Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care External Quality Review Organization

2007-2008 Annual Report of Performance for Western Health Advantage

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DHCS
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Improving Health in the Communities We Serve

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2007 - 2008 Annual Report: Western Health Advantage

Introduction

The Medi-Cal Managed Care Division (MMCD) of the California Department of Health Care Services (DHCS) contracts with managed care plans to provide care to 3.4 million Medi-Cal beneficiaries enrolled in managed care plans in 23 counties throughout California. Healthcare providers within each plan's contracted network provide comprehensive healthcare services—primary and preventive care, as well as the full range of specialty care mandated by federal and state law.

Federal law pertaining to Medicaid managed care programs (42 CFR § 438.240) requires the DHCS to contract with an External Quality Review Organization (EQRO) to independently evaluate the quality of care provided to Medi-Cal beneficiaries enrolled in any of California's managed care plans. The DHCS has retained the services of the Delmarva Foundation for Medical Care, Inc. (Delmarva) as its EQRO to provide this independent evaluation as to whether the care and service delivered meets the federal standards for quality, access, and timeliness. Among the services provided by the EQRO is an annual assessment of each contracted plan's "… quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract…" as stated in Title 42 of the U.S. Codes.

This annual review is for the reporting years 2007 and 2008, covering performance results and quality improvement activities during 2006 and 2007.

Definitions

The terms quality, access, and timeliness provide the framework for this plan-specific review of Western Health Advantage ("WHA" or "the plan"). Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions are provided below:

- **Quality**, as it pertains to external quality review, is defined by the Centers for Medicare & Medicaid Service (CMS) as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." (CMS, 2008.)

- **Access** (or accessibility) to health care, according to the Agency for Healthcare Research and Quality (AHRQ), means having "the timely use of personal health services to achieve the best health outcomes. Attaining good access to care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services; and, finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust." (AHRQ, 2007.)

- **Timeliness,** according to AHRQ, is defined as "…the health care system's capacity to provide health care quickly after a need is recognized….Measures of timeliness include waiting time spent in doctors' offices and emergency departments (EDs) and the interval between identifying a need for specific tests and treatments and actually receiving those services." (AHRQ, 2007.)

It is important to note that some interdependence exists among the categories (also referred to as "domains") of quality, access, and timeliness. A measure or attribute identified in one of the categories of quality, access, or timeliness may also be noted under one or both of the other two categories throughout this review.

Data Sources

Delmarva used five sets of standards or information sources for the evaluation of performance. Each of the sources listed were used to systematically assess the contracted health plan's ability to provide its members with care that meets the requirements for quality, access, and timeliness:

- The Healthcare Effectiveness Data and Information Set (HEDIS®)[1] is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). These measures are used by health care purchasers to assess the quality, access, and timeliness of care and service provided to members of managed care plans.

- In June 2007, each DHCS health plan submitted its results to Delmarva for the 12 required HEDIS measures, which reflect 16 measurement indicators, since several measures have multiple indicators.[2] The 2007 HEDIS results reflect data collected for the period January 1, 2006, through December 31, 2006.

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[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008).

[2] In 2007 and 2008, the DHCS required plans to report on 12 HEDIS measures. Some of these measures have multiple indicators (such as the *Comprehensive Diabetes Care* measure), so results are presented for the total number of indicators – 16 in 2007 and 23 in 2008. This report refers to the total number of indicators reported as "measures" since a result is reported for each indicator.

- In June 2008, each DHCS health plan submitted its results for the 12 required HEDIS measures, which reflect a total of 23 indicators. The 2008 HEDIS results reflect data collected for the period January 1, 2007, through December 31, 2007.[3] For a more detailed explanation of HEDIS, see the "Quality Assessment" discussion later under "HEDIS Performance Measures" and Appendix A: HEDIS.

- AHRQ developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] surveys to support the assessment of consumers' experiences with health care. This report utilizes results from the 2007 4.0H Adult Medicaid and the 3.0H Child Medicaid. Delmarva conducted these surveys between February and May 2007. For a more detailed explanation of CAHPS, see "Quality Assessment" in this report, see subsection "CAHPS Survey Results" and Appendix B: CAHPS.

- Summaries of plan-conducted Quality Improvement Projects conducted during the period January 1, 2006, and December 31, 2007.

- The DHCS's Audits and Investigations Division and the California Department of Managed Health Care jointly conduct audits to assess compliance with contract requirements and state regulations. Findings from any audits that were conducted during the period January 1, 2006, and December 31, 2007, will be discussed in this report.

- Grievance and appeal data by contracted plans submitted to the DHCS and reports prepared by MMCD's Office of the Ombudsman during 2006 and 2007.

Report Organization

This report provides the plan's background and discusses each data source within the framework of quality, access, and timeliness. Due to some variations between the measures reported in the 2007 and 2008 HEDIS reports, the results and analysis of this source are presented separately by year. Where appropriate, sustainability of the plan's performance is discussed. The plan's performance is compared to other plan models of similar type and other state and national benchmarks. The document concludes with the plan's overall strengths and recommendations for improving the plan's quality of care, access to care, and timeliness of care for its members.

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[3] The *Report of the [Annual] Performance Measures for Medi-Cal Managed Care Members* is produced for the DHCS by the EQRO from the measurement results and comparisons of all contracted plans.

[4] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ, 2008).

Background

WHA is a full-service health plan contracted in Sacramento County as a Geographic Managed Care (GMC) plan—one of three plan model types. GMC plan members choose from several commercial plans within a geographic area—in this case, Sacramento County. Enrollment is mandatory for some specified Medi-Cal beneficiaries and voluntary for others. WHA has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since September 19, 1997. As of December 2007, WHA's Medi-Cal enrollment was 12,803 members.

Quality of Care Assessment

According to the CMS (2008), "[q]uality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results." The section below describes the measures used to assess WHA's healthcare delivery in regards to quality.

HEDIS Performance Measures

Delmarva categorized the HEDIS performance measures used in this report into quality, access, and timeliness areas for assessment. For a more detailed explanation of HEDIS and the specific HEDIS measures used in this report, see Appendix A: HEDIS.

Changes in HEDIS Performance Measures from 2007 to 2008

Health plans reported on 12 measures for the HEDIS 2007 reporting year, which included multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum Care*. The 2007 reporting year represents the data collection period January through December 2006. MMCD made some performance measure changes between 2007 and 2008 reporting years as explained below.

MMCD retired the *Chlamydia Screening for Women* performance measure from the required measurement set. The required HEDIS measures included several other measures focused on women's health screening (*Breast Cancer Screening* and *Cervical Cancer Screening*) and overall plan results for *Chlamydia Screening* had trended upward for a number of years. As a result, MMCD decided to eliminate the *Chlamydia Screening* measure and, instead, require the *Ambulatory Care* measure in order to focus more on the entire Medi-Cal managed care population, including seniors and persons with disabilities.

The *Ambulatory Care* measure provides utilization information across the whole spectrum of the population – from birth to 85+ years of age. Plus, this measure provides insight regarding emergency room (ER) use,

which is an area of particular interest to MMCD because many members use the ER for avoidable visits and, as a result, may not be getting appropriate preventive care and follow-up care with chronic conditions. The *Ambulatory Care* measure consists of four indicators:

- *Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)*
- *Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)*
- *Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)*
- *Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)*

Additionally, in order to increase the focus on chronic diseases, MMCD added three more *Comprehensive Diabetes Care* indicators:

- *Comprehensive Diabetes Care—HbA1c Control (<7.0%)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- *Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*

Comparisons of HEDIS Performance Measures

This report contains several charts displaying HEDIS rates for WHA and state and national benchmarks used for assessing plan performance. The plan's multi-year performance is also evaluated.

In some years, MMCD makes changes to the list of required measures. Moreover, NCQA continually updates the technical specifications for HEDIS measures. Some of the specification changes or a combination of changes can cause a significant change in the results and make comparisons with previous years' rates inappropriate. MMCD does not hold the plan to the Minimum Performance Level (MPL) in the baseline year (the first year a score is reported) and does not compare results to previous years in years when a measure's specifications have changed substantively. For these reasons, rates for measures may be displayed in the charts, but not compared in the narratives.

2007 HEDIS Quality Performance Measures

Table 1 provides WHA's 2007 HEDIS results for those measures specifically related to clinical quality of care along with the state's 2007 Medi-Cal managed care weighted averages[5] and the 2006 national Medicaid averages for these measures.

Table 1. 2007 HEDIS Quality Measure Results Comparing Western Health Advantage to State and National Programs.

2007 Quality Measure	2007 Western Health Advantage Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Appropriate Treatment for Children With Upper Respiratory Infection	92.8%	78.9%	82.5%
Chlamydia Screening in Women	61.0%	52.8%	50.6%
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis†‡	72.3%	71.0%	69.4%
Use of Appropriate Medications for People With Asthma	83.8%	86.8%	85.7%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.3%	54.1%	48.6%
Comprehensive Diabetes Care—HbA1c Testing	82.0%	79.5%	76.2%
Comprehensive Diabetes Care—LDL-C Screening‡	69.6%	75.9%	80.5%
Comprehensive Diabetes Care—Medical Attention for Nephropathy‡	70.6%	81.0%	48.8%
Cervical Cancer Screening‡	58.4%	67.9%	65.0%

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*.
† For this 2007 measure, a lower rate indicates better performance.
‡ Due to significant changes in technical specifications, MPLs and HPLs had not yet been established for 2007. The rate is displayed for informational purposes only and will not be compared to benchmarks.

WHA scored better than the 2007 Medi-Cal managed care weighted average and 2006 national Medicaid average in three of the five comparable HEDIS measures in the quality domain: *Appropriate Treatment for Children With Upper Respiratory Infection, Chlamydia Screening in Women,* and *Comprehensive Diabetes Care—HbA1c Testing.* WHA performed lower than the Medi-Cal managed care weighted average for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.* WHA performed worse than both the Medi-Cal managed care weighted average and the Medicaid HEDIS average for the measure *Use of Appropriate Medications for People With Asthma.*

[5] For each measure, a Medi-Cal managed care weighted average has been calculated to provide a comparative statistic. A weighted average, unlike a simple average, accounts for variations in membership across plans.

2008 HEDIS Quality Performance Measures

Table 2 provides WHA's 2008 HEDIS results for those measures specifically related to clinical quality of care along with the state's 2008 Medi-Cal managed care weighted averages and the 2007 national Medicaid averages for these measures.

Table 2. 2008 HEDIS Quality Measure Results Comparing Western Health Advantage to State and National Programs.

2008 Quality Measure	2008 Western Health Advantage Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Appropriate Treatment for Children With Upper Respiratory Infection	95.5%	83.1%	83.3%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis†‡	31.1%	28.4%	†
Use of Appropriate Medications for People With Asthma	84.0%	88.8%	87.1%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.8%	58.1%	51.4%
Comprehensive Diabetes Care—HbA1c Testing	78.8%	82.1%	78.0%
Comprehensive Diabetes Care—HbA1c Control (<7.0%)‡	24.1%	32.6%	¶
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)‡§	51.6%	42.6%	48.7%
Comprehensive Diabetes Care—LDL-C Screening Performed	67.2%	77.8%	71.1%
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)‡	37.0%	34.2%	30.6%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.7%	78.3%	74.6%
Cervical Cancer Screening	59.9%	68.7%	65.7%

* Rates obtained from the Report of the 2008 Performance Measures for Medi-Cal Managed Care Members.
† The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis,* and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score is better.
‡ 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.
§ A lower rate for this measure is better as it represents better diabetes control.
¶ NCQA first-year measure; national benchmark not available.

WHA's rates were higher than both benchmark performance rates for *Appropriate Treatment for Children With Upper Respiratory Infection* and *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.* The plan scored below the Medi-Cal managed care weighted average on the measure, *Comprehensive Diabetes Care—HbA1c Testing*, but

above the national benchmark. WHA rates for the *Use of Appropriate Medications for People With Asthma, Comprehensive Diabetes Care—LDL-C Screening Performed, Comprehensive Diabetes Care—Medical Attention for Nephropathy,* and *Cervical Cancer Screening* were below their respective state and national benchmarks. MMCD retired the *Chlamydia Screening for Women* performance measure from the required measurement set for 2008.

CAHPS Survey Results Pertaining to Quality

During this reporting period, the 2007 CAHPS 4.0H Adult Medicaid and 3.0H Child Medicaid Surveys were conducted among Medi-Cal Managed Care's contracted health plans. The table reflects survey results for three populations: Adult, Child, and Children with Special Health Care Needs (CSHCN). (See Appendix B: CAHPS for further detail.)

Delmarva chose two CAHPS composite areas to most appropriately represent the quality domain in this report: *Getting Needed Care* and *How Well Doctors Communicate*. Table 3 shows the plan's CAHPS scores for these composite categories.[6]

Table 3. 2007 CAHPS Quality Survey Results Comparing Western Health Advantage to the Medi-Cal Managed Care Plan Average.

CAHPS Composite	Population	2007 Western Health Advantage Results	2007 Medi-Cal Managed Care Weighted Average*
Getting Needed Care	Adult	38%	40%
	Child	77%	80%
	CSHCN†	72%§	‡
How Well Doctors Communicate	Adult	64%	59%
	Child	62%	52%
	CSHCN†	64%	‡

* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.
† CSHCN - Child with Special Health Care Needs.
‡ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.
§ The plan received <100 responses to some of the questions in this area, so this result is not statistically valid.

WHA's composite score for *Getting Needed Care* indicates some possible areas for improvement with just 38 percent of adult members responding that they got the care they needed. It should be noted, however, that WHA's score was only two percentage points lower than the 2007 Medi-Cal managed care weighted average in this category. Sixty-four percent of WHA's adult members indicated their doctor communicated well,

[6] See Appendix B: CAHPS for further detail about categories and the DHCS's "Results of the 2007 CAHPS for Medi-Cal Managed Care Health Plans" for more detail about calculation methods.

ranking WHA higher than the Medi-Cal managed care weighted average for the composite regarding *How Well Doctors Communicate*.

Parents/guardians of child members appeared more pleased in these two areas than WHA's adult members. Seventy-seven percent of parents/guardians indicated they had no problem getting needed care while 62 percent (significantly higher than the Medi-Cal managed care weighted average) of parents/guardians indicated their doctor or health care provider communicated well.

Quality Improvement Projects

One of WHA's Quality Improvement Projects (QIPs)—*Improving Diabetes Care*—is categorized in the quality domain for assessment purposes. The QIP and its results are discussed below:

Improving Diabetes Care

- ***Relevance:***

  WHA reported that diabetes ranked as a top ten diagnosis by frequency of services per thousand and by cost.

- ***Goals:***
  - Improve the HEDIS rates for *Comprehensive Diabetes Care* measures: *HbA1c Testing, LDL-C Screening, Retinal Eye Exams,* and *Nephropathy Monitoring*.
  - Increase participation, by 25 percent, of diabetic members in a registry or electronic medical record system that provides tracking and reminders for *HbA1c Testing, LDL-C Screening, Retinal Eye Exams,* and *Nephropathy Monitoring*.

- ***Best Interventions:***
  - Updated and posted diabetes clinical practice guidelines on WHA's website.
  - Implemented diabetes registry that electronically tracks diabetic members.
  - Developed and distributed diabetes self-help brochures to members.
  - Distributed diabetes nephropathy toolkit to primary care providers.

- ***Outcomes:***
  - Improvement over remeasurement rate for *HbA1c Testing*.
    - ◊ 2003 (Baseline): 62.1%
    - ◊ 2004 (Remeasurement 1): 68.6%
    - ◊ 2005 (Remeasurement 2): 81.5%
    - ◊ 2006 (Remeasurement 3): 82.5%

- Improvement over remeasurement rate for *LDL-C Screening*.
  - ◊ 2003 (Baseline): 12.6%
  - ◊ 2004 (Remeasurement 1): 71.1%
  - ◊ 2005 (Remeasurement 2): 87.4%
  - ◊ 2006 (Remeasurement 3): 89.3%

- Improvement over remeasurement rate for *Retinal Eye Exams*.
  - ◊ 2002 (Baseline): 38.2%
  - ◊ 2003 (Remeasurement 1): 44.8%
  - ◊ 2004 (Remeasurement 2): 45.5%
  - ◊ 2005 (Remeasurement 3): 48.2%

- Improvement over remeasurement rate for *Monitoring Diabetic Nephropathy*.
  - ◊ 2003 (Baseline): 38.9%
  - ◊ 2004 (Remeasurement 1): 53.8%
  - ◊ 2005 (Remeasurement 2): 56.0%

➢ ***Attributes and Barriers to Outcomes:***

- Attribute: Developed a registry that allowed WHA to generate reminders for diabetes-related care.
- Attribute: Identified members with co-morbidities, which aided in referral to case management and communication to primary care physicians.
- Barrier: Providers lacked technical equipment and internet access, which hindered participation in the registry.
- Barrier: Members lacked education regarding self-management of diabetes.
- Barrier: Providers did not have up-to-date knowledge regarding clinical practice guidelines for diabetes.
- Barrier: Members failed to return to their providers for services, which interrupted appropriate care.

This QIP was closed during this reporting period. WHA improved results of all four measures used in this QIP when baseline (initial) and final reporting periods were compared.

Medi-Cal Audit Findings

The plan was not audited during this reporting period.

Sustainability of Quality Indicators

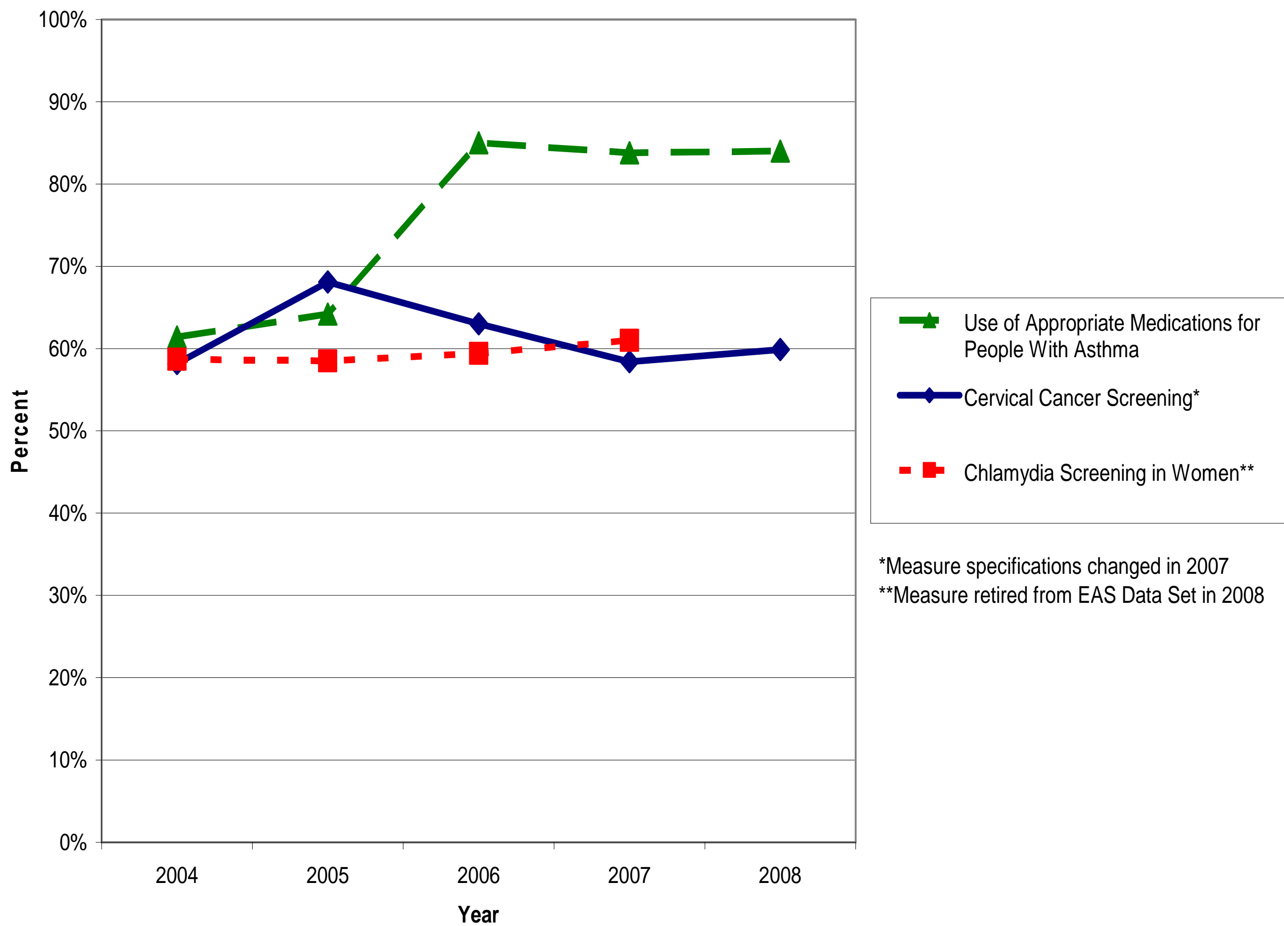
Sustainability of quality improvement correlates with a health plan's ability to bring about positive change in health care processes. For the purpose of this report, a plan's ability to achieve sustainability is generally categorized as follows:

- Sustained improvement – performance level improves at some point and then levels off or continues to improve.
- Maintaining performance level – rates over multiple years reflect no meaningful change (generally a flat line).
- Declining – performance goes down.

Figure 1 depicts the plan's sustainability of performance in a trending graph. Note that performance measurement results are trended when three or more years of data are available.

WHA showed sustained improvement for the measure, *Use of Appropriate Medications for People With Asthma*. WHA maintained its performance level for *Chlamydia Screening in Women* until the 2007 measurement period when its rates increased 2.7 percent over the last two measurement periods, indicating a slight improvement. The *Chlamydia Screening in Women* measure was retired in 2008. The *Cervical Cancer Screening* measure was assigned specification changes in 2007; however, the measure remained trendable. While the plan achieved an initial rate increase for this measure, the rate declined in 2007 and in 2008 the rate returned to near its original performance level. The plan was unable to demonstrate sustainability for the *Cervical Cancer Screening* measure.

Figure 1. Western Health Advantage's Sustainability of Quality of Care Indicators.



Grievance and Ombudsman Reports

The Medi-Cal Managed Care Division (MMCD) requires that contracted health plans maintain grievance systems as required by state law (California Code of Regulation Title 28, Section 1300.68). All grievances received by a plan—in writing or verbally—must be tracked in a grievance log. Plans submit quarterly reports to MMCD, as well as to the Department of Managed Health Care, with detailed information about pending grievances and those that were not resolved within 30 days (MMCD All Plan Letter No. 03-008).

MMCD's Office of the Ombudsman also provides assistance to members who have questions or problems related to provider and plan services, as well as other areas, such as Medi-Cal eligibility. The Office of the Ombudsman functions, in part, to help solve problems from a neutral standpoint to ensure that members receive all medically necessary covered services for which plans are contractually responsible. Complaints or issues that are not resolved immediately by the Office of the Ombudsman are entered into the Ombudsman

Case Management System (OCMS) for tracking and follow-up. The Office of the Ombudsman also assists members who wish to request a formal hearing with the State Fair Hearings Board.

It should be noted that the DHCS monitors plans' quarterly grievance reports and MMCD Office of the Ombudsman monthly statistics in order to understand what aspects of provider and plan performance generate more or less grievances, calls, or requests for State Fair Hearings over time. Unusual patterns in grievances, calls, or hearing requests are discussed with plans when appropriate. The DHCS does not generally perceive any particular number of grievances, calls, or hearing requests as indicators of poor plan performance. Rather, these statistics are an ongoing indication of the degree to which plan members are using the various avenues available to them to ask questions or raise concerns about healthcare quality and plan service.

Western Health Advantage's Grievance Reports

WHA reported a total of 147 grievances in quarterly reports during 2006 (three quarters) and all quarters of 2007. WHA categorized grievances as follows:

- Timely assignment to a provider (0)
- Issues related to cultural linguistic sensitivity (0)
- Difficulty with accessing specialists (15)
- Coverage disputes (4)
- Disputes involving medical necessity (5)
- Quality of care (24)
- Access to care, including appointments (54)
- Quality of service (43)
- Other (2)

Office of the Ombudsman's Reports[7]

- 2006: 3 OCMS cases (0.1% of all cases; 0.258 cases per 1,000 members)
- 2006: 10 State Fair Hearings (1.0% of all cases; 0.860 cases per 1,000 members)
- 2007: 9 OCMS cases (0.2% of all cases; 0.744 cases per 1,000 members)
- 2007: 6 State Fair Hearings (1.2% of all cases; 0.496 cases per 1,000 members)

[7] OCMS cases and State Fair Hearings are presented as a percentage of all managed care plan cases and rates per 1,000 members.

Summary of Quality

Delmarva assessed WHA in five areas of the quality domain: HEDIS performance measures, CAHPS survey results, QIPs, sustainability, and grievance and Ombudsman reports. No audit results were available for this reporting period.

When comparing WHA's 2007 rates to the Medi-Cal managed care weighted average, the plan performed better in three of the five comparable measures in the quality domain. When comparing 2007 HEDIS scores, WHA scored better than the 2006 national Medicaid average in four of the six comparable HEDIS measures. WHA performed worse than both the Medi-Cal managed care weighted average and the Medicaid HEDIS average for two measures and for one Medi-Cal managed care weighted average.

For the 2008 reporting year, WHA's rates were higher than both benchmark performance rates for two comparable HEDIS measures. WHA scored better on one measure than the national benchmark. WHA rates for four measures performed below both state and national benchmarks.

When WHA's population was surveyed regarding *How Well Doctors Communicate*, the plan's results were higher than the Medi-Cal managed care weighted average in both categories. However, WHA showed lower performance than the Medi-Cal managed care weighted average for the CAHPS composite *Getting Needed Care* in both Adult and Child categories.

WHA worked on one QIP categorized in the quality area: *Improving Diabetes Care*. This QIP was closed during this reporting period. All four measures of this project improved over baseline measures.

Finally, in the sustainability area, WHA maintained its performance level for *Chlamydia Screening in Women* in 2007. This measure was retired in 2008. The plan was unable to demonstrate sustainability for the *Cervical Cancer Screening* measure. WHA showed sustained improvement for the measure, *Use of Appropriate Medications for People With Asthma* for the 2007 and 2008 reporting period.

Access to Care Assessment

One of MMCD's goals is to protect enrollee access to care. Access is an essential component of a quality-driven system of care. The findings with regard to access for WHA are presented in the following section.

2007 HEDIS Performance Measures Pertaining to Access

Delmarva used two HEDIS measures *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* as indicators for access to care in this report. Table 4 shows WHA's 2007 results for these access-related HEDIS measures.

Table 4. 2007 HEDIS Access Measure Results Comparing Western Health Advantage to State and National Programs.

2007 Access Measure	2007 Western Health Advantage Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Adolescent Well-Care Visits	30.9%	36.9%	40.6%
Prenatal and Postpartum Care—Postpartum Care	NR	58.7%	57.0%

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*.
NR (Not Reported) - Rate biased or plan did not report.

WHA reported a score lower than both the Medi-Cal managed care weighted average and the 2006 national Medicaid average for the *Adolescent Well-Care Visits* measure. WHA did not report a score for the *Prenatal and Postpartum Care—Postpartum Care* measure.

2008 HEDIS Performance Measures Pertaining to Access

Table 5 shows the results obtained by WHA for these 2008 HEDIS access measures.

Table 5. 2008 HEDIS Access Measure Results Comparing Western Health Advantage to State and National Programs.

2008 Access Measure	2008 Western Health Advantage Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Adolescent Well-Care Visits	32.4%	39.6%	43.7%
Prenatal and Postpartum Care—Postpartum Care	53.3%	59.1%	59.1%

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.

WHA reported 2008 scores lower than both the Medi-Cal managed care weighted average and the national Medicaid average for the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures.

CAHPS Survey Results Pertaining to Access

Delmarva chose the CAHPS composite, *Getting Care Quickly*, to represent the access domain of this report. The results of this composite are depicted in Table 6 and discussed below.

Table 6. 2007 CAHPS Access Survey Results Comparing Western Health Advantage to the Medi-Cal Managed Care Plan Average.

CAHPS Composite	Population	2007 Western Health Advantage Result	2007 Medi-Cal Managed Care Weighted Average*
Getting Care Quickly	Adult	46%	45%
	Child	43%	37%
	CSHCN†	42%§	‡

* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.
† CSHCN - Child with Special Health Care Needs.
‡ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.
§ The plan received <100 responses to some of the questions in this area, so this result is not statistically valid.

WHA's composite score for *Getting Care Quickly* showed 46 percent of adult members indicated they received care quickly, slightly above the Medi-Cal managed care weighted average. Forty-three percent of parents/guardians of WHA's child members indicated they received care quickly. The child member composite score is slightly less than the adult member score, but greater than the Medi-Cal managed care weighted average.

Quality Improvement Projects

WHA engaged in two Quality Improvement Projects (QIPs) that were categorized in the access domain:

- *Improving Access To and Quality of Adolescent Well-Care Visits*
- *Avoidable Emergency Room Visits*

Both of these QIPs are statewide collaborative projects (2006-2007 QIP Quarterly Reports). The *Avoidable Emergency Room Visits* QIP was implemented in 2007. The *Improving Access to and Quality of Adolescent Well-Care Visits* QIP was completed during this reporting period. The QIPs and associated outcomes are discussed below.

Improving Access to and Quality of Adolescent Well-Care Visits

- ***Relevance:***

  Twenty-five percent of WHA members are within the adolescent age range. During 2002, the plan's adolescent well-care visit rate was 37.2 percent, indicating an opportunity for improvement.

- ***Goal:***

  Achieve 47.9 percent on the HEDIS *Adolescent Well-Care Visits* indicator by 2006.

- ***Best Interventions:***
  - Met with family practices and pediatric clinics for review and discussion of activities pertaining to adolescent well-visit survey results and to distribute educational materials, including posters and toolkits.
  - Mailed birthday cards to members with reminders to schedule yearly well-care visits and immunizations.

- ***Outcomes:***
  - HEDIS *Adolescent Well-Care Visits*:
    - ◊ 2003 (Baseline): 37.23%
    - ◊ 2004 (Remeasurement 1): 31.14%
    - ◊ 2005 (Remeasurement 2): 38.20%
    - ◊ 2006 (Remeasurement 3): 30.90%

- ***Attributes/Barriers to Outcomes:***
  - Attribute: Rates reveal a cyclical trend with adolescents seeking well-care visits every two years.
  - Barrier: Perception that adolescents do not need annual well-care visits.
  - Barrier: Providers unfamiliar with current well-care visit recommendations.

Avoidable Emergency Room Visits

- ***Relevance:***

  In 2006, 14.24 percent of WHA's emergency room (ER) visits were defined as avoidable, and the plan noted opportunity for improvement. The plan identified "frequent flyers" (members with three or more ER visits) and anticipated that these members will benefit from referrals to case management, especially if they had chronic illnesses and/or were in need of pain management care.

- ***Goals:***
  - Achieve 25 visits or less per 1,000 member months for the ER visits indicator by Remeasurement 1.
  - Improve the avoidable ER visits measure by ten percent by Remeasurement 2.

- ***Best Intervention:***

  Collaborative interventions are being developed.

- ***Outcomes:***
  - HEDIS rate of members seen in the ER (per 1,000 member months):
    - ◊ 2006 (Baseline): 25.97 visits per 1,000 member months
  - Rate of members seen in the ER with designated avoidable visits:
    - ◊ 2006 (Baseline): 14.24%

- ***Attributes/Barriers to Outcomes:***

  Not applicable, as this QIP was in the baseline stage.

WHA's final results for the statewide collaborative project, *Improving Access to and Quality of Adolescent Well-Care Visits,* were disappointing as the plan saw a 6.3 percent decrease from baseline in adolescent well-care visits. The plan indicated that there appeared to be a cyclic trend in these rates. This project closed during the third quarter of 2006, and WHA began participating in a new statewide collaborative project, *Avoidable Emergency Room Visits*. Because this QIP is in the baseline phase, no results are available yet.

Medi-Cal Audit Findings

There were no updated audit findings during this reporting period.

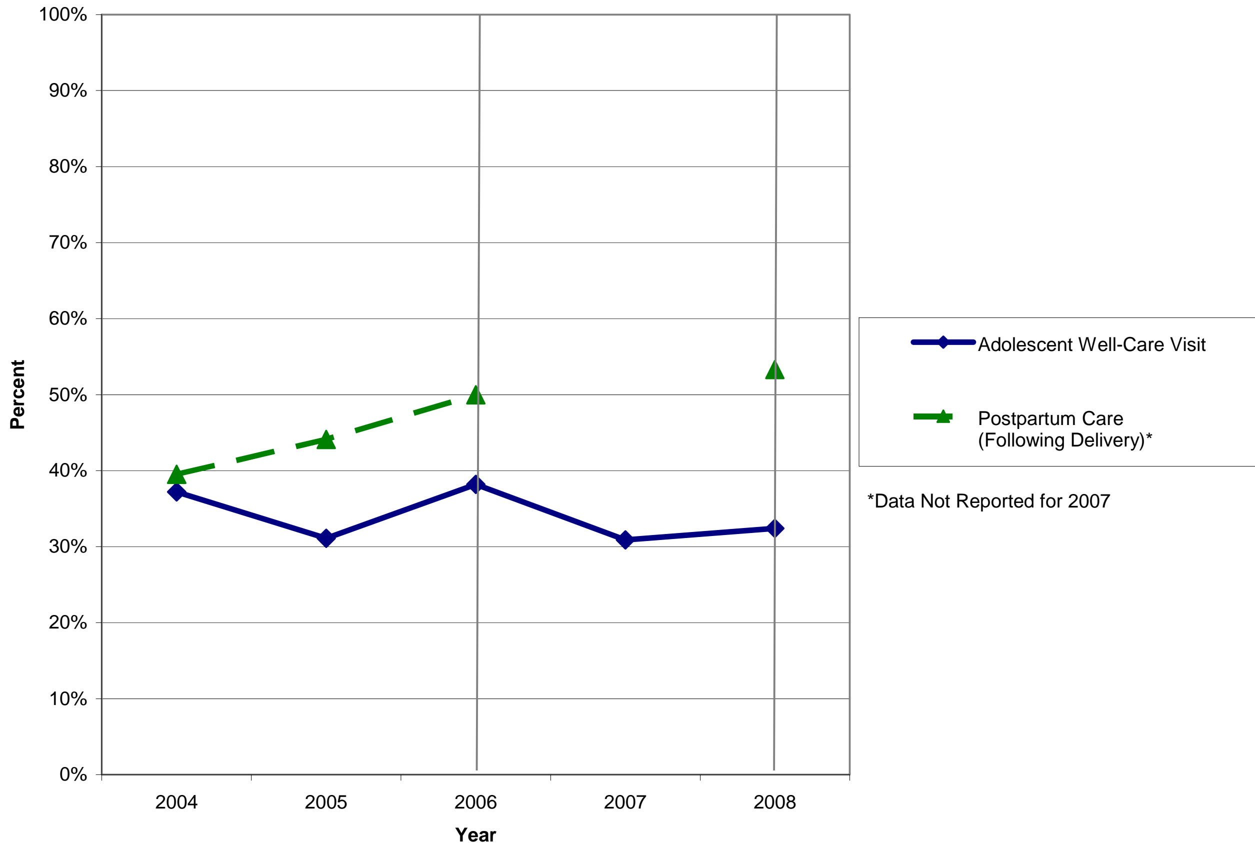
Sustainability of Access Measures

Sustainability of access measures indicates a plan's ability to improve and maintain improvement of enrollee access to health care services. Delmarva chose two measures to represent the access domain: *Prenatal and Postpartum Care—Postpartum Care* and *Adolescent Well-Care Visits*. Figure 2 charts the rates for those measures over a four-year period.

WHA did not report rates for the *Prenatal and Postpartum Care—Postpartum Care* measure in 2007. *Adolescent Well-Care Visits* rates went fluctuated over a four-year period, indicating that the plan has not yet been able to sustain improvement in that area. The plan was not able to sustain improvement in *Adolescent Well-Care Visits* during the 2008 reporting period. Delmarva cannot make a determination of sustainability for this measure

for 2008, because data was not reported in 2007 for the *Prenatal and Postpartum Care—Postpartum Care* measure (depicted in the graph by a break in the trend line).

Figure 2. Western Health Advantage's Sustainability of Access to Care Indicators.



Summary of Access

Delmarva assessed WHA in four areas of the access domain: HEDIS performance measures, CAHPS survey rates, QIPs, and sustainability of improvement.

The plan reported a rate for only one 2007 HEDIS measure in this domain, *Adolescent Well-Care Visits*. WHA performed lower than both benchmarks for this measure. In 2008, WHA reported scores lower than both the Medi-Cal managed care weighted average and the national Medicaid average for the *Adolescent Well-Care Visits* and *Prenatal and Postpartum Care—Postpartum Care* measures.

CAHPS survey results showed that WHA enrollees rated the plan higher than the national and state benchmarks in both Adult and Child categories for the composite area *Getting Care Quickly*.

In the QIP area, Western Health Advantage's results of the *Improving Access To and Quality of Adolescent Well-Care Visits* project were disappointing. The plan saw a 6.3 percent decrease from the baseline measure in *Adolescent Well-Care Visits*. WHA did not report results for the *Avoidable Emergency Room Visits* because this project was still in the baseline phase during this reporting period.

WHA could not show sustained improvement on the *Adolescent Well-Care Visits* during 2007 and 2008. Because data was not reported in 2007 for the *Prenatal and Postpartum Care—Postpartum Care* measure, Delmarva cannot make a determination of sustainability for this measure for both years.

Timeliness of Care Assessment

Access to necessary health care and related services alone is insufficient to advance the health status of Medi-Cal managed care enrollees. Timely delivery of those services is equally important. The findings related to timeliness are described in the following section.

2007 HEDIS Performance Measures Pertaining to Timeliness of Care

Delmarva included the five measures shown in Table 7 in the timeliness domain because each measure is associated with the receipt of services within a certain timeframe.

Table 7. 2007 HEDIS Timeliness Measure Results Comparing Western Health Advantage to State and National Programs.

2007 Timeliness Measure	2007 Western Health Advantage Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*
Breast Cancer Screening†	46.6%	48.6%	53.9%
Childhood Immunization Status—Combination 2	NR	77.9%	70.4%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	NR	79.4%	79.1%
Well-Child Visits in the First 15 Months of Life	NR	57.7%	48.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NR	74.3%	63.3%

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members*.
† Due to significant changes in technical specifications, this measure is treated as a first-year measure in 2007. Because new MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.
NR (Not Reported) - Rate biased or plan did not report.

Comparisons in the timeliness domain were limited for WHA in 2007. The *Breast Cancer Screening* rate of 2007 cannot be compared to benchmarks due to changes in this measure's technical specifications. WHA did not report measures for *Childhood Immunization Status—Combination 2*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, *Well-Child Visits in the First 15 Months of Life* and *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, therefore, no measures can be compared to state and national benchmarks in the timeliness domain for the plan.

2008 HEDIS Performance Measures Pertaining to Timeliness of Care

For the 2008 reporting year, Delmarva used the same measures to represent the timeliness domain and added a newly required measure, *Childhood Immunization Status—Combination 3*. Table 8 shows the results of the 2008 HEDIS timeliness measures.

Table 8. 2008 HEDIS Timeliness Measure Results Comparing Western Health Advantage to State and National Programs.

2008 Timeliness Measure	2008 Western Health Advantage Rate*	2008 Medi-Cal Managed Care Weighted Average*	2007 HEDIS National Medicaid Average*
Breast Cancer Screening	41.4%	50.4%	49.1%
Childhood Immunization Status—Combination 2	67.6%	80.1%	73.3%
Childhood Immunization Status—Combination 3†	57.9%	72.0%	60.6%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	71.0%	82.6%	81.2%
Well-Child Visits in the First 15 Months of Life	48.8%	60.2%	55.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	61.1%	75.8%	66.8%

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.
† 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the rate is displayed for informational purposes only and will not be compared to benchmarks.

In the timeliness domain, WHA reported lower scores in 2008 for all measures for both comparable benchmarks.

CAHPS Survey Results Pertaining to Timeliness

Delmarva chose two CAHPS composites, *Courteous and Helpful Office Staff* and *Health Plan's Customer Service*, to represent timeliness of care domain. Table 9 shows results of the composite scores and is followed by a discussion of the results.

Table 9. 2007 CAHPS Timeliness Survey Results Comparing Western Health Advantage to the Medi-Cal Managed Care Plan Average.

CAHPS Composite	Population	2007 Western Health Advantage Result	2007 Medi-Cal Managed Care Weighted Average*
Courteous and Helpful Office Staff	Adult	†	†
	Child	56%	52%
	CSHCN‡	63%§	¶
Health Plan's Customer Service	Adult	42%§	45%
	Child	66%§	79%
	CSHCN‡	50%§	¶

* Medi-Cal average was calculated from scores of all contracted health plans and weighted to be proportionate to plan enrollment.
† The composite *Courteous and Helpful Office Staff* was eliminated from the 2007 CAHPS Adult survey.
‡ CSHCN - Child with Special Health Care Needs.
§ The plan received <100 responses to some of the questions in this area, so this result is not statistically valid.
¶ MCMC overall averages were not calculated for CSHCN members because they are subsets of the same sampling and data cannot be used due to possibility of double counting. Refer to Appendix B: CAHPS for further detail.

WHA's parents/guardians of child members indicated that the office staff was courteous and helpful 56 percent of the time, whereas the Medi-Cal managed care weighted average for this composite was 52 percent. WHA adult and parents/guardians of child members were less satisfied with their health plan's customer service than the Medi-Cal managed care weighted average, indicating some possible issues and areas for improvement.

Quality Improvement Projects

WHA engaged in two QIPs that were categorized in the timeliness domain: *Improving Timeliness of Prenatal and Postpartum Care* and *Improving Childhood Immunization Rates*. Results of these projects are discussed below.

Improving Timeliness of Prenatal and Postpartum Care

- ***Relevance:***
  - WHA's Medi-Cal members of childbearing age comprise about half of the plan's female members.
  - HEDIS 2004 *Prenatal Care and Postpartum Care* rates were below the DHCS minimum performance level, which is the 25th percentile of the national Medicaid average.

- ***Goal:***

  Increase prenatal care and postpartum care screening rates to the DHCS's minimum performance level.

- ***Best Interventions:***
  - WHA quality improvement staff and UC Davis Health System Obstetrician/Gynecologist (OB/GYN) clinic managers conducted a collaboration focusing on improving the timeliness of prenatal and postpartum care rates, goals, and activities.
  - A pregnancy care newsletter was mailed to members.
  - Monthly prenatal educational mailer was sent to all females, 18 to 42 years of age, who were identified in pharmacy data as having been prescribed a prenatal vitamin.

- ***Outcomes:***
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care.*
    - ◊ 2005 (Baseline): 67.7%
    - ◊ 2006 (Remeasurement 1): 66.7%

  - *Prenatal and Postpartum Care—Postpartum Care.*
    - ◊ 2005 (Baseline): 44.1%
    - ◊ 2006 (Remeasurement 1): 50.0%

- ***Attributes and Barriers to Outcomes:***
  - Barrier: Members have transportation and childcare issues, which make it difficult to attend appointments.
  - Barrier: Providers have limited knowledge of contractually specified timeframes for prenatal care and postpartum care.
  - Barrier: There is no automated process to follow-up with members after missed appointments.

Improving Childhood Immunization Rates

- ***Relevance:***
  - WHA recognized the need for timely immunizations for children.
  - WHA is a member of the California Coalition for Childhood Immunization whose goal is to immunize 90 percent of children in California by age two.

- ***Goals:***
  - Improve the HEDIS *Childhood Immunization Status Combination 2* rate.
  - Improve the percentage of high-volume providers who use the immunization registry.

- Improve the percentage of children, birth to two years of age, seen by providers who use the immunization registry.

➢ ***Best Interventions:***

- Implemented pay-for-performance provider incentives for timely immunizations.
- Mailed birthday card reminders to members addressing the need for a physical exam and immunization follow-up.
- Held education sessions with providers about the immunization registry.
- Sent targeted mailings to network pediatric clinics with Shots for Tots brochures, registry software application, and an American Academy of Pediatrics article with strategies to engage vaccine-hesitant parents.

➢ ***Outcomes:***

- HEDIS *Childhood Immunization Status—Combination 2*:
  - ◊ 2005 (Remeasurement 1): 47.8%
  - ◊ 2006 (Remeasurement 2): 64.2%
- Immunization registry use among high-volume providers:
  - ◊ 2005 (Remeasurement 1): 66.0%
  - ◊ 2006 (Remeasurement 2): 83.0%

- Children, birth to two years of age, seen by providers using immunization registry:
  - ◊ 2005 (Remeasurement 1): 47.3%
  - ◊ 2006 (Remeasurement 2): 63.5%

➢ ***Attributes and Barriers to Outcomes:***

- Barrier: Providers lack computer equipment and internet access, which limits registry participation.
- Barrier: Providers may miss opportunities to vaccinate patients during acute care visits.
- Barrier: Lack of in-person interventions during one-on-one contact with members and providers. Interventions used to date have been mass mailings, brochures, posters, and articles.

WHA was successful in improving the rates of all three indicators used in the *Improving Childhood Immunizations* QIP between the first remeasurement and the second (final) remeasurement as noted above. The project was closed during this reporting period.

Medi-Cal Audit Findings

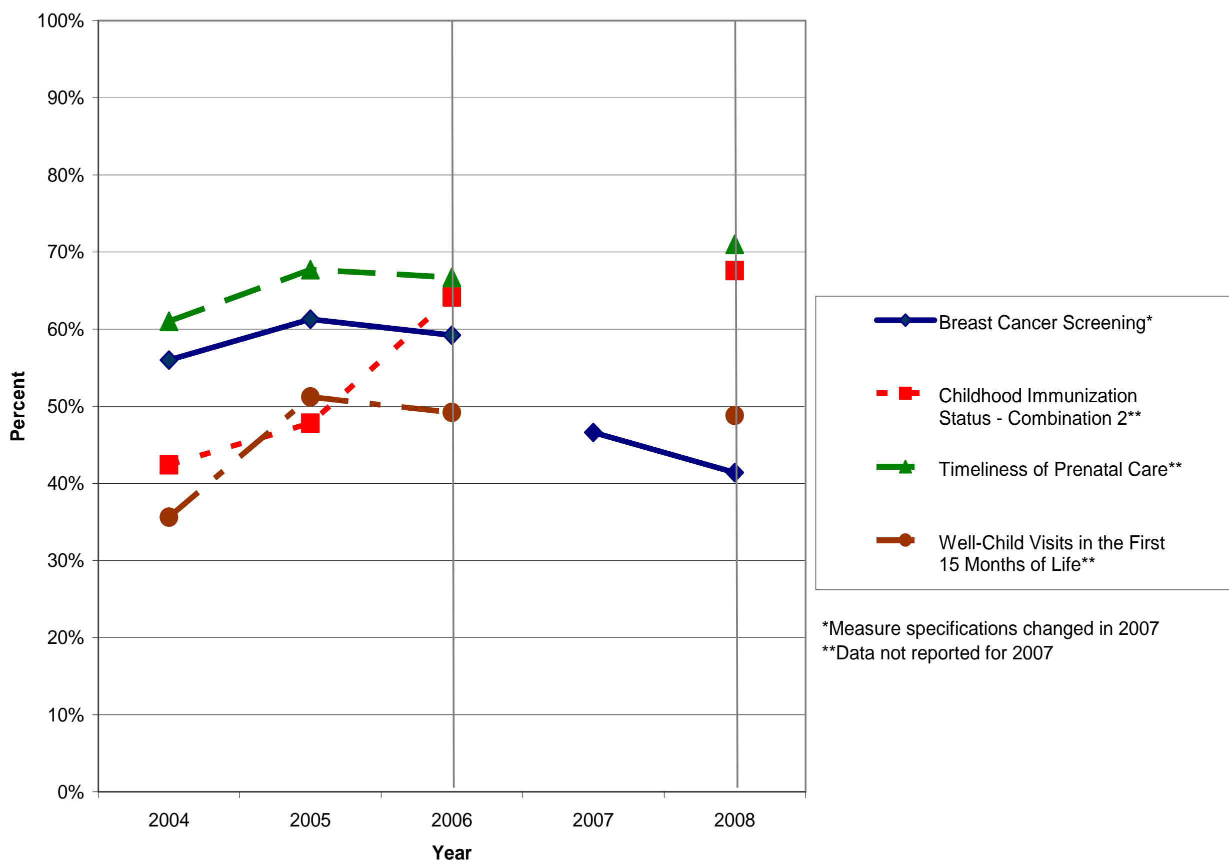
The plan was not audited during this reporting period.

Sustainability of Timeliness of Care Measures

Sustainability of timeliness relates to the plan's delivery of screening tests, preventive health visits, and/or preventive health procedures early enough to prevent the consequences of delayed care. Delmarva chose four measures to represent timeliness for this assessment. Figure 3 charts those measures.

WHA did not provide results for three measures in the timeliness domain for the 2007 reporting period. Furthermore, the trend line for the *Breast Cancer Screening* measure is broken between 2006 and 2007 to reflect the substantive changes in the measure's 2007 technical specifications. Symbols appear representing rates for all measures for the 2008 reporting year as WHA did report these rates. However, Delmarva cannot determine sustainability of rates for 2007 or 2008, as trending patterns cannot be determined with missing data points.

Figure 3. Western Health Advantage's Sustainability of Timeliness of Care Indicators.



Summary of Timeliness of Care

Delmarva's ability to assess WHA in the timeliness of care domain was limited by available sources.

WHA reported 2007 HEDIS scores for only one measure in the timeliness domain—*Breast Cancer Screening*. Due to technical specification changes, this measure is not comparable to benchmarks. In 2008, WHA reported lower scores for all comparable measures for both benchmarks in the timeliness domain.

CAHPS survey results showed that the parents of child members were satisfied with the plan's staff (56% versus 52% for state benchmark) in the composite area *Courteous and Helpful Office Staff*. The plan's adult respondents were less satisfied with their health plan's customer service when compared to the state benchmark (42% versus 45% for state benchmark) and parents/guardians of child members were even less satisfied (66% versus 79% for state benchmark) than the Medi-Cal managed care weighted average.

In 2006, WHA's QIP—*Improving Childhood Immunization Rates*—closed with no updated results during this reporting period. Delmarva did not discuss the outcomes of the *Improving Timeliness of Prenatal* and *Postpartum Care* QIP, as they were not available during the inclusionary dates of this report.

In 2007, WHA did not provide rates for three of the four timeliness sustainability indicators, and the fourth, *Breast Cancer Screening,* could not be compared to benchmarks due to specification changes. Although WHA did report rates for all timeliness measures during 2008, Delmarva cannot determine sustainability for any of the measures for either year due to missing data points, or incomparable rates due to specification changes.

Comparison of Western Health Advantage's 2007 and 2008 HEDIS Scores

Delmarva presents WHA's 2007 and 2008 HEDIS rates in Table 10 and provides a discussion of the rate comparisons following the table.

Table 10. Comparison of Western Health Advantage's 2008 and 2007 HEDIS Performance Rates.

2008 Performance Measure	2008 Western Health Advantage Rate*	2007 Western Health Advantage Rate*
Childhood Immunization Status—Combination 2	67.6%	NR
Childhood Immunization Status—Combination 3[†]	57.9%	†
Well-Child Visits in the First 15 Months of Life	48.8%	NR
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	61.1%	NR
Adolescent Well-Care Visits	32.4%	30.9%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	71.0%	NR
Prenatal and Postpartum Care—Postpartum Care	53.3%	NR
Breast Cancer Screening	41.4%	46.6%
Cervical Cancer Screening	59.9%	58.4%
Use of Appropriate Medications for People With Asthma	84.0%	83.8%
Appropriate Treatment for Children With Upper Respiratory Infection	95.5%	92.8%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[†‡]	31.1%	†
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.8%	52.3%
Comprehensive Diabetes Care—HbA1c Testing	78.8%	82.0%
Comprehensive Diabetes Care—HbA1c Control (<7.0%)[†]	24.1%	†
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)[†§]	51.6%[§]	†
Comprehensive Diabetes Care—LDL-C Screening Performed	67.2%	69.6%
Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)[†]	37.0%	†
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.7%	70.6%

2008 Performance Measure	2008 Western Health Advantage Rate*	2007 Western Health Advantage Rate*
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months) †	198.80	†
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months) †	26.35	†
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months) †	3.80	†
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months) †	0.10	†

* Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*
† 2008 is the first year MMCD required reporting of this measure. Because MPLs and HPLs had not yet been established, the 2008 rate is displayed for informational purposes only and will not be compared to benchmarks.
‡ 2007 and 2008 rates cannot be compared. The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis,* and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score is better.
§ This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.
NR (Not Reported) - Rate biased or plan did not report.

Due to 2007 specification changes, the plan's rates of *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* cannot be compared between reporting years 2007 and 2008. MMCD eliminated the *Chlamydia Screening* measure and instead required the *Ambulatory Care* measure in order to focus more on the entire Medi-Cal managed care population, including seniors and persons with disabilities. The *Ambulatory Care* measure provides utilization information across the whole spectrum of the population – from birth to 85+ years of age. Plus, this measure provides insight regarding emergency room (ER) use, which is an area of particular interest to MMCD because many members use the ER for avoidable visits and, as a result, may not be getting appropriate preventive care and follow-up care with chronic conditions. Rates for the four *Ambulatory Care* indicators are included for discussion purposes only. Conclusions should not be drawn regarding plan performance for these indicators as noted in the Table 10 footnotes.

- WHA improved on five of the comparable HEDIS measures:
  - *Adolescent Well-Care Visits*
  - *Cervical Cancer Screening*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

- WHA's score remained relatively unchanged for one measure:
  - *Use of Appropriate Medications for People with Asthma*

- WHA's performance for three measures decreased:
  - *Breast Cancer Screening*
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Comprehensive Diabetes Care—LDL-C Screening Performed*

Comparison of 2007 and 2008 HEDIS Measures by Model Type

Medi-Cal beneficiaries receive their health care through three models of health care delivery: County Organized Health Systems (COHS), Two-Plan, and Geographic Managed Care (GMC). COHS plans are county-operated managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS. The Two-Plan model consists of two plan types: Commercial Plans (CPs), which are commercially operated managed care plans; and Local Initiatives (LIs), which are community developed managed care plans operated as quasi-governmental agencies. In a Two-Plan model, county members choose between an LI and CP. Enrollment is mandatory for specified beneficiaries. In the GMC model, enrollees choose from several commercially operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.

WHA is contracted in Sacramento County as a GMC-North plan. Tables 11 (2007) and 12 (2008) show the ranking (1 through 5) of the five different plan models when HEDIS results were compared across plan types. Note that averages are not ranked (1 through 5) for measures where MPL and HPLs were not applied in the reporting year. See GMC-N column of Tables 11 and 12.

Table 11. Comparison of 2007 Medi-Cal Managed Care Weighted Averages by Plan Model Type.

2007 Performance Measure	Plan Model Type Rate (ranking among models)				
	COHS*	CP†	LI†	GMC – N‡	GMC – S‡
Childhood Immunization Status—Combination 2	82.9% (1)	79.5% (3)	75.6% (4)	73.6% (5)	80.2% (2)
Well-Child Visits in the First 15 Months of Life	68.0% (1)	44.8% (5)	53.0% (3)	57.2% (2)	51.4% (4)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	76.3% (1)	73.6% (3)	74.6% (2)	70.3% (5)	72.5% (4)
Adolescent Well-Care Visits	47.8% (1)	36.8% (3)	34.0% (5)	36.7% (4)	37.8% (2)
Prenatal and Postpartum Care—Timeliness of Prenatal Care	82.0% (2)	81.4% (3)	77.5% (5)	77.9% (4)	82.6% (1)
Prenatal and Postpartum Care—Postpartum Care	64.3% (1)	56.6% (4)	58.7% (2)	58.5% (3)	53.8% (5)
Chlamydia Screening in Women	54.4% (3)	52.8% (4)	50.5% (5)	58.1% (2)	59.8% (1)
Breast Cancer Screening ¶	55.6%	42.8%	48.4%	47.8%	50.6%
Cervical Cancer Screening ¶	70.1%	65.7%	69.3%	62.9%	66.5%
Use of Appropriate Medications for People With Asthma	88.7% (1)	85.8% (4)	86.9% (2)	86.4% (3)	84.9% (5)
Appropriate Treatment for Children With Upper Respiratory Infection	81.3% (3)	74.5% (5)	79.3% (4)	84.8% (2)	85.1% (1)
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis § ¶	71.0%	73.7%	70.2%	71.8%	64.6%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	68.7% (1)	54.6% (3)	45.5% (5)	54.2% (4)	56.9% (2)
Comprehensive Diabetes Care—HbA1c Testing	85.4% (1)	79.5% (2)	76.7% (4)	76.1% (5)	78.0% (3)
Comprehensive Diabetes Care—LDL-C Screening ¶	80.7%	74.5%	74.2%	71.4%	77.5%
Comprehensive Diabetes Care—Medical Attention for Nephropathy ¶	81.2%	75.4%	83.8%	77.7%	78.3%

Plan Model Definitions:
* County Organized Health System (COHS) – County operated and managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
† Two-Plan consists of two plan types:
Commercial Plans (CPs) are commercially operated managed care plans.
Local Initiatives (LIs) are community developed managed care plans operated as quasi-governmental agencies.
Members choose between an LI and CP. Enrollment is mandatory for specified beneficiaries.
‡ Geographic Managed Care (GMC) - Enrollees choose from several commercially operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.
§ For this measure, a lower score indicates better performance.
¶ Averages not ranked for measures where MPLs and HPLs are not applied in the reporting year.

The GMC-N plan model has no measures in the first ranking of the five model types. For balance of the measures, GMC-N plans ranked as follows:

- GMC-N plans ranked second of the five model types in the following HEDIS measures:
  - *Well-Child Visits in the First 15 Months of Life*
  - *Chlamydia Screening in Women*
  - *Appropriate Treatment for Children With Upper Respiratory Infection*

- GMC-N plans ranked third of the five model types in the following measures:
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Use of Appropriate Medications for People With Asthma*

- GMC-N plans ranked fourth of the five model types in the following measures:
  - *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

- GMC-N plans ranked fifth of the five model types in the following measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Comprehensive Diabetes Care—HbA1c Testing*

Table 12. Comparison of 2008 Medi-Cal Managed Care Weighted Averages by Plan Model Type.

2008 Performance Measure	Plan Model Type Rate (ranking among models)				
	COHS*	CP†	LI†	GMC – N‡	GMC – S‡
Childhood Immunization Status—Combination 2	83.3% (1)	77.4% (3)	82.3% (2)	70.8% (5)	71.4% (4)
Childhood Immunization Status—Combination 3¶	77.4%	68.8%	73.6%	65.8%	62.8%
Well-Child Visits in the First 15 Months of Life	72.3% (1)	46.6% (5)	56.7% (2)	55.9% (3)	49.5% (4)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.9% (1)	75.1% (3)	76.1% (2)	69.1% (5)	73.1% (4)
Adolescent Well-Care Visits	48.4% (1)	38.8% (2)	38.4% (4)	38.7% (3)	37.1% (5)
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.2% (1)	83.1% (2)	81.9% (3)	81.7% (4)	80.8% (5)
Prenatal and Postpartum Care—Postpartum Care	66.9% (1)	57.4% (3)	59.1% (2)	54.8% (4)	52.0% (5)
Breast Cancer Screening	56.4% (1)	45.3% (5)	50.5% (3)	47.4% (4)	51.3% (2)
Cervical Cancer Screening	69.1% (2)	69.9% (1)	68.2% (3)	68.2% (3)	67.0% (4)
Use of Appropriate Medications for People with Asthma	90.1% (1)	88.8% (3)	89.0% (2)	86.6% (4)	85.1% (5)
Appropriate Treatment for Children with Upper Respiratory Infection	85.2% (3)	81.3% (5)	82.5% (4)	89.5% (1)	88.4% (2)
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis¶	26.1%	30.3%	28.4%	28.7%	26.5%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	69.6% (1)	58.2% (2)	52.0% (5)	56.2% (3)	52.4% (4)
Comprehensive Diabetes Care—HbA1c Testing	85.3% (1)	81.0% (4)	81.4% (2)	78.1% (5)	81.1% (3)
Comprehensive Diabetes Care—HbA1c Control (<7.0%)¶	39.7%	27.4%	31.0%	32.8%	32.1%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)§¶	35.5%	49.4%	43.1%	42.9%	45.5%
Comprehensive Diabetes Care—LDL-C Screening Performed	81.3% (1)	76.4% (4)	77.4% (2)	72.0% (5)	77.0% (3)
Comprehensive Diabetes Care—LDL-C Control(<100mg/dL) ¶	40.0%	28.9%	32.9%	32.3%	40.6%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.0% (1)	77.7% (3)	76.9% (4)	75.1% (5)	78.8% (2)

2008 Performance Measure	Plan Model Type Rate (ranking among models)				
	COHS*	CP†	LI†	GMC – N‡	GMC – S‡
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months) ¶	322.38	254.75	268.14	263.24	250.02
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months) ¶	43.49	33.42	38.17	33.98	33.79
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months) ¶	4.95	2.04	2.09	2.48	2.92
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months) ¶	2.87	0.29	0.52	0.26	0.40

Plan Model Definitions:
* County Organized Health System (COHS) – County operated and managed care organizations. Enrollment is mandatory for almost all Medi-Cal beneficiaries within a county operating a COHS.
† Two-Plan consists of two plan types:
Commercial Plans (CPs) are commercially operated managed care plans.
Local Initiatives (LIs) are community developed managed care plans operated as quasi-governmental agencies. Members choose between an LI and CP. Enrollment is mandatory for specified beneficiaries.
‡ Geographic Managed Care (GMC) - Enrollees choose from several commercially operated plans within a certain geographic area. Enrollment is mandatory for specified Medi-Cal beneficiaries.
§ This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.
¶ Averages not ranked for measures where MPLs and HPLs are not applied in the reporting year.

- GMC-N plans ranked first of the five model types in the following HEDIS measures:
  - *Appropriate Treatment for Children with Upper Respiratory Infection*
- GMC-N plans ranked third of the five model types in the following HEDIS measures:
  - *Well-Child Visits in the First 15 Months of Life*
  - *Adolescent Well-Care Visits*
  - *Cervical Cancer Screening*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- GMC-N plans ranked fourth of the five model types in the following HEDIS measures:
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Breast Cancer Screening*
  - *Use of Appropriate Medications for People with Asthma*

- GMC-N plans ranked fifth of the five model types in the following HEDIS measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Comprehensive Diabetes Care—LDL-C Screening Performed*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Comparison to Other National and California State Programs

In each of the quality, access and timeliness assessments provided earlier in this report, WHA's performance was compared with the Medi-Cal managed care weighted average and the national Medicaid average. This section provides two comparisons that have not been made elsewhere in this report—national commercial averages and the California Healthy Families Program averages. The Healthy Families Program, administered by the Managed Risk Medical Insurance Board, is a low cost health, dental, and vision coverage plan for uninsured children (up to age 19) of working families. In addition to the new rate comparisons, the Medi-Cal managed care weighted averages and the national Medicaid averages are provided in Tables 13 and 14.

Table 13. 2007 Performance Measurement Rates Comparing Western Health Advantage to National and State Programs.

2007 Performance Measure	2007 Western Health Advantage Rate*	2007 Medi-Cal Managed Care Weighted Average*	2006 HEDIS National Medicaid Average*	2006 HEDIS National Commercial Average*	2007 CA Healthy Families Average†
Childhood Immunization Status—Combination 2	NR	77.9%	70.4%	77.8%	79.2%
Well-Child Visits in the First 15 Months of Life	NR	57.7%	48.6%	71.0%	56.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NR	74.3%	63.3%	64.4%	72.9%
Adolescent Well-Care Visits	30.9%	36.9%	40.6%	38.7%	43.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	NR	79.4%	79.1%	91.9%	‡
Prenatal and Postpartum Care—Postpartum Care	NR	58.7%	57.0%	81.5%	‡
Chlamydia Screening in Women	61.0%	52.8%	50.6%	34.9%	41.1%
Breast Cancer Screening§	46.6%	48.6%	53.9%	72.0%	‡
Cervical Cancer Screening§	58.4%	67.9%	65.0%	81.8%	‡
Use of Appropriate Medications for People With Asthma	83.8%	86.8%	85.7%	89.9%	94.0%
Appropriate Treatment for Children With Upper Respiratory Infection	92.8%	78.9%	82.5%	82.9%	83.1%
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis¶§	72.3%	71.0%	69.4%	66.1%	‡
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	52.3%	54.1%	48.6%	54.8%	‡
Comprehensive Diabetes Care—HbA1c Testing	82.0%	79.5%	76.2%	87.6%	‡
Comprehensive Diabetes Care—LDL-C Screening §	69.6%	75.9%	80.5%	92.3%	‡
Comprehensive Diabetes Care—Medical Attention for Nephropathy§	70.6%	81.0%	48.8%	55.1%	‡

* Rates obtained from the *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members.*
† 2007 rates obtained from the Healthy Families Program at http://www.mrmib.ca.gov/MRMIB/quality_reports.html.
‡ Healthy Families did not report data on these measures.
§ Due to significant changes in technical specifications, MPLs and HPLs had not yet been established for 2007. The rate is displayed for informational purposes only and will not be compared to benchmarks.
¶ For this 2007 measure, a lower the rate indicates better the performance
NR (Not Reported) - Rate biased or plan did not report.

- WHA did not report on five measures.

- WHA reported higher rates than other comparable benchmarks for the *Chlamydia Screening in Women* and *Appropriate Treatment for Children With Upper Respiratory Infection* measures.

- WHA had mixed results on two measures:
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (WHA scored higher than the national Medicaid average but lower than both the Medi-Cal managed care weighted average and the national commercial average.)
  - *Comprehensive Diabetes Care—HbA1c Testing* (WHA scored higher than both the national Medicaid average and the Medi-Cal managed care weighted average, but lower than the national commercial average.)

- WHA reported lower rates than other comparable benchmarks on two measures:
  - *Use of Appropriate Medications for People With Asthma*
  - *Adolescent Well-Care Visits*

Table 14. 2008 Performance Measurement Rates Comparing Western Health Advantage to National and State Programs.

2008 Performance Measure	2008 Western Health Advantage Rate[a]	2008 Medi-Cal Managed Care Weighted Average[a]	2007 HEDIS National Medicaid Average[a]	2007 HEDIS National Commercial Average[a]	2007 CA Healthy Families Average[b]
Childhood Immunization Status—Combination 2	67.6%	80.1%	73.3%	79.8%	79.2%
Childhood Immunization Status—Combination 3[c]	57.9%	72.0%	60.6%	65.8%	73.4%
Well-Child Visits in the First 15 Months of Life	48.8%	60.2%	55.6%	72.9%	56.6%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	61.1%	75.8%	66.8%	66.7%	72.9%
Adolescent Well-Care Visits	32.4%	39.6%	43.7%	40.3%	43.5%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	71.0%	82.6%	81.2%	90.6%	(d)
Prenatal and Postpartum Care—Postpartum Care	53.3%	59.1%	59.1%	79.9%	(d)
Breast Cancer Screening	41.4%	50.4%	49.1%	68.9%	(d)
Cervical Cancer Screening	59.9%	68.7%	65.7%	81.0%	(d)
Use of Appropriate Medications for People with Asthma	84.0%	88.8%	87.1%	91.6%	94.0%
Appropriate Treatment for Children with Upper Respiratory Infection	95.5%	83.1%	83.3%	82.8%	83.1%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[e]	31.1%	28.4%	(e)	(e)	(d)
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	60.8%	58.1%	51.4%	54.7%	(d)
Comprehensive Diabetes Care—HbA1c Testing	78.8%	82.1%	78.0%	87.5%	(d)
Comprehensive Diabetes Care—HbA1c Control (<7.0%)[c]	24.1%	32.6%	N/A	41.8%	(d)
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)[c][f]	51.6%	42.6%	48.7%	29.6%	(d)
Comprehensive Diabetes Care—LDL-C Screening Performed	67.2%	77.8%	71.1%	83.4%	(d)
Comprehensive Diabetes Care—LDL-C Control(<100mg/dL)[c]	37.0%	34.2%	30.6%	43.0%	(d)
Comprehensive Diabetes Care—Medical Attention for Nephropathy	73.7%	78.3%	74.6%	79.7%	(d)

2008 Performance Measure	2008 Western Health Advantage Rate[(a)]	2008 Medi-Cal Managed Care Weighted Average[(a)]	2007 HEDIS National Medicaid Average[(a)]	2007 HEDIS National Commercial Average[(a)]	2007 CA Healthy Families Average[(b)]
Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)[(c) (g)]	198.80	271.57	317.97	296.73	(d)
Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)[(c) (g)]	26.35	37.26	57.02	16.71	(d)
Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)[(c) (g)]	3.80	2.58	5.30	10.49	(d)
Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)[(c) (g)]	0.10	0.79	1.78	.83	(d)

(a) Rates obtained from the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members*.
(b) 2007 rates obtained from the Healthy Families Program at http://www.mrmib.ca.gov/MRMIB/quality_reports.html.
(c) Due to first-year reporting requirements, MPLs and HPLs were not established for 2008. The rate is displayed for informational purposes only and will not be compared to benchmarks.
(d) Healthy Families did not report data on these measures.
(e) 2007 and 2008 rates cannot be compared. The 2007 measure was called *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis,* and a lower score was better. The 2008 measure is called *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and a higher score is better.
(f) This measure represents poor diabetes control as measured by HbA1c levels. A lower number represents better diabetes control.
(g) MMCD has yet to determine whether to apply an MPL or HPL to the *Ambulatory Care* measure. Scores are reported, but no conclusions should be drawn regarding plan performance in this area.

The performance of newly required measures are not assessed because the first-year results are considered "baseline" results, and MMCD does not apply the MPL or HPL to these measures. In addition, the newly required *Ambulatory Care* indicators are not scored as percentages, but rather as utilization counts per 1,000 member months. MMCD has yet to determine whether to apply MPLs or HPLs to these measures.

- WHA's rates were higher than all benchmark rates for the following measures:
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

- WHA had mixed results when comparing rates to benchmarks for the following measures:
  - *Comprehensive Diabetes Care—HbA1c Testing* (WHA scored higher than the HEDIS Medicaid average but lower than the other benchmarks.)

- WHA's rates were lower than all benchmark rates for the following measures:
  - *Childhood Immunization Status—Combination 2*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
  - *Adolescent Well-Care Visits*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Use of Appropriate Medications for People With Asthma*
  - *Comprehensive Diabetes Care—LDL-C Screening Performed*
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

2007 Overall Strengths

- WHA rated better than the national benchmark in four of the five comparable HEDIS measures in the quality domain.
- WHA outperformed both benchmarks in the three of five comparable HEDIS measures in the quality domain.
- WHA rated higher than the state benchmark in both the Adult and Child categories for the CAHPS composite item *How Well Doctors Communicate*.
- All four measures in the WHA QIP, *Improving Diabetes Care*, improved over the baseline measures.
- In the sustainability area, WHA successfully improved rates for two comparable HEDIS measures: U*se of Appropriate Medications for People With Asthma* and *Chlamydia Screening for Women*.
- WHA performed better than the 2007 Medi-Cal managed care weighted average in the CAHPS adult composite area *Getting Care Quickly*.
- WHA respondents indicated that the office staff was courteous and helpful in the Child category more often than the Medi-Cal managed care weighted average for the CAHPS composite area *Courteous and Helpful Office Staff*.

2007 Recommendations

Delmarva's overall assessment of WHA in the areas of quality, access, and timeliness has identified several opportunities for improvement. Delmarva recommends that the plan focus on:

- Why its performance on the HEDIS measure *Use of Appropriate Medications for People With Asthma* was worse than other benchmarks.
- Which factors may be causing WHA's adult and child populations to respond with lower rates for WHA in the CAHPS survey item *Getting Needed Care*.
- Which factors may be causing WHA's child population to respond with rates lower than the Medi-Cal managed care weighted average to the CAHPS survey item *Getting Care Quickly*.
- Which factors may be causing WHA respondents to rate the health plan's customer service lower than the Medi-Cal managed care weighted average in both the Adult and Child categories.
- Published reports on the Adolescent Well-Care Visit statewide collaborative project to identify some of the "best practices" that may have led other plans to have greater successes (WHA had a 6.3 percent decrease in visits from baseline measurement).
- Why rates for five HEDIS measures were not reported (NR). The lack of reported rates in the access and timeliness domains adversely affected Delmarva's ability to provide a thorough assessment in these areas.

2007 Summary

Both strengths and continued opportunities for improvement exist for WHA in the areas of quality, access, and timeliness. WHA is performing well in several areas, including the HEDIS measures *Comprehensive Diabetes Care—HbA1c Testing*, *Chlamydia Screening in Women*, and *Appropriate Treatment for Children With Upper Respiratory Infection*. Additionally, on the CAHPS survey, WHA enrollees scored the plan's performance higher than Medi-Cal managed care weighted averages in the areas *How Well Doctors Communicate*, *Getting Care Quickly* for adult members, and *Courteous and Helpful Office Staff* for child members.

Delmarva recommends that WHA focus on enrollee perceptions for *Getting Needed Care*, *Getting Care Quickly*, and *Health Plan's Customer Service* areas. The plan also should address its lower performance compared to benchmarks for the *Use of Appropriate Medications for People With Asthma* measure. The plan should explain why it did not report on five HEDIS measures and implement practices to ensure timely reporting. Finally, the plan should attempt to implement some of the "best practices" used by other plans involved in the Adolescent Health Collaborative to improve WHA's performance on *Adolescent Well-Care Visits* measures.

2008 HEDIS Measure Strengths

WHA is performing well in a few areas:

- WHA's rates were higher than all benchmark rates for the following measures:
  - *Appropriate Treatment for Children With Upper Respiratory Infection*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- WHA scored higher than the HEDIS Medicaid average for the *Comprehensive Diabetes Care—HbA1c Testing* measure.

2008 Recommendations

Delmarva's assessment of WHA's 2008 HEDIS measures in the areas of quality, access, and timeliness has identified several opportunities for improvement. Delmarva recommends that the plan focus on:

- Why its performance on the HEDIS measures *Childhood Immunization Status—Combination 2, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits, Comprehensive Diabetes Care—LDL-C Screening Performed,* and *Comprehensive Diabetes Care—Medical Attention for Nephropathy* was worse than other benchmarks.
- Factors that have led to its excellent performance on the measure *Appropriate Treatment for Children with Upper Respiratory Infection.* Once identified, WHA should consider reproducing the activity/behavior for other projects.

2008 Summary

Delmarva concludes that both strengths and continued opportunities for improvement exist for WHA in the area of HEDIS performance measures as presented in this report. In particular, WHA is performing well on the measure *Appropriate Treatment for Children with Upper Respiratory Infection*. WHA should focus on improving rates for child/adolescent measures and two indicators for the *Comprehensive Diabetes Care* measure.

Appendix A: HEDIS®

HEDIS Background

The Healthcare Effectiveness Data and Information Set (HEDIS®)[8] is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA). NCQA's Committee on Performance Measurement annually evaluates and makes collective decisions about the content of the measures and the entire HEDIS process. State governments, employer and business groups, payers, and consumers use the results of these measures. More than 90 percent of all national health plans use HEDIS to measure their performance on established dimensions of health care and plan services.

HEDIS data collection and validation is standardized across all plans. HEDIS methodology makes it possible to compare the performance of health plans to each other and to national benchmarks. Results are used to identify performance variances to help plans focus their quality improvement activities.

HEDIS Domains of Care

- NCQA assigns each of the technically-defined HEDIS measures (71 measures in 2007 and 70 measures in 2008) to one of eight domains of care:
  - Effectiveness of Care
  - Access/Availability of Care
  - Satisfaction with the Experience of Care (Adult and Child CAHPS)
  - Use of Services
  - Cost of Care
  - Health Plan Descriptive Information
  - Health Plan Stability
  - Informed Health Care Choices

[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

DHCS-Required Measures

2007 DHCS-Required HEDIS Measures

For the 2007 Reporting Year, the DHCS required plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and *Prenatal and Postpartum Care*—for a total of 16 measurement indicators.[9]

- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Breast Cancer Screening**
- *Cervical Cancer Screening**
- *Childhood Immunization Status—Combination 2*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—LDL-C Screening**
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy**
- *Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis**
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Appropriate Medications for People With Asthma*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*

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[9] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 06-010, entitled "Quality and Performance Improvement Program Requirements for 2007."

* MPL/HPL were not applied to these measures in 2007.

2008 DHCS-Required HEDIS Measures

For the 2008 Reporting Year, the DHCS required plans to report on 12 selected HEDIS measures—including multiple indicators for _Ambulatory Care_, _Childhood Immunization Status_, _Comprehensive Diabetes Care,_ and _Prenatal and Postpartum Care_—for a total of 23 measurement indicators.[10]

- _Adolescent Well-Care Visits_
- _Ambulatory Care—Outpatient Visits (Total Visits per 1,000 Member Months)*_
- _Ambulatory Care—Emergency Department Visits (Total Visits per 1,000 Member Months)*_
- _Ambulatory Care—Ambulatory Surgery/Procedures (Total Procedures per 1,000 Member Months)*_
- _Ambulatory Care—Observation Room Stays (Total Stays per 1,000 Member Months)*_
- _Appropriate Treatment for Children With Upper Respiratory Infection_
- _Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*_
- _Breast Cancer Screening_
- _Cervical Cancer Screening_
- _Childhood Immunization Status—Combination 2_
- _Childhood Immunization Status—Combination 3*_
- _Comprehensive Diabetes Care—Eye Exam (Retinal) Performed_
- _Comprehensive Diabetes Care—HbA1c Control (<7.0%)*_
- _Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*_
- _Comprehensive Diabetes Care—HbA1c Testing_
- _Comprehensive Diabetes Care—LDL-C Screening Performed_
- _Comprehensive Diabetes Care—LDL-C Control (<100mg/dL)*_
- _Comprehensive Diabetes Care—Medical Attention for Nephropathy_
- _Prenatal and Postpartum Care—Postpartum Care_
- _Prenatal and Postpartum Care—Timeliness of Prenatal Care_
- _Use of Appropriate Medications for People With Asthma_
- _Well-Child Visits in the First 15 Months of Life_
- _Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life_

The DHCS strives to select measures that gauge the quality of care provided to and access to care experienced by the largest segments of the Medi-Cal managed care population. The EQRO compiles and validates the measurement results from all the plans and communicates the results to the DHCS in an annual _Performance Measures for Medi-Cal Managed Care Members_ report.

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[10] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 07-013, entitled "Quality and Performance Improvement Program Requirements for 2008."

* MPL/HPL were not applied to these measures in 2008.

The *Report of the 2007 Performance Measures for Medi-Cal Managed Care Members* and the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Members* ("*Annual Performance Measures reports*"), provide the Medi-Cal managed care weighted average for each measure. The Medi-Cal managed care weighted average accounts for variation in membership across plans. The plans' HEDIS data processes are audited according to the protocols described in the *Annual Performance Measures reports*. WHA's rates in this plan report were taken from the *Annual Performance Measures reports*, as were the state and national benchmark rates used for comparison.

Performance Level Criteria

This report utilizes the following established benchmarks in assessing plans' performance on measures:

- Medi-Cal Managed Care Weighted Average (Same Year)
- National Medicaid Average (Prior Year)
- National Commercial Average (Prior Year)

The DHCS compares plan rates to Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) for each measure to assess further program-wide quality of care and to identify specific health plan improvement needs. MPLs and HPLs are equal to the 25th and the 90th percentiles, respectively, of the 2006 and 2007 national Medicaid results. The performance benchmarks (MPLs and HPLs) were taken from NCQA's *Quality Compass* for the previous year.

The HPL rates help identify plans that outperform the national Medicaid 90th percentile from the previous year. The DHCS does not apply the MPL and HPL to the first-year scores reported for any measure since that rate establishes a "baseline." Similarly, the MPL and HPL are not applied in years when there were substantive changes to a measure's technical specifications, since making a comparison to the previous rate would be inappropriate.

Appendix B: CAHPS®

CAHPS Background

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[11] program is funded and administered by the U.S. Agency of Healthcare Research and Quality (AHRQ). AHRQ works closely with a consortium of public and private organizations to develop and support a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their health care experiences.

The CAHPS surveys capture members' ratings of health care experiences and probe those aspects of care for which members are the best, and sometimes, the only source of information. CAHPS results allow the DHCS to determine how well health plans are meeting their members' expectations and provide individual feedback to plans. This data-driven communication encourages health plan accountability and supports health plan efforts to develop and implement action plans for improving members' satisfaction with their healthcare and plan services. CAHPS results are presented and discussed in this report in relation to quality, access, and timeliness.

The DHCS generally has CAHPS surveys administered every two years. The surveys discussed in this report were administered between February and May 2007. Across all MCMC plans, a total of 38,824 adult surveys and 85,028 child surveys were mailed to members. A total of 12,985 adult members and 25,224 child members responded to this survey—a 35 percent and 30 percent adjusted response rate[12], respectively.

CAHPS Measurements

During this reporting period, the 2007 CAHPS 4.0H Adult Medicaid Survey and the 3.0H Child Medicaid Survey were administered to members of the Medi-Cal Managed Care contracted health plans.

The 2007 Adult (4.0H CAHPS) survey consisted of 51 questions. The 51 questions were categorized into five major areas:

- Your Health Care in the Last 6 Months
- Your Personal Doctor
- Getting Health Care From Specialists

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[11] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

[12] The adjusted response rate for the category is calculated by dividing the total number of surveys completed by the difference between the number of surveys mailed and the number of surveys found to be ineligible.

- Your Health Plan
- About You

The 2007 Child (3.0H CAHPS) survey consisted of 110 questions. The 110 questions were categorized into seven major areas:

- Your Child's Personal Doctor or Nurse
- Getting Health Care From a Specialist
- Your Child's Health Care in the Last 6 Months
- Specialized Services
- Your Child's Health Plan
- Prescription Medicines
- About Your Child and You

Survey results were divided into composite areas. The composite areas are used to report plan scores and are derived by combining similar questions. Composite areas include: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Courteous and Helpful Office Staff,* and *Customer Service.* As with other data sources used throughout this report, Delmarva assessed CAHPS scores using the quality, access, and timeliness framework. CAHPS composite scores were divided as follows:

- Quality
  - *Getting Needed Care*
  - *How Well Doctors Communicate*
- Access
  - *Getting Care Quickly*
- Timeliness
  - *Courteous and Helpful Office Staff*
  - *Customer Service*

Adult members were classified as those 18 years or older and child members were classified as those members 17 years or younger for survey purposes.

Medi-Cal Adult and Child overall averages were calculated from the ratings of all 30 contracts within the Medi-Cal managed care plans operating in the State of California and were weighted to be proportionate to plan enrollment. Delmarva employed a calculation method whereby a plan's result is considered indicative of high performance in a CAHPS composite area when 80 percent or more of the total responses for the composite area fall within the most positive response category (*i.e.,* definitely yes, always, etc.). It should be noted that this calculation method differs from the standardized scoring method established by NCQA. For future CAHPS surveys, California is likely to adopt NCQA's calculation methods, including scoring.

Sample Selection and Survey Methodology

Sample selection and survey methodology are summarized below:

Sample Groups

Surveyors pulled a random sample of eligible members from each managed care plan for participation in the survey.

Adult Sample

For each managed care plan, the CAHPS 4.0H adult survey sample was drawn first, employing the required sample size. An overall score was calculated for the adult population by collecting the results from all plans and weighting the results by each plan's population size relative to the total Medi-Cal managed care population.

Child Sample

The CAHPS 3.0H child survey sample was drawn second, employing the required sample size.

Children with Chronic Conditions and CSHCN Population

The Children with Chronic Conditions (CCC) supplemental sample is drawn from the set of prescreened members who were not already selected for the CAHPS 3.0H child survey sample. The CCC survey-based screening tool contains five questions representing five different health consequences. A child member is identified as having a chronic condition if all parts of the question for at least one of the specific health consequences are answered "Yes."

The CSHCN population consists of all child members identified as having a chronic condition, as defined by the parent's/guardian's responses to the CCC survey-based screening tool. The term "CSHCN" refers to all child members surveyed who met the criteria for Children with Special Health Care Needs. After Sample A was drawn, an oversample (Sample B) was drawn as required by NCQA sampling methodology. Sample B contains the CCC Measurement Set. These children were identified by the prescreening process described above. Therefore, it is important to note that the CCC population data set is a subset of Sample A/General Population and the CCC population may also have been included in the results for Sample B.

Calculating an overall score by collecting the results from all plans and weighting the results by plan population size could not be accomplished for the CSHCN population due to the selection methodology and possibility of "double counting." Overall, 31 percent of child members across all plans qualified as having special health care needs based on parent's/guardian's responses to the CCC screening tool.

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