Iowa Department of Human Services

Annual Report of the hawk-i Board to The Governor, General Assembly, and Council on Human Services

December 2015

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Executive Summary

This is the State Fiscal Year 2015 Annual Report for the Healthy and Well Kids in Iowa (***hawk-i)*** program. This report reflects one entire fiscal year of the Accountable Care Act changes. One of those changes was the method of how eligibility is determined. The Modified Adjusted Gross Income (MAGI) was implemented on January 1, 2014, changing the income levels to 168 percent to 302 percent of the Federal Poverty Level (FPL). Also at this time, the Medicaid application and the ***hawk-i*** application became a single streamlined application. This report shows the activity of eligibility and enrollment using the new Modified Adjusted Gross Income (MAGI) eligibility method from July 1, 2014, through June 30, 2015.

The number of children enrolled in the program did show a decrease. This is most likely due to the compressed range of the income levels. (Prior to January 1, 2014, the income levels were 134-300 percent of the FPL for ***hawk-i***. There continues to be interest and satisfaction in the ***hawk-i*** program. Outreach continues at the local level to help assure that low-income children in Iowa get the health care they need either through Medicaid or the ***hawk-i*** program.

Transitioning to New Managed Care Plans

The health plans that participate in the ***hawk-i*** program are changing when approval is given by the Centers for Medicare and Medicaid Services (CMS). The new managed care organizations (MCOs) are Amerigroup Iowa, Inc., AmeriHealth Caritas of Iowa, and UnitedHealthcare of the River Valley. The current contract with Wellmark Health Plan of Iowa (WHPI) will be sunsetting effective December 31, 2015. UnitedHealthcare of the River Valley will be the health plan for January and February 2016.
. A list of current providers with WHPI and UHC will be sent to the new MCOs so the members can continue with their current provider. Dental services and the Dental only program will continue to be provided by Delta Dental of Iowa.

The ***hawk-i*** office is sending enrollment packet information to all current ***hawk-i*** members, so members can choose the MCO that will work for them. The DHS continues to work with the IDPH to inform ***hawk-i*** outreach coordinators of the change in order to assist families with this transition. Information to support continuity of care will be coordinated through the transition to the new MCO health plans. Prior authorizations, case management assignment, and single case agreement information will be transferred to the IME and then distributed to the appropriate MCO to facilitate a seamless shift for members already engaged in care as the new enrollments are completed.

Monitoring and reporting has been a critical element of CHIP-funded program oversight from its beginning. As such, the ***hawk-i*** program will continue to receive distinct reports on access to care, claims (encounter data) and health performance measures affecting this population that are consistent with those in place today. In addition, the Third Party Administrator will continue to refer and escalate individual concerns from ***hawk-i***

families regarding the new health plans or other issues to appropriate department staff as they do today. Department staff will continue to work with the plans to address and resolve any concerns.

Introduction

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.

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.

Effective January 1, 2014, the countable income levels were changed based on the introduction of the Modified Adjustable Gross Income (MAGI) methodology in accordance with the Affordable Care Act. This change aligns financial eligibility rules across all insurance affordability programs; creates a seamless and coordinated system of eligibility and enrollment; and maintains eligibility of low-income populations, especially children.

For the Period July 1, 2014, through June 30, 2015, the following MAGI methodology was followed:

> The Medicaid Expansion component covers children ages 6 to 18 years of age whose countable family income is between 122 and 167 percent of the Federal Poverty Level (FPL) and infants 0 to 1 year of age whose countable family income is between 240 and 375 percent of the FPL. The ***hawk-i*** program provides healthcare coverage to children under the age of 19 whose countable family income is less than or equal to 302 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.

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 authorized 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 September 30, 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 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.

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 cchildren 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

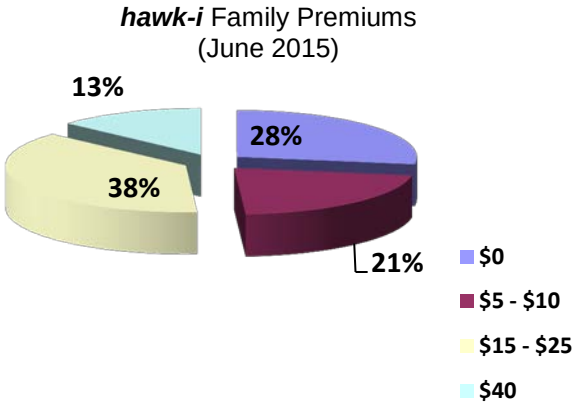
comprehensive commercial health and dental insurance plan. The children covered are those with family income higher than the Medicaid Expansion program, and below 302 percent of the Federal Poverty Level (FPL).

- **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 302 percent of the FPL that do not qualify for healthcare benefits under ***hawk-i*** because they have health insurance.

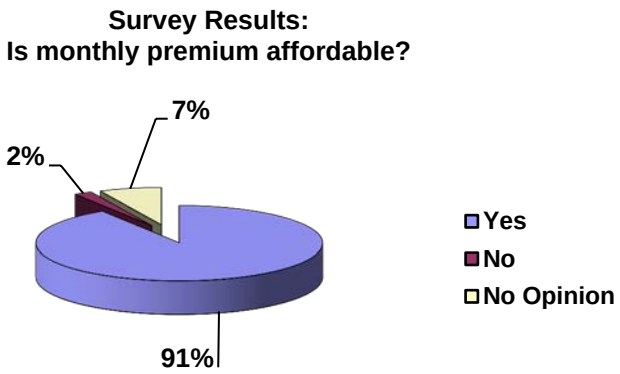
Key Characteristics of the *hawk-i* Program

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 (effective January 1, 2014); families with income over 181 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 2015, 73 percent of enrolled ***hawk-i*** families paid a monthly premium and 27 percent paid no monthly premium amount.



According to the SFY2015 ***hawk-i*** enrollee satisfaction survey conducted by the third party administrator, 91 percent of respondents reported that the monthly premium was affordable while only two 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.

Budget

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.

Rebasing occurred in FFY13 using the allotments and expenditures from FFY12.

State Funding:

The total original appropriation of state funds for SFY15 was: $45,877,998.

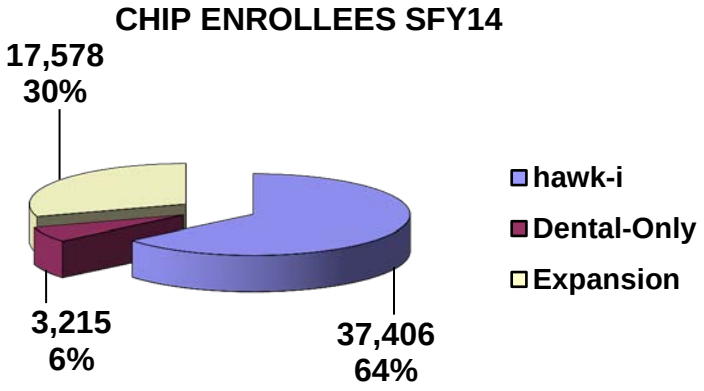
Available state funding for SFY15 appropriation includes:	
General Fund	$45,877,998
SFY14 ***hawk-i*** trust fund carried over to SFY15	$ 0
Total State Funding (prior to transfer $39,867,475)	**$45,877,998**

Available state funding for SFY15 appropriation includes:	
General Fund	$20,413,844
SFY14 ***hawk-i*** trust fund carried over to SFY15	$ 0
Total State Funding	**$20,413,844**

See Attachment One: Federal Funding and Expenditure History, SFY14 Final Budget, SFY14 Budget, and Orthodontia Cases.

Enrollment and Disenrollment

As of June 30, 2015, 58,199 children were enrolled in Iowa's CHIP program. Of the total number enrolled, 17,578 (30 percent) were enrolled in Medicaid Expansion (M-CHIP), 37,406 (64 percent) in ***hawk-i***, and 3,215 (6 percent) in the ***hawk-i*** Dental-Only program. It is projected that by June 30, 2015, the total number of children enrolled in CHIP will reach 60,024. Enrollment is projected to increase to approximately 62,005 in SFY16.



In the 12 month period between July 1, 2014, and June 30, 2015, total growth in Medicaid and CHIP equaled 8,466 children.

Enrollment Growth by Program
July 1, 2014 to June 30, 2015

Program	Enrollment July 1, 2014	Enrollment July 1, 2015	Enrollment Increase
Medicaid Children	259,400	267,372	7,972/ 3.1%
Medicaid Expansion	17,604	17,578	-26/ -.001%
hawk-i	36,200	37,406	1,206/ 3.3%
Dental-Only	3,901	3,215	-686/ -17.6%
Total Enrollment	**317,105**	**325,571**	**8,466/2.7%**

Number of Applications

From July 1, 2014, to June 30, 2015, the ***hawk-i*** program received 15,521 renewal applications.

Number of Children Disenrolled

Important Note: the member enrollment and termination process transitioned to the ELIAS system effective January 1, 2014. This new enrollment system does not report why a termination occurred and; therefore, it is not possible to identify the reason for why a termination occurred. Steps are being taken to collect this important information.

Quality

The department contracts with Telligen 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 activities performed in SFY15 are discussed below.

Annual *hawk-i* Provider Network Analysis

In March 2015, Telligen completed the Annual ***hawk-i*** Provider Network Analysis which assesses the proximity of ***hawk-i*** provider networks to ***hawk-i*** members. Essentially, accessibility standards for different provider types are compared to the location of members within the plan. Provider types that are assessed include primary care providers (family/general practice, pediatric, and OB/GYN providers), hospitals, behavioral health, and dental providers. The established guidelines are that 95 percent of members will have access to a provider within 30 miles to a primary care physician, hospital, or dentist, and within 60 miles for mental health providers. For this study, Telligen reported accessibility levels using two sources:

(1) Overall Method: accessibility analyzed using provider data submitted by Wellmark Health Plan of Iowa, UnitedHealthCare of the River Valley, and Delta Dental of Iowa;
(2) Focused Method: Telligen made phone calls to all providers in a specific region of the state (Region 1) to confirm accessibility.

Telligen concluded from their analysis that all of the ***hawk-i*** health plans met accessibility guidelines for the majority of the provider types. Specifically, in the area of family/general practice providers, 100 percent of UnitedHealthcare (UHC) and Wellmark Health Plan of Iowa (WHPI) members were within 30 miles of at least one provider using both the overall method and focused method. Member accessibility to providers through Delta Dental of Iowa was found to be 100 percent based on the overall method and 99.9 percent accessible based on the focused method. (Guideline is 1 dental provider within 30 miles.)

The areas where the health plans were found to have lower accessibility and in some cases did not meet the guideline were access to pediatric, OB/GYN, and mental health

providers. Accessibility to pediatric providers was found to be within the guideline for members with UHC (91.4 percent based on the overall method but only 42.5 percent using the focused method); and for WHPI access to pediatric providers was found to be 88.1 percent based on the overall method and only 38.7 percent using the focused method. Access to OB/GYN providers was found to be within the guideline for members with UHC (overall was 91.4 percent and focused was 42.5 percent) and with members with WHPI (overall was 98.0 percent and focused was 56.2 percent). Accessibility to mental health providers was found to be 100 percent for both health plans based on the overall and focused methods. An additional measure was undertaken for mental health providers, singling out mental health providers with prescribing authority and access was demonstrated for UHC to be 98.9 percent while WHPI demonstrated 100 percent accessibility within 60 miles.

Outreach – Four Required Focus Areas

Below is a summary of outreach strategies implemented at a statewide and local level in SFY15.

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. All local outreach coordinators have built relationships with school nurses to ensure uninsured children are connected to coverage. Many local outreach coordinators attend kindergarten roundups and school registrations to talk directly to families about healthcare coverage, and some are able to complete Presumptive Eligibility determinations on the spot so the children walk away with coverage. In some communities, outreach coordinators also work with guidance counselors, coaches, or teachers in order to reach uninsured children. The state ***hawk-i*** Outreach Coordinator attends the Iowa School Nurse Organization Conference twice a year to talk to school nurses about ***hawk-i*** and provide updated information about the program.

Several agencies work directly with their School-Based Sealant programs to provide ***hawk-i*** information to children whose parents request information on the release form. This is an excellent way to identify uninsured children who may be eligible for ***hawk-i*** or Medicaid.

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.

Many local agencies provide ***hawk-i*** materials to faith-based organizations through email list serves and mass mailings.

- One key to success in working with faith-based communities many ***hawk-i*** outreach coordinators have discovered is improving their partnerships within the community and with providers, community stakeholders, and leadership of faith-based organizations. Building these relationships allows the outreach coordinators to provide ***hawk-i*** materials to members, and establishes them as a trusted resource for families in need.

Outreach to Medical Providers:

Outreach coordinators provide direct outreach to Iowa's medical and dental providers to educate them about ***hawk-i***. 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.

- Since January 2014, hospitals and other provider types have had the ability to become Qualified Entities to provide Presumptive Eligibility for children and other populations. All of the local ***hawk-i*** outreach coordinators work with medical providers to encourage them to become Qualified Entities, or to establish a referral system to ensure uninsured children are able to access coverage.

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 ethnic 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. The state ***hawk-i*** outreach coordinator works closely with the IDPH Office of Minority and Multicultural Health, and presented on the ***hawk-i*** program to the Office's Advisory Council.

- An outreach coordinator in eastern Iowa works with the 6th Judicial board to provide ***hawk-i*** and Presumptive Eligibility to families with children that are working towards recidivism. This outreach coordinator also attends a variety of meetings throughout the service area to address special populations, including Immigrant Concerns, Civil Rights Commission, and Immaculate Conception Hispanic Outreach, among others.

Additional Outreach Activities:

The local grassroots ***hawk-i*** Outreach Coordinators focus on many different areas outside of the four required focus areas. They have a strong understanding of their community needs and have developed partnerships to ensure families in their service area are aware of the ***hawk-i*** program. They also work closely with other professionals who know which families need healthcare coverage and other services. Below are examples of additional outreach activities:

- Many coordinators work with insurance agents to identify children who need affordable healthcare coverage. They provide training and updated information and accept referrals from insurance agents.
- Outreach coordinators attend health fairs and community events to promote the ***hawk-i*** program and increase awareness. The outreach coordinators are always working on new and innovative ways to bring families to their booth to talk to them about ***hawk-i***, such as unique promotional items and fun activities for children.
- Several outreach coordinators work with tax preparers to provide information about ***hawk-i*** for families who were not aware of the tax penalty for not having health insurance.
- All outreach coordinators are encouraged to work closely with their I-Smile™ Coordinator to promote the ***hawk-i*** Dental Only program. I-Smile™ Coordinators provide care coordination for children who need dental care. They frequently work with local dental offices and in schools to find children who need dental care, and provide ***hawk-i*** Dental Only information to families in need of dental coverage who may qualify for ***hawk-i***.
- Outreach coordinators also utilize social media to promote the ***hawk-i*** program. The IDPH State Outreach Coordinator provides pre-approved social media content on a quarterly basis for local outreach coordinators to use.
- In the spring of 2015, the outreach coordinators met in four regional meetings to discuss current ***hawk-i*** outreach materials and make recommendations for improvements, updates, and potential new resources that would help families understand the ***hawk-i*** program.
- The IDPH state coordinator exhibited ***hawk-i*** information at several conferences, including the Iowa School Nurse Organization's Conference, Nurse Practitioner Conference, Risky Business, the Governor's Conference on Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ), the Immunization Conference, the Nurse Practitioner Conference, human immunodeficiency virus (HIV), Sexually Transmitted Diseases (STD), and Hepatitis Conference, Governor's Conference on Public Health, and several Farmers Markets.

Presumptive Eligibility

Iowa Code 514I.5(e) requires 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 (FQHC), local and area education agencies, maternal health centers, and birthing centers. As of September 30, 2015, there are 635 qualified entities that have been authorized to sign up children for the presumptive eligibility program. In SFY15, a total of 5,753 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***.

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

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

***hawk-i* Health Plan**	**SFY15 Monthly Capitation Rate**
UnitedHealthcare	$195.20
Wellmark Health Plan of Iowa	$208.22
Delta Dental of Iowa	$22.99

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, 2014 (for SFY15), the Board approved a 0 percent change for Wellmark Health Plan of Iowa, a 3.9 percent increase for United Healthcare, and no change for Delta Dental of Iowa.

SFY15 monthly capitation rates for the participating ***hawk-i*** plans will be:

***hawk-i* Health Plan**	**SFY16 Monthly Capitation Rate**
UnitedHealthcare	$202.75
Wellmark Health Plan of Iowa	$208.22
Delta Dental of Iowa	$22.99

See Attachment Four: History of Per Member Per Month Capitation Rate.

Board of Directors

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

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 of every other month; meeting agenda and minutes are available on the ***hawk-i*** program web site at www.hawk-i.org. Highlights from SFY15 board meetings are as follows:

July 2014
No Meeting

August 2014
The Board was updated on the following**:**

- Mr. Schlueter reported that the ***hawk-i*** program remains stable even considering the problems encountered while implementing the ACA. The eligibility determination and application process is maturing and becoming more established. The efficiency of processing ***hawk-i*** applications is improving.

- Overall enrollment is showing a stable trend; however, there has been shifting enrollment with Medicaid expansion enrollees, funded under Title XXI, increasing and ***hawk-i*** enrollment decreasing. This can be attributed to the changes in federal poverty levels and using the MAGI formula. Dental-only enrollment continues to decrease and may be attributed to administrative issues involved with the single-streamlined application being used now. Mr. Schlueter called on Sylvia Petersen, Department of Public Health ***hawk-i*** Outreach coordinator, to update outreach efforts across the state. Ms. Petersen reported that local outreach continues to highlight the dental-only program although there was still some confusion on using the new application. Tracy Rogers, the Department of Public Health I-Smile coordinator, gave an update on marketing plans they have and will conduct for the ***hawk-i*** dental-only program.

- Mr. Schlueter reported to the board that Jennifer Vermeer was leaving her position as IME Director. Ms. Vermeer moved to a position with The University of Iowa. Julie Lovelady was been appointed as Interim Medicaid Director.
  .

September 2014
No Meeting

October 2014
The Board was updated on the following**:**

- Mr. Schlueter reported that overall enrollment was showing an upward trend when looking at the retroactivity. The dental-only enrollment was still showing a decrease in numbers.

- Diane Barrett, from the DHS fiscal bureau, gave an update on the budget. Ms. Barrett said the projected enrollment was down for ***hawk-i***, but the spending was on target as budgeted.

- Mr. Schlueter informed the Board that CHIP would need reauthorization for federal fiscal year 2016, which began October 1, 2015. There was a general consensus that CHIP would be reauthorized. The Department is starting to get requests for information. There have been discussions of this at the federal level.

- Anna Ruggle reported that the State Plan Amendment (SPA) for funding for the Iowa Poison Control Center was submitted in draft format to CMS on September 30, 2014. The formal SPA will be submitted this week.

November 2014
No Meeting

December 2014
The Board was updated on the following**:**

- Mr. Schlueter reported that the Affordable Care Act had contributed to enrollment shifts. Overall, Iowa has a fairly low uninsured rate compared to states around us. He went on to say that the most reliable data was from 2013, as the data comes in from the implementation of the Affordable Care Act (ACA), will likely show that Iowa is doing a good job getting people into coverage.

- Mr. Schlueter called on Dr. Bob Russell for any comments on the falling dental numbers. Dr. Russell commented that due to the new single application process with the ACA, there had been delays in processing

which caused retroactive enrollment. Dr. Russell also noted his concern about the shift in participation from the ***hawk-i*** dental program to the Medicaid program. There was also a decrease in the number of dental providers taking Medicaid and a decrease in the percentage of people being seen. Mr. Schlueter said that this trend is being seen in Iowa and nationally. He noted that Medicaid reimbursement is lower than commercial plans and some providers are reluctant to take on large Medicaid populations.

- Mr. Schlueter gave information about a letter sent to all State Governors regarding the reauthorization or Children's Health Insurance Plan (CHIP) and upcoming renewal possibilities. Current CHIP funding ended on September 30, 2015. The Iowa Governor's office has joined others in calling for an additional two years of funding. There are options that may be used if CHIP funds are lost; however, that conversation will need to occur after much thought and initial planning.

January 2015
No Meeting

February 2015
The Board was updated on the following**:**

- Mr. Schlueter reported that the Affordable Care Act had contributed to enrollment shifts and the changes may be because of the Modified Adjusted Gross Income (MAGI) income guidelines. Overall, Iowa has a fairly low uninsured rate compared to states around us. He reported that data from 2014 should be available soon so we can see what trends there are in the states around us and look at our numbers in a bigger picture.

- Diane Barrett, DHS Budget Analyst, commented on the budget. Ms. Barrett referred the board to the reports and stated that although enrollment numbers were down, expenditures remained constant which may be attributed to the retroactive enrollment numbers each month.

- Mr. Schlueter gave an overview of a contact he made to The University of Iowa Public Policy Center. As a follow-up to previous board discussions on dental care in Iowa, he asked the Public Policy Center to provide an overview of dental coverage in Iowa and he asked if children's ***hawk-i*** dental care had been impacted in Iowa by the Iowa Dental Plan, available to Medicaid recipients, because of the eligibility guidelines. This may require commissioning a study to see how Iowa children are receiving dental services.

- Mr. Schlueter reported to the board about work being done implementing Medicaid Modernization as introduced in the Governor's 2016 budget. This

project would result in Iowa Medicaid transitioning administration to managed care through private companies. A request for proposal (RFP) regarding this initiative would be released in the near future. This plan may affect the administration of ***hawk-i*** and CHIP. Mr. Schlueter will conduct a conference call with the board after the RFP is released and provide more information.

April 2015

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

- Dr. Hansen recognized that two future board members were in attendance and asked for everyone to introduce themselves. New board members, who took official duties on May 1, 2015, are Eric Kohlsdorf and Kelly Renfrow.

- Dr. Hansen reflected on the recent death of board member Joe Hutter and reflected on what a truly great person he was and how she had enjoyed working with him through time on many civic projects. She asked that the Governor's office be contacted to request a card to be sent to Joe's family. There was also a card available for board members to sign. The board gave Joe a round of applause

- Mr. Bob Schlueter reported that enrollment numbers were beginning to trend upward and the significant retroactive numbers were beginning to lessen due to eligibility system demonstrating more timely results. Dental numbers were also trending upwards.

- Mr. Schlueter also reported that CHIP funding had been renewed by congress for the next two years.

- Dr. Hansen shared her concerns and questions about managed care and the role of the board in determining ***hawk-i*** governance.

- Mr. Schlueter addressed the questions. As he saw it, the Medicaid Modernization RFP essentially takes ***hawk-i***, and largely rolls it back into Medicaid, although the benefit package would stay the same as it is now. Dental coverage would remain a stand-alone program.

- Mr. Schlueter suggested a separate governing board would be needed for ***hawk-i*** under the new managed care model since ***hawk-i*** is now included alongside Medicaid as opposed to a distinct, private coverage. He noted that since the ***hawk-i*** board was legislatively established; however, he would expect that consideration of the future of the board's role would go through that process.

    - Diane Barrett, DHS Budget Analyst, noted that although enrollment numbers was down, expenditures remained constant which may be attributed to the retroactive enrollment numbers each month.

- Certificates of Appreciation were given to Bob Skow and Ruth Evans as they were retiring from the Board.

May 2015
The Board was updated on the following**:**

- Ms. Anna Ruggle reviewed the contracts that would be up for review by the Board. Delta Dental – new contract for one year with one year extension available. Per person cost is static at $22.99. Mr. Jim Donoghue and Mr. Eric Kohlsdorf moved to approve the Delta Dental contract and Ms. Angele Burke Boston seconded the motion to approve. Mr. Kohlsdorf asked for clarification on the time frame of the contract and Ms. Ruggle clarified that the dental program was carved out of Medicaid Modernization. Motion approved unanimously by roll call vote.

- UnitedHealthcare has a new contract. Their rate increase was requested at 3.8 percent per member per month, making the new monthly cost $195.97. The contract is essentially the same as previous and this is a six (6) month contract with a six (6) month extension available. Motion to approve contract by Ms. Burke Boston, second by Mr. Donoghue. Ms. Burke Boston asked a question about Hepatitis C drugs and the high cost. United Healthcare made an adjustment to normalize rates among CHIP population. Adjustment is .018%. Iowa is not currently experiencing any increase in use of Hepatitis C drugs.

June 2015
No Meeting

Attachment One

Federal Funding and Expenditure History
SFY13 Final Budget
SFY 14 Budget
Orthodontia Cases

Iowa's Federal Funding for Children's Insurance Program

Federal Fiscal Year (FFY)	Allotment	Balance carryforward (from previous years)	Retained dollars	Redistributed dollars	Supplemental dollars	Contingency fund payments	Total federal dollars available	total federal dollars spent	balance remaining	
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	$ 70,818,467	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	$ 91,561,200	$ 50,637,946	13
2013	$ 92,496,029	$ 50,637,946					$ 143,133,975	$ 108,536,473	$ 34,597,502	14
2014	$ 98,296,803	$ 34,597,502					$ 132,894,305	$ 106,050,723	$ 26,843,582	15
2015	$ 126,011,540	$ 26,843,582					$ 152,855,122	$ 114,483,336	$ 38,371,786	16
2016	$ 149,001,388	$ 38,371,786					$ 187,373,174	$ -	$ 187,373,174	17

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 supplemental 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 FY09 due to the CHIPRA legislation

11 Total federal dollars spent do NOT include the OIG adjustment. This adjustment will be done 1st qtr FFY11

12 Iowa received $29,517,883 as a contingency fund payment in FFY11 because Iowa experienced a shortfall in federal funding during the 4th quarter of FFY11, and qualified for the contingency fund payment by exceeding a target level of enrollees

13 The balance carryforward from FFY 2011 is from the contingency fund payment. Contingency funds are not always expended for CHIP related activities.

14 $24,652,065 of the carryforward amount from FFY12 is contingency funds

15 $12,039,162 of the carryforward amount from FFY13 is contingency funds

16 $8,775,391 of the carryforward amount from FFY14 is contingency funds.

17 $149,001,388 is the draft allotment projected for Iowa.

CHIP Program Budget - Preliminary
SFY 2016 - Preliminary

FY16 Appropriation	$ 20.413,844
Amount of ***hawk-i*** Trust Fund dollars added to appropriation	$ 0
Possible Outreach and PERM dollars from Medicaid	$ 0
Total state appropriation for FY14	$ 20,413,844
Federal Revenues Budgeted	$126,716,415
*Other Revenues Budgeted	$ 7,577,499
Total	$ 154,707,758

State dollars spent YTD	$ 0
Federal Revenue earned YTD	$ 0
Other revenues YTD	$ 0
Total Revenues YTD	$ 0

* other revenues include rebates and recoveries, client premium payments and ***hawk-i*** trust fund interest

	State Dollars	
Budget Category	**Projected Expenditures**	**YTD Expenditures**
Medicaid Expansion	$4,635,693	$0
hawk-i premiums (includes up to 300% FPL group)	$13,896,493	$0
Supplemental Dental	$162,029	$0
Processing Medicaid claims / AG fees	$722,073	$0
Outreach	$71,000	$0
hawk-i administration	$695,246	$0
Earned interest from ***hawk-i*** fund	$	$0
Totals	$19,745,075	$0

Orthodontia Cases SFY14

Delta Dental of Iowa

Month	Cases Approved	Cases Denied	Total Cases	Percent Approved	Percent Denied	Total Cost
July **2013**	39	40	79	49.37%	50.63%	$262,605.84
August	59	56	115	51.30%	48.70%	$170,282.71
September	67	53	120	55.83%	44.17%	$237,809.19
October	63	62	125	50.40%	49.60%	$314,896.33
November	56	57	113	49.56%	50.44%	$262,639.80
December	41	34	75	54.67%	45.33%	$211,455.77
January **2014**	47	41	88	53.41%	46.59%	$202,367.49
February	34	28	62	54.84%	45.16%	$164,675.78
March	31	42	73	42.47%	57.53%	$208,340.86
April	33	40	73	45.21%	54.79%	$200,360.40
May	46	43	89	51.69%	48.31%	$119,357.50
June	28	37	65	43.08%	56.92%	$156,765.73
Totals	**544**	**533**	**1,077**	**50.51%**	**49.49%**	**$2,511,557.40**

Note:

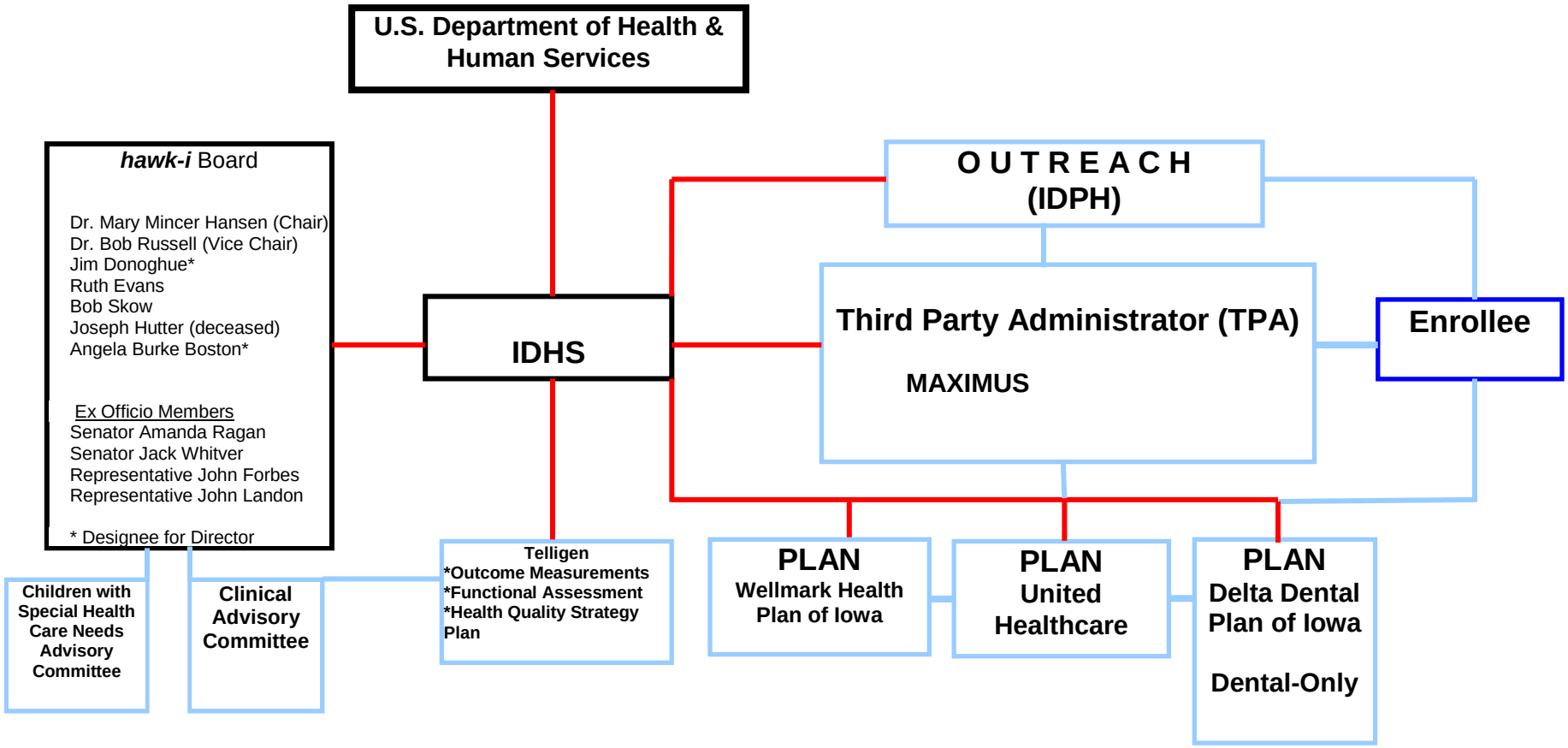
Cases are requests for orthodontic treatment, not the number of actual claims submitted.

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.

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.

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.

History of Participation

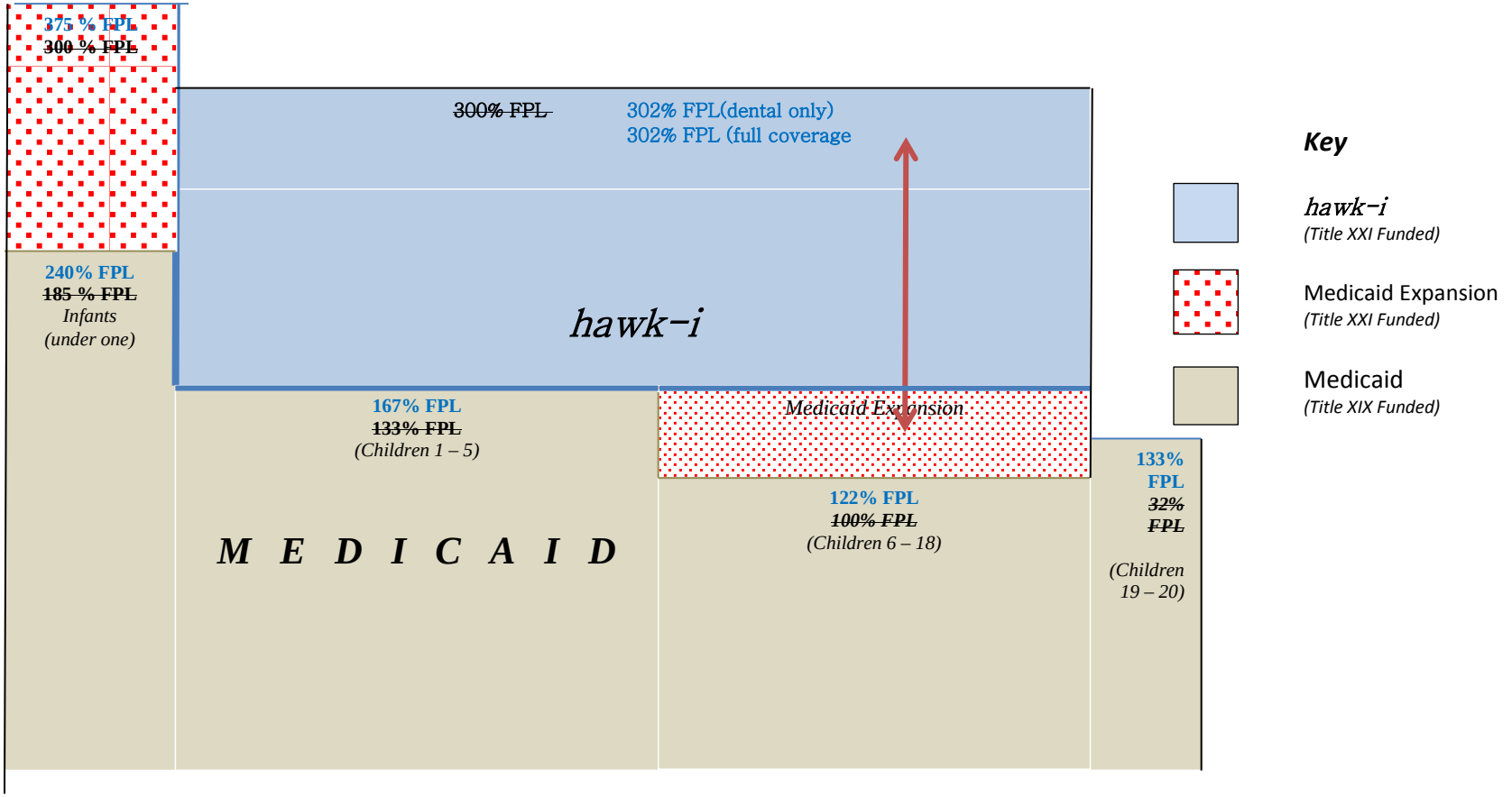
Month/SFY	Total Children on Medicaid	CHIP (Title XXI Program)		
		Expanded Medicaid*	*hawk-i* (began 1/1/99)	Dental Only (began 3/1/10)
SFY99	91,737			
SFY00 Jul-99	104,156	7,891	2,104	
SFY01 Jul-00	106,058	8,477	5,911	
SFY02 Jul-01	126,370	11,316	10,273	
SFY03 Jul-02	140,599	12,526	13,847	
SFY04 Jul-03	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
SFY 14 **June-14**	259,400	26,937	38,646	3,237
SFY 15 **June 15**	262,372	25,513	37,406	3,343
		Total CHIP Enrollment		**66,262**

Total Medicaid growth from SFY99 to present=	170,635
Total ***hawk-i*** enrollment growth from SFY99 to present =	37,406
Total Dental-Only growth from SFY10 to present=	3,343
Total children covered=	211,384

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

Iowa's Health Care Programs for Non-Disabled Children

MAGI Income Conversion Adjustment

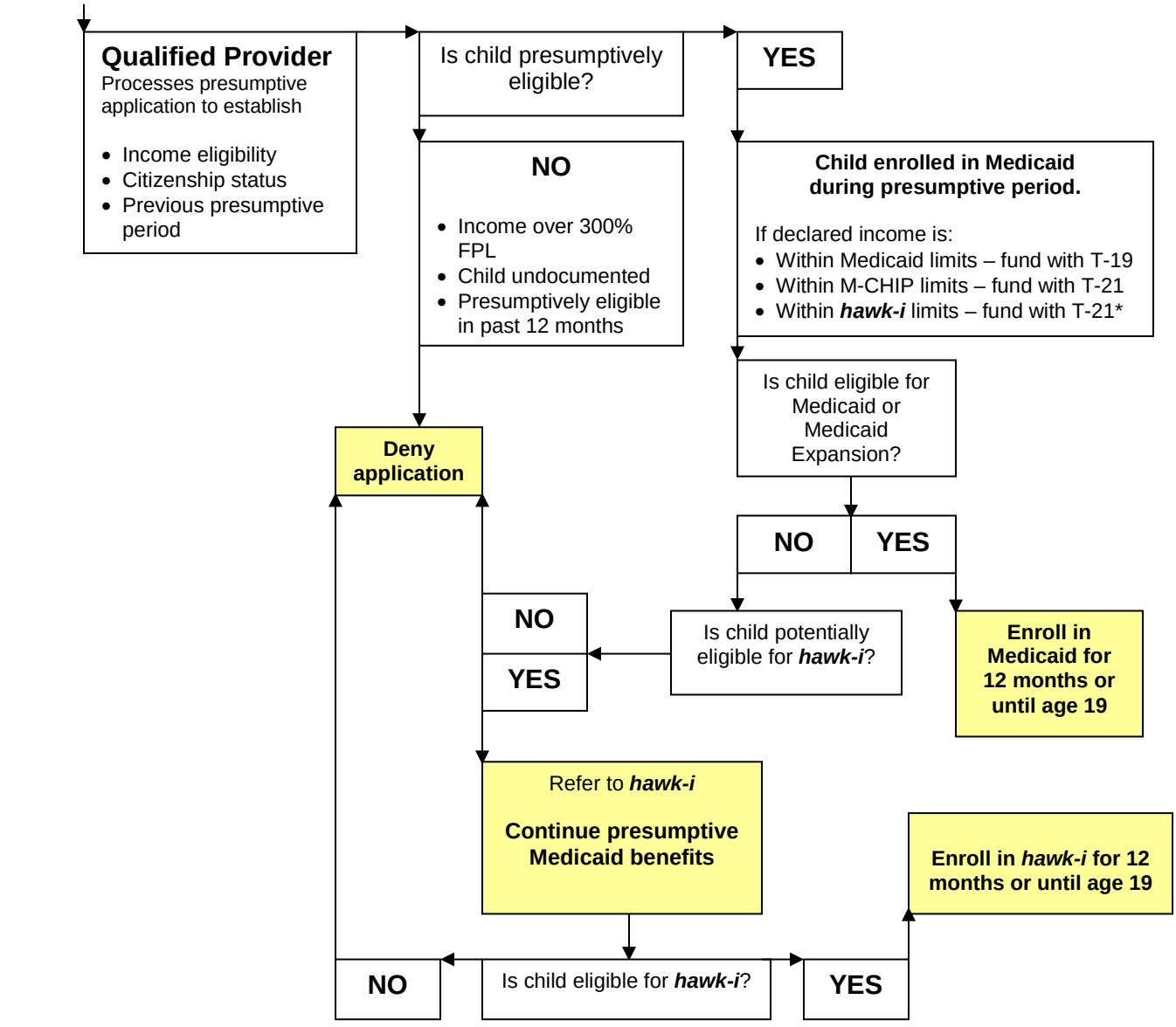


Attachment Three

Presumptive Eligibility for Medicaid

Presumptive Eligibility for Medicaid

Point of Entry



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

Attachment Four

History of Per Member Per Month Capitation Rate

History of Per Member Per Month Capitation Rate

PLAN	Federal Share	State Share	Increase Above Prior Year
SFY15			
UnitedHealthcare	$195.20 69.30% $135.27	 29.45% $59.93	3.46%
Wellmark Health Plan of Iowa	$208.22 $144.30	 $63.92	4.38%
Delta Dental of Iowa	$22.99 $15.93	 $7.06	0%
SFY2014			
UnitedHealthcare	$188.67 70.55% $133.11	 29.45% $55.56	3.9%
Wellmark Health Plan of Iowa	$199.48 $140.73	 $58.75	4.3%
Delta Dental of Iowa	$22.99 $16.22	 $6.77	1.0%
SFY13			
UnitedHealthcare	$181.59 71.71% $130.22	 28.29% $51.37	1.5%
Wellmark Health Plan of Iowa	$191.26 $137.15	 $54.11	5.5%
Delta Dental of Iowa	$22.76 $16.32	 $6.44	1.0%
SFY12			
UnitedHealthcare	$178.91 72.50% $129.71	 27.50% $49.20	1.4%
Wellmark Health Plan of Iowa	$181.29 $131.44	 $49.85	1.5%
Delta Dental of Iowa	$22.53 $16.33	 $6.20	0.0%
SFY11			
UnitedHealthcare	$176.44 73.84% $130.28	 26.16% $46.16	1.7%
Wellmark Health Plan of Iowa	$178.61 $131.89	 $46.72	3.0%
Delta Dental of Iowa	$22.53 ($1.35 extra for dental-only enrollees)		7.5%
SFY10			
UnitedHealthcare	$173.41 74.46% $129.12	 25.55% $44.29	2.0%
Wellmark HPI (Classic Blue Contract ended 9-30-09)	$173.41 $129.12	 $44.29	4.0%
Delta Dental of Iowa (Blue Access Dental contract ended 7/1/2009.)	$20.96 $15.61	 $5.35	2.2%
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 Five

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 the 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 the next meeting or immediately upon the resignation of the current officer(s).

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.

Board Members

As of July 1, 2015

Mary Mincer Hansen, Chair **Bob Russell, Vice Chair**

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