FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- **A.** Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- B. Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- C. Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- D. Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **IN**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Signature:

E Mitch Roob

SCHIP Program Name(s): **All, Indiana**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☒ Combination of the above

Reporting Period: **2006** *Note: Federal Fiscal Year 2006 starts 10/1/05 and ends 9/30/06.*

Contact Person/Title: **Sarah Murphy, Medical Policy and Select Children's**

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Submission Date: **12/30/2006**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

~~1)~~ To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						**From**	0	% of FPL conception to birth	0	% of FPL
	From	0	% of FPL for **infants**	0	% of FPL	**From**	150	% of FPL for **infants**	200	% of FPL
	From	133	% of FPL for children ages **1 through 5**	150	% of FPL	**From**	150	% of FPL for 1 **through 5**	200	% of FPL
	From	100	% of FPL for children ages **6 through 16**	150	% of FPL	**From**	150	% of FPL for children ages **6 through 16**	200	% of FPL
	From	100	% of FPL for children ages **17 and 18**	150	% of FPL	**From**	150	% of FPL for children ages **17 and 18**	200	% of FPL

Is presumptive eligibility provided for children?	☒	No	☒	No
	☐	Yes, for whom and how long?	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☐	No
	☒	Yes, for whom and how long? Benefits are retroactive for up to 3 months for those determined to be eligible	☒	Yes, for whom and how long? Benefits are retroactive to the first day of the month of application, once the first premium has been paid
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☒	No
		☐	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☒	No	☒	No
	☐	Yes – please check all that apply	☐	Yes – please check all that apply
	☐	Signature page must be printed and mailed in	☐	Signature page must be printed and mailed in
	☐	Family documentation must be mailed (i.e., income documentation)	☐	Family documentation must be mailed (i.e., income documentation)
	☐	Electronic signature is required	☐	Electronic signature is required
			☐	No Signature is required
	☐	N/A	☐	N/A

Does your program require a face-to-face interview during initial application	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	3
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☒	No	☒	No
	☐	Yes	☐	Yes
	Specify number of months		Specify number of months	
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	

	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☒	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	
	Premium amount		Premium amount	22
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Families with incomes between 150-175% FPL pay a monthly premium of $22/1 child & $33/2 or more children. Families with incomes between 175-200% FPL pay a monthly premium of $33/1 child and $50/2 or more children.	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☒	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☒	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

Does your program require income disregards?	☐	No	☐	No
	☒	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
	An earned income work expense disregard of $90 is allowed to applicants in the financial eligibility determination.		An earned income work expense disregard of $90 is allowed to applicants in the financial eligibility determination.	
	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☒	No	☒	No
	☐	Yes	☐	Yes
		☐ We send out form to family with their information pre-completed and ask for confirmation		☐ We send out form to family with their information pre-completed and ask for confirmation
		☐ We send out form but do not require a response unless income or other circumstances have changed		☐ We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Enter any Narrative text below.

~~2.~~ Is there an assets test for children in your Medicaid program?	☐ Yes	☒ No	☐ N/A
~~3.~~ Is it different from the assets test in your separate child health program?	☐ Yes	☐ No	☒ N/A
~~4.~~ Are there income disregards for your Medicaid program?	☒ Yes	☐ No	☐ N/A
~~5.~~ Are they different from the income disregards in your separate child health program?	☐ Yes	☒ No	☐ N/A
~~6.~~ Is a joint application used for your Medicaid and separate child health program?	☒ Yes	☐ No	☐ N/A

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program			**Separate Child Health Program**		
	Yes	No Change	N/A	Yes	No Change	N/A
~~a)~~ Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
~~b)~~ Application	☐	☒	☐	☐	☒	☐

~~c)~~ Application documentation requirements	☒	☐	☐	☒	☐	☐
~~d)~~ Benefit structure	☐	☒	☐	☐	☒	☐
~~e)~~ Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☒	☐	☐
~~f)~~ Crowd out policies	☐	☒	☐	☐	☒	☐
~~g)~~ Delivery system	☐	☒	☐	☐	☒	☐
~~h)~~ Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☒	☐	☐	☒	☐	☐
~~i)~~ Eligibility levels / target population	☐	☒	☐	☐	☒	☐
~~j)~~ Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
~~k)~~ Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
~~l)~~ Eligibility redetermination process	☒	☐	☐	☒	☐	☐
~~m)~~ Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
~~n)~~ Family coverage	☐	☒	☐	☐	☒	☐
~~o)~~ Outreach (e.g., decrease funds, target outreach)	☐	☒	☐	☐	☒	☐
~~p)~~ Premium assistance	☐	☒	☐	☐	☒	☐
~~q)~~ Prenatal Eligibility expansion	☐	☒	☐	☐	☒	☐
~~r)~~ Waiver populations (funded under title XXI)						
Parents	☐	☒	☐	☐	☒	☐
Pregnant women	☐	☒	☐	☐	☒	☐
Childless adults	☐	☒	☐	☐	☒	☐

~~s)~~ Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☐	☐
~~t)~~ Other – please specify						
~~a.~~ _____	☐	☐	☒	☐	☐	☒
~~b.~~ _____	☐	☐	☐	☐	☐	☐
~~c.~~ _____	☐	☐	☐	☐	☐	☐

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

~~a)~~ Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
~~b)~~ Application	
~~c)~~ Application documentation requirements	Proof of citizenship per DFR Proof of citizenship per DFR
~~d)~~ Benefit structure	
~~e)~~ Cost sharing (including amounts, populations, & collection process)	Increased premium amounts
~~f)~~ Crowd out policies	
~~g)~~ Delivery system	
~~h)~~ Eligibility determination process (including implementing a waiting lists or open enrollment periods)	Proof of Citizenship per DFR Proof of Citizenship per DFR
~~i)~~ Eligibility levels / target population	
~~j)~~ Assets test in Medicaid and/or SCHIP	
~~k)~~ Income disregards in Medicaid and/or SCHIP	

~~l)~~ Eligibility redetermination process	Proof of Citizenship per DFR Proof of Citizenship per DFR
~~m)~~ Enrollment process for health plan selection	
~~n)~~ Family coverage	
~~o)~~ Outreach	
~~p)~~ Premium assistance	
~~q)~~ Prenatal Eligibility Expansion	
~~r)~~ Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
~~s)~~ Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
~~t)~~ Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three subsections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four core child health measures:

- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is <u>not</u> required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, report data from the previous two years' annual reports (FFY 2004 and FFY 2005). If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2006). Additional instructions for completing each row of the table are provided below.

If Data Not Reported, Please Explain Why:
If you cannot provide a specific measure, please check the box that applies to your State for each performance measure as follows:

- <u>Population not covered</u>: Check this box if your program does not cover the population included in the measure.
- <u>Data not available</u>: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- <u>Small sample size</u>: Check this box if the sample size (i.e., denominator) for a particular measure is less than 30. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- <u>Other</u>: Please specify if there is another reason why your state cannot report the measure.

Status of Data Reported:
Please indicate the status of the data you are reporting, as follows:

- <u>Provisional</u>: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.
- <u>Final</u>: Check this box if the data you are reporting are considered final for FFY 2006.

– Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data – administrative data (claims), hybrid data (claims and medical records), survey data, or other source. If another data source was used, please explain the source.

Definition of Population included in the Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined. Also provide a definition of the numerator (such as the number of visits required for inclusion).

Note: You do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators, denominators, and rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

Note: SARTS will calculate the rate if you enter the numerator and denominator. Otherwise, if you only have the rate, enter it in the rate box.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small

increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

MEASURE: Well Child Visits in the First 15 Months of Life

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: 2006 reporting is not finalized as yet.
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☒ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: Children studied included those children in Hoosier Healthwise (CHIP and Medicaid) who were enrolled for at least six months in SFY2004 who were 6-12 months old or had turned age 1 or 2 by June 30, 2004. CMS-1500 claims were analyzed and the incidence of well-child visits, primary care visits, and other non-hospital medical visits by age group were determined. The definition of a primary care visit was one where the child was seen by a physician under one of five specialties defined by Indiana as a primary care provider. A non-hospital medical visit was defined as one in which the provider was a physician, clinic, or public health agency. HEDIS guidelines were used to determine which procedure codes to include defining a well-child visit. However, we slightly modified the age groups that HEDIS uses. Where HEDIS defines procedure codes for children in the first 15 months of life, we defined the group as being up to and through the second year of life. For this group, claims with procedure codes 99381, 99382, 99391, 99392 or 99432 defined a well-child visit.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 technical specifications were used. This measure is the percentage of children who turned 15 months old during the measurement year receiving between one and five well-child visits, six or more well-child visits, or no well-child visits during their first 15 months of life. The measurement year for HEDIS 2005 measures is 2004.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 technical specifications were used. This measure is the percentage of children who turned 15 months old during the measurement year receiving between one and five well-child visits, six or more well-child visits, or no well-child visits during their first 15 months of life. The measurement year for HEDIS 2006 measures is 2005.

FFY 2004	FFY 2005	FFY 2006
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: IndianaAim (Medicaid Management Information System)	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies. The data used for this measure is the result of combining administrative data (i.e. claims and encounter data) with data from medical record review.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies. The data used for this measure is the result of combining administrative data (i.e. claims and encounter data) with data from medical record review.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Indiana's Hoosier Healthwise program (Medicaid and CHIP) who were enrolled for at least six months in SFY2004 and who were ages 6-12 months or who had turned age 1 or age 2 by June 30, 2004.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery system that turned 15 months old during 2004. The figures are reported separately for each of the three Indiana MCOs, Harmony Health Plan, MDWise and MHS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery system that turned 15 months old during 2005. The figures are reported separately for three of the five Indiana MCOs, Harmony Health Plan, MDWise and MHS. The other two MCOs, CareSource and Molina, did not have populations satisfying the 2 year enrollment criteria as they were new MCOs for this reporting period.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

Well Child Visits in the First 15 Months of Life (continued)

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: Denominator: Rate: 4 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 5 visits Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 6+ visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure: In SFY2004, for children in the PCCM or RBMC program, the percentages of children with visits by age group were: 6 – 12 months - well-child 59%, primary care 65%, and non-hospital medical 94%. For children age 1- well-child 47%, primary care 63%, and non-hospital medical 92%. Results in the PCCM portion of the program were slightly higher for well-child but slightly lower for primary care visits as compared to results for children in the RBMC portion of the program.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: Denominator: Rate: 4 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 5 visits Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 6+ visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure: Comparison Baseline is NCQA Medicaid 2003 Median Rate and base year was HEDIS 2004. No change in definition of measurement in HEDIS did between HEDIS 2004/HEDIS 2005 so the data can be compared. The HEDIS 2004 values for children with no visits vs. those with > or = six visits were 8%/22% for Harmony, 4%/40% for MDWise, and 9%/26% for MHS, respectively. The HEDIS 2005 values for children with no visits vs. those with > or = six visits were 7%/45%/Harmony, 3%/44%/MDWise and 6%/33%/MHS.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: Denominator: Rate: 4 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 5 visits Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 6+ visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure: Comparison baseline is NCQA Medicaid 2004 Median Rate and base year 2004 data. HEDIS 2005 values for children with no visits vs. those with > or = six visits were 7%/45% for Harmony, 3%/44% for MDWise, and 6%/33% for MHS, respectively. With respect to measurements against HEDIS 2005, all three MCOs improved their performance on the measurements in the HEDIS 2006. HEDIS 2005 values for children with no visits vs. those with > or = six visits were 2%/55%/Harmony, 3%/56%/MDWise and 4%/49%/MHS.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate:

Additional notes on measure:	Additional notes on measure: Opportunities to improve upon these measurements, however, when compared to the NCQA Medicaid 2003 Median rates.National median for the percentage of children receiving no well-child visits is 2%; the national median for the percentage receiving > or = six is 46%. MCOs slightly above the national median for no visits and slightly below the median for > or = six visits.	Additional notes on measure: Opportunities to improve when compared to NCQA Medicaid 2004 Median rates. National median for % of children receiving no visits is 2% and for > or = six is 46%. The weighted statewide aggregates for 2004 were 5% and 41%; for 2005 were 3% and 53%. MCOs have improved and are all above the median for six or more visits but although improved are still slightly above the national median for no visits.

Explanation of Progress:

Annual Performance Objective for FFY 2007: To decrease the number of children with no medical visits by 3% statewide. To increase the number of children with 6 or more visits by 2% statewide.

Annual Performance Objective for FFY 2008: To decrease the number of children with no medical visits by 3% statewide. To increase the number of children with 6 or more visits by 2% statewide.

Annual Performance Objective for FFY 2009: To decrease the number of children with no medical visits by 3% statewide. To increase the number of children with 6 or more visits by 2% statewide.

Explain how these objectives were set: Projected goals are based upon aggregate rate increase from data from previous years for all participating and qualifying managed care organization

Other Comments on Measure: These measures are for all Hoosier Healthwise children, including CHIP to keep data consistent

MEASURE: Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: 2006 data is not complete and finalized to date
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☒ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: Children studied included those children in Hoosier Healthwise (CHIP and Medicaid) who were enrolled for at least six months in SFY2004 who had turned age 2, 3, 4, 5 or 6 by June 30, 2004. CMS-1500 claims were analyzed and the incidence of well-child visits, primary care visits, and other non-hospital medical visits by age group were determined. The definition of a primary care visit was one where the child was seen by a physician under one of five specialties defined by Indiana as a primary care provider. A non-hospital medical visit was defined as one in which the provider was a physician, clinic, or public health agency. HEDIS guidelines were used to determine which procedure codes to include defining a well-child visit. For children in the 3rd, 4th, 5th, and 6th year of life, a well-child visit was defined as a visit with a procedure code of 99382, 99383, 99392, or 99393.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 technical specifications were used. This measure is the percentage of enrolled children age three through six receiving one or more well-child visits with a primary care practitioner during 2004.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 technical specifications were used. This measure is the percentage of enrolled children age three through six receiving one or more well-child visits with a primary care practitioner during 2005.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:

FFY 2004	FFY 2005	FFY 2006
IndianaAIM (Medicaid Management Information System)	The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies	The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Indiana's Hoosier Healthwise program (Medicaid and CHIP) who were enrolled for at least six months in SFY2004 and who had turned age 2, 3, 4, 5 or 6 by June 30, 2004.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery systems that were three to six years old during 2004. The figures are reported separately for each of the three Indiana MCOs, Harmony Health Plan, MDWise and MHS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery systems that were three to six years old during 2005. The figures are reported separately for three of the five Indiana MCOs, Harmony Health Plan, MDWise and MHS. The other two MCOs, CareSource and Molina, did not have populations satisfying the 2 year enrollment criteria as they were new MCOs for this reporting period.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: Denominator: Rate: Additional notes on measure: In SFY2003 for all children PCCM or RBMC), % of visits by age group/well-child/primary care/non-hospital medical were: age 2/34%/60%/86%; age 3/26%/53%/79%; age 4- well-child 23%, primary care 53%, and non-hospital medical 78%; age 5- well-child 20%, primary care 51%, and non-hospital medical 78%. PCCM program portion results slightly higher for well-child but slightly lower for primary care visits compared to children in the RBMC portion.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: Denominator: Rate: Additional notes on measure: Comparison baseline is NCQA Medicaid 2003 Median Rate and base year is 2003 data. Base year data from last year showed % of children in age range who received at least one visit in 2003 was 49%/Harmony, 58%/MDWise, and 56%/ MHS. 2004 statistics were compared to baseline and NCQA Medicaid 2003 median rate. Harmony improved its performance in 2004, increasing to 56%. MDWise and MHS remained same at 57% and 54%, respectively; all slightly below NCQA Medicaid median of 61%.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: Denominator: Rate: Additional notes on measure: Comparison baseline is NCQA Medicaid 2004 Median Rate and base year is 2004 data. Percentage of children in this age range who received at least one well-child visit during 2004 was 56%/Harmony, 57%/MDWise, and 54%/ MHS. 2005 data was compared to baseline statistics and NCQA Medicaid 2004 median rate. Harmony improved increasing to 62% in 2005. MDWise and MHS improved slightly over last year at 60% and 60%, respectively.

Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life (continued)

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Well-child visits may be understated because it is not clear whether certain provider groups, such as clinics, are properly recording the well-child procedure codes on claims. SFY2004 is most likely understated because not all claims were reported by the time the data were retrieved (September 2004).	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The performance on this measure for all three MCOs, while improving, is still slightly below the NCQA Medicaid median of 64%. The weighted statewide aggregate for 2004 was 56% while the weighted statewide aggregate for 2005 was 61%.

Explanation of Progress:

Annual Performance Objective for FFY 2007: To increase statewide the number of children in each age group receiving one visit at least per year by 2%.

Annual Performance Objective for FFY 2008: To increase statewide the number of children in each age group receiving one visit at least per year by 2%.

Annual Performance Objective for FFY 2009: To increase statewide the number of children in each age group receiving one visit at least per year by 2%.

Explain how these objectives were set: Projected goals are based upon aggregate rate increase from data from previous years for all participating and qualifying managed care organization In 2007 we return to only 3 MCOs- one is new and the other 2 will be going statewide with new populations of providers and members.

Other Comments on Measure:

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☒ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: The submission rate of encounters reported by the managed care organizations in Indiana's CHIP was not high enough to conduct this analysis.	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: This data is not complete and not ready to be finalized.
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☒ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 technical specifications were used. This measure is the percentages of enrolled children who have persistent asthma and were prescribed appropriate medications. The measure is reported separately for children age five to nine and children age ten to seventeen.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 technical specifications were used. This measure is the percentages of enrolled children who have persistent asthma and were prescribed appropriate medications. The measure is reported separately for children age five to nine and children age ten to seventeen.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies.	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies.

FFY 2004	FFY 2005	FFY 2006
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery systems that were identified as having persistent asthma. The figures are reported separately for each of the three Indiana MCOs, Harmony Health Plan, MDWise and MHS	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery systems that were identified as having persistent asthma. The figures are reported separately for three of the five Indiana MCOs, Harmony Health Plan, MDWise and MHS. The other two MCOs, CareSource and Molina, did not have populations satisfying the 2 year enrollment criteria as they were new MCOs for this reporting period.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure: Comparison baseline is NCQA Medicaid 2003 Median Rate and base year is 2003 data. HEDIS 2004 measures for children five to nine: 74%/Harmony, 54%/MDWise, and 37%/MHS. Children ten to seventeen were 63%/Harmony, 59%/MDWise, and 49%/MHS. In 2004 in the five to nine year old category Harmony/74%, in the age ten to seventeen category 74%; MDWise for five to nine year olds and ten to seventeen year olds 65%/64% respectively; MHS 40% for five to nine-year-olds/55% for 10 to 17-year-olds.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure: Comparison baseline is NCQA Medicaid 2004 Median Rate and base year is 2004 data. HEDIS 2005 measures for children five to nine were: 74%/Harmony, 65%/MDWise, and 40%/MHS; Children ten to seventeen were 74%/Harmony, 64%/MDWise, and 55%/MHS. 2005 performance in the five to nine category Harmony/91% and in the ten to seventeen category/88%; MDWise/90%/87% respectively; MHS/86%/80%. All three MCOs reported findings above the NCQA median values (67% for 5-9 year-olds and 64% for 10-17 year-olds).
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Harmony reported findings above the NCQA median values and MDWise reported findings at the NCQA median values (65% for 5-9 year-olds and 64% for 10-17 year-olds).	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The weighted statewide aggregates for 2004 were 60% and 64% respectively. The weighted statewide aggregates for 2005 were 89% and 85%.

Explanation of Progress: **Annual Performance Objective for FFY 2007:** To increase statewide the results by 3% for both age groups. **Annual Performance Objective for FFY 2008:** To increase statewide the results by 3% for both age groups. **Annual Performance Objective for FFY 2009:** To increase statewide the results by 3% for both age groups. *Explain how these objectives were set:* Based upon previous years results and due to all MCOs choosing this program for compliance reporting and disease management
Other Comments on Measure:

MEASURE: Children's Access to Primary Care Practitioners

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: Data not complete for this time frame.
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☒ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Children studied included those children in Hoosier Healthwise (CHIP and Medicaid) who were enrolled for at least six months in SFY2004 who were 6-12 months old or had turned age 1, 2, 3, 4, or 5 by June 30, 2004. CMS-1500 claims were analyzed and the incidence of well-child visits, primary care visits, and other non-hospital medical visits by age group were determined. The definition of a primary care visit was one where the child was seen by a physician under one of five specialties defined by Indiana as a primary care provider. These include family practitioner, general practitioner, obstetrician/gynecologist, general internist, or general pediatrician. A non-hospital medical visit was defined as one in which the provider was a physician, clinic, or public health agency.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 technical specifications were used. This measure is the percentage of enrolled children who had a visit with a primary care practitioner (PCP). The measure is reported separately for children in the following age groups: 12 to 24 months, 25 months to 6 years, 7 to 11 years and 12 to 19 years.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 technical specifications were used. This measure is the percentage of enrolled children who had a visit with a primary care practitioner (PCP). The measure is reported separately for children in the following age groups: 12 to 24 months, 25 months to 6 years, 7 to 11 years and 12 to 19 years.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: IndianaAIM (Medicaid Management Information System)	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies.	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies.

FFY 2004	FFY 2005	FFY 2006
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Indiana's Hoosier Healthwise program (Medicaid and CHIP) who were enrolled for at least six months in SFY2004 and who were ages six months through six years old.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery system. The figures are reported separately for each of the three Indiana MCOs, Harmony Health Plan, MDWise and MHS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery system. The figures are reported separately for three of the five Indiana MCOs, Harmony Health Plan, MDWise and MHS. The other two MCOs, CareSource and Molina, did not have populations satisfying the 2 year enrollment criteria as they were new MCOs for this reporting period.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months / 7-11 years Numerator: / Numerator: Denominator: / Denominator: Rate: / Rate: 25 months-6 years / 12-19 years Numerator: / Numerator: Denominator: / Denominator: Rate: / Rate: Additional notes on measure: CMS-1500 claims reviewed for primary care visit defined as any visit to a primary medical provider of five physician specialties/non-hospital medical visit. Separate analyses completed for PCCM and RBMC programs. In SFY2003 % with visits by age group: 6-12 months/primary care 70%/non-hospital medical 95%; age 1-/67%/92%; age 2-/60%/86%; age 3- primary care 53%/non-hospital medical 79%; age 4- primary care 53%/non-hospital medical 78%; age 5- primary care 51%/non-hospital medical 78%.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months / 7-11 years Numerator: / Numerator: Denominator: / Denominator: Rate: / Rate: 25 months-6 years / 12-19 years Numerator: / Numerator: Denominator: / Denominator: Rate: / Rate: Additional notes on measure: The baseline for comparison is the NCQA Medicaid 2003 Median Rate. The base year for comparison is data collected under HEDIS 2004 (based on 2003 data). The following are the respective percentages of children with PCP visits who are between the ages of 12 and 24 months, 25 months and 6 years, 7 and 11 years and 12 and 19 years from HEDIS 2004: Harmony: 94%, 82%, 80% and 78%; MDWise: 94%, 81%, 80% and 80%; MHS: 94%, 83%, 78% and 78%	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months / 7-11 years Numerator: / Numerator: Denominator: / Denominator: Rate: / Rate: 25 months-6 years / 12-19 years Numerator: / Numerator: Denominator: / Denominator: Rate: / Rate: Additional notes on measure: The baseline for comparison is the NCQA Medicaid 2004 Median Rate. The base year for comparison is data collected under HEDIS 2005 (based on 2004 data). The following are the respective percentages of children with PCP visits who are between the ages of 12 and 24 months, 25 months and 6 years, 7 and 11 years and 12 and 19 years from HEDIS 2005: Harmony: 96%, 87%, 87% and 86% MDWise: 96%, 83%, 84% and 83% MHS: 94%, 81%, 81% and 82%
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: SFY2004 is most likely understated because not all claims were reported at the time the data were retrieved (September 2004).	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The respective % of children with PCP visits between the ages of 12 and 24 months/25 months and 6 years/7 and 11 years/12 and 19 years from HEDIS 2005: Harmony: 96%/ 87%/ 87%/86%; MDWise: 96%/83%/84%/83%; MHS: 94%/81%/81%/82% All three were also near the NCQA national medians, Harmony being slightly above and MHS being slightly below.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The following respective % of children with PCP visits between the ages of 12 and 24 months/25 months and 6 years/7 and 11 years/12 and 19 years from HEDIS 2006:Harmony: 96%/88%/88%/86%; MDWise: 96%/85%/85%/84%; MHS: 94%/83%/81%/81%. The NCQA national medians are: 96%, 85%, 84%, and 82%. The weighted statewide aggregates for 2004 were 95%, 84%, 84%, and 84%. The weighted statewide aggregates for 2005 were 95%, 85%, 85%, and 84%.

FFY 2004	FFY 2005	FFY 2006

Explanation of Progress:

Annual Performance Objective for FFY 2007: To increase access to primary care providers for all children by 2% statewide and across all of these populations.

Annual Performance Objective for FFY 2008: To increase access to primary care providers for all children by 2% statewide and across all of these populations.

Annual Performance Objective for FFY 2009: To increase access to primary care providers for all children by 2% statewide and across all of these populations.

Explain how these objectives were set: Based upon previous years results

Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

~~1.~~ The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2005	FFY 2006	Percent change FFY 2005-2006
SCHIP Medicaid Expansion Program	93666	97213	3.79
Separate Child Health Program	35878	36483	1.69

~~A.~~ Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

~~2.~~ The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2003-2005. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2006 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996 - 1998	123	26.9	7.8	1.7
1998 - 2000	122	26.1	7.8	1.6
2000 - 2002	109	16.6	6.8	1.0
2002 - 2004	100	15.8	6.0	.9
2003 - 2005	95	16.5	5.7	1.0
Percent change 1996-1998 vs. 2003-2005	-22.8%	NA	-26.9%	NA

~~A.~~ Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children.

~~B.~~ Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

~~3.~~ Please indicate by checking the box below whether your State has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)

☒ No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	
Reporting period (2 or more points in time)	
Methodology	
Population (Please include ages and income levels)	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

~~A.~~ Please explain why your State chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

~~B.~~ What is your State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

~~C.~~ What are the limitations of the data or estimation methodology?

~~4.~~ How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information

As of September 30, 2006, Title XIX Medicaid enrollment of children under age 19 had increased 7% since October 1, 2005.

Enrollment information was obtained by the State's actuary that derives data from the Indiana Client Eligibility System. The enrollment of children in the Title XIX program (defined as children under age 19) on July 1, 1997 was 245,839. The enrollment as of June 30, 2006 was 530,345, a 47

% increase over the same period. The overall enrollment in Indiana's CHIP program grew 7.5 percent from the middle of 2004 to the middle of 2005. This is the same rate as the previous 12- month period. However, the Phase II portion of the program grew 11 percent whereas Phase I enrollment grew by 6 percent. Since June 2005, enrollment in CHIP Phase II has grown by at least another 1,000 members. Note that this percentage increase only measures the number of children enrolled in Title XIX at the two points in time studied. Additional children who were enrolled in Title XIX between these two time periods have since left the program.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. The format of this section has been revised for FFY 2006 to provide your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- SCHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, please enter the data you reported for each objective in the previous two years' annual reports (FFY 2004 and FFY 2005). In the third column, please report the most recent data available at the time you are submitting the annual report.

Note that the term *performance measure* is used differently in Section IIA versus IIC. In Section IIA, the term refers to the four core child health measures. In this section, the term is used more broadly, to refer to any data your State provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are State-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported in Sections IIA or IIB. The intent of this section is to capture goals and measures that your State did not_report elsewhere in Section II.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective.

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.
- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.
- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:
Please indicate the status of the data you are reporting for each goal, as follows:

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.

- Final: Check this box if the data you are reporting are considered final for FFY 2006.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and SCHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source. For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims), hybrid data (claims and medical records), survey data (specify the survey used), or other source. In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Also provide a definition of the numerator (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

For measures related to increasing access to care and use of preventative care , please also check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Performance Measurement Data:
Describe what is being measured: Please provide a brief explanation of the information you intend to capture through the performance measure.

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for

each measure. If the form fields do not give you enough space to fully report on your measure, please use the “additional notes” section.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a “weighted rate” by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an “unweighted average” by taking the mean rate across health plans.

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and “best guesses” to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3)

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe)	**Goal #1 (Describe)**	**Goal #1 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to SCHIP Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) By September 30, 2002, 52,000 targeted low-income children will have health insurance through Title XXI.	**Goal #1 (Describe)** By September 30, 2002, 52,000 targeted low-income children will have health insurance through Title XXI.	**Goal #1 (Describe)** By September 30, 2002 , 52,000 targeted low-income children will have health insurance through Title XXI.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II).	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II).	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II).
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: IndianaAIM (Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: IndianaAIM (Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: MedInsight, a data warehouse for IndianaAim (Medicaid Management Information System)
Definition of Population Included in the Measure: Definition of denominator: Children enrolled in the Medicaid expansion portion and the separate state-designed portion of CHIP, both combined and separately. The unduplicated count of children in the Title XXI program on September 30, 2003; July 31, 2004; and for the period October 1, 2003 through July 31, 2004 (most recent available) were found. Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Children enrolled in the Medicaid expansion portion and the separate state-designed portion of CHIP, both combined and separately. The unduplicated count of children in the Title XXI program between October 1, 2004 and May 31, 2005 (most recent available) were found. Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Children enrolled in the Medicaid expansion portion and the separate state-designed portion of CHIP, both combined and separately. The unduplicated count of children in the Title XXI program between October 1, 2005 and September 30, 2006 were found. Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: At end FFY 2003, CHIP enrollment was 62,505 (47,490 in Medicaid expansion and 15,015 in state-designed portion of program). Towards end of FFY 2004 (July 2004), the enrollment in CHIP was 63,607 (46,365 in the Medicaid expansion portion and 17,242 in the state-designed portion of the program). There were 86,312 children in Medicaid expansion portion and 30,279 in the state-designed portion of the program who obtained health insurance at some point between October 1, 2003 and July 31, 2004. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: End FFY 2004 unduplicated count of children ever enrolled in CHIP was 127,865/94,516 in Medicaid expansion/33,349 in state designed program). At end of FFY 2005 the unduplicated count of children ever enrolled in CHIP was 133,192/96,865 in Medicaid expansion/36,327 in state-designed program). There were 2,349 children in Medicaid expansion portion/2,978 in the state-designed portion of the program who obtained health insurance at some point between October 1, 2004 and September 30, 2005. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: End of FFY 2005 unduplicated count of children ever enrolled in CHIP was 133,192/96,865 in Medicaid expansion and 36,327 in state designed program. At end of FFY 2006 unduplicated count of children ever enrolled during FFY 2006 in CHIP was 138,080/100,951 in Medicaid expansion and 37,129 in state-designed program). 4,086 children in Medicaid expansion portion and 802 in state-designed portion of program who obtained health insurance at some point between October 1, 2005 and September 30, 2006. Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: To enroll every qualified child who can be enrolled.

Annual Performance Objective for FFY 2008: To enroll every qualified child who can be enrolled.

Annual Performance Objective for FFY 2009: To enroll every qualified child who can be enrolled.

Explain how these objectives were set: There is no change in outreach plan, but all of the avenues for advertisement and enrollment are in place and functioning.

Other Comments on Measure:

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) By January 1, 1999 there will be at least a 10% increase in non-CHIP Medicaid enrollment by children under 19.	**Goal #1 (Describe)** By January 1, 1999 there will be at least a 10% increase in non-CHIP Medicaid enrollment by children under 19.	**Goal #1 (Describe)** By January 1, 1999 there will be at least a 10% increase in non-CHIP Medicaid enrollment by children under 19.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children currently enrolled in Medicaid will be identified and enrolled in that program. (Objective from original State Plan for Phase I that was approved 6/26/98)	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children currently enrolled in Medicaid will be identified and enrolled in that program. (Objective from original State Plan for Phase I that was approved 6/26/98)	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children currently enrolled in Medicaid will be identified and enrolled in that program. (Objective from original State Plan for Phase I that was approved 6/26/98)
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: IndianaAIM (Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: IndianaAIM (Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: MedInsight, a data warehouse for IndianaAim (Medicaid Management Information System)
Definition of Population Included in the Measure: Definition of denominator: The unduplicated count of children in the Title XIX program on September 30, 2003; July 31, 2004; and for the period October 1, 2003 through July 31, 2004 (most recent available) were found. Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Count of children under age 19 in Indiana's Medicaid program by June 2005 (most recent available). The unduplicated count of children in the Title XIX program between June 2004 and June 2005 (most recent available) were found. Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: The unduplicated count of children under age 19 in the Title XIX, Indiana's Medicaid program between October 2005 and September 2006 were found. Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: At the end of FFY 2003, the enrollment of children in Title XIX was 375,587 (a 52.7% increase since the implementation of CHIP). Near the end of FFY 2004 (July 2004), the enrollment was 408,843 (a 66.3% increase since the implementation of CHIP). Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: At the end of FFY 2004, 440,378 children were enrolled in the non-CHIP Medicaid program. By June 2005, the enrollment of children in the non-CHIP Medicaid program was 454,264, an 85% increase since the implementation of CHIP. A total of 13,886 children in the non-CHIP Medicaid program became newly enrolled at some point between June 2004 and June 2005. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: At the end of FFY 2006, 583,723 children were enrolled in the non-CHIP Medicaid program, an 138% increase since the implementation of CHIP. Numerator: Denominator: Rate: Additional notes on measure: No additional information
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe)	**Goal #1 (Describe)**	**Goal #1 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) At least 60% of 2 year olds enrolled in the Title XXI program will receive immunizations consistent with HEDIS recommendation	**Goal #1 (Describe)** At least 60% of 2 year olds enrolled in the Title XXI program will receive immunizations consistent with HEDIS recommendation	**Goal #1 (Describe)** At least 60% of 2 year olds enrolled in the Title XXI program will receive immunizations consistent with HEDIS recommendation
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children enrolled in Indiana's Title XXI program will enjoy improved health status. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II)	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children enrolled in Indiana's Title XXI program will enjoy improved health status. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II)	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children enrolled in Indiana's Title XXI program will enjoy improved health status. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II)
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: At least 60% of 2 year olds enrolled in the Title XXI program will receive immunizations consistent with HEDIS recommendations. The analysis was not evaluated to verify the recommended HEDIS periodicity schedule but rather that all immunizations were given by the time the child turned age two.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 technical specifications were used. This measure is the percentage of children who turned two years old during the measurement year, were continuously enrolled in the plan for the 12 months prior to the child's second birthday and received the following vaccinations: - Four doses DTaP or DT (diphtheria-tetanus) - Three doses OPV/IPV (polio) - One dose MMR (measles-mumps-rubella) - Three doses HiB (influenza) - Three doses Hepatitis B - One dose VZV (chicken pox) Also reports two separate combination rates: - Combination One: Four DTaP/DT, three OPV/IPV, one MMR, three HiB and three Hepatitis B vaccinations - Combination Two: All of the vaccinations listed in Combination One and one or more VZV vaccinations. The measurement year for HEDIS 2005 measures is 2004.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2006 technical specifications were used. This measure is the percentage of children who turned two years old during the measurement year, were continuously enrolled in the plan for the 12 months prior to the child's second birthday and received the following vaccinations: - Four doses DTaP or DT (diphtheria-tetanus)(at least) - Three doses OPV/IPV (polio)(at least) - One dose MMR (measles-mumps-rubella)(at least) - Two doses HiB (influenza) - Three doses Hepatitis B - One dose VZV (chicken pox)(at least) Also reports two separate combination rates: - Combination Two: Four DTP/DTaP, three OPV/IPV, one MMR, two HiB and three Hepatitis B vaccinations, and one VZV - Combination Three: All of the vaccinations listed in Combination Two and four pneumococcal conjugate vaccinations vaccinations. The measurement year for HEDIS 2006 measures is 2005

FFY 2004	FFY 2005	FFY 2006
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: CMS-1500 claims were reviewed for the period January 1, 2002 through June 30, 2004 and the procedure codes were analyzed to evaluate the incidence of codes for diphtheria/pertussis/tetanus, polio, mumps/measles/rubella, hemophilus influenza type B, hepatitis B, and chicken pox.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies. The data used for this measure is the result of combining administrative data (i.e. claims and encounter data) with data from medical record review and the Child's Hoosier Immunization Registry Project (CHIRP) database.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: The measures are reported by the Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies. The data used for this measure is the result of combining administrative data (i.e. claims and encounter data) with data from medical record review and the Child's Hoosier Immunization Registry Project (CHIRP) database.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Indiana's CHIP and were born during the period January 1, 2002 and June 30, 2002. All children in the study were enrolled in the CHIP for at least 18 months. Total sample is 829 children.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Two year-old children in the Medicaid expansion portion of CHIP and the separate state-designed portion of CHIP who are enrolled in the risk-based managed care delivery system. The figures are reported separately for each of the three Indiana MCOs, Harmony Health Plan, MDWise and MHS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Two year-old children in the Medicaid expansion portion of CHIP and the separate state-designed portion of CHIP who are enrolled in the risk-based managed care delivery system. The figures are reported separately for three of the five Indiana MCOs, Harmony Health Plan, MDWise and MHS. The other two MCOs, CareSource and Molina, did not have populations satisfying the 2 year enrollment criteria as they were new MCOs for this reporting period.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: 1. The available data showed that 23% of the children were reported as having none of the required immunizations as defined by HEDIS. 2. 41% had 14 or more immunizations (number required by HEDIS) and 60% had 7 or more. 3. The % of children that had an immunization for a specific disease are as follows: diphtheria/pertussis/tetanus- 72%; polio- 67%; mumps/measles/rubella- 54%; hemophilus influenza type B- 60%; hepatitis B- 64%; chicken pox- 49%. Immunizations are under-reported.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: Statistics from 2004 were compared to baseline statistics and to the NCQA Medicaid 2003 median rates. Immunization rates improved at all three MCOs. In 2004, Harmony's rates for combinations 1 and 2 were 56% and 49%, MDWise's rates were 55% and 53%, and MHS' rates were 49% and 44%. All of these rates represented substantial increases over the base year, but they all fell short of the 60% NCQA Medicaid median.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: Statistics from 2005 compared to baseline statistics and to NCQA Medicaid 2004 median rates. In 2005, Harmony's rates for combinations 2 and 3 were 62% and 43%, MDWise's rates were 73% and 47%, and MHS' rates were 41% and 24%. The Combination two rates for Harmony and MDwise represented increases over last year, but Harmony and MHS fell short of the 66% NCQA Medicaid median. There was no 2004 NCQA Medicaid median for Combination Three to compare to the reported rates from these four MCOs.

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Many providers delivering immunizations don't seek reimbursement and don't have claims data. Available data show goal set by the state has not been met. At least 60% of 2 year olds have received one shot for each of the HEDIS-required immunization categories except for mumps/measles/rubella/chicken pox. Further research needed to determine if all data from MCOs have been submitted. More research also required to determine if clinics providing these immunizations have submitted all claims.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The weighted statewide aggregate for 2004 were Combination Two was 49%. The weighted statewide aggregates for Combinations Two and Three were 59% and 38% respectively for 2005.

Explanation of Progress:

Annual Performance Objective for FFY 2007: To reach the 2004 NCQA median of 66% for Combination Two Immunizations across all MCOs

Annual Performance Objective for FFY 2008: To increase by 1% statewide for Combination Two Immunizations

Annual Performance Objective for FFY 2009: To increase by 1% statewide for Combination Two Immunizations

Explain how these objectives were set: Based on previous years data and the fact that two of the three MCOs for 2007 will be going statewide with new populations of physicians and members.

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) At least 60% of enrollees in the Title XXI program will receive recommended preventive services.	**Goal #2 (Describe)** At least 60% of enrollees in the Title XXI program will receive recommended preventive services	**Goal #2 (Describe)** At least 60% of enrollees in the Title XXI program will receive recommended preventive services.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children enrolled in Indiana's Title XXI program will enjoy improved health status. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II)	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children enrolled in Indiana's Title XXI program will enjoy improved health status. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II)	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: Children enrolled in Indiana's Title XXI program will enjoy improved health status. (Objective from State Plan for Phase I and subsequent State Plan that was approved 12/22/99 for Phase II)
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☒ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2006
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Children studied included those children in Hoosier Healthwise (CHIP and Medicaid) who were enrolled for at least six months in SFY2004 who were 6-12 months old or had turned age 1, 2, 3, 4, or 5 by June 30, 2004. CMS-1500 claims were analyzed and the incidence of well-child visits, primary care visits, and other non-hospital medical visits by age group were determined. The definition of a primary care visit was one where the child was seen by a physician under one of five specialties defined by Indiana as a primary care provider. These include family practitioner, general practitioner, obstetrician/gynecologist, general internist, or general pediatrician. A non-hospital medical visit was defined as one in which the provider was a physician, clinic, or public health agency	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 technical specifications were used. This measure reports the percentage of enrolled children and adolescents who had a visit with a Primary Care Practitioner (PCP). Rates are reported in four age categories: - 12 months through 24 months old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year - 25 months through 6 years old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year - 7 through 11 years old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year - 12 through 19 years old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 technical specifications were used. This measure reports the percentage of enrolled children and adolescents who had a visit with a Primary Care Practitioner (PCP). Rates are reported in four age categories: - 12 months through 24 months old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year - 25 months through 6 years old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year - 7 through 11 years old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year - 12 through 19 years old, continuously enrolled during the measurement year and had a visit with a PCP during the measurement year.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:

FFY 2004	FFY 2005	FFY 2006
IndianaAim (Medicaid Management Information System)	Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies	Managed Care Organizations (MCO) who collected data using NCQA-approved data collection and reporting methodologies
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children studied included those children in Hoosier Healthwise (CHIP and Medicaid) who were enrolled for at least six months in SFY2004 who were 6-12 months old or had turned age 1, 2, 3, 4, or 5 by June 30, 2004	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery system. The figures are reported separately for each of the three Indiana MCOs, Harmony Health Plan, MDWise and MHS.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children enrolled in Medicaid or CHIP in the risk-based managed care delivery system. The figures are reported separately for three of the five Indiana MCOs, Harmony Health Plan, MDWise and MHS. The other two MCOs, CareSource and Molina, did not have populations satisfying the 2 year enrollment criteria as they were new MCOs for this reporting period.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: In SFY2004, in either the PCCM or RBMC program, % of children with visits by age group were: 6-12 months/primary care 65%/non-hospital medical 94%; age 1/primary care 63%/non-hospital medical 92%; age 2/primary care 57%/non-hospital medical 86%; age 3/primary care 52%/non-hospital medical 80%; age 4/primary care 50%/non-hospital medical 78%; age 5/primary care 50%/non-hospital medical 78%. Results in PCCM portion of the program were slightly lower for primary care visits.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: The base year for comparison is 2003. The following are the respective percentages of children with PCP visits who are between the ages of 12 and 24 months, 25 months and 6 years, 7 and 11 years and 12 and 19 years: - Harmony: 94%, 82%, 80% and 78% - MDWise: 94%, 81%, 80% and 80% - MHS: 94%, 83%, 78% and 78%	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: The base year for comparison is 2004. The following are the respective percentages of children with PCP visits who are between the ages of 12 and 24 months, 25 months and 6 years, 7 and 11 years and 12 and 19 years: - Harmony: 96%, 88%, 88% and 86% - MDWise: 96%, 85%, 85% and 84% - MHS: 94%, 83%, 81% and 88%
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The NCQA median benchmarks were: 95%, 85%, 84%, and 82%. The weighted statewide aggregates for 2005 are 95%, 85%, 95%, and 86%.

FFY 2004	FFY 2005	FFY 2006
Explanation of Progress: **Annual Performance Objective for FFY 2007:** To maintain statewide the current % of PCP visits per age cohort. **Annual Performance Objective for FFY 2008:** To increase the % of PCP office visits by 1% for each age cohort statewide **Annual Performance Objective for FFY 2009:** To increase the % of PCP office visits by 1% for each age cohort statewide *Explain how these objectives were set:* Based upon previous years data and the rollout of statewide coverage for the two continuing MCOs and the addition of a new in 2007		
Other Comments on Measure:		

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

1. What other strategies does your State use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

Hoosier Healthwise (Medicaid and CHIP) enrollees are surveyed annually regarding their opinion of health services provided. The survey instrument includes questions related to overall satisfaction with the program, physician courtesy, quality of care, staff courtesy, appointment access, time spent with the doctor, and their opinions of their health plans and personal doctors. The Myers Group, an NCQA-Certified HEDIS®1 Survey Vendor, was selected by each of the MCOs to conduct its 2006 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2 3.0H Medicaid Adult Member Satisfaction Survey. They used a mix of mail and telephone survey administration methodology (following NCQA protocol) and collected responses from each eligible member population from January through May of 2006.

The following highlight the results of the 2005 managed care members' surveys:

Overall, children in Hoosier Healthwise rated their health plan and their doctors at

a rate similar to national benchmarks of surveys to parents of children in Medicaid programs. When results for CHIP members/parents could be isolated (from the survey of PCCM members), both CHIP Phase I and CHIP Phase II members gave responses that were as favorable as or more favorable than the general Hoosier Healthwise population.

* When asked how often they were treated with courtesy by the doctor or office staff, 88% responded "always" or "usually."

* When asked to rate the child's health plan, between 65% and 81% gave their health plan a "very good" or "excellent" rating.

* In rating the child's personal doctor, between 72% and 88% gave their doctor a "very good" or "excellent" rating.

Regarding access, we measure on an annual basis the utilization of claims per 1,000 members for services such as primary care physician visits, specialty care physician visits, dental visits, pharmacy claims, and inpatient and outpatient hospital services.

Findings by service category for data in calendar year 2005 (with comparisons to calendar year 2004):

* Primary care physician claims per 1,000 members were 120/1,000 for Phase I and 165/1,000 for Phase II members of the Title XXI program, as compared to 139/1,000 for Phase I and 169/1,000 for Phase II in calendar year 2004.

* Non-Primary care physician claims per 1,000 members were 143/1,000 for Phase I and 170/1,000 for Phase II members of the Title XXI program, as compared to 141/1,000 and 1511/1,000 in calendar year 2004.

* Dental service claims per 1,000 members were 114/1,000 for Phase I and 137/1,000 for Phase II members of the Title XXI program, as compared to 116/1,000 and 124/1,000 in calendar year 2004.

* Pharmacy claims per 1,000 members were 408/1,000 for Phase I and 398/1,000 for Phase II members of the Title XXI program, as compared to 426/1,000 and 399/1,000 in calendar year 2004.

* Outpatient hospital claims per 1,000 members were 84/1,000 for Phase I and 99/1,000 for Phase II members of the Title XXI program, as compared to 87/1,000 and 88/1,000 in calendar year 2004.

The only categories that showed significant changes in utilization in 2005 were the two physician categories. The large shifts in utilization of physician services reported above is primarily the result of

changing how the claims are counted, instead of a major change in how CHIP members are accessing services. Historically, the utilization rates for all five of these categories have been stable.

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

Each year, the CHIP office contracts with an outside vendor to conduct an independent evaluation of the program. The findings from this evaluation are presented in a report to the Indiana Legislature. The 2006 evaluation has been included in this report as Attachment B. The evaluations in the past have included: a review of trends in utilization and payments by category of service; enrollment trends for both phases of Title XXI as well as between our Risk-Based Managed Care system and our Primary Care Case Management system; and member access to primary care physicians at the county level. We anticipate that these analyses will continue in future years as well as more detailed analyses that will be added to the evaluation.

We also maintain a monitoring manual which was first developed in 2002. It was updated with another year of information in 2003, 2004, 2005 and 2006. The current monitoring manual includes over 70 measurements to review on an annual (or more frequent) basis. Results from this year's manual were compared to previous years and summarized in a "scorecard" that tracks each year's results. Areas shown on the scorecard that merit additional study are easily identifiable.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

No additional focus studies were conducted in FFY 2006.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

Attachment A: Comparison of CHIP Benefits

Attachment B: 2006 Independent Evaluation of the Indiana Children's Health Insurance Program

Attachment C: Hoosier Healthwise 2006 Managed Care Member Satisfaction Surveys Results- Harmony

Attachment D: Hoosier Healthwise 2006 Managed Care Member Satisfaction Surveys Results- MDwise

Attachment E: Hoosier Healthwise 2006 Managed Care Member Satisfaction Surveys Results- MHS

Attachment F: Application for Hoosier Healthwise (English)

Attachment G: Sample Letter of Redetermination to Families

Attachment H: Application for Hoosier Healthwise (Spanish)

Attachment I: Citizenship Verification Documentation Requirement (English)

Attachment J: Citizenship Verification Documentation Requirement (Spanish)

Enter any Narrative text below.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

~~1.~~ How have you redirected/changed your outreach strategies during the reporting period?

CHIP I was implemented July 1, 1998 and CHIP II was implemented January 1, 2000 so a large-scale outreach/communications campaign was not warranted in FFY 2006. CHIP, however, continued to focus on conducting outreach on a local basis and through schools. The relationship that CHIP shares with the community advocates of the Robert Wood Johnson Foundation's four-year Covering Kids and Families grant has helped develop work plans to improve enrollment processes, further developed local partnerships with schools and community health centers, and increased the use of enrollment trend data.

CHIP continues to collaborate with the Indiana Department of Education to mail Hoosier Healthwise applications to families who applied for the Free and Reduced-Price Meal program, notifying families that if their children qualified for the meal program, they would probably also qualify for Hoosier Healthwise

~~2.~~ What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

Successful methods of reaching low-income, uninsured children during FFY 2006 include:

• Alternative enrollment options such as mail-in applications and 500 local enrollment centers (such as hospitals, health clinics, and community centers) throughout the state remained popular alternatives to applying at the local DFR office. The effectiveness and popularity of the mail-in application is measured by the number of applications received. For FFY 2006, the central mail-in unit processed an average of 216 approved applications each month, while the 500 local enrollment centers combined processed an average of 438 applications per month that were approved by the central DFR office.

• A Robert Wood Johnson Foundation Covering Kids and Families (CKF) grant targeting hard-to-reach, uninsured populations completed it final year in FFY 2005. Six local coalitions and a statewide coalition have implemented outreach and enrollment projects that identify, enroll, and retain children and adults who are eligible for Medicaid and Hoosier Healthwise. The Covering Kids and Families coalitions have found that creating partnerships with community networks that include schools, hospitals, and managed care organizations has led to outreach success. Through the CKF partnerships, more community entities are made aware of Hoosier Healthwise and can refer uninsured families to an enrollment center or to the local Division of Family Resources.

• CHIP discontinued its data matching program that compared lists of children enrolled in the Free and Reduced-Price Meal program with Medicaid/SCHIP enrollees. This program found less than two percent of children enrolled in the free and reduced lunch program were not already enrolled in Medicaid or CHIP. This could indicate that families qualifying for free and reduced lunch have been successfully enrolled through other outreach efforts and through the current process available through the Division of Family Resources and associated enrollment centers.

Effectiveness of combined outreach efforts has been measured in accordance with the number of children who have enrolled. CHIP I and II enrollment continued to increase from FFY 2005 to 2006. This increase is the clearest evidence that outreach succeeded in bringing more eligible children into Hoosier Healthwise.

• The Hoosier Healthwise Helpline assists in measuring successful outreach strategies by asking callers where they heard about Hoosier Healthwise. The Helpline received over 13,654 requests for applications during FFY 2006. Word of mouth continues to be the most common source of information and outreach. During FFY 06, 22 percent of callers requesting applications said they had heard of Hoosier Healthwise from a friend or family member, 13% were members in the past, 10% were through Healthy Families, 4% found the information on bus placards, and 2% of the callers learned of Hoosier Healthwise through work. Billboards, schools, physicians, brochures, and clinics each represented about 16% of the information source, while WIC agencies, hospitals and the health department informed about 5% of the inquirers. Only 2% heard of the program on TV, most likely as a result of Covering Kids or Insure Kids Now campaigns. A variety of other sources, including the Internet, health fairs, and clinics, also explained the program to potential members.

~~3.~~ Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

Collaboration with the Free and Reduced-Price Meal program has been effective in raising awareness of the program and in soliciting Hoosier Healthwise applications among rural counties and families. Most of the participating schools and childcare providers were in rural counties, and most of the families applying through this collaboration live in rural counties.

Local community organizations are a source of information for underserved communities. Many local Division of Family and Children offices and Covering Kids projects have distributed information to local organizations and have enlisted their help in outreach efforts.

The most recent statistics available (July 2004 for census data and September 2006 for enrollment data) reflect the percentages among population groups and the participation of Indiana's minority populations in Medicaid, CHIP I, and CHIP II compared to White, Not Hispanic/Latino population.

Population: White, Not Hispanic/Latino = 80.3%

Children on Medicaid = 62%

CHIP Medicaid Expansion (up to 150% FPL) = 68%

CHIP State-Designed Program (up to 200% FPL) = 62%

Participation in CHIP Medicaid Expansion and CHIP decreased.

Population: Black or African American = 10.6%

Children on Medicaid = 26.0%

CHIP Medicaid Expansion = 18%

CHIP State-Designed Program = 12%

Population: Hispanic of Latino Origin = 5.8%

Children on Medicaid = 11%

CHIP Medicaid Expansion = 13%

CHIP State-Designed Program = 11%

Population: “All Other” includes American Indian, Alaska Native, Asian, Native Hawaiian, and Pacific Islander = 3.3%

Children on Medicaid = 2.2%

CHIP Medicaid Expansion = 2.4%

CHIP State-Designed Program = 2.0%

Findings – Comparison of 2004 and 2005 Statistics

Population - The population of White/Not-Hispanic/Latino decreased by 5% from last year’s report. Each of the other three groups increased population with the Black/African Americans showing the greatest population increase of 2.4%.

Children on Medicaid – Statistics reflect a small increase of children on Medicaid for Hispanic/Latino (1.1%) and for “All Other” groups (0.3%). Black/African Americans and White/Not Hispanic/Latino stayed the same for children on Medicaid.

CHIP Medicaid Expansion (CHIP I) – An increase in CHIP I participation occurred for the Hispanic/Latino (2%) and the "All Other" groups (.5%) while participation by White/Not Hispanic/Latino and for Black/African Americans stayed the same.

CHIP State-Designed Program (CHIP II)- An decrease in CHIP II participation occurred for Black/African Americans (0.5%) and the White/Not Hispanic/Latino (13%). The Hispanic/Latino and the "All Other" groups stayed the same.

The White/Not-Hispanic/Latino group decreased in two of the four areas – Population 0%, Children on Medicaid 0%, CHIP Medicaid Expansion 1%, and CHIP State-Designed Program 13%.

Black/African Americans showed a 0% increase in population and a 0.5% increase in participation in CHIP II. Their participation of Children on Medicaid and CHIP I stayed the same.

Overall, the Hispanic/Latinos increased in participation for Children on Medicaid 1.1%, CHIP I 0.8%, and CHIP II 0.6%.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

~~1.~~ Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

- ☐ Yes
- ☒ No
- ☐ N/A

If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

~~2.~~ Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

- ☐ Yes
- ☐ No

☒ N/A

If yes, identify your substitution prevention provisions (waiting periods, etc.).

All States must complete the following 3 questions

~~3.~~ Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

Substitution of coverage is monitored through the application process. If applicants attest to having other insurance, their eligibility for a state insurance program is determined by their income level. For children in families with income between 100% and 150% of the FPL, evidence of other insurance precludes them from eligibility in the CHIP program but these children are eligible for Indiana's Medicaid program. For children in families with income between 150% and 200% of the FPL, evidence of other insurance precludes them from eligibility in the CHIP program and the Medicaid program. Therefore, there are no children enrolled in CHIP whose families have other insurance.

There are certain limitations to eligibility under Hoosier Healthwise Package C relative to the coverage or possible coverage of the children under other insurance as follows:

Access to the State of Indiana Health Insurance Plan:

Children whose parents, caretakers or spouses can cover them under the State of Indiana's health coverage plans offered prohibition applies even if the State employee has chosen not to cover the child, and regardless of whether or not an open enrollment period is available to the employee at the time of the Hoosier Healthwise application. The prohibition does not apply if it is a non-custodial parent who is the State employee.

To qualify for coverage for a dependent, the State employee must be a full-time employee living with the dependent, and must be the parent, stepparent, foster parent, legal guardian, or spouse of the dependent. This excludes grandparents who do not have legal guardianship of grandchildren in their care. A married dependent may not be covered under a parent's State benefit package, regardless of age. If the requirements for coverage under the State benefit package appear to be met but the State employee maintains that the child in his or her care cannot be covered, the employee must present or obtain verification from the agency's health plan administrator. The application should suspend (pend) awaiting this verification.

Coverage by other health insurance:

Children who are covered by comprehensive health insurance (hospital and medical or major medical) are not eligible for SCHIP (package C or MA 10), even if there is a pre-existing condition or specific diagnosis exclusion clause. This differs from the limitation above as the issue is verified coverage, not merely access. If a child has health insurance, the MA 10 eligibility determination must pend for verification of the insurance benefit types

Dropping health insurance coverage:

Children whose health insurance coverage has been dropped voluntarily may not receive MA 10 for three months following the month of termination. The Hoosier Healthwise application (Form 2030) asks for information concerning the reason for the termination of coverage. If "could not afford" is indicated as the reason, the insurance is considered to have been terminated voluntarily and the child is subject to the three-month waiting period. Termination of insurance due to loss of employment (even if the loss was due to a voluntary quit) does not affect the child's eligibility for MA 10. If the family lists a reason that is not on the application or the ICES table, and the worker is uncertain as to whether the termination should be considered voluntary, the Policy Answer Line should be contacted.

Once eligibility has been passed from ICES to IndianaAIM, the computer system continues to provide a 30, 60, and 90 day look back of any additional insurance information that may have been provided for each member once they were determined eligible for the SCHIP coverage.

~~4.~~ At the time of application, what percent of applicants are found to have insurance?

The percent of applicants found to have insurance at the point of application for children in families with income between 150% and 200% of the FPL is not tracked by the State. However, for children in families with income between 100% and 150% of the FPL, it is tracked because these children are eligible for Indiana's Medicaid program. In FFY 2006 the percentage of children in families between 100% and 150% of the FPL with and without insurance was 16% and 84%, respectively. This distribution has not changed much in recent years.

Indiana children are more likely than children in the rest of the country to be covered by private health insurance. This fact, in conjunction with the Hoosier Healthwise program, means that Indiana's uninsured rate for children is lower than the national average. This is true for the uninsured rate for all children (9.4% in Indiana versus 11.7% nationwide) as well as for children in families under 200% of the federal poverty level (16.6% in Indiana versus 19.0% nationally).

~~5.~~ Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

This statistic is not tracked by the State. However, the only population that may have an incentive to do this would be the children in families between 150% and 200% of the FPL (the part of the program that is not the Medicaid expansion). Enrollment in this portion of Indiana's CHIP has never been more than 27% of total CHIP enrollment prior to 2006. Throughout 2005/ 2006, enrollment in this portion of the program was between 22% and 29%.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

~~1.~~ Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

Yes. SCHIP was built upon the existing infrastructure of the Medicaid program and uses the same application and procedures. The seamless application process accommodates families whose income range fluctuates between the two programs. Income fluctuation, therefore, does not interrupt coverage even though it may require a change in program funding. (See Attachment A: Application for Hoosier Healthwise)

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

For uninsured children ages one through five whose family income exceeds 133% FPL or children six through eighteen whose family income exceeds 100% FPL, the transition from Medicaid to SCHIP will have no discernible effect on the family. Instead, a change in funding source will be documented by the Indiana Client Eligibility System (ICES). For uninsured children who are in the under one year through 19 year age group and whose family income exceeds 150% FPL , ICES assigns a new eligibility code to that child and the family is notified in writing that they must pay a premium, which varies with income, in order to maintain health insurance coverage. Included in the written notice is the information that coverage will begin after a premium payment has been made. One administrative challenge is that Medicaid enrollment can allow for up to three months of retroactive coverage. When a SCHIP family qualifies for Medicaid, the state must refund premiums paid for the period, which retroactively became premium-free.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes. CHIP is based on the same eligibility and service delivery infrastructure as Medicaid. As a result, all providers enroll as Medicaid and CHIP providers and cannot choose to serve one population or the other. This has been an essential part of our success in keeping children enrolled as their family income changes

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

☐ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program?
  The state sends three notices to families whose income is 150%-200% FPL and who fail to pay the premium required for coverage. Disenrollment actions that are not related to premium payment trigger one notice.
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)
  Indiana's eligibility system includes a scheduler that automatically notifies families of an appointment to discuss their eligibility redetermination 45 days prior to the end of the current period. The system also has a tracking function that lists families and their due date for redetermination. When it becomes necessary to take adverse action (that is, reduce the benefit level) there must be time to give advance notice of the adverse action. The time period is 13 calendar days for all programs

☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

☐ Holds information campaigns

☒ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined

Medicaid/SCHIP application)

Applicant information is retained in the Indiana Client Information System and may be updated via a phone interview with a caseworker for initial applications, re-applications, and redeterminations.

☐ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:*

☒ Other, *please explain*:

For families in the 150%-200%FPL income group, monthly invoices include a warning that nonpayment of a premium may result in discontinuing coverage. When two consecutive months of payment are missed, the Indiana Client Eligibility System (ICES) generates a notice to a family that has failed to pay premiums, warning that coverage will end the last day of the month in which payment has not been made. Three notices are sent to families that fail their premium payment obligations.

~~2.~~ Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

No formal studies have been conducted to determine which methods specifically have been most effective in retaining children in CHIP. However, because the State discontinued 12-month eligibility for children on July 1, 2002, it ensures that members receive renewal reminder notices so that eligible members remain in the program.

~~3.~~ Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

☐ Yes
☒ No
☐ N/A

When was the monthly report or assessment last conducted?

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

COST SHARING

~~1.~~ Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

No formal assessment was undertaken to determine the effects of premiums/enrollment fees on participation in CHIP. However, the SEDS FFY 2006 reflect approximately 97,213 children enrolled in the CHIP Medicaid-expansion program, representing a 3.79% increase from the prior year. In CHIP Phase II, for which members pay monthly premium fees, enrollment for FFY 2006 was 36,483, an increase of 1.69% from the prior year. Since the enrollment in this phase of the CHIP program continues to grow, we can conclude that premium payments do not present a barrier to enrollment, and therefore do not present a barrier to service.

~~2.~~ Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

The State has collected information that pertains to the impact of cost sharing on service use. Indiana evaluates its CHIP program every year through an independent evaluator. The last independent evaluation was performed for calendar year (CY) 2005 and contains the following.

The findings of the annual evaluation report for the CHIP program for CY 2005 are very similar to the findings of the previous year. There were no systemic issues that affected enrollment into the CHIP or CHIP children's access to services Overall, children in Hoosier Healthwise rated their health plan and their doctors at a rate similar to national benchmarks of surveys to parents of children in Medicaid programs. When results for CHIP members/parents could be isolated (from the survey of PCCM members), both CHIP Phase I and CHIP Phase II members gave responses that were as favorable as or more favorable than the general Hoosier Healthwise population. The only area where CHIP Phase II differed from either CHIP Phase I or the general Hoosier Healthwise population in a meaningful way was related to the question about receiving courtesy and respect from the doctor's office.

Service Utilization: CHIP vs. Medicaid

Service utilization patterns differed between Medicaid and CHIP depending upon the service reviewed. However, some of this can be attributed to the large population of infants in the Medicaid program which is not a part of CHIP (because most infants in low- income families are eligible for Medicaid already). Utilization trends based on claims per 1,000 enrollees has remained stable over the last three years when the claims from MCOs were analyzed for inpatient hospital, outpatient hospital, primary care, specialist care, clinic, pharmacy and dental services. With a couple of exceptions, there is also little difference between the two CHIP packages in their utilization patterns. When compared to Medicaid children, CHIP children had a higher dental claims rate, pharmacy claims rate, and PMP physician claims rate per 1,000.

Prescription Drug Utilization

CHIP Phase II recipients share cost for prescribed drugs with a $3 co-payment for generic brand drugs or a $10 co-payment for name brand drugs. CHIP I and traditional Medicaid recipients make co-payments for prescribed drugs of $0.50, $1.00, $2.00, or $3.00 based on cost and whether they are brand name or generic. No co-payments are required for hospital, physician, or dental services. Since all Medicaid and CHIP recipients pay something for pharmacy services, the comparison must be considered in light of the greater cost of pharmacy service to CHIP Phase II recipients.

PAYMENTS MADE FOR CHIP MEMBERS

The payments made by CHIP to provide services to its members increased quite a bit from 2004 to 2005, when measured on a per member per month basis. The MCOs participating in the RBMC delivery system are paid a monthly capitation payment to serve their members, regardless of the amount, duration or scope of services provided to the members (except as limited to what the MCOs are contractually obligated to deliver). From 2004 to 2005, overall PMPM payments in the RBMC system grew 13 percent. This is further detailed as a 4 percent growth for children ages 1-5, a 26 percent growth for children ages 6-12, and a 6 percent growth for children ages 13-18

Although in CY 2003 and CY 2004, the PMPM payments made for children enrolled in the PCCM delivery system exceeded those made for children in the RBMC delivery system, this trend changed in CY 2005 for children ages 6-12 and children ages 13-18. This finding would need more exploration, however, since the population in the PCCM delivery system may have been less representative in 2005 as compared to prior years since the program was phasing out.

~~3.~~ If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

In February 2006 Indiana made changes in cost sharing (FFY 2006). Families with incomes between 150-175% federal poverty level (FPL) now pay a monthly premium of $22 for one child or $33 for two or more children. Families with incomes between 175-200% FPL pay a monthly premium of $33 for one child and $50 per two or more children. This information was shared with currently enrolled children's families who reported that these premium amounts were still reasonable. We continue to monitor enrollments due to the increased premium and are noting that enrollment in CHIP I continues to decline while enrollment in CHIP II increases.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

~~1.~~ Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

☐ Yes, please answer questions below.
☒ No, skip to Program Integrity subsection.

Children

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan (Incidentally)
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

~~2.~~ Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☐ Parents and Caretaker Relatives
☐ Childless Adults

~~3.~~ Briefly describe your program (including current status, progress, difficulties, etc.)

~~4.~~ What benefit package does the program use?

~~5.~~ Does the program provide wrap-around coverage for benefits or cost sharing?

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured?

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced?

9. During the reporting period, what accomplishments have been achieved in your premium assistance program?

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned.

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.)**

PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE SCHIP PROGRAMS (I.E. THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for prevention, investigation and referral of cases of fraud and abuse? Please explain.
Yes, the OMPP Compliance Unit has procedures for ensuring program integrity and detecting fraudulent or abusive activity.

The Office of Medicaid Policy and Planning (OMPP), in conjunction with contracted staff, maintains written manuals and requirements on the process for identification and referral of cases of fraud and abuse.

The Managed Care Organizations are required to refer cases upon identification to the Medicaid Fraud Control Unit (MFCU). The MFCU, an arm of the Attorney Generals' Office with whom the Office maintains a Memorandum Of Understanding, conducts formal investigations of such cases.

In addition, identified overpayments are recovered through routine surveillance and utilization processes. The Division of Family Resources (DFR) completes the eligibility determination process. Eligibility fraud referrals are forwarded to the Bureau of Investigation (BOI) within the DFR.

The OMPP Compliance Unit employs numerous methods to identify and investigate suspected fraud. Such methods include random sampling, provider rankings, providers' self auditing, and algorithms.

The statistical analyses, algorithms, and neural network strategies contribute to the identification of provider cases for review and serve as a cross-reference to validate referrals. Providers are flagged if they exhibit payment patterns that vary greatly from their peers. If necessary, further review will take place through medical record or onsite review. The SUR Operations Manual outlines this process in detail.

Providers are afforded due process through appeals, according to 405 Indiana Administrative Code 1-1.5-1. This process is also outlined in the Indiana Health Coverage Programs (IHCP) Provider Manual.

In addition to the OMPP Compliance Unit's procedures, each MCO who contracts with Hoosier Healthwise must submit a program integrity plan annually.

Also, each MCO must employ key staff, dedicated to the Hoosier Healthwise program. The Compliance Officer is a key staff member at the MCO and is described below.

• Compliance Officer – The MCO must employ a Compliance Officer who is dedicated full-time to the Hoosier Healthwise program. This individual will be the primary liaison with the State (or its designees) to facilitate communications between OMPP, the State's contractors and the MCO's executive leadership and staff. This individual must maintain a current knowledge of Federal and State legislation, legislative initiatives, and regulations that may impact the MCO's Hoosier Healthwise program. OMPP must approve of the candidate who will fill this position. The compliance officer, in close coordination with other key staff, has primary responsibility for ensuring all MCO functions are in compliance with the terms of the MCO's contract.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC or the Program), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Department's Inspector General (HHS/OIG), designated to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. In its tenth year of operation, the Program's continued success again confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud and abuse, and to protect program beneficiaries.

The United States Attorneys and their assistants, or AUSAs, are the nation's principal prosecutors of federal crimes, including crimes committed by health care providers

2. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

~~a)~~ Provider credentialing

Number of cases investigated 0

Number of cases referred to appropriate law enforcement officials 0

~~b)~~ Provider billing

Number of cases investigated 26

Number of cases referred to appropriate law enforcement officials 26

~~c)~~ Beneficiary eligibility

Number of cases investigated 0

Number of cases referred to appropriate law enforcement officials 0

3. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors?
The Office contracts surveillance and utilization review (SUR) functions out to Health Care Excel (HCE). The Office also maintains a Memorandum Of Understanding (MOU) with the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office which investigates provider fraud and abuse and an MOU with the Bureau of Investigations (BOI) within the Division of Family Resources which investigates recipient eligibility fraud.

The Office provides oversight of HCE through approval of manuals, by conducting onsite reviews and meetings, and routine approval and collaboration of work efforts. The Office receives regular deliverables regarding review of contract requirement expectations. The Office also meets with MFCU on a regular basis and routinely provides feedback regarding referrals. The Office has updated the MOU with the BOI to receive regular reporting as well.

Enter any Narrative text below.

PROVIDER CREDENTIALING: IHCP does not credential providers. IHCP requires license and certificate information for many provider types. The follow-up action is to disenroll the provider which, in many cases, prompts them to update their provider profiles with IHCP.

PROVIDER BILLING: MFCU reported from October 2005 through June 2006 to have investigated 177 cases for fraud.

In 2005 a district court sentenced a dentist to 57 months for a Medicaid fraud scheme relating to the provision of dental services from the defendant's mobile van. Two corporations also pleaded guilty and were sentenced to three years probation. The defendants were ordered to pay over $2.4 million in restitution and in excess of $70,000 to the Indiana Attorney General's Office for the costs of investigation incurred by the state's Medicaid Fraud Control Unit (MFCU).

Separately, the Civil Rights Division of HCFAC in ongoing Civil Rights of Institutionalized Persons (CRIPA) activities in 2005 reviewed conditions in health care facilities across the nation to determine whether there was sufficient information supporting allegations of abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and appropriate placement. The Section continued activities in residential facilities for persons with developmental disabilities, including Fort Wayne Developmental Center in Indiana.

BENEFICIARY ELIGIBILITY: The eligibility issues are referred back to the individual counties for follow-up when identified by Bureau of Investigation (BOI).

The Indiana Attorney General stated that all AG referrals must be routed through him and that three have been routed in the last year. Note that some judgments, settlements and administrative actions that occur in one year will result in transfers in future years, just as some of the transfers in the current FFY are attributable to actions from prior years.

NOTE: These investigative activities for the most part represent the total Medicaid/CHIP population and are currently not separately tracked. Multiple levels of investigation available.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2005. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2006**	**2007**	**2008**
Insurance payments			
Managed Care	48,121,051	51,008,314	54068813
per member/per month rate @ # of eligibles			
Fee for Service	72,988,623	77,367,940	82,010,017
Total Benefit Costs	121,109,674	128,376,254	136,078,830
(Offsetting beneficiary cost sharing payments)	(2,446,315)	(2,935,578)	(3,111,713)
Net Benefit Costs	$ 118,663,359	$ 125,440,676	$ 132,967,117

Administration Costs			
Personnel	189,936	186,284	186,284
General Administration	7,582	7,734	7,765
Contractors/Brokers (e.g., enrollment contractors)	1,231,755	1,293,343	1,358,010
Claims Processing	1,385,980	1,455,279	1,528,043
Outreach/Marketing costs			
Other Indirect Costs	2,025,565	2,126,843	2,233,185
Health Services Initiatives			
Total Administration Costs	4,840,818	5,069,483	5,313,287
10% Administrative Cap (net benefit costs ÷ 9)	13,184,818	13,937,853	14,774,124

Federal Title XXI Share	91,504,245	96,355,650	102,161,562
State Share	31,999,932	34,154,509	36,118,842

TOTAL COSTS OF APPROVED SCHIP PLAN	123,504,177	130,510,159	138,280,404

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☐ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☒ Tobacco settlement

☒ Other (specify) Premium payments collected from CHIP II recipients are used to reduce expenditures

Enter any Narrative text below.
Expenditures are based on CMS-64. Managed care numbers are from line 1 of the CMS-64.21 and CMS-21.
Administration break-out is based on June 30 budget report and contract sheet.
FFY 2003 assistance costs are increased by 11.6%.
FFY 2004 assistance costs are increased by 7.9%.
FFY 2005 assistance costs are increased by 13.3%.
FFY 2006 assistance costs are increased by 18.7%.
FFY 2007 assistance costs are increased by 6.6%.
This was revised downward from earlier projections. **Source doc - 10-06 Medicaid Forecast
This was revised downward from earlier projections.
FFY 2008 assistance costs are increased by 6.6%. **Source doc - 10-06 Medicaid Forecast

"Other" category includes cost allocated expenditures

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

~~1.~~ If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

~~3.~~ What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

~~4.~~ Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2006**	**2007**	**2008**	**2009**	**2010**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3
(e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4
(e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)?

Please provide a description of any assumptions that are included in your calculations.

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

~~1.~~ For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

Political Environment

For sixteen years, Indiana had a Democrat for Governor. During that period the Senate was Republican while the House of Representatives was either Democrat or split 50-50 with two speakers. The administration changed in January 2005 with the election of Republican Governor Mitchell E. Daniels, Jr. and a majority of Republicans for both chambers of the state legislature.

The Daniels administration is re-engineering health care for Indiana. Initiatives begun in 2005 that affect CHIP include: revamping the old eligibility system to provide a web delivered single portal of entry for Food Stamps, TANF, Medicaid, and associated programs; expanding risk based managed care to all 92 Indiana counties; re-bidding all current managed care organization contracts according to medical marketplaces that encompass/engage hospitals, schools, and other community healthcare providers; and expanding the Medicaid/CHIP population to include working parents. Supporting healthcare re-engineering will be changes in state agency configurations including integrating Medicaid and Public Health personnel who will jointly develop policy and govern health financing. These initiatives and agency reorganizations were inspired in part by the health status of Indiana's citizens.

Indiana's Health Rankings

* Indiana's 800,000 uninsured population is growing more than twice as fast as the national average

* Indianapolis is the 2nd most expensive city in the nation for per family annual health insurance premiums

* We have the highest per capita rate of medically bankrupt families in the nation, amounting to over 77,000 Hoosiers

* 4th most obese state (26%)

* 6th highest state in the number of smokers - Over 26% of Hoosiers smoke

* 5th highest in no flu shot for seniors (34%)

* 7th highest in high cholesterol (35%)

* 4th highest state for cancer deaths

* 13.9% of all Hoosiers are uninsured

* Large health disparities: Only 59% of pregnant black women receive adequate prenatal care, compared to 76% of pregnant white women

Fiscal Environment

Indiana's economy as reflected by the following indicators also points to a need for system change.

* In a 4-year period since June 2000, Indiana lost 138,800 jobs (Indiana Workforce Development)

* Ranked #1 in bankruptcies (Indianapolis Star 8/1/2002)

* Average Hoosier income is 91 cents for $1 of the average American (U.S. Bureau of Labor Statistics)

* Ranked 45th in percentage of adults with 4-year college degree (U.S. Census Bureau)

Food Stamps and TANF participation have nearly doubled in 5 yrs (FNS, DHHS

Per the American Community Survey of 2005:

• 85% of the Indiana population had high school degree or higher

• 21% a Bachelor's degree or higher

• Indiana has a reported disability status of just under 20%

• 67% were also reported as being part of the workforce (population 16 years and older)

• Indiana was also identified to have 9% of the families below the poverty level and

• 12% of the individuals are below the poverty level.

Reducing the cost of healthcare for low income families was an expected 2005 state priority. The cost of Medicaid by the end of 2004 had reached almost 30% of the total state budget. One out of six people and one out of three children in Indiana were covered by either Medicaid or CHIP.

In January 2005 all state agencies were asked to review ways to reduce program costs. CHIP made changes to two administrative rules that became effective February 1, 2006, that will reduce the cost of assistance, but will not affect healthcare benefits.

The first change was an increase in the premiums for CHIP II to the amounts listed below.

a. Families with an income over 150% to 175% of federal poverty level will pay $22 for one child enrolled and $33 for two or more children enrolled.

b. Families with an income over 175% to 200% of federal poverty level will pay $33 for one child enrolled and $50 for two or more children enrolled.

The second change in CHIP II eliminates the time limit for paying delinquent premiums. Previously, an individual could re-enroll their children in Hoosier Healthwise Package C (CHIP II) without paying premiums that were more than two years delinquent. The new rule stipulates that the individual must pay all delinquent premiums owed before an applicant for whom that individual has cost-sharing responsibility may enroll in the program.

Indiana's Medicaid/SCHIP rate of growth will be held to 7% over the 2005-2006 biennium despite projections of a higher rate. The commensurate projected cost increase will be primarily due to increased enrollment. Cost containment measures undertaken during the last reporting period, including increasing risk-based managed care service delivery, managing pharmacy benefits, managing cases and care for those with chronic disease, and those who are aged, blind and disabled will continue to affect SCHIP as well as Medicaid recipients.

For the 2006-2007 biennium, growth has been projected to average 7.3% per year for the CHIP I (Medicaid expansion) and 12% for CHIP II populations. The projected enrollment growth for CHIP was developed from historic eligibility patterns and also takes into account that Indiana may be reaching a ceiling in terms of eligible children. The forecast estimates that almost 691,607 children (Medicaid + CHIP) will be enrolled in the program by June 2007.

Budget analysts project that Indiana will have sufficient federal match available to continue the CHIP program with the current eligibility criteria until FFY08. Any change in current eligibility criteria or a reduction in federal allotments could cause Indiana SCHIP expenditures to exceed federal allotments.

~~2.~~ During the reporting period, what has been the greatest challenge your program has experienced?

The CHIP office was challenged to find ways to reduce the cost of the program. Premiums for families whose incomes exceed 150% FPL increased. The increase in premiums did not result in families discontinuing coverage. The office has been monitoring disenrollment to gauge the effect of the premium increase.

~~3.~~ During the reporting period, what accomplishments have been achieved in your program?

During the previous year, Indiana transitioned all 92 counties into risk-based managed care (RBMC) for Hoosier Healthwise of which CHIP is a component. Indiana's independent evaluator has found that the RBMC delivery system tends to increase access to preventative care while lowering overall costs.

About 60 percent of the CHIP members visited their PMP during each of the last three calendar years. When visits to specialists and clinics are included, about 80 percent of CHIP children saw a physician during the calendar year. This rate is much higher for young children and decreases as the children get older. For example, 98 percent of all one year-olds saw some type of physician in CY 2004, whereas about 80 percent of children ages six through 12 saw a physician during this time period. The percentage of children who had a PMP visit varies by health plan, between 40 percent and 75 percent.

Indiana contracted with two additional Managed Care Organizations (MCO) for Hoosier Healthwise in 2005, increasing the number to five MCOs throughout the State. For 2007 the MCO contracts will be reduced back to three but will become statewide. Provider access should be enhanced with the move toward fewer contracts with better penetration.

~~4.~~ What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

The increased premiums for CHIP II began February 2006 and the implementation of no time limit for collecting unpaid delinquent premiums. Previously, an individual could re-enroll their children in Hoosier Healthwise Package C (CHIP II) without making payment of delinquent premiums that were more than two (2) years old. Now they will be required to pay any unpaid delinquent premiums in addition to the current enrollment premium.

For 2007 there will be only three MCOs with statewide expansion.

- Approximately 225,000 Hoosier Healthwise members (42% of all Hoosier Healthwise members) will switch MCOs.
- 1,000 primary medical providers (PMPs) will need to contract with a new MCO.
- The Office of Medicaid Policy and Planning (OMPP) is holding orientation sessions for MCOs and interested parties to address transition issues. The sessions are held every Friday at 1:00 in the Conference Center of the Indiana Government Center South.
- MCOs have begun contacting providers, particularly PMPs, in order to build their state-wide networks. MCOs must be able to demonstrate to OMPP that they have contracted with a sufficient number and type of providers before they begin 2007 operation.

Enter any Narrative text below.

The new managed care system design has been developed to improve health care delivery and outcomes by changing the way health care is delivered to the Hoosier Healthwise population the system needed to accomplish the following.

- Provide a comprehensive and complete “medical home” for each Hoosier Healthwise member.
- Encourage provider ownership of healthcare delivery.
- Reward quality care and improved outcomes.
- Promote personal accountability.
- Leverage community- and school-based health services and technology advances.
- Develop an infrastructure that can support an increasing indigent population in the future.