

BURNS & ASSOCIATES, INC.

Health Policy Consultants

**INDEPENDENT EVALUATION OF INDIANA'S
CHILDREN'S HEALTH INSURANCE PROGRAM**

FINAL REPORT

APRIL 13, 2009

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Executive Summary

Indiana's Children's Health Insurance Program (CHIP) ended Calendar Year 2008 with 71,294 members, a 2.0 percent decrease from December 2007. The all-time high is 73,014 in February 2008. The CHIP continues to be a very effective source for keeping the uninsured rate among low-income children in the state below that of most states. In fact, the most recent data available shows that Indiana ranks 10th lowest (tied with Washington) among states for the uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL).

CHIPRA 2009

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. After a short-term extension which funded the program through March 31, 2009, CHIPRA 2009 authorizes \$33 billion in federal funds over four and half years beginning in April 2009. CHIPRA 2009 continues the funding pattern used in previous legislation for this program. Each state is allotted an annual amount based upon a combination of their state's child population living in families below 200% FPL and the number of uninsured children within this population. For Federal Fiscal Year (FFY) 2008, Indiana was allotted \$97.4 million. States draw down federal funds in the same manner as in the Medicaid program but at an enhanced match rate. For example, in FFY 2008 Indiana's Medicaid match rate was 62.69% while the enhanced CHIP rate was 73.88%. In FFY 2009, the rates are 64.26% and 74.98%, respectively. Unlike the Medicaid program, however, the federal CHIP limits federal matching dollars to each state's allotment. Funding may be carried over into a future year, but CHIPRA 2009 now limits states the availability to two years from three years previously.

Allotments over the duration of the coverage period are at present or higher levels for each state than they have been in recent years. Indiana's Office of Medicaid Policy and Planning (OMPP) reports that there is sufficient funding from the pre-CHIPRA 2009 allotments to cover Indiana's CHIP expenditures until the new allotment takes effect in April. The new legislation also allows for the redistribution of federal funds from one state to another if states do not spend their full allotments. State allotments will be rebased in 2011 with new data related to the uninsured rate in each state.

Indiana's CHIP and Its Impact on Reducing the Uninsured Rate

Using data from the Census Bureau's Current Population Survey which surveys citizens on their health insurance status every March, Indiana's three-year average of a 10.3 percent uninsured rate for low-income children (under 200% of the FPL) is far below the national average of 18.3 percent. Indiana's average has dropped nine percentage points in five years. Indiana's CHIP has been able to decrease the actual number of low-income uninsured children despite the fact that the number of low-income children in the state has grown by 100,000 in the last five years. The latest estimate shows 66,000 uninsured children in families below 200 percent of the FPL out of a total 626,000.

Indiana's Legislature, like 11 other states in 2007, authorized raising eligibility for children in their CHIP programs to 300 percent of the FPL. President Obama's rescission of the previous Administration's policy related to eligibility expansion enables states to pursue expansions above the 250 percent FPL level. Indiana has already implemented expansion of its CHIP to children in families with incomes up to 250 percent of the FPL effective October 1, 2008. The OMPP reports that 1,047 children in families above 200 up to 250 percent FPL income category enrolled

from October to December 2008. The latest estimate of the Census Bureau's Current Population Survey, however, showed that Indiana still had 75,564 children (citizens) that were in families at income levels that were eligible for Indiana's CHIP but not yet enrolled. Another 19,322 children are families with incomes above 250 percent up to 300 percent FPL.

Indiana's CHIP enrollment, while enjoying explosive growth in the early years of the program, has stabilized in the last few years. But it remains to be seen what the impact of enabling children in the higher 201-250 percent FPL category will bring. Nevertheless, the funding in the new CHIPRA legislation provides more stability to states than the prior authorizations which dipped midway through the 10-year coverage period.

Indiana's CHIP at a Glance

Indiana's CHIP is defined as a combination program based on how it was originally structured, which is the same option adopted by 20 other states. There are two main components to the program. The Medicaid expansion portion (called CHIP Package A in Indiana) covers uninsured children in families with incomes up to 150 percent of the FPL (\$26,400 per year for a family of three in 2008) who are not already eligible for Medicaid. The State-designed portion (called CHIP Package C in Indiana) covers children in families with incomes above 150 percent up to 250 percent of the FPL (\$44,000 per year for a family of three in 2008). In December 2008, there were 52,746 children enrolled in Indiana's CHIP Package A and 18,548 children enrolled in CHIP Package C.

Because CHIP Package C is the state-designed portion of the program, the State opted to impose premiums for families with incomes at or above 150 percent of the FPL. The premium amount varies by the income level and the number of children covered in the family.

Monthly Premiums Charged to Families in Indiana's CHIP Package C

Family FPL	1 Child	2 or More Children
150% up to 175%	\$22	\$33
175% up to 200%	\$33	\$50
200% up to 225%	\$42	\$53
225% up to 250%	\$53	\$70

Also, there are some co-pay requirements for CHIP Package C members such as for prescriptions (\$3 co-pay for generic drugs and \$10 for brand name drugs). There are no co-pay requirements for children in CHIP Package A.

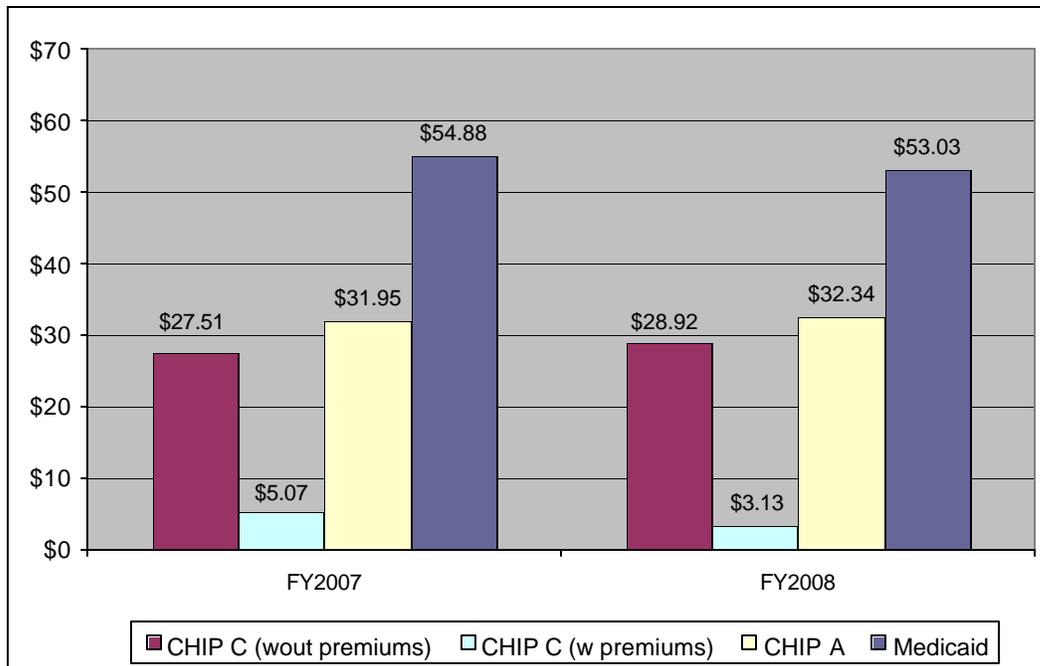
Benefits for CHIP members are quite robust, with some limitations under CHIP Package C.

Benefits Offered to Indiana's CHIP Enrollees in the Hoosier Healthwise Program

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

Because of the enhanced federal funding for CHIP and the premiums collected to offset expenditures, the State's effective outlay for CHIP Package C members was \$3.13 per member per month (PMPM) during Federal Fiscal Year (FFY) 2008, a decline from \$5.07 PMPM in FFY 2007. For CHIP Package A, the state share was \$32.34 PMPM, a 1.2 percent increase from FFY 2007. By comparison, the state share of the PMPM for children in the regular Medicaid program (excluding infants) was \$53.03 in FFY 2008.

**Trends in the Cost Per Member Per Month (PMPM)
State Share Only**

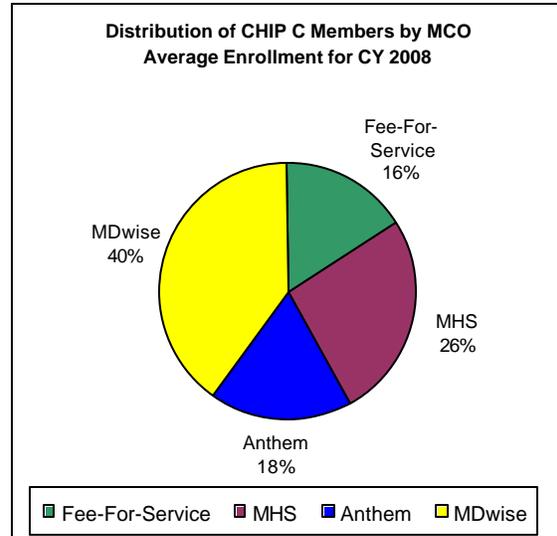
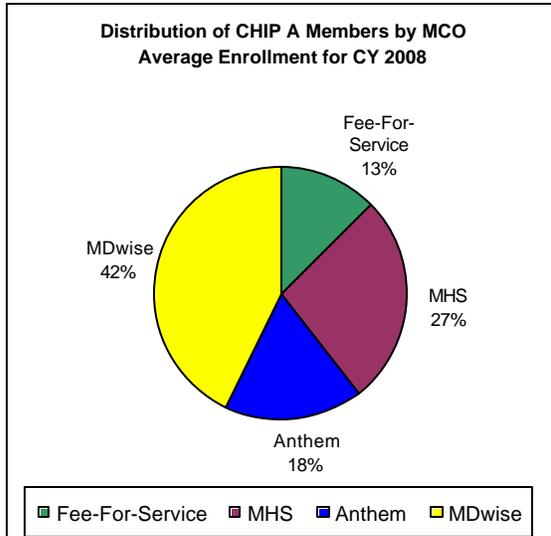


Enrollment

Since October 2005, enrollment in Indiana's CHIP has exceeded 70,000. Since that time, it has fluctuated between 70,000 and 73,000, hitting an all-time high of 73,014 in February 2008. Year over year, CHIP A enrollment decreased 4.1 percent from December 2007 to December 2008. CHIP C enrollment increased 4.4 percent during this time period.

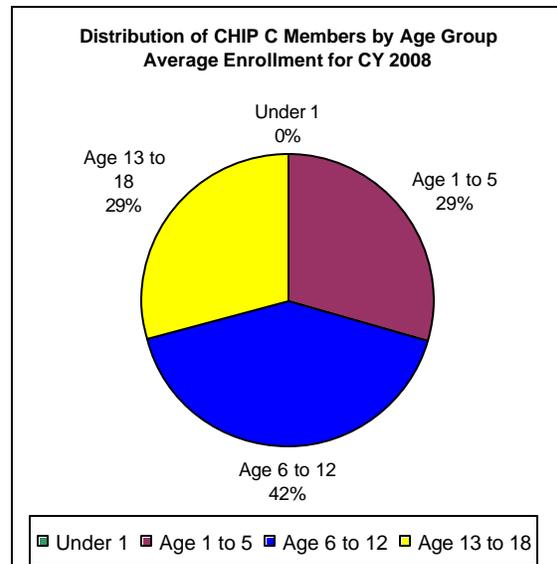
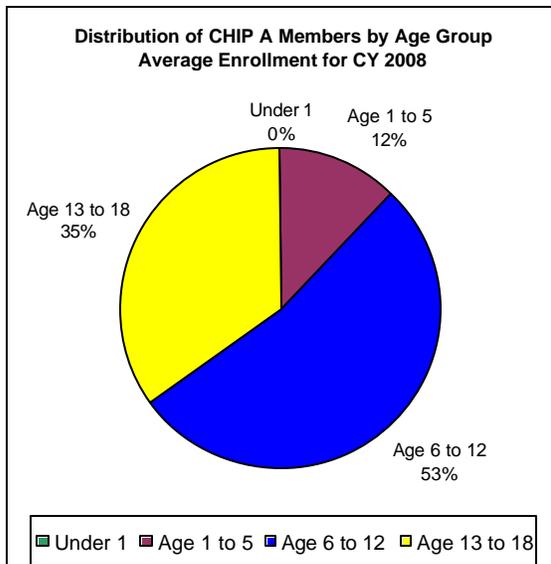
Despite the fact that the disenrollment rate is high in the CHIP, there is still a stable membership in both programs. In CHIP A, 75 percent of CHIP A members have been enrolled for more than two years. In CHIP C, it is 68 percent of members.

In CY 2008, CHIP members had the option to enroll in one of three managed care organizations (MCOs)—Anthem, MDwise, or Managed Health Services (MHS). All three MCOs are required to serve the entire state. The distribution of enrollment between the MCOs in CY 2008 did not change much from CY 2007.



In any given month, some members are temporarily enrolled in the Fee-for-Service program until they select an MCO and Primary Medical Provider (PMP) or they are automatically assigned to one.

Because younger children are eligible for Medicaid up to different family income levels, the distribution of children in Indiana’s CHIP skews towards older children. This has been the case throughout the program’s existence.



There are no infants in CHIP A and few in CHIP C since they are eligible for Medicaid if born to a Medicaid-eligible mother. The distribution by age within CHIP did not change between CY 2007 and CY 2008.

The distribution of CHIP enrollees by race/ethnicity does not match the composition of all children residing in the state. Based on state population estimates for 2007, minorities are

represented more in CHIP than the overall state composition (31% of CHIP population, 21% of state population). The distribution of CHIP members by region in the state, however, matches the distribution of the child population overall.

Access to Services

Chapter III examines CHIP members' (and other Hoosier Healthwise children's) access to pediatricians and other PMPs by county. There are 37 counties in the state that do not have a pediatrician available to Hoosier Healthwise members. There are, however, other providers (e.g. general practitioners, family practitioners) available to serve these children. Each of the three MCOs is required to contract with PMPs separately. In addition to the 37 counties where no MCO has a pediatrician, Anthem does not have one in an additional 19 counties, MHS lacks one in an additional 21 counties, and MDwise lacks one in an additional 11 counties. Burns & Associates measured overall access to primary care to determine if the level of provider availability is influencing utilization both for primary care and ER use (which may be a substitute when primary care access is lacking). We categorized each county as low, medium or high PMP availability. There are 11 counties deemed low availability counties. Among these, the data shows that only members in four counties (Clinton, Dubois, Elkhart and Tippecanoe) may be influenced by lower PMP availability. Clinton, Dubois and Elkhart have primary care visits per 1,000 CHIP members lower than the statewide average. Tippecanoe and Dubois have higher ER use than other counties in the state.

The only county where there appears to be a definitive relationship between PMP availability and impact on access to care is Dubois County, since it has lower primary care utilization for CHIP members and the highest ER visits per 1,000 of any county in the state.

Maps that show each of the eight Hoosier Healthwise regions with county-specific information are displayed in Chapter III.

Use of Services

B&A extracted data from the OMPP's data warehouse related to member enrollment and claims submitted by MCOs that report when children encounter the health care system. We analyzed services used by CHIP members who were enrolled for at least nine months in an MCO in FFY 2007 and FFY 2008. Specific services studied include primary care visits, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services, specialty physician services, emergency room visits, outpatient hospital services (other than the ER), inpatient hospital stays, preventive dental services, and pharmacy scripts. Use of these services by CHIP members was examined across multiple dimensions, including:

- Usage by CHIP A members versus CHIP C members
- Usage across four age/gender groups
- Usage by members enrolled in each of the three Hoosier Healthwise MCOs
- Usage across four race/ethnicity populations
- Usage by members from the eight regions in the state

Each service is studied in more detail in Chapter IV. A summary of our findings is shown on the next page.

Service	Usage Rate in FFYs 2007-2008	Change from Prior Years	Differences Among Subpopulations
Primary Care Visits	70%	Similar	Lowest among African Americans; Highest among young children and teenage girls; Lowest in Northwest Region
EPSDT Services	25% -30%, but varies greatly by age group	Slightly higher usage	Higher for Anthem and MDwise than MHS; Highest among Hispanics
Specialty Care	10%	Similar	Nothing significant
ER Visits	Near 25%	Slightly lower usage	Slightly higher among Caucasians; Lower in Northwest Region
Outpatient Hospital	20% -25%	Similar	Highest among teenage girls; higher for MDwise
Inpatient Stays	1%-2%	Similar	Slightly higher for teenage girls
Preventive Dental	60% -65%	Slightly lower usage	Highest among children age 6-12; Lowest in Northwest and Southeast Regions
Pharmacy	65% -70%	Similar	Highest among Caucasians

Measuring Quality and Outcomes

Chapter VI of this report examines the multi-faceted approach that the OMPP has taken to measure the quality of services delivered to CHIP members in the Hoosier Healthwise program. This is achieved through a combination of reporting required of all state Medicaid programs by the federal government, the development of Indiana-specific initiatives developed by the OMPP's Quality Strategy Committee, and requirements imposed by the OMPP to the Hoosier Healthwise MCOs. In the last year, the OMPP has significantly increased the requirements for the MCOs with respect to the reporting of measurable outcomes for members. A primary category of measures relates to children and adolescents. Additionally, the requirements for reporting HEDIS® measures, which are reported by Medicaid health plans nationally to allow for comparisons to national benchmarks, have been expanded by the OMPP. The MCOs have not always achieved the targets set by the OMPP, so the OMPP has placed increased importance on striving to meet these targets. Additionally, most of the HEDIS® measure targets increased effective in CY 2009. Additional pay-for-performance incentives were put in place related to HEDIS® results, and many of these tie to HEDIS® measures related to children's health and access to services.

The OMPP also requires that each MCO conduct a member survey each year using a nationally-recognized survey instrument. This enables comparisons across the three MCOs as well as to other Medicaid health plans nationally. A separate survey is conducted of parents of children in the Hoosier Healthwise program.

Composite scores are tabulated across a series of related questions. All three MCOs exceeded the national average for the composite ratings for Getting Needed Care, and MHS and MDwise exceeded the national benchmark for How Well Doctors Communicate. Customer Service is an area of improvement for all of the Hoosier Healthwise MCOs.

Other questions on the survey relate to the respondents offering ratings on a scale of zero to 10, where zero is "worst possible" and 10 is "best possible". The ratings for specialists and for the

member's own health care were high for Anthem and near the national average for MHS and MDwise. All three MCOs were at or near the national average for Rating of Health Plan.

About This Evaluation

Burns & Associates, Inc., a health care consulting firm that works with state public programs, was contracted to conduct this year's independent evaluation. The OMPP is required by statute (IC 12-17.6-2-12) to report by April 1 of each year on the activities of Indiana's CHIP for the prior calendar year. Chapters within this evaluation highlight the key components studied—enrollment, access, use of services, quality, and cost. Chapter VII offers items for consideration by the Legislature and by the OMPP to improve upon an already successful program.

I. Overview of the National State Children’s Health Insurance Program and How Indiana’s Program is Reducing the Uninsured Rate in Indiana

Indiana’s Children’s Health Insurance Program (CHIP) ended Calendar Year 2008 with 71,294 members, a 2.0 percent decrease from December 2007. The all-time high is 73,014 in February 2008. The CHIP continues to be a very effective source for keeping the uninsured rate among low-income children in the state below that of most states. In fact, the most recent data available shows that Indiana ranks 10th lowest (tied with Washington) among states for the uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL)¹.

The Impact of CHIP on Reducing the Rate of Uninsured Children

The federal CHIP has been successful in providing insurance to low-income children who were not eligible for Medicaid previously or who had been eligible but, due to targeted outreach, had not enrolled prior to the implementation of CHIP. The uninsured rate nationally dropped from 23% in 1997 to 14% in 2005 for children in families with incomes at 200% of the FPL and below. This reduction was seen across racial and ethnic groups. The uninsured rate for Hispanic children nationally fell from 33% to 27%; for African American children, from 22% to 15%; and for Caucasian children, from 20% to 14%.²

The most recent data from the Census Bureau’s Current Population Study, conducted each March, shows that Indiana has enjoyed more success in reducing the uninsured rate among low-income children than the national average. There are approximately 75,000 children (citizens only) not enrolled in Indiana’s CHIP that are eligible for the program (see Exhibit I.1 below).

Exhibit I.1
Distribution of Uninsured Children (Age 0-18) by Family Income in Indiana
2005 - 2007 Three-Year Average

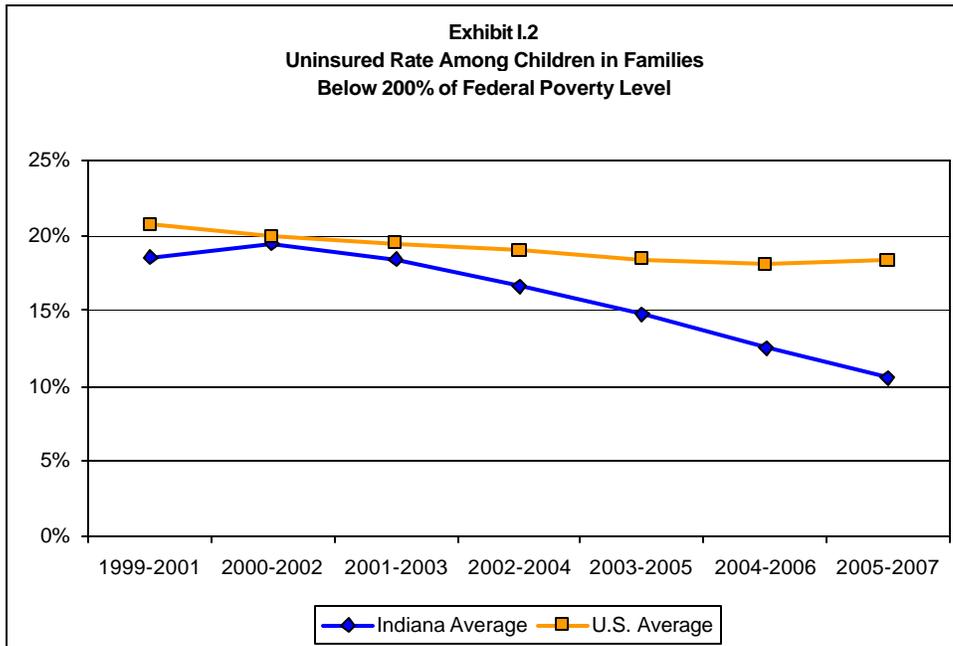
Family Federal Poverty Level	Total Uninsured	Percent of All Uninsured Children	Total Population	Uninsurance Rate
Up to 100%	30,648	24%	277,778	11.0%
101-150%	19,098	15%	149,173	12.8%
151-200%	12,751	10%	181,939	7.0%
201-250%	13,067	10%	176,207	7.4%
Total for Children Eligible for Indiana's CHIP	75,564	59%	785,097	9.6%
251-300%	19,322	15%	191,401	10.1%
301+%	32,850	26%	674,185	4.9%
All Children	127,736	100%	1,650,683	7.7%

Source: U.S. Census Bureau, Housing and Household Economic Statistics Division Current Population Survey <http://www.census.gov/hhes/www/hlthins/hlthins.html>

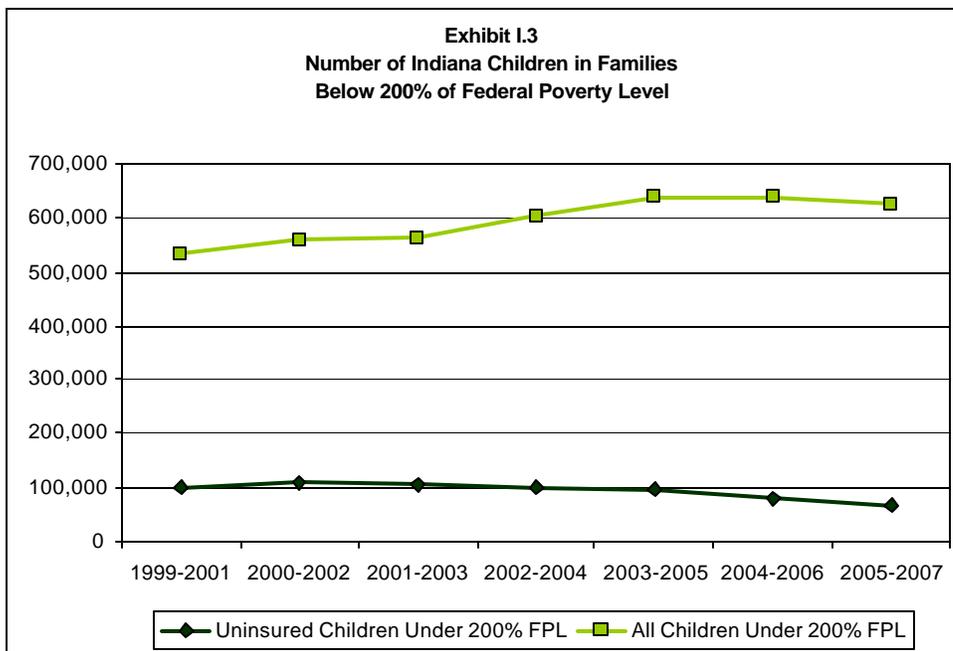
¹ Schwartz, K., Howard, J. with Williams, A. and Cook, A. (January 2009). Health Insurance Coverage of America’s Children. Washington, DC: Kaiser Commission on Medicaid and the Uninsured with The Urban Institute. The ranking represents a two-year average (2006-2007).

² Ku, L., Lin, M., Broaddus, M. (January 2007) Improving Children’s Health: A Chartbook about the Roles of Medicaid and SCHIP, 2007 Edition. Washington, DC: Center on Budget and Policy Priorities

Indiana's three-year average of 10.3% for children in families below 200 percent of the FPL is far below the national average of 18.3%, dropping nine percentage points in five years³.



Indiana's CHIP has been able to decrease the actual number of low-income uninsured children despite the fact that the number of low-income children in the state has grown by 100,000 in the last five years. The latest estimate shows 66,000 uninsured children in families below 200% of the FPL out of a total 626,000, citizens and non-citizens combined (see Exhibit I.3 below).



³ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. Number and Percent of Children under 19 Years of Age, at or below 200 Percent of Poverty. Counts of children in each 3-year analysis period reflect an average of the figures computed for each year individually. <http://www.census.gov/hhes/www/hlthins/lowinckid.html>

Indiana's CHIP at a Glance

Indiana's CHIP is defined as a combination program based on how it was originally structured, which is the same option adopted by 20 other states. There are two main components to the program. The Medicaid expansion portion (called CHIP Package A in Indiana) covers children in families with incomes up to 150% of the FPL (\$26,400 per year for a family of three in 2008) who are not already eligible for Medicaid. The State-designed portion (called CHIP Package C in Indiana) covers children in families with incomes above 150% up to 250% of the FPL (\$44,000 per year for a family of three in 2008). In December 2008, there were 52,746 children enrolled in Indiana's CHIP Package A and 18,548 children enrolled in CHIP Package C⁴.

Because CHIP Package C is the state-designed portion of the program, the State opted to impose premiums for families with incomes at or above 150% of the FPL. The premium amount varies by the income level and the number of children covered in the family. Also, there are some co-pay requirements for CHIP Package C members, such as for prescriptions (\$3 co-pay for generic drugs and \$10 for brand name drugs). There are no co-pay requirements for children in CHIP Package A.

Exhibit I.4
Monthly Premiums Charged to Families in Indiana's CHIP Package C

Family FPL	1 Child	2 or More Children
150% up to 175%	\$22	\$33
175% up to 200%	\$33	\$50
200% up to 225%	\$42	\$53
225% up to 250%	\$53	\$70

⁴ Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on February 6, 2009.

Design features of Indiana’s CHIP are similar to those taken by other states. Notable differences are less prohibitive co-pays and a shorter “going bare” period than many states⁵.

**Exhibit I.5
Design Features of Indiana’s CHIP Compared to Other States**

Design Feature	Adopted by Indiana?	Number of States with Policy
No face-to-face interview at application	Yes	49 states
No face-to-face interview at renewal	Yes	48 states
No asset test in determining child's eligibility	Yes	46 states
12-month renewal period	Yes	45 states
Continuous eligibility for 12 months, regardless of change in circumstances	No, except for age 0-3	16 states
Joint application for Medicaid and CHIP	Yes	33 of 37 states with State-only programs
"Going bare" period (must be uninsured before enrolling)	3 months	16 states impose 1-3 months; 21 states impose > 3 months
Premiums charged to members	Yes	35 states
At 101% FPL	\$0	9 out of 35 states
At 151% FPL	Starting at 151% FPL, scales up based on income	24 out of 35 states
At 200% FPL		24 out of 35 states
Co-payments required for prescription drugs	Some	25 states
Prescription drugs	\$3 for generics; \$10 for brand name	24 states have a co-pay
Non-emergent ER	No	15 states have a co-pay
Non-preventive physician care	No	19 states have a co-pay
Inpatient hospital stays	No	10 states have a co-pay

Within the State, Indiana’s CHIP is seamlessly integrated into Hoosier Healthwise, Indiana’s Medicaid managed care program for children, pregnant women and low-income families. CHIP enrollees, like all children in Hoosier Healthwise, select a primary medical provider (PMP) or one is assigned to them if a selection is not made by the member. CHIP enrollees have access to all of the other providers available to Hoosier Healthwise members depending upon the managed care organization (MCO) they join. Since January 2007, CHIP members have had the option to enroll with one of three MCOs—Anthem, Managed Health Services or MDwise.

With respect to the services offered, Indiana has opted to provide its CHIP members with services very similar to those offered other children in Hoosier Healthwise, with a few limitations. This is a practice seen in other states as well. The types of services offered CHIP members are also like those offered in other state programs.

⁵ Cohen Ross, D. and Marks, C. (January 2009) Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009. Washington, DC: The Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured.

Exhibit I.6
Benefits Offered to Indiana's CHIP Enrollees in the Hoosier Healthwise Program

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

The operation of Indiana's CHIP is shared among divisions of the State's Family and Social Services Administration (FSSA), with primary functions provided by the Office of Medicaid Policy and Planning (OMPP), the designated single state agency charged with administering Hoosier Healthwise, and the Division of Family Resources, which conducts CHIP eligibility determination.

Federal Policy Implications for Indiana's CHIP

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. After a short-term extension which funded the program through March 31, 2009, CHIPRA 2009 authorizes \$33 billion in federal funds over four and half years beginning in April 2009. The Congressional Budget Office estimates that CHIPRA will provide coverage to 4.1 million children in Medicaid and CHIP⁶ who would have otherwise been uninsured by 2013.

Indiana's Legislature, like 11 other states in 2007, authorized raising eligibility for children in their CHIP programs to 300% of the FPL.⁷ President Obama's rescinded a Centers for Medicare and Medicaid (CMS) guidance letter from the previous Administration that limited state CHIP expansions beyond the 250% FPL. Indiana has already been approved by CMS to expand its CHIP to children in families with incomes up to 250% of the FPL. Eligible children entered the program beginning in October 2008. OMPP reports that 1,047 children in the income category above 200% FPL up to 250% FPL enrolled from October to December 2008.

Although the Deficit Reduction Act (DRA) of 2005 intended to streamline the verification of citizenship requirement, states have reported an unintended consequence from this regulation affecting legal U.S. citizens at the time of application or renewal for Medicaid/CHIP benefits. According to a 50-state survey of state Medicaid agencies in October 2007, 37 states reported that this new requirement (implemented in July 2006) contributed to slower enrollment or actual drops in enrollment of otherwise eligible U.S. citizens.⁸ The survey also found that 45 states have incurred increased administrative costs as a result of the requirement, mostly to train employees on the requirements and to match against other databases such as Vital Records.

⁶ The new legislation specifically changes the acronym for the federal program from SCHIP to CHIP.

⁷ Cohen Ross, D., Horn, A. and Marks, C. (January 2008) Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles. Washington, DC: The Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured.

⁸ Smith, V. et al. (October 2007) As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for Fiscal Years 2007 and 2008. Washington DC: Kaiser Commission on Medicaid and the Uninsured.

In Indiana, the verification of citizenship has come on the heels of the modernization project at the Division of Family Resources. Last year, it was reported that enrollment in Indiana's CHIP had been growing steadily since July 2006 with the exception of the months immediately after the citizenship requirement took effect. This year, we find that CHIP enrollment has dipped in some counties where the modernization project has already taken effect. More details are shown in Chapter II which explores enrollment trends in more detail.

Indiana's CHIP enrollment, while enjoying explosive growth in the early years of the program, has stabilized in the last few years. But it remains to be seen what the impact of enabling children in the higher 201%-250% FPL category will bring. Nevertheless, the funding in the new CHIPRA legislation provides more stability to states than the prior authorizations which dipped midway through the 10-year coverage period. It appears that the funding allocated in the next few years at 110% of actual CHIP spending or 110% of spending projections should be able to cover current CHIP enrollment in Indiana with room for growth. If Indiana's CHIP grows faster than expected, the state may be eligible for potential redistributed funds from unused allotments from other states. Other opportunities afforded states through the CHIPRA 2009 legislation are discussed in Chapter VII.

Focus of this Evaluation

Burns & Associates, Inc. was hired by the OMPP to conduct this annual evaluation of CHIP Package A and CHIP Package C. Indiana Code 12-17.6-2-1 established Indiana's Children's Health Insurance Program. IC 12-17.6-2-12 requires 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) Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

The report must be in electronic format under IC 5-14-6.

The remainder of this report provides an in-depth analysis of various aspects of the program from Calendar Year 2008:

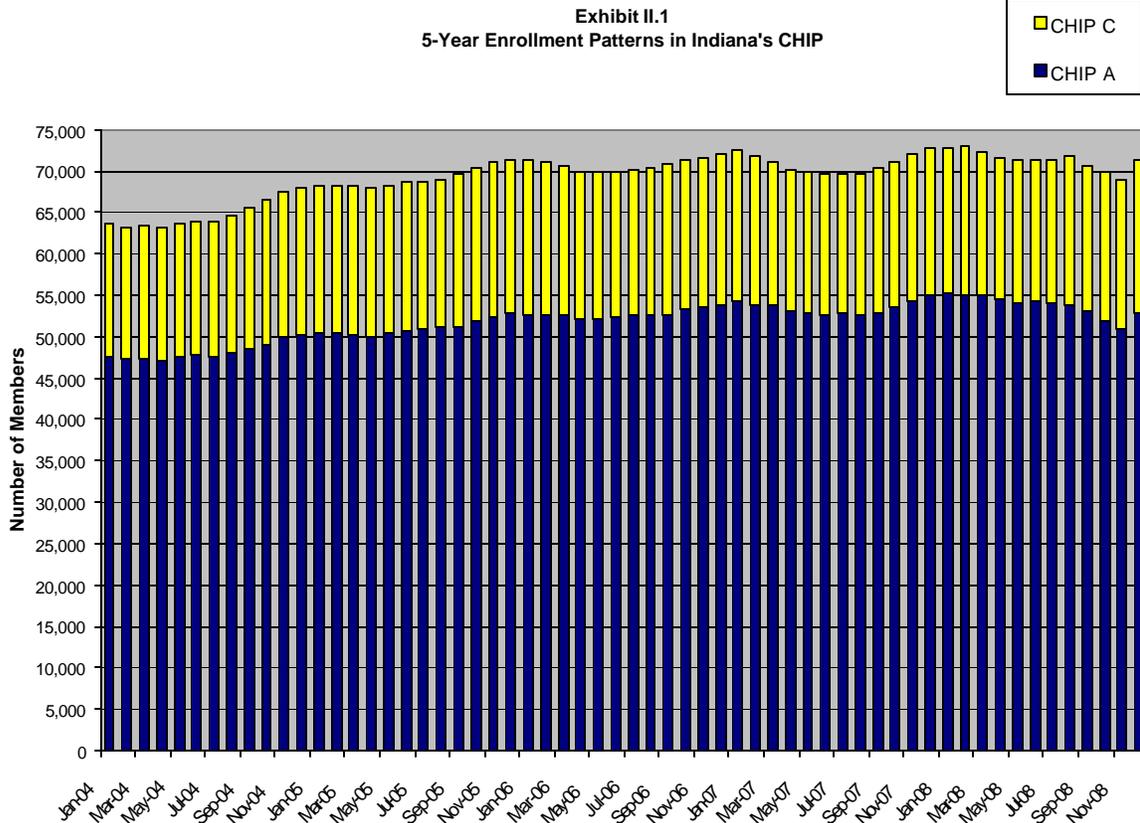
- Chapter II: Enrollment in Indiana's CHIP
- Chapter III: Access to Primary Care Services for CHIP Members
- Chapter IV: Utilization of Services for CHIP Members
- Chapter V: Expenditures in Indiana's CHIP
- Chapter VI: Measuring Quality and Outcomes in Indiana's CHIP
- Chapter VII: Items for Consideration for Indiana's Legislature and the OMPP

II. Enrollment in Indiana's CHIP

This chapter examines enrollment trends in Indiana's Children's Health Insurance Program (CHIP) in recent years as well as a profile of enrollees across demographic features.

Enrollment and Disenrollment Trends

Since October 2005, enrollment in Indiana's CHIP has exceeded 70,000. Since that time, it has fluctuated between 70,000 and 73,000, hitting an all-time high of 73,014 in February 2008. As of December 2008, Indiana's CHIP Package A (children in families with incomes up to 150% of the federal poverty level, or FPL) enrollment was 52,746. Its all-time high was in January 2008 at 55,166. Indiana's CHIP Package C (children in families with incomes between 151% and 250% of the FPL) had enrollment of 18,548 in December 2008, just below its all-time high of 18,744 set in January 2006. Year over year, CHIP A enrollment decreased 4.1 percent from December 2007 to December 2008. CHIP C enrollment increased 4.4 percent during this time period. Effective October 2008, children in families with incomes above 200% up to 250% of the FPL were eligible to enroll. There were 1,047 children in this category enrolled between October and December 2008.



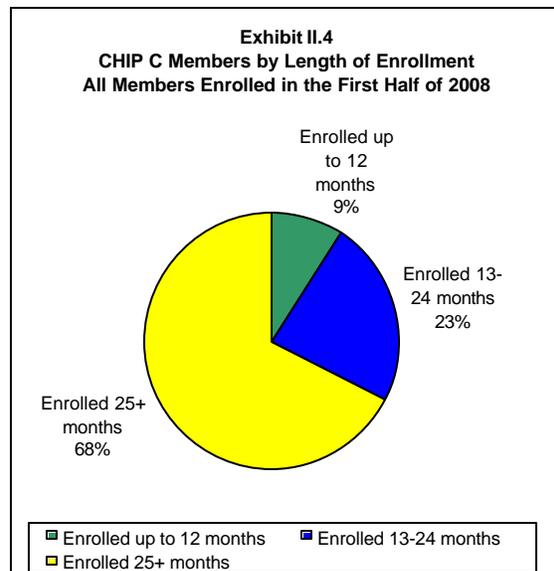
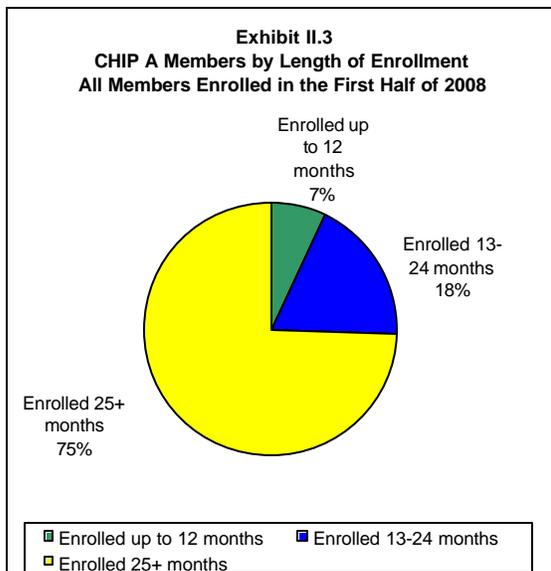
CHIP members, like Medicaid members, disenroll from the program at a high rate. There is also quite a bit of movement within the Hoosier Healthwise program between CHIP A, CHIP C and regular Medicaid as family incomes change. There were 97,376 children enrolled in CHIP A at some point in time in Calendar Year 2008; for CHIP C, 33,722 children. Yet only 55 percent of

these children were enrolled at the end of the year. Not all of them left Hoosier Healthwise completely. One quarter of the ever-enrolled CHIP A children moved to Medicaid and 13 percent of the CHIP C children did as well. Others moved from CHIP A to CHIP C, or vice versa. Therefore, the net disenrollment rate for CHIP A in CY 2008 was 15 percent, the same as CY 2007. For CHIP C, the net disenrollment rate was 22 percent, a slight decrease from the 26 percent rate in CY 2007. Details are shown in Exhibit II.2 below.

**Exhibit II.2
Calculation of Member Disenrollment Rate**

	CHIP A	CHIP C
Ever Enrolled in CY 2008	97,376	33,722
<i>Which is distributed across the following categories:</i>		
Enrollment as of Dec 2008	52,746	18,548
Moved to Medicaid	25,747	4,361
Moved to other CHIP program	4,042	3,347
<i>The difference is the disenrollees:</i>		
Disenrolled from Hoosier Healthwise	14,841	7,466
Disenrollment rate = (Disenrolled divided by ever enrolled)	15%	22%

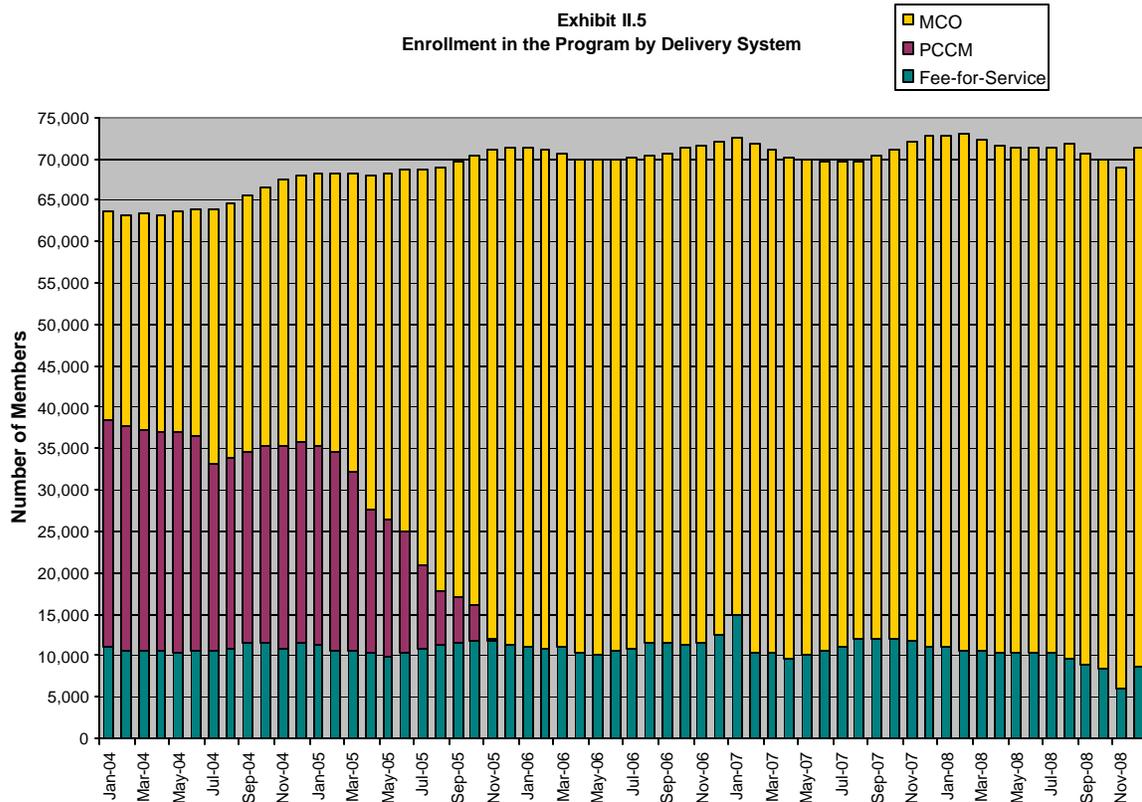
Despite the fact that disenrollment is high, there is still a stable membership in both programs. Children that were enrolled in either CHIP A or CHIP C in the first half of 2008 were selected to compute the number of months that they had been enrolled in the program thus far (including those that have since disenrolled). Exhibits II.3 and II.4 below show that 75 percent of CHIP A members and 68 percent of CHIP C members have been enrolled for more than two years.



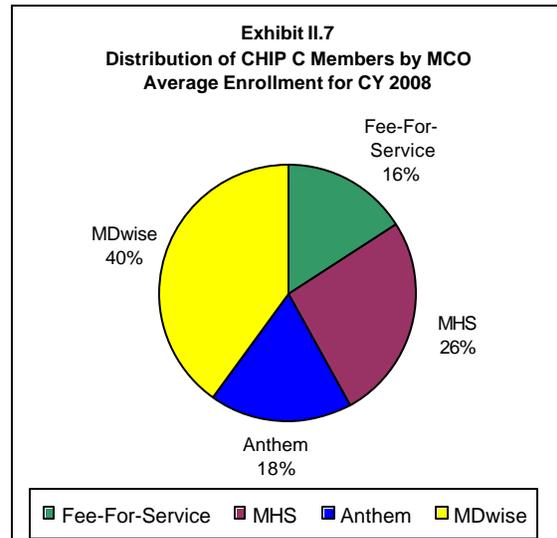
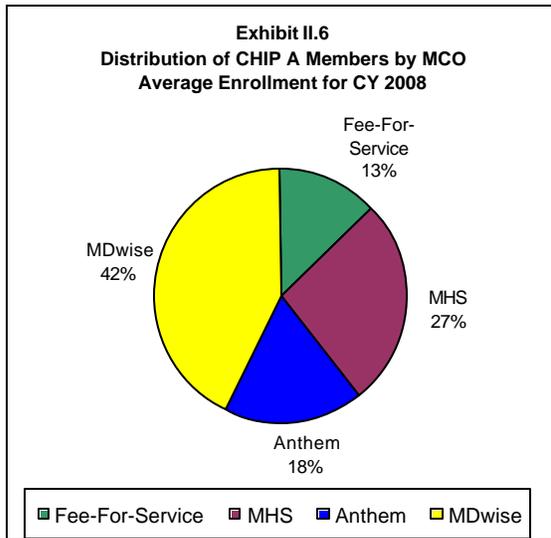
Because of the premium requirements in CHIP C, children are placed in the program that maximizes their benefit package and also minimizes payment requirements to their parents for premiums or co-pays. But because Medicaid and CHIP are part of the same Hoosier Healthwise delivery system, children do not need to change doctors or health plans when they move between CHIP and Medicaid.

Enrollment Within Hoosier Healthwise

Since the Hoosier Healthwise Primary Care Case Management Program (PCCM) was eliminated in December 2005, CHIP members now enroll with a managed care organization (MCO). Children and their families have 30 days after their eligibility effective date to select a primary medical provider (PMP) and MCO. Until the selection is made, the member remains in Fee-For-Service (FFS). If the member does not select a PMP and health plan within 30 days, the State’s policy is to automatically assign the child to a PMP and health plan in their geographic region. Because of the high turnover in CHIP as shown on the previous page, in any given month there are about 10,000 CHIP members (about 15 percent) temporarily enrolled in the FFS program.

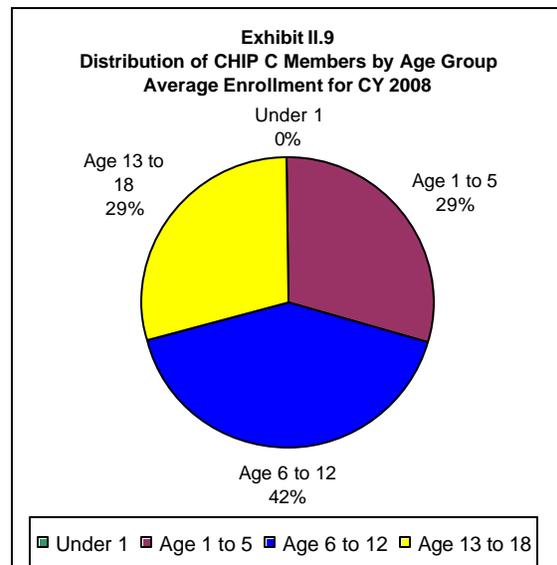
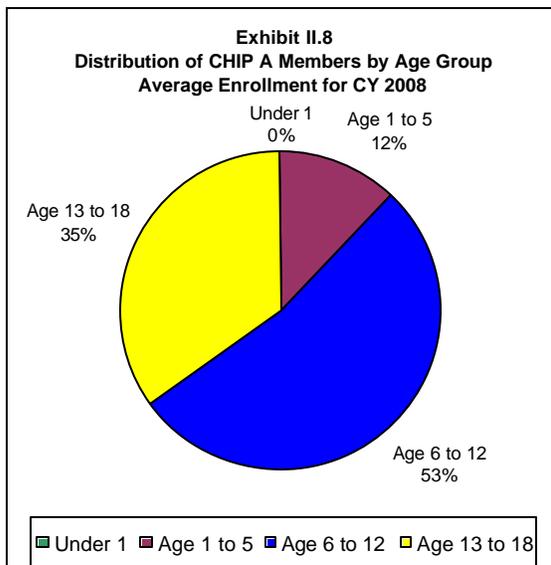


In CY 2008, CHIP members had the option to enroll in one of three MCOs—Anthem, MDwise, or Managed Health Services (MHS). All three MCOs are required to serve the entire state. The distribution of enrollment between the MCOs in CY 2008 did not change much from CY 2007. MDwise enrollment of CHIP A and CHIP C members decreased very slightly while MHS’s enrollment increased slightly. Anthem’s enrollment stayed the same from CY 2007. The percentage of members that each MCO has for CHIP A and CHIP C is almost identical (see Exhibits II.6 and II.7 on the next page).



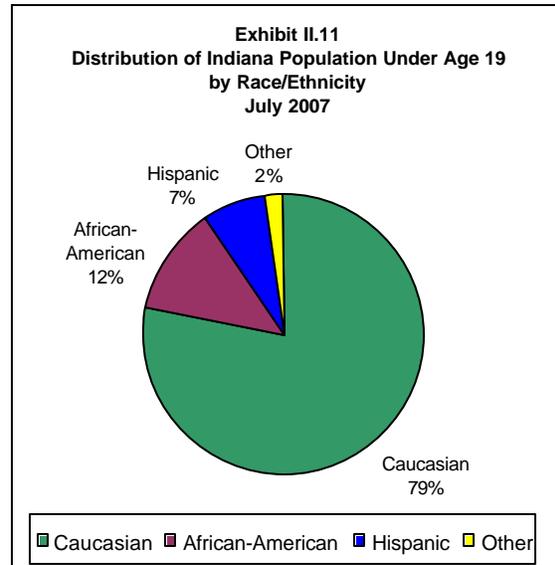
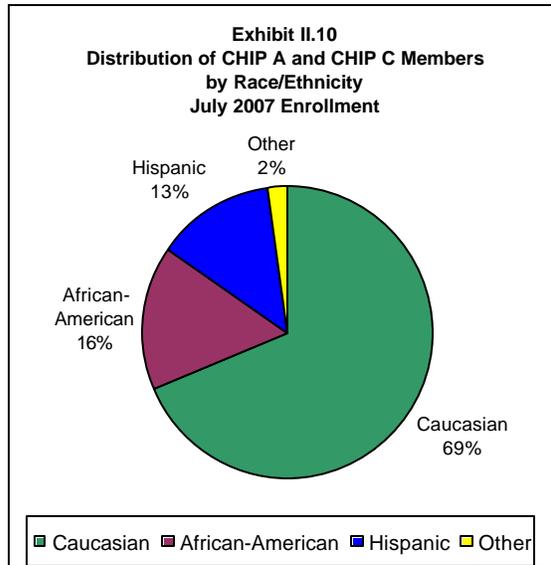
Enrollment by Age

Because younger children are eligible for Medicaid up to different family income levels, the distribution of children in Indiana’s CHIP skews towards older children. This has been the case throughout the program’s existence. In 2008, children ages 1 through 5 comprised 12 percent of the CHIP A population but 29 percent of CHIP C members. Children ages 6 through 12 comprised 53 percent and 42 percent, respectively. Teenagers (age 13-18) made up 35 percent of CHIP A and 29 percent of CHIP C. There are no infants in CHIP A and few in CHIP C since they are eligible for Medicaid. The distribution by age within CHIP did not change between CY 2007 and CY 2008.



Enrollment by Race/Ethnicity

The Indiana OMPP tracks Hoosier Healthwise members' race/ethnicity in an effort to best serve intended outcomes for conditions that may be more prominent in different populations. The distribution of the race/ethnicity composition of children in CHIP does not match the overall child population in Indiana. Compared to the U.S. census estimate as of July 2007¹ (most recent available), African-American children and Hispanic children are represented more in CHIP than in the statewide population.

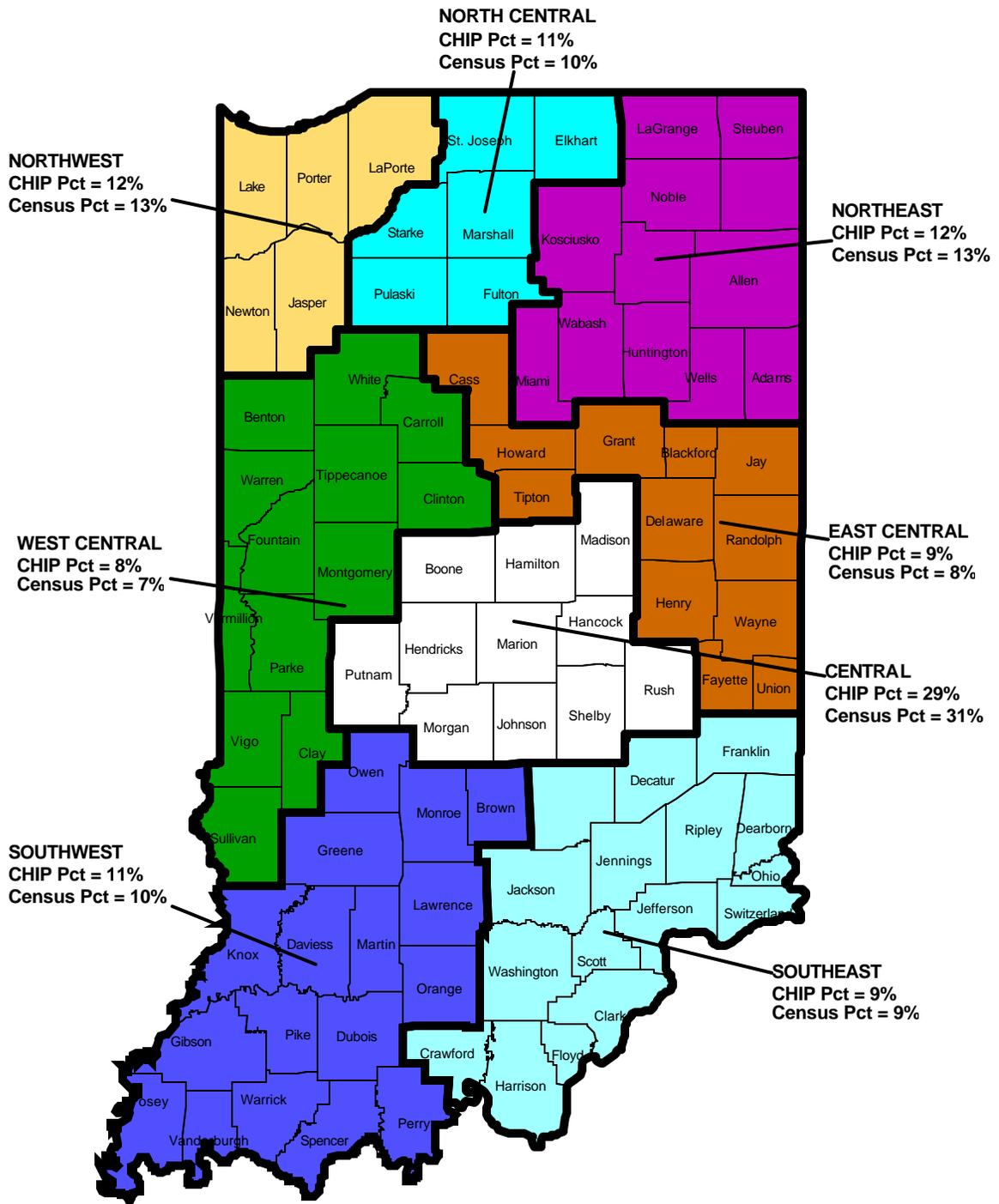


¹ County Population Estimates by Age, Sex, Race and Hispanic Origin: April 1, 2000 to July 1, 2007, Population Estimates Program, Population Division, U.S. Census Bureau

Enrollment by Region

The distribution of CHIP members by MCO region closely matches the overall child population in Indiana. CHIP A and CHIP C members enrolled as of July 2007 are compared to the total child population in Indiana as of July 2007 (most recent data available from US Census) below.

**Exhibit II.12
Distribution of CHIP Members by MCO Region**



III. Access to Primary Care Services for CHIP Members

This chapter examines the access that CHIP members have to primary medical providers (PMPs) and whether or not the availability of physicians in a particular county is impacting the rate of primary care visits or ER visits. CHIP members select both a PMP and the managed care organization (MCO) that they want to join, but if a specific PMP is preferred then the member must join one of the MCOs that the PMP contracts with. As of January 2007, PMPs may contract with one or more MCO. Their reimbursement rate may differ between MCOs. Once contracted, a PMP commits to accept a specified number of Hoosier Healthwise members (known as the PMP's panel size) with the MCO. A member's decision on which MCO to join may be influenced by whether or not their preferred PMP contracts with a particular MCO.

In the event that a member does not select a PMP or MCO within 30 days of becoming eligible for Hoosier Healthwise, a PMP and MCO are assigned to them. Among other factors, an attempt is made to "auto-assign" members to PMPs near where they live.

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.¹ When they contract with an MCO, the PMP identifies whether or not they are willing to accept children as patients. However, the panel size that a PMP negotiates does not differentiate between the number of children and the number of adults that the PMP will accept. (The obvious exception is Pediatricians.) All Hoosier Healthwise members, both adults and children, select a PMP. Therefore, it is not possible to assess with precision the availability of PMPs for CHIP members since they are seamlessly integrated into the Hoosier Healthwise program with Medicaid children and adults.

In an effort to gain a better understanding of primary care access for children in particular, Burns & Associates, Inc. (B&A) studied access under three scenarios:

- First, counties with access to pediatricians were identified both at the statewide level and at the MCO level.
- Second, CHIP members were assessed as to whether or not the PMP they are assigned to is located in the same county in which they live. Although it may be just as easy for members to cross county lines to see their PMP, the level of members seeking out-of-county care may be an indicator of limited access in the county.
- Third, overall access was measured for all Hoosier Healthwise members (children and adults) among all available PMPs² based upon their panel size commitments and how much of the panel size is already committed. This was reviewed at both the statewide level, for each of the eight Hoosier Healthwise regions, and by county. Primary care visits and emergency room visits (measured on a per 1,000 member basis) are compared across counties and regions to determine if there is a correlation between lower availability of PMPs in a county and lower use of primary care visits or higher visits to the ER for members in the county.

¹ OB/GYNs may, but are not obligated, to sign up as PMPs. They may also sign up as a specialist.

² For this particular analysis, OB/GYNs were excluded since they are unlikely to be PMPs for most CHIP members.

Availability of Pediatricians

Exhibits III.1 through III.4 which appear on the following pages show the counties in which pediatricians have contracted with Hoosier Healthwise MCOs to serve children (both Medicaid and CHIP). There are many counties where pediatricians are not available. Since the MCOs must participate statewide, they are required to offer access to primary care in all regions of the state. Among the three MCOs, MDwise has the most counties with a pediatrician available. The results shown in each exhibit are as follows:

- Exhibit III.1, which shows the availability of pediatricians across all MCOs, reveals that there are 37 counties in the state where no MCO has contracted with a pediatrician. In the remaining 55 counties, however, there are other physicians (e.g. family practitioners, general practitioners) available to see children.
- Exhibit III.2 maps the availability of pediatricians in the Anthem MCO. In addition to the 37 counties mentioned above, Anthem has 19 additional counties where it does not contract with a pediatrician.
- Exhibit III.3 maps the availability of pediatricians in the Managed Health Services (MHS) MCO. In addition to the 37 counties among all MCOs with no pediatrician, MHS has 21 additional counties where it does not contract with a pediatrician.
- Exhibit III.4 maps the availability of pediatricians in the MDwise MCO. In addition to the 37 counties among all MCOs with no pediatrician, MDwise has 11 additional counties where it does not contract with a pediatrician.

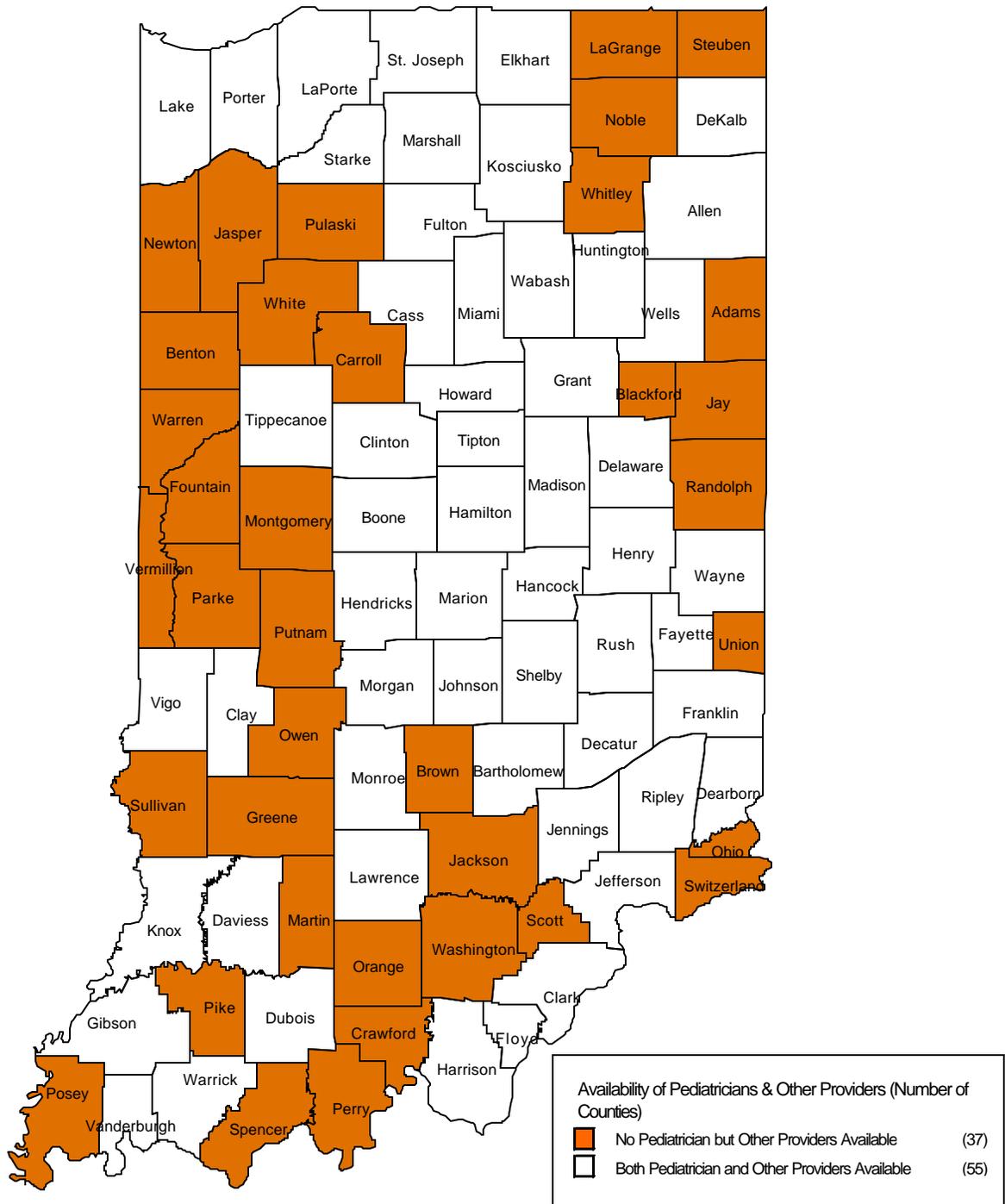
Accessing Primary Care Outside of Residing County

On page III-7, Exhibit III.5 displays at the county level the percentage of CHIP children who were enrolled in September 2008³ and whether or not they selected or were assigned to a PMP in or outside of the county they reside. There is wide variation on this statistic at the county level. Among the counties with the 10 highest member:PMP same-county ratios, the percentage in each county is at least 84 percent. For the 10 lowest member:PMP same-county ratios, the percentage in each county is below 15 percent. The 10 highest member:PMP same-county ratios are urban counties with a significant population center which may influence the total number of physicians available for all citizens, not just Medicaid members. The 10 lowest member:PMP same-county ratios are rural counties. In fact, four counties (Crawford, Jennings, Parke and Switzerland) have been designated Health Professional Shortage Areas by the U.S. Department of Health and Human Services' Health Resources and Services Administration.

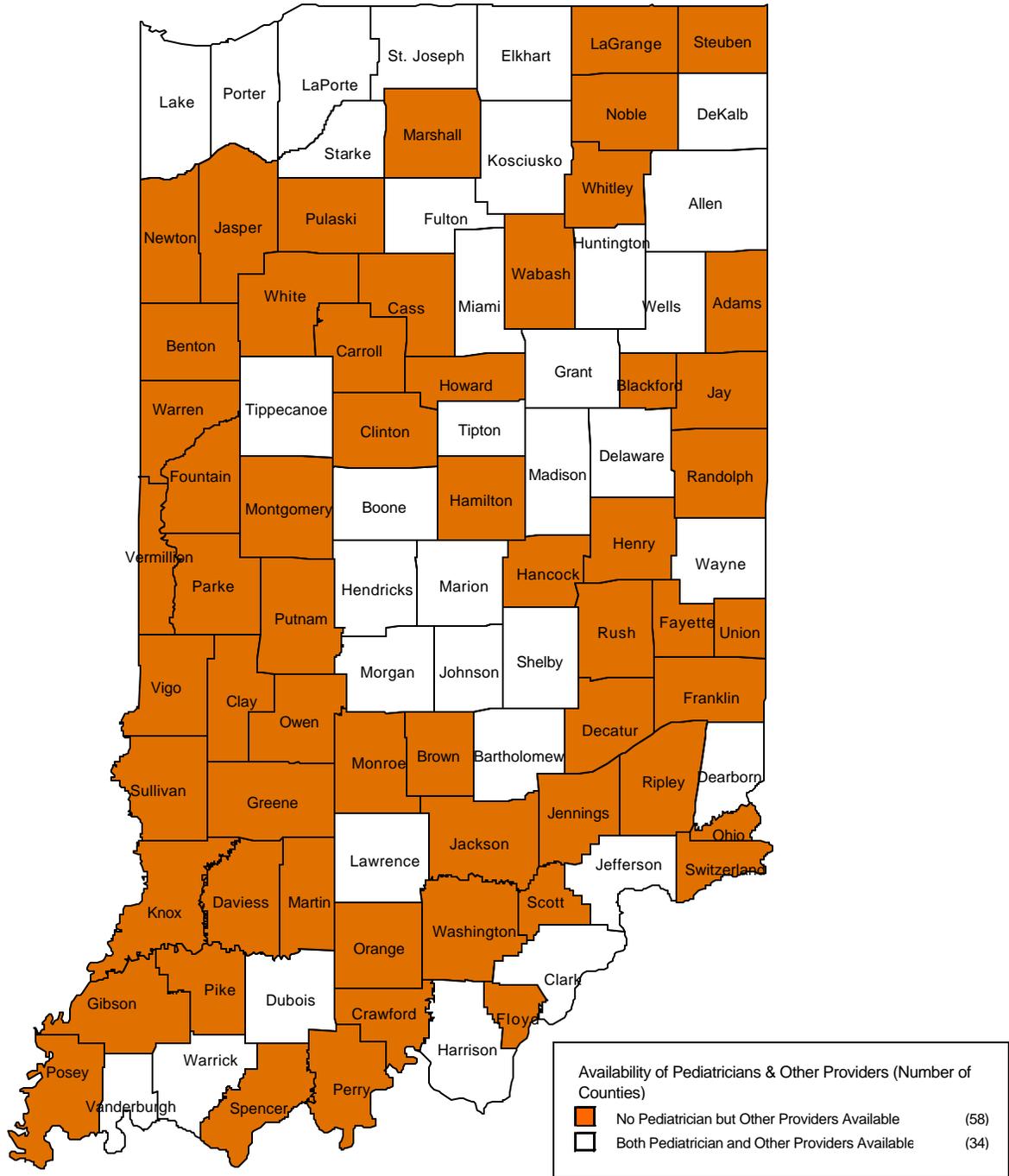
There are three counties (Adams, Benton and Parke) for which no CHIP members either were selected or were assigned to PMPs inside their home county. In Adams County, 92 percent of the members selected or were assigned a PMP in either Allen County to the north or Wells County to the west because there was only one PMP in all of Adams County that contracted with Hoosier Healthwise. For Benton County (also only one contracted PMP), two-thirds of members either selected or were assigned to a PMP in either Jasper County to the north or Tippecanoe County to the east. For Parke County (five contracted PMPs), three-quarters of members selected or were assigned to a PMP in either Vermillion County to the west or Vigo County to the southwest.

³ Members who were still enrolled in fee-for-service and had not yet selected a PMP were excluded from this analysis.

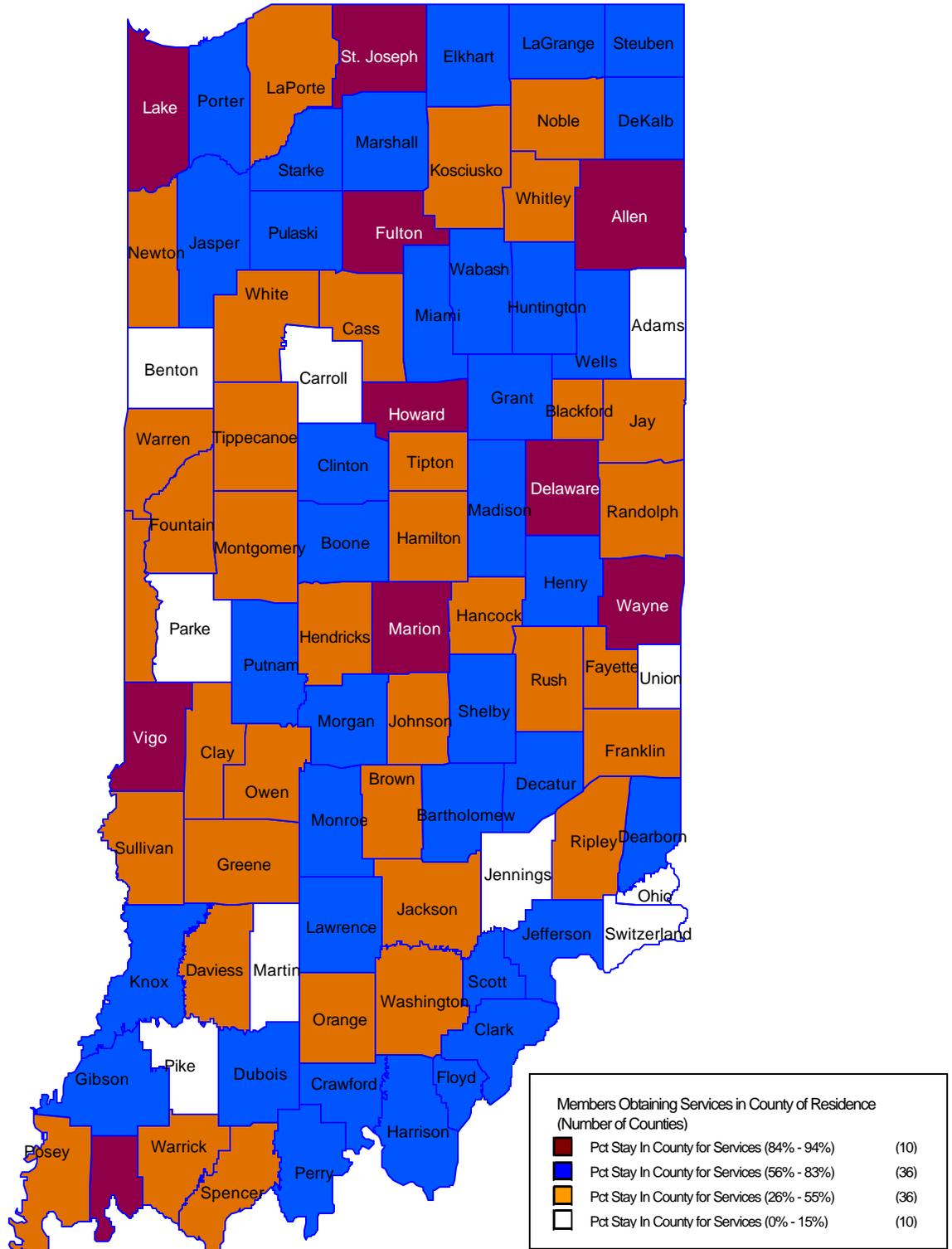
**Exhibit III.1
Availability of Pediatricians and Other Primary Care Providers Serving Children- All MCOs**



**Exhibit III.3
Availability of Pediatricians and Other Primary Care Providers Serving Children - MHS**



**Exhibit III.5
Members Obtaining Services in Residing County**



Panel Capacity Levels

The remaining maps in this chapter display for the state as a whole (Exhibit III.7 on page III-10) or by region (Exhibits III.8 through III.15 on the remaining pages) a measure of the level of panel capacity for all Hoosier Healthwise members. Since CHIP children and Medicaid children comprise the majority of Hoosier Healthwise members, a study of panel capacity for the entire program can also inform the level of access to CHIP members.

Panel capacity is defined as the number of members enrolled with a PMP divided by the total number (panel) that the PMP is willing to accept. A physician who sees members from counties outside of the county where he/she practices count against his/her panel. Data used in the exhibits is based on PMP panel levels and Hoosier Healthwise enrollment in December 2008. The panel capacity levels are calculated at the county level and include PMPs from all three MCOs but exclude OB/GYNs. Three levels of availability have been assigned:

- Low Availability = counties where the county-wide panel is 80 percent full or greater
- High Availability = counties where the county-wide panel is 20 percent full or less
- Medium Availability = counties where the county-wide panel is between 20 percent and 80 percent full

Of greatest concern are the counties with Low Availability. Exhibit III.7 shows that there are 11 counties categorized as Low Availability: Bartholemew, Clinton, Dubois, Elkhart, Hendricks, Jefferson, Ohio, Shelby, Steuben, Tippecanoe and White. Clinton and Shelby Counties actually border counties with high availability (Tipton and Rush, respectively).

Exhibits III.8 through III.15 repeat the findings found on the map in Exhibit III.7 but for the specified region. Also included on these exhibits is a table showing the actual value of percent full panels, the percentage of CHIP children who are assigned to a PMP in the county they reside, utilization of primary care visits per 1,000 CHIP members in the county, and utilization of ER visits per 1,000 CHIP members in the county. This information is shown together in an effort to ascertain if the level of availability of PMPs in a particular county or region results in lower primary care visits or higher ER visits from members.

The average across all counties for full PMP panels is 49 percent. On average, 71 percent of CHIP members are assigned to a PMP within the county they reside. The average number of primary care visits per 1,000 CHIP members is 131, but there is a wide range from a low of 87 per 1,000 in Adams County to a high of 224 per 1,000 CHIP members in Huntington County. Likewise, there is quite a bit of variation in the number of ER visits per 1,000 CHIP members. Although the average statewide is 32 visits per 1,000, the range is from a low of 14 per 1,000 in Knox and Monroe Counties to a high of 53 in Dubois County.

A summary of the low availability counties with the primary care and ER utilization for CHIP members in these counties is shown in Exhibit III.6 on the next page.

**Exhibit III.6
Comparison of PMP Availability and Primary Care and ER Usage for CHIP Members**

*How County Statistics Compare to
Statewide Averages for*

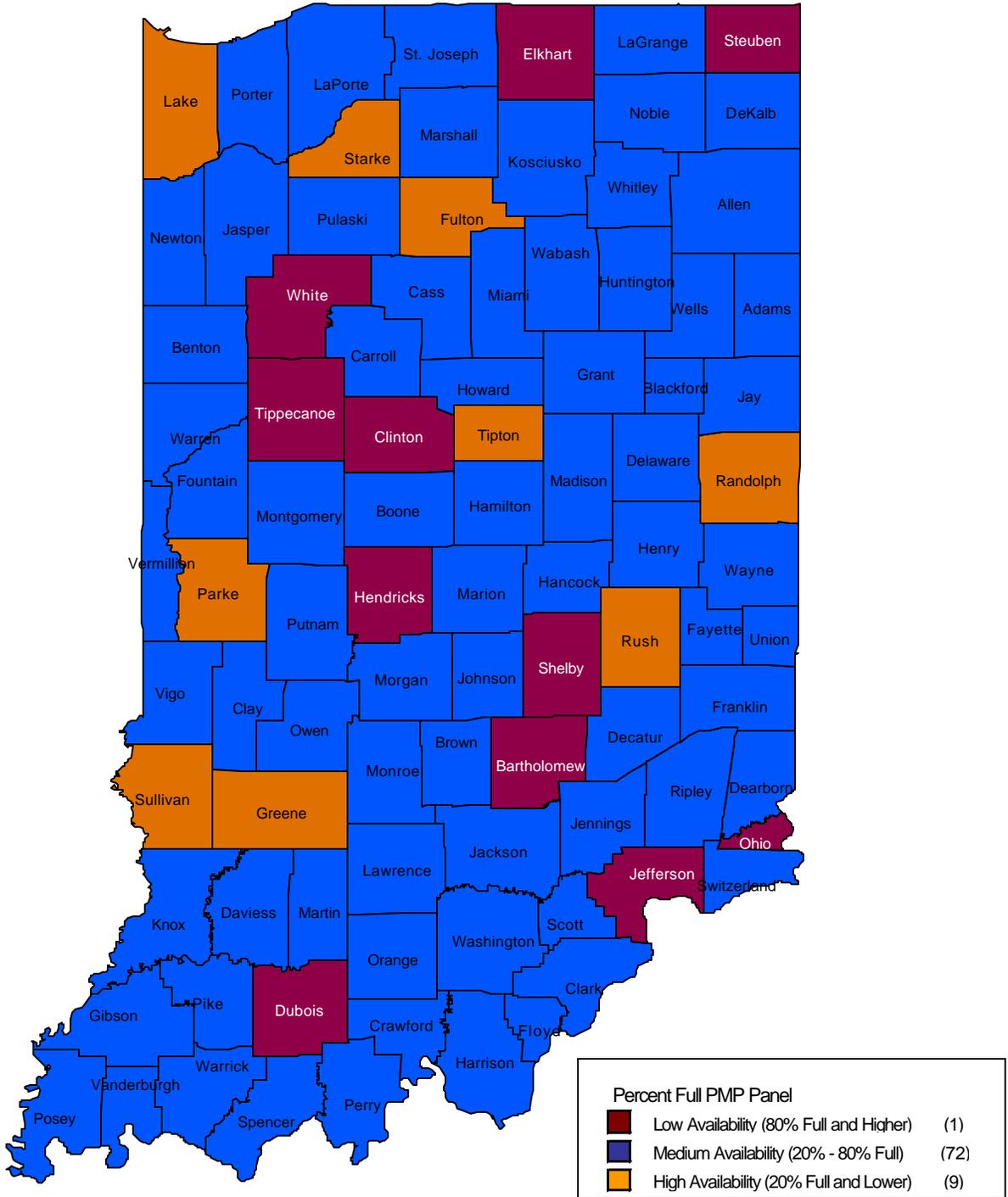
County	Region	Percent Full Panel	Percent of CHIP Members Assigned to a PMP in their Home County	Primary Care Visits Per 1,000 CHIP Members	ER Visits Per 1,000 CHIP Members
Elkhart	North Central	88%	72%	<i>Lower</i>	Similar
Steuben	Northeast	87%	59%	Much higher	Similar
Clinton	West Central	88%	66%	<i>Much lower</i>	Same
Tippecanoe	West Central	84%	53%	Same	<i>Higher</i>
White	West Central	103%	40%	Higher	Higher
Hendricks	Central	101%	36%	Higher	Similar
Shelby	Central	113%	64%	Higher	Similar
Dubois	Southwest	85%	70%	<i>Lower</i>	<i>Much higher</i>
Bartholemew	Southeast	90%	62%	Higher	Much lower
Jefferson	Southeast	93%	70%	Higher	Similar
Ohio	Southeast	86%	9%	Higher	Lower

Each of these counties is classified as low access (i.e. PMP panels greater than 80 percent full). In fact, three counties have panels greater than 100 percent full, meaning that the physicians have taken more Hoosier Healthwise members as patients than they contractually obligated to.

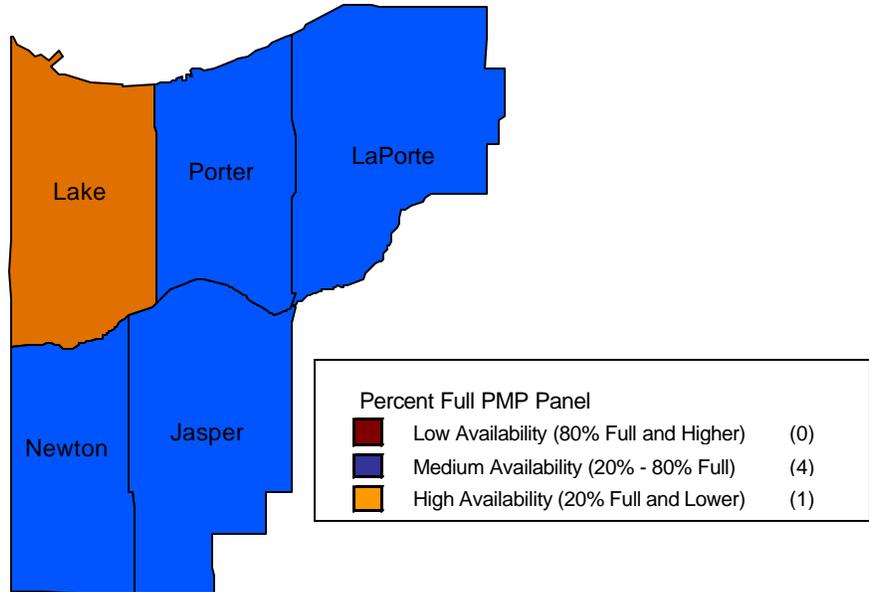
Although many counties have a low member:PMP same-county ratio versus other counties in the state, neither this fact nor the fuller panels appear to be influencing access to care.

This is illustrated in the last two columns of Exhibit III.6. B&A compared the average number of primary care visits per 1,000 and ER visits per 1,000 statistics in each of these counties and compared them to the statewide averages. Counties with lower primary care visits per 1,000 members (highlighted in bold italics) or higher ER visits per 1,000 (also in bold italics) than the statewide average may be impacted by the fuller PMP panel sizes in the county. But the data shows that only Elkhart, Clinton, Tippecanoe and Dubois Counties may in fact be influenced by the PMP availability. The only county where there appears to be a relationship between PMP availability and impact on access to care is Dubois County, since it has lower primary care utilization for CHIP members and the highest ER visits per 1,000 of any county in the state.

**Exhibit III.7
Panel Capacity for All Hoosier Healthwise Members**

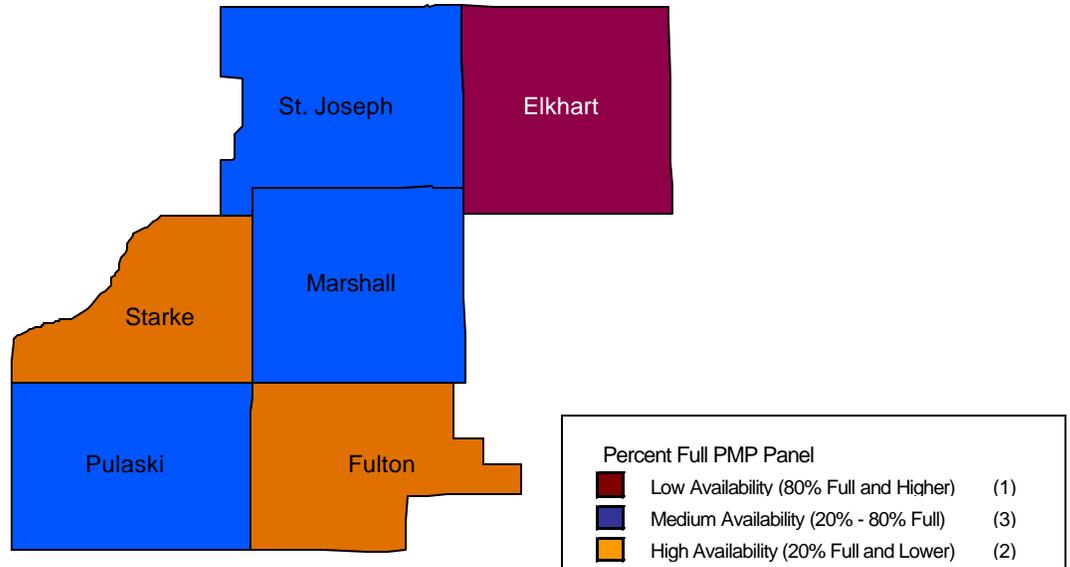


**Exhibit III.8
Panel Capacity – Northwest Region**



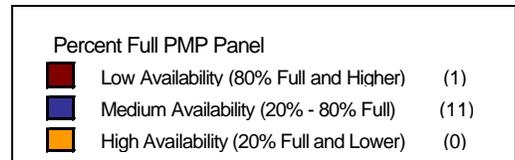
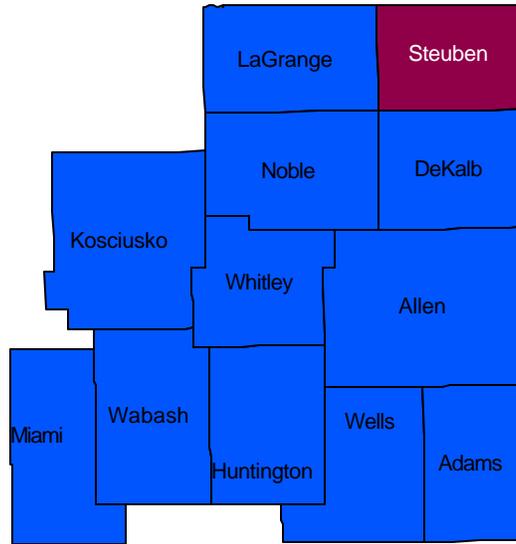
	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
Northwest Average	26%	79%	119	24
Jasper County	25%	76%	160	36
Lake County	18%	94%	112	21
LaPorte County	40%	45%	136	31
Newton County	27%	26%	154	27
Porter County	21%	56%	134	28

**Exhibit III.9
Panel Capacity – North Central Region**



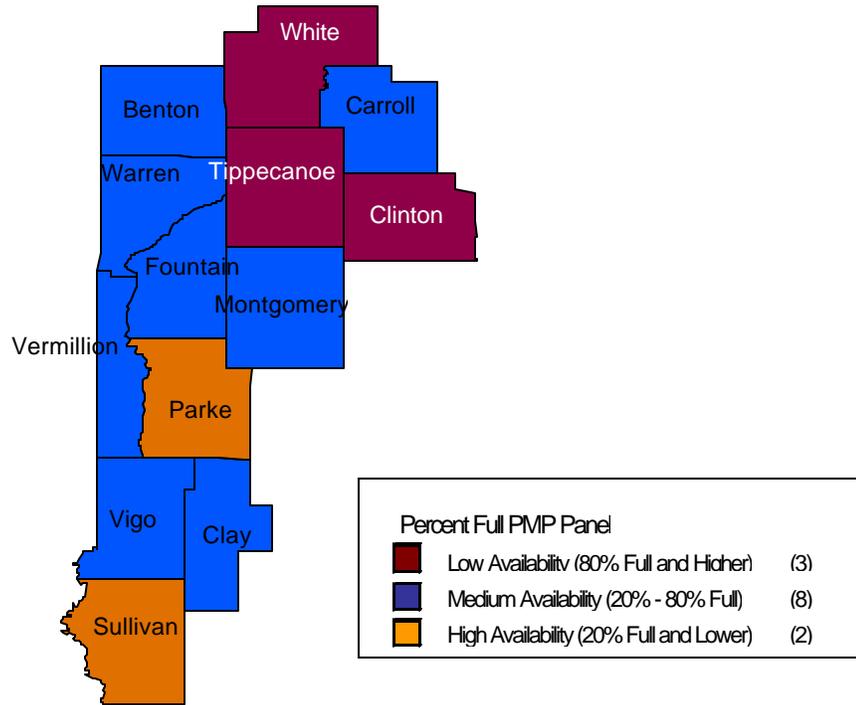
	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
North Central Average	48%	80%	122	23
Elkhart County	88%	72%	103	28
Fulton County	9%	85%	184	26
Marshall County	79%	58%	143	23
Pulaski County	44%	68%	135	35
St. Joseph County	53%	94%	124	17
Starke County	15%	63%	162	34

**Exhibit III.10
Panel Capacity – Northeast Region**



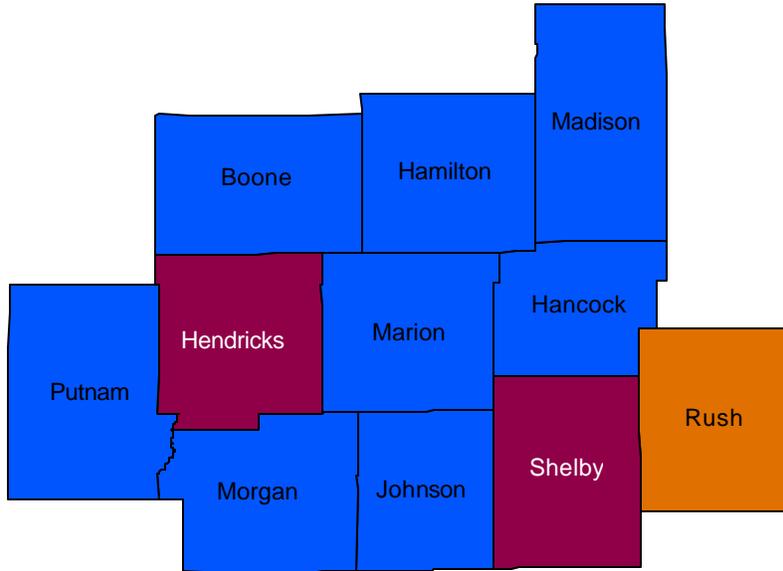
	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
Northeast Average	56%	69%	137	31
Adams County	51%	0%	87	28
Allen County	50%	90%	128	31
DeKalb County	80%	57%	142	30
Huntington County	52%	69%	224	33
Kosciusko County	68%	49%	132	25
LaGrange County	36%	68%	109	31
Miami County	58%	64%	192	32
Noble County	53%	18%	96	38
Steuben County	87%	59%	186	28
Wabash County	38%	59%	140	29
Wells County	34%	76%	160	33
Whitley County	70%	38%	142	36

**Exhibit III.11
Panel Capacity – West Central Region**



	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
West Central Average	49%	53%	138	38
Benton County	42%	0%	136	30
Carroll County	67%	12%	143	29
Clay County	28%	30%	150	42
Clinton County	88%	66%	91	34
Fountain County	50%	29%	155	25
Montgomery County	66%	43%	128	46
Parke County	19%	0%	161	36
Sullivan County	9%	42%	204	26
Tippecanoe County	84%	53%	131	38
Vermillion County	25%	46%	148	42
Vigo County	34%	88%	138	43
Warren County	24%	21%	157	18
White County	103%	40%	156	43

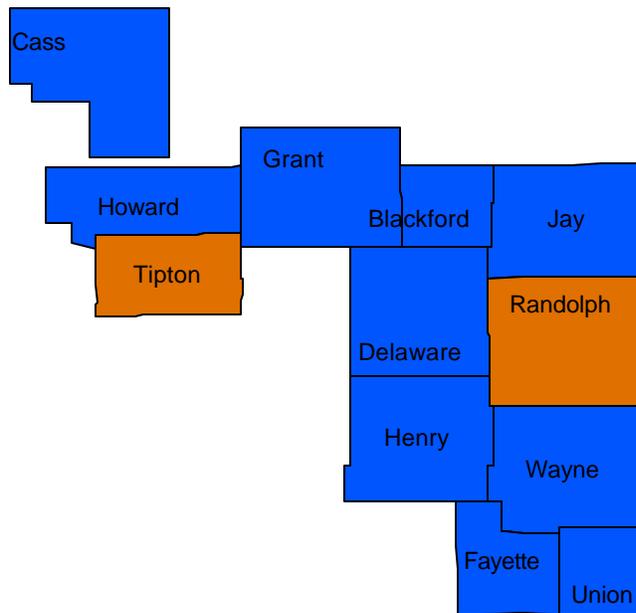
**Exhibit III.12
Panel Capacity – Central Region**



Percent Full PMP Panel		
■	Low Availability (80% Full and Higher)	(2)
■	Medium Availability (20% - 80% Full)	(8)
■	High Availability (20% Full and Lower)	(1)

	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
Central Average	58%	78%	112	38
Boone County	28%	77%	140	37
Hamilton County	76%	43%	113	30
Hancock County	75%	44%	163	36
Hendricks County	101%	36%	141	30
Johnson County	46%	52%	172	31
Madison County	36%	76%	129	32
Marion County	36%	91%	97	41
Morgan County	69%	58%	149	41
Putnam County	51%	81%	147	34
Rush County	12%	39%	151	36
Shelby County	113%	64%	162	36

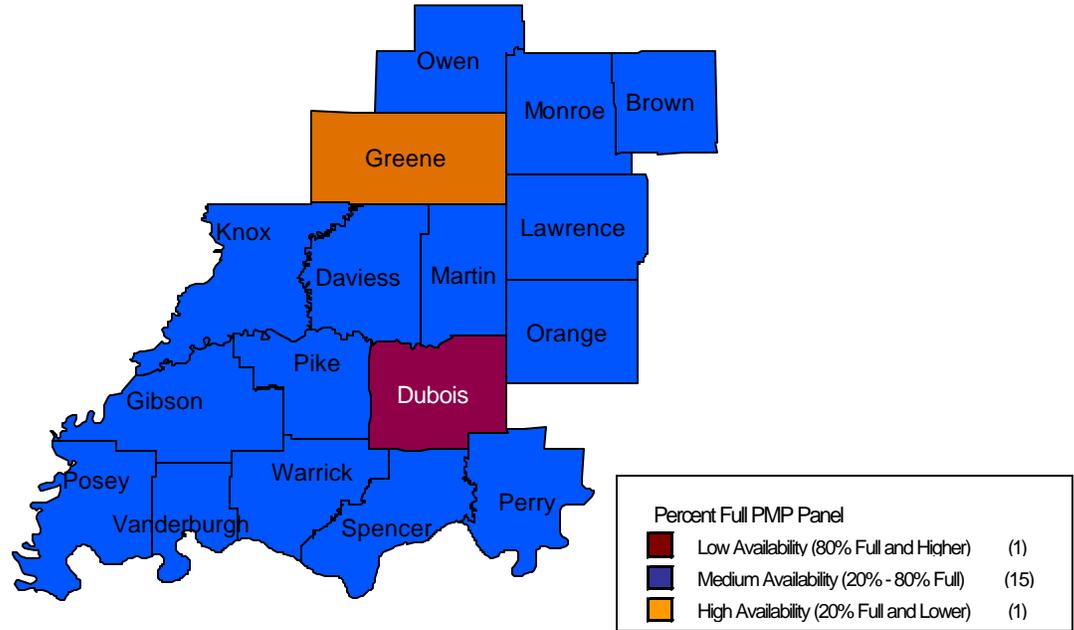
**Exhibit III.13
Panel Capacity – East Central Region**



Percent Full PMP Panel		
■	Low Availability (80% Full and Higher)	(0)
■	Medium Availability (20% - 80% Full)	(10)
■	High Availability (20% Full and Lower)	(2)

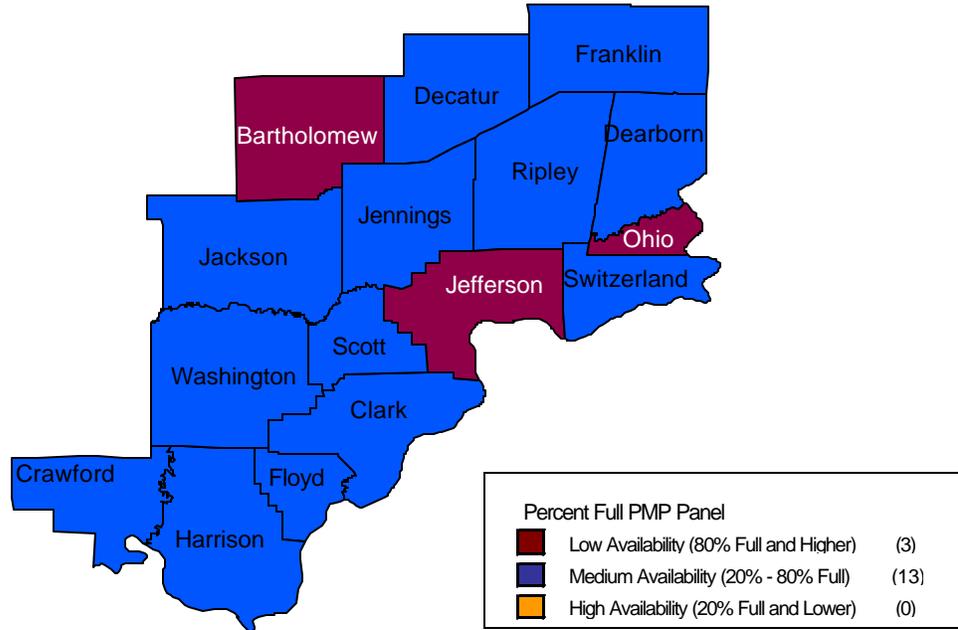
	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
East Central Average	47%	73%	141	38
Blackford County	72%	42%	151	40
Cass County	59%	54%	117	33
Delaware County	40%	84%	153	26
Fayette County	76%	51%	162	52
Grant County	27%	80%	132	44
Henry County	33%	66%	174	39
Howard County	54%	86%	136	32
Jay County	59%	52%	189	38
Randolph County	18%	52%	130	38
Tipton County	15%	45%	143	32
Union County	38%	12%	139	51
Wayne County	67%	88%	113	49

**Exhibit III.14
Panel Capacity – Southwest Region**



	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
Southwest Average	37%	57%	170	24
Brown County	71%	16%	180	18
Daviess County	25%	54%	172	42
Dubois County	85%	70%	112	53
Gibson County	44%	62%	190	24
Greene County	11%	17%	197	26
Knox County	74%	79%	193	14
Lawrence County	33%	75%	185	24
Martin County	33%	14%	183	36
Monroe County	31%	77%	179	14
Orange County	66%	31%	183	44
Owen County	38%	36%	150	20
Perry County	64%	71%	161	42
Pike County	62%	13%	150	28
Posey County	22%	54%	167	18
Spencer County	44%	49%	198	34
Vanderburgh County	45%	87%	153	19
Warrick County	32%	18%	173	26

**Exhibit III.15
Panel Capacity – Southeast Region**



	PMP Availability (Percent Full Panels)	Pct of CHIP Children Assigned to a PMP in the County they Reside	Primary Care Office Visits Per 1,000 Members	ER Visits Per 1,000 Members
Statewide Average	49%	71%	131	32
Southeast Average	52%	48%	161	28
Bartholomew County	90%	62%	153	16
Clark County	38%	81%	169	28
Crawford County	64%	69%	167	28
Dearborn County	28%	68%	154	18
Decatur County	47%	59%	156	30
Floyd County	40%	66%	176	35
Franklin County	58%	32%	141	36
Harrison County	65%	60%	174	26
Jackson County	28%	25%	119	36
Jefferson County	93%	70%	174	51
Jennings County	37%	14%	190	25
Ohio County	86%	9%	163	16
Ripley County	40%	45%	137	25
Scott County	34%	64%	179	37
Switzerland County	61%	15%	170	27
Washington County	20%	37%	134	16

IV. Utilization of Services for CHIP Members

This chapter analyzes the trends in utilization in Indiana’s CHIP for services commonly used by children. Service usage is compared across two periods—Federal Fiscal Year (FFY) 2007 (10/1/06 – 9/30/07) and Federal Fiscal Year 2008 (10/1/07 – 9/30/07). In an effort to understand if usage patterns differ within the CHIP population, each service reviewed is examined across these dimensions:

- Usage by CHIP A members versus CHIP C members
- Usage across four age/gender groups
- Usage by members enrolled in each of the three Hoosier Healthwise managed care organizations (MCOs)
- Usage across four race/ethnicity populations
- Usage by members from eight regions in the state

Utilization data used in this analysis was retrieved by Burns & Associates, Inc. (B&A) from the Office of Medicaid Policy and Planning’s data warehouse in early January 2009. The data warehouse stores information about the members as well as the services they use. Utilization for members in the Hoosier Healthwise is reported by the MCOs through “encounters”. Since CHIP members may only stay in the fee-for-service program for a limited time upon initial enrollment, B&A limited its utilization analysis to encounter data and did not include claims directly submitted by providers, with the exception of preventive dental services¹. It should be noted that data from FFY 2008 may be incomplete if the MCOs have not submitted all of their encounter data for this time period yet.

Methodology for Examining Utilization Patterns

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2007 or FFY 2008. The discussion in Chapter II described how CHIP members often move between CHIP A, CHIP C and Medicaid and that members can join and drop off Medicaid/CHIP frequently. Therefore, in order to best assess utilization patterns, B&A limited the member base to a more stable population than total enrollees. Only members enrolled for at least nine months in either FFY 07 or FFY 08 were included in the study. Members could be included in one year and not the other based upon their enrollment history. Members may have been enrolled in a combination of CHIP A, CHIP C and Medicaid, but since all three programs are a part of the Hoosier Healthwise program, the member was included if they met the nine month minimum threshold. However, because our analysis focused on the MCOs’ ability to manage their members’ care, we also limited the population to those enrolled for at least nine months within a single MCO.

Members were ultimately categorized into either CHIP A or CHIP C depending upon where they were enrolled at the end of each calendar year (or where they were enrolled before disenrolling completely). Once the children were identified, they were assigned an indicator for the MCO they were enrolled with, the region where they live in the state, their age, and their race/ethnicity. 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.

¹ Dental services are “carved out” of the managed care contracts. Dentists bill the OMPP directly for services to Medicaid members.

Our selection criteria yielded a sample of 60 percent of the children ever enrolled in CHIP in each of the two years. Exhibit IV.1 provides a profile of the members included in this study.

**Exhibit IV.1
Profile of CHIP Members in the Utilization Study**

	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
FFY 07 Total Population	59,923	21,756	81,679
FFY 07 Study Population	37,775	10,983	48,758
Study Population- Pct of Total	63%	50%	60%
FFY 08 Total Population	64,976	26,977	91,953
FFY 08 Study Population	41,011	14,287	55,298
Study Population- Pct of Total	63%	53%	60%

Study Population for CHIP A and CHIP C Combined

	<u>FFY07</u>		<u>FFY08</u>	
Total	48,758		55,298	
<u>By Age Group</u>		<u>Pct of Total</u>		<u>Pct of Total</u>
Age 1-5	7,776	16%	9,024	16%
Age 6-12	24,406	50%	27,019	49%
Age 13-18 Females	8,260	17%	9,487	17%
Age 13-18 Males	8,316	17%	9,768	18%
<u>By MCO</u>		<u>Pct of Total</u>		<u>Pct of Total</u>
MHS	15,236	31%	17,840	32%
Anthem	7,450	15%	10,788	20%
MDwise	26,072	53%	26,670	48%
<u>By Race/Ethnicity</u>		<u>Pct of Total</u>		<u>Pct of Total</u>
White	34,502	71%	38,427	69%
African American	7,750	16%	8,923	16%
Hispanic	5,514	11%	6,667	12%
Other	992	2%	1,281	2%

Services were defined across eight mutually-exclusive categories:

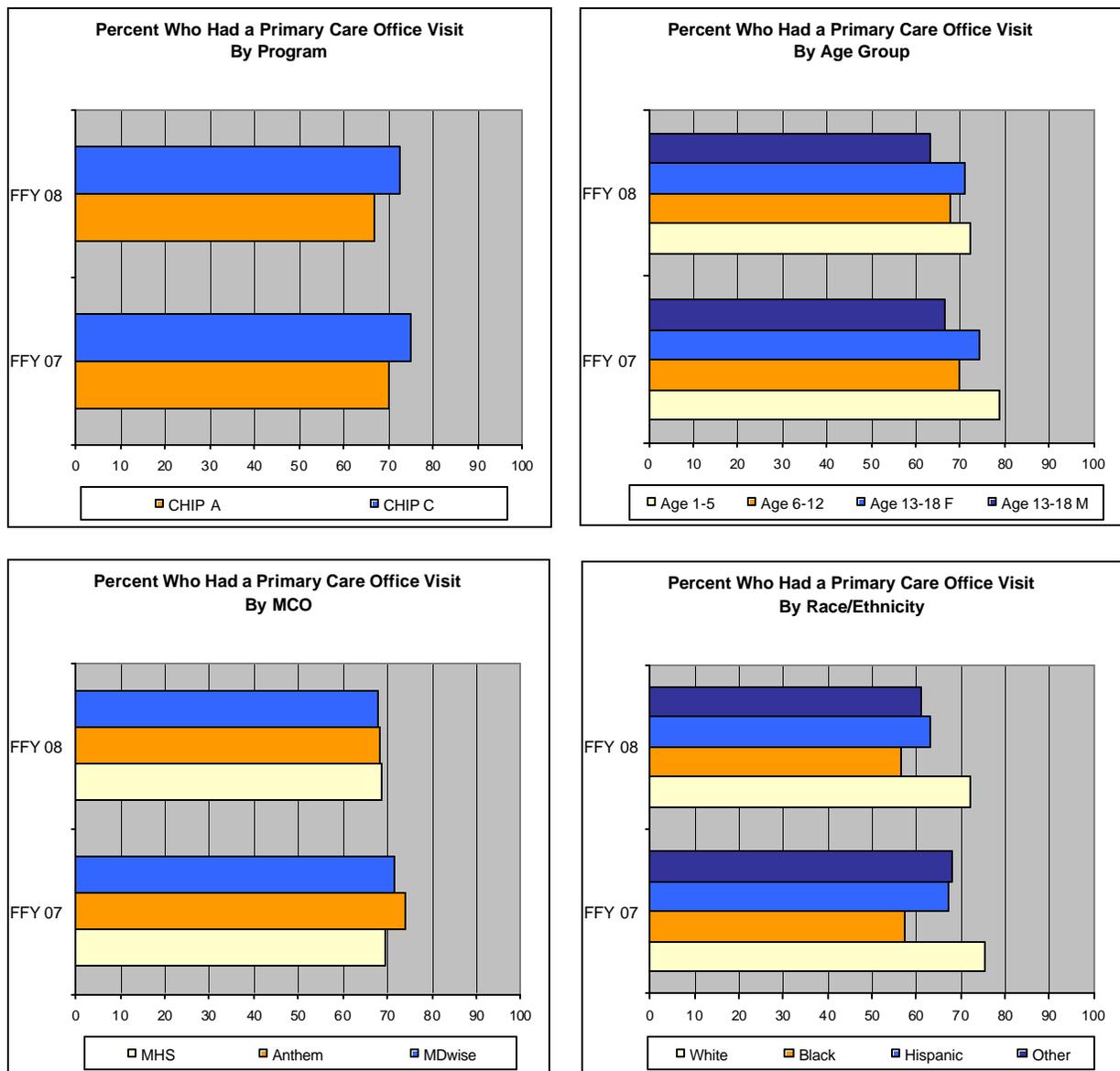
- Primary Care
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
- Specialty Physician Services
- Emergency Room Visits
- Outpatient Hospital services other than the ER
- Inpatient Hospital Stays
- Preventive Dental Services
- Pharmacy Scripts

Findings for each service examined are presented in the pages that follow. Appendix A also presents service use stratified by demographic group (e.g. by MCO, by region, by race/ethnicity).

Primary Care Office Visits

Primary care office visits include visits to doctor's offices or clinics specializing in primary care and include well-child visits and visits for specific ailments. Exhibit IV.2 shows that about 70 percent of CHIP A and CHIP C members had a primary care visit in each of the last two years. There is a slight dip in the percentage of children overall who had a primary care visit from FFY 2007 to FFY 2008, but this could be unreported data by the MCOs more than lower usage. Utilization is highest among the youngest children (age 1-5) and female teenagers. This has been found in prior years as well. Utilization is nearly identical across the MCOs in FFY 2008. There is a disparity in primary care usage between African-Americans and other race/ethnicities. With only 57 percent of African-American children utilizing the service in both FFY 2007 and FFY 2008, this is the same percentage found in last year's study. The percentage of Hispanic children receiving primary care is also lower than Caucasians. Their rate of usage in FFY 2007 and 2008 is slightly lower than what was reported last year.

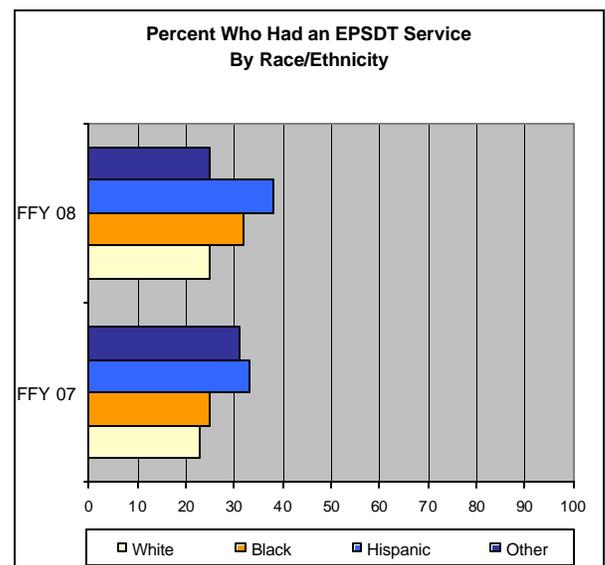
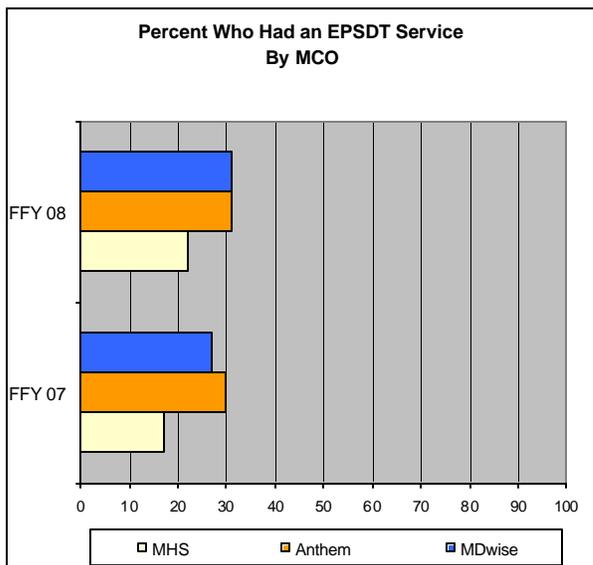
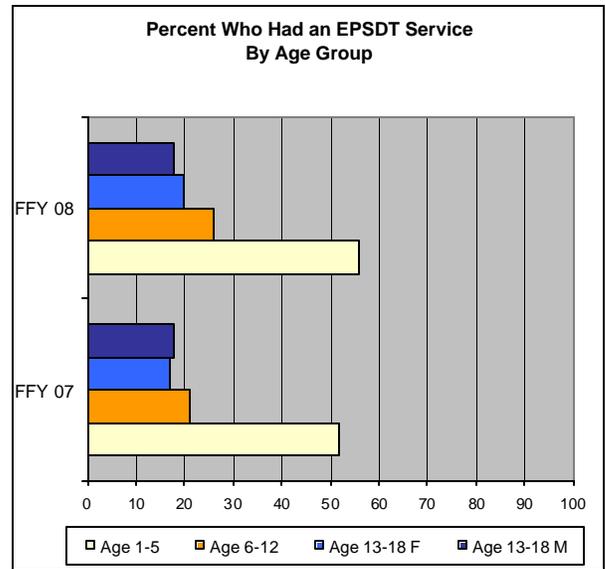
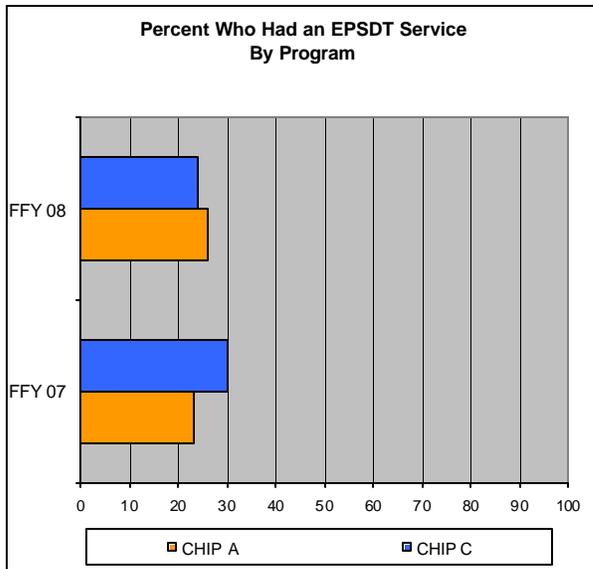
Exhibit IV.2
Primary Care Office Usage



EPSDT Services

An EPSDT service is a specific type of visit in which a screening, diagnosis or treatment is done to test certain conditions or diagnoses. It can include a health and developmental assessment, a physical exam, or screenings for dental, vision, hearing and blood lead levels. Although often administered by a primary medical provider, the OMPP separately identifies EPSDT visits, so a child who received an EPSDT visit as part of a primary care visit would be recorded here and not in the previous exhibit. Of course, children could receive both types of services in a given year. CHIP A and CHIP C members received an EPSDT at about the same rate in FFYs 2007 and 2008. EPSDT usage tends to be age-specific as seen in the distribution by age since more screenings are done at the younger age. However, EPSDT visits are recommended for all ages up through age 20. Anthem and MDwise members have higher EPSDT usage rates than MHS. Hispanic children have the highest EPSDT usage rate followed by African-Americans. This was also observed last year.

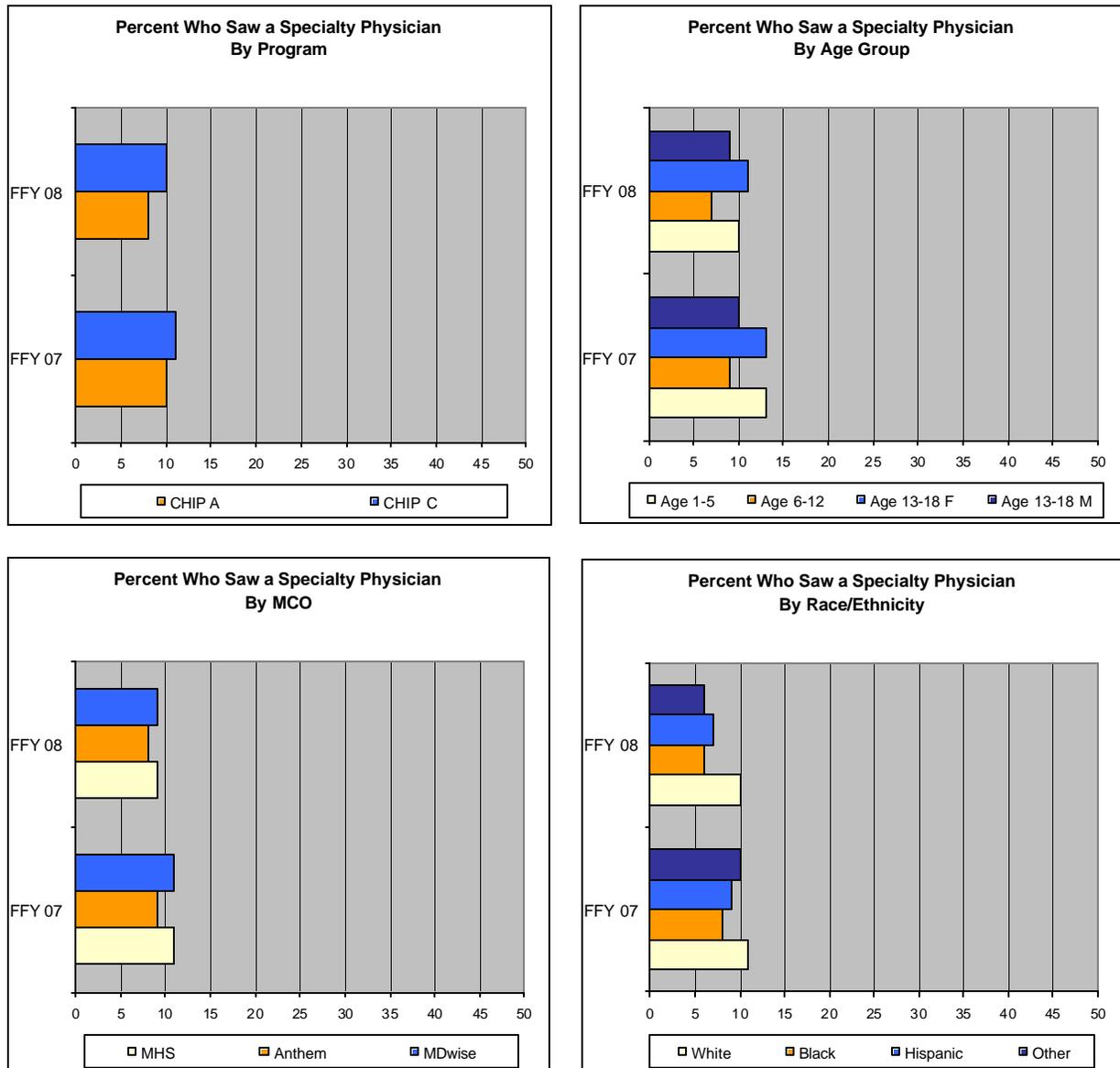
Exhibit IV.3
Visits for Early Periodic Screening, Diagnosis and Treatment Services



Specialty Physician Services

Only about 10 percent of CHIP members saw a specialty physician of any kind in FFY 2007 or FFY 2008. Specialty visits include any made to a physician that is not deemed a Primary Medical Provider in Hoosier Healthwise. Similar to primary care visits, children ages 1-5 and teenage females are slightly more likely to have seen a specialist than children of other ages. (Note that OB/GYN visits for girls are considered primary care visits.) There is little difference in usage from members across the MCOs. Caucasian children used specialist services a bit more than children of other race/ethnicity groups.

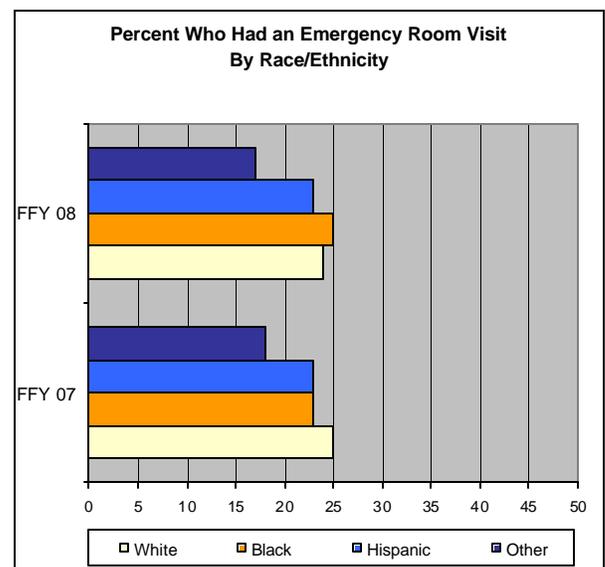
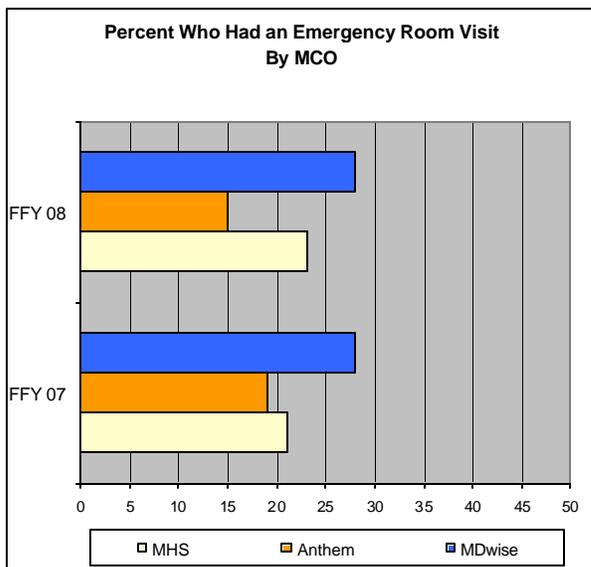
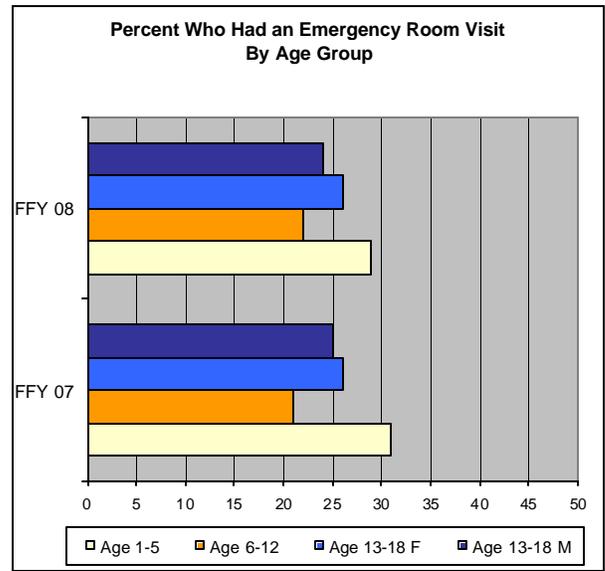
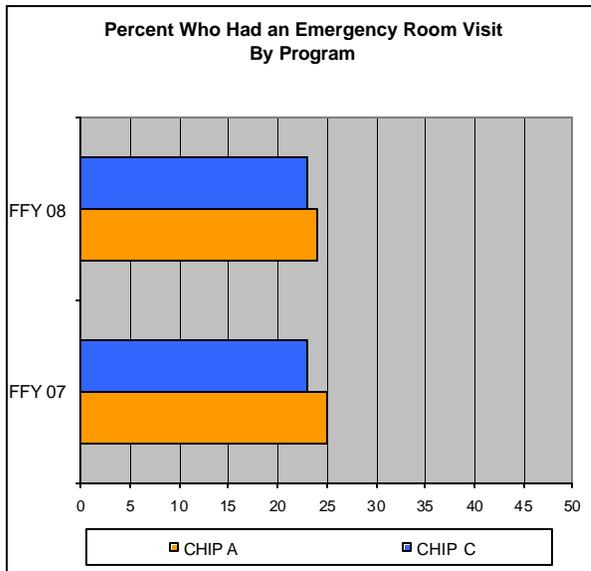
Exhibit IV.4
Visits to Specialty Physicians



Emergency Room Visits

Emergency room visits are counted in Exhibit IV.5 below regardless of whether the visit was emergent or non-emergent. Teaching members about the appropriate use of the ER has been a struggle for Medicaid programs nationally and Indiana is no exception. Actually, though still high, the overall percentage of CHIP members using the ER in FFY 07 and FFY 2008 has gone down some from what was reported last year when it was closer to 30 percent. Children ages 1-5 are most likely to have an ER visit, the same pattern shown in years past. MDwise members are much more likely to use the ER than Anthem or MHS members. There is little difference in ER usage among the race/ethnicities examined except that members classified as “Other” (includes mixed race, Asian, Indian, Native America), though a small population of the total, have lower ER usage.

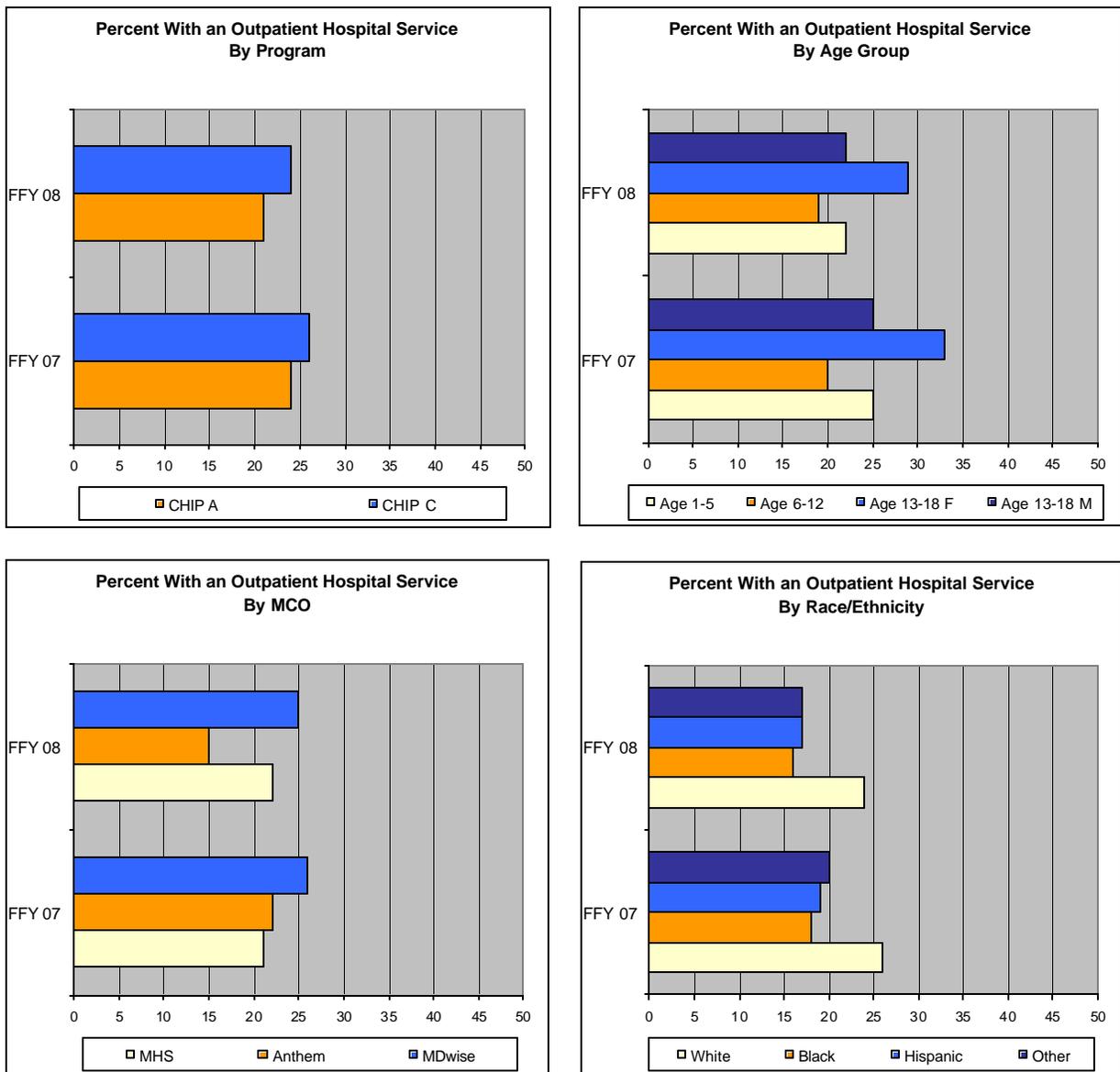
**Exhibit IV.5
Emergency Room Visits**



Outpatient Hospital Services

Twenty-five percent of CHIP A and CHIP C members alike had an outpatient hospital service (other than the ER). It was found that the top services utilized were for x-rays or lab tests. Teenage girls are the highest users of this service category, a trend found in years past as well. There is a ten percentage point difference between the percent of MDwise members using outpatient services (25 percent) and Anthem members (15 percent). This may be due to the MDwise delivery system's strong hospital-based relationships. Caucasian children were more likely to use outpatient services than the other race/ethnicity groups in both FFY 2007 and FFY 2008.

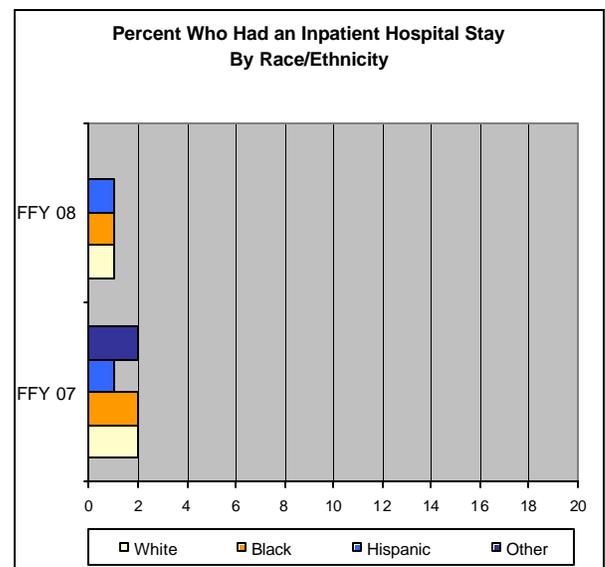
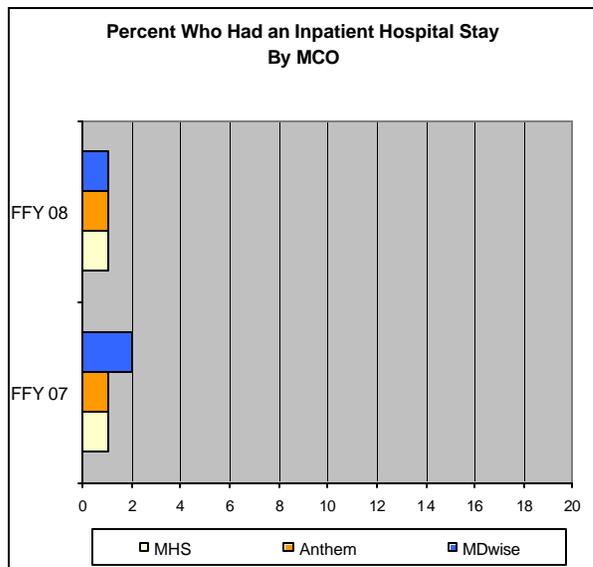
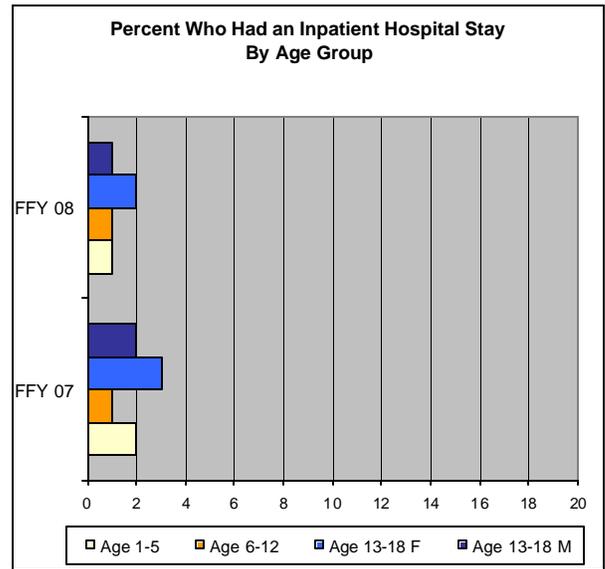
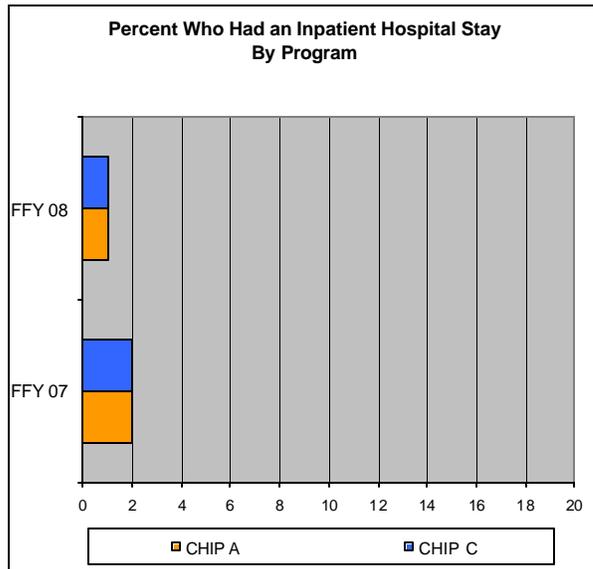
Exhibit IV.6
Usage of Outpatient Hospital Services (other than ER)



Inpatient Hospital Stays

Fortunately, inpatient hospital stays are very low for children in general and this was found to be true for the CHIP population. Hospital use is between one and two percent of all members each year. Though not too significant, the only outlier is among teenage girls, whose higher usage is due to childbirth. Specifically in the CHIP Package A population, almost two-thirds of all inpatient stays among teenagers were maternity-related stays among teenage girls.

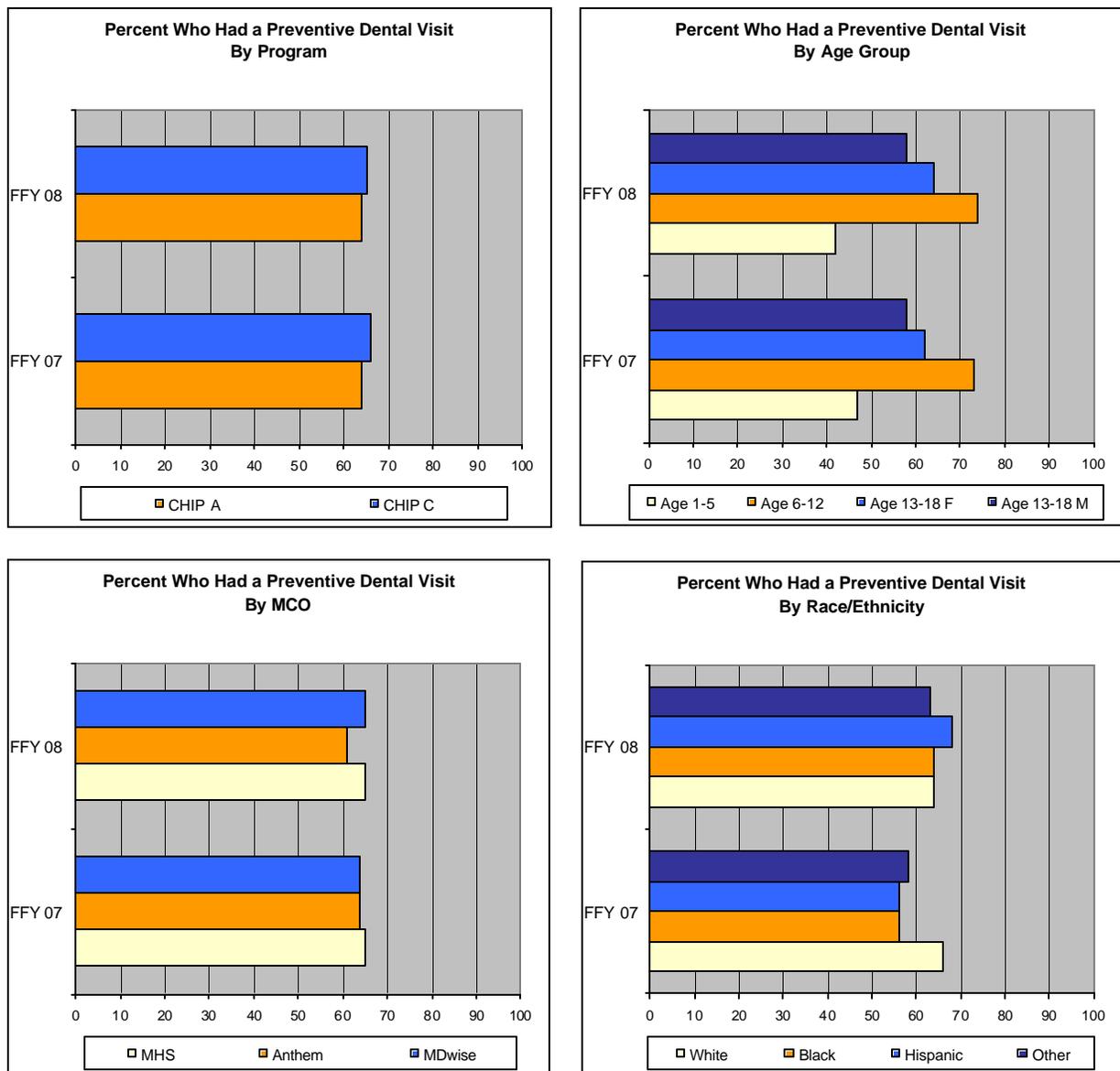
Exhibit IV.7
Inpatient Hospital Stays



Preventive Dental Visits

Indiana's Hoosier Healthwise has shown high preventive dental utilization in the last five years and this year's study is no exception. Preventive dental visits, used by about 65 percent of CHIP members in both FFY 2007 and FFY 2008, are almost as high as primary care doctor visits. At more than 70 percent, children in the age group 6-12 years are the highest utilizers of preventive dental. There is little difference between members of each of the MCOs, even though dental services are carved out of managed care and the MCOs are not responsible for this service. We found small differences in preventive dental usage among race/ethnicity groups in FFY 2008, but there was increased usage among non-Caucasians in FFY 2008 while there was a slight decrease in the percentage of Caucasian children with a preventive dental visit.

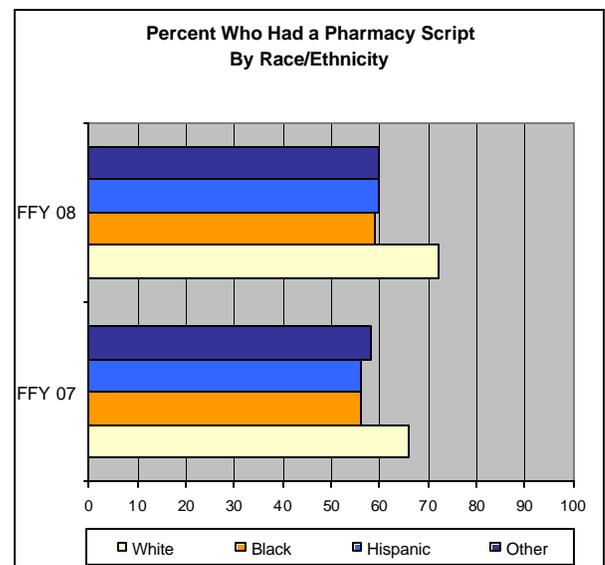
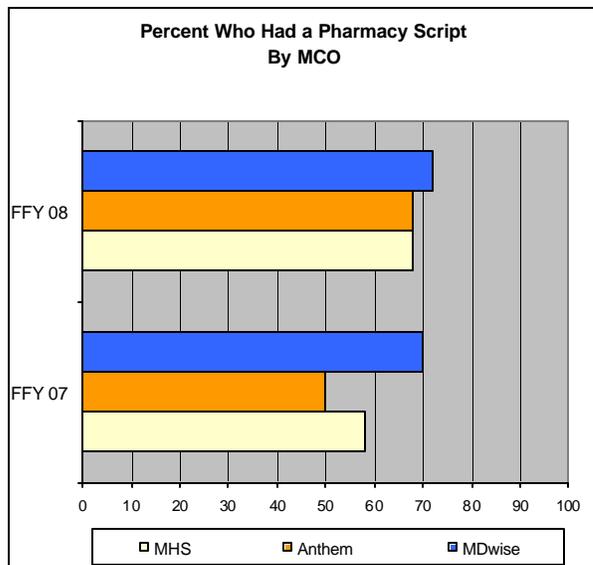
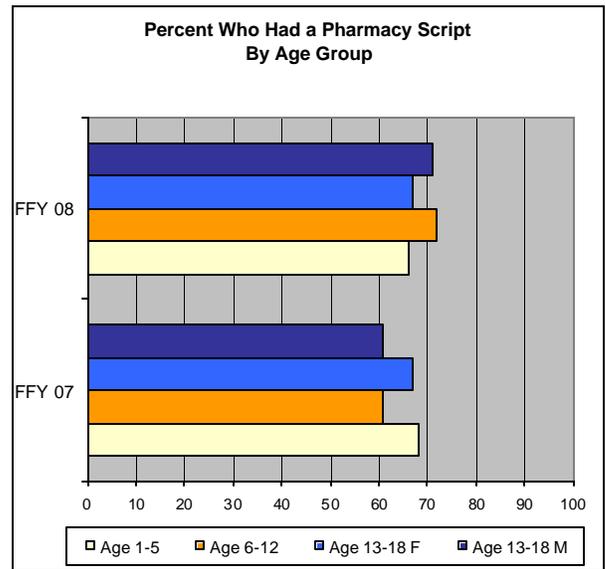
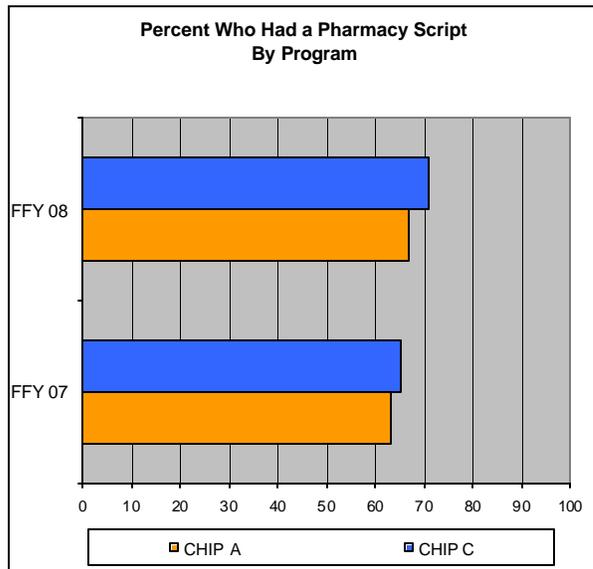
Exhibit IV.8
Preventive Dental Visits



Pharmacy Scripts

The percentage of children who have obtained a pharmacy script has grown among CHIP members between FFY 2007 and FFY 2008 by about four percentage points, though CHIP C is slightly higher than CHIP A in both years. Last year, teenage girls were the higher users of scripts than other age groups, but this year we find less of a distinction in usage among the age groups. Anthem's lower percentage usage in FFY 2007 is most likely attributable to their lack of reporting all of the scripts than actual lower usage. The FFY 2008 percentage is more in line with the other MCOs. Caucasian members are higher users of scripts than other race/ethnicities. This was a finding shown last year as well.

**Exhibit IV.9
Pharmacy Usage**



Summary of Service Utilization by Region

Exhibits IV.10 and IV.11 which appear on the next two pages provide a summary of the usage rates of CHIP members by region for all of the services reviewed in this chapter. The eight regions conform to the Hoosier Healthwise MCO regions previously shown in Chapter II and the regions identified in the discussion of access in Chapter III. Exhibit IV.10 shows the percent of members in each region that used the service in FFY 2007. Exhibit IV.11 shows the percent of members in each region that used the service in FFY 2008. Further details are provided in exhibits that appear in Appendix A.

Key findings from both exhibits are as follows:

- *Within a particular region*, there was little change in the percent of members that used each service between FFY 2007 and FFY 2008 with the following exceptions:
 - Primary Care Office Visits decreased in FFY 2008 in the Northeast and West Central Regions by five to seven percentage points
 - EPSDT Services increased in the Northwest, North Central and Central Regions in FFY 2008 by five to eight percentage points
 - Outpatient (non-ER) Services decreased in the Southwest and Southeast Regions in FFY 2008 by five to six percentage points
 - Pharmacy Scripts increased five to nine percentage points in FFY 2008 in the North Central, Northeast, West Central, Southwest and Southeast Regions
- Across regions, the variation in the usage of each service was limited in both FFY 2007 and FFY 2008 with a few notable exceptions:
 - Primary Care Office Visits were lowest in the Central Region; however, this region also had the highest EPSDT visit usage. Because EPSDT services are not counted as Primary Care visits, the net effect of these two findings may be that Primary Care plus EPSDT usage combined in the Central Region is similar to other regions.
 - In the Northwest Region, Primary Care Office Visits are lower than other regions, but there is not a corresponding increase in EPSDT Services as was seen in the Central Region.
 - Emergency Room Visit usage varies from a low of 18 percent of CHIP members in the Northwest Region to a high of 29 percent in the Central Region.
 - Preventive Dental Visits were lowest in the Northwest and Southeast Regions in both years studied.
 - The North Central and West Central Regions have considerably lower usage of pharmacy scripts in FFY 2007 than the other regions, but the usage was more in line with the other regions in FFY 2008.

Exhibit IV.10
Variance in Utilization Statistics for CHIP Children in FFY 2007 By Region
Percent of Members Enrolled at least 9 Months in an MCO Who Used Service

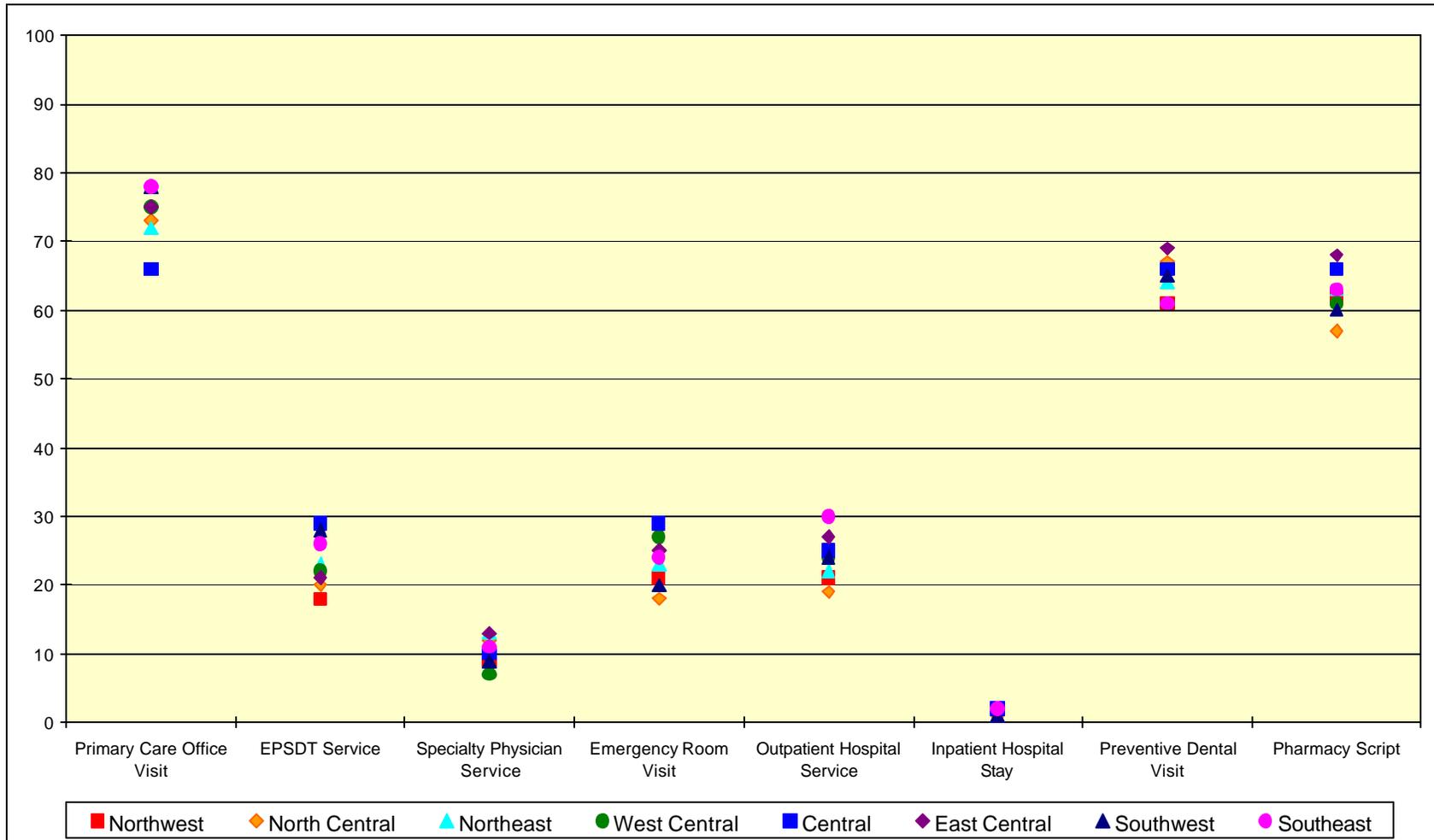
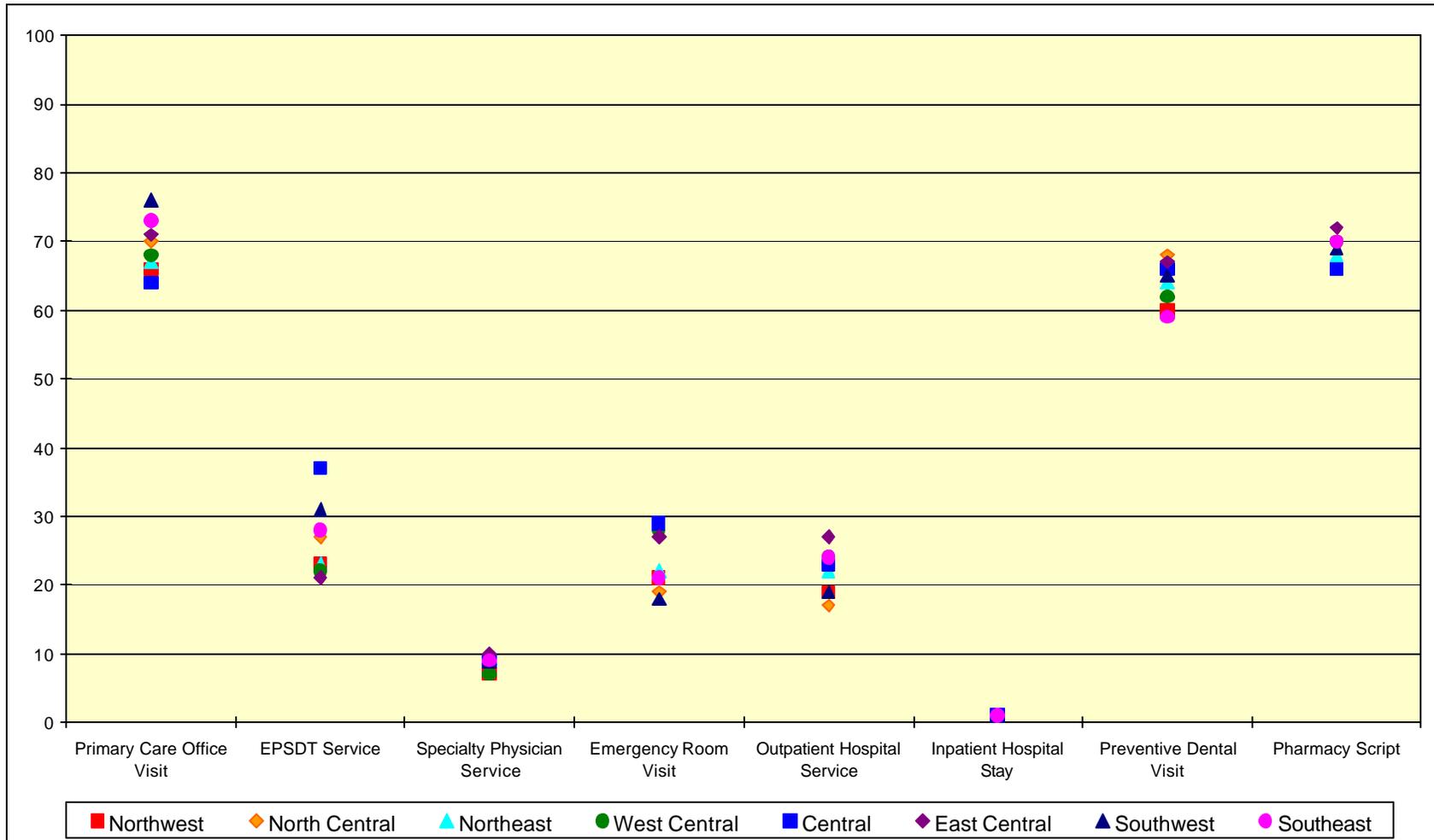


Exhibit IV.11
Variance in Utilization Statistics for CHIP Children in FFY 2008 By Region
Percent of Members Enrolled at least 9 Months in an MCO Who Used Service



Prevalence and Utilization of Services for Children with Specific Diagnoses in CHIP

This section considers the prevalence and utilization of services among CHIP members with specific diagnoses. Three categories of special diagnosis claims are considered:

- (1) Asthma (ICD-9 Diagnoses 493.xx)
- (2) Behavioral Disorders (ICD-9 Diagnoses 290.xx – 299.xx and 300.xx – 316.xx)
- (3) Obesity (ICD-9 Diagnoses 278.0, 783.1 and 783.6).

These conditions warrant special attention because children receiving these diagnoses frequently require more services and account for higher health care expenditures. Frequently such conditions are chronic in nature and CHIP members receiving such diagnoses rely more heavily on the health care service infrastructure than the average child.

As in the previous utilization exhibits, the population of CHIP members was limited to those in an MCO for at least nine months in the fiscal year. Newborns were also excluded. Prevalence of a specific diagnosis is defined as the percent of the study population with a specific diagnosis claim or encounter during FFY 2007 or FFY 2008. Not only is prevalence determined for the study population as a whole, but also for demographic groups including age, MCO, and race/ethnicity.

Utilization exhibits compare CHIP members who were diagnosed with a specific diagnosis and those without a specific diagnosis in FFY 2008. The percent of services received per 1,000 members is examined for these two groups. Services include: primary care visits, specialist visits, inpatient hospital stays, non-emergency room outpatient visits, emergency room visits and prescriptions filled. These exhibits help determine whether CHIP members diagnosed with asthma, a behavioral health condition, or obesity in FFY 2008 had more claims and encounters than CHIP members without a specific diagnosis.

Asthma

The percent of CHIP members who received a diagnosis of asthma was about 8.6 percent in FFY 07 and about 8.3 percent in FFY 08. CHIP C members are slightly more likely than CHIP A members to have received an asthma diagnosis in the last two years. Diagnosis of asthma frequently occurs at an early age and is more prevalent in African Americans than other minority races and ethnicities. CHIP members enrolled with Managed Health Services (MHS) were less likely than members in other MCOs to have received an asthma diagnosis in the last two years. This finding may be connected to the lower utilization of EPSDT screenings among MHS members seen in Exhibit IV.3. EPSDT screenings were most prevalent in children age 1 to 5. These early screenings may lead to the slightly larger than average asthma diagnosis rate in children age 1 to 5.

Exhibit IV.12 Profile of CHIP Members With Asthma

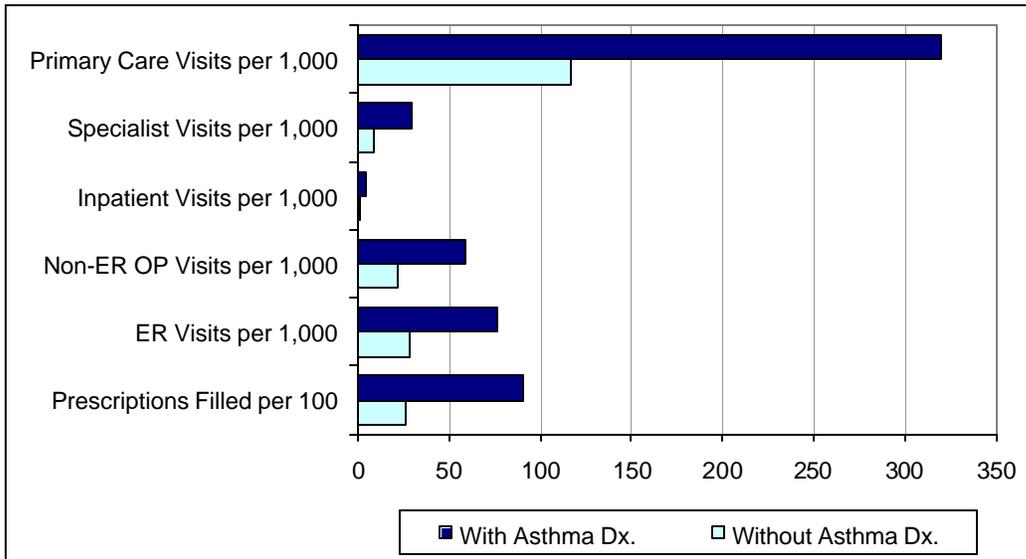
	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
FFY 07 Study Population	37,775	10,983	48,758
Asthma Diagnosis in FFY 07	3,158	1,028	4,186
Study Population- Pct of Total	8.4%	9.4%	8.6%
FFY 08 Study Population	41,011	14,287	55,298
Asthma Diagnosis in FFY 08	3,313	1,266	4,579
Study Population- Pct of Total	8.1%	8.9%	8.3%

Children with Asthma Diagnosis for CHIP A and CHIP C Combined

	<u>FFY07</u>		<u>FFY08</u>	
Total	4,186		4,579	
<u>By Age Group</u>		<u>Pct Asthma Dx.</u>		<u>Pct Asthma Dx.</u>
Age 1-5	751	9.7%	845	9.4%
Age 6-12	2,171	8.9%	2,318	8.6%
Age 13-18 Females	643	7.8%	709	7.5%
Age 13-18 Males	620	7.5%	707	7.2%
<u>By MCO</u>		<u>Pct Asthma Dx.</u>		<u>Pct Asthma Dx.</u>
MHS	979	6.4%	1,116	6.3%
Anthem	743	10.0%	1,020	9.5%
MDwise	2,464	9.4%	2,443	9.2%
<u>By Race/Ethnicity</u>		<u>Pct Asthma Dx.</u>		<u>Pct Asthma Dx.</u>
White	2,972	8.6%	3,134	8.2%
African American	798	10.3%	916	10.3%
Hispanic	342	6.2%	444	6.7%
Other	74	7.5%	85	6.6%

CHIP members diagnosed with asthma in FFY 2008 received much more health care services during that year than members not diagnosed with asthma. Children with asthma had three times the number of inpatient hospital visits as children without asthma. They also had more than twice as many visits to a specialist and prescriptions filled as children without asthma.

Exhibit IV.13
Utilization Statistics in CHIP A and CHIP C
Members with and without Asthma Diagnoses



Behavioral Health

Diagnosis of a behavioral health condition such as schizophrenia, depression, or substance abuse was the most common of the three specific diagnoses to be given to CHIP members. The prevalence of behavioral health conditions did not increase between FFY 2007 and FFY 2008, however, still exceeded 15 percent of CHIP members. Although CHIP C members were slightly more likely than CHIP A members to have received an asthma diagnosis, CHIP A members received more behavioral health diagnoses than CHIP C members in the last two years.

Teenagers were more likely than younger children to have received a diagnosis of a behavioral health condition in FFY 2007 and FFY 2008. Males between the ages of 13 and 18, in particular, had a high prevalence of behavioral health diagnoses. In FFY 2007, one fourth of CHIP members in this demographic group had a behavioral health diagnosis. Caucasian children had the greatest likelihood of any race/ethnicity group to have had a behavioral health claim in the last two years. About one-fifth of Caucasians received a behavioral health diagnosis while only 13 percent of African Americans and 7 percent of Hispanics received such a diagnosis.

Exhibit IV.14 Profile of CHIP Members With a Behavioral Health Condition

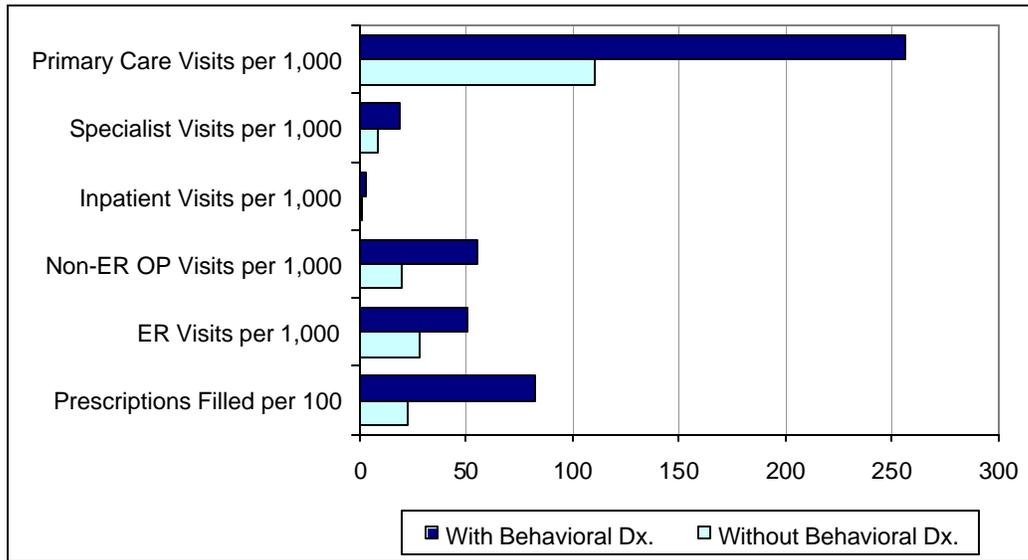
	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
FFY 07 Study Population	37,775	10,983	48,758
Behavioral Diagnosis in FFY 07	7,431	1,707	9,138
Study Population- Pct of Total	19.7%	15.5%	18.7%
FFY 08 Study Population	41,011	14,287	55,298
Behavioral Diagnosis in FFY 08	7,245	2,112	9,357
Study Population- Pct of Total	17.7%	14.8%	16.9%

Children with Behavioral Diagnosis for CHIP A and CHIP C Combined

	<u>FFY07</u>		<u>FFY08</u>	
Total	9,138		9,357	
<u>By Age Group</u>		<u>Pct Behavioral Dx.</u>		<u>Pct Behavioral Dx.</u>
Age 1-5	563	7.2%	586	6.5%
Age 6-12	4,751	19.5%	4,740	17.5%
Age 13-18 Females	1,730	20.9%	1,768	18.6%
Age 13-18 Males	2,094	25.2%	2,263	23.2%
<u>By MCO</u>		<u>Pct Behavioral Dx.</u>		<u>Pct Behavioral Dx.</u>
MHS	2,738	18.0%	2,950	16.5%
Anthem	1,423	19.1%	1,799	16.7%
MDwise	4,977	19.1%	4,608	17.3%
<u>By Race/Ethnicity</u>		<u>Pct Behavioral Dx.</u>		<u>Pct Behavioral Dx.</u>
White	7,524	21.8%	7,589	19.7%
African American	1,061	13.7%	1,180	13.2%
Hispanic	453	8.2%	484	7.3%
Other	100	10.1%	104	8.1%

The number of primary care visits, specialist visits, inpatient hospital stays, outpatient visits, ER visits, and prescriptions filled per 1,000 members were greater for CHIP members diagnosed with a behavioral health condition than for CHIP members for no such diagnosis. The greatest disparity between these two groups occurred in the number of prescriptions filled per 100 members. CHIP members with a behavioral health condition had 2.7 times the number of prescriptions as members without a behavioral health condition in FFY 2008. The number of ER visits per 1,000 members was only slightly higher for members with a behavioral health condition than for those without one.

Exhibit IV.15
Utilization Statistics in CHIP A and CHIP C
Members with and without Behavioral Health Diagnoses



Obesity

Although only a small percent of CHIP members had an obesity diagnosis in FFY 2007 or FFY 2008, the risks of such a diagnosis are immense. Children who had a diagnosis of obesity, abnormal weight gain, or polyphagia are at an increased risk of high blood pressure, high cholesterol, Type 2 diabetes, and other health conditions in the future. The prevalence of obesity has leveled off or slightly decreased in the last year in our study population.

Diagnosis of obesity is more common in teenagers, especially females between the ages of 13 and 18, than it is in younger children. About 4% of females age 13 to 18 received an obesity diagnosis in FFY 2007 and FFY 2008. Minorities were slightly more likely than Caucasians to be obese. African Americans and Hispanics had an obesity prevalence rate of about three percent in the last two years. Similar to the finding with asthma diagnoses, MHS had fewer members receive an obesity diagnosis than other MCOs. Only about one percent of CHIP members in MHS received a diagnosis of obesity in FFY 2007 or FFY 2008. Again, this might be the result of lower EPSDT screenings among MHS members.

Exhibit IV.16 Profile of CHIP Members With an Obesity Diagnosis

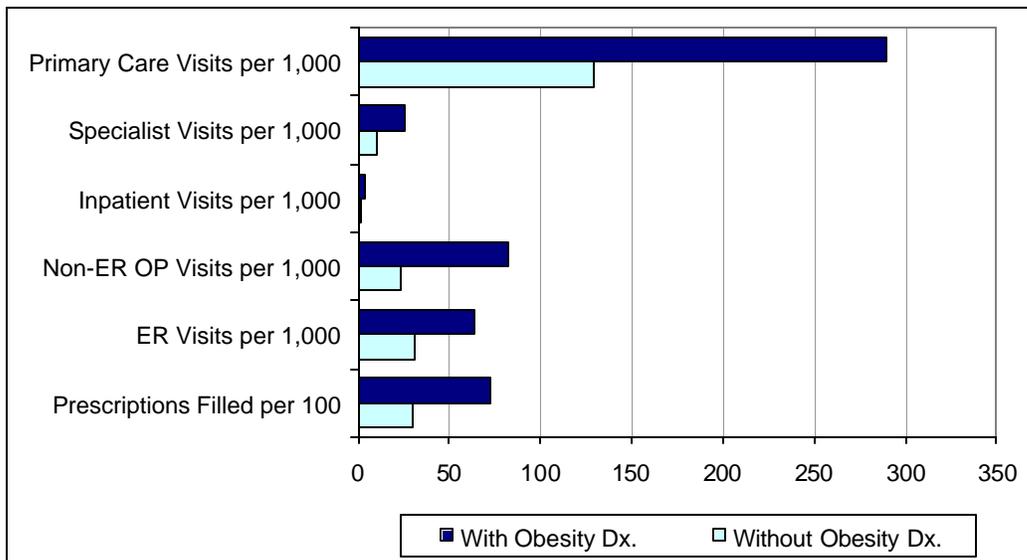
	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
FFY 07 Study Population	37,775	10,983	48,758
Obesity Diagnosis in FFY 07	984	230	1,214
Study Population- Pct of Total	2.6%	2.1%	2.5%
FFY 08 Study Population	41,011	14,287	55,298
Obesity Diagnosis in FFY 08	956	331	1,287
Study Population- Pct of Total	2.3%	2.3%	2.3%

Children with Obesity Diagnosis for CHIP A and CHIP C Combined

	<u>FFY07</u>			<u>FFY08</u>
Total	1,214			1,287
<u>By Age Group</u>		<u>Pct Obesity Dx.</u>		<u>Pct Obesity Dx.</u>
Age 1-5	67	0.9%	72	0.8%
Age 6-12	565	2.3%	569	2.1%
Age 13-18 Females	331	4.0%	369	3.9%
Age 13-18 Males	251	3.0%	277	2.8%
<u>By MCO</u>		<u>Pct Obesity Dx.</u>		<u>Pct Obesity Dx.</u>
MHS	215	1.4%	237	1.3%
Anthem	193	2.6%	283	2.6%
MDwise	806	3.1%	767	2.9%
<u>By Race/Ethnicity</u>		<u>Pct Obesity Dx.</u>		<u>Pct Obesity Dx.</u>
White	794	2.3%	800	2.1%
African American	235	3.0%	260	2.9%
Hispanic	172	3.1%	210	3.1%
Other	13	1.3%	17	1.3%

As was true with asthma and behavioral diagnoses, obesity diagnoses are consistent with a higher utilization of services. Obese CHIP members used more services per 1,000 members than members who were not obese. Specifically, members diagnosed with obesity in FFY 2008 had a high number of non-emergent outpatient visits per 1,000 members. CHIP members with an obesity diagnosis had more than three times the number of outpatient visits per 1,000 members as those not diagnosed with obesity. They also had considerably more outpatient visits per 1,000 members than those diagnosed with asthma or a behavioral health condition.

**Exhibit IV.17
Utilization Statistics in CHIP A and CHIP C
Members with and without Obesity Health Diagnoses**



In order to examine the chronic nature of asthma, behavioral health conditions, and obesity in more detail, we might consider the number of CHIP members who received a diagnosis in FFY 2007 and then received the same diagnosis in FFY 2008. It is apparent that a specific diagnosis in a current year leads to greater service utilization and greater expenditures in the year of diagnosis. However, it would be interesting to track CHIP members in years after their diagnosis to determine if service utilization remains high. Although two years of data is limited and disenrollment statistics were not factored in, Exhibit IV.18 provides a cursory look at repetition of diagnoses.

A behavioral health condition was the most prevalent of the three specific diagnoses. It also had the highest percent of CHIP members diagnosed with the condition in FFY 2007 receive the same diagnosis in the following year. About 60% of members with a behavioral diagnosis in FFY 2007 had another diagnosis for behavioral health in FFY 2008. This rate may continue to remain high because of the high usage of prescription drugs associated with this diagnosis. In order to refill and maintain usage of prescriptions, children receive a behavioral diagnosis in many years following initial diagnosis.

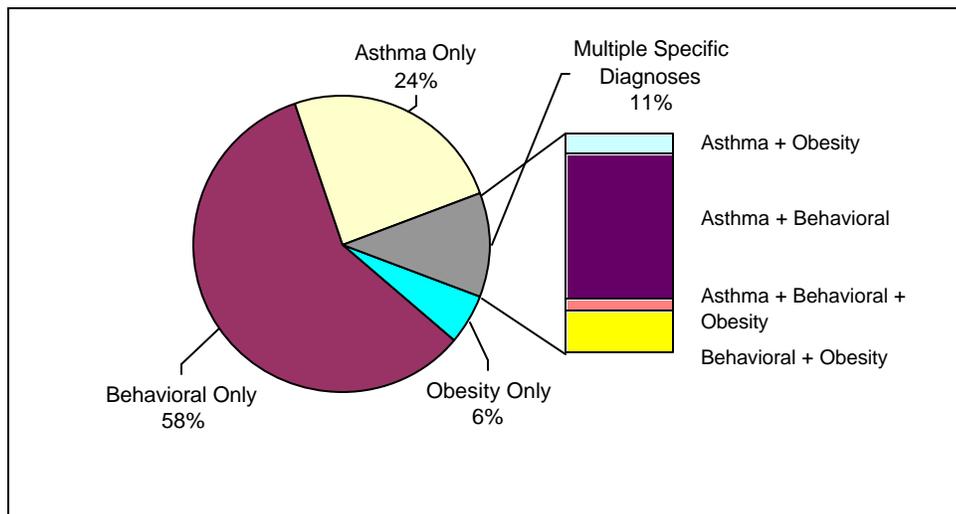
**Exhibit IV.18
CHIP Members with Specific Diagnosis in FFY 07 to Repeat Diagnosis in FFY 08**

	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
Asthma Diagnosis in FFY 07	3,158	1,028	4,186
Asthma Diagnosis again in FFY 08	1,396	440	1,836
Pct Repetitive Asthma Diagnosis	44.2%	42.8%	43.9%
	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
Behavioral Diagnosis in FFY 07	7,431	1,707	9,138
Behavioral Diagnosis again in FFY 08	4,515	933	5,448
Pct Repetitive Behavioral Diagnosis	60.8%	54.7%	59.6%
	<u>CHIP A</u>	<u>CHIP C</u>	<u>Total</u>
Obesity Diagnosis in FFY 07	984	230	1,214
Obesity Diagnosis again in FFY 08	251	63	314
Pct Repetitive Obesity Diagnosis	25.5%	27.4%	25.9%

One other factor to consider when analyzing specific diagnoses is whether CHIP members who have a specific diagnosis actually have multiple specific diagnoses. It is known that one health condition may lead to other conditions and it is apparent that members diagnosed with asthma, a behavioral health condition, or obesity have high utilization of health care services. Exhibit IV.19 further examines whether there is an overlap in the members represented in these groups. In other words, are members who received a diagnosis for one of the three specific diagnoses in FFY 2008 more likely to receive a diagnosis of a second specific diagnosis in the same year?

Only 11 percent of CHIP members who were diagnosed with asthma, behavioral health condition, and/or obesity in FFY 2008 had more than one of these diagnoses. However, this analysis was meant to shed light on the relatively high prevalence of these conditions within the CHIP population. The Hoosier Healthwise MCOs are encouraged to examine these and other co-morbidity conditions (e.g. diabetes, ADHD) among CHIP members to best serve their medical needs.

**Exhibit IV.19
CHIP Members with Multiple Specific Diagnoses**



V. Expenditures in Indiana's CHIP

Payments for services provided to CHIP members are made by two primary mechanisms:

- Services delivered by managed care organizations (MCOs) are paid by the State on a per member per month (PMPM) basis to cover all of the services for which the MCO is contractually obligated to provide. This is also known as a capitation payment.
- Services delivered on a fee-for-service basis are those services offered to CHIP members for which the MCOs are not responsible for delivering and not reflected in the capitation payment. These are billed directly by the individual provider to the State. With the carve-in of behavioral health services into the MCO contract in 2007, the primary service now delivered on a fee-for-service basis to CHIP members is dental care.

The inclusion of more services into managed care results in the majority of payments on behalf of CHIP members to be made under the capitation payment arrangement. Exhibit V.1 shows that 72 percent of CHIP A payments and 82 percent of CHIP C payments were made in this way in Federal Fiscal Year (FFY) 2008. Dental services account for about 15 percent of payments.

**Exhibit V.1
Trends in Expenditures for CHIP A and CHIP C**

	CHIP A FFY07	Pct	CHIP A FFY08	Pct
Monthly Per Member Payments Made to MCOs	\$53,519,678	69%	\$57,960,156	72%
Payments for Dental Services Made Outside of MCO Payments	\$11,361,462	15%	\$12,469,072	15%
Other Payments Made Outside of MCO Payments	\$13,148,640	17%	\$10,222,117	13%
Total Payments (Using State and Federal Funds)	\$78,029,780	100%	\$80,651,345	100%
Increase from Previous Year			3.4%	

	CHIP C FFY07	Pct	CHIP C FFY08	Pct
Monthly Per Member Payments Made to MCOs	\$17,002,440	77%	\$19,015,957	82%
Payments for Dental Services Made Outside of MCO Payments	\$3,694,923	17%	\$3,827,264	16%
Other Payments Made Outside of MCO Payments	\$1,417,438	6%	\$469,310	2%
Total Payments (Using State and Federal Funds)	\$22,114,801	100%	\$23,312,531	100%
Increase from Previous Year			5.4%	

Premiums Paid by Families	(\$18,040,615)	(\$20,790,702)
Net Payments (Adjusted for Premiums)	\$4,074,186	\$2,521,829

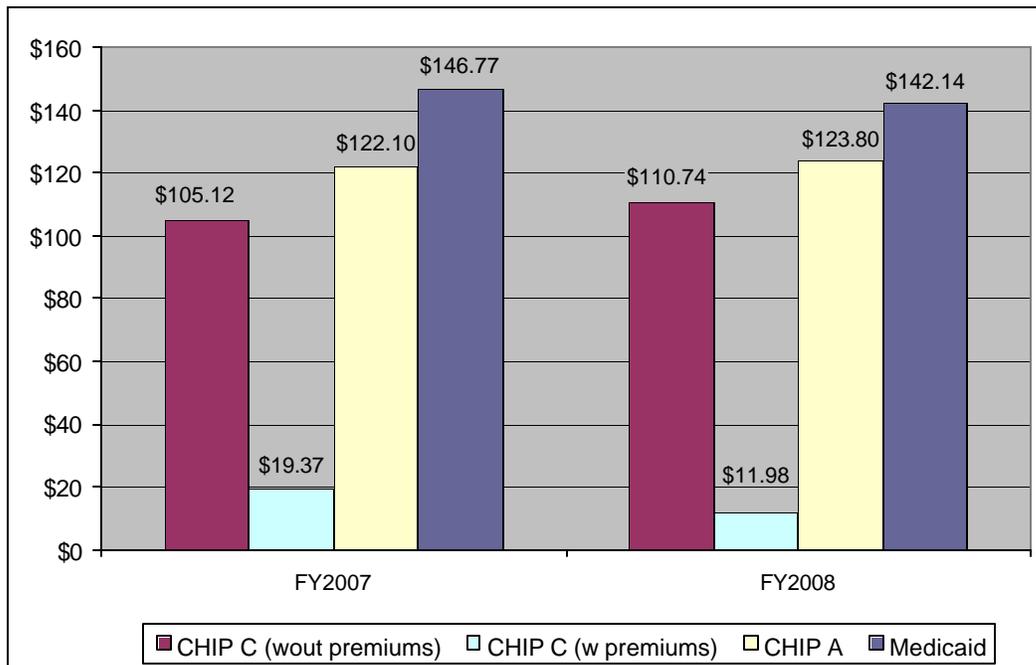
Other payments made under the fee-for-service arrangement besides dental include a variety of services provided to CHIP members during the period prior to enrolling in managed care.

Total expenditures (state and federal share) for CHIP A increased 3.4 percent from FFY 2007 to FFY 2008. CHIP C expenditures increased 5.4 percent. However, in the CHIP C portion of the program families are charged premiums on a sliding scale based on their income. In FFY 2008, premiums exceeded \$20 million. The net result of this is that the total outlay for the CHIP C portion of the program actually decreased from FFY 2007 to FFY 2008.

Gross expenditures can increase due both to enrollment increases as well as medical cost increases. When analyzed on a per member per month basis, the CHIP A PMPM increased from \$122.10 to \$123.80 and the CHIP C PMPM increased from \$105.12 to \$110.74 from FFY 2007 to FFY 2008. As Exhibit V.2 below illustrates, both CHIP A and CHIP C members cost less than Medicaid children¹. This has been the trend since the introduction of Indiana's CHIP. Shown on a PMPM basis, CHIP A increased 1.4 percent while CHIP C increased 5.3 percent.

The premiums paid by CHIP C families reduce the State's liability for these members significantly. After including the premium offsets, CHIP C members cost the State just under \$12.00 on a PMPM basis in FFY 2008. This includes federal and state funds.

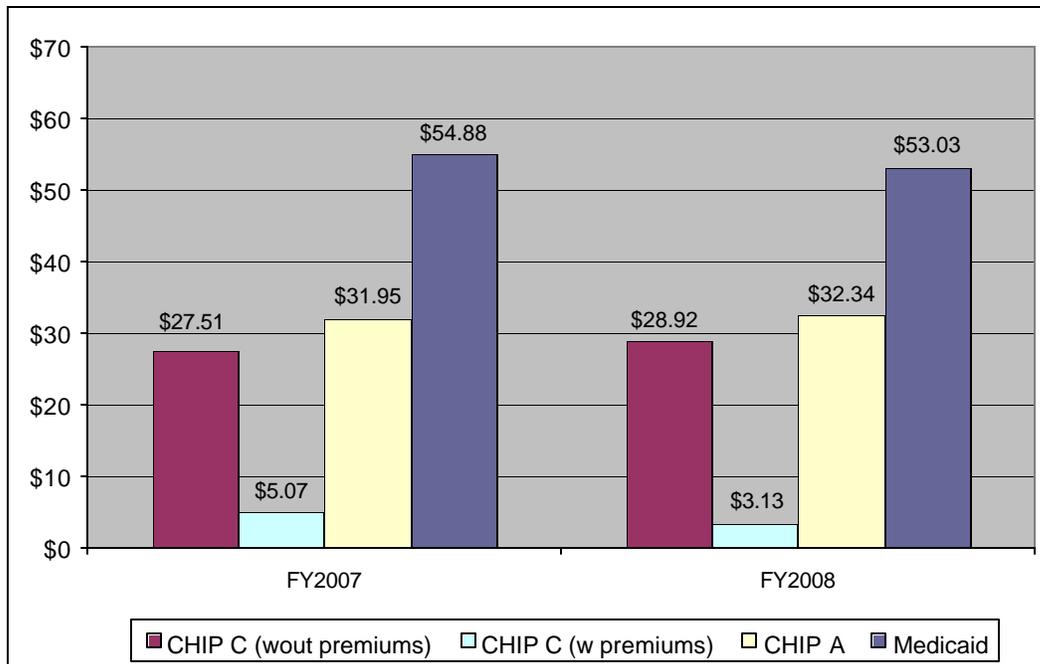
Exhibit V.2
Trends in the Cost Per Member Per Month (PMPM)
Total Federal and State Share



¹ Because there are so few children in CHIP under age one, the infants in the Medicaid program have been removed to reflect a more accurate comparison between the two portions of Hoosier Healthwise.

Because the federal CHIP program provides states with an enhanced match rate from what is paid for the Medicaid program, the expenditures for CHIP are even further reduced when examining the state-only outlays. CHIP A members cost the State just over \$30 PMPM while CHIP C members cost just under this amount. But when the premiums for CHIP C are factored in, the State's net outlay for CHIP C is under \$5 PMPM.

Exhibit V.3
Trends in the Cost Per Member Per Month (PMPM)
State Share Only



Federal match rates

FFY 2007: Medicaid- 62.61 cents/dollar; CHIP- 73.83 cents/dollar

FFY 2008: Medicaid- 62.69 cents/dollar; CHIP- 73.88 cents/dollar

VI. Measuring Quality and Outcomes in Indiana's CHIP

The Office of Medicaid Policy and Planning (OMPP) assumes the overall responsibility for ensuring that children in Indiana's CHIP receive accessible, high-quality services. Chapters III and IV of this report identified that, in general, these goals are being met. The findings illustrate that there are some counties in the state where accessibility to primary care providers can be improved. Outcomes have become a focused effort of the OMPP in the last two years, in particular with respect to children's care. Chapter IV identified some differences in utilization across age groups and racial/ethnic populations.

In fulfilling its oversight responsibilities, the OMPP utilizes a variety of reporting and feedback methods to measure quality and outcomes for Indiana's CHIP. Since the CHIP members are seamlessly integrated into the overall Hoosier Healthwise program, the oversight process is completed for Hoosier Healthwise as a whole rather than for the CHIP specifically. However, recognizing that children represent the majority of Hoosier Healthwise members (either in the Medicaid program or the CHIP), quality and outcomes related to children are given high priority.

Specific quality and outcome reporting requirements are required of all states by the Centers for Medicare and Medicaid (CMS). Others have been developed by the OMPP specifically for Indiana's program. Among these, the OMPP assumes day-to-day responsibility for some activities and requires that the managed care organizations (MCOs) assume other responsibilities. Examples of quality and outcome reporting are discussed in this chapter. The items presented are only a subset of what is completed by the various entities, but these represent the activities affecting children in Hoosier Healthwise the most.

Requirements from CMS

Quality Strategy

CMS requires an annual State Quality Strategy plan from every state. The OMPP developed a 2007-2008 Quality Strategy plan with extensive stakeholder input, collection of nationally recognized data sources, and evidence-based medicine. The OMPP stated that the purpose of the State Quality Strategy is to have "a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess and continually improve the quality of health care services to participants in managed care¹." Areas of specific focus that were identified for all of the OMPP's health care programs include (1) Preventive health, (2) Tobacco cessation, (3) Behavioral health, (4) Contract-based incentives, (5) Health plan partnerships, and (6) Technology.

For Hoosier Healthwise in particular, the following five areas for performance improvement were identified:

- Infant, childhood and adolescent well care utilization
- Improve prenatal care and pregnancy outcomes
- Implement annual open enrollment
- Improve continuity of care
- EPSDT (Early Periodic Screening, Diagnosis and Treatment) updates

¹ State of Indiana Office of Medicaid Policy and Planning, Hoosier Healthwise Quality Strategy <http://www.in.gov/fssa/2408.htm>

The State Quality Strategy also includes a chapter on processes that OMPP will use to improve outcomes:

1. Implementing and maintaining a robust quality improvement framework and quality strategy
2. Collecting and analyzing baseline data, especially for behavioral health and targeted performance measures
3. Implementing a pay-for-performance program
4. Mandating and monitoring HEDIS® and CAHPS® results
5. Conducting provider surveys
6. Conducting statewide focus studies
7. Monitoring MCO quality improvement initiatives
8. Consumer and provider participation in work groups (especially community mental health centers and other behavioral health providers)
9. Educating providers and members
10. Cross-agency collaboration, especially with the Department of Mental Health (DMHA), the Indiana State Department of Health (ISDH) and the OMPP
11. Using feedback from the EQR process
12. Intermediate sanctions and corrective action plans

Some examples of these processes are discussed in later sections in this chapter.

External Quality Review

State Medicaid agencies that have implemented risk-based managed care programs are required to hire an independent entity to conduct an external quality review (EQR) of their managed care entities. The OMPP retained Burns & Associates, Inc. (B&A, the authors of this report) to conduct the EQR in the last two years. The most recent EQR was completed in the Fall of 2008 for the period covering Calendar Year 2007. The final report was delivered to CMS and results were provided to each MCO that was reviewed.

CMS requires that the EQR contain the following components:

1. Validation of performance improvement projects undertaken by the MCOs
2. Validation of performance measures produced by an MCO
3. A review to determine MCO compliance with federal Medicaid managed care regulations

A review protocol was developed by CMS for EQR organizations to use as a guideline to ensure that review components are consistent nationally.

With respect to performance improvement projects, B&A identified three areas for review that were some of the pay-for-performance measures in the MCOs' contract in CY 2007. Two in particular directly impact CHIP members:

- Well-child visits in the 3rd through 6th years of life
- Blood lead screening
- Frequency of ongoing prenatal care

The validation includes assessing the credibility of the data used to measure improvement and assessing if “real” improvement has occurred. Scores are measured based on the confidence level

of the data and processes used by the MCO to improve performance. B&A scored each MCO as follows:

**Exhibit VI.1
Summary Findings of Validation of Performance Improvement Projects**

Performance Improvement Project	Summary Finding		
	Anthem	MHS	MDwise
Frequency of Ongoing Prenatal Care	Not Reviewed	Confidence	High Confidence
Well Child Care in the 3rd through 6th Years of Life	Not Reviewed	High Confidence	High Confidence
Blood Lead Screening	High Confidence	Low Confidence	High Confidence

Anthem was a new MCO in CY 2007 and the measures for prenatal care and well child visits required a look-back period into CY 2006. Thus, these two measures were not reviewed for Anthem. MHS's low confidence score for lead screening was because the data used to support the percent of children screened for lead over time was incomplete in their performance improvement tool.

B&A recommended to the OMPP that there be some performance improvement projects mandated each year by the OMPP and others that are required but can be selected by each MCO with OMPP approval. The OMPP accepted this recommendation and is also working with the MCOs on a common performance improvement reporting template to ensure consistency in reporting and monitoring.

With respect to validating performance measures, B&A reviewed the results of 20 measures for which the OMPP has given the MCOs and their subcontracted managed behavioral health organizations (MBHOs) targets in order to adhere to contract compliance. Most of these measures are related to claims processing, financial stability, and timely feedback to members and providers. A specific validation was completed on the compilation of three specific performance measures. B&A found that all three MCOs were fully compliant for the data reporting for these performance measures, as shown below.

**Exhibit VI.2
Summary Results from Validation of Performance Measures**

Performance Measure	Category	Summary Finding		
		Anthem	MHS	MDwise
Claims Adjudication Rates	Claims Processing	Fully Compliant	Fully Compliant	Fully Compliant
Medical Loss Ratio	Financial Stability	Fully Compliant	Fully Compliant	Fully Compliant
Provider Call Center Response Rate	Provider Relations	Fully Compliant	Fully Compliant	Fully Compliant

For the operational review, items for scoring were divided into 10 main categories for the purposes of scoring.

- Enrollee Rights
- Information to Enrollees
- Access and Availability of Services
- Provider Services and Credentialing
- Subcontracted Relationships and Delegations
- Coordination of Care
- Utilization Management
- Quality Assessment and Performance Improvement
- Health Information Systems
- Grievance and Appeals

There were 155 individual items scored using a compliance rating of ‘Met’, ‘Partially Met’ or ‘Not Met’. Overall scores for each MCO are as follows:

**Exhibit VI.3
Summary Scores for MCOs on Operational Review in EQR**

Percent of Scores in Each Category	Anthem	MHS	MDwise
Met	94%	85%	96%
Partially Met	4%	9%	4%
Not Met	2%	6%	0%

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Reporting

The CMS EPSDT Participation Report is an annual report required by CMS to be submitted by all Medicaid programs on an annual basis. All programs report on various screenings in the same manner so that data can be aggregated at the national level. The OMPP compiles the report on behalf of all Hoosier Healthwise children (except CHIP Package C) and for CHIP Package C children separately since these children are in non-entitlement portion of the program.

The EPSDT report measures the rate of age-appropriate screenings for items such as health and developmental assessment, physical exam, and screenings for dental, vision, hearing and blood lead levels. Results are stratified seven age groups: <1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20. Each state defines its recommended screening schedule which specifies what screenings should be given at each age and how often. The Medicaid agency is instructed to calculate the number of expected screenings that should be reported at each age group based on the number of children in the age group and the screening schedule. More screenings are required in the younger years. For example, Indiana’s screening schedule recommends the following:

- | | |
|--------------------|----------------------|
| Age <1: 7 screens | Age 6-9: 2 screens |
| Age 1-2: 4 screens | Age 10-14: 3 screens |
| Age 3-5: 3 screens | Age 15-18: 2 screens |

A screening ratio is calculated that tabulates the rate of screenings actually received as compared to the suggested number of screenings. This ratio can be greater than 100%, especially for younger age groups, but 100% is reported if the value exceeds 100%.

A participant ratio is also calculated which reflects the percentage of children in each age group that received at least one screening in the year. The maximum ratio for any age group is 100%.

Indiana's CHIP C EPSDT participant and screening ratios were compared to Indiana's Hoosier Healthwise program as a whole. Results are shown in the exhibit below. Data to compare to the national averages is still not available for FFY07 from CMS.

**Exhibit VI.4
Summary of EPSDT Results**

Screening Ratio

Number of Actual Screens / Number of Expected Screens per Age Group

Age Group	CHIP C FFY08	CHIP C FFY07	Medicaid FFY08	Medicaid FFY07
Under Age 1	89%	64%	56%	73%
Age 1-2	100%	100%	100%	100%
Age 3-5	78%	100%	63%	75%
Age 6-9	83%	100%	67%	74%
Age 10-14	82%	100%	61%	68%
Age 15-18	77%	90%	55%	62%

Participant Ratio

*Number of Members Receiving at Least One Screen /
Number of Members that Should Receive at Least One Screen*

Age Group	CHIP C FFY08	CHIP C FFY07	Medicaid FFY08	Medicaid FFY07
Under Age 1	92%	85%	84%	89%
Age 1-2	100%	100%	82%	82%
Age 3-5	100%	100%	83%	84%
Age 6-9	100%	100%	100%	72%
Age 10-14	100%	100%	100%	69%
Age 15-18	100%	100%	100%	71%

As seen above, the participant ratio is at 100% in CHIP C for all age groups except under age 1. However, children in the under age 1 age group in CHIP C are less than one-tenth of one percent of the total. CHIP C results are much higher than Medicaid as a whole. The screening ratios for CHIP C were very high in FFY07.

It should be noted that the EPSDT results shown in Exhibit VI.4 differ from the analysis that B&A showed for EPSDT usage in Exhibit IV.3. The table above highlights EPSDT utilization across all CHIP C and Medicaid members in the year. B&A's analysis highlights EPSDT utilization for CHIP A and CHIP C members combined. Our EPSDT usage is not as high as what is shown here because the CHIP A population does not have as favorable results as CHIP C alone.

OMPP Quality Initiatives

In addition to the CMS requirements, the OMPP has also developed quality initiatives of its own that are tailored to Indiana's health coverage programs. Two of the areas highlighted in the State Quality Strategy document are described below.

Quality Strategy Committee

The Quality Strategy Committee reports to the OMPP Medicaid Director and Executive Team. The Committee is charged with developing and monitoring the State Quality Strategy. The Committee meets at least quarterly and is composed of individuals from the OMPP, the DMHA, the ISDH, providers, MCO Quality Managers, advocacy groups, consumers and academia.

Subcommittees were created (called Quality Initiative Workgroups) in late 2007 to focus on neonatal outcomes, preventive care, and behavioral health. A focus of these workgroups was to develop enhanced outcome reporting requirements (see next section for details).

More recently, the Quality Strategy Committee has worked on developing more consistent reporting across all of the OMPP's health care programs (Hoosier Healthwise, Care Select and the Healthy Indiana Program). Other activities for Hoosier Healthwise have been the development of a Notification of Pregnancy form for providers to submit to the MCOs, a standard assessment form for pregnant enrollees, and work on a standardized set of interventions for smoking cessation to be used by all the MCOs.

Pay for Performance

The Hoosier Healthwise MCO contract broadly outlines OMPP's Pay for Performance (P4P) and Incentive requirements for its MCOs. In addition to the contract, Appendix D of the OMPP State Quality Strategy specifies the performance measurements and targets that were in place for the 2007 P4P program². OMPP provides each MCO with their results and related incentive payments on October 1st of the year following the measurement year. If the full allocation is not paid to the MCOs because they didn't meet the performance targets, then OMPP has the flexibility to allocate the undistributed funds for meeting other performance measures that were not included in the P4P program for that year. Results from the 2007 program have been reported to the MCOs. The 2008 results will be calculated in the fall of 2009.

OMPP may reward its contracted MCOs for quality performance incentives (both financial and non-financial) if the MCO meet targets identified by OMPP. The P4P program design has three tiers. The first tier is OMPP's incentives to the MCOs. Tiers two and three are the MCOs' incentives to their providers and members:

- Tier 1: OMPP will provide financial and/or non-financial performance incentives to MCOs based on performance targets in priority areas established by the State.
- Tier 2: MCOs will be responsible for providing incentives to their contracted providers.
- Tier 3: MCOs will be responsible for providing incentives to their members.

² State of Indiana Office of Medicaid Policy and Planning, Hoosier Healthwise Quality Strategy, Pay for Performance Program Summary

The State Quality Strategy Plan identified the following performance measures for calendar year 2007:

Performance Measure	Total Allocable Bonus from P4P Funds
Frequency of Ongoing Prenatal Care	One-third of total
Well Child Visits (3 rd to 6 th Year of Life)	One-third of total
Blood lead screening	One-third of total

The MCOs were required to develop P4P strategies for, at a minimum, their top 10% contracted PMPs based upon enrollment. Like the Tier 1 incentives, Tier 2 incentives may be both financial and non-financial. If an MCO earns an incentive from the State, they are required to reinvest at least 50% of the earned amount in member and provider incentives depending on how the MCO is developing its strategies. Provider incentives are most often an increase in reimbursement. Member incentives are limited to \$50 per year. For members, OMPP suggests that MCOs offer gift certificates for groceries, phone cards, or gifts such as diaper bags.

P4P payments are tiered and tied to measures against national averages or other pre-defined benchmarks. For the prenatal care measure, MCOs could receive 20% of the total bonus, 70% of the total bonus or the full bonus based on their results compared to the benchmark. The same tier structure was used for the well child visit measure. For the blood lead screening measure, the MCOs could receive either 85% of the total bonus or 100% of the total bonus depending upon how they performed compared to the target.

The results of the 2007 Pay for Performance program are shown below.

**Exhibit VI.5
Summary of Payouts from the 2007 Pay-for-Performance Program**

Performance Measure	Summary Finding		
	Anthem	MHS	MDwise
Frequency of Ongoing Prenatal Care	No Payment	Received 70% of Payment	Received 70% of Payment
Well Child Care in the 3rd through 6th Years of Life	No Payment	No Payment	No Payment
Blood Lead Screening	Received 100% of Payment	Received 100% of Payment	Received 100% of Payment

Quality and Outcome Reporting Requirements for the MCOs

The MCOs are required to submit reports on the outcomes of care delivered to their members. Many of these reports are related to children. One series of measures were customized to the quality strategies put in place for Indiana's Hoosier Healthwise program. Other measures are voluntarily reported by Medicaid health plans nationwide so that individual plans can compare themselves to their peers.

Enhanced Outcomes Reporting in 2008

Discussions from the Quality Strategy Subcommittees informed the decision by OMPP to enhance the reporting requirements of Hoosier Healthwise MCOs related to specific outcomes. Beginning in 2008, the MCOs were required to submit quarterly data related to the following:

- Preventive Health
- Children and Adolescents
- Mothers and Newborns
- Behavioral Health

The first quarterly reports were due to the OMPP on July 31, 2008. Many of the measures are related to HEDIS® but will be reported on a rolling basis each quarter instead of once a year as HEDIS® requires. Other measures were defined by the OMPP and are aligned with the areas for performance improvement identified for Hoosier Healthwise in the State Quality Strategy for 2007-2008. A listing of the reporting requirements specific to CHIP and Medicaid children appears in Exhibit VI.6 below.

Exhibit VI.6 New Outcome Reporting Measures Required by the OMPP

Children and Adolescents

Children and Adolescents' Access to Primary Care Practitioners Well-Child Visits in the First 36 Months of Life Well-Child Visits in the 3rd through 6th Years of Life Adolescent Well-Care Visits Emergency Room Utilization Inpatient Utilization- General Hospital Acute Care Antibiotic Utilization Appropriate Treatment for Children with Upper Respiratory Infection Appropriate Testing for Children with Pharyngitis Use of Appropriate Medications for People with Asthma
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Behavioral Health (all ages)

Behavioral Health Medical Expenses Mental Health Utilization Identification of Alcohol and Other Drug Services Behavioral Health Utilization Readmission to Behavioral Health Inpatient Treatment Multiple Behavioral Health Emergency Room Visits Follow-up After Hospitalization for Mental Illness Timeliness of Behavioral Health Utilization Management Decisions Behavioral Health Geoaccess Requirements Follow-up Care for Members Prescribed ADHD Medication Behavioral Health Case Management Services Antidepressant Medication Management Management of Medication for Members with a Diagnosis of Schizophrenia, Schizo-Affective Disorders and Related Diagnoses Management of Medication for Members with a Diagnosis of Bipolar Disorder and Related Diagnoses Credentialing Behavioral Health Providers
--

HEDIS® Measures

The OMPP requires that the MCOs submit HEDIS® measures annually that have been audited by a certified NCQA⁴ auditor. In Calendar Year 2008 (from this point forward referred to as HEDIS® 2008), the MCOs reported on 38 different HEDIS® measures. These measures represent MCO member experience in Calendar Year 2007. The OMPP gave the MCOs targets for 25 specific measures. Among the 38 total measures, 13 are specific to children and the OMPP gave the MCOs targets for each of them. The measures themselves report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome.

Exhibit VI.7 on the next page compares the MCO's HEDIS® 2008 scores to the OMPP targets as well as to national benchmarks. Four of the HEDIS® measures for Anthem are considered Unable to Report (UTR) because the requirements for the HEDIS® measure require a time period that is beyond 12 months and would require data from CY 2006 when Anthem was not under contract with Hoosier Healthwise. Two other measures are Not Reported (NR) because Anthem did not submit data for these measures to be audited. Although the results have been forwarded to the OMPP, the HEDIS® auditor determined that these measures could not be compared publicly with audited results from other plans.

The results shown in Exhibit VI.7 are disappointing. MDwise exceeded the OMPP targets on seven of the 13 measures, MHS on three of the 13, and Anthem on two of the six measures it reported on. Many of the measures that MCOs exceeded the OMPP targets on were common across MCOs:

- MDwise and Anthem exceeded the target for Childhood Immunization Status and Adolescent Well-Care Visits
- MDwise and MHS exceeded the target for Use of Appropriate Medications for People with Asthma and Well-Child Visits in the First 15 Months of Life
- MDwise alone exceeded the target for Children's Access to Primary Care Practitioners for ages 12-24 months and 7-11 years.

But even some of these results are not as favorable to Medicaid health plans nationally. The bottom of the exhibit shows how each of Indiana's MCOs compared to Medicaid managed care plans nationally. Of the 13 measures related to children, MDwise was below the national median rate nine times, MHS was all 13 times, and Anthem was for five of the six measures it reported on.

Definitions for each measure appear on page VI-11.

³ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁴ National Committee on Quality Assurance

Exhibit VI.7

Comparison of MCO HEDIS 2008 Scores Against OMPP Targets and National Benchmarks

MEASURE	OMPP Target	MCO HEDIS 2008 Rates (Measurement Year 2007)			Ranking to National			Met OMPP Target?		
		Anthem	MHS	MDwise	Anthem	MHS	MDwise	Anthem	MHS	MDwise
Childhood Immunization Status (Combination 2)	65	72	61	75	<50th	<25th	<75th	Yes	No	Yes
Appropriate Treatment for Children with Upper Respiratory Infection	87	NR	76	80	N/A	<25th	<50th	N/A	No	No
Appropriate Testing for Children with Pharyngitis	55	NR	47	54	N/A	<50th	<50th	N/A	No	No
Chlamydia Screening in Women, Age 16-20 years	52	39	42	43	<25th	<25th	<25th	No	No	No
Use of Appropriate Medications for People with Asthma										
Age 5 Years - 9 Years	70	UTR	87	91	N/A	<25th	<50th	N/A	Yes	Yes
Age 10 Years - 17 Years	70	UTR	88	86	N/A	<50th	<50th	N/A	Yes	Yes
Children's Access to Primary Care										
Age 12 Months - 24 Months	97	87	95	97	<10th	<50th	<75th	No	No	Yes
Age 25 Months - 6 Years	88	78	84	86	<25th	<50th	<50th	No	No	No
Age 7 Years - 11 Years	88	UTR	85	88	N/A	<50th	<75th	N/A	No	Yes
Age 12 Years - 19 Years	88	UTR	84	86	N/A	<50th	<75th	N/A	No	No
Well-Child Visits in First 15 Months of Life (>= 6 visits)	50	UTR	50	51	N/A	<50th	<50th	N/A	Yes	Yes
Well-Child Visits in the 3rd through 6th Years of Life (>= 1 visit)	65	61	59	57	<25th	<25th	<25th	No	No	No
Adolescent Well-Care Visits (>= 1 visit)	40	45	37	42	<75th	<50th	<50th	Yes	No	Yes

NR = Not Reported; UTR = Unable to Report (Anthem could not report due to continuous eligibility definitions in HEDIS.)

Ranking to National represents the closest benchmark to national measures, e.g. "<75th" means below the 75th but above the 50th percentile.

Definitions for HEDIS® 2008 Measures Shown in Exhibit VI.7

Childhood Immunization Status (Combination 2): The percentage of children who turned age two 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
Three doses of polio
One dose of measles-mumps-rubella

Three doses of influenza
Three doses of Hepatitis B
One dose of chicken pox

Appropriate Treatment for Upper Respiratory Infection: The percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable, because if an antibiotic was not given it means that the infection was treated more quickly.

Appropriate Testing for Children with Pharyngitis: The percentage of children between the ages of two and 18 who were diagnosed with strep throat, were prescribed an antibiotic, and who received a Group A streptococcus test. A higher rating is more favorable since it indicates better testing for those diagnosed with strep throat.

Chlamydia Screening in Women, Age 16-20 Years: The percentage of women in the age group who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Use of Appropriate Medications for People with Asthma: The percentage of members who were identified as having persistent asthma and who were prescribed appropriate medication.

Children's Access to Primary Care Practitioners: The percentage of children who had a visit with their primary care practitioner (called PMPs in Indiana) in the measurement year.

Well Child Visits in the First 15 Months of Life: The percentage of children who turned 15 months old during the measurement year and received six or more well child visits with a primary care practitioner in their first 15 months of life.

Well Child Visits (3rd through 6th Years of Life and Adolescents): The percentage of children that had one or more well child visits during the measurement year. Each age group is tracked separately. For the adolescents, a visit to an OB/GYN also counts as a well child visit.

CAHPS®⁵ Measures

The Hoosier Healthwise MCOs contract with an outside survey firm annually to conduct a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Separate surveys are conducted for adults and parents of children enrolled in Hoosier Healthwise. The findings reported in Exhibit VI.8 below represent the results from survey of parents conducted in early 2008. The sample of members interviewed included members that had been enrolled for at least six months with the MCO in 2007. The surveys were administered using the CAHPS® 2008 3.0H Medicaid Child Member Satisfaction Survey instrument.

The CAHPS® is designed so that surveyors ask a number of questions around a specific domain so that they can develop composite scores. The first four lines in the exhibit represent the composite scores commonly reported. The Hoosier Healthwise MCO composite scores are compared to the CAHPS® 2007 national benchmark. All three MCOs exceeded the national average for Getting Needed Care, and MHS and MDwise exceeded the national benchmark for How Well Doctors Communicate. Customer Service is an area of improvement for all of the Hoosier Healthwise MCOs.

Other questions on the survey relate to the respondents offering ratings on a scale of zero to 10. The percentages in the exhibit below reflect those members that gave a rating of 9 or 10 for each measure, where zero is “worst possible” and 10 is “best possible”. The ratings for specialists and for the member’s own health care were high for Anthem and near the national average for MHS and MDwise. All three MCOs were at or near the national average for Rating of Health Plan.

**Exhibit VI.8
Summary of Scores from CAHPS 2008 Child Survey**

	Anthem	MHS	MDwise	CAHPS 2007 National Benchmark*
Getting Needed Care	78%	81%	83%	70%
Getting Care Quickly	83%	81%	86%	89%
How Well Doctors Communicate	89%	93%	93%	91%
Customer Service	60%	64%	69%	78%

	Anthem	MHS	MDwise	CAHPS 2007 National Benchmark*
Rating of Personal Doctor	64%	64%	65%	72%
Rating of Specialist	75%	67%	67%	66%
Rating of Health Care	67%	68%	67%	61%
Rating of Health Plan	61%	63%	65%	61%

*From the 2007 CAHPS Health Plan Survey Chartbook , published by the AHRQ in Dec 2007.

Bold items indicate where Indiana's MCOs exceeded the national median benchmark.

⁵ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

VII. Items for Consideration for Indiana's Legislature and the OMPP

When compared to other states, Indiana's Children's Health Insurance Program (CHIP) has already been very successful in its outreach to offering insurance coverage to uninsured children in lower-income families. Early rapid growth in the program has been tempered recently, but nonetheless there have been over 70,000 children covered in the program in each of the last three years. The recent expansion to children in families above 200% up to 250% of the federal poverty level (FPL), in conjunction with the downturn in the economy, will likely result in a further increase in the CHIP's enrollment. The recent passage of CHIPRA 2009 guarantees sufficient funding to Indiana over the next four and a half years for the program.

Burns & Associates, Inc. (B&A) reviewed the access, quality and cost of delivering services to children in the CHIP. In our role as the External Quality Reviewer of the Hoosier Healthwise program as a whole, we have the opportunity to review close-hand the context in which services are delivered to CHIP members as well as all children in Hoosier Healthwise. We have observed that, particularly in the last two years, the Office of Medicaid Policy and Planning (OMPP) has taken a more robust approach to ensuring the intended outcomes for children in Hoosier Healthwise.

Many of our recommendations in prior years of this report have already been implemented. Our observation is that the OMPP is requiring more accountability from its partners in delivering high quality accessible health care to children and fostering more feedback from all parties to improve outcomes. B&A suggests that these activities continue and expand. The items identified below are areas for the Legislature to consider regarding the future of the program and for the OMPP to consider encouraging greater accountability related to improving outcomes for children in the CHIP and Hoosier Healthwise as a whole.

Considerations for the Legislature as a Result of CHIPRA 2009

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, signed into law on February 4, 2009, authorizes \$33 billion in federal funds over four and half years beginning in April 2009. The Congressional Budget Office estimates that CHIPRA will provide coverage to 4.1 million children in Medicaid and CHIP¹ who would have otherwise been uninsured by 2013.

CHIPRA 2009 continues the funding pattern used in previous legislation for this program. Each state is allotted an annual amount based upon a combination of their state's child population living in families below 200% FPL and the number of uninsured children within this population. For Federal Fiscal Year (FFY) 2008, Indiana was allotted \$97.4 million. States draw down federal funds in the same manner as in the Medicaid program but at an enhanced match rate. For example, in FFY 2008 Indiana's Medicaid match rate was 62.69% while the enhanced CHIP rate was 73.88%. In FFY 2009, the rates are 64.26% and 74.98%, respectively. Unlike the Medicaid program, however, the federal CHIP limits federal matching dollars to each state's allotment. Funding may be carried over into a future year, but CHIPRA 2009 now limits states the availability to two years from three years previously.

Allotments over the duration of the coverage period are at present or higher levels for each state than they have been in recent years. The new legislation also allows for the redistribution of

¹ The new legislation specifically changes the acronym for the federal program from SCHIP to CHIP.

federal funds from one state to another if states do not spend their full allotments. In fact, the redistribution is now required whereas in the previous legislation the excess funds could return to the Treasury. State allotments will be rebased in 2011.

Many of the policies that have been debated in recent years about the federal CHIP have been addressed in the enabling legislation. Some of the highlights new to CHIPRA 2009 include:

- States may seek authority to cover children in families with incomes up to 300% of the FPL and beyond, but the match rate for children above 300% FPL would be at the Medicaid match rate, not the enhanced match rate.
- States have the option to cover targeted low-income pregnant women under CHIP through a state plan amendment provided that certain conditions are met, including that the state already covers pregnant women up to 185% of the FPL in the Medicaid program (like Indiana).
- States have the option to cover legal immigrant children and pregnant women during their first five years in the country. This five-year ban was imposed as part of welfare reform in 1996 but has since been lifted for many public programs (e.g. food stamps). Undocumented immigrants are still ineligible for CHIP.
- Although the citizenship documentation currently required for Medicaid also applies to CHIP, new authority was provided to states to use a verification process with the Commissioner of Social Security to match the member's name and social security number.
- States may provide premium assistance to qualifying families who purchase employer-sponsored private coverage if the parent voluntarily elects to receive the subsidy. The subsidy can be made to the employer or the employee.
- All states are required to include dental coverage in their benefit package (Indiana already does). If premium assistance is offered to enrollees but their private insurance does not include dental coverage, states can offer wrap-around coverage for this benefit.
- Mental health or substance abuse services are also now required in the CHIP benefit package (Indiana already does).
- Incentive bonus payments will be offered to states that exceed target enrollment levels. The target is the 2007 baseline enrollment figure plus four percentage points. Additionally, states must adopt five out of eight eligibility simplification efforts to receive the bonus payments.
- Targeted outreach dollars will also be made available to states.

On August 17, 2007, CMS issued guidance stating that states who were seeking to expand insurance coverage to children in families above 250% of the FPL must meet participation tests for children below 200% of the FPL. This included ensuring that more than 95 percent of the eligible population was already enrolled in the state's Medicaid/CHIP program and that private insurance coverage for children had not declined by more than two percentage points in the last

five years. This guidance letter was not addressed in CHIPRA 2009, but the guidance letter was withdrawn by President Obama on February 4.

1. The Legislature has already authorized expansion of the CHIP to children in families up to 300 percent of the FPL. The OMPP was limited in seeking this authority from the federal government due to the CMS guidance letter. Now that this has been rescinded, the Legislature may want to encourage the OMPP to swiftly seek federal approval to expand the program to 300 percent of the FPL.

The CHIPRA allow states to expand beyond the 300 percent FPL, but federal matching funds would be limited to the Medicaid match rate and not the enhanced CHIP match rate. However, it may still be worth investigating expansion to even higher income levels given the limited financial exposure to the State. After premiums were collected, the average cost to the State for the higher-income level children enrolled in CHIP in FFY 2008 was \$3.13 per member per month.

Indiana's CHIP Package C is a state-designed program, not an entitlement program like other states have. Therefore, even if the Legislature were to expand coverage to children in higher-income families, the State still has authority to cap the number of actual participants in the program if there is a fiscal concern.

CHIPRA 2009 enables states to seek authority to offer a premium assistance benefit to children in families that meet the income requirements for CHIP but may purchase insurance through an employer-sponsored plan. This is intended to eliminate the "crowd out" from private insurance that has been a concern of policymakers since the introduction of the program, particularly with children in families at the higher threshold of the eligibility scale. The Legislature may consider directing the OMPP to study the potential take-up of a premium assistance benefit in Indiana's CHIP. This could be a possibility to offer to higher-income children in the CHIP (i.e. children in families above 300% FPL) instead of the current Medicaid buy-in program currently in place (i.e. parents pay premiums to obtain a slightly-reduced Medicaid benefit package).

2. CHIPRA 2009 also offers bonus payments to states that show meaningful increases in their CHIP enrollment and who also adopt at least five out of eight eligibility simplification efforts. Indiana has already implemented some, but not all, of the simplification efforts. The Legislature may want to have the OMPP examine what additional requirements may be required to implement to be eligible for the bonus payments.

Other Considerations for the Legislature

3. Immunization rates, as reported in the HEDIS® score and the OMPP reports to the federal government shown in Chapter VI, could be improved. When B&A conducted the External Quality Review of the managed care organizations (MCOs) in the Fall of 2008, the MCOs stated that they utilize the Children and Hoosiers Immunization Registry Program (CHIRP) database housed at the Department of Health to retrieve data on immunizations administered by county health departments to their members. The MCOs report that extracting data from the CHIRP is a very labor-intensive process and that the data is not validated in most cases. This poses issues for utilizing CHIRP data to report HEDIS® measurements related to immunizations. It

also impacts the potential incentives that the OMPP has built into its contracts with the MCOs related to improving HEDIS scores. Since Hoosier Healthwise children may use county-based clinics or other sites where immunizations can be administered and the MCOs will never receive notification of the service that was delivered, the MCOs become even more dependent on the CHIRP for accuracy. The lack of reliable reporting can also result in over-immunization of children.

The Legislature may want to consider allocating resources to streamline the data exchange between the Department of Health (who maintains the CHIRP) and the OMPP and its partners so that the CHIRP can be a more usable tool for all. Feedback from the OMPP and its MCOs can be instrumental in improving the navigation and functionality of the CHIRP database. Additionally, information should be more transparent to all stakeholders and researchers in the state who may have a need to access immunization trends (at composite levels, not individual person records).

Considerations for the OMPP

1. The HEDIS® scores for the access to and effectiveness of care reported by the MCOs in 2008 that were shown in Chapter VI were disappointing as they have been the last few years. Of the 13 measures cited in this report, the OMPP has already taken action to increase the targets in 2009 for the MCOs on ten of the 13 measures (in all, the OMPP has created targets for 39 measures). Additionally, ten additional measures have performance-based incentives tied to them, including well child visits for infants, young children and adolescents. The OMPP is encouraged to continually monitor these benchmarks and to adjust the targets accordingly each year. In addition to incentives, the OMPP may want to consider performance penalties (e.g. reduced capitation payments) for MCOs that do not show steady improvement.
2. B&A's investigation of emergency room visits for CHIP members (page IV-6) did decline from what we reported last year. About 25 percent of CHIP members used the ER in each of the last two years, which is lower than the 30 percent reported in last year's report. To further encourage lower ER usage when inappropriate, the OMPP may want to consider a performance-based incentive to the MCOs around this issue or a Performance Improvement Project to be developed by all three MCOs in conjunction with the OMPP. For example, we know already that some of the MCOs are working with hospitals to have the hospitals fax back information on ER usage immediately after the Hoosier Healthwise member presents at the ER so that the MCO can do near real-time triage with the member, particularly for nonemergent visits. A performance-based incentive may yield additional innovative approaches by the MCOs to discourage inappropriate ER use by members.
3. B&A reported in Chapter IV the significantly higher utilization of services among children diagnosed with asthma, obesity and behavioral health conditions. Through our study of claims and encounters submitted by the MCOs, we found that over 8% of CHIP members had an asthma diagnosis, over 17% had a behavioral health diagnosis, and over 2% had an obesity diagnosis.

B&A learned from the MCOs in the External Quality Review conducted last year that asthma is already included in the MCOs' disease management plans. Also, specialized care plans are developed for some children with special health care needs in Hoosier Healthwise. Other conditions are handled on a case-by-case basis through

either an assessment of the individual or a review of historical service utilization. But it appeared that more attention could be paid to ensure that the children in Hoosier Healthwise with the most complex medical needs do not “fall through the cracks”.

For all three special diagnoses B&A analyzed for this report (asthma, behavioral health conditions, obesity), we suggest that the OMPP develop a feedback mechanism with the MCOs to ensure proper care coordination and improved outcomes for these vulnerable members.

- a. The OMPP should reconcile B&A’s list of members with the conditions we studied to the internal reporting completed by the MCOs to ensure that the MCOs properly identify members with these conditions. Other medically-needy conditions may also be included during this reconciliation that were not reported on here (e.g. high blood levels).
- b. Each of the children identified in B&A’s study should either be a part of the MCOs’ disease management program or their special health care needs program. Besides conducting a review of the identification of these members, the OMPP should ensure that the most effective care plan of care is in place for these members by evaluating the mechanisms implemented by each MCO and how these mechanisms may differ by the medical condition(s) of the member.
- c. B&A lauds the OMPP Quality Strategy Committee’s work on developing the Notification of Pregnancy form in which PMPs notify the MCOs if they discover that one of their patients is pregnant before the MCO learns of it. This is to ensure appropriate care is delivered as quickly as possible. The OMPP may want to consider a similar type of feedback loop between PMPs and the MCOs for conditions specific to children, such as conditions that would be appropriate for attention by the MCOs’ disease management programs. This feedback may also be built into the revised assessment tool for children which is currently being drafted by the OMPP’s Medical Advisory Committee.

Appendix A: Detailed Information by Subpopulation within Indiana's CHIP

The tables in this Appendix represent the numeric values for the information presented in graphical format throughout the report.

Appendices A-1 through A-3 examine results for each of the three MCOs.

Appendices A-4 through A-11 examine results for each of the eight regions studied.

Appendices A-12 through A-15 examine results for each of the race/ethnicity populations studied.

**Appendix A-1
Statistics for Anthem MCO**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	<u>CHIP A</u>	<u>Percent of All CHIP A</u>	<u>CHIP C</u>	<u>Percent of All CHIP C</u>		<u>CHIP A Pct In Region</u>	<u>CHIP A Percent Statewide</u>	<u>CHIP C Pct in Region</u>	<u>CHIP C Percent Statewide</u>
CY 2008	9,631	18%	3,157	18%	Northwest	18%		17%	
CY 2007	8,338	16%	2,742	16%	NorthCentral	12%		11%	
CY 2006	not under contract in 2006				Northeast	18%		20%	
					WestCentral	11%	18%	13%	18%
					Central	9%		7%	
					EastCentral	11%		9%	
					Southwest	49%		47%	
					Southeast	32%		32%	

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Anthem	All MCOs Combined
Number of Members with a Pediatrician as their PMP	5,555	23,708
Number of Members with another Practice as their PMP	4,360	23,934
Percent of Children with a Pediatrician as their PMP	56%	50%
	Anthem	All MCOs Combined
Percent of Members Assigned to a PMP in their County	65%	71%
Percent of Members Assigned to a PMP outside County	35%	29%
Percent of Panel Size Full for All Hoosier Healthwise	28%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Anthem			All CHIP Children		
	<u>7,116</u>	<u>9,969</u>	<u>Change</u>	<u>46,393</u>	<u>52,184</u>	<u>Change</u>
Sample Size =	<u>FFY 07</u>	<u>FFY 08</u>		<u>FFY 07</u>	<u>FFY 08</u>	
Primary Care	74%	68%	-6%	71%	68%	-3%
EPSDT Services	30%	31%	1%	24%	28%	4%
Specialist Care	9%	8%	-1%	10%	9%	-1%
Emergency Room	19%	15%	-4%	24%	24%	0%
Non-ER Outpatient	22%	15%	-7%	24%	22%	-2%
Inpatient Stays	1%	1%	0%	2%	1%	-1%
Dental	64%	61%	-3%	65%	64%	-1%
Prescription Drugs	50%	60%	10%	63%	68%	5%

**Appendix A-2
Statistics for MDwise MCO**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	CHIP A	Percent of All CHIP A	CHIP C	Percent of All CHIP C	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
CY 2008	22,930	43%	7,206	41%	Northwest	43%	43%		
CY 2007	23,212	43%	7,232	41%	NorthCentral	18%	18%		
CY 2006	9,422	18%	2,905	16%	Northeast	46%	41%		
					WestCentral	49%	44%	43%	41%
					Central	60%	59%		
					EastCentral	37%	38%		
					Southwest	22%	19%		
					Southeast	35%	34%		

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	MDwise	All MCOs Combined
Number of Members with a Pediatrician as their PMP	10,584	23,708
Number of Members with another Practice as their PMP	11,555	23,934
Percent of Children with a Pediatrician as their PMP	48%	50%
	MDwise	All MCOs Combined
Percent of Members Assigned to a PMP in their County	72%	71%
Percent of Members Assigned to a PMP outside County	28%	29%
Percent of Panel Size Full for All Hoosier Healthwise	38%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	MDwise			All CHIP Children		
	24,877 FFY 07	25,332 FFY 08	Change	46,393 FFY 07	52,184 FFY 08	Change
Primary Care	72%	68%	-4%	71%	68%	-3%
EPSDT Services	27%	31%	4%	24%	28%	4%
Specialist Care	11%	9%	-2%	10%	9%	-1%
Emergency Room	28%	28%	0%	24%	24%	0%
Non-ER Outpatient	26%	25%	-1%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	65%	65%	0%	65%	64%	-1%
Prescription Drugs	70%	72%	2%	63%	68%	5%

**Appendix A-3
Statistics for MHS MCO**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	<u>CHIP A</u>	<u>Percent of All CHIP A</u>	<u>CHIP C</u>	<u>Percent of All CHIP C</u>		<u>CHIP A Pct In Region</u>	<u>CHIP A Percent Statewide</u>	<u>CHIP C Pct in Region</u>	<u>CHIP C Percent Statewide</u>
CY 2008	14,341	27%	4,513	26%	Northwest	27%		24%	
					NorthCentral	54%		53%	
					Northeast	26%		25%	
CY 2007	13,855	26%	4,229	24%	WestCentral	29%	27%	28%	26%
					Central	16%		15%	
					EastCentral	41%		37%	
CY 2006	15,812	30%	4,997	28%	Southwest	21%		22%	
					Southeast	22%		20%	

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	MHS	All MCOs Combined
Number of Members with a Pediatrician as their PMP	7,569	23,708
Number of Members with another Practice as their PMP	8,019	23,934
Percent of Children with a Pediatrician as their PMP	49%	50%
	MHS	All MCOs Combined
Percent of Members Assigned to a PMP in their County	73%	71%
Percent of Members Assigned to a PMP outside County	27%	29%
Percent of Panel Size Full for All Hoosier Healthwise	37%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	MHS			All CHIP Children		
	<u>14,400</u> <u>FFY 07</u>	<u>16,883</u> <u>FFY 08</u>	<u>Change</u>	<u>46,393</u> <u>FFY 07</u>	<u>52,184</u> <u>FFY 08</u>	<u>Change</u>
Primary Care	70%	69%	-1%	71%	68%	-3%
EPSDT Services	18%	22%	4%	24%	28%	4%
Specialist Care	11%	9%	-2%	10%	9%	-1%
Emergency Room	21%	23%	2%	24%	24%	0%
Non-ER Outpatient	21%	22%	1%	24%	22%	-2%
Inpatient Stays	1%	1%	0%	2%	1%	-1%
Dental	64%	65%	1%	65%	64%	-1%
Prescription Drugs	58%	68%	10%	63%	68%	5%

**Appendix A-4
Statistics for the Northwest Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	6,301	12%	2,118	4%	Anthem	18%	18%	17%	18%
CY 2007	6,260	12%	1,988	4%	MDwise	43%	43%	43%	41%
CY 2006	6,103	12%	2,067	4%	MHS	27%	27%	24%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Northwest Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	3,689	23,708
Number of Members with another Practice as their PMP	2,625	23,934
Percent of Children with a Pediatrician as their PMP	58%	50%

	Northwest Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	79%	71%
Percent of Members Assigned to a PMP outside County	21%	29%
Percent of Panel Size Full for All Hoosier Healthwise	26%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Northwest Region			Statewide		
Sample Size =	5,453 <u>FFY 07</u>	6,149 <u>FFY 08</u>	<u>Change</u>	46,393 <u>FFY 07</u>	52,184 <u>FFY 08</u>	<u>Change</u>
Primary Care	66%	66%	0%	71%	68%	-3%
EPSDT Services	18%	23%	5%	24%	28%	4%
Specialist Care	9%	7%	-2%	10%	9%	-1%
Emergency Room	21%	21%	0%	24%	24%	0%
Non-ER Outpatient	21%	19%	-2%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	61%	60%	-1%	65%	64%	-1%
Prescription Drugs	62%	66%	4%	63%	68%	5%

**Appendix A-5
Statistics for the North Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	5,741	11%	1,893	4%	Anthem	12%	18%	11%	18%
CY 2007	5,642	11%	1,854	4%	MDwise	18%	43%	18%	41%
CY 2006	5,460	10%	1,891	4%	MHS	54%	27%	53%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	North Central Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	1,588	23,708
Number of Members with another Practice as their PMP	3,427	23,934
Percent of Children with a Pediatrician as their PMP	32%	50%

	North Central Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	78%	71%
Percent of Members Assigned to a PMP outside County	22%	29%
Percent of Panel Size Full for All Hoosier Healthwise	48%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	North Central Region			Statewide		
Sample Size =	4,848	5,400		46,393	52,184	
	<u>FFY 07</u>	<u>FFY 08</u>	<u>Change</u>	<u>FFY 07</u>	<u>FFY 08</u>	<u>Change</u>
Primary Care	73%	70%	-3%	71%	68%	-3%
EPSDT Services	20%	27%	7%	24%	28%	4%
Specialist Care	12%	9%	-3%	10%	9%	-1%
Emergency Room	18%	19%	1%	24%	24%	0%
Non-ER Outpatient	19%	17%	-2%	24%	22%	-2%
Inpatient Stays	1%	1%	0%	2%	1%	-1%
Dental	67%	68%	1%	65%	64%	-1%
Prescription Drugs	57%	66%	9%	63%	68%	5%

**Appendix A-6
Statistics for the Northeast Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	6,625	12%	2,136	4%	Anthem	18%	18%	20%	18%
CY 2007	6,490	12%	2,150	4%	MDwise	46%	43%	41%	41%
CY 2006	6,509	12%	2,224	4%	MHS	26%	27%	25%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Northeast Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	2,346	23,708
Number of Members with another Practice as their PMP	4,122	23,934
Percent of Children with a Pediatrician as their PMP	36%	50%

	Northeast Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	70%	71%
Percent of Members Assigned to a PMP outside County	30%	29%
Percent of Panel Size Full for All Hoosier Healthwise	56%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Northeast Region			Statewide		
Sample Size =	5,568 <u>FFY 07</u>	6,284 <u>FFY 08</u>	<u>Change</u>	46,393 <u>FFY 07</u>	52,184 <u>FFY 08</u>	<u>Change</u>
Primary Care	72%	67%	-5%	71%	68%	-3%
EPSDT Services	23%	23%	0%	24%	28%	4%
Specialist Care	13%	10%	-3%	10%	9%	-1%
Emergency Room	23%	22%	-1%	24%	24%	0%
Non-ER Outpatient	22%	22%	0%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	64%	64%	0%	65%	64%	-1%
Prescription Drugs	63%	68%	5%	63%	68%	5%

**Appendix A-7
Statistics for the West Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	4,137	8%	1,464	3%	Anthem	11%	18%	13%	18%
CY 2007	4,329	8%	1,321	3%	MDwise	49%	43%	44%	41%
CY 2006	4,362	8%	1,339	3%	MHS	29%	27%	28%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	West Central Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	900	23,708
Number of Members with another Practice as their PMP	2,211	23,934
Percent of Children with a Pediatrician as their PMP	29%	50%

	West Central Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	54%	71%
Percent of Members Assigned to a PMP outside County	46%	29%
Percent of Panel Size Full for All Hoosier Healthwise	49%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	West Central Region			Statewide		
Sample Size =	3,871 <u>FFY 07</u>	4,297 <u>FFY 08</u>	<u>Change</u>	46,393 <u>FFY 07</u>	52,184 <u>FFY 08</u>	<u>Change</u>
Primary Care	75%	68%	-7%	71%	68%	-3%
EPSDT Services	22%	22%	0%	24%	28%	4%
Specialist Care	7%	7%	0%	10%	9%	-1%
Emergency Room	27%	28%	1%	24%	24%	0%
Non-ER Outpatient	24%	24%	0%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	61%	62%	1%	65%	64%	-1%
Prescription Drugs	61%	70%	9%	63%	68%	5%

**Appendix A-8
Statistics for the Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	16,028	30%	5,132	10%	Anthem	9%	18%	7%	18%
CY 2007	15,642	29%	4,991	9%	MDwise	60%	43%	59%	41%
CY 2006	15,105	29%	4,986	9%	MHS	16%	27%	15%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Central Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	7,998	23,708
Number of Members with another Practice as their PMP	4,933	23,934
Percent of Children with a Pediatrician as their PMP	62%	50%

	Central Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	77%	71%
Percent of Members Assigned to a PMP outside County	23%	29%
Percent of Panel Size Full for All Hoosier Healthwise	58%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Central Region			Statewide		
Sample Size =	12,949 FFY 07	14,709 FFY 08	Change	46,393 FFY 07	52,184 FFY 08	Change
Primary Care	66%	64%	-2%	71%	68%	-3%
EPSDT Services	29%	37%	8%	24%	28%	4%
Specialist Care	10%	9%	-1%	10%	9%	-1%
Emergency Room	29%	29%	0%	24%	24%	0%
Non-ER Outpatient	25%	23%	-2%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	66%	66%	0%	65%	64%	-1%
Prescription Drugs	66%	66%	0%	63%	68%	5%

**Appendix A-9
Statistics for the East Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	4,543	8%	1,452	3%	Anthem	11%	18%	9%	18%
CY 2007	4,751	9%	1,487	3%	MDwise	37%	43%	38%	41%
CY 2006	4,813	9%	1,563	3%	MHS	41%	27%	37%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	East Central Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	1,848	23,708
Number of Members with another Practice as their PMP	2,027	23,934
Percent of Children with a Pediatrician as their PMP	48%	50%
	East Central Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	74%	71%
Percent of Members Assigned to a PMP outside County	26%	29%
Percent of Panel Size Full for All Hoosier Healthwise	47%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	East Central Region			Statewide		
Sample Size =	4,297 <u>FFY 07</u>	4,437 <u>FFY 08</u>	<u>Change</u>	46,393 <u>FFY 07</u>	52,184 <u>FFY 08</u>	<u>Change</u>
Primary Care	75%	71%	-4%	71%	68%	-3%
EPSDT Services	21%	21%	0%	24%	28%	4%
Specialist Care	13%	10%	-3%	10%	9%	-1%
Emergency Room	25%	27%	2%	24%	24%	0%
Non-ER Outpatient	27%	27%	0%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	69%	67%	-2%	65%	64%	-1%
Prescription Drugs	68%	72%	4%	63%	68%	5%

**Appendix A-10
Statistics for the Southwest Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	5,779	11%	2,072	4%	Anthem	49%	18%	47%	18%
CY 2007	5,684	11%	2,102	4%	MDwise	22%	43%	19%	41%
CY 2006	5,725	11%	2,132	4%	MHS	21%	27%	22%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Southwest Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	2,965	23,708
Number of Members with another Practice as their PMP	2,812	23,934
Percent of Children with a Pediatrician as their PMP	51%	50%

	Southwest Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	59%	71%
Percent of Members Assigned to a PMP outside County	41%	29%
Percent of Panel Size Full for All Hoosier Healthwise	46%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Southwest Region			Statewide		
Sample Size =	5,379 <u>FFY 07</u>	6,278 <u>FFY 08</u>	<u>Change</u>	46,393 <u>FFY 07</u>	52,184 <u>FFY 08</u>	<u>Change</u>
Primary Care	78%	76%	-2%	71%	68%	-3%
EPSDT Services	28%	31%	3%	24%	28%	4%
Specialist Care	9%	9%	0%	10%	9%	-1%
Emergency Room	20%	18%	-2%	24%	24%	0%
Non-ER Outpatient	24%	19%	-5%	24%	22%	-2%
Inpatient Stays	1%	1%	0%	2%	1%	-1%
Dental	65%	65%	0%	65%	64%	-1%
Prescription Drugs	60%	69%	9%	63%	68%	5%

**Appendix A-11
Statistics for the Southeast Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2008				
		Percent of All		Percent of All	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
	<u>CHIP A</u>	<u>CHIP A</u>	<u>CHIP C</u>	<u>CHIP C</u>					
CY 2008	4,457	8%	1,507	3%	Anthem	32%	18%	32%	18%
CY 2007	4,548	9%	1,546	3%	MDwise	35%	43%	34%	41%
CY 2006	4,684	9%	1,643	3%	MHS	22%	27%	20%	26%

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Southeast Region	All Regions Combined
Number of Members with a Pediatrician as their PMP	2,314	23,708
Number of Members with another Practice as their PMP	1,761	23,934
Percent of Children with a Pediatrician as their PMP	57%	50%

	Southeast Region	All Regions Combined
Percent of Members Assigned to a PMP in their County	58%	71%
Percent of Members Assigned to a PMP outside County	42%	29%
Percent of Panel Size Full for All Hoosier Healthwise	49%	35%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Southeast Region			Statewide		
Sample Size =	3,959 <u>FFY 07</u>	4,538 <u>FFY 08</u>	<u>Change</u>	46,393 <u>FFY 07</u>	52,184 <u>FFY 08</u>	<u>Change</u>
Primary Care	78%	73%	-5%	71%	68%	-3%
EPSDT Services	26%	28%	2%	24%	28%	4%
Specialist Care	11%	9%	-2%	10%	9%	-1%
Emergency Room	24%	21%	-3%	24%	24%	0%
Non-ER Outpatient	30%	24%	-6%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	61%	59%	-2%	65%	64%	-1%
Prescription Drugs	63%	70%	7%	63%	68%	5%

**Appendix A-12
Statistics for Caucasian CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	<u>CHIP A</u>	Percent of All <u>CHIP</u> <u>A</u>	<u>CHIP C</u>	Percent of All <u>CHIP</u> <u>C</u>		<u>CHIP A</u> Pct In <u>Region</u>	<u>CHIP A</u> Percent <u>Statewide</u>	<u>CHIP C</u> Pct in <u>Region</u>	<u>CHIP C</u> Percent <u>Statewide</u>
CY 2008	35,350	66%	12,938	73%	Northwest	46%		56%	
					NorthCentral	58%		67%	
					Northeast	71%		78%	
CY 2007	35,738	67%	12,960	74%	WestCentral	82%	66%	83%	73%
					Central	50%		61%	
					EastCentral	86%		86%	
CY 2006	35,774	68%	13,449	75%	Southwest	89%		92%	
					Southeast	89%		93%	

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Caucasian CHIP Members	All CHIP Children
Number of Members with a Pediatrician as their PMP	14,889	23,708
Number of Members with another Practice as their PMP	18,136	23,934
Percent of Children with a Pediatrician as their PMP	45%	50%

	Caucasian CHIP Members	All CHIP Children
Percent of Members Assigned to a PMP in their County	65%	71%
Percent of Members Assigned to a PMP outside County	35%	29%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Caucasian CHIP Members			All CHIP Children		
	<u>FFY 07</u>	<u>FFY 08</u>	<u>Change</u>	<u>FFY 07</u>	<u>FFY 08</u>	<u>Change</u>
Sample Size =	33,101	36,559		46,393	52,184	
Primary Care	75%	72%	-3%	71%	68%	-3%
EPSDT Services	23%	25%	2%	24%	28%	4%
Specialist Care	11%	10%	-1%	10%	9%	-1%
Emergency Room	25%	24%	-1%	24%	24%	0%
Non-ER Outpatient	26%	24%	-2%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	64%	64%	0%	65%	64%	-1%
Prescription Drugs	66%	72%	6%	63%	68%	5%

**Appendix A-13
Statistics for African American CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	<u>CHIP A</u>	Percent of All <u>CHIP</u>		Percent of All <u>CHIP</u>	CHIP A Pct In <u>Region</u>	CHIP A Percent <u>Statewide</u>	CHIP C Pct in <u>Region</u>	CHIP C Percent <u>Statewide</u>	
		<u>A</u>	<u>C</u>						
CY 2008	9,519	18%	2,039	12%	Northwest	30%	20%		
					NorthCentral	13%	7%		
					Northeast	13%	7%		
CY 2007	9,342	17%	1,970	11%	WestCentral	4%	3%	12%	
					Central	30%	21%		
					EastCentral	8%	6%		
CY 2006	9,350	18%	2,084	12%	Southwest	7%	4%		
					Southeast	5%	3%		

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Afr Amer CHIP Members	All CHIP Children
Number of Members with a Pediatrician as their PMP	5,248	23,708
Number of Members with another Practice as their PMP	2,695	23,934
Percent of Children with a Pediatrician as their PMP	66%	50%

	Afr Amer CHIP Members	All CHIP Children
Percent of Members Assigned to a PMP in their County	90%	71%
Percent of Members Assigned to a PMP outside County	10%	29%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Afr American CHIP Members			All CHIP Children		
	<u>7,109</u> FFY 07	<u>8,159</u> FFY 08	<u>Change</u>	<u>46,393</u> FFY 07	<u>52,184</u> FFY 08	<u>Change</u>
Primary Care	57%	57%	0%	71%	68%	-3%
EPSDT Services	25%	32%	7%	24%	28%	4%
Specialist Care	8%	6%	-2%	10%	9%	-1%
Emergency Room	23%	25%	2%	24%	24%	0%
Non-ER Outpatient	18%	16%	-2%	24%	22%	-2%
Inpatient Stays	2%	1%	-1%	2%	1%	-1%
Dental	65%	64%	-1%	65%	64%	-1%
Prescription Drugs	56%	59%	3%	63%	68%	5%

**Appendix A-14
Statistics for Hispanic CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	<u>CHIP A</u>	Percent of	<u>CHIP C</u>	Percent of	<u>Region</u>	<u>CHIP A</u>	<u>Statewide</u>	<u>CHIP C</u>	<u>Statewide</u>
		All <u>CHIP</u>		All <u>CHIP</u>		Pct In		Percent	
		<u>A</u>		<u>C</u>					
CY 2008	7,627	14%	2,213	13%	Northwest	23%		22%	
					NorthCentral	28%		23%	
					Northeast	12%		11%	
CY 2007	7,247	14%	2,103	12%	WestCentral	12%	14%	12%	13%
					Central	17%		14%	
					EastCentral	5%		5%	
CY 2006	6,616	13%	2,007	11%	Southwest	3%		3%	
					Southeast	5%		3%	

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Hispanic CHIP Members	All CHIP Children
Number of Members with a Pediatrician as their PMP	2,973	23,708
Number of Members with another Practice as their PMP	2,638	23,934
Percent of Children with a Pediatrician as their PMP	53%	50%

	Hispanic CHIP Members	All CHIP Children
Percent of Members Assigned to a PMP in their County	80%	71%
Percent of Members Assigned to a PMP outside County	20%	29%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Hispanic CHIP Members		
	<u>FFY 07</u>	<u>FFY 08</u>	<u>Change</u>
Sample Size =	5,255	6,273	
Primary Care	67%	63%	-4%
EPSDT Services	33%	38%	5%
Specialist Care	9%	7%	-2%
Emergency Room	23%	23%	0%
Non-ER Outpatient	19%	17%	-2%
Inpatient Stays	1%	1%	0%
Dental	67%	68%	1%
Prescription Drugs	56%	60%	4%

	All CHIP Children		
	<u>FFY 07</u>	<u>FFY 08</u>	<u>Change</u>
Sample Size =	46,393	52,184	
Primary Care	71%	68%	-3%
EPSDT Services	24%	28%	4%
Specialist Care	10%	9%	-1%
Emergency Room	24%	24%	0%
Non-ER Outpatient	24%	22%	-2%
Inpatient Stays	2%	1%	-1%
Dental	65%	64%	-1%
Prescription Drugs	63%	68%	5%

**Appendix A-15
Statistics for Other Race/Ethnicities CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2008				
	CHIP A	Percent of All CHIP		Percent of All CHIP	CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide	
		A	C						
CY 2008	397	2%	160	3%	Northwest	1%	2%		
					NorthCentral	2%	2%		
					Northeast	3%	4%		
CY 2007	364	2%	143	2%	WestCentral	2%	2%	3%	
					Central	3%	4%		
					EastCentral	1%	2%		
CY 2006	324	2%	140	2%	Southwest	1%	1%		
					Southeast	1%	1%		

Access to Primary Care

Data shown is for pediatricians in September 2008. Other Primary Medical Providers may provide services to children.

	Other Races CHIP Members:	All CHIP Children
Number of Members with a Pediatrician as their PMP	598	23,708
Number of Members with another Practice as their PMP	465	23,934
Percent of Children with a Pediatrician as their PMP	56%	50%

	Other Races CHIP Members:	All CHIP Children
Percent of Members Assigned to a PMP in their County	73%	71%
Percent of Members Assigned to a PMP outside County	27%	29%

Utilization of Services

For CHIP members enrolled at least 9 months in an MCO during the time period

Results show the percentage of children who utilized the service in the Federal Fiscal Year (FFY).

	Other Races CHIP Members			All CHIP Children		
	FFY 07	FFY 08	Change	FFY 07	FFY 08	Change
Sample Size =	928	1,193		46,393	52,184	
Primary Care	68%	61%	-7%	71%	68%	-3%
EPSDT Services	31%	36%	5%	24%	28%	4%
Specialist Care	10%	6%	-4%	10%	9%	-1%
Emergency Room	18%	17%	-1%	24%	24%	0%
Non-ER Outpatient	20%	17%	-3%	24%	22%	-2%
Inpatient Stays	2%	0%	-2%	2%	1%	-1%
Dental	65%	63%	-2%	65%	64%	-1%
Prescription Drugs	58%	60%	2%	63%	68%	5%