Indiana's Children's Health Insurance Program Annual Evaluation Report

April 1, 2006

EP&P CONSULTING, INC.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

CHAPTER I OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AT THE FEDERAL LEVEL I-1
INDIANA'S CHIP PROGRAM COMPARED TO OTHER STATES I-3
OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM I-5
HOW SERVICES ARE DELIVERED IN INDIANA'S CHIP I-7
ADMINISTRATION OF INDIANA'S CHIP I-7
ISSUES IMPACTING CHIP PROGRAMS NATIONWIDE AND IN INDIANA I-8

CHAPTER II ENROLLMENT TRENDS FOR CHILDREN IN HOOSIER HEALTHWISE

INTRODUCTION II-1
KEY FINDINGS II-1
SPECIFIC ANALYSES II-2

CHAPTER III ACCESS

INTRODUCTION III-1
SPECIFIC ANALYSES III-2

CHAPTER IV SERVICE UTILIZATION

INTRODUCTION IV-1
KEY FINDINGS IV-2
SPECIFIC ANALYSES IV-4

CHAPTER V PAYMENTS MADE FOR CHIP MEMBERS

CHAPTER VI EVALUATION OF QUALITY DATA MEASURES RELATED TO THE CHIP

INTRODUCTION VI-1
KEY FINDINGS VI-3

RESULTS FROM THE 2005 MEMBER SATISFACTION SURVEYS VI-4
RESULTS FROM THE 2005 PMP SATISFACTION SURVEY VI-10
HEDIS 2005 MEASUREMENTS VI-12
QUALITY IMPROVEMENT COMMITTEE MEETING MINUTES FOR 2005 VI-21

CHAPTER VII OVERVIEW OF FINDINGS AND RECOMMENDATIONS

KEY FINDINGS RELATED TO ENROLLMENT VII-2
KEY FINDINGS RELATED TO ACCESS VII-3
KEY FINDINGS RELATED TO SERVICE UTILIZATION VII-4
KEY FINDINGS RELATED TO PAYMENTS VII-4
KEY FINDINGS RELATED TO QUALITY VII-5
RECOMMENDATIONS FOR FURTHER RESEARCH VII-6

LISTING OF EXHIBITS

CHAPTER I

Exhibit I.1 FFY 2005 Federal Matching Rate (FMAP) for SCHIP and Medicaid in Indiana and Border States

Exhibit I.2 States with SCHIP Enrollment Growth Above 10% or 10,000 December 2003 to December 2004

Exhibit I.3 Percentage Change in SCHIP Enrollment December 2003 to December 2004

Exhibit I.4 SCHIP Premiums and Enrollment Fees as of December 2004 for Indiana and Nearby States

Exhibit I.5 National and Indiana SCHIP Program Allotment for Selected Years

Exhibit I.6 SCHIP Program Allotment and Percent Change in Allotment for Selected Years

Exhibit I.7 Anticipated SCHIP Spending and Balances for FFY2005 by State

CHAPTER II

Exhibit II.1 Health Insurance Coverage for All Children Up to Age 19 by Insurance Status, 2002-2004

Exhibit II.2 Health Insurance Coverage for Low-Income Children Up to Age 19 by Insurance Status, 2002-2004

Exhibit II.3 Total Indiana CHIP Program Enrollment

Exhibit II.4 Comparison of SCHIP Enrollment Across States for FFYs 2004 and 2005

Exhibit II.5 Age Distribution of Children Up to Age 19 by Program Type for Past Three Years

Exhibit II.6 Average Age of Enrollees by Program for Past Three Years

Exhibit II.7 Distribution of RBMC Members by MCO for Children Up to Age 19 (as of December 2005)

Exhibit II.8 Average Period of Enrollment for CHIP and Medicaid Child Members For Members that Disenrolled Before July 1, 2005

Exhibit II.9 Map of CHIP Enrollment per 1,000 Children by County (July 2004)

Exhibit II.10 Map of Medicaid Enrollment per 1,000 Children by County (July 2004)

Exhibit II.11 CHIP to Medicaid Enrollment Ratio by County (December 2005)

CHAPTER III

Exhibit III.1 Pediatric PMP Panel Capacity by County

Exhibit III.2 Percentage of CHIP Members with a PMP Visit in CY 2005

Exhibit III.3 Average Members Per PMP by County

CHAPTER IV

Exhibit IV.1 Percent of CHIP I Enrollees that Used Services
Based on Unique Number of Eligibles in All Delivery Systems

Exhibit IV.2 Percent of CHIP II Enrollees that Used Services
Based on Unique Number of Eligibles in All Delivery Systems

Exhibit IV.3 Percent of CHIP I Enrollees that Used Services
Based on Unique Number of Eligibles in the RBMC Delivery System

Exhibit IV.4 Percent of CHIP II Enrollees that Used Services
Based on Unique Number of Eligibles in the RBMC Delivery System

Exhibit IV.5 Percent of CHIP I Enrollees that Used PMP Services
Based on Unique Number of Eligibles in All Delivery Systems

Exhibit IV.6 Percent of CHIP II Enrollees that Used PMP Services
Based on Unique Number of Eligibles in All Delivery Systems

Exhibit IV.7 Percent of CHIP I Enrollees that Used PMP Services
Based on Unique Number of Eligibles in the RBMC Delivery System

Exhibit IV.8 Percent of CHIP II Enrollees that Used PMP Services
Based on Unique Number of Eligibles in the RBMC Delivery System

Exhibit IV.9 Percent of CHIP Enrollees (Phases I and II) that Used PMP Services Based on Unique Number of Eligibles

Exhibit IV.10 Percent of Medicaid Enrollees that Used PMP Services Based on Unique Number of Eligibles

Exhibit IV.11 Percent of CHIP Enrollees (Phases I and II) that Used PMP Services by MCO Based on Unique Number of Eligibles

Exhibit IV.12 Percent of Medicaid Enrollees that Used PMP Services by MCO Based on Unique Number of Eligibles

Exhibit IV.13 Percent of CHIP Enrollees (Phases I and II) that Used Physician Services in CY 2004 Based on Unique Number of Eligibles in All Delivery Systems

Exhibit IV.14 Percent of CHIP Enrollees (Phases I and II) that Used Physician Services in CY 2004 Based on Unique Number of Eligibles in the RBMC Delivery System

Exhibit IV.15 Inpatient Hospital Days Per 1,000 Eligibles for CHIP I, CHIP II and Medicaid January 2003 – October 2005

Exhibit IV.16 Outpatient Hospital Claims Per 1,000 Eligibles for CHIP I, CHIP II and Medicaid January 2003 – October 2005

Exhibit IV.17 PMP Physician Claims Per 1,000 Eligibles for CHIP I, CHIP II, and Medicaid January 2003 – October 2005

Exhibit IV.18 Other PMP Physician Claims Per 1,000 Eligibles for CHIP I, CHIP II, and Medicaid January 2003 – October 2005

Exhibit IV.19 Specialty Physician Claims Per 1,000 Eligibles for CHIP I, CHIP II and Medicaid January 2003 – October 2005

Exhibit IV.20 Clinic Claims Per 1,000 Eligibles for CHIP I, CHIP II and Medicaid January 2003 – October 2005

Exhibit IV.21 Pharmacy Claims Per 1,000 Eligibles for CHIP I, CHIP I and Medicaid January 2003 – October 2005

Exhibit IV.22 Dental Claims Per 1,000 Eligibles for CHIP I, CHIP II and Medicaid January 2003 – October 2005

CHAPTER V

Exhibit V.1 Comparison of PMPM Payments Between Delivery Systems and Age Groups

Exhibit V.2 PMPM Growth Rate Comparison

CHAPTER VI

Exhibit VI.1 Response to Rating of Child's Health Plan

Exhibit VI.2 Response to Rating of Child's Personal Doctor or Nurse

Exhibit VI.3 Number of Doctor's Office or Clinic Visits for Child

Exhibit VI.4 No Emergency Room Visits for Child

Exhibit VI.5 Selected Responses from 2005 Survey of PCCM Members

Exhibit VI.6 Level of Satisfaction with the Hoosier Healthwise Program

Exhibit VI.7 Results from PMPs on Selected Evaluation Criteria
Ratings from 1 ("Excellent") to 5 ("Poor")

Exhibit VI.8 Results of HEDIS 2005 Measure: Childhood Immunization Status

Exhibit VI.9 Results of HEDIS 2005 Measure: Adolescent Immunization Status

Exhibit VI.10 Results of HEDIS 2005 Measure: Appropriate Treatment for Children with Upper Respiratory Infection

Exhibit VI.11 Results of HEDIS 2005 Measure: Appropriate Testing for Children with Pharyngitis

Exhibit VI.12 Results of HEDIS 2005 Measure: Children and Adolescents' Access to Primary Care Practitioners

Exhibit VI.13 Results of HEDIS 2005 Measure: Well-Child Visits in the First 15 Months of Life

Exhibit VI.14 Results of HEDIS 2005 Measure: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Exhibit VI.15 Results of HEDIS 2005 Measure: Adolescent Well-Care Visits

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) grew at a faster rate than 25 other states from September 2004 to September 2005 (data from four states not available). This has enabled Indiana to achieve an uninsured rate for children of 9.4 percent, which is below the national average of 11.7 percent (as of 2004). For children in the family income range eligible for CHIP (less than 200% of the federal poverty level), Indiana also has an uninsured rate for children below the national average (16.6% versus 19.0%). Enrollment continued to grow in both CHIP Phase I and Phase II throughout 2005, but at different rates. For CHIP Phase I, enrollment grew 6 percent while for CHIP Phase II enrollment grew by 11 percent. These growth rates are similar to those found last year.

It is uncertain what the impact of federal changes to the State Children's Health Insurance Program (SCHIP) program will have on Indiana's CHIP at this time. The national program is scheduled to expire at the end of federal fiscal year 2007. Based on available funding and guaranteed allocations in the next two years, Indiana's CHIP should be able to cover anticipated expenditures into SFY 2008.

The children in CHIP all moved to the Risk-Based Managed Care (RBMC) delivery model by the end of 2005 and out of the Primary Care Case Management (PCCM) delivery model. By requiring the managed care organizations (MCOs) in the RBMC model to meet certain quality standards, the State has placed greater emphasis on such aspects as measuring the rate of well-child visits for children in CHIP as well as all of Hoosier Healthwise. Although the MCOs contracting with the State prior to January 2005 reported this past year that their utilization levels for well-child visits were similar to national median rates for Medicaid MCOs, there is still opportunity for improvement. This is particularly true for immunization rates, which fell below the national median. The OMPP, which oversees the RBMC delivery system, has already imposed higher benchmarks for the MCOs on these measures for the next two years and has promised to work with the two new MCOs entering the market in the past year on their reporting of these measures.

Overall, however, utilization of other services (e.g. hospital, pharmacy scripts, and dental) has remained stable for the past three years among CHIP members. The members and their parents continue to report high rates of satisfaction with the program.

This is the sixth annual evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. (EP&P). As in past years, our evaluation focused on the most recent data available to identify trends in enrollment, service utilization, payments, access to services/providers, and quality monitoring. More of our analysis focused on the delivery of services in the RBMC model, since 2005 will lay the framework for benchmarks for future years under this delivery system.

KEY FINDINGS RELATED TO ENROLLMENT

- Indiana children are more likely than children in the rest of the country to be covered by private health insurance. This fact, in conjunction with the Hoosier Healthwise program, means that Indiana's uninsured rate for children is lower than the national average. This is true for the uninsured rate for all children (9.4% in Indiana versus 11.7% nationwide) as well as for children in families under 200% of the federal poverty level (16.6% in Indiana versus 19.0% nationally).

- The overall enrollment in Indiana's CHIP program grew 7.5 percent from the middle of 2004 to the middle of 2005. This is the same rate as the previous 12-month period. However, the Phase II portion of the program grew 11 percent whereas Phase I enrollment grew by 6 percent. Since June 2005, enrollment in CHIP Phase II has grown by at least another 1,000 members.

- Indiana's growth rate in its CHIP is still more favorable than most other states. From the 4th Quarter of federal fiscal year (FFY) 2004 to the 4th Quarter of FFY 2005, Indiana's CHIP enrollment grew 6.1% (based on point-in-time counts), ranking it 21st among all states and much higher than the national average of 1.2% growth.

- The age distribution within CHIP Phase I and the age distribution within CHIP Phase II have remained unchanged in the last three years. However, due to differences in eligibility criteria for each phase of CHIP, the enrollment in CHIP Phase II includes younger children than CHIP Phase I. At the end of 2005, the average age in CHIP Phase I was 10.3 years as compared to 8.6 years in CHIP Phase II and 7.4 years in Medicaid, among all children under age 19.

- CHIP children are enrolled in all five contracted MCOs. The percentage of children enrolled in CHIP I versus CHIP II within each MCO does not vary greatly. However, CHIP I and II enrollment distribution across the MCOs varies, with Managed Health Services enrolling about one-third of all CHIP children, followed by CareSource with nearly one-quarter, MDWise with about one in five, Harmony Health Plan with around 7%, and Molina with 4%. It should be noted that CareSource and Molina are the two new MCOs in 2005.

KEY FINDINGS RELATED TO ACCESS

- In nine counties, the PMP panel capacities are full. This means that the number of members enrolled is at or exceeds the number of slots in which PMPs are willing to accept Hoosier Healthwise patients. An additional nine counties had PMP panels that were above 80% full capacity. However, 15 of these 18 counties became mandatory RBMC counties some time in 2005.

- There does not appear to be a strong relationship between panel capacities and visit rates, however. Many of the counties that had full panels had high percentages of children that saw a PMP in calendar year 2005. The two exceptions were Clinton and Tippecanoe Counties, which had full PMP panels and low visit rates for CHIP children.

- Counties with full panel sizes do not necessarily mean that there could not be available capacity in the county. EP&P measured the average number of members assigned to each PMP and weighted this at the county level. For those counties with full panels currently, only two counties (Montgomery and Tippecanoe) also had above-average number of patients per PMP. This means that there may be an opportunity in the remaining counties with full panels to encourage providers to accept more patients without compromising waits for appointments or an over-commitment by providers to serve Hoosier Healthwise members.

KEY FINDINGS RELATED TO SERVICE UTILIZATION

- About 60 percent of the CHIP members visited their PMP, as defined by EP&P, during each of the last three calendar years.

- When visits to specialists and clinics are included, about 80 percent of CHIP children saw a physician during the calendar year. This rate is much higher for young children and decreases as the children get older. For example, 98 percent of all one year-olds saw some type of physician in CY 2004, whereas about 80 percent of children ages six through 12 saw a physician during this time period.

- The percentage of children who visit their PMP is higher in the RBMC delivery system, but the percentage of children who visit any type of physician (PMP, specialist, clinic) was found to not be different between RBMC and PCCM.

- The percentage of children who had a PMP visit varies by health plan, between 40 percent and 75 percent.

- There is little difference between the percentage of children seeing their PMP between the CHIP and Medicaid populations. This holds true at the overall level and by MCO.

- Utilization trends based on claims per 1,000 enrollees has remained stable over the last three years when the claims from MCOs were analyzed for inpatient hospital, outpatient hospital, primary care, specialist care, clinic, pharmacy and dental services. With a couple of exceptions, there is also little difference between the two CHIP packages in their utilization patterns. When compared to

Medicaid children, CHIP children had a higher dental claims rate, pharmacy claims rate, and PMP physician claims rate per 1,000.

KEY FINDINGS RELATED TO PAYMENTS

- The payments made by CHIP to provide services to its members increased quite a bit from 2004 to 2005, when measured on a per member per month (PMPM) basis. The MCOs participating in the RBMC delivery system are paid a monthly capitation payment to serve their members, regardless of the amount, duration or scope of services provided to the members (except as limited to what the MCOs are contractually obligated to deliver). From 2004 to 2005, overall PMPM payments in the RBMC system grew 13 percent. This is further detailed as a 4 percent growth for children ages 1-5, a 26 percent growth for children ages 6-12 and a 6 percent growth for children ages 13-18.

- Although in CY 2003 and CY 2004, the PMPM payments made for children enrolled in the PCCM delivery system exceeded those made for children in the RBMC delivery system, this trend changed in CY 2005 for children ages 6-12 and children ages 13-18. This finding would need more exploration, however, since the population in the PCCM delivery system may have been less representative in 2005 as compared to prior years since the program was phasing out.

KEY FINDINGS RELATED TO QUALITY

- Overall, children in Hoosier Healthwise rated their health plan and their doctors at a rate similar to national benchmarks of surveys to parents of children in Medicaid programs. When results for CHIP members/parents could be isolated (from the survey of PCCM members), both CHIP Phase I and CHIP Phase II members gave responses that were as favorable as or more favorable than the general Hoosier Healthwise population.

- PMP satisfaction, as measured by the results from their annual survey, is at its lowest point in recent years. This appears to stem from multiple criteria, such as lower ratings on items such as communication with the health plans, timeliness of claims processing, reimbursement rates, authorization requirements for patient referrals, and the auto-assignment process.

- The results from the study of the Health Plan Employer Data and Information Set (HEDIS) measures in 2005 (based on 2004 utilization) were mixed. On the one hand, the three participating MCOs from 2004 had improved on most measures pertaining to children from the prior year results. However, the Indiana Hoosier Healthwise plans still reported results that were below national Medicaid medians on such measures as immunizations and appropriate treatment of strep throat.

The MCOs did, however, meet or exceed national Medicaid medians on access to primary care physicians (for all ages) and for well-child visits.

RECOMMENDATIONS FOR FURTHER RESEARCH

Through a review of the documentation and discussions with State staff and the MCOs during our external quality review in late 2005, we found that there was an active dialogue between the parties with respect to identifying opportunities to improve the RBMC delivery system. Specifically, we noticed two areas that pertain to children specifically that the State is working closely with the MCOs on:

- Improving HEDIS scores
- Reducing unnecessary utilization in the emergency room setting

EP&P concurs that these are areas that could use the most improvement, and was encouraged that both the OMPP and the MCOs have taken an active role to do this. With respect to the HEDIS scores, the area that can still be improved upon the most are measures related to immunizations. EP&P understands that the immunization scores may not be as low as reported because historically there have been barriers to obtaining information on when children in Hoosier Healthwise are getting immunizations if it is not through their PMP. The Children and Hoosiers Immunization Registry Program (CHIRP) database was developed by the Indiana State Department of Health (ISDH) as mandated by state law to help solve this problem. Although the CHIRP does help quite a bit in addressing some of the issues of the past, MCOs reported that there was difficulty at times in accessing the data from the CHIRP registry. Therefore, although HEDIS rates for immunizations improved over the prior year, there was still substantial room for improvement. To this end, EP&P makes the following recommendations to the OMPP:

1. Develop strategies with the MCOs to improve immunization rates. For example, identify the children that were in the HEDIS measure analysis that were found to not have their immunizations. Construct a targeted study of these individuals.

2. Provide incentives to MCOs to both meet national standards (e.g. the NCQA Medicaid medians) on immunizations and to improve their scores year-over-year. This could be done through a pay-for-performance program that was tracked through verifiable data reporting.

3. With respect to emergency room utilization, EP&P recognizes that one of the challenges for both the OMPP and the MCOs as managed care penetration has occurred across the state is educating new RBMC members regarding how to access care. Tracking the improper accessing of ER services is already occurring, and EP&P suggests that this be continued, if not enhanced, for both current and new MCOs.

4. Develop a “HEDIS-like” measure related to the percentage of emergency room visits that were deemed nonemergent. Although each MCO uses slightly different measures to define emergent care, the OMPP could develop a common list of diagnoses for purposes of this measure. Provide incentives to MCOs that hit a desired benchmark or that show a reduction in inappropriate ER use year-over-year.

CHAPTER I

OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

CHAPTER I
OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

EP&P Consulting, Inc. (EP&P) was hired by the Office of the Children's Health Insurance Program (CHIP) to conduct the independent evaluation of the Indiana CHIP as required by Legislature. This is the sixth annual evaluation conducted by EP&P. During this time, Indiana's CHIP has changed in many ways that are similar to changes occurring nationally in CHIP programs, while other changes are Indiana-specific.

Nationally, CHIP programs are seeing enrollment that is beginning to level off and in some cases remain flat. Indiana is no exception, although growth in the portion of the program for higher-income families who pay monthly premiums into the program continued to grow at a steady pace in 2005.

Specifically in Indiana, a large composition of the CHIP was comprised of children in the Medicaid expansion of the program that were born before October of 1983. These children have all "aged out" of the CHIP since they have turned age 19 and are no longer eligible. As a result, the composition of children by age group in Indiana's CHIP is now much more similar to that found in the Medicaid portion of Hoosier Healthwise. The only exception to this is that there are very few infants enrolled in the CHIP since they are already eligible for Medicaid. Understanding the composition of the enrollees in CHIP helps to better understand utilization trends in the program, as will be detailed in Chapter IV.

This chapter provides a brief background of the national State Children's Health Insurance Program SCHIP program, how Indiana's CHIP was designed, who is enrolled, the State's funding situation in light of the end of the three year decline in federal funding from 2002 to 2004, how services are delivered, and issues affecting SCHIP programs nationally and in Indiana. Later chapters in this evaluation address enrollment trends, access to and utilization of services, payment trends and quality monitoring.

The State Children's Health Insurance Program (SCHIP) at the Federal Level

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Under SCHIP, states could develop programs offering health coverage to uninsured children up to age 19 in families who are not eligible for Medicaid. In implementing SCHIP, states had the option of providing benefits by expanding their existing Medicaid program, by establishing a separate non-Medicaid program, or through a combination of these two program designs. Like 20 other states, Indiana has a "combination" program. Children are determined eligible based upon a family's income level. These income limitations vary across the states based on each state's SCHIP design. Income thresholds range from below 200% of the Federal Poverty Level (FPL) to 350% of the FPL. In Indiana, the children under the Medicaid expansion of

CHIP, known in Indiana as "CHIP Phase I" of "CHIP Package A", are children in families up to 150% of the FPL who are not already eligible for Medicaid. The children in the state-designed portion of the program, known in Indiana as "CHIP Phase II" or "CHIP Package C", are children in families above 150% up to 200% of the FPL.

Similar to Medicaid, Title XXI is a jointly federal-state funded program in which states receive federal matching dollars. Title XXI offers states a federal allotment for their SCHIP programs. The amount the federal government pays to each state depends on the state's SCHIP federal matching rate up to a pre-defined annual cap. The SCHIP federal matching rate is a percentage of the total program costs that the federal government will pay. (The term "enhanced" is often used when referring to the SCHIP federal matching rate because the SCHIP matching rate was set at a higher percentage than the Medicaid matching rate as an incentive for states to participate in the Title XXI program.)

The SCHIP federal matching rate differs from state to state because it was originally based on a calculation of the state's share of low-income and uninsured children, as determined through estimates from the Current Population Survey, conducted by the U.S. Census Bureau. A state cannot receive a matching rate of less than 65% or more than 85% and cannot receive an annual payment of less than $2 million.

Indiana's SCHIP federal matching rate was 73.95% in Federal Fiscal Year (FFY) 2005, up from 73.62% in FFY 2004. This means that for every dollar spent using state dollars on the Indiana CHIP, the federal government remits back to Indiana almost 74 cents. This federal match rate for CHIP compares to Indiana's regular Medicaid match rate of 62.78% for FFY 2005. These matching rates rank Indiana near the middle of all states (see Exhibit I.1). In comparison to the border states, only Kentucky has a more favorable SCHIP and Medicaid FMAP match rate.

Exhibit I.1
FFY 2005 Federal Matching Rate (FMAP) for SCHIP and Medicaid in Indiana and Border States

State	SCHIP		Medicaid	
	Percentage	Rank	Percentage	Rank
Indiana	73.62%	21	62.78%	21
Illinois	65.00%	39	50.00%	40
Kentucky	79.06%	11	69.60%	13
Michigan	69.12%	36	56.71%	35
Ohio	71.46%	30	59.68%	28

Ranking includes all 50 states plus the District of Columbia

Source: The Kaiser Family Foundation, statehealthfacts.org.

Indiana's CHIP Program Compared to Other States

Based on December 2004 data collected for all 50 states plus the District of Columbia, Indiana's CHIP program is the 14th largest in the country based on total enrollment and smaller than Illinois and Ohio among nearby states. Indiana led the nation with respect to its CHIP enrollment in the early years of the program, and remains one of the fastest growing CHIP programs in the country (see Appendix A). While enrollment in CHIP programs across the country grew by less than one percent nationwide between December 2003 and December 2004, the Indiana CHIP program grew by 16 percent (see Exhibit I.2).

Exhibit I.2
States with SCHIP Enrollment Growth Above 10% or 10,000
December 2003 to December 2004

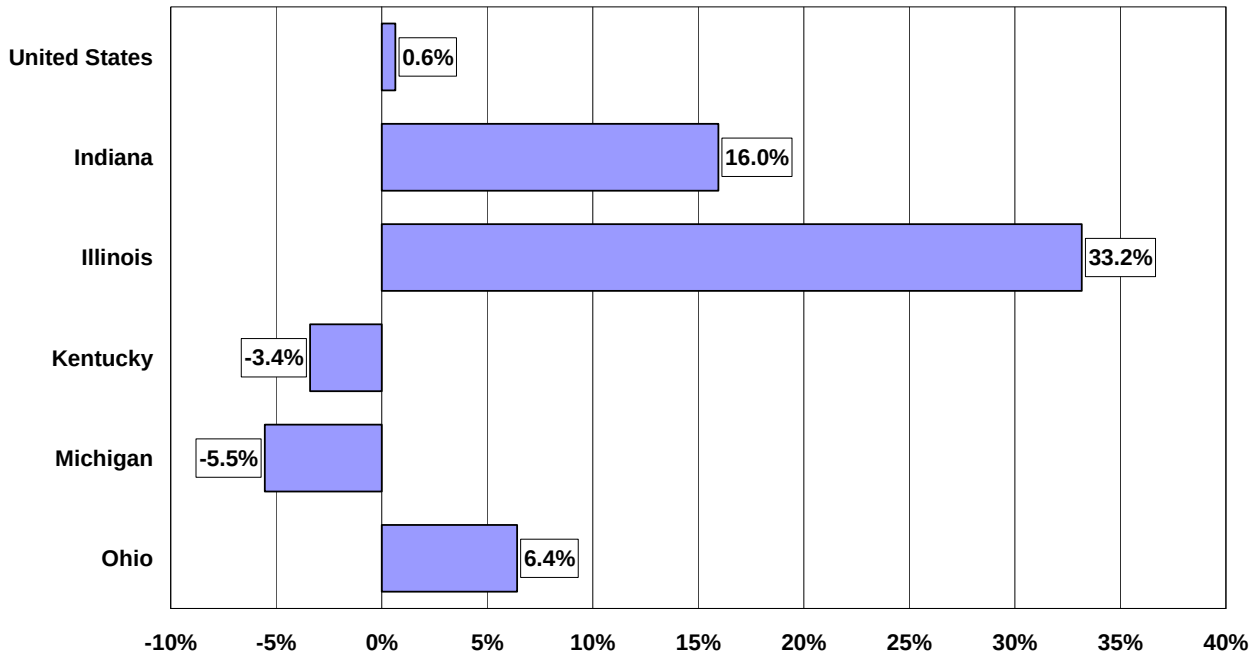
	Monthly Enrollment		Enrollment Growth	Percent Change
State	**Dec-03**	**Dec-04**	**Dec-03 to Dec-04**	**Dec-03 to Dec-04**
Washington	9,206	13,585	4,379	47.6%
Illinois	92,144	122,711	30,567	33.2%
Hawaii	10,907	13,719	2,812	25.8%
Wyoming	3,144	3,854	710	22.6%
Virginia	56,258	68,524	12,266	21.8%
Oklahoma	46,110	54,905	8,795	19.1%
Oregon	20,473	24,254	3,781	18.5%
District of Columbia	3,720	4,379	659	17.7%
Vermont	2,911	3,418	507	17.4%
North Carolina	104,923	122,613	17,690	16.9%
Indiana	**61,577**	**71,401**	**9,824**	**16.0%**
Idaho	11,237	12,884	1,647	14.7%
South Carolina	45,534	51,469	5,935	13.0%
Louisiana	94,799	106,091	11,292	11.9%
Maine	13,085	14,436	1,351	10.3%
Kansas	31,012	34,169	3,157	10.2%
Georgia	196,615	211,857	15,242	7.8%
California	722,901	771,283	48,382	6.7%

Source: The Kaiser Commission on Medicaid and the Uninsured, SCHIP Enrollment in 50 States: December 2004 Data Update, September 2005, pg. 4 from data compiled by Health Management Associates from state enrollment data

In comparison to border states, only Illinois had a higher CHIP enrollment growth rate than Indiana. Two of the states (Kentucky and Michigan) saw declines in their CHIP enrollment during 2004, while Ohio saw its enrollment grow, but at a slower rate than Indiana. Exhibit

I.3 shows the growth rate in Indiana in comparison to the border states as well as the national growth rate.

Exhibit I.3
Percentage Change in SCHIP Enrollment
December 2003 to December 2004



Source: The Kaiser Commission on Medicaid and the Uninsured, SCHIP Enrollment in the 50 States.

Indiana is one of 30 states that charges premiums or enrollment fees to SCHIP enrollees. The state's premium range of $132 to $297 per year ($11 to $24.75 per month) depending upon the child's family income is in line with the premiums charged by many other states. Indiana is also one of many states where eligibility coverage is offered to children with family incomes up to 200% of the FPL, or $38,700 for a family of four in 2005. Exhibit I.4 on the next page shows premium requirements for Indiana and its border states. Appendix B shows this information for all of the states.

Exhibit I.4
SCHIP Premiums and Enrollment Fees as of December 2004
For Indiana and Nearby States

State	Requires Premiums or Enrollment Fees		The Premium is Charged to those Members:
	Yes	No	
Indiana	X		At 150-175% FPL: $11-$16.50 per month At 176-200% FPL: $16.50-$24.75 per month
Illinois	X		At 150% FPL or higher: $15 one child, $25 for two; $30 for three or more children
Kentucky	X		For all members: $20 per family per month
Michigan	X		For all members: $5 per family per month
Ohio		X	

Note: Information in this table provided by state SCHIP officials in March 2005 in response to the survey question: "As of December 2004, were there premiums or enrollment fees?"

Source: The Kaiser Commission on Medicaid and the Uninsured, SCHIP Enrollment in 50 States: December 2004 Data Update, September 2005, pg. 18-19

Overview of Indiana's Children's Health Insurance Program

Indiana's CHIP Phase I began in October 1997 and extended Medicaid eligibility to uninsured children not previously eligible for Medicaid who:

- Were born before October 1, 1983 and
- With family incomes up to 100% of the Federal Poverty Level (FPL)

The last of these children enrolled in CHIP reached the age of 19 on September 30, 2002.

In July 1998, CHIP Phase I was expanded by extending eligibility to a second group of children:

- Uninsured children from age one through age five with family income between 133% and 150% of FPL who were not previously eligible for Medicaid; and

- Uninsured children from age six through age 18 with family income between 100% and 150% of FPL who were not previously eligible for Medicaid

Average enrollment in CHIP Phase I in the last quarter of CY 2005 was 50,491 children, about 800 children more than the last quarter of CY 2004 (Source: MedInsight data).

Phase II of Indiana's CHIP was designed as a state-specific, non-Medicaid expansion. Implemented in January 2000, this phase further expanded access to health care coverage by

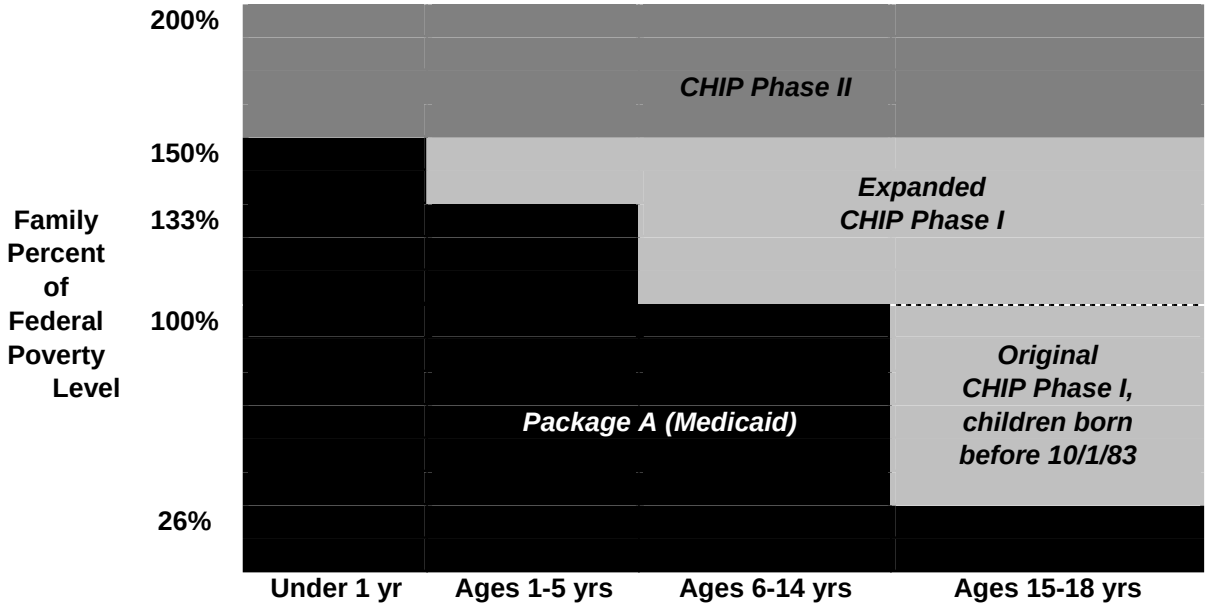
extending eligibility to uninsured children from birth through age 18 with family income above 150% and up to 200% of FPL.

Because the second phase is a state-defined program, the State had more flexibility in designing the program. The State used this flexibility to create a benefit package that differs slightly from the Medicaid managed care benefit package and requires members to pay premiums and co-payments. Also, because this phase is not part of Medicaid, coverage is not an entitlement.

Average enrollment in CHIP Phase II in the last quarter of CY 2005 was 19,422 children, almost 2,000 children, or 10% higher, than the last quarter of CY 2004 (Source: MedInsight data).

Enrollment in both phases of Indiana's CHIP program totaled just over 70,000 children at the end of 2005.

The diagram below illustrates the "stair-step" eligibility structure for children in CHIP.



Source: Office of Medicaid Policy and Planning

How Services are Delivered in Indiana's CHIP

Children enrolled in both CHIP Phase I and CHIP Phase II receive health care services through the existing Medicaid delivery system, Hoosier Healthwise. Like other members of Hoosier Healthwise, all CHIP children transitioned into the Risk-Based Managed Care (RBMC) delivery system by the end of 2005 and out of the Primary Care Case Management (PCCM) system. CHIP enrollees select their Primary Medical Provider (PMP), and this decision determines to which of the five managed care organizations (MCOs) the member will be assigned. Member PMP selection drives MCO selection because each PMP contracts with only one MCO.

The State contracts with MCOs to provide comprehensive preventive and primary care services. MCOs are paid a capitation rate per member per month, regardless of whether or not members use services. The MCOs then contract directly with PMPs and other providers either under a capitation or a fee-for-service arrangement. Certain services, including dental services and services delivered by mental health providers, are not included in the capitation rate. Findings will be presented later in the report that detail the percentage of children utilizing services available to them, in particular primary care doctor visits. This will also be compared across the MCOs.

It should be noted that when members first become eligible for Hoosier Healthwise managed care, there is a 30-day period of time referred to as the "Fee-For-Service" (FFS) window. During this time period, members are covered by Hoosier Healthwise but may not yet be enrolled with an MCO. The FFS window allows members time to review their coverage options and to select a PMP. It also provides time for the selected physician to receive notification about his/her selection as the member's PMP. During this period, a CHIP enrollee can receive services from any doctor participating in the Hoosier Healthwise program, whether or not the doctor has contracted with an MCO.

Administration of Indiana's CHIP

The State's Family and Social Services Administration (FSSA) has a number of divisions involved in the operation of Indiana CHIP:

- Public Law 273-1999, the legislation authorizing Phase II of CHIP, created the Office of the Children's Health Insurance Program and charged it with the responsibility of designing and administering CHIP Phase II.

- The Office of Medicaid Policy and Planning (OMPP) is the designated single state agency for Medicaid. The Hoosier Healthwise program, which includes CHIP, is operated by the Managed Care unit of the OMPP.

- CHIP eligibility determination is conducted by the Division of Family Resources.

Issues Impacting CHIP Programs Nationwide and in Indiana

Funding for CHIP programs from the federal government is provided through a matching of state dollars up to a pre-defined annual cap. The annual allotments for each state were defined in the Balanced Budget Act of 1997. Due to federal budget constraints, annual allotments were not evenly distributed across the ten-year duration of the SCHIP authorization. In federal years 2002, 2003 and 2004, allotments were, in the aggregate, 26% below the allotments in the first four years of the initiative. This has come to be known as the "CHIP dip". Allotments went back to pre-2002 levels starting in 2005. Exhibit I.5 shows that although Indiana's percentage of the total national allotment for the SCHIP has remained relatively stable over time, the State received $20 million less per year during the "dip" years. However, Indiana's allotments for FFY 2005 and 2006 are higher than its 1998 funding level, even though the total federal allotment for the national SCHIP program is still below its 1998 funding level.

Exhibit I.5
National and Indiana SCHIP Program Allotment for Selected Years (Dollars in Thousands)

Federal Fiscal Year	National Allotment	Indiana Allotment	% of National Allotment
1998	$ 4,235,000	$ 70,512	1.66%
2002	$ 3,115,200	$ 47,030	1.51%
2004	$ 3,175,200	$ 54,027	1.70%
2005	$ 4,082,400	$ 73,422	1.80%
2006	$ 4,082,400	$ 73,001	1.79%

Source: Federal Funds Information for States, Issue Brief 05-29 FY2006 SCHIP Allotments: Level Funding with Distribution Changes, June 24, 2005, page 5. Data Source: Federal Register notices for FY2003-2006 SCHIP allocations.

Indiana's funding fluctuation due to the "CHIP dip" was more extreme than most of its border and other nearby states. While the State's 23% reduction from 1998 to 2004 was close to the national average of 25% (see Exhibit I.6 on the next page), Indiana has the worst dip when compared to its border states. Alternatively, Indiana's 36% increase in funding from 2004 to 2005 is one of the highest increases in the nation with only Kentucky and Illinois receiving a larger percent increase among the comparison states. Indiana's funding from FFY 2005 to FFY 2006 is relatively flat.

Exhibit I.6
SCHIP Program Allotment and Percent Change in Allotment for Selected Years

State	Federal Fiscal Year Allotment (In Millions)				Percent Change in Allotment (Between Selected Years)		
	1998	2004	2005	2006	1998 and 2004	2004 and 2005	2005 and 2006
United States	$ 4,235	$ 3,175	$ 4,082	$ 4,082	-25%	29%	None
Indiana	$ 70.5	$ 54.0	$ 73.4	$ 73.0	-23%	36%	-0.6%
Illinois	$ 122.5	$ 121.0	$ 164.9	$ 169.2	-1%	36%	2.6%
Kentucky	$ 49.9	$ 39.3	$ 54.1	$ 57.8	-21%	38%	6.8%
Michigan	$ 91.6	$ 89.1	$ 111.3	$ 117.2	-3%	25%	5.2%
Ohio	$ 115.7	$ 103.8	$ 125.8	$ 124.6	-10%	21%	-1.0%

Ranking includes all 50 states plus the District of Columbia

Source: Federal Funds Information for States, Issue Brief 05-29 FY2006 SCHIP Allotments: Level Funding with Distribution Changes, June 24, 2005, page 5. Data Source: Federal Register notices for FY2003-2006 SCHIP allocations.

Because some state CHIP programs did not attain the level of enrollment that they had projected for the initial years of the program, they were unable to spend their entire allotments from these initial years. The Centers for Medicare and Medicaid (CMS), the federal entity that oversees CHIP, allowed states to retain allotments from prior years for use in one of three years starting with the initial allotment year. Because Indiana had a large enrollment in CHIP at the outset, it was able to spend all of its allotments in the early years. CMS provided for unspent allotments by redistributing monies unused by some states to those states that had exhausted a yearly allotment. Indiana benefited from this redistribution by receiving an additional $48 million from FFY 1998 redistributed funds and $105 million from FFY 1999 redistributed funds. However, due to strict timeframes to spend all redistributions, $53.5 million of it reverted back to the U.S. Treasury in 2003 and 2004. For FFY 2005, after all redistributions and funds required to be reverted back to the federal government are accounted for, Indiana was expected to have $122.5 million remaining at the end of the federal year (see Exhibit I.7 on the next page). This would rank Indiana 10th highest among states with respect to available funds going into FFY 2006.

Exhibit I.7
Anticipated SCHIP Spending and Balances for FFY2005
by State (Dollars in Thousands)

				Expected FFY2005 Spending [1]		Anticipated Ending FFY2005 Balance	
State	**Start-of-Year Available [2]**	**2002 Redistri-bution [3]**	**Total Available**	**Amount**	**% of Allotment**	**Amount**	**Rank**
United States	$10,177,339	$ 635,870	$10,813,209	$5,310,322	131%	$5,502,887	
Indiana	$ 195,729	$ 0	$ 195,729	$ 73,188	100%	$ 122,541	10
Illinois	$ 345,102	$ 15,933	$ 361,035	$ 290,190	176%	$ 70,845	25
Kentucky	$ 165,075	$ 9,974	$ 175,049	$ 78,498	145%	$ 96,551	17
Michigan	$ 287,052	$ 9,332	$ 296,384	$ 173,446	156%	$ 122,938	9
Ohio	$ 290,126	$ 18,700	$ 308,826	$ 175,175	139%	$ 133,651	8

Ranking includes all 50 states plus the District of Columbia

[1] From May 2005 CMS-37 and CMS 21B reports

[2] Includes available FY2003-2005 allotments and redistributed FY 2001 funds

[3] Revised Redistributions from FFIS Issue Brief 05-38

Sources: Federal Funds Information for States, Issue Brief 05-29 FY2006 SCHIP Allotments: Level Funding with Distribution Changes, June 24, 2005, page 8 and Federal Funds Information for States, Issue Brief 05-38 Last Minute Changes of FY2002 SCHIP Redistributions, September 27, 2005, page 2

According to FFIS, states were expected to spend 131% of their total federal allotments in FFY 2005 and spending in 33 states was expected to exceed their allotments. Despite this spending, however, only Rhode Island was expected to have a negative funding balance at the end of FFY 2005. By FFY 2006, 14 states are expected to face federal SCHIP funding shortfalls and by FFY 2007 this number will increase to 19 states (Source: Kaiser Commission on Medicaid and the Uninsured, *Financing Health Coverage: The State Children's Health Insurance Program Experience*, February 2005). Since Indiana's CHIP expenditures are occurring at the same pace as new funding is available, it appears that if no program or policy changes are made, Indiana will have sufficient federal matching funds available to continue Indiana's CHIP with the current eligibility criteria until SFY 2008 (Source: *OMPP Budget Analysis Report*, December 14, 2004). Unknown variables such as what programmatic design changes to the federal SCHIP program may occur after its initial 10-year funding cycle is completed in FFY 2007 or, whether the program will continue as currently designed, may affect how federal funding methodology will change.

CHAPTER II

ENROLLMENT TRENDS FOR CHILDREN IN HOOSIER HEALTHWISE

CHAPTER II
ENROLLMENT TRENDS FOR CHILDREN IN HOOSIER HEALTHWISE

INTRODUCTION

This chapter reviews the changes in enrollment for children in CHIP Phase I (CHIP Package A), CHIP Phase II (CHIP Package C), and the Medicaid portion of Hoosier Healthwise over the last three years. Specific analyses focus on enrollment across a number of parameters including:

- Distribution of members by age
- Distribution of members within the Risk-Based Managed Care (RBMC) delivery system
- The average period of enrollment for CHIP members
- Distribution of CHIP members within regions of the state and as compared to the distribution of Medicaid children
- The variation of enrollment between CHIP and Medicaid children by county

The chapter begins with an overview of the rate of uninsurance for children in Indiana compared to that of nearby states and the national average.

KEY FINDINGS

- Indiana children are more likely than children in the rest of the country to be covered by private health insurance. This fact, in conjunction with the Hoosier Healthwise program, means that Indiana's uninsured rate for children is lower than the national average. This is true for the uninsured rate for all children (9.4% in Indiana versus 11.7% nationwide) as well as for children in families under 200% of the federal poverty level (16.6% in Indiana versus 19.0% nationally).

- The overall enrollment in Indiana's CHIP program grew 7.5 percent from the middle of 2004 to the middle of 2005. This is the same rate as the previous 12-month period. However, the Phase II portion of the program grew 11 percent whereas Phase I enrollment grew by 6 percent. Since June 2005, enrollment in CHIP Phase II has grown by at least another 1,000 members.

- Indiana's growth rate in its CHIP is still more favorable than most other states. From the 4th Quarter of federal fiscal year (FFY) 2004 to the 4th Quarter of FFY 2005, Indiana's CHIP enrollment grew 6.1% (based on point in time reports), ranking it 21st among all states and much higher than the national average of 1.2% growth.

- The age distribution within CHIP Phase I and the age distribution within CHIP Phase II have remained unchanged in the last three years. However, due to differences in

eligibility criteria for each phase of CHIP, the enrollment in CHIP Phase II includes older children than CHIP Phase I. Further, both portions of the CHIP have older children than the Medicaid program, since there are no infants in CHIP Phase I and very few infants are in CHIP Phase II. At the end of 2005, the average age in CHIP Phase I was 10.3 years as compared to 8.6 years in CHIP Phase II and 7.4 years in Medicaid, among all children under age 19.

- Now that Risk-Based Managed Care is mandatory in every county, there are no Hoosier Healthwise children remaining in the Primary Care Case Management (PCCM) delivery system. There are always some children temporarily in the Fee for Service (FFS) portion of the program until they select their primary medical provider, or one is selected for them.

- In the beginning of 2005, two additional managed care organizations (MCOs) began contracts with Hoosier Healthwise. As a result, CHIP children are enrolled in all five contracted MCOs. The percentage of children in each MCO is not very different when measuring the CHIP Phase I population separately from CHIP Phase II. However, CHIP I and II enrollment distribution across the MCOs varies, with Managed Health Services enrolling about one-third of all CHIP children, followed by CareSource with nearly one-quarter, MDWise with about one in five, Harmony Health Plan with around 7%, and Molina with 4%. It should be noted that CareSource and Molina are the two new MCOs in 2005.

- In terms of geography, the only clear pattern of enrollment in either CHIP or Medicaid enrollment density (percent of all children) is that the counties in the northeast corner of the state tend to have lower enrollment rates than the rest of the state. The counties with the highest CHIP enrollment density are all rural, while most of the counties with the lowest enrollment density are urban. Urban counties are more likely than rural ones to have high Medicaid enrollment density rates. Also, some of the urban counties with the highest Medicaid enrollment density rates have the lowest CHIP enrollment density rates.

SPECIFIC ANALYSES

How does Indiana's child uninsurance rate compare to the national average and other states?

For all children up to age 19, Indiana's uninsurance rate of 9.4% is lower than the national average of 11.7% and ranks 28th among all states (including the District of Columbia). In comparison to the border states, Illinois and Kentucky have higher uninsurance rates than Indiana, while Michigan and Ohio have lower uninsurance rates.

This lower rate of uninsured among children does not seem to stem from higher enrollment in government programs, but from a higher rate of insurance from the private sector. In terms of Medicaid coverage, only 20.9% of Indiana children are covered by Medicaid versus

25.1% nationally. Only Illinois has a lower rate of coverage by Medicaid among the border states.

Exhibit II.1
Health Insurance Coverage for All Children Up to Age 19
by Insurance Status, 2002-2004

State	Uninsured			Insured by Medicaid		
	Data	% of Total Population	Rank	Data	% of Population	Rank
United States	8,979,037	11.7%		19,296,762	25.1%	
Indiana	157,623	9.4%	28	350,112	20.9%	36
Illinois	380,917	11.2%	18	668,448	19.6%	40
Kentucky	109,028	10.6%	20	283,136	27.5%	17
Michigan	179,815	6.8%	44	680,346	25.6%	25
Ohio	246,695	8.2%	37	647,187	21.4%	33

Ranking includes all 50 states plus the District of Columbia

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003 through 2005.

When low-income children are measured alone (defined as those in families with incomes below 200% of the federal poverty level, or FPL, the threshold for Indiana's CHIP), 16.6% of low-income children in Indiana are uninsured as compared with 19.0% nationally (see Exhibit II.2). Among the border states, only Michigan has a considerably lower percentage of uninsured low-income children.

As seen in the rates of Medicaid coverage among all children, Indiana has 46.3% of all of its low-income children enrolled in Medicaid, ranked 39th nationally. Illinois is the only border state with a lower percentage of low-income children covered under Medicaid.

Exhibit II.2
Health Insurance Coverage for Low-Income Children Up to Age 19
by Insurance Status, 2002-2004

	Uninsured			Insured by Medicaid		
State	Data	% of Low-Income Population	Rank	Data	% of Low-Income Population	Rank
United States	5,640,644	19.0%		14,973,691	50.4%	
Indiana	100,117	16.6%	27	279,147	46.3%	39
Illinois	243,380	19.4%	12	551,243	43.9%	43
Kentucky	78,167	17.2%	24	229,279	50.3%	25
Michigan	107,426	11.2%	44	512,197	53.5%	15
Ohio	155,993	15.1%	33	519,549	50.2%	26

Ranking includes all 50 states plus the District of Columbia

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003 through 2005.

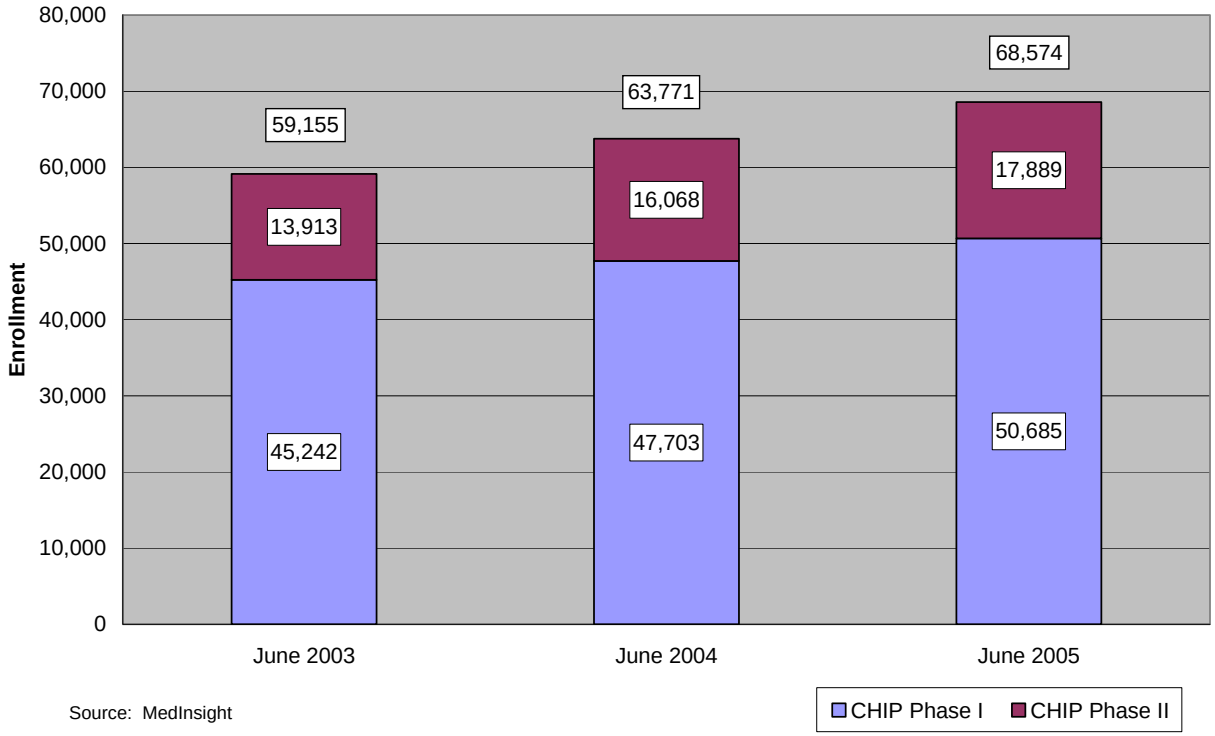
What is the growth rate in 2005 of the CHIP Program (Phases I and II)?

Overall, as of June 2005, over 68,000 children in total were enrolled in the Indiana CHIP program, an increase of close to 10,000 children over the past two years and close to 5,000 over the past year. The overall program grew by 7.8 percent from 2003 to 2004 and by 7.5 percent from 2004 to 2005 (see Exhibit II.3 on the next page).

While CHIP Phase I comprises more of the children enrolled in the program, its growth rate is lower than that for CHIP Phase II. CHIP Phase I grew 5.4 percent from June 2003 to June 2004 and 6.3 percent from June 2004 to June 2005.

In contrast, CHIP Phase II grew 15.5 percent from June 2003 to June 2004 and 11.3 percent from June 2004 to June 2005. Between June 2003 and June 2005, almost 4,000 have been added to CHIP Phase II. Just in the last half of 2005, enrollment has grown by at least another 1,000. The reason why June figures are shown instead of December figures is because there are eligibility adjustments normally made for a few months which, in the case of CHIP, tend to increase the number of enrollees. Therefore, the December 2005 results are considered understated with the data available at this time.

Exhibit II.3
Total Indiana CHIP Program Enrollment



Source: MedInsight

How does Indiana's CHIP enrollment trend compare to nationwide trends?

Between the end of Federal Fiscal Year (FFY) 2004 and FFY 2005, there was an increase of only 1.2 percent in enrollment in SCHIP programs throughout the U.S., with significant variation among the states (see Exhibit II.4 on the next page). SCHIP enrollment in Indiana grew at a rate of 6.1 percent during this time period. The state ranks just above the median (21st out of 46 states) in enrollment growth. Five states (Arkansas, Colorado, Michigan, Tennessee and Vermont) are not included in the analysis due to missing data. Indiana's ranking remained similar to last year's analysis, when the state was ranked 22nd out of 44 states included in our 2004 analysis.

It should be noted that these figures reported by states are at a point in time and do not account for adjustments to eligibility. As stated on the previous page, the figures reported to the federal government are most likely understated for both FFY 2004 and FFY 2005.

Exhibit II.4
Comparison of SCHIP Enrollment Across States for FFYs 2004 and 2005

State	Point in Time FFY 2005 Fourth Quarter Total	Point in Time FFY 2004 Fourth Quarter Total	Enrollment Change FY2004 to FY2005	Percent Change FY2004 to FY2005
Oregon	29,113	22,730	6,383	28.1%
Wyoming	4,908	3,924	984	25.1%
Georgia	234,519	189,219	45,300	23.9%
Utah	33,025	27,329	5,696	20.8%
Virginia	77,580	65,689	11,891	18.1%
North Dakota	4,006	3,448	558	16.2%
Illinois	141,795	122,194	19,601	16.0%
Iowa	31,368	27,516	3,852	14.0%
Mississippi	93,723	82,900	10,823	13.1%
Massachusetts	72,657	65,152	7,505	11.5%
North Carolina	140,286	126,312	13,974	11.1%
California	824,252	746,807	77,445	10.4%
New Hampshire	7,378	6,717	661	9.8%
District of Columbia	4,390	3,998	392	9.8%
Nevada	28,129	25,679	2,450	9.5%
Hawaii	14,873	13,592	1,281	9.4%
Maryland	96,961	89,946	7,015	7.8%
Connecticut	15,162	14,167	995	7.0%
Kansas	35,309	33,100	2,209	6.7%
Nebraska	23,608	22,204	1,404	6.3%
Indiana	**65,322**	**61,551**	**3,771**	**6.1%**
New Jersey	107,848	101,712	6,136	6.0%
Montana	11,613	10,989	624	5.7%
Alabama	63,948	60,754	3,194	5.3%
South Dakota	10,869	10,330	539	5.2%
Arizona	51,345	49,375	1,970	4.0%
Louisiana	103,962	100,244	3,718	3.7%
Rhode Island	11,699	11,406	293	2.6%
West Virginia	24,648	24,047	601	2.5%
Idaho	13,267	12,953	314	2.4%
Kentucky	50,245	49,127	1,118	2.3%
Pennsylvania	128,589	126,555	2,034	1.6%
Maine	14,386	14,171	215	1.5%
Washington	13,418	13,402	16	0.1%
Delaware	4,864	4,984	-120	-2.4%
Alaska	11,366	11,674	-308	-2.6%
Ohio	121,539	126,453	-4,914	-3.9%
Missouri	86,221	89,815	-3,594	-4.0%
South Carolina	50,312	52,727	-2,415	-4.6%
Minnesota	2,067	2,180	-113	-5.2%
Oklahoma	57,351	62,163	-4,812	-7.7%
Texas	326,550	355,518	-28,968	-8.1%
Wisconsin	29,352	32,168	-2,816	-8.8%
New York	326,103	417,880	-91,777	-22.0%
New Mexico	8,133	11,016	-2,883	-26.2%
Florida	203,632	322,348	-118,716	-36.8%
TOTALS	**3,876,664**	**3,831,310**	**45,354**	**1.2%**

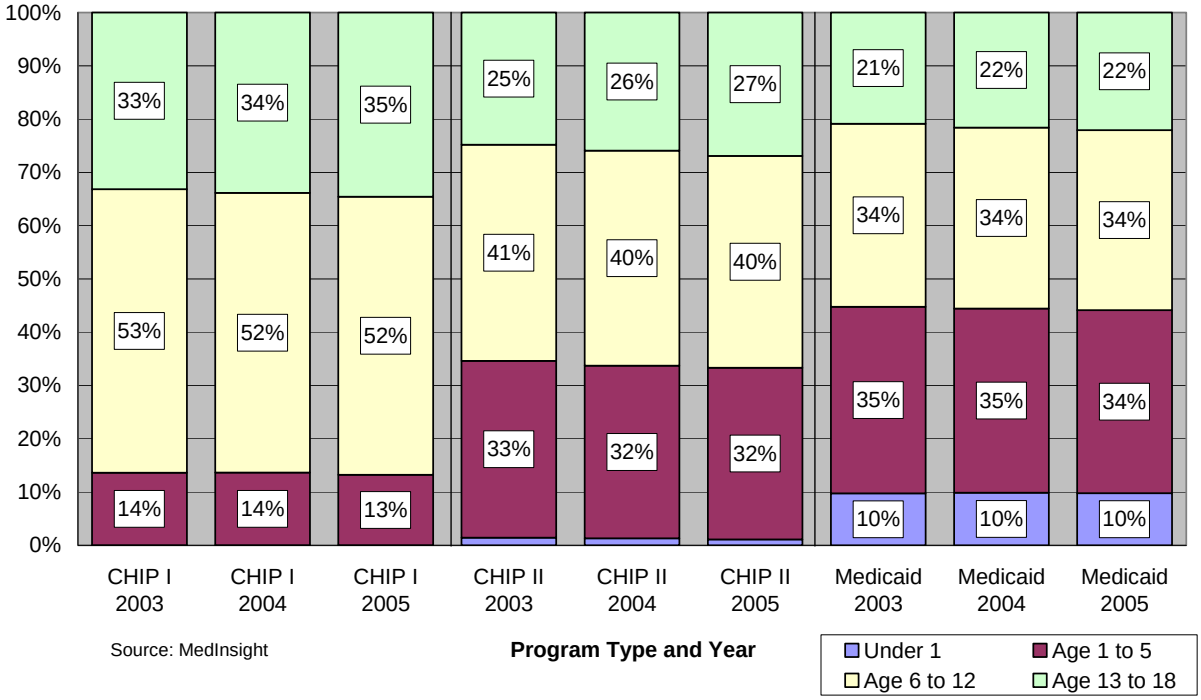
Source: CMS, FY 2005 Quarter 4 and FY 2004 Quarter 4 Enrollment Reports.

How does the age distribution of members in CHIP Phase I compare to the distribution in CHIP Phase II and Medicaid?

Exhibit II.5 shows the age distribution of children under 19 enrolled in CHIP Phase I, CHIP Phase II, and Medicaid across the past three years. There is very little difference in the distribution by year as the percentages for each program across the four age groupings remained stable.

However, there are differences across the programs with respect to the distribution of children by age group, due mainly to the different eligibility requirements for each of the programs. For instance, children under age 1 with family incomes up to 150% of the FPL are covered under Medicaid, meaning no children under age one are enrolled in CHIP Phase I and very few are covered by CHIP Phase II. Furthermore, children ages one through five in families up to 133% of the FPL are still covered under Medicaid, which only leaves the gap between 133% and 150% of FPL for the age group in CHIP Phase I. Not until a child reaches age six is Medicaid eligibility reduced to 100% of the FPL. As a result of these program eligibility differences, the children in the CHIP Phase I program tend to be older than those in either CHIP Phase II or Medicaid.

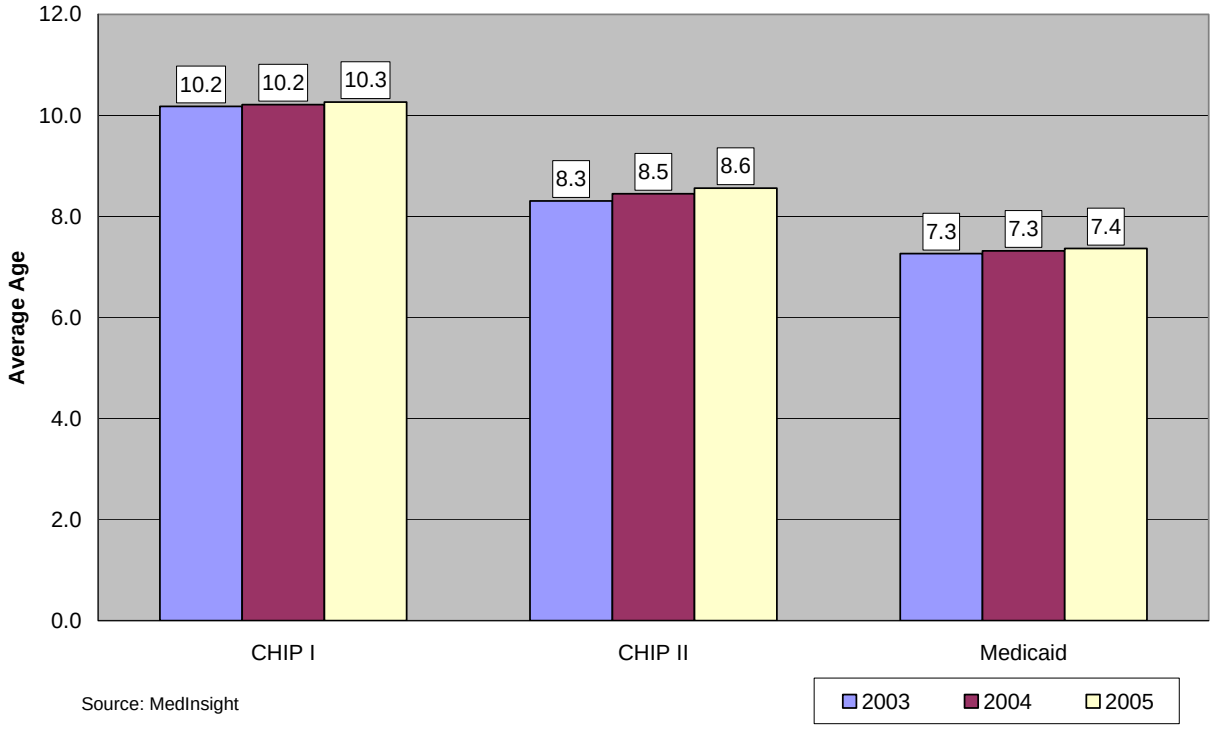
Exhibit II.5
Age Distribution of Children Up to Age 19
by Program Type for Past Three Years



For each of the past three years, over half of the children in CHIP Phase I were between the ages of 6 and 12, while one-third were ages 13 to 18. For the same time period, about two-fifths percent of CHIP II children were ages 6 to 12, while about one-quarter were ages 13 to 18. Most of the rest of the children were between the ages of 1 and 5.

Children in the Medicaid portion of Hoosier Healthwise are younger than those in either portion of the CHIP. As Exhibit II.6 illustrates, Medicaid has the youngest child population of the three groups with an average age of 7.4 years in 2005. This is because almost all of the children under age one are in Medicaid. In 2005 CHIP Phase I had an average age of 10.3 years, while CHIP Phase II had an average of 8.6 years. These average age findings have remained unchanged in the last three calendar years.

Exhibit II.6
Average Age of Enrollees by Program for Past Three Years



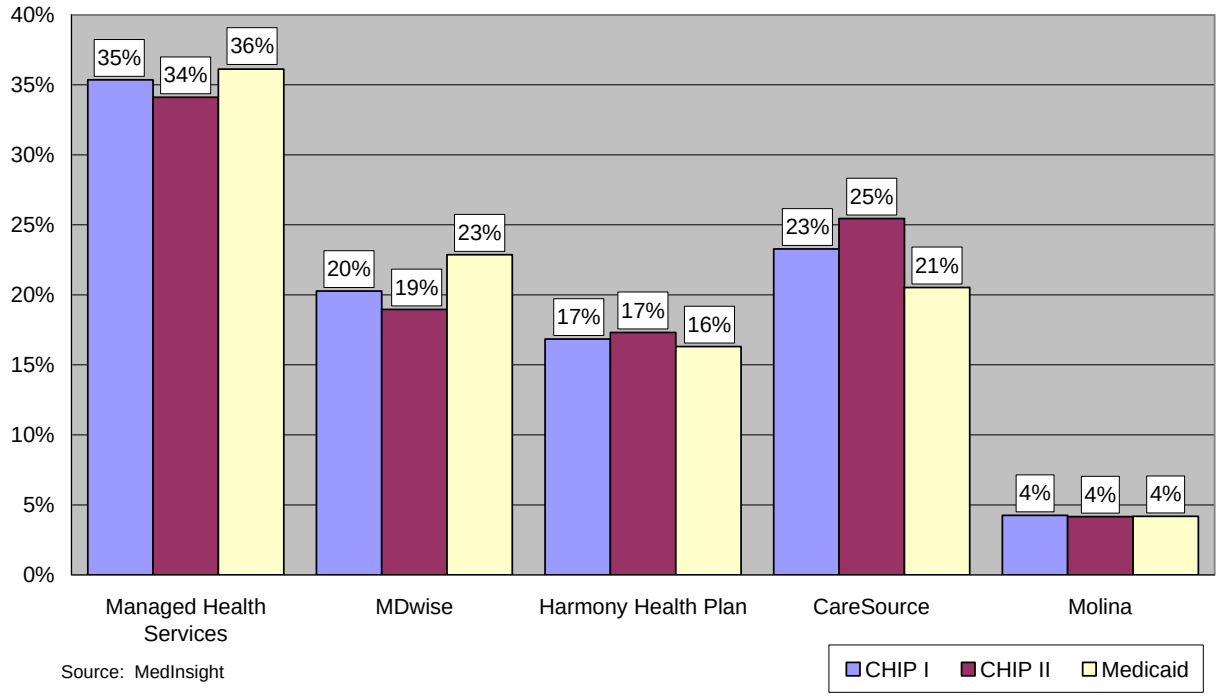
Source: MedInsight

What is the distribution of enrollment of CHIP Phase I, CHIP Phase II, and Medicaid members in the RBMC delivery system?

As of the end of calendar year 2005, all children in Hoosier Healthwise are required to enroll in the RBMC delivery system. Under this system, members are enrolled with doctors who are affiliated with one of five managed care organizations (MCOs). An initially qualified Hoosier Healthwise enrollee enters the fee-for-service (FFS) portion of the program until they select a primary medical provider (PMP) in the RBMC delivery system or are automatically assigned to a PMP.

EP&P confirmed that by December 2005, the children in CHIP and Medicaid transitioned from the former Primary Care Case Management (PCCM) system to one of the five MCOs in the RBMC system. As Exhibit II.7 shows, Managed Health Services has the largest share of the CHIP members in RBMC with about one-third of all of the members. CareSource, one of the two new MCOs in 2005, has almost 25 percent of the enrolled members. MDWise has another 20 percent of the CHIP enrollees, while Harmony Health Plan and Molina each have 17 percent and 4 percent, respectively.

Exhibit II.7
Distribution of RBMC Members by MCO
for Children Up to Age 19 (as of December 2005)



Source: MedInsight

What is the average period of enrollment for CHIP members, and how does this compare to children in Medicaid?

Children in CHIP Phase I and CHIP Phase II showed similar patterns with respect to their average period of enrollment, and in both cases this average period of enrollment was slightly higher than what was found for Medicaid children.

All members who disenrolled from CHIP during calendar years 2003 and 2004 and through June 30, 2005 were identified. For each member, the number of months they were enrolled before leaving the program were counted. In this analysis, the maximum number of months a member could be enrolled was 30 months (from January 2003 to June 2005). Children who turned age 19 were excluded because the eligibility system would have automatically disenrolled them one month after their nineteenth birthday.

Of the almost 35,000 children in CHIP who disenrolled for a reason other than turning age nineteen, 40 percent were enrolled for 10 months or less and almost 40 percent were enrolled for between 11 and 20 months. Only 2 percent were enrolled for 30 months or more (see Exhibit II.8 below).

Exhibit II.8
Average Period of Enrollment for CHIP and Medicaid Child Members
For Members that Disenrolled Before July 1, 2005

Number of Months Enrolled	CHIP Phase I (20,095 members)	CHIP Phase II (14,431 members)	Medicaid Children (140,886 members)
	% of Total	% of Total	% of Total
1 to 5 months	17%	17%	20%
6 to 10 months	23%	23%	24%
11 to 15 months	22%	20%	24%
16 to 20 months	16%	16%	14%
21 to 25 months	13%	14%	10%
26 to 29 months	8%	8%	6%
30 or more months	2%	2%	1%
Total	**100%**	**100%**	**100%**

Note: 18 year-olds excluded from this analysis due to the fact that the eligibility system would have automatically disenrolled them one month after their nineteenth birthday

Source: MedInsight

Are CHIP enrollees distributed evenly across the state?

There is variation in the proportion of CHIP enrollees by county in Indiana, as shown by Exhibit II.9 on the next page. The total child population (age up to 18) was derived from U.S. Census Bureau data from July 2004 estimates (the most recent available). The combined CHIP Phase I and Phase II enrollment for July 2004 was also used and compared to the census figures. Because counties have varied population levels, a measurement of CHIP enrollment per 1,000 children in each county in Indiana was calculated. Red counties have the highest rates, while those in white have the lowest rates.

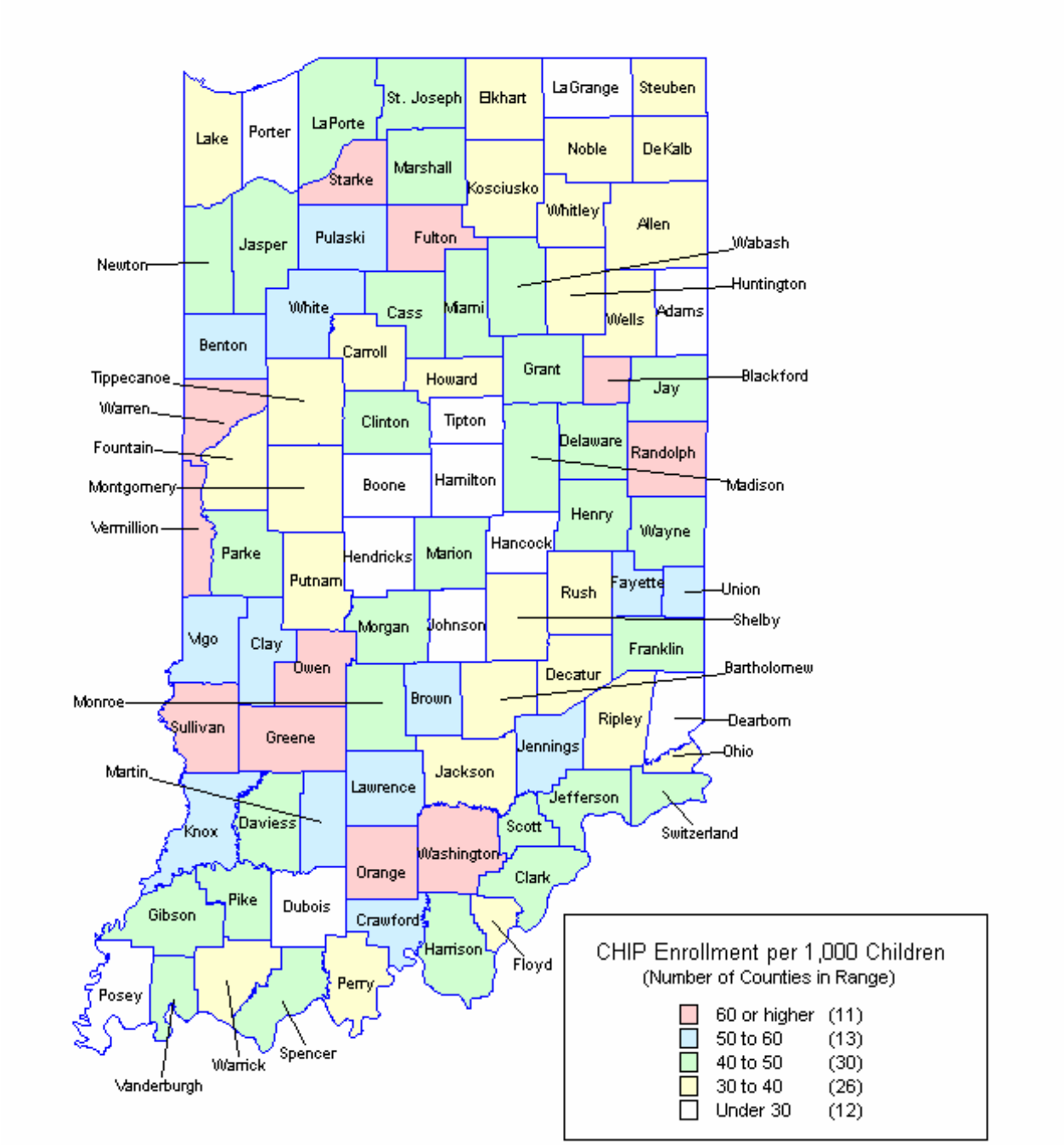
For the entire state, 40 out of every 1,000 children are enrolled in the CHIP program. Eleven counties have 60 or more children per 1,000 enrolled in CHIP. The highest rate of CHIP enrollment is in Orange County (73 children per 1,000), and the lowest is Hamilton County with 14 children per 1,000. All of the counties with the highest CHIP enrollment rates per 1,000 are considered rural (meaning they are not part of a metropolitan statistical area). Out of the twelve counties with under 30 CHIP children enrolled per 1,000, six of them are located in the middle of the state and nine out of the twelve are classified as urban.

Are Medicaid enrollees distributed evenly across the state?

As found with CHIP children, there is variation in the proportion of children enrolled in Medicaid by county in Indiana, as shown by Exhibit II.10. For the entire state, for every 1,000 children, 272 are enrolled in Medicaid, meaning more than one-quarter of the children in Indiana have health insurance from Medicaid. This ranges from a high of 382 children per 1,000 in Lake County to a low of 64 children per 1,000 in Hamilton County.

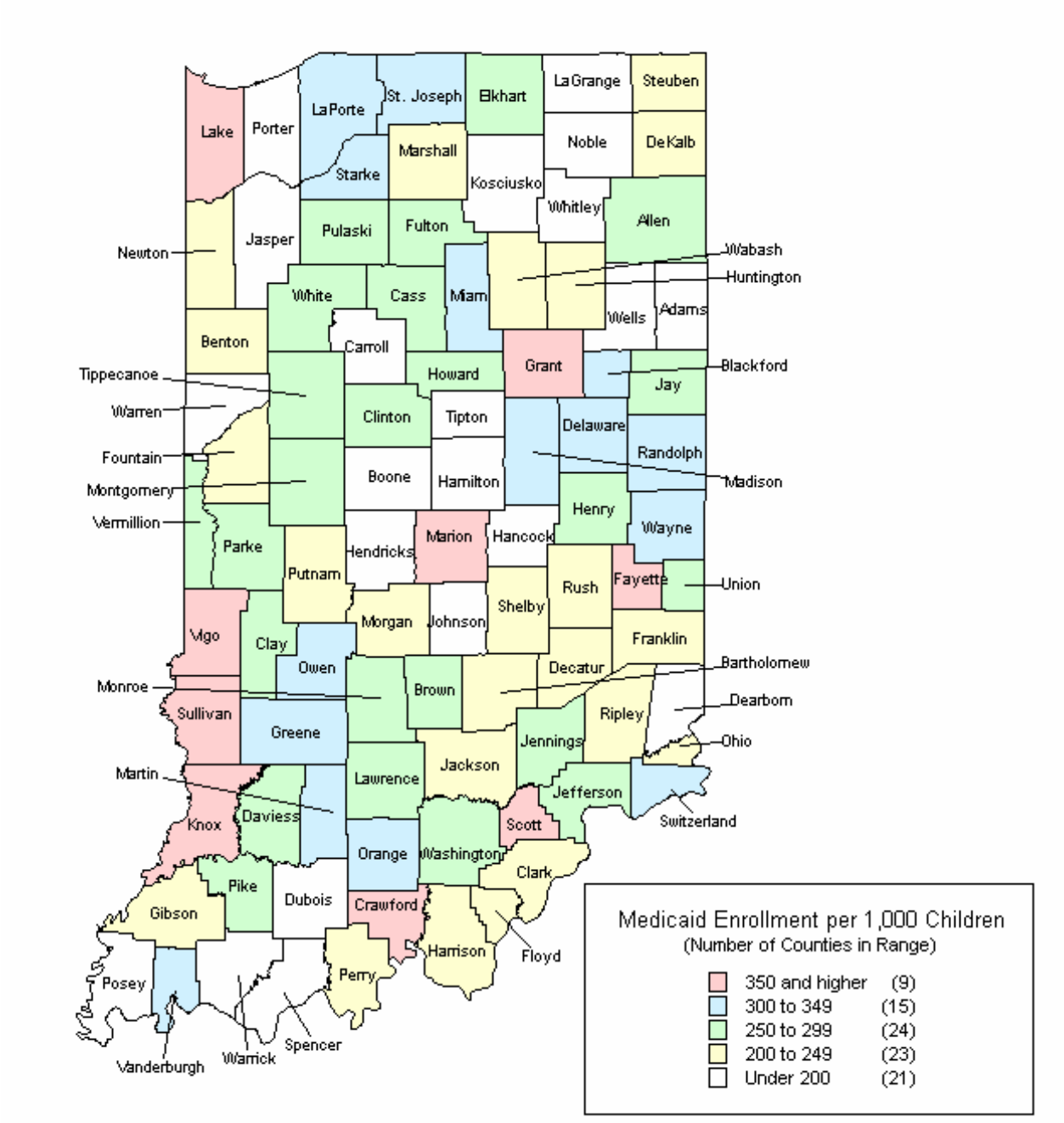
Contrary to the finding of CHIP density, six out of the nine Medicaid counties with the highest density (350 or more children per 1,000 enrolled in Medicaid) are urban counties. Most of these counties are situated near the state's border, with the exception of Marion County. But in a finding similar to the CHIP density map, five of the seven counties surrounding Marion County have low Medicaid enrollment density rates (below 200 per 1,000 children). The northeast corner of the state also has lower Medicaid enrollment density, and these counties also had lower CHIP enrollment density. All twelve counties that have the lowest CHIP enrollment density also fall into the bottom category on the Medicaid enrollment scale. At the high end, only Sullivan County is at the top of the scale in terms of both CHIP and Medicaid enrollment density.

Exhibit II.9
Map of CHIP Enrollment per 1,000 Children by County
July 2004



Source: MedInsight and U.S. Census Bureau data for July 2004

Exhibit II.10
Map of Medicaid Enrollment per 1,000 Children by County
July 2004



Source: MedInsight and U.S. Census Bureau data for July 2004

Is there a relationship between CHIP and Medicaid enrollment in a county?

The map shown in Exhibit II.11 compares enrollment of children in CHIP to enrollment of children in Medicaid within each county in December 2005. The statewide CHIP to Medicaid enrollment ratio is .16 or, for every one child enrolled in CHIP, there are six children enrolled in Medicaid. A variance of 50 percent from this average means that disproportionately high CHIP counties have a CHIP to Medicaid ratio above .24, while disproportionately low CHIP counties have a ratio below .08.

There are 12 counties with a disproportionately high CHIP enrollment when compared to Medicaid. They include the counties of Benton, Brown, Hendricks, Kosciusko, Marshall, Newton, Orange, Spencer, Wabash, Warren, Wells and White. However, there are no counties with a disproportionately low CHIP enrollment when compared to Medicaid. The lowest is Lake County at .11. Marion County is also below the statewide average at .14. Due to their large population, these two counties bring down the overall average.

Interestingly, only Orange and Warren Counties have both a disproportionately high CHIP to Medicaid child enrollment ratio and are also high CHIP counties with respect to CHIP enrollees per 1,000 children in the county. The fact that there are few counties that have a disproportionately high CHIP enrollment versus Medicaid and no counties have a disproportionately low CHIP enrollment versus Medicaid indicates that the patterns of CHIP and Medicaid enrollment in a county are similar.

Exhibit II.11
CHIP to Medicaid Enrollment Ratio by County
December 2005

Source: MedInsight Data from December 2005

CHAPTER III

ACCESS

CHAPTER III
ACCESS

INTRODUCTION

Having completed the transition to the Risk-Based Managed Care (RBMC) delivery system during 2005, every family whose child has enrolled in CHIP has chosen or been assigned a primary medical provider (PMP). The child automatically becomes a member of the managed care organization (MCO) with which their PMP has contracted. The PMP is the child's primary source for preventative care, such as well-child visits, but also plays a key role in the coordination of other care required by unexpected problems. The Office of Medicaid Policy and Planning (OMPP) contracts with MCOs to deliver care through the RBMC system. The contracts stipulate how many PMPs must enroll with each MCO based upon the number of members it has in its contract area.

Each PMP that contracts with an MCO negotiates the number of members that he/she is willing to accept as patients. This is known as the panel size of the PMP. To measure the availability of PMPs for children in CHIP, EP&P Consulting (EP&P) looked first at PMP capacities throughout the state. The panel capacity measures how full the panel is for each PMP. For example, for a PMP that is willing to accept 100 new children, an 80% panel capacity means that the PMP has already accepted 80 children and is willing to accept 20 more. Due to shortages of enrolled PMPs in certain counties, panel capacities for children sometimes exceed 100%, which may place undue pressure on the PMPs and may restrict children's access to their PMPs.

Another indicator used to determine that access to PMPs may be restricted is a low percentage of children who use PMP services during the year. In this chapter, EP&P compares access rates for PMP services across the state and compares these rates to the panel capacities in those areas. We also compare panel capacities and access rates between the different MCOs to reveal any differences within the MCO networks.

The last section of the chapter compares the average number of patients per PMP in each county against the panel capacities. Counties with full panels and a high average number of patients per PMP are the most likely to have PMP shortages that adversely affect access to care. Counties with full panels but relatively few patients per PMP and counties with many patients per PMP but relatively empty panels probably have the means to either expand the panel size or increase the number of patients per doctor to make any potential shortage less of a concern.

SPECIFIC ANALYSES

How do PMP panel capacities vary across the state?

The OMPP tracks the number of pediatric primary medical providers (PMPs) enrolled in Hoosier Healthwise each year. By tracking the pediatric PMPs and their corresponding panel sizes, the OMPP knows where there is excess capacity for future enrollment and where there may be a need to enroll more pediatric PMPs or negotiate to expand current PMP panel sizes.

For this analysis, pediatric PMPs include General Practitioners, Family Practitioners, and Pediatricians, but do not include Internal Medicine, OB/GYNs or any type of PMP that only treats patients older than 17. Findings from 2005 showed that:

- The number of pediatric PMPs, as defined above, did not change between December 2004 (1,883 PMPs) and December 2005 (1,882 PMPs), indicating that most doctors enrolled in the PCCM portion of Hoosier Healthwise moved into the RBMC portion of the program.

- Increasing enrollment caused the average number of enrollees per pediatric PMP to increase 1.9% to 267.

- The overall committed pediatric panel capacity rose one percent to 51% of total between December 2004 and December 2005. In other words, Hoosier Healthwise enrollment could double and the current number of pediatric PMPs could support them.

Though overall panel capacity is not a problem, county-specific shortages persist. The map on the next page (Exhibit III.1) shows panel capacity on a county-by-county basis. The analysis of panel size for Hoosier Healthwise as of January 2006 showed that:

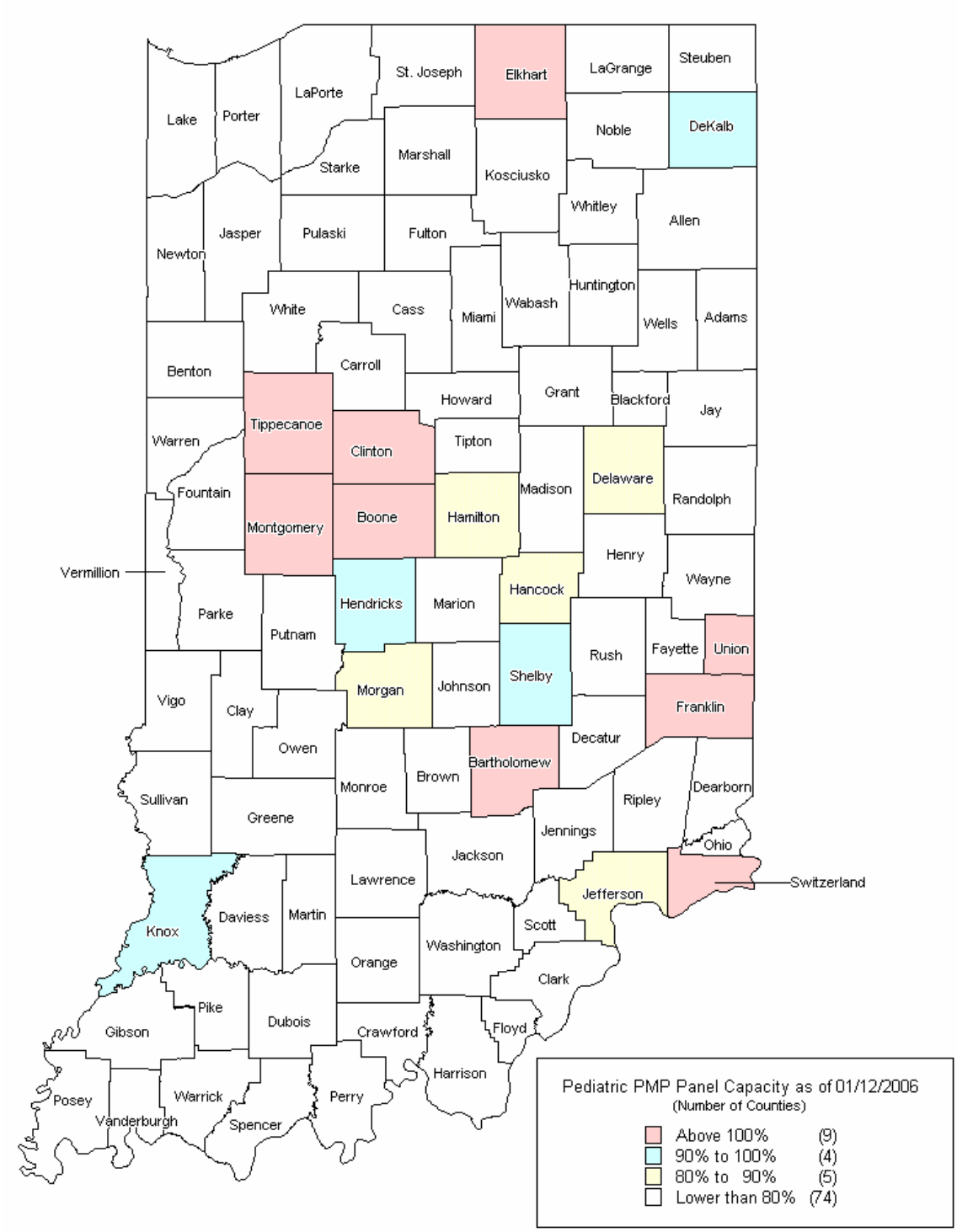
- 74 counties have more than 20% unused capacity in their panels.

- The number of counties with full panels fell to nine in 2005 from 12 a year earlier. These counties are Bartholomew, Boone, Clinton, Elkhart, Franklin, Montgomery, Switzerland, Tippecanoe and Union counties and they account for 8 percent of total CHIP enrollment in 2005. Three counties (Boone, Elkhart and Switzerland) are new to this list, but the rest have had full panels for three years.

- An additional nine counties are above 80% used panel capacity but do not yet have full panels.

Of the 18 counties that have more than 80% used panel capacity, only three were mandatory RBMC counties before 2005. As new mandatory RBMC counties, the State is encouraged to work with the MCOs to incentivize enrolling more pediatric PMPs.

Exhibit III.1
Pediatric PMP Panel Capacity by County



Source: MedInsight

In counties with full panel capacities, do a lower percentage of children use PMP services?

The percentage of children that visit a PMP during the year is covered in more detail in Chapter IV, but one version of this measure is included here as a direct comparison to the PMP panel capacity maps. Only children with nine months of enrollment are counted in this exhibit, because children with fewer months of enrollment may not have the same opportunity or need to access services. Children are also classified based on the aid category they are located in Hoosier Healthwise in the last month of enrollment in the year, so if a child started in Medicaid but ended in CHIP Phase I, they are counted as if they were in CHIP Phase I for the entire year.

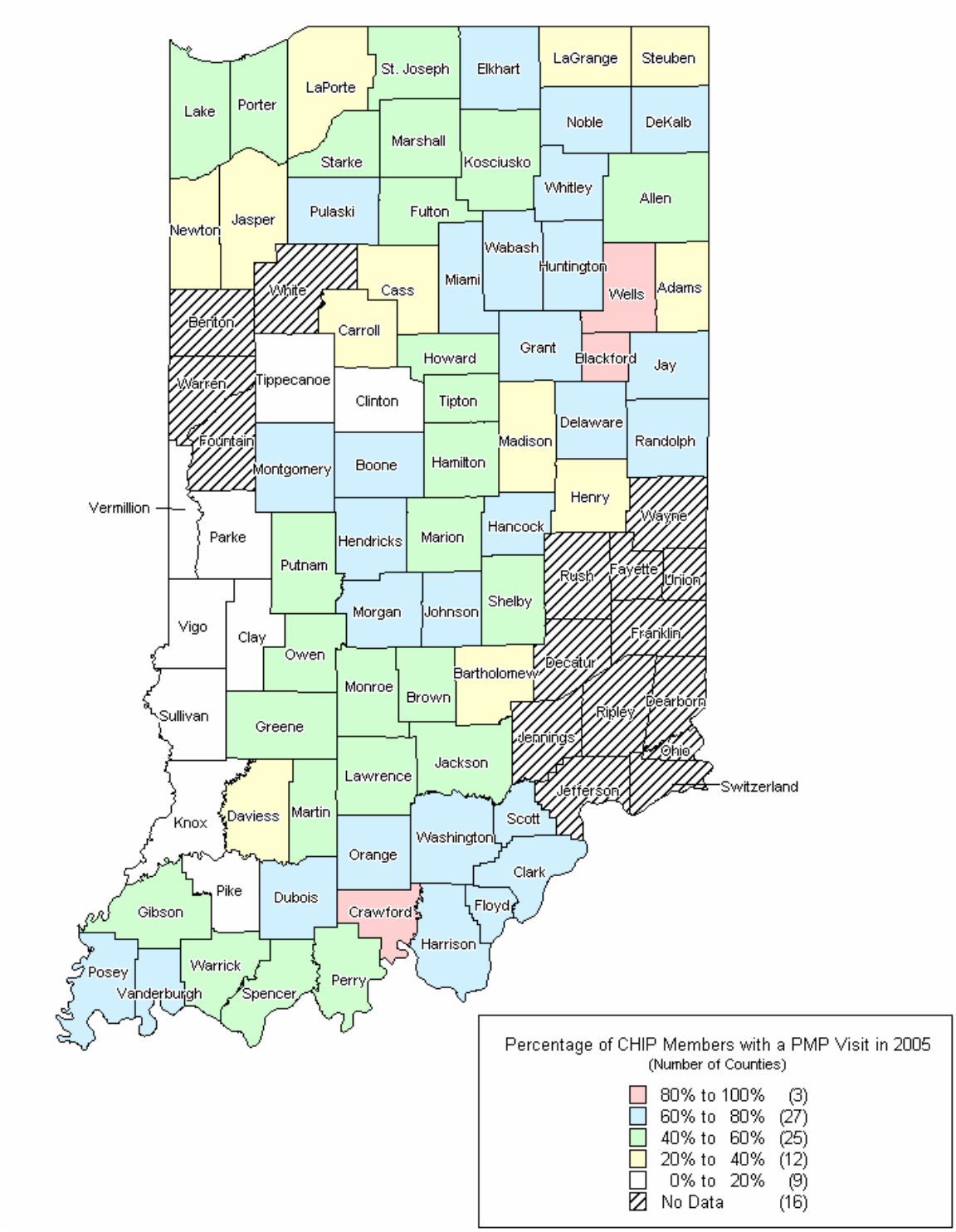
Exhibit III.2 on the next page shows the percentage of children by county in the RBMC delivery system who visited a PMP in 2005. Counties that had less than ten members with at least nine months of enrollment in the year are marked and do not have a percentage calculated for them.

The exhibit shows that the percentage of children visiting PMPs during the year varies widely among the counties, but it does not suggest a strong connection between panel capacities (Exhibit III.1) and the percentage of children using PMP services. If there was a strong connection, then counties with constrained panel capacities would have a lower percentage of children visiting PMPs. This is true for Tippecanoe and Clinton counties, which both have full panel capacities and low PMP visitation rates, but the two counties next to them, Montgomery and Boone, have the same panel capacity issue but higher than average PMP visitation rates. Other counties with full panel capacities (Franklin, Switzerland and Union) did not have enough data to analyze their visitation rates, while the results are split between Bartholomew and Elkhart counties.

Though there does not appear to be a strong relationship between panel capacities and visitation rates, they are both concerns independently. For example, the counties on the western border of the state between Vermillion and Pike all have PMP visitation rates below 20%. Since all but one (Knox) have adequate panel capacities, there are obviously other factors affecting the PMP visitation rates besides adequate access to a PMP.

It should be noted that this analysis used a strict interpretation of PMP visits. That is, a PMP is defined as a physician working in a private practice that was one of five provider specialties. To the extent that there are PMPs working in a clinic setting, they are not represented in Exhibit III.2. If there are clinics in a county where PMPs are seeing CHIP members, then the findings of the percentage of CHIP members with a PMP visit on Exhibit III.2 may be understated.

Exhibit III.2
Percentage of CHIP Members with a PMP Visit in CY 2005



Source: MedInsight

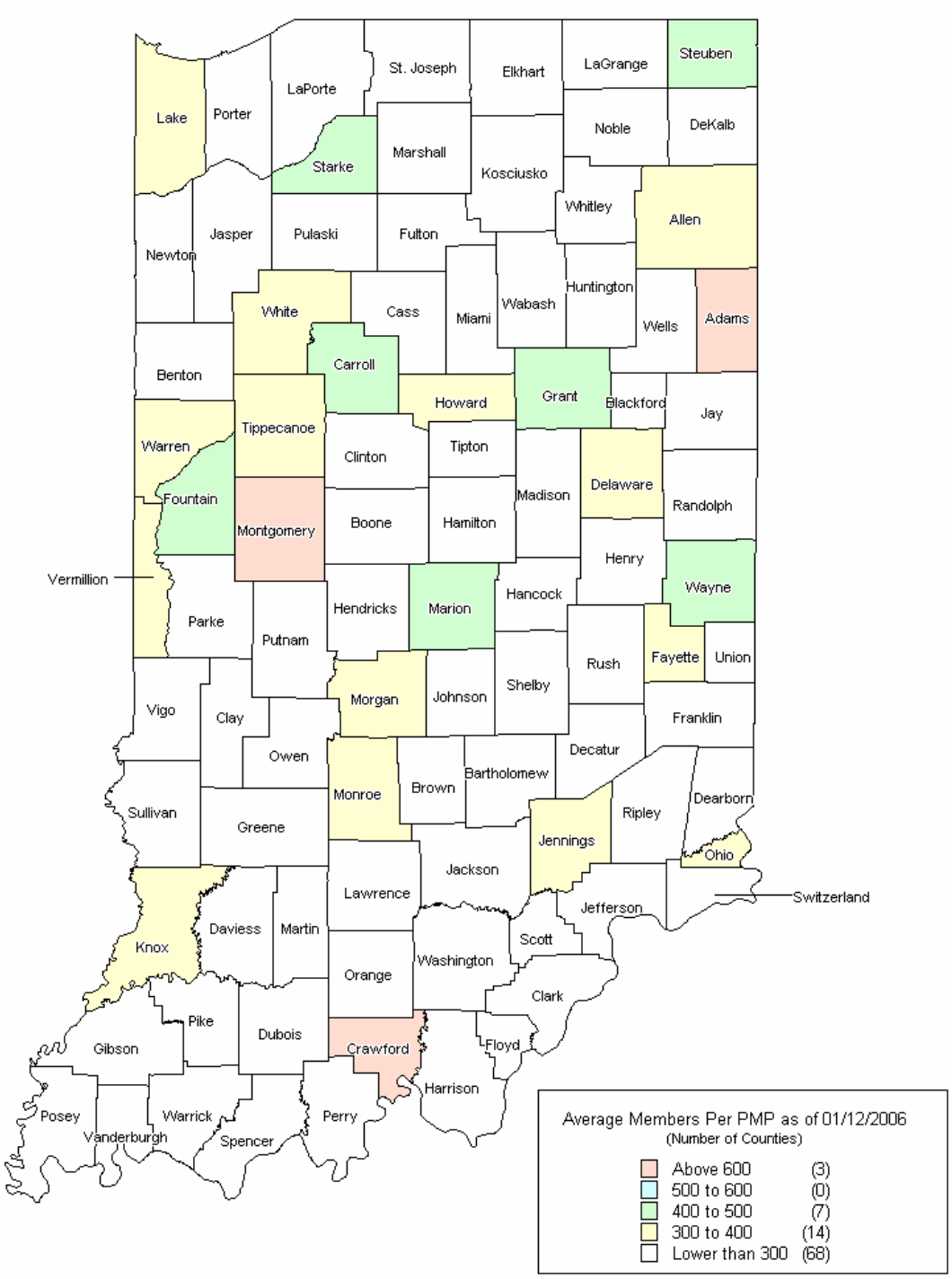
Do counties with full panels also have a higher than average number of members assigned to each PMP?

Panel capacity is one measure of how many CHIP children a given number of PMPs can support in a county. It is based on how many patients the PMP agreed to accept when he or she negotiated with their MCO, but the number of patients that each PMP agrees to accept varies widely across the state. A county might appear, therefore, to have a shortage of PMPs based on panel capacity statistics, when the PMPs in the county only agreed to accept a minimal number of patients. The statewide average number of patients per pediatric PMP was 267 in January of 2006. If a county has a full panel but average number of patients per PMP of 100, then that county may be equivalent to a county with 50% panel capacity and an average number of patients per PMP of 200. On the other hand, looking at the average number of patients per PMP for a county might reinforce that the county has a shortage of PMPs. For example, a county with a full panel and over 400 patients per PMP on average is much less likely to be able to solve the panel capacity problem by persuading doctors to accept more patients.

Exhibit III.3 on the next page is a map showing the counties with above-average numbers of patients per PMP. The darker colors indicate counties with high numbers of patients per pediatric PMP. (Note that the patients per "pediatric" PMP also includes adults assigned to the PMP, since the three provider specialties that are included in the definition of pediatric are those that accept children as patients. However, these PMPs may also accept adults as patients, for example, General Practitioners and Family Practitioners). Comparing this exhibit to Exhibit III.1, there are only two counties (Montgomery and Tippecanoe) that have full panels and an above-average number of patients per PMP, Montgomery being the one that stands out the most. The rest of the counties with full panels have average numbers of patients per PMP, and the rest of the counties with high numbers of patients per PMP have less than full PMP panels. In the case of Montgomery and Tippecanoe Counties, it might be possible for the providers with full panels to expand their panel sizes, while in the second case, the panel capacities in place suggest that the PMPs are willing to accept more patients since their panels are not full.

Exhibit III.3 alone cannot determine the percentage of children who visit a PMP. However, both the panel size and the average number of patients probably do have some impact on the PMPs' availability to the children since both factors can influence the amount of time that a PMP spends with each patient.

Exhibit III.3
Average Members Per PMP by County



Source: MedInsight

CHAPTER IV

SERVICE UTILIZATION

CHAPTER IV
SERVICE UTILIZATION

INTRODUCTION

This chapter provides an analysis of the service utilization trends in the CHIP program. Service utilization is an underlying factor for both overall and per member per month (PMPM) expenditures and can be an indicator of the quality of access to the program and the quality of services provided. For example, zero utilization of a particular service might indicate an access problem whereas a high number of ER visits might indicate poor quality of services. EP&P used the following measures of utilization for the analysis in this chapter:

- First, we reviewed the *actual number* (or the percentage of children) that used services during the year.
- Second, we reviewed the number of *claims per 1,000* members for children in each delivery system and package.

To compute the percentage of children using services, we identified all the children with at least nine months of enrollment during each of the calendar years 2003, 2004 and 2005 and pulled all of the claims for these children. The children are categorized based on the delivery system (primary care case management (PCCM), risk-based managed care (RBMC), or fee-for-service (FFS)) and package (CHIP I, CHIP II or Medicaid) that they were enrolled in at the end of the year. This means that each child is categorized under only one group.

Because the three packages have different sized populations, the number of claims per 1,000 members' statistic allows for comparison across the three packages. A claim generally represents an episode of service, so the number of claims represents the number of episodes of service delivered. The services we reviewed include primary care doctor visits, specialist visits, clinic visits, inpatient hospital stays, outpatient hospital visits, pharmacy prescriptions, and dentist visits. Unlike in the actual number (or percentage) statistics, each member could be counted more than once in the claims per 1,000 member statistics if they used a particular service more than once in the year (e.g. a child that had three different prescriptions filled in a year would be counted three times in the claims per 1,000 calculation).

Each measure indicates a different aspect of utilization. The first indicates how many (as a percentage) of the children are using particular services, which is especially useful for determining if all children are receiving periodic preventative care services. The second indicates the relative claim volumes between services. This measure is used to determine if the rate of utilization of particular services is increasing or decreasing over time.

While all services are considered, this chapter puts emphasis on visits to primary medical providers (PMP), because these are the primary source of preventative care services for most

children and the PMP is an important contributor to the coordination of each child's care. Low utilization of these services detracts from the overall quality of care provided and might be an indicator of an access problem for these services. To analyze claims data, we grouped services into the following eight major service categories:

- PMP visits to the child's assigned PMP
- Visits to another PMP
- Specialty physician visits
- Clinic visits (not including hospital-based clinics)
- Inpatient hospital services
- Outpatient hospital services
- Pharmacy services
- Dental services

To capture utilization trends for specific time periods, EP&P evaluated utilization based upon the date when the service was provided, not when the service was paid for by the State or managed care organization (MCO). As a result, not all claims for the latter half of calendar year (CY) 2005 are represented because providers are still submitting claims for payment. This is especially true for hospital claims. Therefore, utilization charts that identify data from CY 2005 only reflect information through the month of October 2005 so that the findings are not artificially skewed.

Another item that EP&P has found each year we have conducted the CHIP evaluation is that service utilization comparisons between CHIP and Medicaid children are always skewed because almost all of the children under age one are in the Medicaid portion of Hoosier Healthwise and not in CHIP. As these children are higher utilizers of some services than older children, the findings for Medicaid children could not be fairly compared to findings for CHIP children. Therefore, all data presented in this chapter exclude information for children enrolled when they were under age one (for both the CHIP and Medicaid portions of the program). By doing this, any differences in utilization for CHIP and Medicaid children would more likely be due to something other than the age groups each program serves.

KEY FINDINGS

- About 60 percent of the CHIP members visited their PMP, as defined by EP&P, during each of the last three calendar years.

- When visits to specialists and clinics are included, about 80 percent of CHIP children saw a physician during the calendar year. This rate is much higher for young children and decreases as the children get older. For example, 98 percent of all one year-olds saw some type of physician in CY 2004, whereas about 80 percent of children ages six through 12 saw a physician during this time period.

- The percentage of children who visit their PMP is higher in the RBMC delivery system, but the percentage of children who visit any type of physician (PMP, specialist, clinic) was found to not be different between RBMC and PCCM.

- The percentage of children who had a PMP visit varies by health plan, between 40 percent and 75 percent.

- There is little difference between the percentage of children seeing their PMP between the CHIP and Medicaid populations. This holds true at the overall level and by MCO.

- Utilization trends based on claims per 1,000 enrollees has remained stable over the last three years when the claims from MCOs were analyzed for inpatient hospital, outpatient hospital, primary care, specialist care, clinic, pharmacy and dental services. With a couple of exceptions, there is also little difference between the two CHIP packages in their utilization patterns. When compared to Medicaid children, CHIP children had a higher dental claims rate, pharmacy claims rate, and PMP physician claims rate per 1,000.

SPECIFIC ANALYSES

Do utilization statistics indicate that CHIP members are accessing services?

Utilization statistics confirm that most CHIP members are accessing some type of service, but the pattern of utilization may not be ideal. For example, approximately half of the children saw their assigned PMP during each calendar year. To arrive at these statistics, we found the CHIP members that were enrolled in the PCCM, FFS and RBMC delivery systems for at least nine months in the calendar year and pulled all of their corresponding claims. We counted members with nine months of enrollment so that only members that had an adequate amount of time in the program to access services would be measured. A member was counted as having accessed a service if he/she had a claim that fell into a major service category eight different categories of service (inpatient hospital, outpatient hospital, member's assigned PMP, a PMP other than the one they were assigned, specialty physician, clinic, pharmacy and dental services) during the year. The percentage of members accessing PMP visits, for example, is the percentage of members with nine months of enrollment that had a claim for a visit to their assigned PMP.

Children often move between CHIP Phase I and CHIP Phase II during the year or between delivery systems (e.g. most enrollees spend a month in FFS before they are assigned a PMP in the RBMC system) during the year. For the purposes of this analysis, each child is categorized in one package and one delivery system, based on which portion of CHIP and which delivery system they were enrolled in at the end of the calendar year.

The exhibits that follow show the percentage of CHIP Phase I and CHIP Phase II children that accessed each service category during the calendar year. Since these exhibits present the percentage of children that used any amount of service, these charts do not show how often the children used the services. The percentages are reported separately for each of calendar years 2003, 2004 and 2005. Note that the lag in reporting claims is probably causing the 2005 statistics to be underreported.

Exhibits IV.1 and IV.2 (appearing on page IV-5) show the percentage of enrollees from all delivery systems that used services in each of the calendar years 2003, 2004 and 2005. Exhibits IV.3 and IV.4 show the same information for children in just the RBMC delivery system. Key findings from this analysis are:

- Utilization is very similar between CHIP Phase I and CHIP Phase II for all but three service categories. A higher percentage of CHIP Phase II children saw either their assigned PMP or another PMP during the year, and a higher percentage of CHIP Phase II children had a pharmacy claim during the year.

- Children in the RBMC delivery system were slightly more likely to visit their PMP in 2005 when compared to children across all delivery systems. Children in the RBMC delivery system are less likely to have a clinic, pharmacy or outpatient hospital claim.

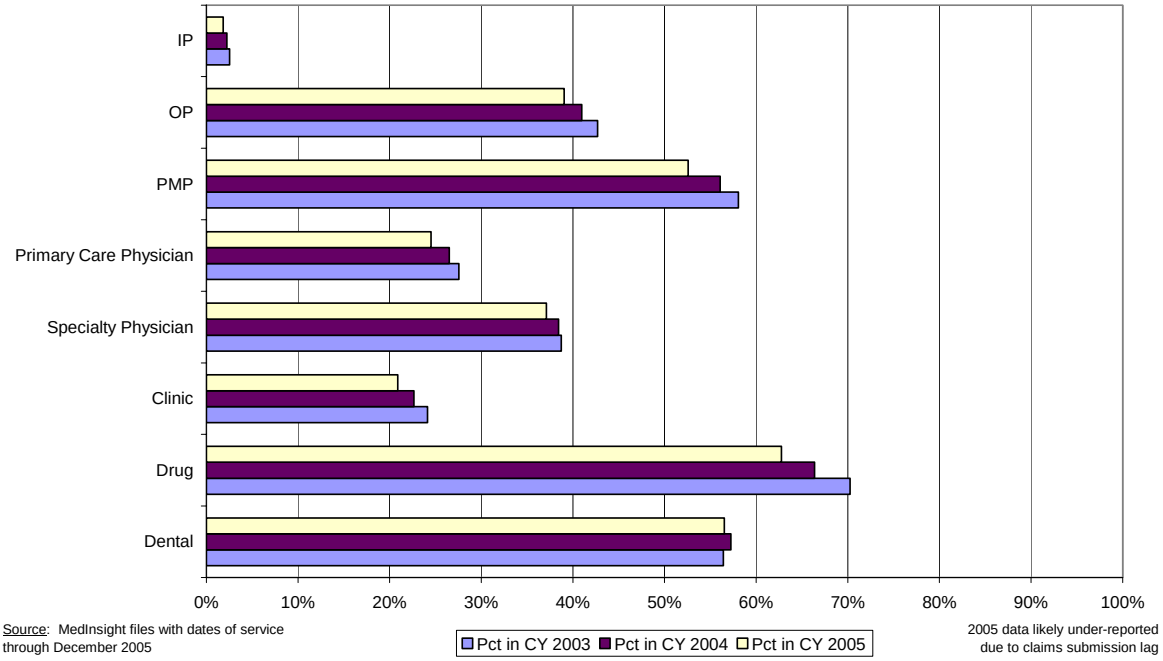
- Over a third of CHIP children access outpatient hospital services during the year, which includes services such as emergency room visits and outpatient surgeries.

- About 60 percent of the children (all ages and all delivery systems) in the CHIP program are visiting their assigned PMP during the year. Access to these services is evaluated in the next section.

- Over 60 percent of the children in CHIP that were enrolled in RBMC had a pharmacy script in both CY 2003 and CY 2004. This percentage of total children was even higher when all delivery systems were measured. The statistic is slightly lower in 2005, however, at about 55 percent of all children.

- About 20 percent of the children accessed services in a clinic setting from someone other than their assigned PMP. This may include primary care in much the same way as it is delivered in a PMP's private office.

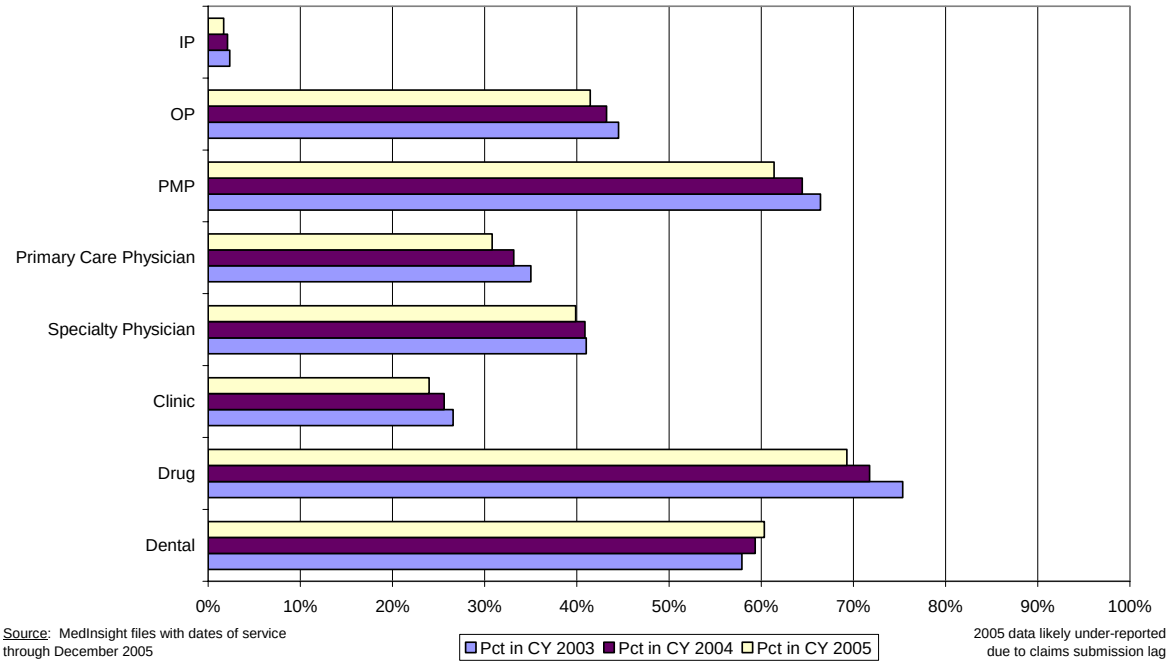
Exhibit IV.1
Percent of CHIP I Enrollees that Used Services
Based on Unique Number of Eligibles in All Delivery Systems



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

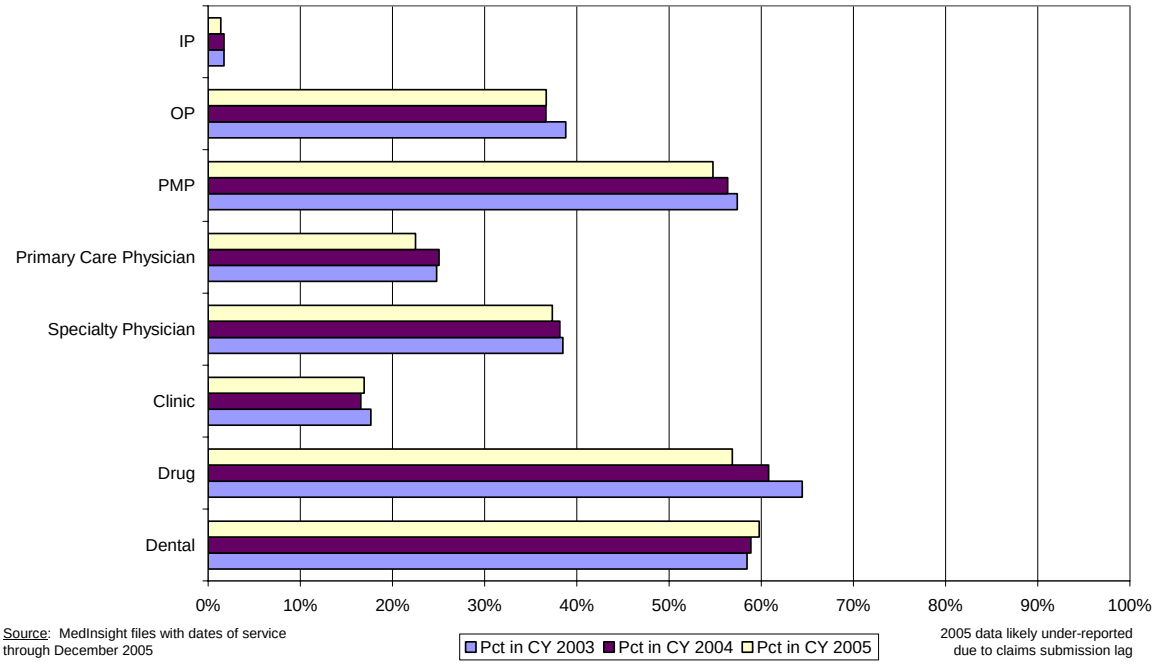
Exhibit IV.2
Percent of CHIP II Enrollees that Used Services
Based on Unique Number of Eligibles in All Delivery Systems



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

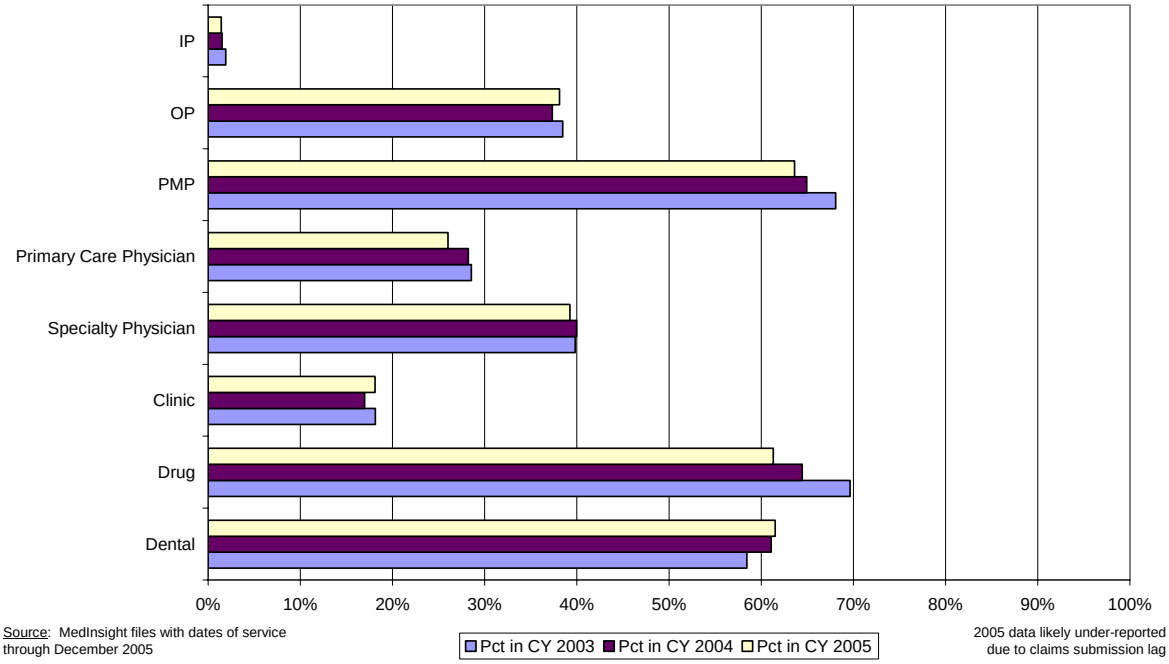
Exhibit IV.3
Percent of CHIP I Enrollees that Used Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

Exhibit IV.4
Percent of CHIP II Enrollees that Used Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

How does utilization of PMP services vary between age groups, delivery systems, and MCOs (within the RBMC delivery system)?

Overall, about 60 percent of CHIP members saw their assigned PMP during 2005, but this percentage varies between different age groups, delivery systems and MCOs. For example, younger members are more likely to have seen their PMP during the year than older members.

The charts in the following exhibits compare utilization of PMP services between age groups, delivery systems and MCOs:

- Exhibits IV.5 through IV.6 compare the utilization of PMP services across age groups in all delivery systems.
- Exhibits IV.7 through IV.8 compare the utilization of PMP services across age groups in the RBMC delivery system.
- Exhibits IV.9 and IV.10 compare the utilization of PMP services across all age groups among children in all delivery systems and those in the RBMC delivery system.
- Exhibits IV.11 and IV.12 compare the utilization of PMP services across MCOs for CHIP Phases I/II and Medicaid.

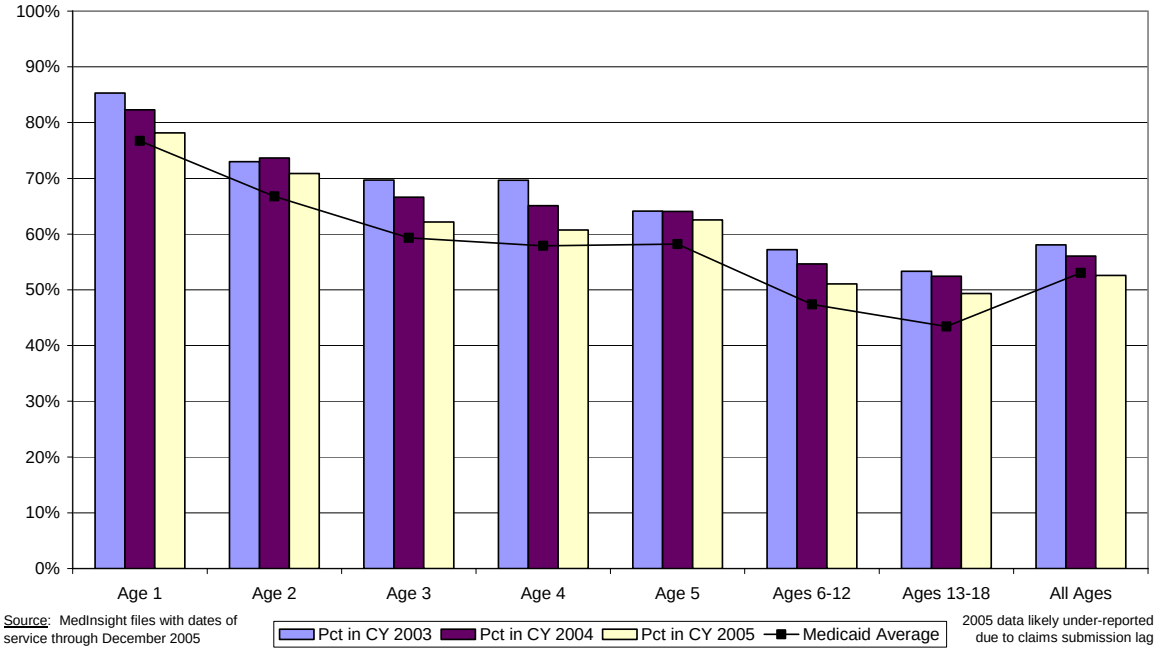
Key findings from these exhibits show that:

- The percentage of children that visit their assigned PMP is highest for one-year olds (80% to 85%) and declines as the children get older, with teenagers having the lowest rates of visitation (50% to 55%).
- A higher percentage of CHIP II children see their PMP than CHIP I children across all age groups. The percentages for both CHIP I children and CHIP II children are higher than the percentage for Medicaid children.
- The percentage of children visiting their PMP is slightly higher in the RBMC delivery system than it is for all delivery systems combined—that is, when PCCM and FFS are included with RBMC. This is true for both CHIP and Medicaid children.
- PMP service use varies significantly between MCOs with Harmony Health Plan having the highest utilization rates and CareSource having the lowest.

- Overall, the percentage of CHIP children using PMP services declined between 2003 and 2004 (due to the lag in claims submissions, 2005 cannot be compared to previous years yet).

For the purposes of these exhibits, the title "used PMP services" means that the member saw the specific PMP assigned to that member. Other physicians, primary care doctors and specialists, may see children for well-care visits, but these visits are not identified as PMP visits here because the provider is not identified as the PMP assigned to the child. These well-care visits may also be provided in a doctor's office or in a clinic. Exhibits IV.13 and IV.14 beginning on page IV-14 explore the issue of children visiting other doctors and the role they play in the delivery of care to CHIP members in Indiana.

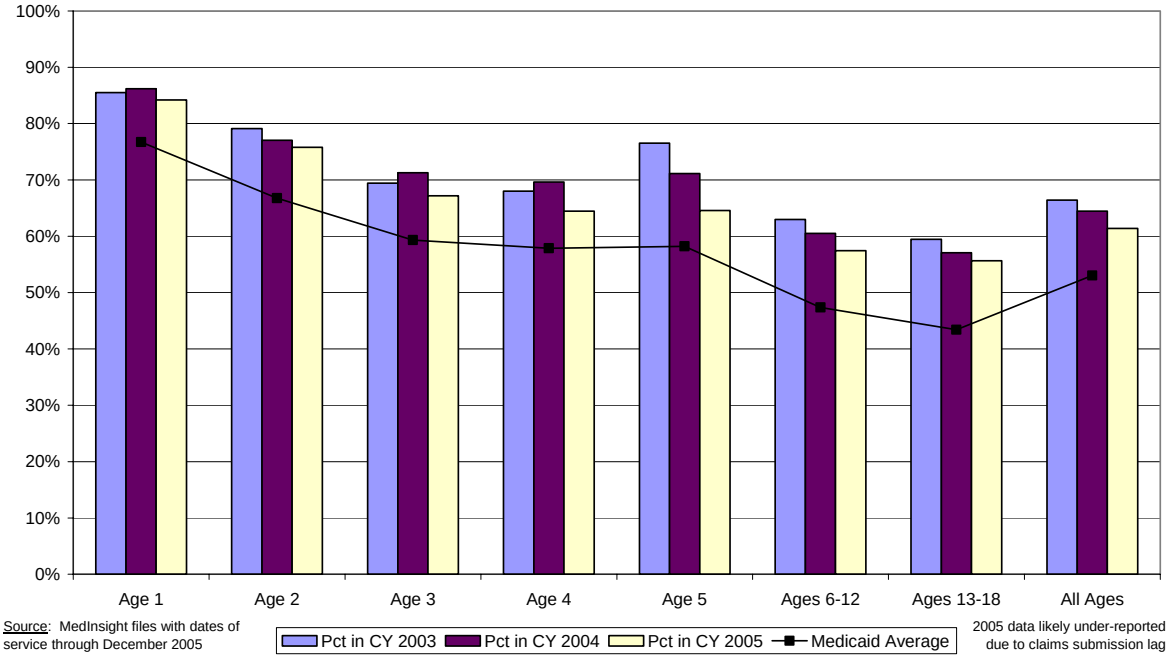
Exhibit IV.5
Percent of CHIP I Enrollees that Used PMP Services
Based on Unique Number of Eligibles in All Delivery Systems



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

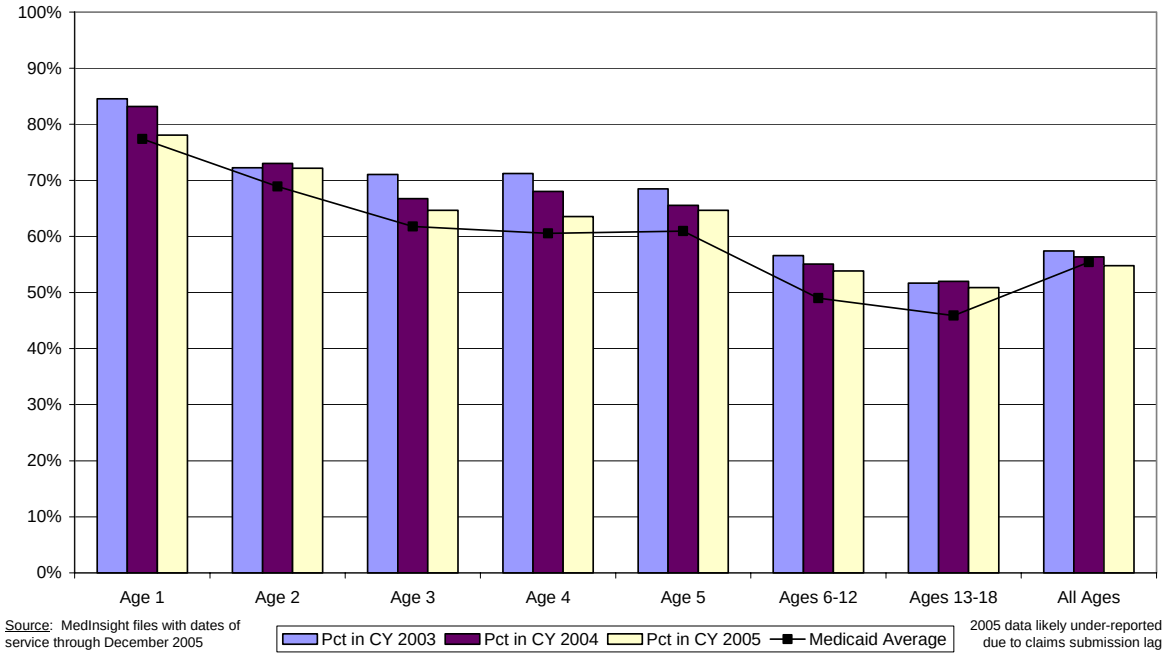
Exhibit IV.6
Percent of CHIP II Enrollees that Used PMP Services
Based on Unique Number of Eligibles in All Delivery Systems



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

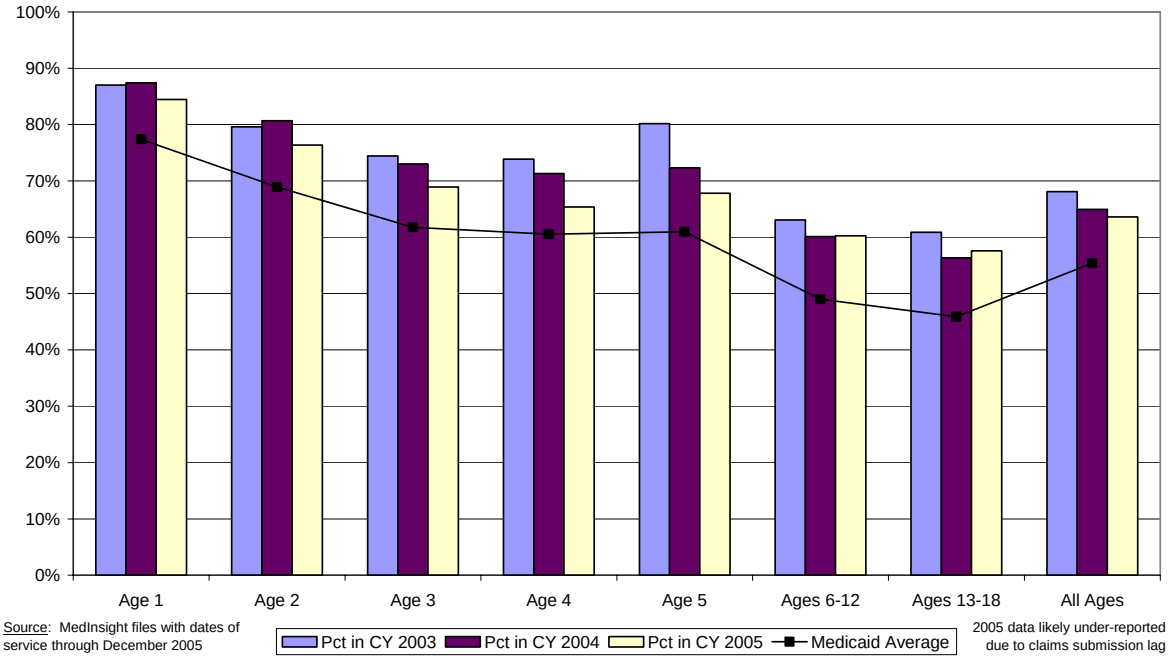
Exhibit IV.7
Percent of CHIP I Enrollees that Used PMP Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

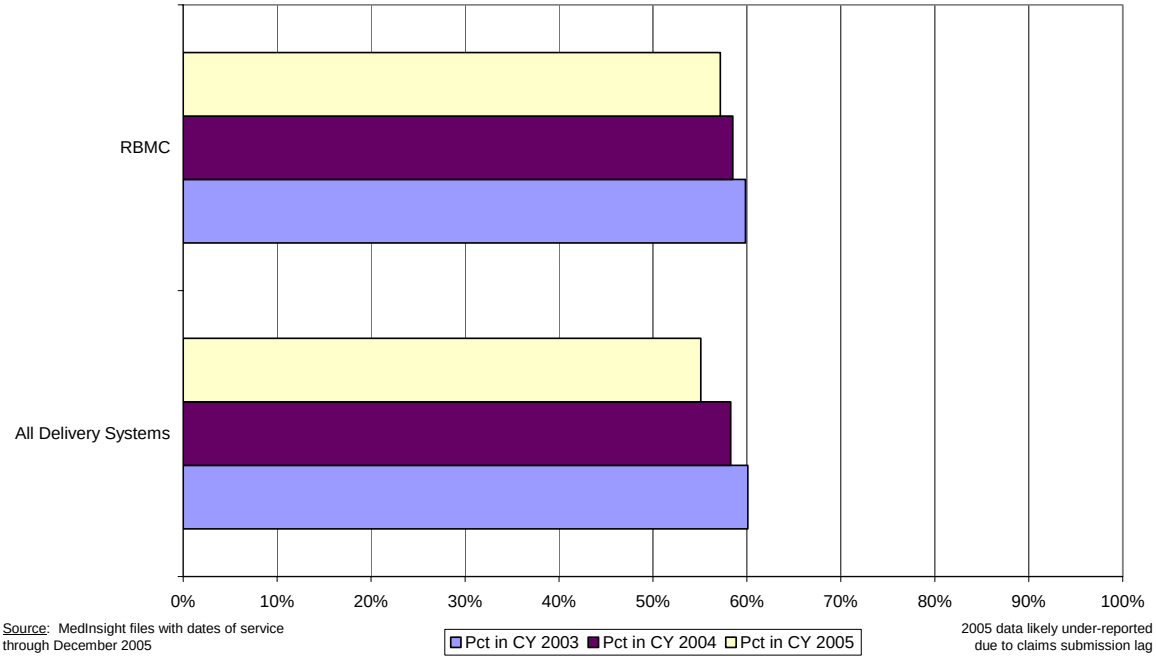
Exhibit IV.8
Percent of CHIP II Enrollees that Used PMP Services
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

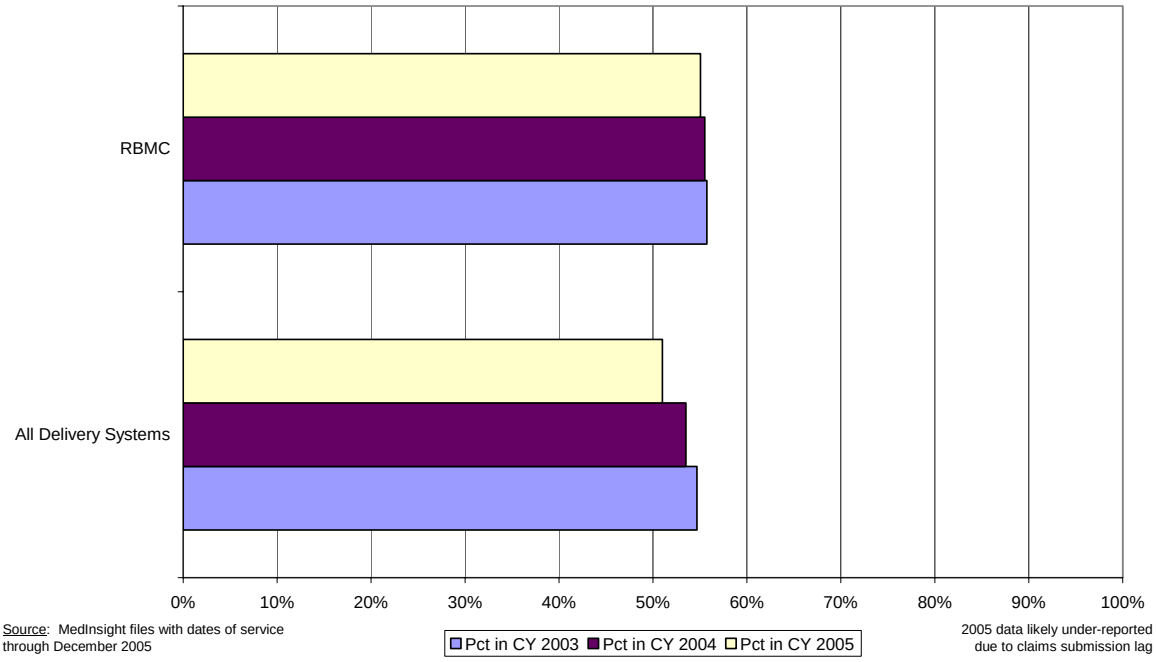
Exhibit IV.9
Percent of CHIP Enrollees (Phases I and II) that Used PMP Services
Based on Unique Number of Eligibles



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

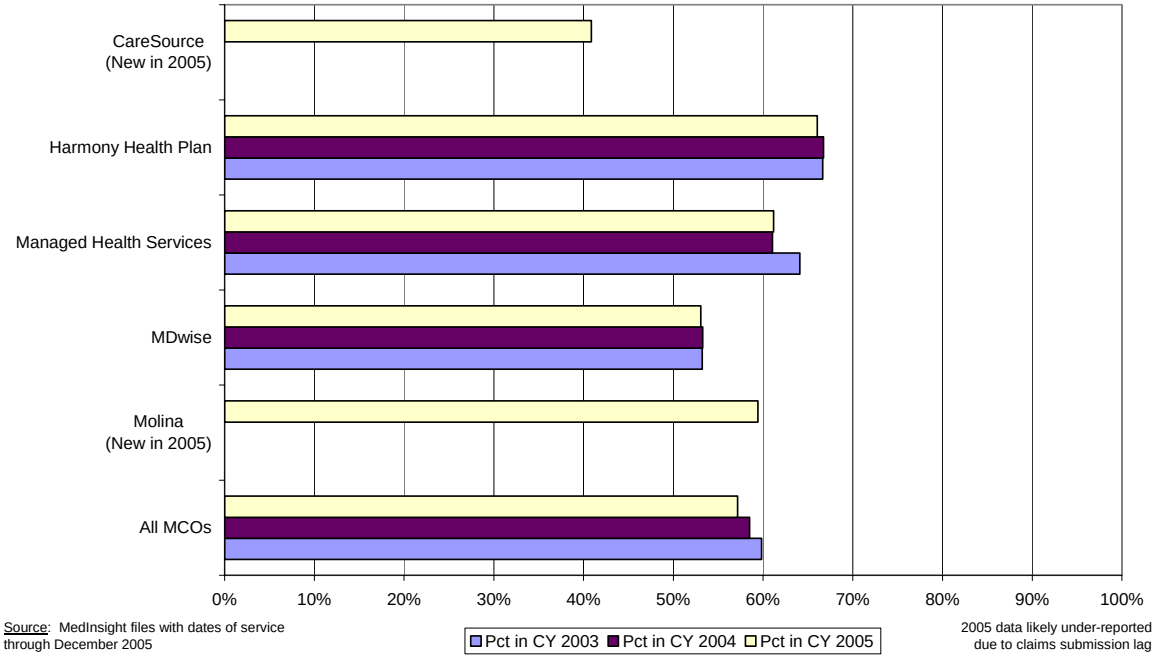
Exhibit IV.10
Percent of Medicaid Enrollees that Used PMP Services
Based on Unique Number of Eligibles



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

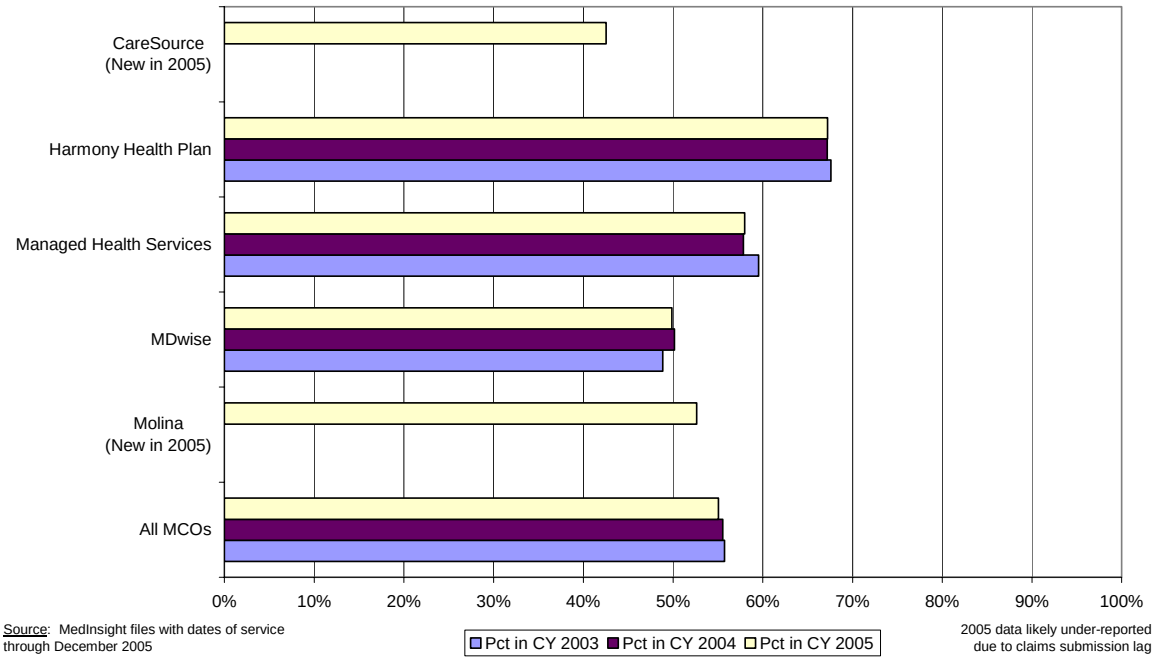
Exhibit IV.11
Percent of CHIP Enrollees (Phases I and II) that Used PMP Services by MCO
Based on Unique Number of Eligibles



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

Exhibit IV.12
Percent of Medicaid Enrollees that Used PMP Services by MCO
Based on Unique Number of Eligibles



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

If a CHIP child does not visit a PMP, does he or she see another type of physician?

About 60 percent of children enrolled in CHIP across all age groups and delivery systems visit their PMP (as defined previously). A PMP is the most likely provider of preventative care, so this rate may be of concern on the surface. However, the children that do not see their own PMP might have seen another type of physician such as another PMP, a specialist physician, or a primary care physician in a clinic.

As a separate proxy for children's access to preventative care, the percentage of children who have visited any type of physician was computed. For children that did not see their PMP in a calendar year, we calculated the percentage of those children that had another type of physician visit, including visits to other primary care physicians, specialists and clinics. The results for CY 2004 for all delivery systems combined and for just the RBMC delivery system are shown in Exhibits IV.13 and IV.14 on the next page. CY 2005 is not shown because the data for this year is incomplete. These exhibits show the following for each age group:

- The blue portion of the bar shows the percentage of children that had a visit to their own PMP (regardless of setting) in the calendar year (repeated from Exhibits IV.1 –IV.4).

- The red portion of the bar shows the percentage of children who did not have a visit to their own PMP in the year but did have a claim for a visit to another physician (hospital-based clinics are not included in this definition).

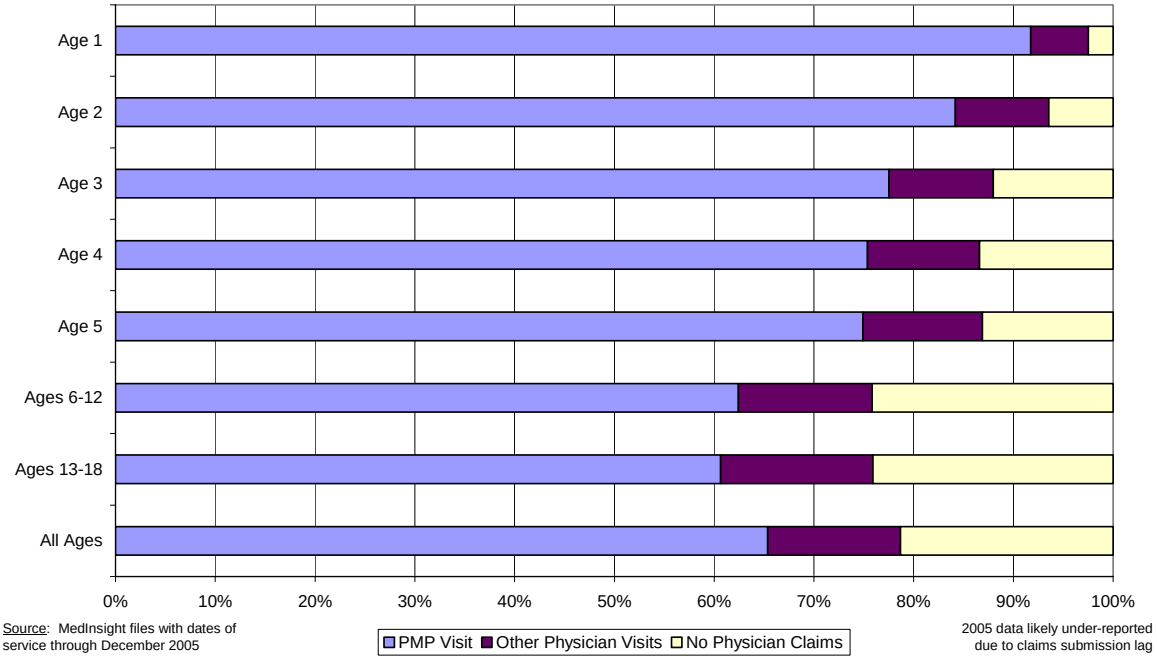
- The yellow portion of the bar shows the percentage of children who did not have a claim for a PMP or other physician or clinic visit during the year.

When visits to a broader range of physicians are taken into account, the percentage of children that have seen a physician improve by about 10 percentage points overall. Only 2% of one-year olds were found to not have any type of physician visit when these other providers were included. The improvement is uniform across all age groups, meaning that all age groups improved by about the same amount.

Moving from the all delivery systems category to the RBMC-only category shows that the percentage of children age 5 or under that saw their own PMP or any type of physician is slightly higher. In fact, this percentage is actually slightly higher when all delivery systems are included.

Although a high percentage of children are seeing their assigned physician during the year, those that are not may not be receiving the best coordination of care. Second, it is of some concern that across all age groups, about 20% of the children are not visiting any physician (as defined in the data) during the year, most of which are probably not receiving any preventative care services.

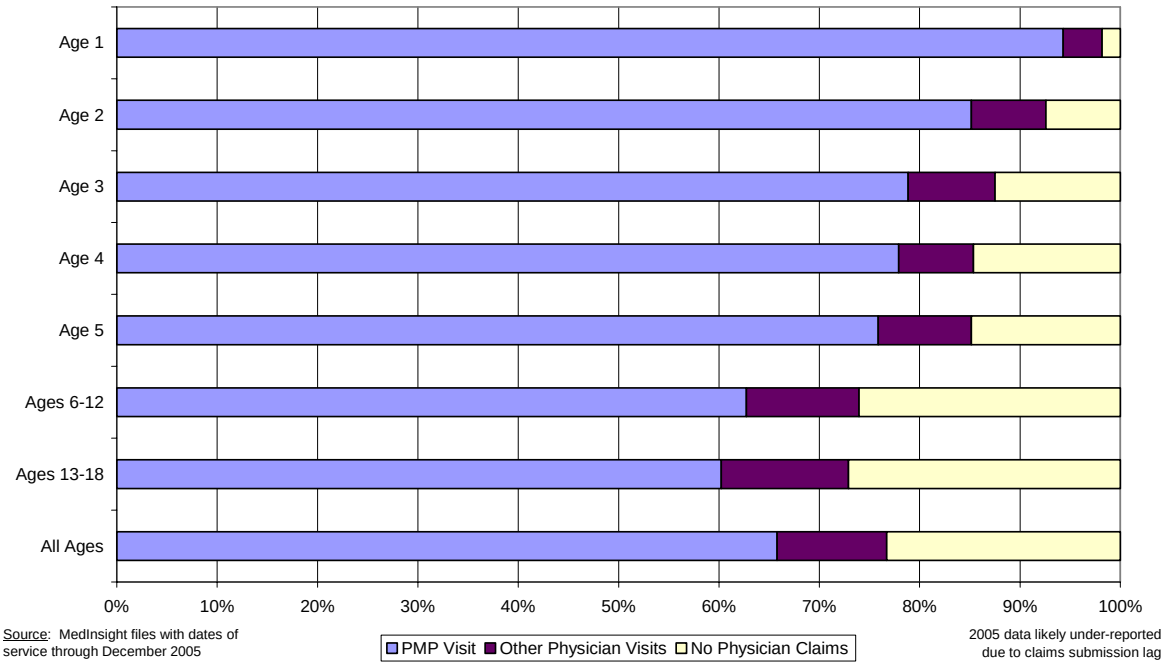
Exhibit IV.13
Percent of CHIP Enrollees (Phases I and II) that Used Physician Services in CY 2004
Based on Unique Number of Eligibles in All Delivery Systems



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

Exhibit IV.14
Percent of CHIP Enrollees (Phases I and II) that Used Physician Services in CY 2004
Based on Unique Number of Eligibles in the RBMC Delivery System



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

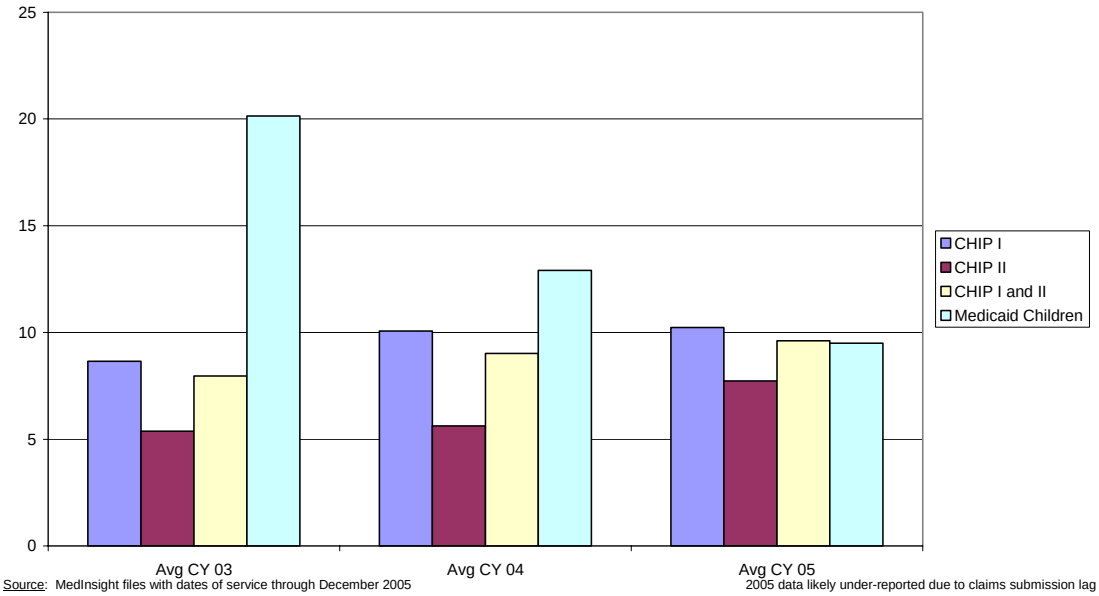
Are there any significant trends in claims per 1,000 enrollees statistics?

The seven exhibits in this section show the claims per 1,000 enrollees for each of eight major service categories across the past three years. The claims per 1,000 enrollees rate is shown for CHIP I, CHIP II, all CHIP and Medicaid. Though these exhibits have appeared in previous reports, this year is the first that utilization is only reported from the RBMC delivery system. The PCCM delivery system was phased out in 2005, so even though RBMC claims do not capture all of the claims in 2005, they represent the benchmark for future reports. They are not, however, comparable to previous reports. Only claims up to October 2005 are included in these statistics, because the lag in claims reporting means that data for the end of 2005 is not yet complete.

Hospital Services

Hospital services cover claims for inpatient and outpatient services. Utilization for inpatient services is reported as inpatient days per 1,000 enrollees instead of inpatient claims per 1,000 enrollees to reflect the magnitude of the claims in the utilization statistics. Utilization of inpatient services is also the most erratic of the seven service categories, caused by the much lower volume of claims for these services. Since inpatient claims are the most expensive and reflect the most severe illnesses, lower utilization is better. In this respect, CHIP II consistently had the best results for this category, and in general both CHIP I and CHIP II compared favorably to Medicaid.

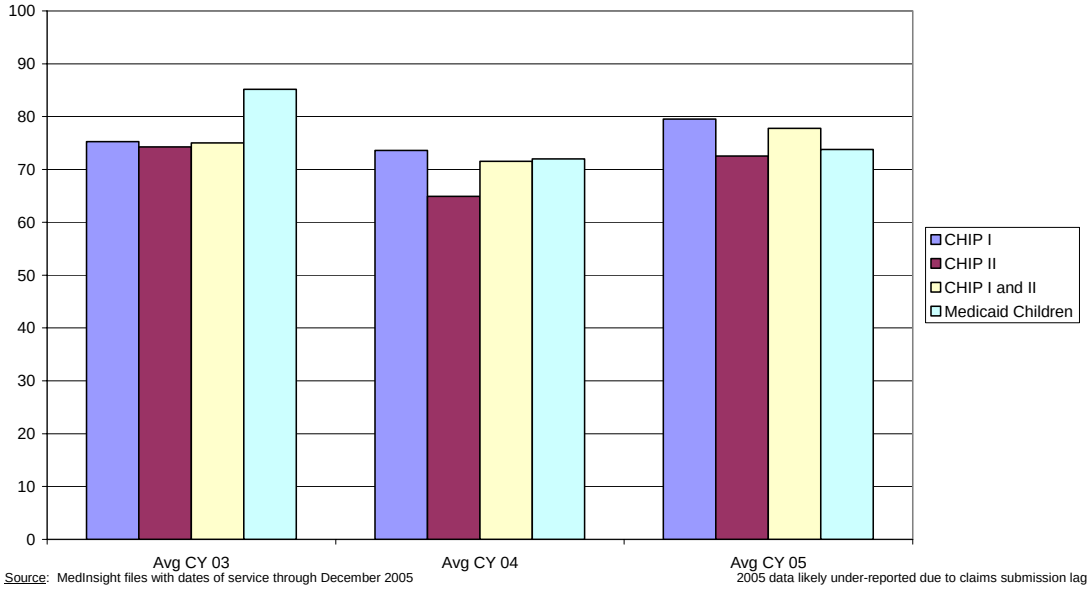
Exhibit IV.15
Inpatient Hospital Days Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005



Source: MedInsight files with dates of service through December 2005
2005 data likely under-reported due to claims submission lag

Outpatient claims cover hospital visits without an overnight stay and can represent a wide variety of services including ER visits, outpatient (minor) surgeries and radiation therapies. These services are also relatively expensive and can reflect severe health conditions. Though the three packages are similar for outpatient claims, CHIP II tends to perform a little better (lower) than either CHIP I or Medicaid. There does not appear to be a significant upward or downward trend in outpatient utilization.

Exhibit IV.16
Outpatient Hospital Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005



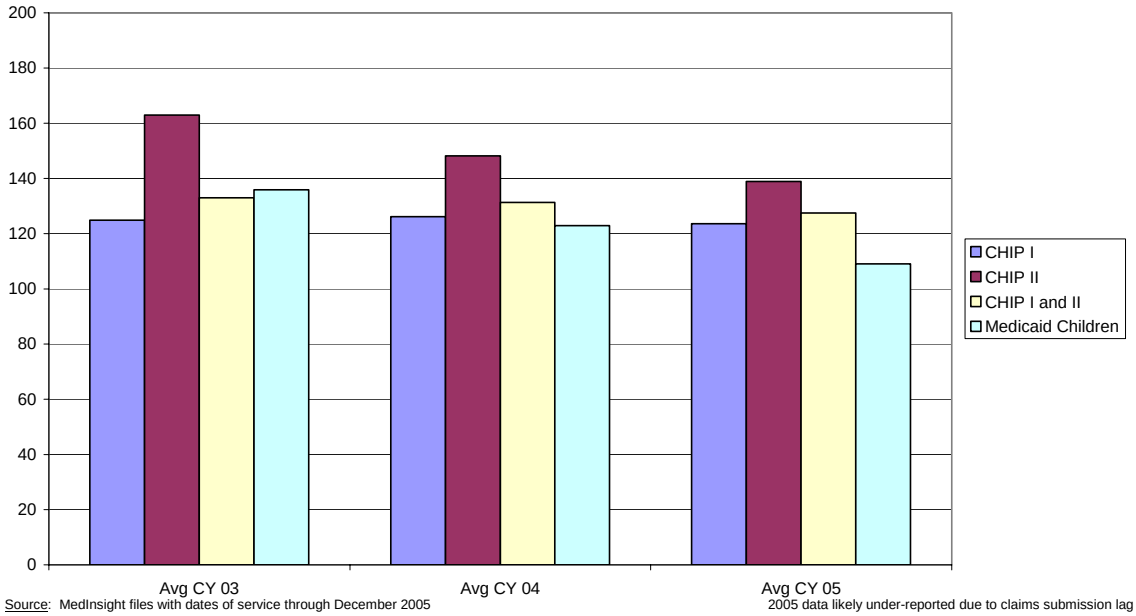
Source: MedInsight files with dates of service through December 2005
2005 data likely under-reported due to claims submission lag

Physician Services

The broad category of physician services covers all services billed on a physician claim form. These include services provided by physicians, primary or specialty, in an office setting and services provided by clinics and public health agencies. Exhibit IV.17 shows that the volume of PMP claims has been declining over the past three years for CHIP and Medicaid children. The charts earlier in this chapter (see Exhibits IV.3 and IV.4) also suggest that the percentage of children using these services is declining. The importance of these visits suggests that this trend is concerning, either because the services are truly not being delivered or because they are not being reported to the state by the MCOs. Visitation rates to physicians not assigned to the child have been relatively low and stable over the past three years.

CHIP Phase II children used PMP services at a higher rate than CHIP Phase I or Medicaid over the past three years.

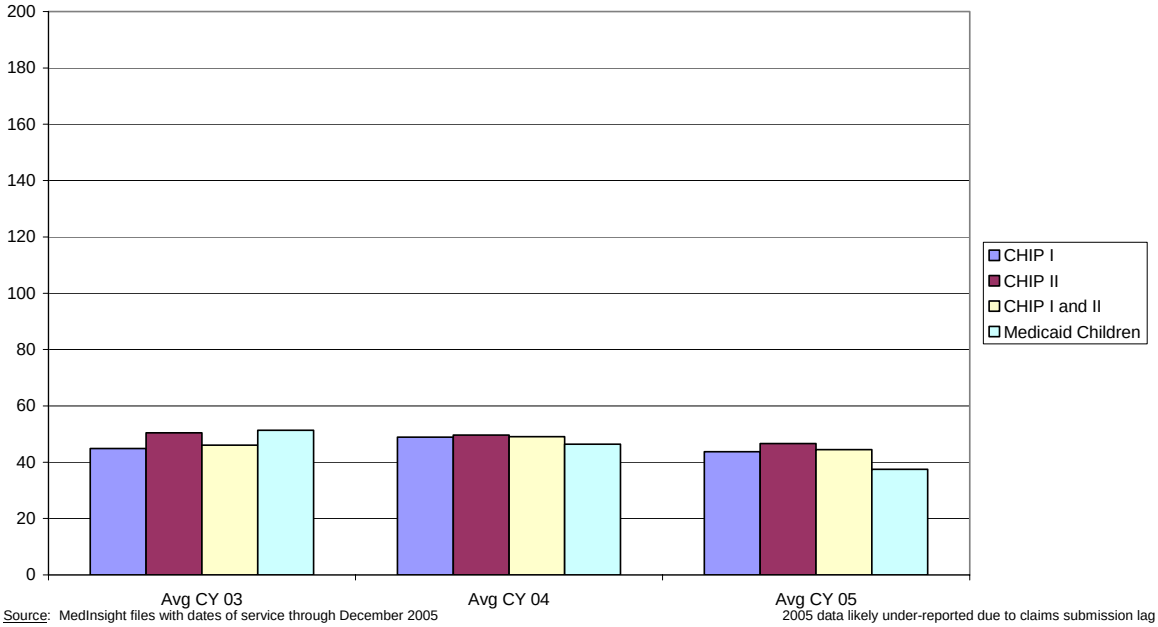
Exhibit IV.17
PMP Physician Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

Exhibit IV.18
Other PMP Physician Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005

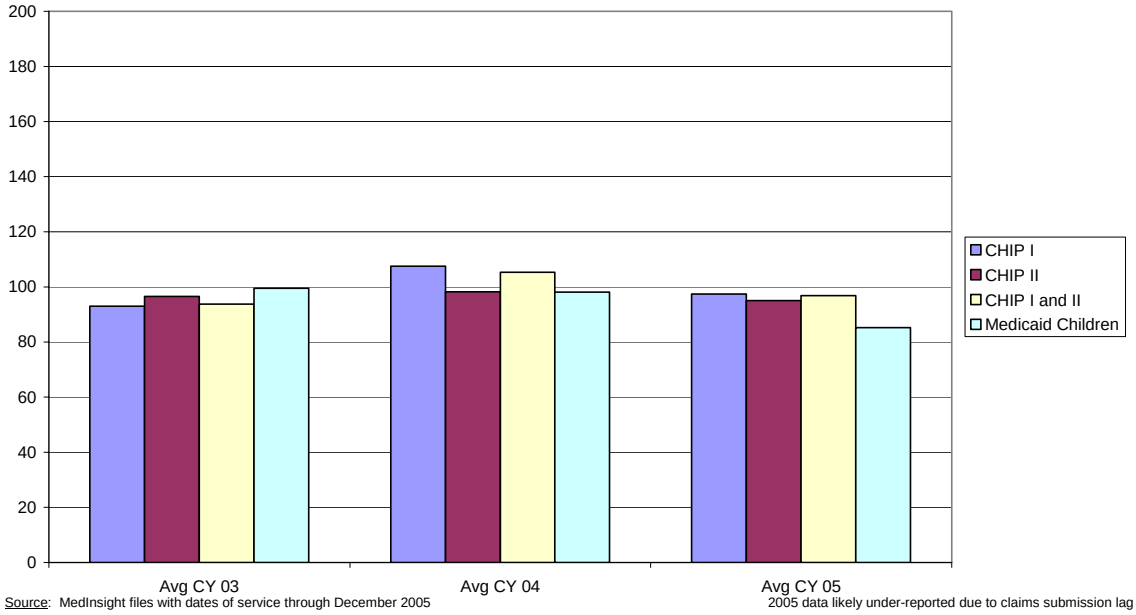


Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

Utilization rates for specialty physicians, on the other hand, have remained fairly stable over the same time period, suggesting that the utilization of specialty physicians has not compensated for a loss in PMP utilization. The packages are nearly indistinguishable for these claims.

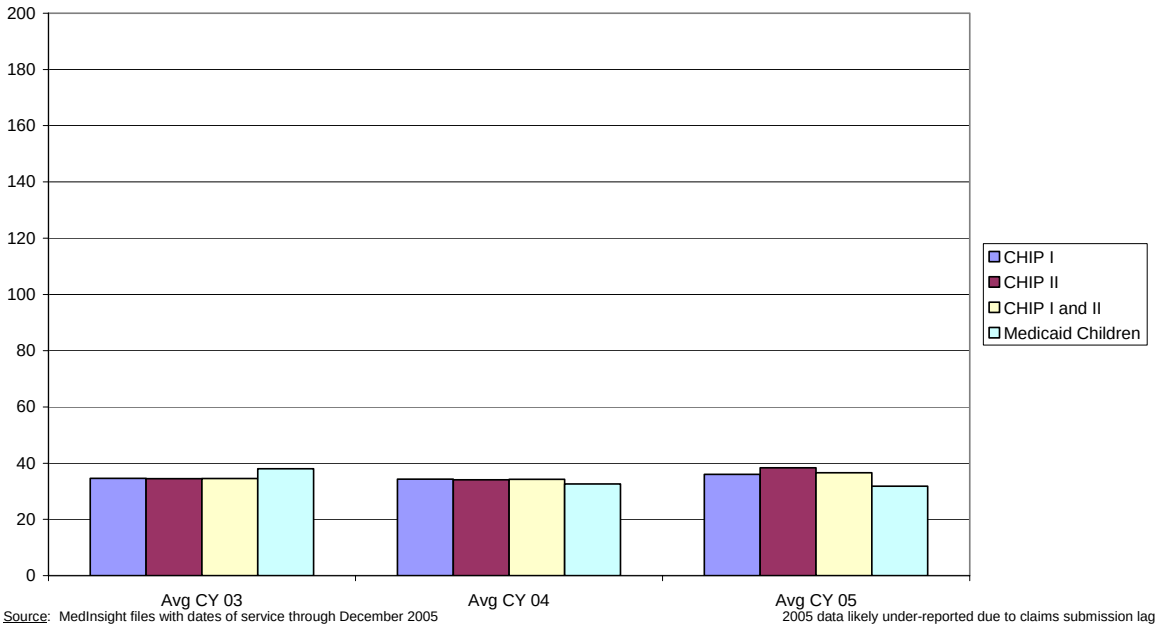
Exhibit IV.19
Specialty Physician Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005



Source: MedInsight files with dates of service through December 2005
2005 data likely under-reported due to claims submission lag

Like specialty physician claims, clinic utilization rates have been fairly stable. The stability of utilization in the clinic category suggests that some physicians routinely see patients in the clinic setting, even if it is not the member's designated PMP (see Exhibit IV.20 below).

Exhibit IV.20
Clinic Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005

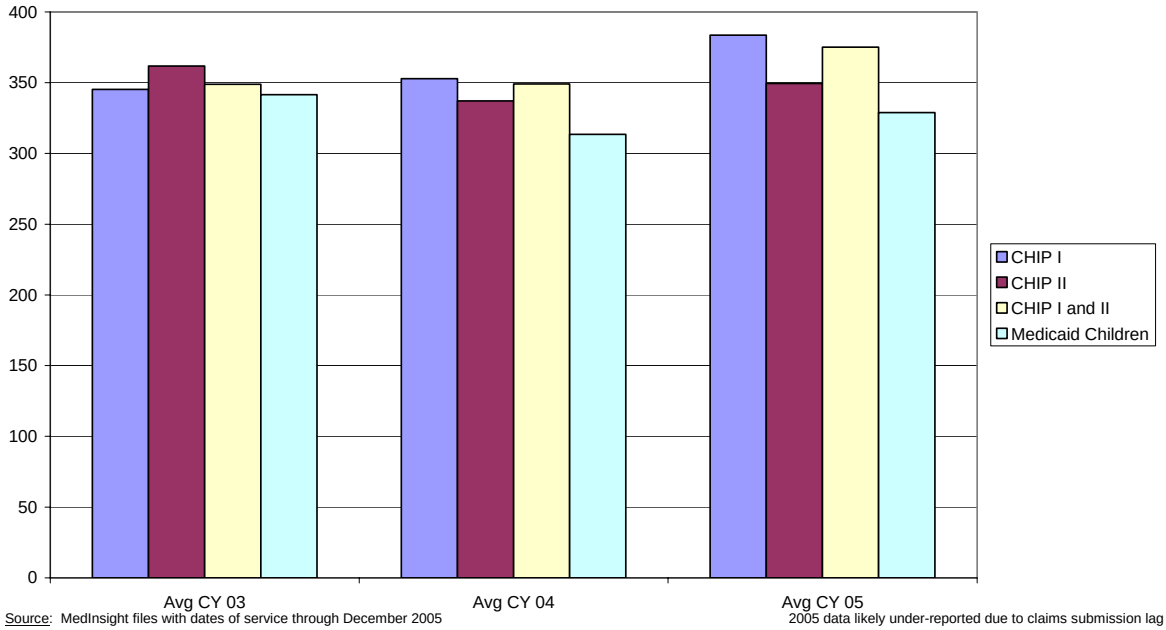


Source: MedInsight files with dates of service through December 2005
2005 data likely under-reported due to claims submission lag

Pharmacy Services

Pharmacy claims have for the past few years represented the category of service with the highest claim volumes, and hence, utilization rates per 1,000. We reported a decline in pharmacy utilization in last year's report, but that decline did not carry over into 2005, since utilization rose. The largest jump in utilization came from children in CHIP I, whereas children in CHIP II and Medicaid only produced modest increases. Interestingly, although CHIP II has a more restrictive benefit package for pharmacy (does not include over-the-counter drugs), children in CHIP II do not generally have lower utilization rates than either CHIP I or Medicaid.

Exhibit IV.21
Pharmacy Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005



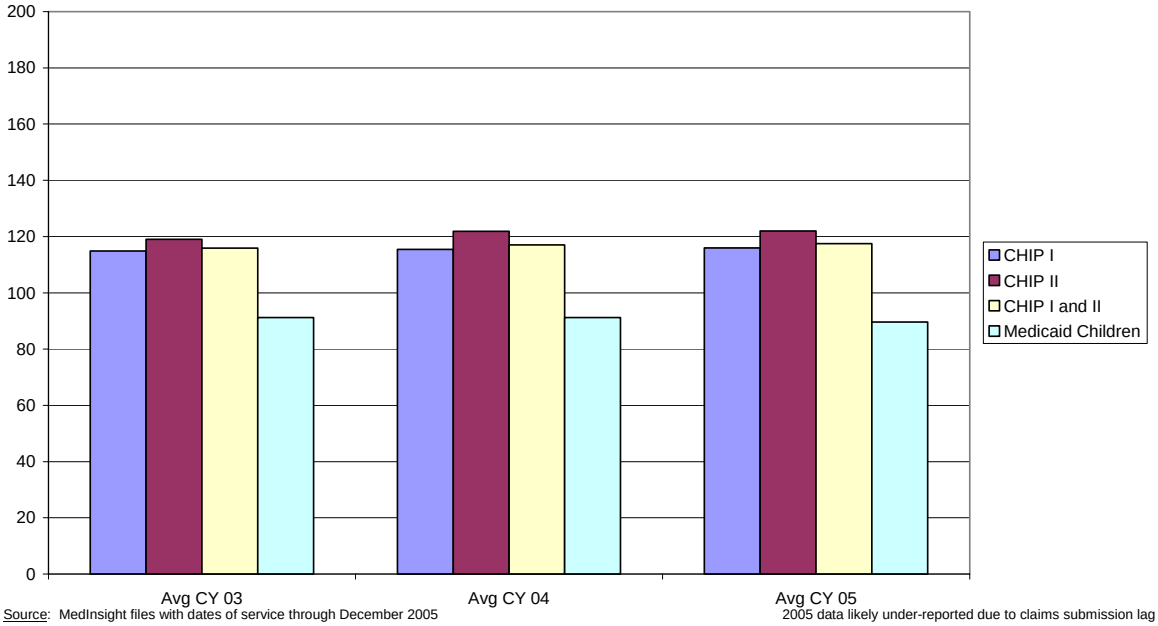
Source: MedInsight files with dates of service through December 2005
2005 data likely under-reported due to claims submission lag

Dental Services

Dental services are reported differently from every other service in the CHIP program. Whereas other services mentioned are covered under the MCO contract, dental services are not covered by the MCOs but are paid directly by the State. As a result, utilization of dental services was calculated here for every delivery system, instead of just RBMC.

There has not been much variation in utilization rates for dental services over the past three years. Medicaid children have historically and continue to use fewer dental services than children in the CHIP program, but within the CHIP program the utilization rates are too similar to differentiate.

Exhibit IV.22
Dental Claims Per 1,000 Eligibles
For CHIP I, CHIP II and Medicaid
January 2003 - October 2005



Source: MedInsight files with dates of service through December 2005

2005 data likely under-reported due to claims submission lag

CHAPTER V

PAYMENTS MADE FOR CHIP MEMBERS

CHAPTER V
PAYMENTS MADE FOR CHIP MEMBERS

The transition from the Primary Care Case Management (PCCM) delivery system to the Risk-Based Managed Care (RBMC) delivery system alters the way the state pays for most services in the CHIP program. Though the RBMC delivery system has been used in Indiana for almost 10 years, the RBMC model became the only delivery system for certain populations, including children, at the end of 2005. There have historically been two payment methodologies in place, depending upon which delivery system a member was enrolled in.

- Under PCCM, the State paid the providers' claims directly on a fee-for-service basis and also paid a $3 monthly administrative fee to each child's primary medical provider (PMP) for the coordination of care.

- Under the RBMC model, the State continues to pay for some services not included in the contracts with the managed care organizations (MCOs), such as dental providers, but the payments to most providers are the responsibility of the MCOs. The MCOs, in turn, receive a monthly capitation payment (or premium) from the State for each child enrolled in their health plan, regardless of the amount, duration, or scope of service provided by the MCO. The RBMC model limits the State's exposure to fluctuations in payments because the State places the burden for the management and payment of children's care on the MCOs.

This chapter addresses how the payments under the RBMC model compare to payments under the PCCM model for children in CHIP. Children that are enrolled in the Fee-for-service (FFS) delivery model, usually on a temporary basis, are included with PCCM because the State pays for services to these children in the same manner as those paid for children in PCCM. The majority of payments made on behalf of services to CHIP children, all of which are also included in the monthly payment made to MCOs, include:

- Primary care physicians
- Specialty physicians
- Clinic services
- Hospital services (both inpatient and outpatient)
- Pharmacy scripts

Payments for other services, in particular dental and certain mental health services, are not included in our comparison because they are not services that the State contracts with the MCOs to deliver and are thus not incorporated into the monthly capitation payment. Capitation payments are set differently for certain age groups based upon the expected differences in the utilization of services across these age groups. Therefore, our analysis compares per member per month (PMPM) costs between RBMC and PCCM/FFS by age group.

How do PMPM payments compare between delivery systems and age groups?

Calendar Year 2005 is the first year since EP&P has reported these figures that PMPM payments for the CHIP population in RBMC were higher than the PMPM payments in the PCCM/FFS delivery system. This is true on average for all children but, when analyzed by age group, it was found to be true specifically for the age 6-12 and age 13-18 age groups.

Payment differences between RBMC and PCCM/FFS vary quite a bit by age group. For example, in the age 1-5 group, the PMPM payments in the PCCM/FFS delivery system have been at least 11 percent higher than the RBMC payments. The largest difference is in CY 2005, where the PCCM/FFS payments were 21 percent higher on a per month basis. Payments in the 6-12 age group, on the other hand, have shifted dramatically. In CY 2003, the PCCM/FFS payments were 30 percent higher than the RBMC payments. By CY 2005, the PCCM/FFS payments were 11 percent lower than the RBMC payments. Payments in the 13-18 age group followed a pattern more similar to the age 6-12 group. In CY 2003, the PCCM/FFS payments were 31 percent higher than the RBMC payments. By CY 2005, the PCCM/FFS payments were 19 percent lower than the RBMC payments.

It should be noted that the $3 administrative fee was included in the PMPM payments for the children in PCCM. The capitation payments represent weighted averages across all MCOs.

Exhibit V.1
Comparison of PMPM Payments Between Delivery Systems and Age Groups

Year and Age Group	PCCM/FFS PMPM Payments	RBMC PMPM Payments	PCCM/FFS vs. RBMC Difference	
			Payments	Payment %
CY 2003				
Ages 1 - 5	$69.60	$61.24	$8.36	13.7%
Ages 6 - 12	$68.03	$52.23	$15.80	30.3%
Ages 13 - 18	$105.03	$80.08	$24.95	31.2%
All Ages	**$79.87**	**$62.68**	**$17.19**	**27.4%**
CY 2004				
Ages 1 - 5	$78.28	$69.93	$8.35	11.9%
Ages 6 - 12	$73.59	$62.19	$11.40	18.3%
Ages 13 - 18	$100.88	$99.92	$0.96	1.0%
All Ages	**$83.11**	**$74.05**	**$9.06**	**12.2%**
CY 2005 (through October 2005)				
Ages 1 - 5	$88.20	$72.79	$15.41	21.2%
Ages 6 - 12	$71.03	$78.65	($7.62)	-9.7%
Ages 13 - 18	$86.07	$106.36	($20.29)	-19.1%
All Ages	**$79.10**	**$83.43**	**($4.33)**	**-5.2%**

Source: MedInsight

How does the growth of PMPM payments compare between delivery systems and age groups?

PMPM payments have grown quickly in the RBMC delivery system in 2004 and 2005 while they declined in the PCCM/FFS delivery systems in 2005. The decline in PCCM and FFS may or may not be noteworthy, because there was a large shift in the underlying population during this time, since PCCM was completely phased out for CHIP children in 2005. However, the increase in RBMC payments indicates that PMPM payments are growing for an increasingly large portion of the population, implying that the costs for the RBMC delivery system are multiplying. PMPM payment increases are also unevenly distributed between the age groups, having risen the fastest for the age 6-12 group in 2005.

Exhibit V.2
PMPM Growth Rate Comparison

Year and Age Group	PCCM/FFS PMPM Annual Payment Growth	RBMC PMPM Annual Payment Growth
CY 2004		
Ages 1 - 5	12.5%	14.2%
Ages 6 - 12	8.2%	19.1%
Ages 13 - 18	-4.0%	24.8%
All Ages	**4.1%**	**18.1%**
CY 2005 (through October 2005)		
Ages 1 - 5	12.7%	4.1%
Ages 6 - 12	-3.5%	26.5%
Ages 13 - 18	-14.7%	6.4%
All Ages	**-4.8%**	**12.7%**

Source: MedInsight

CHAPTER VI

EVALUATION OF QUALITY DATA MEASURES RELATED TO THE CHIP

CHAPTER VI
EVALUATION OF QUALITY DATA MEASURES RELATED TO THE CHIP

INTRODUCTION

Indiana's Children's Health Insurance Program (CHIP) uses the Hoosier Healthwise program to deliver services to its members. Although children in CHIP Phase II have a slightly reduced benefit package as compared to children in Hoosier Healthwise, the delivery of key services—e.g. primary care, well-child visits, hospital services, dental, and pharmacy—are delivered the same way. All children in CHIP are now enrolled in the Risk-Based Managed Care (RBMC) delivery system, meaning that they are enrolled with a Primary Medical Provider (PMP) who contracts directly with one of five Managed Care Organizations (MCOs).

The Office of Medicaid Policy and Planning (OMPP), which oversees the RBMC delivery system, takes the lead responsibility for ensuring that quality care is delivered to Hoosier Healthwise members. There are a number of methods by which the OMPP monitors quality:

- The Quality Improvement Committee (QIC) usually meets on a monthly basis to review specific areas of service delivery in RBMC. These meetings are attended by OMPP staff and representatives from all five MCOs as well as the State's monitoring contractor.

- The Clinical Studies subcommittee of the QIC meets to assess specific issues related to the clinical aspects of care. For example, the methods for reporting data that are a part of HEDIS (Health Plan Employer Data and Information Set) measures have been an ongoing focus of this committee.

- On an annual basis, the State is required by the Centers for Medicare and Medicaid (CMS) to conduct an external quality review of its managed care program. EP&P Consulting (EP&P) provided this review of the RBMC delivery system for calendar year 2004 and will be doing so again for calendar year in 2005. This review entailed onsite interviews with MCO representatives and the review of policies and procedures both onsite and offsite. Areas specifically reviewed included:

  1) Enrollee rights
  2) Enrollee information
  3) Provider selection
  4) Provider-enrollee communications
  5) Assurances of adequate capacity and services
  6) Coordination and continuity of care
  7) Coverage and authorization of services

8) Availability of services
9) Emergency and poststabilization services
10) Confidentiality
11) Grievance systems
12) Subcontractual relationships and delegation
13) Practice guidelines
14) Quality assessment and performance improvement program
15) Health information systems

There are a number of participants in the overall quality monitoring process for the Hoosier Healthwise program. These include:

- State staff from the CHIP Office and the OMPP

- The MCOs participating in the RBMC delivery system (in 2005, these included Managed Health Services, Harmony Health Plan, MDwise, Molina and CareSource)

- AmeriChoice, the enrollment broker in 2005; AmeriChoice also served as the administrator of the Primary Care Case Management (PCCM) delivery system for CHIP members while that program was still in effect in 2005

- Navigant Consulting, the monitoring contractor for the Hoosier Healthwise program

- Market Measurement, the contractor who conducted the annual member satisfaction survey for members enrolled in the PCCM program in 2005 and continues to serve as the survey administrator of the annual PMP satisfaction survey

Because CHIP members use the same service delivery system as other Hoosier Healthwise members, specific monitoring activities are not conducted by the CHIP Office with the exception of occasional focus studies that pinpoint findings related to the CHIP exclusively. As such, EP&P's review of quality initiatives discussed in this chapter focus on OMPP's monitoring efforts of the overall Hoosier Healthwise program. Specific discussions are related to those monitoring efforts that affect CHIP members most.

Key areas reviewed, which will be discussed in more detail in this chapter, include:

- Results of the 2005 member satisfaction surveys conducted by the MCOs for parents of children in Hoosier Healthwise, along with a comparison of findings in Indiana to responses among parents of child members in Medicaid and CHIP programs nationwide

- Results of the 2005 PMP satisfaction survey conducted by Market Measurement

- An examination of the findings from a study of HEDIS measures collected by the MCOs in 2005 and tabulated by Navigant Consulting. The results described here are those measures that specifically pertain to children.

- A summary of issues discussed at Quality Improvement Committee meetings in 2005

KEY FINDINGS

Our evaluation of the monitoring activities within the Hoosier Healthwise program yielded these key findings:

- Overall, children in Hoosier Healthwise rated their health plan and their doctors at a rate similar to national benchmarks of surveys to parents of children in Medicaid programs. When results for CHIP members/parents could be isolated (from the survey of PCCM members), both CHIP Phase I and CHIP Phase II members gave responses that were as favorable or more favorable than the general Hoosier Healthwise population.

- PMP satisfaction, as measured by the results from their annual survey, is at its lowest point in recent years. This appears to stem from multiple criteria, such as lower ratings on items such as communication with the health plans, timeliness of claims processing, reimbursement rates, authorization requirements for patient referrals, and the auto-assignment process.

- The results from the study of HEDIS measures in 2005 (based on 2004 utilization) were mixed. On the one hand, the three participating MCOs from 2004 had improved on most measures pertaining to children from the prior year results. However, the Indiana Hoosier Healthwise plans still reported results that were below national Medicaid medians on such measures as immunizations and appropriate treatment of strep throat. The MCOs did, however, meet or exceed national Medicaid medians on access to primary care physicians (for all ages) and for well-child visits.

- As a result of the findings from the HEDIS, the MCOs discussed methods to improve these scores at the QIC meetings in 2005. The OMPP is instituting more aggressive benchmarks that the MCOs will be expected to meet for the child-related HEDIS measures in 2006 and 2007. Another area of focus that will be a "HEDIS-like" measure in 2006 is screening blood for lead levels.

RESULTS FROM THE 2005 MEMBER SATISFACTION SURVEYS

The Myers Group conducted and summarized the results of the member surveys for the three MCOs participating in Hoosier Healthwise in 2005 – Harmony Health Plan, Managed Health Services, and MDWise. The results from four key survey questions are compared across each MCO and to the 2005 CAHPS® (Consumer Assessment of Health Plans Survey) Benchmark. The benchmark represents the national average for respondents of the same question posed to parents of children of Medicaid recipients nationally.

Exhibit V.1 and V.2 ask the individual to rate the child's health plan and personal doctor or nurse. The rating scale ranges from 0 to 10 with 0 being the lowest and 10 being the highest. The percentage depicted in the exhibit is the percentage of individuals rating their health plan or personal doctor or nurse between 8 and 10.

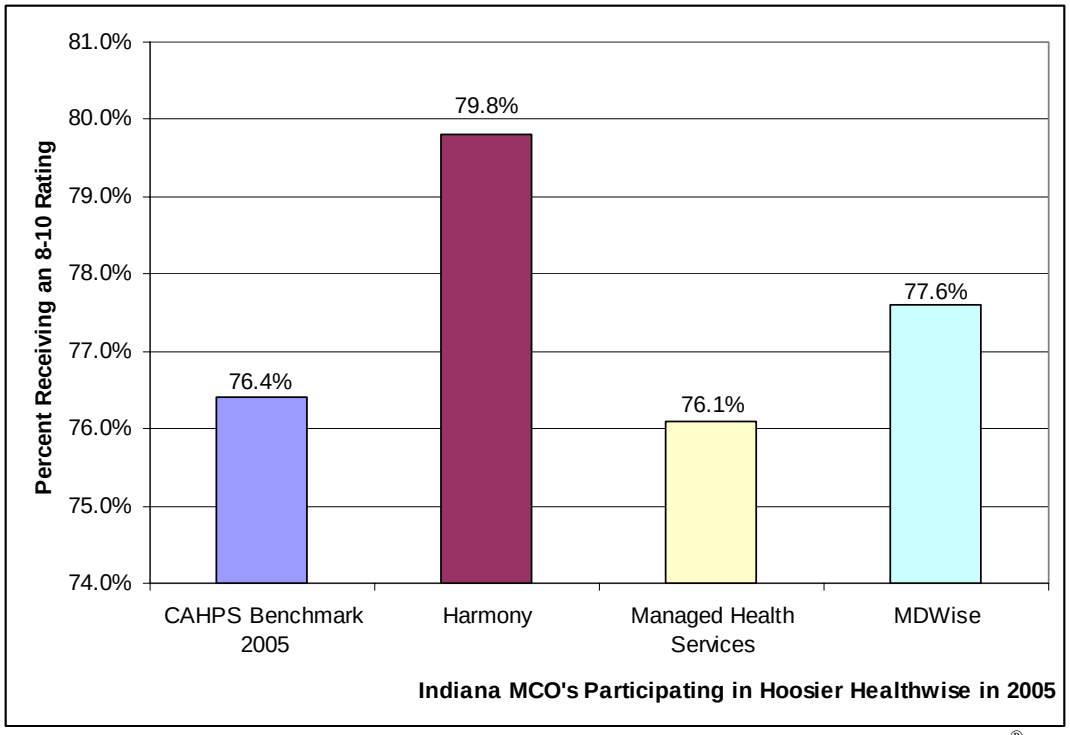
Exhibit V.3 and V.4 ask the individual to state the number of times the child made a visit to the doctor and to the emergency room. The survey allowed for the individual to select the specific number of occurrences for each visit. However, the 2005 CAHPS® Survey only provided a benchmark for the percentage responding they had no doctor visits and no emergency room visits.

Rating of Child's Health Plan

Question: What number would you use to rate your child's health plan?

Finding: All plans have more than 75% of survey respondents rating their child's plan between 8 and 10 (on a 10 point scale). Two of the Hoosier Healthwise plans exceed the 2005 CAHPS benchmark of 76.4% and the third MCO is with .3% of the benchmark.

Exhibit VI.1
Response to Rating of Child's Health Plan



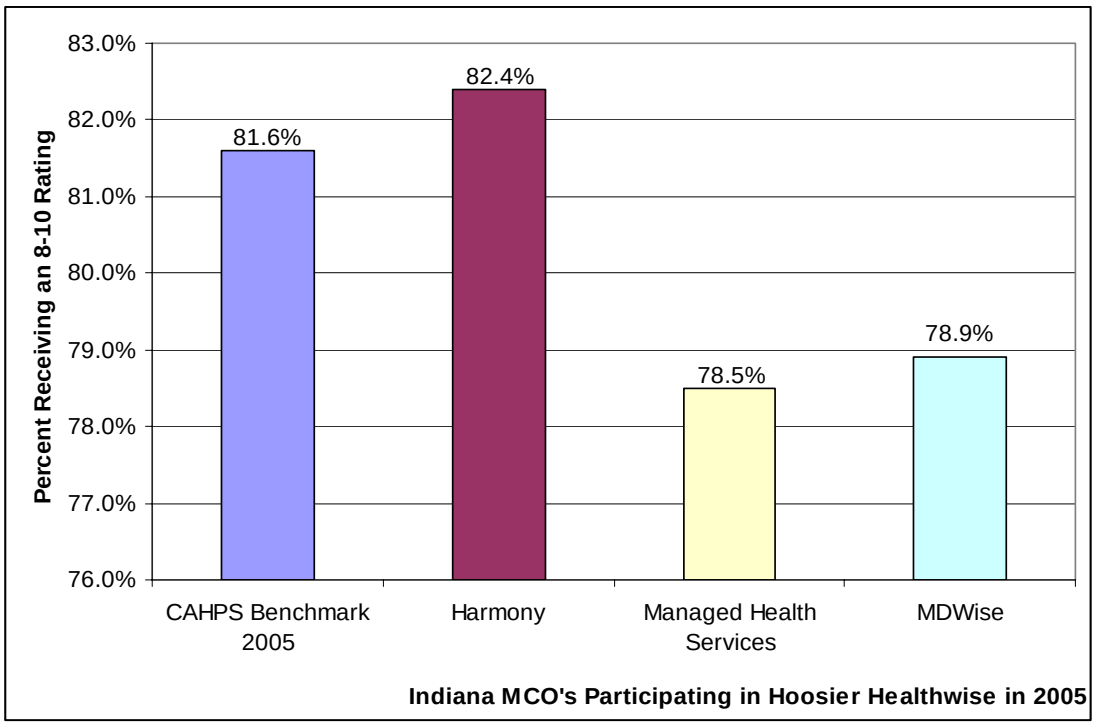
Source: The Myers Group 2005 Final Report for the Consumer Assessment of Health Plans (CAHPS®) Survey

Rating of Child's Personal Doctor or Nurse

Question: What number would you use to rate your child's personal doctor or nurse?

Finding: All plans have more than 78% of survey respondents rating their child's personal doctor or nurse between 8 and 10 (on a 10 point scale). One of the Hoosier Healthwise plans exceeds the 2005 CAHPS benchmark of 81.6% and the other two are probably within the margin of error.

Exhibit VI.2
Response to Rating of Child's Personal Doctor or Nurse



Source: The Myers Group 2005 Final Report for the Consumer Assessment of Health Plans (CAHPS®) Survey

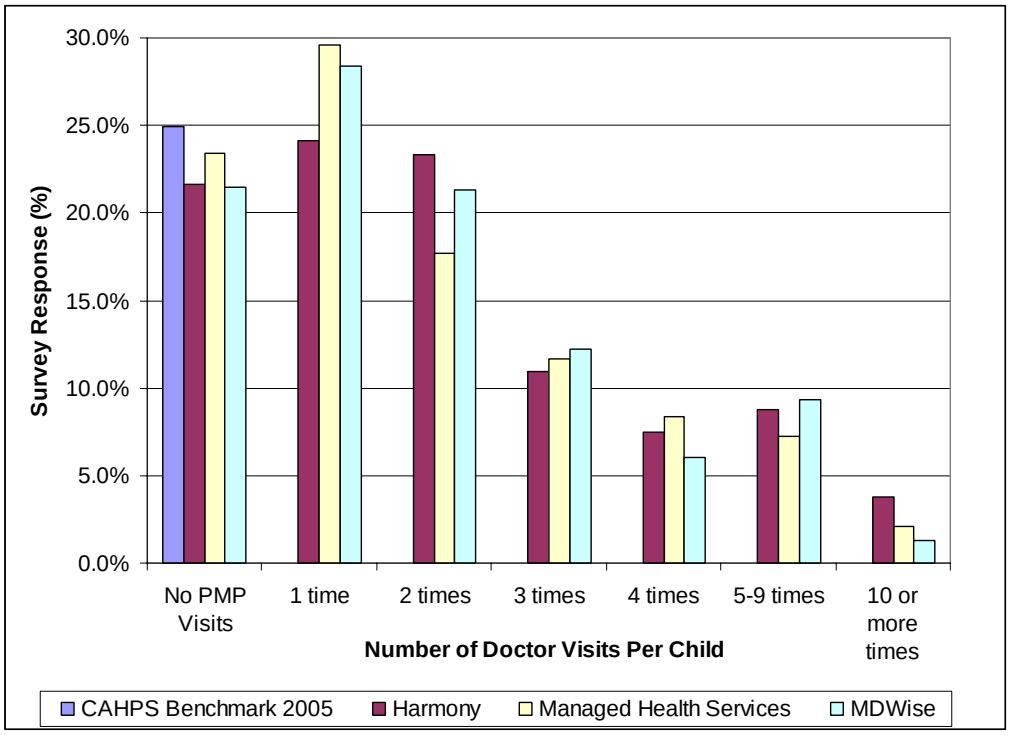
Number of Doctor's Visits for Child

Question: In the last 6 months (not counting times your child went to an emergency room), how many times did your child go to a doctor's office or clinic?

Finding: All three Hoosier Healthwise plans reported that more than 75% of their members went to a doctor's office or clinic in the last six months. This is better than the national average. All three plans reported that almost 50% of respondents had one or two doctor's office or clinic visits, and there was little difference between the plans on the number of visits each child had.

This result is comparable to EP&P's finding on utilization of PMP visits shown in Chapter IV. We found that just under 80% of children who were enrolled in the RBMC delivery system for at least nine months in CY 2004 had at least one visit to the doctor's office or clinic.

Exhibit VI.3
Number of Doctor's Office or Clinic Visits for Child



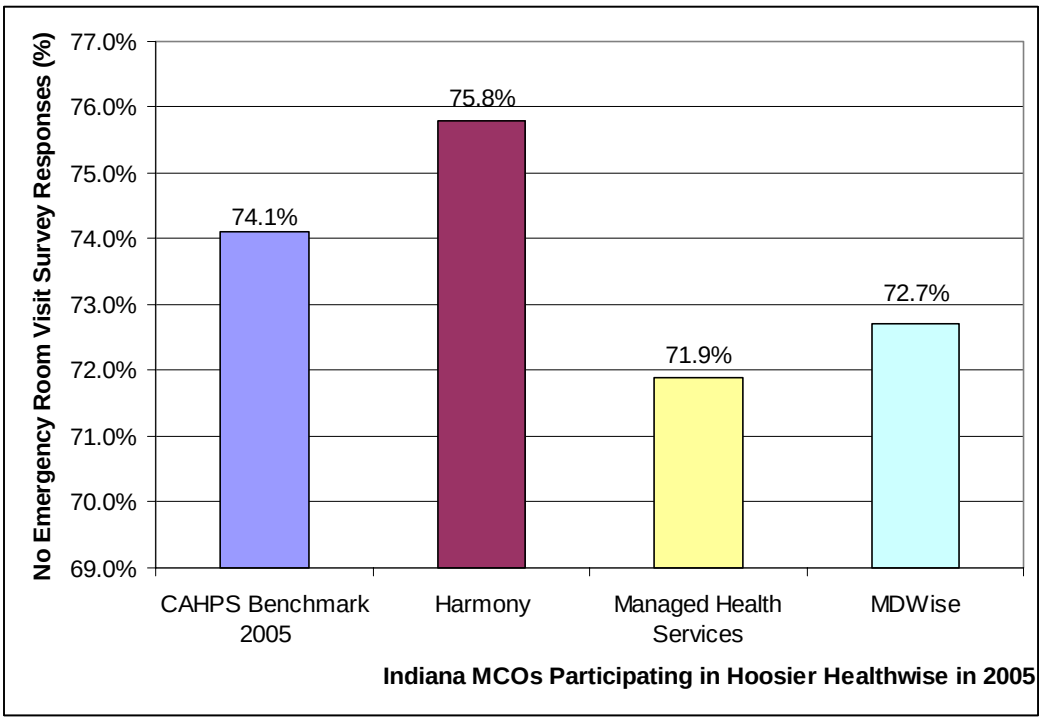
Source: The Myers Group 2005 Final Report for the Consumer Assessment of Health Plans (CAHPS®) Survey

Number of Emergency Room Visits for Child

Question: In the last 6 months, how many times did your child go to an emergency room?

Finding: All three Hoosier Healthwise plans reported favorably that more than 70% of survey respondents had no emergency room visits in 2005. Harmony reported a rate better than the 2005 CAHPS benchmark of 74.1%, while the other two plans have rates that are probably within the margin of error.

Exhibit VI.4
No Emergency Room Visits for Child



Source: The Myers Group 2005 Final Report for the Consumer Assessment of Health Plans (CAHPS®) Survey

PCCM Member Satisfaction Survey Results

The OMPP contracted with Market Measurement in 2005 to conduct a member satisfaction survey of the Hoosier Healthwise members still enrolled in the PCCM delivery system. The sample size was much smaller than the previous year's survey since past PCCM enrollees were transitioning into the RBMC delivery system. Surveys were based on a telephone interview.

The results from this year's survey were no different than prior years in that responses from parents of CHIP members were similar to or more favorable than those of the general population. Certain responses in particular showed that CHIP members/parents have a very favorable impression of the program. To the extent that the questions related to the member's doctors are highly favorable, it is important to keep this in mind even as the PCCM system goes away since most of these same doctors have contracted with an MCO.

Questions found in Exhibit VI.5 below are those where the responses from CHIP members differed from the general population by a statistically significant amount.

Exhibit VI.5
Selected Responses from 2005 Survey of PCCM Members

	All Hoosier Healthwise Members	CHIP Phase I Members	CHIP Phase II Members
Rate healthcare received in past six months 8 to 10 (out of 10)	84%	92%	86%
Rate health plan 8 to 10 (out of 10)	86%	96%	90%
Doctors "always" or "usually" explain things in a way that can be understood	90%	97%	94%
Doctor's office "always" treats patient with courtesy and respect	85%	89%	75%
Child is able to talk with doctors about his or her healthcare	56%	87%	76%
Source: Market Measurement, Inc. 2005 Hoosier Healthwise CHIP I and CHIP II analysis			

Overall, CHIP Phase I members have an even more favorable impression of the program than CHIP Phase II members. The only area where CHIP Phase II differed from either CHIP Phase I or the general Hoosier Healthwise population in a meaningful way was related to the question about receiving courtesy and respect from the doctor's office.

RESULTS FROM THE 2005 PMP SATISFACTION SURVEY

Market Measurement, the firm that conducts the PMP satisfaction survey, tabulated the results from the 2005 survey for the OMPP. Their report discusses PMP attitudes and perceptions of Hoosier Healthwise during 2004. The 2005 survey yielded 426 responses for an overall response rate of 29%. This compares with a 36% response rate in 2004 and a 39% response rate in 2003.

Market Measurement reported that PMP satisfaction rates for 2005 are at the lowest level since 1995. The percent of respondents that indicated they were "very satisfied" or "somewhat satisfied" with Hoosier Healthwise fell to 57% as compared to 63% in the prior year. The average in the last four years has been 65%, as shown in Exhibit VI.6 below.

Exhibit VI.6
Level of Satisfaction with the Hoosier Healthwise Program

Survey Conducted in	2002	2003	2004	2005
Evaluation Criteria:				
Very Satisfied	14%	13%	11%	6%
Somewhat Satisfied	57%	54%	52%	51%
Somewhat Dissatisfied	18%	21%	24%	29%
Very Dissatisfied	11%	12%	13%	14%

Source: 2005 Hoosier Healthwise PMP Survey Results and Analysis, Market Measurement, Inc. and AmeriChoice

There appear to be a number of potential reasons why the satisfaction rate has decreased. In the 2005 survey, Market Measurement found that:

- More PMPs reported this year versus prior years that their relationships with Hoosier Healthwise members are worse than their relationships with commercial health plan members.
- More PMPs indicate their practice has "too many" Hoosier Healthwise members than in prior years.
- More PMPs report inappropriate emergency room use and missed appointments by members than in prior years.

For a number of questions, the PMPs were asked to rank the evaluation criteria on a scale from 1 to 5, where 1 is excellent and 5 is poor. The results of these evaluations and how they compare to prior years are shown in Exhibit VI.7.

Exhibit VI.7
Results from PMPs on Selected Evaluation Criteria
Ratings from 1 ("Excellent") to 5 ("Poor")

	Rated "1" or "2"					Rated "4" or "5"			
Survey Conducted in	**2002**	**2003**	**2004**	**2005**		**2002**	**2003**	**2004**	**2005**
Evaluation Criteria:									
Overall communication from your health plan	43%	46%	32%	28%		18%	20%	22%	37%
Overall satisfaction with your network	NA	NA	33%	25%		NA	NA	26%	34%
Timeliness of claims processing	50%	46%	41%	37%		20%	22%	23%	21%
Timeliness of network responses to your questions	NA	NA	35%	25%		NA	NA	25%	32%
Authorization process for patients to access care from another provider	42%	39%	31%	24%		28%	29%	31%	39%
Your network's preferred drug list	NA	NA	12%	13%		NA	NA	64%	62%
Auto-assignment process	14%	14%	14%	10%		63%	60%	58%	68%
Reimbursement rates	18%	17%	13%	13%		60%	61%	64%	70%

Note: NA = Not Asked

Source: 2005 Hoosier Healthwise PMP Survey Results and Analysis, Market Measurement, Inc. and AmeriChoice

HEDIS®[1] 2005 MEASUREMENTS

Indiana's OMPP required Harmony Health Plan, MDwise, and Managed Health Services (MHS) to report in 2005 on the performance of 25 selected measures for the period of calendar year 2004. The measures are categorized under three main domains: Effectiveness of Care, Access/Availability of Care, and Use of Services. Indiana has been collecting HEDIS measures since 2001. The National Committee for Quality Assurance (NCQA) developed the HEDIS and collects data from states to formulate national median values for the Medicaid population. States can compare their measures to HEDIS definitions to ensure the results are comparable.

Navigant Consulting summarized the HEDIS measurements reported by each of the Hoosier Healthwise managed care entities. There were eight measurements that directly pertain to children and adolescents:

- Effectiveness of Care Domain
  - Childhood Immunization Status
  - Adolescent Immunization Status
  - Appropriate Treatment for Children with Upper Respiratory Infection
  - Appropriate Testing for Children with Pharyngitis
- Access/Availability of Care Domain
  - Children and Adolescents' Access to Primary Care Practitioners
- Use of Services Domain
  - Well-Child Visits in the First Fifteen Months of Life
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
  - Adolescent Well-Care Visits

Navigant Consulting compared the findings for each MCO's HEDIS measure against the NCQA 2003 Medicaid median. The exhibits on the following pages show the rates reported for the given measure by each health plan and how these rates compare to the NCQA 2003 Medicaid median.

<u>Effectiveness of Care Domain</u>

Immunization Measures

Although all three MCOs reported improvement in their HEDIS rates for childhood and adolescent immunizations as compared to measurement year 2003, there is still significant room for improvement as compared to Medicaid health plans nationally. The "childhood"

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

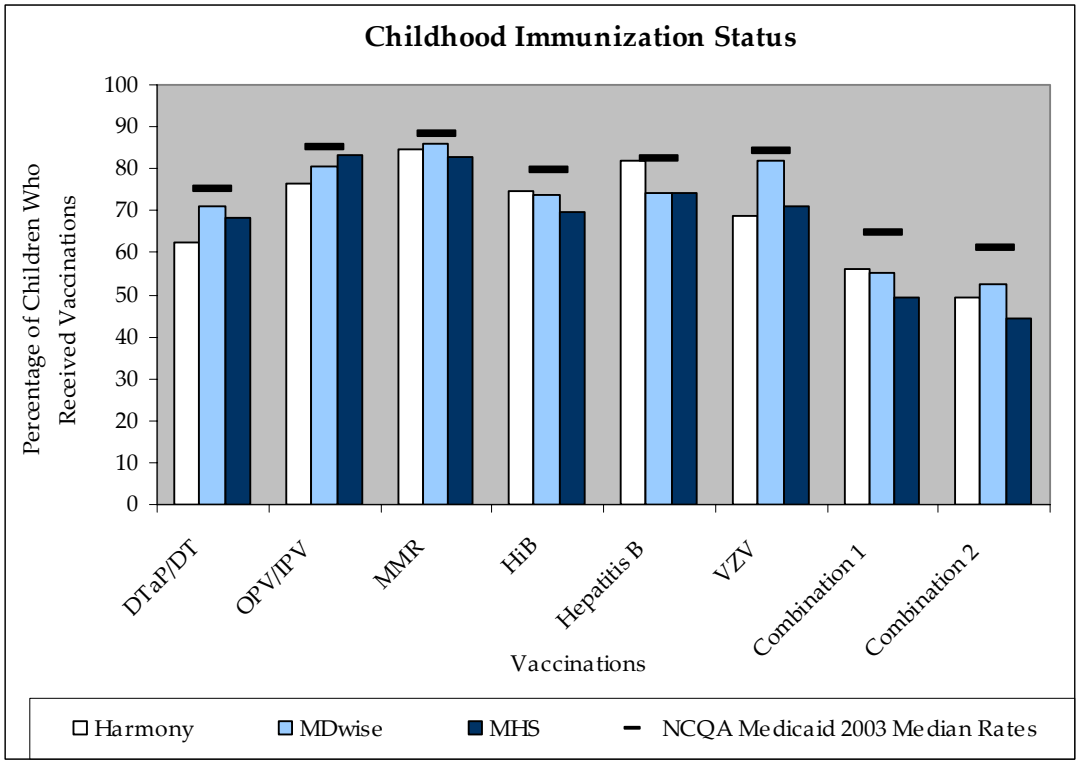
immunization measure (see Exhibit VI.8) includes the percentage of children who turned two years old during the measurement year who are continuously enrolled in the plan for the 12 months prior to their second birthday. Specific immunizations measured include diptheria-tetanus, polio, measles-mumps-rubella, influenza, hepatitis, and chicken pox. There are also two "combination" immunization rates measured. Combination one includes:

- Four doses DTaP or DT (diphtheria-tetanus)
- Three doses OPV/IPV (polio)
- One dose MMR (measles-mumps-rubella)
- Three doses HiB (influenza)
- Three doses Hepatitis B

Combination Two includes all of the Combination One immunizations plus one or more VZV (chicken pox) vaccinations.

As the exhibit shows, all three Hoosier Healthwise plans reported immunization rates below the NCQA median for Combination One and Combination Two. This ranked them below the 25th percentile nationally, except for MDWise on Combination Two. It should be noted, however, that all three plans showed improvement from the prior year's results.

Exhibit VI.8
Results of HEDIS 2005 Measure: Childhood Immunization Status

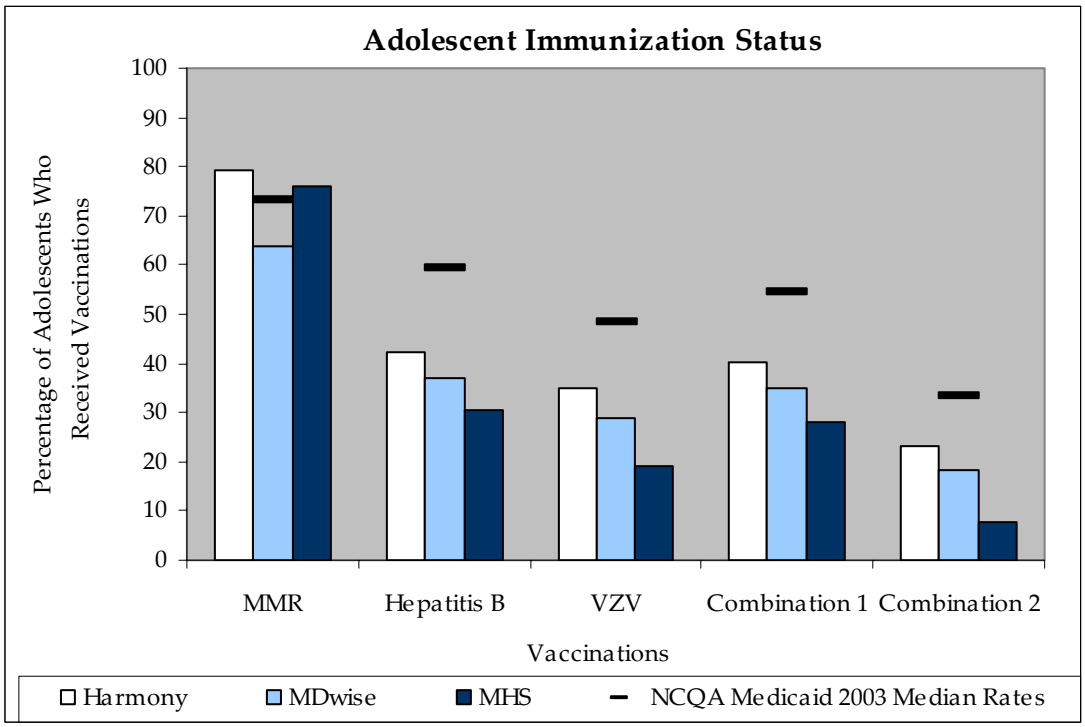


Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

The "adolescent" measure includes those who turned age 13 during the measurement year. For adolescents, Combination One includes the second dose of MMR and three Hepatitis B vaccinations. Combination Two includes all of the Combination One immunizations plus another VZV vaccination.

Exhibit VI.9 shows that the Hoosier Healthwise MCOs fell below the national medians for adolescents on this measure also. All plans were below the 25th percentile for the national rate for Combination One and Combination Two, and MHS was below the 10th percentile for Combination Two.

Exhibit VI.9
Results of HEDIS 2005 Measure: Adolescent Immunization Status



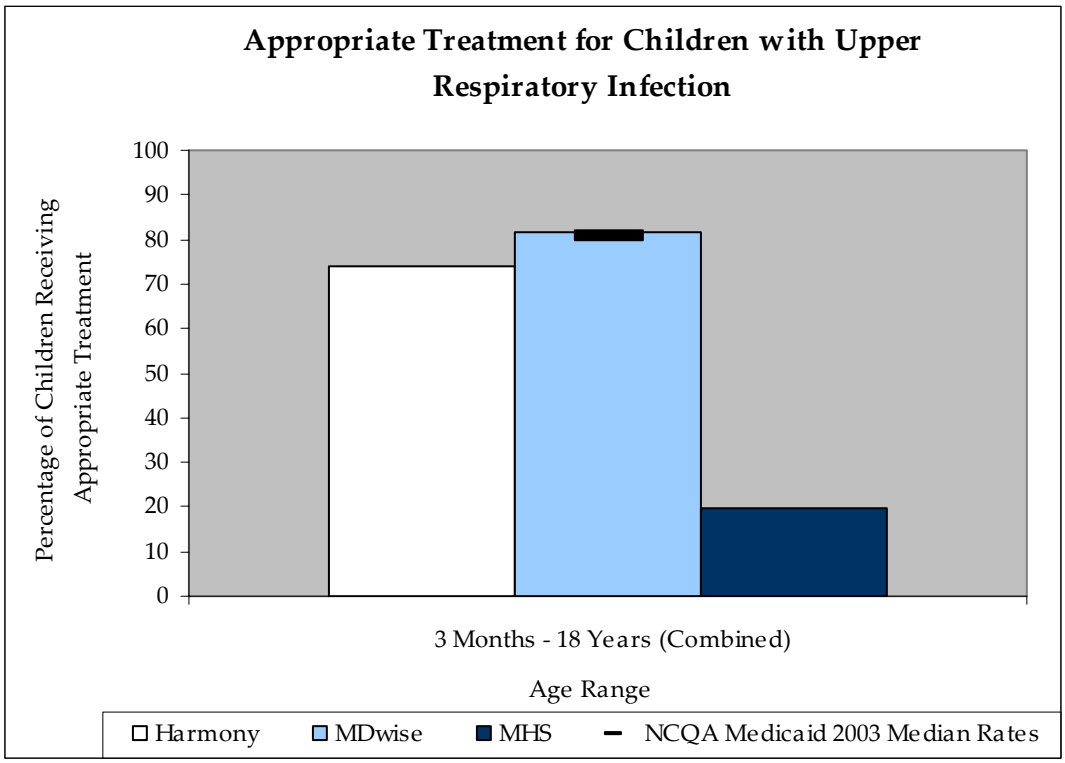
Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

As a result of these findings, all three of the Hoosier Healthwise health plans designed quality improvement projects to improve immunization rates. The MCOs indicated that they are now using the Children's Hoosier Immunization Registry Project (CHIRP) database to capture childhood and adolescent immunizations. This may be the primary reason for the significant increases in the HEDIS reporting measures from 2003 to 2004 and it is expected to continue in 2005.

Appropriate Treatment for Children with Upper Respiratory Infection

This 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 dispensed an antibiotic prescription. Therefore, a higher percentage rate for this measure is considered more favorable (i.e. proportion of children where antibiotics were not prescribed). Both Harmony and MDwise reported rates near the 2004 NCQA Medicaid median of 81%, with Harmony at 74% and MDwise at 82%. MHS, however, reported poorly at a rate of 20%, meaning that 80% of children with an upper respiratory infection were prescribed an antibiotic.

Exhibit VI.10
Results of HEDIS 2005 Measure:
Appropriate Treatment for Children with Upper Respiratory Infection



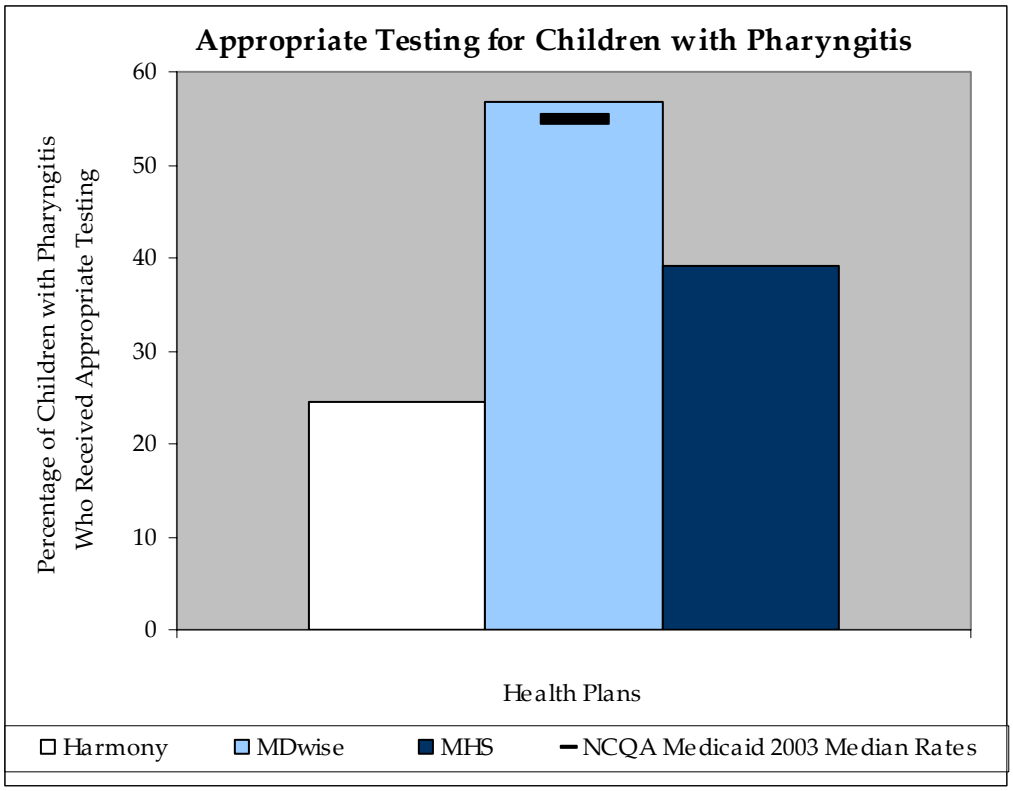
Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

Appropriate Testing for Children with Pharyngitis (Strep Throat)

This measure estimates the percentage of children who were between the ages of 2 and 18 years who were diagnosed with pharyngitis, prescribed an antibiotic, and received a Group A streptococcus test.

MCO performance varied widely on this measure (see Exhibit VI.11). Harmony's rate was below the NCQA Medicaid 10th percentile, possibly due to incomplete data collection. MDwise reported a rate of 57%, which was between the 2004 NCQA Medicaid 50th and 75th percentiles. MHS reported a rate of 39%, a small decrease from their HEDIS 2004 and just above the 2004 NCQA Medicaid 10th percentile.

Exhibit VI.11
Results of HEDIS 2005 Measure: Appropriate Testing for Children with Pharyngitis



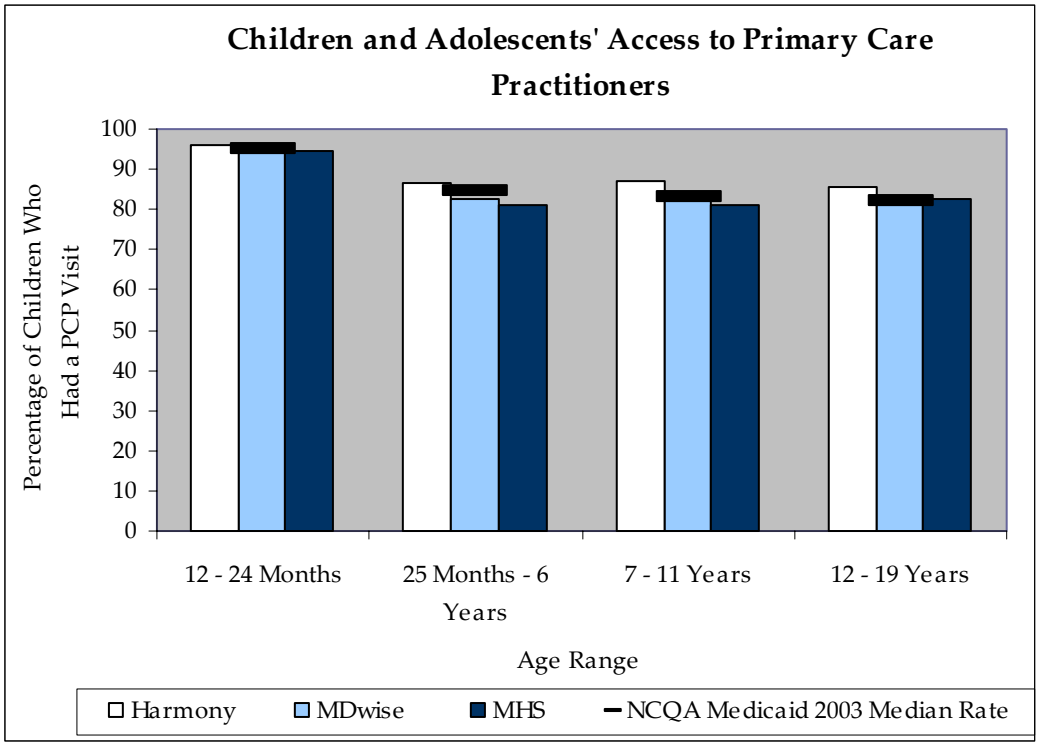
Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

Access/Availability of Care Domain

Children and Adolescents' Access to Primary Care Practitioners

This measure reports the percentage of enrolled children who had a visit with a primary care practitioner for the following age groups: 12 to 24 months, 25 months to 6 years, 7 to 11 years and 12 to 19 years. In 2004, both Harmony and MDwise improved upon their 2003 rates for all age groups. MHS experienced a slight decrease in its 2004 rate for the age group 25 months to 6 years, from 83% to 81%. Each of the health plans exceeded OMPP's targets for children and were at or above the national Medicaid median rates.

Exhibit VI.12
Results of HEDIS 2005 Measure:
Children and Adolescents' Access to Primary Care Practitioners



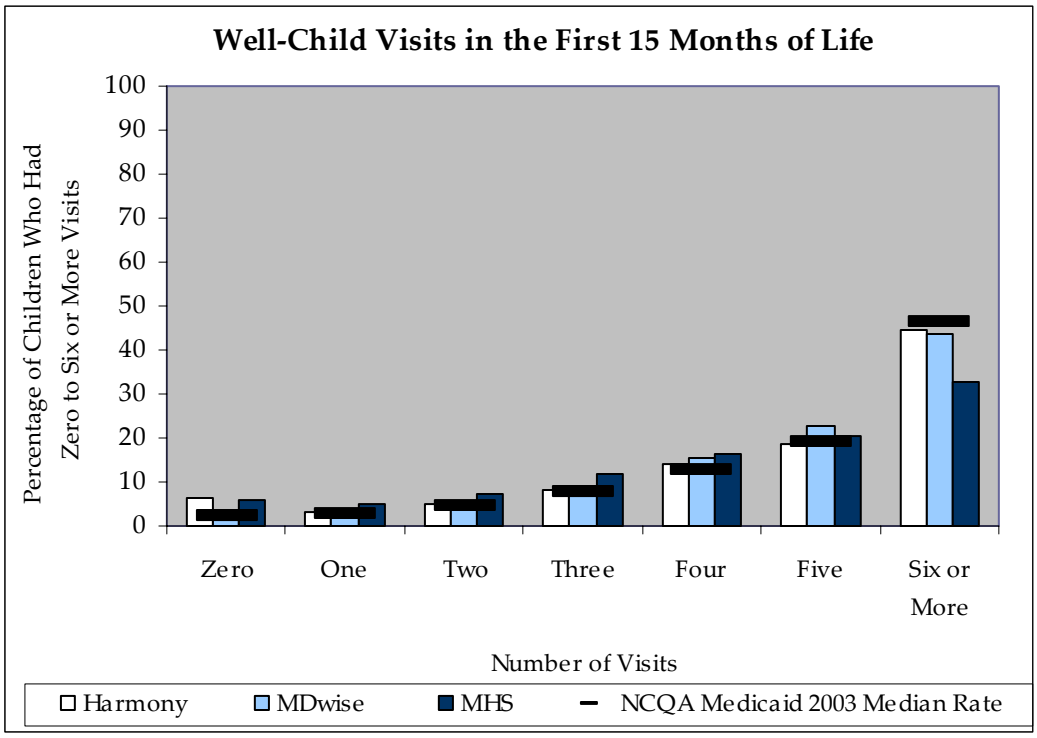
Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

Use of Services Domain

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 the following number of well-child visits with a primary care practitioner during their first 15 months of life: zero, one, two, three, four, five and six or more visits. For measurement year 2004, all three health plans improved their well-child visit rates for children in the first 15 months of life who had six or more visits. Harmony's rate more than doubled, from 22% in 2003 to 45% in 2004. Harmony's rate and MDwise's rate of 44% were still slightly below the 2004 NCQA Medicaid median rate. MHS, which improved its rate from 26% in measurement year 2003 to 33% in measurement year 2004, ranked below the 2004 NCQA Medicaid 25th percentile.

Exhibit VI.13
Results of HEDIS 2005 Measure:
Well-Child Visits in the First 15 Months of Life

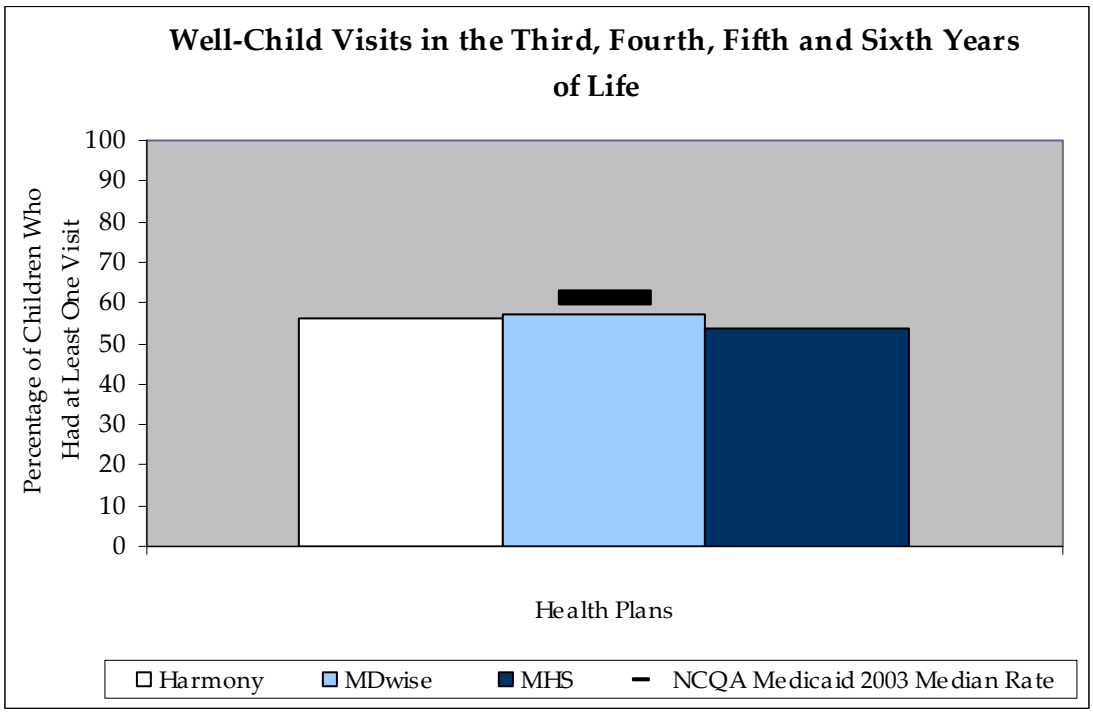


Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

This measure reports the percentage of enrolled three to six year old children who received one or more well-child visits with a primary care practitioner during the measurement year. Exhibit VI.14 shows that each of the three Hoosier Healthwise MCOs is near the NCQA Medicaid median.

Exhibit VI.14
Results of HEDIS 2005 Measure:
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

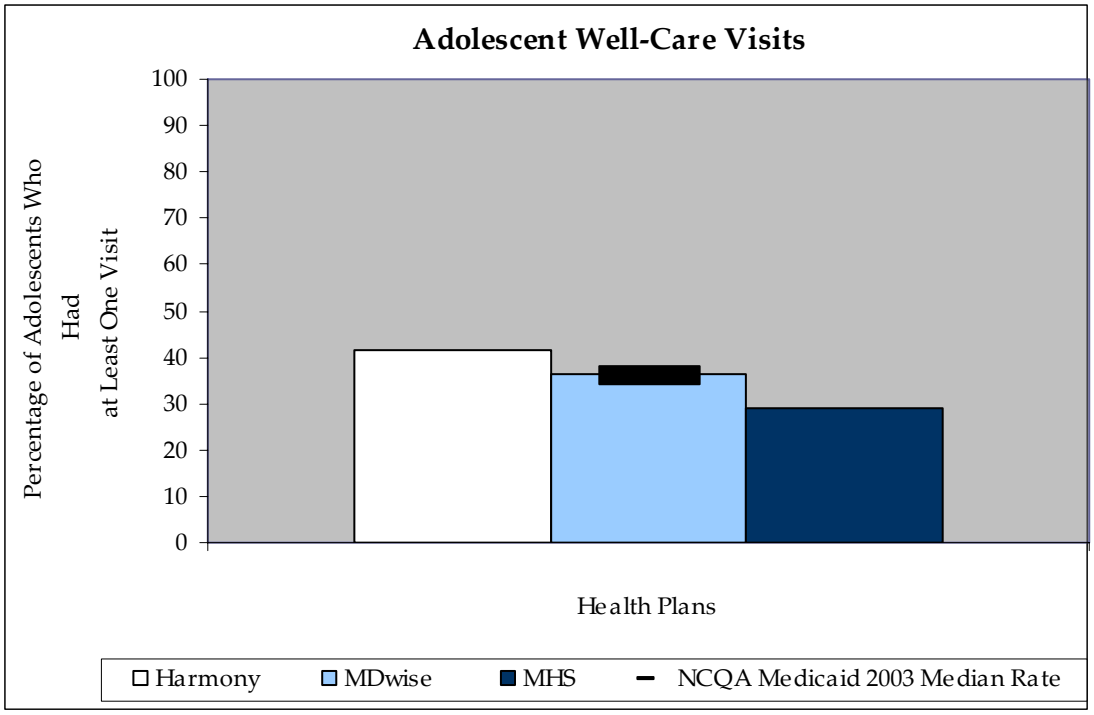


Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

Adolescent Well-Care Visits

This measure reports the percentage of enrolled adolescents 12 through 21 years old who received one or more comprehensive well-care visits with a primary care practitioner or obstetrician/gynecologist during the measurement year. Harmony reported that 42% of their members had a well-care visit, which is greater than the national Medicaid median. MDwise's rate of 37% was at the Medicaid median, whereas MHS's rate of 29% fell below the 2004 NCQA Medicaid 25th percentile.

Exhibit VI.15
Results of HEDIS 2005 Measure: Adolescent Well-Care Visits



Source: Navigant Consulting's Hoosier Healthwise HEDIS 2005 Findings, October 2005

QUALITY IMPROVEMENT COMMITTEE MEETING MINUTES FOR 2005

Quality Improvement Committee (QIC) meetings are scheduled to review issues that impact multiple stakeholders in the quality review process of the Hoosier Healthwise program. As such, the QIC meetings usually have at least one representative from each of the following parties in attendance:

- Each of the managed care organizations (MCOs)
- AmeriChoice, the enrollment broker and administrator of the member helpline
- Office of Medicaid Policy and Planning (OMPP)
- Navigant Consulting (the monitoring contractor for Hoosier Healthwise)

Some meetings also included representatives from the CHIP program, various Hoosier Healthwise contractors and additional guest speakers. A review of the minutes from the 2005 QIC meetings demonstrate that the committee continues to address some of the issues from 2004 and is actively identifying and highlighting areas that may need improvement. Examples of specific areas that impact CHIP members are discussed in detail below.

Blood Lead Screening Measure

Blood lead screening measures are an ongoing issue for the Hoosier Healthwise program. Children ages 1-5 years enrolled in Medicaid are at increased risk for having elevated blood lead levels (BLLs). According to estimates from the National Health and Nutrition Examination Survey (NHANES), Medicaid enrollees accounted for 83% of U.S. children ages 1-5 years who had BLLs greater than 20 ug/dL, a national benchmark. Despite longstanding requirements for blood lead screening in the Medicaid program, an estimated 81% of young children enrolled in Medicaid had not been screened with a blood lead test. As a result, most children with elevated BLLs are not identified and, therefore, do not receive appropriate treatment or environmental intervention.[2] Below are the measures the Indiana QIC discussed in reviewing this issue for Hoosier Healthwise.

- The Department of Health obtains blood lead screening data for children less than or equal to age six for another project. OMPP will make the data for this expanded age group available to the MCOs for the first time (which occurred in October 2005). OMPP will provide data for all age groups combined in a report to the MCOs, which they can review and use to improve lead screening and treatment. The age range for the annual HEDIS-like measure related to blood lead screening will remain unchanged at 27 months.

- OMPP confirmed that it will be requiring the new MCOs to report rates for the blood lead screening measure in 2005, but not on the HEDIS 2005 schedule.

[2] "Morbidity and Mortality Weekly Report," CDC. December 8, 2000/ Vo. 49/ No. RR-14 http://www.cdc.gov/mmwr/pdf/rr/rr4914.pdf, accessed 2/27/06.

OMPP and Navigant developed a draft report template to collect and report blood lead screening data. OMPP will report the data publicly (possibly with caveats) outlining the various limitations of the data collection process.

- The Indiana State Department of Health (ISDH) has begun working with immigration services to ensure immigrant children, as well as other children in Indiana, get tested. ISDH distributed case management recommendations for Medicaid providers. The educational materials include risk assessment questions for the physician to ask parents to determine if a child needs to be tested for lead levels. Hoosier Healthwise MCOs began distributing the educational materials.

- The Filter Paper Test Pilot is an ongoing project in 49 clinics around the state. County health departments bill the MCOs for blood lead screenings they perform, and the MCOs have access to the blood lead screening data for reporting.

HEDIS 2006 Targets and Benchmarks

- Target recommendations for the 2006 measurement year (based on 2005 data) will be based in part on MCO performance over the last two or three years. OMPP benchmarks for child-related measures will be at or near NCQA Medicaid medians, even if the health plans had not met these levels in the HEDIS 2005 study.

- New MCOs (Molina and CareSource) will not be penalized if they do not meet the 2006 targets. OMPP will be providing technical assistance to these plans to help them capture the data required for the HEDIS measures.

- Two new voluntary measures will be implemented in HEDIS 2006, although neither is directly applicable to the CHIP population—Breast Cancer Screening and Controlling High Blood Pressure.

CHAPTER VII

OVERVIEW OF FINDINGS AND RECOMMENDATIONS

CHAPTER VII
OVERVIEW OF FINDINGS AND RECOMMENDATIONS

Indiana's CHIP grew at a faster rate than 25 other states from September 2004 to September 2005 (data from four states not available). This has enabled Indiana to achieve an uninsured rate for children of 9.4 percent, which is below the national average of 11.7 percent (as of 2004). For children in the family income range eligible for CHIP (less than 200% of the federal poverty level), Indiana also has an uninsured rate for children below the national average (16.6% versus 19.0%). Enrollment continued to grow in both CHIP Phase I and Phase II throughout 2005, but at different rates. For CHIP Phase I, enrollment grew 6 percent while for CHIP Phase II enrollment grew by 11 percent. These growth rates are similar to those found last year.

It is uncertain what the impact of federal changes to the SCHIP program will have on Indiana's CHIP at this time. The national program is scheduled to expire at the end of federal fiscal year 2007. Based on available funding and guaranteed allocations in the next two years, Indiana's CHIP should be able to cover anticipated expenditures into SFY 2008.

The children in CHIP all moved to the Risk-Based Managed Care (RBMC) delivery model by the end of 2005 and out of the Primary Care Case Management (PCCM) delivery model. By requiring the managed care organizations (MCOs) in the RBMC model to meet certain quality standards, the State has placed greater emphasis on such aspects as measuring the rate of well-child visits for children in CHIP as well as all of Hoosier Healthwise. Although the MCOs contracting with the State prior to January 2005 reported this past year that their utilization levels for well-child visits were similar to national median rates for Medicaid MCOs, there is still opportunity for improvement. This is particularly true for immunization rates, which fell below national median reporting rates. The OMMP, which oversees the RBMC delivery system, has already imposed higher benchmarks for the MCOs on these measures in the next two years and has promised to work with the two new MCOs entering the market in the past year on their reporting of these measures.

Overall, however, utilization of other services (e.g. hospital, pharmacy scripts, and dental) have remained stable for the past three years among CHIP members. The members and their parents continue to report high rates of satisfaction with the program.

This chapter summarizes the findings discussed throughout this report. This is the sixth annual evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. (EP&P). As in past years, our evaluation focused on the most recent data available to identify trends in enrollment, service utilization, payments, access to services/providers, and quality monitoring. More of our analysis focused on the delivery of services in the RBMC model, since 2005 will lay the framework for benchmarks for future years under this delivery system. We conclude this chapter with recommendations to further strengthen an already successful program.

KEY FINDINGS RELATED TO ENROLLMENT

- Indiana children are more likely than children in the rest of the country to be covered by private health insurance. This fact, in conjunction with the Hoosier Healthwise program, means that Indiana's uninsured rate for children is lower than the national average. This is true for the uninsured rate for all children (9.4% in Indiana versus 11.7% nationwide) as well as for children in families under 200% of the federal poverty level (16.6% in Indiana versus 19.0% nationally).

- The overall enrollment in Indiana's CHIP program grew 7.5 percent from the middle of 2004 to the middle of 2005. This is the same rate as the previous 12-month period. However, the Phase II portion of the program grew 11 percent whereas Phase I enrollment grew by 6 percent. Since June 2005, enrollment in CHIP Phase II has grown by at least another 1,000 members.

- Indiana's growth rate in its CHIP is still more favorable than most other states. From the 4th Quarter of federal fiscal year (FFY) 2004 to the 4th Quarter of FFY 2005, Indiana's CHIP enrollment grew 6.1% (based on point-in-time counts), ranking it 21st among all states and much higher than the national average of 1.2% growth.

- The age distribution within CHIP Phase I and the age distribution within CHIP Phase II have remained unchanged in the last three years. However, due to differences in eligibility criteria for each phase of CHIP, the enrollment in CHIP Phase II includes younger children than CHIP Phase I. Further, both portions of the CHIP have older children than the Medicaid program, since there are no infants in CHIP Phase I and very few in CHIP Phase II. At the end of 2005, the average age in CHIP Phase I was 10.3 years as compared to 8.6 years in CHIP Phase II and 7.4 years in Medicaid, among all children under age 19.

- Now that managed care is mandatory in every county, there are no children remaining in the Primary Care Case Management (PCCM) delivery system. There are always some children temporarily in the Fee for Service (FFS) portion of the program until they select their primary medical provider, or one is selected for them.

- In the beginning of 2005, two additional managed care organizations (MCOs) began contracts with Hoosier Healthwise. As a result, CHIP children are enrolled in all five contracted MCOs. The percentage of children enrolled in CHIP I versus CHIP II within each MCO does not vary greatly. However, CHIP I and II enrollment distribution across the MCOs varies, with Managed Health Services enrolling about one-third of all CHIP children, followed by CareSource with nearly one-quarter, MDWise with about one in five, Harmony Health Plan with

around 7%, and Molina with 4%. It should be noted that CareSource and Molina are the two new MCOs in 2005.

- In terms of geography, the only clear pattern of enrollment in either CHIP or Medicaid enrollment density (percent of all children) is that the counties in the northeast corner of the state tend to have lower enrollment rates than the rest of the state. The counties with the highest CHIP enrollment density are all rural, while most of the counties with the lowest enrollment density are urban. Urban counties are more likely than rural ones to have high Medicaid enrollment density rates. Also, some of the urban counties with the highest Medicaid enrollment density rates have the lowest CHIP enrollment density rates.

KEY FINDINGS RELATED TO ACCESS

- Despite the movement to the RBMC delivery model, the number of PMPs that accept children as patients remained unchanged from December 2004 to December 2005.

- In nine counties, the panel capacities are full. This means that the number of members enrolled is at or exceeds the number of slots in which PMPs are willing to accept Hoosier Healthwise patients. An additional nine counties had PMP panels that were above 80% full capacity. However, 15 of these18 counties became mandatory RBMC counties some time in 2005.

- There does not appear to be a strong relationship between panel capacities and visit rates, however. Many of the counties that had full panels had high percentages of children that saw a PMP in calendar year 2005. The two exceptions were Clinton and Tippecanoe Counties, which had full PMP panels and low visit rates for CHIP children.

- Counties with full panel sizes do not necessarily mean that there could not be available capacity in the county. EP&P measured the average number of members assigned to each PMP and weighted this at the county level. For those counties with full panels currently, only two counties (Montgomery and Tippecanoe) also had above-average number of patients per PMP. This means that there may be an opportunity in the remaining counties with full panels to encourage providers to accept more patients without compromising waits for appointments or an over-commitment by providers to serve Hoosier Healthwise members.

KEY FINDINGS RELATED TO SERVICE UTILIZATION

- About 60 percent of the CHIP members visited their PMP, as defined by EP&P, during each of the last three calendar years.

- When visits to specialists and clinics are included, about 80 percent of CHIP children saw a physician during the calendar year. This rate is much higher for young children and decreases as the children get older. For example, 98 percent of all one year-olds saw some type of physician in CY 2004, whereas about 80 percent of children ages six through 12 saw a physician during this time period.

- The percentage of children who visit their PMP is higher in the RBMC delivery system, but the percentage of children who visit any type of physician (PMP, specialist, clinic) was found to not be different between RBMC and PCCM.

- The percentage of children who had a PMP visit varies by health plan, between 40 percent and 75 percent.

- There is little difference between the percentage of children seeing their PMP between the CHIP and Medicaid populations. This holds true at the overall level and by MCO.

- Utilization trends based on claims per 1,000 enrollees has remained stable over the last three years when the claims from MCOs were analyzed for inpatient hospital, outpatient hospital, primary care, specialist care, clinic, pharmacy and dental services. With a couple of exceptions, there is also little difference between the two CHIP packages in their utilization patterns. When compared to Medicaid children, CHIP children had a higher dental claims rate, pharmacy claims rate, and PMP physician claims rate per 1,000.

KEY FINDINGS RELATED TO PAYMENTS

- The payments made by CHIP to provide services to its members increased quite a bit from 2004 to 2005, when measured on a per member per month basis. The MCOs participating in the RBMC delivery system are paid a monthly capitation payment to serve their members, regardless of the amount, duration or scope of services provided to the members (except as limited to what the MCOs are contractually obligated to deliver). From 2004 to 2005, overall PMPM payments in the RBMC system grew 13 percent. This is further detailed as a 4 percent growth for children ages 1-5, a 26 percent growth for children ages 6-12, and a 6 percent growth for children ages 13-18.

- Although in CY 2003 and CY 2004, the PMPM payments made for children enrolled in the PCCM delivery system exceeded those made for children in the

RBMC delivery system, this trend changed in CY 2005 for children ages 6-12 and children ages 13-18. This finding would need more exploration, however, since the population in the PCCM delivery system may have been less representative in 2005 as compared to prior years since the program was phasing out.

KEY FINDINGS RELATED TO QUALITY

- Overall, children in Hoosier Healthwise rated their health plan and their doctors at a rate similar to national benchmarks of surveys to parents of children in Medicaid programs. When results for CHIP members/parents could be isolated (from the survey of PCCM members), both CHIP Phase I and CHIP Phase II members gave responses that were as favorable or more favorable than the general Hoosier Healthwise population.

- PMP satisfaction, as measured by the results from their annual survey, is at its lowest point in recent years. This appears to stem from multiple criteria, such as lower ratings on items such as communication with the health plans, timeliness of claims processing, reimbursement rates, authorization requirements for patient referrals, and the auto-assignment process.

- The results from the study of HEDIS measures in 2005 (based on 2004 utilization) were mixed. On the one hand, the three participating MCOs from 2004 had improved on most measures pertaining to children from the prior year results. However, the Indiana Hoosier Healthwise plans still reported results that were below national Medicaid medians on such measures as immunizations and appropriate treatment of strep throat. The MCOs did, however, meet or exceed national Medicaid medians on access to primary care physicians (for all ages) and for well-child visits.

- As a result of the findings from the HEDIS, the MCOs discussed methods to improve these scores at the QIC meetings in 2005. The OMPP is instituting more aggressive benchmarks that the MCOs will be expected to meet for the child-related HEDIS measures in 2006 and 2007. Another area of focus that will be a "HEDIS-like" measure in 2006 is screening blood for lead levels.

RECOMMENDATIONS FOR FURTHER RESEARCH

Through a review of the documentation and discussions with State staff and the MCOs during our external quality review in late 2005, we found that there was an active dialogue between the parties with respect to identifying opportunities to improve the RBMC delivery system. Specifically, we noticed two areas that pertain to children specifically that the State is working closely with the MCOs on:

- Improving HEDIS scores
- Reducing unnecessary utilization in the emergency room setting

EP&P concurs that these are areas that could use the most improvement, and was encouraged that both the OMPP and the MCOs have taken an active role to do this. With respect to the HEDIS scores, the area that can still be improved upon the most are measures related to immunizations. EP&P understands that the immunization scores may not be as low as reported because historically there have been barriers to obtaining information on when children in Hoosier Healthwise are getting immunizations if it is not through their PMP. The Children and Hoosiers Immunization Registry Program (CHIRP) database was developed by the Indiana State Department of Health (ISDH) as mandated by state law to help solve this problem. Although the CHIRP does help quite a bit in addressing some of the issues of the past, MCOs reported that there was difficulty at times in accessing the data from the CHIRP registry. Therefore, although HEDIS rates for immunizations improved over the prior year, there was still substantial room for improvement. To this end, EP&P makes the following recommendations to the OMPP:

1. Develop strategies with the MCOs to improve immunization rates. For example, identify the children that were in the HEDIS measure analysis that were found to not have their immunizations. Construct a targeted study of these individuals. Some questions to pose could be:

    a. When the Combination One and Combination Two measures are analyzed, were the children not counted as being compliant because they were only missing one of the many immunizations required, or was it that they were missing all of them?
    b. Was the issue that the immunizations were administered, but just not under the periodicity schedule required (e.g. the first 15 months of life)?
    c. Is there an issue regarding the immunizations inventory not being supplied to the doctors?
    d. Did the MCOs follow-up with the PMPs responsible for these children to find out if they knew whether or not the children had received their immunizations, but just not from the PMP?

2. Provide incentives to MCOs to both meet national standards (e.g. the NCQA Medicaid medians) on immunizations and to improve their scores year-over-year.

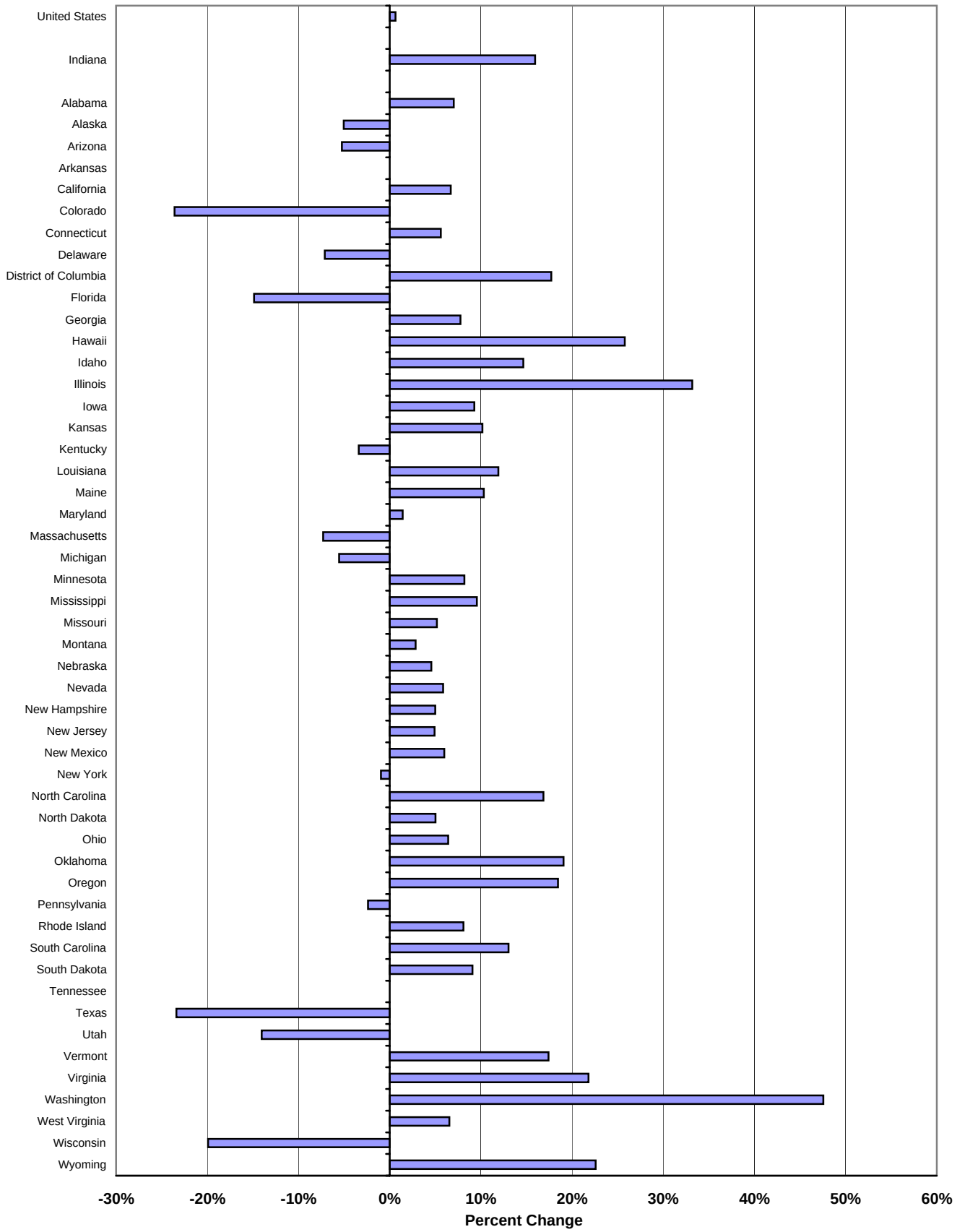
This could be done through a pay-for-performance program that was tracked through verifiable data reporting.

3. With respect to emergency room utilization, EP&P recognizes that one of the challenges for both the OMPP and the MCOs as managed care penetration has occurred across the state is educating new RBMC members regarding how to access care. Tracking the improper accessing of ER services is already occurring, and EP&P suggests that this be continued, if not enhanced, for both current and new MCOs.

4. Develop a "HEDIS-like" measure related to the percentage of emergency room visits that were deemed nonemergent. Although each MCO uses slightly different measures to define emergent care, the OMPP could develop a common list of diagnoses for purposes of this measure. Provide incentives to MCOs that hit a desired benchmark or that show a reduction in inappropriate ER use year-over-year.

APPENDIX A

Appendix A
Percent Change in SCHIP Enrollment
December 2003 to December 2004



APPENDIX B

Appendix B
SCHIP Premiums and Enrollment Fees as of December 2004

State	Requires Premiums or Enrollment Fees		Notes
	Yes	No	
Alabama	X		100-150% FPL: $50 per year per child, $150 maximum premiums per family 151-200% FPL: $100 per year per child, $300 maximum premiums per family
Alaska		X	
Arizona	X		100-150% of FPL: $15 for parents, $10 for one child, $15 for two or more children 150-175% of FPL: $20 for parents, $20 for one child, $30 for two or more children 175-200% of FPL: $25 for parents, $25 for one child, $35 for two or more children
Arkansas		X	
California	X		Based upon income. Premiums range from $4-$9 per month per child with a family maximum of $27 per month; 25% discount for those using Electronic funds transfer
Colorado	X		Up to 150%: no enrollment fee 151-185% FPL: $25 single child, $35 for two or more children Fee waived for families with eligible pregnant women
Connecticut	X		Band 1: $30 per child, $50 two or more children Band 2: $50 per child, $75 two or more children Band 3: based upon group rate, between $158-$230 per child per month
Delaware	X		101-133% FPL: $10 per family per month 134-166% FPL: $15 per family per month 167-200% FPL: $25 per family per month
District of Columbia		X	
Florida	X		Below 150% FPL: $15 per family per month Above 150% FPL: $20 per family per month
Georgia	X		Monthly household premiums are based on FPL; 100%-150% FPL: $10 per child; $15 family cap 151%-160% FPL: $20 per child; $40 family cap 161%-170% FPL: $22 per child; $44 family cap 171%-180% FPL: $24 per child; $48 family cap 181%-190% FPL: $26 per child; $52 family cap 191%-200% FPL: $28 per child; $56 family cap 201%-210% FPL: $29 per child; $58 family cap 211%-220% FPL: $31 per child; $62 family cap 221%-230% FPL: $33 per child; $66 family cap 231%-235% FPL: $35 per child; $70 family cap
Hawaii		X	
Idaho	X		$15 per month
Illinois	X		150% FPL: $15 one child, $25 for two; $30 three or more
Indiana	X		150-175% FPL: $11-$16.50 per month 176-200% FPL: $16.50-$24.75 per month
Iowa	X		$10 per child per month up to $20 per family (more than one child) per month

Appendix B
SCHIP Premiums and Enrollment Fees as of December 2004

State	Requires Premiums or Enrollment Fees		Notes
	Yes	No	
Kansas	X		151-175% FPL: $15 per family per month 176-200% FPL: $30 per family per month
Kentucky	X		$20 per family per month
Louisiana		X	
Maine	X		$8-$64 per month depending upon family size and income
Maryland	X		200-250% FPL: $41 per family per month 250-300% FPL: $52 per family per month
Massachusetts	X		Below 150% FPL: $12 per child per month with a maximum of $15 per family per month Above 150% FPL: $12 per child per month with a maximum of $36 per family per month
Michigan	X		$5 per family per month
Minnesota	X		For the parents and relative caretakers under the Section 1115 waiver, premiums are determined on a sliding scale based upon income
Mississippi		X	
Missouri	X		226-300% FPL: $62-$252 monthly premium depending upon income and family size
Montana		X	
Nebraska		X	
Nevada	X		100-150% FPL: $15 151-175% FPL: $35 167-200% FPL: $70
New Hampshire	X		185-250% FPL: $25 per child per month with a $100 maximum per month 250-300% FPL: $43 per child per month with a $135 maximum per month
New Jersey	X		Below 250% FPL: family monthly premium is $17 250-299% FPL: family monthly premium is $34 300-349% FPL: family monthly premium is $68 Above 350% FPL: family monthly premium is $113.50
New Mexico		X	
New York		X	Note: Although not reported on the survey, families above 160% FPL are required to pay a monthly premium of $9 or $15 per child (up to 3 children) depending upon income and family size; above 250%, the family must pay the full premium charged by the health plan
North Carolina	X		Annual enrollment fee for above 150% FPL: $50 per child with a maximum of $100 per family
North Dakota		X	
Ohio		X	
Oklahoma		X	
Oregon		X	
Pennsylvania		X	
Rhode Island	X		150-185% FPL: $61 per family per month 185-200% FPL: $77 per family per month 200-250% FPL: $92 per family per month

Appendix B
SCHIP Premiums and Enrollment Fees as of December 2004

State	Requires Premiums or Enrollment Fees		Notes
	Yes	No	
South Carolina		X	
South Dakota		X	
Tennessee		X	
Texas	X		Sliding scale based upon income
Utah	X		Below 100% FPL: none 101-150% FPL: $13 per family per quarter 151-200% FPL: $25 per family per quarter
Vermont	X		$70 per family per month
Virginia		X	
Washington	X		$15 per child per month; maximum of $45 per family per month
West Virginia		X	
Wisconsin	X		150% FPL or above: 5% of income
Wyoming		X	

Note: Information in this table provided by state SCHIP officials in March 2005 in response to the survey question: "As of December 2004, were there premiums or enrollment fees?"

Source: The Kaiser Commission on Medicaid and the Uninsured, SCHIP Enrollment in 50 States: December 2004 Data Update, September 2005, pg. 18-19