STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

Annual Hawki Board Report

December 2022

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Contents

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Executive Summary

This report has been developed for the state fiscal year 2022 (SFY22), Annual Report July 1, 2021, to June 30, 2022, for the Healthy and Well Kids in Iowa (Hawki) program. Iowa Code Section 5141.5(6)(f) directs the Hawki Board to submit an annual report concerning the Board's activities, findings, and recommendations.

On March 13, 2020, the Federal government issued a Public Health Emergency (PHE) for the coronavirus (COVID-19) disease. This PHE has continued to affect the Hawki Program throughout the SFY 22 in determining disenrollment, premium collection, and the type of services provided. Due to the PHE, children were not disenrolled from the program at the time of their renewal, the collection of premiums stopped, and healthcare services were added. Children that have acquired other primary health insurance are still discontinued from the Hawki insurance program. Telehealth was one of the services added and continues to allow Hawki members to be able to receive needed health services without the need to go to a provider's office. Telehealth services have remained in place throughout SFY 22.

Program Description

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 Hawki 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 Hawki Dental-Only Program covers children who meet the financial requirements of the Hawki program but are not eligible because they have health insurance. The Dental-Only program and the dental coverage with Hawki provide preventive and restorative dental care services as well as medically necessary orthodontia.
See Attachment One: Organization of the Hawki program.

Iowa's CHIP Program

CHIP is a federal program operated by the state, financed with federal and state funds at a current match rate of approximately 78 cents to $1.00. 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 multiple components:

- **Medicaid Expansion** (Implemented 1998) – Provides health and dental services to infants 0 to 1 year of age and qualified children ages 6 to19 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 Hawki program.

- **Hawki** (Implemented 1999) – Qualified children are covered through contracts with MCOs and a dental plan to deliver a full array of health and dental services. The Hawki 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 FPL.

- **Hawki Dental-Only Program** (Implemented 2010) - The Hawki Dental-Only Program provides preventive and restorative dental care services from Delta Dental of Iowa as well as medically necessary orthodontia to children with income under 302 percent of the FPL that do not qualify for healthcare benefits under Hawki because they have health insurance.

- **Managed Care Organizations** (Implemented April 2016) – Most Medicaid members, including those enrolled in the Hawki program, were transitioned to a managed care program, and receive health coverage through a MCO.

See Attachment 2: Iowa's Health Care Programs for Non-Disabled Children.

Key Characteristics of the Hawki Program

The Department pays a monthly capitation premium to the MCOs and Hawki program benefits are provided in the same manner as for commercial beneficiaries. The covered services under Hawki are different from regular Medicaid and are approximately equivalent to the benefit package of the state's largest employee plan available at the beginning of the program.
The capitation payment made to Amerigroup for SFY22 was $154.85 per member per month (pmpm), for Iowa Total Care the capitation payment was $156.15 pmpm and for Delta Dental of Iowa the capitation payment was $23.04 pmpm. Within the Hawki program families with income over 181 percent of the FPL pay a monthly premium of $10 - $20 per child with a maximum of $40 per family based on family income. Premiums have not increased since the program's implementation and Iowa's monthly premium compared to established FPLs are consistently lower than most other states charging a monthly enrollee premium. In June 2020, 65 percent of enrolled Hawki families paid a monthly premium and 35 percent paid no monthly premium amount. All premiums have been on hold since March 2020 due to the PHE.

See Attachment Three: History of Participation.

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 reflect projected state and program spending more accurately. The new allotment formula for each of the 50 states and the 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 based on 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.

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State Funding for SFY22:
CHIP Program Budget – SFY 2022 Final

CHIP Program Budget -- SFY 2022 Final	
FY22 Appropriation	**$37,957,643**
Amount of Hawki Trust Fund dollars added to appropriation	6,221,297
Total state appropriation for FY22	**$44,178,940**
Federal Revenues Budgeted	130,784,625
*Other Revenues Budgeted	6,867,435
Total	**$181,831,000**
State dollars spent Final	37,463,681
Federal Revenue earned Final	128,453,313
Other revenues Final	5,088,363
Total Revenues Final	171,005,357
* Other revenues include rebates and recoveries; client premium payments and Hawki trust fund interest.	

See Attachment Four: Budget Information.

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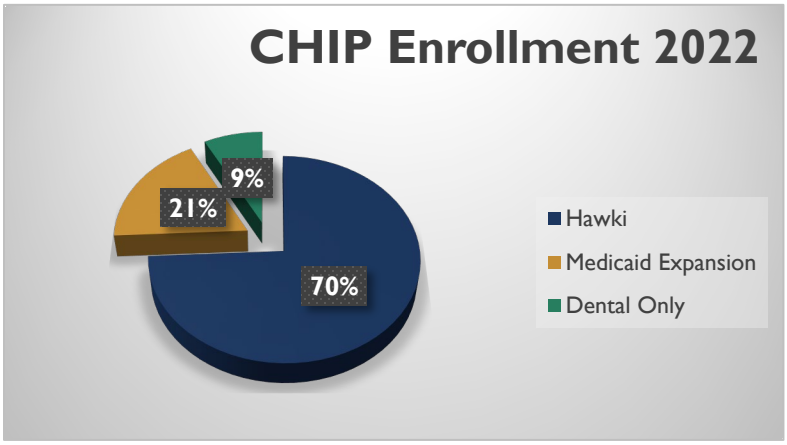
Enrollment

As of June 30, 2022, 77,436 children were enrolled in Iowa's CHIP program. Of the total number enrolled in SFY22:

- 16,508 (21 percent) were enrolled in Medicaid Expansion (M-CHIP),
- 54,258 (70 percent) in Hawki, and
- 6,670 (9 percent) in the Hawki Dental-Only program



COVID-19

The Department worked quickly when the PHE was issued on March 13, 2020, to ensure Hawki members would continue to be enrolled in the program and receive needed health care services. The Department requested authority through the CHIP Disaster SPA to be able to delay renewals for CHIP and not disenroll members until the PHE is over. Additionally, Hawki members who had a decrease in family income during the PHE, could still be eligible for Medicaid.

Federal guidance also allowed for the discontinuation of collecting premiums for Hawki families during the PHE. The Department sent letters to the affected families in March 2020, notifying them that during the PHE no Hawki member would be disenrolled from the program for not paying their premium.

Iowa Medicaid has been working on the PHE unwind to ensure all members have up to date information that will be utilized for redetermination once the PHE has ended. Iowa Medicaid is also conducting research to determine telehealth services/codes that will remain available once the PHE has ended.

Quality

The MCOs are responsible for developing a quality management/quality improvement program to improve quality outcomes for Medicaid and Hawki members. The MCOs are also to report on quality measures such as well-child visits, adolescent well-child visits, diabetes management, etc. The Department monitors the quality measures to ensure that children, as well as adults, are receiving needed medical care. These reports can be found on the Department's website: https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports.

Provider Network Access

The Department reviews the provider networks of the MCOs on a monthly basis to ensure that there is adequate access to all Medicaid and CHIP members. Assessment of the provider networks includes reviewing the number of primary care providers, specialists, and hospitals.

Outreach

In SFY22, successful collaboration continued between the Department, Iowa Department of Public Health (IDPH) and the Hawki Board. Designated Hawki outreach coordinators were established in each child and adolescent center agency that is contracted with IDPH. Local agency outreach coordinators provided presumptive eligibility determinations for children and teens, which allowed immediate access to Medicaid covered services until a formal Medicaid eligibility or Hawki eligibility determination was made. Outreach coordinators continue to provide critical outreach to communities in each of four required focus areas:

- Schools
- Faith-based communities
- Medical/Dental providers
- Diverse populations

Outreach to Schools

Providing outreach to schools at both the local and statewide levels 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 coordinators develop significant relationships with school nurses to ensure uninsured children are connected to coverage. Many local coordinators attended kindergarten round-ups and school registrations to talk directly to families about healthcare coverage, and some were able to complete presumptive eligibility determinations on the spot so the children could walk away with coverage. In some communities, coordinators also worked with guidance counselors, coaches, or teachers in order to reach uninsured children. The state Hawki outreach coordinator attended the Iowa School Nurse Organization Conference virtually to talk to school nurses about Hawki and provide updated information about the program.

Almost all the agencies worked directly with their school-based sealant programs to provide Hawki information to children whose parents requested information on the release form. This was and is an effective way to identify uninsured children who may be eligible for Medicaid or Hawki.

Outreach to the Faith-Based Community

Local coordinators establish relationships with faith-based organizations in their service areas to promote the Hawki program. Many local coordinators provide Hawki materials to faith-based organizations through email list-serves and mass mailings. Building relationships with the leadership of faith-based organizations allows the outreach coordinators to provide Hawki materials to members and establishes the coordinators as a resource for families in need.

Outreach to Medical/Dental Providers

Coordinators provide direct outreach to Iowa's medical and dental providers to educate them about the Hawki program. There was continued emphasis on engaging hospitals, medical clinics, dental offices, and pharmacists across the state and having these trusted community leaders to talk to families about the Hawki program. Since January 2014, hospitals and other provider types have the ability to become Qualified Entities (QE) to provide presumptive eligibility for children and other populations. All local coordinators worked with medical providers to encourage them to become QEs or establish a referral system to ensure uninsured children are able to access healthcare coverage.

Outreach to Diverse Populations

Local 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. Local coordinators were offered culturally competent resources and information throughout the year to help in their local outreach efforts. These resources were typically print resources, face–to-face trainings and webinars

Additional Outreach Activities

This year outreach coordinators are conducting specific targeted outreach in some areas of the state with high percentages of uninsured rates. See figure 1. Initially, completing an environmental scan to see what barriers exist and why large percentages are occurring and then planning collaboration with local community partners to devise and implement a strategic plan to increase numbers.
Outreach coordinators also developed a follow up process to ensure the numbers remain sustainable.

Figure 1

CSA	Counties (percent of children uninsured)
6	Floyd (11.5%)
9	Decatur (7.8%); Wayne (18.2%)
10	Chickasaw (11.5%); Allamakee (11.1%); Clayton (10.1%)
15	Davis (42.3%); Van Buren (17.3%); Appanoose (10%)

In addition, Outreach Coordinators are focusing more attention on outcomes and data - capturing return on investment in a more significant manner. Iowa ranks number four in states in having the highest insured rates for children, but there is still room for improvement. The outreach coordinators would like to capture more data on existing barriers that families are confronting when applying for state health benefits (e.g., new refugees and immigrants coming into the state and difficulty accessing the system, etc.). Lastly, the Outreach Coordinators will continue sharing and capturing success stories which give Hawki Board Members/community members tangible evidence outreach efforts are working.

The state Hawki Outreach Coordinator is going to do more traveling the state with additional outreach to state and non-profit organizations to share/speak on Hawki Outreach message of awareness and

knowledge (Hawki/Medicaid) in their local communities e.g., Independent Insurance Agents of Iowa, Iowa Restaurant Association, etc. The outreach coordinators plan to focus attention on small and independent businesses who do not provide health coverage to their employees.

See Attachment Five: Referral Sources -Outreach Points.

Presumptive Eligibility

Iowa Code 514I.5(e) requires the Department 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 Department 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 Hawki outreach coordinators.

To date, Iowa has gradually expanded Qualified Entities (QE)s and continues to add QEs in provider categories including: Head Start programs, Women's and Infant Clinics (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 June 30, 2021, 228 QEs (individuals, hospitals, and agencies) were authorized to sign up children for the presumptive eligibility program. In SFY22, a monthly average of 266 children were approved for presumptive eligibility.

All presumptive eligibility applications are automatically forwarded from the QE to the Department for a determination of ongoing Medicaid or Hawki coverage.

See Attachment Six: Presumptive eligibility for Medicaid and Hawki program design.

Participating MCOs and Dental Plans

During SFY22, families in all 99 counties had a choice of two MCOs: Amerigroup Iowa Inc. (Amerigroup) and Iowa Total Care (ITC).
There is one dental plan, Delta Dental of Iowa that participated in Hawki in SFY22.

Board of Directors

Membership

The Hawki Board is comprised of four public members, the Directors of Education and Public Health, and the Insurance Commissioner or their respective designees. There are four ex-officio legislative members, two from the House and two from the Senate.
See Attachment Seven: Hawki Board Members.

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Board Activities and Milestones

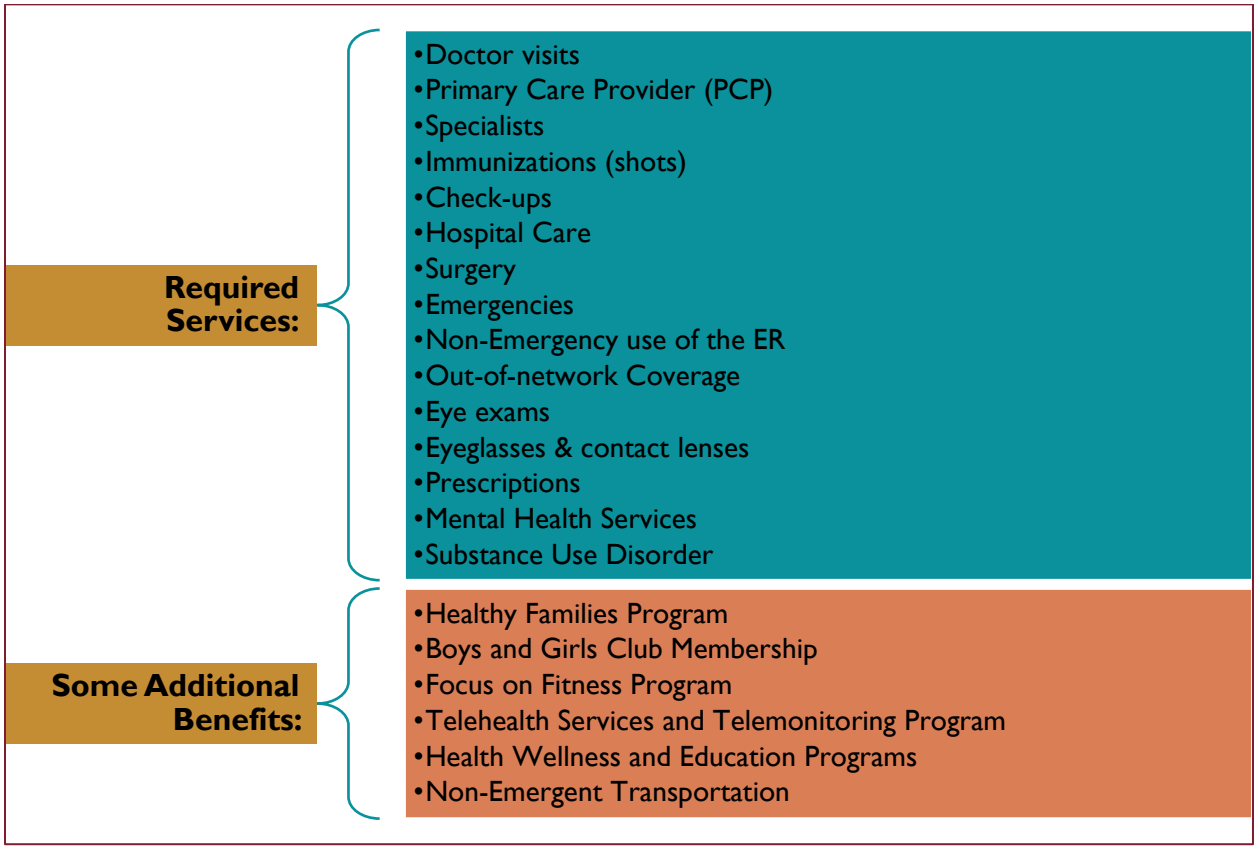
Iowa Code Section 514I.5(1) requires the Hawki Board to meet no less than six and no more than 12 times per calendar year. The Board generally meets the third Monday of every other month; meeting agendas and minutes are available on the Department's website at https://dhs.iowa.gov/hawki.

Hawki Board Strategic Planning

The Hawki Board has a robust charge identified in Iowa Code Section 514I.5. As strategic planning began in October 2021, opportunities for maintaining fidelity to the charge was found in the duties, reporting, recommendations, and approvals sections articulated in the code.

Members identified a contrast between the narrative within the code and the present status and maturity of the program and the Board. Modernizing the code was noted as a future action step.

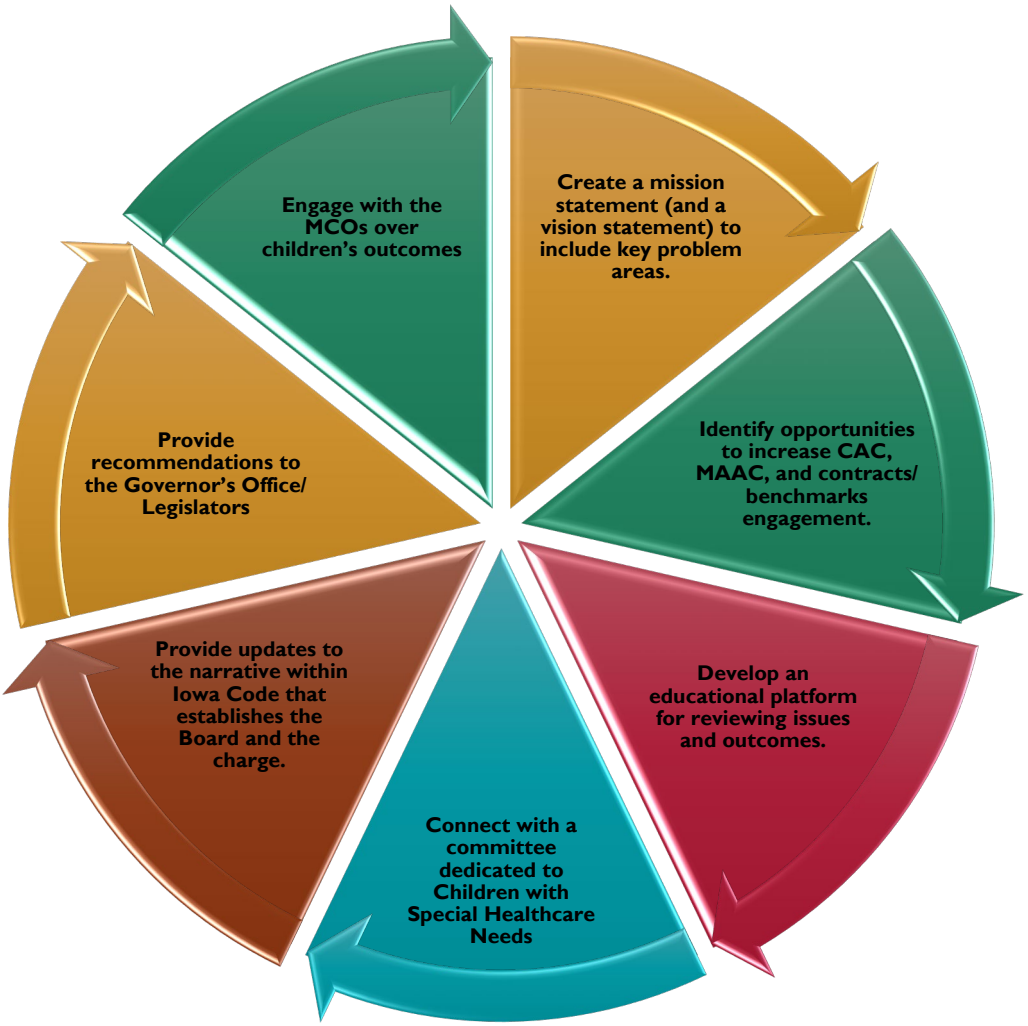
The Hawki Benefit Package was central to strategic planning discussions. The benefit package is:



The group identified the following activities as cornerstone steps for strategic planning:

1. Creating a mission and vision statement.
2. Identifying opportunities to increase interactions with aligned councils and boards.
3. Developing an educational platform for reviewing issues and outcomes.
4. Engaging with the MCOs to support children's health outcomes.
5. Providing recommendations to the Governor's Office and Legislators.

Members identified a contrast between the narrative within the code and the present status and maturity of the program and the Board. Modernizing the code was noted as a future action step.



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Priority 1: The Board created new vision and mission statements:

VISION STATEMENT	The Hawki Board is a group of leaders who support standards for pediatric coverage that result in a high-performing program where positive outcomes for children are prioritized. The scope of the program includes the range of medical, dental, and mental health services. To accomplish its goals, the Board maintains engagement with the MCOs; MAAC, CAC, and CSHCN boards, committees, and councils; families; and covered individuals. A shared a vision, along with the steps for achieving it, guides these partnerships. Robust engagement with the public is valued. The lifespan perspective and social determinants of health are guiding frames of reference for the Board's approach.
MISSION STATEMENT	We ensure eligible children can access the health services they need to grow and be healthy. We promote transparency and serve as a conduit for communication with other programs and stakeholders. We reinforce the importance of behavioral health care for children. We provide recommendations for change through a data-driven and informed process. We take action to improve the lives of members; support a bridge between Medicaid and private insurance; and promote system development. We have a shared interest in public sector healthcare.

In addition, the Board identified their target audiences and process for decision-making:

TARGET AUDIENCES	The Governor and Legislature Members, families, and caregivers Providers Other Boards Focused on Children Community-Based Organizations MCOs
OUR PROCESS	Building action-oriented agendas Learning from our partners including Medicaid and the Managed Care Organizations Supporting outcomes for covered children through assessment of programmatic activities and developing recommendations Engaging with outreach activities and existing initiatives Providing a link between decision-makers and the public

Priority 2 and Priority 3: Increase Engagement with the Hawki Clinical Advisory Council (CAC) and Children with Special Healthcare Needs (CSHCN) Committees:

The Board has proposed a charge to establish the duties and actions of the Hawki Clinical Advisory Committee (CAC). The proposed charge includes the following:

- Provide clinical expertise and recommendations to the Hawki Board
- Develop a "pediatric criterion" for Hawki to help clarify the unique health and developmental needs for children covered by Hawki
- Help identify gaps in Hawki benefits

Over the next year, updates on adoption of these duties and actions will be provided and expectations and authority of this entity will mature. Additional steps may be required to ensure the voice of the Hawki CAC is included in the Board's agendas, recommendations, and reports.

The Board's duties associated with establishing an advisory committee to make recommendations concerning the provision of coverage to children with special healthcare needs (CSHCN) were central to the strategic planning discussions. The infrastructure for this task within the charge was minimal and required development. A working group was established to develop a clear definition of CSHCN and understand the footprint of the population within Hawki. Upon completion of assessment activities, additional steps may be required to ensure topics relevant to CSHCN are included in the Board's agendas, recommendations, and reports.

Priority 4: Develop an Educational Platform for Reviewing Issues and Outcomes

The Board developed the process for establishing an educational platform and including subject matter expert presentations into their meetings. In addition, members suggested developing a library of documents to be accessed by Board members who do not have state agency experience.

Priority 5: Engagement with the Managed Care Organizations

The Board developed a framework for engaging with the managed care organizations (MCOs) to address health conditions and focus on outcomes. The group shared health conditions they felt were relevant to the Hawki population and used sources from the Commonwealth Fund and the Centers for Medicare and Medicaid Services to select a list of priority health conditions and outcomes. The final list will be used for annual planning. Three to five topics will be selected for emphasis over the calendar year. The topics will be incorporated into each meeting agenda. The MCOs will provide brief presentations and a dialogue with the Board will follow.

Priority 6: Provide Recommendations to the Governor's Office and Legislators

The Hawki Board is charged with preparing, with the assistance of the Department, and submitting a report to the Governor, the general assembly, and the Council on Human Services, concerning the Board's activities, findings, and recommendations. These details are due by January 1st each year. A process for delivering the content for this report may follow these steps:

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1. Utilize the notes from each meeting to summarize the Board's activities. Presentations by subject matter experts, collaboration with councils or committees, and communication with the managed care organizations should be highlighted. This section should answer, "What were the major actions taken by the Board this year?"

2. Glean the results of each meeting from the meeting notes to share key findings. Findings can be defined as conclusions reached as results from an inquiry into a topic or set of topics. This section should answer, "What did the Board learn in the past year?"

3. Choose 2-3 major findings and build recommendations from this foundation. The recommendations could be as simple as a paragraph and as complex as an issue brief. This section should answer, "What does the Board feel the Governor should know about the program or the population?" and "What should be done about this topic?"

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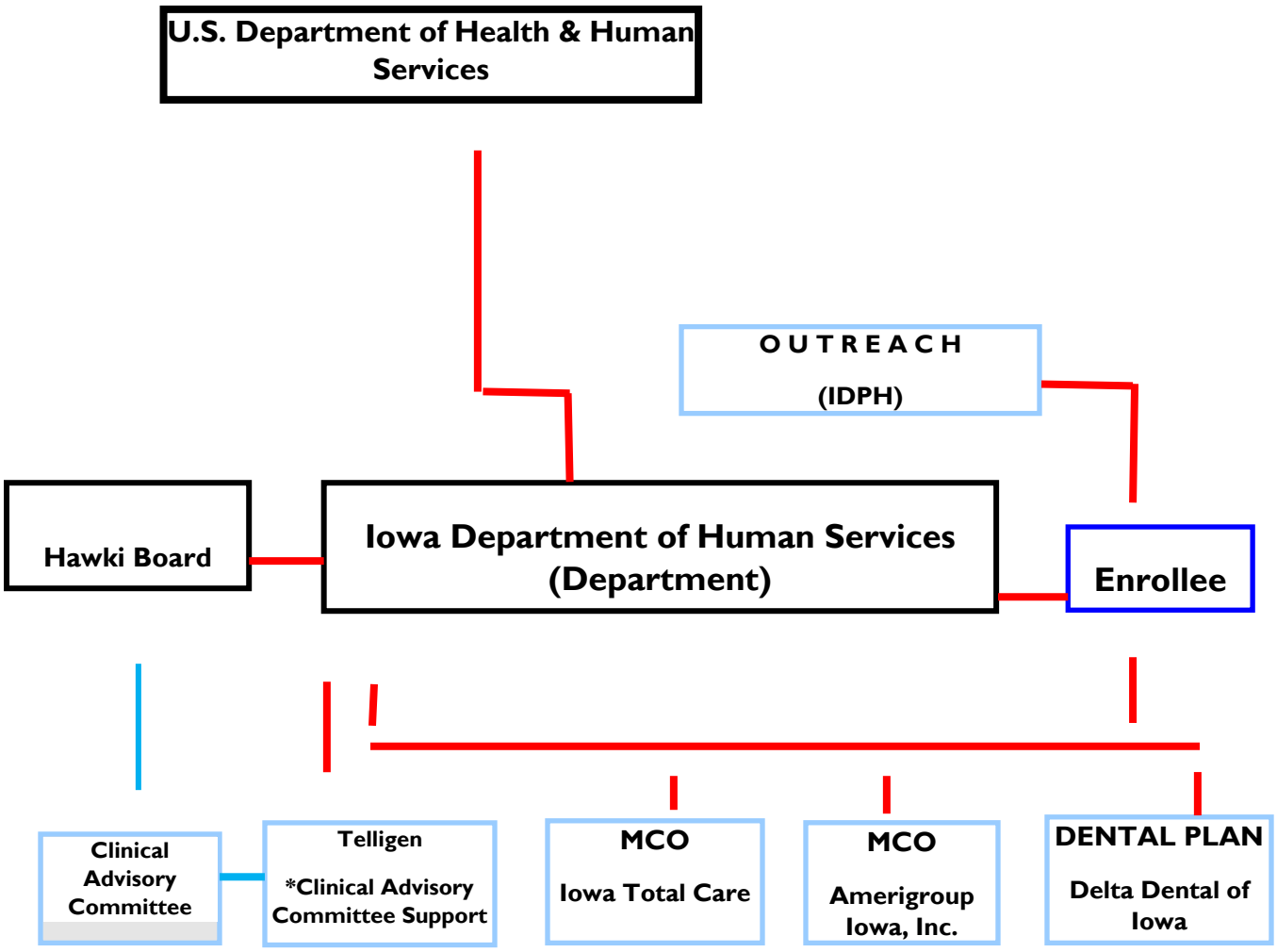
Attachment One – Organization of the Hawki Program

Organization of the Hawki Program as of June 30, 2022



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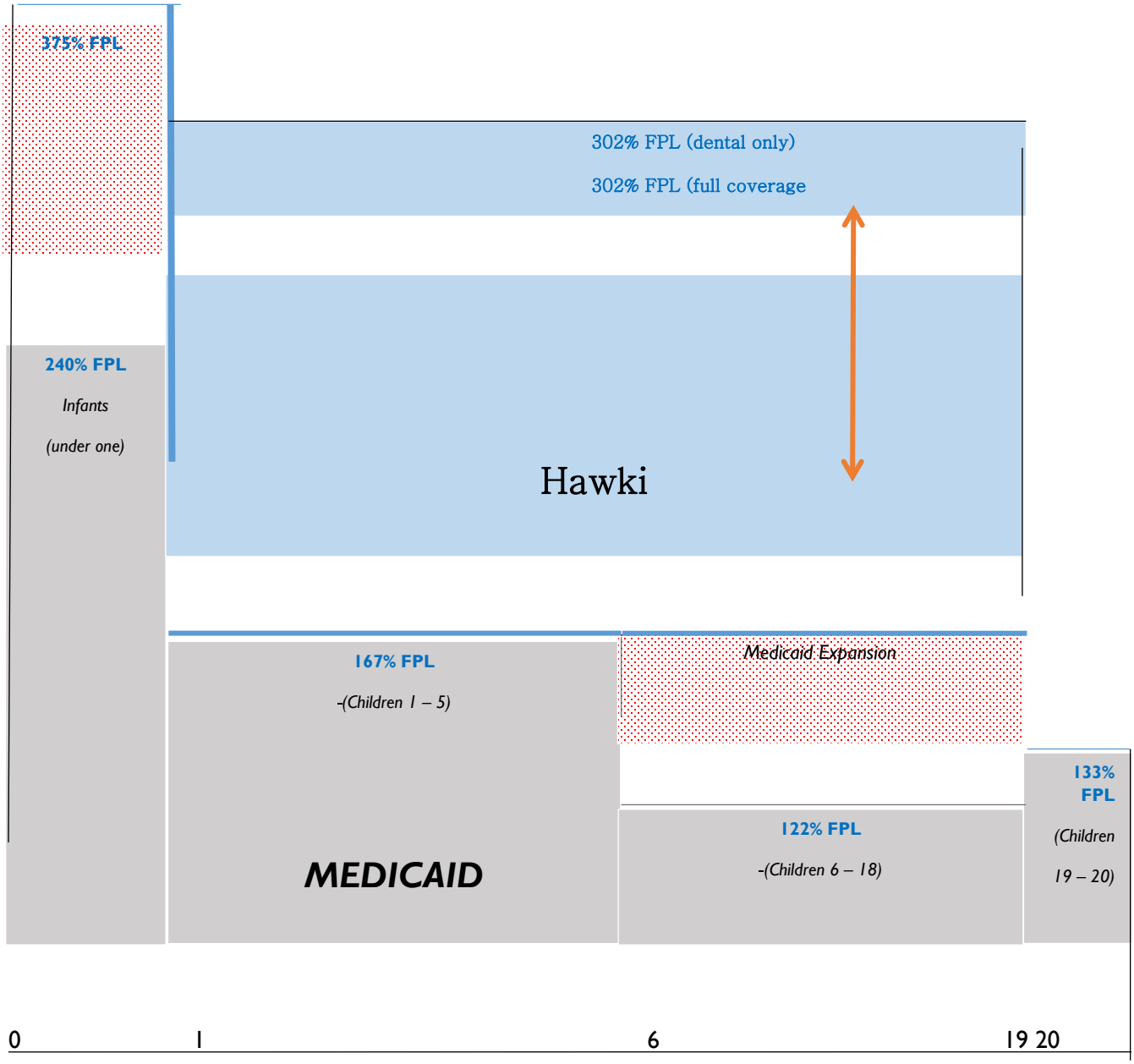
Attachment Two – Iowa's Health Care Programs for Non-Disabled Children

Iowa's Health Care Programs for Non-Disabled Children

MAGI Income Conversion Adjustment



Hawki	Medicaid Expansion	Medicaid
Title XXI funded	*Title XXI funded*	*Title XIX funded*

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Attachment Three – History of Participation

Enrollment as of June 30 of the Fiscal Year

		CHIP (Title XXI Program)		
SFY	**Total Children on Medicaid**	**Expanded Medicaid***	**Hawki (began 1/1/99)**	**Hawki Dental-Only (began 3/1/10)**
SFY99	91,737			
SFY00	104,156	7,891	2,104	
SFY01	106,058	8,477	5,911	
SFY02	126,370	11,316	10,273	
SFY03	140,599	12,526	13,847	
SFY04	152,228	13,751	15,644	
SFY05	164,047	14,764	17,523	
SFY06	171,727	15,497	20,412	
SFY07	179,967	16,140	20,775	
SFY08	181,515	16,071	21,877	
SFY09	190,054	17,044	22,458	
SFY10	219,476	22,300	22,300	
SFY11	236,864	22,757	28,584	2,172
SFY12	245,924	23,634	33,509	3,369
SFY13	253,199	24,996	36,255	4,100
SFY14	256,818	25,444	38,156	4,315
SFY15	258,628	27,078	38,263	3,127
SFY16	267,780	24,845	37,155	3,342
SFY17	272,535	16,075	42,984	3,361
SFY18	274,699	17,761	51,323	3,816
SFY19	264,506	17,077	53,270	3,450
SFY20**	255,845	16,819	64,613	5,816
SFY21**	272,308	15,750	64,787	6,759
SFY22	363,520	16,508	54,258	6,670

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

**No children were disenrolled from Medicaid, or Hawki Dental only beginning 3-1-2020

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Attachment Four Budget Information

Federal Fiscal Year	Allotment	Balance Carryforward	Retained Dollars	Redistributed Dollars	Supplemental Dollars	Contingency Fund Payments	Total Federal Dollars Available	Total Federal Dollars Spent	Balance Remaining
2017	145,720,122	53,937,216	-	-	-	-	199,657,338	124,852,151	74,805,187
2018	163,436,140	49,870,125	-	-	-	-	213,306,265	123,442,977	89,863,288
2019	130,026,133	89,863,288	-	-	-	-	219,889,421	137,377,388	82,512,033
2020	145,523,677	82,512,033	-	-	-	-	228,035,710	158,053,292	69,982,418
2021	166,551,061	69,982,418	-	-	-	-	236,533,479	135,959,472	100,574,007
2022	176,467,048	100,574,007	-	-	-	-	277,041,055	132,615,088	144,425,967

18 - Section 2104(m)(2)(B)(iv) of the Social Security Act reduced by one-third any amounts of unused FY 2017 CHIP allotment that remain available for expenditure by the state in FY 2018. As a result, the $74,805,187 FY 2017 remaining balance was reduced to $49,870,125.

*This information reflects the activity that is reported in the CMS 21C report

State Funding for SFY22:

The total original appropriation of state funds for SFY22 was:	$37,957,643
Amount of Hawki Trust Fund Dollars added to appropriation:	$6,221,297
Amount of supplemental appropriation for SFY22	$0
Total State Funding:	$44,178,940

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CHIP Program Budget -- SFY 2022 Final	
FY22 Appropriation	**$37,957,643**
Amount of Hawki Trust Fund dollars added to appropriation	6,221,297
Total state appropriation for FY22	**44,178,940**
Federal Revenues Budgeted	130,784,625
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Federal Revenue earned Final	128,453,313
Other revenues Final	5,088,363
Total Revenues Final	171,005,357
* Other revenues include rebates and recoveries; client premium payments and Hawki trust fund interest.	

State Dollars		
Budget Category	**Projected Expenditures**	**Final Expenditures**
Medicaid Expansion	$8,994,845	$9,172,414
hawk-i premiums (includes up to 300% FPL group)	29,310,697	26,681,040
Supplemental Dental	453,510	393,016
Processing Medicaid claims / AG fees	78,123	75,364
Outreach	152,352	135,493
hawk-i administration	761,568	451,014
Earned interest from hawk-i fund	(61,129)	(63,339)
Health Insurer Fee/Withhold	581,010	618,678
Totals	**$40,270,977**	**$37,463,681**

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CHIP Program Budget – SFY 2023 Preliminary

CHIP Program Budget -- SFY 2023 Preliminary	
FY23 Appropriation	**$38,661,688**
Amount of Hawki Trust Fund dollars added to appropriation	6,715,259
Total state appropriation for FY23	**45,376,947**
Federal Revenues Budgeted	127,409,513
*Other Revenues Budgeted	5,609,550
Total	**$178,396,010**
State dollars spent Final	-
Federal Revenue earned Final	-
Other revenues Final	-
Total Revenues Final	-
* Other revenues include rebates and recoveries; client premium payments and Hawki trust fund interest.	

State Dollars		
Budget Category	**Projected Expenditures**	**Final Expenditures**
Medicaid Expansion	$9,838,600	$0
hawk-i premiums (includes up to 300% FPL group)	$23,675,226	-
Supplemental Dental	$453,510	-
Processing Medicaid claims / AG fees	$84,089	-
Outreach	$140,407	-
hawk-i administration	$794,239	-
Earned interest from hawk-i fund	($126,297)	-
Health Insurer Fee/Withhold	$607,588	-
Totals	**$35,467,362**	**$0**

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Attachment Five – 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 Hawki 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 and their families (churches, schools, health fairs, etc.).

Functions of the outreach points:

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

1. Disseminating information about the program.
2. Assisting with the application process if able.

Hawki Board

The function of the Hawki 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 Hawki 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 Health and Human Services (HHS)

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

1. Determine eligibility, premium processing, and enrollment.
2. Work with the Hawki Board to develop policy for the program.
3. Oversee administration of the program.
4. Administer the contracts with the MCOs, Dental Plan, IDPH and Telligen.
5. Administer the State Plan.
6. Provide statistical data and reports to CMS.

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Clinical Advisory Committee

The Clinical Advisory Committee is made up of health care professionals who advise the Hawki Board on issues around coverage and benefits.

MCO and Dental Plans

The functions of the MCOs and dental plan 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.

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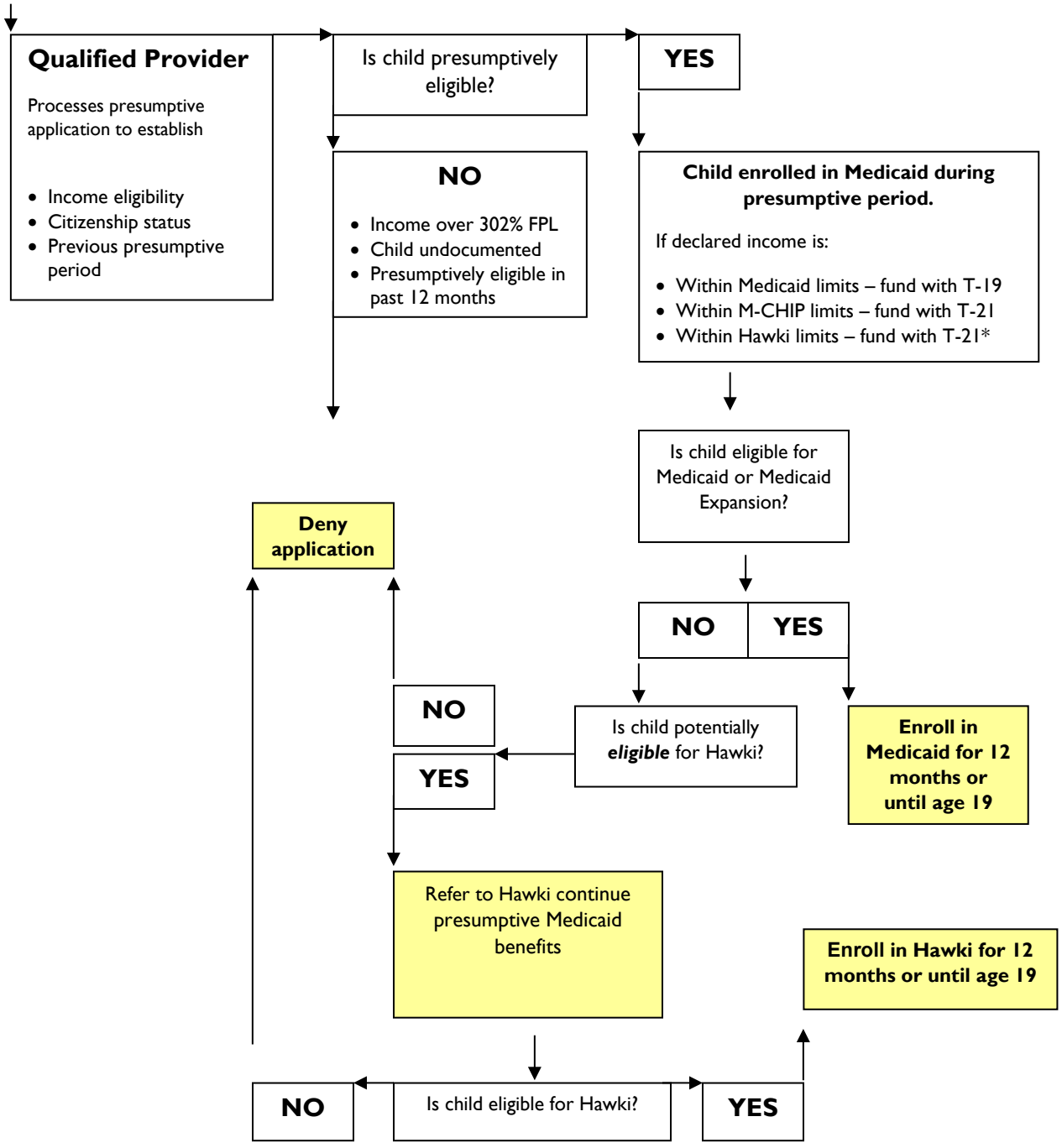
Attachment Six – Presumptive Eligibility for Medicaid and Hawki

Point of Entry



* Medicaid services exceeding Hawki benefits package are paid with CHIP administrative funds

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Attachment Seven – Hawki Board Members

Hawki

Elizabeth Matney, Medicaid Director | **Healthy and Well Kids in Iowa (Hawki) Board**

Board Members

as of November 21, 2022

Mary Nelle Trefz, Chair | **Mary Scieszinski, Vice Chair**

PUBLIC MEMBERS

MaryNelle Trefz Term ends 04/30/24
4124 Lincoln Place Dr.
Des Moines, IA 50312
319-400-5056
mntrefz@aces360.org

Shawn Garrington Term ends 04/2024
19718 Concord Ave
Wellsburg, IA 50680
515-875-9890
shawn@garrington.com

Mary Scieszinski Term ends 04/30/23
6063 Aspen Dr
West Des Moines, IA 51525
515-250-6280
bakersigkap@gmail.com

Mike Stopulos Term ends 04/2024
16 Oak Park Dr.
Bettendorf, IA 56357 563-579-3249
mdstopl@gmail.com

STATUTORY MEMBERS:

Doug Ommen, Commissioner
Insurance Division
Iowa Department of Commerce
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
515-725.1220
doug.ommen@iid.iowa.gov

Commissioner Ommen designee:
Angela Burke Boston
515-654-6543
angela.burke.boston@iid.iowa.gov

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Dr. Ann Lebo, Director
Iowa Department of Education
Grimes State Office Building, 2nd Floor
400 East 14th Street
Des Moines, IA 50319
515-281-3436
ann.lebo@iowa.gov

Director Lebo's designee:
Jim Donoghue
515-281-8505
Jim.Donoghue@iowa.gov

Kelly Garcia, Director
Iowa Department of Public Health
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319
515-281-7689
kgarcia@dhs.state.ia.us

Director Garcia's designee:
Angie Doyle Scar
515-954-9537
angela.doylescar@idph.iowa.gov

LEGISLATIVE MEMBERS – EX OFFICIO

Senator Nate Boulton
Iowa Senate
State Capitol Building
Des Moines, IA 50319
515-281-3371
nate.boulton@legis.iowa.gov

Home:
2670 Wisconsin Ave.
Des Moines, IA 50317

Senator Mark Costello
Iowa Senate
State Capitol Building
Des Moines, IA 50319
515-281-3371
mark.costello@legis.iowa.gov

Home:
37265 Rains Ave,
Imogene, IA 51645

Representative John Forbes
Iowa House of Representatives
State Capitol Building
Des Moines, IA 50319
Phone: 515-281-3221
john.forbes@legis.state.ia.us

Home:
12816 Cardinal Lane
Urbandale, IA 50323

Representative Shannon Lundgren
Iowa House of Representatives
State Capitol Building
Des Moines, IA 50319
515-281-3221
shannon.lundgren@legis.state.ia.us

Home:
918 Heather Drive
Peosta IA 52068

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DEPARTMENT OF HUMAN SERVICES STAFF

Elizabeth Matney, Iowa Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services
1305 E. Walnut St.
Des Moines, IA 50319
515-256-4640
ematney@dhs.state.ia.us

Tashina Hornaday, Management Analyst
Iowa Medicaid Enterprise
Iowa Department of Human Services
1305 E. Walnut St.
Des Moines, IA 50319
515-201-3553
thornad@dhs.state.ia.us