For Those We Serve

A Challenge for the Next President

And a Commitment from the Nation's Health And Human Services Leaders

Published by

The American Public Human Services Association; all rights reserved.
810 First St. NE, Suite 500 • Washington, DC 20002 • (202) 682-0100

APHSA
American Public Human Services Association

Washington, DC • September 15, 2008

Introduction

This paper represents the view of the nation's public health and human service leaders. We are Republicans and Democrats, liberals, and conservatives. We are from big states and small states, serving urban and rural populations. We administer health and human service programs including, but not limited to:

- Medicaid and the State Children's Health Insurance Program (SCHIP)
- Child Protective Services
- Other children's services such as Adoption Assistance and Foster Care
- Adult Protective Services
- Child Support Enforcement
- Subsidized Child Care
- Temporary Assistance for Needy Families (TANF)
- Food Stamps, now called the Supplemental Nutrition Assistance Program
- Low-Income Home Energy Assistance

Our states, including our local agency partners, spend over $25 billion per year to pay their financial share of the programs that we administer. The combined budgets of the programs that we administer equal one-third to one-half of all state and local expenditures. One in five Americans is touched by the services that we offer, and we are among the largest employers in our states. Our employees are committed to their work and to our ideals: they are active in contributing to their communities, they vote, and they care about what candidates say regarding their work. Together, our agencies and our staff make a tremendous and positive impact on the individuals and families we serve and on our nation.

For the past quarter-century, state innovations in program and service delivery have demonstrated how to reform and revitalize the work that we are charged to do. For example, the WIN Demonstration programs of the late 1970s and 1980s showed policymakers that state and local health and human service agencies could put welfare recipients to work, and in 1986 the leaders of these agencies presented the blueprint for comprehensive welfare reform to the United States Congress. That blueprint led to the most significant reduction in welfare rolls since the passage of the Social Security Act. Through federal Medicaid waivers, the states' expansion of eligibility to new groups, including children, led to the creation of the SCHIP program.

And the work of innovation continues today. In New York State for example, welfare rolls declined from 1.6 million to 500,000. Not content to simply see the rolls decline, the state agency has also embarked on a multi-faceted program to enhance the economic security of all low-income families, including the integrated efforts of 20 state agencies that form the Governor's Economic Security Cabinet. In California, similar declines in welfare rolls also occurred (declines from 1 million down to 489,000). Additionally, families began combining work and welfare at unprecedented levels (from 8 percent pre-TANF to almost 50 percent today).

The leadership and success of state health and human service agencies can also be seen in the child welfare arena where, for instance, Michigan has established several initiatives that avoid the abrupt termination of support that traditionally occurred when youth "age out" of foster care. Aging Out scholarships, as much as $5,000 a year, are offered at two major public universities and help foster youth complete higher education by covering tuition, supplies, and housing. Michigan also has a subsidized guardianship program for older foster youths for whom adoption is not a viable goal in achieving permanency. Similarly, California has taken steps to support "aging out" foster youth by recently creating an abbreviated Food Stamp Program eligibility and application process that can occur in advance of the foster youths' emancipation date. This mirrors a process put in place previously to ensure foster youth have access to adequate medical care once they leave foster care. In addition, the state recently launched the first-in-the-nation effort to enroll disabled foster kids in federal disability benefits (SSI) prior to their emancipation from foster care. Combined, these efforts illustrate effective state strategies targeted to ensuring more successful transition into adulthood by a very vulnerable population.

A child welfare initiative in Arkansas also illustrates how states join with a variety of community partners to strengthen and expand their efforts. Children of Arkansas Loved for a Lifetime is a joint effort of the state with churches to recruit, train, and support foster and adoptive families; in less than a year, the project has recruited 140 foster/adoptive homes in one county alone.

In the area of health care, many states have initiatives to proactively transform personal care and long-term care services. Oklahoma has enacted legislation to promote the purchase of long-term care insurance policies in a way that both controls costs and encourages individual responsibility and planning. The effort brings together a wide range of public and private partners, and is expected to save nearly $100 million per year in state and federal funds. New Jersey has made significant advances in personal care services through the "Cash and Counseling" model. The state's initiative provides elders and people with disabilities the same funds directly that the state would have paid to a provider, and to choose their own plans and services. This allows them dignity, choice, and control in the receipt of personal care and related in-home care services, while at the same time containing costs.

States are serving increasing proportions of elderly and disabled with chronic conditions who are "dually eligible" for both Medicare and Medicaid. Care for dual eligibles is costly, fragmented, and confusing to beneficiaries, and the fiscal incentives between Medicare and Medicaid often result in poor clinical care. Care became even more fragmented for duals when Medicare Part D took over some (but not all) drug coverage in 2006, while Medicaid continues to cover the remainder. Minnesota has responded to this challenge with an infrastructure that can manage care across Medicare and Medicaid primary, acute, and long-term care services. These programs have increased access, simplified procedures, and integrated all Medicaid and Medicare Part D drug coverage under one health plan. As a result, consumer satisfaction has been high, disenrollments low, and costs controlled.

While we are proud of our accomplishments and certain of our commitment to continue to do better, we are also aware of the enormous challenges that face our nation with regard to the most vulnerable of our citizens. These are challenges that face you as you seek to lead us as President of the United States. From our informed and bipartisan vantage point, we offer this paper for your consideration and action.

Background

The public health and human services system we administer is often called the "social safety net" and the system "of last resort." The implication of these phrases is clear: by the time an individual or family reaches the doors of one of our agencies, they have nowhere else to turn. Regardless of the reasons citizens may seek our services, whether because of human error or societal failures or a million other unique stories, it is the responsibility of our public agencies to serve them. In those stories, which are the case records of our organizations, we can read what might have been, could have been, and should have been. In more sophisticated language, we read about a lapse in sound judgment or decision-making or absence of primary prevention and early intervention and the consequences of those lost opportunities. As public agencies, we must undertake our work within the resources the public has deemed appropriate to provide.

It is also in these case records that we can see the basic interconnectedness that we share as members of the same family, community, nation, and world. We read about the impact of a father's decision to use drugs on the children who adore him – or the effect of an unsafe neighborhood on a family simply trying to survive – or the consequence of the diminishing purchasing power of the dollar for a single parent working full-time and still unable to meet basic family needs or access affordable, quality child care. We have many stories of the aged and disabled in need of long-term care, and of children who need preventive medical care. The stories and the circumstances are endless, but they serve to remind us about the futility of seeking to isolate and simplify when the reality is inclusive and complex.

Poverty is an ever-increasing and grinding presence in the stories of the people we serve. Sometimes it is temporary, but for too many families poverty is a multi-generational condition. Poverty is not only about the money people do not have but, as our case records demonstrate, it is about where people live, how people learn, how healthy they are and what they believe is possible for themselves and their children. Poverty helps to sustain deficits that stand as a barrier to many opportunities for individuals and families, and also as a barrier to this nation's ability to compete effectively in a global economy.

Woven throughout the stories of those we serve are the accounts of many different public system attempts to serve them. Sometimes those attempts are timely, relevant, and successful. Sometimes they are not. The reasons for success or failure are multiple, but certain themes emerge as we study these efforts. Notably, they are rarely integrated toward an agreed-upon outcome. They are often more closely related to the requirements of the funding source than they are to the needs of the family and/or individual. The need for the service never guarantees its sustainability. The success or failure of the attempt is often evaluated against process requirements rather than positive outcomes achieved in the lives of the people we serve.

As this paper is being written, the stories of the people whom we serve are growing and becoming more diverse because

of the current economic downturn. Hard-working people who never thought they would be homeless face foreclosure, and people who counted on the reasonable cost of food are now counting on food stamps. The elderly and disabled are facing the need for long-term care but are unable to afford it. And there is no silver lining in the cloud that hangs over public human service financing. The costs of the Medicaid program already consume a large part of each state's budget. At current projections and without appropriate interventions, federal and state budgets may not be able to sustain the long-term costs of the program.

There is no escape from the reality of growing need and limited resources. There is no escape from the truth that primary prevention and early intervention are always better and less expensive than remediation and the provision of acute core services. There is no way to pretend that what happens to the least of us does not happen, ultimately, to all of us. There is no substitute for the power of personal responsibility and accountability. There is no way to adequately explain why, out of the 25 developed nations of the world, the United States of America has a poverty rate greater than 24 other nations. There is no question that public organizations will do their best to respond to people in need and there is no question that, in many cases, yet more may be required.

Now is the time for a conversation about what we want for ourselves, our children and our society – about the policy directions to which we must commit – about how to use public dollars as strategic investments. We can no longer afford to ignore the facts that surround the lives of many of our citizens nor can we offer sentimental bromides about the inherent decency of the American people. As together we define the future that we want, we need leadership to direct us through the difficult choices that lay ahead.

In the pages that follow, we have attempted to discuss some of the issues that we urge you to consider as you define your health and human services policy platform. They are issues that emerge from the stories of our clients, and we are certain that you have heard echoes of them on the campaign trail. As we share their stories we also believe that we have an obligation to help them write a successful ending. The challenge of leadership has always been to clear the path so that those who follow can reach their goal.

Poverty

In 1986, we wrote "Poverty is not an acceptable condition for America's children and their families. Neither is a lifetime of dependence." We stand by that statement and would only add that poverty is not an acceptable condition for any American citizen. We also note that an increasing number of families experience acute crises and cannot find adequate assistance to see them through what ought be a brief period of need. We add our voices to those of individuals and groups, politicians, and citizen activists who are calling for a strategic and sustained attack on both poverty and short-term, but significant, needs.

For the past 12 years we have been providing time-limited support to needy families. A program that used to have income maintenance as a goal is now focused on work. The assumption of personal responsibility for self and family is a core value. The reforms conceptualized by states over a decade ago have produced historic reductions in welfare caseloads, and we have learned many lessons along the way, including:

- The "poor" are not a homogeneous group – there are distinct temporal, racial, cultural, and gender characteristics of poverty that must be understood.
- Working, full-time and year-round, does not mean a family is not poor – although working is an essential component of the personal responsibility that society expects from adults who are able.
- There are many proximate causes of poverty – divorce, no family formation, unemployment, underemployment, accident, illness, discrimination – which means any one-dimensional approach to poverty is doomed to failure.
- People who are chronically poor live in communities with fewer resources, attend struggling inferior schools, generally pay more for the same goods and services as their middle-class counterparts, are more likely to be homeless, involved in domestic violence, and are simply outside the economic mainstream (for example, never having a bank account).
- The economics of self-sufficiency are far less well understood than the economics of poverty.
- There is a group who will never be able to sustain themselves or their families without public support, and that support must be sufficient so that children may grow and thrive and adults live with a measure of dignity consistent with their citizenship.
- There are many individuals and families who encounter specific, time-limited needs, and if helped quickly and adequately, can avoid becoming trapped in long-term dependence.
- Well-targeted preventive investments in individuals and families yield significant, long-term benefits in health, stability, and earning power.

We are also concerned that we really do not have a good way to ascertain the economic well-being of American families. The federal government assigns an absolute poverty measure comparing incomes to a standard set years ago. Critics on both sides of the political spectrum have noted the inadequacies of this methodology, and we find it simply arbitrary and outdated. In our 1986 document, *One Child in Four,* we called on the President to charge the National Academy of Sciences with researching a new formula, the Family Living Standard, that would examine the real costs, by state and family size, associated with a basic standard of living. We also urged a better calculation of the effect of tax policy, the near-cash benefits of programs such as food stamps, and the impact of work expenses on family budgets. We believe that the pursuit of such an idea is long overdue and would help to clarify a great many questions about the financial realities faced by American families.

What we know, and what establishing good financial benchmarks will help to make clear, is that many people who work full-time, year-round, remain in poverty or in a very precarious financial situation. The declining purchasing power of the dollar, the lack of sufficient jobs that pay a sustaining wage, the absence of a comprehensive workforce development strategy for those who are underemployed, all conspire to create a permanent group of working poor who cannot, through their own efforts, change the nature of their situation.

We must find a way to support those who are doing all they can to support themselves. Public support for these families and individuals is often cut off with the first dollar earned over some arbitrary limit. This kind of approach only guarantees the status quo. We must also understand and articulate the role that asset accumulation plays in moving people from poverty or financial insecurity to self-sufficiency.

Finally, we must speak to the poverty of mind and spirit that often attends economic poverty but is far more corrosive. This is the kind of poverty that surrounds young people who, because of their life circumstances, see nothing in their future that isn't simply an extension of their past. Their hopelessness contributes to at-risk behaviors such as getting pregnant and joining gangs. There is a poverty of expectations that, for example, causes parents not to demand more from the schools that educate their children. There are poor communities in which the sights and smells proclaim the absence of any hope for something better. This is not the poverty that can be understood using an economic calculus, but it must be comprehended and addressed in any successful attack on poverty.

"Americans take pride in their humanitarian ethos, economic vitality, and technological achievements. America takes pride in its affluence and power. But its strength as a country is based on something more than military capacity and the value of the dollar. It is based on the commonly shared belief in the worth of the individual. To tolerate hunger and deprivation, to permit large numbers of citizens to grow up un-educated, ill-housed, and malnourished not only limits future productivity but undermines the integrity of our strength as a nation." *(One Child in Four)*

Supporting Individuals, Families And Communities

We can all agree that citizens, families and communities in need must be supported. We will also agree that government has a role to play in that support. Beyond these basic agreements, however, there is neither commonality of purpose that helps us decide what kind of support should be provided nor any sense of who should be responsible for its provision.

In human services we are charged with remediation and are constantly trying to shore up deficits. We find our caseloads grow as other systems tighten eligibility requirements or redefine their service population. We see the evidence in our case records of well-intended actions being totally misdirected. We see evidence of public agencies working at cross-purposes, all in the purported interests of their clients. We see evidence of money wasted, efforts thwarted, and, most importantly, a lack of positive progress in the lives of those we serve.

Health and human service administrators want to place their work in an appropriate context and to evaluate it against appropriate outcomes. Therefore:

- We ask that you engage us and others in the task of building a new vision for individual and family well-being that comports with our nation's norms and sense of human dignity.
- We believe that this vision must encompass both individual accountability and responsibility and the obligation of society to care for those in need of support.
- Further, we ask that you sustain the work necessary to translate the vision into concrete, achievable outcomes and the metrics to measure our progress and the effectiveness of our investments.

While we want to engage the process of creating such a vision, we also have suggestions about some of its components. For example, we believe work for a meaningful wage is central to the well-being of adult individuals and families. With the

minimum wage now equal to only 30 percent of the average wage, it is clear that working full-time at a minimum wage job is not enough to sustain a reasonable personal or family life. We also know that a debilitating illness or injury can throw individuals into poverty and prevent access to needed health care.

We believe that we must fully explore the meaning of family that includes the realization of the growth of single-parent families and their needs, such as for reliable receipt of child support payments, and the absence of a concern for men in our policy focus. We must talk about the strength of two-parent families and the supports necessary to stimulate their creation without prejudice toward the remarkable work of the many single parents raising happy and healthy children.

We must also explore how to support development efforts aimed at the poorest of America's communities. Just as we have learned that children cannot be understood out of the context of their families, so too families need to be understood in the context of their communities. Both the physical and social infrastructure of communities support or undermine the successful functions of family life. While we are not community development specialists, we know the consequence of ignoring the impact of life beyond the four walls of a family dwelling.

We must ensure that our vision of well-being is one that promotes the capacity of individuals and families to achieve their own dreams – dreams that include the opportunity to gather assets, to live in a safe place, to attend a decent school, and earn a living wage. Our national vision must offer opportunity rather than prescription.

Our national vision must provide a way for public and private sectors, faith communities, and civic communities to connect around shared values and common purpose. It should allow us to make strategic decisions about how to use our resources and lay the groundwork for collaborative efforts across public systems rather than a competition for resources that diminishes all of our efforts.

Child Well-Being

Children are our future. One-fifth of all children are poor, and if they are black, Hispanic, or Native American, the numbers are closer to one in four. Children are the poorest age group and poor children

- Are not as healthy as non-poor children
- Often come to school less ready to learn
- Fail to graduate in much higher numbers that their non-poor counterparts
- Have children before they are ready
- Have more contact with law enforcement
- Have a higher rate of homelessness than their non-poor counterparts
- Often lack preventive health and dental care

Children are our future, and increasingly the cost of quality child care is out of reach for middle-class working families, not just the poor. This fact, coupled with the research on growth and development from 0 to 3 years of age, means that unless there is a meaningful change, significant developmental opportunities may be lost forever for the majority of children needing out-of-home child care. Children without the benefit of well-child care and immunizations may also face significant developmental delays, causing problems with their ability to learn.

Children are the parents of tomorrow, and approximately 900,000 are annually substantiated as having been abused or neglected by the parents of today.

Children in need of protection come into the care of a public child welfare system that is overburdened, understaffed, and funded in such a way that it cannot adequately support family reunification, the most desired of all outcomes for kids in public care. And that public care (and frequently their Medicaid coverage), unlike the continuity of family, often abruptly ends at age 18 with limited preparation for the transition.

We can continue to express our rhetorical commitment to our children; however, by internationally accepted standards of child well-being, the United States ranks almost last among the developed nations of the world in meeting those standards. In some areas our statistics are those of third-world countries.

Something is very wrong when our cherished belief about the importance of our children is so far from what many of them experience. The next President must help us as a nation look at the facts about our children and determine how to make our idealism a reality, as suggested by the following statements:

- Supporting the well-being of children, youth, and their families is a shared community and government responsibility
- Children are entitled to live in a safe and permanent home and need families to succeed

- Working parents should be able to count on affordable child care that contributes positively to early learning and development
- Public policy must support and not supplant the work of families.

Health Care

It seems that health care reform has been on the national agenda for as long as we can remember. As citizens, every aspect of that conversation is vitally important to us. We have, however, a unique perspective on the topic, given that many of us administer the Medicaid program within our agencies or, in some cases, run stand-alone State Children's Health Insurance Programs. But regardless of where the programs are organizationally placed, Medicaid and SCHIP are critical to each state's health care infrastructure. It is from the vantage point of managing these programs that we enter the health care debate.

There can be no question that the underlying costs of health care must be thoroughly examined and made clear to the American people if reform is seriously contemplated. There must be no mysterious curtain behind which a health care wizard works the magic. As state health and human service leaders, we are also very aware that health care coverage will require equal scrutiny and collaborative effort.

The Medicaid program, which now is the largest health care insurer by population, offers a well-honed and cost-effective vehicle that can be used as part of a national health care reform strategy. Medicaid and/or SCHIP can provide part of the answer to the problem of 47 million uninsured Americans. Any health care reform agenda must include an answer to the question of the uninsured.

In addition to providing preventive and acute health care services to clients, Medicaid is also the program that meets the long-term care needs of thousands of senior citizens and those who are disabled or chronically ill. For this population, Medicaid is the critical safety net and one of the few sources of payment for long-term care. In fact, it is the cost for this population that drives the health care budgets of federal and state governments alike. Experts say that 75 percent of the Medicaid expenditures are made on behalf of 25 percent of the population. Part of the health care reform debate must be the question of long-term care and the need to rebalance financing so that community-based care rather than institutionalization can be the norm, not the exception. Given both the aging of American society and the amazing advances in medicine, long-term care solutions for seniors and the chronically ill and disabled must be a top priority on the action list of health care reformers.

The Medicaid program highlights the need for frequent assessments of federal/state responsibilities with regard to the health care environment. Perhaps one of the most frustrating examples of a federal failure is the inability of federal programs to work together with the states. For those citizens who are eligible for both Medicaid and Medicare, there is no coherent service delivery strategy at the federal level. Acute medical care is provided by Medicare while long-term care is provided under Medicaid, with virtually no communication between the two programs. State Medicaid agencies see the impact and expense of this failure to communicate on a daily basis. Therefore, any comprehensive health care reform effort must include the integration of philosophy, program, and services at the federal level before the reform is rolled out to the states.

In the wider health care reform debate, as within the Medicaid program, focus must be steady on cost and quality. Such an effort must include activity at the level of the individual patient as well as system-wide pay-for-performance. The Medicaid program experience is quite instructive to those who will be crafting a larger health reform effort.

The need for federal leadership, funding, and financing of a technological infrastructure for health care cannot be overstated. The same need exists for developing staff at both federal and state levels so that the technology can be utilized to its fullest capacity.

In the final analysis, the comprehensive debate on health care reform should, we believe, include the following ideals and the ways to make them a reality:

- We are first our own caretakers: responsible in our choices, informed about our options, and proactive in our care
- We count on health care providers and administrators who are: patient-centered, competency-based, and performance-focused
- We expect our health care facilities, technologies, and delivery systems to be: the highest quality, safe and secure, and cost-effective
- We have a primary concern that health care is accessible, affordable, and available, especially to those who are most vulnerable or in greatest need

Federal/State Relationships

This document is primarily and appropriately focused on the people we serve, but we must also raise for your consideration the primary relationship through which that service is delivered. The federal/state partnership in human services is no longer satisfactory to either partner, nor is it producing results that best serve those for whom it was designed.

While we understand the natural tension that exists in an intergovernmental funding and delivery system, practice and circumstances have conspired to make adversaries of public servants who should be united by common cause.

Money, or the lack of it, is certainly one of the most divisive forces. Federal dollars for human services are shrinking and state budgets cannot absorb new or unreimbursed costs that may be passed along from the federal government. In an effort to save money or recoup costs, the federal government is employing various audit and micro-management techniques that are counter-productive and that state agencies are vigorously determined to fight off.

Another set of problems is associated with the states' insistence on the need for flexibility in program design and the use of federal dollars, with the counter-insistence from the federal government on accountability. There would seem to be no inherent incompatibility between the notions of flexibility and accountability, but they have come to represent the two poles of a very sterile argument.

We have evidence in the recent past of a successful collaborative effort to meet an agreed-upon goal. Enactment of the Temporary Assistance for Needy Families program in 1996 gave states unprecedented flexibility to meet an agreed-upon goal of reducing welfare dependency and putting people to work. The collaboration worked in an historic way, and states demonstrated the effectiveness of being able to tailor programs and services to the real needs of families rather than to the program requirements of a "one size fits all" system. Despite the success of this effort, the continuing state request for flexibility in the use of money and program design is met with counter-offers that signal the eventual reduction of federal financial support.

What made this aspect of the welfare reform collaboration so very special was the ability to package the services almost entirely around the needs of the customer. Another example is the passage of the SCHIP program and certain provisions of the Deficit Reduction Act, which provided states with significant flexibility in structuring their Medicaid and SCHIP programs. States can now build health care programs designed to meet the specific needs of their citizens.

But other than these relatively few examples, being able to put the individual or family at the center of the service system is virtually impossible and therefore, money is always wasted, service interventions are always sub-optimal, evaluation is distorted, and client outcomes are not achieved.

We believe that a clearly articulated national vision about what we want for American citizens and families could, at the very least, move the current stalemate off dead center. Perhaps program dollars could be tied to the outcomes described in such a vision. It may be that the conversation about levels of flexibility could occur on a program-by-program basis with states able to opt in or out. We also believe that when the federal and state levels work together, as we have seen them do, dynamic partnerships can result that move all of us forward in building new and more effective assistance and service models.

We must have a conversation about equity and fairness. Can we, for example, operate 50 different systems directed toward common outcomes, and then examine the consequences in real rather than hypothetical terms to determine if fairness can be preserved without requiring sameness? The experience with welfare reform would suggest that the answer is yes.

The single most important fact that compels a rethinking of the federal/state relationship in human services is the leadership states have demonstrated over the past 20 years as they have revised practices and redesigned targeted services to more efficiently and effectively use money. In the case of the TANF program, the states also provided the policy leadership to Congress as they debated reform of the welfare system. Not so many years ago, a new administration proclaimed that it was time for a "new Federalism"; perhaps that time has come again.

Conclusion

We appreciate this opportunity to share our thoughts with you. This paper does not make any programmatic recommendations or offer solutions. Those documents will come from us and others in the weeks and months ahead. This paper is about the leadership we need to find common purpose. It is about the need for candor about the America that is and discipline to reach the America that we want. It is about creating the vision that will sustain us as choices get harder, so that no matter how small the step, it is in the right direction. It is a paper about the challenges the President of the United States can demand that we meet, and that we, in the state health and human service agencies, are eager to accept.