhode Island (14.2%); Maine (14.4); South Dakota (14.2); and Arkansas (13.9%). In nine states, the 65+ population increased by 20% or more between 1992 and 2002 (Figure 6): Nevada (63.8%); Alaska (53.6%); Arizona (35.2%); New Mexico (28.4%); Colorado (24.3%); Hawaii (24.0%); Delaware (24.0%); Utah (23.7%) and South Carolina (20.7%). The ten jurisdictions with the highest poverty rates for elderly over the period 2000-2002 were the District of Columbia (18.8%); Mississippi (17.9%); Alabama (15.2%); Tennessee (14.6%); North Carolina (14.0%); Arkansas (15.2%); New Mexico (13.8%); Texas (13.7%); Louisiana (13.2%); and Kentucky (12.4%).

Most persons 65+ lived in metropolitan areas in 2002 (77.4%). About 50% of older persons lived in the suburbs, 27.4% lived in central cities, and 22.6% lived in nonmetropolitan areas.

The elderly are less likely to change residence than other age groups. In the five year period from 1995 to 2000, 22.8% of older persons had moved (compared to 47.7% of persons under 65). Most older movers (59.7%) stayed in the same county while only 18.8% (of the movers) moved to another state. The 85+ segment of the older population had a much high rate of moving. During this period, 32.3% of the 85+ population moved, 61.1% of them within the same county.

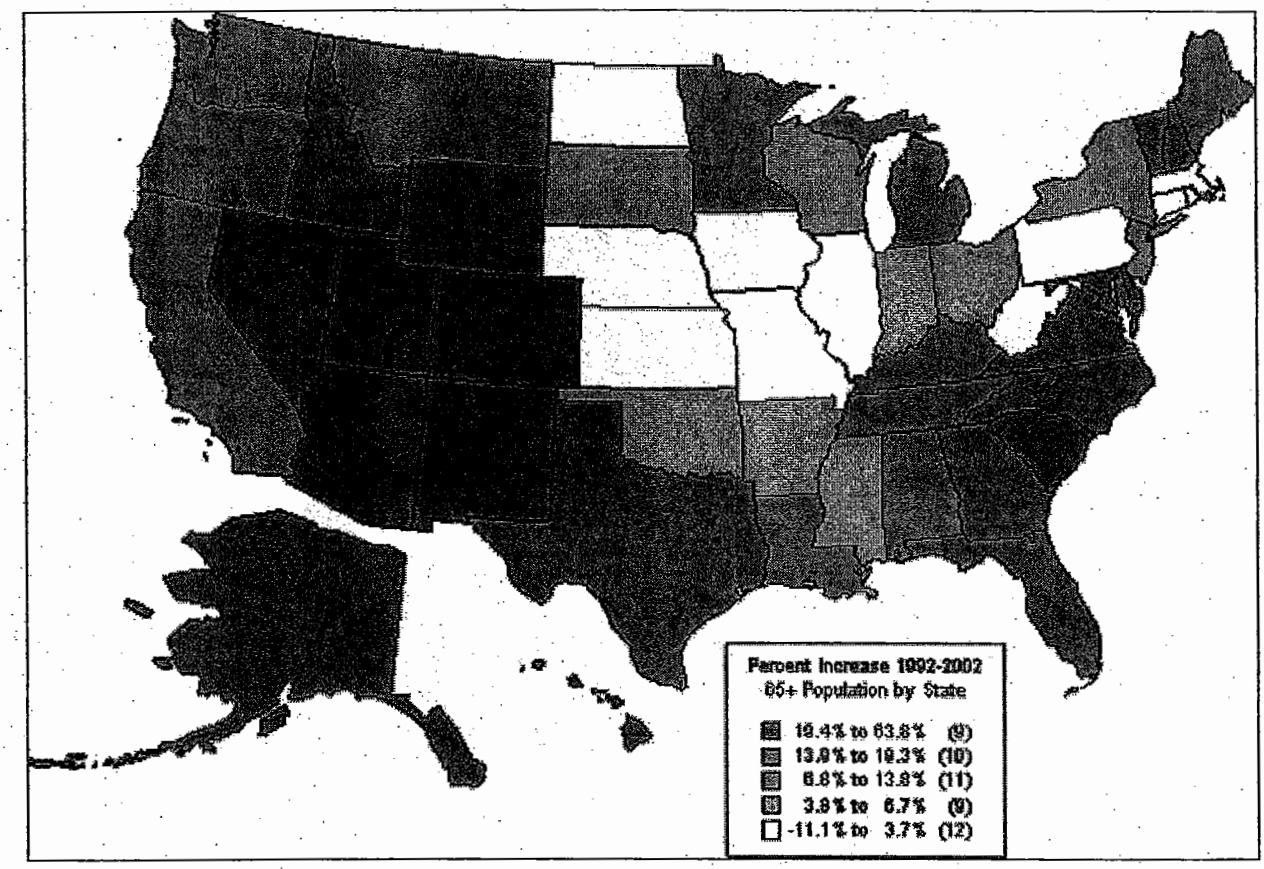
(Data for this section and for Figure 4 were compiled primarily from the Census Population Estimates for 2002 as well as other Internet releases of the U.S. Bureau of the Census including tables from the March 2002 Current Population Survey and "Internal Migration of the Older Population: 1995 to 2000," Census 2000 Special Report, CENSR-10, August 2003).

Figure 4: Persons 65+ as a Percentage of Total Population - 2002



Based on Census 2002 Population Estimates from the U.S. Bureau of the Census

Figure 5: Percentage Increase in Population 65+ -- 1992 to 2002



Based on Census 2002 Population Estimates from the U.S. Bureau of the Census

Figure 6: The 65+ Population by State 2002

Numbers	Number of Persons	Percent of All Ages	Percent Increase 1992-2002	Percent Below Poverty 2000-2002
US Total (50 States + DC)	35,601,911	12.3%	10.2%	10.2
Alabama	588,542	13.1%	9.6%	15.2
Alaska	39,200	6.1%	53.6%	6.3
Arizona	701,243	12.9%	35.2%	7.5
Arkansas	376,387	13.9%	5.6%	15.2
California	3,716,836	10.6%	13.8%	8.4
Colorado	434,472	9.6%	24.3%	8.2
Connecticut	472,314	13.6%	3.7%	6.5
Delaware	105,488	13.1%	24.0%	6.5
District of Columbia	68,534	12.0%	-11.1%	18.8
Florida	2,854,838	17.1%	15.2%	10.0
Georgia	813,652	9.5%	19.3%	12.6
Hawaii	166,910	13.4%	24.0%	8.1
Idaho	151,141	11.3%	19.3%	6.6
Illinois	1,499,249	11.9%	2.2%	8.6
Indiana	757,451	12.3%	5.8%	8.9
Iowa	432,785	14.7%	0.4%	8.4
Kansas	355,094	13.1%	1.7%	7.9
Kentucky	509,476	12.4%	7.0%	12.4
Louisiana	520,446	11.6%	8.4%	13.2
Maine	186,383	14.4%	10.8%	11.2
Maryland	616,699	11.3%	14.1%	11.1
Massachusetts	863,695	13.4%	2.9%	10.6
Michigan	1,231,920	12.3%	6.8%	9.3
Minnesota	601,741	12.0%	7.4%	9.0
Mississippi	346,251	12.1%	6.1%	17.9
Missouri	757,197	13.3%	3.5%	6.8
Montana	122,806	13.5%	11.8%	9.6
Nebraska	232,134	13.4%	2.8%	9.2
Nevada	240,255	11.1%	63.8%	8.0
New Hampshire	152,577	12.0%	16.9%	6.8
New Jersey	1,121,197	13.1%	5.9%	8.4
New Mexico	221,454	11.9%	28.4%	13.8
New York	2,473,510	12.9%	4.0%	11.8
North Carolina	998,391	12.0%	17.9%	14.0
North Dakota	94,076	14.8%	1.6%	11.5
Ohio	1,513,372	13.3%	4.2%	7.5
Oklahoma	460,459	13.2%	6.1%	11.6
Oregon	443,968	12.6%	8.5%	6.0
Pennsylvania	1,908,962	15.5%	1.8%	8.4
Rhode Island	152,286	14.2%	-0.6%	11.4
South Carolina	503,256	12.3%	20.7%	14.2
South Dakota	108,322	14.2%	4.4%	10.3
Tennessee	719,177	12.4%	12.7%	14.6
Texas	2,152,896	9.9%	19.3%	13.7
Utah	199,041	8.6%	23.7%	10.1
Vermont	79,241	12.9%	16.6%	10.5
Virginia	817,441	11.2%	17.4%	9.8
Washington	677,532	11.2%	13.0%	7.9
West Virginia	275,974	15.3%	1.0%	10.6
Wisconsin	706,418	13.0%	5.9%	8.0
Wyoming	59,222	11.9%	19.4%	7.9
Puerto Rico	449,176	11.6%		

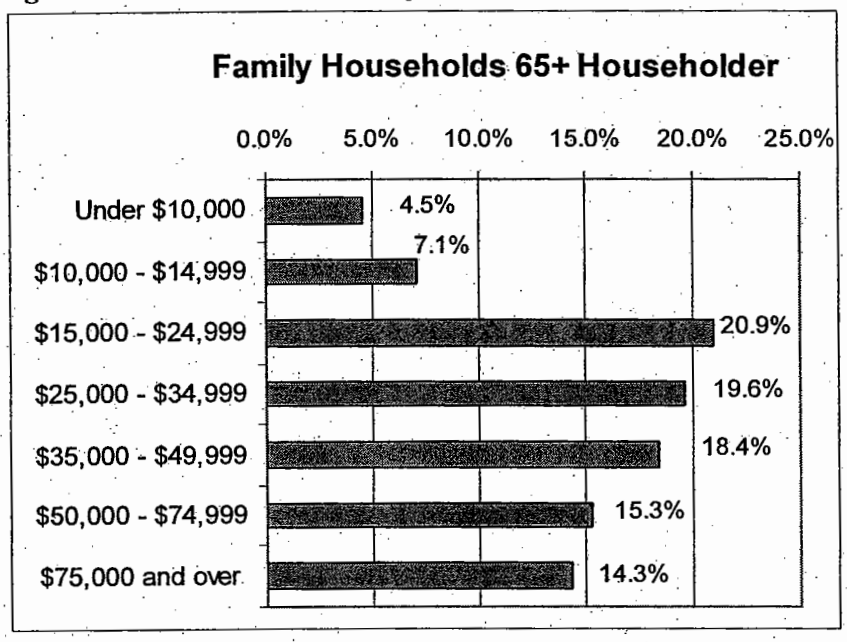
Population data is from the Census Bureau Population Estimates and poverty data is from the Current Population Survey, 2001, 2002, and 2003 Annual Social and Economic Supplements.

Income

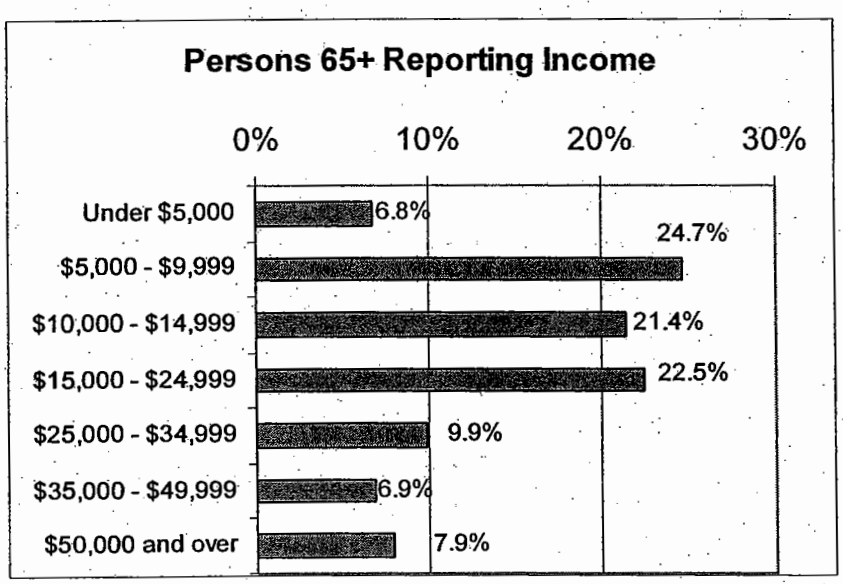
The median income of older persons in 2002 was $19,436 for males and $11,406 for females. Median money income of all households headed by older people fell by –1.4% from 2001 to 2002; however, this difference was not statistically significant.

Households containing families headed by persons 65+ reported a median income in 2002 of $33,802 ($35,219 for non-Hispanic Whites, $26,174 for African-Americans, $38,533 for Asians, and $25,123 for Hispanics). About one of every nine (11.6%) family households with an elderly householder had incomes less than $15,000 and 48.0% had incomes of $35,000 or more (Figure 7).

Figure 7: Percent Distribution by Income: 2002*



$33,802 median for 11.7 million family households 65+



$14,251 median for 33.3 million persons 65+ reporting income

For all older persons reporting income in 2002 (33.3 million), 31.5% reported less than $10,000. Only 24.7% reported $25,000 or more. The median income reported was $14,251.

The major sources of income as reported by the Social Security Administration for older persons in 2001 were Social Security (reported by 91% of older persons), income from assets (reported by 58%), public and private pensions (reported by 40%), earnings (reported by 22%), public assistance (reported by 5%) and veterans' benefits (reported by 4%). In 2000, Social Security benefits accounted for 38% of the aggregate income of the older population. The bulk of the remainder consisted of earnings (23%), assets (18%), and pensions (17%).

(Based on data from Current Population Reports, "Money Income in the United States: 2002," P60-221, issued September, 2002, by the U.S. Bureau of the Census, related Census detailed tables on the Census web site, and from Income of the Aged Chartbook, 2001 and Fast Facts and Figures About Social Security, 2002, Social Security Administration)

Poverty

About 3.6 million elderly persons (10.4%) were below the poverty level in 2002. This poverty rate was not statistically different from the poverty rate in 2001. The historic lowest level of 9.7% reached in 1999. Another 2.2 million or 6.4% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level).

One of every twelve (8.3%) elderly Whites was poor in 2002, compared to 23.8% of elderly African-Americans and 21.4% of elderly Hispanics. Higher than average poverty rates for older persons were found among those who lived in central cities (12.2%), outside metropolitan areas (i.e. rural areas) (11.9%), and in the South (12.7%).

Older women had a higher poverty rate (12.4%) than older men (7.7%) in 2002. Older persons living alone were much more likely to be poor (19.2%) than were older persons living with families (6.0%). The highest poverty rates (47.1%) were experienced by older Hispanic women who lived alone.

(Based on data from Current Population Reports, "Poverty in the United States: 2002," P60-229, Issued September, 2003 and related Internet releases of the U.S. Bureau of the Census).

Housing

Of the 21.8 million households headed by older persons in 2001, 80% were owners and 20% were renters. The median family income of older homeowners was $23,409. The median family income of older renters was $12,233. In 2001, 41% of older householders spent more than one-fourth of their income on housing costs, compared to 39% of for householders of all ages.

For homes occupied by older householders in 2001, the median year of construction was 1963 (it was 1970 for all householders) and 5.4% had physical problems.

In 2001, the median value of homes owned by older persons was $107,398, compared to a median home value of $123,887 for all homeowners. About 73% of older homeowners in 2001 owned their homes free and clear.

(Source: "American Housing Survey for the United States in 2001, Current Housing Reports" H150/01.)

Employment

In 2002, 4.5 million (13.2 %) Americans age 65 and over were in the labor force (working or actively seeking work), including 2.5 million men (17.9%) and 1.9 million women (9.8%). They constituted 3.1% of the U.S. labor force. About 3.6% were unemployed. Labor force participation of men 65+ decreased steadily from 2 of 3 in 1900 to 15.8% in 1985, and has stayed at 16%-18% since then. The participation rate for women 65+ rose slightly from 1 of 12 in 1900 to 10.8% in 1956, fell to 7.3% in 1985, and has been around 8%-10% since 1988.

(Source: Bureau of Labor Statistics web-site: http://www.bls.gov/cps/home.htm)

Education

The educational level of the older population is increasing. Between 1970 and 2002, the percentage who had completed high school rose from 28% to 70% Almost 17% in 2002 had a bachelor's degree or more. The percentage who had completed high school varied considerably by race and ethnic origin in 2002: 74% of Whites**, 68% of Asians and Pacific Islanders**, 51% of African-Americans**, and 35% of Hispanics. The increase in educational levels is also evident within these groups. In 1970, only 30% of older Whites and 9% of older African-Americans were high school graduates.

(Source: Current Population Survey, Annual Social and Economic Supplement (formerly the Annual Demographic Survey), 2002 and related tables on the Census Bureau web site)

Health and Health Care

In 2003, 38.6% of noninstitutionalized older persons assessed their heath as excellent or very good (compared to 66.6% for persons aged 18-64). There was little difference between the sexes on this measure, but older African-Americans (57.7%) and older Hispanics (60.5%) were less likely to rate their health as excellent or good than were older Whites (75.4%).***** Most older persons have at least one chronic condition and many have multiple conditions. Among the most frequently occurring conditions of elderly in 2000-2001 were: hypertension (49.2%), arthritic symptoms (36.1%), all types of heart disease (31.1%), any cancer (20.0), sinusitis (15.1%), and diabetes (15.0).

Almost 67% reported that they received an influenza vaccination during the past 12 months and 55% reported that they had ever received a pneumococcal vaccination. About 22% (of persons 60+) report height/weight combinations that place them among the obese. Over 27% of persons aged 65-74 and 17% of persons 75+ report that they engage in regular leisure-time physical activity. Only 9% reported that they are current smokers and only 4% reported excessive alcohol consumption. Only 2.5% reported that they had experienced psychological distress during the past 30 days.

In 2002, over 12.5 million persons aged 65 and older were discharged from hospitals. This is a rate of 3,549 for every 10,000 persons aged 65+ which is more than three times the comparable rate for persons aged 45-64 (which was 1,121 per 10,000). The average length of stay for persons aged 65+ was 5.8 days; the comparable rate for persons aged 45-64 was 5.0 days. The average length of stay for older people has decreased almost 5 days since 1980. Older persons averaged more office visits with doctors in 2001 – 6.2 for those aged 65-74 and 7.4 for persons over 75 while persons aged 45-65 averaged only 3.8 office visits during that year. Almost 97% of older persons reported that they did have a usual place to go for medical

care and only 2.5% said that they failed to obtain needed medical care during the previous 12 months due to financial barriers.

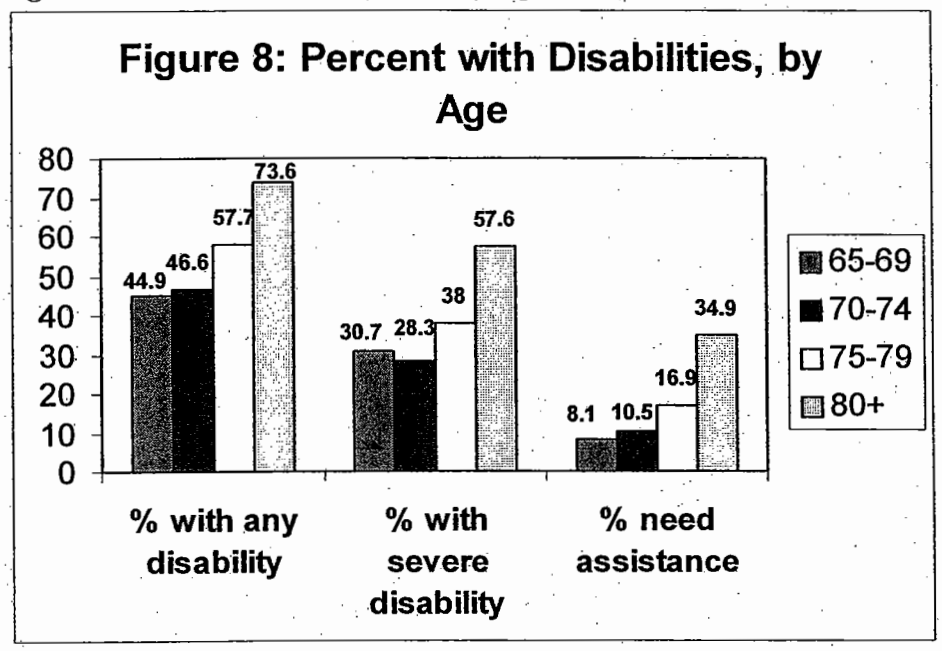
In 2002, older consumers averaged $3,586 in out-of-pocket health care expenditures, an increase of 45% since 1992. In contrast, the total population spent considerably less, averaging $2,350 in out-of-pocket costs. Older Americans spent 12.8%of their total expenditures on health, more than twice the proportion spent by all consumers (5.8%). Health costs incurred on average by older consumers in 2001 consisted of $1,886 (53%) for insurance, $955 (27%) for drugs, $582 (16%) for medical services, and $163 (5%) for medical supplies.

(Sources: Health United States: 2003; Advanced Data From Vital and Health Statistics and other data releases from the National Center for Health Statistics web site; and the Bureau of Labor Statistics web site)

Disability and Activity Limitations

In 1997, more than half of the older population (54.5%) reported having at least one disability of some type (physical or nonphysical). Some of these disabilities may be relatively minor but others cause people to require assistance to meet important personal needs. Over a third (37.7%) reported at least one severe disability. The percentages with disabilities increase sharply with age (Figure 8). Disability takes a much heavier toll on the very old. Almost three-fourths (73.6%) of those aged 80+ report at least one disability. Over half (57.6%) of those aged 80+ had one or more severe disabilities and 34.9% of the 80+ population reported needing assistance as a result of disability. There is a strong relationship between disability status and reported health status. Among those 65+ with a severe disability, 68.0% reported their health as fair or poor. Among the 65+ persons who reported no disability, only 10.5% reported their health as fair or poor. Presence of a severe disability is also associated with lower income levels and educational attainment.

Figure 8: Percent With Disabilities, By Age: 1997



In another study which focused on the ability to perform specific activities of daily living (ADLs), over 27.3% of community-resident Medicare beneficiaries over age 65 in 1999 had difficulty in performing one or more ADLs and an additional 13.0% reported difficulties with instrumental activities of daily living (IADLs). By contrast, 93.3% of institutionalized Medicare beneficiaries had difficulties with one or more ADLs and 76.3% of them had difficulty with three or more ADLS. [ADLs include bathing, dressing, eating, and getting around the house. IADLs include preparing meals, shopping, managing money, using the telephone, doing housework, and taking medication]. Limitations on activities because of chronic conditions increase with age. Among those 65-74 years old, 19.9 percent had difficulties with ADLs. In contrast, over half (52.5%) of these 85 years and older had difficulties with ADLs.

It should be noted that (except where noted) the figures above are taken from surveys of the noninstitutionalized elderly. Although nursing homes are being increasingly used for short-stay post-acute care, about 1.6 million elderly are in nursing homes (about half are age 85 and over). These individuals often have high needs for care with their ADLs and/or have severe cognitive impairment, due to Alzheimer's disease or other dementias.

(Sources: Current Population Reports, "Americans with Disabilities, 1997" P70-73, February 2001 and related Internet data; Internet releases of the Census Bureau and the National Center on Health Statistics)

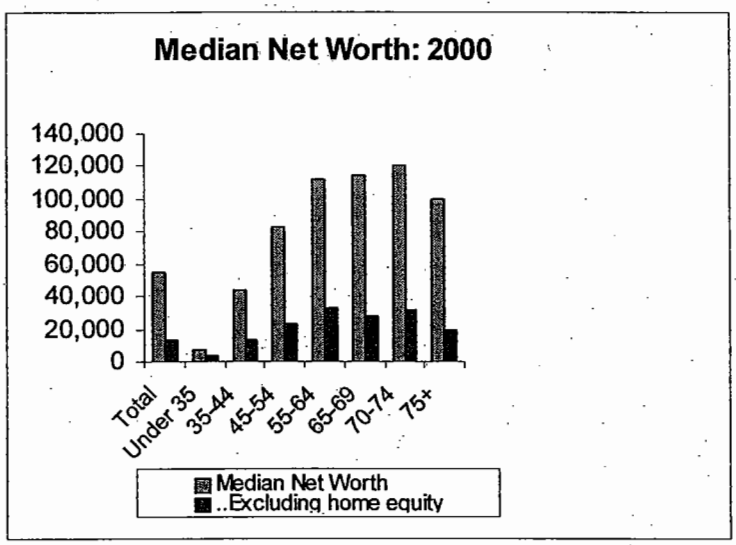
Special Topic: Net Worth of Older Households

The net worth (assets minus liabilities) of households increases with age until age 74 and declines somewhat from age 75. The median net worth of the elderly households (with a householder aged 65+) in 2000 was $108,885 as compared to $55,000 for the total population. The largest asset type is home ownership which accounts for $85,516 or 78.5% of this net worth. Over 78% of elderly households own their own home. Other major asset types owned by the elderly include: stock and mutual funds (29%), regular checking accounts (31%), interest-earning accounts at financial institutions (71%), IRA and Keogh accounts (25%), and motor vehicles (78%).

There are major differences in the median net worth of different household types. Elderly married couple households have a median net worth of $173,950 ($57,586 when home equity is excluded). Male households have a median net worth of $84,000 ($15,375) when home equity is excluded). Female households have a median net worth of $76,000 ($10,475 when home equity is excluded).

This household net worth is not found in all segments of the elderly population. 70% of elderly households have a net worth of at least $50,000 and another 8.4 % have a net worth of $25,000 to $49,999. On the other hand, about 21.5% of elderly households have a net worth of less than $25,000 – 6.7% have a zero or negative net worth and another 6.6% have a net worth of $1-4,999.

Figure 9: Median Net Worth of Households with Householder 65+: 2000



(Source: Current Population Reports: Net Worth and Asset Ownership of Households: 1998 and 2000, P70–88, May 2003 and related tables (http://www.census.gov/hhes/www/wealth/1998_2000/wealth98_00.html))

Notes:

*Principal sources of data for the Profile are the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics. The Profile incorporates the latest data available but not all items are updated on an annual basis.

**Excludes persons of Hispanic origin.
***Calculated on the basis of the official poverty definitions for the years 2000-2002
**** Census 2000 figure
***** 2000 figure

A Profile of Older Americans: 2003 was prepared by the Administration on Aging (AoA), U.S. Department of Health and Human Services. The annual Profile of Older Americans was originally developed and researched by Donald G. Fowles, AoA. Saadia Greenberg, AoA, developed the 2003 edition.

AoA serves as an advocate for the elderly within the federal government and is working to encourage and coordinate a responsive system of family and community based services throughout the nation. AoA helps states develop comprehensive service systems which are administer by 56 State and Territorial Units on Aging, 655 Area Agencies on Aging, 226 Native American and Hawaiian organizations, and more than 29,000 local service providers.

Attachment 7

Long Term Care in Iowa
Long Range Plan Draft (summary)
Recommendations from the Senior Living Coordinating Unit
August 31, 2004

The goal of the long term care system in Iowa is to ensure that no Iowan is lonely, hopeless or bored as a result of disability or the frailties of aging. Disabled adults and older Iowans should enjoy the freedom to choose from a variety of living and service options which guarantee their dignity, autonomy and independence. A person's limited income and personal resources should not prevent access to the full array of quality services sufficient to provide a safe environment in which to live. The problems that afflict the government and individuals as they face the challenges of being disabled and growing old will yield to the power of Iowans working together. Iowans must join together to accept responsibility for each other's safety and welfare. If we accept collective responsibility for our fellow human beings, we can construct a long term care system which ensures that all Iowans have access to the services they need to live with their disabilities and to cope with the frailties of aging with maximum dignity and respect.

The Senior Living Coordinating Unit has been developing a long range plan for the long term care system to better meet the needs of older Iowans and the state government. A copy of the full report is available upon request from the Department of elder Affairs. The following represent the recommendations for policy change contained in the report.

a) **The SLCU recommends that Iowa press for changes in the Medicaid program to expand the states ability to provide services to people in ways which delay and prevent institutional placement rather than merely serve those already eligible for institutional care.**
b) **"Fast Track Eligibility" for HCBS Waiver services**
c) **Develop "nursing home transition programs" to help people return to their homes and communities by amending Medicaid waivers or Medicaid State Plan to include transition dollars and nursing home transition case management.**
d) **"Money Follows the Person" type funding strategies that allow people to move from the nursing homes to community based services.**
e) **Increase the resource limit for Waiver clients who want to stay in their homes so that they can have enough money to maintain the house.**

f) Develop a program to provide services to Naturally Occurring Retirement Communities (NORC).
g) Establish standards for communities to be "Elder Friendly."
   i) Communities should have some universal design standards that are of value to all citizens.
h) The SLCU recommends that Iowa adopt available opportunities to implement consumer direction in the LTC system, including, but not limited to, Cash (Service Voucher) and Counseling and Money Follows the Person.
i) more efforts to educate people about the importance of planning for their long term care needs;
j) expanded case management services and a universal assessment available for all Iowans.
k) a much streamlined system of eligibility determination and assessment of need as envisioned by the Seamless project within the Department of Elder Affairs should be implemented and available for all targeted populations.
l) Full implementation of the Resource Center Grant from the Administration on Aging.
m) The SLCU recommends that the LTC system provide support, assistance, training and respite for the families which assume responsibility for long term care.
n) The SLCU recommends that we continue to partner with the Iowa Caregivers Association and especially their Better Jobs Better Care grant to ensure that trends in consumer directed care not erode the quality and wages of caregivers. The SCLU also supports ICA's efforts to expand the Iowa Nurse Aide Registry to include other direct care workers. Currently, only nurse aides working in nursing facilities are required by federal law to be on the Registry. The new Registry could potentially include in its data bank a pool of personal assistants seeking employment through the Cash and Counseling model. The SCLU also supports partnership with the minority communities to promote caregiving as quality jobs for recent immigrants.
o) The SLCU recommends that Iowa explore managed care options such as PACE for the provision of LTC.
p) The SCLU recommends that the Case Management Program for the Frail Elderly (CMPFE) be used to manage the care component of affordable assisted living programs where services are separated from housing and billed directly to Medicaid and the Elderly Waiver program.
q) The SLCU recommends that a study be commissioned to assess the true costs for home and community based services for a variety of acuity levels to determine the extent of the savings for

providing long term care in the community rather than in an institution.

r) **The SLCU recommends that the state government support efforts to make housing more available, affordable and accessible for older Iowans and those with disabilities.**
   i) It supports the efforts of the Iowa Finance Authority to implement affordable assisted living options which combine subsidized housing and Medicaid Waiver services to low income older Iowans and disabled adults.
   ii) It recommends building codes which include accessibility and "visitability"[1] standards so that increasing numbers of homes are able to accommodate those with limited mobility.
   iii) It supports the efforts of DEA and others to promote the use of universal design in all new homes built in Iowa.

s) **The SCLU recommends that state government help older people learn about and acquire adaptive technologies which allow them to live in their own homes more safely and convenience.**

t) **The SLCU supports efforts by private and governmental units to measure and encourage the kind of quality in long term care which helps people make informed choices about how to receive long term care services.**

u) **The SCLU recommends that DIA and DEA cooperate to ensure that information about certification reports, monitoring visits, complaints investigations and other information valuable to consumers be readily available on department Web sites.**

v) **The SLCU recommends the development and implementation of reasonable standards for oversight of consumer directed care.**

w) **The SCLU recommends that Demonstration projects in long term care be allowed which create truly resident centered, home like care using principles of what's called "culture change" and other concepts to make nursing homes more like homes and less like hospitals.**

x) **The SLCU recommends the following changes in CMPFE to continue re-balancing LTC in favor of home and community based services:**
   i) The implementation of a universal assessment process.
   ii) The admissions law should be changed to narrow the criteria for admission to a nursing facility and to prefer a home and community based setting.
   iii) Adequate reimbursements for case management services.

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[1] "Visitability" refers to the accessibility of homes by those who "visit" even those who live there do not require accessible. An accessible bathroom on the ground floor of all new construction would make life much easier for the handicapped and disabled guest, as well as improve the resale value of homes.

iv) Some accommodation for high vacancy rates in nursing homes should be a part of the rebalancing effort to facilitate a smooth transition to a decreased reliance on institutional care.

v) A state wide system of case management needs coordinated and uniform administration to ensure consistent quality and adherence to the goal of rebalancing. This need not be one entity, but it must have some sort of central administration, coordination and training.

vi) Home and community based services are not yet sufficiently available to meet the increasing demand for their services which a rebalanced system will require. It may be that various subsidies and other support will be needed to help develop the quantity and quality of HCBS. Some nursing homes need to convert unused capacity into HCBS and new ventures in HCBS need technical and financial assistance to create added capacity. The Department of Elder Affairs and Human Services should create the capacity to respond to this need for technical assistance.

vii) The long term care system should also provide support for assistive devices and home modifications which can enable disabled and frail people to remain independent and in the community.

y)

IDEA MISSION STATEMENT - ***The mission of the Iowa Department of Elder Affairs is to provide advocacy, educational and prevention services to older Iowans so they can find Iowa a healthy, safe, productive and enjoyable place to live and work.***

Service Category	Funding Sources	Funders and/or Providers
Advocacy	SLP	IDEA
Advocate to sustain and develop services for aging Iowans	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Outreach	SLP	IDEA
Identify aging Iowans who need and are eligible for services	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Info & Assistance	SLP	IDEA
Provide Information and referral services to aging Iowans	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Public Information	SLP	IDEA
Provide Information and referral services to aging Iowans	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Training/Education	SLP	IDEA
Provide training and education for older Iowans to find and keep employment.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Case Management	SLP	IDEA
Provide assessment and care plans for older Iowans and their families. Acts as a gate for the Elderly Waiver and for the Senior Living Program	General Fund	AAAs
	Fed. Older Americans Act	Home Health Agencies & others under agreement with AAAs
	Other	
Assessment & Intervention	SLP	AAAs
Provide the assessment services for CMPFE	General Fund	Home Health Agencies & others under agreement with AAAs
	Federal	
	Other	
Mental Health Outreach	SLP	AAAs
Provde mental health services to older Iowans	General Fund	Others
	Fed. Older Americans Act	
	Other	

Adult Day Care	SLP	IDEA
Provide adult day services to older Iowans not eligible for the Elderly Waiver.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Ass't Transportation	SLP	IDEA
Provide transportation services to older, disabled Iowans	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	

Chore	SLP	IDEA
Provide chore services to older Iowans	General Fund	AAAs
	Fed. Older Americans Act	Home Health Agencies
	Other	Others
Counseling	SLP	IDEA
Provide counseling services to older Iowans	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Homemaker	SLP	IDEA
Help people care for their homes (yard work, housecleaning and such).	General Fund	AAAs
	Fed. Older Americans Act	Home Health Agencies
	Other	Others
Material Aid	SLP	IDEA
Provide supplies and repairs and apppliances and such for older Iowans' homes	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Personal Care	SLP	IDEA
Provide services which help a person take care of dressing, toileting, bathing and such.	General Fund	AAAs
	Fed. Older Americans Act	Home Health Agencies
	Other	Others
Reassurance	SLP	IDEA
This is largely phone calls to see if	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Respite	SLP	IDEA
Provide a caregiver a chance to take a break from taking care of an older person.	General Fund	AAAs
	Fed. Older Americans Act	Home Health Agencies
	Other	Others
Transportation	SLP	IDEA
Provide transportation services of older Iowans.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Visiting	SLP	IDEA
Provide someone to visit a person to check on their well being.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Emergency Response System	SLP	IDEA
Provide a service to older Iowans who need a way to alert someone	General Fund	AAAs
	Fed. Older Americans Act	Others

n case of a fall or sudden incapacitation.	Other	
Home Repair	SLP	IDEA
Help an older person repair his or her home.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Placement Services	SLP	IDEA
For t5he most part this is placing a person in a job.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Older Worker Employment		IDEA
Hellp older people find jobs.	General Fund	Some AAAs
	Fed. Older Americans Act	IWD
	Other	Others
Caregiver Support		IDEA
	General Fund	AAAs
Help caregivers find the services	Fed. Older Americans Act	Others

and information they need to care for their dependent.	Other	
Protective Payee	SLP	IDEA
Provide someone to handle a	Fed. Older Americans Act	AAAs

persons benefit checks, i.e social security and SSI.	Other	Others
Legal Education	SLP	IDEA
Provide education services to help older Iowans understand how to deal with their legal needs.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Legal Assistance	SLP	IDEA
Provide some to help an older Iowans with wills, guardianships and such.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Long Term Care Ombudsman Off	FUNDING	Actual
	SLP	IDEA
Help resolve complaints and quality problems in nursing facilities and other residential care.	General Fund	
	Fed. Older Americans Act	
	Other	
RESIDENT ADVOCATE COMM.	General Fund	
Recruit, train and support volunteers who visit people in NF.	Fed. Older Americans Act	
Congregate Meals	SLP	IDEA
Federal meal programs which provide older Iowans meals and opportunities to socialize.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Home Delivered Meals	SLP	IDEA
Federal program to provide meals to home bound older Iowans.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Nutrition Education	SLP	IDEA
Ediucationin nutrition for older Iowans. Brochures, workshops, fair booths and such.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Nutrition Counseling	SLP	IDEA
	General Fund	AAAs
Counseling for older Iowans to help them know more about their dietary needs.	Fed. Older Americans Act	Others
	Other	
	SLP	IDEA
Preventive Health/Promotion	General Fund	AAAs
Information and promotion about preventive health.	Fed. Older Americans Act	Home Health Agencies
	Other	Others

Medication Management	SLP	IDEA
Helping older Iowans take their medications properly and safely.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Health Screening/Well Elderly Clinics	SLP	IDEA
Providing health screens and primary health care for older Iowans.	General Fund	AAAs
	Fed. Older Americans Act	Home Health Agencies
	Other	Others
Senior Centers/Recreation	SLP	IDEA
Provide opprtunties for older Iowans to gather for learning, education, relazation, socialization and such.	General Fund	AAAs
	Fed. Older Americans Act	Others
	Other	
Retired & Senior Volunteer Program	SLP	Others
Provide opprtunties for older ilowans to volunteer in schools and their communities	General Fund	
	Fed. Older Americans Act	
	Other	

Aging and Disability

A Long-Range Plan for Long-Term Care in Iowa

August 31, 2004

Draft

Introduction

Among other responsibilities related to management of Iowa's long-term care system, the Senior Living Coordinating Unit (SLCU) has responsibility for developing a long-range plan for the provision of long-term care services within the state, including proposing rules and procedures for the development of a comprehensive long-term care and community-based services program. This working document reflects the findings of an initial long-term care planning session Nov. 4-5, 2003, and the additional public comment and input as a result of a series of long-range plan feedback sessions scheduled throughout the state in 2004.

Overview

The goal of the long term care system in Iowa is to ensure that no Iowan is lonely, hopeless or bored as a result of disability or the frailties of aging. Disabled adults and older Iowans should enjoy the freedom to choose from a variety of living and service options which guarantee their dignity, autonomy and independence. A person's limited income and personal resources should not prevent access to the full array of quality services sufficient to provide a safe environment in which to live. The problems that afflict the government and individuals as they face the challenges of being disabled and growing old will yield to the power of Iowans working together. Iowans must join together to accept responsibility for each other's safety and welfare. If we accept collective responsibility for our fellow human beings, we can construct a long term care system which ensures that all Iowans have access to the services they need to live with their disabilities and to cope with the frailties of aging with maximum dignity and respect.

Iowans and their government are ill prepared for the expense and incapacitation which comes with aging and developmental disabilities. Most people simply cannot afford to grow old at the same time that more of us are in fact living to advanced ages. 25% of Iowans over the age of 65 live on less than $856/month. The average retiree has $30,000 in assets. More than half of older Iowans rely on Social Security for more than half of their income. Those who retire in the next decade will fare no better. Half of Americans do not have pensions. Only 15% of working-age Americans has an individual retirement account and only 22% contributes to a 401(k) plan. Barely 1 in 3 working Americans has saved more than $100,000 for retirement.[1] Although household net worth is at an all-time high, most people do not enjoy the abundance.

[1] "Retirement Finances at Risk," The Christian Science Monitor, March 9, 2004.

Average net worth per household was more than $400,000 in 2003. However, the median net worth per household was about $65,000 (half the households had net worth less than that).[2] 40 million Americans are paid less than $10 an hour and 66 percent of the population earns less than $45,000 a year.[3] And of course, credit card debt is at historic and alarming highs and inheritance prospects are dim as the current generation of older Iowans are spending themselves into poverty with their own long term care needs.

Recent studies indicate that boomers may not fare are poorly as first thought.[4] Median household wealth at age 67 for those born between 1946 and 1964 will grow from $448,000 among current retirees to $600,000 among boomers. With the inflation rate in health care costs and the added years to a person's eventual frailty, however, future generations likely will fare no better than current retirees most of whom face financial ruin when faced with the costs of extended long term care. Nursing home costs of $50,000 (a bargain in most parts of the country) per year will quickly eviscerate most people's income and resources. The average senior spends down to be eligible for Medicaid after only 5 ½ months in a nursing home. The high costs of long term care drive many to desperation. Many seek, often illegally, to hide or transfer assets to avoid spending their own money for long term care. Some even choose to divorce to protect some assets for the surviving spouse. Others refuse services which they need rather than spend their meager resources or accept help. A recent study by AARP, the nation's largest group representing seniors, surveyed 1,000 Iowans 50 and older and held focus groups with consumers and health care providers. Half said they would rather do without long-term care than seek assistance in obtaining care.

Long-term care problems extend beyond aging Iowans. They are a a concern to government officials and tax payers as well. The problem for them is that LTC allocations ($2.0 billion and rising exponentially) may not be happening in the most efficient manner possible. Medicaid expenditures appear to be on track to absorb all available state government spending. Far short of this, state government must find ways to limit the resources applied to the care of Iowa's disabled adults and frail elders. Unsustainable trends tend not to be sustained. To no small measure, the re-balancing efforts of this document reflect the reality that no state government can afford to spend whatever it takes to care for those needing long term care in the manner current expenditures are made.

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[2] Gary L. Maydew, "This rising tide is lifting only yachts," Des Moines Register, Monday, April 26, 2004, page 9A.

[3] Harper's Magazine/September 2004, "Tentacles of Rage," by Lewis Lapham, page 32.

[4] "*How Will Boomers Fare at Retirement?*" The Urban Institute for AARP.

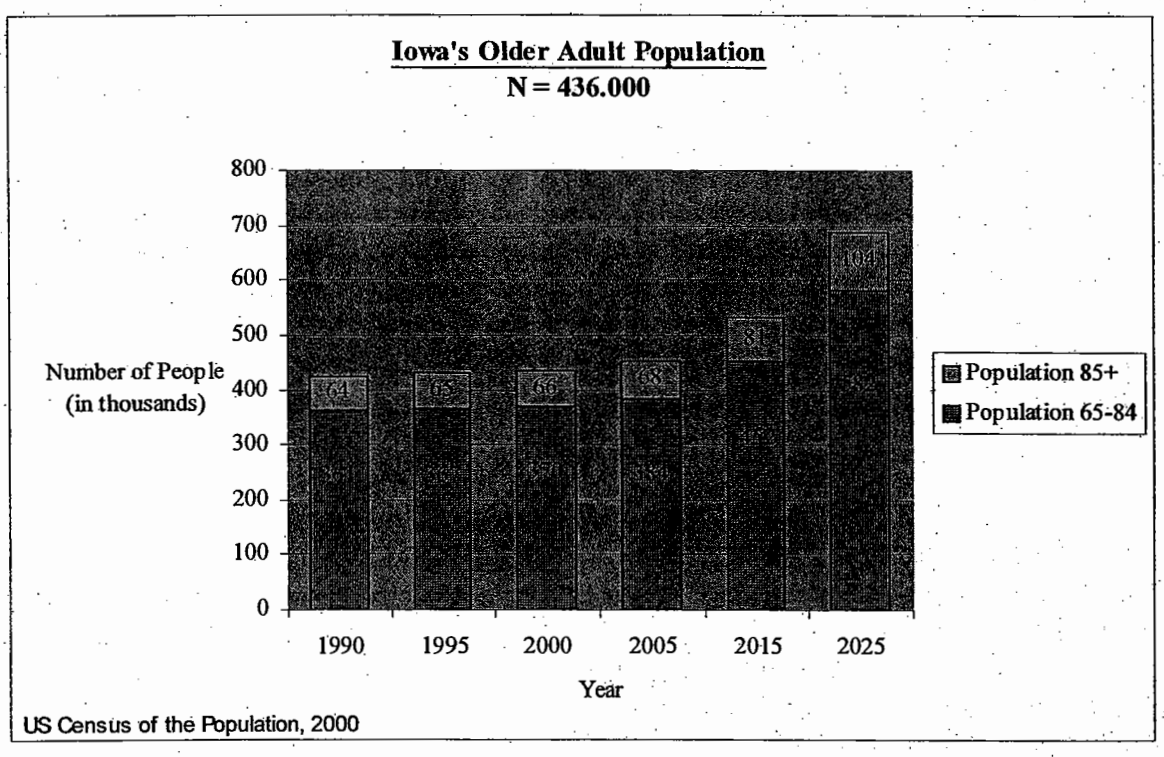
Providers of services to older Iowans and the disabled also face huge challenges in an unbalanced system. They face pressure from state and federal governments who keep reimbursements artificially low. They deliver services to low income people at prices which compromise their ability to deliver quality care. The flight of relatively healthy and wealthy individuals into non-nursing home settings leaves the nursing home industry to care for an increasingly frail and poor population. Meanwhile providers of home and community based services under the Medicaid Waiver program and the state's own Case Management Program for the Frail Elderly receive increasingly meager reimbursement rates and have difficulty expanding their business to serve the number of needy individuals who also want and need care outside of nursing homes.

These are troubling trends for people who can likely expect to live longer and need more care as they do so. The aging population is increasing rapidly and the fastest growing segment is those over the age of 85 – precisely those in most need of long term care. The looming costs of this burgeoning demographic combined with a shrinking workforce of those willing and able to take care of the elderly and disabled require us to do long term care in the future much more efficiently and effectively. The purpose of this long range plan is to lay out some suggestions for change which will enable Iowans and their government to meet the challenges of aging and disability.

The goal of this plan is to maximize the independence of older Iowans and those with disabilities, to enable them to live in their communities of choice for as long as possible and to receive the care they need in the setting they choose by providers they trust at a cost they can afford.

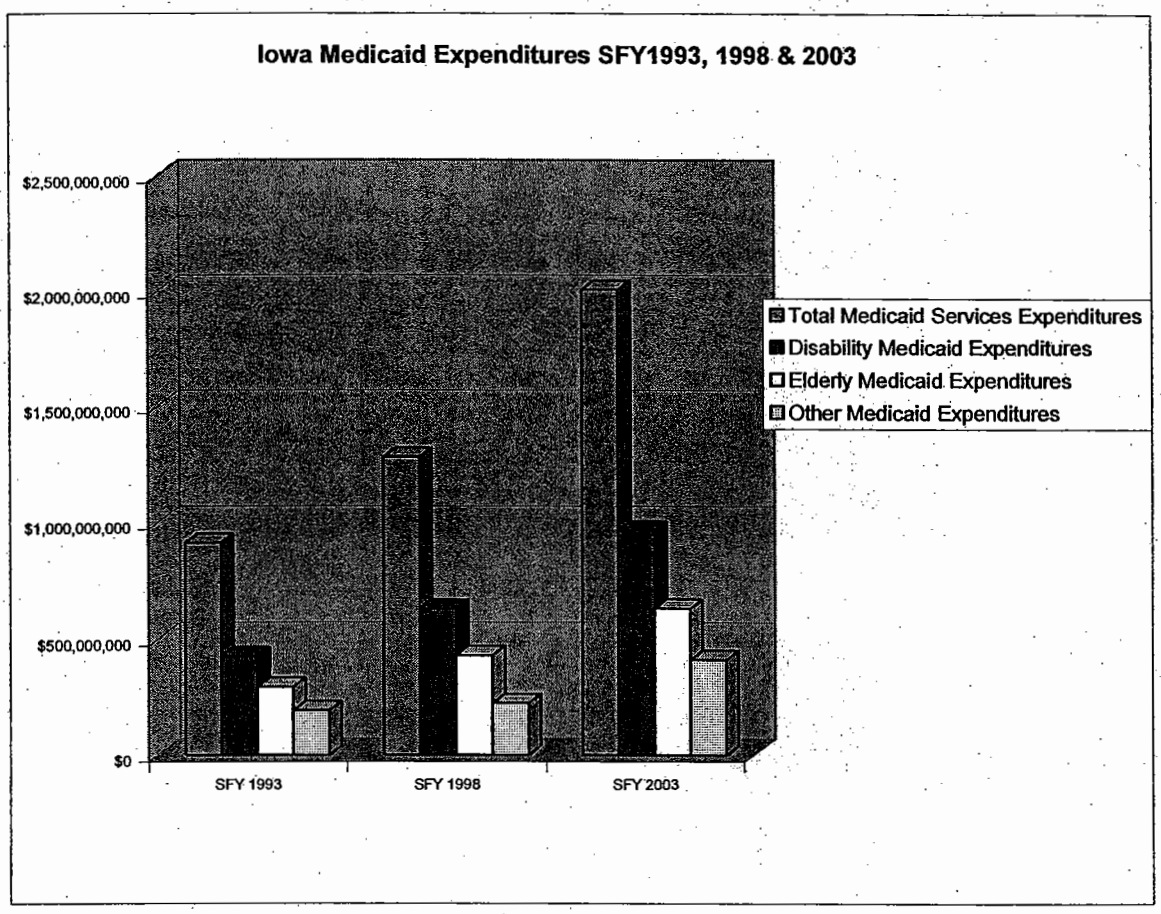
Iowa's Aging Population

The aging of the American population constitutes an unprecedented demographic event, and Iowa leads the nation as one of the grayest states. The 2000 U.S. Census indicated that 436,000 Iowans are over 65, and this age group constitutes 15% of the state's population. Iowa's aging population is projected to increase by more than 55% over the next 25 years as the Baby Boomers reach and surpass their 65th birthday. By 2025, Iowans over the age of 65 could number almost 686,000 and represent close to 1 out of every 4 (22.5%) persons in the State.

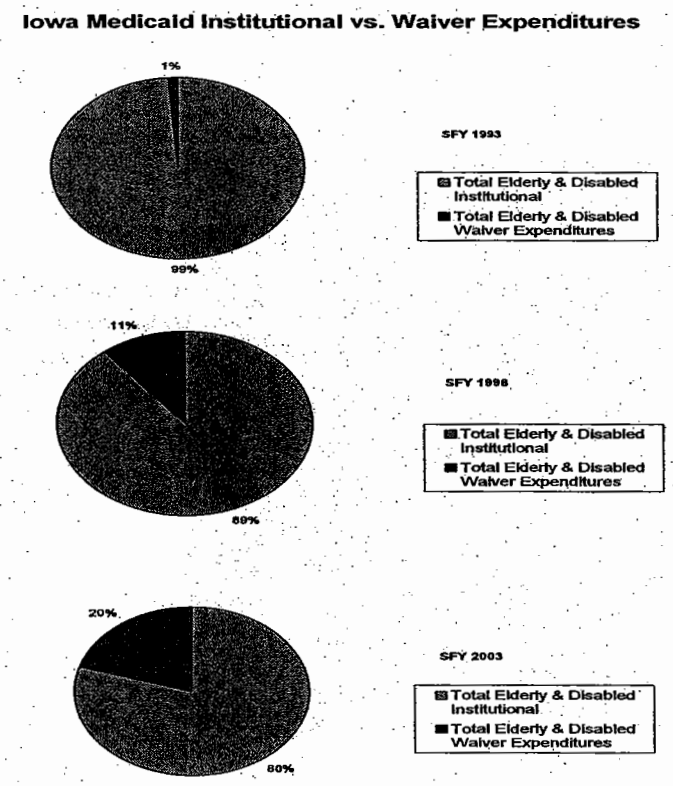


The aging population has become increasingly older. The Census indicated that 233,500 Iowans are over the age of 75, and our state, along with North Dakota, leads the nation in the percentage of citizens over the age of 85 (Iowa has 2.2%; North Dakota has 2.3%). In the next 20 years, the oldest-old (those over 85 years old) will constitute the fastest growing population group in Iowa, and 1 out of every 6 older Iowans actually will be over the age of 85. This particular trend is worth highlighting because the oldest-old are at greatest risk for age-related illnesses and disabilities such as Alzheimer's disease and severe arthritis. As a result, they are more likely to require a spectrum of home, community-based and residential services. [i]

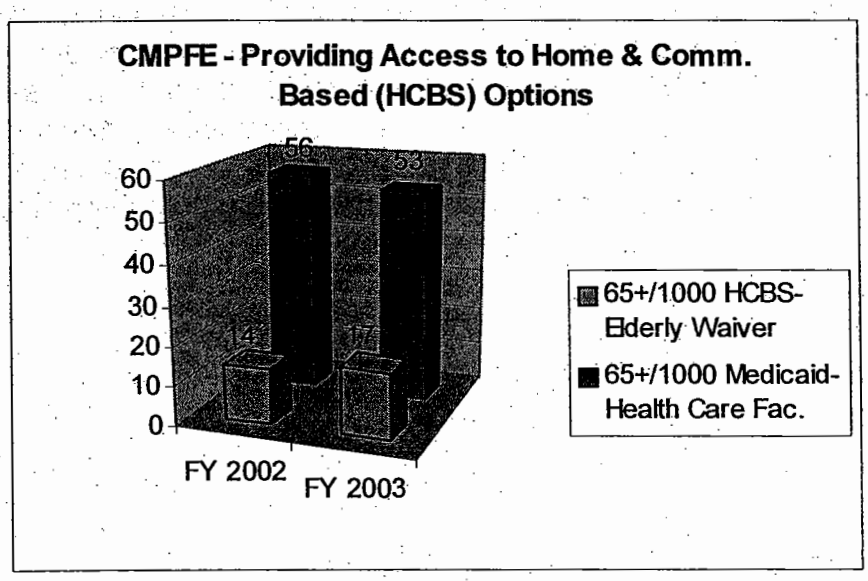
The growth of Medicaid spending in Iowa for the old and disabled is alarming and constitutes nearly 4/5 of total Medicaid expenditures. In 2003, the total spent in the Medicaid budget (both federal and state shares) was $2,007,826,315. Of this number, $966,658,633, or 48% was spent on the disability community and $629,817,495, or 31% was spent on those over 65 years of age. In other words, 79% of Medicaid expenditures were for the disability and elderly populations. The following graph shows that while this ratio has remained fairly constant over the past ten years, the increase in total spending for Medicaid is increasing exponentially, increasing 40% from 1993 to 1998 and 56% from 1998 to 2003.[ii]



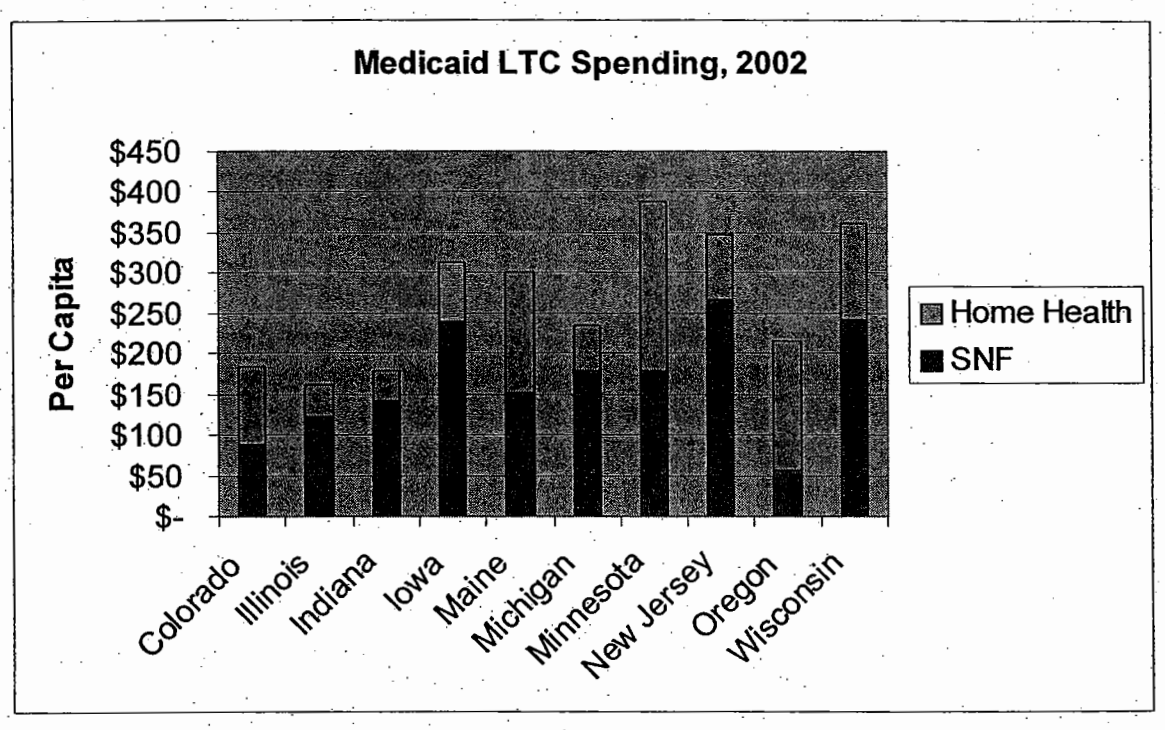
State government in Iowa has initiated several programs over the past several years to address the increasing costs of care to the elderly and disabled. Funded in large measure by the Senior Living Trust, these efforts have included the Case Management Program for the Frail Elderly (CMPFE) and conversion grants to help develop home and community based services. In addition, the Elderly and Disabled Waivers in the Medicaid program have had their desired effect of re-allocating resources away from institutional care and toward services in people homes and communities. One measure of this change is a gradual increase in the percentage of Medicaid funds spent for home and community based services in the HCBS Waiver program. The following graph illustrates this trend:



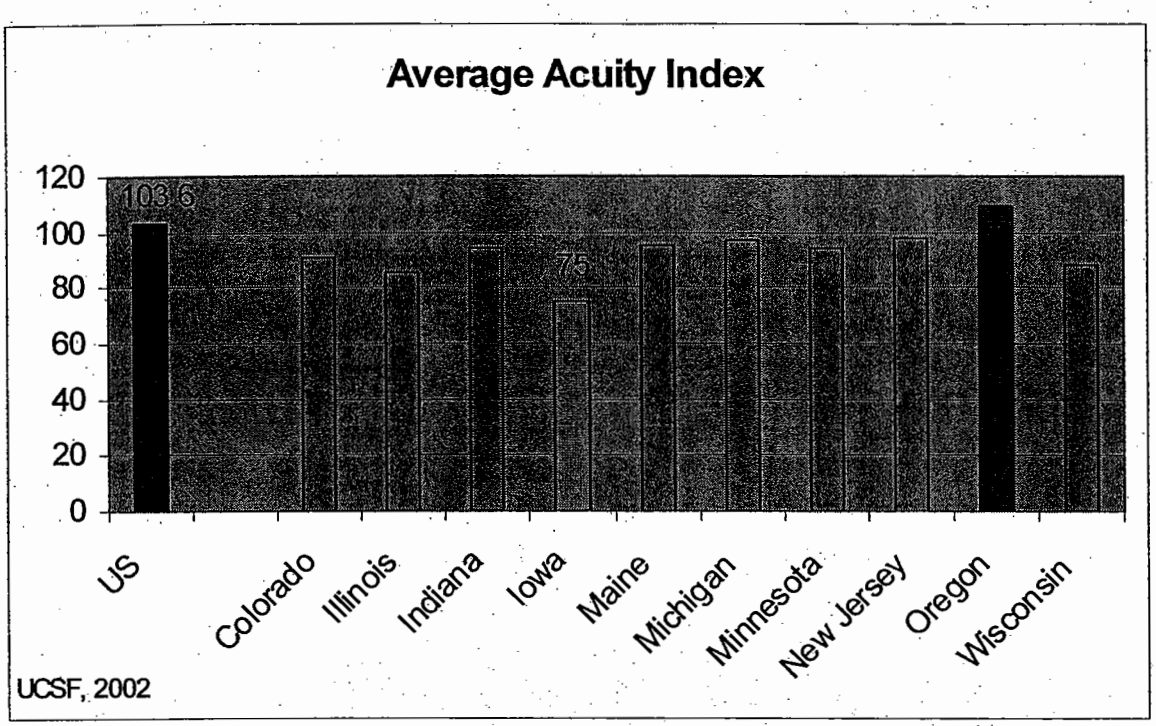
In other words, Iowa along with many other states is experiencing a re-balancing of long term care expenditures. People who once were served in a nursing facility now seem to be receiving needed services in their homes and in homelike settings. As the following graph indicates, the number of people per thousand over 65 in nursing homes is decreasing at the same rate that the ratio for those in home and community based services is increasing:



In spite of this progress, Iowa, like most states, still relies more on institutional care for frail elderly and disabled than on care in home and community based care. Relative to the national average and the nine other states included in this analysis, Iowa has an abundant supply of residential care. For example, the State provides 77 nursing facility beds for older adults, 15 assisted living beds, 33 hospital beds, and 13 residential care beds for every 1,000 older citizens. Of the estimated 59,500 functionally disabled older Iowans, slightly more than 33,000 live in some type of residential care facility. The majority of these, nearly 80%, live in a nursing facility. The Iowa Medicaid program continues to allocate more towards institutional-based long-term care when compared to other states.



Polls indicate that people prefer by large margins to age in their homes and communities. Such care is also much less costly for government payers. Effective home health care can also delay or eliminate more costly institutional placement. The goal, then, must be to continue to re-balance the LTC system so that it increasingly favors home and community based care rather than institutional care. Many of the people in nursing facilities in Iowa do not really need to be there. The following graph indicates that the level of care of residents in Iowa nursing facilities is much lower than is common in other states.



Still, it will not be possible for all families to provide the quality services that older Iowans need. Indeed, not all older Iowans even have adequate homes or competent families. Some families will be unable and/or unwilling to provide the free care and lodging which replaces residential care otherwise paid for with tax money. Indeed, as the population of America ages and eventually moves from 12.5% to 20% of the entire population, the cohort of adult children who today account for 80% of their support only increases by 7%.[5] Some older Iowans may even choose to purchase care in a congregate setting to avoid "burdening" their families or because they prefer the security and peace of mind that goes along with purchasing professional care. A significant portion of older Iowans will always reside in institutional settings as they age and become more frail and disabled. Increased attention to the quality and affordability of such institutional care must remain a high priority.

The guiding principles in the LTC system of Iowa must be independence, dignity and choice. Older Iowans and disabled adults must retain control over their living circumstances. Needing help with ADLs and becoming dependent on others for health care must not take away a person's autonomy, privacy and the freedom to choose which services to receive and where to receive them. Caregivers, whether professional or amateur, must always cede to the informed, competent older Iowan's or disabled adult's final discretion over the location and extent of services he or she receives.

[5] From an unpublished paper by Thomas Nerney, 2003.

Citizens of Iowa rely on their state government to see that their rights are maintained and that they have access to safe and affordable options in LTC. For this reason, the SLCU adopts this Strategic Plan to ensure that all disabled and frail Iowans have independence, dignity and autonomy as they access a multi-layered LTC system.

1) **Consumer Direction**[7]: Older and disabled Iowans should have maximum control over the care they receive, who provides that care and where they receive that care. There are several emerging initiatives which encourage consumer direction of care such as the Independence Plus or Service Voucher and Counseling, and Money Follows the Person. These and other forms of consumer direction provide care which disabled adults and older Iowans themselves choose, supervise and manage. Much research indicates that such programs maintain the dignity and privacy and choice which are important to those needing help due to frailty, disease and disability. People receive better, more timely and reliable care to the extent that they control who provides the care.[8] Trust in a caregiver, after all, is the most important ingredient in effective caregiving. Cost analyses of the various consumer directed care options indicate that the programs save considerable money by avoiding and delaying more expensive care in hospitals and institutions.[9]
   a) **The SLCU recommends that Iowa adopt available opportunities to implement consumer direction in the LTC system, including, but not limited to, Service Voucher and Counseling and Money Follows the Person.**

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[7] The consumer responsibilities typically considered to be key to consumer direction models include: 1)recruiting, hiring, and training a worker; 2) defining the aide's duties and work schedule; 3) supervising the aide in specific tasks; 4) giving performance feedback; and 5) firing the aide if his or her work is unsatisfactory

[8] *"Improving the Quality of Medicaid Peronal Assistance Through Consumer Direction,"* Datawatch, 26 March 2003.

[9] Health Affairs, *Counseling on Personal Care, Services and Medicaid Costs in Arkansas, ABSTRACT: The Service Voucher and Counseling Demonstration gives Medicaid beneficiaries who are eligible for personal care services a consumer-directed allowance in lieu of traditional agency services. Using survey and Medicaid claims data on 2,008 adult applicants randomly assigned to treatment or control groups, we find the program increased the receipt of paid care but reduced unpaid care. The treatment group had higher Medicaid personal care expenditures than controls did, because many controls received no paid help, and recipients obtained only two-thirds of entitled services. By the second year after enrollment, these higher personal care expenditures were offset by lower spending for nursing homes and other Medicaid services.*

2) **Community Based Services:** 93% percent of older Iowans prefer to remain in their homes and communities as they age and need services. Many barriers inhibit an effective rebalancing of the use of institutional care and HCBS care. Nursing homes are a mandatory Medicaid service, while HCBS programs require a waiver. They require rigid budget neutrality, annual reporting requirements, reauthorization every 3-5 years. Those eligible for the HCBS waivers must be nursing home eligible, preventing the use of Medicaid to target those who with some preventive services might avoid or delay nursing home eligibility. States are prevented from providing selective services to targeted populations with special needs. People either get all Medicaid services or none. And Medicaid allows for payment of room-and-board in nursing facilities but not in community settings such as assisted living or foster care homes.

   a) **The SLCU recommends that Iowa press for changes in the Medicaid program to expand the states ability to provide services to people in ways which delay and prevent institutional placement rather than merely serve those already eligible for institutional care.**
   b) **"Fast Track Eligibility" for HCBS Waiver services**
   c) **Develop "nursing home transition programs" to help people return to their homes and communities by amending Medicaid waivers or Medicaid State Plan to include transition dollars and nursing home transition case management.**
   d) **"Money Follows the Person" type funding strategies that allow people to move from the nursing homes to community based services.**
   e) **Increase the resource limit for Waiver clients who want to stay in their homes so that they can have enough money to maintain the house.**
   f) **Develop a program to provide services to Naturally Occurring Retirement Communities (NORC).**
   g) **Establish standards for communities to be "Elder Friendly."**
      i) **Communities should have some universal design standards that are of value to all citizens.**

3) **Information and referral:** Seniors and their families are very confused about the long term care system. They tend not to plan well for their inevitable frailty. Important decisions get made in a crisis. The SLCU recommends:

   a) **more efforts to educate people about the importance of planning for their long term care needs;**
   b) **expanded case management services and a universal assessment available for all Iowans.**

c) **a much streamlined system of eligibility determination and assessment of need as envisioned by the Seamless project within the Department of Elder Affairs should be implemented and available for all targeted populations.**
d) **Full implementation of the Resource Center Grant from the Administration on Aging.**

4) **Caregivers:** Families remain primarily responsible for long term care in the United States. Indeed, 75% of Iowans with disabilities currently reside in family settings. 44 million Americans currently care for someone with a disability. This is 20% of the population. This means that family members provide most of the care which those with disabilities and older Iowans currently receive. According to a report released April 6, 2004 by the National Alliance for Caregiving and AARP, one out of five U.S. residents provides unpaid caregiving services to an adult. The study, which surveyed 6,139 adults and identified 1,247 caregivers, estimated that about 44.4 million U.S. residents in 22.9 million households provide care to a family member. (Caregiving was defined as unpaid services provided by people ages 18 and older to people older than age 18. Researchers considered caregiving services ranging from help with balancing a checkbook to assistance with activities of daily living, such as eating, dressing or bathing.) The study found that 48 percent of caregivers provide eight or fewer hours of care per week, and 17 percent say they provide more than 40 hours of care per week. Additionally, the study found that 39 percent of caregivers are men, higher than the 25 percent found in earlier studies, although on average, women spend four more hours caregiving than men do. Researchers estimate that the value of caregiving services is $257 billion per year. The National Family Caregiver Support Program provided $159 million to families this year, and the Bush administration has proposed $161 million for FY 2005. According to the Census Bureau, the 65-and-over population will increase from 12 to 21 percent by 2050, most likely raising the number of U.S. residents who will require caregiving. (The study is available online, at http://research.aarp.org/il/us_caregiving.pdf.[10]

A family based system of LTC, however, is not without costs. Some of the most important costs are intangible. 40% of caregivers are spouses who are frail themselves and care for loved ones at no small danger to their own wellbeing. The financial cost to caregivers still in the workforce and their employers is substantial due to lost wages, absenteeism and lost productivity. 70% of caregivers are women who have many other conflicting obligations and duties. Many caregivers lack the training, skills and support to provide

[10] (Kornblum, *USA Today,* April 6; Lipman, *Cox News/Arizona Daily Star*, April 6.

competent care. Paid direct care workers to help and replace family care givers are in short supply, poorly paid and overworked.

a) **The SLCU recommends that the LTC system provide support, assistance, training and respite for the families which assume responsibility for long term care.**

The increased use of in-home services without adequate standards, training, oversight and certification for direct care workers raises concerns about quality and abuse. The increased use of non-certified staff in consumer directed home care settings increases the chance that people will experience substandard care or worse. Many caregivers are professionals who receive extensive training for the skills necessary to care for people with disabilities and with the frail elderly.

The future demand for this workforce far outstrips the supply of those willing and able to work in this field. Current pay levels do not draw enough people into and retain enough existing workers to meet the current and future need for care givers. Furthermore, the advent of consumer direction in long term care may allow consumers to hire poorly qualified people rather than rely on the shrinking pool of professional caregivers.

b) **The SLCU recommends that we continue to partner with the Iowa Caregivers Association and especially their Better Jobs Better Care grant to ensure that trends in consumer directed care not erode the quality and wages of caregivers. The SCLU also supports ICA's efforts to expand the Iowa Nurse Aide Registry to include other direct care workers. Currently, only nurse aides working in nursing facilities are required by federal law to be on the Registry. The new Registry could potentially include in its data bank a pool of personal assistants seeking employment through the Cash and Counseling model. The SCLU also supports partnership with the minority communities to promote caregiving as quality jobs for recent immigrants.**

5) **Managed Care:** Nursing homes represent the longest running and most consistent use of managed health care strategies iin the United States. Recent attempts to remove from nursing homes those who are less frail and in need of services have disrupted the capitation rates by raising the average acuity of residents. That overall costs continue to rise dramatically indicate that this "creaming" of the healthy and wealthy from nursing homes has not reduced overall system costs even if it has reduced costs for those removed to less expensive options. The principals of managed care (capitation and

"managing" care) remain valid and effective at restraining costs and improving quality by providing only the services necessary to improve health status. Fee for service systems carry perverse incentives for providers who gain from providing care rather than for improving health outcomes.

a) **The SLCU recommends that Iowa explore managed care options such as PACE for the provision of LTC.**
b) **The SCLU recommends that the Case Management Program for the Frail Elderly (CMPFE) be used to manage the care component of affordable assisted living programs where services are separated from housing and billed directly to Medicaid and the Elderly Waiver program.**
c) **The SLCU recommends that a study be commissioned to assess the true costs for home and community based services for a variety of acuity levels to determine the extent of the savings for providing long term care in the community rather than in an institution.**

6) **Housing**: Increasing numbers of the disabled and frail elderly will live in non-institutional housing. But large numbers of Iowans will continue to have too few resources to afford the modifications which enable them to live safely in their own homes, not to mention the even more significant costs of residential care. Iowans need affordable options for those who need residential care and assistance with home modification for those who want to remain in the community. Many innovative ideas (often captured under the rubric "Universal Design") exist to remodel existing homes and build new ones which accommodate the needs of those with disabilities. Innovative programs such as the Coming Home Project currently funded in Iowa by RWJ promise to make residential care available for those with limited resources. It would be very helpful if Medicaid, or other public source of money, paid for home modifications which might delay or prevent institutional placement

Technology may also greatly add to a home's safety and convenience. It will likely be possible for the home of the future to have technology which passively monitors a person's whereabouts, movement and even health status to relay to caregivers. Various new appliances offer ease and safe operation even for the frail, fumbling fingers of an older person or disabled adult. Communication devices hidden in fixtures allow environmental control with voice commands and preprogrammed operational commands. Computers will soon sense your entry to a room and turn themselves on, anticipate or even request your wish to send an email, plan your calendar, prepare a meal, or create a shopping list for items in short supply. Unsolicited, they will remind you of favorite TV programs, cultural events and other important dates for grandchildren's birthdays and soccer tournaments. Chips in food packages will signal the cash register to ring up the proper

price, control the refrigerator for proper storage and tell the oven the cooking time and temperature as well as keep track of the day's dietary needs and add it's own replacement to your shopping list. Technology has only begun to transform our lives, making them more convenient and safe for older people.[11]

a) **The SLCU recommends that the state government support efforts to make housing more available, affordable and accessible for older Iowans and those with disabilities.**
   i) It supports the efforts of the Iowa Finance Authority to implement affordable assisted living options which combine subsidized housing and Medicaid Waiver services to low income older Iowans and disabled adults.
   ii) It recommends building codes which include accessibility and "visitability"[12] standards so that increasing numbers of homes are able to accommodate those with limited mobility.
   iii) It supports the efforts of DEA and others to promote the use of universal design in all new homes built in Iowa.

b) **The SCLU recommends that state government help older people learn about and acquire adaptive technologies which allow them to live in their own homes more safely and convenience.**

7) **Quality**: Quality in home and community based services is often an elusive target. It's difficult to define and measure. Consumers tend to focus on intangibles like friendliness and helpfulness while regulators stress training and process. Institutional care also proves difficult to assess in ways which truly measure what people expect and require. People assume nursing homes will be safe and hygienic. What they want is a home-like environment which supports them as individuals with worth and dignity. The Personal Experience Survey (PES) from Medstat and the Culture Change movement in nursing homes are examples of innovative efforts to improve and measure quality in long term care by focusing on the experience of residents and program participants rather than regulatory requirements. In addition, inherent in consumer directed care is the danger associated with a lack of oversight, training, and certification of care givers.

   a) **The SLCU supports efforts by private and governmental units to measure and encourage the kind of quality in long term care which helps people make informed choices about how to receive long term care services.**

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[11] Among the many references for such futuristic home technology is the Article in the February 23, 2004 issue of the Wall Street Journal, *Inside the Home of the Future.*

[12] "Visitability" refers to the accessibility of homes by those who "visit" even those who live there do not require accessible. An accessible bathroom on the ground floor of all new construction would make life much easier for the handicapped and disabled guest, as well as improve the resale value of homes.

b) **The SCLU recommends that DIA and DEA cooperate to ensure that information about certification reports, monitoring visits, complaints investigations and other information valuable to consumers be readily available on department Web sites.**
c) **The SLCU recommends the development and implementation of reasonable standards for oversight of consumer directed care.**
d) **The SCLU recommends that Demonstration projects in long term care be allowed which create truly resident centered, home like care using principles of what's called "culture change" and other concepts to make nursing homes more like homes and less like hospitals.**

8) **Case Management for the Frail Elderly (CMPFE):** The case management system in Iowa is a partially state funded initiative which provides a range of services which help the frail elderly determine needed services and providers. Case managers located in the area agencies on aging assess client needs with the goal of providing those services which maximize the ability of the client to choose which services he or she will receive and where he or she will receive them. The goal of the case management system is to intervene early enough to prevent or delay institutional placement. Most people prefer to avoid nursing home stays as long as possible. CMPFE is a program in state government which attempts to honor these preferences. The cost savings to individuals and the government when institutional placement is avoided or delayed are significant.

a) **The SLCU recommends the following changes in CMPFE to continue re-balancing LTC in favor of home and community based services:**
   i) The implementation of a universal assessment process.
   ii) The admissions law should be changed to narrow the criteria for admission to a nursing facility and to prefer a home and community based setting.
   iii) Adequate reimbursements for case management services.
   iv) Some accommodation for high vacancy rates in nursing homes should be a part of the rebalancing effort to facilitate a smooth transition to a decreased reliance on institutional care.
   v) A state wide system of case management needs coordinated and uniform administration to ensure consistent quality and adherence to the goal of rebalancing. This need not be one entity, but it must have some sort of central administration, coordination and training.
   vi) Home and community based services are not yet sufficiently available to meet the increasing demand for their services which a rebalanced system will require. It may be that various subsidies and other support will be needed to help develop the quantity and quality of

HCBS. Some nursing homes need to convert unused capacity into HCBS and new ventures in HCBS need technical and financial assistance to create added capacity. The Department of Elder Affairs and Human Services should create the capacity to respond to this need for technical assistance.

vii) The long term care system should also provide support for assistive devices and home modifications which can enable disabled and frail people to remain independent and in the community.

9) **Consolidated Services for the Disabled and Elderly:** Policy and administration of programs for the elderly and disabled are currently spread among several state departments. This has restricted the state's ability to coordinate policy and adopt new and comprehensive ways of delivering services. The states that have been most successful at progressive reform of the LTC system have enjoyed better coordination long term policy and service delivery.

a) The SLCU recommends that increasingly LTC policy development and service delivery be coordinated through entities such as the Senior Living Coordinating Unit and other cabinet level groups which enable the responsible departments to share information and develop policy more effectively.

10) **Meaning and Significance**: Older Iowans continue to need more than just adequate nutrition, medication management and socialization (the usual three legged stool of long term care). They also want to stay engaged in meaningful mental, physical and spiritual activities and invested in their community. Older people and disabled adults continue to have sexual desires which are often denied expression in long term care settings. Many people will continue to seek employment opportunities as they age, perhaps even while in an institution. In fact, older workers will grow as a percentage of the labor pool over the next decade and beyond because older workers are choosing to prolong their working years at a time when the oldest baby boomers are approaching their sixties and the share of workers ages 25-54 is projected to decline.[13] Older workers will continue to need the money, social interaction and meaningful activity which employment offers. A recent AARP working in retirement study indicates that 70% of workers who have not yet retired report that they plan to work into their retirement years or never retire. And the top motivations for working retirement included not only the need for extra money but also a general desire to work for enjoyment, to have something interesting to do and to stay physically active.[14] Those who earn their living with their minds, personalities and creativity will want and

[13] "Staying Ahead of the Curve 2003: The AARP Working in Retirement Study, copy right 2003, page 10.
[14] AARP, *Staying Ahead of the Curve: The AARP Work and Career Study* (Washington, DC: AARP, 2002).

need to be employed long after traditional retirement. Indeed, retirement will no longer be an extended leisure period but a time of continued engagement with all the activities that make life meaningful and significant. Long term care should maximize people's attachment to the community by encouraging involvement in churches and civic groups, volunteerism and education, travel and entertainment. Retirement should be a time for older Iowans to find meaningful activities in employment, volunteer activities, and engagement in the civic life.

a) **The SLCU recommends that senior employment programs expand to meet the needs of older Iowans for continued employment and that employers be encouraged to recognize the value of older workers.**
b) **The SLCU recommends that state government help Iowa develop as a place where seniors can stay engaged in activities that nourish their spirits and minds through meaningful life-long learning, volunteerism, employment and recreation.**
c) **The SLCU recommends that the state adopt employee and pension policies which encourage older workers to stay in the work force by eliminating penalties for re-employment in IPERS, adopting flexible work schedules, and adapting the workplace to accommodate the needs of older workers.**
d) **The SLCU recommends that the long term care system explore ways to allow the expression of the legitimate sexual needs of older Iowans and adults with disabilities.**

11) **Diversity:** Older Iowans will increasingly create non-traditional partnerships as they make retirement and long term care decisions. Older sisters, mother-daughter combinations, same sex couples, co-habiting heterosexual couples and caregivers to frail or disabled adults and their clients, among others, may increasingly wish to be considered a "couple" with the same rights and privileged as a traditional married, heterosexual couple. These groups of people currently are disadvantaged by a system which allows married couples distinct financial and legal advantages over unmarried partnerships. Married couples often get opportunities for joint decision making, rights of survivorship and continued occupancies, and better pricing of services. Non-traditional couples deserve equal treatment and opportunities in these and other regards.

Iowa will become increasingly diverse as immigrants and minorities increase in their percentage of the population. People from Hispanic countries, Southeast Asia and Eastern Europe all bring their own peculiar cultural traditions and values about aging. They will present demands and provide opportunities for aging services that need to be explored. The workforce of those serving frail and disabled Iowans is likely to come increasingly from

ethnic and racial minorities and from recent immigrants. A diverse workforce serving a diverse client base must be culturally competent.

a) **The SLCU recommends that Iowa encourage the long term care industry to offer expanded opportunities for non-traditional couples to receive equal treatment.**
b) **The SLCU recommends that Iowa explore ways to include diversity training in LTC curriculums.**

12) **Transportation:** Autonomy and choice require available and affordable transportation. People in their communities and in facilities need convenient access to services which enable them to be mobile.

a) **The SLCU recommends that the state explore ways to provide public transit for more frail elderly and others by designing roads and highways so that they accommodate the changing ability of older people to drive safely.**

13) **Elder Abuse, Neglect or Exploitation.** Elder abuse is one of the most under-recognized and under-reported social problems in the United States. It is far less likely to be reported than other types of abuse due to the lack of public awareness and understanding. According to the Fall 2003, Journal of National Academy of Elder Law Attorneys, 84% of elder abuse cases go unreported and 40% of all elder abuse involves some form of financial exploitation.

We become more vulnerable as we grow older due to the infirmities of aging. The rate and extent to which this occurs varies from person to person. Many individuals have family, friends and resources to provide them with assistance. Many others do not have such resources. Both scenarios can become breeding grounds for incidents of abuse, neglect and exploitation. These unsafe situations may stem from caregiver stress, ill prepared and untrained caretakers, or pure criminal activity. The continuum of potential victims, victims, and perpetrators is as vast as are the reasons why someone becomes a victim and why someone victimizes another. In order to address these issues and to provide a safe and healthy environment for this at risk population, it is vital that a comprehensive adult protective system be developed by combining available resources and partnerships.

a) **The SLCU recommends that a holistic, comprehensive system addressing the areas of prevention, detection, intervention and reporting of elder abuse, neglect and exploitation be expanded statewide through the Elder Abuse Initiative. This initiative educates individuals at risk, communities, providers and other stakeholders of available options and assistance, including legal assistance, services, housing, and employment.**

b) The SLCU recommends that the state adopt policies and legislation to increase the safety of individuals experiencing abuse, neglect, or exploitation. The legislation would include enhanced criminal penalties for violations against individuals aged 60 or older or disabled adults of any age.

14) **Legal Assistance:** Aging and disabled people experience increased need for legal help. Issues surrounding advance directives and planning for potential incapacity, guardianship, conservatorship, powers of attorney, Medicaid application and appeals, residents rights, fair housing, consumer protection and discrimination based on age or disability are all areas where individuals may need legal advice, counsel or representation.

Some older Iowans and disabled adults may experience impaired decision-making relating to their personal care needs or financial management. Our state does not currently have an organized system of assisting individuals in need of decision-making if they have no family or friends available to help. A public guardianship program would assist many older Iowans receive the decision making help that they need relating to long term care services and supports.

Many older Iowans and disabled adults may be vulnerable to scams, fraud, abuse and neglect. The wide range of programs offered through consumer protection and advocacy programs that are part of the aging network may help those Iowans. Whether the issue relates to abuse or neglect within the long term care system or by a family member or contractor or whether it is serving as a resource and clearinghouse of information on Medicaid eligibility, Medicare payment or appeal, suspected fraud related to payment of claims under Medicare or Medicaid, suspected abuse of financial instruments or the need for substitute decision making documents such as health care powers of attorney, living wills or guardianship, legal advocacy is a part of what all persons entering the long term care system need.

The SLCU recommends a public guardianship program to assist older Iowans receive the decision making and legal help they need.

The SLCU recommends additional funding of legal assistance programs for the elderly and disabled to meet their legal advocacy needs.

15) **Continuous care retirement communities** are a popular option for many older Iowans. They enable people to make arrangements for the progressive decline in physical and mental ability which all will experience. Making

arrangements and decisions well in advance of a crisis reduces the trauma of increased dependence on care and raises the likelihood of successful placement in appropriate settings as needs increase.[15]

a) **The SLCU recommends that continuous care retirement communities be encouraged to expand their services to additional social and economic groups so that more people can plan well in advance for the decline in physical and mental capacity that often accompanies aging.**
b) **The SLCU also recommends that the statues and administrative rules which govern the operation of CCRCs be examined to facilitate their ability to serve older Iowans and protect consumers.**

16) **Healthy Aging:** Healthy Aging: Healthy aging is supported by good nutrition and physical activity. Good nutrition is essential to the health, self-sufficiency and quality of life for people as they age. For example, consuming an adequate diet reduces risk of cancer, heart disease, osteoporosis and obesity. Unfortunately, many older adults do not consume the recommended levels of nutrients. In Iowa, only 33% of older adults report eating the recommended five servings of fruits and vegetables daily. The consequence of poor nutrition status is the hastening of many diseases associated with aging. As older adults chronically consume an inadequate diet, they are more likely to have an unhealthy weight, experience decline in both mental and physical health, and have a higher risk of dying. Nutrition services such as congregate and home delivered meals improve daily intake of nutrients. The cost of providing meals for one year is equivalent to one day of hospitalization. Nutrition education and nutrition counseling have been demonstrated to reduce health care costs.

Regular physical activity improves physical functioning and may reduce falls significantly lower risk of hip fractures. Additional benefits to older adults include improvements in blood pressure, diabetes, cholesterol levels, osteoarthritis and cognitive function. Physical activity is related to postponed disability and independent living. Encouraging physical activity in older adults can help individuals reach and maintain their highest level of function and quality of life. All levels of activity are beneficial and it is never to late to receive these benefits.

a) **The SLCU recommends that efforts be made to improve the performance of congregate meals and home delivered meals and that nutritional counseling be added as an eligible service under the Elderly Waiver Program and that more seniors be enrolled in the Food Stamp Program.**

[15] One valuable resource for consumer information about CCRCs which also has links to other government and industry association information is from AARP: http://www.aarp.org/confacts/housing/ccrc.html.

17) Future Issues

a) Mental Health
- i) Older people suffer many undiagnosed and untreated mental health problems. Some of these problems are masked by serious illness and hidden by the normal reaction to the inevitable losses of aging.

b) Rural concerns
- i) Rural areas experience a loss of population and economic well being which make the provision of services difficult.

c) Who pays for long term care
- (1) Will we continue to require individuals to finance their own long term care needs or will the public financing of long term care expand to pay for more than those with virtually no resources (left) to pay for long term care.

d) Physical Laborers
- (1) People who labor for a living in jobs which require physical effort often experience more health care needs at an earlier age and are prevented from working longer to compensate for lower life time earnings.

e) Death and Dying
- i) Will Americans continue to allow the health care system to extend life without protesting? It is entirely possible that Americans will want to have control over the time and manner of their dying. This presents enormous ethical dangers and dilemmas.

f) Caregiver workforce
- i) The supply of people willing and able to work for the low wages paid caregivers does not begin to meet future demand. Iowa must be able to recruit and retaining a new source of people to provide direct care to disabled adults and the frail elderly.

g) Consumer Education
- i) People need lots of help making the necessary choices in long term care. They need encouragement and assistance to plan for their eventual long term care needs.

18) Conclusion:

Iowa must come to grips with the challenges of the disability and frail elderly demographics. The financial drain on government budgets for services to the frail elderly and disabled adults demands action. The costs aging and disability are no less tragic for personal and public finances. Iowa must also ensure that no older person nor disabled adult be lonely, helpless or bored. The solution to the challenges of aging and disabled services will be found in increased use of consumer direction, home and community based services, and managed care. An increased sense of collective responsibility to assist each other afford adequate long term care service would help a great deal. Iowa must expand the range of

choices and opportunities of disabled and older Iowans to find affordable options to stay independent, autonomous and engaged in life.

19) Performance Measures:

a) Decrease in the number of nursing homes in Iowa.
b) Decrease the nursing home census.
c) Change in the ratio of nursing home care to Elderly Waiver expenditures in the Medicaid system.
d) Increase the average acuity level of nursing home residents.
e) Increase in the number of nursing homes who adopt "Culture Change".
f) Increase the supply of HSBS providers.

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[i] Kaskie, page 11

[ii]

Money spent in Medicaid:	SFY 1993	SFY 1998	SFY 2003
1. for all Medicaid Services	$912,736,443	$1,280,916,908	$2,007,826,315
2. on the disability population within Medicaid	425,675,632	626,503,421	966,658,633
3. on the elderly population within Medicaid	294,264,231	430,582,296	629,817,495
4. on the elderly population for institutional care	207,065,209	299,331,089	383,893,187
5. on the disability population for institutional care	*N/A	278,404,487	313,350,287
6. on the elderly waiver services	90,424	7,257,712	25,118,681
7. in each of the other waivers	2,297,275	62,440,964	150,711,065
8. in each of the non-elderly waivers for those over 60	39,631	3,688,247	11,047,036

Attachment 8

Iowa Department of Human Services

Long Term Care Services

Kevin Concannon, Director

September 2004

Iowa Long Term Care Medicaid is a partnership between Iowa and the Federal Government which allows the Iowa Department of Human Services to provide a continuum of medical services to needy Iowans that:

- Pays Iowa Health Care providers about $2 billion a year to care for, on average, 275,000 Iowans each month who can't afford to purchase health insurance which meets their health care needs.
    - About half of the Iowans receiving health care through Medicaid are children.
    - Health care spending for elderly and disabled Iowans, however, accounts for about three quarters (3/4) of the total cost of the program.
- Provides substantial financial support to Iowa counties to fulfilling their longstanding responsibilities to care for the mentally challenged and those with developmental disabilities

The Terms of the partnership are set out in the Iowa "State Medicaid Plan". This is a very lengthy document which:

- Explains how the Iowa Medicaid program works, who is eligible, reimbursement methods, and so forth; and
- Certifies that Iowa is aware of, and complies with, Federal Medicaid rules.

Every State's Medicaid program is unique- but they all have a lot in common.

- Overall, Iowa's program has more generous eligibility rules than programs in other States – but its guidelines are certainly far more restrictive than those of some states.
- Overall, Iowa's program is quite comprehensive in the services that it covers. (If you compare Medicaid's covered services with those of a commercial insurance plan, Medicaid appears more generous. But that is largely due to the fact that Medicaid pays for an array of long term care services for low income elderly and disabled.)

Who is eligible for Medicaid Long Term Care Services in Iowa?

What kind of care do they receive?

How much does it cost?

- **Elderly** (36,872 Iowans) with family income below 73% of FPL and no more than $2,000 (single)/$3,000 (couple) of countable assets and
  - Frail elderly (i.e. those eligible for nursing facility level of care) living in the community with incomes to 300% of the SSI level (which is equal to 221% of FPL).
  - Elderly living in nursing homes with incomes to 300% of the SSI level.
  - Elderly with income below 65% of FPL and nor more than $10,000 of countable assets and with extraordinary medical expenses.
  - Qualified Low Income Medicare Beneficiaries (QMBs). Medicare eligible Iowans with family income to 100% of FPL and no more than $4,000 single)/$6,000 (couple) in countable assets. Medicaid pays the Part B premiums and Medicare co-payments and deductibles.
  - Specified Low Income Medicare Beneficiaries (SLMBs). Medicare eligible Iowans with family income to 120% of FPL and no more than $4,000 (single)/$6,000 (couple) in countable assets. Medicaid pays the Part B premiums only.

- **Disabled** (58,494 Iowans) with family income below 73% of FPL and no more than $2,000 (single)/$3,000 (couple) countable assets and:
  - MR/DD Adults with family incomes to 300% of SSI.
  - Adults with AIDS and/or Traumatic Brain Injuries with family incomes to 300% SSI.
  - Working Disabled with family incomes to 250% of FPL.
  - Disabled with income below 65% of FPL and no more than $10,000 of countable assets and with extraordinary medical expenses.

Are there any low income Iowans who are not covered by Medicaid?

- Single individuals and childless couples (i.e. no minor children) between the ages of 21 and 64 are not covered by Medicaid no matter how little income they have – unless they meet the Social Security Act's definition of disabled.
- Iowans who can't afford health insurance, but don't meet the income and asset tests for Medicaid.

Federal Poverty Levels				
Monthly Income Limits				
Poverty Level				
	1	2	3	4
65%	$504	$677	$849	$1,021
73%	$566	$760	$953	$1,147
100%	$776	$1,041	$1,306	$1,571
120%	$931	$1,249	$1,567	$1,885
133%	$1,032	$1,385	$1,737	$2,089
200%	$1,552	$2,082	$2,612	$3,142
250%	$1,940	$2,603	$3,265	$3,928

Optional Medicaid Services	Chosen by Iowa? Yes or No
1. Chiropractors' Services	Y
2. Private Duty Nursing Services	N
3. Clinic Services	Y
4. Dental Services	Y
5. Physical Therapy, Occupational Therapy, and services for individuals with speech, hearing and language disorders	Y
6. Prescribed Drugs	Y
7. Dentures, Prosthetic Devices, and Eyeglasses (Includes all medical supplies and durable medical equipment, as they aren't separated on current reports.)	Y
8. Diagnostic, screening, preventive and rehabilitative services (individual age 21 and older)	Y
9. Inpatient Hospital Services and Nursing Facility services for individuals age 65 or older in institutions for mental diseases	Y
10. Intermediate Care Facility (ICF/MR)	Y
11. Nursing Facility other than in institutions for mental diseases	Y
12. Inpatient psychiatric services for individuals under age 21	Y
13. Transportation (Note: "Access is required." Provided as an administrative service.)	Y
14. Podiatrists' services	Y
15. Optometrists' services	Y
16. Psychologists' services	Y
17. Medical Social Workers' services	Y
18. Christian Science Nurses	N

19. Christian Science Sanatoriums	N
20. Emergency Hospital Services (Note: Provided in a hospital which does not meet the condition for participation under Medicare or the services don't meet the definition of inpatient or outpatient hospital services.)	N
21. Personal Care Services	N
22. Home or Community-Based Services (waivers required)	Y
23. Hospice Care Services	Y
24. Respiratory Care Services	N
25. TB-Related Services	N
26. Critical Access Hospital Services (Note: Inpatient and Outpatient Hospital Services are mandatory. The designation as a Critical Access Hospital (CAH) for participation in Medicare as an option. CAH's are reimbursed based on cost versus other reimbursement methods.)	Y

MEDICAID LONG-TERM CARE PROGRAM SUMMARY

Intermediate Care Facility - $391,749,671

Provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident, in accordance with the resident's assessment and care plan. Services include nursing, social work, activity programs, individual and group therapy, rehabilitation or habilitation programs, nutrition, comfort, grooming, medical equipment and supplies, specified nonlegend drugs and transportation.

Home and Community Based Services Waiver Programs

Provides service funding and individualized supports to maintain eligible consumers in their own homes or communities who would otherwise require care in a medical institution. These programs are limited to certain targeted consumer groups. Medicaid waiver program services are limited to certain target groups.

Waiver Program	Dollars	Begin Date
Elderly	$31,267,081	8/1/90
Ill & Handicapped	$14,163,390	10/1/84
Brain Injury	$7,151,614	10/1/96
Physical Disability	$1,578,247	8/1/99
AIDS/HIV	$328,707	7/1/92
Mental Retardation	$159,014,918	3/1/92

TOTAL ANNUAL COSTS IN $M FOR Nursing Facilities and Home and Community Based Services Individuals.

Fiscal Year	NF Costs	HCBS Costs
1999	$326M	$85M
2000	$356 M	$103M
2001	$369M	$124M
2002	$387M	$152M
2003	$398M	$176M
2004	$392M	$214M

The average monthly number of clients/eligibles accessing nursing home services and HCBS services:

	NF Clients	HCBS Consumers
FY 04	13,951	14,098

The Total Annual Costs in $M for Nursing Facilities and HCBS:

	NF Clients	HCBS Consumers
FY 04	$391.7	$213.5

The average monthly cost per client for Nursing Facilities and HCBS:

	NF Clients	HCBS Consumers
FY 04	$2383	$1262

Skilled Nursing Facility – FY 2004 $14,011,455
Provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident that requires skilled services. Services are provided in accordance with the resident's assessment and care pan. Services include nursing, social work, activity programs, individual and group therapy, rehabilitation or habilitation program, nutrition, comfort, grooming, medical equipment and supplies, specified nonlegend drugs and transportation.

Nursing Facility for the Mentally Ill - $3,182,108
Provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident who are persons with a serious and persistent mental illness who also require nursing care. Services are provided in accordance with the resident's assessment and care plan. Services include nursing, social work, activity programs, individual and group therapy, rehabilitation or habilitation programs, nutrition, comfort, grooming, medical equipment and supplies, specified nonlegend drugs and transportation.

Intermediate Care Facility for Individuals with Mental Retardation - $207,366,066
Provide the 24-hour care and services with continuous active treatment for individuals with mental retardation, in accordance with the resident's assessment and care plan.

Home Health - $70,446,361
Provide an appropriate alternative to unnecessary institutionalization. The services provided in the Patient's home by a registered nurse, a licensed practical nurse, a home health aide, a speech therapist, a physical therapist, an occupational therapist, or a social worker employed by the agency.

Adult Rehabilitation Option (ARO) - $30,308,635
Provide services that include rehabilitative skills training and support for chronically mentally ill individuals to promote their ability to be integrated in the community and avoid intensive and expensive levels of service such as inpatient psychiatric hospitalization.

Targeted Case Management - $19,422,286
Provides for the coordination of services for individuals who are chronically mentally ill, mentally retarded or developmental disabled. Individuals who utilize this service need service coordination by a case manager due to their disability, as they are unable to function in the community independently. The targeted case manager assists the individual by identifying their strengths and arranging for assistance to either manage the disability or to assure basic needs are being met.
Hospice – This program serves approximately 1000 hospice recipients. To be eligible for the hospice program, an individual must be diagnosed with a terminal illness that if the illness runs its normal course, the patient has a life expectancy of six months or less. Clients receive palliative services during their terminal illness.

All regular Medicaid Services
Provides services including Physician, Clinics, Podiatric, Family/Pediatric, Certified Nurse Midwife, CRNA, Birth Centers, Family Planning Clinics, Psychologist, Transplant, Sterilization, Audiology, Pharmacy (drug and supplies), Durable Medical Equipment, Hospital (inpatient and outpatient), Dentist, Emergency Room Services, Ambulance, Hearing Aids, Optical & Optometric Services, Orthopedic Shoes, and Screening Center Services.

Non-Medicaid Services

Food Assistance Program (Food Stamps)
A nutrition assistance program designed to help low-income individuals the families buy and consume nutritional food.

Residential Care Facility and Residential Care Facility for individuals with Mental Retardation - $7,702,016
Payment is made for residential care by the recipient of a State Supplementary Assistance grant and covers three or more meals per day, living and sleeping quarters, laundry, assistance with personal care, general supervision, activities and socialization experiences.

State Supplementary Assistance In-Home Health Related Care - $7,148,000
Provides health care as an alternative to nursing home care. A consumer chosen provider provides the services in the home. The services are ordered by the person's physician and supervised by a registered nurse. Provides in-home health care services to approximately 1500 persons annually.

Dependent Adult Protective Services - $1,840,471
Accepts reports of abuse and neglect of dependent adults. Completes evaluations and assessments on the allegations of abuse and neglect of adults who are not able to care or protect themselves. Completes approximately 2000 evaluations and assessments of abuse or neglect annually. Works with law enforcement and county attorneys to prevent person responsible for abuse from having access to other dependent adults. Creates and conducts multidisciplinary teams with local providers to develop care plans for abused dependent adults. Makes referrals for services for the abused or neglected dependent adult and person responsible for abuse. Provides mandatory reporter training to local mandatory reporters.

Central Abuse Registry - $82,486
Completes child and dependent adult abuse background checks on prospective health care employees for employers. Completes Record Check Evaluations on prospective employees with criminal or abuse backgrounds to determine employability. The Central Abuse Registry completes approximately 36,000 background checks and 4800 Record Check Evaluations annually.

Senior Living Trust Conversion Grants
Per Senate File 2298, twenty million dollars has been allocated for FY 05 for the Senior Living Trust Fund Grants. This funding has been allocated to provide grants to nursing facilities for conversion to assisted living programs or to provide long-term care alternatives or to provide grants to intermediate care facilities for persons with mental retardation for conversion to assisted living. The FY 05allocation is as follows:

- Up to 25% ($5,000,000) is designated to reduce the numbers of persons in the state resource centers and other ICF's/MR.
- Funding ($7,000,000) will be transferred to the Iowa Finance Authority to develop two revolving loan programs. $5,000,000 has been allocated to further develop affordable assisted living and housing for seniors and persons with disabilities.

$2,000,000 has been allocated to the loan program that will encourage the expansion of adult day services, respite services and congregate meals.

Previous Senior Living Trust Fund Conversion Grants

- Grant year 2000-2001
  - Grants were allocated to 25 agencies for a total of $9,974,461.
  - As of 10/03 17 agencies have completed their approved projects. 8 agencies have not completed their approved project.
- Grant year 2001-2002
  - Grants were allocated to 10 agencies as of 10/03. As of 5/04 8 agencies are proceeding with their application for a total of $3,080,000.

The Legislature allocated $20,000,000 for these grants of which $16,626,148 has been taken back by the Legislature.

New Initiatives/Requirements

- Iowa is developing a Preferred Drug List for prescription drugs.

- Iowa is in the process of expanding its "lock-in" program (controls utilization by very high end users).

- Iowa has planned expansion of its disease management program.

- Iowa has planned expansion of its primary care case management program.

- The Rebalancing Initiative Grant-
  - To develop a uniform methodology, incorporating person-centered planning, for calculating all individual budgets while demonstrating cost neutrality;
  - Develop a Independent Support Broker and financial management function to support a self directed service delivery system;
  - To provide a statewide marketing campaign about the availability of long term care choices to address unrecognized barriers to community integration and to build the capacity of key stakeholders to implement and utilize self-direction in HCBS.

- The Medicare Prescription Drug (Part D)

- Universal Assessment pre-admission screening tool.

- The Quality Assurance and Quality Improvements HCBS Grant:
  - To enhance the existing Quality Framework for traditional HCBS;

- To evaluate and monitor a consumers success with self directed services.

- Integrating Long Term Supports in Affordable Housing Grant – Application made by the Iowa Finance Authority
  - Establishing the "Integrating Long-term Supports with Affordable Housing" Subcommittee of the Olmstead Real Choices Consumer Task Force;
  - Holding a Summit on Housing for People with Disabilities each year of the grant to assess progress in implementing the Housing for Persons with Disabilities State Action Plan;
  - Creating an accessible housing search website that people with disabilities can access on the internet or through an aging and disability resource center;
  - Providing technical assistance to housing developers to create 3 demonstration models of affordable, accessible housing with access to long-term supports that can be replicated;
  - Reducing barriers for consumers who desire to move from an institution to the community by providing outplacement counseling and assisting with transition costs; and
  - Creating an educational initiative to reduce barriers to homeownership, including counseling.

- The Robert Wood Johnson Cash and Counseling Project:
  - Expands consumer choice and control over program support expenditures.
  - Creates a system that has the potential to be far more cost-effective and prevents and/or delays the need for more costly institutional services.
  - Creates public policy that has high expectations for individuals with disabilities.
  - Expands the workforce of personal assistance service providers in the home *and* at work.

Attachment 9

Iowa Department of Public Health's
Connection With the Long-Term Care System in Iowa
September 2, 2004

Continuum of Services

Public Health's contribution to long-term living and healthy aging is truly a population-based continuum of services. One of the goals of this continuum is to generate a progressive course in which populations of the community encounter systems that promote healthy aging that leads to an overall healthier community. Supported by the Iowa Department of Public Health, local boards of health and local communities assess and assure the access to resources that promote health and wellness in a community by identifying specific needs of target populations unique to that community.

Healthy Children

Aging begins at birth. Thus, the continuum for promoting healthy aging by public health also begins with the youngest population: children. The IDPH has an essential role in supporting activities that promote healthy growth and development of children. Many of the department's programs such as immunizations, nutritional education such as "Pick a Better Snack" and WIC, dental health programs, tobacco prevention programs, and primary- / -preventative screenings and health care all contribute towards the successful aging and development into a healthy adult.

Healthy Adults

As this continuum continues into adulthood, the department provides services that focus on maintaining health for as long as possible and early prevention and detection of chronic disease. Local public health entities are instrumental in promoting healthy communities with campaigns aimed at reducing the risk of cardiovascular disease or tobacco use. Screenings for acute disease such as high blood pressure or elevated cholesterol, exercise programs and walking paths, nutritional education sessions including weight reduction, adult immunizations, and substance abuse prevention program are strategies utilized by public health providers and community partners in creating a healthy community.

Healthy Seniors

Finally, as adults advance in years, they become frailer and are encumbered with chronic disease. It becomes necessary for communities to provide personal health services and home maintenance programs that will allow the older adult to remain at home for as long as possible. Again public health is instrumental in assisting older adults to access personal health and home maintenance services. Through direct service provision or through care coordination, public health identifies health care concerns impacting the older adult and targets interventions to achieve the goal of promoting a healthier aging process. Preventative services such as flu vaccine administration, fall prevention programs, home safety evaluations, and foot care clinics aid the older adult in optimal living. Skilled nursing home visits assist in preventing, delaying, or reducing

inappropriate institutionalization. Home Care Aide and Homemaker services, respite care, and chore services assist the frail elderly to maintain good personal hygiene and activities of daily living as well as maintain a safe, clean environment within their home. Protective services stabilize a family's home environment to prevent abuse or neglect of the older adult.

Conclusion

Although policymakers often focus on the short-term needs of the long-term care system, the role of public health's model of a continuum of services should not be overlooked in its contribution to long-term living and healthy aging. Investment in promoting healthy aging now may reduce the need for and financial burden on the long-term care system in the future. Collaborative efforts between local and state public health entities provide a strong foundation in which communities are able to build upon this process in creating healthy communities as a way of life.

Attachment 10

Background Information for the Long-Term Care System Task Force from Department of Inspections and Appeals

September 16, 2004

Overview of the Current System

The Department of Inspections and Appeals (DIA) is a multifaceted regulatory agency charged with protecting the health, safety and well being of Iowans.

Three divisions of the Department of Inspections and Appeals provide services impacting long-term care in Iowa – Health Facilities, Investigations, and Administrative Hearings.

The ***Health Facilities Division*** (HFD) is authorized under Iowa Code chapters 135C, 231B, 231C, and 231D and associated administrative rules under the Administrative Code agency numbers 321 and 481 to license/certify, inspect and provide regulatory oversight to more than 1200 health care facilities, assisted living programs, elder group homes, and adult day services programs with capacity to serve over 53,000 persons. Health care facilities include residential care facilities, nursing facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded, residential care facilities for the mentally retarded, residential care facilities for persons with mental illness and intermediate care facilities for persons with mental illness. Some of these health care facilities and programs are located in hospital settings.

In addition, HFD is the "state survey agency" for the purpose of determining compliance with federal certification requirements by health care service providers, such as nursing facilities, intermediate care facilities for the mentally retarded, hospitals, home health agencies and community mental health centers, for participation in the Medicare/Medicaid programs under the jurisdiction of the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

HFD's statutory and certification duties are discharged so as to ensure the health, safety, and welfare of those Iowans receiving services from the health care providers it licenses and certifies.

In the inspections performed in skilled nursing facilities and nursing facilities, the Division must apply the federal statute found at 42 U.S.C. 1396r et. seq. and the federal regulations found at 42 CFR parts 483 and 488. To guide the Division in the application of these complex federal laws, CMS developed the State Operations Manual for Provider Certification (SOM). The SOM is a comprehensive manual detailing the application of the federal standards and the survey/certification process. It contains literally hundreds of pages of instructions for survey staff and supervisory personnel. The SOM is provided by CMS as a tool to assist state survey agencies in determining whether nursing facilities are in compliance with federal regulations.

In Iowa, the Division applies the same detailed process in the SOM's survey protocol when determining compliance with state regulations. Licensure and certification surveys involve

on-site inspection, fact gathering, interviews, clinical record review, and direct observation of nursing care, treatment and services by field surveyors. The information gathered in the field by the HFD's trained and Surveyor Minimum Qualifications Test (SMQT) certified surveyors is transmitted to the central office for both supervisory review and, when warranted, compliance officer review.

Upon the completion of central office review, three different reports may be issued. Those reports are:

- Federally-required forms - recite the noncompliance with federal standards detected during the survey/complaint investigation, which may result in federal sanctions;
- State Citation - sets forth noncompliance with state law standards, is only issued when the Compliance Officer of HFD has determined that the state law violation is egregious enough to warrant a Class I, II, or III citation and associated fine under Iowa Code section 135C.36; and,
- State Statement of Deficiencies - recites state law violations that were detected at the time of survey, but which are not serious enough to warrant a citation.

HFD also conducts complaint investigations of health care facilities and various provider programs and entities, following the same state and federal regulations and protocol, as mentioned above.

An on-line Report Card system is available to the public at https://www.dia-hfd.state.ia.us/reportcards/. The system provides findings of health care facility inspections, re-inspections, and complaint investigations, any fining and citation action taken, and any other adverse action taken against a health care facility. The information provided by the system is helpful to persons considering available long-term care options, considering a specific health care facility, wanting to compare facilities or wanting to know the compliance status of a facility currently caring for a family member or friend. Because the system is web-based, people in Iowa and other states have access to the information 24/7.

The ***Investigations Division***, Medicaid Fraud Control Unit, conducts criminal investigations of alleged abuse and neglect of residents in long-term care facilities that receive Medicaid reimbursements from the federal government. Investigators also conduct what are known as Divestiture investigations to look into allegations that residents have been defrauded of personal funds or possessions. In addition, investigators investigate allegations of fraud by persons or entities providing goods or services being paid for by Medicaid.

When abuse or fraud is substantiated, the Investigations Division works with local law enforcement officials and state and federal prosecutors to bring the offenders to trial. This activity enhances the work of HFD related to dependent adult abuse complaints.

In addition, the Investigations Division conducts investigations into abuses of public assistance, including food assistance, family investment program, and medical assistance, conducts audits of resident funds in health care facilities, and conducts collection efforts to recover overpaid amounts for the state and federal governments. By identifying and collecting overpayments, which go back into the programs, resources are more available to those persons eligible to receive the public assistance. This would include persons needing long-term care services in the community.

The ***Administrative Hearings Division*** conducts quasi-judicial contested case hearings involving Iowans who disagree with an administrative ruling issued by a state government agency. Hearings are conducted in accordance with Iowa Code chapter 17A and specific state or federal statutory requirements related to an action. Administrative law judges (ALJs) listen to evidence provided by the departments and the affected individuals regarding actions taken by the agency. After a thorough review of the information, the ALJ issues a proposed decision to both parties. The decision is then subject to final review by the director of the agency involved in the contested case proceeding.

Iowa Code chapters 135C, 231B, 231C, and 231D allow a health care facility or other long-term care provider/entity to appeal the denial, suspension or revocation of a state license or certification or other adverse action, such as a fine or citation.

ALJs also hear cases regarding the involuntary discharge of a resident. These cases only involve the resident and the health facility; DIA is not a party to the case.

New Initiatives/Proactive Efforts

In recent years, DIA has taken proactive steps to enhance regulatory activity and oversight.

- In September 2003, DIA hired a full time General Counsel. This allows legal services to be on ready call to assist HFD staff, provide training, and handle contested case hearings, rather than relying on limited availability of an Assistant Attorney General. The individual hired previously served as DIA's assigned Assistant Attorney General, who possesses vast experience in health care regulation. The tightening of the Division's operations with this initiative has provided positive trends

- In December 2003, DIA initiated discussions with CMS to adjust the state match rate for survey and certification expenditures. This discussion was initiated as a result of recognizing that the federal government continued to place more regulatory demands on DIA's oversight responsibilities. In March 2004, CMS agreed to adjust the state match rate effective retroactively to October 1, 2003.

- Funding generated by the adjusted match rate stretched limited state funding and permitted DIA to seek, and receive approval, to hire five dedicated complaint investigation surveyors. Existing, experienced staff has filled these positions. Vacancies created by these transfers are in process of being filled.

Dedicating experienced surveyor staff to only conduct complaint investigations has at least three positive benefits. First, since complaint investigations are time sensitive and the results can potentially immediately impact the health, safety and welfare of nursing home residents, having dedicated staff will ensure an effective regulatory presence. Second, the expertise gained from specialization in complaint processing will undoubtedly have a positive impact on consistent oversight. Third, staff responsible for conducting annual surveys will not often be called upon to also conduct complaint investigations. This should benefit DIA's ability to become more unpredictable in the frequency/timing of its surveys, as DIA will be better able to ensure a consistent presence dedicated to this regulatory mandate.

- In September 2002, the central office Complaint Unit was increased to three experienced surveyors, federally SMQT trained. Recently in 2004, decisions were made to reclassify two positions to assist in complaint intake, oversight and consistency. One position will become a coordinating point between the Complaint Unit, complaint surveyors, the Investigation Division's dependent adult abuse investigator, and DIA's General Counsel. In addition, to ensure precise tracking of cases and consistent application of regulatory standards, this position will also assist in "prosecuting" administratively the heavy informal dispute resolution and contested case hearing workload. Another position is being reclassified within the Investigation Division from "field auditor" to "investigator." This position will be assigned to the Medicaid Fraud Control Unit and will investigate provider fraud, divestitures, and dependent adult abuse referrals made from HFD.

- In July, 2003 an additional investigator was assigned to the collections efforts in the Investigations Division to provide additional resources to collect overpayments made in public assistance programs which go back to those programs to provide more resources to those people eligible to receive benefits from those programs.

- Generating a "Top 16" list of most troubling nursing facilities, and maintaining a prominent presence in them, has honed HFD's priorities and reduced serious violations at these facilities.

- Currently collaborating with the Iowa Caregivers Association and others to expand the current Nurse Aide Registry to include direct care workers.
- Currently making changes to the DIA and HFD website and database to enhance DIA's ability to be responsive to regulatory changes.

- When confronted with a near doubling of complaints, HFD reached out to retired surveyors to assist with complaint investigations. Use of experienced and SMQT trained surveyors allowed existing staff to conduct timely annual surveys, with improved ability to be unpredictable in scheduling.

- DIA will continue to pursue legislative initiatives to strengthen regulatory enforcement.