

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

Final Report – April 2012



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Executive Summary



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2011

As of November 2011, enrollment in Indiana's CHIP was at an all-time high of 86,459, a 1.1 percent increase over the prior year. Over the last five years, enrollment has grown 20.1 percent. Continued enrollment growth in Indiana's CHIP has made Indiana's program more successful than many other states' programs in lowering the uninsured rate among children in low-income families. Indiana's uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL) is now 9.7 percent compared to the national average of 15.4 percent. This places Indiana 10th lowest among states nationally. The most recent estimate for Indiana is the same as the previous year's uninsured rate¹.

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

- CHIP Package A (the Medicaid expansion portion) covers uninsured children in families with incomes up to 150 percent of the FPL (\$33,525 per year for a family of four in 2011) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.
- CHIP Package C (the non-entitlement portion) rolled out in two eligibility increments. Families in CHIP Package C pay monthly premiums whereas the families in CHIP 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 150 percent up to 200 percent of the FPL (\$44,700 per year for a family of four in 2011).
 - The second portion was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL (\$55,875 per year for a family of four in 2011).

The largest enrollment growth has been among families enrolled in the expansion portion of CHIP Package C. In the last three years, this portion of the program has grown 259 percent (compared to a 9.9% increase in CHIP Package A since December 2006).

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) *Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2011. 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.

¹ Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.
<http://www.census.gov/hhes/www/hlthins/lowinckid.html>

Background on Indiana’s CHIP

The enrollment of children in Indiana’s CHIP is spread proportionally across the regions of the state when compared to the overall census of children in each region. Half of the children enrolled in the CHIP are between the ages of six and 12. This is because children under age six are eligible for Medicaid at higher family income levels. Just under 35 percent of CHIP enrollees are teenagers, while the remaining 16 percent are under age five. This distribution has been the case since the CHIP was introduced.

All CHIP members enroll in the OMPP’s Hoosier Healthwise program in the same manner as children and parents in the Medicaid program. CHIP families select from one of the three contracted managed care organizations (MCOs)—Anthem, Managed Health Services or MDwise.

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

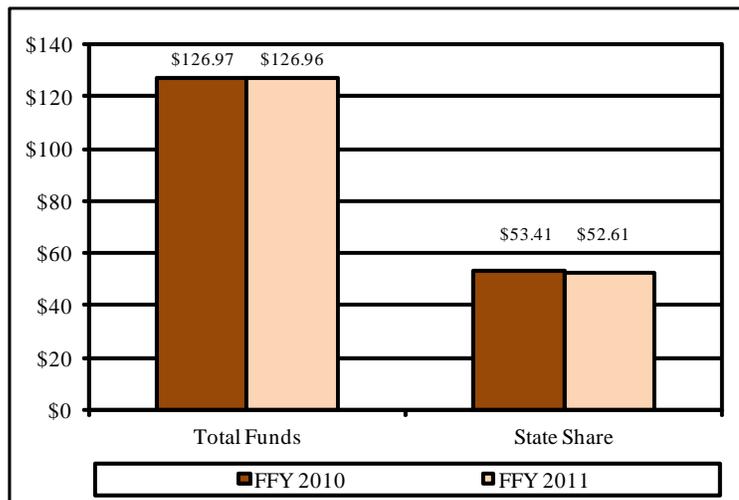
Premiums Charged to Families in Indiana's CHIP Package C

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states, subject to an annual cap. In the CHIP, however, the federal match rate is higher than Medicaid. For example, in Federal Fiscal Year (FFY) 2011, for every dollar spent on medical services in Indiana’s CHIP, the state paid 23.44 cents and the federal government matched the remaining 76.56 cents. In the Medicaid program, the federal government match rate was 65.52 cents. However, for a time-limited period, the federal government matched at an enhanced rate that was allocated under the American Recovery and Reinvestment Act of 2009 (ARRA). This ended in June 2011.

Because of the higher federal match rate and the premiums paid by CHIP Package C families, the state share paid towards CHIP Package C members when measured on a per member per month (PMPM) basis decreased slightly from FFY 2010 to FFY 2011. The PMPMs shown here are lower than the amount paid for children in Medicaid portion of Hoosier Healthwise.

Trends in the Medical Cost Per Member Per Month (PMPM) For the Premium Portion of CHIP (CHIP C)



Source: CMS-21 expenditure reports submitted by the State to CMS. Member months derived by B&A from OMPP’s data warehouse.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCOs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. In this past year’s survey, all three Hoosier Healthwise MCOs rated higher than national benchmarks on member satisfaction for questions related to Getting Needed Care, Getting Care Quickly and overall Rating of Health Plan. Managed Health Services and MDwise also exceeded national benchmarks on members’ Rating of Health Care and Rating of Specialist.

Access to Services

B&A reviewed access by examining where CHIP members receive primary care services and preventive dental services. We matched claims of actual services received at the county level between where the member lives and where the attending provider is located. Of all CHIP members that had a preventive dental visit in CY 2011, 94 percent of children obtained their visit either in their home county of residence or in a contiguous county. There were no counties where more than half of dental visits by members were in a non-contiguous county.

For primary care visits, B&A first examined the counties where there may be an access issue because the number of patients that providers are willing to accept (the doctor’s panel) for Hoosier Healthwise is greater than 80 percent of the total that the providers in that county contracted for. As of December 2011, there are 13 counties where the pediatric providers’ panels are above 80 percent. We then examined the location where CHIP members access primary care using the same method that we did for the dental analysis. When we compared the counties where members traveled further to have a primary care visit against the counties with limited panel capacity, only three counties—Brown, Decatur, and Switzerland—appeared to have limited access for CHIP members based on the data studied.

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency room visits, preventive dental visits, and had a pharmacy prescriptions for the periods FFY 2010 and FFY 2011. The overall rate of usage for each category remained relatively unchanged over the two years. Comparisons were also made across various demographic cohorts, such as by MCO, by age and by race/ethnicity.

B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall for 2010 and 2011 and also by each of the demographic cohorts.

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

	in FFY 2010	in FFY 2011
Primary Care Visit (office or clinic setting)	71%	70%
Emergency Room Visit	29%	26%
Preventive Dental Visit	63%	65%
Pharmacy Script	71%	71%

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Some of the key findings from these analyses are:

- Primary care visits were more prevalent among younger members, as 77 percent of children age five and younger had a visit in FFYs 2010 and 2011. The percentages of children in the older age groups that had a primary care visit were lower (66% for age 6-12 and 65% for age 13 and over in FFY 2011).
- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. African American and Hispanic CHIP children had primary care visits at the same rate (59% in FFY 2011) but it was significantly below the 73 percent rate for Caucasian children.
- In addition to more actual children having a primary care visit, there is also a disparity in the number of visits per 1,000 CHIP children for primary care in an office setting. The rate for Caucasian children is approximately 234 per 1,000 children in any given month, but the rate for African American and Hispanic children is closer to 144 per 1,000 children.
- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCO, but it more pronounced when reviewed at the per 1,000 member statistic. In CY 2010 and 2011, the average rate among MDwise members was 54 ER visits per 1,000 CHIP members; for Anthem, it was 30 per 1,000; for MHS, it was 37 per 1,000.
- Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (33% of all members in FFY 2011) and lowest among children age six to 12 (24% of all members in FFY 2011).
- One in four CHIP members of all race/ethnicities had used the emergency room in each of the years studied, but African-American children were more likely to have had multiple visits.
- The overall percentage of CHIP members receiving a preventive dental visit was 65 percent in FFY 2011. This is an increase from 58 percent in FFY 2008.
- There is little difference from the statewide average in preventive dental usage among the race/ethnicities studied.
- The overall percentage of members that had a pharmacy prescription has remained relatively unchanged (71%) in the last three years, but was highest among children under age six (78%).
- The trend in total prescriptions received, however, is different. The number of prescriptions per 1,000 CHIP members is highest for children age 13-18 (577 per 1,000 on average in each month of FFY 2010 through FFY 2011), followed by children age 6-12 (434 per 1,000), then by children age 0-5 (343 per 1,000).
- Caucasian children have a utilization rate of 545 prescriptions per 1,000 members each month, which is 52 percent higher than the rate for African-American children (358 prescriptions per 1,000) and more than double the rate for Hispanic children (243 prescriptions per 1,000 children).

I

Introduction



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2011

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 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) Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

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

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2011. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

The State Children's Health Insurance Program (S-CHIP) was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. In this legislation, states were allocated funds on an annual basis for a 10-year period to expand health coverage to low-income children. The original legislation was extended to March 31, 2009. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009¹ extended the program to September 2013. The Congressional Budget Office estimates that the expansion of federal funds will provide coverage to 4.1 million additional children in state Medicaid and CHIP programs who would have otherwise been uninsured by 2013.

The funding in the CHIPRA legislation provides more stability to states than the prior authorizations when funding dipped midway through the 10-year coverage period. Now, funding to states is set at 110 percent of each state's historical spending on CHIP or 110 percent of spending projections, whichever is greater. If Indiana's CHIP grows faster than expected, the state may be eligible for potential redistributed funds from unused allotments from other states.

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

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

- CHIP Package A (the Medicaid expansion portion) covers uninsured children in families with incomes up to 150 percent of the Federal Poverty Level, or FPL (\$33,525 per year for a family of four in 2011) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.
- CHIP Package C (the non-entitlement portion) rolled out in two eligibility increments. Families in CHIP Package C pay monthly premiums whereas the families in CHIP

¹ CHIPRA 2009 changed the acronym for the federal program from S-CHIP to CHIP.

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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 150 percent up to 200 percent of the FPL (\$44,700 per year for a family of four in 2011).
- The second portion was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL (\$55,875 per year for a family of four in 2011).

Half of the states have income eligibility thresholds similar to Indiana. As of January 2012, 26 states (including the District of Columbia) cover children at 250 percent FPL or above; 21 states cover children at a maximum between 200 and 249 percent FPL; and four states set a maximum below 200 percent FPL².

As of November 2011, enrollment in Indiana's CHIP was at an all-time high of 86,459³, a 1.7 percent increase over the prior year:

- CHIP Package A enrollment was 59,193 (down 2.5 percent from December 2010)
- Enrollment in the initial group of CHIP Package C members was 20,442 (up 9.1 percent from December 2010)
- Enrollment in the 2008 expansion group of CHIP Package C members was 6,824 (up 11.2 percent from December 2010)

More enrollment statistics appear in Chapter II of this report.

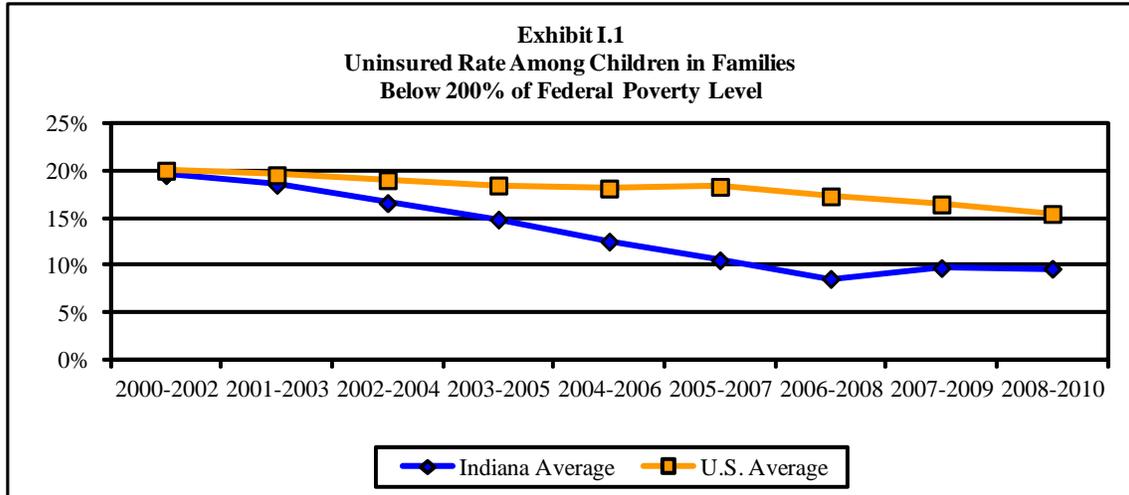
The Impact of CHIP on Reducing the Rate of Uninsured Children in Indiana

The Census Bureau's Current Population Study (CPS) surveys citizens each March on their health insurance status. An uninsured rate is computed for each state, but because state-specific samples are usually small, it is customary to measure this rate over a three year average. The CPS survey conducted in March 2011 measured insurance status in CY 2010. Therefore, the 2008-2010 timeframe is the most recent three-year average period available.

Indiana has been more effective than the nation as a whole in reducing the uninsured rate among low-income children. Among children in families with incomes below 200 percent of the FPL, Indiana's most recent uninsured rate is 9.7 percent compared to the national average of 15.4 percent. Indiana's uninsured rate declined for six consecutive study periods before increasing in 2009 (refer to Exhibit I.1 on the next page). It has held steady in the last year. The success in lowering the uninsured rate can be partially attributed to Indiana's effective outreach to enroll children in its CHIP.

² Heberlein, M., Brooks, T., Guyer, J., Artiga, S., Stephens, J. (January 2012) *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost Sharing Practices in Medicaid and CHIP, 2011-2012*. Washington, DC: Georgetown University Center for Children and Families and The Henry J. Kaiser Family Foundation.

³ Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on February 9, 2012.



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

http://www.census.gov/hhes/www/hlthins/data/children/uninsured_low-income.html

In absolute numbers, the number of uninsured children in families with incomes below 200 percent of the FPL has been cut from an estimated 109,000 in the 2000-2002 three-year average period to 72,000 in the 2008-2010 three year average period (Source: Current Population Survey).

Indiana’s 9.7 percent uninsured rate among children in families below 200 percent of the FPL places the State as the 10th lowest uninsured rate in the country for this income group among all states.

The uninsured rate varies by family income level and by race/ethnicity in the state (refer to Exhibits I.2 and I.3 below). Using the three-year 2008-2010 averages from the Current Population Survey, 74 percent of all uninsured children in Indiana may already be eligible for CHIP based on family income.⁴

Exhibit I.2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana
2008 - 2010 Three-Year Average

	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Total for Children that may be Eligible for Indiana's CHIP			
Income up to 250% FPL	88,054	74%	9.6%
Total for Children Not Eligible for Indiana's CHIP			
250% and above	30,551	26%	3.9%
All Children	118,605	100%	6.9%

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

http://www.census.gov/hhes/www/cpssc/csp_table_creator.html

⁴ Although family income is used to determine eligibility, another criterion for eligibility in CHIP Package C is that children cannot have credible health coverage from another source, regardless of family income.

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The uninsured rate for African American children (5.5%) in this income group is lower than other race/ethnicities. The rate for Caucasian children (9.8%) was near the statewide average, while the rate for Hispanic children (15.4%) and children of other race/ethnicities (11.6%) were much higher.

**Exhibit I3
Uninsured Rates for Children (Age 0-18) by Race/Ethnicity in Indiana
For Children in Families At or Below 250% FPL
2008 - 2010 Three-Year Average**

Family Federal Poverty Level	Total Uninsured	Pct of Uninsured Children at this FPL	Uninsured Rate
Caucasian Non-Hispanic	60,737	69%	9.8%
African Amer. Non-Hispanic	9,754	11%	5.5%
Hispanic (any race)	13,325	15%	15.4%
All Other Races	4,237	5%	11.6%
All Children	88,053	100%	9.6%

Source: U.S. Census Bureau, Current Population Survey
http://www.census.gov/hhes/www/cpssc/csp_table_creator.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, pregnant women and low-income families. CHIP enrollees, like all children in Hoosier Healthwise, select a primary medical provider (PMP) or they are assigned one if their family does not select one. CHIP members must enroll with one of three managed care organizations (MCOs) that contract with the state—Anthem, Managed Health Services or MDwise. CHIP enrollees have access to all of the providers available to Hoosier Healthwise members that are enrolled with the MCO they select.

With just a few limitations, Indiana’s CHIP Package C members are able to access the same services as their peers in the traditional Medicaid program. This is a practice often seen in other states as well. The actual services offered to CHIP members are also similar to those found in other state CHIP programs.

One design difference between Indiana’s CHIP and traditional Medicaid are co-payments that are imposed. Members in CHIP 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 CHIP Package A.

**Exhibit I4
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 (some limits)
Vision Care	Transportation (some limits)
Mental Health Care	Nurse Practitioner Services
Substance Abuse Services	Nurse Midwife Services
Curative Care Hospice	Family Planning Services

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The other design difference between CHIP and traditional Medicaid is that families of children enrolled in CHIP 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.

Exhibit L5
Monthly Premiums Charged to Families in Indiana's CHIP Package C

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

Design features of Indiana's CHIP Package C are similar to those taken by other states. In a 50-state survey of CHIP programs nationwide, Indiana was similar to the other states in the following areas (with number of states having a similar policy to Indiana)⁵:

- Integrated Medicaid/CHIP eligibility determination system (36 states)
- Face-to-face interview not required at the time of application (49 states) or at renewal (50 states), although Indiana requires a telephone interview unlike other states
- Asset test not required in determining eligibility (48 states)
- Renewal occurs every 12 months (49 states)
- Co-pays charged for generic prescriptions (24 states) and brand name prescriptions (26 states)
- Premiums charged to members (34 states). Of those that charge premiums,
 - Up to the 150% FPL level, Indiana charges \$0 (like 21 other states)
 - At the 151-200% FPL level, Indiana charges premiums on a sliding scale (like 21 other states)
 - At the 201%-250% FPL level, Indiana charges higher premiums than the lower FPL group (like 31 other states)

Notable differences in Indiana's CHIP compared to other states are less prohibitive co-pays on non-pharmacy services and a shorter "going bare" period than many states. However, Indiana is stricter on its continuous eligibility policy.

- Indiana does not impose co-pays for non-emergent ER visits (20 states do), non-preventive physician visits (17 states do), or inpatient hospital visits (12 states do).
- The required period of no insurance prior to enrolling (also known as the "going bare" period) is three months in Indiana. Eleven states have no go bare period, 19 states are like Indiana with a go bare period of one to three months, and 21 states impose a go bare period greater than three months.
- Enrollment is continuous for 12 months, regardless of circumstance in 28 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

⁵ Heberlein et al.

Expenditures in Indiana’s CHIP

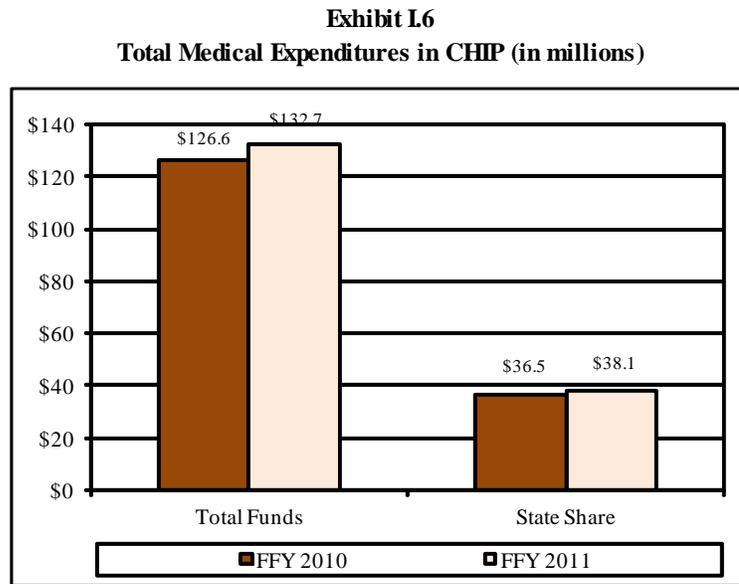
A key difference between the CHIP and Medicaid programs is the way in which each is financed. Both the CHIP and Medicaid programs are jointly funded by states and the federal government. In the CHIP, however, the matching rate provided by the federal government for medical services is higher than it is in the Medicaid program. For example, in Federal Fiscal Year (FFY) 2011, for every dollar spent on medical services in Indiana’s CHIP, the state paid 23.44 cents and the federal government matched the remaining 76.56 cents. In the Medicaid program, the standard rate paid by the state is 33.48 cents and the federal government matched the remaining 66.52 cents. However, for a time-limited period, the federal government matched at an enhanced rate that was allocated under the American Recovery and Reinvestment Act of 2009 (ARRA). This ended in June 2011.

Most of the service expenditures in Indiana’s CHIP are paid to MCOs through what is known as a capitation payment. This is a set amount paid to the MCOs per member per month (PMPM). The capitation PMPM rate is adjusted for age and also adjusted by Package. There are also some services covered in the program but paid on a fee-for-service basis outside of the MCO contract. These include dental services and, beginning in CY 2010, pharmacy prescriptions. Other services may be paid fee-for-service in the CHIP if an enrollee utilizes a service during the short time period before they have selected which MCO to join.

In addition to the higher federal match rate, for CHIP Package C the state’s outlay is further reduced by premiums paid by parents. There are no premiums charged to parents for children enrolled in CHIP Package A.

B&A examined expenditures made on behalf of CHIP members in FFYs 2010 and 2011.⁶ Data was pulled from the CMS-21 expenditure reports that the OMPP is required to submit quarterly to CMS.

Medical expenditures in the CHIP (total funds) increased 4.8 percent over the two-year



Source: CMS-21 expenditure reports submitted by the State to CMS.

period, from \$126.6 million in FFY 2010 to \$132.7 million in FFY 2011. The state share of these expenditures increased 4.3 percent, from \$36.5 million to \$38.1 million. On a percentage basis, the state’s portion did not increase as much as the total funds because the expenditures were offset by an increased federal match rate along with an increase in the amount of premiums collected from parents. Premiums paid for all CHIP Package C members exceeded \$6.9 million.

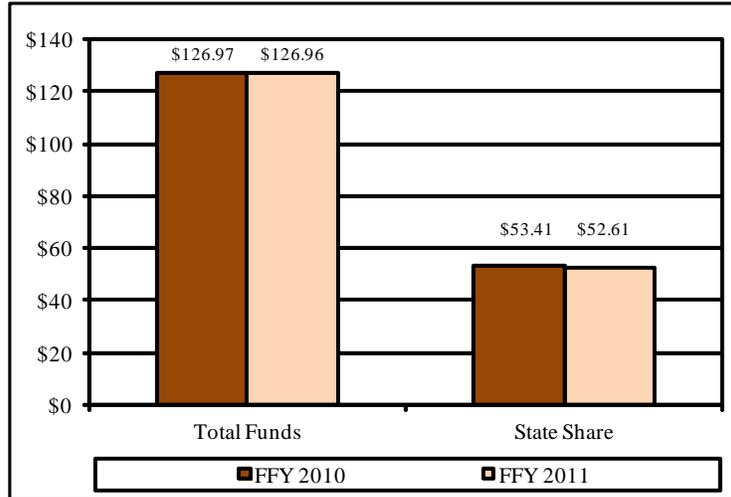
Because CHIP Package C is the faster-growing portion of the program, total expenditures are increasing but so are member months. To compare apples to apples, therefore, it is helpful to analyze the expenditure trends on a PMPM basis. Exhibit I.7 shows the PMPM medical costs in CHIP Package C for FFYs 2010 and 2011, expressed both in total funds and in state-only funds (net of

⁶ The federal fiscal year runs from October 1 through September 30.

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premiums paid by members and the federal matching funds). The PMPM in total funds stayed the same over the two-year period, while the state's outlay on a PMPM basis decreased from \$53.41 to \$52.61.

Exhibit L7
Trends in the Medical Cost Per Member Per Month (PMPM)
For the Premium Portion of CHIP (CHIP C)



Source: CMS-21 expenditure reports submitted by the State to CMS.
Member months derived by B&A from OMPP's data warehouse.

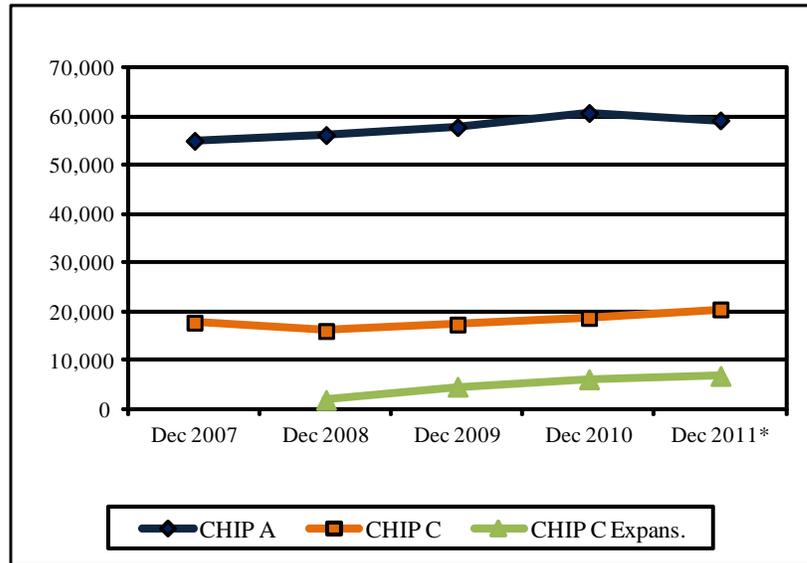
II

Enrollment Trends in Indiana's CHIP



Indiana's Children's Health Insurance Program (CHIP) experienced its all-time high enrollment at the end of Calendar Year (CY) 2011 of 86,459, a 1.1 percent increase over the prior year. Over the last four years, enrollment has grown 18.8 percent. In CHIP Package A, the entitlement portion of the program for children in families with incomes up to 150% of the federal poverty level (FPL), enrollment has grown 7.6 percent since December 2007. In CHIP Package C, the non-entitlement program for children in families with incomes 150%-200% of the FPL, enrollment has grown 15.1 percent during this five-year period. The CHIP C Expansion group instituted in October 2008 (201-250% of the FPL) saw enrollment grow 11.2 percent in the last year.

Exhibit II.1
Recent Enrollment in Indiana's CHIP

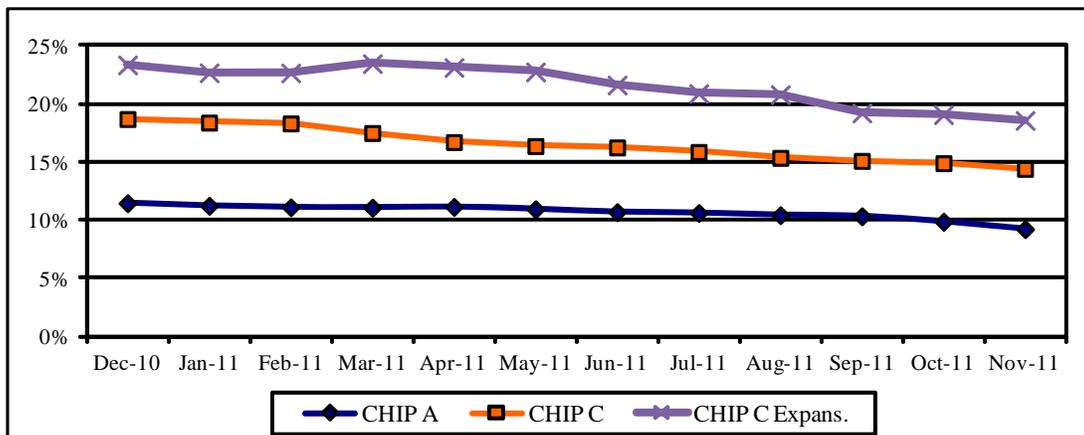


*Estimate based on final eligibility determinations

Enrollment and Disenrollment Trends

New enrollees continue to remain a large percentage of children in the program, but the proportion of total members that are new each month is decreasing. CHIP members enrolled during CY 2011 were examined to measure how many were new to CHIP within the last 12 months. Exhibit II.2 shows that 11.5 percent of CHIP Package A members enrolled in December 2010 were new to the program in the prior 12 months. This rate dropped to 9.2 percent by the end of the next year. In CHIP Package C, 18.7 percent of members enrolled in December 2010 were new to the program in the prior 12 months. This dropped to 14.4 percent by November 2011. The expansion portion of CHIP C had 23.4 percent new members in December 2010, dropping to 18.6 percent one year later.

Exhibit II.2
Percent of Enrollees in the Month that were New in Previous 12 Months

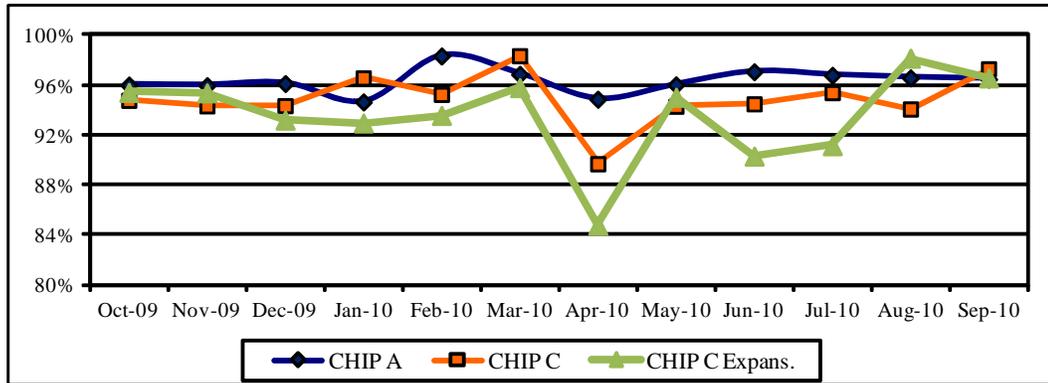


Source: MedInsight, Indiana OMPP's data warehouse

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In addition to the large number of new individuals, the total number of enrollees that stay within Indiana’s CHIP also remains high. New enrollees in CHIP were identified in Federal Fiscal Year (FFY) 2010. Burns & Associates (B&A) reviewed the membership status for each child after 12 months of enrollment when members are required to be redetermined eligible for the program. Among this group of members, the average retention rate was 96.3 percent for CHIP Package A members, 94.9 percent for CHIP Package C members and 93.5 percent for CHIP C Expansion members.¹ This is essentially the same as last year’s findings, when the results were 96.9 for CHIP A and 95.8 percent for CHIP C (we did not break out CHIP C Expansion members in previous reports).

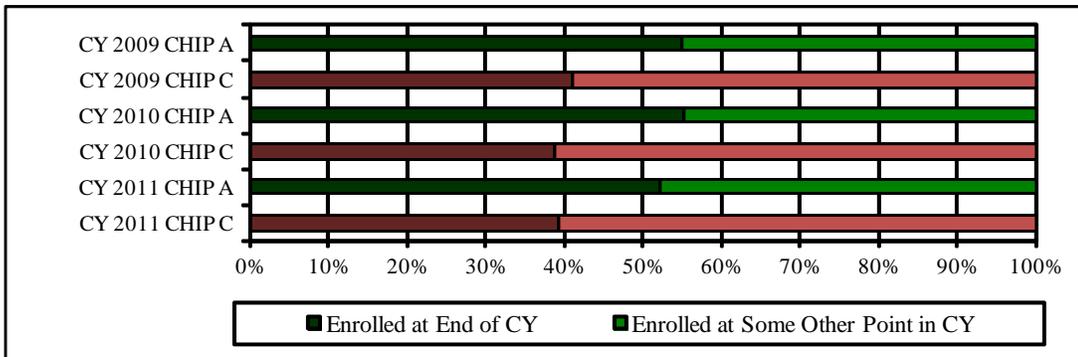
Exhibit II.3
Retention Rate in the CHIP at Time of Member's Recertification
 Percentage Includes Members New in the Month Shown who Recertified After 12 Months



Source: MedInsight, Indiana OMPP's data warehouse. Excludes members who turned age 19 (no longer eligible) and those that disenrolled prior to the month when they would need to recertify.

The number of children currently enrolled in the program each year continues to increase, but the number of children ever enrolled in each calendar year also continues to rise. In fact, in the last three calendar years there have been almost twice as many children enrolled at some point in the year when compared to the number enrolled at the end of the year. In CY 2011, there were 164,402 children enrolled in Indiana’s CHIP at some point during the year—111,239 in CHIP Package A and 53,163 in CHIP Package C (including the expansion population). The difference between currently enrolled and ever enrolled can be because children move between the CHIP and Medicaid program, lose coverage when they turn age 19, or may disenroll for other reasons.

Exhibit II.4
Status of Children Ever Enrolled in CHIP, by Calendar Year

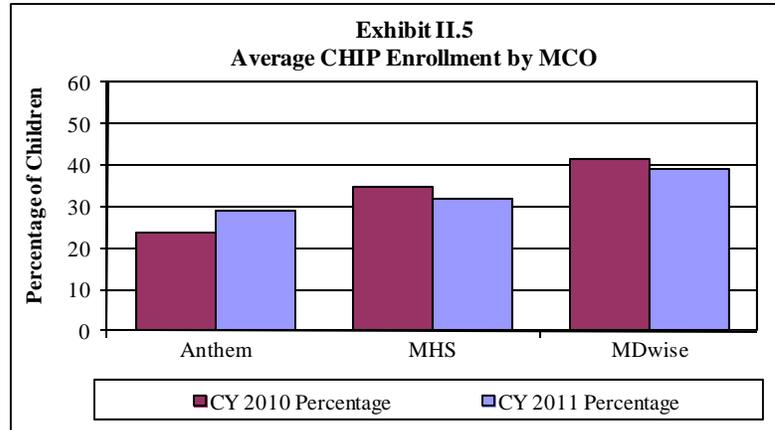


Source: MedInsight, Indiana OMPP's data warehouse

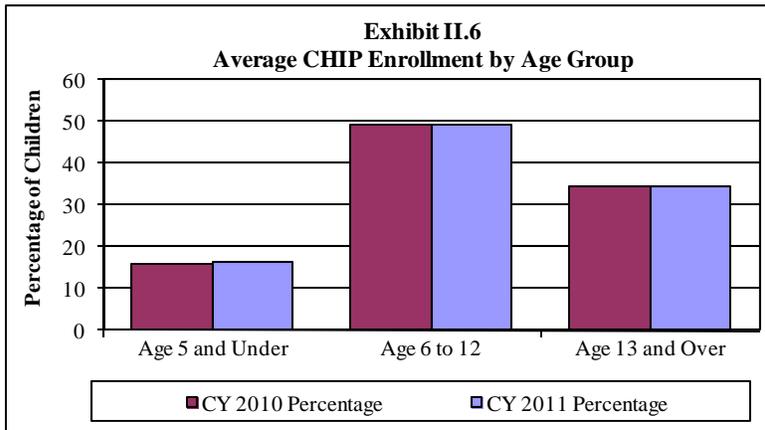
¹ It should be noted that a member is considered “retained” in Hoosier Healthwise if they move from the CHIP program to the traditional Medicaid program, or between CHIP Package A and CHIP Package C.

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Families select a managed care organization (MCO) at the time of application to Hoosier Healthwise. There was some movement in the MCO selected by CHIP members in 2011. In CY 2011, Anthem had 28.8 percent of all CHIP enrollees as compared to 23.7 percent in CY 2010. Managed Health Services decreased its CHIP membership share, from 34.9 percent of all CHIP enrollees in CY 2010 to 31.9 percent in CY 2011. MDwise also lost membership share among CHIP members, from its total of 41.4 percent in CY 2010 to 39.3 percent in CY 2011.

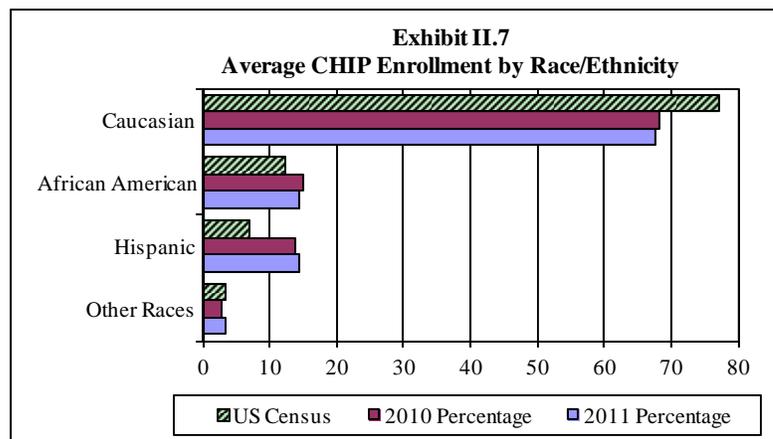


Demographic Profile of CHIP Members



Half of the children enrolled in the CHIP are between the ages of six and 12. This is because children under age six are eligible for Medicaid at higher family income levels. Just under 35 percent of CHIP enrollees are teenagers, while the remaining 16 percent are under age five. This distribution has been the case since the CHIP was introduced.

There is a higher distribution of minorities in Indiana’s CHIP than the overall population in Indiana for children age 18 and younger. Compared to the U.S. Census estimate,² African-American children (14.6% of CHIP enrollees in CY 2011) and Hispanic children (14.4% of CHIP enrollees in CY 2011) are represented more in CHIP than in the statewide population. Between CY 2010 and CY 2011, the proportion of



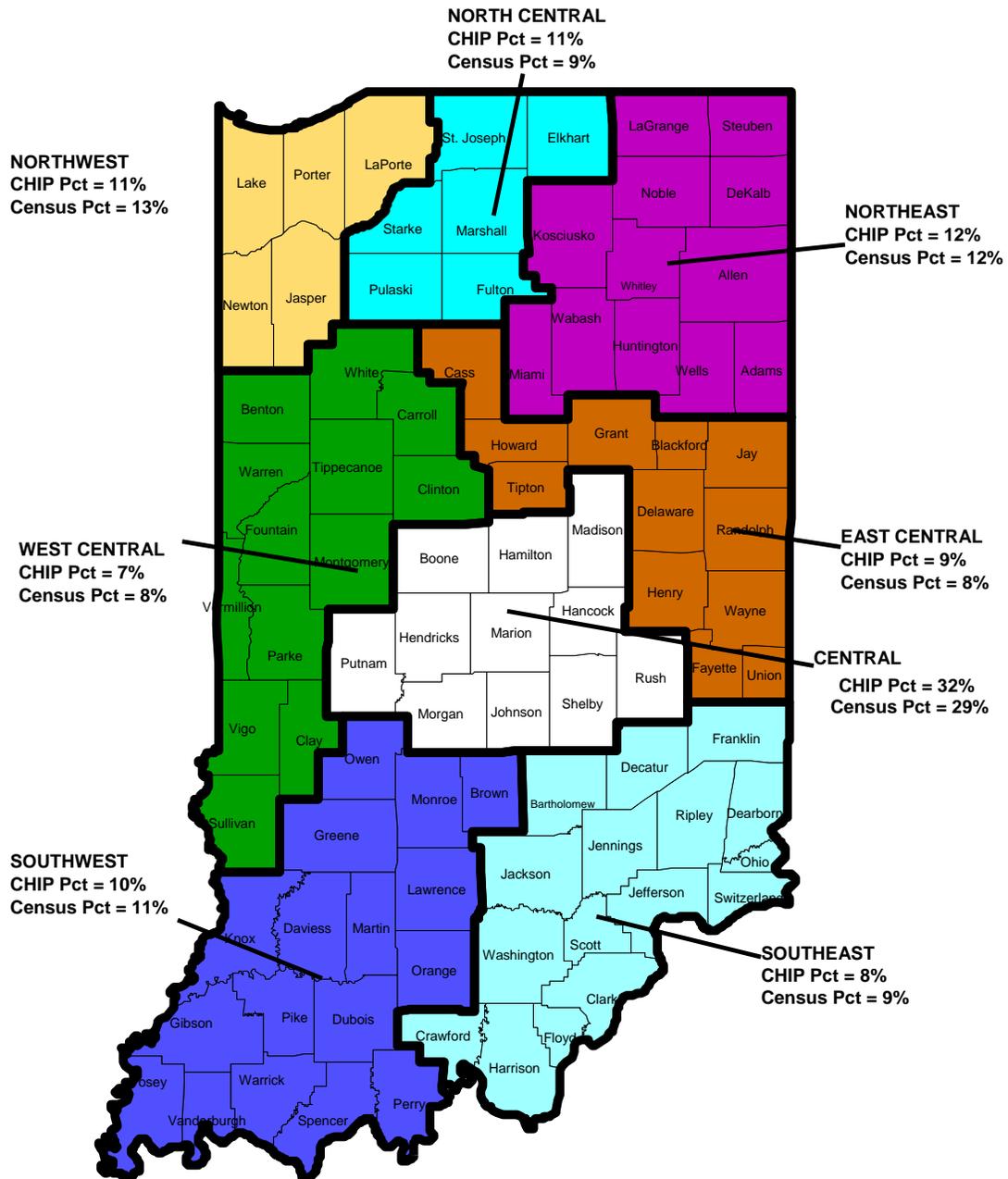
² U.S. Census Bureau, Current Population Survey, three year average for Indiana 2008-2010. <http://www.census.gov/hhes/www/hlthins/hlthins.html>

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Caucasian CHIP members remained essentially the same (68.3 percent and 67.8 percent, respectively) while the African-American proportion decreased slightly and the Hispanic proportion increased slightly.

The distribution of CHIP members by region closely matches the overall child population in Indiana. B&A compared CHIP members enrolled to the total child population in Indiana as of July 2011.

**Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2011**



III

Access and Availability of Providers in Indiana's CHIP



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

Access to Primary Medical Providers

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

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.¹ When he/she contracts with an MCO, the PMP identifies whether or not they are willing to accept children as patients. If so, they are considered by the OMPP to be a pediatric provider. The number of pediatric providers in Hoosier Healthwise has grown from just under 2,900 in January 2009 to 3,337 in September 2011.

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

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

The OMPP's fiscal agent, HP, measures panel capacity for pediatric providers in each county of the state as required by the Centers for Medicare and Medicaid (CMS). It is important to measure panel capacity to assess if there are potential gaps in the state where there are fewer PMPs available to accept new patients. B&A analyzed HP's pediatric panel capacity report for September 2011.² The average number of members enrolled with each pediatric PMP was 185 during Federal Fiscal Year (FFY) 2011.

In September 2011, on average statewide the pediatric PMPs' panels were 32 percent full, an improvement from our study last year when the average was 35 percent full. This rate varies significantly on a county-by-county basis, however. In Exhibit III.1 on the next page, B&A color-coded each county's PMP panel capacity as tabulated by HP at the end of FFY 2011. Counties colored white (79 out of 92) are those where the PMP panel is less than 80 percent full. Thirteen counties are considered potentially at risk since their panel capacity among all providers in the county was more than 80 percent full. Counties colored orange (5) are those where the PMP panels are 80 to 89 percent full. Counties colored blue (4) are those where the PMP panels are 90 to 99 percent full. Four counties are technically more than 100 percent full (in brick red), which means that, when analyzed as a group, the PMPs in each of these counties have actually accepted more CHIP and Medicaid members than they contractually agreed to accept. . Eleven of the 13 counties also had

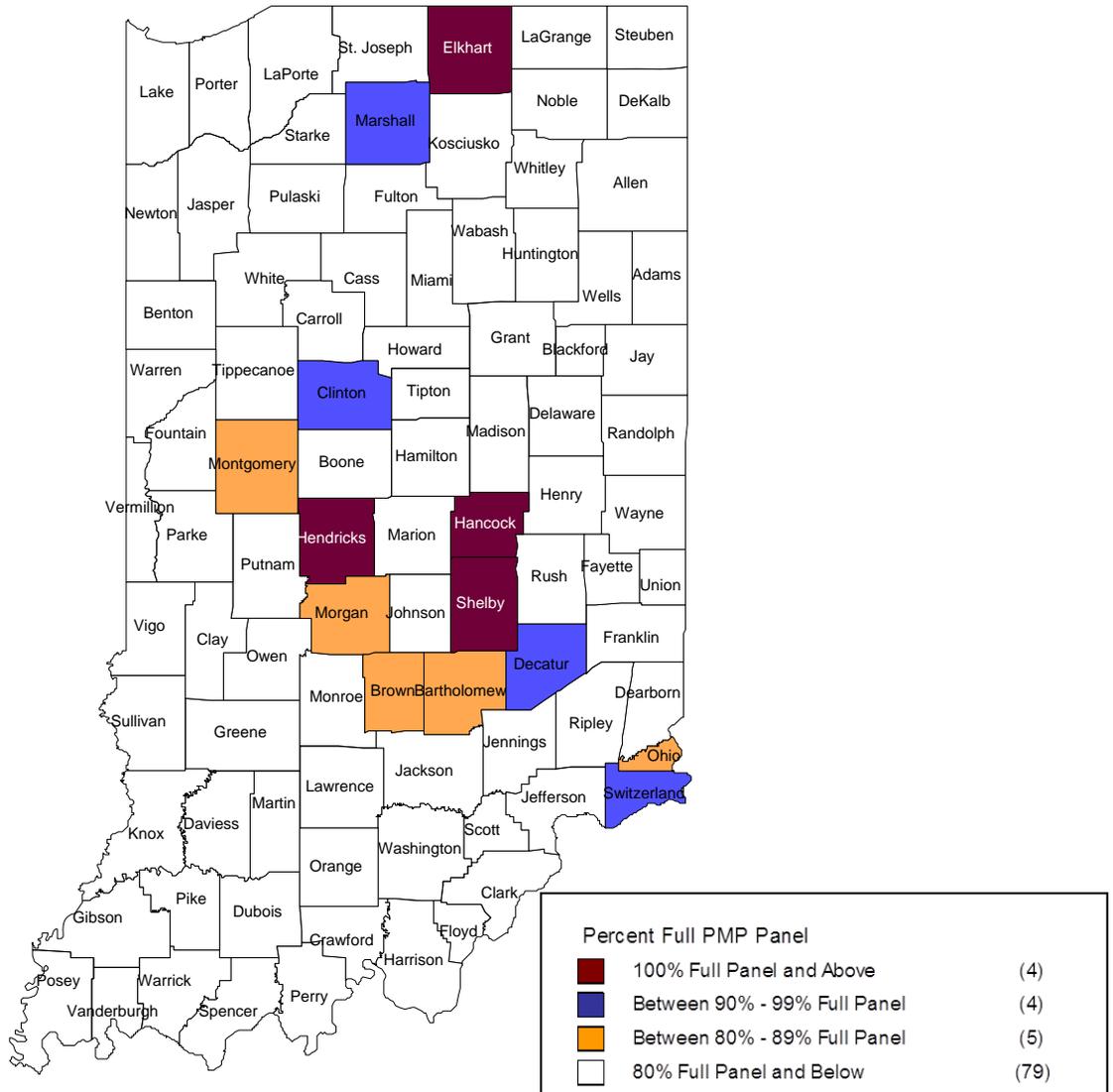
¹ OB/GYNs may, but are not obligated, to sign up as PMPs. They may also sign up as a specialist.

² It should be noted, however, that HP's reports of how full each pediatric panel is includes both children and adult patients if the PMP is willing to accept both.

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panel sizes greater than 80 percent last year. Four counties went below this threshold over the past year, but two counties (Bartholomew and Decatur) were added to the list in 2011.

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



A county with a higher percentage of full panels, however, is not necessarily indicative of access problems. For example, a Hoosier Healthwise child may see a PMP in a county next to their home county since it is not a far distance to travel. Therefore, the panel capacity in their home county may or may not have an ultimate impact on their access to primary care.

Another component of last year's EQR was that B&A used encounters submitted by the MCOs to examine member's actual visits to primary care physicians within their county of residence, in a

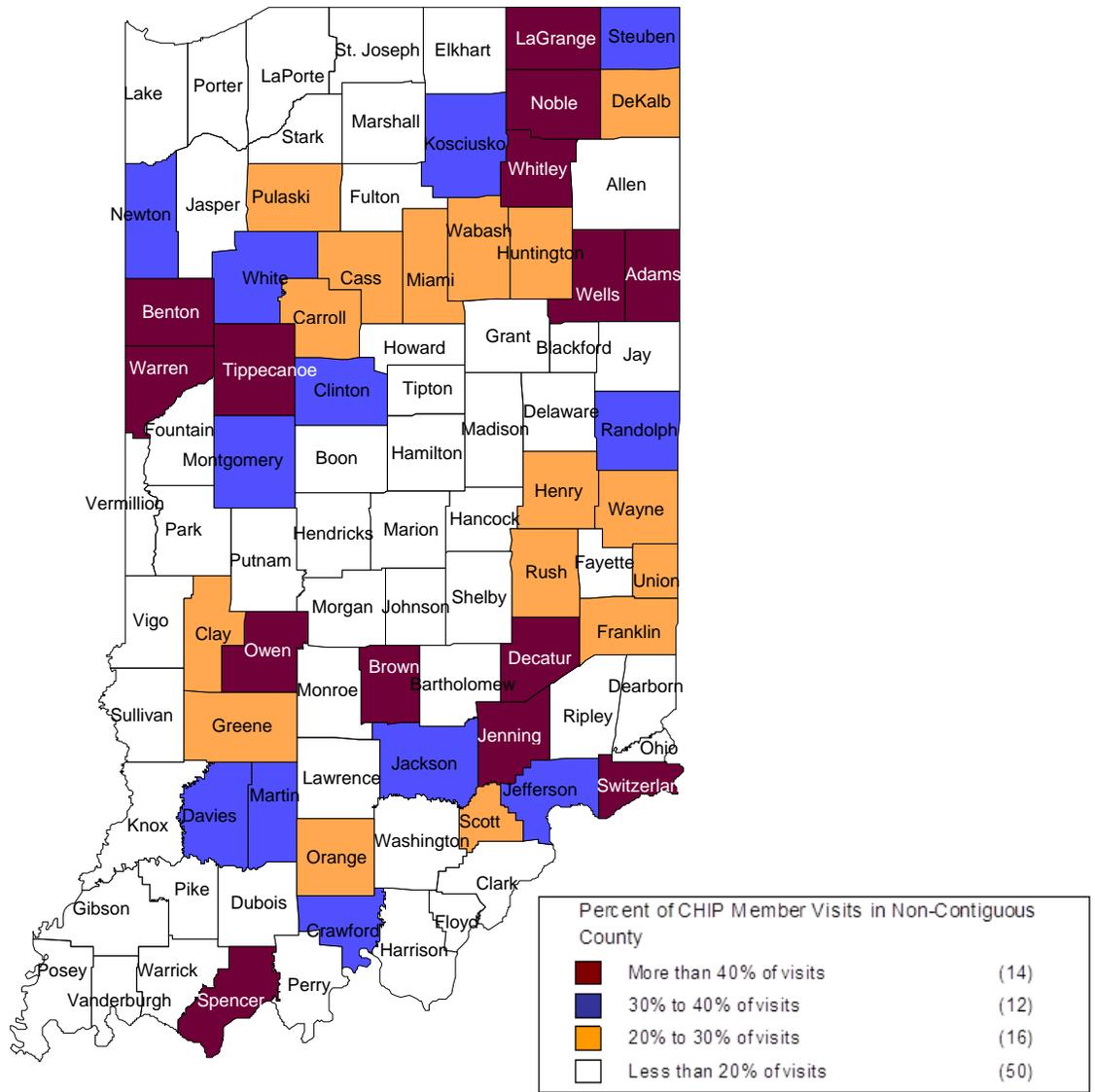
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contiguous county of their residence, or in a non-contiguous county. This analysis has been replicated here specifically for the CHIP population.

B&A identified and analyzed when a child received a primary care service in a doctor's office (49% of all children received this service across 135,434 encounters). Primary care utilization was then examined at the county level.

Statewide, 66 percent of CHIP members received a primary care service in the county in which they live in FFY 2011. An additional 22 percent received a primary care service in a contiguous county. Like the panel capacity map shown in Exhibit III.1, the percentage of CHIP children who had a primary care visit in a county not contiguous to their residence varied greatly by county.

**Exhibit III.2
Volume of CHIP Members Receiving Primary Care Services
in a County Not Contiguous to their Residing County**



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It should be noted that, based on the land area of Indiana’s counties, it is possible that CHIP members may travel to receive a primary care service in a non-contiguous county to their home residence and still be within 30 miles of their home (as per OMPP’s benchmark). There were fourteen counties where more than 40 percent of CHIP members’ primary care visits were received in a county not contiguous to their home county: Adams, Benton, Brown, Decatur, Jennings, Lagrange, Noble, Owen, Spencer, Switzerland, Tippecanoe, Warren, Wells and Whitley (refer back to Exhibit III.2). Of these, only three counties are potentially at risk for full panels: Brown County has 86 percent of its panel full, Decatur is 94 percent full, and Switzerland County has 93 percent of its panel full (refer back to Exhibit III.1).

When cross-referenced the other way, the 13 counties that had panel sizes more than 80 percent full had a wide variety of their CHIP members who received services in non-contiguous counties. This range was from a low of only four percent (Elkhart) to a high of 81 percent (Switzerland).

Five of the 13 counties with fuller panels also had more than 30 percent of their member’s primary care visits to counties not contiguous to their home. When reviewed at the MCO level, in some situations the high level of non-contiguous county provider use is limited to specific MCOs. The MCOs that may have specific access issues are shown in italics in Exhibit III.3 below.

**Exhibit III.3
Comparison of Counties with Fuller Pediatric Panels and whose CHIP Members Access
Primary Care Visits to Non-Contiguous Counties at a Higher than Average Rate**

County	The Percent Full for the County's Pediatric Panel	Percent of Member's Primary Care Visits to Non-Contiguous Counties from Home Residence			
		All 3 MCOs Combined	Anthem only	MHS only	MDwise only
Brown	86%	53%	<i>83%</i>	36%	<i>72%</i>
Clinton	95%	35%	24%	<i>60%</i>	19%
Decatur	94%	51%	33%	<i>48%</i>	<i>62%</i>
Montgomery	84%	36%	25%	35%	<i>63%</i>
Switzerland	93%	81%	<i>100%</i>	37%	<i>98%</i>

Source: Encounters stored in MedInsight, OMPP's data warehouse matched against the MedInsight CHIP enrollment files

The data from Exhibits III.1 through III.3 suggests, therefore, that any direct relationship between panel size and access to primary care among CHIP members may be limited to just five counties and only to some of the MCOs in each county. The three counties where both the panel size is fuller and where CHIP members access primary care in a non-contiguous county the majority of the time are Brown, Decatur, and Switzerland County.

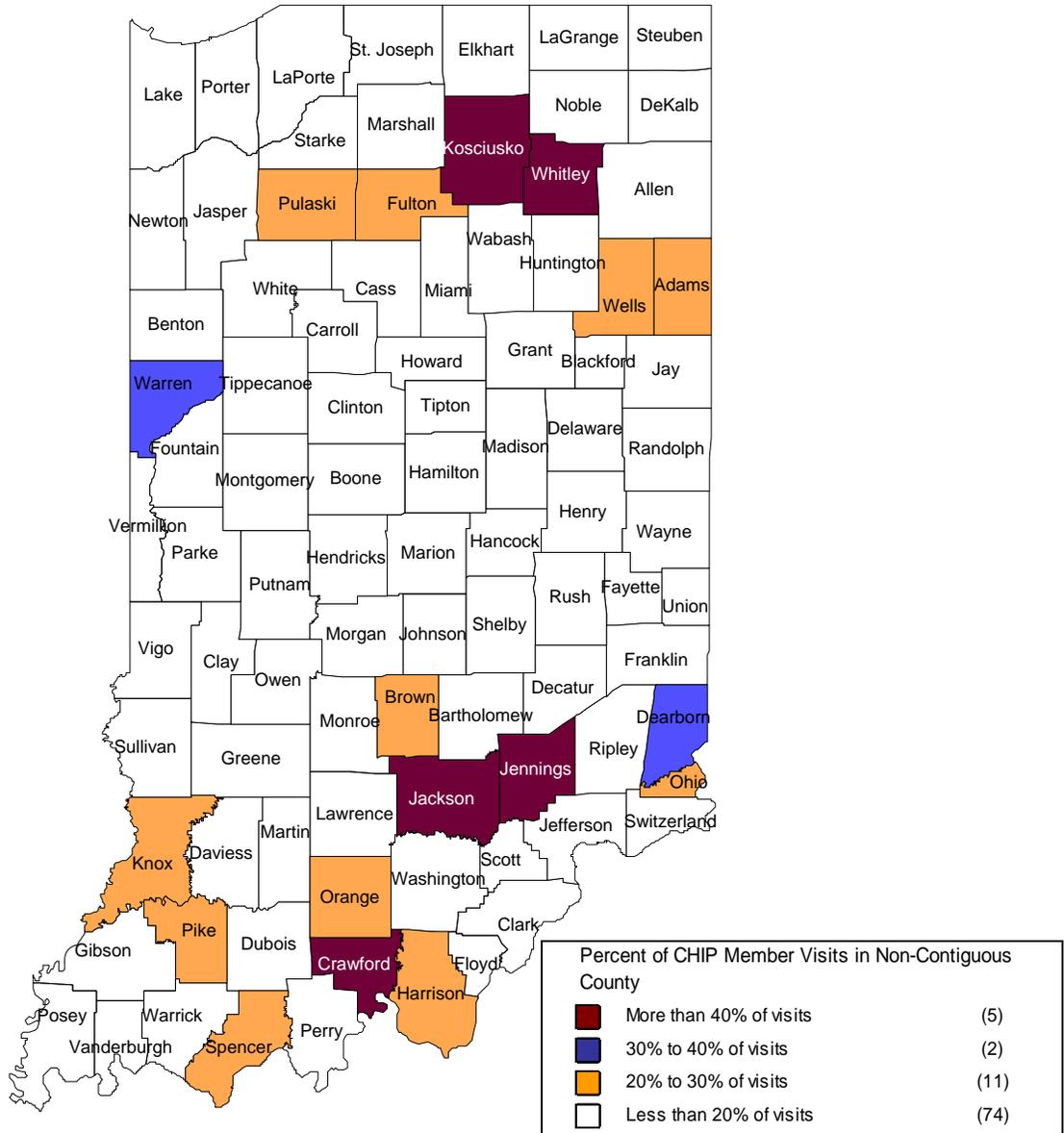
Access to Dentists

B&A conducted a similar analysis of where CHIP members access services for dental providers. Overall, it was found that 65 percent of CHIP members had a preventive dental visit in FFY 2011. The members with visits were once again analyzed to determine if the dental visit was in the member’s home county, a contiguous county or a non-contiguous county.

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Statewide, access to dentists is high since 74 percent of CHIP members had their preventive dental visit in their home county and an additional 20 percent had their visit in a contiguous county. Exhibit III.4 shows the 18 counties where the percentage of visits received in non-contiguous counties from the member's home county exceeded 20 percent. Five counties (Crawford, Jackson, Jennings, Kosciusko and Whitley) are greater than 40 percent.

**Exhibit III.4
Volume of CHIP Members Received Preventive Dental Visits
in a County Not Contiguous to their Residing County**



IV

Service Use Patterns among Populations in Indiana's CHIP



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In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also analyzed the percentage of CHIP members that had 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) 2010 and 2011 across populations within the CHIP by age, by MCO and by race/ethnicity.

Data used in this analysis was retrieved by B&A from the Office of Medicaid Policy and Planning’s data warehouse in February 2012. The majority of the services examined are paid for by the MCOs directly to providers and then reported as encounters to the OMPP after the fact. The FFY was selected instead of the Calendar Year to account for time for the MCOs to submit encounters to the OMPP. That being said, the findings for FFY 2011 may still be incomplete if the MCOs have not submitted all of their encounter data to the OMPP yet.

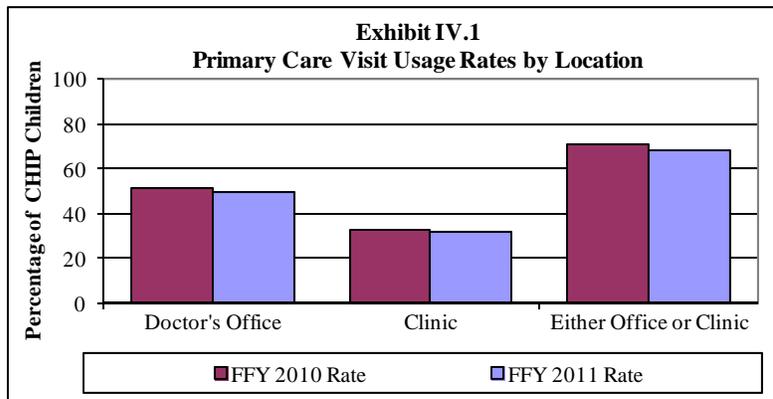
B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2010 or 2011. Since the *usage rate* measures the percentage of members that had actually used the service, we are allowing for a minimum of nine months enrollment in the year to identify only those members that would have had an opportunity to actually use the service. Members could be included in one year and not the other based upon their enrollment history. If CHIP members switched between CHIP Package A, CHIP Package C and/or Medicaid during the year, they were retained in the analysis as long as they met the nine month minimum and were enrolled in the CHIP at the end of the year. CHIP members included in the analysis were assigned to one MCO, one race/ethnicity group, and one age group. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member’s age was assigned based upon their age at the end of each year.

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

Primary Care Visits

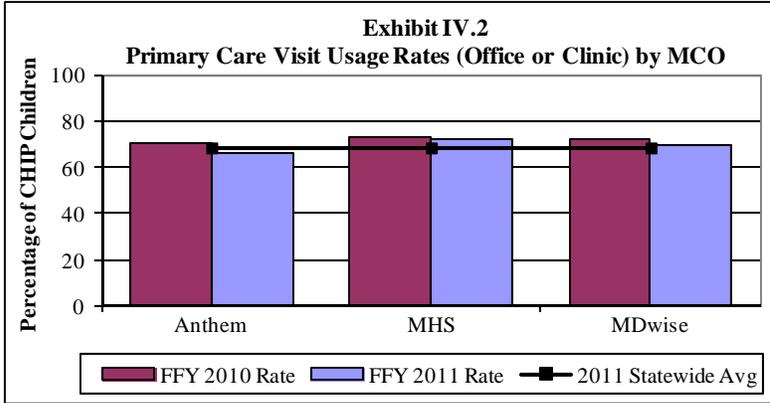
Primary care visits include visits to doctor’s offices or clinics specializing in primary care and include well-child visits and visits for specific ailments. Although children usually see their PMP for such visits, B&A did not limit our analysis to PMP visits exclusively.¹

On a statewide level, B&A found that 71 percent of CHIP children in the study sample had a primary care visit (either in a doctor’s office or a clinic) in FFY 2010 and 70 percent had a visit in FFY 2011. There were 49 percent of CHIP children that had a visit in a doctor’s office and 32 percent had a visit in a clinic in 2011.



¹ B&A did limit our definition of primary care visit to claims/encounters with the presence of one of the following CPT codes: 59425-59430, 99201-99215, 99241-99245, 90862, 99381-99397.

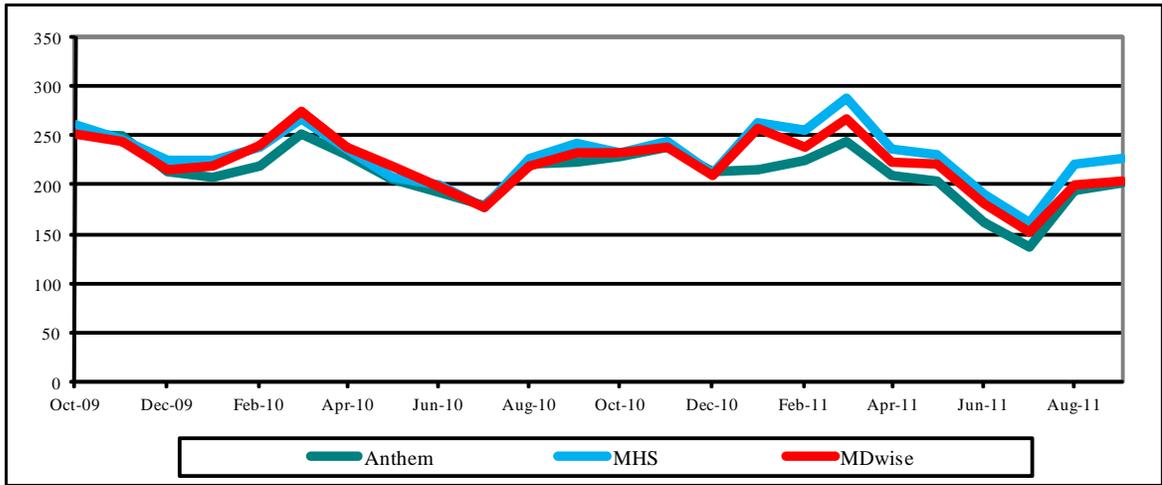
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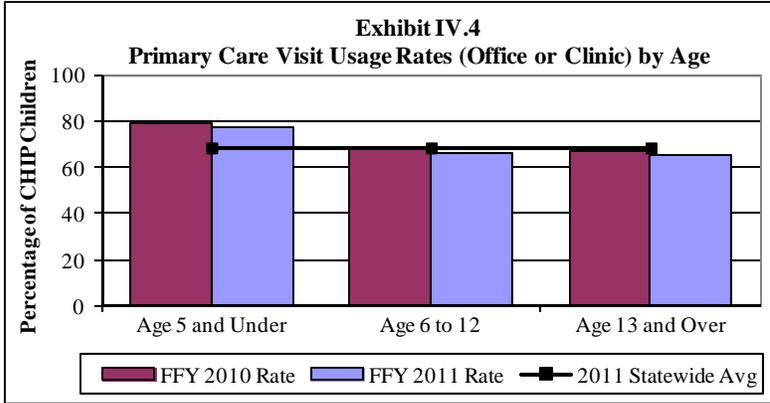
The percent of children that had a primary care visit (either office or clinic setting) was similar (69%) across the MCOs in FFY 2011 and the rates changed only slightly from FFY 2010.

When utilization is measured on individual claims per 1,000 CHIP members, the results fluctuate a bit on a month to month basis, but the results within each month are very similar across the MCOs. For the period October 2009 to September 2011, the utilization rate per 1,000 CHIP members was in the range from a low of 136 visits per 1,000 members to a high of 288 visits per 1,000 members (refer to Exhibit IV.3 below). Said another way, in any given month in the study period, between 1.36 and 2.88 children out of 10 that were enrolled in the CHIP had a primary care visit each month.

Exhibit IV.3
Utilization Rate of Primary Care Visits (Office or Clinic) Per 1,000 CHIP Children By MCO

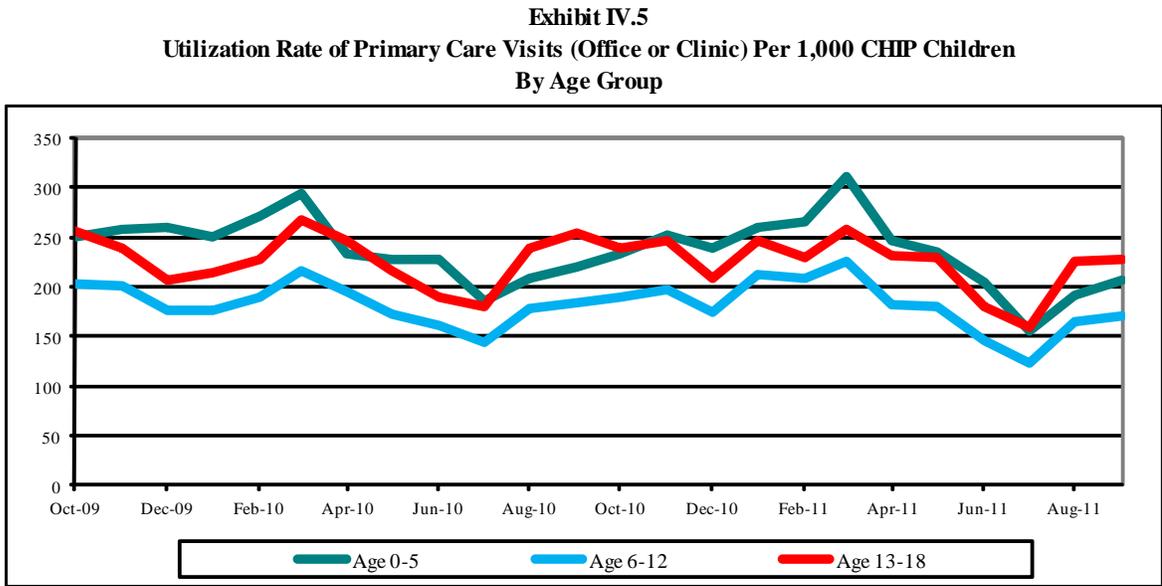


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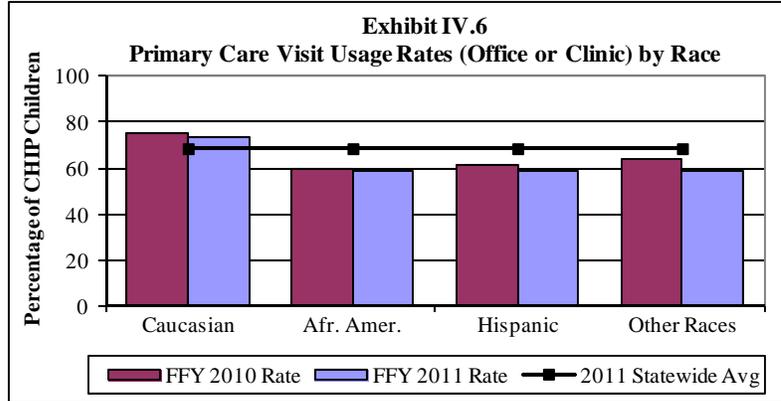
Primary care visits were more prevalent among younger members, as 77 percent of children age five and younger had a visit in FFY 2011. The percentages of children in the older age groups that had a primary care visit were lower (66% for age 6-12 and 65% for age 13-18 in FFY 2011).

Although the primary care usage rate for children age 6 to 12 and age 13 to 18 in FFY 2011 was about the same, the actual number of office visits per 1,000 members was higher among children in the age 13 to 18 group than in the age 6 to 12 group (refer to Exhibit IV.5 below). Children in the age 0 to 5 group had a primary care visit utilization rate similar to the age 13 to 18 group.



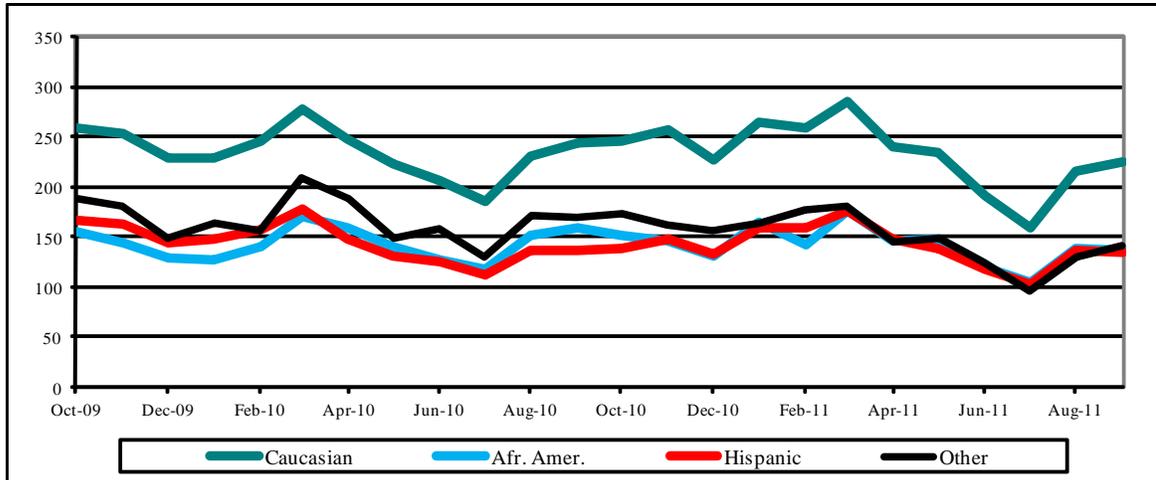
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The percent of children that had a primary care visit remained relatively stable within each race/ethnicity examined between FFY 2010 and FFY 2011. When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. African American and Hispanic CHIP children had primary care visits at the same rate (59% of each had a visit in FFY 2011), significantly below the 73 percent rate for Caucasian children.



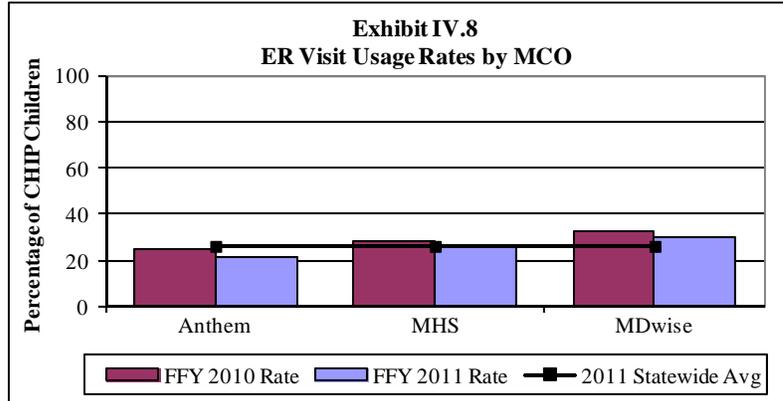
As seen above in the usage rate of actual children having a primary care visit, the utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the months studied, the median rate per 1,000 Caucasian children was 237, whereas the median rate was 143 and 141 among African American and Hispanic children respectively (refer to Exhibit IV.7 below). The utilization rate for children in other race/ethnicities was slightly higher at a median rate of 160 visits per 1,000 CHIP children.

**Exhibit IV.7
Utilization Rate of Primary Care Visits (Office or Clinic) Per 1,000 CHIP Children
By Race/Ethnicity**



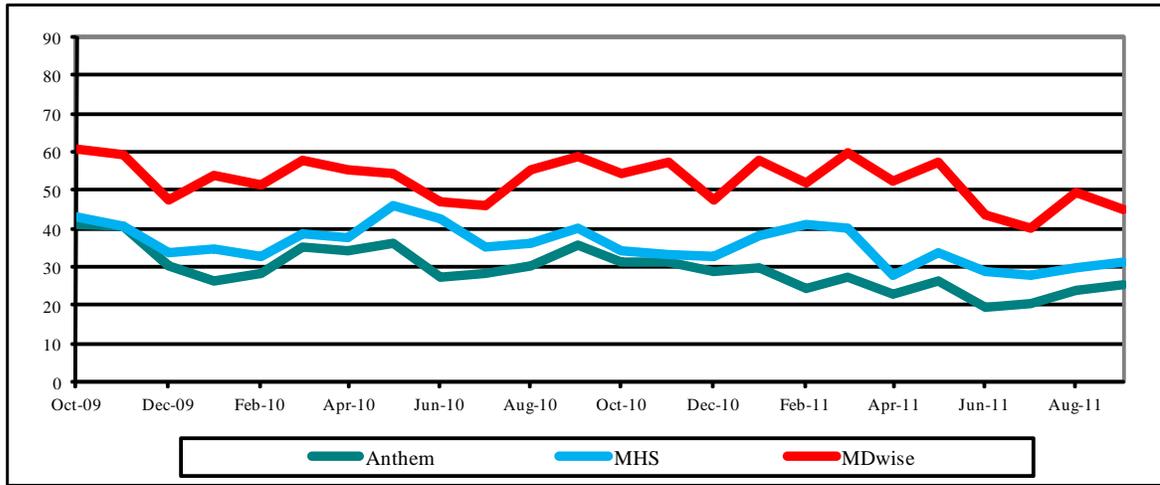
Emergency Room Visits

There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCO. In both FFY 2010 and FFY 2011, more MDwise members had ER visits (30% in 2011) than either Anthem (21%) or MHS (26%).

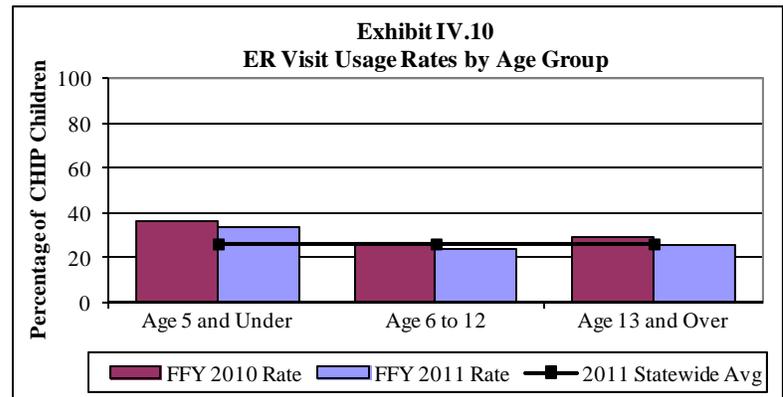


The difference between MCOs is even more pronounced when measured in emergency room visits per 1,000 CHIP members. In FFY 2010 and 2011, the average rate among MDwise members was 53 ER visits per 1,000; for Anthem, it was 29 per 1,000; for MHS, it was 36 per 1,000 (refer to Exhibit IV.9 below).

Exhibit IV.9
Utilization Rate of Emergency Room Visits Per 1,000 CHIP Children
By MCO



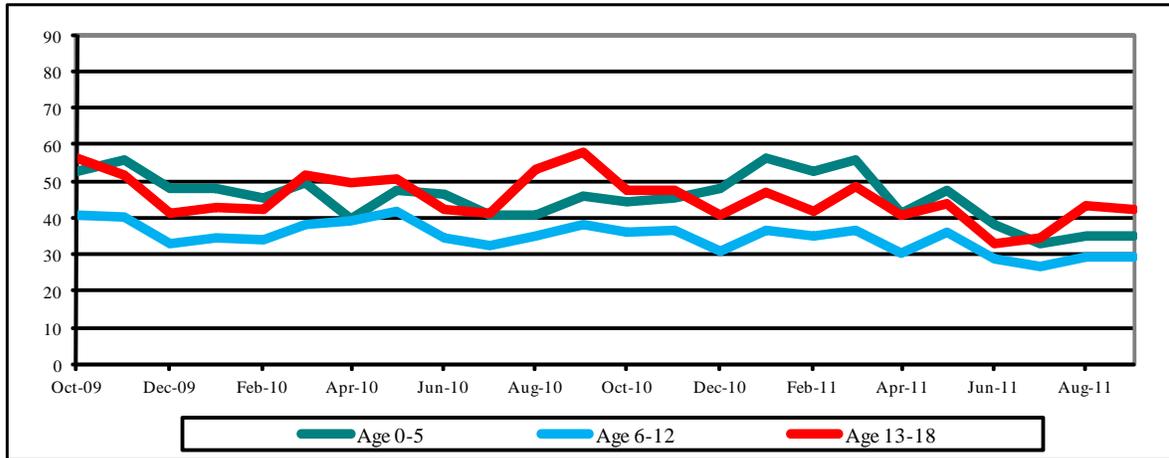
Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (33% of all members in FFY 2011) and lowest among children age 6 to 12 (24% of all members in FFY 2011). ER usage did go down slightly for all age groups from FFY 2010.



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Although the percentage of CHIP children that had an ER visit was highest among children age 0 to 5, the utilization rate for ER was just as high for children age 13 to 18 as the younger children (refer to Exhibit IV.11). The rate was 46 per 1,000 members on average for age 0 to 5 and 45 per 1,000 for 13 to 18 year olds in the months from October 2009 to September 2011. The rate was lower for children age 6 to 12 (35 visits per 1,000 on average).

**Exhibit IV.11
Utilization Rate of Emergency Room Visits Per 1,000 CHIP Children
By Age Group**



The large majority of children (86%) who used the ER during FFY 2011 had one or two visits during the year. As shown in Exhibit IV.12, MHS and Anthem had a similar rate of “frequent flyers” – children who used the ER more than two times during the study year. MDWise had a higher frequent flier rate than the other two MCOs at 17 percent.

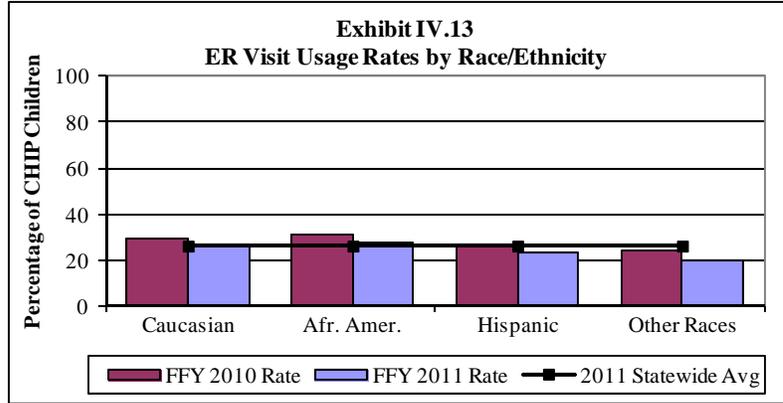
**Exhibit IV.12
Rate of ER Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2010 - Sept 30, 2011**

Number of ER Visits per Member	Percentage of All ER Visits by MCO			Total
	Anthem	MHS	MDWise	
1 to 2	86.1%	86.9%	82.7%	85.6%
3 to 5	12.0%	11.7%	14.2%	12.2%
6 to 10	1.6%	1.3%	2.3%	1.7%
11 to 20	0.2%	0.2%	0.5%	0.3%
More than 20	0.0%	0.0%	0.2%	0.1%

Source: MedInsight, OMPP's data warehouse

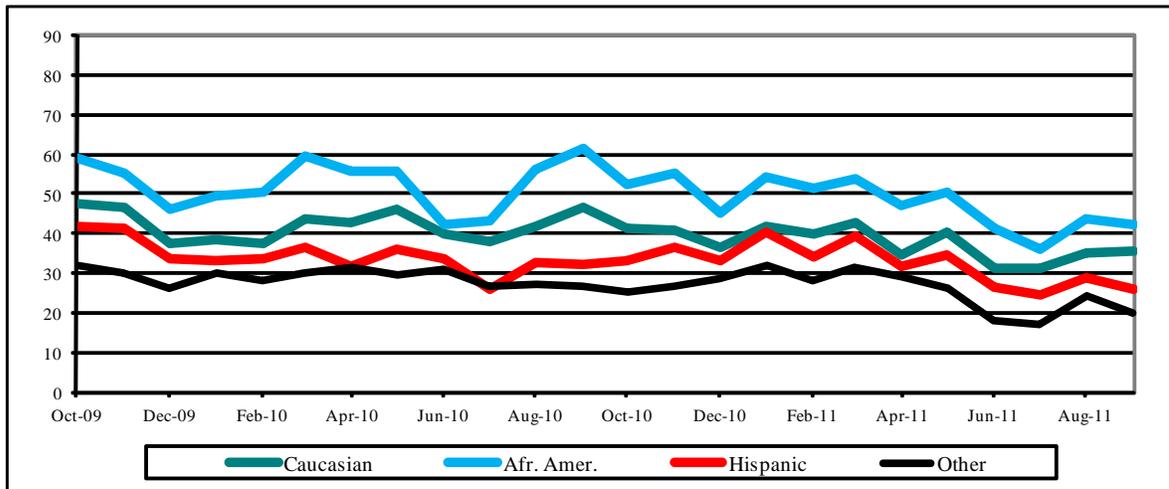
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When compared across race/ethnicities, the use of ER visits is quite similar. Hispanic children have a slightly lower rate of ER usage in FFY 2011 (23%) than Caucasians and African-Americans (27% and 28% respectively). Children of other races are the lowest (20%).



The percentage of children shown that had used the ER in the calendar year was similar, but the rate at which the ER is used varies by race/ethnicity (refer to Exhibit IV.14 below). The average utilization rate of ER use per 1,000 members among African-American children is 50, whereas the average rate among Caucasians is 40 in FFY 2009 through 2011. The rate is even lower for Hispanics (33) and children of other race/ethnicities (27).

Exhibit IV.14
Utilization Rate of Emergency Room Visits Per 1,000 CHIP Children
By Race/Ethnicity

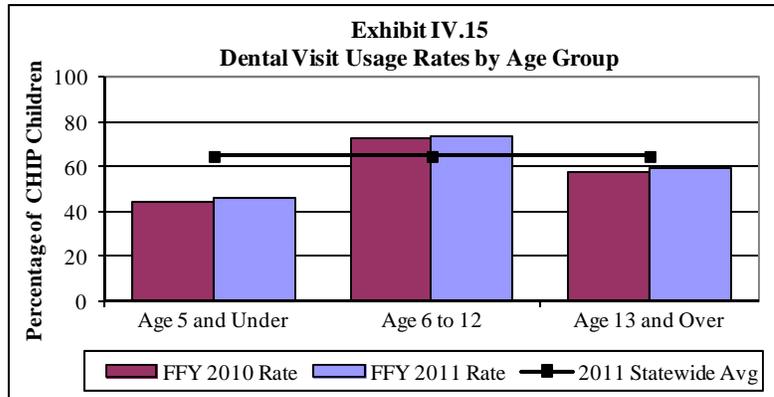


Preventive Dental Visits

The overall percentage of CHIP members receiving a preventive dental visit at some time in the year was 65 percent in FFY 2011. This is an increase from 58 percent in FFY 2008. Dental care is one of the few services that the MCOs are not responsible for managing.

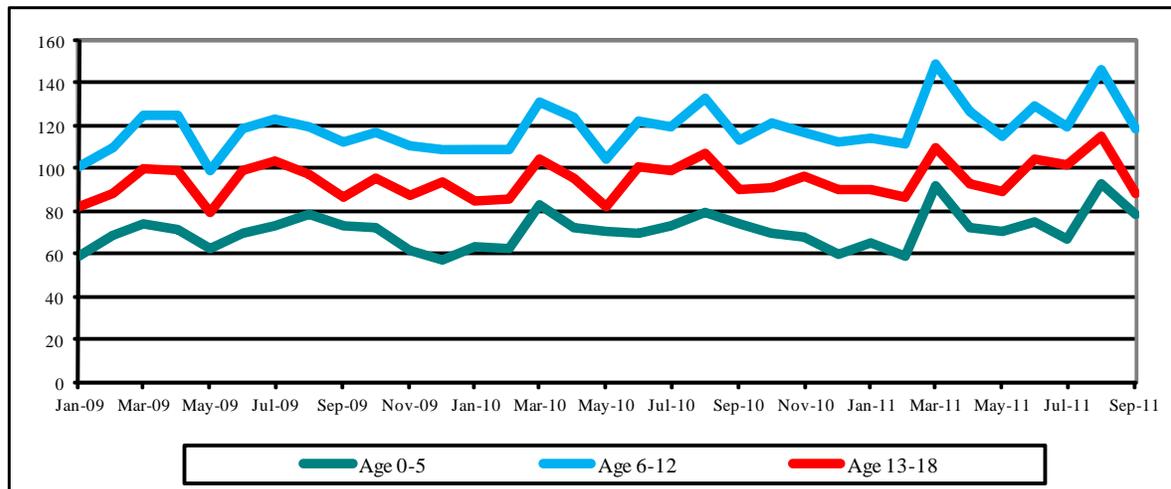
Contracting with dental providers has historically been challenging for CHIP and Medicaid programs nationally, but Indiana appears to have addressed dental access throughout the state as evidenced by the usage rates reported here.

Children age six to 12 are most likely to have received a preventive dental visit (73% of the members in FFY 2011), which is significantly higher than the teenagers (59%). The youngest children had the lowest usage rate (41%) given that this group includes toddlers. These rates of usage were steady between FFY 2010 and FFY 2011.



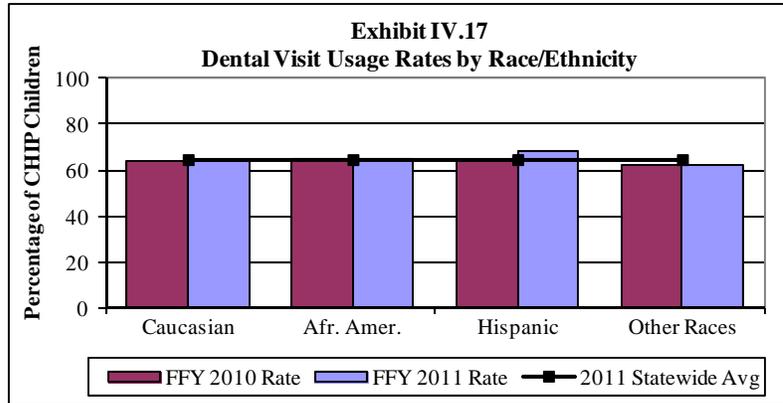
A similar pattern was found by age group when measuring the utilization rate of dental visits per 1,000 CHIP members. The rate of 120 visits per 1,000 members age 6 to 12 is 26 percent higher than the rate for children age 13 to 18 and 68 percent higher than the rate for children age 0 to 5.

Exhibit IV.16
Utilization Rate of Preventive Dental Visits Per 1,000 CHIP Children
By Age Group



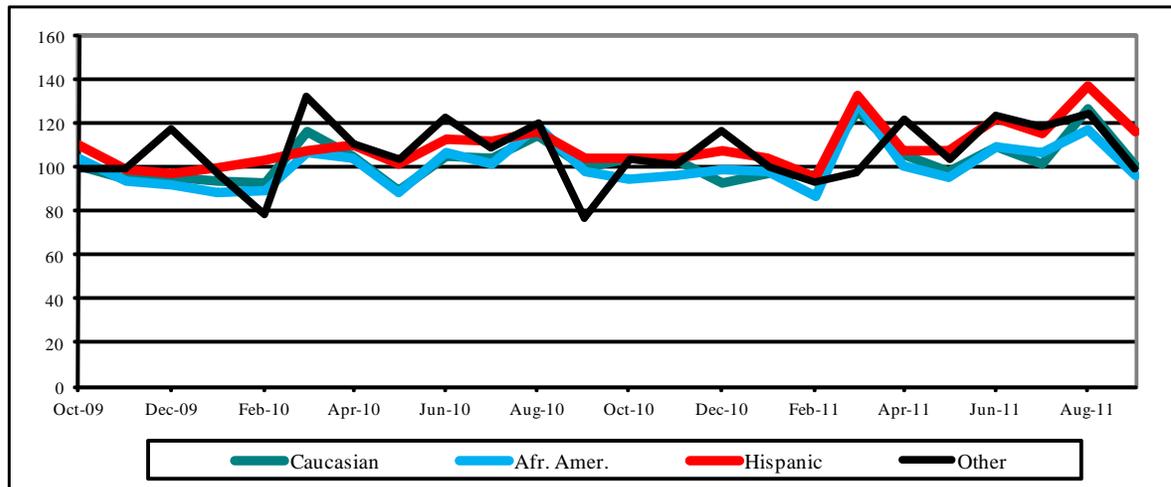
Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2011

The preventive dental usage rate remained relatively steady at about 64 percent for all race/ethnicities between FFYs 2010 and 2011, and there is little difference from the statewide average in the usage rate among the race/ethnicities.



The utilization rate per 1,000 CHIP members is also the same among race/ethnicities at approximately 100 visits per 1,000 members each month studied in FFYs 2010 and 2011.

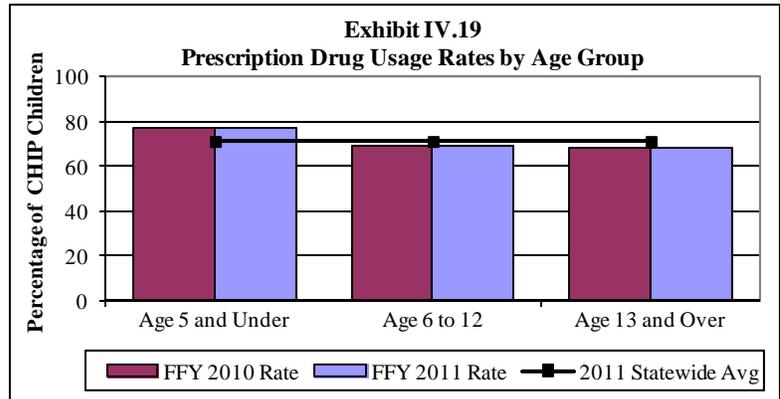
Exhibit IV.18
Utilization Rate of Preventive Dental Visits Per 1,000 CHIP Children
By Race/Ethnicity



Pharmacy Prescriptions

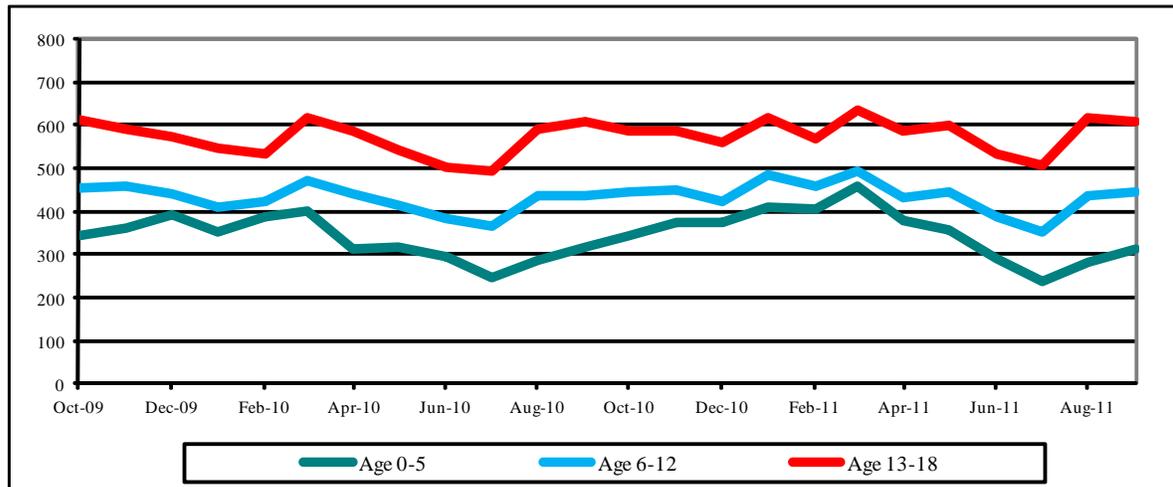
In CY 2010, the administration of the pharmacy benefit was taken back by the State and is no longer included in the capitation payment paid to the managed care organizations. Across all members enrolled at least nine months of the year, the percentage of members that had a prescription filled has remained relatively unchanged (71%) in the last two years.

There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children age five and younger in both FFY 2010 and 2011 (78% in 2011). Children in the older age groups were both 69 percent in FFY 2011.



The exhibit above showed that a lower percentage of teenagers obtained a prescription than children in younger age groups. But among those teenagers that did obtain a prescription, the number of prescriptions filled per child was higher for the teenagers than other age groups. This is evident in the utilization rate of prescriptions filled per 1,000 CHIP children in Exhibit IV.20 below. The utilization rate for children age 13 to 18 was 575 per 1,000 on average for 2009 through 2011, followed by children age 6 to 12 (432 per 1,000), then by children age 0 to 5 (343 per 1,000).

**Exhibit IV.20
Utilization Rate of Prescriptions Filled Per 1,000 CHIP Children
By Age Group**



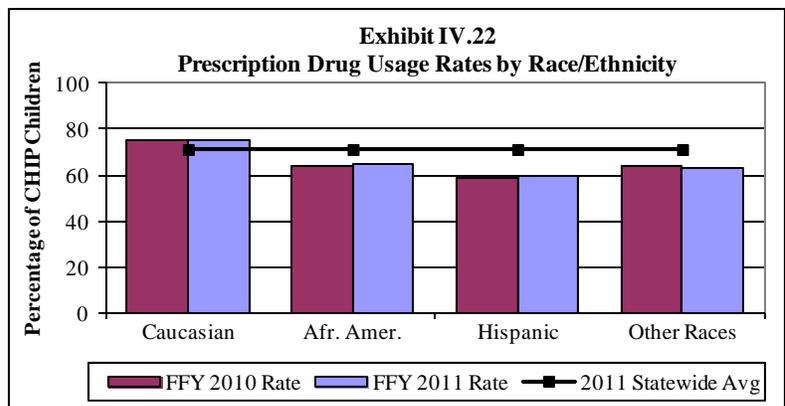
The type of prescriptions obtained by children in each age group also varies widely. For the youngest children in CHIP, 36 percent of scripts filled in CY 2011 were to treat infections. Among children age 6 to 12, half of the scripts were either for treating infections or for anxiety or seizure disorders. For teenagers in CHIP, 52 percent of the scripts were for the same treatments that were used for other children. Another 10 percent of scripts were for hormones. (Refer to Exhibit IV.21 on page IV-11.)

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Exhibit IV.21
Highest Volume Pharmacy Scripts in Calendar Year 2010
By Age Group and by Program

Therapeutic Class	Age 1-5			Age 6-12			Age 13-18		
	CHIP A	CHIP C	C Exp.	CHIP A	CHIP C	C Exp.	CHIP A	CHIP C	C Exp.
	Percentage of All Prescriptions in the Age Group								
Antiperspirants, Topical preparations, Skin and mucous membrane preparations	9.5%	7.9%	8.2%	5.4%	4.8%	4.2%	6.7%	6.4%	7.0%
Antiprotozoals, Antileprotic, Anti-infective	33.8%	37.8%	37.1%	16.6%	18.4%	18.8%	14.6%	15.9%	15.8%
Autonomic drugs	7.0%	6.7%	6.8%	6.8%	5.9%	6.2%	5.6%	4.3%	4.8%
Benzodiazepine antagonists, Central nervous system drugs	10.8%	8.5%	7.7%	33.4%	32.8%	32.1%	37.1%	38.2%	37.3%
Electrolytic, caloric and water balance	9.9%	8.7%	8.5%	8.8%	8.5%	8.0%	6.3%	5.8%	5.3%
Expectorants and cough preparations	5.6%	6.0%	6.0%	5.6%	5.3%	6.2%	3.0%	2.6%	2.8%
Gastrointestinal drugs	4.7%	4.2%	4.5%	3.3%	3.1%	3.3%	3.9%	3.6%	3.5%
Hormones	8.1%	9.6%	10.4%	7.4%	8.1%	8.2%	11.7%	12.4%	13.7%
Ointments Solutions Suspensions, ophthalmic Otic nasal, Ophthalmic preparations	6.8%	7.9%	7.0%	5.8%	6.1%	6.1%	3.6%	3.9%	3.6%
All Other	3.8%	2.7%	3.8%	6.9%	7.0%	6.9%	7.4%	7.0%	6.3%

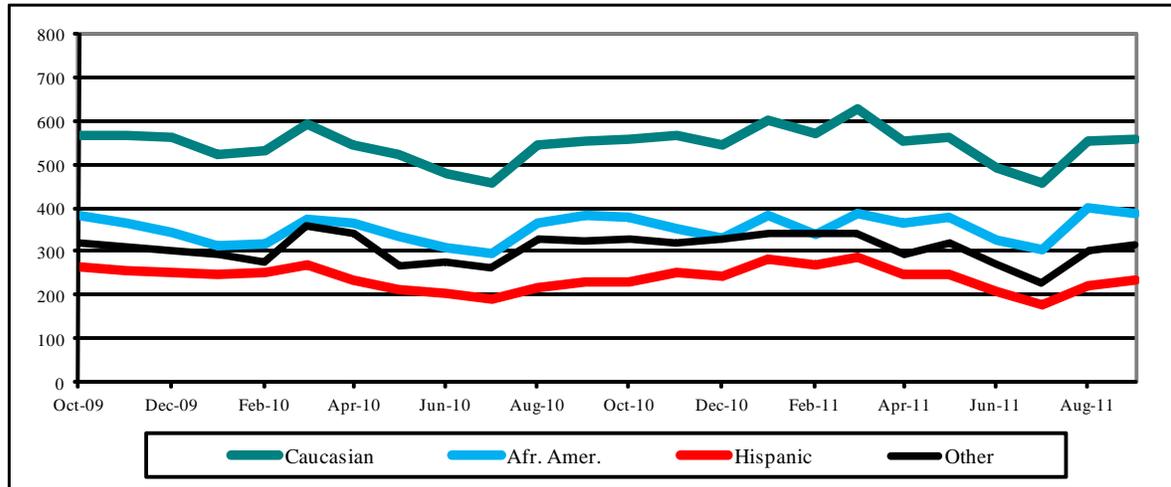
The percentage of children with a prescription increased slightly for each race/ethnicity group studied except for other races between FFY 2010 and FFY 2011. Comparing across race/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than minorities. In 2011, the usage rate among Caucasians was 76 percent but it was 65 percent for African American children and 60 percent for Hispanic children. The rate was also lower for children of other race/ethnicities (63%). This has been a consistent finding in the CHIP for the last four years.



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The trend for the number of prescriptions filled per 1,000 CHIP children by race/ethnicity followed the same pattern found for the usage rate trend on the prior page. Caucasian children have a utilization rate of 545 scripts per 1,000 members each month, which is 54 percent higher than the rate for African-American children (353 scripts per 1,000) and more than double the rate for Hispanic children (238 scripts per 1,000 children). It is 77 higher than the rate of children of other race/ethnicities (308 scripts per 1,000 children). Refer to Exhibit IV.23 below.

Exhibit IV.23
Utilization Rate of Prescriptions Filled Per 1,000 CHIP Children
By Race/Ethnicity



V

Measuring Quality and Outcomes in Indiana's CHIP



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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 approximately 84 percent of HHW members, quality and outcomes related to children are given high priority.

OMPP staff review data from reports submitted by the managed care organizations (MCOs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCO's site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity¹ to conduct an annual external quality review of each MCO and reviews the results with each MCO.

Measuring outcomes have become a focused effort of the OMPP in recent years, particularly with respect to children's care. In fulfilling its oversight responsibilities, the OMPP utilizes a variety of reporting and feedback methods to measure quality and outcomes for Indiana's CHIP:

1. OMPP requires the three HHW MCOs to report the results of HEDIS² and CAHPS³ measures. The HEDIS are nationally-recognized measures since the health plans that report their results nationally use standard definitions and results are attested by certified auditors of the NCQA. The OMPP compares the results of the HEDIS measures across the three MCOs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS survey is separated between one for adults and one for parents of children. The OMPP requires the MCOs to administer each survey annually.
2. Separately, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Centers for Medicare and Medicaid (CMS) was required to develop a core set of measures related to children's health and to collect the results of these measures on a voluntary basis from state Medicaid and CHIP programs. There were 24 core measures identified by CMS in 2010. Indiana's CHIP, through OMPP, has already been collecting the results on 15 of these measures (namely, the HEDIS measures) and voluntarily reported these in the annual report on the CHIP program required by CMS. Mandatory reporting for the other measures will begin in 2013.
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.

In 2009, the OMPP required the HHW MCOs to select three topic areas for which they would develop Performance Improvement Projects (PIPs). Some of the PIPs were related to children's care. As part of the external quality review, Burns & Associates (B&A) validated the data used in these PIPs and assessed the approach used by each MCO to work toward achieving improvement. The results are described later in this section.

¹ Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.

² The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

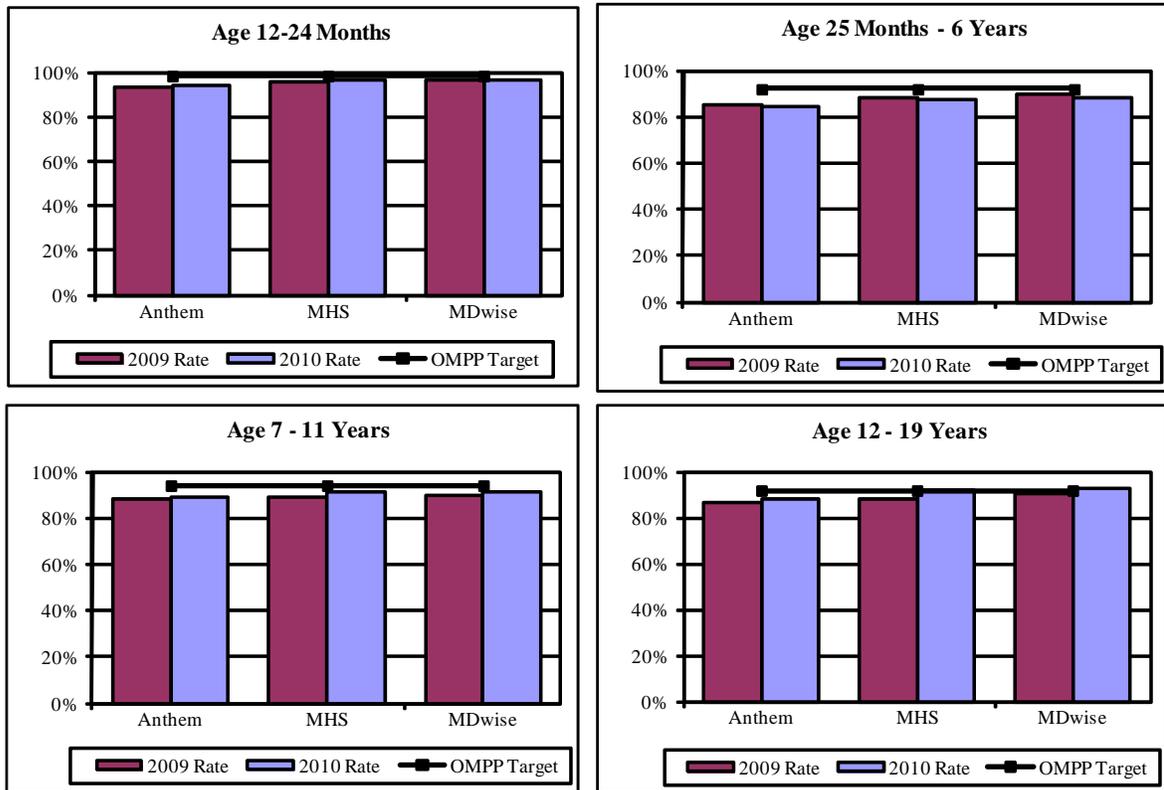
HEDIS and CAHPS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members from the prior year. Therefore, in CY 2011, tabulations were collected on HEDIS rates for 2010 utilization. The HEDIS measures report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome. OMPP gave the MCOs targets to meet for all of the HEDIS measures collected that are specific to children’s care.

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

The exhibit shows the 2009 and 2010 rates reported for each MCO for four age groups. OMPP has set a different target rate of the percentage of children who will have a primary care visit for each age group. However, in each case the target represents the rate at the 90th percentile among all Medicaid health plans nationally. Every MCO had effectively the same rate or better in CY 2010 as compared to their CY 2009 rate in each age group with the exception of the 25 months to 6 year-old age group. In that group, all three MCOs saw slight declines in performance. The OMPP target was met by some MCOs within each age group but was within five percentage points of the target in every case. When reviewed by MCO, the pattern was the same for each age group—MDwise was closest to the OMPP target, followed by MHS and Anthem.

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



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Exhibit V.2 shows the results for well care visits. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life, the rate shown represents the percentage of children with six or more well child visits. For children in the age 3-6 years and age 12-20 years groups, the rate shown represents children that had at least an annual visit. For the adolescents, a visit to an OB/GYN also counts as a well child visit. The OMPP target in every case is the 75th percentile among all Medicaid health plans nationally.

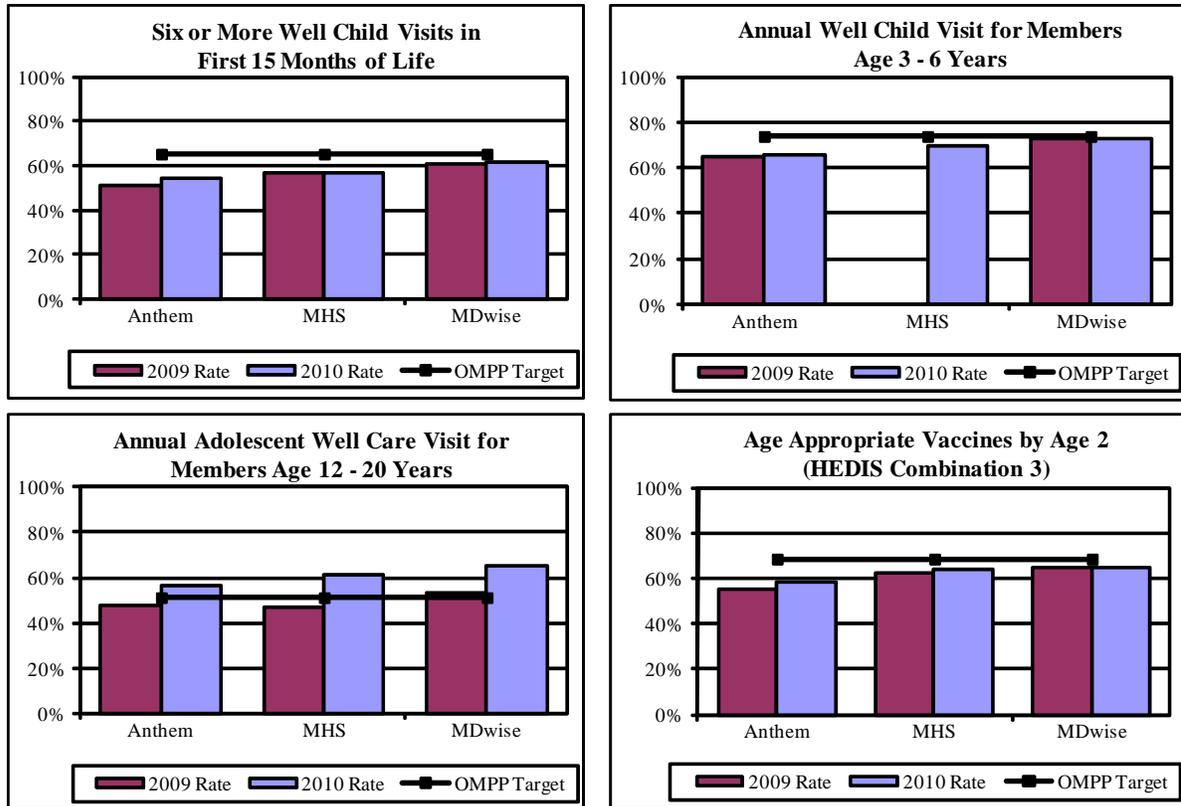
All of the MCOs met the OMPP target for adolescent well care (see lower left box) in 2010 where significant improvement was shown. MDwise also met the target in 2010 for children age 3-6 years. As seen in the prior exhibit, MDwise was closest to the target, followed by MHS, then Anthem for each measure. Other than the findings cited above, all MCOs had slight improvement or maintained the same results in 2010 as they did for 2009 on the remaining measures.

Another measure for well child care relates to immunizations. There is a HEDIS measure to report the percentage of children who turned age two during the measurement year who were enrolled for the 12 months prior to their second birthday who received the following immunizations:

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

All three MCOs saw modest increases between 2009 and 2010. MDwise’s rate is closest to the OMPP target.

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



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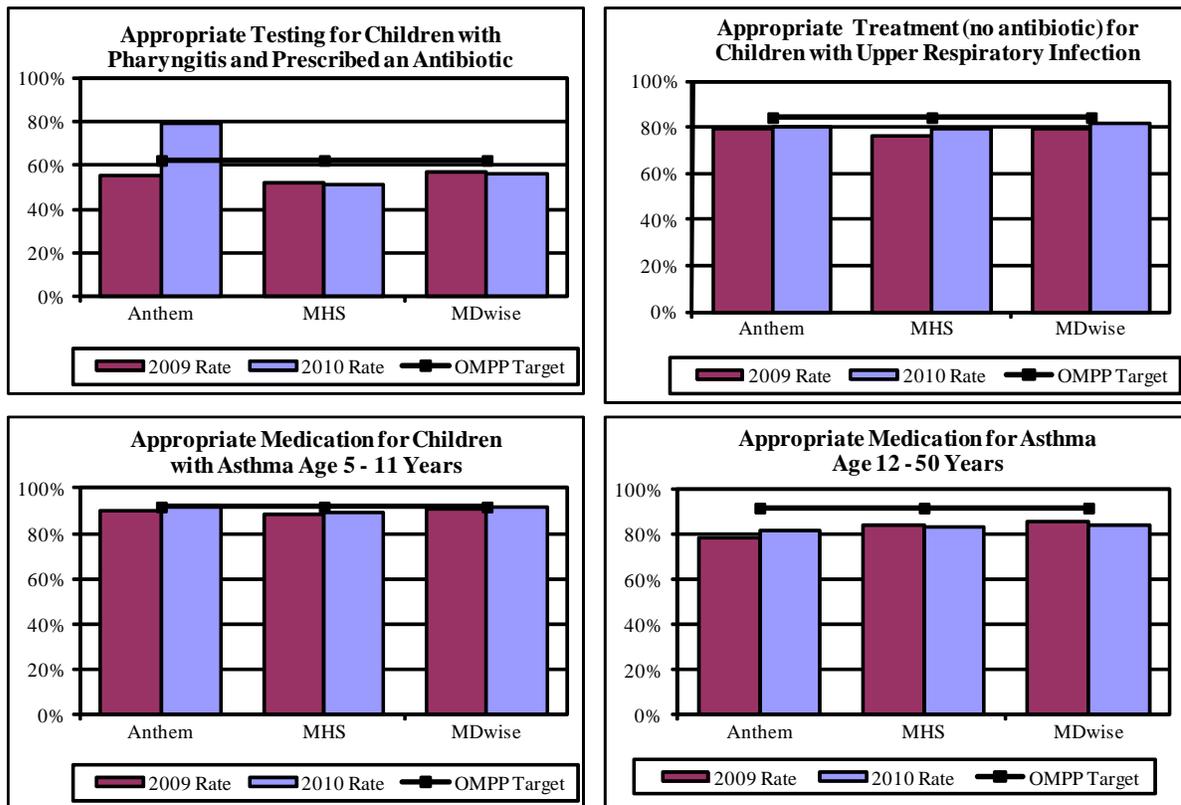
Exhibit V.3 presents the results from HEDIS measures related to respiratory care for children. The upper two boxes present results related to measuring proper treatment while the lower two boxes present results of appropriate medications for children with asthma.

For appropriate testing of children with pharyngitis (sore throat), MDWise and MHS reported 2010 rates slightly below the 2009 rates and below the OMPP target of the national 50th percentile among all Medicaid health plans nationally (see upper left box). Anthem showed a significant 24 percentage point increase between 2009 and 2010. For this measure, a higher rating is more favorable since it indicates better testing.

The MCOs reported results for 2010 that were slightly above their 2009 results for appropriate treatment for children with upper respiratory infection. This measure reports the percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable because most upper respiratory infections are viral, not bacterial.

Indiana’s MCOs did better for the two age-specific measures related to appropriate medication for children with asthma. In the lower left box, the rate is measured for children age 5 to 11. Both Anthem and MDwise are near the OMPP target of 91.9 percent. OMPP has set the same target for those ages 12 to 50. All three MCOs are further from the OMPP goal for this age group than for the goal for young children.

Exhibit V.3
Summary of Results from HEDIS Respiratory Care Measures (Percentage of Total)

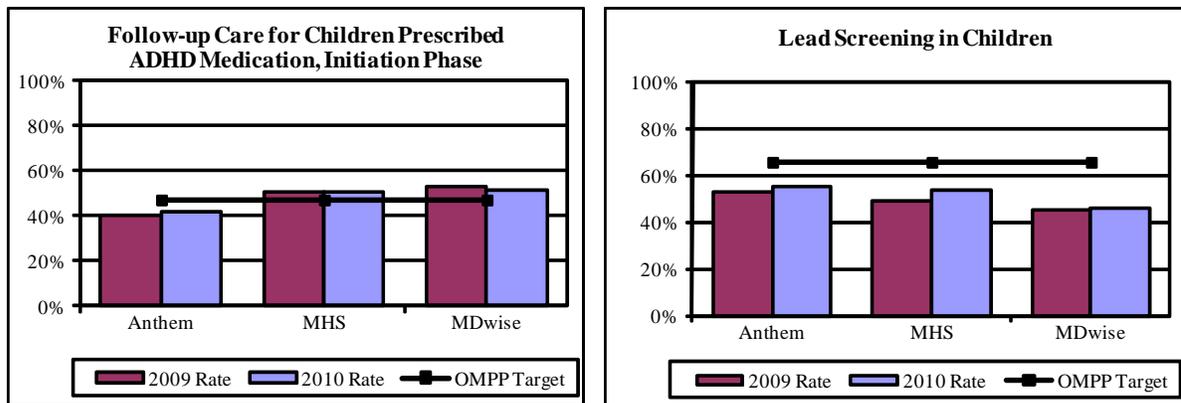


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Exhibit V.4 presents the results of two other HEDIS measures related to children. One measures the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. The OMPP set a target at the 90th percentile among all Medicaid health plans nationally. Both MHS and MDwise exceeded this target. Anthem is below the target but saw improvement in their rate between 2009 and 2010.

The other measure shown is for the percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. This is an area identified by the OMPP that needs improvement in Hoosier Healthwise. The OMPP has set a target of the 50th percentile among Medicaid health plans nationally. Anthem saw improvement between their 2009 and 2010 rates, most likely because this was one of their performance improvement projects. The rates for MHS and MDwise also increased between 2009 and 2010.

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



CAHPS Survey

The Hoosier Healthwise MCOs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCOs to the OMPP. Exhibit V.5 on the next page summarizes the results from the surveys that were administered in early 2011 and compares the results on key questions to the results from the 2010 survey. The results can also be compared to the 2010 CAHPS benchmark, which represents approximately 132 Medicaid health plans that submitted data in 2010.

The percentages in the first set of results in the exhibit reflect those members that gave a rating of 8, 9 or 10 for each rating, where zero is “worst possible” and 10 is “best possible”. All three MCOs received a score in 2011 that was better than the CAHPS benchmark for Rating of Health Plan. However, Anthem’s ratings worsened from the 2010 to the 2011 survey, MHS’ rating increased significantly and MDwise’s held steady. MDwise exceeded the CAHPS Benchmark score for every category in the first set. MHS exceeded the CAHPS Benchmark in every category except Rating of Personal Doctor.

The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The second set of results in the exhibit represent four composite scores that show the percentage of respondents that answered “Usually” or “Always” to the series of questions on the topic. For the domain Getting Needed Care, all three MCOs exceeded the CAHPS Benchmark score

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of 77.0 percent. Similarly, all three MCOs reported results that were better than the national average for Getting Care Quickly, and these results were very consistent across the MCOs. MHS exceeded the CAHPS Benchmark for all four categories in this set. Anthem and MDwise both exceeded the Benchmarks for Getting Needed Care and Getting Care Quickly.

Exhibit V.5

Summary of Scores from CAHPS 2010 and 2011 Child Survey

Bold items indicate results exceed the CAHPS 2010 Benchmark.

	Anthem		MHS		MDwise		CAHPS 2010 Benchmark
	2010	2011	2010	2011	2010	2011	
Members giving a rating of 8, 9 or 10 on a 10-point scale.							
Rating of Health Care	77.7%	78.4%	77.9%	83.5%	78.9%	80.8%	79.8%
Rating of Personal Doctor	81.0%	78.5%	80.3%	84.0%	85.4%	85.2%	84.7%
Rating of Specialist	***	***	***	85.2%	84.1%	82.7%	81.3%
Rating of Health Plan	83.1%	82.9%	80.7%	85.6%	84.8%	84.9%	80.1%

Percentages reflect responses of "Usually" or "Always"

Getting Needed Care	85.2%	74.5%	81.5%	84.7%	83.5%	84.9%	77.0%
Getting Care Quickly	89.0%	88.5%	89.6%	90.1%	89.0%	89.0%	85.4%
How Well Doctors Communicat	88.8%	87.9%	90.4%	91.6%	93.5%	88.1%	90.6%
Customer Service	***	***	***	79.8%	80.7%	***	78.9%

*** Indicates that the number of respondents to the question were too low (< 100) to be able to extrapolate the rating to the entire population with confidence.

OMPP's Strategic Objectives and Performance Goals for the CHIP

As part of the authority to gain federal participation in Indiana's CHIP, the OMPP set goals for the program and for insurance coverage for children as a whole. Three of these goals were discussed above (childhood immunization rates, well child and adolescent care visit rates and follow-up care for children prescribed ADHD medication). The status of the other four performance goals is described below.

Goal #1: Maintain the state's uninsured rate for the population at or below 200 percent of the Federal Poverty Level (FPL) below the 25th percentile of states nationally.

Using data tabulated by the US Census Bureau's Current Population Survey, Indiana's uninsured rate of 9.7 percent over the three-year average of 2008-2010 was below the 25th percentile (11.2%) among all states for the same time period. Indiana has been able to meet this goal in each of the last four years.

Goal #2: By September 30, 2012 increase by 10,000 the number of children in families between 200 and 250 percent of the FPL in the CHIP program.

The OMPP had set a goal of an increase of 10,000 children in the CHIP when CMS granted the State authority to expand eligibility in October 2008. As of September 2011, there were 6,824 children in this income category enrolled in the CHIP program.

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Goal #3: Reduce the churn rate by five percent annually among Medicaid children.

“Churn” is defined as cycling on and off the rolls, or having a lapse in coverage when the child had been previously enrolled. In each month of State Fiscal Years (SFY) 2010 and 2011, the number of Medicaid children that had a lapse in coverage but had been enrolled at some point in the 12 months prior to the lapse in coverage were identified. Then, an average for SFY 2010 and an average for SFY 2011 (each weighted by monthly enrollment) of the percent that lapsed was calculated. Then, the percentage change from the SFY 2010 figure to the SFY 2011 figure was calculated.

The results showed a lapse rate of 0.77% in SFY 2010 and a lapse rate of 0.75% in SFY 2011. Therefore, the change from year to year was a reduction of 3.1 percent, which is below the performance goal.

Goal #4: By Federal Fiscal Year (FFY) 2012, meet or exceed an overall EPSDT screening ratio of 85 percent.

EPSDT stands for Early Periodic Screening, Diagnosis and Treatment. These visits are a specialized category of preventive care visits intended to monitor a child's development. The visit includes specific elements based on the child's age, such as a physical exam, screenings for dental, vision, hearing and blood lead levels, or a health and developmental assessment. EPSDT visits must include all components of the outlined screenings and assessments set forth by CMS. Thus, EPSDT visits are reported separately from the primary care visits shown earlier in this report. Also, an EPSDT visit is often, though not always, administered in a primary medical provider's office. For example, an EPSDT visit could be completed in a clinic setting.

The screening rate for CHIP Package C in FFY 2010 was 74.0 percent. Therefore, the goal has not been met. In the past year, the OMPP has undertaken an extensive review of how EPSDT data is collected and reported to CMS to ensure that it is as accurate as possible.

MCO Performance Improvement Projects

The validation of performance improvement projects (PIPs) is one of the mandatory activities specified in the CMS protocol for conducting external quality reviews (EQR) of Medicaid managed care plans.

For the EQR conducted in 2010, B&A validated three PIPs from each Hoosier Healthwise MCO. A review tool was used that focuses on the validity of the data reported rather than a critique of actual performance improvement. Another part of the review is to study the steps that the MCOs took to try to achieve real improvement. B&A reviewed updated results in 2011 to see if improvement was found.

OMPP requested that the MCOs select one topic from each of three groups—behavioral health, preventive health, and other disease/condition-specific care. Some topics were child-specific, some were adult-specific, and some covered both populations. The results of one study from each MCO that involved children are discussed below.

Anthem's PIP on Lead Screening

Anthem developed this PIP in light of the fact that their HEDIS rate was significantly below the OMPP's target and below the HEDIS 25th percentile benchmark.

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For their PIP, Anthem set a benchmark of 49.3 percent, which is the HEDIS 25th percentile rate. Their baseline rate (measured in the HEDIS 2008 year) was 41.2 percent; in HEDIS 2009, it grew to 43.5 percent; in HEDIS 2010, it grew to 53.0 percent; in HEDIS 2011 it grew to 55.1 percent. Based upon their improvement, Anthem has increased their benchmark to the HEDIS 50th percentile (71.6%) beginning in HEDIS 2011 year.

Anthem attributed their improvement to adding lead screening to the list of monthly automated reminder calls made to children at ages 3, 6, 9, 12, 15 and 18 related to immunizations and to the introduction of a new laboratory service for lead screening in participating doctor's offices.

MHS's PIP on Timely Prenatal and Postpartum Care

Timely prenatal visits during pregnancy and postpartum visits after delivery lead to better outcomes for members. MHS's percentage of timely prenatal visits and rate of postpartum care have historically been below the HEDIS 75th percentile. MHS used the standard HEDIS definitions of timely prenatal and postpartum visits when they compared their results after the PIP was implemented against the baseline period.

For both measures, MHS used the HEDIS 75th percentile as the benchmark (89.9% for timely prenatal and 70.3% for postpartum visit). The baseline rate for timely prenatal care was 87.5 percent in HEDIS 2007. The rate has improved in the subsequent four HEDIS years at 89.8 percent, 92.7 percent, 90.8 percent and 90.6 percent, respectively. The baseline rate for postpartum visits was 63.5 percent in HEDIS 2007. This rate has also improved in the subsequent four HEDIS years at 66.4 percent, 70.1 percent, 72.7 percent and 70.7 percent.

MHS indicated that the specific interventions that they found most success in were implementing a program specific to pregnant members that assisted them in obtaining prenatal care, education and coordination of referrals. It also includes a phone program where the member receives a limited-use cell phone to high-risk pregnant members without dependable access to a phone.

MDwise's PIP on Adolescent Well Care Visits

MDwise chose this measure since their results on this HEDIS measure have been below the HEDIS 25th percentile. MDwise included two different HEDIS measures in this PIP—one for Adolescent Well Care and the other for Children's Access to Primary Care, Age 12-19.

For both measures, MDwise used the HEDIS 90th percentile as the benchmark (63.2% for adolescent well care and 92.2% for access to primary care age 12-19). The baseline rate for adolescent well care was 36.2 percent in HEDIS 2009. The rate in the HEDIS 2010 was 48.6 percent and in 2011 was 57.7 percent, a statistically significant increase. The baseline rate for access to primary care age 12-19 was 88.3 percent in HEDIS 2009. The rate in HEDIS 2010 was 90.3 percent and in 2011 was 92.8 percent, a statistically significant increase and one that exceeds the benchmark for that measure.

MDwise indicated that the specific interventions they found most successful included a \$20 member incentive for members listed as non-compliant with their well-child visits and outreach to large provider offices showing them patient listings of non-compliant members so that the providers can assist in outreach to members.