

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

Final Report – April 2015



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ACKNOWLEDGMENTS

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Executive Summary



Independent Evaluation of Indiana's Children's Health Insurance Program for CY 2014

As of December 2014, enrollment in Indiana's CHIP was at 73,334, a 4.6 percent decrease from the prior year's membership of 76,898. Over the last three years, enrollment has decreased 1.9 percent. Growth in Indiana's CHIP over the last 15 years enabled the State to lower its uninsured rate among children in low-income families rapidly, although other states have recently improving their trend in reducing uninsured rates among children as well. Indiana's uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL) is now 9.7 percent compared to the national average of 10.7 percent. This places Indiana 28th lowest among states nationally¹. Last year, Indiana was ranked 15th lowest among states nationally.

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

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 150 percent of the FPL (\$35,775 per year for a family of four in 2014) 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 150 percent up to 200 percent of the FPL (\$47,700 per year for a family of four in 2014).
 - 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 (\$59,625 per year for a family of four in 2014).

Although the overall CHIP enrollment decreased 4.6 percent from December 2013 to December 2014, most all of the decrease was in the SCHIP Expansion portion. In the last year, there was a 2.1 percent decrease in MCHIP (Package A) enrollment. In contrast, enrollment in SCHIP Expansion decreased by more than 6,500 members.

Indiana is similar to many states that are seeing changes in enrollment in their CHIP programs in the last five years. Whereas Indiana's enrollment in its CHIP was fairly steady for many years in the first decade of the new century, enrollment began to rise toward the end of the decade as the Great Recession occurred. Now that the economy is improving, CHIP enrollment is experiencing some decline either due to the fact that families have improved incomes and no longer meet the income thresholds for eligibility or they have obtained employer-sponsored insurance. Additionally, although this cannot be verified, it is speculated that many families obtained coverage for their children under CHIP but adults went without coverage since they were not Medicaid eligible and had no employer-sponsored insurance. With the advent of health insurance coverage mandates for adults and for employers as outlined in the Affordable Care Act, the take up rate for insurance coverage has increased for adults. Many of these adults are likely purchasing coverage through their employer or through state or federal exchange sites. It is anticipated that some are adding their children to their new coverage and, in effect, substituting this coverage for CHIP coverage.

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

Independent Evaluation of Indiana’s Children’s Health Insurance Program for CY 2014

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 Calendar Year (CY) 2014. 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

The enrollment of children in Indiana’s CHIP is spread proportionally across the regions of the state when compared to the overall census of children in each region. Half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Just fewer than 33 percent of CHIP enrollees are teenagers, while the remaining 16 percent are under age 5. This distribution has been the case since the CHIP was introduced.

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

Monthly Premiums Charged to Families in Indiana's SCHIP (Package C)

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states, subject to an annual cap. In the CHIP, however, the federal match rate is higher than Medicaid. For example, in Federal Fiscal Year (FFY) 2014, for every dollar spent on medical services in Indiana’s CHIP, the state paid 23.16 cents and the federal government matched the remaining 76.84 cents. In the Medicaid program, the federal government match rate was 66.92 cents. The exception to the higher federal match rate is that MCHIP (Package A) children with Third Party Liability (TPL) insurance are not eligible for the higher match rate.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCEs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. In this past year’s survey, all three Hoosier Healthwise MCEs maintained high scores with all MCE’s scoring above 80 percent in each category and Anthem scoring above 90 percent in three categories (Getting Care Quickly, How Well Doctors Communicate, and Customer Service) MHS scoring above 90 percent in one category (How Well Doctors Communicate), and MDwise scoring above 90 percent in two categories (Getting Care Quickly and How Well Doctors Communicate).

Access to Services

B&A reviewed access by examining where CHIP members receive primary care services and preventive dental services. We matched claims of actual services received at the county level between where the member lives and where the attending provider is located.

For primary care visits, B&A first examined the counties where there may be an access issue. Statewide, 50 percent of CHIP members received a primary care service in the county in which they lived in FFY 2014. An additional 30 percent received a primary care service in a contiguous county. Statewide, access to dentists is high since 60 percent of CHIP members had their preventive dental visit in their home county and an additional 20 percent had their visit in a contiguous county. These results are similar to what was found in our study of these measures last year.

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency room visits, preventive dental visits, and had a pharmacy prescription for the periods FFY 2012, FFY 2013 and FFY 2014. The overall rate of usage for Emergency Room Visits and Pharmacy Scripts has decreased over the three years, while the use of primary care and preventive dental visits has remained steady. Comparisons were also made across various demographic cohorts, such as by MCE, by age and by race/ethnicity.

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

	FFY 2012	FFY 2013	FFY 2014
Primary Care Visit (office or clinic setting)	71%	71%	70%
Emergency Room Visit	28%	27%	24%
Preventive Dental Visit	68%	68%	68%
Pharmacy Script	72%	71%	68%

B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall for 2012, 2013 and 2014 and also by each of the demographic cohorts.

Some of the key findings from these two separate analyses are:

- Primary care visits were more prevalent among the youngest and eldest members, as 81 percent of children ages 5 and younger had a visit in FFY 2014. The percentage was lower for children in the middle age group (66 percent for ages 6-12 in FFY 2014).

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- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. Hispanic CHIP children had a primary care visit rate of 65 percent and African American children had a primary care visit rate of 59 percent which was significantly below the 73 percent rate for Caucasian children.
- In addition to more actual children having a primary care visit, there is also a disparity in the number of visits per 1,000 CHIP children for primary care in an office setting. The rate for Caucasian children is approximately 250 visits per 1,000 children during FFY 2014, but the rate for African American and Hispanic children is closer to 160 visits per 1,000.
- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCE, but it is more pronounced when reviewed at the per 1,000 member statistic. In FFY 2014, the average rate among MDwise members was 39 ER visits per 1,000 CHIP members; for MHS, it was 35 per 1,000; for Anthem, it was 27 per 1,000.
- Differences in ER use are found by age group within the CHIP. The highest use is among children under age 5 (32 percent of all members in FFY 2014) and lowest among children ages 6 to 12 (21 percent of all members in FFY 2014).
- One in five CHIP members of all race/ethnicities had used the emergency room in each of the years studied, but African-American children were more likely to have had multiple visits.
- The overall percentage of CHIP members receiving a preventive dental visit was 68 percent in FFY 2014.
- Hispanic CHIP children were more likely than children of other races/ethnicities to have a preventive dental visit with a rate of 78 percent in FFY 2014. Caucasian and African American children had a preventive dental visit rate of 67 percent and 65 percent, respectively.
- The overall percentage of members that had a pharmacy prescription has decreased from 72 percent to 68 percent in the last three years.
- The trend in total prescriptions received decreased modestly from last year's results as well, but the utilization varies by age group. The number of prescriptions per 1,000 CHIP members is highest for children ages 13-18 (541 prescriptions per 1,000 members on average in FFY 2014), followed by children ages 6-12 (408 prescriptions per 1,000 members), then by children ages 0-5 (321 prescriptions per 1,000 members).
- Caucasian children have a utilization rate of 522 prescriptions per 1,000 members in FFY 2014, which is 45 percent higher than the rate for African-American children (329 prescriptions per 1,000 children) and more than double the rate for Hispanic children (230 prescriptions per 1,000 children).

I

Introduction



Indiana CHIP at a Glance

- The uninsured rate for low income children in Indiana is 28th lowest in the country.
- Indiana's CHIP design features are similar to those found in a majority of state programs.

Independent Evaluation of Indiana's Children's Health Insurance Program for CY 2014

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

Not later than April 1, the office shall provide a report describing the program's activities during the preceding calendar year to the:

- (1) Budget committee;*
- (2) Legislative council;*
- (3) Children's health policy board established by IC 4-23-27-2; and*
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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 Calendar Year (CY) 2014. 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. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009² extended the program to September 2013. The Patient Protection and Affordable Care Act of 2010 extends funding for CHIP through Federal Fiscal Year (FFY 2015) and continues the authority for the program through FFY 2019. The Congressional Budget Office estimates that the expansion of federal funds will provide coverage to 4.1 million additional children in state Medicaid and CHIP programs who would have otherwise been uninsured by 2013.

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

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

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

- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 150 percent of the Federal Poverty Level, or FPL (\$35,775 per year for a family of four in 2014) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

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

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- 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 150 percent up to 200 percent of the FPL (\$47,700 per year for a family of four in 2014).
 - 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 (\$59,625 per year for a family of four in 2014).

Ten states have income eligibility thresholds similar to Indiana. As of January 2014, 19 states (including the District of Columbia) cover children at 300 percent FPL or above; 10 states cover children at a maximum between 250 and 299 percent FPL; and 22 states set a maximum between 175 and 249 percent³ (this is the group that Indiana falls under).

As of December 2014, enrollment in Indiana's CHIP was at 73,334⁴, a 4.6 percent decrease over the prior year's membership of 76,898:

- MCHIP (Package A) enrollment was 51,239 (down 2.1 percent from December 2013)
- Enrollment in the initial group of SCHIP (Package C) members was 21,628 (up 17.7 percent from December 2013)
- Enrollment in the 2008 expansion group of SCHIP (Package C) members was 467. This was a sharp reduction from the enrollment of 7,058 reported at the end of December 2013.

Indiana is similar to many states that are seeing changes in enrollment in their CHIP programs in the last five years. Whereas Indiana's enrollment in its CHIP was fairly steady for many years in the first decade of the new century, enrollment began to rise toward the end of the decade as the Great Recession occurred. Now that the economy is improving, CHIP enrollment is experiencing some decline either due to the fact that families have improved incomes and no longer meet the income thresholds for eligibility or they have obtained employer-sponsored insurance. Additionally, although this cannot be verified, it is speculated that many families obtained coverage for their children under CHIP but adults went without coverage since they were not Medicaid eligible and had no employer-sponsored insurance. With the advent of health insurance coverage mandates for adults and for employers as outlined in the Affordable Care Act, the take up rate for insurance coverage has increased for adults. Many of these adults are likely purchasing coverage through their employer or through state or federal exchange sites. It is anticipated that some are adding their children to their new coverage and, in effect, substituting this coverage for CHIP coverage.

More enrollment statistics appear in Chapter II of this report.

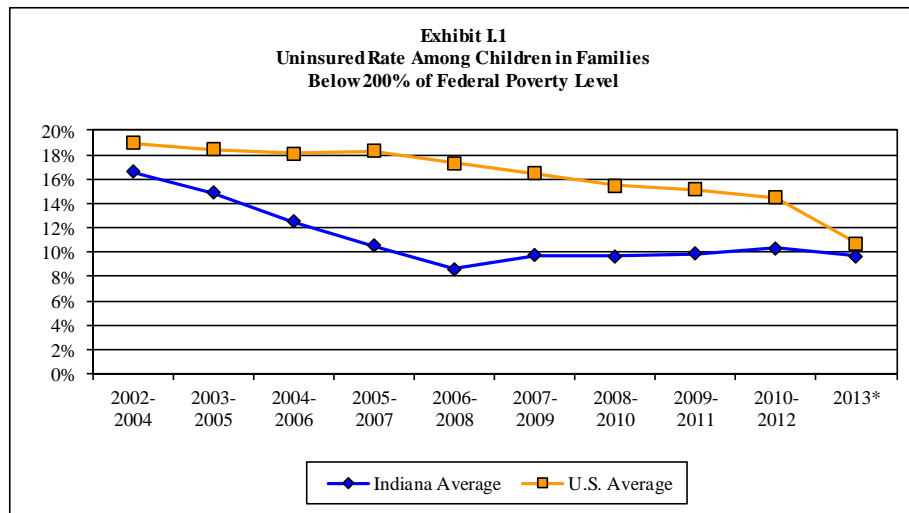
³ Heberlein, M., Brooks, T., Alker, J., Artiga, S., Stephens, J. (January 2013) *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*. Washington, DC: Georgetown University Center for Children and Families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

⁴ Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, FSSA Enterprise Data Warehouse, on February 6, 2015. Due to retroactive eligibility, this enrollment figure for December 2014 may be slightly understated from what will be the final figure for this time period.

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

The Census Bureau’s Current Population Study (CPS) surveys citizens each March on their health insurance status. An uninsured rate is computed for each state, but because state-specific samples are usually small, it is customary to measure this rate over a three year average. However, because of redesigned measures beginning in 2013, multi-year averages are not possible for the 2013 CPS survey conducted in March of 2014; therefore, the 2013 one-year time period is the most recent available.

Indiana has been more effective than the nation as a whole in reducing the uninsured rate among low-income children. Among children in families with incomes below 200 percent of the FPL, Indiana’s most recent uninsured rate is 9.7 percent compared to the national average of 10.7 percent. Indiana’s uninsured rate declined for six consecutive study periods before increasing in 2009 (refer to Exhibit I.1 on the next page). The rate has remained steady for the last five measurement periods while the national average decreased significantly in the last year. Success in remaining lower than the national average can be partially attributed to Indiana’s effective outreach to enroll children in its CHIP.



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements
http://www.census.gov/hhes/www/hlthins/data/children/uninsured_low-income.html
 * Due to redesigned measures beginning in 2013 multi-year averages are not possible.

In absolute numbers, the number of uninsured children in families with incomes below 200 percent of the FPL has been cut from an estimated 109,000 in the 2000-2002 three-year average period to 74,000 in the 2013 period (Source: Current Population Survey).

Indiana’s 9.7 percent uninsured rate among children in families below 200 percent of the FPL places the State as the 28th lowest uninsured rate in the country for this income group among all states. Last year, Indiana was ranked 15th lowest among states nationally.

The uninsured rate varies by family income level in the state (refer to Exhibits I.2 below and I.3 on the following page). Using the data from the 2014 Current Population Survey, 58 percent of all uninsured children in Indiana may already be eligible for CHIP based on family income.⁵

⁵ Although family income is used to determine eligibility, another criterion for eligibility in SCHIP (Package C) is that children cannot have credible health coverage from another source, regardless of family income.

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**Exhibit L2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana
2013**

	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Total for Children that may be Eligible for Indiana's CHIP			
Income up to 250% FPL	77,048	58%	8.9%
Total for Children Not Eligible for Indiana's CHIP			
250% and above	55,914	42%	6.4%
All Children	132,962	100%	7.7%

Source: U.S. Census Bureau, Current Population Survey

http://www.census.gov/hhes/www/cpstc/csp_table_creator.html

The uninsured rate for Caucasian children (3.8 percent) in this income group is lower than other race/ethnicities. The rate for African American children (14.9 percent) and Hispanic children (31.0 percent) were much higher than the state average.

**Exhibit L3
Uninsured Rates for Children (Age 0-18) by Race/Ethnicity in Indiana
For Children in Families At or Below 250% FPL
2013**

Race/Ethnicity	Total Uninsured	Pct of Uninsured Children at this FPL	Uninsured Rate
Caucasian Non-Hispanic	20,794	27%	3.8%
African Amer. Non-Hispanic	26,498	34%	14.9%
Hispanic (any race)	29,756	39%	31.0%
All Children	77,048	100%	8.9%

Source: U.S. Census Bureau, Current Population Survey

http://www.census.gov/hhes/www/cpstc/csp_table_creator.html

Indiana’s CHIP is Integrated with Other Medicaid Programs

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

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

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

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

One design difference between Indiana’s CHIP and traditional Medicaid are co-payments that are imposed. Members in 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 \$10 co-pay for ambulance service. There are no co-pays charged to children in MCHIP (Package A).

The other design difference between CHIP and traditional Medicaid is that families of children enrolled in SCHIP (Package C) are required to pay a monthly premium. The premium varies by the income level and the number of children covered in the family as outlined in Exhibit L.5 below.

**Exhibit L5
Monthly Premiums Charged to Families in Indiana's SCHIP (Package C)**

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

Design features of Indiana’s SCHIP (Package C) are similar to those taken by other states. In a 51-state survey of CHIP programs nationwide (including the District of Columbia), Indiana was similar to the other states in the following areas (with number of states having a similar policy to Indiana)⁶:

⁶ Heberlein et al.

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- Integrated Medicaid/CHIP eligibility determination system (36 states)
- Face-to-face interview not required at the time of application or at renewal (50 states), although Indiana requires a telephone interview unlike other states
- Asset test not required in determining eligibility (36 states)
- Electronic verification data match with SSA to verify citizenship (30 states)
- Renewal occurs every 12 months (49 states)
- Co-pays charged for prescriptions (26 states)
- Premiums charged to members (33 states). Of those that charge premiums,
 - Up to the 150% FPL level, Indiana charges \$0 (like 34 other states)
 - At the 151-200% FPL level, Indiana charges premiums on a sliding scale (like 27 other states)
 - At the 201%-250% FPL level, Indiana charges higher premiums than the lower FPL group (like 18 other states)

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

- Indiana does not impose co-pays for non-emergent ER visits (23 states do), non-preventive physician visits (23 states do), or inpatient hospital visits (16 states do).
- The required period of no insurance prior to enrolling (also known as the "going bare" period) is three months in Indiana. Thirteen states have no go bare period, 19 states are like Indiana with a go bare period of one to three months, and 18 states impose a go bare period greater than three months.
- Enrollment is continuous for 12 months, regardless of circumstance in 32 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

II

Enrollment Trends in Indiana's CHIP



Enrollment Trends at a Glance

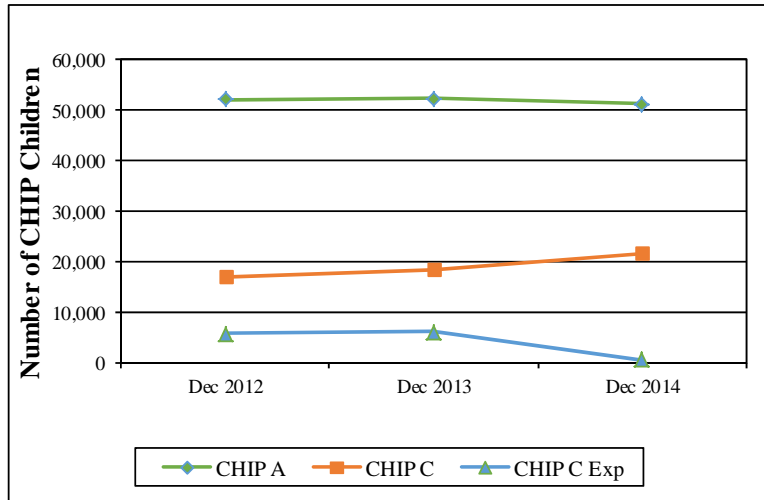
CHIP Enrollment Dec 2013: 76,898

CHIP Enrollment Dec 2014: 73,334

134,390 children enrolled in Indiana's CHIP at some point in
State Fiscal Year 2014

Indiana's Children's Health Insurance Program (CHIP) experienced a decrease in enrollment in 2014 to 73,334 members from Calendar Year (CY) 2013 of 76,898, a 4.6 percent decrease. Over the last three years, enrollment has decreased 1.9 percent. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 150% of the federal poverty level (FPL), enrollment has decreased 1.7 percent since December 2012. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 150%-200% of the FPL, enrollment has grown 27.3 percent during this three-year period. The SCHIP (Package C) Expansion group instituted in October 2008 (201-250% of the FPL) saw enrollment decrease 91.8 percent since 2012.

Exhibit II.1
Recent Enrollment in Indiana's CHIP



Source: Indiana's FSSA Enterprise Data Warehouse

Enrollment and Disenrollment Trends

New enrollees continue to remain a large percentage of children in the program, but the proportion of total members that are new each year is decreasing. Burns & Associates, Inc. (B&A) analyzed the enrollment of members within each portion of Indiana's CHIP on a monthly basis. From this, we tabulated how many members in the month were new to the program within the previous 12 months. An average of this statistic was computed across months in CY 2014 and was then compared to a similar statistic for two prior time periods examined in previous reports.

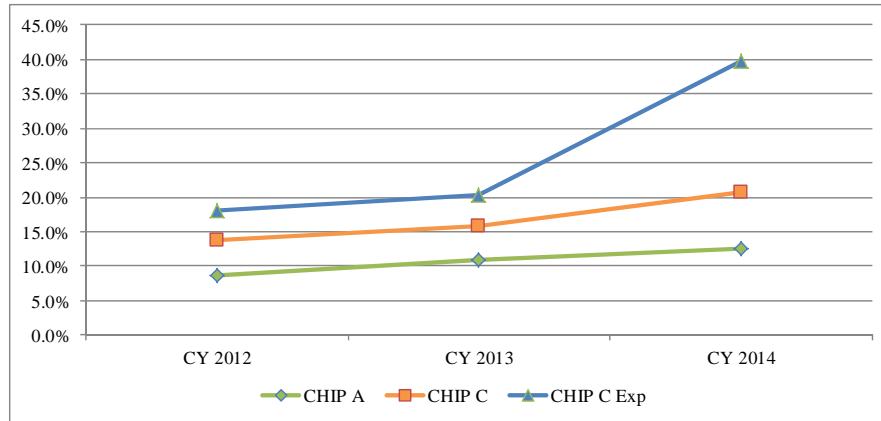
For MCHIP (Package A), the percentage of new enrollees in CY 2014 on average was 12.6 percent per month, an increase from 11.0 percent in CY 2013 and 8.7 percent in CY 2012 (refer to Exhibit II.2 on the next page).

The percentage of members that were new to the program within SCHIP (Package C), however, was higher. For the original SCHIP (Package C) program (members in families at 150% to 200% of FPL), 20.7 percent of members were new in CY 2014 as compared to 15.8 percent in CY 2013 and 13.7 percent in CY 2012.

For the expansion portion of SCHIP (Package C) (members in families at 151% to 200% FPL), 39.7 percent of members were new in CY 2014 as compared to 20.3 percent new in CY 2013 and 18.0 percent in 2012.

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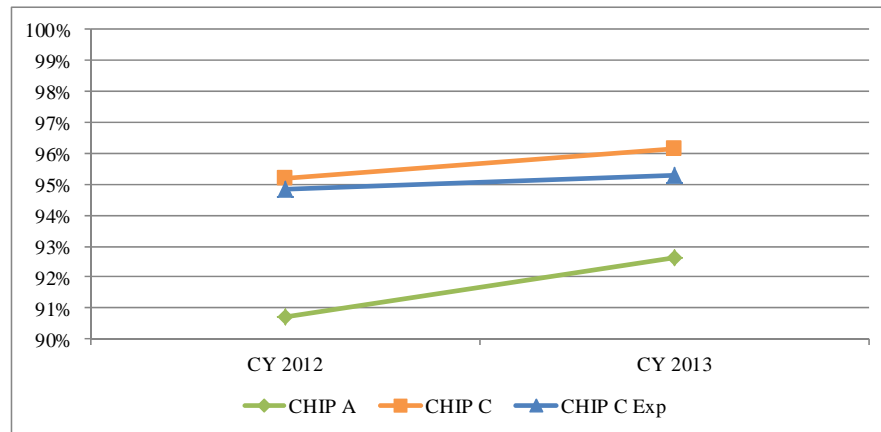
Exhibit II.2
Percent of Enrollees that were New to Program in Previous 12 Months, by Year



Source: Indiana's FSSA Enterprise Data Warehouse

In addition to the large number of new individuals, the total number of enrollees that stay within Indiana’s CHIP also remains high. The retention rates increased for MCHIP (Package A) members, SCHIP (Package C) members, and SCHIP (Package C) Expansion members from CY 2012 to CY 2013. To determine retention, new enrollees in CHIP were identified for Calendar Years (CY) 2012 and 2013. B&A reviewed the membership status for each child after 12 months of enrollment when members are required to be redetermined eligible for the program. Among this group of members, the average retention rate was 92.6 percent for MCHIP (Package A) members, 96.1 percent for SCHIP (Package C) members and 95.3 percent for SCHIP (Package C) Expansion members.⁷

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



Source: Indiana's FSSA Enterprise Data Warehouse

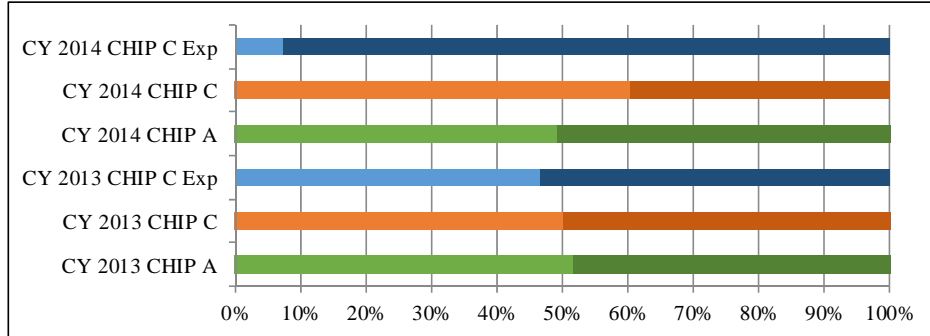
The number of children enrolled at the end of the year decreased from CY 2013 to CY 2014 (from 76,898 to 73,334 respectively) and the number of children enrolled at any time during the year also decreased from CY 2013 to CY 2014 (from 135,191 to 134,390 respectively). However, as was the case for the last three calendar years, there were almost twice as many children enrolled at some point in the year when compared to the number enrolled at the end of the year. The one exception is

⁷ A member is considered “retained” in Hoosier Healthwise if they move from the CHIP program to the traditional Medicaid program, or between MCHIP (Package A) and SCHIP (Package C).

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SCHIP (Package C) Expansion, which saw a monthly decrease in enrollment in 2014. In CY 2014, there were 134,390⁸ children enrolled in Indiana’s CHIP at some point during the year—104,453 in MCHIP (Package A), 35,858 in the original portion of SCHIP (Package C) and 6,400 in the SCHIP (Package C) Expansion population. The difference between currently enrolled and ever enrolled can be because children move between the CHIP and Medicaid program, lose coverage when they turn age 19, or may disenroll for other reasons. Exhibit II.4 below shows the difference between enrolled at the end of the calendar year (light colors) and enrolled at any time during the year (dark colors)

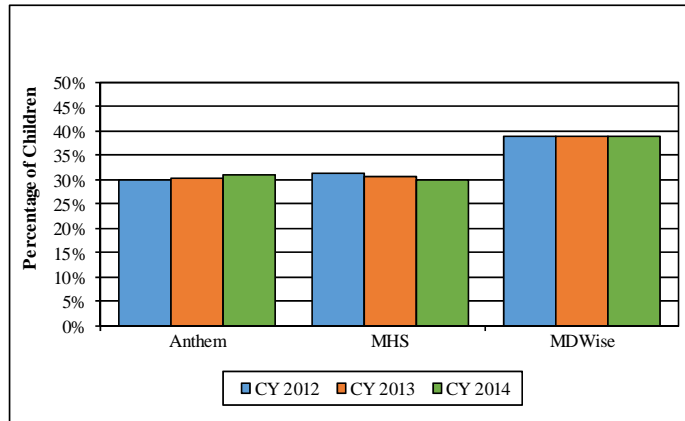
Exhibit II.4
Status of Children Ever Enrolled in CHIP, by Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There was some movement in the MCE selected by CHIP members in CY 2014. Anthem increased its percent of all CHIP enrollees from 30.4 percent in CY 2013 to 31.1 percent in CY 2014. MHS decreased its CHIP membership share, from 30.7 percent of all CHIP enrollees in CY 2013 to 29.9 percent in CY 2014. MDwise’s membership share was unchanged among CHIP members, from its total of 38.9 percent in CY 2013 to 39.0 percent in CY 2014.

Exhibit II.5
Average CHIP Enrollment by MCE



Source: Indiana's FSSA Enterprise Data Warehouse

⁸ A member is only counted once in the enrolled at some point figure, but may be counted in more than one aid category.

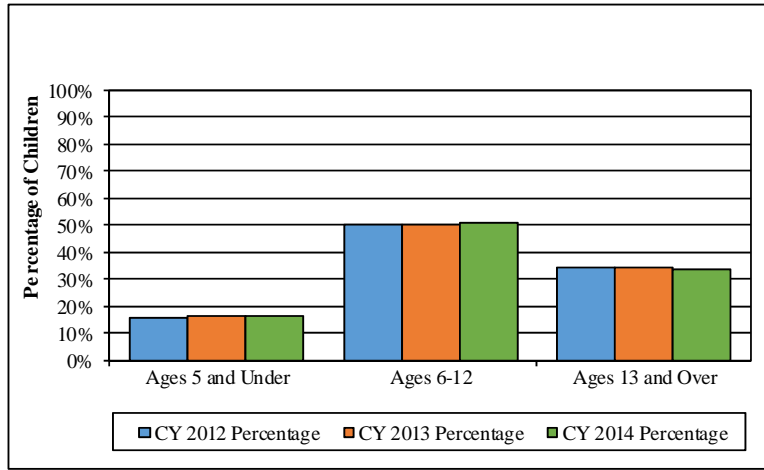
Demographic Profile of CHIP Members

Half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Just fewer than 33 percent of CHIP enrollees are teenagers, while the remaining 16 percent are under age 6. This distribution has been the case since the CHIP was introduced.

There is a higher distribution of minorities in Indiana's CHIP than the overall population in Indiana for

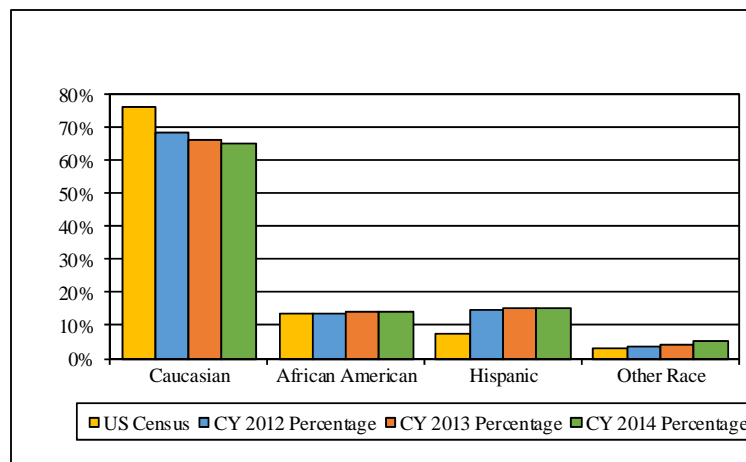
children ages 18 and younger. Compared to the U.S. Census estimate,⁹ African-American children (14.3% of CHIP enrollees in CY 2014) and Hispanic children (15.5% of CHIP enrollees in CY 2014) are represented more in CHIP than in the statewide population. Between CY 2012 and CY 2014, the proportion of Caucasian CHIP members declined (68.0 percent and 65.0 percent, respectively). The African-American proportion increased from 13.8 percent in 2012 to 14.3 percent in 2014. The Hispanic proportion increased from 14.5 percent in 2012 to 15.5 percent in 2014. Other races have increased from 3.7 percent in 2012 to 5.2 percent in 2014.

Exhibit II.6
Average CHIP Enrollment by Age Group



Source: Indiana's FSSA Enterprise Data Warehouse

Exhibit II.7
Average CHIP Enrollment by Race/Ethnicity



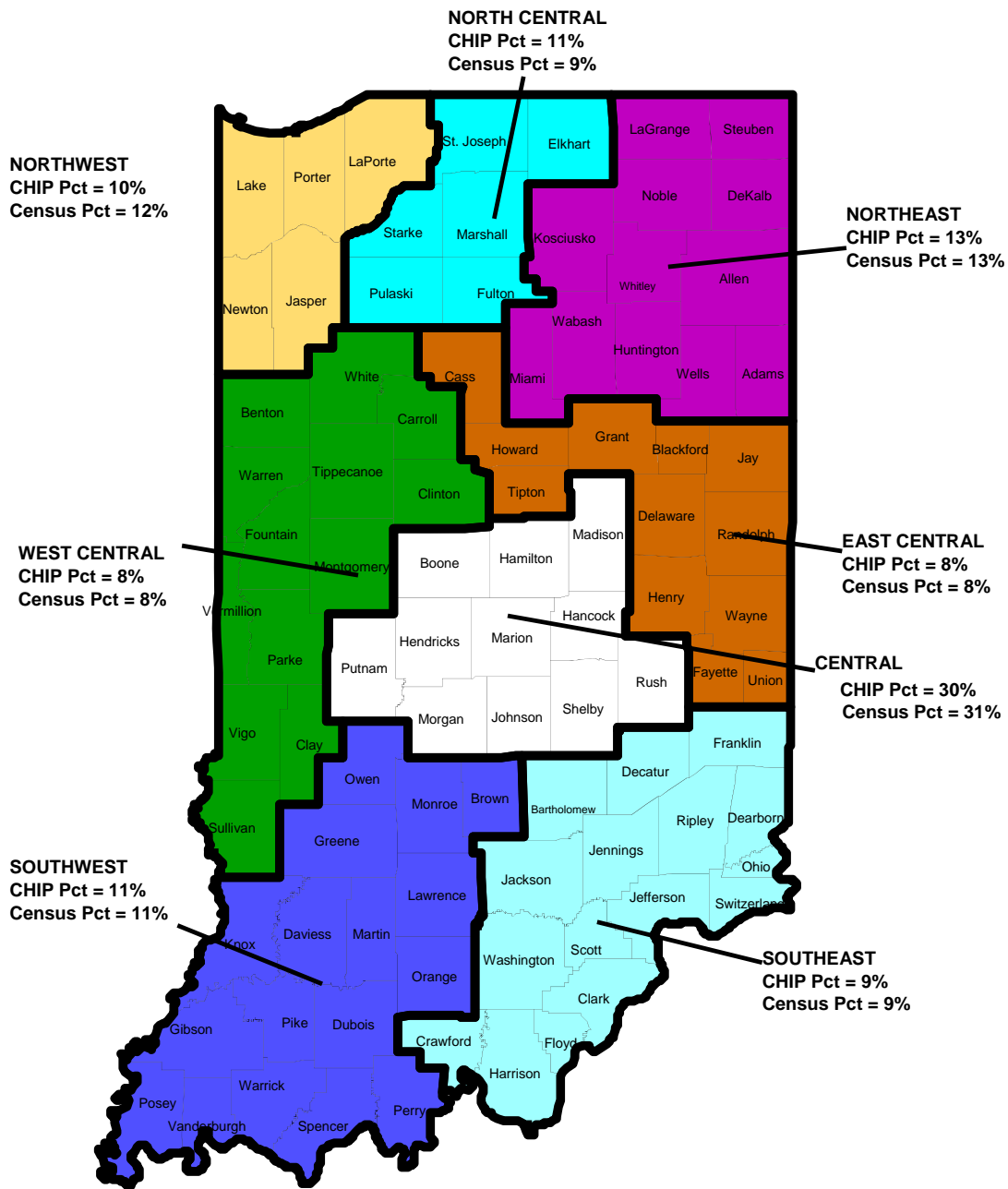
Source: Indiana's FSSA Enterprise Data Warehouse and US Census Bureau

⁹ U.S. Census Bureau, Current Population Survey, for Indiana 2013.
<http://www.census.gov/hhes/www/hlthins/hlthins.html>

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B&A compared CHIP members enrolled to the total child population in Indiana as of July 2014. The distribution of CHIP members by region matches the overall child population in Indiana within one percentage point, with the exception of the North Central region (11 percent CHIP percentage and 9 percent census percentage) and Northwest region (10 percent CHIP percentage and 12 percent census percentage). The regions are defined by the OMPP.

**Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2014**



III

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



Access Facts at a Glance

70% of CHIP members accessed primary care in 2014:

- 50% visited a primary care doctor's office in their home county
- 30% visited a primary care doctor's office in a contiguous county

68% of CHIP members accessed preventive dental care in 2014:

- 60% visited a dentist in their home county
- 20% visited a dentist in a contiguous county

The OMPP requires that Hoosier Healthwise members enrolled with its three managed care entities (MCEs) have access to a primary medical provider (PMP) within 30 miles of their residence. Additionally, for particular specialty providers there must be two of each specialty type within 60 miles of the member's residence. In this section, Burns & Associates (B&A) examines the availability of PMPs and dentists in Indiana's CHIP.

Access to Primary Medical Providers

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

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.¹⁰ When the PMP contracts with an MCE, the PMP identifies whether or not they are willing to accept children as patients. If so, they are considered by the OMPP to be a pediatric provider. The number of pediatric providers in Hoosier Healthwise has grown from just under 2,900 in January 2009 to 4,171 in September 2014.

The PMP agrees to a specific number of Medicaid/CHIP members he/she will see in his/her practice (often called the PMP's *panel size*). The panel size that a PMP negotiates with an MCE does not differentiate between the number of children and the number of adults that the PMP will accept. (The obvious exception is Pediatricians.)

Panel capacity measures how many slots in a PMP's panel are already filled by the PMP's existing patients. It is defined as the number of members enrolled with a PMP divided by the total number of members that the PMP is willing to accept. A physician who sees members from counties outside of the county where he/she practices are included in his/her panel.

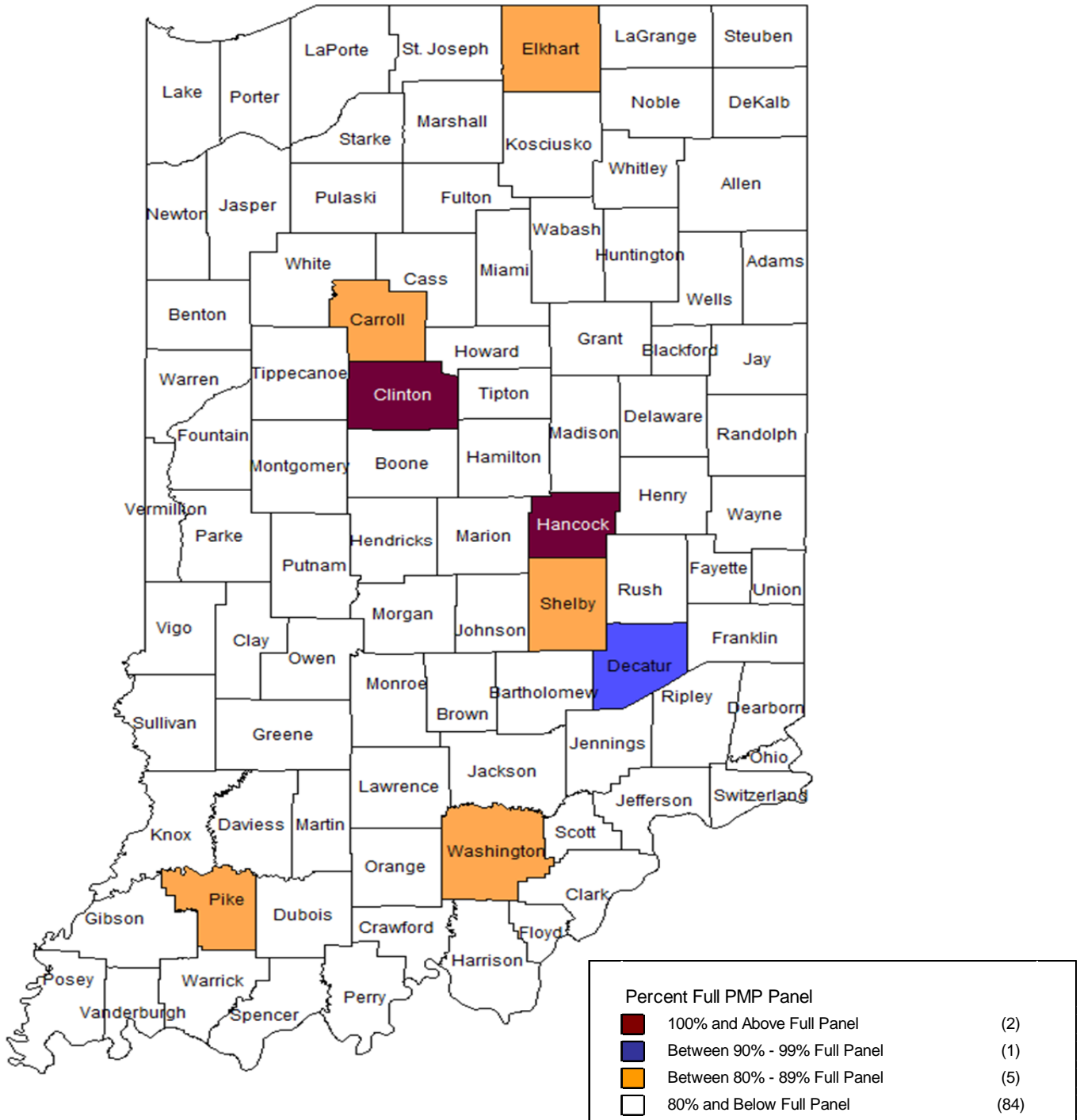
It is important to measure panel capacity to assess if there are potential gaps in the state where there are fewer PMPs available to accept new patients. B&A reviewed data compiled by OMPP's fiscal agent, HP, which measured pediatric panel capacity as of September 2014.¹¹ There were an average number of 148 members enrolled with each pediatric PMP in this month.

In September 2014, on average statewide the pediatric PMPs' panels were 42 percent full, a reduction from 45 percent from the September 2013 period. This rate varies significantly on a county-by-county basis, however. In Exhibit III.1 on the next page, B&A color-coded each county's PMP panel capacity as tabulated by HP. Counties colored white (84 out of 92) are those where the PMP panel is less than 80 percent full. Eight counties are considered potentially at risk since their panel capacity among all providers in the county was more than 80 percent full, a change from our study last year when eleven counties were more than 80 percent full. Counties colored orange (5) are those where the PMP panels are 80 to 89 percent full. Counties colored blue (1) are those where the PMP panels are 90 to 99 percent full. Two counties are technically more than 100 percent full (in brick red), which means that, when analyzed as a group, the PMPs in each of these counties have actually accepted more CHIP and Medicaid members than they contractually agreed to accept. Six of the eight counties also had panel sizes greater than 80 percent last year (Clinton, Decatur, Elkhart, Hancock, Pike, and Shelby). Two counties (Hamilton and Whitley) went below this threshold over the past year, but three counties (Carroll and Washington) were added to the list in 2014.

¹⁰ OB/GYNs may, but are not obligated, to sign up as PMPs. They may also sign up as a specialist.

¹¹ It should be noted, however, that HP's panel capacity reports include both children and adult patients if the PMP is willing to accept both.

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



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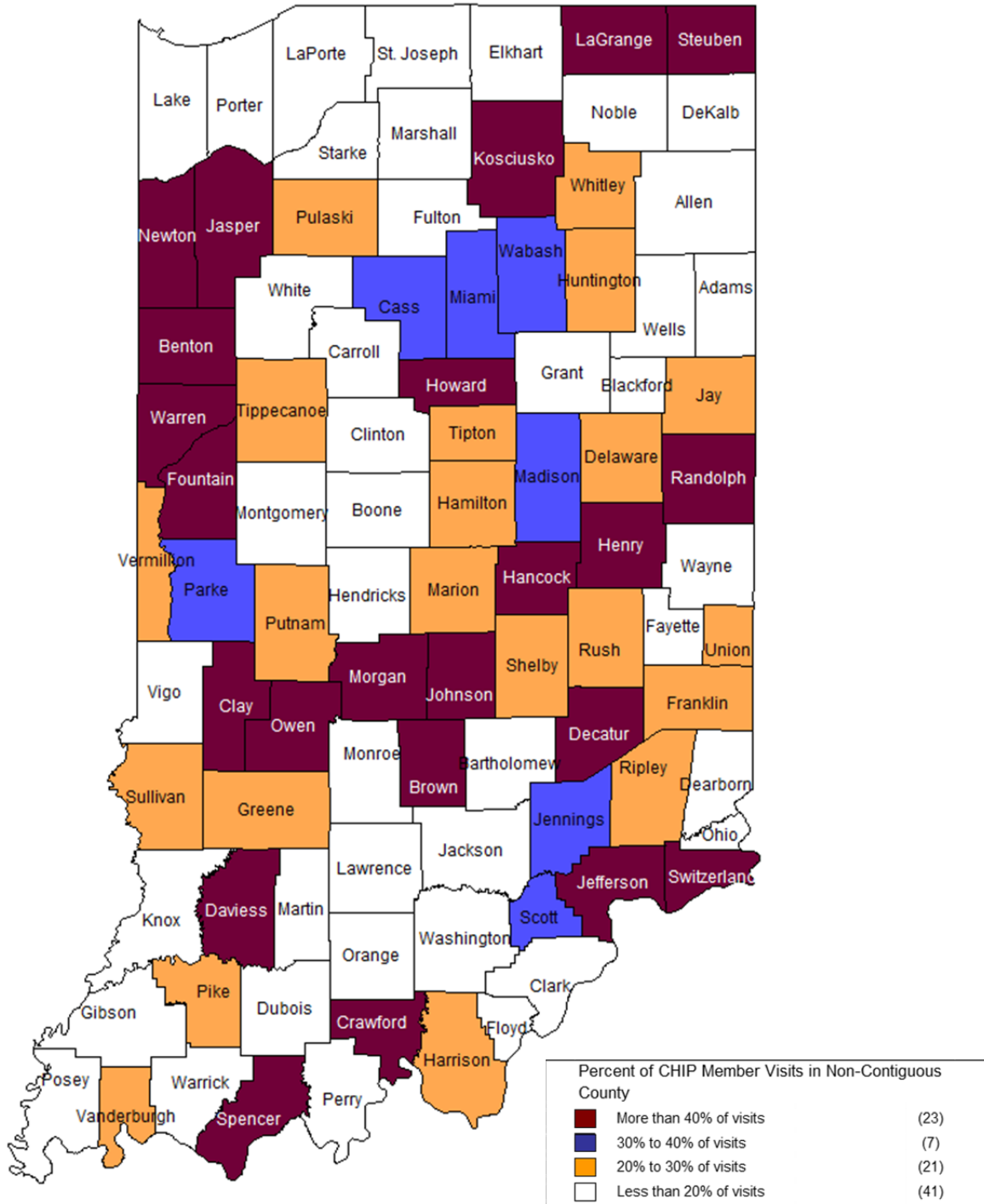
A county with a higher percentage of full panels, however, is not necessarily indicative of access problems. For example, a Hoosier Healthwise child may see a PMP in a county next to their home county since it is not a far distance to travel. Therefore, the panel capacity in their home county may or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

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

B&A identified and analyzed when a child received a primary care service from an MCE PMP in a doctor's office during Federal Fiscal Year 2014 (70% of all children received this service). Primary care utilization was then examined at the county level.

Statewide, 50 percent of CHIP members that accessed primary care service received the service in the county in which they lived in FFY 2014. An additional 30 percent received a primary care service in a contiguous county. Like the panel capacity map shown in Exhibit III.1, the percentage of CHIP children who had a primary care visit in a county not contiguous to their residence varied greatly by county.

Exhibit III.2
Volume of CHIP Members Receiving Primary Care Services
in a County Not Contiguous to their Residing County



It should be noted that, based on the land area of Indiana's counties, it is possible that CHIP members may travel to receive a primary care service in a non-contiguous county to their home residence and still be within 30 miles of their home (as per OMPP's benchmark). There were 23 counties where more than 40 percent of CHIP members' primary care visits were received in a county not contiguous to their home county: Benton, Brown, Clay, Crawford, Daviess, Decatur, Fountain, Hancock, Henry, Howard, Jasper, Jefferson, Johnson, Kosciusko, Lagrange, Morgan, Newton, Owen, Randolph, Spencer, Steuben, Switzerland, and Warren (refer back to Exhibit III.2). Of these, one county has a full panel (Hancock) and one county is potentially at risk for full panels: Decatur has 94 percent of its panel full (refer back to Exhibit III.1).

Four of the eight counties with fuller panels (Exhibit III.1) also had more than 30 percent of their member's primary care visits to counties not contiguous to their home. When these are cross-referenced the four counties that appeared in both groups are: Decatur, Hancock, Pike and Shelby counties. Pike County was on this list last year but has improved its pediatric panel percent full rate from 90 percent full panel to 80 percent full panel.

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

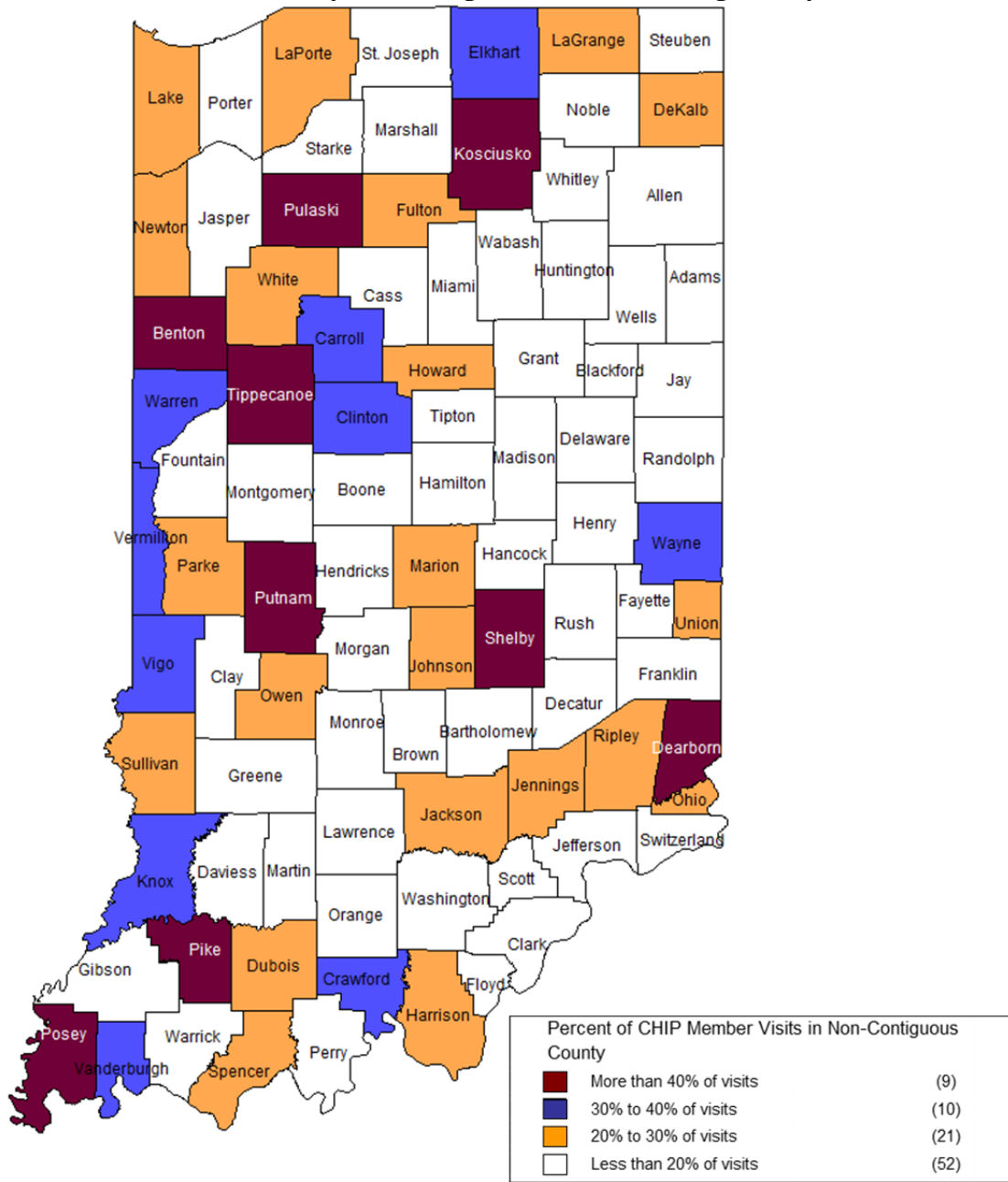
Access to Dentists

B&A conducted a similar analysis of where CHIP members access services for dental providers. Overall, it was found that 68 percent of CHIP members had a preventive dental visit in FFY 2014. The members with visits were once again analyzed to determine if the dental visit was in the member's home county, a contiguous county or a non-contiguous county.

Statewide, access to dentists is high since 60 percent of CHIP members that accessed preventive dental services had their visit in their home county and an additional 20 percent had their visit in a contiguous county. The same county access percentage this year is one percent lower than what was found in last year's evaluation. The access in home or contiguous county (80 percent) this year was also lower than what was found last year (85 percent).

Exhibit III.3 shows the 40 counties where the percentage of visits received in non-contiguous counties from the member's home county exceeded 20 percent. Nine counties (Benton, Dearborn, Kosciusko, Pike, Posey, Pulaski, Putnam, Shelby, and Tippecanoe) are greater than 40 percent. Of the nine counties noted in FFY 2014, only three (Dearborn, Kosciusko, and Putnam) were noted as above 40 percent in FFY 2013. Eight counties noted as above 40 percent in FFY 2013 are now below the 40 percent threshold.

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



IV

Service Use Patterns among Populations in Indiana's CHIP



Quality Goals at a Glance

For CHIP members who were enrolled in Federal Fiscal Year 2014:

- 70% had a primary care visit
- 24% had an emergency room visit
- 68% had a preventive dental visit
- 68% obtained a prescription

These are consistent trends during the past three years.

In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency room (ER) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2012, 2013 and 2014 across populations within the CHIP by CHIP Package, by age, by managed care entity (MCE) and by race/ethnicity.

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning’s (OMPP’s) data warehouse in February 2015. The majority of the services examined are paid for by the MCEs directly to providers and then reported as encounters to the OMPP after the fact. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP. That being said, the findings for FFY 2014 may still be incomplete if the MCEs have not submitted all of their encounter data to the OMPP yet.

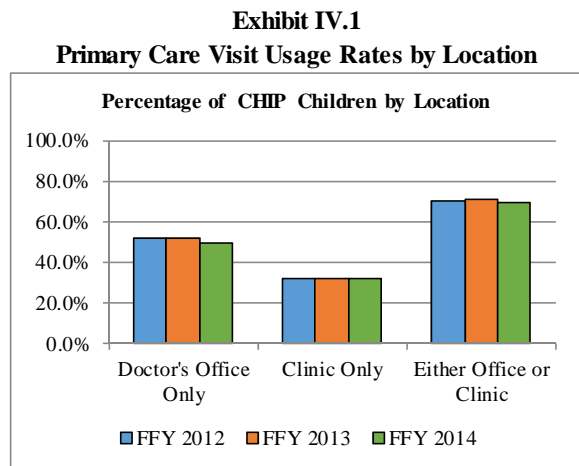
B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2012, 2013 or 2014. Since the *usage rate* measures the percentage of members that had actually used the service, we are allowing for a minimum of nine months enrollment in the year to identify only those members that would have had an opportunity to actually use the service. Members could be included in one year and not the other based upon their enrollment history. If CHIP members switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year, they were retained in the analysis as long as they met the nine month minimum and were enrolled in the CHIP at the end of the year. CHIP members included in the analysis were assigned to one MCE, one race/ethnicity group, and one age group. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member’s age was assigned based upon their age at the end of each year.

On the other hand, the *utilization per 1,000 member rate* includes every CHIP member enrolled in the month being examined. It can also be helpful to measure the utilization per 1,000 rate across different populations (e.g., by age or by race/ethnicity) in a way that is an apples-to-apples comparison since the number of actual CHIP children enrolled in each population group varies significantly.

Primary Care Visits

Primary care visits include visits to doctor’s offices or clinics specializing in primary care and include well-child visits and visits for specific ailments. Although children usually see their PMP for such visits, B&A did not limit our analysis to PMP visits exclusively.¹²

On a statewide level, B&A found that 70 percent of CHIP children in the study sample had a primary care visit (either in a doctor’s office or a clinic) in FFY 2014. This is a slight decrease from FFY 2013 when 71 percent of CHIP children had primary care visits.

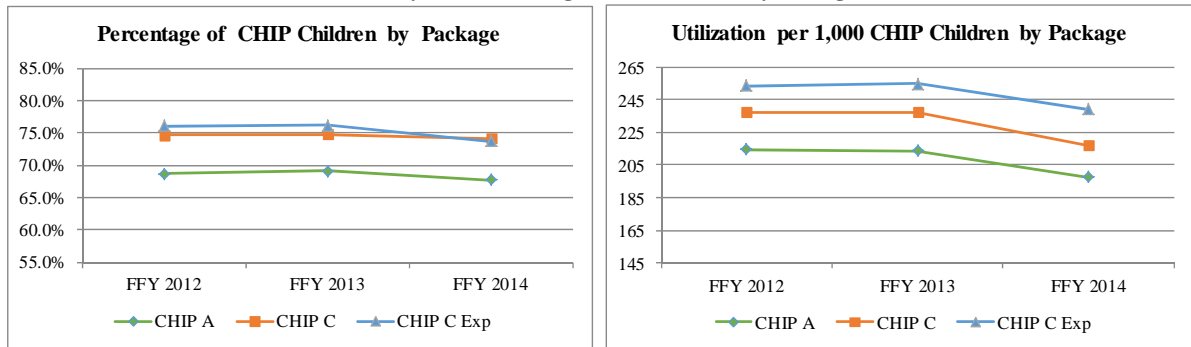


¹² B&A did limit our definition of primary care visit to claims/encounters with the presence of one of the following CPT codes: 59425-59430, 99201-99215, 99241-99245, 90862, 99381-99397.

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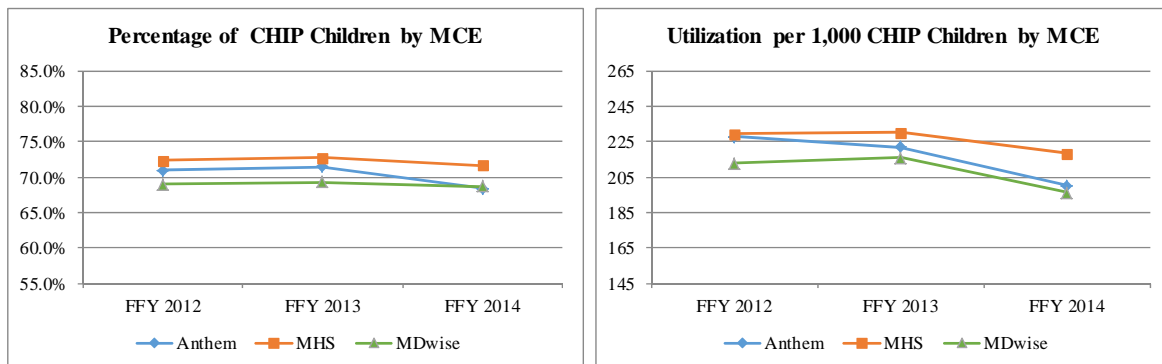
The percent of children that had a primary care visit (either office or clinic setting) has decreased slightly over the past three years for all CHIP Packages. As stated previously, the reduction shown here may be due, in fact, to claims not being fully submitted to OMPP for the FFY 2014 time period. The percentage of MCHIP (Package A) children that had a primary care visit in FFY 2014 was lower (68 percent) than SCHIP (Package C) (74 percent) and SCHIP (Package C) Expansion (74 percent) children, which have similar rates of primary care visits. The utilization per 1,000 CHIP children decreased in 2014 after remaining stable from 2012 to 2013 (refer to Exhibit IV.2). Because the trend was more stable for FFYs 2012 and 2013, B&A infers that the reduced utilization in FFY 2014 may, in fact, be because not all of the encounter visits have been submitted by the MCEs to the OMPP for B&A to report here.

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



Although it was observed that the percent of children that had a primary care visit (either office or clinic setting) has decreased over the past two years for all three MCEs, all three MCEs’ rates are within three percentage points of one another. When utilization is measured on individual claims per 1,000 CHIP members, Anthem has seen the most significant decrease. However, utilization is still similar between MCEs with a low of 196 visits per 1,000 members to a high of 218 visits per 1,000 members (refer to Exhibit IV.3 below). Said another way, between 1.96 and 2.18 children out of 10 CHIP members that were enrolled with an MCE had a primary care visit each month.

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



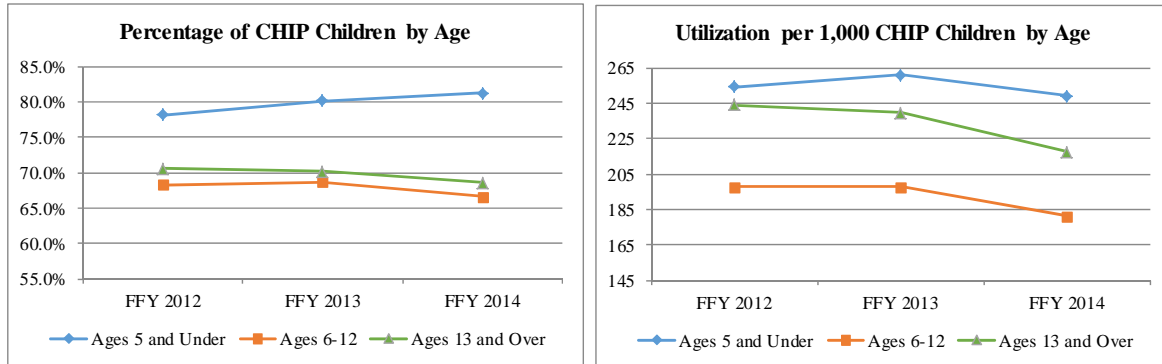
Primary care visits are more prevalent among the youngest members, as 81 percent of children ages 5 and younger had a visit in FFY 2014. The percentage was lower for children in the other age groups (66 percent for children ages 6 to 12 and 69 percent of children ages 13 to 18 in FFY 2014).

Although the primary care usage rate for children ages 6 to 12 and ages 13 to 18 in FFY 2014 was

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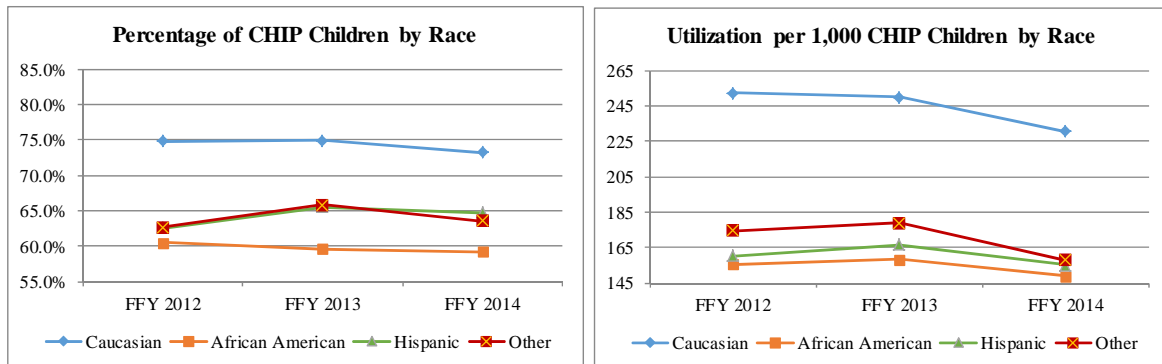
about the same, the actual number of office visits per 1,000 members was higher among children ages 13 to 18 than children ages 6 to 12. Children ages 6 to 12 had a primary care visit utilization rate lower than the other two groups. Both of these trends have remained consistent over the past three years (refer to Exhibit IV.4 below).

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



The percent of children that had a primary care visit within each race/ethnicity examined has seen a slight decline over the past three years. When comparing the rates across races/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other races/ethnicities. For Caucasian children, the usage rate was 73 percent in FFY 2014; for Hispanic children and children of other races/ethnicities it was 65 and 64 percent respectively, and for African American children the rate was 59 percent. The utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the years studied, the median rate per 1,000 Caucasian children was 250, whereas the median rate was 155 and 160 among African American and Hispanic children respectively (refer to Exhibit IV.5 below). The utilization rate for children in other race/ethnicities was slightly higher at a median rate of 174 visits per 1,000 CHIP children.

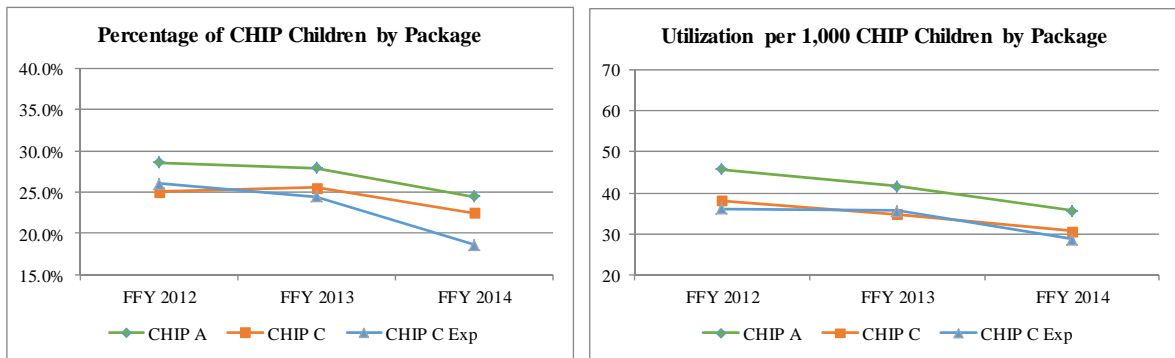
Exhibit IV.5
Primary Care Visit Usage (Office or Clinic) by Race



Emergency Room Visits

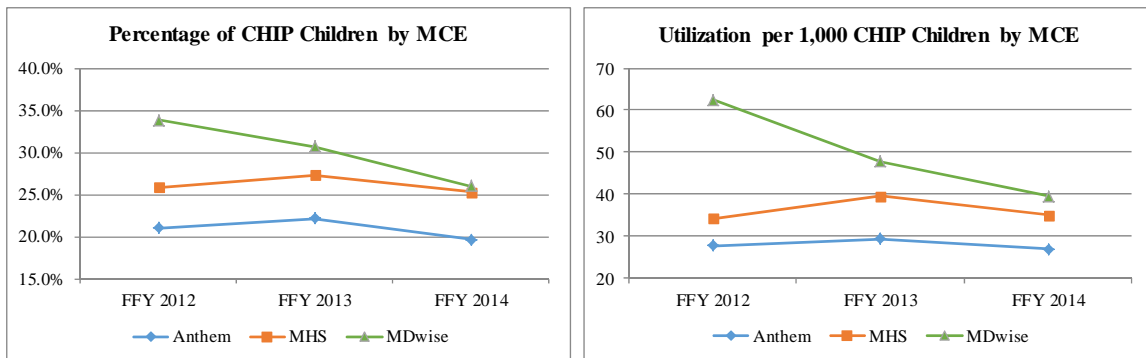
The rate of Emergency Room visits by CHIP children in all Packages has declined in FFY2014 after remaining steady from FFY 2012 to FFY 2013. The rate of Emergency Room visits by Package varied by six percent in FFY 2014. Once again, some of this reduction may, in fact, be attributable to the fact that the MCEs have not yet submitted all of their encounter ER visits to the OMPP data warehouse for FFY 2014. The expansion portion of SCHIP (Package C) children had a lower rate (19 percent) of Emergency Room visits in FFY 2014 than MCHIP (Package A) and SCHIP (Package C) children (25 and 23 percent respectively). When considering emergency room visits per 1,000 CHIP children in the trend was similar with MCHIP (Package A) having the highest number of visits at 36 per 1,000 children while SCHIP (Package C) and SCHIP (Package C) Expansion had 31 and 29 visits per 1,000 children respectively (refer to Exhibit IV.6 below).

Exhibit IV.6
Emergency Room Usage by Package



There is a difference in the percentage of CHIP children that had an ER visit when analyzed by MCE. In the last three years, MDwise members had more ER visits than either Anthem or MHS. However, MDwise decreased from FFY 2013 (31 percent) to FFY 2014 (26 percent) which results in a rate similar to the other MCEs (Anthem and MHS at 20 percent and 25 percent respectively in FFY 2014). Similarly, over the past three years, MDwise members consistently had more ER visits per 1,000 members than Anthem or MHS, but the results are closer in 2014. From 2012 to 2013, Anthem and MHS had slight increases (29 visits per 1,000 members and 39 visits per 1,000 members, respectively) while MDwise decreased to 48 visits per 1,000 members. In 2014, all three MCEs decreased in ER visits per 1,000 member months (39 visits per 1,000 members for MDwise, 35 visits per 1,000 members for MHS and 27 visits per 1,000 members for Anthem) (refer to Exhibit IV.5 below).

Exhibit IV.7
Emergency Room Usage by MCE



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The large majority of children (81 percent) who used the ER during FFY 2014 had one or two visits during the year. As shown in Exhibit IV.8 below, Anthem had the lowest rate of children who used the ER more than two times during the study year (17.6 percent). MHS had a rate of 18.1 percent and MDwise had a rate of 19.7 percent.

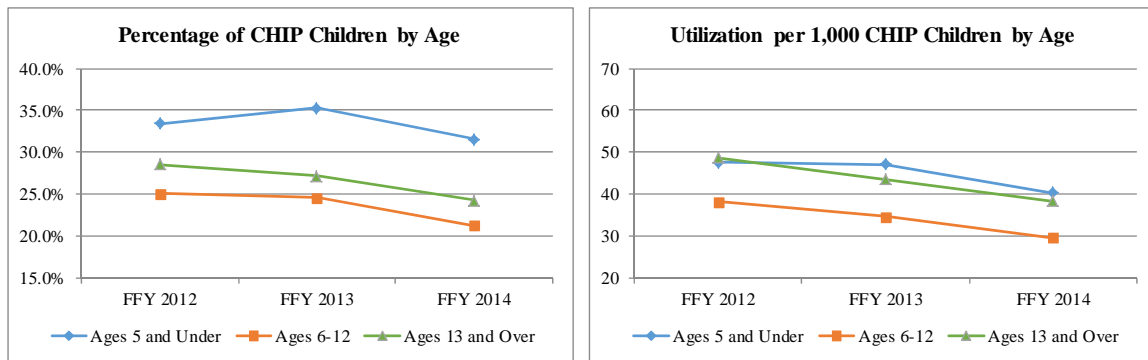
Exhibit IV.8
Rate of ER Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2013 - Sept 30, 2014

Number of ER Visits per Member	Percentage of All ER Visits by MCE			Total
	Anthem	MHS	MDWise	
1 to 2	82.4%	81.9%	80.3%	81.3%
3 to 5	14.3%	15.0%	15.9%	15.2%
6 to 10	2.8%	2.5%	2.7%	2.7%
11 to 20	0.4%	0.4%	0.7%	0.5%
More than 20	0.0%	0.1%	0.3%	0.2%

Source: Indiana’s FSSA Enterprise Data Warehouse

Differences in ER use are found by age group within the CHIP. Higher use was found among children ages 5 and under (32 percent of all members in this age group used the ER in FFY 2014). ER use was lowest among children ages 6 to 12 (21 percent of all members in the age group used the ER in FFY 2013). ER usage has decreased for all age groups over the past three years. The utilization rate for ER followed a similar pattern (refer to Exhibit IV.7 below). The rate was 40 visits per 1,000 members on average for ages 0 to 5 and 38 visits per 1,000 members for 13 to 18 year olds in FFY 2014. The rate was lower for children ages 6 to 12 (30 visits per 1,000 members).

Exhibit IV.9
Emergency Room Usage by Age

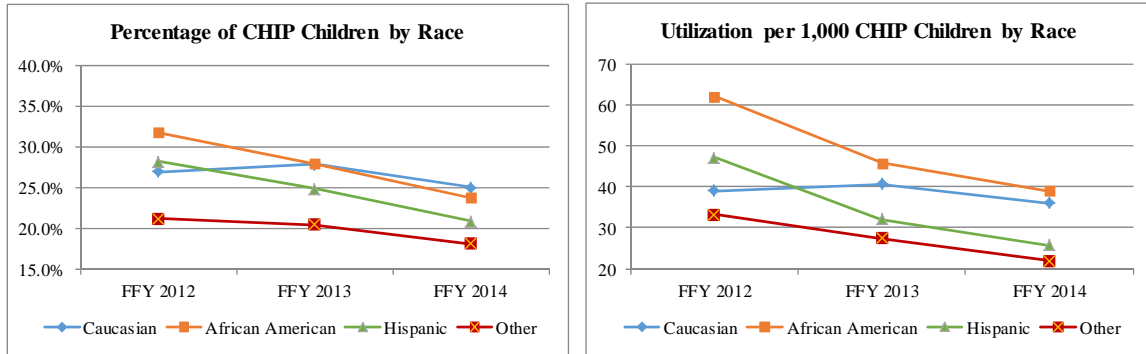


The percent of CHIP children that had an emergency room visit declined for each race/ethnicity in FFY 2014. Caucasian children declined from 28 percent to 25 percent from FFY 2013 to FFY 2014, while African American children declined from 28 percent to 24 percent, Hispanic children declined from 25 percent to 21 percent and children of other races/ethnicities declined from 20 percent to 18 percent. While Caucasian children now have an emergency room utilization rate that is higher compared to children of all other races/ethnicities, African American children still visit the emergency room more frequently. When reviewing the utilization rates per 1,000 members, similar patterns to the rate changes were noted for children of all races/ethnicities (African American children decreased to 39 visits per 1,000 members, Caucasian children decreased to 36 visits per 1,000

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members, Hispanic children decreased to 26 visits per 1,000 members, and children of all other races/ethnicities decreased to 22 visits per 1,000 members) (Refer to Exhibit IV.10 below).

**Exhibit IV.10
Emergency Room Usage by Race**

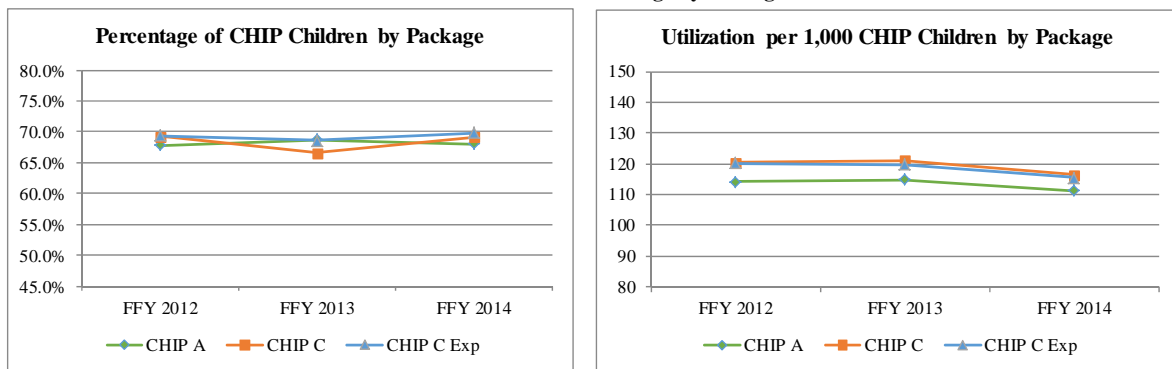


Preventive Dental Visits

Dental care is one of the few services that the MCEs are not responsible for managing. Instead, this service is paid directly to providers by the OMPP. The rate of preventive dental care has remained stable for CHIP children in all Packages over the past three years (refer to Exhibit IV.11 below). The percentage of children in MCHIP (Package A), SCHIP (Package C) and SCHIP (Package C) Expansion in FFY 2014 with a preventive dental visit were all between 68 and 70 percent of the total children within each enrollment group.

The same trend of utilization per 1,000 members was found. MCHIP (Package A) children had 111 services per 1,000 members while SCHIP (Package C) Expansion children had 115 services per 1,000 members and SCHIP (Package C) had 116 services per 1,000 members. Utilization per 1,000 members has remained stable over the past three years.

**Exhibit IV.11
Preventive Dental Care Usage by Package**

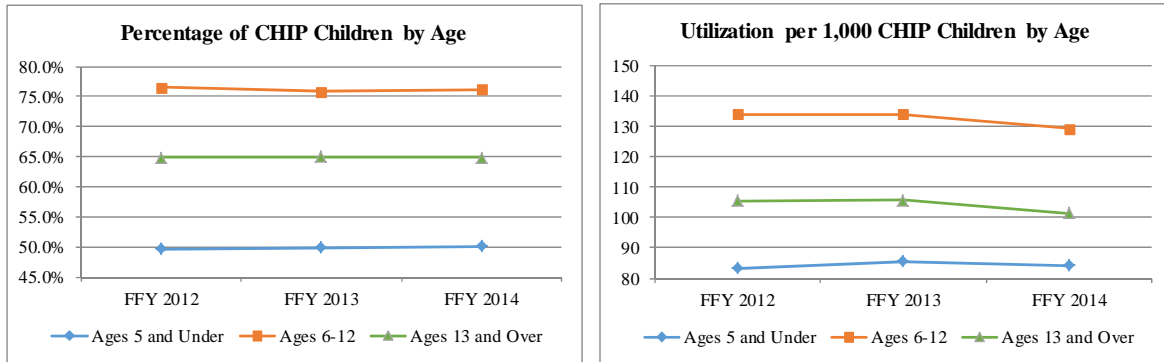


The overall percentage of CHIP members receiving a preventive dental visit at some time in the year was 68 percent in FFY 2014. Over the past three years, the rate of dental visits has remained steady for all ages, though children ages 6 to 12 are most likely to have received a preventive dental visit (76 percent of the members in FFY 2014), which is significantly higher than teenagers (65 percent). The youngest children had the lowest usage rate (50 percent) given that this group includes toddlers.

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A similar pattern was found by age group when measuring the utilization rate of dental visits per 1,000 CHIP members. The rate of 129 visits per 1,000 members ages 6 to 12 remained consistent with prior years and also remains higher than the rate for children ages 13 to 18 (101 visits per 1,000 members) and higher than the rate for children ages 0 to 5 (84 visits per 1,000 members). The number of visits per 1,000 CHIP members decreased slightly in the last year (refer to Exhibit IV.12 below).

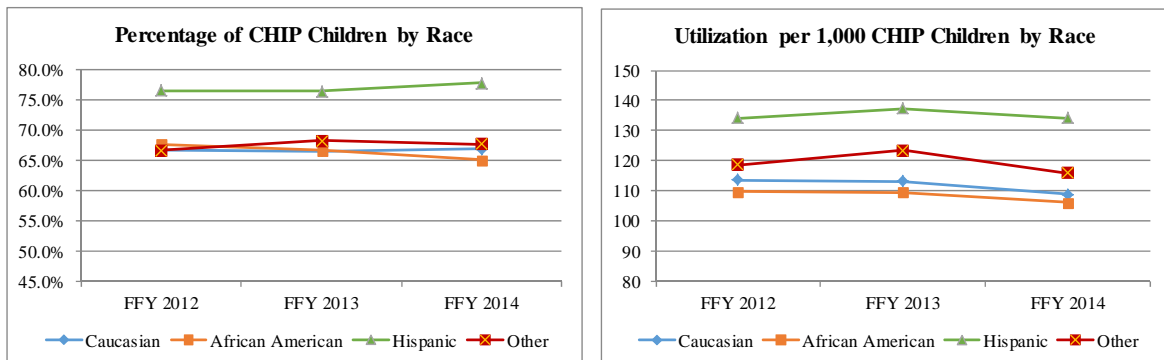
Exhibit IV.12
Preventive Dental Care Usage by Age



The preventive dental usage rate by race/ethnicity increased slightly from FFY 2012 to FFY 2013, and decreased slightly from FFY 2013 to FFY 2014. There is little difference from the statewide average in the usage rate among the race/ethnicities, though the rate for Hispanic children has increased more than the other races/ethnicities with 78 percent receiving a preventive dental visit in FFY 2014.

There is a slight variation in the utilization rate per 1,000 CHIP members among races/ethnicities. Hispanic children are most likely to have a preventive dental visit at 134 visits per 1,000 members in FFY 2014, while African American children and Caucasian children were least likely at 106 visits and 109 visits per 1,000 members, respectively, in FFY 2014. Children of all other races had 116 visit per 1,000 members in FFY 2014 (refer to Exhibit IV.13 below).

Exhibit IV.13
Preventive Dental Care Usage by Race

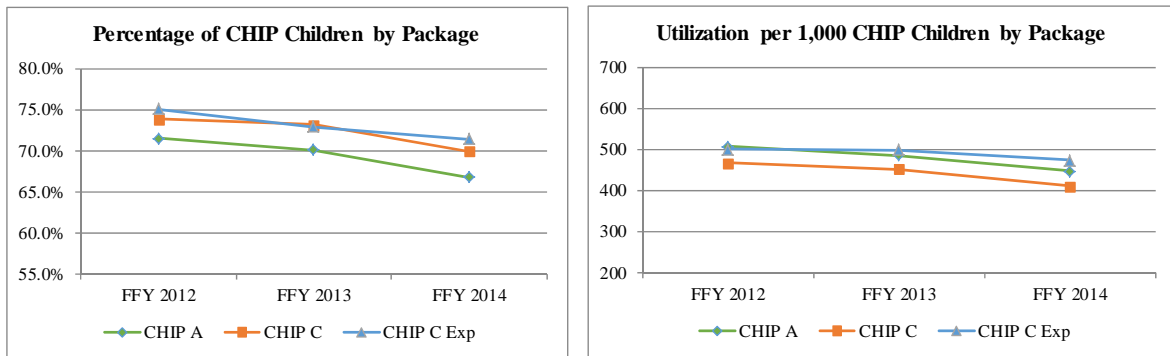


Pharmacy Prescriptions

The administration of the pharmacy benefit is the other major service managed by the State and is not included in the capitation payment paid to the MCEs. Across all members enrolled at least nine months of the year, the percentage of members that had a prescription filled has decreased in the last three years from 72 percent to 68 percent.

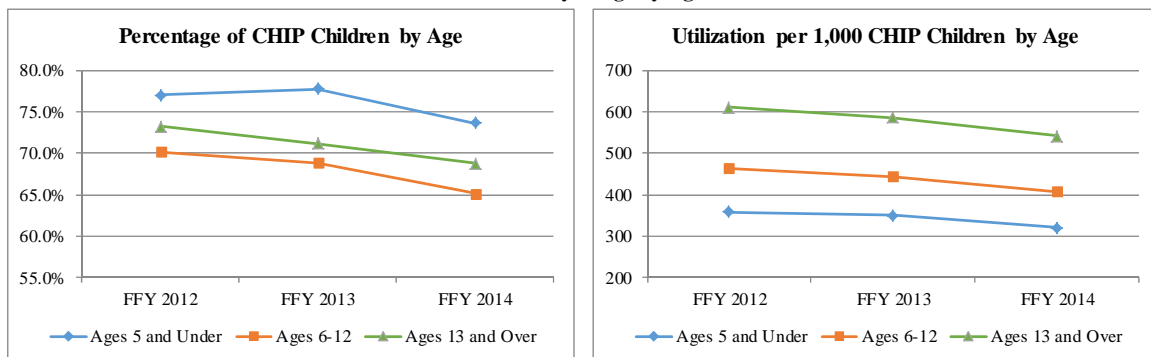
MCHIP (Package A) children are least likely to have a prescription with 67 percent in FFY 2014. SCHIP (Package C) children (original and expansion populations) are more likely to have a prescription with a rate of 70 and 71 percent, respectively, in FFY 2014. Utilization per 1,000 members decreased slightly for MCHIP (Package A) members to 447 prescriptions per 1,000 members and SCHIP (Package C) member declined to 410 prescriptions per 1,000 members. Utilization for SCHIP (Package C) Expansion members also decreased slightly but remains the highest of the three aid categories with 474 prescriptions per 1,000 members. (Refer to Exhibit IV.14)

**Exhibit IV.14
Pharmacy Usage by Package**



There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children ages 5 and under over the last three years (74% in 2014). Children in the two older groups were slightly less with 68 percent of teenagers and 65 percent of children ages 6 to 12 in FFY 2014. Though a lower percentage of 6 to 12 year olds obtained a prescription as children in the youngest age group, the number of prescriptions filled per child was higher for the 6 to 12 year olds. This is evident in the utilization rate of prescriptions filled per 1,000 CHIP children in Exhibit IV.15 below. The utilization rate for children ages 13 to 18 was 541 prescriptions per 1,000 members for FFY 2014, followed by children ages 6 to 12 (408 prescriptions per 1,000 members), then by children ages 0 to 5 (321 prescriptions per 1,000 members).

**Exhibit IV.15
Pharmacy Usage by Age**



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The type of prescriptions obtained by children in each age group also varies greatly. For the youngest children in CHIP, 37 percent of prescriptions filled in CY 2014 were to treat infections (see the row for Group G in Exhibit IV.16 below). Among children ages 6 to 12, nearly half of the prescriptions were either for treating infections or for anxiety or seizure disorders (see the rows for Groups B and G). There were similar findings for the teenagers in CHIP as shown for children ages 6 to 12, plus another 15 percent of teenage prescriptions were for hormones (Group F).

**Exhibit IV.16
Highest Volume Pharmacy Scripts in Calendar Year 2014
By Age Group and by Package**

Group	Therapeutic Class	Ages 1-5			Ages 6-12			Ages 13-19		
		CHIP A	CHIP C	CHIP C Exp	CHIP A	CHIP C	CHIP C Exp	CHIP A	CHIP C	CHIP C Exp
Percentage of All Prescriptions in the Age Group										
A	Autonomic drugs	7.0%	5.9%	8.0%	11.5%	10.9%	14.8%	9.4%	8.7%	12.0%
B	Benzodiazepine antagonists, Central nervous system drugs	11.3%	8.7%	5.1%	28.4%	26.2%	21.8%	27.4%	27.1%	22.5%
C	Electrolytic, caloric and water balance	2.2%	1.8%	0.9%	4.9%	4.7%	4.2%	4.9%	4.3%	4.2%
D	Ointments Solutions Suspensions, ophthalmic Otic nasal, Ophthalmic preparations	11.1%	12.9%	13.8%	9.3%	10.2%	11.1%	6.0%	5.7%	6.4%
E	Gastrointestinal	4.8%	5.3%	3.8%	4.4%	4.0%	4.6%	3.2%	3.3%	1.7%
F	Hormones	9.5%	10.4%	10.2%	7.8%	9.0%	8.0%	14.4%	15.6%	14.6%
G	Antiprotozoals, Antileprotic, Anti-infective	35.8%	36.2%	41.9%	19.1%	21.2%	25.4%	20.3%	21.0%	24.6%
H	Antiperspirants, Topical preparations, Skin and mucous membrane preparations	14.6%	15.8%	14.1%	8.5%	7.6%	7.3%	8.9%	9.2%	10.2%
	All Others	3.6%	3.1%	2.3%	6.1%	6.2%	2.8%	5.5%	5.3%	3.8%

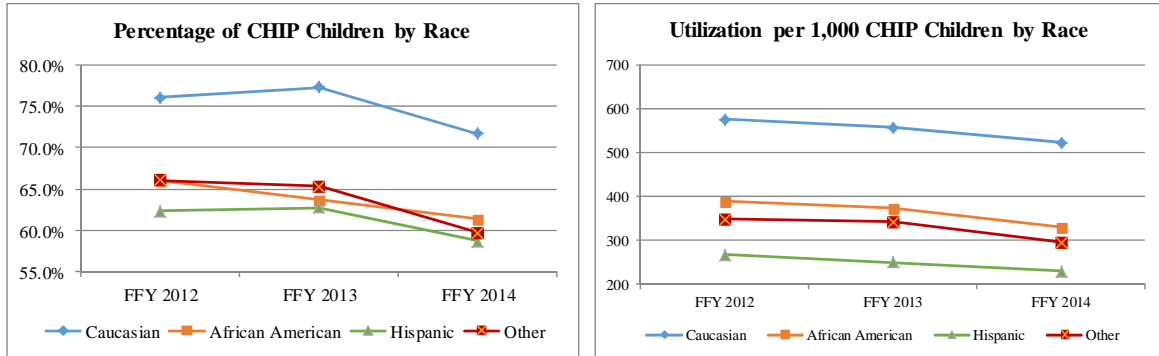
The percentage of children with a prescription decreased for each race/ethnicity group studied. Comparing across races/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities. In FFY 2014, the usage rate among Caucasians children was 72 percent but it was 61 percent for African American children, 60 percent for children of other races/ethnicities, and 59 percent for Hispanic children. This has been a consistent finding in the CHIP for the last six years.

The trend for the number of prescriptions filled per 1,000 CHIP children by race/ethnicity followed the same pattern found for the usage rate trend. Caucasian children have a utilization rate of 522 prescriptions per 1,000 members each month, which is 45 percent higher than the rate for African-American children (329 prescriptions per 1,000 children) and more than double the rate of children of

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other races/ethnicities (296 prescriptions per 1,000 children). It is 78 percent higher than the rate of Hispanic children (230 prescriptions per 1,000 children). Refer to Exhibit IV.17 below.

**Exhibit IV.17
Pharmacy Usage by Race**



Measuring Quality and Outcomes in Indiana's CHIP



CHIP Survey Results at a Glance

2014 HEDIS Measures (based on 2013 utilization)

- All three MCEs remain strong with Access to Primary Care
- All three MCEs have had a marked increase in Well Care visits over the last five years

2014 CAHPS (Consumer Satisfaction) Survey

- All three MCEs scored above 80% on each measure and above 90% on How Well Doctors Communicate

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The Office of Medicaid Policy and Planning (OMPP) has the overall responsibility for ensuring that children in Indiana's CHIP receive accessible, high-quality services. The oversight process for the CHIP is completed as part of the review for Hoosier Healthwise (HHW) since CHIP members are seamlessly integrated into HHW. Since children represent approximately 84 percent of HHW members, quality and outcomes related to children are given high priority.

OMPP staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCE's site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity¹³ to conduct an annual external quality review of each MCE and reviews the results with each MCE.

Measuring outcomes have become a focused effort of the OMPP in recent years, particularly with respect to children's care. In fulfilling its oversight responsibilities, the OMPP utilizes a variety of reporting and feedback methods to measure quality and outcomes for Indiana's CHIP:

1. OMPP requires the three HHW MCEs to report the results of HEDIS®¹⁴ and CAHPS®¹⁵ measures. The HEDIS are nationally-recognized measures since the health plans that report their results nationally use standard definitions and results are attested by certified auditors of the NCQA. The OMPP compares the results of the HEDIS measures across the three MCEs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS survey is separated between one for adults and one for parents of children. The OMPP requires the MCEs to administer each survey annually.
2. Separately, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Centers for Medicare and Medicaid (CMS) was required to develop a core set of measures related to children's health and to collect the results of these measures on a voluntary basis from state Medicaid and CHIP programs. There were 24 core measures identified by CMS in 2010. Indiana's CHIP, through OMPP, began reporting all 24 measures as required by CMS in 2013.
3. When OMPP developed the CHIP and gained CMS approval for federal matching funds, the federal government required that the State develop strategic objectives and performance goals for Indiana's CHIP. The review of these performance goals are part of the OMPP's overall quality strategy and results are submitted in an annual report required by CMS.
4. In addition to the goals set for its CHIP program specifically, the OMPP also develops a Quality Strategy plan each year. Many items within the Quality Strategy pertain to outcomes for children, both CHIP and traditional Medicaid members.

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) 2014, tabulations were collected on HEDIS rates for 2013 utilization. The

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

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

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

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HEDIS measures report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome.

Exhibit V.1 presents the HEDIS results for access to primary care. There are differences in the methodology used by B&A in reporting primary care usage (shown in Chapter IV) and the HEDIS results. B&A's analysis was an administrative review (i.e. claims data) and includes all claims reported to OMPP. The HEDIS analysis includes a sample of HHW members but incorporates both an administrative review and a medical chart review. The HEDIS results represent the percentage of children who had a visit with their primary care practitioner (called PMPs) in the measurement year.

Exhibit V.1 below shows the five year trend reported for each MCE for four age groups. Anthem increased slightly on two measures, maintained on one measure and decreased on one measure. MHS maintained their rate on all four measures. MDwise maintained their rate on three measures and increased slightly on one measure. All three plans were within one percentage point of each other for HEDIS 2014 on these four measures.

Exhibit V.1

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

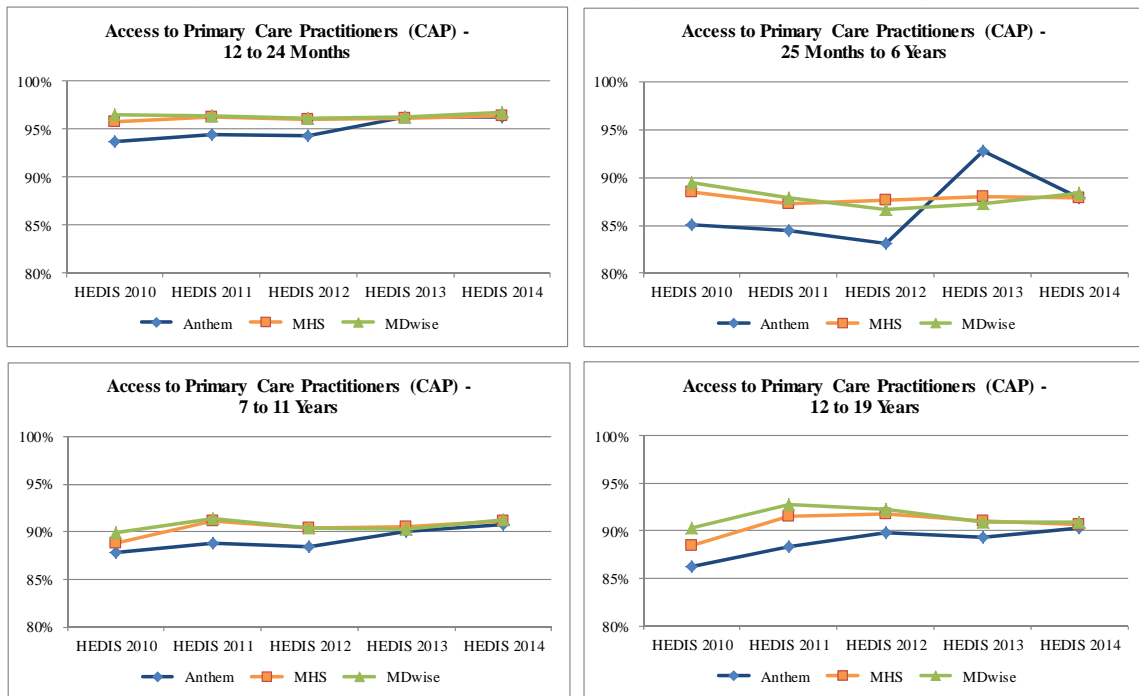


Exhibit V.2 on the next page shows the five year trend for well care visits for each MCE. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life (upper left box), the rate shown represents the percentage of children with six or more well child visits. For children in the ages 3-6 years (upper right box) and ages 12-20 years (lower left box) groups, the rate shown represents children that had at least an annual visit. Every MCE has had a marked increase related to well child visits over time.

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Another measure for well child care relates to immunizations (bottom right box). There is a HEDIS measure to report the percentage of children who turned age 2 during the measurement year who were enrolled for the 12 months prior to their second birthday who received the following immunizations:

- | | |
|--|--------------------------------|
| Four doses of diphtheria-tetanus (DTaP) | Three doses of influenza (HiB) |
| Three doses of polio (IPV) | Three doses of Hepatitis B |
| One dose of measles-mumps-rubella (MMR) | One dose of chicken pox (VZV) |
| Four doses of pneumococcal conjugate vaccine to prevent bacterial meningitis | |

Anthem and MHS decreased in the most recent year, but all three have had an increasing trend as measured over five years.

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

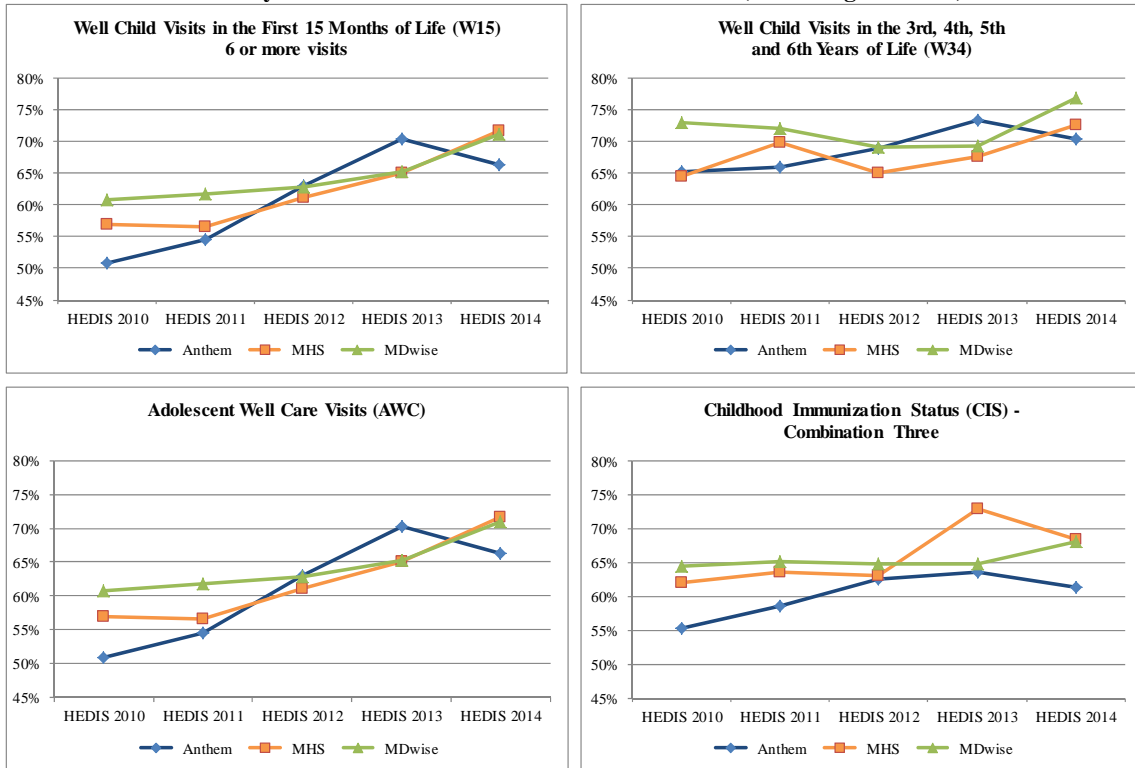


Exhibit V.3 on the next page presents the results from HEDIS measures related to respiratory care for children. The upper two boxes present results related to measuring proper treatment while the lower two boxes present results of appropriate medications for children with asthma.

For appropriate testing of children with pharyngitis (sore throat), all three plans have remained stable over the five years reviewed (see upper left box). Anthem showed a significant 24 percentage point increase between 2010 and 2011, but decreased in 2012 while remaining above the other MCEs in 2014. For this measure, a higher rating is more favorable since it indicates better testing.

When measuring treatment for upper respiratory infection (see upper right box), all three MCEs realized improvement in 2014. This measure reports the percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable because most upper respiratory infections are viral, not bacterial.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for CY 2014

Indiana’s MCEs did better for the two age-specific measures related to appropriate medication for children with asthma. In the lower left box, the rate is measured for children ages 5 to 11. Anthem and MDwise increase slightly while MHS maintained their rate. In the lower right box, the rate is measured for children ages 12 to 18 years. All three MCEs are further from the OMPP goal for this age group. MDwise and MHS decreased for the second year in a row and are at a five year low while Anthem increased slightly.

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

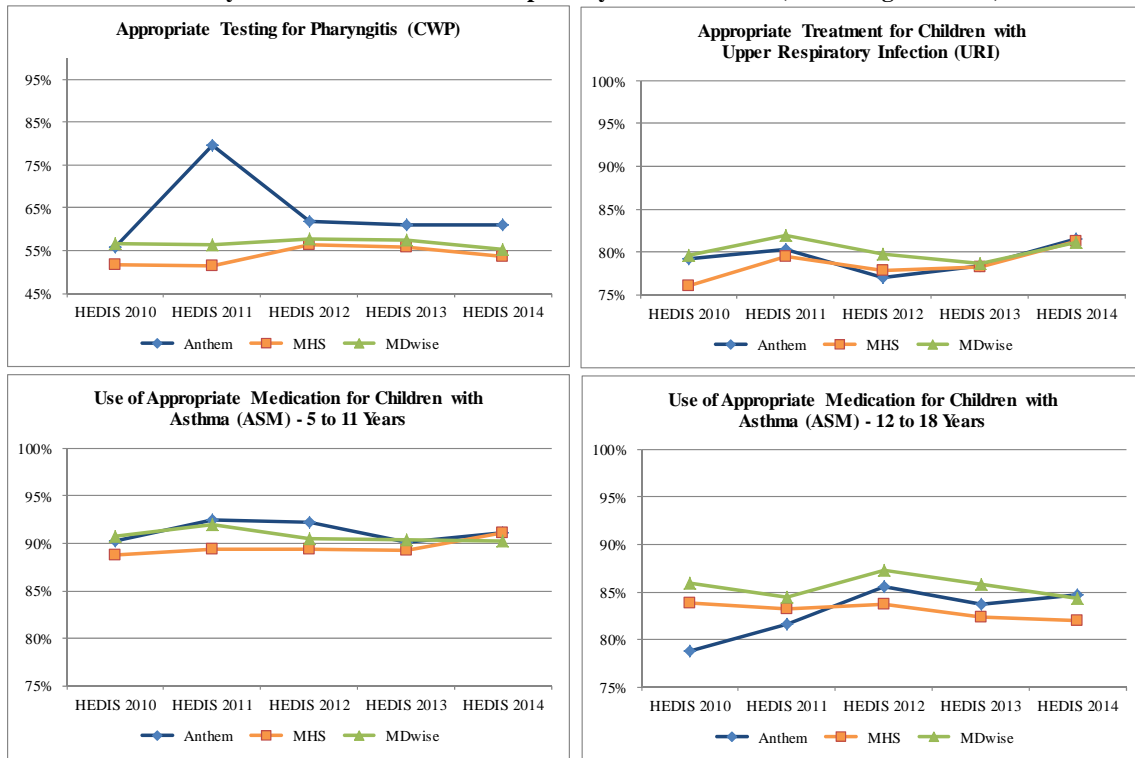
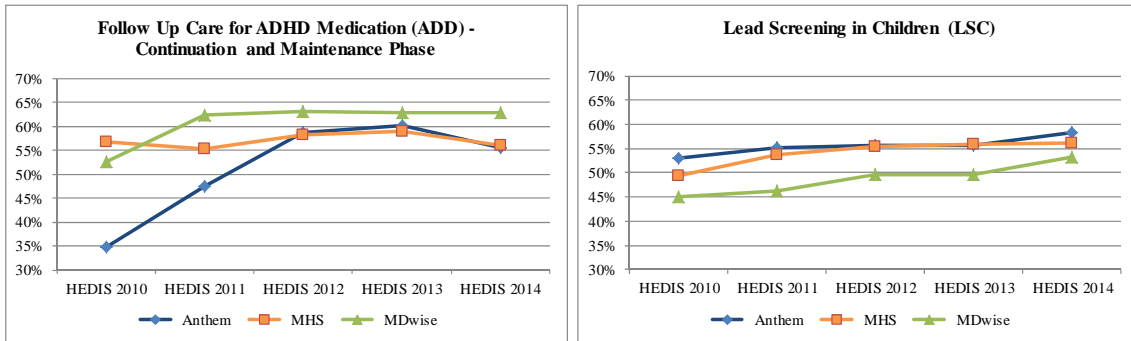


Exhibit V.4 on the next page presents the results of two other HEDIS measures related to children. One measures the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. The OMPP set a target at the 90th percentile among all Medicaid health plans nationally. Although there has been general improvement over the last five years for all three MCEs on this measure, no MCE is meeting the OMPP’s target goal.

The other measure shown is for the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. The OMPP has set a target of the 50th percentile among Medicaid health plans nationally. All three plans realized an increase in the most recent measurement period.

Exhibit V.4

Summary of Results from Selected Other HEDIS Measures (Percentage of Total)



CAHPS Results for Children Enrolled in Hoosier Healthwise

The Hoosier Healthwise MCEs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCEs to the OMPP. Exhibits V.5 and V.6 on the next page summarize the results from the surveys that were administered over the last five years. Missing health plan data indicates the number of respondents to questions were too low (< 100) to be able to extrapolate the rating to the entire population with confidence.

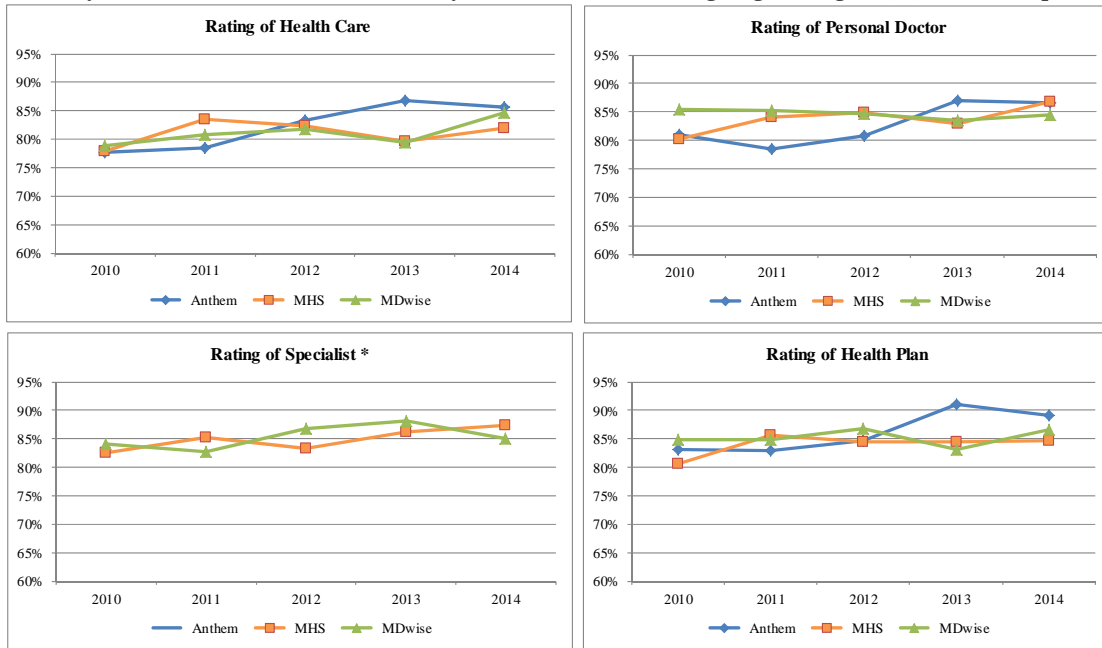
The percentages in Exhibit V.5 on the next page reflect those members that gave a rating of 8, 9 or 10 for each rating, where zero is the “worst possible” and 10 is the “best possible.” Anthem saw a slight decrease on Rating of Health Care and Rating of Health Plan, but remained the highest score of the three MCEs for these two measures. Anthem’s sample for Rating of Specialist was too small and, therefore, was not reported. MHS saw an increase on all four measures while MDwise saw an increase on three of the four measures. For these measures, the three MCEs’ rates are within four percent of each other.

The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The results in Exhibit V.6 on the next page represent four composite scores that show the percentage of respondents that answered “Usually” or “Always” to the series of questions on the topic. Anthem increased on all four measures and remains rated above the other MCEs. MHS increased on Getting Needed Care and How Well Doctors Communicate, while decreasing on Getting Care Quickly and Customer Service. MDwise increased on all four measures.

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Exhibit V.5

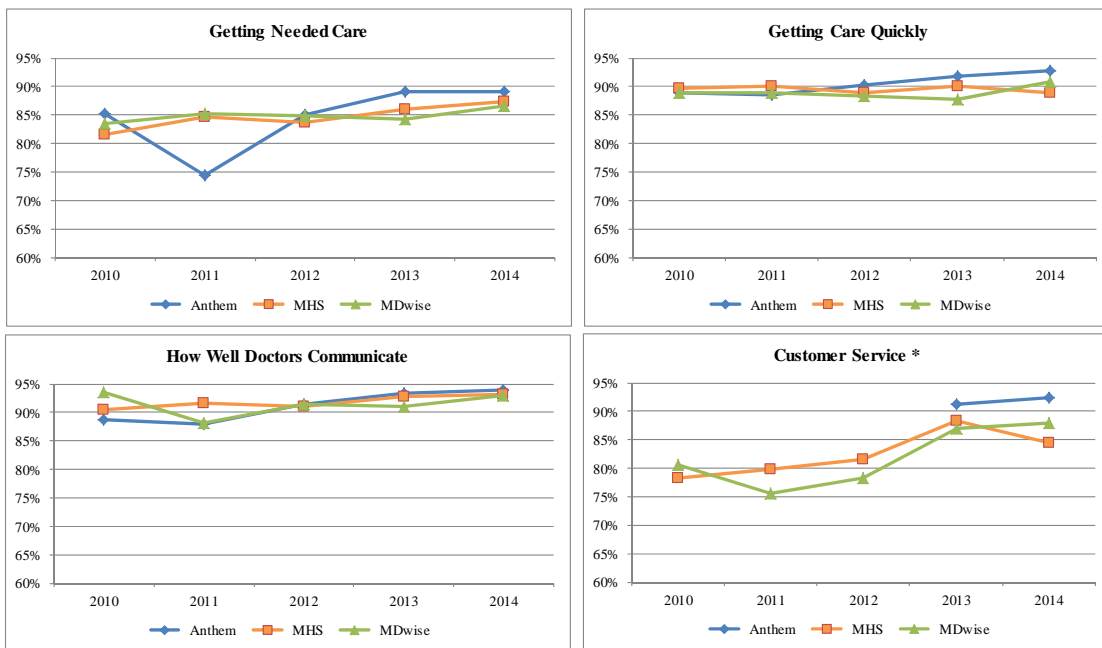
Summary of Scores from CAHPS Child Survey 2010 to 2014 (Members giving a rating of 8, 9, or 10 on 10-point scale)



* Anthem data not reported because the number of respondents to the questions were too low (< 100) to be able to extrapolate the rating to the entire population with confidence.

Exhibit V.6

Summary of Scores from CAHPS Child Survey 2010 to 2014 (Percentages reflect responses of "Usually" or "Always")



* Anthem not reported in 2010, 2011, or 2012 because the number of respondents to the questions were too low (< 100) to be able to extrapolate the rating to the entire population with confidence.

OMPP's Quality Strategy

The OMPP develops Quality Strategy Initiatives based on consideration of identified trends in health care issues within the State of Indiana, attainment of current quality strategy goals, close monitoring of the MCEs' performance and unmet objectives, and issues raised by external stakeholders and partners. Within HHW, the program in which CHIP members are enrolled, the OMPP identified 11 initiatives for CY 2014. Of these, four initiatives focus on children specifically, three initiatives focus on both children and adults, and another four are focused more on the adult population. The initiatives with the measure used to track performance are shown below.¹⁶

1. Achieve at or above the 90th percentile for improvements in children and adolescents well-care (HEDIS).
2. Improve the Early Periodic Screening, Diagnosis and Treatment (EPSDT) participation rate to 80% in 2014.
3. Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
4. Achieve at or above the 75th percentile of Ambulatory Outpatient Care Visit and Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).
5. Achieve a rate at or above the 50th percentile for members who are advised to quit smoking during at least one visit with a health care provider.
6. Achieve a rate at or above the 75th percentile of diabetic members who receive a LDL-C screening.
7. Achieve a rate of less than 27% Cesarean Delivery rate in an effort to decrease the number of elective inductions prior to 39th week of pregnancy.
8. Achieve at or above the 90th percentile for the frequency of both prenatal and post-partum care (HEDIS).
9. Increase the overall number of provider submitted Notification of Pregnancy forms by 1% above the 2013 rate in an effort to identify high-risk pregnancies for case management by the MCEs.
10. Increase the number of submitted Presumptive Eligibility applications during the 1st trimester of pregnancy by 2% in an effort to improve access to early prenatal care.
11. Achieve at or above the 96% of the Right Choices Program periodic reviews that are complete on time.

¹⁶ Office of Medicaid Policy and Planning, Family and Social Services Administration, Quality Strategy Plan 2014, page 6.