

HEALTHY AND WELL KIDS IN IOWA (*hawk-i*)
BOARD MEETING
MINUTES

April 16, 2007

BOARD MEMBERS:

Susan Salter, Chair
John Baker, Vice Chair
Julie McMahon (for Thomas Newton)
Angela Burke Boston (for Susan Voss)
Dann Stevens (for Judy Jeffrey) (absent)
Jim Yeast (absent)
Angelita Ramirez (absent)

LEGISLATIVE BOARD MEMBERS:

Senator Amanda Ragan (absent)
Senator James Seymour (absent)
Representative Polly Granzow (absent)
Representative Mary Mascher (absent)

DEPARTMENT OF HUMAN SERVICES:

Anita Smith
Shellie Goldman

GUESTS:

Diane Schroeder
Barbara Fox-Goldizen
Angie Doyle Scar
Jenny Hodges
Linda Sims
Diane Morrill
Kathy Shey
Nancy Lind
Gina Livingston
Lynn Tague
Dee Bradley
Carrie Fitzgerald
Eric Nemmers
Erin Paugh

AFFILIATION:

Delta Dental of Iowa
MAXIMUS
hawk-i Outreach Coordinator
Iowa Department of Public Health
Iowa Foundation for Medical Care
Iowa Foundation for Medical Care
Johnson County Visiting Nurse Services
AmeriChoice
AmeriChoice
Wellmark Blue Cross Blue Shield of Iowa
Jefferson & Keokuk County *hawk-i* Outreach
Child and Family Policy Center
Iowa Medical Society
Visiting Nurse Service

MEETING CALLED TO ORDER AND ROLL CALL:

The Healthy and Well Kids in Iowa (*hawk-i*) Board met on Monday, April 16, 2007, in the Levitt Room, Des Moines Botanical Center, 909 E. River Drive, Des Moines, Iowa. Susan Salter, Chair, called the meeting to order at 12:45 p.m. There was not a quorum present.

WELCOME, INTRODUCTIONS:

Ms. Salter asked the audience members to introduce themselves. Ms. Salter informed the guests that there would be an opportunity for public comment later in the agenda.

APPROVAL OF MINUTES OF FEBRUARY 19 AND FEBRUARY 22, 2007, MEETING:

Due to the lack of a quorum, approval of the minutes will be deferred until the June 18, 2007, meeting.

RECOGNITION OF OUTGOING BOARD MEMBER:

Ms. Smith stated that Board Member Jim Yeast elected not to be reappointed to the Board. The Department issued a certificate of recognition, signed by Director Concannon, expressing the Department's appreciation for all of Mr. Yeast's contributions and input into the Board.

A new Board member has been appointed. Dr. Selden Spencer's appointment is effective May 1st.

CORRESPONDENCE, REPORTS & OTHER STATE NEWS:

Anita Smith reported on news from other states:

Florida – The Florida legislature is considering a bill that would consolidate their SCHIP program to a new division within their department of health. They are also proposing to expand the program to cover dependents of state employees and certain legal immigrants. The bill also includes increased outreach funding to try to re-enroll the 120,000 kids who have lost coverage and to reach an additional 600,000 who have never been covered

Georgia – Governor Perdue has been one of the most vocal proponents for additional funding to get the shortfall states through the current fiscal year. However, the Georgia congressional delegation advised him that the state would have to come up with the money if the program will operate past March. There is a provision in the Iraq funding bill, but President Bush has already stated his intent to veto that bill. Governor Perdue has committed state-only funds to keep their program afloat until the additional federal funding becomes available.

Illinois – Governor Blagojevich has unveiled a plan to require all 1.4 million uninsured Illinois residents, including undocumented immigrants and non-resident students, to obtain health care coverage. Under his plan, every insurer in the state would be required to offer a standardized health plan to uninsured residents regardless of pre-existing medical conditions. His plan has three different components. The "Assist" plan is primarily for childless adults with income below 100% of federal poverty level (FPL) and who are not eligible for Medicaid or their Family Care program. "Choice" is a low cost insurance plan for residents up to 400% of FPL who can't get coverage through employers. They could get a state subsidy to help pay premium costs. People with

income greater than 400% of FPL could enroll in that plan, but they would not get a subsidy. There is also a rebate program that helps residents pay premiums for existing employer-sponsored plans. Participation in the program will be voluntary for the first three years, then become mandatory. Estimates are that over 500,000 people would sign up in the first three years.

Iowa – On March 14th the Des Moines Register ran an editorial highlighting the SCHIP funding formula and the impact on Iowa. The position of the editorial writer is that *hawk-i* should be funded like Medicaid, an open-ended entitlement so that all eligible children can be served, rather than having a capped funding program.

Louisiana – A plan is being considered to provide universal health care coverage to children in families with income up to 300% of FPL. Due to Hurricane Katrina, thousands of children lost coverage, or never got enrolled in their LaCHIP program. The state has lost track of people who were displaced, while others have lost employer-sponsored coverage. A media blitz is planned to get children into the program. The Governor is considering a mandate that all parents enroll their children in insurance plans or face penalties. Another consideration is to cover children of undocumented immigrants who are coming to the area looking for hurricane rebuilding work and are seeking care in emergency rooms. Had it not been for the hurricane and all the children losing coverage, Louisiana would also be a shortfall state.

Ohio – Is considering a plan that would expand Medicaid to 300% of FPL.

Oklahoma – The Oklahoma Senate has passed the “All Kids Act” to expand coverage to Medicaid-eligible children up to 300% of FPL.

Pennsylvania – Their plan to expand coverage to children up to 300% of FPL has been approved by CMS. Families with income up to 200% of FPL would not have to pay a premium. Premiums will be assessed on a sliding fee scale for families with incomes between 200% and 300%. However, children between 200% and 300% of FPL have to be uninsured for six months in order to qualify.

Texas – After several years of program cuts that have lead to a program loss of about 500,000 kids from their SCHIP program, legislation was introduced that is designed to help get kids back into the program. The legislation would return to a 12-month enrollment period (they had gone to 6-month reviews); eliminate the 90-day waiting period; require schools to provide SCHIP information to parents, increase the monetary value of vehicles; and allow a deduction for child care when considering income. Not all proposals were adopted, the legislature did eliminate the 90-day waiting period, increased the enrollment period to 12 months, and increased the amount of assets a family could have, but did not eliminate the asset test.

Washington – A bill has been passed by the Washington legislature that will expand health care coverage to children of families with incomes below 250% of FPL and increase to 300% beginning in 2009.

Wyoming – Has submitted a state plan amendment to expand their SCHIP program to cover parents. However, with the funding shortfalls, and the position that “there is no “A” in SCHIP” taken by some key Congressman, it is unclear whether CMS will approve that state plan amendment.

Citizenship Requirements – Three articles were provided to the Board that discussed the new citizenship requirements and their impact on Medicaid enrollment. While the verification requirements do not apply to SCHIP, there are several Congressmen who have stated they plan to expand those requirements to the SCHIP program. Currently there is an indirect impact because approximately 40% of families that apply for SCHIP are referred to Medicaid. If they do not cooperate and it turns out they are not eligible for Medicaid, they cannot come back to the SCHIP program.

Other News – According to a “Washington Times” report, the U.S. Census Bureau has overestimated the number of uninsured U. S. residents by nearly 2 million people since 1995 due to a computer programming error. Ms. Smith said that she has been told that the impact on the Department’s uninsured estimates will be negligible.

A recent Robert Wood Johnson Foundation report, “Whose Kids are Covered? A State-by-State Look at Uninsured Children” used a three-year average between 2003 and 2005.

Uninsured	0 – 5 Years	6 – 12 Years	13 – 18 Years	All 0 – 18 Years	Total Number Uninsured
Iowa	8.3%	6.3%	6.4%	6.9%	51,084
U.S.	10.2%	10.6%	13.7%	11.5%	8,960,547

The report identified that 66.1% of all Iowa uninsured children are under 200% of FPL; which would put the uninsured rate under 200% of FPL at 4.7%. This means that 34,500 uninsured children could potentially qualify for our programs.

Iowa generally is ranked in the top 5 for the lowest uninsured rate. This report ranks Iowa at 9, compared to Vermont at 5.6%; New Hampshire at 6.0%; and Michigan 6.1%. Nebraska is at 6.5% and Kansas 6.8%. The three highest uninsured states are: Texas, 20.3%; Florida 16.9%; and New Mexico at 16.6%.

ADMINISTRATOR’S REPORT:

Enrollment and Statistics:

Total SCHIP enrollment as of March 31, 2007, was 37,693; with 21,635 enrolled in *hawk-i* and 16,058 in Medicaid Expansion. Compared to one year ago, the program is steadily growing at 3.6%.

SFY '07 Budget Update:

SFY 07 expenditures to date are \$12,854,123. Of this amount, \$3.9 million has been spent on Medicaid expansion; \$8.9 million on *hawk-i* premiums; \$72, thousand on

outreach; and \$297 thousand on *hawk-i* administration. Interest earned from the *hawk-i* trust fund is \$333,917.

Federal Funding Shortfall Options:

Ms. Smith reported that discussions have been held about what would happen if Congress does not authorize additional federal funding in the last quarter of FFY 07. Projections are that there will be enough federal funding to get through the state fiscal year, which ends June 30th. However, July through September, there is a federal dollar shortfall of approximately \$13.4 million.

Options:

1. Appropriate additional state funds (\$13.4 million) to supplement federal funding shortfalls to cover July through September, 2007.
2. Establish a waiting list beginning May 1 and disenroll approximately 13,200 children beginning July 1 to stay within available resources.

Ms. Smith said that this is not as easy as it sounds. Several years ago the Board was asked to come up with options if Iowa ran out of either state or federal money. At that time the Board directed the Department to promulgate rules to go to a waiting list when it was determined that all funds were going to be exhausted. Ms. Smith said that in this case, the waiting list should have been implemented back in October 2006 in order to have enough funds, so at this point in time it would require disenrollment as well. Prior to actually disenrolling kids they will have to be evaluated to see if they could now qualify for Medicaid.

All new *hawk-i* applications beginning no later than May 1st would have to be held and thoroughly evaluated for Medicaid. Currently there is just a Medicaid screen and enroll requirement. Notices would have to be issued in June to families of 13,200 children for July 1st cancellation. Administrative rules would need to be promulgated because the current rules only address the waiting list. The rules would have to define the disenrollment process, whether it is last in, first out, or other parameters.

3. Eliminate the Title 21-funded Medicaid expansion program entirely and submit a state plan amendment to cover these children under Title 19-funded Medicaid. This could be accomplished through an income disregard under 1902(r)(2) (the Social Security Act) to disregard income between 100% and 133%. As a result, the regular Medicaid program would cover these children and all Title 21 funding could then be directed toward the separate SCHIP program (*hawk-i*). This option would be transparent to families, there would be no change in benefits for the children affected.
4. Discontinue the *hawk-i* program in its entirety and move from a combination program to a Medicaid expansion only program effective July 1. The state would continue to receive federal funding at the reduced Medicaid FFP rate when the

Title 21 funding is exhausted. This option would require legislation and rules. Currently Iowa Code Chapter 514I mandates the Department to have a separate program and contract with a third party administrator and commercial health plans. This option would require the termination of multiple contracts, including MAXIMUS, Wellmark, AmeriChoice, Delta Dental, Department of Public Health, Iowa Foundation for Medical Care, Health Management Systems, and the Department of Education. Additional field and systems costs would have to be factored in and it would require an additional \$11.4 million to supplement the FY 08 state Medicaid budget request.

The Department's Medicaid eligibility system is not compatible with the MAXIMUS eligibility system so it may be difficult if not impossible to systematically transition kids from one program to another. Each case would have to be entered into the system. In theory, no children would lose coverage, however, due to the policy differences between Medicaid and *hawk-i* some children may no longer qualify. For example: Medicaid requires proof of citizenship and identity; Medicaid does not allow depreciation of capital assets for people who are self-employed; *hawk-i* cannot require a social security number, Medicaid does. Many children may have to change providers due to differences in provider networks.

Since Medicaid is an entitlement program the state could not cap enrollment to limit benefits. A possible unintended consequence is that approximately 40% of the children applying for *hawk-i* are Medicaid eligible. If families are no longer able to apply for *hawk-i*, which is not perceived as a welfare program, the state may not continue to realize the reduction in the number of uninsured kids at the same rate as in the past.

5. Follow Georgia's example and address the SCHIP shortfall by temporarily using state funds earmarked for Medicaid. Georgia is changing a state law to allow them to borrow state funds already slated to be used for Medicaid costs to cover the SCHIP shortfall. If additional federal dollars are not appropriated, a supplemental request will be made for Medicaid dollars used to fund SCHIP.

After internal meetings and receiving advice from the outside, the Department is drafting language to include in the Department's appropriation bill to provide flexibility so that in the event Iowa is not made whole for FFY '07, 100% state SCHIP dollars can be used to maintain the program as it is currently designed. The current budget request is \$23 million. The Department is asking for authority to use the funding to maintain the program in the interim. In the event there is not enough federal money by October 1, 2007, the Department has asked for authorization to use state funds from the Medicaid program. A supplemental appropriation would be requested next year to replace the Medicaid money.

Ms. Smith said she participated in a conference call last week and the states were strongly advised not to do option 3 or 4. One state moved their kids to Medicaid, but later found the perception is that they have taken care of their problem so they did not need additional SCHIP funding.

Ms. Smith said that before options 1, 2, 3, or 4 could be implemented, the Board would have to give their approval in order to give direction to the Department on the administration of the *hawk-i* program. They would not under Option 5 because it does not change the structure of the program.

Ms. McMahon asked about the potential of more states becoming shortfall states as their SCHIP programs grow, and the impact that could have on future allotments, particularly with the number of states increasing the income levels to 300% of FPL. Ms. Smith responded that some states are not relying totally upon federal allotments but are using other funding streams such as tobacco revenues.

Reauthorization

Ms. Smith and Carrie Fitzgerald, Child and Family Policy Center, reported on the status of SCHIP reauthorization.

Ms. Smith said that NASHP convened a group of SCHIP directors to develop policy changes as part of reauthorization. The National Governor's Association released their principles on reauthorization as well. Ms. Smith said that both groups were close on what they agree should happen.

Basic principles are:

1. Funding should be renewed and increased substantially to provide sufficient and predictable funds for states to effectively manage programs and reduce the number of uninsured.

If the funding is not increased next spring, Iowa will have a larger shortfall, probably in the range of \$20 – \$30 million, instead of this year's \$12 - \$13 million range. Part of the problem is that states are at different points with their programs. Some states have already increased the income levels up to 300% – 350% of FPL, but 9 states are below 200%. The northeastern states point out that the cost of living is so high, that what you can buy with 200% of FPL in Georgia is twice as much as you can buy in Connecticut. They question whether it is fair to apply the same poverty level standard across the country? All states agree that the funding formula needs to be revisited. They are concerned about the numbers of uninsured children being used in the formula because states get penalized because the better they are at decreasing the number of uninsured, the fewer dollars are available. The number of children enrolled is not factored into the formula.

2. SCHIP and Medicaid play vital, complementary roles in covering children and adolescents, and each program needs to be maintained and strengthened.

Due to the federal "pay as you go" requirements, Congress is considering putting more money into SCHIP by taking it from Medicaid. States do not want to see this happen. States want the option to cover legal resident children and state employees and maintain flexibility in the program. For example, the option to let

families choose between Medicaid and SCHIP. One of the issues Ms. Smith said she raised is that states with separate programs are discriminated against because they chose a separate program. In Medicaid, state employees can be covered, under a separate SCHIP program they cannot. In Medicaid there is no administrative cap, there is in SCHIP. Medicaid kids can have other insurance, SCHIP kids cannot. So even though states were given the option of how to design their program, states are penalized for not doing a pure Medicaid expansion. Currently 39 states have a separate SCHIP program.

3. The progress that states have achieved in simplifying enrollment for children and families should be supported and not hampered by federal program requirements.

States do not want the citizenship and identity requirements in SCHIP, they would like to see them rescinded. All of the directors want flexibility to implement express lane or auto enrollment systems. Express lane is a concept that if a child is eligible for one federal means-tested program they would not have to prove eligibility for a program with eligibility criteria that is equal, or less than equal.

4. State flexibility in specific areas of program design has been an important component of SCHIP's success and should be supported and enhanced.

More flexibility to coordinate with private coverage. States would like to see single coverage plans such as a dental only plan or being able to better coordinate with private health insurance.

5. States should be supported in their efforts to improve program performance and promote access to quality care.

There is a lot of concern about quality. States don't want unfunded mandates, for example, Payment Error Rate Measurement (PERM). That was an unfunded mandate and will impact the administrative cap.

The National Governor's Association wants Congress to fill the shortfalls prior to reauthorization, provide predictable federal funding, and maintain flexibility. Reauthorization should not include any unfunded mandates or restrictions that would reduce state flexibility with SCHIP. They want options to provide health care insurance to state employees, to expand coverage to otherwise eligible children including legal immigrants, pregnant women, and those eligible for teacher dependent coverage. They want to repeal crowd out language that doesn't apply to states under 200% of FPL. There has been a lot of talk about doing outreach at the federal level but states feel that it should be an option because if they do a lot of outreach at the federal level without state matching dollars available, it is a promise that can't be fulfilled. They agree to eliminate the barriers that don't apply to Medicaid and the 10% administrative cap.

Ms. Smith told the Board that the Governor's budget request includes additional money for expanded coverage and outreach for both Medicaid and *hawk-i* to cover 25% of the estimated uninsured children.

Ms. Fitzgerald told the Board that last week she was with Congressman Loeb sack in Ottumwa. Approximately 35 people were in attendance including several pediatricians and a family whose children receives *hawk-i*. Participants told the Congressman that they are very concerned that the supplemental funding is attached to such a controversial bill (Iraq War funding). They don't think children's health insurance should be on such a controversial bill and Iowa needs someone in Congress to move that legislation somewhere else. Ms. Fitzgerald said that in a recent meeting with Congressman Boswell he was told the same thing. Ms. Fitzgerald said that she was asked if supplemental funding was not received, how many children would be affected. She responded that 13,200 would be disenrolled. Ms. Smith said that when she testified in Washington earlier this year, the numbers had not been updated so her response was that 15,000 would be disenrolled because at that point a \$15.4 million shortfall was projected.

Ms. Fitzgerald shared summaries of the bills Ms. Smith referenced along with an amendment that was discussed when the Senate was voting on the \$50 billion for SCHIP reauthorization. This shows how the Senators voted and what the amendments were. The bill that is out now is the "Children's Health First Act", which is the Dingell/Clinton bill. A lot of the recommendations made by the SCHIP Directors and National Governors Association are in this bill. A bill that is receiving a lot of attention is the Rockefeller/Snowe bill which is a bipartisan bill. Both bills are based on an additional \$50 billion appropriation (President Bush's budget is for \$5 billion for SCHIP). Another bill is the "Children's Dental Health Improvement Act of 2007" by Dingell. Dental health is getting a lot of press right now and there is interest in how dental can be included in SCHIP reauthorization, particularly the wrap around services. If a child had private insurance but not dental coverage they could access dental through SCHIP.

PUBLIC COMMENT:

No public comment was received.

OUTREACH:

Kathy Shey, a social worker with Visiting Nurse Association Johnson County, was invited to brief the Board on outreach activities in her area.

Ms. Shey said her role is to provide social work services at the child health clinic at the public health office. She said they used to see a lot of Medicaid kids at the clinic but that is no longer the case as they have been encouraged to have their own medical home. Now most of the children seen at the clinic are uninsured.

Ms. Shey said she has a very imaginative assistant who conducts most of the *hawk-i* outreach activities in the area. She has very good contacts in the community and is

really good at working with families to educate them about **hawk-i** and assisting them with the application process. In April she is targeting hair salons.

Ms. Shey is a member of the empowerment board in her area and talks about **hawk-i** at their monthly meetings. Several city council members were at one of these meetings and suggested she talk with the city about what they can do to get involved. As a result, a **hawk-i** flyer was enclosed with each water bill that was mailed in Iowa City.

Angie Doyle Scar, state outreach coordinator, said that when other outreach workers heard about this success they were excited about doing the same thing in their communities. They requested a Spanish version, and as a result, Ms. Smith's staff has revised the "**hawk-i** stuffer", making it a little larger so that it has English on one side and Spanish on the other. These will be available for order around June 1st.

A medical student at the University of Iowa is working with the local medical association group on covering the uninsured. They will be providing **hawk-i** information at the presentations they do. This group is also arranging for **hawk-i** information to be included in the "Val-Pak" mailing that is done in the Iowa City area, particularly the rural areas.

Ms. Shey told the Board the most successful outreach is when she can talk directly to parents. She is able to assess the situation at the time and work with the family. This is much more effective than just handing out flyers and applications and hoping families read them.

SFY '08 HEALTH PLAN RATE REQUESTS:

Ms. Smith said that the Department is waiting for the actuary's report before bringing the rate requests to the Board. Once that information is available, the Department can make their recommendation, based on the budget available.

Wellmark has requested a 3.4% increase for both their indemnity and managed care plans; AmeriChoice has requested 6%; and Delta Dental a 9% increase.

IMMUNIZATION STATUS OF CHILDREN ENROLLED IN THE *hawk-i* PROGRAM:

Diane Morrill, Iowa Foundation for Medical Care, discussed their March 2007 report with the Board.

The Clinical Advisory Committee asked IFMC to complete a study of the immunization status of **hawk-i** children to determine if changes in recommended immunizations were occurring. Specifically, to determine the number of children who had received a meningococcal vaccine (which was added to the immunization schedule in 2006) and the number of children who received a Tdap (tetanus, diphtheria, and pertussis booster) rather than the Td (tetanus and diphtheria booster).

A sample of children age 11 to 18 during calendar year 2005 was selected. These kids were either in Wellmark or AmeriChoice during the time frame. Records were requested from physician offices for 631 children for a total of 1,766 requests. One child could have been seen in as many as 5 different offices according to encounter data claims. Over 97% of the requests were responded to. The Iowa Department of Public Health's Immunization Registry Information System was also used for records for the children used in the study, for a total of 634 *hawk-i* members used in this study.

Once the medical records were received the immunization records were put in a database and trained abstractors reviewed the immunization records. A statistician did the overall evaluation and came up with the results in the report.

These results were compared to last year's report. The outcomes are not good compared to the 90% goal rate; but there is a slight increase in immunization since last year's results. Ms. Morrill said she is hopeful that when next year's data is reviewed they will see a trend that kids are getting their immunizations at a greater rate.

Children age 11 to 18 are the recommended age group for the two new recommended immunizations. Immunizations these children have received from birth are included, so even though the children were not enrolled in *hawk-i* at the time most of these immunizations were given, it is hoped that the current physician is getting records from previous providers.

Ms. Salter asked Ms. Morrill if the Board could assume that this report is not a very accurate record of the actual immunizations, because it seems like a low number. Ms. Morrill responded that they have to take into consideration that the providers giving immunizations 16 years ago are probably not the child's provider today. Incomplete or inaccurate documentation on the provider part is the biggest downfall; there is no way to get immunization records from 16 years ago. Ms. Salter said that the Board would not want to say that 36% of the children had their DPT, because hopefully that is not correct. Ms. Smith added that the children could not be in school if they were not up-to-date on their immunizations. Ms. Salter said she is very concerned that this report only reflects what the medical records contain, not whether the not a child has received an immunization.

Shellie Goldman said it has been her experience working with Medicaid and *hawk-i*, that this is a very transient population and difficult to have 100% accuracy when doing a records review. Not all doctors participate in the Department of Public Health's registry, so a child may have visited a rural health clinic and were referred to another place for immunization because these clinics generally don't store these vaccines.

Ms. Smith added that she is concerned about the perception too. This report would indicate only 36% of *hawk-i* children had the vaccine, when it is not a symptom of the program, but a symptom of recordkeeping and the availability of data. Ms. Smith asked Ms. Morrill if she had any suggestions. Ms. Morrill responded that unless the providers are mandated to have this in their records, there is no way to know. Ms. Smith asked if a better source of records would be through the schools? Since these immunizations

are required for school enrollment, it would be safe to assume 100% immunizations for school children unless they are home schooled.

Ms. Smith said she is concerned that if there are very strict expectations or standards placed on states to get data that is not readily accessible, how will states prove they are meeting quality standards.

Ms. Salter said she questions the value of doing the study if they know that the data isn't valid. Ms. Smith suggested the Board have a discussion with the Clinical Advisory Committee at the June Board meeting to discuss their focus of study, the availability of data, and how valuable it is.

OIG REPORT: "FRAUD AND ABUSE SAFEGUARDS IN SEPARATE CHILDREN'S HEALTH INSURANCE PROGRAMS":

Iowa was one of six states chosen to be in this program study for the year 2005. The study report was published in March 2007. The report presents an overview of the findings, but does not contain state-specific findings. The other five participating states were Massachusetts, Michigan, New York, Pennsylvania, and Texas.

The purpose was to assess the extent to which the states have met requirements to establish safeguards for SCHIP fraud and abuse prevention, detection, and investigation and to assess the state's oversight of SCHIP contractors and CMS's oversight of the states.

Ms. Goldman said that the

Ms. Goldman said she contacted the CMS representative to see if she could get the specific findings for the State of Iowa. OIG said they weren't sure if they had the information broken out like that, but would try to get something to the Department. Ms. Goldman said that Iowa has procedures in place for detecting fraud and abuse. There is a contract with DIA, who is notified when the Department is made aware of fraudulent activity, 600 eligibility reviews are done each year, insurance matches and Medicaid matches are performed, and the Department works closely with the health plans who have fraud and abuse plans in place. IFMC also does a review of claims submitted to the state and does a medical record review to see if there is an encounter that did take place. The PERM study gave Iowa 100% accuracy.

CHILDREN'S FREE AND REDUCED MEALS INFORMATION SHARING:

Ms. Goldman told the Board that on April 11, 2007, Food and Nutrition Services, U. S. Department of Agriculture, issued final rules establishing requirements for disclosure for children's free and reduced-price meals or free milk eligibility information. The rule states that child nutrition programs *may* disclose eligibility information to persons directly connected with state Medicaid and SCHIP programs when parents/guardians do not decline to have their information disclosed. The information that is disclosed will be used by the Department to identify eligible children and seek to enroll them. School child nutrition programs must have a written agreement with the state or local agency or agencies administering the Medicaid or SCHIP program prior to disclosing the child's eligibility information.

The Department currently has a contract with the Iowa Department of Education and when they send out their applications for the program, the form contains disclosure information. Parents that do not want their information disclosed will sign the form. Currently, there is no requirement that schools participate. There is a memorandum of understanding that willing schools send in the file of eligible children to MAXIMUS every school year. There are a number of schools that do this, but there are many that don't. Last year MAXIMUS mailed 17,433 applications to potential enrollees through this program.

The Department's appropriation bill this year includes language for a new subsection which states: "Each school district that operates or provides for a school breakfast or lunch program shall provide for the forwarding of information from the applications for the school breakfast or lunch program, for which federal funding is provided, to identify children for enrollment in the medical assistance program pursuant to chapter 249A or the healthy and well kids in Iowa program pursuant to chapter 514I to the department of human services."

NEW BUSINESS:

There was no new business.

The meeting was adjourned.

The next regular *hawk-i* Board meeting is scheduled for Monday, June 18, 2007, at 12:30 p.m. at the Des Moines Botanical Center, Levitt Room, 909 Robert D. Ray Drive, Des Moines, Iowa.