Commonwealth Pennsylvania Department of Human Services Children's Health Insurance Program

2018 External Quality Review Report
Geisinger Health Plan

Final Report
April 2019

IPRO
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realized.

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Introduction

Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted CHIP Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to CHIP Managed Care enrollees.

The EQR-related activities that must be included in detailed technical reports are as follows:

- review to determine MCO compliance with structure and operations standards established by the State (42 CFR §438.358)
- validation of performance improvement projects
- validation of MCO performance measures.

The Pennsylvania (PA) Department of Human Services (DHS) Children's Health Insurance Program (CHIP) provides free or low-cost health insurance to uninsured children and teens that are not eligible for or enrolled in Medicaid Medical Assistance (MA). PA CHIP has contracted with IPRO as its EQRO vendor to conduct the 2018 EQRs for the CHIP MCOs and to prepare the technical reports. This is the first year of PA CHIP technical reports. The report includes five core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey
IV. 2018 Strengths and Opportunities for Improvement
V. Summary of Activities

For the CHIP MCOs, the information for the compliance with Structure and Operations Standards section of the report is derived from the results of on site reviews conducted by PA CHIP staff, with findings entered into the department's on site monitoring tool, and follow up materials provided as needed or requested. Standards presented in the on site tool are those currently reviewed and utilized by PA CHIP staff to conduct reviews; these standards may be applicable to other subparts, and will be crosswalked to reflect regulations as applicable.

Information for Section II of this report is derived from activities conducted with and on behalf of DHS CHIP to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle. Information for Section III of this report is derived from IPRO's validation of each CHIP MCO's performance measure submissions. Performance measure validation as conducted by IPRO includes both Pennsylvania specific performance measures as well as Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures for each CHIP MCO. Within Section III, CAHPS® Survey results follow the performance measures.

Section IV has a summary of the MCO's strengths and opportunities for improvement for this review period as determined by IPRO. This section will highlight peformance measures across HEDIS® and PA-specfic performance measures where the MCO has performed highest and lowest. Section V provides a summary of EQR activities for the CHIP MCO for this review period.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

I: Structure and Operations Standards

This section of the EQR report presents a review of the CHIP MCO's compliance with structure and operations standards. The review is based on information derived from the most recent reviews of the MCO. On site reviews are conducted by CHIP every three years.

The format for this section of the report was developed to be consistent with the subparts prescribed by the Balanced Budget Act regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol.* Under each subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three BBA regulations subparts as explained in the Protocol, i.e., Subpart C: Enrollee Rights and Protections; Subpart D: Quality Assessment And Performance Improvement (including access, structure and operation and measurement and improvement standards); and Subpart H: Certifications and Program Integrity. As PA CHIP continues to move forward with alignment of the EQR provisions to the CHIP population, re-assessment of the review items and crosswalks may be warranted.

Methodology and Format

Prior to the onsite monitoring visit performed at the MCO, documents are provided to CHIP by the MCO, which addresses various areas of compliance. This includes training materials, provider manuals, MCO organization charts, policies and procedures manuals, and geo access maps. These documents are reviewed prior to the onsite monitoring visit and are used to address areas of compliance which include Quality of Care of Medical Services, Provider Adequacy, Applications and Eligibility, Customer Service, Marketing Outreach, Audits, and IT Reports. These items are used to assess the MCO's overall operational, fiscal, and programmatic activities to ensure compliance with contractual obligations. Federal and state law require that CHIP conduct monitoring and oversight of its MCOs.

Throughout the visit, these areas of compliance are discussed with the MCO and clarifying information is provided, where possible. Discussions that occur are compiled along with the reviewed documentation to provide a final determination of compliance, partial compliance, or non-compliance for each section. Table 1.1 showcases each of the items and subcategories.

IPRO reviewed the most recent elements in the areas that CHIP monitors and created a crosswalk to pertinent BBA regulations. A total of 29 unique items were identified that were relevant to evaluation of CHIP MCOs' compliance with the BBA regulations. These Items vary in review periodicity from annually, semi-annually, quarterly, monthly and as needed. The items from Review Year (RY) 2017, 2016, and 2015, as applicable, provide the information necessary for this assessment.

Table 1.1: Compliance Items and Subcategories

Subpart C: Enrollee Rights and Protections
Medical Services
PH-95
Case Management
Covered Services
Utilization Management
EPSDT/Bright Futures
Quality Improvement Plans
Quality of Care
Provider Network and Adequacy
Provider Credentialing
Appointment Standards
Application Timeliness and Renewal Rates
Communication to Providers and Members
Provider Enrollment

Subpart D: Quality Assessment and Performance Improvement Regulations
Customer Service
CHIP Dedicated Customer Service Staff
Application Input
UFI Random Sample
General Website and Online Manuals
Blue and Green Sheets
Marketing and Outreach
Quarterly Intended and Completed
Programmatic Change Requests
Subpart H: Certifications and Program Integrity
Audits and Reports
ERP
Fraud and Abuse
HIPAA Breaches
PERM
PPS Reporting
A-133
Information Technology Files and Reports
Ad Hoc
TMSIS/Encounter Data
Provider Files
Testing

Determination of Compliance

Information necessary for the review is provided through an on-site review that is conducted by CHIP, Quality Assurance Division. Throughout the duration of this on-site, each area highlighted above is reviewed and a rating scale is utilized to determine compliance. The CHIP MCO can be rated either "non-compliant", "partially compliant", or "compliant" in each area based on the findings of the audit. Following each rating scale, a comprehensive description of identified strengths and weaknesses are provided to the CHIP MCO. If all items were Compliant, the CHIP MCO was evaluated as Compliant. If some were Compliant and some were non-Compliant, the CHIP MCO was evaluated as partially-Compliant. If all items were non-Compliant, the CHIP MCO was evaluated as non-Compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

Subpart C: Enrollee Rights and Protections

29 items were evaluated for the CHIP MCO in Review Year (RY) 2017.

The general purpose of the Subpart C regulations is to ensure that each CHIP MCO has written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights and that the CHIP MCO ensures that the MCO's staff and affiliated providers take into account those rights when furnishing services to enrollees. [42 C.F.R. § 438.100 (a), (b)]

Table 1.2: MCO Compliance with Subpart C: Enrollee Rights and Protections Regulations

Subpart C: Categories	Compliance	Comments
PH-95	Compliant	
Case Management	Compliant	
Covered Services	Compliant	

Subpart C: Categories	Compliance	Comments
Utilization Management	Compliant	
EPSDT/Bright Futures	Compliant	
Quality Improvement Plans	Compliant	
Provider Network and Adequacy	Compliant	
Provider Credentialing	Compliant	
Appointment Standards	Compliant	
Application Timeliness and Renewal Rates	Compliant	
Communication to Providers and Members	Compliant	
Provider Enrollment	Compliant	

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this heading is to ensure that all services covered under the DHS's CHIP program are available and accessible to CHIP enrollees. [42 C.F.R. § 438.206 (a)]

Table 1.3: MCO Compliance with Subpart D: Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	Compliance	Comments
CHIP Dedicated Customer Service Staff	Compliant	
Application Input	Compliant	
UFI Random Sample	Compliant	
General Website and Online Manuals	Compliant	
Blue and Green Sheets	Compliant	
Quarterly Intended and Completed	Compliant	
Programmatic Change Requests	Partially Compliant	A noticeable decrease in programmatic change requests has occurred in the last year. GHP reports that a summer newsletter will be sent to CHIP for approval, as well as a third phase of their website over the next year. A review of the literature used in these media will also occur.

Subpart H: Certifications and Program Integrity

The general purpose of the Subpart H regulations is to ensure the promotion of program integrity through programs which prevent fraud and abuse through means of misspent program funds and to promote quality health care services for CHIP enrollees. These safeguards require that the CHIP MCO make a commitment to a formal and effective fraud and abuse program. [42 C.F.R. § 438.600 (a)]

Table 1.4: MCO Compliance with Subpart H: Certifications and Program Integrity

Subpart H: Categories	Compliance	Comments
ERP	Compliant	
Fraud and Abuse	Compliant	
HIPAA Breaches	Compliant	
PERM	Compliant	
PPS Reporting	Partially Compliant	During the on-site demonstration of the PPS claims processing system, it was discovered that Geisinger's behavioral health subcontractor does not recognize the HCPC T-1015 code resulting in the PPS rate not being applied or associated with FQHC/RHC encounters. GHP will provide verification that their subcontractor is now paying the PPS rate for all eligible encounters, and that past denials or incorrect payments are adjudicated.
A-133	Compliant	
Ad Hoc	Compliant	
TMSIS/Encounter Data	Partially Compliant	For gap grids, it was discovered that Geisinger struggles at times to get their encounter data submitted timely. This was attributed to lag on the part of their subcontractor, which they intend to address and verify that their subcontractor is up to date with their encounter data submissions.
Provider Files	Compliant	
Testing	Compliant	

II. Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHIP MCO. For the purposes of the EQR, CHIP MCOs were required to participate in studies selected by DHS CHIP for validation by IPRO in 2017 for 2018 activities. Under the applicable Agreement with the DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two new PIPs were initiated as part of this requirement. For all PIPs, CHIP MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the new EQR PIP cycle that was initiated for all CHIP MCOs in 2017, IPRO has adopted the LEAN methodology, following the Centers for Medicare & Medicaid Services (CMS) recommendation that Quality Improvement Organizations (QIOs) and other healthcare stakeholders embrace LEAN in order to promote continuous quality improvement in healthcare.

CHIP MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years" and "Improving Blood Lead Screening Rate in Children 2 Years of Age".

"Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years" was selected after review of the HEDIS® Developmental Screening in the First Three Years measure, as well as a number of additional developmental measures. The performance of these measures across Pennsylvania CHIP MCOs has been flat, and in some cases has not improved across years. Available data indicate that fewer than half of Pennsylvania children from birth to age 3 enrolled in CHIP and Medicaid in 2014 were receiving recommended screenings. Considering that approximately 1 in 10 Pennsylvania children may experience a delay in one or more aspects of development, this topic was selected with the aim of all children at risk are reached. The Aim Statement for the topic is "By the end of 2020 the CHIP MCO aims to increase developmental screening rates for children ages one, two and three years old." CHIP MCOs are asked to create objectives that support this Aim Statement.

For this PIP, DHS CHIP is requiring all CHIP MCOs to submit rates at the baseline, interim, and final measurement years for "Developmental Screening in the First Three Years of Life". Additionally, CHIP MCOs are encouraged to consider other performance measures such as:

- Proportion of children identified at-risk for developmental, behavioral, and social delays who were referred to early intervention.
- Percentage of children and adolescents with access to primary care practitioners.
- Percentage of children with well-child visits in the first 15 months of life.

"Improving Blood Lead Screening Rates in Children 2 Years of Age" was selected as the result of several observations. Despite an overall decrease over the last 30 years in children with elevated blood lead levels in the United States, children from low-income families in specific states, including Pennsylvania, have seen decreased rates of screening of blood lead levels. Current CHIP policy requires that all children ages one and two years old and all children ages three through six without a prior lead blood test have blood levels screened consistent with current Department of Health and CDC standards. The average national lead screening rate in 2016 is 66.5%, while the Pennsylvania CHIP average is 53.2%. Despite an overall improvement in lead screening rates for Pennsylvania CHIP MCOs over the past few years, rates by CHIP MCO and weighted average fall below the national average. In addition to the lead screening rate, CHIP MCOs are encouraged to consider these measures as optional initiatives:

- Percentage of home investigations where lead exposure risk hazards/factors are identified,
- Total number of children successfully identified with elevated blood lead levels,
- Percent of the population under the age of five suffering from elevated blood lead levels, or
- Percent of individuals employed in the agriculture, forestry, mining, and construction industries.

The PIPs extend from January 2017 through December 2020; with research beginning in 2017, initial PIP proposals developed and submitted in second quarter 2017, and a final report due in June 2021. The non-intervention baseline

period is January 2017 to December 2017. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in June 2019 and June 2020, as well as a final report in June 2021.

2018 is the tenth year to include validation of PIPs. For each PIP, all CHIP MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHIP provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

All CHIP MCOs are required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions

Validation Methodology

IPRO's review evaluates each project against seven review elements:

Element 1. Project Topic/Rationale
Element 2. Aim
Element 3. Methodology
Element 4. Barrier Analysis
Element 5. Robust Interventions
Element 6. Results Table
Element 7. Discussion and Validity of Reported Improvement

The first six elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement.

Review Element Designation/Weighting

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. Measurement Year (MY) 2017 is the baseline year, and during the 2018 review year, due to the several levels of feedback required, elements were reviewed and scored at multiple points during the year to provide guidance to the CHIP MCOs towards improving their proposals.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. The elements are not formally scored beyond the full/partial/non-compliant determination.

Table 2.1 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1: Element Designation

Element Designation		
Element Designation	**Definition**	**Weight**
Full	Met or exceeded the element requirements	100%
Partial	Met essential requirements but is deficient in some areas	50%
Non-compliant	Has not met the essential requirements of the element	0%

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of "Met", "Partially Met", or "Not Met". Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.

Findings

To encourage focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the CHIP MCOs, and IPRO continued and progressed throughout the review year.

Proposal documents were submitted in March 2018. Review of these submissions began in April 2018. Baseline documents were submitted in May 2018, and review of these submissions began in May and continued through September 2018. Upon initial review of the submissions, CHIP MCOs were provided findings for each PIP with request for clarification/revision as necessary. CHIP MCOs requiring additional discussion and potential modification were contacted for individual CHIP MCO conference calls.

Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years

Geisinger's topic rationale provided for the potential for meaningful impact on member health, functional status, and satisfaction in terms of developmental screening for its population. Although the proposal also demonstrated that the issue of developmental screening is one that reflects high-volume and high-risk conditions in their population, it was noted that the plan's focus on follow-up education for already identified members may be less effective than a focus on members that have not been screened at all. Additionally, historical data were not provided to support the topic rationale to compare to statewide or nationwide rates. It was noted these data should be included to strengthen rationale.

The Aim statement developed by the plan specifies performance indicators for improvement, along with corresponding goals. Geisinger align this aim and its goals with interventions to provide a coherent direction for the proposal. The goal, which is a 15 percentage point increase in screenings, was noted to be very ambitious, especially considering that the interventions that the plan developed are educational in nature. The plan was encouraged to revisit this goal, keeping in mind that a successful goal for the project should be bold, yet attainable.

Geisinger has not identified any additional indicators to follow throughout the proposal, including only the Developmental Screening PA performance measure as the sole indicator. Geisinger has been prompted to include a secondary indicator to monitor throughout this PIP, per the direction of CHIP. The study design that is proposed by Geisinger specifies data collection methodologies that are valid and reliable, and data analysis procedures which are clear and logical.

In the plan's barrier analysis, susceptible subpopulations were identified using claims data on performance measures, stratified by demographic and clinical characteristics, as well as provider input at focus groups or Quality Meetings and literature review. It was noted that inclusion of member level input could be included to identify additional barriers. The

barriers that were identified were utilized to develop robust interventions, mainly focusing on provider education. It was noted that tracking individual educational interventions could produce a more targeted invention.

A recommendation was included for Geisinger to provide final reportable rates for all results, per baseline instructions. Additionally, final goals and targets were needed for all performance indicators.

Improving Blood Lead Screening Rate in Children 2 Years of Age

Geisinger's topic rationale for Lead Screening provided for the potential for meaningful impact on member health, functional status, and satisfaction in terms of developmental screening for its population. The proposal also demonstrated that the issue of developmental screening is one that reflects high-volume and high-risk conditions in their population. As with the Developmental Screening PIP, it was noted that historical data was not provided to support topic rationale. Historical data can be used to compare to statewide or national benchmarks, and can further inform the topic selection process.

The Aim statement provided sets a target improvement rate that is bold, yet feasible and based upon baseline data and strength of interventions. All indicators identified have baselines and goals identified, however, it was noted that descriptions of the indicators selected have not been included. Inclusion of these descriptions should be included in order to improve continuity and understanding of the Aim statement in context with the objectives identified.

The plan did include indicators which measure change in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes. However, one of the Plan's selected indicators is not discussed in this section (the "two screenings before two years" measure). This should be included, as well as all numerators and denominators, and populations relevant to the indicator identified. The study design specifies data collection methods that are valid and analysis procedures that are reliable.

Barriers were identified primarily through literature review and use of prior barrier analyses to inform interventions. It was noted, as with the Developmental Screening PIP, that additional analysis utilizing claims data analysis or member input to identify demographics or trends could bring additional barriers to light. Interventions that were developed were informed by the barrier analysis and focus on education for the member and provider, but none that focus on the MCO. It was also noted that each intervention developed has a passive educational component. It was noted that these types of interventions are difficult to track and ensure the target audience has received and utilized it properly. Subsequently, tracking measures in place to follow passive interventions can be unreliable to measure effectiveness. It was noted that for these reasons, considerations for more targeted interventions be included.

As with the Developmental Screening PIP, a recommendation was included for Geisinger to provide final reportable rates for all results, per baseline instructions. Additionally, final goals and targets were needed for all performance indicators.

Table 2.2: Geisinger PIP Compliance Assessments – Baseline Reports

Review Element	Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	Improving Blood Lead Screening Rate in Children 2 Years of Age
1. Project Topic and Rationale	Partial	Partial
2. Aim Statement	Partial	Partial
3. Methodology	Partial	Partial
4. Barrier Analysis	Partial	Partial
5. Robust Interventions	Partial	Partial
6. Results Table	Partial	Partial
7. Discussion	N/A	N/A

III. Performance Measures and CAHPS® Survey

Methodology

IPRO validated PA specific performance measures and HEDIS® data for each of the CHIP MCOs.

The CHIP MCOs were provided with final specifications for the PA Performance Measures from April to May 2018. Source code, raw data and rate sheets were submitted by the CHIP MCOs to IPRO for review in 2018. IPRO conducted an initial validation of each measure, including source code review and provided each CHIP MCO with formal written feedback. The CHIP MCOs were then given the opportunity for resubmission, if necessary. Source code was reviewed by IPRO. Raw data were also reviewed for reasonability and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally, CHIP MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. Differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates.

Evaluation of CHIP MCO's performance is based on both PA-specific performance measures and selected HEDIS® measures for the EQR. The following is a list of the performance measures included in this year's EQR report.

Table 3.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS®	Children and Adolescents' Access to PCPs (Age 12 - 24 months)
HEDIS®	Children and Adolescents' Access to PCPs (Age 25 months - 6 years)
HEDIS®	Children and Adolescents' Access to PCPs (Age 7-11 years)
HEDIS®	Children and Adolescents' Access to PCPs (Age 12-19 years)
PA EQR	Contraceptive Care for All Women Most/Moderately Effective (Age 15 months – 2 years)
PA EQR	Contraceptive Care for All Women LARC (Age 15 months – 2 years)
PA EQR	Contraceptive Care for Postpartum Women Most/Moderately Effective – 3 days (Age 15 months – 20 years)
PA EQR	Contraceptive Care for Postpartum Women Most/Moderately Effective – 60 days (Age 15 months – 20 years)
PA EQR	Contraceptive Care for Postpartum Women LARC – 3 days (Age 15 months – 20 years)
PA EQR	Contraceptive Care for Postpartum Women LARC – 60 days (Age 15 months – 20 years)
Well-Care Visits and Immunizations	
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 3-11 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 12-17 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Total)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 3-11 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 12-17 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Total)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 3-11 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 12-17 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical Activity: (Total)
HEDIS®	Childhood Immunization Status by Age 2 (DtaP)
HEDIS®	Childhood Immunization Status by Age 2 (IPV)
HEDIS®	Childhood Immunization Status by Age 2 (MMR)
HEDIS®	Childhood Immunization Status by Age 2 (HiB)

Source	Measures
HEDIS®	Childhood Immunization Status by Age 2 (Hepatitis B)
HEDIS®	Childhood Immunization Status by Age 2 (VZV)
HEDIS®	Childhood Immunization Status by Age 2 (Pneumococcal Conjugate)
HEDIS®	Childhood Immunization Status by Age 2 (Hepatitis A)
HEDIS®	Childhood Immunization Status by Age 2 (Rotavirus)
HEDIS®	Childhood Immunization Status by Age 2 (Influenza)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 2)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 3)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 4)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 5)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 6)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 7)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 8)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 9)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 10)
HEDIS®	Immunizations for Adolescents (Meningococcal)
HEDIS®	Immunizations for Adolescents (Tdap/Td)
HEDIS®	Immunizations for Adolescents (HPV)
HEDIS®	Immunizations for Adolescents (Combination 1)
HEDIS®	Immunizations for Adolescents (Combination 2)
EPSDT/Bright Futures: Screenings and Follow-up	
HEDIS®	Lead Screening in Children (Age 2 years)
HEDIS®	Chlamydia Screening in Women (Age 16-19 years)
PA EQR	Developmental Screening in the First Three Years of Life – 1 year
PA EQR	Developmental Screening in the First Three Years of Life – 2 years
PA EQR	Developmental Screening in the First Three Years of Life – 3 years
PA EQR	Developmental Screening in the First Three Years of Life – Total
Dental Care for Children	
HEDIS®	Annual Dental Visit (Age 2-20 years)
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)
Respiratory Conditions	
HEDIS®	Appropriate Testing for Children with Pharyngitis
HEDIS®	Appropriate Treatment for Children with Upper Respiratory Infection
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Age 5-11 years)
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Age 12-18 years)
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Age 19 years)
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Total)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Age 19 years)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Total)
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2 – 19 years)
Behavioral Health	
HEDIS®	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) – Initiation Phase
HEDIS®	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase
HEDIS®	Follow-Up Care After Hospitalization for Mental Illness (7 Days)
HEDIS®	Follow-Up Care After Hospitalization for Mental Illness (30 Days)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 1 – 5 years)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 6 – 11 years)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 12 – 17 years)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)

Source	Measures
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 1 – 5 years)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 6 – 11 years)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 12 – 17 years)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 1 – 5 years)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 6 – 11 years)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 12 – 17 years)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)
Utilization	
HEDIS®	Well-Child Visits in the First 15 Months of Life (0 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (1Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (2 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (3 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (4 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (5 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (>= 6 Visits)
HEDIS®	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 – 6 years)
HEDIS®	Adolescent Well-Care Visits (Age 12 – 19 years)

PA-Specific Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each CHIP MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS® specifications. Measures previously developed and added as mandated by CMS for children in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) were continued as applicable to revised CMS specifications. Additionally, new measures were developed and added in 2018 as mandated in accordance with the ACA. For each indicator, the criteria that were specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications, as needed.

PA Specific Administrative Measures

Developmental Screening in the First Three Years of Life– CHIPRA Core Set

This performance measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. Four rates, one for each group and a combined rate, are to be calculated and reported for each numerator.

Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk – CHIPRA Core Set

This performance measure assesses the percentage of enrolled children ages 6-9 years at elevated risk of dental caries who received a sealant on a permanent first molar tooth within the measurement year.

Additionally, to be more closely aligned to the CHIPRA Core Set Measure specifications, a second enhanced measure is reported which includes additional available dental data (Dental-enhanced).

Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits

This performance measure assesses the percentage of children and adolescents, two years of age through 19 years of age, with an asthma diagnosis who have ≥1 emergency department (ED) visit during the measurement year.

Contraceptive Care for All Women – CHIPRA Core Set – New for 2018

This performance measure assesses the percentage of women ages 15 through 20 at risk of unintended pregnancy and were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC). For the CMS Core measures, two rates are reported: one each for (1) the provision of most/moderately effective contraception and for (2) the provision of LARC.

Contraceptive Care for Postpartum Women – CHIPRA Core Set – New for 2018

This performance measure assesses the percentage of women ages 15 through 20 who had a live birth and were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC), within 3 days and within 60 days of delivery. For the CMS Core measures, four rates are reported in total (1) Most or moderately effective contraception – 3 days, (2) Most or moderately effective contraception – 60 days, (3) LARC – 3 days, and (4) LARC – 60 days.

HEDIS® Performance Measure Selection and Descriptions

Each CHIP MCO underwent a full HEDIS® compliance audit in 2018. As indicated previously, performance on selected HEDIS® measures is included in this year's EQR report. Development of HEDIS® measures and the clinical rationale for their inclusion in the HEDIS® measurement set can be found in HEDIS® 2018, Volume 2 Narrative. The measurement year for HEDIS® 2018 measures is 2017, as well as prior years for selected measures. Each year, DHS updates its requirements for the CHIP MCOs to be consistent with NCQA's requirement for the reporting year. CHIP MCOs are required to report the complete set of CHIP measures, as specified in the HEDIS® Technical Specifications, Volume 2. Depending on the measure, HEDIS® indicator rates are calculated through one of two methods: (1) administrative, which uses only the CHIP MCO's data systems to identify numerator positives and (2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator "hits" for rate calculation. In addition, DHS does not require the CHIP MCOs to produce the Chronic Conditions component of the CAHPS® 5.0 – Child Survey.

Children and Adolescents' Access to Primary Care Practitioners

This measure assesses the percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Well-Child Visits in the First 15 Months of Life

This measure assessed the percentage of enrollees who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age through 15 months of age who received six or more well-child visits with a PCP during their first 15 months of life.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure assessed the percentage of enrollees who were 3, 4, 5, or 6 years of age during the measurement year, who were continuously enrolled during the measurement year and received one or more well-child visits with a PCP during the measurement year.

Childhood Immunization Status

This measure assessed the percentage of children who turned two years of age in the measurement year who were continuously enrolled for the 12 months preceding their second birthday and who received one or both of two

immunization combinations on or before their second birthday. Separate rate were calculated for each Combination. Combination 2 and 3 consists of the following immunizations:
(4) Diphtheria and Tetanus, and Pertussis Vaccine/Diphtheria and Tetanus (DTaP/DT)
(3) Injectable Polio Vaccine (IPV)
(1) Measles, Mumps, and Rubella (MMR)
(3) Haemophilius Influenza Type B (HiB)
(3) Hepatitis B (HepB)
(1) Chicken Pox (VZV)
(4) Pneumococcal Conjugate Vaccine – Combination 3 only

Adolescent Well-Care Visits

This measure assessed the percentage of enrolled members 12–19 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation.
- Counseling for nutrition.
- Counseling for physical activity

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Immunization for Adolescents

This measure assessed the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

- Combination 1: Meningococcal and Tdap
- Combination 2: Meningococcal, Tdap, and HPV

Lead Screening in Children

This measure assessed the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Follow-up Care for Children Prescribed ADHD Medication

This measure assessed the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Follow Up After Hospitalization for Mental Illness

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported.

- The percentage of discharges for which the member received follow-up within 30 days after discharge.
- The percentage of discharges for which the member received follow-up within 7 days after discharge.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Annual Dental Visit

This measure assessed the percentage of children and adolescents between the ages of 2 and 20 years of age who were continuously enrolled in the MCO for the measurement year who had a dental visit during the measurement year.

Chlamydia Screening in Women

This measure assessed the percentage of women 16–19 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Appropriate Testing for Children with Pharyngitis

This measure assessed the percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Appropriate Treatment for Children with Upper Respiratory Infection

This measure assessed the percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Medication Management for People with Asthma - 75% Compliance

This measure assessed the percentage of members 5–19 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period and remained on an asthma controller medication for at least 75% of their treatment period.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

This measure assessed the percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications.

For this measure a lower rate indicates better performance.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assessed the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Additional HEDIS Measures

Ambulatory Care, Inpatient Utilization, Mental Health Utilization, and Identification of Alcohol and Other Drug Services measures, due to differences in reporting metrics compared to the above measures, are included in Tables A1 through A4 in Appendix A of this report.

CAHPS® Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is overseen by the Agency of Healthcare Research and Quality (AHRQ) and includes many survey products designed to capture consumer and patient perspectives on health care quality. NCQA uses the adult and child versions of the CAHPS® Health Plan Surveys for HEDIS.

Implementation of PA-Specific Performance Measures and HEDIS Audit

The CHIP MCO successfully implemented all of the PA-specific measures for 2018 that were reported with MCO-submitted data. The CHIP MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the CHIP MCO. All rates submitted by the CHIP MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures.

The Contraceptive Care for All Women and Contraceptive Care for Postpartum Women (CCW; CCP) were new in 2018 for all CHIP MCOs.

The Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH) measure underwent some modifications for 2018. This measure was new in 2016 and several issues were discovered during the 2016 validation process. Feedback received from MCOs regarding the 2016 implementation was highlighted for discussion and led to modifications to the measure specifications for the 2017 validation process. One issue in particular was that many MCOs noted that there were providers other than the ones specified by CMS potentially applying the sealants. Based on the issues, a second numerator was developed in addition to the CMS numerator. Cases included in this numerator are cases that would not have been accepted per the CMS guidance because the provider type could not be crosswalked to an acceptable CMS provider. The second numerator was created to quantify these cases, and to provide additional information for DHS about whether sealants were being applied by providers other than those outlined by CMS, for potential future consideration when discussing the measure. There was a wide range of other providers identified across MCOs for the second numerator. Because the second numerator and the total created by adding both numerators deviate from CMS guidance, they were provided to DHS for informational purposes but are not included for reporting. The SEAL-CH and enhanced SEAL-CH rates reported in this section for are comparable to the 2016 rates and are aligned with the CMS guidance. In 2018, these changes were continued, and applicable CDT codes used for numerator compliance were updated and/or added.

The Developmental Screening in the First Three Years of Life measure was modified in 2018 in order to clarify the age cohorts that are used when reporting for this measure. This clarification noted that children can be screened in the 12 months preceding or on their 1st, 2nd, or 3rd birthday. Specifically, the member must be screened in the following timeframes in order to be compliant for their age cohort:

- Age Cohort 1: member must be screened anytime between birth to 1st birthday
- Age Cohort 2: member must be screened anytime between 1 day after 1st birthday to day of 2nd birthday
- Age Cohort 3: member must be screened anytime between 1 day after 2nd birthday to day of 3rd birthday

This application of compliance was a common issue across CHIP MCOs this year.

Findings

CHIP MCO results are presented in Tables 3.2 through 3.8. For each measure, the denominator, numerator, and measurement year rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95%

confidence interval indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the confidence interval 95 times, or 95% of the time.

Rates for both the measurement year and the previous year are presented, as available [i.e., 2018 (MY 2017) and 2017 (MY 2016)]. In addition, statistical comparisons are made between the 2018 and 2017 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of 2018 rates to 2017 rates, statistically significant increases are indicated by "+", statistically significant decreases by "–" and no statistically significant change by "n.s."

In addition to each individual CHIP MCO's rate, the CHIP average for 2018 (MY 2017) is presented. The CHIP average is a weighted average, which is an average that takes into account the proportional relevance of each CHIP MCO. Each table also presents the significance of difference between the plan's measurement year rate and the CHIP average for the same year. For comparison of 2018 rates to CHIP rates, the "+" symbol denotes that the plan rate exceeds the CHIP rate; the "–" symbol denotes that the CHIP rate exceeds the plan rate and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant, and display at least a **3**-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates may not yield statistical significance due to reduced power; if statistical significance is not achieved, results will not be highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "NA" (Not Applicable) appears in the corresponding cells. However, "NA" (Not Available) also appears in the cells under the HEDIS 2018 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

The tables below show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates that are reported in the narrative may differ slightly from the difference between the rates as presented in the table.

Graphical representation of findings is provided for a subset of measures with sufficient data to provide informative illustration to the tables provided below. These can be found in Appendix B.

Access to/Availability of Care

No strengths are identified for 2018 (MY 2017) Access/Availability of Care performance measures.

No opportunities for improvement are identified for 2018 (MY 2017) Access/Availability of Care performance measures.

Table 3.2: Access to Care

Indicator		2018 (MY 2017)					2018 (MY 2017)				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Children and Adolescents' Access To PCP (12-24 Months)	249	244	97.99%	96.05%	99.93%	99.12%	n.s.	98.24%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Children and Adolescents' Access To PCP (25 Months-6 Yrs)	2,127	1,997	93.89%	92.85%	94.93%	94.68%	n.s.	94.30%	n.s.	>= 95th Percentile
HEDIS	Children and Adolescents' Access To PCP (7-11 Yrs)	1,870	1,810	96.79%	95.96%	97.62%	96.44%	n.s.	96.92%	n.s.	>= 90th Percentile and < 95th Percentile

HEDIS	Children and Adolescents' Access To PCP (12-19 Yrs)	2,472	2,387	96.56%	95.82%	97.30%	96.40%	n.s.	96.66%	n.s.	>= 95th Percentile

Well-Care Visits and Immunizations

No strengths are identified for 2018 (MY 2017) Well-Care Visits and Immunizations performance measures.

No opportunities for improvement are identified for 2018 (MY 2017) Well-Care Visits and Immunizations performance measures.

Table 3.3: Well-Care Visits and Immunizations

Indicator		2018 (MY 2017)					2018 (MY 2017)				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 years)	226	184	81.42%	76.13%	86.71%	84.87%	n.s.	80.75%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 years)	158	132	83.54%	77.44%	89.64%	78.44%	n.s.	78.82%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	384	316	82.29%	78.34%	86.24%	82.22%	n.s.	79.96%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 years)	226	159	70.35%	64.17%	76.53%	75.63%	n.s.	77.63%	-	>= 25th Percentile and < 50th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 years)	158	113	71.52%	64.17%	78.87%	73.05%	n.s.	75.65%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	384	272	70.83%	66.15%	75.51%	74.57%	n.s.	76.90%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 years)	226	146	64.60%	58.14%	71.06%	63.45%	n.s.	70.41%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 years)	158	108	68.35%	60.78%	75.92%	74.25%	n.s.	74.35%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	384	254	66.15%	61.29%	71.01%	67.90%	n.s.	72.29%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Childhood Immunization Status - DTaP	338	297	87.87%	84.24%	91.50%	86.83%	n.s.	86.54%	n.s.	>= 95th Percentile
HEDIS	Childhood Immunization Status - IPV	338	316	93.49%	90.71%	96.27%	94.65%	n.s.	91.77%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - MMR	338	314	92.90%	90.01%	95.79%	92.18%	n.s.	92.03%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - HiB	338	313	92.60%	89.66%	95.54%	92.18%	n.s.	92.64%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - Hepatitis B	338	319	94.38%	91.78%	96.98%	95.06%	n.s.	91.10%	+	>= 90th Percentile and < 95th Percentile
HEDIS	Childhood Immunization Status - VZV	338	307	90.83%	87.61%	94.05%	89.71%	n.s.	92.26%	n.s.	>= 50th Percentile and < 75th Percentile

HEDIS	Childhood Immunization Status - Pneumococcal Conjugate	338	299	88.46%	84.91%	92.01%	86.83%	n.s.	87.17%	n.s.	>= 95th Percentile
HEDIS	Childhood Immunization Status - Hepatitis A	338	276	81.66%	77.39%	85.93%	83.13%	n.s.	88.22%	-	>= 25th Percentile and < 50th Percentile
HEDIS	Childhood Immunization Status - Rotavirus	338	270	79.88%	75.46%	84.30%	83.54%	n.s.	79.91%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Childhood Immunization Status - Influenza	338	154	45.56%	40.10%	51.02%	54.32%	-	60.07%	-	>= 25th Percentile and < 50th Percentile
HEDIS	Childhood Immunization Status - Combo 2	338	276	81.66%	77.39%	85.93%	83.13%	n.s.	81.58%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - Combo 3	338	268	79.29%	74.82%	83.76%	81.48%	n.s.	79.49%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - Combo 4	338	248	73.37%	68.51%	78.23%	75.31%	n.s.	76.72%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - Combo 5	338	233	68.93%	63.85%	74.01%	73.25%	n.s.	70.46%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - Combo 6	338	142	42.01%	36.60%	47.42%	47.74%	n.s.	54.11%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Childhood Immunization Status - Combo 7	338	218	64.50%	59.25%	69.75%	67.90%	n.s.	68.63%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Childhood Immunization Status - Combo 8	338	137	40.53%	35.15%	45.91%	46.50%	n.s.	53.40%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Childhood Immunization Status - Combo 9	338	126	37.28%	31.98%	42.58%	43.62%	n.s.	49.27%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Childhood Immunization Status - Combo 10	338	121	35.80%	30.54%	41.06%	42.39%	n.s.	48.78%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Immunizations for Adolescents - Meningococcal	411	373	90.75%	87.83%	93.67%	91.28%	n.s.	90.78%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Immunizations for Adolescents - Tdap	411	379	92.21%	89.50%	94.92%	93.08%	n.s.	93.02%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Immunizations for Adolescents - HPV	411	100	24.33%	20.06%	28.60%	15.38%	+	32.27%	-	>= 10th Percentile and < 25th Percentile
HEDIS	Immunizations for Adolescents - Combination 1	411	364	88.56%	85.36%	91.76%	90.51%	n.s.	89.52%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Immunizations for Adolescents - Combination 2	411	94	22.87%	18.69%	27.05%	14.87%	+	30.46%	-	>= 10th Percentile and < 25th Percentile

EPSDT/Bright Futures: Screenings and Follow-up

Strengths are identified for the following 2018 (MY 2017) EPSDT/Bright Futures: Screenings and Follow-up performance measures.

- The following rates are statistically significantly above/better than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Contraceptive Care for All Women (Age 15 – 20 years): Most or Moderately Effective

Opportunities for improvement are identified for 2018 (MY 2017) EPSDT/Bright Futures: Screenings and Follow-up and Immunizations performance measures.

- The following rates are statistically significantly below/worse than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Chlamydia Screening in Women (16-20)
    - Chlamydia Screening in Women - Total

Table 3.4: EPSDT/Bright Futures: Screenings and Follow-up

Indicator		2018 (MY 2017)					2018 (MY 2017)				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Lead Screening in Children	338	238	70.41%	65.40%	75.42%	77.78%	-	61.91%	+	>= 25th Percentile and < 50th Percentile
HEDIS	Chlamydia Screening in Women (16-20)	333	119	35.74%	30.44%	41.04%	30.74%	n.s.	38.58%	n.s.	< 5th Percentile
HEDIS	Chlamydia Screening in Women - Total	333	119	35.74%	30.44%	41.04%	30.74%	n.s.	38.59%	n.s.	< 5th Percentile
PA EQR	Developmental Screening in the First Three Years of Life – 1 year	132	91	68.94%	60.67%	77.21%	69.34%	n.s.	52.48%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life – 2 years	281	113	40.21%	34.30%	46.12%	45.97%	n.s.	56.36%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life – 3 years	329	122	37.08%	31.71%	42.45%	44.04%	n.s.	51.41%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life – Total	742	326	43.94%	40.30%	47.57%	50.00%	-	53.11%	-	NA
PA EQR	Contraceptive Care for All Women (Age 15 – 20 years): Most or Moderately Effective	970	210	21.65%	19.01%	24.29%	NA	NA	17.93%	+	NA
PA EQR	Contraceptive Care for All Women (Age 15 – 20 years): LARC	970	19	1.96%	1.04%	2.88%	NA	NA	2.27%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): Most or moderately effective contraception – 3 days	3	0	NA	NA	NA	NA	NA	NA	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): Most or moderately effective contraception – 60 days	3	1	NA	NA	NA	NA	NA	NA	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): LARC – 3 days	3	0	NA	NA	NA	NA	NA	NA	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): LARC – 60 days	3	1	NA	NA	NA	NA	NA	NA	NA	NA

Dental Care for Children

Strengths are identified for the following 2018 (MY 2017) Dental Care for Children performance measures.

- The following rates are statistically significantly above/better than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Annual Dental Visit (7-10 Yrs)
    - Annual Dental Visit (11-14 Yrs)
    - Annual Dental Visit (15-18 Yrs)
    - Annual Dental Visit (Total)

Opportunities for improvement are identified for 2018 (MY 2017) Dental Care for Children performance measures.

- The following rates are statistically significantly below/worse than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Annual Dental Visit (2-3 Yrs)
    - Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)
    - Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)

Table 3.5: Dental Care for Children

Indicator		2018 (MY 2017)					2018 (MY 2017)				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Annual Dental Visit (2-3 Yrs)	834	314	37.65%	34.30%	41.00%	38.63%	n.s.	46.13%	-	>= 25th Percentile and < 50th Percentile
HEDIS	Annual Dental Visit (4-6 Yrs)	1,314	903	68.72%	66.18%	71.26%	69.03%	n.s.	76.57%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Annual Dental Visit (7-10 Yrs)	2,287	1,608	70.31%	68.42%	72.20%	72.12%	n.s.	79.36%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Annual Dental Visit (11-14 Yrs)	2,215	1,466	66.19%	64.20%	68.18%	68.19%	n.s.	76.11%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Annual Dental Visit (15-18 Yrs)	1,913	1,085	56.72%	54.47%	58.97%	57.82%	n.s.	67.27%	-	>= 50th Percentile and < 75th Percentile
HEDIS	Annual Dental Visit (19-20 Yrs)	60	22	36.67%	23.64%	49.70%	NA	NA	54.63%	-	>= 25th Percentile and < 50th Percentile
HEDIS	Annual Dental Visit (Total)	8,623	5,398	62.60%	61.57%	63.63%	64.08%	n.s.	72.33%	-	>= 50th Percentile and < 75th Percentile
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)	1,269	466	36.72%	34.03%	39.41%	21.43%	+	25.21%	+	NA
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)	1,289	471	36.54%	33.87%	39.21%	20.41%	+	25.17%	+	NA

Note: The ADV 19-20 year old age cohort is reported here as only 19 year olds, in order to include only members that are CHIP eligible.

Respiratory Conditions

Strengths are identified for the following 2018 (MY 2017) Respiratory performance measures.

- The following rates are statistically significantly above/better than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Medication Management for People With Asthma - Medication Compliance 75% (12-18)
    - Medication Management for People With Asthma - Medication Compliance 75% (Total)

Opportunities for improvement are identified for 2018 (MY 2017) Respiratory Conditions performance measures.

- The following rate is statistically significantly below/worse than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Appropriate Treatment for Children With Upper Respiratory Infection

Table 3.6: Respiratory Conditions

Indicator		2018 (MY 2017)						2018 (MY 2017)			
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Appropriate Testing for Children With Pharyngitis	715	628	87.83%	85.36%	90.30%	82.60%	+	86.70%	n.s.	>= 75th Percentile and < 90th Percentile
HEDIS	Appropriate Treatment for Children With Upper Respiratory Infection[1]	588	48	91.84%	89.54%	94.14%	92.15%	n.s.	89.71%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Medication Management for People with Asthma - 50% Compliance (Age 5-11 years)	75	50	66.67%	55.33%	78.01%	68.00%	n.s.	59.54%	n.s.	NA
HEDIS	Medication Management for People with Asthma - 50% Compliance (Age 12-18 years)	57	35	61.40%	47.88%	74.92%	67.44%	n.s.	58.96%	n.s.	NA
HEDIS	Medication Management for People with Asthma - 50% Compliance (Total)	132	85	64.39%	55.84%	72.94%	67.80%	n.s.	59.35%	n.s.	NA

HEDIS	Medication Management for People With Asthma - Medication Compliance 75% (5-11)	75	33	44.00%	32.10%	55.90%	36.00%	n.s.	35.39%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Medication Management for People With Asthma - Medication Compliance 75% (12-18)	57	19	33.33%	20.22%	46.44%	39.53%	n.s.	34.56%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Medication Management for People With Asthma - Medication Compliance 75% (Total)	132	52	39.39%	30.68%	48.10%	37.29%	n.s.	35.15%	n.s.	>= 50th Percentile and < 75th Percentile
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2 – 19 years)	967	46	4.76%	3.36%	6.15%	4.37%	n.s.	7.71%	-	NA

[1] Per NCQA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
Note: Although reporting for age cohort 19 - 50 year olds for the MMA measure, it is not included in CHIP reporting as most members in this cohort are not eligible for CHIP based on age.

Behavioral Health

No strengths are identified for 2018 (MY 2017) Behavioral Health performance measures.

No opportunities for improvement are identified for 2018 (MY 2017) Behavioral Health performance measures.

Table 3.7: Behavioral Health

Indicator		2018 (MY 2017)					2018 (MY 2017)				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	66	33	50.00%	37.18%	62.82%	56.36%	n.s.	50.15%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	20	11	55.00%	30.7%	79.3%	NA	NA	62.64%	NA	NA
HEDIS	Follow Up After Hospitalization For Mental Illness - 7 days	40	18	45.00%	28.33%	61.67%	84.38%	-	53.63%	n.s.	>= 50th Percentile and < 75th Percentile
HEDIS	Follow Up After Hospitalization For Mental Illness - 30 days	40	30	75.00%	60.33%	89.67%	96.88%	-	77.34%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (6-11 years)	0	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5 Years)	10	8	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (12-17 years)	24	12	NA	NA	NA	NA	NA	61.11%	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	34	20	58.82%	40.81%	76.83%	61.29%	n.s.	47.25%	n.s.	>= 90th Percentile and < 95th Percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-5 Years)	0	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (6-11 years)	3	2	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 years)	19	8	NA	NA	NA	NA	NA	70.97%	NA	NA
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	23	10	NA	NA	NA	NA	NA	65.35%	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (1-5 Years)	0	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6-11 years)	9	0	NA	NA	NA	NA	NA	NA	NA	NA

HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12-17 years)	17	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)	26	0	NA	NA	NA	NA	NA	0.00%	NA	NA

Utilization

No strengths are identified for 2018 (MY 2017) Utilization performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 CHIP weighted average by ≥ 3 percentage points:
    - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

Table 3.8: Utilization

Indicator		2018 (MY 2017)					2018 (MY 2017)				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2017 (MY2016) Rate	2018 Rate Compared to 2017	CHIP	2018 Rate Compared to CHIP	HEDIS 2018 National Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (0 visits)	156	0	0.00%	-0.32%	0.32%	0.00%	NA	0.68%	n.s.	< 5th Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (1 visit)	156	0	0.00%	-0.32%	0.32%	0.00%	NA	0.29%	n.s.	< 5th Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (2 visits)	156	1	0.64%	-0.93%	2.21%	1.79%	n.s.	0.39%	n.s.	< 5th Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (3 visits)	156	2	1.28%	-0.80%	3.36%	1.19%	n.s.	1.55%	n.s.	< 5th Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (4 visits)	156	7	4.49%	0.92%	8.06%	3.57%	n.s.	3.78%	n.s.	>= 5th Percentile and < 10th Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (5 visits)	156	21	13.46%	7.78%	19.14%	13.10%	n.s.	13.29%	n.s.	>= 25th Percentile and < 50th Percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (6 or more visits)	156	125	80.13%	73.55%	86.71%	80.36%	n.s.	80.02%	n.s.	>= 95th Percentile
HEDIS	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	296	243	82.09%	77.55%	86.63%	77.20%	n.s.	86.54%	-	>= 75th Percentile and < 90th Percentile
HEDIS	Adolescent Well-Care Visits	366	232	63.39%	58.32%	68.46%	67.97%	n.s.	70.44%	-	>= 75th Percentile and < 90th Percentile

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Satisfaction with the Experience of Care

The following tables provide the survey results of four composite questions by two specific categories for the CHIP MCO across the last three measurement years, as available. The composite questions will target the CHIP MCO's performance strengths as well as opportunities for improvement.

Due to differences in the CAHPS® submissions from year to year, direct comparisons of results are not always available. Questions that are not included in the most recent survey version are not presented in the tables.

2018 Child CAHPS® 5.0H Survey Results

Table 3.9: CAHPS® 2018 Child Survey Results

CAHPS® Items Satisfaction with Child's Care	2018 (MY 2017)	2018 Rate Compared to 2017	2017 (MY 2016)	2017 Rate Compared to 2016	2016 (MY 2015)	2018 CHIP Weighted Average
Satisfaction with your child's current personal doctor (rating of 8 to 10)	88.25%	▼	88.32%	▼	91.00%	89.78%
Satisfaction with specialist (rating of 8 to 10)	82.69%	▼	88.10%	▲	80.43%	86.52%
Satisfaction with health plan (rating of 8 to 10) (satisfaction with child's plan)	84.22%	▲	84.13%	▼	85.44%	86.49%
Satisfaction with child's health care (rating of 8 to 10)	84.91%	▼	86.36%	▼	86.38%	87.45%
Quality of Mental Health Care						
Received care for child's mental health from any provider? (usually or always)	31.72%	▲	10.05%	▼	11.82%	8.37%
Easy to get needed mental health care? (usually or always)	36.89%	▼	38.16%	▲	24.06%	26.76%
Provider you would contact for mental health services? (PCP)	69.33%	▼	71.47%	▼	77.92%	69.73%
Child's overall mental or emotional health? (very good or excellent)	85.32%	▲	81.82%	▼	85.78%	83.79%

▲▼ = Performance compared to prior years' rate
Shaded boxes reflect rates above the 2018 CHIP Weighted Average.

IV. 2018 Strengths and Opportunities for Improvement

The review of CHIP MCO's 2018 performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for Medicaid members served by this CHIP MCO.

Strengths

- The CHIP MCO's performance was statistically significantly above/better than the CHIP weighted average in 2018 (MY 2017) on the following measures:
    - Contraceptive Care for All Women (Age 15 – 20 years): Most or Moderately Effective
    - Annual Dental Visit (7-10 Yrs)
    - Annual Dental Visit (11-14 Yrs)
    - Annual Dental Visit (15-18 Yrs)
    - Annual Dental Visit (Total)
    - Medication Management for People With Asthma - Medication Compliance 75% (12-18)
    - Medication Management for People With Asthma - Medication Compliance 75% (Total)

Opportunities for Improvement

- The CHIP MCO's performance was statistically significantly below/worse than the CHIP rate in 2018 (MY 2017) as indicated by the following measures:
    - Chlamydia Screening in Women (16-20)
    - Chlamydia Screening in Women - Total
    - Annual Dental Visit (2-3 Yrs)
    - Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)
    - Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)
    - Appropriate Treatment for Children With Upper Respiratory Infection
    - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

V. Summary of Activities

Structure and Operations Standards

- Geisinger was found to be fully compliant on Subpart C, and partially compliant on one category in Subpart D and two categories in Subpart H. Items from Review Year (RY) 2017, 2016, and 2015, as applicable, provided the information necessary for this assessment.

Performance Improvement Projects

- Geisinger's Lead Screening and Developmental Screening PIP Baseline Update were both validated. The CHIP MCO received feedback and subsequent information related to these activities from IPRO and CHIP.

Performance Measures

- Geisinger reported all HEDIS®, PA Performance Measures, and CAHPS® Survey performance measures in 2018 for which the CHIP MCO had a sufficient denominator.

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for Geisinger in 2018. A response will be required by the CHIP MCO for the noted opportunities for improvement in 2019.

Appendix A

Table 4.1: Ambulatory Care

Indicator	2018 (MY 2017) Rate	2017 (MY2016) Rate	2018 Rate Compared to 2017
AMBA: Outpatient Visits/1000 MM Ages <1 year	826.28	750.72	+
AMBA: Outpatient Visits/1000 MM Ages 1 - 9 years	303.81	312.29	-
AMBA: Outpatient Visits/1000 MM Ages 10 - 19 years	261.59	260.13	+
AMBA: Outpatient Visits/1000 MM Ages <1 - 19 years Total Rate	285.40	288.55	-
AMBA: Emergency Department Visits/1000 MM Ages <1 year	38.00	25.79	+
AMBA: Emergency Department Visits/1000 MM Ages 1 - 9 years	32.20	33.34	-
AMBA: Emergency Department Visits/1000 MM Ages 10 - 19 years	30.13	32.04	-
AMBA: Emergency Department Visits/1000 MM Ages <1 - 19 years Total Rate	31.18	32.64	-

Table 4.2: Inpatient Utilization

Indicator	2018 (MY 2017) Rate	2017 (MY2016) Rate	2018 Rate Compared to 2017
IPUA: Total Discharges/1000 MM Ages <1 year	5.43	0.00	+
IPUA: Total Discharges/1000 MM Ages 1 - 9 years	0.73	0.98	-
IPUA: Total Discharges/1000 MM Ages 10 - 19 years	0.82	0.92	-
IPUA: Total Discharges/1000 MM Ages <1 - 19 years Total Rate	0.81	0.95	-
IPUA: Total Inpatient ALOS Ages <1 year	2.60	NA	NA
IPUA: Total Inpatient ALOS Ages 1 - 9 Years	2.09	3.29	-
IPUA: Total Inpatient ALOS Ages 10 - 19 years	4.27	4.19	+
IPUA: Total Inpatient ALOS Ages <1 - 19 years Total Rate	3.24	3.73	-
IPUA: Surgery Discharges/1000 MM Ages <1 year	1.09	0.00	+
IPUA: Surgery Discharges/1000 MM Ages 1 - 9 years	0.16	0.17	-
IPUA: Surgery Discharges/1000 MM Ages 10 - 19 years	0.19	0.19	-
IPUA: Surgery Discharges/1000 MM Ages <1 - 19 years Total Rate	0.18	0.18	+
IPUA: Surgery ALOS Ages <1 year	2.00	NA	NA
IPUA: Surgery ALOS Ages 1 - 9 years	2.08	4.70	-
IPUA: Surgery ALOS Ages 10 - 19 years	5.13	7.92	-
IPUA: Surgery ALOS Ages <1 - 19 years Total Rate	3.71	6.45	-
IPUA: Medicine Discharges/1000 MM Ages <1 year	4.34	0.00	+

IPUA: Medicine Discharges/1000 MM Ages 1 - 9 years	0.58	0.81	-
IPUA: Medicine Discharges/1000 MM Ages 10 - 19 years	0.54	0.66	-
IPUA: Medicine Discharges/1000 MM Ages <1 - 19 years Total Rate	0.58	0.73	-
IPUA: Medicine ALOS Ages <1 year	2.75	NA	NA
IPUA: Medicine ALOS Ages 1 - 9 years	2.09	3.00	-
IPUA: Medicine ALOS Ages 10 - 19 years	4.16	3.20	+
IPUA: Medicine ALOS Ages <1 - 19 years Total Rate	3.10	3.09	+
IPUA: Maternity/1000 MM Ages 10 - 19 years	0.10	0.06	+
IPUA: Maternity ALOS Ages 10 - 19 years Total Rate	3.25	3.25	-

Table 4.3: Mental Health Utilization

Indicator	2018 (MY 2017) Rate	2017 (MY2016) Rate	2018 Rate Compared to 2017
MPT: Any Services/1000 MM Ages 0 - 12 years - Male	7.54%	7.48%	+
MPT: Any Services/1000 MM Ages 0 - 12 years - Female	5.83%	5.65%	+
MPT: Any Services/1000 MM Ages 0 - 12 years - Total Rate	6.69%	6.58%	+
MPT: Any Services/1000 MM Ages 13 - 17 years - Male	9.48%	9.52%	-
MPT: Any Services/1000 MM Ages 13 - 17 years - Female	15.32%	14.70%	+
MPT: Any Services/1000 MM Ages 13 - 17 years - Total Rate	12.38%	12.08%	+
MPT: Inpatient/1000 MM Ages 0 - 12 years - Male	0.02%	0.08%	-
MPT: Inpatient/1000 MM Ages 0 - 12 years - Female	0.05%	0.12%	-
MPT: Inpatient/1000 MM Ages 0 - 12 years - Total Rate	0.03%	0.10%	-
MPT: Inpatient/1000 MM Ages 13 - 17 years - Male	0.22%	0.63%	-
MPT: Inpatient/1000 MM Ages 13 - 17 years - Female	0.93%	1.51%	-
MPT: Inpatient/1000 MM Ages 13 - 17 years - Total Rate	0.57%	1.06%	-
MPT: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 0 - 12 years - Male	0.05%	0.03%	+
MPT: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 0 - 12 years - Female	0.02%	0.06%	-
MPT: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 0 - 12 years - Total Rate	0.03%	0.04%	-
MPT: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 13 - 17 years - Male	0.05%	0.00%	+
MPT: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 13 - 17 years - Female	0.00%	0.14%	-
MPT: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 13 - 17 years - Total Rate	0.03%	0.07%	-
MPT: Outpatient/1000 MM Ages 0 - 12 years - Male	7.47%	NA	NA
MPT: Outpatient/1000 MM Ages 0 - 12 years - Female	5.76%	NA	NA
MPT: Outpatient/1000 MM Ages 0 - 12 years - Total Rate	6.62%	NA	NA
MPT: Outpatient/1000 MM Ages 13 - 17 years - Male	9.16%	NA	NA
MPT: Outpatient/1000 MM Ages 13 - 17 years - Female	14.44%	NA	NA
MPT: Outpatient/1000 MM Ages 13 - 17 years - Total Rate	11.78%	NA	NA

MPT: ED/1000 MM Ages 0 - 12 years - Male	0.00%	NA	NA
MPT: ED/1000 MM Ages 0 - 12 years - Female	0.00%	NA	NA
MPT: ED/1000 MM Ages 0 - 12 years - Total Rate	0.00%	NA	NA
MPT: ED/1000 MM Ages 13 - 17 years - Male	0.05%	NA	NA
MPT: ED/1000 MM Ages 13 - 17 years - Female	0.00%	NA	NA
MPT: ED/1000 MM Ages 13 - 17 years - Total Rate	0.03%	NA	NA
MPT: Telehealth/1000 MM Ages 0 - 12 years - Male	0.00%	NA	NA
MPT: Telehealth/1000 MM Ages 0 - 12 years - Female	0.00%	NA	NA
MPT: Telehealth/1000 MM Ages 0 - 12 years - Total Rate	0.00%	NA	NA
MPT: Telehealth/1000 MM Ages 13 - 17 years - Male	0.00%	NA	NA
MPT: Telehealth/1000 MM Ages 13 - 17 years - Female	0.00%	NA	NA
MPT: Telehealth/1000 MM Ages 13 - 17 years - Total Rate	0.00%	NA	NA

Table 4.4: Identification of Alcohol and Other Drug Services

Indicator	2018 (MY 2017) Rate	2017 (MY2016) Rate	2018 Rate Compared to 2017
IAD: Any Services/1000 MM Ages 0 - 12 years - Male	0.00%	0.06%	-
IAD: Any Services/1000 MM Ages 0 - 12 years - Female	0.00%	0.03%	-
IAD: Any Services/1000 MM Ages 0 - 12 years - Total Rate	0.00%	0.04%	-
IAD: Any Services/1000 MM Ages 13 - 17 years - Male	0.76%	1.68%	-
IAD: Any Services/1000 MM Ages 13 - 17 years - Female	1.10%	1.15%	-
IAD: Any Services/1000 MM Ages 13 - 17 years - Total Rate	0.93%	1.42%	-
IAD: Inpatient/1000 MM Ages 0 - 12 years - Male	0.00%	0.00%	-
IAD: Inpatient/1000 MM Ages 0 - 12 years - Female	0.00%	0.03%	-
IAD: Inpatient/1000 MM Ages 0 - 12 years - Total Rate	0.00%	0.01%	-
IAD: Inpatient/1000 MM Ages 13 - 17 years - Male	0.16%	0.28%	-
IAD: Inpatient/1000 MM Ages 13 - 17 years - Female	0.22%	0.36%	-
IAD: Inpatient/1000 MM Ages 13 - 17 years - Total Rate	0.19%	0.32%	-
IAD: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 0 - 12 years - Male	0.00%	0.00%	-
IAD: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 0 - 12 years - Female	0.00%	0.00%	-
IAD: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 0 - 12 years - Total Rate	0.00%	0.00%	-
IAD: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 13 - 17 years - Male	0.00%	0.07%	-
IAD: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 13 - 17 years - Female	0.00%	0.00%	-
IAD: Intensive Outpatient/Partial Hospitalization/1000 MM Ages 13 - 17 years - Total Rate	0.00%	0.04%	-
IAD: Outpatient/1000 MM Ages 0 - 12 years - Male	0.00%	NA	NA
IAD: Outpatient/1000 MM Ages 0 - 12 years - Female	0.00%	NA	NA
IAD: Outpatient/1000 MM Ages 0 - 12 years - Total Rate	0.00%	NA	NA
IAD: Outpatient/1000 MM Ages 13 - 17 years - Male	0.43%	NA	NA
IAD: Outpatient/1000 MM Ages 13 - 17 years - Female	0.82%	NA	NA

IAD: Outpatient/1000 MM Ages 13 - 17 years - Total Rate	0.63%	NA	NA
IAD: ED/1000 MM Ages 0 - 12 years - Male	0.00%	NA	NA
IAD: ED/1000 MM Ages 0 - 12 years - Female	0.00%	NA	NA
IAD: ED/1000 MM Ages 0 - 12 years - Total Rate	0.00%	NA	NA
IAD: ED/1000 MM Ages 13 - 17 years - Male	0.22%	NA	NA
IAD: ED/1000 MM Ages 13 - 17 years - Female	0.05%	NA	NA
IAD: ED/1000 MM Ages 13 - 17 years - Total Rate	0.14%	NA	NA
IAD: Telehealth/1000 MM Ages 0 - 12 years - Male	0.00%	NA	NA
IAD: Telehealth/1000 MM Ages 0 - 12 years - Female	0.00%	NA	NA
IAD: Telehealth/1000 MM Ages 0 - 12 years - Total Rate	0.00%	NA	NA
IAD: Telehealth/1000 MM Ages 13 - 17 years - Male	0.00%	NA	NA
IAD: Telehealth/1000 MM Ages 13 - 17 years - Female	0.00%	NA	NA
IAD: Telehealth/1000 MM Ages 13 - 17 years - Total Rate	0.00%	NA	NA

Appendix B

Figure 1: Access to Care

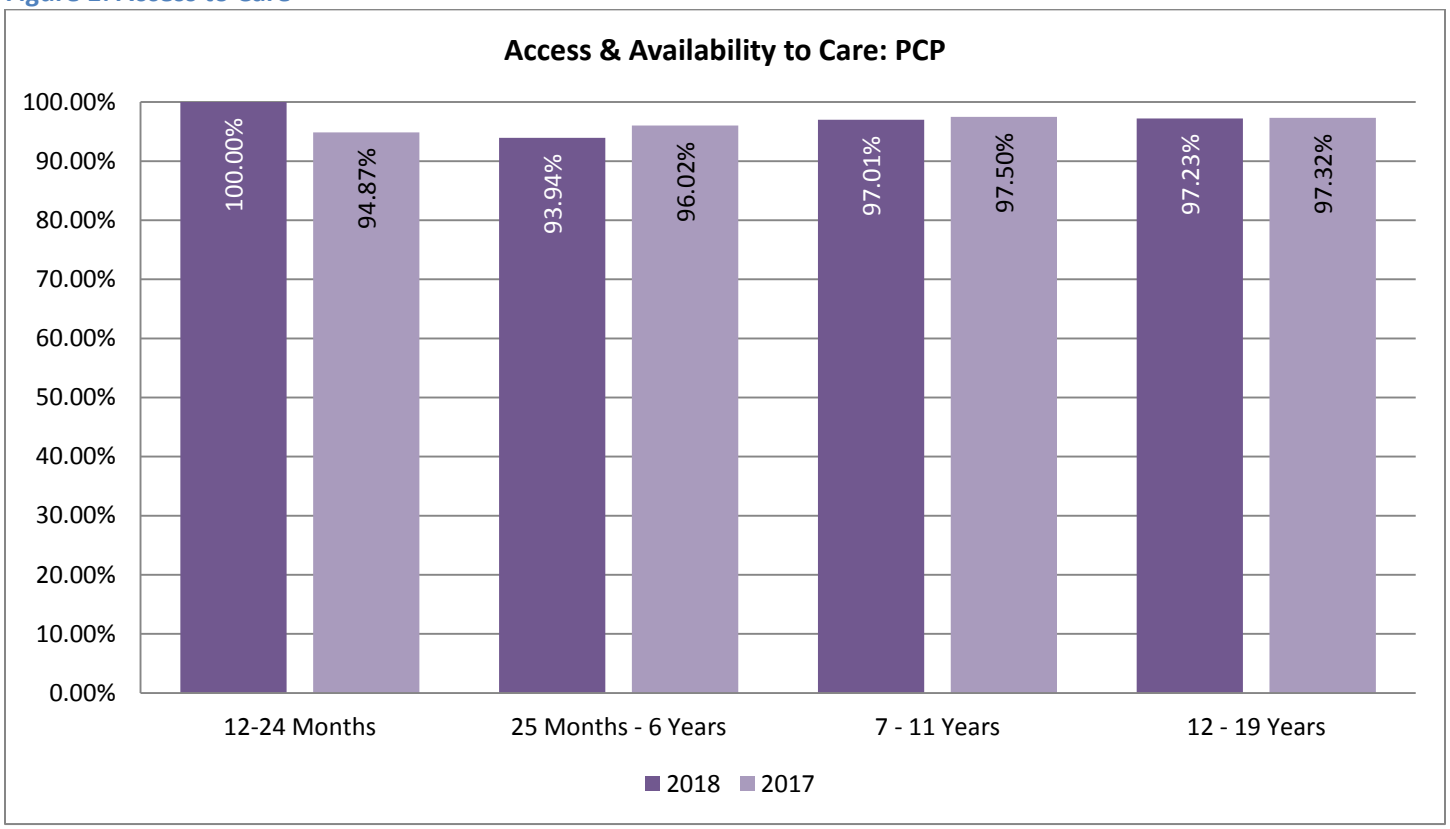

Figure 2: Well Care I

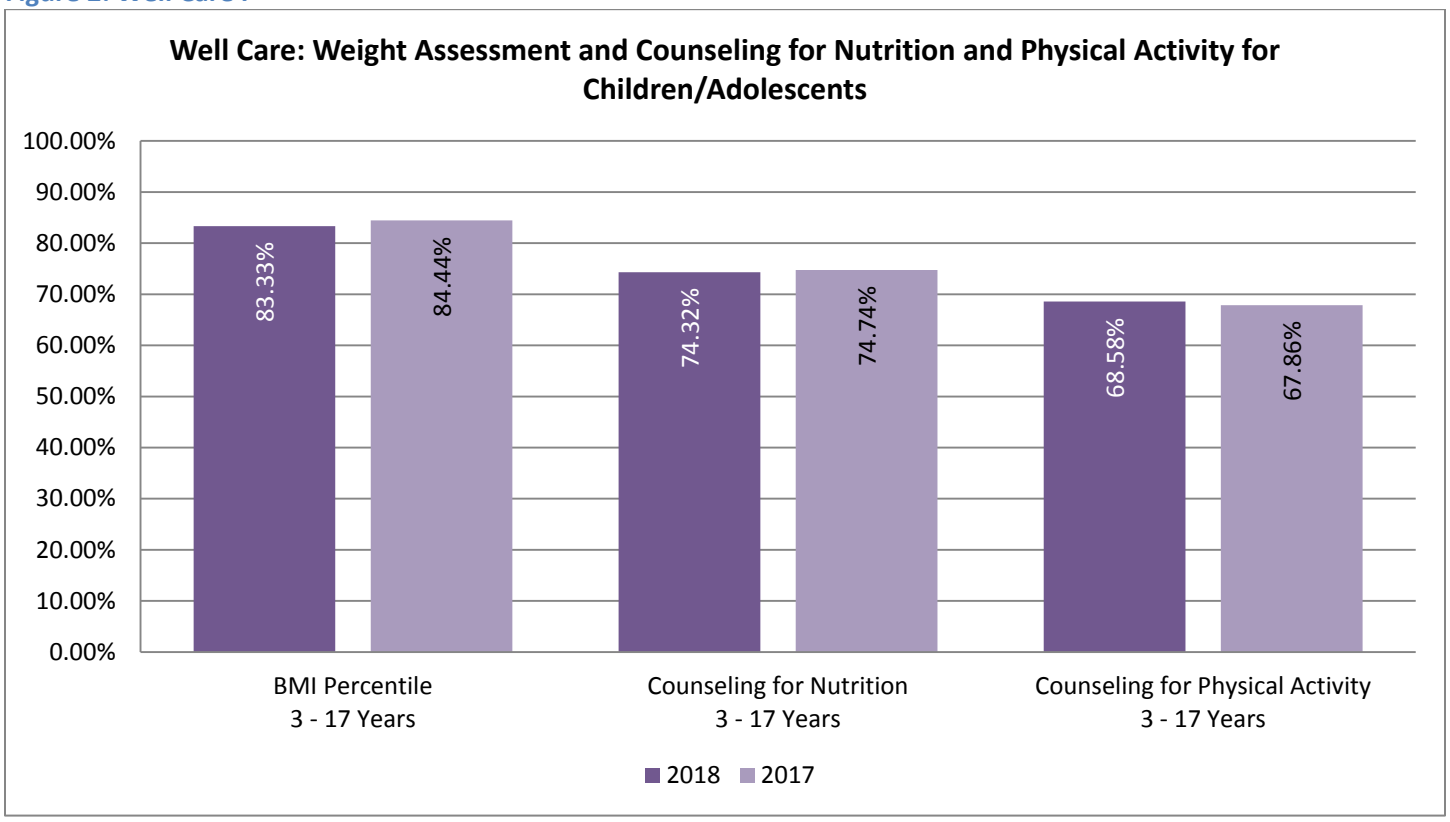

Figure 3: Well Care II

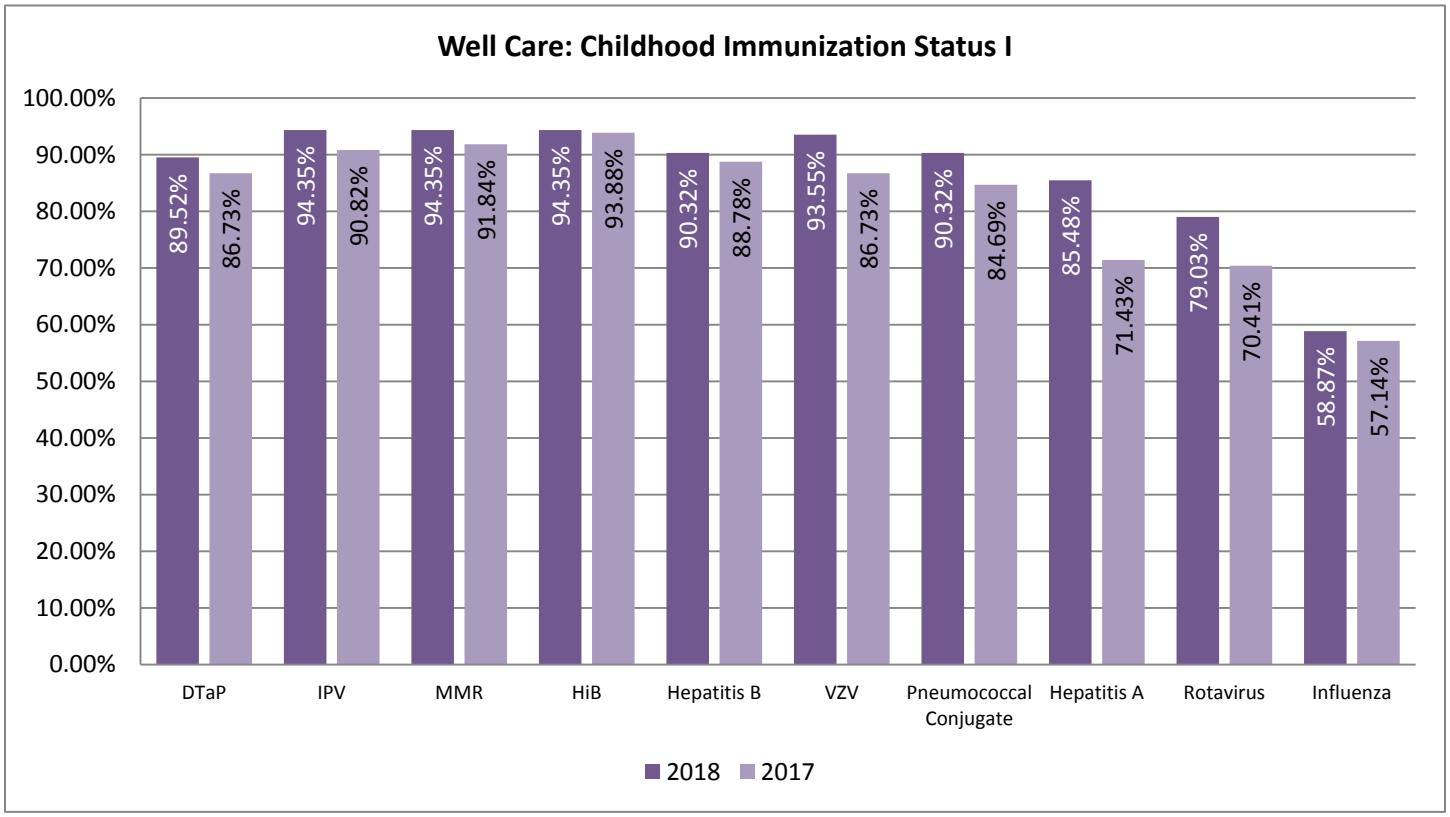

Figure 4: Well Care III

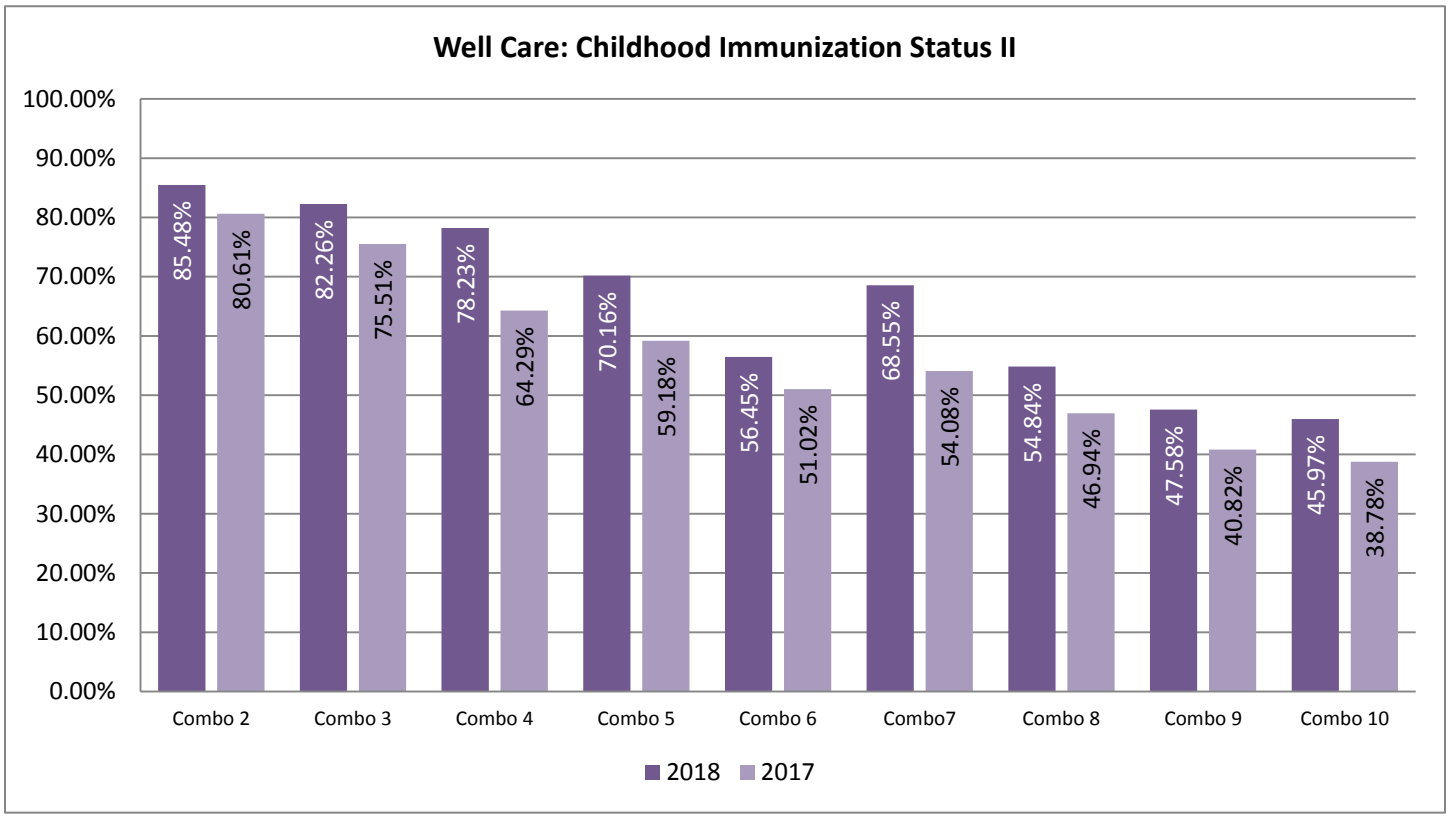

Figure 5: Well Care IV

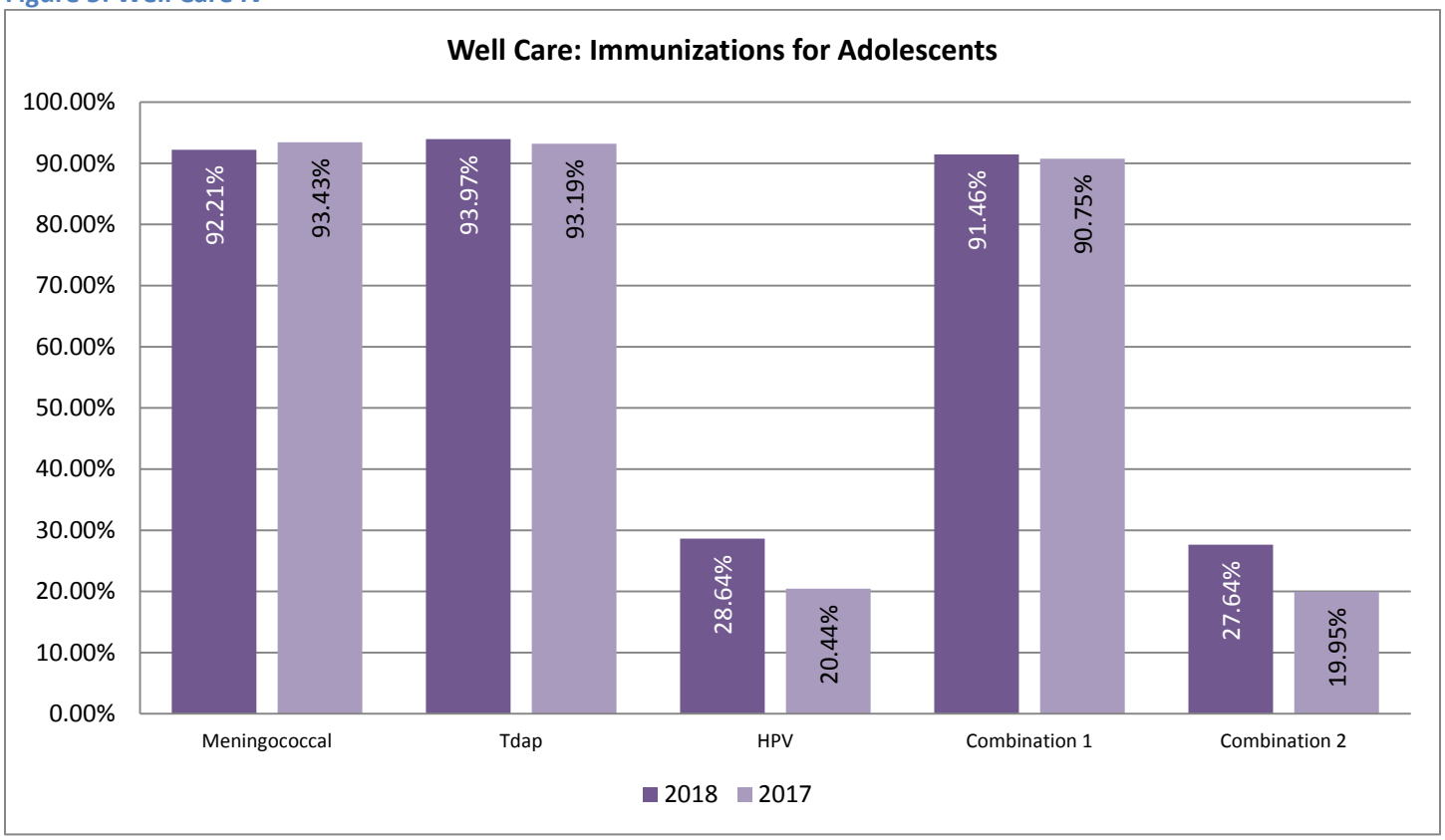

Figure 6: EPSDT/Bright Futures I

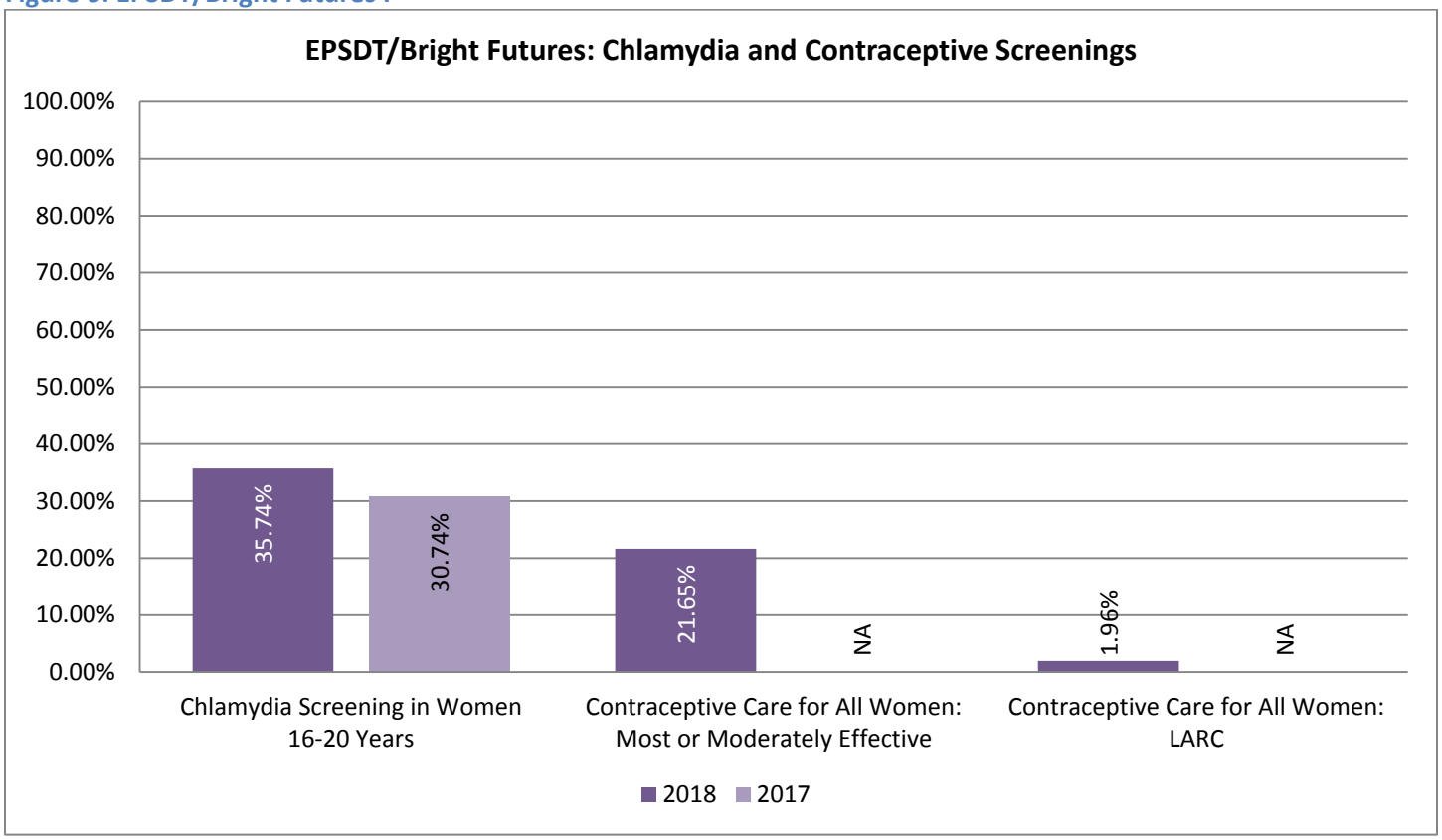

Figure 7: EPSDT/Bright Futures II

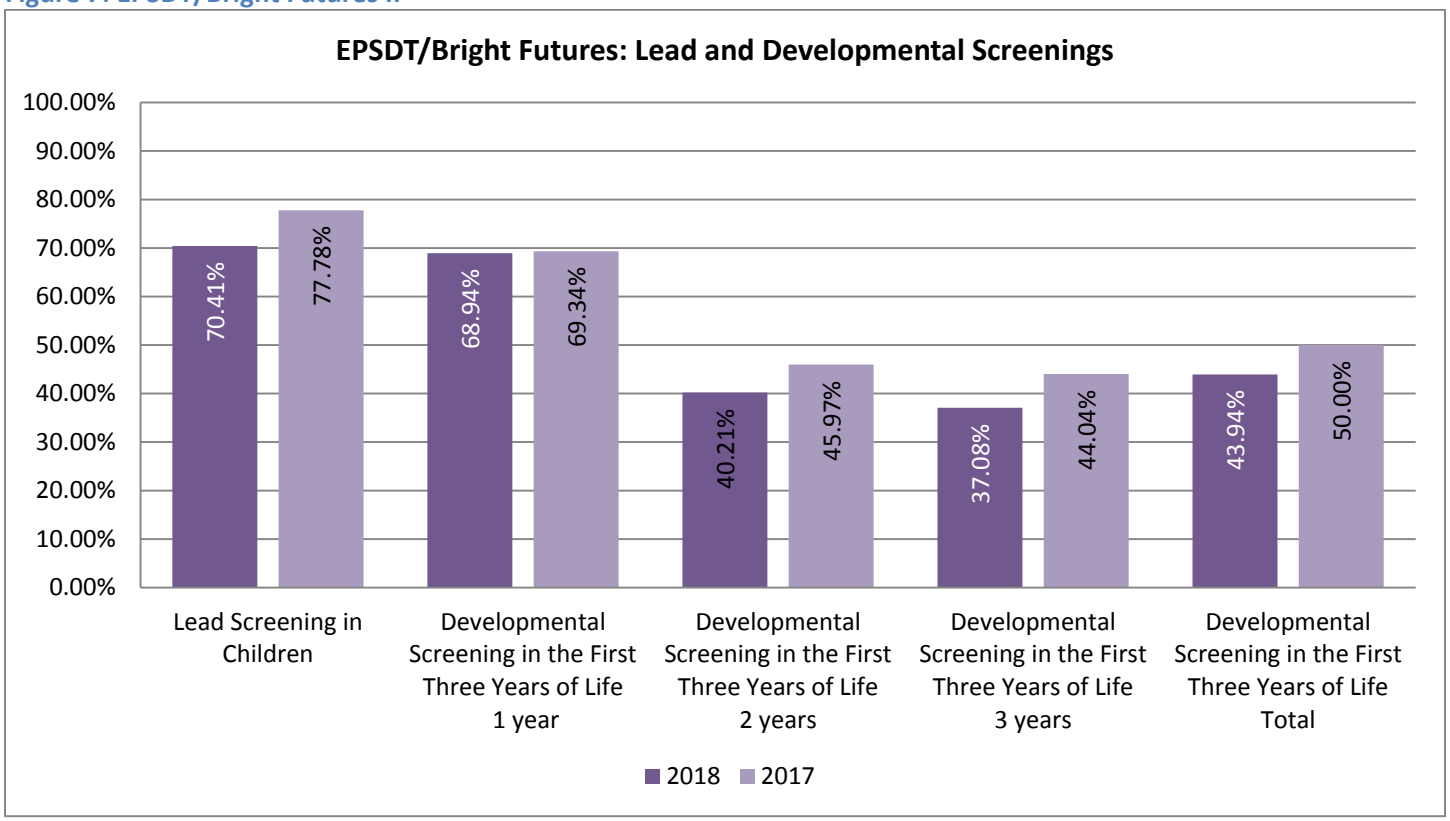

Figure 8: Dental Care for Children I

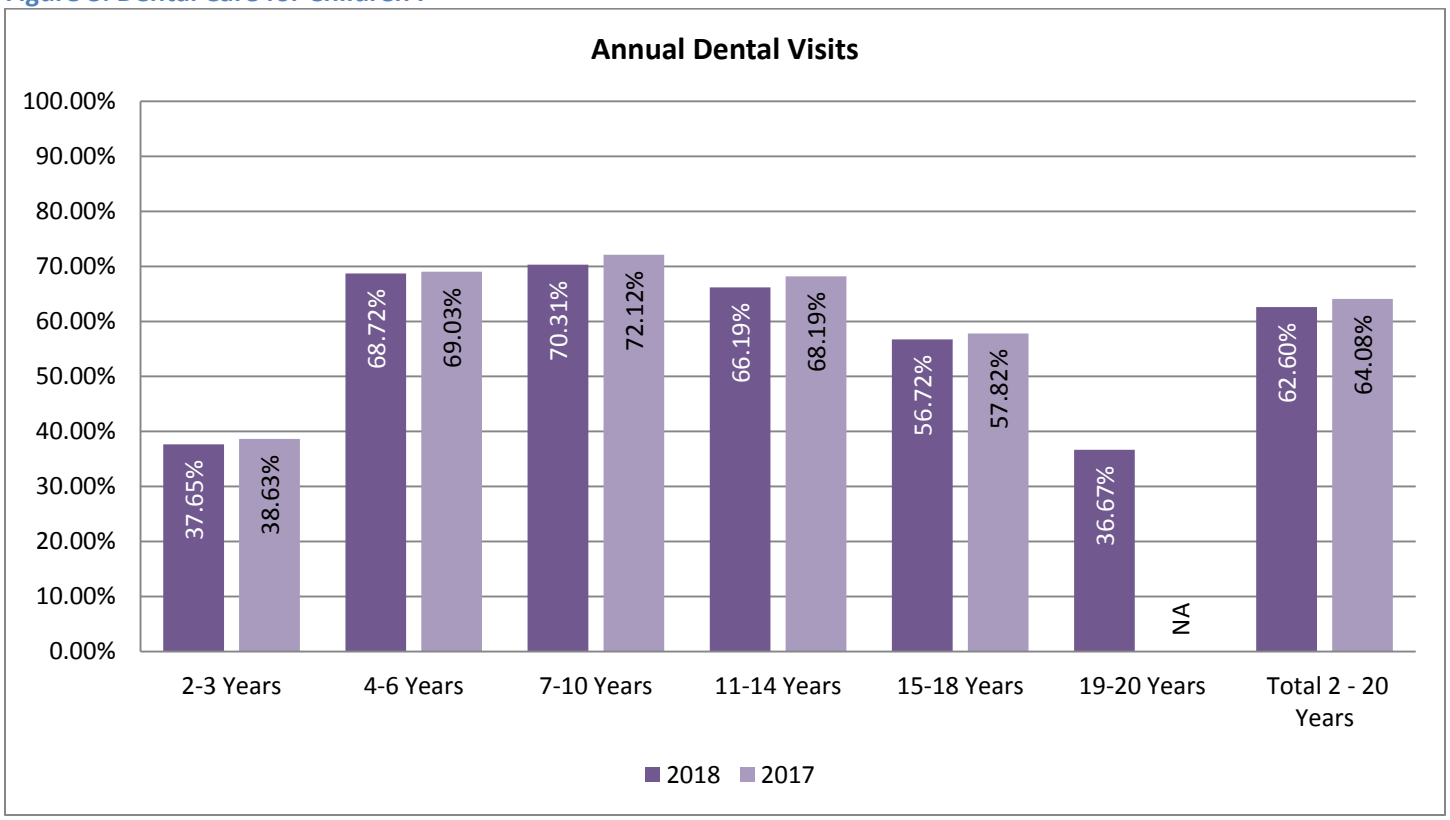

Figure 9: Dental Care for Children II

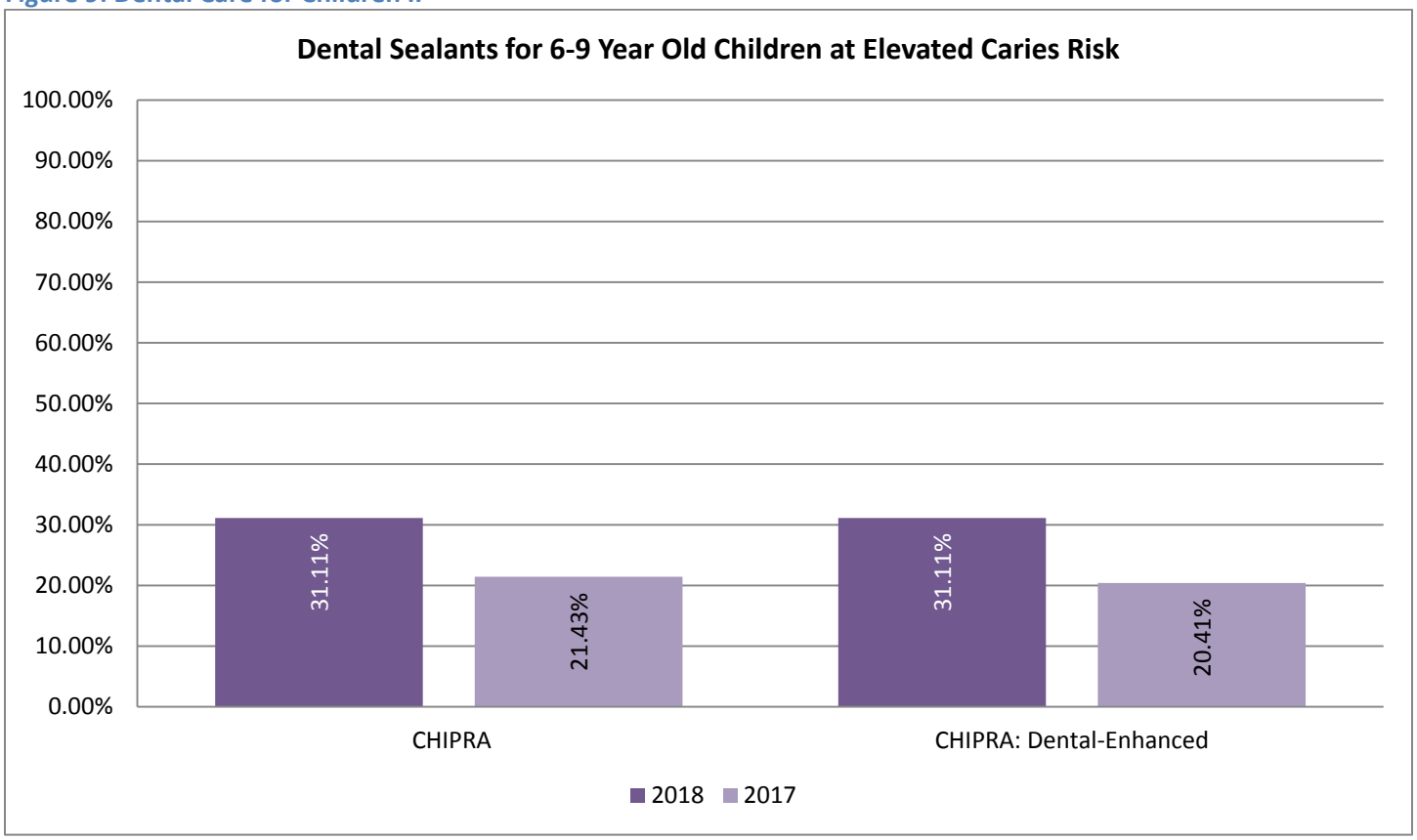

Figure 10: Respiratory Conditions

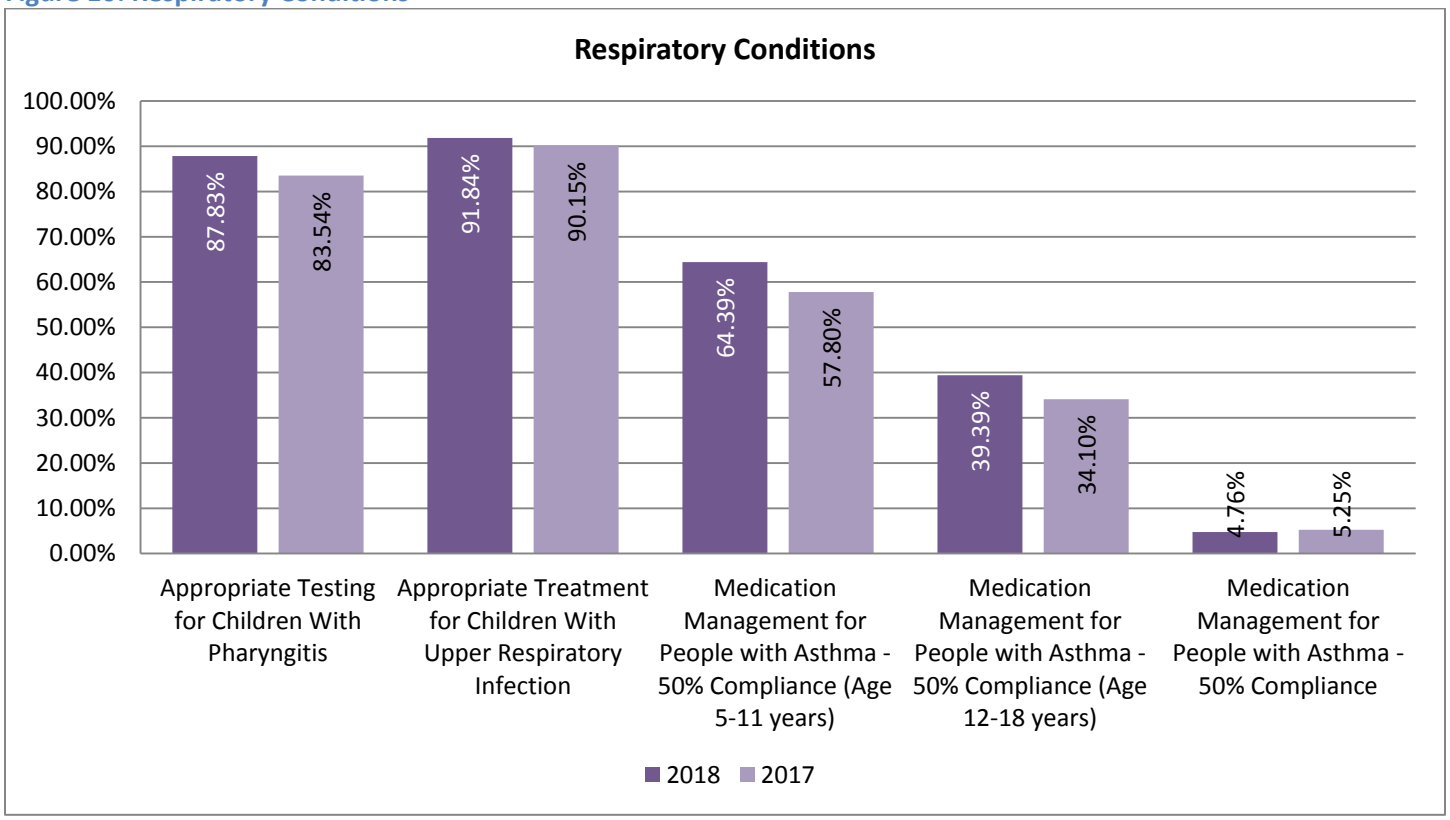

Figure 11: Behavioral Health

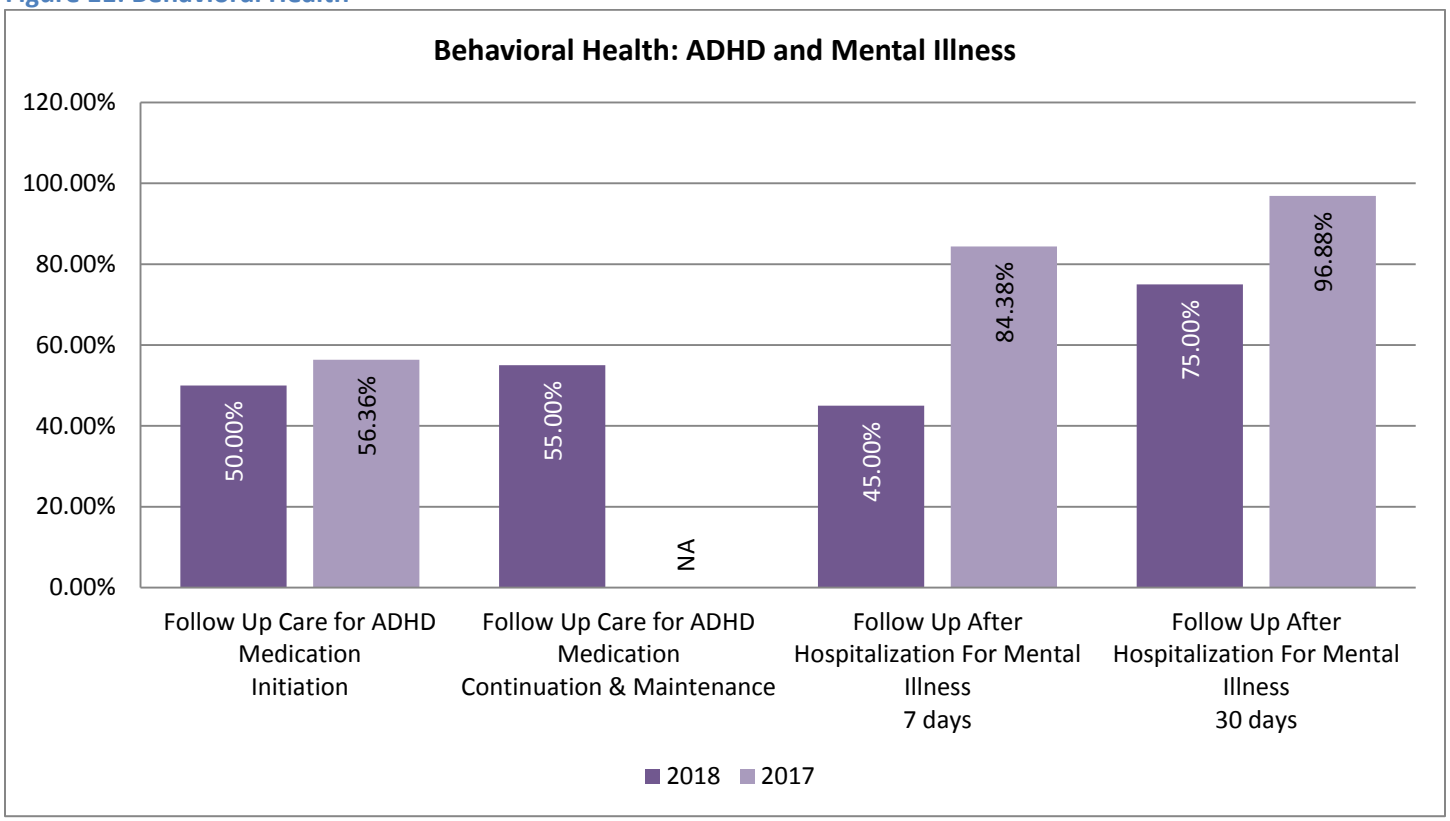

Figure 12: Utilization