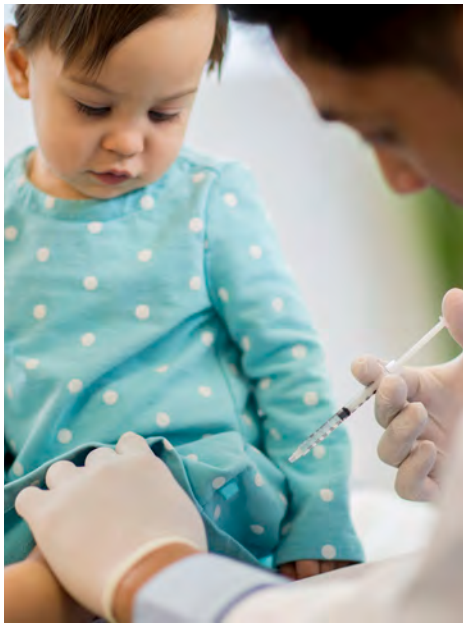
Independent Evaluation of Indiana's Children's Health Insurance Program

Final Report – April 2023



BURNS & ASSOCIATES

A Division of Health Management Associates

ACKNOWLEDGMENTS

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

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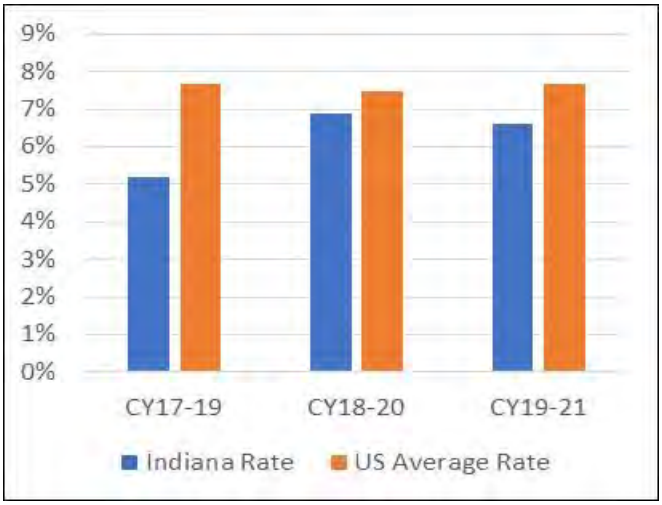
EXECUTIVE SUMMARY

As of December 2022, enrollment in Indiana's Children's Health Insurance Program (CHIP) was at an all-time high of 125,576, an increase of 28% from the previous December. All of this increase occurred in CHIP Package A, which is the portion of the program for families at the lower level of the income scale (defined as families with incomes up to 158% of the federal poverty level, or $43,845 per year for a family of four in 2022). In fact, there was a slight decrease during CY 2022 in CHIP Package C, which is the portion of the program for families at the higher level of the income scale (defined as families with incomes up to 250% of the federal poverty level, or $69,375 per year for a family of four in 2022). At the end of CY 2022, 73% of CHIP members are in Package A and 27% are in Package C.

Since the public health emergency began in March 2020, child enrollment in Medicaid and CHIP combined in Indiana has increased by 206,955, or 29%. During CY 2022, CHIP Package A enrollment increased by 49%, CHIP Package C decreased by 9%, and regular child Medicaid increased almost 4%. During the pandemic, state Medicaid agencies have been prohibited by the federal government from disenrolling members from Medicaid or CHIP. The "unwinding" of this enrollment mandate will begin April 1, 2023.

Indiana's CHIP continues to serve as a way to keep the uninsured rate for children in lower-income families below the national average. For the most recent three years of reporting available, Indiana's uninsured rate for children in families at or below 250% of the federal poverty level (FPL) has been below the national average. (The uninsured rate is expressed as the most recent three years averaged together.) In the most recent period of reporting (the 3-year average of CY2020, CY2021 and CY2022 reporting), Indiana's child uninsured rate was 6.6% and the national average rate was 7.7%.



Enrollment in CHIP is spread evenly throughout the state, but there is a higher distribution of minorities in Indiana's CHIP than the overall population of children ages 18 and younger. Because children under age 6 are eligible for regular Medicaid at higher family income levels, the CHIP has a higher proportion of members in older child age groups. Children ages 6 to 12 represent 46% of CHIP enrollees while teenagers represent 43% of CHIP enrollees.

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

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

Burns & Associates, a Division of Health Management Associates (HMA-Burns), was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for CY 2022. The HMA-Burns team has conducted this annual study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

Background on Indiana's CHIP

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

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

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

In a report released by the Kaiser Family Foundation in March 2020, it was found that Indiana's program resembles many other state CHIP programs in its design features as well. Among the CHIP programs nationwide, 22 states (including Indiana) require families to pay premiums for their children's coverage when the family income is above 200% FPL. States do differ on co-pays required in their programs. Like 16 other states, Indiana requires co-pays on some pharmacy scripts. But Indiana does not require co-pays on emergency department visits or non-preventive physician visits like some other states do.

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

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage (FMAP) for states is higher than the FMAP for Medicaid.

For illustration, for every $100 spent in Indiana's CHIP, in FFY 2022 the state's responsibility was $17.84. Once the public health emergency (PHE) ends, this will increase to $24.04. For comparison, for every $100 spent in the traditional Medicaid program in FFY 2022, the state's responsibility was $28.14. When the PHE ends, this will increase to $34.34.

Total expenditures in Indiana's CHIP in CY 2022 were $282.3 million, an increase of 5.4% from the previous year. But since enrollment also increased during CY 2022, the total cost to the state on a per

member per month basis increased only 0.4%, from $217.68 during CY 2021 to $218.49 in CY 2022. The state's share of the per member per month cost during CY 2022 was $38.89.

Dashboard of Metrics to Review Indiana's CHIP at a Glance

The dashboard report that appears at the end of this Executive Summary shows metrics related to Indiana's CHIP related to enrollment, expenditures, access to services, outcome measures, and parent satisfaction with the program.

Access

With respect to access, HMA-Burns matched claims of actual services received in FFY 2022 for primary care and dental services between where the member lives and where the provider is located. HMA-Burns found each provider's location and drew a 10-mile coverage radius to assess the availability of primary care and dental providers to CHIP members. On a statewide level, there are very few gaps. In fact, less than 1% of all CHIP members live more than 10 miles from an available primary medical provider. Less than 2% live more than 10 miles from an available dentist.

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

Separately, HMA-Burns computed the average distance that members actually travelled to their providers of choice. An average driving distance was computed for CHIP members in each of the 92 counties. The OMPP targets a threshold of no more than 30 miles for members to travel to seek primary care or dental care. For primary care, there are four counties where members, on average, travelled more than 30 miles. For dental care, there are 9 counties. The maps that show the results at the individual county level appear in Section III.

Outcomes

The OMPP requires its MCEs in Hoosier Healthwise to measure health outcomes for children. Many of the measures that the MCEs report on are Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are nationally-recognized measures that health plans report on and are subject to an external auditor to compute. The OMPP compares the results of the HEDIS measures across the four MCEs and has set performance targets against national benchmarks for Medicaid health plans. HMA-Burns reviewed 12 HEDIS measures in this evaluation that are commonly used to assess the health outcomes for children. Eight of these measures are shown on the dashboard report. All findings on selected HEDIS measures are reported in Section V.

- When compared to the median results for Medicaid health plans nationally, among the 12 measures reviewed, Anthem had 10 in which its rates exceeded the national median values, CareSource had 7, MDwise had 5, and MHS had 4.

- When comparing each MCE's own results year-over-year, among the 12 measures reviewed,
    - Anthem saw meaningful improvement on 3 measures, 3 measures remained steady, and 6 measures saw a meaningful decline.
    - CareSource saw meaningful improvement on 3 measures, 4 measures remained steady, and 5 measures saw a meaningful decline.
    - MDwise saw meaningful improvement on 2 measures, 2 measures remained steady, and 8 measures saw a meaningful decline.
    - MHS saw meaningful improvement on 2 measures, 4 measures remained steady, and 6 measures saw a meaningful decline.

Member Satisfaction

The OMPP requires the MCEs to conduct an annual survey of parents of children enrolled in Hoosier Healthwise. The survey includes a sample of both CHIP and Medicaid children. The 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. Of these measures, 6 are shown on the dashboard report. All findings on selected CAHPS measures are reported in Section V.

- When compared to the median results for Medicaid health plans nationally, among the 8 measures reviewed, Anthem had 3 in which its rates exceeded the national median values, CareSource had 8, MDwise had 3, and MHS had 3.

- When comparing each MCE's own results year-over-year, among the 8 measures reviewed,
    - Anthem saw meaningful improvement on 2 measures.
    - CareSource saw meaningful improvement on 7 measures.
    - MDwise saw meaningful improvement on no measures.
    - MHS saw meaningful improvement on 1 measure.

Service Utilization

HMA-Burns measured the percentage of CHIP children that used primary care services, emergency department visits, preventive dental visits, and pharmacy prescription for the periods FFY 2020, FFY 2021 and FFY 2022. The focus on users of each service was limited to children who were enrolled in the program for at least 9 months within each year. Comparisons were also made across various demographic cohorts, such as by Package (CHIP A, CHIP C and CHIP C Expansion), by MCE, by age group and by race/ethnicity. HMA-Burns also analyzed the utilization rate per 1,000 CHIP members for these same services. In the examination of utilization, unlike for users, all members who were enrolled in CHIP in each year were included, regardless of enrollment duration.

The key findings from studying this data are shown below.

- Primary care visits
    - The percentage of CHIP Package A members that accessed primary care remained steady over the three-year period studied (75% of members received a primary care service each year). But the usage rate declined from FFY 2020 to FFY 2022 in CHIP Package C. The CHIP Package C usage rate has historically been higher than CHIP Package A, but now the rates are the same. Trends for the volume of services, or the utilization per 1,000 members, showed similar results.
    - Primary care visits are used more by children ages 5 and younger (84% of all members in FFY 2022) each year than the older members enrolled in CHIP (75% of all members).
    - When examined by race/ethnicity, the usage rate was lower for African-American children than for Caucasian and Hispanic children (in FFY 2021, Caucasian and Hispanic were 76%, African-American 71%).
- Emergency department visits
    - The percentage of children enrolled at least 9 months in CHIP that use the ER each year was consistent across CHIP A, CHIP C, and CHIP C Expansion and across the MCEs.
    - Children in CHIP Package A are using the ED slightly more in FFY 2022 (20% of all children compared to 16% of children in CHIP Package C).
    - Use of the ER by race/ethnicity is similar, although slightly lower for Hispanic children.
- Preventive dental visits
    - The utilization of preventive dental services has declined during the pandemic years.
    - Dental usage is much higher for children ages 6 to 12 (60-61% in each of the three years examined) than children ages 13 and over (47-50% across the three years) or children ages 5 and under (42-46% across the three years).
    - Hispanic children in Indiana's CHIP have traditionally had a higher usage rate for dental services than other race/ethnicities. Although African-American children show a lower usage rate in the first two years of the study, their usage rate is slightly higher than Caucasian children in FFY 2022.
- Pharmacy scripts
    - Pharmacy scripts have decreased during the early years of the pandemic but have increased again during FFY 2022. There were 60% of CHIP children who received a pharmacy script in FFY 2022. This usage rate was also similar among the three age groups studied (ages 5 and under, ages 6-12, and ages 13 to 18).
    - A significantly higher percentage of Caucasian children have had pharmacy scripts (63% in FFY 2022) compared to minority children (54% to 58% in FFY 2022).

INDIANA CHILDREN'S HEALTH INSURANCE PROGRAM AT A GLANCE

ENROLLMENT in CHIP as of December 2022	**125,576**	**27.70%** percentage reflects change from Dec 2021					
CHIP A	92,198	49.1%	CHIP C Original	18,664	-6.1%	CHIP C Expansion	14,714	-11.4%
Child Enrollment in MEDICAID as of Dec 2022	**796,640**	**3.60%** percentage reflects change from Dec 2021					

UNINSURED RATE, for children in families up to 250% of the Federal Poverty Level			
3-Year Average Rate	**Indiana**	**6.6%**	**US Average** **7.7%**

EXPENDITURES IN CHIP	**CY 2021**	**$267.7M**	**CY 2022**	**$282.3M**
PMPM = Per Member Per Month	PMPM	$217.68	PMPM	$218.49

WHERE CHIP MEMBERS RECEIVED SERVICES Average Driving Distance to Provider who Delivered the Service

Number of Counties within each range of number of miles to provider

		0-10 miles	11-20 miles	21-30 miles	>30 miles
PRIMARY CARE	FFY 2021	7	42	40	3
	FFY 2022	6	51	31	4
DENTAL CARE	FFY 2021	15	39	28	10
	FFY 2022	17	35	31	9

HEDIS & CAHPS MEASURES

HEDIS are used to measure health access and outcomes. CAHPS are used to measure client satisfaction.

Colors compare scores to health plans nationally.

If MCE is below the 25th percentile nationally:	
If MCE is >25th percentile but <50th percentile nationally:	
If MCE is >50th percentile but <75th percentile nationally:	
If MCE is >75th percentile but <90th percentile nationally:	
If MCE is above the 90th percentile nationally:	

	Anthem	CareSource	MDwise	MHS
HEDIS Measures, 2022 reporting				
6 or more well visits, first 15 mo	61.9%	56.2%	54.4%	56.2%
2 or more well visits, 15-30 mo	67.0%	63.2%	61.0%	63.3%
Annual well visit, age 3 - 11	58.0%	56.8%	53.1%	55.5%
Annual well visit, age 12 - 17	51.8%	48.7%	48.7%	51.3%
Appropriate asthma meds, age 5-11	83.2%	87.8%	74.9%	74.9%
Immunizations, young children	56.4%	60.1%	51.8%	60.1%
Immunizations, adolescents	83.0%	73.2%	80.3%	83.2%
Initial Follow-up after ADHD meds	42.9%	48.0%	44.6%	39.7%
CAHPS Measures, 2022 reporting				
Rating of the health plan	87.7%	88.3%	84.2%	86.9%
Rating of their own health	87.5%	89.6%	84.4%	86.9%
Rating of their personal doctor	90.0%	92.5%	87.0%	87.3%
Getting Needed Care	87.5%	89.0%	82.6%	87.8%
Getting Care Quickly	89.5%	90.6%	86.4%	90.7%
MCE Customer Service	87.0%	92.0%	89.2%	85.9%

SECTION I: INTRODUCTION

Each year, an independent evaluation of Indiana's Children's Health Insurance Program (CHIP) is conducted as required by Indiana Code 12-17.6-2-12 and is due to the Legislature by April 1. Burns & Associates, a Division of Health Management Associates (HMA-Burns), was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2022. HMA-Burns has conducted this study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

History of the Federal SCHIP and Indiana's CHIP

The State Children's Health Insurance Program (SCHIP, or simply CHIP) was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. Since this time, federal legislation has been enacted to extend funding for the program. The most recent legislation by Congress related to CHIP, the Bipartisan Budget Act of 2018 enacted on February 9, 2018, provided appropriations for CHIP for Federal Fiscal Years (FFYs) 2024 through 2027.

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage, or FMAP, for states is higher than the FMAP for Medicaid. This is often referred to as the "enhanced FMAP." Further, during the public health emergency (PHE), State Medicaid Agencies across the country were each given a 6.2 percentage point increase on their normal FMAP and enhanced FMAP. The 6.2 percentage point increase will end on December 31, 2023. The table below shows an illustration of funding during FFY 2022 (October 1, 2021 – September 30, 2022). As an illustration, for every $100 spend in Indiana's Medicaid/CHIP program, the state share of this $100 is shown:

FFY	Regular Medicaid FMAP	Regular Medicaid FMAP during PHE period	CHIP Only With Enhanced FMAP	CHIP Only With Enhanced FMAP during PHE period
2022	$34.34	$28.14	$24.04	$17.84

When the original federal SCHIP 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 a combination of the two. Indiana opted to implement the "combination" program similar to 20 other states. Therefore, Indiana's CHIP has two distinct components—CHIP Package A and CHIP Package C. CHIP Package A (the Medicaid expansion portion, also called MCHIP in Indiana) covers uninsured children in families with incomes up to 158% of the Federal Poverty Level, or FPL ($43,845 per year for a family of four in 2022) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998. CHIP Package C (the non-entitlement portion, also called SCHIP in Indiana) covers uninsured children in families up to 250% of the FPL ($69,375 per year for a family of four in 2021). CHIP Package C was first introduced on January 1, 2000 to cover children in families with incomes up to 200% of the FPL. CHIP Package C was expanded on October 1, 2008 to cover children in families up to 250% of the FPL.

Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests, children in SCHIP cannot have insurance coverage from another source.

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

In March 2020, the Kaiser Family Foundation released a report in which the 50 states (and District of Columbia) were surveyed to compare Medicaid and CHIP eligibility policies.[1] As of January 2020, 49 states cover children with incomes at or above 200% of the FPL. Of these, 19 states extend eligibility to at least 300% of the FPL.

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

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

As of December 2022, enrollment in Indiana's CHIP was at 125,576, an all-time high and an increase of 27,276 children, or 28%, from December 2021. All of this increase occurred in CHIP Package A (families at the lower income along the spectrum). In fact, there was a slight decrease during CY 2022 in CHIP Package C (families at the higher-level income levels). Since the PHE began in March 2020, child enrollment in Medicaid and CHIP combined in Indiana has increased by 206,955, or 29%. In addition to economic factors of the pandemic, states have not been allowed to disenroll members from Medicaid in exchange for the higher FMAP rate from the federal government. This means that children who may be determined no longer eligible at the time of annual renewal (in particular, children who turn age 19) are still enrolled in Medicaid or CHIP. The "unwinding" of this enrollment mandate will begin April 1, 2023.

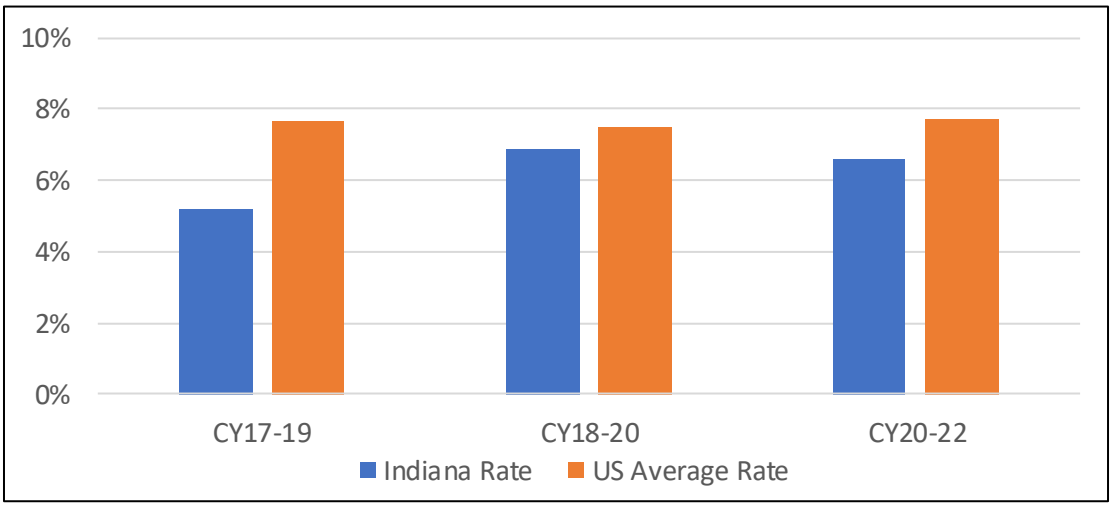
More enrollment statistics appear in Section II of this report.

The Census Bureau's Current Population Survey (CPS) surveys citizens annually on their health insurance status. An uninsured rate is computed for each state. Researchers often use an average over three years of annual CPS surveys to mitigate large swings in year-to-year results at the individual state level due to lower sample size in the study.

Exhibit I.1 compares the uninsured rate in Indiana against the national average over the most recent three-year period available for reporting for children in families with incomes up to 250% of the FPL. Indiana has consistently had an uninsured rate for children at this income level that is lower than the national average. For the most recent three-year period of CYs 2020 to 2022, Indiana's uninsured rate was 6.6%; the US average was 7.7%.

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

Exhibit I.1
Uninsured Rate Among Children in Families at or Below 250% of the Federal Poverty Level
For the Most Recent 3 Years of Reporting
The Uninsured Rate is Computed Using a Three-Year Average



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

Indiana's CHIP is Integrated with Other Medicaid Programs

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

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

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

Exhibit I.2
Benefits Offered to Indiana's CHIP Enrollees

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

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

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

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

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

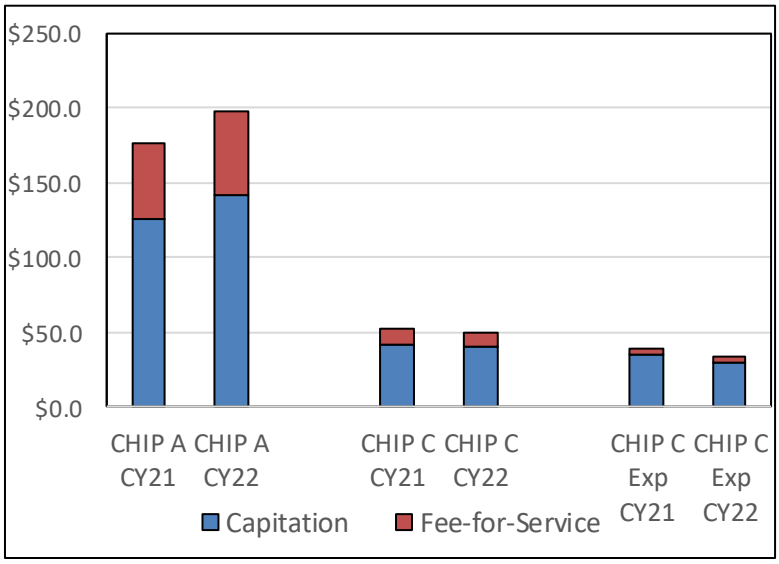
Expenditures in Indiana's CHIP

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

Some expenditures are made outside of the PMPM payment to the MCEs where each service is paid individually in what is called the fee-for-service program. The greatest percentage of payments made under this arrangement are for mental health rehabilitation services and some high-cost drugs that the OMPP pays outside of managed care.

HMA-Burns examined expenditures made on behalf of CHIP members from data included in the state's data warehouse. Total expenditures in the CHIP were $267.7 million in CY 2021 and $282.3 million in CY 2022. In both years, approximately 75% of CHIP expenditures were made to the MCEs through the PMPM. The remaining 25% was paid out by the OMPP through fee-for-service claims.

Exhibit I.4
Expenditures in Indiana's CHIP, in millions
Calendar Year 2021 and 2022



In CHIP Package A, total expenditures were $198.0 million in CY 2021, a 12.1% increase from CY 2021. But enrollment also grew in CHIP Package A, so the PMPM payment actually decreased 1.0%, from $224.49 to $222.34.

In CHIP Package C, expenditures were $50.0 million in CY 2022, a 4.8% decrease from CY 2021. The PMPM payment was steady, from $216.74 to $217.00.

In the expansion portion of CHIP Package C, total expenditures were $34.0 million in CY 2022, an 11.1% decrease from CY 2021. But enrollment also declined in CY 2022, so the PMPM payment actually increased 4.4%, from $192.07 to $200.43.

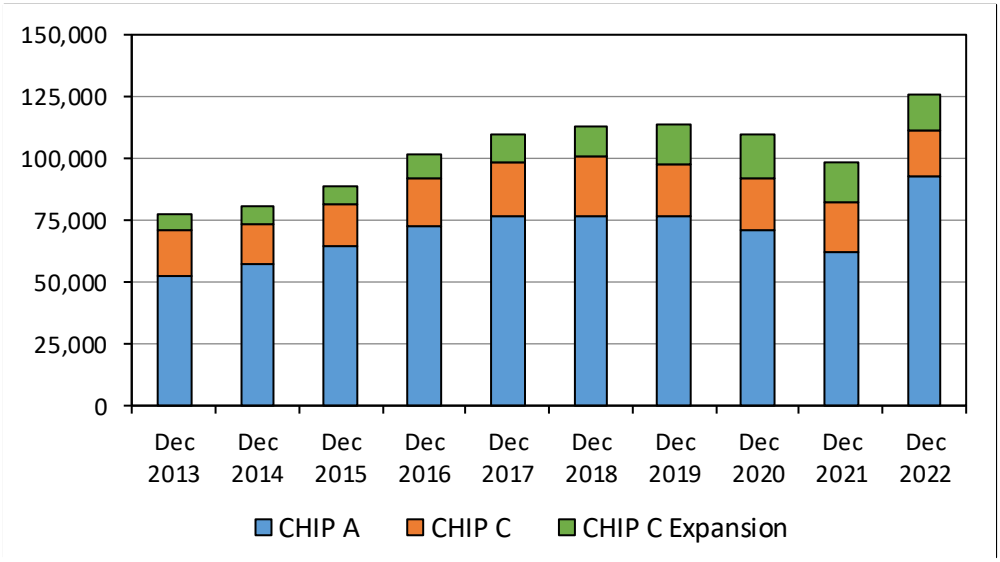
The results shown above are the total funds expended in the CHIP. As stated earlier, the federal government contributes more to state CHIP programs than the regular Medicaid program. For most of CY 2022, the state contribution was near 17.8% of total expenditures. For the entire CHIP program, therefore, the total expenditures in CY 2022 were $218.49 per member per month, but the state share was $38.89. Furthermore, for CHIP Package C, the state's outlay is further reduced by premiums paid by parents.

SECTION II: ENROLLMENT TRENDS IN INDIANA'S CHIP

Enrollment in Recent Years

Indiana's Children's Health Insurance Program (CHIP) experienced an increase in enrollment in CY 2022 to its all-time high level of 125,576 at the end of the year. The previous all-time high was at the start of the pandemic with enrollment of 119,216 in March 2020. The 10-year enrollment trend in Indiana's CHIP is shown in Exhibit II.1.

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

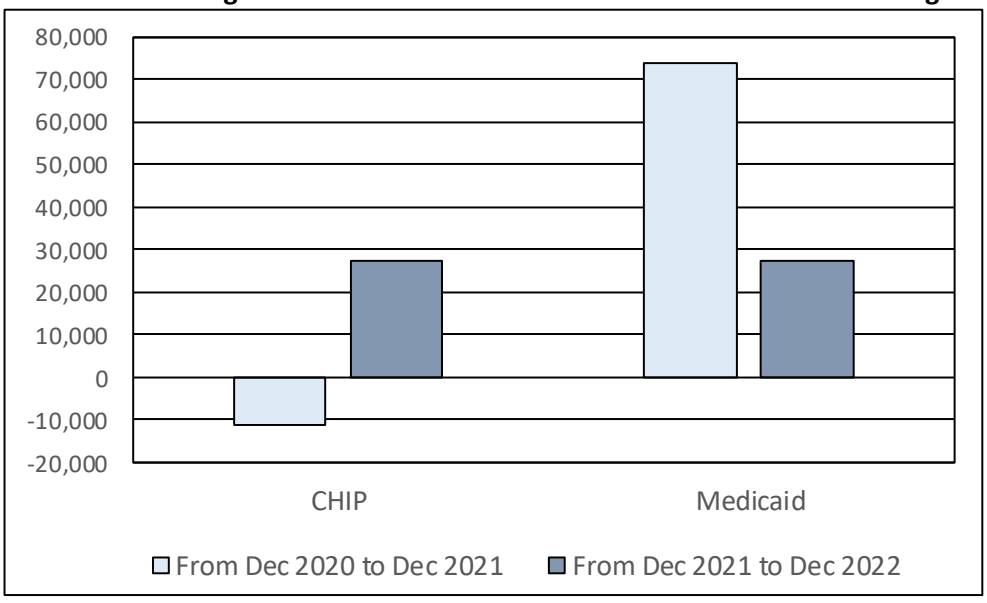


Source: Indiana's FSSA Enterprise Data Warehouse

At the end of CY 2022, 73.4% of enrollees were in the MCHIP portion and 26.6% were in the SCHIP portion of Indiana's CHIP. In MCHIP (Package A), the entitlement portion of the program, enrollment grew 49.15 from December 2021 to December 2022. In SCHIP (Package C), the non-entitlement portion of the program, enrollment decreased by 8.5%.

The reduction in CHIP enrollment during CY 2021 was more than compensated for by the increase of the child enrollment in the regular Medicaid program (refer to Exhibit II.2). In CY 2022, however, both CHIP and regular Medicaid enrollment for children grew, albeit the Medicaid portion grew at a slower pace during CY 2022.

Exhibit II.2
Year-to-Year Change in Child Enrollment in Indiana's CHIP and Medicaid Programs

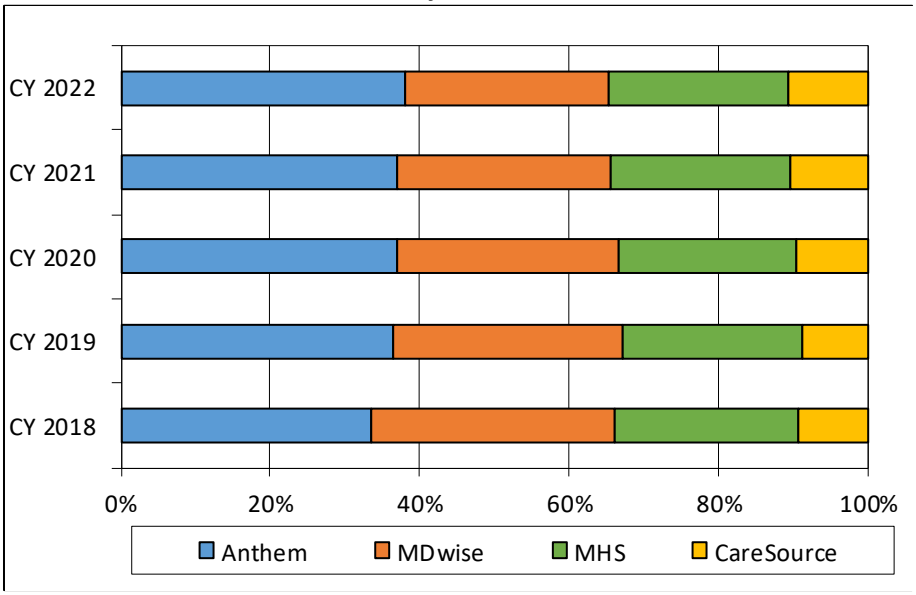


Source: Indiana's FSSA Enterprise Data Warehouse

Demographic Profile of CHIP Members

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There are four MCEs that families can choose from. There has been some movement in the distribution of CHIP members across the MCEs in the last 5 years. At the end of CY 2022, Anthem had 38.1% of all CHIP enrollees, MDwise had 27.3%, MHS had 24.1%, and CareSource had 10.5%.

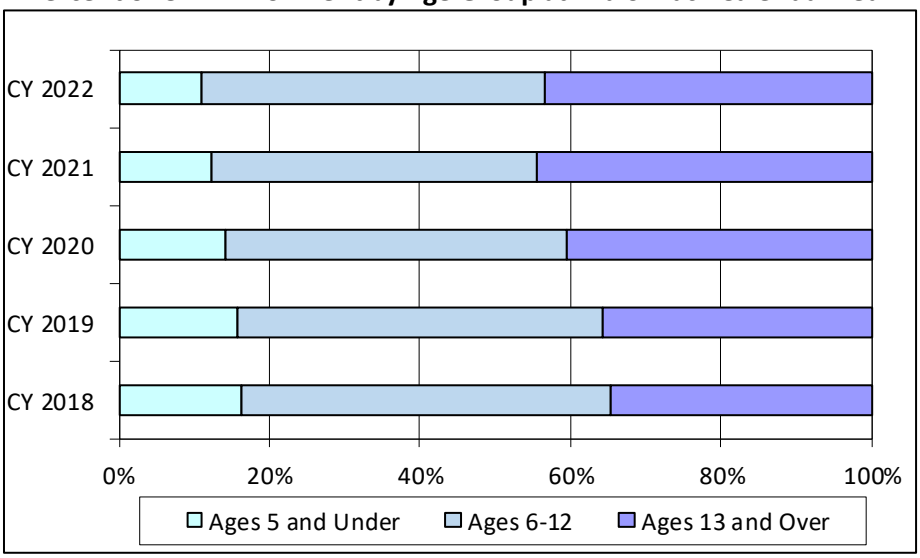
Exhibit II.3
Percent of CHIP Enrollment by MCE at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

In CY2022, the proportion of members enrolled in CHIP ages 6-12 and ages 13-18 was similar, 45.6% of the total were ages 6-12 and 43.4% were ages 13-18. The remaining 11% of members are ages 5 and under. Children at the lower age group are under-represented in CHIP because children under age 6 are eligible for Medicaid at higher family income levels.

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

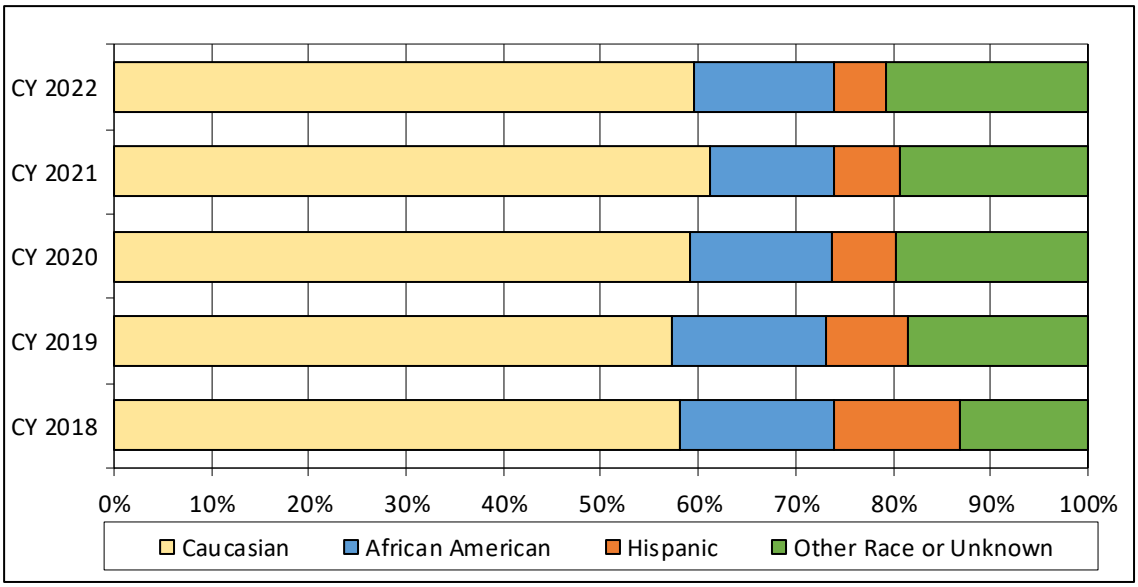


Source: Indiana's FSSA Enterprise Data Warehouse

There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for children ages 18 and younger. African-American children represented 14.3% of total CHIP enrollment in

CY 2022. Hispanic children represented 5.9% of the total (as reported). This percentage has decreased in recent years, but the proportion in "Other Race or Unknown" has increased from 13.2% in CY 2018 to 20.7% in CY 2022. Some Hispanic children are likely in this group as well. The percentage of Caucasian children has held fairly steady between 57% and 61% of total CHIP enrollment in each of the last 5 years.

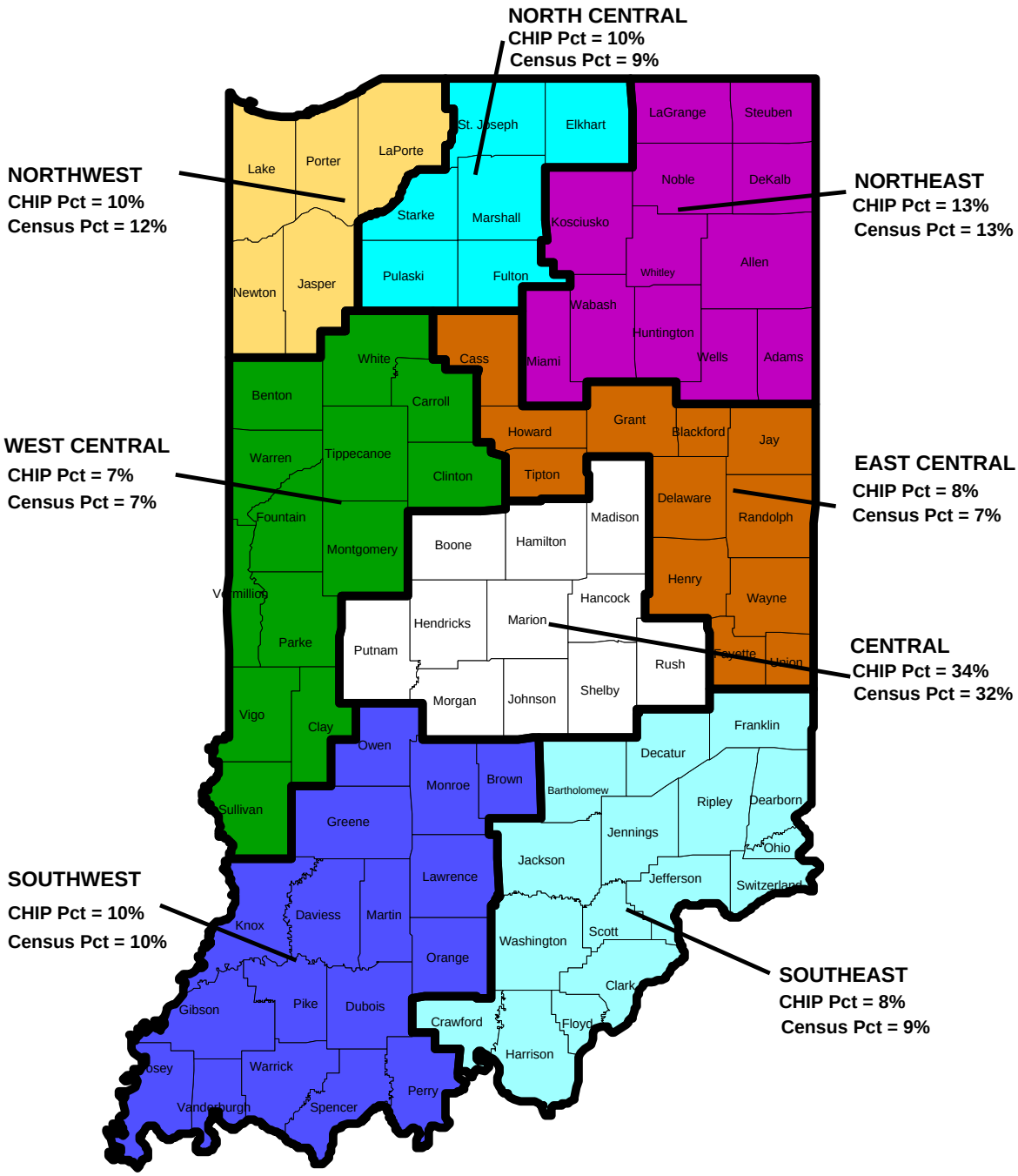
Exhibit II.5
Percent of CHIP Enrollment by Race/Ethnicity at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

HMA-Burns compared CHIP members enrolled to the total child population in Indiana as of July 2022. The distribution of CHIP members by region generally matches the overall child population in Indiana. The Central region has 34% of all CHIP members but only 32% of the state's child population. The Northwest region has 10% of all CHIP members but 12% of the child state population. The regions are defined by the OMPP. These statistics have also remained relatively unchanged in the last 5 years.

Exhibit II.6
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2022



SECTION III: ACCESS TO PRIMARY MEDICAL PROVIDERS AND DENTISTS

Background

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

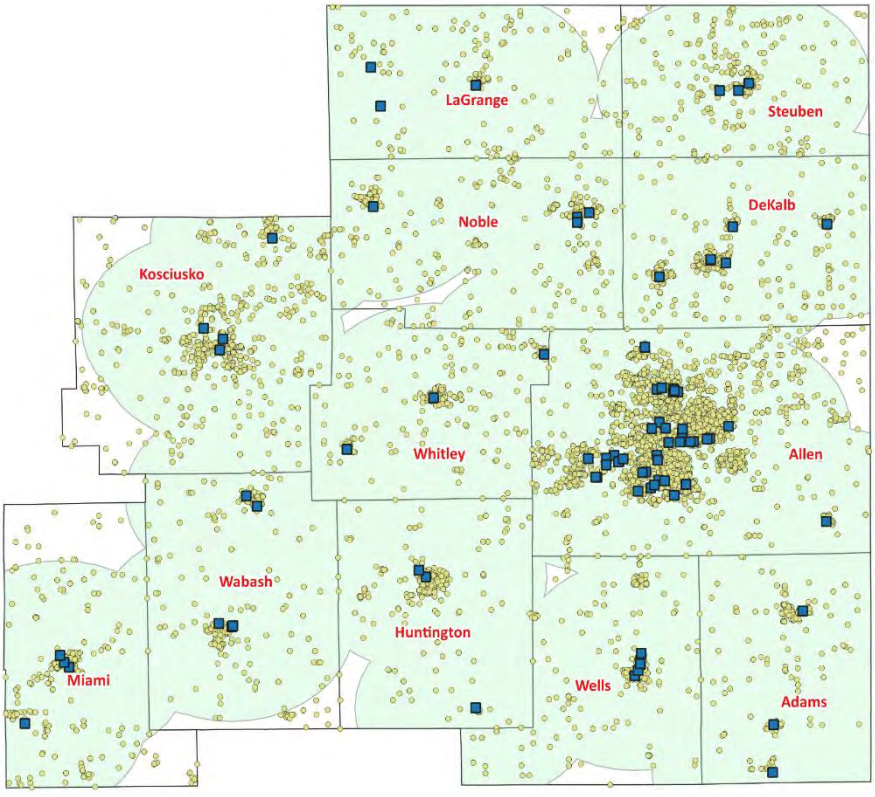
HMA-Burns examined both the proximity (nearest provider) of members to providers as well the average distance travelled by CHIP members within each county to seek primary medical and dental care.

Proximity to the Nearest Provider

The data used to conduct this analysis was provided to HMA-Burns by the OMPP from its Enterprise Data Warehouse (EDW). Information was tabulated for access to primary medical providers (PMPs) and dental providers based on utilization from the time period October 1, 2021 – September 30, 2022. This time span was used in lieu of Calendar Year (CY) 2022 to allow the lag time for claims to be submitted by providers.

Claims were matched to each individual in the study. Each individual was mapped to one of Indiana's 92 counties based on their home address in the enrollment file provided from the EDW. The latitude and longitude coordinates of each member's home address were plotted. Likewise, the latitude and longitude coordinates of every provider with a claim in the study database was plotted. Radius circles were drawn to assess which providers were within 10 miles of the members' homes.

An example of how this data is displayed is showed to the right.
The map shows the counties that comprise the Northeast Region.
The blue squares on the map represent the locations of dentists that provide services to Medicaid and CHIP children. The yellow dots represent the home location of actual CHIP members enrolled in September 2022. Any area in green means that CHIP members have used a dentist within 10 miles of their home. Areas in white in each county means the distance is greater than 10 miles.



In total, 16 maps were created like the one shown on the prior page in an effort to assess proximity to providers. Eight maps were created to assess access to primary medical providers and another eight were created to assess access to dentists. Each map represents a region commonly used by the OMPP for comparisons. These regions are listed in Exhibit III.1. Each of Indiana's 92 counties are mapped to one of these eight regions. The maps showing CHIP member access to primary medical providers appear in Appendix A. The same display showing access to dental providers appear in Appendix B.

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

Because the actual CHIP enrollment can change month-to-month, for purposes of display, HMA-Burns plotted children who were enrolled in CHIP as of September 2022 on each map in any portion of the program (CHIP Package A, CHIP Package C, or CHIP C Expansion).

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

Findings

On a statewide level, there are very few gaps when measuring access to both primary medical providers and dental providers using a 10-mile service coverage radius. In fact, less than 1% of all CHIP members live more than 10 miles from an available primary medical provider. Less than 2% of all CHIP members live more than 10 miles from an available dentist.

Although the gaps are few throughout the state, there is some differentiation by region. Refer to Appendices A and B for the graphical representations shown for each region. Exhibit III.1 on the next page summarizes the counties within each region where at least 5 CHIP members live more than 10 miles from a provider. It should be noted that HMA-Burns is using a stricter metric with the 10-mile radius than what the OMPP requires in its contracts with its MCEs which is 30 miles. When the distance radius is broadened to 30 miles, access is greatly improved.

Exhibit III.1
Assessing Accessibility of CHIP Members to Primary Medical and Dental Care
For Services Delivered Oct 1, 2021 - Sept 30, 2022

	Counties Where Some Members Reside More than 10 Miles from a Provider	
Region	**Primary Medical Provider**	**Dental Provider**
Northeast	Kosciusko, LaGrange, Miami	Kosciusko, LaGrange, Miami, Steuben, Wabash
North Central	None	Elkhart, Fulton, Marshall, Pulaski, Starke, St. Joseph
Northwest	Jasper, LaPorte, Newton	Jasper, LaPorte, Newton
East Central	Cass, Jay, Randolph	Cass, Jay, Randolph, Union
Central	Putnam, Rush	Boone, Putnam, Rush
West Central	Benton, Clay, Clinton, Montgomery, Parke, Tippecanoe, White	Benton, Carroll, Clay, Clinton, Fountain, Montgomery, Parke, Tippecanoe, Warren, White
Southeast	Crawford, Decatur, Franklin, Harrison, Jackson, Ohio, Switzerland	Clark, Crawford, Decatur, Dearborn, Franklin, Harrison, Jackson, Jefferson, Ohio, Ripley, Switzerland, Washington
Southwest	Brown, Owen	Brown, Dubois, Greene, Lawrence, Martin, Orange, Owen, Perry, Posey

Average Distance Travelled to Providers

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

Software is used to map the driving distance from the member's home to the primary medical provider's or dentist's office[2]. In some cases, the latitude/longitude coordinates were not valid for either the member's home or the rendering provider's office. When this occurred, HMA-Burns excluded from the study the claims/encounters and computed distances when the trip was less than 0.2% of a mile or greater than 100.0 miles. The average distance for each county was then computed as the total miles across all non-excluded trips divided by the total trips for members to the specific specialty.

[2] Note that HMA-Burns computes the driving distance (turn by turn) as opposed to a crow flies distance.

Findings

In 4 of the 92 counties, CHIP members travelled, on average, more than 30 miles to seek primary medical care. This is up from 3 counties reported in last year's evaluation. There were 9 counties where CHIP members travelled, on average, more than 30 miles to seek dental care. This is down from 10 counties reported last year.

For primary care, the greatest average distance travelled was 34 miles (Warren County). For dental care, the greatest average distance travelled was 51 miles (Switzerland County). For the other 8 counties where the average distance was greater than 30 miles for dental services, 4 counties in the Northwestern part of the state fall into this category: Benton, Newton, Pulaski, and White. The remaining counties with higher average distance (besides Switzerland) are in the southern portion of the state: Jefferson, Ohio, Ripley and Union. All but Pulaski and Switzerland, however, have an average distance of 35 miles or less.

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

Exhibit III.2
Average Driving Distance (in miles) for CHIP Members Seeking Primary Care
During the Period October 1, 2021 – September 30, 2022
Color coding and values represent the average for each county

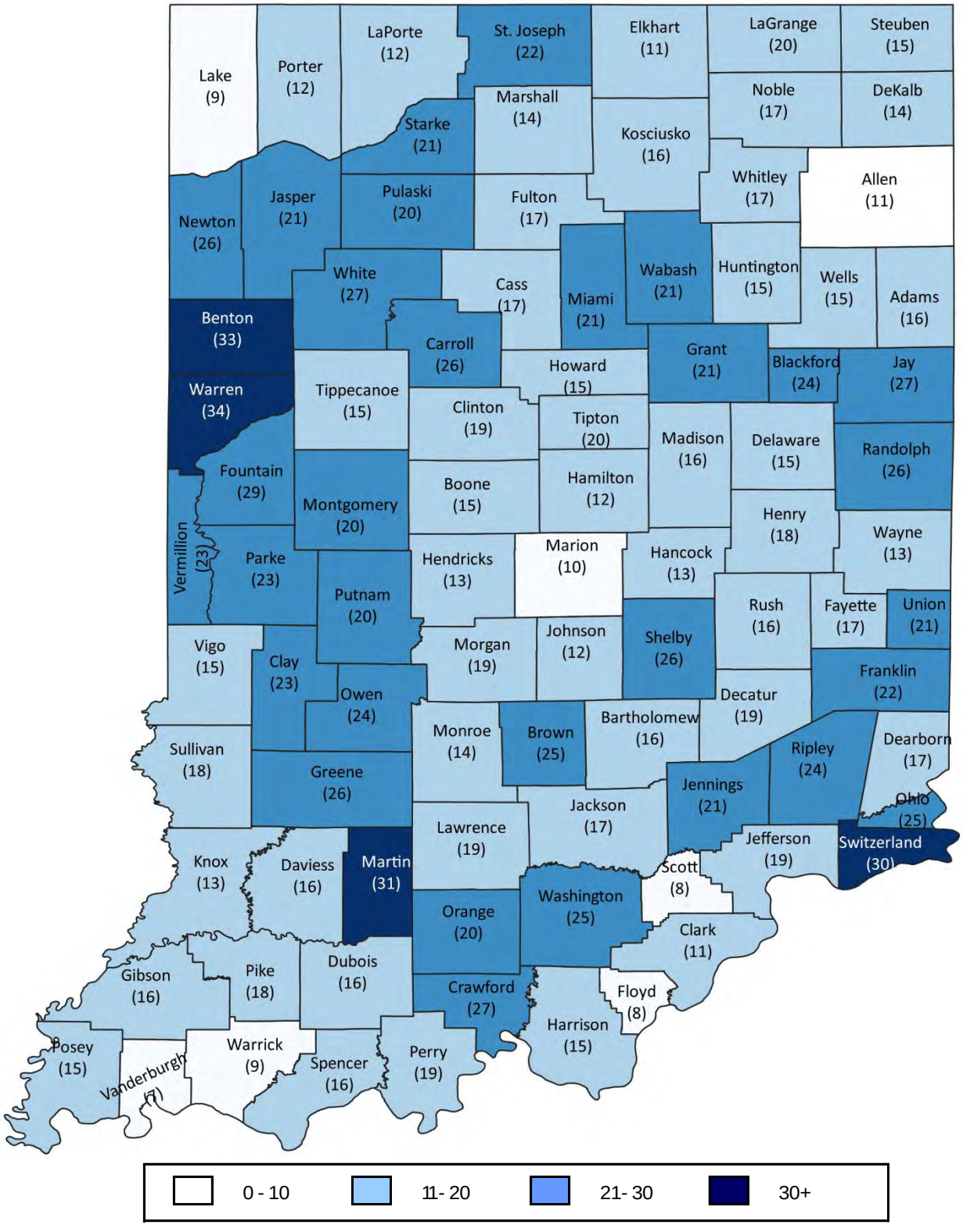
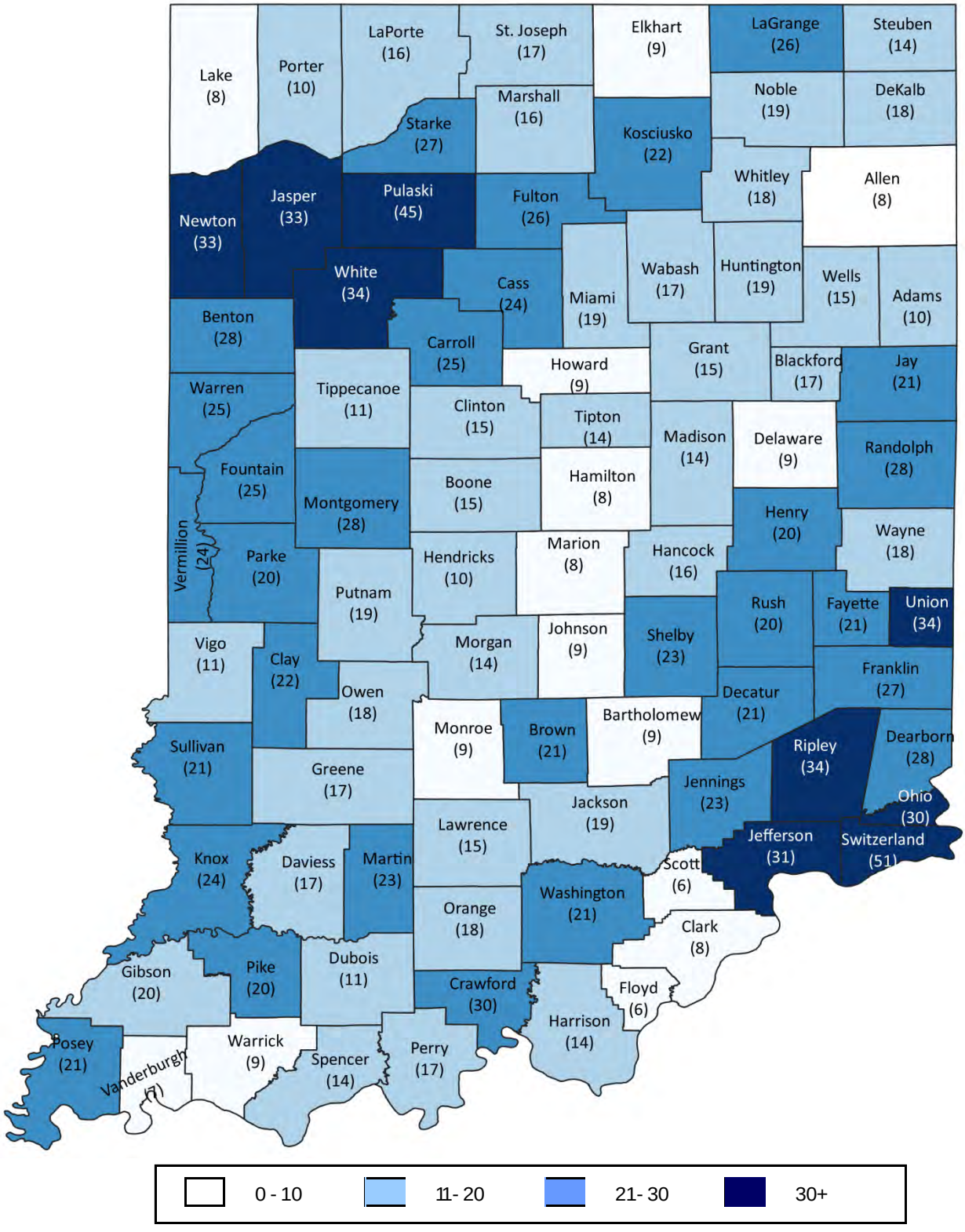


Exhibit III.3
Average Driving Distance (in miles) for CHIP Members Seeking Dental Care
During the Period October 1, 2021 – September 30, 2022
Color coding and values represent the average for each county



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

Introduction

In addition to examining the access to providers, the HMA-Burns team analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency department (ED) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2020, 2021 and 2022 across populations within the CHIP such as by CHIP Package, by managed care entity (MCE), by age, and by race/ethnicity.

HMA-Burns identified each unique member enrolled in CHIP at some point in time in either FFY 2020, 2021 or 2022. The *usage rate* is an annual measure. It measures the percentage of members that received the service during the FFY. HMA-Burns limited this calculation to those children who were enrolled for a minimum of 9 months in each year. This accounts for members that would have had an opportunity to actually use the service. Members could be included in one FFY of the study but not another year based upon their enrollment history. Children were included in the usage reports if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year as long as they were enrolled for 9 months during the year in any program. In the event that a child did cross CHIP packages during a study year, the child was assigned to the enrollment category that s/he was in at the end of the study year. Therefore, each child is counted only once on each report. A member's age was assigned based upon his/her age at the end of the study year.

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

Data used in this analysis was provided to HMA-Burns from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2023. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP.

For ease of comparison, the exhibits are displayed in a similar manner throughout this section. A single service is shown on one page. On the left side of the exhibit, the percentage of members who used the service in the FFY is displayed. Information is shown by CHIP package, by MCE, by age group and by race/ethnicity. On the right side, the utilization per 1,000 members is shown for these same member categories for FFY 2020, FFY 2021 and FFY 2022.

Primary Care Visits

Primary care visits include visits to doctor's offices or clinics specializing in primary care. It can include both well visits and sick visits. All results are displayed on Exhibit IV.1 on the next page.

The percentage of CHIP Package A members that accessed primary care remained steady over the three-year period studied (75% of members received a primary care service each year). But the usage rate declined from FFY 2020 to FFY 2022 in CHIP Package C. The CHIP Package C usage rate has historically been higher than CHIP Package A, but now the rates are the same. Trends for the volume of services, or the utilization per 1,000 members, showed similar results. Refer to the top two boxes in Exhibit IV.1.

For FFY 2022, the percentage of members who used primary care was in the range of 71% to 84% of members depending upon the subgroup examined. Notable variations in primary care use were observed in the following subgroups:

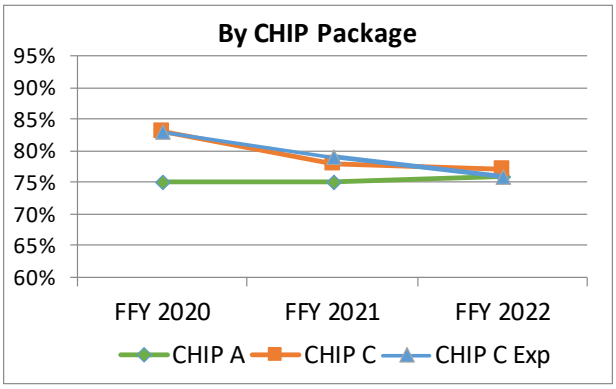
- When examined across MCEs, 3 of the 4 MCEs have similar usage rates for primary care each year, but CareSource was always a bit lower than its peers. Refer to second box on left side of the exhibit.
- Primary care visits are used more by children ages 5 and younger than the older members enrolled in CHIP. Refer to the third box on the left side of the exhibit.
- When examined by race/ethnicity, the usage rate was lower for African-American children in every year than was observed for other race/ethnicities. Refer to the bottom left box of the exhibit.

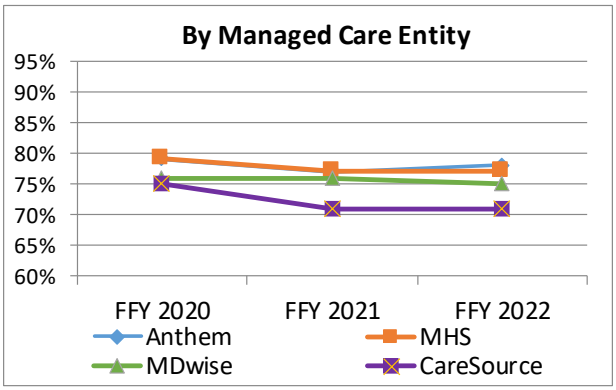
The utilization per 1,000 member trends for primary care shown on the right side of the exhibit mirror the usage trends on the left side. The one area where utilization was slightly different during the pandemic months was by age group. Children up to age 5 utilized primary care at a much lower rate in FFY 2021 compared to FFY 2020. But the utilization bounced back for this age group in FFY 2022. Refer to the third box on the right hand side of the exhibit.

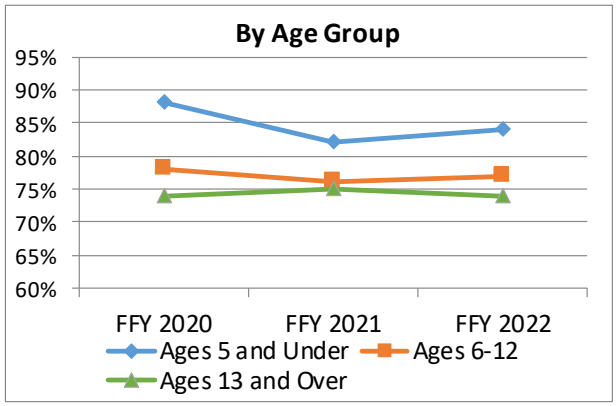
Although the percentage of children receiving primary care services was similar by race/ethnicity with the exception of African-American children, it was found that Caucasian children used more of this service (that is, had more visits) than children in other race/ethnicities. Refer to the bottom right box of the exhibit for details.

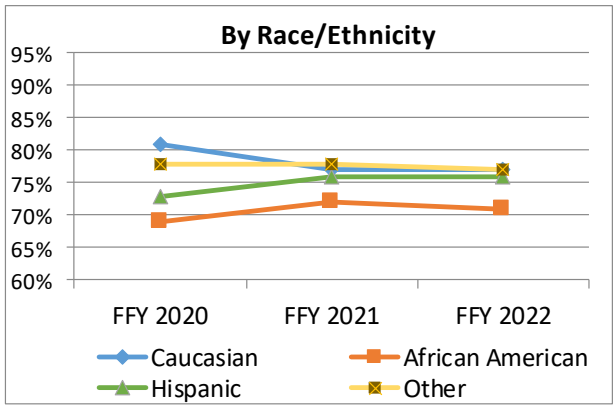
Exhibit IV.1
Utilization of Primary Care in Indiana's CHIP

Percent of Members Using the Service Each Year

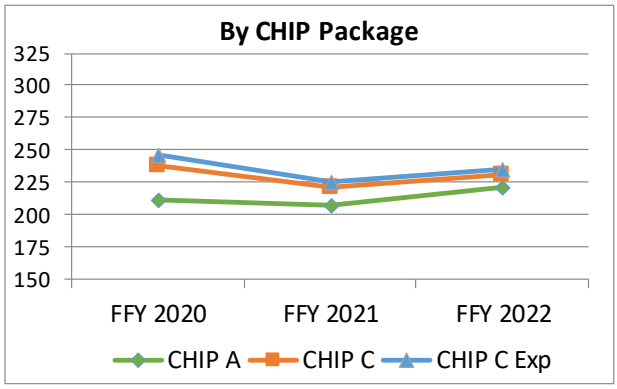


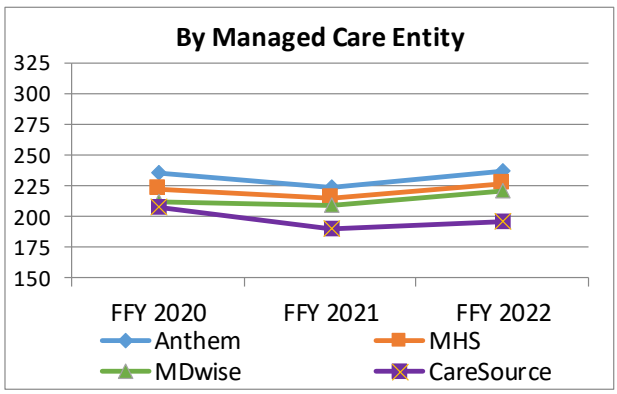


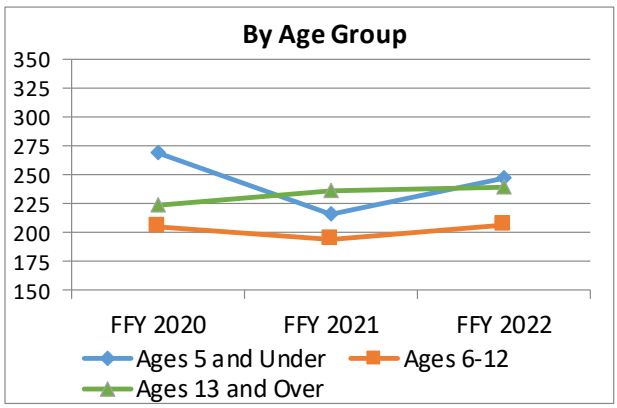


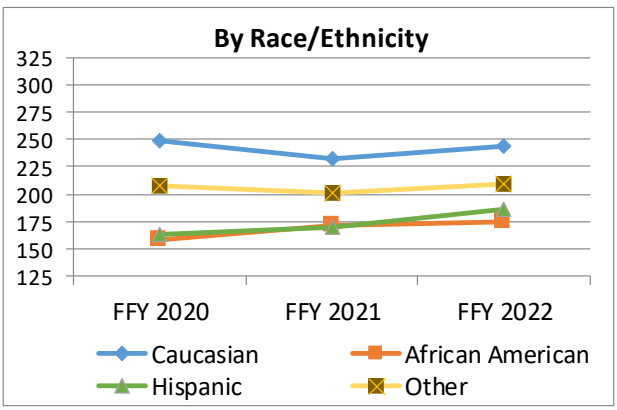


Utilization Per 1,000 Members During Time Period









Emergency Department Visits

On the left side of Exhibit IV.2 shown on page IV-5, it was found that the percentage of CHIP members that accessed the emergency department was consistent across Package (CHIP A, CHIP C and CHIP C Expansion) and across MCEs in each of the years FFYs 2020 and 2021. Children in CHIP Package A are using the ED slightly more in FFY 2022 (20% of children compared to 16% of children in CHIP Package C). Refer to the upper left box in the exhibit. Utilization of the ED decreased for all portions of the CHIP during the initial years of the pandemic and has stayed steady since then. Refer to the upper right box in the exhibit.

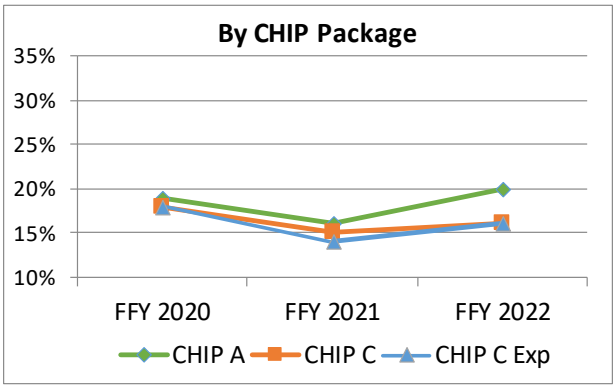
Both the usage rate and utilization per 1,000 members for ED visits is consistent across the MCEs in each reporting year. Refer to the second row of boxes in the exhibit.

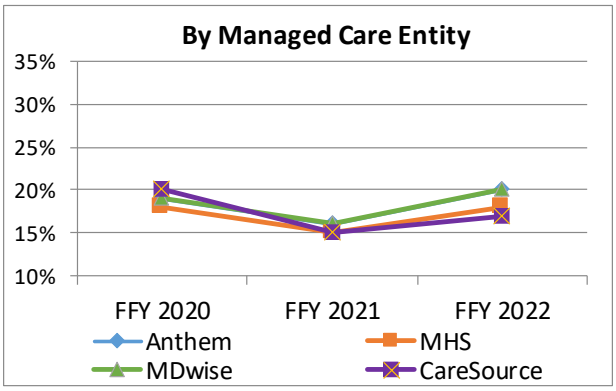
When stratified by age, younger children use the ED more often than older children. In FFY 2022, 26% of children ages 5 and under used the ED compared to 17% of children ages 6 to 12 and 20% of children ages 13 and over. When measured on a per 1,000 member basis, the rates are more similar between the ages 5 and under and the ages 13 and over age groups. What this means is that although a lower percentage of children ages 13 and over used the ED at all, there is a higher proportion of children in this age group that used the ED multiple times during the year. Refer to the third row of boxes in the exhibit for details.

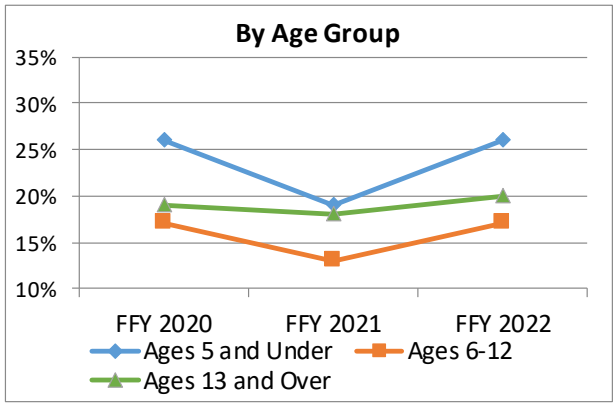
There is some variation in ED use by race/ethnicity, but nothing significant except that Hispanic children used the ED less often than others. Refer to the bottom row of boxes in the exhibit.

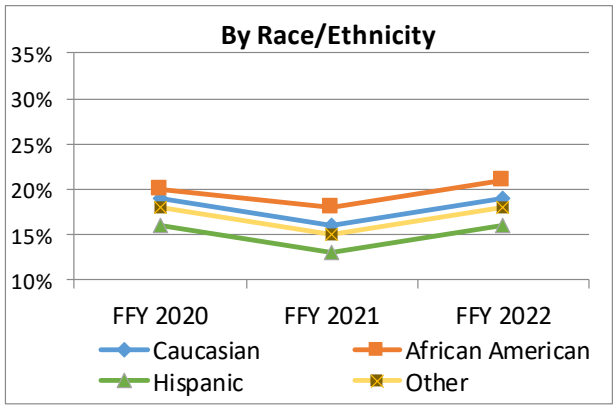
Exhibit IV.2
Utilization of the Emergency Department in Indiana's CHIP

Percent of Members Using the Service Each Year

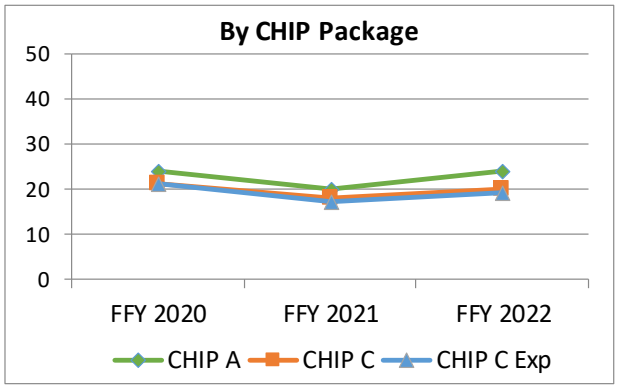


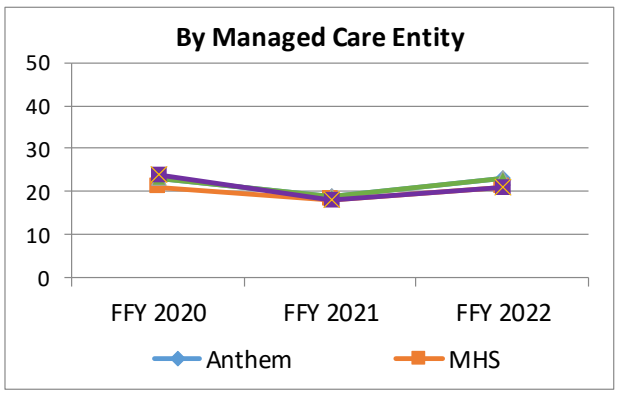


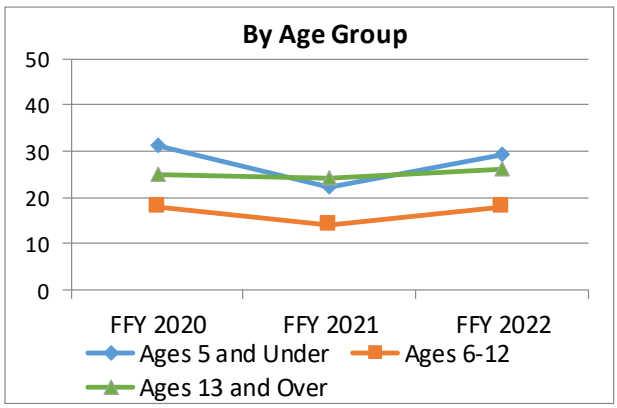


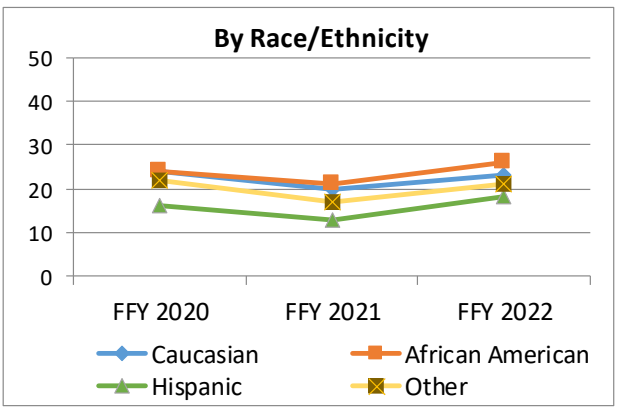


Utilization Per 1,000 Members During Time Period









HMA-Burns also examined the prevalence of children who are frequent users of the ED. In the most recent FFY, most CHIP children (83.9%) had no ED visits. There were 12.8% of children that had one or two ED visits during the year while 2.8% had 3-5 visits. These results are consistent across the MCEs as well. There is a higher percentage of CHIP children that used the ED in the most recent year compared to what was observed in the same study last year (refer to the far-right column).

It should be noted that Exhibit IV.3 below differs from Exhibit IV.2 on the previous page when examining the percentage of members who used the ED due to the enrollment period of members in each exhibit. An average of 19% of CHIP children were found to use the ED in FFY 2022 in Exhibit IV.2. This examined children who were enrolled in CHIP for at least 9 months of the year. The usage rate of 16.1% shown below examines all children enrolled in CHIP during FFY 2022, regardless of their length of enrollment.

Exhibit IV.3
Frequency of ED Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2021 - September 30, 2022

	Percentage of All Members Using ER by MCE					
Number of ER Visits per Member	**Anthem**	**CareSource**	**MHS**	**MDwise**	**All MCEs This Year**	**All MCEs Last Year**
Zero	83.9%	85.9%	84.3%	82.7%	83.9%	90.6%
1 to 2	13.0%	11.4%	12.8%	13.0%	12.8%	8.0%
3 to 5	2.7%	2.2%	2.3%	3.6%	2.8%	1.2%
6 to 10	0.4%	0.4%	0.5%	0.6%	0.5%	0.2%
More than 10	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%

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

Preventive Dental Visits

On the left side of Exhibit IV.4 shown on page IV-8, it was found that the percentage of CHIP members that had a preventive dental visit was slightly higher for CHIP C members than CHIP A members, but this gap closed in FFY 2022. For all three areas of CHIP, the percentage of users of preventive dental visits declined during the pandemic years compared to pre-pandemic levels.

There is variation in the percentage of CHIP members using dental services across the MCEs. MDwise and MHS show similar rates with the highest usage, and Anthem is slightly below them. CareSource is much below the other MCEs.

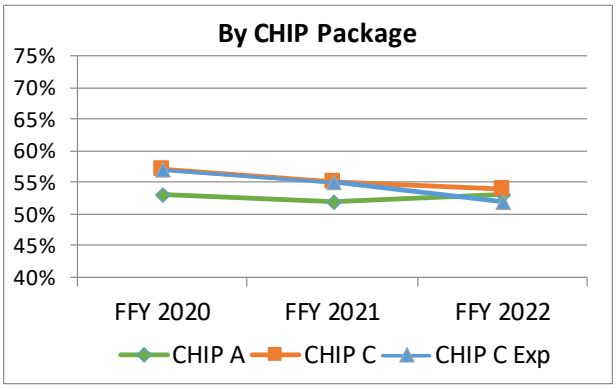
Dental usage is much higher for children ages 6 to 12 (60-61% each year) than children ages 13 and over (47% to 50% across the years) or children ages 5 and under (42% to 46% across the years).

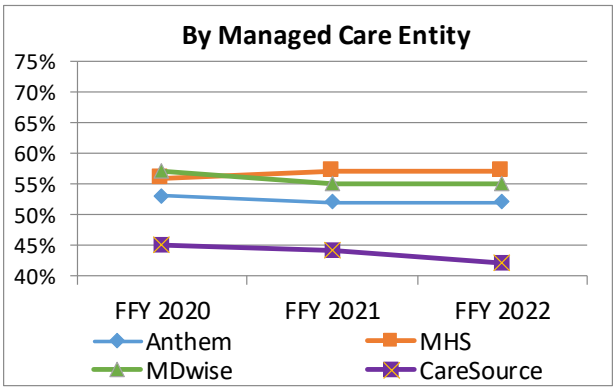
Hispanic children in Indiana's CHIP have traditionally had a higher usage rate for dental services than other race/ethnicities. Although African-American children show a lower usage rate in the first two years of the study, their usage rate is slightly higher than Caucasian children in FFY 2022.

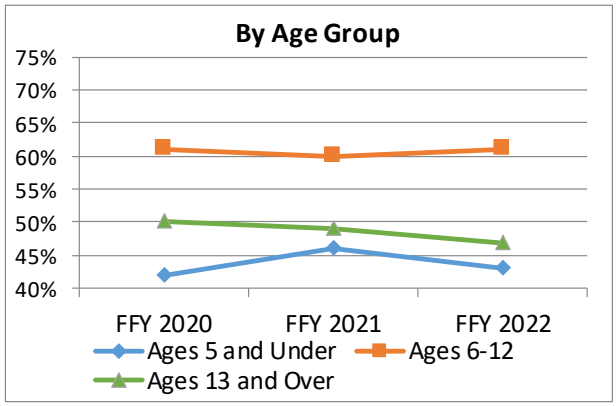
The utilization per 1,000 member trends for preventive dental visits shown on the right side of the exhibit mirror the usage trends on the left side, with the exception of the utilization by age groups. The utilization per 1,000 members for the age groups 5 and under and 13 and over are similar, but it was found that fewer children ages 5 and under have actually had a visit each year compared to the teenagers.

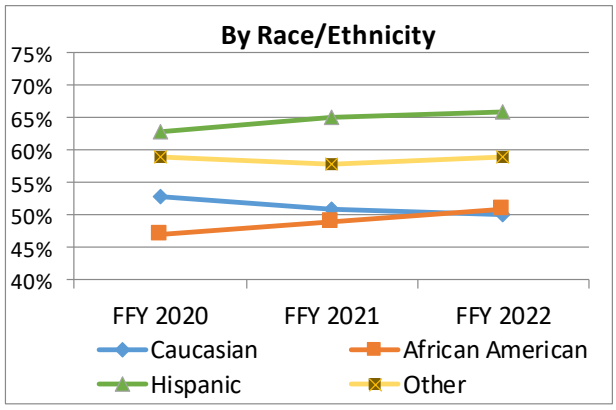
Exhibit IV.4
Utilization of Dental Care in Indiana's CHIP

Percent of Members Using the Service Each Year

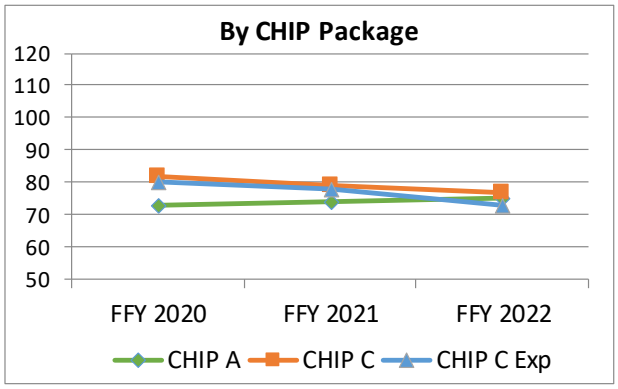


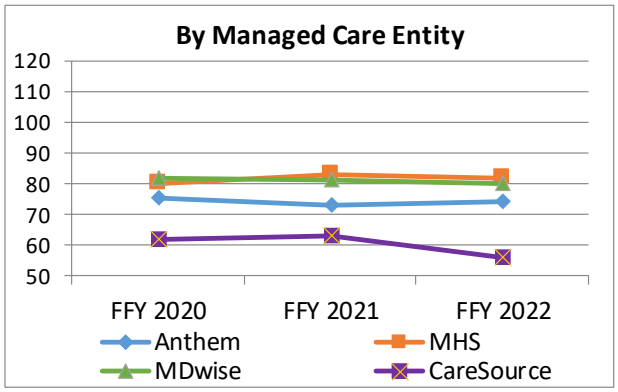


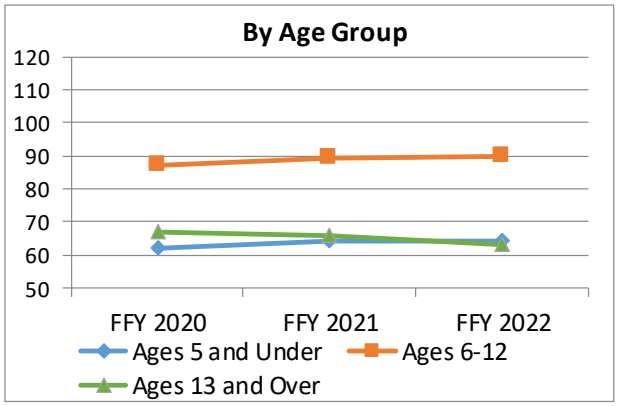


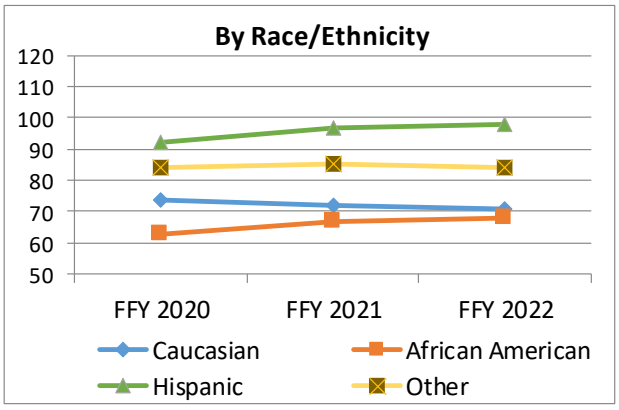


Utilization Per 1,000 Members During Time Period









Pharmacy Prescriptions

Exhibit IV.5, shown on page IV-10, compares usage rates and utilization (scripts) for pharmacy across the subgroups within CHIP. Both the usage rate and the utilization per 1,000 member rates have been consistent between CHIP Package A and CHIP Package C across the three years studied. There were 60% of CHIP children who received a pharmacy script in FFY 2022. The utilization per 1,000 members varied from 554 to 600 scripts. Pharmacy usage increased from FFY 2021 to FFY 2022, but it is still not as high as it was pre-pandemic.

Usage rates are similar across three of the MCEs, but CareSource children have a lower usage rate than the other MCEs each year. Children ages 13 and over have had a steady rate of pharmacy use during the pandemic and their utilization per 1,000 members is also much higher than the lower age groups. The percentage of pharmacy users decreased considerably in FFY 2021 but picked back up in FFY 2022.

A significantly higher percentage of Caucasian children have had pharmacy scripts (63% in FFY 2022) compared to minority children (54% to 58% in FFY 2022).

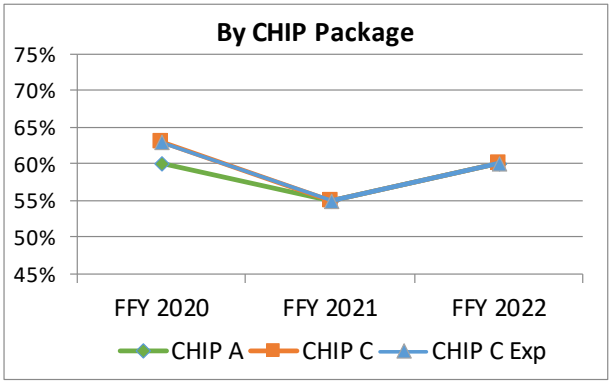
Whereas the utilization per 1,000 member trends were found to mirror the usage trends for primary care, ED visits, and dental services, there are some differences when examining pharmacy scripts. Most notably:

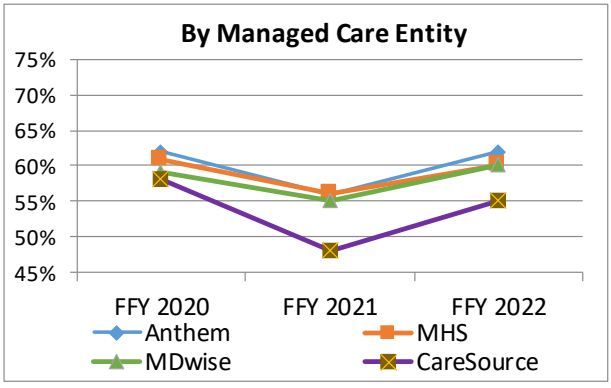
- Although the percentage of CHIP members who have pharmacy scripts is similar across the MCEs, CHIP members enrolled with MDwise have a higher number of scripts per 1,000 members than other MCEs. [Compare the 2nd row of boxes on the left and right side of the exhibit.]
- The oldest children in CHIP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

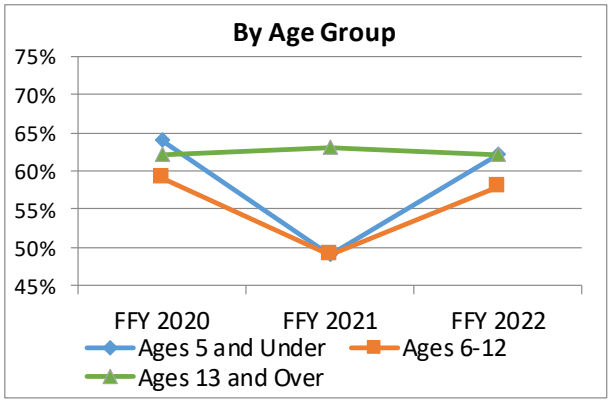
Exhibit IV.5

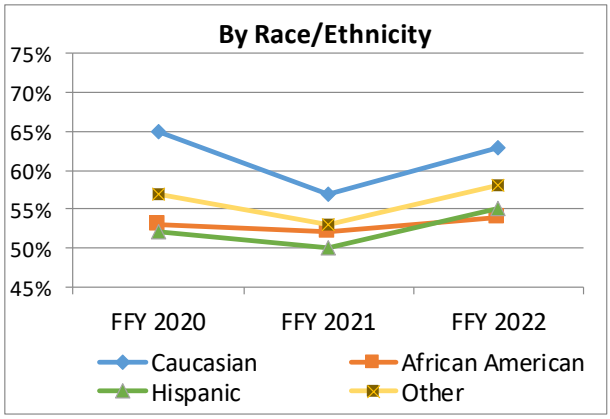
Utilization of Pharmacy Scripts in Indiana's CHIP

Percent of Members Using the Service Each Year

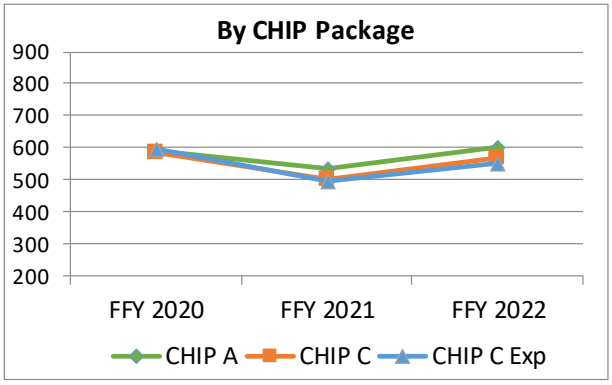


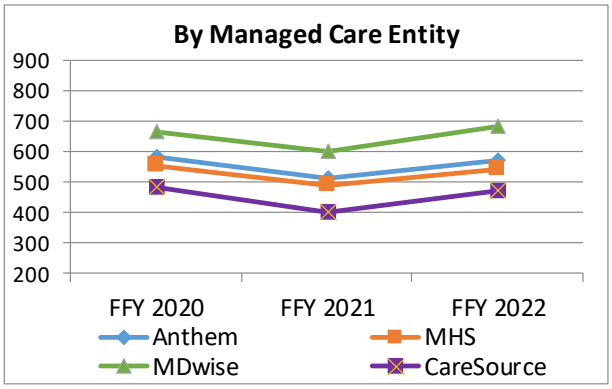


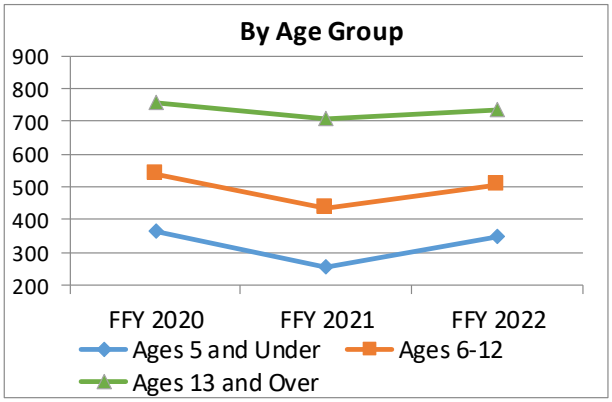


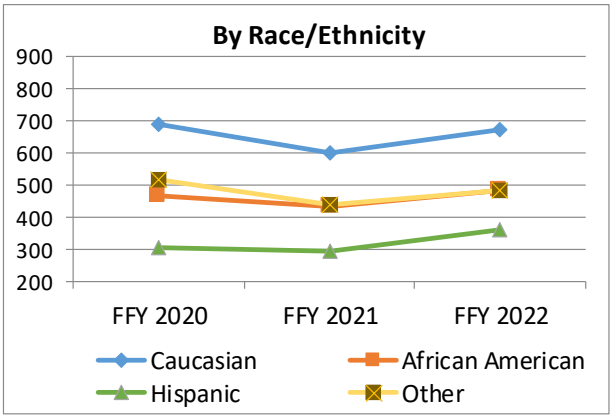


Utilization Per 1,000 Members During Time Period









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

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

OMPP's Oversight of Quality

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

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

1. OMPP requires the MCEs to report the results of HEDIS®[3] and CAHPS®[4] measures. The HEDIS are nationally-recognized measures that use standard definitions. Results are attested to by certified auditors. The OMPP requires that its MCEs report their results to the National Committee of Quality Assurance (NCQA). The OMPP compares the results of the HEDIS measures across the MCEs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS is a satisfaction survey and there are different surveys administered for adults and for parents of children. The OMPP requires the MCEs to administer each survey annually.

2. Separately, the Centers for Medicare and Medicaid (CMS) requires each state to report a set of core child measures annually to CMS. Currently, there are 23 core measures. These include some HEDIS and CAHPS measures as well. CMS hires a national evaluator to analyze the results of these measures and make comparisons across the state Medicaid agencies.

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

4. In addition to the goals set for its CHIP program specifically, the OMPP also develops a Quality Strategy plan each year. Many items within the Quality Strategy pertain to outcomes for children, both CHIP and traditional Medicaid members, such as improving the participation rate for Early Periodic Screening, Diagnosis and Treatment (EPSDT) and ensuring follow-up care for behavioral health hospitalizations within 7 days of discharge.

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

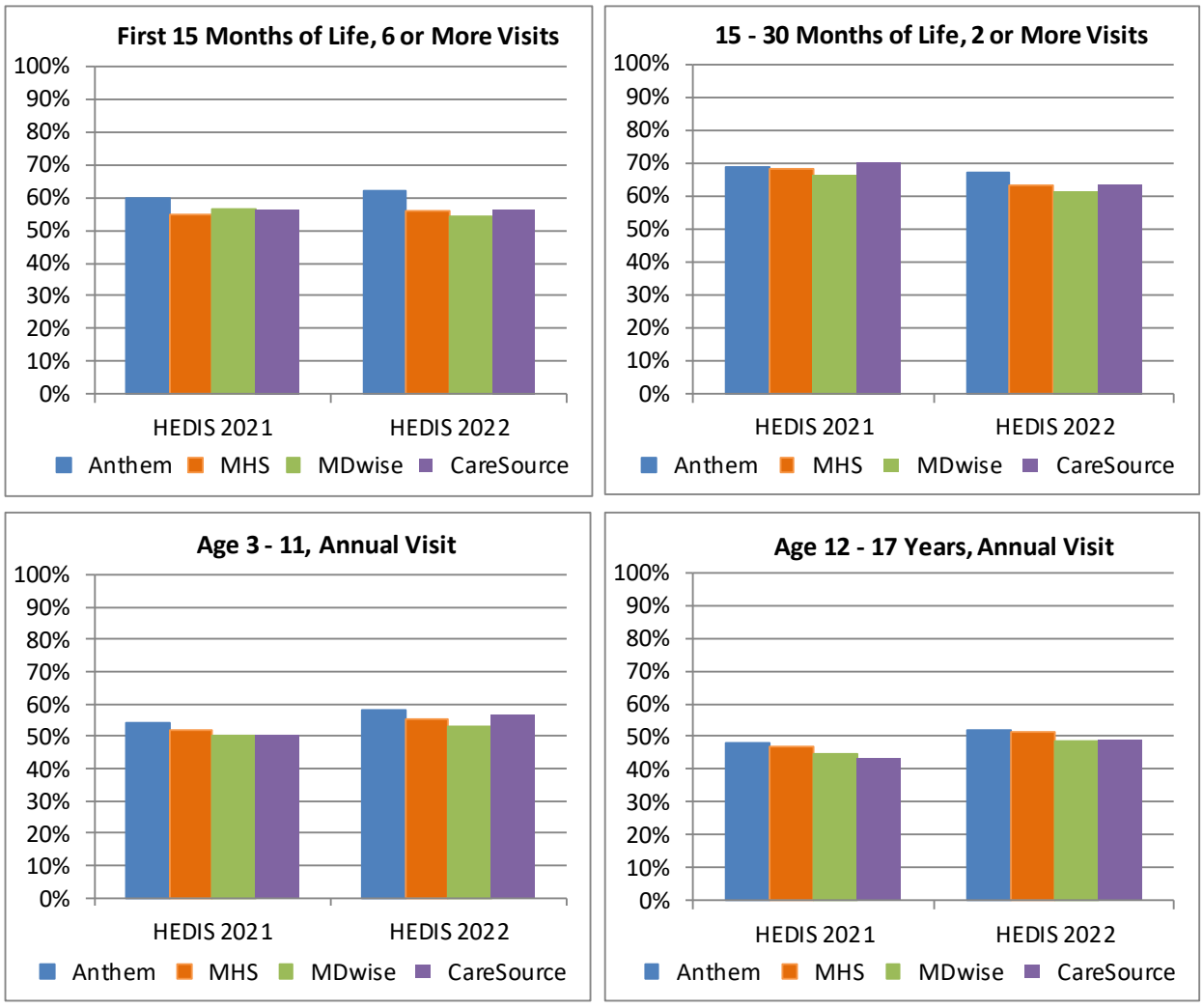
[4] The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members (both CHIP and Medicaid members) from the prior year. Therefore, in Calendar Year (CY) 2022, tabulations were collected on HEDIS rates for 2021 utilization.

Exhibit V.1 presents the HEDIS results for well care visits for each MCE. For children in the first 15 months of life (upper left box), the HEDIS rate shown represents the percentage of children with 6 or more well child visits. For the most current reporting year, the rate varied from 54% for MDwise to 62% for Anthem. For children ages 15 to 30 months, the measure is for two or more visits during this time (upper right box). The MCEs reported similar rates on this measure, ranging from 61% for MDwise to 67% for Anthem. For children ages 3-11 years (lower left box) and adolescents (lower right box), the rate shown represents the percentage of children that had at least one annual visit. For the ages 3 to 11 group, the annual visit rate varied from 53% for MDwise to 58% for Anthem. For the adolescents, the rate varied from 49% for CareSource and MDwise to 52% for Anthem.

Exhibit V.1
Summary of Results from HEDIS Well Care Measures (Percentage of Total)



Some other annual HEDIS measures for children relate to asthma medication use and immunizations. In the upper two boxes of Exhibit V.2, the asthma medication ratio represents the percentage of children who remained on an asthma controller for at least 505 of their treatment period. For the younger children (upper left box), CareSource had the highest rate reported in HEDIS 2022 at 88%. MHS and MDwise had lower rates at 75%. For the older children (upper right box), Anthem and CareSource reported similar rates in HEDIS 2022 (73-74%) whereas MHS and MDwise were lower (63-65%).

For the childhood immunization measure (bottom lower box), the rate reports the percentage of children who turned age 2 during the measurement year who were enrolled for the 12 months prior to their second birthday who received the immunizations as recommended by the American Academy of Pediatrics. The rate varied from 52% (MDwise) to 60% (CareSource and MHS) in HEDIS 2022. For the adolescent immunizations HEDIS measure, 3 of the MCEs reported similar results while CareSource was lower.

Exhibit V.2
Summary of Results from Selected Child HEDIS Measures for Physical Health

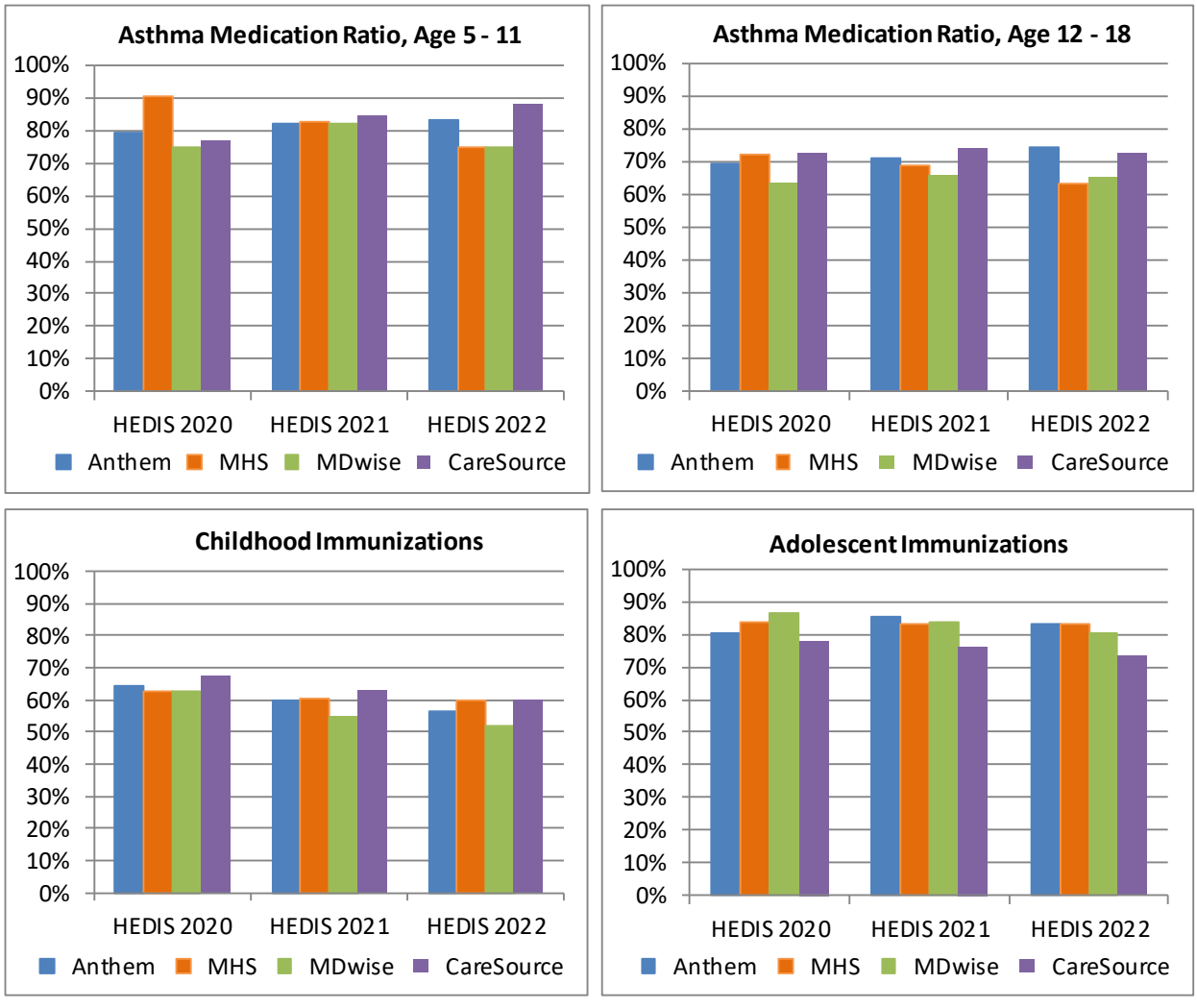
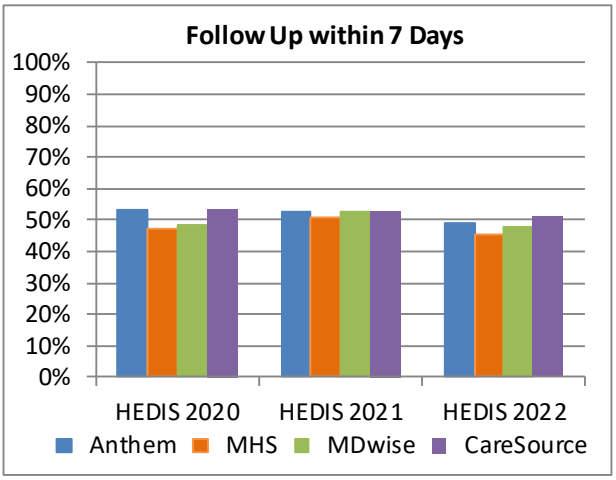


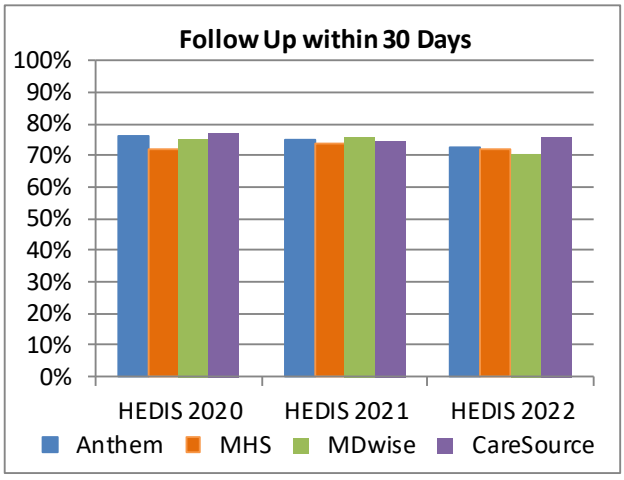
Exhibit V.3 presents the results of behavioral health HEDIS measures. The measures in the top boxes show the percentage of children in HHW with follow-up visits (within 7 days and 30 days) in the community after a hospitalization for mental illness. In the lower boxes, the measures show the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period. The left box shows percentage of children who had a follow-up visit within 30 days of prescribing ("initiation phase"). The right box shows the percentage who continued taking ADHD medication and had at least two visits after the first visit ("the continuation and maintenance phase").

The MCEs reported similar results for the follow-up visits after hospitalization, in the range of 45% to 51% for visits within 7 days and 70% to 76% of members who had a visit within 30 days. CareSource had the highest rates for follow-up after ADHD medication prescribed in both measures. The rate in the range reported was 40% for MHS to 48% for CareSource (initiation phase) and 50% for MHS to 57% for CareSource (continuation and maintenance phase).

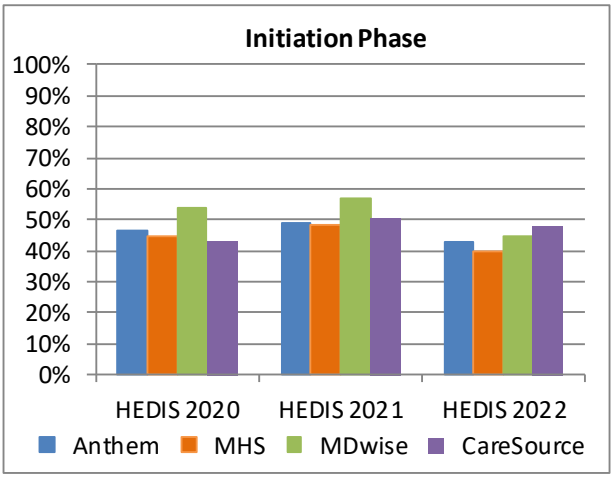
Exhibit V.3
Summary of Results from Selected Child HEDIS Measures for Behavioral Health

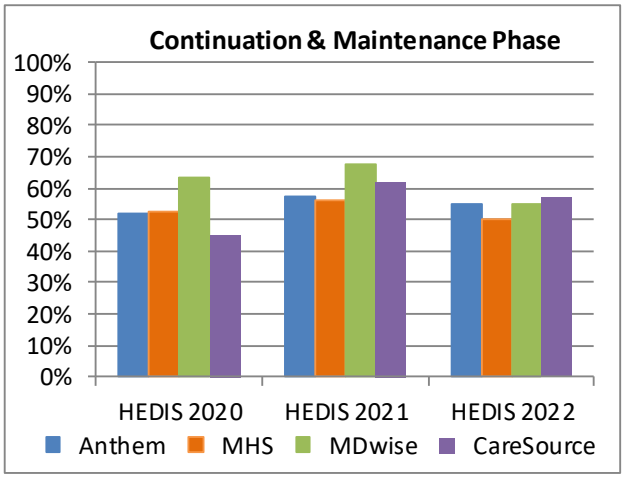
Follow-Up After Hospitalization for Mental Illness





Follow-Up Care for Children Prescribed ADHD Medication





In addition to the year-over-year changes for each MCE, HMA-Burns compared the latest HEDIS year results to see how Indiana's MCEs compared to Medicaid health plans nationally. The measures shown in Exhibit V.4 below track back to what was shown in Exhibits V.1 through V.3. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the 12 measures reviewed, Anthem had 10 in which its rates exceeded the national median values, CareSource had 7, MDwise had 5, and MHS had 4.

Exhibit V.4
Comparing Hoosier Healthwise MCEs to Health Plans Nationally on Selected HEDIS Measures

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

	Hoosier Healthwise HEDIS 2022			
	Anthem	CareSource	MDwise	MHS
6 or More Well Child Visits First 15 Months of Life	61.9%	56.2%	54.4%	56.2%
2 or More Well Child Visits, Months 15 - 30	67.0%	63.2% ↓	61.0% ↓	63.3% ↓
Annual Well-Care Visit Ages 3 - 11	58.0% ↑	56.8% ↑	53.1% ↑	55.5% ↑
Annual Well-Care Visit Ages 12 - 17	51.8% ↑	48.7% ↑	48.7% ↑	51.3% ↑
Appropriate asthma medication, Age 5-11 Years	83.2%	87.8% ↑	74.9% ↓	74.9% ↓
Appropriate asthma medication, Age 12-18 Years	74.4% ↑	72.5%	65.3%	63.1% ↓
Childhood Immunizations, Combination #3	56.4% ↓	60.1%	51.8% ↓	60.1%
Adolescent Immunizations, Combination #1	83.0% ↓	73.2% ↓	80.3% ↓	83.2%
Follow-Up After Mental Health Hospitalization:				
Within 7 Days	49.2% ↓	51.0% ↓	48.1% ↓	45.4% ↓
Within 30 Days	72.4% ↓	76.0%	70.5% ↓	72.2%
Follow-Up Care when Prescribed ADHD Meds:				
Initiation Phase	42.9% ↓	48.0% ↓	44.6% ↓	39.7% ↓
Maintenance Phase	54.9% ↓	57.3% ↓	54.8% ↓	49.9% ↓

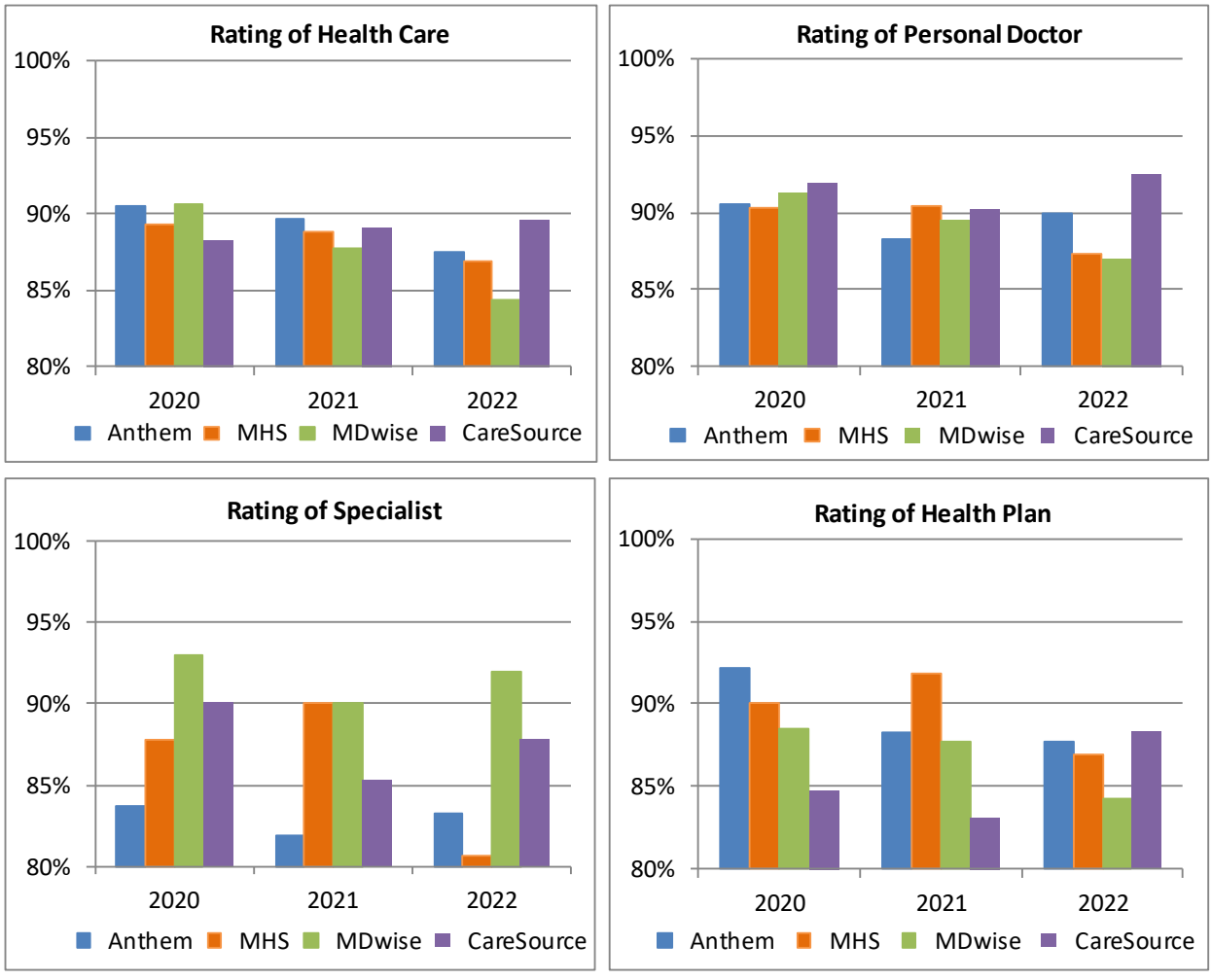
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

CAHPS Results for Children Enrolled in Hoosier Healthwise

The Hoosier Healthwise MCEs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCEs to the OMPP. One survey is specific to adults and another is specific to children. Exhibit V.5 below summarizes the results from the child surveys that were administered over the last three years. The results presented include all children in Hoosier Healthwise—CHIP and traditional Medicaid.

The percentages in Exhibit V.5 reflect those members that assigned a value of 8, 9 or 10 for each rating, where zero is the "worst possible" and 10 is the "best possible." The ratings themselves represent a composite of multiple questions on the survey related to the topic. The results varied among MCEs in the most recent survey year. CareSource ranked higher than others in the ratings of Health Care and Personal Doctor. MDwise had the highest rating for Specialists. Three of the four MCEs had a similar rating of the Health Plan itself, with MDwise coming in lower than others. Compared to the prior year, CareSource saw improvement on each of the four ratings while MHS saw a decline in all four ratings. MDwise saw a decline in 3 of the 4 ratings. Anthem's results were more consistent across the 2021 and 2022 surveys.

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



The CAHPS instrument also compiles composite scores from a series of related questions on other topics as well. 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. All four MCEs scored best on the composite score for How Well Doctors Communicate in the 2022 survey (93% to 97%). Three of the four MCEs also scored at or above 90% in the most recent survey for Getting Care Quickly, an improvement from the prior year survey but still not as high as the 2020 results.

For Getting Needed Care, Anthem and CareSource saw improvement over the prior year survey while MHS and MDwise both declined. For Customer Service, CareSource had the highest rating at 92% while the other MCEs had a rating between 86% and 89%. Compared to the prior year, CareSource saw improvement on each of the 4 ratings while MHS saw a decline in 3 of the 4 ratings. MDwise saw a decline in 2 of the 4 ratings with the other 2 measures were steady. Anthem saw an improvement in 2 of the 4 ratings with the other 2 measures holding steady.

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

Similar to what was shown in Exhibit V.4 in the comparison of Indiana's HEDIS results to national health plans, HMA-Burns conducted a similar comparison for the CAHPS survey results. The measures shown in Exhibit V.7 below track back to what was shown in Exhibits V.5 and V.6. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the 8 measures reviewed, Anthem, MDwise and MHS had 3 in which its rates exceeded the national median values, while CareSource had 8.

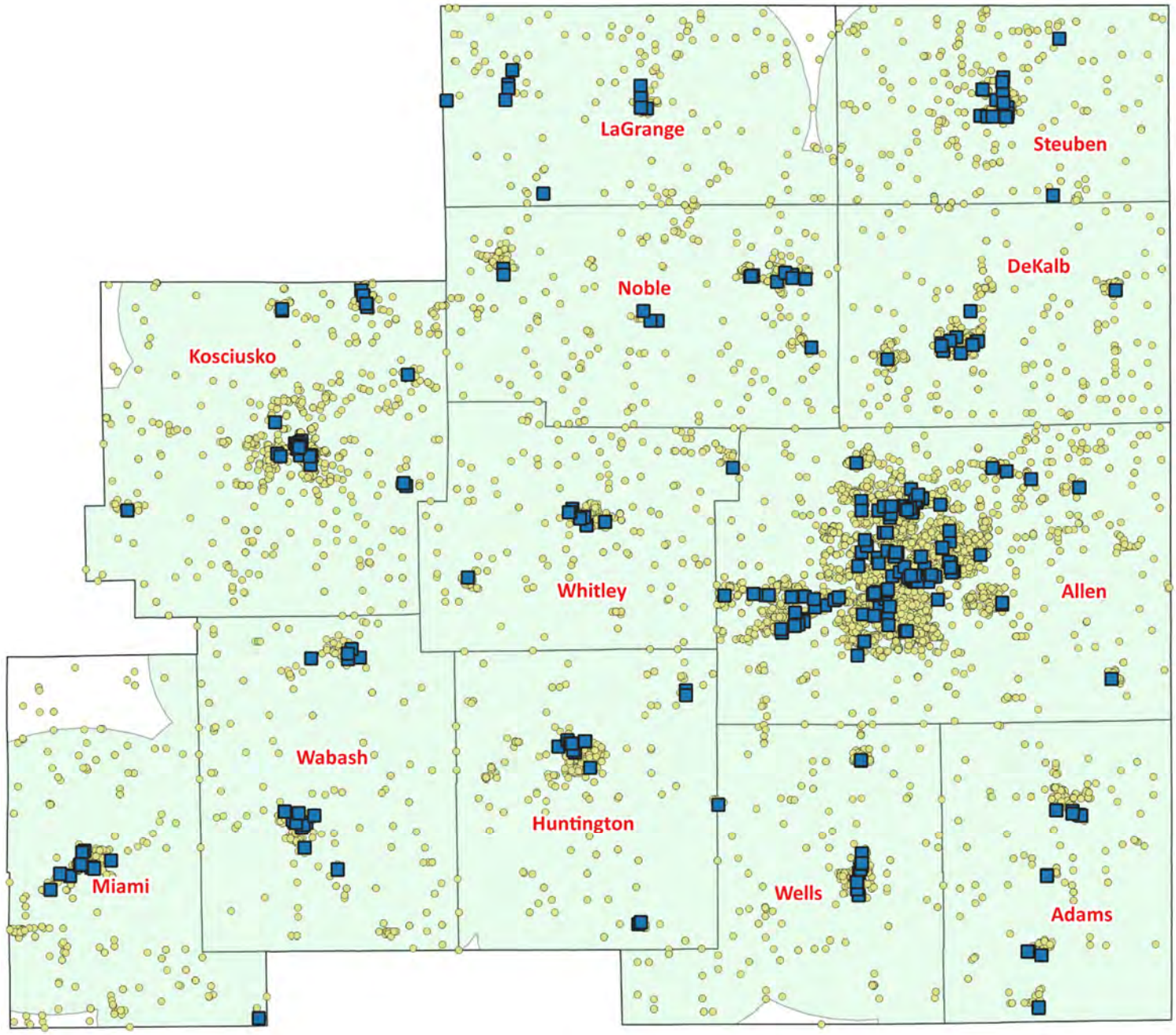
Exhibit V.7
Comparing Hoosier Healthwise MCEs to Health Plans Nationally on Selected CAHPS Measures

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

	Hoosier Healthwise Child Survey in 2022			
Composite Ratings	Anthem	CareSource	MDwise	MHS
Members are asked to give a rating of 1 to 10 on the survey (a 10 is the best score).				
The percentages shown are the percent of members who gave the MCE a score of 8, 9 or 10.				
Rating of the health plan (the MCE)	87.7%	88.3% ↑	84.2% ↓	86.9% ↓
Rating of their own health care	87.5% ↓	89.6%	84.4% ↓	86.9%
Rating of their personal doctor	90.0%	92.5% ↑	87.0% ↓	87.3% ↓
Rating of specialist seen most often	83.3%	87.8% ↑	92.0%	80.7% ↓
Composite Scores on Key Measures				
Members are asked questions on items important to the MCE's delivery of serv				
For each question, members can answer "Always", "Usually", "Sometimes" or				
The percentages shown are the percent of members who responded "Always" or "Usually".				
Customer Service provided by the MCE	87.0%	92.0% ↑	89.2% ↓	85.9% ↓
Getting Needed Care	87.5% ↑	89.0% ↑	82.6% ↓	87.8% ↓
Getting Care Quickly	89.5% ↑	90.6% ↑	86.4%	90.7% ↑
How Well Doctors Communicate	93.0%	96.7% ↑	95.5%	94.0%

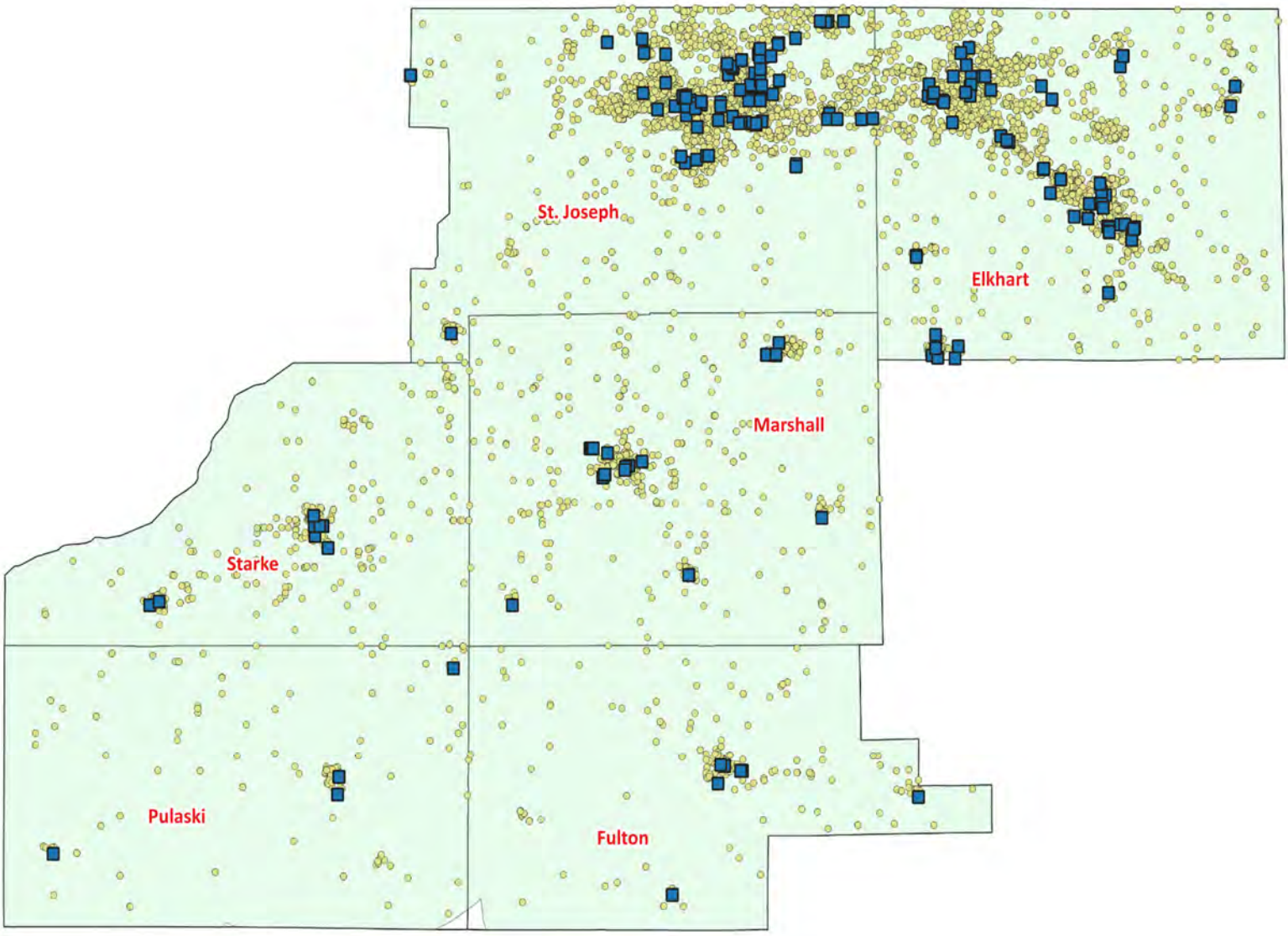
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

Map A.1
Measuring Accessibility to Primary Care Providers
Northeast Region



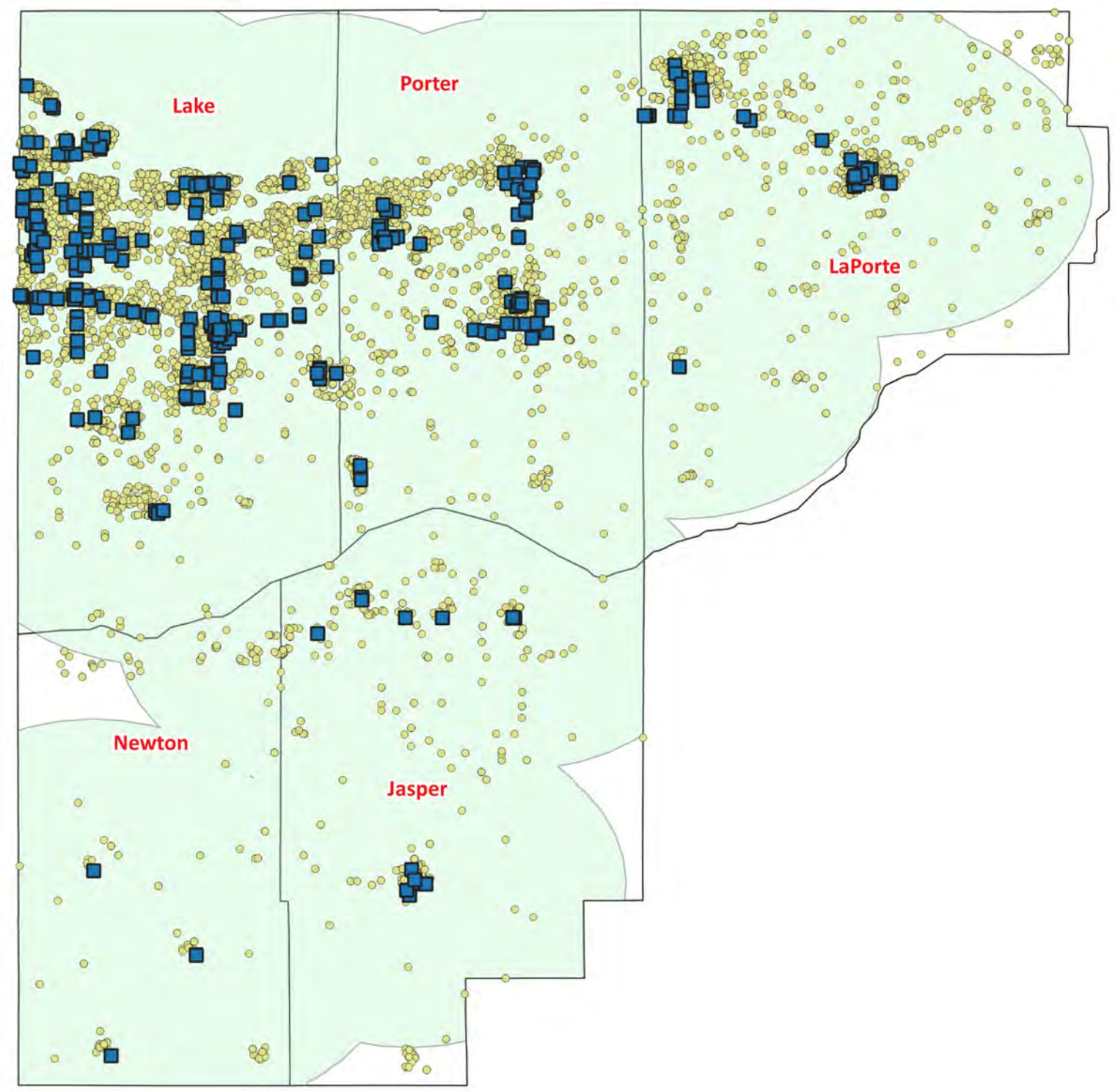
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.2
Measuring Accessibility to Primary Care Providers
North Central Region



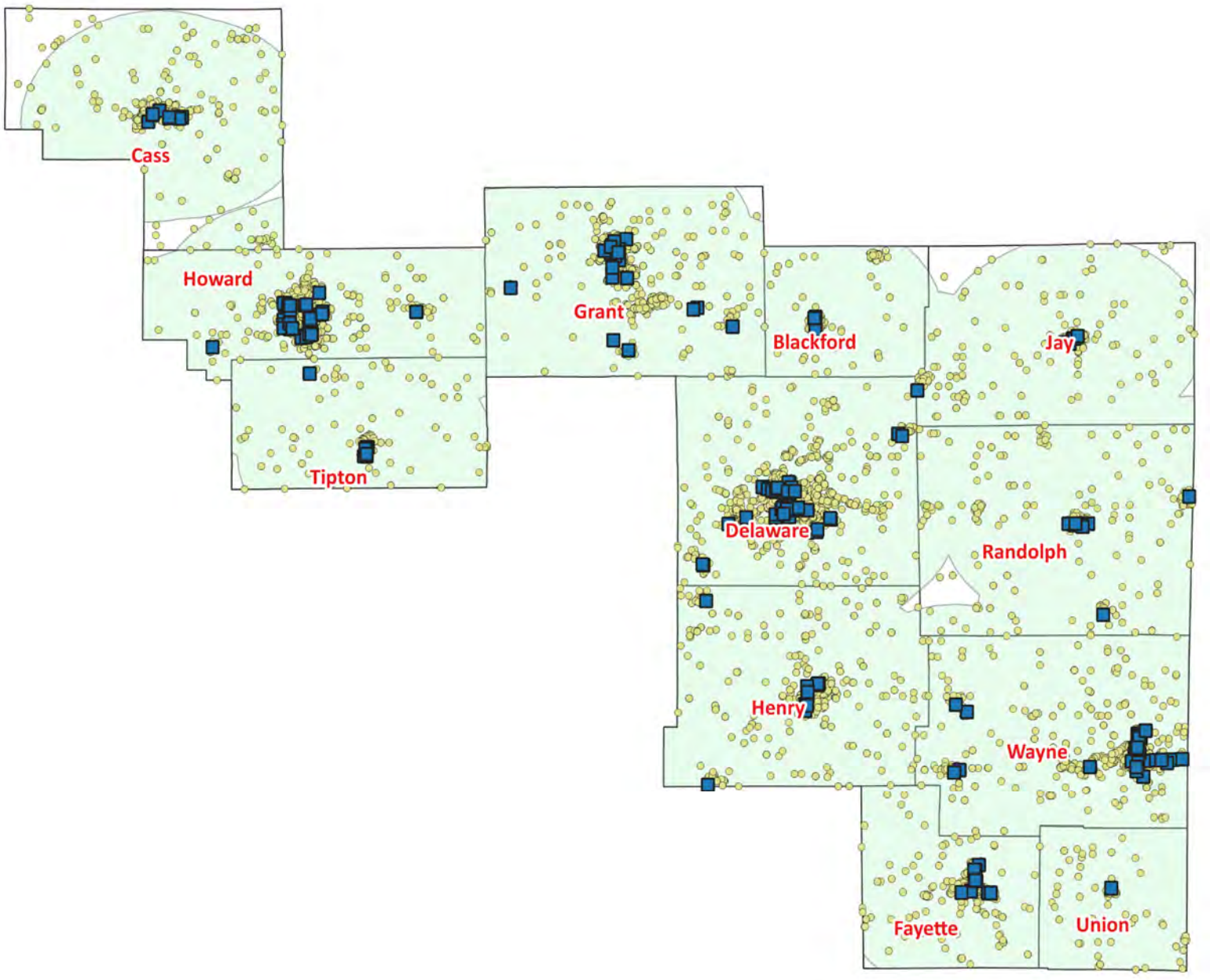
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.3
Measuring Accessibility to Primary Care Providers
Northwest Region



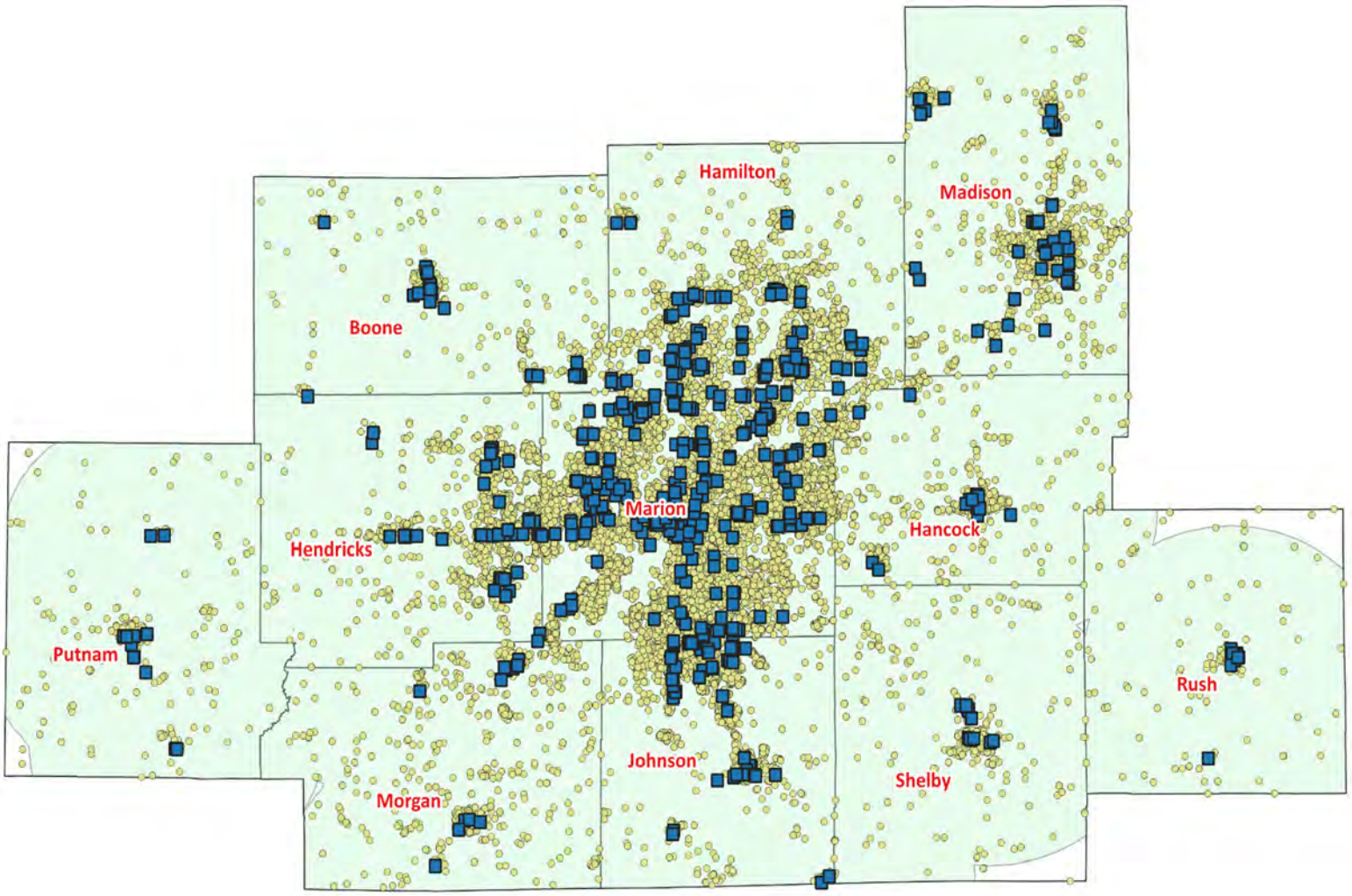
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.4
Measuring Accessibility to Primary Care Providers
East Central Region



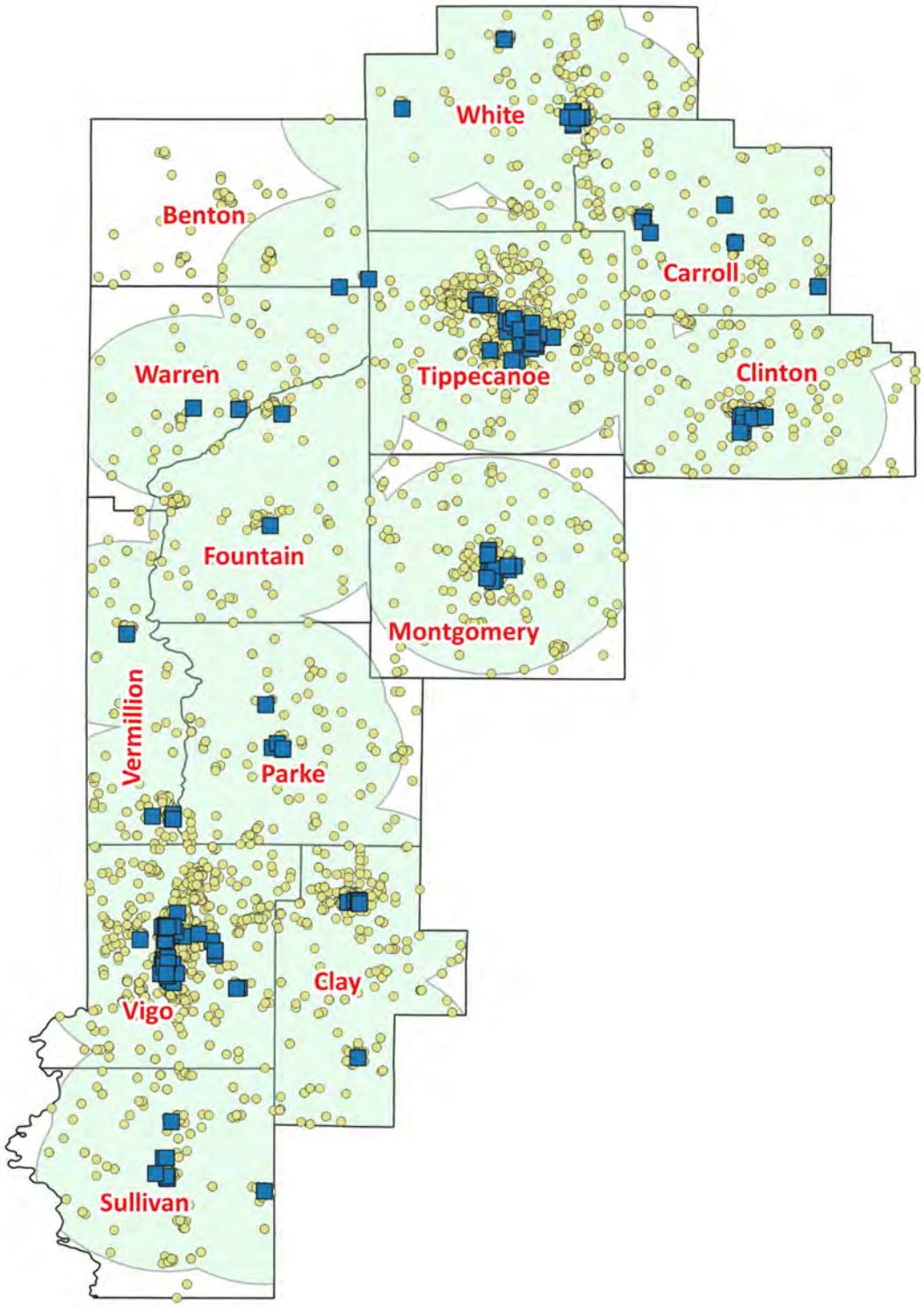
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.5
Measuring Accessibility to Primary Care Providers
Central Region



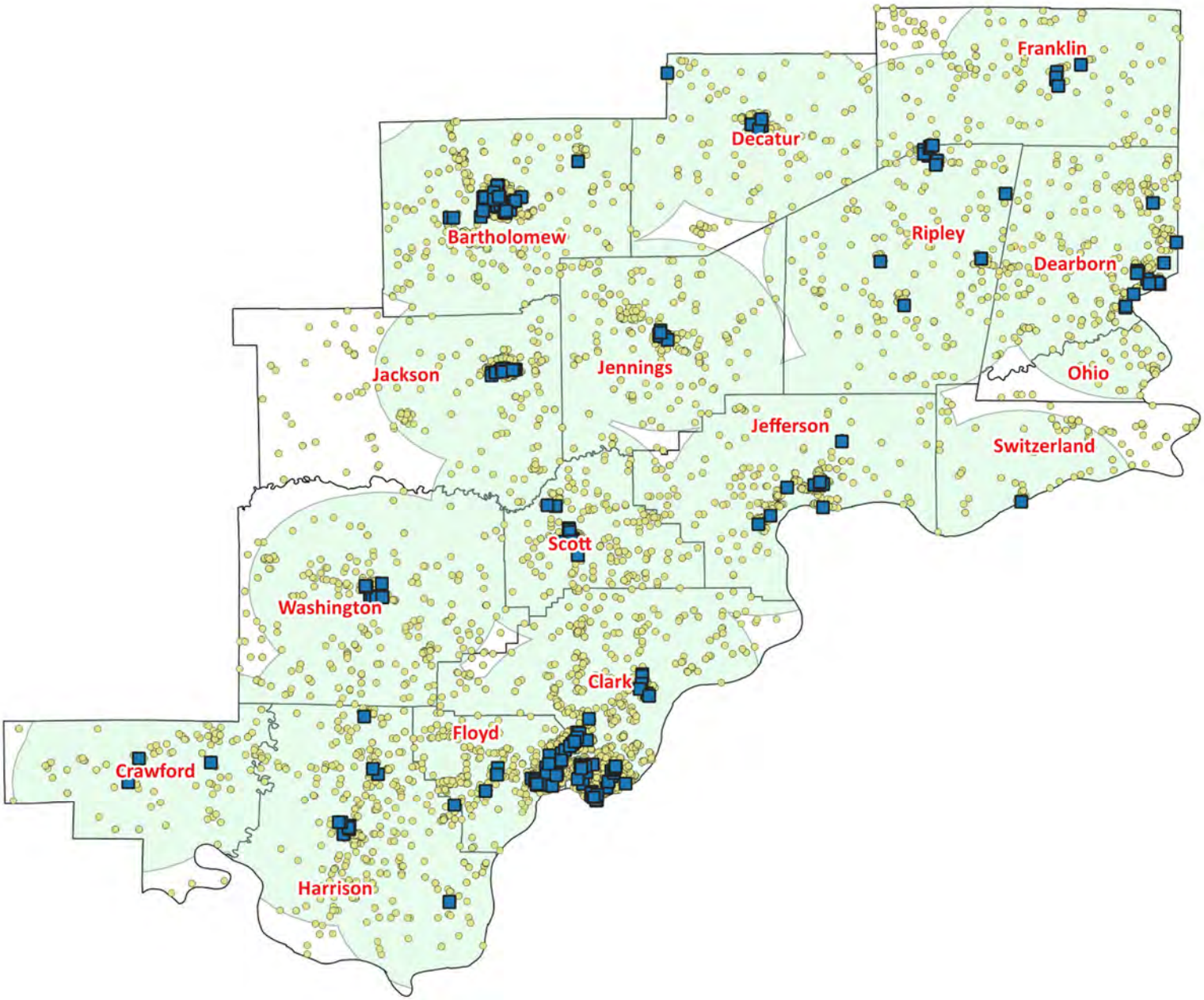
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.6
Measuring Accessibility to Primary Care Providers
West Central Region



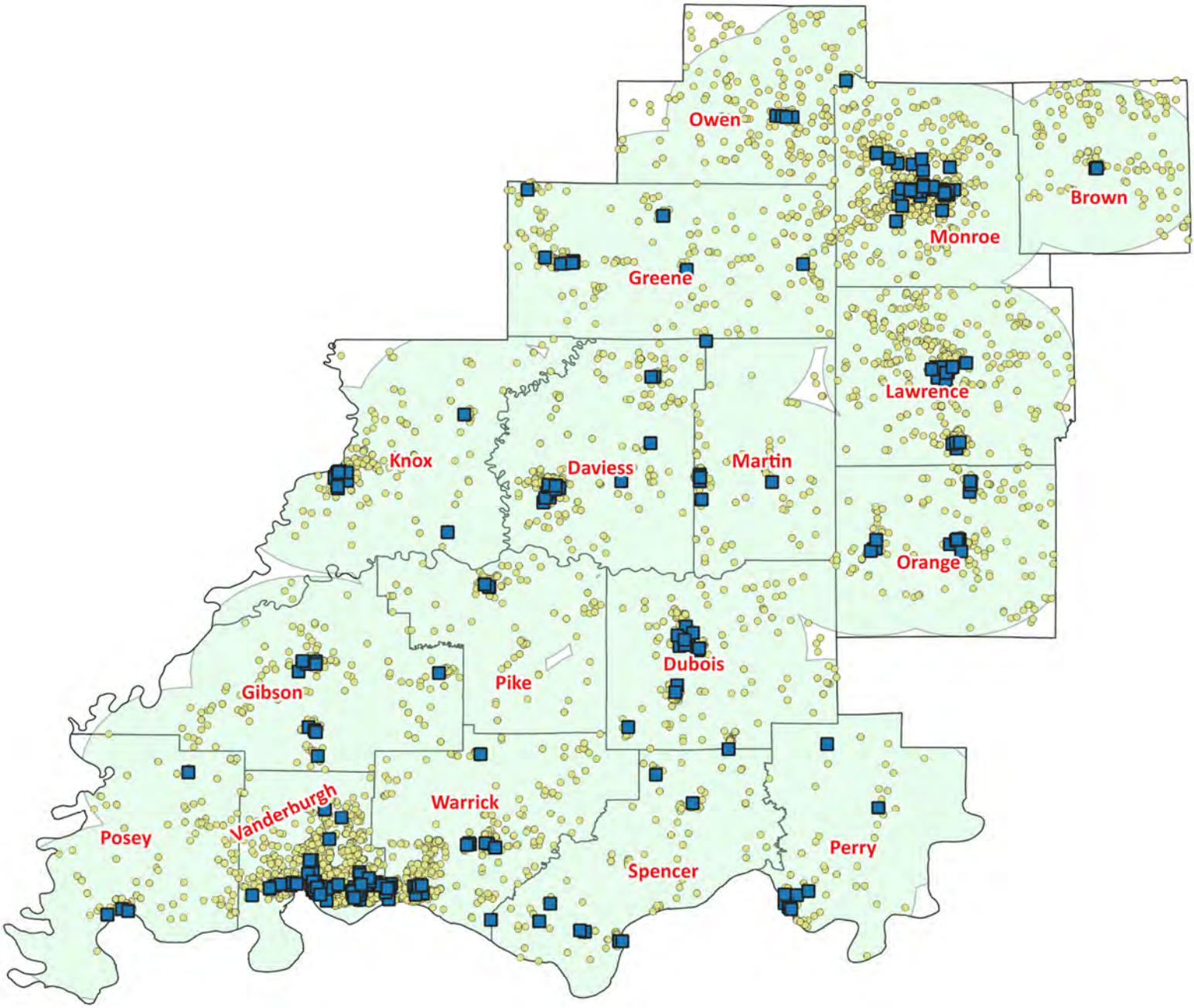
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.7
Measuring Accessibility to Primary Care Providers
Southeast Region



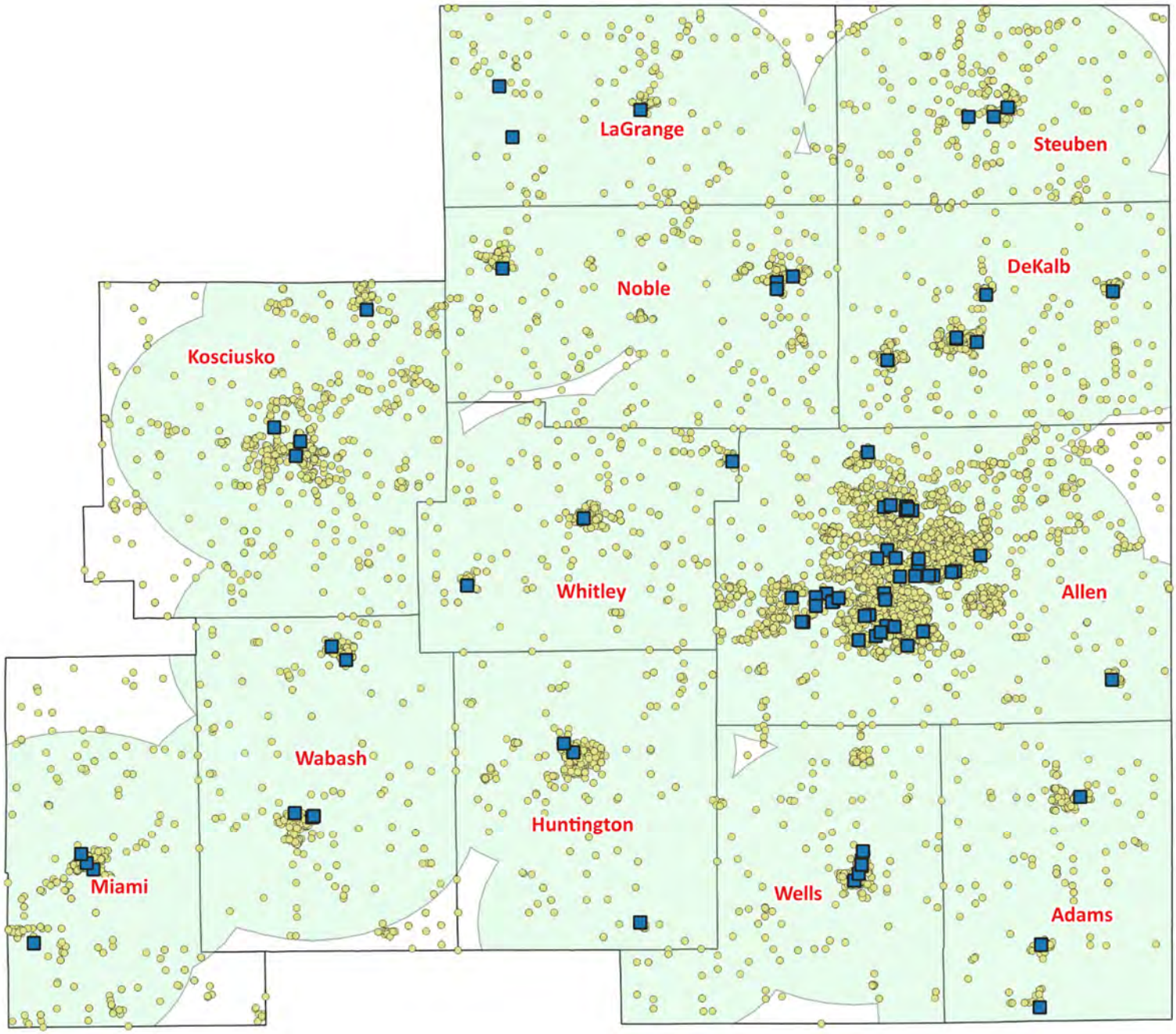
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map A.8
Measuring Accessibility to Primary Care Providers
Southwest Region



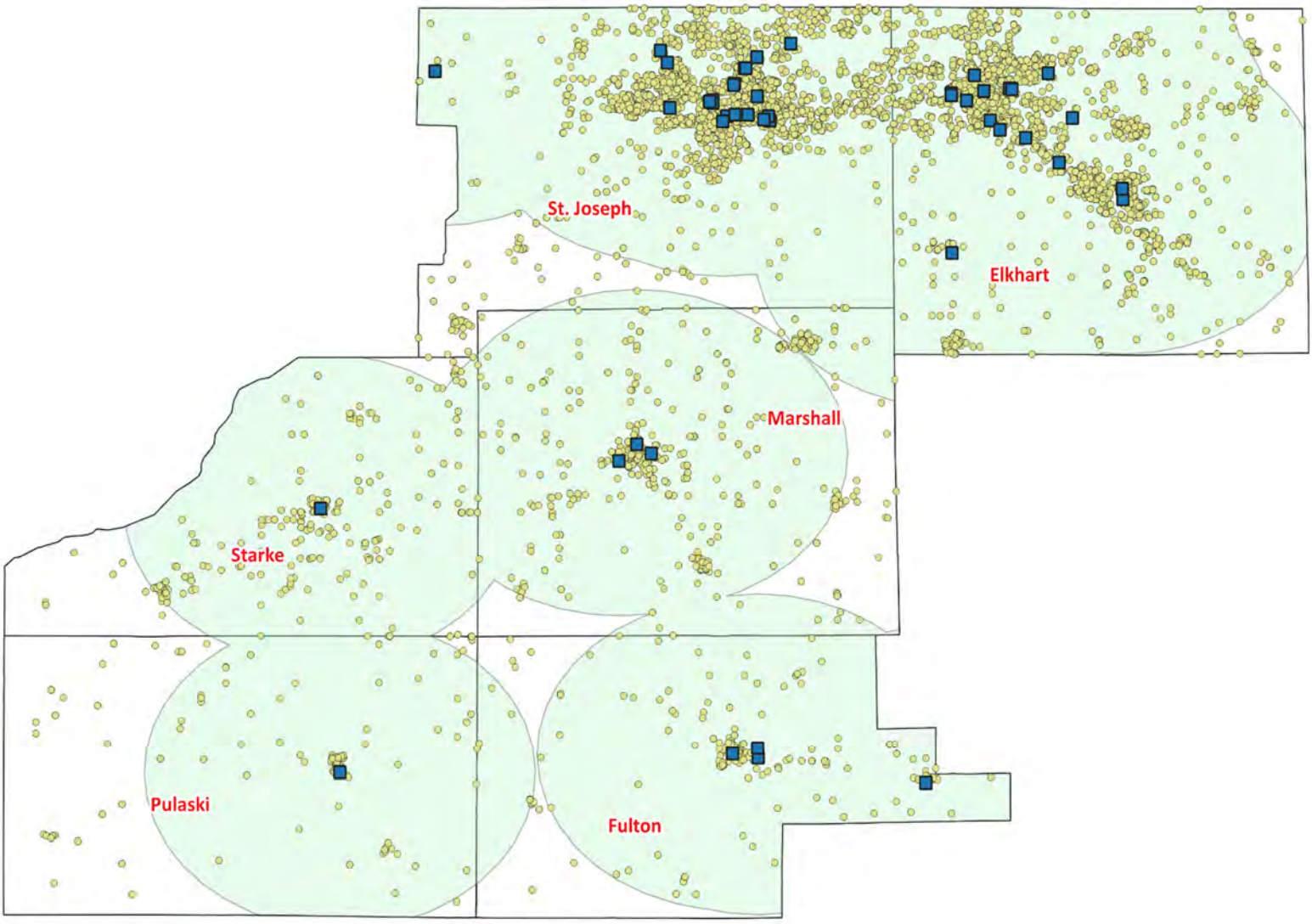
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.1
Measuring Accessibility to Dental Providers
Northeast Region



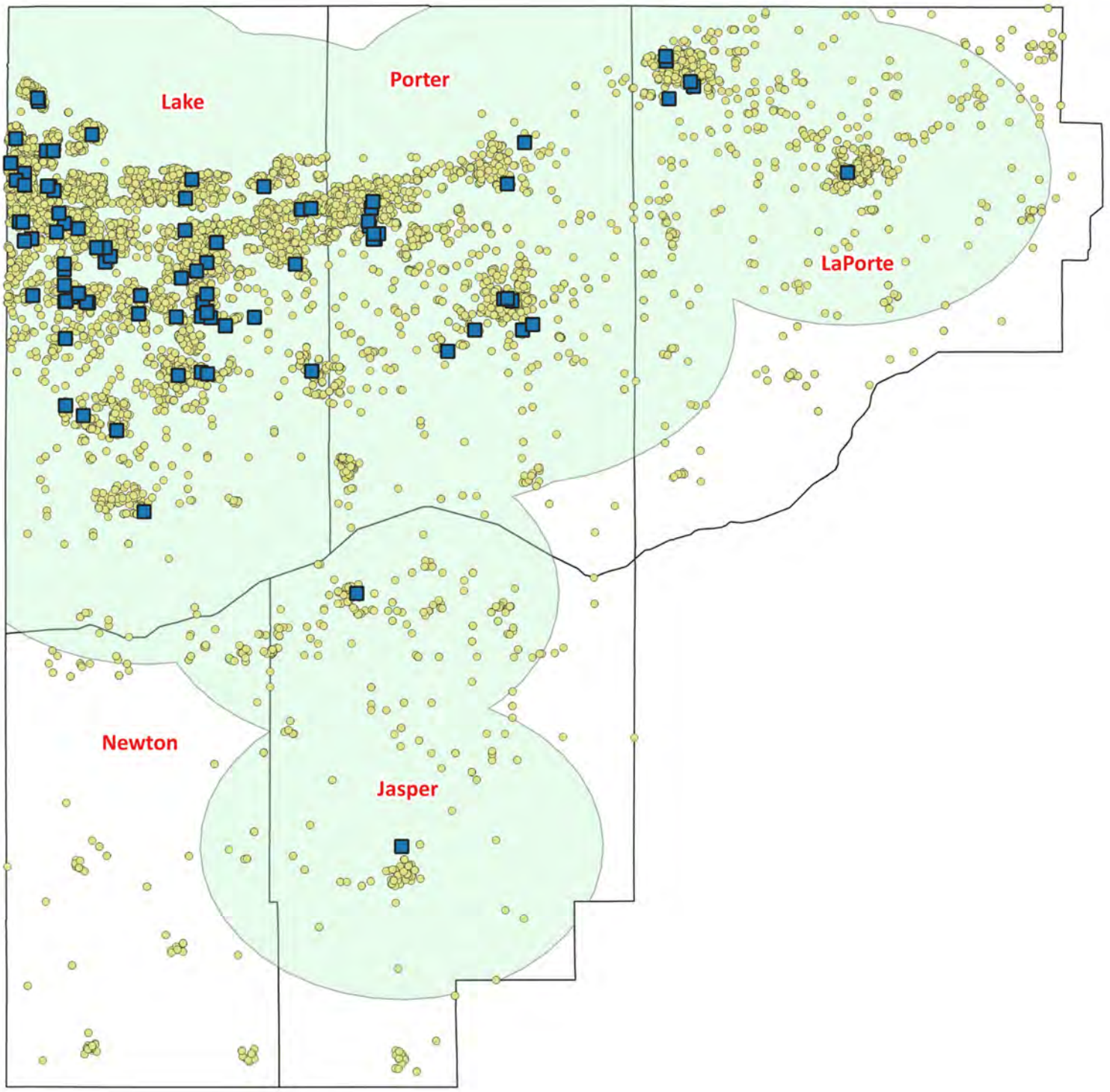
Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.2
Measuring Accessibility to Dental Providers
North Central Region



Providers shown served CHIP members during Oct 2021 - Sep 2022 period
Members shown were enrolled in CHIP as of September 2022
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.3
Measuring Accessibility to Dental Providers
Northwest Region



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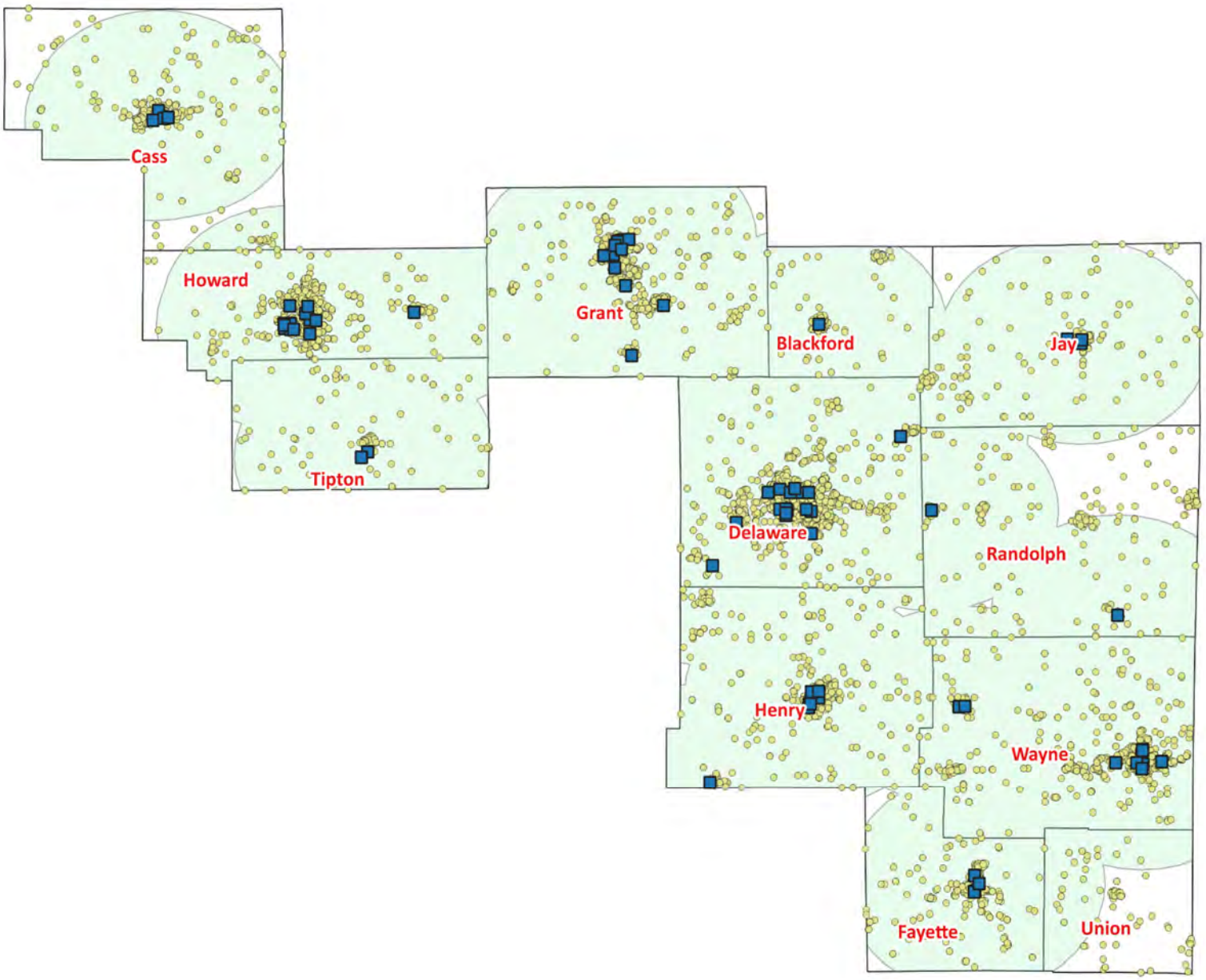
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.4
Measuring Accessibility to Dental Providers
East Central Region



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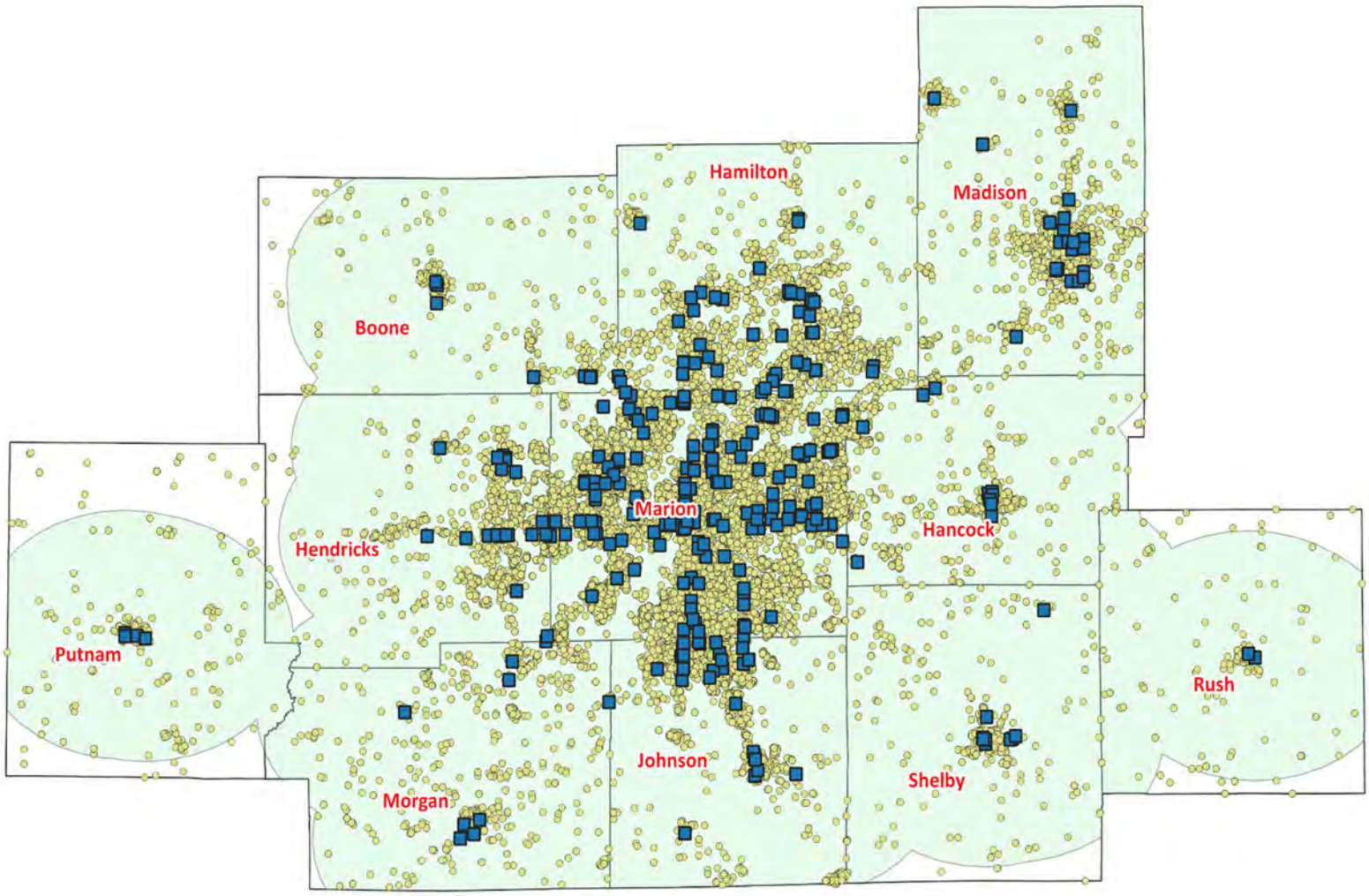
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.5
Measuring Accessibility to Dental Providers
Central Region



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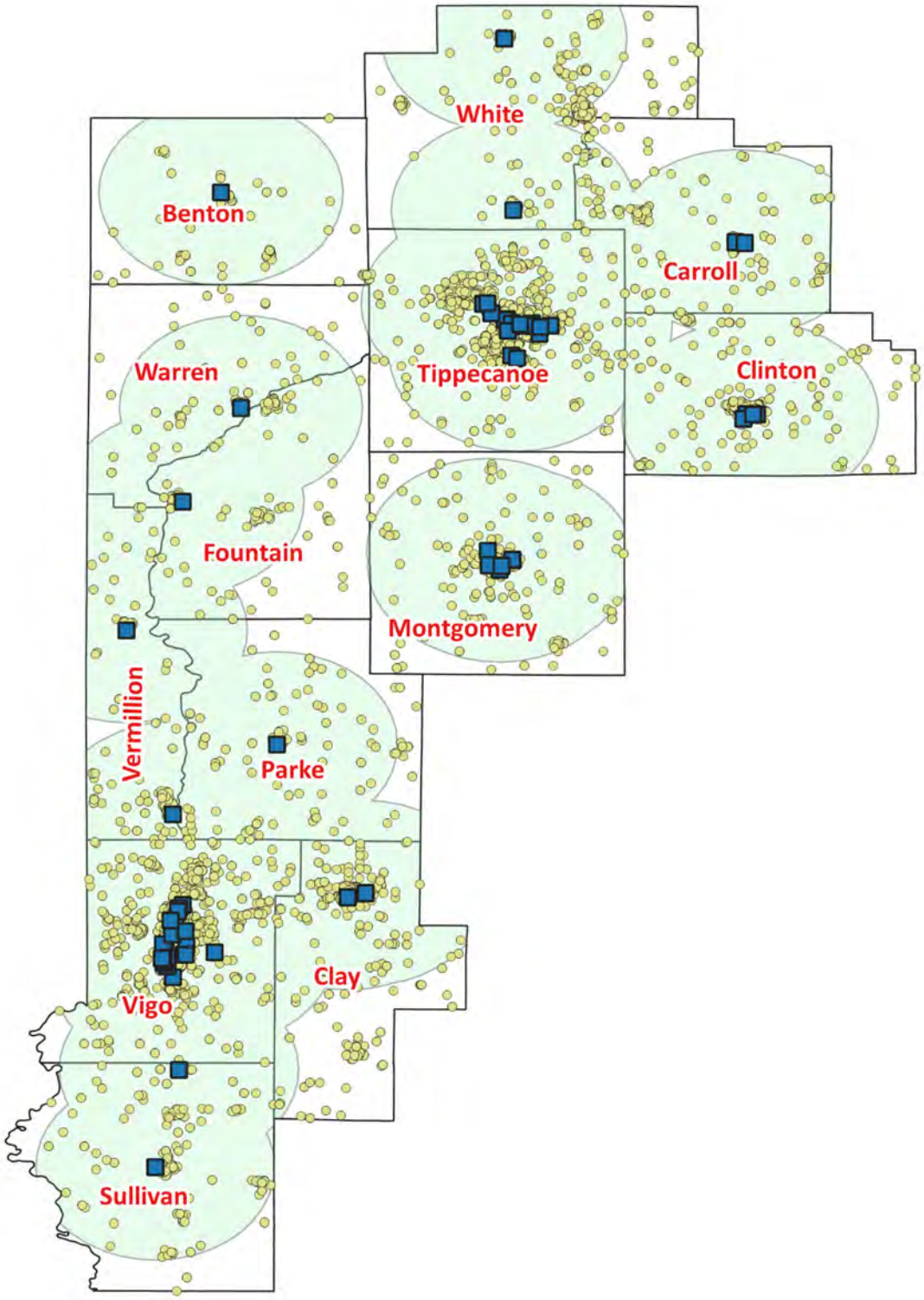
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.6
Measuring Accessibility to Dental Providers
West Central Region



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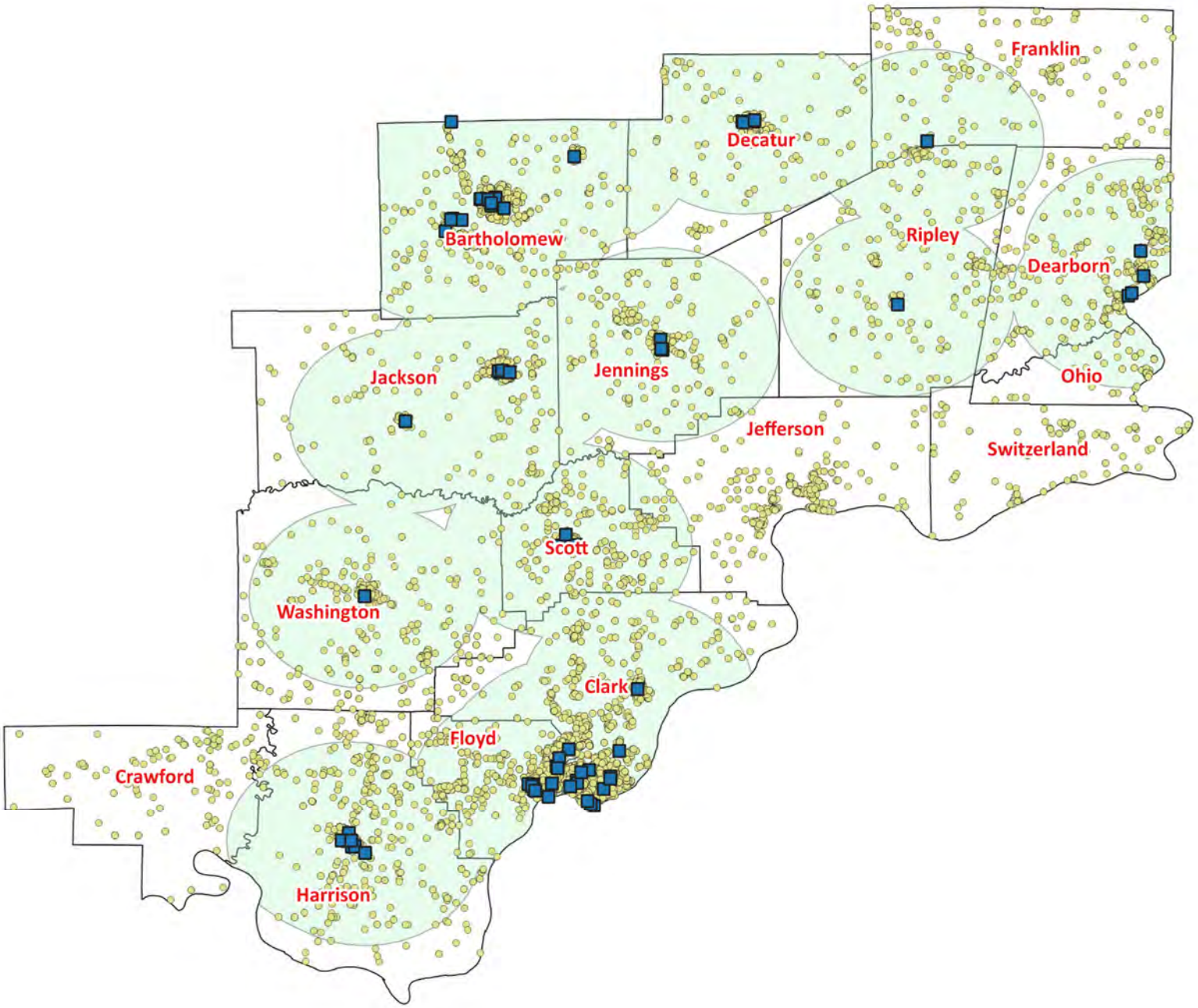
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

Map B.7
Measuring Accessibility to Dental Providers
Southeast Region



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Area shown where members live within 10 miles of a provider
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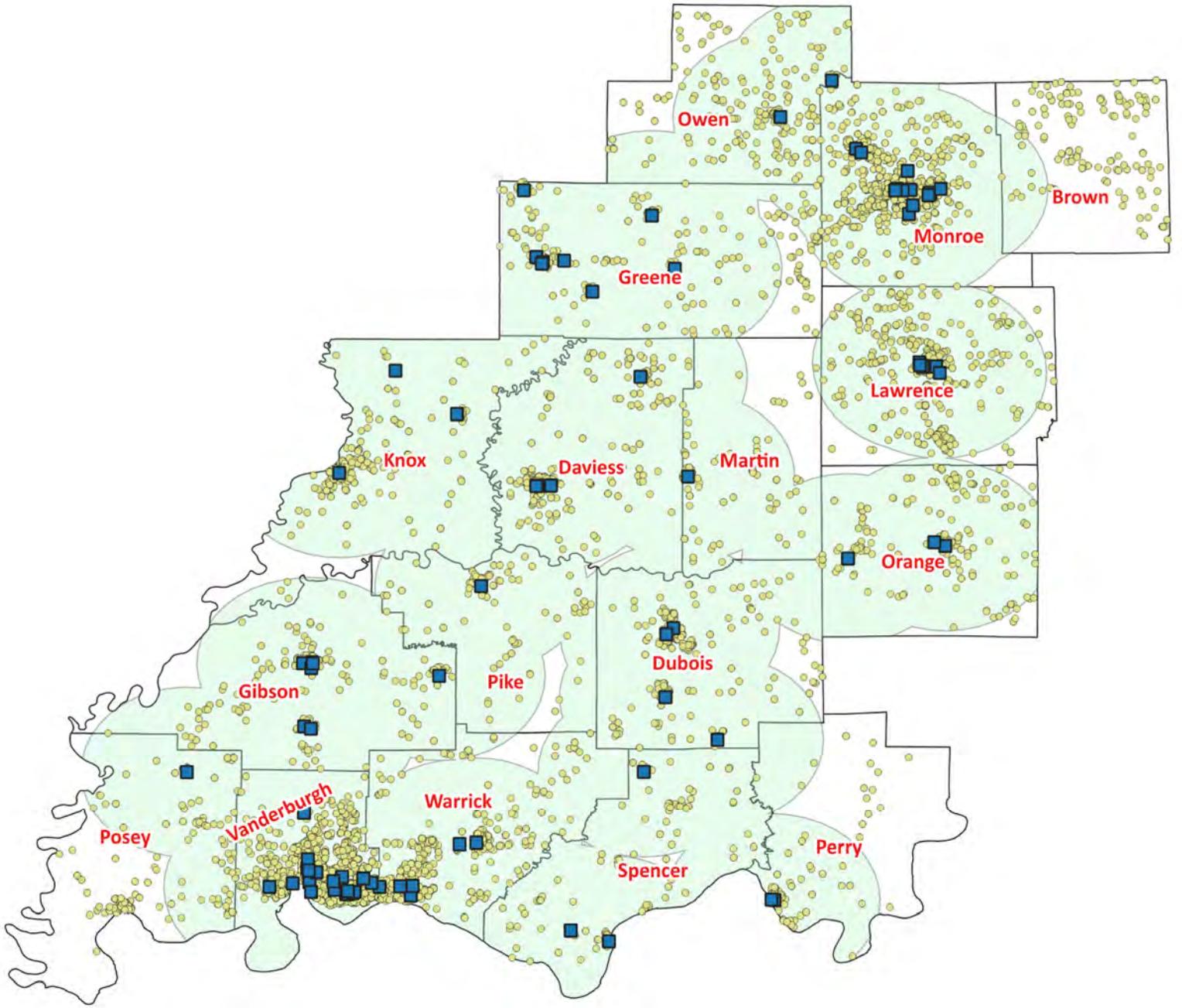
Map B.8
Measuring Accessibility to Dental Providers
Southwest Region



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