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

Final Report – April 2013

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Executive Summary

As of December 2012, enrollment in Indiana's CHIP was at 82,660, a 4.3 percent decrease over the prior year's all-time high membership of 86,400. Over the last five years, enrollment has grown 13.6 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 9.9 percent compared to the national average of 15.2 percent. This places Indiana 10th lowest among states nationally. The most recent estimate for Indiana is the same as the previous year's uninsured rate[1].

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 ($34,575 per year for a family of four in 2012) 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 ($46,100 per year for a family of four in 2012).
    - The second portion (referred to as CHIP C Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($57,625 per year for a family of four in 2012).

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 44.4 percent (compared to a 4.3% decrease in CHIP Package A and a 17.8% increase in non-expansion CHIP package C during the same time period).

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) 2012. 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.

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[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 fewer than 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 entities (MCEs)—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.

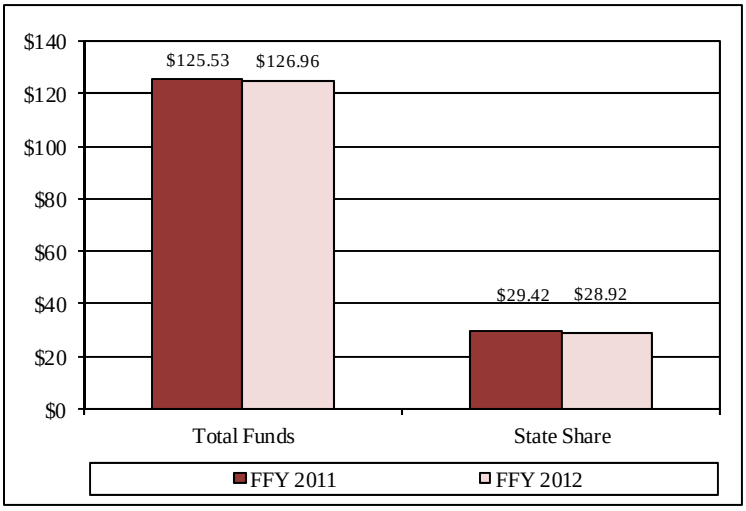
Premiums Charged to Families in Indiana's CHIP Package C

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 23.13 cents and the federal government matched the remaining 76.87 cents. In the Medicaid program, the federal government match rate was 66.96 cents.

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 2011 to FFY 2012. 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)



Sources: Expenditures from MedInsight, Indiana OMPP's data warehouse
Member months also from MedInsight (as of Feb 2013).
Premium payments from CMS-21 reports submitted by the State to CMS.

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, all three Hoosier Healthwise MCEs rated higher than national benchmarks on member satisfaction for questions related to Getting Needed Care, Getting Care Quickly, members' Rating of Health Care and overall Rating of Health Plan. Managed Health Services and MDwise also exceeded national benchmarks on 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.

For primary care visits, B&A first examined the counties where there may be an access issue. Statewide, 63 percent of CHIP members received a primary care service in the county in which they lived in FFY 2012. An additional 22 percent received a primary care service in a contiguous county. Statewide, access to dentists is high since 74 percent of CHIP members had their preventive dental visit in their home county and an additional 19 percent had their visit in a contiguous county.

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 prescription for the periods FFY 2010, FFY 2011 and FFY 2012. The overall rate of usage for each category remained relatively unchanged over the three years. Comparisons were also made across various demographic cohorts, such as by MCE, by age and by race/ethnicity.

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

	in FFY 2010	in FFY 2011	in FFY 2012
Primary Care Visit (office or clinic setting)	71%	70%	68%
Emergency Room Visit	29%	26%	27%
Preventive Dental Visit	63%	65%	66%
Pharmacy Script	71%	71%	71%

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, 2011 and 2012 and also by each of the demographic cohorts.

Some of the key findings from these analyses are:

- Primary care visits were more prevalent among younger members, as 76 percent of children age five and younger had a visit in FFY 2012. The percentages of children in the older age groups that had a primary care visit were lower (65% for age 6-12 and 67% for age 13 and over in FFY 2012).

- 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 (58% in FFY 2012) but it was significantly below the 72 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 240 per 1,000 children during FFY 2012, but the rate for African American children is closer to 148 per 1,000 children and the rate for Hispanic children is closer to 143 per 1,000 children.

- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCE, but it is more pronounced when reviewed at the per 1,000 member statistic. In FFY 2012, the average rate among MDwise members was 56 ER visits per 1,000 CHIP members; for Anthem, it was 28 per 1,000; for MHS, it was 34 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 2012) and lowest among children age six to 12 (25% of all members in FFY 2012).

- 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 66 percent in FFY 2012. 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 (76%).

- 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 (587 per 1,000 on average in FFY 2012), followed by children age 6-12 (448 per 1,000), then by children age 0-5 (348 per 1,000).

- Caucasian children have a utilization rate of 561 prescriptions per 1,000 members in FFY 2012, which is 49 percent higher than the rate for African-American children (377 prescriptions per 1,000) and more than double the rate for Hispanic children (241 prescriptions per 1,000 children).

I

Introduction

Indiana CHIP at a Glance

- The uninsured rate for low income children in Indiana is 10th lowest in the country.
- Indiana's CHIP design features are similar to those found in a majority of state programs.

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:*
> *(5) Budget committee;*
> *(6) Legislative council;*
> *(7) Children's health policy board established by IC 4-23-27-2; and*
> *(8) 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) 2012. 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 2009[2] 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 ($34,575 per year for a family of four in 2012) 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

[2] CHIPRA 2009 changed the acronym for the federal program from S-CHIP to 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 ($46,100 per year for a family of four in 2012).
- The second portion (referred to as CHIP C Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($57,625 per year for a family of four in 2012).

Half of the states have income eligibility thresholds similar to Indiana. As of January 2012, 25 states (including the District of Columbia) cover children at 250 percent FPL or above; 22 states cover children at a maximum between 200 and 249 percent FPL; and four states set a maximum below 200 percent FPL[3].

As of December 2012, enrollment in Indiana's CHIP was at 82,660[4], a 4.3 percent decrease over the prior year:

- CHIP Package A enrollment was 55,567 (down 7.6 percent from December 2011)
- Enrollment in the initial group of CHIP Package C members was 20,447 (up 4.9 percent from December 2011)
- Enrollment in the 2008 expansion group of CHIP Package C members was 6,646 (down 1.7 percent from December 2011)

More enrollment statistics appear in Chapter II of this report.

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

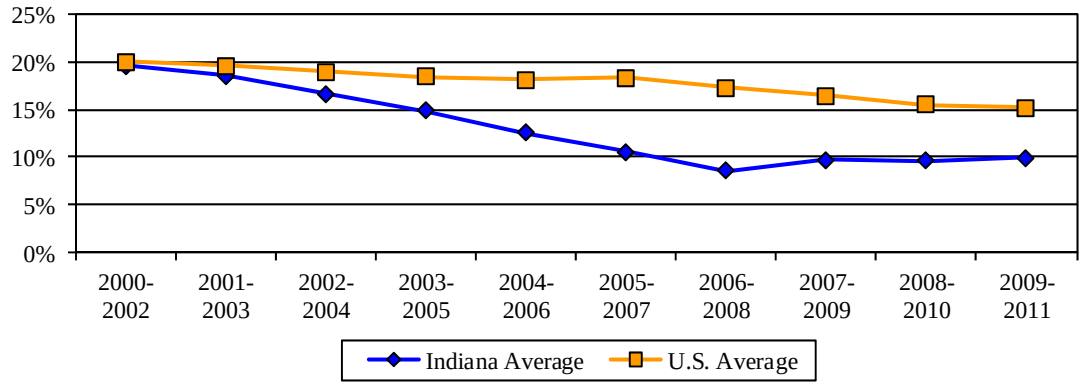
The Census Bureau's Current Population Study (CPS) surveys citizens each March on their health insurance status. An uninsured rate is computed for each state, but because state-specific samples are usually small, it is customary to measure this rate over a three year average. The CPS survey conducted in March 2012 measured insurance status in CY 2011. Therefore, the 2009-2011 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 9.9 percent compared to the national average of 15.2 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.

[3] Heberlein, M., Brooks, T., Alker, J., Artiga, S., Stephens, J. (January 2013) *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013.* Washington, DC: Georgetown University Center for Children and Families and The Henry J. Kaiser Family Foundation.

[4] Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on March 4, 2013.

Exhibit I.1
Uninsured Rate Among Children in Families Below 200% of Federal Poverty Level



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 75,000 in the 2009-2011 three year average period (Source: Current Population Survey).

Indiana's 9.9 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 2009-2011 averages from the Current Population Survey, 75 percent of all uninsured children in Indiana may already be eligible for CHIP based on family income.[5]

Exhibit I.2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana
2009 - 2011 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	91,739	75%	10.5%
Total for Children Not Eligible for Indiana's CHIP			
250% and above	30,438	25%	3.8%
All Children	**122,177**	**100%**	**6.9%**

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

[5] 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.

The uninsured rate for African American children (7.2%) in this income group is lower than other race/ethnicities. The rate for Caucasian children (10.5%) was near the statewide average, while the rate for Hispanic children (16.7%) and children of other race/ethnicities (13.2%) were much higher.

Exhibit I.3
Uninsured Rates for Children (Age 0-18) by Race/Ethnicity in Indiana
For Children in Families At or Below 250% FPL
2009 - 2011 Three-Year Average

Family Federal Poverty Level	Total Uninsured	Pct of Uninsured Children at this FPL	Uninsured Rate
Caucasian Non-Hispanic	59,844	65%	10.5%
African Amer. Non-Hispanic	13,141	14%	7.2%
Hispanic (any race)	12,392	14%	16.7%
All Other Races	6,362	7%	13.2%
All Children	**91,739**	**100%**	**10.5%**

Source: U.S. Census Bureau, Current Population Survey
http://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, 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 entities (MCEs) 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 MCE 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.

Exhibit I.4
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

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.

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 I.5
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 51-state survey of CHIP programs nationwide (including the District of Columbia), Indiana was similar to the other states in the following areas (with number of states having a similar policy to Indiana)[6]:

- Integrated Medicaid/CHIP eligibility determination system (36 states)
- Face-to-face interview not required at the time of application or at renewal (50 states), although Indiana requires a telephone interview unlike other states
- Asset test not required in determining eligibility (36 states)
- Electronic verification data match with SSA to verify citizenship (30 states)
- Renewal occurs every 12 months (49 states)
- Co-pays charged for prescriptions (26 states)
- Premiums charged to members (33 states). Of those that charge premiums,
    - Up to the 150% FPL level, Indiana charges $0 (like 34 other states)
    - At the 151-200% FPL level, Indiana charges premiums on a sliding scale (like 27 other states)
    - At the 201%-250% FPL level, Indiana charges higher premiums than the lower FPL group (like 18 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 (23 states do), non-preventive physician visits (23 states do), or inpatient hospital visits (16 states do).
- The required period of no insurance prior to enrolling (also known as the "going bare" period) is three months in Indiana. Thirteen states have no go bare period, 19 states are like Indiana with a go bare period of one to three months, and 18 states impose a go bare period greater than three months.
- Enrollment is continuous for 12 months, regardless of circumstance in 32 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

[6] 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) 2012, for every dollar spent on medical services in Indiana's CHIP, the state paid 23.13 cents and the federal government matched the remaining 76.87 cents. In the Medicaid program, the standard rate paid by the state is 33.04 cents and the federal government matched the remaining 66.96 cents.

Medical services other than pharmacy scripts and dental visits (and a few other minor services) in Indiana's CHIP are paid to 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 for Package A and Package C separately. 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 MCE 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.

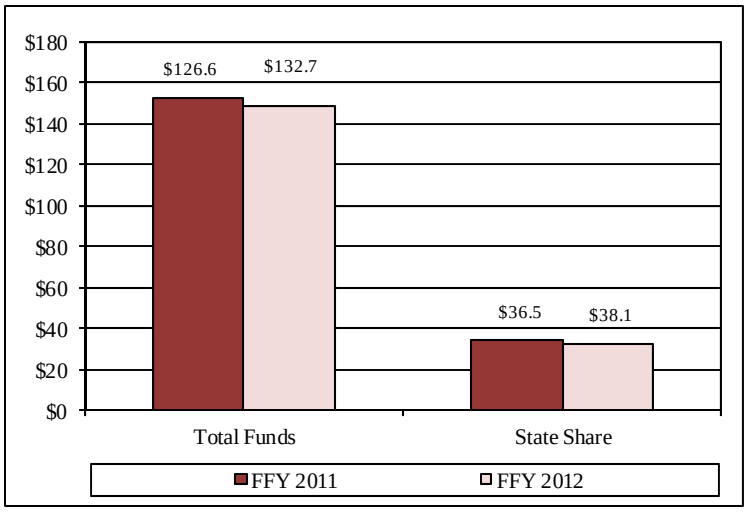
B&A examined expenditures made on behalf of CHIP members in FFYs 2011 and 2012.[7] Data was pulled from the OMPP data warehouse to collect the payments made either as a PMPM to the MCEs or as a fee-for-service payment (for pharmacy and dental services). The premiums paid by CHIP Package C families (where the premium is required) were obtained from the CMS-21 expenditure reports that the OMPP is required to submit quarterly to CMS.

Medical expenditures in the CHIP (total funds) increased 2.8 percent over the two-year period, from $152.5 million in FFY 2011 to $148.3 million in FFY 2012. The state share of these expenditures decreased 4.2 percent, from $34.1 million to $32.7 million. The state's portion decreased because the CHIP Package C portion of the program grew more than CHIP Package A and CHIP Package C is where the premium payments are required. Premiums paid by families in CHIP Package C were near $7.0 million in both FFYs 2011 and 2012. (Refer to Exhibit I.6 on the next page.)

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 2011 and 2012, expressed both in total funds and in state-only funds (net of 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 $29.42 to $28.92. (Refer to Exhibit I.6 on the next page.)

[7] The federal fiscal year runs from October 1 through September 30.

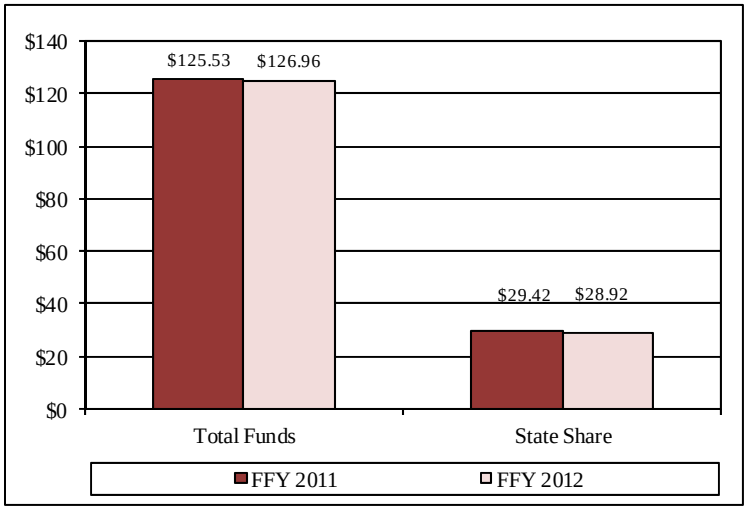
Exhibit I.6
Total Medical Expenditures in CHIP (in millions)
CHIP Package A and CHIP Package C Combined



Source: MedInsight, Indiana OMPP's data warehouse
Payments shown are based on experience period.

Note: Some claims payments may still come in for FFY 2012 which will increase total expenditures in this year.

Exhibit I.7
Trends in the Medical Cost Per Member Per Month (PMPM)
For the Premium Portion of CHIP (CHIP C)



Sources: Expenditures from MedInsight, Indiana OMPP's data wareho
Member months also from MedInsight (as of Feb 2013).

Premium payments from CMS-21 reports submitted by the State to CM

II

Enrollment Trends in Indiana's CHIP

Enrollment Trends at a Glance

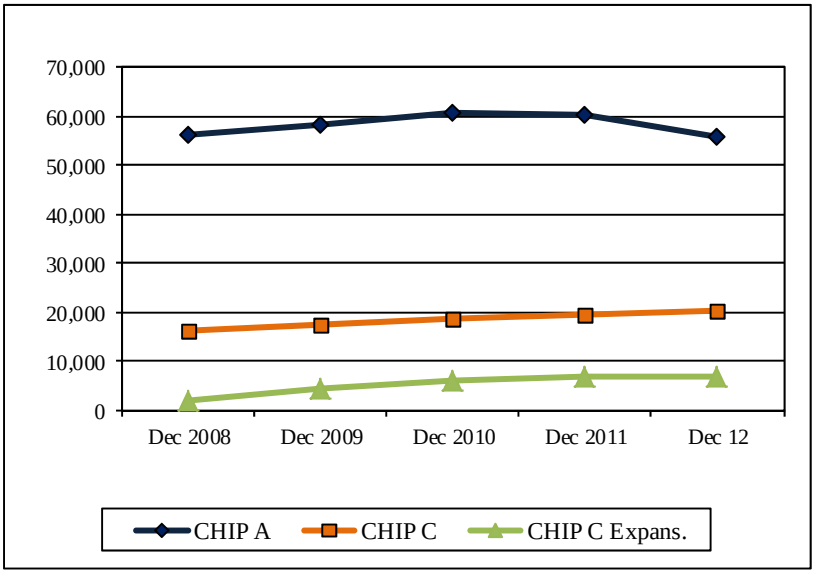
CHIP Enrollment Dec 2011: 86,400
CHIP Enrollment Dec 2012: 82,660

- -7.6% year-to-year growth rate in CHIP Package A
- 4.9% year-to-year growth rate in CHIP Package C
- -1.7% year-to-year growth rate in CHIP Package C Expansion

159,559 children were enrolled in Indiana's CHIP at some point in State Fiscal Year 2012

Indiana's Children's Health Insurance Program (CHIP) experienced a decrease in 2012 to 82,660 members from its all-time high enrollment at the end of Calendar Year (CY) 2011 of 86,400, a 4.3 percent decrease. Over the last four years, enrollment has grown 11.5 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 decreased 1.1 percent since December 2008. In CHIP Package C, the non-entitlement program for children in families with incomes 150%-200% of the FPL, enrollment has grown 27.5 percent during this four-year period. The CHIP C Expansion group instituted in October 2008 (201-250% of the FPL) saw enrollment decrease 1.7 percent in the last year.

Exhibit II.1
Recent Enrollment in Indiana's CHIP



Enrollment and Disenrollment Trends

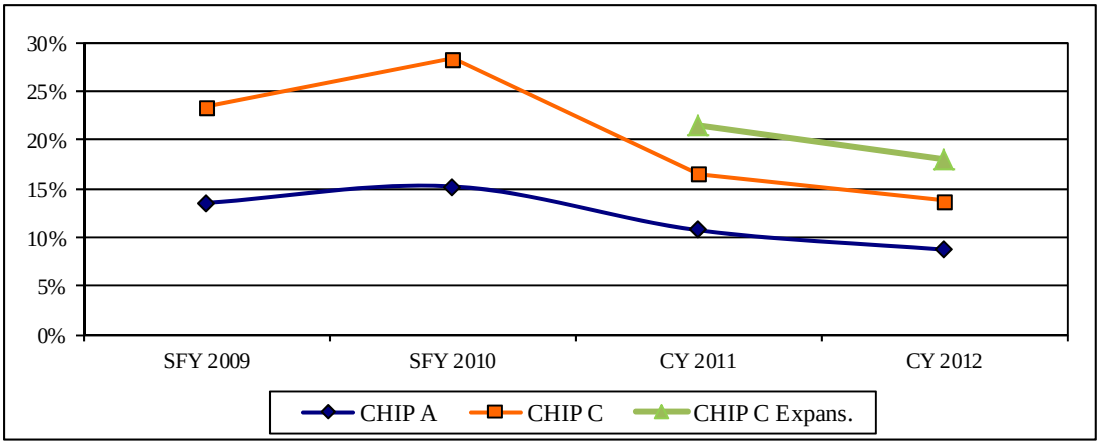
New enrollees continue to remain a large percentage of children in the program, but the proportion of total members that are new each year is decreasing. Burns & Associates, Inc. (B&A) analyzed the enrollment of members within each portion of Indiana's CHIP on a monthly basis. From this, we tabulated how many members in the month were new to the program within the previous 12 months. An average of this statistic was computed across months in CY 2012 and was then compared to a similar statistic for three prior time periods examined in previous reports.

For CHIP Package A, the percentage of new enrollees in CY 2012 on average was 8.7 percent per month, a decrease from 10.7 percent in CY 2011 and 15.2 percent during State Fiscal Year (SFY) 2010 (refer to Exhibit II.2 on the next page).

The percentage of members that were new to the program within CHIP Package C, however, was higher. For the original CHIP Package C program (members in families at 150% to 200% of FPL), 13.7 percent of members were new in CY 2012 as compared to 16.5 percent in CY 2011 and 28.3 percent in SFY 2010.

For the expansion portion of CHIP Package C (members in families at 151% to 200% FPL), 18.0 percent of members were new in CY 2012 and 21.5 percent were new in CY 2011 (the first time period analyzed since CHIP C expansion began in October 2008).

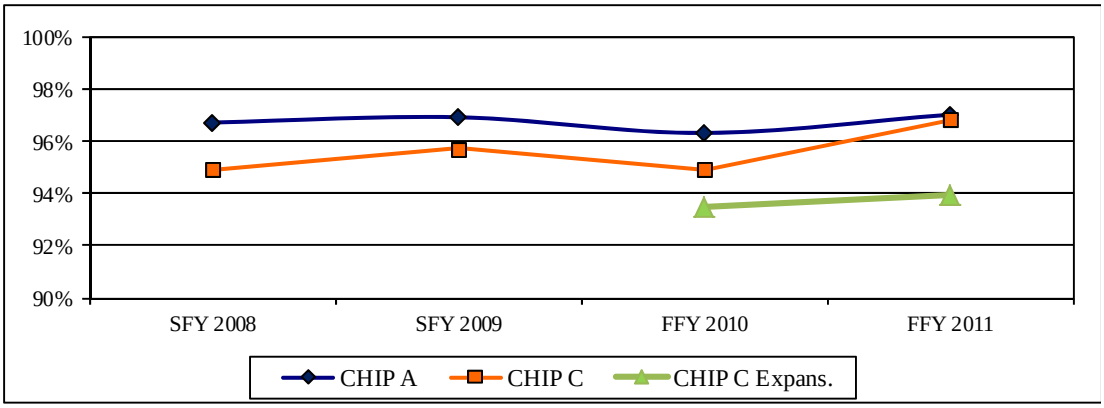
Exhibit II.2
Percent of Enrollees that were New to Program in Previous 12 Months, by Year



Source: MedInsight, Indiana OMPP's data warehouse

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) 2011. 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 97.0 percent for CHIP Package A members, 96.8 percent for CHIP Package C members and 93.9 percent for CHIP C Expansion members.[8] The retention rates have remained steady for CHIP Package A when compared to results reported in three prior periods (FFY 2010, SFY 2009 and SFY 2008). The retention rate has improved for CHIP Package C. For the CHIP Package C expansion population, the retention rate is slightly lower but remained steady over the two time periods examined (we did not break out CHIP C Expansion members in the previous time periods).

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

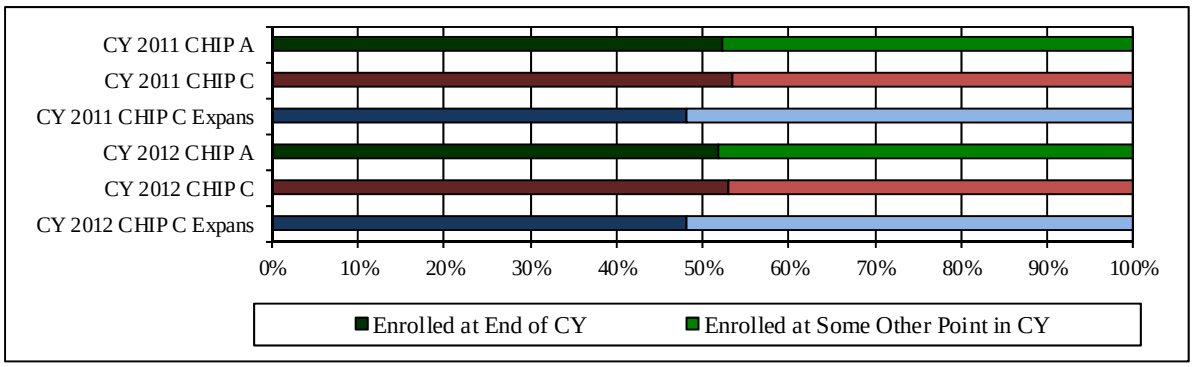


Source: MedInsight, Indiana OMPP's data warehouse. Excludes members who turned age 19 (no longer eligible) and those that disenrolled prior to the month when they would need to recertify.

[8] 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.

The number of children currently enrolled in the program slightly decreased from 2011 (to 82,660 from 86,400) and the number of children ever enrolled in the calendar year also slightly decreased (to 159,559 from 164,402). However, as was the case for the last three calendar years, there were 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 2012, there were 159,559 children enrolled in Indiana's CHIP at some point during the year—107,219 in CHIP Package A, 38,548 in original portion of CHIP Package C, and 13,792 in the CHIP Package C 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.

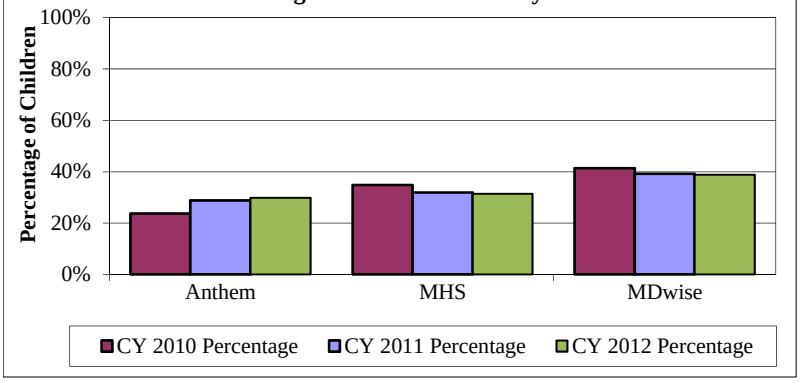
Exhibit II.4
Status of Children Ever Enrolled in CHIP, by Calendar Year



Source: MedInsight, Indiana OMPP's data warehouse

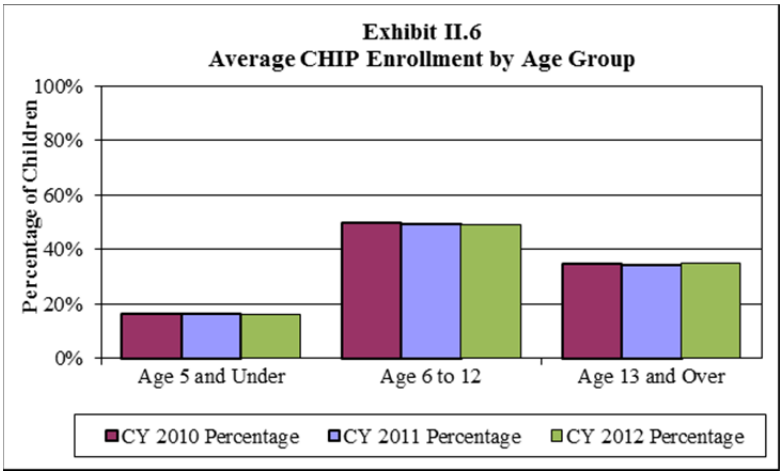
Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There was some movement in the MCE selected by CHIP members in 2012. Anthem increased its percent of all CHIP enrollees from 28.8 percent in CY 2011 to 29.8 percent in CY 2012. Managed Health Services decreased its CHIP membership share, from 31.9 percent of all CHIP enrollees in CY 2011 to 31.4 percent in CY 2012. MDwise also lost membership share among CHIP members, from its total of 39.3 percent in CY 2011 to 38.8 percent in CY 2012.

Exhibit II.5
Average CHIP Enrollment by MCE

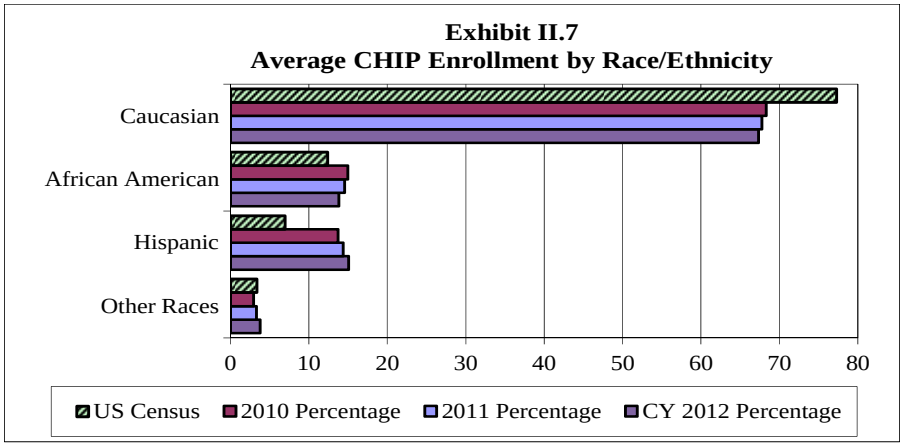


Demographic Profile of CHIP Members

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 fewer than 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.



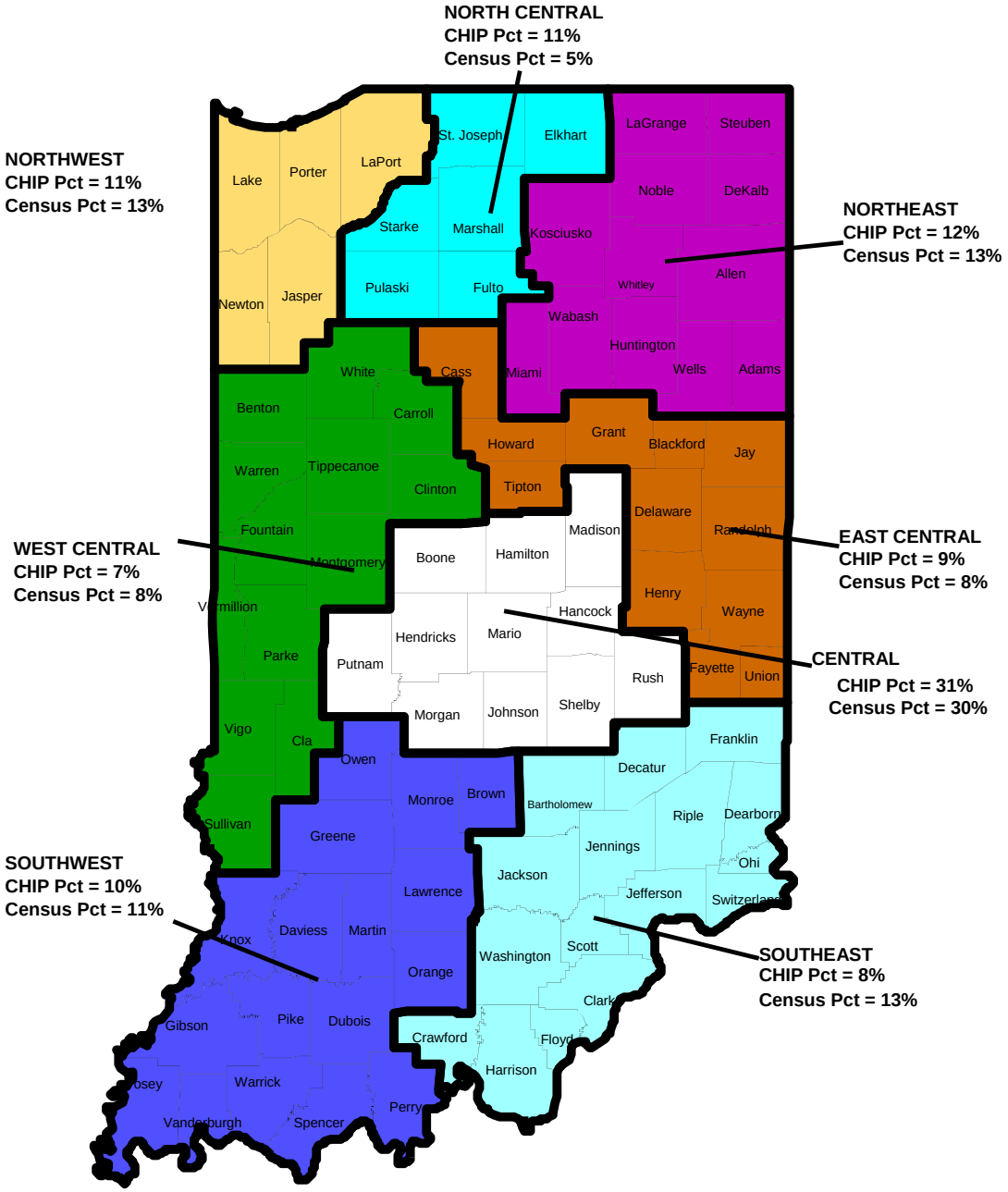
There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for children age 18 and younger. Compared to the U.S. Census estimate,[10] African-American children (13.8% of CHIP enrollees in CY 2012) and Hispanic children (15.1% of CHIP enrollees in CY 2012) are represented more in CHIP than in the statewide population. Between CY 2011 and CY 2012, the proportion of Caucasian CHIP members remained essentially the same (67.8 percent and 67.4 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, with the exception of the north central region (11% CHIP percentage and 5% census percentage) and the southeast region (8% CHIP percentage and 13% census percentage). The regions are defined by the OMPP. B&A compared CHIP members enrolled to the total child population in Indiana as of July 2012.

[10] U.S. Census Bureau, Current Population Survey, three year average for Indiana 2009-2011. http://www.census.gov/hhes/www/hlthins/hlthins.html

Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2012



III

Review of Access and Availability of Providers in Indiana's CHIP

Access Facts at a Glance

68% of CHIP members accessed primary care in FFY 2012:

- 63% visited a primary care doctor's office in their home county
- 22% visited a primary care doctor's office in a contiguous county

66% of CHIP members accessed preventive dental care in FFY 2012:

- 74% visited a dentist in their home county
- 19% visited a dentist in a contiguous county

The OMPP requires that Hoosier Healthwise members enrolled with its three managed care entities (MCEs) 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, a PMP is selected 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.[11] When he/she contracts with an MCE, 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 3,571 in September 2012.

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 MCE 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.

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 reviewed data compiled by OMPP's fiscal agent, HP, which measured pediatric panel capacity as of September 2012.[12] There was an average number of 174 members enrolled with each pediatric PMP in this month.

In September 2012, on average statewide the pediatric PMPs' panels were 31 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. Counties colored white (83 out of 92) are those where the PMP panel is less than 80 percent full. Nine counties are considered potentially at risk since their panel capacity among all providers in the county was more than 80 percent full, an improvement from our study last year when thirteen counties were more than 80 percent full. Counties colored orange (3) are those where the PMP panels are 80 to 89 percent full. Counties colored blue (3) are those where the PMP panels are 90 to 99 percent full. Three 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. Six of the nine counties also had panel sizes greater than 80 percent last year (Clinton, Decatur, Elkhart, Hancock, Hendricks and Shelby). Seven counties went below this threshold over the past year, but three counties (Hamilton, Pike and Whitley) were added to the list in 2012.

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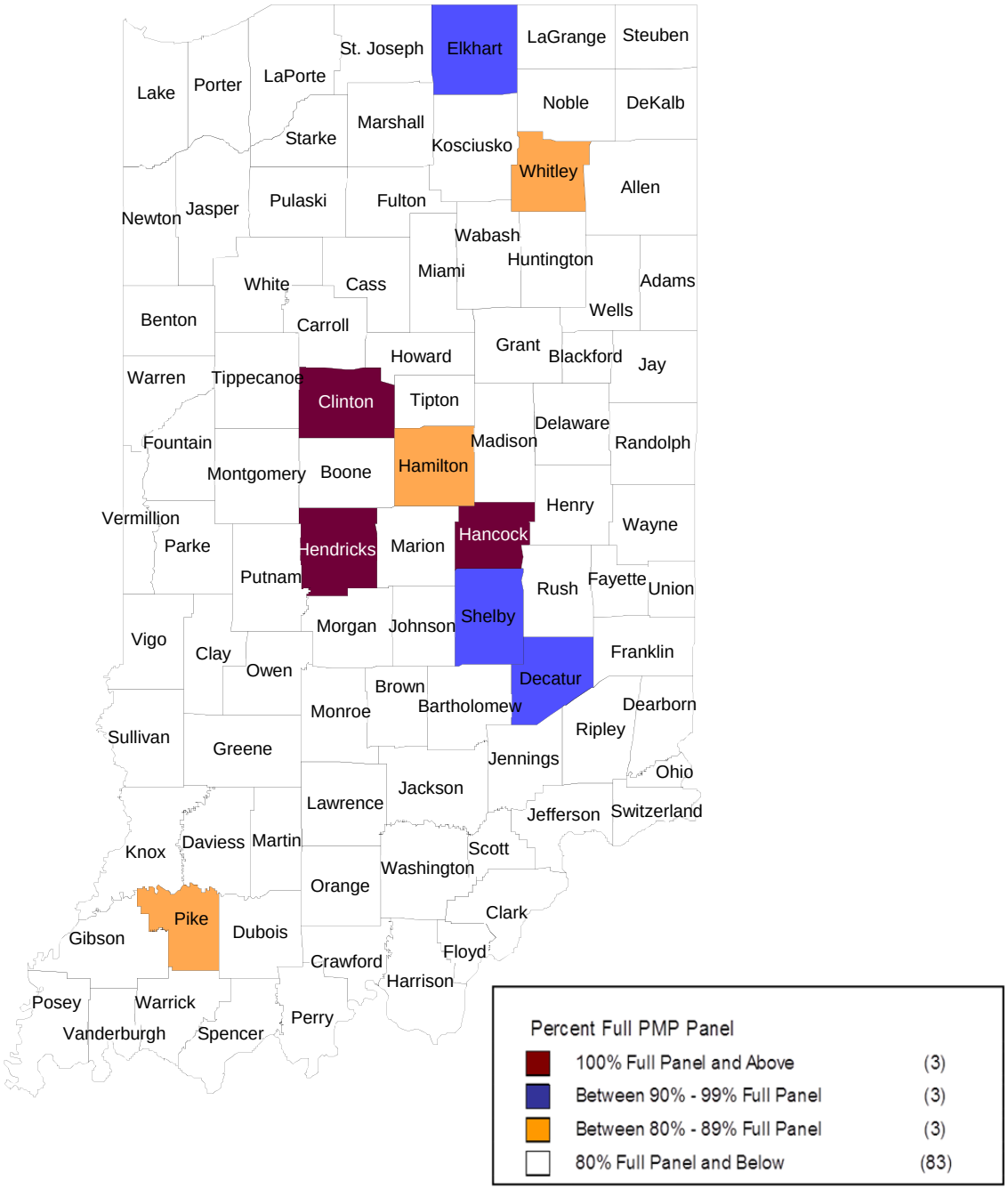
[11] OB/GYNs may, but are not obligated, to sign up as PMPs. They may also sign up as a specialist.

[12] 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.

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



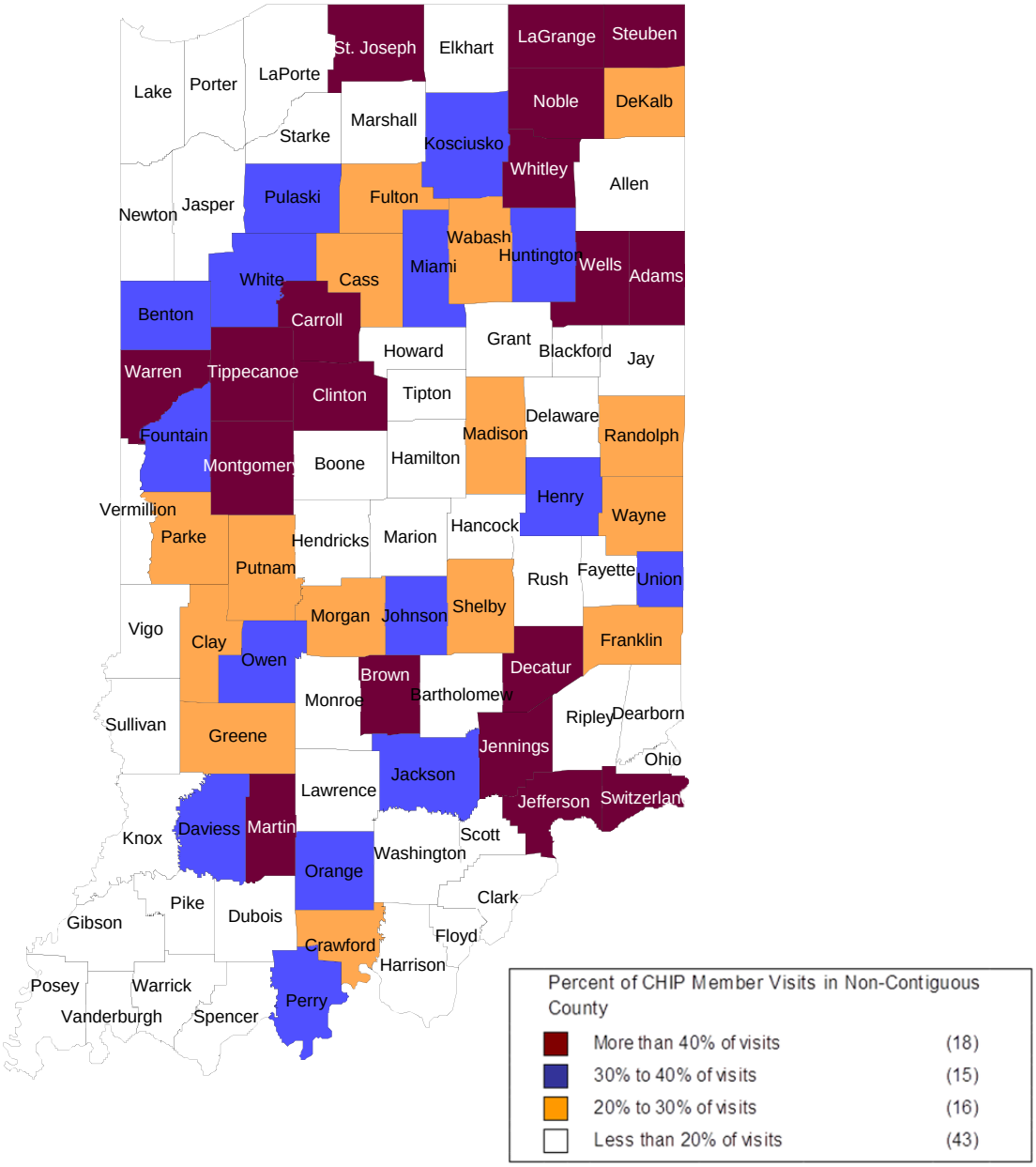
A county with a higher percentage of full panels, however, is not necessarily indicative of access problems. For example, a Hoosier Healthwise child may see a PMP in a county next to their home county since it is not a far distance to travel. Therefore, the panel capacity in their home county may or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

As another method to measure access, B&A used encounters submitted by the MCEs to examine member's actual visits to primary care physicians within their county of residence, in a contiguous county of their residence, or in a non-contiguous county. Unlike the HP report, the analysis shown here is specifically for the CHIP population.

B&A identified and analyzed when a child received a primary care service from an MCE PMP in a doctor's office during Federal Fiscal Year 2012 (51% of all children received this service). Primary care utilization was then examined at the county level.

Statewide, 63 percent of CHIP members received a primary care service in the county in which they live in FFY 2012. 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



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 eighteen counties where more than 40 percent of CHIP members' primary care visits were received in a county not contiguous to their home county: Adams, Brown, Carroll, Clinton, Decatur, Jefferson, Jennings, Lagrange, Martin, Montgomery, Noble, St. Joseph, Steuben, Switzerland, Tippecanoe, Warren, Wells and Whitley (refer back to Exhibit III.2). Of these, one county has a full panel (Clinton) and two counties are potentially at risk for full panels: Decatur has 94 percent of its panel full and Whitley has 83 percent of its panel full (refer back to Exhibit III.1).

Three of the nine counties with fuller panels (Exhibit III.1) also had more than 30 percent of their member's primary care visits to counties not contiguous to their home. When these are cross-referenced, only three counties appeared in both groups: Clinton, Decatur and Whitley counties. Both Clinton and Decatur counties were on this list last year but each has improved their pediatric panel percent full rate (Clinton went from 95% full panel to 48% full panel; Decatur went from 94% full panel to 52% full panel).

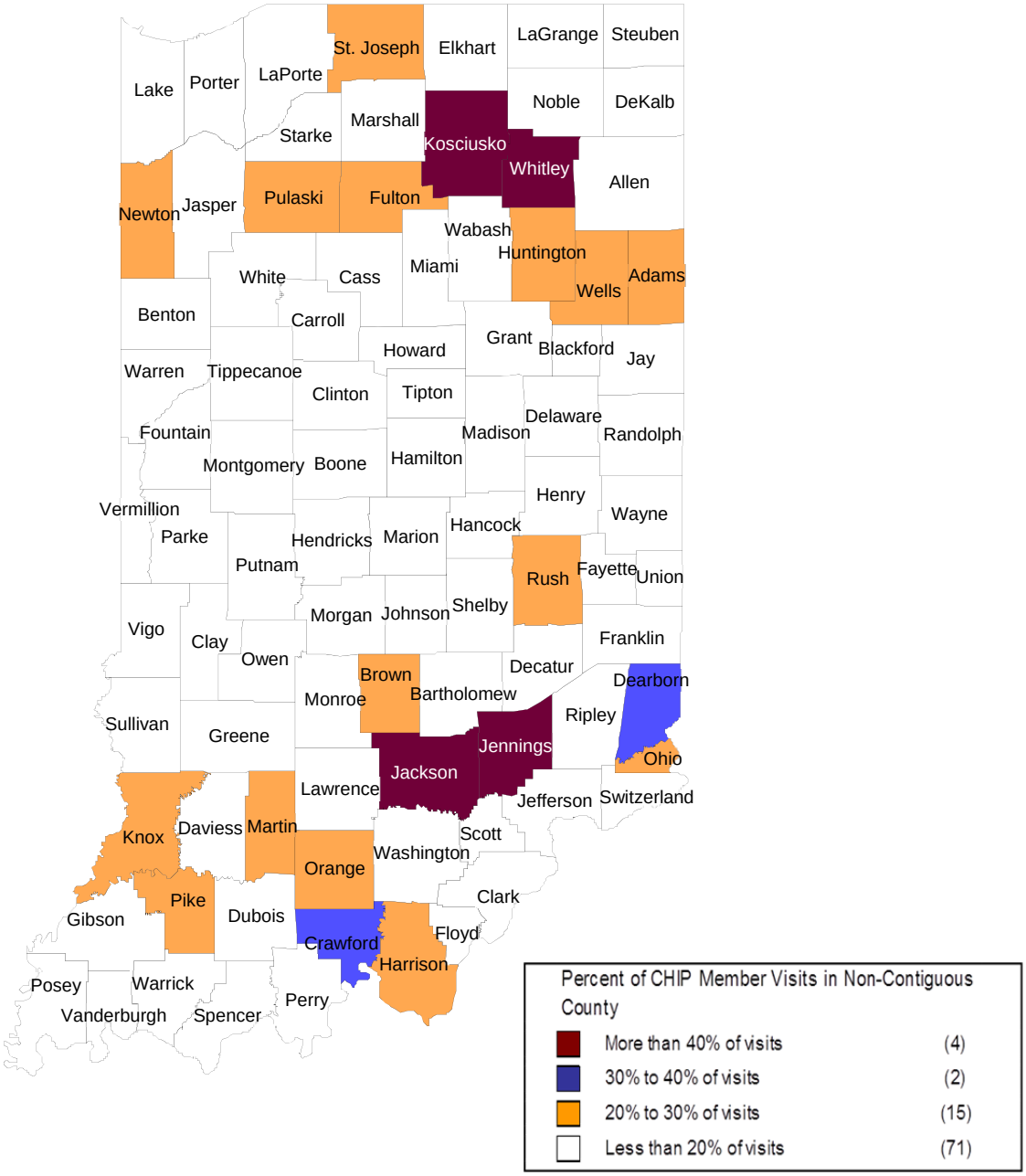
The data above suggests, therefore, that the counties with fuller pediatric panels tend to have CHIP members that can easily access pediatric services in a contiguous county. Further, counties with a higher rate of CHIP members accessing services in a non-contiguous county are not doing so due to lack of available providers in their own county. In summary, access to primary care does not appear to be an issue in Indiana's CHIP.

Access to Dentists

B&A conducted a similar analysis of where CHIP members access services for dental providers. Overall, it was found that 66 percent of CHIP members had a preventive dental visit in FFY 2012. 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.

Statewide, access to dentists is high since 74 percent of CHIP members had their preventive dental visit in their home county and an additional 19 percent had their visit in a contiguous county. This is unchanged from last year's study. Exhibit III.3 shows the 21 counties where the percentage of visits received in non-contiguous counties from the member's home county exceeded 20 percent. Four counties (Jackson, Jennings, Kosciusko and Whitley) are greater than 40 percent.

Exhibit III.3
Volume of CHIP Members Receiving Preventive Dental Visits in a County Not Contiguous to their Residing County



IV

Service Use Patterns among Populations in Indiana's CHIP

Utilization Facts at a Glance

For CHIP members who were enrolled in Federal Fiscal Year 2012:

- 68% had a primary care visit
- 27% had an emergency room visit
- 66% had a preventive dental visit
- 71% obtained a prescription

These are consistent trends during the past three years.

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, 2011 and 2012 across populations within the CHIP by CHIP program, by age, by managed care entity (MCE) and by race/ethnicity.

Data used in this analysis was retrieved by B&A from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2012. The majority of the services examined are paid for by the MCEs 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 MCEs to submit encounters to the OMPP. That being said, the findings for FFY 2012 may still be incomplete if the MCEs 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, 2011 or 2012. 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 MCE, 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.

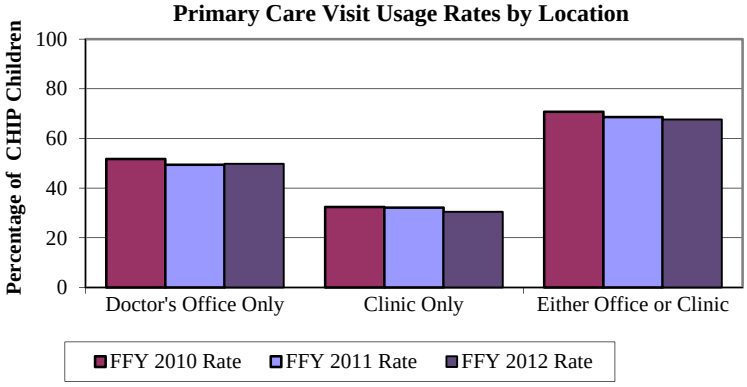
On the other hand, the *utilization per 1,000 member rate* includes every CHIP member enrolled in the month being examined. It can also be helpful to measure the utilization per 1,000 rate across different populations (e.g., by age or by race/ethnicity) in a way that is an apples-to-apples comparison 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.[13]

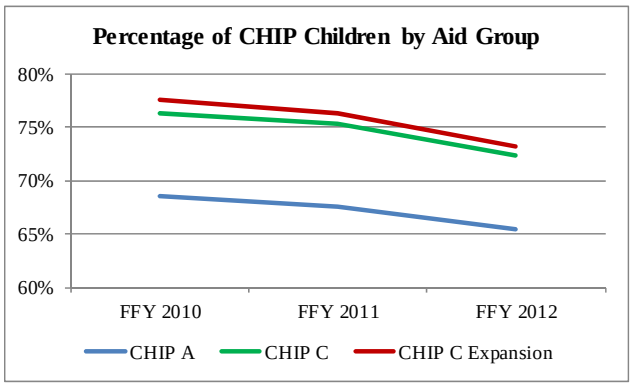
On a statewide level, B&A found that 67.6 percent of CHIP children in the study sample had a primary care visit (either in a doctor's office or a clinic) in FFY 2012. This is a decrease from FFY 2010 and FFY 2011 when 70.7 and 68.6 percent of CHIP children had primary care visits, respectively.

Exhibit IV.1
Primary Care Visit Usage Rates by Location



[13] 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.

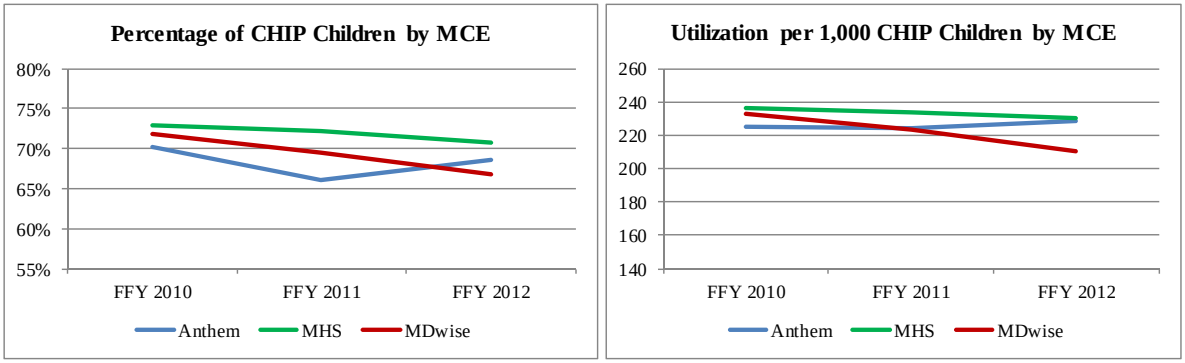
Exhibit IV.2
Primary Care Visit Usage (Office or Clinic) by Aid Group



The percent of children that had a primary care visit (either office or clinic setting) has decreased over the past three years for all CHIP Aid Groups. As stated previously, the reduction shown here may be due, in fact, to claims not being fully submitted to OMPP for the FFY 2012 time period. The percentage of CHIP Package A children that had a primary care visit in FFY 2012 was lower (65%) than CHIP Package C (72%) and CHIP Package C Expansion (73%) children, which have similar rates of primary care visits (refer to Exhibit IV.2)

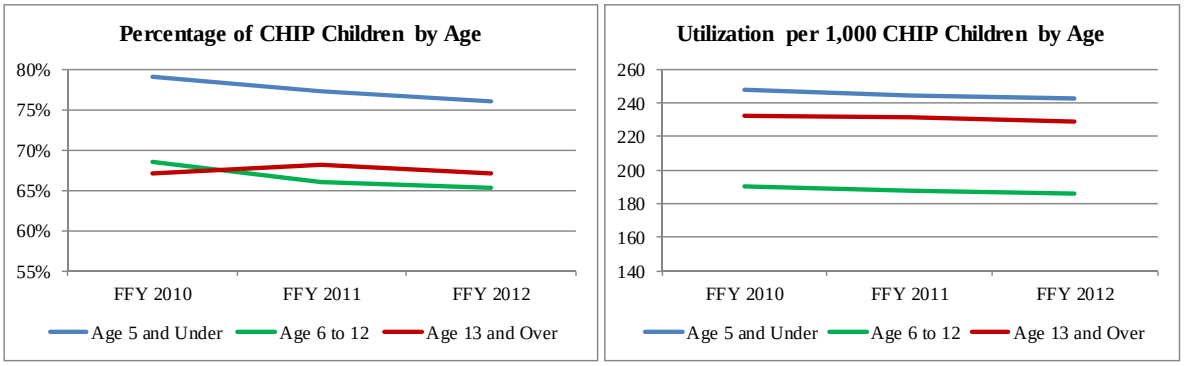
The percent of children that had a primary care visit (either office or clinic setting) has decreased over the past two years for two MCEs (MDwise and MHS), while the other MCE (Anthem) saw a decrease from 2010 to 2011 but an increase from 2011 to 2012. All three MCEs rates are within five points of one another. When utilization is measured on individual claims per 1,000 CHIP members, the same trend was apparent with MDwise and MHS decreasing from 2010 to 2012 while Anthem slightly decreased from 2010 to 2011 but increased from 2011 to 2012. However, utilization is still similar between MCEs with a low of 211 visits per 1,000 members to a high of 230 visits per 1,000 members (refer to Exhibit IV.3 below). Said another way, between 2.11 and 2.30 children out of 10 CHIP members that were enrolled with an MCE had a primary care visit each month.

Exhibit IV.3
Primary Care Visit Usage (Office or Clinic) by MCE



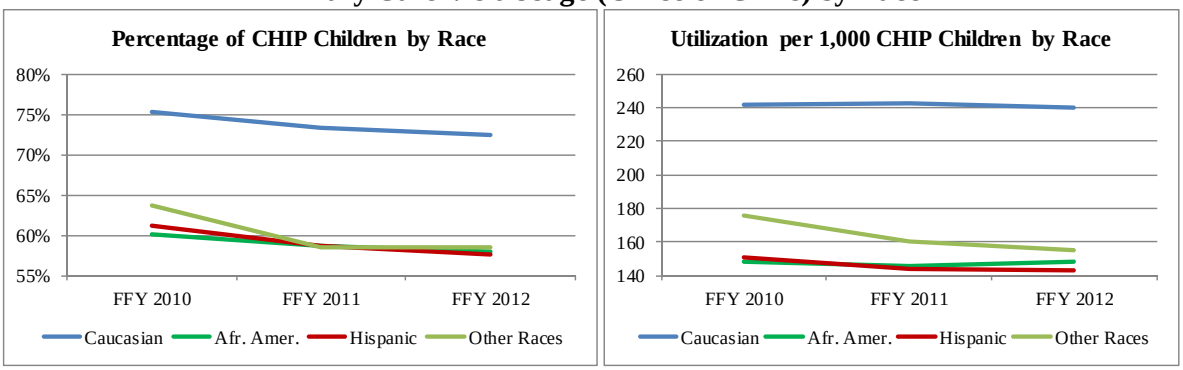
Primary care visits remain more prevalent among younger members, as 76 percent of children age five and younger had a visit in FFY 2012. The percentages of children in the older age groups that had a primary care visit were lower (65% for age 6-12 and 67% for age 13-18 in FFY 2012). Although the primary 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. Children in the age 0 to 5 group had a primary care visit utilization rate similar to the age 13 to 18 group. Both of these trends have remained consistent over the past three years (refer to Exhibit IV.4 on the following page).

Exhibit IV.4
Primary Care Visit Usage (Office or Clinic) by Age



The percent of children that had a primary care visit within each race/ethnicity examined has seen a slight decline over the past three years. When comparing the rates across races/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other races/ethnicities. For Caucasian children, the usage rate was 72 percent in FFY 2012; for other races/ethnicities, it was 58 percent. The utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the years studied, the median rate per 1,000 Caucasian children was 242, whereas the median rate was 148 and 144 among African American and Hispanic children respectively (refer to Exhibit IV.5 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.

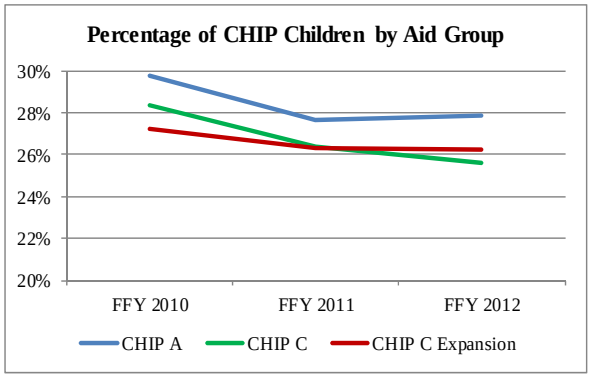
Exhibit IV.5
Primary Care Visit Usage (Office or Clinic) by Race



Emergency Room Visits

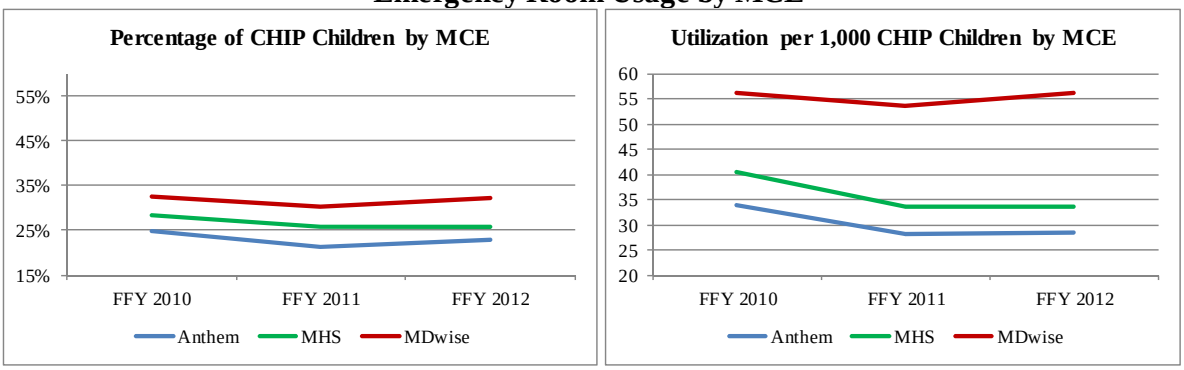
The rate of Emergency Room visits by CHIP Children in all Aid Groups has decreased over the past three years (refer to Exhibit IV.6). From FFY 2011 to FFY 2012 the rate of Emergency Room visits for all CHIP children varied by less than one percent. CHIP Package A children had a slightly higher rate (28 percent) of Emergency Room visits in FFY 2012 than CHIP Package C and CHIP Package C Expansion children (26 percent each).

Exhibit IV.6
Emergency Room Usage by Aid Group



There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCE. In the last three years, MDwise members had more ER visits (32% in 2012) than either Anthem (23%) or MHS (26%). The difference between MCEs is even more pronounced when measured in emergency room visits per 1,000 CHIP members. Over the past three years, MDwise members consistently had more ER visits per 1,000 than Anthem or MHS. From 2011 to 2012, Anthem and MHS remained steady (28 per 1,000 and 34 per 1,000 respectively) while MDwise increased to 56 per 1,000 (refer to Exhibit IV.5 below).

Exhibit IV.7
Emergency Room Usage by MCE



The large majority of children (82%) who used the ER during FFY 2012 had one or two visits during the year. As shown in Exhibit IV.6, MHS and Anthem had a similar rate of children who used the ER more than two times during the study year (17% and 18% respectively). MDwise had a higher rate than the other two MCEs at 22 percent.

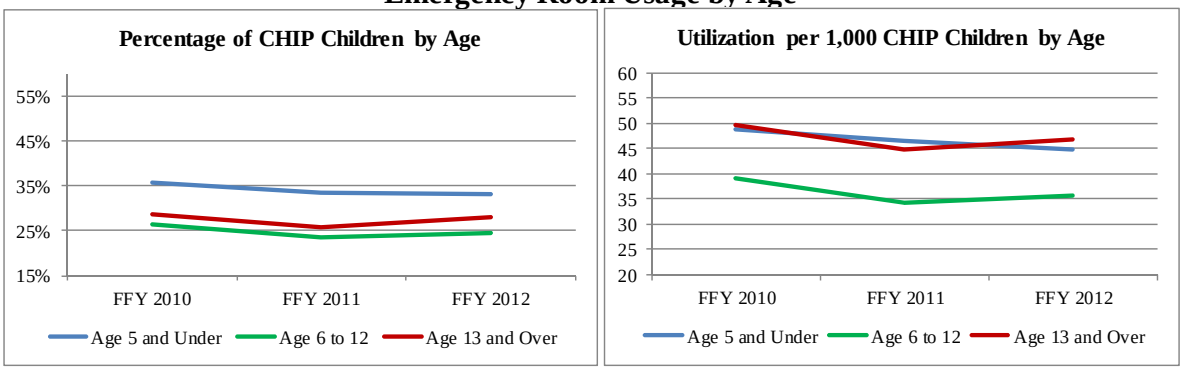
Exhibit IV.8
Rate of ER Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2011 - Sept 30, 2012

	Percentage of All ER Visits by MCO			
Number of ER Visits per Member	**Anthem**	**MHS**	**MDWise**	**Total**
1 to 2	82.2%	83.3%	78.5%	81.7%
3 to 5	14.8%	14.1%	16.9%	14.7%
6 to 10	2.6%	2.0%	3.5%	2.7%
11 to 20	0.5%	0.5%	0.8%	0.6%
More than 20	0.0%	0.1%	0.4%	0.3%

Source: MedInsight, OMPP's data warehouse

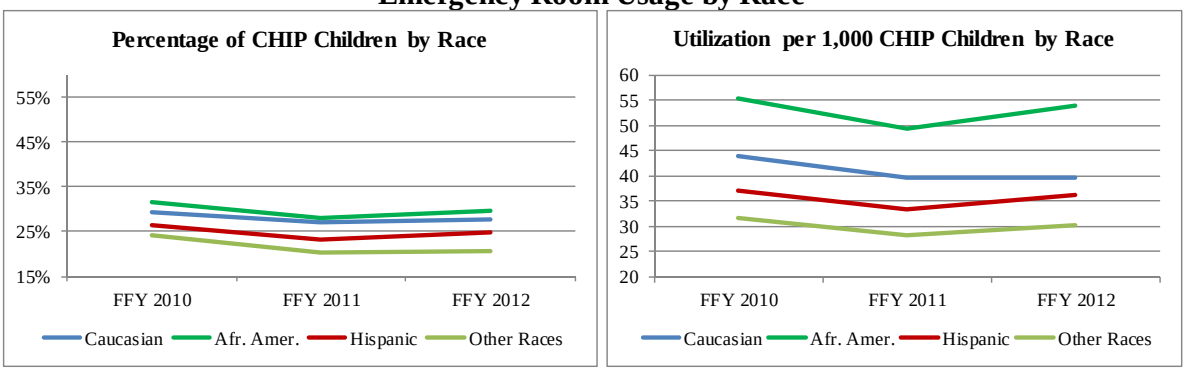
Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (33% of all members in FFY 2012) and lowest among children age 6 to 12 (25% of all members in FFY 2012). ER usage has remained steady for all age groups over the past three years. Although the 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.7 on the following page). The rate was 45 per 1,000 members on average for age 0 to 5 and 47 per 1,000 for 13 to 18 year olds in 2012. The rate was lower for children age 6 to 12 (37 visits per 1,000 on average).

Exhibit IV.9
Emergency Room Usage by Age



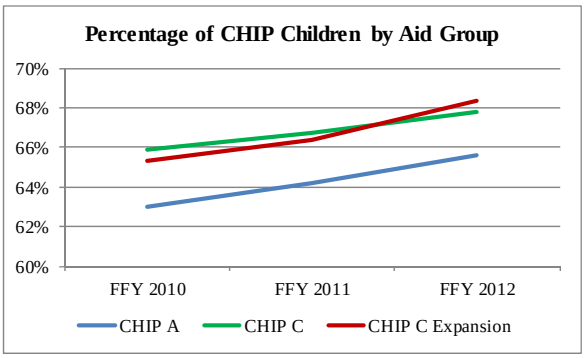
The percent of children that had an Emergency Room visit within each race/ethnicity examined saw a slight decline from 2010 to 2011, but a slight increase from 2011 to 2012. When comparing the rates across races/ethnicities over the past three years, African American children had more Emergency Room visits (30%), follow by Caucasian children (28%), Hispanic children (25%), and children of all other races/ethnicities (21%). Across the years studied, the median rate per 1,000 of African American children was 54, whereas the median rate was 40 and 36 among Caucasian and Hispanic children respectively (refer to Exhibit IV.10 below). The utilization rate for children in other race/ethnicities was slightly lower at a median rate of 30 visits per 1,000 CHIP children.

Exhibit IV.10
Emergency Room Usage by Race



Preventive Dental Visits

Exhibit IV.11
Preventive Dental Care Usage by Aid Group

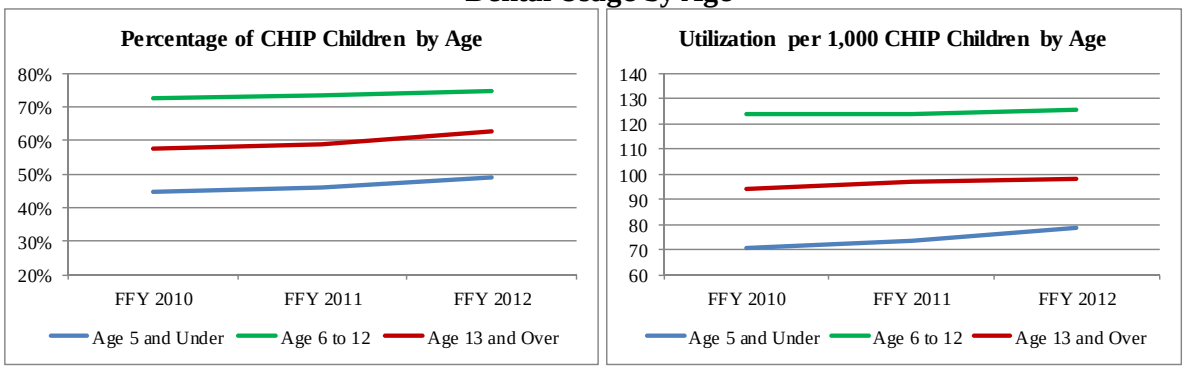


The rate of preventive dental care has increased for CHIP children in all Aid Groups over the past three years (refer to Exhibit IV.11). The percentage of CHIP Package A children (66 percent in FFY 2012) that had a preventive dental care visit remains slightly below CHIP Package C and CHIP Package C Expansion children (68 percent each in FFY 2012).

The overall percentage of CHIP members receiving a preventive dental visit at some time in the year was 66 percent in FFY 2012. This is an increase from 58 percent in FFY 2008. Dental care is one of the few services that the MCEs 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. Over the past three years the rate of dental visits has steadily increased for all ages, though children age 6 to 12 are most likely to have received a preventive dental visit (79% of the members in FFY 2012), which is significantly higher than teenagers (63%). The youngest children had the lowest usage rate (49%) given that this group includes toddlers.

A similar pattern was found by age group when measuring the utilization rate of dental visits per 1,000 CHIP members. The rate of 126 visits per 1,000 members age 6 to 12 is 25 percent higher than the rate for children age 13 to 18 and 46 percent higher than the rate for children age 0 to 5. The number of visits per 1,000 CHIP members has steadily increased over the past three years, but the largest increase was seen with members age 0 to 5 years (refer to Exhibit IV.12 below).

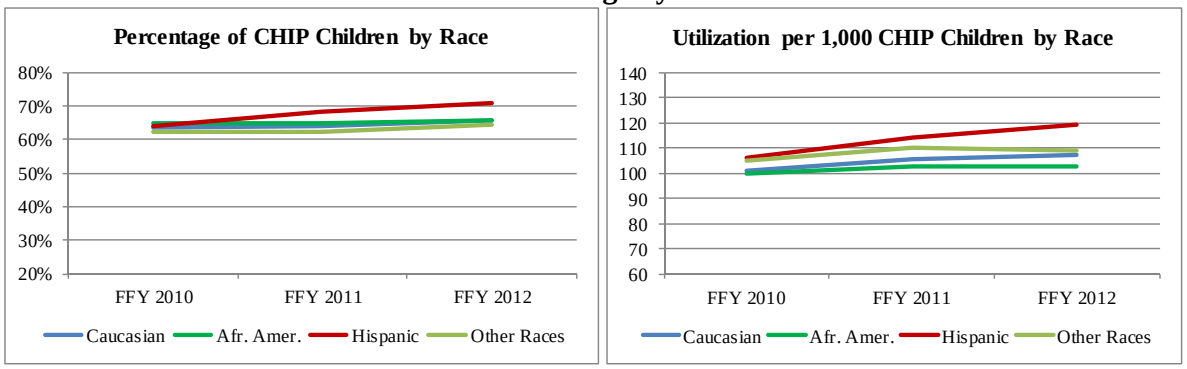
Exhibit IV.12
Dental Usage by Age



The preventive dental usage rate has steadily increased over the past three years with 66 percent for all race/ethnicities in FFY 2012. There is little difference from the statewide average in the usage rate among the race/ethnicities, though the rate for Hispanic children has increased more than the other races/ethnicities with 71 percent receiving a preventive dental visit in FFY 2012.

The utilization rate per 1,000 CHIP members is also similar among race/ethnicities at approximately 109 visits per 1,000 members in FFY 2012 (refer to Exhibit IV.13 below).

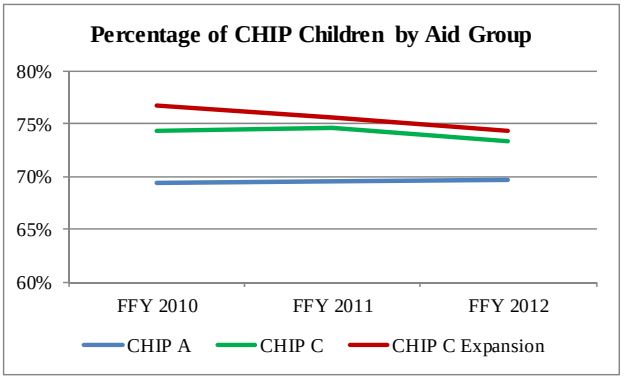
Exhibit IV.13
Dental Usage by Race



Pharmacy Prescriptions

The rate of pharmacy usage for CHIP Package A children has remained constant over the past three years at 70 percent. The rate of pharmacy usage for CHIP Package C children decreased from 74 percent in FFY 2010 to 73 percent in FFY 2012. The rate of pharmacy usage for CHIP Package C Expansion children decreased from 77 percent in FFY 2010 to 74 percent in FFY 2012. (Refer to Exhibit IV.14)

Exhibit IV.14
Pharmacy Usage by Aid Group

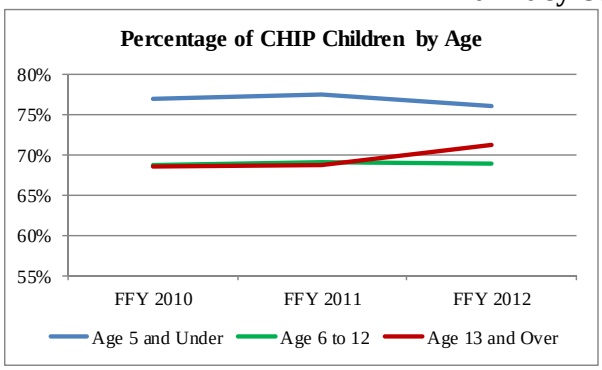


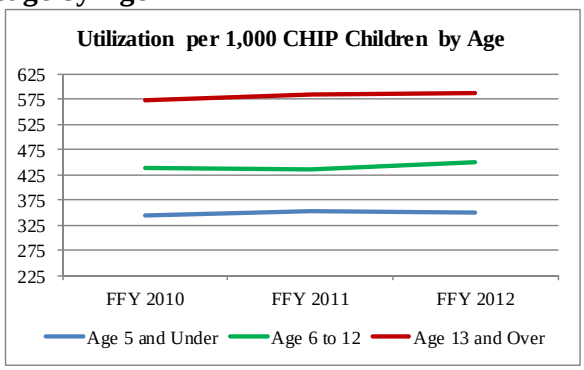
In CY 2010, the administration of the pharmacy benefit was taken back by the State and is no longer included in the capitation payment paid to the managed care organizations. Across all members enrolled at least nine months of the year, the percentage of members that had a prescription filled has remained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

There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children age five and younger over the last three years (76% in 2012). Children in the older age groups were both similar at 69 and 71 percent (6 to 12 years and 13 to 18 years respectively) in FFY 2012.

Though a lower percentage of teenagers obtained a prescription than children in younger age groups, 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.15 on the following page. The utilization rate for children age 13 to 18 was 587 per 1,000 on average for 2012, followed by children age 6 to 12 (448 per 1,000), then by children age 0 to 5 (348 per 1,000).

Exhibit IV.15
Pharmacy Usage by Age





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 2012 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 12 percent of scripts were for hormones. (Refer to Exhibit IV.16 on the next page)

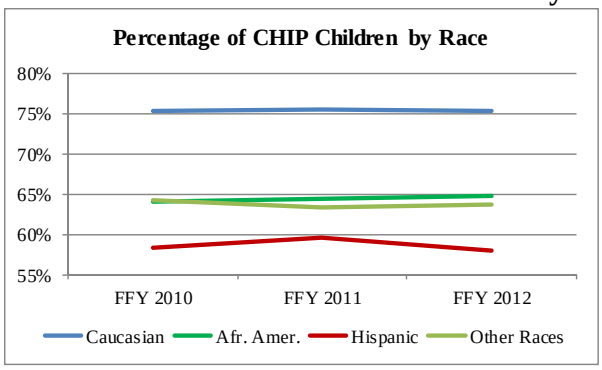
Exhibit IV.16
Highest Volume Pharmacy Scripts Received in Federal Fiscal Year 2012
By Age Group and by Program

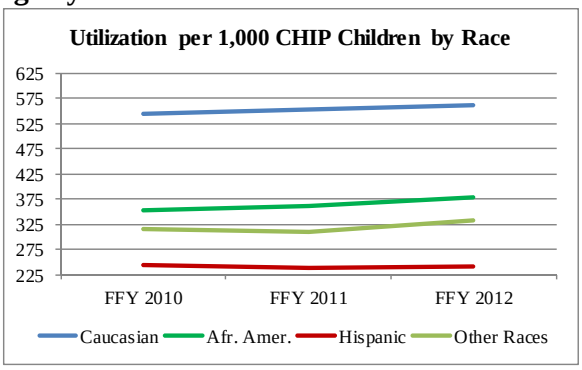
Therapeutic Class	Age 1-5			Age 6-12			Age 13-18		
	CHIP A	CHIP C	CHIP C Expansion	CHIP A	CHIP C	CHIP C Expansion	CHIP A	CHIP C	CHIP C Expansion
	Percentage of All Prescriptions in the Age Group								
Autonomic drugs	7.3%	7.2%	7.1%	7.3%	6.7%	6.7%	6.1%	5.4%	5.7%
Benzodiazepine antagonists, Central nervous system drugs	9.7%	7.7%	7.4%	33.7%	32.8%	32.6%	37.2%	38.7%	36.9%
Electrolytic, caloric and water balance	10.5%	9.5%	8.2%	9.5%	8.4%	7.6%	6.9%	5.6%	5.9%
Expectorants and cough preparations	4.9%	5.1%	5.3%	5.2%	5.0%	6.1%	2.9%	2.7%	3.2%
Ointments Solutions Suspensions, ophthalmic Otic nasal, Ophthalmic	7.5%	8.4%	8.2%	6.3%	6.0%	6.8%	4.1%	4.1%	3.8%
Gastrointestinal	4.6%	4.7%	4.4%	3.6%	4.0%	3.3%	4.7%	4.2%	4.7%
Hormones	9.3%	9.8%	10.1%	8.2%	9.3%	9.6%	11.7%	12.3%	13.4%
Antiprotozoals, Antileprotic, Anti-infective	33.0%	36.7%	37.4%	15.4%	17.7%	17.3%	14.6%	16.2%	15.4%
Antiperspirants, Topical preparations, Skin and mucous membrane preparations	9.9%	9.0%	9.5%	5.8%	5.1%	5.3%	6.9%	6.6%	6.9%
All Others	3.2%	2.0%	2.3%	4.9%	4.8%	4.7%	4.9%	4.2%	4.0%

The percentage of children with a prescription has remained steady for each race/ethnicity group studied for the last three years. Comparing across race/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities. In 2012, the usage rate among Caucasians was 75 percent but it was 65 percent for African American children, 58 percent for Hispanic children, and 64 percent for children of other races/ethnicities. This has been a consistent finding in the CHIP for the last five years.

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. Caucasian children have a utilization rate of 561 scripts per 1,000 members each month, which is 49 percent higher than the rate for African-American children (377 scripts per 1,000) and more than double the rate for Hispanic children (241 scripts per 1,000 children). It is 69 percent higher than the rate of children of other race/ethnicities (332 scripts per 1,000 children). Refer to Exhibit IV.17 on the next page.

Exhibit IV.17
Pharmacy Usage by Race





V

Measuring Quality and Outcomes in Indiana's CHIP

HEDIS and CAHPS Survey Results at a Glance

2012 HEDIS Survey

- All three MCEs exceeded the 90th percentile for Access to Primary Care
- All three MCEs have had a marked increase in Well Care visits over the last five years
- All three MCEs remain below the 90th percentile for Respiratory Care for Children measures

2012 CAHPS Survey

- All three MCEs are above the national average for Rating of Health Plan, Getting Needed Care and Getting Care Quickly

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 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[14] to conduct an annual external quality review of each MCE and reviews the results with each MCE.

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 MCEs to report the results of HEDIS®[15] and CAHPS®[16] 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 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 survey is separated between one for adults and one for parents of children. The OMPP requires the MCEs 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.

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.

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[14] Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.
[15] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).
[16] 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 from the prior year. Therefore, in calendar year (CY) 2012, tabulations were collected on HEDIS rates for 2011 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.

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 IV) 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.

Exhibit V.1 on the following page shows the five year trend reported for each MCE for four age groups (Anthem 2008 data not reported for all measures until 2009). Every MCE has had a stable or an increasing trend for access over time, with the exception of MDwise which has trended slightly down in the 12 to 24 month category; however, MDwise's rate has remained at least as high as the other MCEs. When reviewed by MCE, the pattern was the same for each age group. The OMPP target rate for each measure shown below is the 90th percentile among all Medicaid MCEs nationally. For HEDIS 2012, these rates were as follows for access to primary care practitioners:

- Age 12 to 24 months: 93.4%
- Age 25 months to 6 years: 92.6%
- Age 7 to 11 years: 94.5%
- Age 12 to 19 years: 93.0%

All three Indiana MCEs exceeded the OMPP target for access to primary care for age 12 to 24 months. For the other ages groups, MDwise was closest to the OMPP target, followed by MHS and Anthem.

Summary of Results from HEDIS Access to Primary Care Measures (Percentage of Total)

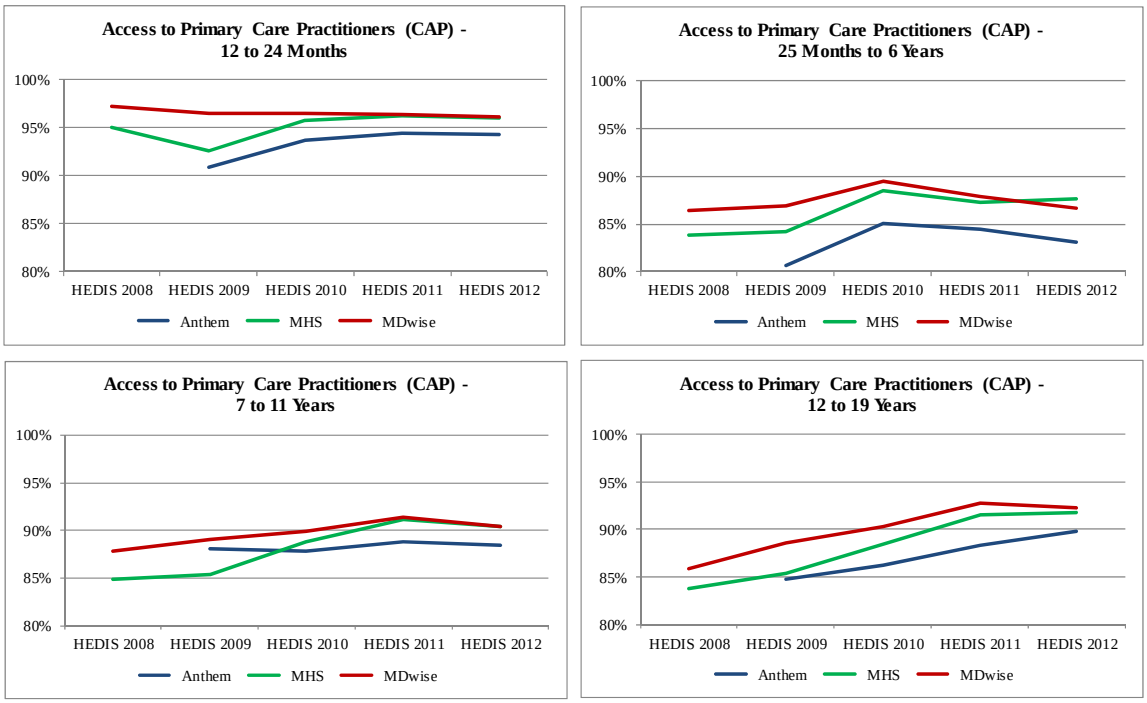


Exhibit V.2 on the next page shows the five year trend for well care visits for each MCE (Anthem 2008 data not reported for all measures until 2009). The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life, the rate shown represents the percentage 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.

Every MCE has had a marked increase related to well child visits over time. MDwise's rate is closest to the OMPP target.

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)
- Three doses of influenza (HiB)
- Three doses of Hepatitis B
- One dose of chicken pox (VZV)
- Four doses of pneumococcal conjugate vaccine to prevent bacterial meningitis

All three MCEs have remained stable over the past four years, with the exception of Anthem. Anthem's rate declined in 2010, but has returned to a rate consistent with the other MCEs in 2012. MDwise's rate is closest to the OMPP target.

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

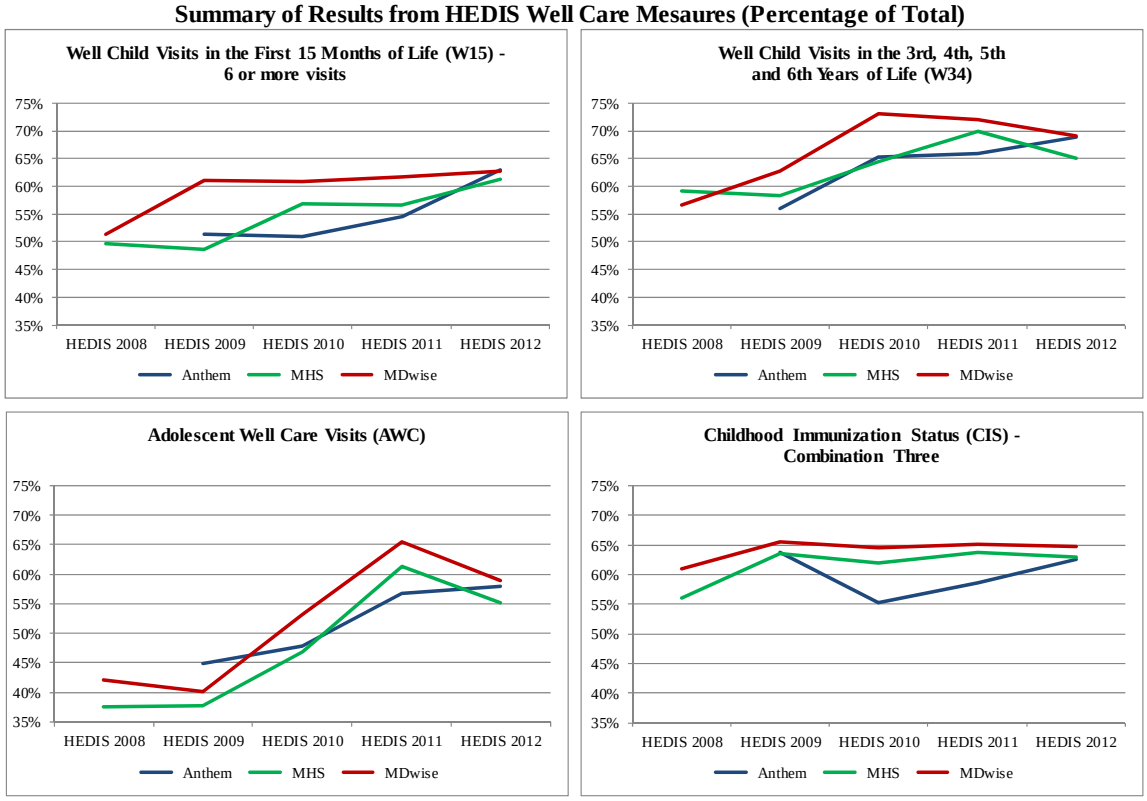


Exhibit V.3 on the following page presents the results from HEDIS measures related to respiratory care for children. The upper two boxes present results related to measuring proper treatment while the lower two boxes present results of appropriate medications for children with asthma.

For appropriate testing of children with pharyngitis (sore throat), all three plans have had a slight increasing trend (see upper left box). Anthem showed a significant 24 percentage point increase between 2010 and 2011, but decreased in 2012 while remaining above the other MCEs. For this measure, a higher rating is more favorable since it indicates better testing.

The MCEs reported results for 2011 that were slightly below their 2010 results for appropriate treatment for children with upper respiratory infection; however, the rates returned to 2010 levels in 2012. 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 MCEs 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. All three MCEs remain stable near 90 percent. The national 90th percentile rate for HEDIS 2012 was 95.4 percent. In the lower right box, the rate is measured for children age 12 to 18 years. All three MCEs are further from the OMPP goal for this age group remaining near 85 percent. The national 90th percentile rate for HEDIS 2012 was 92.3 percent.

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

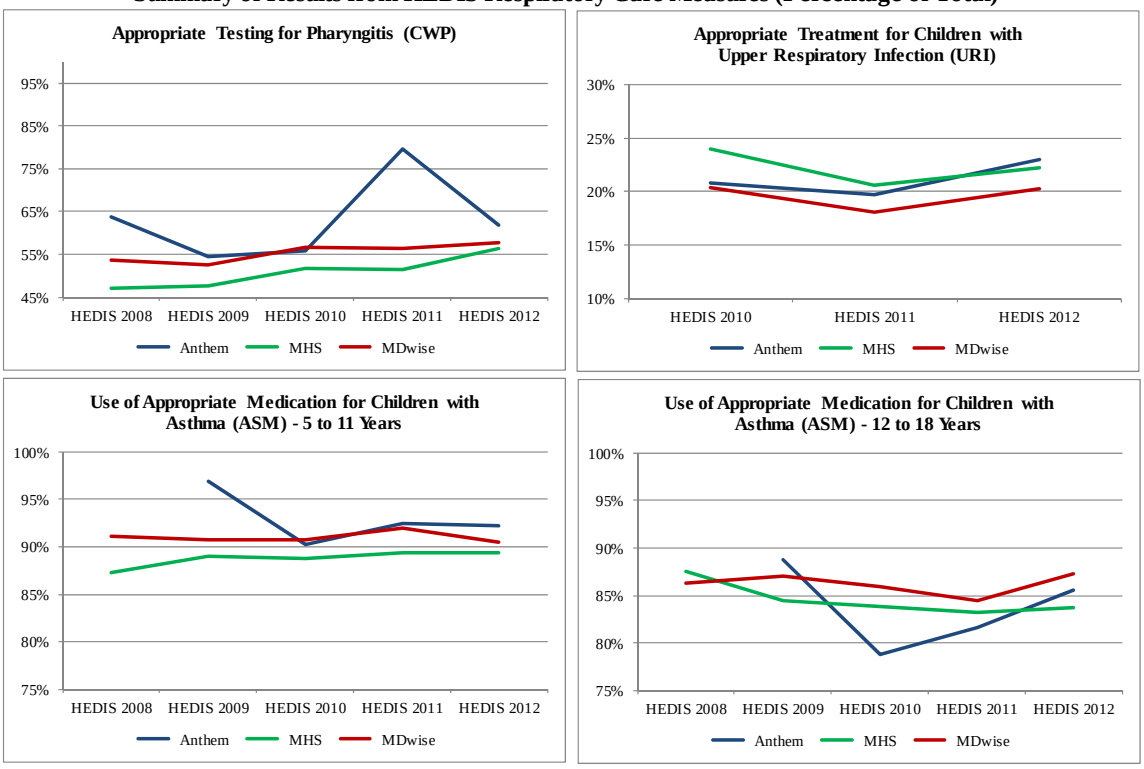
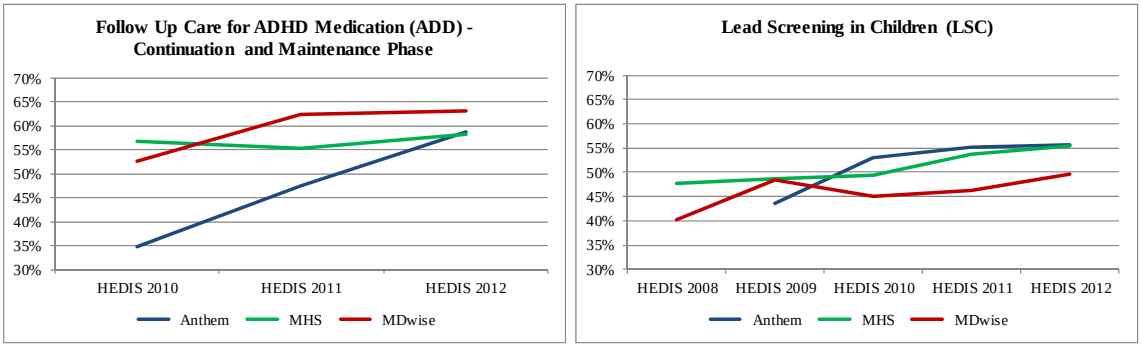


Exhibit V.4 below presents the results of two other HEDIS measures related to children. One measures the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period, one of which was within 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. In 2012, all three plans were near the national 90th percentile target of 63.1 percent.

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. All three plans have shown an increasing trend over time, with Anthem at 56 percent, MHS at 55 percent and MDwise at 50 percent.

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



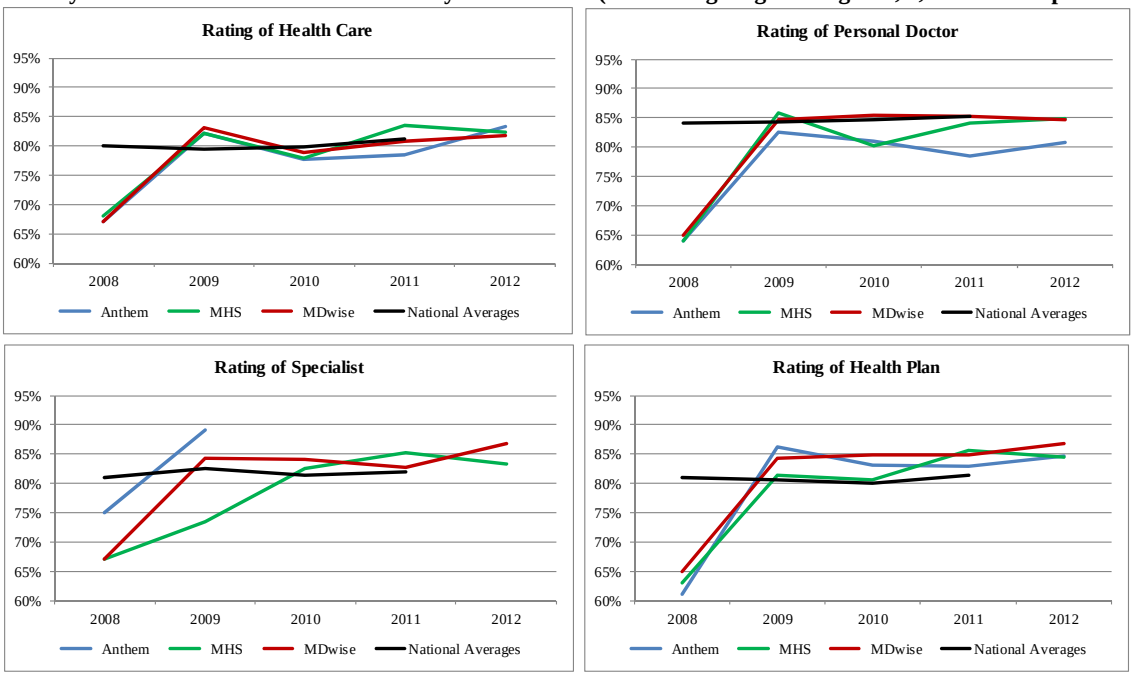
CAHPS Results for Children Enrolled in Hoosier Healthwise

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. Exhibits V.5 and V.6 on the next page summarize the results from the surveys that were administered over the last five years and compares the results on key questions to the results from the national average which represents approximately 130 Medicaid health plans that submitted data. Missing health plan data indicates the number of respondents to questions were too low (< 100) to be able to extrapolate the rating to the entire population with confidence. National Average data is available from 2008 to 2011.

The percentages in Exhibit V.5 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 MCEs have maintained ratings above the national average trend over the past four years for Rating of Health Plan. MDwise and MHS are on target with the trend of the national average for Rating of Personal Doctor while Anthem's rating is below the national average. All three plans are on target with the trend of the national average for Rating of Health Care with Anthem's rating increasing from last to first place compared to the other plans from 2011 to 2012.

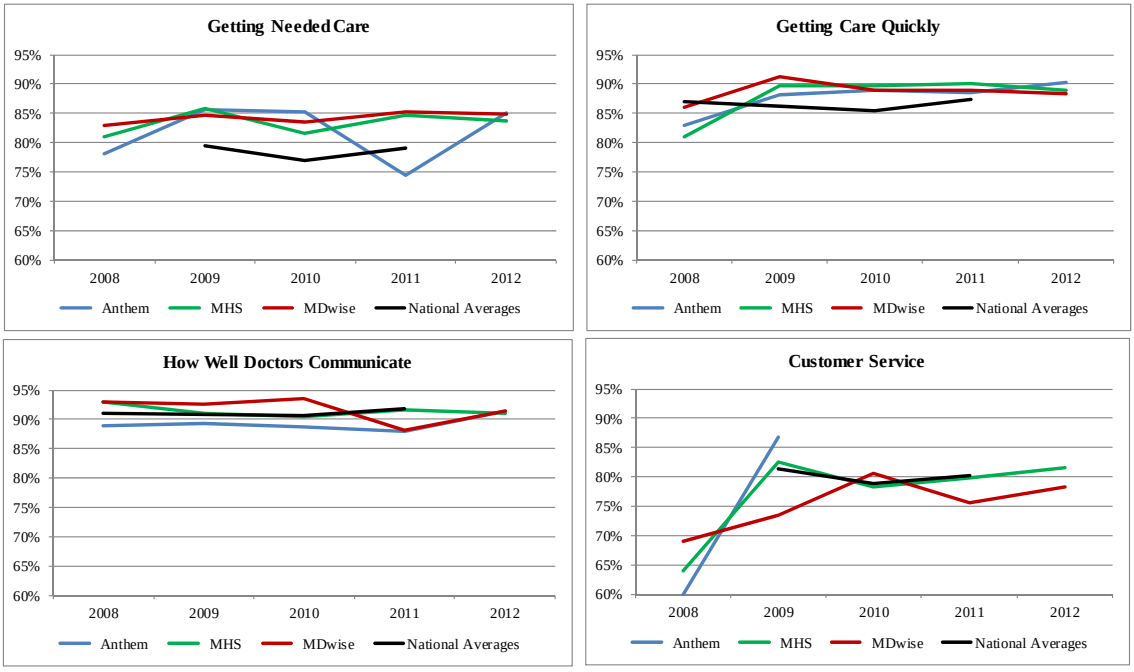
The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The results in Exhibit V.6 represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. For the domains Getting Needed Care and Getting Care Quickly, all three MCEs continually exceeded the CAHPS national average. Anthem's rating for Getting Needed Care declined in 2011, but returned to 2010's rating in 2012. All three plans are on target for the trend of the national average for How Well Doctors Communicate.

Exhibit V.5
Summary of Scores from CAHPS Child Survey 2008 to 2012 (Members giving a rating of 8, 9, or 10 on 10-point scale)



* Missing Health Plan data indicates that the number of respondents to the quations were too low (< 100) to be able to extrpolate the rating to the entire population with conficence.
**Missing CAHPS national average data indicates data not available

Exhibit V.6
Summary of Scores from CAHPS Child Survey 2008 to 2012 (Percentages reflect responses of "Usually" or "Always")



* Missing Health Plan data indicates that the number of respondents to the quations were too low (< 100) to be able to extrpolate the rating to the entire population with conficence.
**Missing CAHPS national average data indicates data not available

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 8.89 percent over the three-year average of 2009-2011 was below the 25th percentile (10.5%) among all states for the same time period. Indiana has been able to meet this goal in each of the last five 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 2012, there were 6,533 children in this income category enrolled in the CHIP program; however, for the period of Federal Fiscal Year (FFY) 2012 there were a total of 14,318 unique children enrolled in this income category. Further details about enrollment and disenrollment trends are noted in Chapter II.

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 FFYs 2011 and 2012, 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 FFY 2011 and an average for FFY 2012 (each weighted by monthly enrollment) of the percent that lapsed was calculated. Then, the percentage change from the FFY 2011 figure to the FFY 2012 figure was calculated.

The results showed a lapse rate of 0.75% in FFY 2011 and a lapse rate of 0.75% in FFY 2012. Therefore, the change from year to year was no reduction; however, there has been progress in this measure since FFY 2010 when the churn rate was 0.96%, a reduction of 21 percent.

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 2011 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.

OMPP's Quality Strategy

The OMPP develops Quality Strategy Initiatives based on consideration of identified trends in health care issues within the State of Indiana, attainment of current quality strategy goals, close monitoring of the MCEs' performance and unmet objectives, and issues raised by external stakeholders and partners. Within HHW, the program in which CHIP members are enrolled, the OMPP identified 12 initiatives for CY 2013. Of these, four initiatives focus on children specifically, four initiatives focus on both children and adults, and another four are focused more on the adult population. The initiatives with the measure used to track performance are shown below.[17]

1. Achieve at or above the 90th percentile for percentage of members with six or more well child visits in the first 15 months of life (HEDIS).
2. Improve the Early Periodic Screening, Diagnosis and Treatment (EPSDT) participation rate to 80% in 2013.
3. Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
4. Achieve at or above the 90% percent of Ambulatory Care Visits (HEDIS).
5. Achieve at or above 76% of the number of members who are advised to quit smoking during at least one visit with a health care provider.
6. Achieve a rate at or above the 75th percentile of diabetic members who receive a LDL-C screening.
7. Achieve a rate of less than 27% Cesarean Delivery rate in an effort to decrease the number of elective inductions prior to 39th week of pregnancy.
8. Achieve at or above the 90th percentile for the frequency of both prenatal and post-partum care (HEDIS).
9. Increase the overall number of provider submitted Notification of Pregnancy forms by 1% above the 2012 rate in an effort to identify high-risk pregnancies for case management by the MCEs.
10. Increase the number of submitted Presumptive Eligibility applications during the 1st trimester of pregnancy by 2% in an effort to improve access to early prenatal care.
11. Monitor and evaluate the quarterly data submitted by MCEs for care and case management and use the data to establish a baseline that will be used for future performance evaluation.
12. Achieve at or above the 96% of the Right Choices Program periodic reviews that are complete on time.

[17] Office of Medicaid Policy and Planning, Family and Social Services Administration, Quality Strategy Plan 2013, page 6.