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

Final Report – April 2014


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**ACKNOWLEDGMENTS**

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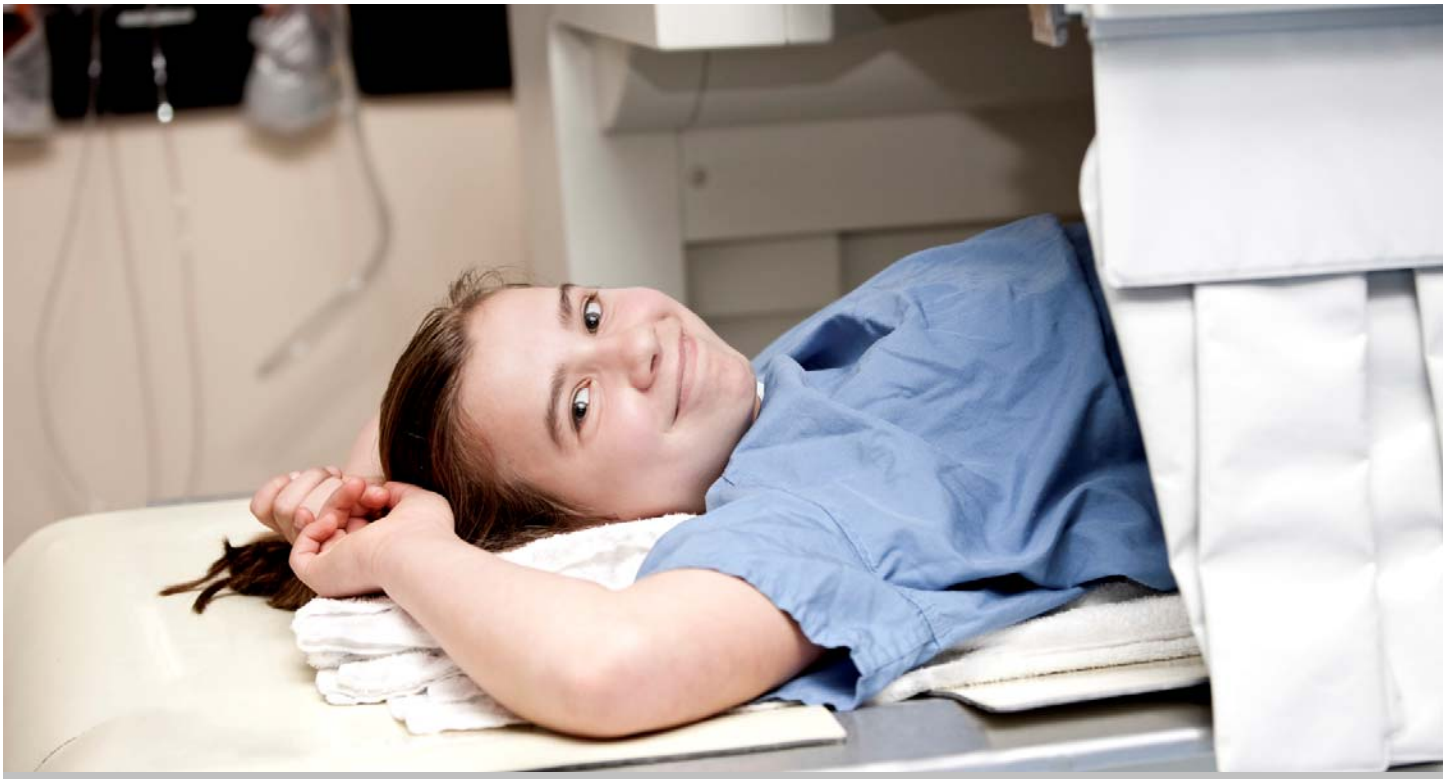
# Executive Summary



As of December 2013, enrollment in Indiana's CHIP was at 84,317, a 1.6 percent increase over the prior year's membership of 83,028. Over the last three years, enrollment has decreased 2.1 percent. Continued enrollment growth in Indiana's CHIP over the last 15 years 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 10.3 percent compared to the national average of 14.4 percent. This places Indiana 15th lowest among states nationally[1].

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

- CHIP Package A (the Medicaid expansion portion or MCHIP) covers uninsured children in families with incomes up to 150 percent of the FPL ($35,325 per year for a family of four in 2013) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

- CHIP Package C (the non-entitlement portion or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.
    - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 150 percent up to 200 percent of the FPL ($47,100 per year for a family of four in 2013).
    - 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 ($58,875 per year for a family of four in 2013).

The largest enrollment growth has been among families enrolled in the expansion portion of SCHIP (Package C). In the last year, this portion of the program has grown 10.2 percent (compared to a 2.0 percent decrease in MCHIP (Package A) and a 9.4 percent increase in non-expansion SCHIP (Package C) during the same time period).

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

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

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2013. The OMPP is a part of the Family and Social

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

Services Administration (FSSA) and is responsible for administering Indiana's CHIP, with support from the Division of Family Resources which conducts eligibility determinations.

## Background on Indiana's CHIP

The enrollment of children in Indiana's CHIP is spread proportionally across the regions of the state when compared to the overall census of children in each region. Nearly 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 17 percent are under age 5. This distribution has been the case since the CHIP was introduced.

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

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

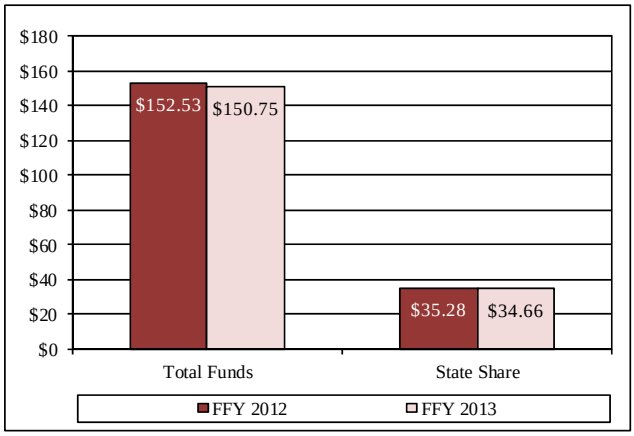
**Monthly Premiums Charged to Families in Indiana's SCHIP (Package C)**

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

Like the Medicaid program, the CHIP is funded jointly by the federal government and the states, subject to an annual cap. In the CHIP, however, the federal match rate is higher than Medicaid. For example, in Federal Fiscal Year (FFY) 2013, for every dollar spent on medical services in Indiana's CHIP, the state paid 22.99 cents and the federal government matched the remaining 77.01 cents. In the Medicaid program, the federal government match rate was 67.16 cents. The exception to the higher federal match rate is that MCHIP (Package A) children with Third Party Liability (TPL) insurance are not eligible for the higher match rate.

Because of the higher federal match rate and the premiums paid by SCHIP (Package C) families, the state share paid towards SCHIP (Package C) members is more cost effective when measured on a per member per month (PMPM) basis when compared to the PMPM paid for children in the Medicaid portion of Hoosier Healthwise. The SCHIP (Package C) PMPM cost to the State decreased slightly from FFY 2012 to FFY 2013 from $35.28 to $34.66.

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




Sources: Expenditures from FSSA Enterprise Data Warehouse
Member months also from Data Warehouse (as of March 2014).
Premium payments from CMS-21 reports submitted by the State to CMS.

## 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 rated higher than national benchmarks on member satisfaction for questions related to Getting Needed Care, Getting Care Quickly, and Customer Service. MHS and MDwise also exceeded national benchmarks on Rating of Specialist while Anthem exceeded benchmark on Rating of Health Care.

## Access to Services

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

For primary care visits, B&A first examined the counties where there may be an access issue. Statewide, 54 percent of CHIP members received a primary care service in the county in which they lived in FFY 2013. An additional 22 percent received a primary care service in a contiguous county. Statewide, access to dentists is high since 61 percent of CHIP members had their preventive dental visit in their home county and an additional 24 percent had their visit in a contiguous county.

## 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 2011, FFY 2012 and FFY 2013. The overall rate of usage for each category remained relatively unchanged over the three years. 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 2011 | FFY 2012 | FFY 2013 |
|---|---|---|---|
| Primary Care Visit (office or clinic setting) | 59% | 59% | 58% |
| Emergency Room Visit | 21% | 22% | 21% |
| Preventive Dental Visit | 55% | 56% | 56% |
| Pharmacy Script | 56% | 61% | 59% |

B&A also analyzed the rate at which these services were used by calculating a utilization rate per 1,000 CHIP members overall for 2011, 2012 and 2013 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 and eldest members, as 60 percent of children ages 5 and younger and children ages 13 to 18 had a visit in FFY 2013. The percentage was lower for children in the middle age group (56 percent for ages 6-12 in FFY 2013).

- When comparing the rates across race/ethnicities, Caucasian children were more likely to have had a primary care visit (office or clinic setting) than other race/ethnicities. Hispanic

CHIP children had a primary care visit rate of 50 percent and African American children had a primary care visit rate of 46 percent which was significantly below the 63 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 240 visits per 1,000 children during FFY 2013, but the rate for African American and Hispanic children is closer to 147 visits per 1,000.

- There is a slight difference in the percentage of CHIP children that had an ER visit when analyzed by MCE, but it is more pronounced when reviewed at the per 1,000 member statistic. In FFY 2013, the average rate among MDwise members was 47 ER visits per 1,000 CHIP members; for MHS, it was 40 per 1,000; for Anthem, it was 30 per 1,000.

- Differences in ER use are found by age group within the CHIP. The highest use is among children under age 5 (24 percent of all members in FFY 2013) and lowest among children ages 6 to 12 (19 percent of all members in FFY 2013).

- One in five CHIP members of all race/ethnicities had used the emergency room in each of the years studied, but African-American children were more likely to have had multiple visits.

- The overall percentage of CHIP members receiving a preventive dental visit was 56 percent in FFY 2013.

- Hispanic CHIP children were more likely than children of other races/ethnicities to have a preventive dental visit with a rate of 60 percent in FFY 2013. Caucasian and African American children had a preventive dental visit rate of 56 percent and 53 percent, respectively.

- The overall percentage of members that had a pharmacy prescription has remained relatively unchanged (59 percent) in the last three years.

- The trend in total prescriptions received, however, is different. The number of prescriptions per 1,000 CHIP members is highest for children ages 13-18 (564 prescriptions per 1,000 members on average in FFY 2013), followed by children ages 6-12 (428 prescriptions per 1,000 members), then by children ages 0-5 (335 prescriptions per 1,000 members).

- Caucasian children have a utilization rate of 543 prescriptions per 1,000 members in FFY 2013, which is 51 percent higher than the rate for African-American children (360 prescriptions per 1,000 children) and more than double the rate for Hispanic children (228 prescriptions per 1,000 children).

# I

# Introduction

## *Indiana CHIP at a Glance*

- The uninsured rate for low income children in Indiana is 15th lowest in the country.
- Indiana's CHIP design features are similar to those found in a majority of state programs.

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) Health finance commission established by IC 2-5-23-3*
> *A report provided under this section to the legislative council must be in an electronic format under 5-14-6.*

Burns & Associates, Inc. (B&A) was hired by the Office of Medicaid Policy and Planning (OMPP) to conduct the evaluation for Calendar Year (CY) 2013. The OMPP is a part of the Family and Social Services Administration (FSSA) and is responsible for administering Indiana's CHIP. The OMPP is supported by the Division of Family Resources which conducts eligibility determination for the CHIP.

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

The State Children's Health Insurance Program (S-CHIP) was created by the Balanced Budget Act of 1997 when Congress enacted Title XXI of the Social Security Act. In this legislation, states were allocated funds on an annual basis for a 10-year period to expand health coverage to low-income children. The original legislation was extended to March 31, 2009. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009[2] extended the program to September 2013. The Patient Protection and Affordable Care Act of 2010 extends funding for CHIP through FFY 2015 and continues the authority for the program through FFY 2019. The Congressional Budget Office estimates that the expansion of federal funds will provide coverage to 4.1 million additional children in state Medicaid and CHIP programs who would have otherwise been uninsured by 2013.

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

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

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

- CHIP Package A (the Medicaid expansion portion or MCHIP) covers uninsured children in families with incomes up to 150 percent of the Federal Poverty Level, or FPL ($35,325 per year for a family of four in 2013) who are not already eligible for Medicaid. This portion of CHIP began July 1, 1998.

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

- CHIP Package C (the non-entitlement portion or SCHIP) rolled out in two eligibility increments. Families in SCHIP (Package C) pay monthly premiums whereas the families in MCHIP (Package A) do not. In addition to the income tests shown below, children cannot have insurance coverage from another source.
    - The first portion was introduced on January 1, 2000 to cover children in families with incomes above 150 percent up to 200 percent of the FPL ($47,100 per year for a family of four in 2013).
    - 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 ($58,875 per year for a family of four in 2013).

Half of the states have income eligibility thresholds similar to Indiana. As of January 2013, 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 FPL[3].

As of December 2013, enrollment in Indiana's CHIP was at 84,317[4], a 1.6 percent increase over the prior year membership of 83,028:

- MCHIP (Package A) enrollment was 56,320 (down 2.0 percent from December 2012)
- Enrollment in the initial group of SCHIP (Package C) members was 20,939 (up 9.4 percent from December 2012)
- Enrollment in the 2008 expansion group of SCHIP (Package C) members was 7,058 (up 10.2 percent from December 2012)

More enrollment statistics appear in Chapter II of this report.

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

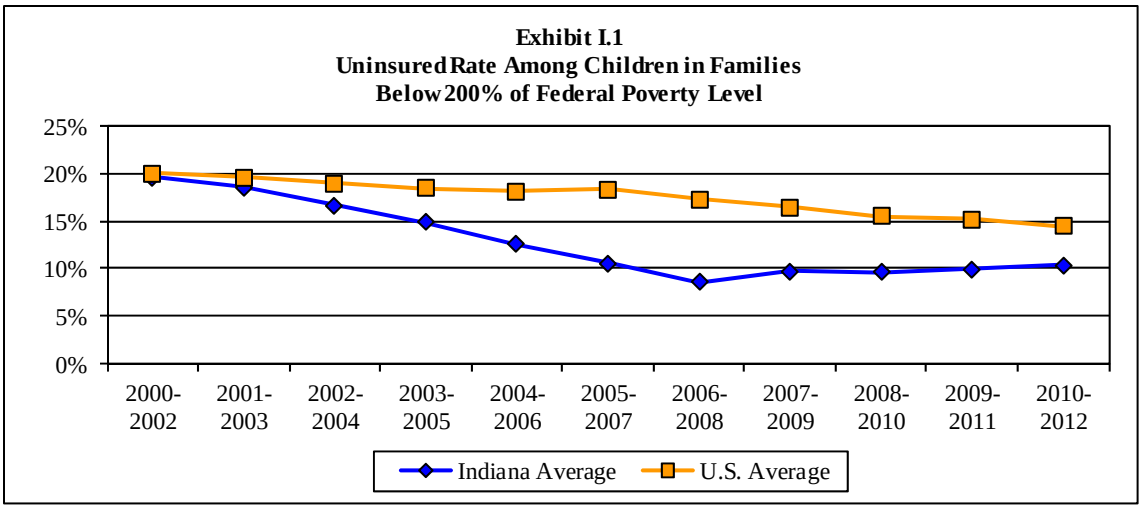
The Census Bureau's Current Population Study (CPS) surveys citizens each March on their health insurance status. An uninsured rate is computed for each state, but because state-specific samples are usually small, it is customary to measure this rate over a three year average. The CPS survey conducted in March 2013 measured insurance status in CY 2012. Therefore, the 2010-2012 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 10.3 percent compared to the national average of 14.4 percent. Indiana's uninsured rate declined for six consecutive study periods before increasing in 2009 (refer to Exhibit I.1 on the next page). It has held steady in the last year. The success in lowering the uninsured rate can be partially attributed to Indiana's effective outreach to enroll children in its CHIP.

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

[4] Enrollment figures retrieved from the Office of Medicaid Policy and Planning's data warehouse, FSSA Enterprise Data Warehouse, on March 14, 2014. Due to still unknown retroactive eligibility, this enrollment figure for December 2013 may be slightly understated from what will be the final figure for this time period.

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




Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements
http://www.census.gov/hhes/www/hlthins/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 81,000 in the 2010-2012 three year average period (Source: Current Population Survey).

Indiana's 10.3 percent uninsured rate among children in families below 200 percent of the FPL places the State as the 15th 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 Exhibits I.2 below and I.3 on the following page). Using the three-year 2010-2012 averages from the Current Population Survey, 81 percent of all uninsured children in Indiana may already be eligible for CHIP based on family income.[5]

**Exhibit I.2**
**Child Uninsured Rates (Age 0-18) by Family Income in Indiana**
**2010 - 2012 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 | 102,024 | 81% | 10.8% |
| Total for Children Not Eligible for Indiana's CHIP | | | |
| 250% and above | 23,174 | 19% | 3.0% |
| **All Children** | **125,198** | **100%** | **9.8%** |

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

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

The uninsured rate for Caucasian children (9.8 percent) in this income group is lower than other race/ethnicities. The rate for African American children (10.6 percent) was near the statewide average, while the rate for Hispanic children (17.0 percent) and children of other race/ethnicities (13.7 percent) 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**
**2010 - 2012 Three-Year Average**

| Race/Ethnicity | Total Uninsured | Pct of Uninsured Children at this FPL | Uninsured Rate |
|---|---|---|---|
| Caucasian Non-Hispanic | 59,911 | 59% | 9.8% |
| African Amer. Non-Hispanic | 19,519 | 19% | 10.6% |
| Hispanic (any race) | 14,274 | 14% | 17.0% |
| All Other Races | 8,320 | 8% | 13.7% |
| **All Children** | **102,024** | **100%** | **10.8%** |

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

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

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

With just a few limitations, Indiana's SCHIP (Package C) members are able to access the same services as their peers in the traditional Medicaid program. 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 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

**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 |
| Curative Care Hospice | Family Planning Services |

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 |
|---|---|---|
| 150% up to 175% | $22 | $33 |
| 175% up to 200% | $33 | $50 |
| 200% up to 225% | $42 | $53 |
| 225% up to 250% | $53 | $70 |

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

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

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

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

[6] Heberlein et al.

## 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) 2013, for every dollar spent on medical services in Indiana's CHIP, the state paid 22.99 cents and the federal government matched the remaining 77.01 cents. In the Medicaid program, the standard rate paid by the State was 32.84 cents and the federal government matched the remaining 67.16 cents. The exception to the higher federal match rate is that MCHIP (Package A) children with Third Party Liability (TPL) insurance are not eligible for the higher match rate.

Medical services other than pharmacy prescriptions and dental visits (and a few other minor services) in Indiana's CHIP are paid to 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 for MCHIP (Package A) and SCHIP (Package C) separately. 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 MCE to join.

In addition to the higher federal match rate for SCHIP (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 MCHIP (Package A).

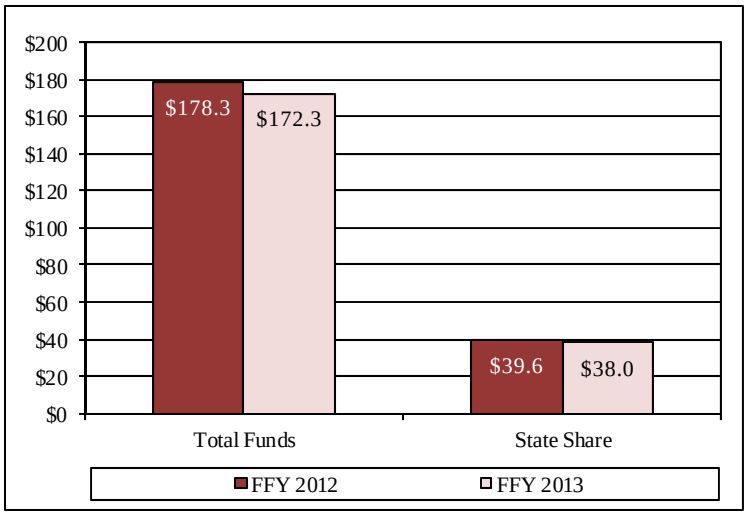
B&A examined expenditures made on behalf of CHIP members in FFYs 2012 and 2013.[7] Data were pulled from the OMPP data warehouse to collect the payments made either as a PMPM to the MCEs or as a fee-for-service payment. The premiums paid by SCHIP (Package C) families (where the premium is required) were obtained from the CMS-21 expenditure reports that the OMPP is required to submit quarterly to CMS.

Medical expenditures in the CHIP (total funds) decreased 3.4 percent over the two-year period, from $178.27 million in FFY 2012 to $172.30 million in FFY 2013. The state share of these expenditures decreased 4.0 percent, from $39.58 million to $38.01 million. The state's portion decreased because the SCHIP (Package C) portion of the program grew more than MCHIP (Package A) and SCHIP (Package C) is where the premium payments are required. Premiums paid by families in SCHIP (Package C) were near $7.0 million in both FFYs 2012 and 2013. (Refer to Exhibit I.6 on the next page.)

Because SCHIP (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 PMPM basis. Exhibit I.7 shows the PMPM medical costs in SCHIP (Package C) for FFYs 2012 and 2013, expressed both in total funds and in state-only funds (net of premiums paid by members and the federal matching funds). The PMPM in total funds decreased by 1.2 percent over the two-year period from $152.53 to $150.75, while the state's outlay on a PMPM basis decreased by 1.8 percent from $35.28 to $34.66. (Refer to Exhibit I.7 on the next page.)

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

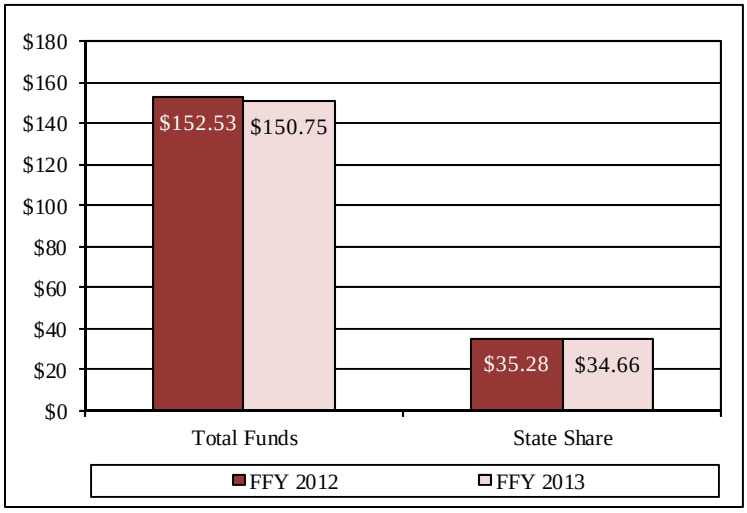
**Exhibit I.6**
**Total Medical Expenditures in CHIP (in millions)**
**MCHIP (Package A) and SCHIP (Package C) Combined**




Sources: Expenditures from FSSA Enterprise Data Warehouse
Payments shown are based on experience period.

Note: Some claims payments may still come in for FFY 2013 which will increase total expenditures in this year.

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




Sources: Expenditures from FSSA Enterprise Data Warehouse
Member months also from Data Warehouse (as of March 2014).
Premium payments from CMS-21 reports submitted by the State to CMS.

# II

# Enrollment Trends in Indiana's CHIP

## *Enrollment Trends at a Glance*

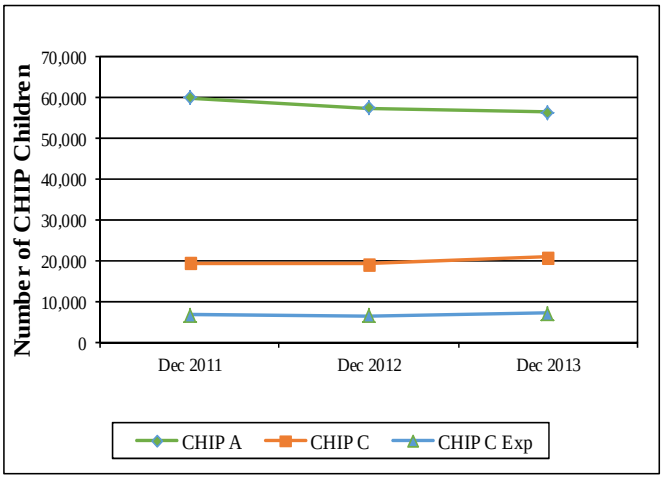
CHIP Enrollment Dec 2012: 83,028
CHIP Enrollment Dec 2013: 84,317

- -2.0% year-to-year growth rate in CHIP Package A
- 9.4% year-to-year growth rate in CHIP Package C
- 10.2% year-to-year growth rate in CHIP Package C Expansion

141,499 children were enrolled in Indiana's CHIP at some point in State Fiscal Year 2013

Indiana's Children's Health Insurance Program (CHIP) experienced an increase in 2013 to 84,317 members from Calendar Year (CY) 2012 of 83,028, a 1.6 percent increase. Over the last three years, enrollment has decreased 2.1 percent. In MCHIP (Package A), the entitlement portion of the program for children in families with incomes up to 150% of the federal poverty level (FPL), enrollment has decreased 6.0 percent since December 2011. In SCHIP (Package C), the non-entitlement portion of the program for children in families with incomes 150%-200% of the FPL, enrollment has grown 7.8 percent during this three-year period. The SCHIP (Package C) Expansion group instituted in October 2008 (201-250% of the FPL) saw enrollment grow 4.7 percent since 2011.

**Exhibit II.1**
**Recent Enrollment in Indiana's CHIP**




Source: Indiana's FSSA Enterprise Data Warehouse

## Enrollment and Disenrollment Trends

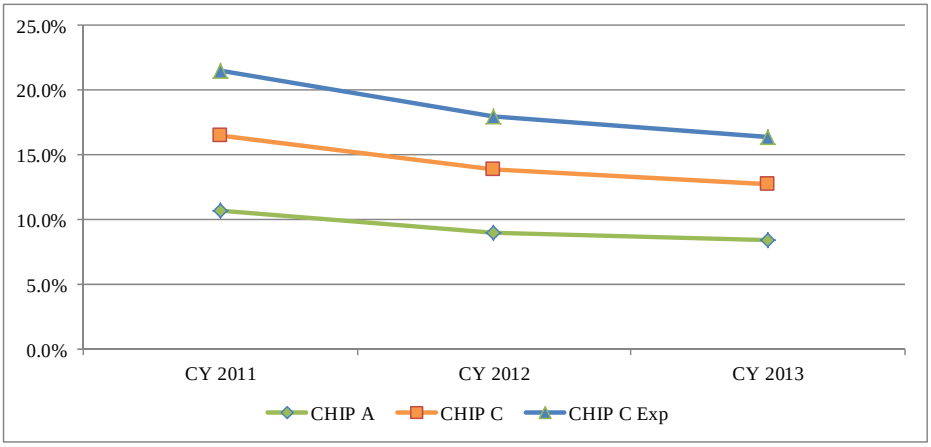
New enrollees continue to remain a large percentage of children in the program, but the proportion of total members that are new each year is decreasing. Burns & Associates, Inc. (B&A) analyzed the enrollment of members within each portion of Indiana's CHIP on a monthly basis. From this, we tabulated how many members in the month were new to the program within the previous 12 months. An average of this statistic was computed across months in CY 2013 and was then compared to a similar statistic for two prior time periods examined in previous reports.

For MCHIP (Package A), the percentage of new enrollees in CY 2013 on average was 8.4 percent per month, a decrease from 8.7 percent in CY 2012 and 10.7 percent in CY 2011 (refer to Exhibit II.2 on the next page).

The percentage of members that were new to the program within SCHIP (Package C), however, was higher. For the original SCHIP (Package C) program (members in families at 150% to 200% of FPL), 12.8 percent of members were new in CY 2013 as compared to 13.7 percent in CY 2012 and 16.5 percent in CY 2011.

For the expansion portion of SCHIP (Package C) (members in families at 151% to 200% FPL), 16.4 percent of members were new in CY 2013 as compared to 18.0 percent new in CY 2012 and 21.5 percent in 2011.

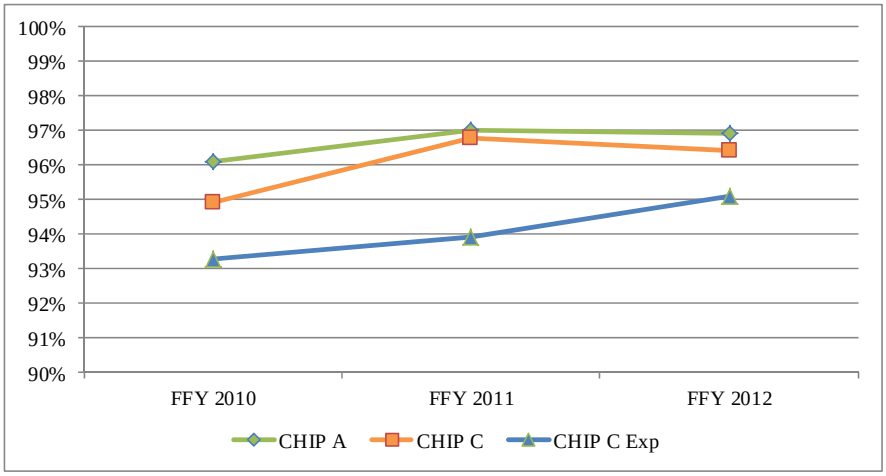
**Exhibit II.2**
**Percent of Enrollees that were New to Program in Previous 12 Months, by Year**




Source: Indiana's FSSA Enterprise Data Warehouse

In addition to the large number of new individuals, the total number of enrollees that stay within Indiana's CHIP also remains high. The retention rates have remained steady for MCHIP (Package A) and SCHIP (Package C) when compared to results reported in two prior periods (FFY 2011 and FFY 2010). For the SCHIP (Package C) Expansion population, the retention rate has improved over the three time periods examined. New enrollees in CHIP were identified in Federal Fiscal Year (FFY) 2012. 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 MCHIP (Package A) members, 96.4 percent for SCHIP (Package C) members and 95.1 percent for SCHIP (Package C) Expansion members.[8]

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



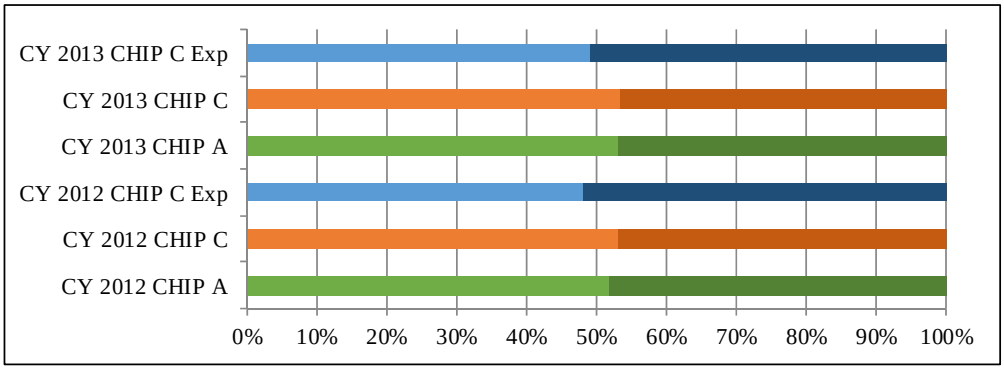

Source: Indiana's FSSA Enterprise Data Warehouse

Although the number of children enrolled at the end of the year increased from CY 2012 to CY 2013 (from 83,028 to 84,317 respectively) the number of children enrolled at any time during the year decreased from CY 2012 to CY 2013 (from 143,709 to 141,499 respectively). However, as was the

[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).

case for the last three calendar years, there were almost twice as many children enrolled at some point in the year when compared to the number enrolled at the end of the year. In CY 2013, there were 141,499[9] children enrolled in Indiana's CHIP at some point during the year—106,252 in MCHIP (Package A), 39,191 in the original portion of SCHIP (Package C) and 14,377 in the SCHIP (Package C) Expansion population. The difference between currently enrolled and ever enrolled can be because children move between the CHIP and Medicaid program, lose coverage when they turn age 19, or may disenroll for other reasons. Exhibit II.4 below shows the difference between enrolled at the end of the calendar year (light colors) and enrolled at any time during the year (dark colors)

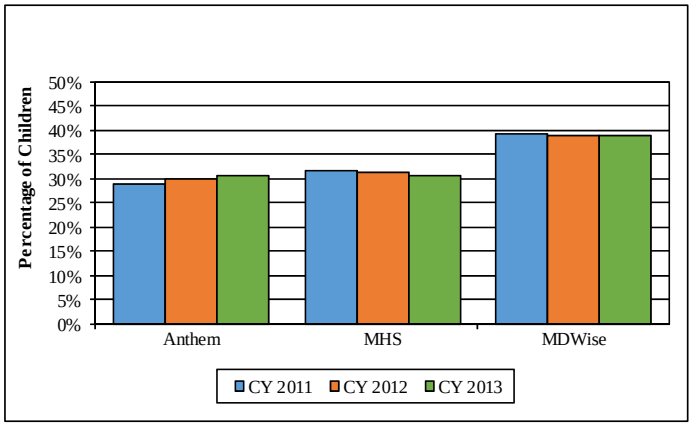
**Exhibit II.4**
**Status of Children Ever Enrolled in CHIP, by Calendar Year**




Source: Indiana's FSSA Enterprise Data Warehouse

Families select a managed care entity (MCE) at the time of application to Hoosier Healthwise. There was some movement in the MCE selected by CHIP members in CY 2013. Anthem increased its percent of all CHIP enrollees from 29.8 percent in CY 2012 to 30.4 percent in CY 2013. MHS decreased its CHIP membership share, from 31.4 percent of all CHIP enrollees in CY 2012 to 30.7 percent in CY 2013. MDwise had a slight decrease in membership share among CHIP members, from its total of 39.8 percent in CY 2012 to 38.9 percent in CY 2013.

**Exhibit II.5**
**Average CHIP Enrollment by MCE**



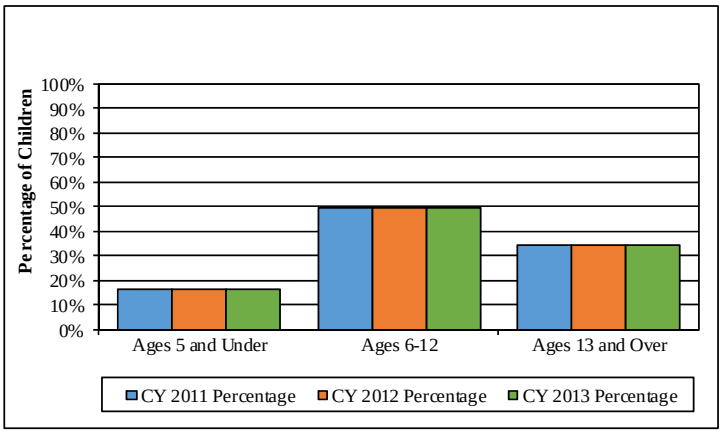

Source: Indiana's FSSA Enterprise Data Warehouse

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

## Demographic Profile of CHIP Members

Nearly 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 17 percent are under age 6. This distribution has been the case since the CHIP was introduced.

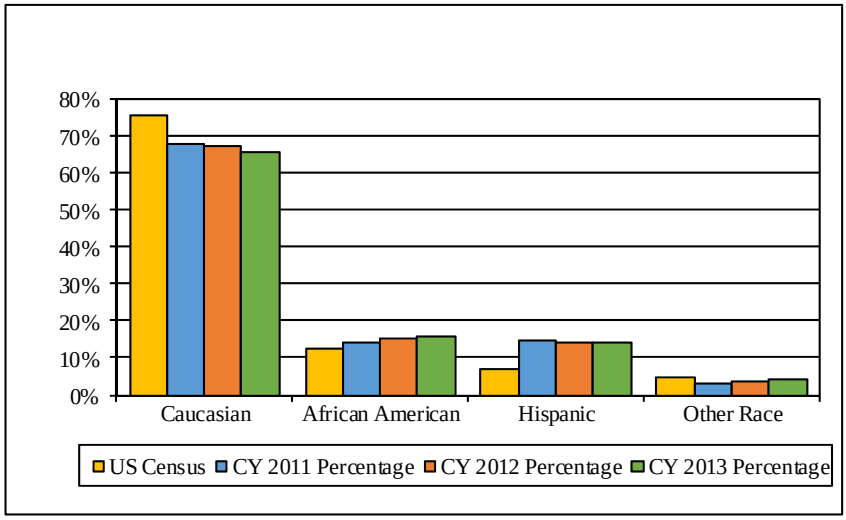
**Exhibit II.6**
**Average CHIP Enrollment by Age Group**




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. Compared to the U.S. Census estimate,[10] African-American children (15.9% of CHIP enrollees in CY 2013) and Hispanic children (14.3% of CHIP enrollees in CY 2013) are represented more in CHIP than in the statewide population. Between CY 2011 and CY 2013, the proportion of Caucasian CHIP members declined (67.5 and 65.5, respectively). The African-American proportion increased from 14.4 percent in 2011 to 15.9 percent in 2013. The Hispanic proportion decreased slightly from 14.8 percent in 2011 to 14.3 percent in 2013. Other races have increased from 3.3 percent in 2011 to 4.3 percent in 2013.

**Exhibit II.7**
**Average CHIP Enrollment by Race/Ethnicity**

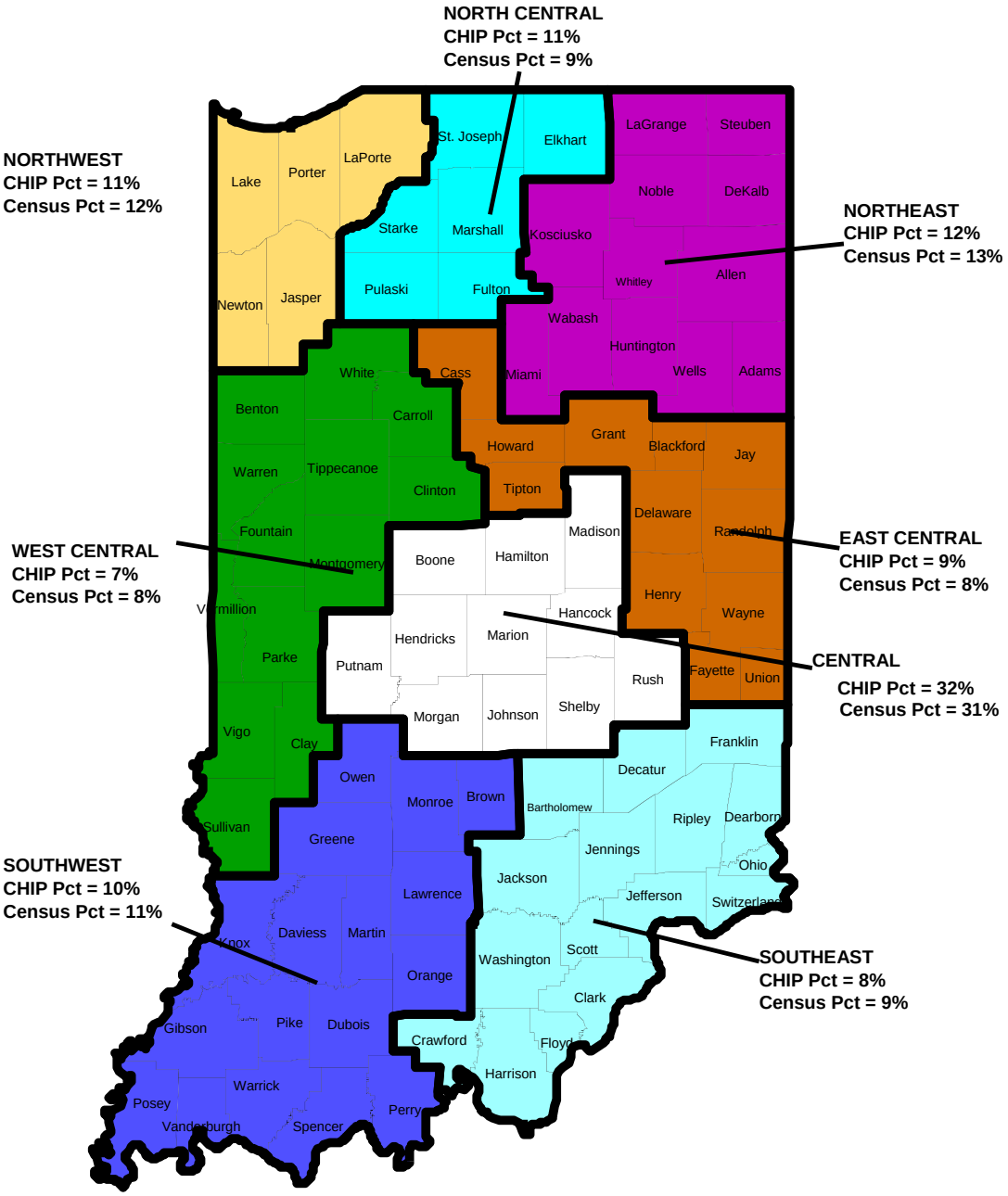



Source: Indiana's FSSA Enterprise Data Warehouse and US Census Bureau

[10] U.S. Census Bureau, Current Population Survey, three year average for Indiana 2010-2012. http://www.census.gov/hhes/www/hlthins/hlthins.html

B&A compared CHIP members enrolled to the total child population in Indiana as of July 2013. The distribution of CHIP members by region matches the overall child population in Indiana within one percentage point, with the exception of the North Central region (11 percent CHIP percentage and 9 percent census percentage). The regions are defined by the OMPP.

**Exhibit II.8**
**Average Distribution of CHIP Members by Region Compared to Census Figures, July 2013**



# III

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

*Access Facts at a Glance*

58% of CHIP members accessed primary care (either doctor's office or clinic setting) in Federal Fiscal Year (FFY) 2013, of which:

- 54% visited a primary care doctor's office in their home county
- 22% visited a primary care doctor's office in a contiguous county

56% of CHIP members accessed preventive dental care in FFY 2013, of which:

- 61% visited a dentist in their home county
- 24% visited a dentist in a contiguous county

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

## Access to Primary Medical Providers

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

PMPs include General Practitioners, Family Practitioners, Pediatricians, General Internists and OB/GYNs.[11] When the PMP contracts with an MCE, the PMP identifies whether or not they are willing to accept children as patients. If so, they are considered by the OMPP to be a pediatric provider. The number of pediatric providers in Hoosier Healthwise has grown from just under 2,900 in January 2009 to 3,777 in September 2013.

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

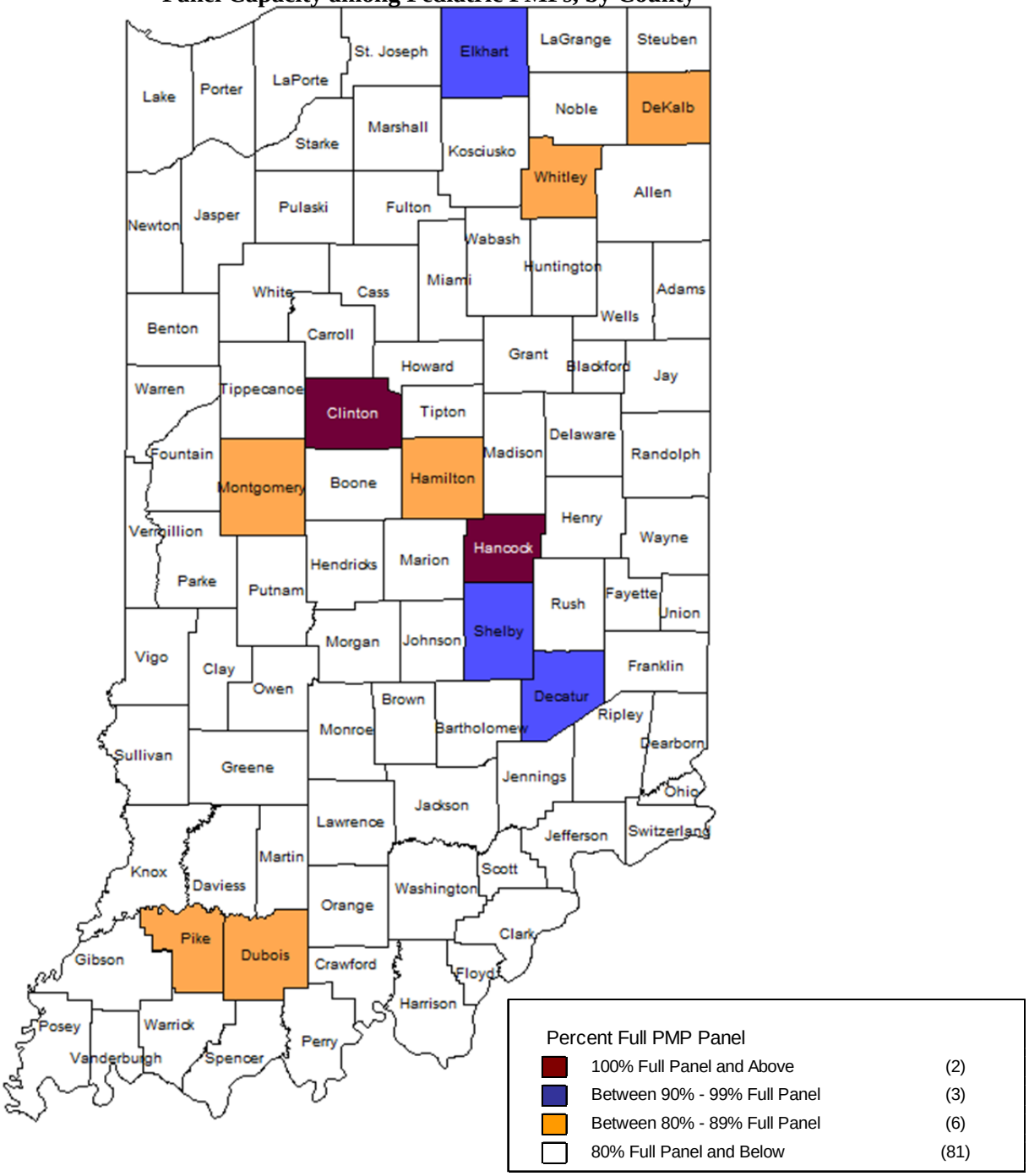
Panel capacity measures how many slots in a PMP's panel are already filled by the PMP's existing patients. It is defined as the number of members enrolled with a PMP divided by the total number of members that the PMP is willing to accept. A physician who sees members from counties outside of the county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

It is important to measure panel capacity to assess if there are potential gaps in the state where there are fewer PMPs available to accept new patients. B&A reviewed data compiled by OMPP's fiscal agent, HP, which measured pediatric panel capacity as of September 2013.[12] There was an average number of 169 members enrolled with each pediatric PMP in this month.

In September 2013, on average statewide the pediatric PMPs' panels were 45 percent full. This rate varies significantly on a county-by-county basis, however. In Exhibit III.1 on the next page, B&A color-coded each county's PMP panel capacity as tabulated by HP. Counties colored white (81 out of 92) are those where the PMP panel is less than 80 percent full. Eleven counties are considered potentially at risk since their panel capacity among all providers in the county was more than 80 percent full, a change from our study last year when nine counties were more than 80 percent full. Counties colored orange (6) are those where the PMP panels are 80 to 89 percent full. Counties colored blue (3) are those where the PMP panels are 90 to 99 percent full. Two counties are technically more than 100 percent full (in brick red), which means that, when analyzed as a group, the PMPs in each of these counties have actually accepted more CHIP and Medicaid members than they contractually agreed to accept. Eight of the eleven counties also had panel sizes greater than 80 percent last year (Clinton, Decatur, Elkhart, Hamilton, Hancock, Pike, Shelby and Whitley). One county went below this threshold over the past year, but three counties (DeKalb, Dubois and Montgomery) were added to the list in 2013.

[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 panel capacity reports include both children and adult patients if the PMP is willing to accept both.

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



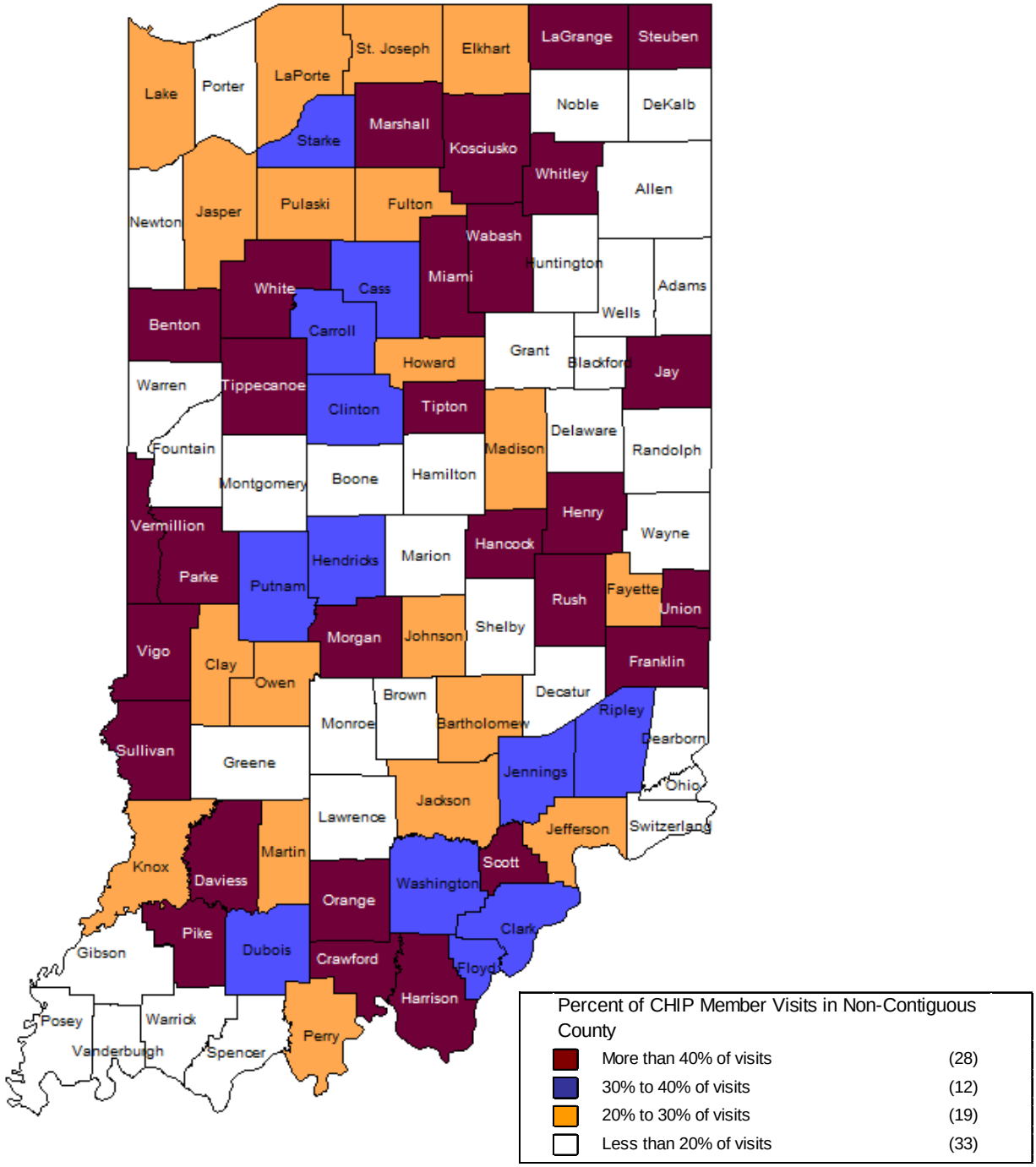
A county with a higher percentage of full panels, however, is not necessarily indicative of access problems. For example, a Hoosier Healthwise child may see a PMP in a county next to their home county since it is not a far distance to travel. Therefore, the panel capacity in their home county may or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

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

B&A identified and analyzed when a child received a primary care service from an MCE PMP in a doctor's office during Federal Fiscal Year 2013 (42% of all children received this service). Primary care utilization was then examined at the county level.

Statewide, 54 percent of CHIP members that accessed primary care service received the service in the county in which they lived in FFY 2013. An additional 22 percent received a primary care service in a contiguous county. Like the panel capacity map shown in Exhibit III.1, the percentage of CHIP children who had a primary care visit in a county not contiguous to their residence varied greatly by county.

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



It should be noted that, based on the land area of Indiana's counties, it is possible that CHIP members may travel to receive a primary care service in a non-contiguous county to their home residence and still be within 30 miles of their home (as per OMPP's benchmark). There were twenty-eight counties where more than 40 percent of CHIP members' primary care visits were received in a county not contiguous to their home county: Benton, Crawford, Daviess, Franklin, Hancock, Harrison, Henry, Jay, Kosciusko, Lagrange, Marshall, Miami, Morgan, Orange, Parke, Pike, Rush, Scott, Steuben, Sullivan, Tippecanoe, Tipton, Union, Vermillion, Vigo, Wabash, White, and Whitley (refer back to Exhibit III.2). Of these, one county has a full panel (Hancock) and two counties are potentially at risk for full panels: Pike has 90 percent of its panel full and Whitley has 82 percent of its panel full (refer back to Exhibit III.1).

Three of the eleven counties with fuller panels (Exhibit III.1) also had more than 30 percent of their member's primary care visits to counties not contiguous to their home. When these are cross-referenced, only three counties appeared in both groups: Dubois, Pike and Whitley counties. Whitley County was on this list last year but has improved its pediatric panel percent full rate from 83 percent full panel to 82 percent full panel.

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

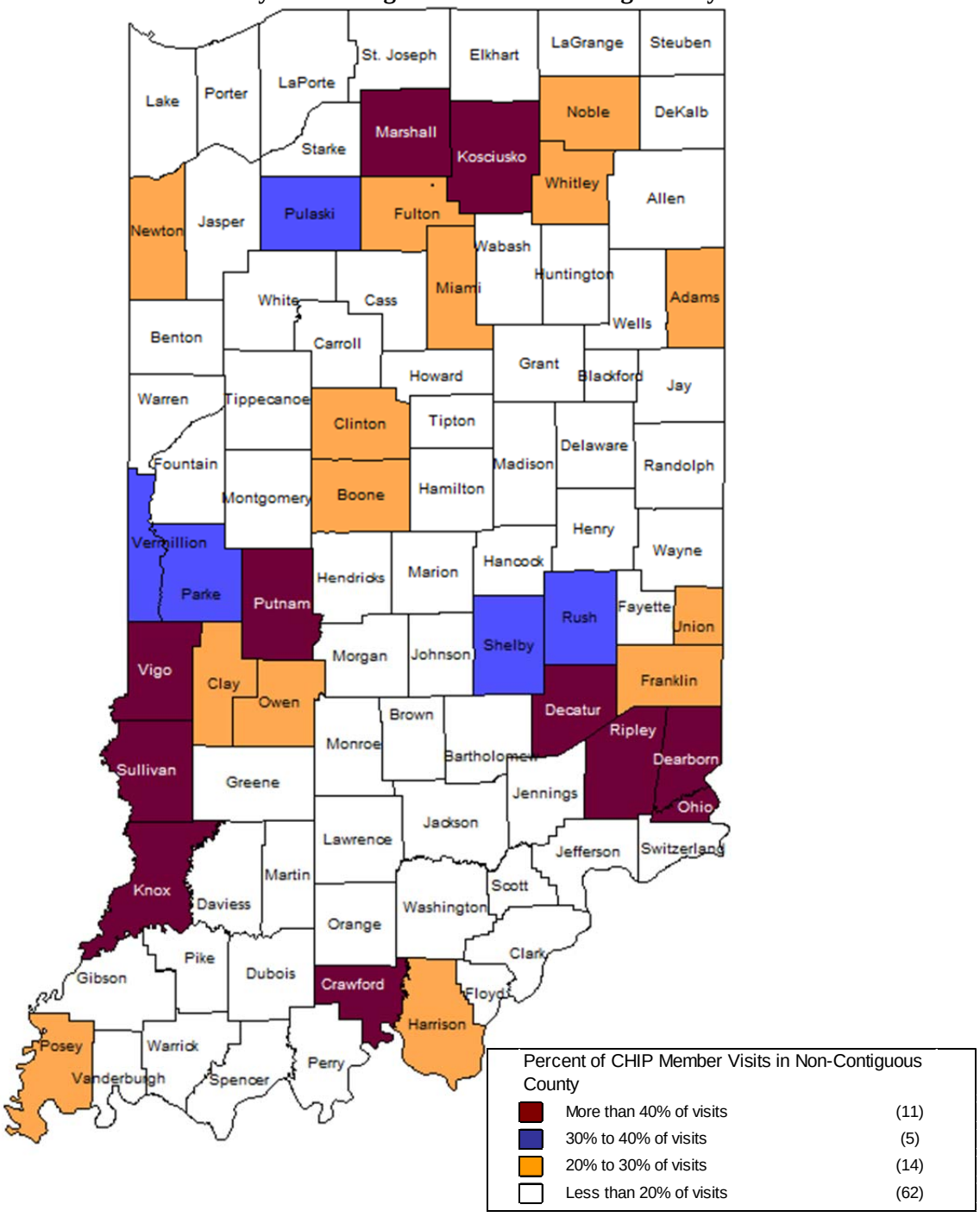
**Access to Dentists**

B&A conducted a similar analysis of where CHIP members access services for dental providers. Overall, it was found that 45 percent of CHIP members had a preventive dental visit in FFY 2013. 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 61 percent of CHIP members that accessed preventive dental services had their visit in their home county and an additional 24 percent had their visit in a contiguous county. The same county access percentage this year is lower than what was found in last year's evaluation. The access in home or contiguous county (85 percent) this year was also lower than what was found last year (93 percent).

Exhibit III.3 shows the 30 counties where the percentage of visits received in non-contiguous counties from the member's home county exceeded 20 percent. Eleven counties (Crawford, Dearborn, Decatur, Knox, Kosciusko, Marshall, Ohio, Putnam, Ripley, Sullivan and Vigo) are greater than 40 percent. While 11 counties are elevated compared to the four counties greater than 40 percent in FFY 2012 the same percent of members (56 percent) accessed preventive dental services in both FFY 2012 and FFY 2013.

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



# IV

# Service Use Patterns among Populations in Indiana's CHIP

## *Utilization Patterns at a Glance*

For CHIP members who were enrolled in Federal Fiscal Year 2013:

- 59% had a primary care visit
- 21% had an emergency room visit
- 56% had a preventive dental visit
- 59% obtained a prescription

These are consistent trends during the past three years.

In addition to examining the access to providers, Burns & Associates, Inc. (B&A) also analyzed the percentage of CHIP members that used particular services (*usage trends*) and the rate at which members utilized these services (*utilization per 1,000 member trends*). Key services offered in the CHIP such as primary care visits, emergency room (ER) visits, preventive dental care and prescriptions were examined. Results were compared between Federal Fiscal Years (FFY) 2011, 2012 and 2013 across populations within the CHIP by CHIP Package, by age, by managed care entity (MCE) and by race/ethnicity.

Data used in this analysis was provided to B&A from the Office of Medicaid Policy and Planning's (OMPP's) data warehouse in March 2014. The majority of the services examined are paid for by the MCEs directly to providers and then reported as encounters to the OMPP after the fact. The FFY was selected instead of the Calendar Year to account for time for the MCEs to submit encounters to the OMPP. That being said, the findings for FFY 2013 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 2011, 2012 or 2013. Since the *usage rate* measures the percentage of members that had actually used the service, we are allowing for a minimum of nine months enrollment in the year to identify only those members that would have had an opportunity to actually use the service. Members could be included in one year and not the other based upon their enrollment history. If CHIP members switched between MCHIP (Package A), SCHIP (Package C) and/or Medicaid during the year, they were retained in the analysis as long as they met the nine month minimum and were enrolled in the CHIP at the end of the year. CHIP members included in the analysis were assigned to one MCE, one race/ethnicity group, and one age group. This enabled B&A to create mutually-exclusive samples of members for additional analysis. A member's age was assigned based upon their age at the end of each year.

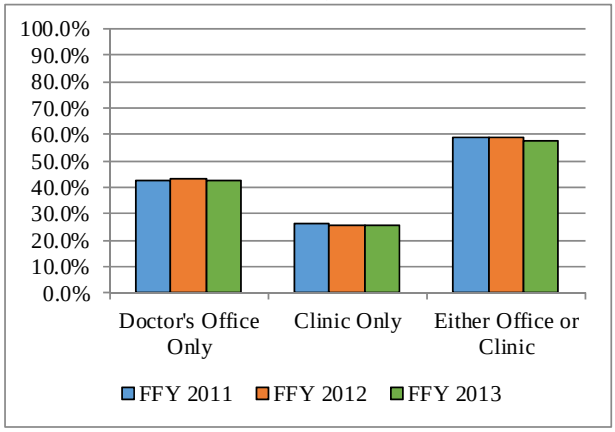
On the other hand, the *utilization per 1,000 member rate* includes every CHIP member enrolled in the month being examined. It can also be helpful to measure the utilization per 1,000 rate across different populations (e.g., by age or by race/ethnicity) in a way that is an apples-to-apples comparison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

## Primary Care Visits

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

On a statewide level, B&A found that 58 percent of CHIP children in the study sample had a primary care visit (either in a doctor's office or a clinic) in FFY 2013. This is a slight decrease from FFY 2010 and FFY 2011 when 59 percent of CHIP children had primary care visits.

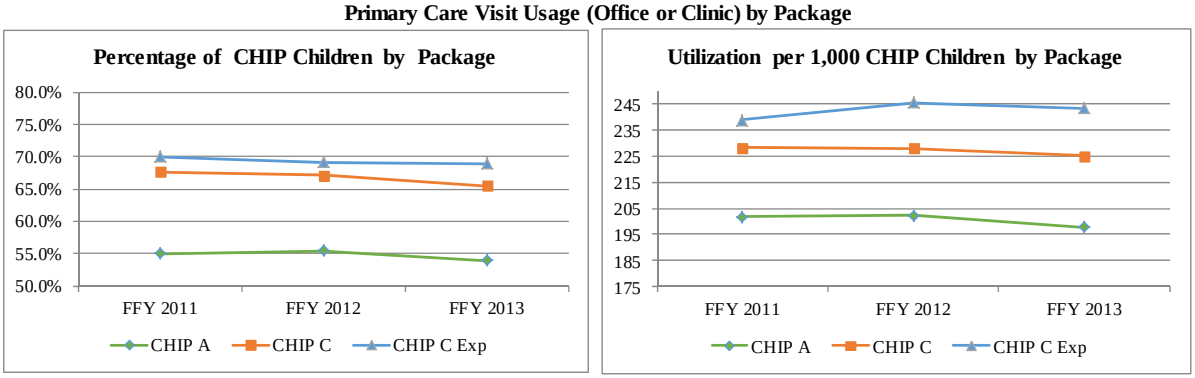
**Exhibit IV.1**
**Primary Care Visit Usage Rates by Location**




[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.

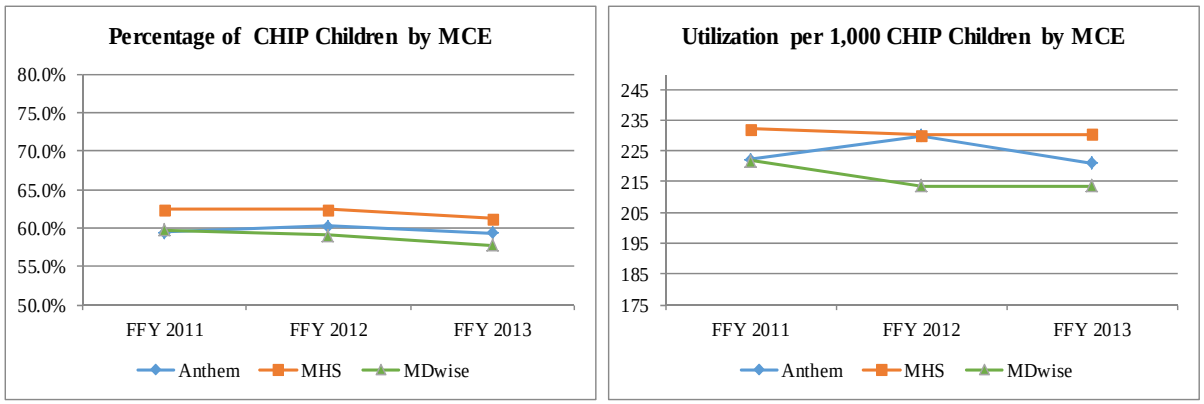
The percent of children that had a primary care visit (either office or clinic setting) has decreased over the past three years for all CHIP Packages. As stated previously, the reduction shown here may be due, in fact, to claims not being fully submitted to OMPP for the FFY 2013 time period. The percentage of MCHIP (Package A) children that had a primary care visit in FFY 2013 was lower (54 percent) than SCHIP (Package C) (66 percent) and SCHIP (Package C) Expansion (69 percent) children, which have similar rates of primary care visits. The utilization per 1,000 CHIP children decreased in 2013 after an increase in 2012 (refer to Exhibit IV.2).

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




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 five percentage points of one another. When utilization is measured on individual claims per 1,000 CHIP members MDwise and MHS saw a decrease from 2011 to 2012, but remained steady from 2012 to 2013. Anthem saw an increase from 2011 to 2012, but a decrease from 2012 to 2013. However, utilization is still similar between MCEs with a low of 214 visits per 1,000 members to a high of 230 visits per 1,000 members (refer to Exhibit IV.3 below). Said another way, between 2.14 and 2.30 children out of 10 CHIP members that were enrolled with an MCE had a primary care visit each month.

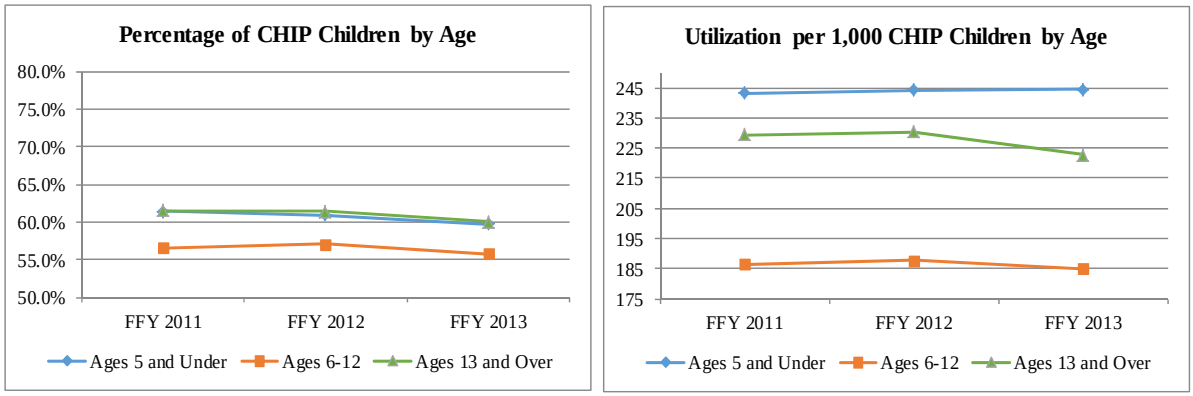
**Exhibit IV.3**
**Primary Care Visit Usage (Office or Clinic) by MCE**




Primary care visits remain more prevalent among the youngest and eldest members, as 60 percent of both children ages 5 and younger and children ages 13 to 18 had a visit in FFY 2013. The percentage was lower for children in the middle age group (56 percent for children ages 6 to 12 in FFY 2013). Although the primary care usage rate for children ages 5 and younger and ages 13 to 18 in FFY 2012 was about the same, the actual number of office visits per 1,000 members was higher among children ages 5 and younger than children ages 13 to 18. Children ages 6 to 12 had a primary care visit

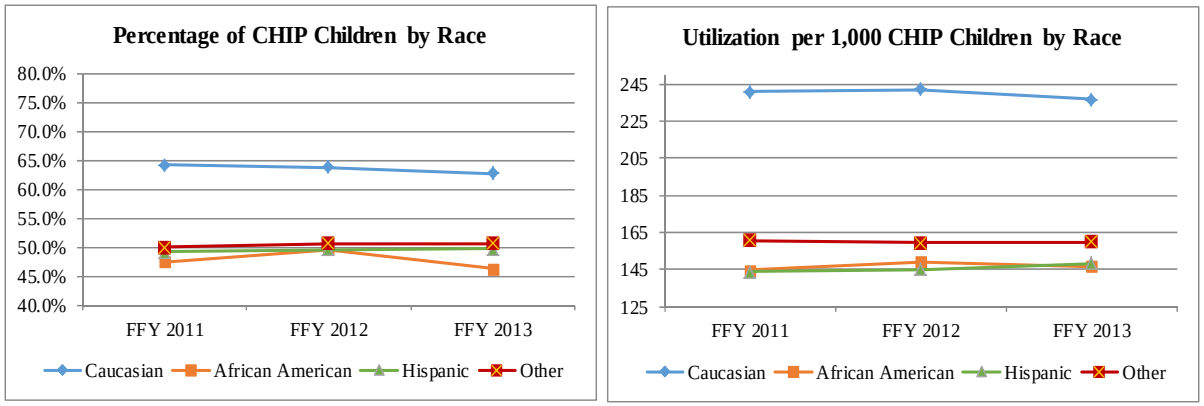
utilization rate lower than the other two groups. Both of these trends have remained consistent over the past three years (refer to Exhibit IV.4 below).

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




The percent of children that had a primary care visit within each race/ethnicity examined has remained steady or 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 63 percent in FFY 2013; for Hispanic children and children of other races/ethnicities it was 50 percent, and for African American children the rate was 46 percent. The utilization rate for primary care visits among Caucasian children is also higher than other race/ethnicities. Across the years studied, the median rate per 1,000 Caucasian children was 240, whereas the median rate was 147 and 146 among African American and Hispanic children respectively (refer to Exhibit IV.5 below). The utilization rate for children in other race/ethnicities was slightly higher at a median rate of 160 visits per 1,000 CHIP children.

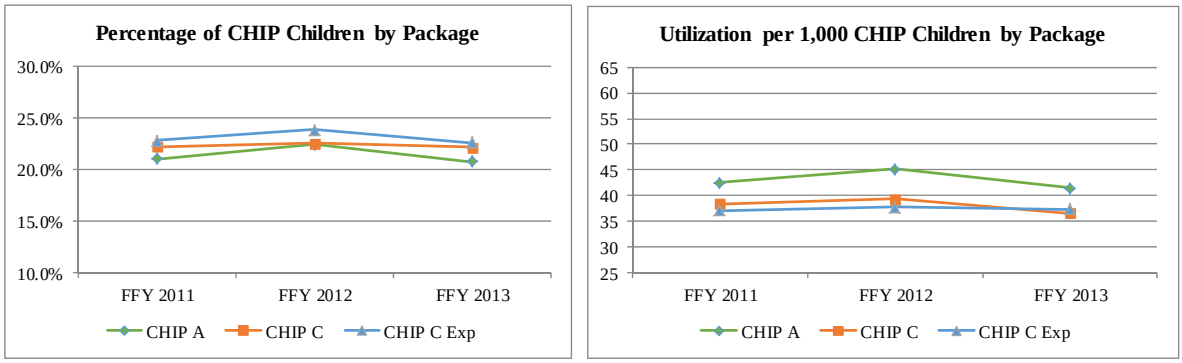
**Exhibit IV.5**
**Primary Care Visit Usage (Office or Clinic) by Race**



## Emergency Room Visits

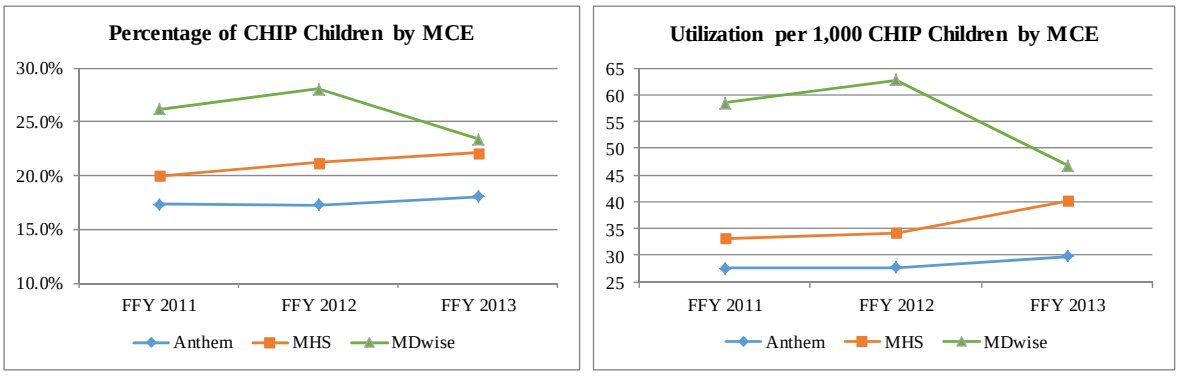
The rate of Emergency Room visits by CHIP children in all Packages has remained steady over the past three years with a slight increase from FFY 2011 to FFY 2012, but a comparable decrease from FFY 2012 to FFY 2013. The rate of Emergency Room visits by Package varied by less than two percent in FFY 2013. The expansion portion of SCHIP (Package C) children had a slightly higher rate (23 percent) of Emergency Room visits in FFY 2013 than MCHIP (Package A) and SCHIP (Package C) children (21 and 22 percent respectively). When considering emergency room visits per 1,000 CHIP children the trend was reversed with MCHIP (Package A) having the highest number of visits at 42 per 1,000 children while SCHIP (Package C) and SCHIP (Package C) Expansion both had 37 visits per 1,000 children (refer to Exhibit IV.6 below). This reverse trend indicates that while a lower percentage of MCHIP (Package A) children had an emergency room visit, those children that did visit the emergency room did so more frequently than SCHIP (Package C) or SCHIP (Package C) Expansion children.

**Exhibit IV.6**
**Emergency Room Usage by Package**




There is a difference in the percentage of CHIP children that had an ER visit when analyzed by MCE. In the last three years, MDwise members had more ER visits than either Anthem or MHS. However, MDwise decreased from FFY 2012 (28 percent) to FFY 2013 (23 percent) which results in a rate similar to the other MCEs (Anthem and MHS at 18 percent and 22 percent respectively in FFY 2013). Similarly, over the past three years, MDwise members consistently had more ER visits per 1,000 members than Anthem or MHS, but the results are closer in 2013. From 2011 to 2012, Anthem and MHS remained steady (28 visits per 1,000 members and 34 visits per 1,000 members, respectively) while MDwise increased to 63 visits per 1,000 members. However, in 2013 Anthem and MHS had a slight increase to 30 visits per 1,000 members and 40 visits per 1,000 members, respectively, while MDwise decreased to 47 visits per 1,000 members (refer to Exhibit IV.5 below).

**Exhibit IV.7**
**Emergency Room Usage by MCE**



The large majority of children (87 percent) who used the ER during FFY 2013 had one or two visits during the year. As shown in Exhibit IV.8 below, MHS had the lowest rate of children who used the ER more than two times during the study year (11.2 percent). Anthem and MDwise had a higher rate than MHS at 14 percent each.

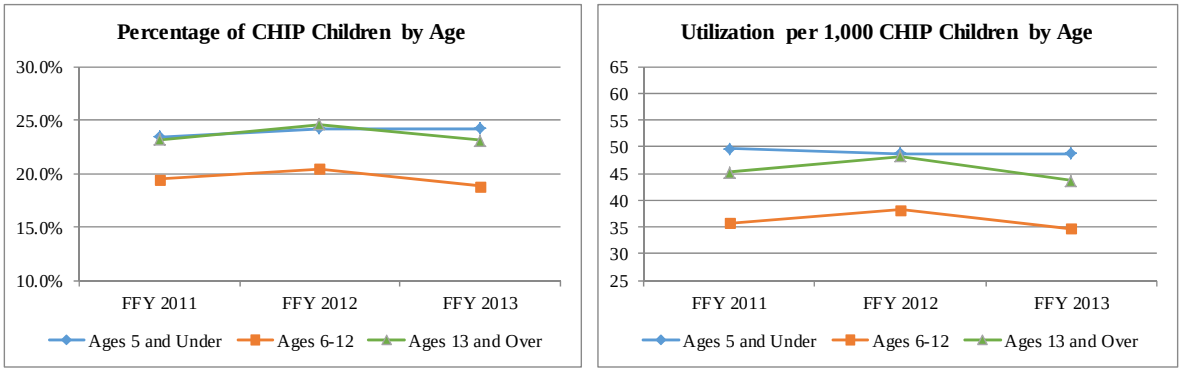
**Exhibit IV.8**
**Rate of ER Utilization Among CHIP Members Using ER Services**
**For Claims Submitted with Dates of Service Oct 1, 2012 - Sept 30, 2013**

| | Percentage of All ER Visits by MCO | | | |
|---|---|---|---|---|
| **Number of ER Visits per Member** | **Anthem** | **MHS** | **MDWise** | **Total** |
| 1 to 2 | 86.0% | 88.7% | 85.8% | 87.4% |
| 3 to 5 | 11.7% | 9.2% | 11.0% | 10.1% |
| 6 to 10 | 1.9% | 1.6% | 2.1% | 1.7% |
| 11 to 20 | 0.3% | 0.4% | 0.8% | 0.5% |
| More than 20 | 0.1% | 0.0% | 0.4% | 0.2% |

Source: Indiana's FSSA Enterprise Data Warehouse

Differences in ER use are found by age group within the CHIP. Higher use was found among children ages 5 and under and the age group 13 and over (24 percent of members in each age group in FFY 2013 used the ER). ER use was lowest among children ages 6 to 12 (19 percent of all members in the age group in FFY 2013 used the ER). ER usage has remained steady for all age groups over the past three years. The utilization rate for ER followed a similar pattern (refer to Exhibit IV.7 below). The rate was 49 visits per 1,000 members on average for ages 0 to 5 and 44 visits per 1,000 members for 13 to 18 year olds in FFY 2013. The rate was lower for children ages 6 to 12 (35 visits per 1,000 members).

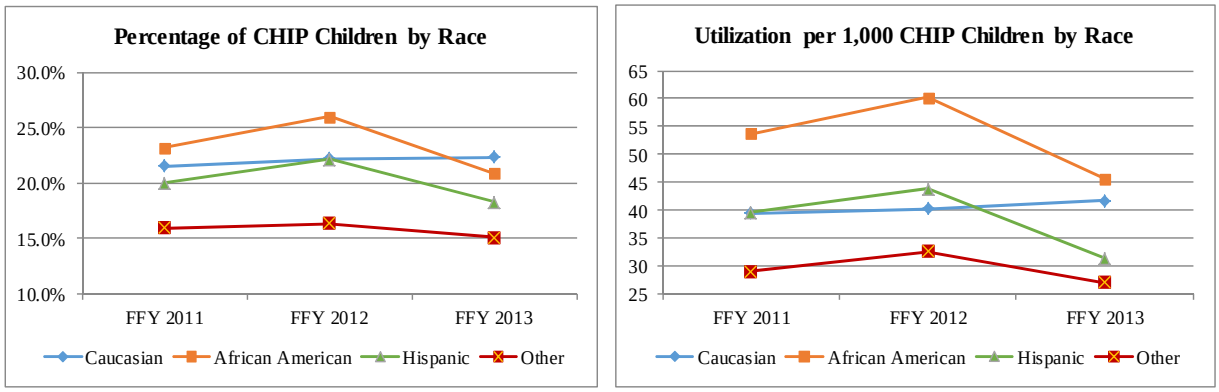
**Exhibit IV.9**
**Emergency Room Usage by Age**




The percent of Caucasian CHIP children that had an emergency room visit remained steady with 22 percent from FFY 2012 to FFY 2013, while African American children declined from 26 percent to 21 percent, Hispanic children declined from 22 percent to 18 percent and children of other races/ethnicities declined from 16 percent to 15 percent. While Caucasian children now have an emergency room utilization rate that is higher compared to children of all other races/ethnicities, African American children still visit the emergency room more frequently. When reviewing the utilization rates per 1,000 members, similar patterns to the rate changes were noted with African

American children, Hispanic children, and children of all other races/ethnicities realizing a decrease in emergency room utilization (60 visits to 46 visits, 44 visits to 31 visits, and 32 visits to 27 visits per 1,000 members respectively), while Caucasian children realized a slight increase (40 visits to 42 visits per 1,000 members). (Refer to Exhibit IV.10 below).

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

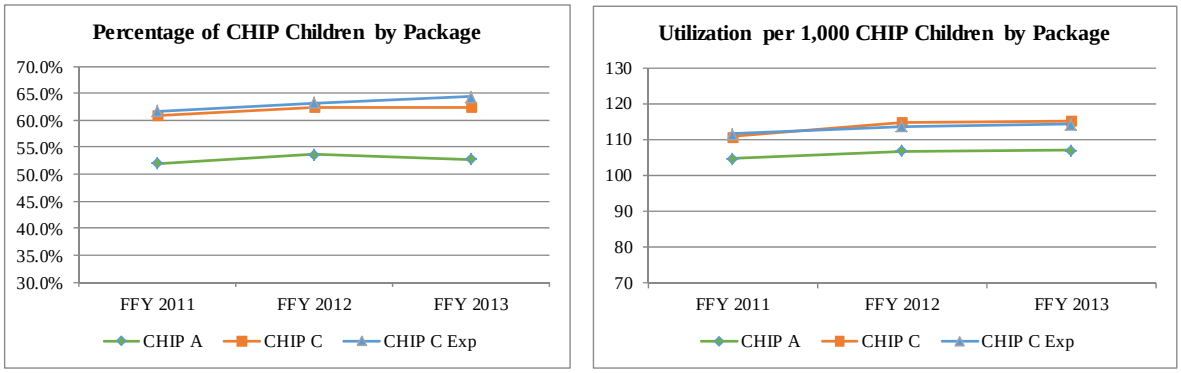



## Preventive Dental Visits

Dental care is one of the few services that the MCEs are not responsible for managing. The rate of preventive dental care has remained stable for CHIP children in all Packages over the past three years (refer to Exhibit IV.11 below). The percentage of MCHIP (Package A) children (53 percent in FFY 2013) that had a preventive dental care visit remains below SCHIP (Package C) and SCHIP (Package C) Expansion children (63 percent and 64 percent respectively in FFY 2013).

The same trend of less utilization by MCHIP (Package A) members is evident when measuring utilization per 1,000 CHIP members. MCHIP (Package A) children had 107 services per 1,000 members while SCHIP (Package C) Expansion children had 114 services per 1,000 members and SCHIP (Package C) had 115 services per 1,000 members. Utilization per 1,000 members has remained stable over the past three years.

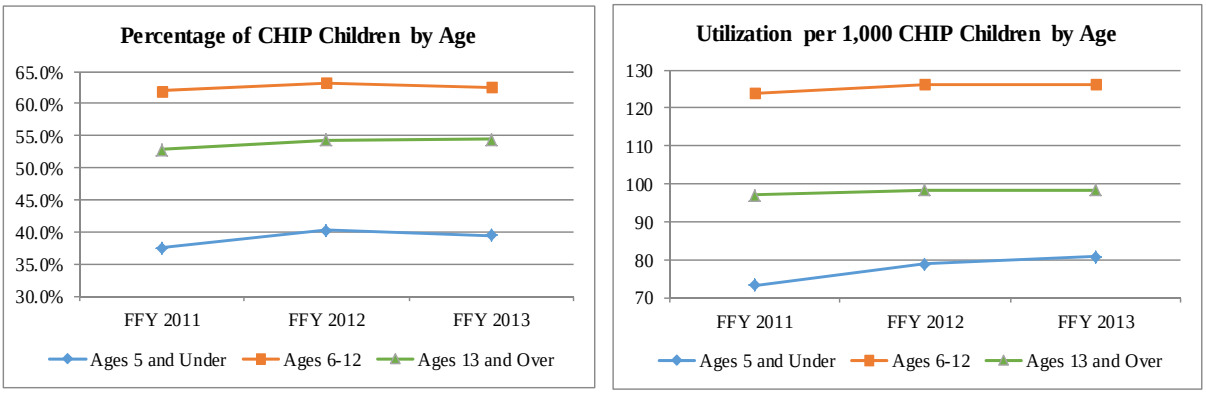
**Exhibit IV.11**
**Preventive Dental Care Usage by Package**




The overall percentage of CHIP members receiving a preventive dental visit at some time in the year was 56 percent in FFY 2013. Over the past three years, the rate of dental visits has remained steady for all ages, though children ages 6 to 12 are most likely to have received a preventive dental visit (63

percent of the members in FFY 2013), which is significantly higher than teenagers (54 percent). The youngest children had the lowest usage rate (39 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 126 visits per 1,000 members ages 6 to 12 remained consistent with prior years and also remains 29 percent higher than the rate for children ages 13 to 18 and 56 percent higher than the rate for children ages 0 to 5. The number of visits per 1,000 CHIP members has steadily increased over the past three years, but the largest increase was seen with members ages 0 to 5 years (refer to Exhibit IV.12 below).

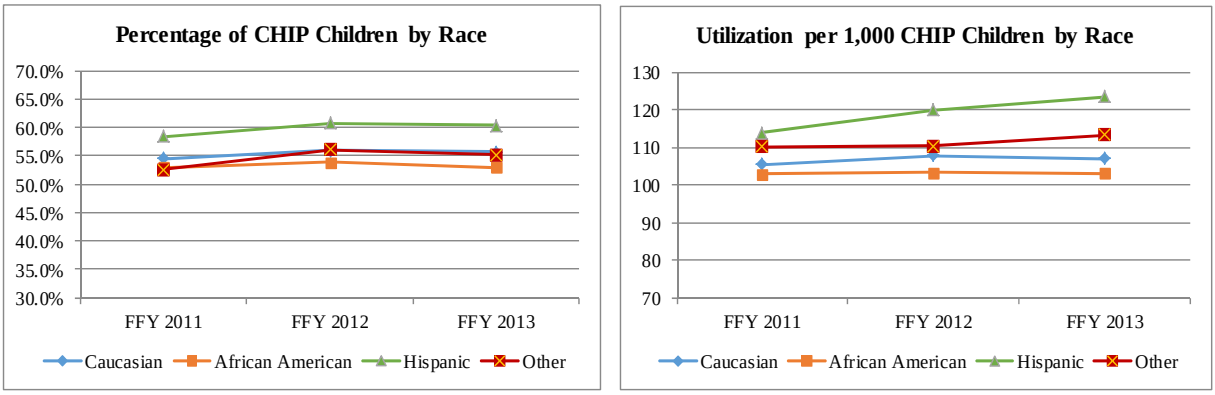
**Exhibit IV.12**
**Preventive Dental Care Usage by Age**




The preventive dental usage rate by race/ethnicity increased slightly from FFY 2011 to FFY 2012, and remained steady from FFY 2012 to FFY 2013 with 56 percent for all race/ethnicities in FFY 2013. There is little difference from the statewide average in the usage rate among the race/ethnicities, though the rate for Hispanic children has increased more than the other races/ethnicities with 60 percent receiving a preventive dental visit in FFY 2013.

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 124 visits per 1,000 members in FFY 2013, while African American children and Caucasian children were least likely at 103 visits and 107 visits per 1,000 members, respectively, in FFY 2013. Children of all other races had 113 visit per 1,000 members in FFY 2013 (refer to Exhibit IV.13 below).

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

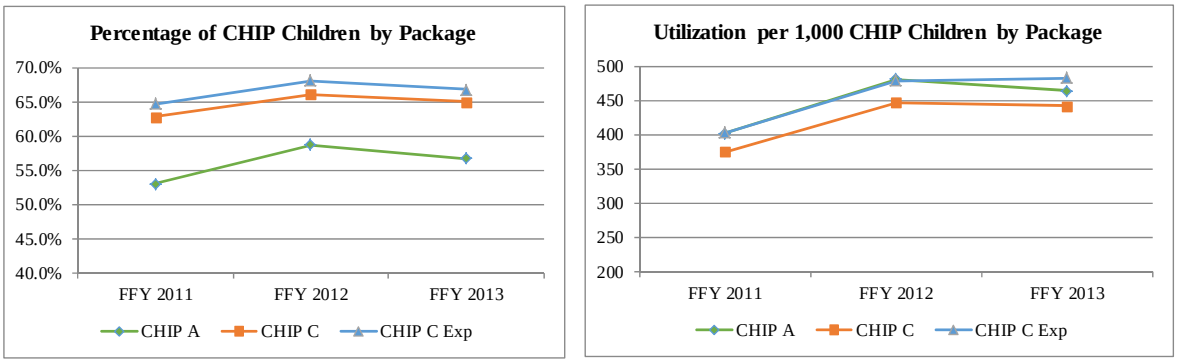


## Pharmacy Prescriptions

The administration of the pharmacy benefit is the other major service managed by the State and is not included in the capitation payment paid to the MCEs. Across all members enrolled at least nine months of the year, the percentage of members that had a prescription filled has remained relatively unchanged (60 percent) in the last three years.

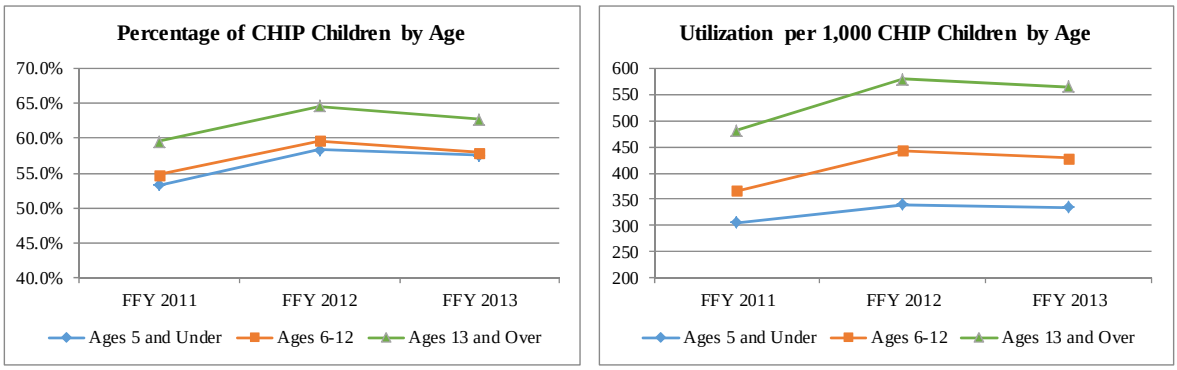
MCHIP (Package A) children are least likely to have a prescription with 57 percent in FFY 2013. SCHIP (Package C) children (original and expansion populations) are more likely to have a prescription with a rate of 65 and 67 percent, respectively, in FFY 2013. Utilization per 1,000 members decreased slightly for MCHIP (Package A) members to 464 prescriptions per 1,000 members and SCHIP (Package C) member declined to 442 prescriptions per 1,000 members. Utilization for SCHIP (Package C) Expansion members increased slightly and remains the highest of the three aid categories with 483 prescriptions per 1,000 members. (Refer to Exhibit IV.14)

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




There are differences, however, in pharmacy usage among the age groups studied. The highest usage rate is among children ages 13 to 18 over the last three years (63% in 2013). Children in the two younger groups were both similar at 58 percent in FFY 2013. Though the same percentage of 6 to 12 year olds obtained a prescription as children in the youngest age group, the number of prescriptions filled per child was higher for the 6 to 12 year olds. This is evident in the utilization rate of prescriptions filled per 1,000 CHIP children in Exhibit IV.15 below. The utilization rate for children ages 13 to 18 was 564 prescriptions per 1,000 members for FFY 2013, followed by children ages 6 to 12 (428 prescriptions per 1,000 members), then by children ages 0 to 5 (335 prescriptions per 1,000 members).

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



The type of prescriptions obtained by children in each age group also varies greatly. For the youngest children in CHIP, 44 percent of prescriptions filled in CY 2013 were to treat infections (see the row for Antiprotozoals, antileprotic, and anti-infective in Exhibit IV.16 below). Among children ages 6 to 12, half of the prescriptions were either for treating infections or for anxiety or seizure disorders (see the row for benzodiazepine antagonists and central nervous system drugs). There were similar findings for the teenagers in CHIP as shown for children ages 6 to 12, plus another 16 percent of teenage prescriptions were for hormones.

**Exhibit IV.16**
**Highest Volume Pharmacy Scripts in Calendar Year 2013**
**By Age Group and by Package**

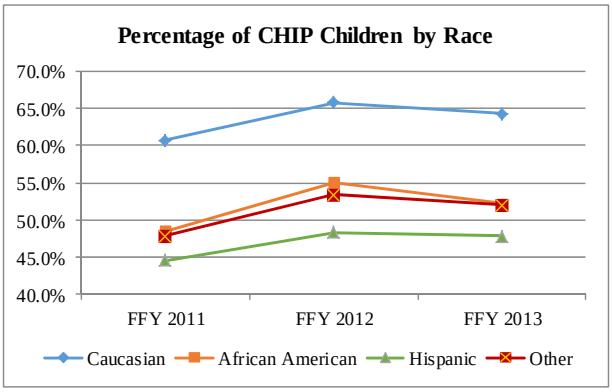
| | Ages 1-5 | | | Ages 6-12 | | | Ages 13-19 | | |
|---|---|---|---|---|---|---|---|---|---|
| | CHIP A | CHIP C | CHIP C Exp | CHIP A | CHIP C | CHIP C Exp | CHIP A | CHIP C | CHIP C Exp |
| **Therapeutic Class** | **Percentage of All Prescriptions in the Age Group** | | | | | | | | |
| Autonomic drugs | 5.2% | 5.1% | 6.1% | 7.6% | 6.8% | 6.8% | 6.8% | 6.0% | 5.8% |
| Benzodiazepine antagonists, Central nervous system drugs | 11.3% | 8.5% | 7.8% | 27.2% | 26.6% | 26.7% | 28.4% | 29.2% | 28.2% |
| Electrolytic, caloric and water balance | 2.1% | 1.7% | 1.2% | 5.5% | 4.4% | 5.7% | 5.3% | 4.6% | 4.0% |
| Ointments Solutions Suspensions, ophthalmic Otic nasal, Ophthalmic preparations | 11.5% | 12.2% | 11.4% | 9.4% | 9.3% | 8.8% | 5.5% | 5.6% | 5.9% |
| Gastrointestinal | 4.8% | 4.7% | 4.5% | 4.2% | 4.4% | 4.7% | 3.8% | 3.2% | 3.1% |
| Hormones | 6.3% | 6.5% | 6.5% | 8.3% | 9.5% | 9.2% | 15.0% | 15.8% | 15.5% |
| Antiprotozoals, Antileprotic, Anti-infective | 40.6% | 45.6% | 48.2% | 22.5% | 25.0% | 24.5% | 20.1% | 21.4% | 21.7% |
| Antiperspirants, Topical preparations, Skin and mucous membrane preparations | 14.7% | 13.7% | 11.9% | 8.5% | 7.6% | 7.1% | 9.2% | 8.9% | 9.1% |
| All Others | 3.5% | 2.0% | 2.5% | 6.8% | 6.4% | 6.6% | 5.9% | 5.4% | 6.7% |

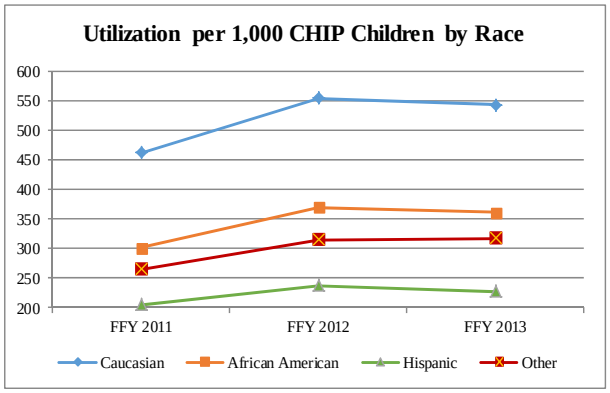
The percentage of children with a prescription increased from FFY 2011 to FFY 2012, and then declined slightly from FFY 2012 to FFY 2013 for each race/ethnicity group studied. Comparing across races/ethnicities, Caucasian children have a significantly higher pharmacy usage rate than other races/ethnicities. In FFY 2013, the usage rate among Caucasians children was 64 percent but it was 42 percent for African American children and children of other races/ethnicities, and 48 percent for Hispanic children. This has been a consistent finding in the CHIP for the last five years.

The trend for the number of prescriptions filled per 1,000 CHIP children by race/ethnicity followed the same pattern found for the usage rate trend. Caucasian children have a utilization rate of 543

prescriptions per 1,000 members each month, which is 51 percent higher than the rate for African-American children (360 prescriptions per 1,000 children) and more than double the rate for Hispanic children (228 prescriptions per 1,000 children). It is 72 percent higher than the rate of children of other race/ethnicities (318 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

## *Results at a Glance*

2013 HEDIS Survey

- All three MCEs exceeded the 90th percentile for Access to Primary Care
- All three MCEs have had a marked increase in Well Care visits over the last five years

2013 CAHPS Survey

- All three MCEs are above the national average for Getting Needed Care, Getting Care Quickly and Customer Service

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

OMPP staff review data from reports submitted by the managed care entities (MCEs) that are contracted under the HHW program. OMPP personnel then conduct reviews at each of the MCE's site on a monthly basis to oversee contractual compliance. Finally, OMPP hires an independent entity[14] to conduct an annual external quality review of each MCE and reviews the results with each MCE.

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

1. OMPP requires the three HHW MCEs to report the results of HEDIS®[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 MCEs and has set performance targets against national benchmarks. For child-specific HEDIS measures, results are reported for children in the CHIP and Medicaid programs combined. The CAHPS survey is separated between one for adults and one for parents of children. The OMPP requires the MCEs to administer each survey annually.

2. Separately, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Centers for Medicare and Medicaid (CMS) was required to develop a core set of measures related to children's health and to collect the results of these measures on a voluntary basis from state Medicaid and CHIP programs. There were 24 core measures identified by CMS in 2010. Indiana's CHIP, through OMPP, began reporting all 24 measures as required by CMS in 2013.

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

4. In addition to the goals set for its CHIP program specifically, the OMPP also develops a Quality Strategy plan each year. Many items within the Quality Strategy pertain to outcomes for children, both CHIP and traditional Medicaid members.

## HEDIS Results for Children Enrolled in Hoosier Healthwise

The results of the HEDIS represent the utilization of HHW members from the prior year. Therefore, in calendar year (CY) 2013, tabulations were collected on HEDIS rates for 2012 utilization. The

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

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

Exhibit V.1 below shows the five year trend reported for each MCE for four age groups. Every MCE has had a stable or an increasing trend for access over time, with the exception of ages 12 to 19 years which has trended slightly down. The OMPP target rate for each measure shown below is the 90$^{th}$ percentile among all Medicaid MCEs nationally. For HEDIS 2012, these rates were as follows for access to primary care practitioners:

- Ages 12 to 24 months: 93.4%
- Ages 25 months to 6 years: 92.6%
- Ages 7 to 11 years: 94.5%
- Ages 12 to 19 years: 93.0%

All three Indiana MCEs exceeded the OMPP target for access to primary care for ages 12 to 24 months with 96 percent. Anthem exceeded the OMPP target for access to primary care for ages 25 months to 6 years, followed by MHS then MDwise. All three plans were within two percentage points of each other for the remaining age groups.

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

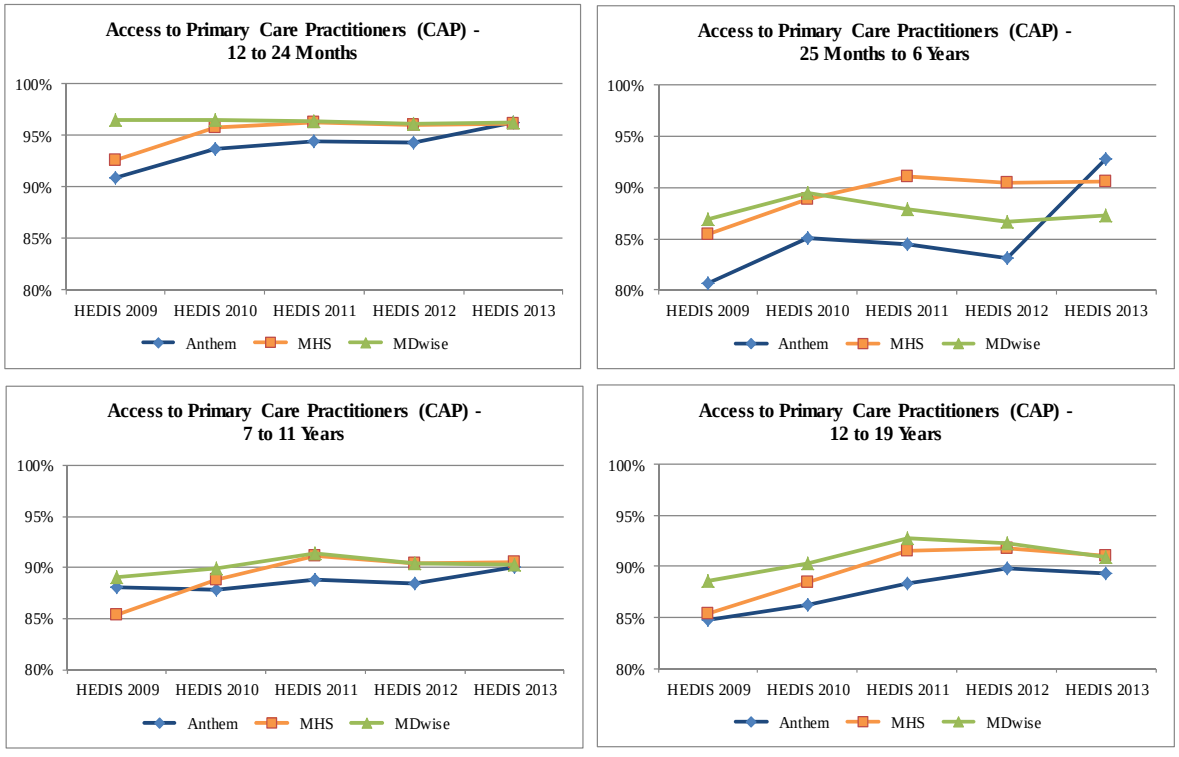


Exhibit V.2 below shows the five year trend for well care visits for each MCE. The number of visits required in the HEDIS definition varies by age group. For children in the first 15 months of life (upper left box), the rate shown represents the percentage of children with six or more well child visits.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

Every MCE has had a marked increase related to well child visits over time. Anthem's rate is closest to the OMPP target.

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

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

Anthem's rate declined in 2010, but returned to a rate consistent with the other MCEs in 2012 and 2013. MHS has seen marked improvement in 2013 and now has the rate closest to the OMPP target.

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

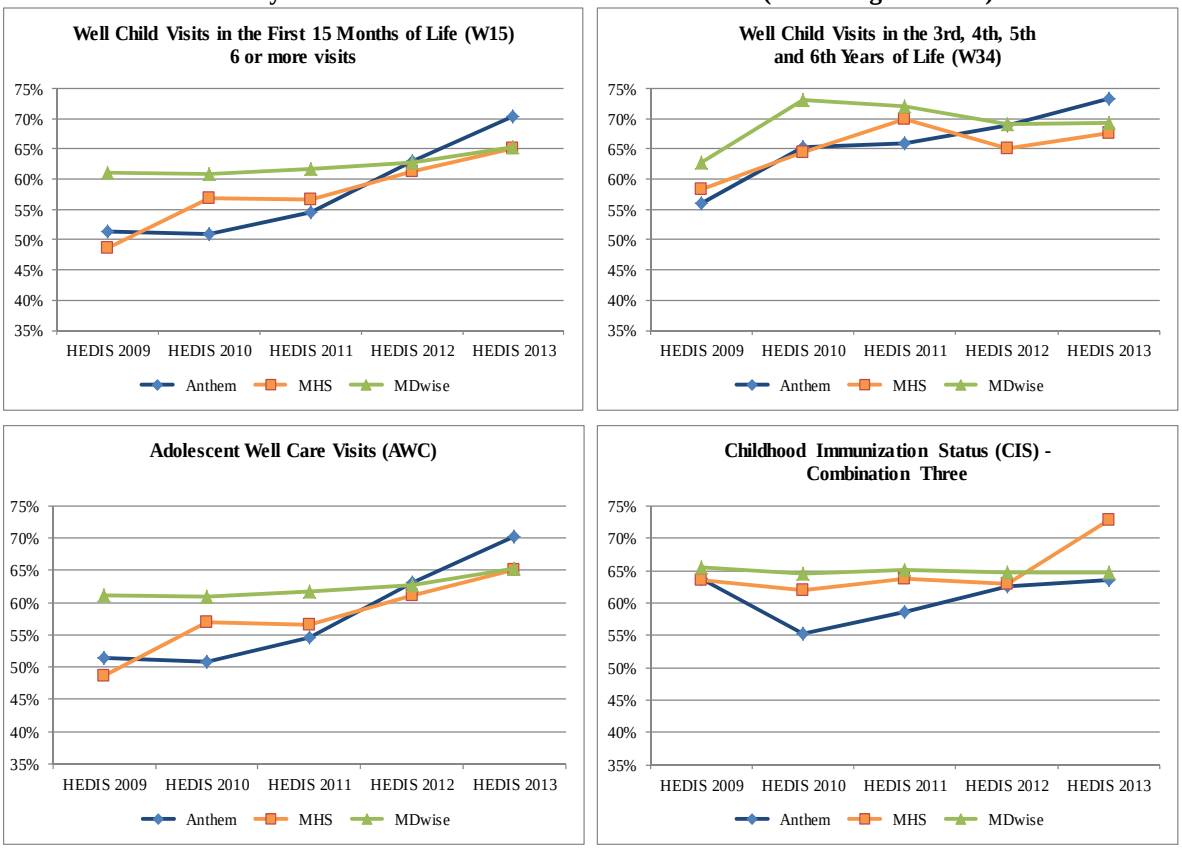


Exhibit V.3 below presents the results from HEDIS measures related to respiratory care for children. The upper two boxes present results related to measuring proper treatment while the lower two boxes present results of appropriate medications for children with asthma.

For appropriate testing of children with pharyngitis (sore throat), all three plans have had an increasing trend over the five years reviewed (see upper left box). Anthem showed a significant 24 percentage point increase between 2010 and 2011, but decreased in 2012 while remaining above the other MCEs in 2013. For this measure, a higher rating is more favorable since it indicates better testing.

When measuring treatment for upper respiratory infection, the MCEs reported an increasing trend from 2009 to 2011. All three MCEs reported a decline in 2012 and remained stable in 2013. 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.

Indiana's MCEs did better for the two age-specific measures related to appropriate medication for children with asthma. In the lower left box, the rate is measured for children ages 5 to 11. All three MCEs remain stable near 90 percent. The national 90th percentile rate for HEDIS 2012 was 95.4 percent. In the lower right box, the rate is measured for children ages 12 to 18 years. All three MCEs are further from the OMPP goal for this age group and all three MCEs declined in 2013. The national 90th percentile rate for HEDIS 2012 was 92.3 percent.

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

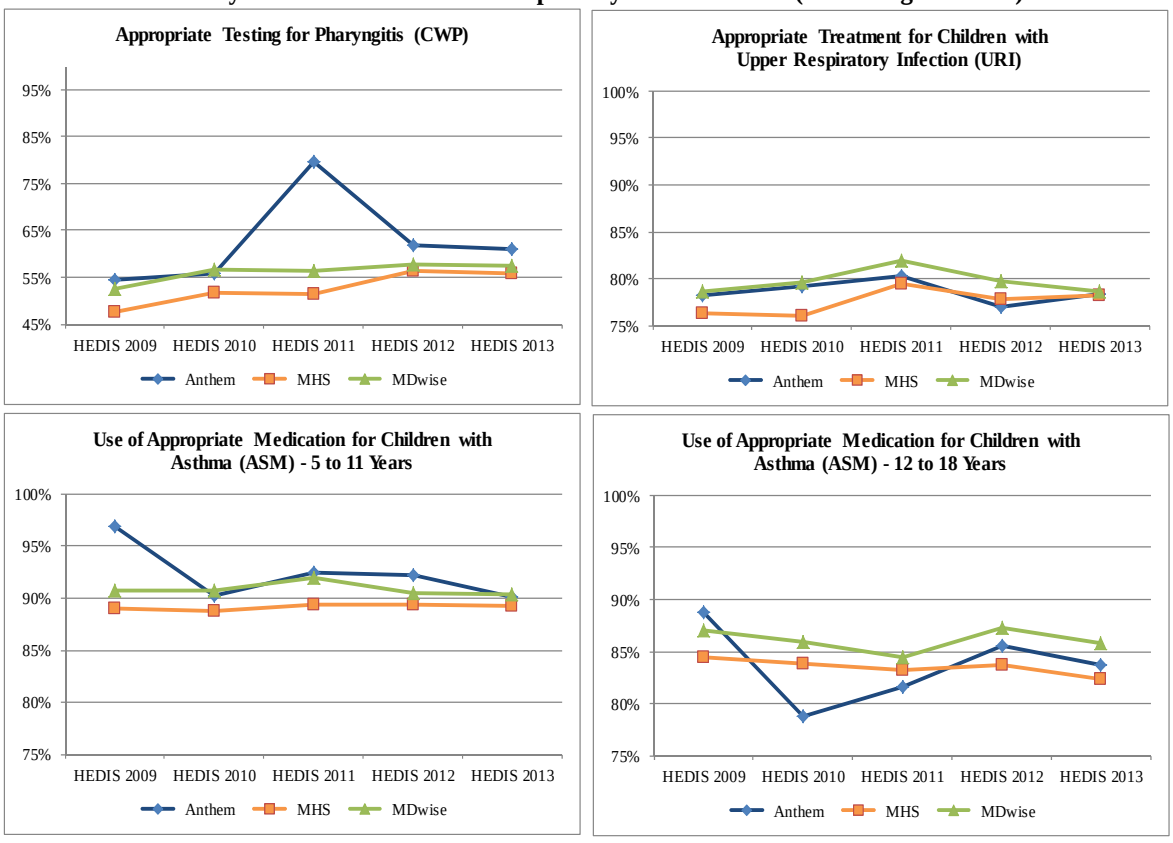
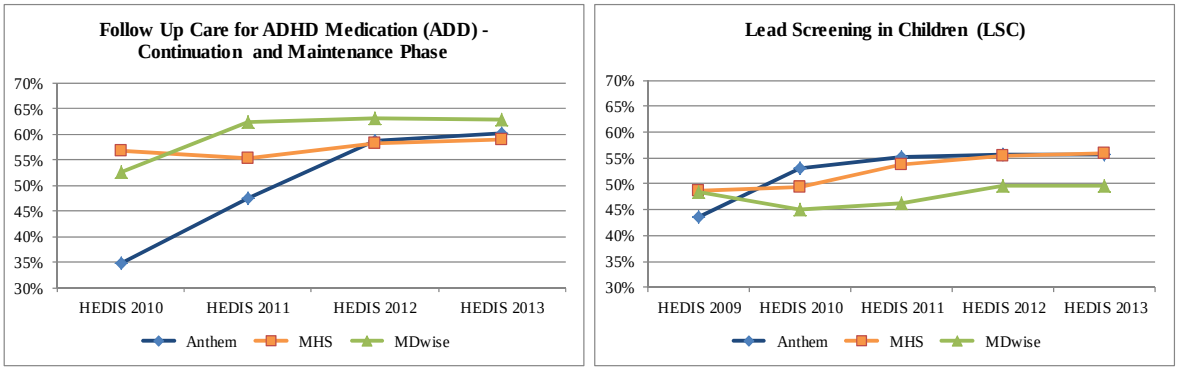


Exhibit V.4 presents the results of two other HEDIS measures related to children. One measures the percentage of children newly prescribed medication for attention deficit/hyperactivity disorder (ADHD) who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. The OMPP set a target at the 90th percentile among all Medicaid health plans nationally. In 2013, all three plans were near the national 90th percentile target of 63.1 percent.

The other measure shown is for the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. The OMPP has set a target of the 50th percentile among Medicaid health plans nationally. All three plans have shown an increasing trend over time, with Anthem and MHS at 56 percent and MDwise at 50 percent.

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



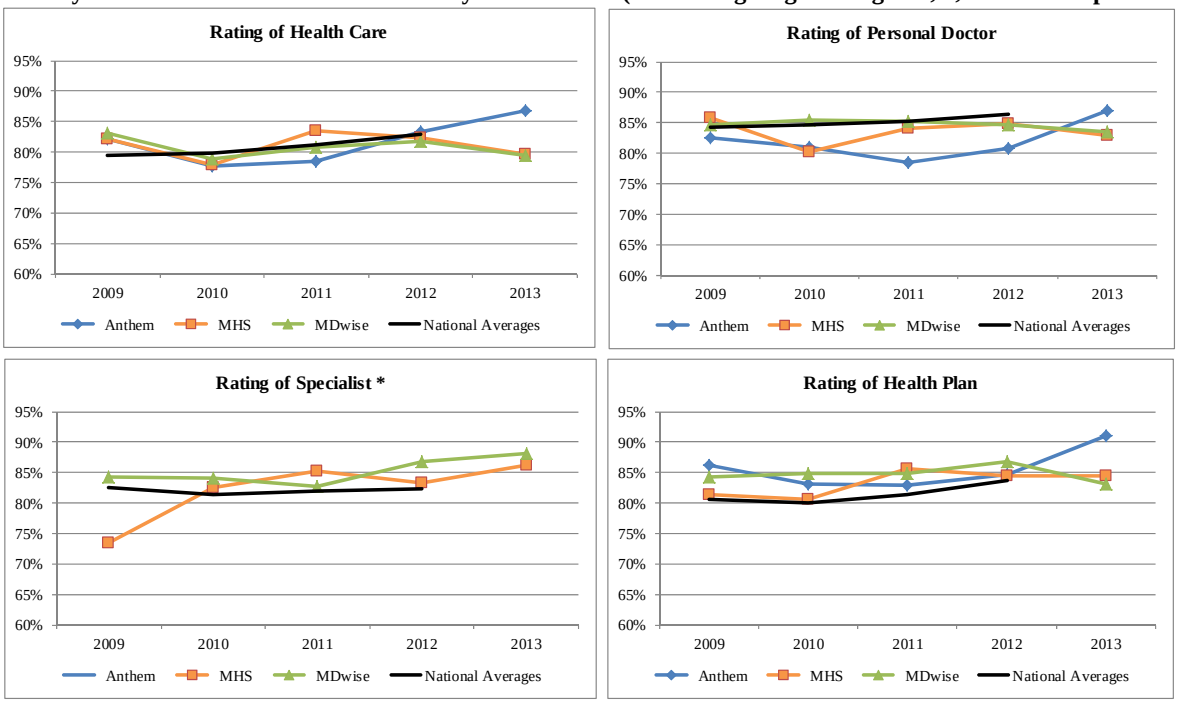

## CAHPS Results for Children Enrolled in Hoosier Healthwise

The Hoosier Healthwise MCEs contract with an outside survey firm to conduct the CAHPS surveys. The external surveyor compiles results which, in turn, are reported by the MCEs to the OMPP. Exhibits V.5 and V.6 on the next page summarize the results from the surveys that were administered over the last five years and compares the results on key questions to the results from the national average which represents approximately 130 Medicaid health plans that submitted data. 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. National average data is available from 2009 to 2012.

The percentages in Exhibit V.5 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." Anthem saw marked improvement in 2013 and is now ranked the highest of the three plans on all three reported measures and above the national average on all three measures (Anthem's sample for Rating of Specialist was too small and, therefore, was not reported). While MDwise and MHS both saw a decline in 2013 for Rating of Health Care and Rating of Personal Doctor and both are now below the national average, both Plans saw an improvement in Rating of Specialist and remain above the national average.

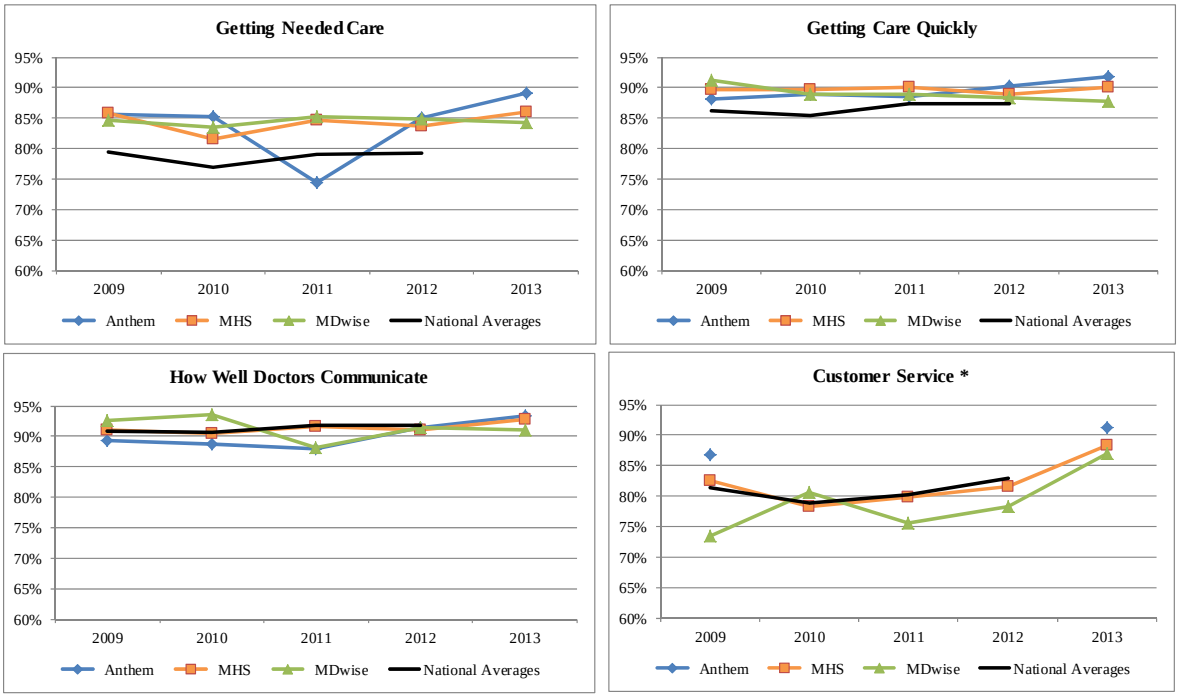
The CAHPS is designed so that composite scores are compiled from the answers to a series of related questions. The results in Exhibit V.6 represent four composite scores that show the percentage of respondents that answered "Usually" or "Always" to the series of questions on the topic. MDwise and MHS have trended at or above the national average over the past five years for all four measures. Anthem saw improvement on all four measures in 2013 and is now ranked the highest on all four measures.

**Exhibit V.5**
**Summary of Scores from CAHPS Child Survey 2009 to 2013 (Members giving a rating of 8, 9, or 10 on 10-point scale)**




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

**Exhibit V.6**
**Summary of Scores from CAHPS Child Survey 2009 to 2013 (Percentages reflect responses of "Usually" or "Always")**




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

## 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, as reported to CMS in December 2013, 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 9.83 percent over the three-year average of 2010-2011 was right at the 25th percentile (9.7%) among all states for the same time period. Indiana was below the 25th percentile nationally in the previous five years.

Goal #2: By September 30, 2012 increase by 13,500 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 13,500 children in the CHIP when CMS granted the State authority to expand eligibility in October 2008. As of September 2013, there were 6,578 children in this income category enrolled in the CHIP program; however, for the period of Federal Fiscal Year (FFY) 2013 there were a total of 14,377 unique children enrolled in this income category. Further details about enrollment and disenrollment trends are noted in Chapter II.

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 FFYs 2012 and 2013, 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 FFY 2012 and an average for FFY 2013 (each weighted by monthly enrollment) of the percent that lapsed was calculated. Then, the percentage change from the FFY 2012 figure to the FFY 2013 figure was calculated.

The results showed a lapse rate of 0.76% in FFY 2012 and a lapse rate of 0.70% in FFY 2013. Therefore, the year to year reduction rate was 7.85 percent, exceeding the target.

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.

The screening rate goal for every age group was set at 85 percent. For all age groups over one year of age, the screening rate in CHIP for the most recent year was greater than 100 percent. This means

that children are getting screened, on average, for these services at an even higher rate than CMS recommends within each age group. In the recent past, 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.

### OMPP's Quality Strategy

The OMPP develops Quality Strategy Initiatives based on consideration of identified trends in health care issues within the State of Indiana, attainment of current quality strategy goals, close monitoring of the MCEs' performance and unmet objectives, and issues raised by external stakeholders and partners. Within HHW, the program in which CHIP members are enrolled, the OMPP identified 12 initiatives for CY 2013. Of these, four initiatives focus on children specifically, four initiatives focus on both children and adults, and another four are focused more on the adult population. The initiatives with the measure used to track performance are shown below.[17]

1. Achieve at or above the 90th percentile for percentage of members with six or more well child visits in the first 15 months of life (HEDIS).
2. Improve the Early Periodic Screening, Diagnosis and Treatment (EPSDT) participation rate to 80% in 2013.
3. Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
4. Achieve at or above the 90% percent of Ambulatory Care Visits (HEDIS).
5. Achieve at or above 76% of the number of members who are advised to quit smoking during at least one visit with a health care provider.
6. Achieve a rate at or above the 75th percentile of diabetic members who receive a LDL-C screening.
7. Achieve a rate of less than 27% Cesarean Delivery rate in an effort to decrease the number of elective inductions prior to 39th week of pregnancy.
8. Achieve at or above the 90th percentile for the frequency of both prenatal and post-partum care (HEDIS).
9. Increase the overall number of provider submitted Notification of Pregnancy forms by 1% above the 2012 rate in an effort to identify high-risk pregnancies for case management by the MCEs.
10. Increase the number of submitted Presumptive Eligibility applications during the 1st trimester of pregnancy by 2% in an effort to improve access to early prenatal care.
11. Monitor and evaluate the quarterly data submitted by MCEs for care and case management and use the data to establish a baseline that will be used for future performance evaluation.
12. Achieve at or above the 96% of the Right Choices Program periodic reviews that are complete on time.

[17] Office of Medicaid Policy and Planning, Family and Social Services Administration, Quality Strategy Plan 2013, page 6.