

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

Final Report – April 2011



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Executive Summary



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2010

As of November 2010, enrollment in Indiana's CHIP was at an all-time high of 83,693, a 4.9 percent increase over the prior year. Over the last five years, enrollment has grown 18.2 percent. Continued enrollment growth in Indiana's CHIP has made Indiana's program more successful than many other states' programs in lowering the uninsured rate among children in low-income families. Indiana's uninsured rate among children in families below 200 percent of the Federal Poverty Level (FPL) is now 9.7 percent compared to the national average of 16.4 percent. This places Indiana 9th lowest among states nationally. The most recent estimate for Indiana is a slight increase from the all-time lowest uninsured rate reported last year of 8.6 percent¹.

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

- CHIP Package A (the Medicaid expansion portion) covers uninsured children in families with incomes up to 150 percent of the FPL (\$33,075 per year for a family of four in 2010) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.
- CHIP Package C (the non-entitlement portion) rolled out in two eligibility increments. Families in CHIP Package C pay monthly premiums whereas the families in CHIP 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 (\$44,100 per year for a family of four in 2010).
 - The second portion was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL (\$55,125 per year for a family of four in 2010).

The largest enrollment growth has been among families enrolled in CHIP Package C. In the last five years, this portion of the program has grown 44 percent (compared to a 9.6% increase in CHIP Package A).

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

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

- (1) *Budget committee;*
- (2) *Legislative council;*
- (3) *Children's health policy board established by IC 4-23-27-2; and*
- (4) *Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2010. 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.

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

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

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

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

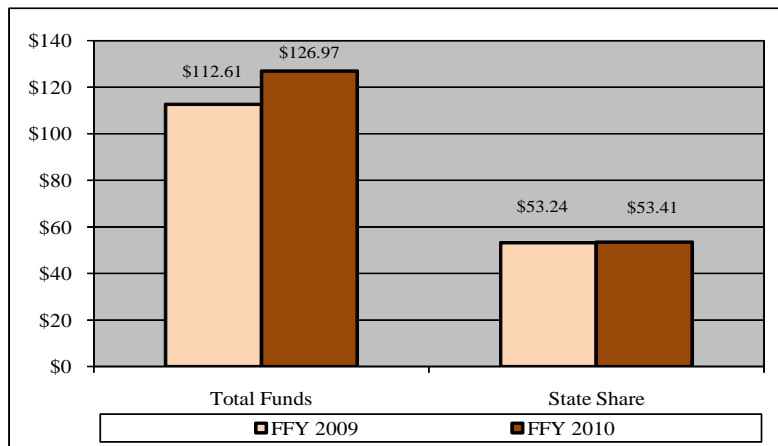
Premiums Charged to Families in Indiana's CHIP Package C

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

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) 2010, for every dollar spent on medical services in Indiana’s CHIP, the state paid 23.85 cents and the federal government matched the remaining 76.15 cents. In the Medicaid program, the federal government match rate was 65.93 cents. However, for a time-limited period, the federal government has been matching at an enhanced rate that was allocated under the American Recovery and Reinvestment Act of 2009 (ARRA).

Trends in the Medical Cost Per Member Per Month (PMPM) For the Premium Portion of CHIP (CHIP C)

Because of the higher federal match rate and the premiums paid by CHIP Package C families, the state share paid towards CHIP Package C members was only \$53 when measured on a per member per month (PMPM) basis in FFY 2010. This remained unchanged from FFY 2009. The PMPMs shown here are lower than the amount paid for children in Medicaid portion of Hoosier Healthwise.²



Source: CMS-21 expenditure reports submitted by the State to CMS. Member months derived by B&A from OMPP’s data warehouse.

² It was discovered after publication of last year’s report that the PMPM figures shown for FFY 2008 and FFY 2009 in last year’s report were incorrect. Please use the figure shown in this report to compare across years.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCOs 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, Indiana’s all three Hoosier Healthwise MCOs rated higher than national benchmark on member satisfaction for questions related to Getting Needed Care, Getting Care Quickly and overall Rating of Health Plan. Anthem and MDwise also exceeded the benchmark score last year and Managed Health Services was at the benchmark last year.

Access to Services

B&A examined the accessibility for Hoosier Healthwise (CHIP and Medicaid) children by reviewing the results of reports submitted to the OMPP by each MCO. The OMPP requires that there be a primary medical provider (PMP) within 30 miles of each Hoosier Healthwise member’s home. The maps for all three MCOs showed that this threshold is met in every part of the state.

B&A also reviewed access by examining where CHIP members receive primary 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. Of all CHIP members that had a preventive dental visit in CY 2010, 94 percent of children obtained their visit either in their home county of residence or in a contiguous county. Only one county (Whitley) had a high proportion of dental visits received from members from a county not connected to their home county.

For primary care visits, B&A first examined the counties where there may be an access issue because the number of patients that providers are willing to accept (the doctor’s panel) for Hoosier Healthwise is greater than 80 percent of the total that the providers in that county contracted for. As of December 2010, there are 15 counties where the pediatric providers’ panels are above 80 percent. We then examined the location where CHIP members access primary care using the same method that we did for the dental analysis. When we compared the counties where members traveled further to have a primary care visit against the counties with limited panel capacity, only one county—Tippecanoe—appeared to have limited access for CHIP members based on the data studied.

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 script for the periods FFY 2009 and FFY 2010. The overall rate of usage for each category remained unchanged over the two years. Comparisons were also made across various demographic cohorts, such as by MCO, by age and by race/ethnicity.

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

	in FFY 2009	in FFY 2010
Primary Care Visit (office or clinic setting)	70%	71%
Emergency Room Visit	30%	29%
Preventive Dental Visit	62%	63%
Pharmacy Script	70%	71%

B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall for 2009 and 2010 and also by each of the demographic cohorts.

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Some of the key findings from these analyses are:

- Primary care visits were more prevalent among younger members, as 80 percent of children age five and younger had a visit in FFYs 2009 and 2010. The percentages of children in the older age groups that had a primary care visit were lower (69% for age 6-12 and 67% for age 13 and over in FFY 2010).
- 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. African American and Hispanic CHIP children had primary care visits at the same rate in each year (60% and 62%, respectively, in FFY 2010) but it was significantly below the 75 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 150 per 1,000 children in any given month, but the rate for African American and Hispanic children is closer to 100 per 1,000 children.
- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCO, but it more pronounced when reviewed at the per 1,000 member statistic. In CY 2009 and 2010, the average rate among MDwise members was 52 ER visits per 1,000 CHIP members; for Anthem, it was 33 per 1,000; for MHS, it was 38 per 1,000.
- Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (37% of all members in FFY 2010) and lowest among children age six to 12 (26% of all members in FFY 2010).
- One in four 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 62 to 63 percent in both FFY 2009 and FFY 2010. This is an increase from 58 percent in FFY 2008.
- The rate of preventive dental visits varies some for CHIP children by region, from a low of 58 percent having a visit in FFY 2010 in the Southeast Region to a high of 68 percent in the East Central Region.
- There is little difference from the statewide average in preventive dental usage among the race/ethnicities studied.
- The overall percentage of members that had a pharmacy script has remained relatively unchanged (71%) in the last two years, but was highest among children under age six (78%).
- The trend in total scripts received, however, is different. The number of scripts per 1,000 CHIP members is highest for children age 13-18 (566 per 1,000 on average in each month of CY 2009 and CY 2010), followed by children age 6-12 (426 per 1,000), then by children age 1-5 (334 per 1,000).
- Caucasian children have a utilization rate of 533 scripts per 1,000 members each month, which is 52 percent higher than the rate for African-American children (351 scripts per 1,000) and more than double the rate for Hispanic children (241 scripts per 1,000 children).

I

Introduction



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2010

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

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

- (1) Budget committee;*
- (2) Legislative council;*
- (3) Children's health policy board established by IC 4-23-27-2; and*
- (4) Select joint commission on Medicaid oversight established by IC 2-5-26-3.*

The report must be in electronic format under IC 5-14-6.

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2010. 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 2009¹ extended the program to September 2013. The Congressional Budget Office estimates that the expansion of federal funds will provide coverage to 4.1 million additional children in state Medicaid and CHIP programs who would have otherwise been uninsured by 2013.

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

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

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

- CHIP Package A (the Medicaid expansion portion) covers uninsured children in families with incomes up to 150 percent of the Federal Poverty Level, or FPL (\$33,075 per year for a family of four in 2010) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.
- CHIP Package C (the non-entitlement portion) rolled out in two eligibility increments. Families in CHIP Package C pay monthly premiums whereas the families in CHIP

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

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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 (\$44,100 per year for a family of four in 2010).
- The second portion was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL (\$55,125 per year for a family of four in 2010).

Half of the states have income eligibility thresholds similar to Indiana. As of January 2011, 25 states (including the District of Columbia) cover children at 250 percent FPL or above; 22 states cover children at a maximum between 200 and 249 percent FPL; and four states set a maximum below 200 percent FPL².

As of November 2010, enrollment in Indiana's CHIP was at an all-time high of 83,693³, a 4.9 percent increase over the prior year:

- CHIP Package A enrollment was 57,804 (steady when compared to December 2009)
- CHIP Package C enrollment was 25,889 (a 17.8% increase from December 2009)

In CHIP Package C, enrollment in the new expansion group increased 36.0 percent in CY 2010 (up to 6,266 enrollees) while the original target group (150%-200% FPL) increased 13.0 percent (up to 19,623 enrollees).

More enrollment statistics appear in Chapter II of this report.

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

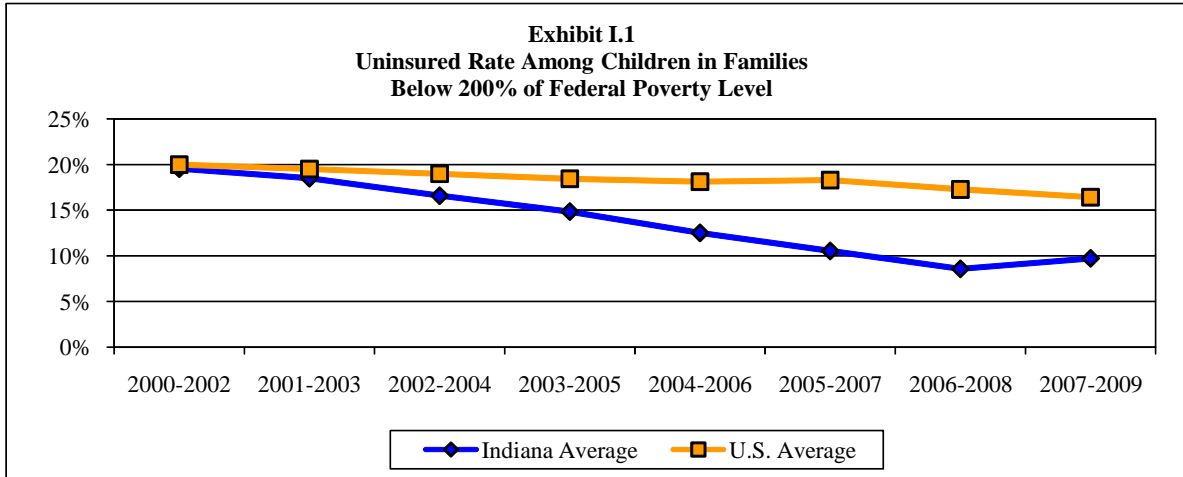
The Census Bureau's Current Population Study (CPS) surveys citizens each March on their health insurance status. An uninsured rate is computed for each state, but because state-specific samples are usually small, it is customary to measure this rate over a three year average. The CPS survey conducted in March 2010 measured insurance status in CY 2009. Therefore, the 2007-2009 timeframe is the most recent three-year average period available.

Indiana has been more effective than the nation as a whole in reducing the uninsured rate among low-income children. Among children in families with incomes below 200 percent of the FPL, Indiana's most recent uninsured rate is 9.7 percent compared to the national average of 16.4 percent. Indiana's uninsured rate declined for six consecutive study periods before increasing this past year (refer to Exhibit I.1 on the next page). The success in lowering the uninsured rate can be partially attributed to Indiana's effective outreach to enroll children in its CHIP.

² Heberlein, M., Brooks, T., Guyer, J., Artiga, S., Stephens, J. (January 2011) Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011. Washington, DC: Georgetown University Center for Children and Families and The Henry J. Kaiser Family Foundation.

³ Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, MedInsight, on January 24, 2011.

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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

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 69,000 in the 2007-2009 three year average 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 9th lowest uninsured rate in the country for this income group among all states.

The uninsured rate varies by family income level and by race/ethnicity in the state (refer to Exhibit I.2 below). Using the three-year 2007-2009 averages from the Current Population Survey, 69 percent of all uninsured children in Indiana may already be eligible for CHIP based on family income.⁴

**Exhibit I.2
Child Uninsured Rates (Age 0-18) by Family Income in Indiana
2007 - 2009 Three-Year Average**

	Total Uninsured	Percent of All Uninsured Children	Uninsured Rate
Total for Children that may be Eligible for Indiana's CHIP			
Income up to 250% FPL	80,732	69%	9.1%
Total for Children Not Eligible for Indiana's CHIP			
250% and above	36,060	31%	4.4%
All Children	116,792	100%	6.9%

Source: U.S. Census Bureau, Current Population Survey
http://www.census.gov/hhes/www/cpstc/csp_table_creator.html

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

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The uninsured rate for African American children (4.7%) in this income group is lower than other race/ethnicities. The rate for Caucasian children (9.6%) was near the statewide average, while the rate for Hispanic children (13.0%) and children of other race/ethnicities (13.3%) were much higher.

**Exhibit I.3
Uninsured Rates for Children (Age 0-18) by Race/Ethnicity in Indiana
For Children in Families At or Below 250% FPL
2007 - 2009 Three-Year Average**

Family Federal Poverty Level	Total Uninsured	Pct of Uninsured Children at this FPL	Uninsured Rate
Caucasian Non-Hispanic	55,944	69%	9.6%
African Amer. Non-Hispanic	7,940	10%	4.7%
Hispanic (any race)	13,096	16%	13.0%
All Other Races	3,752	5%	13.3%
All Children	80,732	100%	9.1%

Source: U.S. Census Bureau, Current Population Survey
http://www.census.gov/hhes/www/cpssc/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 organizations (MCOs) that contract with the state—Anthem, Managed Health Services or MDwise. CHIP enrollees have access to all of the providers available to Hoosier Healthwise members that are enrolled with the MCO they select.

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

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

**Exhibit I.4
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 (some limits)
Vision Care	Transportation (some limits)
Mental Health Care	Nurse Practitioner Services
Substance Abuse Services	Nurse Midwife Services
	Family Planning Services

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Exhibit I.5

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

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

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

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

- Integrated Medicaid/CHIP eligibility determination system (34 states)
- Face-to-face interview not required at the time of application (49 states) or at renewal (50 states), although Indiana requires a telephone interview unlike other states
- Asset test not required in determining eligibility (47 states)
- Renewal occurs every 12 months (49 states)
- Co-pays charged for generic prescriptions (24 states) and brand name prescriptions (26 states)
- Premiums charged to members (34 states). Of those that charge premiums,
 - Up to the 150% FPL level, Indiana charges \$0 (like 21 other states)
 - At the 151-200% FPL level, Indiana charges premiums on a sliding scale (like 21 other states)
 - At the 201%-250% FPL level, Indiana charges higher premiums than the lower FPL group (like 31 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.

- Indiana does not impose co-pays for non-emergent ER visits (14 states do), non-preventive physician visits (17 states do), or inpatient hospital visits (12 states do).
- The required period of no insurance prior to enrolling (also known as the “going bare” period) is 3 months in Indiana. Ten states have no go bare period, 19 states are like Indiana with a go bare period of one to three months, and 21 states impose a go bare period greater than 3 months.
- Enrollment is continuous for 12 months, regardless of circumstance in 23 states. In Indiana, the only members in CHIP that have continuous eligibility for 12 months are those ages zero to three.

⁵ Heberlein, M., Brooks, T., Guyer, J., Artiga, S., Stephens, J. (January 2011) Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011. Washington, DC: Georgetown University Center for Children and Families and The Henry J. Kaiser Family Foundation.

Expenditures in Indiana’s CHIP

A key difference between the CHIP and Medicaid programs is the way in which each is financed. Both the CHIP and Medicaid programs are jointly funded by states and the federal government. In the CHIP, however, the matching rate provided by the federal government for medical services is higher than it is in the Medicaid program. For example, in Federal Fiscal Year (FFY) 2010, for every dollar spent on medical services in Indiana’s CHIP, the state paid 23.85 cents and the federal government matched the remaining 76.15 cents. In the Medicaid program, the standard rate paid by the state is 34.07 cents and the federal government matched the remaining 65.93 cents. However, for a time-limited period, the federal government has been matching at an enhanced rate that was allocated under the American Recovery and Reinvestment Act of 2009 (ARRA).

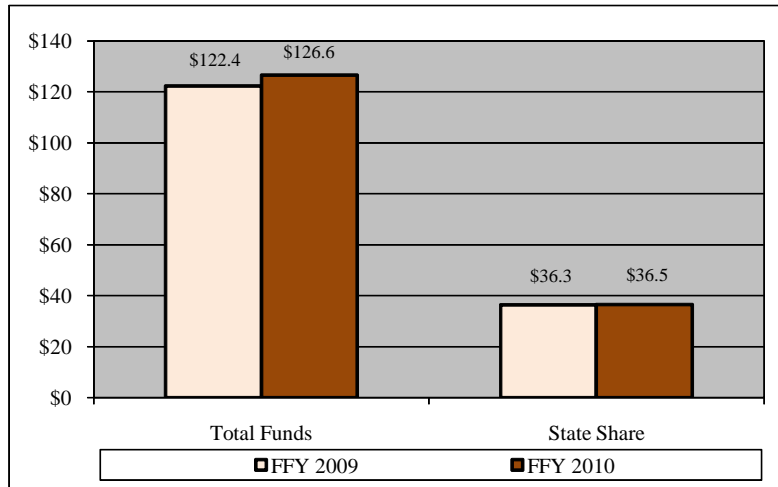
Most of the service expenditures in Indiana’s CHIP are paid to MCOs through what is known as a capitation payment. This is a set amount paid to the MCOs per member per month (PMPM). The capitation PMPM rate is adjusted for age and also adjusted by Package. There are also some services covered in the program but paid on a fee-for-service basis outside of the MCO contract. These include dental services and, beginning in CY 2010, pharmacy prescriptions. Other services may be paid fee-for-service in the CHIP if an enrollee utilizes a service during the short time period before they have selected which MCO to join.

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.

B&A examined expenditures made on behalf of CHIP members in FFYs 2009 and 2010.⁶ Data was pulled from the CMS-21 expenditure reports that the OMPP is required to submit quarterly to CMS.

Medical expenditures in the CHIP (total funds) increased 3.5 percent over the two-year period, from \$122.4 million in FFY 2009 to \$126.6 million in FFY 2010. The state share of these expenditures increased only 0.5 percent, from \$36.3 million to \$36.5 million. On a percentage basis, the state’s portion did not increase as much as the total funds because the expenditures were offset by an increased federal match rate along with an increase in the amount of premiums collected from parents. For example, total member months for

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



Source: CMS-21 expenditure reports submitted by the State to CMS.

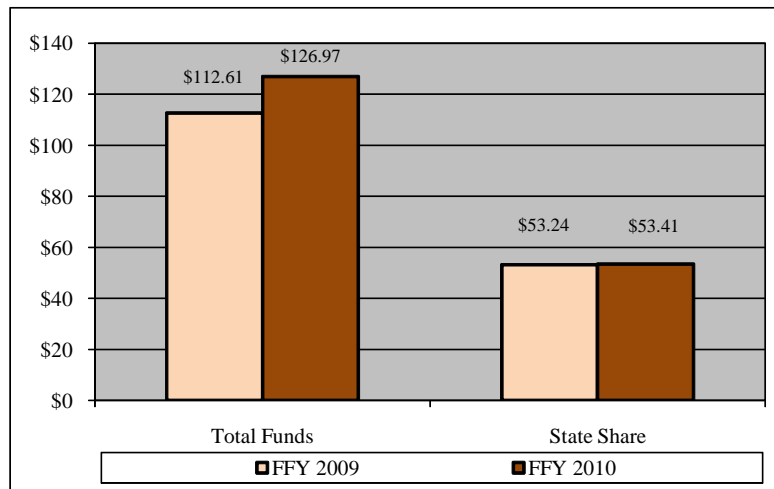
children in the highest income bracket of eligibility (200-250% FPL) increased 89 percent during this time period. The families at this income level also pay the highest premiums of any eligibility group. In FFY 2010, premiums that were paid for all CHIP Package C members exceeded \$6.3 million.

⁶ The federal fiscal year runs from October 1 through September 30.

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Because CHIP Package C is the faster-growing portion of the program, total expenditures are increasing but so are member months. To compare apples to apples, therefore, it is helpful to analyze the expenditure trends on a per member per month (PMPM) basis. Exhibit I.7 shows the PMPM costs in CHIP Package C for FFYs 2009 and 2010, expressed both in total funds and in state-only funds (net of premiums paid by members and the federal matching funds). Although the PMPM increased from \$112.61 to \$126.97 in CHIP Package C expressed as total funds, the state's outlay on a PMPM basis remained unchanged at \$53 in the last two years.⁷

Exhibit I.7
Trends in the Medical Cost Per Member Per Month (PMPM)
For the Premium Portion of CHIP (CHIP C)



Source: CMS-21 expenditure reports submitted by the State to CMS.
Member months derived by B&A from OMPP's data warehouse.

⁷ It was discovered after publication of last year's report that the PMPM figures shown for FFY 2008 and FFY 2009 in last year's report were incorrect. Please use the figure shown in this report to compare across years.

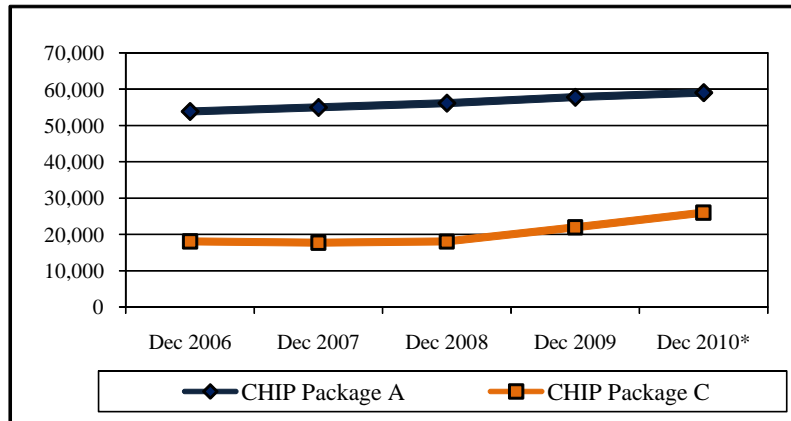
II

Enrollment Trends in Indiana's CHIP



Indiana's Children's Health Insurance Program (CHIP) experienced its all-time high enrollment at the end of Calendar Year (CY) 2010 of 83,693, a 4.9 percent increase over the prior year. Over the last five years, enrollment has grown 18.2 percent. In CHIP Package A, the entitlement portion of the program for children in families with incomes up to 150% of the federal poverty level (FPL), enrollment has grown 9.6 percent since December 2006.

Exhibit II.1
Recent Enrollment in Indiana's CHIP



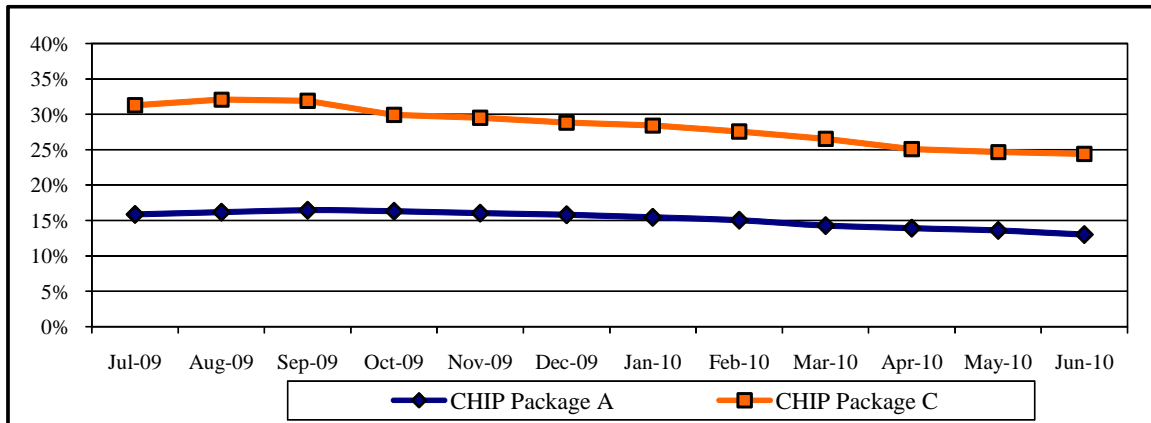
*Estimate based on final eligibility determinations

In CHIP Package C, the non-entitlement program for children in families with incomes 150%-250% of the FPL, enrollment has grown 43.8 percent during this five-year period. The rapid growth in CHIP Package C stems from the expansion of eligibility to higher income families beginning in October 2008. In the original portion of CHIP Package C (150%-200% FPL), enrollment grew more modestly from December 2006 to December 2010 at 9.6 percent, the same rate as CHIP Package A.

Enrollment and Disenrollment Trends

New enrollees continue to remain a large percentage of children in the program. CHIP members enrolled during State Fiscal Year (SFY) 2010⁸ were examined to measure how many were new to CHIP within the last 12 months. Exhibit II.2 shows that 15.9 percent of CHIP Package A members enrolled in July 2009 were new to the program in the prior 12 months. This rate at the beginning of the SFY dropped to 13.0 percent by the end of the year. In CHIP Package C, 31.3 percent of members enrolled in July 2009 were new to the program in the prior 12 months. This dropped to 24.4 percent by June 2010.

Exhibit II.2
Percent of Enrollees in the Month that were New in Previous 12 Months



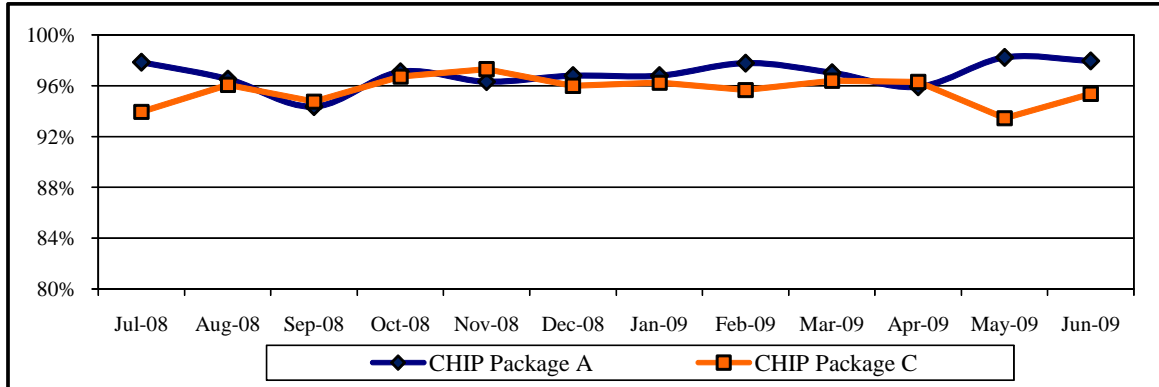
Source: MedInsight, Indiana OMPP's data warehouse

⁸ July 1, 2008 – June 30, 2009

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In addition to the large number of new individuals, the total number of enrollees that stay within Indiana’s CHIP also remains high. New enrollees in CHIP were identified in SFY 2009. B&A reviewed the membership status for each child after 12 months of enrollment when members are required to be redetermined eligible for the program. Among this group of members, the average retention rate was 96.9 percent for CHIP Package A members and 95.8 percent for CHIP Package C members.⁹ This is a slight improvement in retention from last year’s findings, when the results were 96.7 and 95.8 percent, respectively.

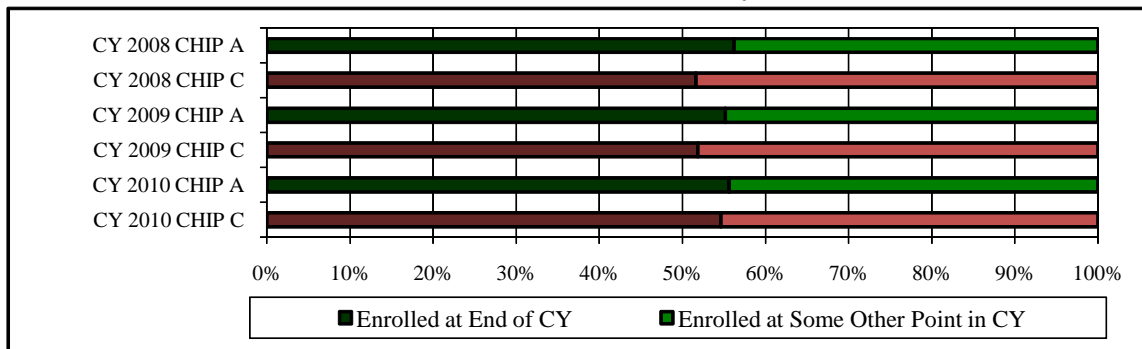
Exhibit II.3
Retention Rate in the CHIP at Time of Member’s Recertification
Percentage Includes Members New in the Month Shown who Recertified After 12 Months



Source: MedInsight, Indiana OMPP’s data warehouse. Excludes members who turned age 19 (no longer eligible) and those that disenrolled prior to the month when they would need to recertify.

The number of children currently enrolled in the program each year continues to increase, but the number of children ever enrolled in each calendar year also continues to rise. In fact, in the last three calendar years there have been almost twice as many children enrolled at some point in the year when compared to the number enrolled at the end of the year. In CY 2010, there were 153,910 children enrolled in Indiana’s CHIP at some point during the year—106,191 in CHIP Package A and 47,719 in CHIP Package C. 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
Status of Children Ever Enrolled in CHIP, by Calendar Year

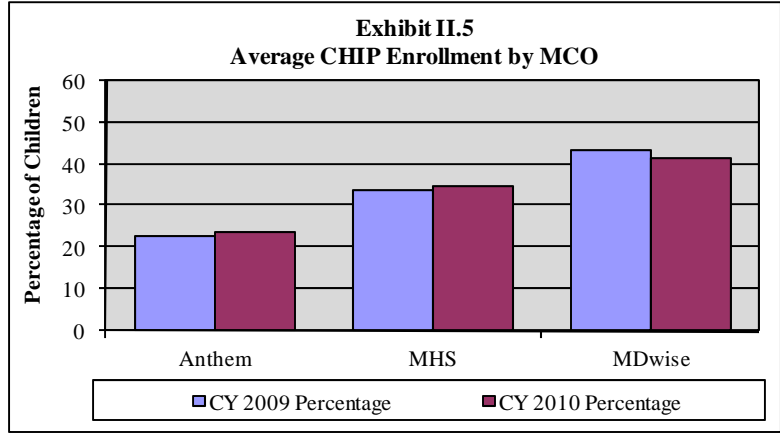


Source: MedInsight, Indiana OMPP’s data warehouse

⁹ CHIP members are considered “retained” so long as they remain within Hoosier Healthwise, that is, they may move from the CHIP to the traditional Medicaid program, or between CHIP Package A and CHIP Package C.

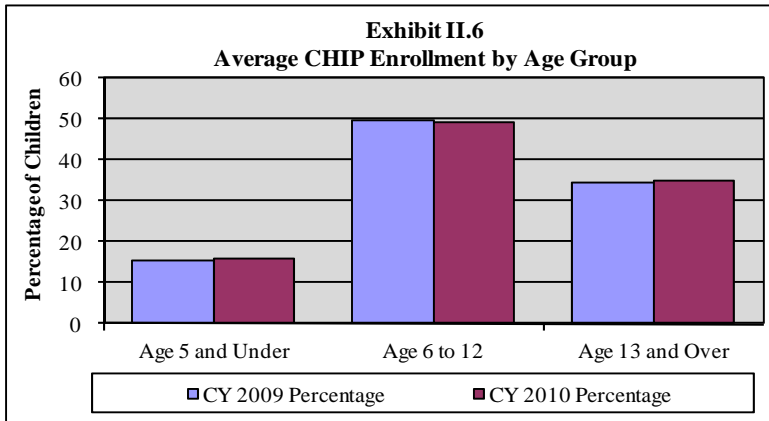
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There was some movement in the MCO selected by CHIP members in 2010. In CY 2010, Anthem had 23.6 percent of all CHIP enrollees as compared to 22.8 percent in CY 2009. Managed Health Services also increased its CHIP membership, from 34.0 percent of all CHIP enrollees in CY 2009 to 34.7 percent in CY 2010. MDwise lost membership among CHIP members, from its total of 43.2 percent in CY 2009 to 41.7 percent in CY 2010.



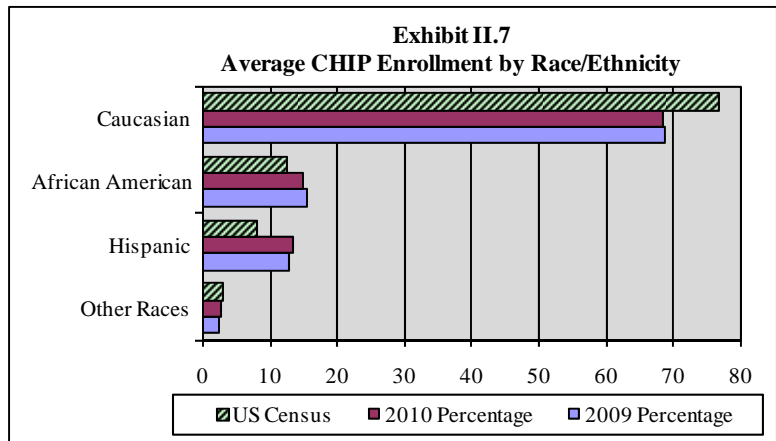
Families have 30 days after their eligibility effective date to select a primary medical provider (PMP) and their MCO; otherwise they will be auto-assigned. Until the member’s selection or an auto-assignment is made, the member is eligible for services in the Fee-For-Service (FFS) portion of the program. There was about 12.5 percent of CHIP members temporarily enrolled in the FFS program in any given month in CY 2010.

Demographic Profile of CHIP Members



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

There is a higher distribution of minorities in Indiana’s CHIP than the overall population in Indiana for children age 18 and younger. Compared to the U.S. Census estimate,¹⁰ African-American children (15.1% of CHIP enrollees in CY 2010) and Hispanic children (13.4% of CHIP enrollees in CY 2010) are represented more in CHIP than in the statewide population. Between CY 2009 and



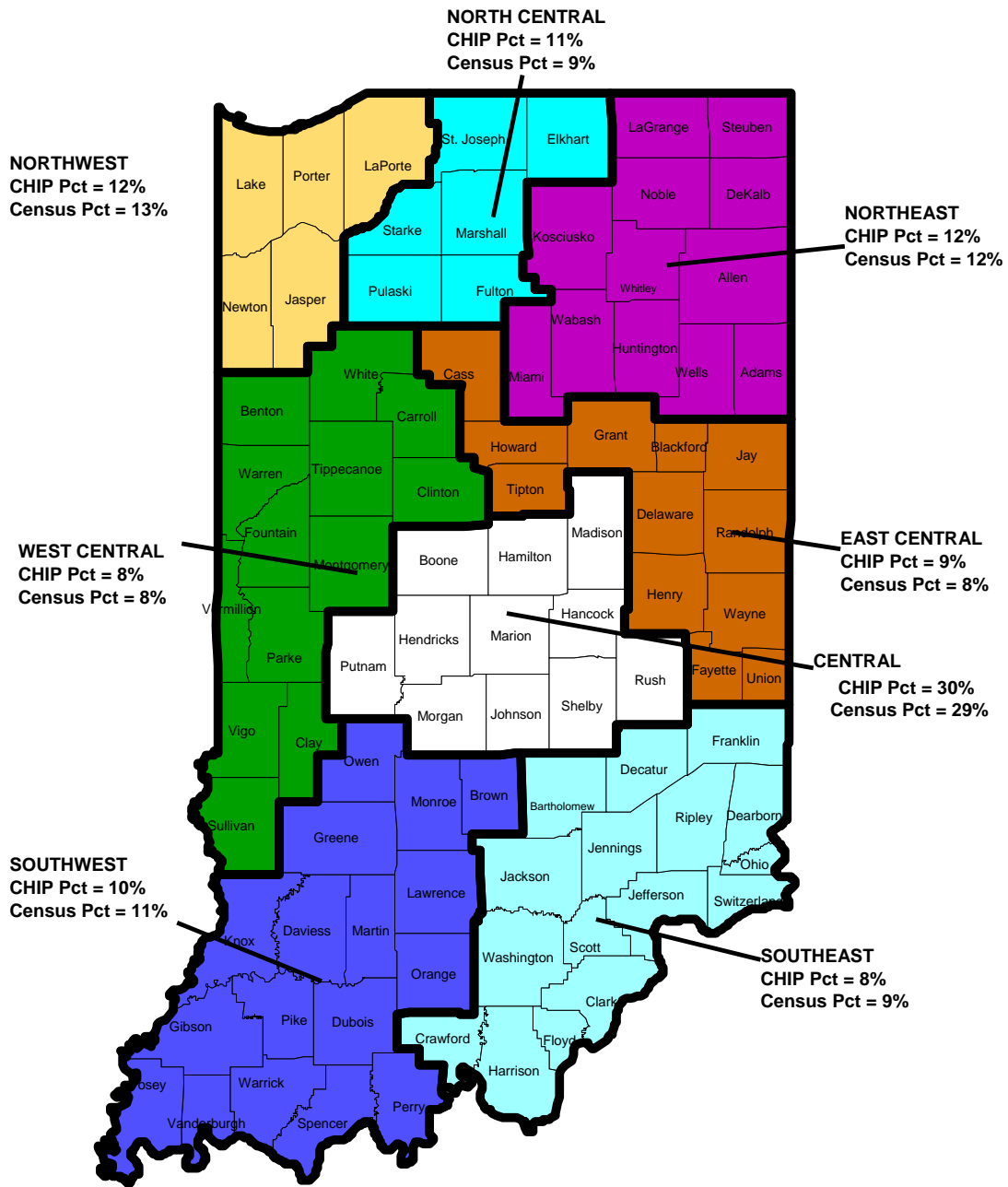
¹⁰ U.S. Census Bureau, Current Population Survey, three year average for Indiana 2007-2009. <http://www.census.gov/hhes/www/hlthins/hlthins.html>

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CY 2010, the proportion of Caucasian CHIP members remained the same (68.6%) while the African-American proportion decreased slightly and the Hispanic proportion increased slightly.

The distribution of CHIP members by region closely matches the overall child population in Indiana. B&A compared CHIP members enrolled to the total child population in Indiana as of July 2009.

Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2009



III

Access and Availability of Providers in Indiana's CHIP



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2010

Burns & Associates, Inc. (B&A) serves as both the Office of Medicaid Policy and Planning's (OMPP's) independent evaluator of the CHIP and also as its external quality review organization (EQRO) for the Hoosier Healthwise program and Healthy Indiana Plan (HIP). In last year's EQR, one focus was on the accessibility and availability of providers in both Hoosier Healthwise and HIP. Part of the study focused on children's access to primary and specialty care. In this section, we present the results of the EQR analysis as well as a more in-depth review of the availability of primary medical providers (PMPs) and dentists in Indiana's CHIP.

Findings from the External Quality Review of Hoosier Healthwise

The OMPP requires that Hoosier Healthwise members enrolled with its three managed care organizations (MCOs) have access to a 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. These include cardiologists, orthopedic surgeons, otolaryngologists, psychiatrists and urologists.

B&A examined the accessibility for Hoosier Healthwise (CHIP and Medicaid) children by reviewing the results of GeoAccess reports submitted in 2010 to the OMPP by each MCO. The GeoAccess reports plot the location of every member enrolled with an MCO and measure if the MCO has a provider of a particular specialty within the required number of miles of that member's residence.

Exhibit III.1 shows the results for desired access for each specialty type in Hoosier Healthwise for both children and adults. The MCOs plotted the location of their providers as well as documenting the location of members without desired access. B&A classified "counties w/o desired access" if *any* members in the county do not have the desired access; however, in each of these counties at least *some* of the members do have desired access.

Exhibit III.1
MCO Reported Network Access for Hoosier Healthwise Members in Indiana's 92 Counties
Source: GeoAccess reports provided by the MCOs to the OMPP or to B&A

Provider Specialty	Standard	Anthem		MDwise		MHS	
		# Counties w/ Desired Access	# Counties w/o Desired Access	# Counties w/ Desired Access	# Counties w/o Desired Access	# Counties w/ Desired Access	# Counties w/o Desired Access
Primary Medical Provider	1 within 30 miles	92	0	92	0	92	0
Cardiologists	2 within 60 miles	92	0	92	0	88	4
Orthopedic Surgeon	2 within 60 miles	92	0	92	0	92	0
Otolaryngologist	2 within 60 miles	at least 79 ²		90	2	Not Reported	
Psychiatrists ¹	2 within 60 miles	92	0	92	0	92	0
Urologist	2 within 60 miles	92	0	92	0	86	6

¹ Anthem reported "Behavioral Health Providers" and not psychiatrists specifically.

² Anthem reported desired access of otolaryngologists in all regions of the state except for the West Central Region.

In this region that includes 13 counties, 62% of members have desired access, but this was not reported at a county level.

For primary care, there is full compliance of the 30 mile requirement. Among the specialists where there must be at least two of the specialty within 60 miles, there is desired access among all MCOs for orthopedic surgeons and psychiatrists or other behavioral health providers. In all but a few counties, there is also desired access for cardiologists and urologists.

Access to Primary Medical Providers

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

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.¹¹ When he/she contracts with an MCO, 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 3,142 in December 2010.

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

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.

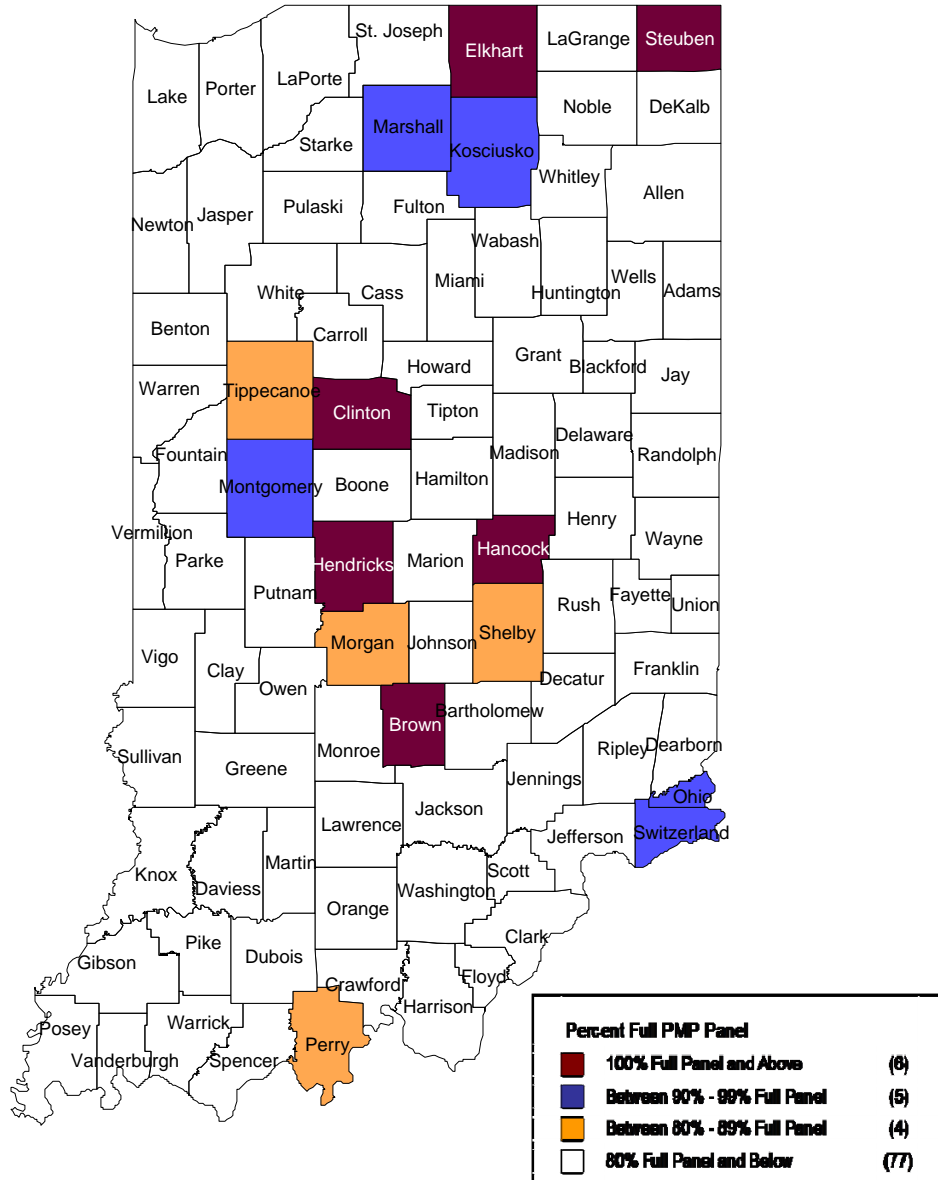
The OMPP's fiscal agent, HP, measures panel capacity for pediatric providers in each county of the state as required by the Centers for Medicare and Medicaid (CMS). It is important to measure panel capacity to assess if there are potential gaps in the state where there are fewer PMPs available to accept new patients. B&A analyzed HP's pediatric panel capacity report for December 2010.¹² The average number of members enrolled with each pediatric PMP was between 200 and 216 throughout CY 2010.

In December 2010, on average statewide the pediatric PMPs' panels were 35 percent full. This rate varies significantly on a county-by-county basis, however. In Exhibit III.2 on the next page, B&A color-coded each county's PMP panel capacity as tabulated by HP at the end of CY 2010. Counties colored white (77 out of 92) are those where the PMP panel is less than 80 percent full. Fifteen counties are considered potentially at risk since their panel capacity among all providers in the county was more than 80 percent full. Counties colored orange (4) are those where the PMP panels are 80 to 89 percent full. Counties colored blue (5) are those where the PMP panels are 90 to 99 percent full. Six counties are technically more than 100 percent full (in brick red), which means that, when analyzed as a group, the PMPs in each of these counties have actually accepted more CHIP and Medicaid members than they contractually agreed to accept.

¹¹ OB/GYNs may, but are not obligated, to sign up as PMPs. They may also sign up as a specialist.

¹² It should be noted, however, that HP's reports of how full each pediatric panel is includes both children and adult patients if the PMP is willing to accept both.

Exhibit III.2
Panel Capacity among Pediatric PMPs, by County



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.

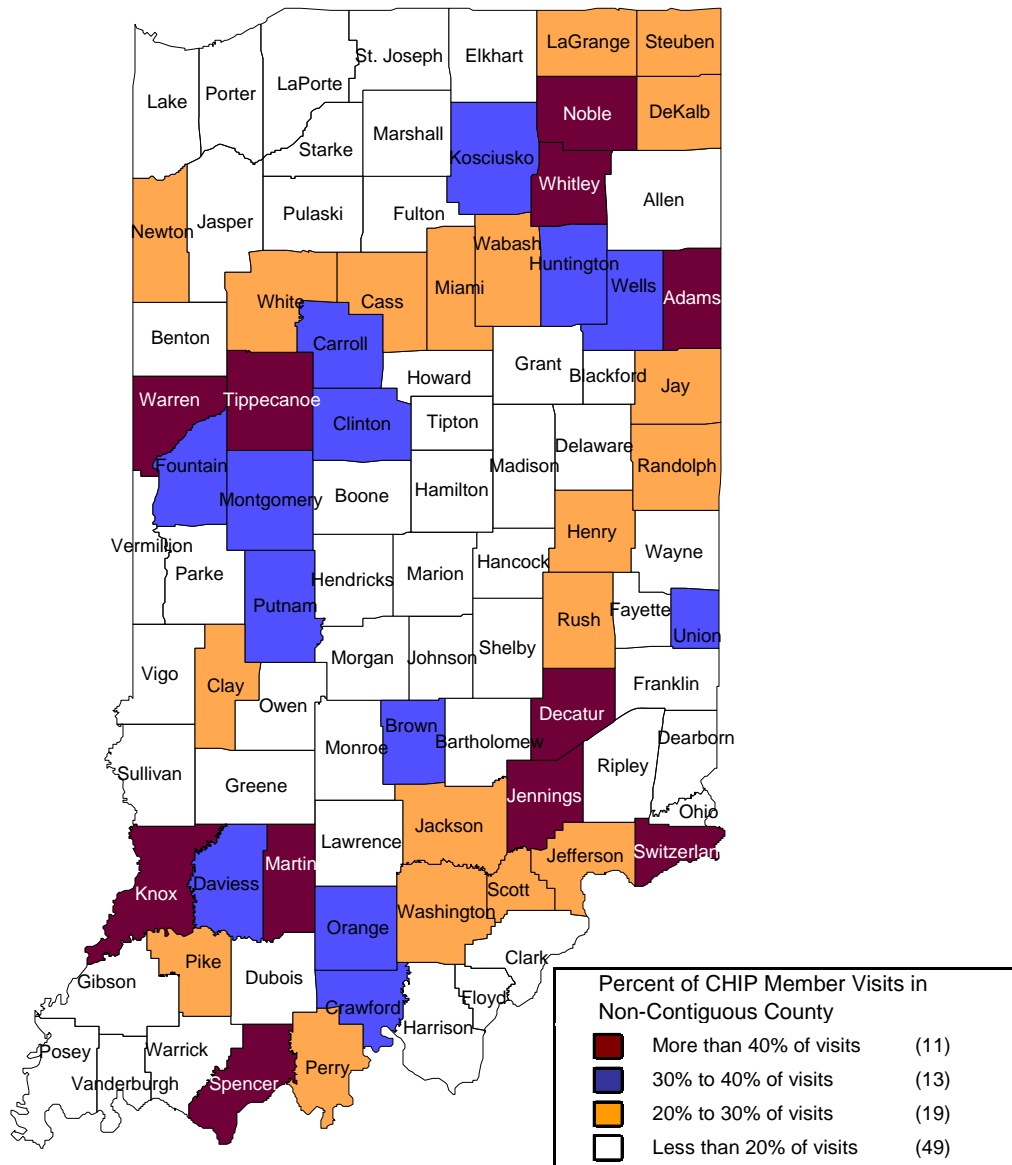
Another component of last year's EQR was that B&A used encounters submitted by the MCOs to examine member's actual visits to primary care physicians within their county of residence, in a contiguous county of their residence, or in a non-contiguous county. This analysis has been replicated here specifically for the CHIP population.

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B&A identified all children enrolled at least nine months in the CHIP in CY 2010 (n=82,179). We analyzed when a child received a primary care service in a doctor's office (48% of all children received this service across 119,277 encounters). Primary care utilization was then examined at the county level.

Statewide, 67 percent of CHIP members received a primary care service in the county in which they live in FFY 2010. An additional 21 percent receive a primary care service in a contiguous county. Like the panel capacity map shown in Exhibit III.2, 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.3
Volume of CHIP Members Receiving Primary Care Services
in a County Not Contiguous to their Residing County**



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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 eleven counties where more than 40 percent of CHIP members’ primary care visits were received in a county not contiguous to their home county: Adams, Decatur, Jennings, Knox, Martin, Noble, Spencer, Switzerland, Tippecanoe, Warren and Whitley (refer back to Exhibit III.3). Of these, only two counties are potentially at risk for full panels: Tippecanoe County has 84 percent of its panel full and Switzerland County has 97 percent of its panel full (refer back to Exhibit III.2).

When cross-referenced the other way, the 15 counties that had panel sizes more than 80 percent full had a wide variety of their CHIP members who received services in non-contiguous counties. This range was from a low of only three or four percent (Elkhart, Morgan and Shelby) to a high of 64 or 65 percent (Switzerland, Tippecanoe).

Six of the 15 counties with fuller panels also had more than 30 percent of their member’s primary care visits to counties not contiguous to their home. When reviewed at the MCO level, in some situations the high level of non-contiguous county provider use is limited to specific MCOs. The MCOs that may have specific access issues are shown in italics in Exhibit III.4 below.

**Exhibit III.4
Comparison of Counties with Fuller Pediatric Panels and whose CHIP Members Access Primary Care Visits to Non-Contiguous Counties at a Higher than Average Rate**

County	The Percent Full for the County's Pediatric Panel	Percent of Member's Primary Care Visits to Non-Contiguous Counties from Home Residence			
		All 3 MCOs Combined	Anthem only	MHS only	MDwise only
Brown	104%	38%	24%	<i>40%</i>	<i>41%</i>
Clinton	101%	39%	10%	<i>43%</i>	21%
Kosciusko	91%	33%	<i>70%</i>	<i>41%</i>	20%
Montgomery	97%	39%	18%	<i>49%</i>	<i>65%</i>
Switzerland	97%	65%	<i>80%</i>	22%	<i>98%</i>
Tippecanoe	84%	64%	<i>56%</i>	<i>67%</i>	<i>65%</i>

Source: Encounters stored in MedInsight, OMPP's data warehouse matched against the MedInsight CHIP enrollment files

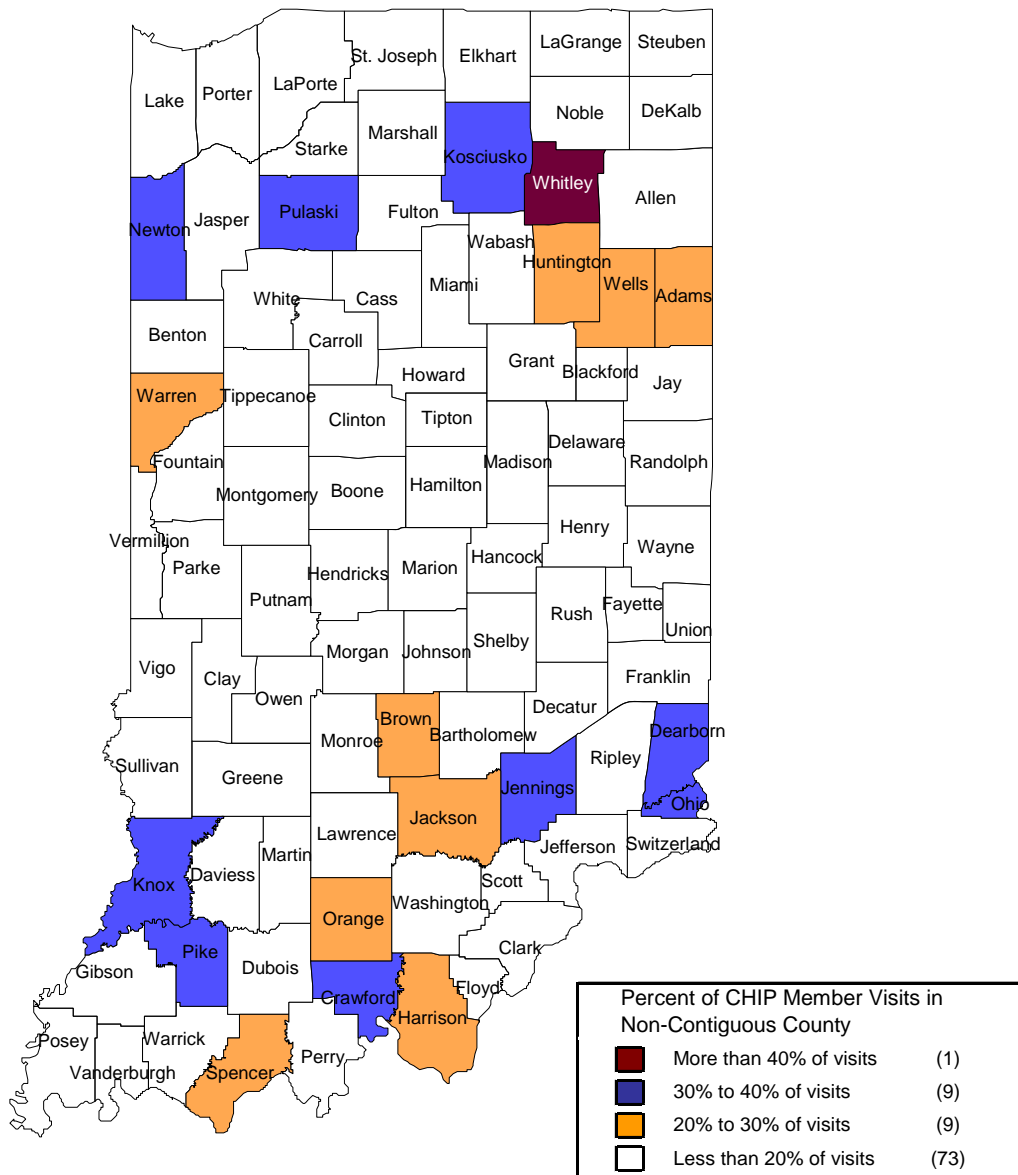
The data from Exhibits III.2 through III.4 suggests, therefore, that any direct relationship between panel size and access to primary care among CHIP members may be limited to just six counties and only to some of the MCOs in each county. The one county where both the panel size is fuller and where CHIP members access primary care in a non-contiguous county the majority of the time in all three MCOs in Tippecanoe County.

Access to Dentists

B&A conducted a similar analysis of where CHIP members access services for dental providers. Overall, it was found that 63 percent of CHIP members had a preventive dental visit in CY 2010. 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 75 percent of CHIP members had their preventive dental visit in their home county and an additional 19 percent had their visit in a contiguous county. Exhibit III.5 shows the 19 counties where the percentage of visits received in non-contiguous counties from the member's home county exceeded 20 percent. Only one (Whitley) is greater than 40 percent.

**Exhibit III.5
Volume of CHIP Members Received Preventive Dental Visits
in a County Not Contiguous to their Residing County**



IV

Service Use Patterns among Populations in Indiana's CHIP



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2010

In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also analyzed the percentage of CHIP members that had 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) 2009 and 2010 across populations within the CHIP by age, by MCO, by race/ethnicity and by region.

Data used in this analysis was retrieved by B&A from the Office of Medicaid Policy and Planning’s data warehouse in January 2011. The majority of the services examined are paid for by the MCOs 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 MCOs to submit encounters to the OMPP. That being said, the findings for FFY 2010 may still be incomplete if the MCOs have not submitted all of their encounter data to the OMPP yet.

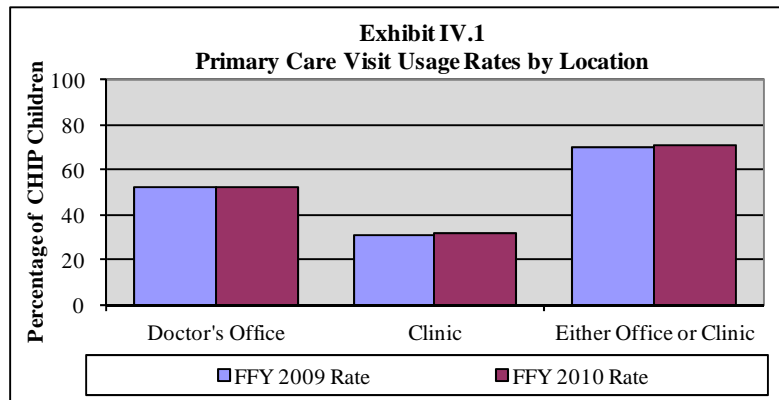
B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2009 or 2010. Since the *usage rate* measures the percentage of members that had actually used the service, we are allowing for a minimum of nine months enrollment in the year to identify only those members that would 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 CHIP Package A, CHIP Package C and/or Medicaid during the year, they were retained in the analysis as long as they met the nine month minimum and were enrolled in the CHIP at the end of the year. CHIP members included in the analysis were assigned to one MCO, one race/ethnicity group, one age group, and one region where they live in the state. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member’s age was assigned based upon their age at the end of each year.

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

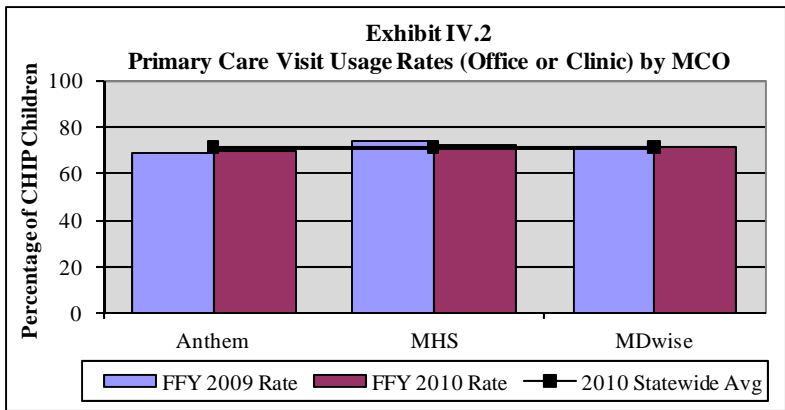
Primary care visits include visits to doctor’s offices or clinics specializing in primary care and include well-child visits and visits for specific ailments. Although children usually see their PMP for such visits, B&A did not limit our analysis to PMP visits exclusively.¹³

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 2009 and 71 had a visit in FFY 2010. There were 52 percent of CHIP children that had a visit in a doctor’s office and 32 percent had a visit in a clinic in 2010.



¹³ 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.

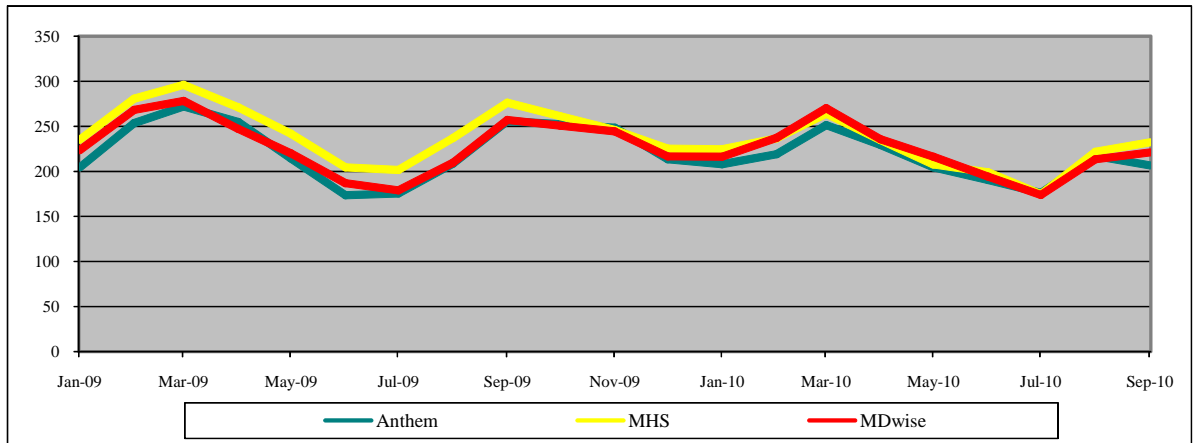
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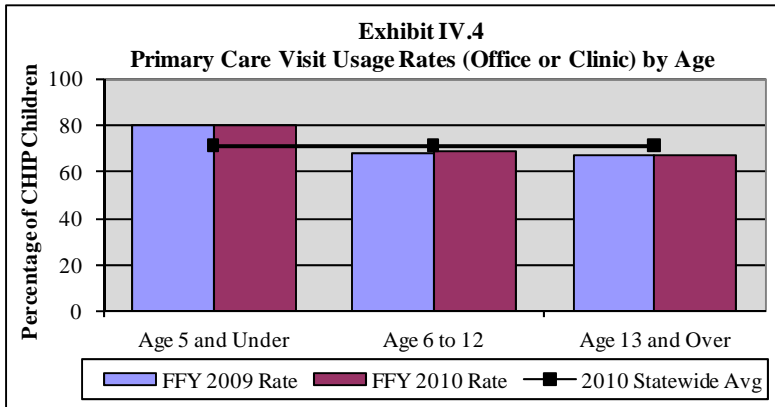
The percent of children that had a primary care visit (either office or clinic setting) was similar (70%-72%) across the MCOs in FFY 2010 and the rates changed only slightly from FFY 2009.

When utilization is measured on individual claims per 1,000 CHIP members, the results fluctuate a bit on a month to month basis, but the results within each month are very similar across the MCOs. For the period January 2009 to September 2010, the utilization rate per 1,000 CHIP members was in the range from a low of 175 visits per 1,000 members to a high of 296 visits per 1,000 members (refer to Exhibit IV.3 below). Said another way, in any given month in the study period, between 1.75 and 2.96 children out of 10 that were enrolled in the CHIP had a primary care visit each month.

Exhibit IV.3
Utilization Rate of Primary Care Visits (Office or Clinic) Per 1,000 CHIP Children
By MCO



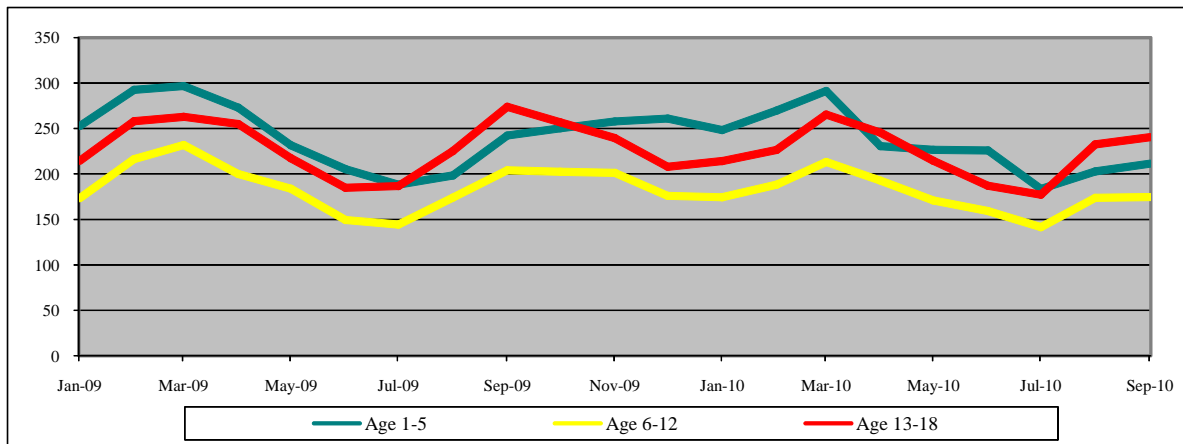
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Primary care visits were more prevalent among younger members, as 80 percent of children age five and younger had a visit in FFYs 2009 and 2010. The percentages of children in the older age groups that had a primary care visit were lower (69% for age 6-12 and 67% for age 13-18 in FFY 2010).

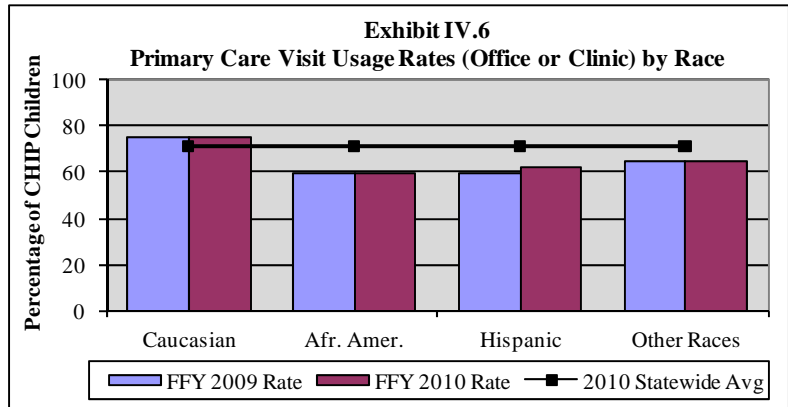
Although the primary care usage rate for children age 6 to 12 and age 13 to 18 in FFY 2010 was the same, the actual number of office visits per 1,000 members was higher among children in the age 13 to 18 group than in the age 6 to 12 group (refer to Exhibit IV.5 below). Children in the age 1 to 5 group had a primary care visit utilization rate similar to the age 13 to 18 group.

Exhibit IV.5
Utilization Rate of Primary Care Visits (Office or Clinic) Per 1,000 CHIP Children By Age Group



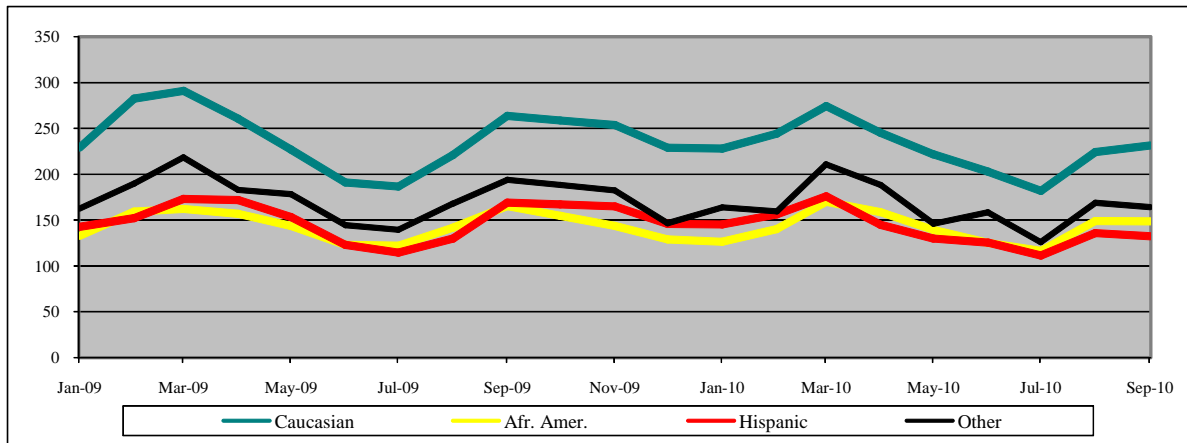
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The percent of children that had a primary care visit remained stable within each race/ethnicity examined between FFY 2009 and FFY 2010. When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. African American and Hispanic CHIP children had primary care visits at the same rate in each year (60% and 62% had a visit, respectively, in FFY 2010), significantly below the 75 percent rate for Caucasian children.



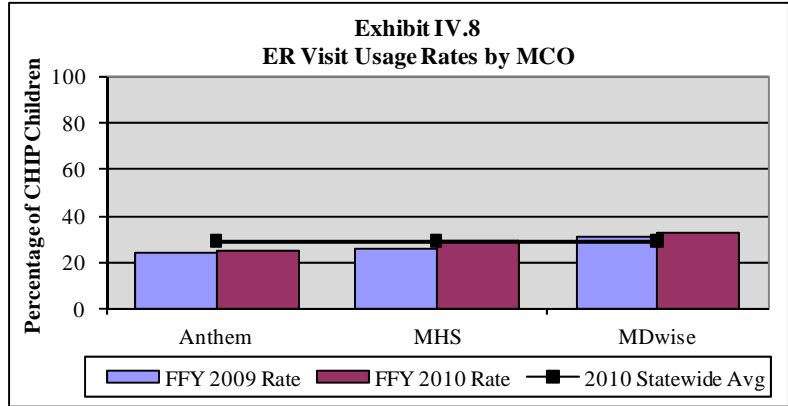
As seen above in the usage rate of actual children having a primary care visit, the utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the months studied, the median rate per 1,000 Caucasian children was 229, whereas the median rate was 144 among African American and Hispanic children (refer to Exhibit IV.7 below). The utilization rate for children in other race/ethnicities was slightly higher at a median rate of 168 visits per 1,000 CHIP children.

**Exhibit IV.7
Utilization Rate of Primary Care Visits (Office or Clinic) Per 1,000 CHIP Children
By Race/Ethnicity**



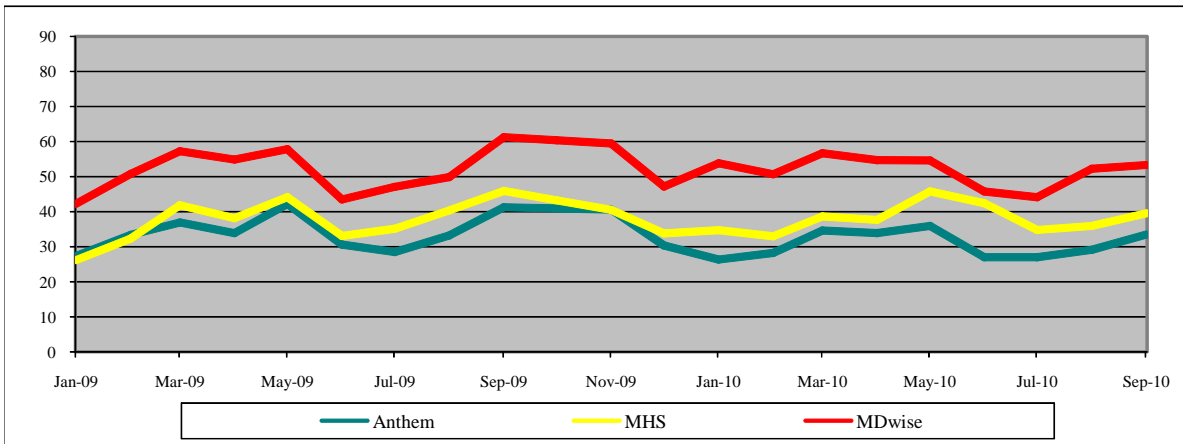
Emergency Room Visits

There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCO. In both FFY 2009 and FFY 2010, MDwise members were more likely to have had an ER visit (33% in 2010) than either Anthem (25%) or MHS (29%).

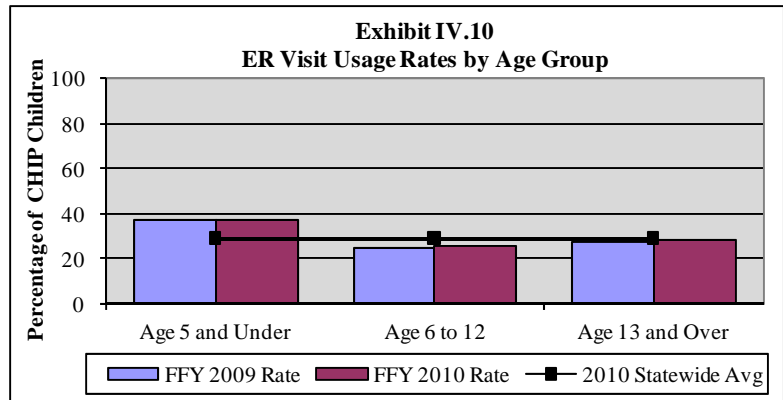


The difference between MCOs is even more pronounced when measured in emergency room visits per 1,000 CHIP members. In CY 2009 and 2010, the average rate among MDwise members was 52 ER visits per 1,000; for Anthem, it was 33 per 1,000; for MHS, it was 38 per 1,000 (refer to Exhibit IV.9 below).

**Exhibit IV.9
Utilization Rate of Emergency Room Visits Per 1,000 CHIP Children
By MCO**



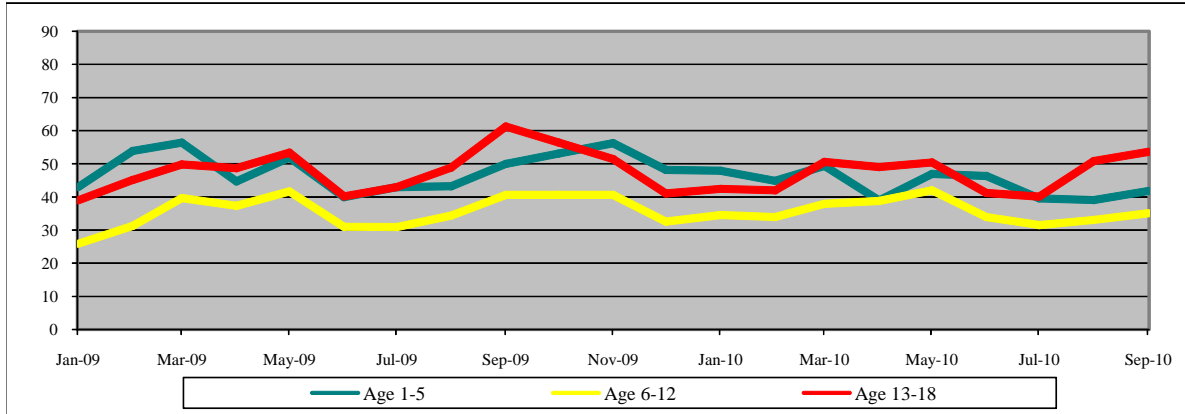
Differences in ER use are found by age group within the CHIP. The highest use is among children under age five (37% of all members in FFY 2010) and lowest among children age 6 to 12 (26% of all members in FFY 2010). Similar trends were found by age group in FFY 2009.



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Although the percentage of CHIP children that had an ER visit was highest among children age 1 to 5, the utilization rate for ER was just as high for children age 13 to 18 as the younger children (refer to Exhibit IV.11). The rate was 47 per 1,000 members on average for both groups in the months from January 2009 to September 2010. The rate was lower for children age 6 to 12 (36 visits per 1,000 on average).

**Exhibit IV.11
Utilization Rate of Emergency Room Visits Per 1,000 CHIP Children
By Age Group**

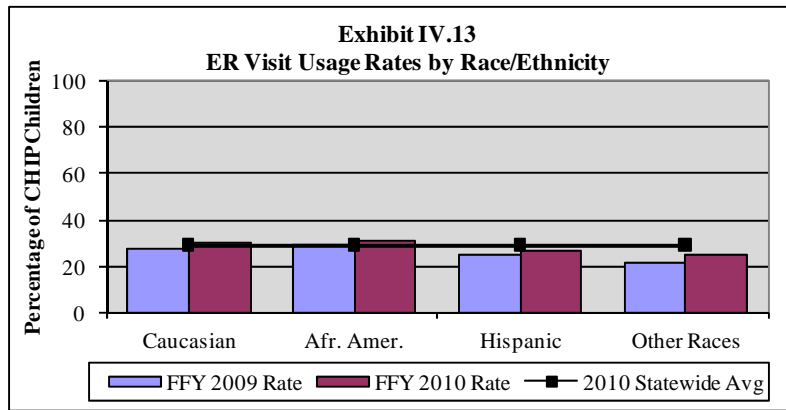


The reasons for ER visits also vary by age group. Among the youngest CHIP members, diagnoses related to diseases of the nervous system and sense organs (e.g., ear aches), diagnoses related to the respiratory system (e.g., asthma), injury and poisoning, and other symptoms (e.g., viral diseases and intestinal infections) are most common. All but the nervous system conditions are also common among children age 6-12 as well as mental disorders. Among teens, the most common reasons for an ER visit are injury and poisoning, mental disorders, and other symptoms (e.g., viral diseases and skin infections).

**Exhibit IV.12
Highest Volume Diagnoses of Children Presenting in the Emergency Room in Calendar Year 2010
By Age Group and by Program**

Diagnosis Category	Age 1-5		Age 6-12		Age 13-18	
	CHIP A	CHIP C	CHIP A	CHIP C	CHIP A	CHIP C
	Percentage of All Diagnoses in the Age Group					
Diseases of the Digestive System	2.9%	3.4%	2.8%	3.0%	2.8%	2.9%
Diseases of the Musculoskeletal System and Connective Tissue	1.4%	1.5%	3.0%	3.2%	5.0%	4.2%
Diseases of the Nervous System, Sense Organs	15.7%	15.1%	8.9%	8.3%	5.0%	4.9%
Diseases of the Respiratory System	21.4%	21.6%	12.9%	13.1%	10.1%	9.7%
Diseases of the Skin and Subcutaneous Tissue	5.2%	4.5%	5.1%	4.3%	5.0%	4.5%
Infectious and Parasitic Diseases	6.2%	5.3%	4.6%	4.6%	2.8%	2.6%
Injury and Poisoning	23.4%	24.5%	25.4%	30.5%	28.7%	32.8%
Mental Disorders	0.7%	1.2%	18.5%	11.3%	11.6%	11.5%
Symptoms, Signs, and Ill-Defined Conditions	17.9%	17.7%	13.9%	16.3%	15.3%	16.4%
All Other	5.1%	5.2%	4.7%	5.2%	13.7%	10.4%

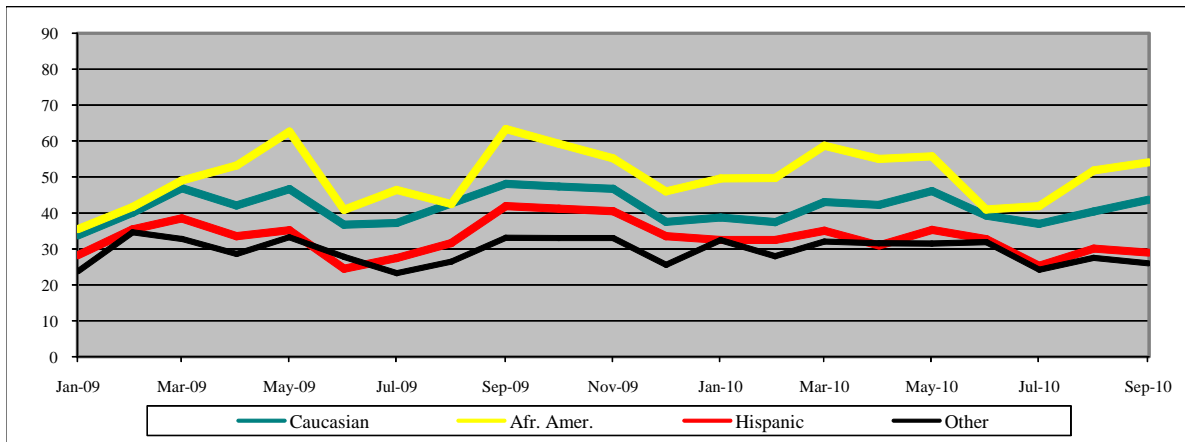
When compared across race/ethnicities, the use of ER visits is quite similar. Hispanic children have a slightly lower rate of ER usage in FFY 2010 (27%) than Caucasians and African-Americans (30%). Children of other races are the lowest (25%).



When reviewed at the regional level, the ER visit usage rate was highest for members in the three Central Regions of the state (33% of members in FFY 2010) and lowest among CHIP members in the North Central Region (22% of members in FFY 2010).

The percentage of children shown above that had used the ER in the calendar year was similar, but the rate at which the ER is used varies by race/ethnicity (refer to Exhibit IV.14 below). The average utilization rate of ER use per 1,000 members among African-American children is 50, whereas the rate among Caucasians is 42 in each month in 2009 and 2010. The rate is even lower for Hispanics (34) and children of other race/ethnicities (31).

Exhibit IV.14
Utilization Rate of Emergency Room Visits Per 1,000 CHIP Children
By Race/Ethnicity

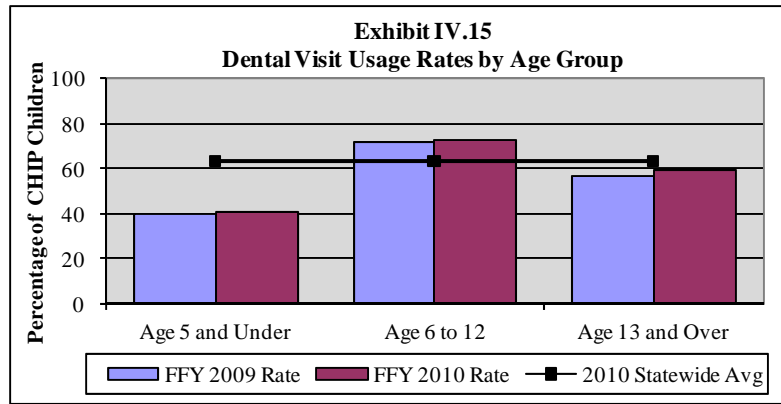


Preventive Dental Visits

The overall percentage of CHIP members receiving a preventive dental visit at some time in the year was 62 to 63 percent in both FFY 2009 and FFY 2010. This is an increase from 58 percent in FFY 2008. Dental care is one of the few services that the MCOs are not responsible for managing.

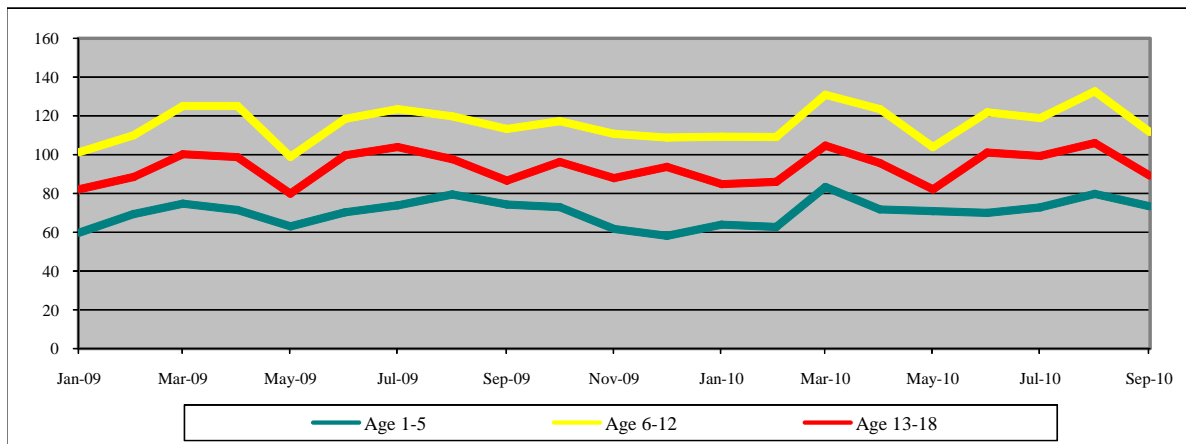
The usage rate of preventive dental visits varies some for CHIP children by region, from a low of 58 percent (Southeast Region) to a high of 68 percent in FFY 2010 (East Central Region). Contracting with dental providers has historically been challenging for CHIP and Medicaid programs nationally, but Indiana appears to have addressed dental access throughout the state as evidenced by the usage rates reported here.

Children age six to 12 are most likely to have received a preventive dental visit (73% of the members in FFY 2010), which is significantly higher than the teenagers (59%). The youngest children had the lowest usage rate (41%) given that this group includes toddlers. These rates of usage were steady between FFY 2009 and FFY 2010.



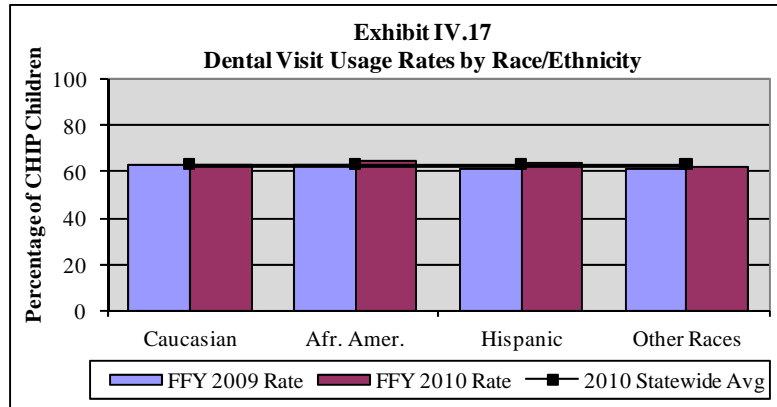
A similar pattern was found by age group when measuring the utilization rate of dental visits per 1,000 CHIP members. The rate of 116 visits per 1,000 members age 6 to 12 is 24 percent higher than the rate for children age 13 to 18 and 65 percent higher than the rate for children age 1 to 5.

**Exhibit IV.16
Utilization Rate of Preventive Dental Visits Per 1,000 CHIP Children
By Age Group**



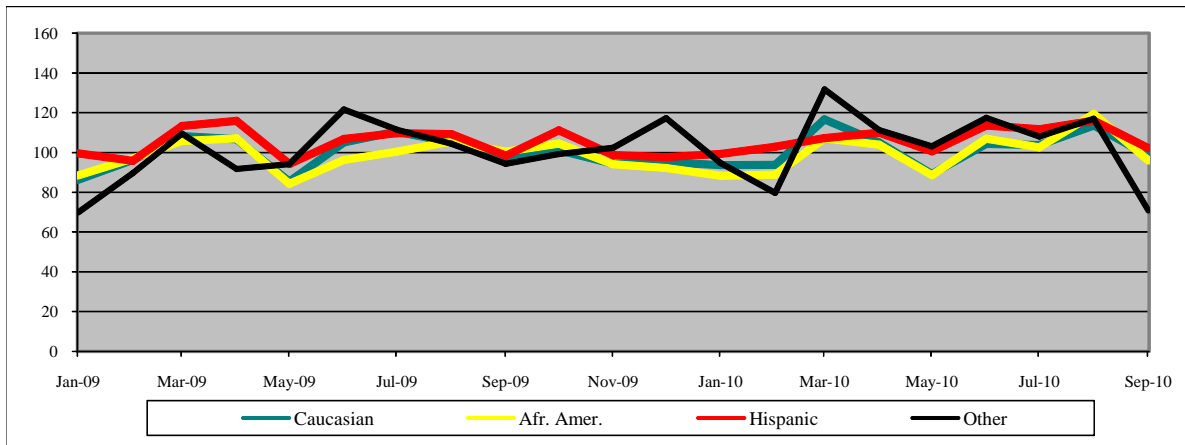
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The preventive dental usage rate remained steady at 63 percent for all race/ethnicities between FFYs 2009 and 2010, and there is little difference from the statewide average in the usage rate among the race/ethnicities.



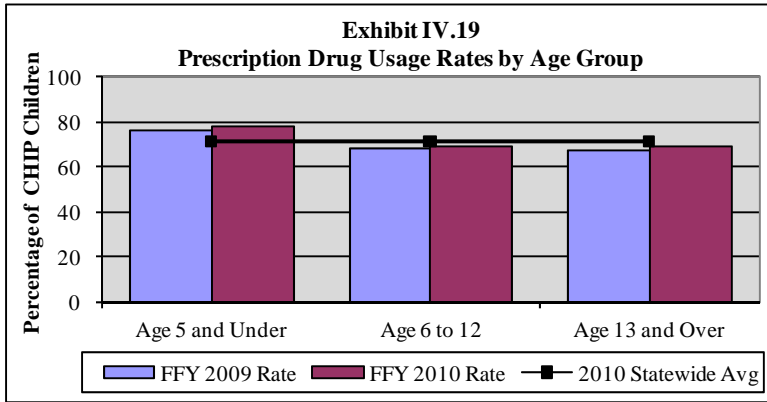
The utilization rate per 1,000 CHIP members is also the same among race/ethnicities at approximately 100 visits per 1,000 members each month studied in 2009 and 2010.

Exhibit IV.18
Utilization Rate of Preventive Dental Visits Per 1,000 CHIP Children
By Race/Ethnicity



Pharmacy Prescriptions

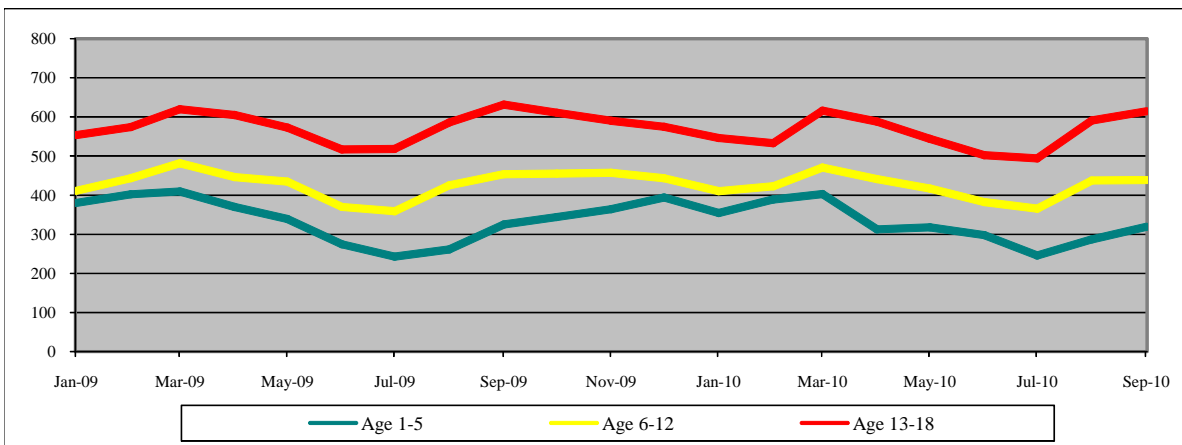
In CY 2010, the administration of the pharmacy benefit was taken back by the State and is no longer included in the capitation payment paid to the managed care organizations. Across all members enrolled at least nine months of the year, the percentage of members that had a prescription filled has remained relatively unchanged (71%) in the last two years.



There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children age five and younger in both FFY 2009 and 2010 (78% in 2010). Children in the older age groups were both 69 percent in FFY 2010.

The exhibit above showed that a lower percentage of teenagers obtained a prescription than children in younger age groups. But among those teenagers that did obtain a prescription, the number of prescriptions filled per child was higher for the teenagers than other age groups. This is evident in the utilization rate of prescriptions filled per 1,000 CHIP children in Exhibit IV.20 below. The utilization rate for children age 13 to 18 was 566 per 1,000 on average in each month of 2009 and 2010) examined, followed by children age 6 to 12 (426 per 1,000), then by children age 1 to 5 (334 per 1,000).

Exhibit IV.20
Utilization Rate of Prescriptions Filled Per 1,000 CHIP Children
By Age Group

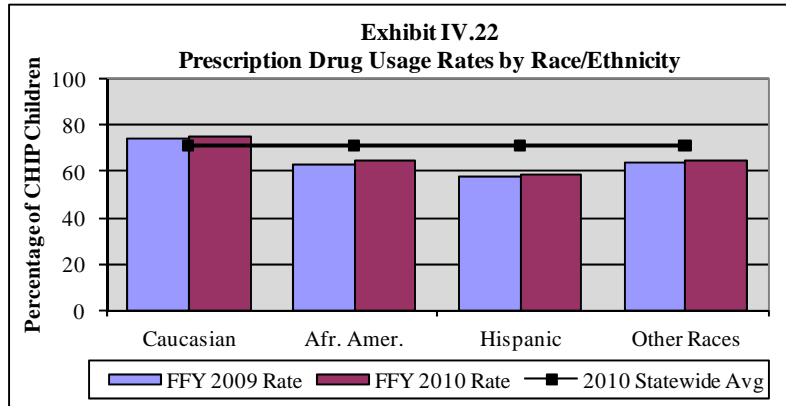


The type of prescriptions obtained by children in each age group also varies widely. For the youngest children in CHIP, 38 percent of prescriptions filled in CY 2010 were to treat infections. Among children age 6 to 12, half of the prescriptions were either for treating infections or for anxiety or seizure disorders. For teenagers in CHIP, half of the prescriptions were for the same treatments that were used for other children. (Refer to Exhibit IV.21 on the next page.)

Exhibit IV.21
Highest Volume Pharmacy Scripts in Calendar Year 2010
By Age Group and by Program

Therapeutic Class	Age 1-5		Age 6-12		Age 13-18	
	CHIP A	CHIP C	CHIP A	CHIP C	CHIP A	CHIP C
	Percentage of All Diagnoses in the Age Group					
Antiperspirants, Topical preparations, Skin and mucous membrane preparations	9.7%	8.9%	5.7%	4.7%	7.1%	7.1%
Antiprotozoals (treat infections)	33.9%	37.7%	15.8%	18.0%	14.8%	16.1%
Autonomic drugs	7.3%	7.4%	6.9%	6.4%	5.8%	4.8%
Benzodiazepine antagonists (anxiety disorder, panic disorder or seizures)	9.1%	7.2%	35.8%	35.8%	37.5%	37.4%
Electrolytic, caloric and water balance	9.9%	8.6%	8.7%	8.1%	6.6%	5.8%
Expectorants and cough preparations	6.8%	6.7%	5.6%	5.6%	3.0%	2.8%
Gastrointestinal drugs	3.8%	3.8%	3.3%	2.9%	3.7%	3.5%
Hormones	9.2%	9.5%	7.7%	8.5%	13.6%	15.2%
Ointments Solutions Suspensions, ophthalmic otic nasal or preparations	7.2%	8.0%	5.7%	5.8%	3.6%	3.5%
All Other	3.2%	2.2%	4.8%	4.3%	4.4%	3.8%

The percentage of children with a prescription increased slightly for each race/ethnicity group studied between FFY 2009 and FFY 2010. Comparing across race/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than minorities. In 2010, the usage rate among Caucasians was 75 percent but it was 65 percent for African American children and only 59 percent for Hispanic children. The rate was also lower for children of other race/ethnicities (65%). This has been a consistent finding in the CHIP for the last three years.

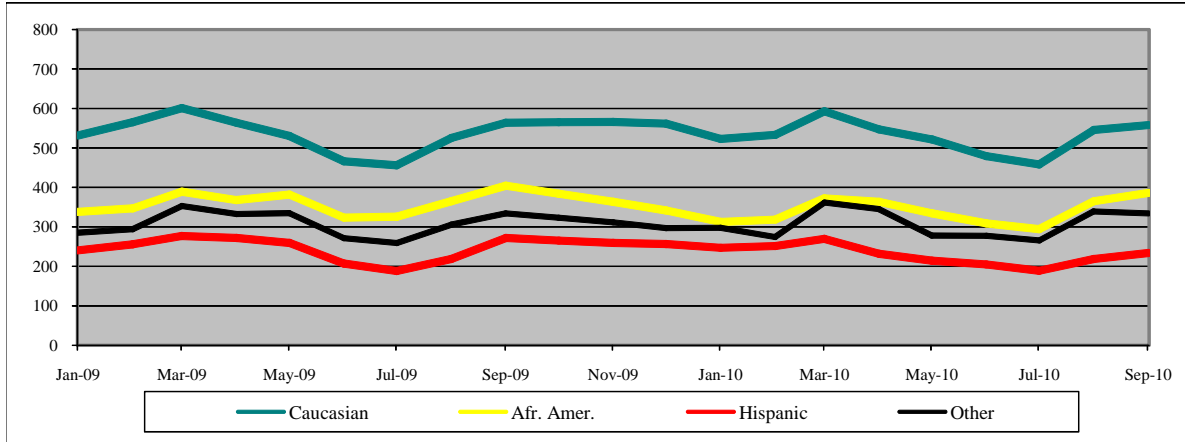


Across regions of the state, pharmacy usage among CHIP children in FFY 2010 varies from a low of 67 percent usage by children in the Central Region to a high of 77 percent usage by children in the Southeast and Southwest Regions (data not shown).

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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 on the prior page. Caucasian children have a utilization rate of 533 scripts per 1,000 members each month, which is 52 percent higher than the rate for African-American children (351 scripts per 1,000) and more than double the rate for Hispanic children (241 scripts per 1,000 children). It is 72 percent higher than the rate of children of other race/ethnicities (309 scripts per 1,000 children). Refer to Exhibit IV.23 below.

Exhibit IV.23
Utilization Rate of Prescriptions Filled Per 1,000 CHIP Children
By Race/Ethnicity



V

Measuring Quality and Outcomes in Indiana's CHIP



Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2010

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 since CHIP members are seamlessly integrated into Hoosier Healthwise. Since children represent approximately 81 percent of Hoosier Healthwise members, quality and outcomes related to children are given high priority.

There are three primary methods of oversight used. First, OMPP staff review data from reports submitted by the managed care organizations (MCOs) that are contracted under the Hoosier Healthwise program. Second, OMPP personnel conduct reviews at each of the MCO's site on a monthly basis to oversee contractual compliance. Finally, the OMPP hires an independent entity¹⁴ to conduct an annual external quality review of each MCO in accordance with federal regulation and reviews the results with each MCO.

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. The OMPP requires the three Hoosier Healthwise MCOs to report the results of HEDIS®¹⁵ and CAHPS®¹⁶ 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 MCOs 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 MCOs 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 the OMPP, has already been collecting the results on 15 of these measures (namely, the HEDIS measures) and voluntarily reported these in the annual report on the CHIP program required by CMS. Mandatory reporting for the other measures will begin in 2013.
3. When the 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.

In 2009, the OMPP required the Hoosier Healthwise MCOs to select three topic areas for which they would develop Performance Improvement Projects (PIPs). Some of the PIPs were related to children's care. As part of the external quality review, Burns & Associates (B&A) validated the data used in these PIPs and assessed the approach used by each MCO to work toward achieving improvement. The results are described later in this section.

¹⁴ Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.

¹⁵ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁶ The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

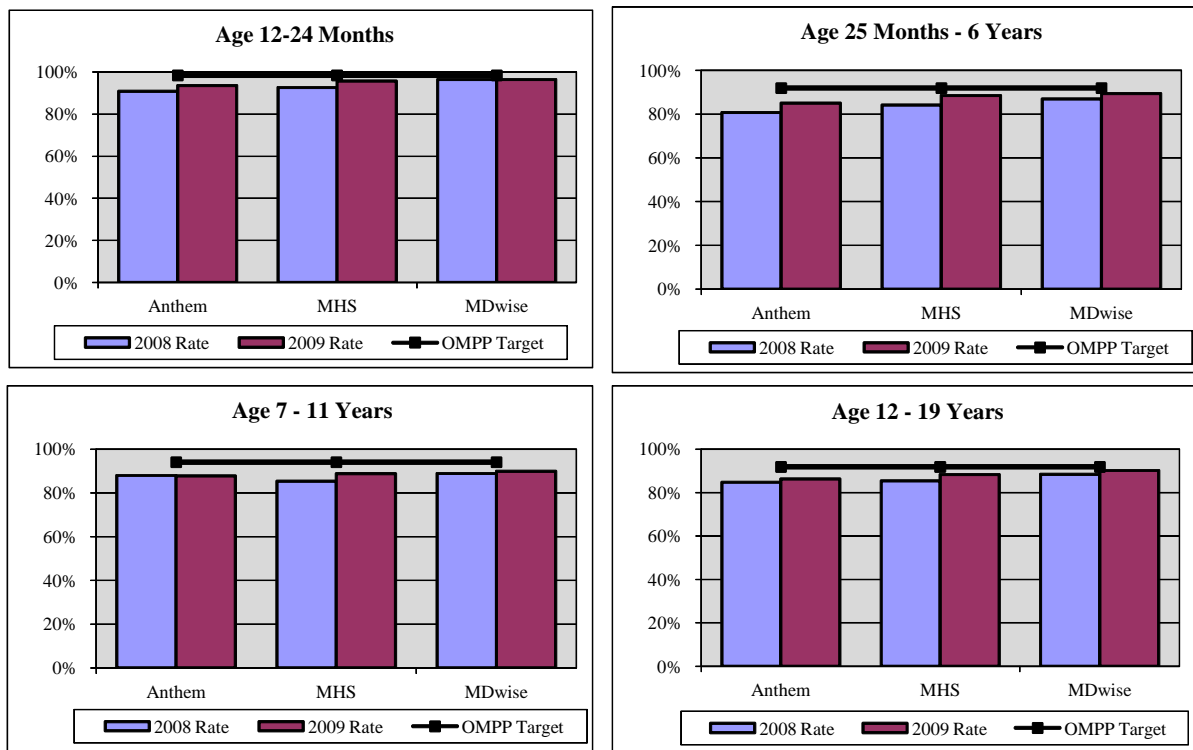
HEDIS and CAHPS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of Hoosier Healthwise members from the prior year. Therefore, in CY 2010, tabulations were collected on HEDIS rates for 2009 utilization. The HEDIS measures report the percentage of children who either accessed a specific service or, due to effective service use, achieved a desired outcome. The OMPP gave the MCOs targets to meet for all of the HEDIS measures collected that are specific to children’s care.

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

The exhibit shows the 2008 and 2009 rates reported for each MCO for four age groups. The OMPP has set a different target rate of the percentage of children who will have a primary care visit for each age group. However, in each case the target represents the rate at the 90th percentile among all Medicaid health plans nationally. Every MCO had a rate the same as or better in CY 2009 as compared to their CY 2008 rate in each age group. A similar trend was found among all age groups; namely, the OMPP target was not met by any MCO but was usually within five percentage points of the target. When reviewed by MCO, the pattern was the same for each age group—MDwise was closest to the OMPP target, followed by MHS, and then followed by Anthem.

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



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Exhibit V.2 shows the results for well care visits. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life, the rate shown represents the percentage of children with six or more well child visits. For children in the age 3-6 years and age 12-20 years groups, the rate shown represents children that had at least an annual visit. For the adolescents, a visit to an OB/GYN also counts as a well child visit.

As was found on the previous page, none of the MCOs met the OMPP target (the 75th percentile among all Medicaid health plans nationally) for the percentage of children with a well child visit in CY 2009, with the exception of MDwise for adolescent well care (see lower left box) where significant improvement was shown. For each age group, MDwise was closest to the target, followed by MHS, then followed by Anthem.

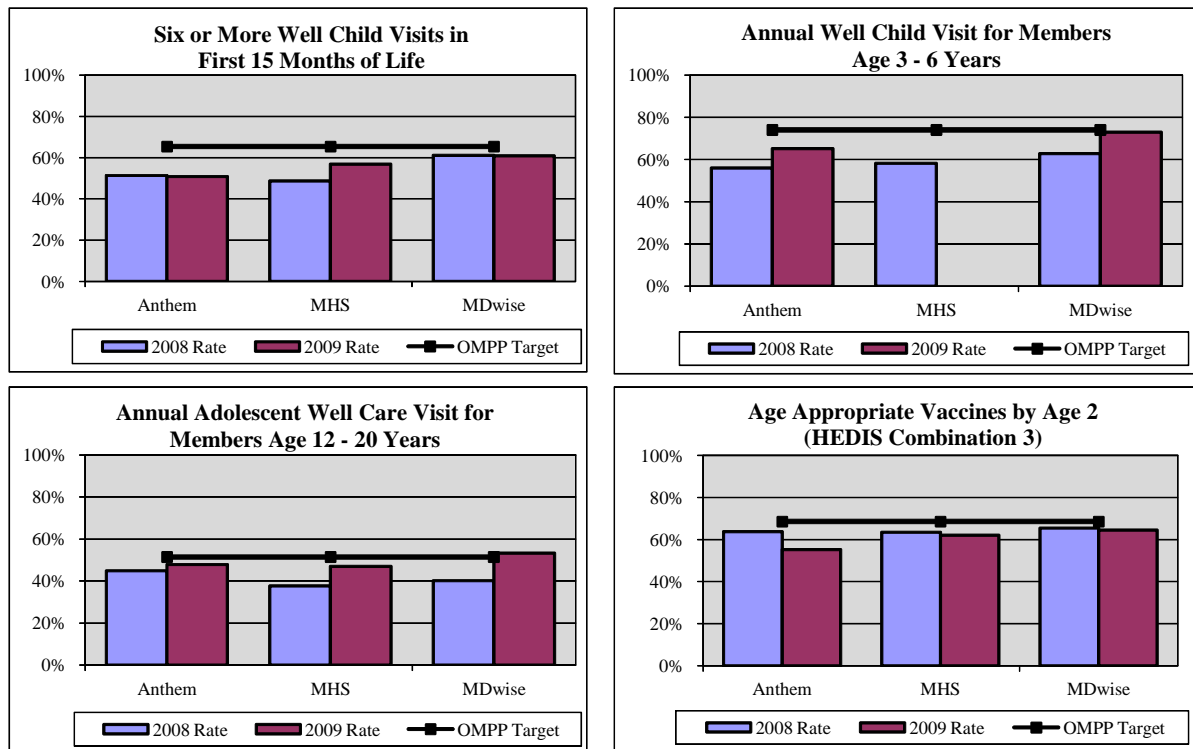
MHS saw significant improvement in the rate of well child visits in the first 15 months of life (see upper left box). Both Anthem and MDwise saw significant improvement in the rate for children age three to six years (see upper right box). The rate for MHS was not reportable on this measure.

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

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

Although MHS and MDwise had steady rates between 2008 and 2009, Anthem's rate declined significantly from 2008 to 2009 (see lower right box). MDwise's rate is closest to the OMPP target.

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



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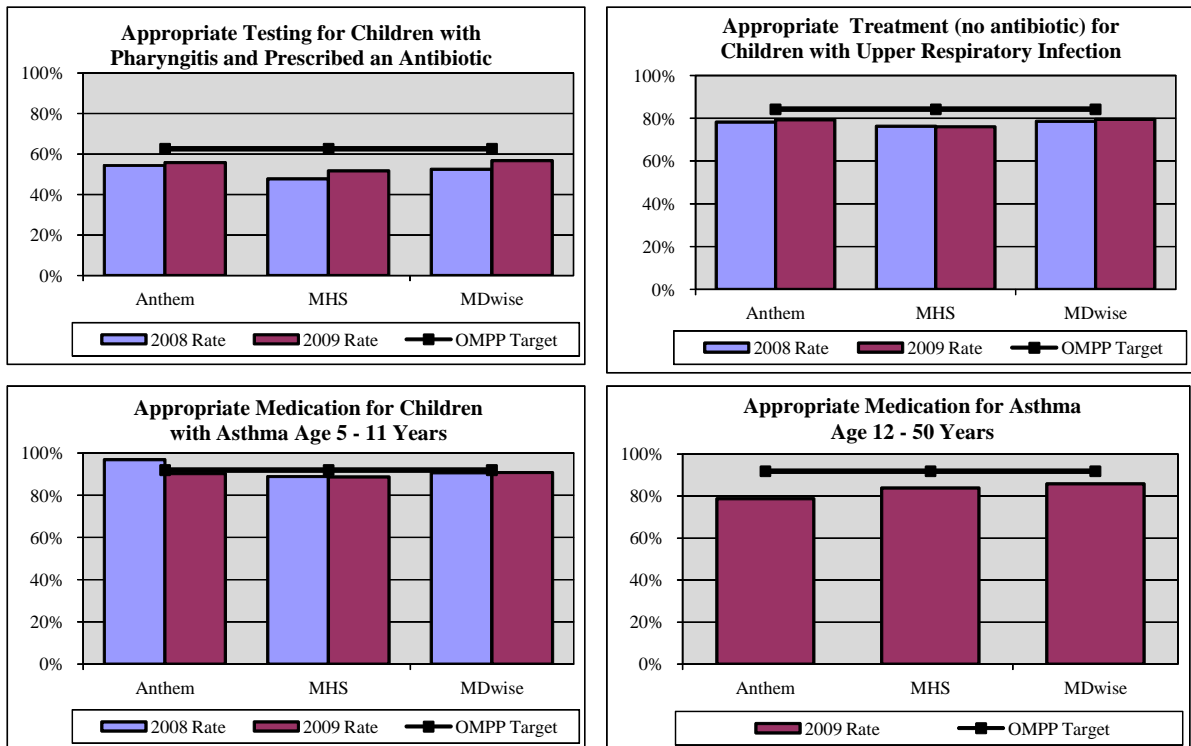
Exhibit V.3 presents the results from HEDIS measures related to respiratory care for children. The upper two boxes present results related to measuring proper treatment while the lower two boxes present results of appropriate medications for children with asthma.

For appropriate testing of children with pharyngitis (sore throat), Indiana’s MCOs all reported 2009 rates above the 2008 rates but still below the OMPP target of the national 50th percentile among all Medicaid health plans nationally (see upper left box). Anthem’s rate was slightly higher but MHS and MDwise had 2009 rates that were four percentage points above their 2008 rates. For this measure, a higher rating is more favorable since it indicates better testing.

The MCOs reported results for 2009 that were almost the same as their 2008 results for appropriate treatment for children with upper respiratory infection. This measure reports the percentage of children aged three months to 18 years who had an upper respiratory infection during the measurement year and were not given an antibiotic. A higher percentage is favorable because most upper respiratory infections are viral, not bacterial. Thus, administering an antibiotic is not appropriate in this case.

Indiana’s MCOs did better for the two age-specific measures related to appropriate medication for children with asthma. The rates from 2008 to 2009 cannot be compared precisely because the NCQA changed the age ranges. However, the OMPP’s target rate did not change between the two years. In the lower left box, the rate is measured for children age 5 to 11 (in CY 2008, the range was age 5 to 9). Both Anthem and MDwise are near the OMPP target of 91.9 percent. OMPP has set the same target for those ages 12 to 50¹⁷. All three MCOs are further from the OMPP goal for this age group than for the goal for young children.

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



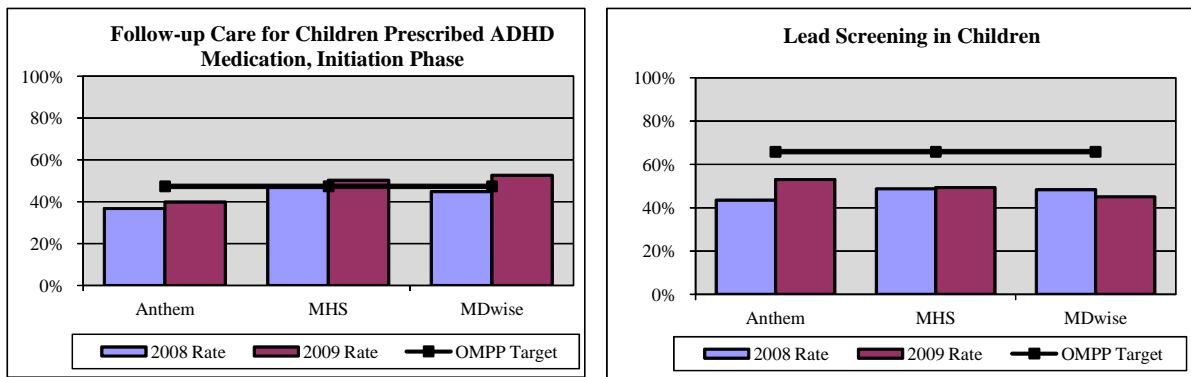
¹⁷ In 2008, there were two age groups—one for age 10-17 years, another for age 18-56 years. NCQA changes these to age 5-11 and 12-50 in 2009. Therefore, there is not a fair comparison between the 2008 and 2009 rates.

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Exhibit V.4 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. Both MHS and MDwise exceeded this target. Anthem is below the target but, like all three MCOs, saw improvement in their rate between 2008 and 2009.

The other measure shown is for the percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. This is an area identified by the OMPP that needs improvement in Hoosier Healthwise. The OMPP has set a target of the 50th percentile among Medicaid health plans nationally. Anthem saw significant improvement between their 2008 and 2009 rates, most likely because this was one of their performance improvement projects. The rate for MHS remained the same across the two years, whereas the rate for MDwise declined between 2008 and 2009.

Exhibit V.4
Summary of Results from Selected Other HEDIS Measures (Percentage of Total)



CAHPS Survey

The Hoosier Healthwise MCOs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCOs to the OMPP. Exhibit V.5 on the next page summarizes the results from the surveys that were administered in early 2010 and compares the results on key questions to the results from the 2009 survey. The results can also be compared to the 2009 CAHPS benchmark, which represents approximately 47 Medicaid health plans that submitted data in 2009.

The percentages in the first set of results in the exhibit reflect those members that gave a rating of 8, 9 or 10 for each rating, where zero is “worst possible” and 10 is “best possible”. All three MCOs received a score in 2010 that was better than the CAHPS benchmark for Rating of Health Plan. However, both Anthem’s and MHS’s ratings worsened from the 2009 to the 2010 survey and MDwise’s held steady. MDwise also exceeded the CAHPS Benchmark score for Rating of Personal Doctor and Rating of Specialist.

The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The second set of results in the exhibit represent four composite scores that show the percentage of respondents that answered “Usually” or “Always” to the series of questions on the topic. For the domain Getting Needed Care, all three MCOs exceeded the CAHPS Benchmark score of 79.4 percent. Similarly, all three MCOs reported results that were better than the national average

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for Getting Care Quickly, and these results were very consistent across the MCOs. MDwise also exceeded the CAHPS Benchmark for How Well Doctors Communicate and MHS was very close to it. MDwise also had a score close to the CAHPS Benchmark for Customer Service.

Exhibit V.5
Summary of Scores from CAHPS 2009 and 2010 Child Survey

Bold items indicate results exceed the CAHPS 2009 Benchmark.

	Anthem		MHS		MDwise		CAHPS 2009 Benchmark
	2009	2010	2009	2010	2009	2010	
Members giving a rating of 8, 9 or 10 on a 10-point scale.							
Rating of Health Care	82.2%	77.7%	82.2%	77.9%	83.2%	78.9%	79.4%
Rating of Personal Doctor	82.6%	81.0%	85.9%	80.3%	84.6%	85.4%	84.2%
Rating of Specialist	89.2%	***	73.4%	***	84.3%	84.1%	82.5%
Rating of Health Plan	86.3%	83.1%	81.4%	80.7%	84.3%	84.8%	80.6%
Percentages reflect responses of "Usually" or "Always"							
Getting Needed Care	85.6%	85.2%	85.8%	81.5%	84.6%	83.5%	79.4%
Getting Care Quickly	88.1%	89.0%	89.6%	89.6%	91.2%	89.0%	86.3%
How Well Doctors Communicate	89.3%	88.8%	91.1%	90.4%	92.5%	93.5%	90.9%
Customer Service	86.7%	***	82.5%	***	73.4%	80.7%	81.3%

*** Indicates that the number of respondents to the question were too low (< 100) to be able to extrapolate the rating to the entire population with confidence.

OMPP's Strategic Objectives and Performance Goals for the CHIP

As part of the authority to gain federal participation in Indiana's CHIP, the OMPP set goals for the program and for insurance coverage for children as a whole. Three of these goals were discussed above (childhood immunization rates, well child and adolescent care visit rates and follow-up care for children prescribed ADHD medication). The status of the other four performance goals is described below.

Goal #1: Maintain the state's uninsured rate for the population at or below 200 percent of the Federal Poverty Level (FPL) below the 25th percentile of states nationally.

Using data tabulated by the US Census Bureau's Current Population Survey, Indiana's uninsured rate of 9.7 percent over the three-year average of 2007-2009 was below the 25th percentile (11.0%) among all states for the same time period. Indiana has been able to meet this goal in each of the last three years.

Goal #2: By September 30, 2012 increase by 10,000 the number of children in families between 200 and 250 percent of the FPL in the CHIP program.

The OMPP had set a goal of an increase of 10,000 children in the CHIP when CMS granted the State authority to expand eligibility in October 2008. As of December 2010, there were 6,199 children in this income category enrolled in the CHIP program.

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Goal #3: Reduce the churn rate by five percent annually among Medicaid children.

“Churn” is defined as cycling on and off the rolls, or having a lapse in coverage when the child had been previously enrolled. In each month of State Fiscal Years (SFY) 2009 and 2010, the number of Medicaid children that had a lapse in coverage but had been enrolled at some point in the 12 months prior to the lapse in coverage were identified. Then, an average for SFY 2009 and an average for SFY 2010 (each weighted by monthly enrollment) of the percent that lapsed was calculated. Then, the percentage change from the SFY 2009 figure to the SFY 2010 figure was calculated.

The results showed a lapse rate of 0.96% in SFY 2009 and a lapse rate of 0.77% in SFY 2010. Therefore, the change from year to year was a reduction of 19 percent, far greater than the performance goal.

Goal #4: By Federal Fiscal Year (FFY) 2012, meet or exceed an overall EPSDT screening ratio of 85 percent.

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

CMS requires screening ratios to be calculated for specific age groups and separately for the Medicaid/CHIP Package A program and the CHIP Package C program. The screening rate for CHIP Package C in FFY 2009 was 85.8 percent; for Medicaid/CHIP Package A, it was 76.6 percent. Therefore, the goal has been met for CHIP Package C but not for the Hoosier Healthwise program as a whole. The OMPP has reviewed the American Academy of Pediatrics' (AAP) periodicity schedule for screenings and is in the process of bringing the rule (405 IAC 15) up to date to incorporate the latest AAP schedule as well as informing providers of this change. Additionally, the OMPP has undertaken an extensive review of how EPSDT data is collected and reported to CMS to ensure that it is as accurate as possible.

MCO Performance Improvement Projects

The validation of performance improvement projects (PIPs) is one of the mandatory activities specified in the CMS protocol for conducting external quality reviews (EQR) of Medicaid managed care plans.

For the EQR conducted last year, B&A validated three PIPs from each Hoosier Healthwise MCO. A review tool was used that focuses on the validity of the data reported rather than a critique of actual performance improvement. Another part of the review is to study the steps that the MCOs took to try to achieve real improvement.

In late 2008, the OMPP requested that the MCOs select one topic from each of three groups—behavioral health, preventive health, and other disease/condition-specific care. Some topics were child-specific, some were adult-specific, and some covered both populations. The results of one study from each MCO that involved children are discussed on the next page.

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Anthem's PIP on Lead Screening

Anthem developed this PIP in light of the fact that their HEDIS rate was significantly below the OMPP's target and below the HEDIS 25th percentile benchmark. To tabulate a rate, Anthem obtained data both from claims data and from the review of medical records, a common practice when tabulating HEDIS rates.

For their PIP, Anthem set a benchmark of 49.3 percent, which is the HEDIS 25th percentile rate. Their baseline rate (measured in the HEDIS 2008 year) was 41.2 percent; in HEDIS 2009, it grew to 43.5 percent; in HEDIS 2010, it grew to 53.0 percent which was a statistically significant improvement over HEDIS 2009. Based upon their improvement, Anthem has increased their benchmark to the HEDIS 50th percentile (70.2%) beginning in HEDIS 2011 year.

Anthem attributed their improvement to the following interventions they conducted:

1. *Introduction of MEDTOX services.* Anthem entered into a relationship with MEDTOX, a laboratory service. Intensive training and informational materials were distributed to the provider community to increase awareness of the proper testing and coding for lead screenings (as well as other required testing).
2. *Member Reminders.* Lead screening reminder calls are part of monthly automated immunization calls made to children ages 3, 6, 9, 12, 15 and 18 months of age and one month before their birthday.

MHS's PIP on Timely Prenatal and Postpartum Care

Timely prenatal visits during pregnancy and postpartum visits after delivery lead to better outcomes for members. MHS's percentage of timely prenatal visits and rate of postpartum care have historically been below the HEDIS 75th percentile. MHS used the standard HEDIS definitions of timely prenatal and postpartum visits when they compared their results after the PIP was implemented against the baseline period.

For both measures, MHS used the HEDIS 75th percentile as the benchmark (88.6% for timely prenatal and 65.7% for postpartum visit). The baseline rate for timely prenatal care was 87.5 percent in HEDIS 2007. The rate in the subsequent three HEDIS years was 89.8 percent, 92.7 percent and 90.8 percent, respectively. This was not a statistically significant increase. The baseline rate for postpartum visits was 63.5 percent in HEDIS 2007. The rate in the subsequent three HEDIS years was 66.4 percent, 70.1 percent and 72.7 percent, a statistically significant improvement from the baseline period.

The initial re-measures have exceeded the goal of the HEDIS 75th percentile and have been increased to the HEDIS 90th percentile for both measures beginning in the HEDIS year.

MHS indicated eight specific interventions they utilized to obtain improvement in these measures. They indicated that they found most success in the following:

1. *Start Smart for Your Baby.* MHS implemented a program to identify pregnant members as early as possible in pregnancy. This has enabled them to assist members with access to prenatal medical care, education and coordination of referrals. The program extends throughout the first 15 months of the child's life, offering ongoing education and reminders related to the importance of regular well-child appointments and immunizations.

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2. *CONNECTION PLUS*. MHS implemented a phone program that issues limited-use cellular phones to members who are identified by an OB case manager or provider as high-risk without dependable access to a phone. The cell phone allows outgoing calls to pre-programmed numbers such as to the member's medical provider; case manager, 24 hour nurse line, and 911.

MDwise's PIP on Adolescent Well Care Visits

Thirty-eight percent of MDwise's Hoosier Healthwise members are between 12 and 21 years old. MDwise chose this measure since their results on this HEDIS measure have been below the HEDIS 25th percentile. MDwise included two different HEDIS measures in this PIP—one for Adolescent Well Care and the other for Children's Access to Primary Care, Age 12-19.

For both measures, MDwise used the HEDIS 90th percentile as the benchmark (56.7% for adolescent well care and 91.9% for access to primary care age 12-19). The baseline rate for adolescent well care was 36.2 percent in HEDIS 2009. The rate in the HEDIS 2010 was 48.6 percent. Although statistical tests were not run, this appears to be a statistically significant increase. The baseline rate for access to primary care age 12-19 was 88.3 percent in HEDIS 2009. The rate in HEDIS 2010 was 90.3 percent, a moderate increase though not tested for statistical significance.

MDwise indicated six specific interventions they utilized to obtain improvement in these measures, but cited two that they found most successful:

1. *Network Improvement Program*. MDwise implemented a team that completed visits with all of its delivery systems and large provider offices. The team produced monthly reports, including non-compliant patient listings and missed opportunities. These reports fill an information gap that allows the providers to know what members to target for outreach.
2. *Member Incentive*. MDwise implemented a \$20 member incentive for members listed as non-compliant for a well-child visit for 2009. Letters were mailed to members outlining the incentive program in conjunction with the providers receiving their non-compliant patient lists.

Conclusion

The MCOs each developed PIPs that were appropriate to the populations that they serve and were meaningful in working to improve outcomes in areas where unmet need was identified. The MCOs did not always see "real" (i.e., statistically significant) improvement in every PIP, but this was the first year that the PIPs were in place at the MCOs. Many of the interventions developed to promote improvement proved to be very successful and will continue, while others were not too successful and have been terminated. For other interventions, it is still too soon to tell the full impact.

B&A had confidence in the data that was collected and reported, especially since many of the data sources were already validated by a certified HEDIS auditor.