Independent Evaluation of Indiana's Children's Health Insurance Program

Final Report - April 2022

BURNS & ASSOCIATES, INC.

A DIVISION OF HEALTH MANAGEMENT ASSOCIATES

ACKNOWLEDGMENTS

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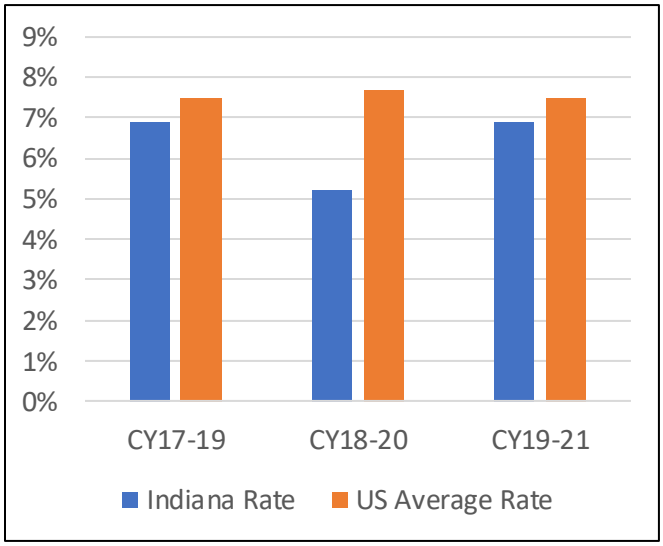
EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) experienced a decrease in enrollment in Calendar Year (CY) 2021 of 10.1 percent. Enrollment fell from 109,312[1] members in December 2020 to 98,300 members in December 2021. This appears to be due to a migration of members to the regular Medicaid program, which is for children in families at lower income levels. Enrollment of children in Indiana's Medicaid program increased 10.6 percent during 2021, from 695,295 in December 2020 to 769,275 in December 2021. During the pandemic, state Medicaid agencies are not allowed to disenroll current CHIP and Medicaid members from the program. So this reduction in CHIP enrollment appears to be due to transfers of children to the traditional Medicaid program. The all-time high enrollment in Indiana's CHIP of 119,216 occurred at the start of the pandemic in March 2020.

Indiana's CHIP continues to serve as a way to keep the uninsured rate for children in lower-income families below the national average. For the most recent three years of reporting, Indiana's uninsured rate for children in families at or below 250% of the federal poverty level (FPL) has been below the national average. (The uninsured rate is expressed as the most recent three years averaged together.) In the most recent period of reporting (the 3-year average of CY2019, CY2020 and CY2021 reporting), Indiana's child uninsured rate was 6.9 percent and the national average rate was 7.5 percent.



At the end of CY 2021, 62.9 percent of enrollees were in the MCHIP portion and 37.1 percent were in the SCHIP portion of the program. Eligibility for CHIP depends on the child's age as well as the family's income. MCHIP (Package A) is the entitlement portion of the program and was put in place at the beginning of the program. SCHIP (Package C) is the name of the non-entitlement portion of the program. SCHIP was introduced in two phases (Package C original and Package C expansion).

Age	CHIP Package A (began 1998)	CHIP Package C (began 2000)	CHIP Package C Expansion (began 2008)
Up to age 1	158 – 208% FPL		208 – 250% FPL
1 – 5	141 – 158% FPL	158 – 200% FPL	200 – 250% FPL
6 – 18	106 – 158% FPL	158 – 200% FPL	200 – 250% FPL

*

Enrollment in CHIP is spread evenly throughout the state, but there is a higher distribution of minorities in Indiana's CHIP than the overall population of children ages 18 and younger. Because children under age 6 are eligible for regular Medicaid at higher family income levels, the CHIP has a higher proportion

[1] Enrollment figures used in this report come from data in the Office of Medicaid Policy and Planning's Enterprise Data Warehouse. The numbers shown in this report differ somewhat from the OMPP's published December 2021 enrollment report because HMA-Burns has access to more recent data since the report published by the OMPP.

of members in older child age groups. Children ages 6 to 12 represent 43 percent of CHIP enrollees while teenagers represent 45 percent of CHIP enrollees.

Each year, an independent evaluation of Indiana's CHIP is conducted as required by Indiana Code 12-17.6-2-12 which states that

> *Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the: (1) Budget committee; (2) Legislative council; (3) Children's health policy board established by IC 4-23-27-2; and (4) Health finance commission established by IC 2-5-23-3.*
> *A report provided under this section to the legislative council must be in an electronic format under 5-14-6.*

Burns & Associates, a Division of Health Management Associates (HMA-Burns), was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for CY 2021. The HMA-Burns team has conducted this annual study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

Background on Indiana's CHIP

All CHIP members enroll in the OMPP's Hoosier Healthwise program in the same manner as children in the Medicaid program. CHIP families select from one of the four contracted managed care entities (MCEs)—Anthem, CareSource, Managed Health Services (MHS) or MDwise.

There are only slight differences in the benefit package offered between MCHIP (Package A) and SCHIP (Package C). Co-pays are charged to SCHIP members for prescription drugs and ambulance services, and monthly premiums are also charged to SCHIP families on a sliding scale based on family income and the number of children enrolled.

	Monthly Premiums	
Family FPL	**1 Child**	**2 or More Children**
158% up to 175%	$22	$33
175% up to 200%	$33	$50
200% up to 225%	$42	$53
225% up to 250%	$53	$70

In a report released by the Kaiser Family Foundation in March 2020, it was found that Indiana's program resembles many other state CHIP programs in its design features as well. Among the CHIP programs nationwide, 22 states (including Indiana) require families to pay premiums for their children's coverage when the family income is above 200% FPL. States do differ on co-pays required in their programs. Like 16 other states, Indiana requires co-pays on some pharmacy scripts. But Indiana does not require co-pays on emergency department visits or non-preventive physician visits like some other states do.

The Federal Government Has Enhanced Funding to States for CHIP in Recent Years

The State Children's Health Insurance Program was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. The original legislation has been extended five times since then. The Bipartisan Budget Act of 2018 authorized CHIP through Federal Fiscal Year (FFY) 2027.

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage (FMAP) for states is higher than the FMAP for Medicaid.

For illustration, for every $100 spent in Indiana's CHIP, in FFY 2021 the state's responsibility was $19.58. Once the public health emergency (PHE) ends, this will increase to $23.92. For comparison, for every $100 spent in the traditional Medicaid program in FFY 2021, the state's responsibility was $27.97. When the PHE ends, this will increase to $34.17.

Total expenditures in Indiana's CHIP in CY 2021 were $253.2 million, a decrease of 5.1 percent from the previous year. But since enrollment also fell during CY 2021, the total cost to the state on a per member per month basis increased 5.1 percent, from $195.90 during CY 2020 to $205.88 in CY 2021. The state's share of the per member per month cost during CY 2021 was $40.31.

Dashboard of Metrics to Review Indiana's CHIP at a Glance

The dashboard report that appears at the end of this Executive Summary shows metrics related to Indiana's CHIP related to enrollment, expenditures, access to services, outcome measures, and parent satisfaction with the program.

Access

With respect to access, HMA-Burns matched claims of actual services received in FFY 2021 for primary care and dental services between where the member lives and where the closest provider is located to each member. HMA-Burns found each provider's location and drew a 10-mile coverage radius to assess the availability of primary care and dental providers to CHIP members. On a statewide level, there are very few gaps. In fact, only 0.3 percent of all CHIP members live more than 10 miles from an available primary medical provider. There are 1.3 percent of CHIP members who live more than 10 miles from an available dentist.

Although the gaps are few throughout the state, there is some differentiation by region. For primary medical providers, a slightly higher proportion of CHIP members in the Southeast Region live more than 10 miles from a provider. For dentists, a slightly higher proportion of members in the West Central, Southeast and Southwest Regions live more than 10 miles from a provider. A visual representation of the service coverage maps for each of the eight regions and the counties within each region appear in the Appendix (Appendix A shows primary care provider care providers, Appendix B shows dentists).

Separately, HMA-Burns computed the average distance that members actually travelled to their providers of choice. An average driving distance was computed for CHIP members in each of the 92 counties. The OMPP targets a threshold of no more than 30 miles for members to travel to seek primary care or dental care. For primary care, there are three counties where members, on average, travelled more than 30 miles. For dental care, there are 10 counties. The maps that show the results at the individual county level appear in Section III.

Outcomes

The OMPP requires its MCEs in Hoosier Healthwise to measure health outcomes for children. Many of the measures that the MCEs report on are Healthcare Effectiveness Data and Information Set (HEDIS)

measures, which are nationally-recognized measures that health plans report on and are subject to an external auditor to compute. The OMPP compares the results of the HEDIS measures across the four MCEs and has set performance targets against national benchmarks for Medicaid health plans. HMA-Burns reviewed 12 HEDIS measures in this evaluation that are commonly used to assess the health outcomes for children. Eight of these measures are shown on the dashboard report. All findings on selected HEDIS measures are reported in Section V.

- When compared to the median results for Medicaid health plans nationally, among the 12 measures reviewed, Anthem had nine in which its rates exceeded the national median values, CareSource had six, MDwise had six, and MHS had seven.

- Three of the four MCEs exceeded national health plan median results in the measure that computes the percentage of children in their first 15 months of life that had six or more well care visits to their doctor.

- Two of the four MCEs exceeded national health plan median results for measures that track the percentage of members who had an annual well visit in the ages 3-11 group and 12-17 group.

- All four MCEs exceeded national health plan median results in the measures for appropriate asthma medication for children ages 5-11 years and follow-up visit within 7 days from a mental health-related hospitalization

- Areas where the Hoosier Healthwise MCEs had rates below national health plan median results include immunization rates for young children and lead screening for young children.

Member Satisfaction

The OMPP requires the MCEs to conduct an annual survey of parents of children enrolled in Hoosier Healthwise. The survey includes a sample of both CHIP and Medicaid children. The survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. Five of these measures are shown on the dashboard report. All findings on selected CAHPS measures are reported in Section V.

- In this past year's survey, three of the four Indiana MCEs scored above the national median values of all Medicaid health plans on the rating of the health plan itself.

- Two MCEs scored above the median values nationally when the parents rated the health of their children.

- When asked questions about getting needed care or getting care quickly, all four MCEs saw a decline in this year's survey of the percent of parents that indicated that they could obtain care quickly either "always" or "usually". However, the percent of parents who indicated that they could obtain needed care always or usually only fell for one MCE in the 2021 survey.

- Two of Indiana's MCEs scored much higher than their peers nationally on the Getting Needed Care series of questions (MDwise and MHS). One MCE (MHS) also scored above its peers nationally on the Getting Care Quickly series of questions.

Service Utilization

HMA-Burns measured the percentage of CHIP children that used primary care services, emergency department visits, preventive dental visits, and pharmacy prescription for the periods FFY 2019, FFY 2020 and FFY 2021. The focus on users of each service was limited to children who were enrolled in the program for at least nine months within each year. Comparisons were also made across various demographic cohorts, such as by Package (CHIP A, CHIP C and CHIP C Expansion), by MCE, by age group and by race/ethnicity. HMA-Burns also analyzed the utilization rate per 1,000 CHIP members for these same services. In the examination of utilization, unlike for users, all members who were enrolled in CHIP in each year were included, regardless of enrollment duration.

The key findings from studying this data are shown below. It was anticipated that users and utilization of service would fall since the public health emergency began in March 2020. The focus was to determine the rate of reduced use and if service fell at different paces.

- Primary care visits
    - The percent of SCHIP (CHIP Package C and CHIP C Expansion) children in the study sample that had a primary care visit each year was higher (89% of total) than for children in MCHIP (CHIP Package A) in the pre-pandemic year of FFY 2019 (81% of total). This continued in FFY 2020 but less so in FFY 2021.
    - Primary care visits are used more by children ages 5 and younger (81%-93% of total) each year than the older members enrolled in CHIP (74%-83% of total).
    - When examined by race/ethnicity, the usage rate was lower for African-American children than for Caucasian and Hispanic children (in FFY 2021, Caucasian and Hispanic were 76%, African-American 71%).
- Emergency department visits
    - The percent of children enrolled at least nine months in CHIP that use the ER each year was consistent across CHIP A, CHIP C, and CHIP C Expansion and across the MCEs.
    - ER use has substantially reduced during the pandemic for children ages 5 and under (a reduction of 42% from FFY 2019 figures), for children ages 6 to 12 (a reduction of 39%), but less so for teens (a reduction of 20%).
    - Use of the ER by race/ethnicity is similar, although slightly lower for Hispanic children.
- Preventive dental visits
    - The utilization of preventive dental services has fallen 18 percent for all age groups studied between FFY 2019 and FFY 2021.
    - Dental usage is much higher for children ages 6 to 12 (70% in FFY 2019) than children ages 13 and over (58% in FFY 2019) or children ages 5 and under (50% in FFY 2019).
    - Hispanic children in Indiana's CHIP have traditionally had a higher usage rate for dental services than other race/ethnicities. African-American and Caucasian children have had similar usage rates.
- Pharmacy scripts
    - Pharmacy scripts have decreased substantially during the pandemic for children ages 5 and under (44% lower). For children ages 6-12, the reduction is 27 percent; for teens, a reduction of 15 percent.
    - The scripts per 1,000 Hispanic children are considerably lower than other races or ethnicities. Caucasian children have much higher usage rates and utilization per 1,000 member rates than minority children for pharmacy scripts.

INDIANA CHILDREN'S HEALTH INSURANCE PROGRAM AT A GLANCE

ENROLLMENT in CHIP as of December 2021			**98,300**	**-10.1%**	percentage reflects change from Dec 2020			
	CHIP A	61,829	-12.8%	CHIP C Original	19,872	-4.5%	CHIP C Expansion	16,599	-5.6%
Child Enrollment in MEDICAID as of Dec 2021			**769,275**	**+10.6%**	percentage reflects change from Dec 2020			

UNINSURED RATE, for children in families up to 250% of the Federal Poverty Level				
3-Year Average Rate	**Indiana**	**6.9%**	**US Average**	**7.5%**

EXPENDITURES IN CHIP	**CY 2020**	**$266.7M**	**CY 2021**	**$253.2M**
PMPM = Per Member Per Month	PMPM	$195.90	PMPM	$205.88

	Percent of CHIP Members who Live within 10 Miles of a Provider			
ACCESS TO PRIMARY CARE	FFY 2020	99.7%	FFY 2021	99.7%
ACCESS TO DENTAL CARE	FFY 2020	99.0%	FFY 2021	98.7%

WHERE CHIP MEMBERS RECEIVED SERVICES Average Driving Distance to Provider who Delivered the Service

		Number of Counties within each range of number of miles to provider			
		0-10 miles	11-20 miles	21-30 miles	>30 miles
PRIMARY CARE	FFY 2020	7	56	25	4
	FFY 2021	7	42	40	3
DENTAL CARE	FFY 2020	11	41	30	10
	FFY 2021	15	39	28	10

HEDIS & CAHPS MEASURES

HEDIS are used to measure health access and outcomes. CAHPS are used to measure client satisfaction.

Colors compare scores to health plans nationally.

If MCE is below the 25th percentile nationally:
If MCE is >25th percentile but <50th percentile nationally:
If MCE is >50th percentile but <75th percentile nationally:
If MCE is >75th percentile but <90th percentile nationally:
If MCE is above the 90th percentile nationally:

	Anthem	CareSource	MDwise	MHS
HEDIS Measures, 2021 reporting				
6 or more well visits, first 15 mo	60.0%	56.4%	56.4%	54.9%
2 or more well visits, 15-30 mo	68.9%	69.9%	66.1%	68.3%
Annual well visit, age 3 - 11	54.3%	50.7%	50.1%	52.1%
Annual well visit, age 12 - 17	47.7%	43.1%	44.5%	46.9%
Appropriate asthma meds, age 5-11	82.3%	84.5%	82.1%	82.9%
Immunizations, young children	62.3%	67.4%	58.2%	63.0%
Lead screening, young children	62.7%	63.5%	60.9%	62.4%
Initial Follow-up after ADHD meds	48.9%	50.2%	56.7%	48.4%
CAHPS Measures, 2021 reporting				
Rating of the health plan	88.2%	83.1%	87.7%	91.8%
Rating of their own health	89.6%	89.2%	87.8%	88.8%
Rating of their personal doctor	88.3%	90.3%	89.5%	90.4%
Getting Needed Care	84.8%	84.6%	89.0%	91.8%

Section I
Introduction

SECTION I: INTRODUCTION

Each year, an independent evaluation of Indiana's Children's Health Insurance Program (CHIP) is conducted as required by Indiana Code 12-17.6-2-12 and is due to the Legislature by April 1. Burns & Associates, a Division of Health Management Associates (HMA-Burns), was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2021. HMA-Burns has conducted this study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

History of the Federal S-CHIP and Indiana's CHIP

The State Children's Health Insurance Program (S-CHIP) was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. In this legislation, states were allocated funds on an annual basis for a 10-year period to expand health coverage to low-income children. The original legislation was extended to March 31, 2009. Since this time, federal legislation has been enacted to extend the program itself as well as funding of the program. The most recent legislation by Congress, the Bipartisan Budget Act of 2018 enacted on February 9, 2018, provided appropriations for CHIP for Federal Fiscal Years (FFYs) 2024 through 2027.

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage, or FMAP, for states is higher than the FMAP for Medicaid. This is often referred to as the "enhanced FMAP". Prior to the Affordable Care Act (ACA), the enhanced FMAP was 30 percent higher for CHIP than the regular FMAP for Medicaid. The ACA increased each state's enhanced FMAP rate for CHIP even further for a five-year period.

During the public health emergency (PHE), each state has also received a 6.2 percentage point increase in its regular Medicaid FMAP. This will continue as long as the PHE is in effect. As of the date of this report, the PHE period for enhanced funding will end on April 16, 2022.

The table below shows an illustration of funding during FFY 2021 (October 1, 2020 – September 30, 2021). As an illustration, for every $100 spend in Indiana's Medicaid/CHIP program, the state share of this $100 is shown:

FFY	Regular Medicaid FMAP	Regular Medicaid FMAP during PHE	CHIP Only With Enhanced FMAP	CHIP Only With Enhanced FMAP during PHE
2021	$34.17	$27.97	$23.92	$19.58

When the original federal S-CHIP legislation was introduced, states had the option to expand their existing Medicaid program, develop a state-specific program (that would not be an entitlement program), or a combination of the two. Indiana opted to implement the "combination" program similar to 20 other states. Therefore, Indiana's CHIP has two distinct components—CHIP Package A and CHIP Package C. CHIP Package A (the Medicaid expansion portion, also called MCHIP in Indiana) covers

uninsured children in families with incomes up to 158[2] percent of the Federal Poverty Level, or FPL ($41,870 per year for a family of four in 2021) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998. CHIP Package C (the non-entitlement portion, also called SCHIP in Indiana) covers uninsured children in families up to 250 percent of the FPL ($66,250 per year for a family of four in 2021). CHIP Package C was first introduced on January 1, 2000 to cover children in families with incomes up to 200 percent of the FPL. CHIP Package C was expanded on October 1, 2008 to cover children in families up to 250 percent of the FPL.

Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests, children in SCHIP cannot have insurance coverage from another source.

The ACA also created what is known as a maintenance of effort requirement on state Medicaid and CHIP programs that prevented states from lowering their income thresholds for eligible groups through December 31, 2019. This maintenance of effort requirement was reauthorized in the HEALTHY KIDS Act of 2017 through September 30, 2023. As a result, Indiana cannot lower the income standard for CHIP below 250 percent of the FPL.

In March 2020, the Kaiser Family Foundation released a report in which the 50 states (and District of Columbia) were surveyed to compare Medicaid and CHIP eligibility policies.[3] As of January 2020, 49 states cover children with incomes at or above 200 percent of the FPL. Of these, 19 states extend eligibility to at least 300 percent of the FPL.

Among the CHIP programs nationwide, 22 states (including Indiana) require families to pay premiums for their children's coverage. The premiums are usually on a sliding scale based on the family's FPL. Among the states that do charge a premium, at the 200 percent FPL level, the range of the monthly premium is from $9 to $50. Indiana's rates are $33 for one child in the family and $50 for two or more children.

Other findings in the Kaiser study reported on design features of state CHIP programs. Indiana's SCHIP (Package C) is similar in many respects to other state programs, particularly with respect to the following features (with number of states having a similar policy to Indiana):

- The ability to submit applications online (51 states including DC);
- The ability to apply by telephone (45 states);
- Processing automated renewals (47 states);
- Co-pays charged for generic drugs (32 states) and brand name drugs (33 states)

The most notable difference in Indiana's CHIP compared to other states is that Indiana required that children have a period of no insurance ("going bare") of three months prior to enrollment. There are 38 states with no waiting period. Also, Indiana does not impose co-pays for non-emergent ER visits (14 states do), non-preventive physician visits (16 states do), or inpatient hospital visits (11 states do).

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[2] Prior to January 1, 2014, this threshold was 150 percent of the FPL. Starting January 1, 2014, the threshold was changed to 158 percent of the FPL to account for changes made by the Centers for Medicare and Medicaid Services in the computation of Modified Adjusted Gross Income.

[3] Brooks, T., Roygardner, L., and Artiga, S. (March 2020) *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey.* Washington, DC: Georgetown University Center for Children and Families and The Kaiser Family Foundation.

The Impact of CHIP on Reducing the Rate of Uninsured Children in Indiana

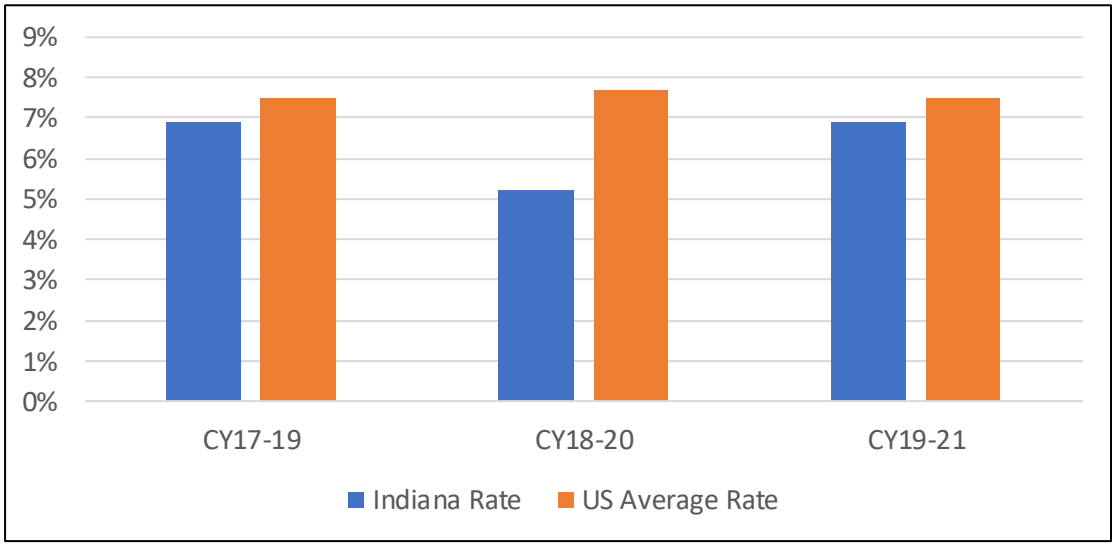
As of December 2021, enrollment in Indiana's CHIP was at 98,300, a decrease of 11,012 children from December 2020. However, during CY2021, the enrollment of children in the Medicaid program increased by 73,980. Many children who had been enrolled in CHIP are likely now enrolled in Medicaid due to a reduction in the family's income level. Since the PHE began, child enrollment in Medicaid and CHIP combined in Indiana has increased by 165,000, or 23 percent. In addition to economic factors, states were required to retain their enrollment during the PHE in exchange for the higher FMAP rate from the federal government. This means that children who may be determined no longer eligible at the time of annual renewal (in particular, children who turn age 19) are still enrolled in Medicaid or CHIP.

More enrollment statistics appear in Section II of this report.

The Census Bureau's Current Population Survey (CPS) surveys citizens annually on their health insurance status. An uninsured rate is computed for each state. Researchers often use an average over three years of annual CPS surveys to mitigate large swings in year-to-year results at the individual state level due to lower sample size in the study.

Exhibit I.1 compares the uninsured rate in Indiana against the national average over the last three period for children in families with incomes up to 250 percent of the FPL. Indiana has consistently had an uninsured rate for children at this income level that is lower than the national average. For the most recent three-year period of CYs 2019 to 2021, Indiana's uninsured rate was 6.9 percent; the US average was 7.5 percent.

Exhibit I.1
Uninsured Rate Among Children in Families at or Below 250% of the Federal Poverty Level
For the Most Recent 3 Years of Reporting
The Uninsured Rate is Computed Using a Three-Year Average



Source: U.S. Census Bureau, Current Population Survey
https://www.census.gov/cps/data/cpstablecreator.html

Indiana's CHIP is Integrated with Other Medicaid Programs

Children in Indiana's CHIP are enrolled in the OMPP's Hoosier Healthwise program like most other children in the Medicaid program. Hoosier Healthwise is the state's Medicaid managed care program for children. CHIP enrollees, like all children in Hoosier Healthwise, select a primary medical provider (PMP) or they are assigned one by the managed care entity (MCE) that they enroll with. CHIP members must enroll with one of four MCEs that contract with the state—Anthem, CareSource, Managed Health Services (MHS), or MDwise. CHIP enrollees have access to all of the providers available to Hoosier Healthwise members that are enrolled with the MCE they select.

With just a few limitations, Indiana's SCHIP (Package C) members are able to access the same services as their peers in the traditional Medicaid program. The actual services offered to CHIP members are also similar to those found in other state CHIP programs.

One design difference between Indiana's CHIP and traditional Medicaid are co-payments that are imposed. Members in SCHIP (Package C) (the non-entitlement program) are charged co-payments for prescriptions ($3 co-pay for generic drugs and $10 for brand name drugs) and a $10 co-pay for ambulance service. There are no co-pays charged to children in MCHIP (Package A).

Exhibit I.2
Benefits Offered to Indiana's CHIP Enrollees in the Hoosier Healthwise Program

Hospital Care	Lab and X-ray Services
Doctor Visits	Medical Supplies/Equipment*
Well-child Visits	Home Health Care
Clinic Services	Therapies
Prescription Drugs	Chiropractors
Dental Care	Foot Care*
Vision Care	Transportation*
Mental Health Care	Nurse Practitioner Services
Substance Abuse Services	Nurse Midwife Services
Curative Care Hospice	Family Planning Services

* Some limits apply to these services in the CHIP compared to the Traditional Medicaid program.

The other design difference between CHIP and traditional Medicaid is that families of children enrolled in SCHIP (Package C) are required to pay a monthly premium. The premium varies by the income level and the number of children covered in the family as outlined in Exhibit I.3 below.

Exhibit I.3
Monthly Premiums Charged to Families in Indiana's SCHIP Package C

Family FPL	1 Child	2 or More Children
158% up to 175%	$22	$33
175% up to 200%	$33	$50
200% up to 225%	$42	$53
225% up to 250%	$53	$70

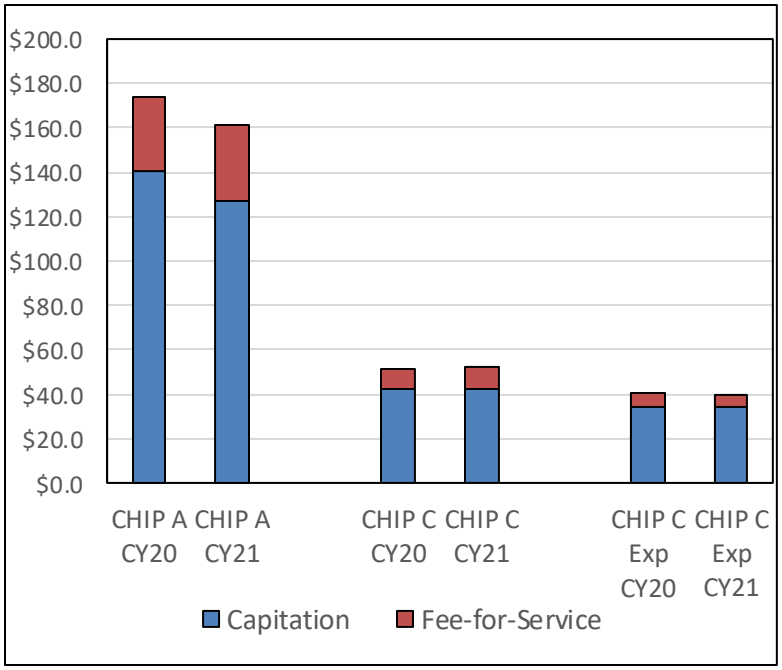
Expenditures in Indiana's CHIP

Expenditures in Indiana's CHIP are paid in two ways. The first method is a payment to the MCEs through what is known as a capitation payment. This is a set amount paid to the MCEs per member per month (PMPM). The capitation PMPM rate is adjusted for age and also adjusted by Package. The MCEs are at risk for the services that they are contracted to deliver.

The largest category of expenditures made in the fee-for-service program (i.e., outside of the MCE payments) is the mental health rehabilitation services. There are also some high-cost pharmaceuticals that the OMPP pays outside of managed care. Other services may also be paid fee-for-service in the CHIP if an enrollee utilizes a service during the short time period before they have selected which MCE to join.

HMA-Burns examined expenditures made on behalf of CHIP members from data included in the state's data warehouse. Total expenditures in the CHIP were $266.7 million in CY 2020 and $253.2 million in CY 2021. The CY 2021 may grow a bit as some additional fee-for-service claims are billed for this service period. In both years, approximately 80 percent of CHIP expenditures were made to the MCEs through the PMPM. The remaining 20 percent was paid out by the OMPP through fee-for-service claims.

Exhibit I.4
Expenditures in Indiana's CHIP, in millions
Calendar Year 2020 and 2021



In CHIP Package A, total expenditures were $160.8 million in CY 2021, a 7.6 percent decrease from CY 2020. The PMPM payment increased 5.9 percent, from $192.87 to $204.26.

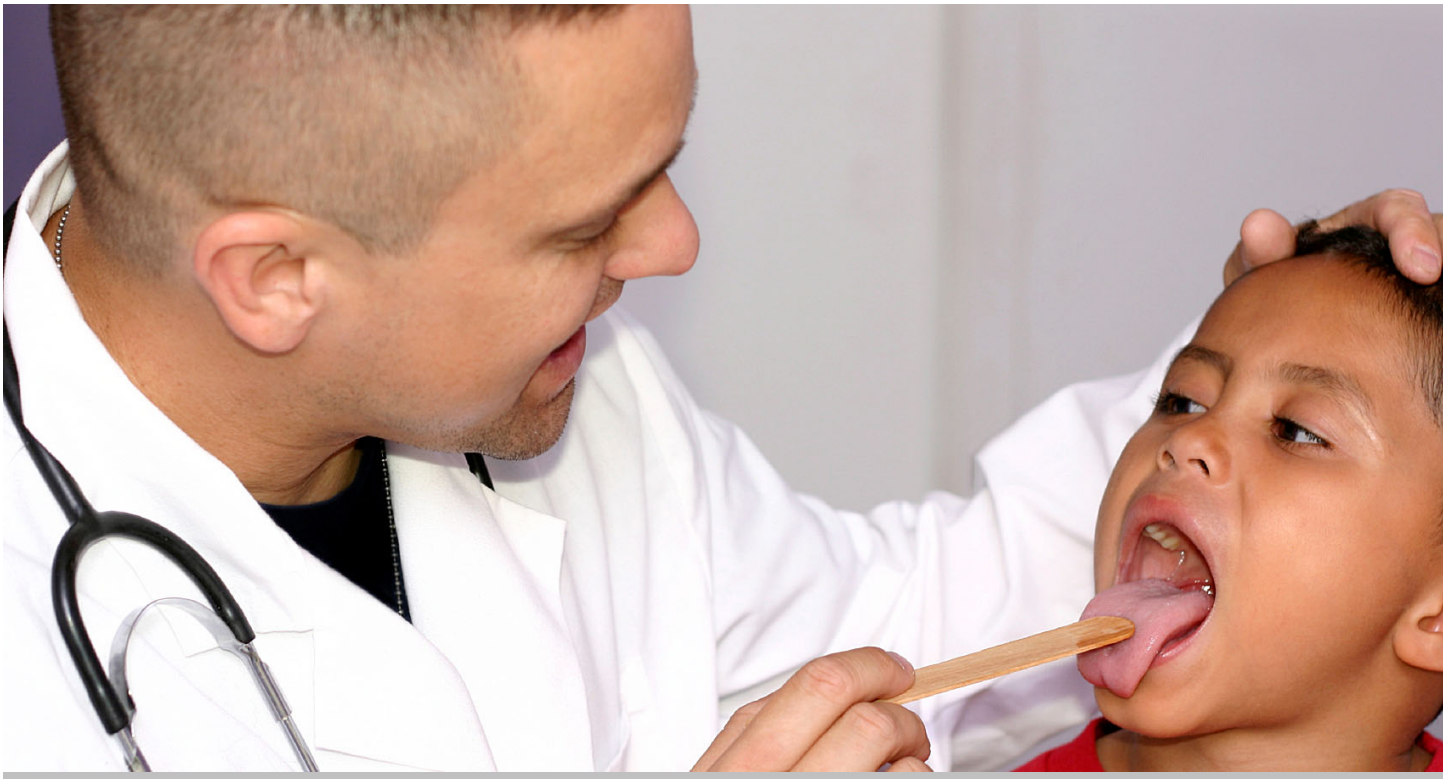
In CHIP Package C, total expenditures were $52.3 million in CY 2021, an increase of 1.1 percent from CY 2020. The PMPM payment increased 5.3 percent, from $204.83 to $215.75.

In the expansion portion of CHIP Package C, total expenditures were $40.1 million in CY 2021, an decrease of 2.0 percent from CY 2020. On a PMPM basis, however, there was an increase of 5.1 percent from $195.90 to $205.88.

The results shown above are the total funds expended in the CHIP. As stated earlier, the federal government contributes more to state CHIP programs than the regular Medicaid program. For most of CY 2021, the state contribution was near 19.5 percent of total expenditures. For the entire CHIP program, therefore, the total expenditures in CY 2021 were $205.88 per member per month, but the state share was $40.31. Furthermore, for CHIP Package C, the state's outlay is further reduced by premiums paid by parents.

Section II

Enrollment Trends in Indiana's CHIP

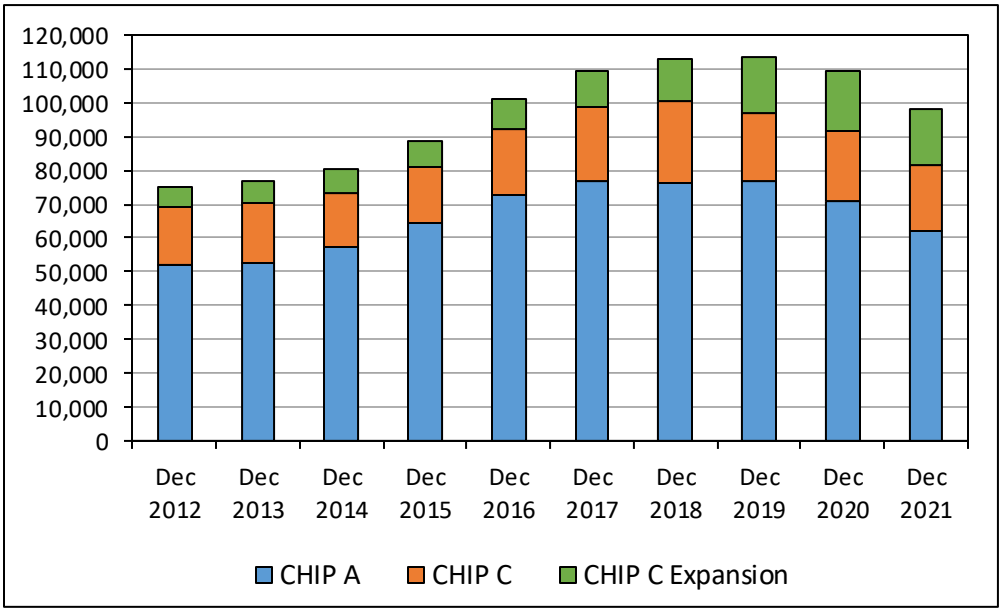


SECTION II: ENROLLMENT TRENDS IN INDIANA'S CHIP

Enrollment in Recent Years

Indiana's Children's Health Insurance Program (CHIP) experienced a decrease in enrollment in both CY2020 and CY2021. Enrollment in CHIP was at an all-time high at the start of the pandemic with enrollment of 119,216 in March 2020. Since then, enrollment in CHIP has fallen to 98,300 as of December 2021. The 10-year enrollment trend in Indiana's CHIP is shown in Exhibit II.1.

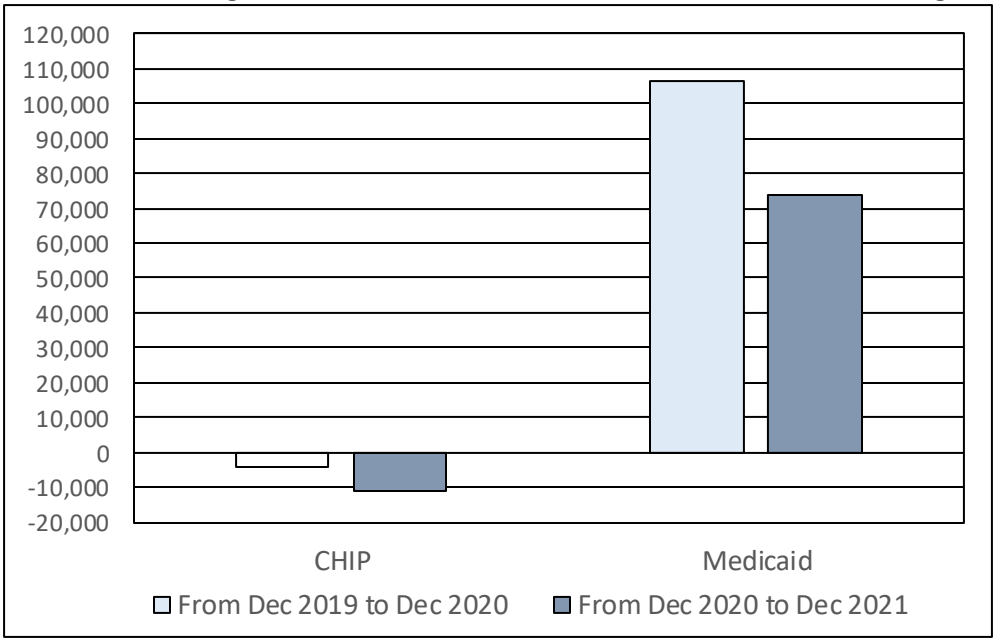
Exhibit II.1
Ten Year Trend in Enrollment in Indiana's CHIP at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

The reduction in CHIP enrollment, however, has been more than compensated for by the increase of the child enrollment in the regular Medicaid program. Although enrollment in CHIP has fallen by over 15,000 members in the last two years, the enrollment of children in Medicaid has increased by over 180,000 during this same time period, as seen in Exhibit II.2.

Exhibit II.2
Year-to-Year Change in Child Enrollment in Indiana's CHIP and Medicaid Programs



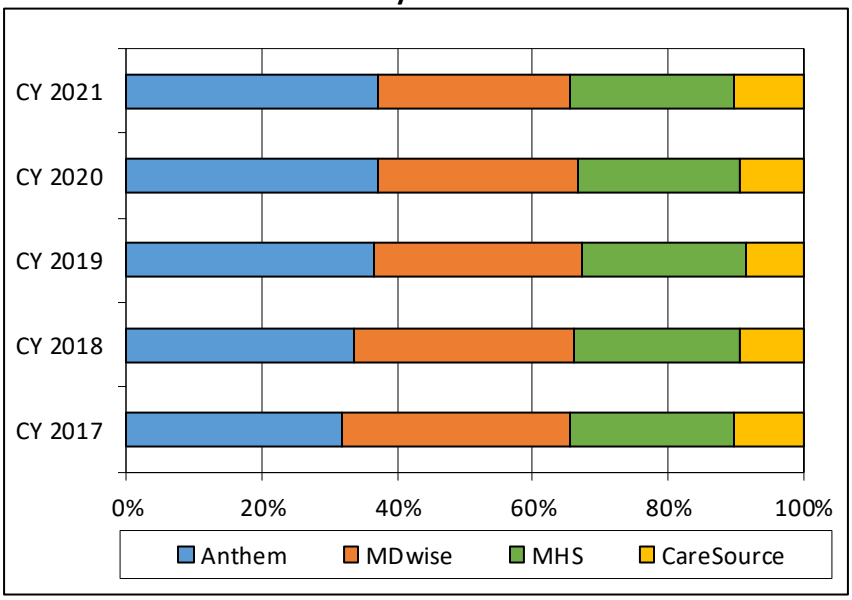
Source: Indiana's FSSA Enterprise Data Warehouse

At the end of CY 2021, 62.9 percent of enrollees were in the MCHIP portion and 37.1 percent were in the SCHIP portion of Indiana's CHIP. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 158 percent of the federal poverty level (FPL), enrollment fell 12.8 percent from December 2020 to December 2021. These are the members most likely to become eligible for Medicaid. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 158 to 250 percent of the FPL, enrollment decreased by 5.0 percent.

Demographic Profile of CHIP Members

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There are four MCEs that families can choose from. There has been some movement in the distribution of CHIP members across the MCEs in the last five years. At the end of CY 2021, Anthem had 37.0 percent of all CHIP enrollees, MDwise had 28.6 percent, MHS had 24.0 percent, and CareSource had 10.3 percent.

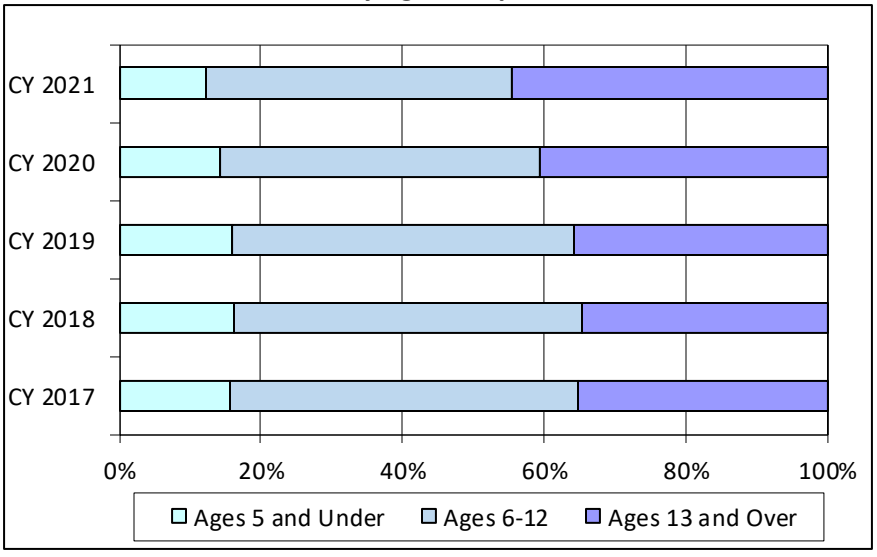
Exhibit II.3
Percent of CHIP Enrollment by MCE at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

In CY2021, the proportion of members enrolled in CHIP ages 6-12 and ages 13-18 are evenly split at 44 percent for each age group. The remaining 12 percent of members are ages five and under. Children at the lower age group are under-represented in CHIP because children under age 6 are eligible for Medicaid at higher family income levels.

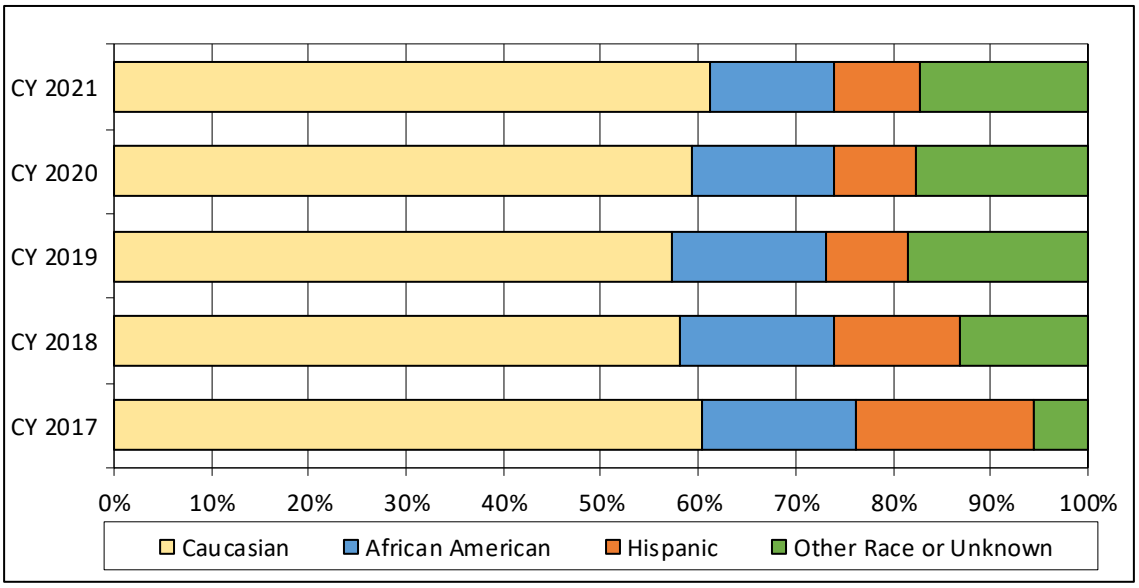
Exhibit II.4
Percent of CHIP Enrollment by Age Group at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for children ages 18 and younger. African-American children and Hispanic children represented 12.7 percent and 8.9 percent, respectively, of the CHIP enrollment at the end of CY 2021. Unfortunately, information is not available on the race/ethnicity of all members. Approximately 12.5 percent of the 17.2 percent of members listed as "Other Race or Unknown" are truly unknown.

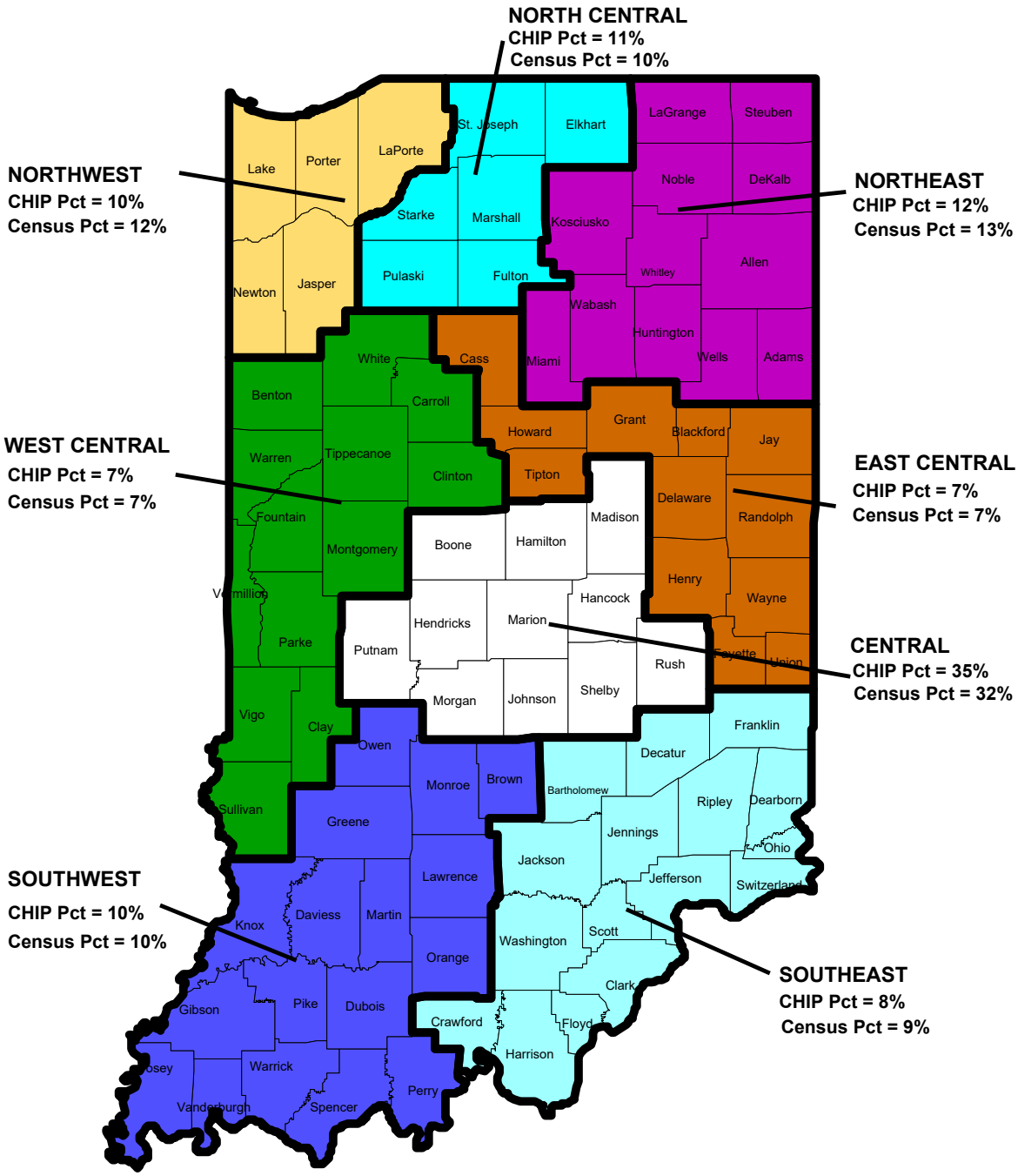
Exhibit II.5
Percent of CHIP Enrollment by Race/Ethnicity at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

HMA-Burns compared CHIP members enrolled to the total child population in Indiana as of July 2021. The distribution of CHIP members by region generally matches the overall child population in Indiana. The Central region has 35 percent of all CHIP members but only 32 percent of the state's child population. The Northwest region has 10 percent of all CHIP members but 12 percent of the child population. The regions are defined by the OMPP. These statistics have also remained relatively unchanged in the last five years.

Exhibit II.6
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2021



Section III

Access to Primary Medical Providers and Dentists

SECTION III: ACCESS TO PRIMARY MEDICAL PROVIDERS AND DENTISTS

Background

The Office of Medicaid Policy and Planning (OMPP) requires that each managed care entity (MCE) maintain a sufficient network of providers such that there is at least one primary medical provider and one dentist within 30 miles of each member's residence who is willing to accept new patients.

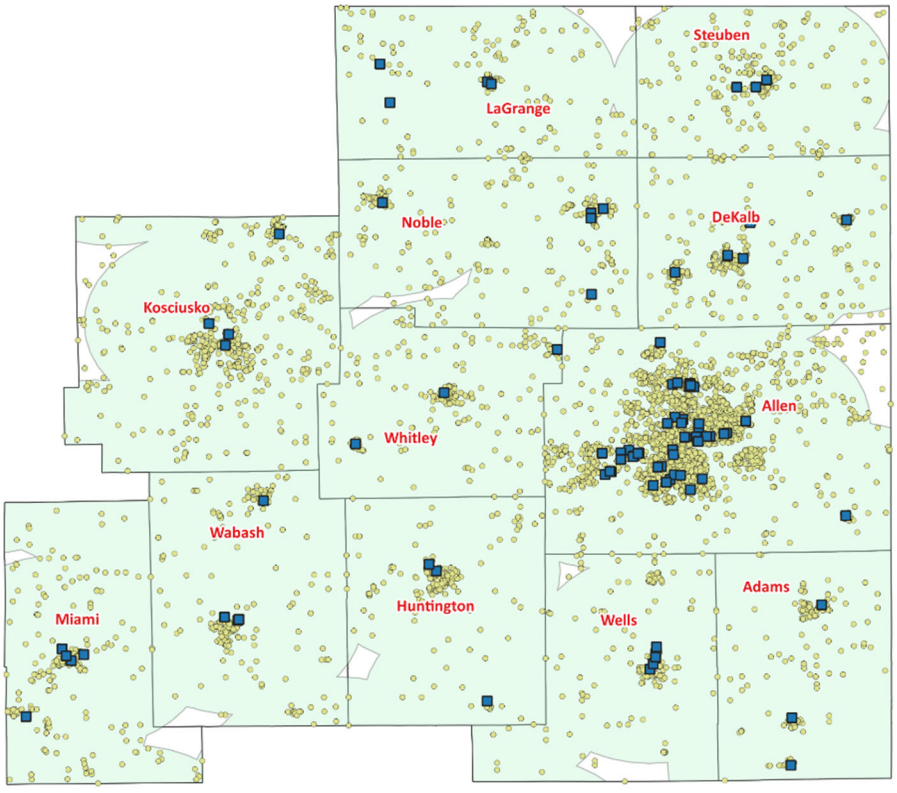
HMA-Burns examined both the proximity (nearest provider) of members to providers as well the average distance travelled by CHIP members within each county to seek primary medical and dental care.

Proximity to the Nearest Provider

The data used to conduct this analysis was provided to HMA-Burns by the OMPP from its Enterprise Data Warehouse (EDW). Information was tabulated for access to primary medical providers (PMPs) and dental providers based on utilization from the time period October 1, 2020 – September 30, 2021. This time span was used in lieu of Calendar Year (CY) 2021 to allow the lag time for claims to be submitted by providers.

Claims were matched to each individual in the study. Each individual was mapped to one of Indiana's 92 counties based on their home address in the enrollment file provided from the EDW. The latitude and longitude coordinates of each member's home address were plotted. Likewise, the latitude and longitude coordinates of every provider with a claim in the study database was plotted. Radius circles were drawn to assess which providers were within 10 miles of the members' homes.

An example of how this data is displayed is showed to the right.
The map shows the counties that comprise the Northeast Region.
The blue squares on the map represent the locations of dentists that provide services to Medicaid and CHIP children. The yellow dots represent the home location of actual CHIP members enrolled in September 2021. Any area in green means that CHIP members have used a dentist within 10 miles of their home. Areas in white in each county means the distance is greater than 10 miles.



In total, 16 maps were created like the one shown on the prior page in an effort to assess proximity to providers. Eight maps were created to assess access to primary medical providers and another eight were created to assess access to dentists. Each of the eight maps in both sets represents a region commonly used by the OMPP for utilization comparisons: Northeast, North Central, Northwest, East Central, Central, West Central, Southeast and Southwest. Each of Indiana's 92 counties are mapped to one of these eight regions. The eight maps showing CHIP member access to primary medical providers appear in Appendix A of this report. The same display by the eight regions showing access to dental providers appear in Appendix B of this report.

It should be noted that only providers for which a service encounter was found to be delivered during the 12-month time period were plotted on the map. The MCEs may have other providers available in their provider directory, but HMA-Burns assumed that the presence of a claim implied that the provider was willing to accept CHIP patients.

Because the actual CHIP enrollment can change month-to-month, for purposes of display HMA-Burns plotted children who were enrolled in CHIP as of September 2021 on the maps with the providers. All CHIP members (CHIP Package A, CHIP Package C, and CHIP C Expansion) are shown together on each map.

Services delivered by Primary Medical Providers are defined as Evaluation & Management (E&M) office-based codes and clinic codes where the provider specialty is one of the following: General Pediatrician, Family Practitioner, General Practitioner, Internist, OB/GYN or Public Health Agency. For dental services, the OMPP utilizes a specific claim type to identify all dental services.

Findings

On a statewide level, there are very few gaps when measuring access to both primary medical providers and dental providers using a 10-mile service coverage radius. In fact, only 0.3 percent of all CHIP members live more than 10 miles from an available primary medical provider. This finding held true using the 12-month period of members and service claims studied in this year's report as well as for the 12-month period studied last year. There are 1.3 percent of CHIP members who live more than 10 miles from an available dentist using this year's data compared to 1.0 percent of members using last year's data. Exhibit III.1 below shows the results for each of the eight regions.

Exhibit III.1
Assessing Accessibility of CHIP Members to Primary Medical and Dental Care

		Primary Medical Provider		Dental Provider	
		Services Delivered Oct 1, 2020 - Sept 30, 2021			
Region	**CHIP Enrollment June 2021**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**
Northeast	12,738	12	0.1%	55	0.4%
North Central	11,047	0	0.0%	131	1.2%
Northwest	9,910	10	0.1%	116	1.2%
East Central	7,444	13	0.2%	131	1.8%
Central	35,861	13	0.0%	46	0.1%
West Central	7,543	79	1.1%	207	2.8%
Southeast	8,147	110	1.4%	484	6.0%
Southwest	9,696	31	0.3%	166	1.7%
Entire State	**102,386**	**268**	**0.3%**	**1,336**	**1.3%**

		Primary Medical Provider		Dental Provider	
		Services Delivered Oct 1, 2019 - Sept 30, 2020			
Region	**CHIP Enrollment June 2020**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**
Northeast	14,201	5	0.0%	48	0.3%
North Central	12,043	4	0.0%	97	0.8%
Northwest	11,667	10	0.1%	111	1.0%
East Central	8,595	13	0.2%	67	0.8%
Central	39,855	11	0.0%	45	0.1%
West Central	8,261	81	1.0%	226	2.7%
Southeast	8,742	144	1.6%	322	3.7%
Southwest	10,656	22	0.2%	239	2.2%
Entire State	**114,020**	**290**	**0.3%**	**1,155**	**1.0%**

Although the gaps are few throughout the state, there is some differentiation by region. Refer to Appendices A and B for the graphic result by region. For primary medical providers, a slightly higher proportion of CHIP members in the Southeast Region live more than 10 miles from a provider. For dentists, a slightly higher proportion of members in the West Central, Southeast and Southwest Regions live more than 10 miles from a provider.

At the county level, there are little to no gaps in access to primary care in the Northeast, North Central, Northwest, East Central, Central and Southwest Regions. In the West Central Region, gaps were found in Benton County, the border between Tippecanoe and Montgomery Counties, and the border between Montgomery and Parke Counties. In the Southeast Region, there is a gap in Jackson County, in southern Harrison County, and in eastern Switzerland County.

When measuring access to dental care using a 10-mile service coverage radius, on a statewide level there are gaps in at least one county in each region. The greatest county gaps, by region, are shown below:

- Northeast- eastern Allen, western Kosciusko
- North Central- St. Joseph, Marshall, Fulton, Pulaski
- Northwest- Newton (almost entire county), LaPorte, Jasper
- East Central- Cass, Randolph, Union
- Central- Boone, Putnam
- West Central- Benton, White, Tippecanoe, Warren, Fountain, Montgomery, Parke, and Clay
- Southeast- Franklin, Decatur, Jackson, Ohio, Switzerland (all), Jefferson, Washington, Clark, Harrison, and Crawford (almost all)
- Southwest- Owen, Brown, Greene, Martin, Lawrence, Posey, Perry

It should be noted that HMA-Burns is using a stricter metric with the 10-mile radius than what the OMPP requires in its contracts with its MCEs which is 30 miles. When the distance radius is broadened to 30 miles, access to dentists is greatly improved.

When families with CHIP members select their preferred MCE, they can use the online provider directory tool available from each MCE to determine the proximity of primary medical providers in the MCE's network.

Average Distance Travelled to Providers

The average distance travelled was computed by taking the average distance for all claims/encounters within primary medical providers or dentists for members' utilization within a county. The data for this tabulation was limited to a single pairing of member-to-provider. For example, a single member may have had five visits to a dentist. Of these visits, three were to the same dentist, the fourth was to a second dentist, and the fifth was to a third dentist. In HMA-Burns' analysis, only three of these claim distances was computed—the first visit of three to provider #1, the only visit (4^{th} overall visit for the member) to provider #2, and the only visit (5^{th} overall visit for the member) to provider #3.

Software is used to map the driving distance from the member's home to the primary medical provider's or dentist's office[4]. In some cases, the latitude/longitude coordinates were not valid for either the member's home or the rendering provider's office. When this occurred, HMA-Burns excluded from the study the claims/encounters and computed distances when the trip was less than 0.2 percent of a mile or greater than 100.0 miles. The average distance for each county was then computed as the total miles across all non-excluded trips divided by the total trips for members to the specific specialty.

Findings

In three of the 92 counties, CHIP members travelled, on average, more than 30 miles to seek primary medical care. This is down from four counties reported in last year's evaluation. There were ten counties where CHIP members travelled, on average, more than 30 miles to seek dental care. This is unchanged from what was reported last year.

For primary care, the greatest average distance travelled was 40 miles (Warren County). For the other two counties, Benton and Fountain, the average distance travelled was between 35 and 36 miles.

For dental care, the greatest average distance travelled was 50 miles (Switzerland County). For the other nine counties where the average distance was greater than 30 miles, the average in each county was between 30.5 and 39 miles. Five counties in the Northwestern part of the state fall into this category: Benton, Newton, Pulaski, Jasper and White. This was also a finding for four of these counties in last year's report as well. The remaining counties with higher average distance (besides Switzerland) are in the southern portion of the state: Crawford, Dearborn, Jefferson, and Ripley.

Maps are color-coded in Exhibits III.2 and III.3 on the next two pages to show the differences in the average driving distance travelled for CHIP members seeking primary medical (Exhibit III.2) and dental (Exhibit III.3) services.

[4] Note that HMA-Burns computes the driving distance (turn by turn) as opposed to a crow flies distance.

Exhibit III.2
Average Driving Distance (in miles) for CHIP Members for FFY 2021 to Primary Care
Color coding and values represent the average for each county

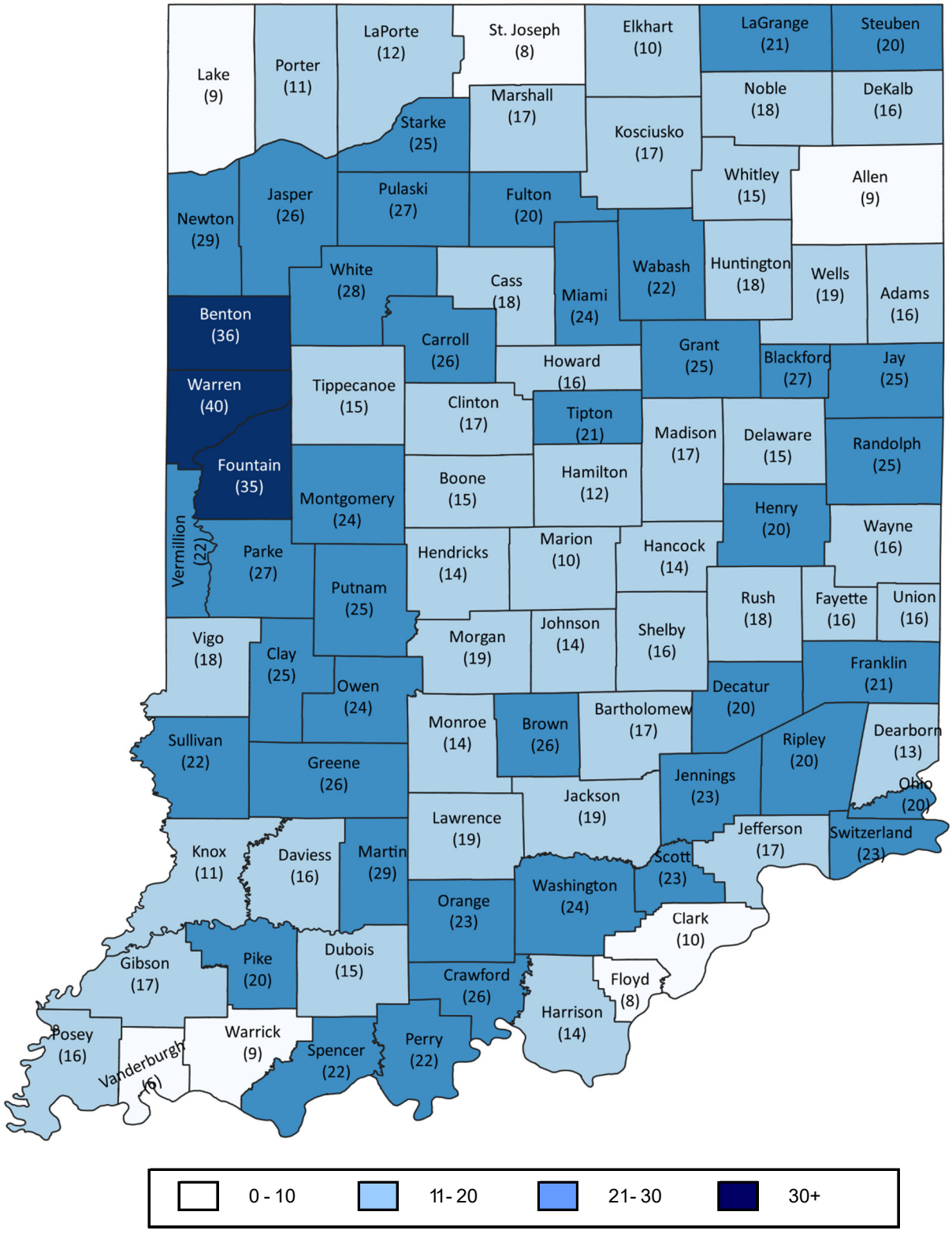
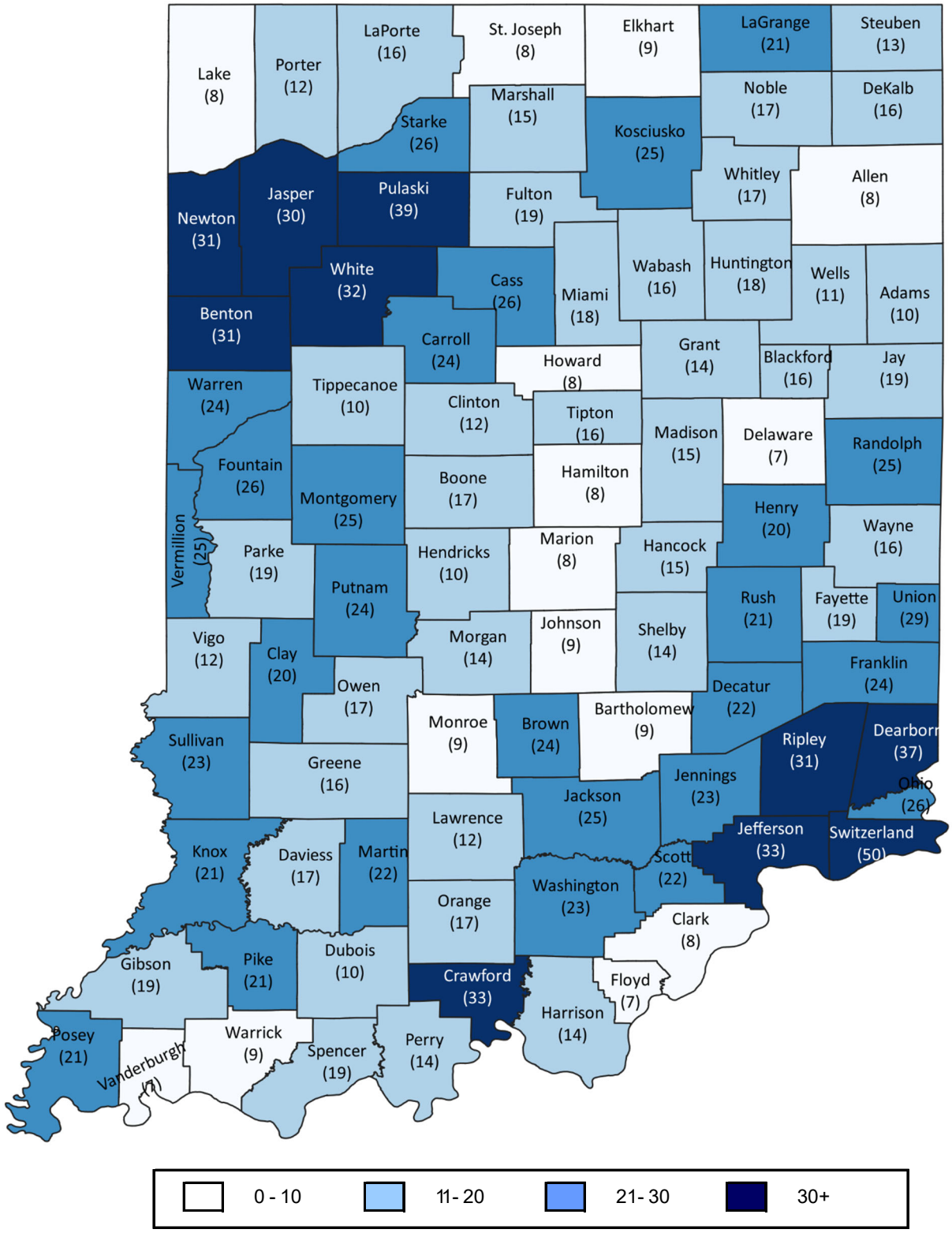


Exhibit III.3
Average Driving Distance (in miles) for CHIP Members for FFY 2021 to Dental Care
Color coding and values represent the average for each county



Section IV

Service Use Among Populations in Indiana's CHIP

SECTION IV: SERVICE USE AMONG POPULATIONS IN INDIANA'S CHIP

Introduction

In addition to examining the access to providers, the HMA-Burns team analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency department (ED) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2019, 2020 and 2021 across populations within the CHIP such as by CHIP Package, by managed care entity (MCE), by age, and by race/ethnicity.

HMA-Burns identified each unique member enrolled in CHIP at some point in time in either FFY 2019, 2020 or 2021. The *usage rate* is an annual measure. It measures the percentage of members that received the service during the FFY. HMA-Burns limited this calculation to those children who were enrolled for a minimum of nine months in each year. This accounts for members that would have had an opportunity to actually use the service. Members could be included in one FFY of the study but not another year based upon their enrollment history. Children were included in the usage reports if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year as long as they were enrolled for nine months during the year in any program. In the event that a child did cross CHIP packages during a study year, the child was assigned to the enrollment category that s/he was in at the end of the study year. Therefore, each child is counted only once on each report. A member's age was assigned based upon his/her age at the end of the study year.

On the other hand, the *utilization per 1,000 member rate* is a point-in-time measure. It captures the number of services received in the service category divided by the number of members enrolled in the given month. For example, if there were 10,000 primary care visits in the month among a population of 50,000 members, this means that .20 of all members in the month (10,000 / 50,000) had a primary care visit. Because each portion of the CHIP has different levels of enrollment, to put the analysis on an apples-to-apples basis, this is shown as a rate of 200 members per 1,000 (.20 * 1,000). This is helpful when measuring the utilization per 1,000 rate across different populations (e.g., by age group).

Data used in this analysis was provided to HMA-Burns from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2022. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP.

For ease of comparison, the exhibits are displayed in a similar manner throughout this section. A single service is shown on one page. On the left side of the exhibit, the percent of members who used the service in the FFY is displayed. Information is shown by CHIP package, by MCE, by age group and by race/ethnicity. On the right side, the utilization per 1,000 members is shown for these same member categories for FFY 2019, FFY 2020 and FFY 2021.

Primary Care Visits

Primary care visits include visits to doctor's offices or clinics specializing in primary care. It can include both well visits and sick visits. All results are displayed on Exhibit IV.1 on the next page.

The percentage of CHIP members that accessed primary care declined from FFY 2019 to FFY 2020. There was a further decline from FFY 2020 to FFY 2021 in CHIP Package C and CHIP C Expansion, but the percent of users held steady in CHIP Package A from FFY 2020 to FFY 2021. Trends for the volume of services, or the utilization per 1,000 members, showed similar results. Refer to the top two boxes in Exhibit IV.1.

For FFY 2019, the percentage of members who used primary care was in the range of 76 to 93 percent of members depending upon the subgroup examined. Notable variations in primary care use were observed in the following subgroups:

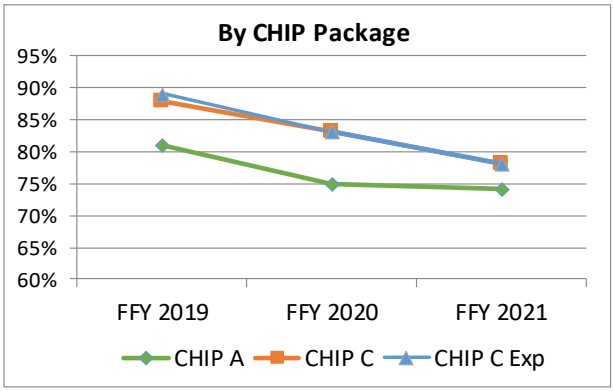
- The percent of SCHIP (CHIP Package C and CHIP C Expansion) children in the study sample that had a primary care visit was higher than for children in MCHIP (CHIP Package A). This continued in FFY 2020 but less so in FFY 2021. Refer to the upper left box in the exhibit.
- MHS members had a slightly higher usage rate than members in the other MCEs, but all MCEs generally have similar usage rates. CareSource was lower than its peers in FFY 2021. Refer to second box on left side of the exhibit.
- Primary care visits are used more by children ages 5 and younger than the older members enrolled in CHIP. Refer to the third box on the left side of the exhibit.
- When examined by race/ethnicity, the usage rate was lower for Hispanic children than Caucasian children in FFYs 2019 and 2020, and African-American children had even lower usage than Hispanic children. The usage rate for African-American children was 5 to 12 percentage points lower than Caucasian children in each of the three years examined. Refer to the bottom left box of the exhibit.

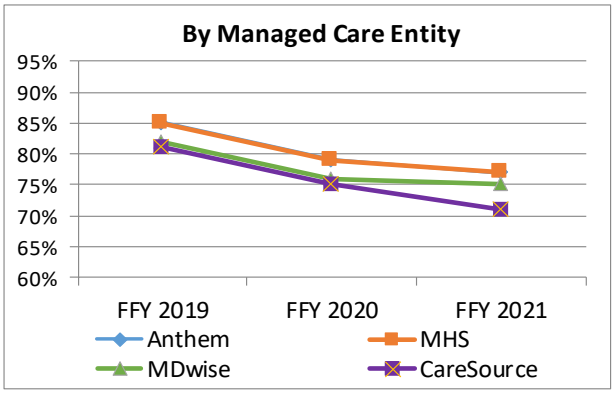
The utilization per 1,000 member trends for primary care shown on the right side of the exhibit mirror the usage trends on the left side. The one area where utilization was slightly different during the pandemic months was by age group. Children up to age 5 utilized primary care at a much lower rate in FFY 2020 compared to FFY 2021. This utilization decreased even further in FFY 2021. Refer to the third box on the right hand side of the exhibit. This shows that, on average, there were 336 primary care visits per 1,000 members in each month of FFY 2019, but only 269 visits each month in FFY 2020 and 214 visits in FFY 2021.

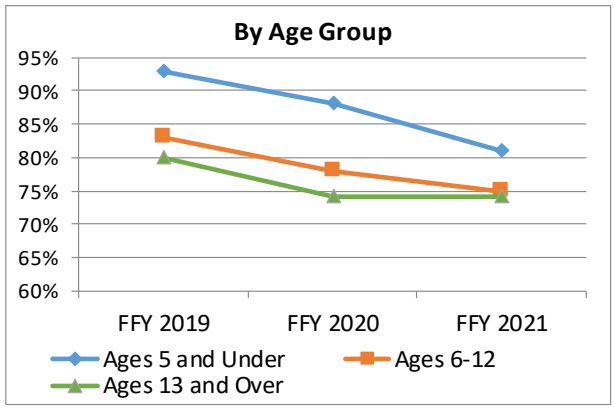
Regardless of which year is reviewed, the greatest variation in primary care use is by age group and by race/ethnicity. African-American children used primary care services at about 68 percent of the rate of Caucasian children on a monthly basis. Hispanic children used primary care services at about 71 percent of the rate of Caucasian children.

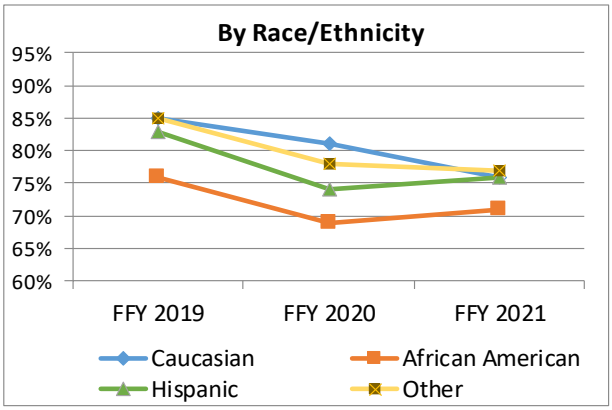
Exhibit IV.1
Utilization of Primary Care in Indiana's CHIP

Percent of Members Using the Service Each Year

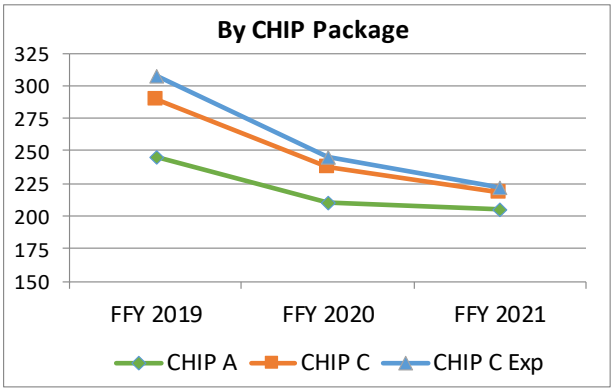


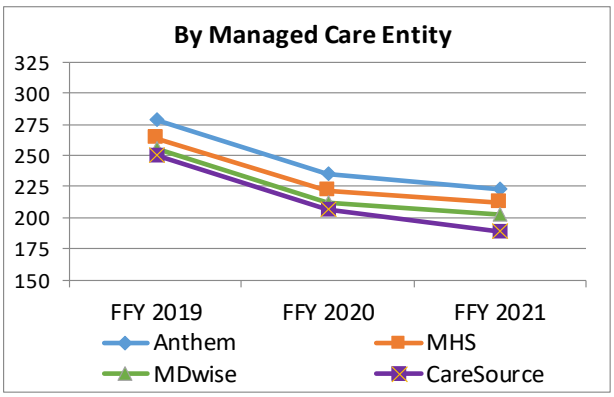


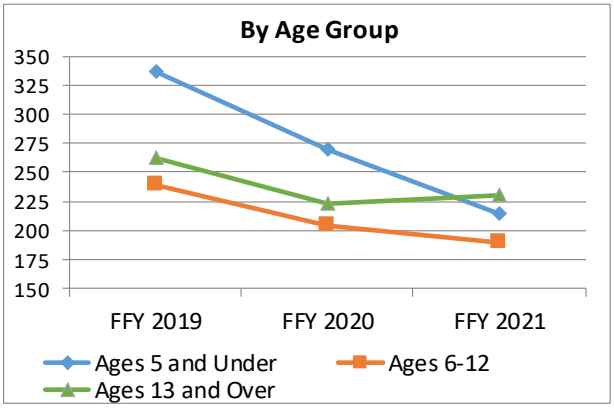


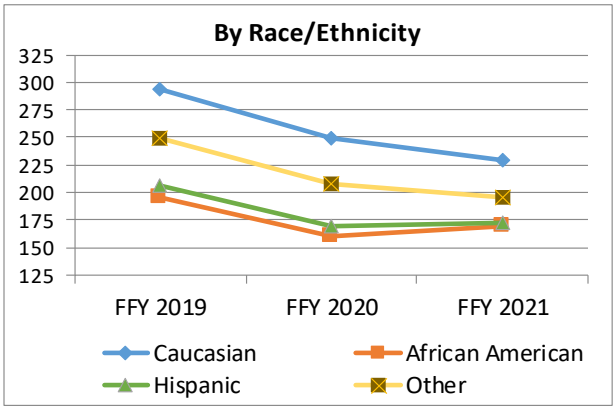


Utilization Per 1,000 Members During Time Period









Emergency Department Visits

On the left side of Exhibit IV.2 shown on page IV-5, it was found that the percentage of CHIP members that accessed the emergency department was consistent across Package (CHIP A, CHIP C and CHIP C Expansion) and across MCEs. In FFY 2019, the percentage that used the ED was between 21 and 23 percent. In FFY 2020, this dropped to 18 to 19 percent. In FFY 2021, this dropped further to 14 to 16 percent.

When stratified by age, younger children use the ED more often than older children. Almost one in three children in the age 5 and younger group (31%) used the ED in FFY 2019, but this decreased to 26 percent in FFY 2020 and 19 percent in FFY 2021. Although children ages 6 to 12 use the ED far less than the youngest children, this age group also saw a sharp decrease in ED use during the pandemic. Only children ages 13 and over had a fairly steady use of the ED both prior to and during the pandemic.

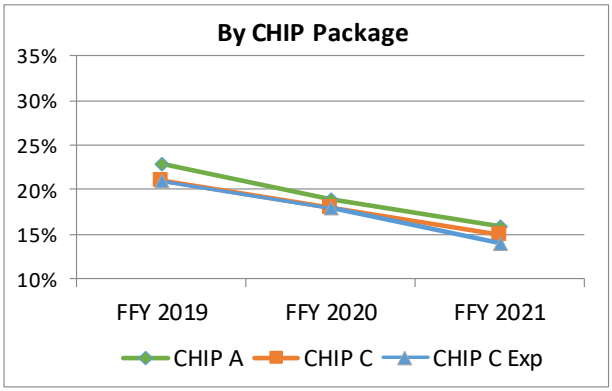
There is some variation in ED use by race/ethnicity, but nothing significant. Caucasian and African-American children used the ED at a similar rate in each year studied, but Hispanic children used the ED less often.

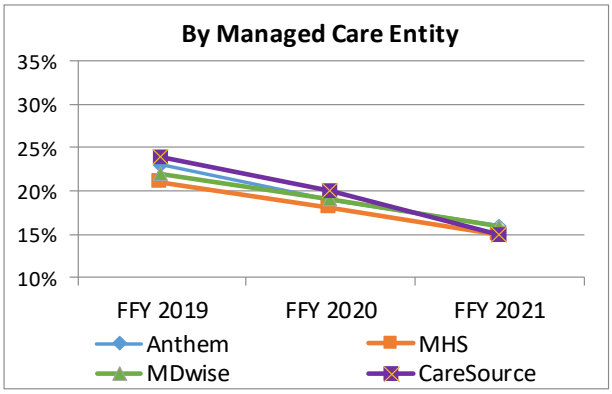
The utilization per 1,000 member trends for ED visits shown on the right side of the exhibit mirror the usage trends on the left side. Utilization dropped for ED visits even more than primary care visits during the time period of the pandemic. Utilization for children ages 5 and under fell 42 percent from the FFY 2019 period to the FFY 2021 period; for ages 6 to 12, ED utilization fell 39 percent; for ages 13 and over, it fell 20 percent.

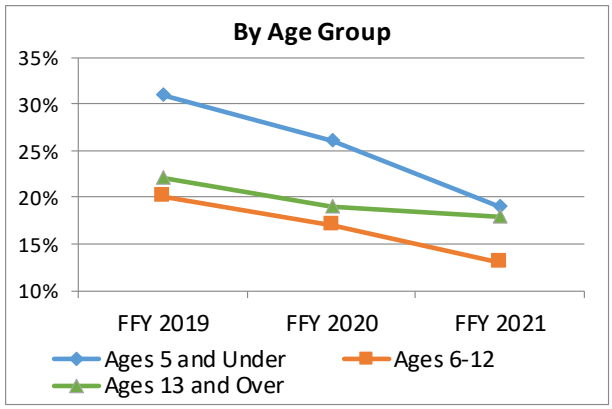
When examined by race/ethnicity, utilization of the ED feel between 30 and 35 percent for all race/ethnicities.

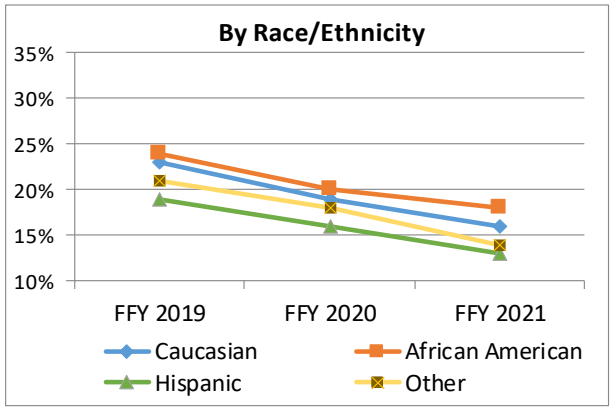
Exhibit IV.2
Utilization of the Emergency Department in Indiana's CHIP

Percent of Members Using the Service Each Year

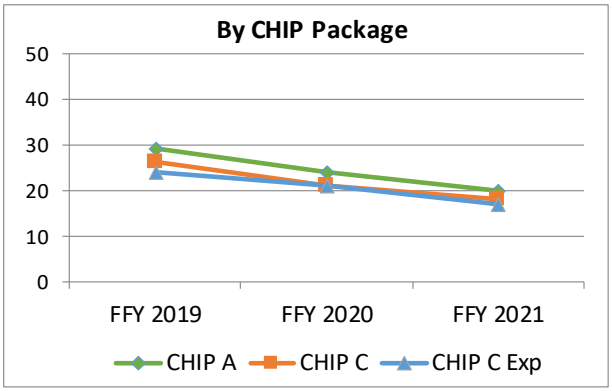


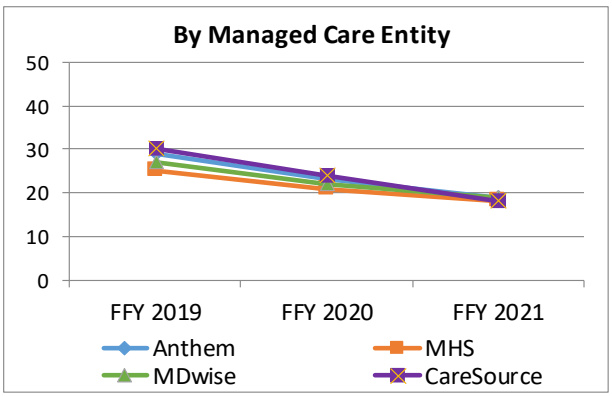


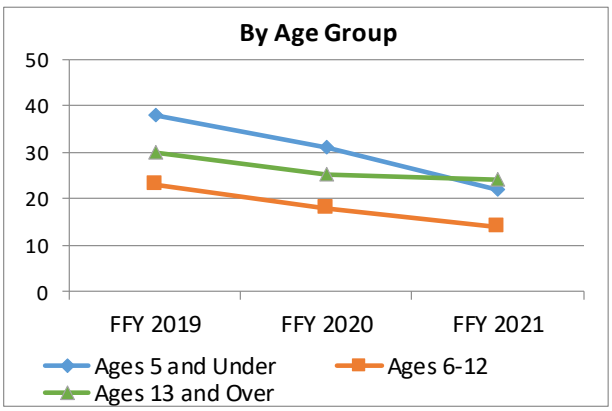


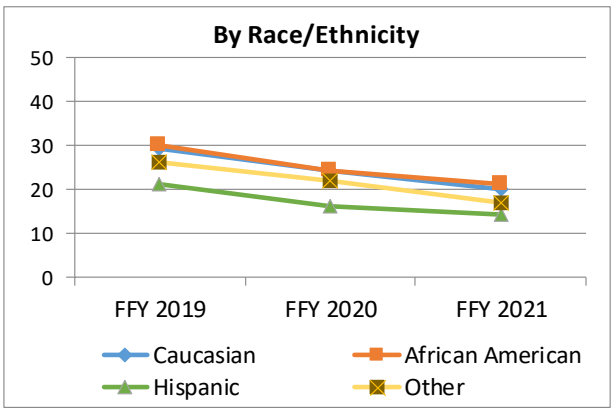


Utilization Per 1,000 Members During Time Period









HMA-Burns also examined the prevalence of children who are frequent users of the ED. In the most recent FFY, most CHIP children (90.6%) had no ED visits. There were 8.0 percent of children that had one or two ED visits during the year while 1.2 percent had three to five visits. These results are consistent across the MCEs as well. There is a slightly lower percentage of CHIP children that used the ED in the most recent year compared to what was observed in the same study last year (refer to the far-right column).

It should be noted that Exhibit IV.3 below differs from Exhibit IV.2 on the previous page when examining the percentage of members who used the ED due to the enrollment period of members in each exhibit. An average of 15 percent of CHIP children were found to use the ED in FFY 2021 in Exhibit IV.2. This examined children who were enrolled in CHIP for at least nine months of the year. The usage rate of 9.4 percent shown below examines all children enrolled in CHIP during FFY 2021, regardless of their length of enrollment.

Exhibit IV.3
Frequency of ED Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2020 - September 30, 2021

	Percentage of All Members Using ER by MCE					
Number of ER Visits per Member	**Anthem**	**CareSource**	**MHS**	**MDwise**	**All MCEs This Year**	**All MCEs Last Year**
Zero	90.5%	90.2%	90.7%	90.7%	90.6%	91.9%
1 to 2	8.1%	8.1%	8.0%	8.1%	8.0%	6.7%
3 to 5	1.3%	1.4%	1.1%	1.2%	1.2%	1.1%
6 to 10	0.2%	0.3%	0.1%	0.1%	0.2%	0.2%
More than 10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: Indiana's FSSA Enterprise Data Warehouse
This exhibit includes all CHIP members in the year, regardless of their duration enrolled.

Preventive Dental Visits

On the left side of Exhibit IV.4 shown on page IV-8, it was found that the percentage of CHIP members that had a preventive dental visit was consistent for CHIP C and CHIP C Expansion in each of the three years studied, but it is lower for CHIP A members. For all three areas of CHIP, the percent of users of preventive dental visits declined during the pandemic years of FFY 2020 and FFY 2021 compared to pre-pandemic levels.

There is variation in the percent of CHIP members using dental services across the MCEs. MDwise and MHS show similar rates with the highest usage, and Anthem is slightly below them in FFYs 2020 and 2021. CareSource is much below the other MCEs.

Dental usage is much higher for children ages 6 to 12 (70% in FFY 2019, 61% in FFY 2020, and 60% in FFY 2021) than children ages 13 and over (48% to 58% in these three years) or children ages 5 and under (42% to 50% in these three years).

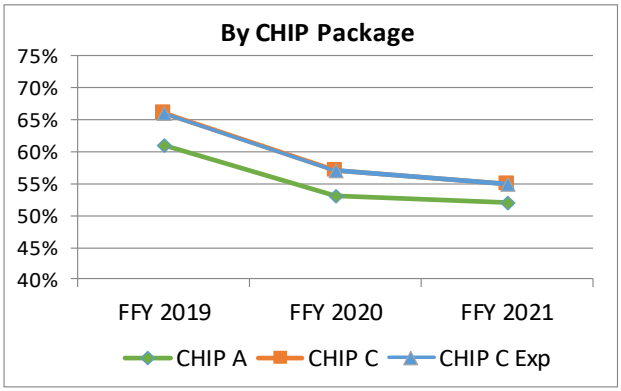
Hispanic children in Indiana's CHIP have traditionally had a higher usage rate for dental services than other race/ethnicities. African-American and Caucasian children have had similar usage rates up until the pandemic started, but now African-American children have the lowest usage of preventive dental visits since the pandemic started in FFY 2020.

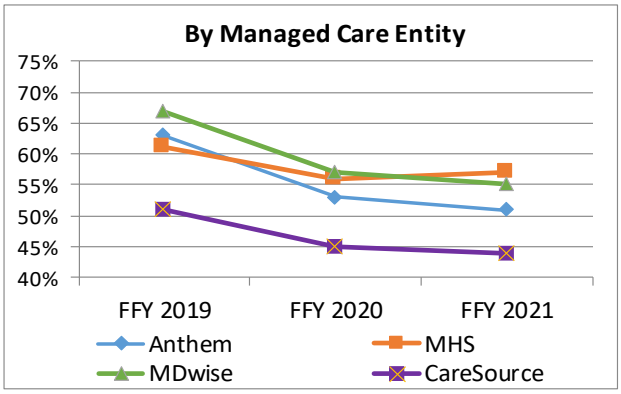
The utilization per 1,000 member trends for preventive dental visits shown on the right side of the exhibit mirror the usage trends on the left side, with the exception of the utilization by age groups. The utilization per 1,000 members for the age groups 5 and under and 13 and over are similar, but it was found that fewer children ages 5 and under have actually had a visit each year compared to the teenagers.

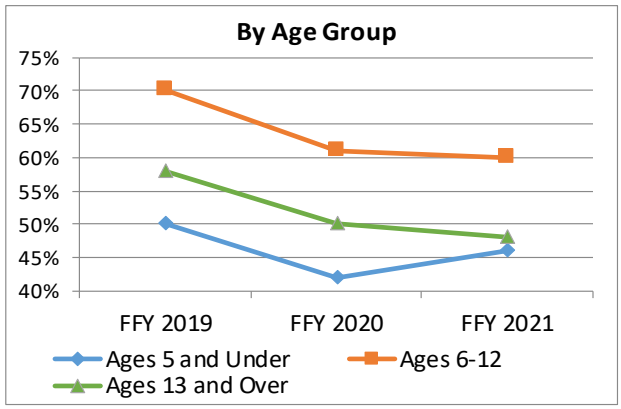
Dental utilization has not fallen as much as primary care or ED visits during the pandemic. Across the three age groups studied, primary care visit utilization fell 12 to 36 percent from FFY 2019 to FFY 2021. ER utilization fell 20 to 42 percent across the three age groups. Dental utilization consistently fell 18 percent for each age group.

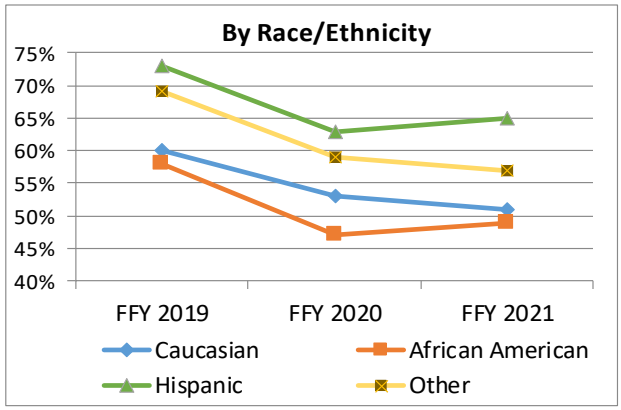
Exhibit IV.4
Utilization of Dental Care in Indiana's CHIP

Percent of Members Using the Service Each Year

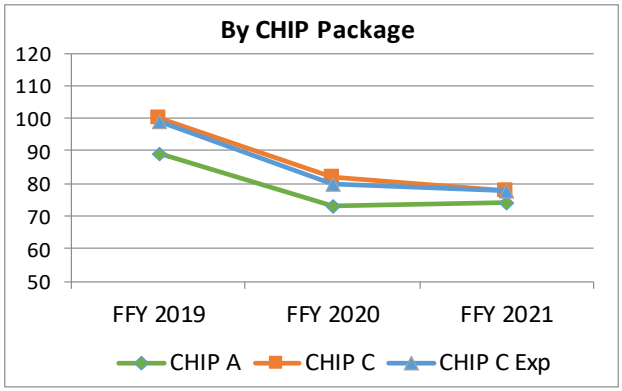


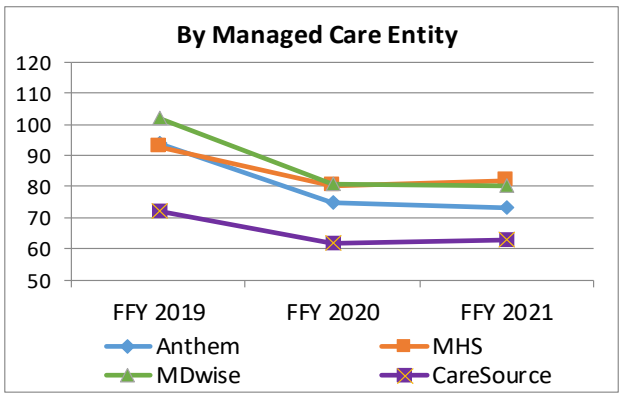


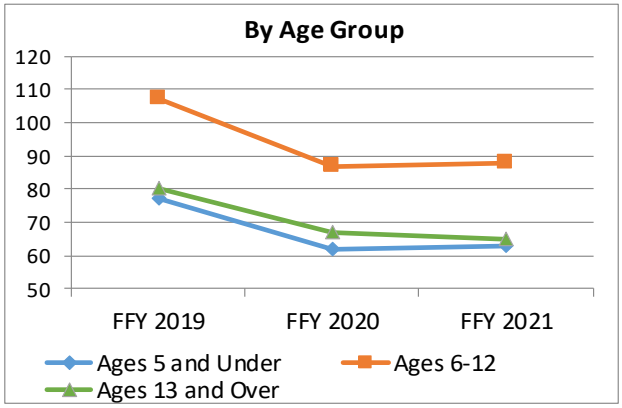


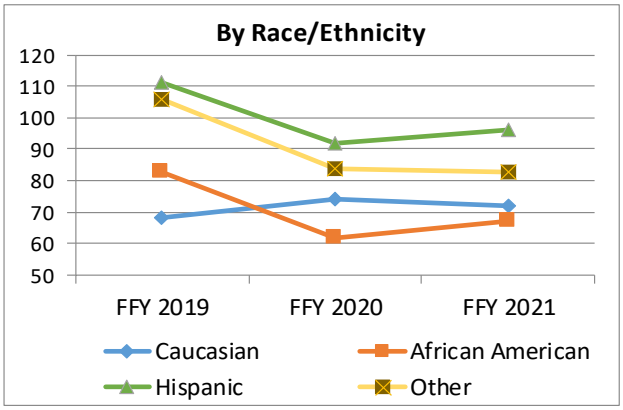


Utilization Per 1,000 Members During Time Period









Pharmacy Prescriptions

Exhibit IV.5, shown on page IV-10, compares usage rates and utilization (scripts) for pharmacy across the subgroups within CHIP. The children in CHIP Package A were less likely to have a pharmacy script than CHIP C or CHIP C Expansion children in FFYs 2019 and 2020. But children in all three portions of CHIP have similar usage (55% of members) in FFY 2021. The utilization per 1,000 members is also very consistent across CHIP A, CHIP C, and CHIP C Expansion.

Usage rates are generally similar across the MCEs, with CareSource children having a slightly lower usage rate than the other MCEs in FFYs 2019 and FFY 2020. But this variance grew in FFY 2021. Children ages 5 and younger were most likely to have pharmacy scripts in the first two years of the study (71% of members in FFY 2019 and 64% in FFY 2020) than older children. But pharmacy usage among the youngest CHIP members decreased considerably in FFY 2021. The usage rate of pharmacy among teenagers has held steady even during the pandemic. A significantly higher percentage of Caucasian children have had pharmacy scripts (57% to 70% across the three years) compared to minority children (51% to 62% across the three years).

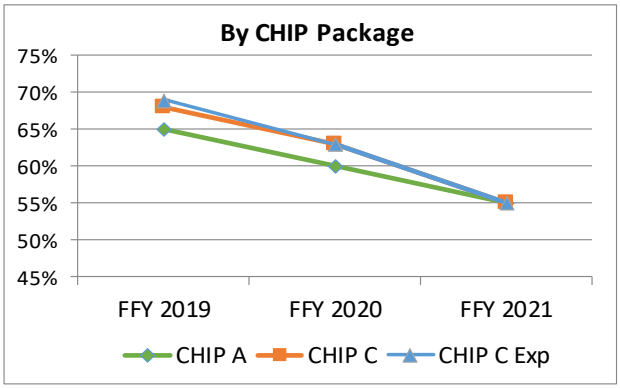
Whereas the utilization per 1,000 member trends were found to mirror the usage trends for primary care, ED visits, and dental services, there are some differences when examining pharmacy scripts. Most notably:

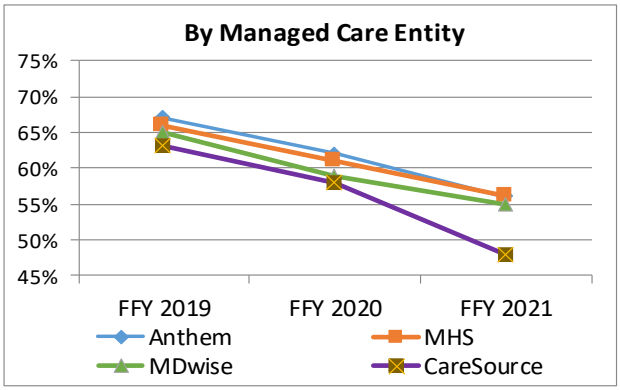
- Although the percentage of CHIP members who have pharmacy scripts is similar across the MCEs, CHIP members enrolled with MDwise have a higher number of scripts per 1,000 members than other MCEs. [Compare the 2nd row of boxes on the left and right side of the exhibit.]
- The percentage of children ages 5 and younger have a higher usage rate by far compared to older children in the first two years studied. But the older children who do use pharmacy have a much higher number of scripts per 1,000 members than the youngest children. [Compare the 3rd row of boxes on the left and right side of the exhibit.]
- Hispanic children were found to have the lowest usage rate of pharmacy among CHIP members (bottom left box of the exhibit), but not much lower than other minorities. The scripts per 1,000 Hispanic children are considerably lower, however, than other race/ethnicities (bottom right box of the exhibit). Caucasian children have much higher usage rates and utilization per 1,000 member rates than minority children for pharmacy scripts.

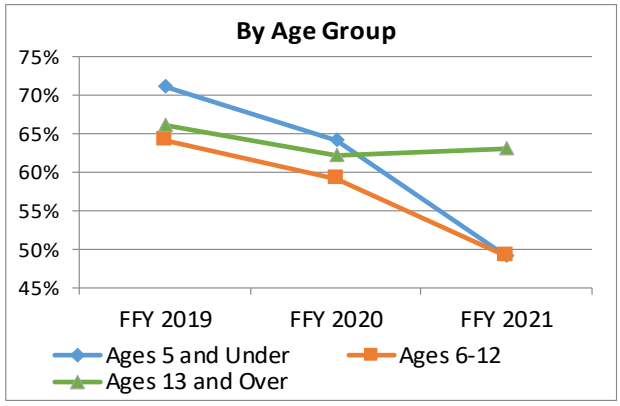
As was observed with the other services examined, the use of pharmacy scripts has been reduced during the pandemic compared to the pre-pandemic levels. For children ages 5 and younger, utilization has decreased 44 percent from FFY 2019 to FFY 2021. For children ages 6 to 12, utilization decreased 27 percent. For children ages 13 and over, utilization decreased 15 percent.

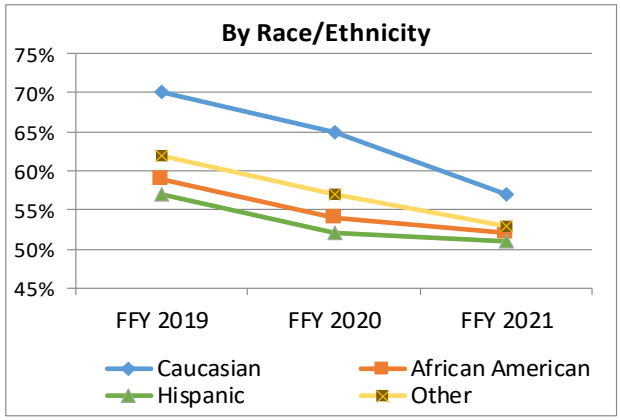
Exhibit IV.5
Utilization of Pharmacy Scripts in Indiana's CHIP

Percent of Members Using the Service Each Year

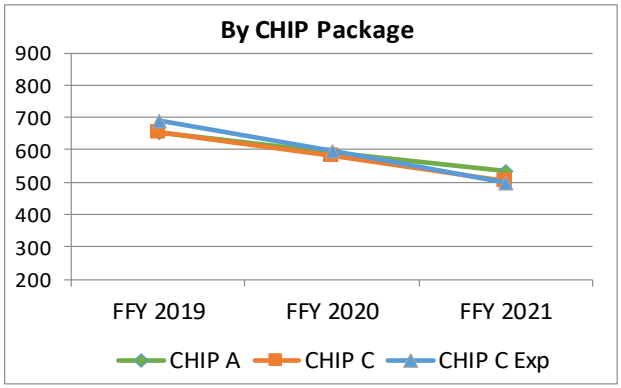


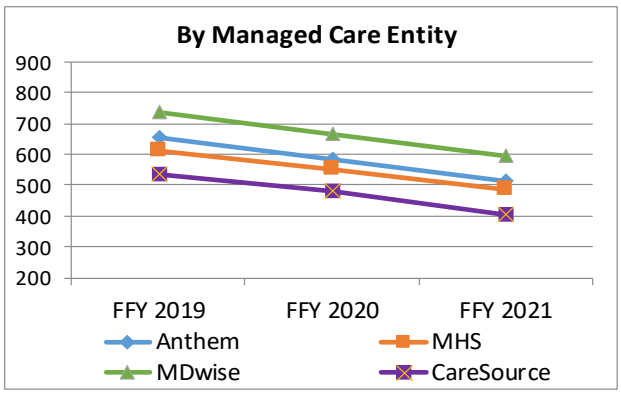


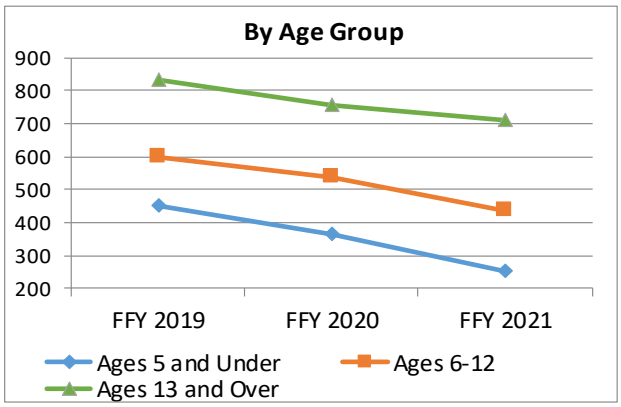


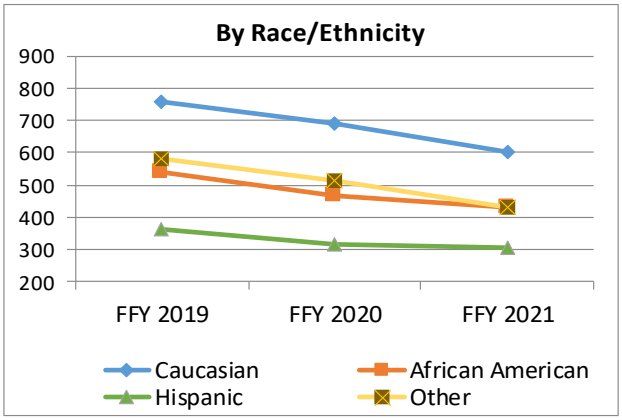


Utilization Per 1,000 Members During Time Period









Section V

Measuring Quality and Outcomes in Indiana's CHIP

SECTION V: MEASURING QUALITY AND OUTCOMES IN INDIANA'S CHIP

The Office of Medicaid Policy and Planning (OMPP) has the overall responsibility for ensuring that children in Indiana's CHIP receive accessible, high-quality services. The oversight process for the CHIP is completed as part of the review for Hoosier Healthwise (HHW) since CHIP members are seamlessly integrated into HHW. Since children represent the vast majority of HHW members, quality and outcomes related to children are given high priority.

OMPP's Oversight of Quality

OMPP staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews of the MCEs on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity to conduct an annual external quality review of each MCE and reviews the results with each MCE.

In fulfilling its oversight responsibilities, the OMPP utilizes a variety of reporting and feedback methods to measure quality and outcomes for Indiana's CHIP:

1. OMPP requires the MCEs to report the results of HEDIS®[5] and CAHPS®[6] measures. The HEDIS are nationally-recognized measures that use standard definitions. Results are attested to by certified auditors. The OMPP requires that its MCEs report their results to the National Committee of Quality Assurance (NCQA). The OMPP compares the results of the HEDIS measures across the MCEs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS is a satisfaction survey and there are different surveys administered for adults and for parents of children. The OMPP requires the MCEs to administer each survey annually.

2. Separately, the Centers for Medicare and Medicaid (CMS) requires each state to report a set of core child measures annually to CMS. Currently, there are 23 core measures. These include some HEDIS and CAHPS measures as well. CMS hires a national evaluator to analyze the results of these measures and make comparisons across the state Medicaid agencies.

3. When OMPP developed the CHIP and gained CMS approval for federal matching funds, the federal government required that the State develop strategic objectives and performance goals for Indiana's CHIP. The review of these performance goals are part of the OMPP's overall quality strategy and results are submitted in an annual report required by CMS.

4. In addition to the goals set for its CHIP program specifically, the OMPP also develops a Quality Strategy plan each year. Many items within the Quality Strategy pertain to outcomes for children, both CHIP and traditional Medicaid members, such as improving the participation rate for Early Periodic Screening, Diagnosis and Treatment (EPSDT) and ensuring follow-up care for behavioral health hospitalizations within seven days of discharge.

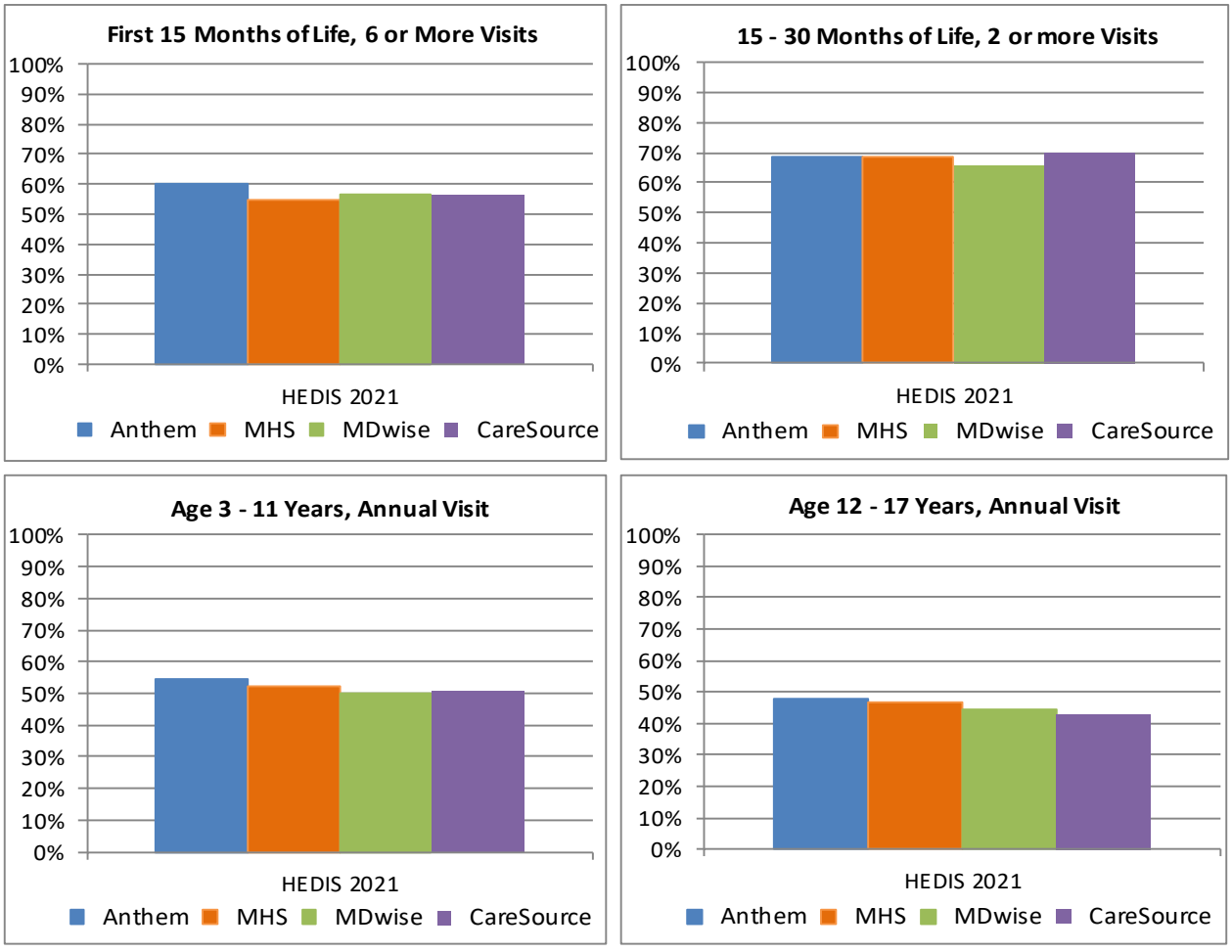
[5] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).
[6] The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members (both CHIP and Medicaid members) from the prior year. Therefore, in Calendar Year (CY) 2021, tabulations were collected on HEDIS rates for 2020 utilization.

Exhibit V.1 presents the HEDIS results for well care visits for each MCE. The NCQA changed the definition of well care visit measures in 2021, so trends against previous years are not comparable. For children in the first 15 months of life (upper left box), the HEDIS rate shown represents the percentage of children with six or more well child visits. Each of the MCEs reported similar rates, ranging from 55 percent for MHS to 60 percent for Anthem. For children ages 15 to 30 months, the measure is for two more visits during this time (upper right box). The MCEs reported similar rates on this measure as well, ranging from 66 percent for MDwise to 70 percent for CareSource. For children ages 3-11 years (lower left box) and adolescents (lower right box), the rate shown represents the percentage of children that had at least an annual visit. There was slightly more variation reported by the MCEs for these two measures. For the children ages 3 to 11, the rate varied from 50 percent that had an annual visit for MDwise members to 54 percent for Anthem members. For the adolescents ages 12 to 17, the rate varied from 43 percent for CareSource members to 48 percent for Anthem members.

Exhibit V.1
Summary of Results from HEDIS Well Care Measures (Percentage of Total)



There are also HEDIS measures that track a number of physical health and behavioral health outcomes. Exhibit V.2 on this page shows examples of selected HEDIS measures that are important for children's physical health. In the upper two boxes, the asthma medication ratio represents the percentage of children who remained on an asthma controller for at least 50 percent of their treatment period. For the younger children (upper left box), CareSource had the highest rate of 74 percent and MDwise had the lowest rate at 66 percent.

Immunizations (bottom left box) and lead screening (bottom right box) are important measures to track for the youngest members. The immunization measure reports the percentage of children who turned age 2 during the measurement year who were enrolled for the 12 months prior to their second birthday who received the immunizations as recommended by the American Academy of Pediatrics. The rate was found to be between 58 percent and 67 percent for each MCE. Lead screening is also recommended for children by their second birthday. The MCEs reported similar results between 60 percent and 64 percent on this measure for the CY 2020 experience year.

Exhibit V.2
Summary of Results from Selected Child HEDIS Measures for Physical Health

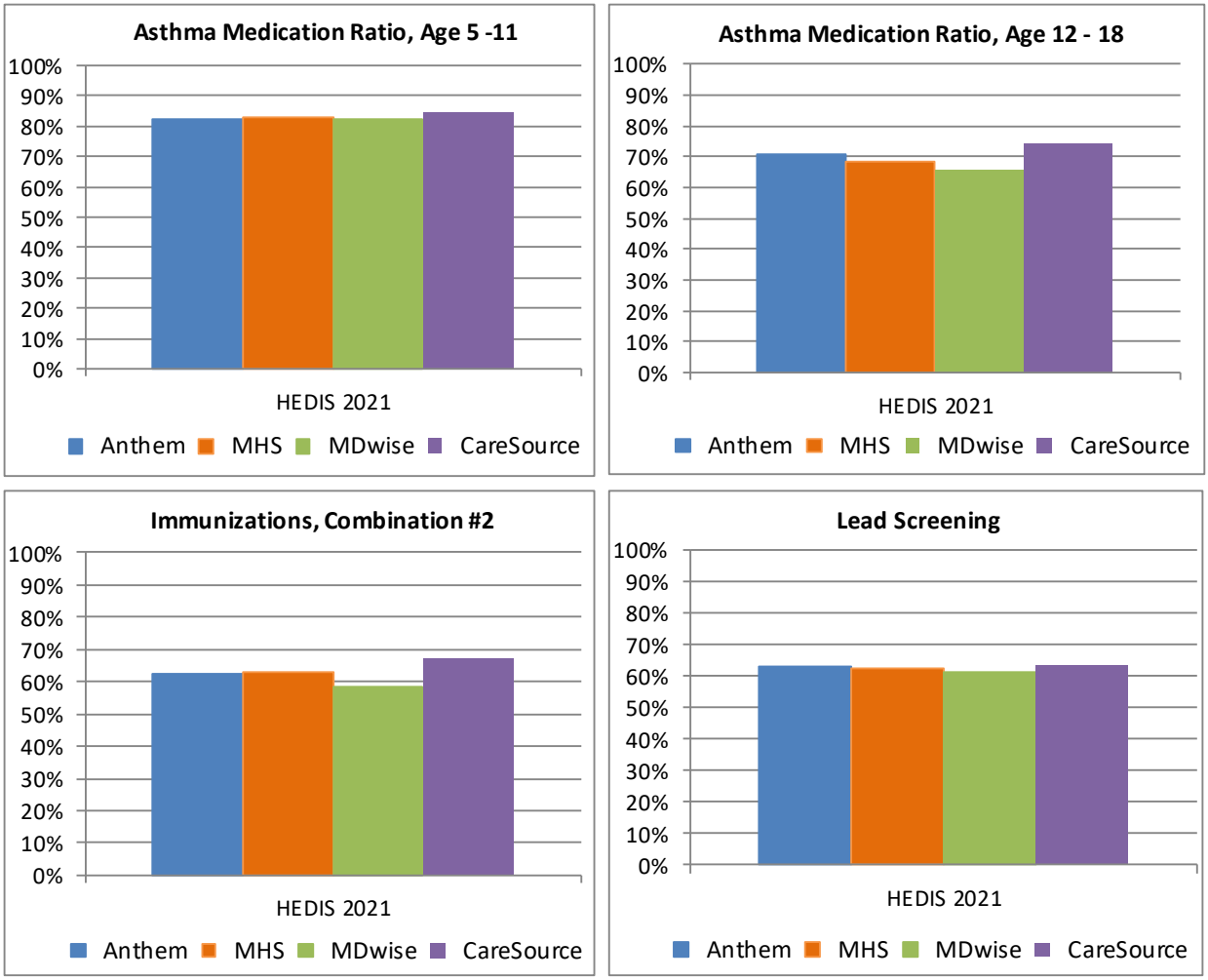
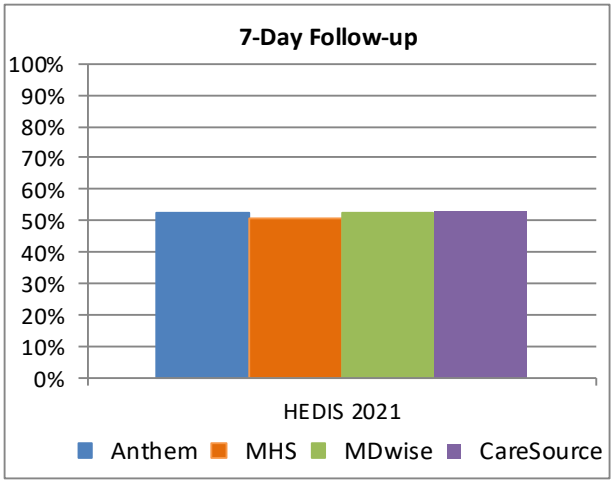


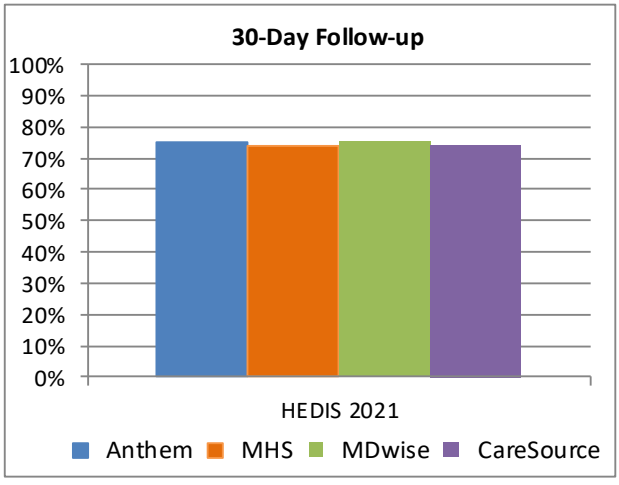
Exhibit V.3 presents the results of behavioral health HEDIS measures. The measures in the top boxes show the percentage of patients in Hoosier Healthwise (which is almost all children) with follow-up visits (within 7 days and 30 days) in the community after a hospitalization for mental illness. In the lower boxes, the measures show the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period. The left box shows percentage of children who had a follow-up visit within 30 days of prescribing ("initiation phase"). The right box shows the percentage who continued taking ADHD medication and had at least two visits after the first visit ("the continuation and maintenance phase").

The MCEs reported very similar results for the follow-up visits after hospitalization, in the range of 51 to 53 percent for visits within 7 days and 74 to 76 percent of members who had a visit within 30 days. Three MCEs reported consistent results in the initiation phase measure (48% to 50%) with MDwise higher at 57 percent. In the continuation and maintenance phase measure, rates were between 56 and 67 percent.

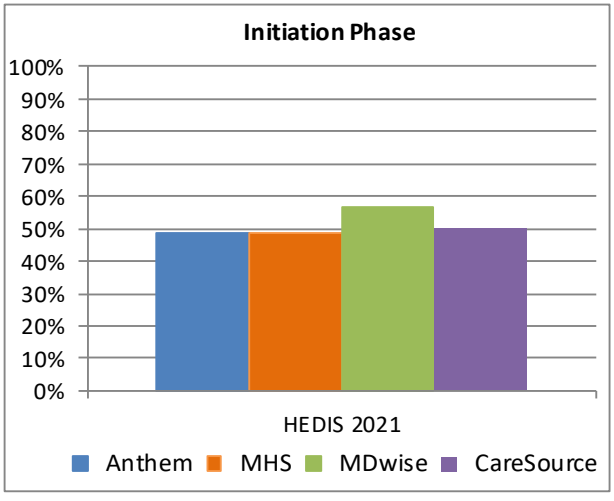
Exhibit V.3
Summary of Results from Selected Child HEDIS Measures for Behavioral Health

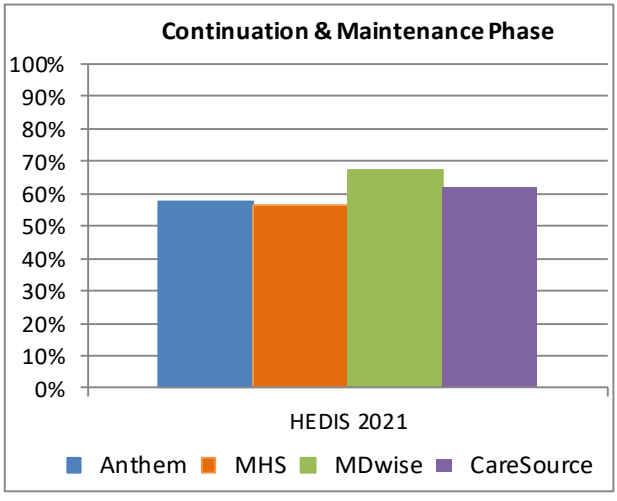
Follow-Up After Hospitalization for Mental Illness





Follow-Up Care for Children Prescribed ADHD Medication





In addition to the year-over-year changes for each MCE, HMA-Burns compared the latest HEDIS year results to see how Indiana's MCEs compared to Medicaid health plans nationally. The measures shown in Exhibit V.4 below track back to what was shown in Exhibits V.1 through V.3. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the 12 measures reviewed, Anthem had nine in which its rates exceeded the national median values, CareSource had six, MDwise had six, and MHS had seven.

Exhibit V.4
Comparing Hoosier Healthwise MCEs to Health Plans Nationally on Selected HEDIS Measures

Each MCE is color-coded to compare it to Medicaid health plans nationally.
If MCE is below the 25th percentile nationally:
If MCE is >25th percentile but <50th percentile nationally:
If MCE is >50th percentile but <75th percentile nationally:
If MCE is >75th percentile but <90th percentile nationally:
If MCE is above the 90th percentile nationally:

	Hoosier Healthwise HEDIS 2021			
	Anthem	CareSource	MDwise	MHS
6 or More Well Child Visits First 15 Months of Life	60.0% ↓	56.4% ↓	56.4% ↓	54.9% ↓
2 or More Well Child Visits, Months 15 - 30	68.9%	69.9%	66.1%	68.3%
Annual Well-Care Visit Ages 3 - 11	54.3%	50.7%	50.1%	52.1%
Annual Well-Care Visit Ages 12 - 17	47.7%	43.1%	44.5%	46.9%
Appropriate asthma medication, Age 5-11 Years	82.3% ↑	84.5% ↑	82.1% ↑	82.9% ↓
Appropriate asthma medication, Age 12-18 Years	70.8%	74.1%	65.5% ↑	68.5% ↓
Immunizations, Combination #2	62.3% ↓	67.4%	58.2% ↓	63.0%
Lead Screening	62.7% ↑	63.5% ↑	60.9% ↑	62.4%
Follow-Up After Mental Health Hospitalization:				
Within 7 Days	52.7%	53.1% ↑	52.7% ↑	50.6% ↑
Within 30 Days	75.1%	74.4% ↓	75.6%	73.7%
Follow-Up Care when Prescribed ADHD Meds:				
Initiation Phase	48.9% ↑	50.2% ↑	56.7% ↑	48.4% ↑
Maintenance Phase	57.3% ↑	61.9% ↑	67.4% ↑	56.4% ↑

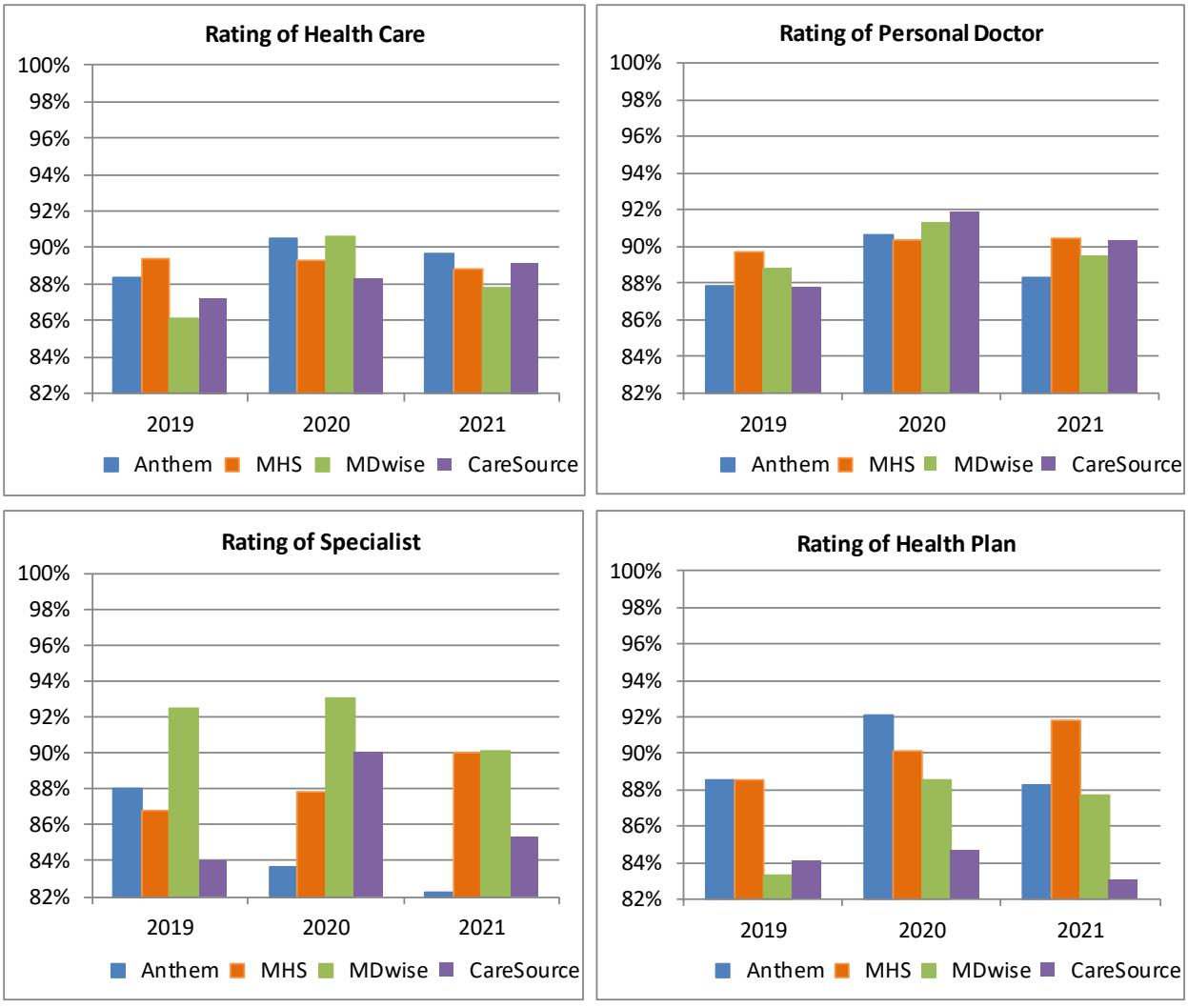
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

CAHPS Results for Children Enrolled in Hoosier Healthwise

The Hoosier Healthwise MCEs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCEs to the OMPP. There is one survey specific to adults and one for children. Exhibits V.5 below summarizes the results from the child surveys that were administered over the last three years. The results presented include all children in Hoosier Healthwise—CHIP and traditional Medicaid.

The percentages in Exhibit V.5 reflect those members that assigned a value of 8, 9 or 10 for each rating, where zero is the "worst possible" and 10 is the "best possible." The ratings themselves represent a composite of multiple questions on the survey related to the topic. The results are generally similar in the most recent survey year for all MCEs for Rating of Health Care, but MDwise saw a greater decline than other MCEs in 2021 compared to the 2020 results. Every MCE also saw a decline in the score for Rating of Personal Doctor in the 2021 survey, but each MCE had a rate of at least 88 percent. MDwise and MHS had a higher rating than its peers for the Rating of Specialist in the most recent year. Anthem, MDwise and MHS had a Rating of Health Plan of 89 to 92 percent and CareSource was at 83 percent.

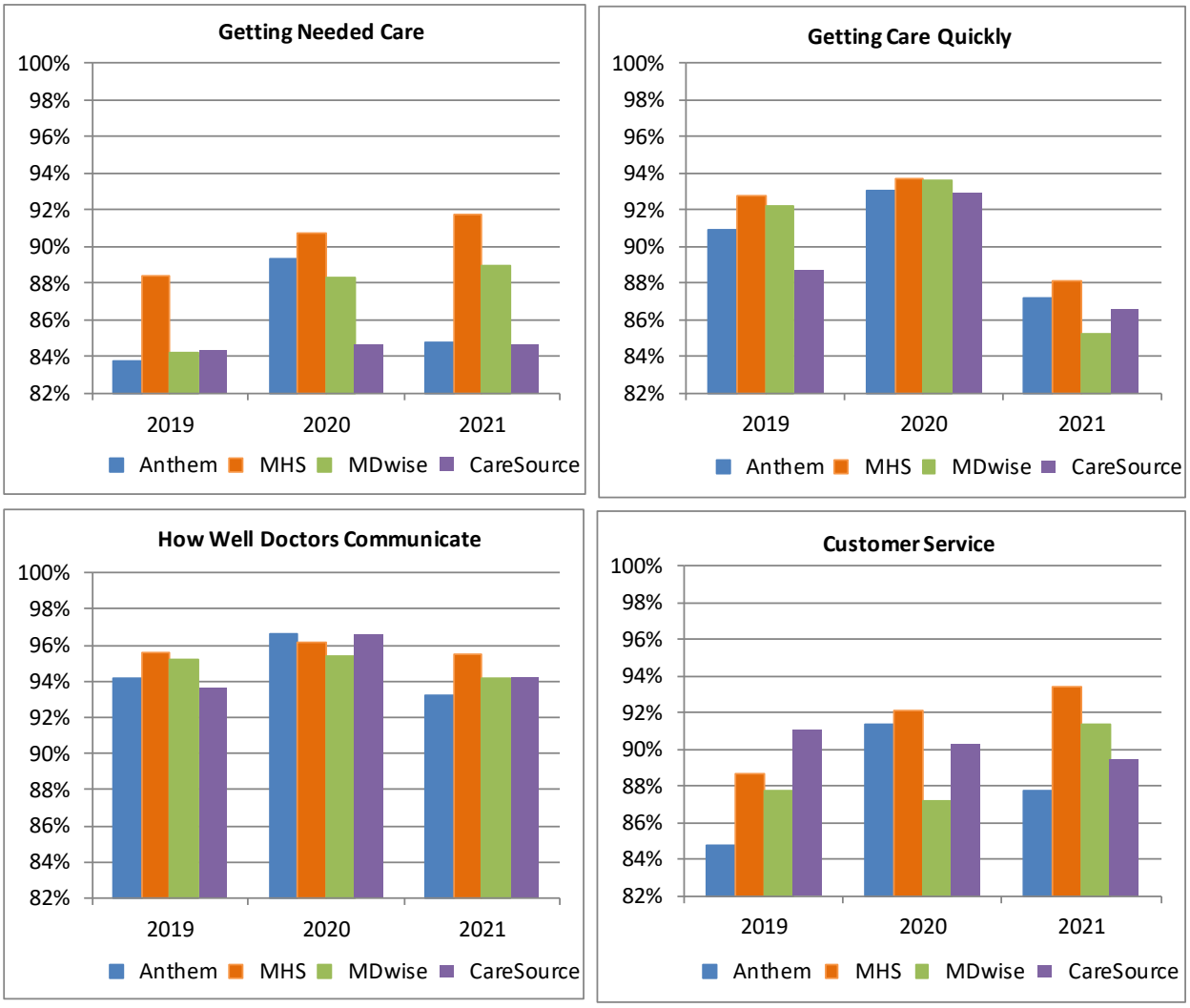
Exhibit V.5
Summary of Scores from CAHPS Child Survey (Members giving a rating of 8, 9, or 10 on 10-point scale)



The CAHPS instrument also compiles composite scores from a series of related questions on other topics as well. The results in Exhibit V.6 represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. All four MCEs scored best on the composite score for How Well Doctors Communicate in the 2021 survey (93 to 96 percent). Three of the four MCEs also scored above 90 percent in the most recent survey for Customer Service, with Anthem at 88 percent.

The greatest decline in the most recent survey compared to prior years was in the questions related to Getting Care Quickly. Because the 2021 survey reflects feedback from the 2020 experience year, this change is likely a reflection of the pandemic. Despite the finding Getting Care Quickly, both MHS and MDwise had improved results on questions related to Getting Needed Care in the 2021 survey compared to 2020. CareSource members had the same response in both years, while Anthem did see a decline in this measure in the 2021 survey.

Exhibit V.6
Summary of Scores from CAHPS Child Survey (Percentages reflect responses of "Usually" or "Always")



Similar to what was shown in Exhibit V.4 in the comparison of Indiana's HEDIS results to national health plans, HMA-Burns conducted a similar comparison for the CAHPS survey results. The measures shown in Exhibit V.7 below track back to what was shown in Exhibits V.5 and V.6. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the eight measures reviewed, Anthem and CareSource had two measures that exceeded the national median values, MDwise had four, and MHS had six.

Exhibit V.7
Comparing Hoosier Healthwise MCEs to Health Plans Nationally on Selected CAHPS Measures

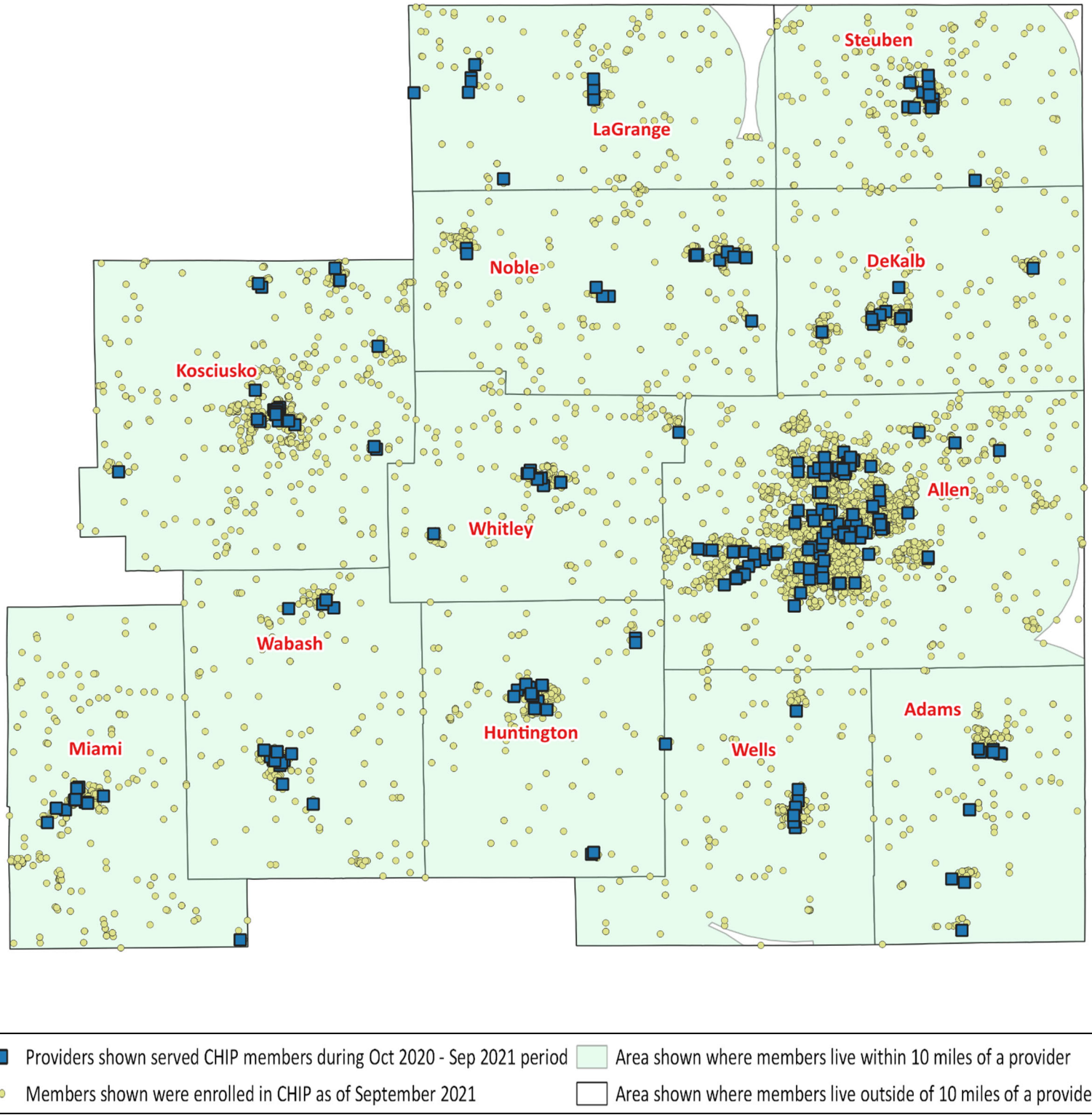
Each MCE is color-coded to compare it to Medicaid health plans nationally.
If MCE is below the 25th percentile nationally:
If MCE is >25th percentile but <50th percentile nationally:
If MCE is >50th percentile but <75th percentile nationally:
If MCE is >75th percentile but <90th percentile nationally:
If MCE is above the 90th percentile nationally:

	Hoosier Healthwise 2020 Survey			
Composite Ratings	Anthem	CareSource	MDwise	MHS
Members are asked to give a rating of 1 to 10 on the survey (a 10 is the best score).				
The percentages shown are the percent of members who gave the MCE a score of 8, 9 or 10.				
Rating of the health plan (the MCE)	88.2% ↓	83.1%	87.7%	91.8%
Rating of their own health care	89.6%	89.2%	87.8% ↓	88.8%
Rating of their personal doctor	88.3% ↓	90.3%	89.5%	90.4%
Rating of specialist seen most often	82.2%	85.3% ↓	90.1% ↓	90.0% ↑
Composite Scores on Key Measures				
Members are asked questions on items important to the MCE's delivery of serv				
For each question, members can answer "Always", "Usually", "Sometimes" or				
The percentages shown are the percent of members who responded "Always" or "Usually".				
Customer Service provided by the MCE	87.7% ↓	89.5%	91.4% ↑	93.4%
Getting Needed Care	84.8% ↓	84.6%	89.0%	91.8%
Getting Care Quickly	87.2% ↓	86.6% ↓	85.2% ↓	88.1% ↓
How Well Doctors Communicate	93.3% ↓	94.2% ↓	94.2%	95.5%

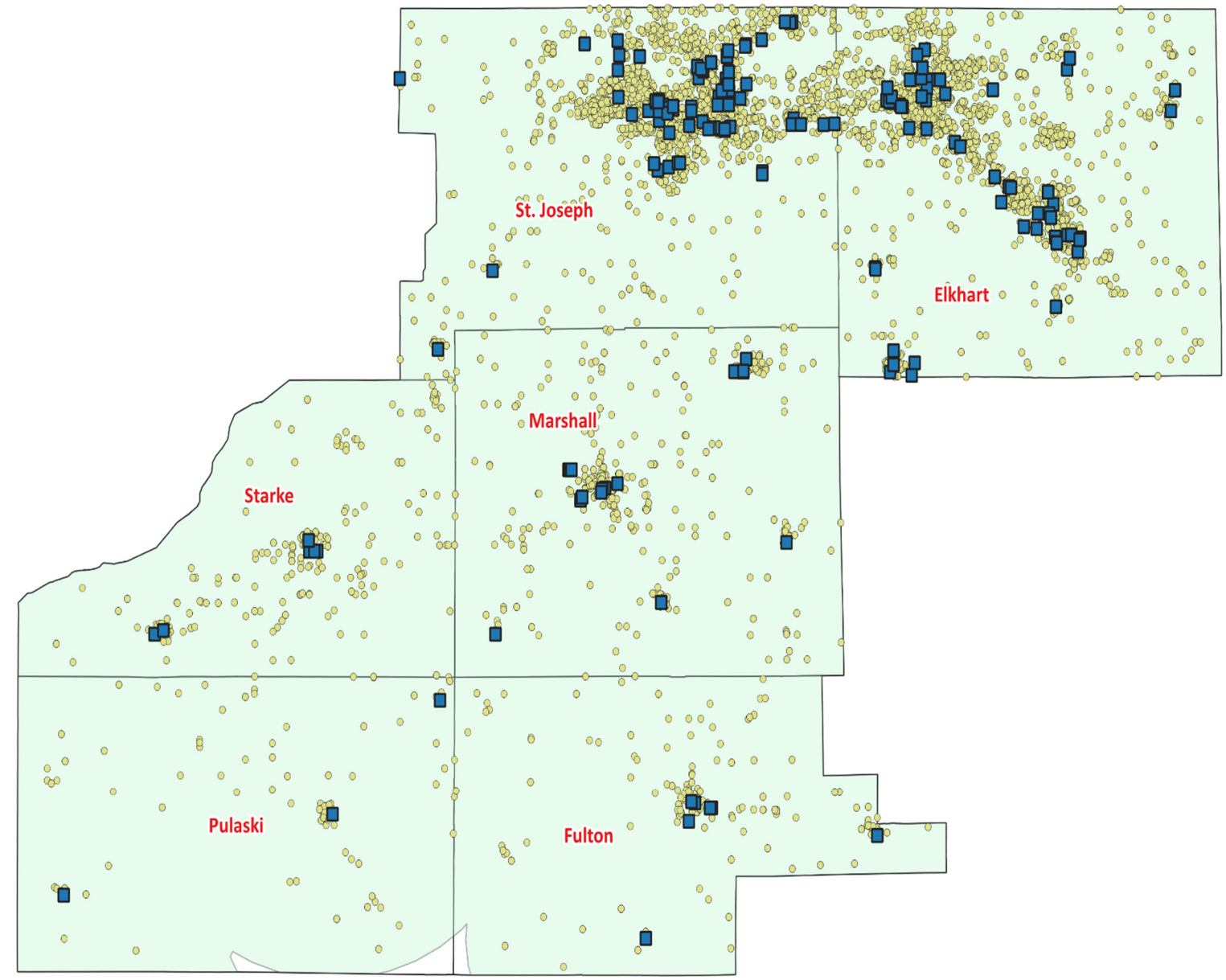
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

Appendix

Map A.1
Measuring Accessibility to Primary Care Providers
Northeast Region

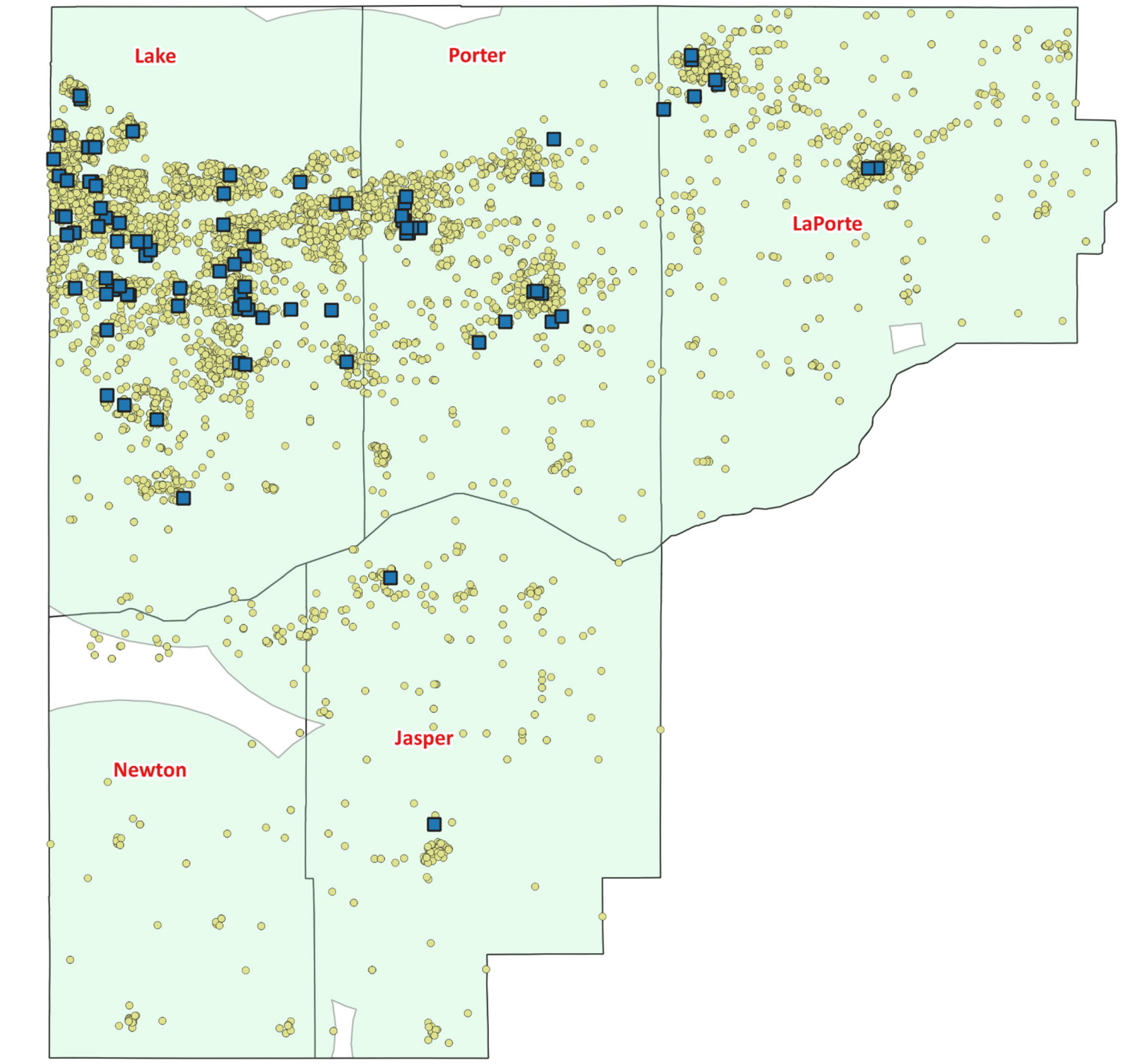


Map A.2
Measuring Accessibility to Primary Care Providers
North Central Region



Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.3
Measuring Accessibility to Primary Care Providers
Northwest Region



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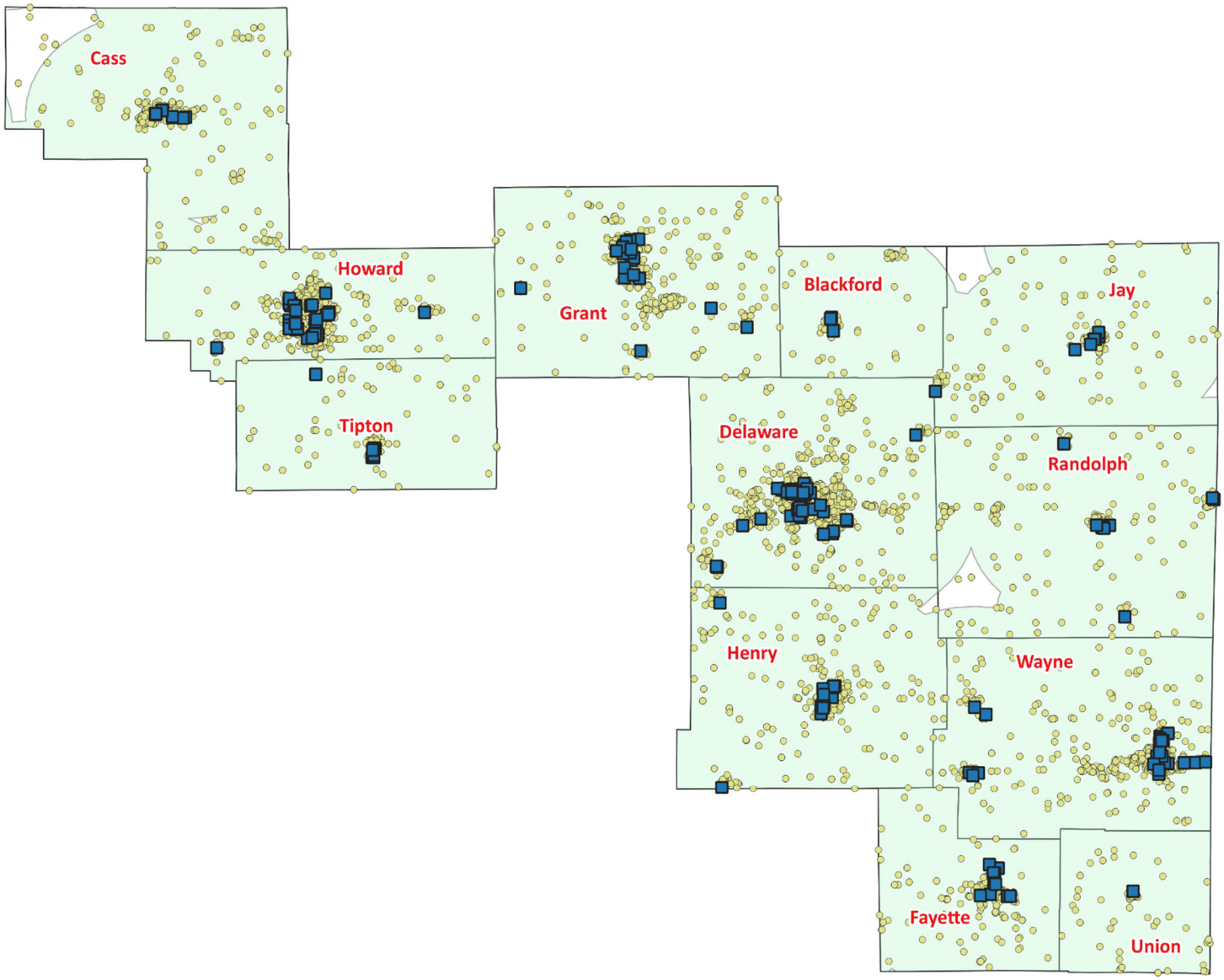
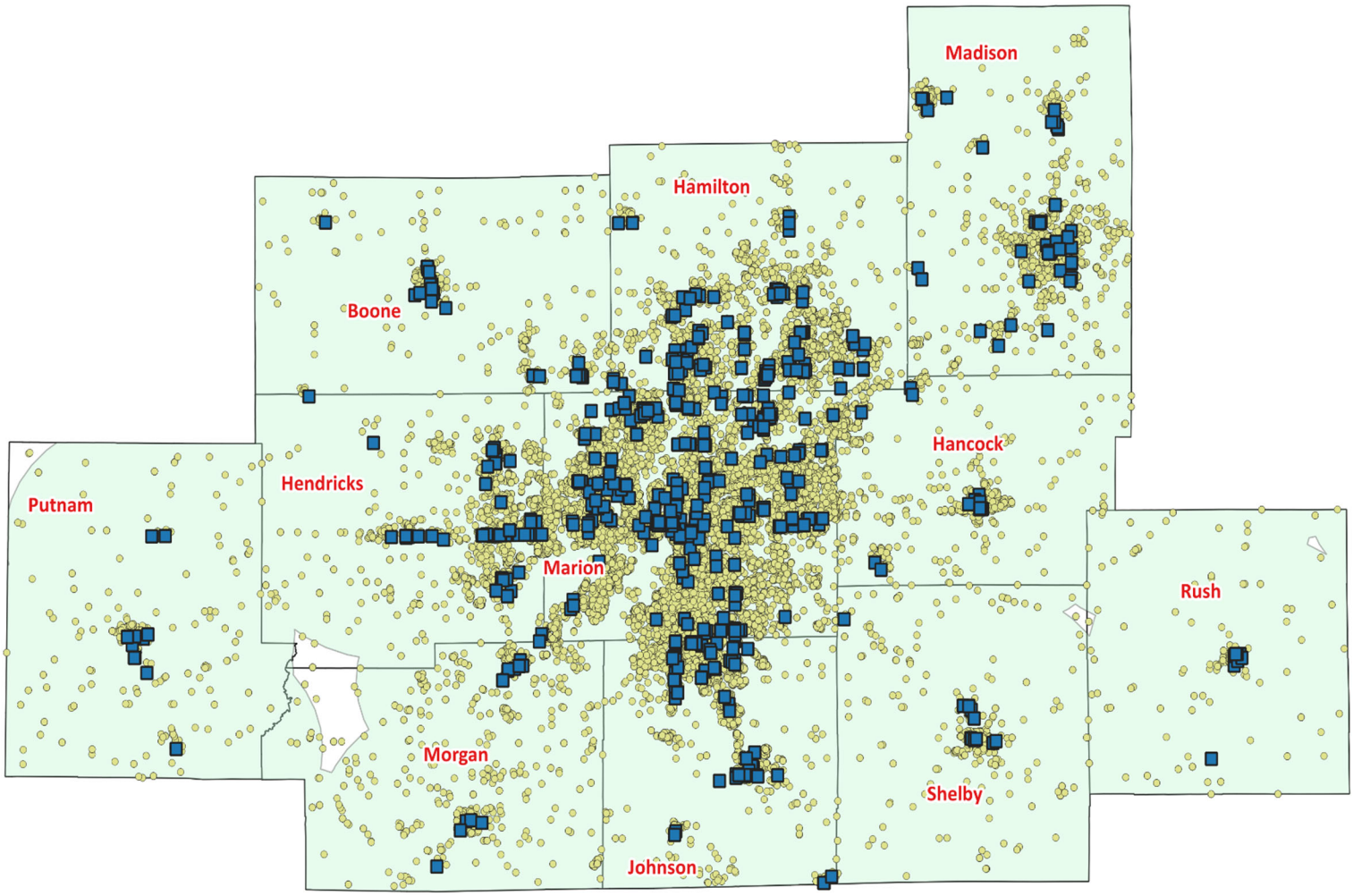
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.4
Measuring Accessibility to Primary Care Providers
East Central Region



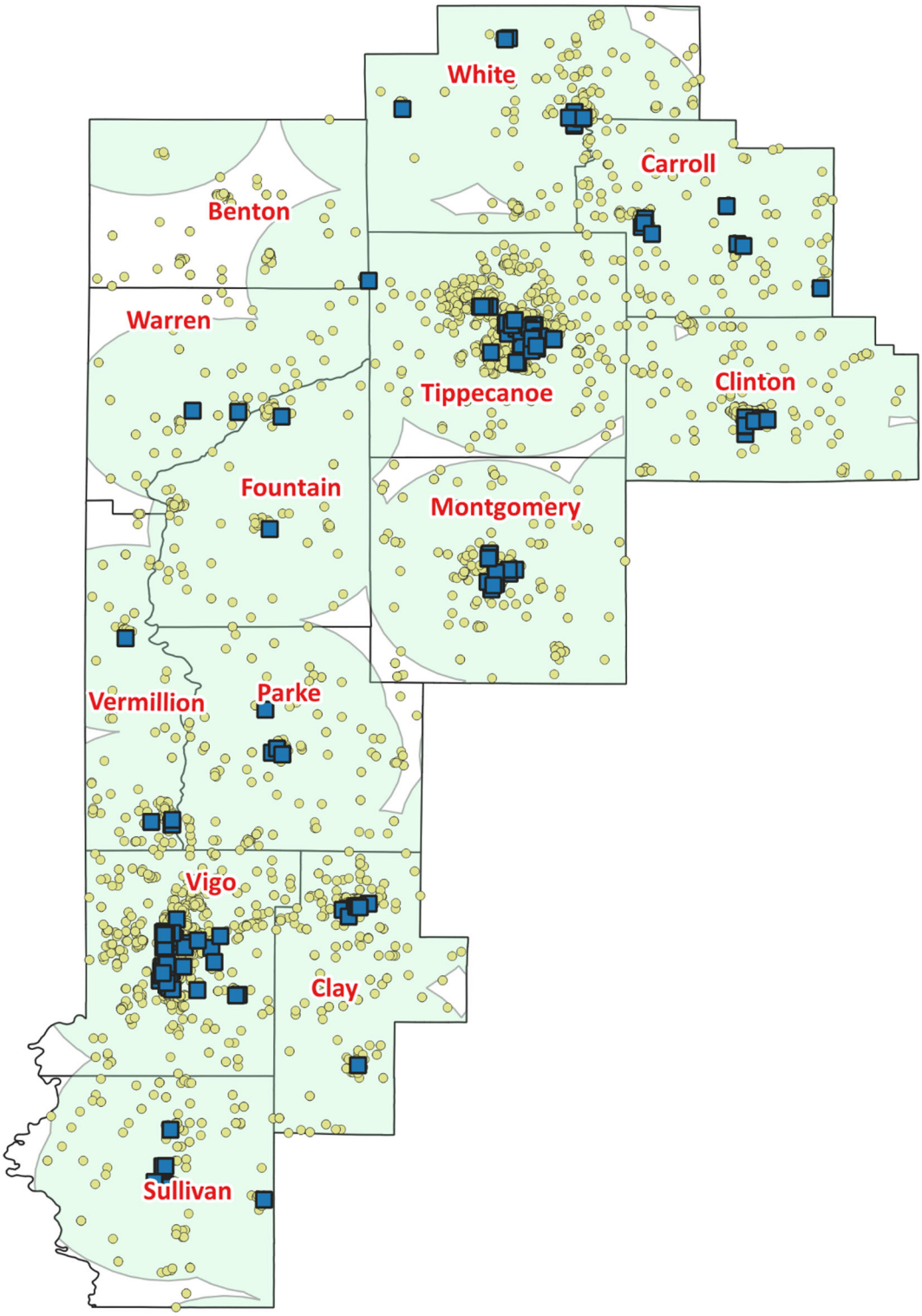
Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.5
Measuring Accessibility to Primary Care Providers
Central Region



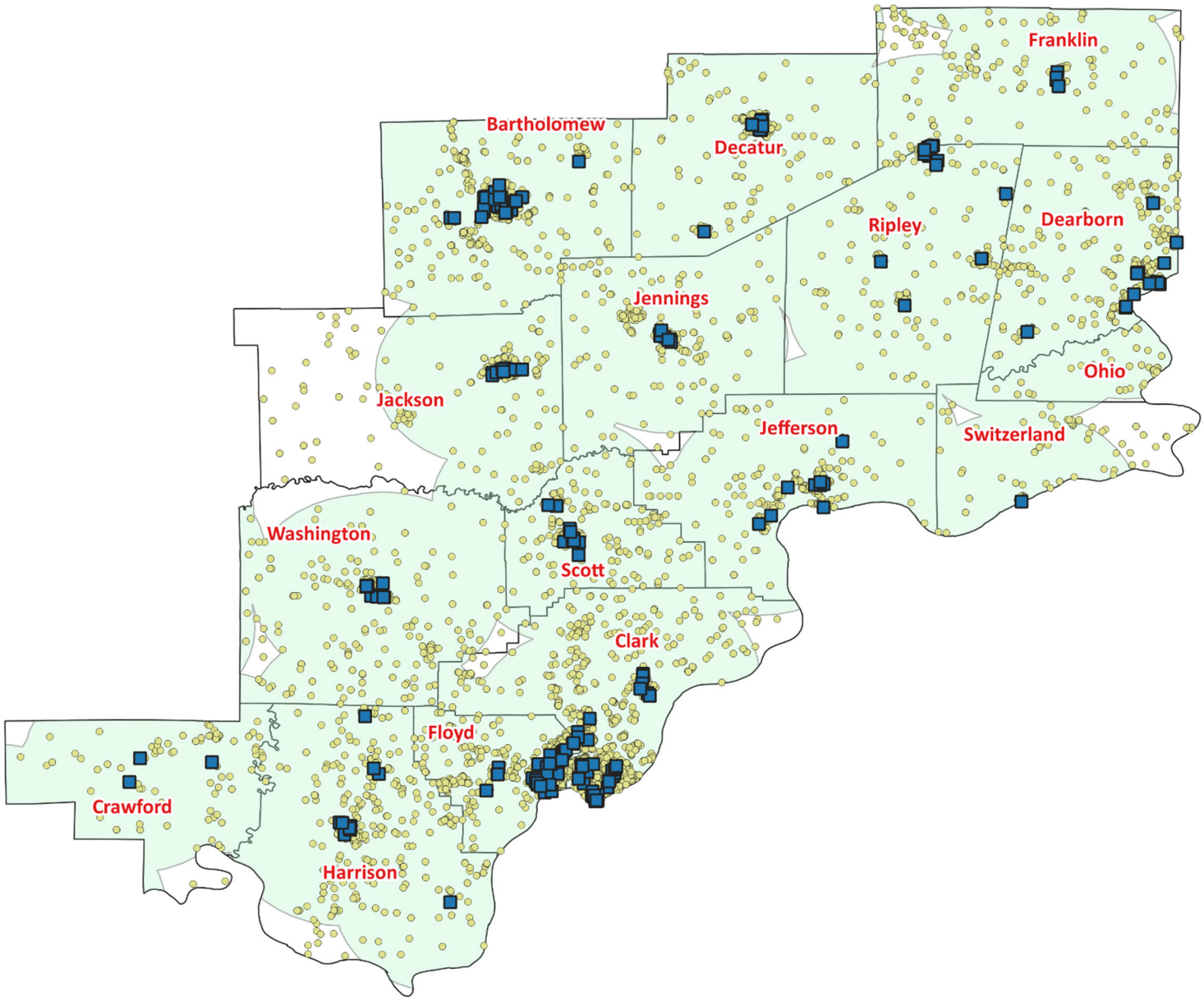
Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.6
Measuring Accessibility to Primary Care Providers
West Central Region



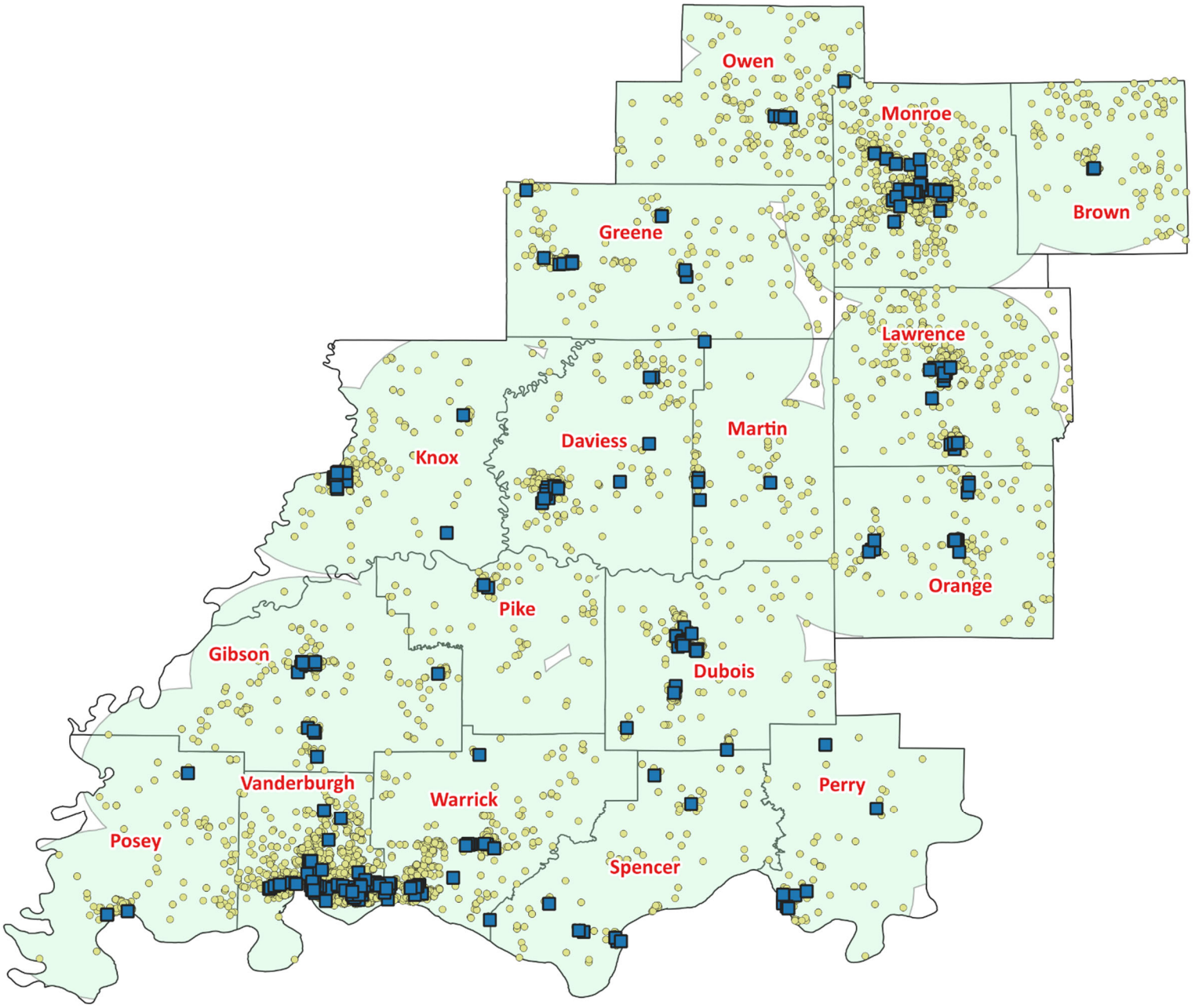
Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.7
Measuring Accessibility to Primary Care Providers
Southeast Region



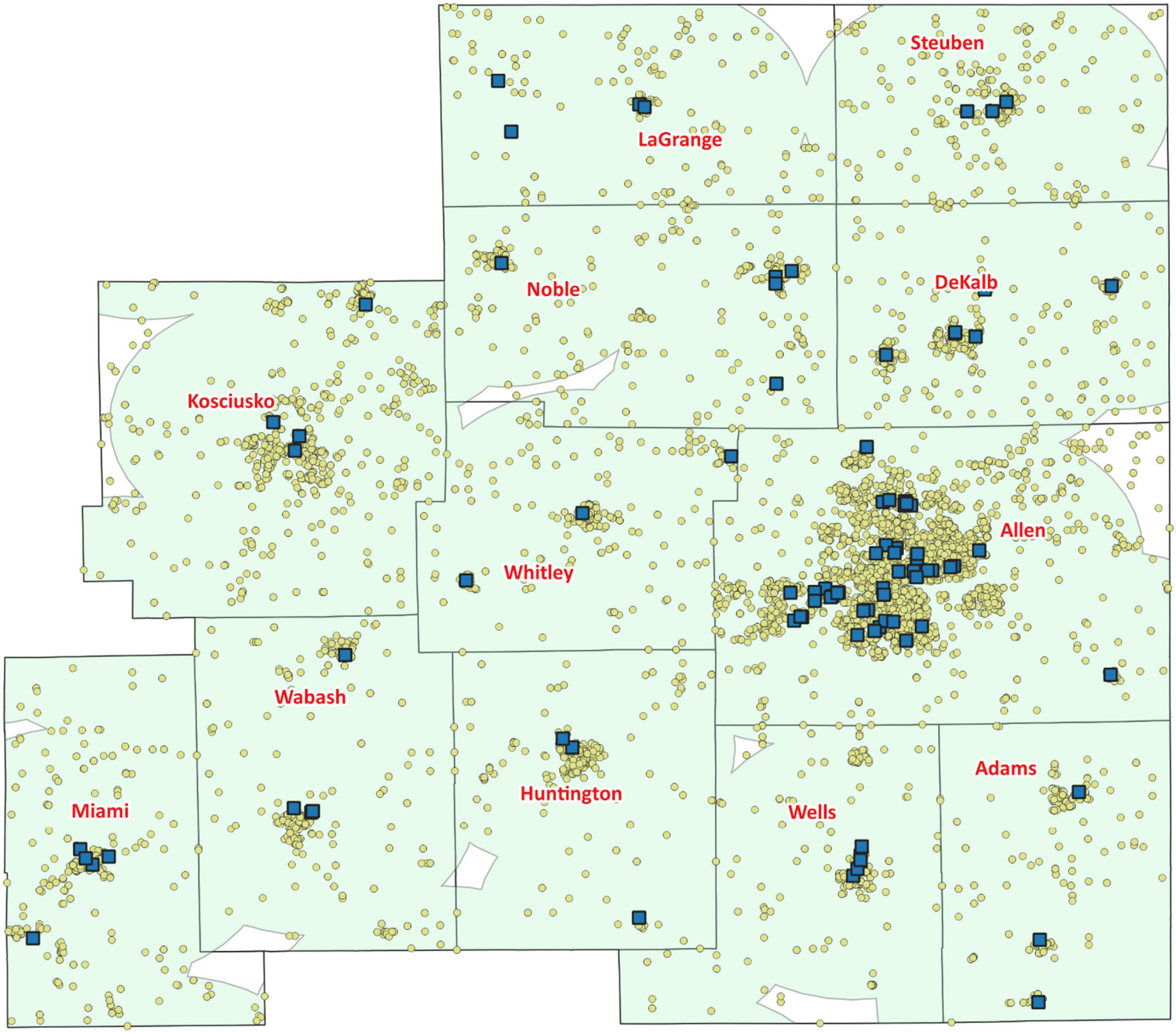
Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.8
Measuring Accessibility to Primary Care Providers
Southwest Region



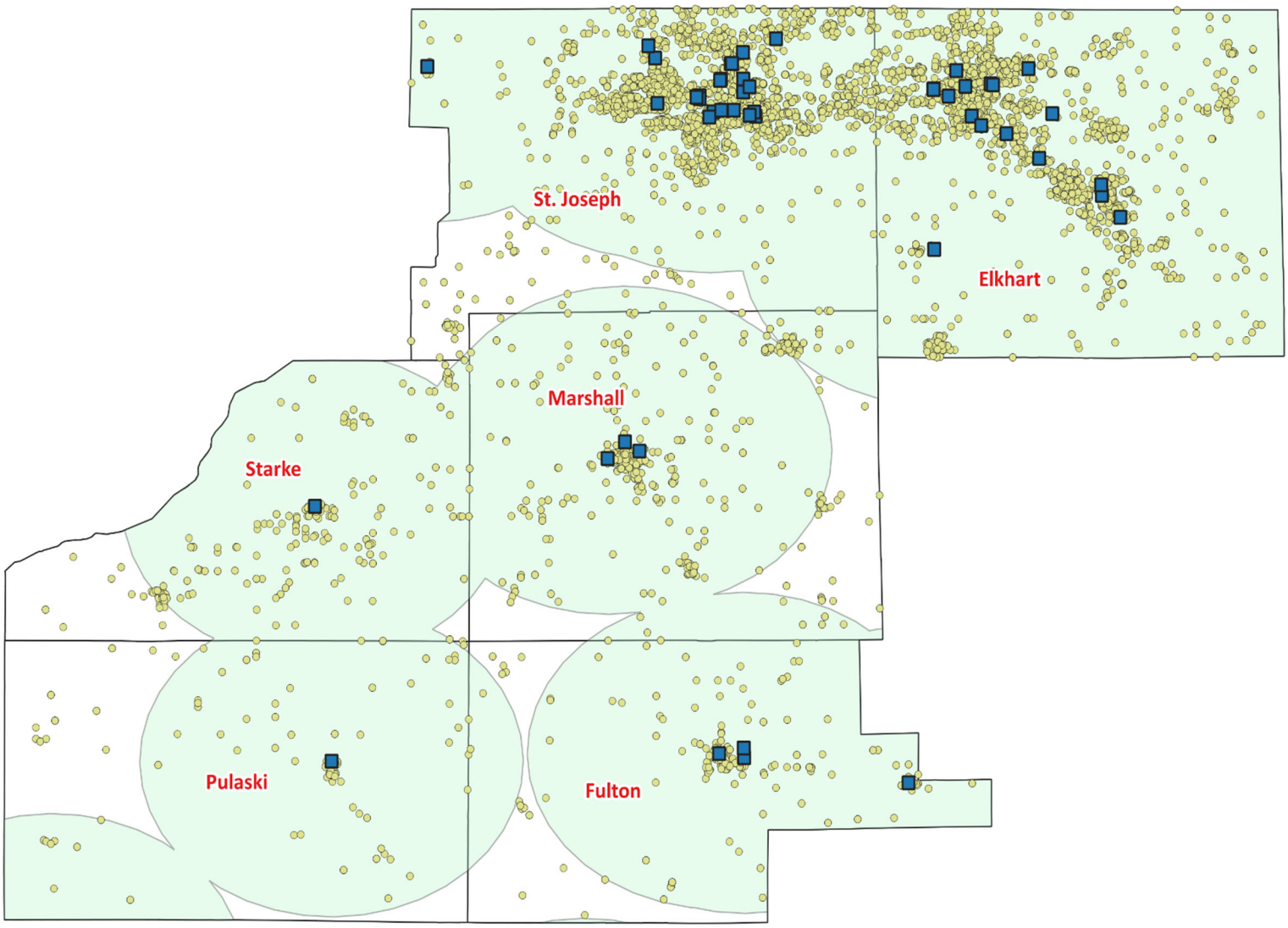
Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.1
Measuring Accessibility to Dental Providers
Northeast Region



Providers shown served CHIP members during Oct 2020 - Sep 2021 period
Members shown were enrolled in CHIP as of September 2021
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.2
Measuring Accessibility to Dental Providers
North Central Region



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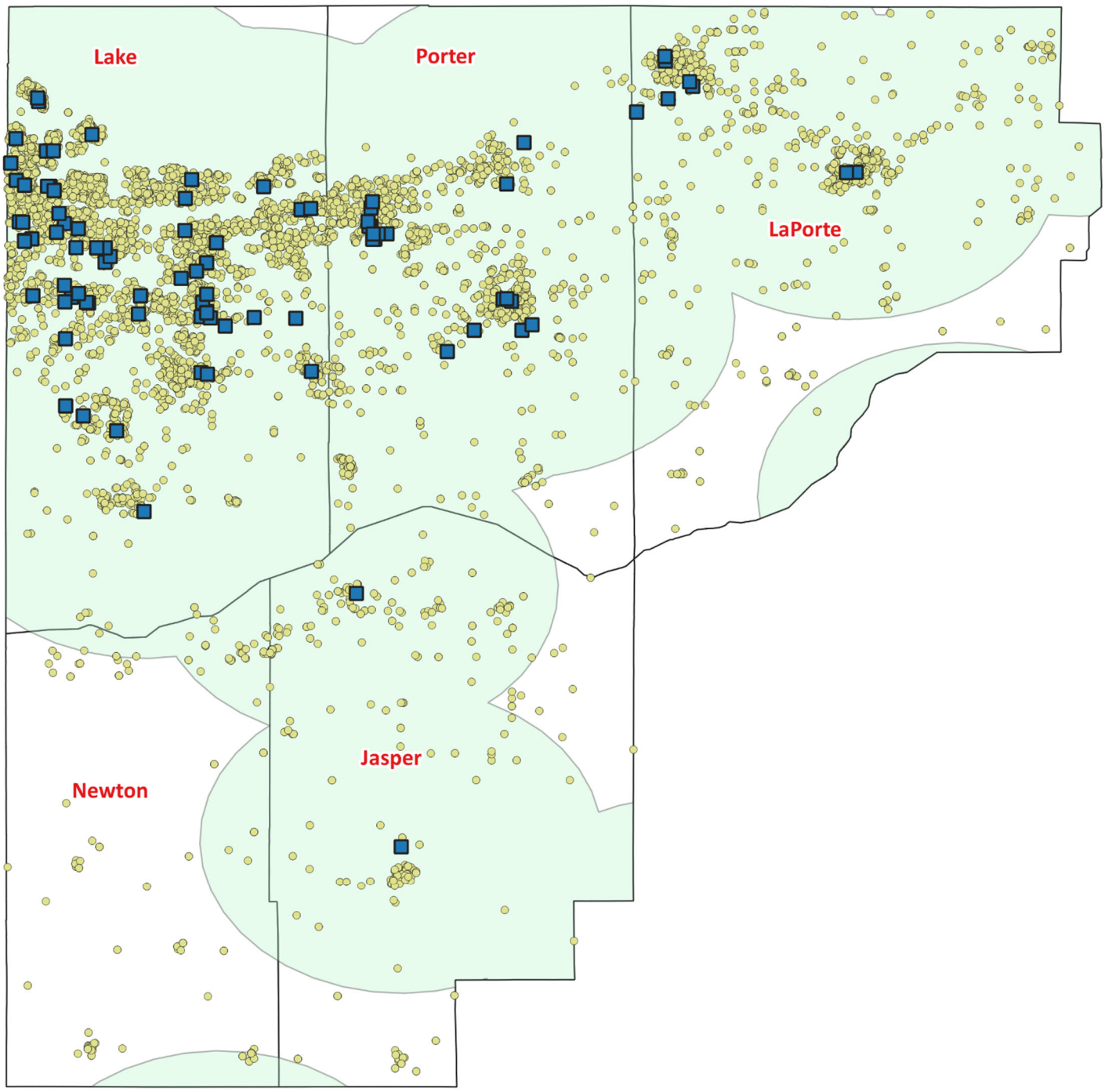
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.3
Measuring Accessibility to Dental Providers
Northwest Region



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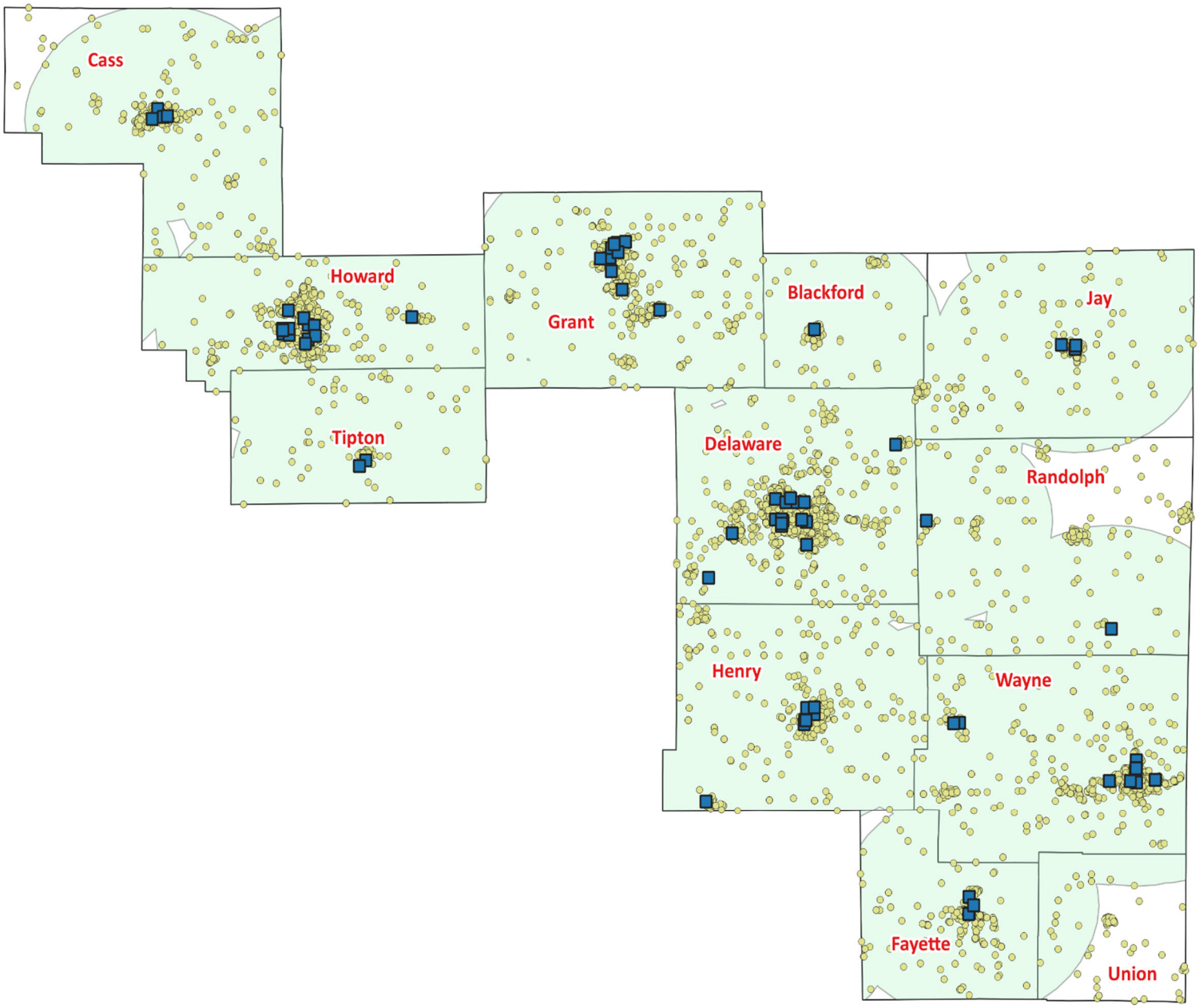
Members shown were enrolled in CHIP as of September 2021

Area shown where members live within 10 miles of a provider

Area shown where members live outside of 10 miles of a provider

Map B.4
Measuring Accessibility to Dental Providers
East Central Region



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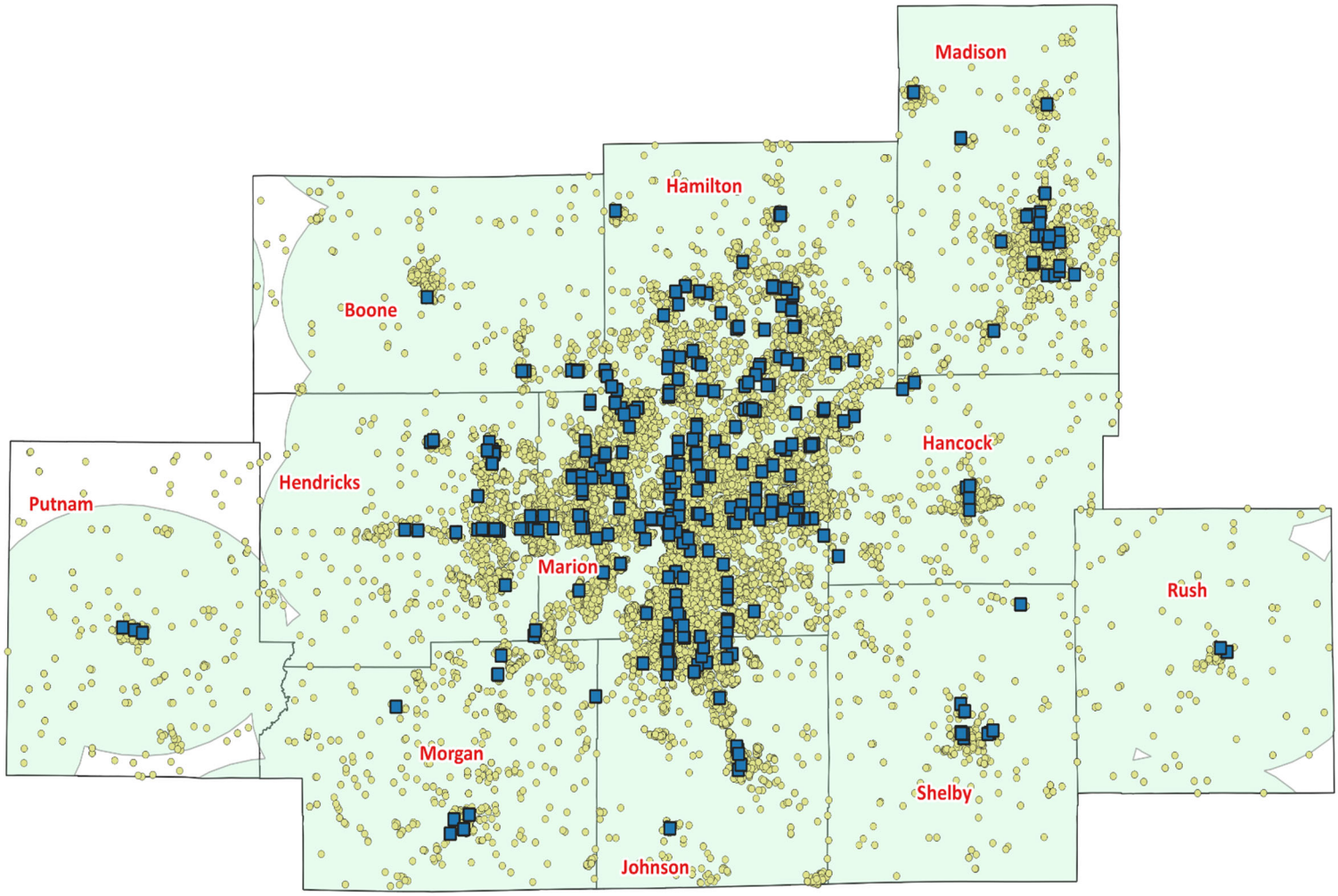
Map B.5
Measuring Accessibility to Dental Providers
Central Region



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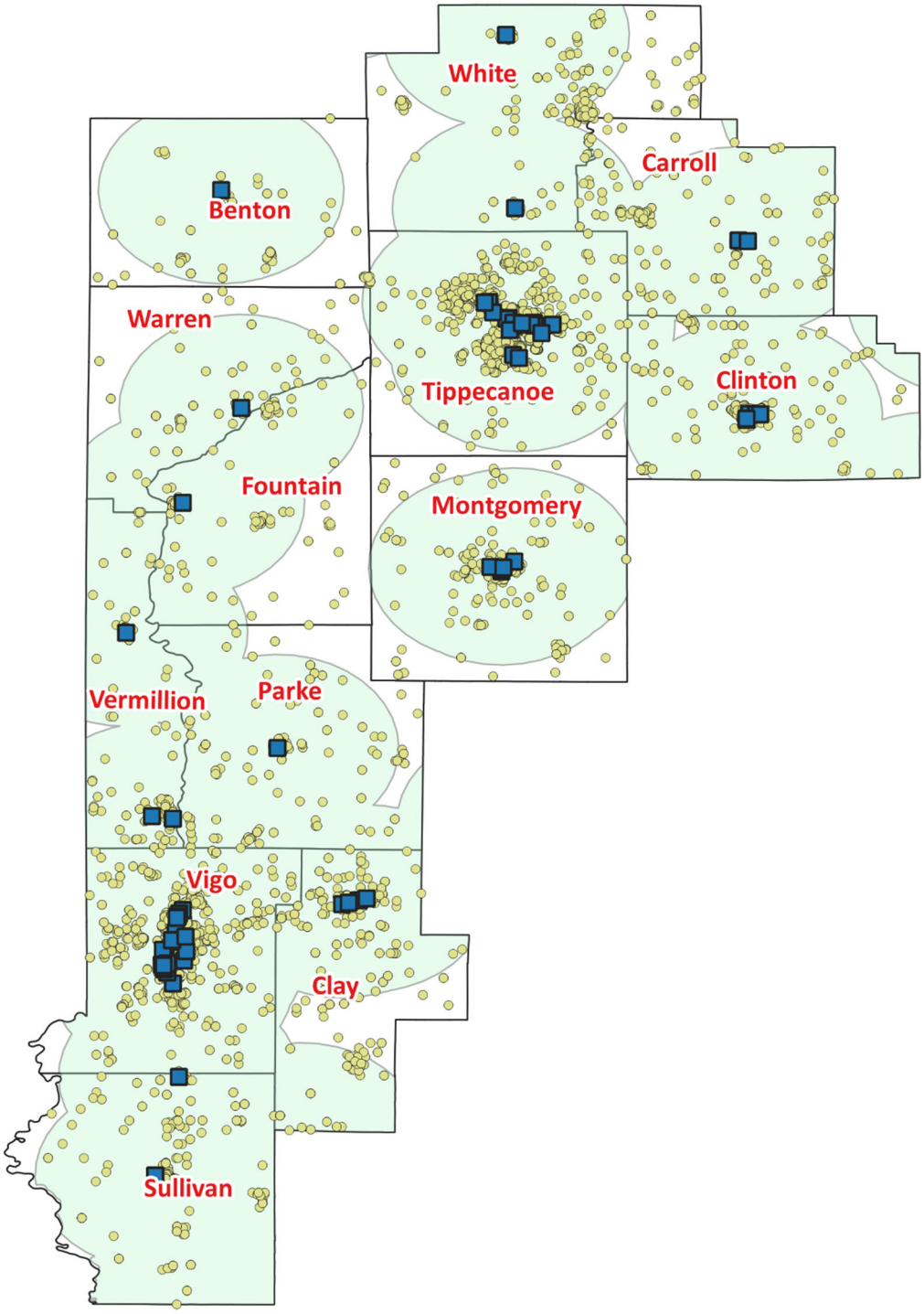
Map B.6
Measuring Accessibility to Dental Providers
West Central Region



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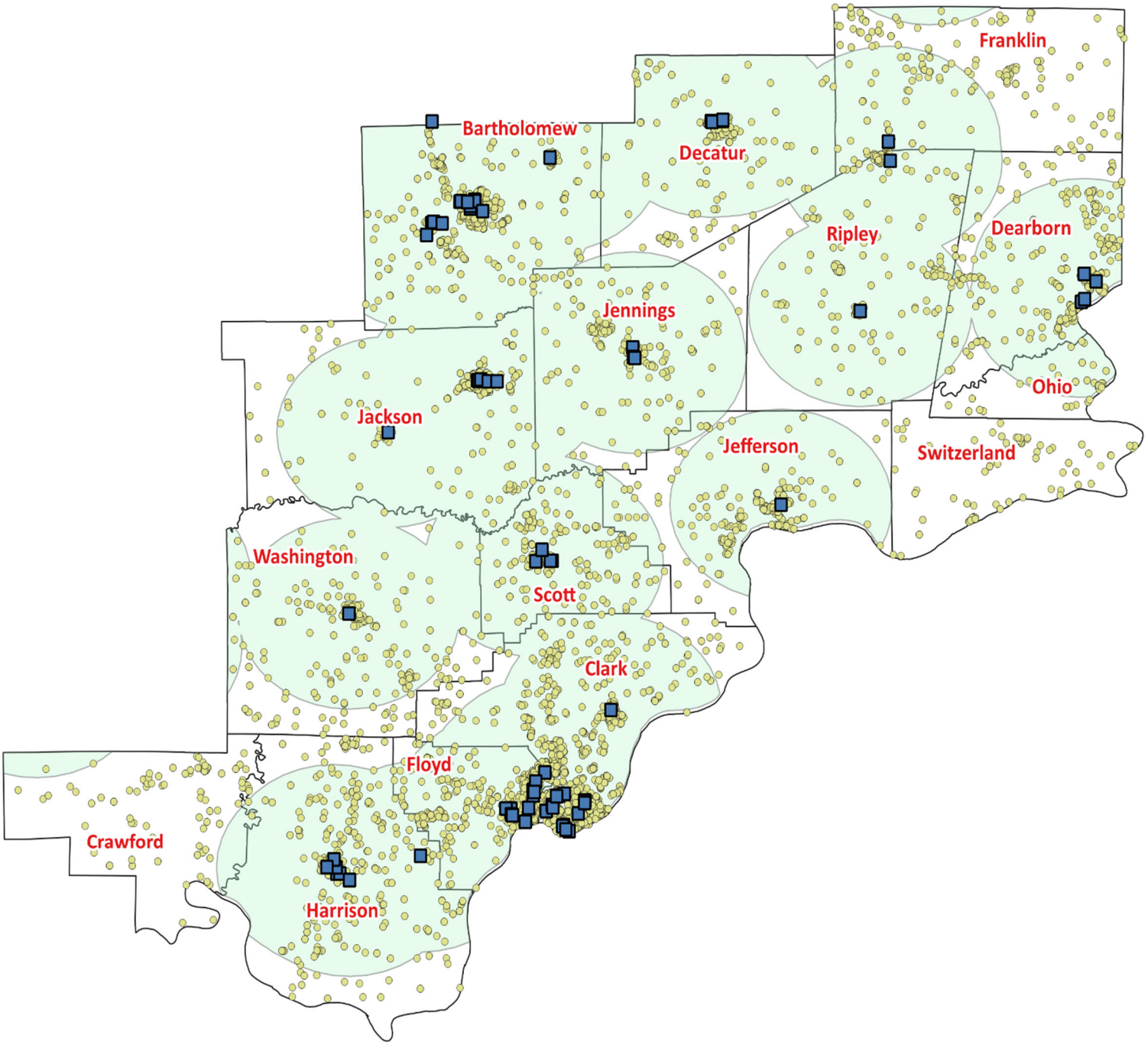
Map B.7
Measuring Accessibility to Dental Providers
Southeast Region



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Map B.8
Measuring Accessibility to Dental Providers
Southwest Region