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

Final Report – April 2010

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Executive Summary

Since the program was introduced in 1997, Indiana's Children's Health Insurance Program (CHIP) has been very successful in its outreach to cover children in low-income families that are not eligible for Medicaid. This success continued in Calendar Year (CY) 2009 since enrollment in the CHIP reached an all-time high of 79,307, a 6.8 percent increase over the prior year.

Eligibility in the CHIP varies to some degree by the child's age, but it covers children in families with incomes that range from 100 percent to 250 percent of the federal poverty level, or FPL (which is $22,050 to $55,125 for a family of four in 2009). The largest enrollment growth in CY 2009 occurred among families with incomes between 150 percent and 250 percent of the FPL (a 26.1 percent increase from the end of 2008).

Continued enrollment growth in Indiana's CHIP has made Indiana's program more successful than many other states' programs in lowering the uninsured rate among children in low-income families. Indiana's uninsured rate among children in families below 200 percent of the FPL is now the lowest it has been in the last decade (8.6%) and a rate that is half of the national average for this population (17.3%)[1].

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

> *Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the:*
> *(1) Budget committee;*
> *(2) Legislative council;*
> *(3) Children's health policy board established by IC 4-23-27-2; and*
> *(4) Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2009. 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

Indiana opted to implement a "combination" CHIP program similar to 20 other states. The combination design is evident in the two components to Indiana's program:

- CHIP Package A (the Medicaid expansion portion and, as such, an entitlement program) covers children in families with incomes up to 150 percent of the FPL who are uninsured and not already eligible for Medicaid.

- CHIP Package C (the non-entitlement program) covers children in families with incomes above 150 percent up to 250 percent of the FPL who do not have other health insurance.

Children at the higher income level (200%-250% FPL) began enrolling in October 2008. Prior to this, CHIP Package C covered children up to 200 percent FPL only.

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

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

Premiums Charged to Families in Indiana's CHIP Package C

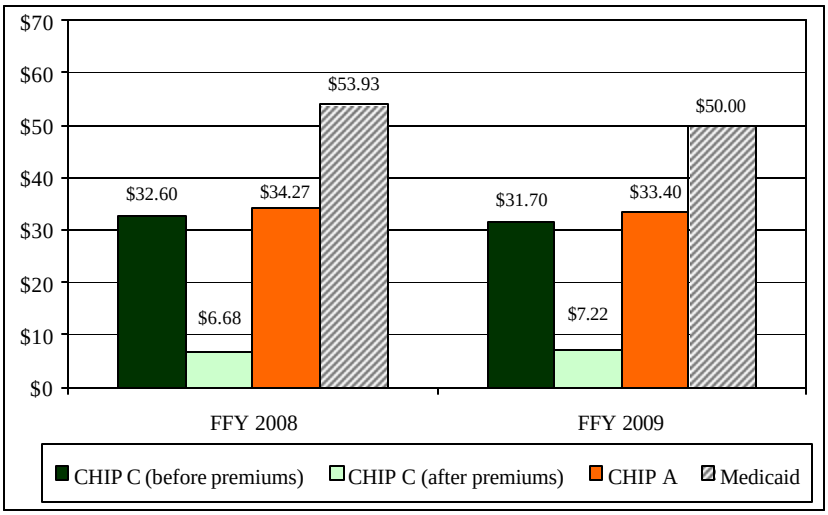
Family FPL	Monthly Premium for 1 Child	Monthly Premium for 2 or More Children
150% up to 175%	$22	$33
175% up to 200%	$33	$50
200% up to 225%	$42	$53
225% up to 250%	$53	$70

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states, subject to an annual cap. In the CHIP, however, the federal match rate is higher than Medicaid. For example, in Federal Fiscal Year (FFY) 2009, for every dollar spent on medical services in Indiana's CHIP, the federal government paid 74.98 cents and the state paid 25.02 cents; for the Medicaid program, the federal government paid 64.26 cents and the state paid 35.74 cents.[2]

Trends in the Cost Per Member Per Month (PMPM)
State Share Only

Because of the higher federal match rate and the premiums paid by CHIP Package C families, the state share paid towards CHIP Package C members was only $7.22 when measured on a per member per month (PMPM) basis in FFY 2009. For CHIP Package A where no premiums are charged, the amount was $31.70 PMPM. Both PMPMs are lower than the amount paid for children in Medicaid.



Figures based on B&A's independent analysis of expenditure data from the OMPP data warehouse retrieved in January 2010. Calculations are based on dates of service and not dates of payment and do not include a completion factor.

Member Satisfaction

As part of this evaluation, B&A mailed surveys to 5,726 member families who had children enrolled in CHIP Package C in the first nine months of 2009. The response rate from the survey was 31 percent (n=1,755). Among the feedback provided by parents, 31 percent stated that their children had not been covered by health insurance prior to enrolling while 48 percent stated that they had been covered by Medicaid at some point previously. Further, 83 percent of parents stated that CHIP

[2] Match rates for Medicaid do not include the one-time, short-term upward adjustment allocated in the American Recovery and Reinvestment Act of 2009.

Package C was the only option for them to get health insurance for their children. This feedback supports the impact that CHIP Package C has had in keeping the uninsured rate low among this population.

Parents indicated that they value the affordability of CHIP Package C. Only 15 percent of respondents indicated that they were very concerned about the cost of the premium that they had to pay. Parents also provided positive feedback about the availability of services and of primary care doctors for their children. When asked about a variety of services needed for their children, between 95 and 99 percent of respondents stated that their child was able to receive the service needed. More than 80 percent of parents also reported that they were satisfied with physician availability at each of the three MCOs, with over 60 percent of parents citing that they were "very satisfied" with the selection of doctors.

Access to Services

B&A examined access to primary medical providers (PMPs) and preventive dental providers for both CHIP Package A and CHIP Package C members by analyzing data from claims submitted by providers. At the county level, the OMPP measures the number of members assigned to PMPs against the number that the PMPs are willing to accept (also called the PMP's panel size). B&A examined utilization in counties where the panel use was above 80 percent (indicative that access could be an issue). It was found, however, that in the 19 counties where PMP panels were more than 80 percent full, CHIP children in all but three of these counties had primary care usage rates above the statewide average. This implies that access to PMPs is not an issue.

Dentists do not contract for a specific panel in CHIP/Medicaid. For dental services, B&A reviewed where dental services were obtained by CHIP members in relation to where they live. Of all CHIP members that had a preventive dental visit in FFY 2009, 94 percent of children obtained their visit either in their home county of residence or in a contiguous county. There were only five counties found that had a lower percentage of children receiving dental care than the statewide average and also a higher rate of members visiting dentists outside of the county where they live.

Service Utilization

B&A measured the percentage of CHIP children that used each of the services available to them for the periods FFY 2008 and FFY 2009. Comparisons were made not only from one year to the next but also across various demographic cohorts, such as by age, by race/ethnicity, by MCO and by region. Between FFY 2008 and FFY 2009, the use of services remained steady overall.

Percentage of CHIP Children using each service

	in 2008	in 2009
Primary care doctor's office visit	73%	73%
Emergency room visit	26%	28%
Specialist doctor's visit	9%	9%
Prescription filled	70%	73%
Dental visit	65%	67%

Some differences were found within specific populations. For example, only 62 percent of African-American children had a primary care office visit as compared to 67 percent of Hispanic children, 77 percent of Caucasian children, and 70 percent of children of other race/ethnicities. There is no difference in ER use among race/ethnicities, however, but there is some variation at the region level (regions are defined on page II-4 of the report). Dental visits increased among all age groups and all race/ethnicities between FFY 2008 and FFY 2009. The percentage of children that obtained a prescription also increased for all demographic cohorts across the two years. The most common types of prescriptions obtained for all age groups were for treating infections and for treating asthma.

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 which states that

> *Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the:*
> *(1) Budget committee;*
> *(2) Legislative council;*
> *(3) Children's health policy board established by IC 4-23-27-2; and*
> *(4) Select joint commission on Medicaid oversight established by IC 2-5-26-3.*
>
> *The report must be in electronic format under IC 5-14-6.*

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2009. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

The State Children's Health Insurance Program (S-CHIP) was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. In this legislation, states were allocated funds on an annual basis for a 10-year period to expand health coverage to low-income children. The original legislation was extended to March 31, 2009. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009[1] extended the program to September 2013. The Congressional Budget Office estimates that the expansion of federal funds will provide coverage to 4.1 million additional children in state Medicaid and CHIP programs who would have otherwise been uninsured by 2013.

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

When the original S-CHIP legislation was introduced, states had the option to expand their existing Medicaid program, develop a state-specific program (that would not be an entitlement program), or both. Indiana opted to implement the "combination" program similar to 20 other states. As such, there are two components to Indiana's program—CHIP Package A (the Medicaid expansion portion) and CHIP Package C (the non-entitlement program).

CHIP Package A covers children in families with incomes up to 150 percent of the Federal Poverty Level, or FPL ($33,075 per year for a family of four in 2009) who are not already eligible for Medicaid. CHIP Package C covers children in families with incomes above 150 percent up to 250 percent of the FPL ($55,125 per year for a family of four in 2009) who are not already insured. In its original design, CHIP Package C covered children in families up to 200 percent of the FPL. Children at the higher income level (200%-250% FPL) began enrolling in October 2008.

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

As of the end of CY 2009, enrollment in Indiana's CHIP was at an all-time high of 79,307[2], a 6.8 percent increase over the prior year:

- CHIP Package A enrollment was 56,524 (0.6% increase from December 2008)
- CHIP Package C enrollment was 22,783 (26.1% increase from December 2008)

Slightly more than half of the increase in 2009 in CHIP Package C is represented by enrollment in the new expansion group while the remainder is represented by an increase in the original target group (150%-200% FPL).

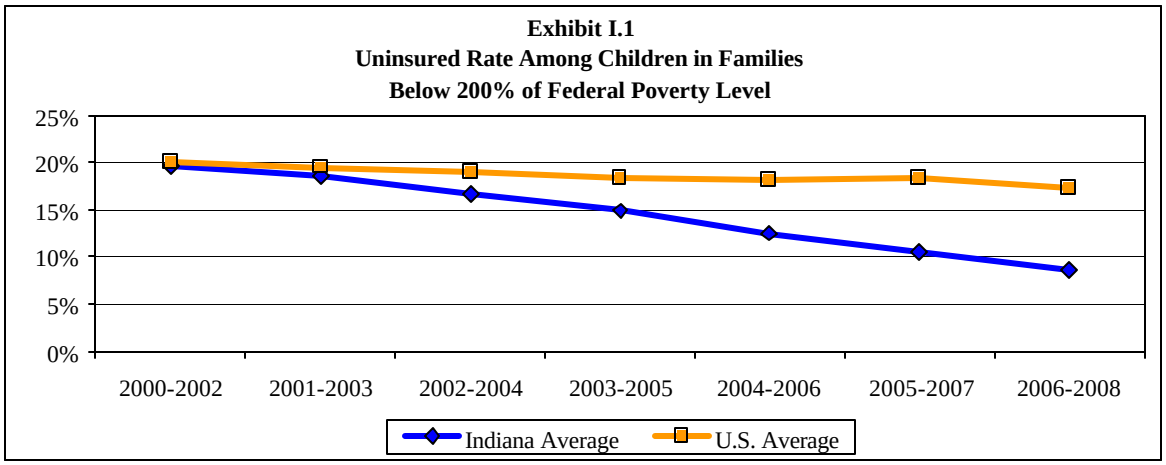
More enrollment statistics appear in Chapter II of this report.

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

The Census Bureau's Current Population Study (CPS) surveys citizens each March on their health insurance status. An uninsured rate is computed for each state, but because state-specific samples are usually small, it is customary to measure this rate over a three year average. The CPS survey conducted in March 2009 measured insurance status in CY 2008. Therefore, the 2006-2008 timeframe is the most recent three-year average period available.

Indiana has been more effective than the nation as a whole in reducing the uninsured rate among low-income children. Among children in families with incomes below 200 percent of the FPL, Indiana's most recent uninsured rate is 8.6 percent compared to the national average of 17.3 percent. Indiana's uninsured rate has declined in each of the last seven study periods. This success can partially be attributed to Indiana's effective outreach to enroll children in its CHIP.

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



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

In absolute numbers, the number of uninsured children in families with incomes below 200 percent of the FPL has been cut in half in the last seven years—from an estimated high of 109,000 in the 2000-2002 three year average period to 54,000 in the 2006-2008 three year average period (Source: Current Population Survey).

[2] Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on February 12, 2010.

The Kaiser Family Foundation (Kaiser), a non-profit health policy research foundation, also utilizes the Census Bureau's CPS data to measure the uninsured rate across states. Kaiser researchers use a two-year average instead of a three-year average to make state comparisons. In its most recent analysis, Indiana's uninsured rate among children in families below 200 percent of the FPL was 9.5 percent (2007-2008 average), which places Indiana as the 6th lowest uninsured rate in the country. The national average computed by Kaiser for this period is 17.6 percent. For children across all income levels, Indiana's uninsured rate of 5.9 percent ranks it tied with Alabama for 9th lowest in the county.[3]

The uninsured rate varies by family income level and by race/ethnicity in the state. Using the three-year 2006-2008 averages from the Current Population Survey, almost two-thirds of all uninsured children in Indiana may already be eligible for CHIP based on family income.[4]

Exhibit I.2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana
2006 - 2008 Three-Year Average

	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Total for Children that may be Eligible for Indiana's CHIP			
Income up to 250% FPL	70,488	64%	8.5%
Total for Children Not Eligible for Indiana's CHIP			
250% and above	38,991	36%	4.6%
All Children	**109,479**	**100%**	**6.5%**

The uninsured rate for Caucasian (5.8%) and African American (6.2%) children is similar in Indiana, but Hispanic children (15.6%) have an uninsured rate that is more than 2.5 times that of the statewide average (6.5%).

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

Family Federal Poverty Level	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Caucasian Non-Hispanic	74,921	68%	5.8%
African Amer. Non-Hispanic	12,157	11%	6.2%
Hispanic (any race)	21,684	20%	15.6%
All Other Races	717	1%	1.6%
All Children	**109,479**	**100%**	**6.5%**

Source for both exhibits: U.S. Census Bureau, Current Population Survey
http://www.census.gov/hhes/www/hlthins/hlthins.html

[3] Health Insurance Coverage in America, 2008. (October 2009) Online chartbook produced by the Henry J. Kaiser Family Foundation. http://www.kff.org/uninsured/7995.cfm

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

Indiana's CHIP is Integrated with Other Medicaid Programs

Children in Indiana's CHIP are enrolled in the OMPP's Hoosier Healthwise program like most other children in the Medicaid program. Hoosier Healthwise is the state's Medicaid managed care program for children, pregnant women and low-income families. CHIP enrollees, like all children in Hoosier Healthwise, select a primary medical provider (PMP) or they are assigned one if their family does not select one. CHIP members must enroll with one of three managed care organizations (MCOs) that contract with the state—Anthem, Managed Health Services or MDwise. CHIP enrollees have access to all of the providers available to Hoosier Healthwise members that are enrolled with the MCO they select.

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

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

B&A tracked utilization in each month of CY 2008 for CHIP Package C members (who are required to make the co-pay) and all other children in CHIP Package A or Medicaid (who are not required to make the co-pay). There was no difference in the utilization (measured on a per 1,000 member basis) between the two populations for generic or brand name drugs. Because ambulance services are less utilized, the comparison was made on a per 10,000 member basis. The difference in utilization is relatively minor for the two populations (18/10,000 members for CHIP C and 8/10,000 members for CHIP A/Medicaid).

Exhibit I.4
Benefits Offered to Indiana's CHIP Enrollees in the Hoosier Healthwise Program

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

Exhibit I.5
Monthly Premiums Charged to Families in Indiana's CHIP Package C

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

The other design difference between CHIP and traditional Medicaid is that families of children enrolled in CHIP Package C are required to pay a monthly premium. The premium varies by the income level and the number of children covered in the family.

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

- Face-to-face interview not required at the time of application (49 states) or at renewal (48 states)
- Asset test not required in determining eligibility (46 states)
- Renewal occurs every 12 months (45 states)
- Joint application for CHIP and Medicaid (true for 89% of the states that have a non-entitlement program)
- Co-pays charged for prescriptions (24 states)
- Premiums are charged to members (34 states), but this varies by state and by income
    - Up to the 150% FPL level, Indiana charges $0 (like 9 out of 34 states)
    - At the 150-200% FPL level, Indiana charges premiums on a sliding scale (like 23 out of 34 states)
    - At the 200%-250% FPL level, Indiana charges higher premiums than the lower FPL group (like 32 out of 34 states)

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

- Indiana does not impose co-pays for non-emergent ER visits (15 states do)
- The required period of no insurance prior to enrolling (also known as the "going bare" period) is 3 months in Indiana (16 states impose a going bare period of 1-3 months but 21 states impose a period greater than 3 months)
- Enrollment is continuous for 12 months, regardless of circumstance in 16 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

Expenditures in Indiana's CHIP

A key difference between the CHIP and Medicaid programs is the way in which each is financed. Both the CHIP and Medicaid programs are jointly funded by states and the federal government. In the CHIP, however, the matching rate provided by the federal government for medical services is higher than it is in the Medicaid program (administrative costs are reimbursed at the same rate). For example, in Federal Fiscal Year (FFY) 2009, for every dollar spent on medical services in Indiana's CHIP, the federal government paid 74.98 cents and the state paid 25.02 cents; for the Medicaid program, the federal government paid 64.26 cents and the state paid 35.74 cents.[6]

Most of the service expenditures in Indiana's CHIP are paid to MCOs through what is known as a capitation payment. This is a set amount paid to the MCOs per member per month (PMPM). The capitation PMPM rate is adjusted for age. Therefore, although the amount paid to the MCOs may be the same for a child enrolled in CHIP as it is for a child in Medicaid, the state's outlay is less for the

[5] Cohen Ross, D., Jarlenski, M, Artiga, S., Marks, C. (December 2009) A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009. Washington, DC: The Center on Budget and Policy Priorities and The Henry J. Kaiser Family Foundation.

[6] Match rates for Medicaid do not include the one-time, short-term upward adjustment allocated in the American Recovery and Reinvestment Act of 2009.

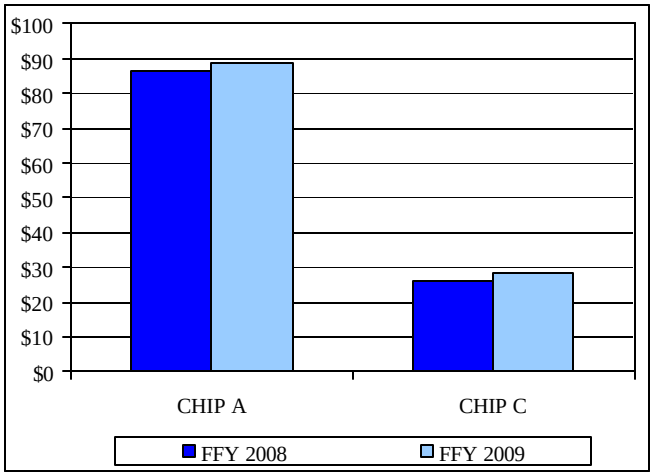
child enrolled in CHIP due to the higher federal match rate and, for CHIP Package C, the outlay is further reduced by premiums paid by parents.

There are also some services covered in the program but paid on a fee-for-service basis outside of the MCO contract. These include dental services and a few other services offered to CHIP members for which the MCOs are not responsible for delivering and not reflected in the capitation payment. Other services may be paid fee-for-service in the CHIP if an enrollee utilizes a service during the short time period before they have selected which MCO to join.

B&A examined expenditures made on behalf of CHIP members in FFYs 2008 and 2009.[7] Data was pulled independently by B&A from MedInsight, the OMPP's data warehouse on January 12, 2010. The calculations shown in the following exhibits represent payments based on the dates that services were rendered and not when they were paid. As such, data at the end of FFY 2009 may be slightly incomplete. B&A did not calculate a completion factor for this time period.

Expenditures in CHIP Package A increased 3.2 percent over the two-year period, from $86.3 million in FFY 2008 to $89.0 million in FFY 2009. Two thirds of the expenditures were made as capitation payments, 16 percent were made as payments for dental services, and the remaining 17 percent were made as fee-for-service payments for non-dental services. Payments in CHIP Package C increased 9.3 percent, from $26.1 million in FFY 2008 to $28.6 million in FFY 2009. The distribution of payments between capitation, dental and other claims was similar to what was found for CHIP Package A.

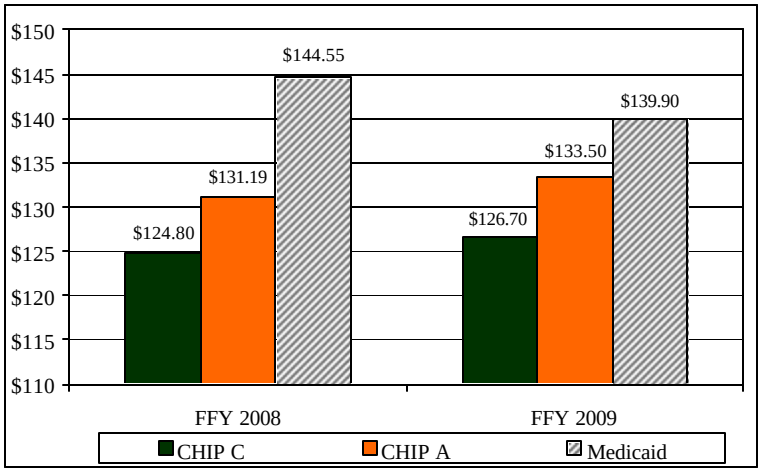
Exhibit I.6
Total Expenditures in CHIP (in millions)



Data from the OMPP data warehouse and tabulated by Burns & Associates.

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

Exhibit I.7
Trends in the Cost Per Member Per Month (PMPM)
Total Expenditures

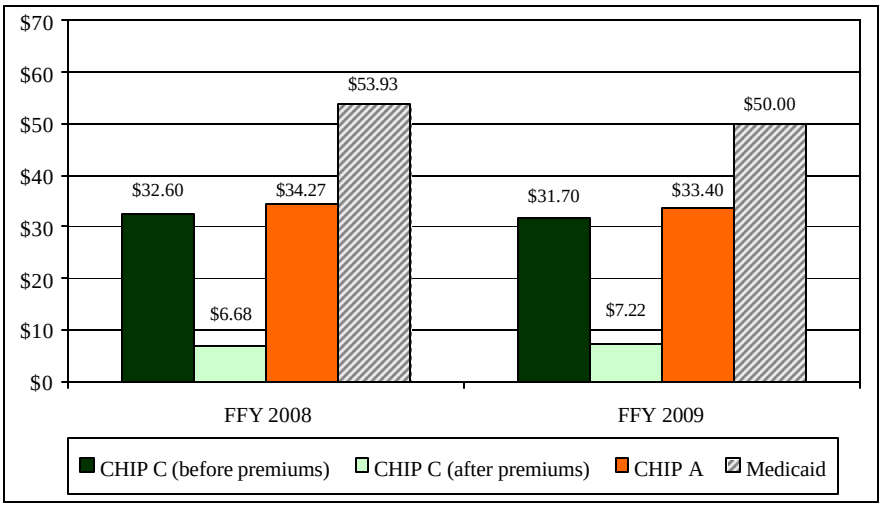


Data from the OMPP data warehouse and tabulated by Burns & Associates.

Because the CHIP had growth in enrollment from FFY 2008 to FFY 2009, it is appropriate to measure expenditures on a PMPM basis to account for this enrollment increase. Exhibit I.7 shows the total PMPM outlays. The CHIP Package A PMPM increased from $131.19 to $133.50 (1.8%). The CHIP Package C PMPM increased from $124.80 to $126.70 (1.5%). As has been the case since the introduction of the CHIP program, CHIP members cost five to ten percent less on a PMPM basis than Medicaid children.[8]

In addition to the enhanced federal match rate, families in CHIP Package C pay premiums which further reduce the state's outlay. In FFY 2009, premiums that were paid exceeded $22 million. The net result of this is that the total state outlay for CHIP Package C was only $6.68 on a PMPM basis in FFY 2008 and $7.22 in FFY 2009. The state share for CHIP Package A actually decreased over the two FFYs, in part because the federal match rate increased from 73.88 cents in FFY 2008 to 74.98 cents of every dollar spent in FFY 2009.

Exhibit I.8
Trends in the Cost Per Member Per Month (PMPM)
State Share Only



Data from the OMPP data warehouse and tabulated by Burns & Associates.

[8] Because there are so few children in CHIP under age one, the infants in the Medicaid program have been removed in this analysis to reflect a more accurate comparison between the CHIP and Medicaid populations.

II

Enrollment Trends in Indiana's CHIP

Enrollment Trends at a Glance

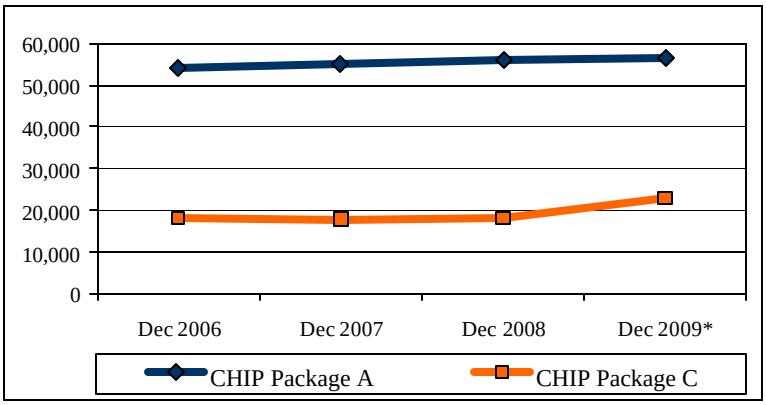
CHIP Enrollment Dec 2008: 74,207
CHIP Enrollment Dec 2009: 79,307
0.6% year-to-year growth rate in CHIP Package A
26.1% year-to-year growth rate in CHIP Package C

87,379 children enrolled in Indiana's CHIP at some point in State Fiscal Year 2009

Disenrollment has decreased from 20% in 2008 to 15% in 2009

Indiana's Children's Health Insurance Program (CHIP) experienced its all-time high enrollment at the end of Calendar Year (CY) 2009 of 79,307, a 6.8 percent increase over the prior year. Enrollment was at its peak at the end of CY 2009 for both portions of the CHIP. Over the last five years, enrollment has grown 16.6 percent. In CHIP Package A, the entitlement portion of the program for children in families with incomes up to 150% of the federal poverty level (FPL), enrollment has grown 12.5 percent since December 2004. In CHIP Package C, the non-entitlement program for children in families with incomes 150%-250% of the FPL, enrollment has grown 28.2 percent during this five-year period. When enrollment is compared between year-end 2008 to year-end 2009, however, the most recent growth in CHIP stems from CHIP Package C. Enrollment growth in CHIP Package A was essentially flat (0.6% increase) in CY 2009 whereas enrollment growth in CHIP Package C was 26.1 percent.

Exhibit II.1
Recent Enrollment in Indiana's CHIP



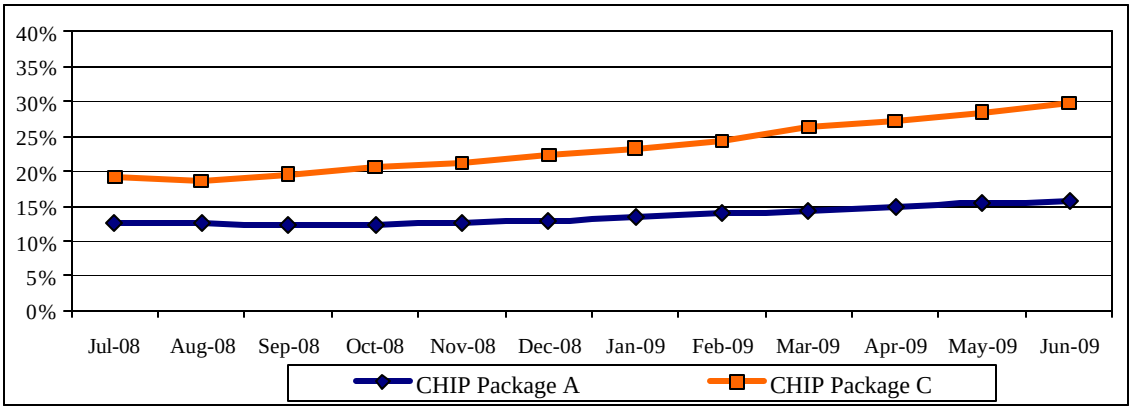
*Estimate based on final eligibility determinations

Enrollment and Disenrollment Trends

The increases in the net enrollment figures for both CHIP Package A and CHIP Package C are the result of an increasing rate among new enrollees accompanied by a decreasing disenrollment rate.

CHIP members enrolled during State Fiscal Year (SFY) 2009[1] were examined to measure how many were new to CHIP within the last 12 months. Exhibit II.2 shows that members new to CHIP Package A in the previous 12 months represented 12.6 percent of all members in July 2008; in June 2009, this increased to 15.7 percent of all members. The increase was more dramatic in CHIP Package C. Members new within the previous 12 months represented 19.1 of all CHIP Package C members in July 2008 but 29.8 percent of all members in June 2009.

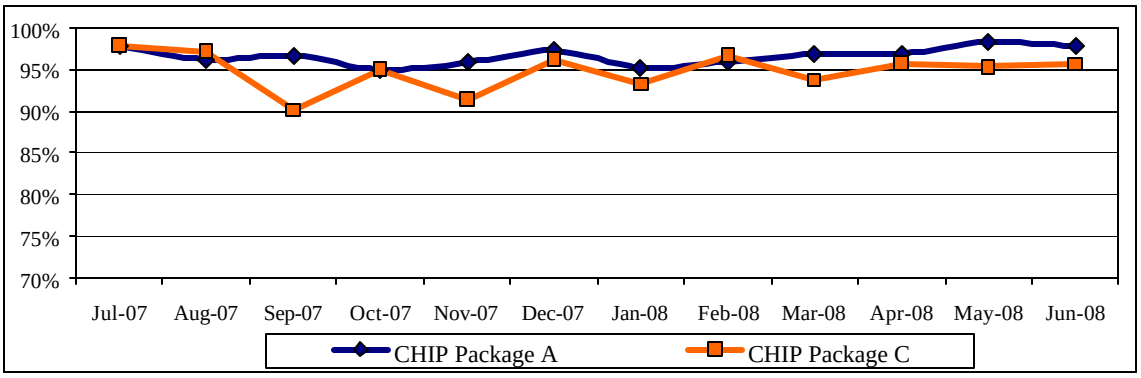
Exhibit II.2
Percent of New CHIP Enrollees Over Previous 12 Months



[1] July 1, 2008 – June 30, 2009

Retention within Hoosier Healthwise also remains high for CHIP members. New enrollees in CHIP were identified in SFY 2008. B&A reviewed the membership status for each child after 12 months of enrollment when members are required to be redetermined eligible for the program. Among this group of members, the average retention rate was 96.7 percent for CHIP Package A members and 94.8 percent for CHIP Package C members.[2]

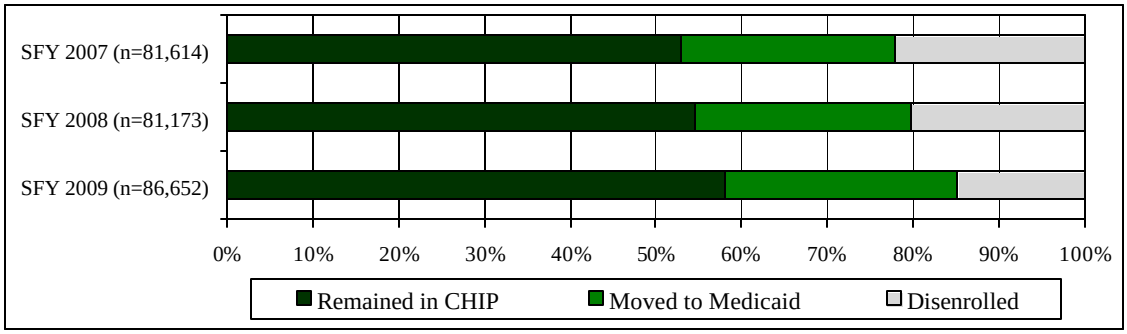
Exhibit II.3
Retention Rate in the CHIP at Time of Member's Recertification
Percentage Includes Members New in the Month Shown who Recertified After 12 Months



Excludes members who turned age 19 (no longer eligible) and those that disenrolled prior to the month when they would need to recertify.

There is also quite a bit of movement within the Hoosier Healthwise program between CHIP Package A, CHIP Package C and the traditional Medicaid program. Children that were enrolled at any time in CHIP in SFYs 2007 through 2009 were examined to determine their enrollment status at the end of the SFY. The disenrollment rate is decreasing, from 22.1 percent of all children ever enrolled in CHIP in SFY 2007 to 14.8 percent in SFY 2009. But the movement between the CHIP and Medicaid program remains high at about one in four members. This occurs when annual family income has decreased. Because of the premium requirements in CHIP Package C, children are placed in the program that maximizes their benefit package and also minimizes payment requirements for their parents for premiums or co-pays. Although this movement across programs occurs, since CHIP and Medicaid children are all part of the Hoosier Healthwise program, children do not need to change doctors or health plans when they change programs.

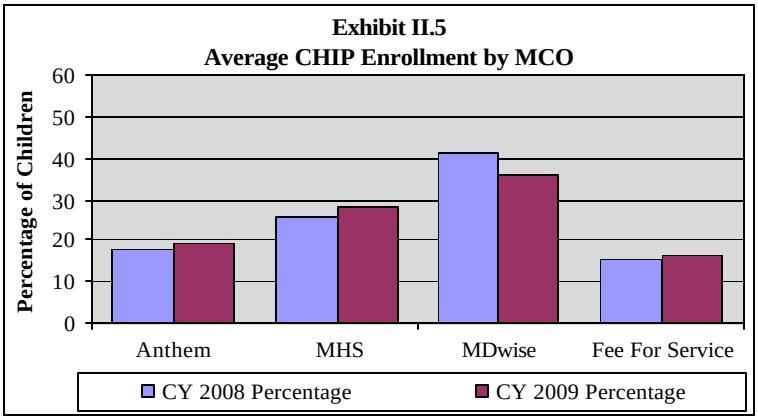
Exhibit II.4
Status of Children Ever Enrolled in CHIP, by State Fiscal Year



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

There was also some movement in the MCO selected by CHIP members. In CY 2009, Anthem had 19.1 percent of all CHIP enrollees as members compared to 17.6 percent in CY 2008. Managed Health Services also increased its CHIP membership, from 25.9 percent of all CHIP enrollees in CY 2008 to 28.6 percent in CY 2009. MDwise lost membership among CHIP members, from its total of 41.3 percent in CY 2008 to 36.3 percent in CY 2009.

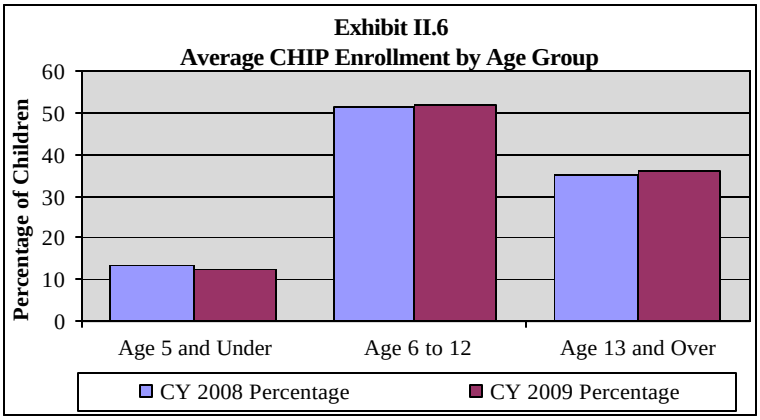
Exhibit II.5
Average CHIP Enrollment by MCO



Families have 30 days after their eligibility effective date to select a primary medical provider (PMP) and an MCO. Until the selection is made, the member is eligible for services in the Fee-For-Service (FFS) portion of the program. Because of the high rate of new enrollees each month in CHIP as shown in Exhibit II.2, in any given month there are about 15 percent of CHIP members temporarily enrolled in the FFS program.

Demographic Profile of CHIP Members

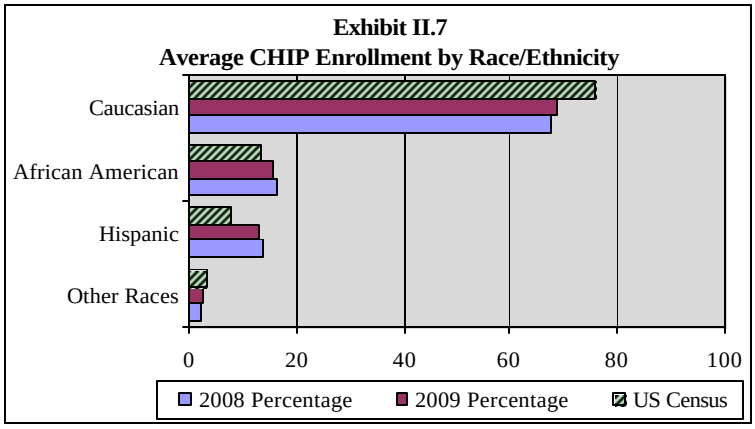
Exhibit II.6
Average CHIP Enrollment by Age Group



Half of the children enrolled in the CHIP are between the ages of six and 12. This is because children under age six are eligible for Medicaid at higher family income levels. Just over 35 percent of CHIP enrollees are teenagers, while the remaining 13 percent are under age five. This distribution has been the case since the CHIP was introduced.

There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for children age 18 and younger. Compared to the U.S. Census estimate as of July 2008[3] (most recent available), African-American children and Hispanic children are represented more in CHIP than in the statewide population. Between CY 2008 and CY 2009, there was actually a slight increase in the proportion of

Exhibit II.7
Average CHIP Enrollment by Race/Ethnicity

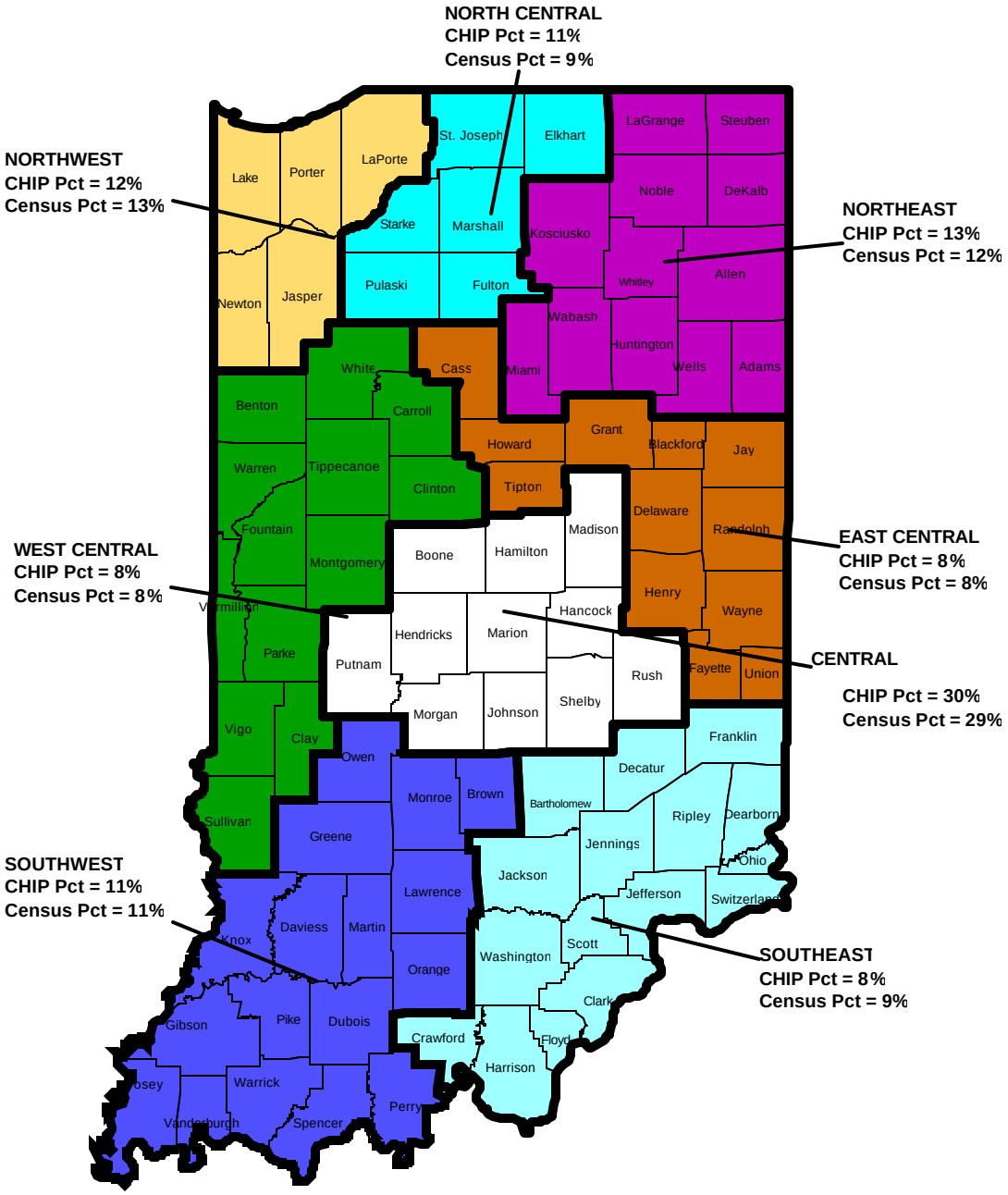


[3] County Population Estimates by Age, Sex, Race and Hispanic Origin: April 1, 2000 to July 1, 2008, Population Estimates Program, Population Division, U.S. Census Bureau

Caucasian CHIP members (from 67.8% of the total in CY 2008 to 68.6% in CY 2009). One reason may be that B&A found that the proportion of Hispanic children in the Medicaid portion of Hoosier Healthwise increased in CY 2009 (from 12.1% in CY 2008 to 12.9% in CY 2009).

The distribution of CHIP members by region closely matches the overall child population in Indiana. B&A compared CHIP members enrolled to the total child population in Indiana as of July 2008.

Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2008



III

Access to Services and Utilization Trends in Indiana's CHIP

Access Facts at a Glance

73% of CHIP members accessed primary care in 2009:

- 80 % visited a primary care doctor's office in their home county
- 16% visited a primary care doctor's office in a contiguous county

67% of CHIP members accessed preventive dental care in 2009:

- 76 % visited a dentist in their home county
- 18% visited a dentist in a contiguous county

Service Use Facts at a Glance

Percent of CHIP children using each service

	in 2008	in 2009
Primary care doctor's office visit	73%	73%
Emergency room visit	26%	28%
Specialist doctor's visit	9%	9%
Prescription filled	70%	73%
Dentist visit	65%	67%

Burns & Associates, Inc. (B&A) analyzed the availability of primary medical providers (PMPs) in Indiana's CHIP to determine if there are any areas of the state where provider access may be limiting utilization, particularly primary care. Utilization trends were also studied across key services offered in the CHIP such as specialist visits, preventive dental care, inpatient and outpatient hospital visits, emergency room (ER) visits, use of prescriptions, and screening tests. The use of these services was compared between Federal Fiscal Years (FFY) 2008 and FFY 2009[1] and across populations within the CHIP membership by age, by race/ethnicity, by MCO and by region.

Access to Primary Medical Providers

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

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.[2] When he/she contracts with an MCO, the PMP identifies whether or not they are willing to accept children as patients. The PMP also agrees to a specific number of slots in his/her practice for Medicaid/CHIP members (often called the PMP's *panel size*). The panel size that a PMP negotiates with an MCO does not differentiate between the number of children and the number of adults that the PMP will accept. (The obvious exception is Pediatricians.)

B&A examined the panel size availability among PMPs within a county. Because all Hoosier Healthwise members select a PMP, it is not possible to assess with precision the availability of PMPs for CHIP members specifically or for children specifically. As a proxy, B&A excluded OB/GYNs from our analysis of PMP panels since they would unlikely be PMPs to a CHIP member. With this exclusion and the fact that children comprised 81 percent of all Hoosier Healthwise members in Calendar Year 2008, B&A believes that our analysis is indicative of what the results would be for a CHIP-specific analysis.

Panel capacity is defined as the number of members enrolled with a PMP divided by the total panel size that the PMP is willing to accept. A physician who sees members from counties outside of the county where he/she practices count against his/her panel.

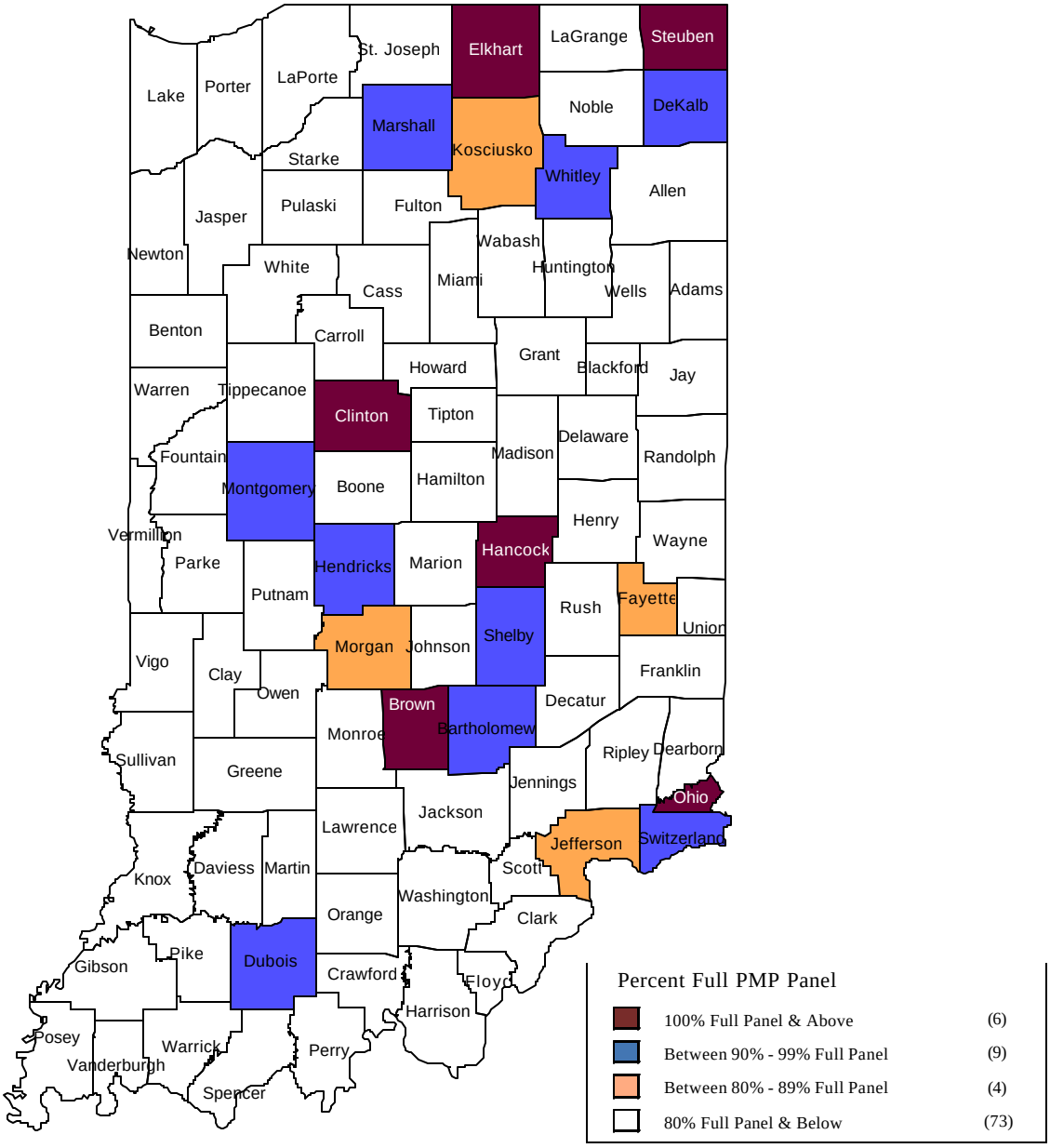
B&A calculated how full the PMP panels are for each county in the state. Data is collected by the OMPP's fiscal agent to track these figures. B&A analyzed data from December 2009.

B&A measured PMP access at four levels. Each county in the map on the next page is color-coded to identify its level of PMP access. Counties colored white (73 out of 92) are those where the PMP panel is less than 80 percent full. Counties colored orange (4) are those where the PMP panels are 80 to 89 percent full. Counties colored blue (9) are those where the PMP panels are 90 to 99 percent full. Six counties are technically more than 100 percent full (in brick red), which means that, when analyzed as a group, the PMPs in each of these counties have actually accepted more CHIP and Medicaid members than they contractually agreed to accept.

[1] B&A tabulated service utilization data from the OMPP's data warehouse. All findings reported include utilization submitted by the MCOs as service encounters as well as claims submitted for payment directly by providers for members when they are briefly in the Fee for Service portion of the program. The Federal Fiscal Year was selected in order to obtain the most complete picture of 2009 since there is often a three to six month lag in the submission of MCO encounters from the date that the service was rendered.

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

Exhibit II.1
Panel Capacity for All Hoosier Healthwise Members, by County



A county with a higher percentage of full panels is not necessarily indicative of access problems, however. To further examine if potential access issues may be occurring in the CHIP, B&A analyzed two aspects of primary care utilization in the counties with panels fuller than 80 percent:

1) The percentage of CHIP children in a county that had a primary care visit in FFY 2009
2) For those children that had a visit, the county location where the service was delivered

B&A identified all children enrolled at least nine months in the CHIP in FFY 2009 (n=52,926). We reviewed the services received by each of these children in FFY 2009 and calculated the percentage of children receiving a primary care service as 73 percent of the total. Primary care utilization was

then examined at the county level. Each county that has a PMP panel fuller than 80 percent was studied to compare primary care use among its CHIP members to the statewide average. From this review, it was found:

- Among the six counties with PMP panels above 100 percent, only two counties (Clinton and Ohio) had children with a primary care usage rate below the statewide average (both at 63%).
- Among the nine counties with PMP panels between 90 and 99 percent full, only one (Dubois-68%) had children with a primary care usage rate below the statewide average.
- Among the four counties with PMP panels between 80 and 89 percent full, all had a rate of children with primary care usage above the statewide average.

Therefore, the data shows that although PMP availability may be lower in these counties, primary care use does not appear to be compromised except in a few situations.

For the children that did receive a primary care service, B&A matched the CHIP member's home county to the location where the primary care service was received. Visits were stratified as follows: (a) visit received in the same county where the member lives; (b) visit received in a county contiguous to the one where the member lives; and (c) visit received in a non-contiguous county to where the member lives.

Statewide, 80 percent of CHIP members received a primary care service in the county in which they live in FFY 2009. An additional 16 percent receive a primary care service in a contiguous county. Therefore, 96 percent received their services in their home county or a contiguous county and only four percent of children received their primary care in a county not contiguous to the one where they reside.

These statistics were also examined among the fuller PMP counties. Once again, the fuller PMP panel sizes do not appear to be influencing access. Among the 19 counties with PMP panels fuller than 80 percent:

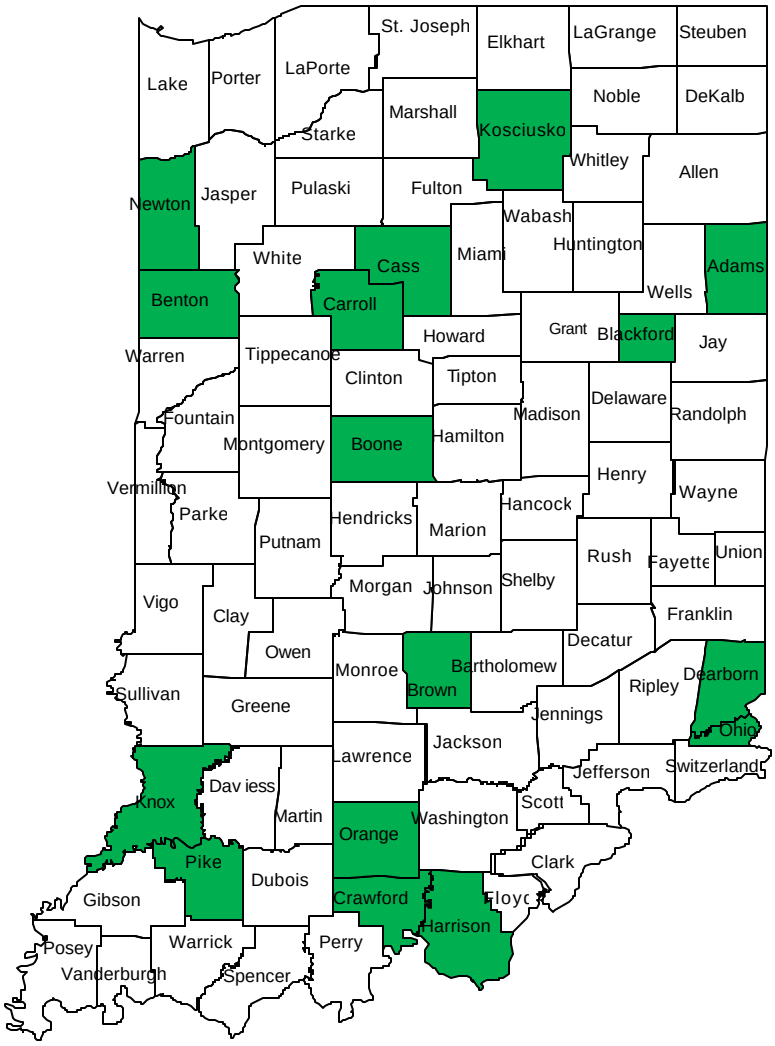
- Sixteen counties had 92 percent or more of their CHIP children receive their primary care services in their home county or in a contiguous county.
- The remaining three counties (Bartholemew, Brown and Switzerland Counties) had a higher rate of non-contiguous county visits among CHIP members, but they also had higher rates of overall primary care use among CHIP children than the statewide averages.

Access to Dentists

B&A conducted an analysis of the location where CHIP members access preventive dental services similar to what was completed for primary care services. Overall, it was found that 67 percent of CHIP members had a preventive dental visit in FFY 2009. The members with visits were once again analyzed to determine if the dental visit was in the member's home county, a contiguous county or a non-contiguous county.

Statewide, 94 percent of CHIP members had their preventive dental visit in their home county or in a contiguous county, a finding similar to that found for primary care visits. Exhibit II.2 shows the 16 counties where the percentage of visits received in non-contiguous counties from the member's home county exceeded 20 percent.

Exhibit II.2
Counties where More than 20% of CHIP Members Received Preventive Dental Visits in a County Not Contiguous to their Residing County



These 16 counties were examined further to see if there was a correlation between the higher rate of member dental visits further from the member's home and the rate of CHIP members who actually had a dental visit in the county. With a statewide average of 67 percent of members that had a preventive dental visit in FFY 2009, B&A identified counties where the dental usage rate was less than 60 percent in any given county. Among the seven counties that meet this criterion, five counties are also counties with a high rate of member visits in non-contiguous counties to where they live:

- Crawford- 56%
- Knox- 58%
- Kosciusko- 53%
- Orange- 56%
- Pike- 50%

The combination of these two utilization statistics may indicate a potential access problem for CHIP members to preventive dental services. But B&A's findings show that the majority of members in Indiana's CHIP do not have issues with accessing dental providers.

Service Use Patterns among Populations within the CHIP

B&A compared the services used by CHIP members in FFYs 2008 and 2009 to measure if usage patterns changed over this time period. Additionally, subpopulations within the CHIP were examined to determine if usage patterns varied across these groups. In the following pages, a variety of services commonly used by children are compared across these dimensions:

- Usage across three age groups
- Usage across four race/ethnicity populations
- Usage by members enrolled with each MCO in Hoosier Healthwise
- Usage by members from the eight regions within the state as defined in Exhibit II.8

Utilization data used in this analysis was retrieved by B&A from the Office of Medicaid Policy and Planning's data warehouse in early January 2010. The FFY periods were reported to enable sufficient time for the encounters that are submitted by the MCOs to be as complete as possible. However, it should be noted that data from FFY 2009 may be incomplete if the MCOs have not submitted all of their encounter data yet.

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2008 or FFY 2009. Our service usage trends only include members that were enrolled for at least nine months in the FFY examined. Members could be included in one year and not the other based upon their enrollment history. If CHIP members switched between CHIP Package A, CHIP Package C and/or Medicaid during the year, they were retained in the analysis as long as they met the nine month minimum since all three programs are a part of the Hoosier Healthwise program. B&A did limit the study population to those enrolled for at least nine months within a single MCO, however, because our analysis focused on the MCOs' ability to manage their members' care.

CHIP members included in the analysis were assigned to one MCO, one race/ethnicity group, one age group, and one region where they live in the state. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member's age was assigned based upon their age at the end of each year. The numeric values for the service use rates by demographic cohort reported in this section appear in tabular form in Appendix A.

Primary Care Office Visits

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

On a statewide level, B&A found that 73 percent of CHIP children in the study sample had a primary care office visit in both FFY 2008 and FFY 2009. The rate of primary care office visits by region ranged from a low of 69 percent of children in the Central Region to a high of 79 percent in the Southwest and Southeast Regions.

Primary care visits were more prevalent among younger members, as 82 percent of children age five and younger had a visit in FFY 2009. The percentages of children in the older age groups that had a primary care visit were lower (71% for age 6-12 and 73% for age 13 and over). Use of primary care services remained steady for each age group from FFY 2008 to FFY 2009.

Exhibit III.3
Primary Care Visit Rates by Age Group

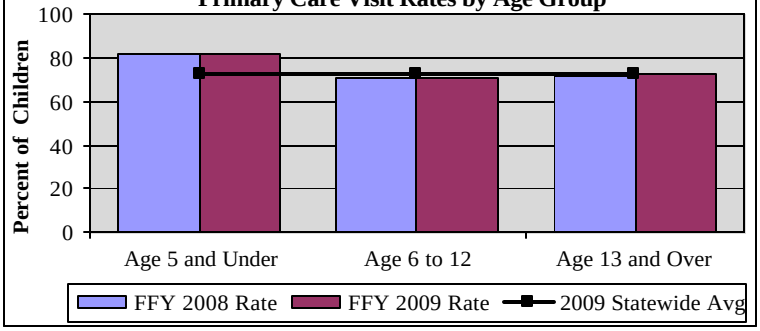
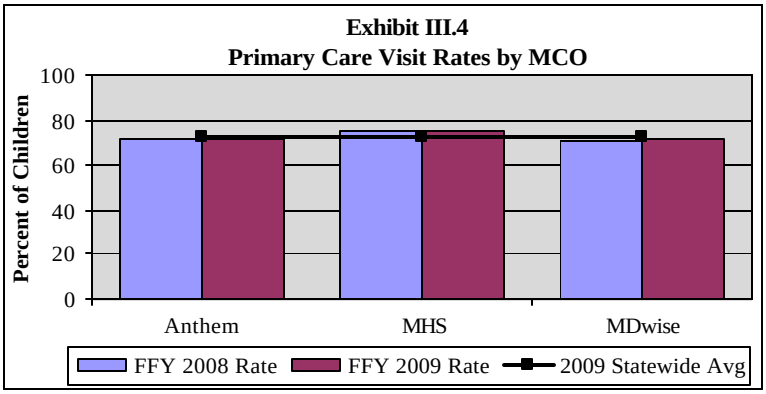


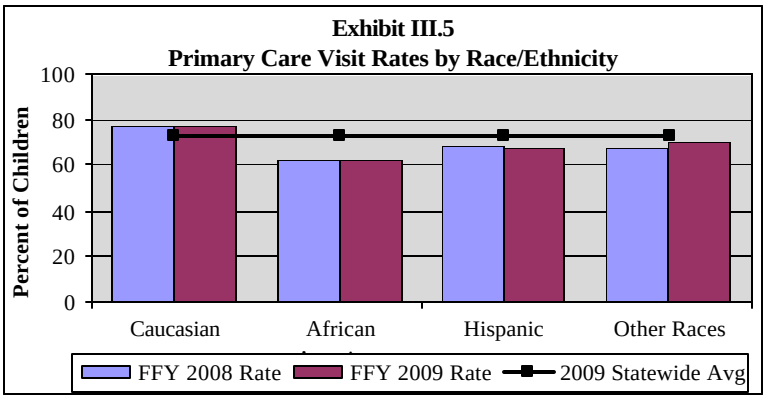
Exhibit III.4
Primary Care Visit Rates by MCO



The utilization rates for primary care services are the same for Anthem and MDwise (72%) and slightly higher for MHS (75%). These usage rates remained steady between FFY 2008 and FFY 2009.

There was little change in the use of primary care office visits between FFY 2008 and FFY 2009 by race/ethnicity, but there continues to be a disparity between African-Americans and other race/ethnicities. Only 62 percent of African-American children had a primary care office visit in FFY 2009, as compared to 67 percent for Hispanic children, 77 percent for Caucasian children, and 70 percent for children of other race/ethnicities.

Exhibit III.5
Primary Care Visit Rates by Race/Ethnicity



EPSDT Visits

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

The OMPP tracks EPSDT visits for federal reporting purposes on an annual basis. For this report, B&A is reporting EPSDT services in the same manner as the other services reported in this section. Although B&A used the same criteria that the OMPP uses to identify EPSDT visits, our categorizations differ from what is required in the federal reports.

The rate of CHIP children receiving an EPSDT visit increased significantly between FFY 2008 and 2009, from 31 percent to 38 percent of all children studied. This increase was true for children in all age groups. The OMPP has recently engaged the MCOs in a coordinated effort to encourage providers to properly code their claims to track these EPSDT visits. The degree to which certain providers (e.g., primary care doctor offices, clinics) offering EPSDT services who had not been properly reporting this service in FFY 2008 but are doing so in FFY 2009 may be influencing the trends reported below.

Based on clinical guidelines, it is expected that EPSDT visits would be most prevalent among the youngest CHIP members. Children age five and younger with a reported EPSDT visit increased from 64 percent in FFY 2008 to 68 percent in FFY 2009. Comparable increases were found for children age six to 12 (28% to 35% from 2008 to 2009) and for teens (21% to 28% from 2008 to 2009).

Exhibit III.6
EPSDT Visit Rates by Age Group

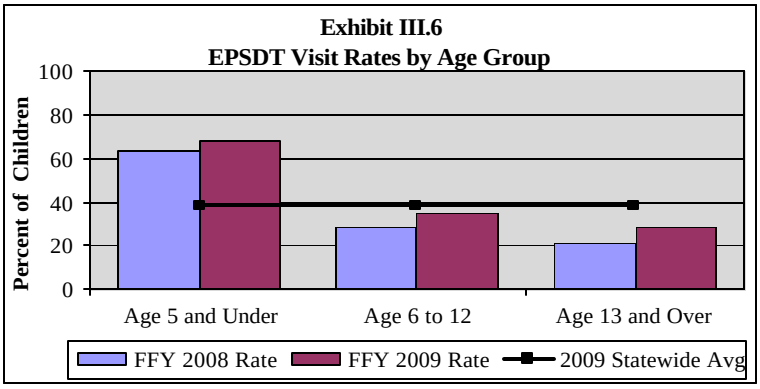
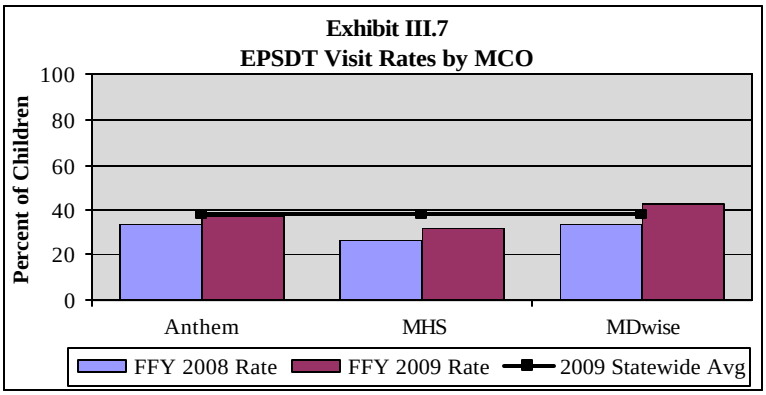


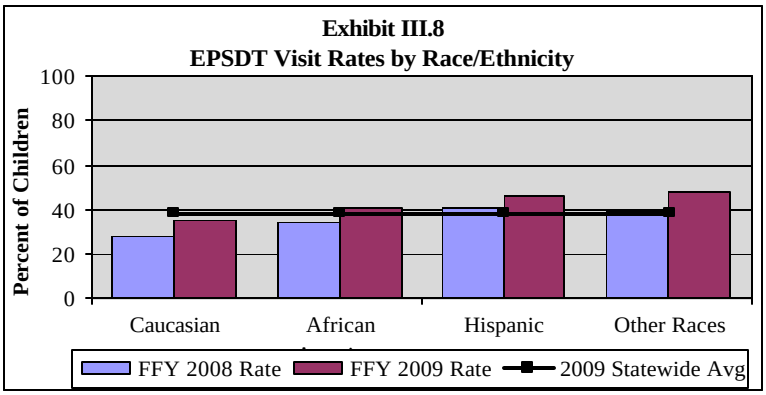
Exhibit III.7
EPSDT Visit Rates by MCO



Reported EPSDT visits increased for each MCO between FFY 2008 and 2009, but MDwise continues to report the highest rate among the three MCOs (43% in FFY 2009). This is because although MDwise had 36 percent of all CHIP enrollees in FFY 2009, they had 44 percent of all CHIP enrollees age five and younger.

EPSDT usage rates also increased for all race/ethnicities between FFY 2008 and 2009. In FFY 2009, the use of this service among all children was higher for Hispanic children (46%) and African American children (41%) than it was for Caucasian children (35%).

Exhibit III.8
EPSDT Visit Rates by Race/Ethnicity

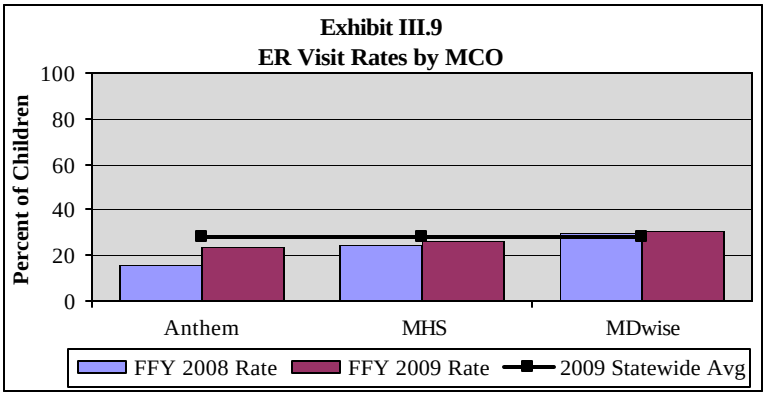


The rate of EPSDT visits by region ranged from a low of 31 percent of children in the Northwest Region to a high of 43 percent in the Central Region. Like the finding by race/ethnicities, this finding may be indicative of more complete reporting by clinics which are utilized more in the Central Region.

Emergency Room Visits

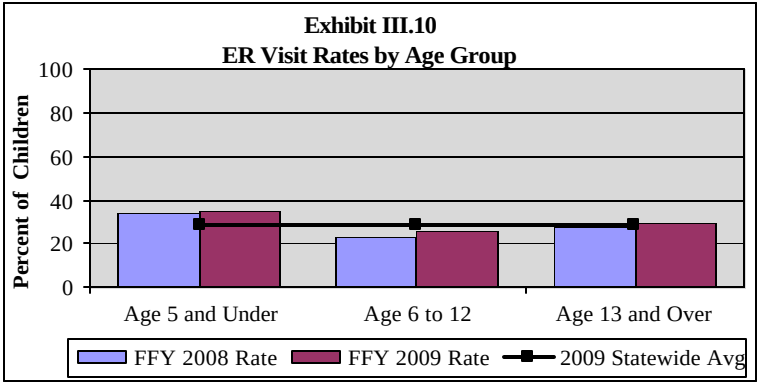
Although the percentage of CHIP members that had an ER visit increased from 26 percent of all members studied in FFY 2008 to 28 percent in FFY 2009, this increase may be misleading. When reviewed in more detail, it appears that Anthem had a significant increase from FFY 2008 to FFY 2009, but their 2009 member usage rate was more like the other two MCOs. This implies that Anthem had not submitted all of its data to the OMPP for ER services in FFY 2008. When Anthem is removed from the analysis, the percentage of CHIP children that had an ER visit in FFY 2008 was 28 percent, the same as FFY 2009.

Exhibit III.9
ER Visit Rates by MCO



ER usage was highest for members in the three Central Regions (32% of members) and lowest among CHIP members in the North Central Region (22%).

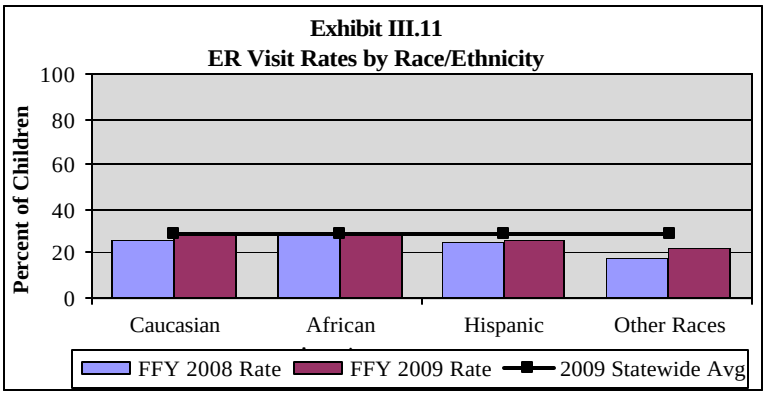
Exhibit III.10
ER Visit Rates by Age Group



Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (35% of all members in FFY 2009) and lowest among children age six to 12 (25% of all members in FFY 2009). Similar trends were found by age group in FFY 2008.

Although the percentage of ER users increased slightly for all race/ethnicities in CHIP between FFY 2008 and FFY 2009 (possibly due to Anthem's reporting), the rates among each of the race/ethnicities is similar.

Exhibit III.11
ER Visit Rates by Race/Ethnicity



Children in the CHIP are seeking assistance from the ER for what appear to be both emergencies and non-emergencies. B&A reviewed the top 50 diagnoses reported for each ER visit made by a CHIP member in FFY 2009. These top 50 were further combined into the categories shown in Exhibit III.12 since many of the top 50 diagnoses were similar.

A more complete review of each case would be required to assess whether a visit was an emergency or not. Among children age five and younger, ear aches and upper respiratory ailments accounted for one quarter of all visits. For children age six and older, ear aches and sore throats were also the most common diagnoses, although not as high as they were for the younger children. There was no diagnosis that represented more than five percent of all ER visits for teenagers except for sprains.

Exhibit III.12
Top 50 Diagnoses for ER Visits by CHIP Members in FFY 2009
Percentages Reflect Percentage of Total Diagnoses by Age Group

	Age 1 to 5	Age 6 to 12	Age 13 to 18	All Ages
Abdominal pain	1.2%	2.4%	3.0%	2.4%
Arm Fracture/pain in limb	0.9%	1.4%	0.9%	1.1%
Asthma attack	2.1%	2.5%	1.2%	1.9%
Attention deficit disorder	0.2%	4.7%	1.2%	2.4%
Bacterial infection	0.0%	0.7%	1.5%	0.9%
Breathing trouble	0.1%	0.2%	0.7%	0.4%
Bronchitis/pneumonia	4.0%	2.4%	1.5%	2.3%
Chest pain	0.1%	0.3%	0.8%	0.5%
Conjunctivitis	1.1%	0.7%	0.4%	0.7%
Contusion on face or neck	2.5%	1.5%	1.3%	1.6%
Convulsion	0.3%	0.3%	0.6%	0.4%
Cough	1.8%	1.0%	0.6%	1.0%
Croup	2.0%	0.3%	0.0%	0.5%
Ear ache	13.8%	5.9%	1.6%	5.4%
Fainting	0.1%	0.3%	0.8%	0.5%
Fever	6.7%	2.5%	0.7%	2.5%
Gastroentiritis/constipation	2.3%	1.9%	1.0%	1.6%
Head injury	1.4%	0.8%	0.6%	0.8%
Headache	0.2%	1.2%	1.7%	1.2%
Sinus infection	0.2%	0.5%	0.6%	0.5%
Skin rash/hives	2.8%	3.0%	1.5%	2.4%
Sore throat	5.4%	7.6%	4.7%	6.0%
Sprains	0.3%	3.1%	5.1%	3.4%
Upper respiratory infection/flu	9.2%	5.0%	2.8%	4.8%
Urinary tract infection	1.6%	1.4%	1.8%	1.6%
Viral infection/meningitis	4.7%	3.4%	2.4%	3.2%
Vomiting	3.3%	1.6%	1.0%	1.7%
Wounds	4.3%	3.3%	3.1%	3.4%
Top 50 Diagnoses	**72.7%**	**60.2%**	**42.9%**	**55.2%**
All Other	**27.3%**	**39.8%**	**57.1%**	**44.8%**

Preventive Dental Visits

The overall percentage of CHIP members receiving a preventive dental visit has increased in each of the last five years and this year continues that trend. The percentage of CHIP members receiving this service increased from 65 percent overall in FFY 2008 to 67 percent in FFY 2009. Dental care is one of the few services that the MCOs are not responsible for managing.

Although the statewide average usage rate is 67 percent, the range across the regions is small, from the lowest rates in the Northwest and West Central Regions (64%) to the highest rate in the East Central Region (71%).

Children age six to 12 are most likely to have received a preventive dental visit (76% of the total members), which is significantly higher than the teenagers (64%). The youngest children had the lowest usage rate (47%) given that this group includes toddlers; but the overall rate did increase for children age five and younger from 45 percent in FFY 2008.

Exhibit III.13
Dental Visit Rates by Age Group

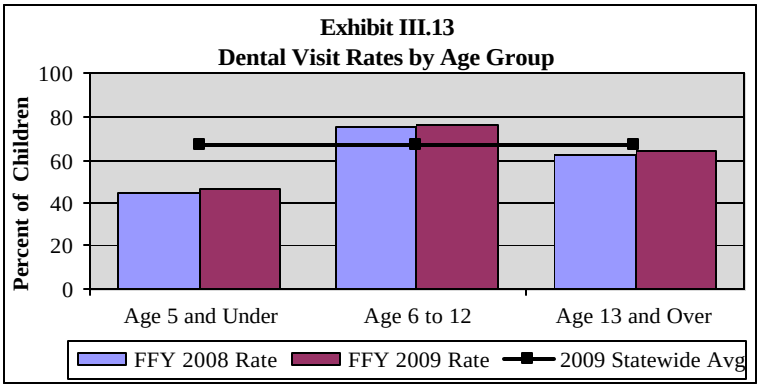
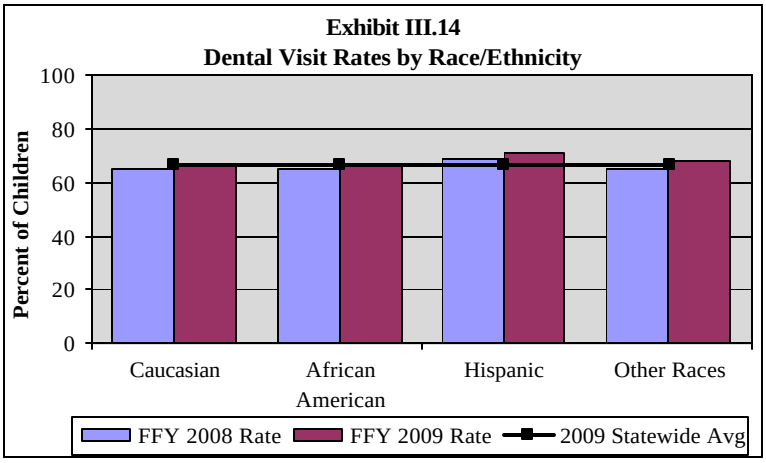


Exhibit III.14
Dental Visit Rates by Race/Ethnicity

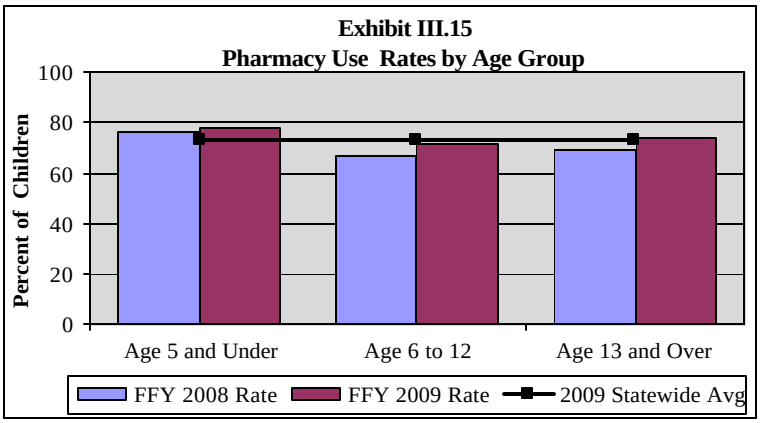


Dental usage rates increased for all race/ethnicities between FFY 2008 and FFY 2009, with Hispanic children once again having a slightly higher usage rate (71%) in FFY 2009 than either Caucasian or African American children (67% each).

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

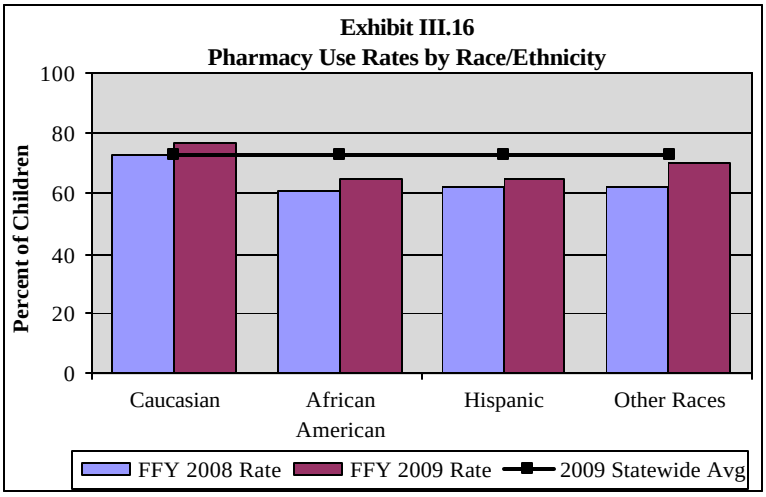
Pharmacy Scripts

The percentage of members receiving a pharmacy script increased between FFY 2008 to FFY 2009, from 70 percent to 73 percent. However, it appears that a similar reporting issue for Anthem with ER visits also occurred with pharmacy scripts in FFY 2008. When Anthem data is excluded, the usage rate for FFY 2008 is 71 percent.



There are differences in pharmacy usage among the age groups studied. The highest usage rate is among children age five and younger in both FFY 2008 and 2009 (78% in 2009). This is followed by children age 13 and over (74% in 2009) and then children age six to 12 (72% in 2009).

The percentage of children with a pharmacy script also increased for each race/ethnicity group studied between FFY 2008 and 2009, but Caucasian children have a significantly higher pharmacy usage rate than minorities. In FFY 2009, the usage rate among Caucasians was 77 percent but it was 65 percent for both African American and Hispanic children. The rate was also lower for children of other race/ethnicities (70%). This has been a consistent finding in the CHIP for the last three years.



Across regions of the state, pharmacy usage among CHIP children is relatively consistent, from a low of 70 percent usage by children in the Northwest Region to a high of 79 percent usage by children in the Southwest Region.

Sixty specific drugs accounted for nine out of ten scripts to children in the CHIP. These are summarized into the categories shown in Exhibit III.17 below. Forty percent of all scripts to children in the CHIP were for treating infections or for asthma. These were also the top medications for children in each of the three age groups studied, although ADHD medication was also common among children age six to 12 and teens.

Exhibit III.17
Top Scripts Prescribed to CHIP Members in FFY 2009
Percentages Reflect Percentage of Total Prescriptions by Age Group

	Age 1 to 5	Age 6 to 12	Age 13 to 18	All Ages
ADHD medication	0.8%	11.4%	7.3%	8.4%
Allergy medication	11.4%	8.7%	5.8%	7.8%
Anti-depressants	1.2%	2.6%	3.6%	2.8%
Anti-inflammatory	0.1%	0.5%	1.0%	0.7%
Anti-psychotics	0.6%	4.5%	3.4%	3.6%
Anxiety medication	3.1%	1.2%	0.2%	1.0%
Asthma medication	16.4%	20.1%	15.3%	17.6%
Birth control			8.8%	4.7%
Cold medication/cough suppressant	4.6%	2.5%	1.8%	2.4%
Constipation Medication	1.7%	0.8%	0.3%	0.7%
Diabetes medication	0.3%	0.7%	0.8%	0.7%
Head lice medication	6.0%	3.8%	3.1%	3.7%
Hypertension treatment	1.0%	4.6%	4.8%	4.3%
Treatment for infections	38.9%	21.8%	20.4%	23.2%
Narcotic cough suppressant	2.5%	1.7%	1.6%	1.8%
Narcotic pain reliever	0.6%	2.1%	5.7%	3.5%
Nausea/stomach ache medication	0.2%	0.9%	2.5%	1.5%
Seizure medication	1.8%	0.9%	0.8%	1.0%
Top Scripts	**90.9%**	**88.8%**	**87.2%**	**89.3%**
All Other	**9.1%**	**11.2%**	**12.8%**	**10.7%**

Specialist Physician Visits

In this study, B&A defines specialist visits as any visit to a physician in an office setting that has not been classified as a primary care visit or an EPSDT visit. The rate of children seeking specialist care has been low in prior years reviewed. Among CHIP children in both FFY 2008 and 2009, the rate was nine percent of all children. The same rate was also found among children at each of the three MCOs. Regionally, the percentage seeking specialist care ranged from a low of six percent in the Northwest Region to a high of 13 percent in the East Central Region.

By age group, the youngest children in CHIP have a slightly higher usage rate for specialist services (11%) than children age six and older. The usage rates have been stable between FFY 2008 and 2009 by age group.

Caucasian children have a slightly higher incidence of seeking specialist care (10% in FFY 2009) than African American (6% in FFY 2009) or Hispanic (6% in FFY 2009) children.

Two-thirds of all specialist visits across all age groups were to allergists, orthopedic surgeons, and otologists. The specialists most frequently seen by CHIP members in FFY 2009, by age group, are as follows:

Exhibit III.18
Specialists Seen by CHIP Members in FFY 2009
Percentages Reflect Percentage of Total Claims from Providers by Age Group

	Age 1 to 5	Age 6 to 12	Age 13 to 19	All Ages
Orthopedic Surgeon	17.6%	20.6%	31.0%	24.3%
Otologist	39.1%	21.9%	16.4%	22.3%
Allergist	11.8%	27.1%	15.0%	20.0%
Dermatologist	7.2%	8.2%	10.1%	8.8%
Neurologist	4.1%	4.6%	6.2%	5.2%
General Surgeon	0.8%	1.0%	3.5%	2.0%
Gastroenterologist	2.9%	2.3%	3.4%	2.8%
Urologist	6.6%	4.4%	2.6%	4.0%
Anesthesiologist	1.9%	2.1%	1.9%	2.0%
Cardiologist	1.0%	1.6%	1.8%	1.6%
All Other Specialities	6.9%	6.1%	8.0%	7.0%

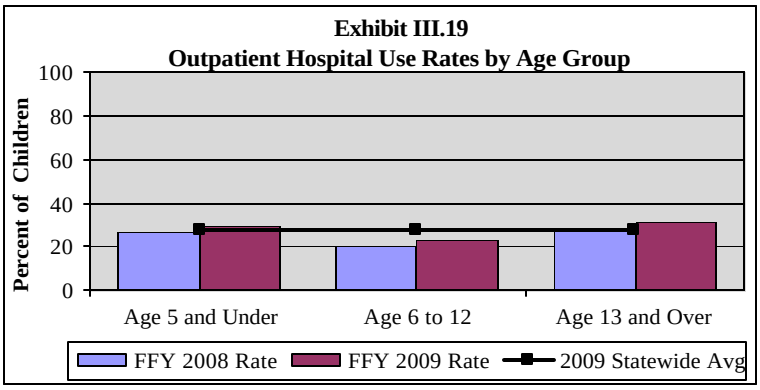
Outpatient Hospital Services

Services provided in an outpatient hospital setting vary quite a bit, from lab and x-ray tests to outpatient surgery to drug administration such as chemotherapy. Excluding ER visits, 27 percent of CHIP members received an outpatient hospital service in FFY 2009, an increase from 23 percent in FFY 2008. The usage rate varies across regions for this service more than other services. This may be because of the array of services provided, for example, in a rural outpatient hospital facility as opposed to an urban outpatient hospital facility. The percentage of CHIP members receiving outpatient hospital services in FFY 2009 was lowest in the North Central Region (19%) and highest in the Southwest (32%) and Southeast Regions (33%).

All three MCOs have the same percentage of CHIP children using outpatient hospitals services as the statewide average in FFY 2009. Caucasian children in CHIP were more likely to have received this service (30% of all children in FFY 2009) than either African American or Hispanic children (19% for each minority group in FFY 2009).

By age group, children in the younger age group (29% for children under age 5) and older age groups (31% for children age 13-18) within CHIP had higher outpatient hospital usage than children in the age six to 12 group (23%).

Exhibit III.19
Outpatient Hospital Use Rates by Age Group



Two-thirds of all outpatient hospital services received by CHIP members in FFY 2009 were for lab tests. X-rays and outpatient surgeries comprised most of the other services received.

Exhibit III.20
Top Outpatient Procedure for CHIP Members in FFY 2009
Percentages Reflect Percentage of Total Procedures by Age Group

	Age 1 to 5	Age 6 to 12	Age 13 to 18	All Ages
Outpatient Surgical Procedures	15.6%	12.4%	11.7%	12.5%
X-rays	15.0%	17.3%	17.4%	17.0%
Lab tests	60.5%	63.7%	65.9%	64.4%
Therapies	1.3%	1.3%	1.0%	1.1%
Electrocardiograms	0.4%	0.6%	0.7%	0.6%
Hearing tests	1.7%	0.7%	0.1%	0.5%
All Other	5.6%	4.0%	3.2%	3.8%

Inpatient Hospital Services

The number of inpatient hospital stays is very low for children in general and this was found to be true for the CHIP population. Only 1.4 percent of all CHIP members had a hospital stay in either FFY 2008 or FFY 2009. When stratified by age group, by MCO, by race/ethnicity, and by region, the usage rate was between one and two percent for all populations studied. It should be noted that the stay when a child is born is not counted in these figures.

In FFY 2009, there were only 1,739 admissions for almost 70,000 members. For the few children that did have an inpatient hospital stay, the types of visits are concentrated within certain categories. Exhibit III.21 below shows the top admission types by age group. Two-thirds of the admissions for teenagers are either childbirth-related or behavioral-related. For children age 6 to 12, the most common admissions are respiratory-related and behavioral-related. For the youngest CHIP members, 28 percent of the admissions are respiratory-related.

Exhibit III.21
Top Inpatient Admissions for CHIP Members in FFY 2009
Percentages Reflect Percentage of Total Admissions by Age Group

	Age 1 to 5	Age 6 to 12	Age 13 to 19	All Ages
Appendectomy	0.4%	3.1%	1.1%	1.6%
Behavioral	1.3%	20.3%	21.2%	18.3%
Chemotherapy	0.4%	4.1%	0.7%	1.6%
Childbirth	N/A	N/A	42.4%	25.0%
Diabetes	1.8%	2.5%	2.6%	2.5%
Ear infections	6.1%	2.1%	1.0%	2.0%
Kidney/Urinary Tract	7.0%	2.5%	1.6%	2.5%
Leukemia/Lymphoma	1.8%	2.5%	1.0%	1.5%
Respiratory (e.g. asthma)	28.1%	18.7%	1.7%	9.9%
All Other	53.1%	44.4%	26.9%	35.2%

IV

Measuring Quality and Outcomes in Indiana's CHIP

Quality Goals at a Glance

Goals for 2009-2010 for all children in Hoosier Healthwise (including CHIP):

1. Increase well care visits among adolescents.
2. Increase screening and immunization rates for young children.
3. Increase follow-up rates after ADHD medication is prescribed.
4. Expand behavioral health benefits in CHIP.
5. Develop an integrated medical/behavioral health pilot.
6. Pilot a new health risk assessment tool.
7. Improve accuracy of quality measures reported by health plans.

The Office of Medicaid Policy and Planning (OMPP) assumes the overall responsibility for ensuring that children in Indiana's CHIP receive accessible, high-quality services. Measuring outcomes have become a focused effort of the OMPP in the last three years, in particular with respect to children's care.

In fulfilling its oversight responsibilities, the OMPP utilizes a variety of reporting and feedback methods to measure quality and outcomes for Indiana's CHIP. Since the CHIP members are seamlessly integrated into the overall Hoosier Healthwise program, the oversight process is completed for Hoosier Healthwise as a whole rather than for the CHIP specifically. However, recognizing that children represent the majority of Hoosier Healthwise members, quality and outcomes related to all children are given high priority.

Specific quality and outcome reporting requirements are required of all states by the Centers for Medicare and Medicaid (CMS). Each state Medicaid managed care program must submit an annual quality strategy plan to CMS.[1] The OMPP Quality Strategy Plan is presented to stakeholders integral to Medicaid health coverage programs and feedback is sought from these stakeholders before the final submission to CMS.

Strategic objectives are developed by the OMPP in the Quality Strategy Plan and there are goals developed to meet each objective. Although there are strategic objectives developed each year that are specific to each of the Indiana Medicaid Care Programs (Hoosier Healthwise, the Healthy Indiana Plan and Care Select), the OMPP strives to develop objectives that are cross-cutting to the three Care Programs in an effort to establish a baseline for quality measurement across all programs.

The Executive Team at the OMPP is charged with successfully maintaining the Medicaid program's efforts to achieve the State's identified strategic objectives. The OMPP assumes the responsibility to achieve some of the outlined goals and in other cases it oversees activities of the managed care organizations (MCOs) to achieve these goals. Besides the specific items that are mentioned in the Quality Strategy Plan, the OMPP have staff that conduct day-to-day operational oversight of its contracted MCOs. There are three primary methods of oversight used. First, OMPP staff review and interpret data from reports submitted monthly, quarterly and annually by the MCOs across all functional areas against established contractual benchmarks. Second, OMPP personnel conduct reviews at each of the MCO's site on a monthly basis to oversee contractual compliance. Finally, the OMPP hires an independent entity to conduct an annual external quality review of each MCO and reviews the results from this review with each MCO.

OMPP Quality Initiatives for Hoosier Healthwise in 2009-2010

Most of the children that are eligible for Medicaid or CHIP are enrolled in the Hoosier Healthwise program. Three of the five strategic objectives for 2009-2010 directly focus on children's health:

1. The State seeks to ensure access to primary and preventive care services.
2. The State seeks to improve access to all necessary health care services.
3. The State seeks to encourage quality, continuity and appropriateness of medical care.

Each strategic objective and associated goals to meet each objective are discussed below.

[1] The Quality Strategy Plan for 2008-2009 is available at http://www.in.gov/fssa/2408.htm

Strategic Objective #1: The State seeks to ensure access to primary and preventive care services.

Two of the three goals associated with this objective are related to children:

1. The State will increase the rate for Adolescent (ages 12-21) Well-Care Visits to the NCQA Medicaid HEDIS®[2] 75th percentile by 2010.
2. The State will improve the EPSDT screening ratio, all ages combined, from 73% in the year 2008 to a ratio of 85% in the year 2011.

Because the rate of adolescents receiving an annual well-care exam is low and remained stable in 2008, the OMPP targeted this as an area for improvement in the 2009 contract with MCOs. In the 2008 results, Anthem reported a rate between the 50th and 75th percentiles of the national rate while MHS and MDwise both reported a rate below the 50th percentile nationally. The OMPP built in a pay-for-performance incentive to improve adolescent well care visits. There is hope that this incentive will result in improvement similar to the incentive that was built into the 2008 MCO contracts for well-child visits in the first 15 months of life. The next results on adolescent well care will be available in the Summer of 2010.

As the OMPP monitors the progress of children receiving EPSDT screenings, it continues to refine the process for aggregating EPSDT data for submission to the Centers for Medicare and Medicaid (CMS) for required federal reporting statistics. After the evaluation of 2008 results, the OMPP pinpointed specific reporting items to be corrected in the 2009 submission. EPSDT results are being used to educate and engage providers on both the need to conduct EPSDT screenings as well as the proper way to report these screenings. Additionally, the OMPP is examining evidence-based guidelines followed by providers across the state to standardize the types of screening tools and methods that may be used to meet both OMPP and national standards.

Strategic Objective #2: The State seeks to improve access to all necessary health care services.

The State has three goals that are associated with this objective:

1. The State will develop and implement an integrated medical/behavioral health care model pilot by the end of 2009.
2. The State will implement an expansion of behavioral health benefits to CHIP members by January 2010.
3. The State will improve rates for the HEDIS® measure Follow-Up Care for ADHD Medications to the NCQA Medicaid 75th percentile by 2010.

Integrated behavioral and physical health care is an important component to ensuring effective and coordinated care for Medicaid members. The OMPP recognizes that integrated care models need to be patient-centric and provide the right services to the right patients in the right setting. For example, persons with severe and persistent mental illness may be best served in a community mental health center, while individuals with less severe mental conditions might benefit from evaluation and treatment in a primary care setting with integrated behavioral health services. The OMPP and Division of Mental Health and Addiction (DMHA) have developed an outcomes-driven integrated care model for the primary care setting in collaboration with a Marion County federally qualified health center (FQHC) system. All patients attending these clinics will be screened for depression and

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

anxiety disorders, treated in the FQHC setting, and those with significant needs will be referred for behavioral care.

In 2009, legislation was passed (IC 12-17.6-4-2) that authorized the expansion of behavioral health coverage for CHIP Package C to more closely resemble Medicaid behavioral health services. Pending state rule promulgation and federal approval of the State Plan, coverage will include inpatient mental health services and substance abuse services provided in an institution, psychiatric residential treatment services, community mental health rehabilitation services, and outpatient mental health services and substance abuse services.

Both MDwise and MHS saw significant improvements in the measure related to ADHD medication follow-up in their 2007 to 2008 HEDIS® reports, with both plans moving from the 50th to the 90th national percentile. Anthem had no report for 2007, but scored in the 75th percentile in 2008. Proper ADHD medication follow-up is also part of the 2009 pay for performance contract with the health plans.

Strategic Objective #3: The State seeks to encourage quality, continuity and appropriateness of medical care.

Three of the four goals associated with this objective are related to children:

1. Increase to 65% the rate of two year olds that will receive immunizations consistent with HEDIS® recommendations for Combination Three.
2. Pilot a Health Risk Screener/Assessment by 2010 across all Care Programs for implementation by 2011.
3. Improve accuracy of MCO quality measures by the fourth quarter of 2009.

All three Hoosier Healthwise MCOs had improvements or even results in the rate of immunizations for children under the age of two, but the MCOs are below the 50th national percentile and thus their scores could be improved. The OMPP has set a target in 2009 that 65% of all two year olds will receive immunizations tabulated in the HEDIS® Combination Three measure.

The OMPP has also developed a Health Risk Screening tool that will be implemented for all three Care Programs that resembles the tool first used by the Care Select Program. The OMPP's Medicaid Medical Advisory Cabinet (MMAC) assisted in developing screening questions for the tool, which will be used to identify enrollees with at risk conditions and help the MCO to determine the needed actions for follow-up care. Stakeholders, including the MCOs, were consulted on the development of the health risk screener and how it could be successfully deployed. The OMPP synthesized the stakeholder input it received as well as staff research on national best practices and is working to create a screening system that meets the needs of its enrollees, that is easy to understand, and that allows for data collection to best track outcomes.

The OMPP Quality staff has been working collaboratively with OMPP staff responsible for each of the Medicaid Care Programs to improve health plan oversight and reporting processes. During the first half of CY 2009, the OMPP worked with the MCOs to refine the quarterly quality of care measure submissions. The changes were intended to improve consistency of the results submitted by the MCOs and to provide the OMPP with information that can be compared against national benchmarks. The reporting manual which identifies the requirements for MCO reporting to the OMPP was recently revised with feedback from the MCOs. Additionally, the OMPP will require public reporting of the MCO's progress on Performance Improvement Projects in Quality Strategy Committee Meetings beginning in 2010.

CAHPS®[3] 2009 Survey Results in Hoosier Healthwise

The Hoosier Healthwise MCOs contract with an outside survey firm to conduct a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Each MCO conducts two annual surveys—one for adults and another for parents of children enrolled in Hoosier Healthwise.

Exhibit IV.1 summarizes the results from the surveys that were administered in early 2009. The sample of members interviewed included members that had been enrolled for at least six months with the MCO in 2008. The MCO results are compared to the average rates reported to the NCQA by Medicaid health plans that administered this same survey.

The percentages in the first set of results in the exhibit reflect those members that gave a rating of 8, 9 or 10 for each rating, where zero is "worst possible" and 10 is "best possible". The ratings for the member's own health care were higher for each Indiana MCO than the national average. The Rating of Personal Doctor was also at or near the national average for all three MCOs, and MHS reported a statistically significant increase from the prior year survey. All three MCOs were at or above the national average for Rating of Health Plan, with Anthem and MDwise showing significant improvement. MHS reported a lower score than the national average for Rating of Specialist, but Anthem and MDwise were both above it.

The CAHPS® is designed so that composite scores are compiled from the answers to a series of related questions. The second set of results in the exhibit represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. For the domain Getting Needed Care, the three MCOs reported almost identical results which were little changed from last year's survey. All three MCOs reported results that were better than the national average for Getting Care Quickly, and Anthem had statistically significant improvement from the prior year's results. MHS and MDwise exceeded the national benchmark for How Well Doctors Communicate, although MHS's results were actually a decrease from the prior year. MDwise had results considerably lower on the Customer Service domain than the other MCOs.

Exhibit IV.1
Summary of Scores from CAHPS 2009 Child Survey

	Anthem	MHS	MDwise	National Mean
	Members givin a rating of 8, 9 or 10 on a 10-point scale.			
Rating of Health Care	82%	82%	83%	80%
Rating of Personal Doctor	83%	**86%**	85%	84%
Rating of Specialist	89%	73%	84%	81%
Rating of Health Plan	**86%**	81%	**84%**	81%
	Percentages reflect responses of "Usually" or "Always"			
Getting Needed Care	86%	86%	85%	Not available
Getting Care Quickly	**88%**	90%	91%	87%
How Well Doctors Communicate	89%	**91.1%**[(a)]	93%	91%
Customer Service	87%	83%	73%	Not available

Bold items indicate a statistically significant change from 2008 to 2009.

(a) All bolded figures were a statistically significant increase in the rating except this was a decrease.

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® Results for Children Enrolled in Hoosier Healthwise

The OMPP requires that the MCOs submit HEDIS® measures annually that have been audited by a certified NCQA auditor. The measures represent the utilization of Hoosier Healthwise members from the prior year. Therefore, in CY 2009, tabulations were collected on HEDIS® rates for 2008 utilization. The HEDIS® measures report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome. The OMPP gave the MCOs targets to meet for all of the HEDIS® measures collected that are specific to children's care.

Exhibit IV.2 presents the HEDIS® results for access to primary care. There are two differences in the methodology used by B&A in reporting primary care usage (shown in Chapter III) and the HEDIS results. B&A's analysis was an administrative (i.e. claims) review and includes all claims reported to the OMPP. The HEDIS® analysis includes a sample of Hoosier Healthwise 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 Indiana) in the measurement year.

The exhibit shows the 2007 and 2008 rates reported for each MCO for four age groups. These rates are compared to the national median rate that is compiled from all Medicaid health plans reporting HEDIS® results to the NCQA. Both MHS and MDwise reported results near the national median values for all four age groups. Anthem's 2008 rates for access to primary care for children age 7-11 years and 12-19 years are also near the national average (2007 rates were not reported by Anthem). However, Anthem's rates for the younger age groups are slightly below the national average and its peers in Indiana.

Exhibit IV.2
Summary of Results from HEDIS Access to Primary Care Measures (Percentage of Total)

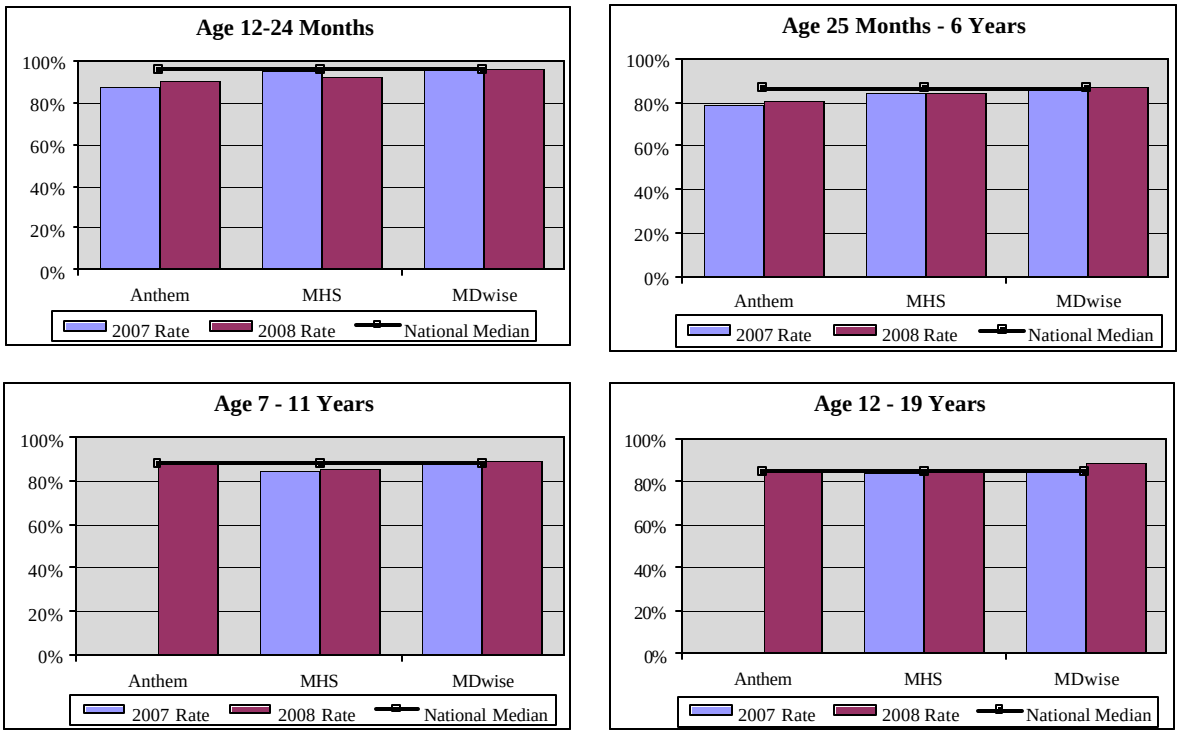


Exhibit IV.3 shows the results for well care visits. The number of visits required in the HEDIS® definition varies by age group. For children in the first 15 months of life, the rate shown represents the percentage of children with six or more well child visits. For children in the age 3-6 years and age 12-20 years groups, the rate shown represents children that had at least an annual visit. For the adolescents, a visit to an OB/GYN also counts as a well child visit.

MDwise exceeded the national median rate for well child visits among children in the first 15 months of life (see upper left box) in 2008 as well as reporting considerable improvement from 2007 to 2008. Both Anthem and MHS, however, were quite a bit below the national median rate of 57.5 percent for this age group.

The three Hoosier Healthwise MCOs reported rates at or near the national median rate for older children (see bottom left box), but none of the MCOs met the national median rate for children age 3-6 years (see upper right box). MDwise, however, did report improvement from 2007 to 2008.

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

Four doses of diphtheria-tetanus	Three doses of influenza
Three doses of polio	Three doses of Hepatitis B
One dose of measles-mumps-rubella	One dose of chicken pox
Four doses of pneumococcal conjugate vaccine to prevent bacterial meningitis	

Although MHS and MDwise showed improvement in the immunization measure from 2007 to 2008, neither MCO reached the national median rate of 68.6 percent. Anthem's rate remained steady over the two years and was also below the national median.

Exhibit IV.3
Summary of Results from HEDIS Well Care Measures (Percentage of Total)

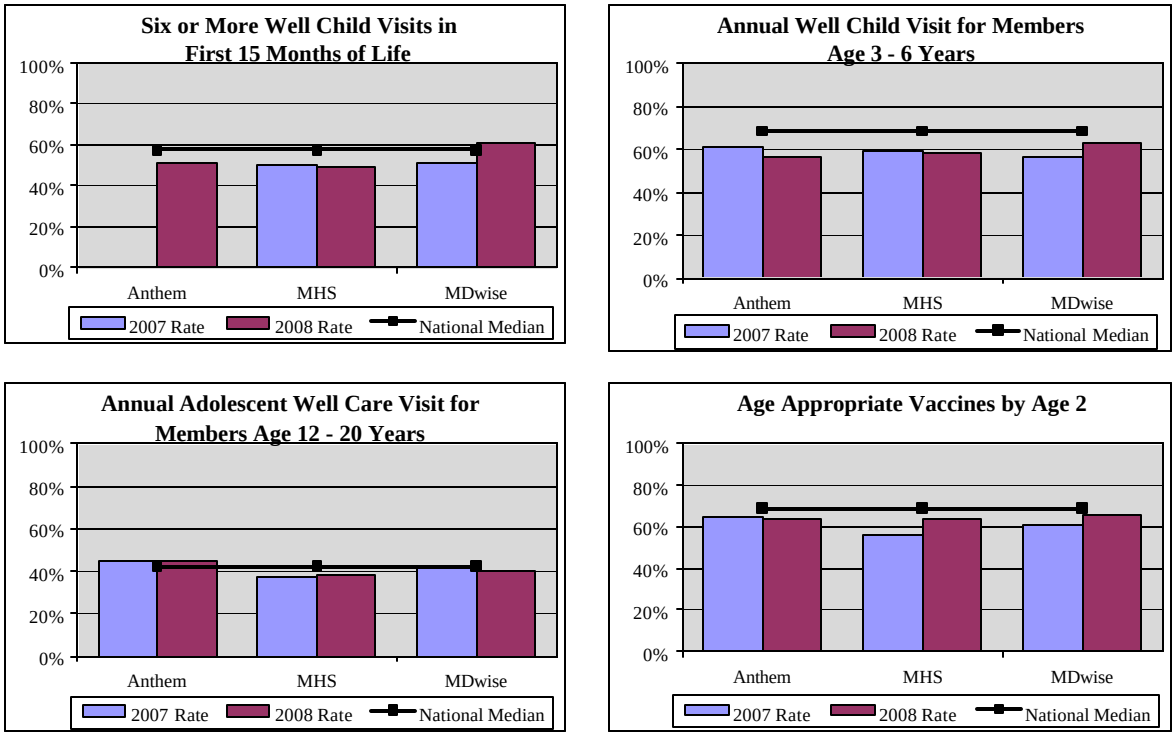


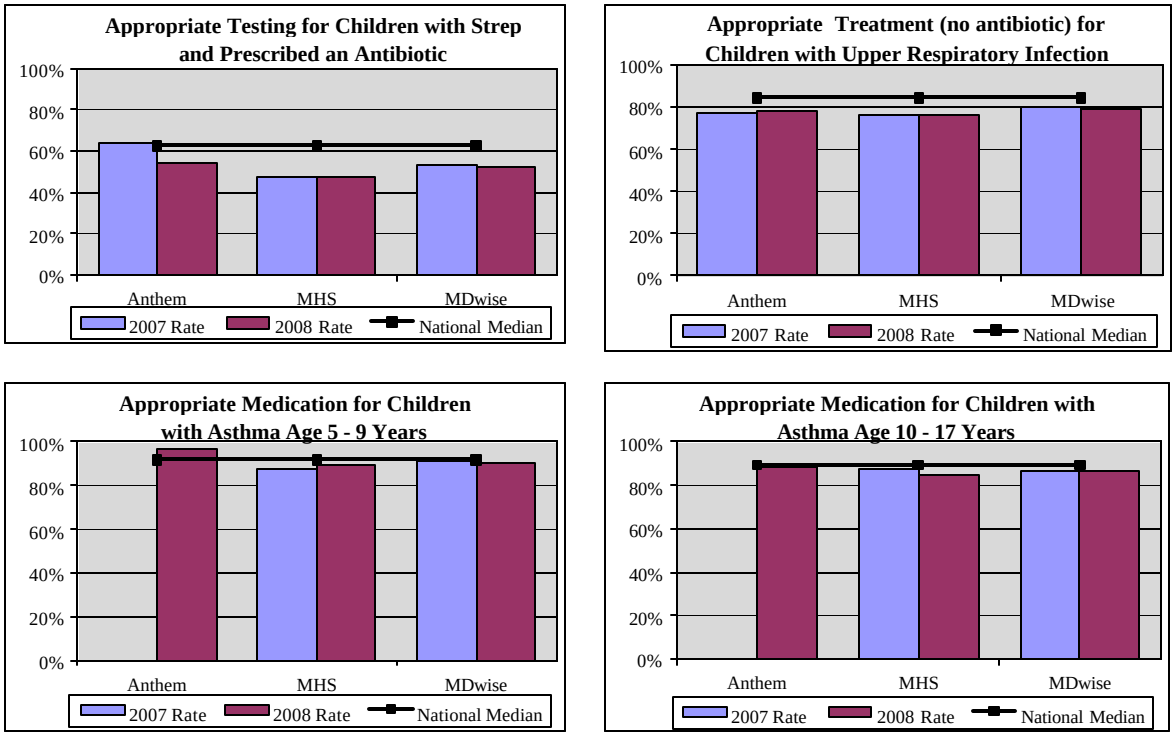
Exhibit IV.4 presents the results from HEDIS® measures related to respiratory care for children. The upper two boxes present results related to measuring proper treatment while the lower two boxes present results of appropriate medications for children with asthma.

For appropriate testing of children with pharyngitis (sore throat), Indiana's MCOs all reported 2008 rates below the national median (see upper left box). In fact, Anthem's rate for 2008 was lower than its 2007 rate and MHS's and MDwise's rates were about the same. For this measure, a higher rating is more favorable since it indicates better testing.

The MCOs reported results closer to, but not quite at, the national median for appropriate treatment for children with upper respiratory infection. This measure reports the percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable because most upper respiratory infections are viral, not bacterial. Thus, administering an antibiotic is not appropriate in this case.

Indiana's MCOs did better for the two age-specific measures related to appropriate medication for children with asthma. For the age 5-9 group, Anthem exceeded both its peers and the national median rate of 91.8 percent. Both MHS and MDwise reported rates near the national median. Anthem also met the national median rate for children in the age 10-17 group. MDwise was just below the national rate and MHS actually reported a lower rate in 2008 than in 2007 when they were at the national median rate.

Exhibit IV.4
Summary of Results from HEDIS Respiratory Care Measures (Percentage of Total)



V

Results from the Survey of Parents of CHIP Package C Members

CHIP Package C Parent Survey Results at a Glance

83% stated that CHIP was their only option to get their children health insurance

Prior to enrolling in CHIP Package C:

- 31% of respondents stated their children were uninsured
- 47% of respondents had been enrolled in another Medicaid program
- 22% of respondents had insurance

Burns & Associates, Inc. (B&A) conducted a mail survey in November 2009 with the parents/guardians (parents) of Indiana's CHIP Package C members. Unlike CHIP Package A members, CHIP Package C families are charged premiums on a sliding scale and are charged co-pays for prescriptions and for ambulance services.

B&A identified all CHIP Package C members continuously enrolled in the first nine months of Calendar Year 2009, who indicated English as their primary language, and who had a valid in-state mailing address. The net result was 8,800 members.

In order to send only one survey per household, B&A identified multiple children in a family that were contained in the sample. For convenience, B&A retained the oldest child in the family in the sample only. The mailing was addressed to "the parent/guardian of [child's name]". Excluding 3,074 children in multiple families left a net result of 5,726 member families that were surveyed.

Nine questions on the survey asked parents about various aspects of their child's coverage in CHIP Package C. An additional four questions were directed to the parents about insurance coverage for themselves and their awareness of the state's Healthy Indiana Plan. The survey instrument appears in Appendix B.

Response Rate

Excluding 75 surveys that were returned to sender, B&A received 1,755 responses for an overall response rate of 31 percent. Of these, there were 871 (50%) households with one child enrolled in CHIP and 884 (50%) households with multiple children enrolled in CHIP. This distribution differs from the composition of 2009 CHIP enrollment, where there were 61 percent of families with one child enrolled in CHIP and 39 percent of families with multiple children enrolled in CHIP.

The profile of the families surveyed shown to the right finds that respondents in the Central Region are underrepresented among respondents and the Northeast and East Central Regions are slightly overrepresented. By MCO, Anthem and MDwise are underrepresented to some degree while MHS has higher representation. For the respondents, the "Unknown" category occurs because 24 respondents tore off the ID number at the bottom of the survey which designated the member's region and MCO.

Exhibit V.1
Survey Response Rates by Region and by MCO

Region	Surveyed	% Surveyed	Responded	% Responded
Northwest	678	11.8%	186	10.6%
North Central	547	9.6%	181	10.3%
Northeast	695	12.1%	249	14.2%
West Central	418	7.3%	142	8.1%
Central	1,617	28.2%	408	23.2%
East Central	502	8.8%	179	10.2%
Southwest	713	12.5%	208	11.9%
Southeast	556	9.7%	178	10.1%
Unknown			24	1.4%
Total	**5,726**	**100.0%**	**1,755**	**100.0%**

MCO	Surveyed	% Surveyed	Responded	% Responded
Anthem	1,356	23.7%	383	21.8%
MDwise	2,357	41.2%	699	39.8%
MHS	2,013	35.2%	649	37.0%
Unknown			24	1.4%
Total	**5,726**	**100.0%**	**1,755**	**100.0%**

Survey Findings

Substitution of Coverage

Parents were asked their child's health insurance coverage status prior to enrolling in CHIP Package C. Among those responding to the question (1,690 out of 1,755 surveys received):

- 22.0% stated that their child/children had health insurance through their employer or their spouse's employer.
- 47.5% stated that their child/children had been enrolled in the portion of Hoosier Healthwise where premiums were not required.
- 30.5% stated that their child/children did not have health insurance.

To be eligible to join CHIP Package C, children must be uninsured for three months prior to the start of enrollment. Parents were asked if they substituted CHIP Package C instead of other options that may have been available to them for their children. It was found that very few had done so. Among respondents (1,681 out of 1,755 surveys received):

- 6.0% stated that their child/children were on a parent's employer's insurance plan, but they disenrolled their child/children from employer coverage to CHIP Package C since it was less expensive.
- 11.4% stated that their child/children did not have health insurance even though they could have enrolled the child/children through employer coverage. The parent decided to enroll the child/children in CHIP Package C since it was less expensive than the employer coverage would have been.
- 82.6% stated that CHIP Package C was the only option to get health insurance for their child/children.

Affordability of Coverage

When asked about the affordability of premiums in CHIP Package C, only 15 percent of respondents indicated that they were "very concerned" about the cost of the premium that they had to pay. Forty-two percent were "somewhat concerned" while 38 percent were "not too concerned" about the premium cost.

Exhibit V.2
Feedback on Concern Regarding Affordability of Premiums in CHIP Package C

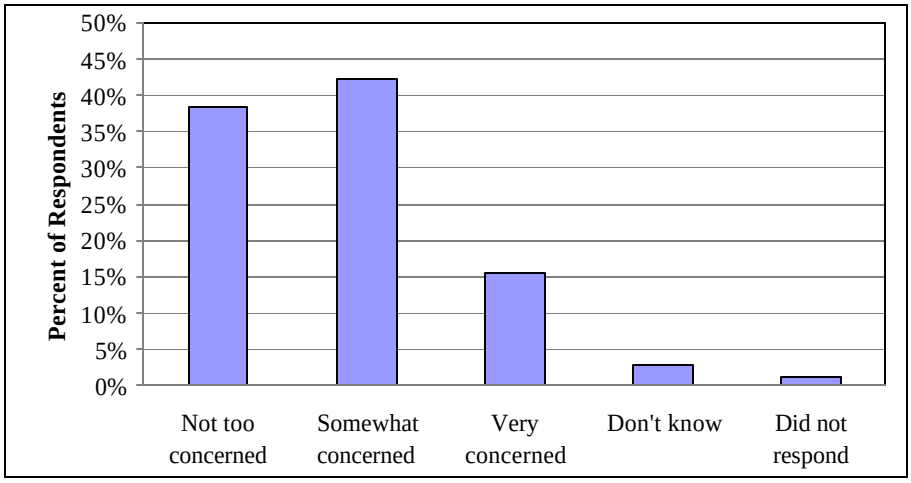
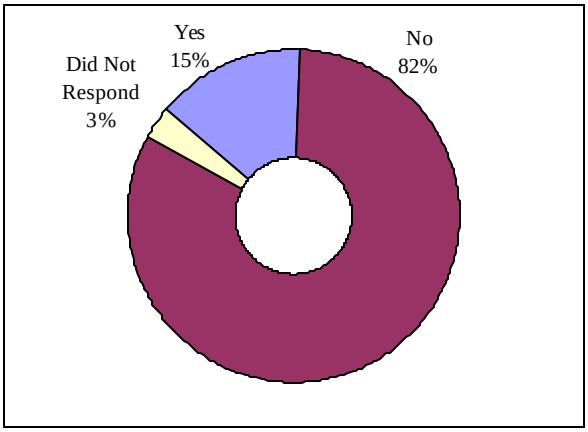


Exhibit V.3
Have you delayed getting a service or not gotten one because you could not afford the co-pay?



In CHIP Package C, co-pays are required for prescription drugs and for ambulance service. For prescriptions, it is $3 for generic drugs and $10 for brand name drugs. The ambulance co-pay is $10 per trip. Eighty-two percent of respondents stated that the cost of the co-pay did not prevent them from getting a service. Only 15 percent stated that had delayed getting a service because the co-pay was prohibitive.

Availability of Services

Parents of CHIP C members were asked about the health care needs of their children in Calendar Year 2009 and if they felt that the services that were needed were available to them. First, parents were asked from a list of services whether or not their child/children *needed* the service. Then, if the child needed a service, they indicated if their child *received* the service.

Exhibit V.4
Services Needed and Received by CHIP Package C Members

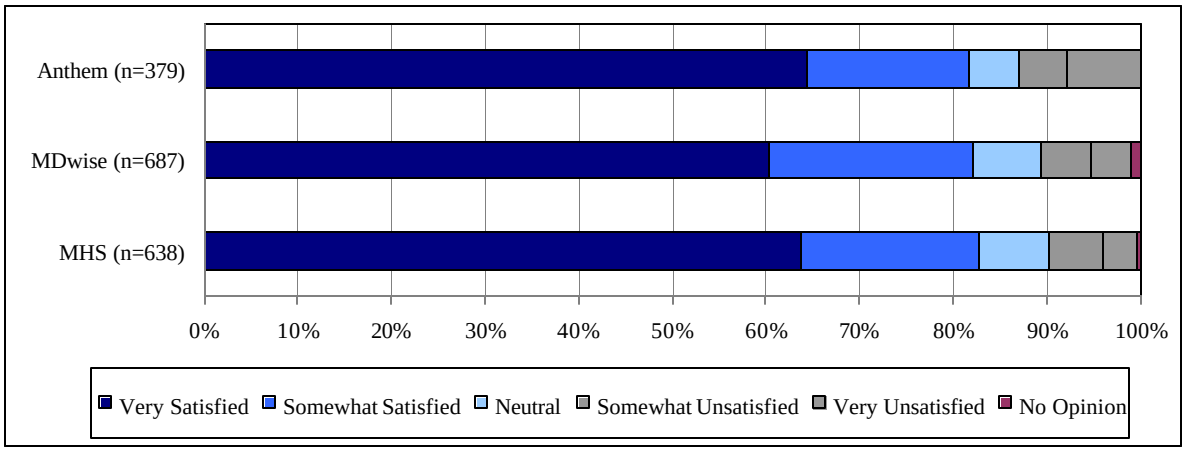
	Needed Service?	If Service was Needed, Did Member Receive Service?	
	(n= 1,755)	Yes	No
Doctor Visit: General Physical	88%	99%	1%
Doctor Visit: Sick Child	85%	99%	1%
Specialist Visit	40%	97%	3%
Obtained Prescription	83%	99%	1%
Emergency Room Visit	42%	98%	2%
Overnight Hospital Stay	8%	99%	1%
Outpatient Hospital Service	21%	99%	1%
Mental Health Services	14%	95%	5%
Waiver Program Services	1%	86%	14%
Transportation to & from Doctor	3%	88%	12%

Exhibit V.4 shows that more than eight out of ten parents indicated that their child needed a doctor's visit for a general physical, a doctor visit because their child was sick, and a prescription. Forty-two percent of respondents stated that they needed to take their child to the emergency room.

For eight of the ten services queried, respondents stated that their children received what they needed 95 percent or more of the time, which is indicative of sufficient access. For the two services where members received services a little less of the time (waiver services and transportation), very few parents actually stated that their child needed these services.

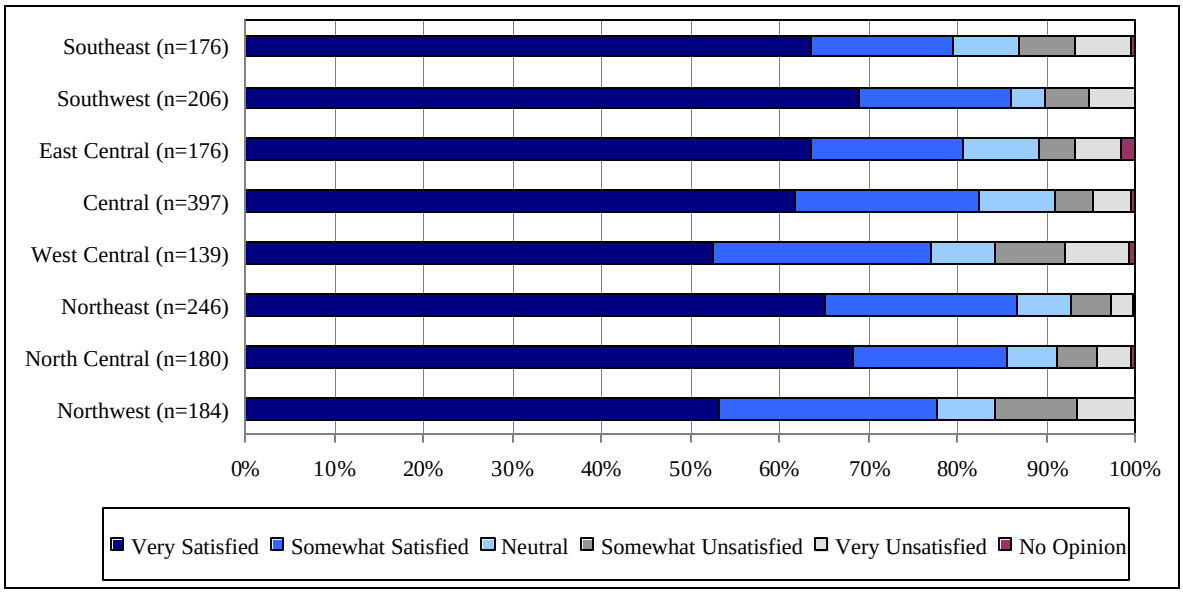
Parents were asked about the availability of doctors in the CHIP C program. B&A stratified responses both by region and by MCO. At least 60 percent of CHIP C enrollees at each MCO were "Very satisfied" with physician availability and more than 80 percent at each MCO were either "Very" or "Somewhat" satisfied. Although dissatisfaction overall was low, it was highest among Anthem's members (12.9% stated they were "very" or "somewhat" dissatisfied) as compared to MDwise (9.7%) or MHS (9.4%) members.

Exhibit V.5
Satisfaction with the Availability of Doctors, by MCO



At the region level, members that were "Very" or "Somewhat" satisfied with the availability of doctors ranged from 78 percent (Northwest and West Central Regions) to 87 percent (Northeast Region). There were some differences in the rates of dissatisfaction across regions, from a low of 6.9 percent (Northeast Region) to a high of 15.8 percent (Northwest Region).

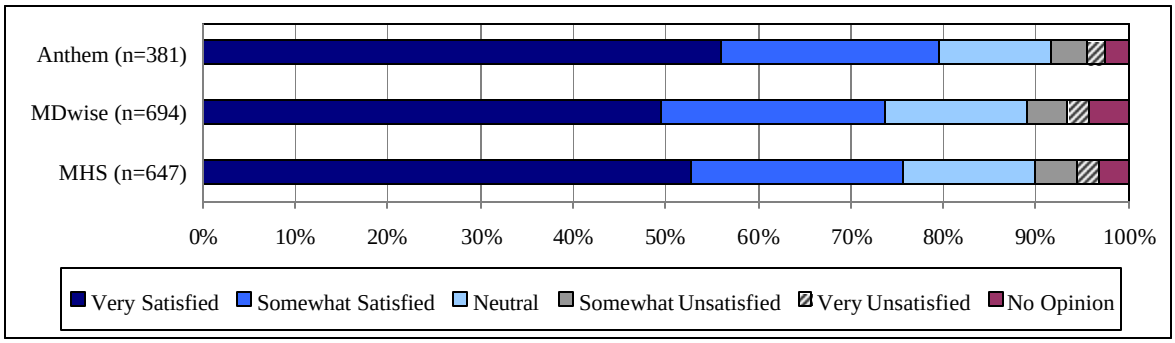
Exhibit V.6
Satisfaction with the Availability of Doctors, by Region



Satisfaction with MCO Customer Service

Satisfaction with customer service varied to some degree by each MCO. The percent of members "Very Satisfied" with their MCO's customer service ranged from 50 percent for MDwise to 56 percent for Anthem. The combination of "Very" and "Somewhat" satisfied ranged from 74 percent for MDwise to 80 percent for Anthem. All three MCOs had "Very" or "Somewhat" dissatisfied rates that were low—at or below seven percent among all respondents.

Exhibit V.7
Satisfaction with Customer Service Provided, by MCO



Qualitative Feedback on the CHIP Package C Program

Parents were also given the opportunity to provide any qualitative feedback they wanted to write about pertaining to their experience with CHIP Package C/Hoosier Healthwise. From the 1,755 respondents, there were 1,213 unique comments. Parents could provide both positive and negative feedback and could address multiple topics in their feedback. Each of these is counted as a unique comment.

Exhibit V.8
Summary of Qualitative Comments from Survey Respodents

Categories of Comments	Percent of All Positive Comments	Percent of All Negative Comments
Comment on Satisfaction with the Program	**91.0%**	**5.1%**
Affordability	**4.2%**	**15.9%**
Benefits	**2.9%**	**49.3%**
Doctor Availability	0.9%	18.7%
Satisfaction with Doctor/Facility	1.5%	10.8%
Prescription Coverage/Cost	0.0%	12.4%
Medical Need Not Covered	0.5%	7.4%
Other	**1.9%**	**29.7%**
Administration (e.g. caseworkers, application process, billing)	0.3%	13.1%
Policies/Procedures	0.0%	5.7%
Customer Service at MCO	1.5%	11.0%

The ratio of positive to negative feedback provided was 53 to 47 percent. On a per 100 respondent basis, positive comments were reported by 37 out of every 100 respondents and negative comments were reported by 32 out of every 100. Among the positive comments, 91 percent stated general satisfaction with the program or mentioned satisfaction with the CHIP program or Hoosier Healthwise in particular. Benefits were mentioned in half of the negative comments, in particular doctor availability, satisfaction with their doctor, a prescription not covered or too expensive, or another medical need not covered. Administrative items and MCO customer service represented 30 percent of the negative comments. Some examples of actual written responses appear below.

"Without my child's health insurance, I would be at a loss. There's no way I could afford health insurance."

"Affordable for working moms. Thanks."

"All my children are on Hoosier Healthwise and we have no problem with the program or speaking with people from the program. Thanks!!"

"All services have been great. I am very thankful this was available for my children as a working single parent. Thanks."

"As a single parent working at a company with no available insurance, this is my only option. The monthly fee is hard to cover some months."

"Being a single mother I don't have insurance but thanks for making if affordable for my son. Thanks."

"I am a single parent father. Being on disability, CHIP is very good for me at a payment of $22 [per month]."

"Both of my children have had outpatient surgeries and other needed medical treatments over the years through the Hoosier Healthwise program. It's been a blessing to us to have this program."

"CHIP has been great for my family because my husband is self-employed and we could not afford insurance any other way. We have been completely satisfied with the service. Thank you."

"CHIP is very affordable for my situation. I'm very pleased that my state "Indiana" has introduced CHIP."

"Excellent program. Administrative process is smooth. I appreciate not dealing with deductibles and copays and charges from MDs above the customary and reasonable."

"A good program. Need more choice of a doctor. Have only one or two in my city."

"I am happy CHIP/Hoosier Healthwise has made my child's health insurance much more affordable. Thank you!"

"I am very blessed to have this program to cover my children's health care needs."

"I don't know what I would have done without it. It's an awesome coverage for lower income families."

"Everything has been wonderful, both with CHIP for our girls & HIP for my husband & I. We could not afford health insurance otherwise."

"We appreciate the opportunity to have insurance for our children. Thank you."

"Very affordable - a great relief to have my child insured! Thanks!"

Feedback on the Awareness of the Healthy Indiana Plan (HIP)

Because the income threshold for CHIP Package C (250% of the Federal Poverty Level) is close to the income threshold for the HIP (200% of the FPL), many of the parents of CHIP members may themselves be eligible for the HIP.

The survey asked parents a few questions about their awareness of the HIP. Awareness of the HIP is quite high among CHIP parents. Two-thirds of the respondents (67%) are aware of the HIP while 33 percent are not aware. Of those that are aware of the program, 47 percent have applied to the program and 53 percent have not applied.

Among the 47 percent that have applied for the HIP (n=536),

- 55.4% that have applied are enrolled
- 42.2% that have applied and not enrolled
- 2.4% did not respond

Therefore, among all respondents to this survey (n=1,755), 16.9 percent of parents of children enrolled in CHIP Package C are also enrolled in the HIP. One-third of all respondents remain uninsured. Overall, the source of health insurance among CHIP Package C parents is as follows:

- Uninsured (33.7%)
- Enrolled through an employer's plan (31.4%)
- Enrolled in the HIP (16.9%)
- Enrolled through "other" insurance (10.7%)
- Purchased an individual insurance policy (5.1%)
- Did not respond (2.2%)

Appendices

APPENDIX A
Tables of Service Use Rates by Demographic Cohort in the CHIP

Service Use Results by Age Cohort
Service Use Results by Race/Ethnicity Cohort
Service Use Results by MCO
Service Use Results by Region

Service Use Results for CHIP Members by Age Cohort

	All	Age 5 and Younger	Age 6 to 12	Age 13 to 18
Number of Members in Study in FFY 2008	54,912	8,923	27,110	18,877
Number of Members in Study in FFY 2009	52,926	8,121	26,154	18,651

	Percent of Members in the Cohort that Used the Service in the Year *Beside each percentage is the difference between the cohort rate and the statewide rate.*					
Primary Care Visits						
FFY 2008	73%	82%	9	71%	(2)	72%	(1)
FFY 2009	73%	82%	9	71%	(2)	73%	0
EPSDT Visits						
FFY 2008	31%	64%	33	28%	(3)	21%	(10)
FFY 2009	38%	68%	30	35%	(3)	28%	(10)
Emergency Room Visits						
FFY 2008	26%	34%	8	23%	(3)	27%	1
FFY 2009	28%	35%	7	25%	(3)	29%	1
Preventive Dental Visits						
FFY 2008	65%	45%	(20)	75%	10	62%	(3)
FFY 2009	67%	47%	(20)	76%	9	64%	(3)
Pharmacy Script						
FFY 2008	70%	76%	6	67%	(3)	69%	(1)
FFY 2009	73%	78%	5	72%	(1)	74%	1
Specialist Physician Visits						
FFY 2008	9%	10%	1	7%	(2)	10%	1
FFY 2009	9%	11%	2	7%	(2)	9%	0
Outpatient Hospital Services						
FFY 2008	23%	26%	3	20%	(3)	27%	4
FFY 2009	27%	29%	2	23%	(4)	31%	4
Inpatient Hospital Stay						
FFY 2008	1.4%	1.8%	0.4	0.9%	(0.5)	1.9%	0.5
FFY 2009	1.4%	1.7%	0.3	1.0%	(0.4)	1.9%	0.5

Members included in this analysis were those that had at least nine months of enrollment in Hoosier Healthwise in the FFY.
At least a portion of this time was enrollment in the CHIP.

Service Use Results for CHIP Members by Race/Ethnicity Cohort

	All	Caucasian	African American	Hispanic	Other
Number of Members in Study in FFY 2008	54,912	38,206	8,827	6,653	1,226
Number of Members in Study in FFY 2009	59,926	36,691	8,409	6,422	1,404

	Percent of Members in the Cohort that Used the Service in the Year *Beside each percentage is the difference between the cohort rate and the statewide rate.*								
Primary Care Visits									
FFY 2008	73%	77%	4	62%	(11)	68%	(5)	67%	(6)
FFY 2009	73%	77%	4	62%	(11)	67%	(6)	70%	(3)
EPSDT Visits									
FFY 2008	31%	28%	(3)	34%	3	41%	10	39%	8
FFY 2009	38%	35%	(3)	41%	3	46%	8	48%	10
Emergency Room Visits									
FFY 2008	26%	26%	0	28%	2	25%	(1)	18%	(8)
FFY 2009	28%	28%	0	29%	1	26%	(2)	22%	(6)
Preventive Dental Visits									
FFY 2008	65%	65%	0	65%	0	69%	4	65%	0
FFY 2009	67%	67%	0	67%	0	71%	4	68%	1
Pharmacy Script									
FFY 2008	70%	73%	3	61%	(9)	62%	(8)	62%	(8)
FFY 2009	73%	77%	4	65%	(8)	65%	(8)	70%	(3)
Specialist Physician Visits									
FFY 2008	9%	10%	1	6%	(3)	7%	(2)	6%	(3)
FFY 2009	9%	10%	1	6%	(3)	6%	(3)	7%	(2)
Outpatient Hospital Services									
FFY 2008	23%	26%	3	17%	(6)	18%	(5)	19%	(4)
FFY 2009	27%	30%	3	19%	(8)	19%	(8)	22%	(5)
Inpatient Hospital Stay									
FFY 2008	1.4%	1.4%	0.0	1.3%	(0.1)	1.1%	(0.3)	0.6%	(0.8)
FFY 2009	1.4%	1.4%	0.0	1.6%	0.2	1.2%	(0.2)	1.0%	(0.4)

Members included in this analysis were those that had at least nine months of enrollment in Hoosier Healthwise in the FFY.
At least a portion of this time was enrollment in the CHIP.

Service Use Results for CHIP Members by MCO

	All	Anthem	MHS	MDwise
Number of Members in Study in FFY 2008	54,912	10,307	16,906	25,436
Number of Members in Study in FFY 2009	59,926	11,297	17,370	21,564

	Percent of Members in the Cohort that Used the Service in the Year *Beside each percentage is the difference between the cohort rate and the statewide rate*						
Primary Care Visits							
FFY 2008	73%	72%	(1)	75%	2	71%	(2)
FFY 2009	73%	72%	(1)	75%	2	72%	(1)
EPSDT Visits							
FFY 2008	31%	33%	2	26%	(5)	33%	2
FFY 2009	38%	37%	(1)	32%	(6)	43%	5
Emergency Room Visits							
FFY 2008	26%	16%	(10)	25%	(1)	30%	4
FFY 2009	28%	24%	(4)	26%	(2)	31%	3
Preventive Dental Visits							
FFY 2008	65%	62%	(3)	66%	1	66%	1
FFY 2009	67%	65%	(2)	68%	1	69%	2
Pharmacy Script							
FFY 2008	70%	62%	(8)	69%	(1)	73%	3
FFY 2009	73%	73%	0	73%	0	73%	0
Specialist Physician Visits							
FFY 2008	9%	9%	0	9%	0	9%	0
FFY 2009	9%	9%	0	9%	0	9%	0
Outpatient Hospital Services							
FFY 2008	23%	16%	(7)	23%	0	26%	3
FFY 2009	27%	27%	0	26%	(1)	27%	0
Inpatient Hospital Stay							
FFY 2008	1.4%	1.1%	(0.3)	1.3%	(0.1)	1.4%	0.0
FFY 2009	1.4%	1.4%	0.0	1.4%	0.0	1.4%	0.0

Members included in this analysis were those that had at least nine months of enrollment in Hoosier Healthwise in the FFY. At least a portion of this time was enrollment in the CHIP.

Service Use Results for CHIP Members by Region

	All	Northwest	North Central	Northeast	West Central	Central	East Central	Southwest	Southeast
Members in Study in FFY 2008	54,912	6,701	5,521	6,722	4,435	15,306	4,635	6,591	4,918
Members in Study in FFY 2009	52,926	6,536	5,619	6,184	4,131	15,901	4,623	5,698	4,151
	Percent of Members in the Cohort that Used the Service in the Year								
Primary Care Visits									
FFY 2008	73%	70%	76%	71%	73%	69%	75%	80%	77%
FFY 2009	73%	71%	77%	71%	75%	69%	76%	79%	79%
EPSDT Visits									
FFY 2008	31%	25%	31%	23%	24%	40%	26%	34%	31%
FFY 2009	38%	31%	36%	35%	32%	43%	35%	40%	38%
Emergency Room Visits									
FFY 2008	26%	23%	20%	24%	30%	32%	30%	19%	25%
FFY 2009	28%	24%	22%	24%	31%	32%	31%	24%	27%
Preventive Dental Visits									
FFY 2008	65%	62%	70%	64%	63%	68%	67%	65%	60%
FFY 2009	67%	64%	69%	66%	64%	69%	71%	66%	65%
Pharmacy Script									
FFY 2008	70%	68%	68%	69%	72%	69%	73%	71%	72%
FFY 2009	73%	70%	72%	72%	76%	71%	77%	79%	77%
Specialist Physician Visits									
FFY 2008	9%	7%	7%	11%	7%	8%	11%	9%	9%
FFY 2009	9%	6%	8%	10%	7%	8%	13%	9%	11%
Outpatient Hospital Services									
FFY 2008	23%	21%	18%	23%	25%	25%	29%	20%	27%
FFY 2009	27%	24%	19%	24%	29%	26%	30%	32%	33%
Inpatient Hospital Stay									
FFY 2008	1.4%	1.5%	1.1%	1.5%	1.3%	1.5%	1.6%	1.0%	1.3%
FFY 2009	1.4%	1.5%	1.0%	1.4%	1.1%	1.6%	1.4%	1.7%	1.3%

Members included in this analysis were those that had at least nine months of enrollment in Hoosier Healthwise in the FFY.
At least a portion of this time was enrollment in the CHIP.

APPENDIX B
Survey Instrument Sent to Parents of CHIP Package C Members

SURVEY OF PARENTS/GUARDIANS OF CHILDREN ENROLLED IN INDIANA'S CHIP

The State of Indiana hired Burns & Associates to conduct an independent survey of parents/guardians of children enrolled in Indiana's Children's Health Insurance Program, also known as "CHIP" or "Hoosier Healthwise Package C". The CHIP Program was designed to assist families like yours obtain insurance for your children for a small monthly fee. In many cases, families do not have any other access to affordable health insurance other than through CHIP. We would like to ask you about health insurance options you may or may not have for your children and for yourselves as parents or guardians. The State also wants to hear from its Hoosier Healthwise members if they are happy with the program.

This is a short survey that will take about 5 minutes to complete. We appreciate your feedback. Please return your comments in the enclosed self-addressed stamped envelope. ***All responses are kept strictly confidential.*** Please send your survey back no later than ***December 9, 2009***.

*** The first set of questions is about your children and their access to health insurance or experience with CHIP. ***

1. How many children under the age of 19 are in your household? _____

2. How many of these children are enrolled in Indiana's CHIP? _____

3. Think back to the time before your child/children were enrolled in CHIP/Hoosier Healthwise. In the year before your child/children started in CHIP, which of the statements below best describes your child's health coverage? (*please check only one*)
   - ❑ My child/children had health insurance through my employer or my spouse's employer (this includes the military as an employer).
   - ❑ My child/children had health insurance through Hoosier Healthwise or Medicaid but there was no monthly fee for the insurance.
   - ❑ My child/children did not have health insurance.

4. When you decided to sign your child/children up for CHIP, which statement best describes your situation? (*please check only one*)
   - ❑ My child/children were on my employer's insurance. When I found out we could sign up with CHIP, I took my child/children off the employer's insurance and moved them to CHIP since it was cheaper.
   - ❑ My child/children did not have health insurance. When I decided to buy insurance, I could have signed up for insurance through my employer, but I went with the CHIP program since it was cheaper.
   - ❑ CHIP was the only option I had to get health insurance for my child/children.

5. A condition for you to sign up for CHIP was that you have to pay a monthly premium. Please rate your level of concern in your ability to pay the premium.
   ❑ Not too concerned ❑ Somewhat concerned ❑ Very concerned ❑ Don't know

6. In the CHIP, there are also some co-pays for things like prescription drugs and ambulance service. Have you delayed getting a service for your child or just not gotten one because you couldn't afford the co-pay? ❑ Yes ❑ No

7. Please place a check next to your satisfaction level with the Hoosier Healthwise plan you signed up with (Anthem, MHS or MDwise) in CHIP on the following features:

	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Unsatisfied	Very Unsatisfied	No Opinion
a. Customer Service provided by the health plan	❑	❑	❑	❑	❑	❑
b. The doctors available to my child/children	❑	❑	❑	❑	❑	❑

Please turn the page to finish the survey.

8. Think back to all of 2009 and the medical services your child/children needed and those that you actually received from the CHIP/Hoosier Healthwise program.

   First, in Column A, check all the services that your child/children needed this year. If you have more than one child enrolled in CHIP, place a check if at least one of your children needed the service. Leave blank the ones that don't apply to you.

   Then, in Column B, check if your child received the service.

Column A Check all services that your child needed in 2009	**Column B** Check Yes or No if your child received the service they needed
❑ Visit to the emergency room	❑ Yes ❑ No
❑ Visit to a family doctor or pediatrician for a general physical	❑ Yes ❑ No
❑ Visit to a family doctor or pediatrician because child was sick	❑ Yes ❑ No
❑ Visit to a specialist	❑ Yes ❑ No
❑ Obtained a prescription	❑ Yes ❑ No
❑ Had a stay overnight in the hospital	❑ Yes ❑ No
❑ Had a service in the outpatient part of the hospital	❑ Yes ❑ No
❑ Services related to mental health (psychologist, psychiatrist, etc.)	❑ Yes ❑ No
❑ Services related to being on a waiver program	❑ Yes ❑ No
❑ Transportation to and from doctor appointments	❑ Yes ❑ No

9. Please tell us anything else, good or bad, we should know about your experience with CHIP/Hoosier Healthwise.

   _____

   _____

*** The remaining questions on the survey ask you as the parent or guardian your own access to health insurance. ***

10. Parents of children enrolled in Indiana's CHIP are eligible for Indiana's new Healthy Indiana Plan (HIP). Are you aware of HIP?
    ❑ Yes (*please go to Question 11*) ❑ No (*please go to Question 12*)

11. Have you applied for HIP? ❑ Yes ❑ No
    If you have applied, are you enrolled in HIP now? ❑ Yes ❑ No

12. If you are not enrolled in HIP, do you have health insurance from some other source?
    ❑ Yes (*please go to Question 13*) ❑ No

13. How do you get your own health insurance? *(please check only one)*
    ❑ An employer-sponsored health plan (my employer or a spouse's employer)
    ❑ An individual policy with a health plan
    ❑ Other (please specify) _____

The survey ends here. Thank you for participating.
Please return your survey form in the stamped return envelope that has been provided.