

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

Final Report – April 2018



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Executive Summary



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

EXECUTIVE SUMMARY

Indiana’s Children’s Health Insurance Program (CHIP) experienced an increase in enrollment in Calendar Year (CY) 2017 with year-end enrollment at 106,301 members, a 5.2 percent increase from CY 2016’s year-end enrollment of 101,069. Enrollment in the program has grown steadily over the last three years by 32.4 percent. The current enrollment is the all-time high since the program began in 1998.

In CY 2017, enrollment grew in all three segments of CHIP:

- MCHIP (CHIP Package A) grew 1.1 percent to 73,408 children in December 2017
- SCHIP (CHIP C original) grew 13.6 percent to 21,916 children in December 2017
- SCHIP (CHIP C expansion) grew 20.1 percent to 10,977 children in December 2017

Eligibility for CHIP depends on the child’s age as well as the family’s income. MCHIP (Package A) is the entitlement portion of the program and was put in place at the beginning of the program. SCHIP (Package C) is the name of the non-entitlement portion of the program. SCHIP was introduced in two phases (Package C original and Package C expansion).

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

*Includes children without any other insurance; otherwise, child is considered Medicaid eligible.

**Newborns below 208% of FPL are considered eligible for Medicaid

Growth in Indiana’s CHIP over the last 20 years enabled the State to lower its uninsured rate among children in low-income families. Citing the most recent year’s Census Bureau statistics, Indiana’s uninsured rate among children in families below 250 percent of the Federal Poverty Level (FPL) is now 7.4 percent which is the same as the national average. For children at all income levels combined, Indiana’s uninsured rate is 5.7 percent.

A portion of the membership in CHIP has been continuously enrolled for long lengths of time while another portion tends to turn over depending upon the financial status of the family. In CY 2017, although there were 106,301 enrollees at the end of the year, there were 182,307 children enrolled in the program for at least some portion of the year. This is a multiple of 1.71 times current enrollment. In CY 2016, the multiple was 1.73. Children may disenroll because their families obtain insurance from another source such as employer or the child may turn age 19 and be no longer eligible for the program. For children that were new to the program during Federal Fiscal Year (FFY) 2016, 81 percent of the children re-enrolled after the first 12 months when their eligibility needed to be redetermined.

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. Half of the children enrolled in the CHIP are between the ages of 6 and 12. Enrollment by age is uneven because children under age 6 are eligible for regular Medicaid at higher family income levels. One-third of CHIP enrollees are teenagers, while the remaining 15 percent are under age 5. This distribution has been the case since the CHIP was introduced.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

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, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for CY 2017. B&A 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. CareSource just came under contract as an MCE in January 2017. The other three MCEs have been serving CHIP members for many years. Another new feature for all MCEs in the January 2017 contract is that, in addition to responsibility for most physical health and mental health services, the MCEs are now also responsible for managing the pharmacy and dental benefit offered to CHIP members.

There are only slight differences in the benefit package offered between MCHIP (Package A) and SCHIP (Package C). Co-pays are charged to SCHIP (Package C) members for prescription drugs and ambulance services, and monthly premiums are also charged to SCHIP (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
158% up to 175%	\$22	\$33
175% up to 200%	\$33	\$50
200% up to 225%	\$42	\$53
225% up to 250%	\$53	\$70

Among the CHIP programs nationwide, 30 states (including Indiana) require families to pay premiums for their children’s coverage. In a report released by the Kaiser Family Foundation in January 2017, it was found that Indiana’s program resembles many other state CHIP programs in its design features as well. States do differ on co-pays required in their programs. Like 18 other states, Indiana requires co-pays on pharmacy scripts. But Indiana does not require co-pays on emergency room visits or non-preventive physician visits like some other states do.

CHIP at the Federal Level

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. 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

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legislation was extended first to 2009, then to 2013, then to 2015 and then again to September 30, 2017. After lengthy debate, Congress once again extended the CHIP program on January 22, 2018 with the HEALTHY KIDS Act of 2017. In this legislation, funding for CHIP was extended for six years to the end of FFY 2023. Then, the Bipartisan Budget Act of 2018 authorized CHIP for another four years through 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. This is often referred to as the enhanced FMAP. Prior to the ACA, the enhanced FMAP was approximately 10 percentage points higher for CHIP than the regular FMAP for Medicaid. The ACA increased each state’s enhanced FMAP rate for CHIP by 23 percentage points beginning in FFY 2016. The new HEALTHY KIDS Act keeps the 23 percentage point bump in the enhanced FMAP through FFY 2019. Then, the enhanced FMAP decreases to an 11.5 percentage point bump beginning in FFY 2020. Starting in FFY 2021 and continuing through the remaining years where funding is authorized for CHIP, the Act returns the FMAP for CHIP to enhanced FMAP rate for CHIP that was in place prior to the ACA.

For illustration, Indiana’s FMAP would have been 75.91 percent in FFY 2018 without the 23 percent bump. The ACA increase in the enhanced FMAP means that Indiana’s enhanced FMAP for CHIP is 98.91 percent. In other words, the state share for every \$100 spent on the CHIP program today is now \$1.09.

Funding is allocated as an allotment to each state. Therefore, even though each state does receive an enhanced FMAP for CHIP, there is an absolute dollar cap. For FFY 2018, the federal share for Indiana’s CHIP is \$202,327,708. States have historically had the option to transfer any unused CHIP funds from one year to the next.

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 three¹ Hoosier Healthwise MCEs maintained high scores with only minor changes in some categories from the prior year survey. On a 10-point scale with 10 being the best score, the percent of members giving each MCE a score of 8, 9 or 10 are tracked. Across the MCEs, the percentage of members giving these scores are:

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

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

- For Getting Needed Care, 85 to 88 percent (last year 85 to 87 percent)
- For Getting Care Quickly, 89 to 90 percent (last year 91 to 92 percent)
- For How Well Doctors Communicate, 94 to 96 percent (last year 92 to 95 percent)
- For MCE Customer Service, 88 to 90 percent (last year the same)

¹ CareSource is excluded because the survey asks members about 2016 experience and this MCE was not yet under contract.

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Access to Services

B&A reviewed access by examining where CHIP members live and the provider networks that each MCE offers for primary care and dental services. We matched claims of actual services received in FFY 2017 between where the member lives and where the attending provider is located. Although each MCE may have more providers in their directory than those that billed for services, using the method used a strict approach for interpreting those providers willing to accept CHIP patients.

B&A found each provider's location and drew a 10-mile coverage radius to assess the availability of primary care and dental providers to CHIP members. On a statewide level, there are very few gaps. In fact, only 0.3 percent of all CHIP members live more than 10 miles from an available primary medical provider. There are 0.7 percent of CHIP members who live more than 10 miles from an available dentist.

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

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 three MCEs and has set performance targets against national benchmarks for Medicaid health plans. Some of the key findings on selected HEDIS measures are reported in Chapter V.

- For access to primary care practitioners, all three MCEs reported that 95 to 96 percent of its members age 12 to 24 months have access; for children age 25 months to six years, 86 to 88 percent; for children age 7 to 11, 91 to 92 percent; for children age 12 to 19 years, all three MCEs reported 91 percent.
- For well child visits received, children in the first 15 months of life are measured to determine the percentage who received six or more visits. Two MCEs have seen improvement in this measure in the last five years (Anthem and MDwise), with between 75 and 77 percent in the most recent year. MHS had seen improvement close to this level but has declined in the last two years.
- There has also been improvement in the rate measuring the percentage with an annual well care visit for children ages 3 to 6 at Anthem (80%) and MDwise (89%) while MHS lags behind at 70 percent. For adolescent well care annual visit, all three MCEs have a rate between 59 and 61 percent.
- There was variation seen across the MCEs in the HEDIS measures related to medication management for children with asthma, but all MCEs are seeing improvement, particularly in the most recent year studied. MDwise had the highest adherence rates for the age 5 to 11 study group (73%) followed by Anthem (66%) then MHS (62%). For children age 12 to 18, MDwise is also highest (67%) followed by Anthem (61%) and then MHS (57%).

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- The rates for follow-up visits after an inpatient stay for mental illness were consistent across the MCEs. This includes both a measure for seven days after discharge (63-69% with a visit across the MCEs) and another for 30 days after discharge (80-84% with a visit across the MCEs).

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency department visits, preventive dental visits, and had a pharmacy prescription for the periods FFY 2015, FFY 2016 and FFY 2017. The overall rate of usage for all of these services has remained fairly steady, particularly in FFYs 2015 and 2016. When examining the data, it appears that there is still some potential missing claims data coming in from the MCEs for FFY 2017 to the OMPP data warehouse. This appears to be the reason by the percentages are lower in each category in FFY 2017, particularly for emergency department visits.

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

	FFY 2015	FFY 2016	FFY 2017
Primary Care Visit	81%	81%	75%
Emergency Dept. Visit	26%	24%	17%
Preventive Dental Visit	66%	66%	59%
Pharmacy Script	66%	65%	63%

Comparisons were also made across various demographic cohorts, such as by MCE, by age group and by race/ethnicity. B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall in each FFY and also by each of the demographic cohorts.

The key findings were found in the examination of this three-year set of data, but these same variations have also held true for the past five years in CHIP (even if the actual values have changed slightly):

- Primary care visits were more prevalent among the youngest members, as 93 percent of children ages 5 and younger had a visit in FFYs 2015 and 2016. The percentage was lower for children in the other age groups (81% for age 6-12 and 77 % for age 13-18).
- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (84% in FFY 2016) than other race/ethnicities (76 to 80 percent).
- 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. The rate for Caucasian children is 272 visits per 1,000 children during FFY 2016, whereas the rates for African American and Hispanic children were 190 and 198, respectively.
- Almost one in four CHIP children used the ED in both FFYs 2015 and 2016 overall. Anthem members used the ED slightly less than MHS and MDwise members. Children ages five and under used the ED the most (33%), then teenage children (24 %), then children age 6-12 (22 %). Caucasian and African-American CHIP children use the ED at the same rate (26% of total) while Hispanic children use it less (21% of total).
- Hispanic CHIP children were more likely than children of other races/ethnicities to have a preventive dental visit (73% of total) in FFY 2016 than other race/ethnicities (63 to 64 percent).
- Caucasian CHIP members have, over the three years, 1.5 times the number of prescriptions as African-American children and more than double the number that Hispanic children have. Children age 13-18 have, over the three years, 1.65 times the number of scripts as children ages five and under and 1.30 times the number of scripts as children ages 6-12.

I

Introduction



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2017

CHAPTER I: INTRODUCTION

Each year, an independent evaluation of Indiana's Children's Health Insurance Program (CHIP) is conducted as required by Indiana Code 12-17.6-2-12 and is due to the Legislature by April 1. Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2017. B&A has conducted this study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

The State Children's Health Insurance Program (S-CHIP) was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. In this legislation, states were allocated funds on an annual basis for a 10-year period to expand health coverage to low-income children. The original legislation was extended to March 31, 2009. Since this time, federal legislation has been enacted to extend the program itself or the funding of the program.

- The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009² extended the program through Federal Fiscal Year (FFY) 2013.
- The Patient Protection and Affordable Care Act (ACA) of 2010 extended CHIP funding through FFY 2015.
- The Medicare Access and CHIP Reauthorization Act of 2015 extended CHIP funding for another two years through FFY 2017.

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage (FMAP) for states is higher than the FMAP for Medicaid. This is often referred to as the enhanced FMAP. Prior to the ACA, the enhanced FMAP was approximately 10 percentage points higher for CHIP than the regular FMAP for Medicaid.

The ACA increased each state's enhanced FMAP rate for CHIP by 23 percentage points beginning in FFY 2016. The 23 percentage point bump remains through FFY 2019. Indiana's FMAP would have been 75.91 percent in FFY 2018 without the 23 percent bump. The ACA increase in the enhanced FMAP means that Indiana's enhanced FMAP for CHIP is 98.91 percent. In other words, the state share for every \$100 spent on the CHIP program today is now \$1.09.

Funding is allocated as an allotment to each state. Therefore, even though each state does receive an enhanced FMAP for CHIP, there is an absolute dollar cap. For FFY 2018, the federal share for Indiana's CHIP is \$202,327,708. States have historically had the option to transfer any unused CHIP funds from one year to the next.

The HEALTHY KIDS³ Act of 2017, which was passed by Congress on January 22, 2018, reauthorized federal funding for CHIP for six years from FFY 2018 through FFY 2023. The Act keeps the 23 percentage point bump in the enhanced FMAP through FFY 2019. Then, the enhanced FMAP decreases

² CHIPRA 2009 changed the acronym for the federal program from S-CHIP to CHIP.

³ Acronym for "Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable".

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to an 11.5 percentage point bump beginning in FFY 2020. Starting in FFY 2021 and continuing through the remaining years where funding is authorized for CHIP, the Act returns the FMAP for CHIP to enhanced FMAP rate for CHIP that was in place prior to the ACA.

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

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

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 158⁴ percent of the Federal Poverty Level, or FPL (\$38,868 per year for a family of four in 2017) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.
- CHIP Package C (the non-entitlement portion, or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.
 - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 158 percent up to 200 percent of the FPL (\$49,200 per year for a family of four in 2017).
 - The second portion (referred to as SCHIP (Package C) Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL (\$61,500 per year for a family of four in 2017).

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

In January 2017, 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.⁵ As of January 2017, 48 states cover children with incomes at or above 200 percent of the FPL. Of these, 19 states extend eligibility to at least 300 percent of the FPL.

Among the CHIP programs nationwide, 30 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. There are 22 states (including Indiana) who charge a premium to families with incomes below 200 percent of the FPL (Indiana's premiums begin at \$22 per month when the family has income at 158% - 175% of the FPL).

⁴ Prior to January 1, 2014, this threshold was 150 percent of the FPL. Starting January 1, 2014, the threshold was changed to 158 percent of the FPL to account for changes made by CMS in the computation of Modified Adjusted Gross Income.

⁵ Brooks, T., Wagnerman, K., Artiga, S., Cornachione, E., Gates, A, Ubri, P. (January 2017) *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2017: Findings from a 50-State Survey*. Washington, DC: Georgetown University Center for Children and Families and The Henry J. Kaiser Family Foundation.

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

- The ability to submit applications online (50 states);
- Processing automated renewals (42 states);
- Co-pays charged for generic drugs (18 states) and brand name drugs (19 states)

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

- The required period of no insurance prior to enrolling (also known as the “going bare” period) is three months in Indiana. There are 36 states with no waiting period.
- Enrollment is continuous for 12 months, regardless of circumstance in 26 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.
- “Real time” eligibility determination (that is, in 24 hours or less) is available in 39 states, but not in Indiana.
- Indiana does not impose co-pays for non-emergent ER visits (18 states do), non-preventive physician visits (19 states do), or inpatient hospital visits (15 states do).

As of December 2017, enrollment in Indiana’s CHIP was at 106,301⁶, a 5.2 percent increase over the prior year’s membership of 101,069 and its highest level ever since the start of the program:

- MCHIP (Package A) enrollment was 73,408 (up 1.1% from December 2016)
- Enrollment in the initial group of SCHIP (Package C) members was 21,916 (up 13.6% from December 2016)
- Enrollment in the 2008 expansion group of SCHIP (Package C) members was 10,977 (up 20.1% from December 2016)

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

Among children in families with incomes below 250 percent of the FPL, Indiana’s most recent uninsured rate using a three year average is 7.4 percent which is the same as the national weighted average rate. When ranked among states, Indiana’s rate for this population is the 34th lowest uninsured rate. When examining the three-year trends, Indiana and the nation as a whole are seeing further improvement.

⁶ Enrollment figures retrieved by B&A come from data in the Office of Medicaid Policy and Planning’s Enterprise Data Warehouse on January 29, 2018. The OMPP also publishes monthly CHIP enrollment reports on its website. Due to retroactive eligibility and the fact that B&A had access to data after the OMPP enrollment report was released, the numbers shown in this report are higher than the OMPP’s December 2017 enrollment report.

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**Exhibit I1
Uninsured Rate Among Children in Families
Below 250% of Federal Poverty Level**

Uninsured Rate as Reported in	Indiana's Rate	U.S. Average Rate	Rank Among States
Avg of 3 year CPS 2013, 2014, 2015	10.2%	10.4%	35
Avg of 3 year CPS 2014, 2015, 2016	7.6%	8.5%	28
Avg of 3 year CPS 2015, 2016, 2017	7.4%	7.4%	34

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

A three-year average is often used because the sample size at the individual state level is often low in a single year.

The uninsured rate in the state varies by family income level. Exhibit I.2 below shows the uninsured rate among families up to 250 percent of the FPL (who may be eligible for Indiana’s CHIP) and the rate among families above the 250 percent of FPL level. For example, whereas the average rate for three CPS years 2015, 2016 and 2017 showed an uninsured rate among all children of 5.7 percent, the rate was 7.4 percent among children who may be CHIP-eligible and 3.9 percent among children who are not CHIP-eligible. In reviewing the column that shows the percent of all uninsured children, the CPS suggests that 66.0 percent of children who are currently uninsured (n= 63,489) may be eligible for Indiana’s CHIP (at least based on family income, other criteria may preclude eligibility).

**Exhibit I2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana**

Current Population Survey Years	Total Children 0-18	Total Insured	Total Uninsured	Uninsured Rate	Percent of All Uninsured Children
Total for Children that may be Eligible for Indiana's CHIP (Income up to 250% FPL)					
Avg CPS 2013-2015	934,881	839,395	95,487	10.2%	68.0%
Avg CPS 2014-2016	902,194	833,218	68,976	7.6%	60.4%
Avg CPS 2015-2017	855,926	792,436	63,489	7.4%	66.0%
Total for Children Not Eligible for Indiana's CHIP (250% and above)					
Avg CPS 2013-2015	781,569	736,575	44,994	5.8%	32.0%
Avg CPS 2014-2016	799,658	754,388	45,270	5.7%	39.6%
Avg CPS 2015-2017	828,607	795,914	32,693	3.9%	34.0%
All Children					
Avg CPS 2013-2015	1,716,450	1,575,970	140,481	8.2%	100.0%
Avg CPS 2014-2016	1,701,852	1,587,606	114,246	6.7%	100.0%
Avg CPS 2015-2017	1,684,533	1,588,351	96,181	5.7%	100.0%

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

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There are differences in the uninsured rate when examined by race/ethnicity. In the most recent survey conducted among the children in families with incomes below 250 percent of the FPL, Caucasian children had an uninsured rate of 6.9 percent, whereas the rate for African American children was 12.0 percent and Hispanic children was 9.3 percent.

Exhibit L3
Uninsured Rates for Children (Age 0-18) by Race/Ethnicity in Indiana
For Children in Families At or Below 250% FPL

Race/Ethnicity	Total Children 0-18	Total Insured	Total Uninsured	Uninsured Rate	Percent of All Uninsured Children
Caucasian Non-Hispanic	501,930	467,117	34,813	6.9%	57.5%
African Amer. Non-Hispanic	102,935	90,577	12,358	12.0%	20.4%
Hispanic (any race)	76,442	69,336	7,107	9.3%	11.7%
Other races or multi-race	43,729	37,418	6,309	14.4%	10.4%
All Children	725,036	664,448	60,587	8.4%	100.0%

Source: U.S. Census Bureau, Current Population Survey (CPS 2017 single year 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 if their family does not select one. CHIP members must enroll with one of four managed care entities (MCEs) that contract with the state—Anthem, CareSource, Managed Health Services (MHS) or MDwise. CHIP enrollees have access to all of the providers available to Hoosier Healthwise members that are enrolled with the MCE they select.

Exhibit L4
Benefits Offered to Indiana's CHIP Enrollees in the
Hoosier Healthwise Program

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.

It should be noted that new contracts with the MCEs began in January 2017. Prior to this time, the MCEs were not responsible for pharmacy and dental care benefits. Beginning with this new contract, the MCEs are now at risk for the expenditures for these two benefits.

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.

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

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.5 below.

Exhibit I.5
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

As stated previously, beginning in FFY 2016 and running through FFY 2019, the ACA increased each state’s enhanced FMAP rate by 23 percentage points. Indiana’s FMAP would have been 75.91 percent in FFY 2018 without the 23 percent bump. The ACA increase in FFY 2018 means that Indiana’s enhanced FMAP for CHIP is 98.91 percent. In other words, the state share for every \$100 spent on the CHIP program today is \$1.09. The expenditures presented in this section represent total funds—both the federal and state contributions. It should be noted that, at least for the time being, the state share of these expenditures is just over one percent of the total.

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.

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

A change was made in the contracts that the OMPP has with each MCE effective January 1, 2017. Prior to this, pharmacy prescriptions, dental services and mental health rehabilitation services were not included in the MCE contracts. These services were paid to providers through the fee-for-service program. As a result, in FFY 2016, approximately 37 percent of all payments for CHIP members were made to the MCEs while 63 percent of payments were made through the fee-for-service program.

Starting January 1, 2017, the MCEs took responsibility for the pharmacy and dental benefits. The mental health rehabilitation services continue to be paid fee-for-service. Other services may also be paid fee-for-service in the CHIP if an enrollee utilizes a service during the short time period before they have selected which MCE to join. Because the pharmacy and dental benefits are significant contributors to the overall

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expenditures in the CHIP, the split in FFY 2017 for CHIP expenditures was 76 percent to the MCEs and 24 percent made through the fee-for-service program.

B&A examined expenditures made on behalf of CHIP members in FFYs 2016 and 2017.⁷ Data was pulled from the state's data warehouse.

Total expenditures in the entire CHIP were \$201.4 million in FFY 2016 and \$220.9 million in FFY 2017.

- In CHIP Package A, total expenditures were \$154.5 million in FFY 2017, an increase of 13.0 percent from FFY 2016. Enrollment throughout FFY 2017 was 10.4 percent higher than it was during FFY 2016.
- In CHIP Package C, total expenditures were \$44.7 million in FFY 2017, an increase of 4.8 percent from FFY 2016. Enrollment throughout FFY 2017 was 14.3 percent higher than it was during FFY 2016.
- In the expansion portion of CHIP Package C, total expenditures were \$21.7 million in FFY 2017, a decrease of 1.1 percent from FFY 2016. Enrollment throughout FFY 2017 was 20.2 percent higher, however, than it was during FFY 2016.

The expenditure data is shown graphically in Exhibit I.6 which appears on the next page.

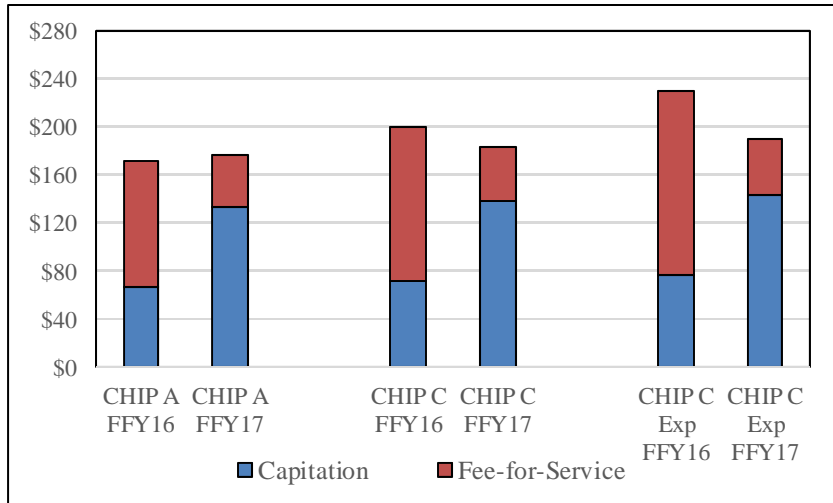
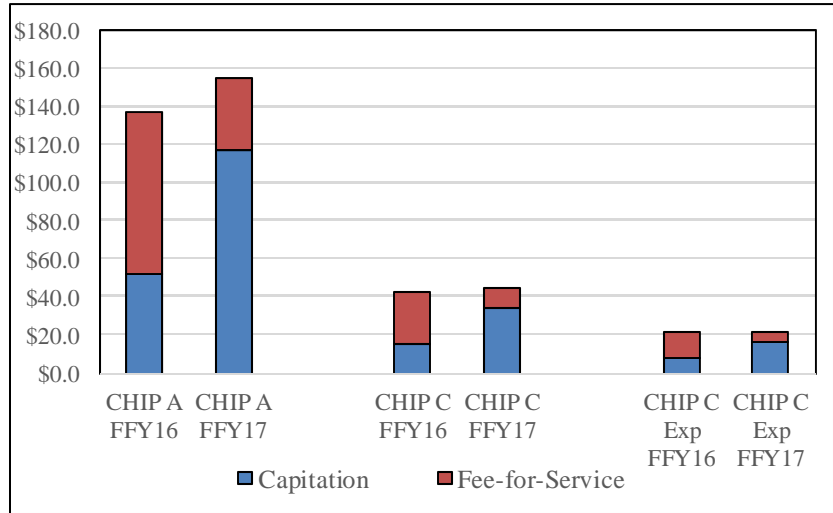
Because of the different enrollment levels in each portion of the CHIP, the bottom half of Exhibit I.6 shows the payments made on a PMPM basis. There is some difference in the PMPM payments made in each portion of the CHIP. In FFY 2017, this varied from an average PMPM of \$175.97 in CHIP A, \$182.58 in CHIP C and \$188.69 in CHIP C Expansion. The PMPMs in SCHIP (CHIP C and CHIP C Expansion) were considerably lower in FFY 2017 than in FFY 2016. A reduction of 8.4 percent was seen in CHIP Package C and a 17.7 percent reduction was seen in CHIP Package C Expansion. The PMPM in CHIP Package A increased 2.3 percent during this time period.

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

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Exhibit L6

**Expenditures in Indiana's CHIP, in millions (top box) and PMPM (bottom box)
Federal Fiscal Year 2016 and 2017**



II

Enrollment Trends in Indiana's CHIP



Enrollment Trends at a Glance

CHIP Enrollment Dec 2016: 101,069

CHIP Enrollment Dec 2017: 106,301

1.1% year-to-year growth rate in CHIP Package A

13.6% year-to-year growth rate in CHIP Package C

20.1% year-to-year growth rate in CHIP Package C Expansion

182,307 children enrolled in Indiana's CHIP at some point in CY 2017.

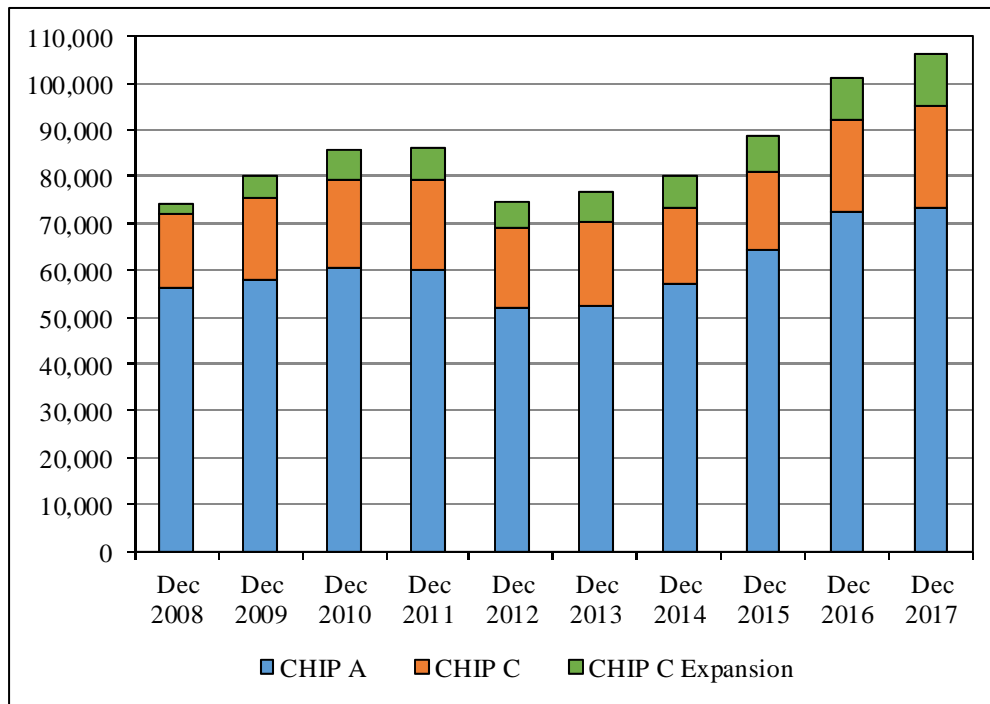
CHAPTER II: ENROLLMENT TRENDS IN INDIANA’S CHIP

Enrollment and Disenrollment Trends

Indiana’s Children’s Health Insurance Program (CHIP) experienced an increase in enrollment in 2017 with year-end enrollment at 106,301 members, a 5.2 percent increase from the Calendar Year (CY) 2016 year-end enrollment of 101,069. After a dip in enrollment in CY 2012 and CY 2013, enrollment has grown steadily. Over the last three years, enrollment has increased 32.4 percent. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 158 percent of the federal poverty level (FPL), enrollment increased 1.1 percent from December 2016 to December 2017. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 158 to 200 percent of the FPL, enrollment increased 13.6 percent during this time period. The SCHIP (Package C) Expansion group (201-250% of the FPL) had enrollment increase 20.1 percent during this time period.

At the end of CY 2017, 69.1 percent of enrollees were in the MCHIP portion and 30.9 percent were in the SCHIP portion of the program. The SCHIP portion of the program has enrolled between 24 and 32 percent of the members in each of the last ten years.

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

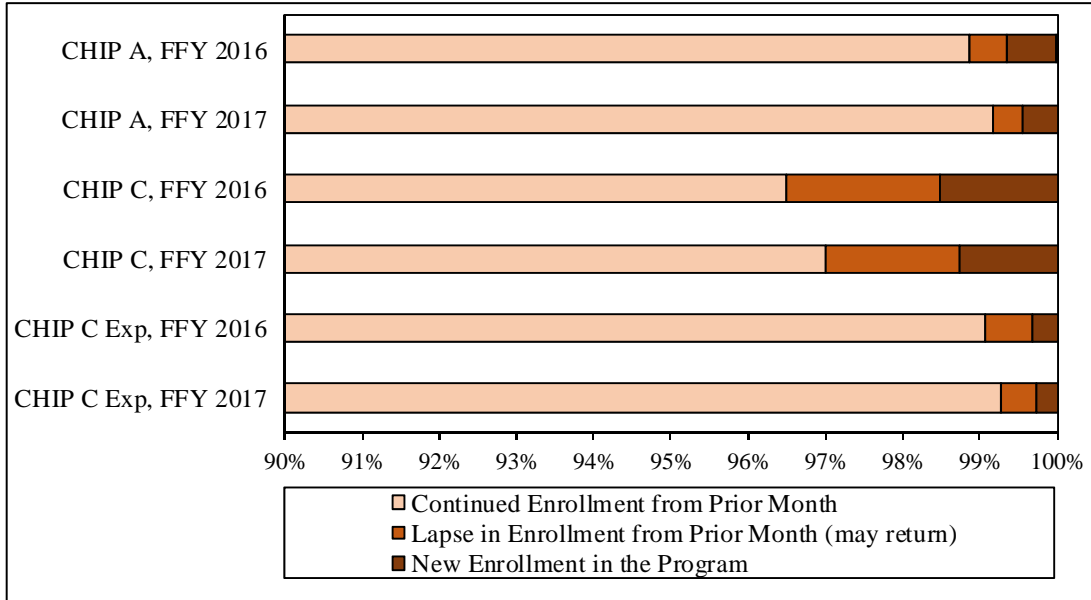


Source: Indiana's FSSA Enterprise Data Warehouse

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The actual children enrolled in Indiana’s CHIP remains fairly steady on a monthly basis, but there are new enrollees coming in each month as well as attrition. Exhibit II.2 shows that in MCHIP (CHIP Package A), on average less than one percent of members either dropped off or were added as new on a monthly basis in Federal Fiscal Years (FFYs) 2016 and 2017. This was also true in the CHIP C Expansion portion of SCHIP. In the original portion of SCHIP (CHIP Package C), between three and four percent of children either drop off or get added new on a monthly basis.

Exhibit II.2
Measuring Enrollment Trends in Indiana’s CHIP: Continuous, Lapsed and New
Percent of CHIP Children in Each Category on an Average Monthly Basis



Source: Indiana’s FSSA Enterprise Data Warehouse

Burns & Associates, Inc. (B&A) counted the child as continuous so long as the child maintained enrollment somewhere within Indiana’s CHIP. There is some movement between the portion of the CHIP even among those who remain continuously enrolled (for example, move from CHIP Package C to CHIP Package A).

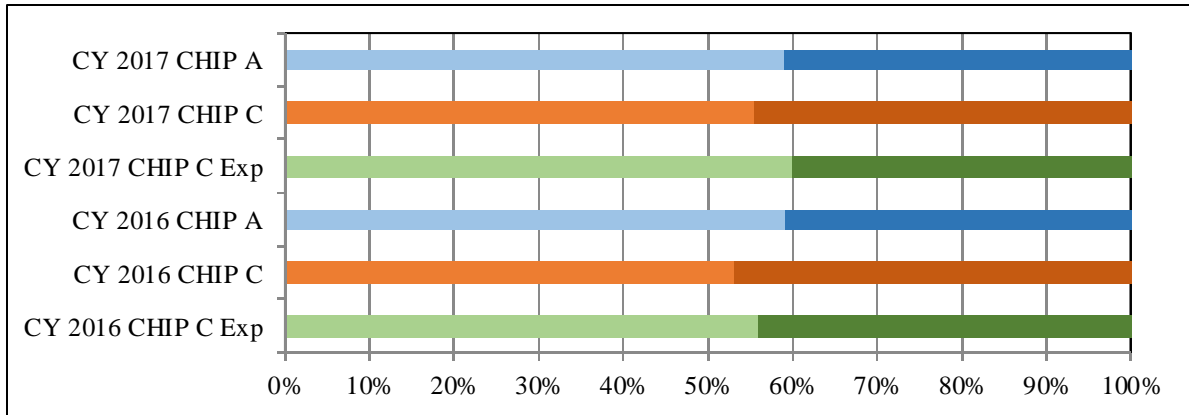
Because of the monthly changes in new enrollments and disenrollments, a much larger number of Hoosier children have been supported by Indiana’s CHIP in any given year than the year end enrollment figures would suggest. The number of children enrolled at any time during CY 2017 was 182,307 compared to 175,212 in CY 2016. Across all three portions of Indiana’s CHIP (CHIP Package A, CHIP Package C, and CHIP Package C Expansion), the enrollment at the end of CY 2017 was between 56 and 60 percent of the total number of children ever enrolled during the year. In CY 2016, the year-end enrollees represented between 53 and 59 percent of all individuals ever enrolled during the year.⁸ Exhibit II.3 below shows the difference between enrolled at the end of the calendar year (light colors) and enrolled at any time during the year (dark colors)

⁸ A member is only counted once in the year in the ever enrolled count within one of the three CHIP packages, but may be counted in more than one package within CHIP during the year.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Exhibit II.3

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

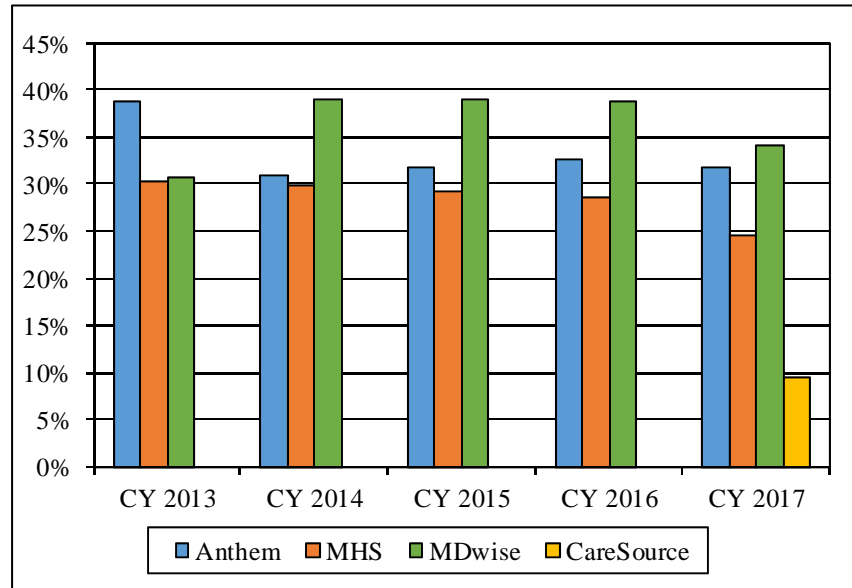


Source: Indiana’s FSSA Enterprise Data Warehouse

Exhibit II.4

Percent of CHIP Enrollment by MCE at End of Each Calendar Year

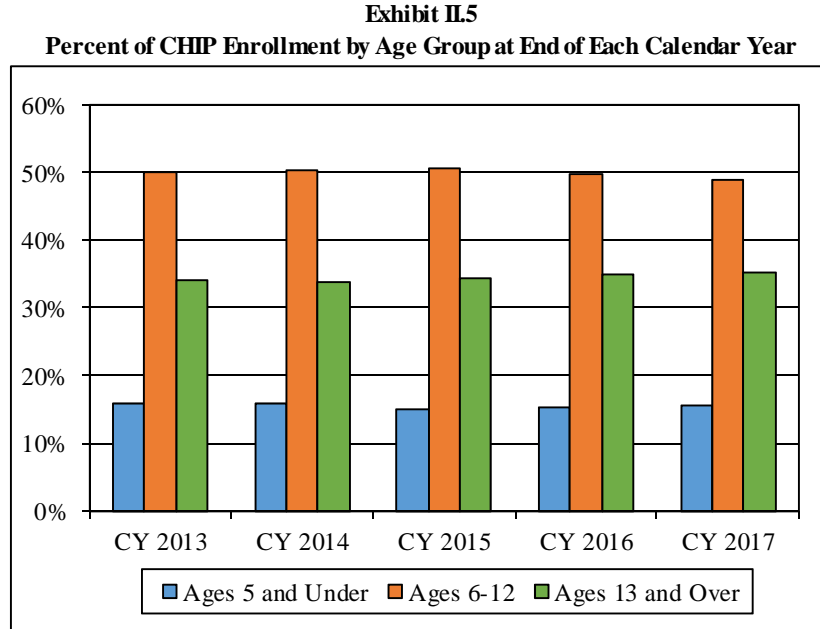
Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. A new MCE, CareSource, came under contract at the start of CY 2017. Now there are four MCEs that families can choose from. Because of this, there has been some movement in the distribution of CHIP members across the MCEs in the most recent year. At the end of CY 2017, Anthem had 31.8 percent of all CHIP enrollees, MHS had 24.6 percent, MDwise had 34.0 percent and CareSource had 9.6 percent.



Source: Indiana’s FSSA Enterprise Data Warehouse

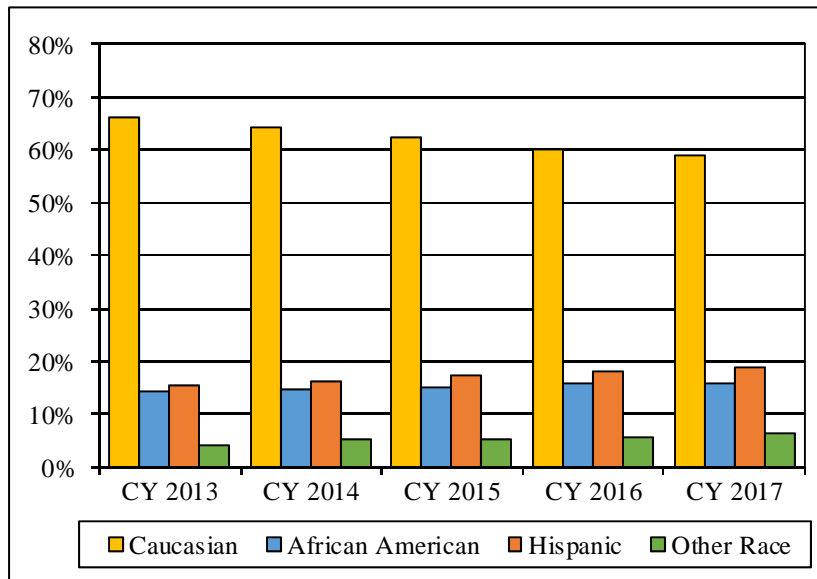
Demographic Profile of CHIP Members

Half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Teenagers represent 35 percent of CHIP enrollees while the remaining 15 percent are under age 6. This distribution has been the case since the CHIP was introduced.



Source: Indiana's FSSA Enterprise Data Warehouse

Exhibit II.6
Percent of CHIP Enrollment by Race/Ethnicity at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

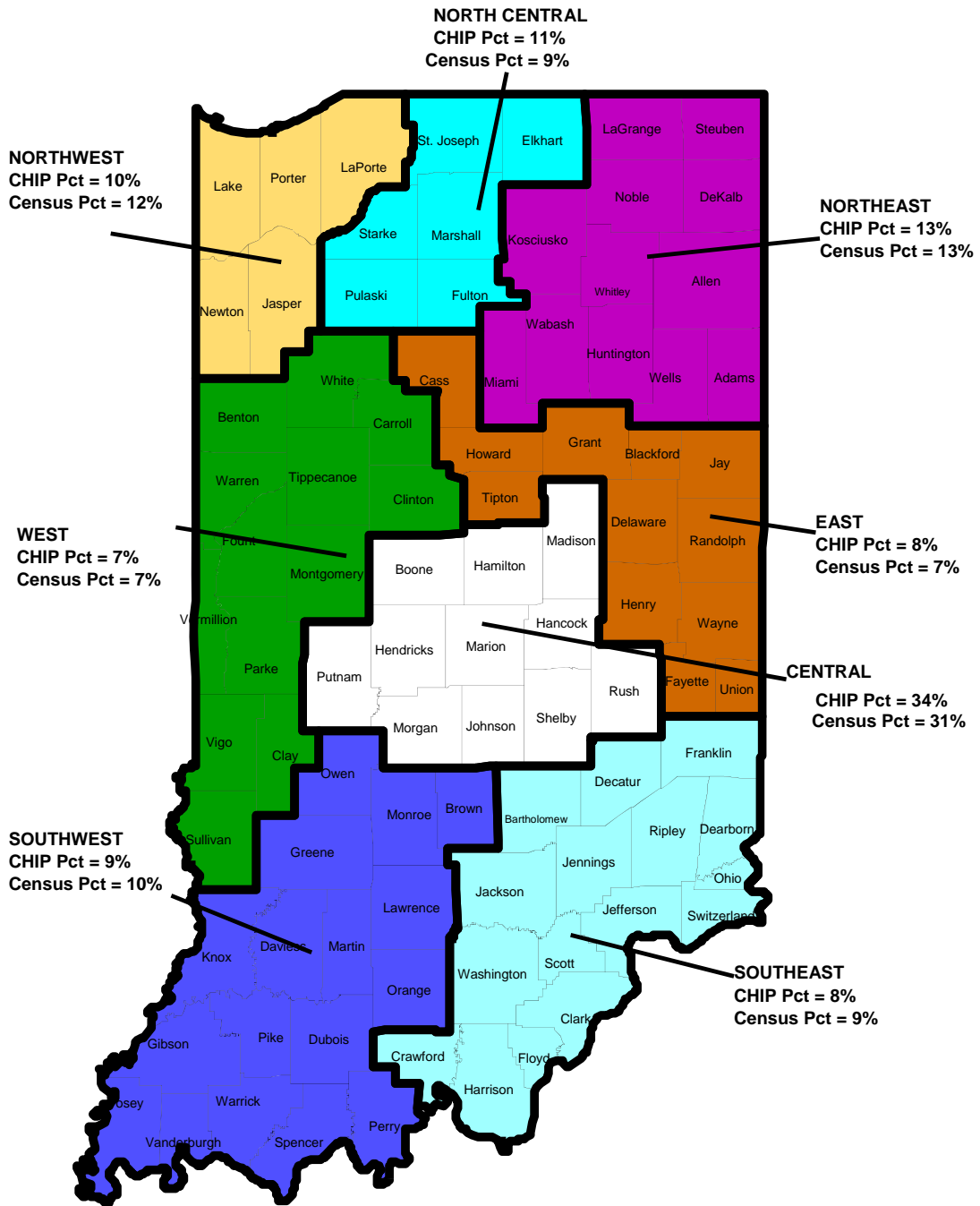
There is a higher distribution of minorities in Indiana’s CHIP than the overall population in Indiana for children ages 18 and younger. African-American children and Hispanic children represented 15.8 percent and 18.7 percent, respectively, of the CHIP enrollment at the end of CY 2017. This compares to 14.2 percent and 10.5 percent, respectively, of all children living in Indiana with family incomes below 250 percent of the Federal Poverty Level according to the U.S. Census estimate.⁹

⁹ U.S. Census Bureau, Current Population Survey for Indiana 2017. <http://www.census.gov/hhes/www/hlthins/hlthins.html>

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B&A compared CHIP members enrolled to the total child population in Indiana as of July 2017. The distribution of CHIP members by region generally matches the overall child population in Indiana. The Central region has 34 percent of all CHIP members but only 31 percent of the state's child population. The Northwest region has 10 percent of all CHIP members but 12 percent of the child population. The regions are defined by the OMPP. These statistics have also remained relatively unchanged in the last five years.

**Exhibit II.7
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2017**



III

Access to Primary Medical Providers and Dentists



Access Facts at a Glance

- 99.7% of CHIP members have access to a primary care provider within 10 miles of their home
- 99.3% of CHIP members have access to a dentist within 10 miles of their home

CHAPTER III: ACCESS TO PRIMARY MEDICAL PROVIDERS AND DENTISTS

Background

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

In last year's report, Burns & Associates, Inc. (B&A) reported findings related to the number of primary medical providers and dentists who served CHIP members in each county of the state. The average driving distance travelled to seek primary care and dental services was also examined.

For primary care, it was found that there were 32 counties where the average distance travelled was greater than 30 miles. In 25 of the 32 counties, the distance was 30-35 miles. The remaining seven counties with the highest average distance travelled are: Cass (36), Wells (36), Newton (39), Huntington (40), Wabash (42), Benton (47) and Randolph (53).

For dental care, there were 16 counties where the average distance travelled was greater than 30 miles. In 12 of the 16 counties, the distance was 30-35 miles. The remaining four counties with the highest average distance travelled are: Benton (36), Putnam (36), White (38) and Jennings (38).

In the counties where the distance travelled was greater than 30 miles, there were providers enrolled with each MCE with proximity closer than 30 miles to the member. Therefore, in this year's evaluation, B&A examined the distance from CHIP member's homes to any *available* primary medical provider or dentist on the MCE's roster of contracted providers. This was analyzed at the statewide level as well as for the CHIP members in each MCE individually.

Defining the Analysis

The data used to conduct this analysis was provided to B&A by the OMPP from its Enterprise Data Warehouse (EDW). Information was tabulated for access to primary medical providers (PMPs) and dental providers¹⁰ based on utilization from the time period October 1, 2016 – September 30, 2017. This time span was used in lieu of Calendar Year (CY) 2017 to allow the lag time for claims to be submitted by providers.

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

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

Because the actual CHIP enrollment can change month-to-month, for purposes of display B&A plotted children who were enrolled in CHIP as of June 1, 2017 on the maps with the providers. All CHIP members (CHIP Package A, CHIP Package C, and CHIP C Expansion) are shown together on each map.

¹⁰ The OMPP's EDW utilizes a specific claim type to identify dental claims. This claim type was used by B&A.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Primary Care is defined as E&M office-based codes and clinic codes¹¹ where the provider specialty is one of the following: General Pediatrician, Family Practitioner, General Practitioner, Internist, OB/GYN or Public Health Agency. For dental services, the OMPP utilizes a specific claim type to identify all dental services.

In total, 80 maps were created in an effort to assess proximity to providers at the statewide, the MCE and the regional level. There are 40 maps representing primary medical providers and 40 maps representing dental providers. Within each of the 40 maps, there are five sets of eight. The set of eight represents the regions commonly used by the OMPP for utilization comparisons: Northeast, North Central, Northwest, East Central, Central, West Central, Southeast and Southwest. One set of eight maps displays the information for all CHIP members in the program. The other four sets of eight represent the results for each MCE individual—Anthem, CareSource, MDwise and MHS.

The eight maps showing access to primary medical providers by region for the statewide population appear in Appendix A of this report. The same display by the eight regions showing access to dental providers appears in Appendix B of this report.

Findings

When measuring access to both primary medical providers and dental providers using a 10 mile service coverage radius, on a statewide level there are very few gaps. In fact, only 0.3 percent of all CHIP members live more than 10 miles from an available primary medical provider. There are 0.7 percent of CHIP members who live more than 10 miles from an available dentist.

Although the gaps are few throughout the state, there is some differentiation by region. For primary medical providers, a slightly higher proportion of CHIP members in the Southeast Region live more than 10 miles from a provider. For dentists, a slightly higher proportion of members in the West Central, Southeast and Southwest Regions live more than 10 miles from a provider. The results of the children who live more than 10 miles from an available provider, by region, are shown in Exhibits III.1 and III.2 on the next page.

At the county level, when analyzing the program as a whole, there are little to no gaps in access in the Northeast, North Central, East Central, Central and Southwest Regions. In the Northwest Region, there are some gaps in LaPorte and Newton Counties. In the West Central Region, Benton and Fountain Counties have some gaps. In the Southeast Region, there is a gap in Jackson County.

At the individual MCE level, the findings on access to primary care resemble the statewide findings with the following exceptions:

- Anthem also has gaps in three additional counties in addition to what was observed statewide.
- CareSource also has gaps in 12 additional counties in addition to what was observed statewide.
- MHS also has gaps in five additional counties in addition to what was observed statewide.
- MDwise also has gaps in five additional counties in addition to what was observed statewide.

It should be noted that because families with CHIP members select their preferred MCE, they can use the online provider directory tool available from each MCE to determine the proximity of primary medical providers in the MCE’s network.

¹¹ B&A defined primary care visits as encounters with the presence of one of the following CPT codes: 59425-59430, 99201-99215, 99241-99245, 90862, 99381-99397, T1015.

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Exhibit III.1

Assessing Accessibility of CHIP Members to Primary Care Providers

Region	CHIP Enrollment June 2017	Children More than 10 Miles from a Provider	Percent of Children Beyond 10 Miles
Northeast	13,095	11	0.1%
North Central	11,605	15	0.1%
Northwest	10,709	23	0.2%
East Central	7,984	10	0.1%
Central	35,778	8	0.0%
West Central	7,489	71	0.9%
Southeast	8,259	105	1.3%
Southwest	9,858	25	0.3%
Entire State	104,777	268	0.3%

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

- Northeast- Allen, Kosciusko
- North Central- Marshall, Fulton
- Northwest- LaPorte, Jasper, Newton
- East Central- Cass, Union
- Central- Putnam, Boone
- West Central- White, Warren, Fountain, Montgomery, Vermillion, Parke
- Southeast- Ohio, Switzerland, Jefferson, Jackson, Washington, Harrison
- Southwest- Owen, Brown, Perry

Exhibit III.2

Assessing Accessibility of CHIP Members to Dental Providers

Region	CHIP Enrollment June 2017	Children More than 10 Miles from a Provider	Percent of Children Beyond 10 Miles
Northeast	13,095	59	0.5%
North Central	11,605	42	0.4%
Northwest	10,709	54	0.5%
East Central	7,984	60	0.8%
Central	35,778	40	0.1%
West Central	7,489	170	2.3%
Southeast	8,259	191	2.3%
Southwest	9,858	119	1.2%
Entire State	104,777	735	0.7%

Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2017

At the individual MCE level, the findings on access to dental care resemble the statewide findings with the following exceptions:

- Anthem also has gaps in one additional county in addition to what was observed statewide.
- CareSource also has gaps in 13 additional counties in addition to what was observed statewide.
- MHS also has gaps in five additional counties in addition to what was observed statewide.
- MDwise also has gaps in four additional counties in addition to what was observed statewide.

IV

Service Use Among Populations in Indiana's CHIP



Service Use at a Glance

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

	FFY 2015	FFY 2016	FFY 2017
Primary Care Visit	81%	81%	75%
Emergency Room Visit	26%	24%	17%
Preventive Dental Visit	66%	66%	59%
Pharmacy Script	66%	65%	63%

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

Introduction

In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also 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) 2015, 2016 and 2017 across populations within the CHIP such as by CHIP Package, by managed care entity (MCE), by age and by race/ethnicity.

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2018. 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 2017 may still be incomplete if the MCEs have not submitted all of their encounter data to the OMPP yet.¹² Also, it is recognized that CareSource became a contracted MCE effective January 1, 2017. Since the MCE was only active in the last few months of this study period, the utilization from CareSource is not shown specifically in any analysis when comparing across MCEs. The utilization of CareSource members is included, however, in other exhibits that show utilization such as by age group.

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2015, 2016 or 2017. The *usage rate* is an annual measure. It measures the percentage of members that had actually used the service, but the measure is limited to those children who were enrolled for a minimum of nine months in each year. This accounts for the fact that these are the members that would have had an opportunity to actually use the service. Members could be included in one FFY of the study but not another year based upon their enrollment history. Children were included in the usage reports if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year as long as they were enrolled for nine months during the year. In the event that a child did cross CHIP packages during a study year, the child was assigned to their enrollment category at the end of the year. As such, each child is counted only once on each report. 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* is a point-in-time measure. It captures the number of services received in the service category divided by the number of members enrolled in the given month. For example, if there were 10,000 primary care visits in the month among a population of 50,000 members, this means that .20 of all members in the month ($10,000 / 50,000$) had a primary care visit. Because each portion of the CHIP has different levels of enrollment, to put the analysis on an apples-to-apples basis, this is shown as a rate of 200 members per 1,000 ($.20 * 1,000$). This is helpful when measuring the utilization per 1,000 rate across different populations (e.g., by age or by race/ethnicity).

For ease of comparison, the exhibits are displayed in a similar manner throughout this section. For each service examined, first the usage rate exhibit is shown as a way to identify if the rate of use for that service varied when examined by CHIP package, by MCE, by age group or by race/ethnicity. Following this, the utilization per 1,000 member exhibit is shown to measure if the intensity of the use varied across the sub-populations within Indiana's CHIP. In both series of exhibits, the data can also be viewed over the last three years.

¹² Consequently, exhibits in this chapter that show utilization per 1,000 member month trends for primary care and emergency department use (Exhibits IV.2 and IV.4) used data only the first six months for FFY 2017 in the analysis.

Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2017

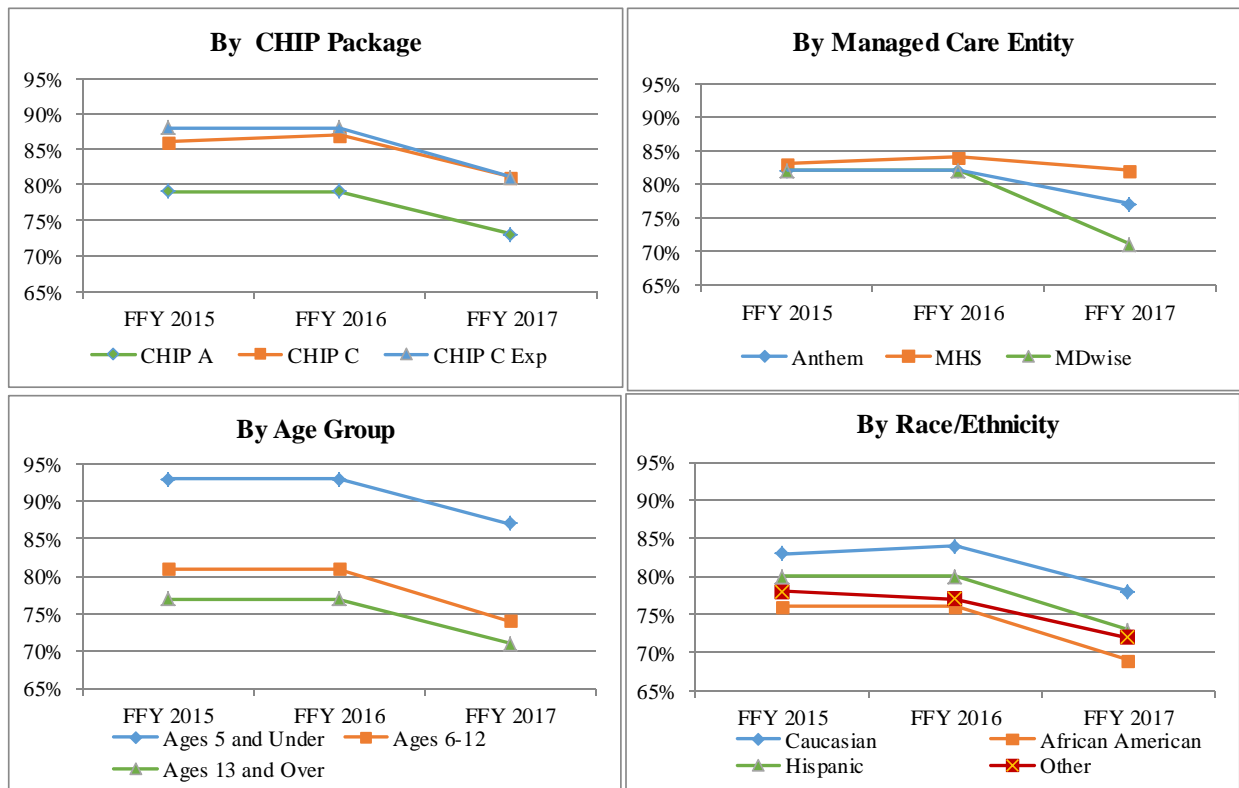
Primary Care Visits

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 primary medical provider (PMP) for such visits, B&A did not limit our analysis to visits to their PMP exclusively.

B&A found that the percent of SCHIP (CHIP Package C and CHIP C Expansion) children in the study sample that had a primary care visit was higher in each of the three years than for children in MCHIP (CHIP Package A) (refer to upper right box). Whereas the percentage with a visit was 86 to 88 percent in the first two years examined for the SCHIP, this dropped to 81 percent in FFY 2017. A similar trend in the reduction of percent using the service was found among MCHIP. Once again, it remains to be seen if this reduction is true since there may still be encounter claims outstanding from the MCE that will ultimately be submitted to the OMPP data warehouse. This is evident when examining the usage rate by MCE (upper right box). All three MCEs reported a usage rate of 82 to 84 percent in FFYs 2015 and 2016 for primary care, but this reduced sharply for each MCE in FFY 2017.

Primary care visits are more prevalent among the youngest members, as 93 percent of children ages 5 and younger had a visit in FFYs 2015 and 2016 (lower left box). The percentage was lower for children in the other age groups (81 percent for children ages 6 to 12 and 77 percent of children ages 13 to 18 in FFYs 2015 and 2016). When examined by race/ethnicity (lower right box), the usage rate for Caucasian children was four to nine percentage points higher than Hispanic, African-American, or children of other races/ethnicities in each year.

Exhibit IV.1
Percent of Member Usage within Populations in Indiana's CHIP for Primary Care
 Only Children Enrolled in 9 Months of the Study Year are Considered



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2017

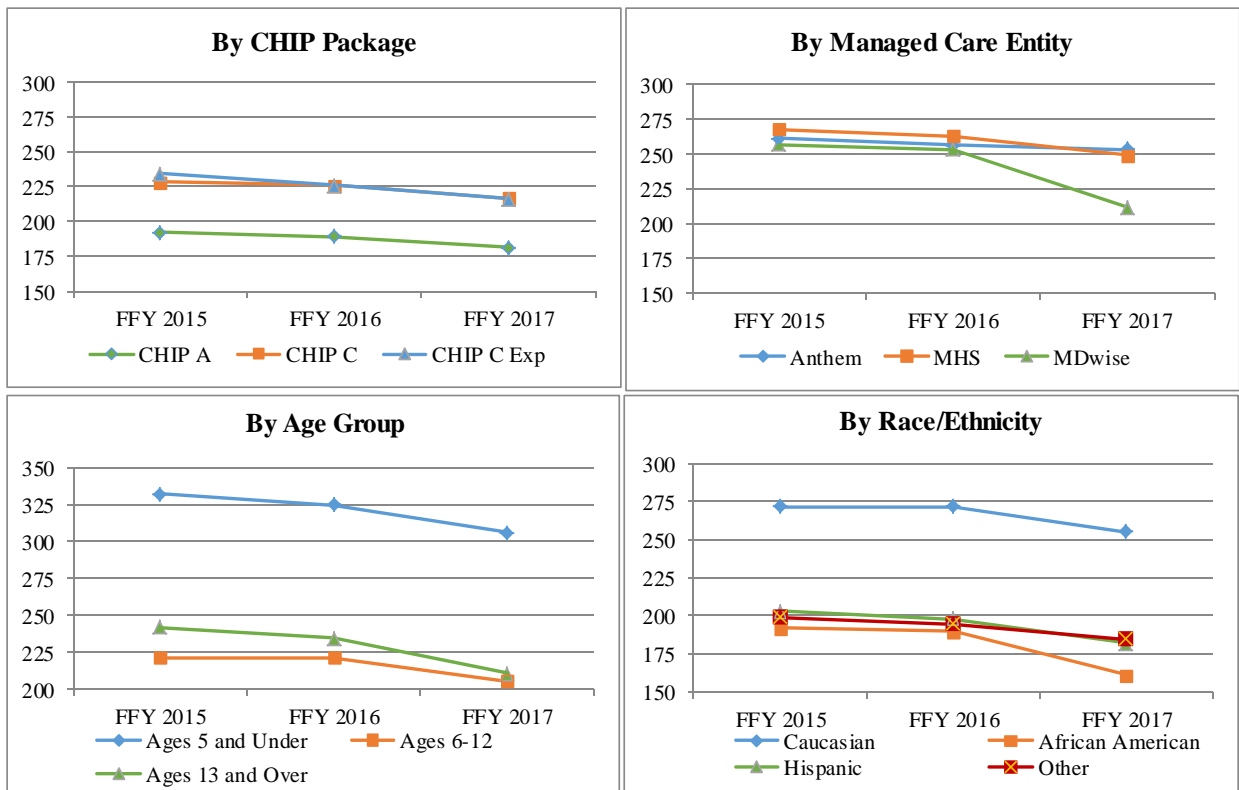
The utilization per 1,000 member trends for primary care shown below in Exhibit IV.2 mirror the percent usage trends in Exhibit IV.1. The greatest variation is seen when comparing utilization by age group (lower left box) and by race/ethnicity (lower right box). The rates per 1,000 members by age show that for children age 5 and under, the rate was close to 330 per 1,000 in FFYs 2015 and 2016. This is much greater than what is seen for children ages 6-12 (220 per 1,000) and ages 13 and over (240 per 1,000) during the same time period. What this means is that, any given month of the year studied, 3.3 out of ten of the youngest children had a primary care visit compared to 2.4 out of 10 for teenagers and 2.2 out of 10 for children in the middle age range.

Caucasian children had a utilization per 1,000 rate near 270 per 1,000 in FFYs 2015 and 2016. But the rate for Caucasian children was 33 to 40 percent higher than the rate for minorities. Primary care utilization was similar across all non-Caucasian groups near 195 per 1,000 in FFYs 2015 and 2016.

The differences in the utilization per 1,000 by CHIP package (upper left box) are an artifact of the age composition within each package. In SCHIP, the composition of members by age range is spread evenly. In MCHIP (CHIP Package A), 90 percent of the children are ages six and older.

There is little variation in the utilization per 1,000 for CHIP members by MCE (upper right box), at least in FFYs 2015 and 2016. The reduction seen for MDwise in FFY 2017 may be an encounter reporting issue.

Exhibit IV.2
Utilization per 1,000 within Populations in Indiana's CHIP for Primary Care
 All Children Enrolled in the Study Year are Considered



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2017

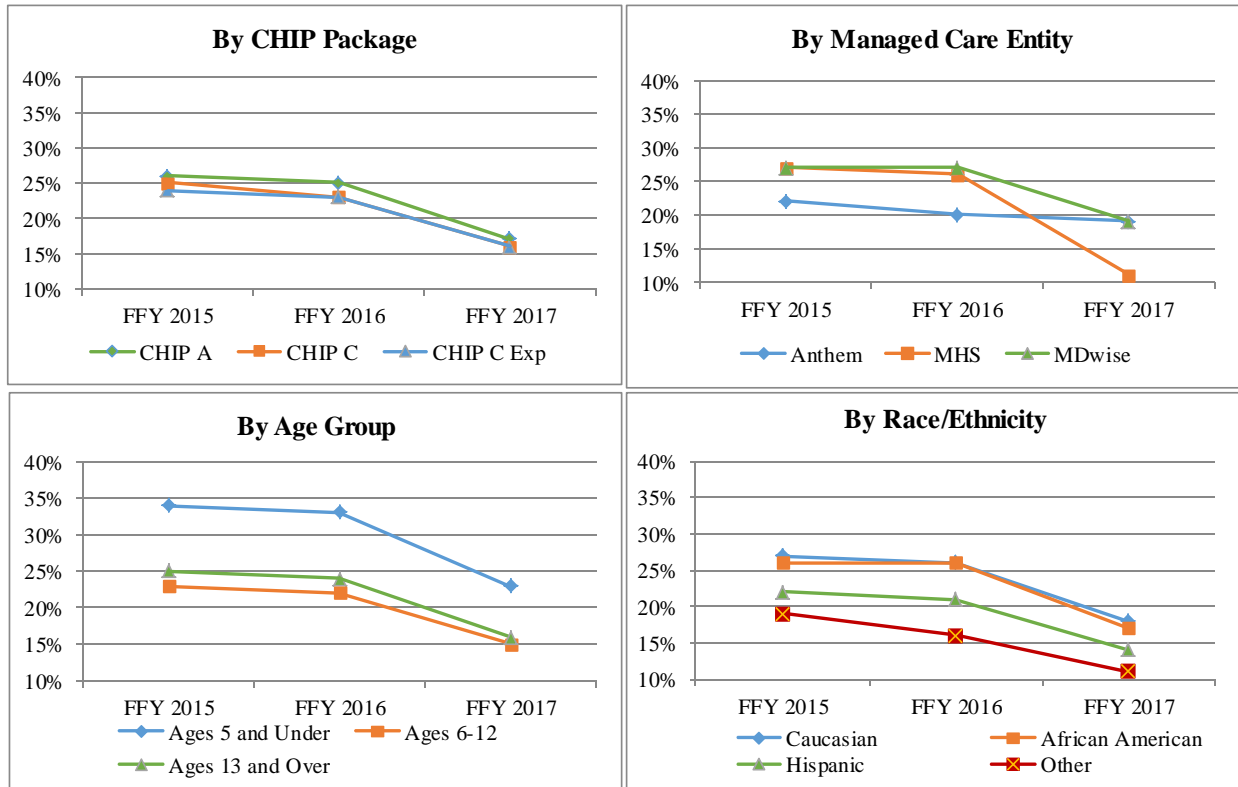
Emergency Department Visits

The usage rate of Emergency Department visits by CHIP children in all packages was consistent in FFYs 2015 and 2016. Exhibit IV.3 shows a usage rate of 23 to 26 percent for both MCHIP and SCHIP in these two years (upper left box). In these years, this means that almost one in four CHIP children went to the ED. A sharp decline was observed in FFY 2017; however, as stated previously, all of the ED visits that occurred may yet be submitted by the MCEs to the OMPP, so this finding should be taken with caution.

This is apparent when reviewing the percent usage by MCE in the upper right box. The trends were consistent in the first two study years. Anthem CHIP members had a usage rate near 20 percent while MHS and MDwise members were closer to 27 percent. The Anthem rate was steady from FFY 2016 to 2017 but the rates for both MHS and MDwise went down significantly.

The usage rate trends over the three-year period followed a similar pattern when examined by age group (lower left box) and by race/ethnicity (lower right box). The FFY 2017 data may be an anomaly due to incomplete reporting. Focusing on FFYs 2015 and 2016, therefore, the usage rate for children ages 5 and younger was much higher (33 percent) than the older age groups (22 to 25 percent). There is little variation found in ED use between Caucasian and African-American CHIP members, but Hispanic members and those of other races used the ED less.

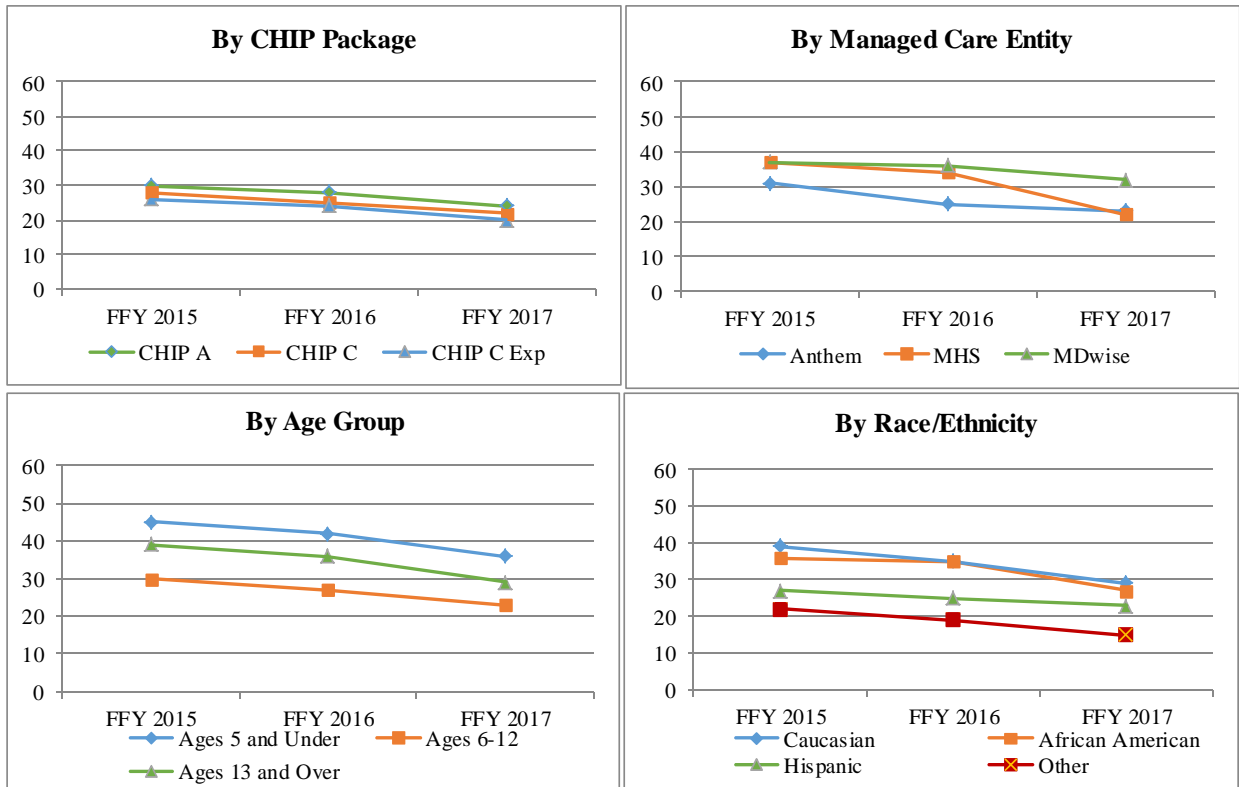
Exhibit IV.3
Percent of Member Usage within Populations in Indiana's CHIP for Emergency Department
 Only Children Enrolled in 9 Months of the Study Year are Considered



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

The ED utilization per 1,000 member trends shown in Exhibit IV.4 below followed the same patterns seen in the usage rates in Exhibit IV.3. The ED utilization per 1,000 members was similar between MCHIP and SCHIP (upper left box), slightly lower for Anthem compared to MHS and MDwise (upper right box), highest for children age 5 and younger (lower left box) and lowest for Hispanic children and other minorities (lower right box).

Exhibit IV.4
Utilization per 1,000 within Populations in Indiana's CHIP for Emergency Department
 All Children Enrolled in the Study Year are Considered



B&A also examined the prevalence of children who are frequent users of the ED. In the most recent FFY, most CHIP children (89.2%) had one or two ED visits during the year (compared to 85.8% in FFY 2016). This statistic is fairly consistent across the MCEs, but MHS has a higher percentage with lower users. This may be indicative of missing data as seen in previous exhibits. From the data available, 98.4 percent of children had five or fewer ED visits in FFY 2017 compared to 97.6 percent in FFY 2016.

Exhibit IV.5
Frequency of ED Utilization Among CHIP Members Using ED Services
 For Claims Submitted with Dates of Service Oct 1, 2016 - September 30, 2017

Number of ED Visits per Member	Percentage of All Members Using ED by MCE					Prior Year
	Anthem	CareSource	MHS	MDwise	All MCEs	
1 to 2	88.3%	91.0%	93.6%	88.0%	89.2%	85.8%
3 to 5	9.9%	7.3%	5.8%	10.2%	9.2%	11.8%
6 to 10	1.4%	0.8%	0.6%	1.5%	1.3%	1.9%
11 to 20	0.4%	0.8%	0.1%	0.3%	0.3%	0.4%
More than 20	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%

CareSource did not begin serving CHIP members until January 1, 2017.

Preventive Dental Visits

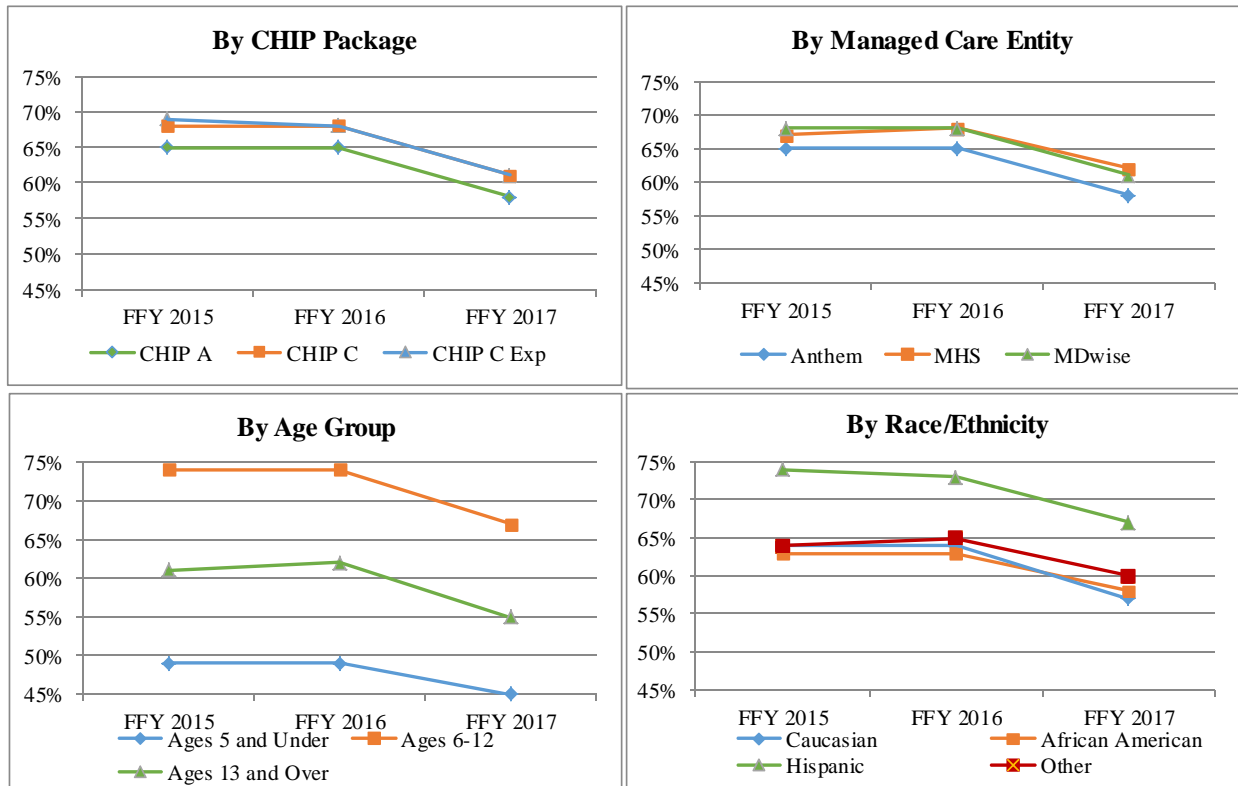
Although dental care has always been a service available to CHIP members, it was not until January 2017 that the MCEs were given responsibility for managing this benefit in the Hoosier Healthwise (HHW) program. Prior to this, CHIP members received services from providers that were paid directly by the OMPP. The rate of preventive dental care usage has remained stable for CHIP children in recent years. The drop in the percentages shown in all of the boxes in Exhibit IV.6 may not be indicative of lower usage; rather, this may be due to the fact that not all of the MCE encounters for dental services have been submitted yet to the OMPP.

The percentage of children in MCHIP (Package A) and SCHIP (Package C and Package C Expansion) in FFYs 2015 and 2016 with a preventive dental visit were all between 65 and 68 percent of the total children within each enrollment group (upper left box). This was also true for members enrolled with each MCE during FFYs 2015 and 2016 when dental services were delivered outside of managed care (upper right box).

The percentage of CHIP members using dental visits was steady in FFYs 2015 and 2016 by age group (lower left box), though children ages 6 to 12 are most likely to have received a preventive dental visit (74 percent of the members), which is significantly higher than teenagers (61 percent). The youngest children had the lowest usage rate (49 percent) given that this group includes toddlers. When examined by race/ethnicity (lower right box), more Hispanic children used dental services (73 percent) than other race/ethnicities (63 to 64 percent). This trend has been consistent in the last five years studied.

Exhibit IV.6

Percent of Member Usage within Populations in Indiana's CHIP for Preventive Dental Care
Only Children Enrolled in 9 Months of the Study Year are Considered



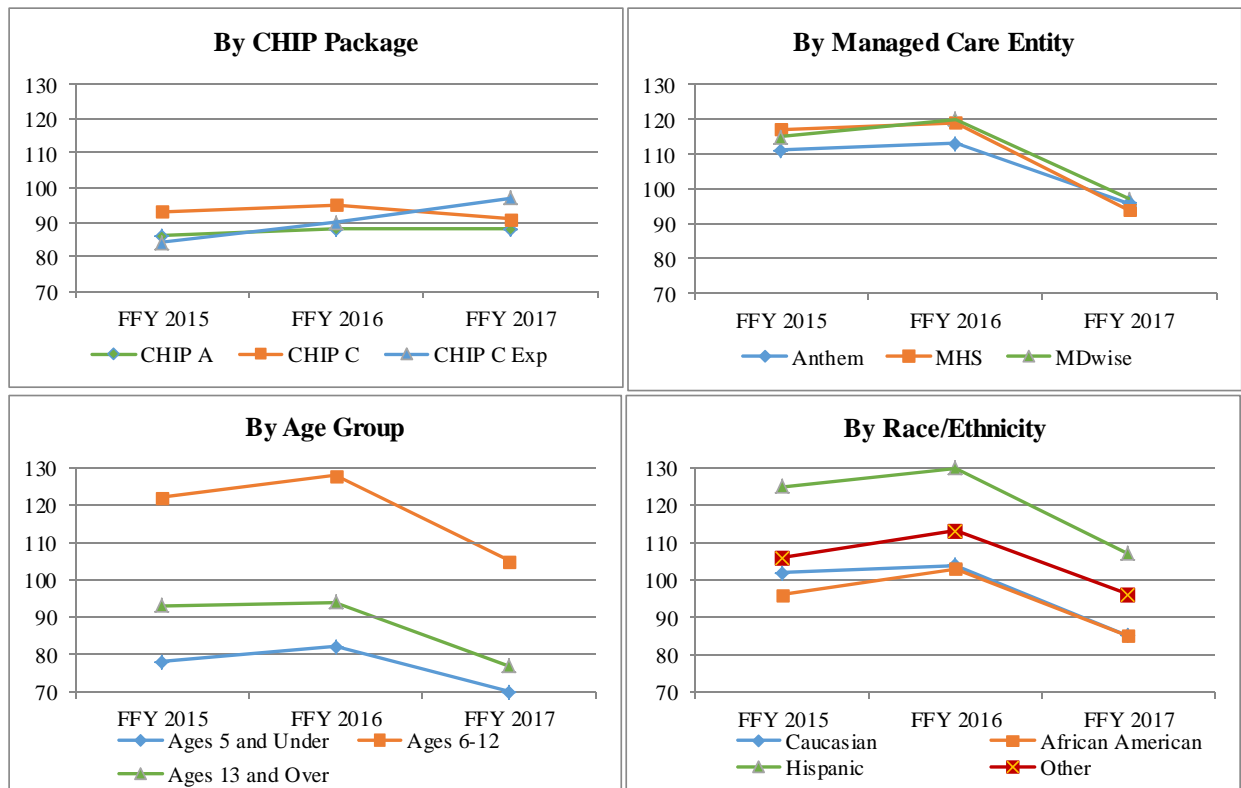
Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2017

The trends in the utilization per 1,000 members for dental services were similar to what was found in the usage rates shown in Exhibit IV.6 with one exception. Although the percent of members using dental services appeared to have dropped for each portion of CHIP in FFY 2017 (upper left box in Exhibit IV.6), the utilization per 1,000 remained more steady (upper left box in Exhibit IV.7). Otherwise, the reduction in utilization in the other three boxes shown for the FFY 2017 time period in Exhibit IV.7 does appear to be incomplete encounter submissions (refer to upper right box). When focusing on FFYs 2015 and 2016, both the MCHIP and SCHIP members had between 84 and 95 services per 1,000 members. In other words, in each month in these two study years, close to one in ten CHIP children had a preventive dental visit.

As was observed in the usage rates, when measuring the utilization rate of dental visits per 1,000 CHIP members, children age 6 to 12 are highest at a rate of 125 per 1,000 members in FFYs 2015 and 2016 followed by the ages 13 to 18 group (94 visits per 1,000 members) and then children ages 0 to 5 (80 visits per 1,000 members). (refer to lower left box)

The variation by race/ethnicity in the usage rate of dental services is also seen when examining utilization per 1,000 members. In FFYs 2015 and 2016, Hispanic children are most likely to have a preventive dental visit at 127 visits per 1,000 members. Both African American children and Caucasian children had near 100 visits per 1,000 members in both of these years, while children of other race/ethnicities varied more (due to small sample size).

Exhibit IV.7
Utilization per 1,000 within Populations in Indiana's CHIP for Preventive Dental Care
 All Children Enrolled in the Study Year are Considered



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Pharmacy Prescriptions

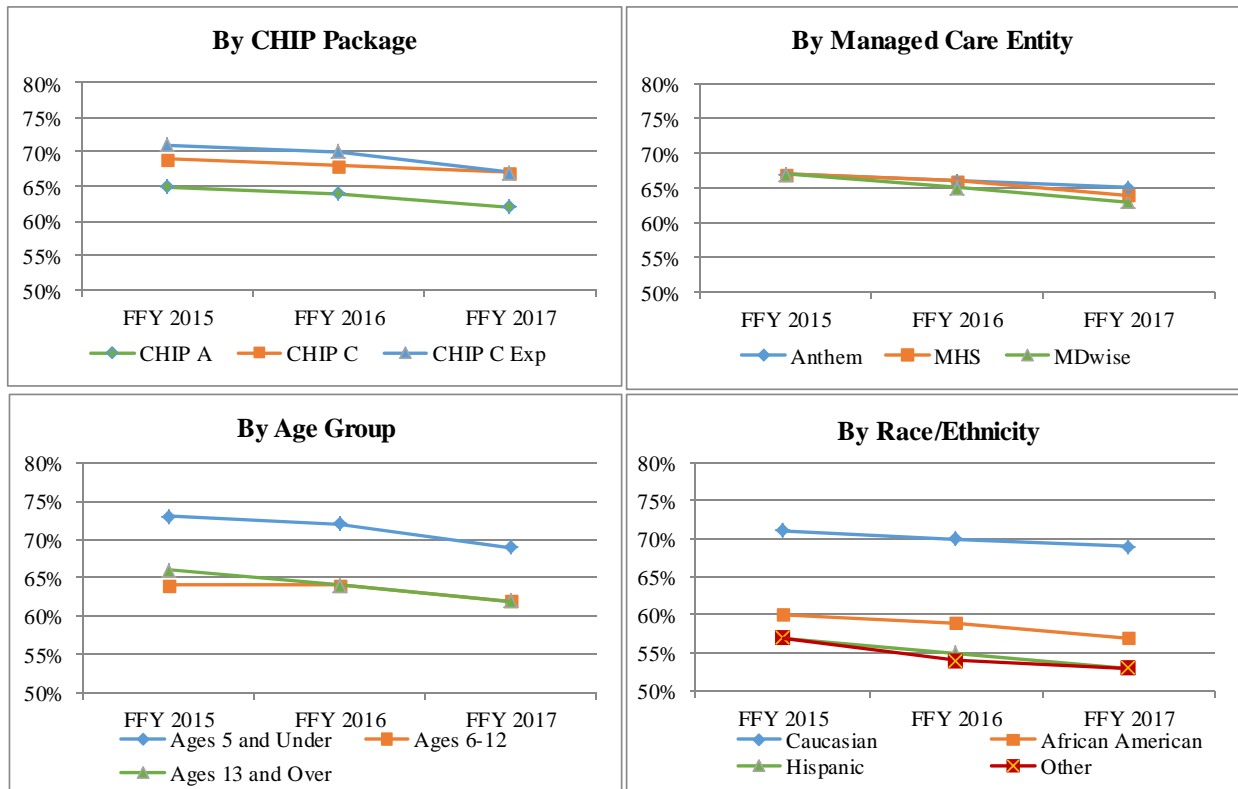
Similar to the dental benefit, the administration of the pharmacy benefit was managed directly by the State up until January 1, 2017 when it became part of the responsibility of the MCEs in their new contract. As seen with the dental exhibits shown on the prior pages, the total number of scripts paid by the MCEs may not all have been submitted to the OMPP data warehouse in FFY 2017, so the data in this time period may be incomplete.

MCHIP (Package A) children are least likely to have a prescription with 65 percent in FFYs 2015 and 2016 (upper left box). SCHIP (Package C) children (original and expansion populations) are more likely to have a prescription with a rate of 68 to 70 percent during this same time period. There is consistency in the usage patterns of CHIP members enrolled with each MCE, both before and after the MCEs took over this benefit (upper right box).

There are differences, however, in pharmacy usage among the age groups studied (lower left box). The highest usage rate is among children ages 5 and under over the last three years (73 percent in FFYs 2015 and 2016). Children in the two older age groups had less usage 64 percent of children ages 6 to 12 and 65 percent of teenagers in FFYs 2015 and 2016.

Across races/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities (lower right box). In FFYs 2015 and 2016, the usage rate among Caucasians children was 71 percent but it was 55 to 60 for minorities. This has been a consistent finding in the CHIP for the last eight years.

Exhibit IV.8
Percent of Member Usage within Populations in Indiana's CHIP for Pharmacy Scripts
 Only Children Enrolled in 9 Months of the Study Year are Considered



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

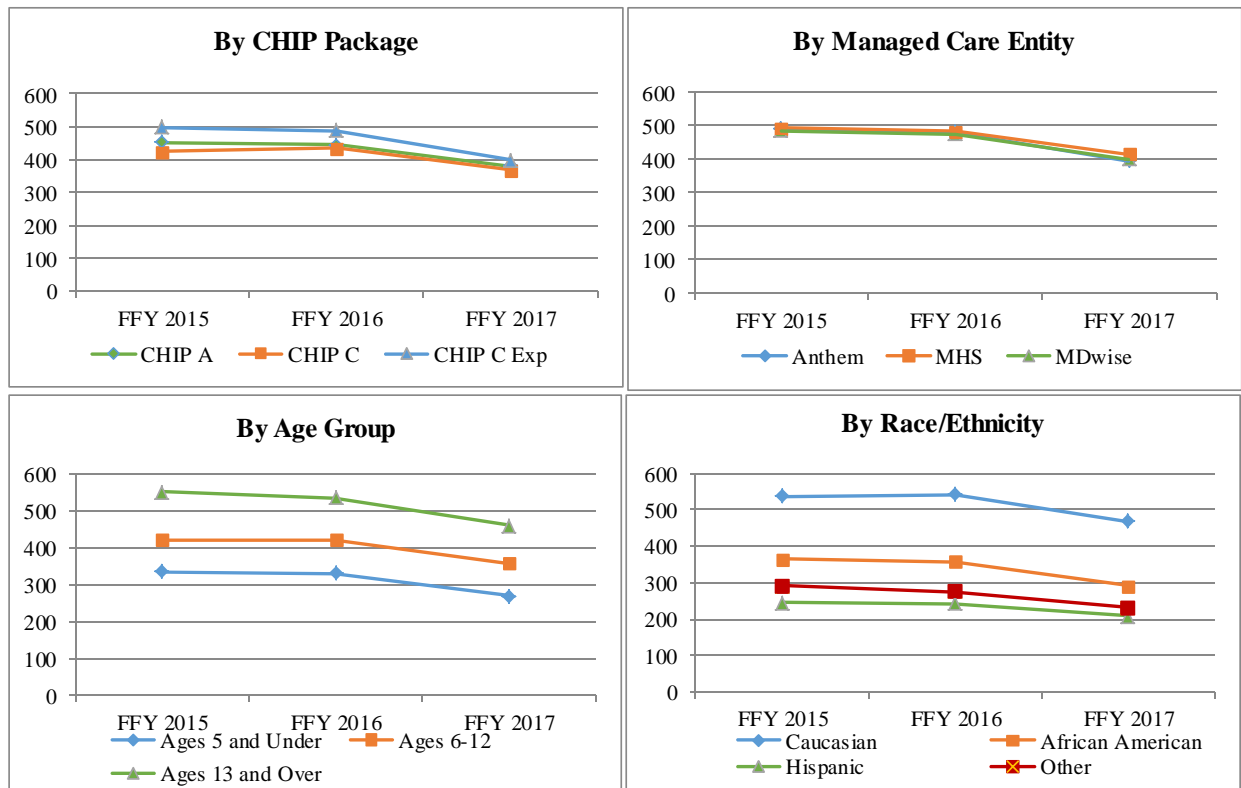
In the other services examined in this chapter (primary care, ED and dental), the usage rates and the utilization per 1,000 trends were generally parallel when analyzing by CHIP package, by MCE, by age group and by race/ethnicity. Among pharmacy scripts, there are some differences between these two ways to look at utilization.

The utilization per 1,000 CHIP C Expansion members is slightly higher than their peers in CHIP Package A and CHIP C (upper left box). The CHIP C Expansion children also had slightly higher usage rates for pharmacy. The utilization per 1,000 members for each MCE is almost identical (upper right box), although all three MCEs show lower utilization in FFY 2017 than the prior two years. This may be due to incomplete encounter submissions. The usage rates shown in Exhibit IV.8 were also similar for each MCE.

The variance is seen in the age group views. Although fewer children in the older age groups obtained a prescription, they obtained more of them in the last three years (lower left box). The prescriptions per 1,000 members in FFYs 2015 and 2016 was an average of 540 per 1,000; for children age 5 and under, 332 per 1,000; for children age 13 to 18, 420 per 1,000.

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 had a utilization rate of 540 prescriptions per 1,000 members in each month of FFYs 2015 and 2016, which is 50 percent higher than the rate for African-American children (361 prescriptions per 1,000) and more than double the rate of children of Hispanic children (243 prescriptions per 1,000). It is 90 percent higher than the rate seen for children of other race/ethnicities (280 prescriptions per 1,000).

Exhibit IV.9
Utilization per 1,000 within Populations in Indiana's CHIP for Pharmacy Scripts
 All Children Enrolled in the Study Year are Considered



V

Measuring Quality and Outcomes in Indiana's CHIP



Quality and Outcomes Results at a Glance

Results from a survey of parents in Hoosier Healthwise about their child's health care:

- 84-87% gave a favorable rating for Rating of Health Care
- 86-88% gave a favorable rating for Rating of Health Plan
- 87-89% gave a favorable rating for Personal Doctor; 83-89% for Specialist

Results from HEDIS access to primary care practitioners:

- 95%-96% rating across the three health plans for ages 12 to 24 months
- 86%-88% rating across the three health plans for children age 25 months to 6 years
- 91%-92% rating across the three health plans for children age 7 to 11
- 91% rating for all three health plans for teenagers

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

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

OMPP’s Oversight of Quality

OMPP staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCE’s site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity¹³ 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 three HHW MCEs to report the results of HEDIS®¹⁴ and CAHPS®¹⁵ 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 National Committee of Quality Assurance. 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. Currently, there are 27 core measures identified by CMS. These include some HEDIS and CAHPS measures as well. CMS hires a national evaluator to analyze the results of these measures and make comparisons across the state Medicaid agencies.
3. When OMPP developed the CHIP and gained CMS approval for federal matching funds, the federal government required that the State develop strategic objectives and performance goals for Indiana’s CHIP. The review of these performance goals are part of the OMPP’s overall quality strategy and results are submitted in an annual report required by CMS.
4. In addition to the goals set for its CHIP program specifically, the OMPP also develops a Quality Strategy plan each year. Many items within the Quality Strategy pertain to outcomes for children, both CHIP and traditional Medicaid members. For example, current goals include improving the participation rate for Early Periodic Screening, Diagnosis and Treatment (EPSDT) and ensuring follow-up care for behavioral health hospitalizations within seven days of discharge.

¹³ Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.

¹⁴ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁵ The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

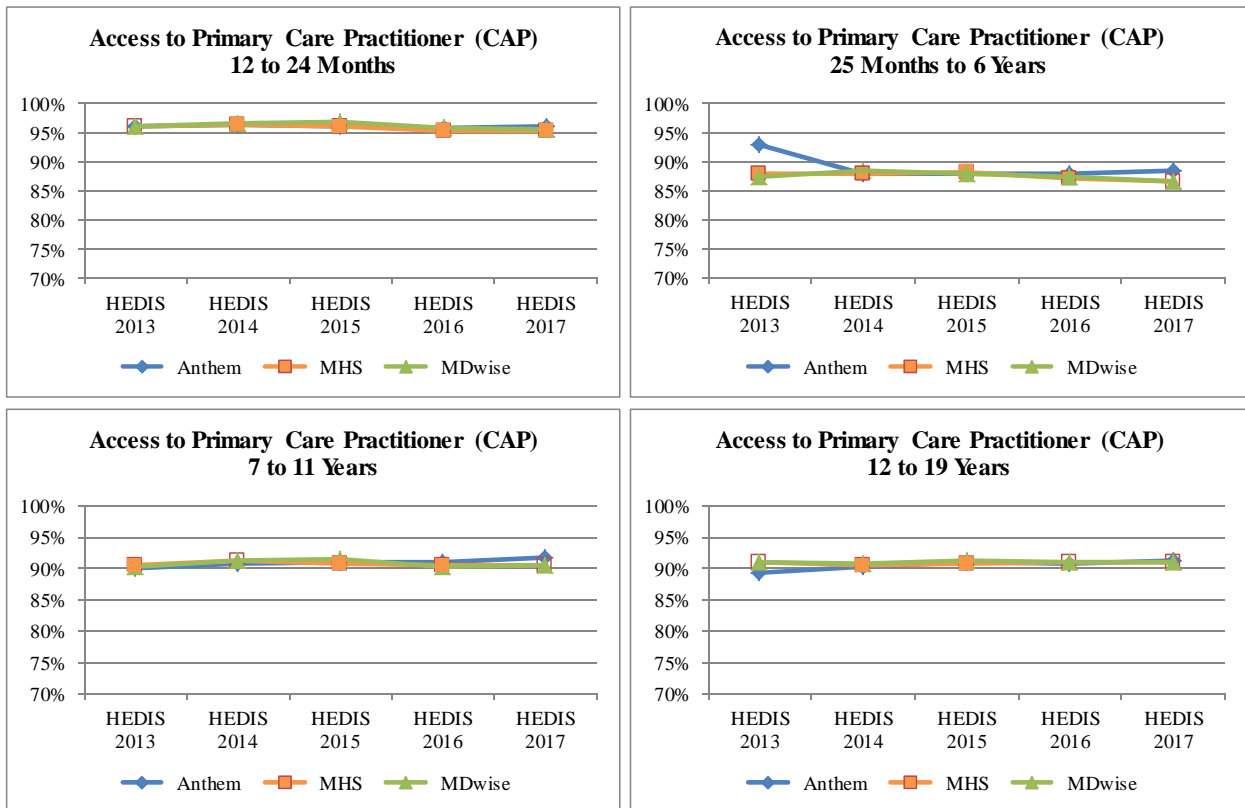
HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members from the prior year. Therefore, in Calendar Year (CY) 2017, tabulations were collected on HEDIS rates for 2016 utilization.¹⁶ The HEDIS measures report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome. The MCEs are required to contract with a certified external HEDIS auditor to collect the results of these measures. All results shown in this section reflect CHIP members as well as children in the traditional Medicaid program who are enrolled in Hoosier Healthwise.

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 review (i.e. claims data) 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 below shows the five year trend reported for each MCE for four age groups. For the youngest children age 12 to 24 months (upper left box), each of the MCEs have similar access at 96 percent. For the age group 25 months to six year (upper right box), all MCEs have reported 86 to 88 percent in the last four measurement years. For children age 7 to 11 years (lower right box) and the oldest children (lower right box), all MCEs reported 90 to 92 percent in the last four measurement years.

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



¹⁶ As a result, information is not shown for CareSource in this chapter since the MCE did not come under contract until January 1, 2017.

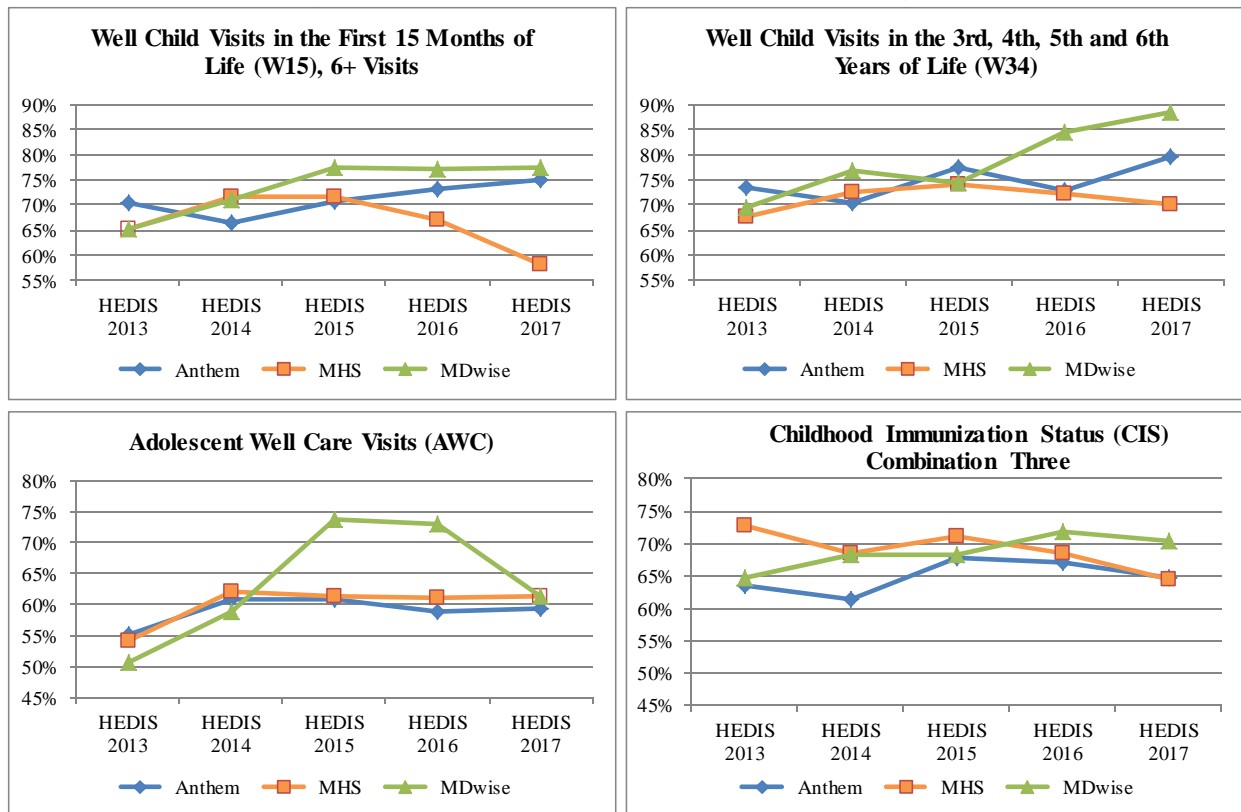
Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Exhibit V.2 shows the five year trend for well care visits for each MCE. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life (upper left box), the rate shown represents the percentage of children with six or more well child visits. For children in the ages 3-6 years (upper right box) and adolescents (lower left box), the rate shown represents the percentage of children that had at least an annual visit.

Significant improvement has been found for the rate of well care visits among infants for both Anthem and MDwise, but MHS has declined considerably. In the most recent reporting year (HEDIS 2017), Anthem reported 75 percent of infants had six or more visits, MDwise reported 77 percent, and MHS reported 58 percent. Anthem and MDwise also saw significant improvement in the annual visits for the age 3-6 group. In the most recent reporting year, Anthem reported that 80 percent had an annual well care visit, MDwise reported 89 percent, and MHS reported 70 percent. For adolescent well care, Anthem and MHS have been steady most years at 59 to 62 percent. MDwise, however, saw significant improvement moving from a rate of 51 percent in HEDIS 2013 to a rate of 73 percent reported in HEDIS 2016. This has dropped back down, however, to 61 percent in HEDIS 2017.

Another measure for well child care relates to immunizations (bottom right box). There is a HEDIS measure to report 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. All three MCEs had results in HEDIS 2017 that declined slightly from the HEDIS 2016 results. For Anthem, the drop was from 67 to 65 percent; for MHS, a drop from 69 to 64 percent; and for MDwise, a drop from 72 to 70 percent.

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

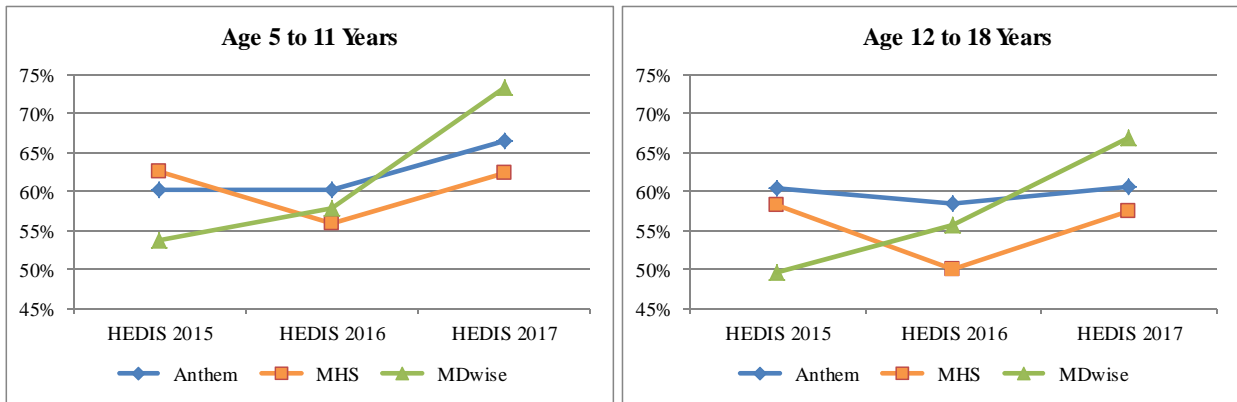


Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Exhibit V.3 presents the results from HEDIS measures related to medication management for people with asthma. Only the last three years are shown because the NCQA, who are the stewards of these measures, changed the way in which they measure medication adherence for asthma in 2015. The new method in which the measure is report is based on the percentage of children who remained on an asthma controller for at least 50 percent of their treatment period. The left box represents findings for children age 5 to 11 whereas the right box represents findings for children age 12 to 18 years.

All three MCEs have seen improvement in this measure in both age groups examined. In the most recent year of HEDIS 2017, MDwise was highest with 73 percent of members adhering at this rate. Anthem had 66 percent with adherence at the rate while MHS has 62 percent adhere at the rate of at least 50 percent of their treatment period. For the 12 to 18 age group, the adherence rates in HEDIS 2017 were 67 percent for MDwise, 61 percent for Anthem, and 57 percent for MHS.

Exhibit V.3
Summary of Results from HEDIS Medication Management for People with Asthma
 Percentage Represents Children Who Remained on an Asthma Controller for at least 50% of their Treatment Period



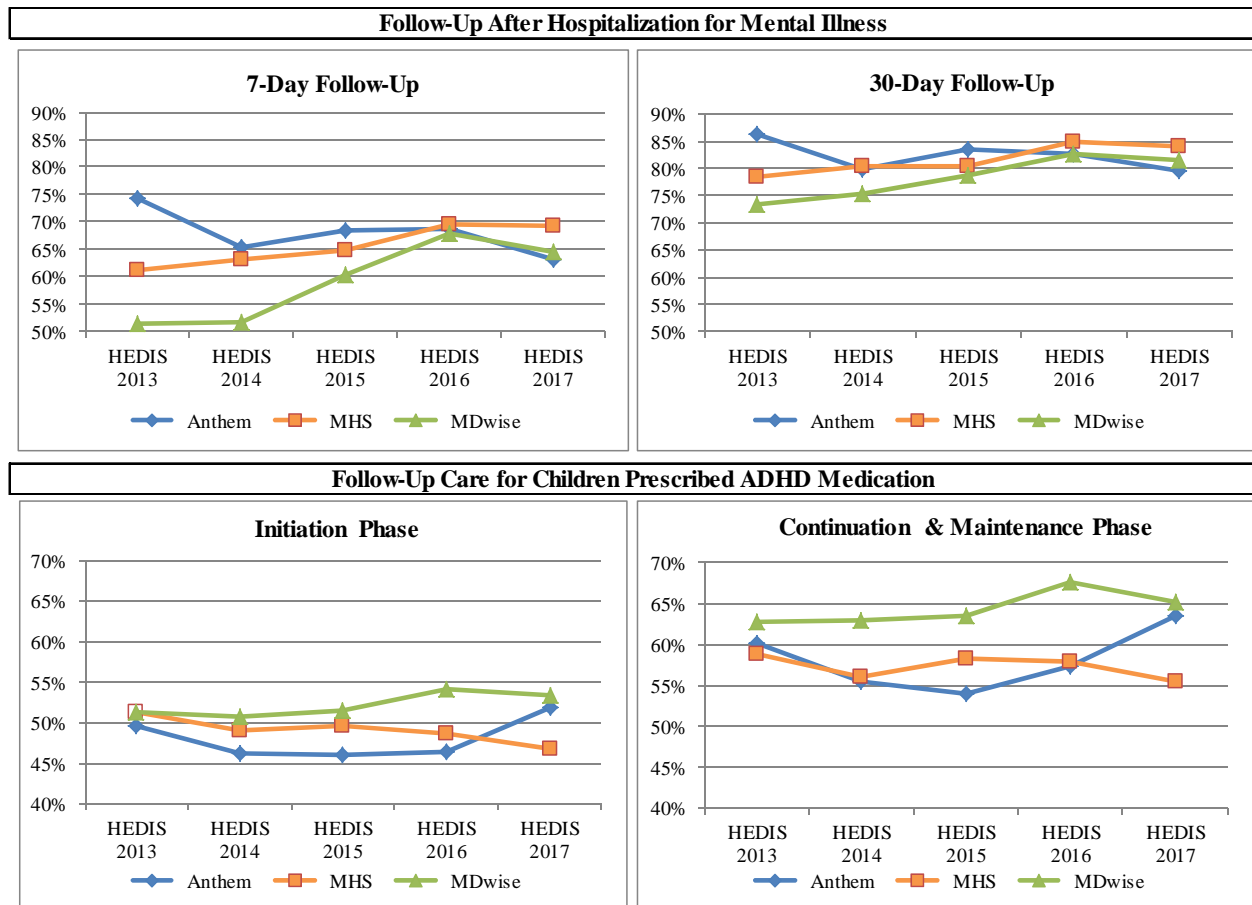
Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Exhibit V.4 presents the results of behavioral health HEDIS measures. It should be noted that for the measures in the top boxes which measure the percentage of patients with follow-up visits in the community after a hospitalization for mental illness, the measures include both children and adults. Prior to 2017, therefore, some of the members reported in these measures were adults in HHW. In the lower boxes, the measures show the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. In the initiation phase, the measure is the percentage of children who had a follow-up visit within 30 days of prescribing. In the continuation and maintenance phase, the measure represents those who continued taking ADHD medication and had at least two visits after the first visit.

Results for the follow-up visit within 7 days of a hospitalization are high and are consistent across the MCEs (upper right box). Whereas all MCEs were at 69 percent in HEDIS 2016, there was some variation in HEDIS 2017 from 63 to 69 percent across the MCEs. There was also similarity across the MCEs in the 30-day measure where all three MCEs reported 80 to 84 percent—Anthem at 80 percent, MHS at 84 percent and MDwise at 82 percent. The rates have been fairly consistent in the last three years.

The compliance related to visits after being prescribed ADHD medication could see improvement. The three MCEs reported consistent results in the initiation phase measure (47 to 53 percent reported in HEDIS 2017). In the continuation and maintenance phase measure, Anthem and MHS reported similar rates near 64 percent but MHS reported a lower rate of 55 percent in the most recent measurement year.

Exhibit V.4
Summary of Results from Selected Behavioral Health 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. There is one survey specific to adults and one for children. Exhibits V.5 and V.6 on the next page summarize the results from the child surveys that were administered over the last five years. The results presented include all children in Hoosier Healthwise—CHIP and traditional Medicaid.

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.” On all four ratings measured, all three MCEs had rates between 83 and 89 percent in the most recent survey and this was also true in the CAHPS 2016 surveys. Notable changes—that is, changes of more than three points up or down—from 2016 were found at MHS. The MHS Rating of Health Care went down four points from 88 to 84 percent, but their Rating of Specialist increased from 83 percent to 89 percent. All other ratings were within +/- 3 points from the prior year’s results for all MCEs.

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. All three MCEs scored best on the composite score for How Well Doctors Communicate (Anthem 94 percent, MHS 95 percent and MDwise 96 percent). The MCEs also scored similarly in the most recent survey on Getting Needed Care (85 to 88 percent), Getting Care Quickly (89 to 90 percent) and Customer Service (88 to 90 percent). All composite score ratings were within +/- 3 points from the prior year’s results.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2017

Exhibit V.5

Summary of Scores from CAHPS Child Survey 2013 to 2017 (Members giving a rating of 8, 9, or 10 on 10-point scale)

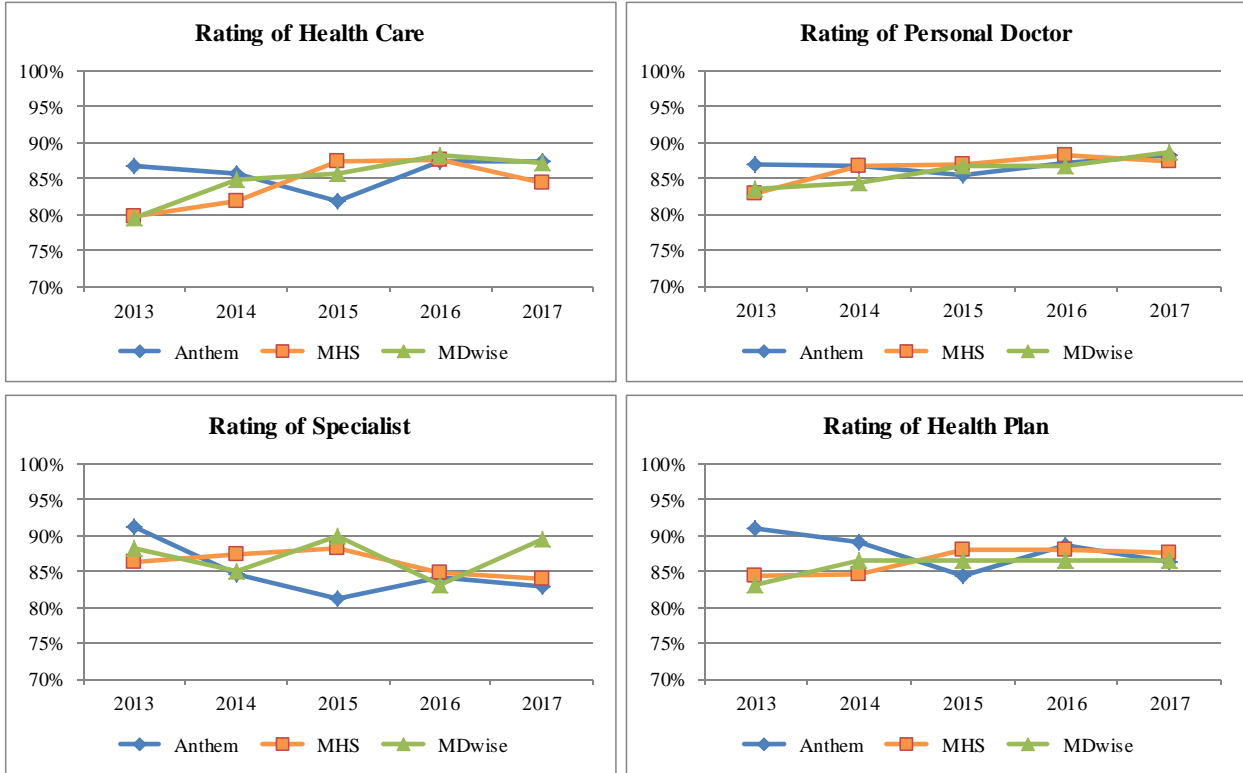
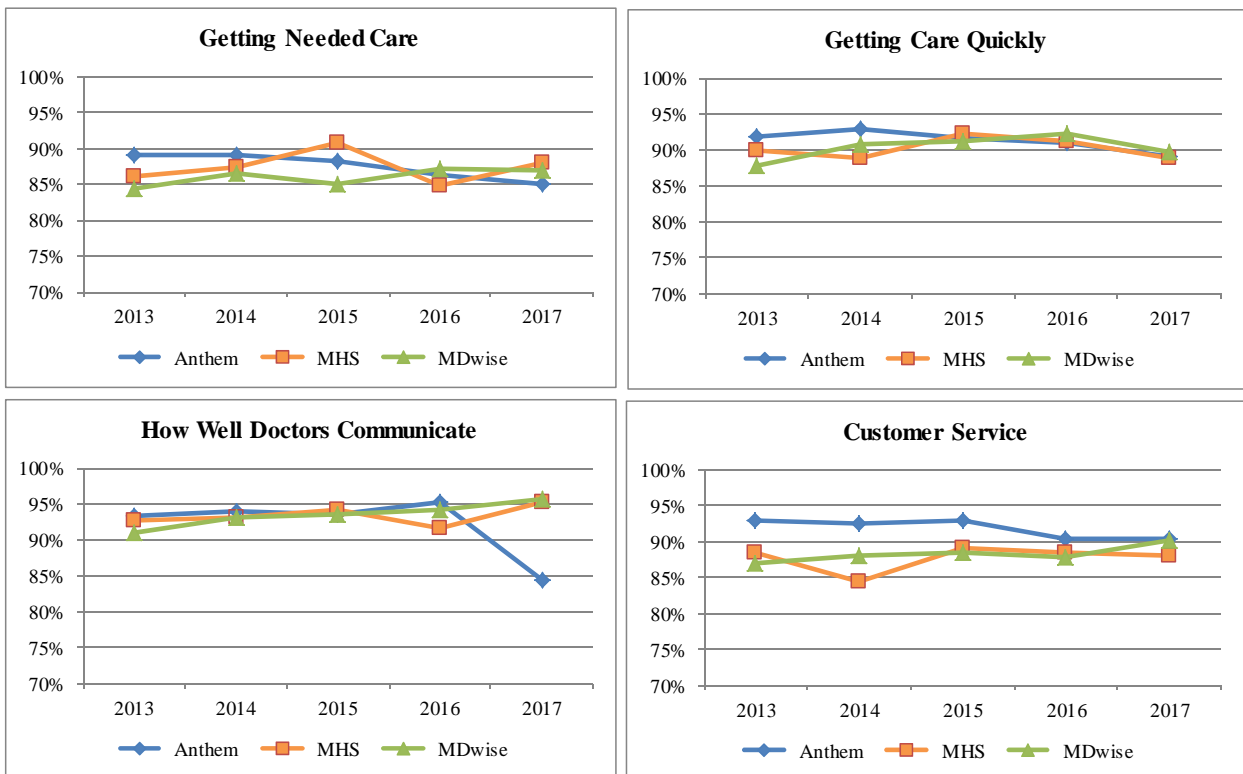


Exhibit V.6

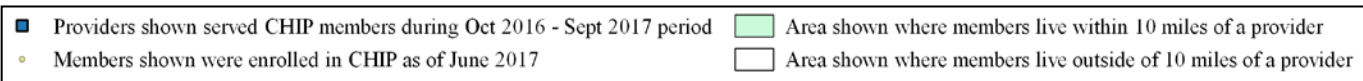
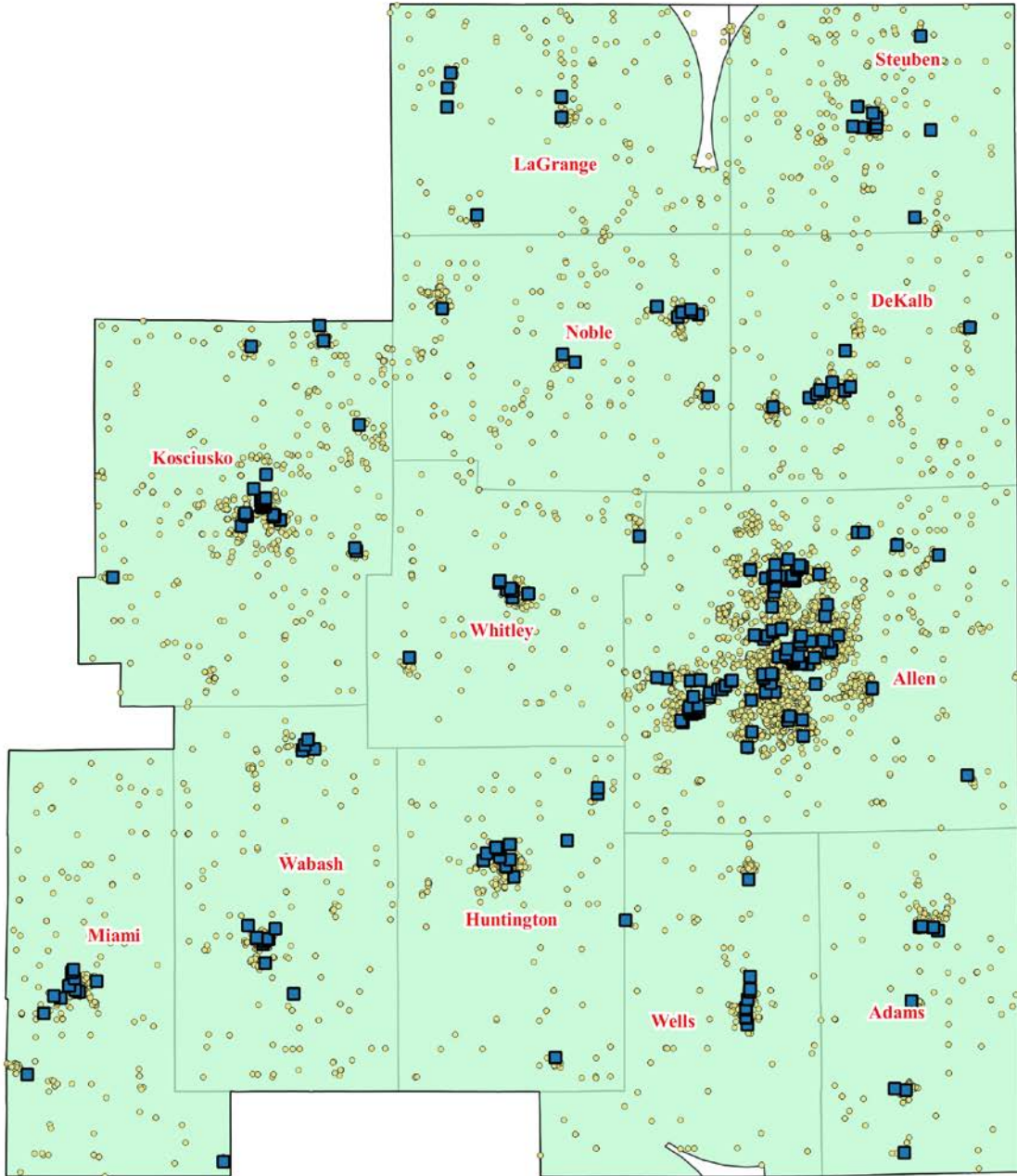
Summary of Scores from CAHPS Child Survey 2013 to 2017 (Percentages reflect responses of "Usually" or "Always")



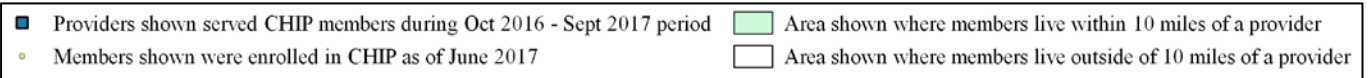
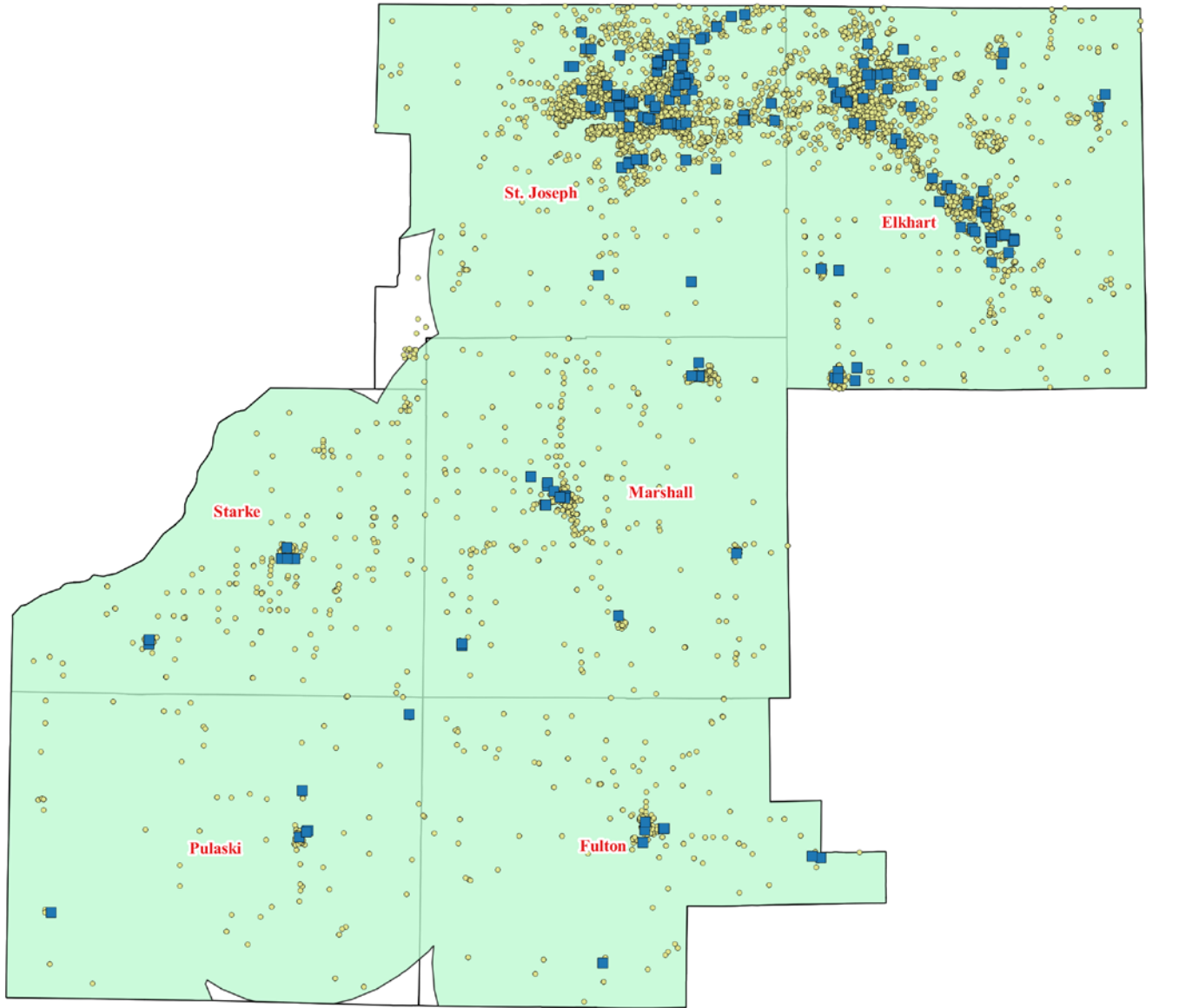
APPENDIX A

Maps Showing Access to Primary Care Providers in CHIP, by Region

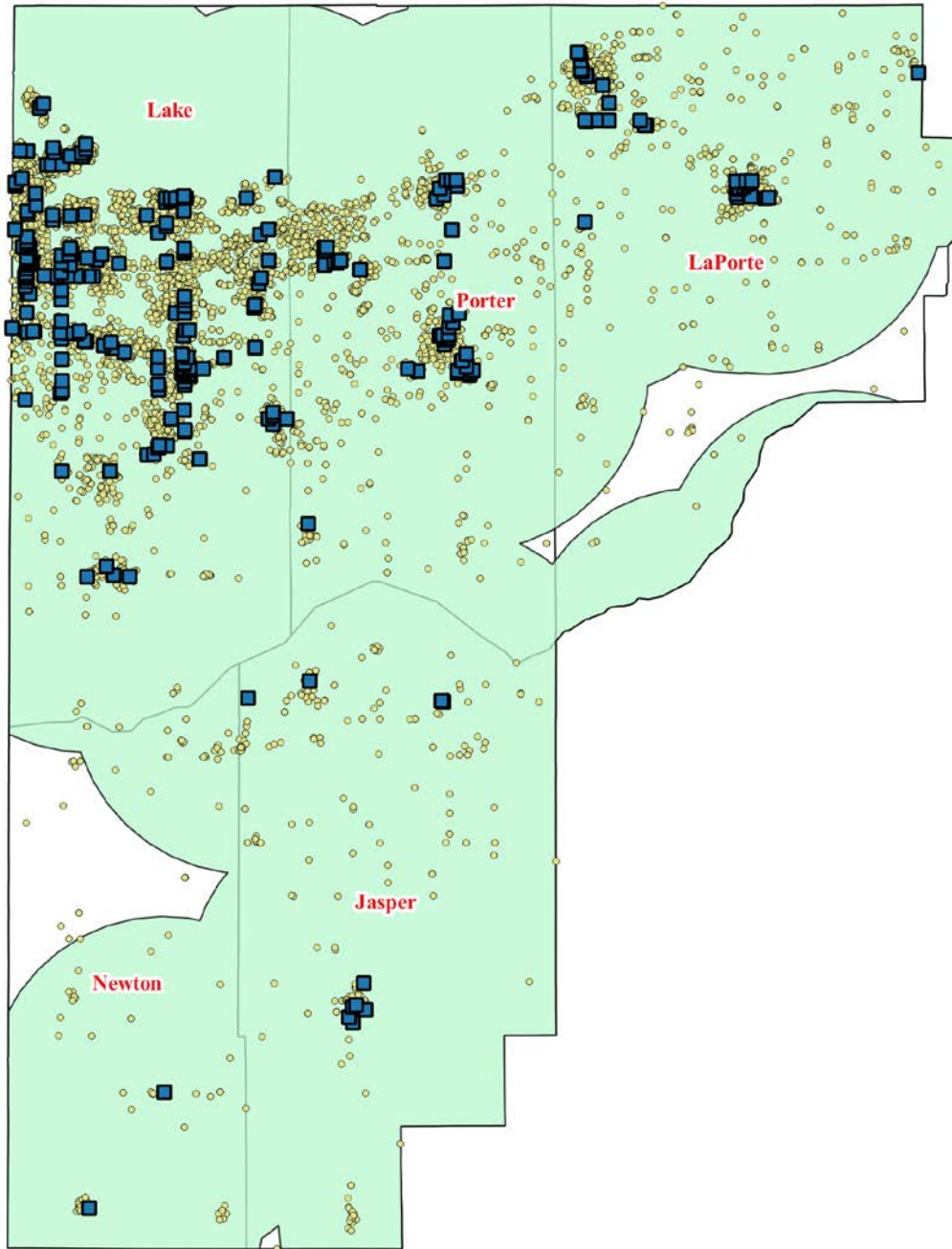
Map A.1
Measuring Accessibility to Primary Care Providers
Northeast Region



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

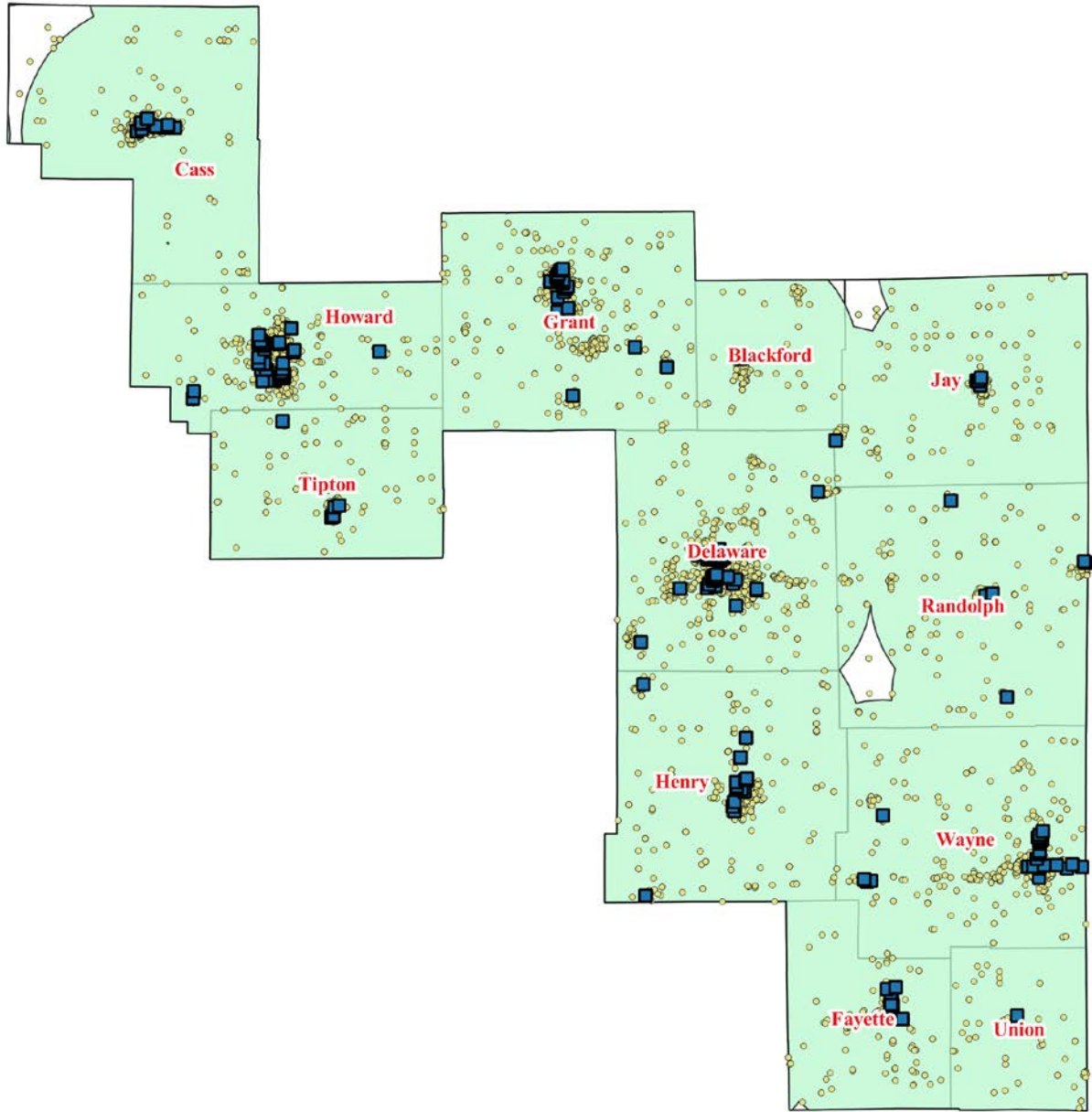


Map A.3
Measuring Accessibility to Primary Care Providers
Northwest Region



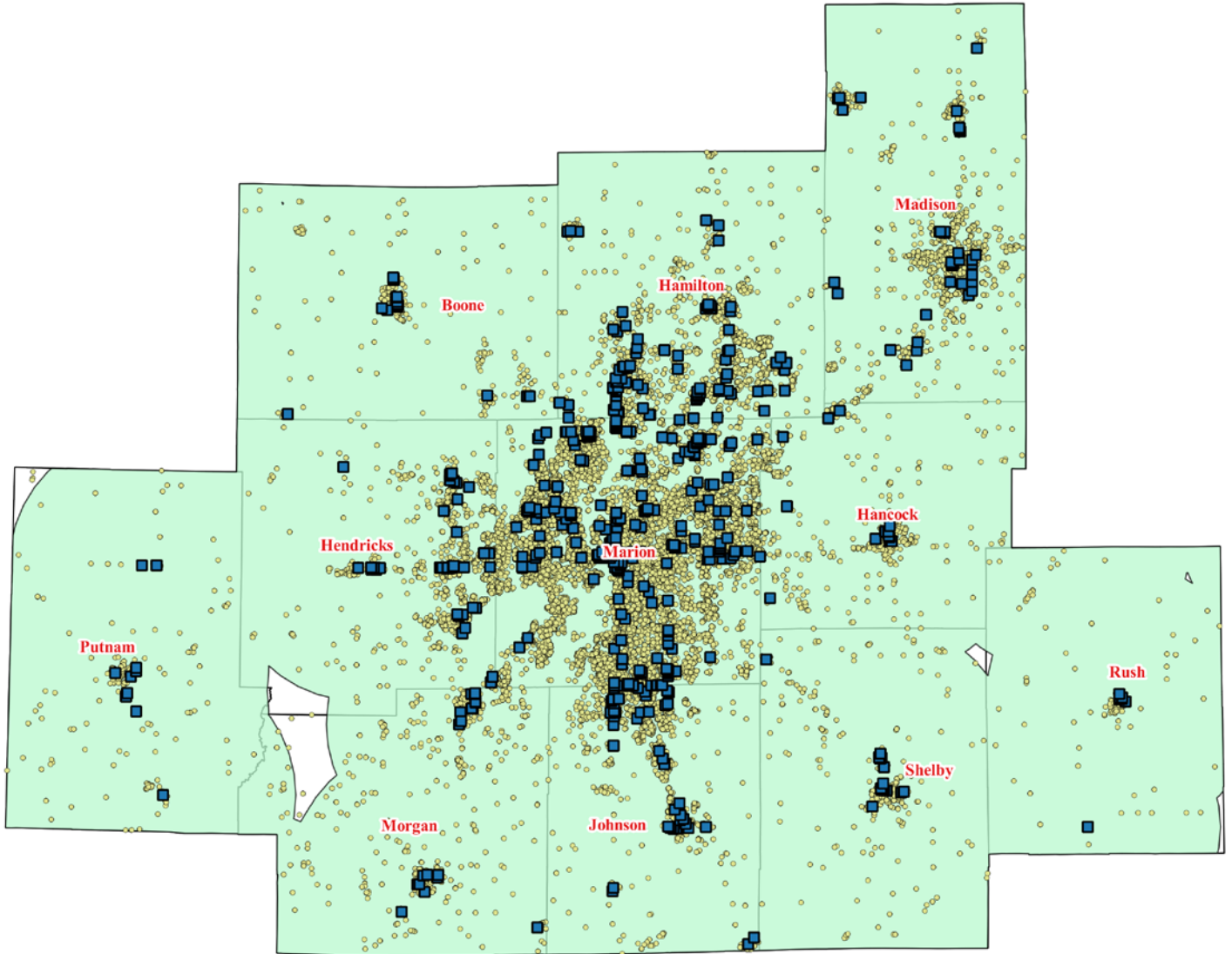
- | | |
|--|---|
| ■ Providers shown served CHIP members during Oct 2016 - Sept 2017 period | ■ Area shown where members live within 10 miles of a provider |
| ● Members shown were enrolled in CHIP as of June 2017 | □ Area shown where members live outside of 10 miles of a provider |

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



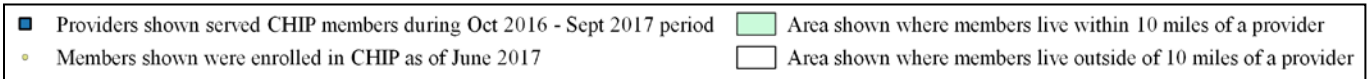
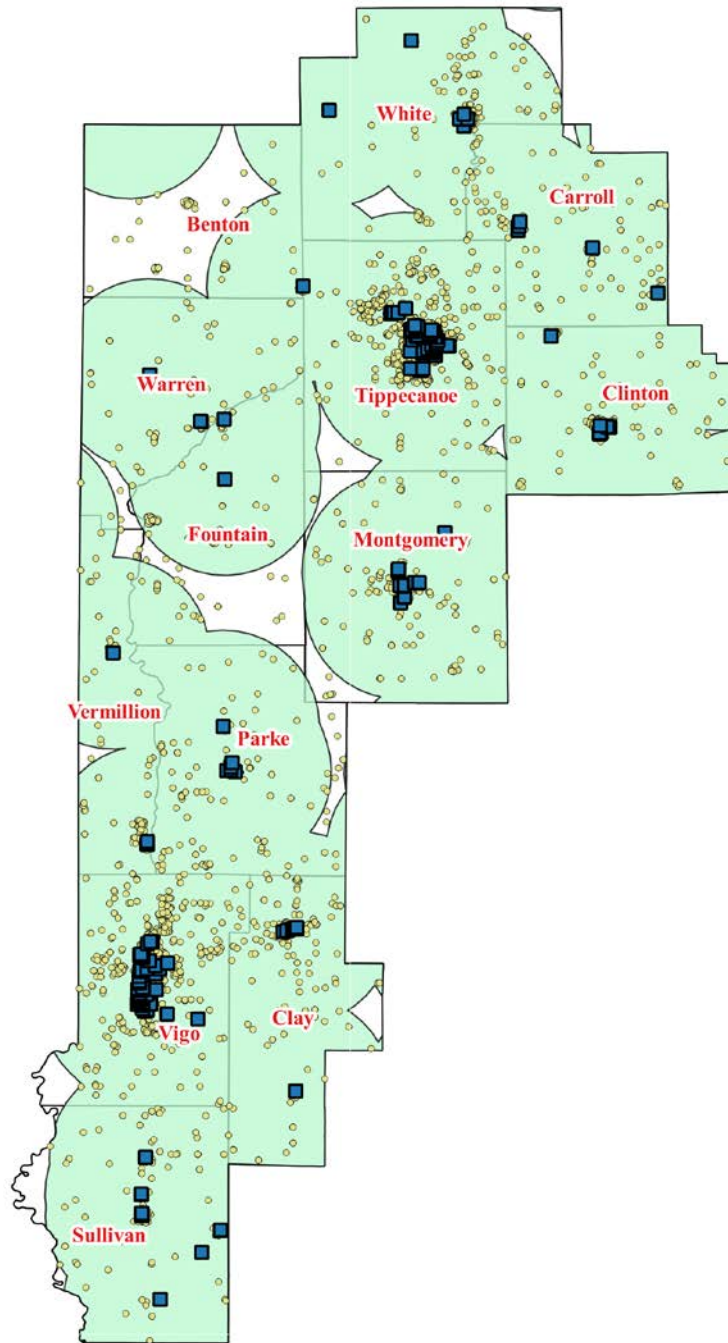
■ Providers shown served CHIP members during Oct 2016 - Sept 2017 period	■ Area shown where members live within 10 miles of a provider
● Members shown were enrolled in CHIP as of June 2017	□ Area shown where members live outside of 10 miles of a provider

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

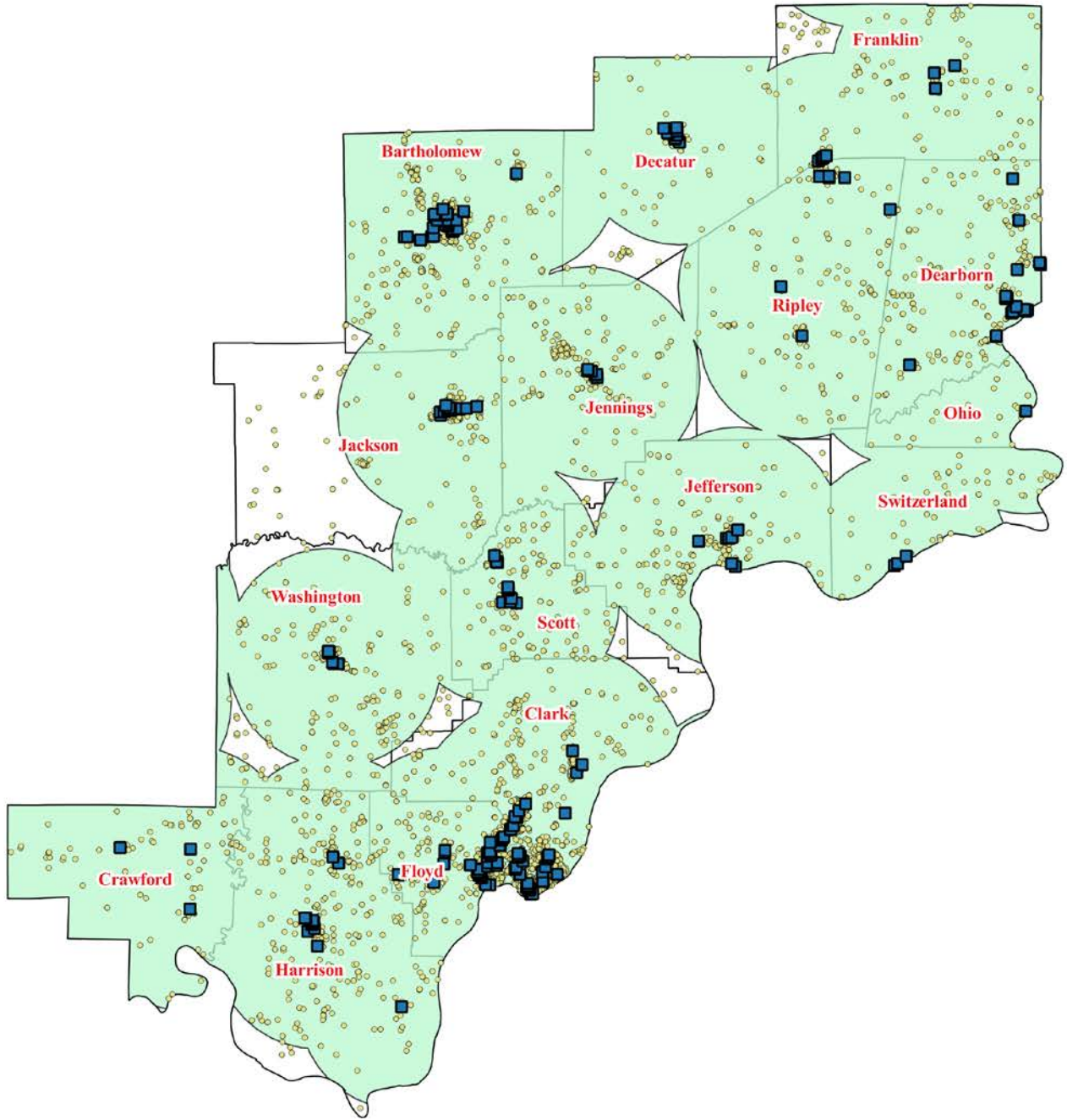


- | | |
|--|---|
| ■ Providers shown served CHIP members during Oct 2016 - Sept 2017 period | ■ Area shown where members live within 10 miles of a provider |
| ● Members shown were enrolled in CHIP as of June 2017 | □ Area shown where members live outside of 10 miles of a provider |

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

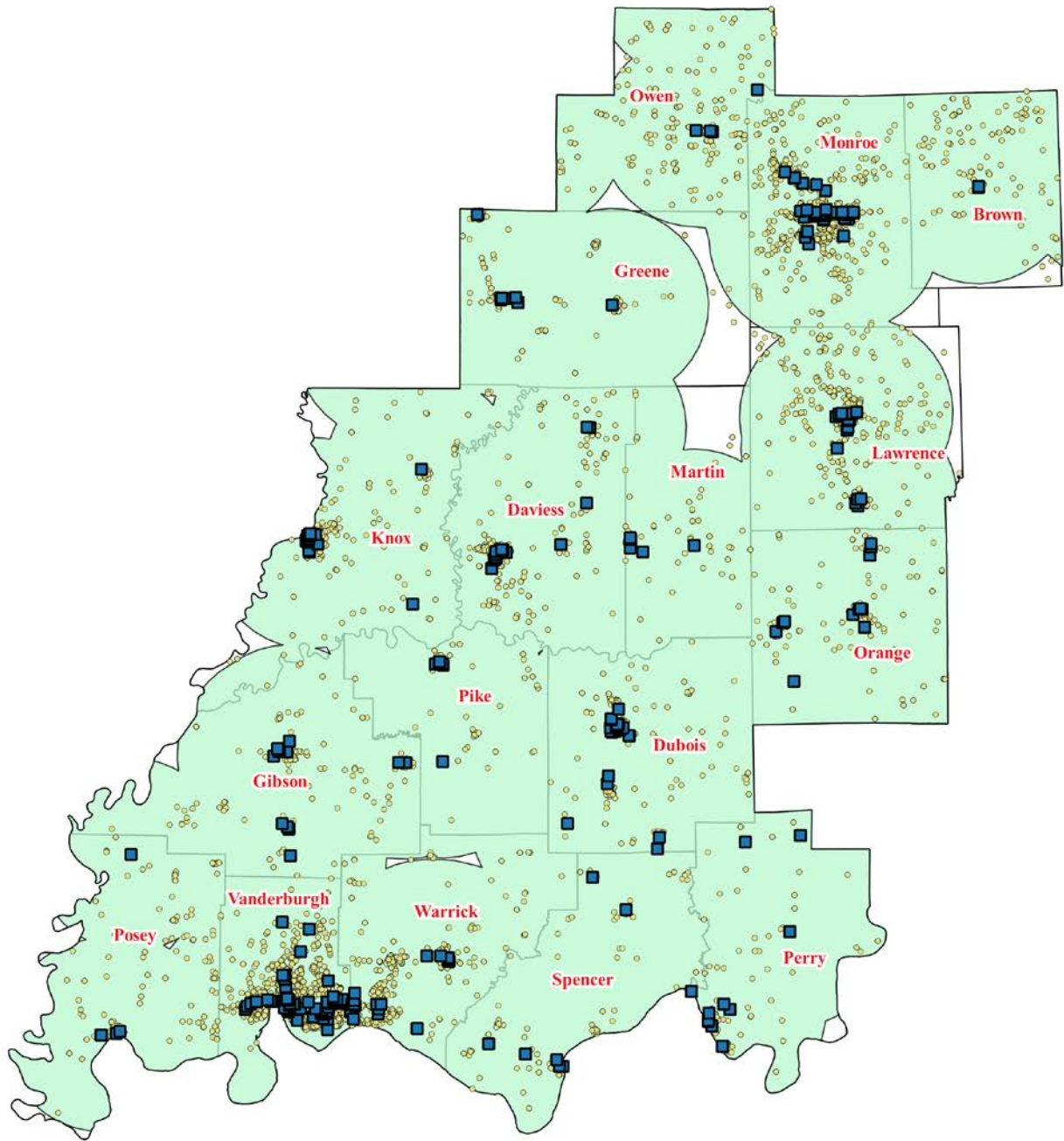


Map A.7
Measuring Accessibility to Primary Care Providers
Southeast Region



■ Providers shown served CHIP members during Oct 2016 - Sept 2017 period	■ Area shown where members live within 10 miles of a provider
● Members shown were enrolled in CHIP as of June 2017	□ Area shown where members live outside of 10 miles of a provider

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

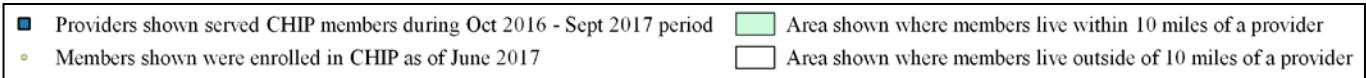
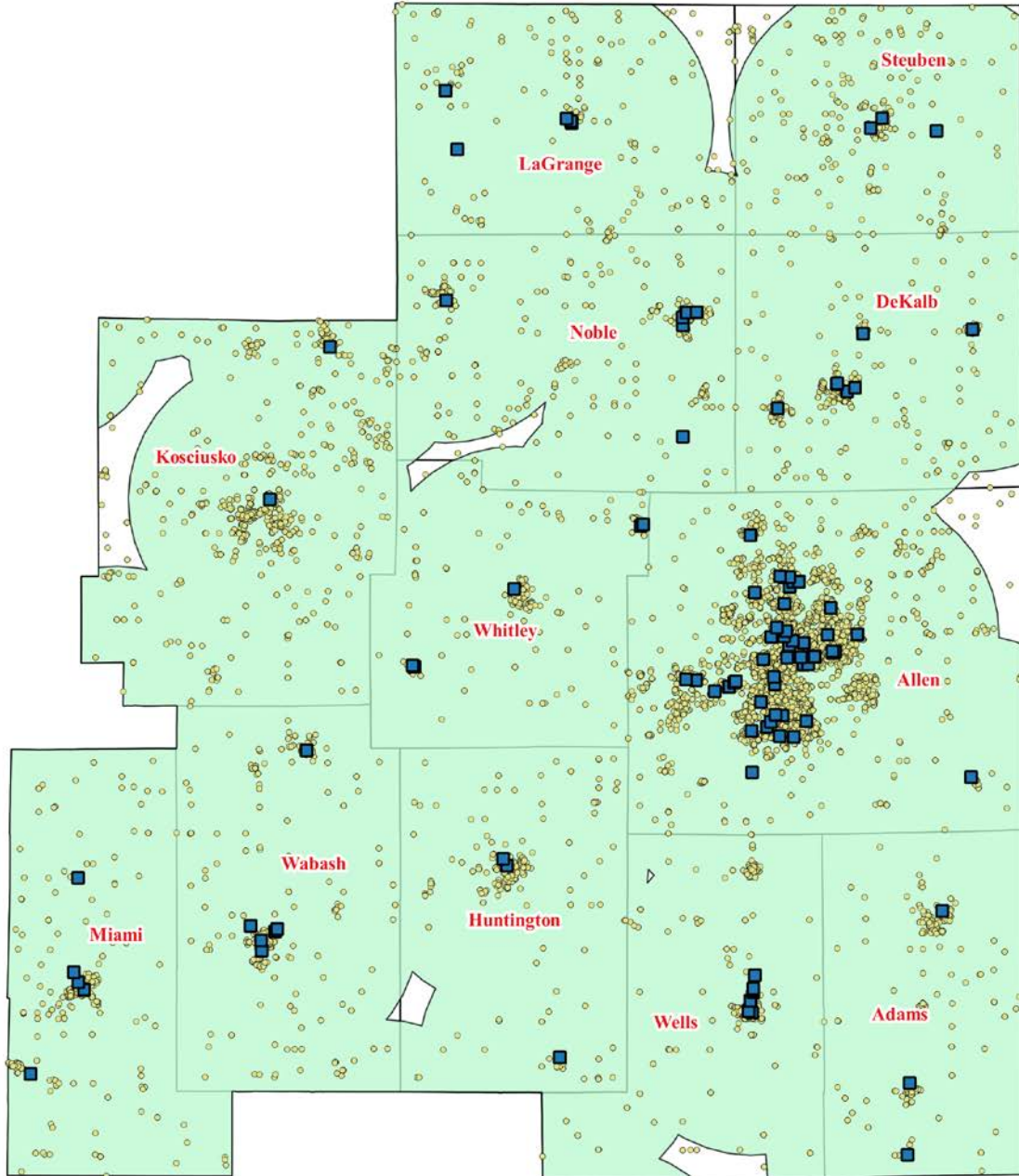


■ Providers shown served CHIP members during Oct 2016 - Sept 2017 period	■ Area shown where members live within 10 miles of a provider
● Members shown were enrolled in CHIP as of June 2017	□ Area shown where members live outside of 10 miles of a provider

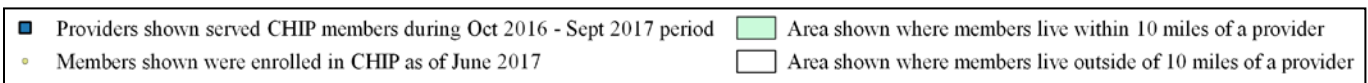
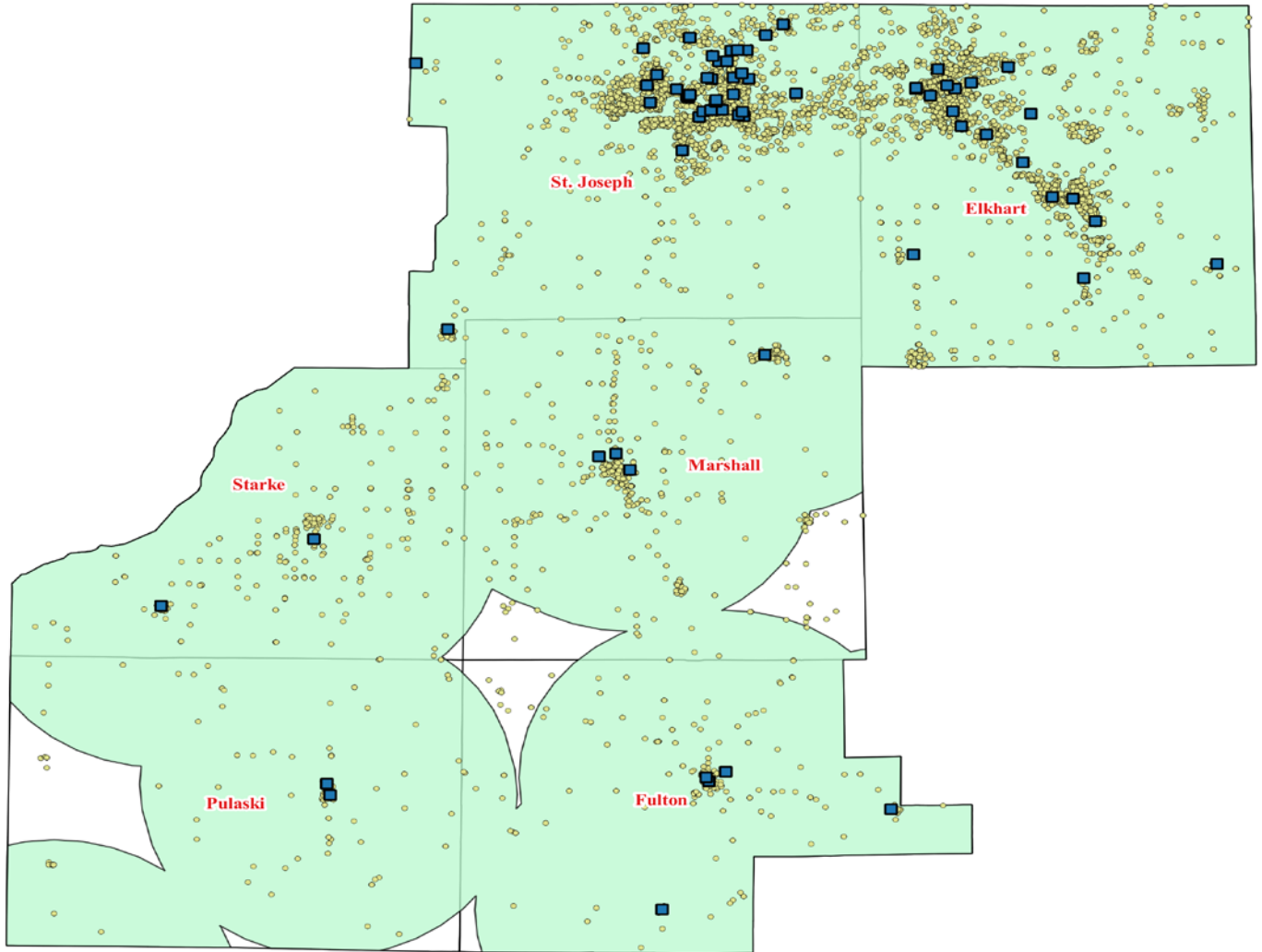
APPENDIX B

Maps Showing Access to Dental Care Providers in CHIP, by Region

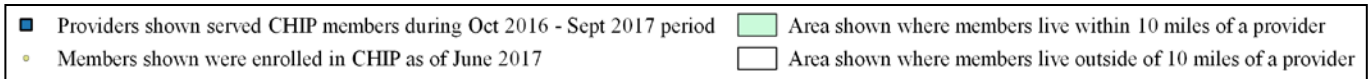
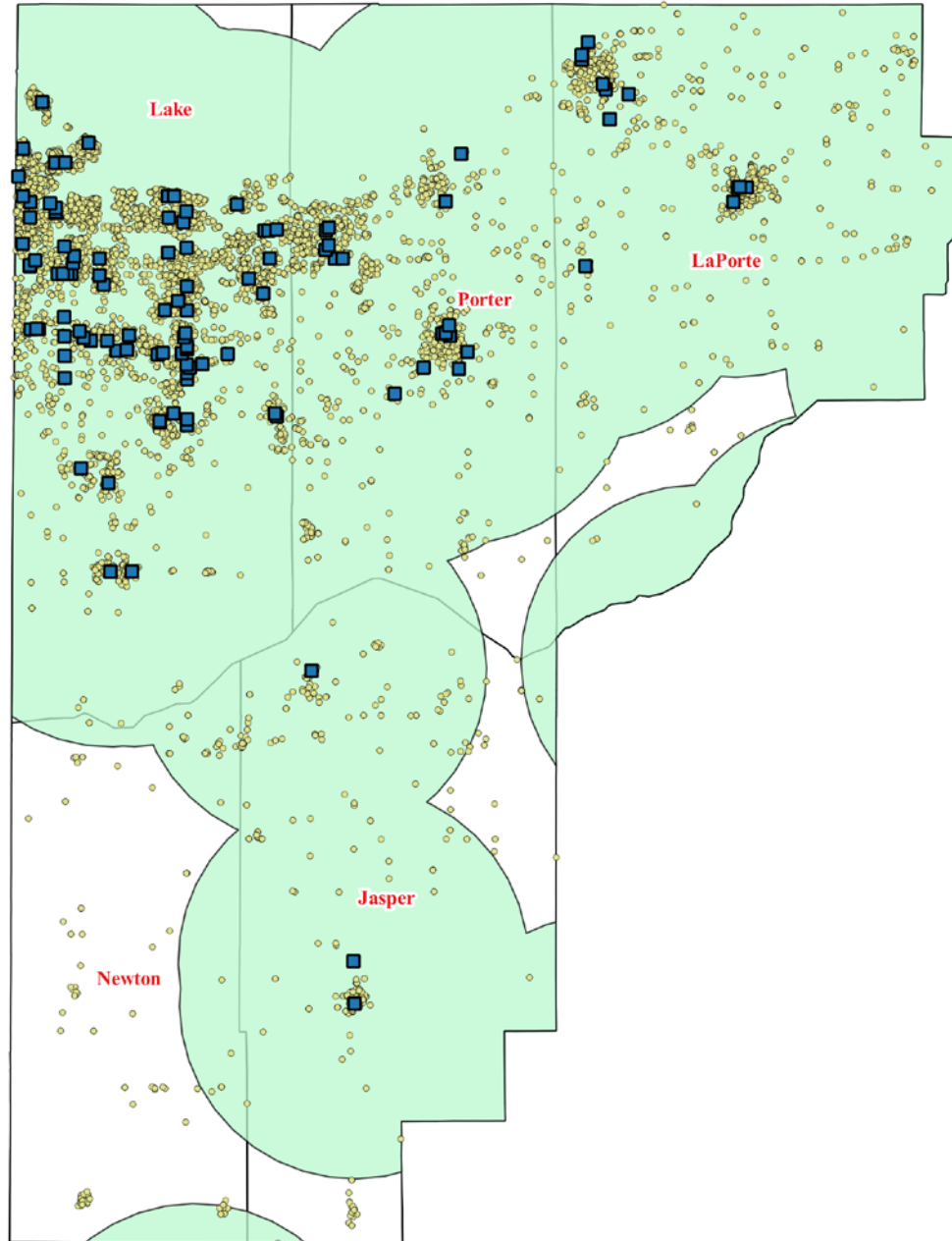
Map B.1
Measuring Accessibility to Dental Care Providers
Northeast Region



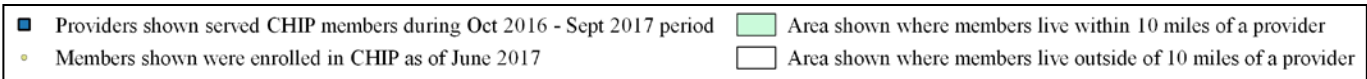
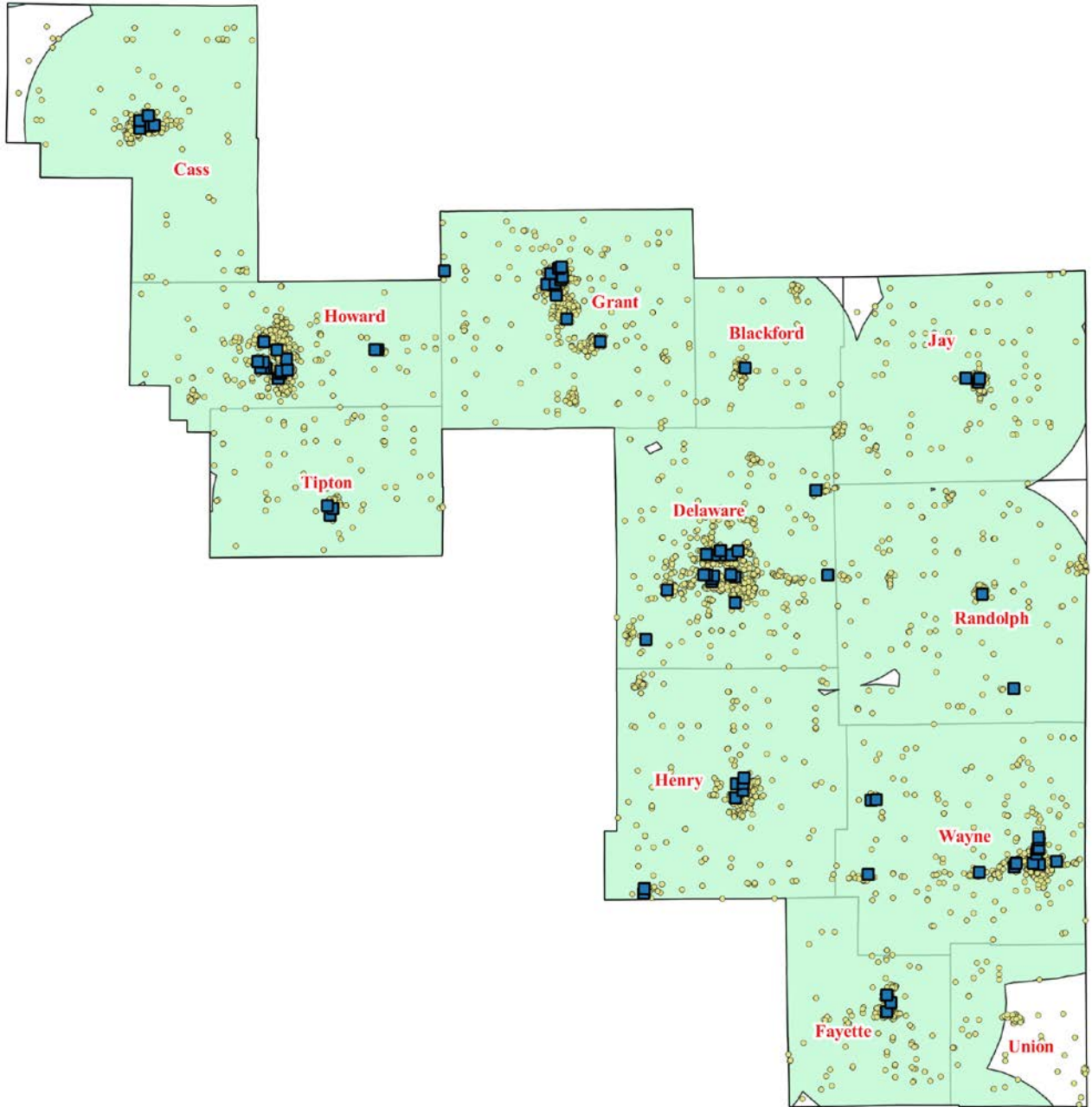
Map B.2
Measuring Accessibility to Dental Care Providers
North Central Region



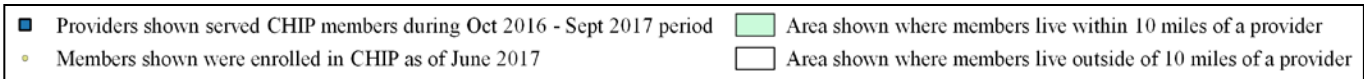
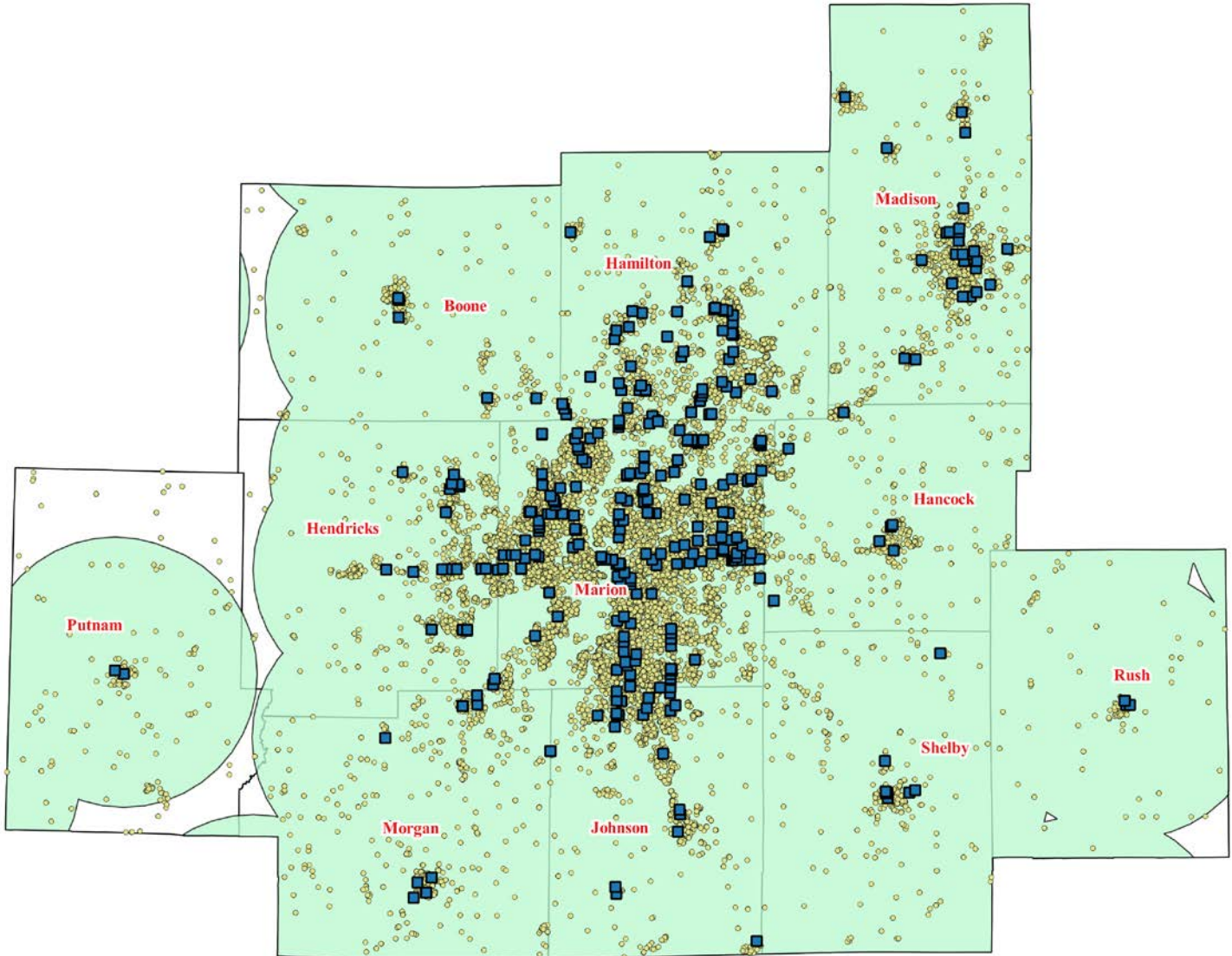
Map B.3
Measuring Accessibility to Dental Care Providers
Northwest Region



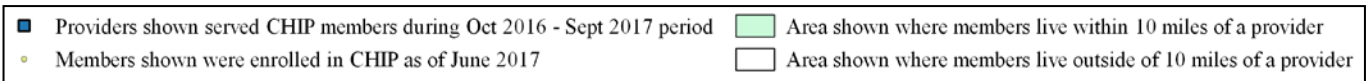
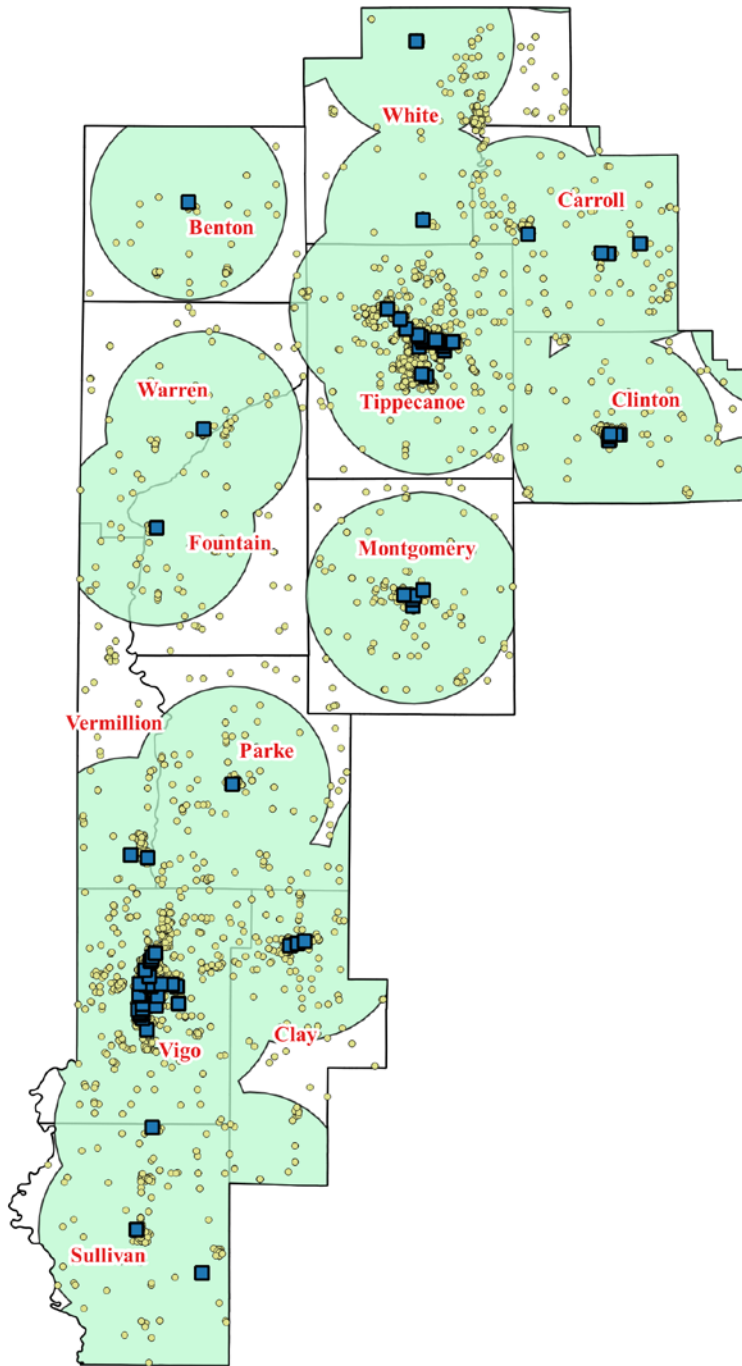
Map B.4
Measuring Accessibility to Dental Care Providers
East Central Region



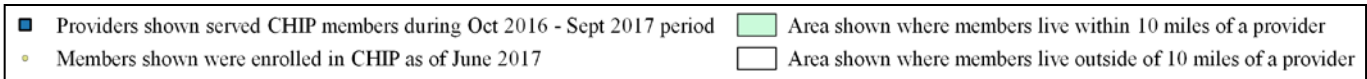
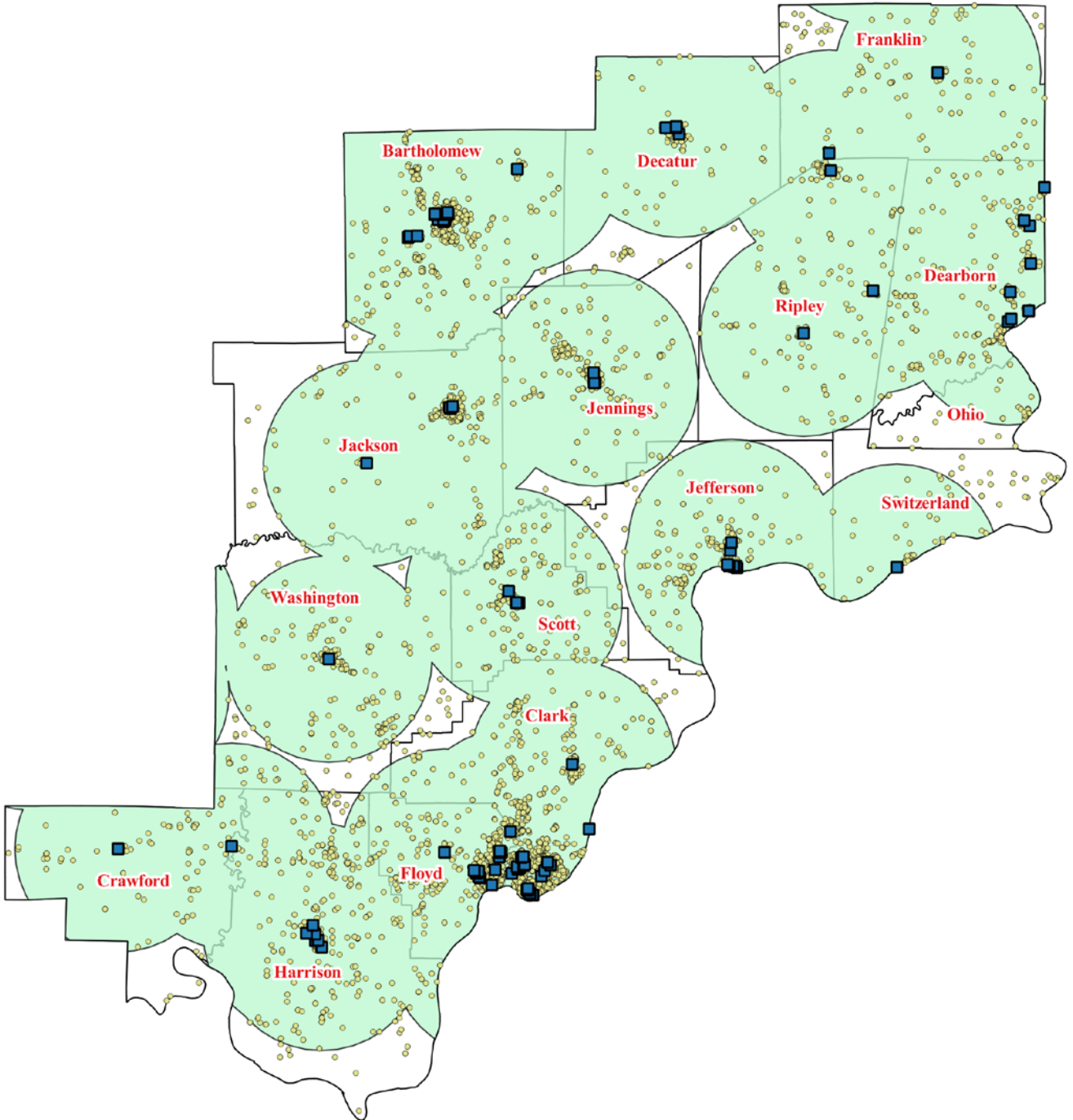
Map B.5
Measuring Accessibility to Dental Care Providers
Central Region



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



Map B.7
Measuring Accessibility to Dental Care Providers
Southeast Region



Map B.8
Measuring Accessibility to Dental Care Providers
Southwest Region

