

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

June 15, 2009

BOARD MEMBERS:

Susan Salter, Chair
Dr. Selden Spencer, Vice Chair
Angela Burke Boston (for Susan Voss)
Jim Donoghue (for Judy Jeffrey)
Julie McMahon (for Thomas Newton)
Kim Carson

LEGISLATIVE BOARD MEMBERS:

Senator Amanda Ragan *
Senator David Hartsuch *
Representative Linda Upmeyer *
Representative Eric Palmer (absent)

**Participated via telephone conference call*

DEPARTMENT OF HUMAN SERVICES:

Anita Smith
Anna Ruggle
Shellie Goldman
Mike Baldwin
Ann Wiebers

ATTORNEY GENERAL'S OFFICE:

Brad Horn

GUESTS:

Michelle Lickteig
Diane Ellis
Lynn Tague
Nancy Lind
Cindy Oraine
Kristine Klauer
Kaye Kellis
Jeremy Morgan
Tracy Rodgers
Diane Schroeder
Carrie Fitzgerald
Andrew Berg
Molly Kottmeyer
Sue Lerdal

AFFILIATION:

Delta Dental of Iowa
Marion County Public Health
Wellmark Blue Cross Blue Shield of Iowa
UnitedHealthCare
UnitedHealthCare
UnitedHealthCare
Iowa Department of Human Services
MAXIMUS
Iowa Department of Public Health
Delta Dental of Iowa
Child & Family Policy Center
Child & Family Policy Center
Iowa Department of Human Services
Legislative Service Agency

MEETING CALLED TO ORDER AND ROLL CALL:

The Healthy and Well Kids in Iowa (*hawk-i*) Board met on Monday, June 15, 2009, at the Department of Human Services office, 1st Floor Conference Room SE, Hoover State Office Building, Des Moines, Iowa. Susan Salter, Chair, called the meeting to order at 12:30 p.m. A quorum was 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 APRIL 20, 2009, MINUTES:

Selden Spencer made a motion to approve the April 20, 2009, minutes. Kim Carson seconded the motion. Angela Burke Boston cited three typographical/grammatical errors in the minutes. Angela Burke Boston, Selden Spencer, Jim Donoghue, Julie McMahan, Kim Carson, and Susan Salter unanimously approved the minutes with corrections.

APPROVAL OF MAY 18, 2009, MINUTES:

Angela Burke Boston made a motion to approve the May 18, 2009, minutes. Julie McMahan seconded the motion. Angela Burke Boston cited a grammatical error on page 4 of the minutes. Angela Burke Boston, Selden Spencer, Jim Donoghue, Julie McMahan, Kim Carson, and Susan Salter unanimously approved the minutes with the correction.

CORRESPONDENCE, REPORTS & OTHER STATE NEWS:

Anita Smith reported on SCHIP news from other states.

Alabama – The Alabama legislature approved increasing the state's ALL Kids program to 300 percent of the federal poverty level (FPL). Families will pay \$100 per year for a child to participate with a \$300 family yearly maximum. Alabama charges an enrollment fee rather than charging a monthly premium.

California – Could become the first state in the nation to end their CHIP program. Voters rejected measures to increase taxes, borrow funds, and reapportion state money that was designed to close the state's budget gap. Therefore, Governor Schwarzenegger is proposing to phase out California's CHIP program in order to save \$570.2 million in fiscal years '09 and '10. California did reach an agreement with the Obama Administration to avoid forfeiture of federal stimulus funding by reinstating the cuts that they had made to their Medicaid program in July 2008. Even with the restoration of \$10 billion in supplemental stimulus funding, California cannot afford the Medicaid program as it is currently structured and the state is projecting a budget deficit of \$24 billion through June 2010.

Delaware – Is considering expanding their CHIP program to 200 percent of FPL with premiums of \$10 and \$25 per month. Families over 200 percent of FPL could buy into the program for a premium of approximately \$110 per child per month.

Florida – A proposed bill would streamline the Florida KidCare program by shortening the time families have to wait to get KidCare after losing private health insurance. The bill would also shorten the time a family has to wait to re-enroll in the program after disenrollment for not paying a premium.

Hawaii – Governor Lingle eliminated the Keiki Care program in October 2008, a few months after it began. As a result, lawmakers are planning on re-establishing the program by including \$600,000 in various appropriations bills instead of passing a single bill that could be vetoed. Governor Lingle opposes the funding saying she believes it will be wasted on providing no cost coverage for children of families who can afford the insurance and the state should not seek to increase frivolous spending at a time when the budget must be decreased overall.

Kansas – May have to cancel recently passed CHIP program expansions because of budget shortfalls projected to be more than \$328 million. Cuts cannot be made to the Medicaid program, so administrative cuts of 10.6 percent are anticipated, which will result in increased caseloads and inability to process applications within the required federal timeframe.

New Jersey – Although they cover children up to 350 percent of FPL, and have mandatory universal health insurance coverage for kids, there were 360,000 uninsured children for part of 2008. A report identified the reasons for the increased uninsured numbers as: families are unaware of the program; families are overwhelmed by the enrollment verification requirements at application and renewal; families cannot afford the monthly premiums; and a huge proportion come from families with at least one noncitizen member who do not understand that their citizen children can qualify for the program.

North Dakota – The legislature defeated a bill to increase their CHIP income level to 200 percent of FPL. North Dakota remains the state with the lowest income level at 150 percent of FPL.

Oregon – The legislature agreed on an expansion to cover children up to 200 percent of FPL, and subsidized commercial coverage for families with income up to 300 percent of FPL.

Texas – A bill is being considered by the legislature to expand coverage to children up to 200 percent of FPL. Texas currently has the highest percentage of uninsured children, 22 percent. The national average is 12 percent. Also under consideration is implementation of annual renewal periods rather than six-month renewals.

ADMINISTRATOR'S REPORT:

Budget Review:

Ms. Smith discussed the **hawk-i** program's SFY '10 state budget. Total state appropriation is \$25,004,175. This includes:

\$14,629,830	General Fund appropriation
4,654,044	hawk-i Trust Fund (estimated carry over)
1,654,058	HF 2539 funding (health care reform bill)
3,899,654	Government stabilization funding
166,600	Medicaid outreach and PERM funding

Estimated expenditures for SFY '10 total \$24,155,093.

Enrollment and Statistics:

Ms. Smith reported that total CHIP enrollment in May was 42,318; 21,273 enrolled in Medicaid expansion and 21,045 in **hawk-i**. This is a 7.8 percent increase since May 2008.

State Legislative Update:

Senate File 389, includes a number of directives for the Department to implement during the next year. At the same time, new requirements because of CHIPRA, the American Recovery and Reinvestment Act of 2009 (ARRA), and HF 820 will be implemented. Ms. Smith discussed the timeline for implementation of these changes.

Authorizing Legislation	May-09	Jul-09	Sep-09	Jan-10	Mar-10	TBD
SF 389	Submit 1 pay stub as verification on earned income when indicative of future income	Expand hawk-i to 300% FPL		Establish hawk-i family cost sharing & graduated premiums based on a rationally developed sliding fee scale for families over 200% FPL	GOAL 3/1/10. Premium Assistance Program for hawk-i & Medicaid under CHIPRA	Mail Medicaid annual renewal form 1st day of the month prior to renewal
SF 389	Average 3 years of income for self employed	Cover all eligible children in hawk-i & Medicaid for whom FFP is available (Legal Permanent Resident children)		Presumptive Eligibility for children in Medicaid and hawk-i		Express Lane eligibility options
SF 389		Cover Infants and Pregnant Women up to 300% FPL		State Tax return - required application for dependent child health care coverage		Paperless Administrative / Renewal process
SF 389		Translation & interpreter services for Medicaid under CHIPRA (Medicaid reimbursement policy)		hawk-i dental-only program		Joint application / supplemental forms & same application & renewal verification processes for both Medicaid & hawk-i

Authorizing Legislation	May-09	Jul-09	Sep-09	Jan-10	Mar-10	TBD
SF 389				CHIPRA Demonstration grants		Joint renewal form
SF 389						Translation & interpreter services for hawk-I under CHIPRA (for enrollment, retention & use of services)
CHIPRA		Eliminate restrictive requirements for infants born to a Medicaid eligible mother		Verification of citizenship & ID requirements to hawk-i		
ARRA			Eliminate Transitional Medical Assistance reporting & look-back requirements			
HF 820				Direct Care Workers premium assistance pilot		

Senator Hartsuch asked about Lawful Permanent Resident Alien children (LPR) and if they had previously been covered under CHIP. Ms. Smith responded yes, if they had been in the United States for at least five years. The change in the CHIPRA law lifts the five-year bar effective July 1, 2009. Those that are undocumented are ineligible.

Expansion to 300% of FPL:

Ms. Smith told the Board that in response to the Department's state plan amendment CMS sent several questions concerning crowd out. If private coverage is dropped in order to enroll in publicly funded programs, this is defined as "crowd out". CMS provided guidance to states last year placing more requirements on states to monitor crowd out. Most states felt that the guidance went beyond the provisions of federal law and there was criticism that CMS didn't go through notice and rule making in providing the guidance that was subsequently repealed by the Obama Administration. CMS is asking questions based on a GAO report that was conducted while the guidance was in place. Ms. Smith questioned requiring waiting periods or disenrolling children. The CMS regional office staff indicated the questions go beyond the requirements. It is anticipated there will be no problems in getting federal funding for 300 percent. State Plan approval has been received for the Medicaid expansion to 300 percent for pregnant women and children.

Representative Upmeyer said that the Legislature was concerned about crowd out and discussed the subject. The hope was that there would not be a great deal of crowd out and this was one of the reasons they provided for graduated premiums in the legislation for the expansion population. Representative Upmeyer asked if and how the Department planned to address crowd out.

Ms. Smith responded that the Department would continue to monitor and if it seems it is happening it will be brought to the Board's attention so it can be addressed. Previous experience shows that very few families dropped coverage when they had affordable coverage available. The federal guideline for affordability is 5 percent of family income. The *hawk-i* application asks if the child has been covered by insurance during the last 6 months, and if so, why the coverage was dropped. Ms. Smith said that she thinks implementation of the employer buy-in program can help some people maintain insurance and they will be less likely to drop coverage.

Concept for Implementing Presumptive Eligibility:

Ms. Smith told the Board that presumptive eligibility allows children to be determined eligible based on statements about family income and to receive services pending a formal eligibility determination. While the original *hawk-i* legislation directed the *hawk-i* Board to implement a presumptive eligibility program, there was concern at that time because it would have to be paid with funding from the CHIP allotment. For the past five or six years, Iowa has been a shortfall state and there weren't enough funds to cover the kids already in the program. Also, under the original funding structure, the cost would have come out of the state's administrative fund, which was limited with a 10 percent administrative cap. Anything spent over that cap would have had to have been paid with state-only dollars. With the passage of CHIPRA, these funding issues have been fixed.

Ms. Smith shared a flow chart of the design concept for implementing presumptive eligibility. It is believed this concept will have the lowest administrative cost, the least complexity, and the least confusion to families. The point of entry would be through qualified providers, starting with those that currently determine presumptive eligibility for pregnant women in Medicaid. Then it would be expanded to other qualified providers on a scheduled basis. The Iowa Medicaid Enterprise (IME) will train providers.

If the provider determines the child is not presumptively eligible and denies the application, the application will still be forwarded for a formal Medicaid eligibility determination. If the child is determined presumptively eligible, they will be enrolled in Medicaid during the presumptive period, even though they may ultimately be enrolled in *hawk-i*. Once the application is formally determined, the child will stay in either program for 12 months.

Ms. Smith said she would like the Board's reaction to the initial concept before the Department proceeds any further. There are many system changes that will need to be made and administrative rule amendments filed in order to be effective by January 1, 2010.

Representative Upmeyer asked what happens if a child is presumptively enrolled and it is later determined the child is not eligible for either Medicaid or *hawk-i*. Ms. Smith said that during the presumptive period the services would be paid, and once the formal determination is done, the benefits would end. There is no recoupment from providers

or the family. The maximum amount of time a child could be determined presumptively eligible is about 60 days.

Representative Upmeyer said that during discussion of the legislation there was a great deal of concern that the cost could be significant, and there wasn't budget assigned to this. Representative Upmeyer believes there will be a lot of questions by the Administrative Rules Review Committee. Ms. Smith agreed that care during the presumptive period could be expensive. While presumptive eligibility for pregnant women does not cover inpatient hospital, presumptive eligibility for children covers all Medicaid services including inpatient hospital. Therefore, it is important that the Department be able to make the formal eligibility determinations as quickly as possible so that children who are not eligible do not continue to receive benefits.

Senator Hartsuch suggested that presumptive eligibility determination applications for hospital admissions be expedited. Ms. Smith said the Department could review the processes and see how they can get this to happen.

Dr. Spencer asked how long it would take to determine eligibility. Ms. Smith responded that the federal government mandates that Medicaid applications be processed within 30 days, but families have a period of time to file an application. Sixty days is the maximum for presumptive eligibility if they have not filed an application, otherwise they could continue to get benefits pending the determination. It is the Department's intent that at the same time a child is determined presumptively eligible a Medicaid application is automatically filed electronically so there is no delay waiting for the family to file the application.

Representative Upmeyer asked if it was a federal mandate that the children are presumed Medicaid eligible first, or the process that the Department has decided on. Ms. Smith responded that they could be determined presumptively eligible for *hawk-i* at first, but it would create a dual system. *hawk-i* is administered through contracts with health insurance companies so it would be a lot more problematic to get presumptively eligible children insurance cards and information on what benefits they are eligible for. If it is later determined they should have been enrolled in Medicaid they would be switched to a different provider network. Ms. Smith said that the appropriate federal funding would be drawn down, so administratively it would be less costly to have everyone come in through the same door.

Ms. Wiebers added that with *hawk-i*, enrollment is not effective until the month following the month of application, and could be tied with the payment of a premium.

Ms. Carson asked if the Department had any statistics as far as how many of the pregnant women who are deemed presumptively eligible actually do not qualify. Ms. Smith said that there is a lack of data on all of these new initiatives, not many states are doing this, and it is hard to know what the experience will be. The big difference between pregnant women and children is that a pregnant woman has an incentive to follow through with the application. With children it is not as certain because once the child's immediate needs are taken care of, there may be no incentive to follow through with the eligibility process. By automatically filing the application upon a presumptive

determination, that step will be taken care of, and then it will just be a matter of obtaining verification.

Representative Upmeyer stated that this is not really the intent of the legislation. It was never anyone's intent that someone that falls into **hawk-i** at 300 percent of FPL end up in the Medicaid system. The Legislature did not anticipate that there was going to be an insurmountable problem when they included presumptive eligibility in the bill. Ms. Smith responded that the Department doesn't want to go down a path that the Legislature is not happy with. The Department is trying to come up with solutions that will have the least budgetary impact, the easiest to administer, and not have to bounce families back and forth between programs.

Senator Hartsuch said that he wasn't privy to past discussions with the committee, but feels that shortening the determination interval is critically important. Senator Hartsuch suggested that the Department consider talking to the Office of Lean Government and work with them on a process to shorten the length of time.

Ms. Wiebers stated that this is also referred to as the Kaizen Process and the Department has participated in several of those, particularly with food assistance. One of the challenges is that there are a lot of federal regulations regarding verification of income and resources for the Medicaid program.

Selden Spencer made a motion to approve the concept that was presented to implement presumptive eligibility. Kim Carson seconded the motion. A roll call vote was taken: Susan Salter, aye; Selden Spencer, aye; Julie McMahon, aye; Angela Burke Boston, aye; Jim Donoghue, aye; Kim Carson, aye. Motion carried.

Concept for Implementing Employer Buy-In:

Ms. Smith explained that when a family has health insurance available to them through an employer, this program could pay what it would cost to enroll the child in the employer's health insurance program in lieu of the full package of **hawk-i** benefits. Per federal rules, in order to buy the insurance, the child has to be uninsured for six months. If the employer plan does not provide benefits up to the **hawk-i** level, the state still needs to provide the wrap around services.

The **hawk-i** application will be changed to ask if applicants are interested in the employer buy-in program. If the child qualifies for **hawk-i**, they will be enrolled in the appropriate health plan and MAXIMUS will refer the application to the Department's Health Insurance Premium Payment (HIPP) Unit to establish whether or not the employer's health plan qualifies for participation. If it does not, then the child will remain enrolled in **hawk-i** as they would today. If the plan does qualify for employer buy-in, they would remain enrolled in the **hawk-i** health plan to pick up the wrap around benefits that are not covered by the employer plan. Ongoing monthly insurance matches would be conducted to make sure the child continues to be enrolled in the employer's plan and the family would be reimbursed for the premium that is withheld from the employee's paycheck, minus the amount of any premiums that are required by the **hawk-i** program.

Currently the *hawk-i* health plans receive a monthly rate per child for full benefits. When another insurance plan is involved, there will need to be coordination of benefits and the payment structure will need to be determined. Any claims will be submitted to the employer's health plan first. Any claim that is not paid by them will then be submitted to the *hawk-i* health plan.

Ms. Carson stated that insurance is very complex to the layperson and thinks it is important that this program be presented and explained in such a way that families understand.

Ms. Salter asked if families have the option of participating in this program. Ms. Smith said yes. Also, according to federal law, the family can opt out of the buy-in program at any time. It is not clear how that will work when there are open enrollment periods and families are "locked in" to the plans. Would the State be liable for continuing to pay for the plan?

Senator Hartsuch asked how the Department could be sure an employer would allow the State to participate in their plan. Ms. Smith said that if the Department determines that the employer's plan is cost effective and meets the criteria, then the employee is asked to enroll and the payments would be withheld from their paychecks. The Department would then reimburse the employee for the payroll deduction, minus any *hawk-i* premiums. There would not be a direct relationship between the Department and the employer. Ms. Smith said one difference with the buy-in rules for CHIP is that employers have to cover at least 40 percent of the cost of the health plan, there is no minimum employer contribution for Medicaid, as long as it is cost effective.

Angela Burke Boston made a motion to approve the concept that was presented to implement employer buy-in. Jim Donoghue seconded the motion. A roll call vote was taken: Susan Salter, aye; Selden Spencer, aye; Julie McMahon, aye; Angela Burke Boston, aye; Jim Donoghue, aye; Kim Carson, aye. Motion carried.

Premiums for Children with Income up to 300% of FPL:

Ms. Smith reviewed the information that was prepared for Board members in December 2008 when implementing HF 2539 passed by the 2008 General Assembly. This legislation directed the Department to expand *hawk-i* coverage to 300 percent of FPL. At that time the Board voted to impose a \$20 premium per child, with a \$40 per family maximum for the expansion group. Those rules are in place effective July 1, 2009. The rules will need to be amended if the Board wants to change the premium rates, which will take approximately 6 months, and be effective January 1, 2010.

SF 389, passed by the 2009 General Assembly, addresses cost sharing. Section 27(b)(2) talks about "family cost-sharing amounts, and graduated premiums based on a rationally developed sliding fee schedule, in accordance with federal law". Section 36 New Subsection 2.A. states "may include co-payments and graduated premium amounts which do not exceed the limitation of the federal law". Ms. Smith noted that federal law limits cost sharing to 5 percent of a family's gross annual income. A total of

35 states impose premiums or an enrollment fee, 9 states charge premiums to families with income as low as 101 percent of FPL. For a family of three at 250 percent of FPL, 5 percent would be \$190 per month. At 300 percent it would be \$228 per month. The Board was also provided with a list of premium rates from other states at 200 percent of FPL and above.

Representative Upmeyer said the Legislature had discussions about the premium levels since the program is expanding to higher income levels. Once a family moves off the *hawk-i* program to private insurance, there is a significant difference in the contribution rate. When that happens, you have a population that is uninsured again because they have not been prepared. It was felt there should be something incremental. The Legislature also wondered how the current premium levels were set and felt it should be more of a graduated system so that the closer a family gets to the top of the income bracket they are more prepared for the reality of private coverage.

Ms. Smith stated the affected group would be very small. Currently, with earned income disregards, income could be up to 250 percent of FPL. At this income, the maximum a family would pay is \$20. Families with income between 250 and 300 percent of FPL would pay up to \$40. The Department presented several options for the Board in December 2008, one option was to leave premiums for the expanded group at the same rate as that for the current program or charging as high as \$40 per child with an \$80 family maximum.

Senator Ragan left the meeting at this time.

Ms. Salter asked if the language in the legislation requires the Board to change the decision made in December 2008. Representative Upmeyer said the intent was that it was expected there would be graduated premiums for the expansion group.

Ms. Smith asked for clarification; was it legislative intent that a premium schedule be implemented to prepare people to go into the private market as opposed to a premium schedule that allows people to stay in the program? Representative Upmeyer said that if the federal level of cost sharing and premium information from other states that was given to the Board had been shared with the Legislative Committee, it would have helped them with the language in the legislation.

Representative Upmeyer left the meeting at this time.

Ms. Salter stated that it seems that the Board is being asked to raise the premium enough so that there is as not a cliff effect when families leave the program. On the other hand, based on the information, they do not want to keep people from enrolling in the program because the premium is too high.

Carrie Fitzgerald, Child and Family Policy Center, said that the conversations she remembers from some of the subcommittee meetings, and conversations with legislators, is the perception was that 200 to 250 percent would be an amount and 250 to 300 percent would be another amount. She heard very little talk that the Legislature was thinking of other breakouts. During the last two legislative sessions discussions

were more about as the income levels go up, those families have more money, so they should contribute more towards the cost of the premium. She does not remember anything about a premium amount that would prepare them for leaving the program. Ms. Fitzgerald said that she does know from conversations with Senator Hatch that he feels very strongly that there is a line where families cannot afford the premiums and won't enroll.

Ms. Smith said that no state has taken the approach that premiums should be so high that when people go into the private market they are prepared. The approach taken by states is that families need to contribute something, and it needs to be affordable so they can get their children covered.

Dr. Spencer said that as a Board member he would be more inclined to make sure that more children are covered. Ms. Carson questioned what families would consider "affordable".

Discussion followed. Ms. Smith said that any change to increase premiums would be an adverse action, so the change could not go through emergency rule making. The soonest it could be implemented would be January 1, 2010, so everyone enrolled at this level between July 1 and December 31 would be at the \$20/\$40 level.

Ms. Boston stated that the Board has spent a lot of time and the Department of Human Services has spent a lot of money, advocating services available and sending the message out that Iowa wants to cover all kids. There are changes going into effect July 1, and it is clear that the Legislature wants a graduated fee schedule. The Board does not have any idea of the number of children that will be enrolled between 250 and 300 percent of FPL, nor do they know what the impact of the other changes will be. Ms. Boston said that with today's economy, the more that the Board tinkers with how people get into the system, the more they may see people drop off or make other decisions. If the legislative intent is having people acclimate themselves to what insurance looks like in the real world, then the Board might want to talk about a program redesign that includes co-pays and co-insurance and all those other factors. None of that exists right now.

Ms. Boston made a motion that the Board maintain the current premium structure that will go into affect July 1, 2009, and will reassess it after six months' experience at their February 2010 Board meeting. Kim Carson seconded the motion. A roll call vote was taken: Susan Salter, aye; Selden Spencer, aye; Julie McMahon, aye; Angela Burke Boston, aye; Jim Donoghue, aye; Kim Carson, aye. Motion carried.

Senator Hartsuch left the meeting at this time.

Concept for Implementing Dental Only Plan:

Ms. Smith told the Board that the Department proposes to implement the supplemental dental-only program the same way as the regular ***hawk-i*** program. The difference is that the child would only get dental benefits. Currently the Department is waiting for clarification from CMS on whether orthodontia coverage will be required. The dental

plan CMS is using as the benchmark is the federal employee's dental plan which does include orthodontia. Before the Department can enter into any discussions with dental plans and determine premiums, they need to know what the benefit requirements will be.

CMS Site Visit:

Ms. Smith reported that the semi-annual site visit went very well. CMS staff was impressed with the insurance match conducted by Health Management Systems. Many states do it at the time of application to verify that the child applying for the program does not have health insurance, but they were not aware of any state besides Iowa that conducts matches on a quarterly basis. It was suggested that Iowa track outreach results from several initiatives, particularly the question on the state income tax form, so CMS can demonstrate to other states how effective some of the efforts are.

Results of the Iowa Income Tax Return Initiative:

The Department of Revenue has mailed a total of 51,376 ***hawk-i*** brochures to taxpayers as a result of the question on the 2008 income tax form. The breakdown is as follows:

Applications mailed by Revenue	51,376
Returned by Post Office as undeliverable	166
Completed applications received	379
Disposition of the 379 Applications Filed:	
Approved	93
Referred to Medicaid	73
Applications pending	8
Applications denied	205
Reasons for Denial:	
Enrolled in Medicaid	109
Missing information not received	35
Over income	23
Non-compliance with Medicaid	20
Over age 19	5
Other health insurance	4
Child did not live with applicant	2
Home address not in Iowa	2
Immigration document invalid or missing	5

Brenda Freshour-Johnston will be meeting with the Department of Revenue on June 16 to discuss improvements for next year's mailing. The wording on the 2009 form will be changed to say "dependents under the age of 19" and the word insured will be clarified to include coverage under ***hawk-i*** or Medicaid. They will also discuss training for tax preparers, possible language changes for legal immigrant children, advertising, and a cost estimate of the initiative for the number of children covered.

PUBLIC COMMENT:

There were no requests for public comment.

CONTRACTS:***Wellmark Blue Cross Blue Shield:***

Ms. Ruggle presented the Fifth Amendment to the contract (FHWS-07-001) the Department has with Wellmark Blue Cross and Blue Shield of Iowa. This is the Classic Blue, or indemnity plan. As a result of discussions between the Department and Wellmark:

- The current contract, due to expire June 30, 2009, will be extended through September 30, 2009.
- The capitation rate for July 1, 2009, through September 30, 2009, will be \$179.93 per member per month.
- No new *hawk-i* members will be enrolled in the Classic Blue plan as of July 1, 2009.
- All *hawk-i* Classic Blue members will be transitioned to Wellmark Health Plan of Iowa's Blue Access on or before September 30, 2009.

Selden Spencer made a motion to approve the contract amendment. Kim Carson seconded the motion. A roll call vote was taken: Susan Salter, aye; Selden Spencer, aye; Julie McMahon, aye; Angela Burke Boston, aye; Jim Donoghue, aye; Kim Carson, aye. Motion carried.

Wellmark Health Plan of Iowa:

Ms. Ruggle explained to the Board that the Fifth Amendment to the contract (FHWS-07-002) the Department has with Wellmark Health Plan of Iowa extends the current contract through September 30, 2009. There are still some outstanding issues with certifications, so the current contract is being extended while those issues are resolved. At that time, a new contract will be presented for approval.

The contract amendment also provides that:

- Effective July 1, 2009, this plan will be available in all 99 counties.
- Effective July 1, 2009, dental services will no longer be provided with this contract.
- Effective July 1, 2009, the capitation rate will be \$173.41 per member per month.

Selden Spencer made a motion to approve the contract amendment. Kim Carson seconded the motion. A roll call vote was taken: Susan Salter, aye; Selden Spencer, aye; Julie McMahon, aye; Angela Burke Boston, aye; Jim Donoghue, aye; Kim Carson, aye. Motion carried.

BOARD DISCUSSION – CLINICAL ADVISORY AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS COMMITTEES:

Ms. Ruggle said that she contacted the members of the Clinical Advisory Committee and received very few responses. Three were returned due to incorrect e-mail addresses. Kathy David, a physical therapist, responded that she saw her role for questions about physical therapy and not anything else, Dr. Garman, Davenport, indicated he is still interested in being on the Committee, but was unable to attend the Board meeting. Dr. Spencer said that he has talked with Dr. Carlyle and Dr. Carlyle is still interested in serving on the Committee.

Ms. Boston asked if staff was able to gather information on what other states do. Ms. Smith said that only two states had any kind of medical advisory committee.

Discussion followed. It was decided:

- A new Clinical Advisory Committee needs to be appointed. The Medical Assistance Advisory Council (MAAC) will be contacted and asked to make recommendations for appointments to the Committee.
- The Committee needs to be empowered with a task. CMS is in the process of developing an initial core set of health quality measures that are to be in effect by January 1, 2010, and the Committee can assist the Department in reviewing.
- Legislation needs to be submitted to do away with the Children With Special Health Care Needs Committee. The function of that Committee will be incorporated into the role of the Clinical Advisory Committee.

Ms. Ruggle will meet with Dr. Spencer and Dr. Carlyle to discuss the role of the Committee and report back to the Board.

NOMINATING COMMITTEE FOR ELECTION OF OFFICERS IN AUGUST:

Ms. Salter appointed Julie McMahon to chair the committee. Mr. Donoghue and Ms. Carson were also appointed. The Committee will bring a slate of officers to the Board's August meeting.

NEW BUSINESS:

There was no new business.

The next regular *hawk-i* Board meeting is scheduled for Monday, August 17, 2009, at 12:30 p.m. The meeting will be held at the Insurance Commission Office at 330 Maple in Des Moines, Iowa.