IDPH Legislative Update – January 30, 2017

This week’s newsletter showcases snapshots from the first three weeks of session.

In this issue:
- IDPH Legislative Budget Package Overview – FY 2018
- HSB 25 – Public Health Omnibus Bill
- IDPH and Iowa Workforce Development’s Plumbing/Contractors Bill Draft
- Subcommittees Attended
- Public Health Bills of Interest

IDPH Legislative Budget Package FY 2018 – Overview

General Funds

The department requested status quo funding for FY 2018 and FY 2019. In other words, IDPH requested the same amount of funding we received from the General Fund for FY 2017 for the next two fiscal years. However, due to the recent estimates of how much the state will receive in revenues in FY 2017, the Governor had to propose a 4.25 percent reduction to the IDPH budget for FY 2017, and for FY 2018 and FY 2019. This means that the department’s budget would be reduced by 4.25 percent in the current fiscal year and the reduction would carry forward into the next two fiscal years.

The Legislature would have had to pass the Governor’s FY 2017 recommendation to have it go into effect. However, they came up with their own set of reduction ideas. SF 130 is the result of the negotiations that took place to reconcile the Legislature’s plans with the Governor’s for FY 2017. It has passed the Senate chamber by a vote of 28-19 and will be taken up by the House next week. The bill reduces the IDPH budget by $2.0 million in FY 2017. However, the bill also makes a general reduction of $11.5 million for all of the state executive branch agencies that will be divvied up by the Governor’s budget staff at the Department of Management.

Therefore, at the time of this writing, it is still unclear what the final reduction will be to IDPH for FY 2017. We know it will be at least $2.0 million, though.

Technology Reinvestment Fund

IDPH has requested and the Governor has recommended two separate appropriations from the Technology Reinvestment Fund. The first is approximately $1.0 million for FY 2018 to replace badly needed equipment for the Office of the State Medical Examiner.

The second request is for $250,000 for FY 2018 and an additional $250,000 for FY 2019. With the assistance of this appropriation, IDPH intends to engage an external entity familiar with government operations and moreover, the functions of public health, to determine the optimal number of software systems required to support the functions of IDPH most efficiently. Currently, the department has approximately 80 systems.

Please see the summary memos at the end of this publication for more information.
**IDPH 2017 Session Omnibus Bill – HSB 25**
The bill was introduced in the House as HSB 25 on January 23. The subcommittee members assigned to the bill are Representatives Greg Forristall, Michael Bergan, and Bruce Hunter. As of this writing, a meeting of the subcommittee has not been scheduled.

The bill text can be found [here](#).

A summary of the legislation can be found at the end of this publication.

**IDPH and Iowa Workforce Development’s Plumbing/Contractors Bill Draft**
This bill aligns the IDPH and Iowa Workforce Development’s (IWD) licensure and registration processes for plumbers and contractors.

IDPH and IWD have worked together to create a unified licensure and registration system to provide a single point of entry for this target population of consumers. However, since the two departments have different timeframes for their respective regulatory functions (three years versus 12 months) the proposed language is needed to prorate the charges to the applicants.

As of this writing, the legislation has not been introduced in either chamber.

For additional information on this legislation, please see the summary memo at the end of this publication.

**Subcommittees Attended**

**SF 2: State Family Planning Services Program:** A subcommittee of Senators Amy Sinclair, Janet Petersen, and Jason Schultz was assigned to the bill. The bill passed out of subcommittee on January 24 and may now be discussed by the full Senate Judiciary Committee.

**SF 76: SNAP Restrictions on Soda:** A subcommittee of Senators Tom Shipley, Herman Quirmbach, and Mark Segebart was assigned to the bill on January 18. The subcommittee members met on January 25 and will continue to consider the information provided at the meeting. As of this writing, the bill has not yet been discussed by the full Senate Human Resources Committee.

**HF 7: Personal Immunization Exemptions.** A subcommittee of Representatives Steven Holt, Sandy Salmon, and Beth Wessel-Kroeschell met on January 26. The bill passed out of the subcommittee and may not be considered by the full House Human Resources Committee. IDPH provided the legislators with information to consider that can be found at the end of this publication.

**HF 32: IDPH In Patient and Out Patient Data.** A subcommittee of Representatives Rob Bacon, Greg Forristall, and Beth Wessel-Kroeschell met on January 25 and will continue to consider the information provided at the meeting.

**Other Public Health Bills of Interest:**

**SF 5: Tobacco Age to 21.** An Act raising the legal age relating to tobacco, tobacco products, alternative nicotine products, vapor products and cigarettes, and including effective date and applicability
provisions. (Referred to State Government Committee. Subcommittee: Senators Randy Feenstra, Jake Chapman, and Janet Petersen.)

**SF 7**: Radon Testing in Schools. An Act requiring radon testing in public schools and including applicability provisions. (Referred to Education Committee. Subcommittee: Senators Jerry Behn, Mark Chelgren, and Jeff Danielson.)

**SF 43**: Gambling License Moratorium. An Act imposing a moratorium on the issuance of licenses for gambling games and including effective date and retroactive applicability provisions. (Referred to Judiciary Committee. Subcommittee: Senators Charles Schneider, Tony Bisignano, and Jeff Edler.)

**SF 48**: Multiple Sclerosis Fund. An Act establishing a multiple sclerosis support fund and authorizing lottery games to benefit persons with multiple sclerosis. (Referred to State Government Committee. Subcommittee: Senators Randy Feenstra, Pam Jochum, and Brad Zaun.)

**SF 51**: cCMV Public Awareness Campaign. An Act relating to a cytomegalovirus public health initiative and the testing of newborns for congenital cytomegalovirus. (Referred to Human Resources Committee. Subcommittee: Senators Jake Chapman, Pam Jochum, and Craig Johnson.) A subcommittee meeting have been scheduled for 11:00 on January 31 in room 206.

**SF 62**: Legalization of Fireworks. An Act relating to the possession, sale, transfer, purchase, and use of fireworks, and the disposition of fireworks sales tax receipts, providing penalties, and including effective date provisions. (Referred to State Government Committee. Subcommittee: Senators Jake Chapman, Tony Bisignano, and Jason Schultz.)

**SF 67**: Pharmacist Prescribing for Oral Contraceptives. An Act relating to the prescribing and dispensing of self-administered oral hormonal contraceptives including by pharmacists and providing insurance coverage for such contraceptives prescribed and dispensed. (Referred to Human Resources Committee. Subcommittee: Senators Thomas Greene, Julian Garrett, and Liz Mathis.)

**SF 68**: cCMV Education w/Appropriation. An Act relating to cytomegalovirus public health initiative, and providing an appropriation. (Referred to Human Resources Committee. Subcommittee: Senators Jake Chapman, Pam Jochum, and Tom Shipley.)

**SF 77**: Mammography Reports. An Act establishing a notification requirement for mammogram reports to patients. (Referred to Human Resources Committee. Subcommittee: Senators Mark Segebart, Mark Costello, and Pam Jochum.)

**SF 107**: Smoke Free Air Act Signs. An Act relating to the elimination of the requirement for the posting of signs and symbols under the Smoke Free Air Act. (Referred to State Government Committee. Subcommittee: Senators Randy Feenstra, Janet Petersen, and Roby Smith.)
**HF 31: Newborn Screening Program Bloodspot Storage.** An Act relating to the storing of residual newborn screening specimens, and including effective date provisions. (Referred to Human Resources Committee. Subcommittee: Representatives Rob Taylor, Michael Bergan, and Mary Mascher.)

**HF 33: Body Piercings for Minors Restrictions.** An Act relating to body piercing for minors and making penalties applicable. (Referred to Judiciary Committee. Subcommittee: Representatives Ashley Hinson, Liz Bennett, and Megan Jones.) A subcommittee meeting has been scheduled for 9:00 on January 31 in the House lounge.

**Texting and Driving and/or Distracted Driving Bills Filed:**
- SF 21
- SF 100
- HF 60

**Other Information**
- To sign up for the IDPH Legislative Update, please visit [IDPH’s Legislative Communications and Engagement](#) website.

For more information, please contact Deborah Thompson, Policy Advisor and Legislative Liaison for IDPH, at 515-240-0530 or Deborah.Thompson@IDPH.iowa.gov.
Problem Statement: Essential equipment for the operation of the State Medical Examiner needs to be replaced due to age of equipment (>10 years) and the inability to repair or obtain parts for obsolete equipment. The equipment to be replaced is utilized on a daily basis to perform medical examiner autopsies and perform medicolegal death investigations.

Technology Reinvestment Fund Request: $1,037,000 for FY 2018

Background: By law, a medical examiner must investigate any death that is not natural, is unexpected, or occurs outside of a healthcare or hospice setting.

Each county appoints a physician who acts as county medical examiner. Many of these physicians are family physicians who are familiar with natural deaths, but often need consultation and guidance with non-natural deaths. The Iowa Office of the State Medical Examiner (IOSME) has the responsibility of oversite and guidance for the 99 county medical examiner offices in the state of Iowa.

Counties with smaller populations typically have fewer county ME resources and depend on the State Medical Examiner’s office regularly for assistance in performing autopsies. A few larger counties (Polk and Johnson) have fulltime forensic pathologists and can function independently. There are times, however, that require the State ME to assist even the large counties when their ME staff are unavailable, need consultation on difficult cases, or the county is experiencing a surge in the number of cases to be autopsied. In 2015 the IOSME performed 751 autopsies. The IOSME performed 859 autopsies in 2016.

Medical examiner services are essential to law enforcement investigations, criminal and civil adjudications, public health investigations, and proper death certification for insurance investigations and vital statistics.

IOSME Equipment Replacement Request Budget (continues on 2nd page)

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Cost</th>
<th>Essential Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray Equipment</td>
<td>$550,000</td>
<td>Without x-ray equipment, the Office could not function. Used daily, for identifying bone fractures and bullets, medical diagnoses, and identification of decomposed and burned human remains. Current equipment has surpassed its usable lifespan and is at high risk of catastrophic failure.</td>
</tr>
<tr>
<td>Autopsy Tables</td>
<td>$56,000</td>
<td>Used daily to transport the body in the building, store the body in the cooler, hold the body during x-rays, and hold the body during autopsy. Ten years of high volume use caused the wheel and hydraulic lift mechanisms to wear and fail. Many of the table tops are cracked, allowing water and body fluids to leak onto the floor of the autopsy room.</td>
</tr>
<tr>
<td>Microscopes</td>
<td>$88,000</td>
<td>Used by pathologists to look at cells in tissue samples for making medical diagnoses and determining cause and manner of death. The vendor has notified OSME that the microscopes are obsolete and need to be replaced. Manufacturers are no longer making parts.</td>
</tr>
<tr>
<td>-70 Degree Freezers and Refrigerators</td>
<td>$66,000</td>
<td>Blood and tissue specimens from every autopsy case are stored in refrigerators and -70 degree freezers to preserve the specimens for toxicology testing (tests</td>
</tr>
</tbody>
</table>
Iowa Department of Public Health  
FY 2018 and FY 2019 Technology Reinvestment Fund Requests

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>for drugs and poisons). The specimens are important pieces of evidence in homicide court cases so freezers and refrigerators must perform 100% of the time to avoid damage to legal evidence. They should be replaced after 7 years.</td>
<td></td>
</tr>
<tr>
<td>Washer and Dryer</td>
<td>$10,000</td>
</tr>
<tr>
<td>All employees involved with the autopsy process must wear protective clothing and covers that must be washed in a commercial grade washer to disinfect and cleanse the soiled scrubs, cover gowns, and autopsy towels. Current equipment has exceeded their expected lifespan and ability to be repaired.</td>
<td></td>
</tr>
<tr>
<td>Servers</td>
<td>$100,000</td>
</tr>
<tr>
<td>OSME has a case management software system that manages the death records from the entire state and the autopsy information for autopsies performed at the facility. The State Medical Examiner is required to maintain the medical examiner death investigation records. The 5-year life cycle for the current servers are due to expire in 1 1/2 years.</td>
<td></td>
</tr>
<tr>
<td>Evidence Drying Cabinet</td>
<td>$17,000</td>
</tr>
<tr>
<td>In violent-crime deaths, clothing is an important piece of evidence. In order to preserve clothing, which is often bloodied and wet, it must be dried to prevent mildew and contamination of the evidence. A drying cabinet hastens the drying process and provides safety for employees via special filters that protect the area from airborne biohazardous organisms.</td>
<td></td>
</tr>
<tr>
<td>Web Portal for ME Case Reporting</td>
<td>$150,000</td>
</tr>
<tr>
<td>County medical examiners are required to submit medical examiner reports on all cases investigated to OSME within 14 days of their investigation. Due to manual typing or handwritten paper reports, many reports are delayed. This causes further delays in entering the data into the OSME’s database. County medical examiners have been requesting a web-based electronic reporting of cases. The construction of a web portal would increase efficiency, data security, and accuracy and would assist county medical examiners in complying with the law.</td>
<td></td>
</tr>
<tr>
<td>Total Request</td>
<td>$1,037,000</td>
</tr>
</tbody>
</table>

For more information, please contact:  
Deborah Thompson, Policy Advisor/Legislative Liaison for IDPH  
Deborah.Thompson@idph.iowa.gov / 515-240-0530  
January 2017
Problem Statement: Funds are requested to engage professional services in a review of software applications/systems in use across the Iowa Department of Public Health (IDPH). The review will be focused on potential efficiencies gained by combining systems based on common functions across the Department as well as increasing the usability of the data collected. Funds are requested for the initial analysis and roadmap only and not for the procurement of systems.

Governor’s Recommended Technology Reinvestment Fund Request:
$250,000 for FY 2018
$250,000 for FY 2019

Background:
A foundational service of the public health sector is data collection. IDPH uses data to monitor the health status of Iowans at the community and state levels. Local public health agencies use data to assess the health disparities in their counties and cities. Without data, public health practitioners would not understand where limited resources should be spent to maximize positive health outcomes for all Iowans.

IDPH has over 80 software systems used in day-to-day business. Many of these systems are not connected and do not share data. Duplicate information is being entered by community organizations (our subcontractors) and stored in multiple places. It’s wasteful and increases the likelihood for human error.

IDPH’s Bureau of Information Management has assessed where these systems are in their lifespan (i.e. Are they in need of immediate replacement?). Red, yellow, and green color coding has been used to clearly identify these stages. We’re seeing a great deal of systems that are in the red. This increases the risk of system failure, among other negative impacts.

The need for replacement presents opportunities.

With the assistance of this appropriation, IDPH intends to engage an external entity familiar with government operations and moreover, the functions of public health, to determine the optimal number of systems required to support the functions of IDPH most efficiently. Integration will result in a better understanding of our clients, the services they are using, and the ability to address their needs across programs, therefore reducing duplication of efforts. This will lead to better prevention efforts by understanding patterns in health problems and service usage. Procuring technology that can be used across programs also decreases the number of systems to host and maintain, makes data consolidation and reporting much easier and provides better service to our community organizations and the Iowans they serve.

Who will benefit?
Community Organizations: IDPH funnels most of our federal and state funding to local organizations that partner with us to protect and improve the health of Iowans. They administer programs and collect the information from the families they serve. However, their effectiveness is hindered by glaring inefficiencies of IDPH’s information technology systems. They spend too much time entering the same data into multiple systems. The technology should also enable them to pull and analyze information about their communities.

Iowans: The core mission of the public health sector is to reduce the leading causes of preventable death and disabilities with a special emphasis on underserved populations and health disparities. Increasing the usability of the data collected and the efficiency at which it’s entered will create better and more effective public health policies and strategies that will benefit all Iowans.

For more information, please contact: Deborah Thompson, Policy Advisor/Legislative Liaison for IDPH
Deborah.Thompson@idph.iowa.gov / 515-240-0530     Date: January 2017
Division I – Program Flexibility and Efficiencies
Division I increases the flexibility for an existing funding stream used by the Bureau of Substance Abuse Treatment and Prevention.

Section by Section Division Summary:

Section 1. Amends Iowa Code section 125.59(1)(b) to increase flexibility for the use of a funding stream that is commonly referred to as “Sunday Sales.”

Iowa Code Section 125.59 authorizes the transfer of funds from the Division of Alcoholic Beverages located in the Department of Commerce to IDPH to be used for substance use prevention efforts in communities. The funding that is unspent by local agencies reverts to the General Fund. IDPH is proposing language to provide for additional uses of the funding that align with best practices in substance use disorder prevention.

Secs. 2 and 3. Strikes Iowa Code section 135.11(31) and amends section 135.150(2) to remove one reporting requirement and to reduce the frequency of another to ease the administrative burden related to each.

IDPH has several reports that are required by the General Assembly on an annual basis. At least two, however, are mandated to be provided more frequently. The first is a financial report that requires IDPH to provide information on federal grants the department applies for or renews that require a state match or maintenance of effort and has a value of over $100,000. The department is proposing to eliminate this reporting requirement. Individual budget units are already identified as being used for match to federal grants within the state's I3 budgeting system. The legislative branch has access to this system, therefore this requirement is duplicative. In addition, obtaining reports from the budget system would provide a better and more complete document. The current method of reporting on an individual grant basis does not provide a clear picture of the total amount of state funding appropriated to IDPH that is used for matching federal funds.

IDPH is also requesting a reduction of the frequency of a gambling report that is required on a semi-annual basis. The report is provided once during the Interim and once in January. The department is proposing to decrease this requirement to once a year in January to reduce the administrative burden.

Information on any of IDPH’s programs or budgets are always available upon request.

Division II – Medical Home and Patient-Centered Health Advisory Council
Division II updates code language relating to this council to better align with current practice and its scope of work. The public health sector and the health care sector are different; however, some of the work overlaps. This council bridges the communication gap to help facilitate the collaboration between the two sectors to improve patient outcomes while reducing health care costs.

Section by Section Division Summary:

Secs. 4 through 10 - Medical Home System - Outdated Language - Background and Summary:
The 2008 Iowa Acts established several directives relating to patient-centered medical homes (PCMH). The code sections provide definitions and parameters for the purpose of a medical home and direct IDPH to establish a medical home credentialing system in partnership with the simultaneously established Medical Home System Advisory Council. This language predated the Patient Protection and Affordable Care Act (ACA) of 2010. It was relevant in 2008 when the concept of the PCMH was a new and emerging topic of interest to states across the country. Since that time, the PCMH concept has evolved and national certification standards have been released and modified numerous times. Therefore, a medical home certification process was never established and health care entities in Iowa had the freedom to implement the medical home concept with necessary flexibility. The Council eventually moved away from the idea of certification requirements altogether to focus instead on discussions and policies relating to patient and clinical outcomes and collaboration with the public health sector. The department is proposing to remove the outdated language in Iowa Code
Sections 135.157, 135.158, and 135.159 and to revise the Council's purpose. Conforming amendments are also included in the language.

Sec. 4 amends Iowa Code Section 135.159 by striking it and replacing it with new language that retains the establishment of the Patient-Centered Health Advisory Council (formerly named the Medical Home System Advisory Council). The directive to establish a medical home certification program is removed. The purpose statement for the Council is revised.

Sec. 5 is a conforming amendment to strike a reference to the medical home certification program in Iowa Code Chapter 136, State Board of Health.

Sec. 6 is a conforming amendment to Section 249N.2(15 and 19) that relates to the Iowa Health and Wellness Plan. The definitions of medical home and primary care provider located under Section 249N.2 referenced the definitions found in Section 135.159. Both definitions would now be located under Section 249N.2.

Sec. 7 is a conforming amendment to move the definition of “personal provider” to Iowa Code Section 249N.2 and out of Section 135.159.

Secs. 8 and 9 are conforming amendments to remove a reference to the medical home certification program in Section 249N.6.

Sec. 10 repeals Iowa Code Sections 135.157 and 135.158 that provides for definitions and describes the purposes and characteristics of medical homes. The characteristics of medical homes were intended to act as parameters for the medical home certification program that was never implemented.

Division III – Workforce Programming
Division III updates code language for various workforce programs in the department. It complements the activities the department has been conducting around evaluation and review of current workforce programming.

Sec. 11 amends Iowa Code Section 84A.11, Department of Workforce Development. The language repeals a reference to Iowa Code Section 135.164 that IDPH is proposing to repeal in Section 18 of this legislation.

Secs. 12 and 13 remove outdated language in Iowa Code Section 135.107(3). The section establishes the Primary Care Provider Recruitment and Retention Endeavor (PRIMECARRE) Program. The proposed language removes one component of the program, the primary care provider community scholarship program, that has never been implemented. Two components will remain. Additional flexibility is added in determining the application process and required matching funds in the community support grant program component of PRIMECARRE. Language to specify the target areas of rural, underserved or special populations for the community support program funding is also added.

Sec. 14 amends Iowa Code Section 135.107(5)(a). It removes the outdated membership slot for the defunct Rural Health Resource Center on the Rural Health and Primary Care Advisory Committee and revises the designation of “the national institute for rural health policy” to “a national or regional institute for rural health policy” to increase the pool of applicants that could be considered for this slot.

Sec. 15 removes the terminology of "long-term care" from the directive in Iowa Code Section 135.163 to better reflect the inclusiveness of the various professions of Iowa’s public health and health care workforce for which the department will analyze and provide strategic recommendations.

Secs. 16 and 17 removes references to Section 135.164 in Iowa Code Section 135.175 that relate to the health care workforce shortage fund. IDPH is proposing to repeal Section 135.164 in Section 18 of this legislation.
Sec. 17 also updates outdated language in Iowa Code Section 135.175. Some of the accounts in the Health Care Workforce Support Initiative Fund have sunset and the remaining policy components are removed. Additional flexibility is provided in lettered paragraph 6c and in paragraph 7 in the administration of the Fund to be better positioned to target funding where needed.

Sec. 18 repeals the remaining directives for the defunct Health and Long-Term Care Access Advisory Council in Iowa Code Section 135.164. The department will continue to work on health care workforce-related issues as stated in 135.163. Iowa Code Section 135.180 that establishes the defunct mental health stipend program is also repealed. The Legislature honored the Governor’s recommendation to eliminate funding to this program in FY 2017 due to a lack of interest and high historical reversions.

**Division IV – Removal of Unfunded and Outdated Programs**

The programs in Division IV have either never been implemented, are unfunded, or may no longer be necessary.

Sec. 19 (and 23) repeals Iowa Code Section 135.130 and Section 135.11(25) that establish a substance abuse treatment facility for persons on probation. An advisory council was also established. These code sections were created in 2001 and were never implemented. The historical knowledge of this issue is scant, but IDPH does not see a current need to implement these directives. The Department of Corrections did not object to the removal of the language.

Sec. 20 repeals Iowa Code Section 135.141(2)(c) that requires IDPH to conduct statewide risk assessment of biological agent danger. Since the creation of this statute in 2003, the federal government has established and implemented an effective national program. The Iowa Homeland Security and Emergency Management Department and the State Hygienic Lab are key partners with IDPH in these efforts, and agree that the federal program for identifying and tracking biological agents is adequately meeting the intent of this statute.

Sec. 21 is a conforming amendment to Section 135.141(2)(e) to strike a reference to Section 135.141(2)(c) that IDPH is requesting to repeal in Section 20 of this legislation.

Sec. 22 removes a reference to the substance abuse treatment facility for persons on probation that IDPH is requesting to remove in Secs. 19 and 23 of this legislation.

Sec. 23 eliminates the following programs that have either never been implemented, are unfunded, or may no longer be necessary:

- The automated external defibrillator (AED) program established in Iowa Code Section 135.26. The program was funded by the legislature to place AEDs around the capitol complex. A federal grant the department had at the time also provided funding to the public via a grant program. It has been 10 years since the federal grant funding was eliminated and the goal of equipping the capitol complex was achieved; therefore, the program may no longer be necessary.
- Iowa Code Section 135.29 that permits counties to form local substitute decision-making boards to act on behalf of patients incapable of making their own medical decisions. The section was created in 1989. To date, neither IDPH nor the Department on Aging (IDA) is aware of any locally-operating boards. No state activity has taken place in many years at IDPH and IDA operates the State Office of Substitute Decision Maker (www.iowaaging.gov/office-substitute-decision-maker-fact-sheet-01) that accomplishes the same goal. IDA is supportive of the removal of the section.
- Iowa Code Section 135.130 that establishes a substance abuse treatment facility for persons on probation. An advisory council was also established. See Section 19 above for additional explanation.
- Iowa Code Section 135.152 that establishes the Statewide Obstetrical and Newborn Indigent Patient Care Program. The program was intended to act as a payer of last resort once a client meets eligibility for the program. The program provides reimbursement for the enrollee’s medical bills associated with antepartum care and the in-patient hospital stay for labor and delivery for both the mother and newborn. The department has not received applications for the program since 2009. There are several reasons for this:
The Department of Human Services (DHS) has consistently increased Medicaid eligibility for infants less than 1 year of age and pregnant women. Iowa women with incomes of 375 percent of the FPL or below are eligible for Medicaid assistance during pregnancy and for 60 days postpartum. Infants are also covered for the first year of life.

There has been an increase in obstetrical providers at Federally Qualified Health Centers. They are now the primary gap filling service for women that are low income and do not qualify for Medicaid. The IDPH program is a duplication of these services.

The funding level is currently $10,000 per year. It comes from the federal Title V Maternal and Child Health Block Grant. Due to the current cost for labor and delivery, only one applicant per year could be served if the program were to receive a request.

**Division V – Miscellaneous Provisions**

**Sec. 24** amends the definition of “local board of health” in Iowa Code Section 135A.2(12) to refer to the definition already established in Iowa Code Section 137.102(11). It is unnecessary to have different definitions.

**Sec. 25** eliminates the Interagency Pharmaceutical Bulk Purchasing Council established in Iowa Code Section 135.132 in 2003. It does not appear that this council was ever convened, nor is it necessary. The purchasing coordination for the state is currently done via an interagency workgroup. The meetings are held in conjunction with the Minnesota Multistate Contracting Alliance for Pharmacy (www.mmd.admin.state.mn.us/mmcap). Approximately 48 states participate in this Alliance, including Iowa.

**Division VI – Iowa Health Information Network**

**Secs. 26 and 27** relate to the Iowa Health Information Network (IHIN) currently housed within IDPH. They are technical fixes to legislation that passed in 2015 that authorized IDPH to conduct an RFP process to move the IHIN out of state government. The conforming change would take effect once that process has been completed. IDPH anticipates completion of the transfer by Spring of 2017.

**Division VII – Organized Delivery Systems**

**Secs. 28 to 102** repeal all references in the Iowa Code and Acts to organized delivery systems (ODS). In the 1990s, the Iowa Legislature directed IDPH to adopt rules and a licensing procedure for the establishment of organized delivery system projects (1993 Iowa Acts, Chapter 158, Section 3). Many subsequent references to this session law were placed in Iowa Code. An ODS is defined in administrative rules as:

> “An organization with defined governance that is responsible for delivering or arranging to deliver the full range of health care services covered under a standard benefit plan and is accountable to the public for the cost, quality and access of its services and for the effect of its services on their health. The organization operating as an ODS shall assume risk and be subject to solvency standards as found in 201.12.” (641 IAC 201.2)

Since the adoption of the rules in 1994, only two entities applied and both were licensed as an ODS. One ceased operations in 2002 and the other in 2010. In 2013, CoOpportunity Health opted not to include ODS, because surrounding states had not implemented ODS systems. The creation of Affordable Care Organizations in the Affordable Care Act have also made ODS regulations irrelevant. The Iowa Insurance Division is supportive of the removal of the code references in their various code sections.
Purpose of the Legislation:

The Iowa Department of Public Health's (IDPH) policy bill aligns the IDPH and Iowa Workforce Development's (IWD) licensure and registration processes for contractors.

Background:

IDPH is responsible for the implementation of Iowa Code Chapter 105 that establishes the Board of Plumbing and Mechanical Systems that is charged with the regulation of plumbing, mechanical professionals, and contractors. The renewal cycle for licenses is once every three years (May/June 2017, 2020, 2023, etc.).

IWD is responsible for the implementation of Iowa Code Chapter 91C that requires the registration contractors to ensure they are properly equipped with specific types of insurance, like workers’ compensation insurance, and surety bonds. Surety bonds protect provide financial guarantees that contracts will be completed according to the mutually agreed upon terms. They protect consumers from fraud and malpractice. The IWD registration is good for twelve months starting with the date of issuance.

Policy Fix Needed:

IDPH and IWD have worked together to create a unified licensure and registration system to provide a single point of entry for this target population of consumers. However, since the two departments have different timeframes for their respective regulatory functions (3 years versus 12 months) the proposed language is needed to prorate the charges to the applicants.

Under the bill’s language, IDPH will receive the applicant’s fees for both licensure and registration on behalf of both departments and will transfer the appropriate amount of funding to IWD. The current code language works well for a new applicant who applies at the three-year renewal date (May or June 2017, 2020, 2023, etc.). However, it does not work well for new applicants or others that may apply at a different time during the three-year cycle.

Currently, for off-cycle applicants, IDPH is required to collect three times the registration fee for IWD regardless of where in the three year cycle the individual applies. This will result in IWD doing an extra step of processing a refund to sync the registration to the license. Authorization to prorate the fees will create a more efficient process for the applicant, IDPH, and IWD.

For more information please contact Deborah Thompson, Policy Advisor for IDPH:
Deborah.Thompson@idph.iowa.gov and 515-240-0530
SENATE/HOUSE FILE _____
BY (PROPOSED DEPARTMENT OF
PUBLIC HEALTH BILL)

A BILL FOR

1 An Act relating to contractor registration and licensing by the
department of public health and the department of workforce
development and related fees and including effective date
provisions.
2 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DRAFT
Section 1. Section 91C.1, subsection 3, Code 2017, is amended to read as follows:

3. a. The labor services division of the department of workforce development and the Iowa department of public health will work with stakeholders to develop a plan to combine the contractor registration and contractor licensing application process for contractors licensed under chapter 105, to be implemented in time for licensing renewals due July 1, 2017. The department of public health shall transfer to the labor services division a portion of each contractor license fee equal to three times the current contractor registration fee.

Effective July 1, 2017, a contractor licensed under chapter 105 shall register as a contractor under this chapter in conjunction with the contractor licensing process. At no cost to the labor services division, the department of public health shall collect both the registration and licensing applications as part of one combined application. The labor commissioner shall design the contractor registration application form to exclude from the division of labor’s contractor registration application process those contractors who are also covered by chapter 105. The labor commissioner is authorized to adopt rules as needed to accomplish a merger of the application systems including transitional registration periods and fees.

b. Effective July 1, 2017, excluding registrations by contractors that are exempt from the registration fee pursuant to this section, the department of public health shall collect and transfer to the labor services division a portion of each contractor license fee equal to three times the contractor registration fee for each three-year license or a prorated portion thereof using a one-sixth deduction for each six-month period of the renewal cycle.

Sec. 2. Section 91C.2, subsection 3, Code 2017, is amended to read as follows:

3. An out-of-state contractor shall either file a surety bond, as provided in section 91C.7, with the division of labor
services in the amount of twenty-five thousand dollars for a one-year period or shall provide a statement to the division of labor services that the contractor is prequalified to bid on projects for the department of transportation pursuant to section 314.1.

Sec. 3. EFFECTIVE UPON ENACTMENT. This Act, being deemed of immediate importance, takes effect upon enactment.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

Under current law, the labor services division of the department of workforce development and the department of public health are directed to develop a plan to combine the contractor registration and contractor licensing application process for contractors licensed under Code chapter 105, the Iowa plumber, mechanical professional, and contractor licensing Act, to be implemented in time for licensing renewals due July 1, 2017. As part of that process, the department of public health is required to transfer to the labor services division a portion of each contractor license fee equal to three times the current contractor registration fee.

This bill strikes language regarding such fee transfers. The bill instead requires the department of public health to collect and transfer to the labor services division a portion of each contractor license fee equal to three times the contractor registration fee for each three-year license or a prorated portion thereof using a one-sixth deduction for each six-month period of the renewal cycle beginning July 1, 2017. The bill excludes from the fee transfer requirements registrations by contractors that are exempt from the registration fee pursuant to Code section 91C.1.

The bill also strikes language providing that $25,000 surety bonds filed with the division of labor services as provided in Code section 91C.7 are filed for a one-year period.

The bill takes effect upon enactment.
Iowa Department of Public Health
Division of Acute Disease Prevention Emergency Response and Environmental Health
Bureau of Immunization and Tuberculosis

Immunization Program
Immunization Exemption Factsheet
January 25, 2017

- Enforcement of mandatory immunization requirements for children entering childcare facilities and schools has resulted in high immunization coverage levels and has significantly reduced or eliminated the occurrence of vaccine preventable diseases.
- All states allow for medical exemptions, 5 states do not allow religious exemptions, 19 allow philosophical exemptions, and three (California, Mississippi and West Virginia) do not allow exemptions for religious or philosophic reasons.
- Iowa law allows for medical and religious exemptions from required vaccines.
- Medical and religious exemption rates in students kindergarten through 12th grade have increased since 2000 (Medical 0.19% - 0.38%, Religious 0.3% - 1.30%).
- The number of Religious Immunization Exemptions continues to increase annually and comprise 1.30% (6,737) student enrollment kindergarten through 12th grade.
- Philosophical exemptions play a role in the increase of unvaccinated populations.
- Studies indicated geographic areas with higher rates of immunization exemptions are more likely to have vaccine preventable disease outbreaks. Omer SB, Enger KS, Moulton LH, Halsey NA, Stokley S, Salmon DA. Am J Epidemiol 2008;168:1389–96.
- Achieving and maintaining high immunization rates is necessary to prevent the spread of vaccine preventable diseases and protects those who cannot be vaccinated because of age or medical reasons.
- The following organizations have position statements against philosophical or personal belief immunization exemptions:
  - American Academy of Family Physicians (AAFP)
  - American Academy of Pediatrics (AAP)
  - American College of Physicians
  - American Medical Association (AMA)
  - Association of Immunization Managers (AIM)
  - Association of State and Territorial Health Officials (ASTHO)
  - Every Child by Two (ECBT)
  - Infectious Disease Society of America
  - Institute for Vaccine Safety, Johns Hopkins Bloomberg School of Public Health
  - National Association of County and City Health Officials (NACCHO)
  - National Conference of State Legislatures Information
  - Pediatric Infectious Disease Society

The following studies demonstrate the negative impact of philosophical exemptions on the nation and communities.
- Research based on nationwide surveillance data has demonstrated that children with exemptions were 22 times more likely to have had measles and 5.9 times more likely to acquire pertussis than children who had not been exempted from vaccination. Feikin DR, Lezotte DC, Hamman RF, Salmon DA, Chen RT, Hoffman RE. Individual and community risks of measles and pertussis associated with personal exemptions to immunization. JAMA 2000; 284:3145-50.
- In some cases, research has found that children with exemptions are as much as 35 times more likely to contract measles than vaccinated children.

- Research shows the overlap between clusters of exemptions and disease. A study conducted in Michigan demonstrated the increased likelihood of a cluster of pertussis cases being within a cluster of exempted children.

- States with philosophical belief exemptions had higher pertussis incidence than those states without philosophical belief exemptions.

- Philosophical belief exemptions also have financial consequences to the society, including the costs to families and public health for treating disease and controlling outbreaks. A study modeling the effects of a philosophical belief exemptions demonstrated that annual hospitalization and non-medical costs, like time missed from work or school, related to pertussis disease would increase by 50% if the state added a philosophical belief exemption.


Immigrants/Refugee

- Immunizations are not required for refugees prior to U.S. departure, but they are still highly recommended, assessed by panel physicians during the visa medical exam, and may be administered (i.e. a series started or continued) overseas depending on availability and what country the refugee is being processed in.

- Upon arrival to the U.S., the CDC leaves it up to individual states and resettlement agencies to ensure that refugees receive a comprehensive initial health screening (ideally within the first 30 days of arrival), and this is meant to include an assessment and update of immunizations (according to ACIP recommendations).

- The initial health assessment is not required by USCIS or the CDC, but it is highly recommended. However, the Reception and Placement Cooperative Agreement (through the Office of Refugee Resettlement) does require that resettlement agencies ensure that every refugee has a health assessment (or linkage with a health clinic) within 30 days. If this is not accomplished, resettlement agencies must provide justification as to why the health assessment was not completed, and may risk loss of funding as a result.

- Immunizations will eventually be required by USCIS when applying for adjustment of status (which for refugees typically happens after they have been in the U.S. for one year).

- The United States Citizenship and Immigration Services (USCIS) does require immunizations for legal permanent resident status. However, exemptions are allowed under the following circumstances:
  - You are opposed to vaccinations in any form– that is, you cannot obtain a waiver based on an objection only as to one vaccination
  - Your objection must be based on religious beliefs or moral convictions; and
  - The religious or moral beliefs must be sincere.

- Immigrant children in Iowa are still required to receive vaccinations in accordance with Iowa Code.
States with best immunization rates

- During the 2015-16 school year, kindergarten students residing in states with both religious and philosophical exemptions, were granted philosophical exemptions four times more than religious exemptions.
- California and Vermont have recently passed laws to repeal philosophical exemptions.
- During the 2015-16 school audit report, four out of five states with the highest kindergarten coverage levels for MMR vaccine did not have a philosophical exemption. One of the four states (Mississippi) only allow for a medical immunization exemption.

<table>
<thead>
<tr>
<th>State</th>
<th>MMR Vaccine Coverage Level (Percent of enrolled Kindergarten students who received 2 doses of MMR vaccine.)</th>
<th>Exemptions Permitted</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>99.4%</td>
<td>Medical, Religious</td>
<td>1</td>
</tr>
<tr>
<td>Mississippi</td>
<td>99.4%</td>
<td>Medical</td>
<td>2</td>
</tr>
<tr>
<td>Delaware</td>
<td>97.6%</td>
<td>Medical, Religious</td>
<td>3</td>
</tr>
<tr>
<td>Texas</td>
<td>97.6%</td>
<td>Medical, Religious, Philosophical</td>
<td>4</td>
</tr>
<tr>
<td>North Carolina</td>
<td>97.3%</td>
<td>Medical</td>
<td>5</td>
</tr>
<tr>
<td>Iowa</td>
<td>91.8%</td>
<td>Medical, Religious</td>
<td>43</td>
</tr>
</tbody>
</table>

- During the 2015-16 school audit report, 100% of the top five states with the highest kindergarten coverage levels for DTaP vaccine did not have a philosophical exemption. Two of the five states (Mississippi and Louisiana) only allow for a medical immunization exemption.

<table>
<thead>
<tr>
<th>State</th>
<th>DTaP Vaccine Coverage Level (Percent of enrolled Kindergarten students who received 5 doses of DTaP vaccine.)</th>
<th>Exemptions Permitted</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>99.6%</td>
<td>Medical, Religious</td>
<td>1</td>
</tr>
<tr>
<td>Mississippi</td>
<td>99.4%</td>
<td>Medical</td>
<td>2</td>
</tr>
<tr>
<td>Louisiana</td>
<td>98.3%</td>
<td>Medical</td>
<td>3</td>
</tr>
<tr>
<td>Virginia</td>
<td>98.3%</td>
<td>Medical, Religious, Philosophical-HPV vaccine only</td>
<td>4</td>
</tr>
<tr>
<td>Delaware</td>
<td>98.0%</td>
<td>Medical, Religious</td>
<td>5</td>
</tr>
<tr>
<td>Iowa</td>
<td>91.8%</td>
<td>Medical, Religious</td>
<td>42</td>
</tr>
</tbody>
</table>
Over 100 years ago our US Supreme Court upheld state's mandatory vaccination laws. Here is the foundational public health law decision that was handed down:

From Jacobson v. Commonwealth of Massachusetts, 25 S.Ct 358 (U.S. 1905):

The authority of the state to enact this statute is to be referred to what is commonly called the police power,—a power which the state did not surrender when becoming a member of the Union under the Constitution. Although this court has refrained from any attempt to define the limits of that power, yet it has distinctly recognized the authority of a state to enact quarantine laws and 'health laws of every description;' indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other states. According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.

The defendant insists that his liberty is invaded when the state subjects him to fine or imprisonment for neglecting or refusing to submit to vaccination; that a compulsory vaccination law is unreasonable, arbitrary, and oppressive, and, therefore, hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best; and that the execution of such a law against one who objects to vaccination, no matter for what reason, is nothing short of an assault upon his person. But the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. Society based on the rule that each one is a law unto himself would soon be confronted with disorder and anarchy. Real liberty for all could not exist under the operation of a principle which recognizes the right of each individual person to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others. This court has more than once recognized it as a fundamental principle that 'persons and property are subjected to all kinds of restraints and burdens in order to secure the general comfort, health, and prosperity of the state.'

In Crowley v. Christensen, 137 U. S. 86, 89, 34 L. ed. 620, 621, 11 Sup. Ct. Rep. 13, we said: 'The possession and enjoyment of all rights are subject to such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order, and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to the equal enjoyment of the
same right by others. It is, then, liberty regulated by law.’ In the Constitution of Massachusetts adopted in 1780 it was laid down as a fundamental principle of the social compact that the whole people covenants with each citizen, and each citizen with the whole people, that all shall be governed by certain laws for ‘the common good,’ and that government is instituted ‘for the common good, for the protection, safety, prosperity, and happiness of the people, and not for the profit, honor, or private interests of any one man, family, or class of men.’

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