Annual Report of the ***hawk-i*** Board

To the Governor, General Assembly, and
Council on Human Services

State Fiscal Year (SFY) 2013

Annual Report of the *hawk-i* Board SFY13
(July 1, 2012 through June 30, 2013)

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Annual Report of the *hawk-i* Board SFY13

To The Governor, General Assembly, and Council on Human Services

Iowa Code Section 514I.5 (g) directs the ***hawk-i*** Board to submit an annual report to the Governor, General Assembly, and Council on Human Services concerning the Board's activities, findings, and recommendations. This report has been developed for the purposes of the above referenced Iowa Code section.

I. PROGRAM DESCRIPTION

Title XXI of the Social Security act enables states to provide health care coverage to uninsured, targeted low-income children. In Iowa, targeted low-income children are those children covered by a Medicaid Expansion, a separate program called Healthy and Well Kids in Iowa (***hawk-i***), and the ***hawk-i*** Dental-Only Program which was implemented on March 1, 2010.

The Medicaid Expansion component covers children ages 6 to 19 years of age whose countable family income is between 100 and 133 percent of the Federal Poverty Level (FPL) and infants 0 to 1 year of age whose countable family income is between 185 and 300 percent of the FPL. The ***hawk-i*** program provides healthcare coverage to children under the age of 19 whose countable family income is between 133 and 300 percent of the FPL, who are not eligible for Medicaid and who are not covered under a group health plan or other health insurance. The ***hawk-i*** Dental-Only Program covers children who meet the financial requirements of the ***hawk-i*** program but are not eligible because they have health insurance. The Dental-Only program provides preventive and restorative dental care services as well as medically-necessary orthodontia.

A. Federal History

Congress established the Children's Health Insurance Program (CHIP) with passage of the Balanced Budget Act of 1997, which authorized $40 billion for the program through Federal Fiscal Year (FFY) 2007. Under the program, a federal block grant was awarded to states to provide health care coverage to children of families with income above Medicaid eligibility levels.

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, into law. The CHIPRA legislation reauthorized CHIP for four and a half years through FFY 2013 and authorizes approximately $44 billion in new funding for the program. Through CHIPRA, Iowa has been able to strengthen existing programs and continue providing coverage to thousands of low-income, uninsured children.

Note: The CHIPRA legislation changed the name of the State Children's Health Insurance Program (SCHIP) to Children's Health Insurance Program (CHIP) upon enactment.

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and continues CHIP programs through September 30, 2019. Federal funding is authorized through 2015. The ACA has resulted in substantial changes to the program. Noteworthy changes include a single streamlined application as part of the enrollment process and switching to the Modified Adjusted Gross Income (MAGI) methodology to determine family income. ACA also prohibits states from reducing current eligibility standards, referred to as maintenance of effort (MOE), until September 30, 2019.

B. Iowa's CHIP Program

CHIP is a federal program operated by the state, financed with federal and state funds at a match rate of approximately 3 to 1. CHIP was enacted to cover uninsured children whose family income is above the income limits for Medicaid. As noted previously, Iowa's CHIP program has three components:

- **Medicaid Expansion** (Implemented 1998) – Provides health and dental services to infants 0 to 1 year of age and qualified children ages 6 – 19 through the state's Medicaid program at the enhanced federal matching rate. The children covered have income that is higher than regular Medicaid but lower than the income criteria for the ***hawk-i*** program.

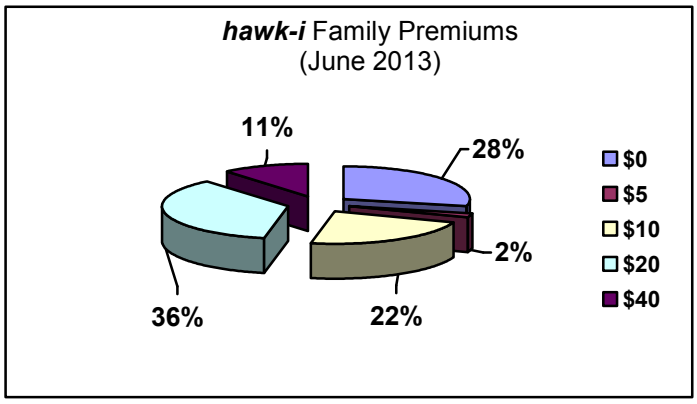
- ***hawk-i*** (Implemented 1999) – Qualified children are covered through contracts with commercial managed care health and dental plans to deliver a full array of health and dental services. The ***hawk-i*** program covers preventive care (immunizations), primary care, hospital and emergency care, chiropractic care, vision, skilled nursing care, dental care, medically necessary orthodontia, and behavioral care including substance abuse and mental health treatment. The coverage package is similar to a comprehensive commercial health and dental insurance plan. The children covered are those with family income higher than the Medicaid Expansion program, and below 300 percent of the Federal Poverty Level (FPL).

- **Dental-Only Program** (Implemented 2010) - Senate File 389 required the implementation of a new federal option to create a CHIP Dental-Only Program. The ***hawk-i*** Dental-Only Program provides preventive and restorative dental care services as well as medically necessary orthodontia to children with income under 300 percent of the FPL that do not qualify for healthcare benefits under ***hawk-i*** because they have health insurance.

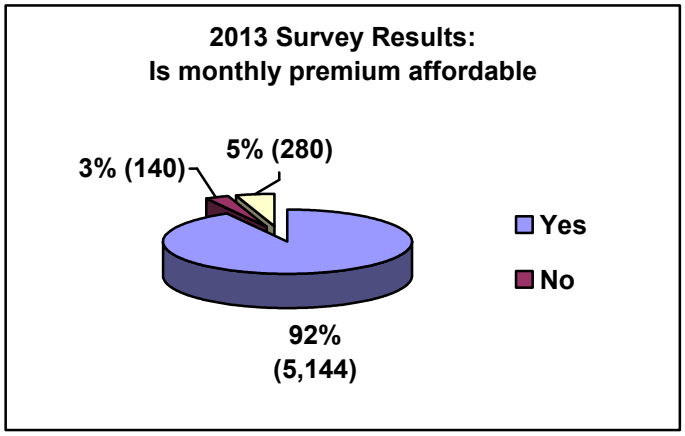
C. Key Characteristics of the *hawk-i* Program

The department pays monthly capitation premiums to commercial insurers and ***hawk-i*** program benefits are provided in the same manner as for commercial beneficiaries. The covered services under ***hawk-i*** are different from regular Medicaid and are approximately equivalent to the benefit package of the state's largest Health Management Organization (HMO).

Within the ***hawk-i*** program, families with income over 150 percent of the FPL pay a monthly premium of $10 - $20 per child with a maximum of $40 based on family income. Premiums have not been increased since the program's implementation and Iowa's monthly premium compared to established federal poverty levels are consistently lower than most other states charging a monthly enrollee premium. In June of 2013, 52 percent (11,437) of enrolled ***hawk-i*** families paid a monthly premium of $10 or less and 11 percent (2,451) paid the $40 monthly premium amount.



According to the SFY2013 ***hawk-i*** enrollee satisfaction survey conducted by the third party administrator, 92 percent of respondents reported that the monthly premium was affordable while only 3 percent responded that the premium was not affordable.



Unlike Medicaid, the department contracts with a third party administrator for all aspects of application processing, eligibility determination, customer service, management of information systems, premium billing and collection, and health and dental plan enrollment. State staff provides policy guidance, contract management, and general program oversight.

Enrollment in Iowa's CHIP program has been instrumental in providing coverage to thousands of uninsured children since 1998 and Iowa has historically been among the top five states with the lowest uninsured rate among children.

II. BUDGET

A. Federal Funding History

The CHIP program is authorized and funded through Title XXI of the Social Security Act. The program is capped with a fixed annual appropriation established by the legislation authorizing the program. Since implementation in 1997, state CHIP programs across the nation have provided healthcare coverage to millions of uninsured children.

From the initial total annual appropriation, every state was provided an allotment for the year based on a statutory formula established in the original legislation. Prior to FFY05, states were allocated federal funding based on the estimated number of uninsured children in the state estimated to be eligible for the program. In FFY06, the allocation formula was based on 50 percent of the number of low-income children for a fiscal year and 50 percent of the number of low-income uninsured children defined in the three most recent population surveys of the Bureau of Census, with an adjustment for duplication.

States were allowed three years to spend each year's original allotment. At the end of the three-year-period, any unused funds were redistributed to other states. States receiving redistributed funds had one year to spend them. Unused funds remaining at the end of the year were returned to the U.S. Treasury.

With the passage of CHIPRA in 2009, the annual allotment formula was revised to more accurately reflect projected state and program spending. The new allotment formula for each of the 50 states and District of Columbia was determined as 110 percent of the highest of the following three amounts:

- Total federal payments under Title XXI to the state for FFY08, multiplied by an "allotment increase factor" for FFY09;
- FFY08 CHIP allotment multiplied by the "allotment increase factor" for FFY09; or
- The projected FFY09 payments under Title XXI as determined on the basis of the February 2009 estimates submitted and certified by states no later than March 31, 2009.

CHIPRA allowed states to maintain the three-year availability of funds for FFY98-FFY08 allotments, but changed to two-year availability of funds for allotments beginning with FFY09. Additionally, unexpended allotments for FFY07 and subsequent years were redistributed to states that were projected to have funding shortfalls after considering all available allotments and contingency fund payments.

Section 2104(m) (2) (A) (ii) of CHIPRA added a "rebasing" process in determining the FFY11 allotments. This requirement meant that the state payments, rather than their allotments, for FFY10 must be considered in calculating the FFY11 allotments. Specifically, the FFY11 allotments are determined by multiplying the increase factor for FFY11 by the sum of:

- Federal payments made from states available allotments in FFY10;
- Amounts provided as redistributed allotments in FFY10 to the state; and
- Federal payments attributable to any contingency fund payments made to the state for FFY10 determined under Section 2104(n) of the Act.

Re-basing occurred in FFY13 using the allotments and expenditures from FFY12.

B. State Funding:

The total original appropriation of state funds for SFY13 was: $36,806,102.

Available state funding for SFY13 appropriation includes:	
General Fund	$36,806,102
SFY12 ***hawk-i*** trust fund carried over to SFY13	$ 2,247,294
Total State Funding	**$39,053,396**

Of this amount, $35,784,178 was expended. Thus, the program ended SFY13 with a balance of $3,050,214 in the ***hawk-i*** trust fund that will be used as carry forward revenue to cover costs in SFY14.

Available state funding for SFY14 appropriation includes:	
General Fund	$36,817,261
SFY13 ***hawk-i*** trust fund carried over to SFY14	$ 3,050,214
Total State Funding	**$39,867,475**

See Attachment One: Federal Funding and Expenditure History, SFY13 Final Budget, SFY13 Budget, and Orthodontia Cases.

C. CHIPRA Performance Bonus

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides performance bonus payments for Federal Fiscal Years (FFY) 2009 though 2013 to help states offset the cost of increased enrollment. To qualify for the bonus payment states must implement five of eight program features and meet enrollment targets established by the CHIPRA legislation. The eight program features include:

- Continuous Eligibility
- Liberalization of Asset (or Resource) Requirements
- Elimination of In-Person Interviews
- The Same Application and Renewal Process for Medicaid and CHIP
- Automatic/Administrative Renewal
- Presumptive Eligibility for Children
- Express Lane Eligibility (ELE)
- Premium Assistance

These program features must be fully operational for a minimum of six months in the fiscal year for which a state is seeking a bonus payment. States can qualify for a bonus payment in each fiscal year, but must actively apply in order to be considered.

The bonus payment calculation is complex, but is primarily based on the number of children enrolled in Medicaid and the per capita cost per child. Iowa did not qualify for a bonus payment in FFY09, but did qualify in FFY10 and FFY11 after implementing presumptive eligibility for children.

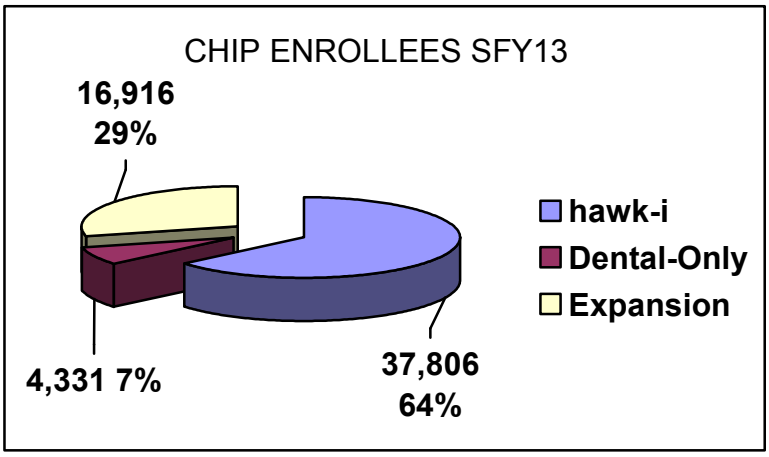
The five program features that were operational in FFY10 include:

- Continuous Eligibility
- Liberalization of Asset (or Resource) Requirements
- Elimination of In-Person Interviews
- The Same Application and Renewal Process for Medicaid and CHIP
- Presumptive Eligibility for Children

The FFY12 bonus payment totaled $11,448,316. The FFY13 bonus payment has been applied for and is estimated at $9,533,991.

III. ENROLLMENT AND DISENROLLMENT

As of June 30, 2013, 59,053 children were enrolled in Iowa's CHIP program. Of the total number enrolled, 16,916 (29%) were enrolled in Medicaid Expansion (M-CHIP), 37,806 (64%) in ***hawk-i***, and 4,331 (7%) in the ***hawk-i*** Dental-Only program. It is projected that by June 30, 2014, the total number of children enrolled in CHIP will reach 60,557. Enrollment is projected to increase to approximately 65,000 in SFY15 and over 69,000 in SFY16.



In the twelve-month period between July 1, 2012, and June 30, 2013, total growth in Medicaid and CHIP equaled 6,101 children.

Enrollment Growth by Program
July 1, 2012 to June 30, 2013

Program	Enrollment July 1, 2012	Enrollment June 30, 2013	Enrollment Increase
Medicaid	253,199	256,760	3,561/ 1.3%
Medicaid Expansion	16,158	16,916	758/ 0.5%
hawk-i	36,255	37,806	1,551/ 4.3%
Dental-Only	4,100	4,331	231/ 5.6%
Total Enrollment	**309,712**	**315,813**	**6,101/ 1.9%**

A. Number of Applications

From July 1, 2012, to June 30, 2013, the ***hawk-i*** program received 13,651 new or initial applications and 15,651 renewal applications; totaling 29,302 applications. Approximately 3,684 (12.57%) of these applications were referred to Medicaid.

In addition, 9,931 applications were referred from Medicaid to ***hawk-i***. The total number of all applications including new, referrals and renewals received in the twelve-month period was 39,233.

*See Attachment Two: Organization of the **hawk-i** Program, Referral Sources/ Outreach Points, History of Participation, Iowa's Health Care Programs for Non-Disabled Children*

B. Number of Children Enrolled

The table below reflects the history of the unduplicated number of children ever enrolled in the ***hawk-i*** program by Federal Fiscal Year (October 1st through September 30th) and by Federal Poverty Level (FPL) since FFY00. Each child is counted once regardless of the number of times a child was enrolled or reenrolled in the program during the year. This unduplicated count represents the total children served by the ***hawk-i*** program rather than a point-in-time enrollment.

Unduplicated Children Ever Enrolled in *hawk-i* (including *hawk-i* Dental-Only)

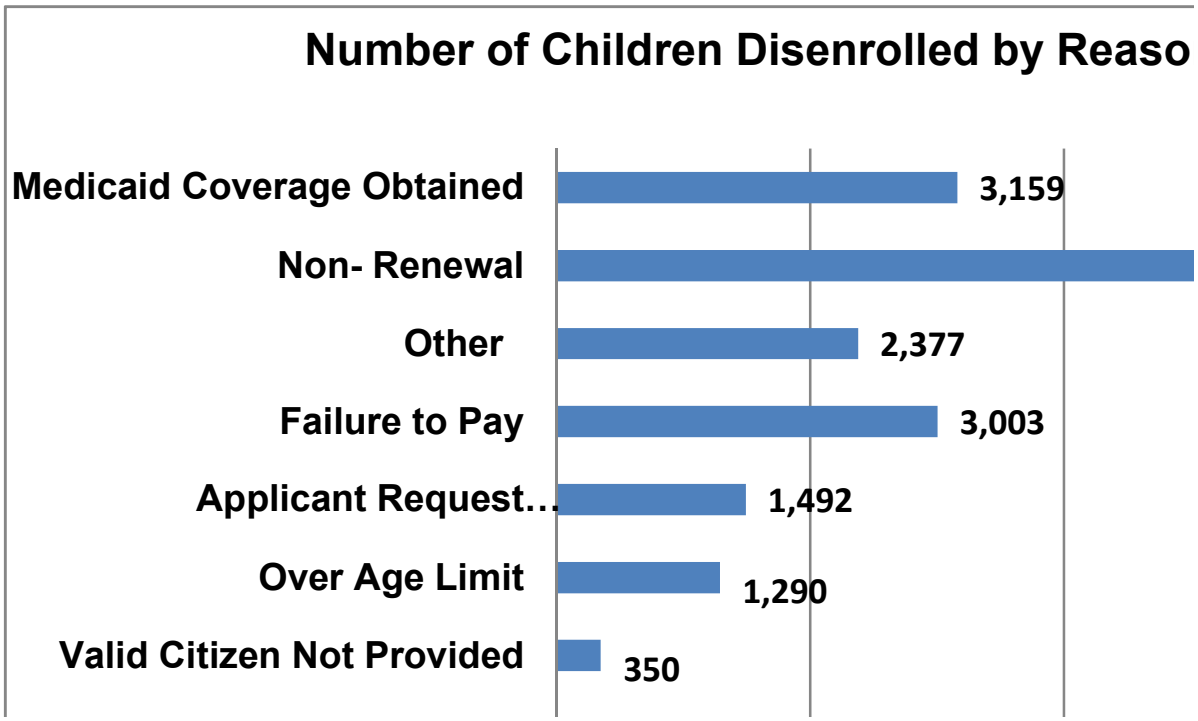
Federal Fiscal Year	Federal Poverty Level				Total Children Served
	<=100%	>=101% <=200%	>=201% <=250%	>=251% <=300%	
FFY00	285	8,414	-	-	8,699
FFY01	679	15,993	-	-	16,672
FFY02	682	20,452	-	-	21,134
FFY03	956	22,103	-	-	23,059
FFY04	1,235	25,405	-	-	26,640
FFY05	1,236	28,873	-	-	30,109
FFY06	1,018	30,801	-	-	31,819
FFY07	1,143	31,169	-	-	32,312
FFY08	1,468	31,213	-	-	32,681
FFY09	1,840	27,178	198	881	30,097
FFY10	2,550	35,844	986	5,463	44,843
FFY11	2,230	41,428	1,439	9,019	54,116
FFY12	**1,854**	**44,777**	**1,474**	**11,085**	**59,190**
FFY13	**1,912**	**39,179**	**1,211**	**10,529**	**52,831**

C. Number of Children Disenrolled

To better understand why children are disenrolled from the ***hawk-i*** program a monthly report is generated that identifies the specific disenrollment reasons. From July 1, 2012, to June 30, 2013, a total of 21,814 children were disenrolled from the ***hawk-i*** program. For the same time period in SFY12, 19,987 children were

disenrolled. This represents a 9 percent increase in disenrollment, or 1,827 more children disenrolled, comparing SFY13 to SFY12.

The most common reason for children being disenrolled from the ***hawk-i*** program in SFY32 was due to failure to renew coverage. In SFY13, 6,967 children were disenrolled due to failure to renew. The next highest reasons for being disenrolled was obtaining Medicaid coverage (3,159), failure to pay premiums (3,003), and other (2,377). The category "other" contains reasons such as child no longer living in household or not able to reach. The full list of reasons for disenrollment and numbers of children disenrolled is found in the chart below.



IV. QUALITY

The department contracts with Telligen (formerly Iowa Foundation for Medical Care) to conduct a number of ongoing quality tasks including encounter data analysis, medical records reviews, health and dental outcome measurements, provider geo-mapping analysis, and external review of the health plans. The ***hawk-i*** program is required by CHIPRA to have a Quality Strategy Plan in place and Telligen is responsible for developing that plan, subject to approval by the ***hawk-i*** Board prior to implementation. All of the quality functions provided by Telligen, including input from the Clinical Quality Committee, contribute to the content of the Quality Plan.

The above mentioned quality functions are all used to measure the impact of the program, ensure the availability of quality health care providers, and ensure children are receiving appropriate care according to clinical guidelines. Specific quality activities performed in SFY13 are discussed below.

➢ Annual *hawk-i* Provider Network Analysis

In March of 2013, Telligen completed the Annual ***hawk-i*** Provider Network Analysis which assesses the proximity of ***hawk-i*** health plan provider networks to ***hawk-i*** enrollees. Essentially, accessibility standards for different provider types are compared to the location of providers within the plan. Provider types that are assessed include primary care providers, hospitals, behavioral health, pediatric, OB/GYN, and dental providers. The established guidelines are that 95 percent of members will have access to a provider within an established radius which is 30 miles to a primary care physician, hospital, dentist, and within 60 miles for specialty and mental health providers.

Telligen concluded from their analysis that all the ***hawk-i*** health plans met accessibility guidelines for the majority of the provider types. Accessibility areas that scored very highly and met the guideline were access to primary care providers, hospital and mental health services, and dental services. Specifically, in the areas of primary care and mental health, 100 percent of UnitedHealthcare and Wellmark Health Plan of Iowa enrollees were within 30 miles of at least one mental health and primary care provider. Dental services through Delta Dental of Iowa were also found to be accessible to 100 percent of enrollees per the guideline (1 provider within 30 miles).

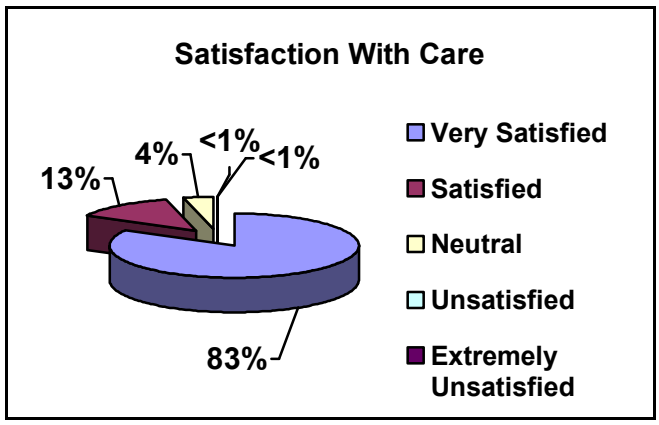
The two areas where the health plans were found to have lower accessibility and in some cases did not meet the guideline were access to pediatric and OB/GYN providers. Accessibility to pediatric providers was found to be within the guideline for 73.3 percent of enrollees with UnitedHealthcare and 66.6 percent among enrollees with Wellmark Health Plan of Iowa. Access to OB/GYN providers was found to be within the guideline for 82.9 percent with enrollees with UnitedHealthcare and 88.3 percent with enrollees with Wellmark Health Plan of Iowa.

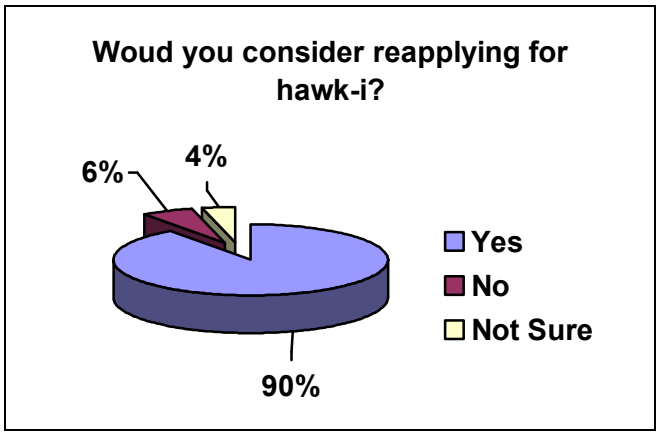
➢ SFY13 *hawk-i* Annual Satisfaction Survey

The department conducts an annual satisfaction survey through the third party administrator, MAXIMUS. Responses are generated for program areas such as how long children have been in the ***hawk-i*** program, ease of the application process, satisfaction with care, affordability of monthly premiums, etc.

In SFY13, 96 percent of survey respondents reported being either “very satisfied” or “satisfied” with care. In this survey response, 4,357 ***hawk-i*** enrollees responded they were very satisfied or satisfied with care while only 7 percent (29) responded they were “unsatisfied” or “extremely unsatisfied” with care. Also from the survey, 90 percent (869) of survey responders said that they would consider reapplying for ***hawk-i*** in the future, while only 6 percent (58) said no to consider reapplying for ***hawk-i*** in the future.

FY13 *hawk-i* Annual Satisfaction Survey Results





V. OUTREACH

Below is a summary of outreach strategies implemented at a statewide and local level in SFY13.

Outreach to Schools:

Providing outreach to schools at both the local and statewide level continues to be important in reaching uninsured, eligible children. Local coordinators from across the state work directly with school nurses as one method of finding these children. Many school nurses refer uninsured children to the ***hawk-i*** outreach coordinators for enrollment assistance. In addition, brochures and application assistance is available at back-to-school fairs and at kindergarten round ups.

- In northeastern Iowa, an outreach coordinator filled binders and canvas bags with *hawk-i* information, promotional items, and applications and hand delivered the materials to school nurses throughout the six-county service

area. This activity greatly strengthened the coordinator's relationship with the school nurses.

Outreach to the Faith-Based Community:

Outreach coordinators have established relationships within their service areas with faith-based organizations. Outreach coordinators collaborate and partner with their local ministerial associations and churches across Iowa to promote the ***hawk-i*** program.

- In eastern Iowa, an outreach coordinator sends an email with updated ***hawk-i*** information to 94 local faith-based organizations. This email communication increased throughout SFY13, and made personal visits to five of these organizations. This outreach coordinator provides continuous information to 101 faith-based organizations, which includes quarterly updates and trainings.

Outreach to Medical Providers:

Outreach coordinators provide direct outreach to Iowa's medical and dental providers to educate them about ***hawk-i***. In addition, outreach coordinators work to recruit staff employed by these medical providers to become Qualified Entities in determining Presumptive Medicaid Eligibility for children. There is a continued emphasis on engaging hospitals, medical clinics, dental offices, and pharmacists across the state and asking these trusted community leaders to talk to families about the ***hawk-i*** program.

- A ***hawk-i*** outreach coordinator in western Iowa provided ***hawk-i*** materials and infant toothbrushes to a local birthing hospital, and continued to provide updated materials throughout SFY13. The coordinator also collaborates with the local I-Smile™ Oral Health Coordinator to provide updated ***hawk-i*** information, with specific emphasis on the ***hawk-i*** dental only program. Updated brochures were also distributed to rural medical and dental clinics in the service area.

Outreach to Diverse Ethnic Populations:

Outreach coordinators continue to partner with and provide outreach to multicultural and diverse populations across Iowa. Outreach continues to be conducted at local and statewide ethnic health fairs, conferences, festivals, ethnic radio stations, and numerous other events that target specific populations. Coordinators are offered culturally competent resources and information throughout the year to help in their local outreach efforts. These resources are usually print/web resources, face–to-face trainings, and webinars.

- An outreach coordinator in central Iowa targets Hispanic families at La Clinica and Primary Health Care, Inc., and provides bilingual outreach to

the local Hispanic population. During SFY13, the outreach coordinator provided materials and information to a community group serving children with special needs, a Vietnamese Buddhist Center, and many other community centers serving diverse ethnic populations.

Additional Outreach Activities:

Every year outreach coordinators go beyond the four focus areas to reach families who may have eligible uninsured children. During SFY13 there was additional focus on outreach to adolescents ages 13-19. Local outreach coordinators developed additional activities to address this population, which included several new and creative strategies for outreach.

- Local outreach activities to adolescents included a texting campaign, raffles, and the use of peer-to-peer outreach through teen committees and using cheerleaders to pass out ***hawk-i*** information during football games.
- State outreach activities to address teen outreach included exhibiting at state wrestling and basketball tournaments and an awareness campaign with a video contest. Teens were asked to submit videos about why health insurance is important to them as a way to increase awareness about the issue and to promote peer-to-peer learning and sharing.
- The IDPH state coordinator exhibited ***hawk-i*** outreach information at several conferences during SFY13, including the Iowa School Nurse Organization's Conference, Risky Business, the Governor's Conference on LGBTQ, Immunization Conference, and several Farmer's Markets.

VI. PRESUMPTIVE ELIGIBILITY

Iowa Senate File 389 (2009 Iowa Acts, Chapter 118, Section 38) required the DHS to utilize presumptive eligibility when determining a child's eligibility for the medical assistance program. Effective March 1, 2010, Iowa implemented presumptive Medicaid eligibility for children under age 19.

Within the presumptive eligibility program, only qualified entities can enroll applicants into the program. A qualified entity is defined in 42 CFR 435.1101 and qualified entities must be determined by the DHS to be capable of making presumptive eligibility determinations. Based on other states' experience implementing presumptive eligibility, certification of qualified entities was initially limited to a select number of ***hawk-i*** outreach coordinators.

To date, Iowa has gradually expanded qualified entities and continues to add qualified entities in provider categories including: Head Start programs, WIC clinics, physicians, rural health clinics, general hospitals, federally qualified health centers, local area education agencies, maternal health centers, and birthing centers. As of September 30, 2013, there are 272 qualified entities that have been authorized to sign up children for the presumptive eligibility program. In SFY13, a total of 1,946 children were approved for presumptive eligibility. Enrollment of children in

presumptive Medicaid is expected to continue to grow as the number of qualified entities determining presumptive Medicaid eligibility increases.

All presumptive eligibility applications are also automatically forwarded from the qualified entity to the DHS for a determination of ongoing Medicaid coverage or ***hawk-i***. Of the 1,946 children approved for presumptive eligibility, 1,077 were approved for Medicaid, 148 were already eligible for Medicaid, 546 children have been denied for Medicaid, 117 have been approved for ***hawk-i*** coverage, and 41 were denied for ***hawk-i*** coverage.

*See Attachment Four: Presumptive eligibility for Medicaid and **hawk-i** program design concept.*

VII. CHIPRA GRANT

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amends section 2107 (e)(1) to make section 1902(bb) applicable to CHIP in the same manner as it applies to Medicaid. Section 1902(bb) governs payment for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) requiring Medicaid programs to make payments for FQHC and RHC services in an amount calculated on a per-visit basis that is equal to the reasonable cost of such services documented for a baseline period, with certain adjustments, or to use an alternative payment methodology to pay for FQHC and RHC services.

CMS released two rounds of grants totaling $5 million to aid in the implementation of the above legislation. As part of the second release, the department applied for and was awarded a one-year grant in the amount of $200,000. The time period of the grant is 07/01/2012 to 06/30/2013. The purpose of the grant is to implement a Prospective Payment System (PPS) or alternate payment methodology ensuring payment for CHIP enrollees receiving services at FQHCs/RHCs at a rate at least equivalent to the Medicaid encounter rate.

Effective July 1, 2013, the hawk-i program, through the participating health plans, will reimburse FQHCs and RHCs as follows:

<u>UnitedHealthcare</u>
UnitedHealthcare will contract with FQHCs and RHCs to reimburse FQHCs and RHCs at the most current Medicaid PPS to conform with the Benefits Improvement and Protection Act (BIPA) of 2000. There are no retroactive settlements required under the PPS.

<u>Wellmark Health Plan of Iowa</u>
Wellmark Health Plan of Iowa (WHPI) will reimburse FQHCs and RHCs using an Alternative Payment Methodology (APM). WHPI will pay FQHCs and RHCs on a fee for service basis. WHPI will analyze the payments on a quarterly basis, comparing them to the BIPA rate. If the FHQC/RHC was paid more than the Medicaid BIPA rate, no additional payments are made. If the

analysis shows that what the FQHC/RHC's have been paid from WHPI fee schedule was less than what they would have received with the Medicaid BIPA rate, a supplemental payment issued through the state, for the difference, is paid to the FQHC/RHC. All supplemental payments will be reviewed by the department.

VIII. PARTICIPATING HEALTH AND DENTAL PLANS

Currently, families in all 99 counties have a choice of two managed care health plans (Wellmark Health Plan of Iowa and UnitedHealthcare) and one dental plan (Delta Dental of Iowa).

- Wellmark Health Plan of Iowa (WHPI) coverage became statewide September 30, 2009.
- UnitedHealthcare coverage became statewide March 1, 2010.
- Delta Dental of Iowa coverage became statewide on July 1, 2009. On March 1, 2010, Delta Dental of Iowa expanded providing ***hawk-i*** Dental-Only coverage including medically necessary orthodontia.

Health and Dental Plan Capitation Rates

In SFY13 monthly capitation rates for the participating ***hawk-i*** plans were:

***hawk-i* Health Plan**	**SFY13 Monthly Capitation Rate**
UnitedHealthcare	$181.59
Wellmark Health Plan of Iowa	$191.26
Delta Dental of Iowa	$22.76

The above rates are paid each month to the plans for each child enrolled with the plan, regardless of whether or not the enrolled child utilizes services.

Effective July 1, 2013 (for SFY14), the Board approved a 4.3 percent increase for Wellmark Health Plan of Iowa, a 3.9 percent increase for United Healthcare, and a 1.0 percent increase for Delta Dental of Iowa.

SFY14 monthly capitation rates for the participating ***hawk-i*** plans will be:

***hawk-i* Health Plan**	**SFY14 Monthly Capitation Rate**
UnitedHealthcare	$188.67
Wellmark Health Plan of Iowa	$199.48
Delta Dental of Iowa	$22.99

See *Attachment Five: History of Per Member Per Month Capitation Rate.*

IX. BOARD MEMBERSHIP

The ***hawk-i*** Board is comprised of four public members, the Directors of Education and Public Health, and the Insurance Commissioner. There are four ex-officio legislative members, two from the House and two from the Senate.

*See Attachment Six: Healthy and Well Kids in Iowa (**hawk-i**) Board Bylaws, Healthy and Well Kids in Iowa (**hawk-i**) Board Members.*

X. BOARD ACTIVITIES AND MILESTONES

Iowa Code Section 514I.5(1) requires the ***hawk-i*** Board to meet no less than six and no more than twelve times per calendar year. The Board generally meets the third Monday every other month; meeting agenda and minutes are available on the ***hawk-i*** program web site at www.hawk-i.org. Highlights from SFY12 board meetings are as follows:

July 2012
No Meeting

August 2012
The Board was updated on the following**:**

- Eric DeTemmerman gave an update on enrollment. At the beginning of SFY12 there were 33,509 children enrolled in ***hawk-i*** (not including dental only). In June 2012, there were 35,997 children enrolled, a 7.4 percent increase. The projected increase for SFY12 was 10.5 percent.
- Mr. DeTemmerman then reported on nationwide premium data. Approximately 67 percent of states charge a premium. Most charge a monthly premium like Iowa. Thirty-eight percent of states require premiums at 151 percent of the federal poverty level (FPL) as Iowa does.
- Mr. DeTemmerman also reported on insurance capitation by county. Payments were made for insurance in all counties. The greatest amount of payments in Polk County and the smallest amount of payments in Adair County.
- Jeremy Morgan from the third-party administrator MAXIMUS shared the SY12 Enrollment and Disenrollment Survey Results.
- Tony Sithonnorath presented an administrative rule for notice for technical corrections clarifying the definitions of application date and client error. This application date change clarifies that if an application is received after normal business hours (4:30 p.m.) it is considered to be received on the next business day. Rule approved by the board.

September 2012
No Meeting

October 2012
The Board was updated on the following**:**

- Anna Ruggle introduced Nick Peters as the new Administrative Assistant for ***hawk-i***.
- Anna Ruggle shared that the Affordable Care Act (ACA) may result in potential changes with eligibility, such as how household size and income are calculated. These changes may require legislation and board action.
- Tony Sithonnorath presented the rule for adoption that clarifies that an application that comes in after office hours will be filed and dated the following day. There were no public comments on this rule. Rule passed unanimously.
- Melissa Ellis reported that the Centers for Medicare and Medicaid Services (CMS) is making awards for a national campaign for outreach efforts.
- The nominating committee, formed to nominate officers for the board, reported nominating:
    - Bob Skow for Chair
    - Mary Mincer Hansen for Vice Chair.

November 2012
No Meeting

December 2012
The Board was updated on the following**:**

- Ms. Smith provided updates for:
    - **Enrollment -** November enrollment is 65,522 compared to October which was 65,904. The November number is likely to increase once all applications are processed. Enrolment in both ***hawk-i*** and the Dental-only program has slowed slightly.
    - **ACA Implementation Update** – The department is in the process of developing an new eligibility system called ELIAS. The ACA requires states to have a single streamlined application of which hawk-i will be a part. All applications will come into a central point and then sent to either to MAXIMUS for hawk-i enrollment or to Income Maintenance staff for Medicaid.
    - Anna Ruggle reported that the administrative rule, clarifying the application date and definition of client error, approved during the October 2012 meeting was approved prematurely. The Board needs to approve at this meeting since the rule has now gone to the Administrative Rules Committee.
- **Payment Error Reduction Measurement** - Eric DeTemmerman reported that Payment Error Reduction Measurement (PERM) results were released on November 17, 2012. Iowa's error rate is 2.7%, which is second lowest of the 17 states audited.
- **Telligen Update on Clinical Advisory Committee and Quality Plan-** Tonya Sickels from Telligen presented an update on the Clinical Advisory Committee (CAC). The first CAC meeting was held on October 2. The meeting covered history of the ***hawk-i*** program and an overview of the quality measures.

January 2013

No Meeting

February 2013
The Board was updated on the following**:**

- Bureau Chief Anita Smith provided updates for:
  - **Enrollment**- Enrollment growth continues slower than anticipated.
  - **ACA Implementation Update**
    Ms. Smith reported that under the ACA, the state has three options for implementing a health care exchange: a state based exchange, a state-partnership exchange and federally facilitated exchange. Iowa has opted for a state-based exchange. ***hawk-i*** staff will work with the health and dental plans because there will be changes in the participant ID (the identification number) for ***hawk-i*** enrollees.
- **Telligen Update-** Tonya Sickels from Telligen reported on the onsite investigations of the managed care organizations. Working with DHS and ***hawk-i*** for the investigations, Ms. Sickels reported that both organizations achieved scores of 106 out of 110 points or a 96.3% compliance.
- **ACA Update-** Tony Sithonnorath presented a PowerPoint presentation on the Affordable Care Act (ACA) and gave an overview regarding ***hawk-i*** interaction with the ACA. He reviewed the eligibility and age guidelines that will affect Iowans.

March 2013
No Meeting

April 2013
The Board was updated on the following**:**

- **Iowa hawk-i rule 86 ACA**
  Anita Smith reviewed the rule that has been submitted for intent to file for notice. The rule will need to be voted for adoption after the date of the next scheduled board meeting. Ms. Smith offered two suggestions: 1) that the regularly scheduled board meeting be held with an additional board meeting at a later date to approve the rule, or 2) delay the schedule board meeting until a later date do the rule can be adopted at that meeting. The board will be polled about their preferneces for the board meeting.
- **SFY14 Capitation Rate Proposals-** Anna Ruggle presented the information on the health and dental plan proposals for SFY14. The rate increases need board approval before they can be implemented. The percent of premium increases are:
  Delta Dental – 1% increase – New monthly rate $22.99
  UnitedHealthcare – 3.9% increase – New monthly rate $188.67
  Wellmark – 4.3% increase – New monthly rate $199.48

June 2013
The Board was updated on the following**:**

- Anita Smith provided updates for:
  - **Enrollment-** Total enrollment for all programs is 66,829 reflecting a year-to-date growth of 2.25%.
  - Ms. Smith reintroduced the amendments to Iowa Administrative Code (IAC) Chapter 86 for adoption. Ms. Smith noted that these changes are to incorporate the provisions of the Affordable Care Act (ACA) and the impact to the hawk-i program in to the rules
- **SFY Capitation Rate Proposals-** Anna Ruggle presented information on the health and dental plan proposals. The rates and the amendments need board approval in SFY14. Each amendment will be voted on separately. The amendments include:
  United Healthcare – 3.9% Capitation increase – New monthly rate $188.67. Extends contract for an additional year, includes quality measures the plan is to report ot the state and payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).
  Wellmark – 4.3% increase – New monthly rate $199.48. This also includes quality measures and payment for FQHCs and RHCs.

ATTACHMENT ONE

FEDERAL FUNDING AND EXPENDITURE HISTORY
SFY12 FINAL BUDGET
SFY13 BUDGET
ORTHODONTIA CASES

FEDERAL FUNDING AND EXPENDITURE HISTORY

Iowa CHIP Program

Federal Fiscal Year (FFY)	Allotment	Prior Year Carry Forward Balance	Retained $	Redistributed $	Supplemental $	Contingency Fund $	Total Federal $ Available	Total Federal $ Spent	Balance Remaining	Note
1998	$32,460,463	-	-	-	-		$32,460,463	$276,280	$32,184,183	
1999	$32,307,161	$32,184,183	-	-	-		$64,491,344	$10,562,636	$53,928,708	
2000	$32,382,884	$53,928,708	-	-	-		$86,311,592	$15,493,125	$70,818,708	1
2001	$32,940,215	$64,690,045	$3,957,863	-	-		$101,588,123	$24,846,556	$76,741,567	2
2002	$22,411,236	$65,323,099	$4,787,171	-	-		$92,521,506	$28,724,907	$63,796,599	3
2003	$21,368,268	$55,351,451	$4,222,574	-	-		$80,942,293	$32,885,307	$48,056,986	4
2004	$19,703,423	$43,779,504	$2,138,741	-	-		$65,621,668	$37,273,256	$28,348,412	5
2005	$28,266,206	$28,348,412	-	$4,379,212	-		$60,993,830	$40,757,756	$20,236,074	6
2006	$26,986,944	$20,236,074	-	-	$6,108,982		$53,332,000	$47,861,826	$5,470,174	7
2007	$36,229,776	$5,470,174	-	-	$14,001,050		$55,701,000	$51,337,743	$4,363,257	8
2008	$33,177,409	-	-	-	$29,196,591		$62,374,000	$55,307,598	$7,066,402	9
2009	$34,057,616	-	-	-	$31,197,684		$65,255,300	$59,174,313	$6,080,987	10
2010	$68,492,373	$6,080,987	-	-	-		$74,573,360	$71,553,044	$3,020,316	11
2011	$75,497,451	$3,020,316	-	-	-	$29,517,883	$108,035,650	$81,088,841	$26,946,809	12
2012	$115,252,337	$26,946,809					$142,199,146	$93,268,092	$48,931,054	13
2013	$69,424,103	$48,931,054					$118,355,157	-	$118,355,157	14
2014	98,305,431									

Note:
1. $6,128,422 of the FFY98 allotment that remains unspent added to redistribution pool.
2. $11,418,468 of the FFY99 allotment that remains unspent added to redistribution pool.
3. $8,445,148 of the FFY00 allotment that remains unspent added to redistribution pool.
4. $4,277,482 of the FFY01 allotment that remains unspent added to redistribution pool.
5. $0 of the FFY02 allotment that remains unspent added to redistribution pool.
6. $0 of the FFY03 allotment that remains unspent added to redistribution pool.
7. $0 of the FFY04 allotment that remains unspent added to redistribution pool.
8. $4,363,257 of the FFY07 allotment that remains unspent reverts to treasury.
9. $7,066,402 of the FFY08 supplemental that remains unspent reverts to treasury.
10. Iowa received $31,197,684 additional dollars in FFY09 due to the CHIPRA legislation.
11. Total federal dollars spent to NOT include the OIG adjustment. This adjustment will be done first quarter FFY11.
12. Iowa experienced a shortfall in federal funding during the fourth quarter of FFY11 and qualified for a contingency fund payment.
13. The balance carry forward from FFY11 is from the contingency fund payment. Contingency funds are not always expended for CHIP related activities. The total federal dollars spent is an estimate as fourth quarter actuals are not yet available.
14. This is just a partial allotment award. It is based on three quarters of FFY12 expenditures. $24,652,065 of the carry forward is contingency funds.

SFY14 Budget (October 2014)

FY14 Appropriation	$	36,817,261	
Amount of ***hawk-i*** Trust Fund dollars added to appropriation	$	3,050,214	(actual)
Outreach and PERM dollars from Medicaid	$		
Total state appropriation for FY14	$	39,867,475	
ELE Revenue	$	7,498,742	
Total	$	47,366,217	

State Dollars

Budget Category	**Projected Expenditures**	**YTD Expenditures**
Medicaid Expansion	$8,664,856	$2,105,447
hawk-i premiums (includes up to 300% FPL group)	$29,147,958	$7,074,970
Supplemental Dental	$447,577	$112,614
Processing Medicaid claims / AG fees	$600,064	$115,555
Outreach	$145,800	$7,919
hawk-i administration	$1,459,381	$230,012
Earned interest from ***hawk-i*** fund	$	($647)
Totals	$40,239,184	$9,645,870

hawk-i Trust Fund Balance (In-State Dollars)

hawk-i Trust Fund amount held in reserve at SFY13 year end	$ 3,050,214

Orthodontia Cases SFY13

Delta Dental of Iowa

Month	Cases Approved	Cases Denied	Total Cases	Percent Approved	Percent Denied	Total Cost
July **2012**	38	30	68	55.9%	44.1%	$197,388.60
August	39	29	68	57.4%	42.6%	$178,872.05
September	46	60	106	43.4%	56.6%	$132,786.01
October	40	32	72	55.6%	44.4%	$227,525.93
November	57	65	122	46.7%	53.2%	$158,185.21
December	44	53	97	45.4%	56.4%	$280,883.96
January **2013**	47	29	76	61.8%	38.2%	$178,663.82
February	56	35	91	61.5%	38.5%	$270,256.01
March	50	40	90	55.6%	44.4%	$182,542.16
April	41	50	91	45%	55%	$180,383.46
May	46	19	65	70.7%	29.3%	$299,953.86
June	47	41	88	53.4%	46.6%	$189,978.02
Totals	**517**	**517**	**1,034**	**53.4%**	**46.6%**	**$2,447,419.09**

Note:

Cases are requests for orthodontic treatment, not the number of actual claims submitted.

Total cost includes actual claims for both treatment and ancillary services and are for services paid in the given month, regardless of when the orthodontia treatment case was approved.

ATTACHMENT TWO

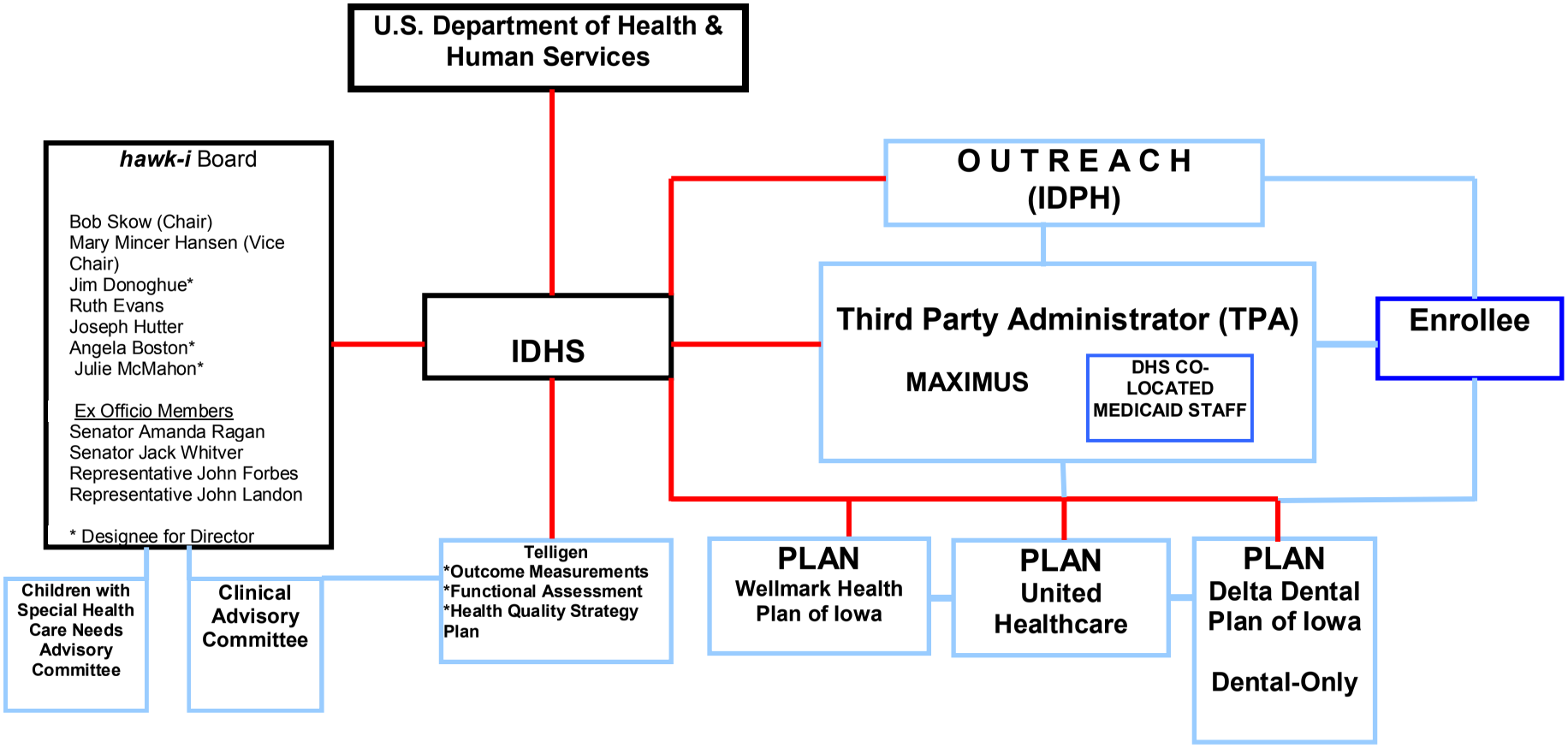
ORGANIZATION OF THE *hawk-i* PROGRAM

REFERRAL SOURCES/ OUTREACH POINTS

HISTORY OF PARTICIPATION

IOWA'S HEALTH CARE PROGRAMS FOR NON-DISABLED CHILDREN

Organization of the *hawk-i* Program



Referral Sources/ Outreach Points

Any entity that is accessed by children or their families is potentially an outreach point where applications and information about the ***hawk-i*** program could be available. In addition to local DHS offices, schools, daycare centers, WIC sites, etc., other potential sources through which information could be provided may include organizations that deal with children (Girl Scouts, Boy Scouts, Little League, Big Brothers and Sisters, YMCA, etc.) and places frequented by children and their families (churches, fast food restaurants, roller skating rinks, & toy stores). Applications would be sent to the ***hawk-i*** third party administrator (TPA), MAXIMUS.

Functions of the outreach points:

The function of the outreach points includes, but is not limited to:

1. Disseminate information about the program.
2. Assist with the application process if able.

Healthy and Well Kids in Iowa (hawk-i) Board

The function of the ***hawk-i*** Board includes, but is not limited to:

1. Adopt administrative rules developed by DHS.
2. Establish criteria for contracts and approve contracts.
3. Approve enrollee benefit package.
4. Define regions of the state.
5. Select a health assessment plan.
6. Solicit public input about the ***hawk-i*** program.
7. Establish and consult with the clinical advisory committee/advisory committee on children with special health care needs.
8. Make recommendations to the Governor and General Assembly on ways to improve the program.

Department of Human Services (DHS)

The function of DHS includes, but is not limited to:

1. Work with the ***hawk-i*** Board to develop policy for the program.
2. Oversee administration of the program.
3. Administer the contracts with the TPA, plans, IDPH and Telligen.
4. Administer the State Plan.
5. Coordinate with the TPA when individuals applying for the ***hawk-i*** program may be Medicaid eligible and when Medicaid eligible recipients lose eligibility.
6. Provide statistical data and reports to CMS.

Third Party Administrator (TPA)

The functions of the TPA include, but may not be limited to:

1. Receive applications and determine eligibility for the program.
2. Staff a 1-800 number to answer questions about the program and assist in the application process.
3. Coordinate with DHS when it appears an applicant may qualify for Medicaid.
4. Determine the amount of family cost sharing.
5. Bill and collect cost sharing.
6. Assist the family in choosing a health plan.
7. Notify the plan of enrollment.
8. Provide customer service functions to the enrollees.
9. Provide statistical data to DHS.
10. Calculate and refer overpayments to DIA.

Health and Dental Plans

The functions of the health and dental plans are to:

1. Provide services to the enrollee in accordance with their contract.
2. Issue insurance cards
3. Process and pay claims
4. Provide statistical and encounter data.

Clinical Advisory Committee

1. The Clinical Advisory Committee is made up of health care professionals who advise the ***hawk-i*** Board on issues around coverage and benefits.

Co-Located Medicaid Staff

The function of the Medicaid staff co-located at third party administrator, MAXIMUS, is to determine Medicaid eligibility when a person who applies for ***hawk-i*** is referred to Medicaid.

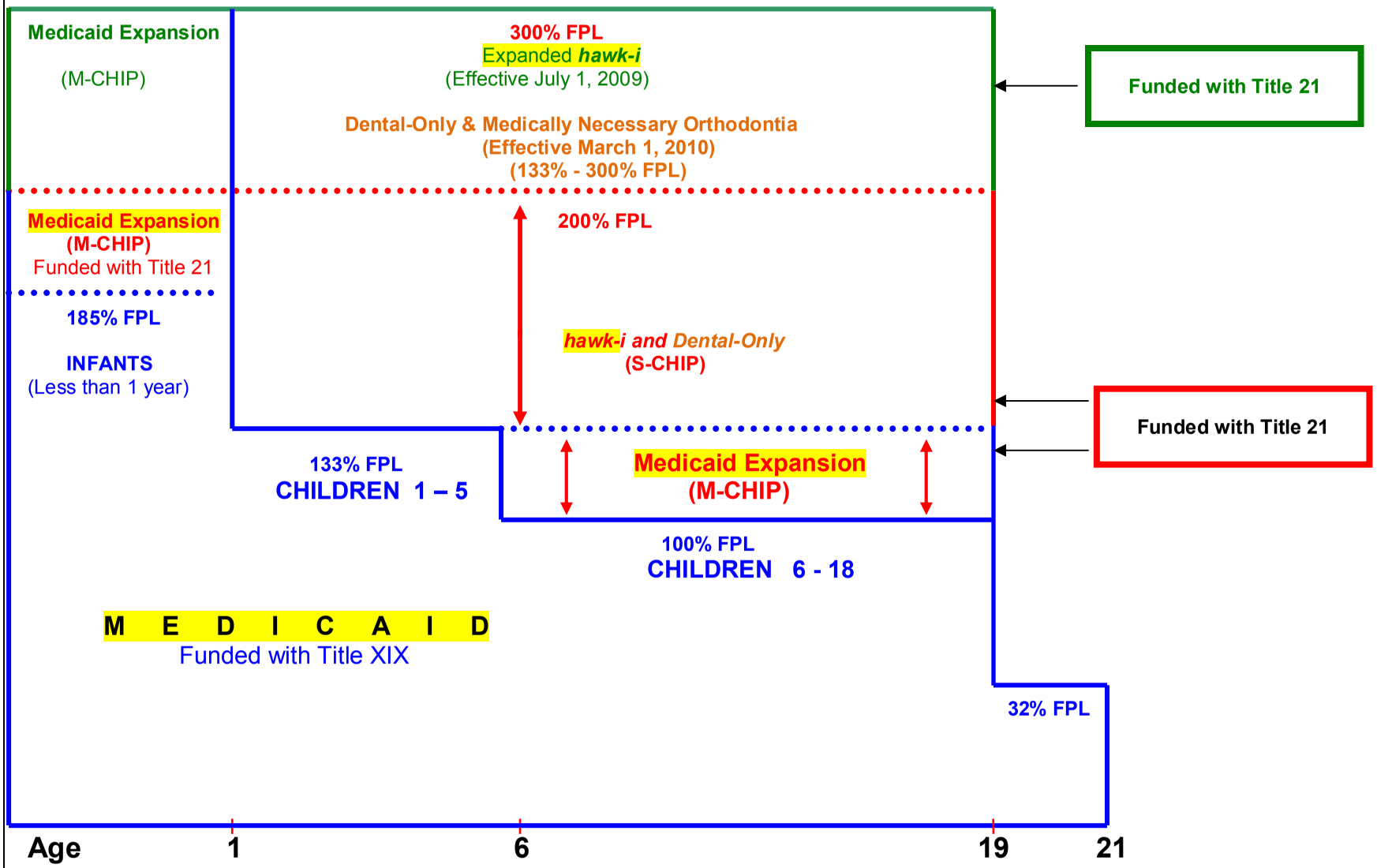
History of Participation

September 30, 2012		CHIP (Title XXI Program)		
Month/SFY	Total Children on Medicaid	Expanded Medicaid*	*hawk-i* (began 1/1/99)	Dental Only (began 3/1/10)
SFY99	91,737			
SFY00 Jul-99	104,156	7,891	2,104	
SFY01 Jul-00	106,058	8,477	5,911	
SFY02 Jul-01	126,370	11,316	10,273	
SFY03 Jul-02	140,599	12,526	13,847	
SFY04 Jul-03	152,228	13,751	15,644	
SFY05 Jul-04	164,047	14,764	17,523	
SFY06 Jul-05	171,727	15,497	20,412	
SFY07 Jul-06	179,967	16,140	20,775	
SFY08 Jul-07	181,515	16,071	21,877	
SFY09 Jul-08	190,054	17,044	22,458	
SFY10 Jul-09	219,476	22,300	22,300	
SFY11 Jul-10	236,864	22,757	28,584	2,172
SFY12 Jul-11	245,924	23,634	33,509	3,369
SFY 13 June-13	256,760	25,463	37,556	4,331
		Total CHIP Enrollment		**67,350**

Total Medicaid growth from SFY99 to present=	165,023
Total ***hawk-i*** enrollment growth from SFY99 to present =	37,556
Total Dental-Only growth from SFY10 to present=	4,331
Total children covered=	206,910

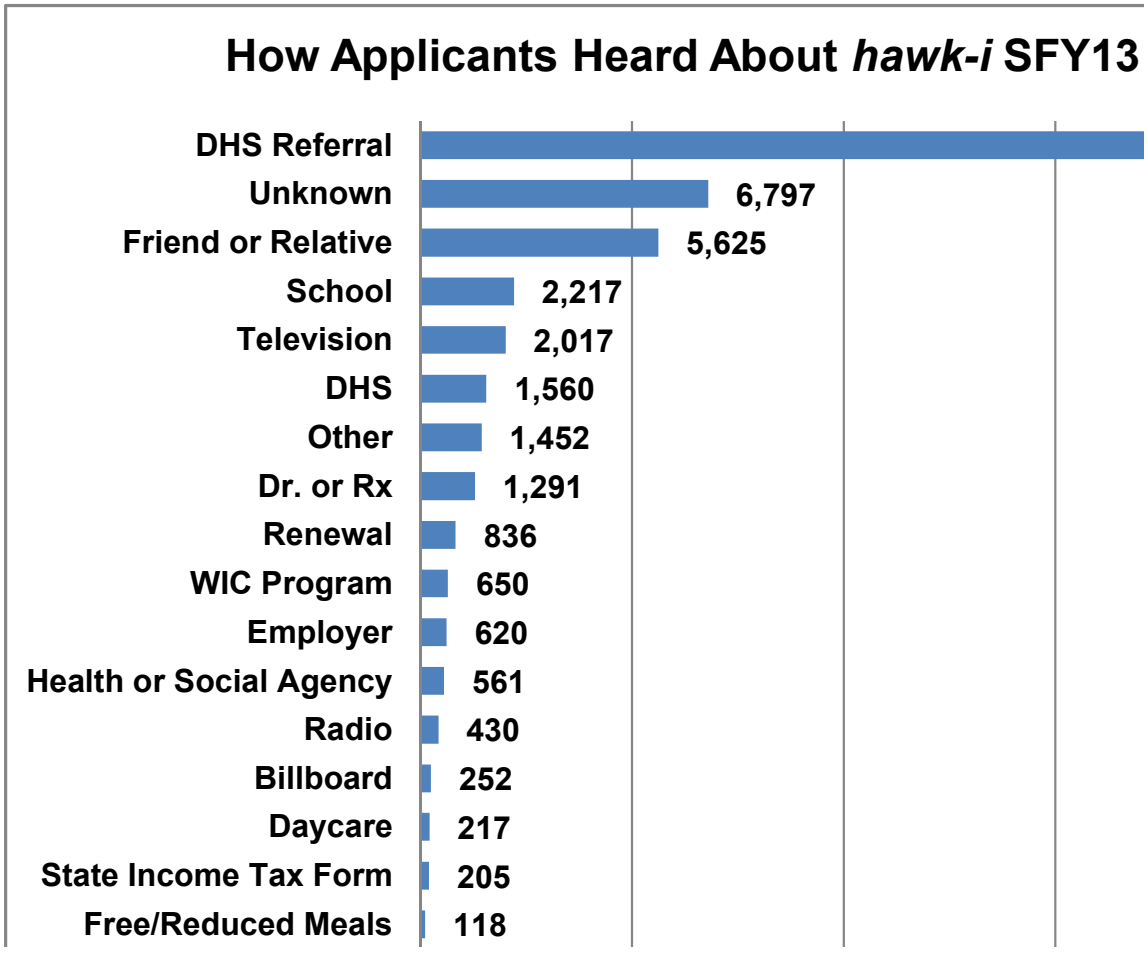
*Expanded Medicaid number is included in "Total Children on Medicaid"

Iowa's Health Care Programs for Non-Disabled Children



ATTACHMENT THREE

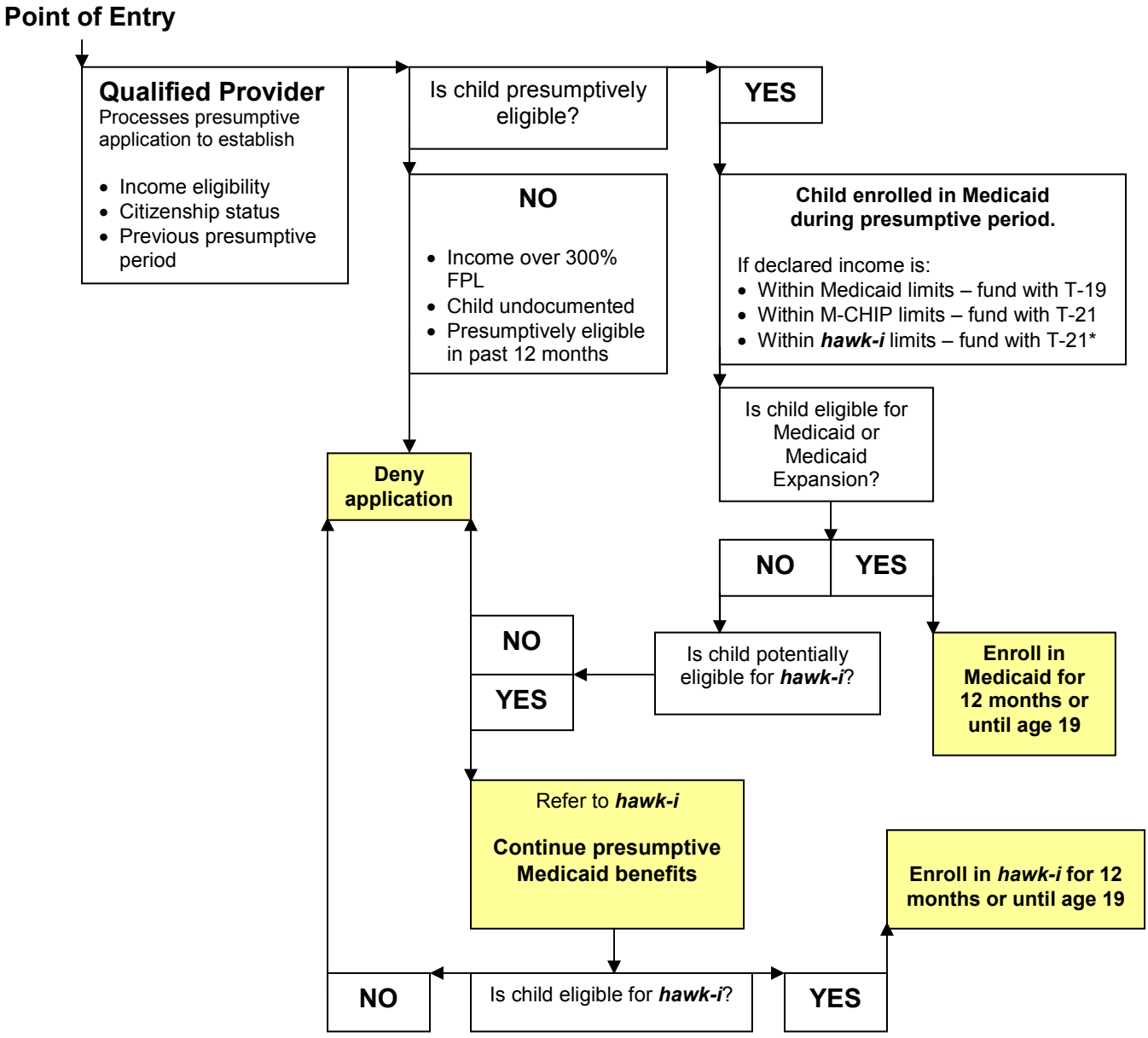
HOW APPLICANTS HEARD ABOUT *hawk-i* IN SFY13


How Applicants Heard About *hawk-i* SFY13
DHS Referral
Unknown
6,797
Friend or Relative
5,625
School
2,217
Television
2,017
DHS
1,560
Other
1,452
Dr. or Rx
1,291
Renewal
836
WIC Program
650
Employer
620
Health or Social Agency
561
Radio
430
Billboard
252
Daycare
217
State Income Tax Form
205
Free/Reduced Meals
118

ATTACHMENT FOUR

PRESUMPTIVE ELIGIBILITY FOR MEDICAID

Presumptive Eligibility for Medicaid



* Medicaid services exceeding ***hawk-i*** benefits package are paid with CHIP administrative funds

ATTACHMENT FIVE

HISTORY OF PER MEMBER PER MONTH CAPITATION RATE

History of Per Member Per Month Capitation Rate

PLAN	Capitation Rate		Increase Above Prior Year
	Federal Share	State Share	
SFY13			
UnitedHealthcare	**$181.59**		**1.5%**
	71.71% $130.22	28.29% $51.37	
Wellmark Health Plan of Iowa	**$191.26**		**5.5%**
	$137.15	$54.11	
Delta Dental of Iowa	**$22.76**		**1.0%**
	$16.32	$6.44	
SFY12			
UnitedHealthcare	$178.91		1.4%
	72.50% $129.71	27.50% $49.20	
Wellmark Health Plan of Iowa	$181.29		1.5%
	$131.44	$49.85	
Delta Dental of Iowa	$22.53		0.0%
	$16.33	$6.20	
SFY11			
UnitedHealthcare	$176.44		1.7%
	73.84% $130.28	26.16% $46.16	
Wellmark Health Plan of Iowa	$178.61		3.0%
	$131.89	$46.72	
Delta Dental of Iowa	$22.53 ($1.35 extra for dental-only enrollees)		7.5%
SFY10			
UnitedHealthcare	$173.41		2.0%
	74.46% $129.12	25.55% $44.29	
Wellmark HPI (Classic Blue Contract ended 9-30-09)	$173.41		4.0%
	$129.12	$44.29	
Delta Dental of Iowa (Blue Access Dental contract ended 7/1/2009.)	$20.96		2.2%
	$15.61	$5.35	
SFY09			
AmeriChoice	$170.01		3.7%
	73.83% $125.52	26.17% $44.29	
Wellmark Classic Blue and Blue Access Dental	$193.56		2.0%
	$142.91	$50.65	
Wellmark HPI and Blue Access Dental	$186.95		2.0%
	$138.03	$48.92	
Delta Dental of Iowa	$20.50		8.0%
	$15.14	$5.36	

ATTACHMENT SIX

HEALTHY AND WELL KIDS IN IOWA (*hawk-i*) BOARD BYLAWS
HEALTHY AND WELL KIDS IN IOWA (*hawk-i*) BOARD MEMBERS

Healthy and Well Kids in Iowa (*hawk-i)* Board Bylaws

I. NAME AND PURPOSE

A. The ***hawk-i*** Board, hereafter referred to as the Board, is established and operates in accordance with the Code of Iowa.

B. The Board's specific powers and duties are set forth in Chapter 514I of the Code of Iowa.

II. MEMBERSHIP

The Board consists of eleven (11) members. Four members are appointed by the Governor to two-year terms. Statutory members are the Director of the Department of Education, the Director of the Department of Public Health, and the Commissioner of Insurance, or their designees. Ex officio members from the General Assembly are appointed: two Senate members and two House members.

III. BOARD MEETINGS

A. The Board shall conduct its meetings in accordance with Iowa's Open Meetings Law.

B. The Board shall conduct its meetings according to parliamentary procedures as outlined in Robert's Rules of Order. These rules may be temporarily suspended by the Chairperson with a majority vote of the Board members in attendance.

C. The Board shall meet at least six times a year at a time and place determined by the chairperson.

D. Department of Human Services (DHS) staff will ship the meeting packets (including the agenda) to Board members at least five days prior to Board meetings.

E. Special meetings may be held at any time at the call of the chairperson, the DHS program manager or at the call of any five members of the Board, provided that notice thereof is given to all Board members at least twenty-four hours in advance of the special meeting.

F. A quorum at any meeting shall consist of five or more voting Board members.

G. DHS staff shall be present and participating at each meeting of the Board.

H. The Board shall record its proceedings as minutes and shall maintain those minutes in accordance with the Iowa Open Records Law.

IV. OFFICERS AND COMMITTEES

A. The officers of the Board shall be chairperson and vice-chairperson. DHS staff will serve as Secretary. The chairperson and vice-chairperson shall be elected at the first regular meeting of each fiscal year and shall assume their duties at next meeting or immediately upon the resignation of the current officers.

B. The duties of all officers shall be such as by custom and law and the provisions of the Act as usually devolving upon such officers in accordance with their titles.

C. The chairperson shall appoint committees as are needed and/or recommended unless provided for statutorily.

D. Each committee shall act in an advisory capacity and shall report its recommendations to the full Board.

V. DUTIES AND RESPONSIBILITIES

A. The Board shall have the opportunity to review, comment, and make recommendations to the proposed ***hawk-i*** budget request.

B. The Board shall set policy and adopt rules. The DHS program manager will periodically make policy recommendations to the Board in order to promote efficiency or to bring the program into compliance with state or federal law.

C. DHS staff shall keep the Board informed on budget, program development, and policy needs.

VI. AMENDMENTS

Amendments to these bylaws may be proposed at any regular meeting but become effective only after a favorable vote at a subsequent meeting. Any of the foregoing rules may be temporarily suspended by a unanimous vote of all the members present at any meeting provided they do not conflict with the provisions of the Act.

Healthy and Well Kids in Iowa (*hawk-i*)
Board Members
(as of September 1, 2013)

Bob Skow, Chair — **Mary Mincer Hansen, Vice Chair**

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Dr. Mary Mincer Hansen, Vice Chair
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