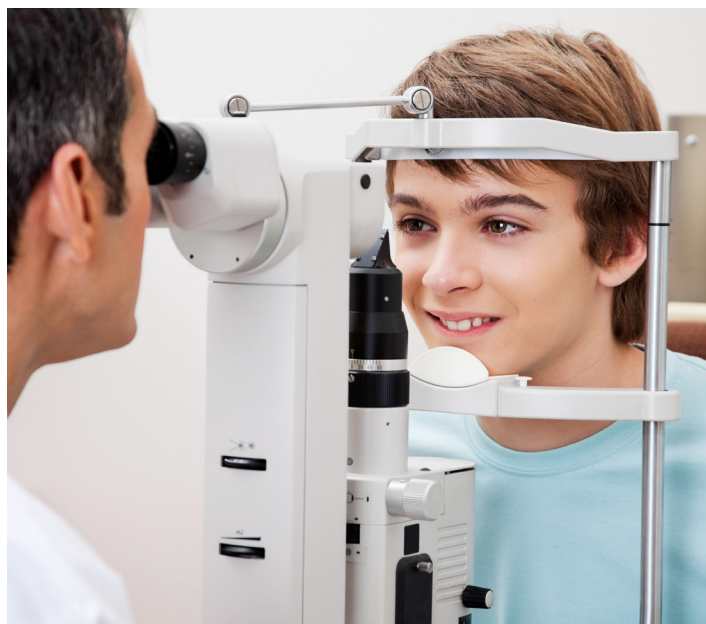


Independent Evaluation of Indiana's Children's Health Insurance Program

Final Report – April 2017



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Executive Summary



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

Indiana’s Children’s Health Insurance Program (CHIP) experienced an increase in enrollment in Calendar Year (CY) 2016 with year-end enrollment at 98,971 members, a 12.6 percent increase from CY 2015’s year-end enrollment of 87,921. After a dip in enrollment in CY 2012 and CY 2013, enrollment has grown steadily. Over the last three years, enrollment has increased 28.7 percent.

In CY 2016, enrollment grew in all three segments of CHIP:

- MCHIP (CHIP Package A) grew 8.4 percent to 69,446 children in December 2016
- SCHIP (CHIP C original) grew 22.1 percent to 20,077 children in December 2016
- SCHIP (CHIP C expansion) grew 27.1 percent to 9,448 children in December 2016

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

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

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

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

Growth in Indiana’s CHIP over the last 15 years enabled the State to lower its uninsured rate among children in low-income families rapidly, although other states have recently improved their trend in reducing uninsured rates among children as well. Citing the most recent year’s Census Bureau statistics, Indiana’s uninsured rate among children in families below 250 percent of the Federal Poverty Level (FPL) is now 7.6 percent compared to the national average of 8.5 percent¹. For children at all income levels, Indiana’s uninsured rate is 6.7 percent compared to the national average rate of 6.4 percent.

There are fluctuations in the program’s enrollment over time and this varies for each of the three groups within CHIP. For children that were new to the program during Federal Fiscal Year (FFY) 2015, 89 percent of those in MCHIP (Package A) re-enrolled after the first 12 months. In SCHIP, 64 percent in the CHIP C original portion re-enrolled while 57 percent of the children in the CHIP C Expansion portion re-enrolled. As a result of this turnover along with overall growth in enrollment, in CY 2016 there were 171,634 Hoosier children enrolled in CHIP at some point during the year. This compares to 153,575 in CY 2015.

Enrollment in CHIP is spread evenly throughout the state, but there is a higher distribution of minorities in Indiana’s CHIP than the overall population of children ages 18 and younger. Half of the children enrolled in the CHIP are between the ages of 6 and 12. Enrollment by age is uneven because children under age 6 are eligible for Medicaid at higher family income levels. One-third of CHIP enrollees are teenagers, while the remaining 15 percent are under age 5. This distribution has been the case since the CHIP was introduced.

¹ Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

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

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

- (1) Budget committee;*
- (2) Legislative council;*
- (3) Children’s health policy board established by IC 4-23-27-2; and*
- (4) Health finance commission established by IC 2-5-23-3.*

A report provided under this section to the legislative council must be in an electronic format under 5-14-6.

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for CY 2016. B&A has conducted this annual study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana’s CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

Background on Indiana’s CHIP

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

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

Premiums Charged to Families in Indiana's CHIP Package C

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

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

Potential Changes to CHIP at the Federal Level

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 percentage (FMAP) is higher than Medicaid.

Starting in FFY 2016 and running through FFY 2019, the ACA increased each state’s enhanced FMAP rate by 23 percentage points. This is in place for state CHIP programs, but not the traditional Medicaid programs. Indiana’s enhanced FMAP would have been 76.62 in FFY 2016, but with the additional

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increase the enhanced FMAP is 99.62. In other words, the state share for \$100 dollars spent on the CHIP program today is now \$0.38.

At the time of publication of this report, it is unknown if Congress will extend CHIP funding past FFY 2017. So, although there is a significant federal contribution to the program due to today's enhanced FMAP, this may become moot if overall funding is ended effective September 30, 2017. Current federal legislation gives states the ability to use any unspent CHIP allotments for two years after September 30, 2017 or until funds run out. Even if Congress allows the CHIP funding to expire, the State is required to continue the MCHIP portion of the program through FFY 2019 due to what is called a maintenance of effort as required by the Affordable Care Act. Although the State must continue MCHIP, once the CHIP funds run out, the federal matching rate for MCHIP will be at the standard matching rate, not the enhanced SCHIP matching rate.

Member Satisfaction

The OMPP requires the Hoosier Healthwise MCEs to conduct a survey of parents of children in the program each year. The survey includes a sample of both CHIP and Medicaid children. The mail survey is a standardized tool used by Medicaid health plans nationally and results are reported to a national organization to benchmark plans against each other. In this past year's survey, all three Hoosier Healthwise MCEs maintained high scores with all MCE's scoring 85 percent or higher in each major category, for example:

- The three MCEs scored 87 or 88 on Rating of Health Care and Rating of Personal Doctor
- The scores for Rating of Health Plan were 87 percent for MDwise, 88 percent for MHS and 89 percent for Anthem
- Near 90 percent of respondents stated that they "usually" or "always" received good customer service from the MCEs
- Over 90 percent of respondents stated that they "usually" or "always" received care quickly

Access to Services

B&A reviewed access by examining where CHIP members receive primary care services and preventive dental services and how often. We matched claims of actual services received in FFY 2016 between where the member lives and where the attending provider is located.

In all but three counties, CHIP members chose from at least 30 different primary medical providers (PMPs) to seek primary care. In all but eight counties, CHIP members received care from at least 20 different dentists.

The average utilization per 1,000 member months for primary care was 182 in FFY 2016. In other words, approximately 18 percent of CHIP members had a primary care visit each month (some members could be counted with more than one visit). There is no county where the utilization for primary care was less than 100 in FFY 2016. For dental services, the average utilization per 1,000 member months was 104 in FFY 2016. There is no county where the utilization per 1,000 member months was less than 50

Statewide, the average distance that CHIP members travel to seek primary care is 21.1 miles, which is below the 30 mile threshold set by the OMPP. For primary care, there were 32 counties where the average distance travelled was greater than 30 miles. In 25 of the 32 counties, the distance was 30-35 miles.

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Statewide, the average distance that CHIP members travel to seek dental care is 14.1 miles. For dental care, there were 16 counties where the average distance travelled was greater than 30 miles. In 12 of the 16 counties, the distance was 30-35 miles.

Outcomes

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

- For access to primary care practitioners, all three MCEs reported that 95 to 96 percent of its members age 12 to 24 months have access; for children age 25 months to six years, 87 to 88 percent; for children age 7 to 11, 90 to 91; for children age 12 to 19 years, all three MCEs reported 91 percent.
- For well child visits received, children in the first 15 months of life are measured to determine the percentage who received six or more visits. All three MCEs have seen improvement in this measure in the last five years, with results between 67 and 77 percent in the most recent year.
- There has also been improvement in the rate measuring the percentage with an annual well care visit for children ages 3 to 6 (Anthem and MHS at 73 percent, but MDwise at 85 percent) and adolescents (Anthem and MHS reported near 60 percent while MDwise reported 73 percent).
- The rates for adherence to asthma medication were consistent across the MCEs. For children age 5 to 11 years, all MCEs reported a rate of 89 percent. For children age 12 to 18 years, the rate varied between 79 percent (Anthem and MHS) and 83 percent (MDwise).
- The rates for follow-up visits after an inpatient stay for mental illness were consistent across the MCEs. For the measurement tracking visits with seven days after discharge, the MCEs had a rate of 69 percent. For the measurement tracking anyone with a visit within 30 days, the MCEs all reported a rate of 83 to 85 percent.

Service Utilization

B&A measured the percentage of CHIP children that used primary care services, emergency room visits, preventive dental visits, and had a pharmacy prescription for the periods FFY 2014, FFY 2015 and FFY 2016. The overall rate of usage for all of these services has remained fairly steady, although ER use has gone down. Some potential missing claims data still coming in from FFY 2016 may be understating the results from this most recent year.² Comparisons were also made across various demographic cohorts, such as by MCE, by age and by race/ethnicity.

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

	FFY 2014	FFY 2015	FFY 2016
Primary Care Visit (office or clinic setting)	68%	67%	65%
Emergency Room Visit	25%	25%	23%
Preventive Dental Visit	66%	66%	65%
Pharmacy Script	66%	67%	66%

² Claims are normally submitted within 90 days of the service date, but providers have 12 months to submit claims.

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

Some of the key findings from these analyses are:

- Primary care visits were more prevalent among the youngest members, as 76 percent of children ages 5 and younger had a visit in FFY 2016. The percentage was lower for children in the other age groups (63 percent).
- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (74 percent in FFY 2016) than other race/ethnicities (55 to 57 percent).
- In addition to more actual children having a primary care visit, there is also a disparity in the number of visits per 1,000 CHIP children for primary care. The rate for Caucasian children is 233 visits per 1,000 children during FFY 2016, whereas the rates for African American and Hispanic children were 144 and 148, respectively.
- The rate of emergency room visits by CHIP children in all packages decreased slightly from FFY 2015 to FFY 2016. Just less than one quarter of all CHIP children who were enrolled at least nine months in the year had an ER visit. There was a difference in utilization when measured on a per 1,000 basis MCE. In FFY 2016, the average rate among Anthem members was 25 visits per 1,000; for MHS and MDwise members, it was 34 per 1,000 in FFY 2016.
- Differences in emergency room use are found by age group within the CHIP. The highest use is among children under age 5 (32 percent of all members in FFY 2016) and lowest among children ages 6 to 12 (21 percent of all members in FFY 2016).
- The percentage of members using the emergency room was almost identical across race/ethnicities. There are differences, however, in emergency room use at the county level with higher use in the East Central and West Central regions of the state.
- Hispanic CHIP children were more likely than children of other races/ethnicities to have a preventive dental visit with a rate of 73 percent in FFY 2016 than other race/ethnicities (63 to 64 percent).
- The utilization of pharmacy scripts varies by age group. The number of prescriptions per 1,000 CHIP members is highest for children ages 13-18 (534 prescriptions per 1,000 members on average in FFY 2016), followed by children ages 6-12 (420 prescriptions per 1,000 members), then by children age 5 and under (330 prescriptions per 1,000 members).
- Caucasian children have a utilization rate of 541 prescriptions per 1,000 members in FFY 2016, which is 51 percent higher than the rate for African-American children (358 prescriptions per 1,000 children) and more than double the rate for Hispanic children (243 prescriptions per 1,000 children).

I

Introduction



Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

Each year, an independent evaluation of Indiana’s Children’s Health Insurance Program (CHIP) is conducted as required by Indiana Code 12-17.6-2-12 and is due to the Legislature by April 1. Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2016. B&A has conducted this study for the OMPP since 2007. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana’s CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

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

- The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009³ extended the program to September 2013.
- The Patient Protection and Affordable Care Act (ACA) of 2010 extended CHIP funding with a higher contribution of the federal match rate percentage (referred to as FMAP or, in this case, enhanced FMAP) through Federal Fiscal Year (FFY) 2015 and continued the authority for the program through FFY 2019.
- The Medicare Access and CHIP Reauthorization Act of 2015 extended CHIP funding for another two years through FFY 2017.

Effective in FFY 2015, the enhanced federal match rate percentage (FMAP) for Indiana’s CHIP was 76.56. In other words, for every dollar that the OMPP spent on its CHIP program, the federal government paid 76.56 cents and the State of Indiana paid 23.44 cents.

Starting in FFY 2016 and running through FFY 2019, the ACA increased each state’s enhanced FMAP rate by 23 percentage points. This is in place for state CHIP programs, but not the traditional Medicaid programs. Indiana’s enhanced FMAP would have been 76.62 in FFY 2016, but with the additional increase the enhanced FMAP is 99.62. In other words, the state share for \$100 dollars spent on the CHIP program today is now \$0.38.

At the time of publication of this report, it is unknown if Congress will extend CHIP funding past FFY 2017. So, although there is a significant federal contribution to the program due to today’s enhanced FMAP, this may become moot if overall funding is ended effective September 30, 2017. One option currently available to states is the ability to use any unspent CHIP allotments for two years after September 30, 2017 even if there is no new funding after this time. At present, the estimate is that Indiana will have approximately \$175 million available in unspent CHIP funds as of September 30, 2017 which is enough to extend the program for another 12 months to September 2018.

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

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

³ CHIPRA 2009 changed the acronym for the federal program from S-CHIP to CHIP.

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- CHIP Package A (the Medicaid expansion portion, or MCHIP) covers uninsured children in families with incomes up to 158⁴ percent of the Federal Poverty Level, or FPL (\$38,394 per year for a family of four in 2016) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.
- CHIP Package C (the non-entitlement portion, or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.
 - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 158 percent up to 200 percent of the FPL (\$48,600 per year for a family of four in 2016).
 - The second portion (referred to as SCHIP (Package C) Expansion) was introduced October 1, 2008 to cover children in families with incomes above 200 percent up to 250 percent of the FPL (\$60,750 per year for a family of four in 2016).

The ACA also created a maintenance of effort requirement on state Medicaid and CHIP programs that prevents states from lowering their income thresholds for eligible groups through December 31, 2019. For example, Indiana cannot lower the income standard for CHIP below 250 percent of the FPL. If federal funding for CHIP is not renewed, Indiana will not be required to continue coverage for SCHIP when all funds are exhausted. However, Indiana would be required to continue coverage for MCHIP due to the Affordable Care Act's (ACA's) maintenance of effort requirement even after federal CHIP funds have been exhausted, because children eligible under MCHIP are covered under both the Medicaid State Plan and the CHIP State Plan, where the CHIP State Plan allows Indiana to receive the higher match. Additionally, Indiana would receive the lower Medicaid match rate for these children, which is estimated to cost an additional \$39 million in state dollars over a 12-month period.

In January 2017, the Kaiser Family Foundation released a report in which the 50 states (and District of Columbia) were surveyed to compare Medicaid and CHIP eligibility policies.⁵ As of January 2017, 48 states cover children with incomes at or above 200 percent of the FPL. Of these, 19 states extend eligibility to at least 300 percent of the FPL.

Among the CHIP programs nationwide, 30 states (including Indiana) require families to pay premiums for their children's coverage. The premiums are usually on a sliding scale based on the family's FPL. There are 22 states (including Indiana) who charge a premium to families with incomes below 200 percent of the FPL (Indiana's premiums begin at \$22 per month when the family has income at 158% - 175% of the FPL).

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

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

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

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

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

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

As of December 2016, enrollment in Indiana’s CHIP was at 98,971⁶, a 12.6 percent increase over the prior year’s membership of 87,921 and its highest level ever since the start of the program:

- MCHIP (Package A) enrollment was 69,446 (up 8.4 percent from December 2015)
- Enrollment in the initial group of SCHIP (Package C) members was 20,077 (up 22.1 percent from December 2015)
- Enrollment in the 2008 expansion group of SCHIP (Package C) members was 9,448 (up 27.1 percent from December 2015)

More enrollment statistics appear in Chapter II of this report.

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

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

Among children in families with incomes below 250 percent of the FPL, Indiana’s most recent uninsured rate using a three year average is 7.6 percent compared to the national average of 8.5 percent. Indiana’s rate for this population is in the middle of all states (ranked 28th lowest uninsured rate). When examining single year trends, Indiana and the nation as a whole are seeing further improvement. Whereas the most recent three-year CPS average for Indiana showed an uninsured rate of 7.6 percent for this child population, the most recent year (2016 survey alone) showed an uninsured rate of 6.0 percent compared to the national average of 7.2 percent for this single year.

⁶ Enrollment figures retrieved from the Office of Medicaid Policy and Planning’s data warehouse, FSSA Enterprise Data Warehouse, on February 8, 2017. Due to retroactive eligibility, this enrollment figure for December 2016 may be slightly understated from what will be the final figure for this time period.

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

Uninsured Rate as Reported in	Indiana's Rate	U.S. Average Rate	Rank Among States
Avg of 3 year CPS 2012, 2013, 2014	10.6%	12.3%	24
Avg of 3 year CPS 2013, 2014, 2015	10.2%	10.4%	34
Avg of 3 year CPS 2014, 2015, 2016	7.6%	8.5%	28
CPS 2016 alone	6.0%	7.2%	22

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

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

The uninsured rate in the state varies by family income level. Exhibit I.2 below shows the uninsured rate among families up to 250 percent of the FPL (who may be eligible for Indiana’s CHIP) and the rate among families above the 250 percent of FPL level. For example, whereas the survey conducted by the Census Bureau in 2016 (which measured insurance status in Calendar Year 2015) showed an uninsured rate among all children of 5.0 percent, the rate was 6.0 percent among children who may be CHIP-eligible and 3.9 percent among children who are not CHIP-eligible. In reviewing the column that shows the percent of all uninsured children, the CPS suggests that 63.8 percent of children who are currently uninsured (n= 53,063) may be eligible for Indiana’s CHIP (at least based on family income, other criteria may preclude eligibility).

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

Current Population Survey Year	Total Children 0-18	Total Insured	Total Uninsured	Uninsured Rate	Percent of All Uninsured Children
Total for Children that may be Eligible for Indiana's CHIP (Income up to 250% FPL)					
CPS 2014	863,840	786,793	77,048	8.9%	57.9%
CPS 2015	961,416	884,599	76,816	8.0%	60.6%
CPS 2016	881,325	828,262	53,063	6.0%	63.8%
Total for Children Not Eligible for Indiana's CHIP (250% and above)					
CPS 2014	872,255	816,342	55,914	6.4%	42.1%
CPS 2015	754,377	704,535	49,842	6.6%	39.4%
CPS 2016	772,343	742,288	30,055	3.9%	36.2%
All Children					
CPS 2014	1,736,095	1,603,135	132,962	7.7%	100.0%
CPS 2015	1,715,793	1,589,134	126,658	7.4%	100.0%
CPS 2016	1,653,668	1,570,550	83,118	5.0%	100.0%

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

There are differences in the uninsured rate when examined by race/ethnicity. In the most recent survey conducted among the children in families with incomes below 250 percent of the FPL, Caucasian children had an uninsured rate of 5.3 percent, whereas the rate for African American children was 14.1 percent and Hispanic children was only 1.9 percent.

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

Race/Ethnicity	Total Children 0-18	Total Insured	Total Uninsured	Uninsured Rate	Percent of All Uninsured Children
Caucasian Non-Hispanic	602,613	570,755	31,858	5.3%	60.0%
African Amer. Non-Hispanic	117,996	101,337	16,658	14.1%	31.4%
Hispanic (any race)	142,141	139,481	2,660	1.9%	5.0%
All Other Races	18,575	16,689	1,887	10.2%	3.6%
All Children	881,325	828,262	53,063	6.0%	100.0%

Source: U.S. Census Bureau, Current Population Survey (CPS 2016 survey)
<https://www.census.gov/cps/data/cpstablecreator.html>

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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 and pregnant women. CHIP enrollees, like all children in Hoosier Healthwise, select a primary medical provider (PMP) or they are assigned one if their family does not select one. CHIP members must enroll with one of three managed care entities (MCEs) that contract with the state—Anthem, Managed Health Services (MHS) or MDwise. CHIP enrollees have access to all of the providers available to Hoosier Healthwise members that are enrolled with the MCE they select.

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

With just a few limitations, Indiana’s SCHIP (Package C) members are able to access the same services as their peers in the traditional Medicaid program (although the MCEs do not administer dental care or prescriptions). This is a practice often seen in other states as well. The actual services offered to CHIP members are also similar to those found in other state CHIP programs.

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

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

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

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

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

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

Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

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 FFY 2015, for every dollar spent on medical services in Indiana's CHIP, the state paid 23.44 cents and the federal government matched the remaining 76.56 cents. In the Medicaid program, the standard rate paid by the state was 33.48 cents and the federal government matched the remaining 66.52 cents.

As stated previously, beginning in FFY 2016 and running through FFY 2019, the ACA increased each state's enhanced FMAP rate by 23 percentage points. Therefore, in FFY 2016, for every \$100 dollars spent in Indiana's CHIP, the state paid \$0.38 and the federal government paid \$99.62.

Expenditures in Indiana's CHIP are paid in two ways. The first method is a payment to the MCEs through what is known as a capitation payment. This is a set amount paid to the MCEs per member per month (PMPM). The capitation PMPM rate is adjusted for age and also adjusted by Package. There are also some services covered in the program but paid on a fee-for-service basis outside of the MCE contract. These include pharmacy prescriptions, dental services and mental health rehabilitation services. 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.

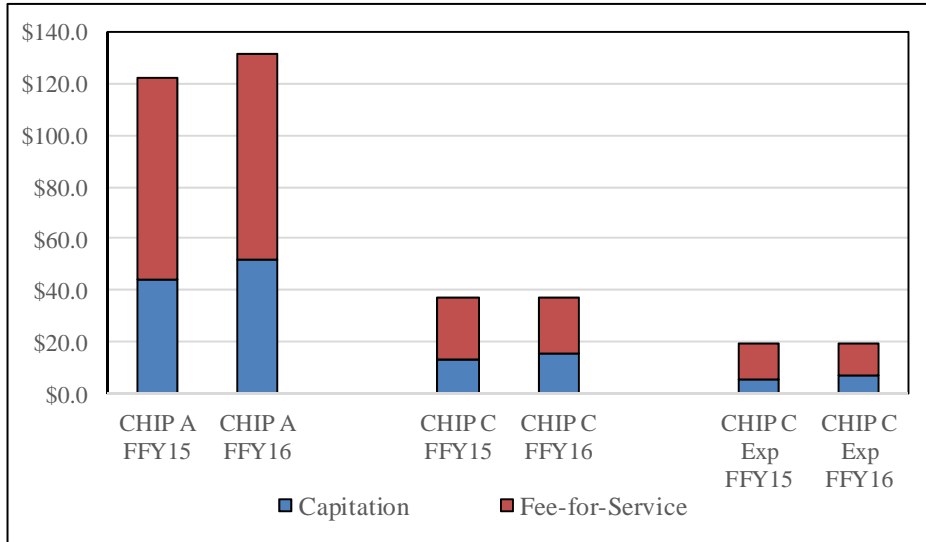
B&A examined expenditures made on behalf of CHIP members in FFYs 2015 and 2016.⁷ Data was pulled from the state's data warehouse.

In all three portions of CHIP, the medical expenditures are split approximately 40 percent using the capitation payment and 60 percent using the fee-for-service payments (refer to Exhibit I.6 below). Total expenditures in CHIP Package A were \$131.5 million in FFY 16, an increase of 7.9 percent from FFY 2015. The enrollment grew 11.5 percent during FFY 2016. Total expenditures in CHIP Package C were \$37.5 million in FFY 16, an increase of 0.6 percent from FFY 2015. But the enrollment grew 19.4 percent during FFY 2016. Total expenditures in the expansion portion of CHIP Package C were \$19.3 million in FFY 16, a decrease of 2.7 percent from FFY 2015. But the enrollment in this portion of the CHIP grew 27.0 percent during FFY 2016. The reason for enrollment growth outpacing expenditure growth in CHIP C and CHIP C Expansion is due to lower expenditures in the fee-for-service portion (pharmacy, dental, mental health services).

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

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**Exhibit I.6
Expenditures in Indiana's CHIP, in millions
Federal Fiscal Year 2015 and 2016**



Because of the different enrollment levels in each portion of the CHIP, Exhibits I.7 and I.8 on the next page show the payments made on a PMPM basis. Like the data shown in Exhibit I.6 above, the PMPMs shown in Exhibit I.7 reflect total funds (state and federal share). Exhibit I.8 uses the same membership but shows the trends in PMPM payments using the state share only.

Exhibit I.7 illustrates that there is some difference in the PMPM payments made in each portion of the CHIP. In FFY 2016, this varied from a PMPM of \$166.48 in CHIP A, \$176.11 in CHIP C and \$201.99 in CHIP C Expansion. All PMPMs were lower in FFY 2016 than in FFY 2015. The reduction range was from -3.4 percent in CHIP Package A to -16.8 percent in CHIP Package C.

The corresponding state share PMPMs are shown in Exhibit I.8. The additional enhanced FMAP beginning in FFY 2016 accounts for the large reduction in the state share beginning that year.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

Exhibit L7
Per Member Per Month Expenditures in Indiana's CHIP
Federal Fiscal Years 2015 and 2016 (Total Funds)

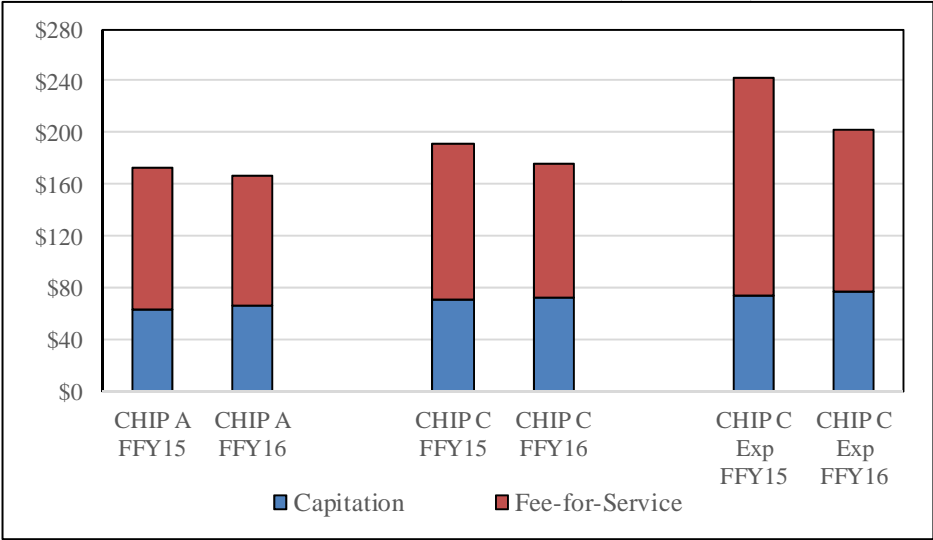
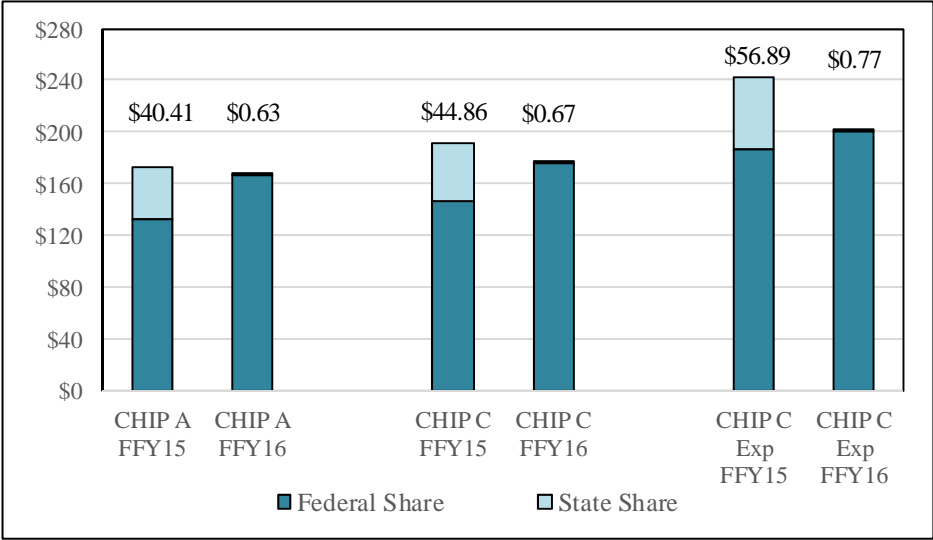


Exhibit L8
Per Member Per Month Expenditures in Indiana's CHIP
Federal Fiscal Years 2015 and 2016 (State Share Only)



II

Enrollment Trends in Indiana's CHIP



Enrollment Trends at a Glance

CHIP Enrollment Dec 2015: 87,921

CHIP Enrollment Dec 2016: 98,971

8.4% year-to-year growth rate in CHIP Package A

22.1% year-to-year growth rate in CHIP Package C

27.1% year-to-year growth rate in CHIP Package C Expansion

171,634 children enrolled in Indiana's CHIP at some point in CY 2016.

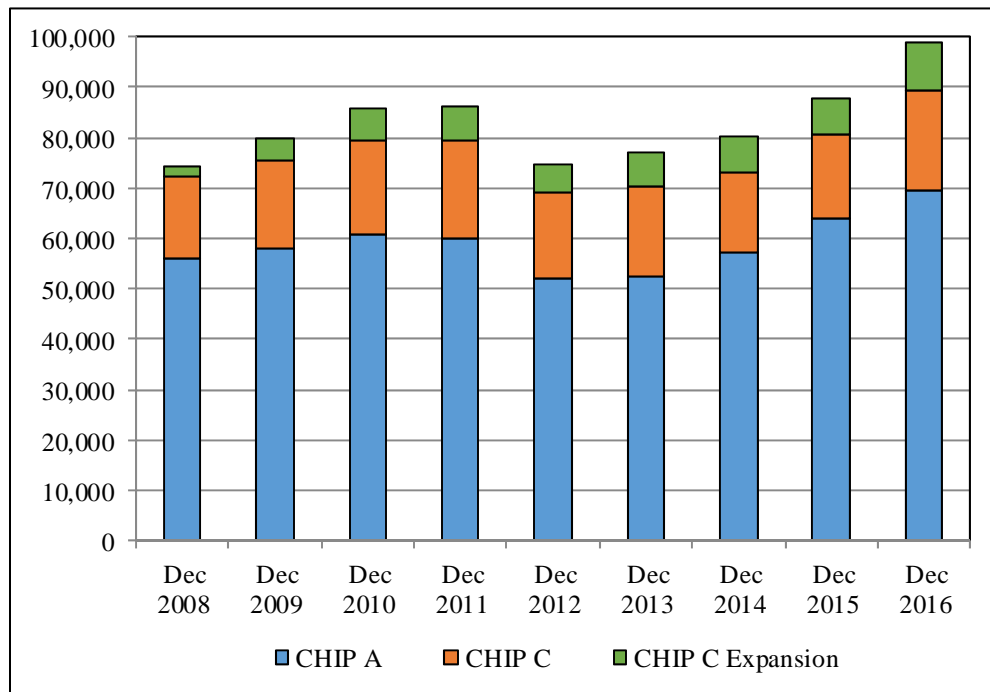
Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

Enrollment and Disenrollment Trends

Indiana's Children's Health Insurance Program (CHIP) experienced an increase in enrollment in 2016 with year-end enrollment at 98,971 members, a 12.6 percent increase from Calendar Year (CY) 2015's year-end enrollment of 87,921. After a dip in enrollment in CY 2012 and CY 2013, enrollment has grown steadily. Over the last three years, enrollment has increased 28.7 percent. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 158 percent of the federal poverty level (FPL), enrollment increased 8.4 percent from December 2015 to December 2016. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 158 to 200 percent of the FPL, enrollment increased 22.1 percent during this time period. The SCHIP (Package C) Expansion group (201-250% of the FPL) had enrollment increase 27.1 percent during this time period.

At the end of CY 2016, 70.2 percent of enrollees were in the MCHIP portion and 29.8 percent were in the SCHIP portion of the program. The SCHIP portion of the program has enrolled between 27.2 and 30.4 percent of the members in each of the last six years.

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

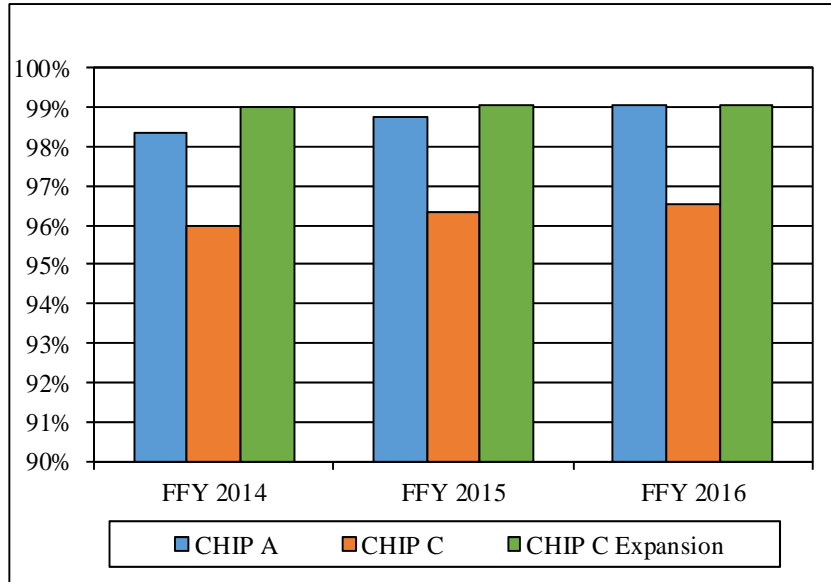


Source: Indiana's FSSA Enterprise Data Warehouse

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

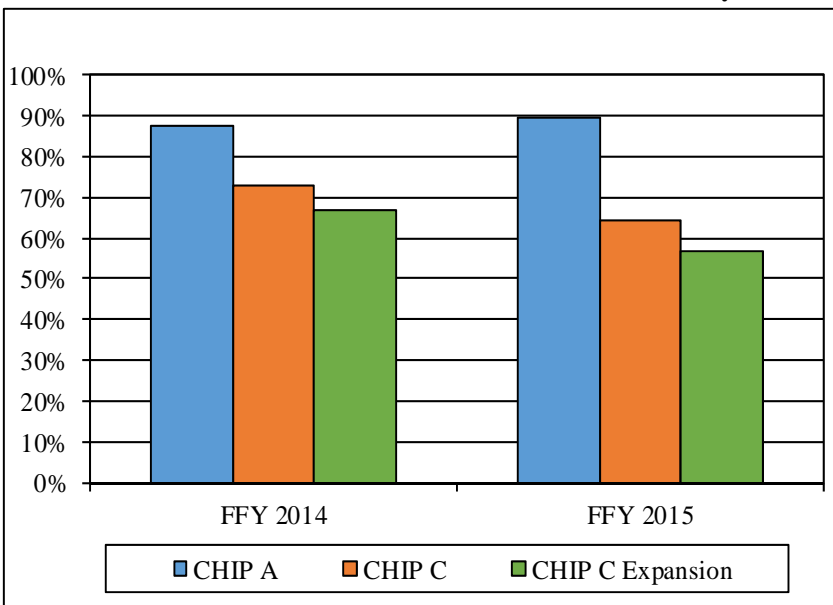
The actual children enrolled in Indiana’s CHIP remains steady on a monthly basis other than accounting for new enrollees and some attrition. This is evidenced by the percent of CHIP enrollees continuously enrolled each month. Burns & Associates, Inc. (B&A) analyzed the enrollment of members within each portion of Indiana’s CHIP on a monthly basis. From this, we tabulated how many members in the month were enrolled in the previous month. Statistics were computed as the average across the months in Federal Fiscal Years (FFYs) 2014, 2015 and 2016 (the federal fiscal year runs from October 1 – September 30). Exhibit II.2 below shows that the members continuously enrolled from one month to the next is from 96 percent in CHIP Package C to 99 percent in the CHIP C Expansion portion.

Exhibit II.2
Percent of CHIP Enrollees Continuously Enrolled Each Month
Average for Three 12 Month Periods, Federal Fiscal Years 2014 - 2016



Source: Indiana's FSSA Enterprise Data Warehouse

Exhibit II.3
Percent of CHIP Enrollees Who Re-Enrolled After 12 Months
New Enrollees in Federal Fiscal Years 2014 and 2015 Only



Source: Indiana's FSSA Enterprise Data Warehouse

B&A also computed the percentage of children who recertified their eligibility 12 months after their original enrollment. B&A examined new enrollees in FFY 2014 then counted 13 months to see what percentage of these enrollees remained in FFY 2015 (in other words, they recertified). The same was done for FFY 2015 new enrollees. In CHIP Package A, the recertification rate was highest at 89.5 percent in FFY 2015. In CHIP Package C, the rate was 64.1 percent. In CHIP Package C Expansion, the rate was 56.6 percent.⁸

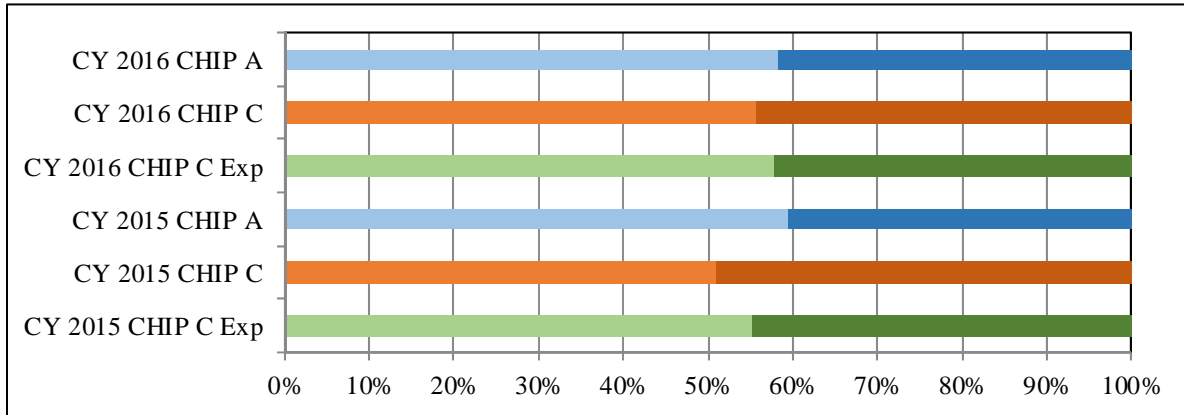
⁸ A member is considered “retained” in Hoosier Healthwise if they move from the CHIP program to the traditional Medicaid program, or between MCHIP (Package A) and SCHIP (Package C).

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

A much greater number of Hoosier children have been supported by Indiana’s CHIP than the year end enrollment figures would suggest. The number of children enrolled at any time during CY 2016 was 171,634 compared to 153,575 in CY 2015. Across all three portions of Indiana’s CHIP (CHIP Package A, CHIP Package C, and CHIP Package C Expansion), the enrollment at the end of CY 2016 was between 56 and 58 percent of the total number of children ever enrolled during the year. In CY 2015, the year-end enrollees represented between 51 and 59 percent of all individuals ever enrolled during the year.

⁹ Exhibit II.4 below shows the difference between enrolled at the end of the calendar year (light colors) and enrolled at any time during the year (dark colors)

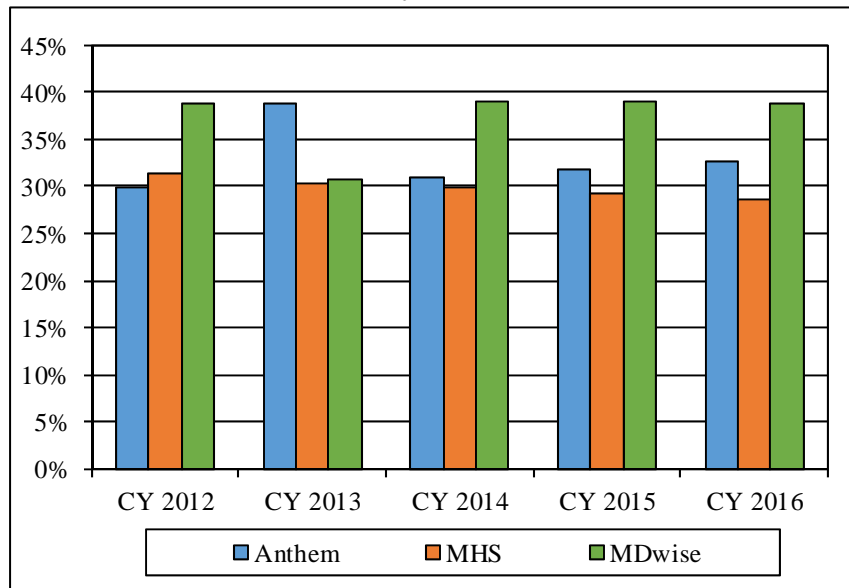
Exhibit II.4
Percent of Children Currently Enrolled (light color) and Ever Enrolled (dark color), by Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

Exhibit II.5
Percent of CHIP Enrollment by MCE at End of Each Calendar Year

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There has been little movement in distribution of CHIP members across the MCEs in the last five years. At the end of CY 2016, Anthem had 32.6 percent of all CHIP enrollees, MHS had 28.5 percent and MDwise had 38.9 percent.



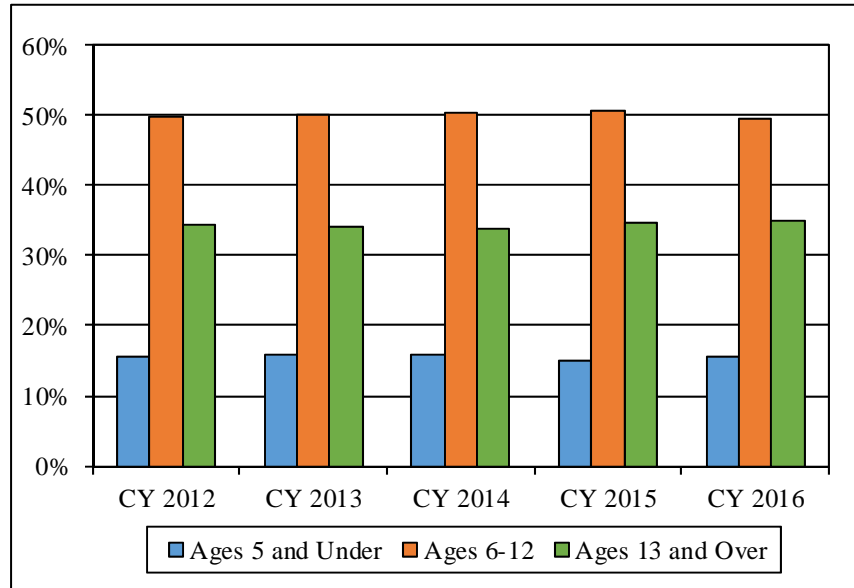
Source: Indiana's FSSA Enterprise Data Warehouse

⁹ A member is only counted once in the year in the ever enrolled count within one of the three CHIP packages, but may be counted in more than one package within CHIP during the year.

Demographic Profile of CHIP Members

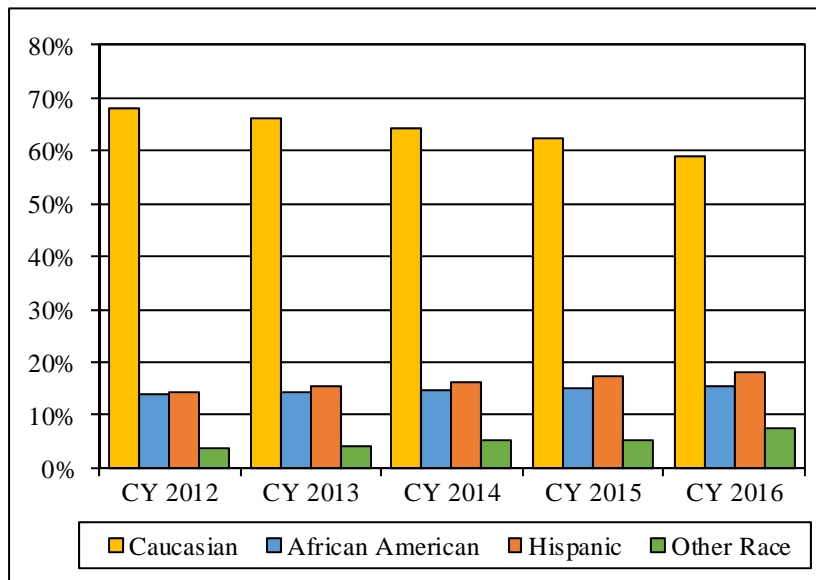
Half of the children enrolled in the CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Just fewer than 35 percent of CHIP enrollees are teenagers, while the remaining 15 percent are under age 6. This distribution has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

Exhibit II.6
Percent of CHIP Enrollment by Age Group at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

Exhibit II.7
Percent of CHIP Enrollment by Race/Ethnicity at End of Each Calendar Year



Source: Indiana's FSSA Enterprise Data Warehouse

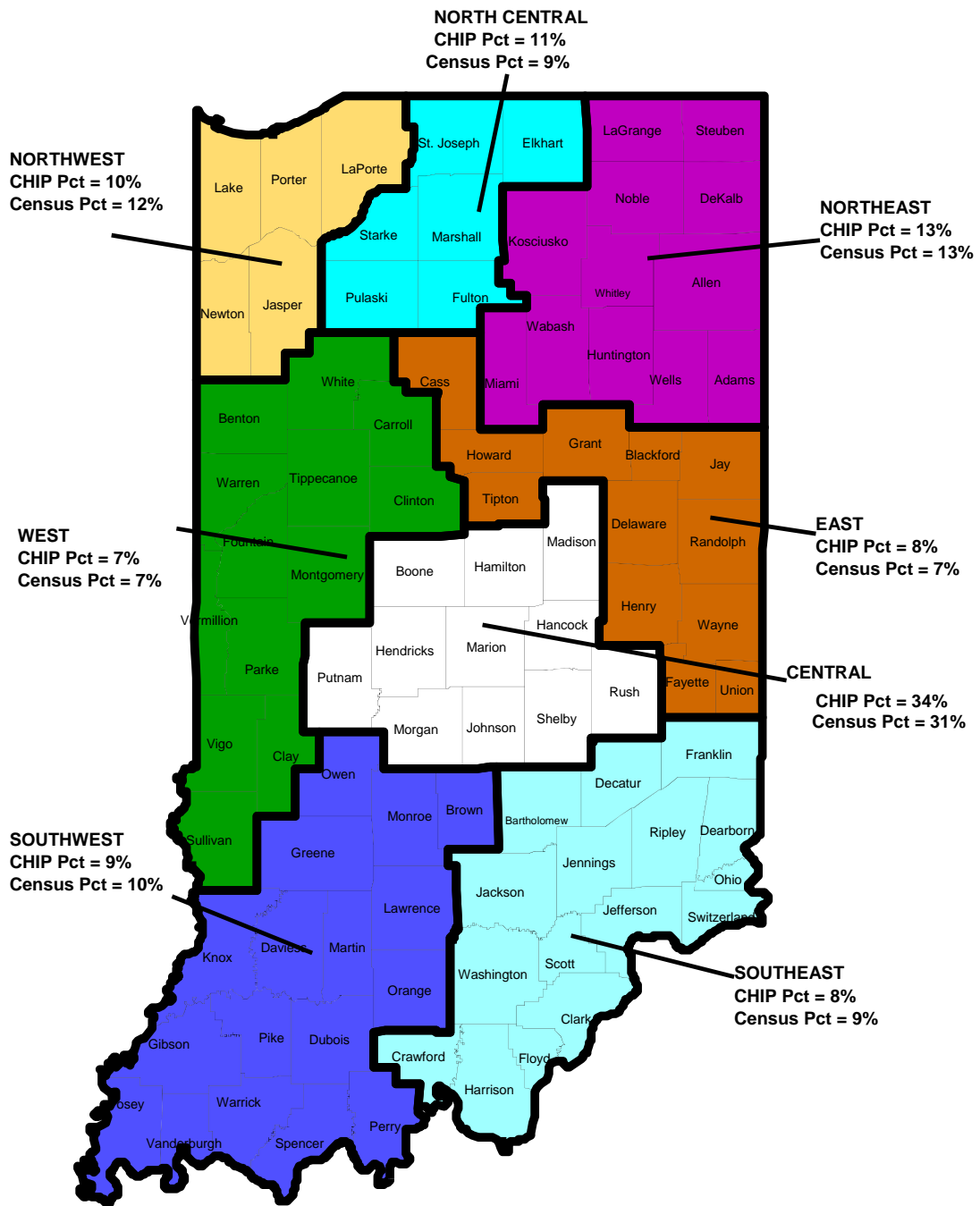
There is a higher distribution of minorities in Indiana’s CHIP than the overall population in Indiana for children ages 18 and younger. African-American children and Hispanic children represented 15.5 percent and 18.0 percent, respectively, of the CHIP enrollment at the end of CY 2016. This compares to 13.4 percent and 16.1 percent, respectively, of all children living in Indiana with family incomes below 250 percent of the Federal Poverty Level according to the U.S. Census estimate.¹⁰ The proportion of children enrolled in CHIP by race/ethnicity has been steady in the last five years.

¹⁰ U.S. Census Bureau, Current Population Survey for Indiana 2016. <http://www.census.gov/hhes/www/hlthins/hlthins.html>

Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

B&A compared CHIP members enrolled to the total child population in Indiana as of July 2016. The distribution of CHIP members by region generally matches the overall child population in Indiana. The Central region has 34 percent of all CHIP members but only 31 percent of the state's child population. The Northwest region has 10 percent of all CHIP members but 12 percent of the child population. The regions are defined by the OMPP.

Exhibit II.8
Average Distribution of CHIP Members by Region Compared to Census Figures, July 2016



III

Access to Primary Medical Providers and Dentists in Indiana's CHIP



Access Facts at a Glance

In 89 out of 92 counties, CHIP members chose from at least 30 primary medical providers to get care.
In 84 out of 92 counties, CHIP members chose from at least 20 dentists to get care.

The average distance that CHIP members travelled to seek primary care was 21.1 miles.

- In 60 counties, the average distance was less than 30 miles.
- In 32 counties, the average distance was greater than 30 miles.

The average distance that CHIP members travelled to seek dental care was 14.1 miles.

- In 76 counties, the average distance was less than 30 miles.
- In 16 counties, the average distance was greater than 30 miles.

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

As a means to measure access to providers in Indiana’s CHIP, Burns & Associates, Inc. (B&A) analyzed three measures at the county level:

- The count of providers accessed by CHIP members,
- The utilization per 1,000 member months of CHIP members, and
- The average distance travelled by CHIP members to receive the service.

The data used to compute these measures was provided to B&A by the Office of Medicaid Policy and Planning (OMPP) from its Enterprise Data Warehouse (EDW). Information was tabulated for access to primary medical providers (PMPs)¹¹ and dental providers¹² based on utilization from the time period October 1, 2015 – September 30, 2016. This time span was used in lieu of Calendar Year (CY) 2016 to allow the lag time for claims to be submitted by providers.

Defining the Measures

Claims were matched to each individual in the study. Each individual was mapped to one of Indiana’s 92 counties based on their home address in the enrollment file provided to B&A from the EDW. The latitude and longitude coordinates of each member’s home address were plotted. Likewise, the latitude and longitude coordinates of every provider specialty with a claim in the study database was plotted.

Frequencies were completed on the number of providers that rendered services within each specialty. The counts were tracked at the county level. Instead of tracking the number of rendering providers within the county, B&A counted the number of providers that members who live in each county accessed. This means that the counts of providers include some who have offices in counties outside of the member’s home county. It also means that the same provider can be included in the count of providers for many counties, especially if the provider is in an area of the state where many counties are in close proximity.

Utilization per 1,000 member months was also calculated at the county level for PMPs and dentists. This measure is used as a way to have a consistent value to compare across the counties since the membership differs so much across counties.

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

Geocoding software (either the Google Distance Matrix web service or BING Maps web service) was used to map the driving distance from the member’s home to the dentist’s office¹³. In some cases, the latitude/longitude coordinates were not valid for either the member’s home or the rendering provider’s office. When this occurred, B&A excluded from the study the claims/encounters and computed distances when the trip was less than 0.2 percent of a mile or greater than 100.0 miles. The average distance for each county was then computed as the total miles across all non-excluded trips divided by the total trips for members to the specific specialty.

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

¹² The OMPP’s EDW utilizes a specific claim type to identify dental claims. This claim type was used by B&A.

¹³ Note that B&A computes the driving distance (turn by turn) as opposed to a crow flies distance.

Findings

The maps that appear on the next three pages are presented in the same format for ease of comparison. In each exhibit, information on access to primary care is shown on the left and access to dental services is shown on the right. On each map, the darker the shade of blue indicates the higher the value for the measure. For example,

- In Exhibit III.1, the darkest blue represents the counties with the most numbers of PMPs or dentists seen by CHIP members.
- In Exhibit III.2, the darkest blue represents the counties with the highest utilization of primary care or dental services among CHIP members, as reflected on a per 1,000 member month basis.
- In Exhibit III.3, the darkest blue represents the counties with the greatest distance that CHIP members have to travel to access primary care or dental services.

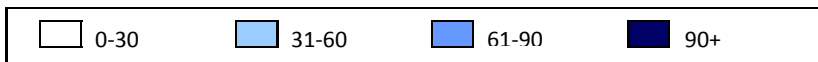
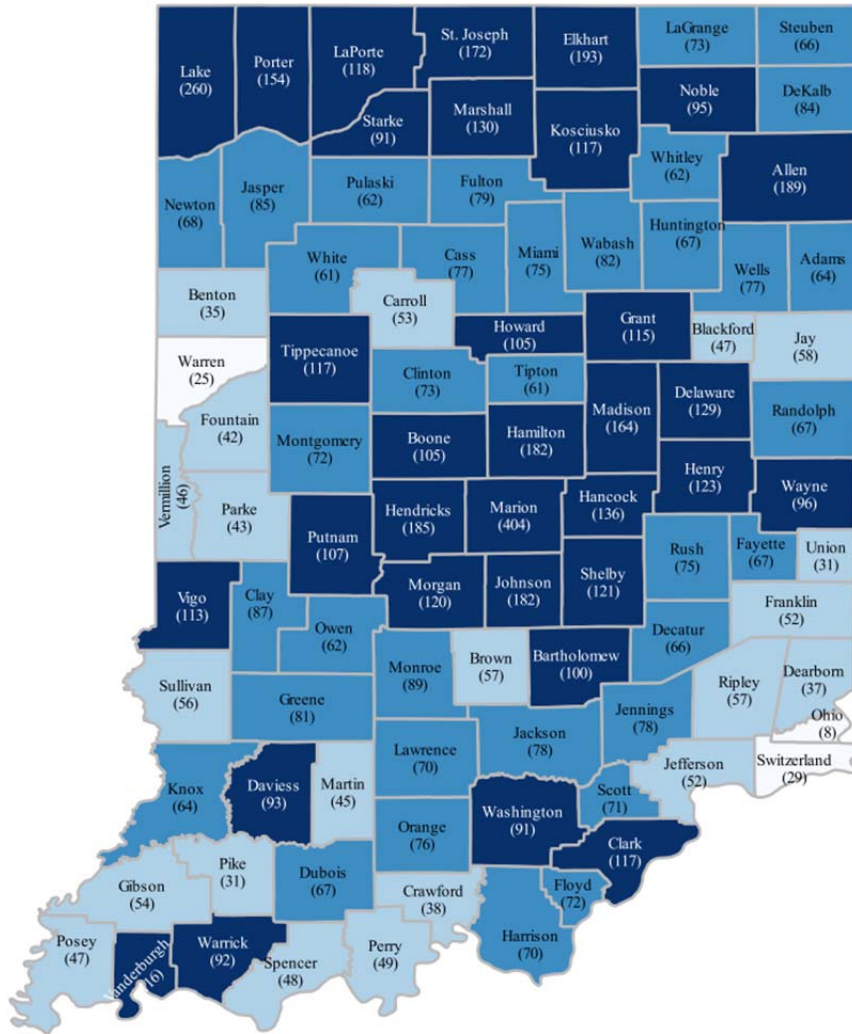
A summary of findings across the three exhibits is discussed below:

- Exhibit III.1 shows a high prevalence of unique providers seen by CHIP members in most counties for both primary care and dental services. For primary care specifically, there were only three counties where CHIP members saw 30 or fewer different PMPs—Ohio (8), Warren (25) and Switzerland (29). For dental services, there were eight counties where CHIP members saw 20 or fewer different dentists—Ohio (6), Perry, Pike and Union (16), Switzerland (17), Warren (18), Benton and Fountain (20).
- The average utilization per 1,000 member months for primary care was 182 in FFY 2016. In other words, approximately 18 percent of CHIP members had a primary care visit each month (some members could be counted with more than one visit). In Exhibit III.2, it is shown that there is no county where the utilization for primary care was less than 100 in FFY 2016. For dental services, the average utilization per 1,000 member months was 104 in FFY 2016. There is no county where the utilization per 1,000 member months was less than 50.
- The average distance travelled by members in each county is shown in Exhibit III.3. For primary care, there were 32 counties where the average distance travelled was greater than 30 miles. In 25 of the 32 counties, the distance was 30-35 miles. The remaining seven counties with the average distance travelled are: Cass (36), Wells (36), Newton (39), Huntington (40), Wabash (42), Benton (47) and Randolph (53).
- For dental care, there were 16 counties where the average distance travelled was greater than 30 miles. In 12 of the 16 counties, the distance was 30-35 miles. The remaining four counties with the average distance travelled are: Benton (36), Putnam (36), White (38) and Jennings (38).

Exhibit III.1

Count of Primary Medical and Dental Providers Serving CHIP Members, by County

Primary Care



Dental

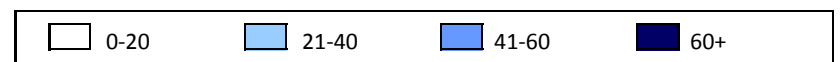
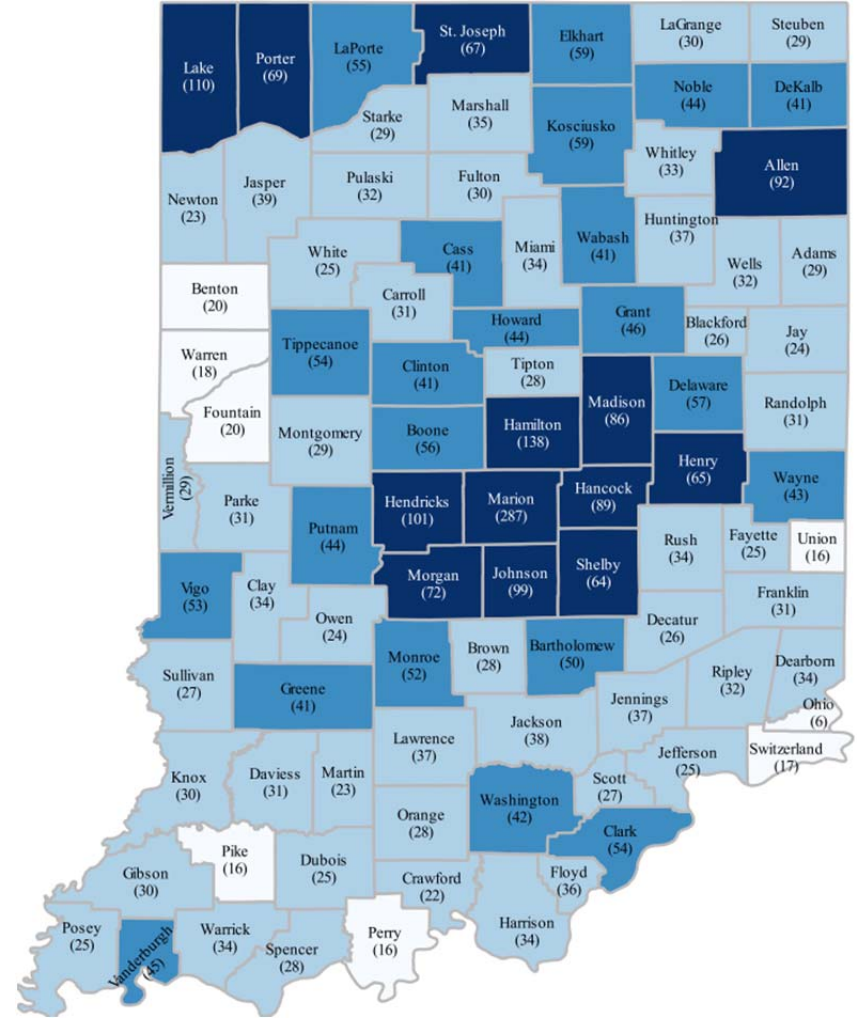


Exhibit III.2
Utilization Per 1,000 Member Months for CHIP

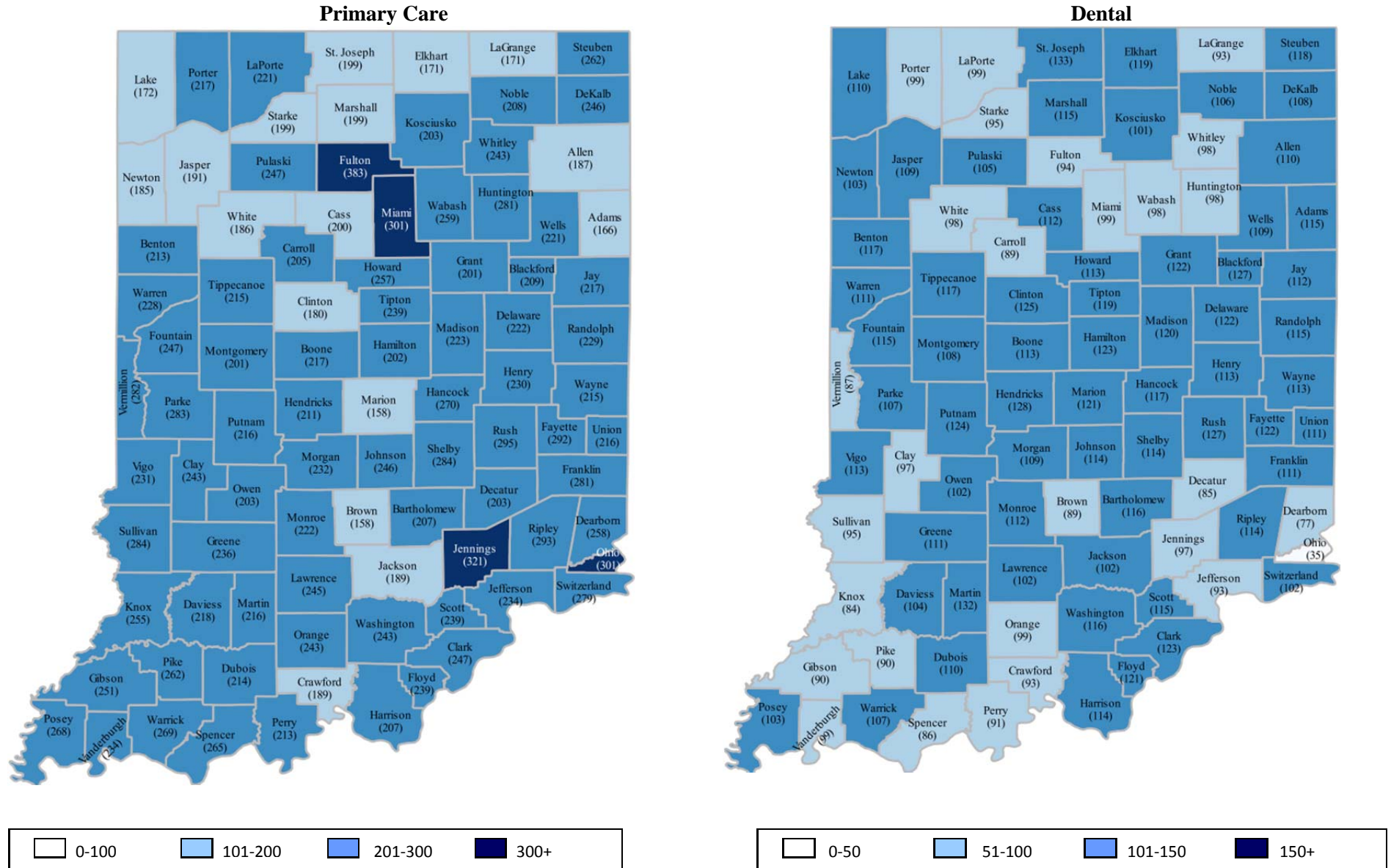


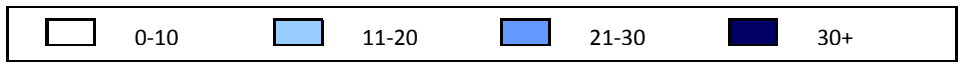
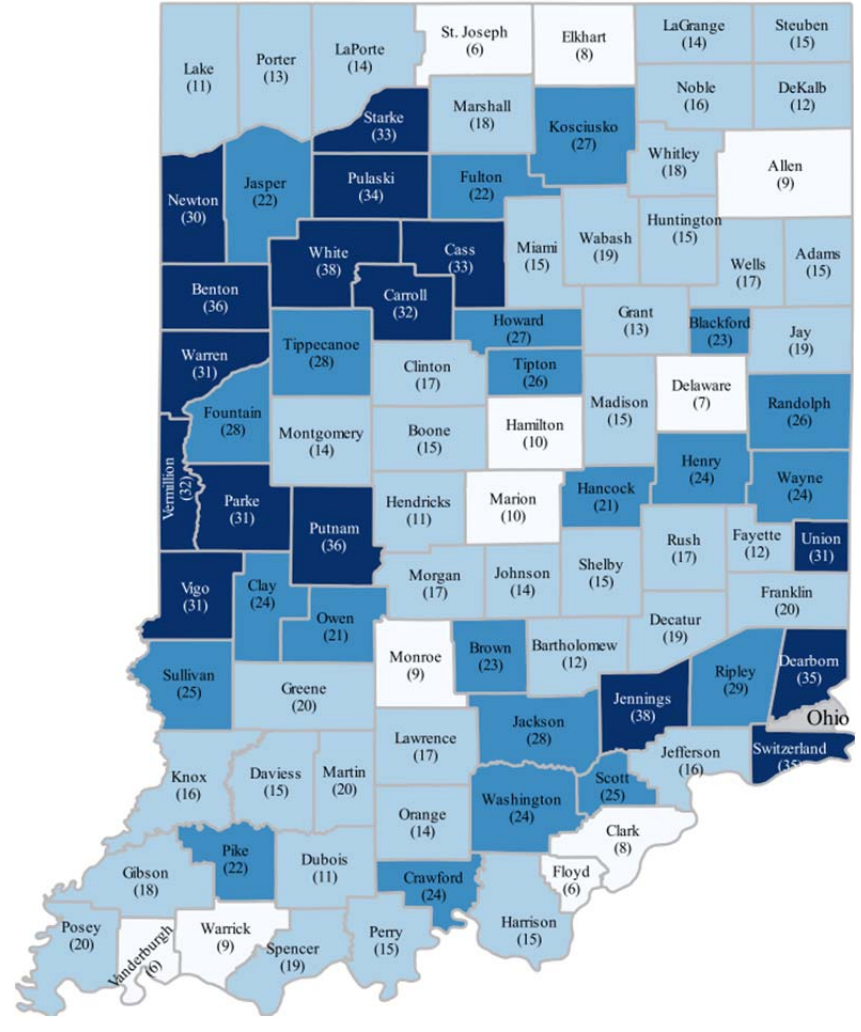
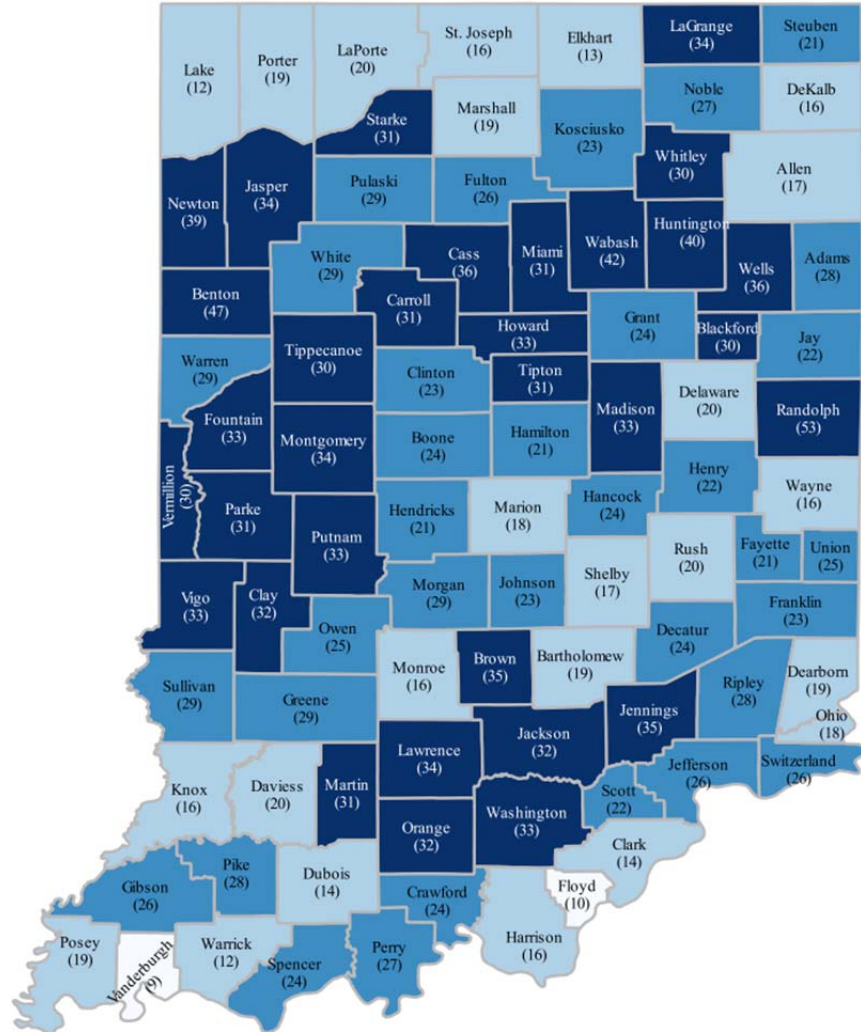
Exhibit III.3

Average Driving Distance for CHIP

(Average distances shown in miles for members using single one-way trips from member home to provider location.)

Primary Care

Dental



IV

Service Use Patterns among Populations in Indiana's CHIP



Service Use Trends at a Glance

The percentage of CHIP members receiving the following in the period Oct 2015 – Sept 2016 (among those enrolled at least nine months):

- Primary care: 65% of all members
- Dental care: 65% of all members
- Pharmacy script: 66% of all members
- Emergency room visits: 23% of all members

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In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency room (ER) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2014, 2015 and 2016 across populations within the CHIP such as by CHIP Package, by age, by managed care entity (MCE) and by race/ethnicity.

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning’s (OMPP’s) data warehouse in February 2017. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP. That being said, the findings for FFY 2016 may still be incomplete if the MCEs have not submitted all of their encounter data to the OMPP yet.

B&A identified each unique member enrolled in CHIP at some point in time in either FFY 2014, 2015 or 2016. Since the *usage rate* measures the percentage of members that had actually used the service, we are requiring 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 of our study but not another year based upon their enrollment history. Children were retained in the analysis if they switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year, as long as they met the nine month minimum and were enrolled in one of the CHIP packages at the end of the year. CHIP members included in the analysis were assigned to one MCE, one race/ethnicity group, and one age group. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member’s age was assigned based upon their age at the end of each year.

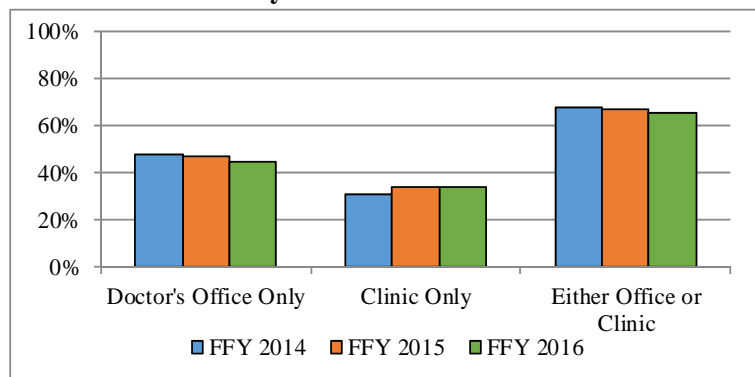
On the other hand, the *utilization per 1,000 member rate* includes every CHIP member enrolled in the month being examined. It is helpful to measure the utilization per 1,000 rate across different populations (e.g., by age or by race/ethnicity) as a way to conduct an apples-to-apples comparison since 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 visits to their PMP exclusively.¹⁴

On a statewide level, B&A found that 65 percent of CHIP children in the study sample had a primary care visit (either in a doctor’s office or a clinic) in FFY 2016. This is a slight decrease from FFY 2015 when 67 percent of CHIP children had primary care visits.

Exhibit IV.1
Percentage of CHIP Children with Primary Care Visits, by Location of Service



The percent of children that had a primary care visit (either office or clinic setting) has decreased slightly over the past three years for all CHIP Packages. As stated previously, the reduction shown here may be

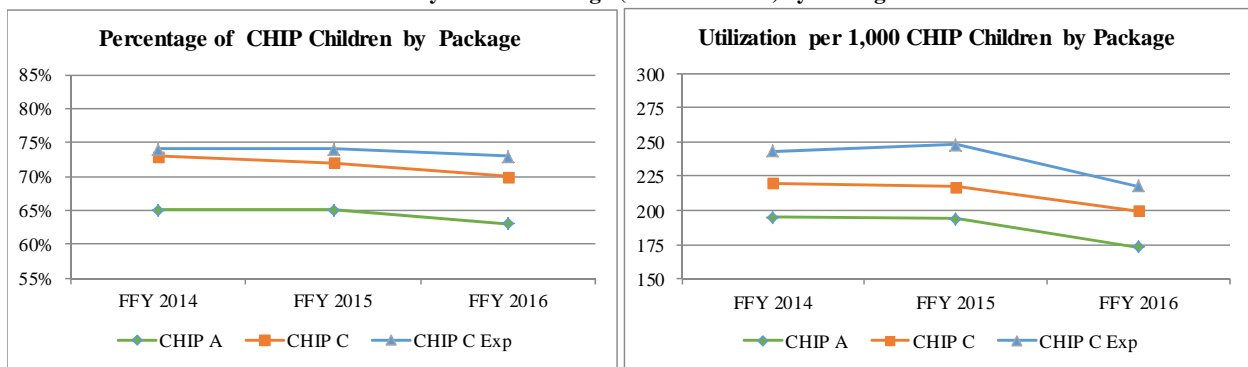
¹⁴ Similar to the access to PMP map in Chapter III, B&A did limit our definition of primary care visit to encounters containing CPT codes in the range: 59425-59430, 99201-99215, 99241-99245, 90862, 99381-99397.

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due, in fact, to claims not being fully submitted to OMPP for the FFY 2016 time period. Because of the large increase in CHIP enrollment in the most recent period, the slightly lower primary care use may be due to educational efforts that the MCEs are conducting with its newest members about the importance of primary care.

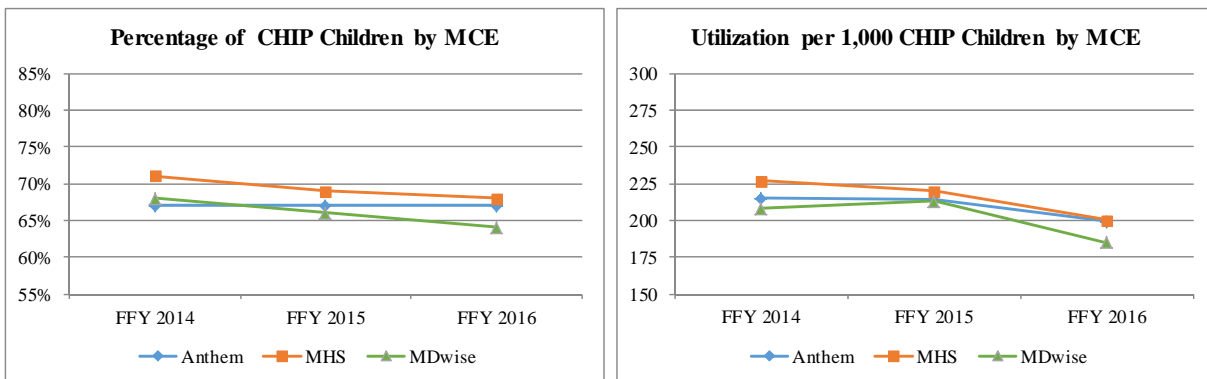
Exhibit IV.2 below shown the use of primary care by CHIP package. The percentage of MCHIP (Package A) children that had a primary care visit in FFY 2016 was lower (63 percent) than SCHIP (Package C) (70 percent) and SCHIP (Package C) Expansion (73 percent) children. The utilization per 1,000 CHIP children decreased in FFY 2016 for all groups within CHIP (refer to Exhibit IV.2, right side). Similar to the chart on the left, children in CHIP Package C Expansion have greater utilization (218 visits per 1,000 members in FFY 2016) than the original CHIP Package C (200 per 1,000) or MCHIP (Package A, 173 per 1,000).

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



Although it was observed that the percent of children that had a primary care visit (either office or clinic setting) has decreased over the past two years for all three MCEs, all three MCEs’ rates are within four percentage points of one another. When utilization is measured on individual claims per 1,000 CHIP members, Anthem and MHS are similar (199 and 200 visits per 1,000 members in FFY 2016, respectively) and MDwise is somewhat lower (185 per 1,000).

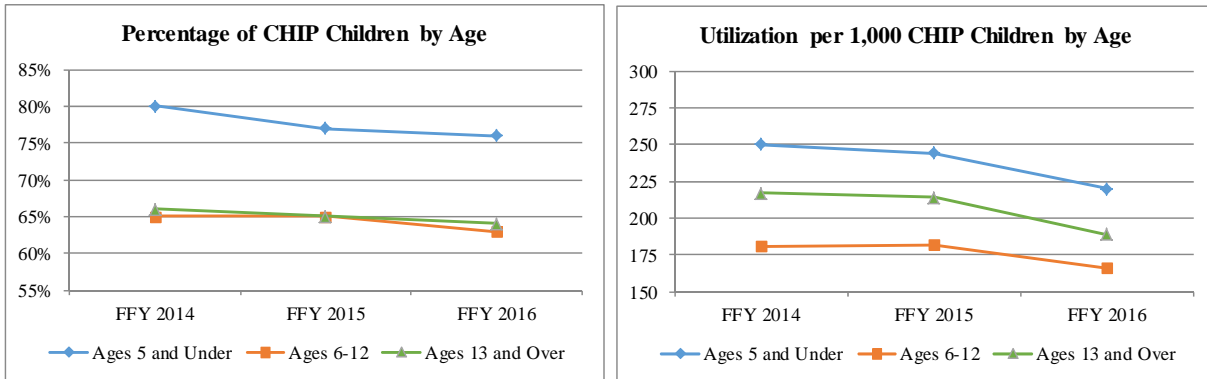
Exhibit IV.3
Primary Care Visit Usage (Office or Clinic) by MCE



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Primary care visits are more prevalent among the youngest members, as 76 percent of children ages 5 and younger had a visit in FFY 2016. The percentage was lower for children in the other age groups (63 percent for children ages 6 to 12 and 64 percent of children ages 13 to 18 in FFY 2016). Although the primary care usage rate was the same for children ages 6 to 12 and ages 13 to 18 in FFY 2016, the actual number of office visits per 1,000 members was higher among children ages 13 to 18 (189 per 1,000) than children ages 6 to 12 (166 per 1,000). It is expected that the children ages 5 and younger will have the highest utilization (220 visits per 1,000) among the age groups. This has remained consistent over the past three years (refer to Exhibit IV.4 below).

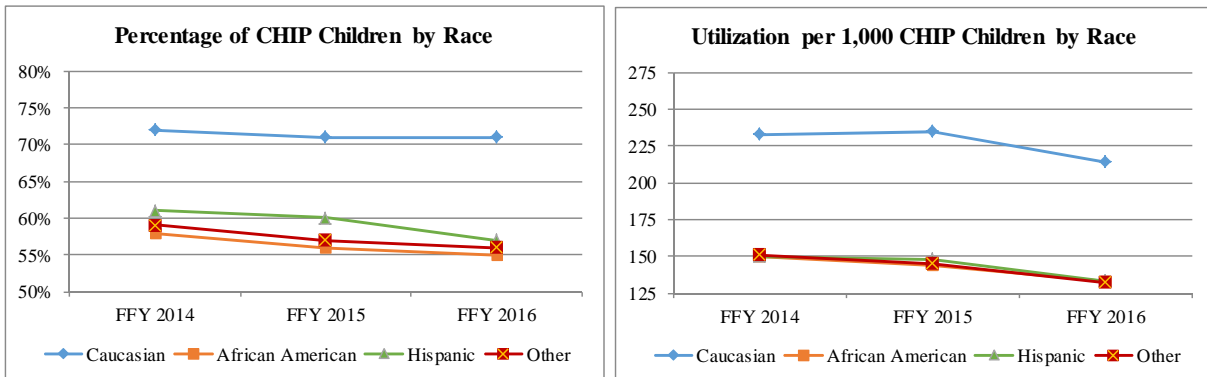
Exhibit IV.4
Primary Care Visit Usage (Office or Clinic) by Age



The percent of children that had a primary care visit within each race/ethnicity examined has seen a slight decline over the past three years. When comparing the rates across races/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other races/ethnicities. For Caucasian children, the usage rate was 71 percent in FFY 2016; for African-American, Hispanic and children other races/ethnicities, the usage rate was similar (55% - 57% for each group).

The utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the years studied, the median rate per 1,000 Caucasian children was 233, whereas the median rate was 144 and 148 among African American and Hispanic children respectively (refer to Exhibit IV.5 below). The utilization rate for children in other race/ethnicities was the same as African-American CHIP children.

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

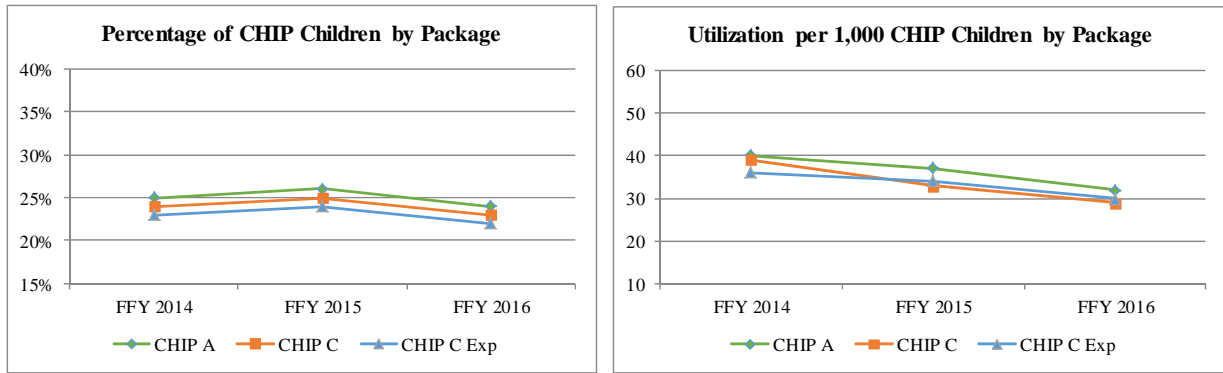


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Emergency Room Visits

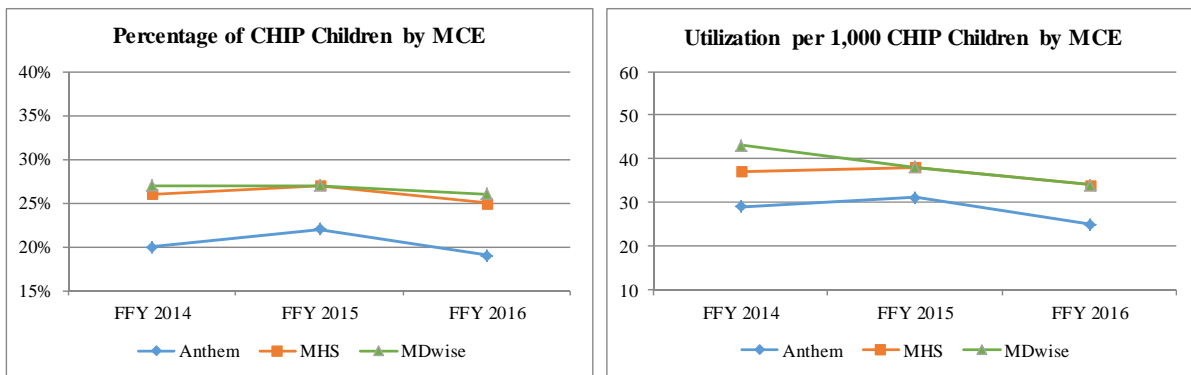
The rate of Emergency Room visits by CHIP children in all packages has decreased slightly from FFY 2015 to FFY 2016 after it increased from FFY 2014 to FFY 2015. The rate of Emergency Room visits by package was similar with a spread of only two percentage points each year. The expansion portion of SCHIP (Package C) children had the lowest rate (22 percent) of Emergency Room visits in FFY 2016, followed by SCHIP (Package C) children (23 percent) and MCHIP (Package A) children (24 percent). When considering emergency room visits per 1,000 CHIP children, the trend is a decrease across years and across packages. There were 29 to 32 ER visits per 1,000 members reported in FFY 2016 (refer to Exhibit IV.6 below). The ER visits among MCHIP, in particular, has gone down since FFY 2013.

Exhibit IV.6
Emergency Room Usage by Package



There was a difference in the percentage of CHIP children that had an ER visit when analyzed by MCE. Anthem has maintained the lowest utilization (25 visits per 1,000 CHIP members in FFY 2016) while MHS and MDwise were the same (34 per 1,000 in FFY 2016). Refer to Exhibit IV.7 below). On a utilization per 1,000 member basis, Anthem had 25 visits in FFY 2016 which was lower than MHS and MDwise (each with 34 visits per 1,000 members).

Exhibit IV.7
Emergency Room Usage by MCE



The large majority of children (85.8%) who used the ER during FFY 2016 had one or two visits during the year. This compares to 84.9 percent that was reported in FFY 2015. As shown in Exhibit IV.8 on the next page, this statistic is consistent across the three MCEs as well. Each of the MCEs improved upon the number of children who had three to five ER visits when compared to the results shown last year (15.2% of children had three to five visits last year).

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Exhibit IV.8

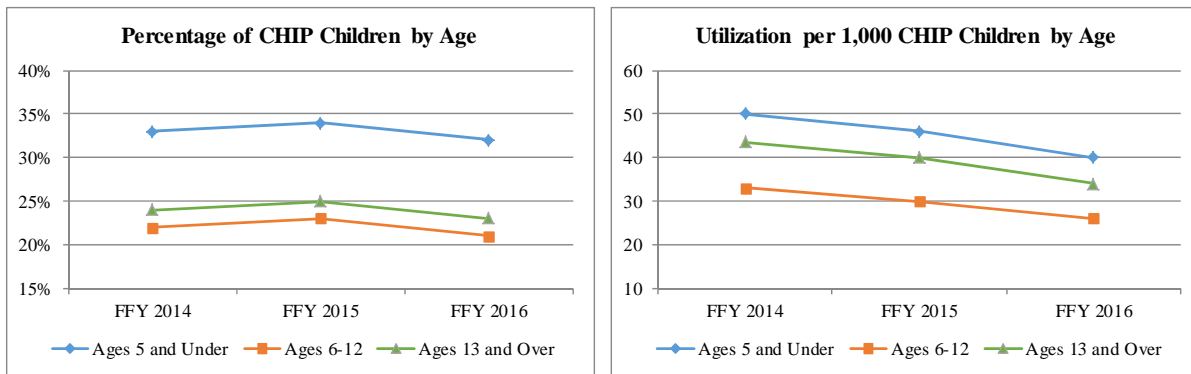
**Rate of ER Utilization Among CHIP Members Using ER Services
For Claims Submitted with Dates of Service Oct 1, 2015 - Sept 30, 2016**

Number of ER Visits per Member	Percentage of All ER Visits by MCE			Total
	Anthem	MHS	MDwise	
1 to 2	86.0%	85.4%	86.0%	85.8%
3 to 5	11.5%	12.0%	11.8%	11.8%
6 to 10	2.0%	2.1%	1.8%	1.9%
11 to 20	0.4%	0.5%	0.3%	0.4%
More than 20	0.0%	0.1%	0.1%	0.1%

Source: Indiana's FSSA Enterprise Data Warehouse

Differences in ER use are found by age group within the CHIP. Higher use was found among children ages 5 and under (32 percent of all members in this age group used the ER in FFY 2016). ER use was lowest among children ages 6 to 12 (21 percent of all members in the age group used the ER in FFY 2016). Like the pattern seen overall, ER usage has decreased slightly for all age groups between FFY 2014 and FFY 2016. The rate was 40 visits per 1,000 members on average for children ages 5 and under and 34 visits per 1,000 members for 13 to 18 year olds in FFY 2016. The rate was lower for children ages 6 to 12 (26 visits per 1,000 members).

**Exhibit IV.9
Emergency Room Usage by Age**

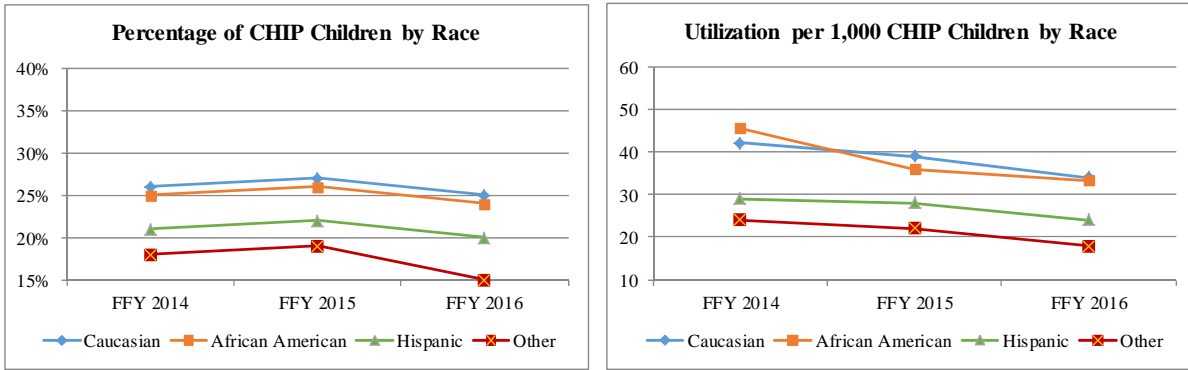


The percent of CHIP children that had an emergency room visit as well as the utilization per 1,000 members was almost identical for Caucasian and African-American CHIP children in FFY 2016. There were 25 percent of Caucasian children with an ER visit, 24 percent of African American children, 20 percent of Hispanic children, and 15 percent of children from other races/ethnicities.

Caucasian children visit the emergency room more frequently than their peers. (Refer to Exhibit IV.10 on the next page). The utilization rate per 1,000 decreased significantly over the three years, however, for African American children (45 ER visits per 1,000 in FFY 2014 to 33 visits per 1,000 in FFY 2016). For children in other race/ethnicities, the ER visit per 1,000 rate has remained steady.

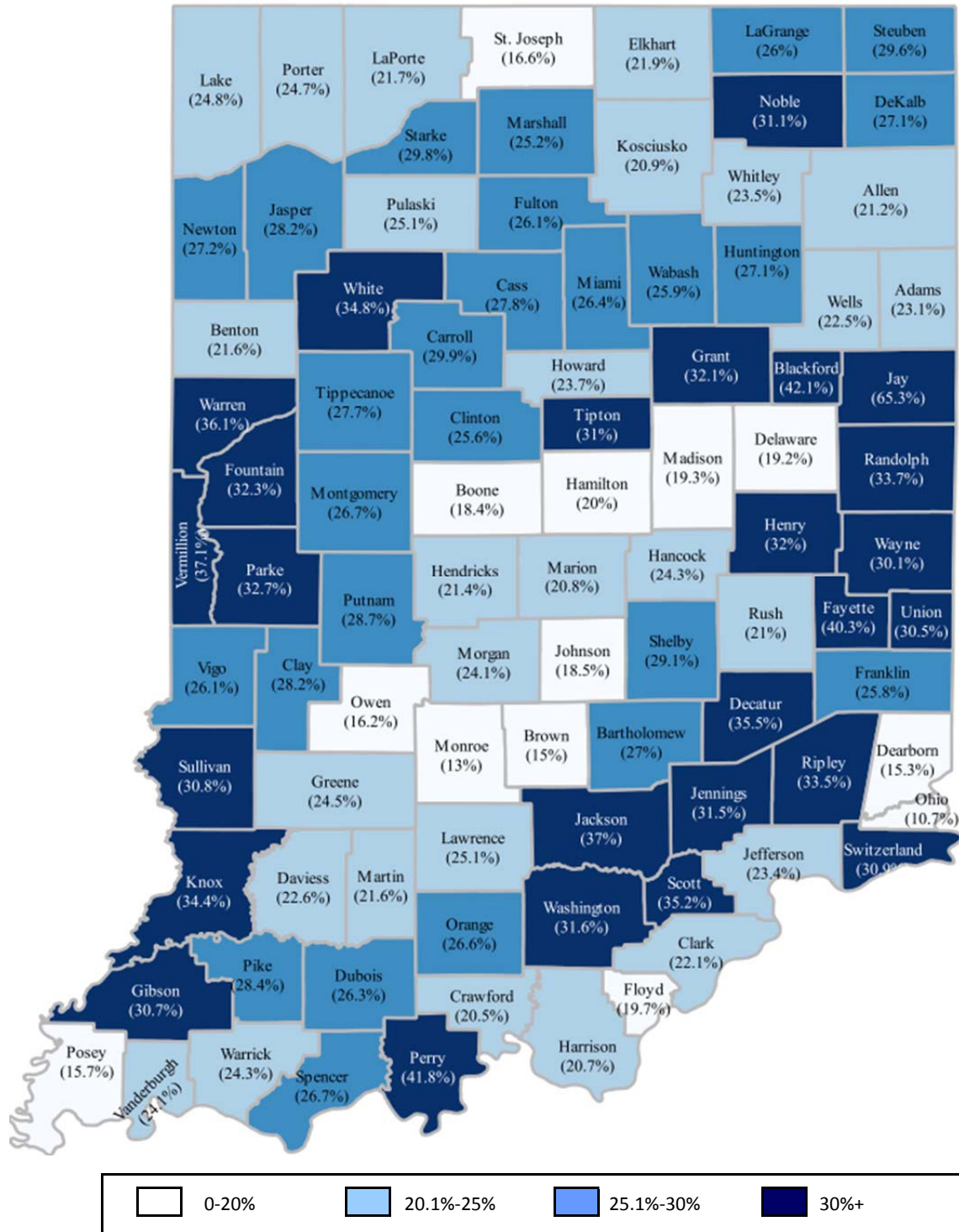
Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

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



ER use does vary at the county level. Exhibit IV.11 on the next page shows that ER use for CHIP members tends to be lowest in the counties located in the Central region of the state and higher in the East Central and West Central counties. In four counties, more than 40 percent of the CHIP members living in the county used the ER in FFY 2016. The counties are Fayette (40.3%), Perry (41.8%), Blackford (42.1%) and Jay (65.3%).

Exhibit IV.11
Percent of CHIP Members Using Hospital Emergency Departments
(During the Period Oct 1, 2015 - Sept 30, 2016)



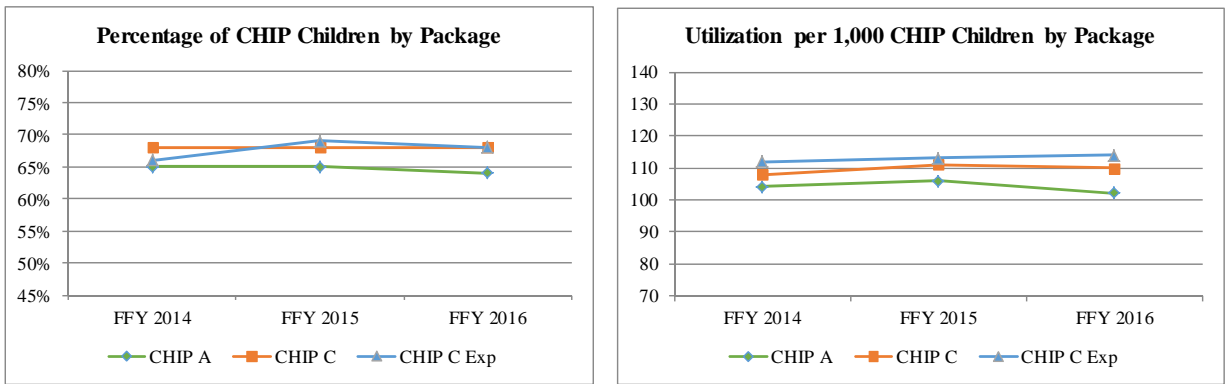
Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

Preventive Dental Visits

Dental care is one of the few services that the MCEs were not responsible for managing in the Hoosier Healthwise (HHW) program in 2016, but this changed at the start of CY 2017 when the MCEs took over this responsibility. In 2016, this service is paid directly to providers by the OMPP. The rate of preventive dental care has remained stable for CHIP children in all packages over the past three years (refer to Exhibit IV.12 below). The percentage of children in MCHIP (Package A), SCHIP (Package C) and SCHIP (Package C) Expansion in FFY 2016 with a preventive dental visit were all between 64 and 68 percent of the total children within each enrollment group.

The same trend was found for utilization per 1,000 members. MCHIP (Package A) children had 102 services per 1,000 members in FFY 2016 while SCHIP (Package C) children had 110 services per 1,000 members and SCHIP (Package C) Expansion had 114 services per 1,000 members. Utilization per 1,000 members has remained stable over the past three years.

Exhibit IV.12
Preventive Dental Care Usage by Package

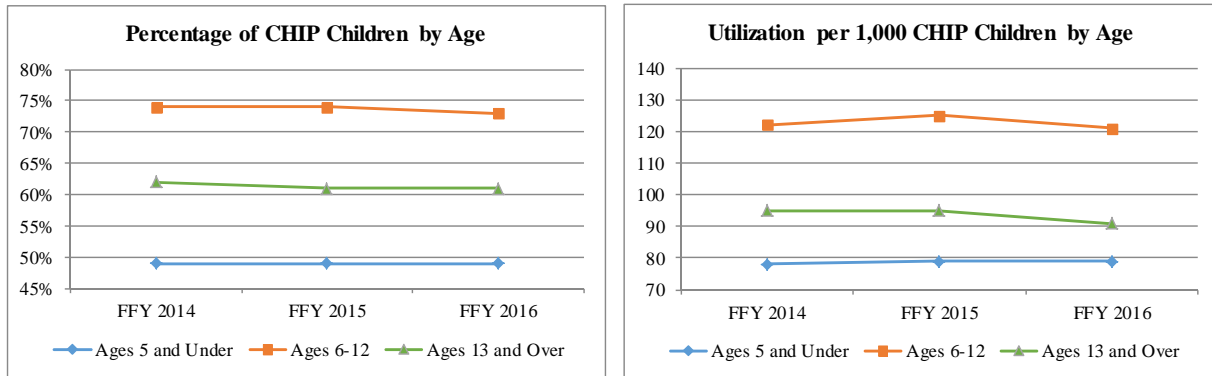


The rate of dental visits has remained steady for all ages in the three years examined, though children ages 6 to 12 are most likely to have received a preventive dental visit (73 percent of the members in FFY 2016), which is significantly higher than teenagers (61 percent). The youngest children had the lowest usage rate (49 percent) given that this group includes toddlers.

A similar pattern was found by age group when measuring the utilization rate of dental visits per 1,000 CHIP members. The rate of 121 visits per 1,000 members ages 6 to 12 remained consistent with prior years and also remains higher than the rate for children ages 13 to 18 (91 visits per 1,000 members) and higher than the rate for children ages 0 to 5 (79 visits per 1,000 members) in FFY 2016. (Refer to Exhibit IV.13 on the next page).

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

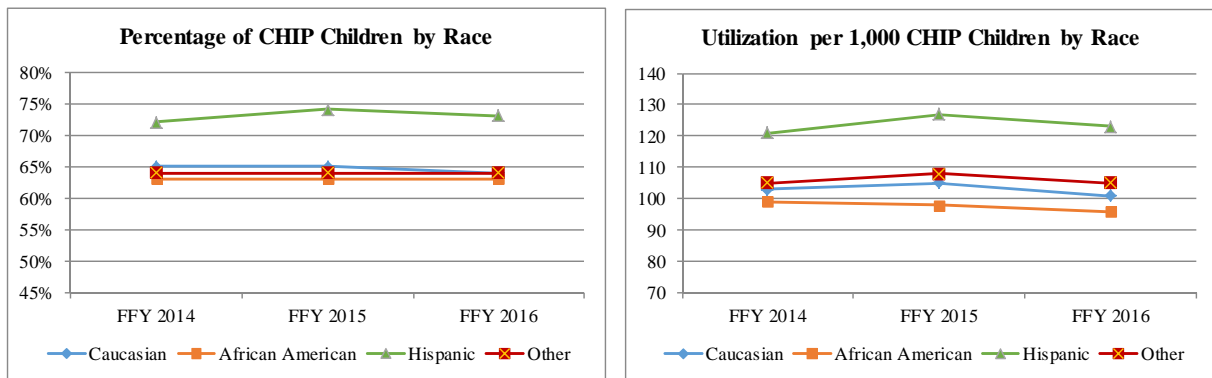
**Exhibit IV.13
Preventive Dental Care Usage by Age**



When examining by race/ethnicity, more Hispanic children used dental services (73 percent) than other race/ethnicities (63 to 64 percent). This trend was consistent across the three years studied.

There is a slight variation in the utilization rate per 1,000 CHIP members among races/ethnicities. Hispanic children are most likely to have a preventive dental visit at 123 visits per 1,000 members in FFY 2016, while African American children and Caucasian children were least likely at 96 visits and 101 visits per 1,000 members, respectively, in FFY 2016. Children of all other races had 105 visit per 1,000 members in FFY 2016 (refer to Exhibit IV.14 below).

**Exhibit IV.14
Preventive Dental Care Usage by Race**

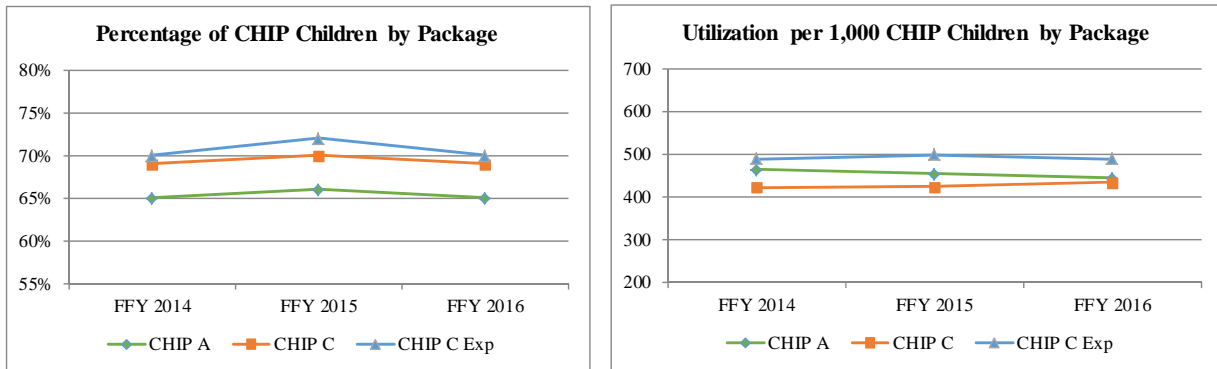


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Pharmacy Prescriptions

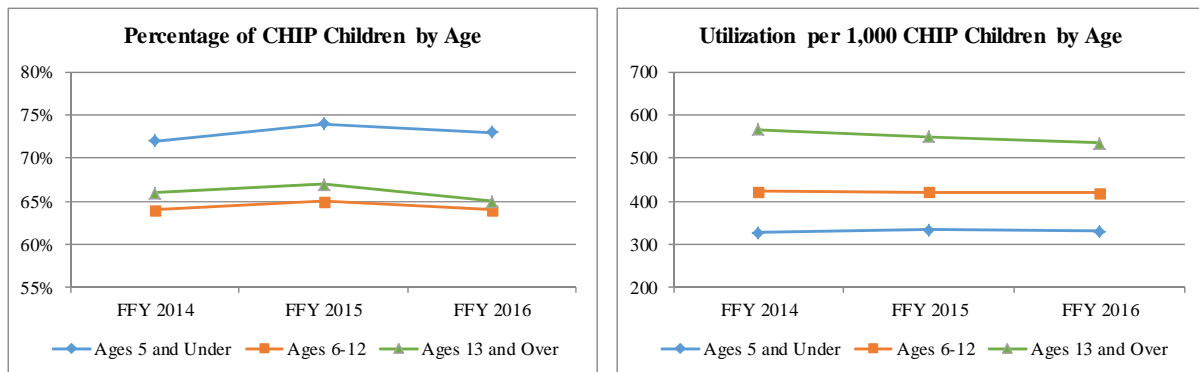
The administration of the pharmacy benefit is the other major service that was managed by the State in 2016 and was not included in the capitation payment paid to the MCEs. MCHIP (Package A) children are least likely to have a prescription with 65 percent in FFY 2016. SCHIP (Package C) children (original and expansion populations) are more likely to have a prescription with a rate of 69 and 70 percent, respectively, in FFY 2016. The utilization per 1,000 members is more similar, however, between MCHIP (Package A) and SCHIP (Package C) at 440 scripts per 1,000 members. For CHIP C Expansion, the utilization is higher at 489 scripts per 1,000 members in FFY 2016. (Refer to Exhibit IV.16)

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



There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children ages 5 and under over the last three years (73 percent in FFY 2016). Children in the two older groups were less with 64 percent of children ages 6 to 12 and 65 percent of teenagers in FFY 2016. Though fewer children in the older age groups obtained a prescription, they obtained more of them in the last three years. The prescriptions per 1,000 members in FFY 2016 was 330 for children age 5 and under, 420 for children age 6 to 12, and 534 for children age 13 to 18 (refer to Exhibit IV.16 below).

**Exhibit IV.16
Pharmacy Usage by Age**

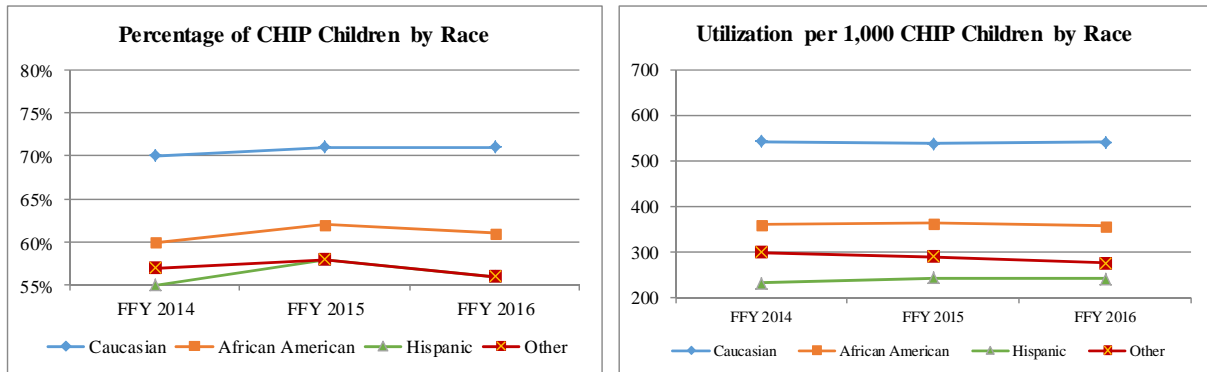


Comparing across races/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities. In FFY 2016, the usage rate among Caucasians children was 71 percent but it was 61 percent for African-American children and 56 percent for Hispanic children and children of other race/ethnicities. This has been a consistent finding in the CHIP for the last seven years.

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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 in FFY 2016. Caucasian children have a utilization rate of 541 prescriptions per 1,000 members each month, which is 51 percent higher than the rate for African-American children (358 prescriptions per 1,000 children) and more than double the rate of children of Hispanic children (243 prescriptions per 1,000 children). It is 96 percent higher than the rate seen for children of other race/ethnicities (276 prescriptions per 1,000 children). (Refer to Exhibit IV.17 below.)

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



V

Measuring Quality and Outcomes in Indiana's CHIP



Quality and Outcome Results at a Glance

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

- 88% favorable rating for their health care and personal doctor
- 87-89% favorable rating among the three health plans
- Over 90% of parents stated they always or usually receive care quickly

Results from HEDIS well child visit measures:

- 67%-77% rating across the three health plans for infant visits (6 or more)
- 72%-85% rating across the health plans for children age 3-6 (annual visit)
- 59%-73% rating across the health plans for adolescents (annual visit)

Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

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

OMPP's Oversight of Quality

OMPP staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCE's site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity¹⁵ to conduct an annual external quality review of each MCE and reviews the results with each MCE.

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

1. OMPP requires the three HHW MCEs to report the results of HEDIS®¹⁶ and CAHPS®¹⁷ measures. The HEDIS are nationally-recognized measures since the health plans that report their results nationally use standard definitions and results are attested by certified auditors of the National Committee of Quality Assurance. The OMPP compares the results of the HEDIS measures across the three MCEs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS survey is separated between one for adults and one for parents of children. The OMPP requires the MCEs to administer each survey annually.
2. Separately, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Centers for Medicare and Medicaid (CMS) was required to develop a core set of measures related to children's health and to collect the results of these measures on a voluntary basis from state Medicaid and CHIP programs. Currently, there are 24 core measures identified by CMS. These include some HEDIS and CAHPS measures as well. CMS hires a national evaluator to analyze the results of these measures and make comparisons across the state Medicaid agencies.
3. When OMPP developed the CHIP and gained CMS approval for federal matching funds, the federal government required that the State develop strategic objectives and performance goals for Indiana's CHIP. The review of these performance goals are part of the OMPP's overall quality strategy and results are submitted in an annual report required by CMS.
4. In addition to the goals set for its CHIP program specifically, the OMPP also develops a Quality Strategy plan each year. Many items within the Quality Strategy pertain to outcomes for children, both CHIP and traditional Medicaid members. For example, current goals include improving the participation rate for Early Periodic Screening, Diagnosis and Treatment (EPSDT) and ensuring follow-up care for behavioral health hospitalizations within seven days of discharge.

¹⁵ Burns & Associates, Inc. is also the External Quality Review Organization under contract with the OMPP.

¹⁶ The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁷ The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

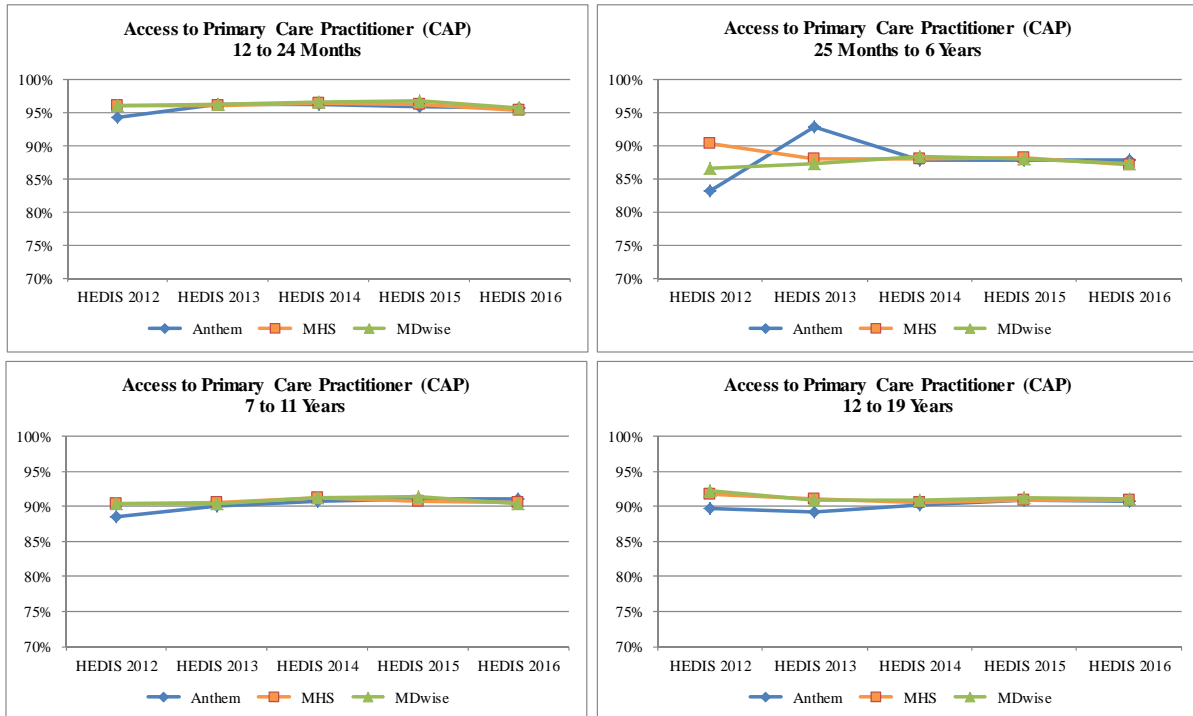
HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members from the prior year. Therefore, in Calendar Year (CY) 2016, tabulations were collected on HEDIS rates for 2015 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 MCEs are required to contract with a certified external HEDIS auditor to collect the results of these measures. It should be noted that all results shown in this section reflect CHIP members as well as children in the traditional Medicaid program who are enrolled in Hoosier Healthwise.

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

Exhibit V.1 below shows the five year trend reported for each MCE for four age groups. For the youngest children age 12 to 24 months (upper left box), each of the MCEs have similar access at 96 percent. For the age group 25 months to six year (upper right box), all MCEs have reported 87 or 88 percent in the last three measurement years. For children age 7 to 11 years (lower right box), Anthem and MHS reported the same result at 91 percent and MDwise reported 90 percent. For the oldest children in the program (lower right box), all three MCEs reported 91 percent.

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



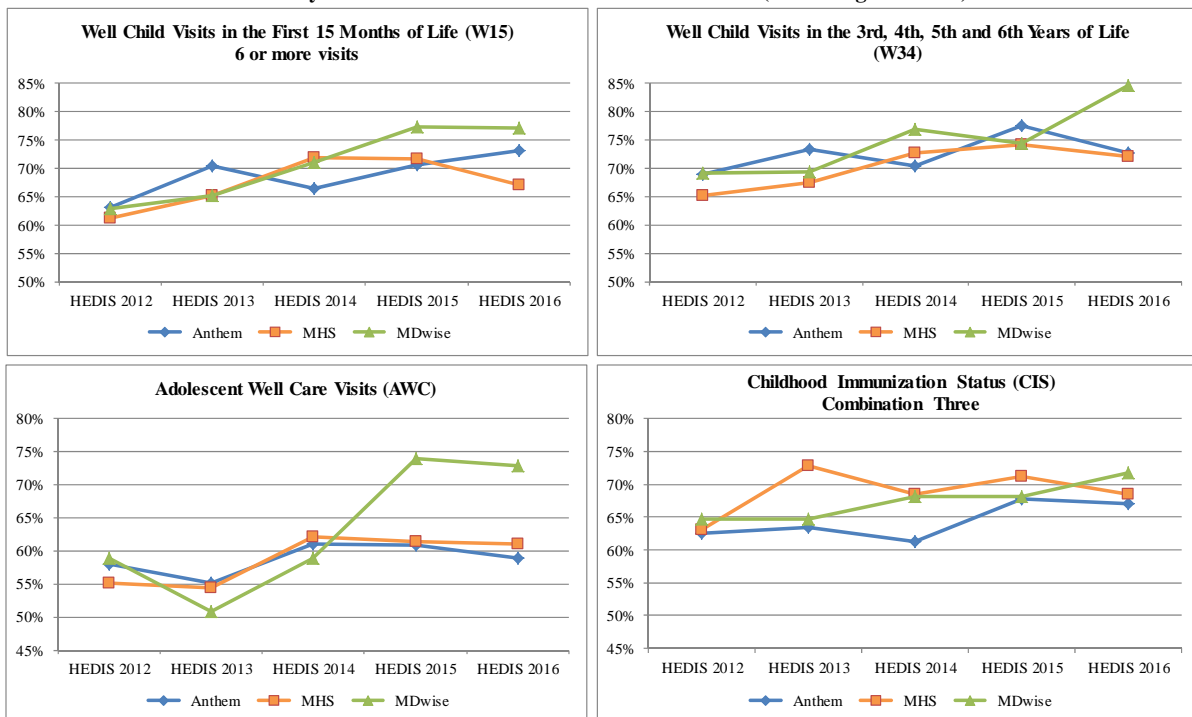
Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

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

Significant improvement has been found for the rate of well care visits among infants. In the most recent reporting year (HEDIS 2016), Anthem reported 73 percent of infants had six or more visits, MHS reported 67 percent, and MDwise reported 77 percent. There has also been improvement in the annual visits for the other age groups. In the most recent reporting year, for children age 3-6, Anthem reported that 73 percent had an annual well care visit, MHS reported 72 percent, and MDwise reported 85 percent. For adolescent well care, both Anthem and MHS have been steady the last two years. Anthem reported a rate of 59 percent in the latest year’s results and MHS reported 61 percent. MDwise, however, saw significant improvement moving from a rate of 59 percent in HEDIS 2014 to a rate of 73 percent reported in HEDIS 2016.

Another measure for well child care relates to immunizations (bottom right box). There is a HEDIS measure to report the percentage of children who turned age 2 during the measurement year who were enrolled for the 12 months prior to their second birthday who received the immunizations as recommended by the American Academy of Pediatrics. Anthem’ results have remained steady in the last two years (67 percent), MHS had a slight drop but still above Anthem (69 percent) and MDwise saw an increase in the last reporting year (72 percent).

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

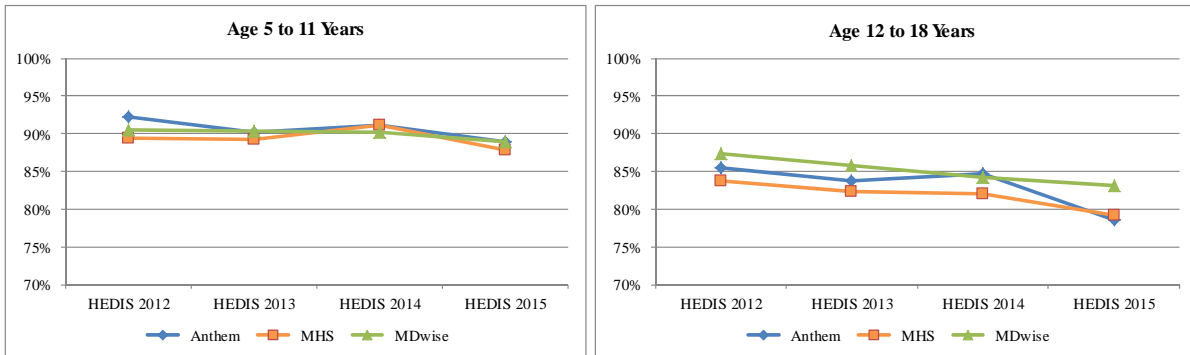


Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

Exhibit V.3 presents the results from HEDIS measures related to appropriate medication for people with asthma. The left box represents findings for children age 5 to 11 whereas the right box represents findings for children age 12 to 18 years. The NCQA, who are the stewards of these measures, has changed the way in which they measure medication adherence for asthma. Therefore, for trending, only the results from HEDIS 2012 through 2015 are shown.

The results for medication adherence for children age 5 to 11 has been very steady in the last four years reported and consistent across the three MCEs. In the most recent year of HEDIS 2015, both Anthem and MDwise reported a rate of 89 percent and MHS reported 88 percent. Medication adherence for children age 12 to 18 has fallen during this time. In HEDIS 2015, both Anthem and MHS reported 79 percent when both MCEs had rates at 84 percent a few years prior. MDwise reported 83 percent in its most recent year but had reported a rate as high as 87 percent in HEDIS 2012.

Exhibit V.3
Summary of Results from HEDIS Use of Appropriate Medication for People with Asthma (Percentage of Total)



Note: NCQA retired this asthma measure in 2015.

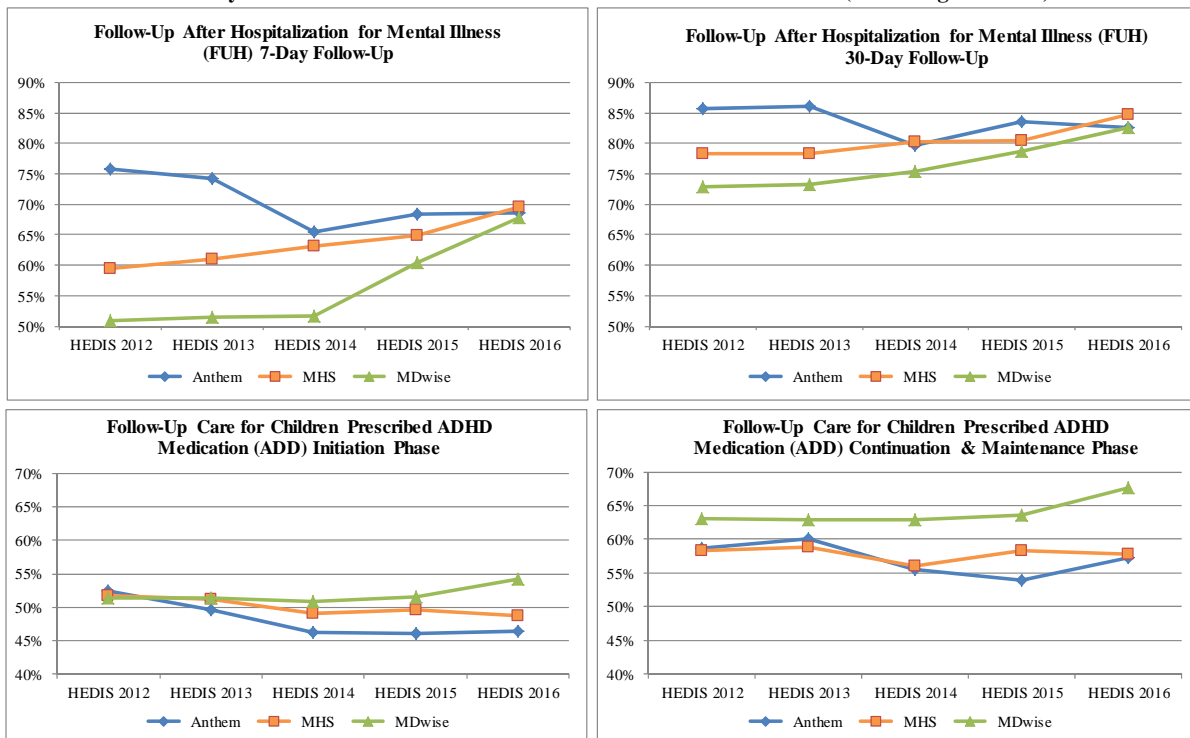
Independent Evaluation of Indiana’s Children’s Health Insurance Program for Calendar Year 2016

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

Results for the follow-up visit within 30 days of a hospitalization are high and are consistent across the MCEs (upper right box). Anthem and MDwise reported 83 percent compliance and MHS reported 85 percent compliance in the HEDIS 2016 year. More immediate follow-up within seven days does not have as high compliance but the trends have not been consistent across the three MCEs. In the most recent year reported, however, all three MCEs had a rate of 69 percent.

The compliance related to visits after being prescribed ADHD medication could see improvement. The three MCEs reported consistent results in the initiation phase measure (46% - 54% reported in HEDIS 2016). In the continuation and maintenance phase measure, Anthem and MHS reported similar rates at 58 percent but MDwise reported a higher rate at 68 percent.

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



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CAHPS Results for Children Enrolled in Hoosier Healthwise

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

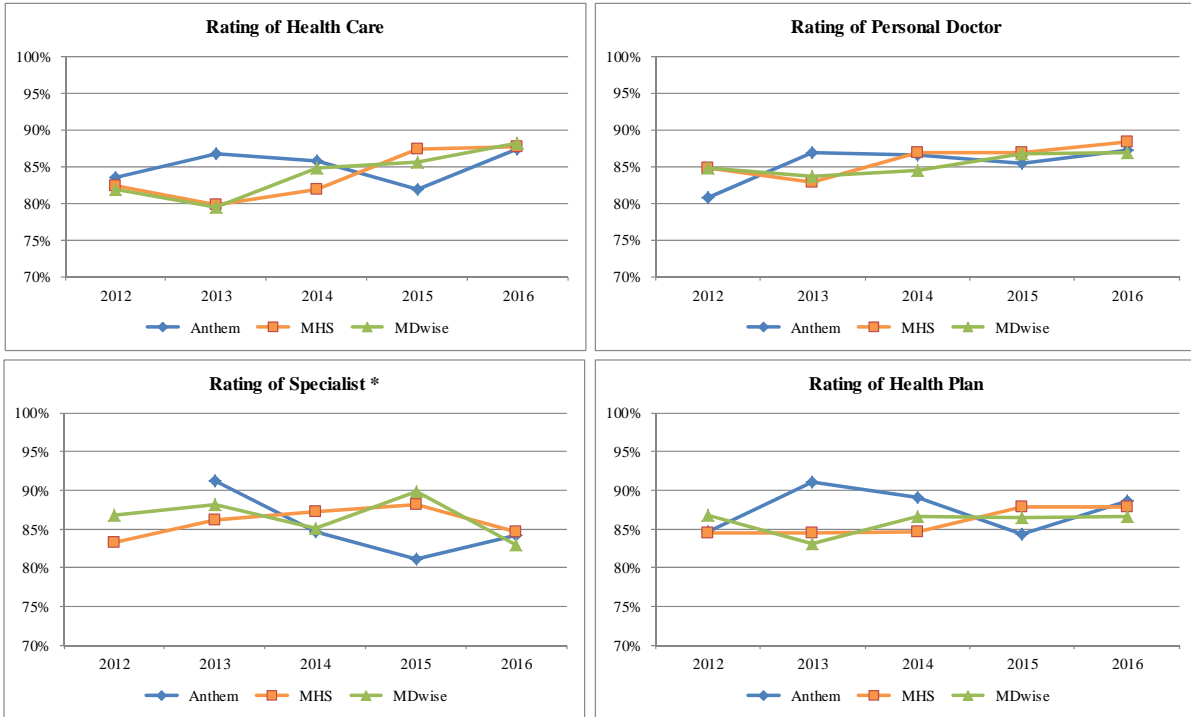
The percentages in Exhibit V.5 on the next page reflect those members that gave a rating of 8, 9 or 10 for each rating, where zero is the “worst possible” and 10 is the “best possible.” On all four ratings measured, all three MCEs had rates between 83 and 89 percent across all five years reviewed. The 2016 results were almost the same for all three MCEs across all four rating categories. Some notable changes from the 2015 survey were that MDwise’s Rating of Specialist dropped from 90 percent to 83 percent while Anthem’s Rating of Health Plan increased from 84 percent to 89 percent.

The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The results in Exhibit V.6 on the next page represent four composite scores that show the percentage of respondents that answered “Usually” or “Always” to the series of questions on the topic. Each of the MCEs scored best on the composite score for How Well Doctors Communicate (92 to 95 percent of members responded usually or always). The MCEs also scored similarly in the most recent survey on Getting Needed Care (85 to 87 percent), Getting Care Quickly (91 to 92 percent) and Customer Service (88 to 90 percent) and. MHS members reported the most favorable rating with 91 percent in the 2015 survey but this has fallen in the 2016 survey closer to the results reported from the other two MCEs.

Independent Evaluation of Indiana's Children's Health Insurance Program for Calendar Year 2016

Exhibit V.5

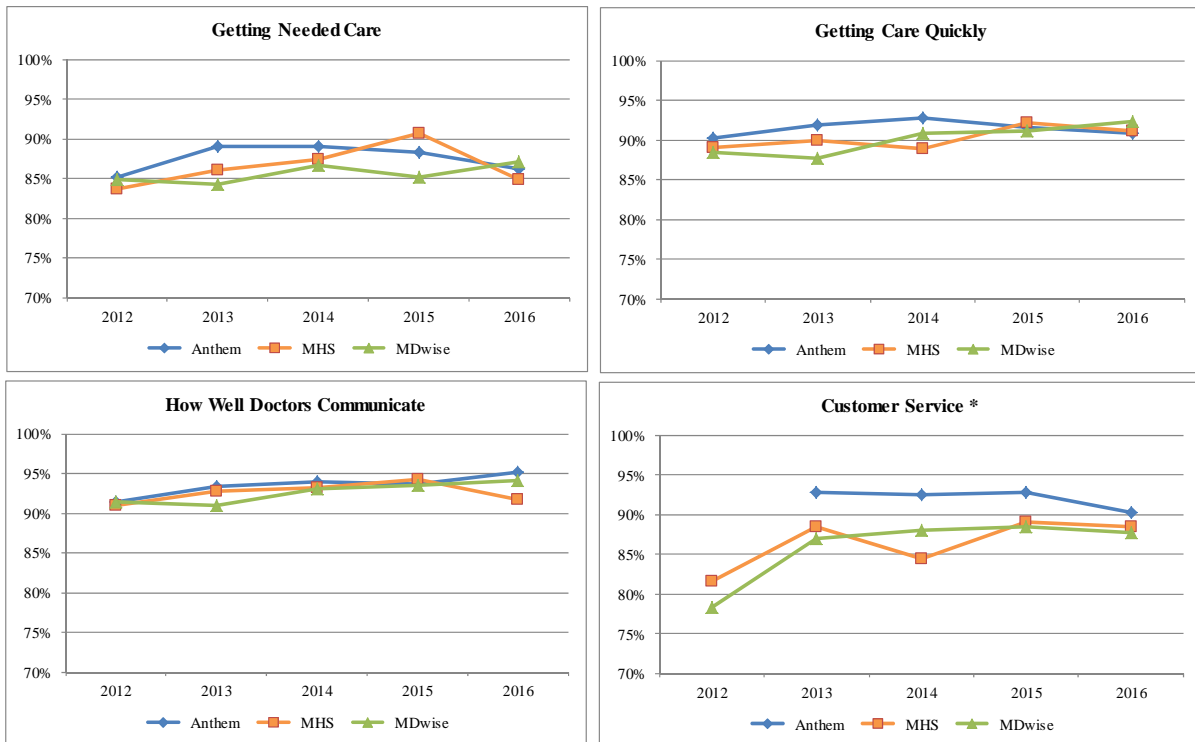
Summary of Scores from CAHPS Child Survey 2011 to 2015 (Members giving a rating of 8, 9, or 10 on 10-point scale)



* Anthem did not report in 2012 due to small sample size.

Exhibit V.6

Summary of Scores from CAHPS Child Survey 2011 to 2015 (Percentages reflect responses of "Usually" or "Always")



* Anthem did not report in 2012 due to small sample size.