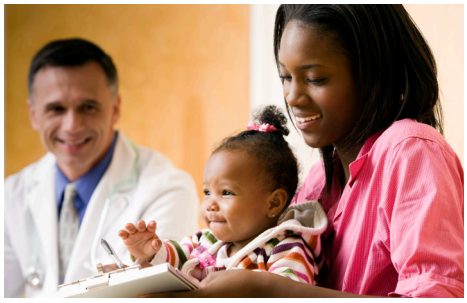
# Independent Evaluation of Indiana's Children's Health Insurance Program

Final Report - April 2020

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**ACKNOWLEDGMENTS**

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# Executive Summary

## EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) experienced an increase in enrollment of 0.8 percent in Calendar Year (CY) 2019 with year-end enrollment at 113,675[1] members compared to 112,765 at the end of CY 2018. Enrollment in the program has grown steadily over the last three years by 12.3 percent. The current enrollment is the all-time high since the program began in 1998.

At the end of CY 2019, 67.4 percent of enrollees were in the MCHIP portion and 32.6 percent were in the SCHIP portion of the program. Eligibility for CHIP depends on the child's age as well as the family's income. MCHIP (Package A) is the entitlement portion of the program and was put in place at the beginning of the program. SCHIP (Package C) is the name of the non-entitlement portion of the program. SCHIP was introduced in two phases (Package C original and Package C expansion).

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

*Includes children without any other insurance; otherwise, child is considered Medicaid eligible.
**Newborns below 208% of FPL are considered eligible for Medicaid

The enrollment changes over CY 2019 are as follows:

- MCHIP (CHIP Package A) increased 0.5 percent to 76,660 children in December 2019
- SCHIP (CHIP C original) decreased 16.0 percent to 20,438 children in December 2019
- SCHIP (CHIP C expansion) grew 36.2 percent to 16,577 children in December 2019

Growth in Indiana's CHIP over the last 20 years enabled the State to lower its uninsured rate among children in low-income families. Citing the most recent year's Census Bureau statistics, Indiana's uninsured rate among children in families below 250 percent of the Federal Poverty Level (FPL) is now 6.9 percent which is lower than the national average of 7.5 percent. However, Indiana is ranked 32nd lowest among states on this statistic.

Some children are continuously enrolled in CHIP for long lengths of time while others turn over depending upon the financial status of the family. There were 113,675 CHIP enrollees at the end of 2019, but there were 185,350 children enrolled in the program for at least some portion of the year.

Enrollment in CHIP is spread evenly throughout the state, but there is a higher distribution of minorities in Indiana's CHIP than the overall population of children ages 18 and younger. Just under half of the children enrolled in the CHIP are between the ages of 6 and 12. Enrollment by age is uneven because children under age 6 are eligible for regular Medicaid at higher family income levels. Teenagers represent 36 percent of CHIP enrollees while the remaining 16 percent are under age 6. This distribution has been the case since the CHIP was introduced.

[1] Enrollment figures retrieved by B&A come from data in the Office of Medicaid Policy and Planning's Enterprise Data Warehouse. The OMPP also publishes monthly CHIP enrollment reports on its website. Due to retroactive eligibility and the fact that B&A had access to data after the OMPP enrollment report was released, the numbers shown in this report differ from the OMPP's December 2019 enrollment report.

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

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

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for CY 2019. B&A has conducted this annual study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

## Background on Indiana's CHIP

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

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

**Premiums Charged to Families in Indiana's CHIP Package C**

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

In a report released by the Kaiser Family Foundation in March 2019, it was found that Indiana's program resembles many other state CHIP programs in its design features as well. Among the CHIP programs nationwide, 22 states (including Indiana) require families to pay premiums for their children's coverage when the family income is above 200% FPL. States do differ on co-pays required in their programs. Like 16 other states, Indiana requires co-pays on some pharmacy scripts. But Indiana does not require co-pays on emergency room visits or non-preventive physician visits like some other states do.

## CHIP at the Federal Level

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

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

than the FMAP for Medicaid. This is often referred to as the enhanced FMAP. Prior to the Affordable Care Act (ACA), the enhanced FMAP was approximately 10 percentage points higher for CHIP than the regular FMAP for Medicaid. The ACA increased each state's enhanced FMAP rate for CHIP by 23 percentage points for the years FFY 2016 through FFY 2019. This "bump" in the enhanced FMAP is reduced to an 11.5 percentage point bump beginning in FFY 2020. Starting in FFY 2021 and continuing through the remaining years where funding is authorized for CHIP, the Act returns the FMAP for CHIP to enhanced FMAP rate for CHIP that was in place prior to the ACA.

For illustration, for every $100 spent in Indiana's CHIP, in FFY 2019 the state's responsibility was 83 cents. In FFY 2020, the state share is $12.41. In FFY 2021, the state's share will be $23.92.

**Member Satisfaction**

The OMPP requires the Hoosier Healthwise MCEs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. In this past year's survey, on a 10-point scale with 10 being the best score, the percent of members giving each MCE a score of 8, 9 or 10 are tracked. Across the MCEs, the percentage of members giving these scores are:

- For Rating of Health Plan, 83 to 89 percent (last year 86 to 90 percent)
- For Rating of Health Care, 86 to 89 percent (last year 87 to 90 percent)
- For Rating of Personal Doctor, 88 to 90 percent (last year 88 to 92 percent)
- For Rating of Specialist, 87 to 93 percent (last year 84 to 94 percent)

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

- For Getting Needed Care, 84 to 88 percent (last year 83 to 89 percent)
- For Getting Care Quickly, 89 to 93 percent (last year 90 to 91 percent)
- For How Well Doctors Communicate, 94 to 96 percent (last year 92 to 96 percent)
- For MCE Customer Service, 85 to 91 percent (last year 87 to 91 percent)

**Access to Services**

B&A reviewed access by examining where CHIP members live and the providers under contract with the MCEs to offer primary care and dental services. We matched claims of actual services received in FFY 2019 between where the member lives and where the closest provider is located to each member. B&A found each provider's location and drew a 10-mile coverage radius to assess the availability of primary care and dental providers to CHIP members. On a statewide level, there are very few gaps. In fact, only 0.2 percent of all CHIP members live more than 10 miles from an available primary medical provider (finding was 0.3 percent last year). There are 0.9 percent of CHIP members who live more than 10 miles from an available dentist (finding was 1.1 percent last year).

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

Separately, B&A computed the average distance that members actually travelled to their providers of choice. An average driving distance was computed for CHIP members in each of the 92 counties. The OMPP targets a threshold of no more than 30 miles for members to travel to seek primary care or dental care. For primary care, there are five counties where members, on average, travelled more than 30 miles (the county with the maximum distance was 34 miles). For dental care, there are 10 counties where members, on average, travelled more than 30 miles (the county with the maximum distance is 39 miles). The maps that show the results at the individual county level appear in Chapter III.

**Outcomes**

The OMPP requires its MCEs in Hoosier Healthwise to measure health outcomes for children. Many of the measures that the MCEs report on are Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are nationally-recognized measures that health plans report on and are subject to an external auditor to compute. The OMPP compares the results of the HEDIS measures across the four MCEs and has set performance targets against national benchmarks for Medicaid health plans. B&A reviewed 14 HEDIS measures in this evaluation that are commonly used to assess the health outcomes for children. Some of the key findings on selected HEDIS measures are reported in Chapter V.

- For access to primary care practitioners, all MCEs reported at or near 94 percent of its members age 12 to 24 months have access; for children age 25 months to six years, all MCEs except CareSource had 85 percent access; for the two groups of children age 7 to 11 and age 12 to 19, all MCEs except CareSource reported 90 to 91 percent. CareSource was lower than its peers.

- For well child visits received, children in the first 15 months of life are measured to determine the percentage who received six or more visits. There is variation across the MCEs on the results of this measure, between 57 and 73 percent. All MCEs aw a decrease in this measure from the prior year.

- For children ages 3 to 6, the rate of annual well visit across the MCEs is 65 (CareSource) to 81 (MDwise) percent. For annual adolescent well care annual visits, the rate across MCEs is 47 (CareSource) to 69 (MDwise) percent.

- There has been significant improvement in the HEDIS measure related to medication management for children with asthma for children ages 5 to 11 and more modest improvement for children ages 12 to 18. The adherence rates for the younger children among the three legacy MCEs was 76 to 84 percent; for the older children, from 63 to 72 percent.

- The rates for follow-up visits after an inpatient stay for mental illness have been consistent across the MCEs. In the most recent year, the rates decreased from the prior year due to a definition change in how the measure is computed. This also impacted health plans nationally. Another HEDIS measure tracks follow-up care for children prescribed ADHD medication. One measure looks at the initiation phase while another measures the continuation and maintenance phase. There has been little change in the last five years on these measures and this is an opportunity for improvement.

- B&A compared each Indiana Medicaid's MCE results against the results reported for health plans nationally for the most recent HEDIS period (2018). Among the 14 measures reviewed, Anthem had ten in which its rates exceeded the national median values, MDwise had eight, MHS had six and CareSource had one. The areas of greatest opportunity for the Hoosier Healthwise MCEs when compared to their peers nationally are in the measures pertaining to access to primary care practitioners and well child visits.

## Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency department visits, preventive dental visits, and had a pharmacy prescription for the periods FFY 2017, FFY 2018 and FFY 2019. The overall rate of usage for all of these services has remained fairly steady, although the rate of preventive dental visits has decreased some.

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

| | FFY 2017 | FFY 2018 | FFY 2019 |
|---|---|---|---|
| Primary Care Visit | 82% | 82% | 82% |
| Emergency Room Visit | 22% | 23% | 22% |
| Preventive Dental Visit | 64% | 62% | 62% |
| Pharmacy Script | 67% | 65% | 66% |

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

The key findings from studying this three-year set of data are shown below; however, these same variations have also held true for the past five years in CHIP (even if actual values have changed slightly):

- Primary care visits were more prevalent among the youngest members, as 92 to 93 percent of children ages 5 and younger had a visit in each of the three years studied. The percentage was lower for children in the other age groups (near 81% for age 6-12 and near 78% for age 13-18).

- When comparing the rates across race/ethnicities, the usage rate was similar for all groups studied except African-American children who were eight to nine percentage points lower each year.

- In addition to more actual children having a primary care visit, there is also a disparity in the number of visits per 1,000 CHIP children for primary care. The rate for Caucasian children is near 290 visits per 1,000 children each month, meaning that in any given month of the year, 2.9 children out of 10 had a visit for primary care. This rate is 33 to 52 percent higher than the rate for minorities depending on the minority group and the year examined.

- The use of the emergency department (ED) has been consistent in the last three years (20% to 22% of CHIP children used the ED, on average, each year). The usage rate is similar across the MCEs. Children ages five and under used the ED the most (29% to 32% each year). There is little variation found in ED use between Caucasian and African-American CHIP members, but Hispanic members and those of other races used the ED less.

- There is an opportunity for the MCEs to educate members on the appropriate use of the ED. Using software licensed to the OMPP from 3M, B&A assessed the rate of potentially preventable ED visits against those that were appropriate to the ED setting. Using data from CY 2018 for all children in Hoosier Healthwise (not just CHIP), 84 percent of visits for infants were deemed potentially preventable; for age 1 to 5, 74 percent; for age 6 to 18, 64 percent.

- Hispanic CHIP children were more likely than children of other races/ethnicities to have a preventive dental visit (69% to 72% each year) than other race/ethnicities (58% to 66%).

- Caucasian CHIP members have, over the three years, 40 percent more prescriptions than African-American children and more than twice the number that Hispanic children have. Fewer teenage CHIP members have a script each year than other age groups, but those that do have more utilization of pharmacy than the children at younger ages.

# I

# Introduction

# CHAPTER I: INTRODUCTION

Each year, an independent evaluation of Indiana's Children's Health Insurance Program (CHIP) is conducted as required by Indiana Code 12-17.6-2-12 and is due to the Legislature by April 1. Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2019. B&A has conducted this study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

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

- The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009[2] extended the program through Federal Fiscal Year (FFY) 2013.
- The Patient Protection and Affordable Care Act (ACA) of 2010 extended CHIP funding through FFY 2015.
- The Medicare Access and CHIP Reauthorization Act of 2015 extended CHIP funding for another two years through FFY 2017.
- The HEALTHY KIDS[3] Act of 2017 reauthorized federal funding for CHIP for six years from FFY 2018 through FFY 2023.
- On February 9, 2018, the Bipartisan Budget Act of 2018 provided appropriations for CHIP for FFY 2024 through FFY 2027.

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states subject to an annual cap. In the CHIP, however, the federal match assistance percentage (FMAP) for states is higher than the FMAP for Medicaid. This is often referred to as the enhanced FMAP. Prior to the ACA, the enhanced FMAP was approximately 10 percentage points higher for CHIP than the regular FMAP for Medicaid. The ACA increased each state's enhanced FMAP rate even further. Beginning in FFY 2016 and continuing through FFY 2019, the "bump" in FMAP was 23 percentage points. The bump is reduced to 11.5 percentage points in FFY 2020. Then, the bump goes away but the enhanced FMAP remains for CHIP. This means that for every $100 spend on Indiana's CHIP, the state share is as follows:

| FFY | With Enhanced FMAP | With Enhanced FMAP + temporary bump |
|---|---|---|
| 2019 | $23.83 | $0.83 |
| 2020 | $23.91 | $12.41 |
| 2021 | $23.92 | Not applicable |

[2] CHIPRA 2009 changed the acronym for the federal program from S-CHIP to CHIP.
[3] Acronym for "Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable".

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

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

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 158[4] percent of the Federal Poverty Level, or FPL ($40,685 per year for a family of four in 2019) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

- CHIP Package C (the non-entitlement portion, or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.

    - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 158 percent up to 200 percent of the FPL ($51,500 per year for a family of four in 2019).

    - The second portion (referred to as SCHIP (Package C) Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL ($64,375 per year for a family of four in 2019).

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

In March 2019, the Kaiser Family Foundation released a report in which the 50 states (and District of Columbia) were surveyed to compare Medicaid and CHIP eligibility policies.[5] As of January 2019, 49 states cover children with incomes at or above 200 percent of the FPL. Of these, 19 states extend eligibility to at least 300 percent of the FPL.

Among the CHIP programs nationwide, 22 states (including Indiana) require families to pay premiums for their children's coverage. The premiums are usually on a sliding scale based on the family's FPL. There are 23 states (including Indiana) who charge a premium to families with incomes at 200 percent of the FPL. Among the states that do charge a premium, at this FPL the range of the monthly premium is from $9 to $50. Indiana's rates are $33 for one child in the family and $50 for two or more children.

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

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

[5] Brooks, T., Roygardner, L., and Artiga, S. (March 2019) *Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies as of January 2019: Findings from a 50-State Survey.* Washington, DC: Georgetown University Center for Children and Families and The Kaiser Family Foundation.

- The ability to submit applications online (50 states);
- The ability to apply by telephone (46 states);
- Processing automated renewals (46 states);
- Co-pays charged for generic drugs (16 states) and brand name drugs (17 states)

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

- The required period of no insurance prior to enrolling (also known as the "going bare" period) is three months in Indiana. There are 36 states with no waiting period.

- Enrollment is continuous for 12 months, regardless of circumstance in 26 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

- "Real time" eligibility determination (that is, in 24 hours or less) is available in 46 states. In 16 states (including DC), more than half of the determinations are done in real time. Indiana is one of 30 states where less than 50 percent of the determinations are done in real time.

- Indiana does not impose co-pays for non-emergent ER visits (13 states do), non-preventive physician visits (18 states do), or inpatient hospital visits (13 states do).

As of December 2019, enrollment in Indiana's CHIP was at 113,765, a 0.8 percent increase over the prior year's membership of 112,765 and its highest level ever since the start of the program:

- MCHIP (Package A) enrollment was 76,660 (up 0.5% from December 2018)
- Enrollment in the initial group of SCHIP (Package C) members was 20,438 (down 16.0% from December 2018)
- Enrollment in the 2008 expansion group of SCHIP (Package C) members was 16,577 (up 36.2% from December 2018)

More enrollment statistics appear in Chapter II of this report.

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

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

Among children in families with incomes below 250 percent of the FPL, Indiana's most recent uninsured rate using a three-year average is 6.9 percent which is lower than the national weighted average rate of 7.5 percent. When ranked among states, Indiana's rate for this population is the 32$^{nd}$ lowest uninsured rate. When examining the three-year trends, Indiana and the nation as a whole are near the seven percent range.

**Exhibit I.1**
**Uninsured Rate Among Children in Families**
**Below 250% of Federal Poverty Level**

| Uninsured Rate as Reported in | Indiana's Rate | U.S. Average Rate | Rank Among States |
|---|---|---|---|
| Avg of 3 year CPS 2015, 2016, 2017 | 7.4% | 7.4% | 34 |
| Avg of 3 year CPS 2016, 2017, 2018 | 6.6% | 7.2% | 32 |
| Avg of 3 year CPS 2017, 2018, 2019 | 6.9% | 7.5% | 32 |

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

The uninsured rate in the state varies by family income level. Exhibit I.2 below shows the uninsured rate among families up to 250 percent of the FPL (who may be eligible for Indiana's CHIP) and the rate among families above the 250 percent of FPL level. For example, whereas the average rate for three CPS years 2017, 2018 and 2019 showed an uninsured rate among all children of 4.3 percent, the rate was 7.1 percent among children who may be CHIP-eligible and 2.0 percent among children who are not CHIP-eligible. In reviewing the column that shows the percent of all uninsured children, the CPS suggests that 53,861 children who are currently uninsured (74.9% of all uninsured children) may be eligible for Indiana's CHIP (at least based on family income, other criteria may preclude eligibility).

**Exhibit I.2**
**Child Uninsured Rates (Age 0-18) by Family Income in Indiana**

| Current Population Survey Years | Total Children 0-18 | Total Insured | Total Uninsured | Uninsured Rate | Percent of All Uninsured Children |
|---|---|---|---|---|---|
| Total for Children that may be Eligible for Indiana's CHIP (Income up to 250% FPL) | | | | | |
| Avg CPS 2015-2017 | 855,926 | 792,436 | 63,489 | 7.4% | 66.0% |
| Avg CPS 2016-2018 | 798,180 | 745,701 | 52,479 | 6.6% | 70.9% |
| Avg CPS 2017-2019 | 763,861 | 710,000 | 53,861 | 7.1% | 74.9% |
| Total for Children Not Eligible for Indiana's CHIP (250% and above) | | | | | |
| Avg CPS 2015-2017 | 828,607 | 795,914 | 32,693 | 3.9% | 34.0% |
| Avg CPS 2016-2018 | 863,601 | 842,099 | 21,503 | 2.5% | 29.1% |
| Avg CPS 2017-2019 | 904,002 | 885,943 | 18,060 | 2.0% | 25.1% |
| **All Children** | | | | | |
| Avg CPS 2015-2017 | 1,684,533 | 1,588,351 | 96,181 | 5.7% | 100.0% |
| Avg CPS 2016-2018 | 1,661,782 | 1,587,799 | 73,982 | 4.5% | 100.0% |
| Avg CPS 2017-2019 | 1,667,864 | 1,595,943 | 71,921 | 4.3% | 100.0% |

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

## Indiana's CHIP is Integrated with Other Medicaid Programs

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

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

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

**Exhibit I.3**
**Benefits Offered to Indiana's CHIP Enrollees in the Hoosier Healthwise Program**

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

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

The other design difference between CHIP and traditional Medicaid is that families of children enrolled in SCHIP (Package C) are required to pay a monthly premium. The premium varies by the income level and the number of children covered in the family as outlined in Exhibit I.4 below.

**Exhibit I.4**
**Monthly Premiums Charged to Families in Indiana's SCHIP Package C**

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

## Expenditures in Indiana's CHIP

As stated previously, beginning in FFY 2016 and running through FFY 2019, the ACA increased each state's enhanced FMAP rate by 23 percentage points. This means that in FFY 2019, the state's share for every $100 spent on the CHIP was 83 cents. In FFY 2020, the state share moves up to $12.41. In addition to the higher federal match rate, for CHIP Package C the state's outlay is further reduced by premiums paid by parents. There are no premiums charged to parents for children enrolled in CHIP Package A.

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

The largest category of expenditures made in the fee-for-service program (i.e., outside of the MCE payments) is the mental health rehabilitation services. There are also some high-cost pharmaceuticals that the OMPP pays outside of managed care. Other services may also be paid fee-for-service in the CHIP if an enrollee utilizes a service during the short time period before they have selected which MCE to join.

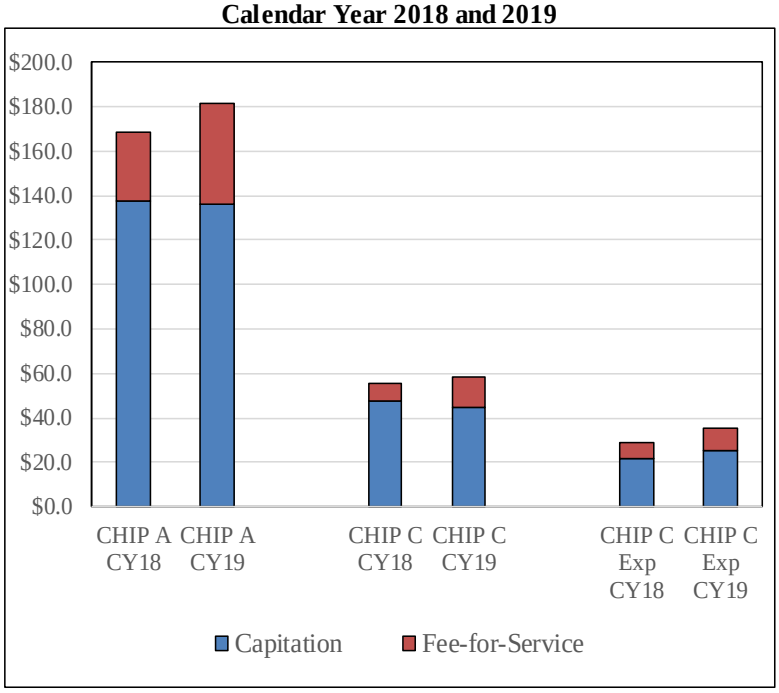
B&A examined expenditures made on behalf of CHIP members from data included in the state's data warehouse. Total expenditures in the CHIP were $252.8 million in CY 2018 and $274.8 million in CY 2019. The CY 2019 may grow a bit as some additional fee-for-service claims are billed for this service period. In CY 2019, 75 percent of expenditures were made to the MCEs through the PMPM compared to 82 percent in CY 2018.

In CHIP Package A, total expenditures were $181.2 million in CY 2019, a 7.6 percent increase from CY 2017. The PMPM payment increased 8.2 percent, from $184.40 to $199.56.

In CHIP Package C, total expenditures were $58.1 million in CY 2019, an increase of 4.9 percent from CY 2018. The PMPM payment increased 7.9 percent, from $191.21 to $206.30.

In the expansion portion of CHIP Package C, total expenditures were $35.5 million in CY 2019, an increase of 22.6 percent from CY 2018. On a PMPM basis, however, the increase was 1.6 percent from $219.68 to $223.15. The PMPM amount only grew a modest amount because the enrollment in CHIP C Expansion grew in CY 2019.

**Exhibit I.5**
**Expenditures in Indiana's CHIP, in millions**
**Calendar Year 2018 and 2019**



# II

# Enrollment Trends in Indiana's CHIP

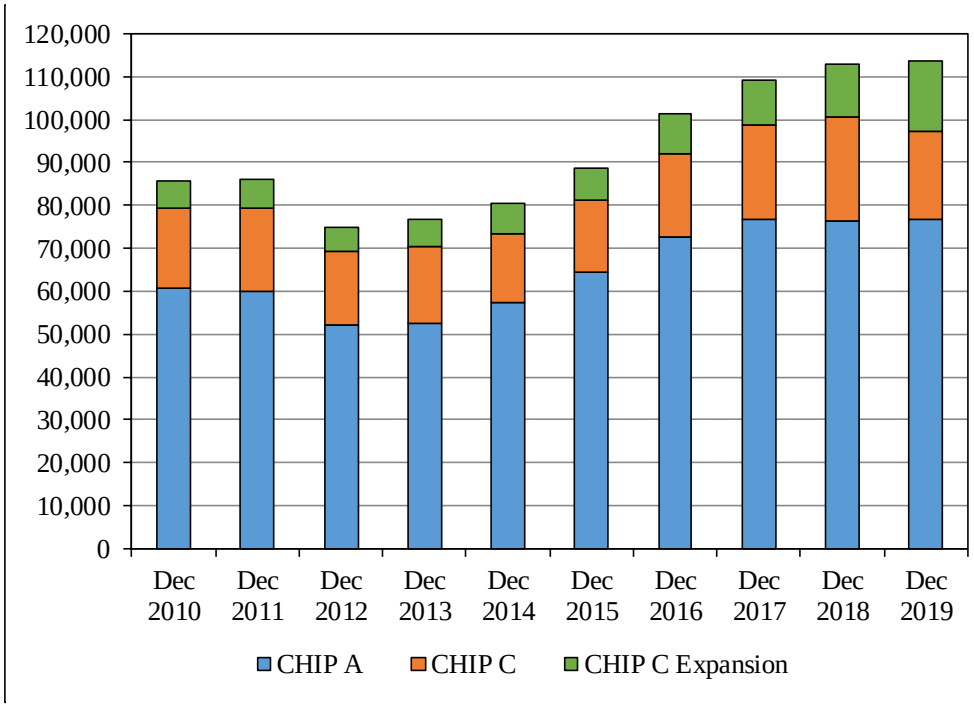
# CHAPTER II: ENROLLMENT TRENDS IN INDIANA'S CHIP

## Enrollment and Disenrollment Trends

Indiana's Children's Health Insurance Program (CHIP) experienced an increase in enrollment in 2019 with year-end enrollment at 113,675 members, a 0.8 percent increase from the Calendar Year (CY) 2018 year-end enrollment of 112,765. Enrollment has grown steadily in the program in the last three years with the December 2019 enrollment 12.3 percent higher than the December 2016 enrollment. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 158 percent of the federal poverty level (FPL), enrollment was effectively constant (an increase of 0.5 percent) from December 2018 to December 2019. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 158 to 200 percent of the FPL, enrollment decreased 16.0 percent during this time period. The SCHIP (Package C) Expansion group (201-250% of the FPL) had an enrollment increase of 36.2 percent during this time period.

At the end of CY 2019, 67.4 percent of enrollees were in the MCHIP portion and 32.6 percent were in the SCHIP portion of the program. The SCHIP portion of the program has enrolled between 27 and 33 percent of the members in each of the last ten years.

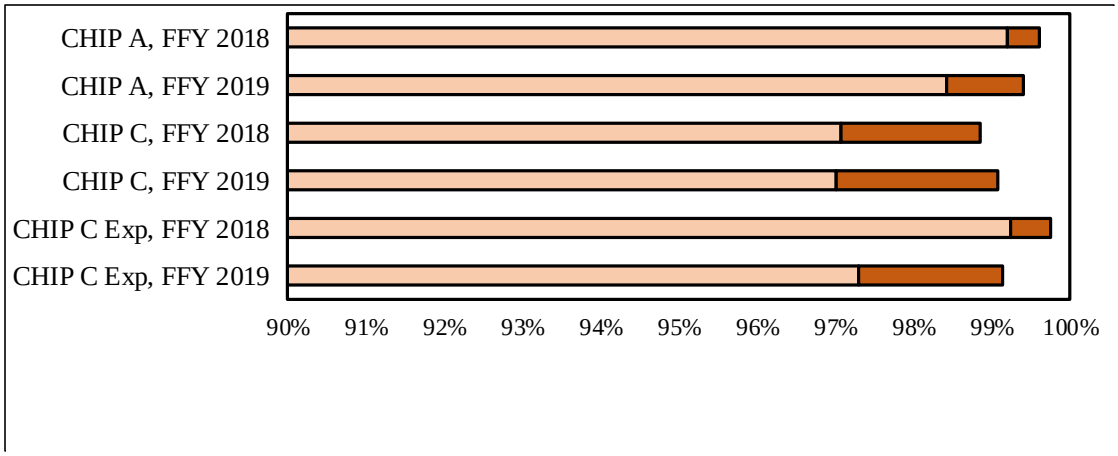
**Exhibit II.1**
**Ten Year Trend in Enrollment in Indiana's CHIP at End of Each Calendar Year**




Source: Indiana's FSSA Enterprise Data Warehouse

The actual children enrolled in Indiana's CHIP remains fairly steady on a monthly basis, but there are new enrollees coming in each month as well as attrition. Exhibit II.2 shows that in MCHIP (CHIP Package A), on average between two and three percent of members either dropped off or were added as new on a monthly basis in Federal Fiscal Years (FFYs) 2018 and 2019. This change is more likely to occur in CHIP Package C or Package C Expansion than in MCHIP.

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



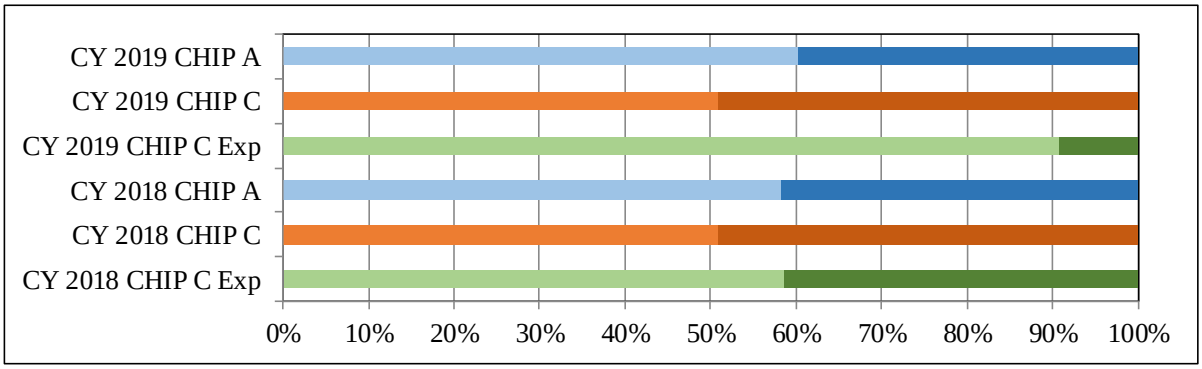

Source: Indiana's FSSA Enterprise Data Warehouse

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

Because of the monthly changes in new enrollments and disenrollments, a much larger number of Hoosier children have been supported by Indiana's CHIP in any given year than the year end enrollment figures would suggest. The number of children enrolled at any time during CY 2019 was 185,350 compared to 199,439 in CY 2018. Across all three portions of Indiana's CHIP (CHIP Package A, CHIP Package C, and CHIP Package C Expansion), the enrollment at the end of CY 2019 was 61 percent of the total number of children ever enrolled during the year. In CY 2018, this figure was 57 percent. Some children may also move between the CHIP and Medicaid programs.

In Exhibit II.3, the members enrolled at the end of the calendar year are the light color of the bar and the children not enrolled at the end of the year, but at some other time in the year, are the dark color.

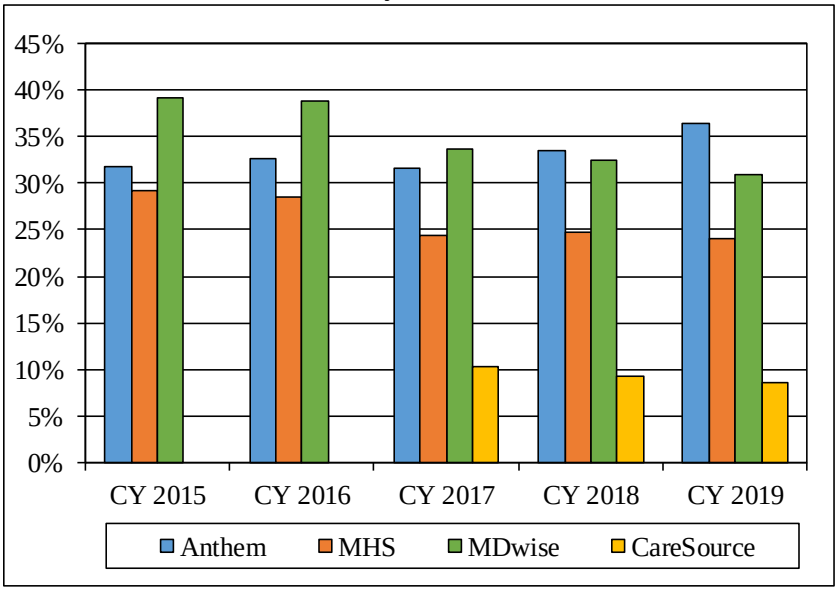
**Exhibit II.3**
**Percent of Children Currently Enrolled (light color) and Ever Enrolled (dark color), by Calendar Year**




Source: Indiana's FSSA Enterprise Data Warehouse

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There are four MCEs that families can choose from. There has been some movement in the distribution of CHIP members across the MCEs in the last five years. At the end of CY 2019, Anthem had 36.4 percent of all CHIP enrollees, MHS had 24.1 percent, MDwise had 30.9 percent and CareSource had 8.6 percent.

**Exhibit II.4**
**Percent of CHIP Enrollment by MCE at End of Each Calendar Year**

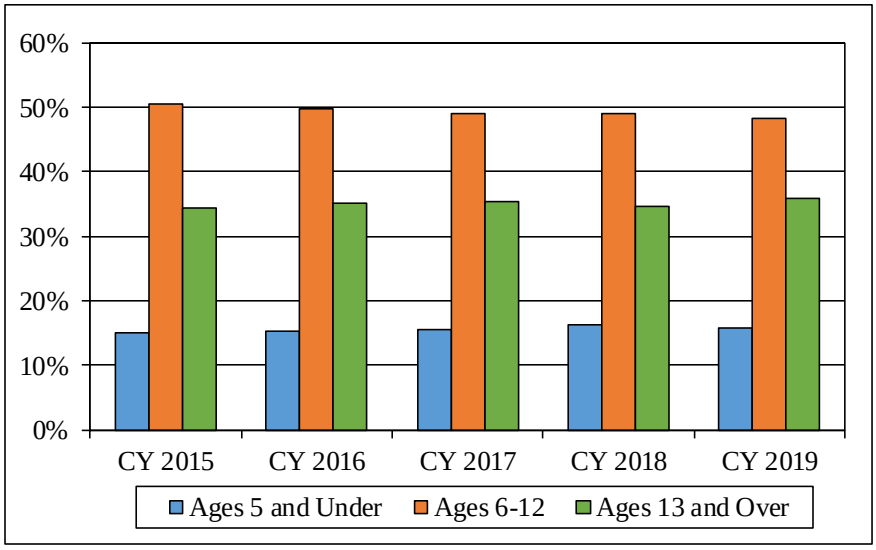



Source: Indiana's FSSA Enterprise Data Warehouse

## Demographic Profile of CHIP Members

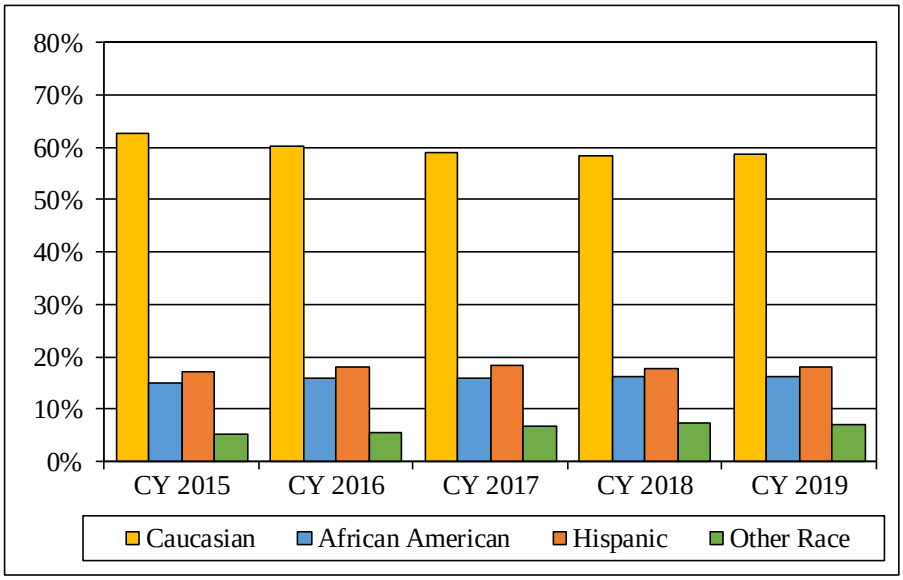
Just under half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Teenagers represent 36 percent of CHIP enrollees while the remaining 16 percent are under age 6.
This distribution has been the case since the CHIP was introduced.

**Exhibit II.5**
**Percent of CHIP Enrollment by Age Group at End of Each Calendar Year**




Source: Indiana's FSSA Enterprise Data Warehouse

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

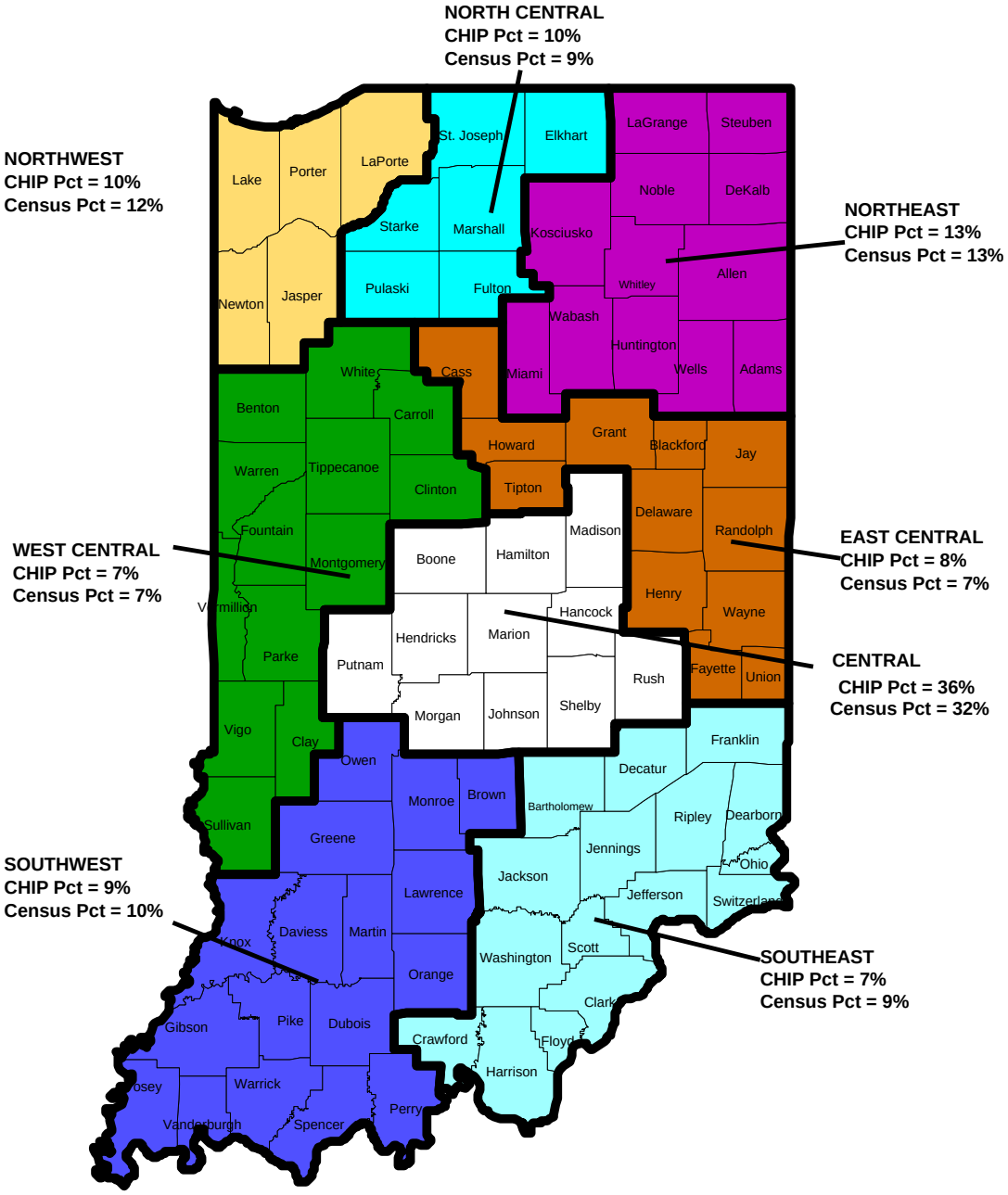



Source: Indiana's FSSA Enterprise Data Warehouse

There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for children ages 18 and younger. African-American children and Hispanic children represented 16.3 percent and 18.1 percent, respectively, of the CHIP enrollment at the end of CY 2019. The ratio of members in CHIP by race/ethnicity has been consistent in the last five years.

B&A compared CHIP members enrolled to the total child population in Indiana as of July 2019. The distribution of CHIP members by region generally matches the overall child population in Indiana. The Central region has 36 percent of all CHIP members but only 32 percent of the state's child population. The Northwest region has 10 percent of all CHIP members but 12 percent of the child population. The regions are defined by the OMPP. These statistics have also remained relatively unchanged in the last five years.

**Exhibit II.7**
**Average Distribution of CHIP Members by Region Compared to Census Figures, July 2018**



# III

# Access to Primary Medical Providers and Dentists

# CHAPTER III: ACCESS TO PRIMARY MEDICAL PROVIDERS AND DENTISTS

## Background

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

Burns & Associates, Inc. (B&A) examined both the proximity (nearest provider) of members to providers as well the average distance travelled by CHIP members within each county to seek primary medical and dental care.

## Proximity to the Nearest Provider

The data used to conduct this analysis was provided to B&A by the OMPP from its Enterprise Data Warehouse (EDW). Information was tabulated for access to primary medical providers (PMPs) and dental providers based on utilization from the time period October 1, 2018 – September 30, 2019. This time span was used in lieu of Calendar Year (CY) 2019 to allow the lag time for claims to be submitted by providers.

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

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

Because the actual CHIP enrollment can change month-to-month, for purposes of display B&A plotted children who were enrolled in CHIP as of June 1, 2019 on the maps with the providers. All CHIP members (CHIP Package A, CHIP Package C, and CHIP C Expansion) are shown together on each map.

Services delivered by Primary Medical Providers are defined as Evaluation & Management (E&M) office-based codes and clinic codes[6] where the provider specialty is one of the following: General Pediatrician, Family Practitioner, General Practitioner, Internist, OB/GYN or Public Health Agency. For dental services, the OMPP utilizes a specific claim type to identify all dental services.

In total, 16 maps were created in an effort to assess proximity to providers. Eight maps were created to assess access to primary medical providers and another eight were created to assess access to dentists. Each of the eight maps in both sets represents a region commonly used by the OMPP for utilization comparisons: Northeast, North Central, Northwest, East Central, Central, West Central, Southeast and Southwest. Each of Indiana's 92 counties are mapped to one of these eight regions. The eight maps showing CHIP member access to primary medical providers appear in Appendix A of this report. The same display by the eight regions showing access to dental providers appear in Appendix B of this report.

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

Findings

On a statewide level, there are very few gaps when measuring access to both primary medical providers and dental providers using a 10-mile service coverage radius. In fact, only 0.2 percent of all CHIP members live more than 10 miles from an available primary medical provider. This finding held true using the 12-month period of members and service claims studied in this year's report as well as for the 12-month period studied last year. There are 0.9 percent of CHIP members who live more than 10 miles from an available dentist using this year's data compared to 1.1 percent of members using last year's data. Exhibit III.1 below shows the results for each of the eight regions.

**Exhibit III.1**
**Assessing Accessibility of CHIP Members to Primary Medical and Dental Care**

| | | Primary Medical Provider | | Dental Provider | |
|---|---|---|---|---|---|
| | | Services Delivered Oct 1, 2018 - Sept 30, 2019 | | | |
| **Region** | **CHIP Enrollment June 2019** | **Children More than 10 Miles from a Provider** | **Percent of Children Beyond 10 Miles** | **Children More than 10 Miles from a Provider** | **Percent of Children Beyond 10 Miles** |
| Northeast | 14,324 | 34 | 0.2% | 40 | 0.3% |
| North Central | 11,824 | 2 | 0.0% | 90 | 0.8% |
| Northwest | 11,339 | 11 | 0.1% | 112 | 1.0% |
| East Central | 8,367 | 17 | 0.2% | 67 | 0.8% |
| Central | 39,261 | 6 | 0.0% | 42 | 0.1% |
| West Central | 8,029 | 39 | 0.5% | 190 | 2.4% |
| Southeast | 8,477 | 131 | 1.5% | 281 | 3.3% |
| Southwest | 10,090 | 34 | 0.3% | 227 | 2.2% |
| **Entire State** | **111,711** | **274** | **0.2%** | **1,049** | **0.9%** |

| | | Primary Medical Provider | | Dental Provider | |
|---|---|---|---|---|---|
| | | Services Delivered Oct 1, 2017 - Sept 30, 2018 | | | |
| **Region** | **CHIP Enrollment June 2018** | **Children More than 10 Miles from a Provider** | **Percent of Children Beyond 10 Miles** | **Children More than 10 Miles from a Provider** | **Percent of Children Beyond 10 Miles** |
| Northeast | 14,110 | 16 | 0.1% | 77 | 0.5% |
| North Central | 12,117 | 30 | 0.2% | 143 | 1.2% |
| Northwest | 11,046 | 23 | 0.2% | 121 | 1.1% |
| East Central | 8,437 | 19 | 0.2% | 133 | 1.6% |
| Central | 38,030 | 9 | 0.0% | 47 | 0.1% |
| West Central | 7,871 | 73 | 0.9% | 194 | 2.5% |
| Southeast | 8,537 | 133 | 1.6% | 239 | 2.8% |
| Southwest | 9,945 | 31 | 0.3% | 203 | 2.0% |
| **Entire State** | **110,093** | **334** | **0.3%** | **1,157** | **1.1%** |

Although the gaps are few throughout the state, there is some differentiation by region. Refer to Appendices A and B for the graphic result by region. For primary medical providers, a slightly higher proportion of CHIP members in the Southeast Region live more than 10 miles from a provider. For dentists, a slightly higher proportion of members in the West Central, Southeast and Southwest Regions live more than 10 miles from a provider.

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

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

- Northeast- Allen
- North Central- Fulton
- Northwest- LaPorte, Newton
- East Central- Cass
- Central- Morgan
- West Central- Benton, Tippecanoe, Warren, Fountain, Parke, Sullivan
- Southeast- Jackson, Decatur, Ohio, Clark, Harrison
- Southwest- Greene, Lawrence

It should be noted that B&A is using a stricter metric with the 10-mile radius than what the OMPP requires in its contracts with its MCEs (30 miles). When the distance radius is broadened to 30 miles, access to dentists is greatly improved.

When families with CHIP members select their preferred MCE, they can use the online provider directory tool available from each MCE to determine the proximity of primary medical providers in the MCE's network.

**Average Distance Travelled to Providers**

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

Geocoding software (either the Google Distance Matrix web service) was used to map the driving distance from the member's home to the primary medical provider's or dentist's office[7]. In some cases, the latitude/longitude coordinates were not valid for either the member's home or the rendering provider's office. When this occurred, B&A excluded from the study the claims/encounters and computed distances when the trip was less than 0.2 percent of a mile or greater than 100.0 miles. The average distance for

[7] Note that B&A computes the driving distance (turn by turn) as opposed to a crow flies distance.

each county was then computed as the total miles across all non-excluded trips divided by the total trips for members to the specific specialty.

Findings

In five of the 92 counties, CHIP members travelled, on average, more than 30 miles to seek primary medical care. This is down from ten counties in the analysis conducted for last year's report. There were 10 counties where CHIP members travelled, on average, more than 30 miles to seek dental care. In last year's report, B&A identified 11 counties where this was true.

For primary care, the greatest average distance travelled was 34 miles (Benton County). For the other four counties, the average distance travelled was between 31 and 33 miles: Fountain, Martin, Newton and Warren. All but Martin County are in the Northwestern portion of the state.

For dental care, the greatest average distance travelled was 39 miles (Benton County). Five counties in the Northwestern part of the state had an average distance travelled between 35 and 39 miles: Benton, Newton, Pulaski, Starke and White. This was also a finding in last year's report. Five counties in the southern part of the state had an average distance travelled between 30 and 38 miles: Greene, Jennings, Ripley, Shelby and Union.

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

**Exhibit III.2**
**Average Driving Distance for CHIP Members for FFY 2019 to Primary Care**
Color coding and values represent the average for each county

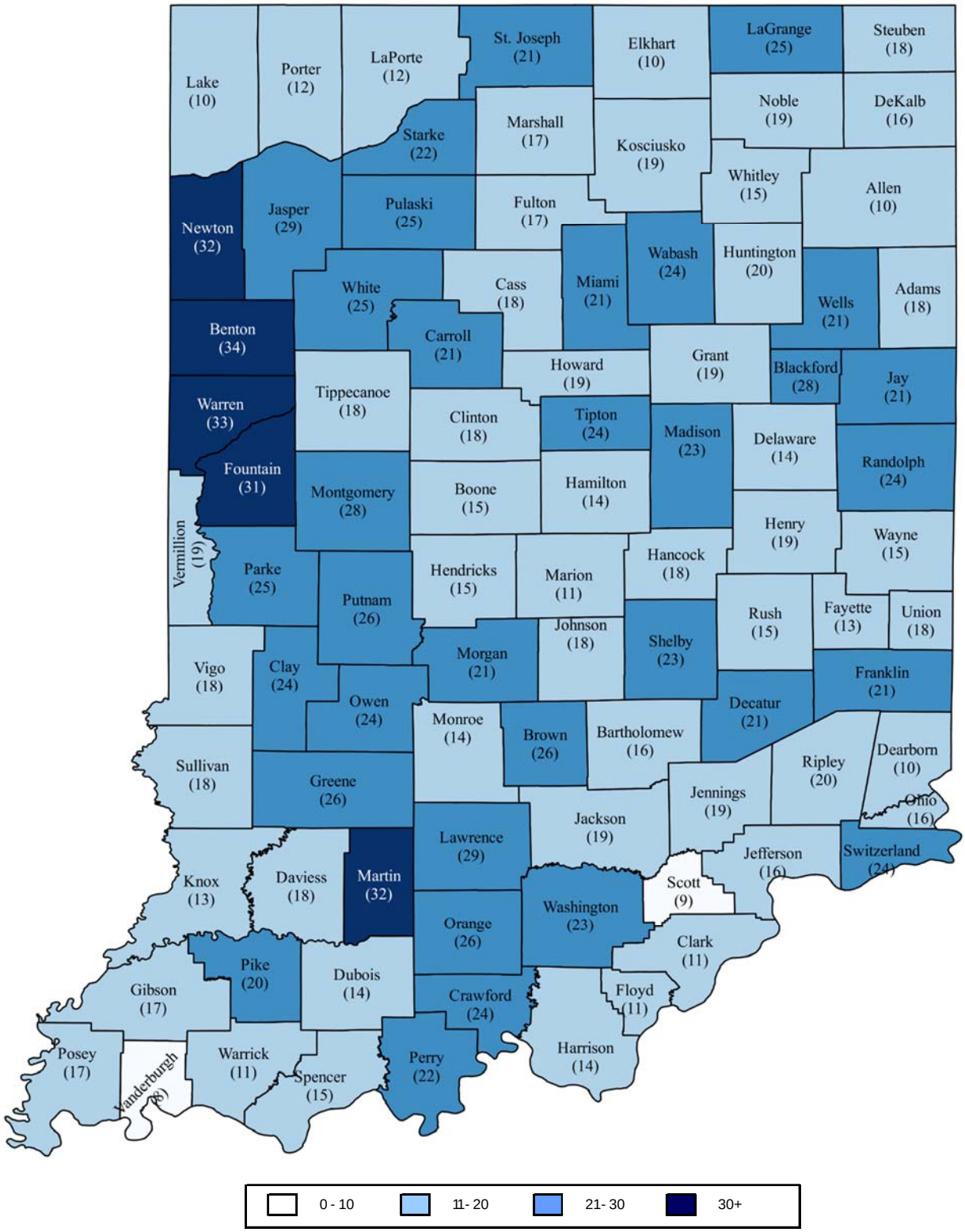
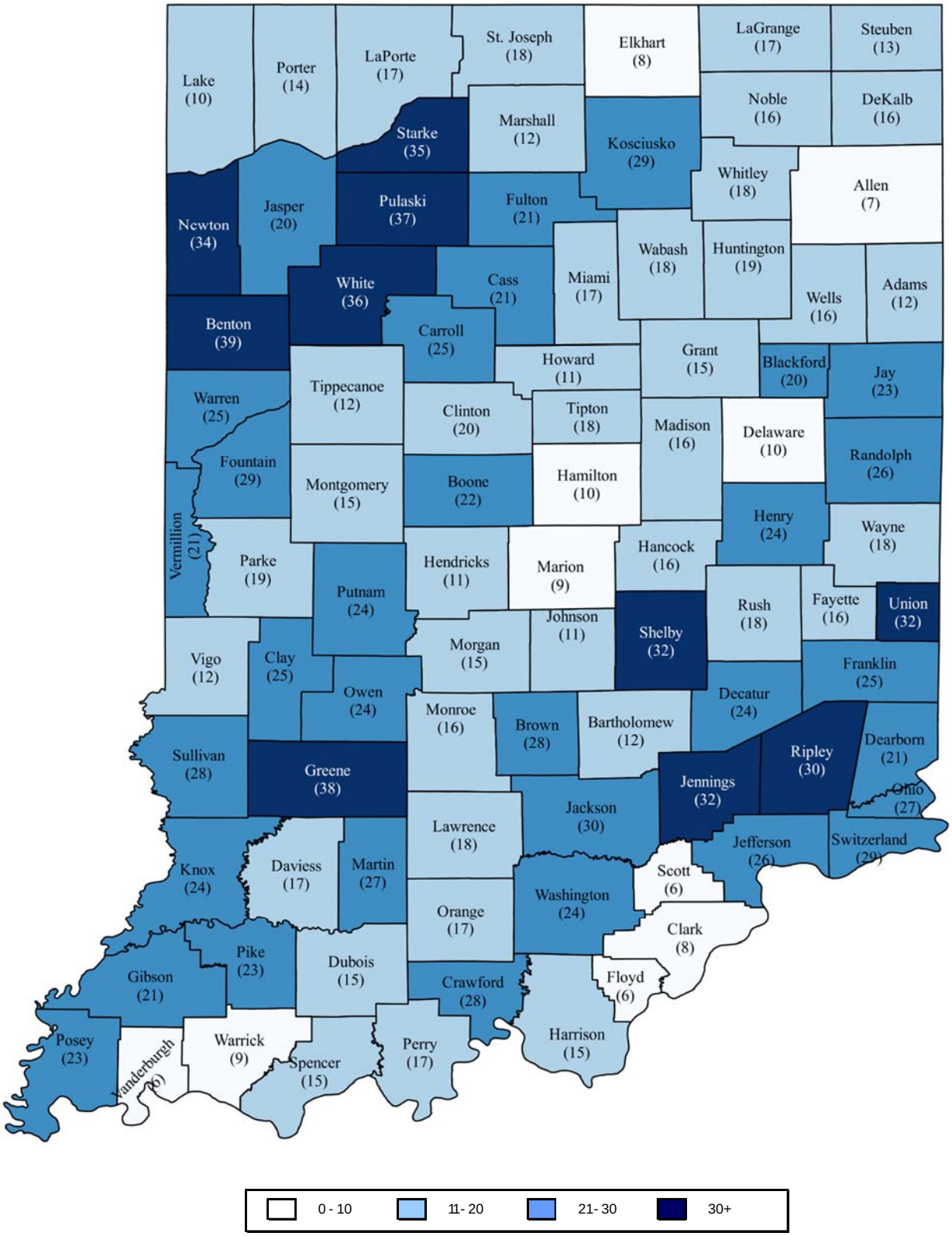


**Exhibit III.3**
**Average Driving Distance for CHIP Members for FFY 2019 to Dental Care**
Color coding and values represent the average for each county



# IV

# Service Use Patterns among Populations in Indiana's CHIP

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

## Introduction

In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency department (ED) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2017, 2018 and 2019 across populations within the CHIP such as by CHIP Package, by managed care entity (MCE), by age and by race/ethnicity.

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2017, 2018 or 2019. The *usage rate* is an annual measure. It measures the percentage of members that had actually used the service, but the measure is limited to those children who were enrolled for a minimum of nine months in each year. This accounts for members that would have had an opportunity to actually use the service. Members could be included in one FFY of the study but not another year based upon their enrollment history. Children were included in the usage reports if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year as long as they were enrolled for nine months during the year. In the event that a child did cross CHIP packages during a study year, the child was assigned to the enrollment category that s/he was in at the end of the study year. Therefore, each child is counted only once on each report. A member's age was assigned based upon his/her age at the end of the study year.

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

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in February 2020. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP. That being said, the findings for FFY 2019 may still be incomplete if the MCEs have not submitted all of their encounter data to the OMPP yet. In previous years, B&A has found that after a retrospective review is conducted, the percent of users often increases two to three percentage points from what is shown in the original release of findings.

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

## Primary Care Visits

Primary care visits include visits to doctor's offices or clinics specializing in primary care which are the same types of visits shown in the access maps in Section III of this report. It can include both well visits and sick visits.

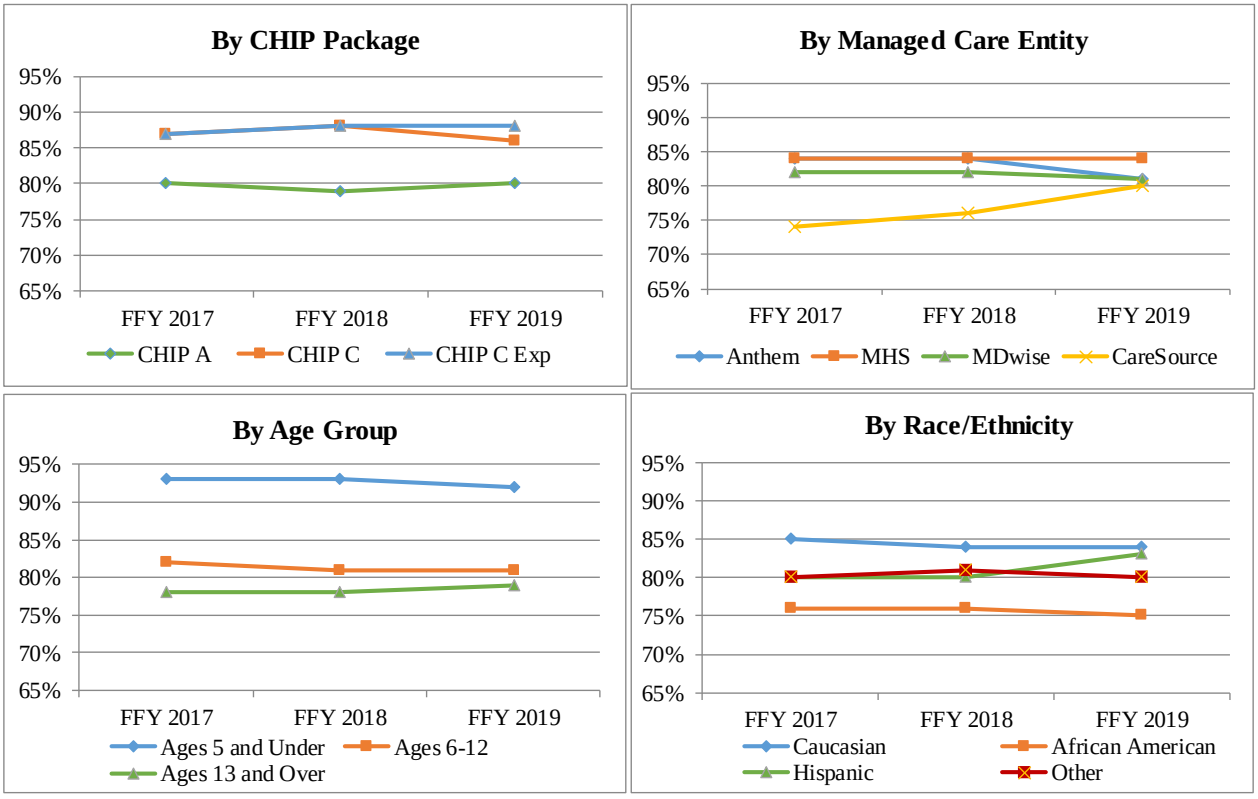
B&A found that the percent of SCHIP (CHIP Package C and CHIP C Expansion) children in the study sample that had a primary care visit was higher in each of the three years than for children in MCHIP (CHIP Package A) (refer to upper left box). The percentage of SCHIP children with a visit was between 86 and 88 percent in all three years examined. For MCHIP, the rate was at or near 80 percent each year.

The usage rates for all MCEs except CareSource are, on average, between 81 and 84 percent in all three years. CareSource was lower in FFYs 2017 and 2018 but near its peers in FFY 2019.

Primary care visits are more prevalent among the youngest members, as 92 to 93 percent of children ages 5 and younger had a visit in each of the three FFYs (lower left box). The percentage was lower for children in the other age groups (near 81% for children ages 6 to 12 and near 78% for children ages 13 to 18).

When examined by race/ethnicity (lower right box), the usage rate was similar for all groups studied except for African-American children. The usage rate for African-American children was eight or nine percentage points lower than Caucasian children in each of the three years examined.

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




*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

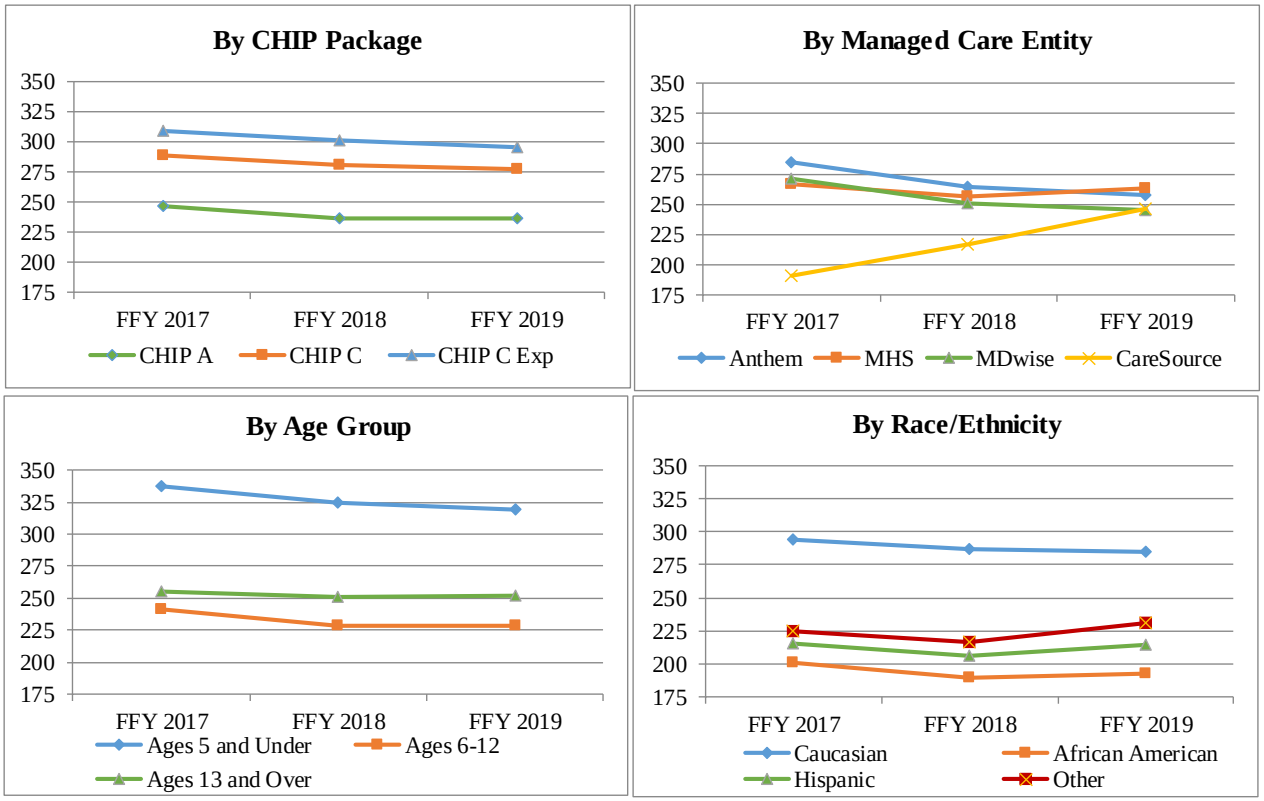
The utilization per 1,000 member trends for primary care shown below in Exhibit IV.2 mirror the percent usage trends in Exhibit IV.1. The greatest variation is seen when comparing utilization by age group (lower left box) and by race/ethnicity (lower right box). The rates per 1,000 members by age show that for children age 5 and under, the rate was 319 to 338 visits per 1,000 members in each year. This is much greater than what is seen for children ages 6-12 (228-241 per 1,000) and ages 13 and over (251-255 per 1,000) during the same time period. What this means is that, in any given month of the year studied, approximately 3.3 out of ten of the youngest children had a primary care visit compared to 2.5 out of 10 for teenagers and 2.3 out of 10 for children in the middle age range.

Caucasian children had a utilization per 1,000 rate near 290 per 1,000 across the three years studied. This rate for Caucasian children was 33 to 52 percent higher than the rate for minorities depending on the minority group and the year examined. As was seen in the usage rate, the primary care utilization per 1,000 was lowest for African-American children (range between 189 and 201 visits per 1,000 across the three years).

The differences in the utilization per 1,000 by CHIP package (upper left box) are an artifact of the age composition within each package. In SCHIP, the composition of members by age range is spread evenly. In MCHIP (CHIP Package A), 90 percent of the children are ages six and older because, starting at age 6, more children who had been enrolled in the regular Medicaid program transition to MCHIP.

There is some variation in the utilization per 1,000 for CHIP members by MCE (upper right box). CareSource's lower rate in FFYs 2017 and 2018 may be an encounter reporting issue.

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



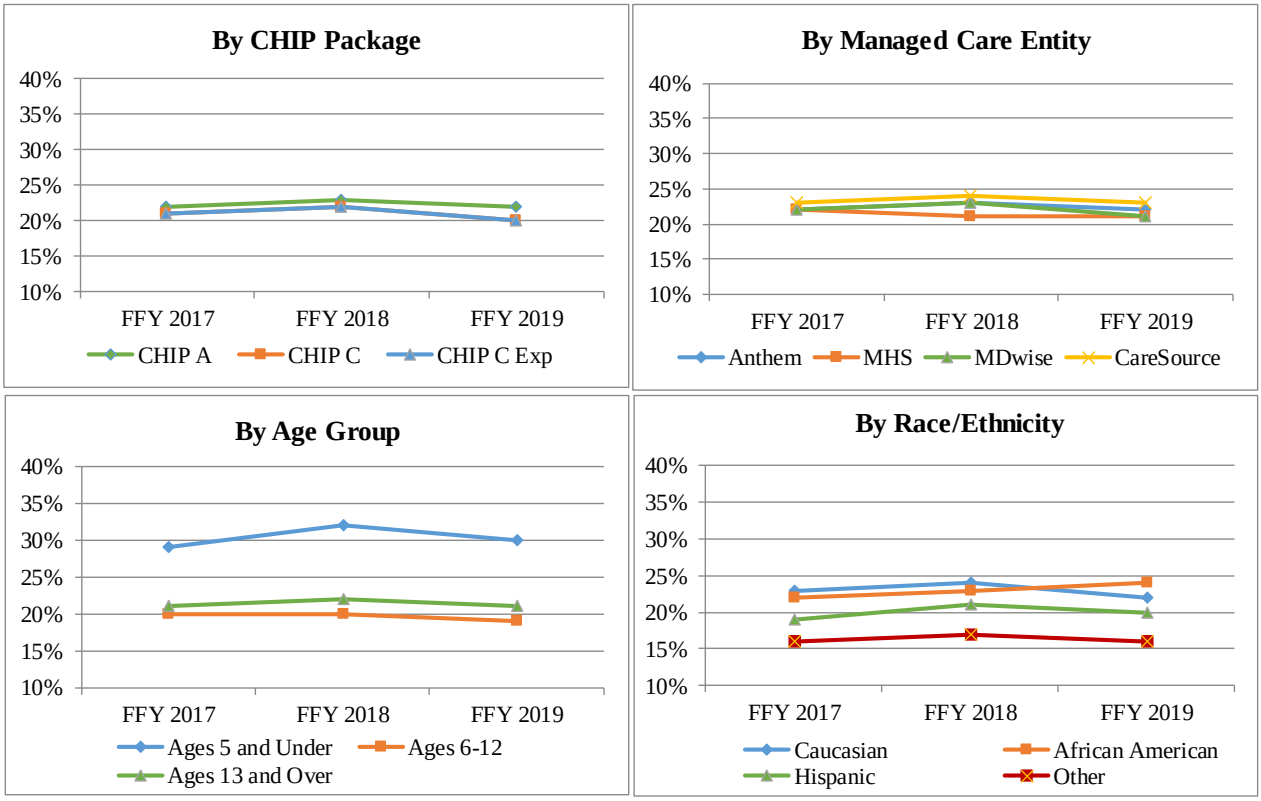

*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

## Emergency Department Visits

The usage rate of Emergency Department visits by CHIP children in all packages was consistent in FFYs 2017 through 2019. Exhibit IV.3 shows a usage rate of 20 to 22 percent for both MCHIP and SCHIP (upper left box). This means that one in five CHIP children went to the ED at some point during the study year. The usage rate pattern is also consistent for each of the MCEs in all three years studied (upper right box).

The usage rate trends over the three-year period followed a similar pattern when examined by age group (lower left box) and by race/ethnicity (lower right box). The usage rate for children ages 5 and younger was much higher (29 to 32 percent) than the older age groups (19 to 22 percent). There is little variation found in ED use between Caucasian and African-American CHIP members, but Hispanic members and those of other races used the ED less.

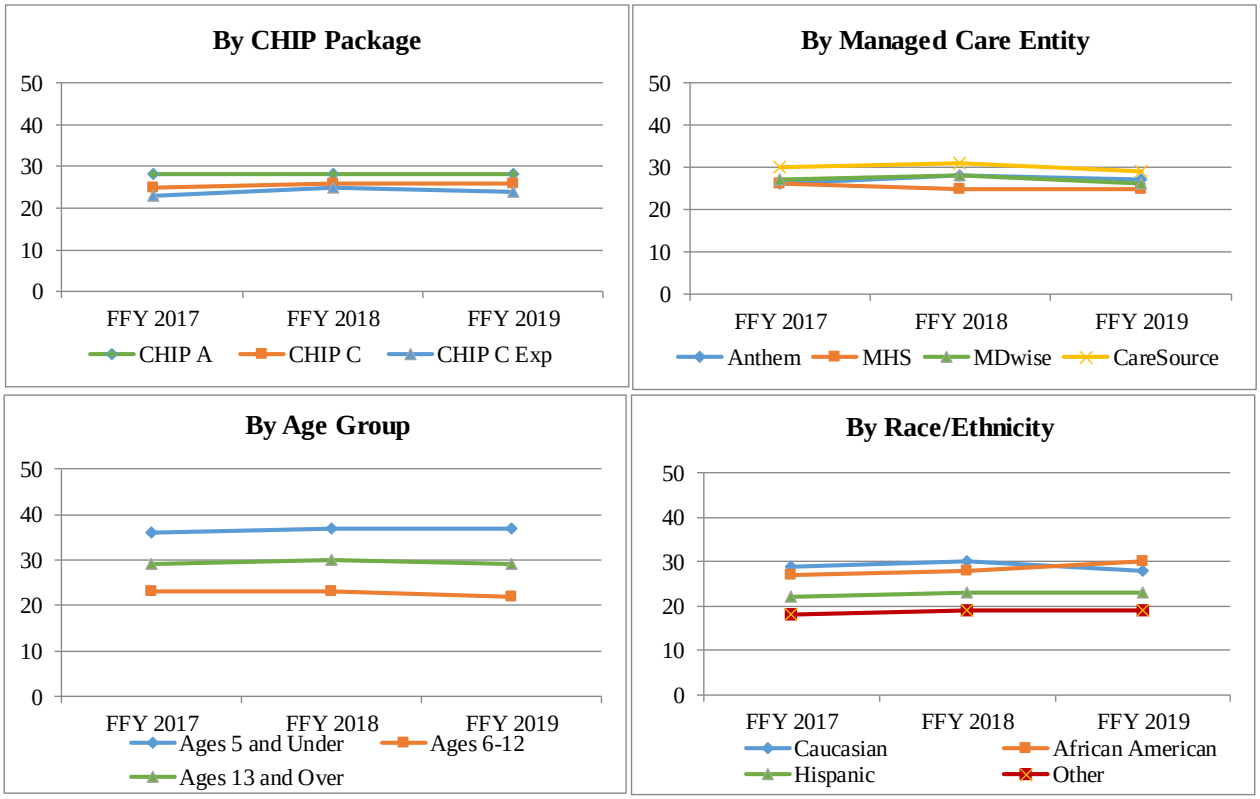
**Exhibit IV.3**
**Percent of Member Usage within Populations in Indiana's CHIP for Emergency Department**
Only Children Enrolled in 9 Months of the Study Year are Considered




*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

The ED utilization per 1,000 member trends shown in Exhibit IV.4 on the next page followed the same patterns seen in the usage rates in Exhibit IV.3. The ED utilization per 1,000 members was similar between MCHIP and SCHIP (upper left box) and between MCEs (upper right box). Usage rates were highest for children age 5 and younger (lower left box) and lowest for Hispanic children and other minorities (lower right box).

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




*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

B&A also examined the prevalence of children who are frequent users of the ED. In the most recent FFY, most CHIP children (85.7%) had no ED visits. There were 12.3 percent of children that had one or two ED visits during the year while 1.8 percent had three to five visits. These results are consistent across the MCEs as well. There is a slightly lower percentage of CHIP children that used the ED in the most recent year compared to what was observed in the same study last year (refer to the far-right column).

**Exhibit IV.5**
**Frequency of ED Utilization Among CHIP Members Using ED Services**
**For Claims Submitted with Dates of Service Oct 1, 2018 - September 30, 2019**

| | Percentage of All Members Using ED by MCE | | | | | |
|---|---|---|---|---|---|---|
| **Number of ED Visits per Member** | **Anthem** | **CareSource** | **MHS** | **MDwise** | **All MCEs** | **Prior Year All MCEs Values** |
| Zero | 85.7% | 85.4% | 85.8% | 85.8% | 85.7% | 84.8% |
| 1 to 2 | 12.0% | 12.7% | 12.3% | 12.4% | 12.3% | 11.5% |
| 3 to 5 | 2.0% | 1.5% | 1.6% | 1.6% | 1.8% | 3.0% |
| 6 to 10 | 0.3% | 0.3% | 0.2% | 0.2% | 0.2% | 0.6% |
| More than 10 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.1% |

Source: Indiana's FSSA Enterprise Data Warehouse

As part of the External Quality Review of the MCEs conducted by B&A in CY 2019, B&A also assessed the types of ED visits that occurred among children in managed care. Specifically, we assessed if the visits were potentially preventable or not, that is, the visit could have been completed in a lower-intensive setting such as a doctor's office, a clinic, or an urgent care center. B&A utilizes software developed by 3M and licensed to the OMPP to assess potentially preventable ED visit (or PPV) rates. The software examines each ED visit and the primary diagnosis reported for the reason for the ED visit. The ED visits are then classified into PPVs or non-PPVs.

Exhibit IV.6 below shows the results among all Medicaid children enrolled in the Hoosier Healthwise program and their ED visits in CY 2018. The PPV rate is highest for infants at 83.7 percent of all visits. For children age one to five, the PPV rate is 74.4 percent. For children age six to 18, the rate is 64.3 percent.

There appears to be an opportunity to educate families to use other places of service to seek care other than the hospital ED, specifically when the reason for the ED visit is examined. The top potentially preventable ED visit for all three age groups is upper respiratory tract infections and otitis media (ear infection). Other top reasons for non-infants are musculoskeletal system and connective tissue diagnoses and contusions or open wounds. For infants, the other top PPV visits are for bronchiolitis and non-bacterial gastroenteritis, nausea and vomiting.

**Exhibit IV.6**
**Frequency of ED Visits Determined to be Potentially Preventable**
**For Visits in CY 2018 All Children Enrolled in Hoosier Healthwise**

| | Age <1 | Age 1 to 5 | Age 6 to 18 |
|---|---|---|---|
| Non-Preventable | 16.3% | 25.6% | 35.7% |
| Preventable | 83.7% | 74.4% | 64.3% |
| **Top 10 Reasons for Preventable ED Visits:** | **Number Shown is Rank in Top 10** | | |
| Upper respiratory tract infections and otitis media | 1 | 1 | 1 |
| Musculoskeletal system and connective tissue diagnoses | not in top 10 | not in top 10 | 2 |
| Contusion, open wound to skin and subcutaneous tissue | not in top 10 | 2 | 3 |
| Ear/Nose/Mouth/Throat and Cranial/Facial Diagnoses | 5 | 4 | 4 |
| Abdominal pain | not in top 10 | not in top 10 | 5 |
| Other skin, subcutaneous and breast diagnoses | 6 | 5 | 6 |
| Non-bacterial gastroenteritis, nausea and vomiting | 3 | 6 | 7 |
| Fractures and dislocations | not in top 10 | not in top 10 | 8 |
| Viral illness | 4 | 3 | 9 |
| Other respiratory diagnoses | 8 | 8 | 10 |
| Bronchiolitis and RSV pneumonia | 2 | 10 | not in top 10 |
| Fever | 7 | 7 | not in top 10 |

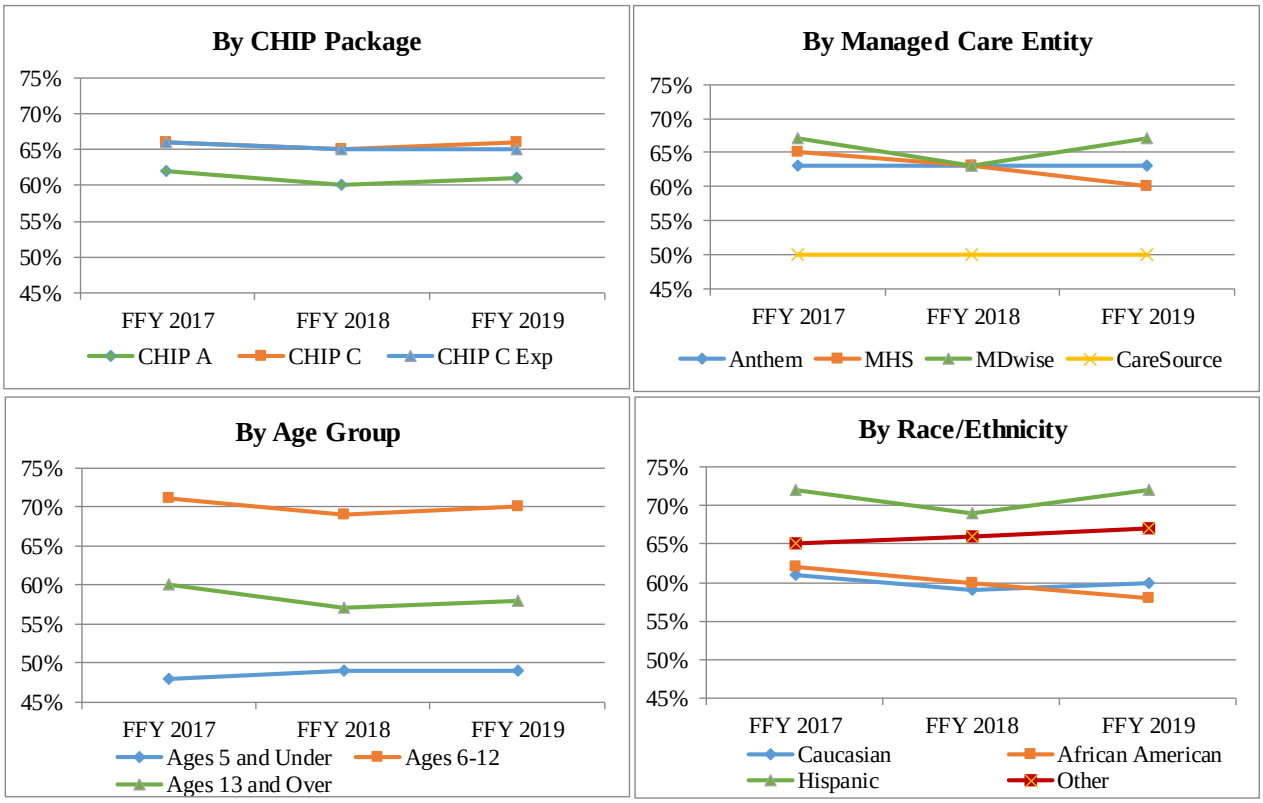
## Preventive Dental Visits

The percentage of children in MCHIP (Package A) and SCHIP (Package C and Package C Expansion) with a preventive dental visit was between 60 and 66 percent within each enrollment group (upper left box), but it was always lower for the MCHIP members. For three of the four MCEs, the percent of dental users among its CHIP members is between 60 or 67 percent each year. For CareSource, the rate is lower at 50 percent each year (upper right box).

There are differences in dental usage by age group (lower left box). Understandably, children under age five had a usage rate near 49 percent of all members in each year studied. Children ages 6 to 12 had the highest usage of 69 to 71 percent of all members, while children age 13 and over were lower with a usage rate of 57 to 60 percent.

When examined by race/ethnicity (lower right box), more Hispanic children used dental services (69 to 72 percent) than the other race/ethnicities (58 to 66 percent). This trend has been consistent in the last five years studied.

**Exhibit IV.7**
**Percent of Member Usage within Populations in Indiana's CHIP for Preventive Dental Care**
Only Children Enrolled in 9 Months of the Study Year are Considered



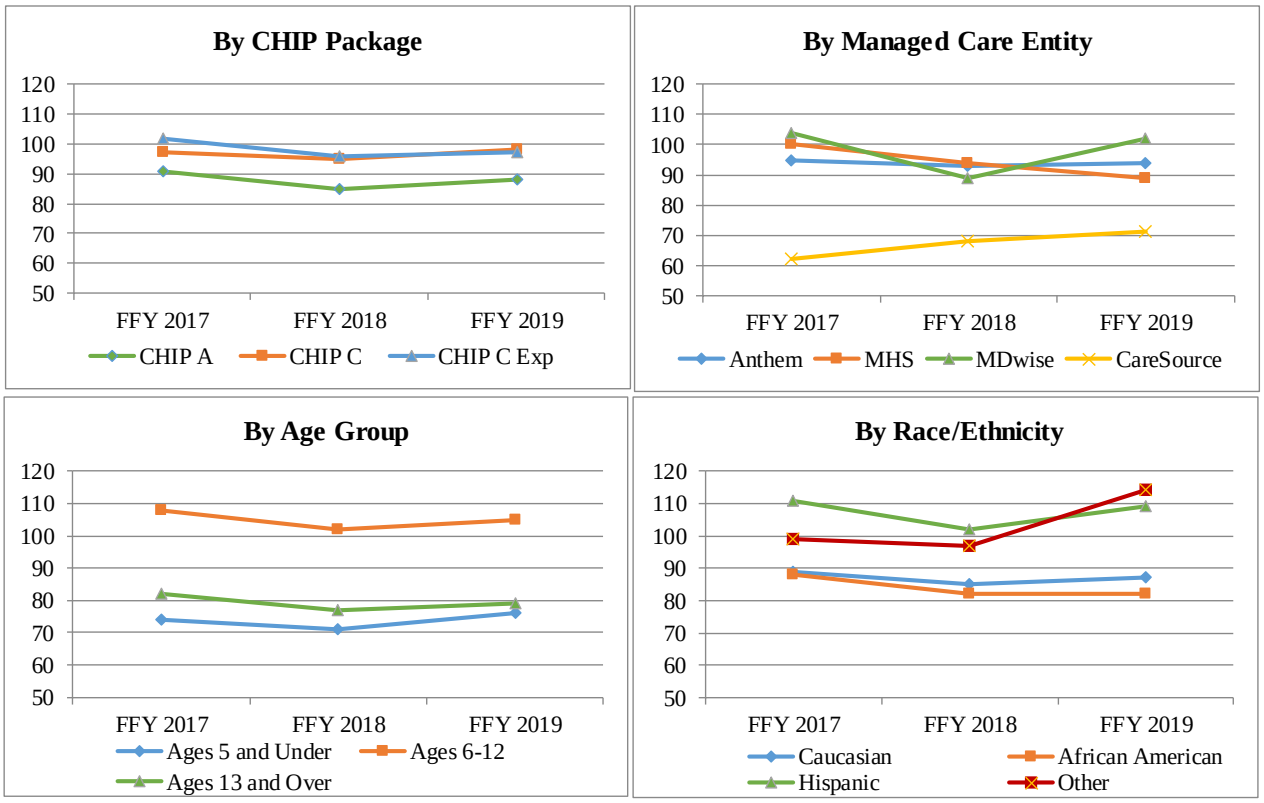

*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

The trends in the utilization per 1,000 members for dental services were similar to what was found in the usage rates shown in Exhibit IV.7. The utilization per 1,000 members is general similar across the CHIP programs as seen in the upper left box of Exhibit IV.8. The utilization is also very consistent across the three MCEs with most of the CHIP members (upper right box).

As was observed in the usage rates, when measuring the utilization rate of dental visits per 1,000 CHIP members, children age 6 to 12 are highest at a rate of 102 to 108 visits per 1,000 members across the three FFYs (refer to lower left box). Said another way, approximately one out of 10 CHIP members in this age group saw the dentist every month. This is followed by the teenagers (77 to 82 visits per 1,000 members) and then children age 5 and younger (71 to 76 visits per 1,000 members).

The variation by race/ethnicity in the usage rate of dental services is also seen when examining utilization per 1,000 members. Hispanic children had utilization between 102 and 111 visits per 1,000 members. Both African American children and Caucasian children had between 82 and 89 visits per 1,000 members.

**Exhibit IV.8**
**Utilization per 1,000 within Populations in Indiana's CHIP for Preventive Dental Care**
All Children Enrolled in the Study Year are Considered




*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

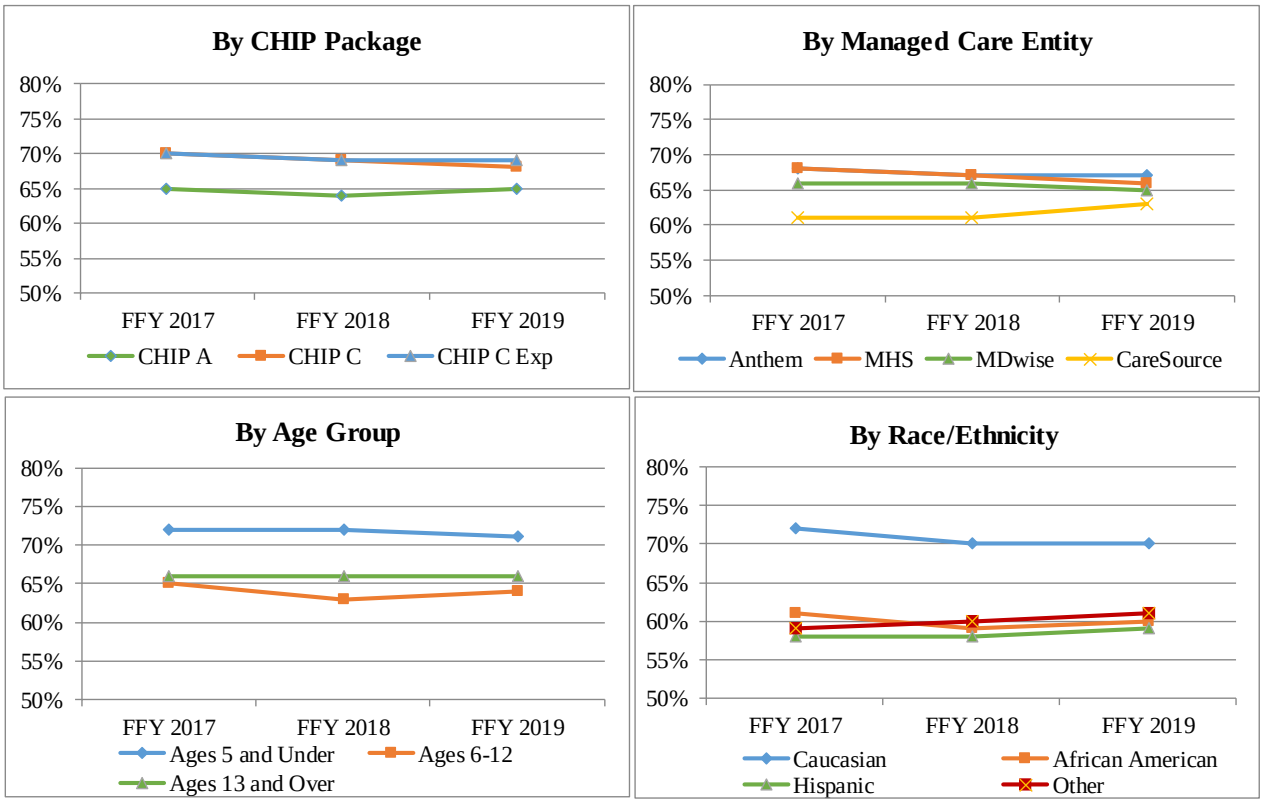
## Pharmacy Prescriptions

MCHIP (Package A) children are least likely to have a prescription with 65 percent having a script in each year examined (refer to upper left box in Exhibit IV.9 below). The SCHIP (Package C) children (original and expansion populations) are more likely to have a prescription with a rate near 70 percent. There is consistency in the usage patterns of CHIP members enrolled with each MCE, although CareSource's rate is slightly lower.

There are differences, however, in pharmacy usage among the age groups studied (lower left box). The highest usage rate is among children ages 5 and under over the last three years (71% in FFY 2019). Children in the two older age groups had less usage (64 to 66 percent in FFY 2019).

Across races/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities (lower right box). In FFYs 2018 and 2019, the usage rate among Caucasians children was 70 percent but it was 58 to 61 percent for minorities. This has been a consistent finding in the CHIP for the last five years.

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



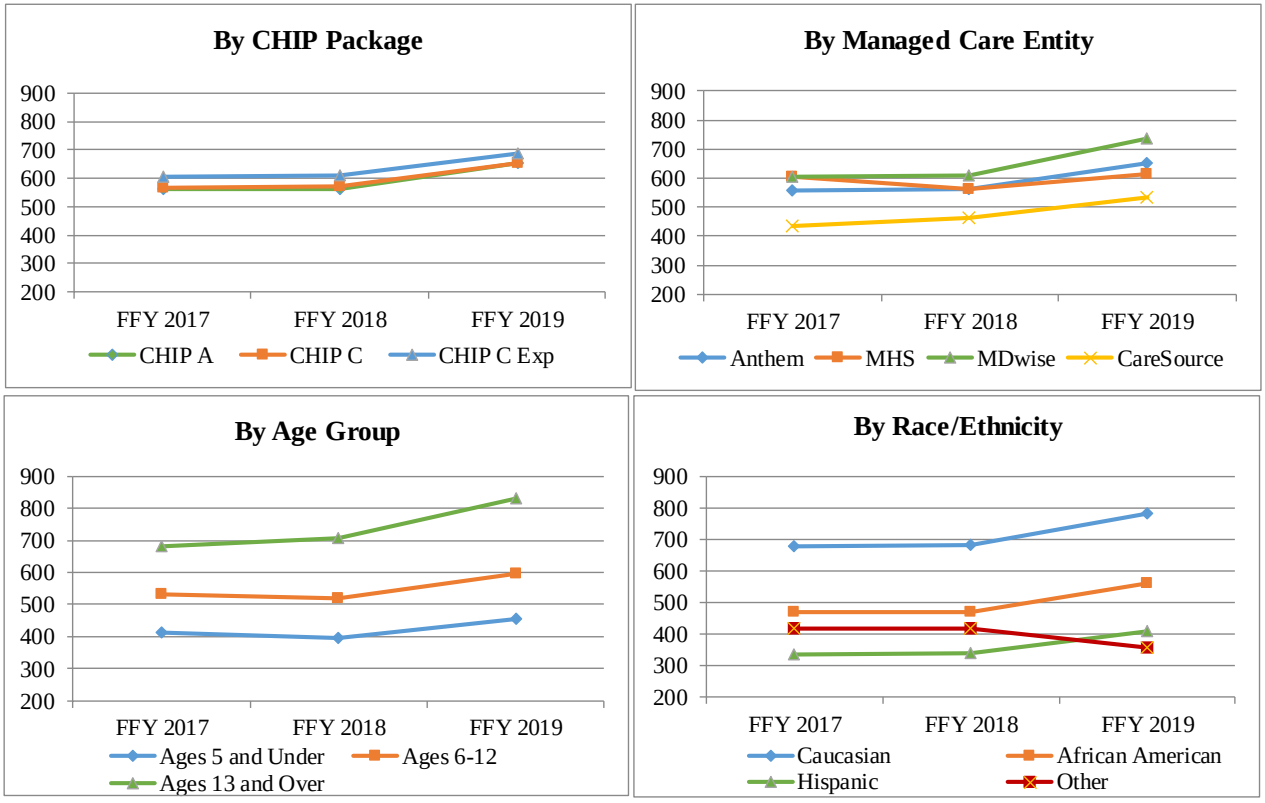

*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

Exhibit IV.10 below shows that the utilization per 1,000 rates for pharmacy services are generally similar for MCHIP and SCHIP members (upper left box) even though the percent of MCHIP pharmacy users was found to be lower (refer back to Exhibit IV.9). The utilization rate has increased over the three years examined. This is also true for each of the MCEs (upper right box). The utilization per 1,000 rates for Anthem, MHS and MDwise members are very similar each year.

The variance is seen in the age group views. Although fewer children in the teenage group obtained a prescription, they obtained more of them in the last three years (lower left box). The prescriptions per 1,000 members in FFYs 2017 through 2019 was 681 to 830 for this age group; for children age 5 and under, 397 to 453 per 1,000; for children age 6 to 12, 521 to 598 per 1,000.

The trend for the number of prescriptions filled per 1,000 CHIP children by race/ethnicity followed the same pattern found for the usage rate trend. Caucasian children had a utilization rate near 700 prescriptions per 1,000 members in FFYs 2017 and 2018, but this has grown in FFY 2019. The utilization rate for Caucasians is 40 percent higher than the rate for African-American children, double the rate for Hispanic children, and 60 percent higher than the rate for other race/ethnicities.

**Exhibit IV.10**
**Utilization per 1,000 within Populations in Indiana's CHIP for Pharmacy Scripts**
All Children Enrolled in the Study Year are Considered




*Data for CareSource in FFY 2017 represents only nine months since their contract with the State began Jan 1, 2017.

# V

# Measuring Quality and Outcomes in Indiana's CHIP

# CHAPTER V: MEASURING QUALITY AND OUTCOMES IN INDIANA'S CHIP

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

## OMPP's Oversight of Quality

OMPP staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCE's site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity[8] to conduct an annual external quality review of each MCE and reviews the results with each MCE.

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

1. OMPP requires the MCEs to report the results of HEDIS®[9] and CAHPS®[10] measures. The HEDIS are nationally-recognized measures since the health plans that report their results to the National Committee of Quality Assurance use standard definitions and results are attested by certified auditors. The OMPP compares the results of the HEDIS measures across the MCEs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS survey is separated between one for adults and one for parents of children. The OMPP requires the MCEs to administer each survey annually.

2. Separately, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Centers for Medicare and Medicaid (CMS) was required to develop a core set of measures related to children's health and to collect the results of these measures on a voluntary basis from state Medicaid and CHIP programs. Currently, there are 26 core measures identified by CMS. These include some HEDIS and CAHPS measures as well. CMS hires a national evaluator to analyze the results of these measures and make comparisons across the state Medicaid agencies.

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

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

[8] Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.
[9] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).
[10] The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

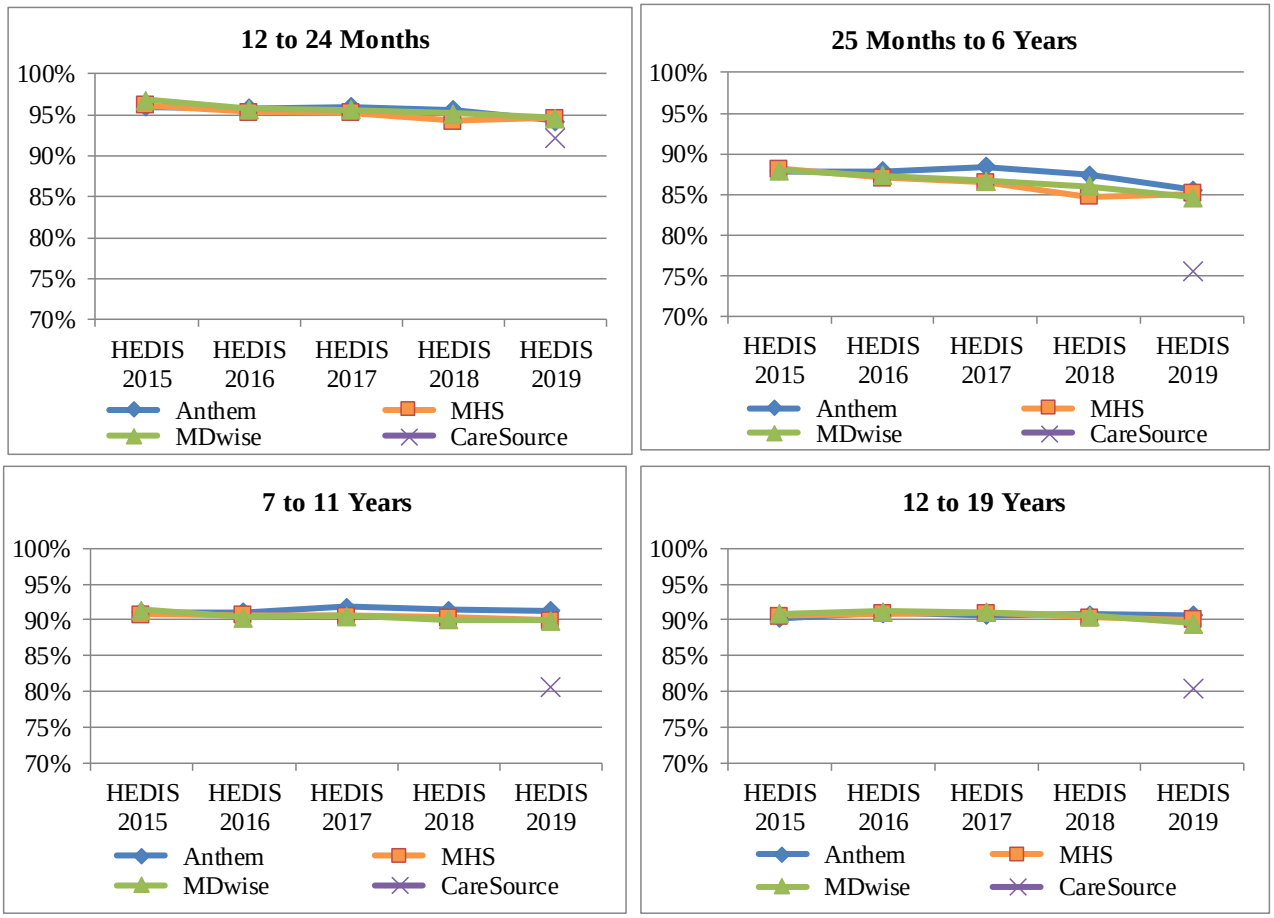
## HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members from the prior year. Therefore, in Calendar Year (CY) 2019, tabulations were collected on HEDIS rates for 2018 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. All results shown in this section reflect CHIP members as well as children in the traditional Medicaid program who are enrolled in Hoosier Healthwise.

Exhibit V.1 presents the HEDIS results for access to primary care. Each measure is defined as the percentage of children who had a visit with their primary care practitioner (called PMPs) in the measurement year (it could be for well care or for illness).

The five-year trends are reported for each MCE for four age groups. In the most recent year, the rate for the youngest children age 12 to 24 months (upper left box) was at or near 94 percent for all MCEs. For the age group 25 months to six year (upper right box), all MCEs except CareSource have reported access at 85 percent. For children age 7 to 11 years (lower right box) and the oldest children (lower right box), all MCEs except CareSource reported 90 to 91 percent in the most recent measurement year.

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



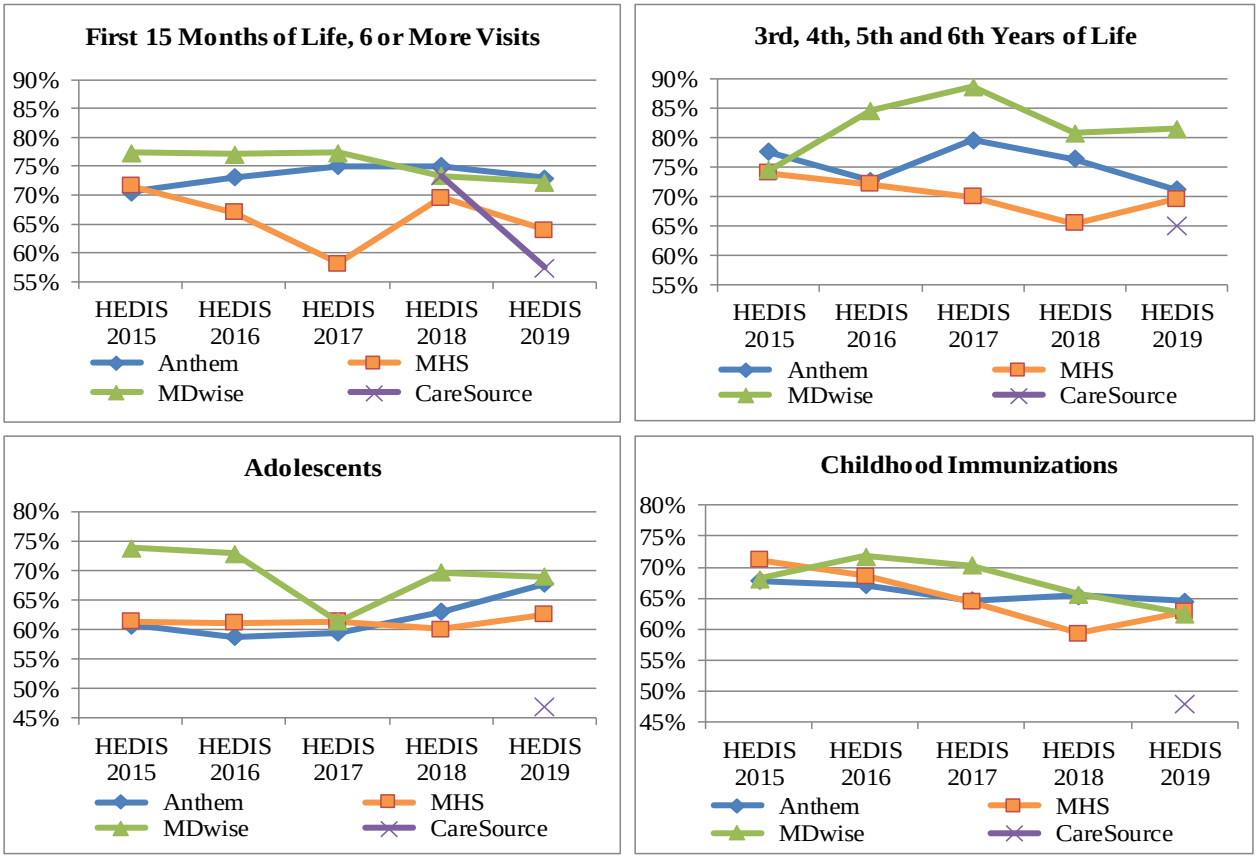

Note: CareSource's contract began Jan 1, 2017. The HEDIS 2018 looked back to CY 2017 utilization. The sample sizes for HEDIS measures were usually too small to report for CareSource until HEDIS 2019.

Exhibit V.2 shows the five-year trend for well care visits for each MCE. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life (upper left box), the rate shown represents the percentage of children with six or more well child visits.[11] For children in the ages 3-6 years (upper right box) and adolescents (lower left box), the rate shown represents the percentage of children that had at least an annual visit.

The rate of well care visits among infants for both Anthem and MDwise has been similar and fairly steady in the last years, although both MCEs decreased a bit in HEDIS 2019. MHS has had more sporadic results across the five years. CareSource is much lower than its peers in HEDIS 2019. The rate of well care visits for ages three to six have typically been in the 70 to 79 percent range each year, but MDwise is higher than its peers on this measure. The three long-standing MCEs have all seen improvement in the rate for adolescent well care in the last five years.

Another measure for well child care relates to immunizations (bottom right box). This measure reports the percentage of children who turned age 2 during the measurement year who were enrolled for the 12 months prior to their second birthday who received the immunizations as recommended by the American Academy of Pediatrics. Three of the four MCEs had a rate of 62 to 64 percent in the most recent HEDIS time period, but CareSource's rate is much lower than its peers (48 percent).

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



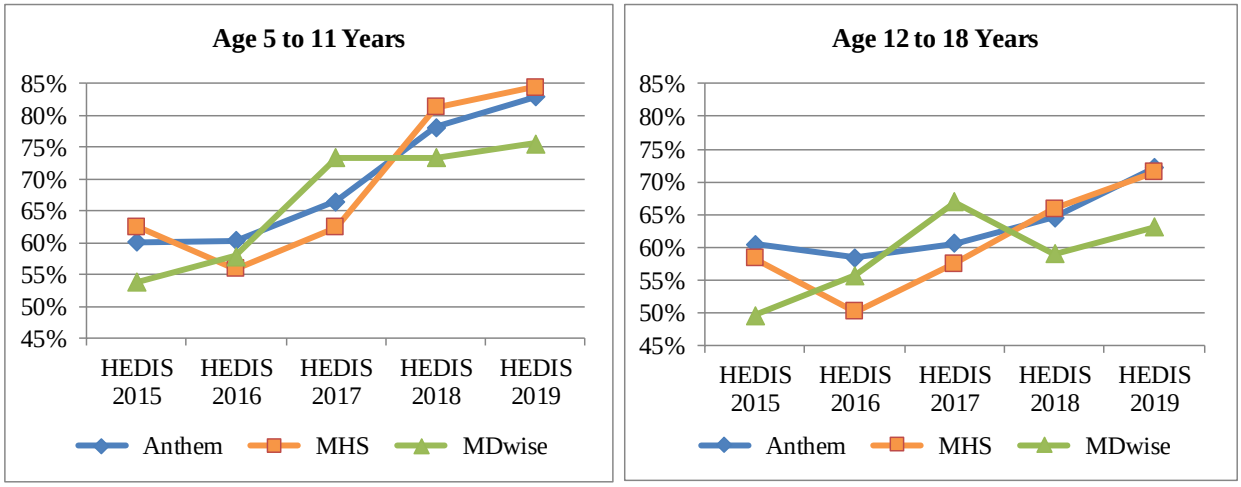

Note: CareSource's contract began Jan 1, 2017. The HEDIS 2018 looked back to CY 2017 utilization. The sample sizes for HEDIS measures were usually too small to report for CareSource until HEDIS 2019.

[11] Note that the current recommendation for Indiana's Bright Futures program is 8 visits up to and include the visit at 15 months of age.

Exhibit V.3 presents the results from HEDIS measures related to medication management for people with asthma. The results shown represent the percentage of children who remained on an asthma controller for at least 50 percent of their treatment period. The left box represents findings for children age 5 to 11 whereas the right box represents findings for children age 12 to 18 years.

The three MCEs reporting this measure have seen improvement in this measure in the age 5 to 11 group. In the most recent year of HEDIS 2018, MHS was highest with 84 percent of members adhering at this rate. Anthem had 83 percent with adherence while MDwise has 76 percent adherence. There has also been improvement in the 12 to 18 age group but not as significant as for the younger age group. The adherence rates in HEDIS 2018 were 71 percent for MHS, 72 percent for Anthem, and 63 percent for MDwise.

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



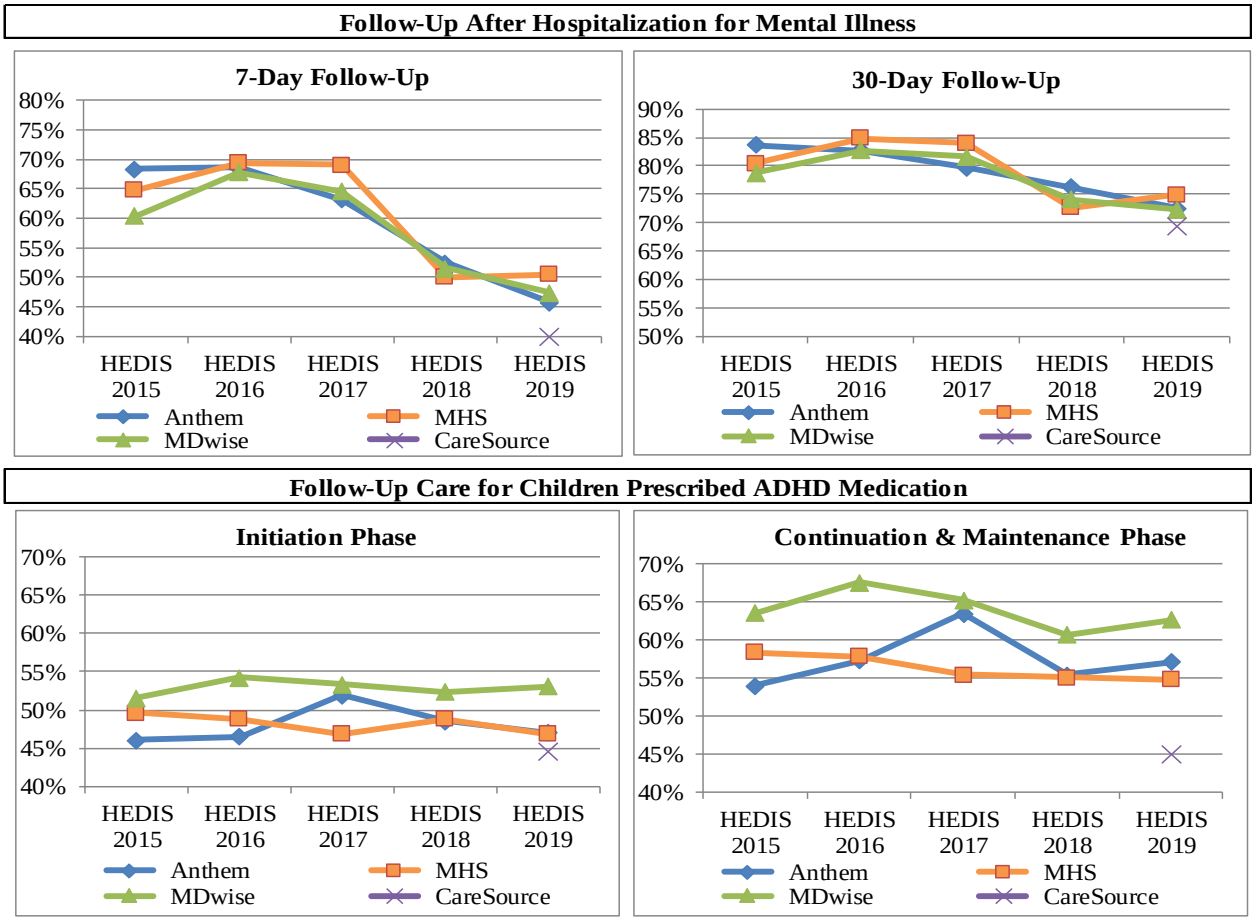

Note: This measure requires reviewing data over a two-year period.
The sample sizes for CareSource were too small to report for this measure.

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

Results for the follow-up visit measures improved in the early years of the five years studied but then decreased in the last two HEDIS years for the 7-day follow-up. This, however, is because NCQA changed the way visits can be counted for follow-up (it was made stricter). The rates have decreased a bit further in HEDIS 2019 with the exception of MHS. The 30-day follow-up rates have been steadier across the five years and across the MCEs.

The compliance related to visits after being prescribed ADHD medication could see improvement. The MCEs reported consistent results in the initiation phase measure (40 to 50 percent in the most recent year). In the continuation and maintenance phase measure, rates have levelled off in recent years.

**Exhibit V.4**
**Summary of Results from Selected Behavioral Health HEDIS Measures (Percentage of Total)**




Note: CareSource's contract began Jan 1, 2017. The HEDIS 2018 looked back to CY 2017 utilization.
The sample sizes for HEDIS measures were usually too small to report for CareSource until HEDIS 2019.

In addition to the year-over-year changes for each MCE, B&A compared the latest HEDIS year results to see how Indiana's MCEs compared to Medicaid health plans nationally. The measures shown in Exhibit V.5 below track back to what was shown in Exhibits V.1 through V.4. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the 14 measures reviewed, Anthem had 10 in which its rates exceeded the national median values. MDwise had eight, MHS has six, and CareSource had one.

**Exhibit V.5**
**Comparing Indiana Hoosier Healthwise Results to Health Plans Nationally on Selected HEDIS Measures**

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

| | Hoosier Healthwise HEDIS 2019 | | | |
|---|---|---|---|---|
| | Anthem | CareSource | MDwise | MHS |
| Access to Primary Care Practitioners 12-24 Months | 94.3% | 92.2% ↑ | 94.6% | 94.6% |
| Access to Primary Care Practitioners 25 Months - 6 Years | 85.5% | 75.6% ↑ | 84.6% | 85.1% |
| Access to Primary Care Practitioners 7-11 Years | 91.3% | 80.7% | 90.0% | 89.9% |
| Access to Primary Care Practitioners 12-19 Years | 90.7% | 80.4% | 89.5% | 90.0% |
| 6 or More Well Child Visits in the First 15 Months of Life | 73.0% ↓ | 57.4% | 72.3% | 64.0% ↓ |
| Annual Well-Child Visit in Third through Sixth Years of Life | 71.1% ↓ | 65.0% ↑ | 81.5% | 69.6% ↑ |
| Annual Adolescent Well-Care Visit Ages 12 to 18 | 67.7% ↑ | 47.0% ↑ | 68.9% | 62.5% ↑ |
| Child Immunizations | 64.5% ↑ | 47.9% ↑ | 62.5% ↑ | 62.8% ↑ |
| Appropriate type of asthma medication, Age 5-11 Years | 82.8% ↑ | not reportable | 75.5% ↑ | 84.4% ↑ |
| Appropriate type of asthma medication), Age 12-18 Years | 72.1% ↑ | not reportable | 63.1% ↑ | 71.4% ↑ |
| 7-Day Follow-Up After Hospitalization for Mental Illness | 45.7% ↓ | 40.0% ↑ | 47.4% ↓ | 50.5% |
| 30-Day Follow-Up After Hospitalization for Mental Illness | 72.6% ↓ | 69.4% ↑ | 72.3% | 74.9% ↑ |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase | 47.0% | 44.6% | 53.1% | 46.8% ↓ |
| Maintenance Phase | 57.1% | 45.1% | 62.7% ↑ | 54.8% |

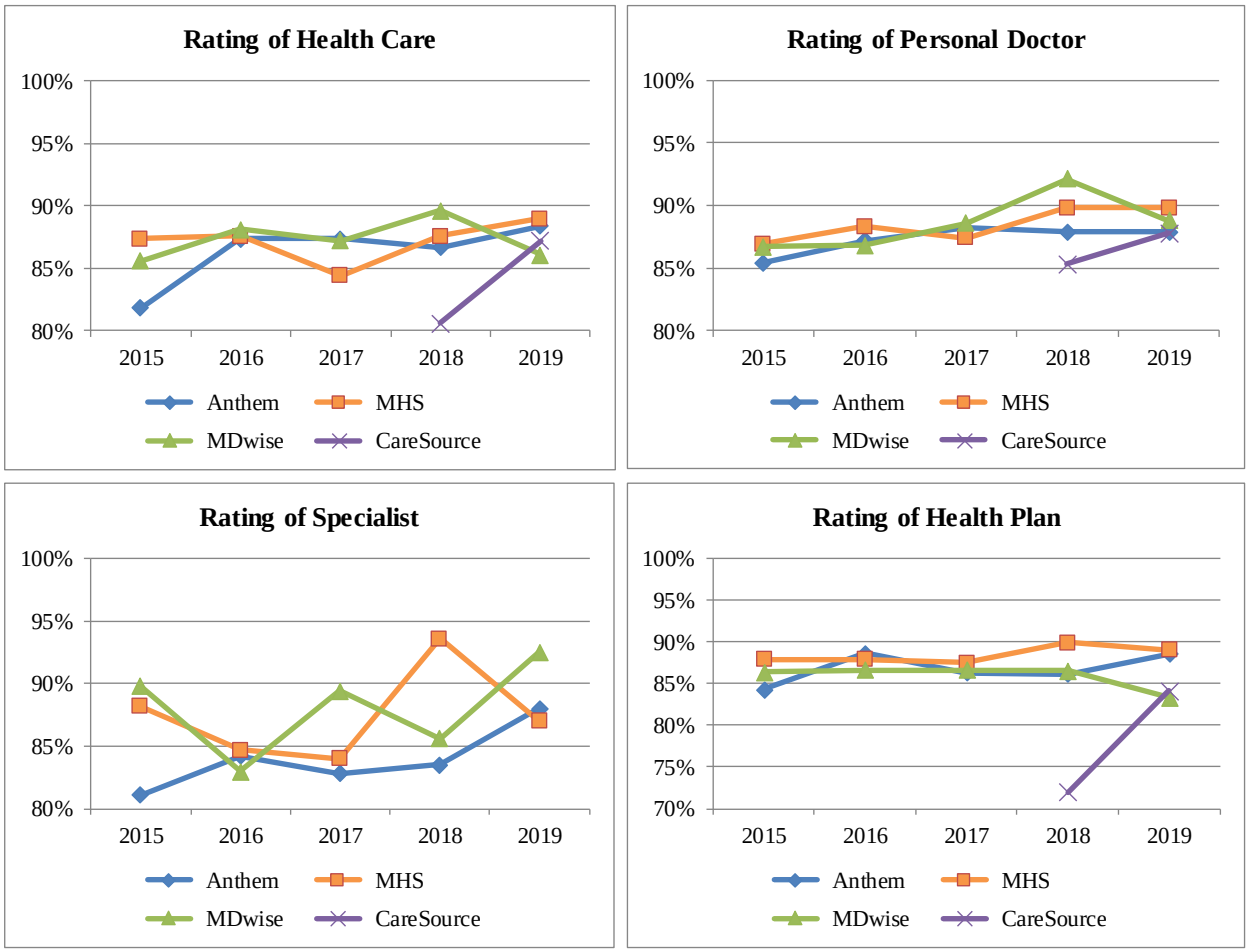
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

## CAHPS Results for Children Enrolled in Hoosier Healthwise

The Hoosier Healthwise MCEs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCEs to the OMPP. There is one survey specific to adults and one for children. Exhibits V.6 below summarizes the results from the child surveys that were administered over the last five years. The results presented include all children in Hoosier Healthwise—CHIP and traditional Medicaid. CareSource is included in these results starting with CAHPS 2018 (when questions were asked of members from 2017)

The percentages in Exhibit V.6 reflect those members that assigned a value of 8, 9 or 10 for each rating, where zero is the "worst possible" and 10 is the "best possible." The ratings themselves represent a composite of multiple questions on the survey related to the topic. The results are generally similar in the most recent survey year for all MCEs for Rating of Health Care and Rating of Personal Doctor. MDwise had a higher rating than its peers for the Rating of Specialist in the most recent year, but MDwise and CareSource had a lower result for Rating of Health Plan than Anthem and MHS.

**Exhibit V.6**
**Summary of Scores from CAHPS Child Survey (Members giving a rating of 8, 9, or 10 on 10-point scale)**

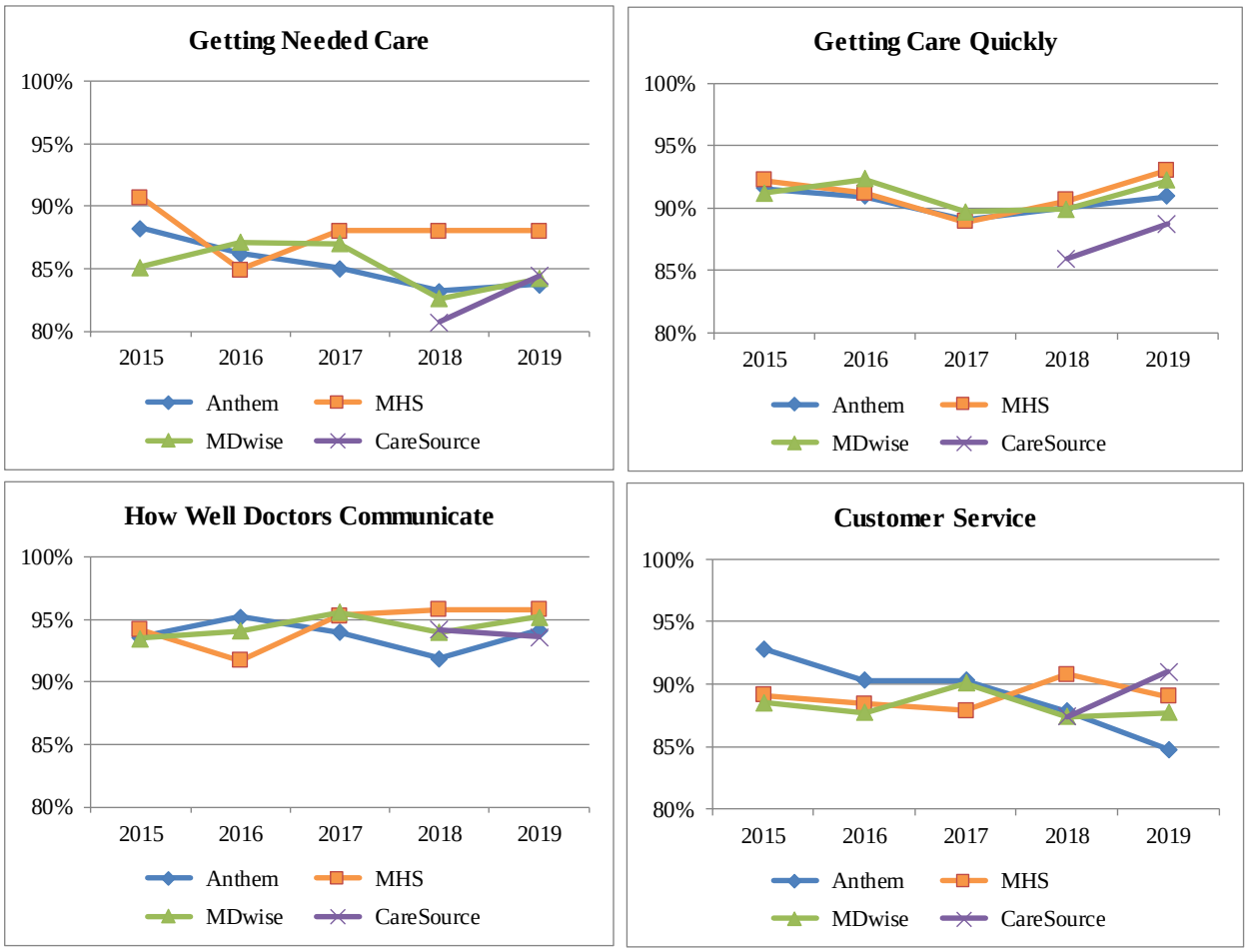



Sample too small for CareSource to report the Specialist rating.

The CAHPS instrument also compiles composite scores from a series of related questions on other topics as well. The results in Exhibit V.7 represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. All four MCEs scored best on the composite score for How Well Doctors Communicate in the 2019 survey (94 to 96 percent). Three of the MCEs also scored above 90 percent in the most recent survey on Getting Care Quickly.

Three of the MCEs were clustered together in the 2018 survey for the Getting Needed Care domain (84 percent), but MHS was higher than its peers (88 percent). The greatest variation was seen in the most recent survey on Customer Service (range from 85 to 91 percent).

**Exhibit V.7**
**Summary of Scores from CAHPS Child Survey (Percentages reflect responses of "Usually" or "Always")**



Similar to what was shown in Exhibit V.5 in the comparison of Indiana's HEDIS results to national health plans, B&A conducted a similar comparison for the CAHPS survey results. The measures shown in Exhibit V.8 below track back to what was shown in Exhibits V.6 through V.7. Values highlighted in green or blue indicate that the MCE scored better than the median value nationally. Among the eight measures reviewed, Anthem had five measures that exceeded the national median values, MHS had six, MDwise had three, and CareSource had one.

It should be noted, however, that the benchmark values for health plans nationally are clustered together. For example, in the How Well Doctors Communicate domain, the value at the 25th percentile nationally is 92.4 percent and the value at the 90th percentile is 96.6 percent. This is a 4.4 percentage point spread. So, although there is only a 2.2 percentage point spread in the results across the four MCEs, three different colors are coded in the exhibit because the spread is so tight among health plans nationally. In fact, the spread between the 25th percentile value and the 90th percentile value on any measure nationally is not greater than 8.5 percentage points.

**Exhibit V.8**
**Comparing Indiana Hoosier Healthwise Results to Health Plans Nationally on Selected CAHPS Measures**

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

| | Hoosier Healthwise 2019 Survey | | | |
|---|---|---|---|---|
| Composite Ratings | Anthem | CareSource | MDwise | MHS |
| Members are asked to give a rating of 1 to 10 on the survey (a 10 is the best score). | | | | |
| *The percentages shown are the percent of members who gave the MCE a score of 8, 9 or 10.* | | | | |
| Rating of the health plan (the MCE) | 88.6% ↑ | 84.1% ↑ | 83.3% ↓ | 89.0% |
| Rating of their own health care | 88.4% | 87.2% ↑ | 86.1% ↓ | 89.0% |
| Rating of their personal doctor | 87.9% | 87.8% ↑ | 88.8% ↓ | 89.8% |
| Rating of specialist seen most often | 88.0% ↑ | not reportable | 92.5% ↑ | 87.0% ↓ |
| Composite Scores on Key Measures | | | | |
| Members are asked questions on items important to the MCE's delivery of services. | | | | |
| For each question, members can answer "Always", "Usually", "Sometimes" or "Never". | | | | |
| *The percentages shown are the percent of members who responded "Always" or "Usually".* | | | | |
| Customer Service provided by the MCE | 84.8% ↓ | 91.0% ↑ | 87.7% | 89.0% |
| Getting Needed Care | 83.7% | 84.4% ↑ | 84.2% | 88.0% |
| Getting Care Quickly | 90.9% | 88.7% ↑ | 92.2% ↑ | 93.0% ↑ |
| How Well Doctors Communicate | 94.1% ↑ | 93.6% | 95.2% | 95.8% |

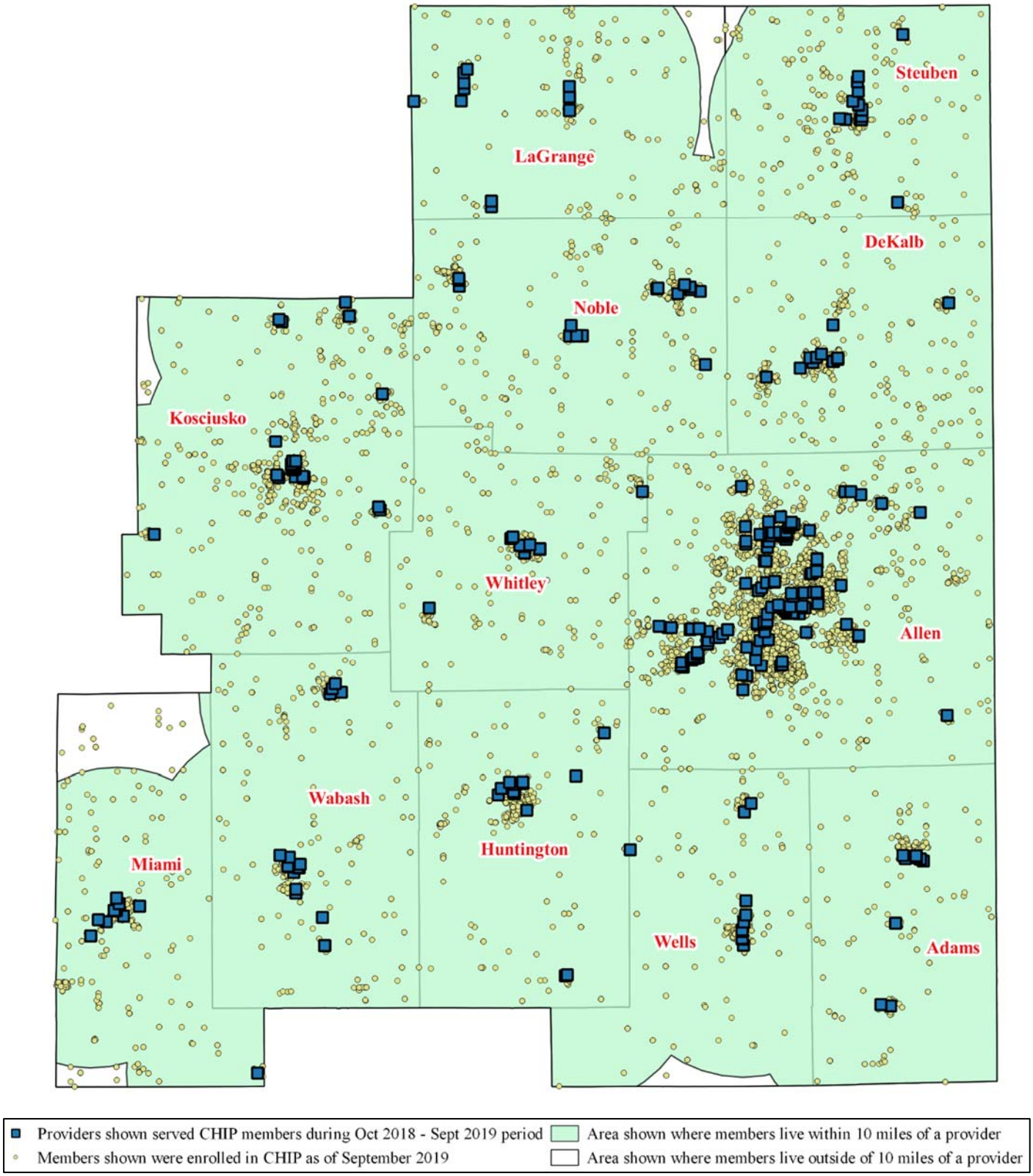
The arrow to the right of the result indicates if the MCE had a meaningful improvement or reduction in its rate from the prior year (+/- 2 percentage points). If there is no arrow, then the change from the prior year was not meaningful.

# Appendix:
## Maps By Region Showing Available Primary Medical Providers and Dentists

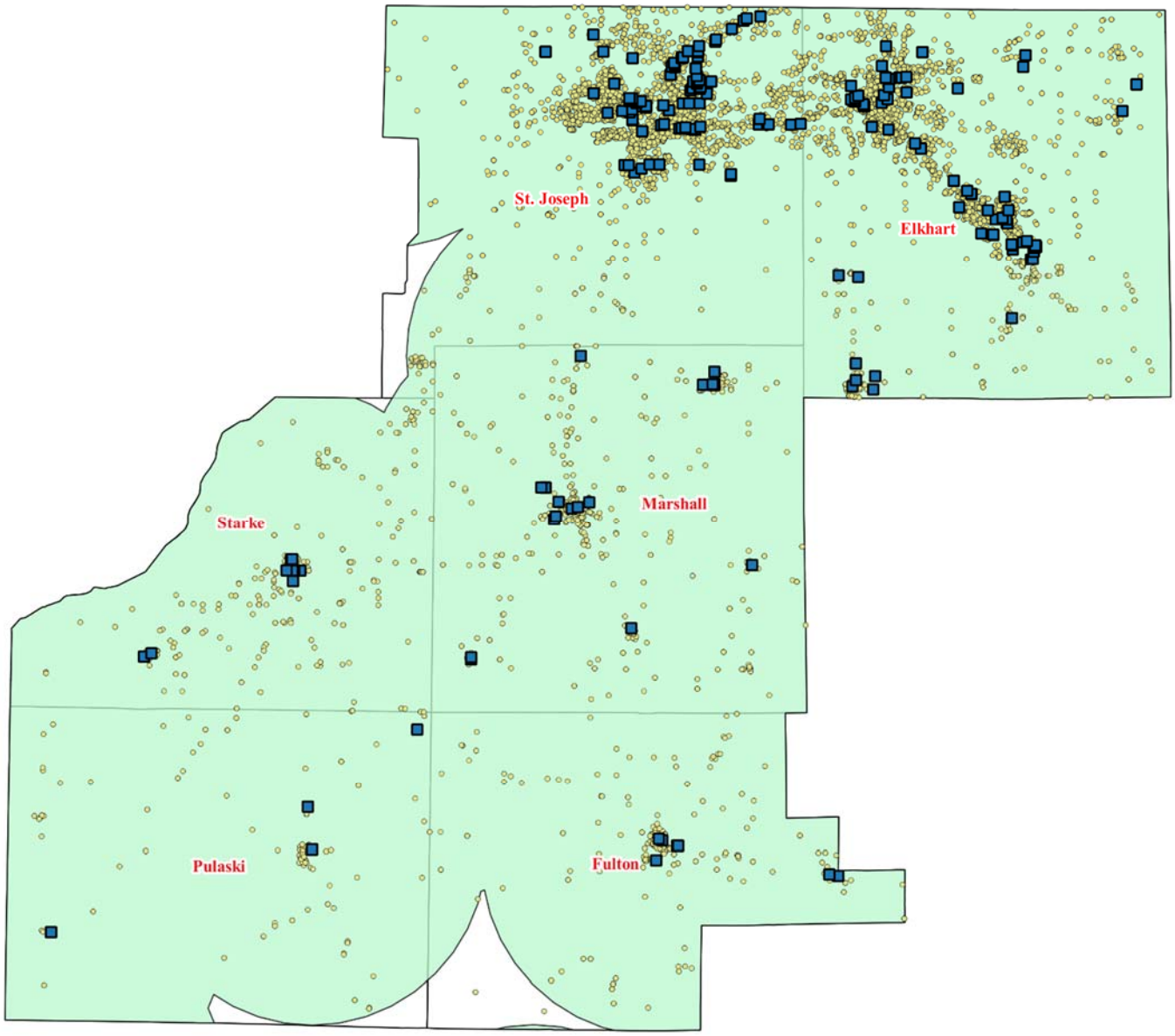
# APPENDIX A

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

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

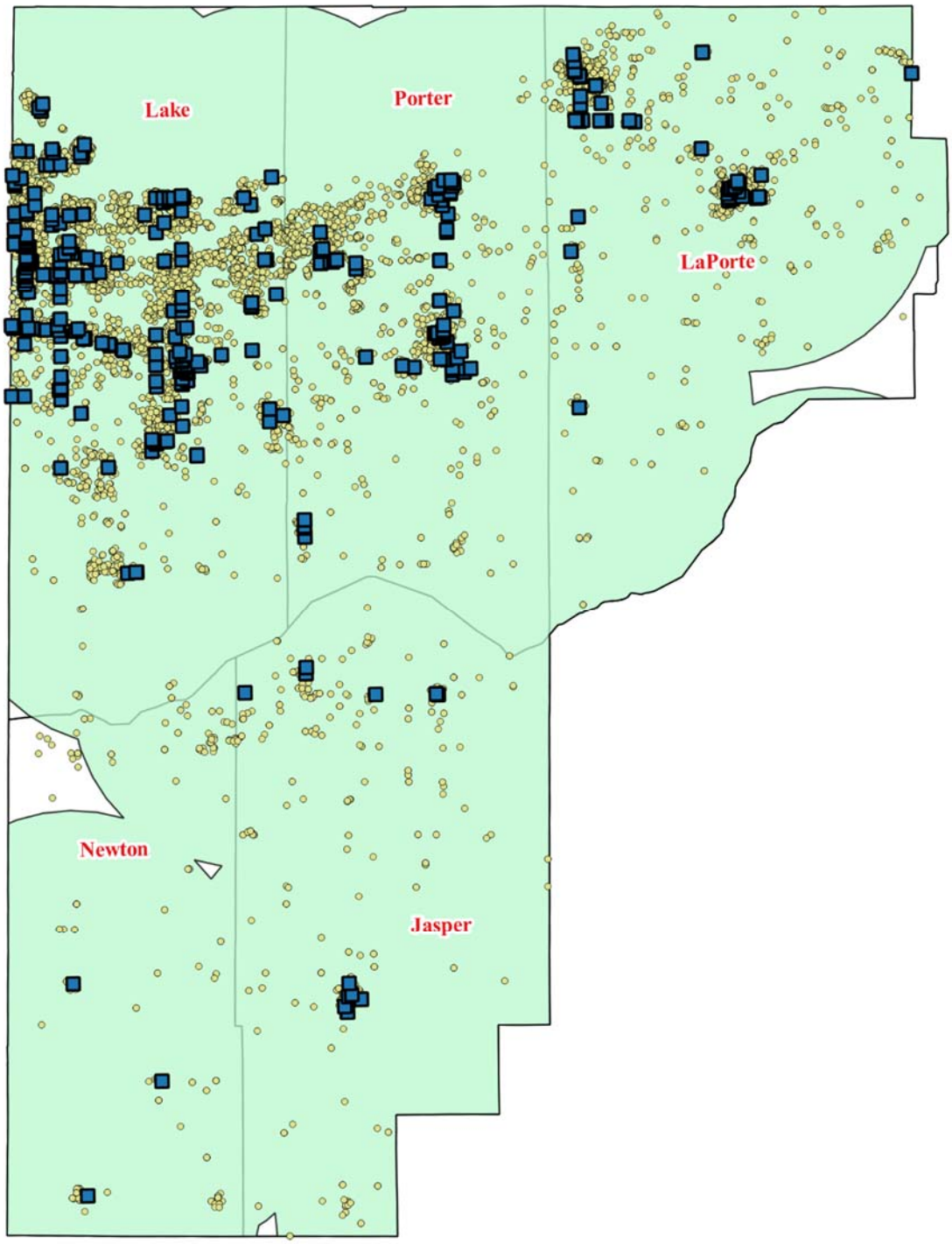


**Map A.2**
**Measuring Accessibility to Primary Care Providers**
**North Central Region**



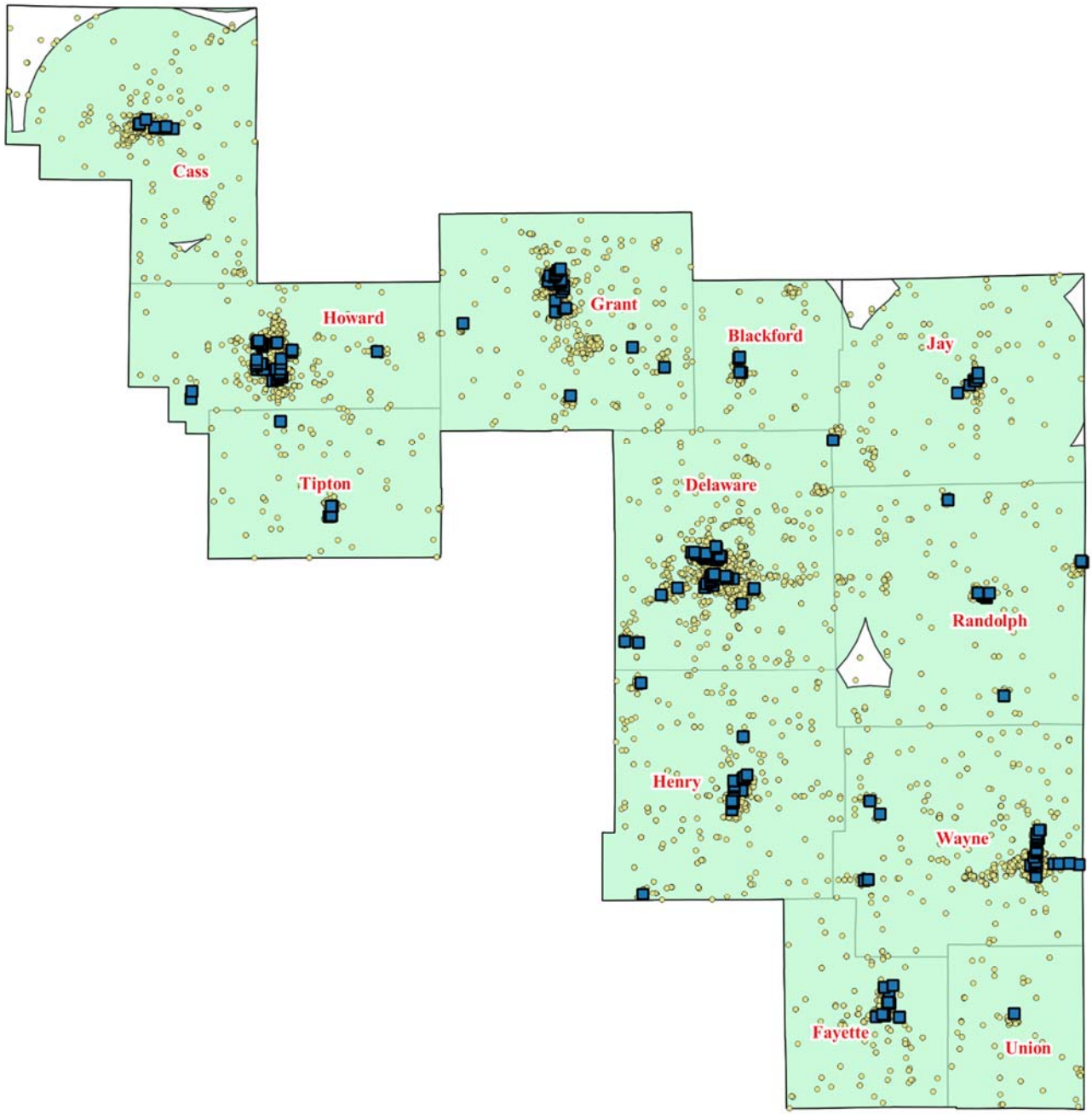

Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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



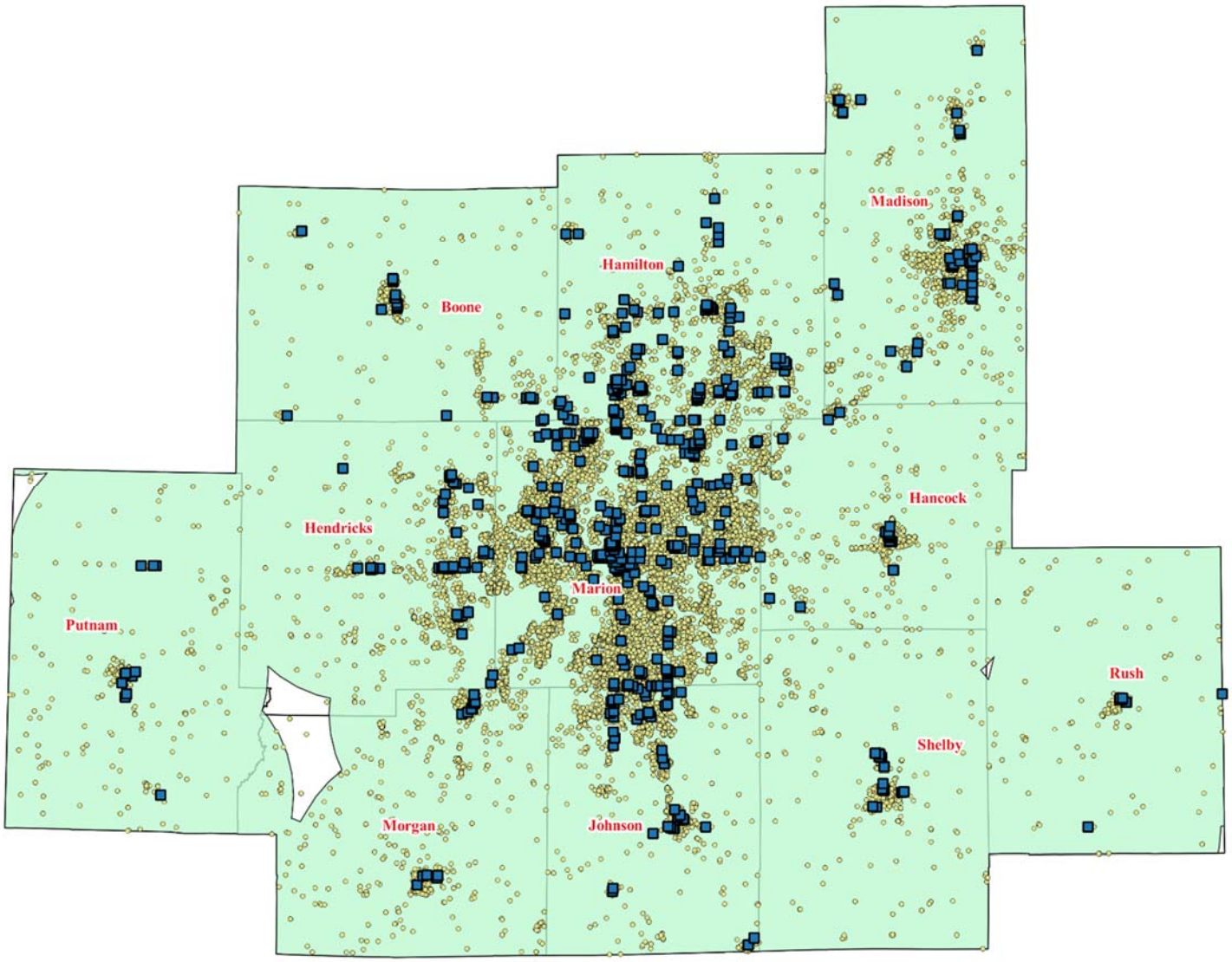

Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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



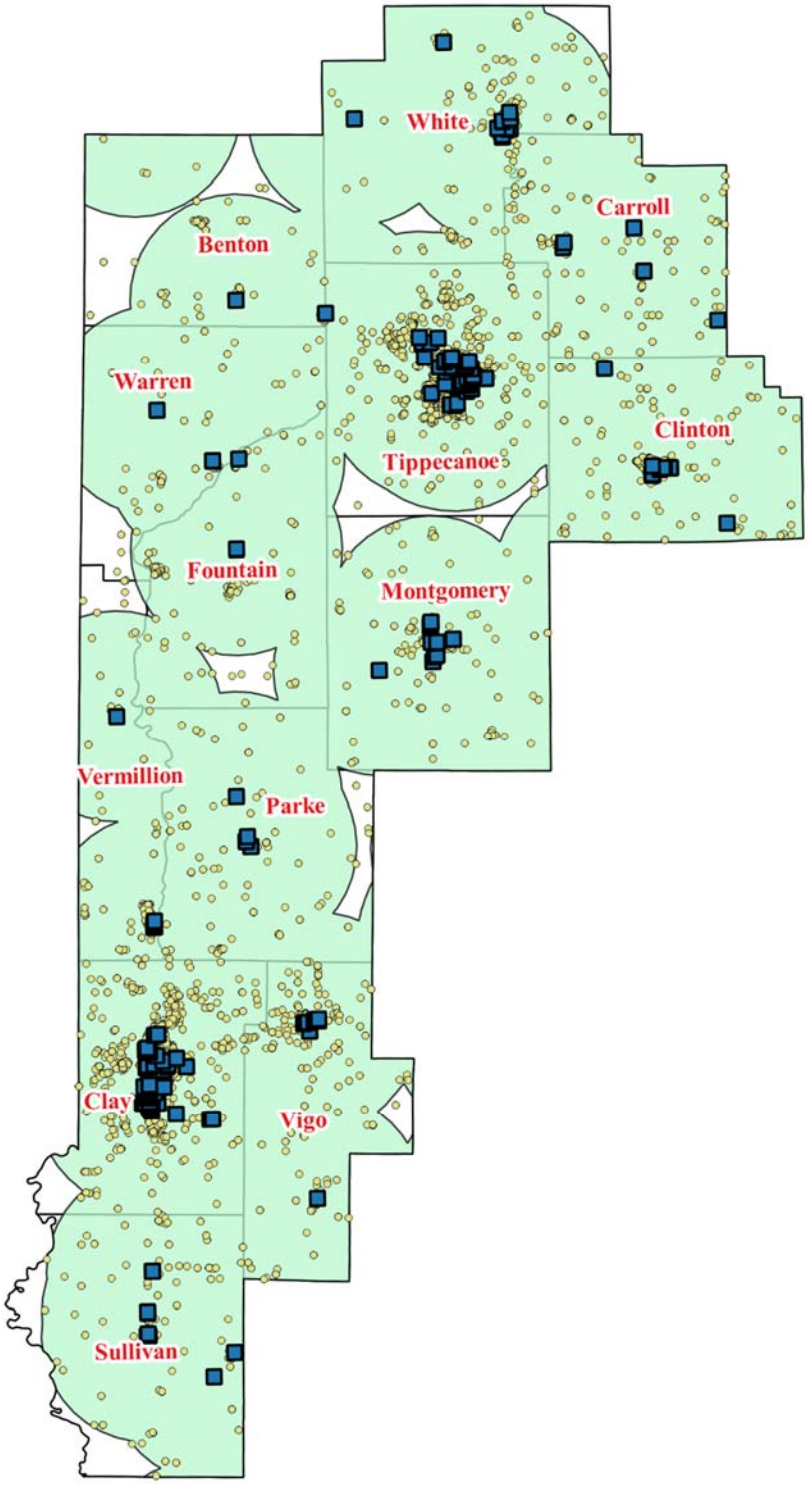

Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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



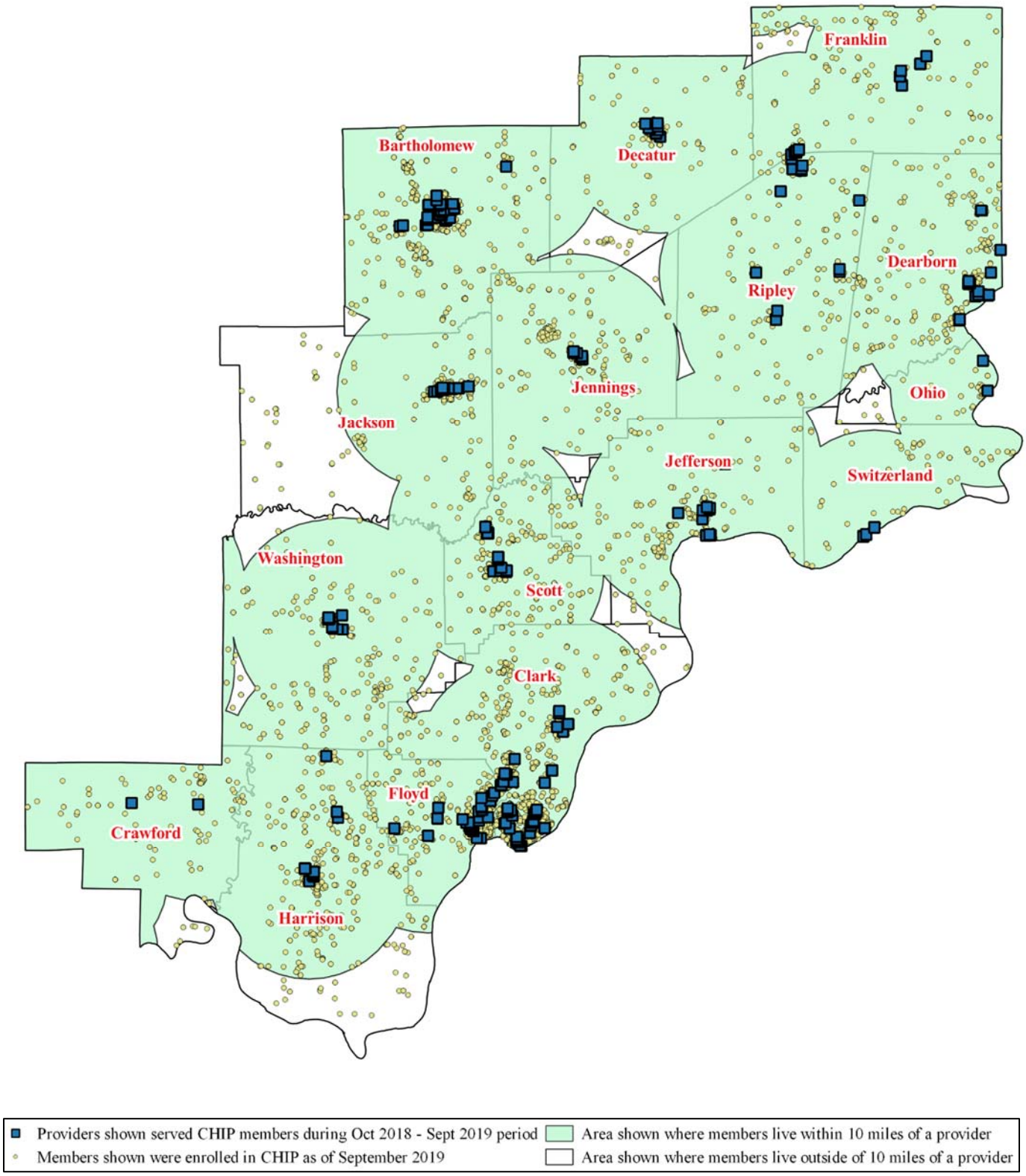

Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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

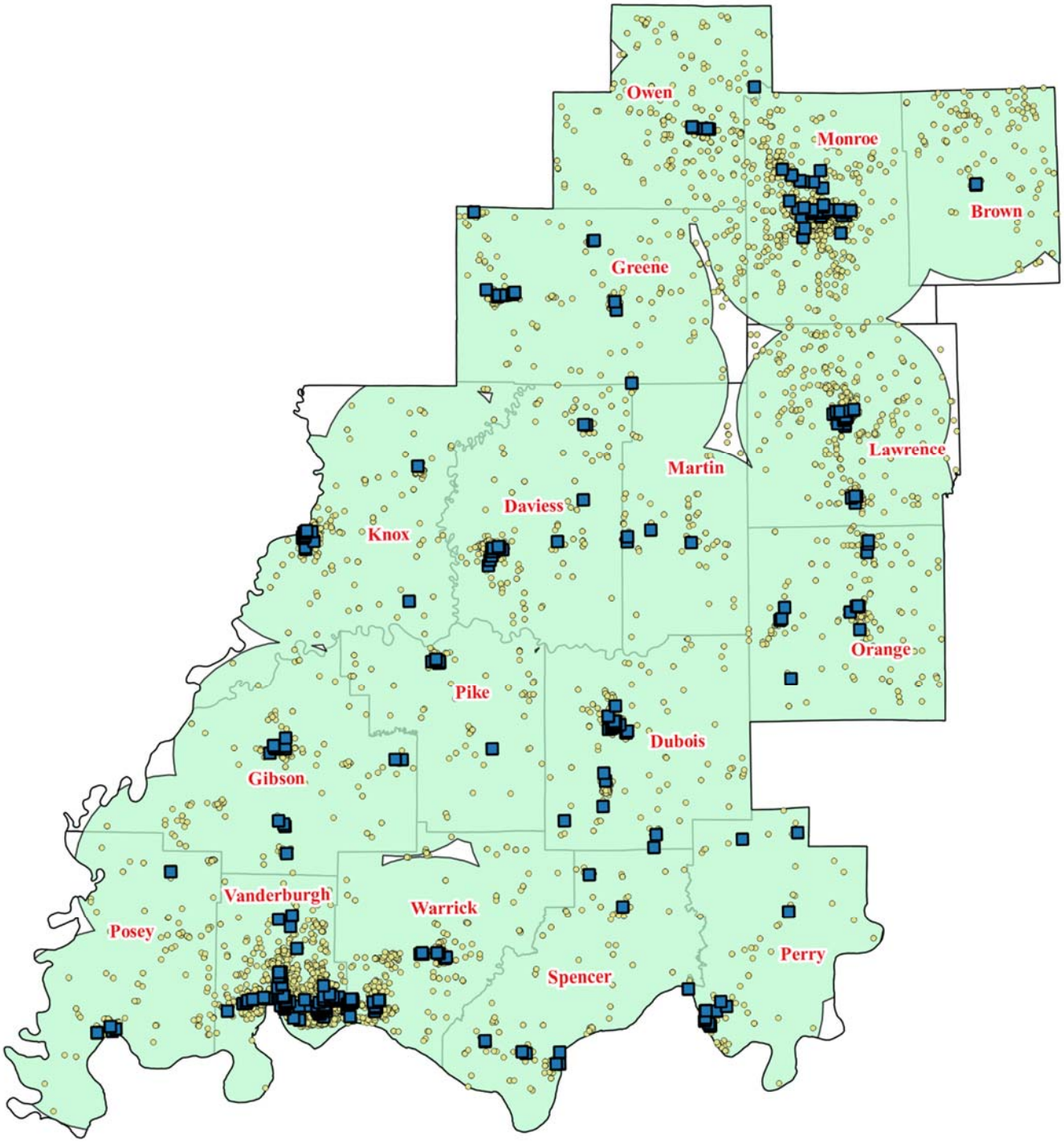



Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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



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

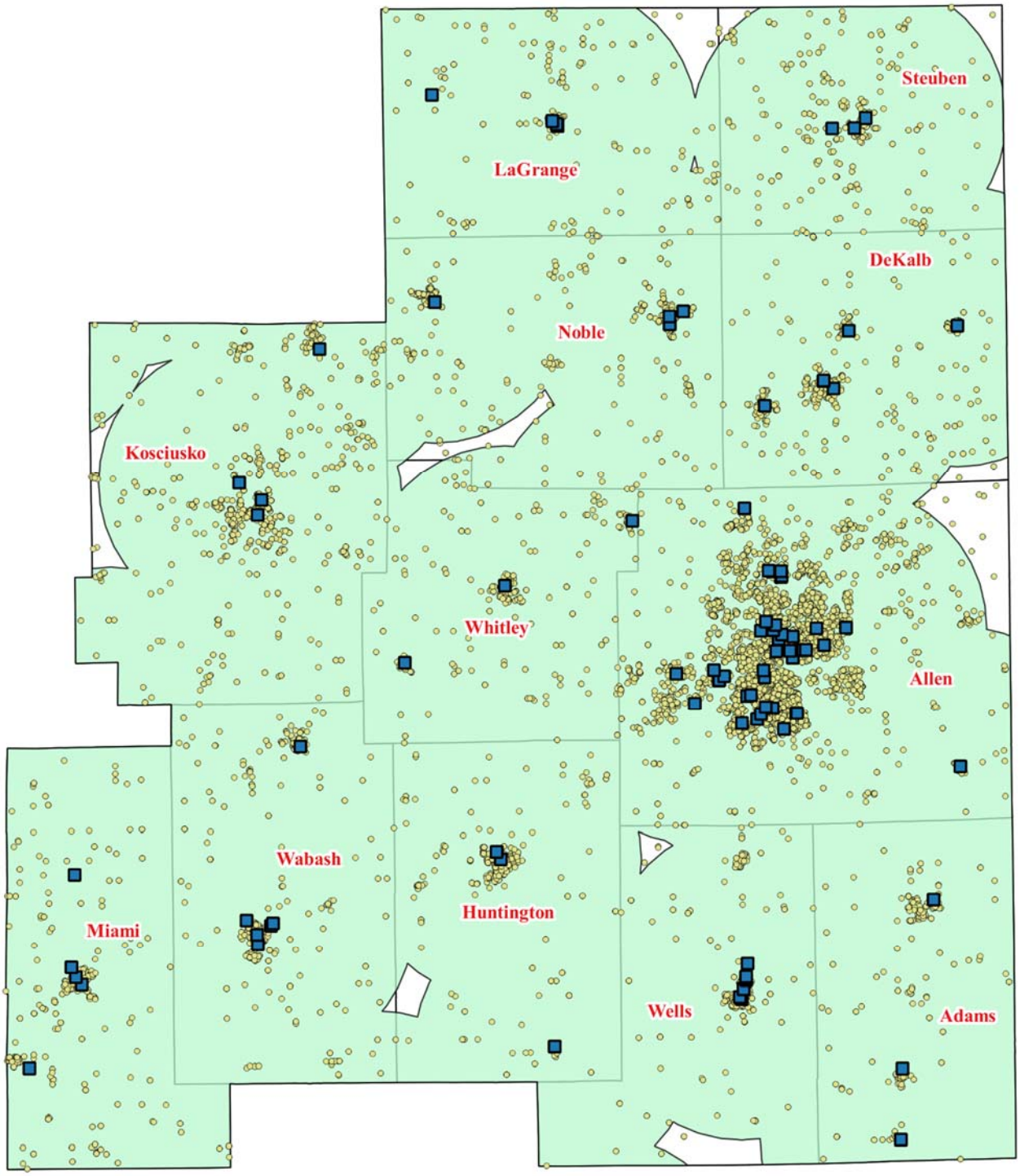



Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

# APPENDIX B

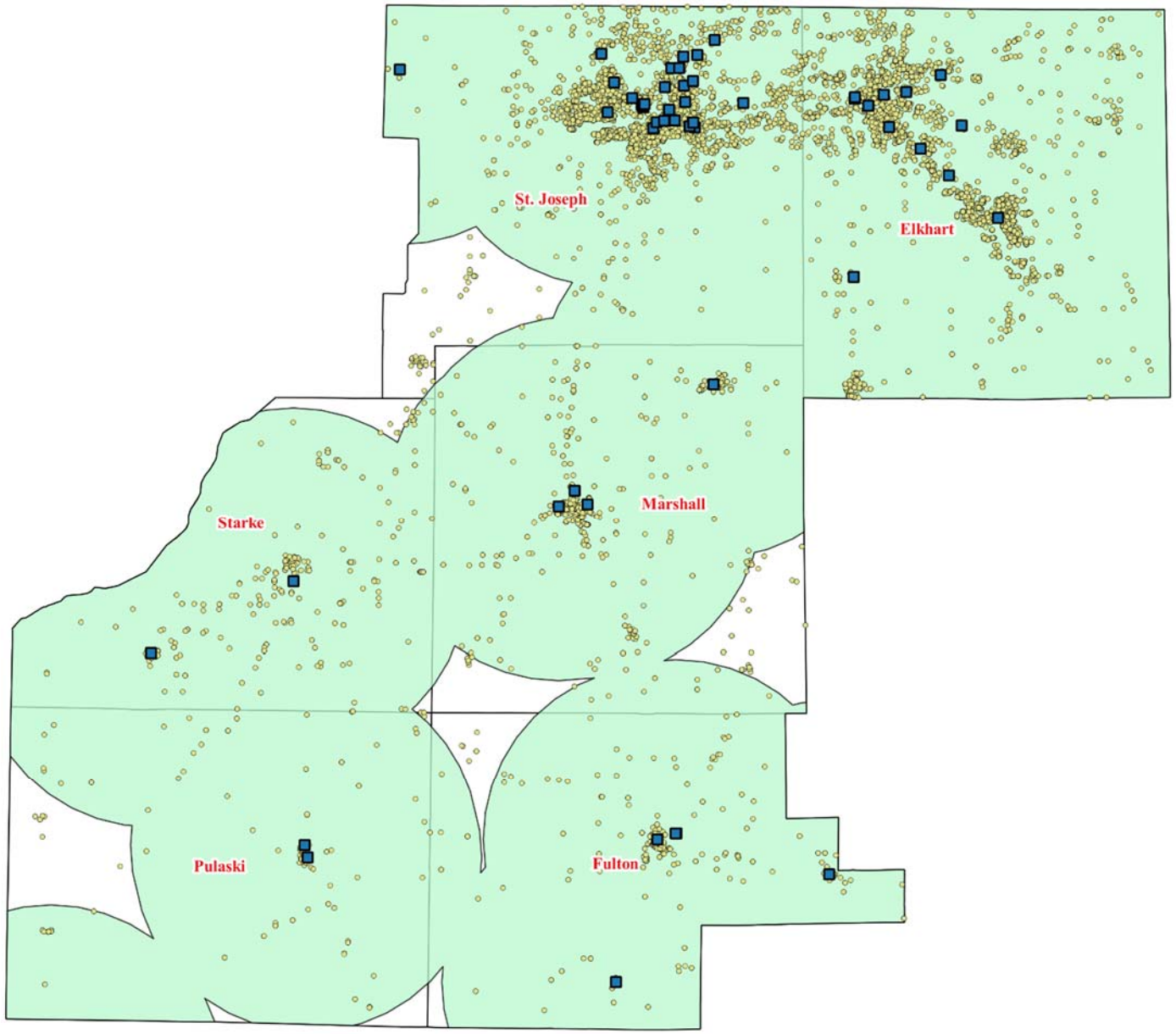
## Maps Showing Access to Dental Care Providers in CHIP, by Region

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



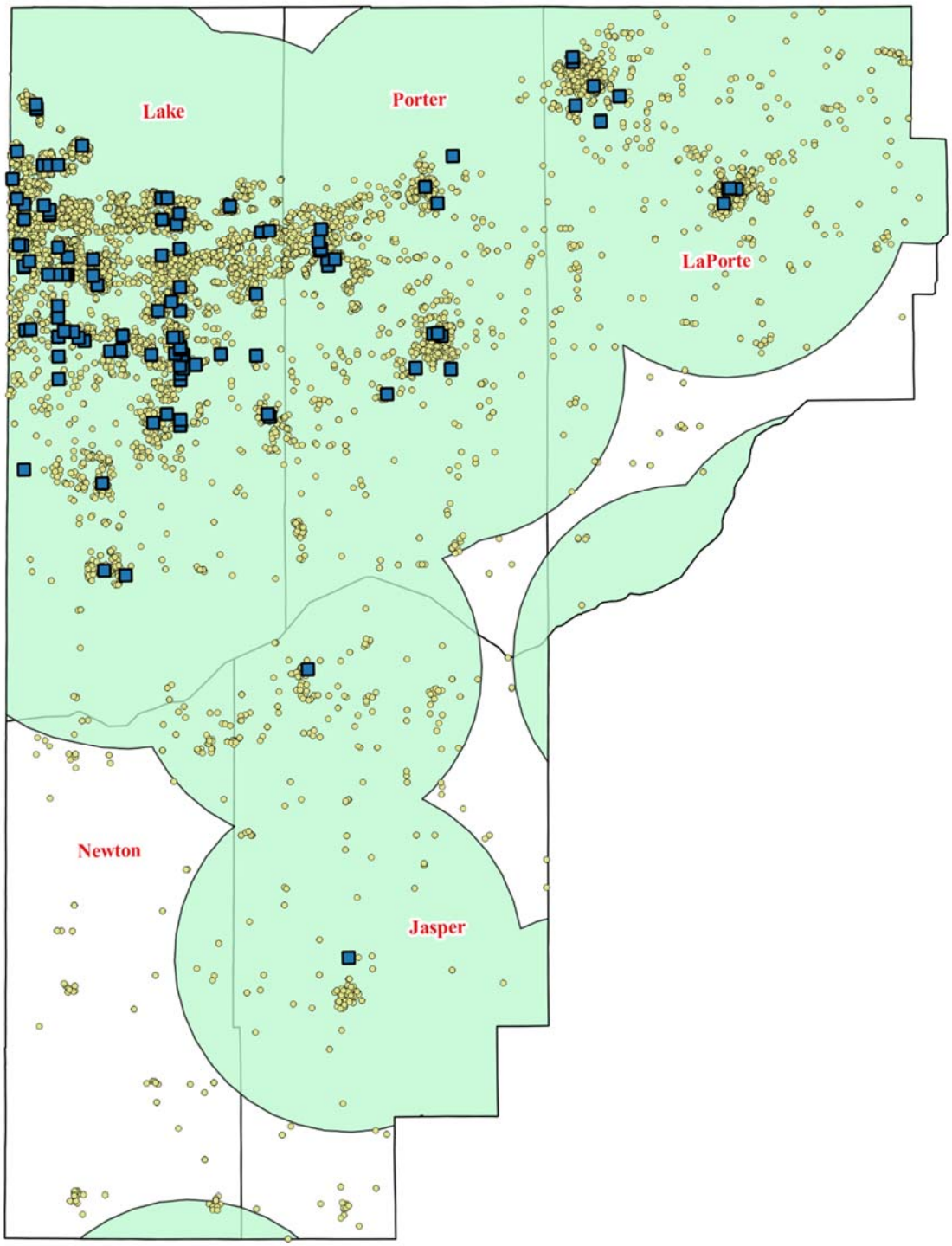

Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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



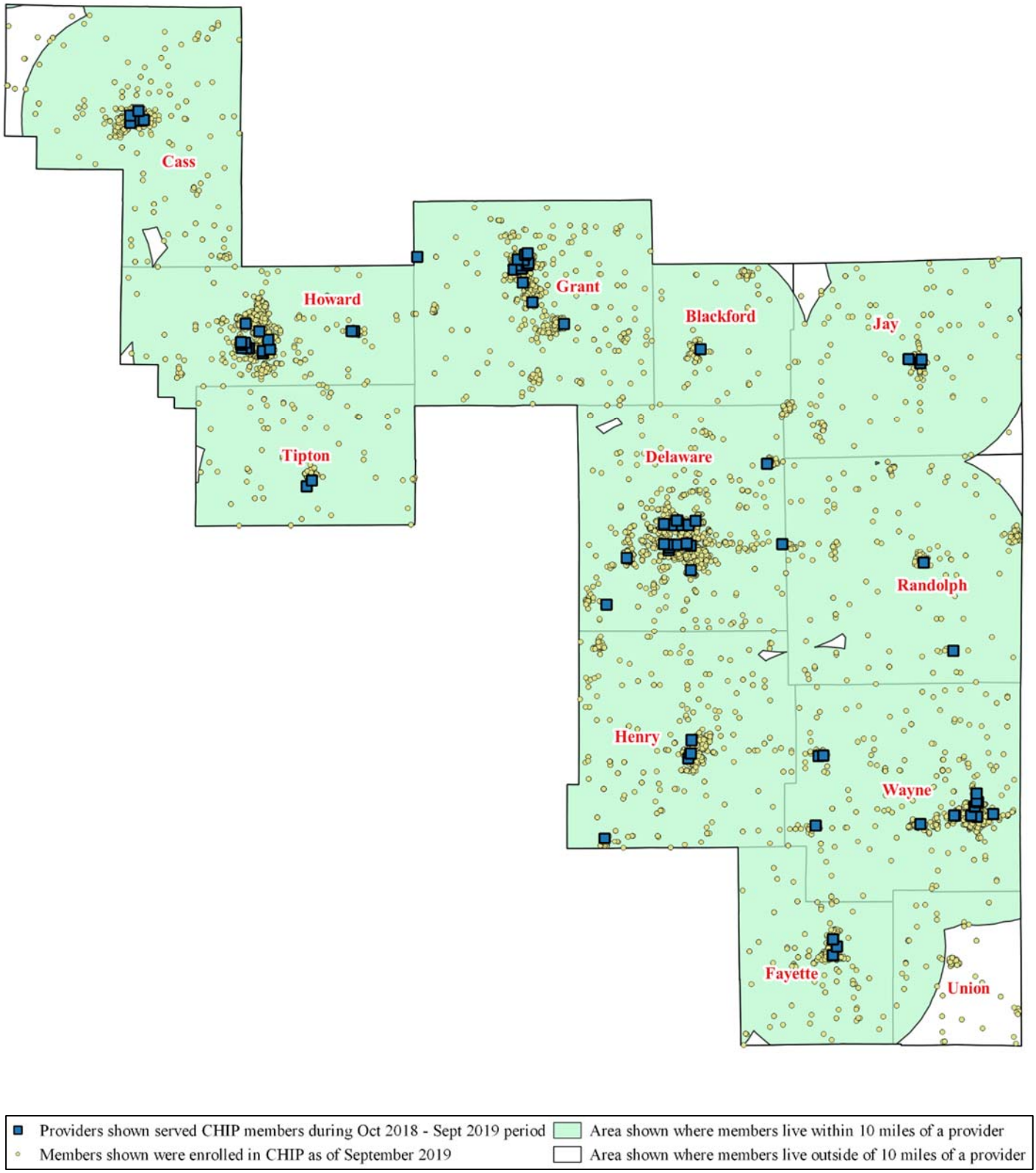

Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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

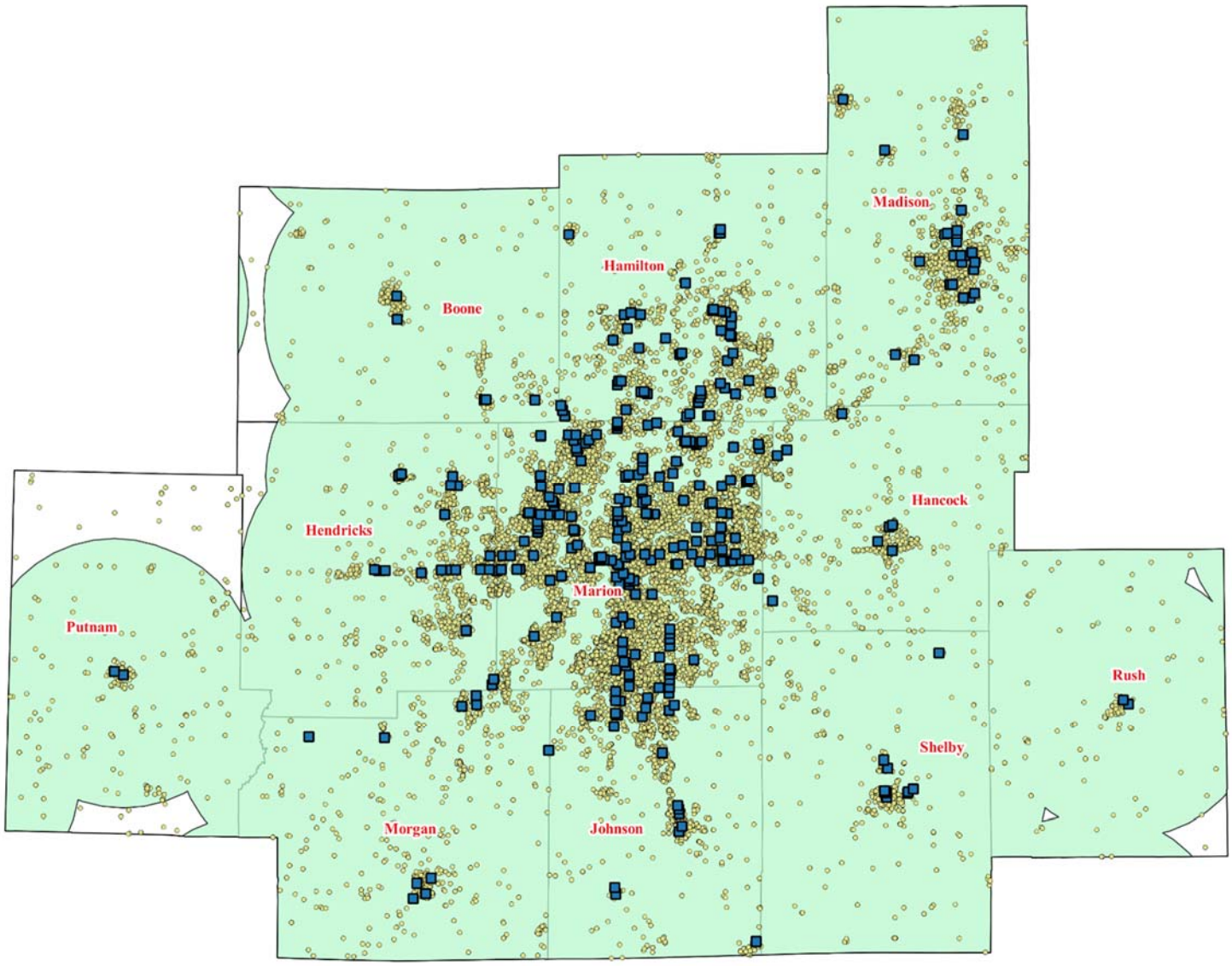



Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

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

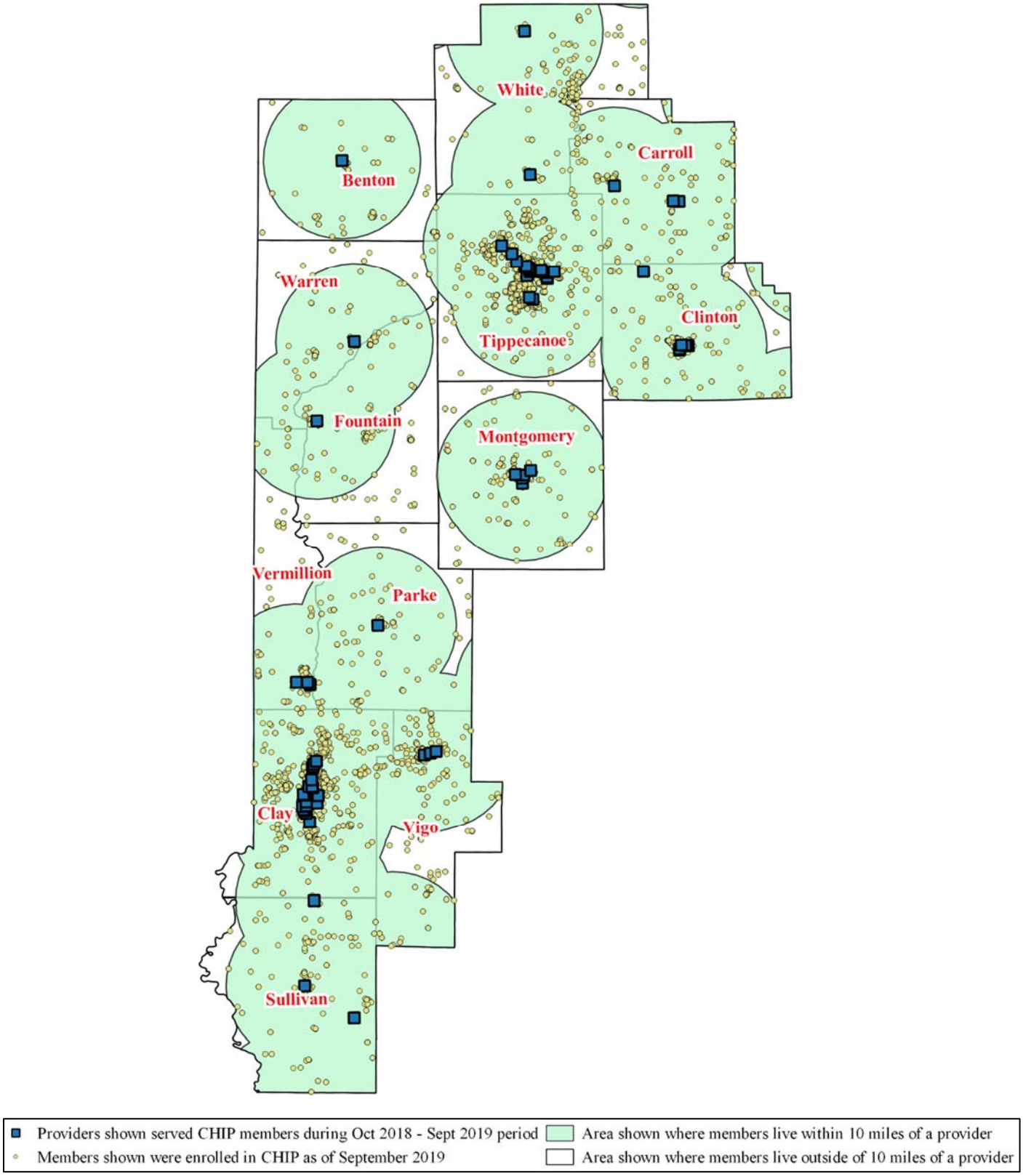


**Map B.5**
**Measuring Accessibility to Dental Providers**
**Central Region**

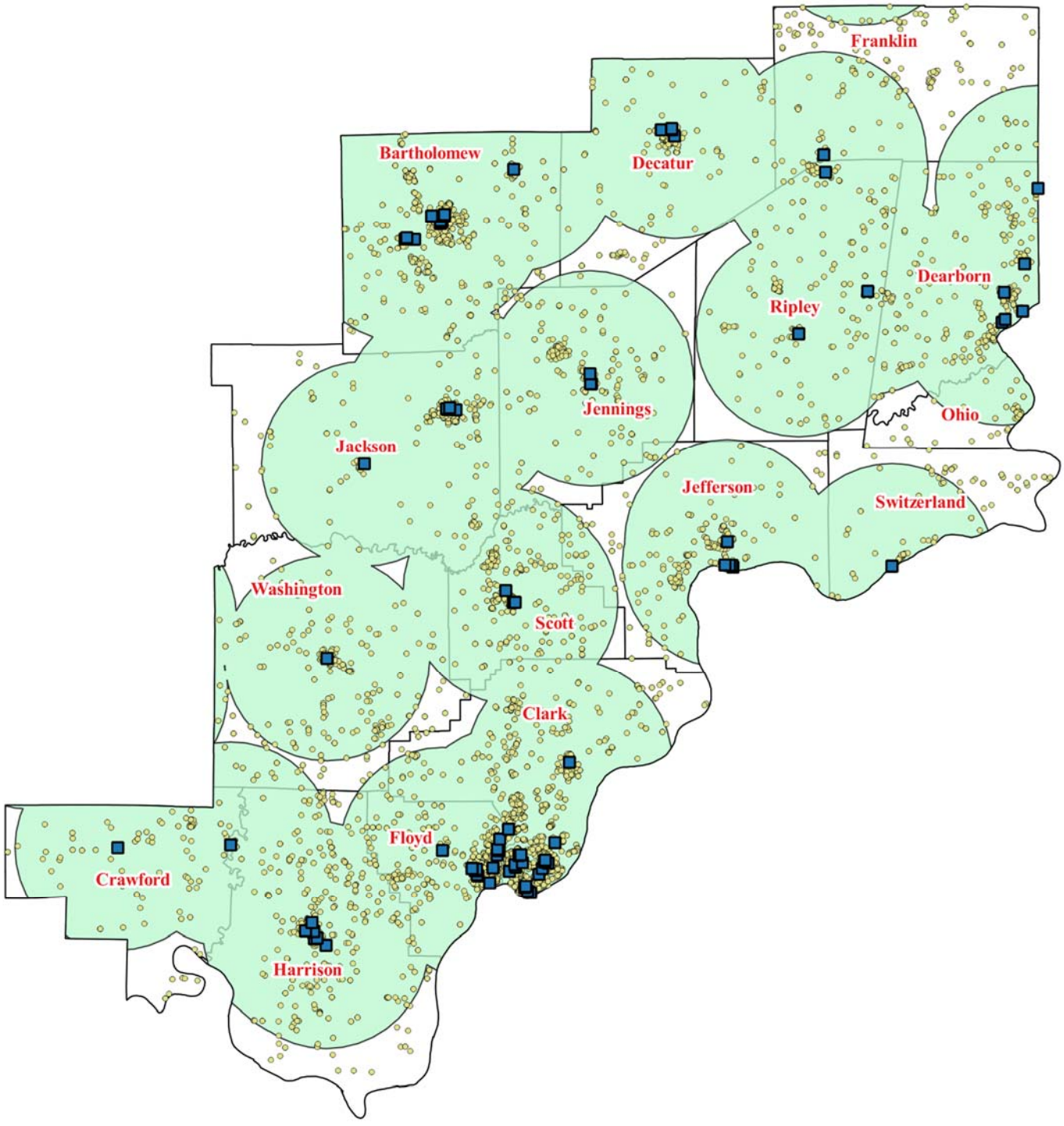



Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider

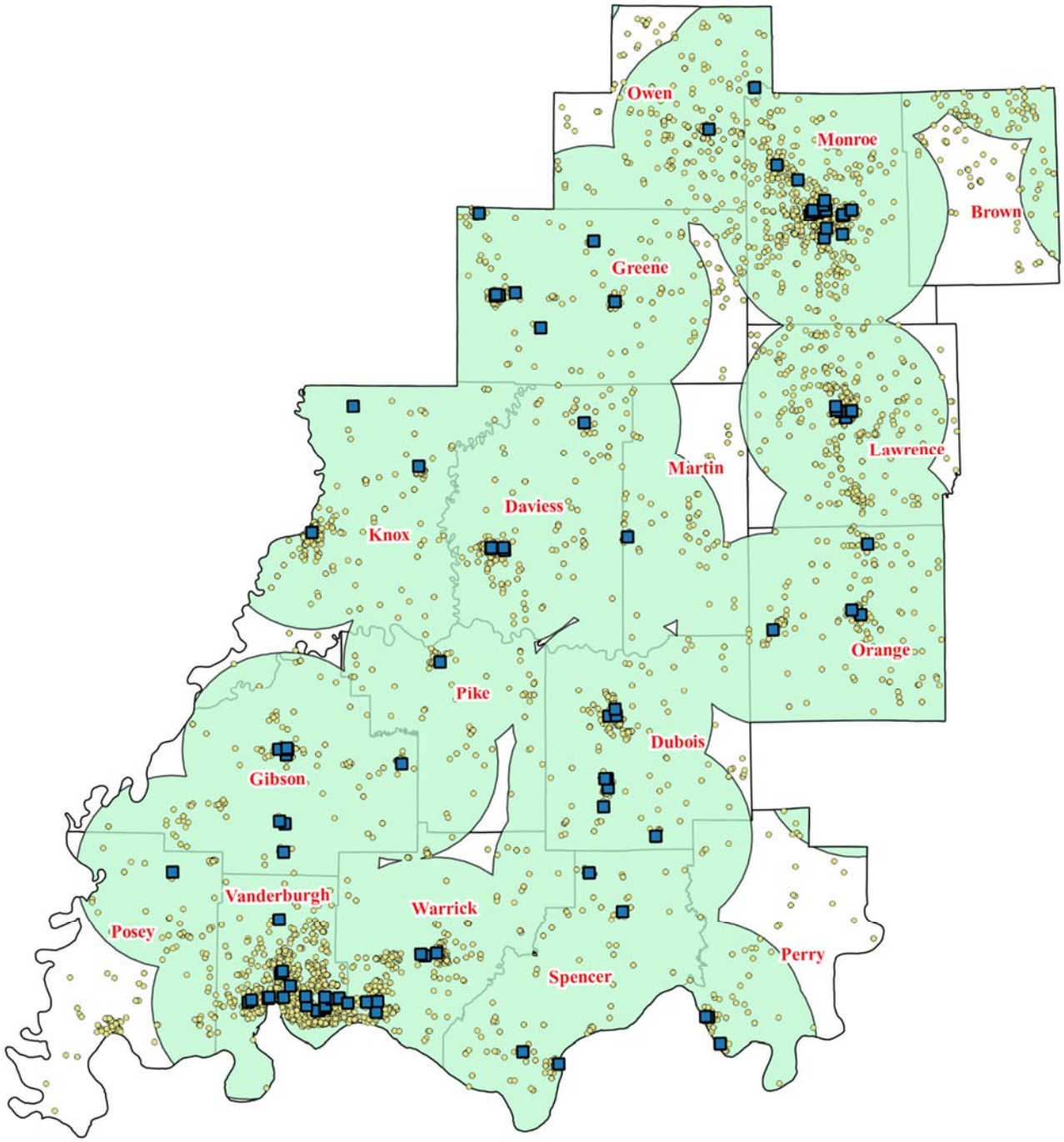
**Map B.6**
**Measuring Accessibility to Dental Providers**
**West Central Region**



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



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




Providers shown served CHIP members during Oct 2018 - Sept 2019 period
Members shown were enrolled in CHIP as of September 2019
Area shown where members live within 10 miles of a provider
Area shown where members live outside of 10 miles of a provider