ACKNOWLEDGMENTS

This report was written by Mark Podrazik (HMA Managing Director) with assistance from Jesse Eng (Programmer) and Barry Smith (Analyst).

Inquiries may be sent to
mpodrazik@healthmanagement.com

BURNS & ASSOCIATES, INC.

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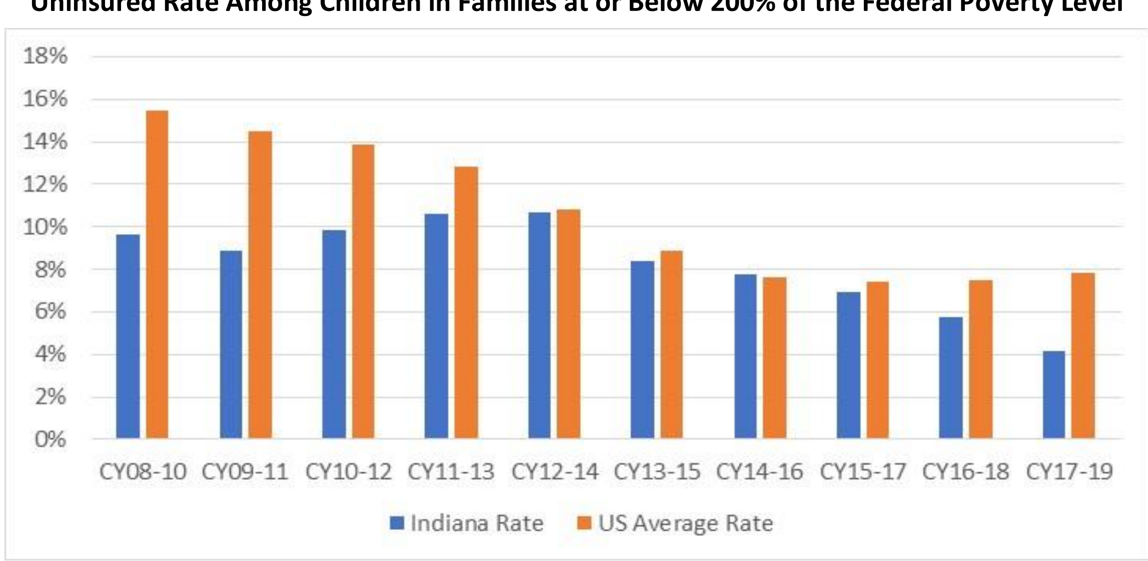
EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) experienced a decrease in the latter half of Calendar Year (CY) 2020 with year-end enrollment at 109,312[1] members, a 3.8 percent decrease from the CY 2019 year-end enrollment of 113,675. Enrollment in the program has been above 109,000 for each of the last four years. The all-time high enrollment in CHIP of 119,216 occurred at the start of the pandemic in March 2020. A reason why enrollment may have decreased during CY 2020 was due to some children gaining eligibility in Medicaid (due to lower family income). Within the traditional Medicaid program in Indiana, enrollment increased by more than 100,000 children during CY 2020.

Indiana's CHIP continues to serve as a way to keep the uninsured rate for children in lower-income families below the national average. For the most recent 10 years of reporting, Indiana's uninsured rate for children in families at or below 200% of the federal poverty level (FPL) has been below the national average. (The uninsured rate is expressed as the most recent three years averaged together.)

Uninsured Rate Among Children in Families at or Below 200% of the Federal Poverty Level



At the end of CY 2020, 64.9 percent of enrollees were in the MCHIP portion and 35.1 percent were in the SCHIP portion of the program. Eligibility for CHIP depends on the child's age as well as the family's income. MCHIP (Package A) is the entitlement portion of the program and was put in place at the beginning of the program. SCHIP (Package C) is the name of the non-entitlement portion of the program. SCHIP was introduced in two phases (Package C original and Package C expansion).

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

[1] Enrollment figures retrieved by B&A come from data in the Office of Medicaid Policy and Planning's Enterprise Data Warehouse. The numbers shown in this report differ somewhat from the OMPP's published December 2020 enrollment report because B&A has access to more recent data since the report published by the OMPP.

The enrollment changes over CY 2020 are as follows:

- MCHIP (CHIP Package A) decreased 7.5 percent to 70,927 children in December 2020
- SCHIP (CHIP C original) increased 1.8 percent to 20,810 children in December 2020
- SCHIP (CHIP C expansion) increased 6.0 percent to 17,575 children in December 2020

Some children are continuously enrolled in CHIP for long lengths of time while others turn over depending upon the financial status of the family. There were 109,312 CHIP enrollees at the end of 2020, but there were 176,143 children enrolled in the program for at least some portion of the year.

Enrollment in CHIP is spread evenly throughout the state, but there is a higher distribution of minorities in Indiana's CHIP than the overall population of children ages 18 and younger. Just under half of the children enrolled in the CHIP are between the ages of 6 and 12. Enrollment by age is uneven because children under age 6 are eligible for regular Medicaid at higher family income levels. Teenagers represent 36 percent of CHIP enrollees while the remaining 15 percent are under age 6. This distribution has been the case since the CHIP was introduced.

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

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

Burns & Associates (B&A), a Division of Health Management Associates, was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for CY 2020. The B&A team has conducted this annual study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

Background on Indiana's CHIP

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

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

Monthly Premiums

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

In a report released by the Kaiser Family Foundation in March 2019, it was found that Indiana's program resembles many other state CHIP programs in its design features as well. Among the CHIP programs nationwide, 22 states (including Indiana) require families to pay premiums for their children's coverage when the family income is above 200% FPL. States do differ on co-pays required in their programs. Like 16 other states, Indiana requires co-pays on some pharmacy scripts. But Indiana does not require co-pays on emergency room visits or non-preventive physician visits like some other states do.

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

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage (FMAP) for states is higher than the FMAP for Medicaid. The Affordable Care Act (ACA) increased each state's enhanced FMAP rate for CHIP by 23 percentage points for the years FFY 2016 through FFY 2019. This "bump" in the enhanced FMAP was reduced to an 11.5 percentage point bump beginning in FFY 2020. The enhanced FMAP remains in CHIP beginning in FFY 2020. Further, during the public health emergency (PHE), each state has also received a 6.2 percentage point increase in its regular Medicaid FMAP. This will continue as long as the PHE is in effect (likely through the end of CY 2021).

For illustration, for every $100 spent in Indiana's CHIP, in FFY 2019 the state's responsibility was 83 cents. In FFY 2020, the state share was between $8.07 and $12.41 (fluctuates because of when the PHE began). In FFY 2021, the state's share is currently $19.58.

Total expenditures in Indiana's CHIP in CY 2020 were $277.7 million. With the various sources of funding from the federal government, this means that the state share to fund CHIP was approximately $33.4 million, or 12.0 percent of total expenditures.

Access to Services

B&A reviewed access by examining where CHIP members live and the providers under contract with the MCEs to offer primary care and dental services. We matched claims of actual services received in FFY 2020 between where the member lives and where the closest provider is located to each member. B&A found each provider's location and drew a 10-mile coverage radius to assess the availability of primary care and dental providers to CHIP members. On a statewide level, there are very few gaps. In fact, only 0.3 percent of all CHIP members live more than 10 miles from an available primary medical provider. There are 1.0 percent of CHIP members who live more than 10 miles from an available dentist.

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

Separately, B&A computed the average distance that members actually travelled to their providers of choice. An average driving distance was computed for CHIP members in each of the 92 counties. The OMPP targets a threshold of no more than 30 miles for members to travel to seek primary care or dental care. For primary care, there are four counties where members, on average, travelled more than 30 miles (the county with the maximum distance was 34 miles). For dental care, there are 10 counties where members, on average, travelled more than 30 miles (the county with the maximum distance is 39 miles). The maps that show the results at the individual county level appear in Chapter III.

Outcomes

The OMPP requires its MCEs in Hoosier Healthwise to measure health outcomes for children. Many of the measures that the MCEs report on are Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are nationally-recognized measures that health plans report on and are subject to an external auditor to compute. The OMPP compares the results of the HEDIS measures across the four MCEs and has set performance targets against national benchmarks for Medicaid health plans. B&A reviewed 14 HEDIS measures in this evaluation that are commonly used to assess the health outcomes for children. Some of the key findings on selected HEDIS measures are reported in Chapter V.

- When compared to the median results for Medicaid health plans nationally, among the 14 measures reviewed, MDwise had eight measures that exceeded national median values, Anthem and MHS had seven, and CareSource had five.

- Areas where all of Indiana's MCEs exceeded national health plan median results include the following:
    - Six or more well child visits in the first 15 months of life
    - Appropriate asthma medication for children age 5-11 years
    - Follow-up visit within 30 days from a mental health-related hospitalization
    - Follow-up care during the initiation phase when prescribed medication for ADHD

- Areas where at least three of the four MCEs in Indiana exceeded national health plan median results include the following:
    - Annual well care visit for adolescents age 12-18
    - Appropriate asthma medication for children age 12-18 years
    - Follow-up visit within 7 days from a mental health-related hospitalization

- Areas where the Hoosier Healthwise MCEs had rates below national health plan median results include the following:
    - All four MCEs were below national median rates for four measures related to access to primary care (age 12-24 months, age 25 months-6 years, age 7-11, age 12-19) and the measure for child immunizations
    - Three of the four MCEs were below national median rates for the measures Annual well care visit for children age 3-6 and follow-up care (maintenance phase) when prescribed medication for ADHD

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency room visits, preventive dental visits, and pharmacy prescription for the periods FFY 2018, FFY 2019 and FFY 2020.

The focus on users of each service was limited to children who were enrolled in the program for at least nine months within each year. Comparisons were also made across various demographic cohorts, such as by Package (CHIP A, CHIP C and CHIP C Expansion), by MCE, by age group and by race/ethnicity. B&A also analyzed the utilization rate per 1,000 CHIP members (for all members enrolled, regardless of duration) in each FFY and also by each of the demographic cohorts.

Due to the pandemic, specific attention was paid to utilization trends in the first six months of FFY 2020 (October 2019 – March 2020) and the last six months of FFY 2020 (April – September 2020).

The key findings from studying this data are shown below; however, these same variations have also held true for the past five years in CHIP (even if actual values have changed slightly):

- Primary care visits
  - The percent of SCHIP (CHIP Package C and CHIP C Expansion) children in the study sample that had a primary care visit each year was higher (89% of total) than for children in MCHIP (CHIP Package A) (81% of total).
  - Primary care visits are used more by children ages 5 and younger (93% of total) each year than the older members enrolled in CHIP (80-83% of total).
  - When examined by race/ethnicity, the usage rate was lower for Hispanic children than Caucasian children, and African-American children had even lower usage than Hispanic children (Caucasian near 85%, Hispanic 79-84%, African-American 76% each year).
  - Generally, primary care visits per 1,000 members in the second half of FFY 2020 occurred at two-thirds of the rate as in the first half of FFY 2020.
- Emergency room visits
  - The percent of children enrolled at least nine months in CHIP that use the ER each year averages to 21%-23% of all members. This is true by Package and by MCE.
  - Children ages 5 and younger are more likely to use the ER (31% of total) than older children (closer to 20% of total). Use of the ER by race/ethnicity is similar, although slightly lower for Hispanic children.
  - ER visits per 1,000 members in the second half of FFY 2020 were at 50-57% of the rate that they were pre-pandemic.
- Preventive dental visits
  - The percentage of CHIP members that had a preventive dental visit each year was consistent for CHIP C and CHIP C Expansion (66% of total) but lower for CHIP A members (61% of total) in FFYs 2018 and 2019.
  - There is variation in the percent of CHIP members using dental services across the MCEs. MDwise has the highest usage rate, Anthem and MHS are slightly below MDwise, and CareSource is much below the other MCEs.
  - Dental usage is much higher for children ages 6 to 12 (near 70% in FFYs 2018 and 2019) than children age 13 and over (near 58% during the same time period) or children age 5 and under (near 50%).
  - Hispanic children in Indiana's CHIP have traditionally had a higher usage rate for dental services than other race/ethnicities. African-American and Caucasian children have had similar usage rates.
  - Although utilization did drop for all subgroups, on average the utilization during the pandemic months was 78 percent of the pre-pandemic months of FFY 2020.

- Pharmacy scripts
  - The children in CHIP Package A are less likely to have a pharmacy script (65% of members) than CHIP C or CHIP C Expansion children (69%).
  - The percentage of children ages 5 and younger have a higher usage rate of pharmacy scripts by far compared to older children. But the older children who do use pharmacy have a much higher number of scripts per 1,000 members than the youngest children.
  - Hispanic children were found to have the lowest usage rate of pharmacy among CHIP members, but not much lower than other minorities. The scripts per 1,000 Hispanic children are considerably lower, however, than other race/ethnicities. Caucasian children have much higher usage rates and utilization per 1,000 member rates than minority children for pharmacy scripts.

The B&A team also conducted an update to a study on lead testing previously conducted in CY 2017. Overall, the rate of lead tests among Medicaid and CHIP children has been improving in the last two years. Attention was focused on children in the program ages 1 and 2 since this is the recommended age for lead testing to occur. The percentage of children age 1 with a test found (through MCE claims or the database at the Indiana Department of Health) increased from 37.1 percent in CY 2016 to 47.6 percent in CY 2019. The percentage of children age 2 with a test found increased from 25.6 percent in CY 2016 to 34.1 percent in CY 2019. The rates improved for each of the four MCEs between CY 2018 and CY 2019 as well.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCEs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. In this past year's survey, on a 10-point scale with 10 being the best score, the percent of members giving each MCE a score of 8, 9 or 10 are tracked. With few exceptions, more favorable ratings were found across-the-board this year compared to the previous year's survey results. Across the MCEs, the percentage of members giving these scores are:

- For Rating of Health Plan, 85 to 92 percent (last year 83 to 89 percent)
- For Rating of Health Care, 88 to 91 percent (last year 86 to 89 percent)
- For Rating of Personal Doctor, 90 to 92 percent (last year 88 to 90 percent)
- For Rating of Specialist, 84 to 93 percent (last year 87 to 93 percent)

Families are also asked to rate how often they "usually" or "always" receive certain aspects of their care. Across the MCEs, the percentage of members giving these scores are:

- For Getting Needed Care, 85 to 91 percent (last year 84 to 88 percent)
- For Getting Care Quickly, 93 to 94 percent (last year 89 to 93 percent)
- For How Well Doctors Communicate, 95 to 97 percent (last year 94 to 96 percent)
- For MCE Customer Service, 87 to 92 percent (last year 85 to 91 percent)

For seven of these eight measures, three of the four MCEs in Indiana fared better than the national median results reported for Medicaid health plans nationally. For one measure, Getting Care Quickly, all four MCEs had results better than the national median values.

CHAPTER I: INTRODUCTION

Each year, an independent evaluation of Indiana's Children's Health Insurance Program (CHIP) is conducted as required by Indiana Code 12-17.6-2-12 and is due to the Legislature by April 1. Burns & Associates, a Division of Health Management Associates (B&A), was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2020. B&A has conducted this study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage (FMAP) for states is higher than the FMAP for Medicaid. This is often referred to as the "enhanced FMAP". Prior to the Affordable Care Act (ACA), the enhanced FMAP was 30 percent higher for CHIP than the regular FMAP for Medicaid. The ACA increased each state's enhanced FMAP rate for CHIP even further. Beginning in FFY 2016 and continuing through FFY 2019, the "bump" in the CHIP FMAP was 23 percentage points. The bump was reduced to 11.5 percentage points in FFY 2020. Starting in FFY 2021 (October 1, 2020 – September 30, 2021), the bump is phased out, but the enhanced FMAP remains for CHIP like it was prior to the ACA legislation.

During the public health emergency (PHE), each state has also received a 6.2 percentage point increase in its regular Medicaid FMAP. This will continue as long as the PHE is in effect (likely through the end of CY 2021).

As an illustration, for every $100 spend in Indiana's Medicaid/CHIP program, the state share is as follows (values in bold are the values actually in effect each year):

FFY	Regular Medicaid FMAP	Regular Medicaid FMAP during PHE	CHIP Only With Enhanced FMAP	CHIP Only With Enhanced FMAP during PHE	CHIP Only With Enhanced FMAP + temporary ACA bump
2019	**$34.04**		$23.83		**$0.83**
2020	**$34.16 (Oct-Mar)**	**$27.96 (Apr-Sept)**	$23.91	**$12.41 (Oct-Mar)**	**$8.07 (Apr-Sept)**
2021	$34.17	**$27.97**	$23.92	**$19.58**	Not applicable

When the original S-CHIP legislation was introduced, states had the option to expand their existing Medicaid program, develop a state-specific program (that would not be an entitlement program), or both. Indiana opted to implement the "combination" program similar to 20 other states.

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

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 158[2] percent of the Federal Poverty Level, or FPL ($41,396 per year for a family of four in 2020) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

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

  - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 158 percent up to 200 percent of the FPL ($52,400 per year for a family of four in 2020).

  - The second portion (referred to as SCHIP (Package C) Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($65,500 per year for a family of four in 2020).

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

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

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

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

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

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

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

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

- The required period of no insurance prior to enrolling (also known as the "going bare" period) is three months in Indiana. There are 38 states with no waiting period.

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

- "Real time" eligibility determination (that is, in 24 hours or less) is available in 47 states. In 15 states (including DC), more than half of the determinations are done in real time. Indiana is one of 32 states where less than 50 percent of the determinations are done in real time.

- Indiana does not impose co-pays for non-emergent ER visits (14 states do), non-preventive physician visits (16 states do), or inpatient hospital visits (11 states do).

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

As of December 2020, enrollment in Indiana's CHIP was at 109,312, a 3.9 percent decrease over the prior year's membership of 113,675. The all-time high enrollment in Indiana's CHIP occurred this year in April 2020 when enrollment was at 119,216. A likely reason why enrollment in CHIP has decreased is because enrollment for Medicaid children has increased significantly since the pandemic started. Child enrollment increased 18.1 percent from December 2019 to December 2020. In addition to economic factors, states were required to retain their enrollment during the PHE in exchange for the higher FMAP rate from the federal government. This means that children who may be determined no longer eligible at the time of annual renewal are still enrolled in Medicaid or CHIP, subject to some exceptions.

The enrollment in CHIP in particular as of December 2020 was as follows:

- MCHIP (Package A, the entitlement program): 70,927 (down 7.5% from December 2019)
- SCHIP (Package C, the non-entitlement program, income up to 200% FPL): 20,810 (up 1.8% from December 2019)
- SCHIP (Package C, the non-entitlement program, income 200%-250% FPL): 17,575 (up 6.0% from December 2020)

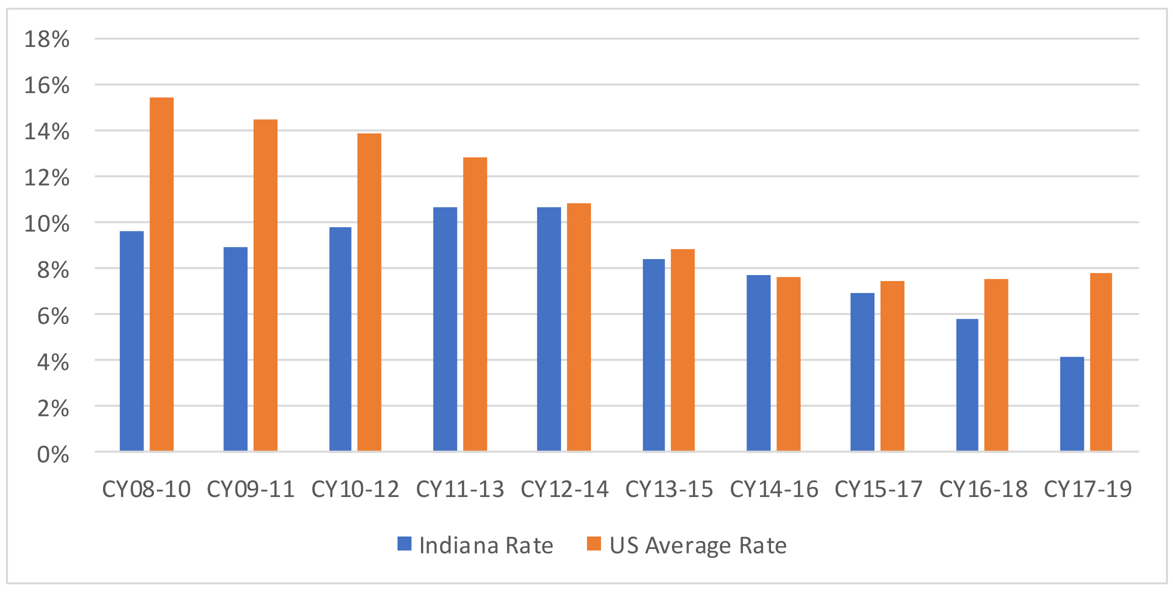
More enrollment statistics appear in Chapter II of this report.

The Census Bureau's Current Population Survey (CPS) surveys citizens annually on their health insurance status. An uninsured rate is computed for each state. In previous studies, it has been found that state-specific samples are often small, so year-to-year findings should be viewed with caution. Researchers often use an average over three years of annual CPS surveys to mitigate large swings in year-to-year results at the individual state level.

Exhibit I.1 compares the uninsured rate in Indiana against the national average over the last ten years for children in families with incomes up to 200 percent of the FPL. This FPL was used since 49 states cover children up to 200 percent of the FPL while fewer states cover children above this level.

Indiana has consistently had an uninsured rate for children at this income level that is lower than the national average. Both Indiana's uninsured rate and the US average uninsured rate continue to fall. For the most recent three-year period of CYs 2017 to 2019, Indiana's uninsured rate was 4.1 percent; the US average was 7.8 percent.

Exhibit I.1
Uninsured Rate Among Children in Families at or Below 200% of the Federal Poverty Level
For the Most Recent 10 Years of Reporting
The Uninsured Rate is Computed Using a Three-Year Average



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

Indiana's CHIP is Integrated with Other Medicaid Programs

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

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

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

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

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

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

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

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

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

Expenditures in Indiana's CHIP

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

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

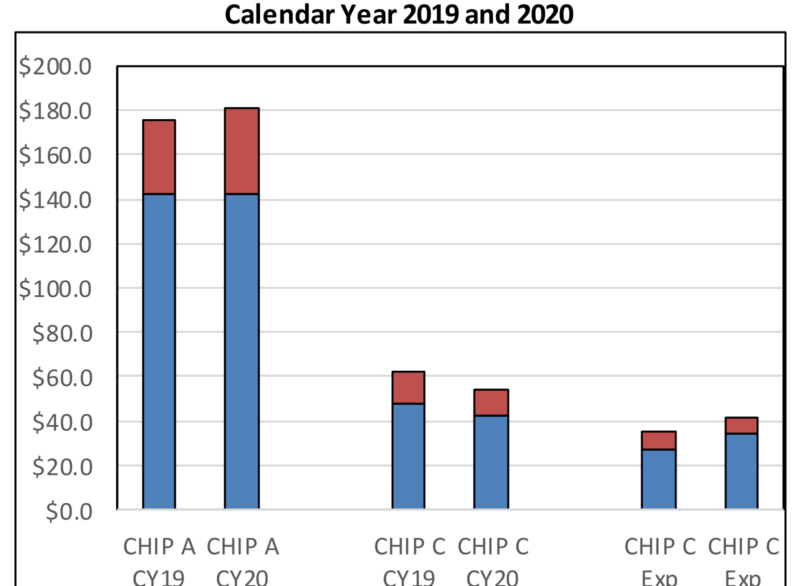
B&A examined expenditures made on behalf of CHIP members from data included in the state's data warehouse. Total expenditures in the CHIP were $272.4 million in CY 2019 and $277.7 million in CY 2020. The CY 2020 may grow a bit as some additional fee-for-service claims are billed for this service period. In both years, approximately 80 percent of CHIP expenditures were made to the MCEs through the PMPM. The remaining 20 percent was paid out by the OMPP through fee-for-service claims.

In CHIP Package A, total expenditures were $181.3 million in CY 2020, a 3.2 percent increase from CY 2019. The PMPM payment increased 3.9 percent, from $193.34 to $200.85.

In CHIP Package C, total expenditures were $62.0 million in CY 2020, a decrease of 12.1 percent from CY 2019. The PMPM payment decreased 2.0 percent, from $220.13 to $215.75.

In the expansion portion of CHIP Package C, total expenditures were $34.9 million in CY 2020, an increase of 20.2 percent from CY 2019. On a PMPM basis, however, there was a decrease of 7.5 percent from $219.31 to $202.82.

Exhibit I.4
Expenditures in Indiana's CHIP, in millions
Calendar Year 2019 and 2020



The results shown above are the total funds expended in the CHIP. As stated earlier, the federal government contributes more to state CHIP programs than the regular Medicaid program. For the first nine months of CY 2019, the state contribution was less than one percent of the total dollars shown in the exhibit. Starting in October 2019 and through the end of CY 2020, the state contribution was between eight percent and 12 percent of the total dollars shown in the exhibit. Furthermore, for CHIP Package C, the state's outlay is further reduced by premiums paid by parents.

CHAPTER II: ENROLLMENT TRENDS IN INDIANA'S CHIP

Enrollment in Recent Years

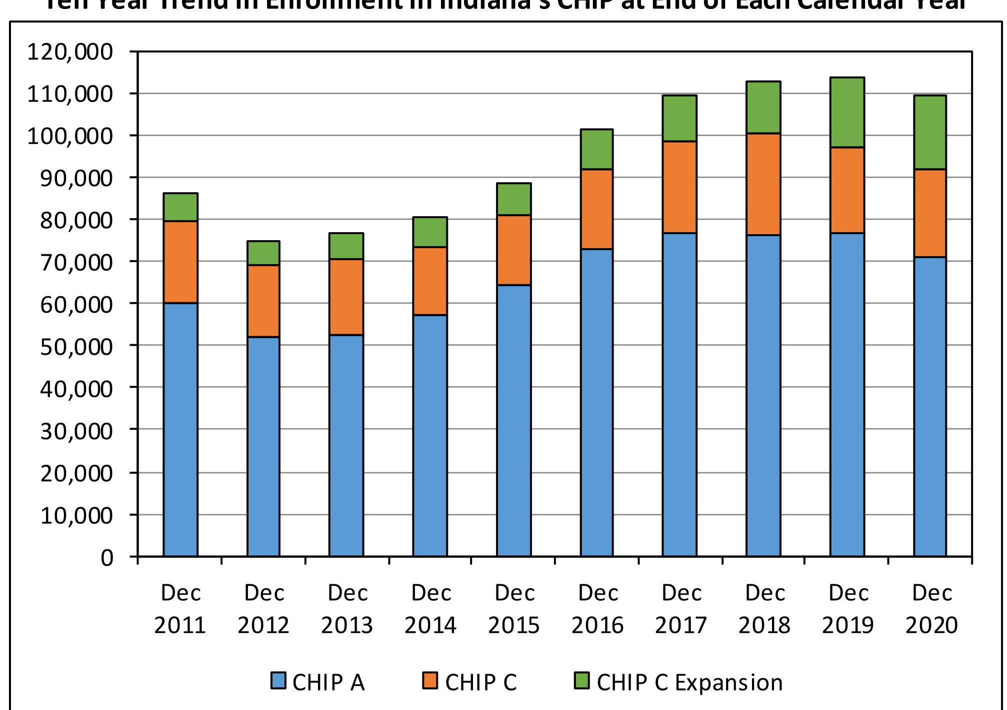
Indiana's Children's Health Insurance Program (CHIP) experienced a decrease in enrollment in the latter half of Calendar Year (CY) 2020 with year-end enrollment at 109,312 members, a 3.8 percent decrease from the CY 2019 year-end enrollment of 113,675. As seen in Exhibit II.1 below, enrollment in CHIP has been above 109,000 for each of the last four years.

Enrollment in CHIP was at an all-time high at the start of the pandemic with enrollment of 119,216 in March 2020. For perspective, children enrolled in the traditional Medicaid program were near 585,000 at the end of CYs 2018 and 2019 but have grown to 695,000 at the end of CY 2020. Some of the reduction in enrollment in CHIP during CY 2020, therefore, may be because children have become eligible for traditional Medicaid due to lower family income.

In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 158 percent of the federal poverty level (FPL), enrollment fell 7.5 percent from December 2019 to December 2020. These are the members most likely to become eligible for Medicaid. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 158 to 200 percent of the FPL, enrollment increased 1.8 percent during this time period. The SCHIP (Package C) Expansion group (201-250% of the FPL) had an enrollment increase of 6.0 percent during this time period.

At the end of CY 2020, 64.9 percent of enrollees were in the MCHIP portion and 35.1 percent were in the SCHIP portion of the program.

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

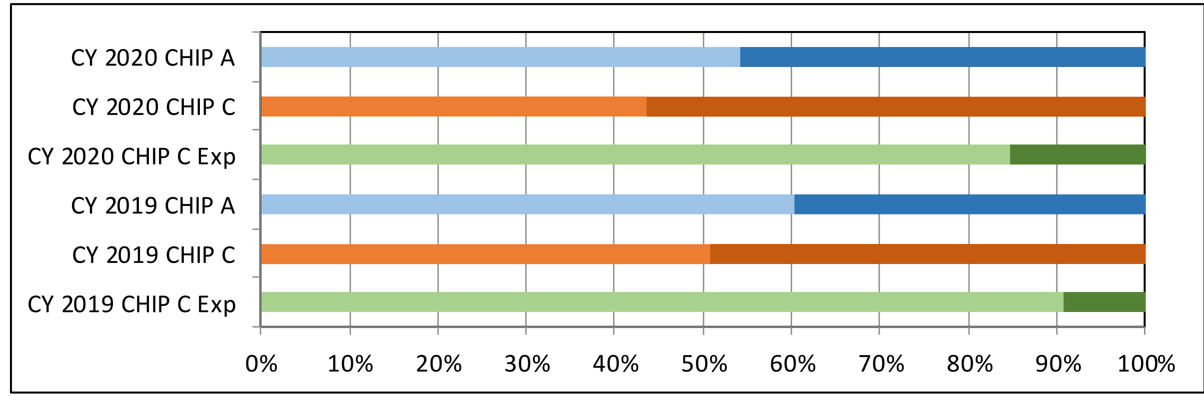


Source: Indiana's FSSA Enterprise Data Warehouse

Because of the monthly changes in new enrollments and disenrollments, a much larger number of Hoosier children have been supported by Indiana's CHIP in any given year than the year end enrollment figures would suggest. The number of children enrolled at any time during CY 2020 was 176,143 compared to 185,350 in CY 2019. Across all three portions of Indiana's CHIP (CHIP Package A, CHIP Package C, and CHIP Package C Expansion), the enrollment at the end of CY 2020 was 55 percent of the total number of children ever enrolled during the year. In CY 2019, this figure was 61 percent. Some children may also move between the CHIP and Medicaid programs.

In Exhibit II.2, the light color of the horizontal bar represents the percentage of members enrolled at the end of the calendar year. The dark color of the horizontal bar represents the percentage of children who were not enrolled at the end of the year, but at some other time in the year.

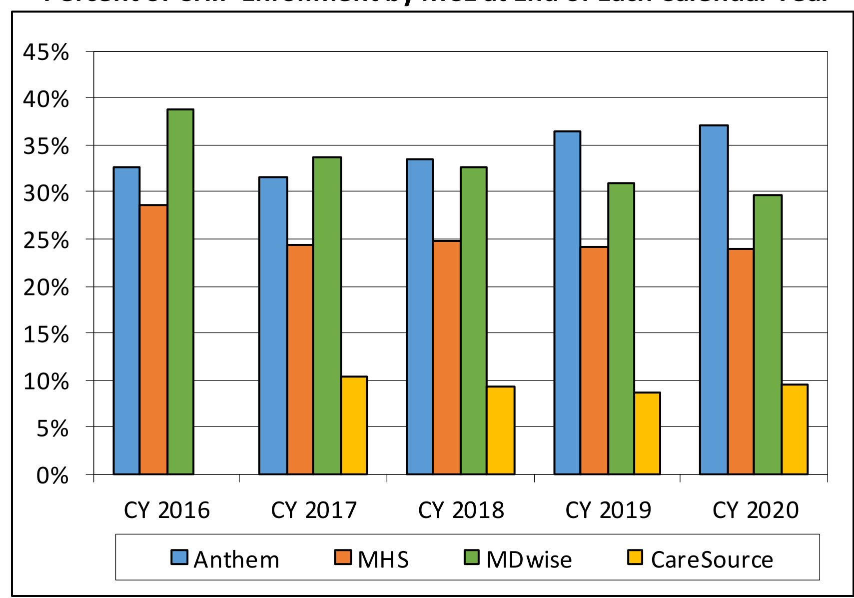
Exhibit II.2
Percent of Children Currently Enrolled (light color) and Ever Enrolled (dark color), by Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There are four MCEs that families can choose from. There has been some movement in the distribution of CHIP members across the MCEs in the last five years. At the end of CY 2020, Anthem had 37.1 percent of all CHIP enrollees, MHS had 23.8 percent, MDwise had 29.6 percent and CareSource had 9.4 percent.

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

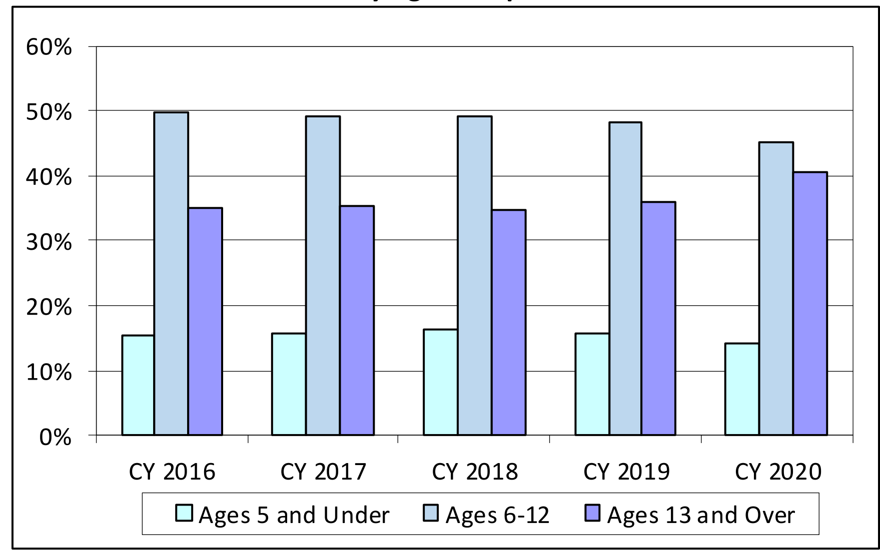


Source: Indiana's FSSA Enterprise Data Warehouse

Demographic Profile of CHIP Members

Just under half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Teenagers represented 36 percent of CHIP enrollees at the end of CY 2019 but 41 percent of members at the end of CY 2020. Approximately 15 percent of members are under age 6. This distribution has been the case since the CHIP was introduced.

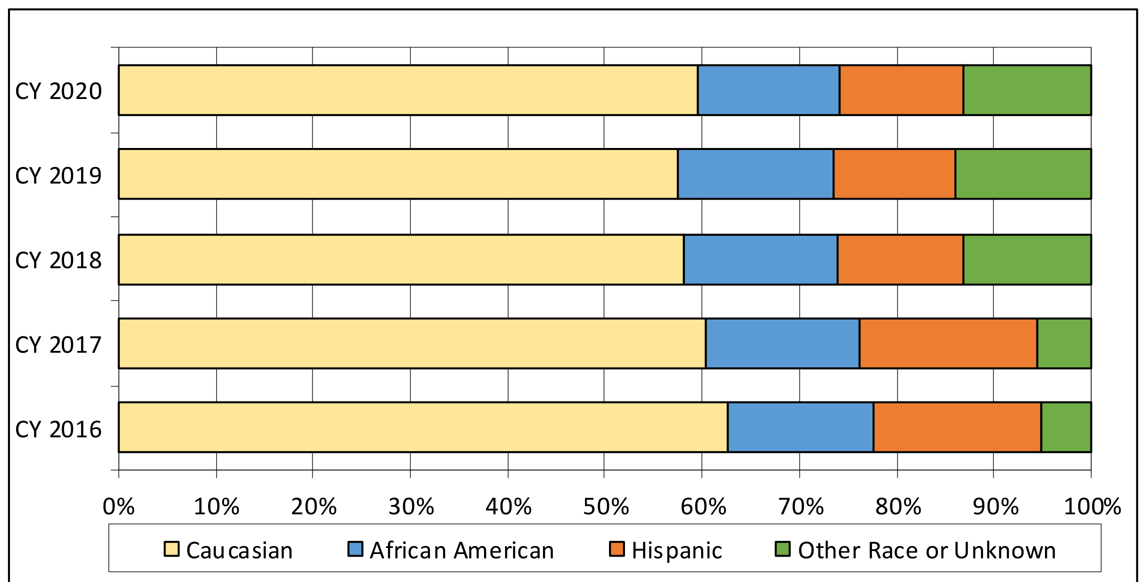
Exhibit II.4
Percent of CHIP Enrollment by Age Group at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for children ages 18 and younger. African-American children and Hispanic children represented 14.6 percent and 12.7 percent, respectively, of the CHIP enrollment at the end of CY 2020. Unfortunately, information is not available on the race/ethnicity of all members. Approximately 8.2 percent of the 13.2 percent of members listed as "Other Race or Unknown" are truly unknown.

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



Source: Indiana's FSSA Enterprise Data Warehouse

B&A compared CHIP members enrolled to the total child population in Indiana as of July 2019. The distribution of CHIP members by region generally matches the overall child population in Indiana. The Central region has 36 percent of all CHIP members but only 32 percent of the state's child population. The Northwest region has 10 percent of all CHIP members but 12 percent of the child population. The regions are defined by the OMPP. These statistics have also remained relatively unchanged in the last five years.

Exhibit II.6
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2020

NORTH CENTRAL
CHIP Pct = 11%
Census Pct = 9%

NORTHWEST
CHIP Pct = 10%
Census Pct = 12%

NORTHEAST
CHIP Pct = 12%
Census Pct = 13%

WEST CENTRAL
CHIP Pct = 7%
Census Pct = 7%

EAST CENTRAL
CHIP Pct = 7%
Census Pct = 7%

CENTRAL
CHIP Pct = 35%
Census Pct = 32%

SOUTHWEST
CHIP Pct = 9%
Census Pct = 10%

SOUTHEAST
CHIP Pct = 8%
Census Pct = 9%

CHAPTER III: ACCESS TO PRIMARY MEDICAL PROVIDERS AND DENTISTS

Background

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

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

Proximity to the Nearest Provider

The data used to conduct this analysis was provided to B&A by the OMPP from its Enterprise Data Warehouse (EDW). Information was tabulated for access to primary medical providers (PMPs) and dental providers based on utilization from the time period October 1, 2019 – September 30, 2020. This time span was used in lieu of Calendar Year (CY) 2020 to allow the lag time for claims to be submitted by providers.

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

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

Because the actual CHIP enrollment can change month-to-month, for purposes of display B&A plotted children who were enrolled in CHIP as of June 1, 2020 on the maps with the providers. All CHIP members (CHIP Package A, CHIP Package C, and CHIP C Expansion) are shown together on each map.

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

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

Findings

On a statewide level, there are very few gaps when measuring access to both primary medical providers and dental providers using a 10-mile service coverage radius. In fact, only 0.3 percent of all CHIP members live more than 10 miles from an available primary medical provider. This finding held true using the 12-month period of members and service claims studied in this year's report as well as for the 12-month period studied last year. There are 1.0 percent of CHIP members who live more than 10 miles from an available dentist using this year's data compared to 0.9 percent of members using last year's data. Exhibit III.1 below shows the results for each of the eight regions.

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

		Primary Medical Provider		Dental Provider	
		Services Delivered Oct 1, 2019 - Sept 30, 2020			
Region	**CHIP Enrollment June 2020**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**
Northeast	13,677	5	0.0%	48	0.4%
North Central	11,728	4	0.0%	97	0.8%
Northwest	10,922	10	0.1%	111	1.0%
East Central	8,173	13	0.2%	67	0.8%
Central	39,217	11	0.0%	45	0.1%
West Central	8,184	81	1.0%	226	2.8%
Southeast	8,497	144	1.7%	322	3.8%
Southwest	10,299	22	0.2%	239	2.3%
Entire State	**110,697**	**290**	**0.3%**	**1,155**	**1.0%**

		Primary Medical Provider		Dental Provider	
		Services Delivered Oct 1, 2018 - Sept 30, 2019			
Region	**CHIP Enrollment June 2019**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**	**Children More than 10 Miles from a Provider**	**Percent of Children Beyond 10 Miles**
Northeast	14,324	34	0.2%	40	0.3%
North Central	11,824	2	0.0%	90	0.8%
Northwest	11,339	11	0.1%	112	1.0%
East Central	8,367	17	0.2%	67	0.8%
Central	39,261	6	0.0%	42	0.1%
West Central	8,029	39	0.5%	190	2.4%
Southeast	8,477	131	1.5%	281	3.3%
Southwest	10,090	34	0.3%	227	2.2%
Entire State	**111,711**	**274**	**0.2%**	**1,049**	**0.9%**

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

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

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

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

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

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

Average Distance Travelled to Providers

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

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

Findings

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

For primary care, the greatest average distance travelled was 34 miles (Warren County). For the other three counties, the average distance travelled was between 30 and 33 miles: Martin, Benton and Fountain. All but Martin County are in the Northwestern portion of the state.

For dental care, the greatest average distance travelled was 39 miles (Benton County). Five counties in the Northwestern part of the state had an average distance travelled between 33 and 39 miles: Benton, Newton, Pulaski, Starke and White. This was also a finding in last year's report. Five counties in the southern part of the state had an average distance travelled between 31 and 38 miles: Greene, Jennings, Ripley, Scott and Union.

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

[4] Note that B&A computes the driving distance (turn by turn) as opposed to a crow flies distance.

Exhibit III.2
Average Driving Distance in Miles for CHIP Members for FFY 2020 to Primary Care
Color coding and values represent the average for each county

Lake (9)
Porter (11)
LaPorte (12)
St. Joseph (8)
Elkhart (10)
LaGrange (22)
Steuben (18)
Noble (18)
DeKalb (15)
Starke (21)
Marshall (16)
Kosciusko (17)
Whitley (15)
Allen (10)
Newton (27)
Jasper (25)
Pulaski (24)
Fulton (17)
Wabash (20)
Huntington (18)
Miami (21)
Cass (17)
White (26)
Wells (19)
Adams (18)
Benton (33)
Carroll (22)
Howard (16)
Grant (20)
Blackford (27)
Jay (20)
Warren (34)
Tippecanoe (13)
Clinton (17)
Tipton (22)
Madison (20)
Delaware (14)
Randolph (24)
Fountain (31)
Montgomery (28)
Boone (14)
Hamilton (13)
Henry (18)
Wayne (13)
Vermillion (20)
Parke (27)
Putnam (23)
Hendricks (14)
Marion (10)
Hancock (15)
Rush (18)
Fayette (16)
Union (20)
Vigo (16)
Clay (21)
Owen (23)
Morgan (17)
Johnson (15)
Shelby (15)
Franklin (21)
Decatur (18)
Monroe (11)
Brown (26)
Bartholomew (14)
Sullivan (19)
Greene (23)
Jennings (20)
Ripley (20)
Dearborn (11)
Ohio (16)
Lawrence (18)
Jackson (17)
Jefferson (17)
Knox (13)
Daviess (16)
Martin (30)
Scott (21)
Washington (24)
Orange (22)
Clark (11)
Pike (18)
Dubois (16)
Gibson (16)
Crawford (26)
Floyd (8)
Harrison (13)
Posey (14)
Vanderburgh (6)
Warrick (9)
Spencer (22)
Perry (20)

0 - 10
11 - 20
21 - 30
30+

Exhibit III.3
Average Driving Distance in Miles for CHIP Members for FFY 2020 to Dental Care
Color coding and values represent the average for each county

Lake (10)
Porter (14)
LaPorte (17)
St. Joseph (6)
Elkhart (8)
LaGrange (17)
Steuben (13)
Noble (16)
DeKalb (16)
Starke (35)
Marshall (12)
Kosciusko (29)
Whitley (18)
Allen (7)
Newton (33)
Jasper (21)
Pulaski (37)
Fulton (18)
Wabash (18)
Huntington (19)
Wells (16)
Adams (12)
Miami (17)
Cass (22)
White (35)
Benton (39)
Carroll (25)
Howard (11)
Grant (15)
Blackford (19)
Jay (23)
Warren (25)
Tippecanoe (12)
Clinton (18)
Tipton (19)
Madison (16)
Delaware (10)
Randolph (25)
Fountain (29)
Montgomery (15)
Boone (22)
Hamilton (10)
Henry (24)
Wayne (18)
Vermillion (22)
Parke (18)
Putnam (25)
Hendricks (11)
Marion (9)
Hancock (16)
Rush (18)
Fayette (16)
Union (31)
Vigo (12)
Clay (25)
Owen (25)
Morgan (15)
Johnson (11)
Shelby (15)
Franklin (25)
Decatur (24)
Monroe (16)
Brown (29)
Bartholomew (12)
Ripley (30)
Dearborn (21)
Sullivan (26)
Greene (38)
Jennings (32)
Lawrence (17)
Jackson (29)
Jefferson (25)
Switzerland (27)
Knox (23)
Daviess (16)
Martin (25)
Scott (32)
Washington (22)
Orange (18)
Clark (8)
Pike (23)
Dubois (15)
Gibson (21)
Crawford (28)
Floyd (5)
Harrison (14)
Posey (23)
Vanderburgh (6)
Warrick (9)
Spencer (18)
Perry (17)

0 - 10 | 11 - 20 | 21 - 30 | 30+

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

Introduction

In addition to examining the access to providers, the Burns & Associates (B&A) team analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency room (ER) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2018, 2019 and 2020 across populations within the CHIP such as by CHIP Package, by managed care entity (MCE), by age and by race/ethnicity.

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2018, 2019 or 2020. The *usage rate* is an annual measure. It measures the percentage of members that received the service during the FFY. B&A limited this calculation to those children who were enrolled for a minimum of nine months in each year. This accounts for members that would have had an opportunity to actually use the service. Members could be included in one FFY of the study but not another year based upon their enrollment history. Children were included in the usage reports if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year as long as they were enrolled for nine months during the year. In the event that a child did cross CHIP packages during a study year, the child was assigned to the enrollment category that s/he was in at the end of the study year. Therefore, each child is counted only once on each report. A member's age was assigned based upon his/her age at the end of the study year.

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

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2021. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP. For this year's report, B&A has segmented the study of the utilization per 1,000 members for FFY 2020 into two six-month periods: Oct 2019 to March 2020, then April 2020 to Sept 2020. This was done to assess the impact that the pandemic has had on service utilization. The impact was found to be meaningful (i.e., much lower utilization in the second half of FFY 2020).

For ease of comparison, the exhibits are displayed in a similar manner throughout this section. A single service is shown on one page. On the left side of the exhibit, the percent of members who used the service in the FFY is displayed. Information is shown by CHIP package, by MCE, by age group and by race/ethnicity. On the right side, the utilization per 1,000 members is shown for these same member categories for FFY 2018, FFY 2019 and for the first half and second half of FFY 2020.

At the end of this section, an update on lead testing among all children in Medicaid is provided.

Primary Care Visits

Primary care visits include visits to doctor's offices or clinics specializing in primary care which are the same types of visits shown in the access maps in Section III of this report. It can include both well visits and sick visits. All results are displayed on Exhibit IV.1 on the next page.

On the left side of the exhibit, the percentage of CHIP members that accessed primary care remained steady ***within*** the subgroup of members studied in FFY 2018 and FFY 2019, but there are differences in the percentage of members using primary care ***across*** the subgroups studied. In FFY 2020, the percentage of members who used primary care fell for every subgroup, which is noted in the utilization trends on the right side once the pandemic was in full force.

For FFYs 2018 and 2019, the percentage of members who used primary care was in the range of 76 to 93 percent of members depending upon the subgroup examined. Notable variations in primary care use were observed in the following subgroups:

- The percent of SCHIP (CHIP Package C and CHIP C Expansion) children in the study sample that had a primary care visit was higher than for children in MCHIP (CHIP Package A). This continued in FFY 2020. Refer to the upper left box in the exhibit.
- The usage rates for all MCEs were similar in FFY 2019 and FFY 2020. CareSource was lower than its peers in FFY 2018. Refer to second box on left side of the exhibit.
- Primary care visits are used more by children ages 5 and younger than the older members enrolled in CHIP. Refer to the third box on the left side of the exhibit.
- When examined by race/ethnicity, the usage rate was lower for Hispanic children than Caucasian children, and African-American children had even lower usage than Hispanic children. The usage rate for African-American children was 8 to 11 percentage points lower than Caucasian children in each of the three years examined. Refer to the bottom left box of the exhibit.

The utilization per 1,000 member trends for primary care shown on the right side of the exhibit mirror the usage trends on the left side. Although the same variances exist across the subgroups when reviewed in this manner, what is most notable is that utilization was similar or even improving in the first six months of FFY 2020 compared to FFY 2019. Then, with the onset of the pandemic, utilization decreased precipitously for all subgroups examined within CHIP.

Generally, primary care visits per 1,000 members in the second half of FFY 2020 occurred at two-thirds of the rate as in the first half of FFY 2020. This was true by Package (CHIP A, CHIP C, CHIP C Expansion), by MCE, and by race/ethnicity. The one area where utilization was slightly different during the pandemic months was by age group. Children age 5 and under used primary care in the second half of FFY 2020 at 53 percent of the rate that they did in the first half of FFY 2020; for children ages 6-12, 64 percent; for children ages 13 and over, 75%.

Regardless of which year is reviewed, the greatest variation in primary care use is by age group and by race/ethnicity. Caucasian children had a utilization per 1,000 rate near 295 per 1,000 up until April 2020. African-American children used primary care services at 66 percent of the rate of Caucasian children on a monthly basis. Hispanic children used primary care services at 70 percent of the rate of Caucasian children.

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

Percent of Members Using the Service Each Year | Average Utilization Per 1,000 Members During Time Period

By CHIP Package

95% 90% 85% 80% 75% 70% 65% 60%
FFY 2018 FFY 2019 FFY 2020
CHIP A CHIP C CHIP C Exp

By CHIP Package

325 300 275 250 225 200 175 150
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
CHIP A CHIP C CHIP C Exp

By Managed Care Entity

95% 90% 85% 80% 75% 70% 65% 60%
FFY 2018 FFY 2019 FFY 2020
Anthem MHS MDwise CareSource

By Managed Care Entity

325 300 275 250 225 200 175 150
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
Anthem MHS MDwise CareSource

By Age Group

95% 90% 85% 80% 75% 70% 65% 60%
FFY 2018 FFY 2019 FFY 2020
Ages 5 and Under Ages 6-12 Ages 13 and Over

By Age Group

350 325 300 275 250 225 200 175 150
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
Ages 5 and Under Ages 6-12 Ages 13 and Over

By Race/Ethnicity

95% 90% 85% 80% 75% 70% 65% 60%
FFY 2018 FFY 2019 FFY 2020
Caucasian African American Hispanic Other

By Race/Ethnicity

325 300 275 250 225 200 175 150 125
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
Caucasian African American Hispanic Other

Emergency Room Visits

On the left side of Exhibit IV.2 shown on page IV-5, it was found that the percentage of CHIP members that accessed the emergency room was consistent across Package (CHIP A, CHIP C and CHIP C Expansion) and across MCEs. In FFYs 2018 and 2019, the percentage that used the ER was between 21 and 23 percent. In FFY 2020, this dropped to 18 to 19 percent.

When stratified by age, younger children use the ER more often than older children. Almost one in three children in the age 5 and younger group (31-32%) used the ER in FFYs 2018 and 2019, but only one in five children above age 5 used the ED during this time period (20-22%).

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

The utilization per 1,000 member trends for ER visits shown on the right side of the exhibit mirror the usage trends on the left side. Utilization dropped for ER visits even more than primary care visits during the time period of the pandemic in the second six months of FFY 2020. Generally, ER visits per 1,000 members in the second half of FFY 2020 occurred at 50 to 57 percent of the rate in the first half of FFY 2020. This was true by Package (CHIP A, CHIP C, CHIP C Expansion) and by MCE.

The areas where ER utilization was slightly different during the pandemic months was by age group and by race/ethnicity. Children age 5 and under used the ER care in the second half of FFY 2020 even less than older children in CHIP (39% of their historic use). Teenage members used the ER more during the pandemic, albeit lower than prior years (67% of their historic use). Caucasian children used the ER more during the pandemic than other race/ethnicities—Caucasians used the ER at 60 percent of their historic use, African-Americans at 50 percent of their historic use, and Hispanics and other race/ethnicities at 45 percent of their historic use.

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

Percent of Members Using the Service Each Year

Average Utilization Per 1,000 Members During Time Period

By CHIP Package

35% 30% 25% 20% 15% 10%
FFY 2018 FFY 2019 FFY 2020
CHIP A CHIP C CHIP C Exp

By CHIP Package

50 40 30 20 10 0
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
CHIP A CHIP C CHIP C Exp

By Managed Care Entity

35% 30% 25% 20% 15% 10%
FFY 2018 FFY 2019 FFY 2020
Anthem MHS MDwise CareSource

By Managed Care Entity

50 40 30 20 10 0
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
Anthem MHS MDwise CareSource

By Age Group

35% 30% 25% 20% 15% 10%
FFY 2018 FFY 2019 FFY 2020
Ages 5 and Under Ages 6-12 Ages 13 and Over

By Age Group

50 40 30 20 10 0
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
Ages 5 and Under Ages 6-12 Ages 13 and Over

By Race/Ethnicity

35% 30% 25% 20% 15% 10%
FFY 2018 FFY 2019 FFY 2020
Caucasian African American Hispanic Other

By Race/Ethnicity

50 40 30 20 10 0
FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep
Caucasian African American Hispanic Other

B&A also examined the prevalence of children who are frequent users of the ER. In the most recent FFY, most CHIP children (89.4%) had no ED visits. There were 8.9 percent of children that had one or two ER visits during the year while 1.5 percent had three to five visits. These results are consistent across the MCEs as well. There is a slightly lower percentage of CHIP children that used the ER in the most recent year compared to what was observed in the same study last year (refer to the far-right column).

It should be noted that Exhibit IV.3 below differs from Exhibit IV.2 on the previous page when examining the percentage of members who used the ER due to the enrollment period of members in each exhibit. An average of 19 percent of CHIP children were found to use the ER in FFY 2020 in Exhibit IV.2. This examined children who were enrolled in CHIP for at least nine months of the year. The usage rate of 10.6 percent shown below examines all children enrolled in CHIP during FFY 2020, regardless of their length of enrollment.

Exhibit IV.3
Frequency of ER Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2019 - September 30, 2020

	Percentage of All Members Using ER by MCE					
Number of ER Visits per Member	**Anthem**	**CareSource**	**MHS**	**MDwise**	**All MCEs This Year**	**All MCEs Last Year**
Zero	89.6%	89.6%	89.3%	89.1%	89.4%	88.1%
1 to 2	8.5%	7.7%	9.2%	9.4%	8.9%	10.1%
3 to 5	1.7%	2.3%	1.3%	1.2%	1.5%	1.6%
6 to 10	0.2%	0.3%	0.1%	0.2%	0.2%	0.2%
More than 10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

Preventive Dental Visits

On the left side of Exhibit IV.3 shown on page IV-8, it was found that the percentage of CHIP members that had a preventive dental visit was consistent for CHIP C and CHIP C Expansion (66% of members) but lower for CHIP A members (61% of members) in FFYs 2018 and 2019. In FFY 2020, the usage rates fell nine percent for all subgroups.

There is variation in the percent of CHIP members using dental services across the MCEs. MDwise has the highest usage rate among the four MCEs, Anthem and MHS are slightly below MDwise, and CareSource is much below the other MCEs.

Dental usage is much higher for children ages 6 to 12 (near 70% in FFYs 2018 and 2019) than children age 13 and over (near 58% during the same time period) or children age 5 and under (near 50%). In FFYs 2018 and 2019, the percentage that used the ER was between 21 and 23 percent. In FFY 2020, this dropped to 18 to 19 percent.

Hispanic children in Indiana's CHIP have traditionally had a higher usage rate for dental services than other race/ethnicities. African-American and Caucasian children have had similar usage rates, but fewer African-American children received preventive dental services (on a per 1,000 member basis) than other race/ethnicities during the pandemic period (second six months of FFY 2020).

The utilization per 1,000 member trends for preventive dental visits shown on the right side of the exhibit mirror the usage trends on the left side. Interestingly, utilization for dental services did not fall as much during the pandemic months as it did for primary care visits or ER visits. Although utilization did drop for all subgroups, on average the utilization during the pandemic months was 78 percent of the pre-pandemic months of FFY 2020. [Recall that these statistics were 66 percent for primary care and 53 percent for ER visits.] The notable exception is African-American children who had dental visits during the pandemic months at a rate of 70 percent of pre-pandemic months.

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

Percent of Members Using the Service Each Year | Average Utilization Per 1,000 Members During Time Period

By CHIP Package

75% 70% 65% 60% 55% 50% 45% 40%

FFY 2018 FFY 2019 FFY 2020

CHIP A CHIP C CHIP C Exp

By CHIP Package

120 110 100 90 80 70 60 50

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

CHIP A CHIP C CHIP C Exp

By Managed Care Entity

75% 70% 65% 60% 55% 50% 45% 40%

FFY 2018 FFY 2019 FFY 2020

Anthem MHS MDwise CareSource

By Managed Care Entity

120 110 100 90 80 70 60 50

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

Anthem MHS MDwise CareSource

By Age Group

75% 70% 65% 60% 55% 50% 45% 40%

FFY 2018 FFY 2019 FFY 2020

Ages 5 and Under Ages 6-12 Ages 13 and Over

By Age Group

120 110 100 90 80 70 60 50

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

Ages 5 and Under Ages 6-12 Ages 13 and Over

By Race/Ethnicity

75% 70% 65% 60% 55% 50% 45% 40%

FFY 2018 FFY 2019 FFY 2020

Caucasian African American Hispanic Other

By Race/Ethnicity

120 110 100 90 80 70 60 50

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

Caucasian African American Hispanic Other

Pharmacy Prescriptions

Exhibit IV.4, shown on page IV-10, compares usage rates and utilization (scripts) for pharmacy across the subgroups within CHIP. The children in CHIP Package A are less likely to have a pharmacy script (65% of members) than CHIP C or CHIP C Expansion children (69%). Usage rates are generally similar across the MCEs, with CareSource children having a slightly lower usage rate than the other MCEs. Children ages 5 and younger are most likely to have pharmacy scripts (71% of members in FFYs 2018 and 2019) than older children (64-66%). A significantly higher percentage of Caucasian children have had pharmacy scripts (70% of the total) compared to minority children (58%-62% of the total).

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

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

As was observed with the other services examined, the use of pharmacy scripts has been reduced during the pandemic months (the second half of FFY 2020) compared to the most recent pre-pandemic months (the first half of FFY 2020). Whereas the reductions in utilization during the pandemic months were more comparable across subgroups for primary care visits, ER visits and dental visits, this is not the case for pharmacy scripts.

When comparing utilization per 1,000 scripts in the April to September 2020 period versus the October 2019 to March 2020 period,

- Overall, pharmacy scripts during the pandemic months are 72 percent of the pre-pandemic months.
- Both Anthem and MHS members are near this overall average, but MDwise members have 69 percent and CareSource members have 64 percent of scripts filled from pre-pandemic months.
- Children ages 5 and younger have only filled 45 percent of scripts in the pandemic months compared to pre-pandemic months. Conversely, teenage members filled 80 percent of scripts when compared to the pre-pandemic months.
- Caucasian and African-American children have filled 74 percent of scripts during pandemic months versus pre-pandemic months. Hispanic children have only filled 64 percent during these months. Other race/ethnicities have filled 69 percent of scripts compared to pre-pandemic levels.

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

Percent of Members Using the Service Each Year

Average Utilization Per 1,000 Members During Time Period

By CHIP Package

75%
70%
65%
60%
55%
50%
45%

FFY 2018 FFY 2019 FFY 2020

CHIP A CHIP C CHIP C Exp

By CHIP Package

900
800
700
600
500
400
300
200

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

CHIP A CHIP C CHIP C Exp

By Managed Care Entity

75%
70%
65%
60%
55%
50%
45%

FFY 2018 FFY 2019 FFY 2020

Anthem MHS MDwise CareSource

By Managed Care Entity

900
800
700
600
500
400
300
200

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

Anthem MHS MDwise CareSource

By Age Group

75%
70%
65%
60%
55%
50%
45%

FFY 2018 FFY 2019 FFY 2020

Ages 5 and Under Ages 6-12 Ages 13 and Over

By Age Group

900
800
700
600
500
400
300
200

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

Ages 5 and Under Ages 6-12 Ages 13 and Over

By Race/Ethnicity

75%
70%
65%
60%
55%
50%
45%

FFY 2018 FFY 2019 FFY 2020

Caucasian African American Hispanic Other

By Race/Ethnicity

900
800
700
600
500
400
300
200

FFY 2018 FFY 2019 FFY 2020 Oct-Mar FFY 2020 Apr-Sep

Caucasian African American Hispanic Other

Lead Testing

As part of an external quality review (EQR) of the OMPP's MCEs conducted in CY 2020, B&A repeated a study originally conducted in the CY 2017 EQR to assess if the rate of lead testing among Medicaid-enrolled children has improved. Although this study was not specific to Indiana's CHIP, it is informative to assess progress in lead testing among CHIP members as well.

In the CY 2020 study, B&A computed a number of measures related to lead testing, including:

- The rate of lead testing at ages 1, 2, 3, 4 and 5;
- The rate of lead testing for children continuously enrolled in Medicaid or CHIP up to age six;
- The rate of lead testing in CY 2019 for Medicaid/CHIP children in each of Indiana's 92 counties;
- The percentage of tests found with elevated lead levels (when the results are known); and
- The locations in the state where elevated lead test levels were found.

To conduct this study, B&A utilized data from the Indiana State Department of Health (ISDH) STELLAR database as well as paid claims for lead tests from each of the MCEs.

Overall, the rate of lead tests has been improving. Attention was focused on children in the program ages 1 and 2 since this is the recommended age for lead testing to occur. The percentage of children age 1 with a test found (through MCE claims or ISDH database) increased from 37.1 percent in CY 2016 to 47.6 percent in CY 2019. The percentage of children age 2 with a test found increased from 25.6 percent in CY 2016 to 34.1 percent in CY 2019. The rates improved for each of the four MCEs between CY 2018 and CY 2019 as well.

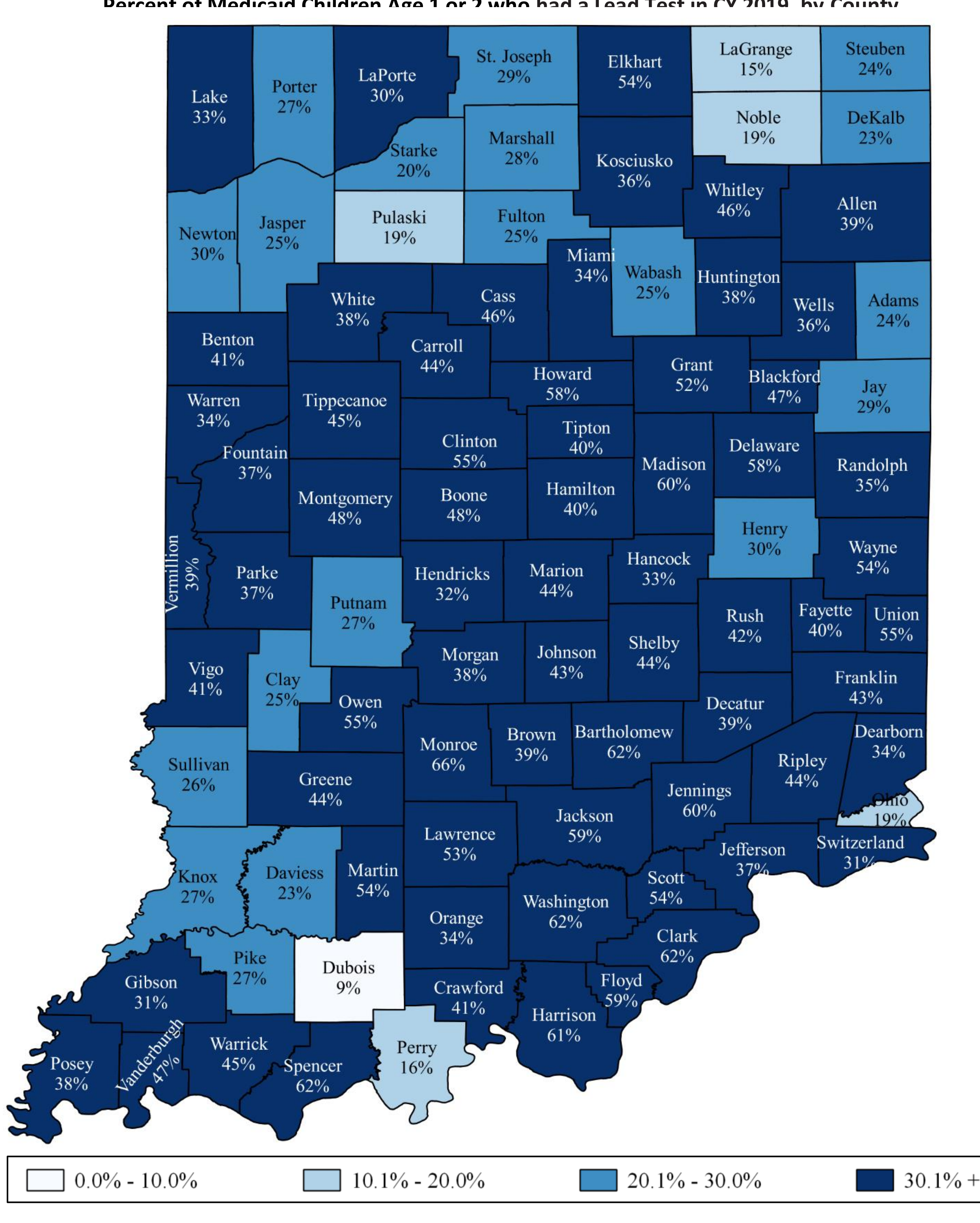
When comparing the testing rates for 1- and 2-year-olds in CY 2017 and CY 2019 by county, the number of counties statewide with a test rate of 30 percent or better of children in this age group increased from 54 counties in CY 2017 to 67 counties in CY 2019. Refer to the map in Exhibit IV.6 on the next page for details. For each MCE, the number of counties where a minimum of 30 percent of its 1- and 2-year-old members had a lead test in CY 2019 was between 59 counties (CareSource) and 71 counties (Anthem).

For those children born in CY 2012 through CY 2015 and continuously enrolled in Medicaid/CHIP through age five, 31 to 33 percent of children had no evidence of a lead test. This has remained constant in the last four study years. In the most recent years, however, more children are receiving this test at age one or two than what was reported in earlier periods.

In CY 2019, the percentage of Medicaid children with a lead test result above 5 micrograms per deciliter (the current standard to define elevated test level) was 0.8 percent of all tests conducted. There are five predominant counties where these children reside (Allen- 33 cases, Elkhart- 20 cases, Lake- 17 cases, Marion- 29 cases and St. Joseph- 42 cases). Among the 321 children with an elevated lead test level in CY 2018, 96 percent of the children were found to have evidence that a follow-up test was conducted later in CY 2018 or CY 2019.

Exhibit IV.6

Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2019, by County



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

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

OMPP's Oversight of Quality

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

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

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

2. Separately, the Centers for Medicare and Medicaid (CMS) requires each state to report a set of core child measures annually to CMS. Currently, there are 26 core measures. These include some HEDIS and CAHPS measures as well. CMS hires a national evaluator to analyze the results of these measures and make comparisons across the state Medicaid agencies.

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

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

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[5] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

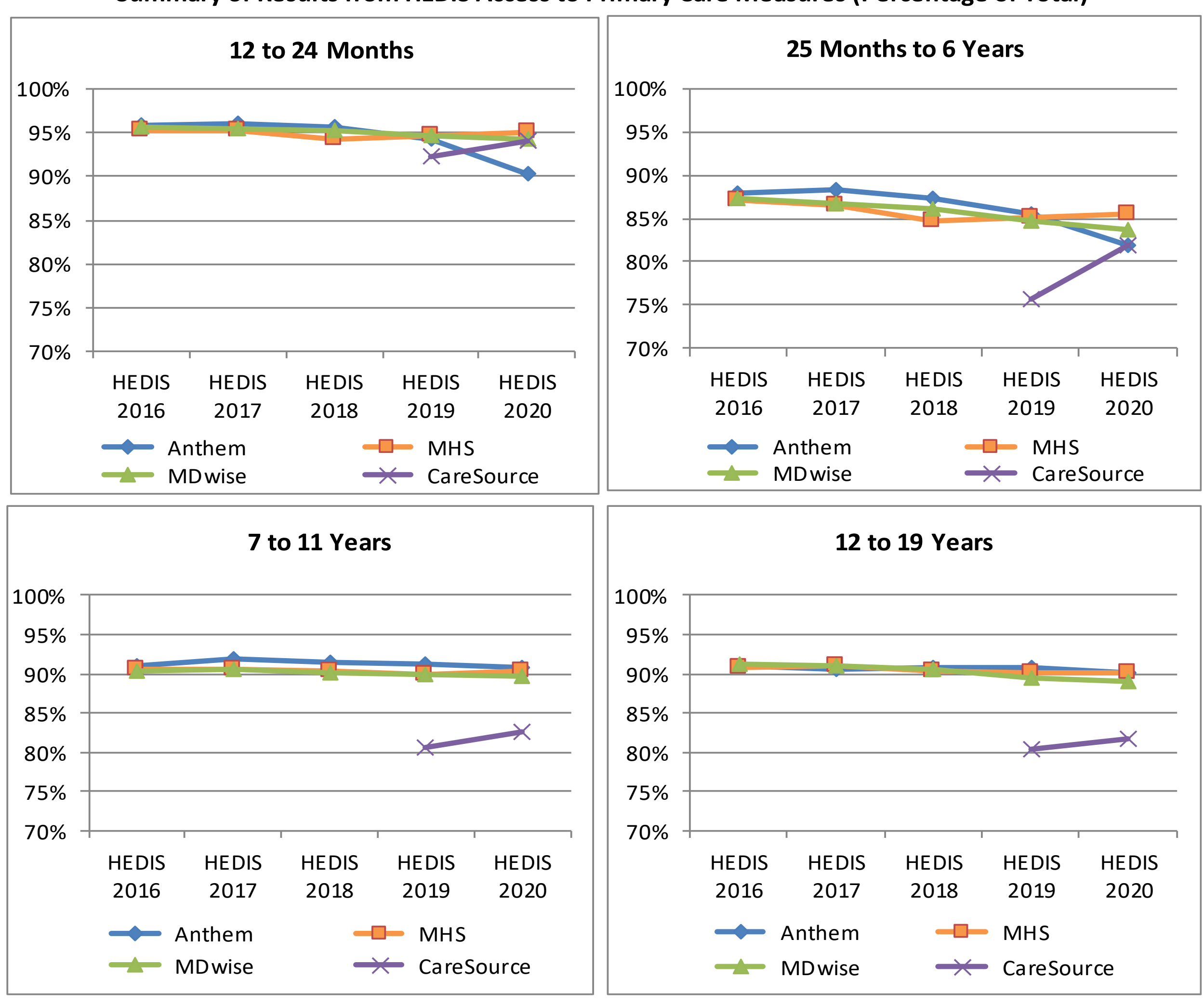
[6] The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members (both CHIP and traditional Medicaid members) from the prior year. Therefore, in Calendar Year (CY) 2020, tabulations were collected on HEDIS rates for 2019 utilization. The HEDIS measures report the percentage of children who either accessed a specific service or achieved a desired outcome.

Exhibit V.1 presents the five-year HEDIS trend results for access to primary care. Each measure is defined as the percentage of children who had a visit with their primary care practitioner in the measurement year (it could be for well care or for illness). In the most recent year, the rate for the youngest children age 12 to 24 months (upper left box) was 94 percent for all MCEs except Anthem. For the age group 25 months to six years (upper right box), results were between 82 and 86 percent for all MCEs. For children age 7 to 11 years (lower right box) and the oldest children (lower right box), all MCEs except CareSource reported 90 to 91 percent in the most recent measurement year.

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

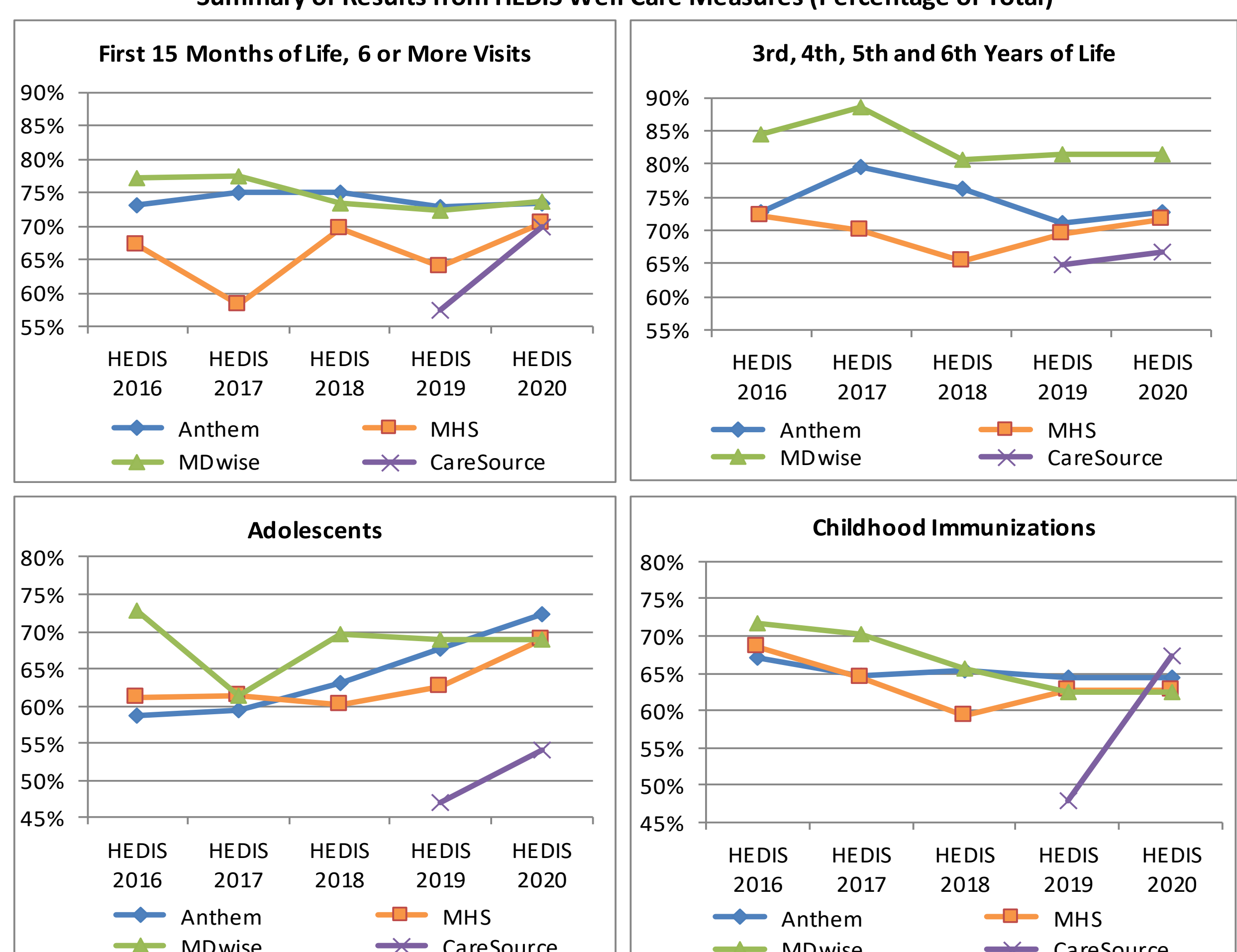


Note: CareSource's contract began Jan 1, 2017. The HEDIS 2018 looked back to CY 2017 utilization.
The sample sizes for HEDIS measures were usually too small to report for CareSource until HEDIS 2019.

Exhibit V.2 shows the five-year trend for well care visits for each MCE. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life (upper left box), the HEDIS rate shown represents the percentage of children with six or more well child visits. For children in the ages 3-6 years (upper right box) and adolescents (lower left box), the rate shown represents the percentage of children that had at least an annual visit. In past years, there was more variation on the rate of well visits for infants, but in the most recent year, all four MCEs are clustered between 70 and 74 percent of infants receiving six or more visits in the first 15 months of life. The rate of well care visits for ages three to six varied in the HEDIS 2020 year from a low of 67 percent for CareSource to a high of 81 percent for MDwise. There has been variation in this measure across the MCEs in prior years as well. There has been improvement in the rate for adolescent well care in the last five years. Three of the four MCEs have a result in HEDIS 2020 near 70 percent.

Another measure for well child care relates to immunizations (bottom right box). This measure reports the percentage of children who turned age 2 during the measurement year who were enrolled for the 12 months prior to their second birthday who received the immunizations as recommended by the American Academy of Pediatrics. The rate was found to be 63 to 67 for each MCE.

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



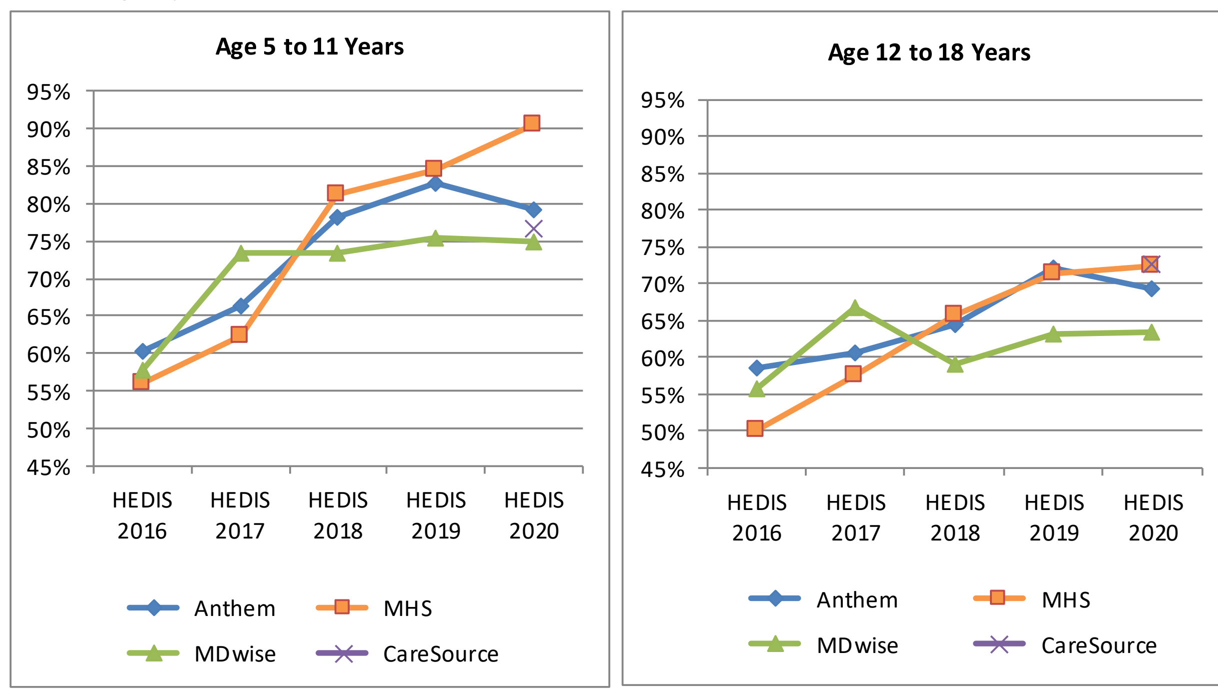
Note: CareSource's contract began Jan 1, 2017. The HEDIS 2018 looked back to CY 2017 utilization. The sample sizes for HEDIS measures were usually too small to report for CareSource until HEDIS 2019.

Exhibit V.3 presents the results from HEDIS measures related to medication management for people with asthma. The results shown represent the percentage of children who remained on an asthma controller for at least 50 percent of their treatment period. The left box represents findings for children age 5 to 11 whereas the right box represents findings for children age 12 to 18 years.

There has been significant improvement in this measure in the age 5 to 11 group in the last five years. In the most recent year of HEDIS 2020, MHS was highest with 91 percent of members adhering at this rate. Anthem had 79 percent with adherence, CareSource had 77 percent, and MDwise had 75 percent adherence. There has also been improvement in the 12 to 18 age group but not as significant as for the younger age group. The adherence rates in HEDIS 2020 were 72 percent for MHS and CareSource, 69 percent for Anthem, and 63 percent for MDwise.

Exhibit V.3
Summary of Results from HEDIS Medication Management for People with Asthma

Percentage Represents Children Who Remained on an Asthma Controller for at least 50% of their Treatment Period



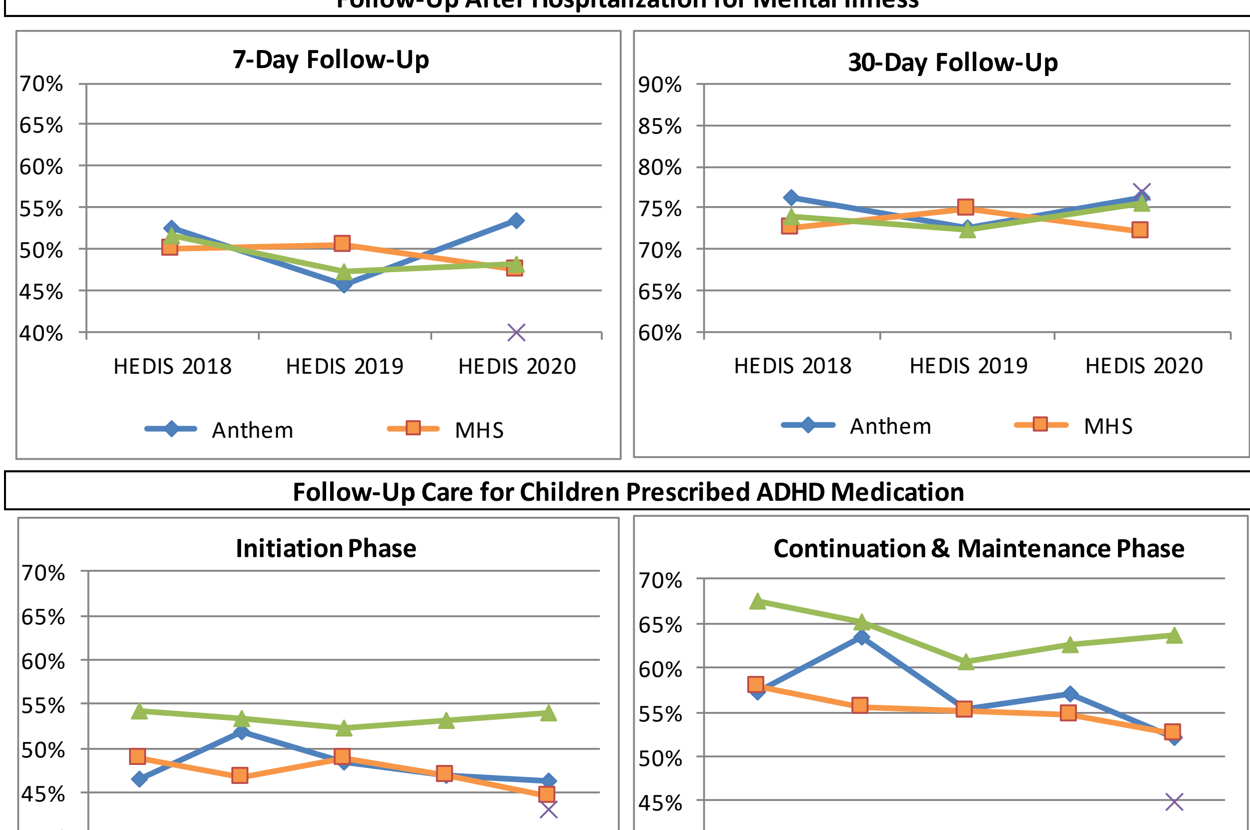
Note: This measure requires reviewing data over a two-year period.
The sample sizes for CareSource were too small to report for this measure prior to HEDIS 2020.

Exhibit V.4 presents the results of behavioral health HEDIS measures. The measures in the top boxes show the percentage of patients with follow-up visits (within 7 days and 30 days) in the community after a hospitalization for mental illness in HHW. In the lower boxes, the measures show the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period. The left box shows percentage of children who had a follow-up visit within 30 days of prescribing ("initiation phase"). The right box shows the percentage who continued taking ADHD medication and had at least two visits after the first visit ("the continuation and maintenance phase").

Follow-up visits after a mental health hospitalization have been steady in the last three years for both the 7-day visit and 30-day visit. (Only three years are shown because the way the results are measured changed in 2018.) For 7-day, the rate is 47 to 53 percent for all except CareSource. For 30-day, all MCEs have a rate from 72 to 76 percent.

The compliance related to visits after being prescribed ADHD medication could see improvement. The MCEs reported consistent results in the initiation phase measure (43 to 54 percent in the most recent year). In the continuation and maintenance phase measure, rates have levelled off in recent years.

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



In addition to the year-over-year changes for each MCE, B&A compared the latest HEDIS year results to see how Indiana's MCEs compared to Medicaid health plans nationally. The measures shown in Exhibit V.5 below track back to what was shown in Exhibits V.1 through V.4. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the 14 measures reviewed, Anthem had seven in which its rates exceeded the national median values, CareSource had five, MDwise had eight, and MHS had seven.

Exhibit V.5
Comparing Hoosier Healthwise MCEs to Health Plans Nationally on Selected HEDIS Measures

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

	Hoosier Healthwise HEDIS 2020			
	Anthem	CareSource	MDwise	MHS
Access to Primary Care, 12-24 Months	90.4% ↓	94.0%	94.2%	95.1%
Access to Primary Care, 25 Months - 6 Years	82.0% ↓	81.8% ↑	83.8%	85.5%
Access to Primary Care, 7-11 Years	90.9%	82.6%	89.7%	90.3%
Access to Primary Care, 12-19 Years	90.2%	81.8%	89.1%	90.2%
6 or More Well Child Visits First 15 Months of Life	73.4%	69.8% ↑	73.7%	70.3% ↑
Annual Well-Child Visit Ages 3-6	72.8%	66.8%	81.5%	71.8% ↑
Annual Adolescent Well-Care Visit Ages 12-18	72.4% ↑	54.0% ↑	68.9%	68.8% ↑
Child Immunizations	64.5%	67.4% ↑	62.5%	62.8%
Appropriate asthma medication, Age 5-11 Years	79.3% ↓	76.6%	75.0%	90.6% ↑
Appropriate asthma medication, Age 12-18 Years	69.2% ↓	72.5%	63.3%	72.3%
Follow-Up After Mental Health Hospitalization:				
Within 7 Days	53.5% ↑	40.0%	48.2%	47.5% ↓
Within 30 Days	76.1% ↑	76.9% ↑	75.5% ↑	72.1% ↓
Follow-Up Care when Prescribed ADHD Meds:				
Initiation Phase	46.3%	43.1%	54.1%	44.6% ↓
Maintenance Phase	52.1% ↓	44.9%	63.6%	52.5% ↓

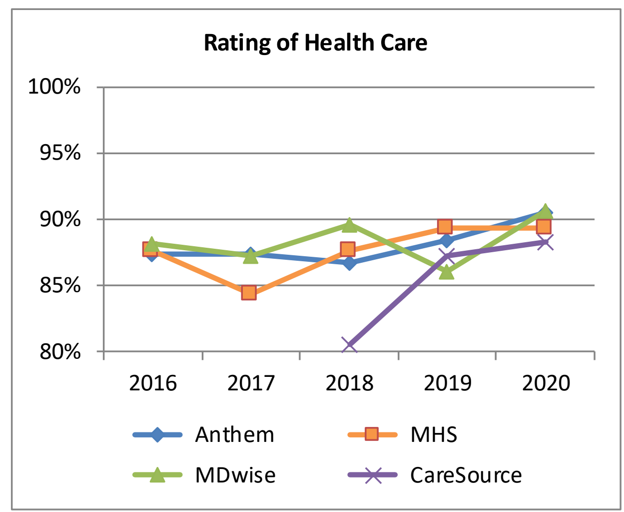
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

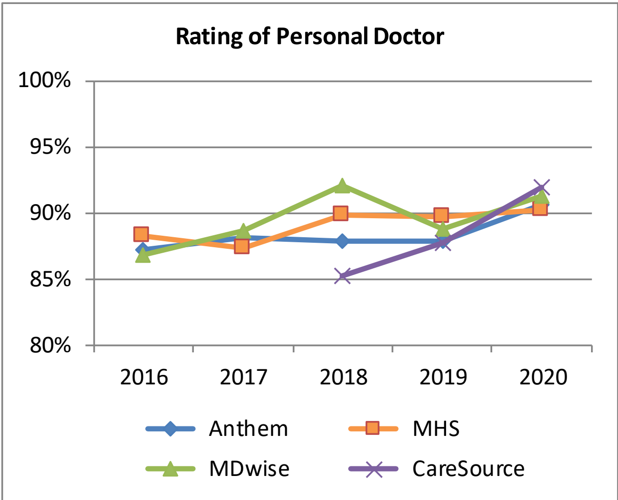
CAHPS Results for Children Enrolled in Hoosier Healthwise

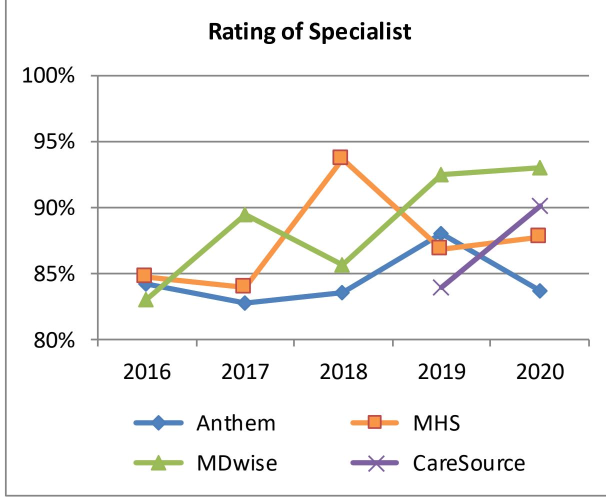
The Hoosier Healthwise MCEs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCEs to the OMPP. There is one survey specific to adults and one for children. Exhibits V.6 below summarizes the results from the child surveys that were administered over the last five years. The results presented include all children in Hoosier Healthwise—CHIP and traditional Medicaid. CareSource is included in these results starting with CAHPS 2018 (when questions were asked of members from 2017)

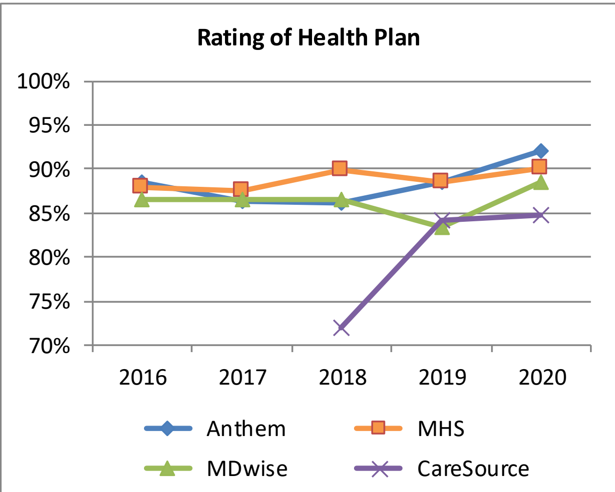
The percentages in Exhibit V.6 reflect those members that assigned a value of 8, 9 or 10 for each rating, where zero is the "worst possible" and 10 is the "best possible." The ratings themselves represent a composite of multiple questions on the survey related to the topic. The results are generally similar in the most recent survey year for all MCEs for Rating of Health Care and Rating of Personal Doctor. MDwise had a higher rating than its peers for the Rating of Specialist in the most recent year. Anthem, MDwise and MHS had a Rating of Health Plan of 89 to 92 percent and CareSource was at 85 percent.

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







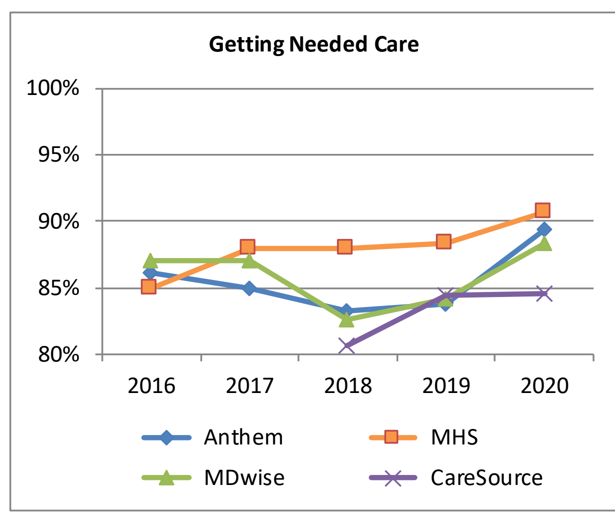


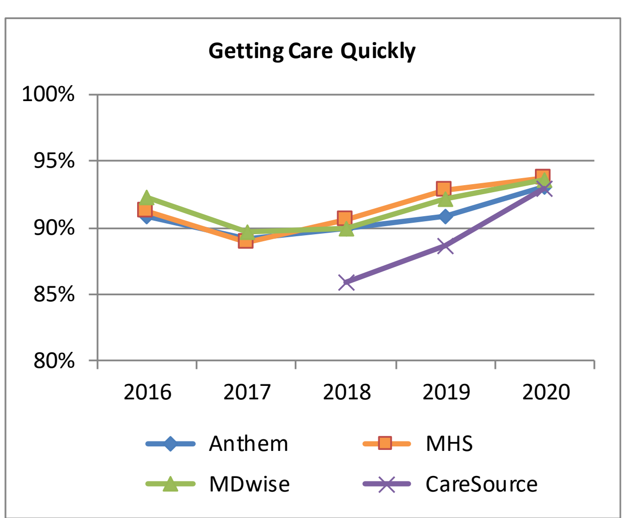
Sample was too small for CareSource to report the Specialist rating in 2018.

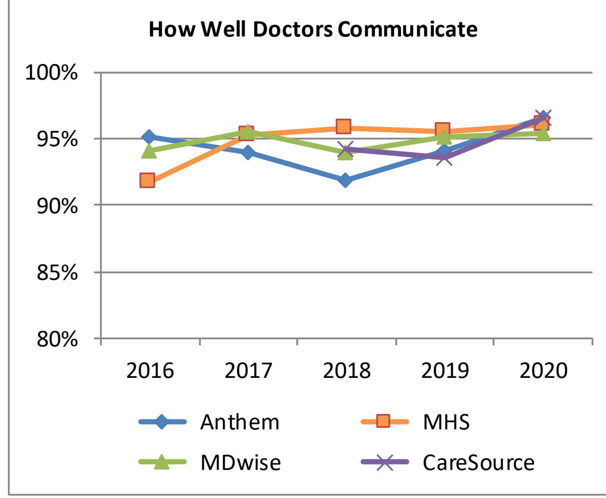
The CAHPS instrument also compiles composite scores from a series of related questions on other topics as well. The results in Exhibit V.7 represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. All four MCEs scored best on the composite score for How Well Doctors Communicate in the 2020 survey (95 to 97 percent). All of the MCEs also scored above 90 percent in the most recent survey for Getting Care Quickly.

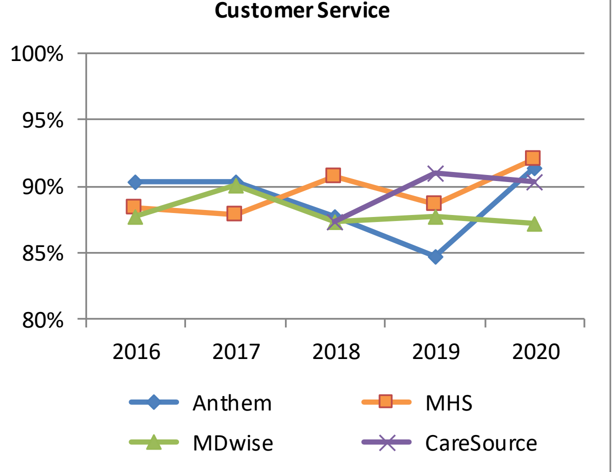
There is some variation for results in the 2020 survey across the MCEs for the Getting Needed Care domain (range from 85 to 91 percent) and the Customer Service domain (range from 87 to 92 percent).

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









Similar to what was shown in Exhibit V.5 in the comparison of Indiana's HEDIS results to national health plans, B&A conducted a similar comparison for the CAHPS survey results. The measures shown in Exhibit V.8 below track back to what was shown in Exhibits V.6 through V.7. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the eight measures reviewed, Anthem and CareSource had five measures that exceeded the national median values, MDwise had six, and MHS had seven.

Exhibit V.8
Comparing Hoosier Healthwise MCEs to Health Plans Nationally on Selected CAHPS Measures

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

	Hoosier Healthwise 2020 Survey			
Composite Ratings	Anthem	CareSource	MDwise	MHS
Members are asked to give a rating of 1 to 10 on the survey (a 10 is the best score). *The percentages shown are the percent of members who gave the MCE a score of 8, 9 or 10.*				
Rating of the health plan (the MCE)	92.1% ↑	84.7%	88.5% ↑	90.1%
Rating of their own health care	90.5% ↑	88.3%	90.6% ↑	89.3%
Rating of their personal doctor	90.6% ↑	91.9% ↑	91.3% ↑	90.3%
Rating of specialist seen most often	83.7% ↓	90.1% ↑	93.0%	87.8%
Composite Scores on Key Measures				
Members are asked questions on items important to the MCE's delivery of serv For each question, members can answer "Always", "Usually", "Sometimes" or *The percentages shown are the percent of members who responded "Always" or "Usually".*				
Customer Service provided by the MCE	91.4% ↑	90.3%	87.2%	92.1% ↑
Getting Needed Care	89.4% ↑	84.6%	88.3% ↑	90.7% ↑
Getting Care Quickly	93.1% ↑	92.9% ↑	93.6%	93.7%
How Well Doctors Communicate	96.6% ↑	96.6% ↑	95.4%	96.1%

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