Quality Measurement Report – 2002

The major quality objective for the Healthy Families Program (HFP) is to "assure that health services purchased for the program are accessible to enrolled children". To meet this objective, the Managed Risk Medical Insurance Board (MRMIB) uses several tools to monitor access and quality of health care. One of these tools is the health plan quality reports that are submitted annually by participating health plans.

The health plan quality report contains information on a selected set of quality indicators. These indicators were selected based on recommendations from the HFP Quality Accountability Framework, (which was commissioned by the California HealthCare Foundation), the HFP Quality Improvement Work Group and the HFP Advisory Panel. The indicators selected include a set of child-relevant HEDIS® (Health Plan Employer Data and Information Set) measures applicable to the calendar year 2002 and a quality measure that was developed by the California Department of Health Services for the Medi-Cal Managed Care Program.

This report, the Healthy Families Program Quality Measurement Report 2002, summarizes the reports received from participating health plans. The report presents comparable plan information for each quality measure (for which sufficient data was available) and aggregate data for the program.

QUALITY INDICATORS

1) HEDIS®

The National Committee for Quality Assurance's (NCQA) HEDIS® is a nationally recognized tool to evaluate services provided by health plans. Public and private organizations that purchase health care services are principal users of HEDIS®. Many purchasers of health insurance use HEDIS® as a standard for quality measurement.

HEDIS® consists of 56 measures related to effectiveness of care, use of services and access to care. Health plans participating in the HFP were required to report five child-relevant measures. These measures included:

- Childhood Immunization Status
- Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life
- Adolescent Well-Care Visits
- Children's Access to Primary Care Practitioners
- Follow-up After Hospitalization for Mental Illness

NCQA allows health plans to use one of two methods for collecting HEDIS® data. The *administrative method* requires plans to search selected administrative databases (e.g., enrollment, claims, and encounter data systems) for evidence of a service.

The *hybrid method* requires plans to select a random sample of 411 eligible members, and search their administrative databases for information about whether each individual in the

sample received a service. If no information is found, plans are allowed to consult medical records for evidence that services were provided.

Of the measures allowing either data collection option (Childhood Immunizations / Well Child Visits / Adolescent Well Visits), most health plans used the *hybrid method*. Health plans were required to use of the *administrative method* for the Access to Primary Care Provider.

2) 120-DAY INITIAL HEALTH ASSESSMENT

This measure was developed as a pilot measure by the California Department of Health Services and was tested by health plans in 2001. Health plans were required to use the administrative method protocols similar to the protocols for HEDIS®. MRMIB adopted the 120-Day Initial Health Assessment to measure the number of newly enrolled children in the HFP who visited a primary care provider within the first 120 days of their enrollment.

COMPLIANCE AUDIT

MRMIB requires plans to have their quality reports audited by an NCQA certified HEDIS® auditor. The audits ensure the credibility of reported data. All health plans participating in the HFP have complied with the audit requirement.

ANALYSIS OF DATA REPORTED BY PLANS

Each health plan submitted its score or *rate* for the five child relevant HEDIS® measures according to HEDIS® reporting guidelines. These rates were calculated by dividing the number of health plan subscribers who received a particular service (numerator) by the number of subscribers who were eligible to receive the service (denominator). Only those rates that had been certified by a HEDIS® auditor were submitted in the plan reports. The individual plan scores were used to calculate an overall plan average. Health plans that had scores one standard deviation above or below the plan average were identified.

In addition to the plan average, an *aggregate program average* was calculated by dividing members from all health plans who received a particular service by the total number of members in all health plans that were eligible to receive the service. The plan average is compared to *National Results for Selected HEDIS®* measures established by NCQA.

PRESENTATION OF RESULTS

Individual Plan Results

NCQA recommends that scores based on sample sizes of less than 30 members should not be reported. Results from small samples do not withstand the statistical analysis used to determine if the results are due to chance. Plans that had fewer than 30 members in the samples are given a "NM" or Not Meaningful.

Program Results

Each measure is presented in tabular form displaying the score for each category along with the sample size (in parentheses). Results by selected language and ethnic groups are also included.

Information on language preference and ethnicity comes from the member's application. Because some subscribers choose not indicate a language preference or declare an ethnicity on their application, the total sample population may not be equal to the total eligible population sampled.

Healthy Families Program
Quality Measurement Report Overview

The following summary represents the HFP aggregate program scores for the 2000 through 2002 calendar year periods. For comparison, results from NCQA's National Results for Selected HEDIS/CAHPS® Measures and National Medicaid Results for Selected HEDIS® and HEDIS/CAHPS® Measures for *calendar year 2001 are presented*. NCQA calendar year 2002 results *were not* available at time of publication. Current NCQA results can be obtained from the NCQA website at www.ncqa.org.

Table 1 – Overview of HFP Scores and Benchmarks

Measure Description	Healthy Families Program Score 2001 Calendar Year	**Healthy Families Program Score 2002 Calendar Year**	Medi-Cal Managed Care Score 2001 Calendar Year	Medi-Cal Managed Care Score 2002 Calendar Year	NCQA National Average Commercial Results 2001 Calendar Year	NCQA National Average Medicaid Results 2001 Calendar Year
Childhood Immunization Status						
Combination 1*	65%	**72%**	56%	60%	68%	59%
Combination 2*	61%	**69%**	51%	57%	58%	52%
Well Child Visits in the 3rd through 6th Years of Life	60%	**63%**	54%	56%	58%	55%
Adolescent Well-Care Visits	33%	**34%**	26%	27%	38%	32%
Children's Access to Primary Care Practitioners						
Cohort 1 (ages 12 - 24 months)	89%	**91%**	Not Included in Medi-Cal Report	Not Included in Medi-Cal Report	95%	90%
Cohort 2 (ages 25 months - 6 years)	80%	**83%**			86%	70%
Cohort 3 (ages 7 - 11 years)	80%	**82%**			86%	70%
Follow-up After Hospitalization for Mental Illness [(1)]						
within 7 Days	27%	**23%**	Not Included in Medi-Cal Report	Not Included in Medi-Cal Report	51%	32%
within 30 Days	46%	**38%**			73%	52%
120-Day Initial Health Assessment	46%	**48%**	Not Included in Medi-Cal Report	Not Included in Medi-Cal Report	Not Applicable	Not Applicable

* Combination 1 includes age appropriate vaccinations for diphtheria/tetanus/pertussis, polio, measles/ mumps/rubella, H. influenza type B, and Hepatitis B. Combination 2 includes all age appropriate vaccinations in Combination 1 and the chicken pox vaccine.

(1) Total sample size for this measure was 469 subscribers in 2002, 225 subscribers in 2001, and 112 subscribers in 2000. A factor that may make tracking data difficult for this measure is the mental health "carve out" in the HFP. Children who are suspected of being severely emotionally disturbed (SED) are referred to county mental health departments for assessment and treatment. Measure is for adults and children in NCQA.

Childhood Immunization Status

Importance of Measure: It is estimated that one million children in the United States do not receive the necessary vaccinations by age two. Immunizations have proven to be one of the easiest and most effective methods of delivering preventative medicine. Immunizations are the first and foremost line of defense against childhood diseases.

Calculation: This measure is the percentage of children who turned two years old during the measurement year, who were continuously enrolled for 12 months preceding their second birthday and received the following immunizations according to the American Academy of Pediatrics established schedule. Based on the above age and timing criteria, a child may have actually received his or her required immunizations but failed to be included in the measure's numerator.

Combination 1
4 DTP/DTaP (diphtheria/tetanus/pertussis)
3 IPV/OPV (polio)
1 MMR (measles/mumps/rubella)
2 HiB (H. influenzae type b)
3 Hep (Hepatitis B)

Combination 2
Same as Combination 1 plus
1 VZV (Chicken Pox)

2002 Performance: Childhood immunizations have improved consistently over the last three years. Immunizations based on the Combination 2 measure have grown from 57 percent in 2000 to 61 percent in 2001 to the current rate of 69 percent for 2002. *(Changes in overall scores were analyzed and determined to be statistically significant.)* In addition to higher values for the combination rates, scores for the individual antigens have also continued to improve in all categories. Compared to the 2001 NCQA national averages, the HFP continues to perform at levels above both commercial and Medicaid benchmarks.

Of the 18 plans that had sufficient data to report for the 2001 and 2002 reporting period, thirteen (13) plan scores improved at least one percentage point, and five (5) plan scores declined. *(NCQA requires a minimum of 30 observations to consider the sample valid. Five (5) plans did not meet this minimum for both 2001 and 2002 and are identified in Table 4 as "NM" or not meaningful).*

The statistical analysis of selected ethnicities on the following page indicates significant improvement among Latino, White, African American and American Indian/Alaskan Native populations. The Asian/Pacific Islander population was most likely to be immunized, while the White population was least likely to have their required immunizations. Spanish speakers were more likely than English speakers to be immunized. The Asian population measured by either ethnicity or language (Asian/Pacific Islander ethnicities, Chinese, Vietnamese, Korean languages) were generally immunized at a higher rate than the other ethnic and language groups studied.

Table 2: Childhood Immunization Status - Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	23	25 *
Total Sample	2,586	3,943	5,620
Number of Plans Reporting - Methodology	Admin – 2 Hybrid – 22	Admin – 1 Hybrid – 22	Admin – 1 Hybrid – 24
Range of Scores	34% to 75%	35% to 83%	52% to 92%
Average / Median Score	54 % / 53%	60% / 62%	70% / 67%
Aggregate Program Score (Combination 2)	**57%**	**61%**	**69%**

Calendar Year	**Combo 2**	Combo 1	DPT	IPV	MMR	HIB	HEP	VZV
2002	**69%**	72%	83%	89%	92%	85%	85%	88%
2001	**61%**	65%	78%	83%	88%	79%	79%	83%
2000	**57%**	61%	75%	78%	83%	75%	72%	77%

* Note: Although L.A. Care Health Plan reported data and is included in this number and overall calculations, L.A. Care Health Plan no longer participates in HFP and is not included in the Individual Plan Scores graphs.

Table 3: Childhood Immunization Status – Demographic Analysis

Childhood Immunization Status – Combination 2

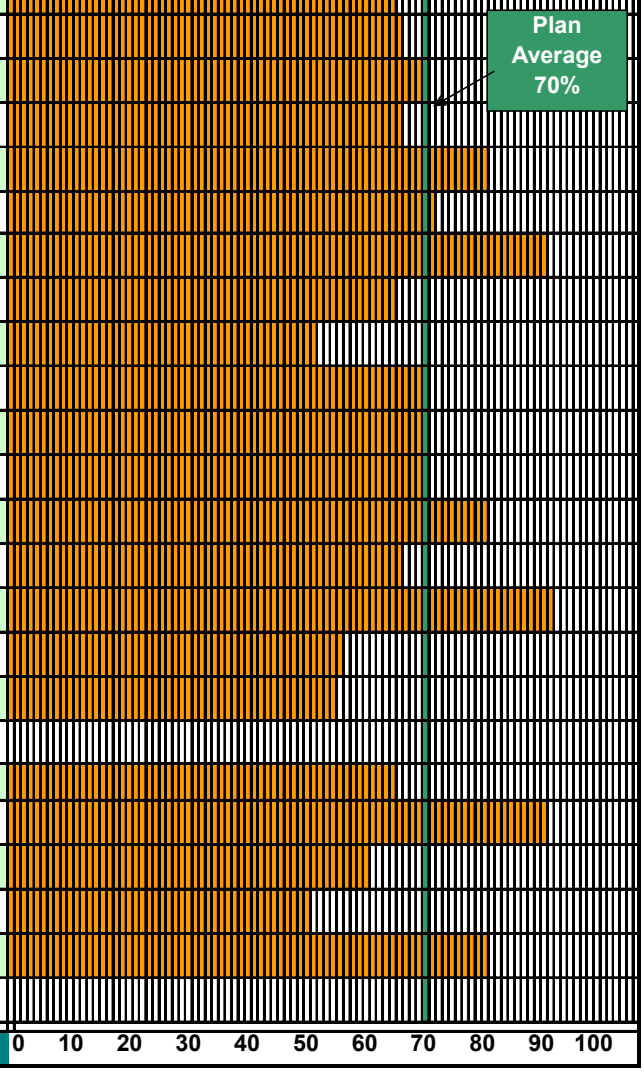
Ethnicity	2001	**2002**
Latino	(1,920) *59%*	(2,813) ***72%***
Asian/Pacific Islander	(335) *72%*	(553) ***77%***
White	(421) *58%*	(627) ***65%***
African American	(56) *54%*	(122) ***75%***
American Indian/ Alaska Native	(9) *33%*	(7) ***100%***

Primary Language of Applicant	2001	**2002**
English	(1,437) *58%*	(2,382) ***69%***
Spanish	(1,393) *61%*	(1,942) ***72%***
Vietnamese	(71) *76%*	(179) ***82%***
Chinese	(125) *66%*	(160) ***74%***
Korean	(50) *80%*	(58) ***76%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 4: Childhood Immunization Status (Combination 2) -- Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score *	57%	61%	69%	
Alameda Alliance for Health	NM	63%	64%	
Blue Cross - EPO	53%	59%	66%	
Blue Cross - HMO	63%	63%	70%	
Blue Shield - HMO	46%	55%	66%	
CalOptima	48%	76%	81%	
Care 1st Health Plan	NA	NA	73%	
Central Coast Alliance for Health	NM	NM	91% ▲	
Community Health Group	61%	72%	64%	
Community Health Plan	56%	35%	52% ▼	
Contra Costa Health Plan	NM	NM	70%	
Health Net of California	49%	56%	71%	
Health Plan of San Joaquin	56%	57%	70%	
Health Plan of San Mateo	NM	NM	80%	
Inland Empire Health Plan	50%	73%	67%	
Kaiser Permanente	75%	71%	92% ▲	
Kern Family Health Care	50%	66%	57% ▼	
Molina	34%	44%	55% ▼	
Santa Barbara Regional Health	NM	NM	NM	
Santa Clara Family Health Plan	60%	67%	65%	
San Francisco Health Plan	57%	78%	90% ▲	
Sharp Health Plan	39%	54%	61%	
UHP Healthcare	NM	61%	50% ▼	
Universal Care	69%	61%	80%	
Ventura County Health Care Plan	NM	NM	NM	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
* Many plans had low sample sizes for calendar year 2000. Please note when comparing changes in individual plan performance.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

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

Importance of Measure: The American Academy of Pediatrics (AAP) recommends annual well-child visits for two to six year olds. Benefits of this measure are detection of potential vision, speech, learning, or other problems that may be prevented by early intervention.

Calculation: This measure describes the percentage of members who were three, four, five, or six years old during the measurement year, who were continuously enrolled in the plan during the measurement year, and who received one or more well-child visit(s) with a primary care provider during the measurement year.

2002 Performance: The tables on pages 8 and 9 describe trends in performance on an aggregate program view as well as individual plan level.

The aggregate HFP scores have continued to improve over the past three years, increasing by 3 percentage points per year with 57% in 2000, 60% in 2001 and 63% in 2002. *(Changes in overall scores were analyzed and determined to be statistically significant).* The HFP performance mirrored the improvements in quality demonstrated by the NCQA national commercial and Medicaid averages, which also improved during the 2001-2002 period. However, the HFP continues to perform at levels above both the 2001 commercial and Medicaid benchmarks.

Individual health plan scores improved steadily with 14 of the 24 plans (60%) improving by at least 1 percentage point, while 7 plans (30%) improved by at least 5 percentage points. Plans that serve the majority of the HFP subscribers (Blue Cross, Health Net, Kaiser, Blue Shield) all showed improvement. Eight plans indicated a decrease in percentage scores for 2002, and one plan remained unchanged.

Based on 2001 and 2002 results, the major trends within the selected demographic analysis are presented in the language and ethnicity of applicant categories. Although scores for this measure have improved marginally for all ethnicities and languages, (with the exception of Korean speakers who demonstrated a drop from 50% to 43%), these improvements are not considered statistically significant. Scores across ethnic groups indicated that Whites were statistically less likely to have a well child visit that either Latinos or Asian/Pacific Islanders. Chinese speakers were more likely to have a visit than either English or Spanish speakers, while Korean speakers were less likely to have received a service compared to all reported languages.

Table 5: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	24	25*
Total Eligible Population	12,330	14,695	13,776
Number of Plans Reporting - Methodology	Admin – 4 Hybrid – 20	Admin – 3 Hybrid – 21	Admin – 2 Hybrid – 23
Range of Scores	38% to 84%	40% to 74%	29 % to 79%
Average / Median Score	57% / 58%	61% / 63%	62% / 65%
Aggregate Program Score	**57%**	**60%**	**63%**

* Note: Although L.A. Care Health Plan reported data and is included in this number and overall calculations, L.A. Care Health Plan no longer participates in HFP and is not included in the Individual Plan Scores graphs.

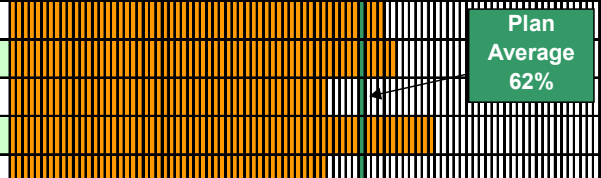
Table 6: Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life--Demographic Analysis

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(6,810) *62%*	(6,732) ***63%***	English	(3,585) *59%*	(4,263) ***60%***
Asian/Pacific Islander	(954) *63%*	(1,056) ***64%***	Spanish	(5,380) *62%*	(5,468) ***63%***
White	(966) *54%*	(1,195) ***58%***	Vietnamese	(152) *62%*	(194) ***62%***
African American	(199) *57%*	(284) ***61%***	Chinese	(390) *64%*	(472) ***69%***
American Indian/ Alaska Native	(19) *58%*	(19) ***68%***	Korean	(125) *50%*	(86) ***43%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 7: Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	57%	60%	63%	
Alameda Alliance for Health	61%	67%	68%	
Blue Cross - EPO	56%	58%	64%	
Blue Cross - HMO	63%	63%	66%	
Blue Shield - HMO	45%	53%	55%	
CalOptima	58%	63%	75% ▲	
Care 1st Health Plan	NA	NA	55%	
Central Coast Alliance for Health	70%	69%	65%	
Community Health Group	66%	68%	65%	
Community Health Plan	40%	43%	35% ▼	
Contra Costa Health Plan	56%	52%	48% ▼	
Health Net of California	49%	54%	61%	
Health Plan of San Joaquin	58%	65%	61%	
Health Plan of San Mateo	44%	69%	69%	
Inland Empire Health Plan	58%	70%	75% ▲	
Kaiser Permanente	59%	64%	65%	
Kern Family Health Care	55%	66%	70%	
Molina	39%	58%	68%	
Santa Barbara Regional Health	61%	74%	69%	
Santa Clara Family Health Plan	72%	73%	65%	
San Francisco Health Plan	84%	74%	79% ▲	
Sharp Health Plan	62%	63%	67%	
UHP Healthcare	62%	40%	29% ▼	
Universal Care	65%	57%	66%	
Ventura County Health Care Plan	49%	57%	58%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NA - No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Adolescent Well-Care Visits

Importance of Measure: Detection of changes in physical, social and emotional health status during this transitional period in a child's life is of great importance. The American Medical Association and the American Academy of Pediatrics stress the need for yearly visits in this population.

Calculation: This measure describes the percentage of members, ages 12 through 21 years old during the measurement year, who were continuously enrolled in the plan during the measurement year, and who received at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Because the HFP only covers children through their 19th birthday, the reports from the plans were based on children between the ages of 12 and 19.

2002 Performance: The aggregate program score improved by 1 percentage point to 34 percent. This score is above the 2001 NCQA national average for Medicaid plans and below the NCQA national average for commercial plans. Statistically, the aggregate percentage score differential between the HFP, Medicaid and Commercial plans may be considered nominal. Of the 24 plans reporting, 15 scores improved, with 6 plans improving by at least 5 percentage points, and 8 scores declining by at least 1 percentage point.

Table 8 on page 11 shows a decrease in 2001 for the total sample even though the HFP population continued to grow significantly during the 2000 to 2001 period. The 2001 decrease is due to a larger number of plans employing the *hybrid method* of data collection. As described on page 2 of this report, this method allows plans to use a random sampling method for scoring. Unless plans have comprehensive administrative data systems, rates based on the *hybrid method* are generally higher, but require more effort and are more costly than the *administrative* method. For 2002, the majority of plans continued to use the hybrid method and the increase in the sample population is reflected accordingly.

The demographic variables show significant improvements in English and Spanish speakers from 2001 to 2001. In addition, Latinos showed significant improvement in scoring from the prior year. Changes in all other language and ethnic categories were not deemed statistically significant. Comparisons between ethnic groups showed Whites being less likely to have a visit than the other groups analyzed and Asian/Pacific Islanders have a higher rate that Latinos. Chinese speakers show a significantly higher rate of visits than both English and Spanish speakers. As with the Well child visits, Korean speakers show significantly lower scores as compared to the other reported groups.

Table 8: Adolescent Well-Care Visits -- Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	24	25*
Total Sample	33,011	17,841	21,976
Number of Plans Reporting - Methodology	Admin – 6 Hybrid – 18	Admin – 3 Hybrid – 21	Admin – 3 Hybrid – 22
Range of Scores	13% to 47%	16% to 53%	12% to 49%
Average / Median Score	29% / 29%	32% / 33%	33% / 34%
Aggregate Program Score	**28%**	**33%**	**34%**

* Note: Although L.A. Care Health Plan reported data and is included in this number and overall calculations, L.A. Care Health Plan no longer participates in HFP and is not included in the Individual Plan Scores graphs.

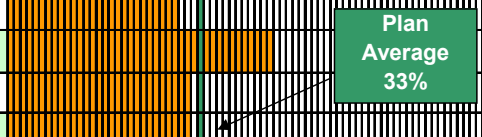
Table 9: Adolescent Well-Care Visits – Demographic Analysis

Adolescent Well-Care Visits					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(6,815) *31%*	(10,207) ***35%***	English	(4,623) *30%*	(8,263) ***34%***
Asian/Pacific Islander	(1,521) *34%*	(1,747) ***38%***	Spanish	(5,335) *31%*	(8,028) ***35%***
White	(1,480) *30%*	(2,707) ***32%***	Vietnamese	(255) *35%*	(273) ***40%***
African American	(402) *33%*	(785) ***38%***	Chinese	(734) *38%*	(838) ***41%***
American Indian/ Alaska Native	(43) *30%*	(52) ***29%***	Korean	(575) *31%*	(217) ***29%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 10: Adolescent Well-Care Visits- Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	27%	33%	34%	
Alameda Alliance for Health	30%	34%	44% ▲	
Blue Cross - EPO	25%	31%	29%	
Blue Cross - HMO	27%	35%	34%	
Blue Shield - HMO	23%	24%	27%	
CalOptima	31%	38%	47% ▲	
Care 1st Health Plan	NA	NA	31%	
Central Coast Alliance for Health	16%	32%	31%	
Community Health Group	38%	32%	34%	
Community Health Plan	20%	18%	20% ▼	
Contra Costa Health Plan	28%	24%	15% ▼	
Health Net of California	25%	27%	35%	
Health Plan of San Joaquin	28%	24%	28%	
Health Plan of San Mateo	26%	35%	48% ▲	
Inland Empire Health Plan	41%	41%	43%	
Kaiser Permanente	31%	32%	35%	
Kern Family Health Care	34%	32%	35%	
Molina	29%	39%	47% ▲	
Santa Barbara Regional Health	40%	36%	34%	
Santa Clara Family Health Plan	45%	36%	33%	
San Francisco Health Plan	47%	40%	49% ▲	
Sharp Health Plan	29%	34%	35%	
UHP Healthcare	22%	16%	12% ▼	
Universal Care	33%	35%	39%	
Ventura County Health Care Plan	19%	27%	22% ▼	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Children's Access to Primary Care Practitioners

Importance of Measure: Childhood access to primary care practitioners is positively associated with successful completion of recommended immunizations and identification and treatment of childhood conditions at early stages of disease.

Calculation: This measure describes children in three different age groups who had a visit with a plan primary care practitioner.

Children age 12 months through 24 months who were continuously enrolled during the measurement year and had a visit with a primary care practitioner during the measurement year.

In the Healthy Families Program, children in this age range constitute a small portion of the program's total enrollment. This is because children in this age range are only eligible if they are in families with incomes between 200% and 250% of Federal income guidelines.

Children age 25 months through 6 years who were continuously enrolled during the measurement year and had a visit with a primary care practitioner during the measurement year.

Children age 7 years through 11 years who were continuously enrolled during the measurement and the calendar year preceding the measurement year who had a visit with a primary care practitioner during the measurement year or the year preceding the measurement year.

Children are allowed one gap of up to 45 days during each year of continuous enrollment.

2002 Performance: This Access/Availability measure continues to show improvement during the 2002 reporting period. The overall aggregate program scores for Cohort 1 (12 to 24 months), Cohort 2 (25 months to 6 years) and Cohort 3 (Age 7 to 11 years) improved by 4, 5 and 3 percentage points, respectively. Trending plans from 2000 to 2002, these scores represent a 10 percentage point improvement for Cohort 2, and a 9 percentage point improvement for Cohort 3. Cohort 1's lesser recognized improvement during the same three-year period may be attributed to the relatively low sample of HFP subscribers in this category. *(Changes in overall score for all cohorts were analyzed and determined to be statistically significant).*

With respect to individual plan scores, 7 plans had scores for Cohort 1 that improved from the 2001 period. CalOptima, Health Plan of San Francisco had scores that improved from 2001 to 2002 by at least 10 percentage points. Over half the plans submitting meaningful data for Cohort 2 (55%) had improved their performance. Blue Shield HMO, Health Net, San Francisco Health Plan and UHP Healthcare registered improvements ranging from 10 to 26 percentage points from the 2001 period. Approximately 32 percent (7 plans), improved their scores by at least 5 percentage points. With respect to Cohort 3, 7 plans had improved scores, with Health Net, San Francisco Health Plan and UHP showing the greatest improvement.

Selected demographic analysis for all three cohorts indicate statistically significant improvements for most ethnic and language groups, the exception being African Americans in cohort 1 and American Indian/Alaskan Natives in Cohort 1 and Indian/Alaskan Natives in Cohort 2.

From 2001 to 2002, Cohort 2 experienced the greatest increase in the Asian/Pacific Islander (8 percentage points) and Latino (7 percentage points) in the ethnicity demographic category. In the primary language

demographic category, Cohort 1 experienced a 19 percentage point increase in the Vietnamese and a 10 percent increase in the Chinese demographic. In Cohorts 2 and 3, 10 percentage point increases were indicated for the Vietnamese (Cohort 2) and Korean (Cohort 3) in the language demographic category.

From 2001 to 2002, in both Cohort 1 and Cohort 2 in the ethnicity demographic category, the greatest meaningful increases were in Asian/Pacific Islander demographic (13 and 8 percentage points, respectively), followed by the Latino demographic with 6 and 7 percentage points in the same cohorts. The Cohort 3 African American category reflects an increase of 9 percentage points. A cross sectional review of these different ethnic groups reveals that the White population was significantly more likely to score higher than the other groups. This observation was similar in all cohorts.

In the primary language demographic category, Cohort 1 experienced a 19 percentage point increase in the Vietnamese and a 10 percent increase in the Chinese demographic. In Cohorts 2 and 3, 10 percentage point increases were indicated for Vietnamese (Cohort 2) and Korean (Cohort 3) languages. In comparing language groups, the only statistically significant observation was the lower scores for Chinese speakers relative to all other categories.

Table 11: Children's Access to Primary Care Practitioners - Cohort 1 (Ages 12 to 24 month) – Performance Overview

HFP Population Statistics *Cohort 1 Age 12 to 24 months*	2000	2001	2002
Number of Plans Reporting	23	23	24
Total Sample	1,500	5,222	7,488
Number of Plans Reporting - Methodology	Admin – 23 Hybrid – 0	Admin – 23 Hybrid – 0	Admin – 24 Hybrid – 0
Range of Scores	56% to 98%	72% to 100%	83% to 100%
Average / Median Score	82% / 84%	89% / 93%	93% / 93%
Aggregate Program Score	**87%**	**89%**	**93%**

Table 12: Children's Access to Primary Care Practitioners - Cohort 1 (Ages 12 to 24 months) – Demographic Analysis

Children's Access to Primary Care Practitioners — Cohort 1

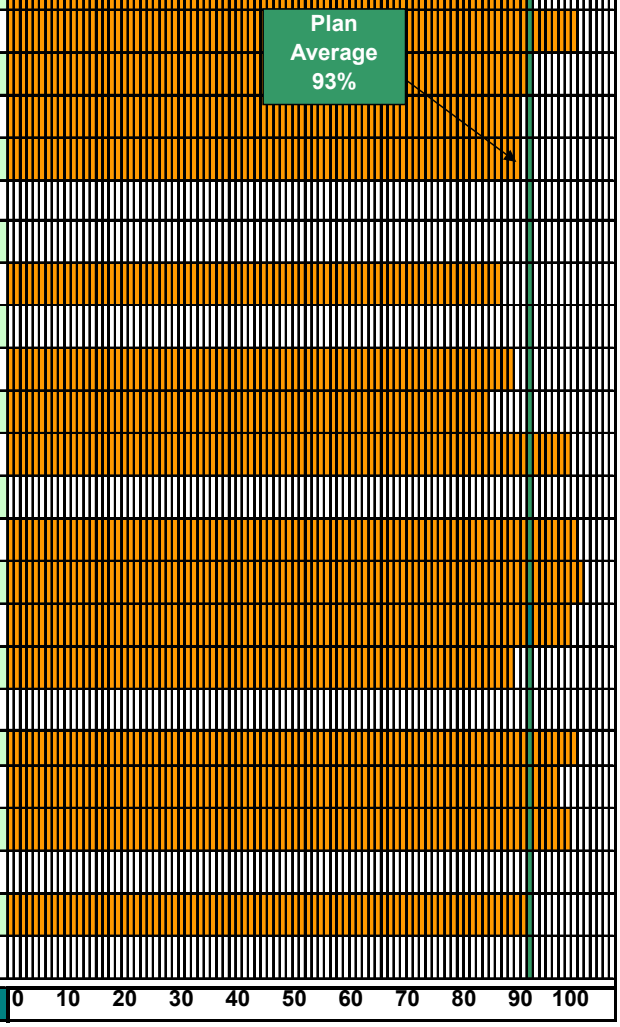
Ethnicity	2001	**2002**
Latino	(2,495) *88%*	(3,377) ***94%***
Asian/Pacific Islander	(645) *81%*	(783) ***94%***
White	(610) *92%*	(990) ***96%***
African American	(98) *87%*	(133) ***92%***
American Indian/ Alaska Native	(8) *88%*	(16) ***100%***

Primary Language of Applicant	2001	**2002**
English	(2,329) *89%*	(3,496) ***94%***
Spanish	(1,607) *88%*	(2,181) ***95%***
Vietnamese	(131) *79%*	(227) ***98%***
Chinese	(158) *79%*	(246) ***89%***
Korean	(112) *90%*	(113) ***90%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 13: Children's Access to Primary Care Practitioners - Cohort 1 (Ages 12 to 24 months) - Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	87%	89%	93%	
Alameda Alliance for Health	NM	93%	93%	
Blue Cross - EPO	98%	99%	99% ▲	
Blue Cross - HMO	90%	91%	93%	
Blue Shield - HMO	72%	78%	89%	
CalOptima	84%	80%	90%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	NM	NM	NM	
Community Health Group	77%	95%	85% ▼	
Community Health Plan	NM	NM	NM	
Contra Costa Health Plan	NM	93%	88%	
Health Net of California	66%	72%	83% ▼	
Health Plan of San Joaquin	NM	97%	97%	
Health Plan of San Mateo	NM	NM	NM	
Inland Empire Health Plan	80%	95%	99% ▲	
Kaiser Permanente	99%	99%	100% ▲	
Kern Family Health Care	NM	97%	97%	
Molina	NM	84%	89%	
Santa Barbara Regional Health	NM	NM	NM	
Santa Clara Family Health Plan	NM	100%	98%	
San Francisco Health Plan	NM	83%	96%	
Sharp Health Plan	89%	93%	97%	
UHP Healthcare	NM	NM	NM	
Universal Care	NM	92%	93%	
Ventura County Health Care Plan	NM	NM	NM	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Table 14: Children's Access to Primary Care Practitioners - Cohort 2 (Ages 25 months to 6 years) – Performance Overview

HFP Population Statistics – *Cohort 2 Age 25 months to 6 years*	2000	2001	2002
Number of Plans Reporting	24	23	24
Total Sample	41,608	72,667	93,509
Number of Plans Reporting - Methodology	Admin – 23 Hybrid – 0	Admin – 23 Hybrid – 0	Admin – 24 Hybrid – 0
Range of Scores	25% to 92%	41% to 92%	51% to 94%
Average / Median Score	71% / 72%	80% / 85%	83% / 86%
Aggregate Average Program Score	**75%**	**80%**	**85%**

Table 15: Children's Access to Primary Care Practitioners - Cohort 2 Ages 25 months to 6 years – Demographic Analysis

Children's Access to Primary Care Practitioners — Cohort 2

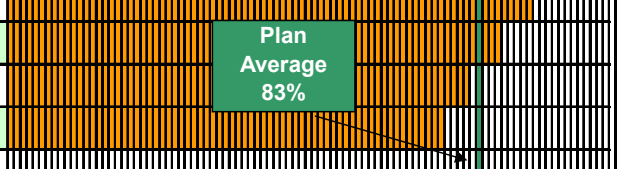
Ethnicity	2001	**2002**
Latino	(40,316) *79%*	(47,312) ***86%***
Asian/Pacific Islander	(5,756) *76%*	(8,522) ***84%***
White	(5,354) *82%*	(10,379) ***87%***
African American	(1,149) *77%*	(1,686) ***83%***
American Indian/ Alaska Native	(213) *79%*	(240) ***79%***

Primary Language of Applicant	2001	**2002**
English	(27,364) *80%*	(34,772) ***86%***
Spanish	(30,344) *79%*	35,304) ***86%***
Vietnamese	(986) *75%*	(1,678) ***85%***
Chinese	(3,170) *74%*	(3,368) ***82%***
Korean	(1,277) *79%*	(1,468) ***84%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 16: Children's Access to Primary Care Practitioners - Cohort 2 (Ages 25 months to 6 years) - Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	75%	80%	85%	
Alameda Alliance for Health	64%	86%	91%	
Blue Cross - EPO	91%	92%	91%	
Blue Cross - HMO	84%	84%	84%	
Blue Shield - HMO	63%	70%	81%	
CalOptima	68%	74%	76%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	92%	90%	86%	
Community Health Group	81%	88%	51% ▼	
Community Health Plan	41%	50%	NM	
Contra Costa Health Plan	85%	84%	77%	
Health Net of California	51%	60%	72%	
Health Plan of San Joaquin	88%	92%	92%	
Health Plan of San Mateo	58%	78%	81%	
Inland Empire Health Plan	51%	83%	89%	
Kaiser Permanente	92%	94%	94%	
Kern Family Health Care	86%	91%	90%	
Molina	50%	64%	70% ▼	
Santa Barbara Regional Health	90%	93%	91%	
Santa Clara Family Health Plan	82%	89%	82%	
San Francisco Health Plan	86%	74%	88%	
Sharp Health Plan	84%	86%	90%	
UHP Healthcare	25%	41%	67% ▼	
Universal Care	83%	85%	86%	
Ventura County Health Care Plan	88%	89%	92%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Table 17: Children's Access to Primary Care Practitioners - Cohort 3 (Ages 7 to 11 years) - Performance Overview

HFP Population Statistics – *Cohort 3 Age 7 to 11 years*	2000	2001	2002
Number of Plans Reporting	23	23	24
Total Eligible Population	14,217	51,250	92,391
Number of Plans Reporting - Methodology	Admin – 23 Hybrid – 0	Admin – 23 Hybrid – 0	Admin – 24 Hybrid – 0
Range of Scores	24% - 94%	46% to 94%	41% to 93%
Average / Median Score	67% / 70%	80% / 85%	81% / 84%
Aggregate Program Score	**74%**	**80%**	**83%**

Table 18: Children's Access to Primary Care Practitioners - Cohort 3 Ages 7 to 11 years – Demographic Analysis

Children's Access to Primary Care Practitioners — Cohort 3

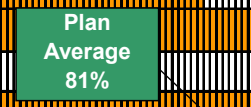
Ethnicity	2001	**2002**
Latino	(20,813) *79%*	(48,183) ***84%***
Asian/Pacific Islander	(4,854) *75%*	(8,984) ***81%***
White	(4,575) *84%*	(10,875) ***86%***
African American	(650) *76%*	(1,625) ***85%***
American Indian/ Alaska Native	(78) *83%*	(278) ***80%***

Primary Language of Applicant	2001	**2002**
English	(13,687) *81%*	(32,734) ***84%***
Spanish	(16,274) *78%*	38,501) ***84%***
Vietnamese	(354) *74%*	(1,027) ***82%***
Chinese	(2,853) *75%*	(4,349) ***79%***
Korean	(888) *73%*	(1,857) ***83%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 19: Children's Access to Primary Care Practitioners - Cohort 3 Ages 7 to 11 years – Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	74%	80%	83%	
Alameda Alliance for Health	79%	87%	90%	
Blue Cross - EPO	76%	90%	87%	
Blue Cross - HMO	70%	84%	81%	
Blue Shield - HMO	61%	70%	70%	
CalOptima	62%	74%	80%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	NM	94%	81%	
Community Health Group	79%	86%	41% ▼	
Community Health Plan	38%	51%	NM	
Contra Costa Health Plan	NM	81%	72%	
Health Net of California	61%	63%	73%	
Health Plan of San Joaquin	85%	83%	82%	
Health Plan of San Mateo	47%	91%	86%	
Inland Empire Health Plan	50%	80%	88%	
Kaiser Permanente	94%	94%	93%	
Kern Family Health Care	69%	88%	89%	
Molina	61%	66%	73%	
Santa Barbara Regional Health	78%	90%	92%	
Santa Clara Family Health Plan	76%	86%	83%	
San Francisco Health Plan	84%	75%	88%	
Sharp Health Plan	89%	88%	90%	
UHP Healthcare	30%	46%	67% ▼	
Universal Care	84%	85%	84%	
Ventura County Health Care Plan	90%	90%	89%	
				0 10 20 30 40 50 60 70 80 90 100



*Blue Shield EPO's sample size to small to report. Not included in report.
NM – Not meaningful. Sample size is too small to meet calculation criteria.
NA – No report. 2002 was the first year Care 1st fully participated.
NOTE: ▲ or ▼ indicate plan score was one or more points above or below the standard deviation from the 2002 plan average.

Follow-up After Hospitalization for Mental Illness

Importance of Measure: According to the National Institute for Mental Health, a significant percentage of individuals experience some form of mental illness, yet only a small percentage are actually diagnosed. For many children, hospitalization often represents the first introduction to mental health services. Regular follow-up therapy is an important component in assuring adequate treatment for patients diagnosed and hospitalized for mental illness.

Calculation: This measure calculates the percentage of subscribers age six and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled for 30 days after discharge (without gaps) and were seen on an ambulatory basis or were in day/night treatment with a mental health provider. Two scores are generated: 1) the percentage of subscribers who had an ambulatory or day/night mental health visit within *30 days* of hospital discharge, and 2) the percentage of subscribers who had an ambulatory or day/night mental health visit within *7 days* of hospital discharge.

2002 Performance: A factor that continues to hinder accurate tracking of meaningful data for this measure is the mental health "carve out" in the HFP. Children who are suspected of being severely emotionally disturbed (SED) are referred to county mental health departments for assessment and treatment. A health plan's ability to track the necessary information for this measure requires an effective exchange of information with the counties about every health plan's HFP enrollee with SED.

This fact limited the total sample size for this measure to 112 subscribers in 2000 and 225 subscribers in 2001. NCQA recommends that individual plan data not be reported when there is a sample size less than 30. In 2002 the sample size increased to 469 subscribers; however, only three out of 25 participating plans met the minimum sample size. Therefore, plan comparisons are not included in this report.

Table 20: Follow-up After Hospitalization for Mental Illness – Performance Overview

HFP Population Statistics Follow-up After Hospitalization for Mental Illness	2000	2001	2002
Number of Plans Reporting	11	11	18
Total Eligible Population	112	225	469
Number of Plans Reporting Methodology	Admin – 3 Hybrid – 8	Admin – 3 Hybrid – 8	Admin – 18 Hybrid – 0
Range of Scores	Insufficient data	Insufficient data	Insufficient data
Average / Median Score	Insufficient data	Insufficient data	Insufficient data
Aggregate Program Score 7 Days 30 Days	 **21%** **34%**	 **27%** **46%**	 **23%** **38%**

120-Day Initial Health Assessment

Importance of Measure: In addition to the HEDIS® measures, MRMIB required participating health plans to provide an additional measure identified as the *120-Day Initial Health Assessment.* This measure was initially developed as a voluntary pilot project through the California Department of Health Services and tested by selected health plans. It is intended to measure whether the primary care practitioner adequately assesses the subscriber's health status and assumes responsibility for the effective management of the subscriber's health care needs.

Calculation: The measure calculates the percentage of subscribers who enrolled during the reporting year and received an initial health assessment within their first 120 days of enrollment. Subscribers eligible for this measure must be two years of age or older upon their effective enrollment date and continuously enrolled for at least 120 days immediately following the effective enrollment date, with no gaps in enrollment.

Data Collection: The 120-Day Initial Health Assessment measure required the use of the *Administrative Method* of data collection for 2001 and 2002. Prior to 2001, plans had the choice of the *Administrative or Hybrid methods* of data collection.

2002 Performance: This measure encompasses the largest sample of children of all measures presented in this report, with over 298,000 subscribers sampled during the 2002 reporting period. Analysis of 2000 to 2002 data indicates overall program aggregate scores steadily improved from 43 percent in 2000 to 46 percent in 2001 to 48 percent in 2002. *(Changes in overall scores were analyzed and determined to be statistically significant).*

Over the three years, results showed 75 percent of plans realized improved scores of at least 2 percentage points. However, 7 plans (33%) showed a decline of 5 or more percentage points from 2001 to 2002.

Almost one-half of plans (41%) reporting meaningful data improved their 2001 score by at least 2 percentage points in 2002, while 5 plans (Blue Shield HMO, Health Net, Inland Empire Health Plan, Molina and San Francisco Health Plan) had improvements of at least 8 percentage points.

Selected demographic analysis for this measure remains relatively consistent across categories, with a general increase of between 1 and 7 percentage points. In the ethnicity demographic, statistically significant improvements were registered by the Latino, Asian Pacific Islander and African American groups, while all language groups experienced improvements deemed significant. Within the ethnic categories, African Americans were less likely to receive their 120 day IHA while Whites were more likely to receive one than the other groups studied. Chinese speakers were less likely to receive this visit that the other groups, while English speakers were more likely to receive this service.

No NCQA benchmarks exist for this measure.

Table 21: 120 Day Initial Health Assessment – Performance Overview

HFP Population Statistics	2000	2001	2002
Number of Plans Reporting	24	24	22
Total Eligible Population	200,011	224,886	298,277
Number of Plans Reporting - Methodology	Admin- 24 Hybrid - 0	Admin - 24 Hybrid - 0	Admin - 22 Hybrid - 0
Range of Scores	14% to 62%	22% to 76%	12% to 71%
Average / Median Score	39% / 39%	44% / 44%	44% / 45%
Aggregate Program Score	**43%**	**46%**	**48%**

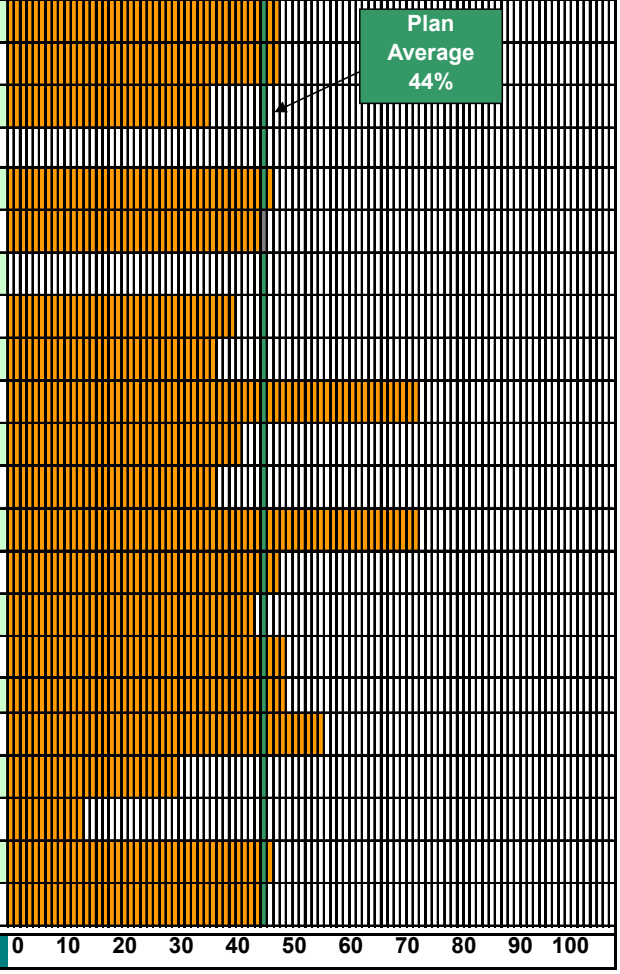
Table 22: 120 Day Initial Health Assessment – Demographic Analysis

120-Day Initial Health Assessment					
Ethnicity			Primary Language of Applicant		
	2001	**2002**		2001	**2002**
Latino	(124,698) *44%*	(132,873) ***49%***	English	(95,586) *48%*	(116,645) ***51%***
Asian/Pacific Islander	(18,398) *45%*	(19,246) ***48%***	Spanish	(99,346) *43%*	(99,579) ***48%***
White	(31,462) *53%*	(41,075) ***54%***	Vietnamese	(3,750) *42%*	(3,230) ***49%***
African American	(6,229) *41%*	(6,983) ***44%***	Chinese	(6,076) *42%*	(4,349) ***44%***
American Indian/ Alaska Native	(938) *47%*	(1,222) ***51%***	Korean	(4,355) *47%*	(4,363) ***52%***

(Number in parentheses indicate the number of children in the eligible sample)

Table 23: 120 Day Initial Health Assessment – Individual Plan Scores

Health Plan	2000 Score	2001 Score	2002 Score	2002 Percent
				0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	43%	46%	48%	
Alameda Alliance for Health	35%	45%	42%	
Blue Cross - EPO	59%	61%	56%	
Blue Cross - HMO	56%	58%	46%	
Blue Shield - HMO	22%	38%	47%	
CalOptima	28%	36%	34%	
Care 1st Health Plan	NA	NA	NM	
Central Coast Alliance for Health	33%	40%	45%	
Community Health Group	39%	42%	44%	
Community Health Plan	25%	22%	NM	
Contra Costa Health Plan	34%	44%	39%	
Health Net of California	21%	28%	36%	
Health Plan of San Joaquin	62%	60%	70% ▲	
Health Plan of San Mateo	49%	76%	40%	
Inland Empire Health Plan	28%	20%	36%	
Kaiser Permanente	57%	67%	71% ▲	
Kern Family Health Care	48%	50%	46%	
Molina	25%	33%	42%	
Santa Barbara Regional Health	52%	54%	48%	
Santa Clara Family Health Plan	51%	54%	49%	
San Francisco Health Plan	41%	39%	53%	
Sharp Health Plan	51%	27%	29%	
UHP Healthcare	19%	32%	12% ▼	
Universal Care	41%	44%	45%	
Ventura County Health Care Plan	39%	44%	43%	
				0 10 20 30 40 50 60 70 80 90 100



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Appendix A -- Scoring Summary By Measure

▲ = Indicates Score 1 Standard Deviation Above the Mean

▼ = Indicates Score 1 Standard Deviation Below the Mean

Measure

PLAN	Child Immun	Well Child 4,5 & 6	Adol Well Child	PCP Access Cohort 1	PCP Access Cohort 2	PCP Access Cohort 3	120-Day IHA
Alameda Alliance for Health			▲				
Blue Cross EPO				▲			
Blue Cross HMO							
Blue Shield HMO							
CalOPTIMA		▲	▲				
Care1st Health Plan							
Central Coast Alliance for Health	▲						
Community Health Group				▼	▼	▼	
Community Health Plan	▼	▼	▼				
Contra Costa Health Plan		▼	▼				
Health Net				▼			
Health Plan of San Joaquin							▲
Health Plan of San Mateo			▲				
Inland Empire Health Plan		▲		▲			
Kaiser Permanente	▲			▲			▲
Kern Health Systems (Kern Family Health Care)	▼						
Molina	▼		▲		▼		
Santa Barbara Regional Health Authority							
Santa Clara Family Health Plan							
San Francisco Health Plan	▲	▲	▲				
Sharp Health Plan							
UHP HealthCare	▼	▼	▼		▼	▼	▼
Universal Care							
Ventura County Health Care Plan			▼				

Endnotes

i. HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care organizations.

NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

ii. Report prepared by Benefits and Quality Monitoring, Managed Risk Medical Insurance Board. For questions, please call Vallita Lewis at (916) 324-4695 or e-mail vlewis@mrmib.ca.gov.