



DIGNITY
INDEPENDENCE
RESPONSIBILITY

Focal Point

Preface

Our nation has just witnessed the dramatic beginning of new national leadership, leadership that has pledged to meet and overcome the many challenges we face – particularly the economic problems that afflict steadily growing numbers of children and families. The new Administration and new Congress take office at a time when all citizens are united in purpose with them to change, improve, and sustain the public programs that keep the most vulnerable among us – and in turn, all of us – healthy and secure.

As those responsible for administering the state and local public health and human service agencies, we offer here our blueprint for meeting the acute present needs of those we serve; for enabling these individuals and families to achieve stability and where possible, self-sufficiency; and for placing our programs on a sustainable footing that will not be derailed by the temporary vagaries of economic downturns or short-term appropriations.

We call on all those who can join with us to first bring about and then support the new system we envision. We ask first that the new Administration and new Congress, which hold in their hands most of the funding and policy decisions that directly affect us, make the investments and provide the flexibility that public health and human service programs need to flourish. We then ask other stakeholders, other public systems, and ordinary citizens to partner with us. The well-being of those we serve cannot be separated from the nation's larger health and welfare, and all of us must work toward the community support and understanding that are essential to our ultimate success.

The document that follows, *Focal Point*, is the latest in a series of analyses and proposals that the American Public Human Services Association has recently issued on both the strengths and the ongoing needs of public health and human service programs. In 2008, we published *For Those We Serve*, our high-level overview of how far we have come, and yet, how we have to go, in assuring a viable and effective system. In that paper we promised to offer to the new Administration and new Congress an operational blueprint for carrying out our proposals and priorities. *Focal Point* is this blueprint, and will be the focus of our efforts as we work together toward the changes that must come.

We also invite your attention to APHSA's Unity of Purpose web site. This site, <http://www.unityofpurpose.org/>, features frequently updated information on APHSA's ongoing policy initiative activities, important national legislative and policy developments, and news "from the front" – our state and local agency members. It symbolizes our belief that all stakeholders in public health and human services are united in their desire to improve the lives of the individuals, families, and children we serve.

Executive Summary

The United States faces its worst economic challenge in decades. APHSA's members, the nation's public health and human service administrators, share the widespread alarm over the difficult circumstances under which so many now suffer. As the nation's experts in helping to alleviate need and promoting the highest possible degree of health and independence, we propose a plan that will:

- create a health and human service system that moves beyond the dysfunction of the past;
- provide the flexibility necessary for state and local agencies to flourish, yet hold both federal and state health and human service leaders accountable;
- deal realistically and with transparency about budget issues;
- pay for what works, not simply what we can count.

Federal-State Relationships

The public health and human service system is grounded in a federal-state partnership. When that partnership is balanced between state flexibility and reasonable federal oversight, it can be productive and beneficial for all levels of government. However, in recent years that relationship has deteriorated into one characterized by distrust, process-based audits, financial penalties rather than incentives, and federal micromanagement.

Key Recommendations:

- **Provide a consulting role for state and local agencies, through APHSA and its affiliates, on all regulations and other administrative rules and policies.**
- **Restore federal administrative matching rates reflecting an equal partnership between the state and federal governments.**
- **Establish a partnership with states that will assure maximum state flexibility in all programs, coupled with performance standards that are reasonable, achievable, and in conformance with the many differences that exist among state programs and caseload demographics.**

Health

Few issues are as important, or raise as much concern, as the delivery of appropriate and cost-effective health care to our most vulnerable citizens. State Medicaid agencies are one of the most significant components of the health care system and efficiently cover millions of individuals.

Key Recommendations:

- **Expedite the reauthorization of SCHIP.**
- **Provide a temporary FMAP increase as part of an economic stimulus package.**
- **Repeal or rescind seven recent CMS regulations that will cost states \$50 billion over the next five years.**
- **Suspend the Medicare Part D "clawback" provision.**
- **Rebalance long-term care by restructuring "required" Medicaid services to reduce emphasis on costly institutional care.**
- **Eliminate administrative barriers that prevent Medicaid-Medicare coordination for the dual-eligible population by integrating data on eligibility and services.**
- **Include Medicaid agency directors in the nation's health care reform discussion.**

Child Welfare and Well-Being

The public child welfare system serves the nation's most vulnerable children and families. Despite certain advances made in recent legislation, public child welfare faces many challenges, particularly during tough economic conditions.

Key Recommendations:

- **All children in care should receive federal support, regardless of income.** Congress should repeal current law that allows services only for the very poor.
- **Federal financing should support cost-effective prevention services;** present financing is disproportionately directed toward funding out-of-home care.
- **The federal Child and Family Services Review process must be reformed** and replaced with a monitoring system that is fair and accountable. Further, the Title IV-E Audit process should end disallowances that take away funds from an already resource-strapped child welfare system, or allow states to reinvest these funds in child welfare services.

Economic Services: TANF, Child Care, Child Support, and SNAP

The critical underpinning of public health and human service system is the array of income assistance and support programs that include self-sufficiency services, nutrition assistance, child support, and quality child care. These needs are greatly exacerbated during economic downturns.

The **Temporary Assistance for Needy Families program** has established a strong record of stabilizing family income and moving millions into the workforce, and has vividly demonstrated the value of a flexible program that can provide funds and services in an innovative and tailored fashion. However, federal policies now hamper the program in numerous ways, from process-based audits to funding limitations that hurt important segments of those the program was designed to serve. Many TANF administrative burdens can and should be quickly rescinded, including unnecessary auditing mandates, reporting requirements, and funding restrictions such as the proposal to repeal states' ability to claim caseload reduction credit for excess maintenance-of-effort expenditures. Going forward, TANF's next reauthorization must address the loss in the block grant's value since 1996; the necessity of returning to TANF's original flexible policies; and the need to differentially address those who are disabled.

The **Child Support Enforcement program** is one of the most cost-effective and efficient of all government programs. Recommendations for improvement include repeal of the Deficit Reduction Act provision that ended federal match for incentive payments; a greater investment in automation; repeal of the \$25 fee charged to non-TANF families; greater incentives to pass through the full amount of child support collections; and allowing cash medical support to pay administrative costs related to "Fee-for-Service" Medicaid.

Child Care is one of the most valuable services performed by human service agencies; it both enables working parents to enter and remain in the workforce and helps nurture children's developmental needs in their critical early years. The Child Care and Development Fund block grant should be increased to improve access to child care subsidies and increase the access of children to high-quality care. Policy changes are also needed that will provide flexibility at the state and local levels so that quality care can be balanced with access and parental choice. Coordination is needed at the federal level among early care and education funding streams to assure consistent policy guidance and reduce policy conflicts. Finally, the effort to impose a national error rate on child care should be ended and replaced with accountability measures appropriate to a flexible block grant.

The Supplemental Nutrition Assistance Program (formerly the Food Stamp Program) has long been critical to the success of the web of benefits and services that states administer. SNAP's federal mandates have recently improved in some respects, but the program's rigid requirements and administrative complexity still present many challenges. SNAP law should allow numerous innovative demonstration programs, not just the handful that stringent federal requirements now approve. Simplified application and eligibility requirements, more flexible automated support, and removal of barriers to expanded Combined Application Projects would also help the program efficiently serve many more families. Other critical SNAP reforms include changes that would enhance access to nutritious foods and the restoration of true 50-50 regular matching funds, combined with enhanced match for automated system upgrades.

Federal-State Relationships

Accomplishments

States have partnered with the federal government since the public human service system began many decades ago. This partnership functions well when federal financial support and reasonable oversight are combined with state initiatives, flexibility, and accountability for outcomes that improve the lives of those we serve and make our administrative systems more efficient.

Each partner has its respective roles and responsibilities. Perhaps the greatest contribution state and local agencies have made is the remarkable array of innovations and tailored solutions they have developed to address a host of challenging social problems. From new approaches to home- and community-based services, to fresh ways to move the hard-to-employ into the workforce, to innovative solutions for processing growing assistance caseloads and managing program data, APHSA's member agencies have led the way in responding to rising demands at a time of stagnant or declining resources.

States have accomplished these successes with a remarkable degree of integrity and accuracy; indeed, some programs are achieving historically high performance levels in their ability to serve customers and meet stringent program requirements. And local agencies regularly collaborate and innovate in real time on behalf of those they serve, leading to improved practices that can be broadly applied.

Challenges

Despite the states' many remarkable achievements, they suffer under a heavy burden of unnecessary constraints and roadblocks that keep them far away from their full potential.

A Place at the Table

One of the most frustrating challenges states face, yet one of the simplest to resolve, is the failure of federal agencies to include them at the table when formulating new or revised administrative policies, including regulations to implement new legislation. States recognize that the federal agencies have the ultimate responsibility for federal regulations and administrative rules. However, state involvement could eliminate wasted time and unnecessary difficulty – to the great benefit of *both* levels of government – if states could offer advice and point out pitfalls of policy ideas *before* they are formally proposed.

Federal Oversight and Monitoring

Another major concern is the current mix of federal reviews, monitoring requirements, and approval procedures. The current system is redundant and costly, and fails to account for the improvements that states have already made to their systems. Health and human service program monitoring and auditing must be reformed to adhere to existing law and the clear intent of Congress. This should be a fair and accountable process that is based on measurements that accurately reflect the work of the states, focuses on client outcomes and not processes, and gathers reliable information needed to design or improve effective programs. The present system results in punitive actions and penalties that threaten the meager resources agencies have to provide critical services.

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The Need for a Person-Centric Approach

Another major obstacle is the many examples of duplicate effort, delays, inefficiency, and confusion caused by the bewildering array of eligibility requirements, funding qualifications, reporting and data collection mandates, and oversight levels that differ (and are frequently in conflict) from one public human service program to the next. Yet these programs come together at the ground level – where state and local agencies operate – to serve the needs of the same family, handled often by the same caseworker, in the same office.

APHSA understands that there is a long history behind each program “silo,” that federal agencies often have their own constraints due to legislative requirements, and that the stakeholders associated with each program often oppose changing the status quo. However, it is unacceptable to acquiesce in these conditions, shrug our collective shoulders, and move on as if nothing can be done. APHSA calls on our federal partners and other stakeholders to join us in making a person-centric approach to human services – not a program-centric approach – a major priority.

APHSA seeks proactive removal of unnecessary differences among programs now through administrative changes, and through future legislative changes where necessary. APHSA also urges an immediate collective effort to identify existing best practices, including waivers already granted, that can be disseminated; identification of additional waivers that could be granted within current authority; and legislative changes that can best cut through the “red tape” that so frequently confuses clients, frustrates administrators, raises administrative costs, and makes programs far more unresponsive and error-prone than is necessary.

Adequate and Equitable Federal Matching Funds

There has been a long funding partnership between the federal and state levels that reflects the vital role that each must play in effective administration of programs. Historically, this relationship has provided for a minimum 50 percent match, and for higher percentages as appropriate to specific programs and needs. There has also been a tradition in which the federal government recognizes the need for adequate and up-to-date information systems as the critically necessary underpinning of state delivery of benefits and services and their effective management and operation. Unfortunately, this federal recognition and commitment have receded in recent years, and certain programs and funding streams are now well below their historic norms. At a time of rapidly rising caseloads and increased demands for accountability, states require, at minimum, a return to previous funding levels. They also seek increases, where necessary, to bring program performance and administration up to modern standards.

Streamlined Federal Approval Processes

Federal approval procedures for straightforward, clearly beneficial improvements in information systems must also be streamlined; specifically, the present “Advance Planning Document” process is outdated, cumbersome, and ineffective.

Policy Proposals

Because federal-state relations are so integral to the administration of all public human service programs, each of this paper’s three program-based chapters (Health, Child Welfare and Well-being, and Economic Support) includes a detailed discussion of federal-state issues affecting specific programs. However, a number of general federal-state concerns run

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through these specific problems. These are summarized in the general recommendations below.

Recommendations

- **The Administration should institutionalize a consulting role for the states, through APHSA and its affiliates, on all regulations and other administrative rules and policies; this consultation must take place prior to their issuance. The respective federal agencies should meet regularly with state administrators, selected from nominees provided by the states, in the development of language and in the assessment of the impact of proposed policies. The agencies should also regularly consult with states on similar matters that bear on the state-federal partnership.**
- **Congress should enact legislative changes that will restore federal administrative matching rates reflecting an equal partnership between the state and federal governments. Matching rates should also be increased as necessary in all programs to encourage and reward investment in new and improved automated systems, enabling states to modernize their systems and provide efficient, accurate, and timely services and benefits.**
- **In developing program requirements and accountability standards, the federal government should partner with the states to assure maximum state flexibility in all programs, achieved through administrative options readily available to all states rather than through cumbersome individual approval procedures. Simultaneously, states should be held accountable for performance standards that are reasonable, achievable, and in conformance with the many differences that exist among state programs and caseload demographics.**
- **A related recommendation is that Congress should allow a wide range of demonstration programs in all states that are based on person-centric, rather than program-centric, systems of determining and maintaining eligibility, delivering benefits, qualifying for matching funds, and meeting performance standards.**
- **Congress should repeal or reform any laws that mandate process-based measures for public human service programs where such measures are clearly inappropriate, counter-productive, or inefficient. The most egregious recent example is the 2002 law that imposes a “national error rate” on block-granted programs explicitly designed by Congress to be innovatively different from one state to the next. That law ignores the many state options and variations that make meaningful national comparisons tenuous at best.**

Such attempts should be replaced by rational program monitoring and evaluation systems that accurately reflect the work of the states; gather reliable information needed to design or improve effective programs; and recognize the highly variable nature of most programs from one state to the next.

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- **Federal data collection mandates on the states should be revised to ensure that data are pertinent to program needs, collected in an effective manner, and analyzed properly to ensure that conclusions are valid and reliable.**
- **Federal agencies should adopt a single, government-wide, and nationally uniform process for approving state information system upgrades, rather than the fractured and ineffective policies now in place. All federal agencies involved should coordinate their responses and questions through a single lead agency, and issue a single approval within a reasonable timeframe.**

Health Care

Accomplishments

In the current political and fiscal environment, the state of America's health care has become an increasingly important topic of discussion. The number of uninsured individuals has risen significantly over the past decade, and the cost of health care services continues to increase faster than the rate of inflation. These issues, coupled with a shortage of skilled nurses, personal attendants, pediatric specialists, and primary care physicians, have created strong public sentiment regarding the need for health care reform. The American Public Human Services Association and its affiliate the National Association of State Medicaid Directors believe that the current health care delivery system should be modernized through investments in health information technology and through policies that promote individualized, coordinated, preventive care. These investments will create a system of value-based, transparent, quality care.

Across the country, Medicaid and the State Children's Health Insurance Program currently finance health care coverage to more than 50 million individuals, including children, low-income working parents, seniors, and individuals with disabilities. In 2008, when studies indicated that the number of uninsured individuals had decreased from the previous year for the first time in nearly a decade, the change was due to an increase in individuals covered by Medicaid and SCHIP. Medicaid also represents the single largest payer for long-term care. The people on Medicaid are often too poor to afford insurance, or are individuals with expensive, chronic conditions who are unable to find or afford coverage in the private market. Medicaid and SCHIP provide a carefully administered and cost-effective health safety net for these vulnerable individuals, families, and children. Through these programs, states have extensive experience in addressing issues of health care quality, cost containment, and access to services. Medicaid and SCHIP programs frequently lead the nation in developing creative solutions to ongoing issues of access, quality, and cost.

Many, if not all, of the services provided through state Medicaid programs would increase in cost if they were administered privately. Despite criticisms of government programs, state agencies do an extraordinary job of administering Medicaid programs in an efficient and cost-effective manner, with an administrative cost of less than 3 percent of the overall operational budget. In comparison, many studies estimate private insurance and managed care organizations' overhead costs to be 20 to 25 percent or more of their overall expenses.

Challenges

This record of accomplishments by the states cannot continue without several urgently needed changes. The topics and recommendations in this chapter deal with the immediate needs of state Medicaid agencies, as well as the ongoing opportunity for Medicaid agencies to be an integral part of health care reform. These recommendations fall into the following areas:

- Federal-state partnership;
- The future of SCHIP;
- Medicaid and SCHIP financing;
- Rebalancing long-term care;

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- Medicare and Medicaid dual-eligible population; and
- Comprehensive health care reform.

Today, state Medicaid agencies are one of the most significant parts of the health care system in the United States. Medicaid agencies will continue to finance services to a significant (and growing) number of Americans and will strive to improve the value, efficiency, and quality of health services in the country. However, states need the active support of the federal government and a collaborative partnership based upon mutual trust and open communication.

Medicaid and SCHIP must have a crucial role in all the proposed health care changes currently under consideration if these changes are to be successful. In both the current health care system and any new system, Medicaid and SCHIP will be an irreplaceable safety net for the most vulnerable populations. As national policymakers discuss health care reform, Medicaid agencies must be included in the ongoing dialogue. No other program has the unique skills and experience in providing quality care that is customized based on the needs of so many separate populations and localities.

We understand that health care reform will be a long-term process. In the interim, there are a number of pressing issues related to the administration and ongoing sustainability of Medicaid and SCHIP programs. These recommendations are applicable both for the short term and in any discussion regarding health care reform. Paramount, and crucial to all of the other recommendations contained herein, is the issue of the state and federal partnership. Repairing the state-federal relationship around the management of Medicaid is the single most important issue facing the Administration's health care agenda, and must be addressed immediately. Without strong collaboration between these two partners, we will continue to squander golden opportunities to improve the efficiency of the Medicaid program. A return to a true partnership will lead to a resolution of the issues discussed within this document. We must begin working together, especially in these dire economic times, to build on our strengths and improve our programs.

Policy Agenda

State-Federal Relations

Medicaid and SCHIP are jointly funded by the state and federal governments. A strong state-federal partnership is crucial for the long-term success of these programs, since state and federal governments must collaborate on a multitude of policy and program issues such as defining eligibility standards; ensuring quality of services; establishing fraud and abuse controls; and modernizing the health care delivery systems through adoption and improvement of Medicaid Management Information Systems, Health Information Technology, and other technological issues. However, in recent years, the partnership has deteriorated. These signs include:

- Detrimental federal regulatory action that drastically reshapes long-standing Medicaid policy and shifts significant costs onto state government;
- Vetoes of legislation to reauthorize the SCHIP program and ensure adequate funding to state programs;
- New policies in the SCHIP program that significantly reduce states' abilities to cover a greater number of uninsured children;
- Federal issuance of formal guidance, regulations, and other directives without opportunity for state input;

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- Audits and error rate methodology that are unnecessarily duplicative and result in unfair repayment protocols;
- Excessively long timeframes and procedural “red tape” required during waiver applications and renewals as well as State Plan Amendments; and
- An absence of effective communication by the Centers for Medicare and Medicaid Services with the executive committee of the National Association of State Medicaid Directors on policy pronouncements that would ensure the most effective policies.

The overarching result of the strained partnership has been an increasingly confrontational approach to the joint administration of Medicaid and SCHIP. Medicaid is financed and administered by both the state and federal governments; an equal partnership is necessary for the ongoing success of the program. Although tension between fiscal partners is natural, the excessive time required to manage the current federal-state relationship is draining resources from the administration of services to beneficiaries. In short, states are becoming embroiled in activities that emphasize administrative process rather than improved client outcomes. *Strengthening the partnership between state Medicaid agencies and the federal government is in the best interest of the federal government and is the states’ most pressing near-term issue.*

Recommendations:

- **Create a Joint State and Federal Workgroup to Set Health Policy Priorities**
Issues surrounding health care reform and benefit administration continue to require ongoing discussion and negotiation between state and federal partners. Communication between the partners in an established policy-focused workgroup would greatly improve their ability to reach jointly acceptable resolutions to fiscal or policy-related issues.
- **Solicit NASMD Input on Political Appointments**
Although the Secretary of the Department of Health and Human Services has been named, other important positions remain unfilled. NASMD and APhSA request the opportunity to provide feedback and suggestions for political appointees for positions such as the Director of the Centers for Medicare and Medicaid Services, the Director of the Center for Medicaid State Operations, and other health care-related posts.
- **Provide States with Opportunity for Input on CMS Actions**
In the past, NASMD has been able to review and provide input on State Medicaid Director and State Health Official letters prior to the formal issuance. The ability of states to provide input before the guidance is finalized is greatly beneficial to the states as well as to federal partners, who can revise the guidance or address any potential issues prior to the letters’ release. Additionally, CMS should use the “Advance Notice of Proposed Rulemaking” mechanism to solicit input and feedback prior to formal regulatory action.
- **Improve and Expedite the Waiver Process**
Currently, a number of states have waiver applications that have been pending in excess of two or three years. In many instances, the individuals who submitted and received the initial waiver application are no longer employed by state or federal agencies when the waiver is approved. This lag in time creates unnecessary duplication of effort in determining and redetermining outstanding questions surrounding the waiver, and submitting and responding to requests for more information.
- **Work with Congress and the General Counsel to Eliminate the “Same Page Review”**
When a state submits a State Plan Amendment (SPA) on the CMS defined document, CMS is required to review any item on that page and associated portions of the state plan. Therefore, if a state needs to make a small substantive change, such as

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implementing a cost-of-living adjustment, the SPA can often snowball into a massive project that delays necessary changes to the Medicaid program and undermines other aspects of the program. Important changes are delayed, creating an unnecessary hardship on beneficiaries and providers in the state.

- **Improve Coordination and Outcomes of Fraud and Abuse Activities**

CMS is currently engaged in a variety of audits and other methodologies to detect fraud and abuse; two of the most prominent are Payment Error Rate Measurement and the Medicaid Integrity Program. In addition to these activities, states have internal auditors to detect potential cases of fraud. CMS and the states need to collaborate to avoid duplication of efforts from the multiple audits occurring simultaneously by both state and federal officials. Furthermore, CMS and the states need to jointly ensure that PERM uses a methodology that results in meaningful measurements that can be used for quality improvement.

State Children's Health Insurance Program

Since its creation in 1997, SCHIP has provided health insurance to millions of children nationwide. SCHIP has been a crucial tool for states as they attempt to ensure that all children have access to quality, affordable health insurance. However, the SCHIP program is currently operating under a short-term extension that is set to expire in March 2009. States need a timely reauthorization of the program to guarantee that there is no lapse in coverage for the millions of children currently enrolled in the programs. Further, states need ongoing flexibility, through demonstration waivers and eligibility expansions, to meet the unique needs of their populations. The flexibility provided through SCHIP has allowed states to address issues of health and safety for children and their immediate families, and to ensure that the youth of this nation are able to thrive.

Recommendations:

- **An Expedited Reauthorization of SCHIP that Preserves State Flexibility**

The reauthorization should preserve and enhance state flexibility to design and implement programs that meet the unique needs and circumstances of individuals in each state. Blanket policies tied to a federal benchmark do not account for any potential regional variance. For example, a family earning 250 percent of Federal Poverty Level in the Washington, D.C., metropolitan area experiences a very different quality of life than a family earning 250 percent of FPL in South Dakota. This is just one simple example of a plethora of nuances that states address through the flexibility offered in SCHIP. States should have the flexibility to develop any income and resource standards that they can accommodate within their allotment.

- **Adequate Resources to Support the SCHIP Program**

The original SCHIP legislation authorized \$40 billion over a 10-year period. As SCHIP programs have matured, states have begun to exceed their annual allotments and Congress has provided additional funding to cover the SCHIP "shortfalls." However, the current economic downturn has led to an increase in both Medicaid and SCHIP enrollment, and this increase is expected to continue through the recession. Congress and the Administration must ensure that the reauthorization legislation provides adequate resources to cover uninsured children in all states.

- **Elimination of the August 17, 2007, State Health Officials Letter Directive**

On August 17, 2007, CMS issued a State Health Officials Letter that implemented new policies intended to limit SCHIP eligibility expansions due to fears of "crowd out," that is, individuals opting out of private coverage and choosing to enroll in public health care. The blanket policies within the August 17 directive exclude children with legitimate

health care needs and create an undue hardship on state programs as they try to comply with federal benchmarks for provision of coverage.

Financing Medicaid and SCHIP

The Medicaid and SCHIP programs cover individuals who are unable to secure medical coverage through a job or the private marketplace. These individuals are often the elderly, chronically ill, people with disabilities, or children of low-income working parents. These populations are also the most vulnerable to layoffs, job loss, or other economic hardships during periods of recession or other economic dislocations. Medicaid and SCHIP therefore experience enrollment growth at exactly the same time that state tax revenue decreases. According to the Government Accountability Office, during the last recession in 2001 and 2002, Medicaid enrollment rose 8.6 percent while state tax revenues fell 7.5 percent. Emergency funding to states through increases in the Federal Medical Assistance Percentage was all that avoided large eligibility reductions across the country. Even prior to official recognition of the current recession, states had already experienced significant revenue declines and budget shortfalls. The weak economy is essentially creating two distinct but related budgetary pressures on states: a decrease in tax revenue and an increase in citizens requiring assistance.

The current economic situation, coupled with current and projected enrollment growth, creates a significant hardship for states during the coming years. This situation is further exacerbated by the imminent expiration of moratoria on six Medicaid regulations and the implementation of one additional regulation. Combined, states estimate that these seven regulations will result in the loss of over \$50 billion in Medicaid funding during the next five years.

States recognize the fiscal pressure of health care spending on budgets, and are committed to working with CMS to ensure that Medicaid funds are used accurately, efficiently, and effectively. However, the current fiscal environment and the prohibition of deficit spending in state budgets require immediate federal relief to ensure that Medicaid programs can continue to finance health care services for the individuals we serve.

Recommendations:

- **A Temporary FMAP Increase**

States are currently unable to maintain funding for the Medicaid systems that they have in place. Even when enrollment remains level, the cost of medical services continues to increase at a pace greater than inflation. In this environment, states have to cope with decreased revenue, increased enrollment, and an increased cost of services. Without a temporary FMAP increase, eligibility reductions will be necessary at the exact time when many Americans need assistance more than ever. The need for a FMAP increase is urgent; the longer Congress waits, the more untenable state fiscal situations become.

- **Repeal Seven Costly Medicaid Regulations**

The six CMS regulations currently under moratoria include Targeted Case Management, Rehabilitation Services Option, School-Based Services, Graduate Medical Education, Public Providers, and Provider Taxes. The seventh regulation, Outpatient Hospital, has been issued as a final rule. The combined cost impact on states will be nearly \$50 billion over the next five years, according to the House Government Oversight and Reform Committee. Such a massive reduction during a period of budget shortfalls and Medicaid reductions will undermine the entire Medicaid program. The Administration and Congress must work together to repeal these regulations and to remove them from the federal budget projections. The Administration should repeal the regulations, wherever possible,

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and should not include them in any Presidential budgets. Congress and the Administration should assure that long-standing, effective policies can be maintained without requiring monetary offsets from other parts of the budget.

- **Restructuring Collections of the Federal Share of Disallowed Claims**

Currently, federal law requires states to repay the federal portion of any disallowed claim or legal settlement within 60 days of the disallowance's discovery. This requirement is in effect regardless of whether the state is able to collect the disallowed claim. As a result of this policy, the state is penalized for engaging in activities to ensure the fiscal integrity of the program. While the federal government is entitled to its share of any recouped funds, states should only be required to repay funds that are actually collected. Congress and the Administration should collaboratively restructure this rule to require federal collection only when the disallowed claims are successfully recovered. Changing this rule will provide states the incentive to engage in potentially costly litigation and other long-term methods of disallowed claims or payment error recovery.

- **Support for Disproportionate Share Hospital Payments**

Disproportionate Share Hospital payments are designed to support hospitals that serve a large number of Medicaid recipients, individuals with low income, and uninsured patients. DSH payments were created through the 1981 Omnibus Reconciliation Act and are a crucial part of supporting the health safety net. With charitable and tax-based revenue streams decreasing and many provider payments reduced by the budget environment, safety-net hospitals can ill afford to bear the brunt of another reduction in funding. Without adequate support for DSH payments, many hospitals will be forced to close their doors completely.

- **Resolution of Costs for Medicare/Medicaid Disability Claims Backlog**

The Social Security Administration has been working to reduce an overwhelming backlog of disability claims and to provide individuals found eligible with the appropriate services. NASMD and APHSA applaud SSA's efforts to resolve the ongoing disability application crisis; however, an unintended consequence has occurred. When individuals are found eligible for Social Security Disability Insurance, they receive Medicare coverage (after a 24-month waiting period). Once Medicare coverage begins, state Medicaid agencies are required to cover the premiums for certain low-income Medicare recipients through the Medicare savings program. Many of the individuals whose claims are being resolved, or corrected, through the SSA efforts are retroactively eligible for many years of Medicare. However, a large number of states have programs in place to cover medical supports for individuals with pending SSA claims. Currently, states are being charged millions of dollars to cover the retroactive Medicare premiums for these individuals and are unable to recoup the costs of the Medicaid coverage provided during that same period. Essentially, states are paying twice—for Medicare premiums and for Medicare's share of the services provided. Since Medicare is the primary payer for many services during cases of dual eligibility, Congress and the Administration must resolve this issue and provide timely reimbursement for these medical services. The current situation that double-bills states for these retroactive payments is yet another financial strain on an already depleted system.

Rebalancing Long-Term Care

Since the 1980s, states have been working to develop home- and community-based services for providing long-term care. States and the federal government have collaborated on the development of methodologies to fund the provision of HCBS services; to promote development of services and supports that emphasize community living and integration; and to promote the transition from institutions to community-based care. These include 1915(c) waivers, the 1915(i) state-plan option, the 1915(j) state-plan option, Money

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Follows the Person grants, real choice systems change grants, and Medicaid infrastructure grants. The drive for HCBS care is further strengthened by the Americans with Disabilities Act, and the subsequent *Olmstead* ruling, which require services to be provided in the most integrated settings available. However, despite over 20 years of efforts to promote community integration, many older adults and individuals with disabilities have no choice but to live in institutional settings.

States have made large strides in ensuring that individuals can live independently in the community, but there is still an inherent disconnect between stated goals and the related federal policies. While the Deficit Reduction Act provided for some opportunities to enhance self-determination and independence, legislative and regulatory deficiencies currently prevent states from utilizing the options to their fullest capacity. Additionally, institutional care remains a core Medicaid service, and states must go through a lengthy waiver approval process to provide HCBS. Continuing and enhancing the Money Follows the Person grants, strengthening and fixing the issues around the DRA HCBS options, and shifting the regulatory emphasis from institutional care to more cost-effective community-based care are essential steps toward ensuring positive client outcomes and fiscally responsible health care.

Once an individual is successfully transitioned to a community-based setting, appropriate supports and services must be in place to provide true community integration. One of the primary activities of community living and of self-determination is employment. The federal government should strengthen and improve state options to provide employment supports through Medicaid, especially Medicaid Buy-in programs.

Recommendations:

- **Restructure “Required” Medicaid Services to Reduce Emphasis on Costly Institutional Care**

States are currently required to provide institutional care to older adults and individuals with disabilities. For persons to qualify for a 1915(c) waiver that enables them to live in a community, they must first qualify for institutional care and then transition to the waiver. The Administration and Congress should work together to create national policies that promote service delivery through HCBS rather than institutional care. HCBS services not only emphasize independence and self-determination, but are also more cost-effective than institutional care. For example, in fiscal year 2006, Kansas spent more than twice the amount of money on institutional care than on HCBS, while serving fewer people in institutions.

- **Improve the 1915(i) State Plan Option**

The 1915(i) option was a crucial first step toward delinking HCBS from institutional care. For the first time, states are not required to obtain a federal waiver to provide HCBS. Additionally, states are given the flexibility to define needs-based criteria for individuals to access 1915(i) services—effectively enabling the state to provide services without first determining that a person requires institutional care. However, this option was created with two major legislative flaws, and the promulgated regulations have created further flaws in the option. Congress must remove the 150 percent FPL cap on individual income for 1915(i) and allow states to define income and resource standards that best fit their own populations. Congress must also add the “other” category of services, which exists in 1915(c) waivers, which allows states to customize service packages that meet the unique needs of individuals in their program. The Administration should redefine the regulations around 1915(i) to remove the stipulation that a state can have only one such program in effect, and to remove the prescriptive definitions of HCBS. States need the

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flexibility to define services and residential settings to meet the unique needs of their own populations.

- **Continue Providing Grants that Support HCBS Services**

The Money Follows the Person grants have provided strong incentives to develop and strengthen HCBS care across the country. Likewise, the Real Choice Systems Change Grants have provided states with flexible funding to research, develop, and share best-practices for services that support older Americans and individuals with disabilities. Grants such as these should be continued to ensure that states are able to provide individuals with cost-effective, high-quality support in the community.

- **Provide Equitable Eligibility Standards for HCBS and Institutional Care**

Despite attempts to rebalance the Medicaid long-term care system, and to provide opportunities for community living to older individuals and persons with disabilities, there is often a disconnect between institutional eligibility standards and HCBS programs. The Administration and Congress can further the goals of rebalancing long-term care by providing states the flexibility to allow people who move to the community from a nursing facility to retain their Medicaid eligibility in the community, based on an institutional eligibility standard.

- **Improve Medicaid Buy-In Programs**

Currently, states are able to provide Medicaid to working individuals with significant disabilities through two state plan options that were created via the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999; these programs are commonly referred to as Medicaid Buy-ins. The Buy-ins are powerful tools that allow individuals with disabilities to continue working without jeopardizing health care coverage, but several policy changes are necessary to fully maximize their effectiveness. The Ticket to Work included an age limit of 16 through 64 for participants in the Buy-in. Therefore, as the age of retirement for Social Security benefits increases over the next decade, some people will be ineligible for this program prior to their eligibility for retirement. States should be given the flexibility to define their own age limits in the program. Additionally, both the Ticket to Work and the BBA legislation did not contain a definition of "employed." CMS has issued guidance that precludes states from attaching requirements that set minimum levels on earnings or hours worked to become eligible, creating difficulty for the states to develop and enforce employment requirements for the Buy-in. States need the flexibility to ensure that the programs are serving the intended population: gainfully employed individuals with disabilities.

- **Expand and Strengthen Employment Supports for People with Disabilities**

Even though the Ticket to Work Act placed a greater emphasis on working for people with disabilities and improved many supports for employment, a number of inherent disincentives still exist. State efforts to support employment for people with disabilities are undermined by Social Security Disability Insurance rules, which effectively financially penalize an individual who crosses a predefined earnings threshold. The SSDI "cash cliff" will continue to prevent many individuals from reaching their fullest potential, regardless of state investments in training and infrastructure supports. Additionally, the Medicare restriction on using Durable Medical Equipment outside of the home prevents individuals with serious conditions from utilizing necessary medical devices in the workplace. States should also be given flexibility to integrate Vocational Rehabilitation and Medicaid funds in a manner that supports an individual throughout his or her entire daily needs—including medical, community, and employment.

- **Continue Crucial Employment Grants through Medicaid**

The Ticket to Work Act created two crucial grant programs for state Medicaid agencies. The first is the Medicaid Infrastructure Grant program, which provides flexible funding to develop and strengthen employment supports in Medicaid agencies. These grants have

been utilized by over 40 states to improve Personal Assistance Services, develop Medicaid Buy-in programs, enhance supported employment services, and create linkages between Medicaid-funded services and other disability and employment systems. The MIG authorizing legislation expires in 2011; extension of these valuable projects is crucial to ongoing development of the program.

The second project is the Demonstration to Maintain Independence and Employment. The DMIE provides health care to individuals with conditions that are likely to result in SSA disability claims, and tests the outcomes of providing such services. DMIE projects have already documented cases where individuals rescind legal appeals to SSA, or drop pending applications when health care is provided. However, due to delays from the federal funding source, the DMIEs have not had enough time to complete the rigorous evaluation and develop scientifically validated conclusions. Results of the DMIE have the potential to save SSA substantial funding, but the DMIE will expire in 2009. Without an extension, validated results and subsequent policy recommendations will not be reached.

Medicare and Medicaid Dual-Eligible Population

There are over six million individuals who obtain health coverage from both Medicare and Medicaid, commonly referred to as "dual eligibles." Individuals who qualify for Medicare are either older retirees, or persons with significant disabilities; dual-eligible individuals are often low-income Medicare beneficiaries who receive wrap-around coverage from Medicaid. In these situations, Medicaid pays for many Medicare premiums, copays, and services not covered through Medicare, such as long-term care. Due to the inherent characteristics of individuals who qualify for Medicare, the dual-eligible population is composed of many of the most costly enrollees.

Unfortunately, current administrative barriers prevent Medicaid agencies from coordinating services with Medicare and collaborating on data-sharing, research, and best practices. Furthermore, legislative and regulatory issues create unnecessary financial and administrative burdens on states, and disrupt provision of necessary services to individuals who need health care the most. The proper coordination of data, outcome measures, and services would increase outcomes and decrease costs for both the federal and state governments.

Recommendations:

- **Integrate Data on Eligibility and Services across Medicaid and Medicare**
Current policy creates barriers to accessing Medicare data from the states. Improving data access and integration between the two programs will allow states and the federal government to appropriately analyze expenditures, utilization patterns, and the cost-effectiveness of approaches. Data integration will also reduce administrative burdens relating to coordination of benefits and provider billing, potentially reducing payment errors and opportunities for fraud. APHSA and NASMD recommend a joint state-federal taskforce to develop policies and protocols that allow states and the federal government to share Medicaid and Medicare data in a secure manner.
- **Promote Greater Service Coordination between Medicare and Medicaid**
Promising practices in medical care involve greater coordination across multiple services, with a primary care provider acting as the point-person for all ancillary services. Current rules around data and information sharing, service coverage, and eligibility create gaps in coverage and barriers to coordinated services. Coordinated services will reduce

duplicative assessments and treatments, leading to improved patient outcomes and decreased costs.

- **Develop Combined Quality Measures for Medicaid and Medicare**
Creation of quality measures that enhance and support coordinated care across Medicaid and Medicare would further the service coordination and quality outcomes for dual-eligible populations. The joint state-federal taskforce would be charged with developing quality measures that apply to Medicaid and Medicare services for dually eligible clients.
- **Provide Shared-Savings Incentives to State Programs for Dual Eligibles**
Developing programs, policies, and systems to properly integrate care across Medicare and Medicaid is a costly and time-consuming endeavor. Implementing a mechanism to share savings achieved through both Medicare and Medicaid would provide an incentive to implement these policies. Currently, savings achieved through Medicare do not benefit the states, and there is no return on investment for the staff and financial resources utilized to improve coordination of services.
- **Suspend the Medicare Part D “Clawback”**
The Medicare “clawback” mechanism partially finances the Part D prescription drug program by collecting funds from state Medicaid agencies for dual-eligible individuals. This policy is the first time that states have been required to finance a federal program, and was not included in either bill authorizing the Part D program. Instead, it was added during the House-Senate conferencing process and was never voted on. Even more troubling is the fact that the clawback rates are based on Medicaid expenditures as of 2003. States that enacted significant Medicaid reforms and cost-containment efforts are still required to finance Part D based on pre-reform expenditures. States should not be required to finance a federal program under dubious authority and actuarial assessments. The clawback must be suspended while federal and state policymakers collaborate to determine the best way to finance prescription drug coverage for dual eligibles.
- **Eliminate the 24-Month Medicare Waiting Period**
Once an individual with a disability is certified for SSDI, the person does not immediately receive health coverage. Medicare coverage is only established after a 24-month waiting period, starting with the date of eligibility—often leaving the individual completely uninsured. During this time, the lack of appropriate care often leads to a worsening of the individual’s disabling conditions, and many end up in emergency care. State Medicaid programs and safety-net providers are often required to pay for the emergency care of these uninsured individuals during this period, creating a more expensive and less efficient model of health coverage. Medicare should eliminate this gap in coverage, which unnecessarily shifts costs onto state budgets.

Health Care Reform

As the nation continues its health care reform discussion, Medicaid agencies must be included in the ongoing deliberations. Medicaid agencies have extensive experience creating and managing health care systems that fit the unique needs of each state, and would be a great asset to national policymakers’ health care initiatives. State programs have acted as laboratories of reform—including developing community-based alternatives to institutional care in the 1980s, creating health care expansions in the 1990s and early 2000s, and developing current initiatives involving health information technology.

Every health care reform proposal would either utilize Medicaid programs at the local level or be greatly enhanced by Medicaid’s knowledge of the specific nuances involved in health care delivery within each state. Medicaid remains one of the largest insurance programs in every state, and the single largest funding source for long-term care. Issues of access to

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services, quality of health care, and cost-containment are paramount to any successful health care reform initiative. Medicaid is uniquely positioned to speak to these issues from a national perspective, while simultaneously recognizing the specific challenges involved in local and regional delivery systems.

The following recommendations are pertinent regardless of the direction of comprehensive health care reforms. NASMD and APHSA believe that these recommendations should be implemented whether health care remains “as-is,” is comprehensively overhauled, or is moderately changed by incremental reform.

Recommendations:

- **Include Medicaid Directors in any Discussion on Health Care Reform**

Medicaid directors are uniquely positioned to speak to the national health care delivery system, with distinct knowledge of the nuances of local delivery. No health reform can be successful without recognition of regional variance, including issues of cost of living, access to services in urban and rural areas, or cultural attitudes around health. In some cases, managed care is the best delivery option; in other cases, fee-for-service arrangements are the only ones that will succeed. Medicaid directors and their staff have experience designing and implementing statewide systems that incorporate this local variance. Health care reform should utilize the knowledge, skills, and experience of Medicaid agency staff to develop a system that effectively serves all parts of the nation.

- **Create Value and Efficiencies**

Medicaid programs have consistently led the nation in the development and implementation of innovative service delivery methods. Currently, a number of important initiatives are under way that will reduce medical errors, improve quality of care, and reduce costs. Examples of these initiatives include implementation of e-prescribing, development of effective technology for telemedicine services, implementation of “medical home” models of care coordination, and increased utilization of electronic health records. Currently, many health reform proposals incorporate these models, and the Medicaid program can be used as an example of an effective way to facilitate the development and adoption of these important initiatives.

- **Further Implement Health Information Technology**

Health Information Technology is an important component of the modern health care delivery system. In addition to the innovative programs already mentioned, there are a number of areas where states and the federal government must collaborate to ensure timely adoption of HIT, with reasonable expectations placed on providers, insurers, and the public sector. These include reasonable timelines for the adoption of the ICD-10 disease classification methodology; implementation of modernized Medicaid management systems; and the development of appropriate ways to coordinate eligibility and services across government agencies, such as Supplemental Nutrition Assistance Program benefits, child welfare, Temporary Assistance for Needy Families, and other related categories. The CMS Division of State Systems has been a strong partner on many of these issues, but a significant body of work remains—including the development of processes and procedures to allow the appropriate blending of funding and sharing of data among state agencies.

- **Remove Documentation Barriers for Legitimate Citizens**

The Deficit Reduction Act of 2005 included a provision requiring Medicaid to verify legal citizenship of applicants and enrollees. The law was passed despite a Government Accountability Office report which found that state efforts to ensure identity and citizenship were effective prior to this requirement being enacted. Furthermore, the promulgated regulations around this provision were much broader and more restrictive

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than the law authorized, and have created serious barriers that prevent legitimate citizens from accessing services. Requirements that individuals provide the original copy of official documents are especially restrictive for many of the people that Medicaid is intended to serve: low-income populations who have historically been excluded from many aspects of society. For example, a large number of individuals from poor neighborhoods or rural settings may have never received an official birth certificate, let alone applied for a passport. The ensuing administrative burden of documentation and collection of original copies of many of these documents delays access to needed medical care and increases states' administrative overhead—shifting resources away from needed services. States and the federal government should work together to develop an appropriate alternative methodology for citizenship verification that utilizes the least amount of administrative resources and that creates the smallest burden for individuals in need of critical medical services.

- **Increase the Pool of Qualified Health Care Workers**

Congress and the Administration should invest in training for skilled nurses, personal assistants, rehabilitation specialists, and other health care professionals where the demand is outpacing the supply. Appropriate skill development and training programs could provide career opportunities for historically underserved populations, such as TANF recipients or individuals with disabilities. The shortage of health care professionals has a disproportionate impact on Medicaid since a large portion of individuals utilizing long-term care are covered by Medicaid.

- **Coordinate Value-Based Purchasing at the Federal Level**

Although every Medicaid program is unique, many of the contracts and services administered at the state level are the same across the country. Nearly every state has large contracts for a Medicaid Management Information System, prescription drug coverage, durable medical equipment, managed care providers, and other services necessary to properly administer health coverage. However, in many cases, states pay for the development and acquisition of these products and services individually; in some cases, Medicaid agencies are explicitly barred from cross-state coordination of bulk purchasing. The federal government should work with states to organize and coordinate value-based purchasing. The states need to be able to leverage the large purchasing power available to reduce costs and improve the efficiency and cost-effectiveness of their contracts.

- **Establish a State Option to Cover Non-Categorical Populations with Incomes Below the Poverty Level**

Currently, childless adults without disabilities often cannot access Medicaid services without a waiver. As states and the federal government look for ways to expand coverage and provide preventative care to individuals, single adults should be able to access services before a condition deteriorates to the point of needing emergency care or becoming a disabling condition. Allowing states the flexibility to include non-categorical populations would simplify and expand coverage options for single adults.

- **Align Commonwealth and Territorial Medicaid Programs with State Medicaid Policy**

It is critical that national health care reform provide the U.S. commonwealths and territories with an opportunity to align with the health care systems of the mainland, particularly the larger jurisdictions. Alignment means addressing disparate policies, holding systems to the same standards of accountability, and providing access to quality health care and services. American citizens in the territories should be able to access health care that other U.S. citizens can receive in their own neighborhoods. Federal funding for these jurisdictions should be based upon a uniform Medicaid policy as opposed to arbitrarily established set-asides.

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Child Welfare and Well-Being

Accomplishments

Children, Youth, and Families Served by Public Child Welfare

The public child welfare system serves the nation's most vulnerable children and families. Those helped by America's child welfare system include children and youth who are abused or neglected; children living in foster care and other alternative care settings; and those who are not in custody, but who are receiving in-home services, sometimes mandated by the court. Child welfare programs not only coordinate services for families in distress, but they also recruit families to care for abused and neglected children and youth as well. Those who work in the child welfare system are witnessing first-hand how the most recent downturn in the economy is negatively affecting families, especially families of color, who are disproportionately represented in child welfare caseloads. A brief glance at the program as it stands today demonstrates the considerable challenge that child welfare administrators face each day, a challenge that will only become more complicated as the nation's economy remains unstable.

Child welfare professionals interact with significant numbers of children and families:

- About 900,000 children are annually substantiated as having been abused or neglected.
- In 2007, approximately 783,000 children were served by the public child welfare system, and nearly 293,000 children entered care due to abuse and/or neglect.
- Approximately 130,000 children and youth are waiting to be adopted and for other permanent arrangements.
- In 2000, African-American children made up less than 15 percent of the U.S. child population, but represented 27 percent of the children who entered foster care in fiscal year 2004 and 34 percent of the children remaining in foster care at the end of that year.
- In 2004, about 283,000 children left foster care to return home, to live with a relative, to be adopted, or were emancipated at the age of 18.
- Between 2001 and 2006 the number of young people, mainly minority youth, aging out of the child welfare system without safe, permanent homes has grown 42.6 percent.

Supporting the well-being of children, youth, and families is a shared family, community, and government responsibility. Public child welfare acts as a catalyst with the family and in the community to engage and empower children, youth, and families to reach their full potential.

Focus on Good Practice

States and counties are making great strides in serving children, youth, and families by making changes in practice and service delivery that enable children to remain safely in their own homes. Several states are incorporating family team decision-making and family group conferencing. With this practice, families are invited to participate in the decisions that affect the child's life, including type of placement, services, and other key decisions.

Many states and counties are now using alternative (differential) response for lower-risk cases. This method of service delivery enables caseworkers to strengthen families by connecting them to community resources and services that ultimately serve as a safety net.

Research on these alternative response strategies has found lower levels of abuse and neglect as well as increased family stability.

However, despite the efforts of creative state and county leaders and dedicated staff, too many children today still remain in harm's way.

Recent Legislation: Good Step Forward for Child Welfare Goals

The Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) was signed into law in the fall of 2008. This law provides federal support for relative placements and supporting youth past the age of 18, among other things. These reforms, when fully phased in, will have a positive impact on disproportionality, a pervasive issue throughout the child welfare system. However, despite the advances made in this new law, it does not resolve the many challenges that public child welfare faces, particularly during tough economic conditions.

Challenges

All Children Need One Comprehensive Financing and Monitoring System

First and foremost, the federal financing system that supports child welfare must be overhauled. The current system hampers public child welfare's efforts to achieve positive outcomes for children. Since 1998, states and counties have lost an estimated \$1.9 billion in federal foster care support due to outdated and administratively burdensome eligibility requirements. These eligibility requirements must be eliminated. Access to, and utilization of, appropriate services must be provided to all children in need regardless of their financial status. The erosion of federal dollars, particularly during the economic crisis, has a detrimental impact on the ability of states and counties to serve at-risk populations.

Foster care provides a much-needed alternative when abused and neglected children cannot remain safely at home. However, alternatives to foster care placement can prevent abuse and neglect from occurring at the outset and, ultimately, prove to be a more cost-effective strategy. Support for a comprehensive array of prevention services, such as emergency housing support, family counseling, and referrals for drug treatment programs, keep children and youth from coming into public child welfare system in the first place. The federal financing system still places an undue amount of focus on removing children from their homes and placing them in foster care. A federal financing system must support a strong, balanced array of front-end services if it is to be truly effective.

Child welfare has become more complicated due to increased federal oversight, audits, and reviews (e.g., Child and Family Services Reviews, Program Improvement Plans, Title IV-E plans, Title IV-E foster care audits, and Title IV-E adoption assistance audits). This process is highly problematic since each audit, review, and data collection system comes with a different set of requirements and rules that are costly in staff resources and time. Federal oversight should be consolidated into one system to eliminate the considerable conflict and administrative burden generated by the current process.

Additionally, there are no incentives in place for states that score well on audits and reviews. However, states are penalized when they do not meet substantial conformity standards even when their overall performance improves. Penalties only compound the states' difficulties and threaten to deplete already limited funds, thus redirecting resources away from children and families. There needs to be a more thoughtful implementation of both incentives and penalties to maximize achievement among child welfare programs.

Policy Agenda

Child Welfare Financing Reform

In 2005, the U.S. Department of Health and Human Services explained that there was no policy reason that the federal government should “care” (in monetary terms) more about children in imminent danger of maltreatment by parents who are poor than those children whose parents have higher incomes. Nonetheless, federal support is available only for the very poor: those children with families who would have been eligible for Aid to Families with Dependent Children (AFDC), a program that was dismantled in 1996. By law, states support all abused and neglected children, and the federal financing system must support all children too.

States and counties must string together a patchwork of fragmented federal funding streams to provide services and supports to children and families. Each funding stream has a different set of rules and regulations. Public child welfare agencies attempt to weave together Title IV-E (including Chafee Independent Living), Medicaid, Title IV-B, the Social Services Block Grant, Temporary Assistance for Needy Families, and Child Abuse Prevention and Treatment Act funds among others to meet the needs of children and families. This does not include the funding streams for mental health, drug and alcohol treatment, housing, and other programs that are necessary to support, treat, and strengthen families. Public child welfare administrators urge Congress to make a single, dedicated federal funding stream with sufficient resources for children and families who come to their attention.

Even though IV-E foster care, adoption, and guardianship are in one funding stream, they have different rules and regulations to determine eligibility. Public child welfare administrators strongly believe there should be one single eligibility determination for all three programs.

A long-standing concern is the lack of flexibility in federal funding for child welfare services. Current funding mechanisms do not allow states the flexibility to effectively develop and support the array of services needed to improve outcomes for children and families. States and counties know how to best spend resources that meet the needs of the at-risk population. Yet, limited flexibility exists to allow them to do so. The single funding stream that child welfare agencies seek must provide states and counties with the flexibility to spend dollars that best serve their populations.

Approximately 3.6 million children were reported to child protection authorities in 2005. Yet, it is estimated that only 2.5 percent of these children received any kind of preventive services. During times of economic crisis, reports and substantiated cases of abuse and neglect increase. Limited resources are available for front-end and prevention services that prevent children from coming into care in the first place. Prevention services may include services such as housing assistance (particularly important as foreclosures continue to plague the economy), transportation, mental health, and substance abuse treatment.

Federal financing is disproportionately directed toward funding out-of-home care. In 2007, The Pew Charitable Trusts reported that about 90 percent of federal child welfare funds supported children in foster care placements. Only the remaining 10 percent was available for front-end, prevention, post-permanency, and reunification services. A federal financing structure should enable states and counties to focus on keeping families together, when that can be achieved safely. Currently, Title IV-B, SSBG, TANF, and CAPTA provide limited federal resources for front-end services.

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Recommendations:

- **Support all children and youth regardless of family income.**
- **Create a single, dedicated flexible funding stream for child welfare.**
- **Support cost-effective prevention services.**
- **Allow states and counties to reinvest federal dollars into IV-B services.**
- **Any increase in the Federal Medical Assistance Percentage should include an associated increase in the Title IV-E matching rate to help support children in foster care.**
- **Reauthorize CAPTA and TANF programs.**
- **Fully fund the Social Services Block Grant.**

Monitoring and Accountability Reform

Child and Family Services Reviews

States and counties understand that with federal funding comes responsibility and accountability, and recognize the need for the federal government to monitor resources that it allocates. Monitoring should be a fair and accountable process based on measurements that accurately reflect the work of the states. Unfortunately, this is not the case under the current monitoring system.

Child and Family Services Reviews do not measure what they are designed to and therefore do not accurately reflect state performance. No state was in substantial conformity on all measures in the first round of reviews and by December 2008, no state was in substantial conformity on all measures in the second round. States are concerned for a variety of reasons that the measures are flawed. Public child welfare administrators are adamant that the CFSRs are poorly designed and set states up to fail.

A major component of the review is primarily based on a "snapshot" of current practices and linear data. Longitudinal data provides a clear and concise picture of the safety, permanency, and well-being for children and a holistic view of state and county performance. Many states use longitudinal data in their own Quality Service Reviews (QSRs), yet the Administration for Children and Families rarely makes use of it.

Not enough cases are reviewed to determine substantial conformity. For smaller states, 65 cases make sense; but for larger states, 65 cases cannot tell an accurate story of how the state is performing.

The CFSRs are very labor-intensive prior to and during the week-long review process. Also, the CFSRs do not account for the age, race, and ethnicity of children—information that could provide much-needed insight into the disproportionality pervasive in child welfare.

Program Improvement Plans

Once a state has completed the CFSR and areas in need of improvement are identified, the next stage is to develop and implement a corrective action strategy known as a Program Improvement Plan. States and counties receive different guidance from regional offices and National Resource Centers regarding the development of the PIPs, which causes labor-intensive rewrites and detracts from other important work. Public child welfare administrators urge ACF to clarify the details needed in the PIPs and allow for flexibility in altering the corrective strategies needed to ensure continuous improvement.

States and counties frequently do not have the Final CFSR Report before they need to begin developing the PIPs, due to ACF delays. The Final Report is a valuable resource tool vital to PIP development. Public child welfare administrators urge ACF to make the Final Report available in a timely manner.

Public child welfare administrators believe it is not enough to know what goals need to be achieved through the PIPs; resources must also be available to make improvements. Congress must allow states to use Title IV-E funds for any purpose approved under the states' PIPs.

IV-E Audits

In addition to the CFSRs, ACF also conducts periodic eligibility reviews for Title IV-E foster care and adoption assistance in accordance with the Improper Payments Information Act of 2002. Like the CFSRs, the audits also have a PIP process when it is determined that states are not in compliance. Public child welfare administrators strongly urge ACF to end Title IV-E disallowances from federal audits that take away funds from an already resource-strapped child welfare system, or allow states to reinvest these funds in child welfare services.

Penalties are counterproductive to the outcomes of the CFSRs, PIPs, and Title IV-E audits. Public child welfare administrators urge ACF and Congress to allow states to reinvest penalties to address the cause of the error, similar to the option available in the Supplemental Nutrition Assistance Program.

States should be provided with financial incentives, as opposed to monetary penalties, under the Child and Family Services Reviews, Title IV-E audits, OIG audits, and other oversight activities. This change would help minimize the significant administrative burden associated with determining eligibility and responding to audits and reviews.

Recommendations:

- **Perform a full-scale evaluation of the CFSRs.**
- **Place a moratorium on the third round of the CFSRs until ACF completes rounds one and two.**
- **Make the final CFSR report and the federal approval of the PIP available in a timely manner.**
- **End all penalties or allow states to reinvest penalties into program improvements.**

SACWIS, AFCARS, NCANDS, and NYTD

Collection of valid and credible data is critical to improving practice at the state and county levels and to guiding research. The current systems that collect data include:

- **The Statewide Automated Child Welfare Information System (SACWIS)** is a comprehensive automated case management tool that supports social workers' foster care and adoption assistance case management practices.
- **The Adoption and Foster Care Analysis and Reporting System (AFCARS)** collects case-level information on all children in foster care for whom state child welfare agencies have responsibility for placement, care, or supervision, and on children who are adopted under the auspices of the state's public child welfare agency.
- **The National Child Abuse and Neglect Data System (NCANDS)** is a voluntary national data collection and analysis system created in response to the requirements of the Child Abuse Prevention and Treatment Act (P.L. 93-247) as amended.

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- **The National Youth in Transition Database (NYTD)** will collect case-level information on youth in care, including the services paid for or provided by the state agencies that administer the Chafee Foster Care Independence Program, as well as the outcome information on youth who are in or who have aged out of foster care.

The current data collection systems do not provide a true picture of what is happening to the child. Accountability structures must be revised to accurately portray what is really happening to children who come into the system.

Recommendations:

- **Child welfare data systems must be able to provide a longitudinal picture.**
- **All systems that touch a child, such as juvenile justice, mental health, education, public housing, substance abuse, and others, must also be able to share their data.**

For Further Consideration

Build an Array of Services to Support a System of Care

Children and families face an array of challenges, including poverty, substandard housing, substance abuse, domestic violence, and mental health issues. These families are touched by many different agencies in addition to child welfare. A full spectrum of services should be available before, during, and after care to ensure the success of children and families.

A system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across systems, is culturally and linguistically competent, and builds meaningful partnerships with families and youth. Public child welfare professionals value approaches that are child- and youth-centered and family-focused, community-based, and culturally competent. Yet, stumbling blocks such as restrictive, categorical funding impede states' and counties' ability to fully integrate a comprehensive system of care approach.

Interagency Coordination and Collaboration

The needs of children and families often extend beyond the purview of the child welfare agency itself. Child welfare alone cannot solve the complex needs of children and families. For example, many of the families who access TANF are the very same families that come to the attention of child welfare. Additionally, children and youth who experience abuse and neglect and enter foster care have an increased likelihood of spending time in juvenile justice systems. These are systems that cannot operate in a vacuum and must collaborate to serve identical populations. Regulations should allow cross-system information-sharing to help agencies and courts make informed decisions about the safety and well-being of children and families. Public child welfare administrators urge Congress and the Administration to consider cross-agency collaboration and coordination when writing legislation and regulations, especially around the reauthorization of TANF and the Juvenile Justice and Delinquency Prevention Act.

Mental Health and Substance Abuse

The vast majority of families served by the child welfare system are affected by substance abuse, mental health issues, or both. Parental substance abuse is a significant factor in more than half of child abuse and neglect cases. Yet the services that help these families are extremely limited. As a result, many children enter and stay in foster care for long periods.

Children and youth in the child welfare system have disproportionately higher mental health needs than their non-foster care peers. One study found that 33 percent of youth in foster care have three or more diagnosed psychiatric problems. Recent studies have shown that youth and adults formerly in foster care experience higher rates of general mental health problems than the general population—54.4 percent versus 22.1 percent. Public child welfare administrators urge Congress to provide adequate resources for quality holistic substance abuse and mental health treatment services for the entire family unit and allow professionals to share information to better serve families.

Overrepresentation of Minority Populations

African Americans and Native Americans are overrepresented in child welfare. In 2004, African-American children made up 34 percent of the foster care populations. Research shows that poverty is a contributing factor to disproportionality. Public child welfare administrators urge Congress and the Administration to focus on access to services that address disproportionality, specifically around differential or alternative responses.

Supports for Youth

Unfortunately the number of young people who age out of foster care continues to grow, with more than 26,000 leaving in 2006—an increase of 46.2 percent since 2001. Youth exiting the foster care system do so with significantly higher levels of need than their non-foster care counterparts. Research documents that many of these transitioning youth will experience homelessness. Very often, their experiences in the foster care system have contributed to or exacerbated their needs. One in four youth aging out of the foster care system experience post-traumatic stress disorder. This population will require additional support services in the areas of housing, education, employment, and permanency connections as they develop independence and self-sufficiency. Public child welfare administrators urge Congress to increase funds for the Chafee Foster Care Independence Program, which provides needed education and support services for transitioning youth.

Repeal Costly Targeted Case Management Regulation

Many state child welfare systems rely heavily on Medicaid funds to pay for health and mental health services for the vulnerable children in their care. All children in foster care and adoptive placements whose expenses are reimbursed through Title IV-E of the Social Security Act are categorically eligible for Medicaid. In addition, all states currently choose to extend Medicaid benefits to non-IV-E eligible foster children. Each state determines its own eligibility standards, services, and payment rates within federal guidelines in its foster care and Medicaid programs. Children in foster care who are eligible for private insurance coverage through their caregivers remain eligible for Medicaid wraparound coverage.

The Centers for Medicare and Medicaid Services must rescind the Targeted Case Management regulation that restricts child welfare workers coordinating medical care for foster children, or continue the present moratorium on a permanent basis. Action is needed prior to April 1, 2009, when the moratorium expires. If these rules go into effect, there will be significant erosion of federal funding for services in many states.

Child Welfare Workforce

The average tenure of a child welfare agency worker, who is often called upon to make life and death decisions for children, is less than two years. The effective delivery of services to children, youth, and families is dependent on a competent, well-trained workforce capable of addressing the safety, permanency, and well-being of all children in need. Heavy workloads coupled with insufficient staff levels lead to extremely high turnover. States,

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counties, and the federal government need to collaborate on ways to address the challenges that the child welfare workforce faces.

Support Interstate Placements

Inter-jurisdictional placements are an invaluable resource for securing safety, permanency, and well-being for children in the child welfare system. The Interstate Compact on the Placement of Children provides the infrastructure for cross-state collaboration and accountability. The compact administration is funded by states themselves. However, it is in need of additional financial support to overcome inherent problems such as delays in home studies, criminal records checks, and inconsistencies in foster care and adoptive training and licensing. Most importantly, to realize true reform in interjurisdictional placements, additional funding will be necessary to ensure states' enactment and implementation of the recently drafted New Interstate Compact for the Placement of Children.

Economic Services and Related Issues

TANF

Accomplishments

In 1996, Congress and the White House agreed to “end welfare as we know it” and passed the Personal Responsibility and Work Opportunity Reconciliation Act. This landmark legislation transformed the long-time cash payment entitlement program, Aid to Families with Dependent Children, into a state block grant program, Temporary Assistance for Needy Families. TANF let states provide time-limited assistance to move clients into work and promote family stabilization as efficiently as possible. Congress gave states explicit authority to design TANF assistance in whatever way they felt best let them meet their individual goals, so long as state plans complied with the broad goals in the statute; state spending was maintained at a federally mandated level; and states were demonstrating that they were reducing caseloads and meeting required work participation rates. The decrease in families on cash welfare assistance was dramatic. According to the House Ways and Means Committee’s “Green Book,” in 1996, 5.1 million families were collecting cash assistance, but this number had dropped to 1.9 million families by 2006.

State TANF spending was framed by the statute’s four nationally mandated goals: (1) assisting needy families so children can remain with their families; (2) reducing dependency of needy parents by promoting job preparation, work, and marriage; (3) preventing out-of-wedlock pregnancies; and (4) encouraging the formation and maintenance of two-parent families. Congress further prohibited HHS from regulating TANF except as explicitly allowed in the statute.

In its early years, TANF’s flexibility allowed states to design programs that not only used cash assistance but also leveraged a host of other assistance services to help families. This let states continue to help families when heads of households moved into the workforce, yet were still in need of additional support, so they did not lapse back into dependence on cash assistance.

Now, well over a decade after TANF replaced AFDC, there is no longer any question that states and localities can design and implement effective welfare-to-work programs, and that legions of poor, single mothers can secure and retain employment. The positive results since 1996 have surpassed all realistic expectations and include:

- Many more single mothers with children who live below the poverty line are now employed;
- 8 percent fewer children are in poverty; and
- 60 percent fewer families are receiving cash assistance.

As the nation confronts the worst economic crisis in more than three generations, TANF, along with tax benefits and other support services, has a critical role to play in combating family poverty by providing cash assistance to enable poor families to maintain housing, helping poor parents to secure and retain employment, and assisting low-income working parents to achieve economic self-sufficiency.

Challenges

TANF was designed as a powerful, but limited, tool to help certain low-income families, and coupled with other programs and strategies, has enabled states to make remarkable progress. However, vulnerable families still endure many deficits:

- Too many families that have left TANF with employment are mired in low-wage jobs that keep them at or near the poverty level.
- Over the period of 1996 to 2005, 128 percent more single-parent families in poverty became disconnected, with no cash assistance and no employment.
- Fewer than 25 percent of poor children and fewer than 40 percent of families who are poor enough to receive TANF assistance under their own state's eligibility rules actually receive TANF assistance.

Although the TANF program has made considerable strides in helping vulnerable families and individuals, over the past several years conflicting federal policy decisions have undermined the innovative spirit of TANF, a cornerstone of the bipartisan welfare reform effort more than a decade ago. Recently the federal government has:

- Imposed a rigid and narrowly focused work participation rate on the program that addresses only one measure among a range of program outcomes, and that is accompanied by extensive verification plans and punitive sanctions;
- Begun imposing a nearly identical version of the former AFDC national quality control program—which Congress explicitly rejected in the 1996 law—through a series of intensive and ill-conceived audits in a growing number of states;
- Issued a regulation that severely restricted state maintenance-of-effort expenditures under purposes 3 and 4 of the statute;
- Published a proposal, based on unsubstantiated justification, to eliminate states' ability to use their excess MOE expenditures for credit toward their caseload reduction credit.

TANF's 2005 Reauthorization – The first reauthorization of TANF, initially due in 2002, presented an ideal opportunity to take stock of the program's successes and its limitations, and engage in a rich debate over how to build on TANF's achievements to more effectively reduce family poverty. Sadly, this opportunity for a broad and sweeping examination of how successful TANF has been in addressing poor families' true needs was lost. Also lost was a valuable opportunity to critically examine the limitations of the TANF program and how these shortfalls could be addressed to produce better outcomes for the people TANF serves. Instead, national policymakers in both Congress and the Administration placed undue focus on TANF procedural changes, including calculation of the work participation rate and onerous work verification procedures, resulting in a reauthorization through the reconciliation process that was in many ways a step backward.

When TANF reauthorization was finally passed as part of the Deficit Reduction Act of 2005, HHS followed with a number of regulations that have further limited the valuable flexibility states have used to produce better outcomes for needy families. Now, as states brace themselves for an extended and painful economic downturn, and as millions find their unemployment insurance dwindling and face the possibility of turning to assistance programs, states are looking at an increasingly challenging environment for meeting TANF's current narrow requirements. The states' task is exacerbated because the relatively easy

cases to move off TANF have already left the program, and those remaining on the caseload often have multiple work barriers.

Since the reauthorization went into effect, states and localities have been forced to devote a disproportionate amount of energy and scarce resources to the technicalities of the work participation rate and new work verification plans, to the detriment of serving poor families and helping low-income working families progress to better employment. Moreover, the series of process-based regulations and similar administrative requirements issued by the HHS Administration for Children and Families has further restricted state flexibility and distracted state and local agencies from the urgent task of helping poor and low-income families.

Policy Agenda

State and local TANF agencies want to work with the Administration and Congress to re-establish the spirit of partnership, flexibility, and accountability that was the basis for TANF's tremendous successes during its earlier years. States agree that a reasonable level of accountability is proper in a federal block grant. However, the great achievement of TANF was that it rewarded states for innovation and encouraged administrators to take the actions they deemed necessary to help the unemployed overcome unique barriers that varied by the state and the individual.

The program works because of that flexibility, yet in the current state-federal discourse it seems as though the debate has moved away from flexibility and program outcomes to more emphasis on process and accountability. There can be both accountability *and* flexibility so long as states are being held accountable for outcomes that are under their control and that represent true progress for needy families toward the program's statutorily defined goals.

States call on national policymakers to join in making these improvements as TANF approaches its next reauthorization milestone in 2010.

Recommendations

Administrative Changes that Can Be Implemented Now

There are many administrative policy issues needing reform in the 2010 reauthorization. While states will work to have these addressed in new statutory language if and where necessary, there is a great deal of progress that can be made now through the Administration's initiative. The Administration should take the following important steps:

- **Relieve states of work participation rate and work verification plan penalties for FYs 2007, 2008, and 2009**, in recognition of the serious downturn in the national economy and the succession of more process-based regulations issued in the last few years.
- **Rescind the May 22, 2008, HHS guidance that effectively eliminated the ability of states to offer pre-assistance programs to new TANF applicants for up to four months.**
- **Eliminate unnecessary work verification requirements**, which are not only burdensome for states administratively but often problematic for employers, educational institutions, and other providers of TANF services.

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- **Rescind the final Deficit Reduction Act regulation restricting allowable state maintenance-of-effort expenditures under TANF purposes 3 and 4**, which contradicts the express language of the federal statute and HHS' own interim final rule.
- **Permanently withdraw the August 8, 2008, proposal that would have repealed the regulation that enables states to claim caseload reduction credit for excess MOE expenditures.**
- **Suspend the development of a national payment error rate** for the TANF program by the HHS Office of Inspector General. Any effort to establish a national payment error rate for a flexible block grant program with different rules in each state will produce meaningless results that will further distract attention and siphon resources from the true goals of the TANF block grant.
- **Permit states to count good-cause absences from work** by a parent and reasonable hours of ongoing part-time job search beyond the current six-week limit to count toward the work participation rate.

The serious downturn in the national economy and the corresponding increase in families' need for basic income assistance reinforce the imperative to refocus TANF on its real goals and away from arcane, technical regulations.

A Framework for TANF Reauthorization

TANF's current authorization expires on September 30, 2010. As that date approaches, it is critical that the Administration, Congress, state and local TANF administrators, and other interested stakeholders engage in a vigorous discussion over how to best meet the needs of poor and low-income families within the context of shrinking state resources and a capped block grant.

APHSA and its affiliate, the National Association of State TANF Administrators, believe strongly that state and local TANF administrators must be closely involved in the discussion on how best to reauthorize the TANF block grant. In this spirit, APHSA and NASTA propose the following points that should be considered in the work that is to come:

- **The amount of the TANF block grant should be increased** to make up for past inflation and indexed for future inflation. Inflation has eroded the real value of the TANF block grant by 26 percent from 1997 to the present.
- Since fewer than 25 percent of poor families with children and fewer than 40 percent of poor families eligible for assistance under each state's TANF program are actually receiving assistance, further caseload reduction has outlived its usefulness as a sole, fair, or accurate measure of state success. **States should be encouraged instead through positive bonus awards** to move forward on other indicators of success in alleviating need and encouraging individuals toward self-sufficiency.
- **The work participation rate, while having some limited use in showing progress in certain respects, should be coupled with additional measures such as a measure of engagement and/or employment earnings.** If the work participation rate is maintained, it should be modified to count partial participation, expand the scope of countable activities, and eliminate the separate two-parent rate, among other changes.
- TANF's results so far have clearly revealed the presence of a substantial number of struggling families who cannot qualify for disability assistance but who are unable to sustain ongoing employment. These families should be served outside of TANF, or if

not, then differentiated within the TANF program. **Additional federal resources should be provided to assist these families, and broad cooperation should be established between the Social Security Administration and HHS to effectively coordinate efforts on behalf of these households.**

- **Congress and the Administration should consider enhancing connections among TANF and other major programs that assist poor and low-income families**, such as the Earned Income Tax Credit, federal housing assistance, child care, Workforce Investment Act, Medicaid, and the Supplemental Nutrition Assistance Program. New legislation and subsequent regulations should facilitate coordinated administration of these programs and minimize program conflicts.
- The state flexibility at the heart of TANF's success must be restored in the next reauthorization through explicit rejection of the array of federal regulations that have encumbered TANF in recent years and through modification of other federal laws that clearly cannot and rationally should not apply in their present form to TANF, such as the Improper Payments Information Act of 2002.

Child Support

Accomplishments

From its beginnings in 1975, child support enforcement has flourished into a comprehensive and effective federal-state partnership. Authorized in Title IV, Part D of the Social Security Act, the program has grown to be a tremendously successful means of providing both substantial financial support to single-parent families and reducing their dependence on other assistance programs, as well as helping repay states for expenditures incurred while a family was receiving assistance.

In 2007, the Office of Child Support Enforcement released its preliminary report citing nearly 15.8 million cases currently in the IV-D program, with just over two million of those cases collecting TANF (Title IV-A) assistance dollars. All totaled, the program collected \$25 billion in child support from non-custodial parents. On average, in 2007 IV-D programs generated \$4.73 for every \$1.00 spent.

Through the Deficit Reduction Act, Congress was able to open up considerably more options for child support enforcement programs, and for state human service agencies overall, by significantly enhancing states' ability to pass through more child support to families on TANF as well as those who had formerly been on TANF. However, this new-found flexibility is moot if states are unable to pass additional money through to families due to the states' own financial struggles.

Challenges

In these difficult financial times for states, there are challenging decisions that must be made; this is especially true when negotiating how collections for current and former assistance families will be handled and when those decisions will be implemented.

The amount of money saved by effective child support and passing through more money to families currently on assistance must be carefully considered in any comprehensive approach to supporting children and families. Policymakers must keep the interrelated nature of child support in mind when addressing these complicated issues.

Clearly, child support enforcement touches a significant percentage of families while managing a considerable amount of money. Today, the goal of child support has become more complex and nuanced. The program no longer focuses purely on collecting back debt that has accumulated to a certain threshold. If child support payments are to be effective and do the most good for the child, they must be received on a regular basis so that the custodial parent household can budget accordingly and avoid financial uncertainty. There is a growing need to work more with non-custodial parents, the majority of whom are men, who are unable to provide a reliable source of financial support for their children.

Today, child support enforcement shares common points with other assistance systems. State CSE offices are now working extensively to help NCPs who are in arrears and unable to pay child support to transition into steady employment and onto a consistent support payment schedule. CSE offices and the courts are now able to establish medical support orders not just for NCPs but for CPs as well, requiring greater coordination with colleagues managing Medicaid. Child support offices are now required to manage requests from their colleagues in child welfare for information housed in the massive federal parent locator service. These tasks come on top of the already consuming responsibility of ensuring that collected child support is delivered as quickly and efficiently as possible.

Policy Agenda

Funding Must Reflect the Steady Increase in CSE's Responsibilities

Child support has evolved into a program that provides greater financial stability for single-parent families and that has been making substantive strides in helping both custodial and non-custodial parents meet their financial obligations to their children. With this expanding role of child support comes even greater need for enhanced federal partnership to ensure that this national program—with its success depending greatly on solid interstate cooperation—maintains high-quality service. APHSA recommends the following changes:

Recommendations

- **Restore the federal match of incentive payments for state child support programs as it existed prior to the Deficit Reduction Act of 2005.** This money would allow states to continue to reinvest in their child support programs and support continuing outreach to both custodial and non-custodial parents.
- **Temporarily increase the federal match rate for acquisition of automated data systems to 90 percent.** With a considerable amount of business in the IV-D program occurring across state lines, it is vital that all states be able to maintain up-to-date automated systems. The last mandatory systems upgrade occurred prior to the 1996 welfare reform legislation, and many systems are now aging and require considerable legacy maintenance. This increase in matching funds would allow states to upgrade their automated systems to more efficiently manage demand from other IV-D agencies as well as other requests received from outside the program.

- **The current work on promoting early intervention strategies to combat the build-up of arrearages has been beneficial, and should continue to be supported.** States and tribes have used the flexibility inherent in the program to implement modification of orders to ensure obligations match ability to pay; more rapid communication with NCPs after a scheduled payment is missed; and other innovations that promote a culture of compliance rather than enforcement. All this has been done with the past encouragement of the federal child support program, and this support should continue.

Child Support Must Go to Families

The financial security of children must continue to be a priority for child support agencies. Placing higher emphasis on ensuring that more of the total support collected is distributed to families goes further in maintaining the stability children need. Such emphasis also helps reinforce the culture of compliance with NCPs, who need to know that the support they pay makes a difference. This is why money that is collected but retained, or funds recovered through fees, can be counterproductive in the interagency effort to promote responsible and self-sufficient households.

Recommendations

- **The \$25 fee charged to non-TANF families who receive more than \$500 in child support should be removed.**
- **There should be greater incentives for states to pass through the full amount of child support collections to families receiving TANF assistance, without having to guarantee the federal share of child support collected on behalf of TANF families.**

Medical Support Continues to Evolve and Requires Additional Guidance

The July 2008 implementation of regulations on enforcement of medical support is a significant administrative milestone. Giving the child support program the ability to enforce medical support that is both reasonable and accessible is quite timely, since the cost of health care continues to climb at the same time the number of employers providing coverage dwindles. Satisfactory administration of medical support for children at a high level requires specific changes that will help make the establishment and maintenance of medical support more efficient.

Recommendation

- **Fee-for-service status should be changed so that cash medical support collected by child support agencies is applied to administrative costs borne by Medicaid, thus reducing federal and state outlays.**

Child Care

Child care plays a central role in the success of working families across the nation. Through the federal Child Care and Development Fund, state agencies are able to provide low-

income working families with subsidized child care. With limited resources however, states are challenged in providing child care that is high in quality, adequate in supply, and affordable. Yet, child care that meets these critical criteria is dually beneficial to children and working families. On one hand, it serves as an economic necessity that allows parents to secure and retain employment and reduce dependency on public assistance. At the same time, quality child care promotes healthy child development and prepares children to be successful in school and life. These benefits are well supported by the research literature. In fact, the National Center for Education Statistics finds that *quality child care is particularly important for children from economically disadvantaged families and those with low maternal education, since they are at high risk of not being ready for school.*

Child Care is Vital to Working Families – High-quality child care allows working families to secure and retain employment in today’s workforce. Research from the Economic Policy Institute finds that:

- Single mothers who receive child care assistance are 40 percent more likely to remain employed after two years than those who do not receive this assistance.
- Mothers with a high school degree or less were just as likely as mothers with some college education to experience increased employment tenure when receiving child-care subsidies.
- Former welfare recipients with young children are 60 percent more likely to still be employed after two years if they receive help paying for child care.

Child Care Promotes Success in School and Beyond – High-quality child care also offers a direct benefit to children, providing them with a safe, nurturing environment that promotes school readiness, high school completion, and skill-building for success in life. For infants, toddlers, and preschoolers, quality early care and education creates positive early learning experiences that promote optimal brain development, shaping the child’s intellectual, linguistic, social-emotional, and physical skills. In turn, these developmental skills help children think critically, learn from teachers and peers, make friends, express thoughts and feelings, build confidence, and cope with frustration—all foundational skills needed for success in school and beyond. Quality early care and education settings help young children acquire these basic skills that then facilitate important academic skills such as reading comprehension and math.

For school-age children, quality after-school programs keep elementary and middle school students safe and healthy during the afternoon hours when juvenile crimes tend to soar. These programs keep youth constructively engaged when they might otherwise be getting into trouble on the streets, taking drugs, joining gangs, or engaging in other inappropriate behavior. Quality after-school programs also provide youth with academic supports such as homework help and tutoring to inspire learning success. In quality after-school settings, trained youth workers develop children’s self-esteem, teach respect and community involvement, and impart values and habits for success in life. In turn, youth who attend these programs get better grades, have better personal conduct in school, and stay in school instead of dropping out.

A Return on Investment – The direct link between child care and our economy is clear. Well-respected studies by business leaders and economists at the Center on Economic Development calculate a high return on investment—as much as \$17 for every \$1 invested in high-quality programs. Not only does high-quality care play a critical role in alleviating

the economic burden our country is currently facing by providing safe, affordable care so that parents can immediately secure and retain employment, it also develops human capital down the road by cultivating crucial academic and life skills that children need to succeed in school and later in life as adults.

Elements of High-quality Care – Families should have the ability to choose and access the child care setting that works best for the family. Whether parents choose center-based care, family child care, or familial kith and kin providers, parents need child care providers to supply care that is reliable and high in quality in order for them to remain in the workforce. Likewise child care should offer meaningful experiences for children to nurture their development. Quality is greatly determined by the caliber of professionals or providers who supply child care. Child care providers are best positioned to provide high-quality care when they are educated, have access to educational opportunities such as training and professional development courses, and receive adequate pay. Child care providers also need resources to obtain evidence-based curricula that embed school readiness, small groups, and high staff-to-child ratios.

Examples of other high-quality care elements include continuity of care and emphasis on health and safety. The importance of having a cadre of highly qualified, well-paid child care professionals and evidence-based curricula is underscored by the fact that children spend a significant amount of time in child care settings—often up to nine hours while parents work. Unfortunately, high quality care is too costly for many families. In fact, low-income families can spend 25 to 30 percent of their net income on child care. Also, low wages often paid to child care workers result in a workforce with minimal skills and high turnover. These workforce issues spill over into service delivery. As an example, most children in infant and toddler care attend child care centers that do not meet quality recommendations.

Potential and Challenges of CCDF – The CCDF block grant provides federal funding for child care to low-income working families. *Adequately* subsidized high-quality child care through CCDF could be a critical support for many more low-income families, providing children with opportunities for healthy growth and development and parents with the opportunity to become self-sufficient. To be eligible for child care assistance, children must be younger than 13, and their parents must be working, receiving training, or in school.

Currently, child care policies generally focus on the work needs of parents and are less invested in the developmental needs of children or the holistic needs of the family. Confined eligibility parameters undermine continuity of care for children. Low benefit levels significantly undermine the ability of parents to choose care that meets the needs of their children. Current regulations allow families with incomes up to 85 percent of the State Median Income to be eligible for the program; however, states have flexibility in adjusting eligibility thresholds downward according to availability of funds. Between 2001 and 2004, due to budget constraints, nearly three-fifths of the states reduced their income eligibility level—decreasing the number of eligible families who were able to benefit from child care subsidies. Many others have reduced or capped payment rates at levels that severely limit access for participants to the providers who offer the most appropriate environment for children’s development.

Funding Constraints and Administrative Burdens – CCDF was last reauthorized in 2002, and funding has continued since then only through short-term extensions. The Deficit Reduction Act of 2005 froze program funding until 2010, and other CCDF funding has

remained static since FY 2002. Issues of funding are compounded by the problem that CCDF is not strategically aligned to leverage funding and collaboration from other programs designed to support children and families (e.g. Maternal and Child Health, Child and Adult Care Food Program, Head Start, and education). As an example, early education funding through federal programs such as Head Start is weighed down with administrative requirements that often make strategic coordination with CCDF and other state and local sources burdensome, if not impossible.

Federal and state governments must partner to develop a healthy, stable workforce infrastructure in child care. The federal-state partnership should aim at improving collaborations beyond early care and education federal programs to other federal agencies that also provide millions of dollars in dedicated funding streams on human development. Finally, the partnership should seek collaborative opportunities with other relevant federal agencies to align payment policies and ultimately leverage limited child care funds.

Inaccuracies of Error Rate Methodology – The Administration for Children and Families has issued the final rule for CCDF error rate reporting that required states to implement provisions of the Improper Payments Information Act of 2002 (P.L. 107-300). The rule required state child care programs to measure, calculate, and report error rates to obtain a national rate of improper authorizations for payment. However, IPIA is clearly intended to focus on the *actual payment* of federal funds rather than the *authorization for payment* utilized in the CCDF error rate methodology.

The methodology used for state child care subsidy programs is particularly problematic since many programs often authorize estimates of maximum payment for which a client is eligible, without ever expending that actual amount. Also, many states do not necessarily “authorize” a specific child care subsidy amount at the time eligibility is determined. Actual “payment” of CCDF funds for many states does not occur until after services have been delivered and billed by a provider. There are many variables that can affect what this amount may be from month to month, particularly the actual amount of services used regardless of the amount that may have been authorized. Consequently, both result in inflated figures, whereas using actual payments would result in actual amounts.

Continuing to implement the current methodology—which relies on authorized amounts that for many states may end up being estimates rather than actual payments—will significantly undermine the accuracy of measured improper payments. States are concerned that improper payments identified may cause states to be unjustifiably penalized. Rather, shifting the focus of the CCDF error rate methodology to actual payments would be more consistent with both the intent and actual language of the IPIA, and will result in far more accurate and meaningful results regarding “actual payment” error amounts.

These considerations aside, however, the attempt to impose a national error rate on a flexible block grant program like CCDF is highly problematic, and it is questionable if the IPIA actually contemplated the inclusion of programs like this.

Policy Agenda

To alleviate these burdens and meet the demand for high-quality care, APHSA and its affiliate, the National Association of State Child Care Administrators, make the following recommendations.

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Recommendations for Legislative Action:

Federal CCDF funding for child care must be sufficiently expanded to:

- Increase low-income families' access to child care subsidies as a support for their employment.
- Support state capacity to improve child care quality for positive child outcomes.
- Support state efforts to address the workforce development needs of child care workers.

Recommendations for Administrative Changes:

- Provide the necessary research, evaluation, and coordinated technical assistance to assure that systems and strategic plans developed by states support positive outcomes for children and families.
- Require coordination and cooperation among the Child Care Bureau, Office of Head Start, Maternal and Child Health Program, Department of Education, and other relevant federal entities so that programs rely on consistent policy guidance from ACF and its federal partners and experience reduced conflict among rules and regulations.
- Terminate the development of a national payment error rate for the Child Care program by the HHS Office of Inspector General, since efforts to establish a national payment error rate for such a flexible block grant program like CCDF with different rules in each state produce misleading results that distract attention and siphon resources from the true goals of the CCDF block grant.

Nutrition Assistance

Accomplishments

Federal food assistance programs have long been critical to the success of the web of benefits and services that states administer. The ability to purchase adequate food and maintain a nutritious diet is essential to the general economic security, health, and overall well-being of the families and children we serve. President Obama's pledge to end hunger in the United States by 2015 recognizes these facts.

There are 15 federal food programs, with the majority distributing their benefits to low-income families and individuals. These programs support working families, children, and the elderly and disabled. Most contain nutrition requirements or a nutrition education component. They were established to promote the health and well-being of families and individuals that do not have the resources to obtain an adequate and healthy diet on their own. They send to the states billions of federal tax dollars that are, in the main, spent in local communities supporting local businesses. All involve federal, state, and local agencies working together to achieve the goals of the programs.

Current Nutrition Programs

The largest of the 15 federal food programs is the **Supplemental Nutrition Assistance Program** (formerly the Food Stamp Program), which at \$33.2 billion (fiscal year 2007) accounted for approximately 66 percent of all food and nutrition spending (excluding food assistance for disaster relief). The next largest programs, which all contain fixed nutrition requirements, account for approximately 33 percent of spending. These are the School Lunch Program (\$8.7 billion); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (\$5.5 billion); and the School Breakfast Program (\$2.2 billion). The remaining 11 programs, which account for about 1 percent of spending, have specific targets such as the Senior Farmers Market Nutrition Programs (approximately \$41 million) and various commodity programs such as The Emergency Food Assistance Program (\$250 million appropriated for FY 2009).

Despite significant advances in SNAP participation in recent years, higher participation in other nutrition programs such as WIC and school meals, and significant SNAP benefit improvements enacted as part of the 2008 farm bill, millions of families still experience food insecurity and have poor nutritional intake. The U.S. Department of Agriculture reported that for 2007, 11.1 percent (13 million) of all households were food insecure. Sometime during the year, these households lacked the resources to provide enough food for all their members. About one-third of these households experienced very low food security (substantial disruptions in eating patterns and food intake) sometime during the year. This figure rose from the 2005 and 2006 level of 10.9 percent (12.6 million) of all households.

Challenges: Closing the Food Security and Nutrition Gap

Nutrition and Chronic Medical Conditions

Millions of Americans (increasingly including children) suffer from obesity, which for many has resulted in Type 2 diabetes. For 2007, the estimated direct and indirect cost of diabetes alone in the United States was \$174 billion, according to Centers for Disease Control data. Direct medical costs accounted for \$116 billion (2.3 times higher than what expenditures

would be in the absence of diabetes) and indirect costs, such as disability, work loss, and premature mortality, were listed at \$58 billion. Other diseases associated with obesity increase this cost by approximately 20 percent to \$139 billion. This takes the issue of food and nutrition beyond hunger and into the health care debate. Prevention of these nutrition-related conditions is far better both for the individual and a society struggling to afford adequate health care for its citizens.

Poor nutritional intake in low-income households has many interrelated causes: inadequate food budgets and skyrocketing food prices that force purchase of the cheapest foods; large and isolated geographic areas where mainstream grocery stores are absent or distant ("food deserts"); insufficient nutrition education; and the pervasive presence of fast foods and enticing advertising.

While the Congress and USDA have shown initiative in addressing some of these areas with benefit improvements, encouragement of outreach activities, and some streamlining of programs, there is little coordination across the federal government generally and an insufficient commitment to better nutrition among the private sector and other stakeholders.

APHSA calls on Congress and the White House to take immediate steps to address these deficits and to encourage other stakeholders to responsibly create an atmosphere where good nutrition knowledge and practice are held up as the desirable norm, not something pushed to the sidelines.

APHSA offers the following strategies to help address the food security and nutrition gap.

Policy Agenda

Actions to Increase Access

SNAP is the bedrock program supporting nutrition of low-income individuals by supplementing the income they have available for food. Its responsiveness to downturns in the economy has been proven repeatedly. Recently, it has been an important support for working households that, despite all their efforts, do not make enough to move beyond the poverty level. Since 2002, through various state, local, and non-government efforts undertaken in cooperation with the Food and Nutrition Service, the participation rate in the program increased 13 percent, so that in 2006 (the most recent year data are available) 67 percent of all eligible individuals were receiving 83 percent of the benefits that all eligible individuals could receive. Also, during this period, states began providing SNAP eligibility information to school districts so that students could be directly certified for free school lunches. Thus, as more eligible families came into the program, their children became eligible for nutrition support at their schools. These activities deserve ongoing support.

Increased access came through a variety of actions and policy changes:

- Partnerships with food banks, Community Action Agencies, health providers, and similar organizations that provide applications and application assistance.
- Projects like MiCAFE in Michigan, Express Stamps in Illinois, "Walk and Talk" in Louisiana, and Nevada's partnership with the Food Bank of Northern Nevada demonstrate that trusted non-profit community partners can bring people into the program by taking applications, interviewing, and either forwarding the information for final certification or

even providing initial benefits (Express Stamps) with the state agency providing follow up certification.

- Providing mobile or satellite offices where access to WiFi technology allowed caseworkers to “take the office to the community,” especially in rural areas where there is no public transportation and people have high commuting costs.
- Simplifying the application process and using technology to make applications readily available on the Internet.
- Simplifying the reporting requirements for households to encourage them to remain on the program.
- Initiating Combined Application Projects for automatic certification of one- and two-person households receiving Supplemental Security Income.

Recommendations

Amend SNAP law so states can test a variety of innovative methods and alternative application strategies that can remove more barriers and further streamline the eligibility and benefit determination process. These methods and strategies should be:

- implemented for between 12 and 18 months;
- followed by an evaluation period of no more than 12 months (during which, absent obvious adverse effects, the project would continue);
- supported by adequate funding to cover start-up costs; and
- made available immediately following a determination of success to all states as standard administrative options.

Incorporate the Combined Application Projects into SNAP law as a state option rather than a demonstration project, and provide the funds necessary for the Social Security Administration to participate in the projects by collecting and providing information to allow automated approval of the standardized SNAP benefit.

Provide a state option patterned on the Minnesota Family Investment Plan to allow states to provide a standardized SNAP benefit to TANF cash assistance recipients. Nationwide, cash assistance cases make up only 13 percent of all SNAP households; simplifying the benefit determination for these households would allow caseworkers to devote more time to the important tasks of supporting work activities and/or handling the more complex earned income cases that now make up nearly 30 percent of all SNAP cases.

Restore eligibility for legal non-citizens by reinstating the non-citizen policies in effect prior to the enactment of welfare reform in August 1996. While subsequent legislation restored federal eligibility to some legal non-citizens, the policy still remains complex and many productive legal immigrants still lack access to supplemental nutrition assistance.

Lift the three-month participation limit on Able-Bodied Adults without Dependents as part of an economic stimulus package. Many states have waivers of this requirement due to the increased unemployment associated with the recession. A blanket waiver for two years would relieve states of the necessity to request waivers and would assure benefits for these individuals.

Reducing Program Complexity

In FY 2006, SNAP administrative costs were \$4.8 billion (excluding the costs of employment and training and nutrition education), or 15.8 cents per benefit dollar issued. Administrative costs include eligibility determination, benefit distribution, information systems, fraud control, program management, staff training, and outreach. Certification costs, that is, the initial determination of eligibility, calculation of benefit amounts, and re-certification of households, accounted for \$2.8 billion of the total or 9.3 cents per benefit dollar issued. Program complexity keeps certification costs high and discourages eligible households from accessing the program.

In 2002, and again in 2008, Congress recognized this fact by making statutory changes that simplified the program, including allowing states to use other program rules when defining countable income; mandating standard utility deductions; and simplifying the complex reporting rules of the program. These changes were moves in the right direction, but a fundamental rethinking of the rules is necessary. Currently, the program attempts to target benefits based on the amount of income a household has available after subtracting certain deductions. These deductions have shifted over time with the vagaries of politics and periodic moves to cut the program's cost. They have now grown so complex that they constitute one of the program's greatest administrative burdens. This difficult process is also a major element of client frustration and misunderstanding, and adds substantially to the program's barriers to access and participation.

The reason deductions are so important to the program is the fact that the 1977 Food Stamp Act set a benefit reduction rate of 30 percent of a household's *net* monthly income. (The benefit reduction rate is the amount of income that a household is presumed to have available for food after all SNAP deductions from income are allowed. For example, if a household has \$300 of net income, it is expected to spend \$90 of this on food while SNAP provides the remainder up to the Thrifty Food Plan amount for the size of household.) This was a politically negotiated rate that represented congressional opinion of a reasonable "investment" on the part of recipient households. The 30 percent benefit reduction rate replaced the variable purchase requirement, which ranged from 4.2 percent to 28.9 percent of net income participants were spending to obtain their allotments. A 30 percent benefit reduction rate demands every effort to reduce gross income so households will actually have a combination of cash and benefits to purchase a nutritionally adequate diet.

Recommendation

Require USDA to study and recommend alternative, simplified methods of determining the allotment using gross income with no deductions, and then authorize several demonstrations to test the effectiveness of these methods. In the Information Age, it should be possible to create a formula or formulas that take into account certain household characteristics and variances in the cost of food that would adequately target benefits without the need to collect and verify numerous household expenses.

Supporting Nutritious Food Choices and Nutrition Education

Given the estimated annual medical cost of \$139 billion to treat diseases associated with obesity, every private and public health insurer should have an interest in supporting nutritious food choices. Since the federal and state governments cover approximately one-half of these costs through Medicare (approximately \$38.9 billion) and Medicaid (approximately \$30.6 billion), their interest in supporting innovative approaches to this subject is self-evident.

All the programs that deal directly with providing food or resources to purchase food have some nutrition component. WIC, child nutrition programs, and adult care food programs all have requirements directly related to the provision of nutritious food. SNAP has had an important nutrition education component that has grown over the years and is conducted in most states as a successful partnership between the state human service agency and university extension services. However, more could be done to reach the target population. In addition, many low-income households live in “food deserts,” where mainstream grocery stores are absent or distant. Between getting to a food store where the produce isn’t on the verge of spoiling (if it is even available), and having enough money to buy any food at all, many low-income shoppers have few food choice opportunities. Steps should be taken to support access to nutritious foods and improve support for nutrition education.

Nutrition education is part of the WIC program for eligible participants (pregnant women and children under 5). Pregnant women not receiving WIC get nutrition counseling as part of their pre-natal care. However, it is important to continue this counseling for children who do not receive WIC. Nutrition counseling should be made part of well-child care. It can be provided when children receive their regularly scheduled vaccinations, as well as part of their yearly health screenings. All people suffering from obesity-related illnesses should receive nutrition counseling as a part of their treatment.

Recommendations

- **Provide strong positive incentives for insurance companies, Medicare, and Medicaid to include nutrition counseling as a part of well-child care and for persons suffering from obesity-related illnesses.**
- **Align nutrition education requirements across all federal nutrition programs so that they provide a consistent nutrition message.**

Access to Wholesome, Nutritious Food

The problem of supplying fresh, wholesome food to low-income households is being addressed by some innovative projects across the nation:

- People’s Grocery in Oakland, California, is building an independent food system and a local economy grounded in community partnerships. This project also provides nutrition education, jobs, and support for urban gardens and for youth to become entrepreneurs and leaders.
- Angel Food Ministries, which now serves people in 30 states, sells boxes of groceries consisting of both fresh and frozen items for approximately 55 percent less than the same items would cost retail. Food sales and distribution are handled by churches or non-profit organizations. This effort was supported by a \$6.97 million loan from USDA Rural Development under the Faith-Based and Community Initiative.
- Burroughs Farmers Market in Fresno, California, located at Burroughs Elementary School, was organized for this low-income neighborhood by the Burroughs Neighborhood Resource Center and Dave Lewis Farms, and is the only farmer’s market in the area. The market accepts SNAP benefits via EBT. Farmers markets located in low-income urban and rural areas supported by community initiatives, SNAP, and the WIC and Senior Farmers Market Nutrition Programs support both local farmers and low-income households’ access to locally grown fruits and vegetables.
- Food co-operatives are worker- or customer-owned businesses that provide grocery items of quality and value to their members, and can take the shape of retail stores or buying clubs.

Food co-ops are committed to consumer education, product quality, and member control, and usually support their local communities by selling produce grown locally. They have been successfully located in both inner city urban areas and rural areas. USDA has sponsored food co-operatives through USDA Community Food Security Grants.

Action must be taken to help SNAP households connect with such low-cost, good-quality food sources. Ideally, USDA, along with non-profit providers and organizations, could develop farmers markets and help SNAP recipients develop their own co-operatives. This would provide not only access to wholesome foods but experience in developing and running a business. Since using them stretches the food dollar, increasing the number of these non-traditional food providers would also reduce the burden on food pantries.

One mechanism for funding this type of project is the USDA Community Food Projects Competitive Grant Program. Its grants are intended to help eligible private nonprofit entities that need a one-time infusion of federal assistance to establish and carry out multipurpose community food security projects. Projects are funded from \$10,000 to \$300,000 and from one to three years with one-time grants that require a dollar-for-dollar match in resources. About 18 percent of the submitted proposals have received awards during the history of this program (established in 1996). Funds have been authorized through 2012 at \$5 million per year.

Recommendations

- **Increase the annual funding for the USDA Community Food Projects Competitive Grant Program and require USDA to actively solicit projects that have a plan for involving SNAP recipients as both customers and project participants.**
- **Require USDA to establish and share a directory of addresses of farmers markets, cooperatives, and other non-traditional food providers in low-income urban and rural areas with human service organizations that administer the SNAP, WIC, and Medicaid programs so that they may provide the information to SNAP recipients.**
- **Develop or identify federal or private grants to provide EBT equipment to non-traditional food providers.**
- **Identify and correct FNS rules that discourage these types of providers from applying to be authorized to accept SNAP benefits.**

Providing Adequate Funding for Nutrition

The major nutrition programs account for food inflation in different ways; the SNAP inflation factor is determined based on the cost of the Thrifty Food Plan in June prior to the allotment adjustment in October. As a result, by the end of the year the allotment is 15 months out of date. In 2008, due to the rapid rise in food prices, the benefit allotment in June 2008 was \$46 below the cost of the Thrifty Food Plan for a family of four; by July 2008 it was \$56 below the cost of the Thrifty Food Plan for a family of four. Thus, when the benefit level for October 2008 was set based on inflation through June 2008, it was already \$10 below the cost of the plan in July. Until 1996, federal law set benefit levels for a given fiscal year at 103 percent of the cost of the Thrifty Food Plan in the previous June to compensate for the lag in data on food prices.

The issue for the WIC program is somewhat different. It delivers a set food package based on the characteristics of the eligible group (for example, pregnant women and post-partum women with young children). If there is food inflation during the year, the package remains the same but costs go up, and in such years there is a chance the program may run out of funds. When this prospect looms, states try not to develop waiting lists, but may delay interviews to stretch dollars. Congress provides a WIC contingency fund to address unforeseen economic changes.

Recommendations

- **Provide a temporary increase in benefits for nutrition programs as a major and immediately available element of an economic stimulus package.**
- **Amend SNAP law to adopt the pre-1996 formula that set benefits at 103 percent of the cost of the Thrifty Food Plan the previous June.**
- **Fully fund the WIC contingency fund.**

Strengthened Support for Administration and Systems Improvement

States that have been early adopters of successful technological advances (document management systems that allow electronic records, WiFi laptops, integrated online application systems, interactive voice response systems, and call centers) have either been fortunate enough to make these improvements when there was some flexibility in the state budget or did so by taking a risk that the technology would be implemented smoothly enough to offset the advance reductions in staff necessary to fund the technology. The latter strategy has proven too risky for most states to pursue, and flexibility in state budgets will not exist for the foreseeable future. Providing more support for technology improvements would reaffirm the federal commitment to human service programs, which for most programs has been reduced in recent years; federal agencies have instead focused more on micro-management and audits intended to reduce federal costs.

In addition, 43 states and the District of Columbia have had their SNAP administrative match reduced by almost \$197 million annually every fiscal year since FY 1999. The Agriculture Research Act of 1998 reduced SNAP match for most states because they (with federal encouragement) charged SNAP administrative costs to the former Aid to Families with Dependent Children program. This in turn resulted in a larger TANF base grant when TANF replaced AFDC in 1996. The 1998 law provision used the rationale that since states were already receiving extra funds through their TANF grants, they should undergo reductions in regular matching funds to bring their federal SNAP support back into balance. However, states were prohibited by TANF law from using TANF money for non-TANF purposes, resulting in an actual net reduction in administrative funds available for SNAP use. As a consequence, states collectively have now lost more than \$2 billion that could have otherwise been invested in staff, offices, automation upgrades, and other administrative needs.

Recommendations

- **Provide an increased, standard federal match for automation across all human service programs.**
- **As part of an economic stimulus package, increase the federal SNAP administrative match to 75 percent.**

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- **Restore the historic 50 percent SNAP administrative match rate when the temporary increase ends.**

Automated Systems

Improving the social and physical well-being of citizens should be the primary goal of all federal agencies that administer health and human services. Instead, it often seems that many of these agencies intend that state and local agencies must meet the participation and reporting requirements of their programs, which are often in conflict with each other. The end result becomes silos of automated systems that are disparate in design, have different data requirements, are duplicative in effort, and utilize Information Technology architectures that conflict, compete, and cannot communicate with other systems serving the same clients.

Recommendation:

Align Automated System Requirements across Programs through a Client-centered, Single Integrated View

A National Business Reference Model

There is a pressing need to develop a national technology-neutral (and vendor-neutral) health and human service Business Reference Model, or BRM, from which the public and private sector can align each state's health and human service agencies' data, technical, service, and performance reference models. Collaboration and coordination across all health and human service programs is essential to achieve effective and efficient service delivery. IT can be the enabler, but only when there are established acceptable national standards. IT now often becomes the driver of business strategy due to the absence of established acceptable national standards.

The Business Reference Model is a framework for describing the business operations of all federal health and human service programs independent of the individual federal agencies. The framework can provide a foundation for the reuse of applications, components, data, and business services needed to administer all related programs. Since this framework puts the client at the center of every transaction instead of the individual program requirement, under the best of circumstances it will allow clients to take a more directive role in the management of the services they receive.

The Service-Centric View

Other benefits to a national BRM would be to eliminate competitive advantages in the marketplace among private sector IT vendors, which now exist with the proprietary business reference models of individual programs. Also, it would allow public chief information officers the opportunity to present their business partners with a view of the health and human service organization that is service-centric rather than program-centric. Further, the federal agencies should also appreciate how funding streams may be optimized and combined to better serve the populations that are enrolled in multiple programs.

Successful implementation of a national BRM will require the federal health and human service agencies to re-examine how they do business. These agencies will need to agree, obviously, on a standard data format; the need to review and modify, wherever possible, eligibility requirements; and performance and reporting requirements. Finally there will be the need to restructure how IT funding is allocated among programs. APHSA proposes taking a lead role in facilitating the dialogue on what changes are needed.

Standard APD Process

To this final point, it is also of utmost importance that the federal agencies standardize requirements for the submission of Advance Planning Documents (APDs) for the development and acquisition of systems and hardware. States should be able to submit a single APD covering all programs that are part of a project, and all federal agencies involved should coordinate their responses and questions through a single lead agency and issue a single approval within a reasonable timeframe. This lead agency should also have the authority to certify that if a state has followed its purchasing practices and procedures, then no APD is necessary. Finally, if a state is using an approved cost-allocation method, then all changes and purchases below a reasonable threshold should be exempt from the APD process.

The goal of the development of a national Business Reference Model is to have the clients' needs drive administration of the programs that serve them instead of the specific—well-intended but often inconsistent—requirements of individual programs. Improving the human condition of the families and individuals served has to be the priority, and can be achieved by allowing IT to be an enabler through an enterprise approach.

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The American Public Human Services Association, founded in 1930, is a nonprofit, bipartisan organization of state and local human service agencies and individuals who work in or are interested in public human service programs. Our mission is to develop and promote policies and practices that improve the health and well-being of families, children, and adults. We educate Congress, the media, and the general public on social policies and practices and help state and local public human service agencies achieve their desired outcomes in Temporary Assistance for Needy Families, child care, child support, Medicaid, Supplemental Nutrition Assistance Program, child welfare, and other program areas and issues that affect families, the elderly, and people who are economically disadvantaged.