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NATIONAL HEALTH POLICY FORUM

Reinventing Medicaid: Hoosier Healthwise and Children's Health Insurance in Indiana

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Indiana

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SITE VISIT REPORT

Contents

Acknowledgments

"Reinventing Medicaid: Hoosier Healthwise and Children's Health Insurance in Indiana" is the first of a planned series of site visits focusing on children's health issues made possible by the generosity of the David and Lucile Packard Foundation. The Robert Wood Johnson and W. K. Kellogg Foundations provided core funding in support of this as well as all other Forum activities.

Planning the site visit was eased and enhanced by the participation of Daryce Kronenberger, the Forum's Indianapolis-based consultant. Special thanks are also due to Tracy Slinkard, Hoosier Healthwise outreach coordinator, who helped to identify contacts, arrange meetings, and sort out logistics.

The Forum is grateful to all the speakers who gave their time and expertise to the site visit program and their behind-the-scenes tutorials to Forum staff. Critical in site visit design was the counsel of Jim Hmurovich, Kathy Gifford, and Nancy Cobb of the Family and Social Services Administration and the wisdom of consultant Katie Humphreys.

Several people were kind enough to host on-site meetings, allowing site visitors to interact with front-line staff from Hoosier Healthwise and its partners at a local level. For their hospitality, the Forum thanks especially Sandra Bell, Clay County director for the Department of Family and Children (DFC), Helen Hardin, director of the Devington office of Marion County's DFC organization, and Booker Thomas, president and chief executive officer of HealthNet Services.

On the Forum staff, Judith Moore and Lisa Sprague organized the site visit, with the able assistance of Wakina Linton, and wrote this report. Forum Director Judith Miller Jones offered her experienced advice. Dagny Wolf served skillfully as always as the site visit coordinator. Moira Muccio Secrest and Diane Harvey assisted with financial and administrative support, while Michele Black edited and managed publication of this report. Federal site visitors were an attentive, enthusiastic, and knowledgeable group.

Reinventing Medicaid: Hoosier Healthwise and Children's Health Insurance in Indiana

BACKGROUND

Indiana's Children's Health Insurance (CHIP)* program received an initial allocation of $70.5 million federal dollars in 1998 and projected that it could enroll 55,000 children previously eligible for Medicaid but not enrolled, along with 36,000 newly eligible children. In fact, by September 1999, approximately 114,000 new children had been signed up. This surpassing of expectations is testimony to the state's industrious outreach and enrollment effort. (Admittedly, it also has cast doubt on the Current Population Suvey data on which original projections were based.) The National Health Policy Forum arranged a site visit to Indiana to examine outreach and enrollment processes in Medicaid and CHIP and to see what lessons other states might learn from Indiana's success.

The Governor's CHIP Panel

When State Children's Health Insurance (SCHIP) legislation was enacted at the federal level, Indiana governor Frank O'Bannon appointed a 21-member bipartisan panel to evaluate long-term program options to meet the needs of Hoosier children and families and to make recommendations for state legislative action. The Governor's Children's Health Advisory Panel (the CHIP panel) was able to build on the work of a predecessor group, the Indiana Commission on Health Care for the Working Poor, established in 1995 and chaired by the same person (Katherine Humphreys) who went on to chair the CHIP panel. The commission's final report was published in December 1997. The CHIP panel recorded that, in 1997, the Medicaid program covered 267,000 children; at that time, eligibility was extended to infants in families with incomes up to 150 percent of the federal poverty level, children ages 1 to 5 in families with incomes below 133 percent of poverty, and children ages 6 through 18 in families with incomes below poverty. However, by no means all eligible children were enrolled—as noted above, at least 55,000 were thought to be eligible but not covered.

As part of its deliberations, the CHIP panel held hearings around the state and convened five subcommittees to work on specific issues such as outreach and education, benefits and cost-sharing, and eligibility and crowd-out. The panel agreed on a set of guiding principles before ultimately arriving at consensus on recommendations. Altogether, the panel involved over 200 people in its considerations, reaching out broadly to diverse groups throughout the state before formulating its consensus-based recommendations.

Hoosier Healthwise

The state CHIP program's first phase—recommended by the panel and adopted in bipartisan consensus by the Indiana General Assembly—was a Medicaid expansion (effective in July 1998) to include all children in families with incomes at or below 150 percent of poverty. Concurrent with the expansion was a re-imaging campaign in which "Medicaid" became "Hoosier Healthwise," a program crafted to feel as much like private insurance as possible. To this end, a new, simplified application form was developed, a new membership card was designed, and new terms were adopted to describe eligibility in an attempt to destigmatize the program. The incremental population was estimated to be 36,000 children, who were targeted along with an estimated 55,000 children already eligible but not participating.

Hoosier Healthwise is a mandatory managed care plan with two components: a primary care case management (PCCM) system and a risk-based managed care system. Participation in one or the other (or both) is a function of a physician's choice or contractual obligations. Both systems rely on primary medical providers (PMPs) to provide primary care services, make appropriate referrals to specialists, and monitor utilization. Families enrolled in Hoosier Healthwise have 30 days to select a PMP from a list of participating providers. Assistance in selecting a PMP is provided by benefit advocates (BAs) under a state

*Federal legislation created the State Children's Health Insurance Program (SCHIP), known by different names in different states. Indiana's program is simply the Children's Health Insurance Program, abbreviated CHIP.

contract with a private organization. If a family fails to make a selection, it is assigned a provider (in a process known as auto-assignment).

CHIP Phase II (also known as Hoosier Healthwise Package C) is a state-designed add-on program. Implemented in January 2000, this program covers children through age 18 in families with incomes between 150 and 200 percent of poverty. The rationale for a separate component was legislators' preference that Package C not be an entitlement program. It has different eligibility criteria, a somewhat different benefits package, and cost-sharing requirements. A single application serves for both Hoosier Healthwise Package A (Medicaid) and CHIP, and the two share eligibility determination and claims payment systems as well as provider networks.

Hoosier Healthwise is administered by the Family and Social Services Administration (FSSA), with the Department of Family and Children (DFC) sharing responsibility with Medicaid and CHIP staff. Before the enactment of CHIP, intake occurred in the county DFC offices. Now these offices are only a part of the more than 500 enrollment centers around the state, along with hospitals, clinics, churches and other sites. DFC staff frequently attend events such as parades and festivals, setting up temporary enrollment facilities. Although applications are taken in the many enrollment centers, eligibility determination remains strictly a DFC responsibility.

It has been a policy of DFC management to give counties enrollment goals and a good deal of flexibility in determining how to achieve them. Resources also have been allocated to counties, including funds to be spent as the local program deems appropriate, and approval of unlimited overtime for DFC staff has been guaranteed. As of December 31, 1999, only 6 of Indiana's 88 counties were below their enrollment goals. The two counties included in the site visit, Clay and Marion, were at 153 percent and 141 percent, respectively, of their goals.

The state is currently undertaking its own survey to better understand the uninsured population in Indiana and to assess the fiscal impact of understated numbers. State officials believe that Congress should review state-by-state SCHIP allotments and make adjustments based on real numbers of children.

Program

On April 17, site visitors participated in an afternoon discussion of the evolution and operations of Hoosier Healthwise, with presentations by state officials and a key state senator. This was followed by a panel discussion on outreach and enrollment featuring speakers from various Hoosier Healthwise constituencies. Numerous Indiana guests joined site visitors at a reception that evening.

The second day presented an urban-rural contrast as site visitors traveled to DFC offices in two counties. In rural Clay County, they heard from DFC staff, other enrollment coordinators, and a Hoosier Healthwise parent. Caseworkers in Marion County (Indianapolis) discussed their outreach efforts, enrollment process, and member follow-up protocols. A third stop for the group was Southeast Community Health Center, a clinic and enrollment center.

The site visit's last morning opened with a panel presenting provider perspectives on Hoosier Healthwise; topics included reimbursement, medically underserved areas, and health care quality. A wrap-up panel explored the factors underlying CHIP's success to date and raised issues that the program will have to address in its continuing development.

IMPRESSIONS

Overall

- **CHIP was viewed by its designers as an opportunity to improve and streamline Medicaid.** For example, the enrollment form was pared down to only two pages. Mail-in application was permitted for the first time. A network of local enrollment centers—beyond DFC offices—was required by statute.
- **A goal in designing CHIP was to create a "seamless system" for members, so that their interactions with providers would be the same regardless of which eligibility category (Medicaid or CHIP) they were in at a given time.** This extends to First Steps (the program for developmentally disabled children up to age three) and Children's Special Health Needs Services, which are intended to provide wrap-around coverage for CHIP enrollees.
- **Hoosier Healthwise's success is attributable to several decisions made along the way:**
  - Commit to a real re-orienting of Medicaid toward getting beneficiaries signed up.
  - Implement a campaign to destigmatize Medicaid and streamline enrollment.
  - Emphasize outreach and seek partners to help find eligible children.
  - Expand greatly the number of enrollment sites.
  - Exchange a state-centered orientation for a philosophy that services—both administrative and clinical—are best delivered at the neighborhood level.
  - Empower local DFC offices to design their own enrollment campaigns. The state DFC provided

money and materials and set goals but allowed great flexibility. Each county is accountable for its own performance.

- Invest in information systems to enable electronic billing and eligibility verification by providers, reduced claims error rates, and more rapid turnaround.

Outreach and Enrollment

- **Hoosier Healthwise may owe some part of its success to the shortcomings of the traditional Medicaid program.** That is, today's caseworkers would not have so many children to enroll if appropriate enrollment had been encouraged all along. With the advent of CHIP, enrollment is not only encouraged but vigorously pursued. Hoosier Healthwise is one element in DFC's mission to provide support for working families.
- **The Hoosier Healthwise caseworkers and managers that site visitors met are distinguished by a discernible commitment to their program.** Access to unlimited funds for overtime pay has undoubtedly been a factor in workers' willingness to participate in evening and weekend health fairs and neighborhood gatherings, but so has real enthusiasm for getting children signed up. Policy guidance and training have been provided by the state DFC.
- **Indiana has maximized dollars available for outreach (including special funds from a $500 million account set up under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996).** This approach appears to have enabled DFC to reach "critical mass" in establishing Hoosier Healthwise. Indiana has achieved this success without having to pay a "bounty" to contract enrollment workers, a technique some other states have used.
- **The effectiveness of caseworker training is a matter of perception.** DFC feels its training programs have been thorough. Non-DFC enrollment center employees suggest that some DFC staff remain attached to old ways of thinking and dealing with clients. However, every caseworker has received training, another commitment not made in many other states.
- **Benefit advocates play a key role in the enrollment process.** They answer questions, explain procedures, counsel, and run interference for Hoosier Healthwise members. The BA contracting agency, Lifemark, also conducts annual surveys of both member and provider satisfaction with the program. An ongoing challenge is to provide adequate access to BA assistance in enrollment centers where the caseload does not justify an onsite BA.
- **Although the state has a Robert Wood Johnson Covering Kids grant that incorporates collaboration with schools, schools have been slow to become directly involved in identifying and enrolling children.** Some school systems are working with DFC offices to share data on children signed up for free- and reduced-cost lunch programs and to make information on Hoosier Healthwise available, but no school serves as an actual enrollment center.
- **There was a noticeable difference between the rural and urban DFC offices in terms of post-enrollment follow-up with Hoosier Healthwise members.** Part of this is a function of caseload size, part may be attributed to culture. Rural DFC staff are closer to their clientele, more likely to know families personally and to have an active working relationship. The implications for care coordination would be interesting to pursue.

Provider Issues

- **Indiana may be unique in that a Hoosier Healthwise enrollee chooses a doctor, not a health plan.** The patient will participate in PCCM or risk-based managed care according to contracting decisions the primary care physician has made.
- **Physician reimbursement rates, not adjusted since 1994, have become a source of contention.** Pediatricians, contending that they are losing money on each Hoosier Healthwise patient they treat, are especially restive. This rate stagnation appears to be why numerous counties are experiencing provider shortages. In four counties, PMP panels are completely full, that is, accepting no new patients. A legislator suggested that Hoosier Healthwise should stop advertising for new members when it could not guarantee access to doctors for those already enrolled.
- **Hoosier Healthwise, supported by consumer groups, has pushed the idea that every enrollee needs to have a "medical home," but this seems to be a concept without specific means of confirming the continuity of care it suggests.** Greater coordination of care among programs is the chief aim of the Children's Health Policy Board, created concurrently with CHIP and comprising the heads of all relevant executive branch agencies.

Next Steps and Pending Questions

- **Outreach and enrollment success is the critical first step, but appropriate care is also vital.** The next question for Indiana policymakers is whether it can be demonstrated that the children now enrolled in Hoosier Healthwise are getting appropriate—and appropriately coordinated—medical care? Or, putting it another way, when and how does the emphasis shift from enrollment to health care?

- **Auto-assignment, which occurs if a beneficiary has not chosen a PMP within 30 days, remains a problem.** Approximately 8 percent of cases are auto-assigned, with a somewhat higher rate (16 percent in March) in Marion County. The auto-assignment algorithm weights a record of a previous relationship with a PMP most heavily, followed by a family member's relationship (to the extent that family members can be identified by case number) and geography. There are anecdotes, however, about siblings being assigned to different PMPs and children being assigned to a PMP in a distant county.
- **CHIP Phase II had not amassed significant enrollment by April, four months after its implementation.** Future take-up rates bear watching to assess the impact of the required partial premium payment.
- **Interest in refining Hoosier Healthwise and CHIP persists.**
  - A controversy—still in the discussion stage—exists around a proposal to allow school-based nurse practitioners to be designated eligible Medicaid providers.
  - Another issue under consideration by some legislators and policymakers is the expansion of Hoosier Healthwise to all family members, not just children.
  - Indiana officials hope federal policymakers will resolve the discrepancy whereby Medicaid is permitted to participate in drug-rebate arrangements, but CHIP is not.
- **The Children's Health Policy Board has the potential to improve coordination of care significantly.** Its object is to forge links among Medicaid, CHIP, Children's Special Health Care Services, and First Steps (a program for developmentally disabled small children) in such a way that the system will be seamless to beneficiaries and providers. The board, which has met monthly since June 1999, is chaired by the FSSA secretary. So far, board meetings seem to have successfully brought together health and social services representatives in productive discussion focused on problem solving for needy children. It remains to be seen whether the board will provide a true integrating body for the myriad children's issues that exist in public policy today, but there appears to be a good beginning.

Advice to Other States from the Indiana CHIP Panel

- Trust that government *can* innovate.
- Take a bird's eye view (take people out of their program/funding silos).
- Listen to the people who are intended to benefit from the program.
- Involve advocates, providers, and decision-makers (don't be afraid to herd cats).
- Know that success doesn't just come through meetings.
- Understand that a good plan today is better than a perfect plan tomorrow.
- Know that one size doesn't fit all.
- Put a face on the children and their families.

Agenda

Monday, April 17, 2000

2:00 pm OVERVIEW OF HOOSIER HEALTHWISE—DEVELOPMENT AND OPERATIONS
[Westin Hotel, Capitol II Room]

Sen. Steven R. Johnson (R-Kokomo)

Nancy Cobb, *Director,* State Children's Health Insurance Program, Family and Social Services Administration (FSSA)

Kathleen D. Gifford, *Assistant Secretary,* Office of Medicaid Policy and Planning, FSSA

- How was Indiana's CHIP* plan developed?
- What are the distinguishing features of today's Hoosier Healthwise? What is the experience to date in implementing Phase II CHIP (Package C)? How does Package C differ from the Medicaid package?
- How has the Medicaid program changed in response to CHIP?
- What is the role of benefit advocates?
- Is there an emphasis on Medicaid enrollment and retention of adults or is the focus strictly on children?

3:30 pm OUTREACH AND ENROLLMENT

James Hmurovich, *Director,* Division of Family and Children (DFC), FSSA

Sen. Vi Simpson (D-Bloomington)

Aquaila Barnes, *Hoosier Healthwise Project Coordinator,* Indiana Black Expo

Silvia Alba, *Outreach Coordinator,* Wishard Hispanic Health Project

Pamela Wilson, *Project Director,* Covering Kids Coalition, Marion County

Donna Gore Olsen, *Executive Director,* Indiana Parent Information Network

- What programs were instituted to reach out to the population eligible for Hoosier Healthwise?
- How does the eligibility and enrollment process work in Indiana?
- What changes were made in the Medicaid application and enrollment systems to implement Hoosier Healthwise and CHIP?
- Were incentives given to local welfare officials to encourage outreach and enrollment? If so, what were they?
- Has the redetermination and re-enrollment process changed? Are children being maintained on the program?
- What special initiatives have been undertaken to reach minority populations?
- How are services for children with special needs coordinated with basic Hoosier Healthwise or CHIP benefits?

5:30 pm Reception *[Capitol III Room]*

Tuesday, April 18, 2000

7:15 am Breakfast available *[Congress I Room]*

8:00 Bus departure for Clay County DFC Office (Brazil)

9:15 ADMINISTERING HOOSIER HEALTHWISE AND CHIP IN A RURAL SETTING

Sandy Bell, *County Director,* Clay County DFC; DFC staff; community representatives

- What changes were made in county office policies and procedures to implement Hoosier Healthwise?
- What activities did you institute to reach out to people potentially eligible for Hoosier Healthwise and CHIP? Were these prescribed by the state or were they your own inventions? How did the DFC office involve community groups and organizations?
- How would you characterize the relationship between the state and enrollment centers as far as getting applications processed and enrollments approved? Does the state set numeric goals for enrollments and re-enrollments?
- How do benefit advocates participate in the enrollment process?

11:30 Bus departure

11:45 Lunch *[Company's Coming]*

12:45 Bus departure for Marion County DFC Office (Devington)

2:00 ADMINISTERING HOOSIER HEALTHWISE AND CHIP IN AN URBAN SETTING

Julia M. Davis, *County Director,* Marion County DFC; DFC staff; community representatives

- What changes were made in county office policies and procedures to implement Hoosier Healthwise?
- What activities did you institute to reach out to people potentially eligible for Hoosier Healthwise and CHIP? Were these prescribed by the state or were they your own inventions? How did the DFC office involve community groups and organizations?
- How would you characterize the relationship between the state and enrollment centers as far as getting applications processed and enrollments approved? Does the state set numeric goals for enrollments and re-enrollments?
- How do benefit advocates participate in the enrollment process?

3:30 Bus departure for HealthNet Southeast Health Center

3:45 CHIP ENROLLMENT IN A HEALTH CARE SETTING

Booker Thomas, *President and Chief Executive Officer,* HealthNet Community Health Centers, and staff at Southeast Health Center

- How do HealthNet Health Centers provide enrollment assistance?
- How does the Southeast clinic relate to state DFC officials?
- How have enrollment and application procedures changed since Hoosier Healthwise was implemented?

Wednesday, April 19, 2000

8:00 Breakfast available *[Capital III Room]*

8:30 am PERSPECTIVES ON ACCESS AND DELIVERY

Rep. William Crawford (D-Indianapolis)

Hazel Katter, *Director, Local Liaison,* Indiana Department of Health

Greg Wilson, M.D., *Director,* Developmental Pediatric Clinic, Wishard Memorial Hospital, and *President,* Indiana Chapter, American Academy of Pediatrics

Mary Haupert, *President,* Neighborhood Health Services, Fort Wayne
Timothy W. Kennedy, *Counsel,* Indiana Hospital Association
Sharon Steadman, *Director, Managed Care,* FSSA

- How do providers view the new Hoosier Healthwise and CHIP programs? Are there different perceptions now compared to those that existed under the previous Medicaid program?
- How do providers view Medicaid reimbursement rates and procedures?
- How do Hoosier Healthwise members become associated with a particular primary care physician?
- What type of relationship exists between community health centers and the state? Physicians and the state? Hospital and acute care providers and the state?
- Is there outreach on the part of Hoosier Healthwise to providers as well as to potential members?
- Are particular areas of the state underserved? Are there problems with particular provider specialties? What steps are being taken to address access problems?
- Once children are enrolled in Hoosier Healthwise, is there evidence that they are receiving care in a continuing relationship with a provider?

10:30 am LESSONS LEARNED AND FUTURE DIRECTIONS

Peter Sybinsky, Ph.D., *Secretary,* FSSA
Katie Humphreys, *Consultant and former Chair,* Governor's Children's Health Insurance Advisory Panel

- What are the principal successes of the CHIP experience, and what features require continued refinement and attention?
- What health financing priorities remain to be addressed by Indiana?
- Are there federal policies that might inhibit Indiana's future policy development for families and children?
- What are the goals and priorities of the Children's Health Policy Board? Is it likely that the Board will be able to further integrate children's health services?

Noon Adjournment (Taxis to airport available)

* *Note to federal participants: Indiana's Children's Health Insurance Program is abbreviated as CHIP; the state does not use SCHIP.*

Federal and Foundation Participants

Evelyne Baumrucker
Analyst in Social Legislation
Education and Public Welfare Division
Congressional Research Service
Library of Congress

Karen Davenport
Program Officer
Robert Wood Johnson Foundation

Shelley Gehshan
Program Manager
National Conference of State Legislatures

Bill Gibson
Caseworker
Office of Sen. Richard Lugar
U.S. Senate

Jason Lee
Majority Counsel
Committee on Commerce
U.S. House of Representatives

Gene Lewit, Ph.D.
Director of Research and Grants Economics
Center for the Future of Children
David and Lucile Packard Foundation

Cindy Mann
Director
Family and Children's Health Programs Group
Center for Medicaid and State Operations
Health Care Financing Administration
U.S. Department of Health and Human Services

JoAnne Martinez
Evaluator
U.S. General Accounting Office

Michelle Mickey
Senior Health Policy Analyst
American Public Human Services Association

Ann Marie Murphy
Health Legislative Assistant
Office of Sen. Richard Durbin
U.S. Senate

Rekha Ramesh
Analyst
Health and Human Resources Division
Congressional Budget Office

Richard Rimkunas
Specialist in Social Legislation
Education and Public Welfare Division
Congressional Research Service
Library of Congress

Jennifer Ryan
Senior State Child Health Insurance Program Analyst
Family and Children's Health Programs Group
Center for Medicaid and State Operations
Health Care Financing Administration
U.S. Department of Health and Human Services

Wendy Wolf, M.D.
Senior Policy Fellow
Health Resources and Services Administration
U.S. Department of Health and Human Services

NHPF Staff

Judith Miller Jones
Director
National Health Policy Forum

Judith D. Moore
Co-Director
National Health Policy Forum

Lisa Sprague
Senior Research Associate
National Health Policy Forum

Dagny Wolf
Program Coordinator
National Health Policy Forum

Biographical Sketches—Indiana Participants

Silvia Alba is the Hoosier Healthwise outreach coordinator for Wishard Memorial Hospital's Hispanic Health Project. Prior to joining the health project staff, she was coordinator of volunteer events with the American Red Cross of Greater Indianapolis.

Aquaila S. Barnes is Indiana Black Expo's Hoosier Healthwise coordinator. She also coordinates other health-related education campaigns having to do with syphilis and HIV/AIDS. Previously, she trained business owners, government employees, and persons with disabilities on the provisions of the Americans with Disabilities Act for the Indianapolis Resources Center for Independent Living.

Sandra K. Bell has been the county director for the Division of Family and Children (DFC) in Clay County for 23 years. In March 1998, she was selected by the division director for a special assignment to assist local offices in planning for the expansion of Hoosier Healthwise and CHIP. Earlier in her career, she worked as a probation officer for the Clay County Circuit Court.

Nancy Cobb has served as director of Indiana's Children's Health Insurance Program since February 1999, having participated in the program's design as project coordinator for Gov. Frank O'Bannon's CHIP advisory panel. Before joining CHIP, Ms. Cobb held various posts in both the O'Bannon and Bayh administrations, including those of senior policy analyst with the Department of Health and executive assistant to the governor. In the latter position, she was responsible for the Department of Health's Special Institutions issues.

William Crawford was elected to the Indiana House of Representatives in 1972 and is currently serving his 14th term. He serves on the Public Health, Ways and Means, and Environmental Committees. He is also a member of the executive committees of the National Black Caucus of State Legislators and the NAACP. Mr. Crawford was a member of the Governor's Advisory Panel on Children's Health Insurance.

Julia M. Davis is county director for the DFC in Marion County (Indianapolis), overseeing 11 programs and a staff of 611. She has been with the DFC for 28 years and serves as well on a number of local, state, and national boards and councils.

Kathleen D. Gifford has been assistant secretary, Office of Medicaid Policy and Planning in the Indiana Family and Social Services Administration (FSSA), since early 1997. She previously held several positions—most recently deputy director—in the state budget agency. Earlier, she practiced law with the firm of Barnes & Thornburg.

Mary S. Haupert is president of Neighborhood Health Services, a community health center serving Fort Wayne, Indiana. Previously, she served as director of a residential program for addicted women and their children and, earlier, supervised residential day treatment for chronically mentally ill adults and severely emotionally disturbed children. She was a member of the governor's CHIP panel.

James M. Hmurovich has been director of the Division of Families and Children in the Indiana Family and Social Services Administration since 1993. In implementing the State Children's Health Insurance Program, the DFC increased the number of children enrolled in Hoosier Healthwise by 106,000 in a period of 14 months. Before joining FSSA, Mr. Hmurovich held a series of management positions with the Indiana Department of Corrections.

Katie Humphreys is a principal in RK Associates, a health care consulting firm. From 1992 to 1998, she served two governors in several policy leadership positions. She chaired the Governor's Advisory Panel on CHIP, was deputy commissioner of the Department of Health, acted as interim general manager of the Indiana Toll Road during a state and federal investigation, and served as state director of health policy for Gov. Evan Bayh.

Steven R. Johnson has served in the Indiana Senate since 1986, following two terms in the state House of Representatives. His background includes small business ownership and an academic appointment in biological and physical sciences at Indiana University. Senator Johnson has chaired many independent commissions as well as legislative committees. He was a member of the Governor's Advisory Panel on Children's Health Insurance.

Timothy W. Kennedy, J.D., a partner with Hall, Render, Killian, Heath, & Lyman, has practiced with the Indianapolis firm since being called to the bar in 1983. His practice emphasizes health law and hospital-related issues; a prominent client is the Indiana Hospital Association.

Donna Gore Olsen is executive director and founder of the Indiana Parent Information Network for parents of children with special health care needs. She has been a project director for the Maternal and Child Health Bureau and the Indiana First Steps Early Intervention System and served as a member of both the Governor's Planning Council for People with Disabilities and the Governor's Advisory Panel on Children's Health Insurance.

Peter A. Sybinsky, Ph.D., is secretary of the Indiana Family and Social Services Administration, with program responsibility for Medicaid, mental health and addictions, developmental disabilities and mental retardation, welfare reform, child welfare, children's health insurance, long-term care, and seniors. He previously served as director of the Hawaii Department of Health.

Greg Wilson, M.D., in practice for 22 years, is a developmental pediatrician at Riley Hospital for Children and Indiana University Medical Center. He also serves as director of the Developmental Pediatric Clinic at Wishard Memorial Hospital. Medical consultant for the state's Children's Special Health Care Services program, he serves on several Medicaid advisory committees and is president of the Indiana chapter of the American Academy of Pediatrics.

Pamela Wilson is project director for the Covering Kids Coalition of Marion County under the Robert Wood Johnson Covering Kids Project, an outreach initiative focused on enrolling the "hardest to reach" children and families in Hoosier Healthwise. Previously, she served as program coordinator for the Minority Health Coalition of Marion County.

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National Health Policy Forum
2131 K Street, NW, Suite 500
Washington, DC 20052-0067
202/872-1390
Fax 202/862-9837