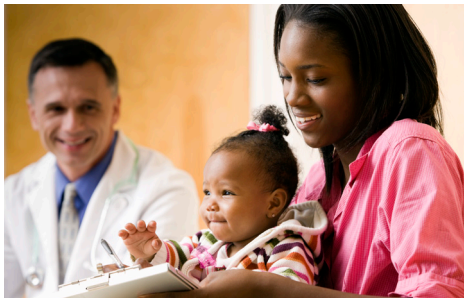
Independent Evaluation of Indiana's Children's Health Insurance Program

Final Report – April 2016



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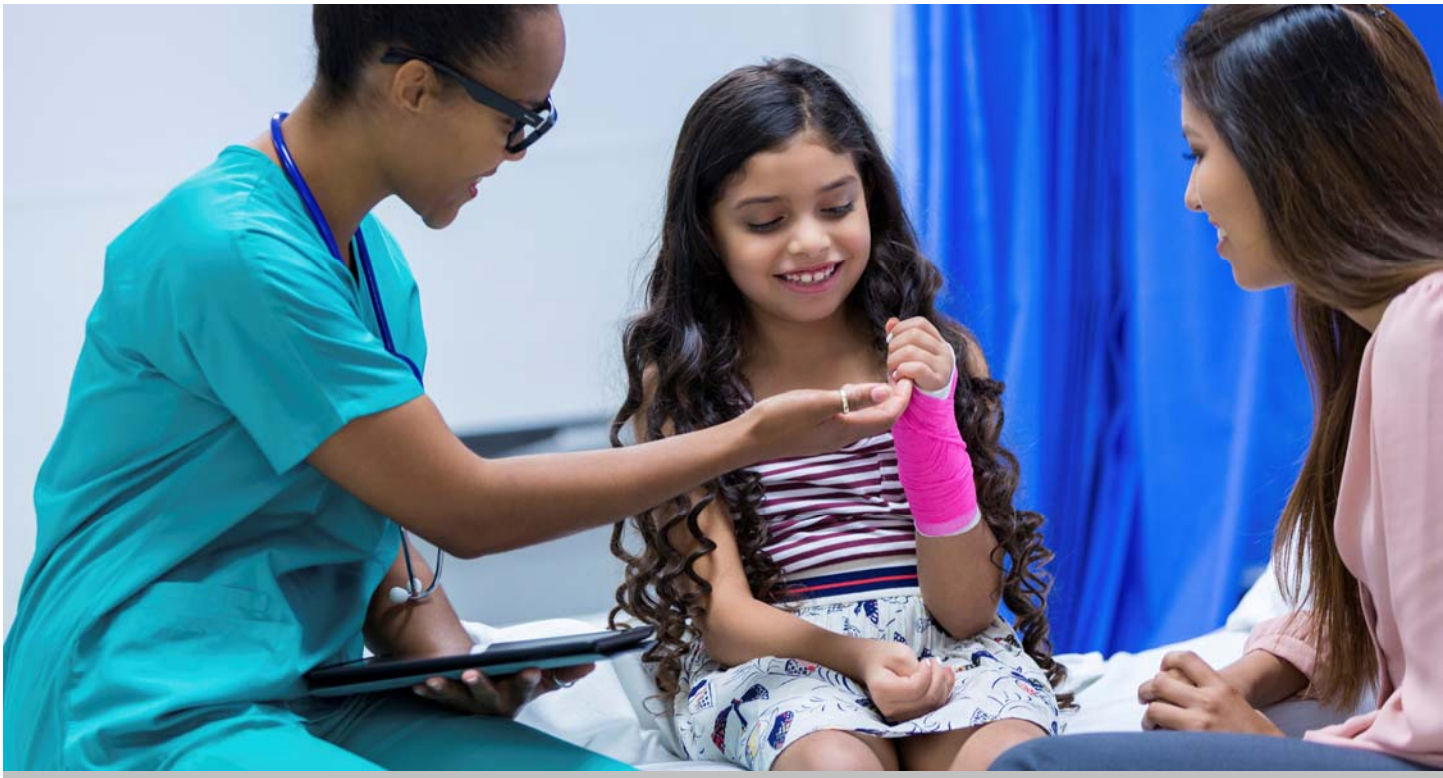
Executive Summary



As of December 2015, enrollment in Indiana's CHIP was at 81,403, a 12.8 percent increase from the December 2014 membership of 72,162. Over the last three years, enrollment has increased 8.8 percent. Growth in Indiana's CHIP over the last 15 years enabled the State to lower its uninsured rate among children in low-income families rapidly, although other states have recently improved their trend in reducing uninsured rates among children as well. Citing the most recent year's Census Bureau statistics, Indiana's uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL) is now 8.2 percent compared to the national average of 8.4 percent. This places Indiana 28th lowest among states nationally[1]. In the same survey conducted by the Census Bureau back in 2012, Indiana was ranked 5th lowest among states nationally (in that report, Indiana uninsured rate of 7.8%, national uninsured rate of 14.5%).

Indiana's CHIP eligibility has expanded over time since the original federal legislation was introduced in 1997:

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 158 percent of the FPL ($36,375 per year for a family of four in 2015) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

- CHIP Package C (the non-entitlement portion, or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.
    - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 158 percent up to 200 percent of the FPL ($48,500 per year for a family of four in 2015).
    - The second portion (referred to as SCHIP (Package C) Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($60,625 per year for a family of four in 2015).

In Calendar Year (CY) 2015, enrollment grew in all three segments of CHIP:

- MCHIP (CHIP Package A) grew 12.3 percent to 58,150 children in December 2015
- SCHIP (CHIP C original) grew 15.0 percent to 15,951 children in December 2015
- SCHIP (CHIP C expansion) grew 12.2 percent to 7,302 children in December 2015

Enrollment in Indiana's CHIP fluctuates greatly year to year. This is evidenced by the percent of new enrollees each year as well as the percent of lapsed enrollees. For MCHIP (CHIP Package A), the percentage of all enrollees that were new in Federal Fiscal Year (FFY) 2014 on average was 7.7 percent; for SCHIP (CHIP C original), it was 22.2 percent; for SCHIP (CHIP C expansion), it was 5.6 percent.

Because of the high influx and outflow in the program, the number of children served by Indiana's CHIP at some point in the year is actually near double the enrollment in any given month. In CY 2015, the number of children ever enrolled in CHIP was 143,667; in CY 2014, it was 147,568.

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.

[1] Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

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, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2015. B&A 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

Half of the children enrolled in the CHIP are between the ages of 6 and 12. Enrollment by age is uneven because children under age 6 are eligible for Medicaid at higher family income levels. One-third of CHIP enrollees are teenagers, while the remaining 15 percent are under age 5. This distribution has been the case since the CHIP was introduced.

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 three contracted managed care entities (MCEs)—Anthem, 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 (Package C) members for prescription drugs and ambulance services, and monthly premiums are also charged to SCHIP (Package C) families on a sliding scale based on family income and the number of children enrolled.

Premiums Charged to Families in Indiana's CHIP Package C

Family FPL	Monthly Premium for 1 Child	Monthly Premium for 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

Among the CHIP programs nationwide, 30 states (including Indiana) require families to pay premiums for their children's coverage. In a report released by the Kaiser Family Foundation in January 2016, it was found that Indiana's program resembles many other state CHIP programs in its design features, such as having an integrated Medicaid/CHIP eligibility determination system (34 states), the ability to submit applications online (50 states), and pre-enrollment verification of income (43 states).

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 rate is higher than Medicaid, with the exception that MCHIP (Package A) children with Third Party Liability (TPL) insurance are not eligible for the higher match rate.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCEs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail 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. In this past year's survey, all three Hoosier Healthwise MCEs maintained high scores with all MCE's scoring above 80 percent in each major category. Some areas in particular were notable in that:

- MHS and MDwise scored 85 percent or higher on Rating of Health Care
- Anthem, MHS and MDwise all scored 85 percent or higher on Rating of Personal Doctor
- MHS and MDwise scored above 85 percent on Rating of Specialist
- MHS and MDwise scored above 85 percent and Anthem scored just below 85 percent on Rating of Health Plan
- Near 90 percent of respondents stated that they "usually" or "always" received good customer service from the MCEs
- Over 90 percent of respondents stated that they "usually" or "always" received care quickly

Access to Services

B&A reviewed access by examining where CHIP members receive primary care services and preventive dental services. We matched claims of actual services received in FFY 2015 between where the member lives and where the attending provider is located.

Statewide, the average distance that CHIP members travel to seek primary care is 16.7 miles, which is below the 30 mile threshold set by the OMPP. In 35 of the 92 counties, the average distance travelled was less than 20 miles. In 32 counties, the average distance was between 20 and 30 miles. There are 19 counties where the average distance was between 30 and 40 miles, and six counties where the average distance was greater than 40 miles (Cass, Decatur, Fountain, Jefferson, Miami, and Warren). The county with the longest average distance was Fountain County at 47.4 miles. It should be noted, however, that in three of the counties (Fountain, Jefferson, and Warren) the sample size was very low (each county had 12 or less clients in the study whereas the median value across all counties was 72).

B&A conducted a similar analysis to see where CHIP members access services for dental providers. Statewide, the average distance that CHIP members travel to seek dental care is 14.4 miles, which is far below the threshold set by the OMPP and even better than the PMP visit average. In 55 of the 92 counties, the average distance travelled was less than 20 miles. In 29 counties, the average distance was between 20 and 30 miles. There are 5 counties where the average distance was between 30 and 40 miles, and just three counties where the average distance was greater than 40 miles (Newton, Vigo and Vermillion). The county with the longest average distance was Vigo County at 43.7 miles.

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 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 three MCEs and has set performance targets against national benchmarks for Medicaid health plans. The federal Department of Health and Human Services also reports on HEDIS measures reported by each state CHIP program in an annual report to the Centers for Medicare and Medicaid due December 31 of each year.

Some of the key findings on selected HEDIS measures are reported in Chapter V.

- For access to primary care practitioners, all three MCEs reported that 96 percent of its members age 12 to 24 months have access; for children age 25 months to six years, 88 percent; for children age 7 to 11, Anthem and MHS reported 91 percent but MDwise reported 99 percent; for children age 12 to 19 years, all three MCEs reported 91 percent.

- For well child visits received, children in the first 15 months of life are measured to determine the percentage who received six or more visits. All three MCEs have seen improvement in this measure in the last five years, with results between 71 and 77 percent in the most recent year. Indiana ranked 16th best among states in the most recent data available for all Medicaid agencies.

- There has also been improvement in the rate measuring the percentage with an annual well care visit for children ages 3 to 6 (now 74 to 78 percent across the MCEs) and adolescents (Anthem and MHS reported 61 percent while MDwise reported 74 percent). Indiana ranked 16th best for ages 3 to 6 and 11th best for adolescents among state Medicaid agencies.

- Timeliness and frequency of prenatal and postpartum care is consistent across the three MCEs and has been steady in the last five years. Across Medicaid agencies, however, Indiana ranks 3rd best on timeliness of prenatal and postpartum care.

- Indiana also ranks well on follow-up visits after a mental illness hospitalization (5th highest among states for a follow-up visit within 30 days) and follow-up visits after medication for ADHD has been prescribed (ranked 12th highest among states).

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency room visits, preventive dental visits, and had a pharmacy prescription for the periods FFY 2013, FFY 2014 and FFY 2015. The overall rate of usage for all of these services has remained fairly steady. Some potential missing claims data still coming in from FFY 2015 may be understating the results from this most recent year. Comparisons were also made across various demographic cohorts, such as by MCE, by age and by race/ethnicity.

Percentage of CHIP Children Using Each Service
(for children enrolled at least 9 months in the year)

	FFY 2013	FFY 2014	FFY 2015
Primary Care Visit (office or clinic setting)	71%	70%	68%
Emergency Room Visit	27%	24%	25%
Preventive Dental Visit	68%	68%	68%
Pharmacy Script	71%	68%	69%

B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall in each FFY and also by each of the demographic cohorts.

Some of the key findings from these two separate analyses are:

- Primary care visits were more prevalent among the youngest and eldest members, as 78 percent of children ages 5 and younger had a visit in FFY 2015. The percentage was lower for children in the middle age group (66 percent for ages 6-12 in FFY 2015).

- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. Hispanic CHIP children had a primary care visit rate of 64 percent and African American children had a primary care visit rate of 57 percent which was significantly below the 72 percent rate for Caucasian children.

- In addition to more actual children having a primary care visit, there is also a disparity in the number of visits per 1,000 CHIP children for primary care. The rate for Caucasian children is approximately 240 visits per 1,000 children during FFY 2015, but the rate for African American and Hispanic children is closer to 155 visits per 1,000.

- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCE, but it is more pronounced when reviewed at the per 1,000 member statistic. In FFY 2015, the average rate among MDwise members was 36 ER visits per 1,000 CHIP members; for Anthem, it was 35 per 1,000; for MHS, it was 27 per 1,000.

- Differences in ER use are found by age group within the CHIP. The highest use is among children under age 5 (33 percent of all members in FFY 2015) and lowest among children ages 6 to 12 (22 percent of all members in FFY 2015).

- One in five CHIP members of all race/ethnicities had used the emergency room in each of the years studied.

- When a study was conducted of how many of the ER visits were potentially preventable, it was found that 81 percent of CHIP member ER visits may be preventable. The conditions which were the most prevalent for potentially preventable visits were ear infections, upper respiratory infections, and musculoskeletal issues (sprains, spasms, twisted joints).

- Hispanic CHIP children were more likely than children of other races/ethnicities to have a preventive dental visit with a rate of 79 percent in FFY 2015. In contrast, 66 percent of Caucasian members and 65 percent of African American members had a preventive dental visit.

- The trend in total prescriptions received increased modestly from last year's results after decreasing from FFY 2013 to FFY 2014. The utilization varies by age group. The number of prescriptions per 1,000 CHIP members is highest for children ages 13-18 (573 prescriptions per 1,000 members on average in FFY 2015), followed by children ages 6-12 (436 prescriptions per 1,000 members), then by children ages 0-5 (350 prescriptions per 1,000 members).

- Caucasian children have a utilization rate of 553 prescriptions per 1,000 members in FFY 2015, which is 46 percent higher than the rate for African-American children (377 prescriptions per 1,000 children) and more than double the rate for Hispanic children (261 prescriptions per 1,000 children).

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, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2015. B&A 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. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009[2] extended the program to September 2013. The Patient Protection and Affordable Care Act (ACA) of 2010 extended CHIP funding with a higher contribution of the federal share (referred to as an enhanced match rate) through Federal Fiscal Year (FFY) 2015 and continued the authority for the program through FFY 2019. In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 extended CHIP funding for another two years through FFY 2017.

When the original 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 both. Indiana opted to implement the "combination" program similar to 20 other states.

Indiana's CHIP eligibility has expanded over time since the original federal legislation was introduced in 1997:

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 158[3] percent of the Federal Poverty Level, or FPL ($36,375 per year for a family of four in 2015) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

- CHIP Package C (the non-entitlement portion, or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.

    - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 158 percent up to 200 percent of the FPL ($48,500 per year for a family of four in 2015).

    - The second portion (referred to as SCHIP (Package C) Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($60,625 per year for a family of four in 2015).

[2] CHIPRA 2009 changed the acronym for the federal program from S-CHIP to CHIP.
[3] 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 CMS in the computation of Modified Adjusted Gross Income.

In January 2016, the Kaiser Family Foundation surveyed the 50 states (and District of Columbia) to compare Medicaid and CHIP eligibility policies.[4] As of January 2016, 48 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, 30 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. There are 22 states (including Indiana) who charge a premium to families with incomes below 200 percent of the FPL (Indiana's premiums begin at $22 per month when the family has income at 158% - 175% of the FPL).

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 in these features (with number of states having a similar policy to Indiana):

- Integrated Medicaid/CHIP eligibility determination system (34 states);
- The ability to submit applications online (50 states);
- Pre-enrollment verification of income (43 states); and
- Co-pays charged for prescriptions (18 states charge for generics, 19 states for brand name drugs; Indiana charges for both)

Indiana's CHIP differs from many other state programs in other design features, however, such as:

- The required period of no insurance prior to enrolling (also known as the "going bare" period) is three months in Indiana. There are 34 states with no waiting period.

- Enrollment is continuous for 12 months, regardless of circumstance in 26 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

- "Real time" eligibility determination (that is, in 24 hours or less) is available in 34 states, but not in Indiana.

- Indiana does not impose co-pays for non-emergent ER visits (20 states do), non-preventive physician visits (20 states do), or inpatient hospital visits (15 states do).

As of December 2015, enrollment in Indiana's CHIP was at 81,403[5], a 12.8 percent increase over the prior year's membership of 72,162:

- MCHIP (Package A) enrollment was 58,150 (up 12.3 percent from December 2014)
- Enrollment in the initial group of SCHIP (Package C) members was 15,951 (up 15.0 percent from December 2014)

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[4] Brooks, T., Miskell, S., Artiga, S., Cornachione, E., Gates, A. (January 2016) *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey, 2015-2016.* Washington, DC: Georgetown University Center for Children and Families and The Henry J. Kaiser Family Foundation.

[5] Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, FSSA Enterprise Data Warehouse, on February 5, 2016. Due to retroactive eligibility, this enrollment figure for December 2015 may be slightly understated from what will be the final figure for this time period.

- Enrollment in the 2008 expansion group of SCHIP (Package C) members was 7,302 (up 12.2 percent from December 2014)[6]

Indiana's CHIP enrollment hit its maximum in Calendar Years 2010 and 2011 when year-end enrollment was slightly above 85,000 children. Enrollment has shifted between approximately 72,000 and 86,000 in the last five years after holding fairly steady for many years in the first decade of the new century. More enrollment statistics appear in Chapter II of this report.

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

The Census Bureau's Current Population Survey (CPS) surveys citizens annually on their health insurance status. An uninsured rate is computed for each state. In previous studies, it has been found that state-specific samples are often small, so year-to-year findings should be viewed with caution.

Indiana has been more effective than the nation as a whole in the last ten years in reducing the uninsured rate among low-income children, but other states are making inroads. Among children in families with incomes below 200 percent of the FPL, Indiana's most recent uninsured rate is 8.2 percent compared to the national average of 8.4 percent. Whereas Indiana's uninsured rate moved up and down in the last five years, the national average has decreased significantly in this time.

Exhibit I.1
Uninsured Rate Among Children in Families
Below 200% of Federal Poverty Level

Uninsured Rate as Reported in	Indiana's Rate	U.S. Average Rate	Indiana's Rank For Lowest Uninsured State
CPS 2011	8.9%	15.4%	8th
CPS 2012	7.8%	14.5%	5th
CPS 2013	13.9%	13.5%	32nd
CPS 2014	9.8%	10.6%	26th
CPS 2015	8.2%	8.4%	28th

Source: U.S. Census Bureau, Current Population Survey

*The state ranked #1 has the lowest uninsured rate.

The uninsured rate in the state varies by family income level. Exhibit I.2 below shows the uninsured rate among families up to 250 percent of the FPL (who may be eligible for Indiana's CHIP) and the rate among families above the 250 percent of FPL level. For example, whereas the survey conducted by the Census Bureau in 2015 (which measured insurance status in Calendar Year 2014) showed an overall uninsured rate among children of 8.0 percent, the rate was 8.7 percent among children who may be CHIP-eligible and 7.1 percent among children who are not CHIP-eligible. In reviewing the column that shows the percent of all uninsured children, the CPS suggests that 60.6 percent of

[6] It should be noted that the organization of data in the FSSA Enterprise Data Warehouse underwent changes in 2014-15. It was discovered that the data delivered to Burns & Associates for this report last year had incorrect assignment of enrollment data by package. In last year's report, B&A reported total CHIP membership in December 2014 was 73,334 which is similar to this year's updated total of 72,162. The distribution reported by MCHIP, SCHIP Package C, and SCHIP Package C Expansion was incorrect, however. The December 2014 comparison numbers shown in this report are correct.

children who are currently uninsured (n= 76,816) may be eligible for Indiana's CHIP (at least based on family income, other criteria may preclude eligibility). [7]

Exhibit I.2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana

Current Population Survey Year	Total Children 0-18	Total Insured	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Total for Children that may be Eligible for Indiana's CHIP (Income up to 250% FPL)					
CPS 2011	946,501	853,110	93,392	83.9%	10.9%
CPS 2012	902,813	822,735	80,078	81.7%	9.7%
CPS 2013	979,388	846,792	132,597	81.9%	15.7%
CPS 2014	863,840	786,793	77,048	57.9%	9.8%
CPS 2015	961,416	884,599	76,816	60.6%	8.7%
Total for Children Not Eligible for Indiana's CHIP (250% and above)					
CPS 2011	783,923	766,023	17,900	16.1%	2.3%
CPS 2012	783,923	766,023	17,900	18.3%	2.3%
CPS 2013	718,074	688,849	29,225	18.1%	4.2%
CPS 2014	872,255	816,342	55,914	42.1%	6.8%
CPS 2015	754,377	704,535	49,842	39.4%	7.1%
All Children					
CPS 2011	1,730,424	1,619,133	111,292	100.0%	**6.9%**
CPS 2012	1,686,736	1,588,758	97,978	100.0%	**6.2%**
CPS 2013	1,697,462	1,535,641	161,822	100.0%	**10.5%**
CPS 2014	1,736,095	1,603,135	132,962	100.0%	**8.3%**
CPS 2015	1,715,793	1,589,134	126,658	100.0%	**8.0%**

Source: U.S. Census Bureau, Current Population Survey
http://www.census.gov/hhes/www/cpstables/032015/health/toc.htm

There are differences in the uninsured rate when examined by race/ethnicity. In the most recent survey conducted among the children in families with incomes below 250 percent of the FPL, Caucasian children had an uninsured rate of 6.8 percent, whereas the rate for African American children was 5.7 percent and Hispanic children was 14.6 percent.

[7] Although family income is used to determine eligibility, another criterion for eligibility in SCHIP (Package C) is that children cannot have credible health coverage from another source, regardless of family income.

Exhibit I.3
Uninsured Rates for Children (Age 0-18) by Race/Ethnicity in Indiana
For Children in Families At or Below 250% FPL

Race/Ethnicity	Total Children 0-18	Total Insured	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Caucasian Non-Hispanic	572,207	533,419	38,787	50.5%	6.8%
African Amer. Non-Hispanic	176,766	166,645	10,121	13.2%	5.7%
Hispanic (any race)	173,115	147,866	25,248	32.9%	14.6%
All Other Races	39,328	36,669	2,660	3.5%	6.8%
All Children	**961,416**	**884,599**	**76,816**	**100.0%**	**8.7%**

Source: U.S. Census Bureau, Current Population Survey (CPS 2015 survey)
http://www.census.gov/hhes/www/cpstables/032015/health/toc.htm

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 and pregnant women. CHIP enrollees, like all children in Hoosier Healthwise, select a primary medical provider (PMP) or they are assigned one if their family does not select one. CHIP members must enroll with one of three managed care entities (MCEs) that contract with the state—Anthem, 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 (although the MCEs do not administer dental care or prescriptions). This is a practice often seen in other states as well. The actual services offered to CHIP members are also similar to those found in other state CHIP programs.

Exhibit I.4
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.

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).

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.5 below.

Exhibit I.5
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

II

Enrollment Trends in Indiana's CHIP

Enrollment Trends at a Glance

- Enrollment in CHIP grew 12.8 percent in Calendar Year 2015.
    - Enrollment at end of Calendar Year 2014 = 72,162
    - Enrollment at end of Calendar Year 2015 = 81,403

- Indiana's uninsured rate among low-income children is near the national median.
    - Indiana's rate among children in families below 200% federal poverty level: 8.2%
    - National rate among children in families below 200% federal poverty level: 8.4%

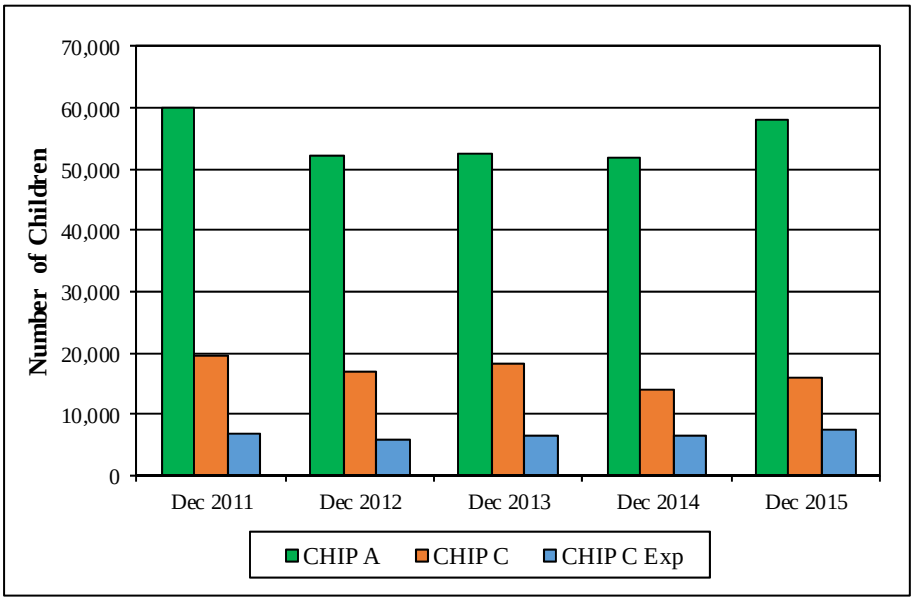
Enrollment and Disenrollment Trends

Indiana's Children's Health Insurance Program (CHIP) experienced an increase in enrollment in 2015 with year-end enrollment at 81,403 members, a 12.8 percent increase from Calendar Year (CY) 2014's year-end enrollment of 72,162. Over the last three years, enrollment has increased 8.8 percent. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 158% of the federal poverty level (FPL), enrollment increased 12.3 percent from December 2014 to December 2015. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 158%-200% of the FPL, enrollment increased 15.0 percent during this time period. The SCHIP (Package C) Expansion group instituted in October 2008 (201-250% of the FPL) had enrollment increase 12.2 percent during this time period.

At the end of CY 2015, 71.4 percent of enrollees (n = 58,150) were in the MCHIP portion and 28.6 percent (n = 23,253) were in the SCHIP portion of the program. The MCHIP portion of the program has enrolled between 68.1 and 71.8 percent of the members in each of the last five years.

Exhibit II.1

Enrollment in Indiana's CHIP at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

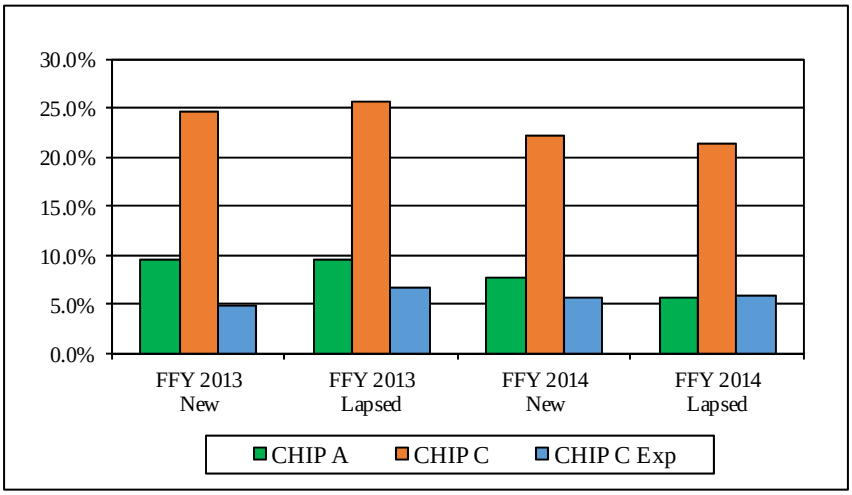
Enrollment in Indiana's CHIP fluctuates greatly year to year. This is evidenced by the percent of new enrollees each year as well as the percent of lapsed enrollees. Burns & Associates, Inc. (B&A) analyzed the enrollment of members within each portion of Indiana's CHIP on a monthly basis. From this, we tabulated how many members in the month were new to the program within the previous 12 months as well as how many lapsed. Statistic were computed for each month in Federal Fiscal Years (FFYs) 2013 and 2014 (the federal fiscal year runs from October 1 – September 30) and annual values were compared across the two years to determine the total that were new in the year and the total that lapsed.

For MCHIP (Package A), the percentage of new enrollees in FFY 2014 on average was 7.7 percent and 9.6 percent in FFY 2014 (refer to Exhibit II.2 on the next page). The percentage of members that were new to the program within SCHIP (Package C), however, was higher. For the original SCHIP (Package C) program, 22.2 percent of members were new in FFY 2014 as compared to 25.7 percent

in FFY 2013. For the expansion portion of SCHIP (Package C), 5.6 percent of members were new in FFY 2014 as compared to 5.0 percent new in FFY 2013.

Similar results were found when the lapsed enrollees were studied. In MCHIP, 5.7 percent of enrollees lapsed in FFY 2014 and 9.5 percent did in FFY 2013. For the original SCHIP program, 21.5 percent lapsed in FFY 2014 and 25.7 did in FFY 2013. For the expansion SCHIP program, 6.0 percent lapsed in FFY 2014 and 6.8 percent did in FFY 2013.

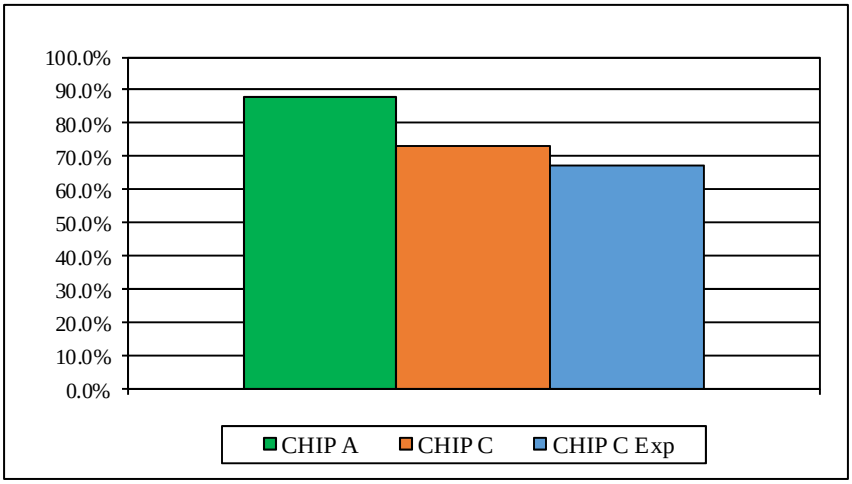
Exhibit II.2
New and Lapsed Enrollment in CHIP In Federal Fiscal Year
(Oct 1 - Sept 30)



Source: Indiana's FSSA Enterprise Data Warehouse

Despite the large movement in and out of the program, a large number of children remain in the program for at least one year. This is evidenced by the percentage of children who recertified their eligibility 12 months after their original enrollment. B&A examined new enrollees in FFY 2013 only then counted 13 months to see what percentage of these enrollees remained in FFY 2014 (in other words, they recertified). The percentage who recertified was 88 percent for MCHIP (CHIP Package A), 73 percent for SCHIP Package C, and 67 percent for SCHIP Package C Expansion. [8]

Exhibit II.3
Perecnt of New CHIP Enrollees Who Recertified
in Federal Fiscal Year 2015
(Members New in FFY 2014 Who Recertified After Initial 12 Months Enrolled)



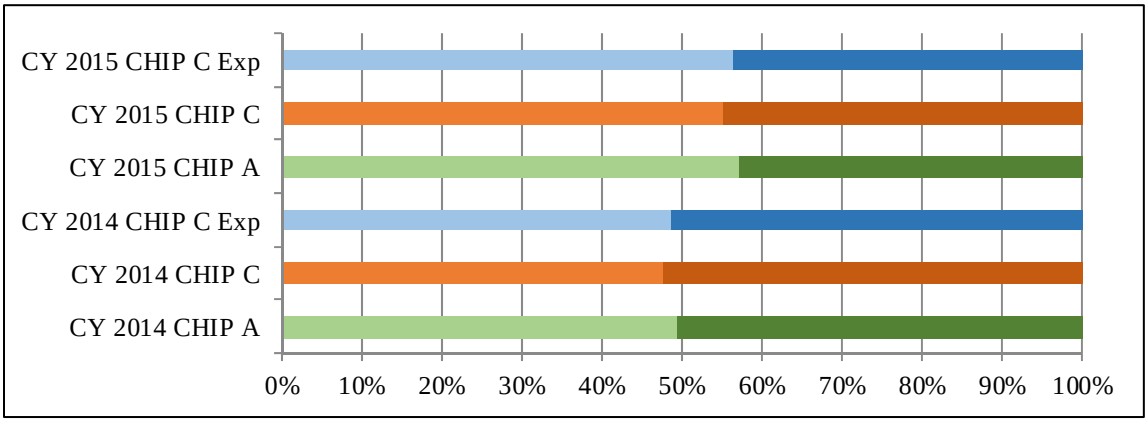
Source: Indiana's FSSA Enterprise Data Warehouse

[8] A member is considered "retained" in Hoosier Healthwise if they move from the CHIP program to the traditional Medicaid program, or between MCHIP (Package A) and SCHIP (Package C).

The large number of new and lapsed enrollees in the program means that a much larger number of Hoosier children have been supported by Indiana's CHIP than the year end enrollment figures would suggest. The number of children enrolled at any time during CY 2015 was 143,667 compared to 147,568 in CY 2014. Across all three portions of Indiana's CHIP (CHIP Package A, CHIP Package C, and CHIP Package C Expansion), the enrollment at the end of CY 2015 was between 55 and 57 percent of the total number of children ever enrolled during the year. In CY 2014, the year-end enrollees represented between 48 and 49 percent of the ever enrolleds during the year. [9] Exhibit II.4 below shows the difference between enrolled at the end of the calendar year (light colors) and enrolled at any time during the year (dark colors)

Exhibit II.4

Percent of Children Enrolled (light color) and Ever Enrolled (dark color), by Calendar Year

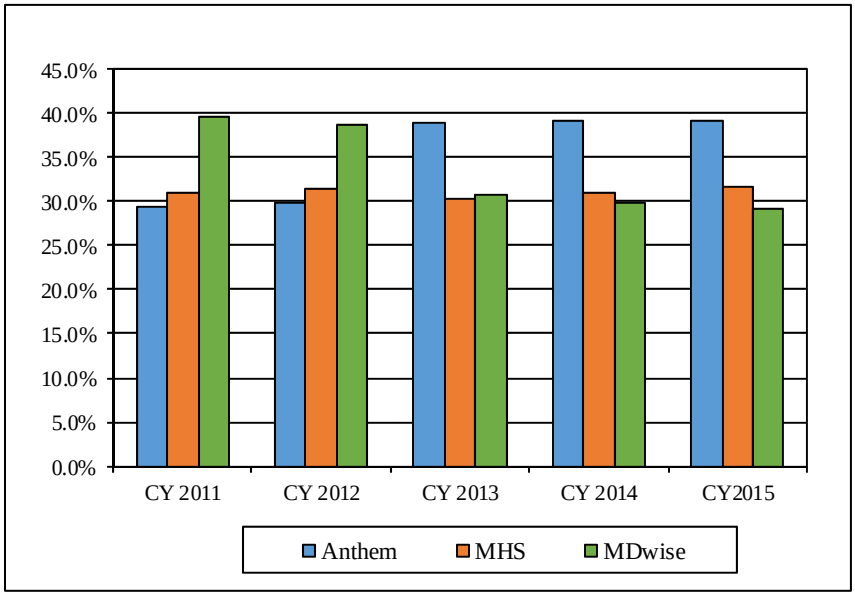


Source: Indiana's FSSA Enterprise Data Warehouse

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There has been little movement in distribution of CHIP members across the MCEs in the last three years. At the end of CY 2015, Anthem had 39.1 percent of all CHIP enrollees, MHS had 31.7 percent and MDwise had 29.1 percent. Compared to CY 2011, however, there has been a change in the enrollment mix. Anthem has increased its percent of enrollees by 10 percentage points while MDwise has lost 10 percentage points. MHS has remained unchanged in the last five years.

Exhibit II.5

Percent of CHIP Enrollment by MCE at End of Each Calendar Year



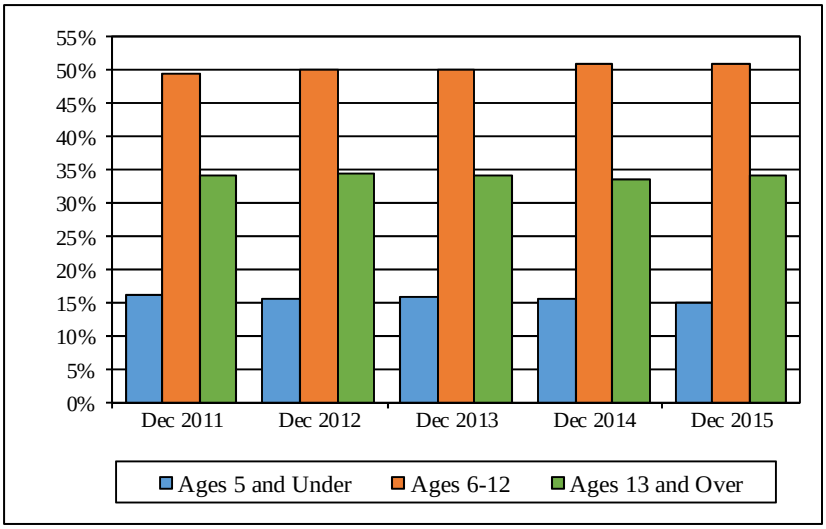
Source: Indiana's FSSA Enterprise Data Warehouse

[9] A member is only counted once in the year in the ever enrolled count within one of the three CHIP packages, but may be counted in more than one package within CHIP during the year.

Demographic Profile of CHIP Members

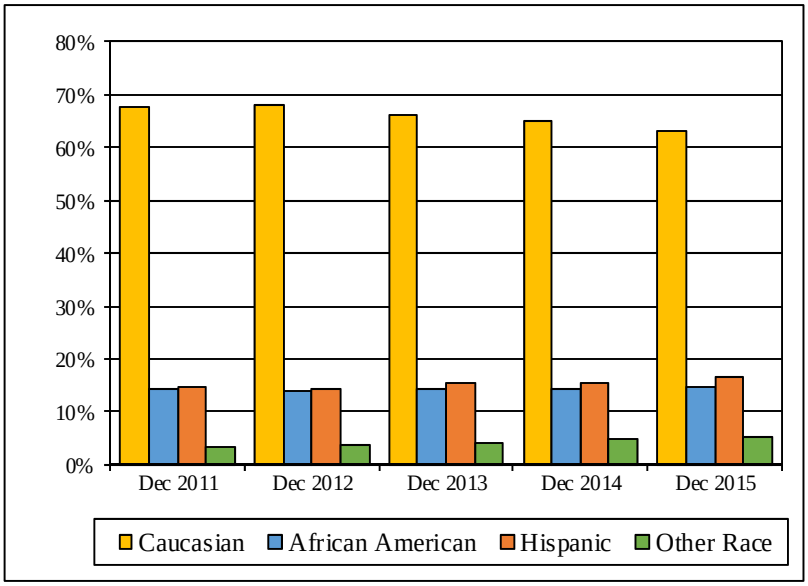
Half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Just fewer than 35 percent of CHIP enrollees are teenagers, while the remaining 15 percent are under age 6. This distribution has been the case since the CHIP was introduced.

Exhibit II.6
Percent of CHIP Enrollment by Age Group at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

Exhibit II.7
Percent of CHIP Enrollment by Race/Ethnicity at End of Each Calendar Year



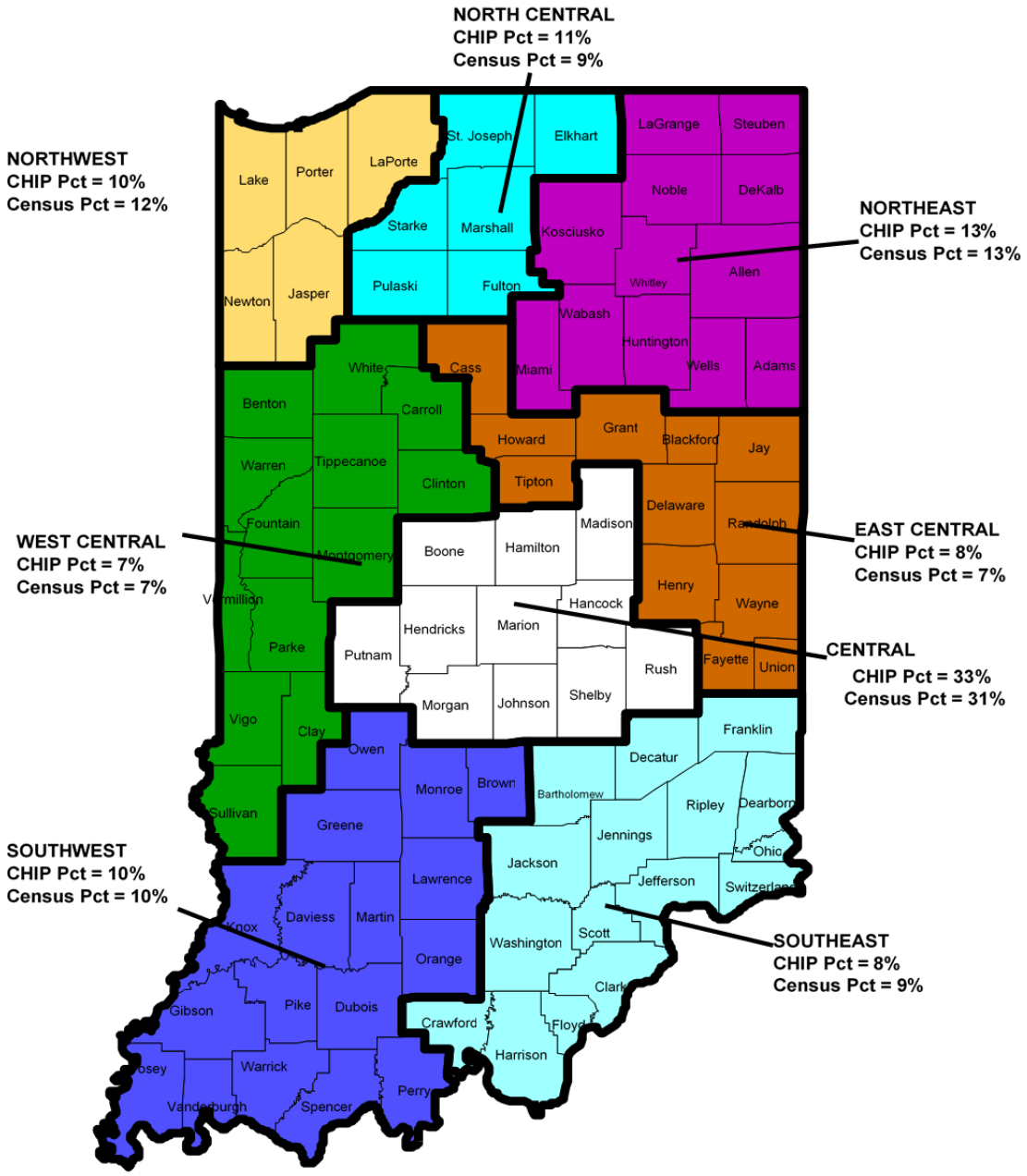
Source: Indiana's FSSA Enterprise Data Warehouse

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 14.8 percent and 16.7 percent, respectively, of the CHIP enrollment at the end of CY 2015. This compares to 13.5 percent and 7.6 percent, respectively, of all children living in Indiana according to the U.S. Census estimate.[10] The proportion of children enrolled in CHIP by race/ethnicity has been steady in the last five years.

[10] U.S. Census Bureau, Current Population Survey for Indiana 2015. http://www.census.gov/hhes/www/hlthins/hlthins.html

B&A compared CHIP members enrolled to the total child population in Indiana as of July 2015. The distribution of CHIP members by region matches the overall child population in Indiana within one percentage point, with the exception of the North Central region (11 percent CHIP percentage and 9 percent census percentage) and Northwest region (10 percent CHIP percentage and 12 percent census percentage) and Central region (33 percent CHIP percentage and 31 percent census percentage). The regions are defined by the OMPP.

Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2015



III

Review of Access and Availability of Providers in Indiana's CHIP

Access Facts at a Glance

- Availability of primary medical providers has increased considerably in Indiana's CHIP
  - Hoosier Healthwise pediatric providers at the end of 2015: 4,614

- On average, only 23% of the slots that primary medical providers in Hoosier Healthwise have committed to for Medicaid members are filled.
  - The median value across the 92 counties is 33%.
  - The highest value among the counties is 84%.

- The average distance to obtain primary care for CHIP children statewide is 16.7 miles.
- The average distance to obtain dental care for CHIP children statewide is 14.4 miles.

Access to Primary Medical Providers

The OMPP requires that Hoosier Healthwise (HHW) members enrolled with its three managed care entities (MCEs) have access to a primary medical provider (PMP) within 30 miles of their residence. Additionally, for particular specialty providers there must be two of each specialty type within 60 miles of the member's residence. In this section, Burns & Associates (B&A) examines the availability of PMPs and dentists in Indiana's Children's Health Insurance Program (CHIP).

Within the first 30 days of eligibility for CHIP, families may select a PMP for their child. If one is not selected by the end of this period, a PMP is selected for the child near where the family lives, based on provider availability and other factors.

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.[11] When the PMP contracts with an MCE, the PMP identifies whether or not they are willing to accept children as patients. If so, they are considered by the OMPP to be a pediatric provider. The number of pediatric providers in Hoosier Healthwise has grown from just under 2,900 in January 2009 to 4,614 in December 2015.

The PMP agrees to a specific number of Medicaid/CHIP members he/she will see in his/her practice (often called the PMP's *panel size*). The panel size that a PMP negotiates with an MCE does not differentiate between the number of children and the number of adults that the PMP will accept. (The obvious exception is Pediatricians.)

Panel capacity measures how many slots in a PMP's panel are already filled by the PMP's existing patients. It is defined as the number of members enrolled with a PMP divided by the total number of members that the PMP is willing to accept. A physician who sees members from counties outside of the county where he/she practices are included in his/her panel.

It is important to measure panel capacity to assess if there are potential gaps in the state where there are fewer PMPs available to accept new patients. B&A reviewed data compiled by OMPP's fiscal agent, Hewlett Packard Enterprises (HPE), which measured pediatric panel capacity as of December 2015.[12] An average of 116 HHW members was enrolled with each pediatric PMP in this month.

In December 2015, on average statewide the pediatric PMPs' panels were 23 percent full, a reduction from 42 percent from the September 2014 period. This rate varies significantly on a county-by-county basis, however. In Exhibit III.1 on the next page, B&A color-coded each county's PMP panel capacity as tabulated by HPE. Counties colored white (63 out of 92) are those where the PMP panel is less than 40 percent full. There are 19 counties where the panel capacity is 40 to 59 percent full and eight counties where the panel capacity is 60 to 79 percent full. Only two counties (Elkhart and Hancock) are considered potentially at risk since their panel capacity among all providers in the county was more than 80 percent full. Even so, the Elkhart County PMP panels are 81 percent full and Hancock County panels are 84 percent full. This finding is a considerable improvement from last year, when it was found that eight counties were greater than 80 percent full and the 2013 study when 11 counties were greater than 80 percent full. Among the 11 counties with potential concerns in 2013, a net total of 144 additional PMPs were added which mitigates the access concerns in these counties.

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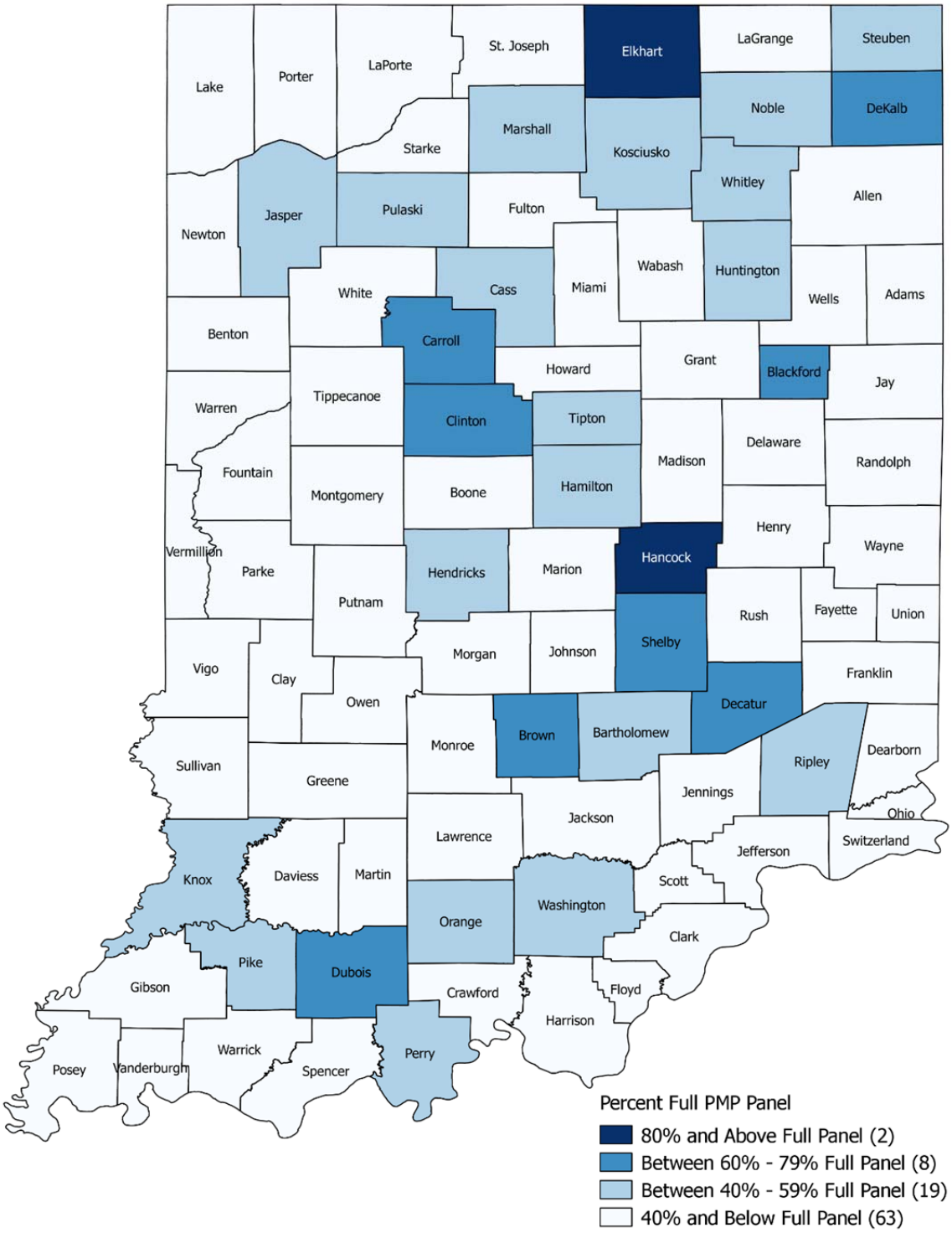
[11] OB/GYNs may, but are not obligated, to sign up as PMPs. They may also sign up as a specialist.

[12] It should be noted, however, that HPE's panel capacity reports include both children and adult patients if the PMP is willing to accept both.

Exhibit III.1
Panel Capacity among Pediatric PMPs, by County



As another method to measure access, B&A used encounters submitted by the MCEs to examine the distance travelled by members to seek primary care visits. Unlike the HPE report, the analysis shown here is specifically for the CHIP population.

B&A identified primary care visits[13] received by enrolled CHIP members in CY 2015. If a member had more than one primary care visit, only the last visit that occurred in the year was retained in the analysis. The coordinates of the member's family residence were matched to the address of the provider's office. In a limited number of cases (less than 3% of all visits), the provider's office coordinates on file were not logical. For example, the provider file from the State's data warehouse states that the provider is located in Marion County but the coordinates listed on the file indicated a location more than 100 miles outside of Marion County (potentially the provider's billing office instead of the service office). In this case, the member's claim was removed when it was found that the distance travelled was greater than 100 miles. In the end, 15,071 CHIP members and 1,455 primary care providers were included in the study.

B&A uses geodistance software to compute the actual one-way driving distance (as opposed to crow flies) for each member-to-provider visit. The visits for all members who live in the same county were added together to obtain a weighted average distance for all members to seek primary care. The average distances were compared at the county level.

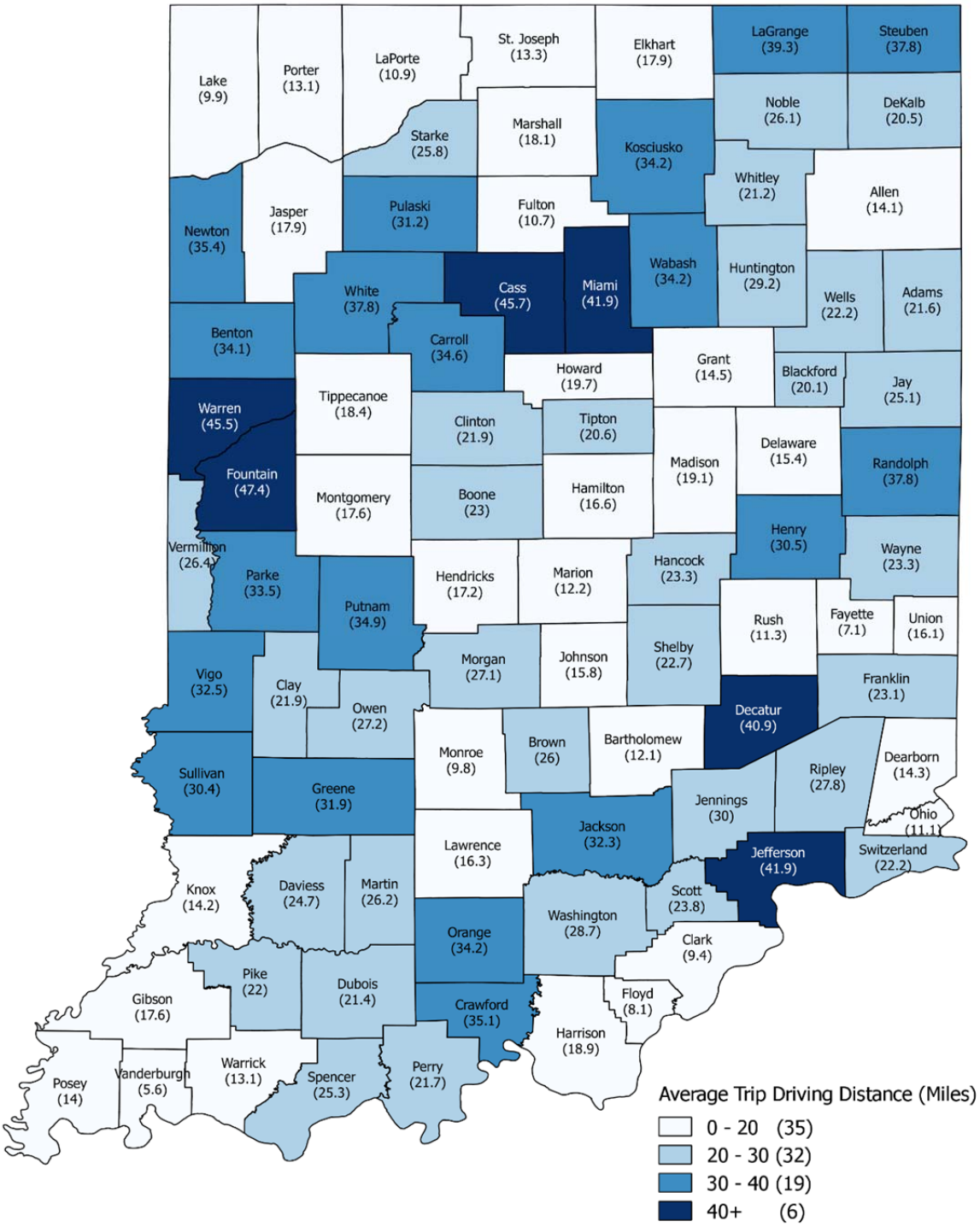
Statewide, the average distance that CHIP members travel to seek primary care is 16.7 miles, which is below the 30 mile threshold set by the OMPP. In 35 of the 92 counties, the average distance travelled was less than 20 miles (refer to Exhibit III.2 on the next page). In 32 counties, the average distance was between 20 and 30 miles. There are 19 counties where the average distance was between 30 and 40 miles, and six counties where the average distance was greater than 40 miles (Cass, Decatur, Fountain, Jefferson, Miami, and Warren). The county with the longest average distance was Fountain County at 47.4 miles.

It should be noted, however, that in three of the counties (Fountain, Jefferson, and Warren) the sample size was very low (only 9 to 12 CHIP members had visits to test in each of these counties) and some of the visits were below 30 miles. Additionally, although a long driving distance implies a potential access issue, the selection of the PMP office to visit may be at the member's choice (such as driving from Covington in Fountain County to Indianapolis).

In Exhibit III.2, the average distance travelled for the CHIP members to see a PMP appears under each county name.

[13] B&A defined primary care visits as encounters with the presence of one of the following CPT codes: 59425-59430, 99201-99215, 99241-99245, 90862, 99381-99397.

Exhibit III.2
Average Driving Distance for CHIP Members to their Last Primary Care Visit in CY 2015
(One-Way Trip)



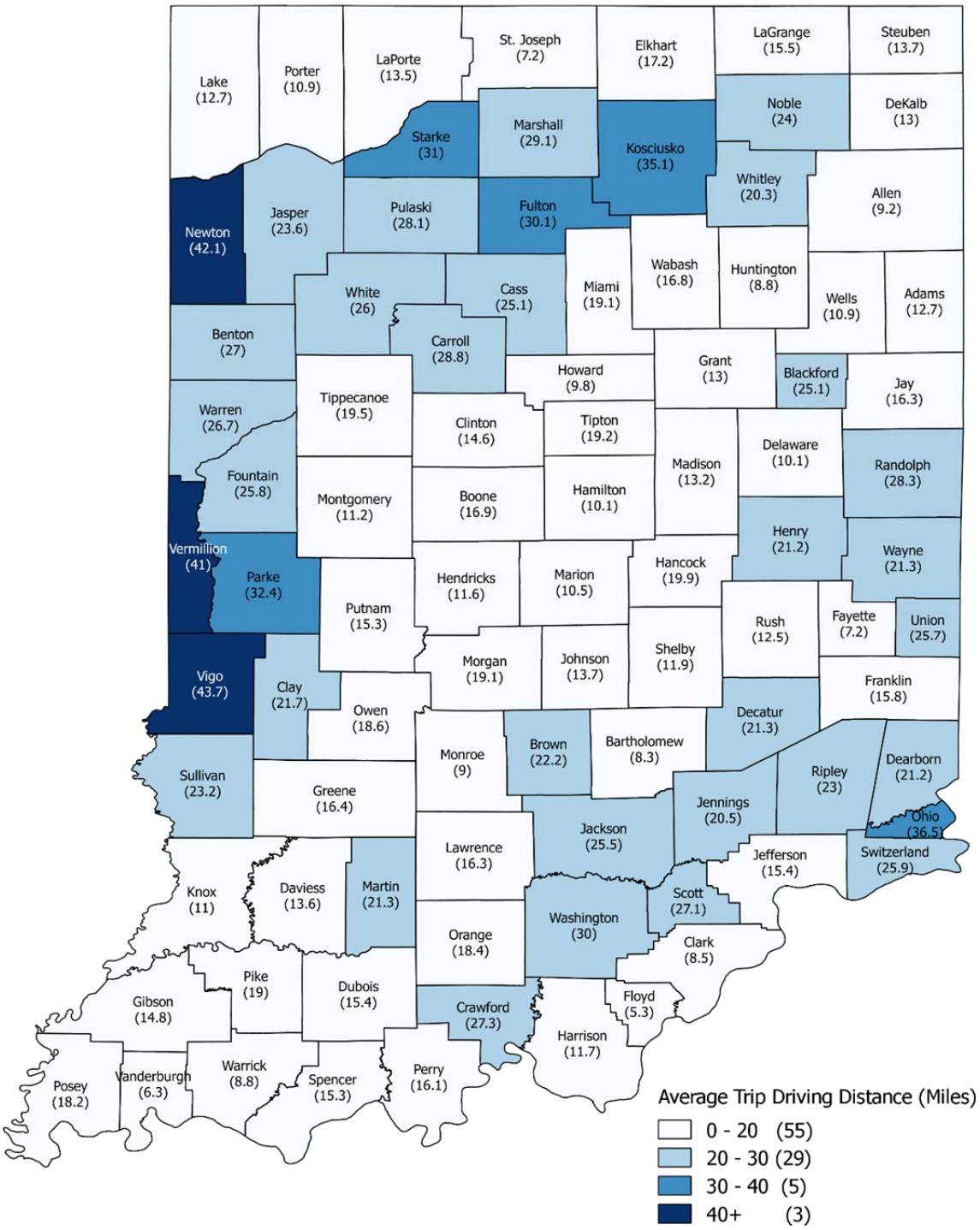
*A small portion of trips (less than 3%) were excluded due to invalid data on the Medicaid provider file for the coordinates of the provider which implied distances in excess of 100 miles.

Access to Dentists

B&A conducted a similar analysis to see where CHIP members access services for dental providers. Utilizing the same exclusion done for PMPs (when the distance from member to provider was determined to be greater than 100 miles), B&A included 31,566 CHIP members and 983 dentists in the study.

Statewide, the average distance that CHIP members travel to seek dental care is 14.4 miles, which is far below the threshold set by the OMPP and even better than the PMP visit average. In 55 of the 92 counties, the average distance travelled was less than 20 miles (refer to Exhibit III.3 on the next page). In 29 counties, the average distance was between 20 and 30 miles. There are five counties where the average distance was between 30 and 40 miles, and just three counties where the average distance was greater than 40 miles (Newton, Vigo and Vermillion). The county with the longest average distance was Vigo County at 43.7 miles.

Exhibit III.3
Average Driving Distance for CHIP Members to their Last Dental Care Visit in CY 2015
(One-Way Trip)



*A small portion of trips (less than 3%) were excluded due to invalid data on the Medicaid provider file for the coordinates of the provider which implied distances in excess of 100 miles.

IV

Service Use Patterns among Populations in Indiana's CHIP

Service Utilization at a Glance

For CHIP members who were enrolled in Federal Fiscal Year 2015:

- 68% had a primary care visit
- 25% had an emergency room visit
- 68% had a preventive dental visit
- 69% obtained a prescription

These are consistent trends during the past three years.

In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also 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 room (ER) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2013, 2014 and 2015 across populations within the CHIP such as by CHIP Package, by age, by managed care entity (MCE) and by race/ethnicity.

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2016. The majority of the services examined are paid for by the MCEs directly to providers and then reported as encounters to the OMPP after the fact. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP. That being said, the findings for FFY 2015 may still be incomplete if the MCEs have not submitted all of their encounter data to the OMPP yet.

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2013, 2014 or 2015. Since the *usage rate* measures the percentage of members that had actually used the service, we are allowing for a minimum of nine months enrollment in the year to identify only those members that would have had an opportunity to actually use the service. Members could be included in one year of our study but not another year based upon their enrollment history. Children were retained in the analysis if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year, as long as they met the nine month minimum and were enrolled in one of the CHIP packages at the end of the year. CHIP members included in the analysis were assigned to one MCE, one race/ethnicity group, and one age group. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member's age was assigned based upon their age at the end of each year.

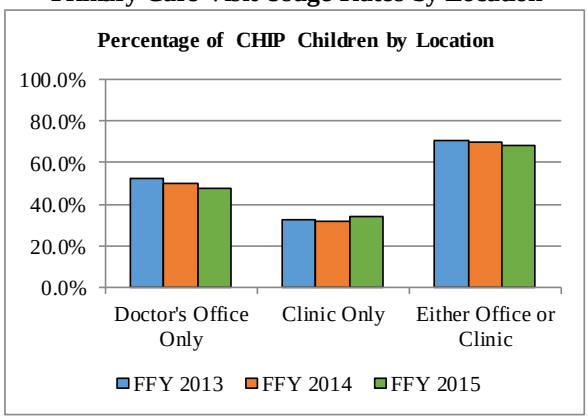
On the other hand, the *utilization per 1,000 member rate* includes every CHIP member enrolled in the month being examined. It is helpful to measure the utilization per 1,000 rate across different populations (e.g., by age or by race/ethnicity) as a way to conduct an apples-to-apples comparison since the number of actual CHIP children enrolled in each population group varies significantly.

Primary Care Visits

Primary care visits include visits to doctor's offices or clinics specializing in primary care and include well-child visits and visits for specific ailments. Although children usually see their PMP for such visits, B&A did not limit our analysis to visits to their PMP exclusively.[14]

On a statewide level, B&A found that 68 percent of CHIP children in the study sample had a primary care visit (either in a doctor's office or a clinic) in FFY 2015. This is a slight decrease from FFY 2014 when 70 percent of CHIP children had primary care visits.

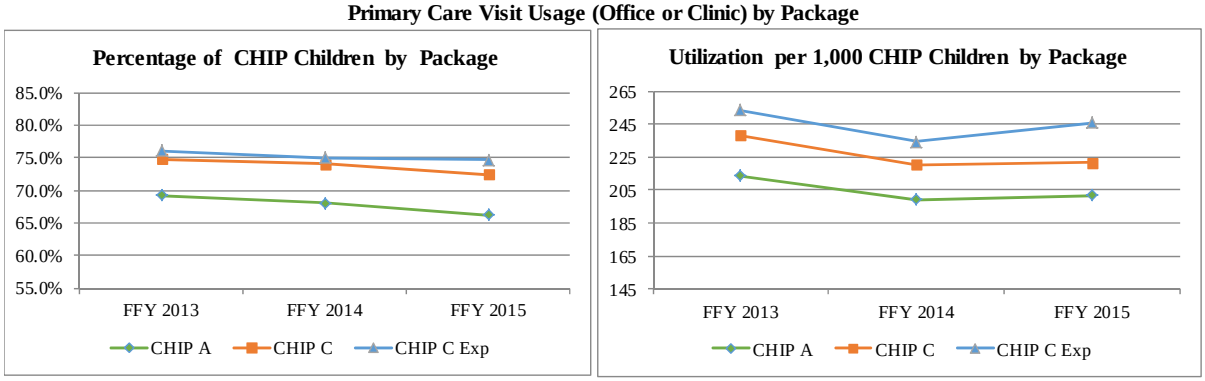
Exhibit IV.1
Primary Care Visit Usage Rates by Location



[14] Similar to the access to PMP map in Chapter III, B&A did limit our definition of primary care visit to encounters containing CPT codes in the range: 59425-59430, 99201-99215, 99241-99245, 90862, 99381-99397.

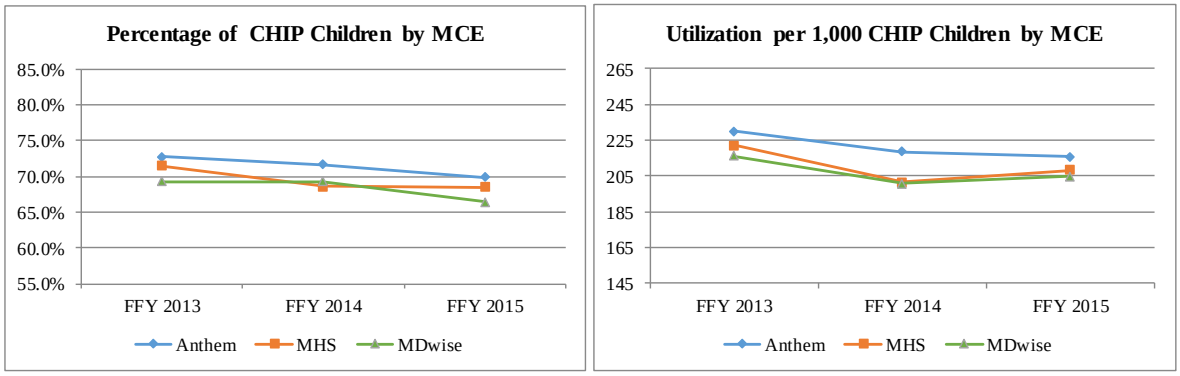
The percent of children that had a primary care visit (either office or clinic setting) has decreased slightly over the past three years for all CHIP Packages. As stated previously, the reduction shown here may be due, in fact, to claims not being fully submitted to OMPP for the FFY 2015 time period. The percentage of MCHIP (Package A) children that had a primary care visit in FFY 2015 was lower (66 percent) than SCHIP (Package C) (72 percent) and SCHIP (Package C) Expansion (75 percent) children. The utilization per 1,000 CHIP children increased in FFY 2015 after decreasing from FFY 2013 to FFY 2014 (refer to Exhibit IV.2, right side). Similar to the chart on the left, children in CHIP Package C Expansion have greater utilization (246 visits per 1,000 members in FFY 2015) than the original CHIP Package C (222 per 1,000) or MCHIP (Package A, 202 per 1,000).

Exhibit IV.2
Primary Care Visit Usage (Office or Clinic) by Package



Although it was observed that the percent of children that had a primary care visit (either office or clinic setting) has decreased over the past two years for all three MCEs, all three MCEs' rates are within three percentage points of one another. When utilization is measured on individual claims per 1,000 CHIP members, Anthem has slightly more utilization (216 visits per 1,000 members in FFY 2015) than MHS (208 per 1,000) or MDwise (205 per 1,000). Said another way, on average, between 2.05 and 2.16 children out of 10 CHIP members that were enrolled with an MCE had a primary care visit each month in FFY 2015.

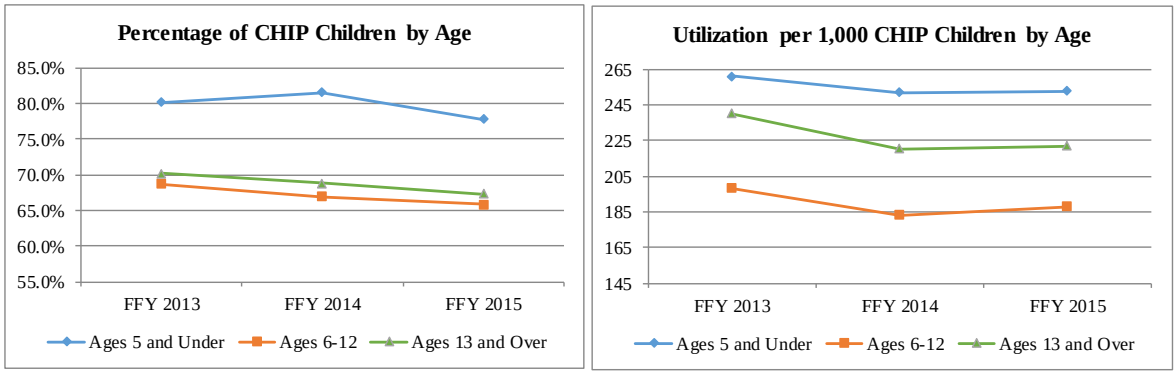
Exhibit IV.3
Primary Care Visit Usage (Office or Clinic) by MCE



Primary care visits are more prevalent among the youngest members, as 78 percent of children ages 5 and younger had a visit in FFY 2015. The percentage was lower for children in the other age groups (66 percent for children ages 6 to 12 and 67 percent of children ages 13 to 18 in FFY 2015). Although the primary care usage rate for children ages 6 to 12 and ages 13 to 18 in FFY 2015 was about the same, the actual number of office visits per 1,000 members was higher among children ages

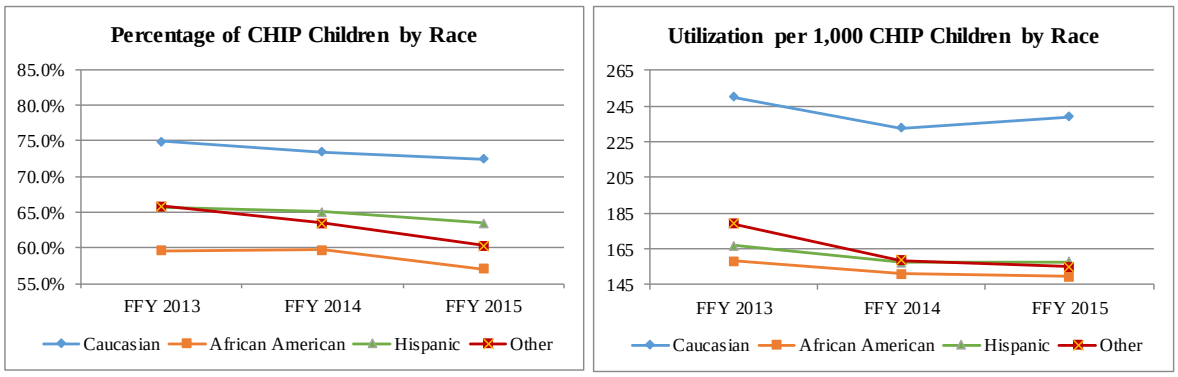
13 to 18 (222 per 1,000) than children ages 6 to 12 (188 per 1,000). It is expected that the children ages 5 and younger will have the highest utilization (252 visits per 1,000) among the age groups. This has remained consistent over the past three years (refer to Exhibit IV.4 below).

Exhibit IV.4
Primary Care Visit Usage (Office or Clinic) by Age



The percent of children that had a primary care visit within each race/ethnicity examined has seen a slight decline over the past three years. When comparing the rates across races/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other races/ethnicities. For Caucasian children, the usage rate was 72 percent in FFY 2015; for Hispanic children and children of other races/ethnicities it was 64 and 60 percent respectively, and for African American children the rate was 57 percent. The utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the years studied, the median rate per 1,000 Caucasian children was 239, whereas the median rate was 151 and 158 among African American and Hispanic children respectively (refer to Exhibit IV.5 below). The utilization rate for children in other race/ethnicities was the same as Hispanic CHIP children.

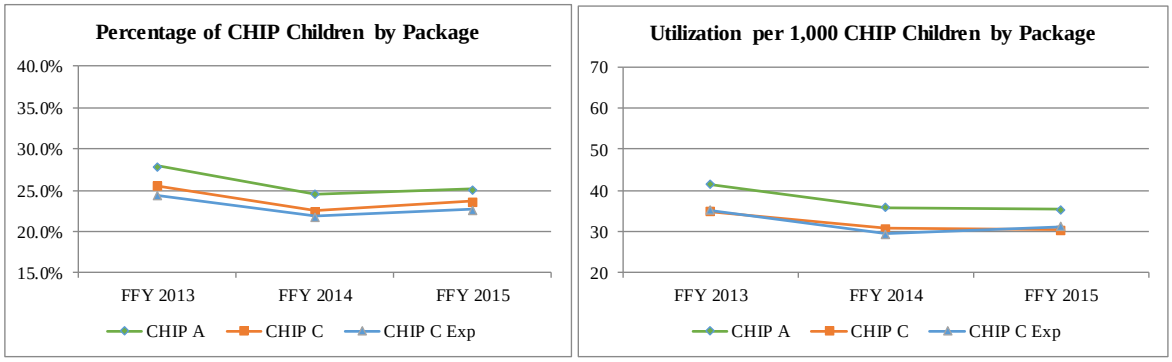
Exhibit IV.5
Primary Care Visit Usage (Office or Clinic) by Race



Emergency Room Visits

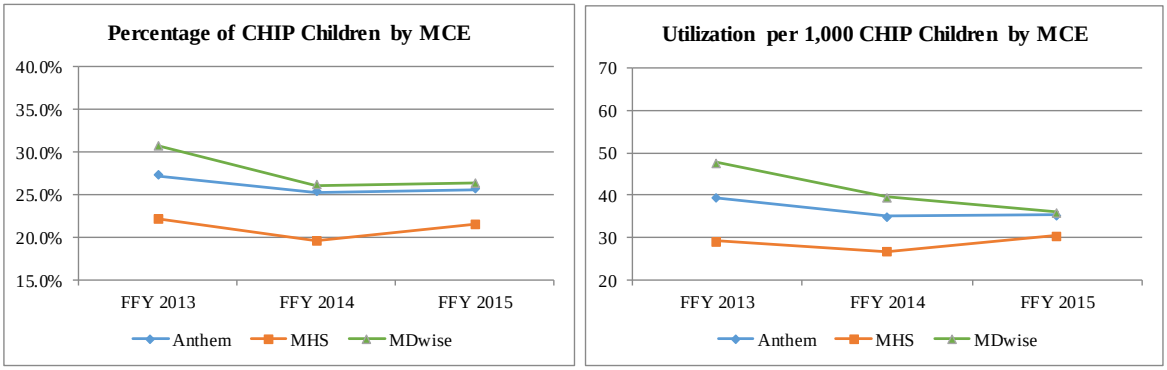
The rate of Emergency Room visits by CHIP children in all Packages has increased slightly from FFY 2014 to FFY 2015 after it decreased from FFY 2013 to FFY 2014. The rate of Emergency Room visits by Package was similar with a spread of only two or three percentage points each year. The expansion portion of SCHIP (Package C) children had the lowest rate (23 percent) of Emergency Room visits in FFY 2015, followed by SCHIP (Package C) children (24 percent) and MCHIP (Package A) children (25 percent). When considering emergency room visits per 1,000 CHIP children, the trend was steady between FFY 2014 and FFY 2015 and also steady across the three packages. There were 30 to 35 ER visits per 1,000 members reported (refer to Exhibit IV.6 below). The ER visits among MCHIP, in particular, has gone down since FFY 2013.

Exhibit IV.6
Emergency Room Usage by Package



There was a difference in the percentage of CHIP children that had an ER visit when analyzed by MCE, but the gap closed in FFYs 2014 and 2015. Among MDwise members in FFY 2013, 31 percent had an ER visit compared to Anthem (27 percent) or MHS (22 percent). In FFY 2015, 26 percent of MDwise and Anthem members had an ER visit compared to 22 percent for MHS. Similarly, MDwise members had more ER visits per 1,000 members (48) than Anthem (39) or MHS (29) in FFY 2013, but the results are closer in FFY 2015. In the most recent year, MDwise had 36 visits per 1,000 members, Anthem had 35 visits per 1,000 members, and MHS had 30 visits per 1,000 members (refer to Exhibit IV.7 below).

Exhibit IV.7
Emergency Room Usage by MCE



The large majority of children (84.9%) who used the ER during FFY 2015 had one or two visits during the year. This compares to 81.3 percent that was reported in FFY 2014. As shown in Exhibit IV.8 below, this statistic is consistent across the three MCEs as well. Each of the MCEs improved upon the number of children who had three to five ER visits when compared to the results shown last year (15.2% of children had three to five visits last year).

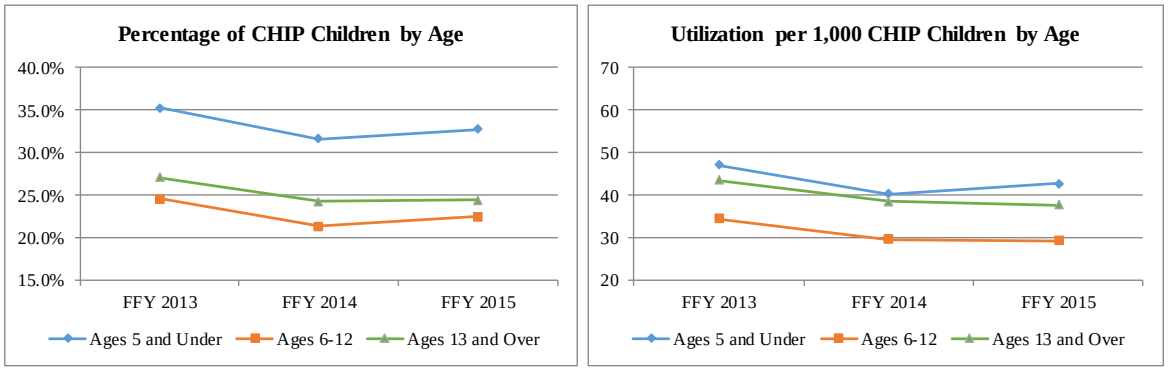
Exhibit IV.8

Rate of ER Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2014 - Sept 30, 2015

	Percentage of All ER Visits by MCE			
Number of ER Visits per Member	**Anthem**	**MHS**	**MDWise**	**Total**
1 to 2	84.7%	85.6%	84.5%	84.9%
3 to 5	12.3%	12.1%	12.8%	12.5%
6 to 10	2.1%	1.9%	2.2%	2.1%
11 to 20	0.7%	0.4%	0.4%	0.5%
More than 20	0.2%	0.1%	0.0%	0.1%

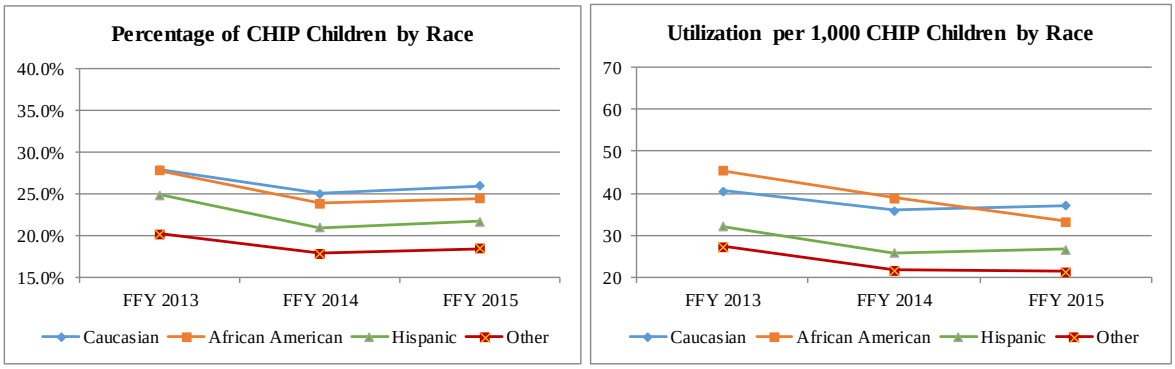
Differences in ER use are found by age group within the CHIP. Higher use was found among children ages 5 and under (33 percent of all members in this age group used the ER in FFY 2015). ER use was lowest among children ages 6 to 12 (23 percent of all members in the age group used the ER in FFY 2015). Like the pattern seen overall, ER usage has increased slightly for all age groups between FFY 2014 and FFY 2015. The utilization rate for ER, however, has been steady during this time (refer to Exhibit IV.9 below). The rate was 43 visits per 1,000 members on average for children ages 5 and under and 38 visits per 1,000 members for 13 to 18 year olds in FFY 2015. The rate was lower for children ages 6 to 12 (29 visits per 1,000 members).

Exhibit IV.9
Emergency Room Usage by Age



The percent of CHIP children that had an emergency room visit remained steady for each race/ethnicity in FFY 2015. There were 26 percent of Caucasian children with an ER visit, 25 percent of African American children, 22 percent of Hispanic children, and 18 percent of children from other races/ethnicities. The utilization rate per 1,000 decreased significantly over the three years, however, for African American children (45 ER visits per 1,000 in FFY 2013 to 33 visits per 1,000 in FFY 2015). For children in other race/ethnicities, the ER visit per 1,000 rate has remained steady. Caucasian children now visit the emergency room more frequently than their peers. (Refer to Exhibit IV.10 on the next page).

Exhibit IV.10
Emergency Room Usage by Race



Potentially Preventable Emergency Room Visits

For each ER visit made by a CHIP member in the previous exhibits, B&A analyzed to determine whether or not the ER visit could have been prevented. When this determination is made, it is called a potentially preventable visit, or PPV.

PPVs are ER visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) in which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate.

The bases upon which ER visits are assessed to determine if they are PPVs is 3M's Enhanced Ambulatory Patient Groupings (EAPGs). The EAPGs are the classification system used in 3M's outpatient hospital payment classification system. It should be noted that there are 555 different EAPGs, but only those EAPGs which are related to ambulatory sensitive conditions are tested for PPVs. Each ER visit is submitted to 3M's software and, using the logic embedded in the software, assesses whether or not the ER visit was a PPV or not a PPV. The primary criteria used to flag a visit as a PPV or not are the diagnosis codes submitted on the ER claim.

A PPV rate is computed which is simply: Number of ER visits tagged as PPVs / All ER visits

Exhibit IV.11 shows the PPV results for ER visits by CHIP members in FFY 2015. The overall rate was 81.8 percent, meaning that more than eight of ten ER visits was potentially preventable according to the software. The term *potentially preventable* is used because the software only has the diagnoses reported on the claim to make the assessment, not individual medical charts. The PPV rate by age group within CHIP is also similar, with the youngest children having a slightly higher PPV rate. Results shown here are consistent with what was found on findings where all of the Hoosier Healthwise population was studied.

Exhibit IV.11
Distribution of PPV and Non-PPV ER Visits for CHIP Children in Federal Fiscal Year 2015, by Age Group

PPV Status	Age 1 - 5	Age 6 - 12	Age 13 and Above	All Ages
PPV	4,369	8,899	7,360	20,628
Non-PPV	854	1,967	1,782	4,603
Total	5,223	10,866	9,142	25,231

PPV Status	Age 1 - 5	Age 6 - 12	Age 13 and Above	All Ages
PPV	83.6%	81.9%	80.5%	81.8%
Non-PPV	16.4%	18.1%	19.5%	18.2%
Total	100.0%	100.0%	100.0%	100.0%

B&A also examined the ambulatory patient groups (EAPGs) to assess the types of conditions that CHIP children were accessing the ER for and which of these were potentially preventable. Although there were 125 different conditions reported overall, in Exhibit IV.12 it was found that 79.4 percent of all PPVs for children age 1 to 5 were concentrated in the top 10 EAPGs by volume. For children age 6 to 12, 74.6 percent of PPVs were in the top 10 categories; for children age 13 and above, 65.5 percent.

The most common reason for PPVs was found to be EAPG number 562: Infections of Upper Respiratory Tract & Otitis Media (ear infection). This accounted for almost one-third of all PPVs among the youngest age group and almost one-quarter of all PPVs in the age 6 to 12 group. For teenagers, another common condition where PPVs were found was EAPG number 661: Level II Other Musculoskeletal System and Connective Tissue Disease (e.g., sprains, spasms, twisted joints).

Exhibit IV.12
Top 10 EAPGs in FFY 2015 with Potentially Preventable ER Visits, by Age Group

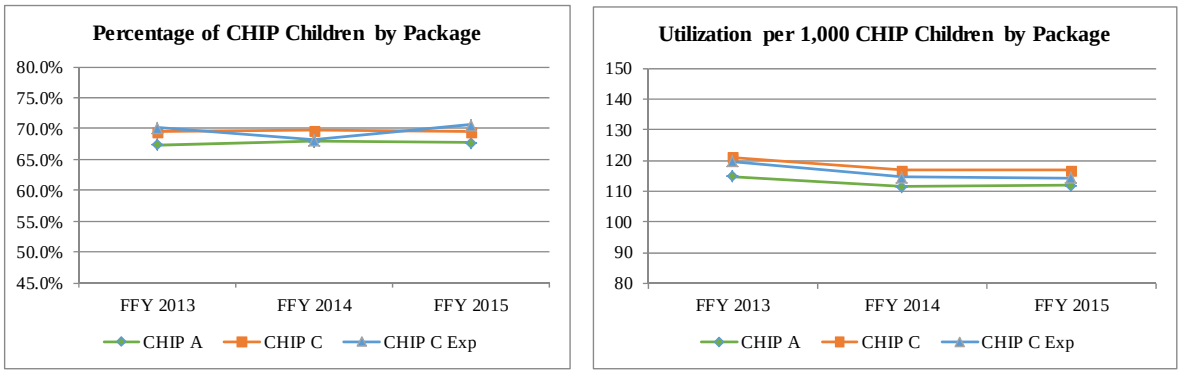
	Age 1 to 5		Age 6 to 12		Age 13 and Above		Total	
	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10	PPVs	Pct in Top 10
Total	**4,369**	**79.4%**	**8,899**	**74.6%**	**7,360**	**65.5%**	**20,628**	**65.8%**
Ambulatory Patient Group (EAPG)								
530 Headaches Other than Migraine					276	3.8%	276	1.3%
562 Infections of Upper Respiratory Tract & Otitis Media	1,330	30.4%	2,018	22.7%	986	13.4%	4,334	21.0%
564 Level I Other Ear, Nose, Mouth, Throat & Cranial/Facial Diagnosis	216	4.9%	487	5.5%			703	3.4%
572 Bronchiolitis & RSV Pneumonia	100	2.3%						
573 Community Acquired Pneumonia	123	2.8%						
575 Asthma			263	3.0%				
576 Level I Other Respiratory Diagnosis	120	2.7%						
604 Chest Pain					273	3.7%		
627 Non-Bacterial Gastroenteritis, Nausea & Vomiting	402	9.2%	528	5.9%	282	3.8%	1,212	5.9%
628 Abdominal Pain			588	6.6%	518	7.0%	1,106	5.4%
661 Level II Other Musculoskeletal System & Connective Tissue Disease			836	9.4%	1,043	14.2%	1,879	9.1%
673 Cellulitis & Other Bacterial Skin Infections					238	3.2%		
674 Contusion, Open Wound & Other Trauma to Skin	200	4.6%	655	7.4%	559	7.6%	1,414	6.9%
675 Other Skin, Subcutaneous Tissue & Breast Disorders	300	6.9%	609	6.8%	408	5.5%	1,317	6.4%
727 Acute Lower Urinary Tract Infections					237	3.2%		
808 Viral Illness	213	4.9%	249	2.8%			462	2.2%
871 Signs, Symptoms & Other Factors Influencing Health Status	466	10.7%	403	4.5%			869	4.2%

Preventive Dental Visits

Dental care is one of the few services that the MCEs are not responsible for managing. Instead, this service is paid directly to providers by the OMPP. The rate of preventive dental care has remained stable for CHIP children in all Packages over the past three years (refer to Exhibit IV.13 below). The percentage of children in MCHIP (Package A), SCHIP (Package C) and SCHIP (Package C) Expansion in FFY 2015 with a preventive dental visit were all between 68 and 70 percent of the total children within each enrollment group.

The same trend was found for utilization per 1,000 members. MCHIP (Package A) children had 112 services per 1,000 members while SCHIP (Package C) Expansion children had 114 services per 1,000 members and SCHIP (Package C) had 117 services per 1,000 members. Utilization per 1,000 members has remained stable over the past three years.

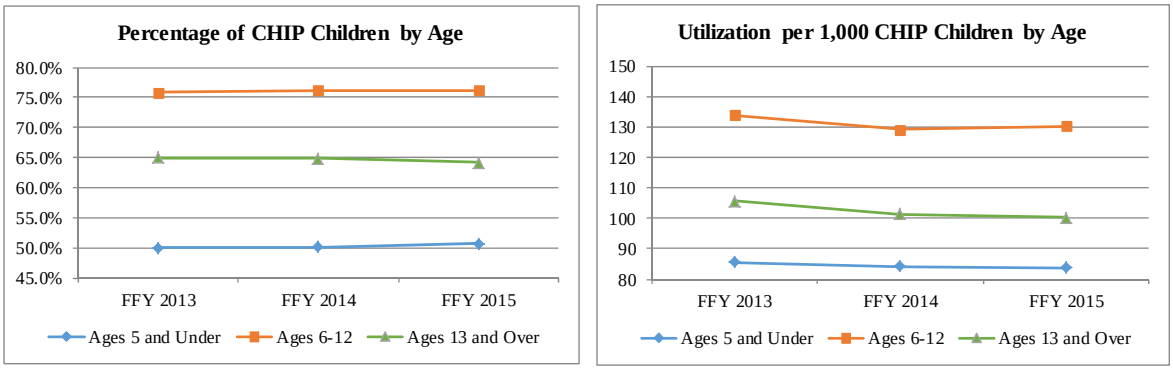
Exhibit IV.13
Preventive Dental Care Usage by Package



Over the past three years, the rate of dental visits has remained steady for all ages, though children ages 6 to 12 are most likely to have received a preventive dental visit (76 percent of the members in FFY 2015), which is significantly higher than teenagers (64 percent). The youngest children had the lowest usage rate (51 percent) given that this group includes toddlers.

A similar pattern was found by age group when measuring the utilization rate of dental visits per 1,000 CHIP members. The rate of 130 visits per 1,000 members ages 6 to 12 remained consistent with prior years and also remains higher than the rate for children ages 13 to 18 (100 visits per 1,000 members) and higher than the rate for children ages 0 to 5 (84 visits per 1,000 members). (Refer to Exhibit IV.14 on the next page).

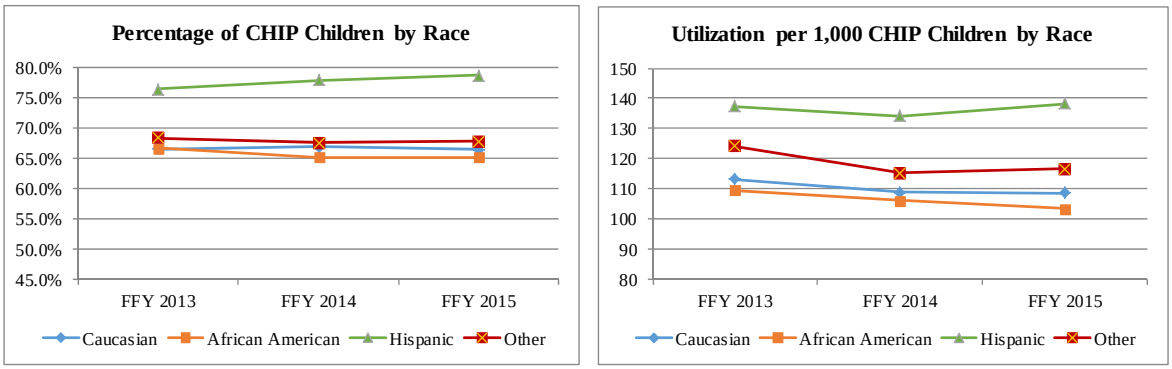
Exhibit IV.14
Preventive Dental Care Usage by Age



The preventive dental usage rate by race/ethnicity increased slightly from FFY 2013 to FFY 2014, then remained steady from FFY 2014 to FFY 2015. There is little difference from the statewide average in the usage rate among most race/ethnicities, except for Hispanic children where 79 percent of children had a preventive dental visit compared to the other groups where approximately 66 percent received a preventive dental visit in FFY 2015.

There is a slight variation in the utilization rate per 1,000 CHIP members among races/ethnicities. Hispanic children are most likely to have a preventive dental visit at 138 visits per 1,000 members in FFY 2015, while African American children and Caucasian children were least likely at 103 visits and 109 visits per 1,000 members, respectively, in FFY 2015. Children of all other races had 117 visit per 1,000 members in FFY 2014 (refer to Exhibit IV.15 below).

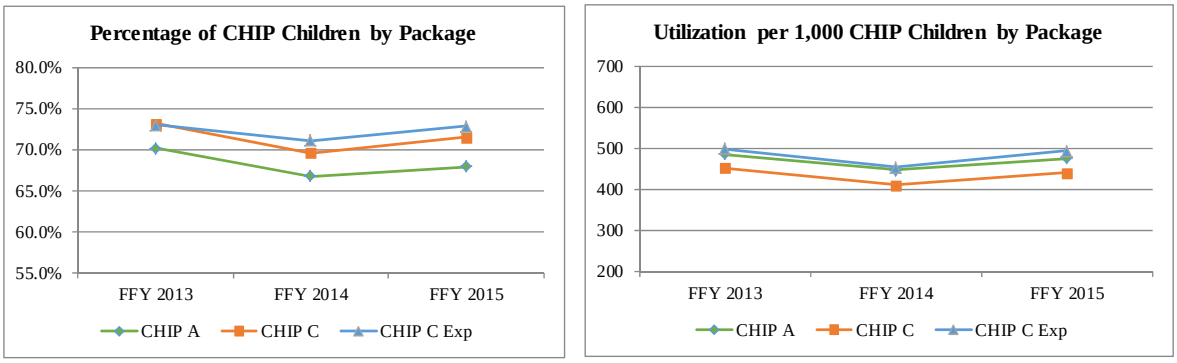
Exhibit IV.15
Preventive Dental Care Usage by Race



Pharmacy Prescriptions

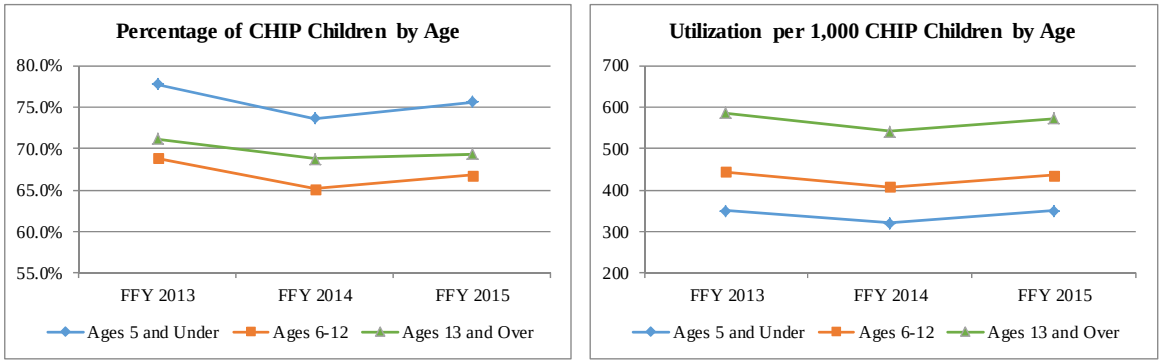
The administration of the pharmacy benefit is the other major service managed by the State and is not included in the capitation payment paid to the MCEs. MCHIP (Package A) children are least likely to have a prescription with 68 percent in FFY 2015. SCHIP (Package C) children (original and expansion populations) are more likely to have a prescription with a rate of 72 and 73 percent, respectively, in FFY 2015. Whereas the utilization per 1,000 members decreased slightly among all three groups from FFY 2013 to FFY 2014, the utilization went back to 2013 levels in FFY 2015. MCHIP (Package A) received 474 prescriptions per 1,000 members, SCHIP (Package C) members received 440 prescriptions per 1,000 members, and SCHIP (Package C) Expansion members received 494 prescriptions per 1,000 members in FFY 2015. (Refer to Exhibit IV.16)

Exhibit IV.16
Pharmacy Usage by Package



There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children ages 5 and under over the last three years (76% in FFY 2015). Children in the two older groups were slightly less with 69 percent of teenagers and 67 percent of children ages 6 to 12 in FFY 2015. Though fewer children in the older age groups obtained a prescription, they obtained more of them in the last three years. The prescriptions per 1,000 members in FFY 2015 was 350 for children age 5 and under, 436 for children age 6 to 12, and 573 for children age 13 to 18 (refer to Exhibit IV.17 below).

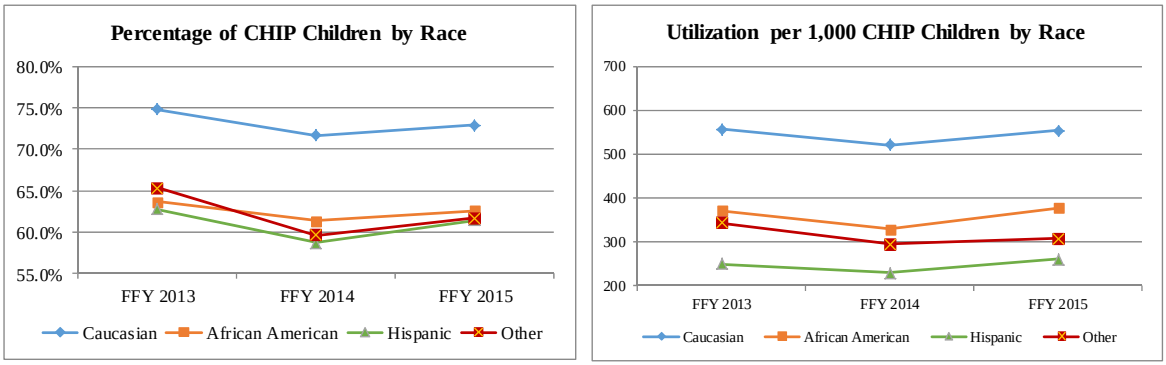
Exhibit IV.17
Pharmacy Usage by Age



Comparing across races/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities. In FFY 2015, the usage rate among Caucasians children was 73 percent but it was 62 to 63 percent for children of other race/ethnicities. This has been a consistent finding in the CHIP for the last seven years.

The trend for the number of prescriptions filled per 1,000 CHIP children by race/ethnicity followed the same pattern found for the usage rate trend in FFY 2015. Caucasian children have a utilization rate of 553 prescriptions per 1,000 members each month, which is 46 percent higher than the rate for African-American children (377 prescriptions per 1,000 children) and more than double the rate of children of Hispanic children (261 prescriptions per 1,000 children). It is 80 percent higher than the rate seen for children of other race/ethnicities (308 prescriptions per 1,000 children). (Refer to Exhibit IV.18 below.)

Exhibit IV.18
Pharmacy Usage by Race



V

Measuring Quality and Outcomes in Indiana's CHIP

Selected Outcome Results at a Glance

- The percent of children receiving well child visits continues to improve in Hoosier Healthwise (results are based on national HEDIS measures, Medicaid and CHIP combined)
    - For children in first 15 months of life: 16th highest among state Medicaid agencies
    - For children age three to six: 16th highest among state Medicaid agencies
    - For adolescents: 11th highest among state Medicaid agencies

- Indiana also outperforms most state Medicaid agencies in some other HEDIS measures:
    - For follow-up visits after ADHD medication was prescribed: 12th highest
    - For follow-up visits within 30 days of a mental health hospitalization: 5th highest
    - For timeliness of prenatal and postpartum care: 3rd highest

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 staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCE's site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity[15] to conduct an annual external quality review of each MCE and reviews the results with each MCE.

Measuring outcomes have become a focused effort of the OMPP in recent years, particularly with respect to children's care. 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 three HHW MCEs to report the results of HEDIS®[16] and CAHPS®[17] measures. The HEDIS are nationally-recognized measures since the health plans that report their results nationally use standard definitions and results are attested by certified auditors of the National Committee of Quality Assurance. The OMPP compares the results of the HEDIS measures across the three 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 survey is separated between one for adults and one for parents of children. The OMPP requires the MCEs to administer each survey annually.

2. Separately, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Centers for Medicare and Medicaid (CMS) was required to develop a core set of measures related to children's health and to collect the results of these measures on a voluntary basis from state Medicaid and CHIP programs. Currently, there are 24 core measures identified by CMS. 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. For example, current goals include 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.

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[15] Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.
[16] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).
[17] 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 from the prior year. Therefore, in Calendar Year (CY) 2015, tabulations were collected on HEDIS rates for 2014 utilization. The HEDIS measures report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome.

Exhibit V.1 presents the HEDIS results for access to primary care. There are differences in the methodology used by B&A in reporting primary care usage (shown in Chapter IV) and the HEDIS results. B&A's analysis was an administrative review (i.e. claims data) and includes all claims reported to OMPP. The HEDIS analysis includes a sample of HHW members but incorporates both an administrative review and a medical chart review. The HEDIS results represent the percentage of children who had a visit with their primary care practitioner (called PMPs) in the measurement year.

Exhibit V.1 below shows the five year trend reported for each MCE for four age groups. For the youngest children age 12 to 24 months (upper left box), each of the MCEs have similar access at 96 percent. For the age group 25 months to six year (upper right box), Anthem was lower than the other two MCEs, but then went above, and now all three MCEs have reported 88 percent in the most recent HEDIS year. For children age 7 to 11 years (lower right box), Anthem and MHS reported the same result at 91 percent, but MDwise reported almost full access at 99 percent. For the oldest children in the program (lower right box), all three plans reported 91 percent.

Exhibit V.1
Summary of Results from HEDIS Access to Primary Care Measures (Percentage of Total)

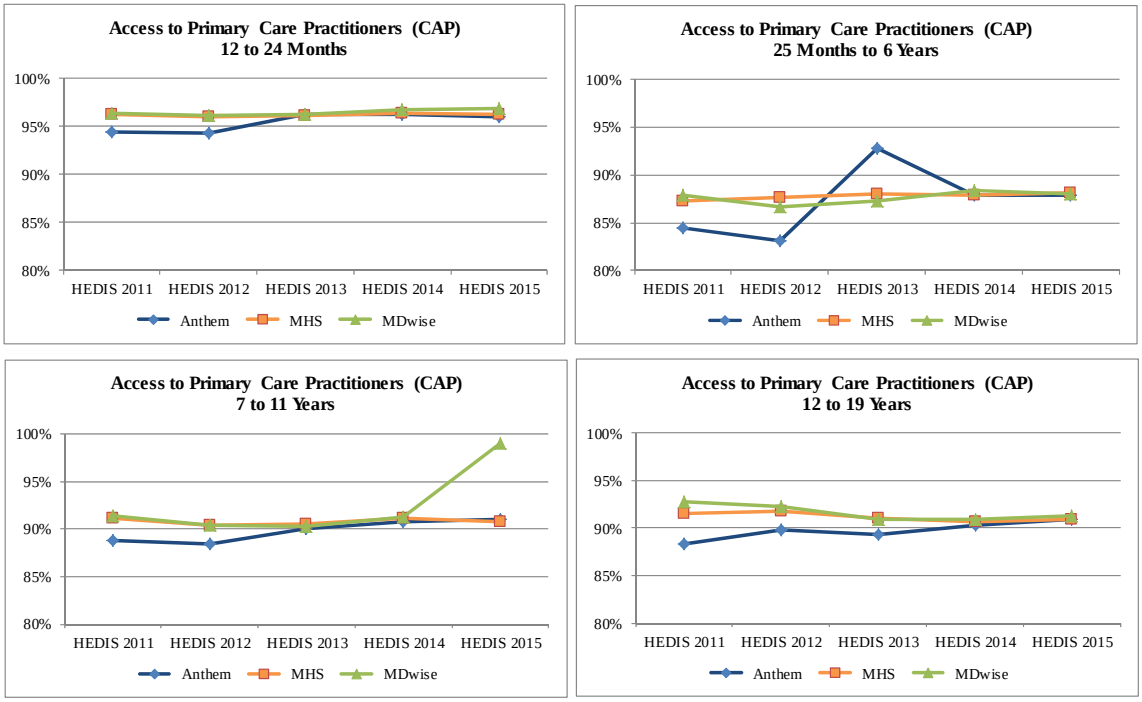


Exhibit V.2 shows the five year trend for well care visits for each MCE. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life (upper left box), the rate shown represents the percentage of children with six or more well child visits. For children in the ages 3-6 years (upper right box) and adolescents (lower left box), the rate shown represents the percentage of children that had at least an annual visit.

Significant improvement has been found for the rate of well care visits among infants. In the most current reporting year (HEDIS 2015), Anthem reported 71 percent of infants had six or more visits, MHS reported 72 percent, and MDwise reported 77 percent. There has also been improvement in the annual visits for the other age groups. For children age 3-6, Anthem reported that 78 percent had an annual well care visit, while MHS and MDwise both reported 74 percent. For adolescent well care, both Anthem and MHS reported 61 percent while MDwise reported 74 percent.

Another measure for well child care relates to immunizations (bottom right box). There is a HEDIS measure to report 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 following immunizations:

Four doses of diphtheria-tetanus (DTaP)	Three doses of influenza (HiB)
Three doses of polio (IPV)	Three doses of Hepatitis B
One dose of measles-mumps-rubella (MMR)	One dose of chicken pox (VZV)
Four doses of pneumococcal conjugate vaccine to prevent bacterial meningitis	

Anthem and MHS improved its results in the most recent year while MDwise remained steady. Both Anthem and MDwise reported a rate of 68 percent and MHS reported a rate of 71 percent.

Exhibit V.2
Summary of Results from HEDIS Well Care Measures (Percentage of Total)

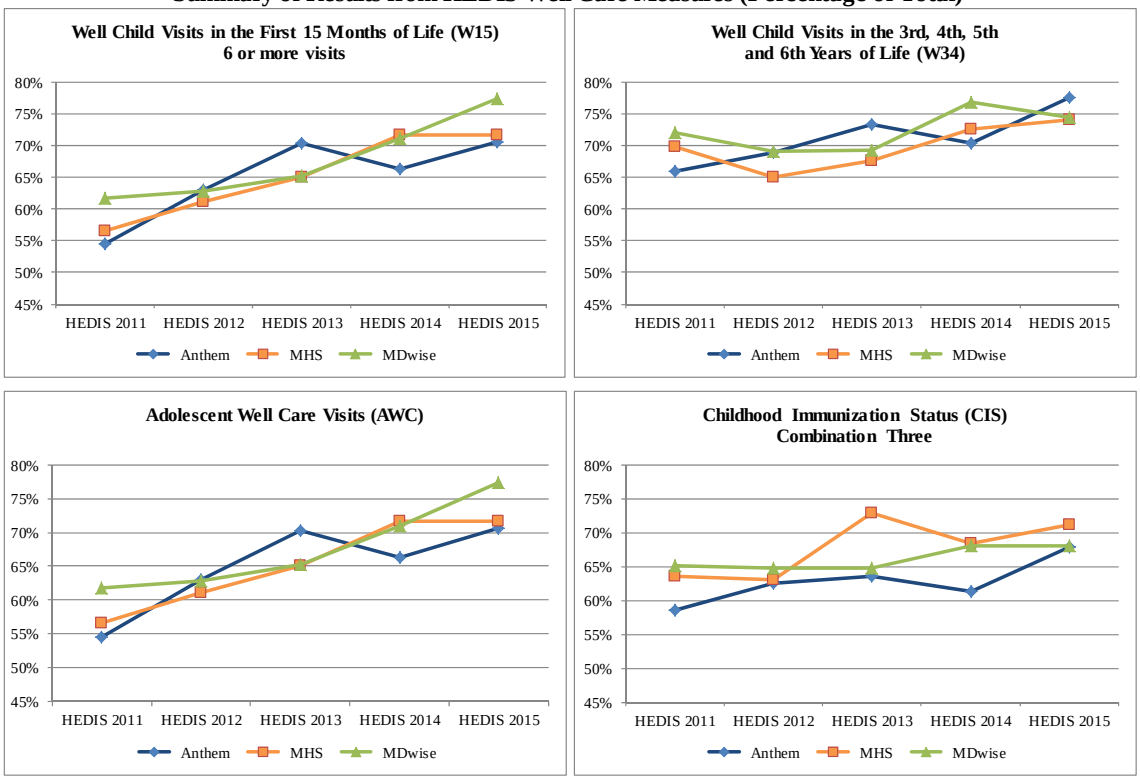
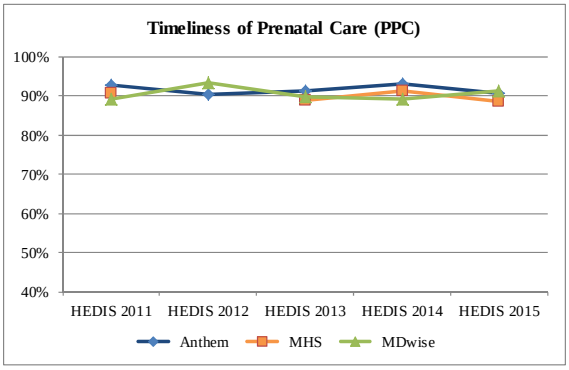


Exhibit V.3 presents the results from HEDIS measures related to prenatal and postpartum care. The timeliness of prenatal care measures the percentage of mothers who had a prenatal visit either in the first trimester or within 42 days of enrolling in Medicaid. The postpartum care measure captures the percentage of mothers who had a postpartum visit between 21 and 56 days after delivery. The frequency of ongoing prenatal care measures the amount of care received over the course of the pregnancy. HEDIS measures are stratified by the percentage of expected visits received. The most common measure is shown in this exhibit – the percentage of mothers who received 81 or more percent of their expected visits during the pregnancy.

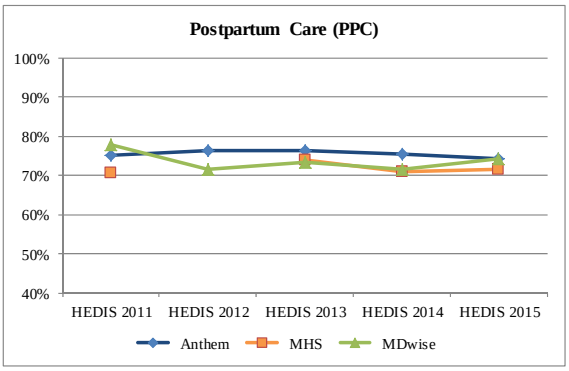
The results for timeliness of prenatal care (upper left box) have been very steady in the last five years and consistent across the three MCEs. In the most recent year of HEDIS 2015, both Anthem and MDwise reported a rate of 91 percent and MHS reported 89 percent. Postpartum care has also been very consistent (upper right box). Both Anthem and MDwise reported a rate of 74 percent and MHS reported a rate of 72 percent.

The frequency of ongoing prenatal care (bottom box) is consistent across the MCEs, but it has decreased slightly in the most recent HEDIS year. Anthem reported that 80 percent of mothers received 81 or more percent of expected visits, MDwise reported 79 percent, and MHS reported 77 percent.

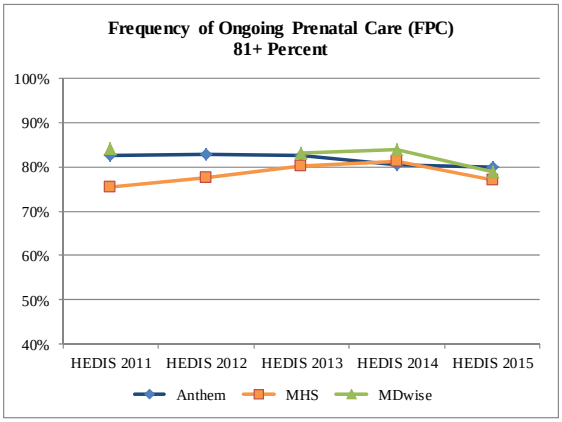
Exhibit V.3
Summary of Results from HEDIS Prenatal and Postpartum Measures (Percentage of Total)



* MHS not reportable in 2012.



* MHS not reportable in 2012.



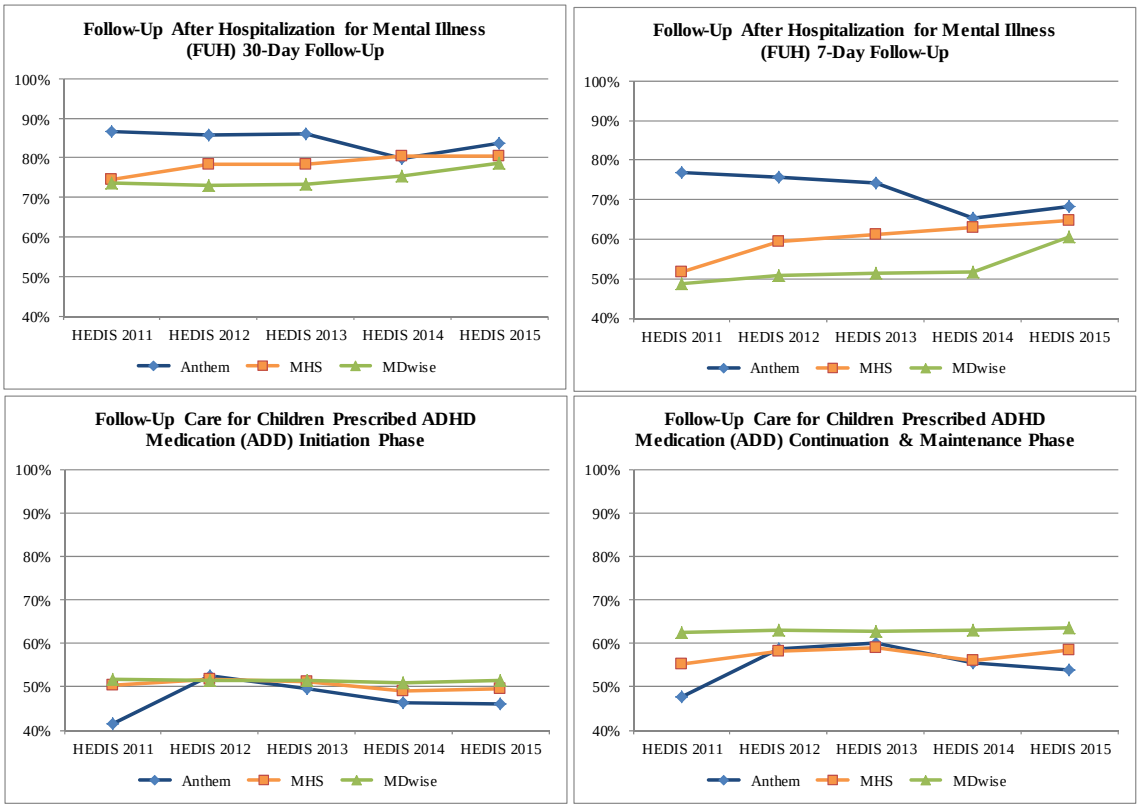
* MDwise not reportable in 2012.

Exhibit V.4 presents the results of behavioral health HEDIS measures. It should be noted that for the FUH measures (top boxes) which measure the percentage of patients with follow-up visits in the community after a hospitalization for mental illness, the measures include both children and adults. But since HHW primarily enrolls children, the children and adolescents comprise a significant number of the members studied in these measures. The other measures (lower boxes) measure 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, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. In the initiation phase, the measure is the percentage of children who had a follow-up visit within 30 days of prescribing. In the continuation and maintenance phase, the measure is isolated to those who continued taking ADHD medication and had at least two visits after the first visit in the initiation phase.

Results for the follow-up visit within 30 days of a hospitalization are high and are consistent across the MCEs (upper left box). Anthem reported 84 percent compliance, MHS reported 80 percent and MDwise reported 79 percent in the HEDIS 2015 year. More immediate follow-up within seven days does not have as high compliance, but it has improved in the last five years. Anthem reported 68 percent, MHS reported 65 percent and MDwise reported 60 percent.

The compliance related to visits after being prescribed ADHD medication could see improvement. The three MCEs reported consistent results in both the initiation phase measure (46% - 52% reported in HEDIS 2015) and in the continuation and maintenance phase measure (54% - 64% reported in HEDIS 2015).

Exhibit V.4
Summary of Results from Selected Behavioral Health HEDIS Measures (Percentage of Total)



Indiana's HEDIS Results Compared to Other States

Each year, state Medicaid agencies are required to submit a report on their CHIP program to the Centers for Medicare and Medicaid (CMS). Among other programmatic features that are reported, the states are required to submit information on a set of child measures. There are 24 measures in all. Although these measures are considered mandatory, in some instances not every state is submitting results for every measure.

The annual CHIP report submission has been in place for over ten years. In the last few years, the Department of Health and Human Services (HHS), which is the federal agency responsible for CMS, has hired an evaluator to examine the results of the annual submissions by all the states. In particular, the evaluator has compiled the results reported by each state for the child core measures.

Information is summarized in an annual report to HHS. There is a lag in reporting. The Medicaid agencies are required to submit their annual report by December 31 each year. The evaluator then usually submits its report later in the following year. The 2015 evaluator report (based on state December 31, 2014 submissions) is not yet public. B&A reviewed the 2014 and 2013 evaluation reports submitted to HHS. In these reports, results from the child core measures were included on a number of HEDIS measures (the child core measures include many HEDIS measures). The HEDIS years reported on in the most recent two reports are HEDIS 2013 and 2012, which means that the experience year of the services delivered in the HEDIS measures was Calendar Years 2012 and 2011, respectively.

Exhibit V.5 compares Indiana Medicaid's submissions over the two years and shows how Indiana compares to other states. It should be noted that CMS allows states to report HEDIS results for children in CHIP and Medicaid combined. Indiana is like many states that report in this manner. Therefore, the results shown in Exhibit V.5 actually reflect results from Medicaid programs for all of their children, not just those enrolled in their CHIP programs.

Among the 13 HEDIS measures shown, Indiana showed improvement from HEDIS 2012 to HEDIS 2013 on eight measures, held steady on one measure, and reported lower results (although not significantly lower) on four measures. Since this data has been reported, Indiana has seen further improvement, particularly in the well child visit measures (refer back to Exhibit V.2 for details).

The exhibit also shows how many states reported on each measure in each year and where Indiana ranked among the states that reported results. The lower the number in the ranking, then the better Indiana's result is compared to other states. For example, Indiana ranked 3rd best out of 37 states reporting for Timeliness of Prenatal and Postpartum Care in the HEDIS 2013 submissions and ranked 5th out of 31 states reporting for Follow-Up After Hospitalization for Mental Illness (30 days).

In the ranking column for HEDIS 2013, a cell colored in green means that Indiana's ranking among states improved between HEDIS 2012 and HEDIS 2013. A cell colored in pink means that Indiana's ranking worsened. The ranking for Timeliness of Prenatal and Postpartum Care is not colored because the ranking effectively remained unchanged and because Indiana is in the top 3 among all states on this measure.

Exhibit V.5
Comparison of Indiana Medicaid HEDIS Measure Results Against Other State Medicaid Agencies Nationally

		HEDIS 2013 (2012 Measurement)			HEDIS 2012 (2011 Measurement)		
HEDIS Measure	HEDIS Measure Description	Indiana Medicaid Value	Number of States Reporting	Ranking for IN Among States Reporting*	Indiana Medicaid Value	Number of States Reporting	Ranking for IN Among States Reporting*
W15	Well Child Visits in the First 15 Months of Life (6 or more visits)	66.7%	49	16	62.3%	45	22
W34	Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life	69.9%	49	16	67.7%	49	24
AWC	Adolescent Well Care Visits	53.4%	48	11	57.3%	46	9
CIS	Childhood Immunization Status	67.2%	34	15	63.4%	34	22
CAP	Access to Primary Care Practitioners (12-24 months)	95.4%	51	37	95.5%	46	31
CAP	Access to Primary Care Practitioners (25 months - 6 years)	87.4%	51	30	86.0%	46	32
CAP	Access to Primary Care Practitioners (7-11 years)	90.3%	51	28	90.0%	46	27
CAP	Access to Primary Care Practitioners (12-19 years)	90.5%	51	20	91.5%	46	12
PPC	Timeliness of Prenatal Care and Postpartum Care	89.8%	37	3	91.5%	32	2
FUH	Follow-Up After Hospitalization for Mental Illness (30 day follow-up)	79.2%	31	5	78.1%	30	10
FUH	Follow-Up After Hospitalization for Mental Illness (7 day follow-up)	62.0%	31	7	60.6%	30	7
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	50.8%	37	13	51.8%	32	6
ADD	Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Mainenance Phase	60.8%	36	12	60.4%	30	9

* In reading this column, the rank of 15 in HEDIS 2014 means that Indiana had the 16th best rate for this measure across all state Medicaid agencies reporting nationally.
In the HEDIS 2014 column, green boxes indicate that Indiana's ranking improved from what was found in the HEDIS 2013 column. Pink boxes mean a lower ranking.

Sources: 1. The Department of Health and Human Services, 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP, November 2014
2. The Department of Health and Human Services, 2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP, September 2013

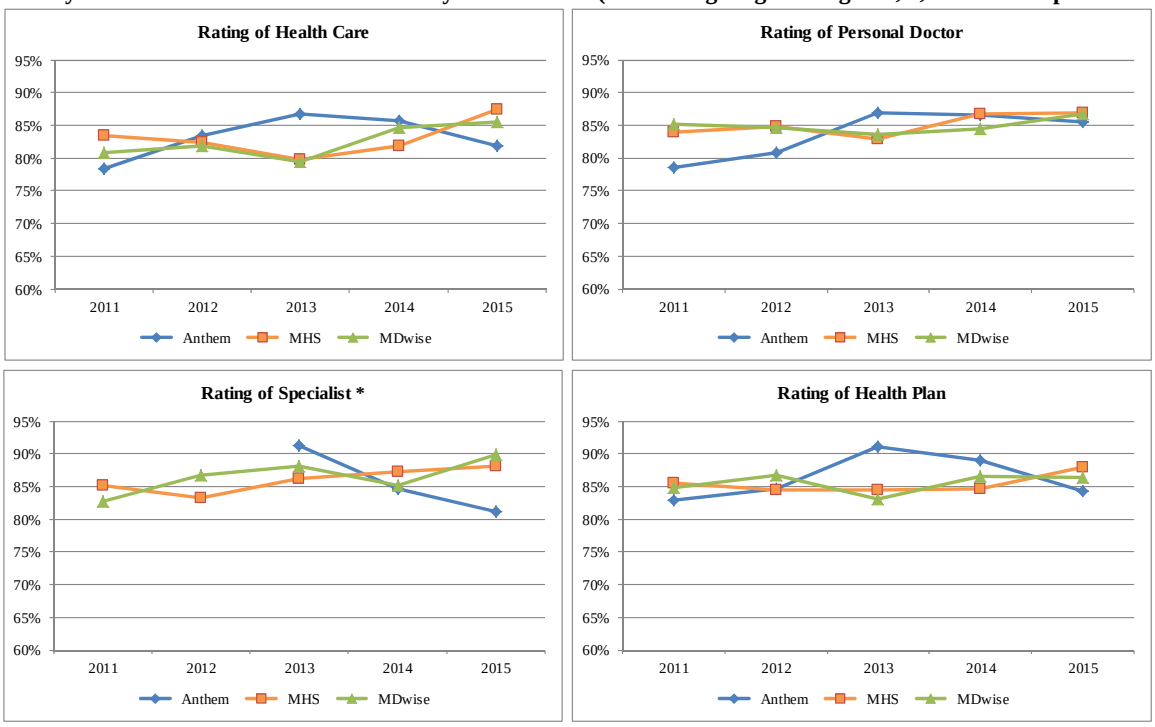
CAHPS Results for Children Enrolled in Hoosier Healthwise

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.6 and V.7 on the next page summarize the results from the child surveys that were administered over the last five years. The results presented include all children in Hoosier Healthwise—CHIP and traditional Medicaid. Missing health plan data indicates the number of respondents to questions were too low (< 100) to be able to extrapolate the rating to the entire population with confidence.

The percentages in Exhibit V.6 on the next page reflect those members that gave a rating of 8, 9 or 10 for each rating, where zero is the "worst possible" and 10 is the "best possible." MHS and MDwise scored 85 percent or higher on all four ratings, whereas Anthem only scored 85 percent on Rating of Personal Doctor. For the other three measures, Anthem had lower ratings in the 2015 survey than in the most recent previous surveys. Both MHS and MDwise have seen either slight improvement or steady results on all of these measures in the last three surveys.

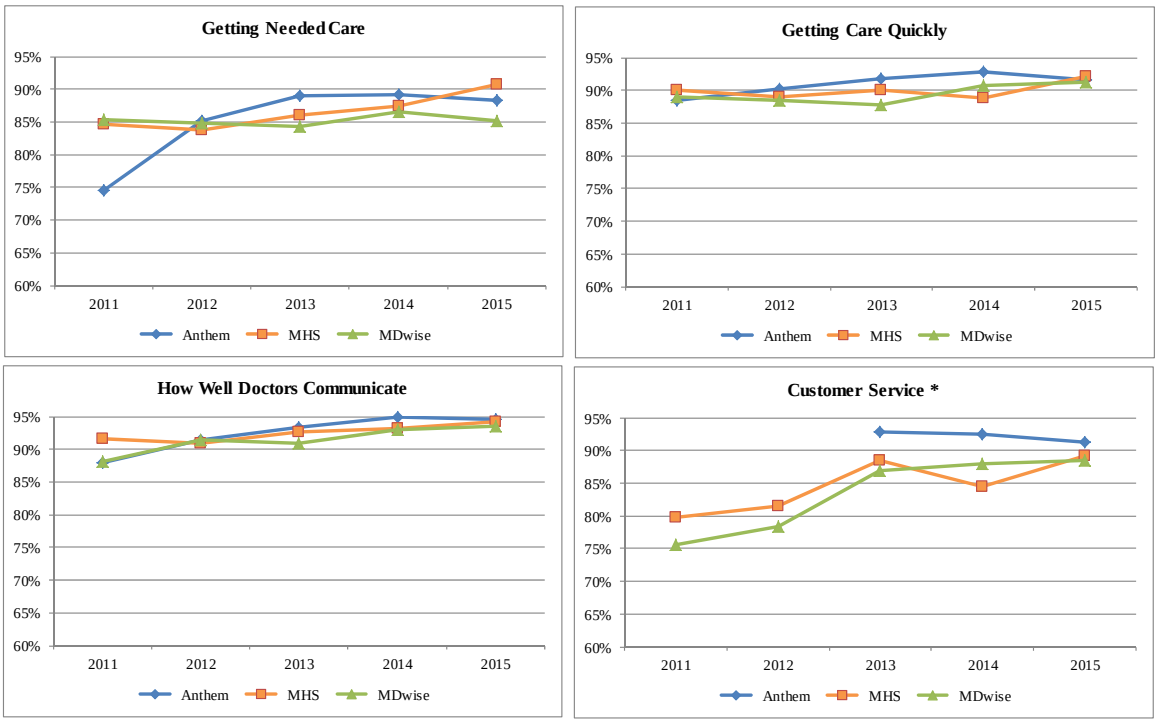
The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The results in Exhibit V.7 on the next page represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. Each of the MCEs scored best on the composite score for How Well Doctors Communicate (close to 95% responded usually or always). The MCEs also scored similarly in the most recent survey on Getting Care Quickly (just above 90%) and Customer Service (all around 90%). The only measure where there are distinguishable differences is in Getting Needed Care. MHS members reported the most favorable rating when 91 percent reported usually or always getting needed care. Anthem members reported doing do 88 percent of the time, while MDwise members reported this 85 percent of the time.

Exhibit V.6
Summary of Scores from CAHPS Child Survey 2011 to 2015 (Members giving a rating of 8, 9, or 10 on 10-point scale)



* Anthem did not report in years 2011 and 2012 due to small sample size.

Exhibit V.7
Summary of Scores from CAHPS Child Survey 2011 to 2015 (Percentages reflect responses of "Usually" or "Always")



* Anthem did not report in years 2011 and 2012 due to small sample size.