

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

to the Governor, General Assembly

and Council on Human Services

Calendar Year 2003

***hawk-i***

***(Healthy and Well Kids in Iowa)***

***Healthy and Well Kids In Iowa***

***(hawk-i***)

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

**Calendar Year 2003**

**C O N T E N T S**

**ANNUAL REPORT OF THE *hawk-i* BOARD**

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**EXECUTIVE SUMMARY**

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

the Governor, General Assembly and Council on Human Services

Calendar Year 2003

Iowa Code Section 514I.5(g) directs the ***hawk-i*** Board to submit an annual report to the Governor, General Assembly, and Council on Human Services concerning the Board's activities, findings, and recommendations.

During calendar year 2003, the ***hawk-i*** Board continued to address the challenge set forth by the Governor and Iowa General Assembly ensuring that Iowa’s children have access to quality health care coverage. The Board has been supported in its work by the Department of Human Services, Department of Public Health, Department of Education, Division of Insurance, advisory committees, advocacy groups, and providers.

Identifying uninsured children in Iowa through community outreach efforts remains a primary focus of the Board and the development of a new grassroots outreach structure was an important issue addressed by the Board this year.

A total of 29,530 children are enrolled in ***hawk-i*** and the Medicaid Expansion Programs as of November 30, 2003. Health status surveys indicate that children enrolled in the program are more likely to receive preventive health care vital to assuring that children grow up healthy.

***hawk‑i*** outreach efforts have also impacted Iowa’s Medicaid Program. When the ***hawk‑i*** Program was implemented in January, 1999, there were 91,737 children covered by Medicaid. That number has now grown to 155,555, as of November 30, 2003.

Highlights of the report are listed below.

**I. Clinical Advisory Committee:**

The Clinical Advisory Committee, created by the Legislature as part of H.F. 2517, to advise the Board on coverage issues, again recommended changes to the current benefits of the ***hawk-i*** Program.

These recommendations were supported by the ***hawk-i*** Board and the Board requested that the legislative members of the Board consider sponsorship of a Bill containing the Clinical Advisory Committee's recommendations. A benefit enhancement bill was introduced but no action was taken by the Legislature.

1. **Benefit Recommendations:**

The Committee’s legislative recommendations covered five areas:

1. Care coordination added as a benefit.
2. Dental benefits yearly maximum increased to $1,500 across the health plans.
3. Mental health and substance abuse benefits comparable across health plans.
4. Medically necessary nutrition services should be covered when provided by a licensed dietician with a physician’s referral. Also, provide for nutrition services beyond basic nutrition when it is medically necessary.
5. Physical and occupational therapy services comparable across health plans.

The Clinical Advisory Committee recommendations were the same that were submitted last year and are attached as *Attachment 1*.

*Attachment 1: Clinical Advisory Committee Benefit Recommendations*

1. **Outcome Measurements**

Federal regulations require states to identify outcome measurements in their state plan. The Clinical Advisory Committee, in collaboration with researchers from the University of Iowa Public Policy Center, identified four service areas that were of greatest interest. The measures were adopted from the Health Plan Employer Data and Information Set (HEDIS). HEDIS are a set of measures developed by the National Committee for Quality Assurance (NCQA) for evaluating the outcomes of health plans. The Clinical Advisory Committee selected the following outcomes measurements:

1. Rate of well child visits for children 3-6 years and adolescent visits 12 – 19 years of age enrolled for at least 11 months by plan. ***hawk‑i*** outcomes are compared to American Public Health Services Association (APHSA) rates;
2. Percent of children with a preventive dental visit by age and plan;
3. Rates of MMR immunizations of children born in 1999 and enrolled between the first and second birthday by months of enrollment by plan;
4. The number and percent of children with an outpatient mental health visit by age and gender and the number and percent of children diagnosed with the three most common mental health diagnoses by gender and age;
5. Special study: Children with Attention Deficit Hyperactivity Disorder (ADHD). The study had five primary aims:

* To determine the prevalence of ADHD diagnosis in the ***hawk‑i*** population by age and gender of the child;
* To establish baseline demographic information regarding children with a diagnosis of ADHD;
* To evaluate the utilization of behavioral and emotional health care services by children with ADHD;
* To compare the information regarding ADHD gleaned from the encounter data and the surveys
* To present additional behavioral and emotional results from the survey

On December 15, 2003, the first outcome reports were presented to the ***hawk-i*** Program Board. Copies of the reports are attached.

*Attachment 2:“Outcomes of Care for Children Enrolled in* ***hawk-i”*** and *“Attention Deficit Hyperactivity Disorder and Children in* ***hawk-i*** *”*

**II. Legislative Action:**

* In calendar year 2003 the ***hawk‑i*** Board supported a proposal, made by DHS, to amend portions of the Code to incorporate the clarifications and policies developed by the ***hawk-i*** Board during the implementation and start-up of the program to the Code. These changes were primarily technical in nature

At the request of Board members, Representatives Greimann and Hansen introduced House File 49 to make the technical amendments to Iowa Code Section 514I and eliminate the policy that required a six month waiting period for families who drop employer-sponsored coverage. The bill passed with two attached amendments:

* + Reduce the required number of Board meetings from 10 to 6 per year,
  + Provides that the Director of DHS, with the permission of the ***hawk‑i*** Board, may contract with participating insurers or enter into a separate contract with a sole source contractor to provide dental only services.
  + The Governor signed the bill on May 12, 2003.
* Representatives Greimann, Petersen, Wise, et al introduced House File 136. Senator Ragan also introduced a companion bill to HF 49, Senate File 26. The bill added the benefit enhancements to ***hawk-i’s*** benefit package as previously recommended by the Clinical Advisory Committee. No action was taken by the Legislature on this bill.

**III. Budget:**

A. **Federal Funding Issues:**

The State Children’s Health Insurance Program (SCHIP) is funded with both state and federal funds. States are allocated federal funding based on the estimated number of uninsured children in the state who could qualify for the program. In order to draw down $3.00 of federal funds, the state must spend approximately $1.00 in state funds.

Iowa’s allotment of federal funds for the SCHIP Program (includes both Medicaid expansion and ***hawk-i***) was in excess of $32 million each year for 1998 through 2001. For the third straight year, the federal SCHIP allotment for Iowa has decreased. The Federal fiscal year 2004 allotment is $19.7 million, a 39.3% reduction from when the state started the ***hawk-i*** Program.

|  |  |  |  |
| --- | --- | --- | --- |
| **Federal Fiscal Year** | **Allotment** | **Dollar Variance from 1st FFY Allotment** | **Percent Variance from 1st FFY Allotment** |
| 1998 | $32,460,463 |  |  |
| 1999 | $32,307,161 | <$153,302> | <.47%> |
| 2000 | $32,282,884 | <$177,579> | <.54%> |
| 2001 | $32,940,215 | + $479,752 | + 1.4% |
| 2002 | $22,411,236 | <$10,049,227> | <30.9%> |
| 2003 | $21,368,268 | <$11,092,195> | <34.2%> |
| 2004 | $19,703,000 | <$12,757,463> | <39.3%> |

PL 108-74, signed by the President on August 15, 2003, extends the availability of unspent SCHIP allotments from FFYs 1998, 1999, 2000, and 2001. Iowa was not eligible to receive additional funding from FFYs 1998 and 1999 because we have spent all of the previously retained funding. However, this action allowed Iowa to retain 50% of the $8.4 million of unspent FFY 2000 funds that would have otherwise been reverted to the redistribution pool. The amount Iowa will be able to retain from FFY 2001 unspent funds has yet to be determined. The remaining 50% will be redistributed to states and territories that have fully expended their allotments for FFYs 2000 and/or 2001.

The three-year period in which to spend the 2001 allotment ended on September 30, 2003, so spending is currently from the FFY 02 allotment. At the point all currently available federal funding is exhausted, Iowa will be eligible to receive additional funds from the redistribution pool since all state allotments are decreasing, more states will be relying on redistributed funds to support their programs at the same time.

B. **State Funding Issues:**

The total appropriation of state funds for SFY ’03 was $14,482,082, inclusive of $2,823,670 ***hawk‑i*** Trust Fund dollars held in reserve at SFY ’02 year-end. Of this amount, $10,091,128 was expended. Thus, the ***hawk-i*** Program ended SFY ’03 with a balance of $4,390,954 in state funds in the ***hawk-i*** trust fund.

By statute, the budget request for the upcoming SFY is included in the Department of Human Services' budget request. All Executive Branch agencies were asked to submit a status quo budget for SFY ’05. The Department requested the same appropriation as SFY 04, $11,118,275. The status quo budget would not allow for any growth in the Program either for normal increased costs or take into consideration that there will be fewer trust fund carryover dollars. Therefore, no additional children could be enrolled and reduction in the number of current children enrolled could become necessary.

The Department is aware that several states have implemented waiting lists and have actually disenrolled many children. Under such a scenario, a status quo budget may well require that a waiting list be implemented as early as January 2004 to maintain enrollment at the currently projected level of 16,274 children. Again on July 1, 2004, approximately 4,106 children would be disenrolled in order to maintain enrollment at 12,168 children for the entire year. It appears the end result of a status quo budget is that 9,610 children would be uninsured; 5,564 not covered due to the waiting list and 4,106 disenrolled as of July 2004.

The Board fully appreciates the budget limitation facing the Governor and Legislature. The Board also knows that both governmental branches have made special efforts in the past to preserve and, where possible, grow the ***hawk-i*** Program. We know the Department will work closely with the Legislature and the Governor’s Office to support the ***hawk-i*** Program in order that the current enrolled and future coverage of additional children can be accomplished.

A copy of the final SFY ’03 final expenditure report and the SFY ’04 budget are attached. These reports reflect state only dollars.

*Attachment 3: Allotment Expenditure History, SFY ’03 Expenditure Report, and SFY ’04 Budget*

**IV. Outreach:**

The Balanced Budget Act of 1997 requires states to conduct outreach activities to communities for local outreach efforts. The Department continues to educate the public about the ***hawk-i*** Program by giving presentations to various groups who can assist in promoting the program.

A. **Structure:**

Effective September 1, 2003, the Iowa Department of Human Services (DHS) contracted with the Iowa Department of Public Health (IDPH) to provide oversight for a statewide ***hawk‑i*** grassroots outreach program. The Bureau of Family Health in the Iowa Department of Public Health administers the outreach program through 26 community-based child health agencies. Each child health agency designates a Local Outreach Coordinator. Statewide activities are coordinated by the State Outreach Coordinator who also provides technical assistance and oversight to the local efforts. This includes, but is not limited to, e-mail communication, list serve linkages, face-to-face visits, and quarterly statewide training meetings. The State Outreach Coordinator also serves as the liaison between the local outreach efforts and DHS. Community-based child health agencies enter into (sub-contracts) with other local entities that have demonstrated successful community outreach and enrollment activities to avoid duplication and assure successful efforts. Each child health agency implements an approved plan that addresses outreach to schools, the faith-based community, health care providers, and underserved populations for the communities they serve.

B. **Progress To-Date:**

DHS has provided the leadership for an effective collaboration between the two state departments and the ***hawk‑i*** Board. Outreach efforts coordinated through IDPH and the local child health agencies have been very successful. This collaboration will continue to guide outreach efforts to reach uninsured families in Iowa. Initial outreach efforts focused on four areas: schools, faith-based, medical providers and underserved populations.

Additional detailed information on how these four areas are being addressed is included in the appendix.

**V. *hawk-i* Enrollment and Referrals to Medicaid:**

The ***hawk-i*** Program continued to experience growth in 2003. Since January 2003, the ***hawk-i*** Program has received 14,688 applications. Similar to past years, approximately 40% of all ***hawk-i*** applications were referred to Medicaid. Although the Medicaid Expansion component of SCHIP (Title XXI funded) remained constant in 2003, the Medicaid program experienced significant growth in the number of children participating.

A. **Enrollment:**

|  |  |  |
| --- | --- | --- |
| Program | Enrollment as of  November 30, 2002 | Enrollment as of  November 30, 2003 |
| Medicaid Expansion | 12,203 | 13,820 |
| ***hawk-i*** Program | 13,998 | 15,710 |
| Total SCHIP Enrollment | 26,201 | 29,530 |

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B. **Unduplicated Number of Children Enrolled by Federal Fiscal Year:**

The Department developed a table of the number identifying children enrolled (unduplicated) in the ***hawk-i*** Program at any time during the FFY (October 1 through September 30) by federal poverty level for FFYs 2000, 2001, 2002 and 2003. Each child enrolled in ***hawk-i*** is counted once regardless of the number of times he or she was enrolled or re-enrolled in the program during the year. This unduplicated count represents the total children served by the program rather than point-in-time enrollment.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Federal Poverty Level** | | | | **Total Children Served** |
| **<=100%** | **>100%<=150%** | **>150%<=200%** | **>200%** |
| **Federal Fiscal**  **Year 2000** | 285 | 4,840 | 3,416 | 158 | 8,699 |
| **Federal Fiscal**  **Year 2001** | 679 | 8,760 | 6,977 | 256 | 16,672 |
| **Federal Fiscal**  **Year 2002** | 682 | 10,415 | 10,034 | 3 | 21,134 |
| **Federal Fiscal**  **Year 2003** | 956 | 10,617 | 11,486 | 0 | 23,059 |

Respectfully submitted,

***hawk-i*** Board

Members:

Eldon Huston, Chair

Terri Vaughan, Vice-Chair

Susan Salter

Wanda Wyatt-Hardwick

Jim Yeast

Mary Mincer Hansen

Ted Stilwill

Senator Amanda Ragan

Senator Kenneth Veenstra

Representative Gerald Jones

Representative Jane Greimann

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The Balanced Budget Act of 1997 requires states to conduct outreach activities to communities for local outreach efforts. The Department continues to educate the public about the ***hawk-i*** Program by giving presentations to various groups who can assist in promoting the program.

A. **Structure:**

Effective September 1, 2003, the Iowa Department of Human Services (DHS) contracted with the Iowa Department of Public Health (IDPH) to provide oversight for a statewide ***hawk‑i*** grassroots outreach program. The Bureau of Family Health in the Iowa Department of Public Health administers the outreach program through 26 community-based child health agencies. Each child health agency designates a Local Outreach Coordinator. Statewide activities are coordinated by the State Outreach Coordinator who also provides technical assistance and oversight to local efforts. This includes, but is not limited to, e-mail communication, list serve linkages, face-to-face visits, and quarterly statewide training meetings. The State Outreach Coordinator also serves as the liaison between the local outreach efforts and DHS. Community-based child health agencies enter into (sub-contracts) with other local entities that have demonstrated successful community outreach and enrollment activities to avoid duplication and assure successful efforts. Each child health agency implements an approved plan that addresses outreach to schools, the faith-based community, health care providers, and underserved populations for the communities they serve.

B. **Progress To-Date:**

DHS has provided the leadership for an effective collaboration between the two state departments and the ***hawk‑i*** Board. Outreach efforts coordinated through IDPH and the local child health agencies have been very successful. This collaboration will continue to guide outreach efforts to reach uninsured families in Iowa. Initial outreach efforts focused on four areas: schools, faith-based, medical providers and underserved populations.

C. **Outreach to Schools:**

Child health agencies have made strong allies in their local schools to reach uninsured children. Local outreach activities include, but are not limited to, working with school nurses, local Head Start Agencies, Area Education Agencies (AEAs) and Empowerment boards. In August of 2003, DHS sent ***hawk‑i*** brochures to every school in Iowa and asked that a brochure be sent home with every child. In addition, the Covering Kids and Families project and local Outreach Coordinators held “Back to School events” across the state. DHS and the Department of Education (DOE) continue to collaborate to allow schools and childcare providers who participate in the Free and Reduced Meals Program to make referrals to the ***hawk‑i*** Program for outreach purposes. Additionally, ***hawk‑i*** information has also been made available at numerous conferences targeting educators, school administrators and superintendents. In the months immediately following this effort, application referrals from schools significantly increased.

**Applications Referred by Schools**

|  |  |  |
| --- | --- | --- |
| **Month & Year** | **# Applications Referred** | **% Increase In Applications Referred** |
| July’02 | 57 |  |
| September’02 | 134 | 174% |
|  |  |  |
| July’03 | 61 |  |
| September’03 | 369 | 505% |

1. **Outreach to the Faith-based Community:**

Great strides have been made in reaching out to faith-based communities through local efforts. Outreach coordinators are working with ministerial associations and churches across Iowa including working with the Amish and Mennonite communities. State staff has also engaged the Iowa Family Policy Center to assist in developing a message to reach out to the evangelical community.

E. **Outreach to Medical Providers:**

The medical community has been responsive in assisting with various ***hawk‑i*** outreach efforts. ***hawk‑i*** material has been distributed to hospitals and medical clinics and offices across the state. Local outreach coordinators have been working with not only physicians and nurses but also front office staff and patient account representatives to ensure comprehensive outreach in the medical community. A Doctor Kit created by the *Covering Kids and Families* initiative has been widely utilized by local outreach coordinators. A decal has been created that can be placed in participating providers’ windows to help ***hawk‑i*** enrollees easily identify providers who accept patients with coverage through the ***hawk‑i*** Program. Informational material has also been made available at various conferences for health care providers.

F. **Additional Activities:**

* 1. Many local outreach coordinators are working with their local businesses, Chambers and workforce offices to assist in local outreach. Dave Roederer, Executive Director of the Chamber Alliance participated in training for Local Outreach Coordinators to offer guidance in outreach to local businesses and chambers.
  2. The Iowa Chamber of Commerce Executives Association has also been engaged with outreach activities.
  3. A presentation was given to the Association of Iowa Workforce Partners (AIWP). AIWP is an association that addresses workforce and employment issues. Most members of the association are Directors of Iowa’s regional workforce office and administer the PROMISE JOBS Program.
  4. The Drake Legal Clinic has also agreed to have ***hawk‑i*** information available to its clients.
  5. During September, the Lt. Governor traveled across Iowa to lead seven community roundtable discussions about ***hawk‑i*** outreach strategies. The roundtables were very well attended by a variety of community outreach strategies. The roundtables were very well attended by a variety of community representatives, including school nurses, medical providers, ministers, Farm Bureau agents, legislators, workforce agencies and childcare organizations.
  6. DHS and the Department of Education (DOE) continue to collaborate to allow schools and childcare providers who participate in the Free and Reduced Meals Program to make referrals to the ***hawk‑i*** Program for outreach purposes. Under this initiative, the names of applicants for the Free and Reduced Meals Program are referred to the ***hawk‑i*** Program unless the family specifically asked not to be referred. Participating schools were asked to submit lists of names to MAXIMUS so an application and information about the program can be mailed to the family.
  7. In March an informational letter and ***hawk‑i*** application was included in a mailing to 1,800 food stamp families who had children not identified as Medicaid eligible. Completed applications have been received in response to the effort. The Department will periodically repeat the mailing.

G. **Covering Kids and Families Grant Project:**

The Iowa Covering Kids and Families Project is a statewide collaborative effort of state and local community-based agencies, child advocacy groups, and professional organizations designed to increase access to health care coverage for all uninsured children in Iowa. The program is made possible by a grant from the Robert Wood Johnson Foundation. The statewide component, led by the State Covering Kids and Families Coalition and supported by the Iowa Department of Public Health, seeks to identify potential barriers to enrollment into all child health insurance programs and implement system changes to remove barriers.

Administrators of the grant work collaboratively with DHS, Department of Education (DOE), grassroots Outreach Coordinators, advocates, medical providers, child care providers and others. Covering Kids and Families project staff coordinate their efforts with DHS to promote coverage for children and provides updates to the ***hawk‑i*** Board on key outreach activities taking place in communities across the state.

**V.** ***hawk-i* Enrollment and Referrals to Medicaid:**

The ***hawk-i*** Program continued to experience growth in 2003. Since January 2003, the ***hawk-i*** Program has received 14,688 applications. Similar to past years, approximately 40% of all ***hawk-i*** applications were referred to Medicaid. Although the Medicaid Expansion component of SCHIP (Title XXI funded) remained constant in 2003, the Medicaid program experienced significant growth in the number of children participating.

A. **Enrollment:**

|  |  |  |
| --- | --- | --- |
| Program | Enrollment as of  November 30, 2002 | Enrollment as of  November 30, 2003 |
| Medicaid Expansion | 12,203 | 13,820 |
| ***hawk-i*** Program | 13,998 | 15,710 |
| Total SCHIP Enrollment | 26,201 | 29,530 |

*Attachment 4: Organization of the* ***hawk-i*** *Program Chart, History of Participation of Children in Medicaid and* ***hawk-i,*** *Iowa’s SCHIP Program Combination Medicaid Expansion and* ***hawk-i,*** *Enrollee Demographic Summary by Federal Poverty Level, Enrollee Demographic Summary by Age, Enrollee Demographic Summary by Gender*

B. **Unduplicated Number of Children Enrolled by Federal Fiscal Year:**

The Department developed a table of the number identifying children enrolled (unduplicated) in the ***hawk-i*** Program at any time during the FFY (October 1 through September 30) by federal poverty level for FFYs 2000, 2001, 2002 and 2003. Each child enrolled in ***hawk-i*** is counted once regardless of the number of times he or she was enrolled or re-enrolled in the program during the year. This unduplicated count represents the total children served by the program rather than point-in-time enrollment.

**Unduplicated Number of *hawk‑i* Children Enrolled by FFY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Federal Poverty Level** | | | | **Total Children Served** |
| **<=100%** | **>100%<=150%** | **>150%<=200%** | **>200%** |
| **Federal Fiscal**  **Year 2000** | 285 | 4,840 | 3,416 | 158 | 8,699 |
| **Federal Fiscal**  **Year 2001** | 679 | 8,760 | 6,977 | 256 | 16,672 |
| **Federal Fiscal**  **Year 2002** | 682 | 10,415 | 10,034 | 3 | 21,134 |
| **Federal Fiscal**  **Year 2003** | 956 | 10,617 | 11,486 | 0 | 23,059 |

C. **Uninsured Projections:**

In 1977 the Census Bureau estimated there were 67,000 uninsured children in Iowa, between the ages of 1 – 19, who lived in households with income under 200% of the federal poverty level. States questioned the reliability of the original projections and in 2001 the Census Bureau changed the methodology used to project uninsured children. Most recent Census Current Population Survey (1998, 1999, and 2000) estimates indicated that the number of uninsured children in Iowa dropped considerably. The decline, in part, can be attributed to the number of children enrolled in Medicaid, Medicaid Expansion, and ***hawk-i****.*

The Department developed new projections in August 2002. Reference information was used from the U.S. Census Bureau, Iowa State County Extension Service, University of Minnesota-SHADAC, and Creighton University Department of Economics. Census current population survey 2000 indicated that there are 245,000 children 0 to 19 year of ages, at or below 200% of FPL in Iowa.

The data was updated in SFY 2002/2003, taking into consideration the economic downturn. This methodology assumed an increase in the number of children falling into the 200% FPL and a decrease in the number of children with private insurance. The SFY 2002/2003 projected uninsured rate potentially eligible for Medicaid, Medicaid Expansion, and ***hawk-i*** is estimated to be 32,500. This estimate represented only those children yet to be covered at the time the estimates were developed and does not consider those who have already attained coverage.

The Department is currently in the process of updating uninsured projections for SFY 2004/2005 based on new census data and economic indicators. Iowa has historically been identified as having one of the lowest percentages of uninsured children in the country, every year the number of uninsured children decreases.

**VI. New Enrollment Initiatives:**

1. **Electronic Application:**

The Department began work with the Third Party Administrator on development of an electronic version of the ***hawk‑i*** application. The electronic application will be available for completion on the Internet. The electronic application will be more efficient and cost effective. Upon submission, the application will automatically populate data into the Third Party Administrator’s database, thus eliminating data entry errors. It will not allow an incomplete application to be submitted and will print out a list of the verifications that will need to be submitted by mail. The electronic application will also reduce printing costs because it is anticipated that fewer paper applications will be needed. The electronic application has been tested by the general public, other agency staff and Department staff and is scheduled for implementation in late December 2003 or early January 2004.

B. **Medicaid Referral Process Improvement Plan**

A new process for referring children who have become ineligible for Medicaid to the

***hawk-i*** Program is being implemented. Although a process is currently in place, it is somewhat labor intensive and cumbersome for field staff. It is anticipated that this project will be implemented in the spring of 2004. The following improvements are being made:

* A system is being developed so that DHS income maintenance workers can refer children automatically through the system electronically, rather than having to manually complete the forms and copy all the paperwork.
* The Medicaid notice of cancellation is being modified so that if a family with children is cancelled from Medicaid due to excess income, the notice will include a statement that the children are being referred to ***hawk-i*** automatically.
* A monthly management report of all the families that were cancelled from Medicaid due to excess income will be created so that follow-up can be made to ensure referrals are being made.
* Upon the generation of a cancellation notice, as described above, the income maintenance worker will receive an e-mail reminder to remind them to complete the referral process.

C. **Reminder Postcard for Renewals**

A test pilot project for ***hawk-i*** renewals will be conducted in December and January. A renewal reminder postcard has been developed to send to families advising them that they will be receiving a renewal form in the mail in the near future and that they should start gathering their income information. The card asks that if they are not planning on renewing, to call and tell us why.

The purpose of the project is to determine whether the reminder postcards have an impact on increasing the number of families who send in renewal forms to renew their child’s coverage for the next 12-month enrollment period. Additionally, it will assist the Department in gathering data on why families don’t renew.

**VII. Evaluations and Surveys:**

Results of the second, third and fourth ***hawk-i*** "Impact on Access and Health Status" evaluation reports were provided to the Board. The reports present an estimate of the effect that providing ***hawk-i*** health coverage had on uninsured children. The study compares the results of a survey that asked about children’s access to care, health status, and family environment in the year prior to joining ***hawk-i*** with one that asked about their experiences while in ***hawk-i*** using standard statistical tests to evaluate differences in responses before and after ***hawk-i***.

A. **Summary of Second, Third and FourthEvaluation Reports**:

| After being in ***hawk-i***  for a year: | Second Evaluation Report  Data Used  January 1999 - October 2000 | Third Evaluation Report  Data Used  July 2001 - October 2002 | Fourth Evaluation Report  Data Used  July 2002 – October 2003 |
| --- | --- | --- | --- |
| **Medical Care** **–** Children needed health care at rates similar to when they joined, however: |  |  |  |
| * they were less likely to be stopped from getting needed care. | 21% before vs. 6% after | 19% before vs. 6% after | 17% before vs. 4% after |
| * they were less likely to be delayed from getting needed care. | 34% before vs. 10% after | 32% before vs. 10% after | 23% before vs. 7% after |
| * children were more likely to have ‘always’ received needed care for an illness or injury | Data not available. | 61% before vs. 80% after | 65% before vs. 82% after |
| **Specialty Care –** Children needed to see a specialist at rates similar to when they joined, however: |  |  |  |
| * they were less likely to be stopped from getting specialty care. | 38% before vs. 13% after | 21% before vs. 15% after | 18% before vs. 10% after |
| * they were less likely to be delayed from getting specialty care | 39% before vs. 23% after | 33% before vs. 15% after | 27% before vs. 13% after |
| **Dental Care –** Children needed dental care at the same rate as when they joined, however: |  |  |  |
| * they were more likely to have a regular source of dental care. | 84% before vs. 88% after | 81% before vs. 88% after | 82% before vs.86% after |
| * they were less likely to be stopped from getting dental care | 25% before vs. 8% after | 23% before vs. 8% after | 22% before vs. 8% after |
| * they were less likely to be delayed from getting dental care | 27% before vs. 9% after | 26% before vs 9% after | 23% before vs.9% after |
| * they were more likely to have had a dental visit in the past year | 55% before vs. 69% after | 54% before vs. 71% after | 56% before vs.69% after |
| **Preventive Care** – | Children were more likely to have ‘always’ received needed routine preventative care (e.g. physical exams or vaccinations) (percentage not available). | Children were more likely to have ‘always’ received needed routine preventative care (e.g. physical exams or vaccinations) (60% before vs. 82% after). | Children were more likely to have “always” received needed routine preventive care (e.g. physical exams or vaccinations) (65% before vs. 82% after)  Children were also as likely to receive anticipatory guidance (preventive counseling) as before they joined. |
| **Other Care –** Children had similar need for vision care, however: |  |  |  |
| * they were less likely to have been stopped from receiving vision care. | 41% before vs. 15% after | 38% before vs. 14% after | 32% before vs. 9% after |
| Children had a similar need for behavioral or emotional care, however: |  |  |  |
| * they were less likely to have been stopped from receiving behavioral or emotional care. | 44% before vs. 15% after | 39% before vs. 17% after | 39% before vs. 16% after |
| Children had a similar need for prescription medicine, however: |  |  | Perceived need for prescription medicine increased from 70% to 75%, however, |
| * they were less likely to have been stopped from receiving prescription medicines. | 20% before vs. 10% after | 17% before vs. 8% after | 15% before vs. 10% after |
| **Health Status –** |  |  |  |
| * children’s overall health status was rated higher | 43% were rated in excellent health before vs. 47% after | 44% were rated in excellent health before vs. 50% after | 45% were rated in excellent health before vs. 46% after |
| * more children’s health was thought to be better than one year earlier. | 26% before vs. 32% after | 26% before vs. 31% after | 24% before vs. 30% after |
| * children had fewer sick days in the previous four weeks | 74% before without a sick day vs. 82% after | 80% before without a sick day vs. 83% after | 79% before without a sick day vs. 82% after |
| * 1 in 4 children with a chronic condition had the condition detected because of care provided while in the ***hawk-i*** Program. | Percentage not available. | 28% | Percentage not available. |
| **Impact on Families –** |  |  |  |
| * stress was reduced | In 95% of families - more than 75% of families said it had reduced stress “a lot” | In 96% of families - more than 75% of families said it had reduced stress “a lot” | In 96% of families – more than 75% of families said it had reduced stress “a lot” |
| * worry about the ability to pay for health care | Reduced significantly | 57% worried “a great deal” before vs. 19% after | 54% worried “a great deal” before vs. 20% after |
| * the activities of significantly fewer children were limited because of the concerns about health care costs | Significantly fewer children were limited. | 25% before vs. 14% after | 23 % before vs. 12% after |
| * parents health coverage status | Significantly more parents had health insurance one year after their children started on the ***hawk-i*** Program. | Significantly more parents had health insurance one year after their children started on the ***hawk-i*** Program. | Significantly more parents had health insurance one year after their children started on the ***hawk-i*** Program. |
| **Health Plans -** | One in five children had to get a new personal doctor or nurse. | One in five children had to get a new personal doctor or nurse. | One in five children had to get a new personal doctor or nurse. (30% in John Deere) |
| One in four had a problem finding a personal doctor or nurse they were happy with. | More than one in four (29%) had a problem finding a personal doctor or nurse they were happy with. | More than one in four (27%) had a problem finding a personal doctor or nurse they were happy with. (37% in John Deere) |
| One in three did not know their health plan had a help line they could call for assistance. | One in three did not know that their health plan had a help line they could call for assistance. | Almost 40% of parents did not know that their health plan had a help line they could call for assistance. |

The University of Iowa Public Policy Center conducted this research for the Iowa Department of Human Services. These reports can be viewed/downloaded at: <http://ppc.uiowa.edu/hawk-i/>

B. **Sample comments received from parents**:

These comments are intended to provide a more complete picture of respondents’ views of the ***hawk‑i*** Program. The last question on the 77-item household survey asked the following: “Please tell us if there is anything else you like or dislike about your ***hawk‑i*** health plan or the effect of having insurance coverage on your child or your family.” Below is a sample of comments received from households:

*“I left a job that kept me away from my children too much and went to a job that allowed me to be a better mom but left me without insurance. I sooo… very much appreciate the fact that* ***hawk‑i*** *was an option for us - no worries, no hassles. Thanks so much for working to keep children healthy, they are the ones that matter most. I now have a job that provides insurance so my children are no longer on* ***hawk-i***.

*“Once again I thank you for your diligence in keeping our kids healthy. I will always pass the word about* ***hawk-i***.”

*“This past year our sons have been on the* ***hawk‑i*** *health plan and it has been a blessing. We’ve experienced no problems with their care or their caregivers. It is wonderful to have this program in the State of Iowa.”*

*“Thank you for offering such a great program. If not for this program many children would be without health insurance*. ***hawk‑i*** *has made medical decisions much easier by providing such great services.*

*“Everything is perfect. Keep up the good work!”*

**VIII. Center for Medicaid and Medicaid Services (CMS) Site Visit Report:**

In September 2003, CMS conducted a site visit review of Iowa’s SCHIP Program. The review protocol focused on ***hawk-i*** updates, follow-up items from the 2001 onsite review, changes from the 2002 annual report, future plans, outreach, national policy issues, National Academy of State Health Policy (NASHP) retention and disenrollment survey, quality surveys, access and satisfaction of care, and performance improvement projects.

1. **Promising Approaches**:

Based on information gathered during the review, we found the State is effectively administering the ***hawk‑i*** Program in accordance with their State plan.

**CMS noted**:

* Iowa continues to improve the ***hawk‑i*** Program by making changes to its program. Iowa has created a new application design and is implementing an electronic application. The State also includes reminder messages on the 12 mail-in payment coupons to keep beneficiaries informed of the Program while being cost effective.
* CMS commends the State for their new extensive efforts in outreach including sending the 500,000 brochures to the schools within Iowa and using a food stamp tape match to mail letters to families of any child on food stamps that is not currently enrolled in Medicaid or SCHIP.
* The State’s new structure for oversight of outreach activities is working well.
* Communication between all entities involved in outreach strategies results in effective collaboration and coordination.
* A full-range of outreach strategies is in place, both statewide and at the local level. These activities are designed in multiple ways to reach multiple audiences.
* The State is successfully evaluating and monitoring its outreach activities providing for methods to measure the success of outreach strategies and opportunity for feedback to identify ideas and potential obstacles.
* Iowa has implemented a number of strategies to help families with the renewal process. However, the number of enrollees who have been disenrolled from ***hawk‑i*** upon renewal appears to have increased from SFY 2002 to SFY 2003. The State continues to evaluate the reasons individuals are disenrolling from the program to ensure that the renewal process is not a deterrent to renewing coverage.
* Iowa has a number of quality assurance mechanisms in place to monitor participating health plans and to ensure that the ***hawk‑i*** Program is operating effectively and meeting the needs of program participants.
* Iowa Department of Human Services evaluates quality of care and access to medical services in the ***hawk‑i*** Program through a number of performance measurement activities, including conducting enrollee surveys and collecting enrollment and quality assurance data.

1. **Recommendations:**

**CMS noted**:

* When sub-contracts are renewed with the Title V agencies, the Department of Public Health should consider offering training for outreach workers by the Department.

**State Response**: This is being considered and is in the planning stages.

* The State should continue to reach out to the American Indian population.

**State Response**: The state agrees. The State Outreach Coordinator is currently developing contacts that will foster relationships with tribal populations along the Iowa/Nebraska and Iowa/South Dakota borders. Additionally, outreach efforts to the Mesquaki Tribe, a subset of the Sac and Fox of the Mississippi and Iowa Tribe, will continue.

* DHS should continue to monitor the ***hawk‑i*** disenrollment population, through enrollee surveys and the renewal process, to ensure that higher utilization kids are not leaving the program and remaining uninsured due to problems they have had with the program.

**State Response**: Monitoring will continue. When additional funding is available. DHS will consider conducting a formal disenrollment survey. In the meantime, DHS is currently developing a reminder postcard pilot project. The postcard will be sent to enrollees approximately one week before their annual renewal form is mailed to reminding them to watch the mail for the form and to call customer service if they don’t receive it. Additionally, the postcard asks families who won’t be renewing coverage to call customer service to tell us why. This effort will be piloted on a small scale and implemented statewide if it is proven successful.

* DHS should be commended for taking steps to help families with the renewal process, and they should continue to evaluate the reasons individuals are disenrolling from the program to ensure that the renewal process is not a deterrent to renewing enrollment.

**State Response**: DHS will continue to evaluate the renewal process in order to make improvements. In addition to the reminder postcard pilot project described above, once the on-line application is implemented, DHS plans to assess the feasibility of an on-line renewal process that incorporates the elements of the on-line application.

* DHS should continue to evaluate the need for a survey of ***hawk‑i*** providers and review provider surveys currently being conducted by health plans to identify any potential problems.

**State Response:** In August 2003, the ***hawk‑i*** Board asked DHS to consider conducting a provider survey. The Department is currently evaluating the feasibility of the project and identifying funding options. No recommendations have been finalized at this time.

**IX. Health Plans:**

Three health plans provided health benefits to ***hawk-i*** Program enrollees in 2003; Iowa Health Solutions, John Deere, and Wellmark.

As of November 30, 2003, ***hawk-i*** Program enrollment by health plan was:

Iowa Health Solutions 3,906

John Deere 3,987

Wellmark 6,564

The Board approved an 8.8 % capitation rate increase for the indemnity plan and a 10 % increase in the managed care capitation rate. The current per member per month (PM/PM) rate by federal and state funding are:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***hawk-i*** | Monthly Cost  SFY '02 | Federal Funding | State Funding | Monthly Cost  SFY '03 | Federal Funding | State Funding | Monthly Cost  SFY ‘04 | Federal Funding | State  Funding |
| Managed Care Plans | $106.52 | $78.82  (74%) | $27.70  (26%) | $119.30 | $88.28  (74%) | $31.02  (26%) | $131.23 | $97.11  (74%) | $34.12  (26%) |
| Indemnity Plan | $131.98 | $97.67  (74%) | $34.31  (26%) | $155.87 | $115.34  (74%) | $40.53  (26%) | $169.58 | $125.49  (74%) | $44.09  (26%) |
| Average of All Plans | $119.25 | $88.25 | $31.00 | $137.85 | $101.81 | $35.78 | $150.41 | $111.30 | $39.11 |

*Attachment 5: County Health Plan Map and Enrollment by Health Plan Chart, Iowa’s Children’s Health Insurance Program Chart*

**X.  *hawk-i* Board Membership:**

The original enabling State legislation required the ***hawk-i***Board to meet at least ten times annually. To date, the ***hawk-i***Board has met every month since it was established in June 1998 with the exception of November 2001, July 2002 and March 2003. On May 12, 2003 Governor Vilsack signed H.F. 49 requiring the number of ***hawk-i*** Board meetings to change from ten to no less than six and no more than twelve per calendar year as of July, 2003, the Board meets on the third Monday of every other month. Meeting agenda and minutes are available on the ***hawk-i*** Program web site at [www.hawk-i.org](http://www.hawk-i.org).

Changes in the Board membership in 2003:

* Director Mary Mincer Hansen replaced Dr. Stephen Gleason. Director Mincer Hansen designated Julie McMahon as her designee to the ***hawk-i*** Board.
* Representative Brad Hansen submitted his resignation from the ***hawk-i*** Board.
* Representative Gerald Jones was appointed to the ***hawk-i*** Board replacing Representative Brad Hansen. The two-year term expires on April 20, 2004.

*Attachment 6: Healthy and Well Kids in Iowa (****hawk-i****) Board Bylaws, Healthy and Well Kids in Iowa -* ***hawk‑i*** *Board Members*

**2003 Board Activities & Milestones:**

January

The Board was advised at the December 2002 meeting that the Office of Inspector General (OIG) is conducting an audit on Iowa’s SCHIP Program. Department staff is educating the auditors on Iowa’s Medicaid and SCHIP Program policy and processes.

The Board was advised that the ***hawk-i*** technical bill filed the past several years was introduced in a Senate File by Senator Ragan; a companion House File was introduced by Representative Greimann and Hansen. The Senate File also includes benefit enhancements introduced in previous years.

The Board approved the Department’s recommendation that the ***hawk-i*** Quality Committee be combined with the Clinical Advisory Committee. Dr. Alexander who chaired the Clinical Advisory Committee moved out-of-state. Dr. Julianne Thomas (Chair of the Quality Committee) and Linda Ruble (Co-Chair) were nominated and elected unanimously to fill those roles on the Clinical Advisory Committee.

The Department informed the Board that Angie Doyle Scar accepted the State Outreach Coordinator position. Ms. Doyle-Scar previously worked for the State Public Policy Group in Des Moines and is experienced in grassroots initiatives.

February

The Department reported to the Board that a ranking of enrollment among the 50 states shows that Iowa increased enrollment 32.57% in FY 02 over 01. The increase nationally was 13.04%.

March

The ***hawk-i*** Board did not meet in March.

April

The Board was advised that the first printing of the revised application has been completed. Permission to develop an electronic application that goes with the new application format was given to the Department.

The Board approved the Fourth Amendment to the Contract with Iowa Health Solutions for health care services for the ***hawk-i*** Program to include expansion into Dallas and Madison Counties effective June 1, 2003. The expansion will provide enrollees a choice between John Deere Health Plan, currently providing health care services in the two counties, and Iowa Health Solutions.

The Department reported on the discussion of the Clinical Advisory Committee meeting. The Committee has determined they will look at attention deficit hyperactivity disorder (ADHD) on children with ***hawk-i***. The University of Iowa’s Public Policy Center will complete the special study.

The Department updated the Board on the implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA). A notice of privacy practices for ***hawk-i*** was developed and distributed to approximately 8,200 households on April 14, 2003. The ***hawk-i*** privacy notice is available in English and Spanish and is posted on the ***hawk-i*** website. Ongoing, when a child is approved to receive benefits under ***hawk-i***, a notice will be sent to the family. In addition to the privacy notice the Department will implement two electronic transaction sets, payment of premiums and enrollment and disenrollment. Implementation for the transaction sets between the Department and contracted health plans is October 16, 2003.

#### May

The Board approved SFY 04 capitation rate increases of 8.8% for Wellmark Indemnity and 10% for Iowa Health Solutions and John Deere managed care plans.

The Board was advised that the Governor signed the Department’s technical bill on May 12, 2003. The technical bill requires the number of ***hawk-i*** Board meetings from ten to no less than six and no more than twelve per calendar year, eliminates the six month waiting period for children who had employer-sponsored health care coverage allowing children to have health care coverage through the ***hawk-i*** Program, changes Healthy and Well Children to Kids to reflect the actual name of the Program and amends the name of the division that currently administers the ***hawk-i*** Program from Medical Services to Financial, Health and Work Supports.

June

The Board unanimously approved two proposed administrative rule amendments based on House File 565, ***hawk-i*** technical bill, reducing the number of Board meetings to not less than six and not more than 12 per year and elimination of the six-month waiting period for the ***hawk-i*** Program. The administrative rule amendments will become effective on July 1, 2003.

The Department presented SFY 2004 health care services contracts between the ***hawk-i*** Program and Wellmark, John Deere and Iowa Health Solutions. The 2004 contracts were amended to comply with the Accountable Government Act. This Act ties payment to performance and monitoring of the contract. The Board unanimously approved the contracts.

July

The ***hawk-i*** Board did not meet in July. Effective July, the number of required Board meetings were reduced to not less than six and not more than 12 per year.

August

The Department presented a proposed rule amendment to the ***hawk-i*** Board. The administrative rule allows for the submission of an electronic application as a valid application for the ***hawk-i***

Program. Even though the application is submitted electronically, the applicant will still be required to mail in an original signature. The Board unanimously approved the administrative rule.

The Department advised the Board that the contract with MAXIMUS to be the ***hawk-i***

Program’s third party administrator second two one-year extension ending June 30, 2004 needs to be extended to June 30, 2005. If the contract were to be re-bid, the procurement process would need to begin now in order for a new bidder to have sufficient start-up time for a July 1, 2004 implementation. The Department proposed that the contract be approved for the second one-year extension, through June 30, 2005. The Board unanimously approved the second one-year contract extension.

The Department reported to the Board that on July 24, 2003, a letter was mailed to all school principals from Director Concannon. In follow-up to the letter, 550,000 ***hawk-i*** applications were mailed to public and private schools on August 15, 2003. The response from the schools has been very positive.

September

The ***hawk-i*** Board did not meet in September.

October

The Department reported to the Board that Delta Dental has approached the Department expressing their interest in providing the dental benefit for ***hawk‑i***. The Chairman of the Board responded to Delta Dental on October 1, 2003, asking them to present a proposal to the Department indicating what type of benefits they would offer under a dental carve out package and what rate they would charge.

The Department reported to the Board that ***hawk‑i*** and Medicaid Programs will participate in a “payment accuracy measurement (PAM)” project sponsored by CMS. Participation is optional this year, but mandatory after that. CMS has developed a model to test the accuracy of fee for service claims, managed care claims, capitation payments and recipient eligibility.

November

The ***hawk-i*** Board did not meet in November.

**XII. Administrative Rule Amendments:**

The Board adopted the following administrative rules:

The ***hawk‑i*** Board unanimously approved and noticed rule amendments June 16, 2003. On October 20, 2003, the Board adopted the rule amendments. The 2003 Iowa Acts, House File 565, mandated the rule amendments. These changes allow families to transition from employer-sponsored health care coverage to the ***hawk-i*** Program without a break in coverage. The amendments became effective on July 1, 2003. Summaries of the rule amendments are outlined below:

* 86.2(4) (a) Rescind the paragraph specifying circumstances when a child could qualify as “uninsured” during the waiting period.
* 86.13(6) (e) Rescind the paragraph requiring the third-party administrator to track waiting periods for applicants.
* The ***hawk‑i*** Board unanimously approved rule amendments August 18, 2003. On December 15, 2003, the Board adopted the rule amendments. Summaries of the rule amendments are outlined below:
* 86.2(2)(a)(2) Unearned Income. The unearned income of all parents, spouses and children under the age of 19 who are living together in accordance with rule 86.2(3) shall be counted.

The amendment clarifies that only income of the family members who are living together is considered in determining ***hawk‑i*** eligibility.

* 86.2(3)(b) Parents. Any parent living with the child under the age of 19 will be included in the family size. This includes the biological parent, stepparent, or adoptive parent of the child and is not dependent upon whether the parents are married to each other. In situations where the parents do not live together but share joint ~~legal or~~ physical custody of the children, the family size shall be based on the household of the applying parent.

This amendment removes references to legal custody. Only the physical custody of the child is considered in determining whether the parent and child are “living together” for purpose of qualifying for ***hawk‑i*** coverage.

* 86.3(2) Application form. An application for the ***hawk‑i*** program shall be submitted on ~~Form 470-3526~~ Comm.156, ~~Healthy and Well Kids in Iowa (~~***~~hawk‑i~~***~~)~~ Application, or on Form 470-4016, ***hawk‑i*** Electronic Application Summary and Signature, unless the family applies for the Medicaid program first.
* 86.3(2)(b) Applications may be obtained by telephoning the toll-free telephone number of the third-party administrator or by accessing the web site at www.***hawk-i***.org.
* 86.3(4) Date and method of filing. The application is considered filed on the date an identifiable application is received by the third-party administrator ~~unless the family has applied for Medicaid first and a referral is made to the third party administrator by the county office of the department, in which case, the date the Medicaid application was originally filed with the department shall be the filing date.~~ An identifiable application is an application containing a legible name, address, and signature.
* 86.3(4)(a) Medicaid applications referred to the ***hawk‑i*** program. When the family has applied for Medicaid first and the department local office makes a referral to the third-party administrator, the date the Medicaid application was originally filed with the department shall be the filing date.

86.3(4)(b) Electronic applications. When an application is submitted electronically to the third party administrator, the application is considered filed on the date the third party administrator receives Form 470-4016, Electronic Application Summary and Signature, containing a legible signature.

The amendments establish a procedure for electronic filing of ***hawk‑i*** applications. Under these amendments, applicants will be able to submit information through the ***hawk‑i*** web site. The third-party administrator will mail the applicant a form summarizing the data submitted and requesting the applicant’s signature. The date that this signed form is returned will be considered the filing date for the ***hawk‑i*** application (and for the Medicaid application if the family is referred for Medicaid eligibility determination).

*Attachment 1: Clinical Advisory Committee Benefit Enhancement Recommendations*

*\*\*\**

Clinical Advisory Committee’s

Recommended Benefit Changes to the HAWK-I Board

| Issue | Health Plan | Cost |
| --- | --- | --- |
| Care Coordination  Care Coordination is defined as providing services to children and families to assure that the children receive health care services. This can include any of the following:  Educating families about the services covered with their plan including preventive health care benefits.  Assisting families with selecting primary medical and dental care providers  Assisting families with scheduling routine and follow-up appointments  Assisting with transportation to provider’s office, child care if needed, needed translation services  Accessing community support resources | Iowa Health Solutions sends reminder letters regarding immunizations, coordinates visits, assists with making appointments, arranges for travel if needed, telephone follow-up, and other activities  John Deere Health Plan does not have a specific definition of care coordination.  Wellmark Classic Blue has a process designed and created to provide a “continuum of care” approach to care management, ensuring that members get the right care at the right time from the appropriate provider. This process monitors and coordinates care processes to achieve optimal outcomes.  MAXIMUS assists families with the initial PCP selection and sends premium payment reminders. | Cost estimate for addition to health plan benefits  .50 to .75 per member per month  2003 projected avg. monthly eligibles = 16,139  .50 x 16,139 = $8,069.50 per month x 12 mos. =  Total annual cost $96,834  $24,741 State $ (25.55%)  $72,093 Federal $ (74.45%)  .75 x 16,139 = $12,104.25 per month x 12 mos. =  Total annual cost $145,251  $ 37,112 State $  $ 108,139 Federal $  2004 projected avg. monthly eligibles = 20,163  50 x 20,163 = $10,081.50 per month x 12 mos. =  Total annual cost $120,978  $30,910 State $ (25.55%)\*  $90,068 Federal $ (74.45%)\*  .75 x20,163 = $15,122.25 per month x 12 mos. =  Total annual cost $181,467  $ 46,365 State $\*  $ 135,102 Federal $\*  \* Note this is the 03 match rate, this rate could change |
| “Service of care coordination that facilitates access, solves problems, addresses both covered and noncovered services and promotes coordination of social support and medical services across different organizations and providers. It is intended to empower families to utilize the community resources available to them and includes assessing, planning implementing, coordinating, monitoring, facilitating, notifying, scheduling and assuring.” |  | Cost estimate if care coordination is carved out from the health plans. #  Based on Medicaid reimbursement rate: $31.68 per hour per family  2003 projected av. monthly eligibles = 16,139/  1.6 av. kids per family = 10,087 families x $31.68 =  Total annual cost $319,556  $ 81,647 State $  $237,909 Federal $  2004 projected avg. monthly eligibles = 20,163  1.6 av. kids per family = 12,602 families x $31.68 =  Total annual cost $399,231  $102,004 State $\*  $297,227 Federal $\*  #Assumes no family receives more than 1 hour of service annually. |
| Case Management for children with special health care needs.  Case management is defined as services intended to coordinate various clinical services to assure the best clinical outcomes.  Children with special health care needs are those who have or are at increase risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. | Iowa Health Solutions has a specific policy and procedure that governs the case management and large case management programs, for children with extensive dental problems and mental problems, as well as other medical and social problems.  John Deere Health Plan has nurse case and utilization review managers. They work with the patient, family physician, associated JDHP staff, allied health care providers, and community resources to coordinate quality health care for patients in most appropriate setting. Key elements of the program include health education, care plan coordination, discharge planning, and development of health resources. Components of case management include individual case management, ante partum risk, transplants, infertility, hemophilia, growth hormone and coordinated care services.  Wellmark has a pediatric nurse case manage who manages children with special needs. A dedicated approach to care management, which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet individual needs over an extended period of time. | Cost estimate = .29-.34 per member per month  2003 projected avg. monthly eligibles = 16,139\*  .29 x16,139 = $4680.31 per month x 12 mos. -  Total annual cost $56,164  $14,350  $41,814  .34 x 16,139 = $5487.26 per month x 12 mos. =  Total annual cost $65, 847  $16,824 State $  $49,023 Federal $  2004 projected avg. monthly eligibles = 20,163  .29 x20,163 = $5,847.27 per month x 12 mos. -  Total annual cost $70,167  $17,928  $52,239  .34 x 20,163 = $6,855.42 per month x 12 mos. =  Total annual cost $82,265  $21,019 State $  $61,246 Federal $ |
| Dental Benefits.  Increase yearly maximum to $1500.  Coverage of partials and dentures | Annual Maximum:  Iowa Health Solutions $1500.  Wellmark Classic Blue $1000  John Deere Health Plan $1000  Wellmark does not cover bridges and dentures.  IHS and John Deere cover partials and dentures. | In order to ensure all children have a $1500/yr max:  Cost estimate =$1.78 per member per month  2003 projected avg. monthly eligibles = 16,139  16,139 x $1.78 =$28,727.42 per month x 12 months =  Total annual cost $344,729  $ 88,078 State $  $256,651 Federal $  2004 projected avg. monthly eligibles = 20,163. 20,163 x $1.78 = 35,890.14 per month x 12 mos. =  Total annual cost $430,682  $110,039 State $  $320,643 Federal $  Partials and dentures were included in the original assumption in the development of the capitation rate. |
| 4. Mental Health & Substance Abuse Benefits.  Comparable benefits across health plans  Coverage of Axis I diagnoses  Coverage for full continuum of treatment services  Adequate provider panels  Admission, discharge, continued stay, and placement criteria are specific to children and adolescents and that the Iowa Juvenile Placement Criteria for substance abuse be used. | IHS = 20 outpatient visits & 60 inpatient hospitals day each year. Inpatient hospital days may be converted to outpatient visits at a ratio of 2 outpatient visits for 1 inpatient day.  John Deere Health Plan – Mental health = 20 outpatient facility days/physician visits per calendar year & 30 inpatient facility days/physician visits per calendar year. Substance abuse =20 outpatient facility days/physician visits per calendar year & 30 inpatient facility days/physician visits per calendar year.  Wellmark = 30 outpatient visits per benefit period & 30 inpatient visits/benefit period (benefit period begins on the effective date and ends on the last day of the 12th month after the effective date; it renews annually thereafter).  Iowa Health Solutions covers axis I diagnoses.  John Deere excludes: dementias and other organic disorders, nicotine and caffeine use problems, pervasive developmental, TIC and neurological disorders, conduct and impulse control disorders, antisocial personality disorder, paraphilias, insomnia and other sleep related disorders (some of these may be covered under the medical part of the plan)  Wellmark excludes bereavement counseling or services, family counseling, impulse control disorders, certain developmental and learning disorders, certain disorders of early childhood, communication disorders, nicotine dependence, sensitivity, shyness and social withdrawal disorder, sexual identification or gender disorders.  All of the health plans provide inpatient and outpatient services subject to above limits. John Deere covers partial hospital/day treatment programs that may be independent or hospital-based. Wellmark reimburses for mental health day programs based out of the hospital setting billing using a UB92. For community mental health centers to be able to provide day programming, they can only bill services using an HCFA-1500; therefore, level of reimbursement for CMHC’s would be different.  Each plan has its own criteria to determine medical necessity for mental health and substance abuse. | Cost estimate to make plans comparable: .37 per member per month  2003 projected avg. monthly eligibles = 16,139  .37 x 16,139 = $5,971.43 per month x 12 mos. =  Total annual cost $71,657  $18,308 State $  $53,349 Federal $  2004 projected avg. monthly eligibles = 20,163  .37 x 20,163 = $7,460.31 per month x 12 mos. =  Total annual cost $89,524  $22,873 State $  $66,650 Federal $  Axis I diagnoses are intended to be covered under the existing pricing assumptions.  The benefits and pricing make provision for inpatient days and outpatient visits. Intent was not to exclude service locations.  Cost is dependent on what method the quality assurance committee would recommend to determine adequate access.  A cost estimate is not necessary for this. |
| 5. Nutrition Services.  Medically necessary nutrition services should be covered by a license dietitian with a physician’s referral.  Provide for nutrition services beyond basic nutrition when it is medically necessary. | Iowa Health Solutions covers medically necessary nutritional services. In certain cases allow coverage for medically necessary formulas. Each case is reviewed individually by the utilization management department and the medical director.  John Deere covers nutrition counseling for certain diagnoses: cardiac, hypertension, and diabetes. Other diagnoses would require a benefit exception. Nutritional supplies, including infant formulas, are excluded.  Wellmark Classic Blue does not cover nutrition education except in connection with outpatient diabetes education programs.  Wellmark covers services provided by a dietician when billed by the employing facility or physician and covers all feedings/formula that are given via a tube or when they are the sole source of nutrition. Examples would include hydrolysate formulas and PKU formulas. Members needing formula feedings receive case management services. | Cost estimate for nutrition services:  $16- $17 per half hour, with an estimated frequency of 200/1000/year = .27 per member per month to .28 per member per month  2003 projected avg. monthly eligibles = 16,139  .27 x 16, 139 = $4,357.53 per month x 12 mos. =  Total annual cost $52,290  $13,360 State $  $38,390 Federal $  2003 projected avg. monthly eligibles = 16,139  .28 x 16,139 = $4,518.92 per month x 12 mos. =  Total annual cost $54,227  $13,855 State $  $40,372 Federal $  2004 projected avg. monthly eligibles = 20,163  .27 x 20,163 = $5,444.01 per month x 12 mos. =  Total annual cost $65,328  $16,691 State $  $48,637 Federal $  2004 projected avg. monthly eligibles = 20,163  .28 x 20,163 = $5,645.64 per month x 12 mos. =  Total annual cost $67,748  $17,310 State $  $50,438 Federal $  Cost estimate for nutritional supplements =  .05 to .10 per member per month  2003 projected av. monthly eligibles = 16, 139  .05 x 16,139 = $806.95 per month x 12 mos =  Total annual cost $9,683  $ 2,474 State $  $ 7,209 Federal $  .10 x 16,139 = $1,613.90 per month x 12 mos. =  Total annual cost $19,367  $ 4,948 State $  $ 14,419 Federal $  2004 projected av. monthly eligibles = 20,163  .05 x 20,163 = $1,008.15 per month x 12 mos =  Total annual cost $12,098  $ 3,091 State $  $ 9,007 Federal $  .10 x 20,163 = $2,016.63 per month x 12 mos. =  Total annual cost $24,196  $ 6,182 State $  $ 18,014 Federal $ |
| Physical and Occupational therapy services. | IHS covers physical and occupational therapy. John Deere covers physical and occupational therapy with a physician’s referral. Wellmark covers physical therapy. Occupational therapy is limited to services to treat the upper extremities. | The current pricing assumptions include physical and occupational therapy on an inpatient and outpatient basis. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | FY 03 | FY 03 | FY 04 | FY 04 |
| All Recommendations | Minimum Costs | Maximum Costs | Minimum Costs | Maximum Costs |
| Care Coordination with health plan | $ 96,834 | $ 145,251 | $ 120,978 | $ 181,467 |
| Carve out care coordination | $ 319,556 | $ 319,556 | $ 399,231 | $ 399,231 |
| 2. Case management | $ 56,164 | $ 65,847 | $ 70,167 | $ 82,265 |
| 3. Dental | $ 344,729 | $ 344,729 | $ 430,682 | $ 430,682 |
| 4. Mental health substance abuse | $ 71,657 | $ 71,657 | $ 89,524 | $ 89,524 |
| 5. Nutrition counseling | $ 52,290 | $ 54,227 | $ 65,328 | $ 67,748 |
| Nutrition supplements | $ 9,683 | $ 19,367 | $ 12,098 | $ 24,196 |
| **Total** | **$ 950,913** | **$ 1,020,634** | **$ 1,188,088** | **$ 1,275,113** |
| *State dollars* | *$ 242,958* | *$ 260,772* | *$ 303,536* | *$ 325,791* |
| Federal dollars | $ 707,955 | $ 759,862 | $ 884,472 | $ 949,322 |
|  |  |  |  |  |
| Recommendations—health plans doing Care Coordination. |  |  |  |  |
| 1. Care Coordination with health plan | $ 96,834 | $ 145,251 | $ 120,978 | $ 181,467 |
| 2. Case management | $ 56,164 | $ 65,847 | $ 70,167 | $ 82,265 |
| 3. Dental | $ 344,729 | $ 344,729 | $ 430,682 | $ 430,682 |
| 4. Mental health substance abuse | $ 71,657 | $ 71,657 | $ 89,524 | $ 89,524 |
| 5. Nutrition counseling | $ 52,290 | $ 54,227 | $ 65,328 | $ 67,748 |
| Nutrition supplements | $ 9,683 | $ 19,367 | $ 12,098 | $ 24,196 |
| **Total** | $ 631,357 | $ 701,078 | $ 788,777 | $ 875,882 |
| *State dollars* | $ 161,312 | $ 179,125 | $ 201,533 | $ 223,788 |
| Federal dollars | $ 470,045 | $ 521,953 | $ 587,244 | $ 652,094 |
|  |  |  |  |  |
| Recommendations with Care Coordination, Carve Out |  |  |  |  |
| 1. Carve out care coordination | $ 319,556 | $ 319,556 | $ 399,231 | $ 399,231 |
| 2. Case management | $ 56,164 | $ 65,847 | $ 70,167 | $ 82,265 |
| 3. Dental | $ 344,729 | $ 344,729 | $ 430,682 | $ 430,682 |
| 4. Mental health substance abuse | $ 71,657 | $ 71,657 | $ 89,524 | $ 89,524 |
| 5. Nutrition counseling | $ 52,290 | $ 54,227 | $ 65,328 | $ 67,748 |
| Nutrition supplements | $ 9,683 | $ 19,367 | $ 12,098 | $ 24,196 |
| **Total** | $ 854,079 | $ 875,383 | $ 1,067,030 | $1,093,646 |
| *State dollars* | $ 218,217 | $ 223,660 | $ 272,626 | $ 279,427 |
| Federal dollars | $ 635,862 | $ 651,723 | $ 794,404 | $ 814,219 |

*Attachment 2: Outcomes of Care for Children Enrolled in*

***hawk‑i*** *and Attention Deficit Hyperactivity*

*Disorder and Children in* ***hawk‑i***

**Outcomes of care for   
children in *hawk-i***

**Report to the   
Iowa Department of Human Services**

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**Outcomes of care for   
children enrolled in hawk-i**

*Introduction*

This report presents results from an analysis of outcomes of care for children enrolled in the Healthy and Well Kids in Iowa program (**hawk-i)**, conducted by the University of Iowa Public Policy Center for the Iowa Department of Human Services (IDHS). The **hawk-i** program is the separate portion of the Iowa State Child Health Insurance Program (SCHIP) and provides services to children in families with incomes between 133 and 200% of the Federal Poverty Level (FPL). The IDHS contracts with John Deere Health Plan, Iowa Health Solutions and Wellmark Blue Cross/Blue Shield to provide services to **hawk-i** enrollees on a county-by-county basis. This report provides a summary of plan-specific results for 10 different outcomes of care in four different service areas: preventive visits for children and adolescents, dental visits, Measles, Mumps and Rubella (MMR) immunization and behavioral and emotional health visits.

This is the first evaluation of outcome measures as part of the quality assurance activities for the **hawk-i** program. The measures were adapted from the Healthplan Employer Data and Information Set (HEDIS)[[1]](#footnote-2). HEDIS are a set of measures developed by the National Committee for Quality Assurance (NCQA) for evaluating the outcomes of health plans. The **hawk-i** clinical advisory committee, in collaboration with researchers from the University of Iowa Public Policy Center, identified four service areas that were of greatest interest. HEDIS measures were then adapted to fit the available **hawk-i** data. The HEDIS outcome measures (i.e., utilization rates) were determined through an analysis of claims, encounter and eligibility data for children in each of the **hawk-i** health plans. With the plan comparisons presented here we can determine whether the plans are meeting the expectations for care provision within the **hawk-i** program.

Outcome data should always be interpreted with caution. Limitations of this data may include differential rates of missing data across the plans, the systematic use of inappropriate codes, or the miscoding of diagnoses. Despite these limitations, important knowledge is gained by comparing outcome results between plans.

**Outcomes of Care for Children in *hawk-i***

***Preventive care for children and adolescents***

The percent of children and adolescents with a preventive visit is divided into two age categories: children ages three through six and adolescents ages twelve through 19 (Figures 1-4). According to the American Academy of Pediatrics (AAP) periodicity schedule[[2]](#footnote-3), children should receive annual visits at ages three, four, five and six years of age and biannual visits at ages eight and ten with annual visits during adolescence for ages 11 through 21. Preventive visits do not just address the medical needs of the child, but can also provide an opportunity for anticipatory guidance to parents and children. Figure 1 provides comparisons for children in the three **hawk-i** plans to data from a report by the American Public Human Services Association (APHSA)[[3]](#footnote-4) that provides a national benchmark for this HEDIS measure for Medicaid plans in 1999 and 2000 for children three through six years of age. This comparison indicates that all three **hawk-i** plans have preventive visit rates this age group that are below the national averages for Medicaid programs. In a previous report, “Evaluating the Iowa Medicaid Managed Care Program: Outcomes of Care”,[[4]](#footnote-5) we reported preventive visit rates for children ages three through six within the Iowa Medicaid program. These rates ranged from 52% for United Health Care to nearly 80% for children within the MediPASS program. Preventive care rates for children within all of the Medicaid plans were above the APHSA rates for 1999 and well above the rates for the plans within **hawk-i**. In fact, over 60% of children ages 3-6 within the Medicaid program enrolled in Iowa Health Solutions for at least 11 months had a preventive visit during 2000, while only 35% of children ages three through six years of age within **hawk-i** enrolled in Iowa Health Solutions for at least 11 months had a preventive visit. The differential for John Deere was 63% versus 43%. Wellmark does not participate in the Medicaid managed care program so comparable figures are not available. These findings indicate that either the plans or their providers are not as effective in providing access to preventive care for children within **hawk-i** or the encounter data is not sufficient for outcome analyses. Further investigation is warranted to determine whether the encounter data is truly reflecting the rates of service.

##### Figure 1. Rate of well child visits for children 3-6 years of age enrolled for at least 11 months by plan and compared to APHSA rates

Figures 2 and 3 indicate the percentage of children receiving preventive care for each of the four individual ages (ages 3-6) during FY 2001. Figure 2 shows rates for all children in **hawk-i** where Figure 3 only includes children who were eligible for 11 or 12 months during 2001. In general, children seem to receive the most preventive care visits during the fourth and fifth years of life, as parents prepare to send their children to school. Within all ages there is variation among the plans however the variation was most apparent for rates when only those children who were eligible for 11 and 12 months were included in the calculations (Figure 3).

##### Figure 2. Percent of children with a well child visit in fiscal year 2001 by age and plan

##### Figure 3. Percent of children enrolled in a plan for at least 11 months with a well child visit in fiscal year 2001 by age and plan

The rates of adolescents who were enrolled for at least 11 or 12 months during the year and had at least one preventive visit during FY 2001 by plan are shown in Figure 4. The rate of preventive visits for adolescents in John Deere is comparable to the national average; however, the rates for adolescents in Iowa Health Solutions and Wellmark are well below this average. John Deere and Iowa Health Solutions also have rates for adolescent preventive care that are below the rates found for adolescents enrolled in these plans through the Medicaid program. Generally, the rates for preventive care are low within the three **hawk-i** plans, especially when compared to the AAP guidelines for annual visits during adolescence, indicating that feedback to the plans and monitoring is necessary to assure future improvement.

##### Figure 4. Rate of well adolescent visits for adolescents 12-19 years of age enrolled for at least 11 months by plan and compared to APHSA rates

**Preventive dental care for children and adolescents**

In addition to regular preventive medical visits, children are recommended to have regular preventive dental visits. Although the AAP does not have a periodicity schedule for dental visits, the American Academy of Pediatric Dentistry guidelines indicate that beginning at age one, children should have preventive dental procedures “every 6 months or as indicated by individual patient’s risk status/susceptibility to disease”[[5]](#footnote-6). Figure 5 indicates the rate of preventive dental visits for children and adolescents for the three plans for children in four different age categories: age 2-6, 7-11, 12-15, 16-18. Within this figure the rates are calculated for all children regardless of length of enrollment. Figure 6 provides the same rates, however, only children who were eligible for at least 11 months during FY 2001 are included. These rates were calculated consistent with the protocol established for the HEDIS dental outcome measures. Across all age groups in both figures, children in Iowa Health Solutions had the lowest rates of preventive dental care. Preventive dental utilization rates for children in Wellmark and John Deere were more comparable.

##### Figure 5. Percent of children with a preventive dental visit in fiscal year 2001 by age and plan

##### Figure 6. Percent of children enrolled in a plan for at least 11 months with a preventive dental visit in fiscal year 2001 by age and plan

The rates of having any dental visit, not just a preventive dental visit, for children enrolled for at least 11 months are presented in Figure 7. Once again, children in Iowa Health Solutions had the lowest visit rates regardless of age group.

##### Figure 7. Percent of children enrolled in a plan for at least 11 months with any type of dental visit in fiscal year 2001 by age and plan

Across the three figures, for children ages two through six and sixteen through eighteen John Deere had the highest utilization rates, while for children seven through fifteen Wellmark had the highest utilization rates.

The consistently low rates for Iowa Health Solutions should be of concern. For some age groups the rates for Iowa Health Solutions are less than half those for the other plans. This may be due to poor access to providers, geographic differences in practice and care seeking, or ineffective communication regarding the services and providers available to enrollees. Further investigation should be undertaken to determine whether these rates continue to be low over time and to determine what factors may underlie these rate differentials.

Figure 8 provides a comparison of dental rates for children enrolled in Medicaid or the **hawk-i** program for at least 11 months. Children in **hawk-i** consistently had higher rates of utilization than children within the Medicaid program. This may be due to increased need in the population entering **hawk-i** or it could be due to enhanced access to dentists through the managed care plan dental panels.

##### Figure 8. Comparison of dental utilization rates for children enrolled for at least 11 months in Medicaid or *hawk-i*

**Childhood immunization status – MMR**

The **hawk-i** program has been operational since January 1, 1999. Children under 1 year of age are not included in the program because they are covered through Medicaid. Therefore, when determining which vaccinations to study for the outcome measures, any vaccination series that required administration prior to the first birthday had to be eliminated. This led to the elimination of DTP/DtaP, OPV/IPV, HiB, and Hepatitis B vaccinations for outcome analyses. The chicken pox vaccine was eliminated because it was not mandatory in Iowa until July 1, 2003. Therefore, the MMR was the only vaccination appropriate for outcome analysis.

All children who were born during 1999 were followed with the administrative data to determine the dates during which an MMR should have occurred. According to the methodology for the HEDIS measure, the MMR should take place during the year between the first and second birthday. Using the eligibility data, we determined the number of months each child was enrolled within the **hawk-i** program during the year between the first and second birthday. Table 1 indicates that the majority of children were enrolled in Wellmark during this time. Additionally, enrollees in the John Deere plan were more likely to have had fewer months in the plan during the immunization period. This was primarily due to John Deere initiating participation in the **hawk-i** program after the other two plans.

##### Table 1. Number of children born in 1999 and enrolled between the first and second birthday by months of enrollment and plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of months** | **Iowa Health Solutions** | **John Deere** | **Wellmark** |
| **1-4 months** | 79 (29%) | 53 (37%) | 160 (28%) |
| **5-7 months** | 65 (23%) | 37 (26%) | 145 (25%) |
| **8-10 months** | 60 (22%) | 28 (20%) | 136 (24%) |
| **11 or more months** | 73 (26%) | 25 (17%) | 134 (23%) |
| **Total** | 277 (100%) | 143 (100%) | 575 (100%) |

Table 2 and Figure 8 indicate the rates of MMR immunization by months enrolled and plan. Overall the MMR immunization rates are very low (7%, 14%, and 11%). However, for the HEDIS measures, only those children eligible for at least 11 months between the first and second birthday are included. For this group, Table 2 shows that John Deere has the highest immunization rate with 44% while Iowa Health Solutions has the lowest rate with only 20%. Though these rates are higher than those across all children regardless of enrollment period, the rates are still low.

##### Table 2. Rates of MMR immunization by months enrolled and plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of months** | **Iowa Health Solutions** | **John Deere** | **Wellmark** |
| **1-4 months** | 1 (1.3%) | 3 (5.7%) | 2 (1.3%) |
| **5-7 months** | 1 (1.5%) | 1 (2.7%) | 11 (7.6%) |
| **8-10 months** | 3 (5.0%) | 5 (17.9%) | 18 (13.2%) |
| **11 or more months** | 15 (20.5%) | 11 (44.0%) | 34 (25.4%) |
| **Total** | 20 (7.2%) | 20 (14.0%) | 65 (11.3%) |

##### Figure 8. Rates of MMR vaccination by number of months enrolled and plan

The low MMR immunization rates may be due, at least in part, to our inability to capture the administration of the vaccine when provided outside of the health plan (e.g., by a public health clinic). Anecdotal information indicates that the receipt of immunizations by **hawk-i** enrollees in public health clinics could be encouraged by some rural physicians who may not be giving the vaccinations in their offices due to the perceived high cost of obtaining and maintaining the supply. Children may also come into the plan with evidence of vaccinations provided prior to entry into the program (i.e., prior to one year of age). These children may not receive another vaccination and the evidence of the receipt of an MMR vaccination would not be present in the encounter data.

**Behavioral and emotional health utilization**

The number and percent of children with an outpatient behavioral or emotional health visit should serve as an indicator of access to mental health care for children within **hawk-i**. Though there is not a guideline or reference point regarding the percent of children that need mental health services, we can conclude that plans with a higher percent of children with a visit provide better access than those with a low percent unless there are differences in the prevalence of behavioral and emotional health problems between the populations in the different plans. In general, the plans within **hawk-i** seem to have comparable rates for mental health services.

##### Table 3. Number and percent of children with an outpatient mental health visit by age and gender

|  |  |  |  |
| --- | --- | --- | --- |
| **Age and gender** | **Iowa Health Solutions** | **John Deere** | **Wellmark** |
| **0-12 years of age** |  |  |  |
| **Male** | 92 (6%) | 48 (7%) | 154 (4%) |
| **Female** | 41 (3%) | 19 (3%) | 68 (2%) |
| **13-18 years of age** |  |  |  |
| **Male** | 53 (9%) | 20 (12%) | 72 (6%) |
| **Female** | 38 (7%) | 9 (5%) | 69 (5%) |

Boys of all ages with a mental health diagnoses are most likely to have been diagnosed with attention deficit-hyperactivity disorder (ADHD) (60% for boys age 0-12 years, 42% for boys age 13-18 years). The next most prevalent diagnoses were adjustment disorder and affective psychoses. These were equally likely in boys thirteen to eighteen years of age, while in boys from birth to twelve years of age adjustment disorder was far more likely than affective psychoses. Girls from birth to twelve years of age with a mental health diagnosis were most likely to be diagnosed with ADHD (26%). The second most prevalent diagnosis was adjustment reaction (30%). For girls thirteen to eighteen years of age the most common diagnosis was adjustment reaction, while the second most common was affective psychosis. Table 4 shows the number and percent of children with the three most common diagnoses by age and gender.

##### Table 4. Number and percent of children diagnosed with the three most common mental health diagnoses by gender and age

|  |  |  |  |
| --- | --- | --- | --- |
| Gender and age | ADHD | Adjustment Reaction | Affective Psychoses |
| Boys 0-12 years | 175 (3%) | 53 (1%) | 9 (<1%) |
| Boys 13-18 years | 61 (3%) | 20 (1%) | 20 (1%) |
| Girls 0-12 years | 60 (1%) | 53 (1%) | 3 (<1%) |
| Girls 13-18 years | 15 (<1%) | 31 (1%) | 30 (1%) |

## 

**Summary of child and adolescent measures**

Unlike Medicaid, the ***hawk-i*** program has children as its only enrollee group. The health and utilization outcomes for this group are extremely important in assessing the quality of care provided. Most particularly, these data allow us to determine whether children have equal access to services across plans. The rates that include children eligible for 11 and 12 months provide the best information as to the effectiveness of the health plans in providing the appropriate services for the children. While 100 percent utilization is the desired goal, factors outside the control of the health plans also affect whether a child receives a service at the appropriate time, make this goal unlikely.

From an overall perspective, children within ***hawk-i*** are not utilizing preventive services at rates consistent with the established AAP or AAPD guidelines. Of greatest concern are the receipt of well child visits, which are at rates lower than those found for Medicaid managed care plans, and preventive dental visits, especially for children in Iowa Health Solutions. The low MMR immunization rates are of concern but without the ability to determine if a child received an immunization at a public health clinic, it is difficult to determine if a problem exists.

**NOTE**-While Medicaid administrative data has been used for quality assurance purposes for many years; this is the first time that the ***hawk-i*** administrative eligibility encounter data have been used to calculate HEDIS-type outcome measures. Thus further investigation is necessary to ensure the adequacy of these data for quality assurance purposes before strong conclusions should be drawn from these results.

**Attention Deficit Hyperactivity Disorder and**

**Children in *hawk-i***

**Report to the   
Iowa Department of Human Services**

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**Study of Children in *hawk-i* with a Diagnosis of   
Attention Deficit Hyperactivity Disorder**

***Introduction***

This report presents the first in a series of studies designed to delve into more detail in a subject of particular salience to children enrolled in the Healthy and Well Kids in Iowa program (***hawk-i)***. These studies are being conducted by the University of Iowa Public Policy Center at the request of the Iowa Department of Human Services (IDHS). For this first study, the IDHS, in collaboration with the Clinical Advisory Committee for the ***hawk-i*** program requested that a study of children with Attention Deficit Hyperactivity Disorder (ADHD) be investigated due to its prevalence and variance regarding the diagnosis and treatment of this condition.

The ***hawk-i*** program is the separate portion of the Iowa State Child Health Insurance Program (SCHIP) and provides services to children in families with incomes between 133 and 200% of the Federal Poverty Level (FPL). The IDHS contracts with John Deere Health Plan, Iowa Health Solutions and Wellmark Blue Cross/Blue Shield to provide services to ***hawk-i*** enrollees on a county-by-county basis.

This study had five primary aims:

* To determine the prevalence of ADHD diagnosis in the ***hawk-i*** population by age and gender of the child
* To establish baseline demographic information regarding children with a diagnosis of ADHD
* To evaluate the utilization of behavioral and emotional health care services by children with ADHD
* To compare the information regarding ADHD gleaned from the encounter data and the surveys
* To present additional behavioral and emotional results from the survey

**Prevalence of ADHD in hawk-i**

In this report, the rates for children in ***hawk-i*** diagnosed with ADHD are reported in four ways:

1. Number and rate of children with an ADHD diagnosis (by diagnosis code)
2. Number and rate of children eligible for at least 11 months with an ADHD diagnosis
3. Number and rate of children with an ADHD diagnosis per 1,000 member months
4. Number of children with “problems with attention” as reported on the survey

For the first three analyses, ***hawk-i*** program enrollment and encounter data were used to identify children and adolescents between the ages of three and eighteen enrolled in the ***hawk-i*** program during calendar year 2001. There were a total of 17,166 children enrolled for at least one month in 2001.

For the fourth analysis, data from the survey used to evaluate changes in health status and access to care for children before and after joining the ***hawk-i*** program were used.

*1) Number and rate of children with an ADHD diagnosis (by diagnosis code)*

Of the 17,166 children enrolled for at least one month in 2001, 563 had at least one claim with a diagnosis of Attention Deficit Disorder (ICD-9 314.00), Attention Deficit with Hyperactivity Disorder (ICD-9 314.01), or Hyperkinetic Conduct Disorder (ICD-9 314.9). The majority of children with a diagnosis had Attention Deficit with Hyperactivity Disorder. Table 1 provides a listing of all children enrolled for at least one month in 2001 by age and the rate of ADHD within the ***hawk-i***enrollees.

**Table 1. Children and adolescents by age and rate of ADHD, 2001**

|  |  |  |  |
| --- | --- | --- | --- |
| **Age group** | **Number with ADHD** | **Total number** | **Percent with ADHD** |
| **3-6 years** | 49 | 4,751 | 1.0% |
| **7-9 years** | 166 | 3,675 | 4.5% |
| **10-12 years** | 185 | 3,492 | 5.3% |
| **13-15 years** | 120 | 2,951 | 4.1% |
| **16-18 years** | 43 | 2,297 | 1.9% |
| **Total** | 563 | 17,166 | 3.3% |

The rate of diagnosis of ADHD from the claims/encounter data was highest for children in the 10-12 age range with about one in twenty children in this age group had received treatment with a diagnosis of ADHD.

*2) Number and rate of children eligible for at least 11 months with an ADHD diagnosis*

There were 4,947 children enrolled for at least 11 months in calendar year 2001. Table 2 provides a listing of these children by age and the rate of ADHD.

**Table 2. Children and adolescents eligible for at least   
11 months by age and rate of ADHD, 2001**

|  |  |  |  |
| --- | --- | --- | --- |
| **Age group** | **Number with ADHD** | **Total number** | **Percent with ADHD** |
| **3-6 years** | 21 | 1,230 | 1.7% |
| **7-9 years** | 72 | 1,039 | 6.9% |
| **10-12 years** | 93 | 1,033 | 9.0% |
| **13-15 years** | 57 | 892 | 6.4% |
| **16-18 years** | 24 | 753 | 3.2% |
| **Total** | 267 | 4,947 | 5.4% |

To better understand the influence of the denominator used to calculate prevalence rates of ADHD in this population, Figure 1 shows the difference in prevalence rates of children diagnosed with ADHD based on the two different denominators used in parts 1 and 2. The rate of ADHD is higher in the group of children who have been enrolled for at least 11 months. For both rates, however, the patterns are the same with the highest rates being for children ages 10-12 years. The difference in rates may be a result of longer enrollment for children who have been diagnosed with a condition or may be the result of children with shorter enrollments not having been diagnosed early in their enrollment.

**Figure 1. ADHD rates by age and enrollment period**

*3) Number and rate of children with an ADHD diagnosis per 1,000 member months*

Table 3 provides the number of children with ADHD per 1,000 member months. The denominator of 1,000 member months provides a standardized method for comparing populations with varying enrollment periods. Each member month is considered a unit of exposure for utilization or diagnosis. The rates across age groups are therefore, standardized and the rates not affected by the average length of enrollment. This calculation again highlights that ADHD is more prevalent in 10-12 year olds.

**Table 3. Rate of ADHD per 1,000 member months, 2001**

|  |  |  |  |
| --- | --- | --- | --- |
| **Age group** | **Number of member months** | **Number with ADHD** | **Number per 1,000 member months** |
| **3-6 years** | 33,253 | 49 | 1.47 |
| **7-9 years** | 26,529 | 166 | 6.26 |
| **10-12 years** | 25,540 | 185 | 7.24 |
| **13-15 years** | 21,868 | 120 | 5.49 |
| **16-18 years** | 17,580 | 43 | 2.45 |
| **Total** | 124,770 | 563 | 4.51 |

*4) Number of children with “problems with attention” reported on the survey*

Figure 2 shows the number of children for whom parents reported ‘attention problems” as a condition their child had for the previous three months. Similar to the encounter data, the highest rates were reported for children ages 10-12 (13%) however the rate for children 7-9 was also 13%.[[6]](#footnote-7)1

**Figure 2. Percent of children with “attention problems”  
reported on the survey**

***Baseline demographic information regarding children with a diagnosis of ADHD***

The rates of children who received a service with a diagnosis of ADHD is further evaluated to determine if differences exist by:

1. Age and gender of the child
2. Gender and race of the child

*1) Prevalence by age and gender*

Tables 4 provide a breakdown of ADHD rates by age and gender. Boys are diagnosed with ADHD at a rate about 3 times that of girls; this pattern is consistent across all age groups.

**Table 4. Rate of ADHD by age and gender for all enrollees, 2001**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Age group** | Gender | **Number with ADHD** | **Total Number** | **Percent with ADHD** |
| **3-6 years** | Female | 8 | 2,309 | 0.3% |
|  | Male | 41 | 2,442 | 1.7% |
| **7-9 years** | Female | 51 | 1,802 | 2.8% |
|  | Male | 115 | 1.873 | 6.1% |
| **10-12 years** | Female | 39 | 1,717 | 2.3% |
|  | Male | 146 | 1,775 | 8.2% |
| **13-15 years** | Female | 24 | 1,436 | 1.7% |
|  | Male | 96 | 1,515 | 6.3% |
| **16-18 years** | Female | 9 | 1,167 | 0.8% |
|  | Male | 34 | 1,130 | 3.0% |
| **Total** | Female | 131 | 8,431 | 1.6% |
|  | Male | 432 | 8,735 | 4.9% |

*2) Prevalence by gender and race*

Table 5 provides a breakdown of ADHD rates by gender and race. Caucasian boys had the highest percentage diagnosed with ADHD (5.3%). African-American boys were the next highest group with a rate of 4.1%. While Hispanic boys had rates higher than girls, they were significantly lower than for Caucasian or African-American boys.

**Table 5. Rate of ADHD by race and gender for   
all enrollees, 2001**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Age group** | Gender | **Number with ADHD** | **Total Number** | **Percent with ADHD** |
| **Caucasian** | Female | 85 | 5,455 | 1.6% |
|  | Male | 296 | 5,602 | 5.3% |
| **African-American** | Female | 2 | 90 | 2.2% |
|  | Male | 5 | 121 | 4.1% |
| **Hispanic** | Female | 1 | 222 | 0.5% |
|  | Male | 3 | 228 | 1.3% |
| **Native American** | Female | 1 | 24 | 4.2%\* |
|  | Male | 0 | 30 | 0.0%\* |
| **Asian** | Female | 0 | 31 | 0.0%\* |
|  | Male | 0 | 32 | 0.0%\* |
| **Other** | Female | 17 | 731 | 2.3% |
|  | Male | 34 | 778 | 4.4% |

\*There are too few children in this category to provide a reliable rate

***Utilization of behavioral and emotional health care services***

Encounter data with a diagnosis of ADHD for calendar year 2001 was used to evaluate the utilization and site of care for children with ADHD. Each claim was coded to reflect whether a psychiatric evaluation or treatment had occurred, an office visit had occurred, or a hospital visit had been made. The five most common types of psychiatric services are as follows:

90806 Individual psychotherapy, 45-50 min.

90862 Pharmacological management

90801 Psychiatric diagnostic interview

90805 Individual psychotherapy with medical evaluation and management

90804 Individual psychotherapy, 20-30 min.

Table 6 and Figure 2 provide data regarding the utilization rates for psychiatric, office and hospital visits for children with an ADHD diagnosis.

**Table 6. Rates of utilization by type of visit and age, 2001**

|  |  |  |  |
| --- | --- | --- | --- |
| **Age group** | Psychiatric visit | **Office visit** | **Hospital visit** |
| **3-6 years** | 34 (69%) | 18 (37%) | 1 (2%) |
| **7-9 years** | 101 (61%) | 79 (48%) | 2 (1%) |
| **10-12 years** | 106 (57%) | 92 (50%) | 4 (2%) |
| **13-15 years** | 69 (58%) | 53 (44%) | 2 (2%) |
| **16-18 years** | 33 (77%) | 14 (33%) | 0 (0%) |
| **Total** | 343 (61%) | 256 (46%) | 9 (2%) |

Approximately 60% of all children with an ADHD diagnosis had a visit coded as a psychiatric evaluation or treatment, almost half (46%) had a physician office visit while about two percent had a physician visit while in a hospital for ADHD.

**Table 7. Rates of psychiatric service utilization by plan, 2001**

|  |  |  |
| --- | --- | --- |
| **HMO** | **Number with psychiatric service** | **Percent with psychiatric service** |
| **Iowa Health Solutions** | 105 | 59% |
| **John Deere** | 90 | 54% |
| **Wellmark** | 148 | 70% |
| **Total** | 343 | 61% |

The site of care did vary by age with the youngest and oldest children being more likely to have a psychiatric office visit and less likely to have had a physician office visit. Table 7 indicates that access to psychiatric services does seem to vary by plan. Seventy percent of children with ADHD in Wellmark accessed psychiatric services within the year compared to less than 55% of children with ADHD in John Deere.

**Figure 2. Utilization rates by type of visit and age, 2001**

The percentage of children overall who were seen for a psychiatric visit seems high, particularly with the low supply of pediatric psychiatrists and psychologists in many parts of Iowa.

***Other behavioral and emotional health issues from the survey***

Within the survey, parents could list “attention problems”, “behavioral or emotional problems”, and “depression” as mental health diagnoses. Of the 158 children or adolescents who were reported as having “attention problems”, 34 (17%) were also reported to have behavioral or emotional problems and depression, 62 (31%) were also reported to have behavioral or emotional problems, and 8 (3%) were also reported to have depression. These results indicate that at least half of the children reported as having attention problems may have additional mental health problems as evaluated by their parents.

Children ages 7-12 were most likely to be reported to have attention problems while those ages 13-19 were most likely to have depression (Table 8). Males ages 7-12 had the largest proportion of children reported by their parents to have a behavioral/emotional chronic condition (Figure 3). Females ages 13-19 were most likely to have depression while males of all ages were more likely to have attention problems or other behavioral/emotional problems.

**Table 8. Behavioral or emotional condition by age (parent reported)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Age 1-6 (n=679) | **Age 7-12 (n=641)** | **Age 13-19 (n=549)** | **Total (n=1869)** |
| **Attention problems** | 3% (n=20) | 10% (n=64) | 7% (n=38) | 6% (n=122) |
| **Behav/emot problems** | 3% (n=20) | 8% (n=51) | 8% (n=44) | 6% (n=115) |
| **Depression** | <1% (n=5) | 1% (n=6) | 7% (n=38) | 3% (n=49) |

***Bold and Italic***=McNemar’s test significantly different, p<0.05

**Figure 3. Behavioral and emotional conditions (parent reported)   
by age and gender**

Need and unmet need for behavioral and emotional services were evaluated with the survey at baseline and follow-up. These were then compared to evaluate any change in perceived need or unmet need that occurred during the child’s first year in the program. This comparison showed that:

* Need for behavioral or emotional services was similar at baseline and follow-up for all respondents (Table 9).
* A higher percentage of boys ages 7-12 (20% baseline, 19% follow-up) were reported to need behavioral/emotional services than girls ages 7-12 (Figure 4).
* A higher proportion of boys ages 13-19 also were in need of behavioral/emotional services than girls (22% boys, 18% girls) with no difference after being in the program for a year.
* Unmet need for behavioral/emotional services declined for all children (39% baseline, 17% follow-up), which held for all age/gender categories (Figure 5).

**Table 9. Impact on need for and access to behavioral and   
emotional services by age**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Age 1-6 (n=679) | | **Age 7-12 (n=641)** | | **Age 13-19 (n=549)** | | **Total (n=1869)** | |
| Factor | Baseline | Follow-up | Baseline | Follow-up | Baseline | Follow-up | Baseline | Follow-up |
| **Needed Behav/emot care** | 6% (n=41) | 6% (n=41) | 16% (n=103) | 15% (n=96) | 20% (n=110) | 20% (n=110) | 14% (n=254) | 13% (n=247) |
| **Unmet need for Behav/emot care** | 2% (n=14) | 2% (n=14) | ***7%*** (n=45) | ***1%*** (n=6) | ***9%*** (n=49) | ***2%*** (n=11) | ***6%*** (n=108) | ***2%*** (n=31) |

***Bold and Italic***=McNemar’s test significantly different, p<0.05

**Figure 4. Percent of children who needed behavioral or emotional health care services while enrolled in *hawk-i***

**Figure 5. Percent of children by age and gender with unmet need for behavioral or emotional health care services (baseline and follow-up)**

***Comparison of the information regarding ADHD from the encounter data and the surveys***

Overall, the percent of children with “attention problems” indicated on the survey is higher than the percent with ADHD in the claims data for all age groups. It is difficult to determine why this rate might be higher. Perhaps parents are likely to report attention problems before children are diagnosed with this or parents with children who have attention problems or are health care utilizers may be more likely to complete the survey.

To compare directly between those for whom we had both a survey and encounter data, results from the survey data were matched back to the encounter data resulting in 2,149 individuals with information for both data sources. Of these, 62 had a diagnosis of ADHD in the encounter data and 200 were reported to have attention problems on the survey. Table 9 provides a summary of the comparison indicating the agreement rates between the survey and encounter data.

**Table 10. Survey and encounter data rate of agreement**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Problems with  attention reported on survey | No problems with  attention reported on survey | Total |
| ADHD diagnosis on encounter | 43 (72%)a | 17 (28%)b | 60 (100%) |
| No ADHD diagnosis on encounter | 157 (8%)c | 1,930 (93%)d | 2,087 (100%) |

Cells a and d in Table 10 indicate agreement between the survey and the encounter data. Ninety-three percent (n=1,930) of the time when there was no ADHD diagnosis in the encounter data parents also did not report any attention problems, while 72% (n=43) of the time when there was an ADHD diagnosis in the encounter data parents did report attention problems. Cells b and c indicate areas of disagreement between the two data sources. Almost 30% of children (n=17) with an ADHD diagnosis in the encounter data were not reported as having attention problems by their parents, while 8% of children (n=157) without an ADHD diagnosis within the encounter files were reported as having attention problems.

ADHD diagnosis is still a rare occurrence, despite that fact that it occurs in up to 15% of the population. It is not difficult to imagine that parents may report attention problems prior to actually seeking a medical intervention for this problem. It could also be that parents are reticent to label their children as having attention problems There are also issues regarding differences in how the survey question was asked and how an encounter is coded that could have produced differences. For example, the survey question specifically asked if the child currently had a problem that lasted at least the past 3 months. Some parents may not have indicated that the child had a problem currently because their symptoms were being controlled by an intervention. Another hypothesis is that the timing of the survey resulted in parents being asked about attention problems before children were actually diagnosed. This is unlikely since the encounters for ADHD were within the year prior to the survey for over 97% of the encounters. Regardless, it is important to know that differences in prevalence rates can occur when using encounter data compared to survey data.

*Attachment 3: Allotment Expenditure History,*

*SFY ’03 Expenditure Report,*

*and SFY ’04 Budget*

*\*\*\**

IOWA’S SCHIP ALLOTMENTS

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **FFY 1998** (began October 1, 1997) | **FFY 1999**  (began October 1, 1998) | **FFY 2000**  (began October 1, 1999) | **FFY 2001**  (began October 1, 2000) | **FFY 2002**  (began October 1, 2001) | FFY03 (began October 1, 2002) | FFY 04 (began Oct. 1, 20003) |
| Allotment\* | $32,460,463 | $32,307,161  +$3,957,863 carryover from FFY 1998 Total $36,265,024 | $32,382,884  +$4,787,171 carryover from FFY 1999 Total $37,170,055 | $32,940,215  +$4,222,574 carryover from FFY 2000 Total $37,162,789 | $22,411,236 | $21,368,268 | $19,703,000 |
| Expenditures \* | $26.3 | $24,846,556 | $28,724,249 | $32,885,307 | $43,968,839  (estimated) | **$** |  |
| Unspent Funds\* | ~~$ 6.1~~  **($2.2) reverted**  $3.96\*\* carried over to  FFY 1999  $0 | ~~$11,387,171~~  **($6.6) reverted**  $4.8\*\* carried over to  FFY 2000  $0 | **~~$8.4 reverted~~**  **($4.2) reverted**  $4.2 \*\*\* carried over to  FFY 2001  $0 | $3.2 estimated) | $ | **$** |  |
| Months of Federal Fiscal Year | 10-11-12-1-2-3-4-5-6-7-8-9 | 10-11-12-1-2-3-4-5-6-7-8-9 | 10-11-12-1-2-3-4-5-6-7-8-9 | 10-11-12-1-2-3-4-5-6-7-8-9 | 10-11-12-1-2-3-4-5-6-7-8-9 |  |  |

\* In Millions

**Note: Beginning 10/1/02, all SCHIP expenditures are being applied to the FFY 2001 allotment**

9/30/02

End of 3-year-period to spend FFY 2000 allotment. BIPA does not apply.

**\*\*\* 7/31/03 S 312 & HR 531 sent to President for signature. Restores 50% of FFY 2000 funds to states**.

9/30/00

End of 3-year-period to spend FFY 1998 allotment.

9/30/01

End of 3-year-period to spend FFY 1999 allotment.

10/1/01

Funding Available

\*\* 12/18/00

Beneficiary Improvement & Protection Act (BIPA) passed. States keep 60% of 1998 & 1999 funds scheduled for reversion.

Must be spent within 1 year.

10/1/00

Funding Available

7/1/00

***hawk-i*** income limit increased to 200% of FPL

1/1/99

***hawk-i*** program to 185% of FPL implemented

10/1/98

Funding Available

7/1/98

Medicaid expansion to 133% of FPL implemented

1/98 – 4/98

LEGISLATIVE SESSION

10/1/97

Funding Available

10/1/99

Funding Available

|  |  |  |
| --- | --- | --- |
| CHIP Budget |  |  |
| SFY 2003 |  |  |
| Sept 03 - FINAL FY 03 |  |  |
|  |  |  |
| FY 2003 Appropriation | $ 11,458,412 |  |
| Amount of HAWK-I Trust Fund dollars added to appropriation | $ 2,823,670 |  |
| Amount funded by Tobacco Trust Fund | $ 200,000 |  |
| Total state appropriation for FY 2003 | $ 14,482,082 |  |
| donations | $ - |  |
| total | $ 14,482,082 |  |
|  |  |  |
|  | **State Dollars** |  |
|  |  |  |
|  | Projected | YTD |
| Budget Category | Expenditures | Expenditures |
|  |  |  |
| Medicaid expansion | $5,054,939 | $4,208,550 |
|  |  |  |
| HAWK-I premiums | $6,547,081 | $5,394,582 |
|  |  |  |
| Fiscal agent costs of processing Medicaid claims | $101,033 | $87,527 |
|  |  |  |
| Outreach | $127,750 | $110,280 |
|  |  |  |
| HAWK-I administration | $484,396 | $437,642 |
|  |  |  |
| Earned interest from HAWK-I fund | $ - | -$159,097 |
|  |  |  |
| Totals | $ 12,315,200 | $10,079,484 |
|  |  |  |
|  |  |  |
| HAWK-I Trust Fund Balance (In State Dollars) |  |  |
| Amount in HAWK-I Trust Fund held in reserve at FY 02 year end |  | $ 2,823,670 |

DHS - Medical Assistance

CHIP BUDGET

SFY 2003

Jul - 02

|  |  |  |
| --- | --- | --- |
| FY 2003 Appropriation | $11,458,412 |  |
| Amount of HAWK-I Trust Fund dollars added to appropriation | $2,823,670 |  |
| Amount funded by Tobacco Trust Fund | $200,000 |  |
| Total state appropriation for FY 2003 | $14,482,082 |  |
| donations | - |  |
| total | $14,482,082 |  |
|  |  |  |
|  | **State Dollars** |  |
|  |  |  |
|  | Projected | YTD \* |
| Budget Category | Expenditures | Expenditures |
|  |  |  |
| Medicaid expansion | $5,054,939 | $168,738 |
|  |  |  |
| HAWK-I premiums | $6,547,081 | $490,559 |
|  |  |  |
| Fiscal agent costs of processing Medicaid claims | $101,033 | $0 |
|  |  |  |
| Outreach | $127,750 | $0 |
|  |  |  |
| HAWK-I administration | $484,396 | $0 |
|  |  |  |
| Earned interest from HAWK-I fund | $ - | $0 |
|  |  |  |
| Totals | $12,315,200 | $659,297 |
|  |  |  |
|  |  |  |
| HAWK-I Trust Fund Balance (In State Dollars) |  |  |
| Amount in HAWK-I Trust Fund held in reserve at FY 01 year end | | $2,823,670 |
|  |  |  |

*Attachment 4: Organization of the* ***hawk-i*** *Program Chart, History of Participation of Children in Medicaid and* ***hawk-i****, Iowa’s SCHIP Program Combination Medicaid Expansion and* ***hawk-****i, Enrollee Demographic Summary by Federal Poverty Level, Enrollee Demographic Summary by Age, Enrollee Demographic Summary by Gender*

***\*\*\****

Organization of the ***hawk-i*** Program

**U.S. Department of Health & Human Services**

**O U T R E A C H**

**(IDPH)**

###### CK/CKF

**Third Party Administrator (TPA)**

# MAXIMUS

***hawk-i* Board**

1. **Mary Mincer Hansen**
2. **Eldon Huston, Chair**
3. **Jim Yeast**
4. **Wanda Wyatt-Hardwick**
5. **Susan Salter**
6. **Ted Stilwill**
7. **Terri Vaughan, Vice Chair**

**Ex Officio Members**

1. **Senator Amanda Ragan**
2. **Rep. Gerald Jones**
3. **Senator Ken Veenstra**
4. **Rep. Jane Greimann**

##### DHS

**Enrollee**

**DHS MEDICAID STAFF**

**PLAN**

**Iowa Health Solutions**

**PLAN**

**Wellmark**

(Classic Blue)

**PLAN**

**John Deere**

**Clinical Advisory Committee/ Quality Team**

**Children with Special Health Care Needs Advisory Committee**

**University of Iowa**

**State Public Policy Center**

**Functional Health Assessment Analysis**

**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 program could be available. In addition to local DHS offices, schools, daycare centers, WIC sites, etc., other potential sources through which information could be provided may include organizations that deal with children (Girl Scouts, Boy Scouts, Little League, Big Brothers and Sisters, YMCA, etc.) and places frequented by children and their families (churches, fast food restaurants, roller skating rinks, & toy stores). Applications would be sent to the TPA.

Function of the outreach points:

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

|  |  |
| --- | --- |
| ***hawk-i* Board**  The function of the ***hawk-i*** Board includes, but is not limited to:   1. Adopt administrative rules developed by DHS 2. Establish criteria for contracts and approve contracts 3. Approve benefit package 4. Define regions of the state 5. Select a health assessment plan 6. Solicit public input about the ***hawk-i*** program 7. Establish and consult with the clinical advisory committee 8. Establish and consult with the advisory committee on children with special health care needs 9. Make recommendations to the Governor and General Assembly on ways to improve the program | **DHS**  The function of DHS includes, but is not limited to:   1. Work with the ***hawk-i*** Board to develop policy for the program 2. Oversee administration of the program. 3. Administer the contracts with the TPA, plans, and U of I. 4. Administer the State Plan. 5. Coordinate with the TPA when individuals applying for the ***hawk-i*** program may be Medicaid eligible and when Medicaid eligible recipients lose eligibility. 6. Provide statistical data and reports to CMS. |
| **Third Party Administrator (TPA)**  The functions of the TPA include, but may not be limited to:   1. Receive applications and determine eligibility for the program. 2. Staff a 1-800 number to answer questions about the program and assist in the application process. 3. Coordinate with DHS when it appears an applicant may qualify for Medicaid. 4. Determine the amount of family cost sharing. 5. Bill and collect cost sharing. 6. Assist the family in choosing a plan. 7. Notifying the plan of the enrollment. 8. Provide customer service functions to the enrollees. 9. Provide statistical data to DHS. | **Plans**  The functions of the plan(s) 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 to the TPA. |
| **Clinical and Children with Special Health Care Needs Advisory Committees**   1. The Clinical Advisory Committee is made up of health care professionals who advise the ***hawk-i*** Board on issues around coverage and benefits. 2. The Children with Special Health Care Needs Advisory Committee is made up of health care professionals, advocates, and parents who provide input to the ***hawk-i*** Board on how to best meet the needs of children with special health care issues. | Medicaid Staff The function of the Medicaid staff who are co-located at MAXIMUS is to determine Medicaid eligibility when a person who applies for ***hawk-i*** is referred to Medicaid. |

History of Participation of Children in Medicaid and ***hawk-i***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **SCHIP (Title XXI Program)** | |
| **Month** | **Total Children on Medicaid** | **Expanded Medicaid\*** | ***hawk-i* Program (began 1/1/99)** |
| **SFY 99** | 91,737 |  |  |
| **SFY 00** |  |  |  |
| Jul-99 | 104,156 | 7,891 | 2,104 |
| **SFY 01** |  |  |  |
| Jul-00 | 106,058 | 8,477 | 5,911 |
| **SFY 02** |  |  |  |
| Jul-01 | 126,370 | 11,316 | 10,273 |
| **SFY 03** |  |  |  |
| Jul-02 | 140,599 | 12,526 | 13,847 |
| **SFY 04** |  |  |  |
| Jul-03 | 152,228 | 13,744 | 15,643 |
| Aug-03 | 152,926 | 13,983 | 15,790 |
| Sep-03 | 154,094 | 14,097 | 15,891 |
| Oct-03 | 155,579 | 13,823 | 15,970 |
| Nov-03 | 155,555 | 13,820 | 15,710 |
|  |  | **Total SCHIP Enrollment** | 29,530 |
|  |  |  |  |
| Total growth in Medicaid enrollment from SFY 99 to present = | | | 63,818 |
| Total growth in ***hawk-i*** enrollment from SFY 99 to present = | | | 15,710 |
| Total children covered | |  | 79,528 |
|  |  |  |  |
|  |  |  |  |
| \*Expanded Medicaid number is included in "Total Children on Medicaid" number | | | |

**IOWA’S CHIP PROGRAM**

**COMBINATION MEDICAID EXPANSION AND *hawk-i***

**200% FPL**

**Medicaid Expansion**

(*Title 21 Funded)*

**185% FPL**

***h* *a* *w* *k* – *i (Title 21 Funded)***

**INFANTS**

(Less than 1 year)

**133% FPL Medicaid Expansion**

**CHILDREN 1 –5 (***Title 21 Funded***)**

**100% FPL**

**CHILDREN 6 - 19**

### M E D I C A I D

*(Title 19 Funded)*

**Age 0 1 6 15 19**

*Attachment 5: County Health Plan Map and Iowa’s Children’s Health Insurance Program Chart*

*\*\*\**

Wellmark Classic Blue

Iowa Health Solutions

Revised

6-1-03

Louisa

Des

Moines

**Health Plan Coverage Areas**

**Effective June 1, 2003**

***hawk-i***

Chickasaw

Floyd

Howard

Mitchell

Cerro

Gordo

Hancock

Worth

Winnebago

Kossuth

Palo Alto

Emmet

Dickinson

Clay

Winneshiek

Allamakee

Clayton

Fayette

Dubuque

Delaware

Buchanan

Black Hawk

Bremer

Grundy

Hardin

Butler

Franklin

Hamilton

Wright

Webster

Humboldt

Calhoun

Pocahontas

Buena

Vista

Sac

Tama

Jackson

Jones

Linn

Benton

Clinton

Cedar

Johnson

Iowa

Poweshiek

Jasper

Polk

Marshall

Story

Dallas

Boone

Guthrie

Greene

Audubon

Carroll

Scott

Muscatine

Washington

Keokuk

Lee

Henry

Van Buren

Jefferson

Davis

Wapello

Mahaska

Marion

Warren

Appanoose

Monroe

Wayne

Lucas

Clarke

Decatur

Madison

Adair

Cass

Ringgold

Union

Taylor

Adams

Montgomery

Page

Fremont

Mills

Pottawattamie

Shelby

Harrison

Crawford

Monona

Ida

Woodbury

Cherokee

Plymouth

Sioux

O’Brien

Osceola

Lyon

Iowa Health Solutions

John Deere

John Deere

*Attachment 6: Healthy and Well Kids in Iowa (****hawk-i****) Board Bylaws*

*\*\*\**

**BYLAWS**

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

1. **NAME AND PURPOSE**
2. The ***hawk-i*** Board, hereafter referred to as the Board, is established and operates in accordance with the Code of Iowa.
3. The Board’s specific powers and duties are set forth in Chapter 514I of the Code of Iowa.
4. **MEMBERSHIP**
5. The Board consists of eleven (11) members. Four members are appointed by the Governor to two-year terms. Statutory members are the Director of the Department of Education, the Director of the Department of Public Health, and the Commissioner of Insurance, or their designees. Ex officio members from the General Assembly are appointed: two Senate members and two House members.
6. **BOARD MEETINGS**
7. The Board shall conduct its meetings in accordance with Iowa's Open Meetings Law.
8. The Board shall conduct its meetings according to parliamentary procedures as outlined in Robert's Rules of Order. These rules may be temporarily suspended by the Chairperson with a majority vote of the Board members in attendance.
9. The Board shall meet at least six times a year at a time and place determined by the chairperson.
10. Department of Human Services (DHS) staff will ship the meeting packets (including the agenda) to Board members at least five days prior to Board meetings.
11. Special meetings may be held at any time at the call of the chairperson, the DHS program manager or at the call of any five members of the Board, provided that notice thereof be given to all Board members at least twenty-four hours in advance of the special meeting.
12. A quorum at any meeting shall consist of five or more voting Board members.
13. DHS staff shall be present and participating at each meeting of the Board.
14. The Board shall record its proceedings as minutes and shall maintain those minutes in accordance with the Iowa Open Records Law.
15. **OFFICERS AND COMMITTEES**
16. The officers of the Board shall be chairperson and vice-chairperson. DHS staff will serve as Secretary. The chairperson and vice-chairperson shall be elected at the first regular meeting of each fiscal year and shall assume their duties at next meeting or immediately upon the resignation of the current officers.
17. The duties of all officers shall be such as by custom and law and the provisions of the Act as usually devolving upon such officers in accordance with their titles.
18. The chairperson shall appoint committees as are needed and/or recommended unless provided for statutorily.
19. Each committee shall act in an advisory capacity and shall report its recommendations to the full Board.
20. **DUTIES AND RESPONSIBILITIES**
21. The Board shall have the opportunity to review, comment, and make recommendations to the proposed ***hawk-i*** budget request.
22. The Board shall set policy and adopt rules. The DHS program manager will periodically make policy recommendations to the Board in order to promote efficiency or to bring the program into compliance with state or federal law.
23. .DHS staff shall keep the Board informed on budget, program development, and policy needs.
24. **AMENDMENTS**
25. Amendments to these bylaws may be proposed at any regular meeting but become effective only after a favorable vote at a subsequent meeting. Any of the foregoing rules may be temporarily suspended by a unanimous vote of all the members present at any meeting provided they do not conflict with the provisions of the Act.

1. National Committee on Quality Assurance. The Healthplan Employer Data and Information Set (HEDIS). <http://www.ncqa.org/Programs/HEDIS/>. Most recently accessed October 3, 2003. Internet. [↑](#footnote-ref-2)
2. American Academy of Pediatrics. Policy statement on Recommendations for Preventive Pediatric Health Care. *Pediatrics.* Vol. 105, Number 03, March 2000, pp 645. Available at <http://www.aap.org/policy/re9939.html>. Most recently accessed October 3, 2003. Internet. [↑](#footnote-ref-3)
3. American Public Human Services Administration. Available at <http://www.aphsa.org/>. Most recently accessed October 3, 2003. Internet. [↑](#footnote-ref-4)
4. Momany ET, Damiano PC, *Evaluating the Iowa Medicaid Managed Care Program: Outcomes of Care.* Final report to the Iowa Department of Human Services, January 2003. University of Iowa, Public Policy Center, Iowa City, IA. [↑](#footnote-ref-5)
5. American Academy of Pediatric Dentistry. 2003-2004 Policy guidelines: Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Children. Available at <http://www.aapd.org/media/policies.asp>. Most recently accessed October 3, 2003. [↑](#footnote-ref-6)
6. More information about the methods use din the survey can be found in the latest report of data from the survey: “Damiano PC, Willard JC, Momany ET, Tyler MC ***hawk‑i***: *Impact on Access and Health Status.* Third Evaluation Report to the Board of Directors of the Healthy and Well Kids in Iowa Program. December 2002. University of Iowa, Public Policy Center, Iowa City, IA. The report can be accessed at http://ppc.uiowa.edu/hawk-i/impact3/inex.html [↑](#footnote-ref-7)