

Measuring the Quality of Pennsylvania's Commercial HMOs



Pennsylvania Health Care Cost Containment Council
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Key Findings

- All Pennsylvania HMOs performed better than the national HMO Average in the following categories: testing blood sugar levels for members with diabetes; cholesterol screening for members with diabetes; controlling “bad” cholesterol for members with diabetes; providing the recommended childhood immunizations; controlling “bad” cholesterol after acute cardiovascular events; and controlling high blood pressure.
- On average, Pennsylvania HMOs improved from the prior year in 12 of the 16 “Staying Healthy” measures.
- On average, Pennsylvania HMOs showed improvements over the prior year in their rates of controlling the “bad” cholesterol of diabetic members (an 11.2% improvement), providing childhood immunizations (a 10.3% improvement), and controlling high blood pressure (an 8.8% improvement).
- All plans reported an increase from the prior year in the percent of plan members who gave their HMO the highest satisfaction rating.
- On average, Pennsylvania HMOs outperformed their national counterparts in all the Member Satisfaction measures for which a national average was available.
- There were significant increases in HMO hospitalization rates since last year for: adult asthma (+40.4%), pediatric asthma (+27.1%), adult ear nose and throat infections (+14.0%), pediatric ear nose and throat infections (+22.0%), and kidney/urinary tract infections (+16.5%).
- Hysterectomy procedure rates vary widely among HMO plans: adjusted rates varied from 33.3 to 89.9 per 10,000 adult female members, and the state average was 56.8. Five of the HMOs had lower than expected rates and the other five HMOs had higher than expected hysterectomy rates.
- The HMO in-hospital complication rate for abdominal hysterectomy decreased significantly (–22.7%) from 2000 to 2003. However, the complication rate for HMOs was significantly higher (25.5%) than the rate for fee-for-service plans.
- The neck and back procedure rate for HMOs increased significantly (+8.4%) over the previous year; significantly more (9.4%) of those procedures included a fusion as well.
- The five clinical conditions listed under “Preventing hospitalizations through primary care” (adult and pediatric ear, nose, and throat infections; high blood pressure; gas trointestinal infections; and kidney/urinary tract infections) show 4,418 hospitalizations, 11,268 inpatient days and \$51.8 million charges in 2003.



About this Report



More than four million Pennsylvanians were enrolled in HMOs (Health Maintenance Organizations) as of December 31, 2003. HMOs often appeal to those who purchase health insurance because, in part, they offer a number of attractive features. These features include:

- Emphasis upon prevention and primary care services for HMO members;
- More efficient management of the health care process;
- Ability to hold down costs; and
- Small out-of-pocket costs for consumers for many services.

While HMOs have delivered on many of these goals, there has

been a growing concern about a perceived lack of continuity of care and access to necessary services and medications. These perceptions have driven a desire by Pennsylvania purchasers, consumers and policy makers for more objective information about the cost and quality of health care for those in HMOs and related Point-of-Service plans.

What is an HMO?

Most Pennsylvanians receive their health care benefits through their employer or from a government-sponsored program such as Medicare or Medical Assistance. An HMO is an organized system that provides prepaid health benefits to a defined group of members. Unlike traditional insurers, HMOs typically offer and encourage members to take advantage of a host of educational materials, disease management programs, preventive health services and other initiatives to keep their members

healthy. HMO members usually are required to select a Primary Care Physician (PCP) who has the responsibility to coordinate the various health services available to members. HMOs may share financial responsibility with PCPs and other providers for the services provided to members. "Point-of-Service" (POS) options offered by HMOs often combine the structure of HMOs (members select PCPs and usually access non-primary care services through pre-approved referrals) with the flexibility to access services without pre-approved referrals and the option to leave the network of participating providers by paying an additional fee. A summary of the characteristics of the types of health insurance plans is provided in the table on the following page.





	HMO	Point-of-Service	Fee-for-Service
Can you get covered services from providers not in the network?	No	Yes, for an additional charge	Yes
Do you have a lot of paperwork?	No claim forms	No claim forms for in-network care	You need a claim form
Do you need to choose a PCP?	Yes	Yes	No
Do you need a referral from your PCP to go to a specialist?	Yes	Usually	No

About the Data

The data in this report is for Calendar Year 2003. One exception is that some HMOs submitted 2002 data for several of the measures, which is allowable under National Committee for Quality Assurance (NCQA) rules. These measures include: Timely Initiation of Prenatal Care, Screening for Breast Cancer, Screening for Cervical Cancer and Controlling High Blood Pressure. Much of the data in the report is risk-adjusted. Please refer to the Technical Report for a full description of this methodology. See page 32 for more information about the data in this report.



How to Use the Information in this Report



The quality of care provided by a managed care network directly affects the health of employees and their families, work force productivity, and an employer's direct and indirect health care costs. This report provides comparisons of the quality and value offered by Pennsylvania HMOs. Here's how to use this report to explore HMO utilization, clinical outcomes and member satisfaction.



Helping to Keep Members Healthy

Keeping patients healthy is a goal of all HMOs. Successful measures in this category include high rates of members receiving screening procedures, appropriate medication usage and disease monitoring.

Questions to ask an HMO representative:

- How are members made aware of insurance coverage for screening procedures, preventive services and education programs?
- Are programs in place to increase member utilization of screenings and preventive services?

- How do you compare your outcomes with other HMOs? Did you score consistently well across all effectiveness of care measures included in this report?

Preventing Hospitalization through Primary Care

One goal of an HMO network, and especially primary care, is to decrease preventable or avoidable hospitalizations. Reporting hospitalization rates for health problems that should not require hospitalization serves as one way to analyze the effectiveness of primary

care and HMOs. The statewide average scores for all HMOs in the report provide a point of comparison for each HMO. For these measures, a higher hospitalization rate is a poorer outcome of care and suggests a less effective HMO network of health providers.

Questions to ask an HMO representative:

- Does your management plan hold the primary care network accountable for treatment of these conditions to avoid inpatient hospitalizations?
- How is member compliance with recommended healthy behaviors assessed?

Managing On-Going Illnesses

HMO members with chronic obstructive pulmonary disease (COPD), asthma, diabetes and mental health conditions are at higher risk for hospitalization if appropriate and on-going treatment is not received. A higher hospitalization rate suggests poorer management of a chronic disease. Generally, shorter lengths of stay suggest that patients recuperated in

less time – a positive outcome. Longer stays in the hospital may indicate adverse or unexpected outcomes, lack of discharge planning, or over-utilization of resources. On the other hand, shorter stays may indicate under-utilization of health care resources or too-soon discharges that cause additional admissions in the future.

Questions to ask an HMO representative:

- Are hospitalization rates high? Are rehospitalizations higher than other plans? How are the providers in the network held accountable for performance?
- What does length of stay indicate? Does a lengthy inpatient stay suggest minimal management or high quality care? Does a short length of stay suggest appropriate use of services or is the HMO discharging members too quickly?
- Is the HMO performing well across the reported indicators of managing on-going illnesses? Is there an area for improvement? What can

the HMO do to improve scores? How well do the reported measures act as a proxy for typical chronic illness management?

Follow-up to an Emergency Situation

HMO members being treated for a heart attack need quick, appropriate treatment and follow-up by a medical professional.

Questions to ask an HMO representative:

- Do the HMO's members have higher than expected mortality? If so, how will the HMO address this issue with providers?
- Are members receiving appropriate procedural care after the heart attack? Did this care include catheterization, a PTCA/Stent or coronary artery bypass graft (CABG) surgery?

Surgical Procedures

Procedures are performed either in an inpatient or an ambulatory surgery setting. Location frequently provides insight into differing treatment standards

among HMOs and may help identify treatment patterns by physicians or hospitals in the HMO provider networks. Practice patterns often vary across providers and geographic location. Procedure rates provide one way to study differences across HMOs associated with network management. Differences among procedure locales may suggest a divergence of network standards and protocols, or the HMO's referral to less expensive ambulatory care settings. Complications may lead to potential patient injury, increased insurance premiums, and increased costs due to rehospitalizations and higher levels of post-procedure utilization.

Questions to ask an HMO representative:

- If lengths of stay differ significantly across HMOs, what are the reasons for this variation? Does the HMO have a plan in place to address a higher than expected percent of complications?
- How do scores translate into potential premium savings?

Staying Healthy

HMOs provide direct services to members, usually at a modest cost, for the prevention or early detection of health problems.

In this section (pages 6 through 10), the graphs show how well the HMOs are providing preventive care to help their members stay healthy.

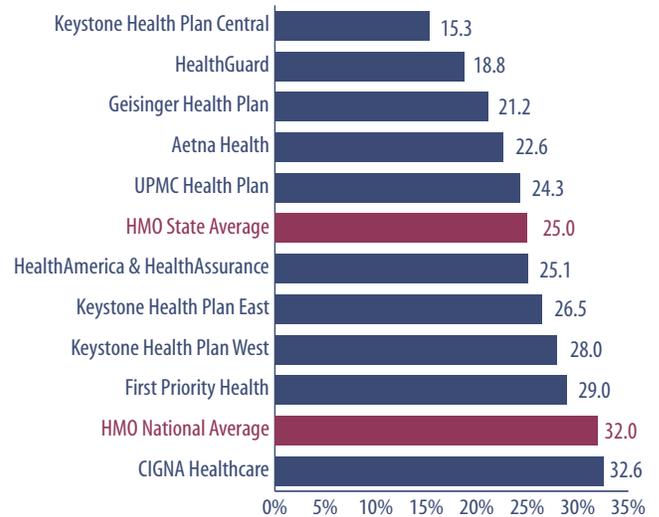
The graphs on pages 6 and 7 show how well the HMO network is screening, testing and helping adult members with diabetes control their disease.

The bar graphs are sorted from highest to lowest percentage. Generally, those HMOs with the **higher percentages** are doing a **better** job of preventing illness and helping their members stay healthy. The **one exception** is the first measure, Poorly Controlled Hemoglobin A1c Levels, in which the lowest percentage is the best outcome.

Scores for HealthGuard reflect only their HMO members, not POS members.

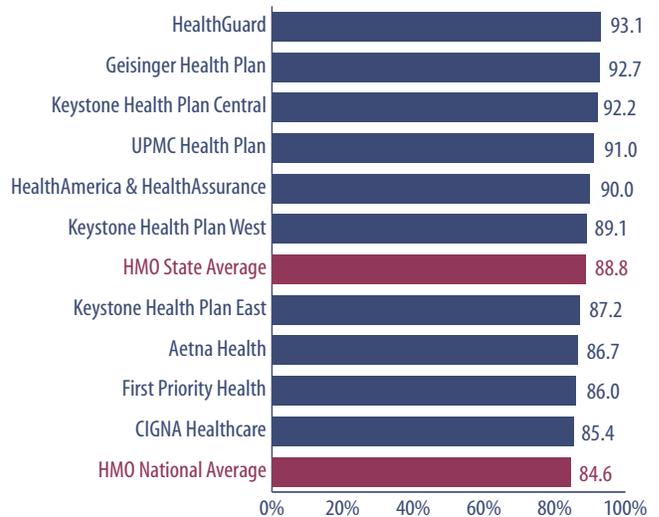
Poorly Controlled Hemoglobin A1c Levels for Members with Diabetes

Regular Hemoglobin A1c (HbA1c) blood tests are recommended in order to monitor diabetes. The graph shows the percent of members with diabetes who have poorly controlled HbA1c levels.



Hemoglobin A1c Blood Tests for Members with Diabetes

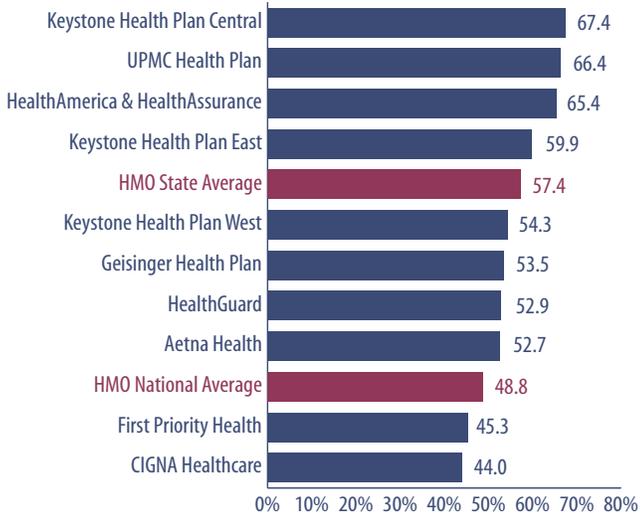
The graph shows the percent of members with diabetes who had their HbA1c tested at least once in the past year.



Staying Healthy

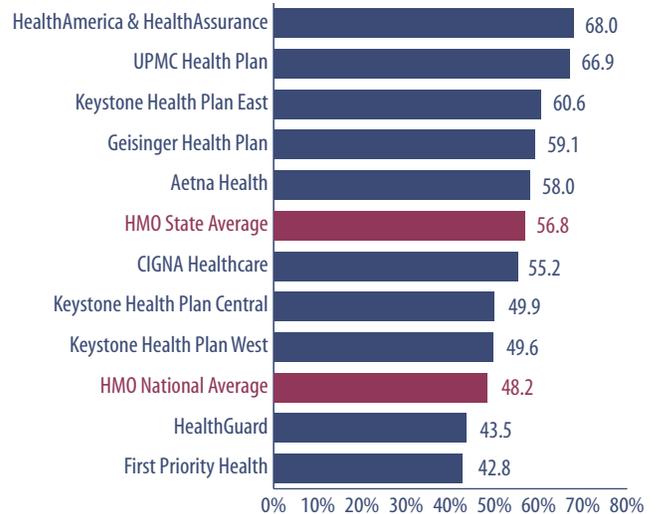
Eye Exams Performed for Members with Diabetes

Retinal eye exams are recommended on a regular basis (usually annually) to reduce the risk of blindness from diabetes. The graph shows the percent of members with diabetes who received an eye exam in the past year.



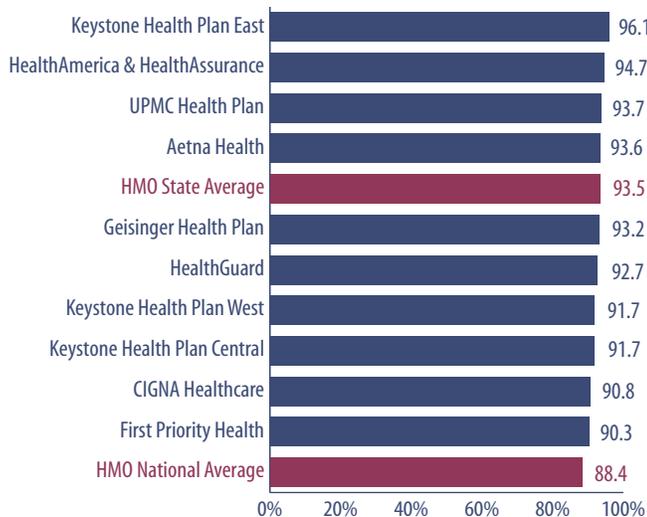
Monitoring Kidney Disease for Members with Diabetes

Kidney disease may be a problem for members with diabetes. The graph shows the percent of members with diabetes who were screened or treated for kidney disease.



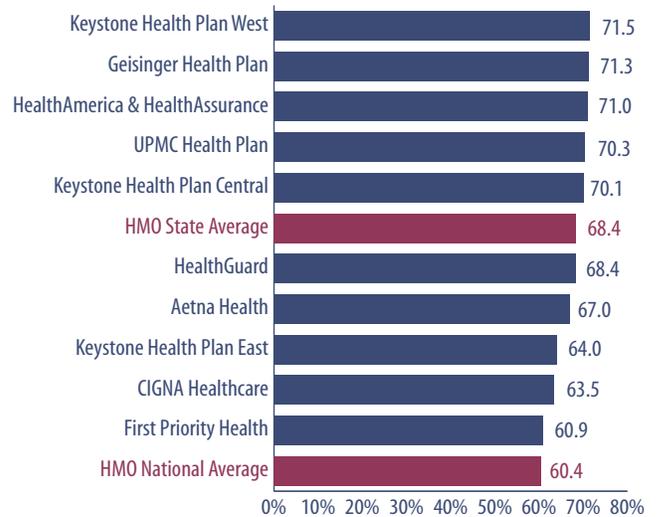
Cholesterol Screening for Members with Diabetes

Cholesterol screening (LDL-C or low-density lipoprotein cholesterol) is recommended on a regular basis for members with diabetes. The graph shows the percent of members with diabetes who received a cholesterol screening in the past year.



“Bad” Cholesterol Controlled for Members with Diabetes

The graph shows the percent of members with diabetes whose LDL-C (“bad” cholesterol) levels are under control.



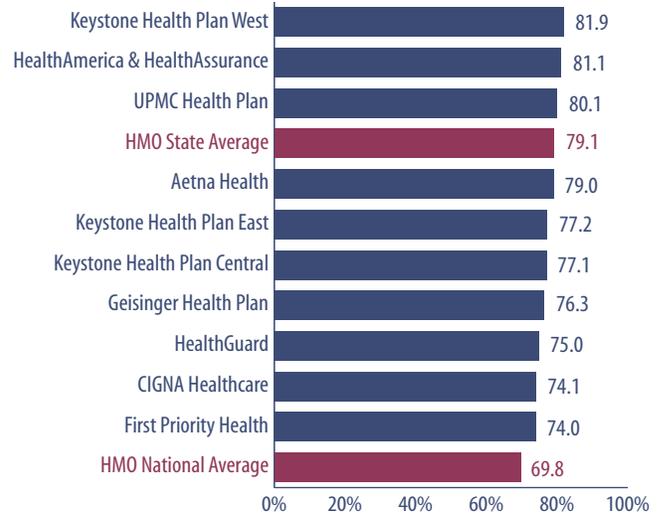
Staying Healthy



The bar graphs are sorted from highest to lowest percentage. Generally, those HMOs with the **higher percentages** are doing a **better** job of preventing illness and helping their members stay healthy.

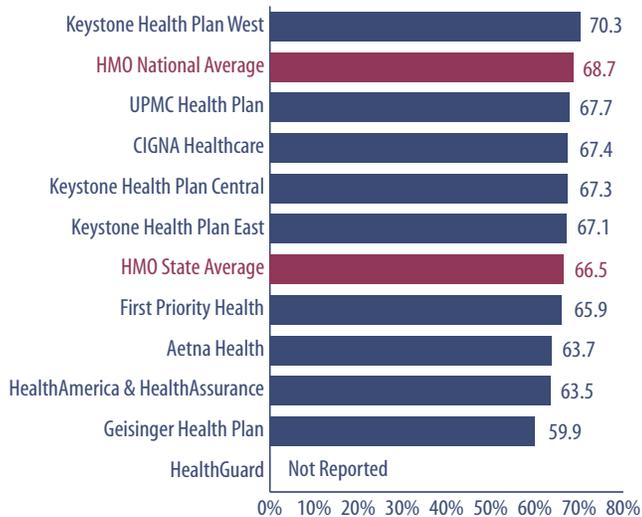
Childhood Immunizations

Immunizations protect children from vaccine-preventable diseases, saving hundreds of lost school days and millions of dollars. The graph shows the percent of children receiving recommended immunizations by their second birthday.



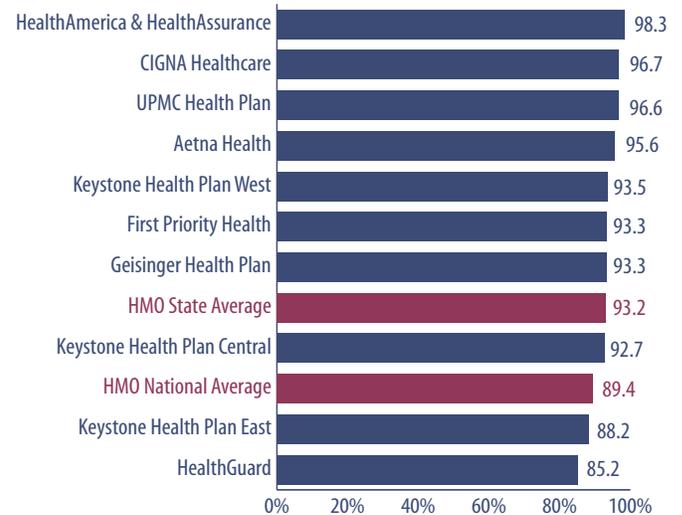
Advising Smokers to Quit

Because smoking is a risk factor for heart disease and other health problems, getting smokers to quit is one of the basic prevention efforts of HMOs. The graph shows the percent of adult members (smokers) advised to quit smoking during a visit to a doctor during the past year.



Timely Initiation of Prenatal Care

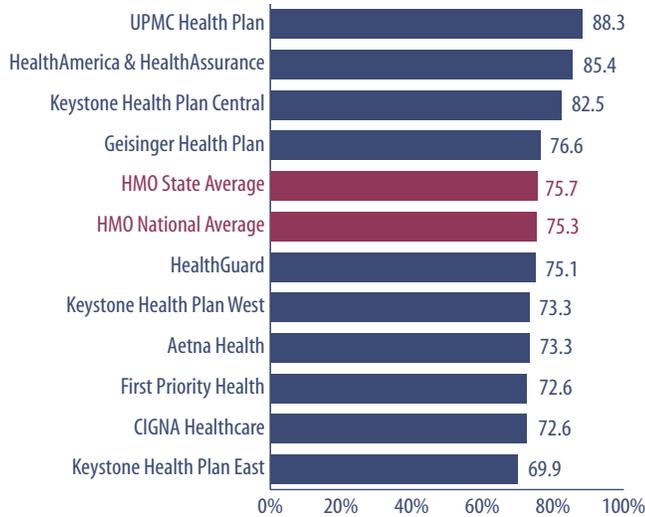
The graph shows the percent of HMO female members who were seen by their doctor during the first three months of pregnancy.



Staying Healthy

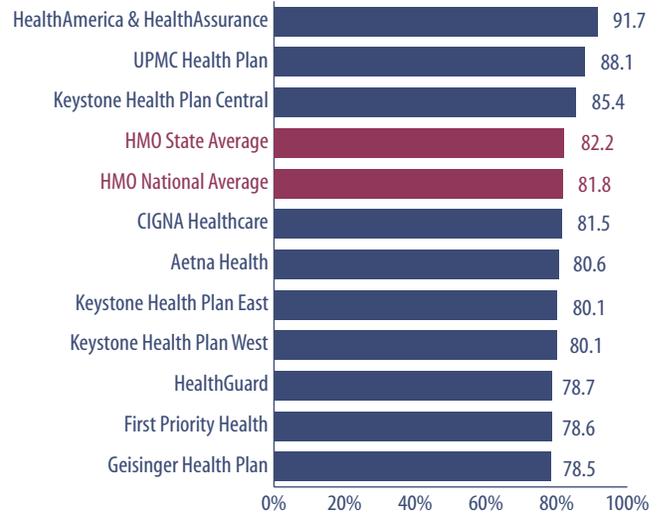
Screening for Breast Cancer

An x-ray of the breast, or mammogram, can help find cancer in the breast when the tumor is too small to be felt during breast examination. The graph shows the percent of female members (age 52 to 69) who had at least one mammogram within the past two years.



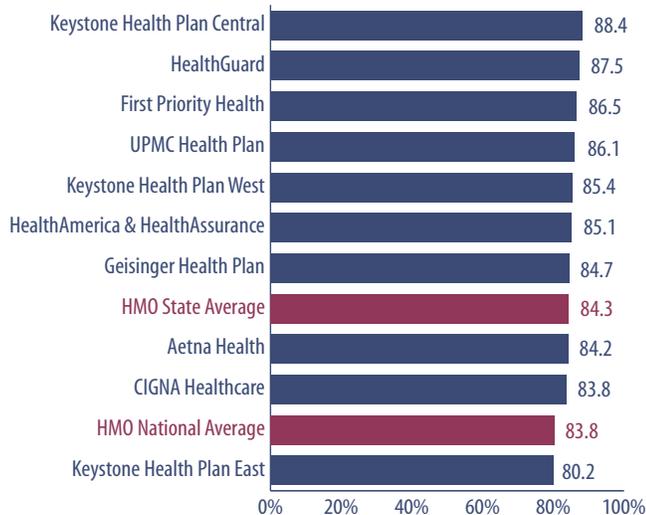
Screening for Cervical Cancer

Women are more likely to survive if cervical cancer is found early through a Pap test. The graph shows the percent of adult women who received a Pap test within the past three years.



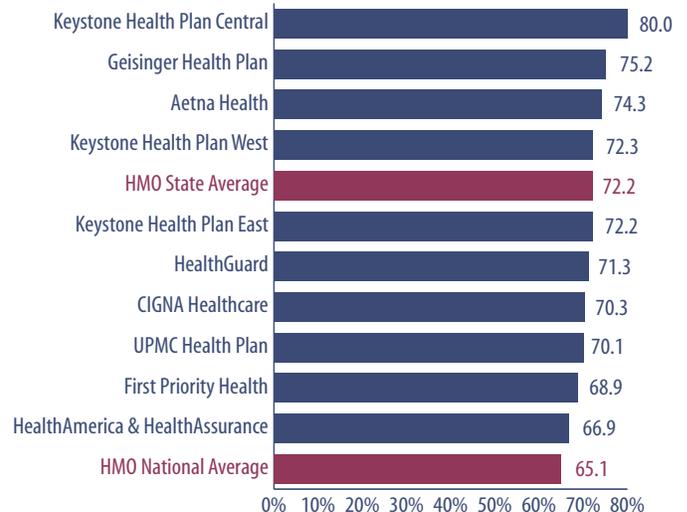
Cholesterol Screening after Acute Cardiovascular Events

The level of “bad” (LDL-C) cholesterol in the blood is directly related to clogged arteries, which can lead to a heart attack. The graph shows the percent of members tested for “bad” cholesterol after a heart attack, a balloon procedure or heart bypass surgery.



“Bad” Cholesterol Controlled after Acute Cardiovascular Events

A “bad” cholesterol level less than 130 mg/dL means there is a decreased risk of heart attack. The graph shows the percent of members who had a “bad” cholesterol score of less than 130 mg/dL after a heart attack, a balloon procedure or heart bypass surgery.

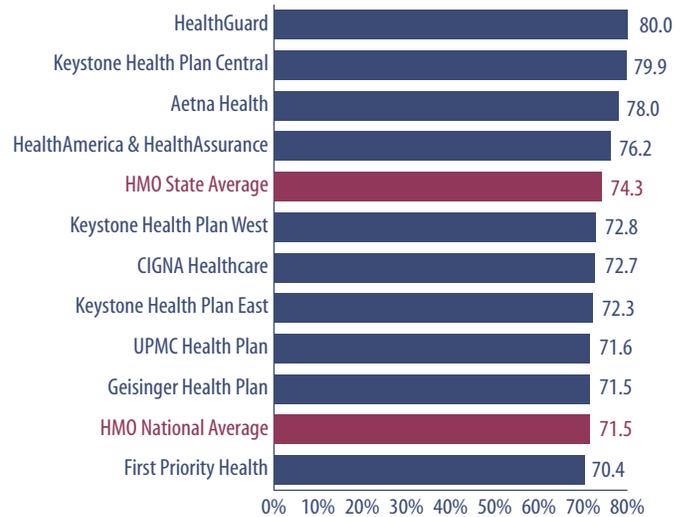


Staying Healthy



Appropriate Medications for Members with Asthma

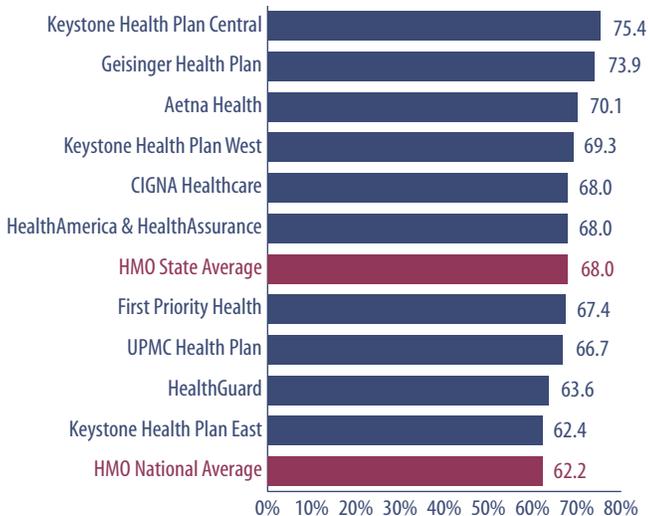
The Expert Panel of the National Heart, Lung, and Blood Institute has recommended use of comprehensive drug therapy designed to reverse and prevent airway inflammation associated with asthma. This graph shows whether members with persistent asthma are being prescribed medications acceptable as a primary therapy for long-term control of asthma.



The bar graphs are sorted from highest to lowest percentage. Generally, those HMOs with the **higher percentages** are doing a **better** job of preventing illness and helping their members stay healthy.

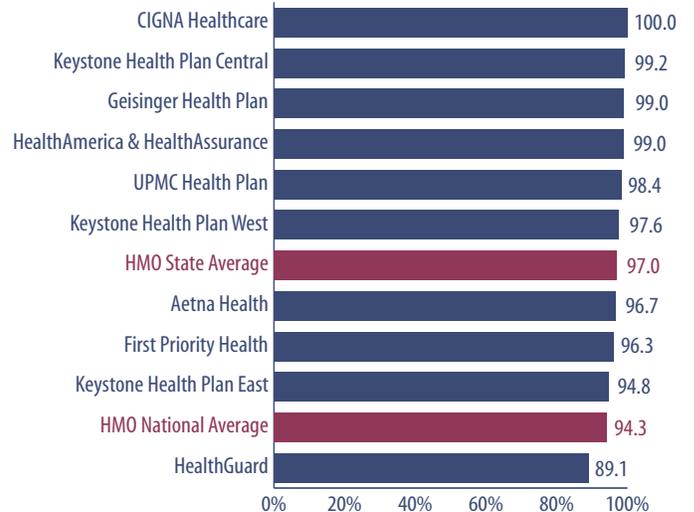
Controlling High Blood Pressure

High blood pressure (hypertension) is a major risk factor for a number of diseases, and must be closely monitored and controlled. The graph shows the percent of members (age 46 to 85) diagnosed with high blood pressure whose blood pressure was under control.



Beta Blockers after a Heart Attack

Use of beta blockers after a heart attack can help prevent future heart attacks. The graph shows the percent of members who had a heart attack and received beta blockers.



Preventing Hospitalization through Primary Care

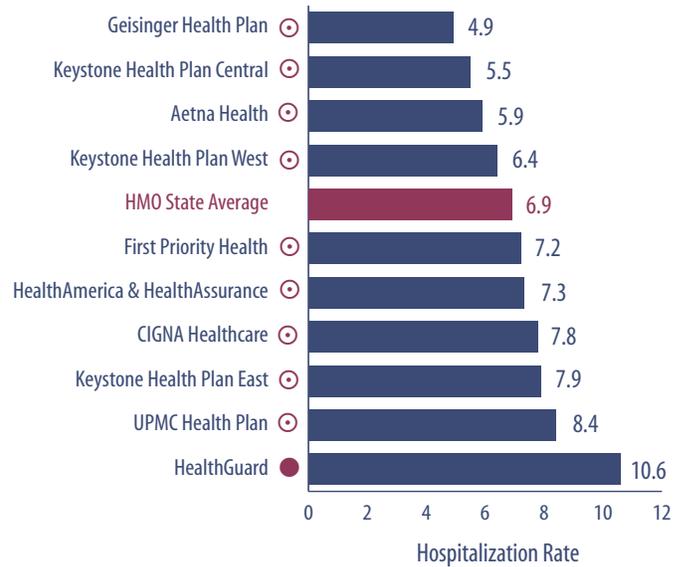
Pages 11 and 12 include several clinical conditions for which effective primary care can prevent or manage an illness, thereby avoiding “unnecessary” or “preventable” hospitalizations.

When the HMO provider network is functioning properly, care for these conditions can generally be provided on an outpatient basis and should not necessitate inpatient hospitalization.

Ear, Nose and Throat Infections

Includes medical conditions that cause an inflammation of the various parts of the head and throat. Outcomes are reported separately for pediatric and adult members.

Pediatric (Under Age 18)



Hospitalization Rate*, Statistical Rating

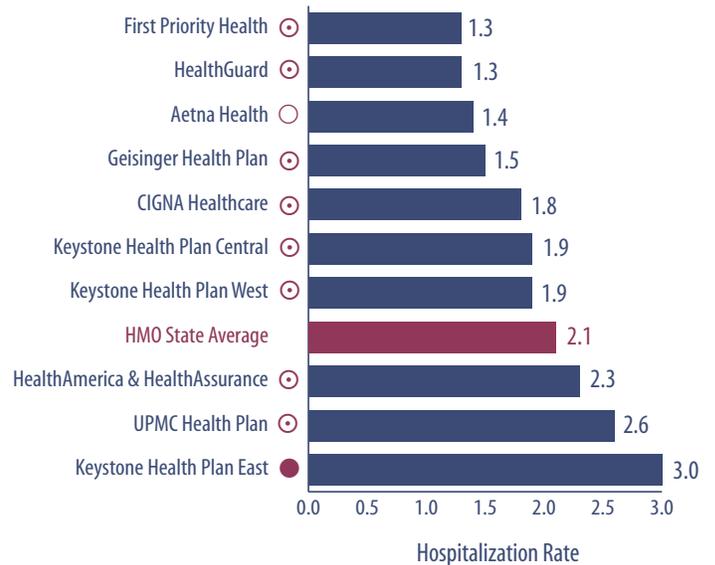
Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

The symbols indicate whether the difference between the expected and actual rates was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

* The number of hospital admissions per 10,000 members, adjusted for patient risk factors.

Adult (Age 18 to 64)



Preventing Hospitalization through Primary Care

Hospitalization Rate*, Statistical Rating

Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

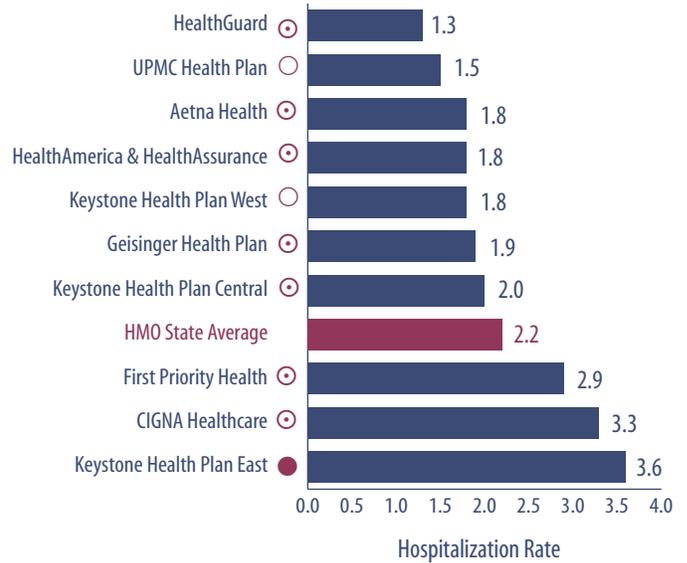
The symbols indicate whether the difference between the expected and actual rates was statistically:

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- Higher than expected

* The number of hospital admissions per 10,000 members, adjusted for patient risk factors.

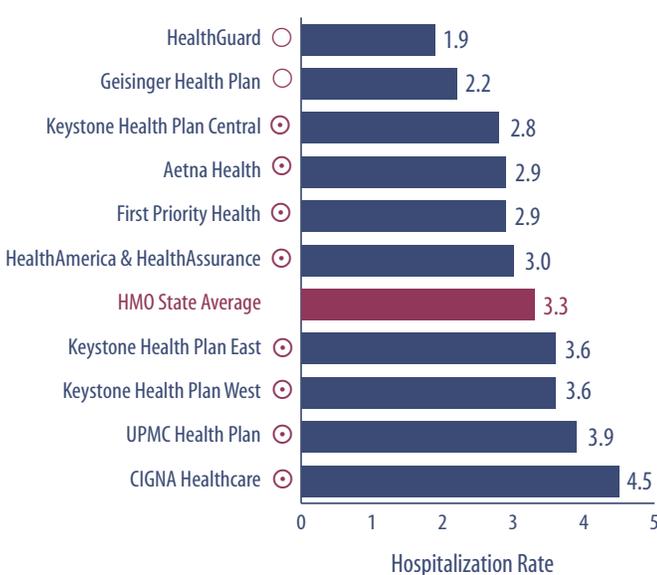
High Blood Pressure

Hypertension, or high blood pressure, is an adult chronic condition that can lead to serious cardiac and circulatory problems if untreated.



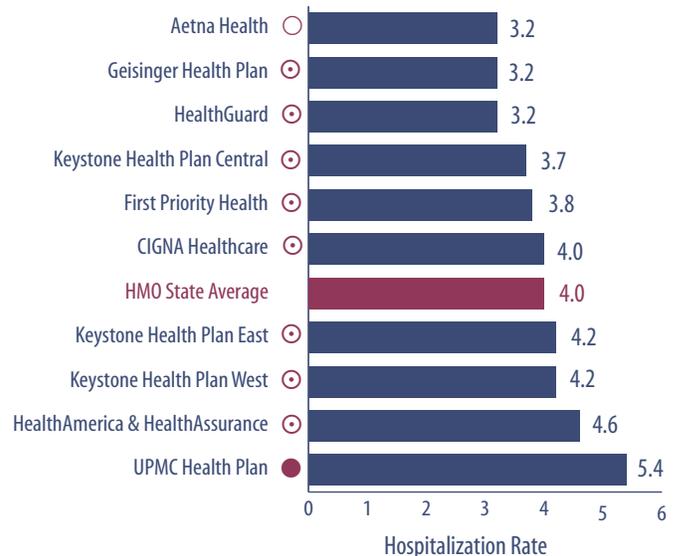
Gastrointestinal Infections

Includes a variety of viral, bacterial or parasitic infections of the digestive tract with symptoms including severe nausea, vomiting, abdominal pain, diarrhea, and fever.



Kidney/Urinary Tract Infections

These infections are common, second only to respiratory infections. Women are especially prone. These infections are usually treated with antibacterial medications.



Managing On-going Illnesses

Chronic Obstructive Pulmonary Disease (COPD)

COPD is an incurable disease of the lungs. It includes chronic lung disorders that obstruct the airways or damage the air sacs deep in the lungs. The disease results from damage to the lungs over a period of years from such factors as smoking, occupational exposure (breathing chemical fumes, cotton, wood or mining dust), or from bacterial or viral infections.

The HMO and its physicians are partners in helping members control their disease and receive appropriate medical treatment if a hospitalization becomes necessary.

Hospitalization Rate, Statistical Rating

Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

The symbols indicate whether the difference between the expected and actual rates was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

HMO	Hospital Admissions	Hospitalization Rate	Statistical Rating, Hospitalization Rate	Length of Stay	Statistical Rating, Percent Rehospitalized
Aetna Health	113	3.1	○	4.0	◉
CIGNA Healthcare	12	4.0	◉	2.7	◉
First Priority Health	44	4.6	◉	3.6	◉
Geisinger Health Plan	66	4.4	◉	3.9	◉
HealthAmerica & HealthAssurance	142	4.5	◉	4.2	◉
HealthGuard	23	3.0	○	3.6	◉
Keystone Health Plan Central	50	4.2	◉	3.8	◉
Keystone Health Plan East	274	5.3	●	3.9	◉
Keystone Health Plan West	305	4.3	◉	4.1	◉
UPMC Health Plan	121	7.0	●	3.7	◉
HMO State Total/Average	1,150	4.5		3.9	
Fee-for-Service Sample *	613			3.7	

* The Fee-for-Service Sample provides a comparison with traditional health insurance. Refer to the Technical Report for details.

Number of HMO members hospitalized in 2003 where COPD was the principal reason for hospitalization.

Hospitalization rate per 10,000 HMO members, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Average number of days spent in the hospital, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual percent of members rehospitalized within 180 days was statistically significant.

Managing On-going Illnesses

Asthma

Asthma is a chronic inflammatory disease of the lungs' airways which makes breathing difficult. It is the most common chronic childhood disease. Studies have shown that hospitalizations, repeat hospitalizations and emergency room visits can be decreased and quality of life improved when patients are taught how to control their disease by following established asthma management guidelines.

Hospitalization Rate, Statistical Rating

Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

The symbols indicate whether the difference between the expected and actual rates was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

Hospitalization for Asthma

HMO	Pediatric (Under Age 18)				Adults (Age 18 to 64)				
	Hospital Admissions	Hospitalization Rate	Statistical Rating, Hospitalization Rate	Length of Stay	Hospital Admissions	Hospitalization Rate	Statistical Rating, Hospitalization Rate	Length of Stay	Statistical Rating, Percent Rehospitalized
Aetna Health	267	15.2	◉	2.0	289	7.5	○	3.1	◉
CIGNA Healthcare	24	13.9	◉	1.6	30	8.4	◉	3.1	◉
First Priority Health	37	10.3	○	2.4	85	8.6	◉	3.1	◉
Geisinger Health Plan	42	8.2	○	2.3	94	6.3	○	2.9	◉
HealthAmerica & HealthAssurance	132	11.4	○	1.9	283	9.2	◉	3.5	◉
HealthGuard	27	11.0	◉	1.8	45	6.2	○	3.2	◉
Keystone Health Plan Central	68	10.3	○	1.9	88	7.1	○	2.9	◉
Keystone Health Plan East	646	28.7	●	2.0	558	10.3	●	3.2	◉
Keystone Health Plan West	274	11.0	○	1.9	577	8.5	◉	3.5	◉
UPMC Health Plan	80	13.9	◉	2.2	219	12.8	●	3.4	◉
HMO State Total/Average	1,597	15.7		2.0	2,268	8.8		3.3	
Fee-for-Service Sample	429			2.1	843			3.3	

Number of pediatric HMO members hospitalized in 2003 where asthma was the principal reason for hospitalization.

Hospitalization rate per 10,000 pediatric HMO members, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Average number of days spent in the hospital, adjusted for patient risk factors.

Number of adult HMO members hospitalized in 2003 where asthma was the principal reason for hospitalization.

Hospitalization rate per 10,000 adult HMO members, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Average number of days spent in the hospital, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual percent of members rehospitalized within 180 days was statistically significant.

Managing On-going Illnesses

Diabetes

A hospitalization for diabetes or a short-term complication of diabetes may represent a problem with access to health care services or deficiencies in outpatient management and follow-up in diabetes care. Appropriate preventive care can minimize these types of admissions. By having easy access to appropriate medical supplies, educational resources and medical tests performed on a regular basis, people with diabetes can better monitor their disease, thus reducing the overall number of hospitalizations.

Hospitalization Rate, Statistical Rating

Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

The symbols indicate whether the difference between the expected and actual rates was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

Hospitalization for Diabetes (Adults Age 18 to 75)

HMO	Members with Diabetes	Hospital Admissions	Hospitalization Rate	Statistical Rating, Hospitalization Rate	Length of Stay	Percent of Admissions for Short-term Complications of Diabetes	Statistical Rating, Percent Rehospitalized
Aetna Health	14,882	107	72.1	○	3.8	50.5	◉
CIGNA Healthcare	1,224	30	245.7	●	4.4	53.3	◉
First Priority Health	4,324	34	77.1	○	5.0	55.9	◉
Geisinger Health Plan	6,139	64	103.6	◉	3.1	51.6	◉
HealthAmerica & HealthAssurance	13,921	153	110.8	◉	4.1	52.3	◉
HealthGuard	3,701	36	103.2	◉	5.0	52.8	◉
Keystone Health Plan Central	5,940	48	82.3	○	4.1	47.9	◉
Keystone Health Plan East	28,356	396	139.3	●	3.9	45.7	◉
Keystone Health Plan West	29,516	392	130.8	◉	3.9	53.3	◉
UPMC Health Plan	9,113	165	184.4	●	4.0	54.5	◉
HMO State Total/Average	117,116	1,425	121.7		3.8	50.8	
Fee-for-Service Sample		777			4.3	50.2	

Number of members with diabetes who met a standard definition for diabetes and continuous enrollment criteria in 2003.

Number of HMO members with diabetes hospitalized in 2003 where diabetes was the principal reason for hospitalization.

Hospitalization rate per 10,000 HMO members with diabetes, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Average number of days spent in the hospital, adjusted for patient risk factors.

Percent of admissions for short-term complications of diabetes. These hospitalizations may be an immediate reflection of how well members are managing their diabetes.

Symbols indicate whether the difference between the expected and actual percent of members with diabetes that were rehospitalized within 180 days was statistically significant.

Managing On-going Illnesses

Mental Health

Depending upon the severity of the symptoms, depression and other mental health conditions can be extremely difficult to diagnose. More than twenty percent of adults suffer from a diagnosable mental disorder in a given year. While effective treatments and interventions are available, mental and depressive disorders are widely

under-recognized and under-treated. Therefore, it is important to measure and report the number of HMO members receiving treatment for mental health conditions.

Post hospitalization care is also important for several reasons. First, there is evidence that failure to coordinate post-hospitalization care can have serious consequences

for the patient, including the need to be readmitted to the hospital. Additionally, a lack of adequate post-hospitalization care may indicate more pervasive problems with an HMO, such as the lack of adequate oversight by mental health professionals or lack of HMO provided case management for hospitalized members.

HMO	Members Receiving Any Mental Health Services	Inpatient Admission Rate	Inpatient Hospitalization Length of Stay	Follow-up after Hospitalization		Antidepressant Medication Management		
				7 Days (Percent)	30 Days (Percent)	Members with at least 3 Follow-up Visits (Percent)	Effective Acute Phase Treatment (Percent)	Effective Continuation Phase Treatment (Percent)
Aetna Health	4.0	3.3	6.2	58.0	73.9	20.2	59.6	42.2
CIGNA Healthcare	4.3	3.0	6.3	50.0	63.3	17.7	64.6	42.7
First Priority Health	5.1	3.5	6.9	39.0	68.6	18.7	59.6	43.8
Geisinger Health Plan	3.9	2.9	5.4	54.4	74.2	14.0	59.5	42.2
HealthAmerica & HealthAssurance	4.8	2.9	5.3	57.8	80.3	16.7	61.5	46.3
HealthGuard	4.9	3.9	5.4	62.7	81.9	17.3	62.9	46.3
Keystone Health Plan Central	4.4	4.9	9.9	58.6	82.5	19.9	68.1	50.8
Keystone Health Plan East	3.3	3.3	6.7	50.9	66.9	9.1	64.0	49.4
Keystone Health Plan West	5.8	3.9	5.9	46.2	71.4	16.3	65.4	48.6
UPMC Health Plan	6.2	2.6	4.5	66.3	84.2	42.9	75.0	62.1
HMO State Average	4.7	3.5	6.2	53.0	73.5	17.3	63.8	47.7
HMO National Average	5.4	2.8	6.0	54.4	74.4	20.3	60.7	44.1

Percent of all HMO members receiving any mental health services in 2003.

Number of HMO members hospitalized in 2003 for a mental health condition per 1,000 plan members.

Average number of days spent in the hospital for treatment of a mental health condition.

Percent of members hospitalized for a mental health disorder who followed up with a doctor's visit within 7 days.

Percent of members hospitalized for a mental health disorder who followed up with a doctor's visit within 30 days of hospital discharge.

Percent of members diagnosed with a new episode of depression who had at least three follow-up visits with a provider within 12 weeks of diagnosis (the Acute Treatment Phase).

Percent of members diagnosed with a new episode of depression who were treated with antidepressant medication and remained on their prescribed drug during the entire 12-week Acute Treatment Phase.

Percent of members diagnosed with a new episode of depression who remained on their antidepressant prescription for 6 months.

Heart Attack

Heart Attack

A heart attack (Acute Myocardial Infarction) occurs when there is insufficient blood supply to an area of heart muscle. Heart attack is among the most common reasons for hospital admissions in the United States. People who have had a heart attack are at high risk for another one, and the mortality rates are high for these patients. Therefore, prevention of a second or subsequent attack should be a high priority.

Ultimately, treatment of a heart attack must address the underlying coronary disease that led to the attack. Several types of procedures are available including catheterization, percutaneous transluminal coronary angioplasty (PTCA)/Stent, and coronary artery bypass graft surgery (CABG). HMOs play an important part in ensuring that their members receive the appropriate treatment for their conditions.

In-Hospital Mortality, Statistical Rating

A statistical test is used to determine if the difference between expected and actual mortality was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

In-Hospital Mortality

HMO	Hospital Admissions	Hospitalization Rate	Number of Days Hospitalized	In-Hospital Mortality			Percent Receiving Catheterization	Percent Receiving PTCA/Stent	Percent Receiving CABG
				Expected (Percent)	Actual (Percent)	Statistical Rating			
Aetna Health	310	8.3	7.1	1.8	2.0	◉	93.0	62.9	17.4
CIGNA Healthcare	38	11.9	6.7	0.9	0.0	◉	94.7	65.8	7.9
First Priority Health	144	14.8	7.0	2.6	1.4	◉	92.4	65.3	16.7
Geisinger Health Plan	185	12.2	5.5	1.9	1.6	◉	86.9	60.1	14.2
HealthAmerica & HealthAssurance	501	15.4	5.6	1.9	1.8	◉	93.2	66.8	12.6
HealthGuard	114	15.0	5.7	2.4	1.8	◉	93.0	71.9	12.3
Keystone Health Plan Central	174	14.6	5.6	3.3	2.9	◉	94.8	71.1	10.4
Keystone Health Plan East	567	11.1	6.6	1.8	1.6	◉	92.1	61.9	14.1
Keystone Health Plan West	826	11.6	6.2	2.3	3.0	◉	93.2	63.9	18.6
UPMC Health Plan	272	16.2	6.0	1.9	1.5	◉	94.8	66.5	14.9
HMO State Total/Average	3,131	12.2	6.2	2.1	2.1		92.8	64.7	15.2
Fee-for-Service Sample	1,998		6.2	2.3	2.0		92.9	64.2	16.5

Number of HMO members hospitalized in 2003 where heart attack was the principal reason for hospitalization.

Number of heart attack hospitalizations per 10,000 members, adjusted for patient risk factors.

Average number of days spent in the hospital within 30 days of the heart attack, adjusted for patient risk factors.

The expected percent mortality within 30 days of hospitalization taking into account patient risk factors.

The actual percent mortality within 30 days of hospitalization.

Symbols indicate whether the difference between the expected and actual mortality was statistically significant.

Percent of heart attack patients receiving a cardiac catheterization within 30 days of hospitalization.

Percent of heart attack patients receiving a PTCA/Stent within 30 days of hospitalization.

Percent of heart attack patients receiving a CABG within 30 days of hospitalization.

Surgical Procedures

This section (pages 18-24) addresses outcomes of care for HMO members who require surgery. Outcomes are dependent on how well the HMO network manages the continuity of care among doctors and hospitals.

Hysterectomy

Hysterectomy is the surgical removal of the uterus. It is a procedure that may have a number of complications associated with it. Common reasons for performing a hysterectomy include uterine fibroids, uterine prolapse, abnormal bleeding, endometriosis and chronic pelvic pain.

Hysterectomies are performed as either an abdominal or a vaginal procedure. Procedure selection by physicians, complicated medical illnesses and diagnoses may result in longer lengths of stay and increased complication rates.

Hysterectomy is to be a treatment of last resort performed only after proper diagnostic tests confirm the underlying condition, conservative treatments have failed to improve the condition and fertility is not an issue.

Abdominal Hysterectomies

HMO	Total Hysterectomy Procedures	Procedure Rate	Statistical Rating, Procedure Rate	Abdominal Hysterectomies				In-Hospital Complications		
				Abdominal Hysterectomy Procedures	Procedure Rate	Statistical Rating, Procedure Rate	Length of Stay	Expected (Percent)	Actual (Percent)	Statistical Rating
Aetna Health	671	33.3	○	495	24.6	○	3.0	9.4	11.8	⊙
CIGNA Healthcare	76	40.4	○	56	29.8	○	2.6	8.8	10.7	⊙
First Priority Health	339	65.4	●	232	44.8	●	2.9	9.3	5.7	⊙
Geisinger Health Plan	349	44.9	○	270	34.7	○	2.6	9.6	5.9	○
HealthAmerica & HealthAssurance	1,185	75.8	●	787	50.3	●	2.6	9.3	10.0	⊙
HealthGuard	164	42.6	○	119	30.9	○	2.6	9.3	5.9	⊙
Keystone Health Plan Central	488	73.9	●	304	46.1	●	2.5	9.3	7.2	⊙
Keystone Health Plan East	1,148	39.4	○	901	30.9	○	3.0	10.4	12.6	●
Keystone Health Plan West	2,421	68.2	●	1,571	44.2	●	2.7	9.5	8.5	⊙
UPMC Health Plan	825	89.9	●	565	61.5	●	2.7	9.6	12.7	●
HMO State Total/Average	7,666	56.8		5,300	39.3		2.7	9.6	9.8	
Fee-for-Service Sample	3,616			2,416			2.6	9.7	7.8	

Total number of hysterectomies performed in 2003 for non-cancerous, non-traumatic conditions.

Procedure rate per 10,000 female members, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Number of hysterectomies involving an incision in the abdomen.

Procedure rate per 10,000 female members, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of abdominal hysterectomies.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Surgical Procedures

Percent of Complications, Statistical Rating

A statistical test is used to determine if the difference between expected and actual percent of complications was statistically:

- Lower than expected
- ⊙ Same as expected
- Higher than expected



Vaginal Hysterectomies

HMO	Vaginal Hysterectomy Procedures	Procedure Rate	Statistical Rating, Procedure Rate	Length of Stay	In-Hospital Complications		
					Expected (Percent)	Actual (Percent)	Statistical Rating
Aetna Health	176	8.7	○	1.9	7.2	8.1	⊙
CIGNA Healthcare	20	10.6	○	1.8	7.9	5.3	⊙
First Priority Health	107	20.6	⊙	1.8	7.0	2.8	⊙
Geisinger Health Plan	79	10.2	○	1.8	8.0	3.8	⊙
HealthAmerica & HealthAssurance	398	25.5	●	1.8	7.3	5.8	⊙
HealthGuard	45	11.7	○	1.9	9.0	11.1	⊙
Keystone Health Plan Central	184	27.8	●	1.6	6.5	7.1	⊙
Keystone Health Plan East	247	8.5	○	1.9	7.3	8.2	⊙
Keystone Health Plan West	850	24.0	●	1.8	6.7	7.9	⊙
UPMC Health Plan	260	28.4	●	1.8	7.0	8.5	⊙
HMO State Total/Average	2,366	17.5		1.8	7.0	7.3	
Fee-for-Service Sample	1,200			1.7	6.9	6.4	

Number of hysterectomies involving removing the uterus through the vaginal canal. Includes laparoscopically assisted vaginal hysterectomy (LAVH).

Procedure rate per 10,000 female members, adjusted for patient risk factors.

Symbols indicate whether the difference between the expected and actual rates was statistically significant.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of vaginal hysterectomies.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Surgical Procedures



Breast Cancer Procedures

The most frequently used treatment for breast cancer is surgery, often supplemented by one or more other treatments. The type of surgical procedure to treat breast cancer is determined by the stage of the disease, the type of tumor, the age and health of the woman, and the woman's preference. Two different surgical procedures are used – lumpectomies and mastectomies.

Lumpectomy is the removal of the lump in the breast and some of the surrounding tissue. Lumpectomy procedures are performed in the inpatient and outpatient setting, though the majority are outpatient procedures. For this report, lumpectomies performed as a diagnosis procedure are not

Lumpectomy

HMO	Total Breast Cancer Procedures	Procedure Rate	Lumpectomy Procedures	Percent Performed Inpatient	Lumpectomy			
					Length of Stay	Inpatient Only		
						Expected (Percent)	Actual (Percent)	Statistical Rating
Aetna Health	412	21.2	308	14.0	1.2	2.8	2.3	⊙
CIGNA Healthcare	32	19.3	21	9.5	NR	NR	NR	NR
First Priority Health	110	21.6	78	15.4	1.5	2.5	0.0	⊙
Geisinger Health Plan	140	17.8	103	6.8	NR	NR	NR	NR
HealthAmerica & HealthAssurance	310	19.8	225	4.9	1.2	4.1	9.1	⊙
HealthGuard	64	16.0	46	6.5	NR	NR	NR	NR
Keystone Health Plan Central	116	18.0	81	11.1	NR	NR	NR	NR
Keystone Health Plan East	629	22.2	472	14.4	1.1	4.3	3.0	⊙
Keystone Health Plan West	451	12.2	294	16.0	1.1	2.3	2.1	⊙
UPMC Health Plan	234	25.0	177	11.3	1.3	3.5	0.0	⊙
HMO State Total/Average	2,498	18.5	1,805	12.3	1.2	3.2	2.3	
Fee-for-Service Sample	1,562		1,109	7.8	1.1	3.5	0.0	

Total number of breast cancer procedures (lumpectomies and mastectomies) performed in 2003.

Procedure rate per 10,000 female members, adjusted for patient risk factors.

Number of lumpectomy procedures performed in 2003.

Percent of lumpectomies performed in an inpatient setting.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of inpatient lumpectomy procedures.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Surgical Procedures

included; only patients with an identified cancer diagnosis are analyzed.

Mastectomy is the removal of the whole breast and some lymph nodes under the arm. Most mastectomy procedures are inpatient (the law mandates that a patient has a right to choose an inpatient procedure). Mastectomies performed as a preventive measure (removal of the breast before cancer is diagnosed) are not included in this analysis.

Reconstruction of the breast after a mastectomy can occur immediately or months and even years later. Under Pennsylvania law, HMOs are required to cover breast reconstruction for women who have a mastectomy.

Percent of Complications, Statistical Rating

A statistical test is used to determine if the difference between expected and actual percent of complications was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

Mastectomy

HMO	Mastectomy Procedures	Percent Performed Inpatient	Inpatient Only				
			Length of Stay	In-Hospital Complications			Percent with Reconstruction during the Same Admission
				Expected (Percent)	Actual (Percent)	Statistical Rating	
Aetna Health	104	96.2	2.4	5.3	3.0	◉	24.0
CIGNA Healthcare	11	100.0	2.3	4.6	0.0	◉	18.2
First Priority Health	32	93.8	2.9	4.5	3.3	◉	13.3
Geisinger Health Plan	37	78.4	2.6	5.6	3.4	◉	37.9
HealthAmerica & HealthAssurance	85	71.8	2.8	5.3	15.0	●	29.5
HealthGuard	18	83.3	2.2	4.9	6.7	◉	26.7
Keystone Health Plan Central	35	74.3	2.3	5.5	0.0	◉	23.1
Keystone Health Plan East	157	97.5	2.5	5.9	3.3	◉	35.9
Keystone Health Plan West	157	94.3	2.2	5.0	5.4	◉	20.9
UPMC Health Plan	57	91.2	2.0	5.6	11.5	◉	23.1
HMO State Total/Average	693	90.2	2.4	5.4	5.5		26.7
Fee-for-Service Sample	453	81.0	2.2	5.2	4.4		26.7

Number of mastectomy procedures performed in 2003.

Percent of mastectomies performed in an inpatient setting.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of inpatient mastectomy procedures.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Percent of reconstruction surgeries during the same admission.

Surgical Procedures

Neck and Back Procedures



Back pain affects over five million Americans annually and is the most common cause of job-related disability and missed workdays. When neck and back problems fail to respond to non-surgical treatments, decompression surgery may offer relief. Some of the more common procedures include laminectomy (removal of a part of the lamina - the back part of the bone over the spinal canal), discectomy (removal of a portion of a disk to relieve pressure on a nerve), and spinal fusion, which involves connecting two or more bones in the spine to improve stability, correct a deformity or treat pain.

HMO	Total Neck & Back Procedures	Procedure Rate	Number of Procedures with Fusion	Length of Stay	With Fusion		
					In-Hospital Complications		
					Expected (Percent)	Actual (Percent)	Statistical Rating
Aetna Health	442	11.5	169	2.3	6.4	5.4	⊙
CIGNA Healthcare	59	16.5	19	2.3	5.9	5.6	⊙
First Priority Health	198	20.1	68	2.3	5.1	4.4	⊙
Geisinger Health Plan	233	15.5	114	2.3	6.8	2.7	⊙
HealthAmerica & HealthAssurance	791	25.0	339	2.1	6.3	3.9	⊙
HealthGuard	192	26.4	90	1.7	6.4	2.3	⊙
Keystone Health Plan Central	233	19.1	106	2.2	6.2	9.4	⊙
Keystone Health Plan East	668	12.6	206	2.6	6.0	7.0	⊙
Keystone Health Plan West	1,682	24.6	659	2.3	6.4	7.0	⊙
UPMC Health Plan	620	37.0	244	2.3	6.4	8.7	⊙
HMO State Total/Average	5,118	20.0	2,014	2.2	6.3	6.1	
Fee-for-Service Sample	2,303		812	2.1	6.5	5.3	

Total number of neck and back procedures (with and without fusion) performed in 2003.

Procedure rate per 10,000 members, adjusted for patient risk factors.

Number of decompression procedures performed with fusion in 2003.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of neck and back procedures with fusion.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Surgical Procedures

Studies have shown that practice patterns for neck and back surgery vary across providers and geographic locations. Most health care professional organizations recommend conservative treatment before performing surgery, but recommendations for the duration of conservative treatment vary widely. Neck and back procedures are high volume, high cost surgeries with important implications for quality of care.

Percent of Complications, Statistical Rating

A statistical test is used to determine if the difference between expected and actual percent of complications was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

Without Fusion

HMO	Number of Procedures without Fusion	Length of Stay	In-Hospital Complications		
			Expected (Percent)	Actual (Percent)	Statistical Rating
Aetna Health	273	1.8	4.0	6.3	◉
CIGNA Healthcare	40	2.0	3.4	2.5	◉
First Priority Health	130	1.6	4.4	1.5	◉
Geisinger Health Plan	119	1.5	5.3	2.5	◉
HealthAmerica & HealthAssurance	452	1.7	5.1	5.8	◉
HealthGuard	102	1.7	4.7	2.0	◉
Keystone Health Plan Central	127	1.7	5.2	3.9	◉
Keystone Health Plan East	462	1.8	4.2	3.3	◉
Keystone Health Plan West	1,023	1.7	4.8	5.1	◉
UPMC Health Plan	376	1.8	4.6	3.7	◉
HMO State Total/Average	3,104	1.7	4.7	4.4	
Fee-for-Service Sample	1,491	1.7	5.0	4.9	

Number of decompression procedures performed without fusion in 2003.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of neck and back procedures without fusion.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Surgical Procedures

Prostatectomy

Prostatectomy is the surgical removal of the prostate (radical prostatectomy). Generally, the entire prostate is removed when cancer is present. Prostatectomy substantially reduces prostate cancer mortality.

Cancer of the prostate is one of the most common forms of cancer in American men. Risks, complications, and side effects that may occur during and after prostatectomy include excessive bleeding, which may require blood transfusion, incontinence, impotence, and narrowing of the urethra.

Percent of Complications, Statistical Rating

A statistical test is used to determine if the difference between expected and actual percent of complications was statistically:

- Lower than expected
- ◉ Same as expected
- Higher than expected

Prostatectomy

HMO	Total	Procedure Rate	Length of Stay	In-Hospital Complications		
				Expected (Percent)	Actual (Percent)	Statistical Rating
Aetna Health	97	5.5	2.9	8.7	11.7	◉
CIGNA Healthcare	12	8.2	3.6	9.5	8.3	◉
First Priority Health	21	4.6	3.5	9.1	4.8	◉
Geisinger Health Plan	32	4.5	3.0	9.1	0.0	◉
HealthAmerica & HealthAssurance	96	6.1	3.0	9.1	9.4	◉
HealthGuard	39	10.7	2.6	10.4	5.1	◉
Keystone Health Plan Central	24	4.3	2.8	7.9	13.0	◉
Keystone Health Plan East	154	6.5	3.0	8.7	8.7	◉
Keystone Health Plan West	232	6.8	2.9	9.0	8.3	◉
UPMC Health Plan	68	8.7	2.8	9.3	7.4	◉
HMO State Total/Average	775	6.4	2.9	9.0	8.4	
Fee-for-Service Sample	421		2.9	8.8	8.8	

Total number of prostatectomy (radical) procedures performed in 2003.

Procedure rate per 10,000 male members, adjusted for patient risk factors.

Average number of days spent in the hospital, adjusted for patient risk factors.

Expected percent of complications is calculated taking into account patient risk factors.

The actual number of complications divided by the total number of prostatectomy procedures.

Symbols indicate whether the difference between the expected and actual percents was statistically significant.

Member Satisfaction

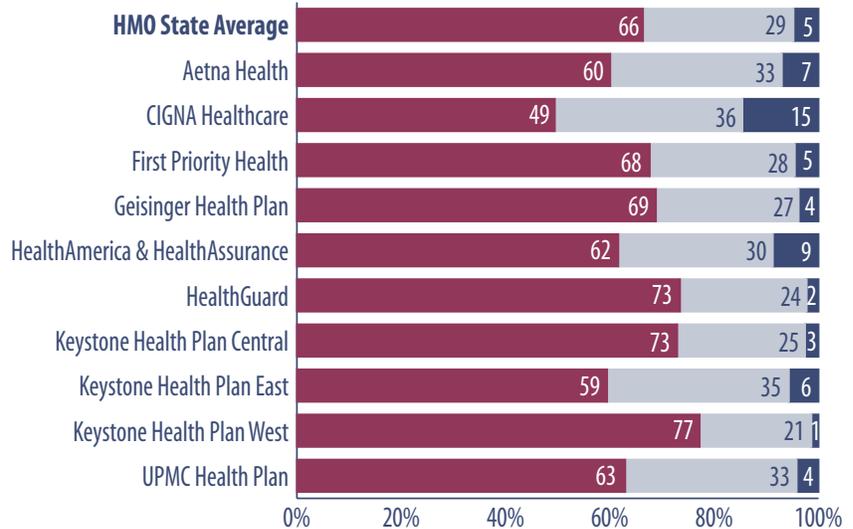
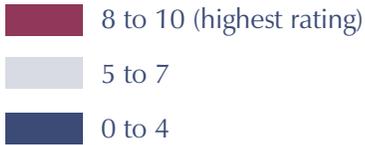
Satisfaction surveys offer a view of HMO quality and service from a member's perspective. Research shows that consumers and potential HMO members value the opinions and ratings of their peers.

These standardized member satisfaction measures were taken from the annual Consumer Assessment of Health Plans Survey® (CAHPS) for calendar year 2003. Independent research companies conduct the survey for each HMO and the resulting member satisfaction measures become part of the HMO's accreditation review. State average and national averages, when available, are included.

Overall Rating of Plan

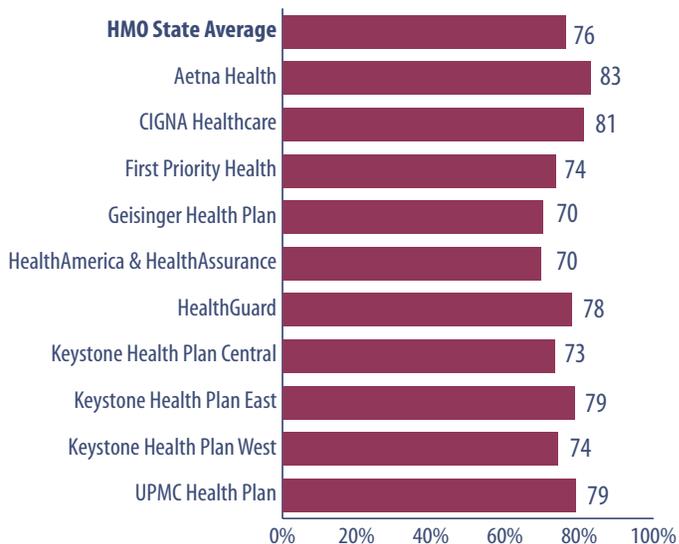
How would you rate your health plan?

Percent who gave their plan a rating of:



Appointments for Routine Care

In the last 12 months, not counting the times you needed health care right away, did you make any appointments with a doctor or other health care provider for health care?



Scores for HealthGuard reflect only their HMO members, not POS members.

Note: Numbers may not add up to 100% due to rounding.

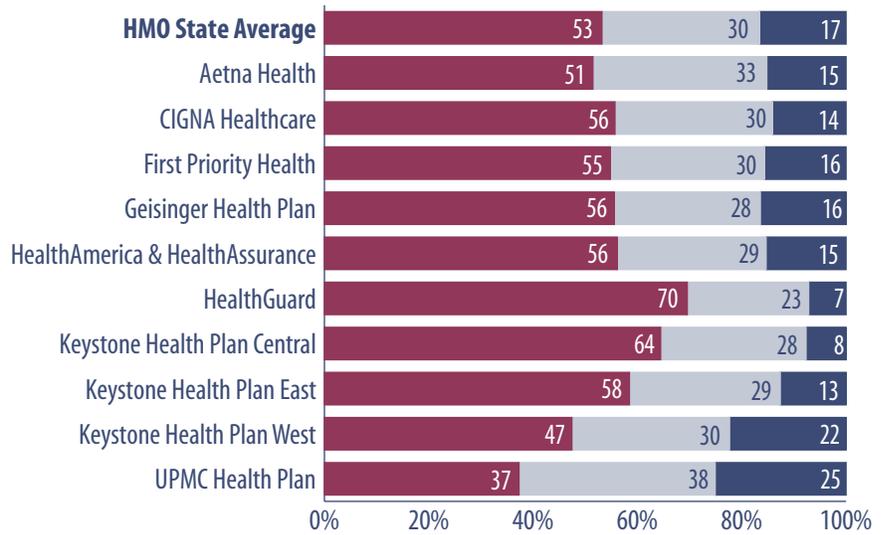
Member Satisfaction

Waiting for Routine Care

In the last 12 months, not counting times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a provider?

Percent who answered:

- Same to 3 days
- 4 to 14 days
- 15+ days

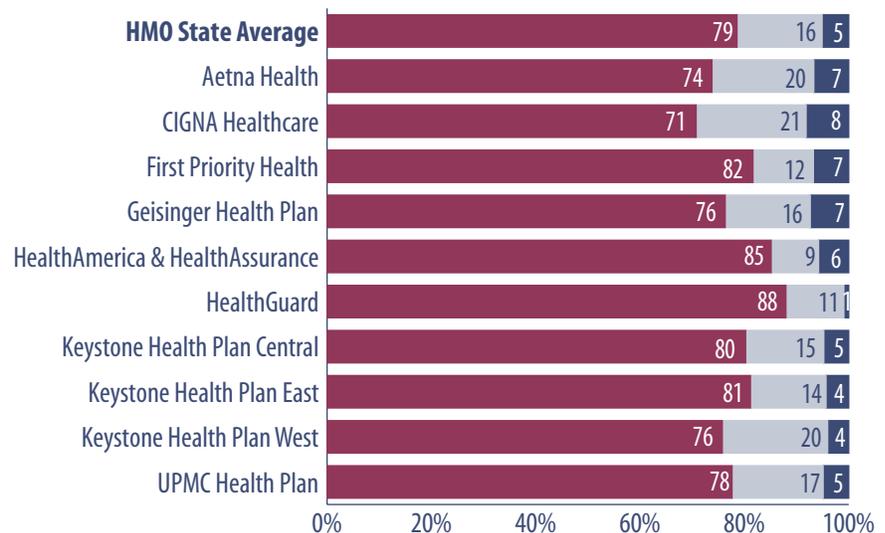


Waiting for Care for an Injury or Illness

In the last 12 months, when you needed care right away for an illness, injury, or condition, how long did you usually have to wait between trying to get care and actually seeing a provider for an illness or injury?

Percent who answered:

- Same to one day
- 2 to 7 days
- 8+ days



Member Satisfaction

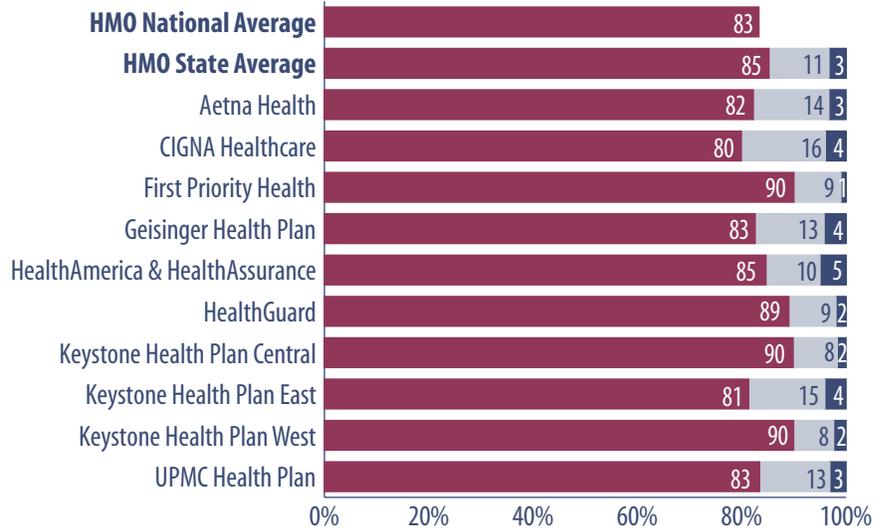


Getting Needed Care

In the last 12 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?

Percent who answered:

- Not a problem
- A small problem
- A big problem

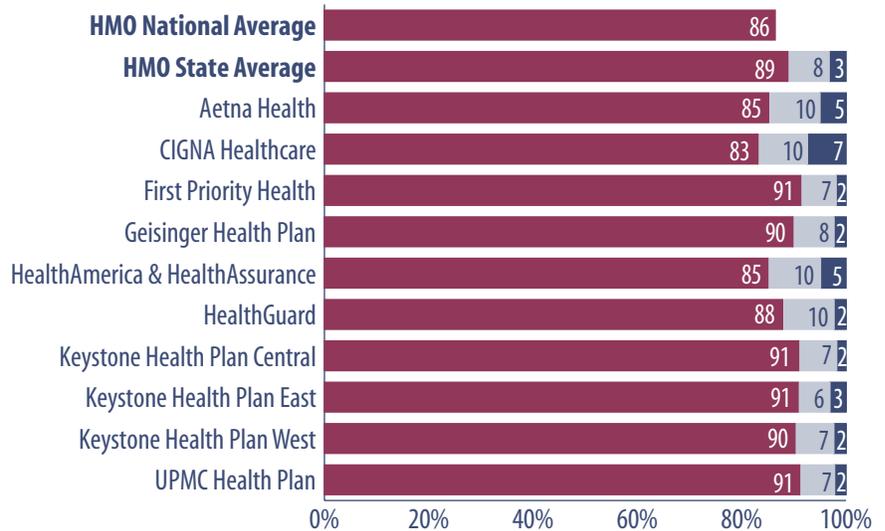


Getting Approvals from the HMO

In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

Percent who answered:

- Not a problem
- A small problem
- A big problem



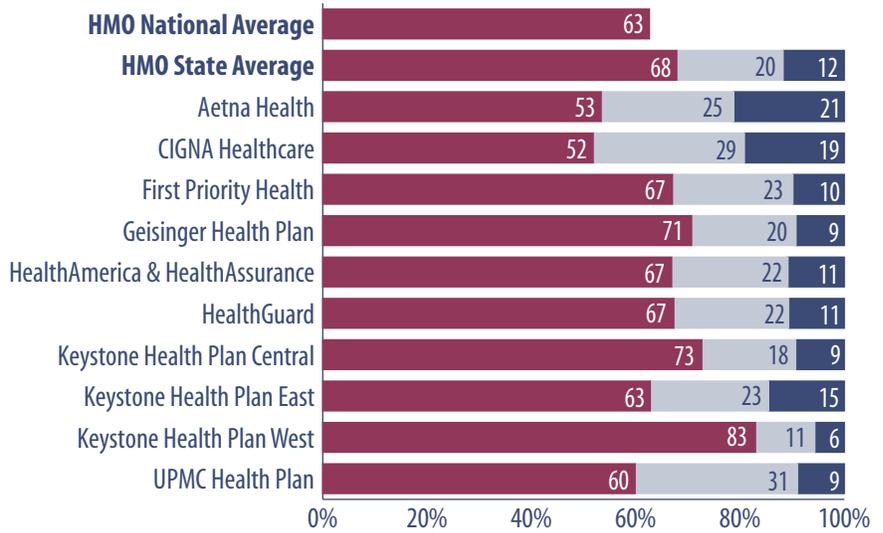
Member Satisfaction

Contacting Customer Service

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?

Percent who answered:

- Not a problem
- A small problem
- A big problem

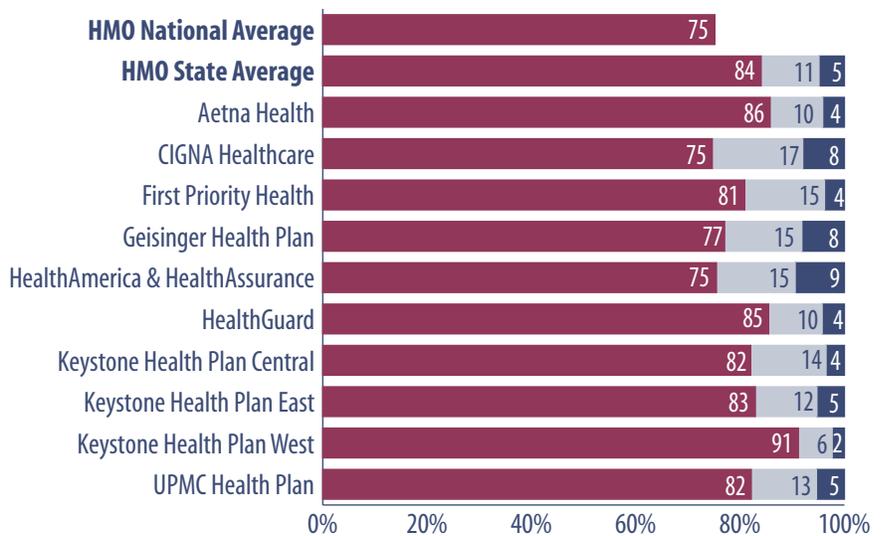


Seeing a Specialist

In the last 12 months, how much of a problem, if any, was it to see a specialist you needed to see?

Percent who answered:

- Not a problem
- A small problem
- A big problem

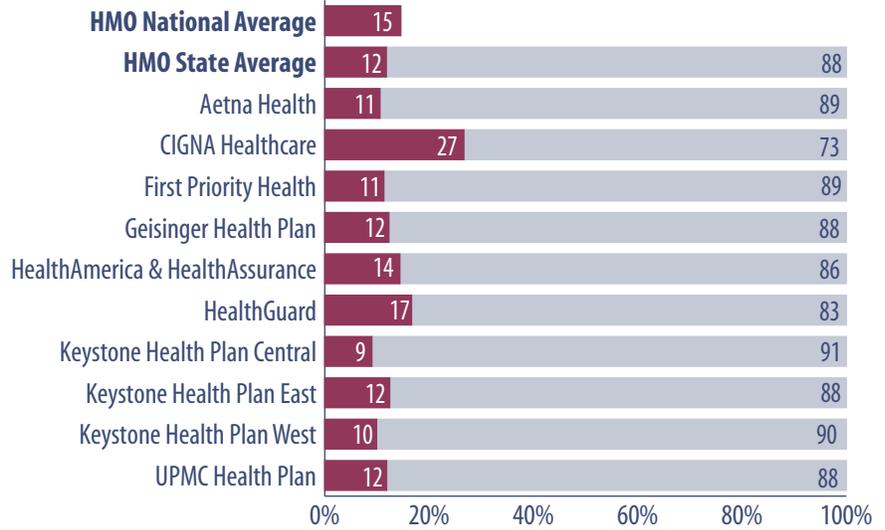


Member Satisfaction

Complaints or Problems

In the last 12 months, have you called or written your health plan with a complaint or problem?

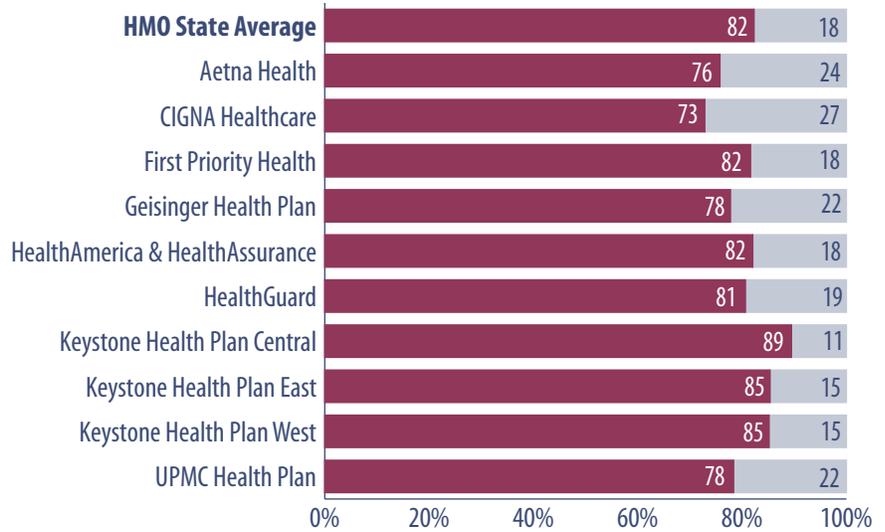
Percent who answered:



Complaints Settled to Satisfaction

Was your complaint or problem settled to your satisfaction?

Percent who answered:



Counties of Operation

Counties where HMOs are licensed to do business by the Pennsylvania Department of Health.

County	Aetna Health	CIGNA Healthcare	First Priority Health	Geisinger Health Plan	HealthAmerica & HealthAssurance	HealthGuard	Highmark Blue Shield	Keystone Health Plan Central	Keystone Health Plan East	Keystone Health Plan West	UPMC Health Plan
Adams	✓				✓	✓	✓	✓			
Allegheny	✓				✓					✓	✓
Armstrong	✓				✓					✓	✓
Beaver	✓				✓					✓	✓
Bedford				*						✓	✓
Berks	✓			✓	✓	✓	✓	✓			
Blair	✓			✓	✓					✓	✓
Bradford	☐		✓	✓							
Bucks	✓	✓							✓		
Butler	✓				✓					✓	✓
Cambria	✓			✓	✓					✓	✓
Cameron				✓	✓					✓	✓
Carbon	✓		✓	✓	✓						
Centre				✓	✓		✓	✓		✓	
Chester	✓	✓			✓				✓		
Clarion	✓				✓					✓	✓
Clearfield				✓	✓					✓	✓
Clinton	☐		✓	✓	✓						
Columbia	☐			✓	✓		✓	✓			
Crawford					✓					✓	✓
Cumberland	✓			*	✓	✓	✓	✓			
Dauphin	✓			✓	✓	✓	✓	✓			
Delaware	✓	✓			✓				✓		
Elk				*	✓					✓	✓
Erie	✓				✓					✓	✓
Fayette	✓				✓					✓	✓
Forest					✓					✓	✓
Franklin	✓				✓		✓	✓			
Fulton	✓						✓	✓			
Greene	✓				✓					✓	✓
Huntingdon				✓	✓					✓	
Indiana	☐				✓					✓	✓
Jefferson	☐			✓	✓					✓	✓

☐ Only Self-Insured and Managed Choice Plans are offered in these counties.

* Partial Coverage is offered in these counties.

Counties of Operation



County	Aetna Health	CIGNA Healthcare	First Priority Health	Geisinger Health Plan	HealthAmerica and HealthAssurance	HealthGuard	Highmark Blue Shield	Keystone Health Plan Central	Keystone Health Plan East	Keystone Health Plan West	UPMC Health Plan
Juniata				✓	✓		✓	✓			
Lackawanna	☐		✓	✓	✓						
Lancaster	✓			✓	✓	✓	✓	✓			
Lawrence	✓				✓					✓	✓
Lebanon	✓			✓	✓	✓	✓	✓			
Lehigh	✓			✓	✓	✓	✓	✓			
Luzerne	☐		✓	✓	✓						
Lycoming	☐		✓	✓	✓						
McKean					✓					✓	✓
Mercer	✓				✓					✓	✓
Mifflin				✓	✓		✓	✓			
Monroe	✓		✓	✓	✓						
Montgomery	✓	✓			✓				✓		
Montour				✓	✓		✓	✓			
Northampton	✓			✓	✓	✓	✓	✓			
Northumberland	☐			✓	✓		✓	✓			
Perry	✓			*	✓	✓	✓	✓			
Philadelphia	✓	✓			✓				✓		
Pike	☐		✓	✓	✓						
Potter				*						✓	✓
Schuylkill	✓			✓	✓		✓	✓			
Snyder	☐			✓	✓		✓	✓			
Somerset	✓				✓					✓	✓
Sullivan	☐		✓	✓							
Susquehanna	☐		✓	✓	✓						
Tioga			✓	✓							
Union				✓	✓		✓	✓			
Venango					✓					✓	✓
Warren					✓					✓	✓
Washington	✓				✓					✓	✓
Wayne	☐		✓	✓	✓						
Westmoreland	✓				✓					✓	✓
Wyoming	☐		✓	✓	✓						
York	✓			✓	✓	✓	✓	✓			

About the Data

Sources of Data

Inpatient hospital and ambulatory procedure data used in the analysis of treatment measures were submitted to PHC4 by Pennsylvania hospitals. The source of data reported for pages 6 through 10, as well as for the mental health measures, is Quality Compass® and is used with permission of the National Committee for Quality Assurance (NCQA). Quality Compass® is a registered trademark of NCQA. NCQA, an independent organization that reports information about managed care plans, was also the source of the Health Plan Employer Data and Information Set® (HEDIS). The member satisfaction measures were taken from the Consumer Assessment of Health Plans Survey® (CAHPS).

Limitations of the Data

This report is not intended to be a sole source of information in making choices about HMO plans since the measures included are important, but limited, indicators of quality. Hospital admissions, complications and rehospitalizations are sometimes unavoidable consequences of a patient’s medical condition. Hospitals, physicians and health insurance plans may do everything right and still the patient may experience problems.

In addition, an HMO’s success in helping members to manage health problems depends in part upon members’ willingness and ability to comply with their providers’ treatment decisions. While HMOs play an important role in the delivery of care, it is hospitals and doctors who ultimately provide health care for patients.

This report may not provide exact comparisons for several reasons. Benefit plan designs differ among and within HMOs. Enrollment in HMOs is constantly changing. Furthermore, since this report includes data from only one year, it is only a snapshot of what occurred during a limited period of time. Finally, PHC4’s risk-adjustment model may not completely capture some groups at higher risk due to social and/or behavioral differences.

HMOs included in this report verified that they were the primary insurer for the hospitalization data analyzed in this report.

Because the methods to compare health plans continue to be developed, this report addresses a limited number of indicators that are not intended to represent an HMO’s overall performance. These data should be interpreted with caution.

PHC4 would like to emphasize that this report is about helping people make more informed choices and stimulating a quality improvement process where differences in important health care measures are identified and appropriate questions are raised and answered.

Accounting for Differences in Illness Level, Age and Sex Across HMOs

PHC4 compiles “expected” rates for many of the measures in this report based on a complex mathematical formula that assesses the degree of illness or risk for patients. In other words, HMOs that have sicker members or a higher percentage of high-risk members are given “credit” in the formula; more patients can be expected to be admitted to the hospital, have longer lengths of stay, be readmitted, or have greater potential for complications because they are more seriously ill or at greater risk. Age and sex adjustments are also applied to some measures. A full description of these methods can be found in the HMO Technical Report at www.phc4.org.

Acknowledgements

PHC4 wishes to acknowledge and thank the individual HMOs and Pennsylvania hospitals that participated in the data collection and verification process.

PHC4 also thanks the Pennsylvania Department of Health and the Pennsylvania Insurance Department for their contribution to this report.

HMO Information

Health Plan	Line of Business	Accreditation Status	Telephone Number	Web Site Address
Aetna Health, Inc.	HMO and Point-of-Service	Excellent	1-800-991-9222	www.aetna.com
CIGNA Healthcare of PA	HMO and Point-of-Service	Excellent	1-800-345-9458	www.cigna.com/health
First Priority Health	HMO and Point-of-Service	Excellent	1-800-822-8753	www.bcnepa.com
Geisinger Health Plan	HMO and Point-of-Service	Excellent	1-800-631-1656	www.thehealthplan.com
HealthAmerica and HealthAssurance, Pennsylvania	HMO and Point-of-Service	Excellent	1-800-788-8445 (Central) 1-800-735-4404 (Pittsburgh)	www.healthamerica.cvty.com
HealthGuard of Lancaster	HMO and Point-of-Service	Excellent	1-800-822-0350	www.hguard.com
Highmark, Inc. d/b/a Highmark Blue Shield	Point-of-Service	Scheduled	1-800-345-3806	www.highmarkblueshield.com
Keystone Health Plan Central	HMO	Excellent	1-800-622-2843	www.khpc.com
Keystone Health Plan East	HMO and Point-of-Service	Excellent	1-800-555-1514 (Outside Philadelphia) 1-215-636-9559 (In Philadelphia)	www.ibx.com
Keystone Health Plan West	HMO and Point-of-Service	Excellent	1-800-386-4944; 1-800-350-4130 (PEBTF)	www.highmarkbcbs.com
UPMC Health Plan	HMO and Point-of-Service	Excellent	1-888-876-2756	www.upmchealthplan.com



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