

BURNS & ASSOCIATES, INC.

Health Policy Consultants

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

ANNUAL REPORT

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Executive Summary

The federal State Children's Health Insurance Program (SCHIP) received considerable attention in 2007 due to the impasse between Congress and President Bush to reauthorize the 10-year program. For now, SCHIP has been reauthorized until March 2009 with the same funding allocated for states as they were allotted in Federal Fiscal Year 2007, with some exceptions.

Burns & Associates, Inc. (B&A), the CHIP evaluators, confirmed with the Office of Medicaid Policy and Planning (OMPP) that Indiana's program will be covered with existing CHIP funding until December 2009. Indiana's Legislature, like 11 other states in 2007, authorized raising eligibility for children in their CHIP programs to 300% of the FPL. However, a new policy was issued by the Centers for Medicare and Medicaid Services (CMS) that effectively limited federal funding for SCHIP to 250% of the FPL (\$42,925 for a family of three in 2007). As a result, the OMPP submitted a state plan amendment to CMS in January 2008 to increase CHIP eligibility to 250% of the FPL only. What remains uncertain is how much Indiana will receive in the SCHIP reauthorization and whether the State will be able to retain its present reserve fund.

Since it was passed as part of the Balanced Budget Act of 1997, the SCHIP has been instrumental in lowering the uninsured rate for children in families below 200% of the FPL. Indiana's CHIP was one of the original success stories at the initial implementation 10 years ago due to an aggressive outreach program. While other states lagged in enrolling eligible children, Indiana achieved rapid enrollment early on. Up until recently, Indiana has outpaced the national average in CHIP enrollment growth, but this has changed in the last few years. Nevertheless, Indiana's uninsured rate for low-income uninsured children (below 200% of FPL) is 12.5% versus the national average of 18.1%. Indiana has been lower than the national average in each of the last six years. Although the number of children in low-income families has increased in Indiana by 100,000 in the last six years, Indiana has been able to reduce the number of uninsured in this group by 20% during the same time period.

Indiana's CHIP at a Glance

Indiana's CHIP is seamlessly integrated into Hoosier Healthwise, the managed care portion of Indiana's Medicaid program. As such, CHIP enrollees have the same access to providers as all other Medicaid managed care members including choice of primary medical provider (PMP). There is no difference in the access to or ability to provide services between CHIP members and children in Hoosier Healthwise. In 2007, CHIP members were enrolled in one of three managed care organizations (MCOs)—Anthem (new in 2007), MDwise, and Managed Health Services (MHS). Throughout this report, references are made to "CHIP A" and "CHIP C". These designations differentiate between the no-premium and premium share components of CHIP, which is based on family income. The Medicaid expansion portion (CHIP A) covers children in families with incomes up to 150% of the FPL (\$25,755 per year for a family of three in 2007) who are not already eligible for Medicaid. The State-designed portion (CHIP C) covers children in families with incomes above 150% up to 250% of the FPL (\$42,925 per year for a family of three in 2007). CHIP C requires premiums based on a sliding scale of income. In December 2007, there were 51,957 children enrolled in Indiana's CHIP A and 18,698 children enrolled in CHIP C for a total of 70,655 children, a 2% reduction from December 2006.

Enrollment

The growth rates are slowing in both CHIP A and C. In the earlier years of this decade, CHIP A experienced annual growth of 5% and CHIP C experienced double-digit growth. But 2006 was the first year that CHIP C posted a decline in enrollment and 2007 was the first year that CHIP A posted a decline. Premiums charged to families were doubled in February 2006 and this appears to have had some impact on enrollment. New proof of citizenship requirements mandated by the federal government may be having an impact on growth in CHIP A. Nevertheless, enrollment in CHIP C is now at an all-time high.

The interesting trend with enrollment in this program is that there appears to be two distinct populations—those that remain enrolled for long periods and another group that moves in and out of the program frequently. CHIP members that were enrolled in the first half of 2007 were examined to measure length of enrollment. Despite the new federal requirements, 74% of CHIP A members studied have been enrolled for more than two years. For CHIP C, it is 68% of the members. On the other hand, member disenrollment continues to be high in both programs—16% for CHIP A and 26% for CHIP C. The same trend was found last year as well.

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. About half of the children enrolled in CHIP are ages 6-12, while one-third are teenagers.

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 2006, minorities are represented more in CHIP than the overall state composition (31% of CHIP population, 22% 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

Each Hoosier Healthwise member (including CHIP members) selects an MCO and a PMP. Although Indiana's public programs have had challenges in the past in contracting with PMPs in some areas of the state, the fact that the current MCO contracts require the health plans to offer services statewide appears to have brought a new effort to recruit PMPs. B&A reviewed access reports tabulated by EDS—OMPP's fiscal agent—on all five provider specialties that serve as primary care providers (pediatricians, general practitioners, family practitioners, OB/GYNs, and general internists). Access to primary care appears to be the best in the history of Hoosier Healthwise, though there are still pockets in the state where access is, or has the potential to be, a concern. Although the MCOs serve members statewide, market share is not equally distributed across the MCOs by region. B&A suggests that the OMPP monitor closely those areas of the state where a particular MCO may be predominant and where their access to primary care for members may be an issue. Chapters III and IV provide more detail on this analysis. Statewide, 45% of CHIP members are enrolled with a pediatrician as their PMP. The remaining children have signed up with a general or family practitioner. We found no disparity in access to pediatricians by race/ethnicity, but some disparity by region in the state.

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 CY 2006 and in CY 2007. These services are presented in 11 categories throughout the report, including the child's visit to their PMP, specialists, clinics, EPSDT (Early Periodic Screening, Diagnosis, and Treatment) services, emergency room, other hospital visits, preventive dental visits, and use of pharmacy scripts. In addition to comparing usage across the two years, subpopulations were analyzed to determine if there were differences in usage across populations. For example, comparisons were made between CHIP A and CHIP C and by the member's age, race/ethnicity, the MCO they were enrolled with, and their location in the state.

Unlike previous years when B&A has conducted this analysis, there was little difference in the percent of CHIP A members using the service versus CHIP C members. In the past, CHIP C members have been higher users of all services across-the-board. The only noticeable difference found this year was PMP visits and EPSDT services, which more CHIP C members continue to use than CHIP A members.

Relatively speaking, the percentage of children utilizing each service was similar across age groups, with some anticipated differences depending upon age. Age groups studied were age 1-5, 6-12, 13-18 female and 13-18 male. The teenage male age group, as expected, had the lowest PMP usage but it was still relatively high for the age group. The age 1-5 group had the highest PMP usage but it was lower than might be expected.

Service usage was also analyzed by CHIP members' race/ethnicity, which was divided into Caucasians, African-Americans, Hispanics, and other minority groups. B&A found that PMP usage was similar in both years studied for all groups except for African-American children, which had lower PMP usage. This trend also held true when we considered the percentage using any physician service (combination of PMP, specialist and clinic usage).

At the MCO level, there were similar usage findings between MDwise and MHS in 2007, with the exception that MDwise reported significantly higher EPSDT and clinic usage for its members. This may be attributed to MDwise's provider network where its delegated contractors are all hospital-based entities. Anthem, however, had lower usage than the other MCOs for physician-based services and pharmacy scripts. Further review showed that this appears to be due to a lack of claims reporting by Anthem; therefore, it is unknown at this time whether children enrolled with Anthem actually use services less than other health plan members. The OMPP has already taken corrective action with Anthem to improve its utilization reporting and re-evaluation will be necessary once this data is submitted completely.

Service use patterns were also examined by region in the state. With the exception of the Southwest Region, the percentage of CHIP members visiting their PMP was consistent across regions. Further investigation found that almost half of the CHIP members in the Southwest Region were enrolled with Anthem. Therefore, this deviation from the statewide average may in fact be a data reporting issue.

Statewide, the usage rate of the hospital emergency room should be studied to determine whether or not the usage is actually emergent care or if the service could be delivered in a

less intensive setting. Normally, ER usage is defined by the presence of one of five usual ER procedure codes. However, most claims identified as being billed out of the ER (using an ER hospital revenue code) were not submitted with the five ER procedure codes. Therefore, B&A was forced to use the more general definition of ER revenue code, which may be overstating ER usage reported (32% of CHIP C children in 2007, 30% of CHIP A children). The OMPP should work closely with the MCOs to insure that the procedure data is reported and, if it is determined that the services were not emergent, develop a performance improvement project related to educating members to divert away from the ER.

Quality Measures

Through its contracts with the MCOs, the OMPP requires that HEDIS statistics be reported annually. The HEDIS statistics are nationally-recognized outcome measures that allow health plans to compare themselves against their peers. For example, the National Committee for Quality Assurance (NCQA), which develops and tracks the HEDIS measures, compares Medicaid health plans nationally and commercial health plans nationally. There are specific HEDIS measures for children, others for adults, and others for all age groups. Chapter VI discusses the results of each HEDIS measurement for children required to be reported by the Hoosier Healthwise MCOs against the NCQA's national benchmarks. Among the 12 measures reviewed, both MHS and MDwise scored the same or better than the Medicaid national average on seven of the measures. The OMPP has also developed its own target scores for each measure—some of which are near the national averages and others are higher. When compared against the OMPP targets, MHS scored at or better than the target on four measures and MDwise did so on eight measures. [Anthem was not reviewed since the HEDIS measures are a lookback review of data from 2006 when Anthem was not yet contracted with the State.]

The MCOs are also required to conduct a member survey each year to obtain feedback on their performance. A national standardized survey tool (CAHPS) was administered to MHS and MDwise parents of children enrolled in Hoosier Healthwise (a separate survey of CHIP members exclusively is not required of the MCOs). The results of these surveys can also be compared to national benchmarks developed by the NCQA for Medicaid health plans. Across nine composite satisfaction measures, Indiana's MCO rates were at or near (some slightly higher, some slightly lower) the national averages. The results from MHS and MDwise were also similar when compared to each other.

There is limited data on national trends for health disparities among race/ethnicities for children specifically. A National Survey of Children's Health was conducted in 2003-2004 as a telephone survey to a random sample of parents and guardians of children ages 0 to 17. There were 102,353 respondents. Forty measures of medical status, access to care, and use of services were analyzed. Using Indiana CHIP's claims data, B&A compared our service use tabulations against the national survey results. We found that African-American children in Indiana's CHIP were less likely to have seen their PMP than other African-American children reported nationally. Indiana's CHIP members also had lower dental utilization across all race/ethnicities than what was reported nationally, yet emergency room usage was higher in Indiana than the national study. Some of these results may not be as significant as the data implicitly shows due to the construct of the national survey versus the data collection completed for this evaluation. However, the differences cited are significant enough to merit further evaluation within Indiana's CHIP.

Chapter VII of our report highlights Hoosier Healthwise MCO initiatives specific to children for the contract year 2007. Specific contract requirements included areas related to school-based health care, asthma disease management programs, services for children with special health care needs, educational outreach, pay for performance initiatives with providers, and member incentives. The specific activities of each MCO are elaborated in the chapter.

Cost

From a fiscal perspective, Indiana's CHIP continues to be a cost-effective program for delivering quality services to low-income children in the state. Total payments made by the State for services for children in the premium-based portion of CHIP (CHIP C) increased 11% in CY 2007. Payments for children in the no-premium portion of CHIP (CHIP A) decreased 4% in CY 2007. Despite the growth in CHIP C expenditures, on a per member per month (PMPM) basis, CHIP C children have cost the State 7%-20% less than CHIP A children in the last three years (federal and state share). Still, CHIP A children are also 20% less costly (federal and state share) than children in traditional Medicaid on a per member per month basis.

CHIP expenditures are also offset by a higher contribution from the federal government (74 cents of every dollar spent by the state) compared to Medicaid (63 cents of every dollar spent by the state). CHIP C specifically is also offset by the premiums charged to families who enroll. When accounting only for the federal match component, the state share on a per member per month (PMPM) basis was \$31.23 for CHIP C and \$33.47 for CHIP A in CY 2007. This compares to \$63.43 for Medicaid children. Though data was not available this year, last year's review of premiums by B&A found that approximately one-quarter of all CHIP C expenditures are reimbursed to the state through the premiums, further reducing the PMPM cost.

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. Each chapter begins with a Chapter Highlights section to offer the reader a condensed review of our findings. Chapter IX offers recommendations to improve upon an already successful program.

I. Review of the National State Children's Health Insurance Program and How Indiana's CHIP Compares to Other State Programs

SCHIP and the Current Debate at the Federal Level

The federal State Children's Health Insurance Program (SCHIP) received considerable attention in 2007 due to the impasse between Congress and President Bush to reauthorize the 10-year program. Congress had passed two reauthorization bills with significant bipartisan support but both were vetoed by the President. For now, SCHIP has been reauthorized until March 2009 with the same funding allocated for states as they were allotted in Federal Fiscal Year 2007, with some exceptions for states in jeopardy of not having enough funds to cover current enrollees.

There is debate among the Legislative and Executive branch over policy decisions surrounding SCHIP. These include:

- Whether to fund the existing SCHIP population without room for growth in the program or to fund for growth to outreach to the over six million Medicaid/SCHIP eligibles currently not enrolled
- Whether to limit any SCHIP funding to children in families at or below 250% of the federal poverty level (FPL)
- Whether to limit SCHIP funding to cover children through age 18 only, even though some states were granted federal authority to cover pregnant women, parents, and childless adults with SCHIP dollars
- The formula to allocate whatever funding is authorized, given the widespread critique of how funds were allocated in the initial 10-year period
- The flexibility given to states to retain unspent SCHIP dollars allocated for a given federal fiscal year to use in future years

Federal Policy Implications for Indiana's CHIP

Burns & Associates, Inc. (B&A), the CHIP evaluators, confirmed with the Office of Medicaid Policy and Planning (OMPP) that Indiana's program will be covered with existing CHIP funding until December 2009. Indiana's Legislature, like 11 other states in 2007, authorized raising eligibility for children in their CHIP programs to 300% of the FPL.¹ However, a new policy was issued by the Centers for Medicare and Medicaid Services (CMS) that effectively limited federal funding for SCHIP to 250% of the FPL (\$42,925 for a family of three in 2007). As a result, the OMPP submitted a state plan amendment to CMS in January 2008 to increase CHIP eligibility to 250% of the FPL only.² What remains uncertain is how much Indiana will receive in the SCHIP reauthorization and whether the State will be able to retain its present reserve fund.

¹ Donna Cohen Ross, Aleya Horn and Caryn Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles", The Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured, January 2008.

² OMPP is still awaiting approval from CMS as of this writing.

Additional federal policies are impacting those already enrolled in SCHIP programs nationwide or who may be eligible to be enrolled. A recent regulation was given a moratorium by Congress that would limit Medicaid funding for outreach and enrollment activities conducted by school personnel.³ These staff often serve as a link for families to secure assistance both in the original application as well as reenrollment procedures.

Also, a regulation mandated by the Deficit Reduction Act of 2005 requires state Medicaid agencies to verify U.S. citizenship for those applying for Medicaid/SCHIP and to review original documents proving citizenship and identity. This issue goes beyond SCHIP for it impacts all Medicaid eligibles. Although the intent of the regulation was to prevent illegal immigrants from receiving government benefits, the unintended consequence is that many legal residents and citizens have been unable to certify their citizenship during the redetermination process. According to 50-state survey of state Medicaid agencies in October 2007, 37 states reported that this new requirement contributed to slower enrollment or actual drops in enrollment of otherwise eligible U.S. citizens.⁴ 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.

No specific studies have been conducted to assess the impact of the new citizenship requirement on Indiana's CHIP, but there may be some impact on the program. Indiana's Medicaid expansion portion of CHIP had enrollment higher in 11 of the last 18 months since the requirement began in July 2006. For the state-designed premium portion of CHIP, enrollment was higher in 10 of the 18 months. The months when enrollment was lower than July 2006, however, are mostly in the last six months of 2007 after the requirement took effect. Although children may ultimately be determined eligible for CHIP, it appears that there may be a delay in making this determination, which may be due to the citizenship requirements.

SCHIP and Its Impact on Reducing the Rate of Uninsured Children

The federal SCHIP 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 SCHIP. Since it was passed as part of the Balanced Budget Act of 1997, the SCHIP has been instrumental in lowering the national uninsured rate for children in families below 200% of the FPL from 23% in 1997 to 14% in 2005. This reduction also held true by racial/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%.⁵

Indiana's CHIP was one of the original success stories at the initial implementation 10 years ago due to an aggressive outreach program. While other states lagged in enrolling eligible

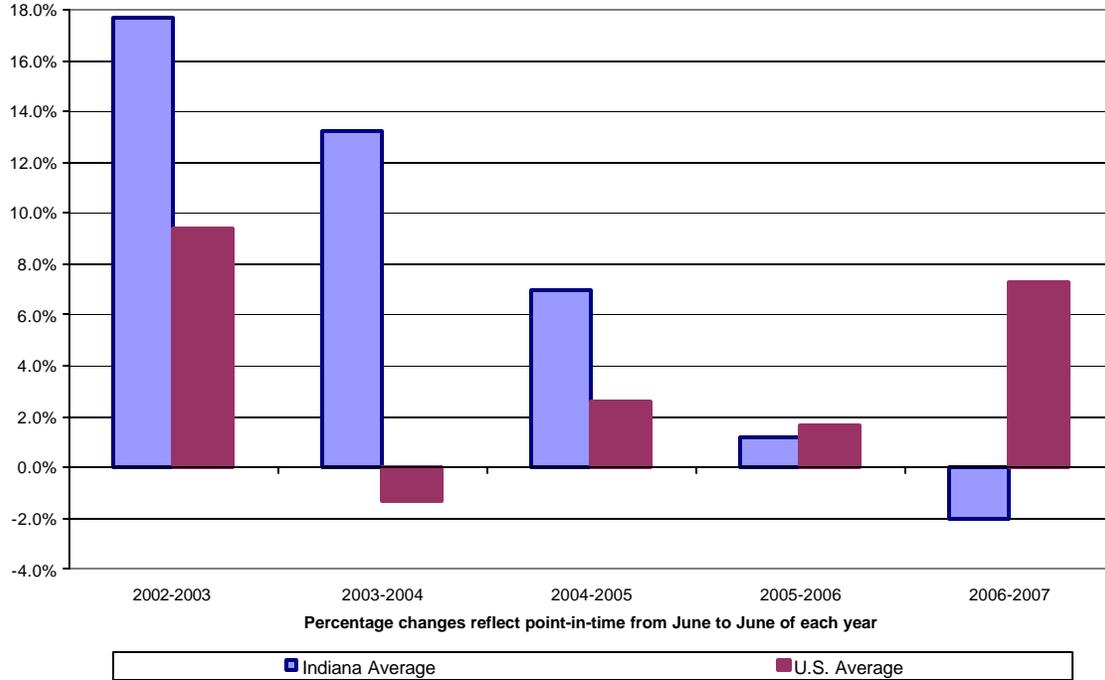
³ Ibid.

⁴ Vernon Smith, et al. "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", Kaiser Commission on Medicaid and the Uninsured, October 2007

⁵ Leighton Ku, Mark Lin, and Matthew Broaddus. "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP, 2007 Edition," Center on Budget and Policy Priorities, January 2007

children, Indiana achieved rapid enrollment early on. Up until recently, Indiana has outpaced the national average in CHIP enrollment growth, but this has changed in the last few years.⁶

**Exhibit I.1
Growth in CHIP Programs: Indiana and Nationally**



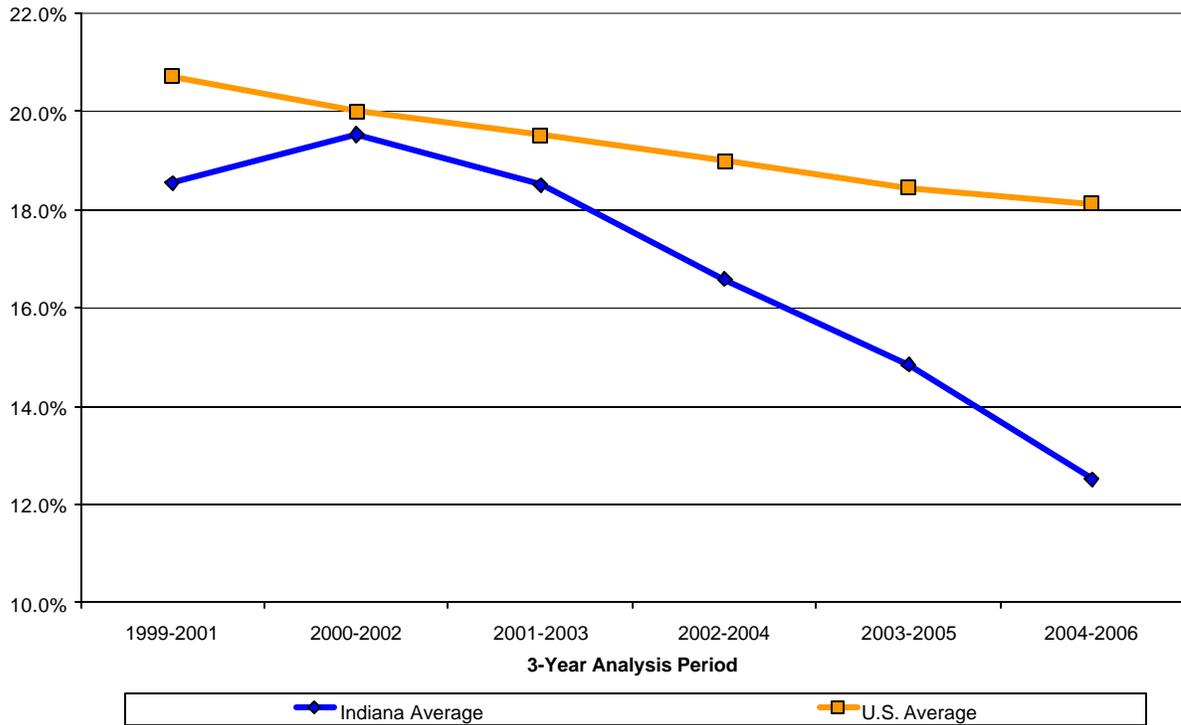
Despite the recent downward trend, however, Indiana has been more successful than other states in reducing the uninsured rate for low-income children (see Exhibit I.2 on the next page). Indiana's uninsured rate of 12.5% for low-income children (families under 200% of the FPL) for the three-year average period 2004-2006 was better than the national average of 18.1%. Indiana has consistently had a lower uninsured rate for this population than the nation as a whole.

The success of Indiana's CHIP has certainly contributed to the State's ability to keep the number of uninsured children in the state from growing despite increases in the overall child population. For example, although the number of children in low-income families has increased by 100,000 in the last six years, Indiana has been able to reduce the number of uninsured in this group by 20% during the time period (see Exhibit I.3 on the next page).⁷

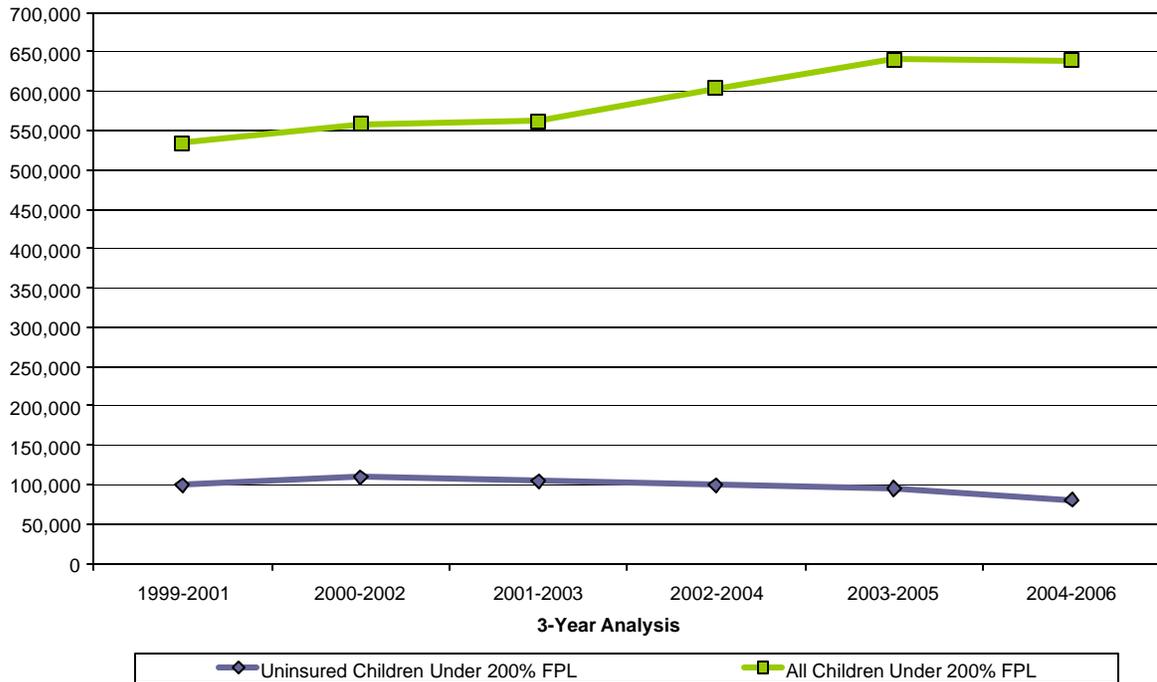
⁶ Vernon Smith, et al. "SCHIP Enrollment in June 2007: An Update on Current Enrollment and SCHIP Policy Directions", Kaiser Commission on Medicaid and the Uninsured, January 2008

⁷ 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>

**Exhibit I.2
Uninsured Rate Among Children in Families Below 200% of Federal Poverty Level**



**Exhibit I.3
Indiana Children in Families Under 200% of Federal Poverty Level**



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 (\$25,755 per year for a family of three in 2007) 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 200% of the FPL (\$34,340 per year for a family of three in 2007). In December 2007, there were 51,957 children enrolled in Indiana's CHIP Package A and 18,698 children enrolled in CHIP Package C for a total of 70,655 children, a 2% reduction from December 2006⁸.

As in the Medicaid program, SCHIP is funded jointly by the federal government and state governments. In an effort to encourage enrollment, the federal government offers an enhanced match rate for every dollar spent to cover enrollees in SCHIP. A state cannot receive less than 65 cents or more than 85 cents for every state dollar spent. Match rates are based on estimates of low-income and uninsured children in each state, as tabulated in the Current Population Survey which is conducted by the U.S. Census Bureau. In Federal Fiscal Year 2007, Indiana's match rate was 74.09%. This means that for every dollar spent by Indiana on its CHIP, the federal government reimburses the State 74.09 cents. Indiana has historically been in the middle of match rates when comparing all states nationwide.

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. For families with one child covered, the premium range is from \$22 to \$33 per month; for families with two or more children covered, the premium range is from \$33 to \$50. Also, there are some co-pay requirements for CHIP Package C for the short time that they are in Fee For Service, 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.

Within the State, Indiana's CHIP is seamlessly integrated into Hoosier Healthwise, the managed care portion of Indiana's Medicaid program. As such, CHIP enrollees have the same access to providers as all other Medicaid managed care members including choice of primary medical provider (PMP). There is no difference in the access to or ability to provide services between CHIP members and children in Hoosier Healthwise. In 2007, CHIP members were enrolled in one of three managed care organizations (MCOs)—Anthem (new in 2007), MDwise, and Managed Health Services.

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 OMPP, the designated single state agency charged with administering Hoosier Healthwise, and the Division of Family Resources, which conducts CHIP eligibility determination.

⁸ Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on February 7, 2008.

How Indiana's CHIP Operations Compare to Other State's Programs

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, including:

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		

Indiana took a streamlined approach at the outset of the program with respect to many design features. Other states took more time in this development, but many states now have similar features to Indiana's, as shown below.⁹

**Exhibit I.4
Design Features of Indiana's CHIP Compared to Other States**

Design Feature	Adopted by Indiana?	Adopted by Other States?
Do not require a face-to-face interview to apply	Yes	46 states
Joint application for Medicaid and CHIP	Yes	33 of 37 states with State-only programs
Do not require interview upon renewal	Yes	48 states
Disregard assets in determining child's eligibility	Yes	46 states
"Going bare" period (must be uninsured before enrolling)	3 months	16 states impose 1-3 months; 21 states impose > 3 months
Continuous eligibility for 12 months, regardless of change in circumstances	No	16 states have continuous eligibility for 12 months
Premiums charged to members	\$0 up to 150% FPL; varying charges above 150% FPL based on income	10 of 34 states require premiums at 100% FPL; 26 of 34 states require at 150% FPL; 29 of 34 states require at 200% FPL
Co-payments required for prescription drugs	\$3 for generics; \$10 for brand name	21 states require co-payments
Co-payments required for non-emergent hospital care, non-preventive physician care, and/or inpatient hospital stays	No	28 states have no co-payments

⁹ Donna Cohen Ross, Aleya Horn and Caryn Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles", The Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured, January 2008

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. IC 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 2007:

- Chapter II: Enrollment
- Chapter III: Access and Utilization of Services: Statewide
- Chapter IV: Access and Utilization of Services: By Subpopulation
- Chapter V: Prevalence and Utilization of Services of CHIP Members with Asthma, Behavioral Health Conditions, and Obesity
- Chapter VI: Comparisons to National Benchmarks
- Chapter VII: MCO Services and Initiatives for Hoosier Healthwise Children
- Chapter VIII: Expenditures in CHIP
- Chapter IX: Recommendations for Indiana's CHIP

At the beginning of each chapter, a section titled "Chapter Highlights" provides a summary of the discussion within the chapter.

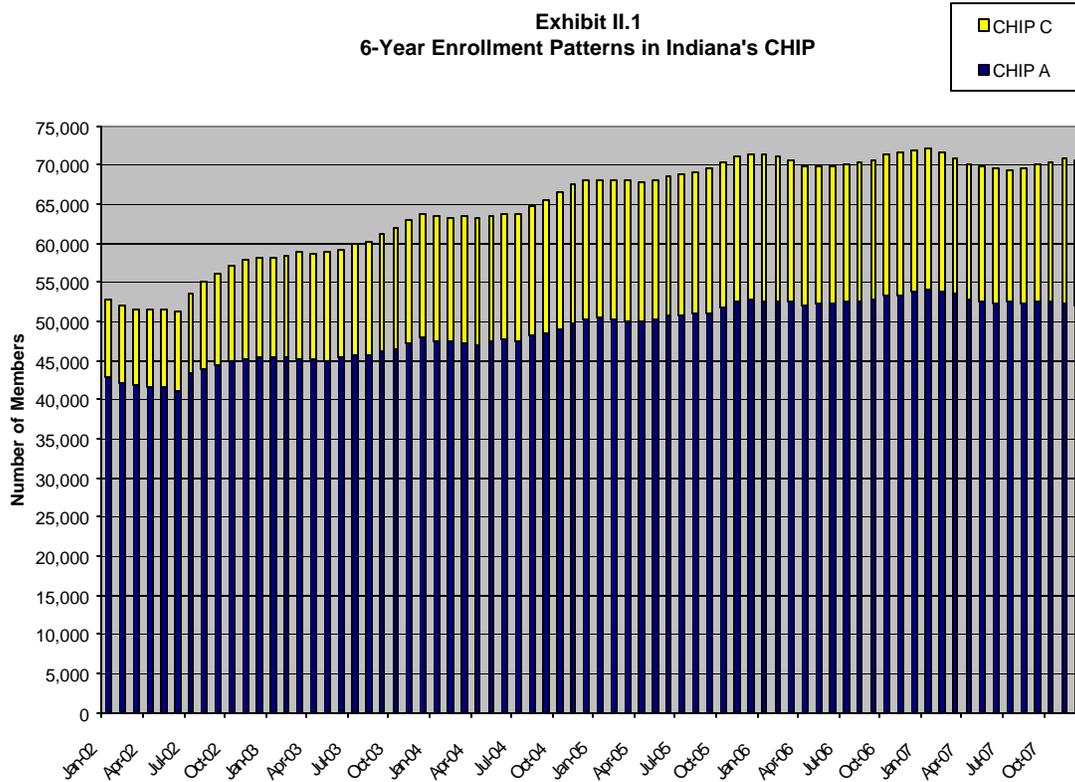
II. Enrollment in Indiana's CHIP

Chapter Highlights

- After consistent growth throughout its history, Indiana's CHIP had a 2% reduction in members from December 2006 to December 2007. This reduction was found to be in CHIP A which outpaced the modest growth in CHIP Package C. In fact, the enrollment of 18,698 in CHIP C at the end of 2007 is an all-time high.
- Disenrollment of members has been and continues to be high in the program. In 2006, the disenrollment rate was 16% for CHIP A and 26% for CHIP C.
- Despite high turnover, there is a significant portion of the population who remains in the program for longer periods. There were 74% of CHIP A children and 68% of CHIP C children who have been enrolled in the program for more than two years.
- The CHIP Office may want to explore further why children are disenrolling from the program. Parents must go through a redetermination process at least once every 12 months to ensure that their children are still eligible for CHIP. Redetermination may be more frequent if the family receives other benefits. Burns & Associates (B&A) did not see an obvious spike in disenrollments after a child has been enrolled for 12 months (implying that their parents did not go through the redetermination process), but the State does not track on a routine basis why members are leaving, e.g. child is determined ineligible upon redetermination (such as family income has increased), parents get coverage at work, parents do not make premium payments, family moves out of state, etc.
- CHIP members enroll with one of the Hoosier Healthwise managed care organizations (MCOs). For a short period, members may be in the Fee-for-Service (FFS) delivery system for one month before they select their primary medical provider (PMP) or one is selected for them. Because of the high turnover in a part of the CHIP membership, in any given month approximately 14% - 17% of children are in the non-managed care portion of the program.
- Because three MCOs terminated at the end of 2006 and a new one was added in 2007, the distribution in CHIP enrollment by MCO changed between 2006 and early 2007. Anthem had 16% of CHIP enrollment, MDWise had 44%, and MHS had 26% on average in 2007.
- Younger children are more represented in CHIP C than in CHIP A. This is mostly due to Hoosier Healthwise eligibility criteria for traditional Medicaid which differs by age.
- When analyzing the race/ethnicity composition of CHIP A and CHIP C, it was found that African-Americans and Hispanics are slightly more represented in CHIP A than in CHIP C, but not much.
- The enrollment distribution in CHIP A and CHIP C by region in the state is consistent with the distribution of child residents throughout the state.

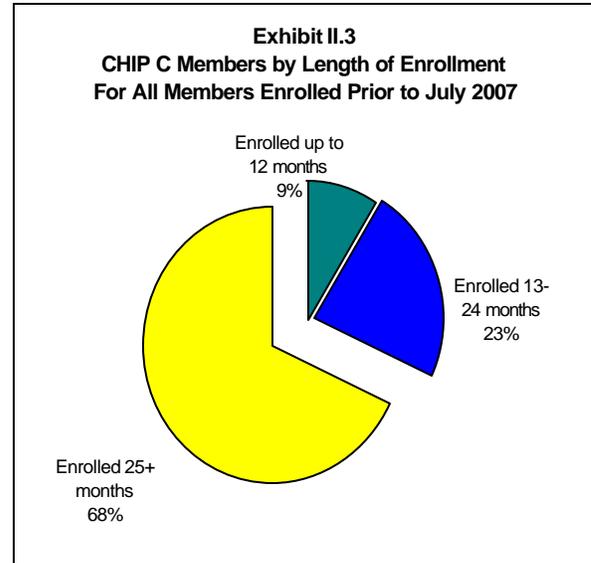
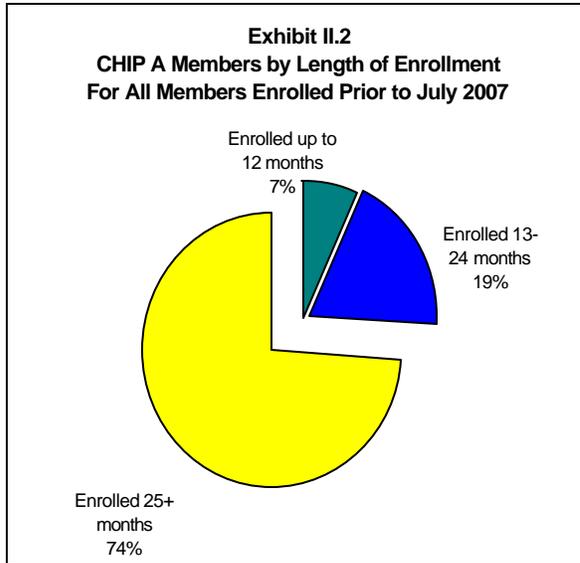
Enrollment and Disenrollment Trends

As of December 2007, Indiana's CHIP Package A (family income up to 150% of federal poverty level) enrollment was 51,957. Indiana's CHIP Package C (family income up to 200% of the federal poverty level) was 18,698. Total enrollment at the end of 2007 of 70,655 is slightly below the all-time high set at the beginning of the year (72,281). This is when CHIP A hit its highest enrollment (54,105). CHIP C, however, has its highest enrollment ever right now (18,698 in December 2007).



The growth rates are slowing in both CHIP A and C. In the earlier years of the six-year period shown, CHIP A experienced annual growth of 5% and CHIP C experienced double-digit growth. But 2006 was the first year that CHIP C posted a decline in enrollment and 2007 was the first year that CHIP A posted a decline. Premiums charged to families in the CHIP C program were doubled in February 2006 and this appears to have had some impact on enrollment. The new proof of citizenship requirements may be having an impact on growth in CHIP A.

The interesting trend with enrollment in this program is that there appears to be two distinct populations—those that remain enrolled for long periods and another group that moves in and out of the program frequently. CHIP members that were enrolled in the first half of 2007 were examined to measure length of enrollment. Despite the new federal requirements, 74% of CHIP A members studied have been enrolled for more than two years in the program. For CHIP C, it is 68% of the members (see exhibits at the top of the next page).



On the other hand, member disenrollment continues to be high in both programs. For example, the actual enrollment in Indiana's CHIP was 70,655 at the end of 2007, but the number of children ever enrolled at a point in time in 2007 in either CHIP A or CHIP C was 135,620. This number is misleading, however, because children transition quite a bit between the two CHIP programs and the Medicaid program based upon changes in their eligibility. There were 31,255 children who were enrolled in CHIP at some point in 2007 but who were enrolled in Medicaid at the end of the year. Likewise, there were 8,987 children who started in CHIP A but moved to CHIP C, or vice versa. The actual number of children who were enrolled in CHIP at some point in 2007 but disenrolled from Hoosier Healthwise completely is 24,723. This yields a disenrollment rate of 16% for CHIP A and 26% for CHIP C. The same trend was found last year as well. What is unknown without further exploration is the reason for these disenrollments, e.g. child is determined ineligible upon redetermination (such as family income has increased), parents get coverage at work, parents do not make premium payments, family moves out of state, etc.

Exhibit II.4
Calculation of Member Disenrollment Rate

	CHIP A	CHIP C
Ever Enrolled in CY 2007	100,337	35,283
<i>Which is distributed across the following categories:</i>		
Enrollment as of Dec 2007	51,957	18,698
Moved to Medicaid	27,131	4,124
Moved to other CHIP program	5,559	3,428
<i>The difference is the disenrollees:</i>		
Disenrolled from Hoosier Healthwise	15,690	9,033
Disenrollment rate = (Disenrolled divided by ever enrolled)	16%	26%

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.

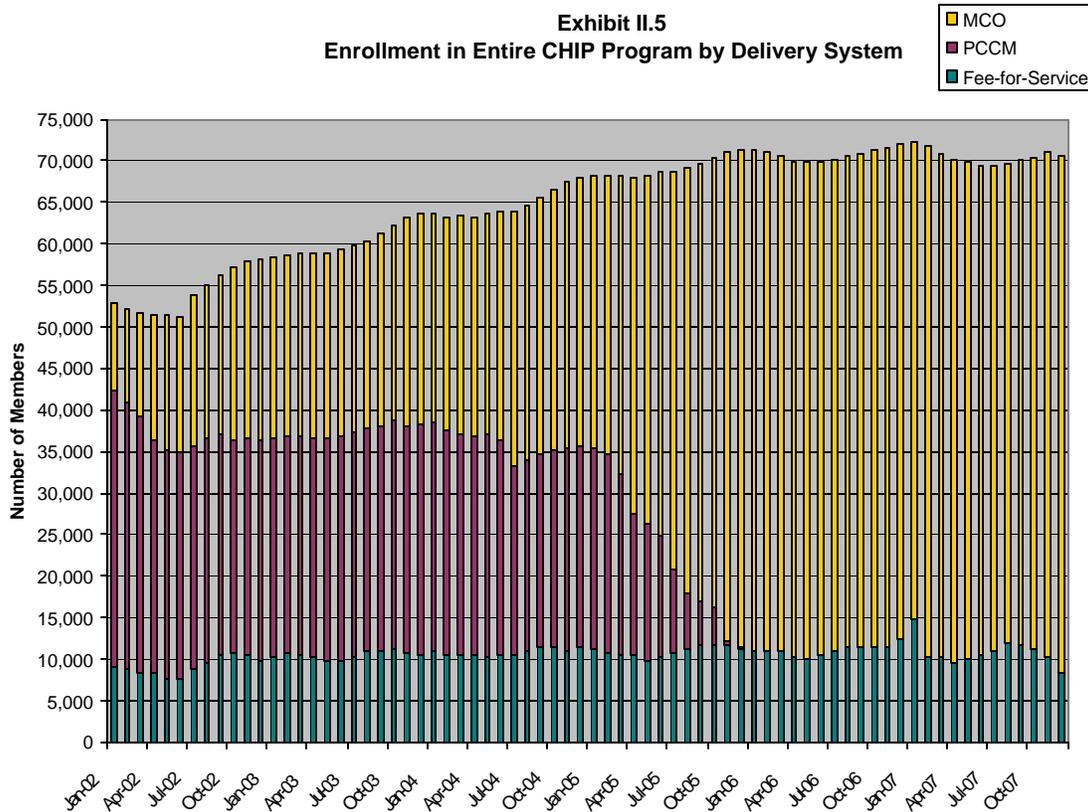
B&A reviewed available data to better understand the reasons for disenrollment. For example, children disenroll due to turning age 19 when they become ineligible for the program. We found this to be a small portion of those who disenrolled (9% of CHIP A members and 3% of CHIP C members in 2007). The State may want to more closely track the reasons for disenrollment in CHIP, e.g. child does not reapply after 12 months, child is determined ineligible upon reapplying (such as family income has increased), parents get coverage at work, parents do not make premium payments, family moves out of state, etc.

Enrollment by Service Delivery System

The Hoosier Healthwise Primary Care Case Management Program (PCCM) was eliminated as of December 2005 when all Hoosier Healthwise members were enrolled with a managed care organization (MCO). Like other enrollees in Hoosier Healthwise, CHIP members that were enrolled in the PCCM delivery system were transitioned to the Risk-Based Managed Care (RBMC) delivery system by enrolling with an MCO.

Children and their families have 30 days after 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. This policy is to promote the continued monitoring of the child's health care needs and to promote continuity among providers. It should also be noted that the high turnover of members in CHIP results in an ever-evolving group of members that are temporarily enrolled in the FFS delivery system. This has tended to be 14% - 17% of all CHIP members in any given month (see Exhibit II.5 on the next page).

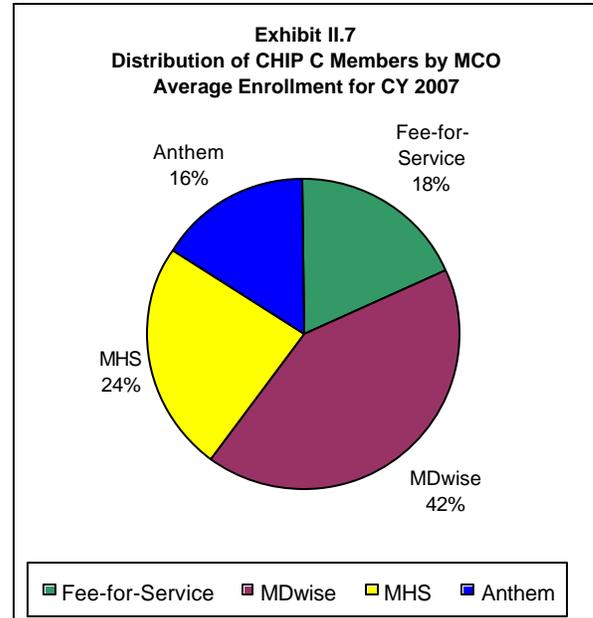
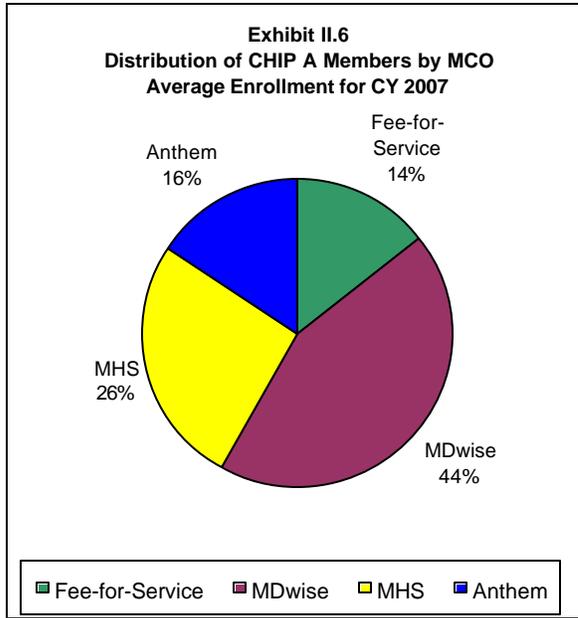
**Exhibit II.5
Enrollment in Entire CHIP Program by Delivery System**



Enrollment by MCO Within Managed Care

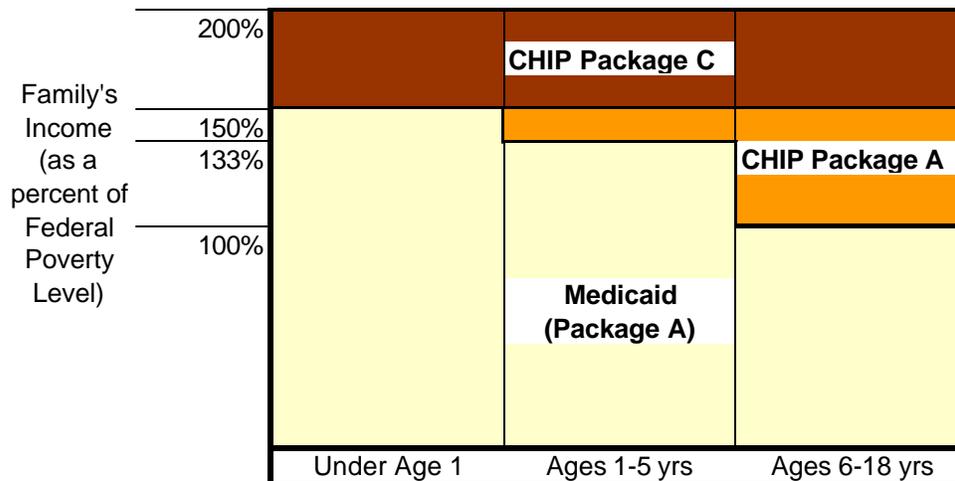
In CY 2007, CHIP members had the option to enroll with PMPs in one of three MCOs—Anthem, MDwise, and Managed Health Services (MHS). The OMPP issued new MCO contracts effective January 1, 2007. MDwise and MHS had previously been serving Hoosier Healthwise members in prior contract periods while Anthem is a new MCO in 2007. All three MCOs are required to serve the entire state.

Because three MCOs terminated at the end of 2006 and a new one was added in 2007, the distribution by MCO changed between 2006 and early 2007. Anthem and MDwise picked up most of the members that were transferred from CareSource, Harmony Health Plan, and Molina at the end of 2006. The proportion of members enrolled with MHS remained relatively constant from 2006 to 2007. It should also be noted that the percentage of children enrolled in FFS has also decreased slightly. This could be due to an active effort to enroll members into managed care. (see Exhibits II.6 and II.7 on the next page).

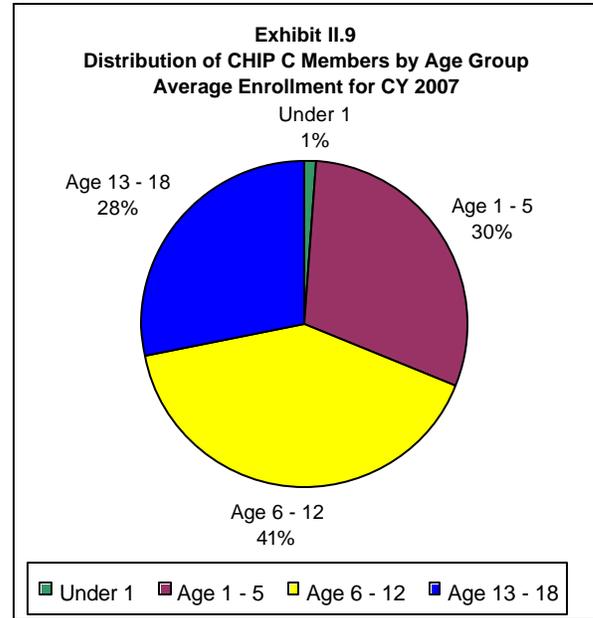
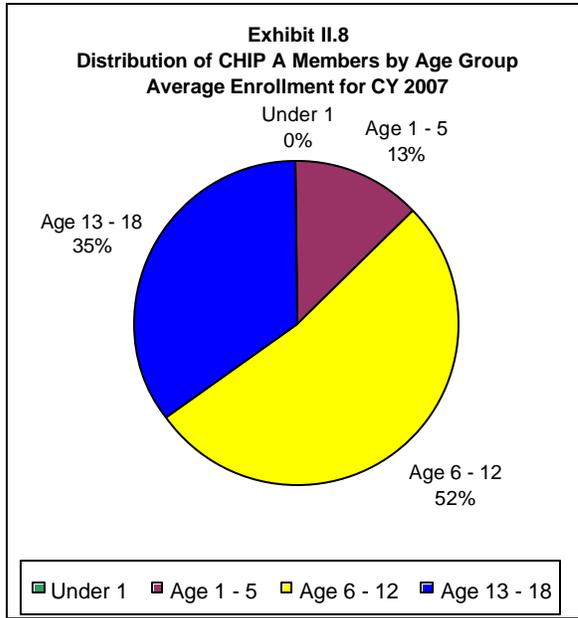


Enrollment by Age

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. The diagram below shows the eligibility levels for children at different ages.

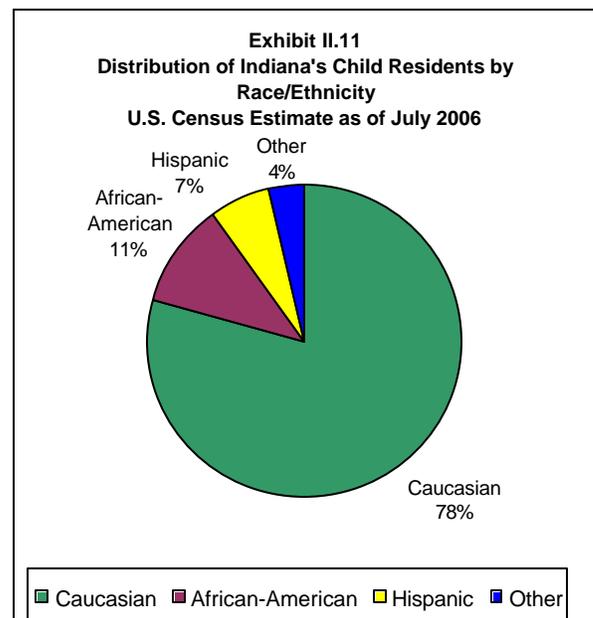
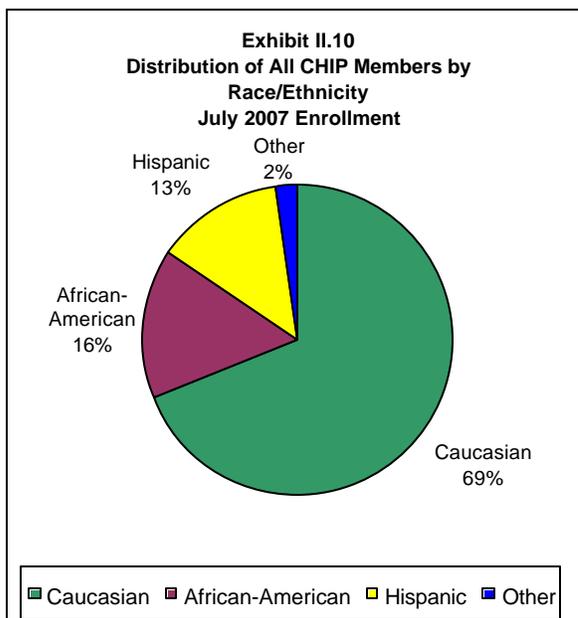


In 2007, children ages 1 through 5 comprised 13% of the CHIP A population but 30% of CHIP C members. Children ages 6 through 12 comprised 52% and 41%, respectively. Teenagers (age 13-18) made up 35% of CHIP A and 28% of CHIP C. There are no infants in CHIP A and few in CHIP C since they are eligible for Medicaid.



Enrollment by Race/Ethnicity

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 2006¹, African-American and Hispanic children are represented more in CHIP than the overall state composition.

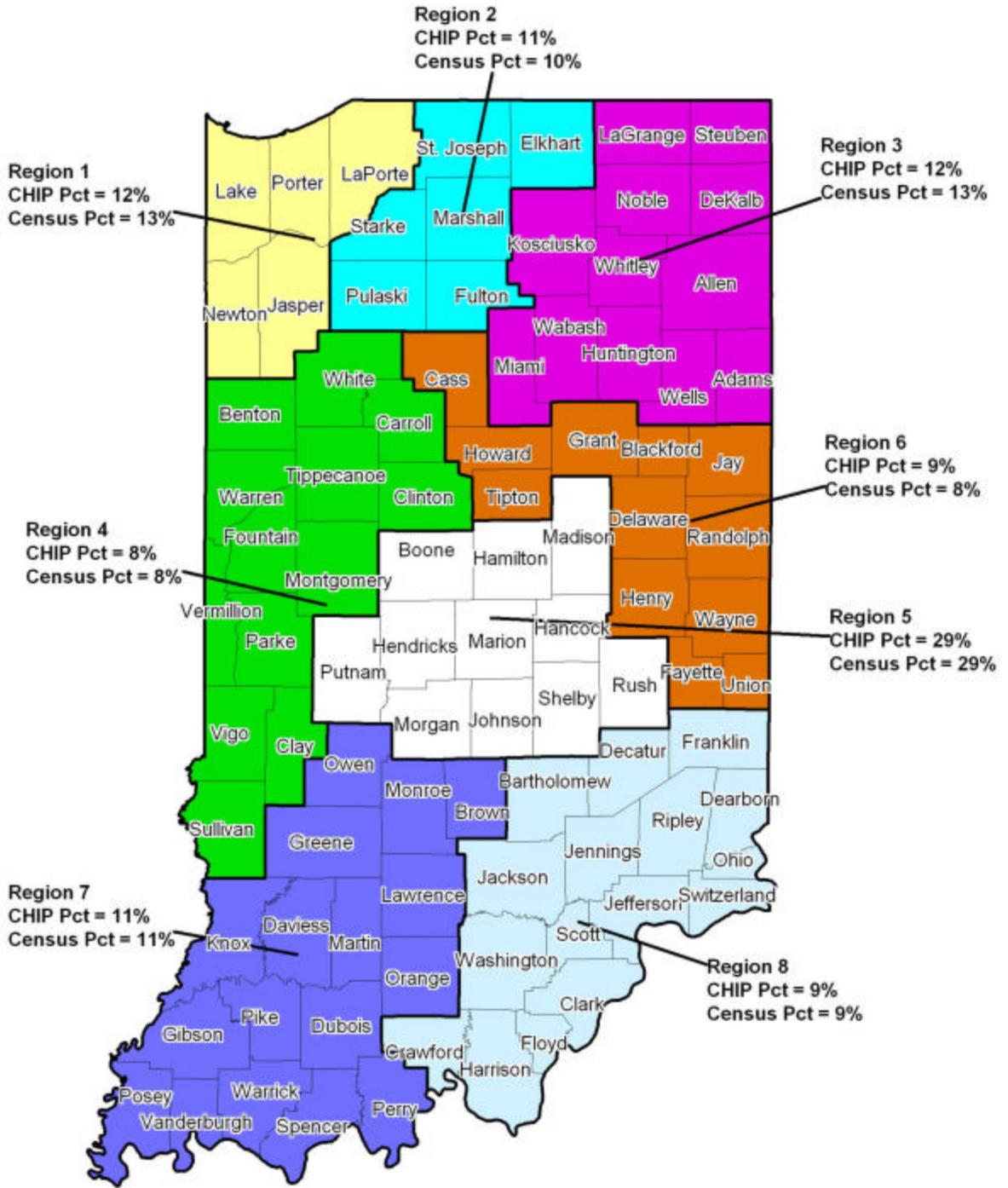


¹ County Population Estimates by Age, Sex, Race and Hispanic Origin: April 1, 2000 to July 1, 2006, Population Estimates Program, Population Division, U.S. Census Bureau

Enrollment by Region

The distribution of CHIP enrollees by region within the state closely matches the overall child population in Indiana.

Exhibit II.12
Distribution of All CHIP Members by Region



III. Access and Utilization of Services in Indiana's CHIP: Statewide

Chapter Highlights Related to Access

- There are now 28 counties in the state that do not have a pediatrician contracted with the Hoosier Healthwise program to serve Medicaid and CHIP children. This is an improvement from the number of counties without a pediatrician last year (34). In all 28 counties, however, there is a family practitioner available instead.
- Of the counties with contracted pediatricians, 12 have full pediatrician panels, meaning that there is no additional pediatrician capacity for new members. Among these 12, six counties do not have any primary care doctors accepting new patients.
- Of the 52 counties with pediatricians and accepting new patients, five of these counties have potential access issues because at least 80% of the panels across all primary care doctors (including pediatricians) are full.
- Among the three MCOs, MDwise has the most counties with a contracted pediatrician (48), and MHS has the least (30). MDwise also has 44% of total CHIP enrollees, however. Where pediatricians are available, MDwise has six counties with full panels, Anthem has seven, and MHS has nine.

Primary Care Access Summary

92 Total Counties

28 No Pediatrician in County

64 Pediatrician in County

12 Pediatrician Not Accepting New Patients

6 Other Primary Care Doctors Accepting New Patients

6 Other Primary Care Doctors Not Accepting New Patients (100% full)

1 Clinton

2 Elkhart

3 Franklin

4 Knox

5 Ohio

6 Tippecanoe

Primary Care Access Issues

52 Pediatrician Accepting New Patients

47 Other Primary Care Doctors Accepting New Patients

5 Other Primary Care Doctors Not Accepting New Patients
or Almost at Capacity (80% full)

1 Bartholemew

2 Hendricks

3 Steuben

4 Switzerland

5 Union

Potential Primary Care Access Issues

Chapter Highlights Related to Utilization

- CHIP A and CHIP C members who were enrolled for at least nine months in an MCO in CY 2006 and in CY 2007 were studied to determine if they had used 11 different types of services available to them. Unlike previous years when B&A has conducted this analysis, there was little difference in the percent of CHIP A members using the service versus CHIP C members. In the past, CHIP C members have been higher users of all services across-the-board. The only noticeable difference found this year was PMP visits and EPSDT (Early Periodic Screening, Diagnosis, and Treatment) services, which more CHIP C members continue to use than CHIP A members.
- Across all 11 service types studied, the percentage of children receiving each service was slightly higher in CY 2006 than what was reported in CY 2007 (when children enrolled at least nine months in each year were studied). This was also found in our report last year and is usually attributable to service claims that have yet to be reported by MCOs for services delivered at the end of 2007. More notably this year, however, was the difference in reporting by MCO. MHS and MDwise followed similar reporting trends for each service in 2006 and 2007. Anthem, however, had significantly lower service claims reported (on a per member basis) for physician services and pharmacy scripts than the other two MCOs in 2007. There is a direct correlation between the lower service use percentages reported at the statewide aggregate level as a result of this, since Anthem was not a contracted MCO in 2006.
- The rate of usage of the hospital emergency room visits should also be studied to determine whether or not the usage is actually emergent care or if the service could be delivered in a less intensive setting. B&A's definition of an ER visit did not require the presence of one of five usual ER procedure codes because we did not see them present on claims submitted to the State. Therefore, the usage reported (32% of CHIP C children in 2007, 30% of CHIP A children) may be overstated. The OMPP should explore the specific types of services being submitted as ER services.
- The percentage of children utilizing each service was also compared by age group to the overall child averages. Age groups studied were age 1-5, 6-12, 13-18 female and 13-18 male. Infants were excluded since there are so few in CHIP. Relatively speaking, the percentage of children utilizing each service was similar across age groups, with some anticipated differences depending upon age. The teenage male age group, as expected, had the lowest PMP usage but it was still relatively high for the age group. The age 1-5 group had the highest PMP usage but it was lower than might be expected.
- The EPSDT usage appears to be lower than expected, particularly for the age 1-5 group, who should be receiving an annual screening each year. In 2006, 63% of CHIP children in this age group had a reported EPSDT visit; in 2007, it was 56%.
- Similar to the comparison by age group, the percentage of children utilizing services was compared at the health plan level. The use of services by members in the five MCOs under contract in CY 2006 was compared against the three MCOs under contract in CY 2007. One common trend found was that children enrolled with CareSource were less likely to use most services than their counterparts in other MCOs in CY 2006, while the same held true for members enrolled with Anthem in CY

2007. B&A found in both of these cases this appears to be lack of reporting by the MCOs rather than definitive lower usage by members.

- MDwise reported significantly higher EPSDT usage for its members in both years than other MCOs in either year. Likewise, clinic usage was higher for MDwise members, but this may be attributed to its provider network where its delegated contractors are all hospital-based entities.
- With the exception of CareSource and Anthem, for the remaining services studied the usage by CHIP members across the MCOs was similar.
- When service usage was analyzed by CHIP members' race/ethnicity, B&A found that while Caucasians, Hispanics and other minority population groups had similar PMP usage in both years, African-American children in CHIP had lower PMP usage. This trend also held true when the combination of PMP, specialist and clinic usage was analyzed.
- A disproportionately higher number of Hispanic children in CHIP had an EPSDT visit, while a lower percentage of Caucasian children reported an EPSDT visit.
- There was a noticeable difference in emergency room usage between Caucasian and African-American children, with Caucasian children in CHIP reporting higher ER usage.
- Service use patterns were also examined by region in the state. With the exception of the Southwest Region, the percentage of CHIP members visiting their PMP was consistent across regions. Further investigation found that almost half of the CHIP members in the Southwest Region were enrolled with Anthem. Because of the lack of reporting of physician claims by Anthem as previously discussed, there is a disparity from the results reported by the other regions. The same is true for the lower EPSDT utilization reported in the Southwest Region.
- The Central Region was significantly higher from other regions for the percentage of children with EPSDT and clinic visits. This is due to the predominant presence of MDwise in the region.
- For all other services reviewed, there was not a significant difference across regions in the percentage of CHIP members using each service studied.

Overview of Access to Primary Care Physicians Statewide

This chapter analyzes potential issues related to CHIP members' ability to access primary care services. In the Risk-Based Managed Care (RBMC) delivery system, CHIP members select a primary medical provider (PMP). If a member does not select a PMP, the State selects one for them based on proximity to their home and the willingness of providers in their area to accept new patients.

PMPs contract with managed care organizations (MCOs) directly. As of January 2007, PMPs may contract with more than one MCO, offering members additional choice not only on which PMP to select but also which MCO to select. PMPs negotiate their "panel size"—that is, how many Hoosier Healthwise patients they are willing to accept. If they contract with more than one MCO, they can also negotiate different sized panels with each MCO. The Office of Medicaid Policy and Planning (OMPP) encourages PMPs to accept a panel size of 2,000 patients for Hoosier Healthwise.

CHIP members use the same delivery system as other children in traditional Medicaid. Therefore, access to physicians must be evaluated for all children in the Hoosier Healthwise program. Burns & Associates (B&A) examined the OMPP's monitoring of PMP providers and their panel size. The maps that appear in Exhibits III.1 through III.5 on the following pages are based on data collected by EDS, the OMPP's fiscal agent, on all five provider specialties that serve as primary care providers—pediatricians, general practitioners, family practitioners, OB/GYNs, and general internists. Each of these provider specialties indicates if they are willing to accept children (18 and younger) as patients when they contract with the MCOs. For the analyses in this chapter, only doctors who accept children were studied. However, it should be noted that the provider specialties other than pediatricians also accept adults as patients so this may impact the available capacity to primary care for children in a given county.

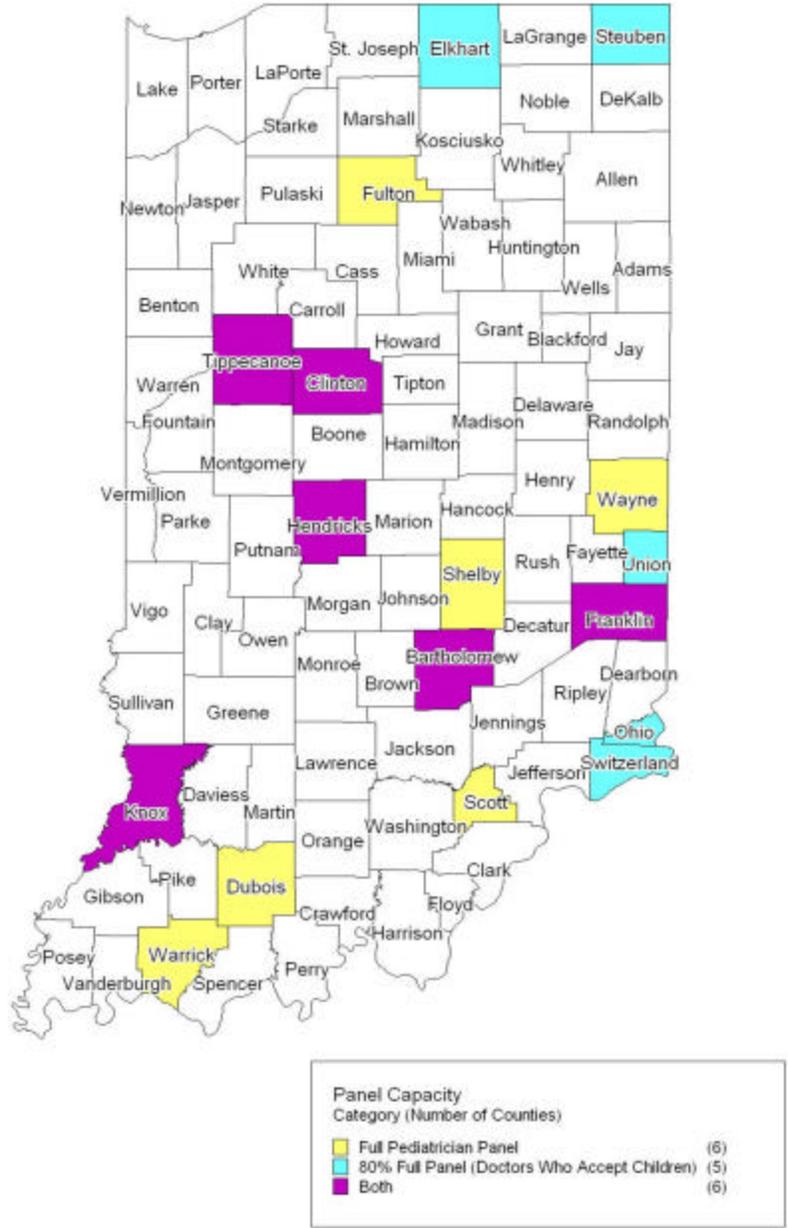
Availability of Pediatricians by County

There are 675 county pediatricians contracted with the Hoosier Healthwise program. The term "county pediatricians" is used because some pediatricians have offered to serve children in more than one county. In all of Hoosier Healthwise, 224,744 children (June 2007 figure) have enrolled with pediatricians (41% of all children enrolled).

Statewide, 47% of the panel slots for pediatricians are full. At the county level, there is some limited access to pediatricians. [Chapter IV provides more information about access to pediatricians across regions in the state.] In 28 counties, there is no pediatrician that has contracted with Hoosier Healthwise. Among these, all have family practitioners available to see CHIP members. Exhibit III.1 on the following page shows the counties with no pediatricians.

the map. Five other counties are deemed by OMPP to be “near full panels”, meaning that they are above 80% capacity. These counties are shown in teal.

**Exhibit III.2
Panel Capacity**



It should also be noted that the eleven counties which are deemed full or near-full panels may still have room to add panel slots. The average panel size among PMPs accepting Hoosier Healthwise patients in these counties is 179 (this is the same as it was last year when B&A studied this). For reference, the average panel size among pediatricians statewide is 705. Therefore, there appears to be adequate opportunity for the MCOs to negotiate with doctors in these counties to accept new patients.

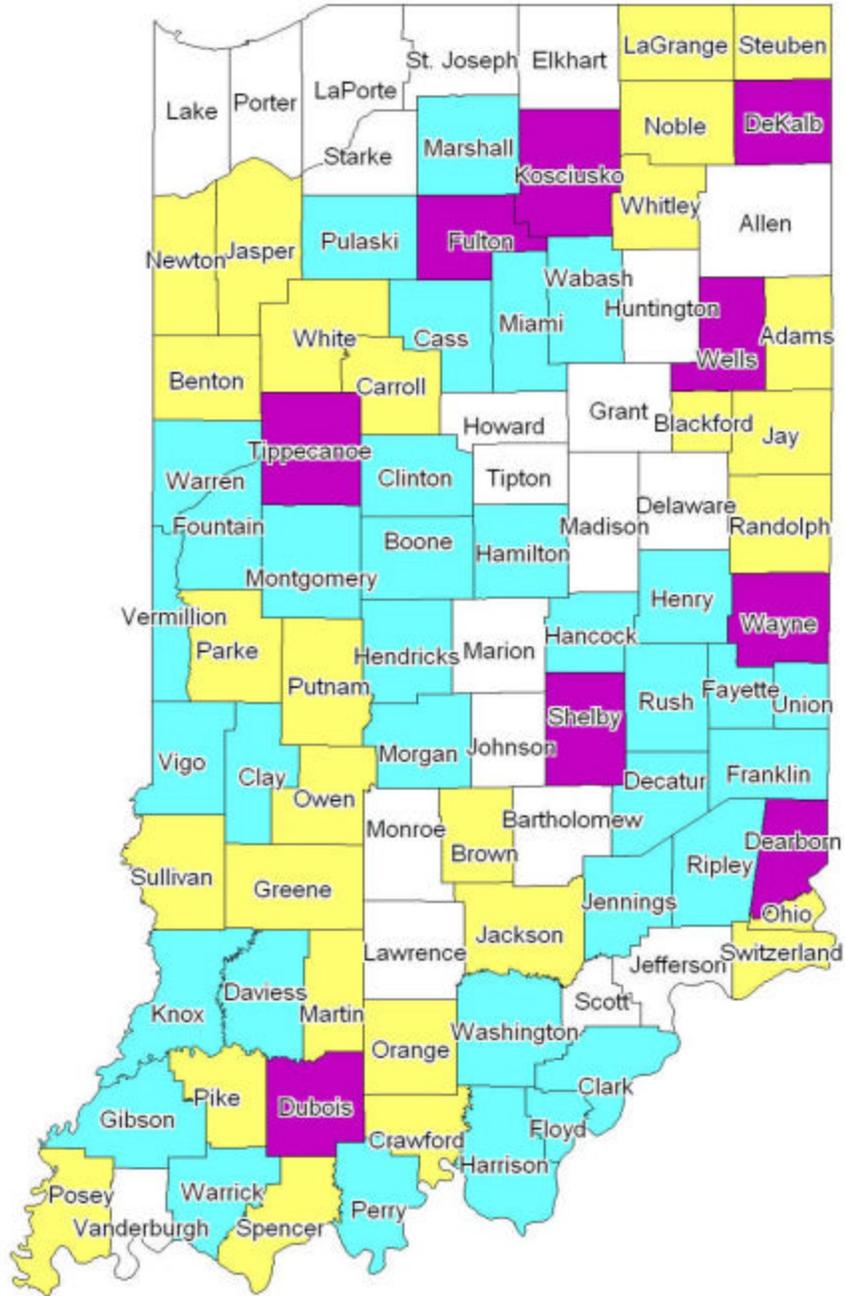
Availability of Pediatricians by MCO

Exhibits III.3 through III.5 on the next few pages show pediatrician availability for each MCO. In each map, the 28 counties without any contracted pediatricians marked in yellow in Exhibit III.1 are again shown in yellow in Exhibits III.3 through III.5. The other two categories highlight counties for which each MCO has either not contracted with a pediatrician (teal) or has a full pediatrician panel (purple).

The sequence of maps shows that there are some significant differences between each MCO's contracted pediatrician network. MDwise appears to provide the best access to pediatricians across the state. MDwise has a total of 48 counties without a contracted pediatrician (28 of these are common to all three MCOs) and six counties with full pediatrician panels. Both MHS and Anthem have significantly more counties with no contracted pediatricians, 62 and 60 counties respectively. Both also have more counties with full pediatrician panels—MHS has nine counties with full panels and Anthem has seven.

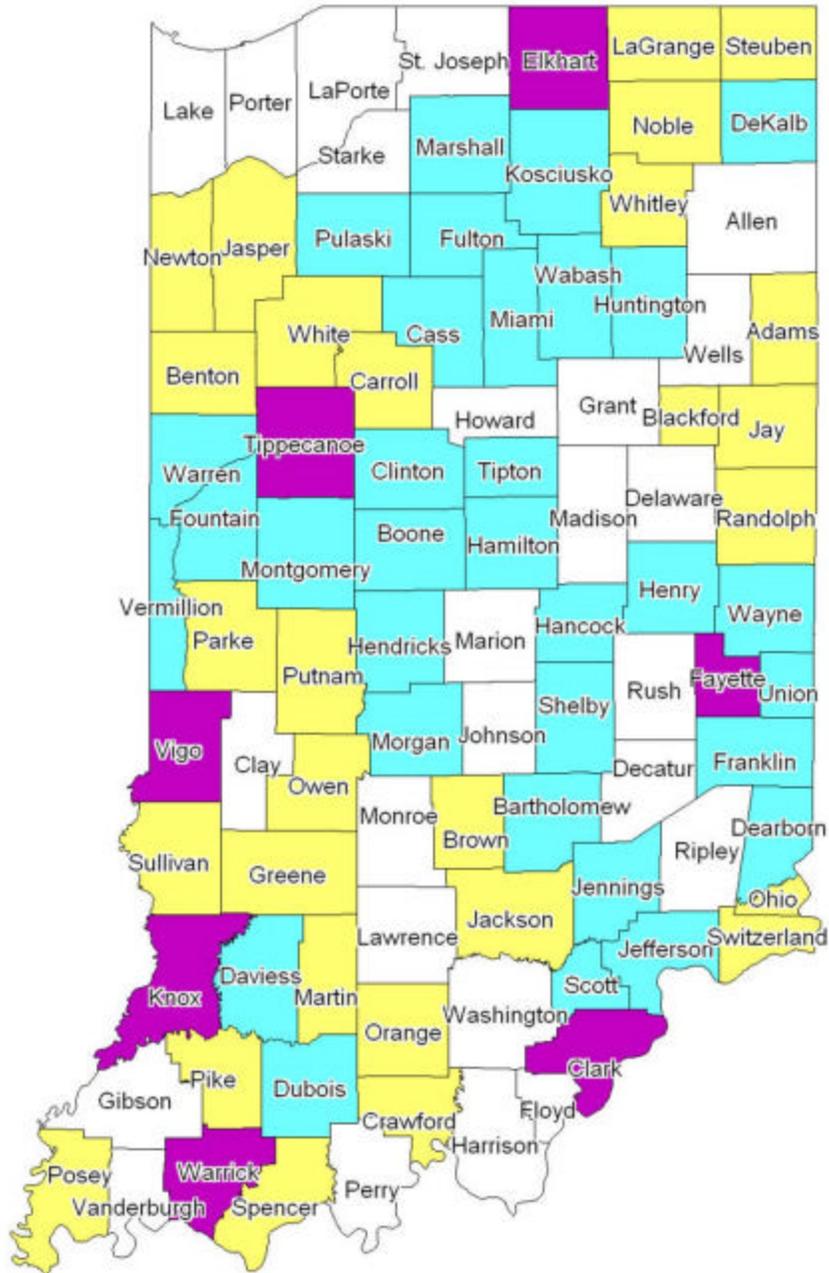
Overall, MDwise may provide the best access to pediatricians but, within certain counties, Anthem and MHS provide better access than MDwise. In Tipton County, for example, MHS is the only MCO to have contracted with a pediatrician.

Exhibit III.4
Counties Where Pediatricians Are Not Available
MHS



Counties Where Pediatricians are Not Available	
Category (Number of Counties)	
■	No Pediatrician - Any MCO (28)
■	No Pediatrician - MHS (34)
■	Full Pediatrician Panel - MHS (9)

**Exhibit III.5
Counties Where Pediatricians Are Not Available
Anthem**



Counties Where Pediatricians are Available		
Category (Number of Counties)		
Yellow	No Pediatricians - All MCOs	(28)
Cyan	No Pediatricians - Anthem	(32)
Purple	Full Pediatrician Panel - Anthem	(7)

Overview of Utilization of Services by CHIP Members

To identify trends in the usage of services among CHIP members, B&A studied usage rates across a number of dimensions, including:

- (1) Usage by CHIP A members as compared to CHIP C members
- (2) Usage by age group within CHIP
- (3) Usage by CHIP members enrolled with different MCOs
- (4) Usage by race/ethnicity of CHIP members
- (5) Usage by region within the state

The data used in the remaining exhibits in this chapter as well as Chapter IV exhibits are data that was extracted by B&A from the OMPP's data warehouse. The data includes information related to member enrollment and claims submitted by MCOs that report when children encounter the health care system (these are known nationally as "encounters" and in Indiana specifically as "shadow claims" because they are not used for reimbursement).

Chapter IV will provide a more in-depth discussion of access and utilization across the dimensions discussed above. This section reviews the key findings statewide.

Methodology

To conduct our study, we identified all members enrolled in CHIP for at least nine months in CY 2006 and separately for at least nine months in CY 2007. We further limited our analysis to those children enrolled at least nine months of the year within a particular MCO. Although many children spend an introductory period in the non-managed care portion of Hoosier Healthwise when first enrolling, we found it appropriate to compare utilization only while children were enrolled with an MCO since this was the time that the MCO had an ability to manage the child's services.

Chapter II discussed how children often fluctuate across eligibility categories in Hoosier Healthwise. B&A included children even if they moved across eligibility categories—provided they were enrolled at least nine months in the year—since the MCOs and services offered in Hoosier Healthwise are the same across eligibility categories. 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 before disenrolling completely). Our selection criteria yielded the following sample, representing about 76% of average enrollment for each program/year:

	CHIP A	CHIP C
CY 2006	38,894	12,302
CY 2007	40,671	13,420

It should be noted that a child may fit the 9-month criteria in one year but not another year. 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. Similar to the assignment to CHIP A or CHIP C, a member's age was assigned based upon their age at the end of each year. Since a child had to be enrolled at least nine months with the same MCO to be included, the MCO assignment could not change during the year.

Services Studied

For the children identified in our sample, B&A reviewed the data submitted by MCOs to the State to determine if each child had utilized one of 11 services. All but one of the services we reviewed (dental) is the responsibility of the MCOs to provide to its members. Therefore, only MCO claim submissions and dental claims were included in our analysis. Besides dental, there are a small number of services that MCOs are not contractually required to cover. These services were not included in the analysis.

The services we analyzed to determine member usage include the following:

Assigned PMP visits	Each member in managed care is assigned a primary medical provider. B&A analyzed to see if the member saw this provider (or a member of the provider's group practice) at some point in the year. Visits by teenage girls to an OB/GYN are also counted as PMP visits.
Visits to another PMP	Although not expected, members may have seen a PMP other than the one assigned to them or one not in their doctor's group practice. B&A matched the PMP ID and his/her group practice ID to the member's assigned PMP. When there was no match, the visit was classified in this category.
Visits to a specialist	Includes services performed by a physician who is not the member's PMP, not considered a PMP using OMPP's definition of a PMP, and is not an ER doctor.
Visits to a clinic	Members may receive services in a clinic in addition to or in lieu of their PMP's office. However, if the member's PMP has their primary location at a clinic, we put these PMP visits in the Assigned PMP category. Also included in this category are hospital-based clinics.
Visits to a PMP, specialist or clinic	A larger categorization if the member had used any one of the four services mentioned above.
EPSDT services	An EPSDT service is a specific type of visit in which a screening is done to test certain conditions or diagnoses. OMPP separately identifies EPSDT visits, so a child who saw their PMP and received an EPSDT visit would be recorded here and not in the Assigned PMP category. Examples of EPSDT services include immunizations, hearing test, vision test, lead screening, and sickle cell anemia test.
Inpatient hospital stay	Any overnight stay in the hospital.
Service in the Emergency Room	Any outpatient service billed by a hospital with an emergency room revenue code. The service may be deemed emergent or non-emergent.
Non-ER outpatient hospital service	Other hospital services outside the ER and clinic performed as an outpatient.
Pharmacy prescriptions	These are identified by specific claims submitted by MCOs.
Preventive dental appointment	Although dental screenings may be included as an EPSDT service, dentists submit separate claims for services they perform for CHIP members. The usage measured here reflects services specifically billed by dentists. Specific codes identify the service as preventive in nature.

Findings

Our findings are discussed before each exhibit presented on the following pages.

Exhibit III.6: Utilization Statistics in CHIP A and CHIP C for CY 2006 and CY 2007

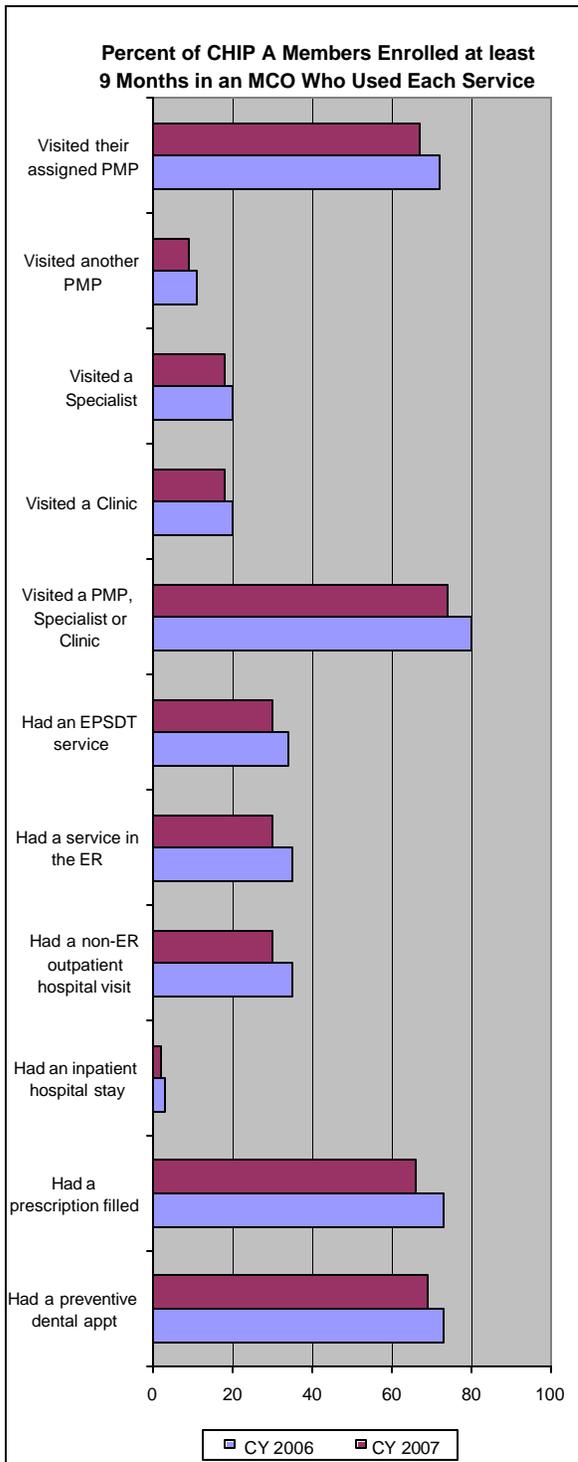
This exhibit includes all CHIP members identified in our study sample categorized between CHIP A and CHIP C. Historically, CHIP C members have been higher utilizers than other children in Hoosier Healthwise. It is assumed that CHIP C parents are more proactive in their child's care since they are responsible for monthly premiums.

Key findings:

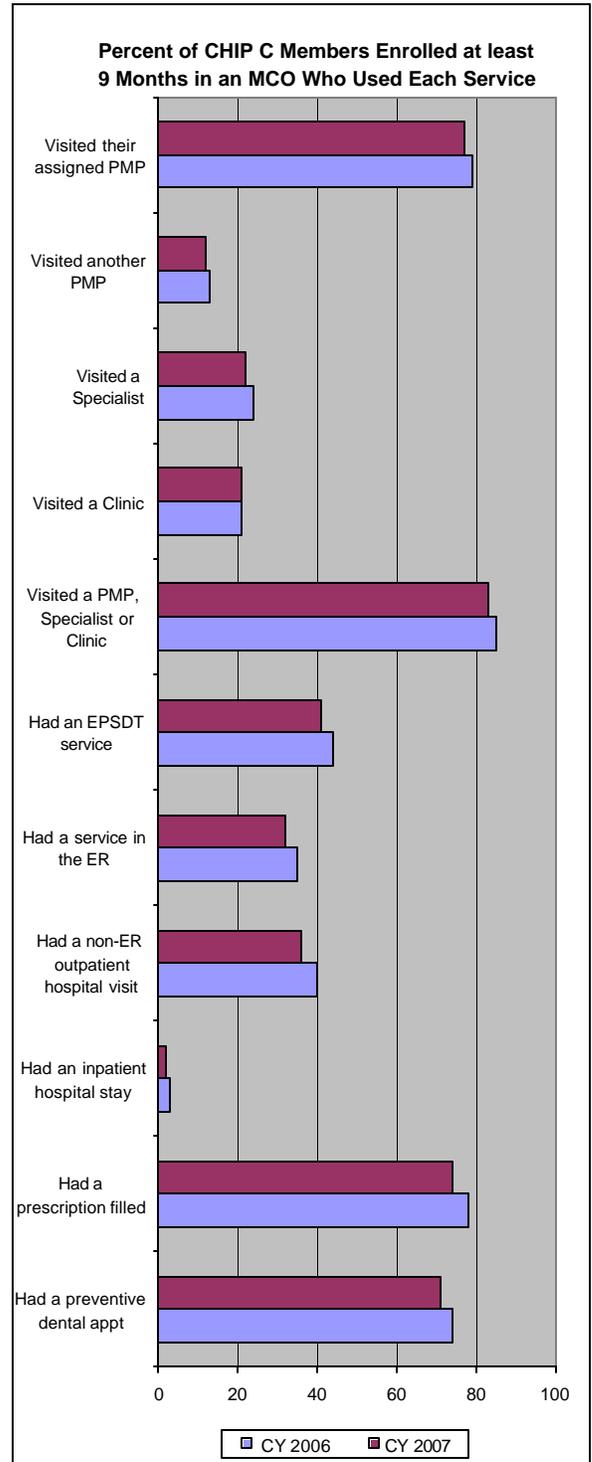
- (1) Differences in utilization between CHIP A members and CHIP C members were not as pronounced in 2006 and 2007 as B&A has seen in prior years. The two exceptions are PMP visits and EPSDT services, which more CHIP C members continue to use than CHIP A members. For CHIP C, 77% of members visited their assigned PMP in 2007 versus 67% of CHIP A members. Likewise, 41% of CHIP C members received an EPSDT service in 2007 versus only 30% of CHIP A members.
- (2) The OMPP should work with the MCOs to improve the rate of EPSDT visits. Although some of these services are age-specific, others are annual screenings for children of all ages and should be recorded as such when the child comes in for a "well-child" visit. Each state is required to submit an EPSDT utilization report to the Centers for Medicare and Medicaid each year for their Medicaid and CHIP populations separately. It is unknown at this time whether the low EPSDT usage reported is due to actual low utilization or improper recording of an EPSDT visit.
- (3) For both CHIP A and CHIP C, there was higher usage among members in CY 2006 than in CY 2007 for physician-related services. This appears to be due to missing claims from one MCO (refer to Exhibits III.9 and III.10 in the following pages). It may also in part be due to some service claims yet to be submitted to the State by all MCOs¹.
- (4) The rate of usage of the hospital emergency room should also be studied to determine whether or not the usage is actually emergent care or if the service could be delivered in a less intensive setting. B&A's definition of an ER visit did not require the presence of one of five ER procedure codes because we did not see them present on claims submitted to the State. Therefore, the usage reported (32% of CHIP C children in 2007, 30% of CHIP A children) may be overstated. The OMPP should explore the specific types of services being submitted as ER services.

¹ Data was retrieved by B&A from OMPP's data warehouse in mid-February. For services delivered late in CY 2007, claims may yet be submitted by the MCOs, particularly hospital-based services.

**Exhibit III.6
Utilization Statistics in CHIP A and CHIP C
Statewide Totals**



2006 sample= 38,894; 2007 sample= 40,671



2006 sample= 12,302; 2007 sample= 13,420

Exhibits III.7 and III.8: Utilization Statistics for CHIP Members by Age

Exhibits III.7 (CY 2006) and III.8 (CY 2007) compare the rate of service use for all CHIP children (CHIP A and CHIP C) but divided into four age groups: ages 1-5, 6-12, 13-18 female, and 13-18 male. Children under age 1 are not shown in the analysis since there are only a few enrolled in all of CHIP. The sample of children included in the exhibits is shown below:

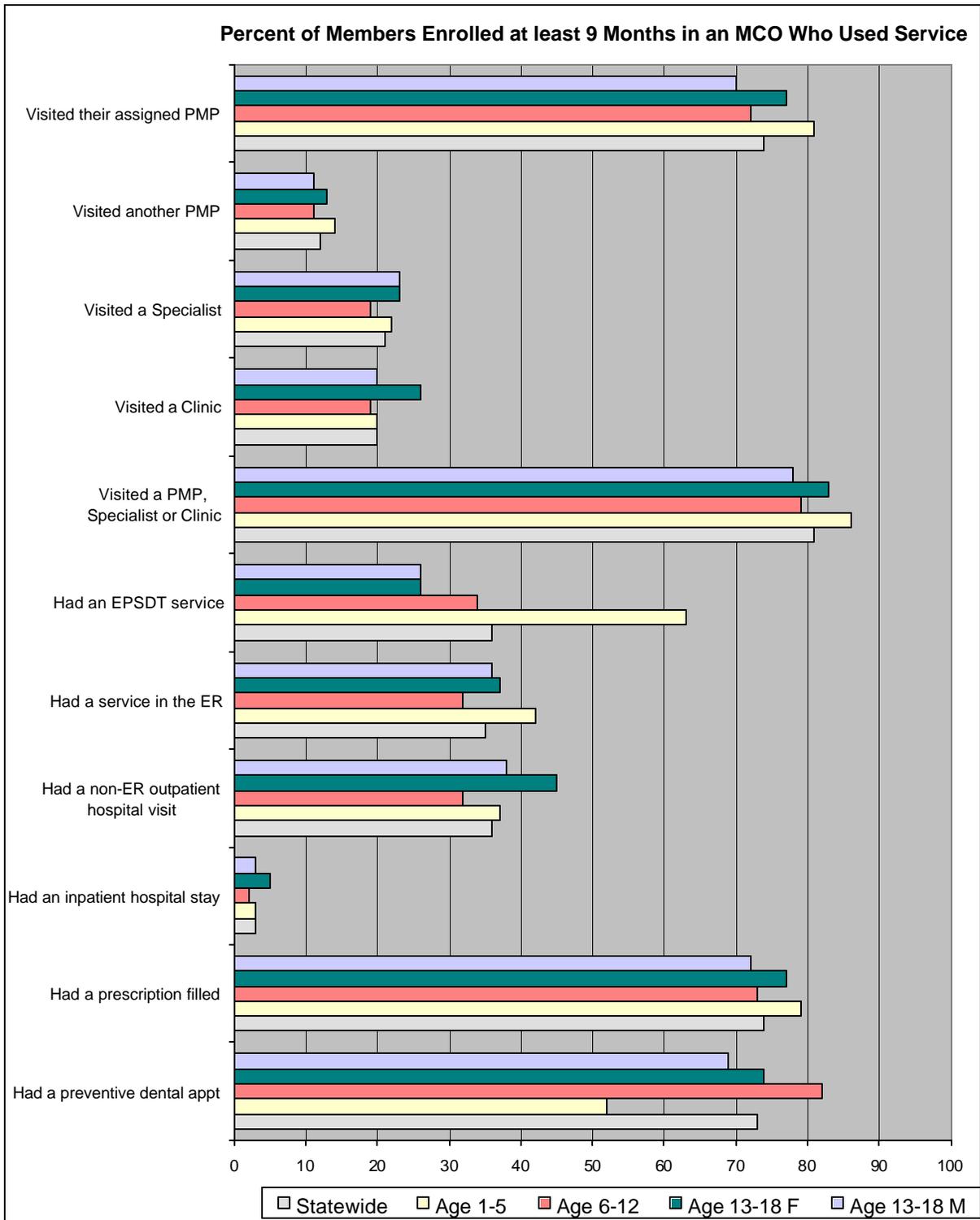
	Age 1-5	Age 6-12	Age 13-18 Female	Age 13-18 Male
CY 2006	8,754 (17%)	25,684 (49%)	8,808 (17%)	8,950 (17%)
CY 2007	8,874 (16%)	26,821 (50%)	9,250 (17%)	9,146 (17%)

Utilization for certain services are expected to vary by age group based upon children's needs (e.g. PMP visits and EPSDT services for younger, dental services for older children). These are evident in the exhibits. The findings for both exhibits are shown together since the trends are similar.

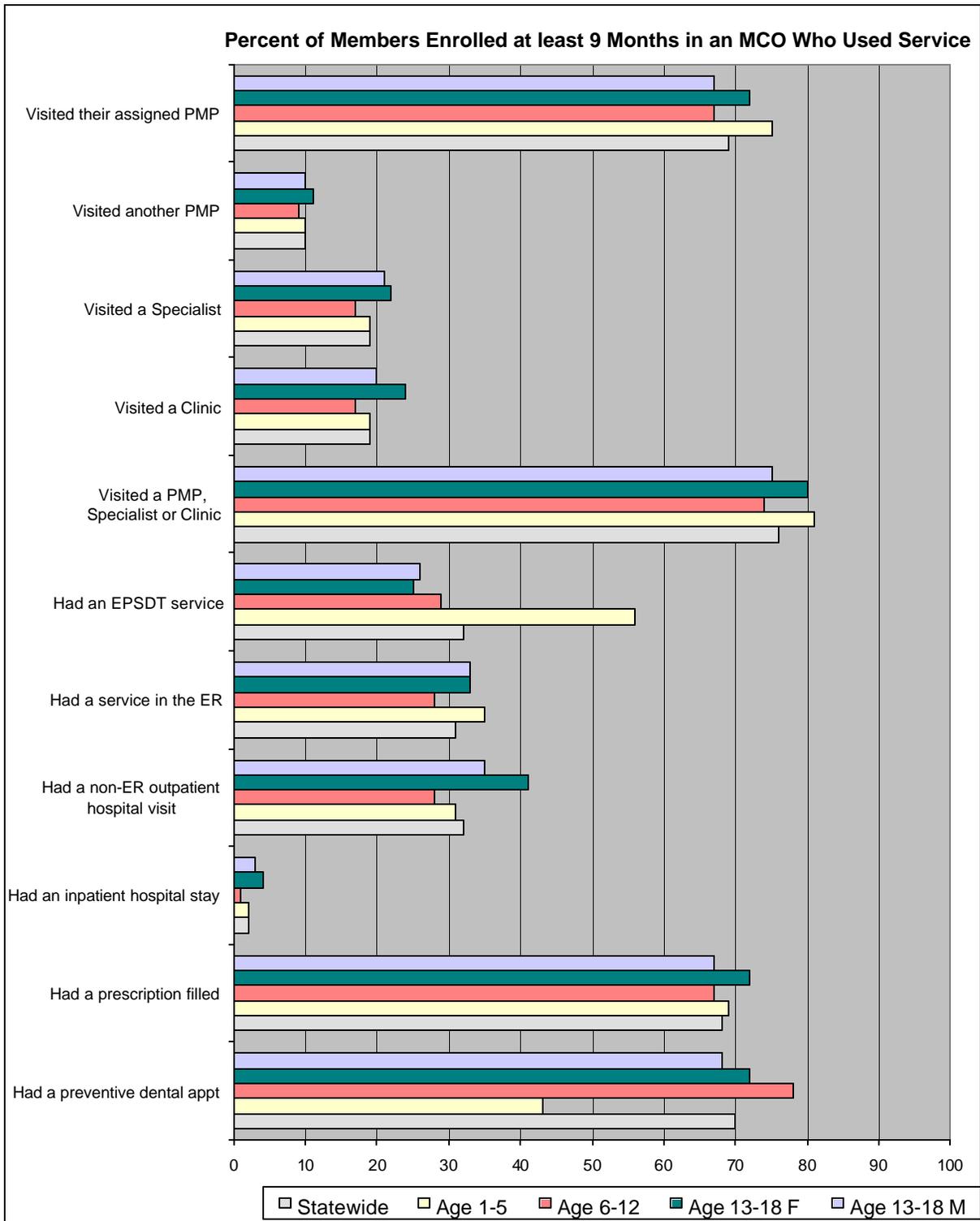
Key findings:

- (1) The teenage male age group, as expected, had the lowest PMP usage (70% of members in 2006 and 67% of members in 2007) but it was still relatively high for the age group. The age 1-5 group had the highest PMP usage (81% in 2006 and 75% in 2007) but it was lower than might be expected.
- (2) The EPSDT usage as reported previously appears to be lower than expected, particularly for the age 1-5 group who should be receiving an annual screening each year. In 2006, 63% of CHIP children in this age group had a reported EPSDT visit; in 2007, it was 56%.
- (3) Teenage girls had slightly higher usage of outpatient hospital services (45% in 2006, 41% in 2007) than the statewide average (36% in 2006, 32% in 2007).
- (4) Preventive dental visits were lower, as expected, for the youngest CHIP members (age 1-5). Other age groups experienced relatively similar dental usage, with the teenage male group using preventive dental services slightly less than the overall CHIP average.
- (5) Emergency room usage, reported as potentially being too high in Exhibit III.6, was relatively similar across age groups in CHIP.
- (6) Usage of all other services reviewed was similar across age groups.

**Exhibit III.7
Utilization Statistics for CHIP Children in 2006
By Age Group**



**Exhibit III.8
Utilization Statistics for CHIP Children in 2007
By Age Group**



Exhibits III.9 and III.10: Utilization Statistics for CHIP Members by MCO

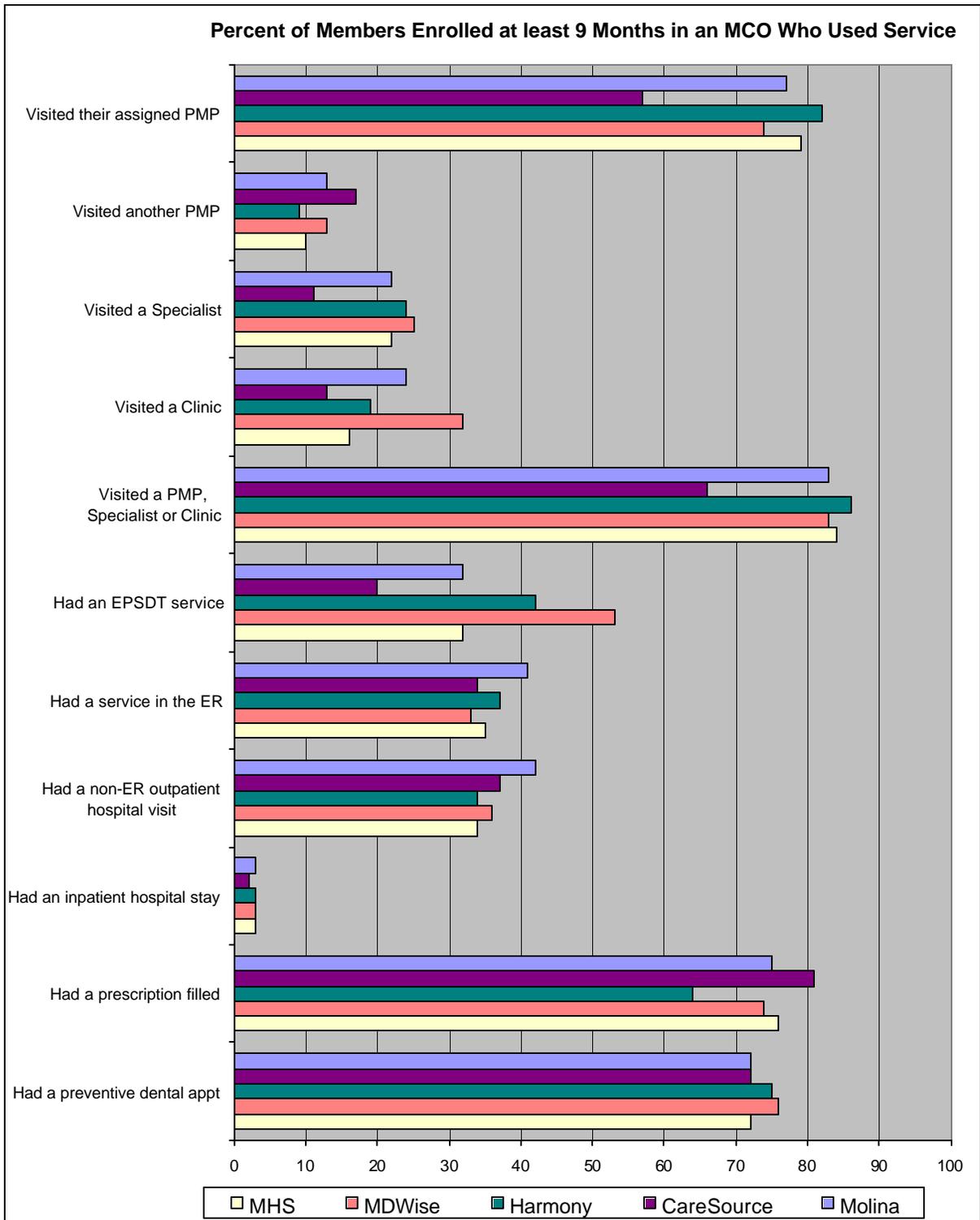
Exhibits III.9 (CY 2006) and III.10 (CY 2007) compare the rate of service use for all CHIP children (CHIP A and CHIP C) but divided by MCO. Contract changes in 2007 mean that there were different MCOs in 2006 than in 2007. Harmony, CareSource, and Molina were terminated as MCOs under Indiana's Hoosier Healthwise program at end of 2006. A new MCO, Anthem, has joined MHS and MDwise as the three current statewide MCOs effective January 1, 2007. The sample of children included in the exhibits is shown below.

	MHS	MDwise	Anthem	Harmony	CareSource	Molina
CY 2006	18,170 (35%)	11,902 (23%)		7,473 (14%)	9,394 (18%)	5,257 (10%)
CY 2007	16,728 (31%)	28,485 (53%)	8,878 (16%)			

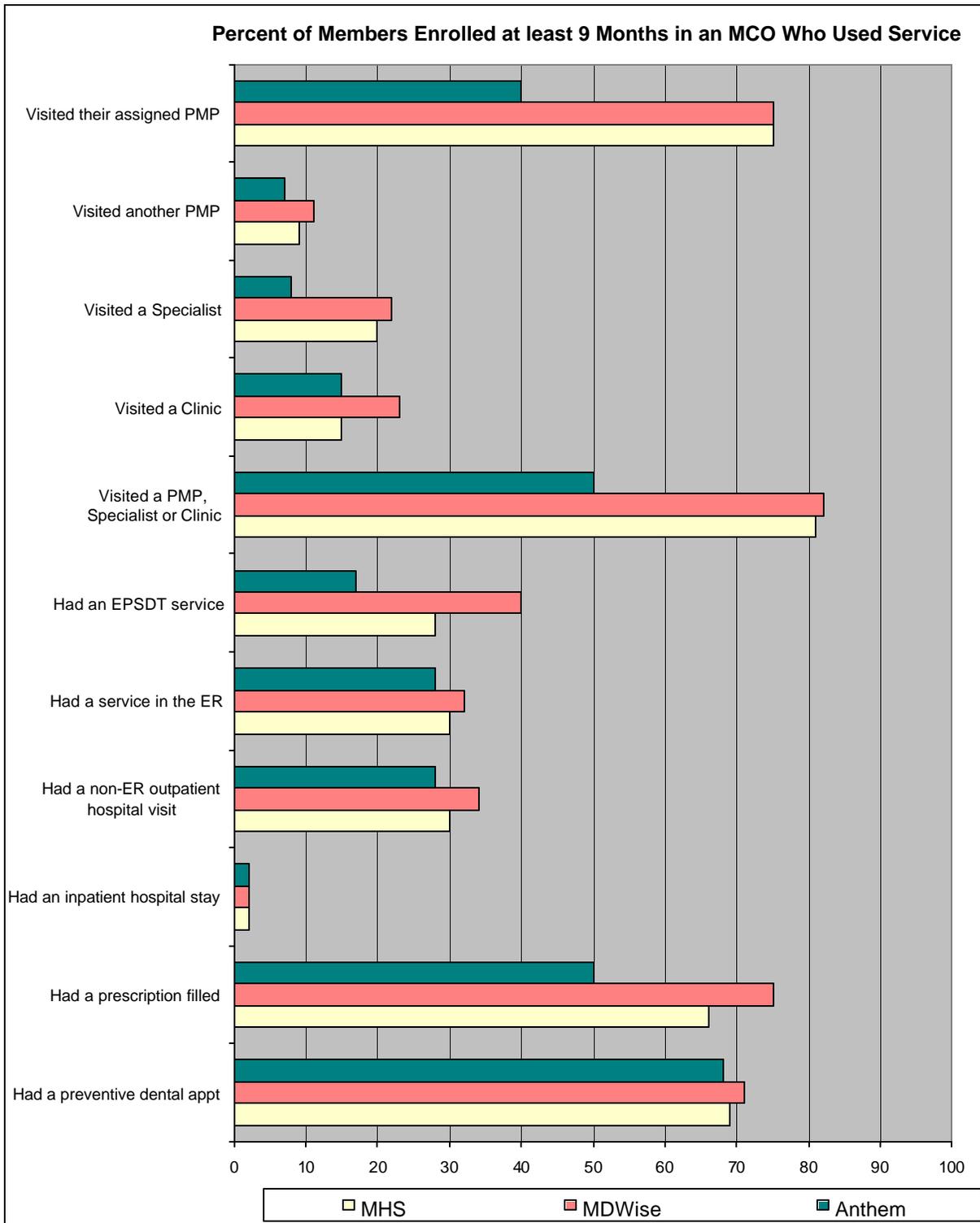
Key findings:

- (1) MDwise reported significantly higher EPSDT usage for its members in both years than other MCOs in either year. Likewise, clinic usage was higher for MDwise members, but this may be attributed to its provider network where its delegated contractors are all hospital-based entities.
- (2) In 2006, CareSource had substantially lower PMP usage than other health plans (57% of members vs. 74% statewide average).
- (3) In 2007, Anthem had even lower usage PMP usage (40% of members vs. 69% statewide average). Further investigation with the OMPP found that this was indicative of the fact that the claims submission rate from Anthem (on a per member basis) in 2007 was significantly lower than other MCOs for physician services and pharmacy scripts. The fact that the claims have not been submitted timely impacts all of our utilization analyses. B&A is attributing the lower utilization usage rates in 2007 versus 2006 to this situation since the PMP usage rates for MHS and MDwise were similar across the two years. This is also impacting our findings related to pharmacy usage.
- (4) With the exception of Anthem and CareSource, usage of all other services not mentioned above was similar across MCOs.

**Exhibit III.9
Utilization Statistics for CHIP Children in 2006
By MCO**



**Exhibit III.10
Utilization Statistics for CHIP Children in 2007
By MCO**



Exhibits III.11 and III.12: Utilization Statistics for CHIP Members by Race/Ethnicity

Exhibits III.11 (CY 2006) and III.12 (CY 2007) compare the rate of service use for all CHIP children (CHIP A and CHIP C) by members' race/ethnicity. Numerous studies have shown that there are indeed disparities in service use among different populations. The Hoosier Healthwise MCOs are required to proactively address racial/ethnic disparities among their enrollees. As part of the annual external quality review of each MCO, B&A suggested to OMPP that the member's race/ethnicity be provided to the MCOs when the member initially enrolls to assist the MCOs in addressing potential disparities up front. This information is now provided to the MCOs. The sample of children included in the exhibits is shown below.

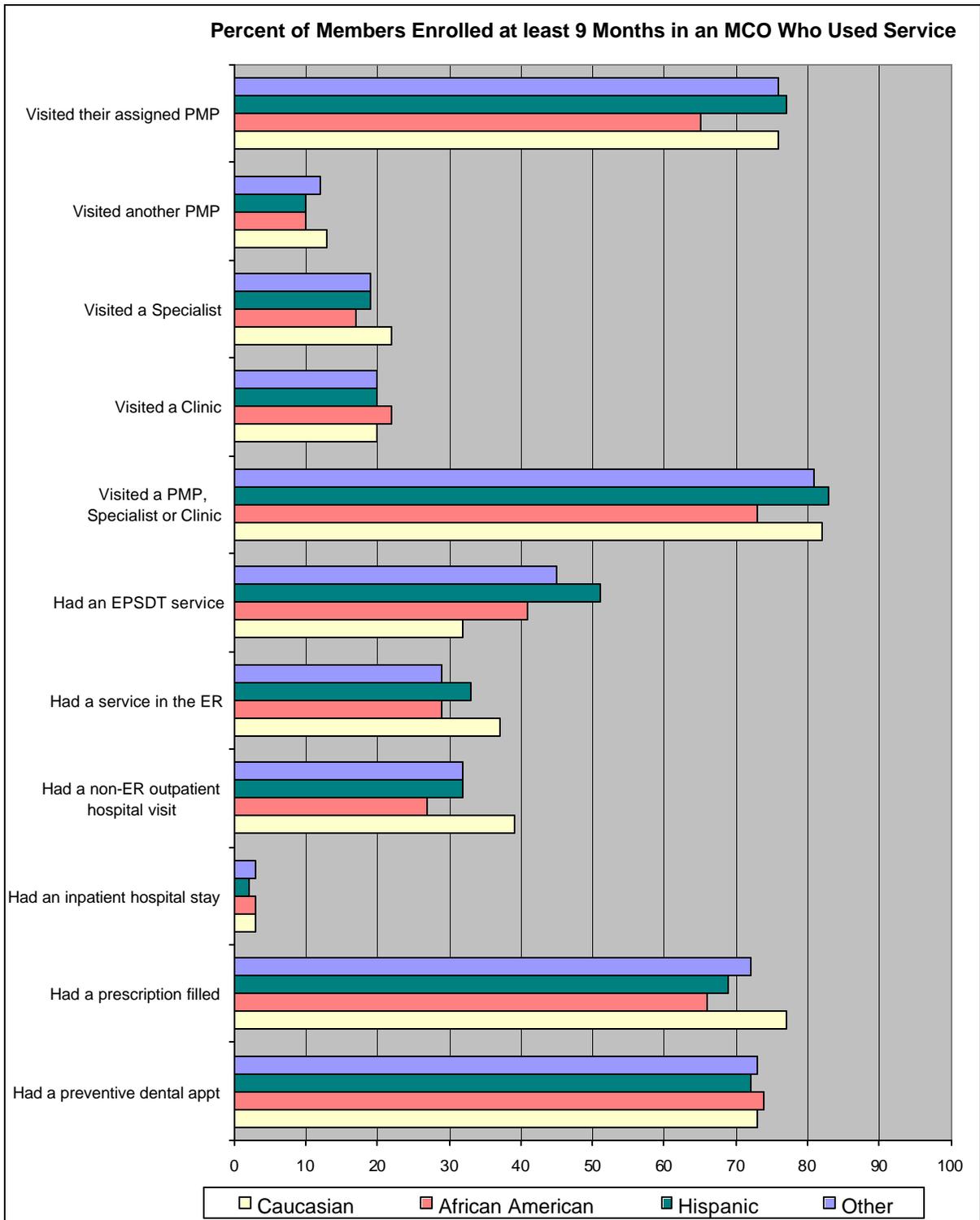
	Caucasian	African-American	Hispanic	Other Race/Ethnicities ²
CY 2006	36,946 (71%)	8,621 (17%)	5,608 (11%)	1,020 (2%)
CY 2007	37,870 (70%)	8,585 (16%)	6,418 (12%)	1,218 (2%)

Key findings:

- (1) While the other three population groups had similar PMP usage in both years, African-American children in CHIP had lower PMP usage (65% in 2006 vs. statewide average of 74%; 58% in 2007 vs. statewide average of 69%). This trend also held true when the combination of PMP, specialist and clinic usage was analyzed.
- (2) A disproportionately higher number of Hispanic children in CHIP had an EPSDT visit, while a lower percentage of Caucasian children reported an EPSDT visit.
- (3) There was a noticeable difference in emergency room usage between Caucasian and African-American children, with Caucasian children in CHIP reporting higher ER usage.
- (4) A lower percentage of African-American children had a pharmacy script in 2006, but the results from 2007 showed that this subgroup reported similar pharmacy usage as the other subgroups.
- (5) Usage of all other services not mentioned above was similar across race/ethnicity, including preventive dental services, clinic services, and inpatient hospital stays.

² Includes Asian, Native American, Indian

**Exhibit III.11
Utilization Statistics for CHIP Children in 2006
By Race/Ethnicity**



**Exhibit III.12
Utilization Statistics for CHIP Children in 2007
By Race/Ethnicity**

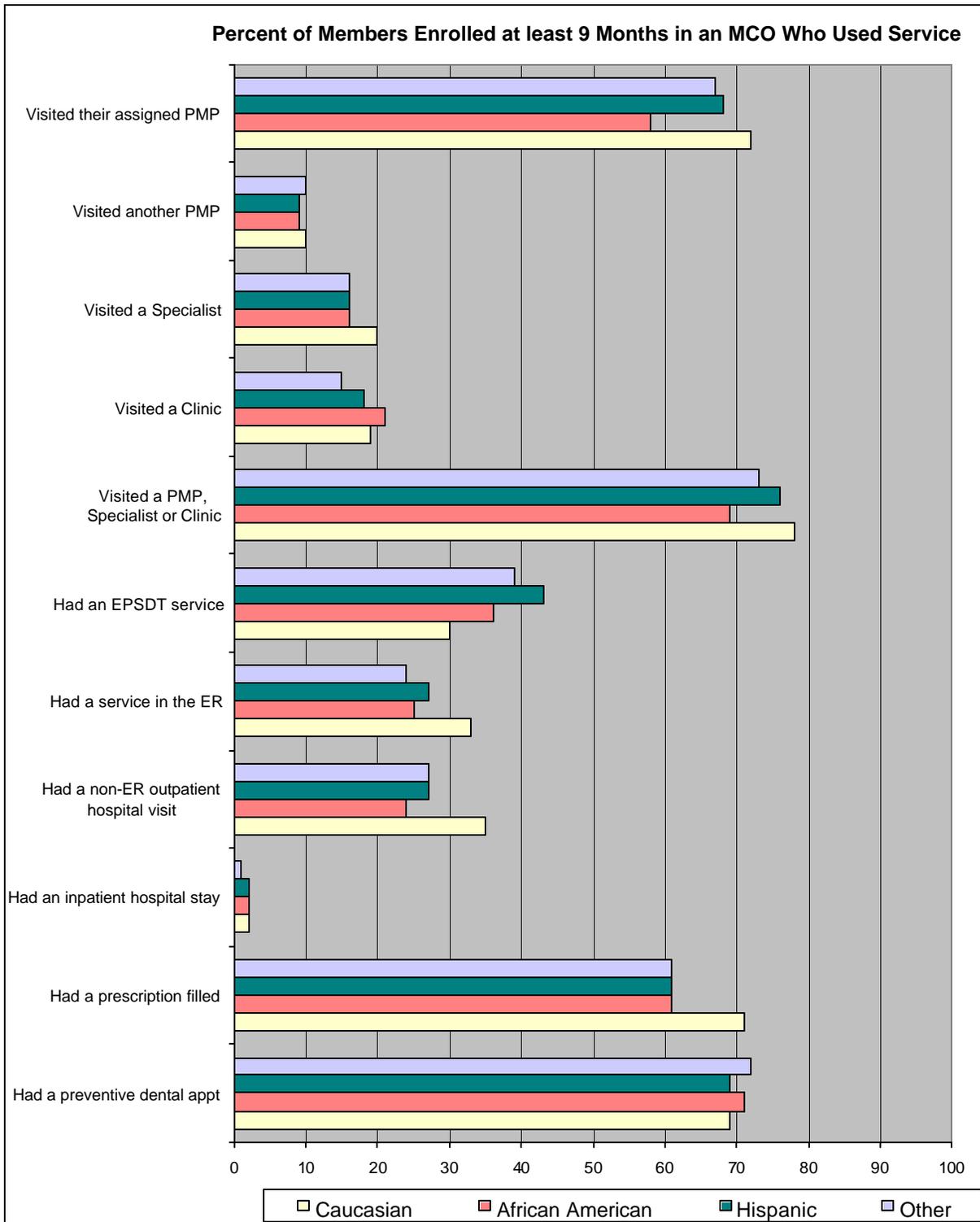


Exhibit III.13: Utilization Statistics for CHIP Members by Region

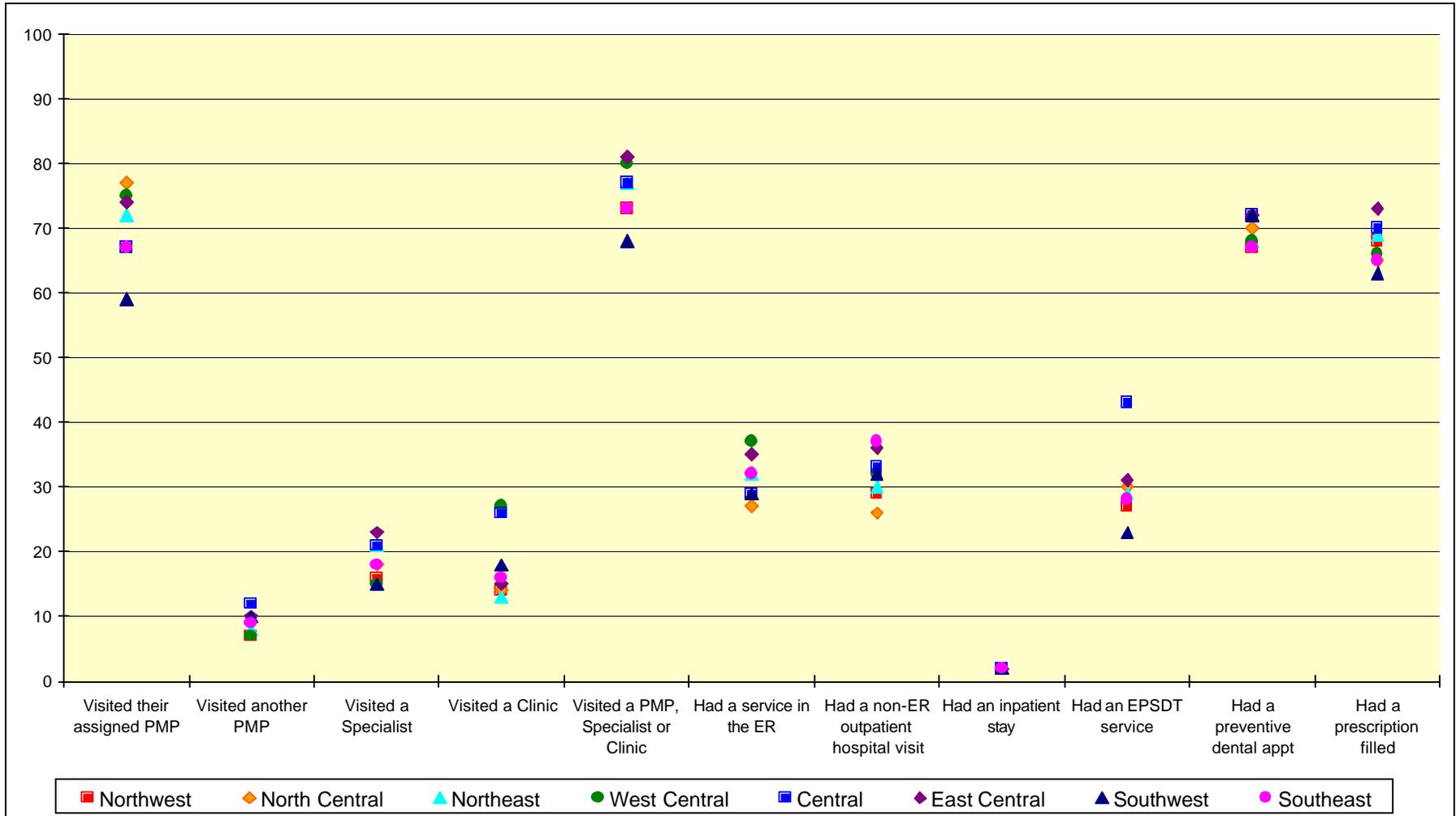
Utilization among CHIP members was also reviewed by region in the state. The regions were defined by county using the same region definitions created by the OMPP for setting capitation rates that are paid to the MCOs in Hoosier Healthwise. There are eight regions in total: Northwest, North Central, Northeast, West Central, Central, East Central, Southwest and Southeast. More detailed analyses of enrollment, access, and use of services is reported in Chapter IV. Exhibit III.13 on the next page is intended to show the variation, if any, of the use of services by CHIP members across regions in CY 2007.

Each service that was studied appears across the bottom of the exhibit. The symbols represent each region and the percentage of CHIP members from that region that used each service. When the symbols are clustered, it means that there is little variation in service use across regions. A larger spread of the symbols indicates wide variation of use of the service across the state.

Key findings:

- (1) With the exception of the Southwest Region, the percentage of CHIP members visiting their PMP was consistent across regions. Further investigation found that almost half of the CHIP members in the Southwest Region were enrolled with Anthem. Because of the lack of reporting of physician claims by Anthem previously discussed, this is the reason for the disparity from the results reported by the other regions. The same is true for the lower EPSDT use reported in the Southwest Region.
- (2) The Central Region was significantly higher from other regions for the percentage of children with EPSDT and clinic visits. MDwise is the predominant MCO serving CHIP members in the Central Region (two-thirds of all members) and it had been previously reported that MDwise had higher EPSDT and clinic usage among its members than the other MCOs (refer back to Exhibits III.9 and III.10).
- (3) For all other services reviewed, there was not a significant difference (defined as more than 10 percentage points) across regions in the percentage of CHIP members using a specific service.

Exhibit III.13
Variance in Utilization Statistics for CHIP Children in 2007 By Region
Percent of Members Enrolled at least 9 Months in an MCO Who Used Service



IV. Access and Utilization of Services in Indiana's CHIP: Subpopulations

Introduction

This chapter is intended for the reader interested in a more in-depth review of the access and utilization findings discussed in Chapter III. Burns & Associates analyzed the same data reported on in the statewide findings in Chapter III but at the subpopulation level. The data used in this chapter was extracted by B&A from the OMPP's data warehouse at the same point in time as the data shown in Chapter III.

In particular, we compared statewide trends across three dimensions:

- By MCO
 - Anthem
 - MDwise
 - Managed Health Services

- By Region
 - Northwest Region
 - North Central Region
 - Northeast Region
 - West Central Region
 - Central Region
 - East Central Region
 - Southwest Region
 - Southeast Region

- By Race/Ethnicity
 - Caucasian CHIP members
 - African-American CHIP members
 - Hispanic CHIP members
 - CHIP members of other race/ethnicities

Each subpopulation was analyzed with respect to enrollment in CY 2006 and CY 2007, access and enrollment with pediatricians as primary medical providers (PMPs), and utilization of 11 categories of services.

A narrative page introduces the data reviewed and findings for each subpopulation. The data sheets that follow the narrative are designed for easy comparison to the statewide findings and across subpopulations.

Anthem

Anthem had 16% of the total CHIP A population and 16% of the total CHIP C population in 2007.



Anthem has a higher concentration of CHIP members in the Southwest (46% of all members) and Southeast (31% of all members) regions relative to their statewide CHIP enrollment. They have a lower concentration in the North Central (8%) and Central (6%) regions.

There are 28 counties in the state with no pediatricians under contract with Hoosier Healthwise. For the remaining 64 counties, pediatrician availability was reviewed in areas where the MCO had a disproportionate number of CHIP members. In the Southwest and Southeast regions, Anthem has insufficient access (full pediatrician panels) in these counties: Knox, Warrick and Clark. Anthem has no contracted pediatrician in these counties in the regions: Daviess, Dubois, Bartholemew, Jennings, Jefferson, Scott, Dearborn and Franklin.

For pediatricians that do contract with the MCO, Anthem has more availability than the statewide average. Anthem's average pediatrician panel size is 595 versus 705 statewide. The percentage of full pediatrician panel sizes is 38% versus 47% statewide.

Since Anthem just started as a Hoosier Healthwise MCO in January 2007, service use data cannot be compared between 2006 and 2007. In 2007, Anthem reported service usage by its CHIP members that was less than the statewide average on all services reviewed except for inpatient hospital use. The starkest contract was with respect to physician-related services. This appears to be due to lack of claims reporting by the MCO.

CHIP members enrolled with Anthem differ from their peers enrolled with other MCOs most significantly with respect to using the following services:

- Lower Member's PMP visits
- Lower Specialist visits
- Lower EPSDT services
- Lower Prescription drug scripts

**Exhibit IV.1
Statistics for Anthem MCO**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	<u>CHIP A</u>	Percent of All CHIP A	<u>CHIP C</u>	Percent of All CHIP C		CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide
CY 2007	8,322	16%	2,773	16%	Northwest	16%		14%	
					NorthCentral	8%		8%	
					Northeast	15%		18%	
CY 2006	not under contract in 2006				WestCentral	13%	16%	13%	
					Central	6%		5%	16%
					EastCentral	10%		10%	
CY 2005	not under contract in 2005				Southwest	46%		44%	
					Southeast	31%		29%	

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Anthem	All MCOs Combined
Pediatricians Under Contract	171	675
Panel Size of All Pediatricians Combined	101,736	475,654
Average Pediatrician Panel Size	595	705
Number of Hoosier Healthwise Children Enrolled	39,032	224,744
Hoosier Healthwise Children per Pediatrician	228	333
Percent Pediatrician Panel Sizes Full	38%	47%

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.

	Anthem			All CHIP Children		
	<u>CY 2006</u>	<u>CY 2007</u>	<u>Change</u>	<u>CY 2006</u>	<u>CY 2007</u>	<u>Change</u>
Sample Size =	8,878			52,196	54,091	
<u>Physican/Primary Care</u>						
Member's PMP		40%		74%	69%	-5%
Another PMP		7%		12%	10%	-2%
Specialist		8%		21%	19%	-2%
Clinic		15%		20%	19%	-1%
Any of the Above		50%		81%	76%	-5%
<u>Hospital</u>						
Emergency Room		28%		35%	31%	-4%
Non-ER Outpatient		28%		36%	32%	-4%
Inpatient		2%		3%	2%	-1%
<u>Other Services</u>						
EPSDT		17%		36%	32%	-4%
Prescription Drugs		50%		74%	68%	-6%
Dental		68%		73%	70%	-3%

MDwise

MDwise had 44% of the total CHIP A population and 42% of the total CHIP C population in 2007.

MDwise has a higher concentration of CHIP members in the Central (66% of all members) region relative to their statewide CHIP enrollment. They have a lower concentration in the North Central (18%) and Southwest (23%) regions.



There are 28 counties in the state with no pediatricians under contract with Hoosier Healthwise. For the remaining 64 counties, pediatrician availability was reviewed in areas where the MCO had a disproportionate number of CHIP members. In the Central region, MDwise has insufficient access (full pediatrician panels) in Hendricks County. MDwise has no contracted pediatrician in these counties in the region: Putnam and Shelby.

For pediatricians that do contract with the MCO, MDwise has similar availability to the statewide average. MDwise's average pediatrician panel size is 759 versus 705 statewide. The percentage of full pediatrician panel sizes is 49% versus 47% statewide.

Earlier in the report it was found that the percentage of CHIP members using services in 2007 was lower than 2006. Some of this is due to lack of reporting by Anthem and some of this is due to claims yet to be submitted by all MCOs for services provided later in 2007. When controlling for MCO type, the level of the drop in usage reported by MDwise from 2006 to 2007 was similar to MHS except for clinic and EPSDT services. MDwise reported a steep drop in the usage of these services from 2006 to 2007.

CHIP members enrolled with MDwise differ from their peers enrolled with other MCOs most significantly with respect to using the following services:

- Higher usage of Member's PMP visits
- Higher usage of EPSDT services
- Higher usage of prescription drug scripts

**Exhibit IV.2
Statistics for MDwise MCO**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	<u>CHIP A</u>	Percent of All CHIP A	<u>CHIP C</u>	Percent of All CHIP C		CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide
CY 2007	23,106	44%	7,329	42%	Northwest	44%		42%	
					NorthCentral	18%		19%	
					Northeast	42%		38%	
CY 2006	9,422	18%	2,905	16%	WestCentral	45%	44%	43%	
					Central	66%		64%	42%
					EastCentral	36%		35%	
CY 2005	8,737	17%	2,752	15%	Southwest	23%		20%	
					Southeast	36%		35%	

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	MDwise	All MCOs Combined
Pediatricians Under Contract	321	675
Panel Size of All Pediatricians Combined	243,791	475,654
Average Pediatrician Panel Size	759	705
Number of Hoosier Healthwise Children Enrolled	120,394	224,744
Hoosier Healthwise Children per Pediatrician	375	333
Percent Pediatrician Panel Sizes Full	49%	47%

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.

Sample Size =	MDwise			All CHIP Children		
	11902 CY 2006	28,485 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
<u>Physican/Primary Care</u>						
Member's PMP	74%	75%	1%	74%	69%	-5%
Another PMP	13%	11%	-2%	12%	10%	-2%
Specialist	25%	22%	-3%	21%	19%	-2%
Clinic	32%	23%	-9%	20%	19%	-1%
Any of the Above	83%	82%	-1%	81%	76%	-5%
<u>Hospital</u>						
Emergency Room	33%	32%	-1%	35%	31%	-4%
Non-ER Outpatient	36%	34%	-2%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
<u>Other Services</u>						
EPSDT	53%	40%	-13%	36%	32%	-4%
Prescription Drugs	74%	75%	1%	74%	68%	-6%
Dental	76%	71%	-5%	73%	70%	-3%

Managed Health Services

MHS had 26% of the total CHIP A population and 24% of the total CHIP C population in 2007.

MHS has a higher concentration of CHIP members in the North Central (57% of all members) and East Central (43% of all members) region relative to their statewide CHIP enrollment. They have a lower concentration in the Central (12%) and Southwest (19%) regions.



There are 28 counties in the state with no pediatricians under contract with Hoosier Healthwise. For the remaining 64 counties, pediatrician availability was reviewed in areas where the MCO had a disproportionate number of CHIP members. In the North Central and East Central regions, MHS has insufficient access (full pediatrician panels) in the following counties: Fulton, Kosciusko, and Wayne. MHS has no contracted pediatrician in these counties in the regions: Marshall, Pulaski, Cass, Miami, Henry, Fayette, and Union.

For pediatricians that do contract with the MCO, MHS has slightly higher availability to the statewide average. MHS's average pediatrician panel size is 811 versus 705 statewide. The percentage of full pediatrician panel sizes is 50% versus 47% statewide.

Earlier in the report it was found that the percentage of CHIP members using services in 2007 was lower than 2006. Some of this is due to lack of reporting by Anthem and some of this is due to claims yet to be submitted by all MCOs for services provided later in 2007. When controlling for MCO type, the level of the drop in usage reported by MHS from 2006 to 2007 was similar to MDwise except for pharmacy scripts. MHS reported a steep drop in usage of this service from 2006 to 2007.

CHIP members enrolled with MHS differ from their peers enrolled with other MCOs most significantly with respect to using the following services:

- Higher usage of Member's PMP visits

**Exhibit IV.3
Statistics for Managed Health Services MCO**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	<u>CHIP A</u>	Percent of All CHIP A	<u>CHIP C</u>	Percent of All CHIP C		CHIP A Pct In Region	CHIP A Percent Statewide	CHIP C Pct in Region	CHIP C Percent Statewide
CY 2007	13,800	26%	4,276	24%	Northwest	27%		27%	
					NorthCentral	57%		56%	
					Northeast	28%		26%	
CY 2006	15,812	30%	4,997	28%	WestCentral	29%	26%	27%	
					Central	12%		11%	24%
					EastCentral	43%		38%	
CY 2005	12,985	25%	4,263	24%	Southwest	19%		18%	
					Southeast	20%		16%	

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	MHS	All MCOs Combined
Pediatricians Under Contract	160	675
Panel Size of All Pediatricians Combined	129,782	475,654
Average Pediatrician Panel Size	811	705
Number of Hoosier Healthwise Children Enrolled	64,685	224,744
Hoosier Healthwise Children per Pediatrician	404	333
Percent Pediatrician Panel Sizes Full	50%	47%

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.

Sample Size =	MHS			All CHIP Children		
	18,170 CY 2006	16,728 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
<u>Physician/Primary Care</u>						
Member's PMP	76%	75%	-1%	74%	69%	-5%
Another PMP	10%	9%	-1%	12%	10%	-2%
Specialist	22%	20%	-2%	21%	19%	-2%
Clinic	16%	15%	-1%	20%	19%	-1%
Any of the Above	84%	81%	-3%	81%	76%	-5%
<u>Hospital</u>						
Emergency Room	35%	30%	-5%	35%	31%	-4%
Non-ER Outpatient	34%	30%	-4%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
<u>Other Services</u>						
EPSDT	32%	28%	-4%	36%	32%	-4%
Prescription Drugs	76%	66%	-10%	74%	68%	-6%
Dental	72%	69%	-3%	73%	70%	-3%

Northwest Region

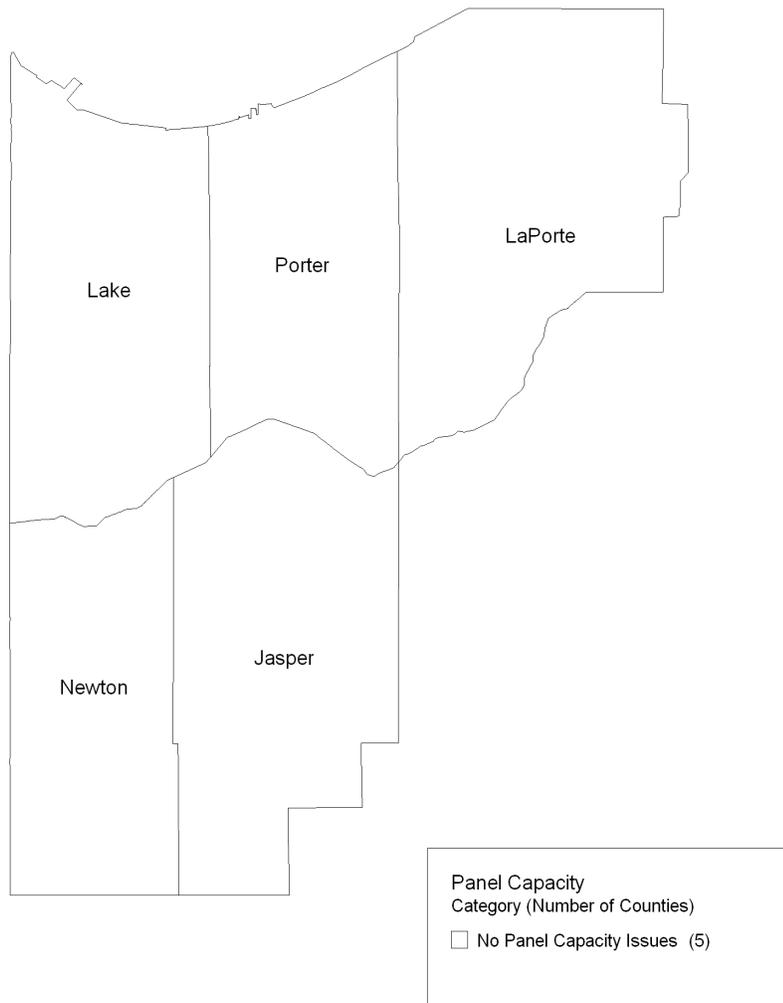
The Northwest Region had 12% of the total CHIP A population and 11% of the total CHIP C population in 2007.

The distribution by MCO of CHIP members in the region is: 16% Anthem, 44% MDwise and 26% MHS. This is in line with statewide enrollment by MCO.

The map to the right shows that there is sufficient access with respect to primary medical providers for children. Across the region, pediatrician panel sizes are 41% full as compared to the statewide average of 47%. However, average pediatrician panel size (1,128) is higher than the statewide average (705).

There may be access issues for children in portions of the region. Neither Newton nor Jasper Counties have a contracted pediatrician with any of the MCOs. All three MCOs have pediatricians in the other counties.

CHIP members enrolled in the Northwest Region do not differ from their peers enrolled in other regions with respect to using any of the 11 services studied.



**Exhibit IV.4
Statistics for the Northwest Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
		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 2007	6,203	12%	2,011	11%	Anthem	16%	16%	14%	16%
CY 2006	6,103	12%	2,067	12%	MDwise	44%	44%	42%	42%
CY 2005	5,966	12%	2,162	12%	MHS	27%	26%	27%	24%
					No MCO	13%	14%	18%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Northwest Region	All Regions Combined
Pediatricians Under Contract	86	675
Panel Size of All Pediatricians Combined	96,984	475,654
Average Pediatrician Panel Size	1,128	705
Number of Hoosier Healthwise Children Enrolled	39,705	224,744
Hoosier Healthwise Children per Pediatrician	462	333
Percent Pediatrician Panel Sizes Full	41%	47%

Utilization of Services

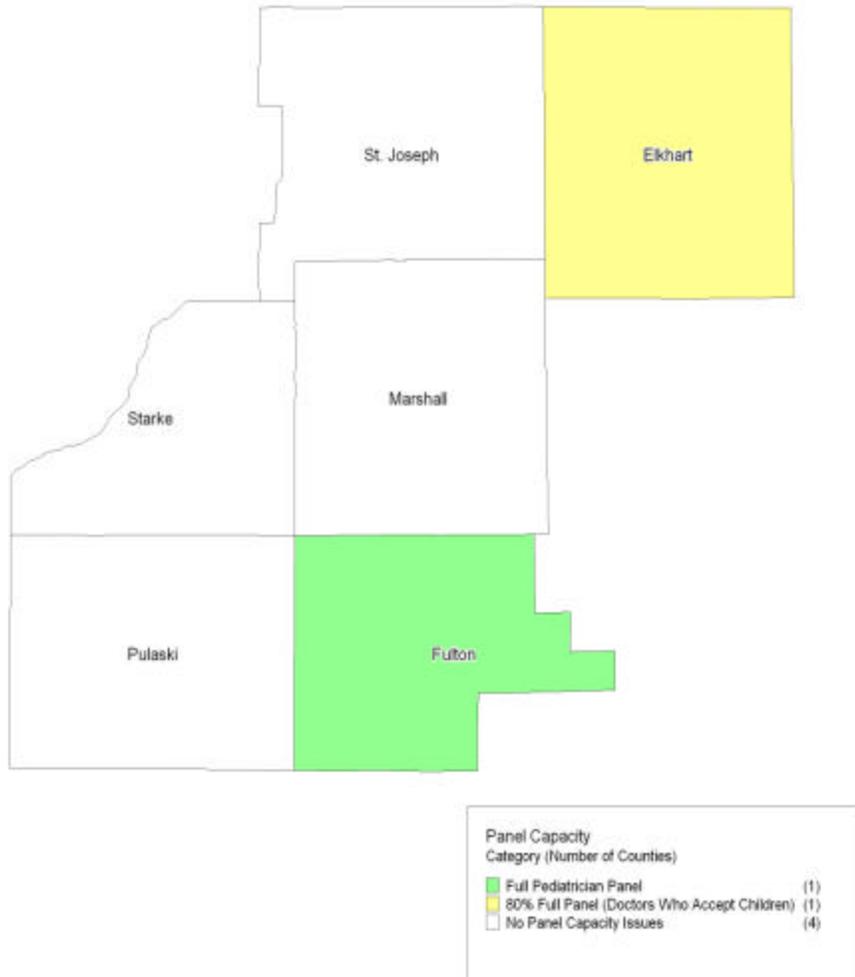
For CHIP members enrolled at least 9 months in an MCO during the time period
Results show the percentage of children who utilized the service.

	Northwest Region			Statewide		
	6,265 CY 2006	6,452 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
Physician/Primary Care						
Member's PMP	75%	67%	-8%	74%	69%	-5%
Another PMP	10%	7%	-3%	12%	10%	-2%
Specialist	18%	16%	-2%	21%	19%	-2%
Clinic	16%	14%	-2%	20%	19%	-1%
Any of the Above	80%	73%	-7%	81%	76%	-5%
Hospital						
Emergency Room	34%	29%	-5%	35%	31%	-4%
Non-ER Outpatient	33%	29%	-4%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
Other Services						
EPSDT	32%	27%	-5%	36%	32%	-4%
Prescription Drugs	74%	68%	-6%	74%	68%	-6%
Dental	72%	67%	-5%	73%	70%	-3%

North Central Region

The North Central Region had 11% of the total CHIP A population and 11% of the total CHIP C population in 2007.

The distribution by MCO of CHIP members in the region is: 8% Anthem, 18% MDwise and 57% MHS. MHS has a higher concentration of North Central members than their share statewide.



The map to the right shows that Elkhart County may have potential access issues since more than

80% of the physicians' panels are full. Also, Fulton County does not have a contracted pediatrician with any of the MCOs. All three MCOs have pediatricians in the other counties. Across the region, pediatrician panel sizes are 65% full as compared to the statewide average of 47%. However, average pediatrician panel size (403) is lower than the statewide average (705).

CHIP members enrolled in the North Central Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Higher usage of Member's PMP visits
- Higher usage of the any physician-related service (PMP, specialist, or clinic)
- Lower usage of non-ER outpatient services

**Exhibit IV.5
Statistics for the North Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
		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 2007	5,590	11%	1,870	11%	Anthem	8%	16%	8%	16%
CY 2006	5,460	10%	1,891	11%	MDwise	18%	44%	19%	44%
CY 2005	5,312	10%	1,898	10%	MHS	57%	26%	56%	24%
					No MCO	17%	14%	18%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	NorthCentral Region	All Regions Combined
Pediatricians Under Contract	58	675
Panel Size of All Pediatricians Combined	23,380	475,654
Average Pediatrician Panel Size	403	705
Number of Hoosier Healthwise Children Enrolled	15,112	224,744
Hoosier Healthwise Children per Pediatrician	261	333
Percent Pediatrician Panel Sizes Full	65%	47%

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.

	North Central Region			Statewide		
	<u>5,460</u> CY 2006	<u>5,622</u> CY 2007	<u>Change</u>	<u>52,196</u> CY 2006	<u>54,091</u> CY 2007	<u>Change</u>
Physican/Primary Care						
Member's PMP	83%	77%	-6%	74%	69%	-5%
Another PMP	11%	10%	-1%	12%	10%	-2%
Specialist	21%	18%	-3%	21%	19%	-2%
Clinic	18%	14%	-4%	20%	19%	-1%
Any of the Above	87%	81%	-6%	81%	76%	-5%
Hospital						
Emergency Room	31%	27%	-4%	35%	31%	-4%
Non-ER Outpatient	30%	26%	-4%	36%	32%	-4%
Inpatient	2%	2%	0%	3%	2%	-1%
Other Services						
EPSDT	36%	30%	-6%	36%	32%	-4%
Prescription Drugs	75%	65%	-10%	74%	68%	-6%
Dental	72%	70%	-2%	73%	70%	-3%

Northeast Region

The Northeast Region had 12% of the total CHIP A population and 12% of the total CHIP C population in 2007.

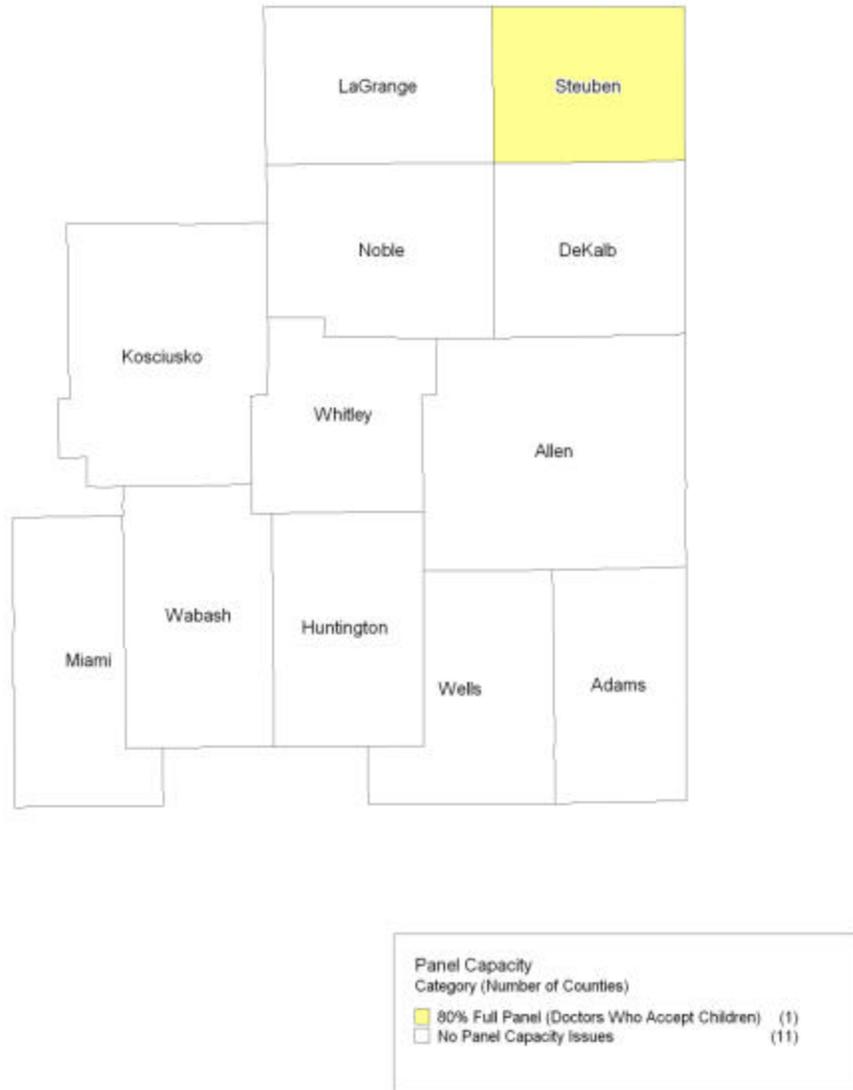
The distribution by MCO of CHIP members in the region is: 15% Anthem, 42% MDwise and 28% MHS. This is in line with statewide enrollment by MCO.

The map to the right shows that Steuben County may have potential access issues since more than 80% of the physicians' panels are full. Also, the following counties do not have a contracted pediatrician with any of the MCOs: LaGrange, Steuben, Noble, Whitley, and Adams.

MHS has a full pediatrician panel in Kosciusko and Wells Counties. MCOs have pediatricians in the other counties. Across the region, pediatrician panel sizes are 58% full as compared to the statewide average of 47%. However, average pediatrician panel size (618) is lower than the statewide average (705).

CHIP members enrolled in the Northeast Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Lower usage of clinic visits



**Exhibit IV.6
Statistics for the Northeast Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
		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 2007	6,377	12%	2,165	12%	Anthem	15%	16%	18%	16%
CY 2006	6,509	12%	2,224	12%	MDwise	42%	44%	38%	42%
CY 2005	6,159	12%	2,182	12%	MHS	28%	26%	26%	24%
					No MCO	14%	14%	18%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Northeast Region	All Regions Combined
Pediatricians Under Contract	55	675
Panel Size of All Pediatricians Combined	33,965	475,654
Average Pediatrician Panel Size	618	705
Number of Hoosier Healthwise Children Enrolled	19,565	224,744
Hoosier Healthwise Children per Pediatrician	356	333
Percent Pediatrician Panel Sizes Full	58%	47%

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.

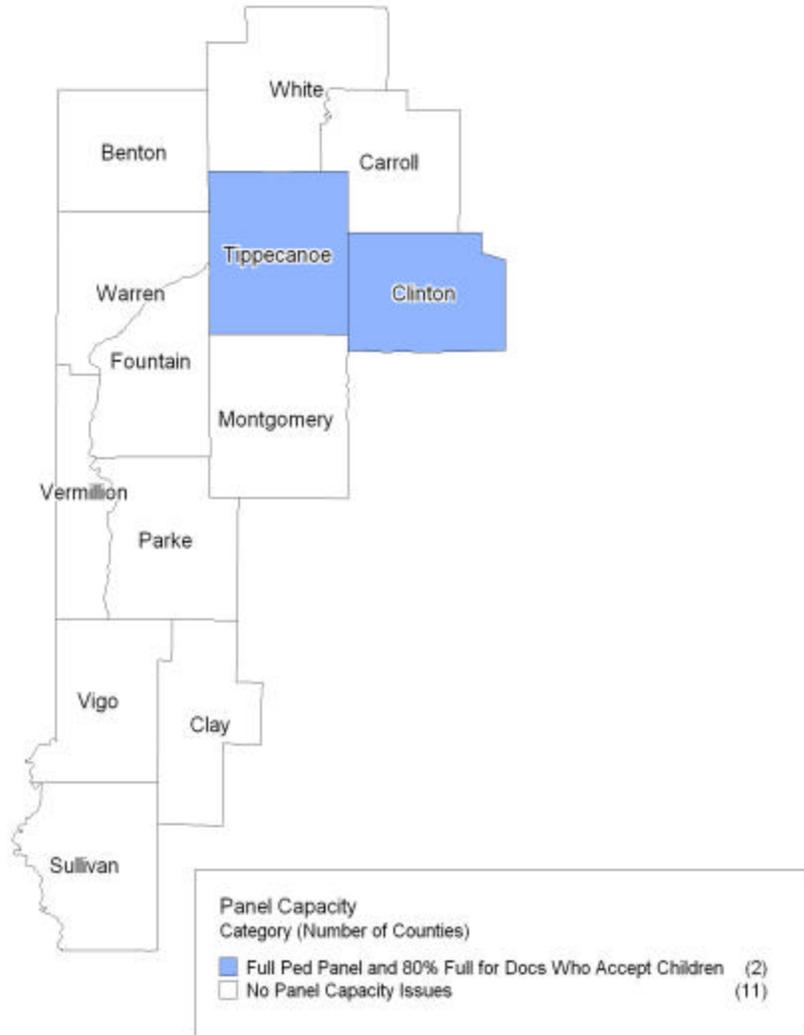
	Northeast Region			Statewide		
	6,239 CY 2006	6,549 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
Physician/Primary Care						
Member's PMP	78%	72%	-6%	74%	69%	-5%
Another PMP	11%	8%	-3%	12%	10%	-2%
Specialist	25%	21%	-4%	21%	19%	-2%
Clinic	14%	13%	-1%	20%	19%	-1%
Any of the Above	84%	77%	-7%	81%	76%	-5%
Hospital						
Emergency Room	37%	32%	-5%	35%	31%	-4%
Non-ER Outpatient	34%	30%	-4%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
Other Services						
EPSDT	34%	29%	-5%	36%	32%	-4%
Prescription Drugs	77%	69%	-8%	74%	68%	-6%
Dental	72%	68%	-4%	73%	70%	-3%

West Central Region

The West Central Region had 8% of the total CHIP A population and 8% of the total CHIP C population in 2007.

The distribution by MCO of CHIP members in the region is: 13% Anthem, 45% MDwise and 29% MHS. This is in line with statewide enrollment by MCO.

The map to the right shows that Clinton and Tippecanoe Counties may have potential access issues since more than 80% of the physicians' panels are full and their pediatrician panels in particular are full. Also, the only other counties to have a contracted pediatrician with any of the MCOs are Clay and Vigo.



Anthem has a full pediatrician panel in Vigo County. It was found that children are accessing pediatricians in neighboring counties, however. Across the region, pediatrician panel sizes are 85% full as compared to the statewide average of 47%. However, average pediatrician panel size (403) is lower than the statewide average (705).

CHIP members enrolled in the West Central Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Higher usage of clinic visits
- Higher usage of the emergency room
- Lower usage of EPSDT services

**Exhibit IV.7
Statistics for the West Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
		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 2007	4,301	8%	1,334	8%	Anthem	13%	16%	13%	16%
CY 2006	4,362	8%	1,464	8%	MDwise	45%	44%	43%	42%
CY 2005	4,218	8%	1,513	8%	MHS	29%	26%	27%	24%
					No MCO	13%	14%	17%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	WestCentral Region	All Regions Combined
Pediatricians Under Contract	38	675
Panel Size of All Pediatricians Combined	15,298	475,654
Average Pediatrician Panel Size	403	705
Number of Hoosier Healthwise Children Enrolled	13,060	224,744
Hoosier Healthwise Children per Pediatrician	344	333
Percent Pediatrician Panel Sizes Full	85%	47%

Utilization of Services

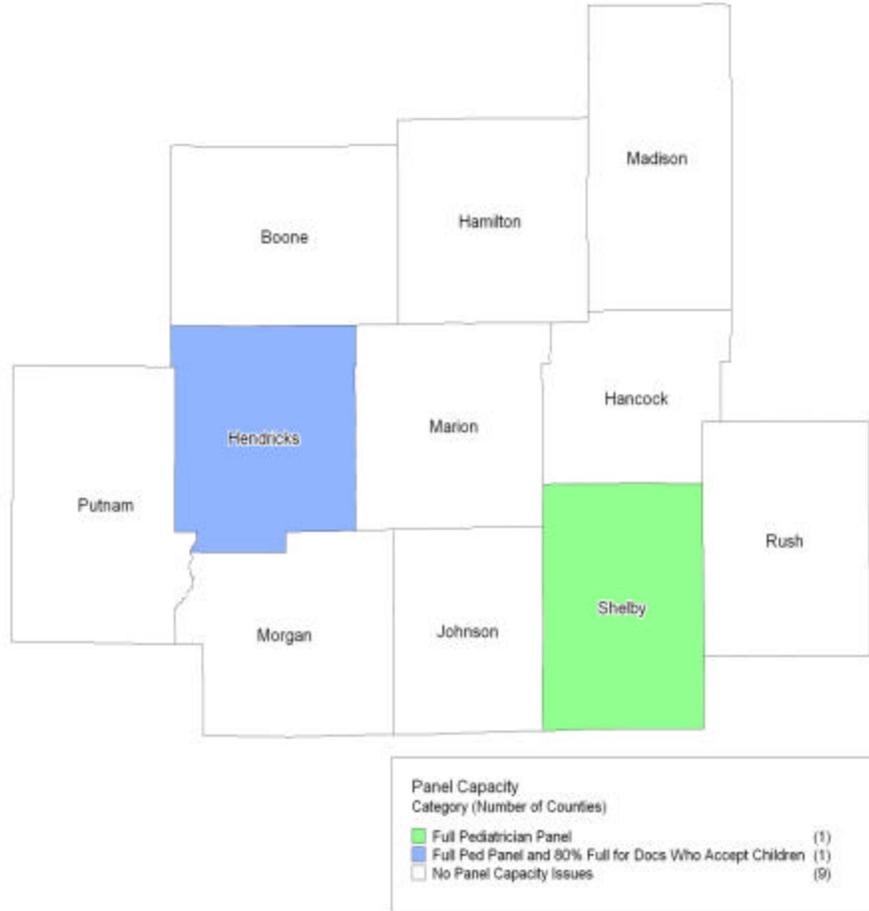
For CHIP members enrolled at least 9 months in an MCO during the time period
Results show the percentage of children who utilized the service.

	West Central Region			Statewide		
	<u>4,374</u> CY 2006	<u>4,452</u> CY 2007	<u>Change</u>	<u>52,196</u> CY 2006	<u>54,091</u> CY 2007	<u>Change</u>
Physican/Primary Care						
Member's PMP	76%	75%	-1%	74%	69%	-5%
Another PMP	9%	7%	-2%	12%	10%	-2%
Specialist	16%	15%	-1%	21%	19%	-2%
Clinic	28%	27%	-1%	20%	19%	-1%
Any of the Above	82%	80%	-2%	81%	76%	-5%
Hospital						
Emergency Room	41%	37%	-4%	35%	31%	-4%
Non-ER Outpatient	35%	32%	-3%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
Other Services						
EPSDT	29%	28%	-1%	36%	32%	-4%
Prescription Drugs	72%	66%	-6%	74%	68%	-6%
Dental	70%	68%	-2%	73%	70%	-3%

Central Region

The Central Region had 29% of the total CHIP A population and 29% of the total CHIP C population in 2007.

The distribution by MCO of CHIP members in the region is: 6% Anthem, 66% MDwise and 12% MHS. MDwise has a disproportionate share of the region's CHIP members when compared to their statewide share.



The map to the right shows that Hendricks County may have potential access issues

since more than 80% of the physicians' panels are full and their pediatrician panels in particular are full. Shelby County also has full pediatrician panels. Putnam County has no pediatrician available. All other counties have contracted pediatricians. Across the region, pediatrician panel sizes are 50% full as compared to the statewide average of 47%. Average pediatrician panel size (741) is similar to the statewide average (705).

CHIP members enrolled in the Central Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Higher usage of clinic visits
- Higher usage of EPSDT services

**Exhibit IV.8
Statistics for the Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
	<u>CHIP A</u>	Percent of All <u>CHIP A</u>	<u>CHIP C</u>	Percent of All <u>CHIP 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 2007	15,439	29%	5,034	29%	Anthem	6%	16%	5%	16%
CY 2006	15,105	29%	4,986	28%	MDwise	66%	44%	64%	42%
CY 2005	14,476	28%	4,924	27%	MHS	12%	26%	11%	24%
					No MCO	16%	14%	20%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Central Region	All Regions Combined
Pediatricians Under Contract	208	675
Panel Size of All Pediatricians Combined	154,061	475,654
Average Pediatrician Panel Size	741	705
Number of Hoosier Healthwise Children Enrolled	76,317	224,744
Hoosier Healthwise Children per Pediatrician	367	333
Percent Pediatrician Panel Sizes Full	50%	47%

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.

	Central Region			Statewide		
	<u>14,436</u> CY 2006	<u>15,061</u> CY 2007	<u>Change</u>	<u>52,196</u> CY 2006	<u>54,091</u> CY 2007	<u>Change</u>
Physician/Primary Care						
Member's PMP	70%	67%	-3%	74%	69%	-5%
Another PMP	13%	12%	-1%	12%	10%	-2%
Specialist	23%	21%	-2%	21%	19%	-2%
Clinic	27%	26%	-1%	20%	19%	-1%
Any of the Above	79%	77%	-2%	81%	76%	-5%
Hospital						
Emergency Room	34%	29%	-5%	35%	31%	-4%
Non-ER Outpatient	37%	33%	-4%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
Other Services						
EPSDT	47%	43%	-4%	36%	32%	-4%
Prescription Drugs	74%	70%	-4%	74%	68%	-6%
Dental	75%	72%	-3%	73%	70%	-3%

East Central Region

The East Central Region had 9% of the total CHIP A population and 9% of the total CHIP C population in 2007.

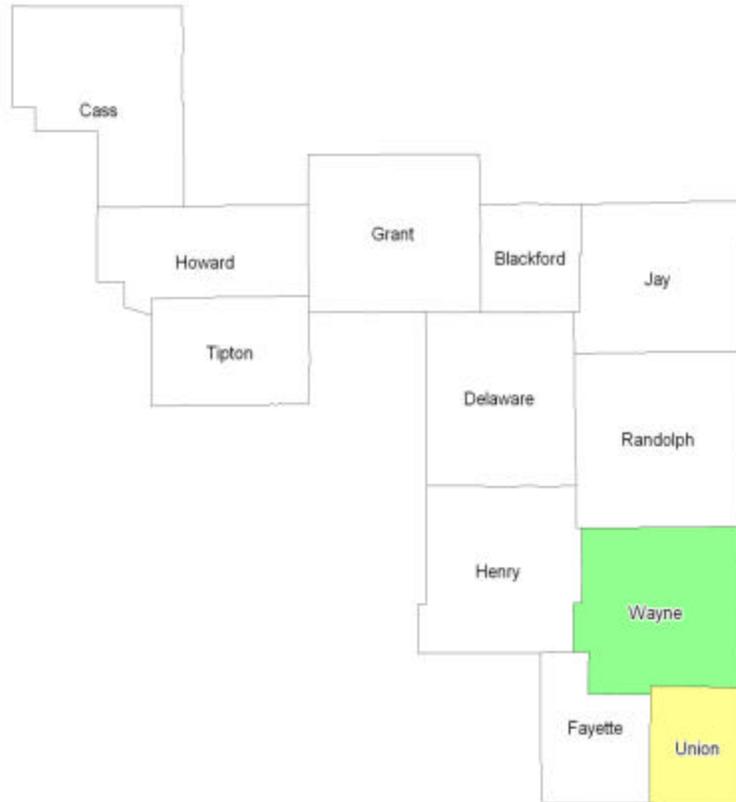
The distribution by MCO of CHIP members in the region is: 10% Anthem, 36% MDwise and 43% MHS. MHS has a disproportionate share of the region's CHIP members when compared to their statewide share.

The map to the right shows that Union County may have potential access issues since more than 80% of the physicians' panels are full. Wayne County also has full pediatrician panels. Counties with no pediatrician available include: Blackford, Jay, and Randolph.

All other counties have contracted pediatricians. Across the region, pediatrician panel sizes are 46% full as compared to the statewide average of 47%. Average pediatrician panel size (762) is similar to the statewide average (705).

CHIP members enrolled in the East Central Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Lower usage of clinic visits



Panel Capacity Category (Number of Counties)	
Full Pediatrician Panel	(1)
80% Full Panel (Doctors Who Accept Children)	(1)
No Panel Capacity Issues	(10)

**Exhibit IV.9
Statistics for the East Central Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
	<u>CHIP A</u>	Percent of All <u>CHIP A</u>	<u>CHIP C</u>	Percent of All <u>CHIP 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 2007	4,694	9%	1,500	9%	Anthem	10%	16%	10%	16%
CY 2006	4,813	9%	1,563	9%	MDwise	36%	44%	35%	42%
CY 2005	4,689	9%	1,558	9%	MHS	43%	26%	38%	24%
					No MCO	12%	14%	17%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	EastCentral Region	All Regions Combined
Pediatricians Under Contract	55	675
Panel Size of All Pediatricians Combined	41,930	475,654
Average Pediatrician Panel Size	762	705
Number of Hoosier Healthwise Children Enrolled	19,375	224,744
Hoosier Healthwise Children per Pediatrician	352	333
Percent Pediatrician Panel Sizes Full	46%	47%

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.

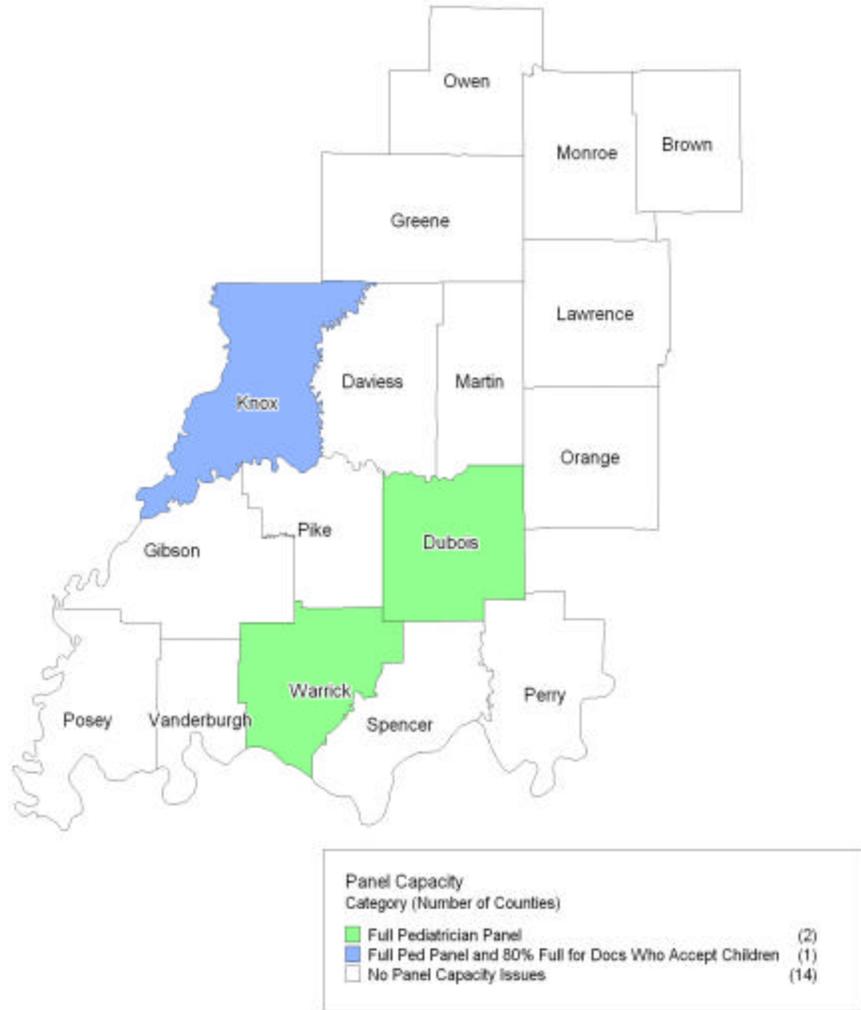
	East Central Region			Statewide		
	<u>4,782</u> CY 2006	<u>5,104</u> CY 2007	<u>Change</u>	<u>52,196</u> CY 2006	<u>54,091</u> CY 2007	<u>Change</u>
Physican/Primary Care						
Member's PMP	73%	74%	1%	74%	69%	-5%
Another PMP	14%	10%	-4%	12%	10%	-2%
Specialist	22%	23%	1%	21%	19%	-2%
Clinic	14%	15%	1%	20%	19%	-1%
Any of the Above	80%	81%	1%	81%	76%	-5%
Hospital						
Emergency Room	39%	35%	-4%	35%	31%	-4%
Non-ER Outpatient	37%	36%	-1%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
Other Services						
EPSDT	33%	31%	-2%	36%	32%	-4%
Prescription Drugs	79%	73%	-6%	74%	68%	-6%
Dental	74%	72%	-2%	73%	70%	-3%

Southwest Region

The Southwest Region had 11% of the total CHIP A population and 12% of the total CHIP C population in 2007.

The distribution by MCO of CHIP members in the region is: 46% Anthem, 23% MDwise and 19% MHS. Anthem has a disproportionate share of the region's CHIP members when compared to their statewide share.

The map to the right shows that Knox County may have potential access issues since more than 80% of the physicians' panels are full and pediatrician panels in particular are full. Dubois and Warrick Counties also have full pediatrician panels. Counties with no pediatrician available include: Owen, Brown, Greene, Martin, Orange, Pike, Spencer and Posey. All other counties have contracted pediatricians. Across the region, pediatrician panel sizes are 32% full as compared to the statewide average of 47%. Average pediatrician panel size (729) is similar to the statewide average (705).



CHIP members enrolled in the Southwest Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Lower usage of EPSDT visits

**Exhibit IV.10
Statistics for the Southwest Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
	Percent of All		Percent of All		CHIP A	CHIP A	CHIP C	CHIP C	
	CHIP A	CHIP A	CHIP C	CHIP C	Pct In Region	Percent Statewide	Pct in Region	Percent Statewide	
CY 2007	5,629	11%	2,123	12%	Anthem	46%	16%	44%	16%
CY 2006	5,725	11%	2,132	12%	MDwise	23%	44%	20%	42%
CY 2005	5,644	11%	2,171	12%	MHS	19%	26%	18%	24%
					No MCO	12%	14%	17%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Southwest Region	All Regions Combined
Pediatricians Under Contract	91	675
Panel Size of All Pediatricians Combined	66,370	475,654
Average Pediatrician Panel Size	729	705
Number of Hoosier Healthwise Children Enrolled	21,040	224,744
Hoosier Healthwise Children per Pediatrician	231	333
Percent Pediatrician Panel Sizes Full	32%	47%

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.

	Southwest Region			Statewide		
	6,040 CY 2006	6,191 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
Physican/Primary Care						
Member's PMP	69%	59%	-10%	74%	69%	-5%
Another PMP	14%	10%	-4%	12%	10%	-2%
Specialist	18%	15%	-3%	21%	19%	-2%
Clinic	19%	18%	-1%	20%	19%	-1%
Any of the Above	77%	68%	-9%	81%	76%	-5%
Hospital						
Emergency Room	34%	29%	-5%	35%	31%	-4%
Non-ER Outpatient	38%	32%	-6%	36%	32%	-4%
Inpatient	2%	2%	0%	3%	2%	-1%
Other Services						
EPSDT	28%	23%	-5%	36%	32%	-4%
Prescription Drugs	75%	63%	-12%	74%	68%	-6%
Dental	74%	72%	-2%	73%	70%	-3%

Southeast Region

The Southeast Region had 9% of the total CHIP A population and 9% of the total CHIP C population in 2007.

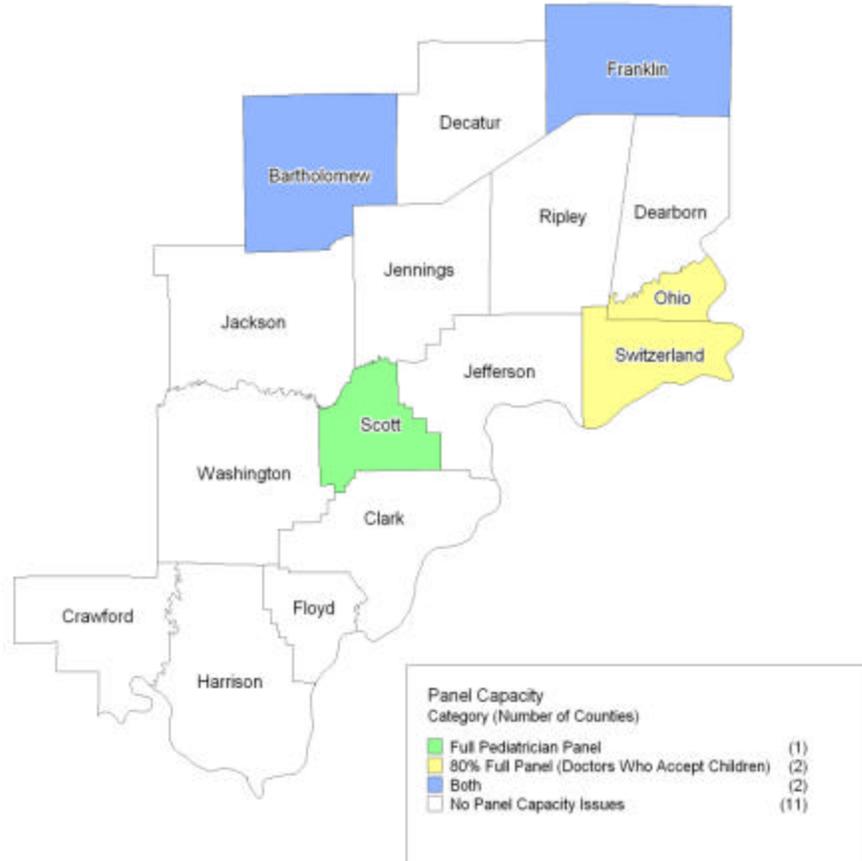
The distribution by MCO of CHIP members in the region is: 31% Anthem, 36% MDwise and 20% MHS. Anthem has a disproportionate share of the region's CHIP members when compared to their statewide share.

The map to the right shows that Bartholemew and Franklin Counties may have potential access issues since more than 80% of the physicians' panels are full and pediatrician panels in particular are full.

Scott County has full pediatrician panels, and Ohio and Switzerland Counties have panel sizes over 80% for all doctors who will accept children. Jackson County has no pediatrician available. All other counties have contracted pediatricians. Across the region, pediatrician panel sizes are 47% full, the same as the statewide average. Average pediatrician panel size (520) is lower than the statewide average (705).

CHIP members enrolled in the Southeast Region differ from their peers enrolled in other regions most significantly with respect to using the following services:

- Lower usage of pharmacy scripts (2006 only)



**Exhibit IV.11
Statistics for the Southeast Region**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by MCO in 2007				
		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 2007	4,511	9%	1,553	9%	Anthem	31%	16%	29%	16%
CY 2006	4,684	9%	1,643	9%	MDwise	36%	44%	35%	42%
CY 2005	4,559	9%	1,696	9%	MHS	20%	26%	16%	24%
					No MCO	14%	14%	19%	18%

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Southeast Region	All Regions Combined
Pediatricians Under Contract	84	675
Panel Size of All Pediatricians Combined	43,667	475,654
Average Pediatrician Panel Size	520	705
Number of Hoosier Healthwise Children Enrolled	20,462	224,744
Hoosier Healthwise Children per Pediatrician	244	333
Percent Pediatrician Panel Sizes Full	47%	47%

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.

	Southeast Region			Statewide		
	4,519 CY 2006	4,566 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
Physician/Primary Care						
Member's PMP	73%	67%	-6%	74%	69%	-5%
Another PMP	13%	9%	-4%	12%	10%	-2%
Specialist	20%	18%	-2%	21%	19%	-2%
Clinic	18%	16%	-2%	20%	19%	-1%
Any of the Above	80%	73%	-7%	81%	76%	-5%
Hospital						
Emergency Room	34%	32%	-2%	35%	31%	-4%
Non-ER Outpatient	41%	37%	-4%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
Other Services						
EPSDT	32%	28%	-4%	36%	32%	-4%
Prescription Drugs	66%	65%	-1%	74%	68%	-6%
Dental	71%	67%	-4%	73%	70%	-3%

Caucasian CHIP Members

Caucasians represented 67% of the total CHIP A population and 74% of the total CHIP C population in 2007.

Caucasian members are more highly represented in the West Central, East Central, Southwest and Southeast Regions than their representation statewide.

There were 42% of Caucasian CHIP members enrolled with a pediatrician as their PMP in June 2007, which is similar to the statewide average of 45% for all CHIP members.

Because this subpopulation represented the majority of CHIP members, Caucasian CHIP members do not differ from the statewide averages with respect to using any of the 11 services studied.

**Exhibit IV.12
Statistics for Caucasian CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	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 2007	35,359	67%	13,065	74%	Northwest	48%		57%	
					NorthCentral	57%		67%	
					Northeast	71%		78%	
CY 2006	35,774	68%	13,449	75%	WestCentral	83%	67%	85%	74%
					Central	51%		62%	
					EastCentral	87%		87%	
CY 2005	35,116	69%	13,649	75%	Southwest	90%		93%	
					Southeast	89%		93%	

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Caucasian CHIP Members	All CHIP Children
Number of Members with a Pediatrician as their PMP	17,507	26,466
Number of Members with another Practice as their PMP	24,166	32,588
Percent of Children with a Pediatrician as their PMP	42%	45%

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.

	Caucasian CHIP Members			All CHIP Children		
	36,946 CY 2006	37,870 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
<u>Physican/Primary Care</u>						
Member's PMP	76%	72%	-4%	74%	69%	-5%
Another PMP	13%	10%	-3%	12%	10%	-2%
Specialist	22%	20%	-2%	21%	19%	-2%
Clinic	20%	19%	-1%	20%	19%	-1%
Any of the Above	82%	78%	-4%	81%	76%	-5%
<u>Hospital</u>						
Emergency Room	37%	33%	-4%	35%	31%	-4%
Non-ER Outpatient	39%	35%	-4%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
<u>Other Services</u>						
EPSDT	32%	30%	-2%	36%	32%	-4%
Prescription Drugs	77%	71%	-6%	74%	68%	-6%
Dental	73%	69%	-4%	73%	70%	-3%

African-American CHIP Members

African-Americans represented 17% of the total CHIP A population and 11% of the total CHIP C population in 2007.

African-American members are more highly represented in the Northwest and Central Regions than their representation statewide.

There were 54% of African-American CHIP members enrolled with a pediatrician as their PMP in June 2007, which is higher than the statewide average of 45% for all CHIP members.

African-American CHIP members differ significantly from the statewide averages with respect to the use of the following services.

- Lower usage of visiting their PMP
- Lower usage of the emergency room
- Lower usage of non-ER outpatient hospital services
- Lower usage of pharmacy scripts

**Exhibit IV.13
Statistics for African-American CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	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 2007	9,323	17%	1,981	11%	Northwest	28%		20%	
					NorthCentral	14%		8%	
					Northeast	13%		7%	
CY 2006	9,350	18%	2,084	12%	WestCentral	4%	17%	3%	11%
					Central	31%		21%	
					EastCentral	7%		6%	
CY 2005	9,069	18%	2,211	12%	Southwest	6%		3%	
					Southeast	5%		3%	

Access to Primary Care

Data shown is for pediatricians in June 2007. 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	5,091	26,466
Number of Members with another Practice as their PMP	4,316	32,588
Percent of Children with a Pediatrician as their PMP	54%	45%

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.

Sample Size =	African-American Members			All CHIP Children		
	CY 2006	CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
<u>Physican/Primary Care</u>						
Member's PMP	65%	58%	-7%	74%	69%	-5%
Another PMP	10%	9%	-1%	12%	10%	-2%
Specialist	17%	16%	-1%	21%	19%	-2%
Clinic	22%	21%	-1%	20%	19%	-1%
Any of the Above	73%	69%	-4%	81%	76%	-5%
<u>Hospital</u>						
Emergency Room	29%	25%	-4%	35%	31%	-4%
Non-ER Outpatient	27%	24%	-3%	36%	32%	-4%
Inpatient	3%	2%	-1%	3%	2%	-1%
<u>Other Services</u>						
EPSDT	41%	36%	-5%	36%	32%	-4%
Prescription Drugs	66%	61%	-5%	74%	68%	-6%
Dental	74%	71%	-3%	73%	70%	-3%

Hispanic CHIP Members

Hispanics represented 14% of the total CHIP A population and 12% of the total CHIP C population in 2007.

Hispanic members are more highly represented in the Northwest and North Central Regions than their representation statewide.

There were 49% of Hispanic CHIP members enrolled with a pediatrician as their PMP in June 2007, which is slightly higher than the statewide average of 45% for all CHIP members.

Hispanic CHIP members differ significantly from the statewide averages with respect to the use of the following services.

- Higher usage of EPSDT services

**Exhibit IV.14
Statistics for Hispanic CHIP Members**

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	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 2007	7,134	14%	2,127	12%	Northwest	22%		20%	
					NorthCentral	28%		24%	
					Northeast	13%		12%	
CY 2006	6,616	13%	2,007	11%	WestCentral	12%	14%	10%	12%
					Central	15%		14%	
					EastCentral	5%		5%	
CY 2005	5,879	12%	1,853	10%	Southwest	3%		3%	
					Southeast	4%		3%	

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Hispanic CHIP Members	All CHIP Children
Number of Members with a Pediatrician as their PMP	3,267	26,466
Number of Members with another Practice as their PMP	3,467	32,588
Percent of Children with a Pediatrician as their PMP	49%	45%

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.

	Hispanic CHIP Members			All CHIP Children		
	5,608 CY 2006	6,418 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
<u>Physican/Primary Care</u>						
Member's PMP	77%	68%	-9%	74%	69%	-5%
Another PMP	10%	9%	-1%	12%	10%	-2%
Specialist	19%	16%	-3%	21%	19%	-2%
Clinic	20%	18%	-2%	20%	19%	-1%
Any of the Above	83%	76%	-7%	81%	76%	-5%
<u>Hospital</u>						
Emergency Room	33%	27%	-6%	35%	31%	-4%
Non-ER Outpatient	32%	27%	-5%	36%	32%	-4%
Inpatient	2%	2%	0%	3%	2%	-1%
<u>Other Services</u>						
EPSDT	51%	43%	-8%	36%	32%	-4%
Prescription Drugs	69%	61%	-8%	74%	68%	-6%
Dental	72%	69%	-3%	73%	70%	-3%

CHIP Members of Other Race/Ethnicities

CHIP members not classified as Caucasian, African-American or Hispanic represented 2% of the total CHIP A population and 3% of the total CHIP C population in 2007.

These members are uniformly distributed across the state.

There were 48% of these CHIP members enrolled with a pediatrician as their PMP in June 2007, which is slightly higher than the statewide average of 45% for all CHIP members.

CHIP members in this subcategory differ significantly from the statewide averages with respect to the use of the following services.

- Lower usage of emergency room services
- Higher usage of EPSDT services

Exhibit IV.15

Statistics for All Other CHIP Members (not Caucasian, African-American, or Hispanic)

Enrollment

Average Monthly Enrollment by Package					Average Enrollment by Region in 2007				
	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 2007	1,091	2%	441	3%	Northwest	1%		2%	
					NorthCentral	2%		2%	
					Northeast	3%		3%	
CY 2006	1,021	2%	430	2%	WestCentral	2%	2%	2%	3%
					Central	3%	2%	4%	
					EastCentral	1%		2%	
CY 2005	959	2%	390	2%	Southwest	1%		1%	
					Southeast	1%		1%	

Access to Primary Care

Data shown is for pediatricians in June 2007. Other Primary Medical Providers may provide services to children.

	Other CHIP Members	All CHIP Children
Number of Members with a Pediatrician as their PMP	601	26,466
Number of Members with another Practice as their PMP	639	32,588
Percent of Children with a Pediatrician as their PMP	48%	45%

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.

	Other CHIP Members			All CHIP Children		
	1,020 CY 2006	1,218 CY 2007	Change	52,196 CY 2006	54,091 CY 2007	Change
Physican/Primary Care						
Member's PMP	76%	67%	-9%	74%	69%	-5%
Another PMP	12%	10%	-2%	12%	10%	-2%
Specialist	19%	16%	-3%	21%	19%	-2%
Clinic	20%	15%	-5%	20%	19%	-1%
Any of the Above	81%	73%	-8%	81%	76%	-5%
Hospital						
Emergency Room	29%	24%	-5%	35%	31%	-4%
Non-ER Outpatient	32%	27%	-5%	36%	32%	-4%
Inpatient	3%	1%	-2%	3%	2%	-1%
Other Services						
EPSDT	45%	39%	-6%	36%	32%	-4%
Prescription Drugs	72%	61%	-11%	74%	68%	-6%
Dental	73%	72%	-1%	73%	70%	-3%

V. Prevalence and Utilization of Services for Children with Specific Diagnoses in Indiana's CHIP

Chapter Highlights

- According to national surveys, asthma prevalence in children has been increasing over time. In 2007, 8.4% of CHIP A members and 9.8% of CHIP C members had an asthma diagnosis. In Indiana's CHIP, it was found that African-Americans and males are most susceptible to asthma while county of residence has less affect on prevalence.
- Current prevalence rates in Indiana's CHIP show that 18.6% of CHIP A members and 15.4% of CHIP C members had a behavioral claim submitted in 2007. National studies indicate that behavioral disorders are a particular concern of children in low-income households.
- Claims submitted by Hoosier Healthwise MCOs for CHIP members in 2007 showed an obesity diagnosis for 2.5% of CHIP A members and 2.2% of CHIP C members. Studies show that minorities especially have a higher risk of becoming overweight.
- The specific conditions analyzed affect CHIP's subpopulations differently. For example, the prevalence of asthma in African-Americans is somewhat higher than that of other races. As many as 11% of African-American children enrolled in CHIP during 2007 had an asthma claim submitted. For behavioral health disorders, Caucasians were the most likely to have a claim submitted with this diagnosis (21%) in 2007.
- Utilization rates associated with children who have had recent diagnoses of asthma, behavioral disorders, or obesity are much greater than those of children without these specific diagnoses. For example, the number of prescriptions filled for CHIP members with recent asthma, behavioral disorder, or obesity diagnoses in 2007 is more than triple that of members without such diagnoses. On average, members with asthma received 4.6 prescriptions and members with behavioral disorders or obesity received 4.0 prescriptions. Only 1.1 prescriptions were filled in 2007 on behalf of members without any of these specific diagnoses.

Introduction

Children diagnosed with certain conditions such as asthma, behavioral health disorders, and obesity warrant special attention for their additional health needs. Often times, children with these chronic diseases depend on the health care service infrastructure more than the average child. Not only do they use more services and account for higher expenditures, but they are more greatly affected by decisions related to access to physicians and the cost of prescriptions.

In this section, prevalence and utilization of children with asthma, behavioral health disorders, and obesity are explored in more detail. Our sample was limited to CHIP members enrolled with an MCO for at least nine months during the year studied. Prevalence is defined as the percent of children with a special diagnosis claim or encounter during the calendar year studied. The three categories of special diagnosis claims considered are:

- (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).

Behavioral disorders include psychoses diagnoses (290.xx – 299.xx) and diagnoses not related to psychoses (300.xx – 316.xx). The former includes conditions such as schizophrenia, while the latter includes conditions such as depression and substance abuse.

Prevalence of special diagnoses for CHIP A and CHIP C are detailed separately. Where possible, statistics are also compared to prevalence rates of all U.S. children. Comparison statistics are offered for reference only. It is important to note that most national data comes from survey reports and does not directly relate to results from claims data like the Indiana results do.

Utilization statistics are shown for the sample of children in 2007 identified with or without the prevalence of the specific diagnoses studied. The utilization results for these 2007 enrollees include claims submitted on their behalf for the last three calendar years: 2005, 2006, or 2007. CHIP A and CHIP C members are combined in these analyses as no significant difference in utilization was found between the two groups. Exhibits show patterns for children with and without the identified diagnosis. Utilization statistics include: specialist visits, clinic visits, inpatient visits, non-emergency room outpatient visits, emergency room visits, and prescriptions filled. To control for differences in the enrollment figures, the utilization measure used is the number of services performed per 1,000 members (except pharmacy scripts per 100 members).

Asthma

Asthma is one of the most common chronic diseases affecting children in the United States today. Asthma attacks can often result in emergency room or hospital visits. Trends from the National Health Interview Survey (NHIS) showed increases in prevalence among children under age 18 in the 1980s and early 1990s. The percent of children reported with an asthma diagnosis increased from 3.6% in 1980 to 7.5% in 1995.¹

Due to a survey redesign, data after 1997 is not comparable to earlier data. However, most recent statistics from the NHIS show that 8.9% of children currently have asthma as of 2005. Children below 100% of the federal poverty level (FPL) were slightly more likely than children in higher income families to have asthma. In 2005, NHIS estimated that 10.6% of children below 100% of the FPL and 8.3% of children within 100 to 199% of the FPL had asthma. The NHIS identifies current prevalence rates by asking parents: "Has a doctor of other health professional EVER told you that your child has asthma?" and "Does you child still have asthma?"²

Prevalence of asthma among Indiana's CHIP enrollees is similar to national estimates. However, it is important to recognize the different definitions between the NHIS survey results and CHIP claims data. While NHIS asks whether children currently have asthma, prevalence rates reported for CHIP enrollees are determined by claims submitted showing visits to a doctor, clinic, or hospital resulting in an asthma diagnosis. If a child under age 19 was enrolled in a CHIP health plan for at least nine months in the calendar year studied and had an asthma claim during that year, then he was considered to currently have asthma. The number of children that met these criteria for asthma in 2006 and 2007 are shown in Exhibit V.1 below.

**Exhibit V.1
Prevalence of Asthma**

CHIP A

	Children with an Asthma Diagnoses	Total Sample	Percentage with Asthma Diagnosis
CY 2006	3,322	41,785	8.0%
CY 2007	3,518	41,863	8.4%

CHIP C

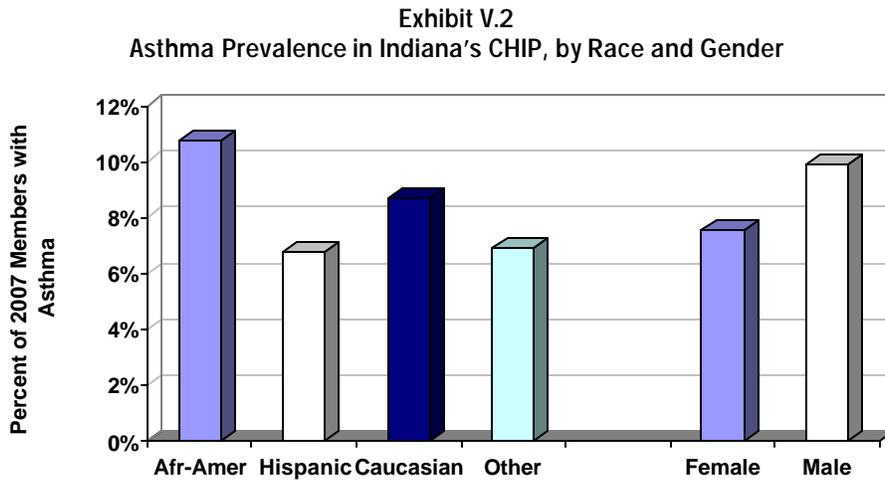
	Children with an Asthma Diagnoses	Total Sample	Percentage with Asthma Diagnosis
CY 2006	1,182	13,875	8.5%
CY 2007	1,425	14,566	9.8%

Prevalence of asthma differs by gender as well as by race. As many as 11% of African-American CHIP members had an asthma claim in 2007, while 7% of Hispanic members and 9% of Caucasian members had an asthma claim. Males were more likely than females to have had an asthma claim in 2007. Prevalence rates for males and females in CHIP were 10% and 8% respectively. National averages from the NHIS in 2005 also found that African-American children had the highest rate of asthma compared to other races. Current asthma

¹ Summary Health Statistics for U.S. Children: National Health Interview Survey 2005. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Dec. 2006

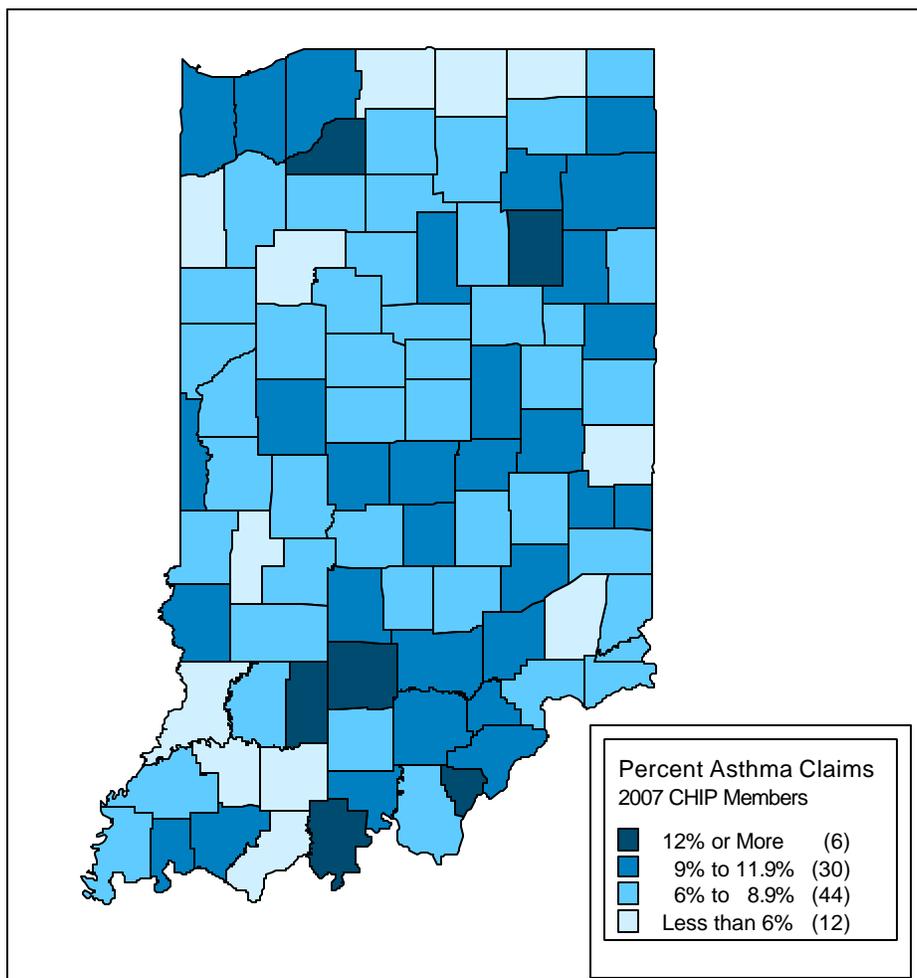
² America's Children: Key National Indicators of Well-Being, 2007.
www.childstats.gov/americaschildren

rates as of 2005 from the NHIS included: African-Americans at 13%, Hispanics at 9% and Caucasians at 8%.



It is also noteworthy to consider the prevalence of asthma by county. Environmental factors such as air pollution and secondhand smoke can increase the likelihood of asthma attacks. Exhibit V.3 displays the percent of children enrolled in a CHIP health plan for at least nine months in 2007 and who had an asthma claim in 2007.

**Exhibit V.3
Asthma Prevalence by County**



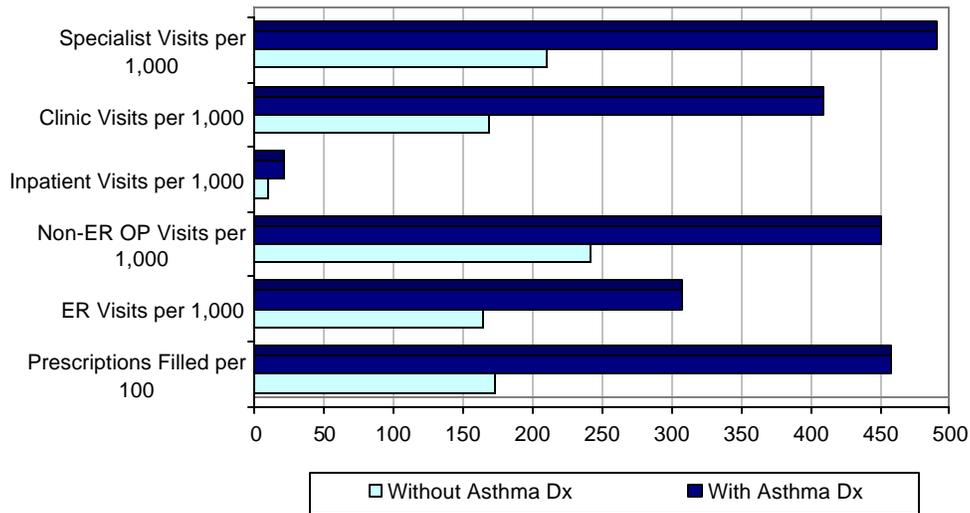
The darkest shaded counties represent counties with the highest rates of CHIP members with asthma claims. These counties are generally outside of larger cities. NHIS shows no difference nationally between central city and non-central city asthma rates in 2001 and 2002. However, by 2005, 10.3% of children in central cities had asthma while 8.4% of children living in non-central cities had asthma. Research has also shown that 80% of asthma in children is allergic asthma³. Exposure to dust mites, cockroaches, cat dander, and fungal spores may be more to blame than pollution.

In reviewing the claims submitted on behalf of the CHIP members in our sample over the last three years, 15% of them had an asthma diagnosis. Comparing those who had an asthma claim to those who did not, it is apparent that members with a recent asthma diagnosis are more likely to visit a specialist, clinic, or hospital. These members had an average of 4.6 prescriptions in 2007 while members in our sample without an asthma diagnosis had an average of 1.7 prescriptions. Clinic visits and specialty physician visits were twice as

³ The Prevalence of Asthma. Alternaria Online. University of Arizona. <http://ag.arizona.edu/PLP/alternaria/online/asthma.htm>, March, 4, 2008.

common for asthma patients as for non-asthma patients. Such visits may be prevented if regular care is given through primary care physicians.

**Exhibit V.4
Utilization Statistics in CHIP A and CHIP C
Members with and without Asthma Diagnoses**



Behavioral Health

Behavioral health conditions such as schizophrenia, depression, and substance abuse among children are a concern with health care providers because there is a linkage between children with behavioral health disorders and more physical health needs, including prescription medications. The NHIS has gathered survey data on severe emotional and behavioral difficulties among children ages 4 to 17 since 2001. There has been a slight decline in the rate of children with behavioral health difficulties since 2001. In 2005, slightly less than 5% of children were reported by a parent to have serious difficulties with emotions, concentration, behavior, or being able to get along with other people. Of these children with definite or serious difficulties, 81% were reported to have contact with a health care provider or school staff, 40% were prescribed medicine, and 47% received treatment other than medication.

Indiana's CHIP data shows a slight decline from 2006 to 2007 in the percent of children with a behavioral health claim. In 2007, 18.6% of children enrolled in CHIP A and 15.4% of those enrolled in CHIP C had received a behavioral health diagnosis in 2007. These rates may be higher than the national averages due to potential underreporting in NHIS survey data. However, NHIS also found the prevalence of children with behavioral health conditions to be higher among lower-income populations. Of children with family incomes below 100% of the FPL, 7.1% had behavioral health difficulties in 2005. As few as 3.8% of children with family incomes at 200% FPL or higher had behavioral health difficulties. The survey also found that family structure might play a role in behavioral health difficulties. Children without any parents had a behavioral health condition rate of 9.8% and children living with only a mother had a rate of 6.9%.

**Exhibit V.5
Prevalence of Behavioral Health Conditions**

CHIP A

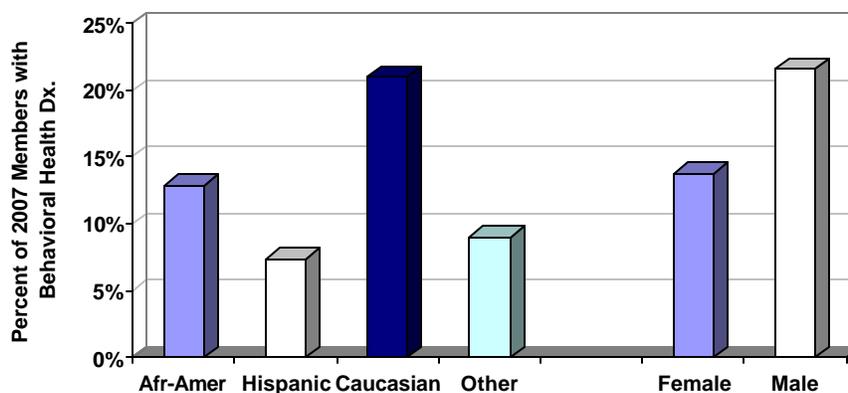
	Children with a Behavioral Health Diagnoses	Total Sample	Percentage with Behavioral Health Diagnosis
CY 2006	8,067	41,785	19.3%
CY 2007	7,798	41,863	18.6%

CHIP C

	Children with a Behavioral Health Diagnoses	Total Sample	Percentage with Behavioral Health Diagnosis
CY 2006	2,230	13,875	16.1%
CY 2007	2,245	14,566	15.4%

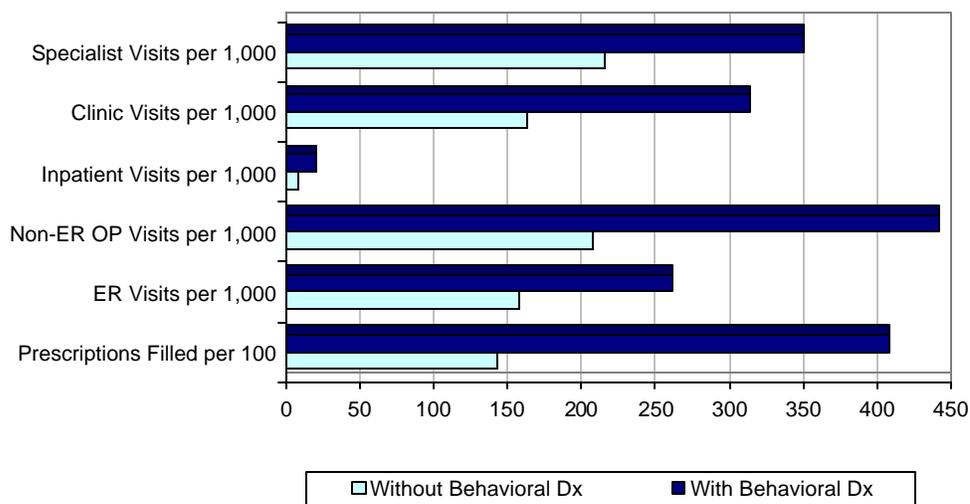
As with asthma, the percent of CHIP children with a behavioral health claim in 2007 differs by gender and by race. Unlike the differences found in asthma rates by race, Caucasian children in our sample had the greatest likelihood of having a behavioral health claim (21%). Only 7% of Hispanic members and 13% of African-American members had a behavioral health claim. Males were about 8% more likely than females to have had a behavioral health claim. The NHIS found almost no racial difference in the prevalence of behavioral difficulties when considering U.S. children of all income levels. However, survey data from the NHIS did find a greater rate of reported behavioral difficulties in male children as compared to females.

**Exhibit V.6
Behavioral Health Prevalence in Indiana's CHIP, by Race and Gender**



Similar to members with asthma, members in our sample who had a claim with a behavioral health diagnosis had greater utilization in the health care system. Hospital inpatient visits and non-emergency outpatient visits among members with behavioral disorders are more than twice that of members without behavioral disorders. Emergency room utilization and specialty physician visits are about 40% greater. Members with behavioral health disorders received an average of 4.1 prescriptions in 2007.

Exhibit V.7
Utilization Statistics in CHIP A and CHIP C
Members with and without Behavioral Health Diagnoses



Obesity

Childhood obesity is a growing health concern. Not only are overweight children more likely to become overweight adults in the future, but immediate risk factors are increased such as high blood pressure, high cholesterol, and Type 2 diabetes. Since the 1980s, there has been a steady increase in the proportion of overweight children. In the late 1970s, 5.7% of children age 6 to 17 were considered overweight. By 1990, this percent increased to 11.2% and by 2004, more than 18% of children were overweight⁴.

Most national studies use the Body Mass Index (BMI) to assess weight in relation to height for children and adolescents. Labels of “at risk of overweight” and “overweight” are generally used for children. Those with a BMI above the 95th percentile of their age group and gender are considered to be overweight.

Considering claims submitted by MCOs with an obesity diagnosis, a slight increase is seen between 2006 and 2007. A total of 2.0% of CHIP A children in our sample had an obesity claim during 2006 and 2.5% of children enrolled in 2007 had a claim that year. The proportion of obesity claims among CHIP C members is slightly less than that of CHIP A members.

⁴ Centers for Disease Control and Prevention, National Center for Health Statistics, [National Health and Nutrition Examination Survey](#).

**Exhibit V.8
Prevalence of Obesity**

CHIP A

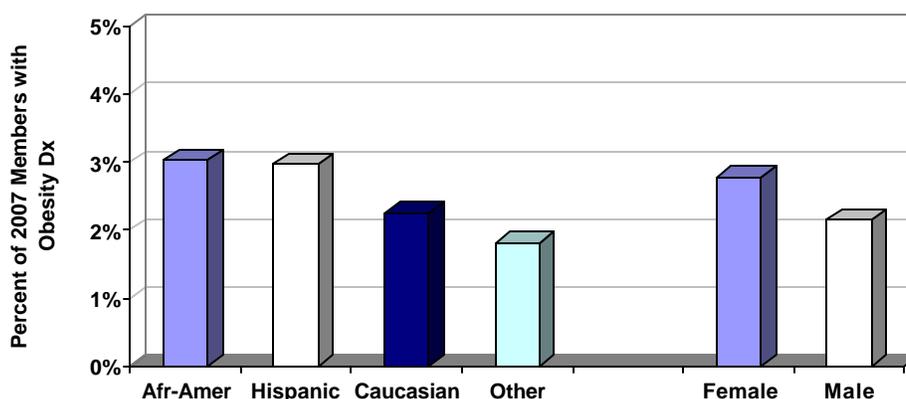
	Children with an Obesity Diagnoses	Total Sample	Percentage of Obesity Diagnosis
CY 2006	837	41,785	2.0%
CY 2007	1,062	41,863	2.5%

CHIP C

	Children with an Obesity Diagnoses	Total Sample	Percentage of Obesity Diagnosis
CY 2006	243	13,875	1.8%
CY 2007	320	14,566	2.2%

Obesity claims of children in our sample vary slightly by race. A slightly higher percentage of African-American Hispanic CHIP members had an obesity diagnosis in 2007 as compared to Caucasian members. Females and males had similar rates of obesity in 2007.

**Exhibit V.9
Obesity Prevalence in Indiana's CHIP, by Race and Gender**



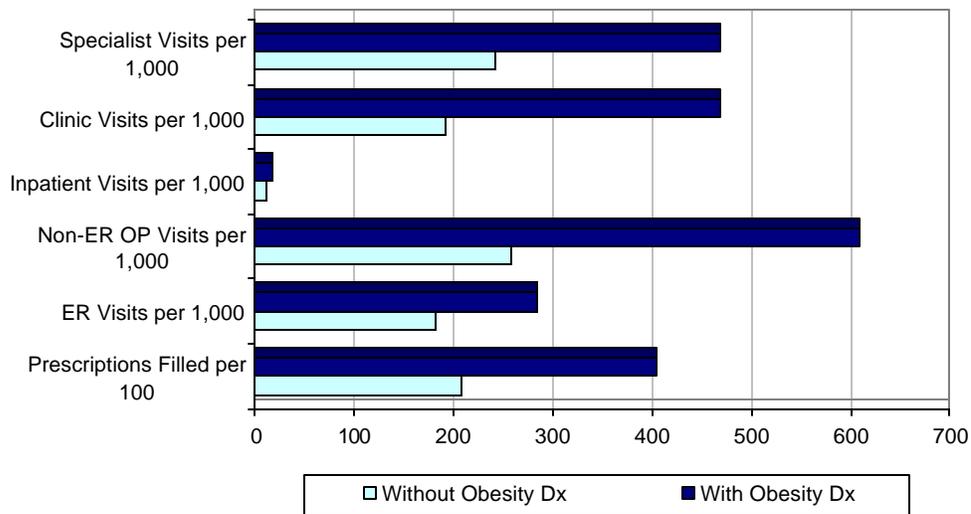
The National Health and Nutrition Examination Survey, which defined overweight children using the BMI, also found a slightly higher percentage of overweight African-American children. In 2004, 17% of Caucasians, 22% of African-Americans, and 20% of Mexican-Americans age 6 to 17 were considered overweight. The survey also reported that 17% of females and 19% of males age 6 to 17 were overweight in 2004.

Burns & Associates attributes the large discrepancy of our findings for obesity prevalence in Indiana's CHIP population due to two factors. One is that the national survey identified children obese and overweight. Because B&A was limited to claims data in the Indiana CHIP sample, the diagnosis used to identify obesity on the claims are used to define obesity more so than just overweight. We found this same discrepancy in the findings between the Indiana claims data and the national survey in last year's review as well.

For the members in our sample, 4.5% of the claims submitted on their behalf had an obesity diagnosis present. This implies that CHIP members who are obese are disproportionate users of services. Members with an obesity diagnosis had the highest rates of 2007

outpatient utilization and clinic utilization among any group considered. In 2007, there were about 600 outpatient visits per 1,000 members with an obesity diagnosis and 470 clinic visits per 1,000 members. Like members with asthma and behavioral health disorders, those with obesity had high health services usage and had especially high numbers of pharmacy claims. On average, members with a recent obesity claim received 4.0 prescriptions in 2007.

Exhibit V.10
Utilization Statistics in CHIP A and CHIP C
Members with and without Obesity Diagnoses



VI. Comparisons to National Benchmarks

Chapter Highlights

- Indiana's MCOs were compared against each other, the OMPP's target rates, and the national average rates reported for the Health Plan Employer Data and Information Set (HEDIS) measures for Medicaid health plans. These measures report the percentage of children receiving a specific service or treatment. Results for each measure showed the following:

	Met OMPP Target?		Met Nat'l Average?	
	MHS	MDwise	MHS	MDwise
Childhood Immunization Status	No	Yes	No	Yes
Adolescent Immunization Status	No	Yes	No	No
Treatment for Upper Respiratory Infection	Yes	No	Yes	Yes
Testing for Strep Throat	No	Yes	No	Yes
Appropriate Meds for People with Asthma	Yes	Yes	Yes	No
Infants' Access to PCPs	No	Yes	Yes	Yes
Access to PCPs- 25 months to 6 years	No	No	Yes	Yes
Access to PCPs- 7 to 11 years	No	No	No	Yes
Access to PCPs- 12 to 19 years	No	No	Yes	Yes
Well Child Visits- First 15 Months of Life	Yes	Yes	Yes	No
Well Child Visit- 3rd through 6th Years	No	Yes	Yes	No
Adolescent Well-Care Visit	Yes	Yes	No	No

- Indiana's MCOs contracted with a survey administrator in 2007 to survey the parents of children in Hoosier Healthwise using a standardized survey tool used by Medicaid health plans nationwide. Across nine composite satisfaction measures, Indiana's MCO rates were at or near (some slightly higher, some slightly lower) the national averages. The results from MHS and MDwise were also similar when compared to each other.
- Disparities studied in the access to care across race/ethnicities found that African-American children in Indiana's CHIP were less likely to have seen their PMP than other African-American children reported nationally. Indiana's CHIP members also had lower dental utilization across all race/ethnicities than what was reported nationally, yet emergency room usage was higher in Indiana than the national study. Some of these results may not be as significant as the data implicitly shows due to the construct of the national survey versus the data collection completed for this evaluation. However, the differences cited are significant enough to merit further evaluation within Indiana's CHIP.

Introduction

There are a number of national data sources which states can use to measure against with respect to the access, utilization, and quality of services they provide to children. Some capture national data with respect to children in Medicaid and SCHIP programs in particular while others measure findings for children across other dimensions (e.g. race/ethnicity, family economic status, or geographic location). There are no national sources with meaningful samples that capture CHIP-specific data. However CHIP children, particularly those enrolled through Medicaid expansion program, are often included in findings reported for state Medicaid programs.

Burns & Associates (B&A) used three nationally-recognized sources to measure the access, utilization and quality of services delivered to Indiana's CHIP members against children nationally. These include:

- (1) The National Committee for Quality Assurance's (NCQA) HEDIS measures^{®1}. The Health Plan Employer Data and Information Set, better known as HEDIS, is the most widely used set of performance measures in the health care industry. The NCQA collects data from both private sector and Medicaid health plans on a variety of measures on an annual basis. For each measure, Medicaid agencies are able to compare their results against national benchmarks reported by other Medicaid health plans. The method of collecting HEDIS data is highly regulated by NCQA-certified firms to ensure data integrity. Indiana required all of its Medicaid MCOs to collect HEDIS results on specific HEDIS measures in 2007.
- (2) The Agency for Healthcare Research and Quality's Consumer Assessment of Health Plans (CAHPS)^{®2} Medicaid Child Member Satisfaction Survey. This survey is administered by mail and by phone on an annual basis by a number of Medicaid agencies and their health plans to determine members' satisfaction (by surveying their parents) with their medical providers and their health plan. Indiana required its Medicaid MCOs to administer the CAHPS survey in 2007. Each MCO used the same survey instrument and survey administrator to assure data integrity across plans.
- (3) The National Survey of Children's Health was a telephone survey in 2003-2004 of a random sample of parents and guardians of children ages 0 to 17. There were 102,353 respondents. Forty measures of medical status, access to care, and use of services were analyzed. A statistically significant sample of different race/ethnicity populations was surveyed in order to analyze potential disparities in health care among children. An article by Flores and Tomany-Korman was written for the journal *Pediatrics* that analyzed the disparities measured from this survey.³ B&A compared Indiana CHIP utilization results across race/ethnicities against the national findings from the *Pediatrics* article.

The results of how Indiana's Hoosier Healthwise program (including CHIP) compared to national benchmarks is discussed below.

¹ HEDIS is a registered trademark of the National Committee for Quality Assurance

² CAHPS is a registered trademark of the Agency for Healthcare Research and Quality

³ Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children, Glenn Flores and Sandra C. Tomany-Korman, *Pediatrics* 2008; 121; e286-e298; originally published online January 14, 2008. <http://www.pediatrics.org/cgi/content/full/121/2/e286>

HEDIS Measures

Indiana's OMPP requires each of its MCOs to report on 66 indicators across 21 unique HEDIS measures. The NCQA, which developed the HEDIS measures, provides a definition for each measure which all health plans follow when reporting their data. Many measures are consistent across years to allow for longitudinal studies.

B&A reviewed the results tabulated by the HEDIS auditors for each MCO. Because Anthem was a newly-contracted MCO in 2007, there is no data to report on Anthem until next year. Therefore, this section reports findings for MDwise and MHS. The findings for each MCO are compared against each other as well as their own performance across two years of data. HEDIS 2007 tabulated findings of access and utilization from 2006; likewise, HEDIS 2006 tabulated findings of access and utilization from 2005. Additionally, Indiana's MCOs were compared against targets set by the OMPP as well as results from health plans nationally—both Medicaid-only health plans and commercial health plans. The national results reflect the average across all submissions by health plans to the NCQA for HEDIS 2007 and 2006.

Nine of the measures are specific to children's access and utilization, including:

- (1) Childhood Immunization Status
- (2) Adolescent Immunization Status
- (3) Appropriate Treatment for Children with Upper Respiratory Infection
- (4) Appropriate Testing for Children with Pharyngitis (strep throat)
- (5) Use of Appropriate Medications for People with Asthma
- (6) Children's Access to Primary Care Practitioners
- (7) Well Child Visit in the First 15 Months of Life
- (8) Well Child Visit in the 3rd through 6th Years of Life
- (9) Adolescent Well-Care Visit

Immunization Measures

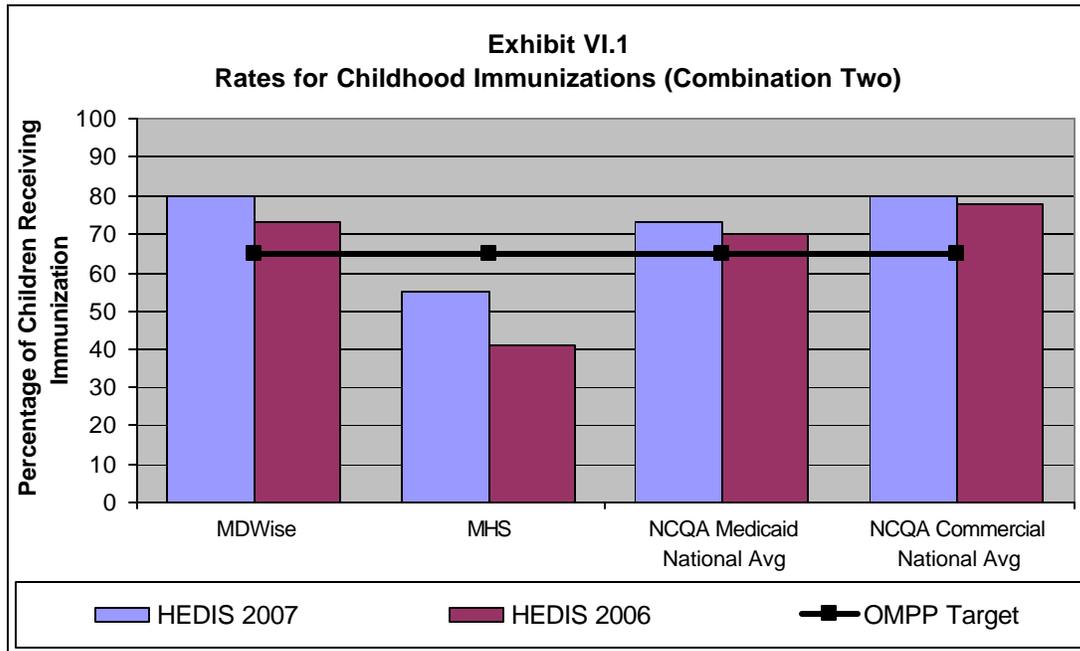
The HEDIS measures for immunizations report on each immunization separately as well as a “combination” measure which encompasses administering multiple immunizations. The Combination Two measure reported on below includes:

- | | |
|-----------------------------------|----------------------------|
| Four doses of diphtheria-tetanus | Three doses of influenza |
| Three doses of polio | Three doses of Hepatitis B |
| One dose of measles-mumps-rubella | One dose of chicken pox |

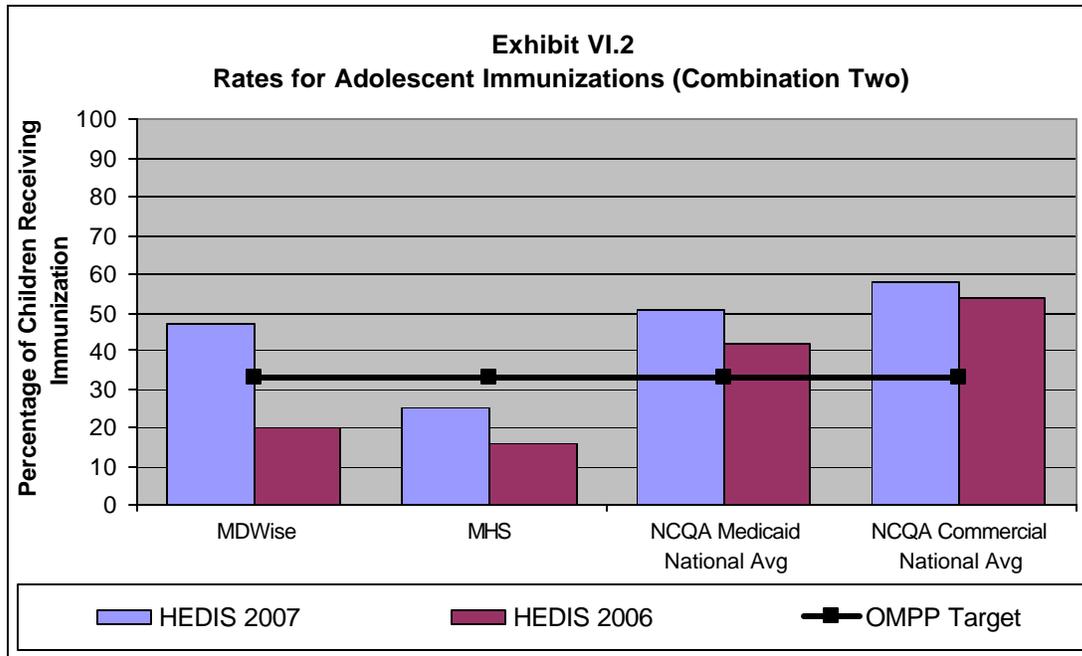
Separate measures are collected depending upon the child’s age. The Childhood Immunization measure includes children who turned age two during the measurement year who were enrolled for the 12 months prior to their second birthday. The Adolescent Immunization measure includes children who turned age 13 during the measurement year.

Exhibit VI.1 below shows the results for the younger children. MDwise exceeded the OMPP target and the national average Medicaid target in both 2006 and 2007. MHS showed improvement (from 41% in 2006 to 55% in 2007) but still did not meet OMPP’s target of 65%.

After the results of the HEDIS 2005 study, both MDwise and MHS designed quality improvement projects to improve immunization rates. These efforts appear to have had success for MDwise, but MHS needs to continue targeted monitoring of this measure.



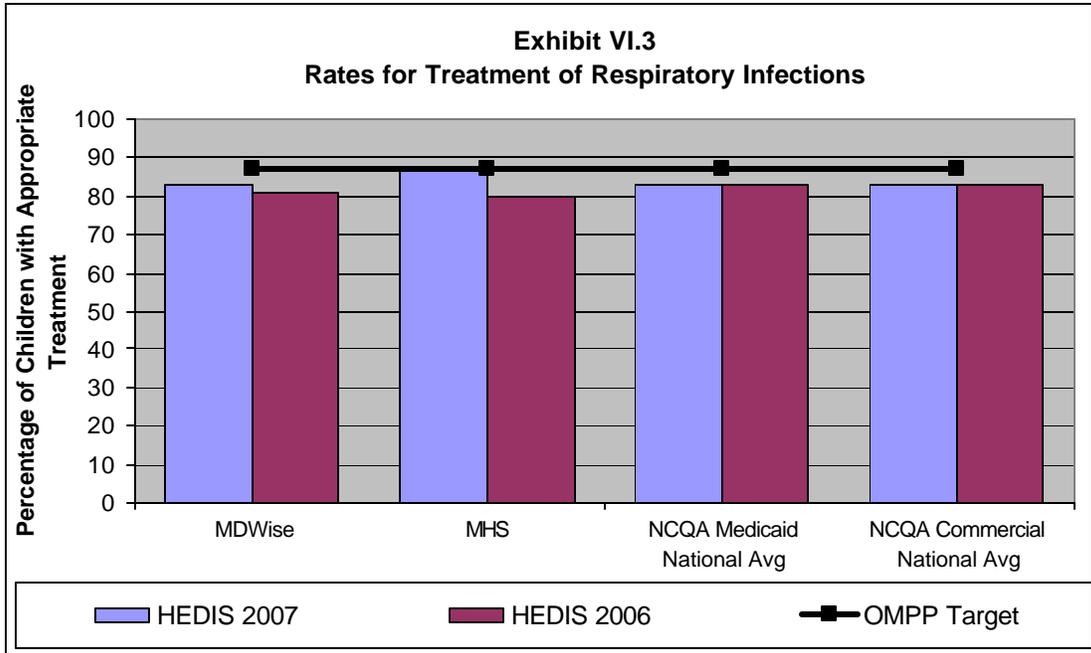
The results for adolescent immunizations follow a similar pattern as those for child immunizations. Both MDwise and MHS were far below the OMPP target in HEDIS 2006, but MDwise showed significant improvement in HEDIS 2007, surpassing the OMPP target of 33% and coming close to the national Medicaid average of 51%. MHS, however, showed only moderate improvement (25%) and remained below the OMPP target.



Appropriate Treatment for Upper Respiratory Infection

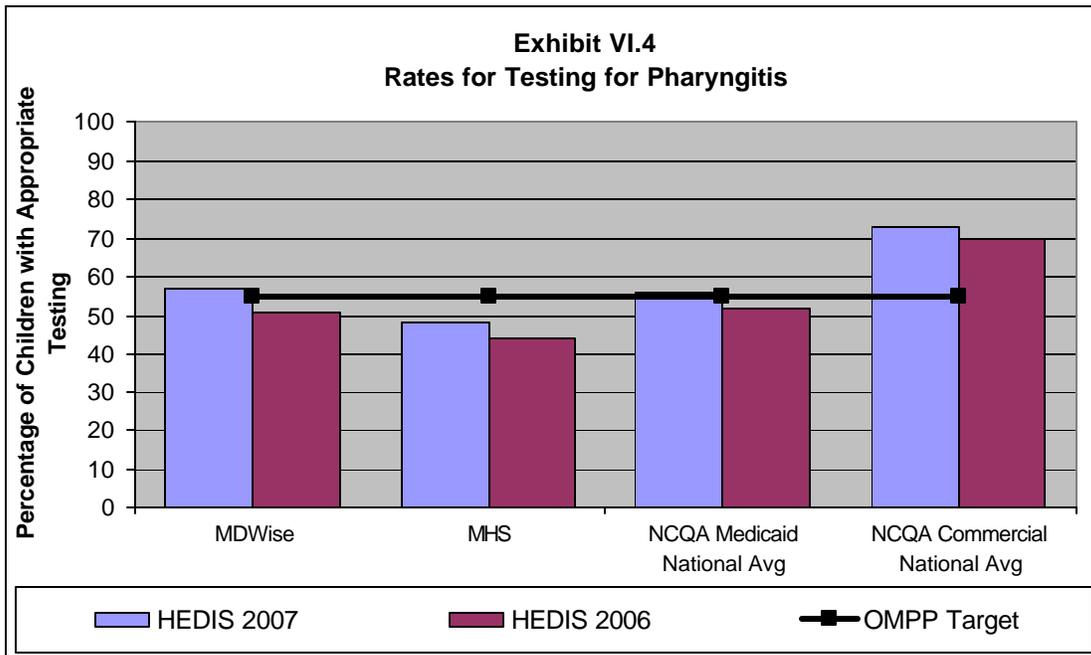
The upper respiratory infection measure reports the percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable, because if an antibiotic was not given it means that the infection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

MHS's measure of 87% in HEDIS 2007 exceeded both the NCQA Medicaid and commercial plan mean scores and was the same as OMPP's target (see Exhibit VI.3 on the next page). MDwise improved its score slightly from 2006 to 2007 but was still slightly below the OMPP target.



Appropriate Testing for Children with Pharyngitis (strep throat)

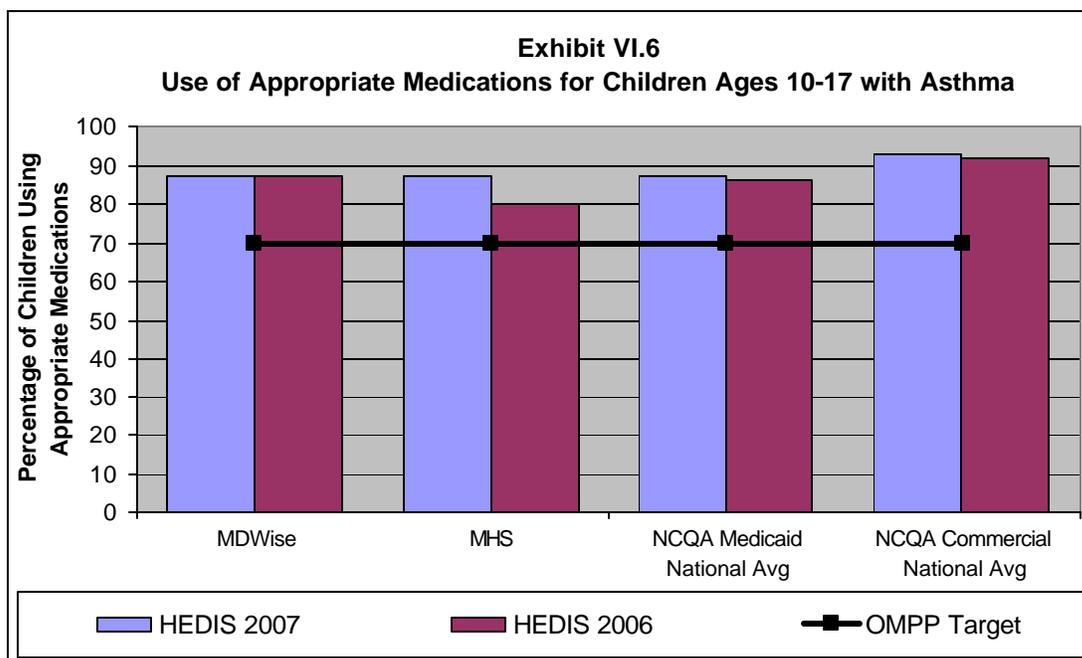
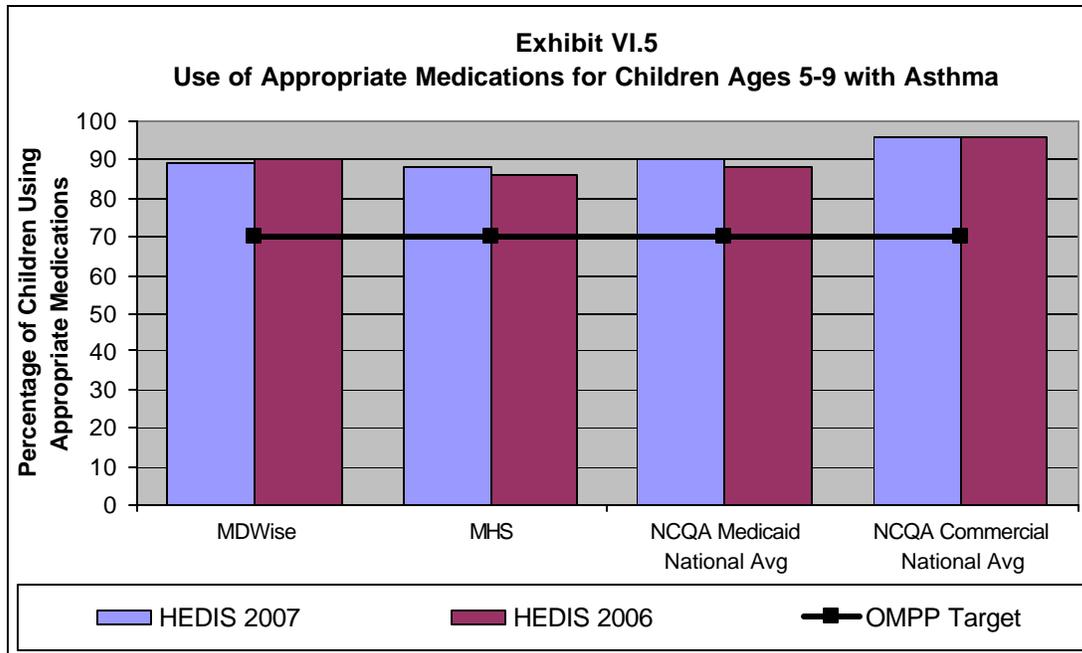
The pharyngitis measure reports on the percentage of children between the ages of two and 18 who were diagnosed with strep throat, were prescribed an antibiotic, and who received a Group A streptococcus test. A higher rating is more favorable since it indicates better testing for those diagnosed with strep throat. Both MCOs improved their scores from 2006 to 2007, and MDWise met the OMPP target of 55% with MHS slightly below.



Use of Appropriate Medications for People with Asthma

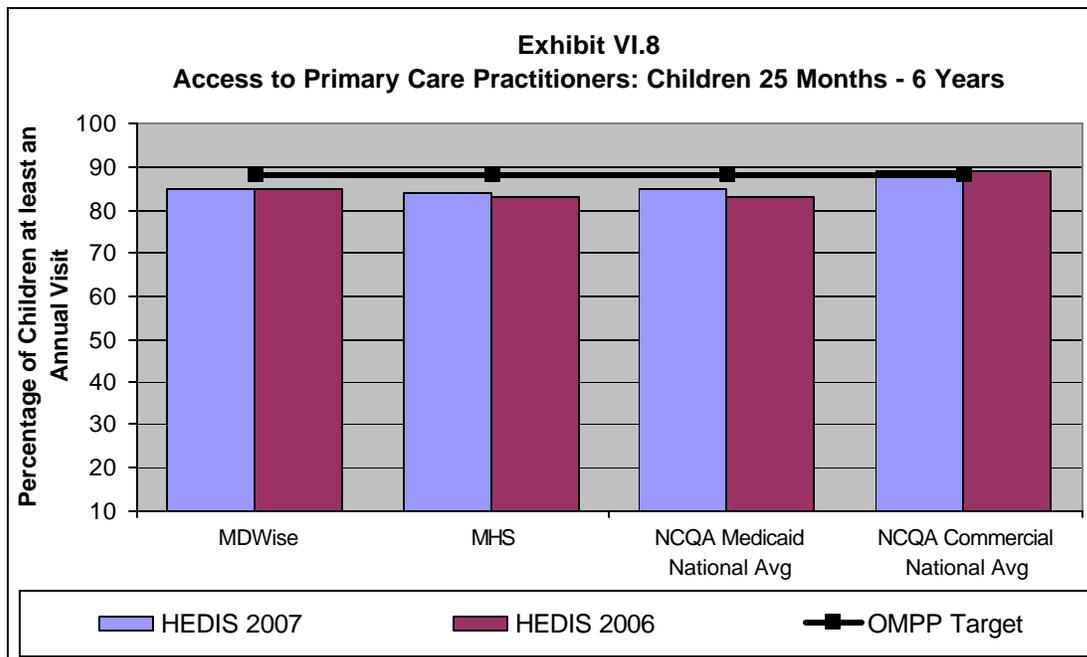
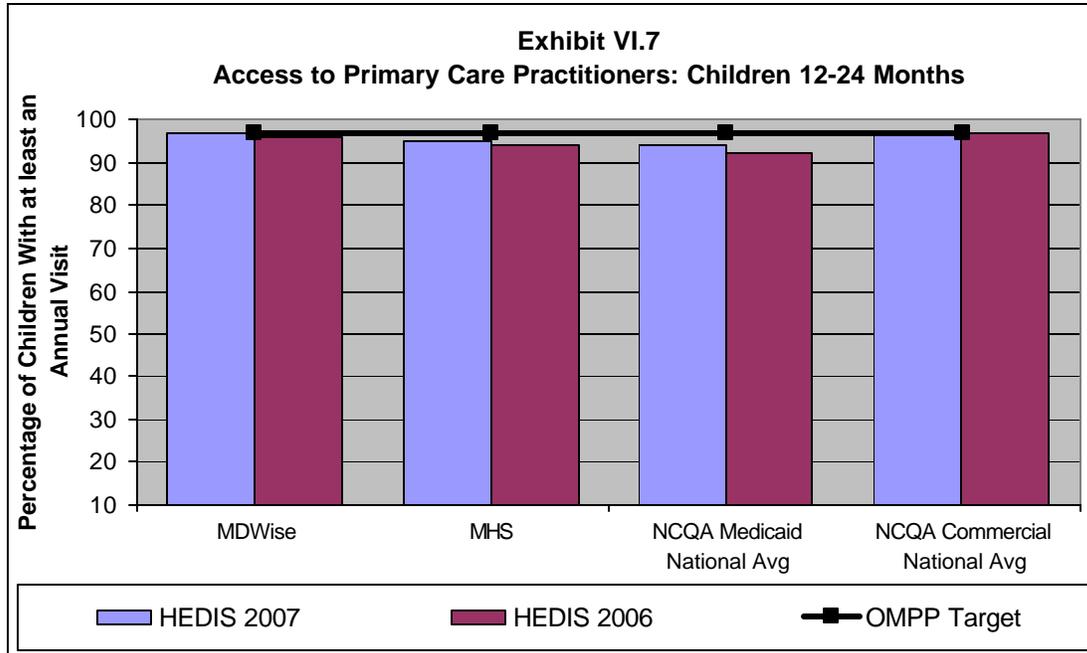
This HEDIS measure reports on the percentage of members who were identified as having persistent asthma and who were prescribed appropriate medication. The measure is subdivided into population groups.

Both MDwise and MHS reported results at or near the NCQA Medicaid average scores of 90% for ages 5-9 and 87% for ages 10-17. Additionally, both MCOs exceeded the OMPP target in HEDIS 2006 and 2007.

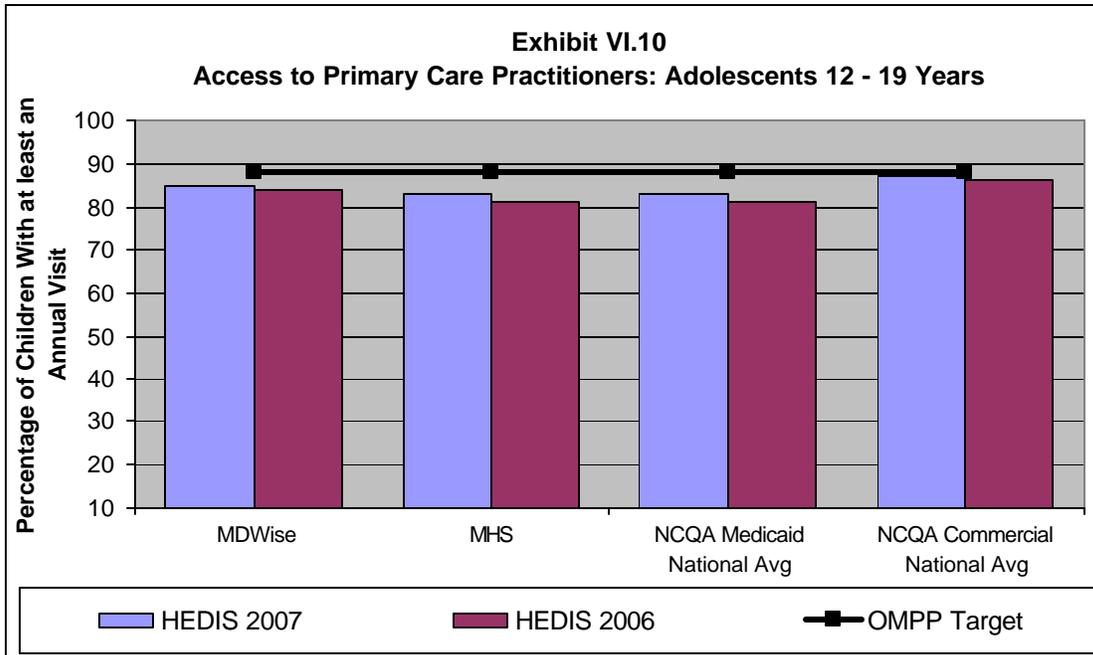
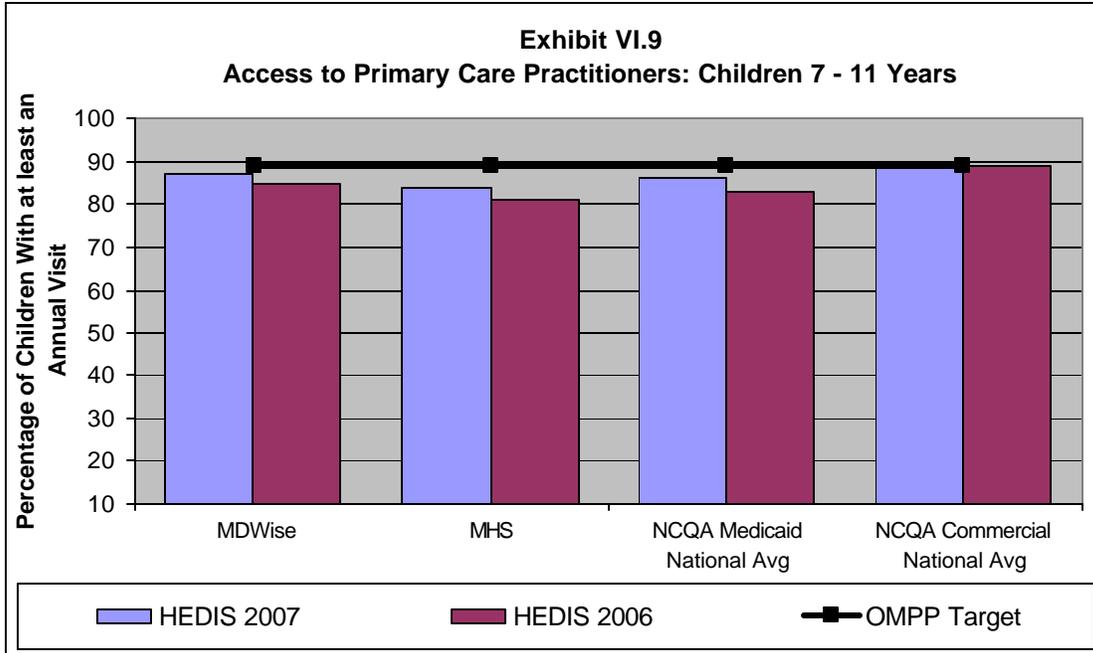


Children's Access to Primary Care Practitioners

This measure reports the percentage of children who had a visit with their primary care practitioner (called PMPs in Indiana) in the measurement year. Separate measures are conducted for four age groups: 12-24 months, 25 months-6 years, 7-11 years, and 12-19 years. The OMPP set their targets at the NCQA commercial averages and both MDwise and MHS met this threshold for children ages 12-24 months. Both MCOs were slightly below the target for children ages 25 months to six years but were at the national Medicaid average of 85%.



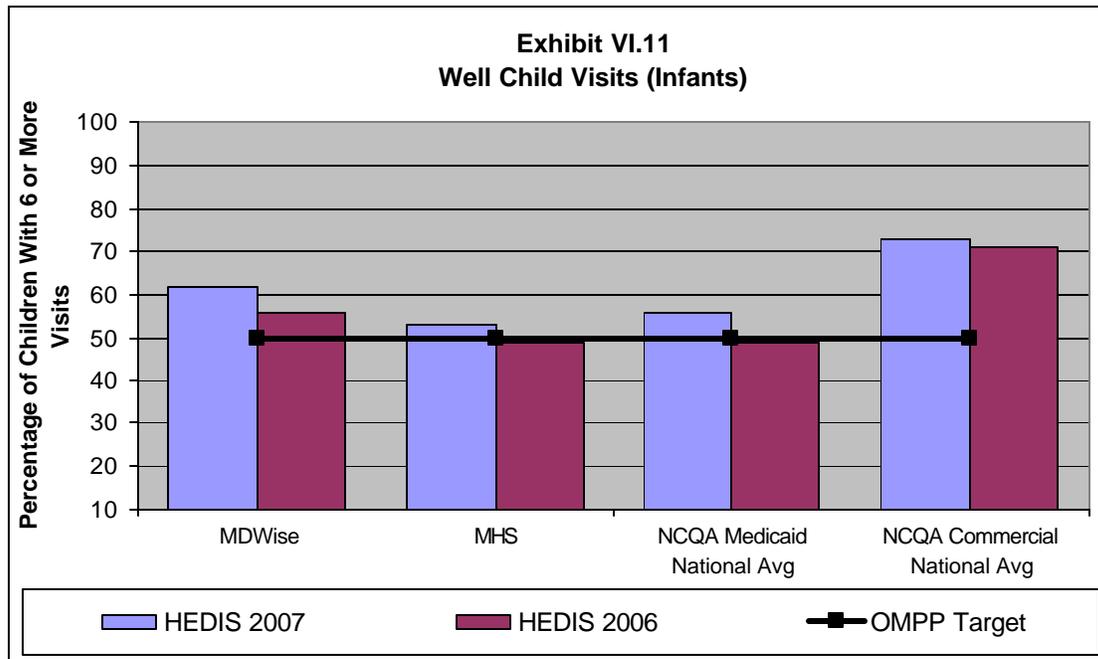
For children in the ages 7-11 year category and 12-19 year category, MDwise and MHS reported scores at or near the NCQA Medicaid average. The MCOs improved their scores slightly from 2006 to 2007 as did Medicaid health plans nationwide. The MCOs' scores were slightly lower than OMPP's targets—for ages 7-11, 89%; for ages 12-19, 88%.



Well Child Visits in the First 15 Months of Life

This measure reports the percentage of children who turned 15 months old during the measurement year and received well child visits with a primary care practitioner in their first 15 months of life. A separate percentage is computed for the number of actual visits. The exhibit below compares Indiana's MCOs to the national median for the percentage of children with six or more visits.

MDwise and MHS met the OMPP target of 50% of children receiving six or more visits in both HEDIS 2006 and HEDIS 2007. MDwise's score of 62% exceeded the national NCOA Medicaid average of 56% in 2007 while MHS was slightly below this average at 53%.

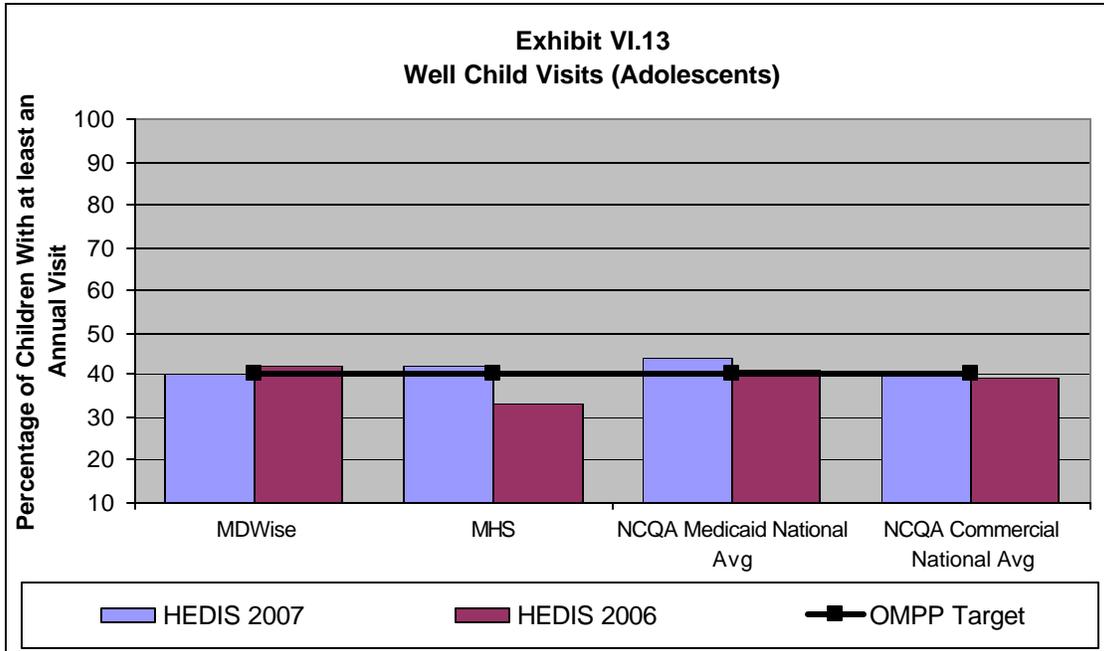
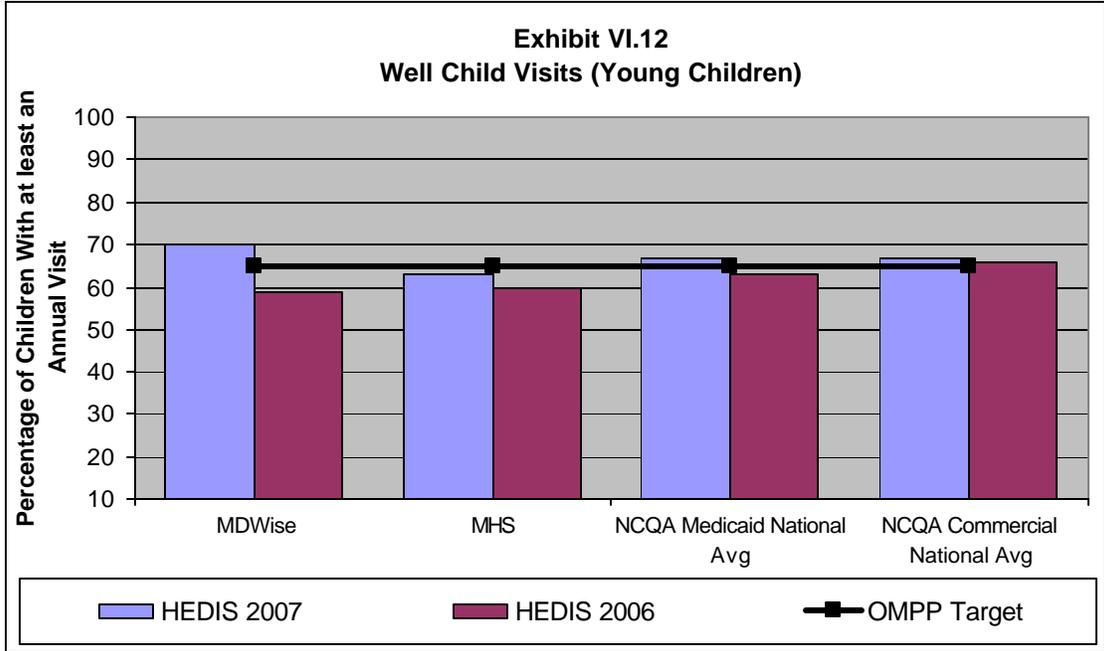


Well Child Visits (Young Children and Adolescents)

Separate ratings are measured for the percentage of children that had one or more well child visits during the measurement year for two age groups—children in their 3rd through 6th years of life and adolescents aged 12 to 21 years. For the adolescents, a visit to an OB/GYN also counts as a well child visit.

Both MDwise and MHS improved their scores from HEDIS 2006 to HEDIS 2007 in the young children measure. MDwise's score of 70% exceeded both the national NCOA Medicaid and commercial plan averages as well as the OMPP target of 65%. MHS was slightly below these targets at 63%.

For adolescents, both MCOs met the OMPP target of 40% and were very similar to other Medicaid and commercial health plans nationally. However, both MCOs reported slightly lower scores in HEDIS 2007 than HEDIS 2006.



CAHPS Medicaid Child Member Satisfaction Survey

Both MDwise and MHS reported their results from the Medicaid Child satisfaction survey conducted in 2007. [Because Anthem was a new MCO in 2007, they were not required to conduct a member satisfaction survey in 2007.] The results shown in Exhibits VI.14 and VI.15 on the following pages reflect results from parents of all children in Hoosier Healthwise and are not CHIP-specific.

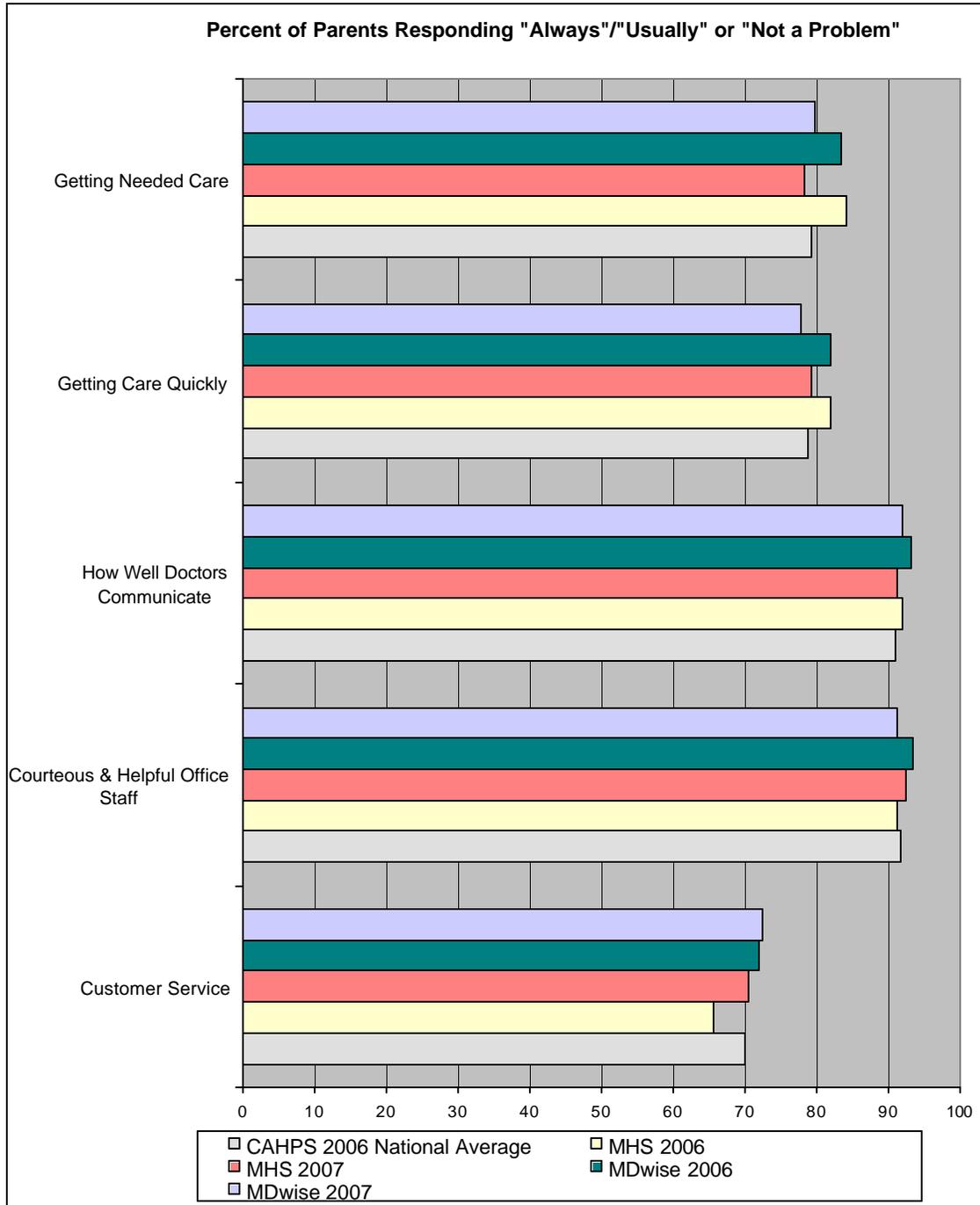
The CAHPS Medicaid Child Member survey tool is designed specifically for the target population. The same tool was used in both 2006 and 2007 by the same contracted CAHPS survey vendor. Therefore, results can be compared across years and across MCOs. The survey was administered in the months of January through May of each year.

For MHS, 454 responses were collected in 2007 (20% response rate) versus 368 responses in 2006 (19% response rate). For MDwise, 334 responses were collected in 2007 (21% response rate) versus 606 responses in 2006 (30% response rate).

The 76-question CAHPS survey asks a variety of questions related to the member's satisfaction with quality and accessibility of the care they are receiving from the health plan. The Myers Group, the survey administrator for both MCOs, summarized the responses from multiple questions in the survey using a CAHPS protocol to develop overall composite ratings for each MCO. The composite ratings are compared across survey years for both MCOs and against the CAHPS 2006 national averages (most recent year available). The summary of findings showed:

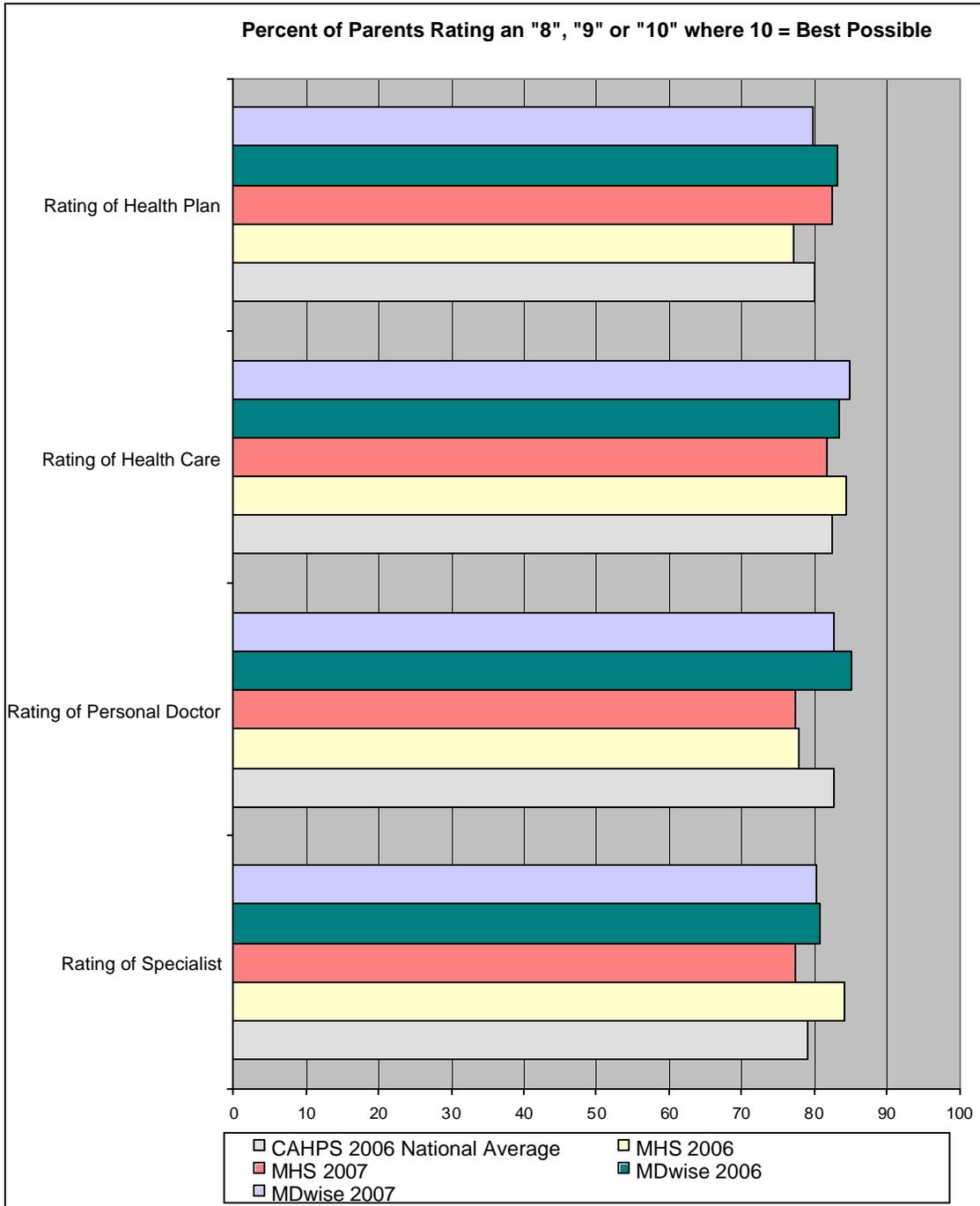
- On the five indicators related to accessing care, both MDwise and MHS were at or near the CAHPS national averages (see Exhibit VI.14 on the next page). Neither MCO had significant differences in their scores on each indicator between the 2006 and 2007 surveys.
- On the four rating indicators (personal doctor, specialist, health care, and health plan), MHS and MDwise had three ratings that were slightly lower in 2007 than 2006. However, MDwise met or exceeded the national averages on all four ratings whereas MHS was higher than the national average on rating of health plan but slightly lower on the other three ratings. (See Exhibit VI.15 on page VI-14.)
- The two MCOs scored relatively similar to each other on all nine indicators.

Exhibit VI.14
Survey Results from Parents of Hoosier Healthwise Children
Composite Scores



Getting Needed Care- percent indicating "not a problem" regard attempt to get care for their child.
Getting Care Quickly- percent stating "always" or "usually" get care in a reasonable time.
How Well Doctors Communicate- percent stating doctors "always" or "usually" listen, explain, spend enough time with, and show respect for members.
Courteous and Helpful Office Staff- percent stating office staff "always" or "usually" courteous.
Customer Service- percent indicating "not a problem" regarding ability to find/understand information.

**Exhibit VI.15
Survey Results from Parents of Hoosier Healthwise Children
Composite Scores**



Disparities in Accessing Health Care by Race/Ethnicity

Chapter III of this report discussed differences in the utilization of services among Caucasian, African-American, Hispanic and other racial minorities within Indiana's CHIP. [Refer back to Exhibits III. 11 and III. 12] It was found that African-American children were much less likely to have seen their PMP than other CHIP children. Yet Caucasian children were most likely to have had an ER visit or to have had a prescription drug filled of any of the sub-populations. There was little difference in preventive dental utilization across race/ethnicity in Indiana's CHIP.

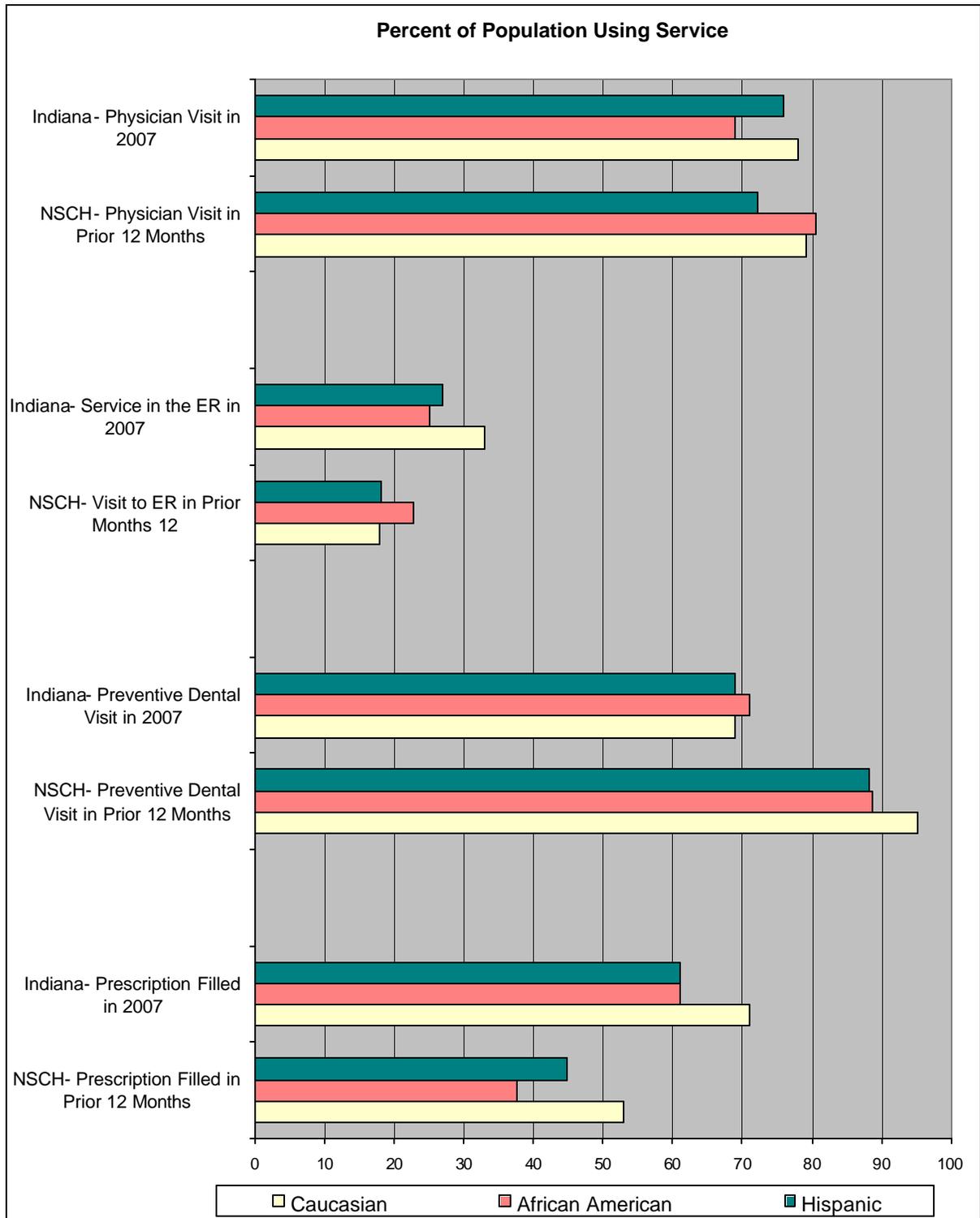
These findings are compared to national results compiled by Flores and Tomany-Korman from their article published in *Pediatrics* earlier this year. Flores and Tomany-Korman studied results from the National Survey of Children's Health (NSCH) conducted in 2003-2004. It should be noted that B&A compiled its findings using actual CHIP claims data submitted by MCOs whereas the NSCH was a telephone survey of parents. Also, B&A only looked at utilization within a calendar year, but the national survey inquired about utilization "in the last year", indicating that the national access results may be higher than what B&A reported because it crossed calendar years.

Questions from the national survey regarding access to a primary care doctor, emergency room visits, preventive dental visits, and pharmacy usage were compared to Indiana's CHIP utilization in 2007. The results are shown on the next page in Exhibit VI.16. B&A's comparison showed that:

- For physician visits, the percent of children accessing PMPs in Indiana for Caucasians and Hispanics were similar to those reported in the national survey. However, Indiana's African-American population had significantly lower PMP access than other children in Indiana, yet had a slightly higher access to their PMPs than other children in the national study.
- Emergency room usage reported was much higher for Indiana than the national usage reported, but this may be attributable to the way it is reported to the OMPP more than anything else.⁴
- All populations studied (Caucasians, African-Americans, Hispanics) reported higher utilization of preventive dental visits nationally than in Indiana. Whereas there was little difference among race/ethnicity in Indiana for dental visits, Caucasian children were more likely than others to have had preventive dental visits in the national survey.
- Although 60% of African-American and Hispanic children in Indiana's CHIP had a prescription script in 2007, this was significantly higher than the national average (near 40%). This same trend also held true for Caucasian children, but at higher percentages (70% and 50%, respectively).

⁴ A specific recommendation to this effect is discussed in Chapter IX.

**Exhibit VI.16
Comparison of Utilization by Race/Ethnicity
Indiana CHIP vs. National Findings**



VII. MCO Services and Initiatives for Hoosier Healthwise Children

This chapter highlights Hoosier Healthwise MCO services and initiatives specific to children for the contract year 2007. The following are highlights of MCO contract requirements for children's services:

- School Based Health Care
- Asthma Disease Management Programs
- Services for Children with Special Health Care Needs
- Educational Outreach
- Pay for Performance Initiatives
- Member Incentives

Summaries of MCO children's initiatives are presented below. Individual summaries of MCO initiatives by Anthem, MDwise and MHS are presented when they are distinctive from those of the other MCOs as reported. Because Anthem was established in 2007, there are not as many initiatives in place. Most of their programs will be implemented in 2008.

School Based Health Care

Beginning in 2007, expanding MCO relationships with School Based Clinics (SBCs) became a mandatory contract requirement. In response to the requirement both MDwise and MHS have robust initiatives with SBCs and school based health care providers to offer services to their enrollees. Anthem spent 2007 reaching out to school based clinics and health care staff to identify opportunities for greater collaboration.

MDwise

MDwise continued and expanded their longstanding relationship with Learning Well, a collaborative of over 100 SBCs in Marion County. Outside of Marion County, MDwise established linkages with the Indiana School Nurses Association and the Indiana Department of Education (IDOE) to develop strategies for promoting school clinics and supporting school nurses in every area of the state.

Learning Well (LW) has a special priority of identifying and promoting medical care and health promotion for asthma and diabetes. In addition to collaborating with LW on asthma and diabetes outreach, MDwise is supplying case managers to work with LW staff when special needs are identified. There are several initiatives that MDwise and LW have initiated in 2007:

- *Data Matching.* LW matches MDwise member enrollment with information in the LW Welligent system to inform MDwise when their members are accessing services through the SBCs.
- *Welligent System Access.* LW will provide MDwise health care providers access to the system applications for treatment purposes. MDwise is assuming the administrative costs for developing the interfaces between the LW SBCs and the provider network serving their members.

- *Service Provision.* MDwise reimburses SBCs for primary care, outreach and education services that are provided to their members.

MDwise has also identified several possible initiatives with the School Nursing Association and IDOE for collaboration. A representative sample includes:

- Collaborating with IDOE to develop the capability for school nurses to enter immunization information in the state immunization registry (CHIRP). This is important because there is chronic under-reporting of immunization information in Indiana which impacts HEDIS measurements. IDOE has purchased software for this capability to be implemented in 2008.
- Improving coordination for children with special needs though collaboration between school nursing staff and MDwise case managers.
- Educating schools on the Medicaid program and working to help them receive Medicaid reimbursement for rendered services.

MHS

MHS supports SBCs through their provider network. These activities include promotion of screenings at school health fairs, participation in immunization initiatives, and provision of financial and human resource underwriting to start up health care programs supported by local school systems.

A major focus of MHS's school-based initiatives center around behavioral health services:

- Centpatico Behavioral Health (CBH), the MHS Managed Behavioral Health Organization (MBHO), hired a School Based Services Administrator to provide leadership in the development and enhancement of school-based mental health initiatives and care.
- MHS with CBH conducted a school-based health care needs assessment with behavioral health providers. The purpose of the survey was to enhance their awareness of existing services, identify potential areas for development of services, and understand the current behavioral health system to establish performance measures and outcomes.
- MHS formed a SBC Advisory Council that meets weekly with MHS and CBH staff to establish and evaluate progress on priorities.
- MHS and CBH have a special initiative to identify health disparities among school-aged children in Lake, Madison and Delaware counties. This information is shared with school administrators to gain support for new school-based initiatives that target health disparities.

Asthma Disease Management Programs

The Hoosier Healthwise MCO contract requires MCOs to have Asthma Disease Management (DM) Programs. In 2005, the State of Indiana received a grant from the Centers for Health Care Strategies (CHCS) to use the Better Clinical and Administrative Program (BCAP) Quality

Framework to help Medicaid health plans integrate with the Indiana Chronic Disease Management Program. This was designed to improve the quality of health care for people living with asthma, diabetes, and congestive heart failure. CHCS and the McColl Institute for Health Care Innovation worked together with Indiana Medicaid staff, health plan leadership, and local physicians to implement a sustainable model of care for people with these three chronic conditions. This initiative is ongoing and the BCAP report has been adopted by the MCOs to track the incidence of asthma.

The MCOs have similar core program elements in their DM plans including identification of members through health risk assessment and claims data; outreach to members; stratification of risk; ongoing education; and possible case management. MHS has specific PMP networks that specialize in the treatment of asthma and related disorders. MDwise enhances its educational activities through provider outreach and education. An asthma disease manager works with clinics on sharing clinic measures and coordinating with members and their PMP. Anthem sends their PMPs quarterly member-specific reports on asthma risk stratification and co-morbidities. They also send the PMPs a monthly report on children identified as having asthma in the emergency department.

Services for Children with Special Health Care Needs

CMS requires that state Medicaid agencies have specific policies and procedure requirements in their MCO contracts for populations with special health care needs. In the 2006 External Quality Review of Indiana's Medicaid MCOs that was performed in 2007, Burns & Associates found that both of the plans reviewed—MDwise and MHS—complied with all of the requirements. In fact, we documented some of their processes as best practices, which are described below.

OMPP takes the definition of Special Health Care Needs from the American Academy of Pediatrics:

"Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

As a result of adopting this broad definition, the MCO contract requires that MCOs analyze, track and report issues related to Children with Special Health Care Needs (CSHCN) including grievance and appeals records to OMPP on a number of diagnoses. There is also a multi-layered approach to conducting risk assessments at the State level, MCO level, and provider level to ensure that children who meet this definition are identified for case management purposes. The OMPP enrollment broker performs the initial assessment of potential members to identify members with special health care needs. If a potential member completes the form, it is transmitted to the MCO upon enrollment for outreach purposes. The MCO must follow up with the member to establish a plan of care. In the event that the enrollment broker does not receive a complete health assessment from the potential member, the MCOs have mechanisms in place to perform their own risk assessments for subsequent outreach. CSHCN are also identified through contact with PMPs and analysis of claims data.

Once a member is identified as having special health care needs, their information is entered into an automated case management tracking system to ensure that service plans are

established and updated as needed. All three MCOs maintain case management tracking systems to enhance their disease management programs, care coordination, and outreach activities.

Anthem

Focusing on children with special health care needs, Anthem instituted the “CSHCN – Care Connect Program.” This initiative promotes a family-centered, culturally competent, community based program. To reduce fragmentation and improve access, the Care Connect Program is built upon the foundational tenets of Anthem’s Case Management Program which emphasizes individual care coordination, advocacy, assistance, advice and encouragement from a Nurse and/or Social Worker Case Manager. In addition to the care management component of the program, the following elements are also emphasized:

- Health education
- Local/community resource linkages
- Physician partnership
- Development of self-care management skills

MDwise

MDwise has several sources for identifying CSHCN. As a result, these sources are monitored to identify the most successful method for identifying members as well as any trends that occur regarding the source for identification. The reports are utilized to monitor the efficacy of the special needs program, monitor the case management of members with special needs, and identify opportunities for additional outreach efforts to identify members. Through their review process, MDwise learned that the health risk assessment performed by a live telephone call resulted in more members identified for special needs than other processes (i.e. welcome calls, utilization data).

An example of trend information captured from MDwise review, including school based initiatives, is that a large proportion of child and adolescent members have special needs due to behavioral health issues, particularly ADHD and Autism. In fact, 76% of members identified by MDwise through their special needs identification process for additional services were due to ADHD and Autism diagnoses.

MHS

MHS has a Connections program in which social workers place calls or make in-home visits to new members. Though this process, Connections team members identify persons with special or chronic health care needs for additional follow up to provide education and collateral materials related to their diagnosis. The following are examples of MHS’ interventions and outcomes.

Interventions

- All children with elevated lead levels are enrolled in lead case management and are followed to ensure re- testing until levels are within normal range
- Tracking of all women who report smoking in pregnancy, including motivational interviewing/education and referral to Tobacco Quit Line

- Intensive Case Management and home visits to high-risk pregnant members
- Diabetes Disease Management Program including outreach/education to all identified diabetics to ensure compliance with Comprehensive Diabetes Care in collaboration with member and primary care provider
- A Lake County Diabetes Pilot which is an intensive Disease Management program to diabetic members with recent hospital admission or ER visit directly related to diabetic ketoacidosis
- Members re-admitted to the hospital within six months receive intensive case management

Outcomes of interventions

- Increased member and provider awareness related to importance of lead testing and a 50%+ increase in the number of members tested for lead in 2007
- 40% decrease in members who report smoking during pregnancy
- 6% reduction in NICU admit rate from January 2007 through December 2007
- Reduction in the hospital readmission rate from 2% in 2006 to 1% in 2007
- 50% decrease in admissions and 30% decrease in ER utilization in the Lake County Diabetes Pilot

Educational Outreach

As part of their 2007 contract, MCOs must have educational activities and services for specific subpopulations and demonstrate how these educational interventions reduce barriers to health care and improve outcomes. All three MCOs report robust educational outreach to their membership. Examples that may be applicable to CHIP members are discussed below.

Anthem

- Anthem operates an educational support program for parents of children with special needs called ASK – About Special Kids. ASK is a “Parent to Parent” organization that works throughout Indiana to answer questions and provide support, information and resources.
- Anthem reviews member utilization data and outcomes to evaluate its health education programs and activities. Results of the annual evaluation are reported in annual program evaluations.
- Anthem obtains member feedback for the prenatal program evaluation process. Members are mailed a member satisfaction survey with return postage paid along with their post partum gift and asked to complete the evaluation based on their experience with the program.

MDwise

- MDwise partnered with the Jared Foundation and Radio Disney to promote healthy eating and exercise to children. These programs have been in place in 30 schools and 300-400 children from each school participated in contests to show how they can eat healthy and exercise more.
- The BLUEBELLE Beginnings program for pregnant members includes an attempt to contact and conduct a prenatal survey on every known pregnant member. After the survey, the member is triaged to either a MDwise Member Advocate (social workers who help with community resources) or to a medical case manager who closely work with members with high-risk pregnancy indicators. MDwise also offers an incentive to promote postpartum doctor visits.
- Pregnant members that complete a survey are sent a packet of educational materials on the importance of folic acid, location of local Women Infants and Children offices, smoking cessation resources, pregnancy booklets, and parenting tips.
- MDwise also offers programs for accessing health tips and resources designed specifically for adolescents.

MHS

- MHS' Start Smart program follows newborns in their first year of life and provides incentives for follow up visits during that time.
- MHS sponsors school art contests to raise awareness about wellness. Students use the theme of "I stay healthy by..." to create art work. Children both in and out of network are eligible; however, if an in-network child has their PMP sign their art work they get an incentive prize.
- Lead poisoning prevention includes materials for parents on the issues facing their children and foods that can fight lead poisoning. Tracking identified 97 members with elevated lead levels and MHS enrolled these members in intensive case management programs.
- Similar educational materials are also available for asthma patients. Overall rate for use of appropriate medications for people with asthma (ages 5-56) increased from 81% (2006) to 86% (2007).
- Educational programs for pregnant women include high risk OB assessments, regular OB assessments, provider follow up, home visits, and postnatal assessments.

Pay for Performance

The OMPP's 2007 Pay for Performance (P4P) Incentive Program for MCOs focused on the following indicators:

- Blood lead screening
- Prenatal and postpartum care
- Behavioral health and physical health coordination
- Childhood and adult immunizations
- Appropriate ER utilization

Outcomes for the 2007 P4P program will be evaluated in 2008.

MDwise

MDwise continued its Reach Out for Quality (ROQ) incentive program where 4% of capitation payments are withheld from the health plan's service delivery providers. The 4% withhold is earned after measurable improvements in HEDIS-based ROQ measurements are identified. The incentive program includes all of the above listed P4P targeted indicators.

Each delivery system developed individual P4P programs. Some delivery systems targeted providers while others targeted clinic staff as well. MDwise reported that most delivery systems showed steady improvement. MDwise evaluates their ROQ and P4P programs at least annually. Currently, they are considering reducing the number of measures included in the ROQ so that the delivery systems can focus on a core set of indicators that align with OMPP priorities.

MHS

MHS established a P4P Incentive Fund for its provider network which is funded by 2% of the capitation rate paid to them by the OMPP.

P4P measures used to evaluate provider performance during the calendar year 2007 include the following indicators:

- Well-child and well-care visits (HEDIS measure)
- Prenatal and postpartum visits (HEDIS measure)
- Blood lead screening (CMS standard)
- Use of Physician Extenders based upon number of MCO-assigned Covered Persons
- Adoption and use of electronic medical records and/or active participation in a health data exchange program within the first six months of a calendar year

Anthem

Anthem is pursuing P4P incentives, but as a new plan has no PMP incentives payable now. The draft 2008 physician incentive brochure is awaiting regulatory approval.

Member Incentives

Implementing member incentives is encouraged by the OMPP in the Hoosier Healthwise MCO contracts. MDwise and MHS have implemented member incentive programs for children's health including the health of the child prior to birth.

MDwise

MDwise offered a member incentive in 2007 to promote prenatal and postpartum doctor visits by offering pregnant MDwise members the BLUEBELLE Beginnings program. If a pregnant member completed eight prenatal visits and a postpartum exam with their doctor, they were eligible to receive a \$40 gift certificate. If the member was only able to make four visits and the postpartum visit, she was eligible for a \$25 gift certificate. If only the postpartum was documented, the member was eligible to receive a \$10 gift certificate.

MDwise also has an initiative to incentivize new members, including children, to see their doctor within the first 90-days of enrolling in the health plan. This incentive provides an opportunity for the PMP to identify and provide needed exams and EPSDT services and promotes the medical home concept. If the member sees their PMP within 90 days, they are eligible for a \$10 gift certificate.

MHS

MHS' current incentive program is called "Step into Wellness" which began in January 2007. This \$20 incentive encourages new members to see their PMP within the first 90 days of joining the MHS network. Members are notified of this program via the new member handbook as well as through welcome calls from the Connections team. The incentive program is also promoted on MHS' website and through quarterly newsletters. MHS also has a "Start Smart" incentive for prenatal care. If a mother made all prenatal visits, then she is eligible to receive up to a \$50 gift for her baby.

Both MCOs reported that it is too soon to fully evaluate their member incentive programs. However, both note that there appears to be mixed results on members qualifying for incentives. For example, MDwise reported that the member incentive to have a PMP visit within 90-days is currently averaging only 8% of members qualifying for the incentive. Some MDwise delivery system member incentives appear to have improved performance on well-child visit rates – most notably for HEDIS measure for well-child visits in the 3rd to 6th years of life which has been the most difficult one to improve at MDwise. MHS reports similar low percentage of participation in its member incentives. Approximately 23% of the members who received incentives were for well-child visits. Both plans are evaluating the programs to make them more robust in future years.

VIII. Expenditures in Indiana's CHIP

Chapter Highlights

- Total payments made by the State for services for children in the premium-based portion of CHIP (CHIP C) increased 11% in CY 2007. Payments for children in the no-premium portion of CHIP (CHIP A) decreased 4% in CY 2007.
- Despite the growth in CHIP C expenditures, on a per member per month (PMPM) basis, CHIP C children have cost the State 7%-20% less (federal and state funds combined) than CHIP A children in the last three years. But CHIP A children are also 20% less (federal and state funds combined) costly than children in traditional Medicaid.
- When accounting for the portion of expenses that the federal government contributes to Indiana's CHIP, the state share on a PMPM basis was \$31.23 for CHIP C and \$33.47 for CHIP A in CY 2007. This compares to \$63.43 for Medicaid children, which are higher both because they utilize more expensive services and because the federal government contributes less for this group.
- Approximately another quarter of all CHIP C expenditures are reimbursed to the state through the premiums paid by families of children in CHIP C, further reducing the per member per month payment cost.
- In CY 2005, half of all payments made for CHIP services were on a fee-for-service basis. In CY 2007, more than two-thirds of all payments were made on a capitated per member per month basis through the Risk-Based Managed Care (RBMC) delivery system. Dental services remain the largest component of expenditures that are still made on a fee-for-service basis. Other items include services covered in the initial period of enrollment before a members selects an MCO to join.

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

- (1) Services delivered by MCOs and paid by the State on a PMPM basis (also known as a capitation payment).
- (2) Services delivered on a fee-for-service, or individual claim basis. These would include services offered to CHIP members for which the MCOs are not responsible for delivering and not reflected in the capitation payment.

As Indiana's Hoosier Healthwise has moved to statewide managed care, the payments made under the CHIP have also moved more towards the capitation arrangement. In CY 2007, 67% of CHIP A expenditures and 72% of CHIP C expenditures were made under the RBMC capitation arrangement. Overall expenditures were lower in CY 2007 for CHIP A than in CY 2006 but CHIP C expenditures grew 11%.

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

	CHIP A CY05	Pct	CHIP A CY06	Pct	CHIP A CY07	Pct
Monthly Per Member Payments Made to MCOs	\$35,537,765	46%	\$50,166,511	59%	\$54,086,911	67%
Payments Made on a Per Claim Basis	\$41,274,794	54%	\$34,214,337	41%	\$26,979,603	33%
Other (PCCM Admin Fees)	\$315,253	0%	\$0	0%	\$0	0%
Total Payments	\$77,127,812	100%	\$84,380,848	100%	\$81,066,514	100%
Increase from Previous Year			9.4%		-3.9%	

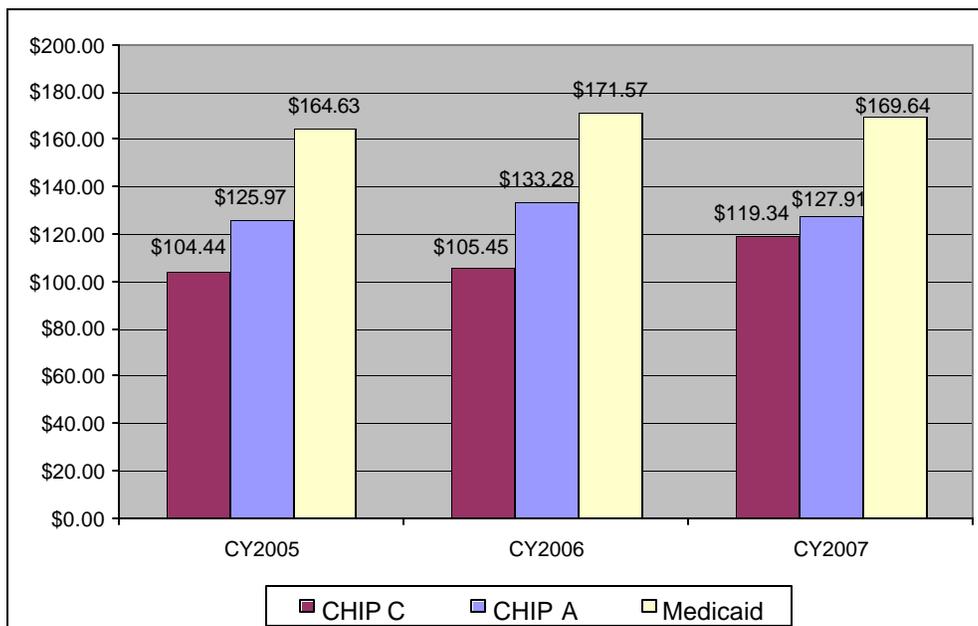
	CHIP C CY05	Pct	CHIP C CY06	Pct	CHIP C CY07	Pct
Monthly Per Member Payments Made to MCOs	\$10,878,950	48%	\$14,514,158	64%	\$18,057,733	72%
Payments Made on a Per Claim Basis	\$11,697,243	52%	\$8,224,719	36%	\$7,166,701	28%
Other (PCCM Admin Fees)	\$111,751	0%	\$0	0%	\$0	0%
Total Payments	\$22,687,944	100%	\$22,738,877	100%	\$25,224,434	100%
Increase from Previous Year			0.2%		10.9%	

As discussed in Chapter II, member month enrollment in both CHIP A and CHIP C was flat in 2007 when compared to 2006. Aggregate expenditures were also flat (-0.8% combined) even though CHIP A expenditures decreased while CHIP C expenditures decreased. Despite this, some increase in expenditures is expected for medical inflation costs.

To account for enrollment fluctuations, expenditures are often measured over time on a PMPM basis. Exhibit VIII.2 on the next page shows the changes in the PMPM cost for children in CHIP C, CHIP A, and Medicaid. What is important to note is that the PMPM cost for CHIP C (the premium portion) has always been and continues to be lower than that of CHIP A (the non-premium portion). The PMPMs for CHIP C have been between 7% and 20% lower than those for CHIP A in the last three years. But, like CHIP C, CHIP A has PMPM costs lower than those found for Medicaid children.

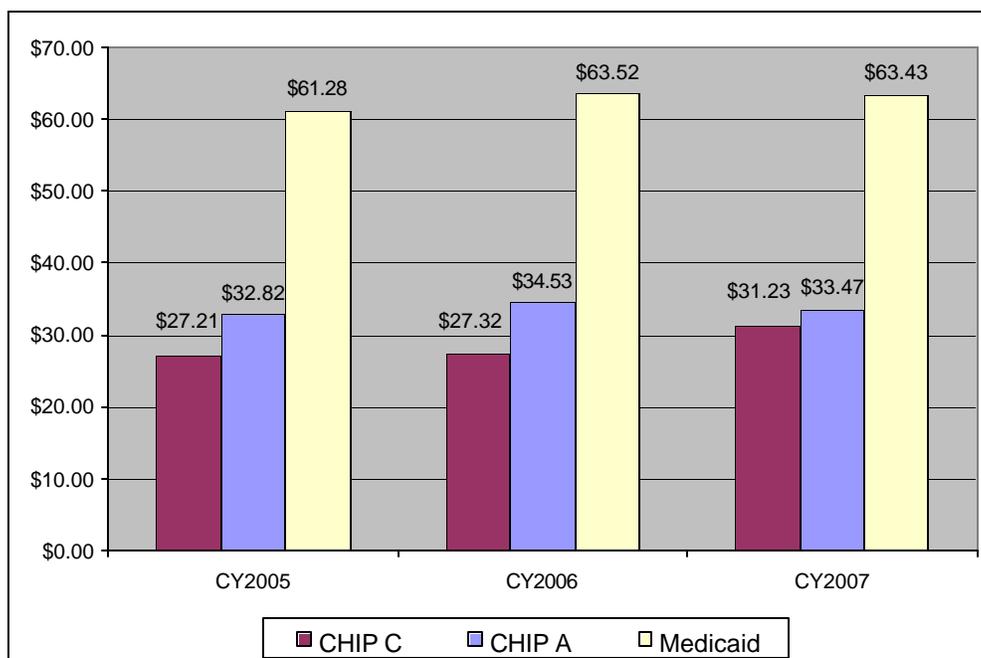
Exhibit VIII.3 shows that, after accounting for federal contributions to Indiana's CHIP, the PMPM cost to the State for CHIP C members was \$31.23 per month in 2007 and was \$33.47 per month for CHIP A members. After remaining flat for three years, the CHIP C PMPM increased 13% from 2006 to 2007. However, higher premiums charged starting in February 2006 have brought in additional funds to offset the CHIP C program. The higher match rate for CHIP (74 cents of every dollar spent by the state) compared to Medicaid (63 cents of every dollar spent by the state) also keeps CHIP state expenditures low.

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



Note that CHIP C costs are not offset by premiums paid by members.

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



Note that CHIP C costs are not offset by premiums paid by members.

IX. Recommendations to OMPP for Indiana's CHIP

Burns & Associates (B&A) has reviewed the access, quality and cost of delivering services to children in Indiana's CHIP. Specific focus this year has been to determine if there are differences in the access and use of services among subpopulations of CHIP, such as by MCO, by region, and by the member's race/ethnicity. Although some distinctions were found, our overall impression is that the CHIP is meeting its goals of providing cost-effective services to children who, in the absence of the program, would most likely be uninsured and have an unmet need. This is the 8th evaluation that the authors have completed of Indiana's CHIP. We have identified specific areas that the Office of Medicaid Policy and Planning (OMPP) may want to pursue further with the aim of continually improving the program. Since CHIP members are part of the Hoosier Healthwise program, many of these recommendations also carry over to the children in the Medicaid program as well.

Recommendation Related to Enrollment

- (1) The OMPP may want to explore further why children are disenrolling from the program. In the past two years, we have found the CHIP A disenrollment rate to be 16% and the CHIP C disenrollment rate to be 26%. A portion of this disenrollment is by design—children who turn age 19 “age out” of the program. But this is a small portion of those who disenroll each year. Disenrollment is especially important to review if the reason pertains to the proof of citizenship requirements. Indiana, like all states, had to build in additional infrastructures to meet this federal requirement. But many state Medicaid agencies are reporting that the unintended consequence of the mandate is that legal residents and citizens are finding it more difficult to reenroll in the program. It may be informative for the OMPP to conduct an analysis for a sample time period both of those that apply for CHIP and those that do not go through the redetermination process or terminate. Examining applications submitted will provide information as to why applicants do not become eligible (e.g. recently had insurance coverage, parents' income just above federal poverty limit, lack of follow-up by applicants). Examining those who recently disenrolled will assist the OMPP and MCOs in understanding if it is an administrative issue (e.g. the citizenship requirement), an outreach issue (e.g. parents are not following up at reenrollment time), or a change in family situation (e.g. family income increased or parents obtained employer-sponsored insurance for the family).

Recommendation Related to Financing

- (2) The coming year could prove to be a significant one for SCHIP at the federal level. The Indiana legislature authorized its own state program to be offered to children up to 300% of the federal poverty level, but CMS currently disallows this. That may change when it is time for Congress to establish the long-term reauthorization of SCHIP beyond March 2009. The OMPP may want to build in forecasts under different scenarios once the new allotments for each state are announced. For example, what is the incremental cost to go to 300% FPL, if allowed by law? What is the incremental cost to the existing program to expand outreach to the remaining 80,000 uninsured children in families below 200% of the FPL program?

Recommendations Related to Access

- (3) There are six counties in the state that currently have access issues for children in Hoosier Healthwise—Clinton, Elkhart, Franklin, Knox, Ohio, and Tippecanoe. All primary care doctors have panel sizes for Hoosier Healthwise at full capacity. The OMPP is encouraged to develop targeted outreach with the MCOs to persuade or provide incentives to PMPs to increase their panel slots, particularly in these areas.
- (4) Although all three MCOs have members statewide, certain MCOs are more concentrated in parts of the state and have a disproportionate share of CHIP enrollees. In these areas in particular, the OMPP should closely monitor MCOs' access to pediatricians and other PMPs. B&A identified specific counties where market share is larger for specific MCOs but they have little to no panel capacity.
 - For Anthem, which is predominant in the Southwest and Southeast regions, there are full pediatrician panels in these counties: Knox, Warrick and Clark. Anthem has no contracted pediatrician in these counties in the regions: Daviess, Dubois, Bartholemew, Jennings, Jefferson, Scott, Dearborn and Franklin.
 - For MDwise, which is predominant in the Central region, there are full pediatrician panels in Hendricks County. MDwise has no contracted pediatrician in Putnam and Shelby Counties.
 - For MHS, which is predominant in the North Central and East Central regions, there are full pediatrician panels in the following counties: Fulton, Kosciusko, and Wayne. MHS has no contracted pediatrician in these counties in the regions: Marshall, Pulaski, Cass, Miami, Henry, Fayette, and Union.
- (5) The rate of usage in hospital emergency rooms was higher than we would have expected. This was also found to be true last year as well. It is unclear from the available data whether or not the usage is truly occurring in the emergency department and whether or not these are emergencies. In 2007, 32% of CHIP C members had a service in the ER; for CHIP A, it was 30%. B&A defined this as a claim submitted by the MCOs with an ER revenue code, which may not correlate to an ER procedure, but most likely does. B&A observed that many of the ER visits did not have one of the five ER procedure codes that normally are listed on an ER claim (there was no procedure code listed). The OMPP should work closely with the MCOs to insure that this data is reported and, if it is determined that the services were not emergent, develop a performance improvement project related to educating members to divert away from the ER.

Recommendations Related to Service Utilization

- (6) Overall, statewide use of service trends were compromised this year from lack of claims reported by Anthem. When controlled by MCO, MDwise and MHS usage trends were similar from 2006 to 2007. Statewide usage went down, however, in physician-related and pharmacy service categories because Anthem's reporting on a per 1,000 member basis for these claims was much lower than the other two MCOs. The OMPP reported to B&A that corrective action has already been taken with Anthem. B&A recommends that, if not already done so, Anthem also submits claims reporting retroactively to correct baseline measures.

- (7) It is unknown whether lower-than-expected EPSDT usage reported is due to actual low utilization or improper recording of an EPSDT visit. This was also reported by B&A in last year's evaluation. In 2007, only 41% of CHIP C members studied had an EPSDT visit; for CHIP A, it was 30%. The EPSDT usage rate was higher among children age 1-6 than other age groups in 2007 (56% of CHIP members had an EPSDT visit), but there is still room for improvement. This is because the State recommends some type of EPSDT visit at 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, and 6 years of age. MDwise reported much higher EPSDT utilization for its CHIP members than the other MCOs. The OMPP may want to develop a performance improvement project around EPSDT reporting and discuss any best practices conducted at MDwise that promotes their higher utilization rates.
- (8) Visits to PMPs are near 70% for all CHIP members, but there are still opportunities for continued improvement. In particular, B&A noticed a large disparity in the percentage of African-American children visiting their PMP in 2007 (58%) versus Caucasian children (72%) and Hispanic children (68%). The MCOs also did not meet the OMPP's Access to PMP HEDIS measure targets in 2007. This is another possible performance improvement project that the OMPP can develop in conjunction with MCO best practices to outreach to children to make the initial doctor's appointment when they enroll with the MCO.
- (9) Child immunization rates have been improving over the last few years for Hoosier Healthwise children overall. MDwise met the OMPP targets for these HEDIS measures in 2007. MHS did not. (Anthem did not report HEDIS measures since they were a new MCO in 2007). Immunization rates are also a pay-for-performance measure in the current MCO contracts. B&A recommends that the OMPP analyze the results from 2007's pay-for-performance activities (which will be available in 2008) related to immunizations to determine the cost effectiveness of these measures and to identify any best practices emerging to meet immunization targets.

Recommendations Related to Quality

- (10) B&A specifically analyzed utilization patterns of CHIP children with asthma, behavioral health conditions, and obesity diagnoses. In the cases of all three diagnoses, the data showed that these children were twice as likely to use clinics, emergency rooms, inpatient hospital stays, outpatient hospital services, and prescription drugs. B&A learned from the MCOs that their disease management plans already include asthma in particular. For all three special diagnoses we analyzed, we suggest that the OMPP develop a feedback mechanism with the MCOs to ensure that the MCOs have identified the children with the special diagnoses studied so that they are currently part of either the MCOs' disease management program or special health care needs program.
- (11) Although the OMPP has set targets for HEDIS measures related to care for children, not all of these targets are at the thresholds of the national average for Medicaid plans nationwide. The OMPP should consider increasing all targets to the HEDIS national Medicaid averages where they currently do not do so over time. Ultimately, the OMPP should aim for targets that meet the HEDIS national commercial plan averages.