

CALIFORNIA HEALTH CARE PERFORMANCE RESULTS

2003 REPORT ON QUALITY



MANAGED CARE IN CALIFORNIA

ABOUT CCHRI

Measuring how well the managed care industry is performing is a challenge. Since 1994, the California Cooperative Healthcare Reporting Initiative (CCHRI) has assumed this challenge. Each year, CCHRI provides the public with important information on how well health plans provide certain preventive and other medical services that managed care members should receive. CCHRI also shares information about members' satisfaction with their HMOs obtained from a statewide member survey of participating health plans.

CCHRI is a collaborative of health care purchasers, plans and providers. It is managed by one of its founding organizations, the Pacific Business Group on Health (PBGH). PBGH is a coalition of large employers that is committed to improving the quality of health care while moderating costs. Thirteen California health plans participate in a variety of CCHRI-sponsored data collection and reporting projects. Because CCHRI projects are voluntary, plan participation may vary but most plans participate in more than one activity.

CCHRI was created to help employers and consumers make informed health care purchasing decisions. By ensuring the utilization of collaborative, standardized processes, plans can be compared on an apples-to-apples basis using data that is collected in similar ways, following similar guidelines. The 2002 Report on Quality is CCHRI's ninth annual account on health plan performance.

The CCHRI yearly report offers these advantages:

- CCHRI promotes comparability of results by providing a single process for collection and analysis of California health plans' quality of care and member satisfaction data. Consistent, standardized data collection makes the results more comparable.
- By using an independent and impartial third party to audit and analyze the data, CCHRI can ensure a greater degree of comparability among health plans. CCHRI believes these audits decrease the uncertainty sometimes associated with data collection and offer consumers additional confidence that CCHRI's publicly reported results are accurate and meaningful.
- Performance reporting definitions are standardized, leading to meaningful rankings and better understanding of the specific measures.

This report does not distinguish between medical groups' and health plans' roles in managing administrative and patient care responsibilities, which often overlap. This is especially true in California, where physician organizations have taken on many functions formerly directed by health plans.

MEASURES OF EFFECTIVENESS OF CARE AND SATISFACTION

Health plan performance results reported by CCHRI on the following pages are part of HEDIS 2002 (Health Plan Employer Data and Information Set), a set of standardized measures developed and maintained by the National Committee for Quality Assurance, NCQA. NCQA is a not-for-profit organization committed to evaluation and public reporting on the quality of managed care plans in the United States.

NCQA developed the Effectiveness of Care clinical measures and the member satisfaction measures so health plans could use comparable tools and methods to evaluate and report the quality of health care provided to their members. Ninety percent of HMOs nationwide and approximately three-quarters of large employers utilize HEDIS to measure and compare health plan outcomes and make informed health care choices.

CAUTION

Use caution when comparing results from California health plans not listed in this report with results that do appear here. CCHRI cannot ensure other data were collected under similar circumstances or that the results can be fairly and uniformly compared.

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CALIFORNIA HEALTH PLAN REPORT CARD

CLINICAL MEASURES

CCHRI'S VOLUNTARY COLLABORATIVE APPROACH TO COLLECTING AND REPORTING IMPORTANT HEALTH CARE INFORMATION HAS HELPED DRIVE QUALITY MEASUREMENT AND IMPROVEMENT IN CALIFORNIA. Health plans are able to use the results for their own quality improvement efforts and, since the start of public reporting in 1994, there have been significant advances in patient care and satisfaction according to CCHRI health plan results. All survey and clinical data are collected using uniform processes and guidelines and undergo a rigorous audit by an independent third party. As a result, the scores listed here are valid and comparisons can be made on an apples-to-apples basis. Results from other, non-CCHRI health plans may not be comparable because of differences in how data were collected or audited.

CLINICAL MEASURES

Findings for the clinical measures listed below were obtained from data collected by CCHRI participating health plans. Results are based on HEDIS Effectiveness of Care measurement and reporting guidelines developed by the National Committee for Quality Assurance (NCQA). HEDIS is the most widely used set of performance measures in the managed care industry and, when used with the NCQA-approved Member Survey, helps identify health plan successes in providing preventive care and other medical services for managed care members. Results were collected in 2003 and reflect the percentage of sampled members who received the specific services during 2002, or in prior years for a few of the measures.

HOW TO INTERPRET THE RESULTS

When reviewing this report card, please compare each plan to the benchmark and not to the other plans. Most ratings are based on a small sample of health plan members. As a result, small differences in the results between plans may not be statistically significant or meaningful.

The information contained in this report pertains only to health maintenance organizations (HMOs). Comparable data about other insurance models, such as fee-for-service and preferred provider organizations, are not readily available because these systems are not designed to manage population-based preventive health care or collect data in the same ways as HMOs. Therefore, results listed are for commercial HMO members only.

CLINICAL MEASURES *1 of 3*

CALIFORNIA HEALTH PLANS

	YOUNG FAMILIES				WOMEN'S HEALTH			
	Prenatal and Postpartum Care		Childhood Immunizations		Adolescent Immunizations		Cervical Cancer Screening	Breast Cancer Screening
	Timely Initiation of Prenatal Care	Postpartum Care	Combo 1	Combo 2	Combo 1		Ages 16-20	Ages 21-26
Aetna	93	83	72	66	60	81	75	15
Blue Cross	95	83	74	70	58	79	75	17
Blue Shield	94	82	71	68	55	80	73	20
CIGNA HealthCare	90	84	70	67	58	78	72	14
Health Net	87	75	71	67	58	79	76	25
Kaiser Permanente — North	89	75	74	70	74	80	75	49
Kaiser Permanente — South	91	87	88	87	76	81	72	57
PacifiCare	93	85	73	71	60	82	76	27
2003 National Mean^a	87	77	69	63	50	80	75	25
2003 National 75th Percentile^a	93	85	78	72	66	84	79	30
2003 National 90th Percentile^a	95	87	82	77	78	87	83	35

NOTES

a – Source: National Centers for Quality Assurance (NCQA) Quality Compass 2002, 90th percentile of the national data

CLINICAL MEASURES *2 of 3*

CALIFORNIA HEALTH PLANS

	CHRONIC DISEASE									
	Use of Appropriate Medications for People with Asthma					Comprehensive Diabetes Care				
	Ages 5-9	Ages 10-17	Ages 18-56	HbA1c Test	HbA1c Level < 9.5%	Retinal Exam	LDL Test	LDL Level of <130 mg/dl	Nephropathy Monitoring	
Aetna	67	66	70	76	62	☒	84	53	48	
Blue Cross	62	64	68	85	69	55	88	57	61	
Blue Shield	65	67	69	80	63	45	89	54	53	
CIGNA HealthCare	60	57	65	85	69	59	88	52	51	
Health Net	67	66	71	83	70	56	88	57	56	
Kaiser Permanente — North	65	62	67	84	69	73	91	63	79	
Kaiser Permanente — South	58	57	65	83	68	6'8	90	62	82	
PacificCare	62	62	66	82	65	61	90	55	62	
2003 National Mean^a	70	65	69	83	34	52	85	55	52	
2003 National 75th Percentile^a	76	70	72	88	26	61	90	61	59	
2003 National 90th Percentile^a	80	74	76	91	21	68	92	66	69	

NOTES

a – Source: National Centers for Quality Assurance (NCQA) Quality Compass 2002, 90th percentile of the national data.

☒ – Data for this measure were not complete.

CLINICAL MEASURES 3 of 3

CALIFORNIA HEALTH PLANS

	MENTAL HEALTH				CARDIOVASCULAR HEALTH			
	Antidepressant Medication Management ^f		Follow-up After Hospitalization for Mental Illness		Beta Blocker After Heart Attack	Controlling High Blood Pressure	Cholesterol Management After Acute Cardiovascular Event ^d	
	Optimal Practitioner Contacts	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Within 30 Days of Hospital Discharge	Within 7 Days of Hospital Discharge		LDL Screening	LDL-C Level of <130 mg/dl ^e
Aetna	18	53	39	65	40	89 ^c	74 ^c	57 ^c
Blue Cross	36	60	41	58	37	90 ^c	74 ^c	60 ^c
Blue Shield	58	57	44	64	45	91 ^c	78 ^b	63 ^b
CIGNA HealthCare	26	58	35	70	48	96 ^c	79 ^c	66 ^c
Health Net	14	59	43	73	41	97 ^b	82 ^b	69 ^b
Kaiser Permanente — North	19	74	57	81	65	97 ^c	86 ^b	79 ^b
Kaiser Permanente — South	19	77	63	78	59	95 ^c	86 ^c	75 ^c
PacificCare	22	57	41	74	52	97 ^b	81 ^b	64 ^b
2003 National Mean^a	19	60	43	74	53	94	79	61
2003 National 75th Percentile^a	23	64	48	80	60	98	83	69
2003 National 90th Percentile^a	31	69	53	84	68	100	86	74

NOTES

a – Source: National Centers for Quality Assurance (NCQA) Quality Compass 2002, 90th percentile of the national data

Cholesterol Management and Beta Blocker After Heart Attack data are not collected yearly. Results reflect a health plan's most recently available data, indicated by the following:

b – reported in 2003

c – reported in 2002

d – Acute cardiovascular events include heart attack, heart bypass surgery and coronary angioplasty.

e – Patients with LDL cholesterol levels less than 130 mg/dL have a lower probability of developing heart disease. Patients with existing heart disease or history of a cardiac event (heart attack, heart bypass surgery, angioplasty) can reduce the likelihood of further illness or complications by lowering cholesterol levels to less than 130 mg.

f – Did adults with a new diagnosis of depression, and who were treated with anti-depressant medication:

Column 1: Have at least three follow-up visits with a health care provider during the 12-week period following diagnosis?

Column 2: Remain on antidepressant medication during the entire 12-week period following diagnosis?

Column 3: Remain on antidepressant medication for at least 6 months following diagnosis?

CALIFORNIA HEALTH PLAN REPORT CARD

MEMBER SURVEY

ABOUT THE MEMBER SURVEY

The results shown in the following table were collected in a member survey developed by the National Committee for Quality Assurance (NCQA) and administered by the California Cooperative Healthcare Reporting Initiative (CCHRI). Results include the percentage of sampled members who responded favorably to questions about their health plan or medical care and are based on random samples of participating health plan members (minimum sample size per plan = 1100). The survey was conducted during 2003 but reflects information about medical care and services provided to members during 2002.

The survey results contain four rated questions that measure members' overall experience with their medical care. Rated questions use a 0 to 10 scale, where 0 is the worst and 10 is the best score possible.

The Report Card also includes member survey results for composite categories. Composite categories include groups of related questions designed to provide a general idea of how well a health plan meets its members' expectations in specific areas. The categories report the combined results of several questions associated with a similar subject (e.g., Getting Needed Care includes responses to questions about choosing a personal physician, obtaining a referral to a specialist and delays in receiving health care).

All the responses included in a composite category are weighted equally to obtain a single score. For example, for questions with four possible answers, the results used to create a composite score include all responses that fall in the top two favorable categories (i.e., Always or Usually). The results listed are for commercial HMO members only and do not include information for Medicare beneficiaries covered under a managed care plan.

It is possible that health plan members who returned the questionnaire or participated in telephone interviews are more satisfied or less satisfied than members who did not return the questionnaire. In addition, because of differences among health plans in the numbers of members who responded to the survey, outcomes that are statistically significant (above average, average, below average) for one plan may not be statistically significant for another, even when the rates are the same. When reviewing the results, please compare each plan to the average and not to the other plans. Most scores are based on small samples of health plan members and small differences between plans may not be statistically significant or meaningful.

MEMBER SURVEY

CALIFORNIA HEALTH PLANS

	OVERALL PERFORMANCE (% of replies scoring 8, 9, or 10 on a 10-point scale)				SURVEY MEASURES				
	Health Plan	All Health Care	Personal Doctor or Nurse	Specialist Most Often Seen	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous & Helpful Office Staff	Customer Service
Aetna	65	67	67	65	71	72	87	90	70
Blue Cross	66	71	77	68	71	70	88	89	69
Blue Shield	66	73	78	74	71	75	91	90	70
CIGNA HealthCare	55	66	72	69	64	67	85	86	70
Health Net	62	74	78	72	71	73	91	90	66
Kaiser Permanente — North	67	67	73	73	75	75	87	90	74
Kaiser Permanente — South	68	68	76	73	74	70	86	88	77
PacificCare	76	76	80	77	78	74	90	92	73
Universal Care	62	69	75	72	73	71	88	89	74
Western Health Advantage	63	71	76	73	71	76	91	91	69
CCHRI Average^a	65	70	75	71	72	72	88	89	71

NOTES

a – This average includes all plans reporting data through CCHRI.

CALIFORNIA HEALTH PLAN REPORT CARD

MEDICARE

SENIOR POPULATION REPORT

In many locations, Medicare beneficiaries have the option to join an HMO managed health care plan designed exclusively for seniors. Medicare managed care plans coordinate medical services from a specific network of physicians and hospitals. Beneficiaries enrolled in senior health plans are entitled to the same services as those provided under traditional Medicare. Some HMOs also cover additional services for seniors, such as prescription medications, eyeglasses, dental care or hearing aids.

The chart below shows how well CCHRI health plans coordinated important preventive services and medical care for their senior members. Not all California health plans offered a Medicare HMO in 2001; only those that did are listed in the chart below.

Several California health plans provide senior HMO services in many portions of the state while others offer services on a more limited, regional or local basis. Consumers should contact health plans directly to ask whether managed Medicare services are available in their area.

MEDICARE CLINICAL MEASURES *1 of 2*

HEALTH PLANS WITH MEDICARE CONTRACTS

	WOMEN'S HEALTH		CHRONIC DISEASE					
	Breast Cancer Screening		HbA1c Test	HbA1c level <9.5%	Retinal Exam	LDL Test	LDL Level of <130 mg/dl	Nephropathy Monitoring
Aetna	72		82	73	NR	88	59	52
Blue Cross	75		85	76	69	93	65	65
Blue Shield	73		86	79	72	91	65	54
Health Net	83		90	81	71	92	65	61
Kaiser Permanente — North	79		91	85	86	96	76	87
Kaiser Permanente — South	78		87	81	89	96	77	88
PacificCare	74		87	82	75	91	64	61

NOTES

a – Source: National Centers for Quality Assurance (NCQA) Quality Compass 2002, 90th percentile of the national data

MEDICARE CLINICAL MEASURES *2 of 2*

HEALTH PLANS WITH MEDICARE CONTRACTS

	MENTAL HEALTH				CARDIOVASCULAR HEALTH			
	Antidepressant Medication Management ^f		Follow-up After Hospitalization for Mental Illness		Beta Blocker After Heart Attack	Controlling High Blood Pressure	Cholesterol Management After Acute Cardiovascular Event ^d	
	Optimal Practitioner Contacts	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Within 30 Days of Hospital Discharge	Within 7 Days of Hospital Discharge		LDL Screening	LDL-C Level of <130 mg/dl ^e
Aetna	6	54	39	NA	NA	69	66	52
Blue Cross	11	62	42	18	8	61	72	57
Blue Shield	9	69	56	48	35	58	76	61
Health Net	10	54	42	37	22	57	81	67
Kaiser Permanente — North	12	74	55	81	53	51	90	83
Kaiser Permanente — South	10	82	70	78	53	50	87	80
PacificCare	41	74	40	30	18	62	76	61

NOTES

a – Source: National Centers for Quality Assurance (NCQA) Quality Compass 2002, 90th percentile of the national data

Cholesterol Management and Beta Blocker After Heart Attack data are not collected yearly. Results reflect a health plan's most recently available data, indicated by the following:

b – reported in 2003
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d – Acute cardiovascular events include heart attack, heart bypass surgery and coronary angioplasty.

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INTRODUCTION

Since 1994, CCHRI health plans, employers and providers have collaborated on the annual collecting and reporting of HEDIS data. While HEDIS results provide useful quality “snapshots”, their contribution to better public health from progressive improvements over time may not be obvious. For example:

- Is there any evidence that the collection of HEDIS data by HMO plans over the past eight years has helped to improve health care quality in California?
- What do these year-on-year HEDIS improvements really mean in terms of improved health outcomes for Californians in managed care plans?

These questions are not easily answered when looking only at HEDIS trends from year to year. However, it is possible to offer additional details by translating HEDIS performance improvements into outcomes that patients and consumers understand, such as lives saved, diseases prevented, or costs avoided. Therefore, this section of the CCHRI Report moves beyond displaying rates to presenting assumptions about the actual health benefits these HEDIS improvements represent.

Two key questions are addressed in this section of the State of Managed Care in California:

1. How many deaths or other negative outcomes were prevented by improvements in HEDIS performance over the past several years?
2. How many deaths or other negative outcomes will be prevented if this improved performance is maintained in these patients over the next five years?

CCHRI is putting the “State of Managed Care in California” into a new perspective in 2002. The intent is to show how HEDIS improvements can be better explained using some common health conditions as examples. CCHRI selected acute cardiovascular events such as heart attacks, angioplasties, and coronary artery bypass surgery and diabetes to illustrate improvements in health care. Also included are examples of “additional progress” over a projected five-year period, based on the assumption that the same level of progress that has been measured by California HMOs over the past few years will continue in the future. CCHRI thinks this assumption is justified because of health plans’ ongoing activities to distinguish their performance from other plans, as well as the California marketplace competition for continuous health care improvement. Consumers actually benefit from this friendly competition as HMO baseline medical care and services annually improve.

CONCLUSION

CCHRI believes the annual HEDIS measurement project is not an end in itself, but rather a means to the end of improved health care outcomes for all Californians. Future CCHRI reports will continue to evaluate and document improvements in HEDIS measures that promote good health and quality medical care.

We used real CCHRI data and the latest medical literature and approved methods of analysis to estimate health benefits and explain what these improvements represent.

NOTE

The number of lives saved and the subsequent heart attacks prevented is much greater for the diabetes measures than for the two heart disease measures. The reason for this is subtle but important to understand. The outcomes for diabetes are based on all CCHRI health plan members who have diabetes, no matter how long ago the condition was diagnosed; this is the “prevalent” population. In contrast, the outcomes for the two heart disease measures are based only on patients who experienced important health problems such as a heart attack, bypass surgery, or angioplasty during a one-year period – the “incident” population. Unlike the diabetes measures, the outcomes for heart disease are not based on the total population of all patients with heart problems. If CCHRI were to estimate outcomes on the total population of people living with heart disease, the number of lives saved and subsequent heart attacks avoided would be very much greater – greater even than the improved outcomes among patients with diabetes.

FUTURE QUESTIONS AND CHALLENGES

As CCHRI moves forward in translating improved HEDIS performance into outcomes that patients and consumers actually experience and understand, additional approaches and lines of inquiry will present themselves, such as:

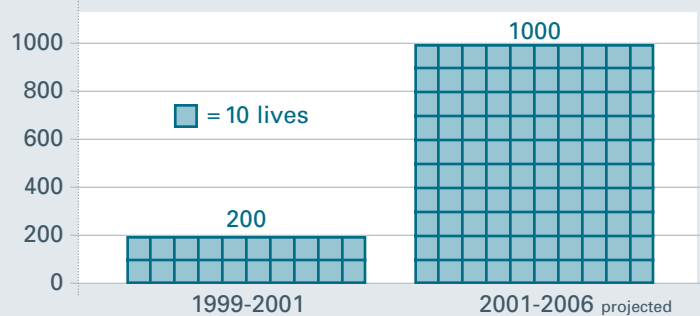
1. If all health plans performed at the level of the best performer among the plans, what health benefits would Californians experience?
2. How does care provided by California’s managed care plans compare with that provided in the fee-for-service world?

Estimates of outcomes provided by Kaiser Permanente’s Care Management Institute, from published clinical studies.

BLOOD SUGAR CONTROL IN PATIENTS WITH DIABETES

Blood sugar control is very important in managing diabetes, and HbA1c levels are a key measure of diabetic blood sugar control. Comparing 1999 and 2001 rates, more than 41,000 additional diabetics achieved an HbA1c level less than 9.5% (the lower the percentage of HbA1c, the better the control). This means that more than 200 deaths or nonfatal heart attacks among diabetics were prevented by better blood sugar control over this time period. If these patients maintain this level of blood sugar control over the next five years, over 1,000 deaths or subsequent heart attacks will have been prevented among diabetics enrolled in California HMOs.

Number of lives saved or heart attacks prevented due to better blood sugar control

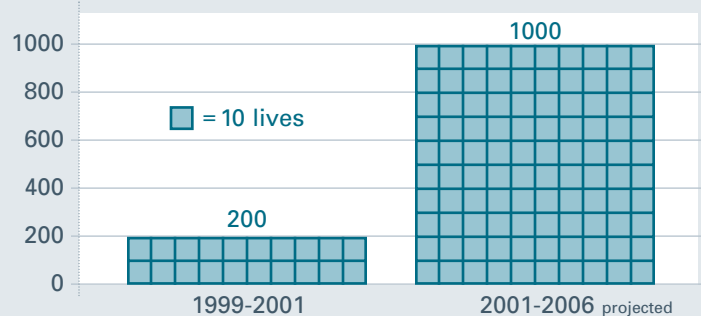


From 1999 to 2001 **41,000** additional patients received better blood sugar control reflected by improved HEDIS rates

CHOLESTEROL CONTROL IN PATIENTS WITH DIABETES

Comparing 1999 and 2001 HEDIS rates, an additional 48,000 diabetics showed improved levels of cholesterol control, preventing almost 200 deaths or subsequent heart attacks in patients with diabetes. If these patients maintain this level of cholesterol control over the next five years, almost 1,000 deaths or nonfatal heart attacks among diabetics will have been prevented in the California managed care population.

Number of lives saved or heart attacks prevented due to improved cholesterol control

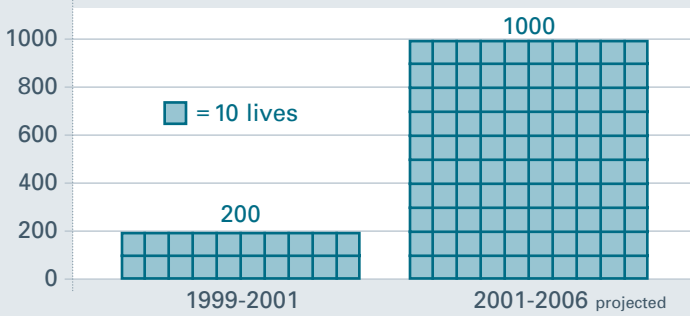


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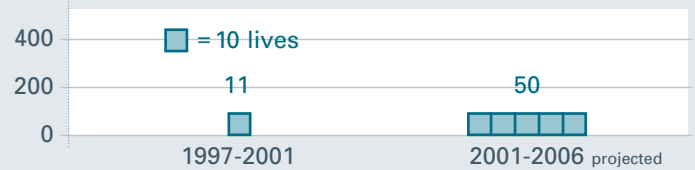


From 1999 to 2001 **48,000** additional patients received better cholesterol control reflected by improved HEDIS rates

USE OF BETA BLOCKER MEDICATION AFTER A HEART ATTACK FOR THE MEDICARE POPULATION

Comparing 1997 HEDIS rates to 2001 rates for Medicare patients who had a heart attack, almost 1,800 additional patients received beta blocker medication following their heart attack. Because beta blocker medications are known to help prevent successive heart attacks, this means that 11 deaths or subsequent heart attacks were prevented in this population. If these patients continue taking their beta blocker medication over the next five years, health plans will prevent over 50 deaths or subsequent heart attacks in this same group. If these statistics are applied to the much larger population of all patients in California with heart disease, many thousands of deaths and nonfatal heart attacks can be prevented.

Number of lives saved or heart attacks prevented due to improved beta blocker medication

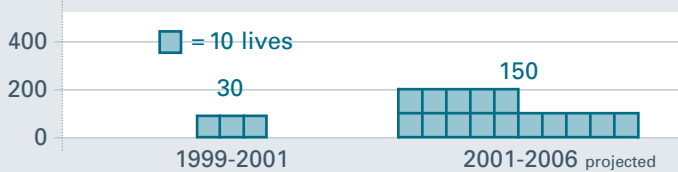


From 1997 to 2001 **1,800** additional patients received beta blocker medication reflected by improved HEDIS rates

CHOLESTEROL CONTROL IN PATIENTS WITH HEART DISEASE

Comparing HEDIS rates from 1999 and 2001, an additional 5,000 people in managed care plans recovering from an acute heart problem demonstrated better levels of cholesterol control. This prevented about 30 deaths or nonfatal heart attacks in these patients over the same time period. If these patients maintain their cholesterol control over the next five years, managed care plans will have helped prevent almost 150 deaths or subsequent heart attacks in this group of patients. If these statistics are applied to the larger number of all patients with heart disease enrolled in HMOs in California, many thousands of deaths and nonfatal heart attacks will be prevented.

Number of lives saved or heart attacks prevented due to improved cholesterol control



From 1999 to 2001 **5,000** additional patients received better cholesterol control reflected by improved HEDIS rates

MEASURES OF EFFECTIVENESS OF CARE

The clinical performance results displayed on the following pages use HEDIS Effectiveness of Care measures to evaluate three important components of quality medical care:

- The use of preventive services and routine screening tests, such as immunizations and mammograms, that help patients stay healthy;
- Utilization of the most up-to-date medical treatment and medication for sudden illnesses such as heart attacks;
- Medical care for patients with chronic conditions, such as asthma and diabetes.

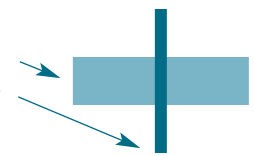
Data for these HEDIS measures are obtained from California health plans, using NCQA specified processes and guidelines that assure the accuracy and comparability of the results.

1. Health plans create lists of randomly selected members who are eligible to receive the recommended HEDIS preventive care or screening services.
2. Health plans supply data on whether or not the selected patients received the recommended service. Information is gathered from administrative (automated or electronic) records, from medical charts, or through a combination of the two methods. Independent auditors verify the accuracy of the information.
3. An independent research firm contracted with CCHRI evaluates and analyzes the data from all the participating health plans.

Ratings may reflect differences in actual clinical practice or differences in the ways plans collect data. Individual plans are scored above average, average or below average using a statistical test that shows differences in plans' results are expected to be true differences, and not random chance differences, at least 95 percent of the time.

HOW TO READ THESE GRAPHS

The horizontal bars show scores for each California health plan. The vertical bar is the best estimate of the plan's true score based on a sample or sub-set, of health plan members. When the horizontal bars for two plans do not overlap, this means the health plan scores are significantly different from each other. The length of the horizontal bar is related to the size of the health plan sample. A smaller sample results in a longer horizontal bar because the exact score is less certain. The score is more accurate if the sample is larger and the bar is smaller. Plans with longer horizontal bars do not necessarily have better scores than plans with shorter bars.



PRENATAL & POSTPARTUM CARE

This is not copy for Prenatal & Postpartum measures. Keeping children up-to-date in their routine immunizations prevents many serious childhood diseases such as measles, mumps, chickenpox, and polio. These once common illnesses are becoming very rare due to the availability of safe and effective vaccines. HMOs promote childhood immunizations through outreach and education to parents, explaining the benefits of vaccination.

The charts on these pages show the performance of California health plans in helping assure that children receive the immunizations they should have. The schedule of recommended immunizations is based on guidelines developed by the Centers for Disease Control and the American Academy of Pediatrics.

MEASLES, MUMPS, AND RUBELLA

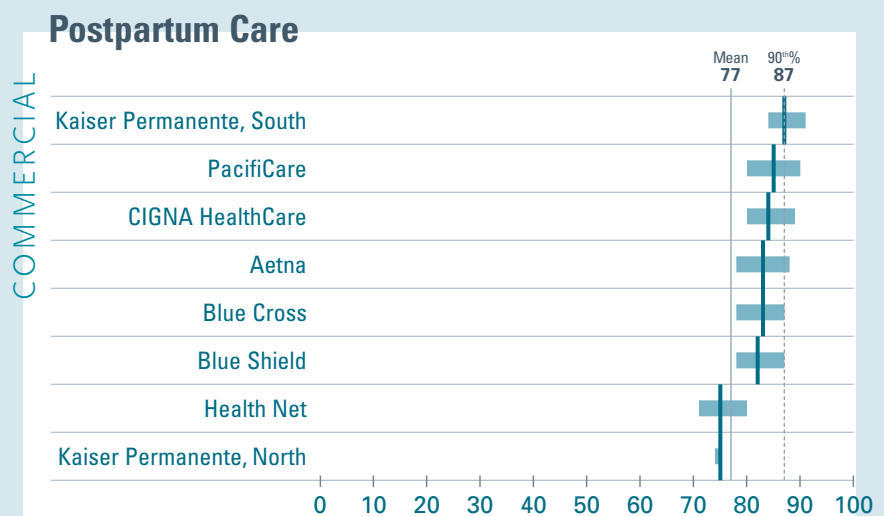
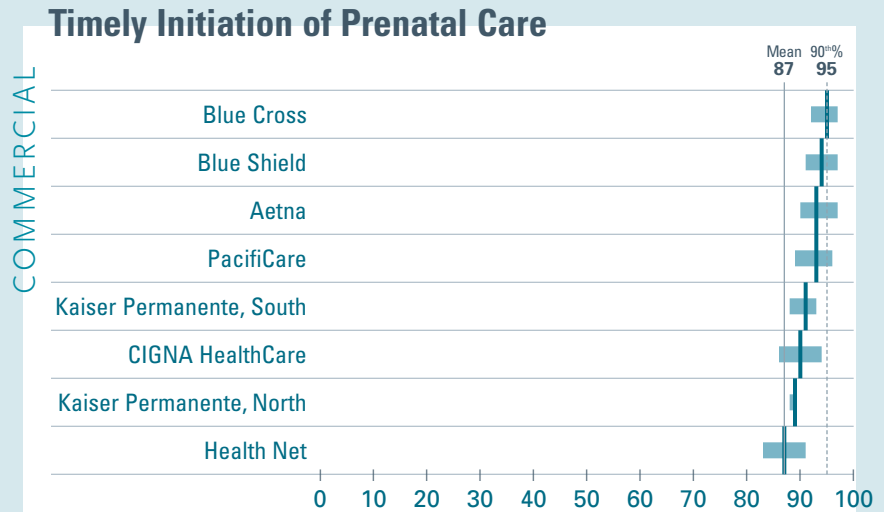
This chart shows the percentage of children who received their first MMR immunization before age 2.

HAEMOPHILUS INFLUENZA TYPE B

Before the mid 1980's when an effective vaccine was developed, Haemophilus influenzae type B or "HiB", caused approximately 12,000 cases of childhood meningitis every year. Guidelines now recommend children receive at least 3 HiB immunizations before age 2. This chart shows the percentage of children who received 3 HiB vaccinations according to those recommendations.

VARICELLA (CHICKENPOX)

This chart measures the percentage of children who received 1 varicella immunization before age 2.



CHILDHOOD IMMUNIZATIONS

Keeping children up-to-date in their routine immunizations prevents many serious childhood diseases such as measles, mumps, chickenpox, and polio. These once common illnesses are becoming very rare due to the availability of safe and effective vaccines. HMOs promote childhood immunizations through outreach and education to parents, explaining the benefits of vaccination.

The charts on these pages show the performance of California health plans in helping assure that children receive the immunizations they should have. The schedule of recommended immunizations is based on guidelines developed by the Centers for Disease Control and the American Academy of Pediatrics.

MEASLES, MUMPS, AND RUBELLA

This chart shows the percentage of children who received their first MMR immunization before age 2.

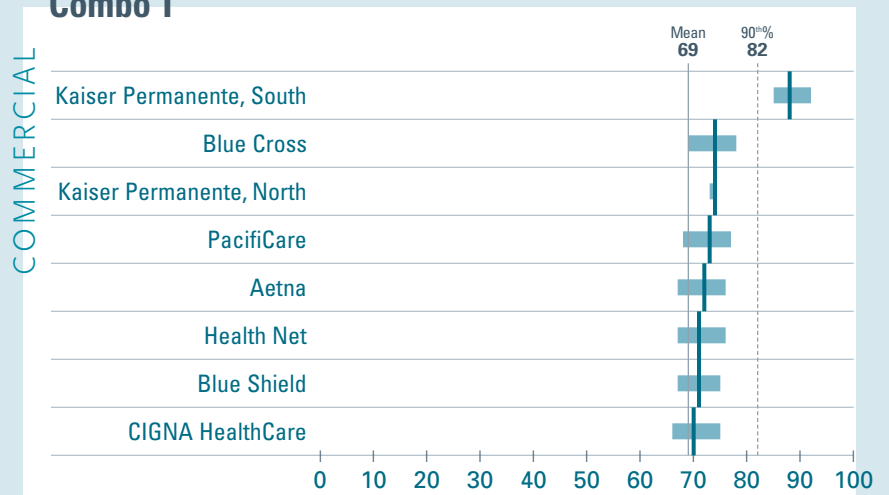
HAEMOPHILUS INFLUENZA TYPE B

Before the mid 1980's when an effective vaccine was developed, Haemophilus influenzae type B or "HiB", caused approximately 12,000 cases of childhood meningitis every year. Guidelines now recommend children receive at least 3 HiB immunizations before age 2. This chart shows the percentage of children who received 3 HiB vaccinations according to those recommendations.

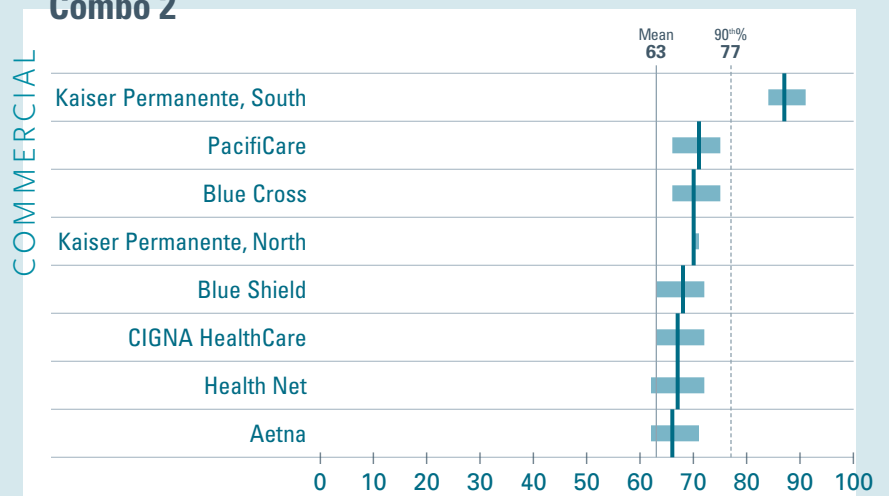
VARICELLA (CHICKENPOX)

This chart measures the percentage of children who received 1 varicella immunization before age 2.

Combo 1



Combo 2



NOTES

Adolescent and Childhood Immunization data are not collected yearly. Results reflect a health plan's most recently available data, indicated by the following:

- a – immunizations reported in 2002
- b – immunizations reported in 2001
- c – immunizations reported in 2000

CCHRI did not compute an all-plan average or performance strata because data collected across different years may not be comparable. However, the table below displays national averages, when available, as reported by NCQA in their 2001 State of Managed Care Quality report. The 50th percentile is most commonly used when making comparisons but the 75th and 90th percentiles demonstrate the average results obtained by the highest performing health plans in the country.

Childhood Immunization	50th percentile	75th percentile	90th percentile
HiB	85%	89%	93%
Varicella	71%	77%	82%

ADOLESCENT IMMUNIZATIONS

Between the ages of four and 13, children need several vaccinations. The adolescent immunization rates shown on this page measures the percentage of adolescents enrolled in a health plan who received a second dose of MMR between ages four and 13 and three hepatitis B vaccinations prior to their 13th birthday. The third chart displays the percentage of children who received all of these recommended immunizations.

HMOs encourage doctors and parents to assess whether adolescents need the MMR and hepatitis vaccines and, if the doctor or nurse believes it is appropriate, to give the vaccination and any follow-up information.

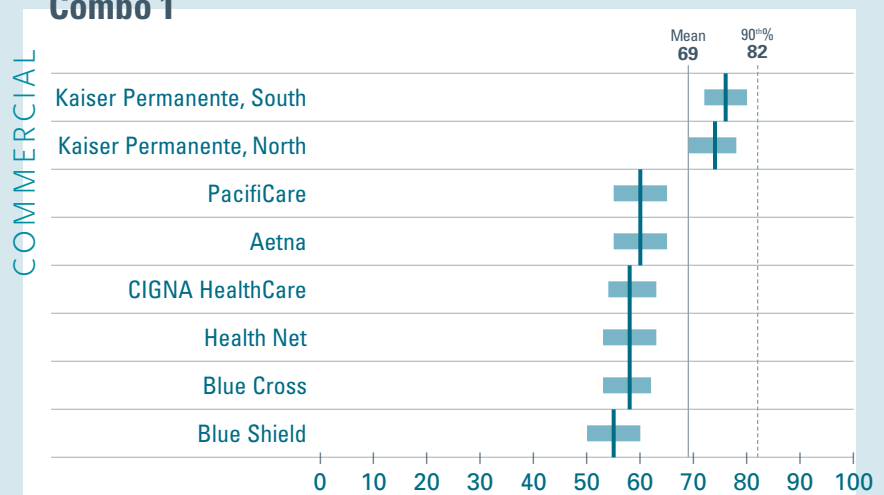
MEASLES, MUMPS, AND RUBELLA

The measles, mumps and rubella (MMR) vaccine prevents common diseases that can cause serious problems.

HEPATITIS B

The Centers for Disease Control and the American Academy of Pediatrics also recommends hepatitis B vaccinations for adolescents. Over 70% of the more than 140,000 new cases of hepatitis B reported each year strike adolescents and young adults. Hepatitis B is a viral illness that affects the liver and can cause serious health problems such as cirrhosis. Hepatitis B vaccinations are safe and proven effective in preventing hepatitis B and its complications.

Combo 1



NOTES

Adolescent and Childhood Immunization data are not collected yearly. Results reflect a health plan's most recently available data, indicated by the following:

- a – immunizations reported in 2002
- b – immunizations reported in 2001
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Adolescent Immunization	50th percentile	75th percentile	90th percentile
MMR	67%	77%	86%
Hepatitis B	41%	57%	69%

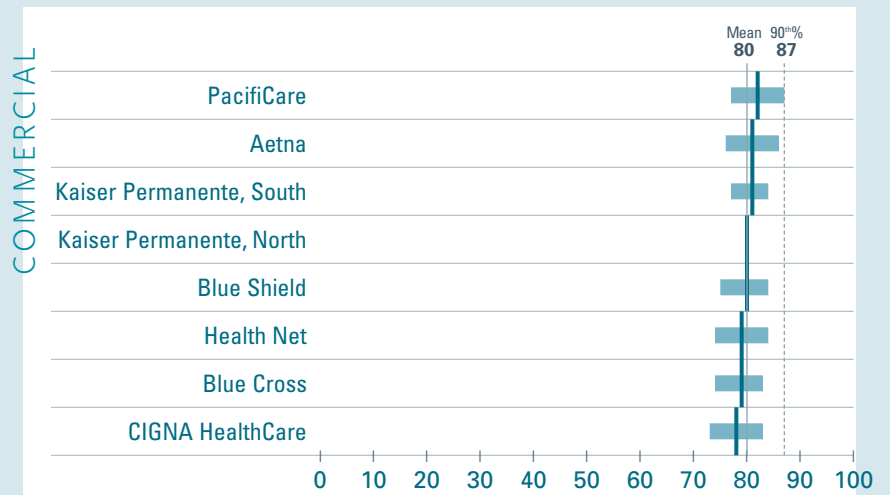
CERVICAL CANCER

CERVICAL CANCER SCREENING

This is not Cervical Cancer copy. Breast cancer develops in one out of every nine American women. About 4,000 women in California (44,000 women in the U.S.) die each year from this condition. Mammograms can detect breast cancer early, when it is most treatable, increasing chances for survival and cure. Mammography screening has been shown to reduce mortality by 20 to 40% among women aged 50 and older.

The breast cancer screening rate measures the percentage of women in the Medicare population, through 69 years of age, who were continuously enrolled in their health plan during 2000 and 2001, and who had at least one mammogram during that two-year period. Screening the Medicare population is especially important because some women in this age group are very reluctant to have a mammogram and need additional encouragement to do so. Early detection leads to earlier treatment of breast cancer, and the potential for better outcomes, for women of all ages.

The chart on this page shows the relative performance of HMOs in providing mammograms. HMOs can encourage regular breast cancer screenings by promoting routine physical health exams and providing members with cancer awareness materials. Health plans also send women and their physicians reminders to schedule a mammogram.



NOTES

CIGNA HealthCare and Universal Care do not offer managed care plans for Medicare beneficiaries.

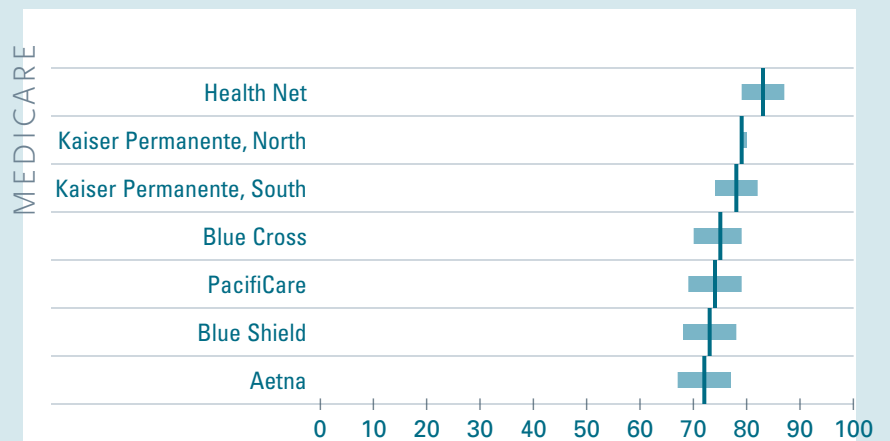
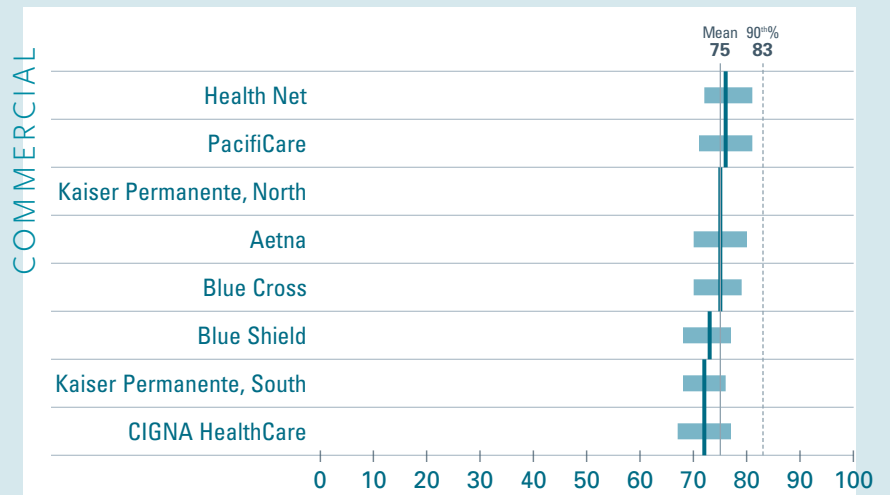
BREAST CANCER

BREAST CANCER SCREENING

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NOTES

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CHLAMYDIA SCREENING

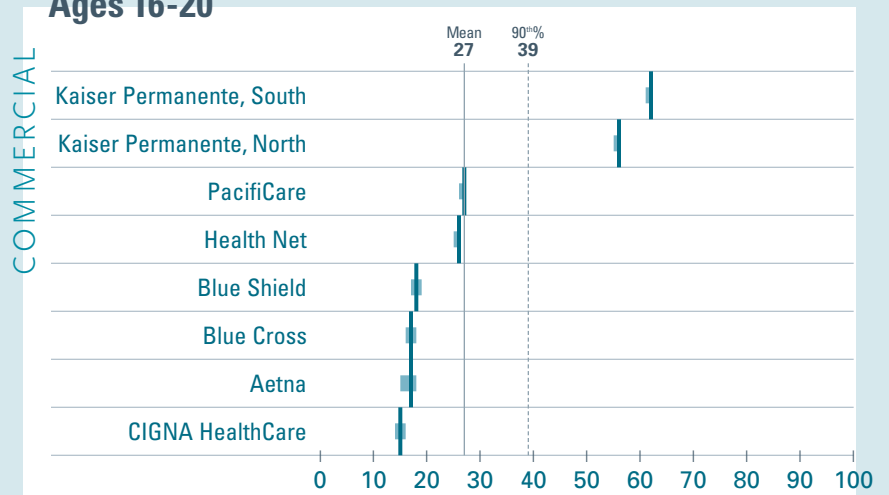
CHLAMYDIA SCREENING IN WOMEN

Chlamydia is a sexually transmitted disease that is especially common in teenagers and young adults. Untreated infections are easily spread between sexual partners and can cause serious health complications. Chlamydia is currently the most commonly reported infectious disease in the United States with an estimated three million cases occurring each year.

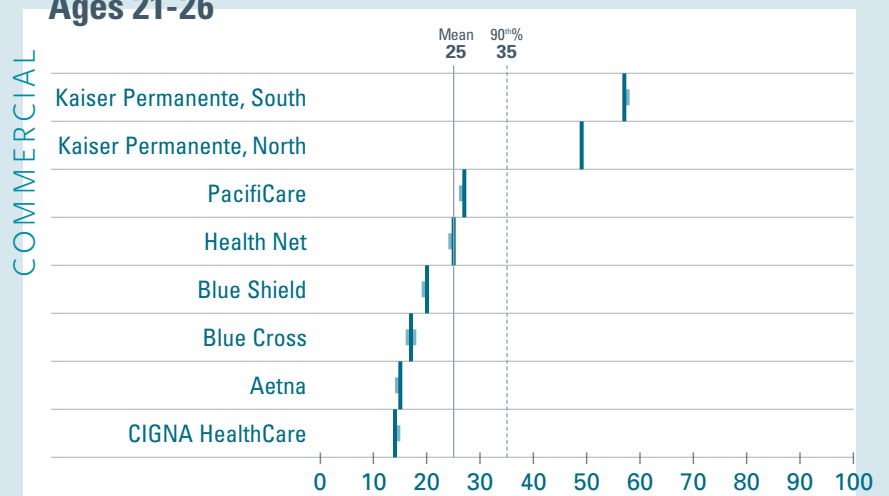
Chlamydia is frequently called a “hidden” disease. Approximately 75% of women and 50% of men with Chlamydia have no symptoms. Therefore, routine screening tests are very important in limiting the complications of an infection. Chlamydia can cause pelvic inflammatory disease, infertility, and tubal or ectopic pregnancies and some of these complications may be life threatening. Chlamydia infections can also cause health problems in newborns whose mothers have an undetected or untreated infection during pregnancy.

Simple, routine-screening tests identify the presence of Chlamydia infections. Treatment with antibiotics is usually successful in preventing further transmission of the disease and limiting future complications. The screening rates reported on this page are intended to measure the percentage of sexually active young women who received a routine screening test for Chlamydia during 2001. Health plans can successfully improve Chlamydia screening rates through distribution of educational materials to both physicians and HMO members.

Ages 16-20



Ages 21-26



NOTES

Universal Care elected not to collect data for this measure.

Obtaining accurate and complete information for this measure is difficult because of data collection issues and concerns about confidentiality. However, results for CCHRI plans compare favorably to the national averages reported by NCQA in their 2001 State of Managed Care Quality report. The 50th percentile is most commonly used when making comparisons but the 75th and 90th percentiles demonstrate the average results obtained by the highest performing health plans in the country.

Chlamydia Screening	50th percentile	75th percentile	90th percentile
Ages 16 – 20	22%	28%	35%
Ages 21 – 26	19%	26%	32%

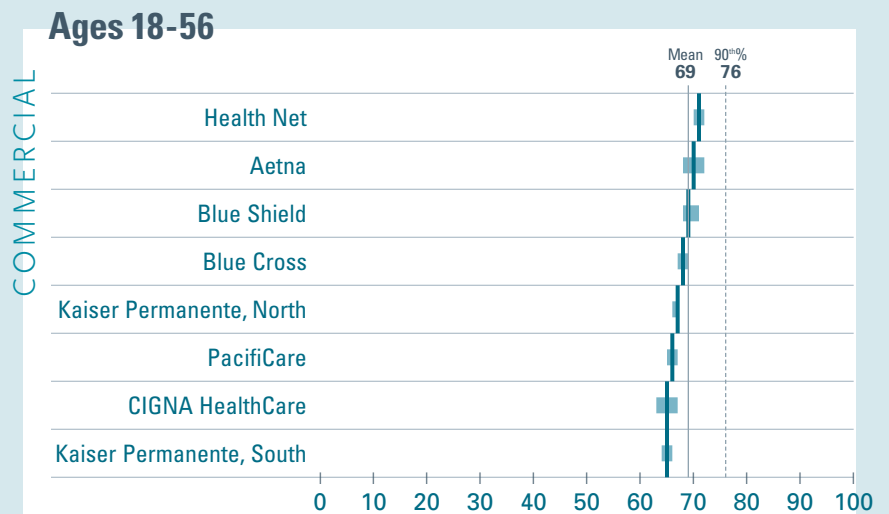
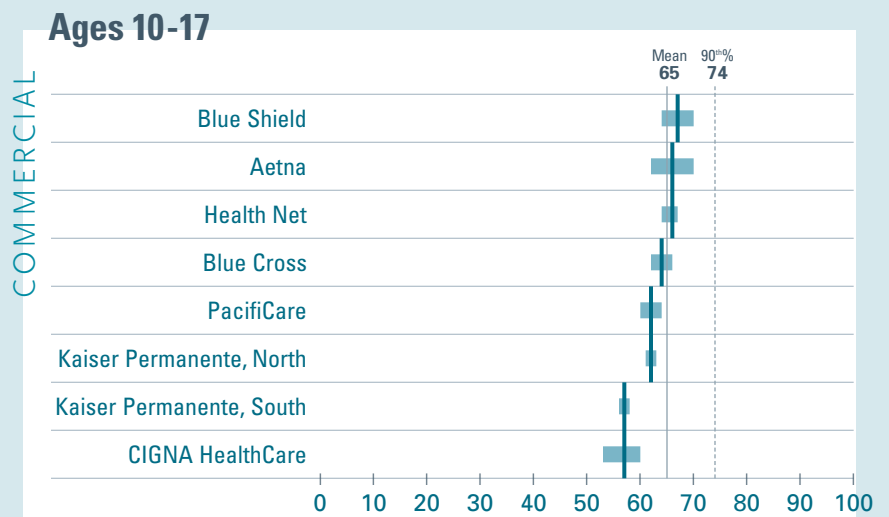
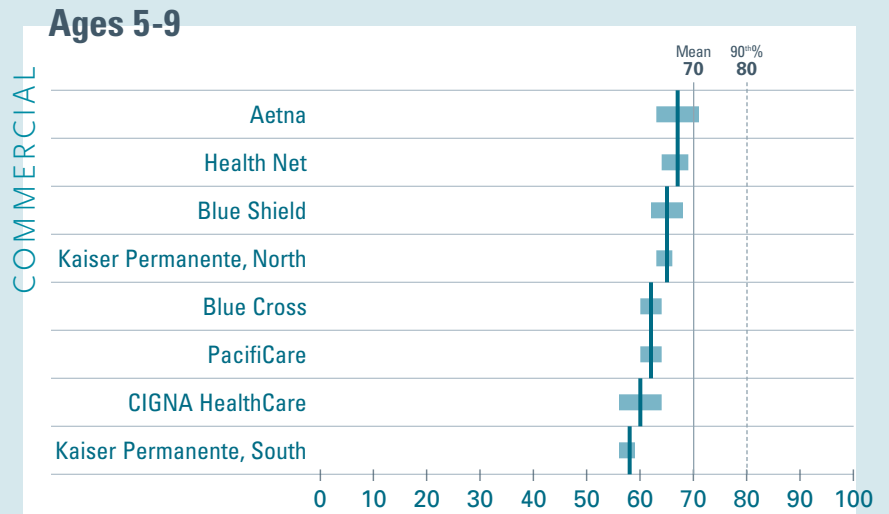
ASTHMA

APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Asthma is a chronic disease that causes airways to become inflamed and swollen, resulting in wheezing, coughing, and reduced airflow to the lungs. Unfortunately, asthma is becoming more common and currently affects more than 15 million Americans, including almost five million children. In fact, it is the most common chronic disease in children (approximately one in ten children have asthma) and can result in life-threatening episodes of illness for both adults and children.

The recommended treatment for most patients with persistent asthma emphasizes daily, long-term prevention therapy that improves the underlying airway inflammation. Appropriate preventive treatment can result in fewer episodes of wheezing and coughing and a decrease in the use of medications needed to treat these break-through symptoms. Commonly used preventive medications include anti-inflammatory prescriptions such as inhaled corticosteroids, Cromolyn Sodium and Nedocromil as well as other alternative oral medications.

Measuring whether HMO members with persistent asthma receive the recommended medications for long-term control of their asthma is very important. Because the challenges in accurately diagnosing and caring for children with persistent asthma are very different from the identification and treatment of asthma in adults, separate measures were obtained in those age groups. This measure reports the percentage of members diagnosed with asthma who received appropriate medication management during 2001.



COMPREHENSIVE DIABETES CARE 1 of 4

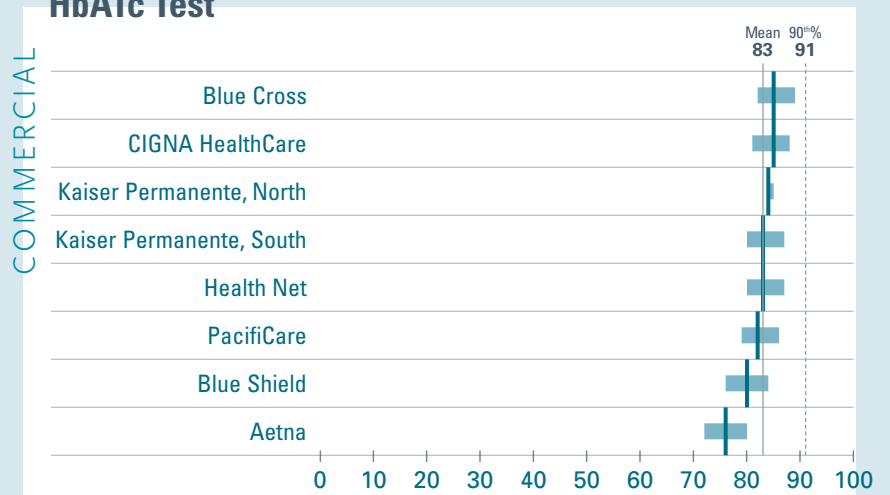
Diabetes is a leading cause of illness and disability in the United States because of its chronic medical complications such as heart disease, kidney problems, and blindness. Approximately 800,000 new cases of diabetes are diagnosed every year and almost 11 million Americans have diabetes. It is also estimated that another five to six million Americans have diabetes but have not yet been diagnosed or treated.

CHOLESTEROL MANAGEMENT

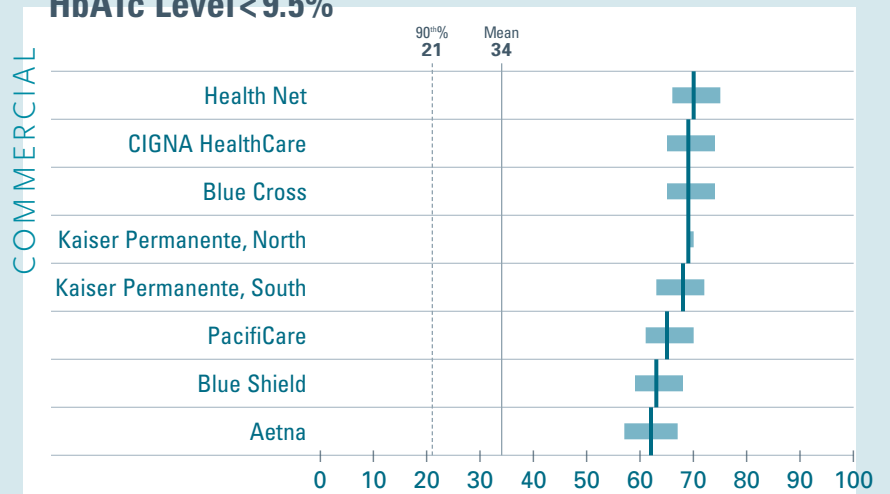
Heart disease is one of the most common and important medical complications of diabetes. Higher levels of cholesterol and fat in the blood greatly contribute to the increased incidence of coronary artery disease and heart disease. Unfortunately, patients with diabetes have much higher rates than the general population of high blood cholesterol levels and develop heart problems much more frequently than people without diabetes.

It is very important that LDL cholesterol levels be measured at least yearly in patients with diabetes. Efforts should be made, depending upon the patient, to maintain LDL cholesterol at levels lower than 130 mg/dl. CCHRI calculated the percentage of patients with diabetes who received an LDL cholesterol screening test during 2001 and the percentage of those who had cholesterol levels below 130 mg/dl. A higher screening rate of LDL cholesterol could indicate that a health plan is working hard to promote regular medical exams for patients with diabetes.

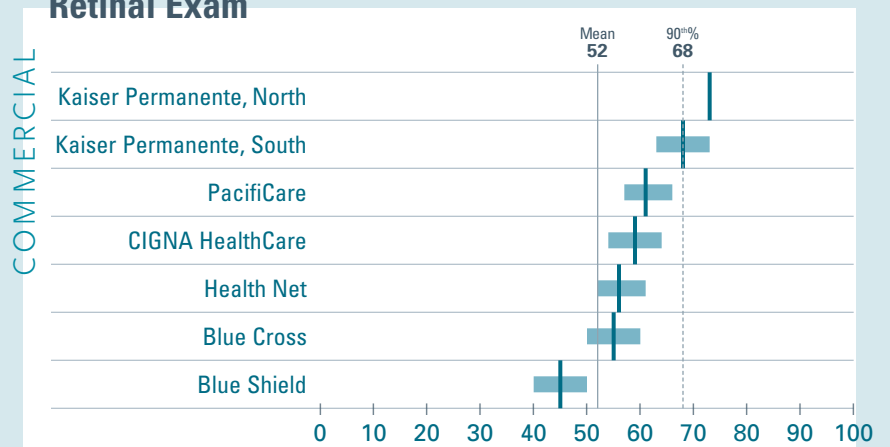
HbA1c Test



HbA1c Level < 9.5%



Retinal Exam



NOTES

CIGNA HealthCare and Universal Care do not offer managed care plans for Medicare beneficiaries.

COMPREHENSIVE DIABETES CARE 2 of 4

RETINAL EXAM

Diabetes can cause blindness. Experts recommend that people with diabetes have an examination of their retina every year because diabetes-related eye disease can be present even if a person has no problem seeing. When doctors find eye disease in diabetic patients early, they can start treatment in time to save vision for most people.

CCHRI measured how many people with diabetes had an examination by an eye care professional during 2001. For some patients, depending upon their over-all health status and how well their diabetes is controlled, an eye exam performed during 2000 was also counted in the results for this measure. A higher rate could mean the health plan works harder to promote regular exams or makes exams easier to obtain. More exams mean earlier medical treatment and less blindness in the diabetic population.

HEMOGLOBIN A1c TEST & LEVELS

High levels of sugar in the blood are one common finding in patients with diabetes. Frequent testing for glycated hemoglobin, also known as hemoglobin A1c (HbA1c), measures a patient's average blood sugar level for the 2-3 month period before the test.

People with poorly controlled diabetes as shown by high blood sugar levels are more likely to develop high blood pressure, high cholesterol and fat levels, heart disease, eye and nerve problems, and kidney problems.

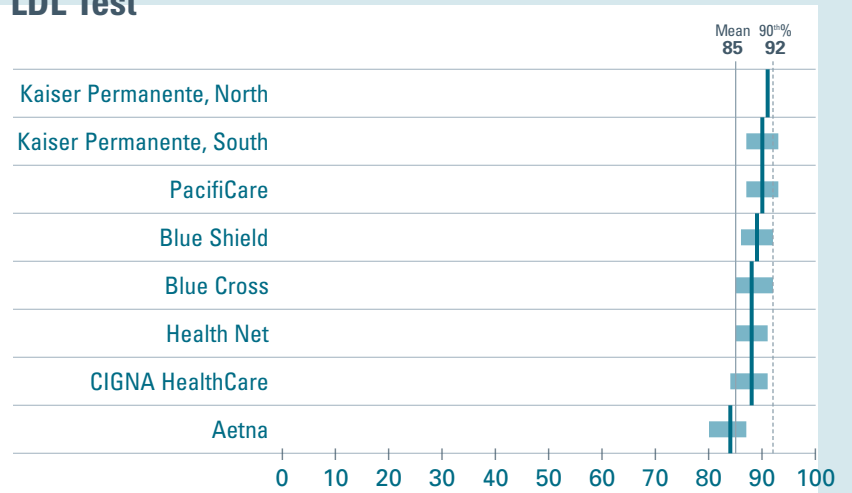
Although HbA1c test results mean different things for different patients depending upon their over-all health status and age, most physicians believe, based on current medical evidence, that levels above 9.5 mean poor over-all diabetes control.

NOTES

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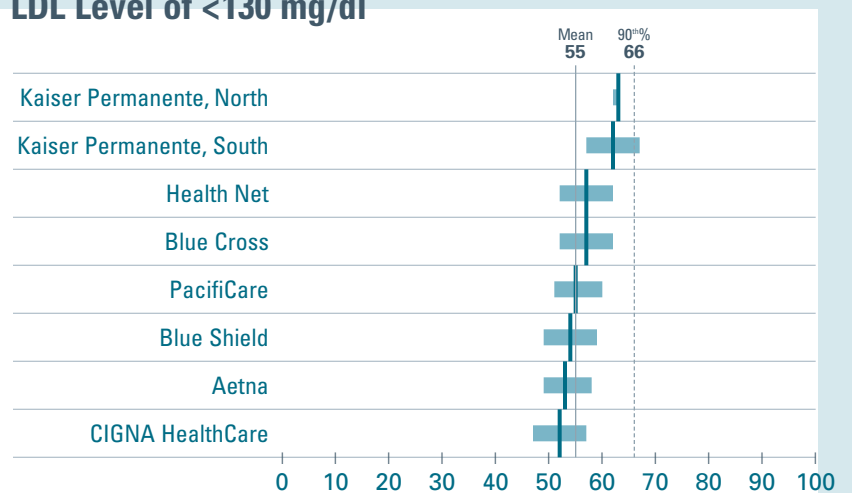
LDL Test

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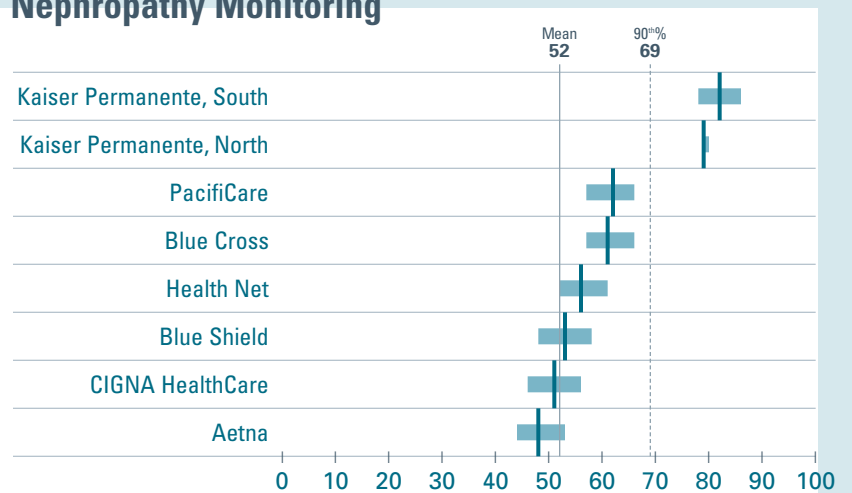
LDL Level of <130 mg/dl

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Nephropathy Monitoring

COMMERCIAL



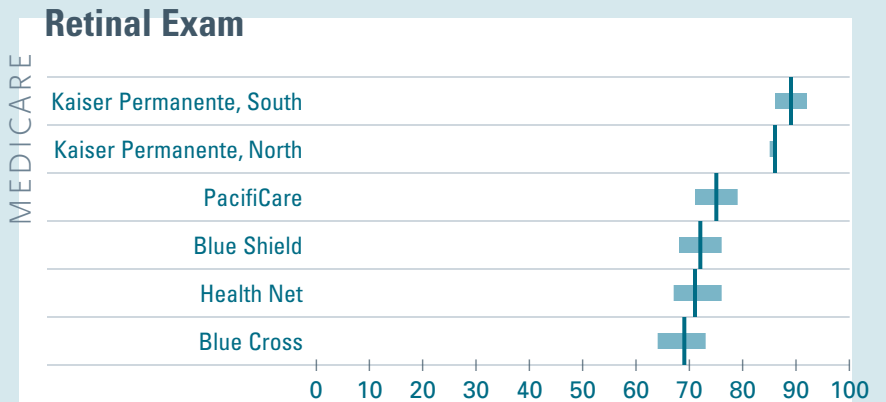
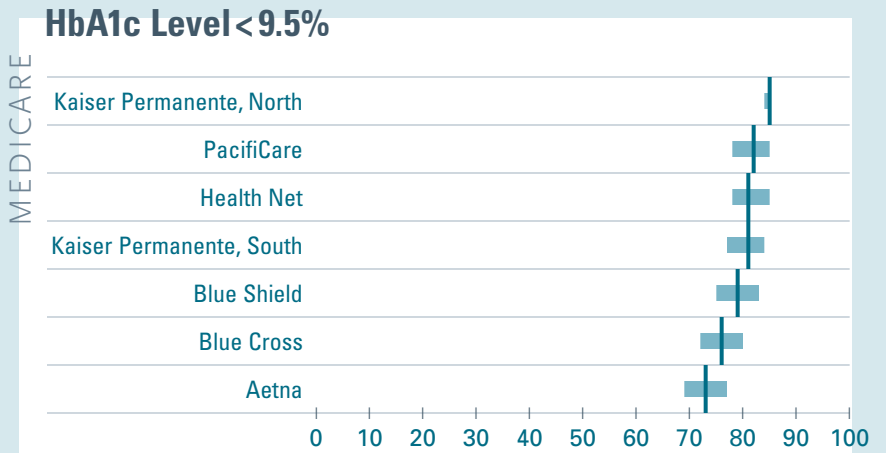
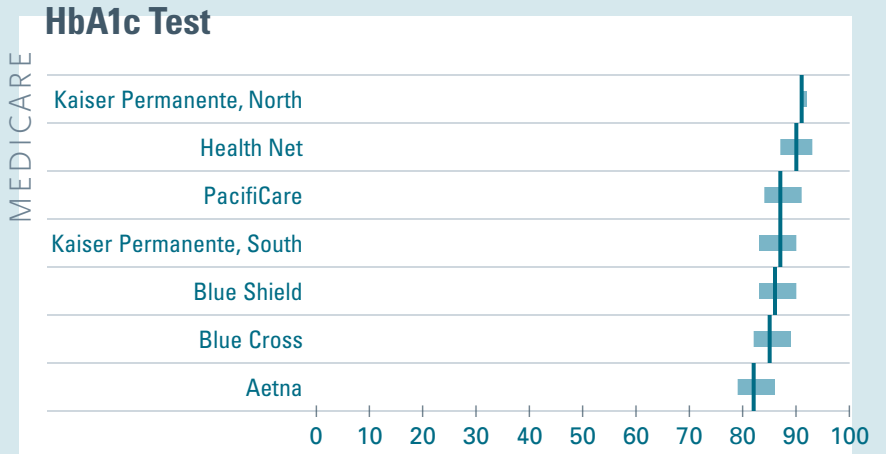
COMPREHENSIVE DIABETES CARE *3 of 4*

The first table displayed on this page measures the percent of patients with diabetes who received at least one screening test for HbA1c during 2001. A higher screening rate can suggest that a health plan works with its provider network to promote more frequent and appropriate blood tests for patients. The next table displays the percentage of patients with results less than 9.5, the cut-off level for this report.

KIDNEY DISEASE MONITORING

People with diabetes are much more likely than the general population to develop acute and chronic kidney problems, such as renal insufficiency, end-stage renal disease and diabetic nephropathy. These serious complications can require long-term kidney dialysis or kidney transplant. Importantly, early detection of kidney disorders can lead to earlier treatment, and slow or prevent further deterioration of the kidneys and help avoid dialysis or transplant.

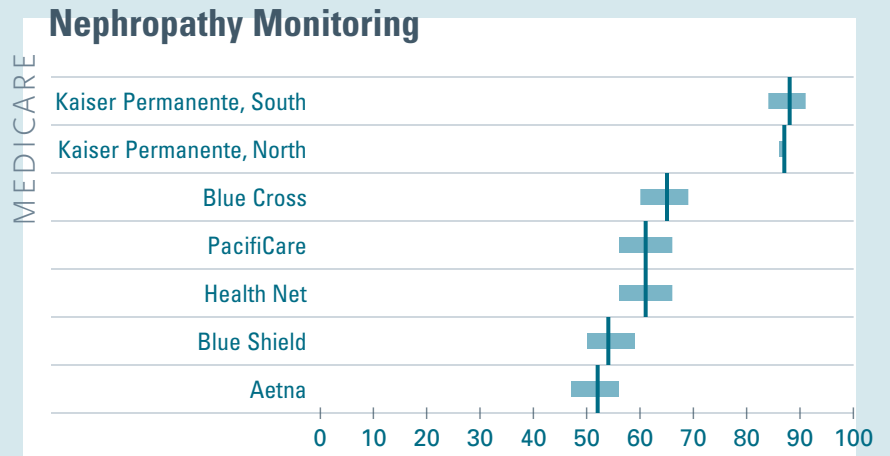
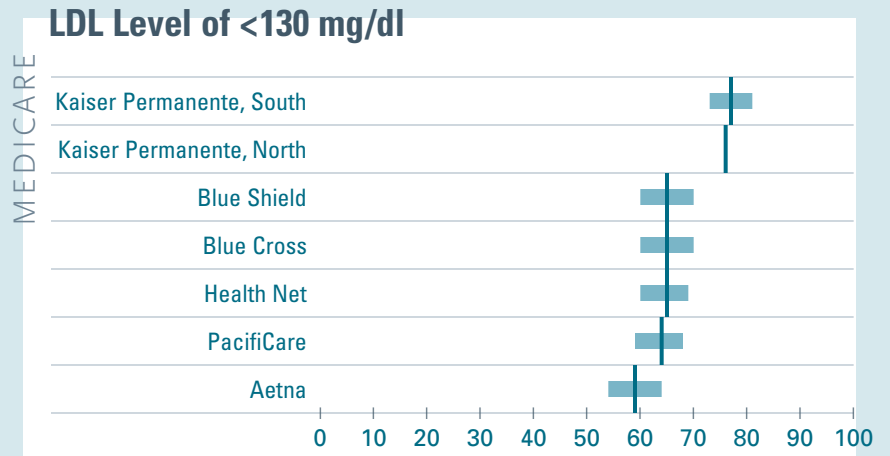
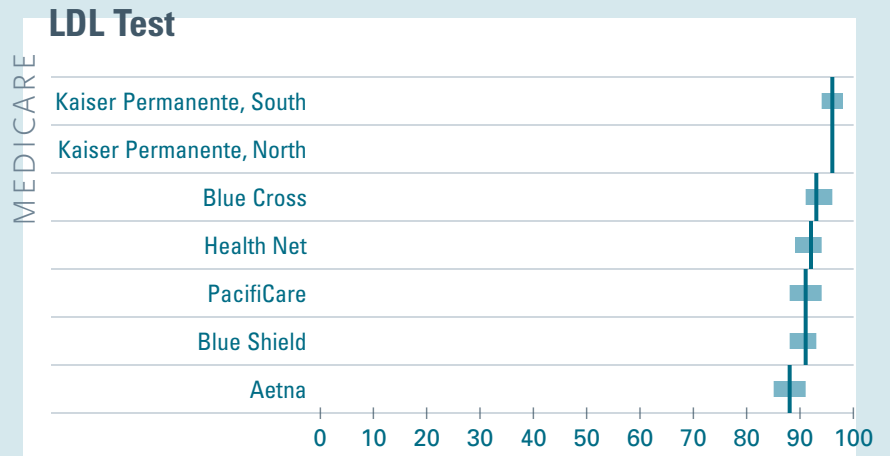
One of the first signs of kidney problems is protein in the urine. It is therefore very important that patients with diabetes have a test at least once a year that measures microalbuminuria. CCHRI reports the percentage of Medicare HMO patients with diabetes who received this test during 2001. For some patients, depending upon their over-all health status and how well their diabetes is controlled, a microalbuminuria test performed during 2000 was also counted in the results for this measure.



NOTES

CIGNA HealthCare and Universal Care do not offer managed care plans for Medicare beneficiaries.

COMPREHENSIVE DIABETES CARE 4 of 4



NOTES

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ANTIDEPRESSANT MEDICATION *1 of 2*

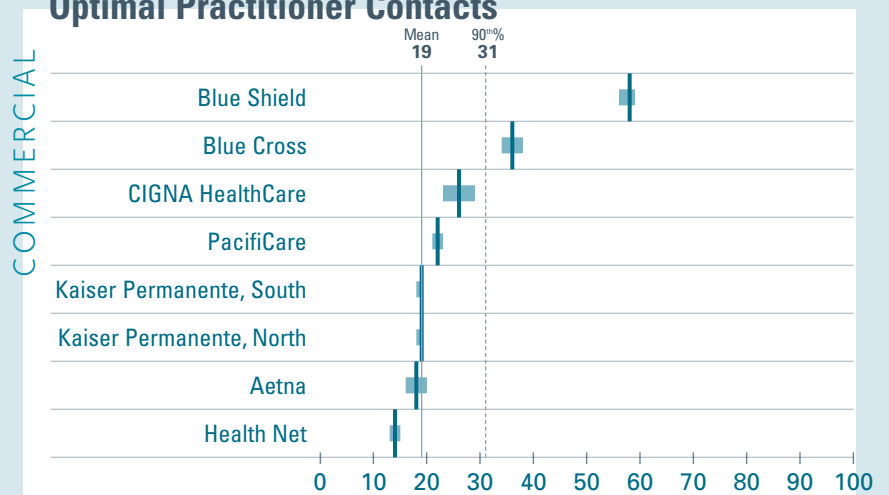
ANTIDEPRESSANT MEDICATION MANAGEMENT

Depression is a common mental health condition that affects approximately 3 to 5% of the adult population in the United States. If not properly treated with counseling and medications, patients can sometimes experience serious complications. Approximately 70% of patients who are diagnosed with severe depression respond favorably to antidepressant medications.

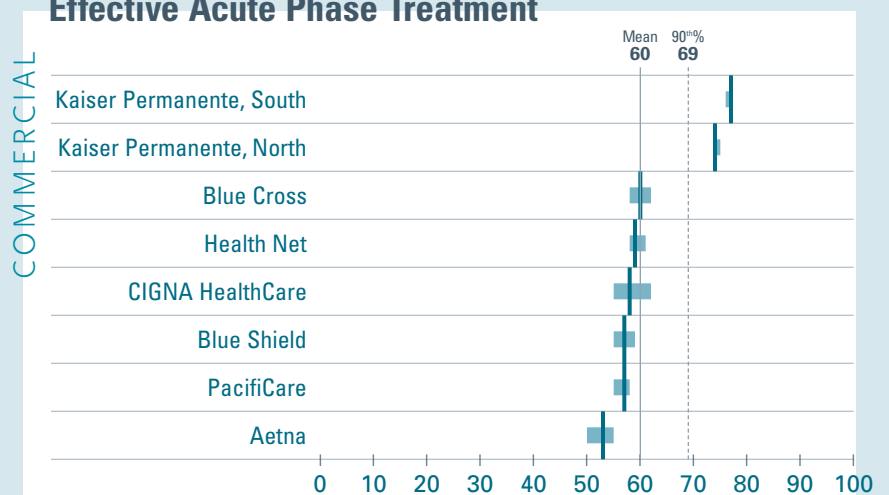
These charts display a three-part measure that examines whether California HMO patients who are treated with medication for a new episode of depression receive good care. Specifically, the first measure looks at whether follow-up visits occur frequently enough for physicians to monitor and adjust medication dosages (at least three visits with the PCP or mental health provider in the first 12 weeks following diagnosis). The second measure shows the percent of patients who remain on antidepressant medications for 12 weeks following diagnosis, and the third measure is the percent who remain on their medication for six months following diagnosis.

Nationally, only about half of all patients treated with antidepressant medications receive care for the recommended period of time, four to nine months. Better treatment rates suggest fewer patients are likely to experience a relapse of their depression symptoms. Health plans can improve clinical outcomes for their members by working in partnership with physicians to encourage appropriate treatment and improved medication management for patients with new episodes of depression.

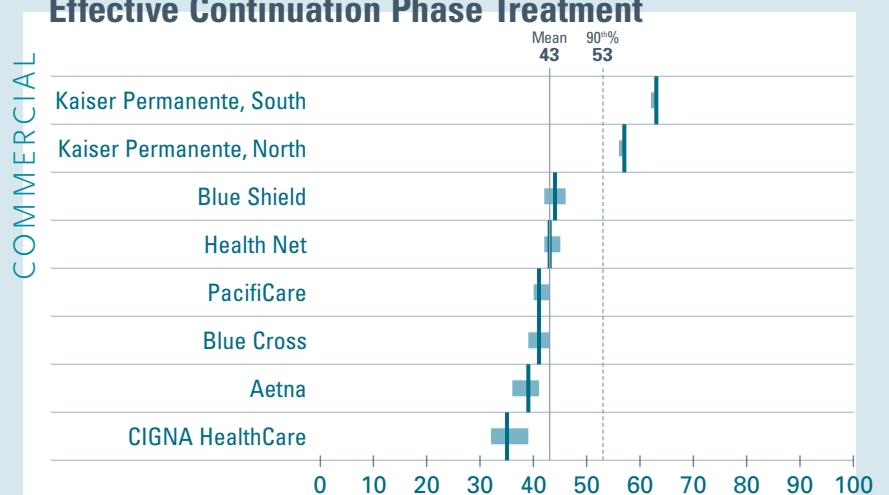
Optimal Practitioner Contacts



Effective Acute Phase Treatment

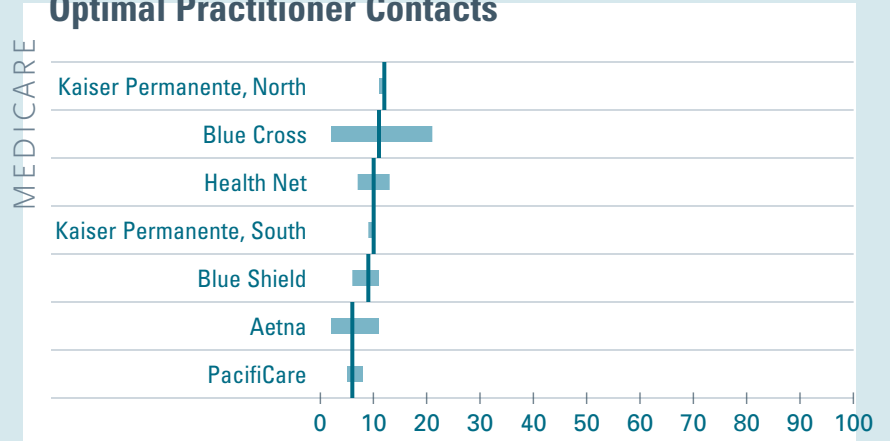


Effective Continuation Phase Treatment

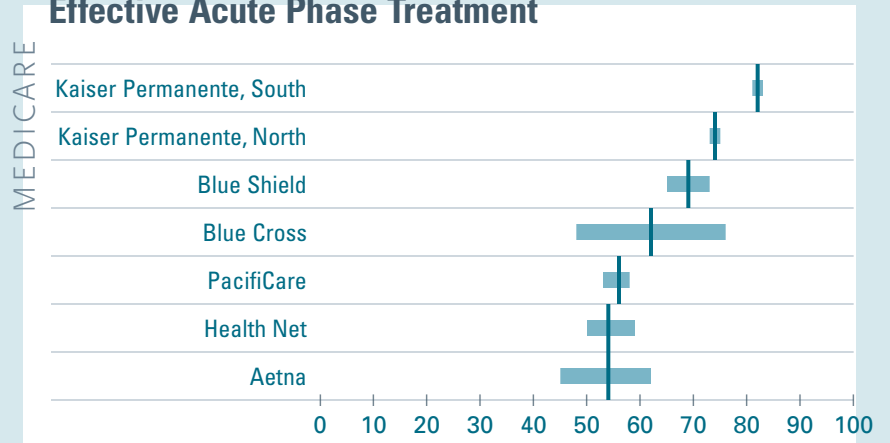


ANTIDEPRESSANT MEDICATION *2 of 2*

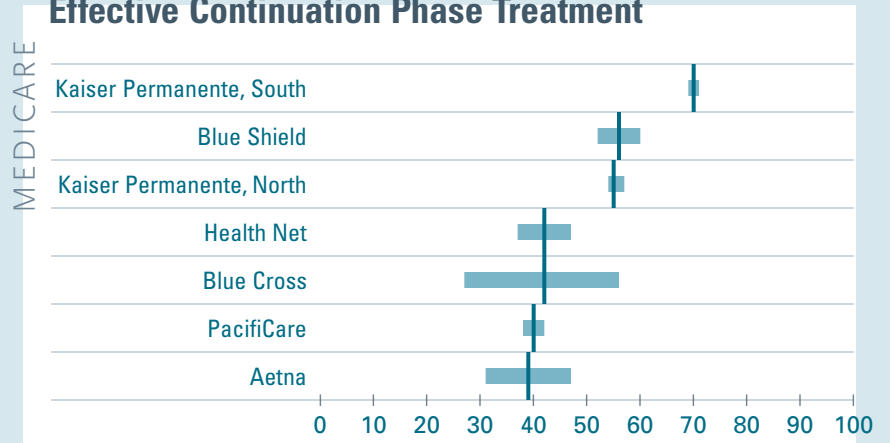
Optimal Practitioner Contacts



Effective Acute Phase Treatment



Effective Continuation Phase Treatment



MENTAL ILLNESS *1 of 2*

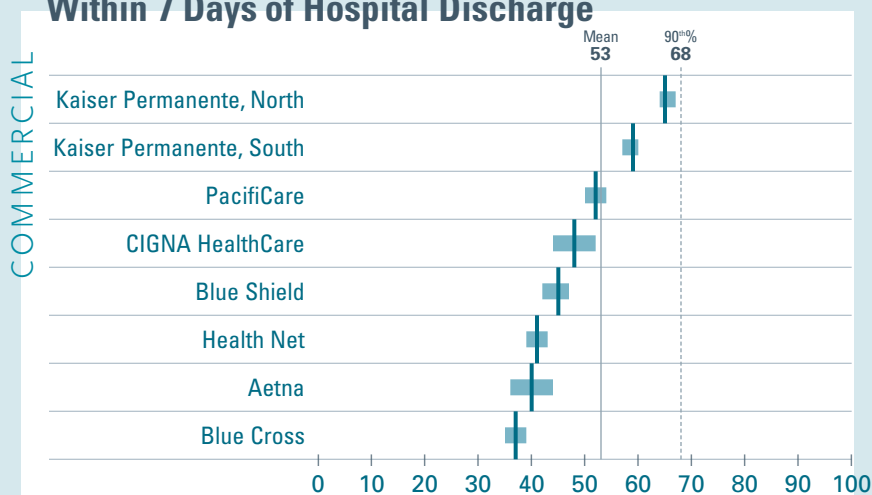
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Mental illnesses such as depression, schizophrenia, and anxiety are real health conditions that, if untreated, can be as disabling and serious as cancer and heart disease. Fortunately, advances in mental health research and the availability of newer, more effective medication have broadened the treatment options for mental health problems and improved the overall level of mental health care.

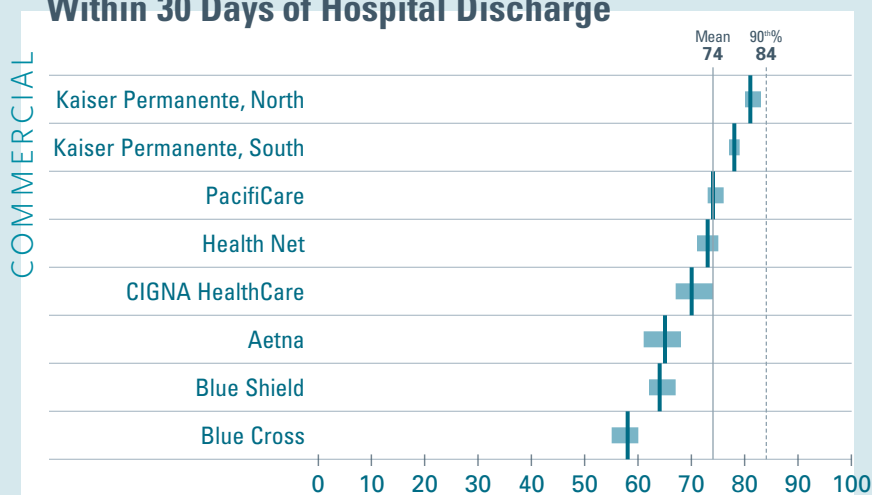
Hospitalization is sometimes the most appropriate treatment for serious mental illness. When patients are discharged from the hospital, ongoing medical care and emotional support is essential to continued recovery. Patients who receive regular follow-up therapy with a mental health provider usually experience a smoother transition back to their regular routines at home and work. They also have lower rates of relapse and re-hospitalization.

This HEDIS indicator measures the percentage of HMO members who were seen on an outpatient basis by a mental health provider within seven days, and within 30 days, after hospitalization for a mental health disorder. HMOs can encourage appropriate follow-up treatment by educating members and physicians regarding the benefits of continued therapy and support in the immediate post-hospitalization period and about the various treatment options available to them.

Within 7 Days of Hospital Discharge



Within 30 Days of Hospital Discharge

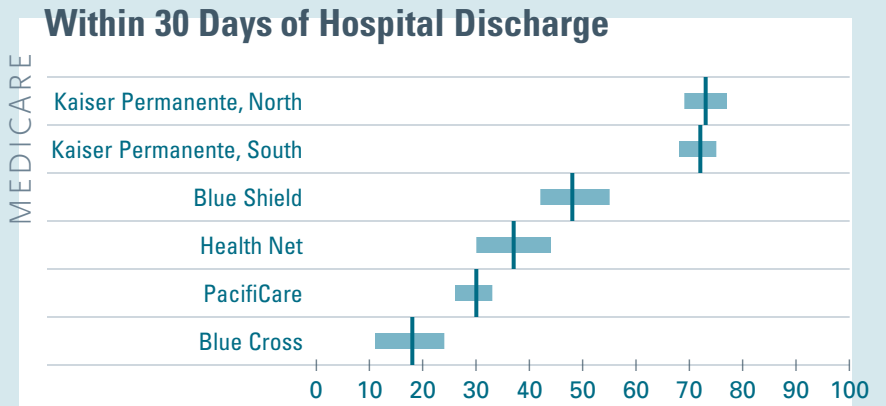
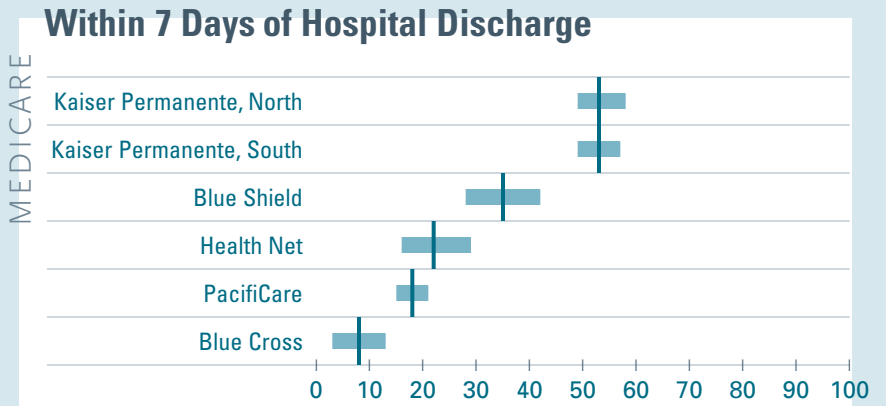


NOTES

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Inter Valley Health Plan's data for these measures were incomplete.

MENTAL ILLNESS *2 of 2*



NOTES

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Inter Valley Health Plan's data for these measures were incomplete.

BETA BLOCKER TREATMENT

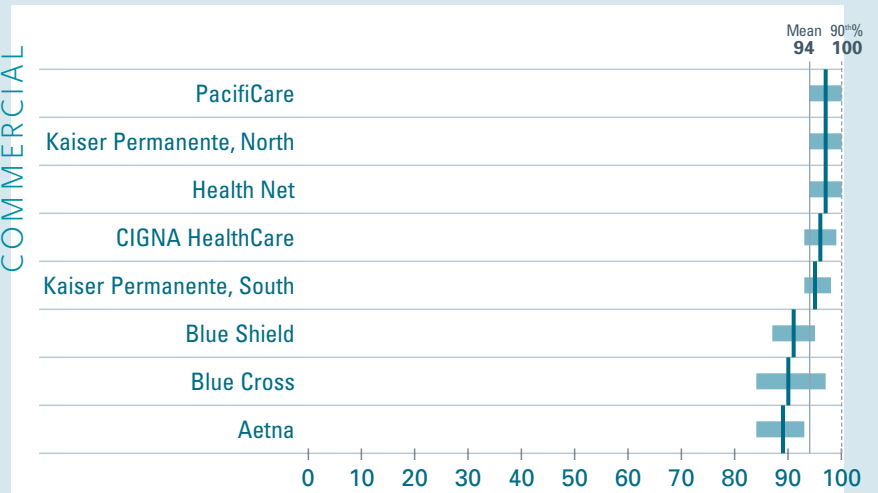
BETA BLOCKER TREATMENT AFTER HEART ATTACK

Heart attacks, also known as acute myocardial infarctions or AMI, occur in approximately 1.5 million Americans each year. Unfortunately, patients who have had a heart attack are at higher risk than the general public to have another one.

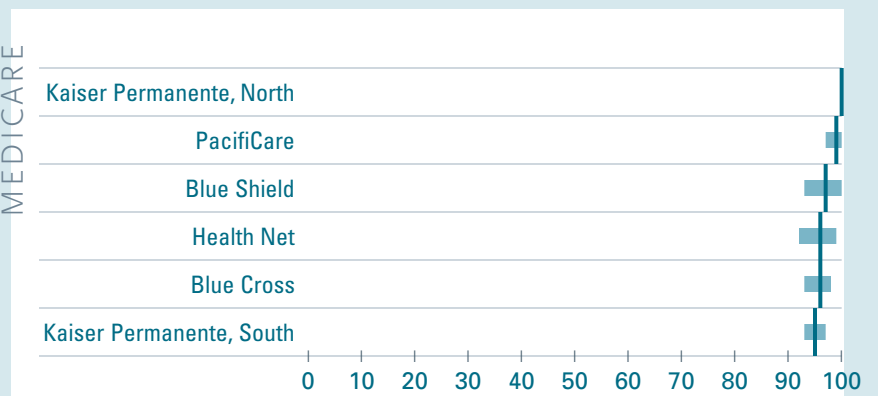
Medications called beta blockers are an important part of follow-up treatment after a heart attack. When taken shortly after a heart attack by patients without other heart problems, beta blockers can help prevent another heart attack by lowering blood pressure and decreasing how hard the heart has to work.

This measure calculates the percentage of HMO patients who had a heart attack and subsequently received a prescription for beta blocker medication. HMOs improve beta blocker treatment rates by encouraging physicians to evaluate clinical options, including the use of medications, for patients with heart disease and especially for those who have suffered a heart attack. Health plans also provide educational materials about the appropriate use of beta blockers to physicians and members.

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MEDICARE



NOTES

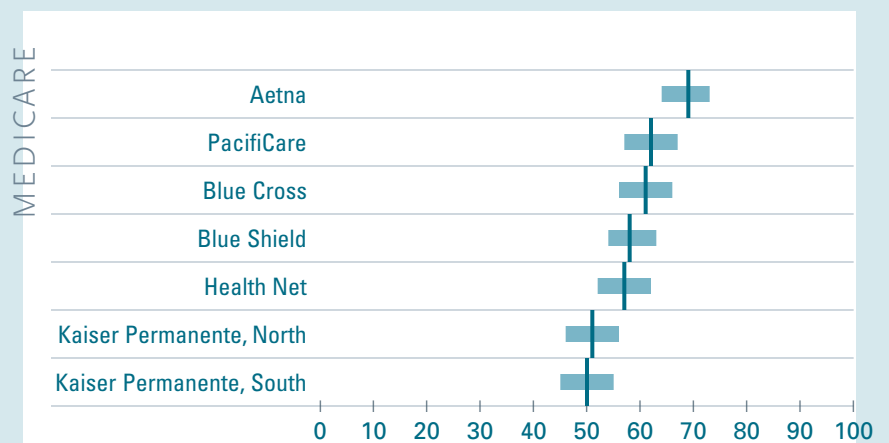
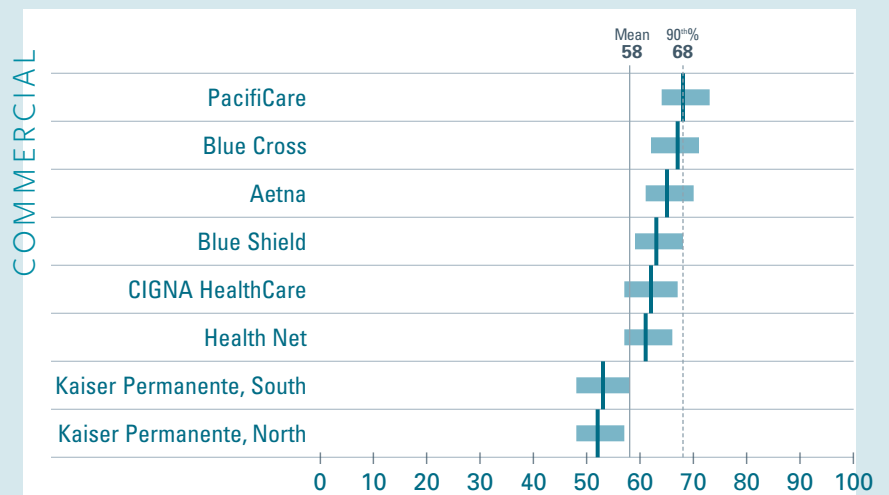
CIGNA HealthCare and Universal Care do not offer managed care plans for Medicare beneficiaries.

HIGH BLOOD PRESSURE

CONTROLLING HIGH BLOOD PRESSURE

Approximately 50 million Americans (30 percent of the adult population) have high blood pressure, also known as hypertension. High blood pressure contributes significantly to the development of serious medical conditions such as coronary heart disease, congestive heart failure, kidney disease and stroke. Lowering blood pressure, even in amounts as small as 5-6mm, has many benefits, including decreased overall risk of developing serious medical problems. In elderly patients where the incidence of congestive heart failure is common, aggressively treating hypertension can reduce coronary heart disease and deaths from stroke.

Hypertension is defined as blood pressure readings consistently higher than 140/90. This measure looks at whether adults in the Medicare population, diagnosed with hypertension, had blood pressure readings below 140/90 during 2001. Hypertension can improve with changes in diet and lifestyle, including increased exercise and the appropriate use and monitoring of medications. With careful, individualized treatment, up to three-quarters of patients diagnosed with hypertension can achieve and maintain adequate blood pressure control. HMOs can use educational programs and newsletters to increase provider and patient awareness of the benefits of controlling high blood pressure.



NOTES

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CHOLESTEROL MANAGEMENT 1 of 2

CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENTS

Cholesterol management is very important in the prevention and control of coronary artery disease, the leading cause of death in the United States. Approximately 490,000 deaths occur each year because of complications of this disease and many clinical studies have shown that high blood cholesterol levels are directly related to the development of coronary artery disease. However, only about one out of every four of the 50 million Americans with high cholesterol has the condition under adequate control.

Elevated cholesterol levels can be lowered through a combination of lifestyle changes including a low-fat diet, increased physical activity and, when appropriate, treatment with cholesterol-lowering medications. Physicians routinely screen patients for high cholesterol. It is especially important for those who have already had a cardiac event such as a heart attack, bypass surgery, or coronary angiography to ask their doctors about treatment choices.

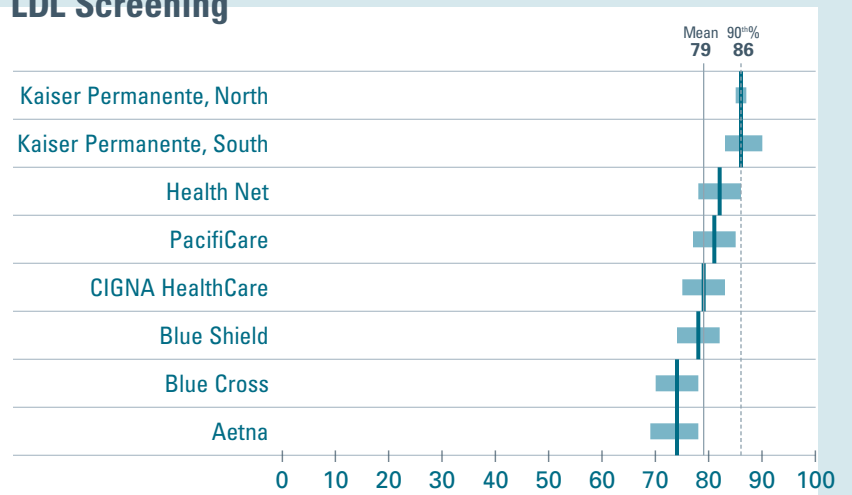
The first of the measures shown on these pages reports the percentage of California adult HMO members discharged from the hospital following a heart attack, bypass surgery, or coronary angioplasty, who were then screened for high cholesterol (LDL cholesterol) during the year after their hospital discharge.

The second measure reflects the percentage of patients with known heart disease who have their cholesterol levels under control. Control for this measure means an LDL cholesterol level less than 130 mg/dl. Controlling LDL cholesterol levels is very important in patients with existing heart disease and can help reduce the risk of a second heart attack by as much as 40 percent.

Separate charts display results for both commercial and Medicare members.

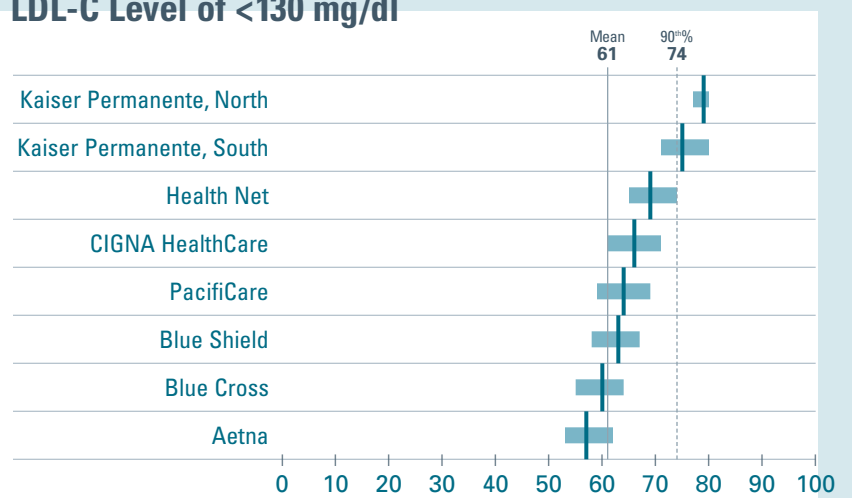
LDL Screening

COMMERCIAL



LDL-C Level of <130 mg/dl

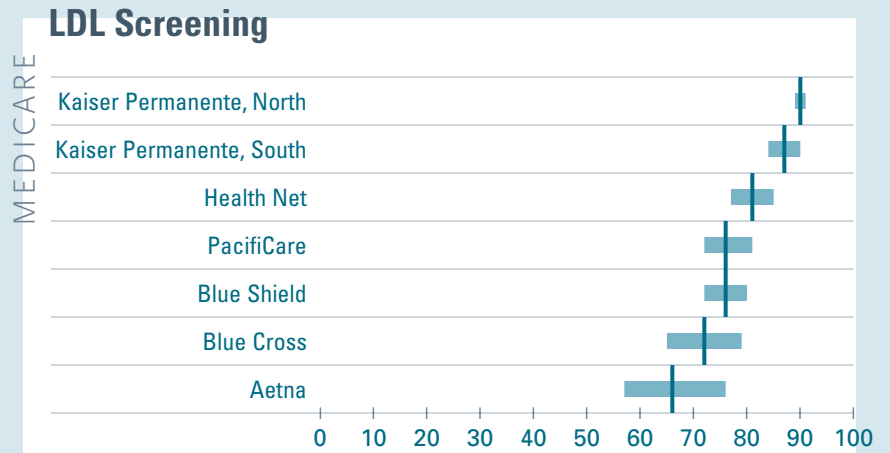
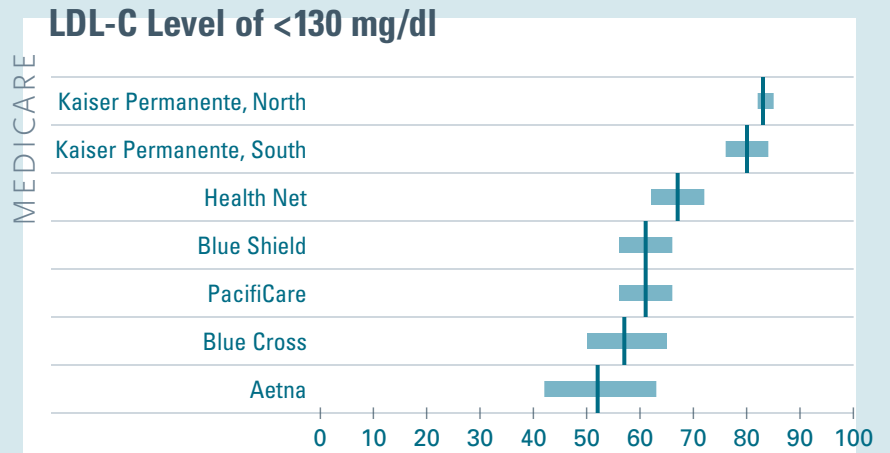
COMMERCIAL



NOTES

CIGNA HealthCare and Universal Care do not offer managed care plans for Medicare beneficiaries.

CHOLESTEROL MANAGEMENT *2 of 2*



NOTES

CIGNA HealthCare and Universal Care do not offer managed care plans for Medicare beneficiaries.

Blue Cross did not meet the minimum population requirement for this measure.

Inter Valley Health Plan's data for these measures were incomplete.

ABOUT THE MEMBER SURVEYS

Another important part of the HEDIS measurement set is a standardized member survey used by HMOs to evaluate patients' experience and satisfaction with their health plan. Information obtained from these surveys helps plans improve the quality of their services. Consumers use the comparative results to learn more about CCHRI health plans.

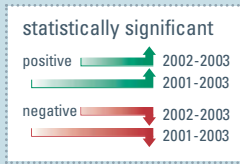
An independent research firm, using a uniform process that produces accurate and comparable results about specific plans, administered the NCQA-approved member survey for CCHRI. The survey was mailed to a randomly selected sub-set of members from each health plan and follow-up telephone calls were conducted for those members who didn't respond to the initial questionnaire.

In early 2002, approximately 15,000 members received questionnaires asking them to evaluate their experiences with their health plan during 2001. The research firm tabulated and reported the results based on answers from members who replied to the survey. Findings shown in this report include responses to individual questions as well as combined responses from several similar questions that are summarized into composite categories.

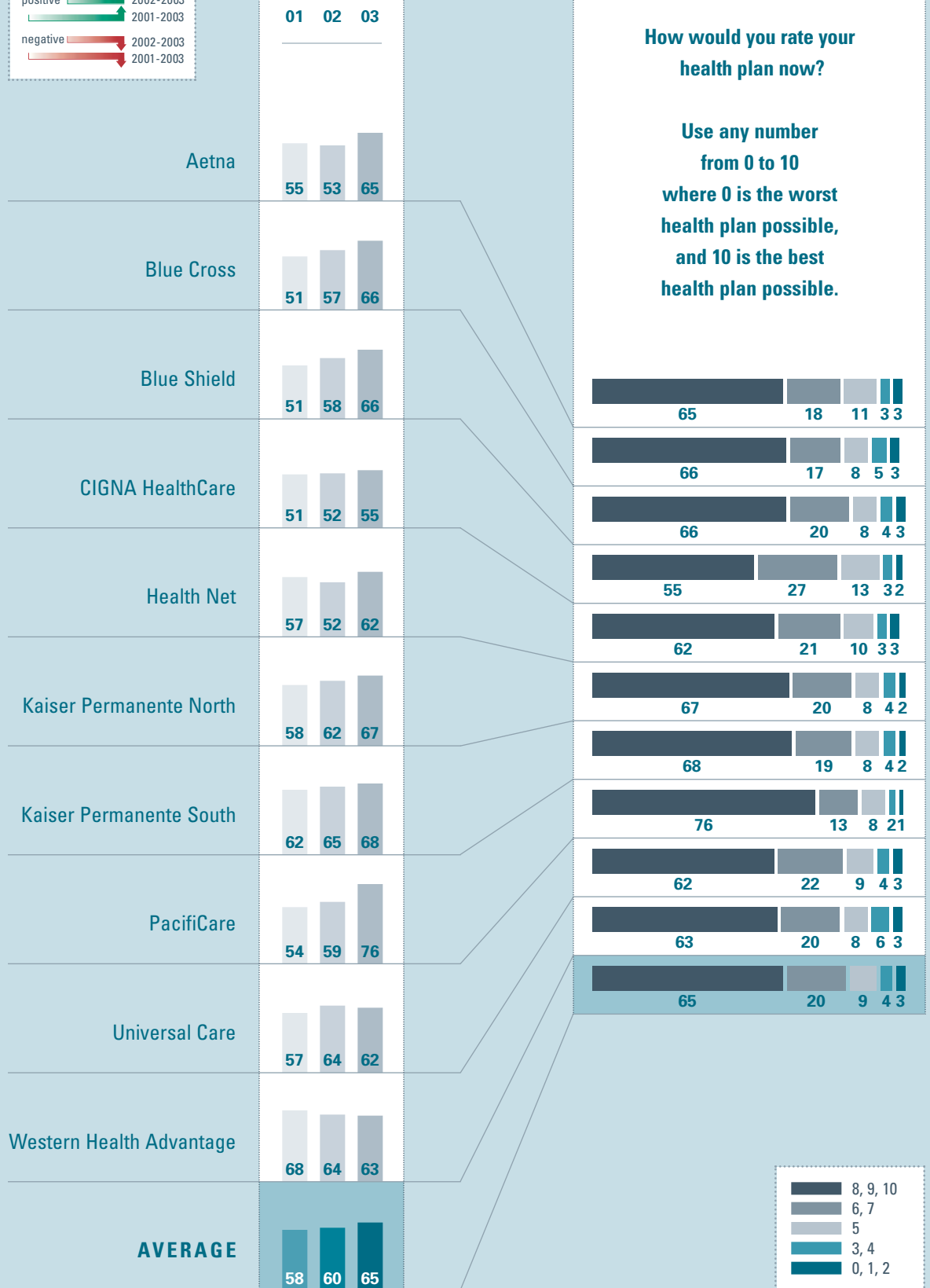
It is possible that members who participated in this survey are more satisfied or less satisfied than members who did not receive questionnaires or participate in the survey. The results were tabulated and reported as above average, average or below average using a statistical test similar to that developed for the clinical Effectiveness of Care measures.

HEALTH PLAN 1 of 2

MEMBER SURVEY



OVERALL HEALTH PLAN RATING



HEALTH PLAN 2 of 2

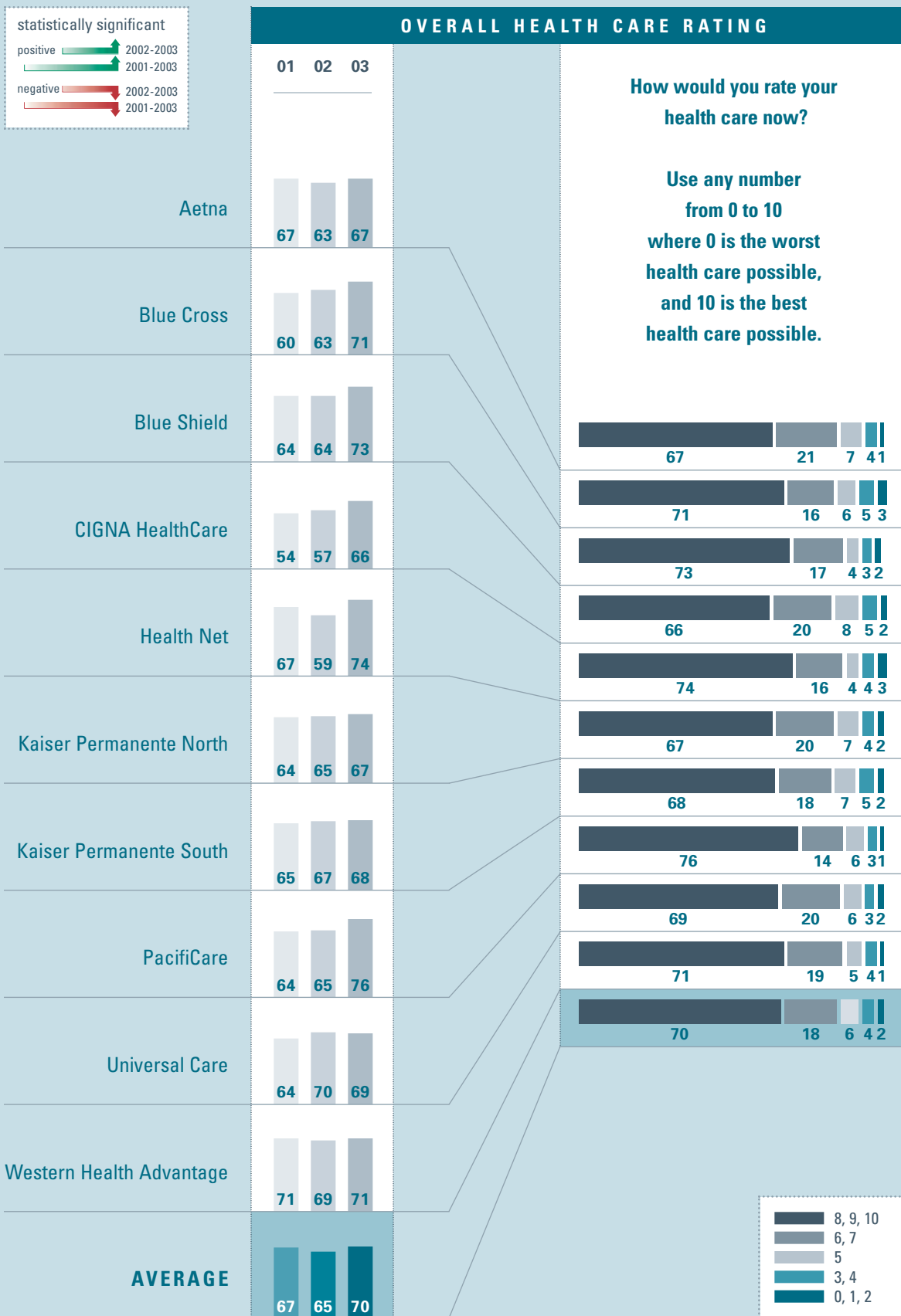
MEMBER SURVEY

	IN THE LAST 12 MONTHS, HOW MUCH OF A PROBLEM, IF ANY, WAS IT TO GET ...			
	the help you needed when you called your health plan's customer service?	the care you or a doctor believed necessary?	a referral to a specialist you needed to see?	
Aetna	63 22 15	77 17 6	62 28 11	
Blue Cross	56 29 15	76 19 5	56 25 19	
Blue Shield	62 25 13	76 18 6	65 18 17	
CIGNA HealthCare	57 26 17	70 23 7	60 25 15	
Health Net	48 32 20	76 17 7	63 26 11	
Kaiser Permanente North	58 25 17	74 19 7	63 24 13	
Kaiser Permanente South	61 26 13	74 18 8	60 23 17	
PacifiCare	63 24 14	81 13 6	70 19 11	
Universal Care	63 20 17	75 17 8	62 23 15	
Western Health Advantage	50 24 27	76 15 9	61 25 14	
AVERAGE	58 25 17	75 18 7	62 24 14	

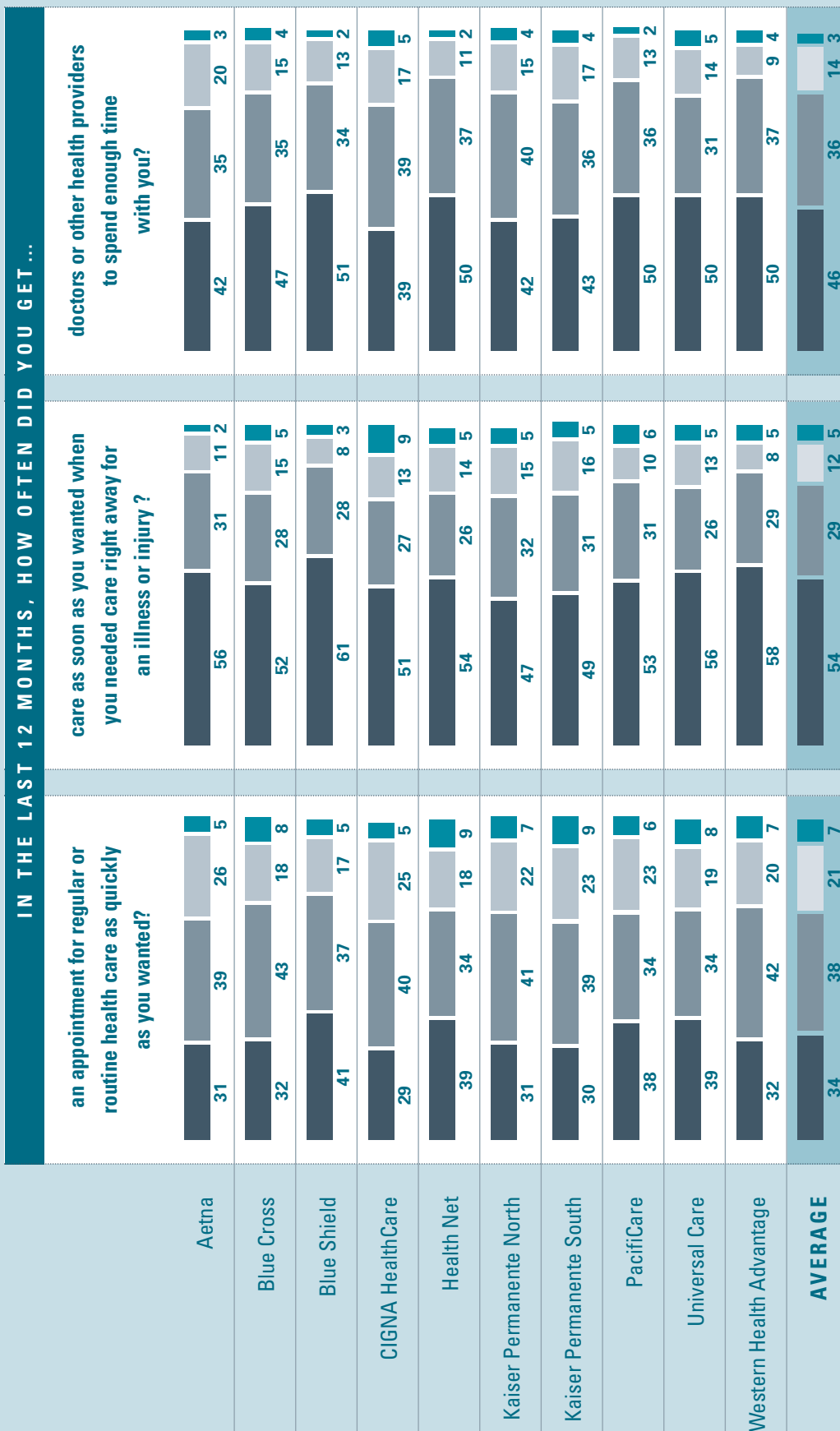


HEALTH CARE 1 of 2

MEMBER SURVEY



MEMBER SURVEY



MEASURES OF EFFECTIVENESS OF CARE

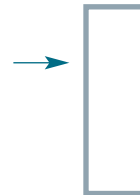
Looking at results obtained over a period of several years can help evaluate whether plans are improving the way they provide care in certain clinical areas.

This chart compares health plan performance for eleven clinical measures in the commercial population. Several of the measures are composed of more than one rating. Depending on the availability of comparable data, results are trended over two or three years. NCQA continuously improves the way performance measures are collected, and occasionally adds new measures, making it difficult to compare ratings for more than three years for specific measures.

Many year-to-year changes are small and may not be meaningful. Changes that are statistically significant are noted with a blue or grey arrow crossing this year's and last year's rates. In addition, longer-term meaningful changes are noted where the arrow crosses all three years of trend data and compares this year's results to the 2000 results. Changes not noted with an arrow are not meaningful and may be due to random chance.

HOW TO READ THESE GRAPHS

The hollow bars indicate data that was collected in the previous year.



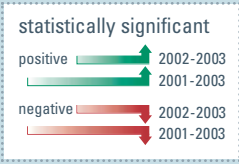
NOTES

☒ – Health Plan did not submit auditor-approved data.

ϕ – No rate reported; denominator was less than 30.

a – CCHRI did not report these measures in 2001, therefore data is not available.

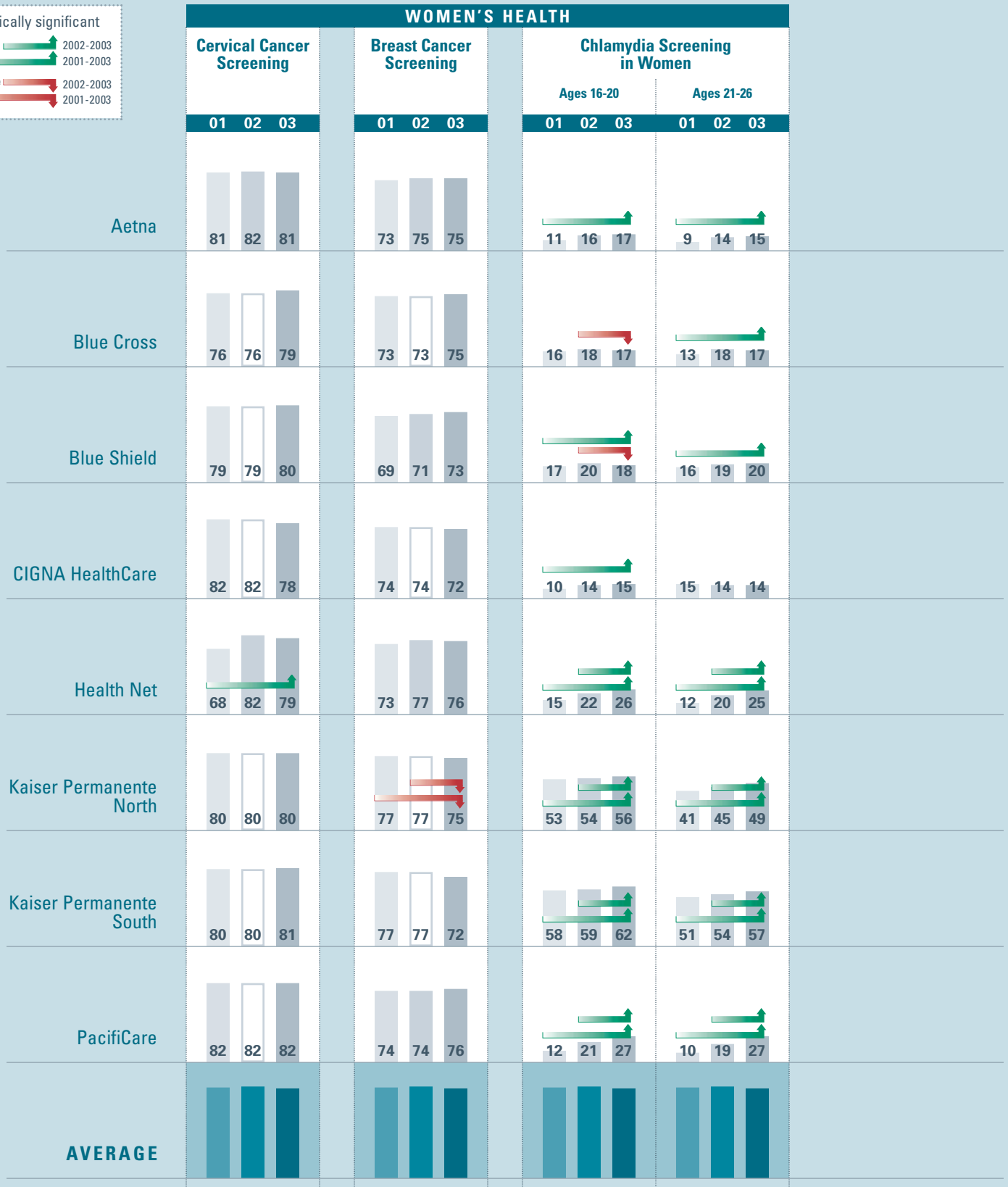
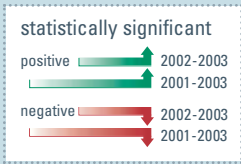
TREND DATA COMMERCIAL *1 of 6*



NOTES

See page 40 for notes.

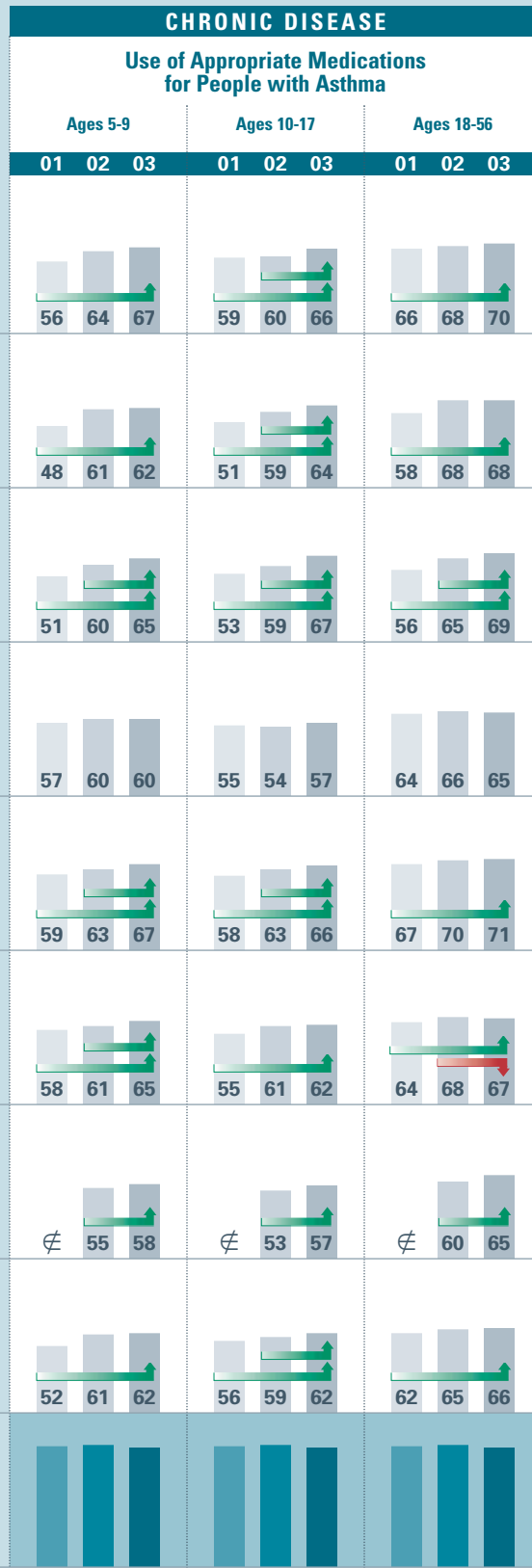
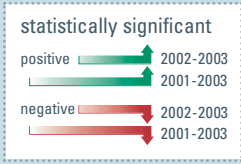
TREND DATA COMMERCIAL *2 of 6*



NOTES

See page 40 for notes.

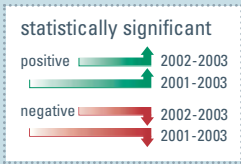
TREND DATA COMMERCIAL *3 of 6*



NOTES

See page 40 for notes.

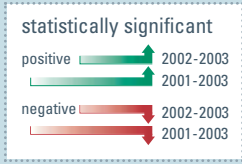
TREND DATA COMMERCIAL *4 of 6*



NOTES

See page 40 for notes.

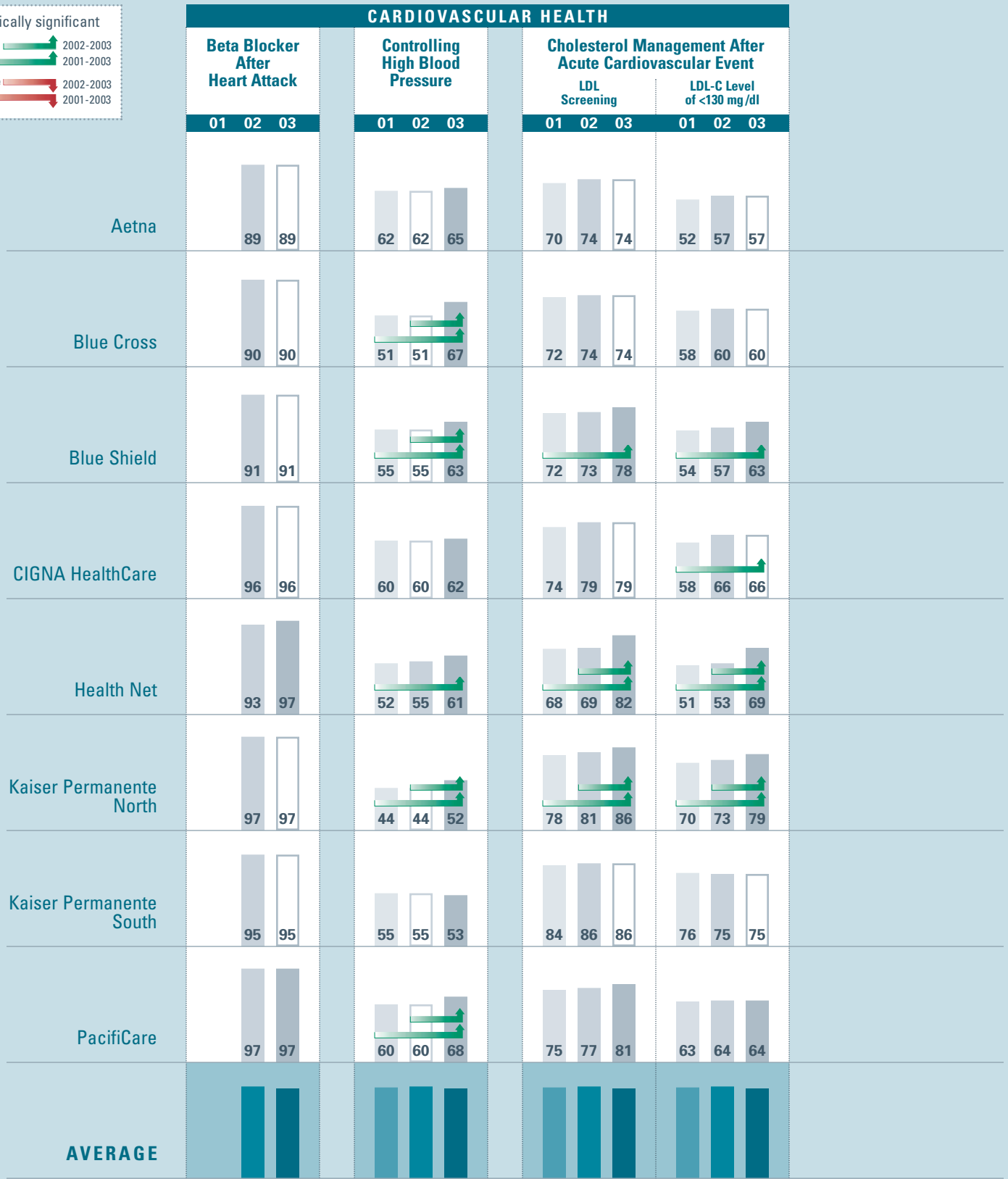
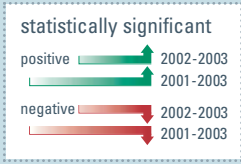
TREND DATA COMMERCIAL *5 of 6*



NOTES

See page 40 for notes.

TREND DATA COMMERCIAL 6 of 6



NOTES

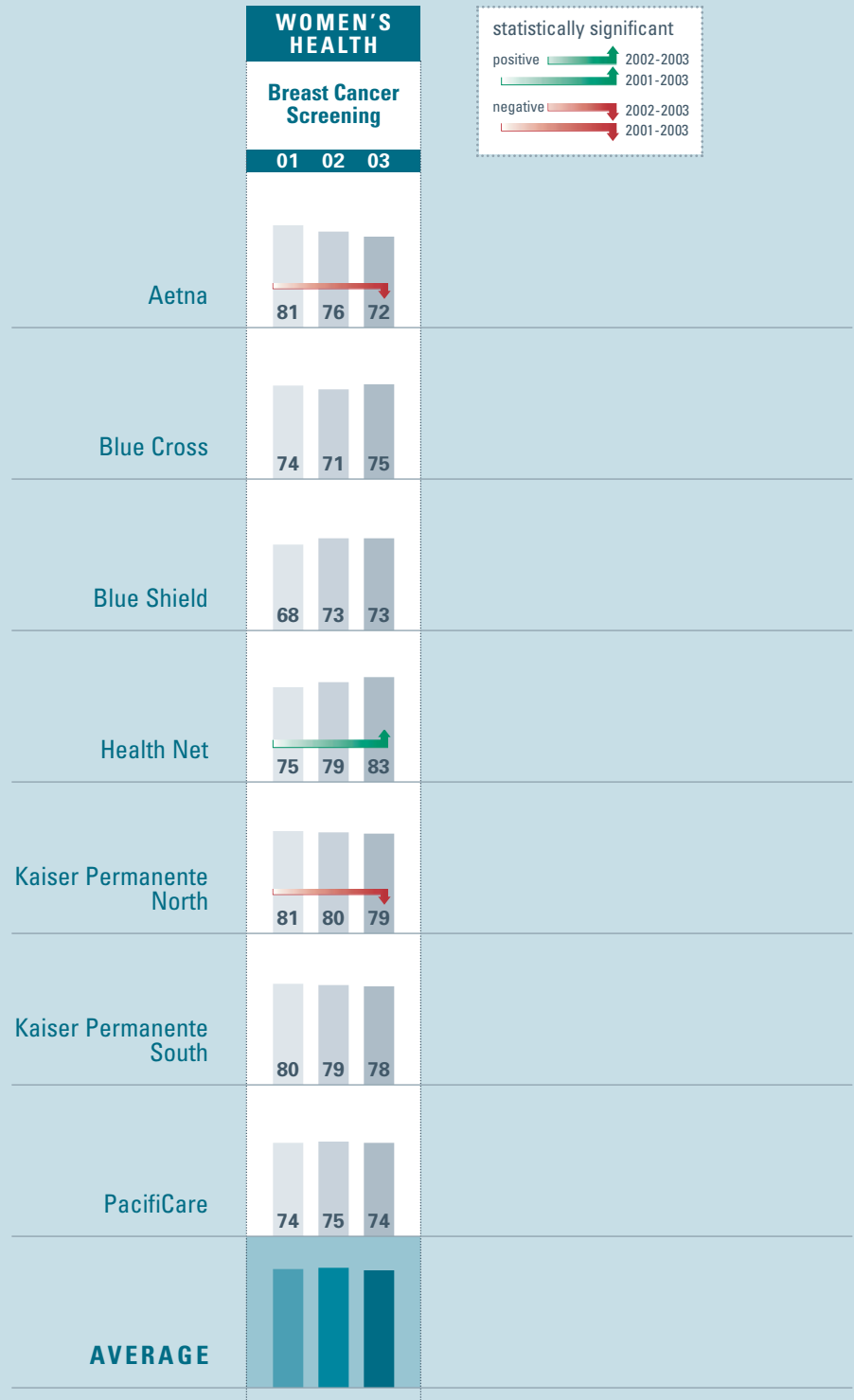
See page 40 for notes.

TREND DATA MEDICARE *1 of 4*

Looking at performance results obtained over a period of several years can help evaluate whether plans are improving the way they provide care in certain clinical areas.

The trend charts on pages 33–34 compare health plan performance for sixteen clinical measures for the Medicare population. Several of the measures are composed of more than one rating. Depending on the availability of comparable data, results are trended over two or three years. NCQA continuously improves the way performance measures are collected, and occasionally adds new measures, making it difficult to compare ratings for more than three years for specific measures.

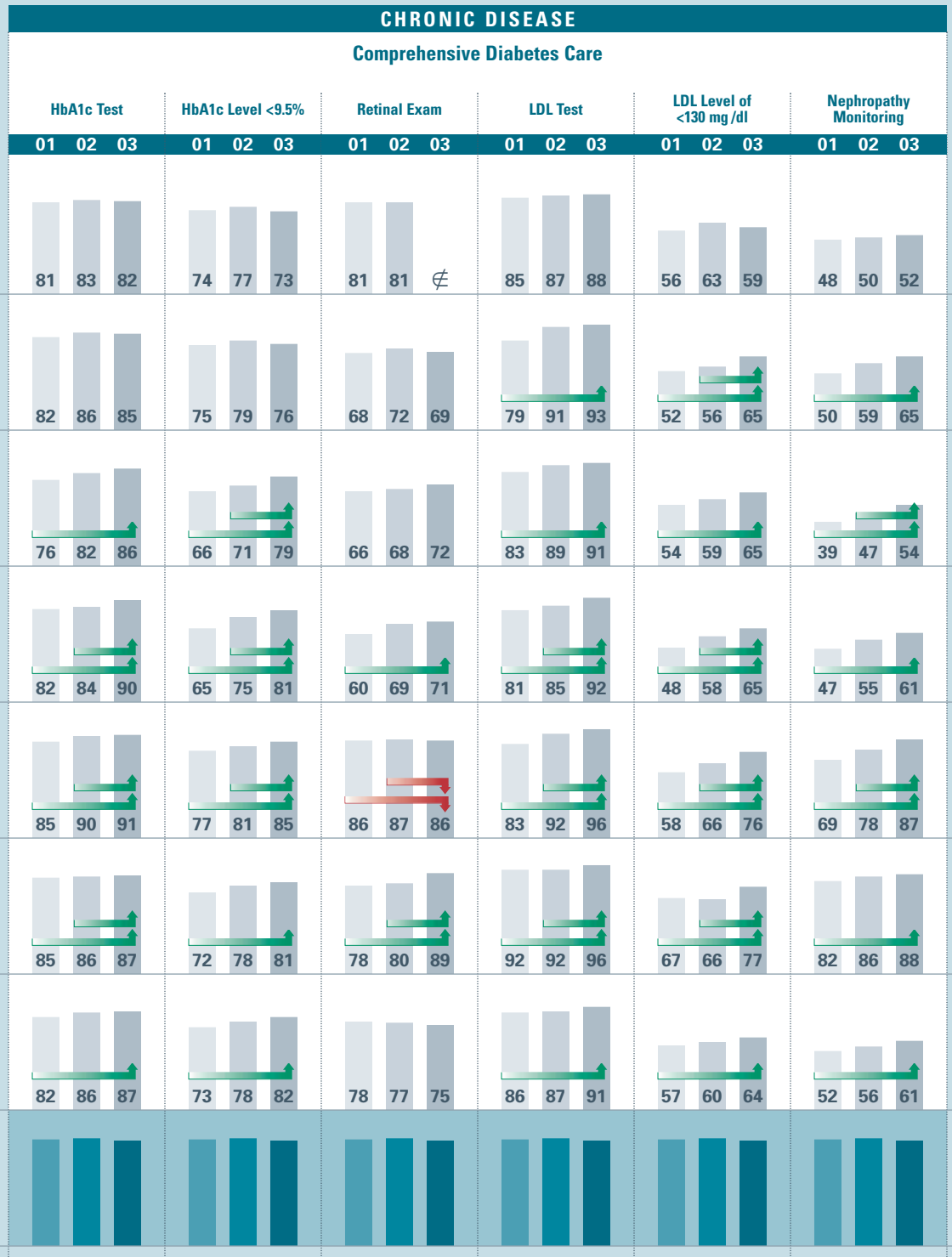
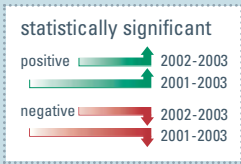
Many year-to-year changes are small and may not be meaningful. Changes that are statistically significant are noted with a blue or grey arrow crossing this year's and last year's rates. In addition, longer-term meaningful changes are noted where the arrow crosses all three years of trend data and compares this year's results to the 2000 results. Changes not noted with an arrow are not meaningful and may be due to random chance.



NOTES

See page 40 for notes.

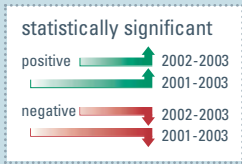
TREND DATA MEDICARE *2 of 4*



NOTES

See page 40 for notes.

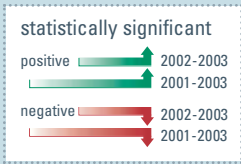
TREND DATA MEDICARE *3 of 4*



NOTES

See page 40 for notes.

TREND DATA MEDICARE *4 of 4*



NOTES

See page 40 for notes.

ABOUT THE SURVEYS

Other sections of this Report help consumers understand the role of health plans in assuring that patients receive good medical care. However, it is also important for consumers to know whether their local medical groups and IPAs provide readily accessible medical treatment and other important health care services for their patients.

For the second year in a row, CCHRI implemented in 2002 the Consumer Assessment Survey (CAS), a nationally recognized and standardized questionnaire used to evaluate and publicly report quality performance and patient satisfaction with their provider group. This survey is different from the member survey used by health plans (see those results in the report card insert) because it attempts to evaluate the care received from physicians and other providers who belong to specific medical groups and IPAs in California.

This Report summarizes the findings of the Consumer Assessment Survey and the supplemental after-hours phone calls. Most of the questions from the CAS are grouped with similar questions that share common interest and are reported as composite scores. For example, the “Timely Care and Service” composite measure includes questions about getting an appointment, getting help or advice during regular office hours, after hours care, and timeliness of care. For more information about particular questions included in each CAS composite category, and for results to specific questions, please see www.healthscope.org where more detailed responses are available.

CCHRI was able to implement the 2002 Consumer Assessment Survey because of the generous financial support and assistance from the following health plans and organization:

- Aetna Health of California, Inc.
- Blue Cross of California
- Blue Shield of California
- Health Net
- Kaiser Foundation Health Plan
- PacifiCare of California
- Pacific Business Group on Health

NOTES

∅ – Health Plan did not submit auditor-approved data.

ϕ – No rate reported; denominator was less than 30.

CONSUMER ASSESSMENT SURVEY

The 2002 Consumer Assessment Survey evaluated patients' experience and the care they received from eighty-two medical groups or IPAs in northern and southern California. These provider groups ranged in size from 2,500 to 2.8 million members and fifty-one were located in southern California and thirty-one in northern California. The results were calculated from over 35,000 individual patients who responded to the survey. In most instances, provider organizations were selected based on the size of their membership and their relationship with the health plans that sponsored the CAS. Significantly, the participating medical groups and IPAs also agreed to publicly report the results from the survey.

Because the California health care delivery system covers such a large geographic area and is so diverse, CCHRI tried to obtain specific information from the Consumer Assessment Survey that is helpful to members in making important health care decisions. Consumers frequently ask the following kinds of questions when weighing decisions about where to receive their health care: "Is my primary care physician available after-hours? Can I get an appointment with my doctor when I need one? Will I receive the important preventive health care services that are recommended for me?" The Consumer Assessment Survey attempts to help answer these questions.

HMO and POS patients, along with seniors covered under a Medicare-risk agreement, and enrolled in the selected medical groups and IPAs participating in the survey, were asked to evaluate the following features of the medical care they receive:

- Overall ratings of their care;
- Communication between doctor and patient;
- Counseling on preventive care topics such as diet, exercise and smoking;
- Access to primary and specialist care for urgent and non-urgent situations.

Nine hundred and fifty adults (over the age 18) were randomly selected from each medical group or IPA to participate in the survey. The CAS questionnaire was mailed directly to them from an independent research organization and all responses were confidential. The results shown on pages 37-40 were tabulated from the mailed survey responses or from follow-up telephone calls to those patients who did not return the mailed questionnaire.

AFTER HOURS ACCESS SURVEY

In order to supplement important access information obtained from the Consumer Assessment Survey, such as appointment availability and access to care information, CCHRI also conducted an after-hours telephone survey of physicians' offices. This Provider Telephone Access Survey focused on the same primary care physicians associated with the eighty-two medical groups and IPAs participating in the CAS. An impartial research firm used a CCHRI-developed telephone interview survey to assess whether PCPs are available after-hours to speak with their patients. They also evaluated whether office recordings and answering services offer appropriate information to after-hours callers experiencing a medical emergency.

More than 3,200 after-hours phone interviews were completed during this project. Results obtained from these phone calls are included, side-by-side, in the same tables that contain results for the access to care and appointment availability questions from the Consumer Assessment Survey. This combination of access responses to questions from the CAS and the after-hours phone calls are listed as the Provider Access Reporting Initiative.

CCHRI asked participating medical groups and IPAs to assist with the provider survey by supplying contact information and telephone numbers for their primary care physicians. Fifty PCP offices were randomly selected from each provider organization; in some instances, if fewer than fifty PCPs were members of a particular medical group or IPA, all PCPs offices from the group were called. Several integrated medical group practices, each with one or more selected locations and centralized after-hours phone access, received phone calls at specific locations, rather than individual physician offices.

Results for the after-hours phone calls are shown as percentage scores. Calculations were made based on the total number of interviews completed and the total number of appropriate responses.

- ▲ significantly above average
- ▼ significantly below average

	CONSUMER ASSESSMENT SURVEY						
	Rating Overall Health Care	Rating of Personal Doctor or Nurse	Rating of Specialist Most Often Seen	Timely Care & Service	Getting Treatment & Specialty Care	Communicating with Patients	Preventive Care Counseling
Affinity Medical Group	67	77	73	75	71	84	43
Alta Bates Medical Group	69	81	72	75	65	85	39
Bakersfield Family Medical Center/Heritage Physicians Network	61 ▼	80	63 ▼	69 ▼	60 ▼	83	37
Brown & Toland Medical Group	70	81	73	75	68	86	43
Camino Medical Group	71	81	75	71	72	88	39
Central Valley Medical Group	68	80	74	72	64	86	34 ▼
Chinese Community Health Care Association	63	70 ▼	62 ▼	68 ▼	63	82	43
Delta IPA	66	72 ▼	73	73	65	80 ▼	39
East County Medical Group	68	77	76	79 ▲	73 ▲	86	41
Golden Empire Managed Care, A Medical Group, Inc. (GEMCare)	67	77	73	75	68	84	35
Golden State Medical	64 ▼	73 ▼	72	73	59 ▼	83	36
Hill Physicians Medical Group	71	79	67	78 ▲	72	86	38
Humboldt-Del Norte IPA	82 ▲	88 ▲	81 ▲	83 ▲	74 ▲	92 ▲	44
John Muir/Mt. Diablo Health Network	77 ▲	84	76	80 ▲	72	89 ▲	43
Marin IPA	74	83	74	78 ▲	71	86	43
Mills-Peninsula Medical Group	69	75	76	74	69	84	44
Palo Alto Medical Foundation	77 ▲	83	77	75	67	89 ▲	40
Physicians Medical Group of San Jose	74	77	⊘	72	⊘	79 ▼	53 ▲
Physicians Medical Group of Santa Cruz County	75	81	78	76	71	86	38
San Jose Good Samaritan Medical Group	63 ▼	79	76	62 ▼	61 ▼	83	36
Santa Clara County IPA	70	77	73	75	72	85	40
Santa Cruz Medical Clinic	69	84	77	69 ▼	74 ▲	88	38
Santé Community Physicians	69	79	68	75	73	86	40
Sonoma County Primary Care IPA	78 ▲	83	⊘	82 ▲	⊘	89 ▲	50 ▲
Sutter Gould Medical Foundation	70	80	73	72	65	86	34 ▼
Sutter Independent Physicians	73	78	81 ▲	77	71	86	40
Sutter Medical Group	68	76	78	71	65	86	34 ▼
Sutter Medical Group of the Redwoods	78 ▲	88 ▲	72	80 ▲	71	90 ▲	38
Sutter West Medical Group	77 ▲	86 ▲	78	77	72	90 ▲	41
The Permanente Medical Group (Bay area)	67	78	74	74	68	83	37
The Permanente Medical Group (Sacramento area)	65 ▼	68 ▼	75	70 ▼	61 ▼	83	33 ▼
University of California Davis Medical Group	70	83	65 ▼	73	62 ▼	86	37
Woodland Clinic Medical Group	65	80	74	69 ▼	66	86	38
NORTHERN CALIFORNIA AVERAGE	70	80	74	74	68	86	39

HOW TO READ THESE GRAPHS

Responses included in a composite category are combined to obtain a single score. For example, for questions with four possible answers, the results used to create a composite score include the total percent of responses that fall in the top two favorable categories (i.e., Always or Usually).

In addition, the Consumer Assessment Survey used a 0-10 rating for measuring overall experience with care from a doctor's office or clinic, care from a personal doctor or

nurse, and care from specialists. The scores reported here show the percentage of responses with the most favorable ratings—8, 9, or 10 on a 10-point scale.

The After Hours results are the percentage of PCP offices in each medical group or IPA that offered appropriate information during the after-hours telephone access survey.

Each group's score is compared to the overall regional average score and statistically significant results above or below the regional average are displayed by arrows.

When reviewing the results, please compare each group to the regional average and not to the other groups. Results are based on a relatively small number of a group's members and differences between groups may not be significant or meaningful.

An average for all the groups located in either northern or southern California was also calculated and specific group results can be compared to their regional average. Comparative group scores that are significantly above or below the regional average are indicated by arrows. ▲ ▼

▲ significantly above average

▼ significantly below average

	CONSUMER ASSESSMENT SURVEY						
	ACCESS TO YOUR PCP			ACCESS TO SPECIALISTS		AFTER HOURS	
	Routine Care	Urgent Care	Preventive Care	Routine Care	Urgent Care	Appropriate Emergency Instructions	Physician Availability
Affinity Medical Group	84	82	83	79	74	φ	φ
Alta Bates Medical Group	84	83	83	69	68	79	93
Bakersfield Family Medical Center/Heritage Physicians Network	83	70 ▼	84	66	67	81	88
Brown & Toland Medical Group	80	85	83	75	72	71	85
Camino Medical Group	81	77	74 ▼	76	74	98	100 ▲
Central Valley Medical Group	79	75	78	68	65	84	98
Chinese Community Health Care Association	73 ▼	55 ▼	67 ▼	63 ▼	∅	46 ▼	84
Delta IPA	84	83	82	72	71	φ	φ
East County Medical Group	90 ▲	88 ▲	88 ▲	77	79	φ	φ
Golden Empire Managed Care, A Medical Group, Inc. (GEMCare)	88 ▲	89 ▲	88 ▲	80	75	90	98
Golden State Medical	84	79	84	66 ▼	63	φ	φ
Hill Physicians Medical Group	87	81	89 ▲	78	68	78	98
Humboldt-Del Norte IPA	88 ▲	89 ▲	90 ▲	82 ▲	81 ▲	75	79
John Muir/Mt. Diablo Health Network	89 ▲	88 ▲	87 ▲	78	79	82	92
Marin IPA	88 ▲	88 ▲	84	76	75	82	100 ▲
Mills-Peninsula Medical Group	81	83	83	79	77	68	98
Palo Alto Medical Foundation	79	76	79	69	76	100 ▲	100 ▲
Physicians Medical Group of San Jose	77	∅	75	∅	∅	98	90
Physicians Medical Group of Santa Cruz County	86	83	82	75	77	94	89
San Jose Good Samaritan Medical Group	73 ▼	76	79	66 ▼	64	83	98
Santa Clara County IPA	86	82	81	78	81 ▲	95	67
Santa Cruz Medical Clinic	73 ▼	73	80	77	79	100 ▲	100 ▲
Santé Community Physicians	86	84	80	82 ▲	∅	φ	φ
Sonoma County Primary Care IPA	86	∅ ▲	87	∅	∅	60	95
Sutter Gould Medical Foundation	83	77	81	71	69	φ	φ
Sutter Independent Physicians	85	80	82	77	72	88	81
Sutter Medical Group	77 ▼	76	78	75	65	96	86
Sutter Medical Group of the Redwoods	88 ▲	85 ▲	85	77	75	67	88
Sutter West Medical Group	84	79	83	77	80	100 ▲	100 ▲
The Permanente Medical Group (Bay area)	81	73	79	77	72	φ	φ
The Permanente Medical Group (Sacramento area)	74 ▼	70 ▼	79	70	73	φ	φ
University of California Davis Medical Group	82	78	82	64 ▼	65	96	94
Woodland Clinic Medical Group	80	73	75 ▼	71	64	φ	φ
NORTHERN CALIFORNIA AVERAGE	83	79	82	74	72	84	92

- ▲ significantly above average
- ▼ significantly below average

CONSUMER ASSESSMENT SURVEY							
	Rating Overall Health Care	Rating of Personal Doctor or Nurse	Rating of Specialist Most Often Seen	Timely Care & Service	Getting Treatment & Specialty Care	Communicating with Patients	Preventive Care Counseling
Access Managed Care (IPA)	62	73	67	70	60	81	38
Affiliated Doctors of Orange County (ADOC)	67	77	66	75 ▲	56 ▼	83	44 ▲
Alamitos IPA	72	80	62	72	60	86	39
Alliance/Unified a Division of HealthCare Partners	65	74	68	71	61	82	37
AMVI Medical Group	62	76	☺	68	☺	74 ▼	48 ▲
Anaheim Memorial IPA	66	74	66	71	67	80	40
Antelope Valley Medical Associates	53 ▼	59 ▼	64	63 ▼	56 ▼	71 ▼	30 ▼
Arta Health Network	61	76	☺ ▼	65	☺ ▼	82	41
Axminster Medical Group	60 ▼	74	66	63 ▼	58	81	39
Bay Area Community Medical Group, Inc. (IPA)	67	78	63	73	63	84	39
Beaver Medical Group	72 ▲	79	75	67	65	86	35
Bright Medical Associates	62	79	66	67	65	84	35
Bristol Park Medical Group	70	82	75	73 ▲	65	84	35
Buenaventura Medical Group	63	75	65	66 ▼	66	85	31 ▼
Cedars-Sinai Health Associates	67	79	74	71	68	84	39
Cedars-Sinai Medical Group	67	83 ▲	67	70	66	87 ▲	42 ▲
Centinela IPA	59	72	☺	71	☺	80	38
Centre for Health Care	67	74	69	70	65	84	37
Desert Medical Group	66	77	70	65 ▼	60	81	31 ▼
Downey Select Medical Group	63	75	76	72	64	83	39
Empire Physicians Medical Group	71	82	72	75 ▲	64	84	37
Exceptional Care Medical Group	☺	☺	☺ ▲	☺	☺	☺	☺
Facey Medical Group	61	75	64	62 ▼	60	81	38
Family Care Specialists IPA	63	77	☺	63 ▼	☺	84	37
Freeman IPA	☺	☺	☺	☺	☺	☺	☺
Greater Newport Physicians	71	79	74	73	65	85	36
Greater Tri-Cities IPA	64	69 ▼	74	74	65	83	30 ▼
Greater Valley Medical Group	69	80	64	70	67	84	35
HealthCare Partners Medical Group (Memorial Medical Group)	75 ▲	82	73	78 ▲	69	86	36
Heritage Victor Valley	☺	☺	☺	☺	☺	☺	☺
High Desert Medical Group	54 ▼	72 ▼	59 ▼	57 ▼	59	76 ▼	30 ▼
Hollywood Presbyterian Medical Group	☺	☺	☺	☺	☺	☺	☺
Lakeside Medical Group, Inc.	64	80	64	69	63	82	33
Lakewood Health Plan, Inc	61	74	69	67	64	82	32 ▼
Memorial HealthCare IPA	69	81	67	68	64	82	39
Mercy Physicians Medical Group	72 ▲	77	69	78 ▲	70 ▲	84	37
Mission Hospital Affiliated Physicians	☺	☺	☺	68	☺	88 ▲	40
Network Medical Management/Allied Physicians of California	66	77	67	70	64	82	39
Network Medical Management/Arcadia Health City	74	88 ▲	☺ ▲	75	71 ▲	89 ▲	40
Network Medical Management/Greater Orange Medical Group	64	76	☺	72	☺	85	38
Network Medical Management/Verdugo Hills Medical Group	70	80	61	74	67	86	43 ▲
Noble AMA	61	☺	☺	68	☺ ▼	76 ▼	50 ▲
Noble Community Medical Associates	64	77	63	71	56 ▼	82	41
Northridge Medical Group	64	79	66	70	63	81	40
Nuestra Familia Medical Group	68	80	☺	70	☺	86	48 ▲
Oasis IPA	63	80	64	67	57 ▼	82	33
Orange Coast Memorial IPA	67	86 ▲	71	71	69	84	39
Pegasus Medical Group	66	82	☺ ▲	63 ▼	☺	88 ▲	37
SOUTHERN CALIFORNIA AVERAGE	67	78	69	70	64	84	37

MEDICAL GROUP RESULTS

- ▲ significantly above average
- ▼ significantly below average

CONSUMER ASSESSMENT SURVEY							
	Rating Overall Health Care	Rating of Personal Doctor or Nurse	Rating of Specialist Most Often Seen	Timely Care & Service	Getting Treatment & Specialty Care	Communicating with Patients	Preventive Care Counseling
Penn Elm Medical Group	74 ▲	87 ▲	76 ▲	75 ▲	71 ▲	87 ▲	33 ▼
Physician Associates of the Greater San Gabriel Valley	68	77	67	72	67	84	37
Pioneer Medical Group	66	75	71	72	67	83	41
Primary Care Associates Medical Group	68	83	63	71	64	84	35
PrimeCare of Chino IPA	62	79	58 ▼	74 ▲	65	80	35
PrimeCare of Corona IPA	66	82	62	67	60	82	35
PrimeCare of Hemet IPA	54 ▼	62 ▼	☹	66	☹	78	35
PrimeCare of Inland Valley IPA	62	70 ▼	63	62 ▼	58 ▼	83	34
PrimeCare of Moreno Valley IPA	58 ▼	70 ▼	63	61 ▼	63	77 ▼	39
PrimeCare of Redlands IPA	73 ▲	83 ▲	70	72	68	90 ▲	40
PrimeCare of Riverside IPA	66	82	57 ▼	70	57 ▼	86	38
PrimeCare of Sun City IPA	65	76	64	66 ▼	66	84	36
PrimeCare of Temecula IPA	57 ▼	70 ▼	56 ▼	63 ▼	57 ▼	76 ▼	32 ▼
Professional Care Medical Group	65	82	71	73	65	86	38
ProMed Health Network of Pomona	70	79	75	72	72 ▲	85	37
Prospect / Health Source Medical Group	52 ▼	66 ▼	52 ▼	63 ▼	51 ▼	75 ▼	35
Prospect Medical Group / Corona	65	☹	☹	78 ▲	☹ ▼	81	36
Prospect Medical Group / Orange County	68	77	67	71	58	84	34
Prospect Medical Group / Sherman Oaks	☹ ▼	☹	☹	☹	☹ ▼	☹	☹
Regal Medical Group	64	80	68	73	59	85	40
Riverside Medical Clinic	70	81	63	69	69	85	36
Riverside Physician Network	64	80	58 ▼	71	55 ▼	84	36
Robert F. Kennedy Medical Group	☹	☹	☹	☹	☹	☹	☹
San Diego Physicians Medical Group	71	76	70	74	67	83	37
San Luis Obispo Select IPA	☹ ▼	☹ ▼	☹	☹ ▼	☹ ▼	☹	☹ ▼
Sansum-Santa Barbara Medical Foundation Clinic	69	79	67	70	70 ▲	85	37
Scripps Clinic Medical Group	67	82	75 ▲	69	70 ▲	85	36
Scripps Mercy Medical Group	75 ▲	86 ▲	75 ▲	76 ▲	66	91 ▲	38
SeaView IPA	59 ▼	71 ▼	66	71	52 ▼	79 ▼	35
Sharp Community Medical Group	72	81	71	71	67	86	37
Sharp Mission Park Medical Group	69	83	82 ▲	70	69	87 ▲	36
Sharp Rees-Stealy Medical Group	71	80	75	71	71 ▲	85	35
Sierra Primary Care Medical Group	59 ▼	76	68	65 ▼	63	79 ▼	34
Southern California Permanente Medical Group (Greater LA metro area)	60 ▼	73 ▼	68	65 ▼	64	82	34
Southern California Permanente Medical Group (San Diego area)	67	76	70	71	61	84	34
St. Francis IPA	66	73	74	68	63	84	42
St. Joseph Heritage Medical Group	67	80	76 ▲	70	67	85	42 ▲
St. Joseph Hospital Affiliated Physicians	71	82	77 ▲	71	69	87	37
St. Jude Affiliated Providers	65	69 ▼	74	72	66	82	34
St. Jude Heritage Medical Group	75 ▲	86 ▲	77 ▲	74 ▲	68	89 ▲	38
St. Vincent IPA	74 ▲	80	68	79 ▲	67	90 ▲	46 ▲
Talbert Medical Group	69	79	70	74 ▲	69	86	37
The Industry Health Network	82 ▲	91 ▲	81 ▲	78 ▲	77 ▲	89 ▲	32 ▼
Torrance Hospital IPA (THIPA)	73 ▲	82	73	77 ▲	73 ▲	86	39
UCLA Medical Group	74 ▲	84 ▲	69	69	65	88 ▲	39
UCSD Medical Group	63	79	74	59 ▼	61	85	37
Valley Care IPA	79 ▲	87 ▲	73	80 ▲	68	89 ▲	39
SOUTHERN CALIFORNIA AVERAGE	67	78	69	70	64	84	37

- ▲ significantly above average
- ▼ significantly below average

	CONSUMER ASSESSMENT SURVEY						
	ACCESS TO YOUR PCP			ACCESS TO SPECIALISTS		AFTER HOURS	
	Routine Care	Urgent Care	Preventive Care	Routine Care	Urgent Care	Appropriate Emergency Instructions	Physician Availability
Access Managed Care (IPA)	80	78	80	64	64	φ	φ
Affiliated Doctors of Orange County (ADOC)	88 ▲	77	84	60 ▼	φ	68	80
Alamitos IPA	81	80	83	67	φ	90	90
Alliance/Unified a Division of HealthCare Partners	86 ▲	80	86	66	φ	85	84
AMVI Medical Group	69 ▼	φ	76	φ	φ	φ	φ
Anaheim Memorial IPA	81	77	76	74	φ	59	82
Antelope Valley Medical Associates	70 ▼	71	73 ▼	62 ▼	63	φ	φ
Arta Health Network	81	φ	φ	φ ▼	φ	φ	φ
Axminster Medical Group	75	72	77	61 ▼	61	100 ▲	100 ▲
Bay Area Community Medical Group, Inc. (IPA)	82	77	83	69	68	84	89
Beaver Medical Group	71 ▼	67 ▼	76	68	68	100	100 ▲
Bright Medical Associates	81	78	78	75	70	87	87
Bristol Park Medical Group	81	79	84	72	φ	100 ▲	40 ▼
Buenaventura Medical Group	72 ▼	66 ▼	75	73	69	71	100 ▲
Cedars-Sinai Health Associates	77	79	85	75	74	96	96
Cedars-Sinai Medical Group	80	77	81	66	71	100 ▲	100 ▲
Centinela IPA	80	φ	83	φ	φ	φ	φ
Centre for Health Care	83	73	76	69	70	100 ▲	100 ▲
Desert Medical Group	72 ▼	68	73 ▼	63	68	71	69
Downey Select Medical Group	80	79	86	69	65	φ	φ
Empire Physicians Medical Group	88 ▲	81	85	70	71	88	92
Exceptional Care Medical Group	φ	φ	φ ▲	φ	φ	φ	φ
Facey Medical Group	65 ▼	69	68 ▼	67	67	100 ▲	100 ▲
Family Care Specialists IPA	74	64 ▼	81	φ	φ	φ	φ
Freeman IPA	φ	φ	φ	φ	φ	φ	φ
Greater Newport Physicians	80	79	76	69	68	98	93
Greater Tri-Cities IPA	85	78	77	70	φ	98	94
Greater Valley Medical Group	81	80	85	74	74	95	58
HealthCare Partners Medical Group (Memorial Medical Group)	87 ▲	75	85 ▲	76	70	64	94
Heritage Victor Valley	φ	φ	φ	φ	φ	φ	φ
High Desert Medical Group	63 ▼	55 ▼	69 ▼	68	62	40 ▼	96
Hollywood Presbyterian Medical Group	φ	φ	φ	φ	φ ▼	φ	φ
Lakeside Medical Group, Inc.	78	75	80	70	71	φ	φ
Lakewood Health Plan, Inc	76	76	77	71	φ	92	96
Memorial HealthCare IPA	78	74	81	71	68	94	94
Mercy Physicians Medical Group	88 ▲	81 ▲	85 ▲	78 ▲	76 ▲	96	89
Mission Hospital Affiliated Physicians	φ	φ	φ	φ	φ	77	79
Network Medical Management/Allied Physicians of California	82	60 ▼	74	72	φ	74	94
Network Medical Management/Arcadia Health City	88 ▲	φ	88 ▲	84 ▲	φ ▲	65	94
Network Medical Management/Greater Orange Medical Group	82	79	82	φ	φ	100 ▲	92
Network Medical Management/Verdugo Hills Medical Group	80	81	81	73	76	89	89
Noble AMA	φ	φ	φ	φ	φ ▼	84	90
Noble Community Medical Associates	86 ▲	78	82	65	φ	φ	φ
Northridge Medical Group	79	75	87 ▲	71	61	φ	φ
Nuestra Familia Medical Group	83	φ	79	φ	φ	φ	φ
Oasis IPA	81	70	81	61 ▼	63	46 ▼	50 ▼
Orange Coast Memorial IPA	80	76	82	73	φ	91	87
Pegasus Medical Group	80	φ	76	φ	φ	φ	φ
SOUTHERN CALIFORNIA AVERAGE	80	75	80	70	68	84	89

- ▲ significantly above average
- ▼ significantly below average

	CONSUMER ASSESSMENT SURVEY						
	ACCESS TO YOUR PCP			ACCESS TO SPECIALISTS		AFTER HOURS	
	Routine Care	Urgent Care	Preventive Care	Routine Care	Urgent Care	Appropriate Emergency Instructions	Physician Availability
Penn Elm Medical Group	82	77	80	74	75	φ	φ
Physician Associates of the Greater San Gabriel Valley	85 ▲	84 ▲	83	75	70	φ	φ
Pioneer Medical Group	82	73	84	75	64	100 ▲	96
Primary Care Associates Medical Group	80	75	79	74	φ	97	77
PrimeCare of Chino IPA	89 ▲	82 ▲	86 ▲	71	72	85	78
PrimeCare of Corona IPA	80	72	82	62 ▼	62	85	78
PrimeCare of Hemet IPA	78	φ	φ	φ	φ	100 ▲	100 ▲
PrimeCare of Inland Valley IPA	76	69	79	66	67	72	96
PrimeCare of Moreno Valley IPA	73	76	74	68	66	69	100 ▲
PrimeCare of Redlands IPA	82	74	87 ▲	75	70	87	93
PrimeCare of Riverside IPA	83	73	81	61 ▼	63	93	89
PrimeCare of Sun City IPA	74	72	77	69	65	89	78
PrimeCare of Temecula IPA	76	64 ▼	74	63	60	97	91
Professional Care Medical Group	85 ▲	77	86 ▲	80 ▲	φ	92	100 ▲
ProMed Health Network of Pomona	80	80	82	82 ▲	76	φ	φ
Prospect / Health Source Medical Group	78	70	78	57 ▼	55 ▼	φ	φ
Prospect Medical Group / Corona	φ ▲	φ	φ	φ	φ	φ	φ
Prospect Medical Group / Orange County	83	75	84	63	φ	φ	φ
Prospect Medical Group / Sherman Oaks	φ	φ	φ	φ	φ	φ	φ
Regal Medical Group	82	77	87 ▲	68	65	φ	φ
Riverside Medical Clinic	79	75	81	72	70	95	100 ▲
Riverside Physician Network	81	78	84	61 ▼	62	φ	φ
Robert F. Kennedy Medical Group	φ ▼	φ	φ	φ	φ ▼	87	80
San Diego Physicians Medical Group	83	81	80	74	69	φ	φ
San Luis Obispo Select IPA	φ	φ	φ ▼	φ ▼	φ ▼	88	98
Sansum-Santa Barbara Medical Foundation Clinic	77	76	77	75	77 ▲	100 ▲	100 ▲
Scripps Clinic Medical Group	74 ▼	77	75 ▼	75	73	42 ▼	100 ▲
Scripps Mercy Medical Group	85 ▲	78	85 ▲	69	68	φ	φ
SeaView IPA	83	80	81	59 ▼	φ	φ	φ
Sharp Community Medical Group	79	73	77	70	75	90	86
Sharp Mission Park Medical Group	76	69	76	70	70	100 ▲	100 ▲
Sharp Rees-Stealy Medical Group	77	76	78	75	76	93	79
Sierra Primary Care Medical Group	75	70	77	70	71	φ	φ
Southern California Permanente Medical Group (Greater LA metro area)	69 ▼	64 ▼	73 ▼	64	75	φ	φ
Southern California Permanente Medical Group (San Diego area)	70 ▼	75	75	64	71	φ	φ
St. Francis IPA	76	68	81	70	φ	φ	φ
St. Joseph Heritage Medical Group	81	77	81	72	65	16	84
St. Joseph Hospital Affiliated Physicians	83	81 ▲	84	82 ▲	67	φ	φ
St. Jude Affiliated Providers	81	77	80	71	67	φ	φ
St. Jude Heritage Medical Group	84 ▲	76	84	73	68	φ	φ
St. Vincent IPA	90 ▲	88 ▲	85	79 ▲	77	69	96
Talbert Medical Group	81	74	84	79 ▲	74	100 ▲	100 ▲
The Industry Health Network	88 ▲	82 ▲	86 ▲	81 ▲	76 ▲	φ	φ
Torrance Hospital IPA (THIPA)	89 ▲	81	90 ▲	76	80 ▲	93	93
UCLA Medical Group	81	76	83	68	62	100 ▲	96
UCSD Medical Group	65 ▼	66 ▼	70 ▼	67	67	93	95
Valley Care IPA	90 ▲	86 ▲	91 ▲	78 ▲	72	36 ▼	82
SOUTHERN CALIFORNIA AVERAGE	80	75	80	70	68	84	89

Each year, CCHRI faces new challenges and new improvement opportunities while navigating the complex, difficult pathways of California health care. And each year, CCHRI accepts greater responsibility and looks to the future with commitment and optimism while advancing health care quality and accountability. Therefore, with much gratitude, CCHRI recognizes the following outstanding leaders and Committees who helped set the tone and frame CCHRI activities during 2002:

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