P e n n s y l v a n i a ’ s

Children’s Health Insurance Program

2008 Annual Report to the Centers for Medicare and Medicaid Services

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

Preamble

Section 2108(a) of the Act provides that the State and Territories *must assess the operation of the State child health plan in each Federal fiscal year, and report to the Secretary, by January 1 following the end of the Federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children. The State is out of compliance with SCHIP statute and regulations if the report is not submitted by January 1. The State is also out of compliance if any section of this report relevant to the State's program is incomplete.

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

The framework is designed to:

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

* - When "State" is referenced throughout this template, "State" is defined as either a state or a territory.

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

DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

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

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

Signature:

SCHIP Program Name(s): **Pennsylvania's Children's Health Insurance Program**

SCHIP Program Type:

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

Reporting Period: **FFY 2008** *Note: Federal Fiscal Year 2008 starts 10/1/07 and ends 9/30/08.*

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Submission Date: December 29, 2008

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

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

	SCHIP Medicaid Expansion Program					**Separate Child Health Program**				
	*** Upper % of FPL are defined as <u>Up to and Including</u>**									
	Gross or Net Income: ALL Age Groups as indicated below									
	Is income calculated as gross or net income?		☐	Gross Income		**Is income calculated as gross or net income?**		☐	Gross Income	
			☐	Income Net of Disregards				☒	Income Net of Disregards	
Eligibility						**From**		% of FPL conception to birth		% of FPL *
	From		% of FPL for **infants**		% of FPL *	**From**	185	% of FPL for **infants**	300	% of FPL *
	From		% of FPL for children ages **1 through 5**		% of FPL *	**From**	133	% of FPL for children ages 1 **through 5**	300	% of FPL *
	From		% of FPL for children ages **6 through 16**		% of FPL *	**From**	100	% of FPL for children ages **6 through 16**	300	% of FPL *
	From		% of FPL for children ages **17 and 18**		% of FPL *	**From**	100	% of FPL for children ages **17 and 18**	300	% of FPL *

Is presumptive eligibility provided for children?	☐	No	☒	No
	☐	Yes, for whom and how long? **[1000]**	☐	Yes - Please describe below: For which populations (include the FPL levels) **[1000]** Average number of presumptive eligibility periods granted per individual and average duration of the presumptive eligibility period **[1000]** Brief description of your presumptive eligibility policies **[1000]**

	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☐	No
	☐	Yes, for whom and how long?	☒	Yes, for whom and how long? Children who are disenrolled from Medicaid because of a change in their circumstances and who are eligible for CHIP may be retroactively enrolled to avoid a lapse in health care coverage.
	☐	N/A	☐	N/A

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

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

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

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

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

	☐	N/A	☐	N/A

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

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☐	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	6
			To which groups (including FPL levels) does the period of uninsurance apply? **[1000]** Children in families with household income of no greater than 200% FPL do not have any waiting period. Children over the age of two in families with household income greater than 200% FPL must be without private insurance for a period of six (6) months.	
			List all exemptions to imposing the period of uninsurance **[1000]** • Child has not passed its second birthday; • The child's parent is eligible to receive benefits pursuant to the act of December 5, 1936 (2nd Sp. Session, 1937 P.L. 2897, No. 1) known as the "Unemployment Compensation Law"; • The child's parent was covered by a health insurance plan, a self-insurance plan, or a self-funded plan, but at the time of application for coverage is no longer employed and is ineligible to receive benefits under the "unemployment Compensation Law"; or • A child is transferring from one government-subsidized health care program to another.	
	☐	N/A	☐	N/A

Does your program match prospective enrollees to a database that details private	☐	No	☐	No
	☐	Yes	☒	Yes

insurance status?			If yes, what database? **[1000]** New applicants in households with income greater than 200% of the FPL are matched against a third party contractor (currently Health Management Systems) to determine if they are currently covered or if they meet the period of uninsurance. Each of our insurers is also required to match all new applicants against their internal data bases.	
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
			• Moves to another state; • Reaches 19 years of age; • Obtains private health insurance or is enrolled in Medicaid; • Becomes an inmate of a public institution or a patient in an institution for mental diseases; • Death of the child; • Misinformation provided at application which would have resulted in a determination of ineligibility if the correct information had been known; or • Voluntary termination request.	
	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☐	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	
	Premium amount		Premium amount	
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	

			Varies based on household income: • No greater than 200% FPL is free; • Greater than 200%, but no greater than 250% FPL pay 25% of the per member per month cost; • Greater than 250% but no greater than 275% FPL pay 35% of the per member per month cost; • Greater than 275% but no greater than 300% FPL pay 40% of the per member per month cost. Cost sharing is capped at 5% of the household income.	
	☐	N/A	☐	N/A

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

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

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

Does your program require income disregards? **(Note: if you checked off net income in the eligibility question, you must complete this question)**	☐	No	☐	No
	☐	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
			• Work deduction for each employed family member whose income must be counted in determining eligibility ($120 monthly; $1,440 annually); • Day care expense incurred up to $200 monthly/$2400 annually for a child under the age of two; up to $175 monthly/$2,100 annually for a child over the age of two or for a disabled adult; • After income disregards above are applied and adjusted income is determined for eligibility and cost-sharing purposes, all income above 200% FPL to 300% FPL is disregarded.	

	☐	N/A	☐	N/A

Which delivery system(s) does your program use?	☐	Managed Care	☒	Managed Care
	☐	Primary Care Case Management	☐	Primary Care Case Management
	☐	Fee for Service	☐	Fee for Service
	Please describe which groups receive which delivery system **[500]**		Please describe which groups receive which delivery system **[500]**	

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

Enter any Narrative text below. **[7500]**

Premium amounts vary by the county of residence and the insurer chosen to provide the benefits. Premiums are paid per enrollee and are capped at 5% of the household income.

The majority of the insurers prepopulate at least a portion of the renewal form.

Comments on Responses in Table:

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

7. If you have a joint application, is the application sufficient to determine eligibility for both Medicaid and SCHIP? ☒ Yes ☐ No ☐ N/A

8. Indicate what documentation is required at initial application

	Self-Declaration	Self-Declaration with internal verification	Documentation Required
Income	☐	☐	☒
Citizenship	☐	☐	☒
Insured Status	☐	☒	☐

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

	Medicaid Expansion SCHIP Program			**Separate Child Health Program**		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☐	☐	☐	☒	☐
b) Application	☐	☐	☐	☐	☒	☐
c) Application documentation requirements	☐	☐	☐	☐	☒	☐
d) Benefit structure	☐	☐	☐	☐	☒	☐
e) Cost sharing (including amounts, populations, & collection process)	☐	☐	☐	☐	☒	☐
f) Crowd out policies	☐	☐	☐	☐	☒	☐
g) Delivery system	☐	☐	☐	☐	☒	☐
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☐	☐	☐	☒	☐
i) Eligibility levels / target population	☐	☐	☐	☐	☒	☐
j) Assets test in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
k) Income disregards in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
l) Eligibility redetermination process	☐	☐	☐	☒	☐	☐
m) Enrollment process for health plan selection	☐	☐	☐	☐	☒	☐
n) Family coverage	☐	☐	☐	☐	☐	☒
o) Outreach (e.g., decrease funds, target outreach)	☐	☐	☐	☒	☐	☐
p) Premium assistance	☐	☐	☐	☐	☒	☐

q) Prenatal Eligibility expansion	☐	☐	☐	☐	☐	☒
r) Waiver populations (funded under title XXI)						
Parents	☐	☐	☐	☐	☐	☒
Pregnant women	☐	☐	☐	☐	☐	☒
Childless adults	☐	☐	☐	☐	☐	☒
s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☐	☐	☐	☒	☐
t) Other – please specify						
a. _____	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐

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

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Application documentation requirements	
d) Benefit structure	
e) Cost sharing (including amounts, populations, & collection process)	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	

i) Eligibility levels / target population	
j) Assets test in Medicaid and/or SCHIP	
k) Income disregards in Medicaid and/or SCHIP	
l) Eligibility redetermination process	If a family fails to renew prior to the renewal due date, we will accept renewal up to 60 days following the renewal due date with no lapse in coverage. After the 60-day grace period a new application is required. This reduces the administrative workload and provides for continuous coverage for families who renew within the grace period.
m) Enrollment process for health plan selection	
n) Family coverage	
o) Outreach	See Section III "Outreach" for detailed description of Outreach during the reporting period.
p) Premium assistance	
q) Prenatal Eligibility Expansion	
r) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
t) Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below. **[7500]**

#5 above – income disregards – Generally, both CHIP and Medicaid use the same disregards for working members of the household and dependent care. CHIP differs in that we disregard all income between 200% and 300% of the FPL.

#8 above – citizenship verification – U.S. citizenship is self-declared; however, if an applicant states on the application that they are a qualified alien, verification documentation is required.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

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

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

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

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

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

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, data from the previous two years' annual reports (FFY 2006 and FFY 2007) will be populated with data from previously reported data in SARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2008). Additional instructions for completing each row of the table are provided below.

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

- Population not covered: Check this box if your program does not cover the population included in the measure.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.

- Small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is less than 30. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

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

- Provisional: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2008.
- Final: Check this box if the data you are reporting are considered final for FFY 2008.
- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2007). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

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

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

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

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

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

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

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio

of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2009, 2010, and 2011. Based on your recent performance on the measure (from FFY 2006 through 2008), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

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

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

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

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

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: combination of hybrid data (3 health plans) and administrative data (3 health plans)	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination of hybrid data (4 health plans) and administrative data (3 health plans)	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination of Hybrid data (4 health plans) and administrative data (5 health plans)

FFY 2006	FFY 2007	FFY 2008
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Seven separate numerators corresponding to number with 0, 1, 2, 3, 4, 5, 6 or more will-child visits with PCP during first 15 months of life Denominator includes eligible population who turned 15 months old during the measurement year	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Seven separate numerators corresponding to number with 0, 1, 2, 3, 4, 5, 6 or more well-child visits with PCP during first 15 months of life. Denominator includes eligible population who turned 15 months old during the measurement year.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007

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

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 1 Denominator: 194 Rate: 0.5 4 visits Numerator: 23 Denominator: 194 Rate: 11.9 1 visit Numerator: 2 Denominator: 194 Rate: 1 5 visits Numerator: 53 Denominator: 194 Rate: 27.3 2 visits Numerator: 4 Denominator: 194 Rate: 2.1 6+ visits Numerator: 102 Denominator: 194 Rate: 52.6 3 visits Numerator: 9 Denominator: 194 Rate: 4.6 Additional notes on measure: Numerator: hybrid data included entire population therefore numerator reportable Denominator: 6 health plans total reporting; small denominator for 3 health plans reported in weighted averages but not reported for HEDIS (unweighted averages) Rate: HEDIS 2006 PA CHIP (unweighted) average reported as: 0 visits = 0%; 1 visit = 0.5% (unweighted); 2 visits = 2.1% (unweighted); 3 visits = 4.2% (unweighted); 4 visits = 9.7% (unweighted); 5 visits =25.3% (unweighted); 6+ visits = 58.2% (unweighted)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 13 Denominator: 379 Rate: 3.4 4 visits Numerator: 34 Denominator: 379 Rate: 9 1 visit Numerator: 5 Denominator: 379 Rate: 1.3 5 visits Numerator: 79 Denominator: 379 Rate: 20.8 2 visits Numerator: 5 Denominator: 379 Rate: 1.3 6+ visits Numerator: 229 Denominator: 379 Rate: 60.4 3 visits Numerator: 14 Denominator: 379 Rate: 3.7 Additional notes on measure: Denominator - 7 health plans total reporting: small denominator for 3 health plans (15-18)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 7 Denominator: 465 Rate: 1.5 4 visits Numerator: 36 Denominator: 465 Rate: 7.7 1 visit Numerator: 5 Denominator: 465 Rate: 1.1 5 visits Numerator: 94 Denominator: 465 Rate: 20.2 2 visits Numerator: 5 Denominator: 465 Rate: 1.1 6+ visits Numerator: 307 Denominator: 465 Rate: 66 3 visits Numerator: 11 Denominator: 465 Rate: 2.4 Additional notes on measure: Nine health plans total reporting: small denominator for 4 health plans (3-23)
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report? The PA CHIP HEDIS 2008 rate of 66.0% was 4.6 percentage points higher than the performance objective of 61.3%.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. In June 2008, the State released revised 2008-2010 performance objectives for the Well Child Visits in the First 15 Months performance measure to the CHIP health insurance contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: HEDIS 2009 - 73.02%

Annual Performance Objective for FFY 2010: HEDIS 2010 - 80.02%

Annual Performance Objective for FFY 2011: HEDIS 2011 - 87.02%

Explain how these objectives were set: W15. Because the 6+ visits rate is the most preferred outcome, goals were set for this measure. Rates have increased by 8% from 2006 to 2007 and 6% from 2007 to 2008, which corresponds with an average increase of 7%. Goals for 2009, 2010 and 2011 were increased by 7% each year. The above goals were adjusted from the goals set in December 2007 based on actual 2008 performance. The new goals were set in November 2008 and may be subject to change pending 2009 results.

Other Comments on Measure: The PA CHIP HEDIS 2008 rate of 66.0% was 4.6 percentage points higher than the performance objective of 61.3%.

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

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: combination hybrid (3 health plans) and administrative (3 health plans)	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination of hybrid (4 health plans) and administrative (3 health plans)	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination of hybrid (5 health plans) and administrative (4 health plans)
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population with at least 1 well child visit with PCP during measurement year Denominator includes percentage of eligible population who were 3, 4, 5, 6 years of age during measurement year	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible population with at least 1 well child visit with PCP during measurement year	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible population with at least 1 well-child visit with PCP during measurement year

FFY 2006	FFY 2007	FFY 2008
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: Denominator: 10588 Rate: 67.4 Additional notes on measure: Numerator: not reported due to combination of hybrid and administrative data since hybrid data did not include entire population Rate: HEDIS 2006 PA CHIP (unweighted) average reported was 69.0%	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 3253 Denominator: 4709 Rate: 69.1 Additional notes on measure: In past two years, used the eligible population rather than the denominator (2005 - 4014; 2006 - 4358) - rates were reported correctly. This year the actual denominator is used, which includes the sample size but does not reflect the eligible population (9144)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 4026 Denominator: 5818 Rate: 69.2 Additional notes on measure: Definition of Denominator: Percentage of eligible population who were 3, 4, 5, 6 years of age during measurement year

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

FFY 2006	FFY 2007	FFY 2008
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report? PA CHIP HEDIS 2008 rate at 69.2% was 0.2% below the 2008 performance objective of 69.4%.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. In June 2008, the State released revised 2008-2010 performance objectives for the Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life performance measure to the CHIP health insurance contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: HEDIS 2009 - 69.60%

Annual Performance Objective for FFY 2010: HEDIS 2010 - 70.00%

Annual Performance Objective for FFY 2011: HEDIS 2011 - 70.40%

Explain how these objectives were set: Given that there was no discernible trend across years, the average of 2006 and 2007 rates was taken and was compared to 2008. This rate was approximately 1% higher than the average, so a goal was set to increase this rate by approximately 0.4% each year over the next three years. Please note that the above goals were adjusted from the goals set in December 2007 based on actual 2008 performance. The new goals were set in November 2008 and may be subject to change pending 2009 results.

Other Comments on Measure: A "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life measure. This measure will be publicly reported beginning with HEDIS 2008 rates.

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2006	FFY 2007	FFY 2008
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population who were appropriately prescribed medication during the measurement year Denominator includes eligible population 5-17 years of age during the measurement year who were identified as having persistent asthma during the year prior to the measurement year and the measurement year; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible population appropriately prescribed medication during measurement year	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible population appropriately prescribed medication during measurement year
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 559 Denominator: 587 Rate: 95.2 10-17 years Numerator: 1233 Denominator: 1356 Rate: 90.9 Combined rate (5-17 years) Numerator: 1792 Denominator: 1943 Rate: 92.2 Additional notes on measure: Rate: HEDIS 2006 PA CHIP (unweighted) average of 6 health plans is 92.3% for the 5-17 year age range	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 616 Denominator: 632 Rate: 97.5 10-17 years Numerator: 1414 Denominator: 1503 Rate: 94.1 Combined rate (5-17 years) Numerator: 2030 Denominator: 2135 Rate: 95.1 Additional notes on measure: Definition of denominator: Eligible population 5-17 years of age during measurement year identified as having persistent asthma during year prior to/and the measurement year	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 744 Denominator: 775 Rate: 96 10-17 years Numerator: 1583 Denominator: 1683 Rate: 94.1 Combined rate (5-17 years) Numerator: 2327 Denominator: 2458 Rate: 94.7 Additional notes on measure: Definition of denominator: Eligible population 5-17 years of age during measurement year identified as having persistent asthma during year prior to/and the measurement year
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report? For the 5-9 age cohort, the PA CHIP HEDIS 2008 rate at 96.0% was 1.7% below the 2008 performance objective of 97.7%. For the 10-17 age cohort, the PA CHIP HEDIS 2008 rate at 96.1% was 2.6% above the 2008 performance objective of 93.5%, and for the 5-17 age cohort, the PA CHIP HEDIS 2008 rate at 94.7% was equal to the performance objective of 97.4%.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. It was anticipated that this educational effort would impact HEDIS 2008 rates. In June 2008, the State released revised 2008-2010 performance objectives for the Use of Appropriate Medications for Children with Asthma performance measure to the CHIP health insurance contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: 5-9 years old: 96.40% 10-17 years old: 94.56% 5-17 years old: 95.24%

Annual Performance Objective for FFY 2010: 5-9 years old: 96.80% 10-17 years old: 95.06% 5-17 years old: 95.74%

Annual Performance Objective for FFY 2011: 5-9 years old: 97.20% 10-17 years old: 95.56% 5-17 years old; 96.24%

Explain how these objectives were set: Because of the challenges associated with continually improving on rates as they approach 100%, a goal was set to increase rates for the 10-17 and 5-17 age groups by 0.5% each year. For the 5-9 age group, the goal was set to increase the rate by 1.2% over the next three years (0.4% each year) in order to approximate the 2007 rate, which was the highest of the rates for the previous three years.

Other Comments on Measure: Please note that the above goals were adjusted from the goals set in December 2007 based on actual 2008 performance. The new goals were set in November 2008 and may be subject to change pending 2009 results. A "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the Use of Appropriate Medications for Children with Asthma measure. This measure will be publicly reported beginning with HEDIS 2008 rates.

MEASURE: Children's Access to Primary Care Practitioners

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2006	FFY 2007	FFY 2008
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population age range 12 months-6 years who had 1 or more visits with PCP during measurement year; age range 7-19 years who had 1 or more visits with PCP during measurement year or year prior to measurement year) Denominator includes eligible population age 12-24 months, 25 months-6 years, 7-11 years, and 12-19 years of age; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible populations: 12 months-6 years who had 1 or more visits with PCP during measurement year; 7-19 years who had 1 or more visits with PCP during measurement year or year prior to measurement year	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible populations: 12 months - 6 years who had 1 or more visits with PCP during measurement year; 7 - 19 years who had 1 or more visits with PCP during measurement year or year prior to measurement year
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 641 Denominator: 679 Rate: 94.4 7-11 years Numerator: 16010 Denominator: 17495 Rate: 91.5 25 months-6 years Numerator: 10765 Denominator: 12129 Rate: 88.8 12-19 years Numerator: 28932 Denominator: 31863 Rate: 90.8 Additional notes on measure: Rate: HEDIS 2006 PA CHIP (unweighted) average reported as 89.8% for age range 2-11 yr	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 631 Denominator: 689 Rate: 91.6 7-11 years Numerator: 16076 Denominator: 18101 Rate: 88.8 25 months-6 years Numerator: 11345 Denominator: 13237 Rate: 85.7 12-19 years Numerator: 30588 Denominator: 34455 Rate: 88.8 Additional notes on measure: Definition of denominator: Eligible population age 12-24 months, 25 months-6 years, 7-11 years, 12-19 years 2 health plans had low denominator (34-35) for age group 12-24 months.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 871 Denominator: 931 Rate: 93.6 7-11 years Numerator: 18083 Denominator: 20094 Rate: 90 25 months-6 years Numerator: 14939 Denominator: 16964 Rate: 88.1 12-19 years Numerator: 33800 Denominator: 38158 Rate: 88.6 Additional notes on measure: Definition of denominator: Eligible population age 12-24 months, 25 months to 6 years, 7 to 11 years, 12 to 19 years
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report? The PA CHIP HEDIS 2008 rate for the 12-24 month age cohort at 93.6% was 0.7% below the 2008 performance objective of 94.3%. The 25 months - 6 years age cohort rate of 88.1% was 0.2% below the 2008 performance objective of 88.3%. The 7-11 age cohort rate at 90.0% was 1.5% below the 2008 performance objective of 91.5%. The 12-19 age cohort rate of 88.6% was 2.8% below the 2008 performance objective of 91.4%.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. It was anticipated that this educational effort would impact HEDIS 2008 rates. In June 2008, the State released revised 2008-2010 performance objectives for the Children's Access to Primary Care Practitioners performance measure to the CHIP health insurance contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: 12-24 months: 95.76% 25 months - 6 years: 89.60% 7-11 years: 92.84% 12-19 years: 90.58%

Annual Performance Objective for FFY 2010: 12-24 months: 97.23% 25 months - 6 years: 90.94% 7-11 years: 94.23% 12-19 years: 91.08%

Annual Performance Objective for FFY 2011: 12-24 months: 97.73% 25 months - 6 years: 91.44% 7-11 years: 94.73% 12-19 years: 91.58%

Explain how these objectives were set: All age cohorts decreased for 2007 by an average of 3%, so goals were set to increase by 3% in 2008, back to 2006 rates. For 2009 and 2010, goals were set for the 12-24 mos, 25 mos-6 years and 7-11 age group rates to increase by 1.5%, followed by 0.5% increases for 2011 because of the challenges of continually improving on rates as they near 100%. For the 12-17 age group, the goal was set to increase the rate by 2% for 2009 back to the 2006 rate, followed by 0.5% increases for 2010 and 2011.

Other Comments on Measure: Please note that the above goals were adjusted from the goals set in December 2007 based on actual CHIP HEDIS 2008 performance. The new goals were set in November 2008 and may be subject to change pending HEDIS 2009 results. A "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the Children's Access to Primary Care Practitioners measure. This measure will be publicly reported beginning with HEDIS 2008 rates

SECTION IIB: ENROLLMENT AND UNINSURED DATA

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

Program	FFY 2007	FFY 2008	Percent change FFY 2007-2008
SCHIP Medicaid Expansion Program	0	0	
Separate Child Health Program	227,367	256,627	12.87

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

As of September 2008, we have seen an increase in enrollment of over 19,000 children since the implementation of Cover All Kids in March 2007. By the end of the 2008 federal fiscal year, there were 7,560 children enrolled in the SCHIP who would not have been eligible to be covered before the initiative. An additional 1,634 children were participating in an at-cost program with no government subsidization. In April 2008, a program (called the Healthcare Handshake) was piloted to automate the process of sending applications to the CHIP eligibility offices from the CAOs in select counties. These counties have seen exaggerated growth compared to the increase statewide and it is expected to rapidly boost the rate of enrollment once the program is implemented in all 67 counties.

2. The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2005-2007. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2008 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996 - 1998	157	25.1	5.1	.8
1998 - 2000	115	21.5	3.7	.7
2000 - 2002	162	21.2	5.5	.7

2002 - 2004	195	23.3	6.5	.8
2003 - 2005	175	22.9	5.9	.7
2004 - 2006	155	22.0	5.3	.7
2005 - 2007	152	30.0	5.2	1.0
Percent change 1996-1998 vs. 2005-2007	-3.2%	NA	2.0%	NA

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

Although the statistics indicate a change in the number and rate of uninsured children from the 1996-1998 estimates to the 2005-2007 estimates, these differences are not statistically significant.

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

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

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

☒ No (skip to Question #4)

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

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

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

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

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

D. How does your State use this alternate data source in SCHIP program planning?

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

Since September 2007, the number of children enrolled in Medicaid has increased from 982,902 to 1,005,268 (an increase of 22,366). While no exact figure is available, it is reasonable to assume that a portion of the increase is caused by CHIP outreach activities and initiatives such as the Healthcare Handshake, which is an automated electronic referral system between the Department of Public Welfare's Medicaid programs and CHIP administered by the Pennsylvania Insurance Department. This figure was obtained from reports obtained from the Department of Public Welfare which administers the Medicaid program in Pennsylvania.

In addition, each month approximately 16% of applicants for CHIP are screened as potentially eligible for Medicaid. Applications associated with these children are automatically sent to Medicaid for disposition. This data was obtained from our centralized eligibility and enrollment system – CHIP and adultBasic Processing System (CAPS).

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. (If your goals reported in the annual report now differ from Section 9 of your SCHIP state plan, please indicate how they differ in "Other Comments on Measure." Also, the state plan should be amended to reconcile these differences). The format of this section provides your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

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

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, report data from the previous two years' annual reports (FFY 2006 and FFY 2008) will be populated with data from previously reported data in SARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2008).

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

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

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

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

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an <u>example</u> goal would be**: "Increase (direction) by 5 percent (target) the number of SCHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

Type of Goal:

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

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

Status of Data Reported:

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

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2008.
- Final: Check this box if the data you are reporting are considered final for FFY 2008.
- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:

This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2008). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:

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

Definition of Population Included in Measure:

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

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

Year of Data:

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

Performance Measurement Data:

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

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

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

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. Any quality improvement activity described should involve the SCHIP program, benefit SCHIP enrollees, and relate to the performance measure and your progress. An example of a quality improvement activity is a state-wide initiative to inform individual families directly of their children's immunization status with the goal of increasing immunization rates. SCHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2009, 2010 and 2011. Based on your recent performance on the measure (from FFY 2006 through 2008), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the SCHIP state plan.

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

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe) Increase state government participation in and administration of outreach efforts and include public service announcements, inter-agency mutual referrals, and revision and distribution of CHIP information.	**Goal #1 (Describe)** Increase state government participation in and administration of outreach efforts and include public service announcements, inter-agency mutual referrals, and revision and distribution of CHIP information.	**Goal #1 (Describe)** Increase state government participation in and administration of outreach efforts by 2% per year and include public service announcements, inter-agency mutual referrals, and revision and distribution of CHIP information.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: added direction and target to goal ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007
Data Source: ☒ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Children enrolled in CHIP and Medicaid, combined, in May 1998 Definition of numerator: Children enrolled in CHIP and Medicaid, combined, in September 2006	**Definition of Population Included in the Measure:** Definition of denominator: Children enrolled in CHIP and Medicaid, combined, in May 1998 Definition of numerator: Children enrolled in CHIP and Medicaid, combined, in September 2007	**Definition of Population Included in the Measure:** Definition of denominator: Children enrolled in CHIP and Medicaid from the month that the CHIP state plan was first approved Definition of numerator: Children enrolled in CHIP and Medicaid combined in September 2008
Year of Data: 2006	**Year of Data:** 2007	**Year of Data:** 2008
Performance Measurement Data: Described what is being measured: Enrollment in CHIP and Medicaid from the month that the CHIP state plan was first approved. Numerator: ((972,697+147,392)-(703,311+54,080)) Denominator: (703,311+54,080) Rate: 47.9% Numerator: 362698 Denominator: 757391 Rate: 47.9	**Performance Measurement Data:** Described what is being measured: Enrollment in CHIP and Medicaid from the month that the CHIP state plan was first approved. Numerator: 389996 Denominator: 757391 Rate: 51.5 Additional notes on measure: Numerator: ((982,902+164,485)-(703,311+54,080)) Denominator: (703,311+54,080) Rate: 51.5%	**Performance Measurement Data:** Described what is being measured: Enrollment in CHIP and Medicaid from the month that the CHIP state plan was first approved Numerator: ((1,005,268+176,151)-(703,311+54,080)) Denominator: (703,311+54,080) Rate: 56.0% Numerator: 424028 Denominator: 757391 Rate: 56 Additional notes on measure: Since approval of the

FFY 2006	FFY 2007	FFY 2008
Additional notes on measure:		Pennsylvania State Plan for CHIP in May 1998, the number of children enrolled in CHIP and Medicaid increased by nearly 48% by the end of FFY 2006, 52% by the end of FFY 2007, and 56% by the end of FFY 2008.
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** The Pennsylvania State Plan for CHIP surpassed the Annual Performance Objective for FFY 2007 by two percentage points. **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Expansion of CHIP through the Cover All Kids initiative	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** The Pennsylvania State Plan for CHIP surpassed the Annual Performance Objective for FFY 2008 by three percentage points. **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** In early summer, we piloted an electronic referral process between Medicaid and SCHIP to ensure that no children were impacted due to transfers between the two programs. A purely manual and paper-based process was moved to a full electronic process. Since its statewide implementation, we have seen an increase in the number of referrals between the two agencies.
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2007:** Since approval of the Pennsylvania state plan for CHIP in May 1998, the number of children enrolled in CHIP and Medicaid increased by nearly 32% by the end of FFY 2004, 38% by the end of FFY 2005, and 48% by the end of FFY 2006. 50% **Annual Performance Objective for FFY 2008:** 52% **Annual Performance Objective for FFY 2009:** 54% *Explain how these objectives were set:* Historical trends were used as a basis for the projection of increased enrollment.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** 52% **Annual Performance Objective for FFY 2009:** 54% **Annual Performance Objective for FFY 2010:** 56% *Explain how these objectives were set:* Historical trends were used as a basis for the projection of increased enrollment	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** 58% **Annual Performance Objective for FFY 2010:** 60% **Annual Performance Objective for FFY 2011:** 62% *Explain how these objectives were set:* Historical trends were used as a basis for the projection of increased enrollment
Other Comments on Measure:	**Other Comments on Measure:** Since approval of the Pennsylvania State Plan for CHIP in May 1998, the number of children enrolled in CHIP and Medicaid increased by nearly 38% by the end of FFY 2005, 48% by the end of FFY 2006, and 52% by the end of FFY 2007.	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe) Seek to establish a working relationship with the Center for Rural Pennsylvania, a not-for-profit organization dedicated to identifying, studying, and offering solutions to public policy issues of concern to rural areas of the Commonwealth, and to identify barriers to access in central and northeastern Pennsylvania.	**Goal #1 (Describe)** Seek to establish a working relationship with the Center for Rural Pennsylvania, a not-for-profit organization dedicated to identifying, studying, and offering solutions to public policy issues of concern to rural areas of the Commonwealth, and to identify barriers to access in central and northeastern Pennsylvania.	**Goal #1 (Describe)** Increase enrollment in rural counties by at least 5% each of the next three years. Seek to establish a working relationship with the Center for Rural Pennsylvania, a not-for-profit organization dedicated to identifying, studying, and offering solutions to public policy issues of concern to rural areas of the Commonwealth, and to identify barriers to access in central and northeastern Pennsylvania.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: added direction and target to goal ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Enrollment in the 19 rural counties in northeastern and central Pennsylvania (Bedford, Clinton, Columbia, Juniata, Lebanon, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming).	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Enrollment in the 19 rural counties in northeastern and central Pennsylvania (Bedford, Clinton, Columbia, Juniata, Lebanon, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming).	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Enrollment in the 19 rural counties in northeastern and central Pennsylvania (Bedford, Clinton, Columbia, Juniata, Lebanon, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming).
Definition of Population Included in the Measure: Definition of denominator: Children enrolled in May 1998 Definition of numerator: (09/06 Enrollment – 05/98 Enrollment)	**Definition of Population Included in the Measure:** Definition of denominator: Children enrolled in May 1998 Definition of numerator: (09/07 Enrollment – 05/98 Enrollment)	**Definition of Population Included in the Measure:** Definition of denominator: Children enrolled in May 1998 Definition of numerator: (09/08 Enrollment – 05/98 Enrollment)
Year of Data: 2006	**Year of Data:** 2007	**Year of Data:** 2008

FFY 2006	FFY 2007	FFY 2008
Performance Measurement Data: Described what is being measured: Percent increase in enrollment in the designated counties since May 1998, when Pennsylvania's initial state plan was approved. Numerator: 14,662 – 4,217 Denominator: 4,217 Rate: 247.7% Numerator: 10445 Denominator: 4217 Rate: 247.7 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Percent increase in enrollment in the designated counties since May 1998, when Pennsylvania's initial state plan was approved. Numerator: 12047 Denominator: 4217 Rate: 285.7 Additional notes on measure: Numerator: 16,263 – 4,217 Denominator: 4,217 Rate: 285.7%	**Performance Measurement Data:** Described what is being measured: Percent increase in enrollment in the designated counties since May 1998, when Pennsylvania's initial state plan was approved. Numerator: 17,866 – 4,217 Denominator: 4,217 Rate: 323.7% Numerator: 13649 Denominator: 4217 Rate: 323.7 Additional notes on measure: Since May 1998, enrollment in the target counties has increased by 323.7%. This increase exceeds the statewide growth of 211.5% during the same period.
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** Since May 1998, enrollment in the target counties has increased by 285.7%. This increase exceeds the statewide growth of 190.9% during the same period. **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** The 2008 Annual Performance Objective was 300%, which was exceeded by almost 24%. **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** Four of the rural counties involved in the measure participated in the pilot of the Healthcare Handshake, resulting in exaggerated increases in enrollment due to better communication between the CAOs and the CHIP eligibility offices.

FFY 2006	FFY 2007	FFY 2008
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2007:** Since May 1998, enrollment in the target counties has increased by 247.7%. This increase exceeds the statewide growth of 172.5% during the same period. 250% **Annual Performance Objective for FFY 2008:** 260% **Annual Performance Objective for FFY 2009:** 270% *Explain how these objectives were set:* Historical trends were used as a basis for the projection of increased enrollment in the rural counties.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** 300% **Annual Performance Objective for FFY 2009:** 310% **Annual Performance Objective for FFY 2010:** 320% *Explain how these objectives were set:* Historical trends were used as a basis for the projection of increased enrollment in the rural counties.	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** 330% **Annual Performance Objective for FFY 2010:** 335% **Annual Performance Objective for FFY 2011:** 340% *Explain how these objectives were set:* Historical trends were used as a basis for the projection of increased enrollment in the rural counties.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe) Contractually require insurance contractors to increase outreach focus on community-based agencies in predominantly minority or non-English speaking areas.	**Goal #2 (Describe)** Contractually require insurance contractors to increase outreach focus on community-based agencies in predominantly minority or non-English speaking areas.	**Goal #2 (Describe)** Increase the proportion of CHIP enrollees to reflect the general population of Pennsylvania by contractually requiring insurance contractors to increase outreach focus on community-based agencies in predominantly minority or non-English speaking areas.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: added direction and target to goal ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007
Data Source: ☒ Eligibility/Enrollment data. ☒ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:** 2008

FFY 2006	FFY 2007	FFY 2008
Performance Measurement Data: Described what is being measured: Compare the proportion of CHIP enrollees that fall into various race and ethnic categories to U.S. Census Bureau data for the general population in Pennsylvania. Numerator: Denominator: Rate: Additional notes on measure: Race PA CHIP General Population Native Hawaiian or Other Pacific Islander 0.0% 0.1% American Indian or Alaska Native 0.1% 0.2% Asian 2.2% 2.8% Black or African American 10.1% 12.6% White 84.6% 50.8% Two or More Races 1.1% 1.6% Unspecified Race N/A 31.9% Ethnicity Hispanic or Latino 4.0% 2.6% Unspecified Ethnicity 96.0% 97.4%	**Performance Measurement Data:** Described what is being measured: Compare the proportion of CHIP enrollees that fall into various race and ethnic categories to U.S. Census Bureau data for the general population in Pennsylvania. Numerator: Denominator: Rate: Additional notes on measure: Race PA CHIP General Population Native Hawaiian or Other Pacific Islander 0.0% 0.0% American Indian or Alaska Native 0.2% 0.2% Asian 2.4% 2.7% Black or African American 10.7% 12.6% White 85.7% 51.3% Two or More Races 1.0% 1.7% Unspecified Race N/A 31.5% Ethnicity Hispanic or Latino 4.2% 2.1% Unspecified Ethnicity 95.8% 97.9%	**Performance Measurement Data:** Described what is being measured: Compare the proportion of CHIP enrollees that fall into various race and ethnic categories to U.S. Census Bureau data for the general population in Pennsylvania. Numerator: Denominator: Rate: Additional notes on measure: Race PA CHIP General Population Native Hawaiian or Other Pacific Islander 0.0% 0.0% American Indian or Alaska Native 0.1% 0.1% Asian 2.3% 2.9% Black or African American 10.4% 12.5% White 83.8% 53.0% Two or More Races 1.2% 2.1% Unspecified Race N/A 29.3% Ethnicity Hispanic or Latino 4.2% 2.2% Unspecified Ethnicity 95.8% 97.8%
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** By and large, the population of CHIP enrollees is reflective of the general population in Pennsylvania.	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** By and large, the population of CHIP enrollees is reflective of the general population in Pennsylvania. The 2008 results proved the Annual Performance Objective correct.

FFY 2006	FFY 2007	FFY 2008
What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2007:** By and large, the population of CHIP enrollees is reflective of the general population in Pennsylvania. CHIP enrollment to continue to reflect the general population in Pennsylvania. **Annual Performance Objective for FFY 2008:** CHIP enrollment to continue to reflect the general population in Pennsylvania. **Annual Performance Objective for FFY 2009:** CHIP enrollment to continue to reflect the general population in Pennsylvania. *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** CHIP enrollment to continue to reflect the general population in Pennsylvania. **Annual Performance Objective for FFY 2009:** CHIP enrollment to continue to reflect the general population in Pennsylvania. **Annual Performance Objective for FFY 2010:** CHIP enrollment to continue to reflect the general population in Pennsylvania. *Explain how these objectives were set:*	**Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** CHIP enrollment to continue to reflect the general population in Pennsylvania. **Annual Performance Objective for FFY 2010:** CHIP enrollment to continue to reflect the general population in Pennsylvania. **Annual Performance Objective for FFY 2011:** CHIP enrollment to continue to reflect the general population in Pennsylvania. *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

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

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe) Ambulatory Care, Emergency Department (ED) visits: reduce unnecessary overutilization	**Goal #1 (Describe)** Ambulatory Care, Emergency Department (ED) visits; address reasons for, and reduce unnecessary utilization	**Goal #1 (Describe)** Reduce the unnecessary overutilization of Ambulatory Care, Emergency Department (ED) visits by 2.2% each of the next three years.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: added direction and target to goal ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: (42,243) Numerator is visits for emergency department services that do not result in inpatient stay; age range <1 year to 19 years; visits/1,000 member years Denominator includes eligible population; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Visits for emergency department services that do not result in inpatient stay; age range <1 year to 19 years; does not include some ED visits for mental health and chemical dependency services	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Visits for emergency department services that do not result in inpatient stay; age range <1 year to 19 years; does not include some ED visits for mental health and chemical dependency services
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: 1489261	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: 1624569	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 59579 Denominator: 2004825

FFY 2006	FFY 2007	FFY 2008
Rate: 340.381 Additional notes on measure: Rate: 340.381 visits/1,000 member years (age <1-19 yr) weighted average Rate: HEDIS 2006 PA CHIP (unweighted) average visits per 1,000 member years: (1) age <1 year = 631 visits/; (2) 1-9 years = 332 visits; (3) 10-19 years = 332 visits; lower rate means less utilization	Rate: Additional notes on measure: Definition of denominator: eligible population Numerator: 47,124 Denominator: 1,624,569 Rate: 348.1 visits/1,000 member years followed commercial specifications - visits/1,000 member years; Lower rate means less utilization (preferred)	Rate: Additional notes on measure: Rate: 356.6 visits/1000 member years (29.72 visits/1000 member months). Lower rate means less utilization (preferred) Definition of denominator: eligible population
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** A HEDIS 2006 (measurement year 2007) performance goal was not set in the FFY 2006 report since utilization had already occurred at the time of the report. The goal previously set for HEDIS 2008 is modified below based on a review of HEDIS 2005, 2006 and 2007 rates.	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** The PA CHIP HEDIS 2008 ED utilization rate at 356.6 visits/1000 member years was 21.7 visits/1000 member years higher than the 2008 performance objective of 334.9 visits/1000 member years.

FFY 2006	FFY 2007	FFY 2008
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2007:** Utilization rates for age group <1 year to 19 years per 1,000 member years: CY 2003 (HEDIS 2004) = 320 visits; CY 2004 (HEDIS 2005) = 312 visits, CY 2005 (HEDIS 2006) = 340 visits. Institute Quality Initiative with CHIP health plans to decrease utilization by 50 visits for CY 2007 (HEDIS 2008). Not able to impact calendar year 2006 (HEDIS 2007) rates since utilization has already occurred. **Annual Performance Objective for FFY 2008:** Develop pay for performance criteria; decrease utilization rate by 50 visits for CY 2008 (HEDIS 2009 **Annual Performance Objective for FFY 2009:** Implement pay for performance; decrease utilization rate by 50 visits for CY 2009 (HEDIS 2010) *Explain how these objectives were set:* Analysis of 3 year PA CHIP data, comparison to HEDIS Commercial benchmarks, and projections based on historical trends	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. It was anticipated that this educational effort would impact HEDIS 2008 rates **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** HEDIS 2008 **Annual Performance Objective for FFY 2009:** HEDIS 2009	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** On March 20, 2007, the State met with all CHIP health insurance contractors. The State addressed 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. In 2007, a program-wide performance improvement project (PIP) targeting ED overutilization was implemented. Interventions implemented in early 2008 are anticipated to impact 2009 rates. The health plans are expected to achieve demonstrable improvement and sustain improvement over a multiple year PIP, validated yearly by an External Quality Review Organization (EQRO) on behalf of the state. In March 2008, the plans submitted methodology and baseline data including January 1 - June 30, 2007 service dates, and quality measures developed through root cause or similar analysis. Interventions were implemented during the 2008 Calendar Year, with the first remeasurement scheduled for the first quarter of calendar year 2009. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** HEDIS 2009 348.61 visits/1000 member years (29.05 visits/1000 member months) **Annual Performance Objective for FFY 2010:** HEDIS 2010 340.79 visits/1000 member years (28.40 visit/1000 member months)

FFY 2006	FFY 2007	FFY 2008
	Annual Performance Objective for FFY 2010: *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2011:** HEDIS 2010 333.14 visits/1000 member years (27.76 visit/1000 member months) *Explain how these objectives were set:* This is an inverted measure; lower Emergency Department visit rates are preferable. Rates have steadily risen over the past three years, increasing by about 8 Visits/1000 Member Years (2.2%) each year. Thus, goals were set to decrease proportionately by 2.2% each year over the next three years, to approximate HEDIS 2006 rates. The above goals were adjusted from the December 2007 goals based on actual 2008 performance. Likewise, the new goals may be subject to change pending 2009 results.
Other Comments on Measure: ED visits 2006 PA CHIP HEDIS average rate (commercial, unweighted) compared to HEDIS 2006 Commercial benchmarks (unweighted): <1year =631 visits; National =334, Regional =376, PA =421 1-9 age =332 visits; National =207; Regional =229; PA =250 10-19 age group =332 visits; National =178, Regional =207, PA =234 For all age groups, 2006 PA CHIP average rates were higher than averages for Commercial benchmarks, which were significantly higher than Medicaid benchmarks.	**Other Comments on Measure:** This measure will be publicly reported beginning with HEDIS 2008 rates. PA SCHIP Contractors are required to conduct a new Performance Improvement Project related to the reduction of ER visits for the CHIP population. The Performance Improvement Project requirement was implemented in calendar year 2007.	**Other Comments on Measure:** A "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the Ambulatory Care, Emergency Department (ED) visits measure. This measure will be publicly reported beginning with HEDIS 2008 rates.

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

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe) Mental health utilization – monitor utilization for inpatient, intermediate, and ambulatory services	**Goal #2 (Describe)** Mental Health Utilization – monitor utilization for inpatient, intermediate and ambulatory services	**Goal #2 (Describe)** Mental Health Utilization - monitor utilization for inpatient, intermediate and ambulatory services
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: no specific goal identified for this measure; therefore, does not meet criteria to report	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: No specific goal identified for this measure; therefore, does not meet criteria to report
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is percentage of eligible population receiving inpatient, intermediate, and ambulatory services during the measurement year Denominator includes eligible population age 0-17 years of age	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 8622	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:

FFY 2006	FFY 2007	FFY 2008
Denominator: 116953 Rate: 7.4 Additional notes on measure: Rate: HEDIS 2006 PA CHIP (unweighted) average of 6 health plans for the age group 0-12 = 5.7%; age group 13-17 = 8.95%; combined 0-17 yr = 7.3%	Denominator: Rate: Additional notes on measure:	Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2007:** Rate for CY 2003 (HEDIS 2004) = 6.8% rate for CY 2004 (HEDIS) 2005 =7.6% and rate for CY 2005 (HEDIS 2006) = 7.4%. Institute Quality Initiative with CHIP health plans and monitor, watching for trends. Not able to impact calendar year 2006 (HEDIS 2007) rates since utilization has already occurred. **Annual Performance Objective for FFY 2008:** Develop pay for performance criteria; monitor and watch for trends **Annual Performance Objective for FFY 2009:** Implement pay for performance; monitor and watch for trends *Explain how these objectives were set:* Analysis of 3 year PA CHIP data, comparison to HEDIS Commercial benchmarks and projections based on historical trends	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*

FFY 2006	FFY 2007	FFY 2008
Other Comments on Measure: Comparison of 2006 PA CHIP rate (commercial, unweighted) to HEDIS Commercial 2006 benchmarks (unweighted) 0-12 age range = 5.7%; National (3.9%), Regional (4%) and PA (3.9%) rates; PA CHIP average rate is slightly higher than the Commercial benchmarks 13-17 age range = 8.9%; National (8%), Regional (8.4%) and PA (7.6%) rates; PA CHIP average rate is comparable to the Commercial benchmarks. In general, Commercial averages are comparable to Medicaid average rates.	**Other Comments on Measure:**	**Other Comments on Measure:**

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

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe) Identify and monitor utilization of services for chemical dependency and substance abuse; monitor for trends and outliers	**Goal #3 (Describe)** Chemical Dependency and substance abuse: identify and monitor utilization of services; watch for trends and outliers	**Goal #3 (Describe)** Chemical Dependency and Substance Abuse: Identify and monitor utilization of services for chemical dependency and substance abuse; monitor for trends and outliers
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: no specific goal identified for this measure; therefore, does not meet criteria to report	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: No specific goal identified for this measure; therefore, does not meet criteria to report
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population with an alcohol or other drug (AOD) claim showing a diagnosis of AOD abuse or dependence and a specific AOD-related service during the measurement year; reported as "any chemical dependency services" (inpatient, intermediate, ambulatory) Denominator includes eligible population; age range 13 – 17 years; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:**

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 388 Denominator: 3342 Rate: 11.6 Additional notes on measure: HEDIS 2006 PA CHIP (unweighted) average of 5 health plans for the age group 13-17 years = 1.2%	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2007:** Rates for CY 2003 (HEDIS 2004) = 0.8%; to CY 2005	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:**

FFY 2006	FFY 2007	FFY 2008
(HEDIS 2006) = 11.6%; Institute Quality Initiative with CHIP health plans to increase rate by 7% for CY 2007 (HEDIS 2008). Not able to impact calendar year 2006 (HEDIS 2007) rates since utilization has already occurred. **Annual Performance Objective for FFY 2008:** Develop pay for performance criteria; monitor and watch for trends **Annual Performance Objective for FFY 2009:** Implement pay for performance; monitor and watch for trends *Explain how these objectives were set:* Analysis of 3 year PA CHIP data, comparison to HEDIS Commercial benchmarks, and projections based on historical trends	**Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*
Other Comments on Measure: Comparison of PA CHIP HEDIS 2006 rate (Commercial, unweighted) = 1.2 % compared to HEDIS 2006 benchmarks (Commercial, unweighted): National = 0.9%, Regional = 0.9%, PA = 0.8%. PA CHIP rate is equal to National Medicaid (unweighted) rate of 1.2%	**Other Comments on Measure:**	**Other Comments on Measure:**

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

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe) Determine frequency of Adolescent Well-care visits; monitor for trends and outliers	**Goal #1 (Describe)** Adolescent Well-Care Visits – increase the percentage of eligible adolescents receiving a well-care visit in the measurement year	**Goal #1 (Describe)** Increase frequency of Adolescent Well-care visits by 3% per year for the next three years; monitor for trends and outliers
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: added direction and target to goal ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination administrative data (3 health plans) and hybrid data (3 health plans)	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination administrative data (3 health plans) and hybrid data (4 health plans)	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Combination administrative data (4 health plans) and hybrid data (5 health plans)
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population with at least 1 comprehensive well-care visit with a PCP or OB/GYN within the measurement year Denominator includes eligible population 12-19 years of age during the measurement year; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: eligible population with at least 1 comprehensive well-care visit with PCP or OB/GYN within measurement year	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible population with at least 1 comprehensive well-care visit with PCP or OB/GYN within measurement year
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: 43288 Rate: 44.4 Additional notes on measure: Numerator: not available since combined administrative and hybrid data – and hybrid is sample of population Rate: 47.2% is the unweighted average of 6 health plans and the PA CHIP rate reported for HEDIS 2006	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 7113 Denominator: 15132 Rate: 47 Additional notes on measure: Definition of denominator: eligible population 12-19 years of age during the measurement year (eligible population is 37312). In the 2006 annual report, the information for 2005 and 2006 was presented differently using eligible population as the denominator; however, if changed, the rates remain the same as presented.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 8495 Denominator: 17108 Rate: 49.7 Additional notes on measure: Definition of denominator: eligible population 12-19 years of age during the measurement year (eligible population is 55,574). In the 2007 annual report, the information for 2006 was presented differently using eligible population as the denominator; however, if changed, the rates remain the same as presented.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** A HEDIS 2006 (measurement year 2007) performance goal was not set in the FFY 2006 report since utilization had already occurred at the time of the report. The goal previously set for HEDIS 2008 is modified below based on a review of HEDIS 2005, 2006 and 2007 rates.	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** The PA CHIP HEDIS 2008 rate of 49.7% exceeded the 2008 performance objective of 47.7% by 2.0%.

FFY 2006	FFY 2007	FFY 2008
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2007:** Utilization rates for age group 12 years to 19 years per 1,000 member years: CY 2003 (HEDIS 2004) = 40.5%; CY 2004 (HEDIS 2005) = 44.7%, CY 2005 (HEDIS 2006) = 44.4%. Institute Quality Initiative with CHIP health plans to increase utilization rates for CY 2007 (HEDIS 2008). Not able to impact calendar year 2006 (HEDIS 2007) rates since utilization has already occurred. **Annual Performance Objective for FFY 2008:** Develop pay for performance criteria; increase utilization rate from previous year. 2% **Annual Performance Objective for FFY 2009:** Implement pay for performance; increase utilization rate from previous year by an additional 2%. *Explain how these objectives were set:* Analysis of 3 year PA CHIP data, comparison to HEDIS Commercial benchmarks, and projections based on historical trends	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** On March 20, 2007, the State held a meeting for all CHIP contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. It was anticipated that this educational effort would impact HEDIS 2008 rates. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** HEDIS 2008 **Annual Performance Objective for FFY 2009:** HEDIS 2009 **Annual Performance Objective for FFY 2010:** HEDIS 2010 *Explain how these objectives were set:*	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. In June 2008, the State released revised 2008-2010 performance objectives for the Adolescent Well-Care Visits performance measure to the CHIP health insurance contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** HEDIS 2009: 52.66% **Annual Performance Objective for FFY 2010:** HEDIS 2010: 55.66% **Annual Performance Objective for FFY 2011:** HEDIS 2011: 58.66% *Explain how these objectives were set:* The rate for this measure has increased by approximately 3% each year over the prior three years. The goal was set to increase the rate by 3% each year over the next three years. Please note that the above goals were adjusted from the goals set in December 2007 based on actual CHIP HEDIS 2008 performance. The new goals were set in November 2008 and may be subject to change pending HEDIS 2009 results.
Other Comments on Measure: Comparison of 2006 PA CHIP rate of 47.2% (commercial, unweighted average) to HEDIS 2006 averages (Commercial, unweighted): National (38.8%), Regional (43.4%), and PA (48.9%) rates. Commercial HEDIS averages are comparable to Medicaid HEDIS averages. The majority of averages for this measure have remained essentially the same or increased only slightly over the 3-year period.	**Other Comments on Measure:** This measure will be publicly reported beginning with HEDIS 2008 rates.	**Other Comments on Measure:** A "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the Adolescent Well-Care visits measure. This measure will be publicly reported beginning with HEDIS 2008 rates

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

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe) Determine Childhood Immunization Status; monitor for trends and outliers	**Goal #2 (Describe)** Childhood Immunization Status – increase the percentage of eligible children receiving all vaccinations in HEDIS Combination 2	**Goal #2 (Describe)** Increase the percentage of eligible children receiving all vaccinations in HEDIS Combination 2 by 0.7% per year for the next three years.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2008
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population who receive all vaccinations in Combination 2 (4-DtaP/DT, 3-IPV, 1-MMR, 3-HiB, 3-Hepatitis B, and 1-VZV) Denominator includes eligible population who turn 2 years of age during the measurement year with continuous enrollment 12 months prior; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: eligible population who receive all vaccinations in Combination 2	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Eligible population who receive all vaccinations in combination 2
Year of Data: 2005	**Year of Data:**	**Year of Data:** 2007

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: 965 Rate: 78.9 Additional notes on measure: Numerator: not available since hybrid acquired data (sample of population) Rate: 78.7% is the unweighted average of 6 health plans and the PA CHIP rate as reported for HEDIS 2006	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 788 Denominator: 1015 Rate: 77.6 Additional notes on measure: Definition of denominator: Eligible population who turn 2 years of age during the measurement year with continuous enrollment 12 months prior. (eligible population 1096). In the 2006 annual report, the information for 2005 and 2006 was presented differently using eligible population as the denominator; however, if changed, the rates remain the same as presented.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 1013 Denominator: 1322 Rate: 76.6 Additional notes on measure: Definition of denominator: Eligible population who turn 2 years of age during the measurement year with continuous enrollment 12 months prior (eligible population 1,433). In the 2007 annual report, the information for 2006 was presented differently using eligible population as the denominator; however, if changed, the rates remain the same as presented
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** A HEDIS 2006 (measurement year 2007) performance goal was not set in the FFY 2006 report since utilization had already occurred at the time of the report. The goal previously set for HEDIS 2008 is modified below based on a review of HEDIS 2005, 2006 and 2007 rates.	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** The HEDIS 2008 rate of 76.6% was 2.3% below the performance objective of 78.9% for 2008.

FFY 2006	FFY 2007	FFY 2008
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. **Annual Performance Objective for FFY 2007:** Rates for children who receive all immunizations: CY 2003 (HEDIS 2004) = 67.5%; CY 2004 (HEDIS 2005) = 70.9%, CY 2005 (HEDIS 2006) = 78.9%. Institute Quality Initiative with CHIP health plans to increase rate by 5% for CY 2007 (HEDIS 2008). Not able to impact calendar year 2006 (HEDIS 2007) rates since utilization has already occurred. Continue to monitor for trends and outliers. **Annual Performance Objective for FFY 2008:** Develop pay for performance criteria; increase rate additional 5% **Annual Performance Objective for FFY 2009:** Implement pay for performance; maintain rate at 90% or above *Explain how these objectives were set:* Analysis of 3 year PA CHIP data, comparison to HEDIS Commercial benchmarks, and projections based on historical trends	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** On March 20, 2007, the State held a meeting for all CHIP contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. It was anticipated that this educational effort would impact HEDIS 2008 rates **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** HEDIS 2008 **Annual Performance Objective for FFY 2009:** HEDIS 2009 **Annual Performance Objective for FFY 2010:** HEDIS 2010 *Explain how these objectives were set:*	**What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** On March 20, 2007, the State held a meeting for all CHIP health insurance contractors. At this meeting, the State addressed CHIP HEDIS 2006 rates, provided comparisons to benchmarks, discussed performance objectives and addressed future plans for public reporting and a pay-for-performance program. In June 2008, the State released revised 2008-2010 performance objectives for the Childhood Immunization Status - Combination 2 performance measure to the CHIP health insurance contractors, which included a comparison of performance over the previous three years and projections for the HEDIS 2008, HEDIS 2009 and HEDIS 2010 measurement years. **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** HEDIS 2009: 77.32% **Annual Performance Objective for FFY 2010:** HEDIS 2010: 78.12% **Annual Performance Objective for FFY 2011:** HEDIS 2011: 78.87% *Explain how these objectives were set:* The Childhood Immunization Status - Combination 2 measure rate decreased by 1.31% for 2008 after decreasing by 1.68% for 2007. A goal was set to increase the rate by 0.7% each year over the next three years to approximate the 2006 rate, which was the highest of the prior three rates.
Other Comments on Measure: Comparison of 2006 PA CHIP rate of 78.7% (commercial, unweighted average) to HEDIS 2006 averages (unweighted): Commercial National (77.7%), Commercial Regional (82.2%), and Commercial PA (83.3%) rates. Commercial averages are slightly higher than Medicaid HEDIS averages. The majority of averages for this measure have gradually increased over the 3-year period.	**Other Comments on Measure:** This measure will be publicly reported beginning with HEDIS 2008 rates.	**Other Comments on Measure:** Please note that the above goals were adjusted from the goals set in December 2007 based on actual CHIP HEDIS 2008 performance. The new goals were set in November 2008 and may be subject to change pending HEDIS 2009 results. A "report card" was developed for public reporting of multiple Pennsylvania CHIP performance measures including the Children's Access to Primary Care Practitioners measure. This measure will be publicly reported beginning with the HEDIS 2008 rate.

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

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe) Determine Adolescent Immunization Status; monitor for trends and outliers	**Goal #3 (Describe)** Adolescent Immunization Status	**Goal #3 (Describe)** Adolescent Immunization Status
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: NCQA discontinued this measure effective HEDIS 2009	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: NCQA discontinued this measure effective HEDIS 2009
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Numerator is eligible population who receive all vaccinations in Combination 2 (MMR, Hepatitis B, VZV) Denominator includes eligible population who turn 13 years of age during the measurement year with continuous enrollment 12 months prior; commercial	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:

FFY 2006	FFY 2007	FFY 2008
Denominator: 6159 Rate: 71.1 Additional notes on measure: Numerator: not available since hybrid acquired data (sample of population) Rate: 71.1% is the unweighted average of 6 health plans and the PA CHIP average as reported for HEDIS 2006	Denominator: Rate: Additional notes on measure:	Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2007:** Utilization rates for age group 13 years: CY 2003	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:**	**Explanation of Progress:** **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:**

FFY 2006	FFY 2007	FFY 2008
(HEDIS 2004) = 60.4%; CY 2004 (HEDIS 2005) = 64.1%, CY 2005 (HEDIS 2006) = 71.1%. Institute Quality Initiative with CHIP health plans to increase utilization by 2% for CY 2007 (HEDIS 2008). Not able to impact calendar year 2006 (HEDIS 2007) rates since utilization has already occurred. Continue to monitor for trends and outliers. **Annual Performance Objective for FFY 2008:** Develop pay for performance criteria; rate increase by 2% **Annual Performance Objective for FFY 2009:** Implement pay for performance; rate increase an additional 1% *Explain how these objectives were set:* Analysis of 3 year PA CHIP data, comparison to HEDIS Commercial benchmarks, and projections based on historical trends	**Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*
Other Comments on Measure: Comparison of 2006 PA CHIP rate of 71.7% (commercial, unweighted average) to HEDIS 2006 averages (Commercial, unweighted): National (53.7%), Regional (63.3%), and PA (75.4%) rates. Commercial HEDIS averages are higher than Medicaid HEDIS averages. All averages for this measure have gradually increased over the 3-year period.	**Other Comments on Measure:**	**Other Comments on Measure:**

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

Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) have been used as primary measurement tools to date. In addition, PA CHIP health plans are contractually required to submit quarterly and annual reports that provide aggregated data on utilization of services.

The PA CHIP HEDIS 2008 report (based on 2006 and 2007 service dates, as appropriate to the measure) compared the PA CHIP health plan weighted average to the weighted average of all PA Medicaid managed care plans and to the average of National Medicaid plans that submitted data to NCQA. For HEDIS 2008, the PA CHIP average was higher than the PA Medicaid managed care average across measures assessing Effectiveness of Care (EOC) and Access and Availability (AA). For HEDIS 2008 Use of Services (UOS) measures, such as Ambulatory Care and Inpatient Utilization, PA CHIP members had lower utilization of health care services than did the PA Medicaid managed care health plan members.

When compared to the National Medicaid health plan average, the PA CHIP health plan average is higher across all EOC, AA and UOS measures with the exception of the Appropriate Treatment For Children with Upper Respiratory Infections measure (78.6 vs. 84.0 percent). In general, the PA CHIP weighted averages for all measures are similar to National Medicaid health plan averages, and range between 0.1 to 23.7 percentage points higher, with most measures falling within 10 percentage points of each other.

An approach to decreasing emergency room usage is currently underway via our newly contracted external quality review organization (EQRO), IPRO. PA CHIP's HEDIS 2007 rates are being used as our baseline for identifying and implementing improvement initiatives.

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

PA CHIP has multiple strategies for measurement and reporting on access to, quality, or outcomes of care received by the CHIP population. In 2007, Pennsylvania CHIP set objectives and performance goals. Those objectives and goals were outlined in the FY 2007 Annual Report. These objectives and the status of each goal follow.

Objective: To expand the CHIP performance measurement set.

Performance goal status:

- For HEDIS 2008, PA CHIP replaced retired HEDIS measures and required reporting of new HEDIS measures.
- For HEDIS 2009, PA CHIP will again replace retired HEDIS measures and require reporting of new HEDIS measures. For HEDIS 2009, the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure will be reported for the first time.
- In 2007, PA CHIP implemented a Pennsylvania-specific performance measure – "Annual Body Mass Index Screening for Children and Adolescents."
- The PA CHIP health plan Annual Body Mass Index Screening For Children and Adolescents performance measure results will be available by the end of January 2009.
- In 2008, PA CHIP will implement an additional Pennsylvania-specific performance measure - Emergency Department Encounter Rate for Asthma in Children and Adolescents. The results of the new performance measure will be available in the fourth quarter 2009.

Objective: To ensure consistency in CHIP performance measurement.

Performance goal status:

- For HEDIS 2008, PA CHIP required that HEDIS performance measures be subject to audit by a National Committee for Quality Assurance (NCQA)-certified HEDIS audit organization. This requirement will continue for HEDIS 2009.

- For HEDIS 2008, PA CHIP required HEDIS performance measures be reported annually and not be subject to rotation. This requirement will continue for HEDIS 2009.
- For HEDIS 2008, PA CHIP required the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to be subject to audit by an NCQA-certified HEDIS audit organization. This requirement will continue for HEDIS 2009.
- For HEDIS 2008, PA CHIP established comparisons to statewide weighted averages and continued comparisons to national benchmarks and year-over-year outcomes. This will continue for HEDIS 2009.
- In 2008, PA CHIP required the Pennsylvania-specific performance measure be subject to validation by an independent organization. This requirement will continue in 2009 for both performance measures.

Objective: To initiate public reporting of CHIP performance measures

Performance goal status:

- In 2008, PA CHIP developed an annual report card that displays each CHIP health insurance companies' rates for selected 2008 CAHPS survey results and 2008 HEDIS measures and compares those results to the statewide average using graphics.
- The report card will be disseminated via attachment at the end of this report.
- PA CHIP will prepare and disseminate a similar report card using 2009 CAHPS survey results and 2009 HEDIS measures. The report card will be available in the third quarter of 2009.

Objective: To implement a CHIP pay-for-performance program

Performance goal status:

- In 2007, PA CHIP received and reviewed the "Pay-For-Performance in State Medicaid Programs" survey that was prepared by IPRO and The Commonwealth Fund.
- In 2008, PA CHIP suspended development and implementation of a pay-for-performance methodology due to other Commonwealth priorities.

It is yet to be determined when data will be available.

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

In calendar year 2007, the Pennsylvania SCHIP program implemented a CHIP-specific Performance Improvement Project (PIP). Pennsylvania selected a PIP focus that is key to advancing CHIP population health outcomes. The PIP topic is reduction of emergency department visits for the CHIP population. The PIP must use as its basis the HEDIS Ambulatory Care measure. The CHIP health insurance contractors are required to implement a new PIP. The PIP may not be a continuation of an existing project. The CHIP health insurance contractors are required to conduct the PIP as defined by the State. Although the PIP must be related to reduction of emergency department visits, the CHIP health insurance contractors can select the specific PIP topic. The CHIP health insurance contractors must do a root cause or similar analysis to determine the reasons for over-utilization in the CHIP population. The reason why each CHIP contractor chooses the topic must be clearly stated and relevant to the contractor's CHIP population. CHIP health insurance contractors received detailed instructions in October 2007 and a follow-up training session in November 2007. CHIP health insurance contractors submitted their topic selection, quality indicators and study design in March 2008, which were validated in April 2008. CHIP health insurance contractors were required to implement targeted interventions during calendar year 2008, which are aimed at reducing emergency department visits, with the first remeasurement period scheduled for early in calendar year 2009. The CHIP PIP submissions will be validated on an annual basis by IPRO, an independent organization.

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

CHIP Performance Improvement Projects (The health plans recently started these initiatives. There are no findings to report at this time.)

Body Mass Index (BMI) Measure Summary (The health plans started this initiative in 2008. The findings will be available the end of January 2009.)

CAHPS survey 3.0H. See summary below.

- From the eight PA CHIP plans which participated in the survey, 6,455 respondents completed the CAHPS 3.0H Questionnaire. The respondents completed the questionnaire on behalf of a child enrolled in one of the commercial-based or Medicaid-based HMO plans.
- Respondent Characteristics—PA CHIP CAHPS 3.0H Survey Respondents
- For CAHPS 2008, the majority of respondents were female (87.1 percent). A high proportion of survey respondents had a high school diploma (43.5 percent) or some college education (35.8 percent). In addition, the majority of respondents indicated that their child is white (77.9 percent) and was in "excellent" or "very good" health (84.3 percent).
- Global Rating Questions
    - The Global Rating Questions asked respondents to rate each of four aspects of their child's health care on a scale of 0 to 10, where 0 is the "worst possible" and 10 is the "best possible."
    - For 2008, the PA CHIP plan average for enrollees who rated their child's health plan 8, 9, or 10 was 86.2 percent. Health plans' rates for rating of child's health plan ranged from 71.6 to 94.0 percent. The average across health plans for PA CHIP enrollees who rated their child's personal doctor 8, 9, or 10 was 84.7 percent.
- Composite Scores
    - Each Composite contained a set of survey questions. To obtain a Composite Score, the responses for all questions comprising a Composite were averaged.
    - The PA CHIP plans' averages ranged from 58.4 to 82.1 percent of enrollees who rated their child's health plan's customer service "not a problem." The PA CHIP plans' rates ranged from 84.9 to 95.2 percent of enrollees who indicated they are "usually" or "always" able to get care quickly for their child. The PA CHIP plans' rates ranged from 73.0 to 93.0 percent of enrollees who indicated that getting needed care for their child is "not a problem."

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

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

CHIP focused its marketing and outreach efforts on motivating parents to "apply now". We shifted our strategy by staggering advertising over the entire year and ran TV and radio during the same weeks – which basically equated to every other week. New pilot programs included some print advertising in targeted minority communities. We also advertised in some parenting magazines in the Pittsburgh market and complimented our Latino outreach with some billboard advertising in heavily populated Latino neighborhoods.

We developed the Community Marketing Initiative, a grassroots marketing initiative which enabled CHIP to leverage existing relationships and trust that community partners have established in the local communities to efficiently and effectively extend grassroots community outreach. A total of 11 organizations were selected to help provide additional outreach and increase enrollment.

CHIP continues to drive the focus more on the teen uninsured population. CHIP focused on school district outreach this year and distributed CHIP information to the districts for use on their Web sites, lunch menus, flyers, newsletters, and call or e-mail blasts. This is in addition to the "Really" CHIP flyer that is distributed to all school districts in the state. We also worked with one of the defensive line football players for the Pittsburgh Steelers to record a special message about CHIP for school districts to use during call blasts to all parents in their district.

To assist with strategic messaging, CHIP developed an electronic toolkit for the Web site. Interested parties can access various materials including collateral materials, news release templates, newsletter articles, and flyer templates to name a few. Our goal is to ensure consistent messaging and to reduce the amount of time and money community organizations need to spend when helping to spread the word about CHIP and assist parents with applications.

Finally, CHIP focused on informing self-employed parents and those employed in the service-industry about the program. To reach the self-employed target, CHIP cultivated a relationship with the Pennsylvania chapter of the National Federation of Independent Businesses and placed ads and articles in its newsletter. To reach the service-industry parents, CHIP worked with the PA Retailers' Association and the PA Restaurant Association, which allowed CHIP to send e-mail blasts to members. CHIP also placed ads and articles in the association newsletters.

Media Plan:

- We continue to run our "no worries" TV ad across the state. The ad ran on network and cable TV year-round and featured a young boy who delivered the message that "no family makes too much money for CHIP" and "apply today." TV reached lower and upper income families, while radio targeted more lower income families.
- CHIP continued to run radio advertising across all markets, including African American and Hispanic communities. Callers to the helpline cite radio advertising as one of the top ways they heard about CHIP.
- CHIP continued its successful Internet search engine advertising, utilizing Google, Yahoo and other popular search engines, which netted more than 3 million hits a month to its Web site.

Retail Partnerships: CHIP expanded its retail partnerships with Giant Foods (grocery store chain), Rite Aid Corporation (drug store chain), Boscov's (department store chain) and Isaac's Restaurant and Deli (restaurant chain) to promote the program in coordination with each company's corporate outreach efforts. Co-branding with these successful companies further expanded CHIP's message in family-oriented locations.

School Notices: CHIP continued its partnership with the Department of Education by sending out the annual CHIP flyers to all public schools statewide (2.2 million flyers).

CHIP Web site: CHIP analyzed statistics from Google analytics to understand what information people are looking for on the CHIP Web site (www.chipcoverspakids.com), how we can best organize that information and what content or functionality we could add as enhancements. Visitors can view eligibility requirements, get updated facts on the expanded program, benefit information, how to apply, FAQs, how to order outreach materials, and various reports. We also worked to translate the whole site into Spanish and expect it to go live next federal fiscal year.

COMPASS: COMPASS, the Web-based application and renewal system (www.COMPASS.state.pa.us), underwent an extensive graphical redesign and the new look was launched in June 2008. In the first four months, we saw a 63 percent increase in the number of users.

Cover the Uninsured Week: In coordination with the Robert Wood Johnson (RWJ) national effort, Pennsylvania continued its statewide outreach efforts during "Cover the Uninsured Week" in April 2008. CHIP contractors and advocate partners blanketed the state with CHIP events and activities, including health fairs, enrollment drives with community-based organizations, and community events. Activities included:

- "Cover the Kids Sunday." Churches were asked to pass messages from the pulpit, post announcements, distribute CHIP brochures and generally share information about CHIP. Approximately 40 churches throughout the Commonwealth participated in the program.

- Minority Health Month Banquet in Harrisburg **–** CHIP material was distributed, a CHIP promotional ad was part of the banquet digital display, and an interview was conducted on WTCY's Sunday morning gospel show in connection with "Cover the Kids Sunday."

- CHIP hosted a statewide radio media tour. The tour centered on the fact that more than one million Pennsylvanians are uninsured, and it also included information about CHIP and the Access to Basic Care initiative. In all, we landed 10 interviews, touching each of Pennsylvania's six media markets. The interviews aired on a total of **461 affiliates**, carrying our message to more than **3.5 million listeners**. The radio stations included powerhouses such as KDKA-AM in Pittsburgh, the American Urban Radio Network (with 367 affiliates) and Radio PA (with 75 affiliates).

- Pennsylvania Charter School Conference, Pittsburgh**.** CHIP was invited to set up a table and recruit charter schools who wanted to provide information to their students and parents about the availability of CHIP. We were able to sign up more than 20 charter schools and the cyber charter school for follow-up events/presentations.

- Parent Information Resource Center (PIRC)/Harrisburg Public Schools initiative. PIRC conducted CHIP information-and-support clinics during kindergarten registration.

- Hispanic community CHIP awareness event with partner organization, Concilio. The event had 80 people in attendance. Speakers included Concilio's executive director, secretary of state for the Commonwealth, deputy insurance commissioner, executive director of the Greater Philadelphia Hispanic Chamber of Commerce, director of the Maria de los Santos Health Center, and Delaware Valley Community Health Inc. The event attracted significant media attention. Outlets attending included: *Al Dia*; *Impacto*; *El Hispano*; *El Sol*, Univision; and WFMZ.

- Radio interview on WURD-Philadelphia. CHIP was featured on the African-American talk station program hosted by the Urban League of Philadelphia.

Pennsylvania Farm Show: CHIP sponsored a Farm Show booth again in January 2008 where information was distributed and application assistance was provided to families. More than 500,000 citizens attended the 10-day Farm Show event.

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

We find that a multi-pronged marketing and outreach approach is very effective in reaching citizens with CHIP's message. In 2008, CHIP continued to utilize valuable data provided by the Helpline to measure how callers heard about CHIP. The data showed that TV ads, radio ads, Web site and Governor PSAs reached the broadest audience; flyers distributed through schools and County Assistance Offices drew the most CHIP calls overall in the shortest amount of time; and word of mouth continued to strongly fuel awareness. CHIP always encourages citizens to tell family, friends, co-workers, and neighbors about the program. The results of this message were reflected in call volumes to the Helpline. In addition to these over-arching strategies, CHIP implemented a number of other strategies to reach uninsured Pennsylvania families.

- The CHIP TV commercial that ran on a schedule of every other week on both network and cable TV was very effective. When CHIP ads ran, the Helpline consistently saw spikes in call volumes. In fact, the TV ad continuously ran in the top three reasons cited by citizens who called the Helpline to request applications or application assistance over the phone.

- CHIP radio advertising complimented the TV spot so that it reinforced the CHIP message and ran during corresponding weeks. Radio advertising was very effective in driving CHIP call volumes up and recently ranked in the top four reasons why citizens called the Helpline for applications or application assistance.

- CHIP's Web-based search engine advertising continued to be an affordable and excellent driver to the CHIP Web site and also to the Helpline. The CHIP Web site receives 3 million hits a month and callers to the Helpline consistently cited the CHIP Web site as one of the top three reasons they called to apply for or inquire more about CHIP.

- CHIP and its insurance company contractors' outreach staff continued daily grassroots outreach, focusing on venues where folks could take the next step and enroll, such as health fairs, libraries, hospitals, community events, and meetings.

- Word of mouth via friends and family consistently ranked as a major source of information and referrals to the CHIP Helpline. Many families learn about and apply for the CHIP program based on the valued and trusted information provided to them from friends and family. To that end, CHIP continued its informal "tell a friend or family member" campaign over the last year to keep those referrals coming!

Helpline – Connecting Citizens with CHIP and Tracking Progress

The Commonwealth continues to work with Policy Studies Inc. (PSI) to manage Pennsylvania's Health and Human Services Call Center. The integrated call center supports eight statewide health and human service information and referral helplines for five state agencies, which provides a "one-stop-shop" for most social services. PSI specialists are cross-trained to handle calls from each of the helplines to maximize resources and offer the full range of available social services and information to citizens on one call.

Helpline staff is also trained to identify uninsured callers and offer information and assistance with programs such as CHIP and Medical Assistance. Most importantly, PSI provides application assistance to callers by giving them the option to receive a paper application, apply or renew over the phone with the assistance of a Helpline counselor, or receive the COMPASS Web site address to

apply or renew on their own via the Web. PSI also maintains a list of applications submitted and paper applications mailed to callers and conducts follow-up calls to ensure that a "result" has occurred with each caller.

PSI has high-quality operations standards that it constantly monitors to ensure a consistent level of service excellence. Quality assurance monitoring is also conducted by the partner agencies. PSI met or exceeded all key performance indicators for SFY 2007-08. In SFY 2007-08, the call center answered 102,937 CHIP calls (2% increase from previous year), mailed 52,369 CHIP/adultBasic applications, and completed 2,624 COMPASS applications online.

Other effective efforts contributing to increased CHIP enrollment include:

30-Day Renewal Outreach

- The Helpline made 2,500 outbound telephone calls a month to families who did not complete renewal applications after receiving three notices from CHIP. Helpline representatives offered renewal assistance over the phone (using COMPASS) and provided reminders to families to mail back their renewal applications.

CHIP offered three ways to apply and renew for the program

- Online via COMPASS, the Commonwealth of Pennsylvania's Web Access to Health and Human Services – a one-stop shop where citizens can apply for many social service programs with one application;
- By paper application; and
- Over the phone through the CHIP Helpline.

Established working relationships with County Assistance Offices

- County Assistance Offices are the largest source of CHIP applications and referrals. They refer more than 3,000 applicants per month to the program. The program worked with the Department of Public Welfare to enhance internal and external communications between the two agencies to further improve the "any form is a good form" process, whereby an application can go to either agency and be referred to the agency that will provide the family benefits.

- CHIP expanded its outreach to county agencies and attended and presented at conferences and events that focus on this community. Examples included WIC directors, CareerLink center directors, public librarians, PTAs/PTOs, domestic relations divisions (family courts) and HeadStart organizations.

Interagency Initiatives

The nationally-recognized Reaching Out Interagency Workgroup continues to reach uninsured children in Pennsylvania. Through this effort, many excellent outreach ideas were exchanged and valuable information was shared, which CHIP incorporated into its strategic outreach and marketing planning. Consumer advocates are viewed as important contributors in the development of new outreach and enrollment strategies and their input is regularly sought by CHIP staff.

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

CHIP insurance company contractors are contractually required to describe how they will identify and address special populations, including non-white and non-English speaking children and children with disabilities; how they will reach different geographic areas, including rural and inner-city areas; and how they will address cultural and ethnic diversity in their outreach efforts.

Going forward, all CHIP insurers are required to develop CHIP-specific Web sites in both English and Spanish and must continue to provide all written materials in English and Spanish.

Hispanic and African American Outreach

CHIP tested and then went statewide with radio advertising across all markets, including African American and Hispanic radio stations.

A new marketing partner, Cardenas-Grant, implemented an updated strategy for the uninsured African American community, focusing on the recruitment of community based organizations with established constituencies to identify uninsured children and teens. The plan brought CHIP presence/awareness and enrollment activities to targeted neighborhoods. These events provided families with information about CHIP and "CHIP crews" provided on-site assistance with completing a CHIP application or give a referral/follow up. Two highlights of the grassroots outreach included:

- Tax season initiative in which EITC tax filers were screened for interest in CHIP, which netted more than 350 families for follow-up.
- The Faith Based Initiative
    - Recruited a total of 70 churches to promote CHIP, reaching 28,125 members.
    - Cardenas-Grant worked through other networks of churches, reaching more than 400 churches with a combined membership of more than 250,000.
    - Another faith based partnership resulted in a Cover the Kids Concert in June, attracting hundreds to hear the CHIP message and referral for follow up.
    - 36 churches are now official CHIP enrollment sites with staff designated to help with applications and/or referrals.
    - The most recent faith-based event netted 35 names of potential applicants who were referred for follow-up.
- Mother's Day promotion
    - Nearly 20,000 mother's day cards, customized with the CHIP message and contact information were distributed to charter schools, after school and early elementary day care centers.
- Charter Schools
    - Cardenas Grant has been working with the Pennsylvania Charter Schools Association to identify uninsured children at these institutions. They requested 10,700 CHIP brochures and a few schools also requested CHIP sign up crews for their back to school open houses.

Media buys (radio and print) were executed in larger metro areas. Radio advertising was tagged with information about local events to drive potential applicants to sources of application assistance.

Cardenas-Grant's focus is on outreach to drive up enrollment: identifying uncovered, uninsured families and actually helping them to complete applications. To do this, Cardenas-Grant has found penetration points within the African American community that have established constituencies either statewide or in identified locations through which they can send CHIP messages and invitations to sign up via:

- Churches
- Community Based organizations serving the African American Community

- Black Fraternal Societies
- Black Professional Association
- African American Advocacy Organizations

Mendoza Group, a Hispanic marketing agency, was selected again based on its successful work of focusing on two demographic segments of the Latino market: those unaware of CHIP and those who do not think that they qualify for CHIP.

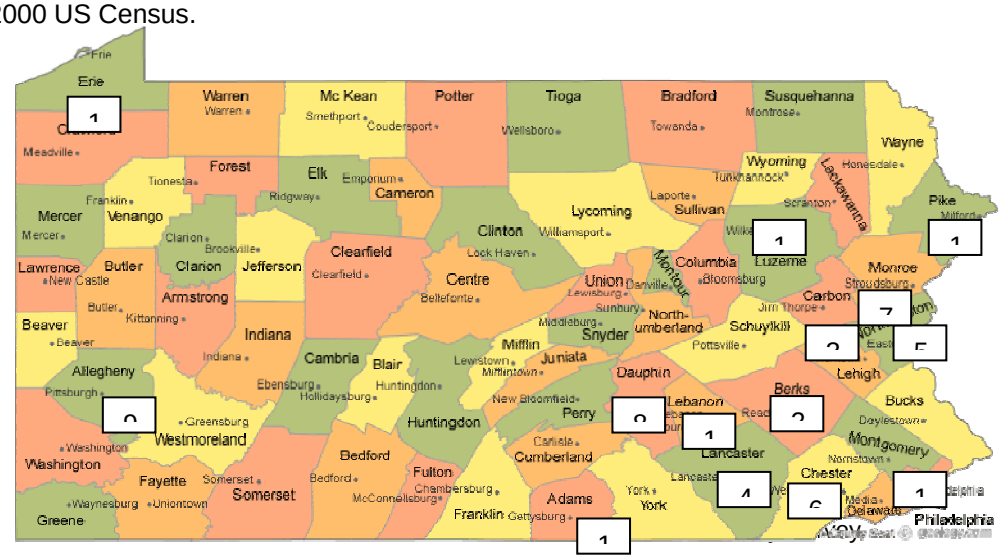
Hispanic marketing efforts implemented by Mendoza Group targeted the top fourteen Hispanic populated counties of Pennsylvania.

The core of the Latino marketing initiative is capturing share-of-heart by delivering a personal CHIP message by community influencers like leaders of community based organizations, Healthcare professionals and the Hispanic media and via spokespeople whom Latinos can identify with, like “real” CHIP moms.

With this in mind and consistent with the overall goal to *raise the understanding among all populations* so that the Hispanic audience is predisposed to CHIP and *increase CHIP enrollment*, Mendoza Group’s Hispanic marketing plan deployed the following strategic concepts:

- CHIP De Mamá a Mamá (from mom to mom) brigade outreach in the community.
- Community outreach, media and quarterly public relations campaigns.
- Enrich and/or establish partnerships with key retailers, community based organizations, school districts and healthcare professionals serving the Hispanic community.
- Continue to earn trust and engage the audience, and create a willingness to call the CHIP Helpline by continuing the “Worry Free” messaging, as this concept is culturally relevant in Spanish and as recent CHIP Helpline reports have indicated, is providing an incentive for Hispanic residents to inquire about CHIP.

Geographically, uninsured children come from population centers like Philadelphia, Harrisburg, Pittsburgh, and Eastern Pennsylvania. Mendoza’s marketing plan focused on the top fourteen Hispanic-populated counties of Pennsylvania, according to the US Census 2005 American Community Survey and the 2000 US Census.



Mendoza's marketing tactics from October 2007 – September 2008 included:

- **Radio Advertising** – "Worry-free with CHIP"
- **Print Advertising** – "CHIP Covers All Uninsured Kids, Including Teens"
- **Outdoor Advertising** - "CHIP Covers All Uninsured Kids, Including Teens"
- **Direct mail and Telemarketing to community influencers** – specialty brochure distribution
- **TV Advertising** – produced a :30 CHIP TV commercial in Spanish
- **School District Outreach** – Backpack friendly "oversized" CHIP envelope with CHIP information.

- **CHIP Hispanic Advisory Network** - In an effort to expand to the secondary Hispanic markets, Mendoza Group recommended a strategy to accommodate community partners and influencers who may not be able to participate at CHIP advisory meetings in Harrisburg. These influencers are key gatekeepers within community-based organizations which primarily cater to Hispanic residents. Target markets included Pittsburgh and Lebanon. The purpose for the advisory network was to establish sustaining relationships with community influencers; utilize their feedback as a metric scorecard of our activities; better understand these organizations' activities and successes; and educate advisory network members about CHIP.
- **CHIP Web site** – translation of the CHIP Web site into Spanish.
- **CHIP Awareness Research** - To gauge CHIP awareness in the Hispanic market of Pennsylvania, Mendoza Group implemented an Insurance Awareness Study during June 2008.

  One hundred, five-minute intercept interviews were conducted with Latina women in the top Hispanic neighborhoods.

  In the larger more established Latino communities of Philadelphia and Reading, CHIP was found to be very well-known as a very good health insurance plan. These communities have been effectively marketed to via solid community outreach and integrated media campaigns utilizing advertising mediums with targeted coverage.

  In the smaller less established, but burgeoning Latino communities of Pittsburgh and Lebanon, CHIP is not well-known. These communities host a rapidly growing Mexican immigrant population, one which historically can be skeptical and apprehensive about participating in any government funded programs. The good news is that as these communities grow, more community based organizations will be formed and Latino advertising vehicles like radio and newspaper will begin to materialize and we will have the proper marketing tactical advantage to brand CHIP into the hearts of this loyal and needing demographic.
- **Cover the Uninsured Week** - Hispanic community CHIP awareness event with partner organization Concilio. The event, held at the Maria De Los Santos Health Center in Philadelphia, had 80 people in attendance. The event attracted significant media attention.

3. **What percentage of children below 200 percent of the Federal poverty level (FPL) who are eligible for Medicaid or SCHIP have been enrolled in those programs? (Identify the data source used).**

To perform this calculation, we used statistics from the United States Census Bureau (Current Population Survey, Annual Social and Economic Supplement, 2005, 2006, 2007), as well as the Pennsylvania Insurance Department and the Department of Public Welfare. To mitigate the variations in timeframe captured by these different sources, as well as to minimize seasonality factors from the enrollment numbers, we performed this calculation using a three-year average (2004-2006) of the data. The data shows the following:

Assurance of 95% Enrollment of Children (0-18) Below 200% FPL

Number of Children at or below 200% FPL – 3 Year Average, 2004, 2005, 2006

Pennsylvania	1,065,000
CHIP Enrollment	133,404
Medicaid Enrollment	909,432
Total CHIP and Medicaid Enrollment	1,042,836

Children Enrolled in CHIP or Medicaid Under 200% - 97.92%

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All states should answer the following question

1. Do you have substitution prevention policies in place?

   ☒ Yes
   ☐ No

   If yes, indicate if you have the following policies:
   ☒ Imposing waiting periods between terminating private coverage and enrolling in SCHIP
   ☒ Imposing cost sharing in approximation to the cost of private coverage
   ☒ Monitoring health insurance status at the time of application
   ☒ Other, please explain

   Pennsylvania has taken a number of steps to guard against and monitor for crowd-out. Questions regarding insurance coverage are contained on the application and renewal forms and cross matches against Medicaid and private insurance files are completed to help determine that only uninsured children are enrolled. We also instituted a third party check to determine if an applicant has private insurance or meets the required period of uninsurance prior to enrolling in CHIP.

States with a separate child health program above 200 through 250% of FPL must complete question 2. All other states should also answer this question if you have a point at which the state will implement or modify a current substitution policy should substitution levels become unacceptable.

2. Identify the trigger mechanism or point at which your substitution prevention policy is instituted or modified if you currently have a substitution policy.

   Monitoring - Pennsylvania will continue to monitor the rate of employer-based coverage for changes. In addition to using information obtained from the applications, Pennsylvania implemented a cross match through a Third Party Liability contract to determine current and recent health insurance status. This match assists in the determination that the applicant is currently uninsured and has met the required period of uninsurance. This match also provides us a source of data, other than applicant-provided information, on the number of individuals who applied for CHIP and had private insurance within the previous six months prior to application. With the addition of this data, we will be able to more accurately determine the possibility of substitution among these individuals.
   Strategy to limit substitution - Children over the age of two: Pennsylvania implemented an uninsured period of six months. Children, over the age of two with a net income of greater than 200% of FPL, who were covered by a health insurance plan, a self-insurance plan, or a self-funded plan, are not eligible to enroll in CHIP for a period of six months following the end date of the private insurance except if the child's parent is eligible to receive unemployment compensation or is no longer employed and is ineligible for unemployment compensation, or the child is transferring from one government-subsidized health care program to another.
   Another disincentive for dropping private coverage is the addition of cost sharing (premiums and co-payments) in the CHIP benefit package for families with net incomes greater than 200% of FPL.
   Strategy to limit substitution - Children under the age of two: In addition to monitoring for overall level of substitution, we will compare the data for the 0 - 2 year olds with data for 2 – 5 year olds to determine if the no period of uninsurance for the 0 – 2 year olds is significantly increasing the rate of substitution in Pennsylvania. If the rate of substitution in the under-2 year olds approaches one-and-a-half times that for 2 – 5 year olds, Pennsylvania will consider implementing a one- or two-month period of uninsurance. If the rate of substitution continues to grow in the under-2 year olds to a point of twice that of the 2 – 5 year olds, Pennsylvania will consider increasing the period of uninsurance incrementally up to six months.
   Cost sharing requirements (premiums and co-payments) also apply to the under age 2 group.

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and how the State evaluates the effectiveness of its policies.

   Applications for coverage include questions relating to other forms of health insurance coverage. Applicants reporting they have other types of health insurance are denied coverage through Pennsylvania's CHIP. In addition, electronic matches with Medicaid and private insurance occur in an effort to prevent children with other insurance from being covered by CHIP. Various reports are available and used to measure substitution.

4. At the time of application, what percent of SCHIP applicants are found to have Medicaid [(# applicants found to have Medicaid/total # applicants) * 100] and what percent of applicants are found to have other insurance [(# applicants found to have other insurance/total # applicants) * 100]? Provide a combined percent if you cannot calculate separate percentages.

   In FFY 08, there were 4,142 (or 3.3%) applicants found to have Medicaid out of 126,533 total applicants. There were also 8,994 (or 7.1%) applicants found to have other insurance during the same time.

   a. Of those found to have had other, private insurance and have been uninsured for only a portion of the state's waiting period, what percent meet your state's exemptions to the waiting period (if your state has a waiting period and exemptions) [(# applicants who are exempt/total # applicants who would have to complete a waiting period)*100]?

   Please see #5 below.

   a. Of those found to have other, private insurance, what percent must remain uninsured until the waiting period is met [(# applicants who must complete waiting period/total # applicants who would have to complete a waiting period)*100]?

      In FFY 08, there were 83 children (or 0.4%) who had to serve the waiting period to be eligible for CHIP. Please see #5 below.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP (i.e., (# applicants who drop coverage/total # applicants) * 100)?

   The direct substitution rate for the children above 200% of the FPL is very low with the strategies in place to prevent it – a child is not eligible unless they meet the CMS-approved period of uninsurance or one of the exceptions. In FFY 08, of the total 126,533 applicants, there were 22,941 children who were reviewed by our contractor, Health Management Services, to see whether they have or have had private insurance. These children were eligible for subsidized or full-cost CHIP. As part of our cost-savings strategy, we do not run extensive checks on children that qualify for Free CHIP, so this analysis only applies to the subsidized and full-cost CHIP participants.

   Of the 22,941 applicants in FFY 08 with incomes above 200% of the FPL, 836 were identified as having private insurance, resulting in the possible incidence of substitution at 3.6%. Of these, 339 were denied benefits, 83 were required to serve some portion of the period of uninsurance, and 414 met one of the exceptions – under the age of two or loss of insurance due to the loss of employment. Using the exceptions in our SPA approved by CMS on February 20, 2007, 497 or approximately 2.1% of the applicants with incomes over 200% of the FPL had private insurance within six months of the eligibility determination and were ultimately enrolled in the program.

COORDINATION BETWEEN SCHIP AND MEDICAID

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

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

   The processes for renewing eligibility for CHIP and redetermining eligibility for Medicaid are alike. Neither requires an interview. Both programs review factors that may have changed since the application was filed or last renewed. CHIP and Medicaid have aligned their requirements as described in the next section, Eligibility Redetermination and Retention.

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

   Children who are being disenrolled from Medicaid because of a change in family circumstances and who are eligible for CHIP can be enrolled in CHIP retroactively back to the first of the month in which disenrollment from Medicaid occurred to avoid a gap in health care coverage. The challenge was to ensure that the paperwork gets to the correct insurance plan and the family knows to which plan the paperwork was sent. To remove this challenge, we automated the referral process.

   Income too low: If an application for health care coverage is filed with a CHIP contractor and the child appears to be eligible for Medicaid, the CHIP contractor sends a notice of ineligibility to the parent or guardian that explains that the application has been forwarded to the local County Assistance Office (CAO) for a determination of Medicaid eligibility. The contractor will send summary screens to the CAO and will maintain the application on file. The CAO will determine eligibility for Medicaid and notify the family of the result of that determination. If it is determined that income is not within Medicaid guidelines, the children are found to be ineligible and are referred back to the originating CHIP contractor. Initial contact to the CHIP contractor is by phone within two days of the determination and is followed up in writing. A challenge here is that applicants will ignore correspondence from the local CAO because they did not apply for Medicaid. This results in the applicants being denied Medicaid for not providing sufficient information for the CAO to determine eligibility. In this case, the file is not referred back to the contractor and the applicant remains uninsured.

   Income too high: If an application is filed with a CAO and the applicant is found not eligible for Medicaid, the CAO sends a notice of ineligibility to the applicant and explains that the application has been forwarded to one of the CHIP health insurance contractors operating within that county. The CAO prepares an e-referal transmittal to the contractor. All information contained on the transmittal is considered verified and does not require any additional verification by the contractor. Upon receipt of the application from the CAO, the CHIP contractor determines eligibility for CHIP and notifies the family of the determination.

3. Are the same delivery systems (such as managed care or fee for service,) or provider networks used in Medicaid and SCHIP? Please explain.

   Of our eight CHIP health insurance contractors, three participate in Medicaid Managed Care. However, many providers participate in more than one insurer's provider network, which allows a child to continue receiving treatment from the same physician when the child's coverage shifts from Medicaid to CHIP and vice versa. Medicaid continues to utilize fee-for-service in areas of the state where managed care is not available. CHIP uses managed care programs statewide (either traditional HMO or PPO).

4. For states that do not use a joint application, please describe the screen and enroll process.

ELIGIBILITY REDETERMINATION AND RETENTION

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

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

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program? Three
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)

  The first notice is initiated 97 days prior to the end of a child's enrollment period, ensuring at least a 90-day notice to the family. Additional notices are sent to give a 60-day and a 30-day notice if the renewal is not received from the family. Telephone outreach is also provided between the 60- and 30-day renewals by the insurance contractors and between the 30-day notice and termination by our health and human services helpline.

☐ Sends targeted mailings to selected populations

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

☒ Holds information campaigns

☒ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Renewal letters and forms have been revised to a more user-friendly format. Renewals are prepopulated with the applicant's information to the extent that the systems will allow. Use of COMPASS, the Commonwealth of Pennsylvania Access to Social Services, allows for electronic renewal and electronic signature. COMPASS is a Web-based application used to apply for many of the social services, including CHIP. Use of the electronic signature eliminates the requirement to fax or mail the signature page

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

The Department tracks the disenrollment population and reviews this data on a monthly basis with CHIP health insurance contractors. Through a joint effort between CHIP and its contractors, the rate of disenrollment has stabilized.

☐ Other, *please explain*:

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

   The number of enrollees who do not respond or fail to complete renewals has leveled off over the past year. All of the above strategies contribute to the high renewal rates.

3. What percentage of children in the program are retained in the program at redetermination (i.e., (# children retained/total # children up for redetermination) * 100)? What percentage of children in the program are disenrolled at redetermination (i.e., (# children disenrolled/total # children up for redetermination) * 100)

   In FY 2008, there were 166,746 children up for redetermination. Of those 166,746, there were 144,716 from which we received a completed renewal (86.8%). From those renewal responses, there were 112,220 (77.5%) who were reenrolled into the CHIP program. Therefore, there were 32,496 (22.5%) children who responded to the redetermination and did not get reenrolled. However, nearly half of these children were referred to Medical Assistance.

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

   ☒ Yes
   ☐ No
   ☐ N/A

   When was the monthly report or assessment last conducted?

   09/01/08 to 09/30/08

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

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

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other (specify)**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
6,255	1,696	27			695	11	91	1	4,011	64

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information. Include the time period reflected in the data (e.g., calendar year, fiscal year, one month, etc.)

The CAPS Data Warehouse provided the Disenrollment Report used here. There were more reasons for disenrollment than the number of children disenrolled because some children had multiple reasons for disenrolling in the program.

The Other column includes:

- Failure to Complete Renewal: 2,464 (39.4%)
- Low Income: 982 (15.7%)
- Failure to Pay Premium: 283 (4.5%)
- Misc. includes individual's request, pregnancy, must be uninsured for six months and other miscellaneous reasons: 282 (4.5%)

Note: We do not specifically track the number of children who remain uninsured at their renewal and we have not performed a study of those enrollees that have not completed the renewal process.

COST SHARING

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

   No

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

   No

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

   N/A

EMPLOYER SPONSORED INSURANCE PROGRAM (INCLUDING PREMIUM ASSISTANCE PROGRAM(S)) UNDER THE SCHIP STATE PLAN OR A SECTION 1115 TITLE XXI DEMONSTRATION

1. Does your State offer an employer sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds?

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

Children

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

☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration

Adults

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

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

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

   ☐ Parents and Caretaker Relatives
   ☐ Childless Adults
   ☐ Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.)

4. What benefit package does the ESI program use?

5. Are there any minimum coverage requirements for the benefit package?

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

7. Are there any limits on cost sharing for children in your ESI program? Are there any limits on cost sharing for adults in your ESI program?

8. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

_____ Number of childless adults ever-enrolled during the reporting period

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

9. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your employer sponsored insurance program (including premium assistance program). Discuss how was this measured?

10. During the reporting period, what has been the greatest challenge your ESI program has experienced?

11. During the reporting period, what accomplishments have been achieved in your ESI program?

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

13. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured?

14. Identify the total state expenditures for providing coverage under your ESI program during the reporting period.

15. Provide the average amount each entity pays towards coverage of the beneficiary under your ESI program:

State: _____

Employer: _____

Employee: _____

16. If you offer a premium assistance program, what, if any, is the minimum employer contribution?

17. Do you have a cost effectiveness test that you apply in determining whether an applicant can receive coverage (e.g., the state's share of a premium assistance payment must be less than or equal to the cost of covering the applicant under SCHIP or Medicaid)?

18. Is there a required period of uninsurance before enrolling in your program? If yes, what is the period of uninsurance?

19. Do you have a waiting list for your program? Can you cap enrollment for your program?

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

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

   (1) prevention,

   (2) investigation,

   (3) referral of cases of fraud and abuse?

   Please explain:

   Yes to all three. Each CHIP health insurance contractor is required to establish written policies and procedures for the detection and prevention of fraud and abuse that may be committed by providers within their networks, by enrollees, or by the CHIP health insurance contractor employees. Each CHIP health insurance contractor must designate appropriate staff to be responsible for the proactive detection, prevention, and elimination of instances or patterns of fraud and abuse involving services to enrollees.

   CHIP health insurance contractors are required to include written provisions in all their contracts with providers and subcontracted entities stating that payments for their services are derived from government funds. Accordingly, each CHIP health insurance contractor is required to advise its providers and subcontractors of the prohibitions against fraudulent activities relating to their involvement with the program.

   Fraud and abuse detection activities must be compatible with the requirements of appropriate law enforcement agencies responsible for fraud and abuse detection and prosecution. CHIP health insurance contractors are held responsible for referring information on suspected fraudulent activities of subcontractors, providers, employees, and enrollees to relevant law enforcement agencies and must cooperate fully with the investigation and prosecution by appropriate law enforcement agencies.

   In the event of successful prosecution, each CHIP health insurance contractor is required to take action to suspend or terminate the person(s) or entity involved in fraudulent activities. CHIP health insurance contractors are required to notify the Department of any actions being taken against a person(s) or entity resulting in successful prosecution for fraudulent activities. In addition to direct notification, each CHIP health insurance contractor is required on an annual basis to report all fraud detection activities.

   If the state does not have a written plan, do managed health care plans with which your program contracts have written plans?

   ☐ Yes

   ☐ No

   Please Explain:

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

Provider Credentialing

0 Number of cases investigated

0 Number of cases referred to appropriate law enforcement officials

Provider Billing

47 Number of cases investigated

_____ Number of cases referred to appropriate law enforcement officials

Beneficiary Eligibility

15 Number of cases investigated

_____ Number of cases referred to appropriate law enforcement officials

Are these cases for:

SCHIP ☒

Medicaid and SCHIP Combined ☐

3. Does your state rely on contractors to perform the above functions?

☒ Yes, please answer question below.

☐ No

4. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain:

The Department has developed a monitoring report that has to be submitted by our health insurance contractors on a yearly basis. Each health insurance contractor is required to keep the Department informed of changes to its written policies and procedures for the detection, prevention, and reporting of fraud and abuse.

CHIP health insurance contractors must provide an organization chart of the office(s)/department(s) responsible for confirming fraud and abuse activity. The names and telephone numbers of management must be included, along with the position titles of other staff members. The health insurance contractor must provide information on senior management personnel to whom the fraud and abuse department directly reports. Health insurance contractors are also required to provide a single point of contact for the Department when communicating about fraud and abuse issues.

Health insurance contractors must identify what departments/employees are specifically trained in fraud and abuse detection, who provides the training, how often the training is provided to each group of employees, and whether training is voluntary or mandatory. The health insurance contractors also have to provide the avenues of communication that are available between fraud and abuse staff and the health insurance contractor's personnel.

Each health insurance contractor must provide the Department with a copy of its provider application. The Department reviews these applications to determine the following: (1) whether the application includes a question that requires the disclosure of any convictions of certain offenses pertaining to

fraud and abuse; and (2) whether the provider has been excluded from providing services under the Medicaid and/or Medicare programs. In addition, the Department asks health insurance contractors if they are checking their provider network against the exclusionary lists of Medicaid and Medicare providers that are maintained by the Office of Medical Assistance Programs and the Office of Inspector General, and how often they are checking these lists.

The Department questions if the health insurance contractor took action to suspend or terminate the provider, subcontractor, employee, or member in the event of successful prosecution, and whether the Department was notified immediately.

When the Department notifies the health insurance contractor of a potential fraud and/or abuse situation, the health insurance contractor is required to provide the Department with a preliminary update in ten (10) days, and then provide an update every thirty (30) days until the case has been resolved.

The health insurance contractors are to report which of the following detection methods are being utilized: manual detection (specify), audits (specify), specific fraud detection software and what it achieves, case referrals, and others.

An individual's legal rights are not to be infringed upon when under investigation for suspected fraud and abuse. Health insurance contractors must explain how an individual is afforded due process of law.

The Department wants to know what procedures the health insurance contractor employs for referring suspected fraud and abuse cases to the appropriate law enforcement officials.

Health insurance contractors are required to report whether they have dedicated toll-free hotlines for reporting suspected fraud and abuse activity. They are also required to report the toll-free number, the hours of operation, and the location of the hotline. If the hotline is outsourced, the name and location of the organization is to be provided. The Department is to be notified of any changes to the number or hours.

The health insurance contractors are to notify the Department of any means available to the providers to verify an individual's eligibility prior to providing a service.

CHIP health insurance contractors are required to include written provisions in all their contracts with providers and subcontracted entities stating that payments for their services are derived from government funds. Accordingly, each CHIP health insurance contractor is required to advise its providers and subcontractors of the prohibitions against fraudulent activities relating to their involvement with the program. CHIP health insurance contractors are required to advise the Department how they monitor their health insurance contractor and/or subcontractors to assure they are providing the same level of fraud and abuse procedural protections as set forth in the contract for the CHIP health insurance contractor.

The Department asks for the following information on fraud detection activities on an annual basis:

- How many fraud and abuse referrals were received in this contract year?
- How many of the referrals received in this contract year were identified through activities internal to the health insurance contractor?
- How many of the referrals received in this contract year were identified through outside sources?
- How many of the referrals received in this contract year were excused or determined to be unfunded?
- How many referrals received in this contract year are currently pending?

- How many referrals received in previous contract years are currently pending?
- What is the total dollar amount involving cases that have been confirmed during this contract year?
- What is the total dollar amount recouped in this contract year for cases received in this contract year?
- What is the total dollar amount recouped this contract year for cases received in previous contract years?
- How many of the total referrals received this contract year involved a provider?
- Provide names of CHIP providers who had their enrollment revoked during this contract year.
- Provide a description of underlying conduct resulting in confirmed cases involving providers.
- How many of the total referrals received this contract year involved a member? How many were confirmed?
- Was any action taken by the health insurance contractor? Describe any action taken.
- How many referrals involved an employee?
- Provide a description of underlying conduct resulting in confirmed cases involving employees.
- How many of the referrals involved a health insurance contractor or subcontractor?
- Provide a description of underlying conduct resulting in confirmed cases involving health insurance contractor or subcontractors.
- Provide name(s) of health insurance contractor or subcontractor of any confirmed cases.
- Has any contract been revoked as a result of investigation?
- How many cases were referred to law enforcement entities?
- How many cases referred were accepted by law enforcement entities?

5. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

☐ Yes

☒ No

Please explain:

Enter any Narrative text below.

Note in response to question number 2 above: Overall, there were 4 cases referred to appropriate law enforcement officials but the health insurance contractors did not differentiate in their annual reports to the CHIP program as to whether they were provider billing cases or beneficiary eligibility cases.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2008. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2008**	**2009**	**2010**
Insurance payments	0	0	0
Managed Care	300,388,537	416,264,822	458,640,313
Fee for Service			
Total Benefit Costs	300,388,537	416,264,822	458,640,313
(Offsetting beneficiary cost sharing payments)	-8,864,268	-12,283,701	-13,534,174
Net Benefit Costs	$ 291,524,269	$ 403,981,121	$ 445,106,139

Administration Costs			
Personnel	1,084,365	21,66,311	2,536,428
General Administration	3,375,800	6,744,071	7,896,305
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	5,224,340	4,500,000	4,500,000
Other (e.g., indirect costs)			
Health Services Initiatives			
Total Administration Costs	9,684,505	13,410,382	14,932,733
10% Administrative Cap (net benefit costs ÷ 9)	32,391,585	44,886,791	49,456,238

Federal Title XXI Share	204,400,274	284,494,048	313,562,495
State Share	96,808,500	132,897,455	146,476,377

TOTAL COSTS OF APPROVED SCHIP PLAN	301,208,774	417,391,503	460,038,872

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

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

3. Did you experience a short fall in SCHIP funds this year? If so, what is your analysis for why there were not enough Federal SCHIP funds for your program?

No

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month cost rounded to a whole number. If you have SCHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2008		2009		2010	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	168,691	$ 162	187,937	$ 171	211,403	$ 181
Fee for Service		$		$		$

Enter any Narrative text below.

In number 4 above, the PMPM amounts are rounded.
The large increase in program costs from 2008 to 2009 is due to paying September 2008 invoices in the Federal Fiscal Year 2009. The September 2008 program cost was $27,639,620.40.
For the PMPM, the average total enrollment less the average full-cost enrollment for that fiscal year was used to find the average enrollment in the fiscal year. The total cost of the approved SCHIP plan was divided by the number of months in the year and then divided by the average enrollment to get the PMPM.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

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

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

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
	* Upper % of FPL are defined as Up to and Including									
Children	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Parents	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Childless Adults	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Pregnant Women	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *

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

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

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

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

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

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children? You are required to evaluate the effectiveness of your demonstration project, so report here on any progress made in this evaluation, specifically as it relates to enrollment, retention, and access to care for children.

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2007 starts 10/1/06 and ends 9/30/07).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2008**	**2009**	**2010**	**2011**	**2012**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care per member/per month rate @ # of eligibles					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #1					

Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					

Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #2					

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

Insurance Payments					
Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #3					

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

Insurance Payments					
Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #3					

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

Administration Costs

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

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

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

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

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

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

   In January 2007, Governor Rendell introduced his Prescription for Pennsylvania. The Prescription for Pennsylvania is a set of integrated, achievable, practical strategies focused on driving down costs, providing access to universal coverage, improving the quality of health care and driving down the inefficiencies of the health care system. A key component of this strategy is a program to provide access to quality, affordable health care to the uninsured. This coverage would be offered through the private insurance market.

   The Governor's Office of Health Care Reform continues to encourage and initiate statewide healthcare efforts relating to both children and adults. In addition to the four initiatives reported in our annual report last year: (1) childhood obesity, (2) mental health, (3) early childhood interventions relating to preventive care and education, and (4) the need for a medical home, the Administration is implementing new programs to improve the way we treat chronic disease, change and improve patient safety, allow all health care professionals such as advance practice nurses and physician assistants to practice to the full extent of their education and training, and make pay-for-performance part of the Medical Assistance program. These initiatives, along with others, are still in the developmental stages or are before the legislature for consideration so their overall impact on SCHIP cannot be determined at this point.

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

   Reaching Pennsylvania's remaining uninsured children and teens has been a great challenge for CHIP. The multi-pronged marketing and outreach approach discussed in Section III describes how the program rose to that challenge. The result has been an increase in enrollment numbers in all categories of the program – a total enrollment increase of 7 percent.

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

   Pennsylvania was fortunate to successfully expand its CHIP eligibility from 200% of the FPL to 300% of the FPL through the Governor's Cover All Kids initiative. Since its implementation in March 2007, Pennsylvania's CHIP enrolled 9,194 children who would not have been previously eligible. Overall, Pennsylvania CHIP has enjoyed a 7% increase in enrollment over September 2007. The expanded outreach implemented as a result of the Cover All Kids initiative is also credited with an increase in enrollment for children in Medicaid.

   Automated Referrals – Pennsylvania pursued an automated solution to assist in the retention of children in its CHIP and Medicaid programs. Leakage had occurred in the transferring of children between the CHIP and Medicaid programs. Previously, all transactions were done manually, causing either delay in a transfer or, in the worst cases, children losing coverage due to a transfer not occurring. In March 2008, a pilot program began in five Counties for the purpose of electronically transferring client health care applications between Medicaid programs and CHIP. Key reason codes trigger these referrals between programs. In October 2008, the pilot was expanded to electronically transfer applications statewide. This new automated process has shown to be very effective in both facilitating continuity of client coverage and assuring that no one "falls through the cracks."

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

   CHIP and its marketing partners are working to form new community relationships with Pennsylvania businesses, including hospital associations, day care centers, and employment staffing agencies.

These partnerships will provide specific CHIP information to be distributed to families that are more likely to be in a state of need.

CHIP is currently working on a direct mail pilot project that will deliver a CHIP postcard to over 250,000 addresses in the Pittsburgh area. This mailing is targeted at lower-income families to encourage them to apply for CHIP.

CHIP is adding sections for school districts and legislators to the current electronic toolkit on the CHIP Web site. This toolkit will contain specific information for each audience. CHIP has spoken to representatives from both targets in order to develop the materials that they find the most useful. By giving school districts and legislators the tools they need, we ensure that there is consistency and cohesion in the CHIP message across all channels of communication.

Update to the Study of Insurance Status in Pennsylvania - Pennsylvania is in the process of updating the 2004 study. From September 2007 through May 2008, individuals in over 20,000 households were interviewed concerning their health care coverage. These individuals represented every county in the commonwealth. Some of the results are:

- The number of uninsured Pennsylvanians rose from under 900,000 in 2004 to over 1,000,000 in 2008.
- The number of both uninsured children and adults increased from 2004 to 2008.
- Over 17% of the uninsured have been without health insurance for over 5 years.
- Over 1/3 of the uninsured are between the ages of 19 and 29.
- Nearly 18% of Pennsylvanians are covered by state-sponsored health care coverage. Most of these individuals indicated that they would not be able to obtain private coverage if the state-sponsored programs were not available.
- Over 90% of parents with a child enrolled in CHIP would recommend the program to a friend, family member, or coworker with an uninsured child.

We expect to use the results of the study to further develop and/or revise programs and policies to reduce the number of individuals without health insurance.

We are in the final stages of review of the survey results directed at determining reasons previous enrollees are no longer enrolled in CHIP. Based on the analysis of the survey results, Pennsylvania may take steps to modify the processes around retention and renewal.

Enter any Narrative text below.

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

www.chipcoverspakids.com

1-800-986-KIDS

Pennsylvania Children's Health Insurance Program (PA CHIP)

HEDIS® 2008 Performance Report

Prepared for the Pennsylvania Insurance Department
Office of CHIP and adultBasic

December 8, 2008

EDWARD G. RENDELL, GOVERNOR
JOEL ARIO, INSURANCE COMMISIONER

Background

Title XXI of the Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP), to address the growing problem of children without health insurance. SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough to purchase private insurance. The current Pennsylvania Children's Health Insurance Program (PA CHIP) was established in 1998 following the repeal of the existing Children's Health Care Act and enacting of Act 1998-68 by the State Senate.

PA CHIP is administered through the Pennsylvania Insurance Department (PID), with the CHIP program supported by both state and federal funds. The program provides payment for health care coverage for eligible children who meet income and other criteria. Approximately 171,200 children are currently enrolled in PA CHIP.

The *Cover All Kids* initiative, led to the expansion of the CHIP program to include all uninsured children and teens in the Commonwealth who are not eligible for Medical Assistance. CHIP is provided by the following private health insurance companies that are licensed and regulated by the Pennsylvania Insurance Department and have contracts with the Commonwealth to offer CHIP coverage.

- **Aetna, Inc.**
- **AmeriChoice of Pennsylvania**
- **Blue Cross of Northeastern PA (BCNEPA)**
- **Capital Blue Cross (CBC)**
- **Keystone Health Plan East**
- **Highmark Blue Cross Blue Shield**
- **Highmark Blue Shield**
- **Unison Kids**
- **UPMC for Kids**

Insurance Department
COMMONWEALTH OF PENNSYLVANIA

Report Card Description

CHIP health insurance company performance is assessed using Healthcare Effectiveness Data Information Set (HEDIS®) 2008 performance measures and the 2008 Consumer Assessment of Healthcare Provider Systems (CAHPS®) 3.0H Survey items and is presented in three sections: Access to Care, Quality of Care and Satisfaction with Care.

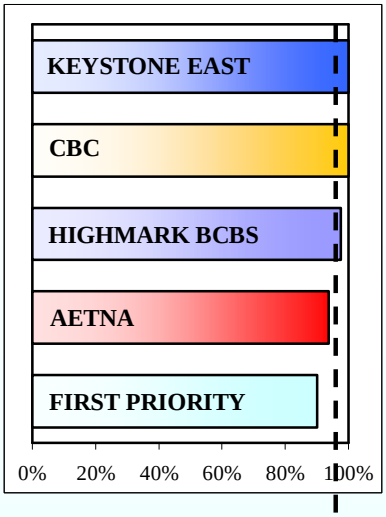
For HEDIS 2008 performance measures, a chart is presented with each bar representing the percentage of CHIP members receiving a specific type of care from their CHIP provider. For charts representing CAHPS survey items, each bar represents the percentage of respondents who selected option 8 or higher on a scale of 1 to 10 when rating the care provided by their CHIP provider.

For each performance indicator, the CHIP health insurance companies are presented in order of performance from high to low with higher performing health insurance companies at the top of each chart.

In addition, the PA CHIP statewide weighted average is represented on each chart by a dotted line. The PA CHIP weighted average is calculated as the total number of events program wide divided by the eligible population program wide.

Insurance Department
COMMONWEALTH OF PENNSYLVANIA

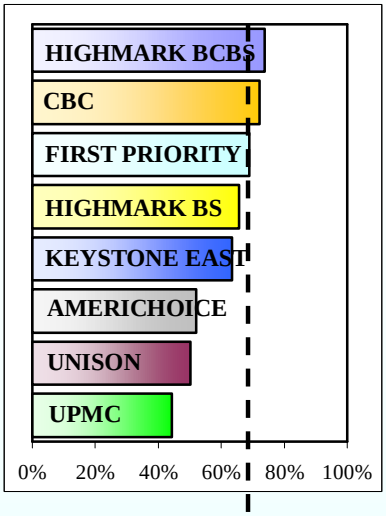
Access to Care: Are children receiving care?



PA CHIP Weighted Average

Regular Checkups for Children in the First 15 Months

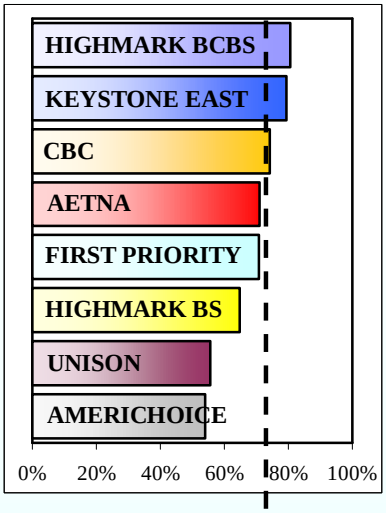
Children who had 3 or more well-child visits with a PCP before turning 15 months old (3, 4, 5 or 6+ visits)



PA CHIP Weighted Average

Annual Dental Visits

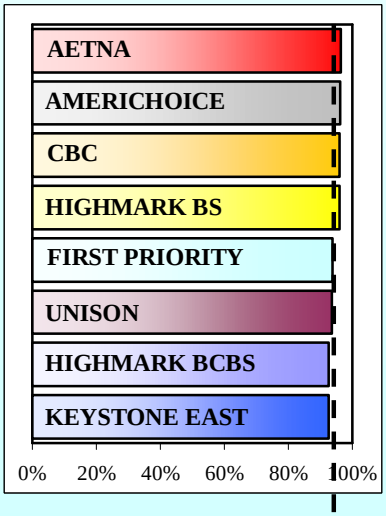
Children and adolescents 2-19 who had a dental visit in the past year



PA CHIP Weighted Average

Childhood Immunization Status – Combination 3

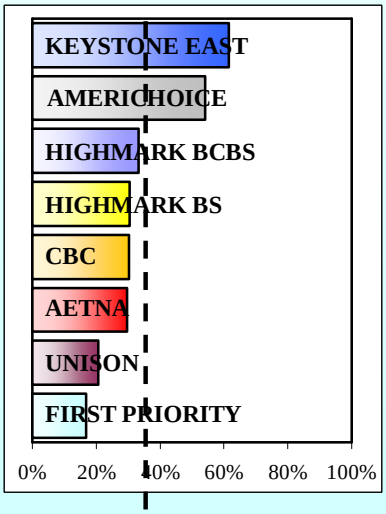
Children who received all recommended vaccines prior to their 2nd birthday



PA CHIP Weighted Average

Use of Appropriate Medication for Children with Asthma

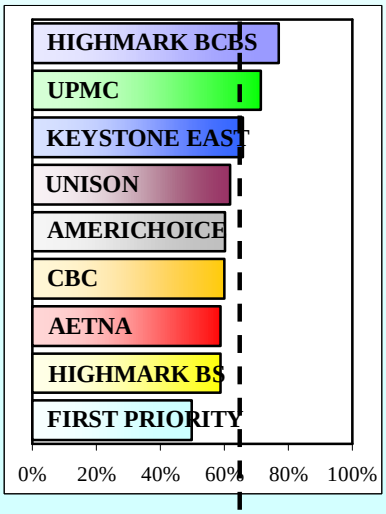
Children and adolescents 5-19 who were diagnosed with persistent asthma and prescribed appropriate medication



PA CHIP Weighted Average

Lead Screening for Children

Children who were tested for lead by their 2nd birthday



PA CHIP Weighted Average

Testing for Children with Pharyngitis (sore throat)

Children 2-18 with a sore throat who were prescribed an antibiotic and tested for Streptococcous bacteria

* Insurance companies with less than 30 CHIP members were excluded from Performance Measure comparisons

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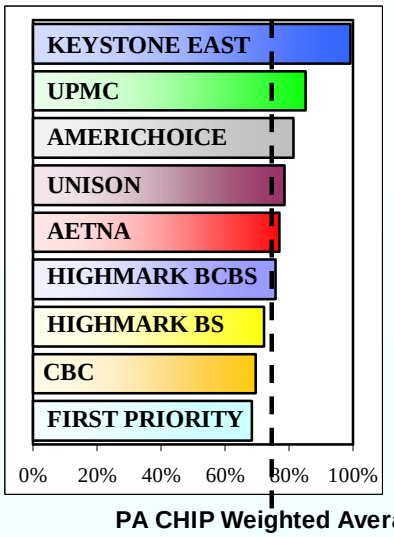
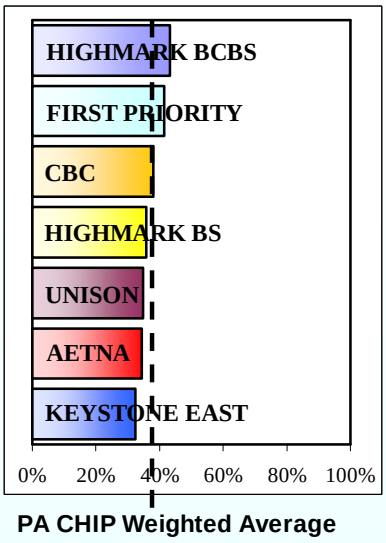
Quality of Care: How good is the care being provided?



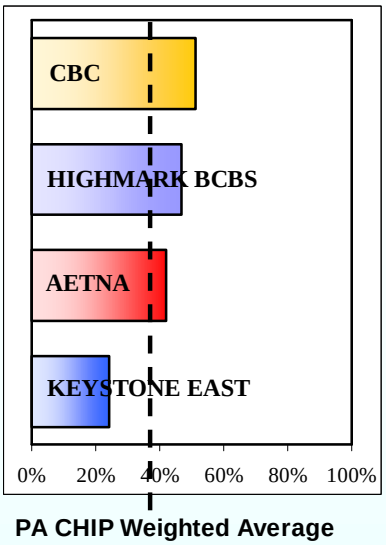
Appropriate Treatment for Upper Respiratory Infection

Children 3 months – 18 years with the common cold who were not prescribed an antibiotic



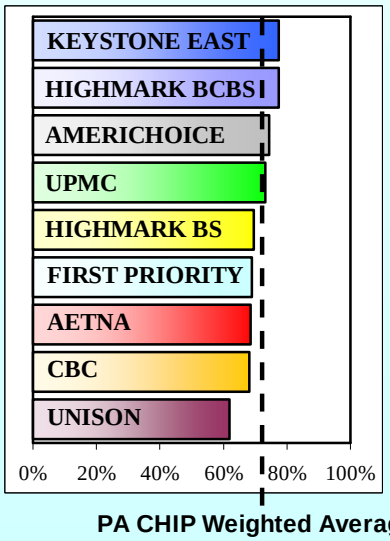
ADHD Follow-Up Care Initiation Phase

Children 6-12 with one follow-up visit within 30 days of being prescribed medication for Attention Deficit Disorder (ADD)



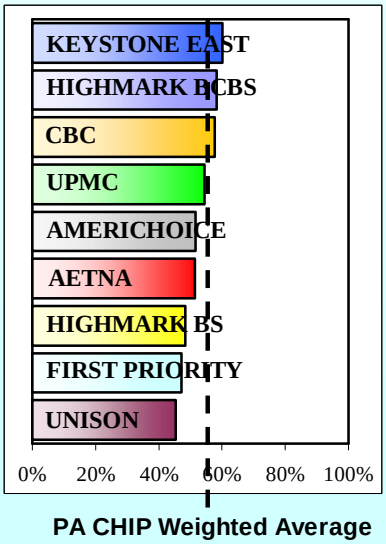
ADHD Follow-Up Care Continuation and Maintenance Phase

Children 6-12 with one follow-up visit during the initiation phase and at least 2 additional visits during the following 9 months



Regular Checkups for Children 3-6 Years Old

Children 3-6 who had one or more well-child visit with a PCP



Regular Checkups for Adolescents

Adolescents 12-19 who had at least one well-care visit with a PCP or OB/GYN

* Insurance companies with less than 30 CHIP members were excluded from Performance Measure comparisons

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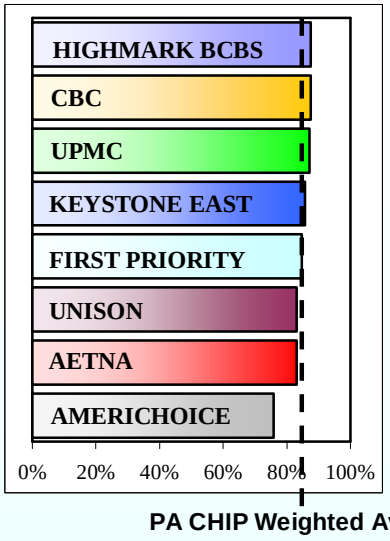
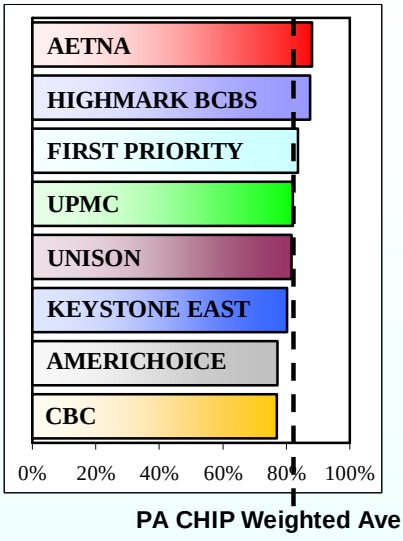
Satisfaction with Care: Is the care meeting your needs?



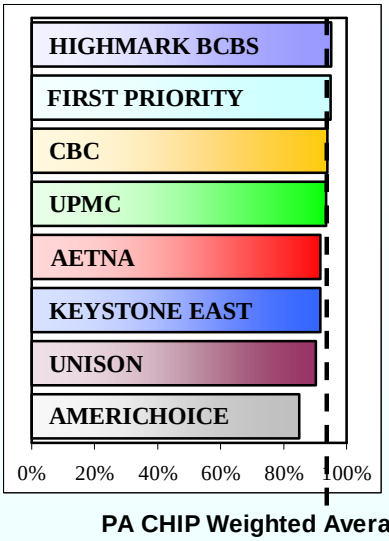
Satisfaction With Current Doctor or Nurse

Parent/Guardian rated their child's current Doctor or Nurse 8 or higher on a scale of 0 to 10



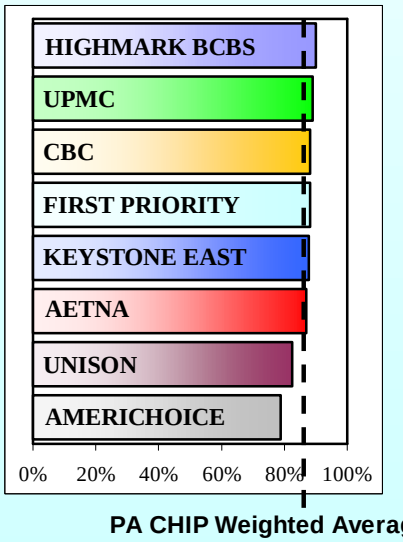
Satisfaction With Your Child's Specialist

Parent/Guardian rated their child's Specialist 8 or higher on a scale of 0 to 10



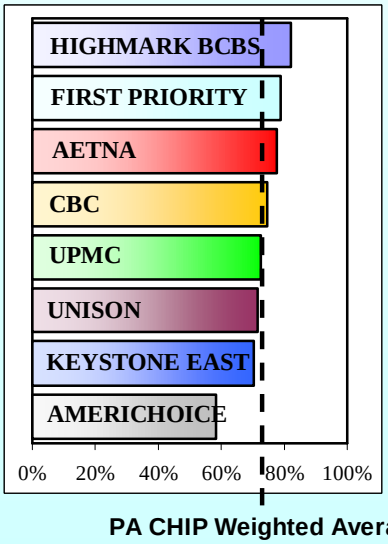
Child Is Able To Get Urgent Care As Soon As Necessary

Parent/Guardian responded "usually" or "always" able to get urgent care



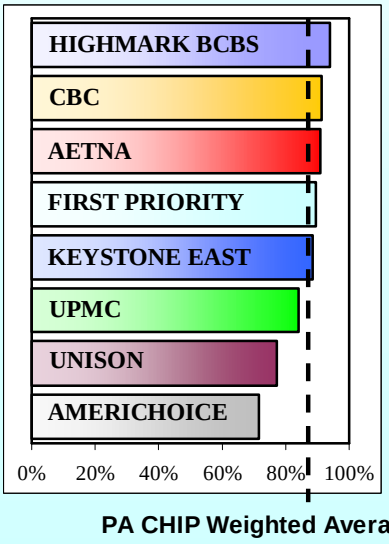
Satisfaction With your Child's Health Care

Parent/Guardian rated their child's Health Care 8 or higher on a scale of 0 to 10



Satisfaction With Customer Service

Parent/Guardian stated that customer service was "not a problem"



Satisfaction With Your CHIP Health Plan

Parent/Guardian rated their child's CHIP health plan 8 or higher on a scale of 0 to 10

* Highmark Blue Shield did not administer a CAHPS® survey

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CHIP Provider Contact Information

AETNA
930 Harvest Drive
PO BOX 937, U32N
BLUE BELL, PA 19422
1-800-822-2447

AMERICHOICE
CHIP Plan – Enrollment Application
Attn: Enrollment Department
PO Box 6300
Eau Claire, WI 54701
1-877-289-1917

CAPITAL BLUE CROSS
PO Box 777014
2500 Elmerton Avenue
Harrisburg, PA 17110-9956
1-800-543-7101

BLUE CROSS OF NEPA
Attn: CHIP/adultBasic
19 N Main St.
Wilkes Barre, PA 18711-9989
1-800-543-7199

HIGHMARK BLUE SHIELD
Attn: CHIP
PO Box 890175
Camp Hill, PA 17001-9705
1-866-727-5437

HIGHMARK BLUE CROSS BLUE SHIELD
PO Box Caring
Pittsburgh, PA 15230-9779
1-800-543-7105

KEYSTONE HEALTH PLAN EAST
Caring Foundation
PO Box 13449
Philadelphia, PA 19101-9552
1-800-464-5437

UNISON KIDS
Unison Administrative Services, LLC.
Unison Plaza
1001 Brinton Road
Monroeville, PA 15221
1-800-414-9025

UPMC HEALTH PLAN
PO Box 2875
Pittsburgh, PA 15230-9911
1-800-978-8762

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1-800-986-KIDS