2012 HEALTH BENEFIT PLAN
QUALITY AND PERFORMANCE REPORT

Measuring the Quality and Performance of Maryland Commercial Health Benefit Plans

2012
HEALTH BENEFIT PLAN
QUALITY AND PERFORMANCE REPORT

On Commercial HMO; PPO; POS; EPO; and other types of Health Benefit Plans in Maryland

Maryland Health Care Commission*

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2012 Health Benefit Plan Quality and Performance Report
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Letter From the Chair and the Executive Director

Thank you for your interest in the 2012 Health Benefit Plan Quality and Performance Report: Measuring the Quality and Performance of Maryland Commercial Health Benefit Plans.
This annual report presents performance information on health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) plans, and exclusive provider organizations (EPOs). The report is a resource for individuals, employers, and employees to compare commercial health benefit plans on quality and performance measures that are closely linked to high quality, value-based care.

MHCC strives to align our performance reports with evolving standards for the presentation of health benefit plan quality information and accreditation requirements. Each year MHCC launches a planning process that identifies presentation approaches and the quality measures that will be used in the next report. Quality measures that are no longer deemed appropriate are retired, promising new measures are added, and sometimes, existing measures are redefined. Employers and health benefit plan representatives play important roles in this planning effort. Employers are helpful in identifying measures that would be most useful to their employees and dependents. Health benefit plan representatives assist the staff in determining if measures can be accurately collected and provide a perspective on information that would be valuable to their enrollees. MHCC thanks both groups for their participation.

New features in the 2012 report include more detailed measures on member satisfaction with their health benefit plan and easy to use dashboards that identify both areas of excellence and those in need of improvement for plans overall. In addition, an entirely new section on health benefit plan performance in managing chronic conditions has been added. Information for Maryland State employees has also been expanded.

We hope you find that this report is useful and the presentation of information is easy to understand. As this is a dynamic report, we invite you to send us suggestions on how the report could be improved for 2013.

Sincerely,

Craig P. Tanio, M.D.
Chair
Maryland Health Care Commission

Ben Steffen
Executive Director
Maryland Health Care Commission

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I. GENERAL INFORMATION

The Maryland Health Care Commission (MHCC)

The Maryland Health Care Commission (MHCC) is a public regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary function of the Commission is to evaluate and publish findings on the quality and performance of commercial health benefit plans that operate in Maryland. The MHCC publishes annual comparative reports with the cooperation of the commercial health benefit plans. These annual quality and performance reports are a source of objective, comprehensive, independently audited information on health benefit plan quality and performance in Maryland. More information about the MHCC and reports it produces is available at **http://mhcc.dhmh.maryland.gov**. For MHCC contact information, please see the last page of this report.

Measuring and Reporting on Health Care Quality and Performance

The Maryland Health Care Commission has been a leader in the evaluation and public reporting of health benefit plan quality and performance information for the last 15 years. In 1997, Maryland became the first state in the nation to release a comprehensive health benefit plan "report card" that contained audited data on health maintenance organizations (HMOs). In 2008, Maryland was again the first state to provide consumers with audited, comparative analyses of clinical and member satisfaction measures for preferred provider organizations (PPOs).

Assessing the performance of Maryland commercial health benefit plans is a critical component of ensuring the availability of quality health care for its residents. Using quality and performance information supports informed health choices, aids in the purchase of the best quality care and ensures that a plan's performance targets patient needs and expectations.

In theory, the result of developing and reporting quality information is that quality attains a value in the marketplace. As health benefit plans begin to compete on the basis of quality, they will devote greater attention and resources to quality improvement activities. Ultimately, high performing health benefit plans should be rewarded with greater market share as quality begins to influence consumer and employer choice.

Health benefit plan disclosure of quality information using reliable, audited, standardized measures helps purchasers and consumers learn which health benefit plans have the best results. A consistent finding in the National Committee for Quality Assurance (NCQA) annual State of Health Care Quality report is that health benefit plans that publicly report performance data perform significantly better than those that do not publicly report. Public reporting of service as well as quality and performance measures promotes competition among health benefit plans and stimulates quality and performance improvement activities.

The 2012 Health Benefit Plan Quality and Performance Report provides detailed, health benefit plan-specific, Maryland-wide indicators of quality and performance based on measures that include clinical performance, member satisfaction with the quality of health care service delivery, as well as health benefit plan descriptive features and quality initiatives. Readers may draw their own conclusions regarding overall health benefit plan quality and performance as it relates to their specific health care needs.

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MHCC MARYLAND HEALTH CARE COMMISSION

I. GENERAL INFORMATION

About This Report

The 2012 Health Benefit Plan Quality and Performance Report allows Marylanders to compare health benefit plans on key quality measures regarding health care delivery and member satisfaction. Quality ratings show a health benefit plan's ability to deliver high-quality care to its members. Quality and performance data are collected from health insurance carriers operating in the State of Maryland who meet pre-defined criteria requiring them to report on the quality and performance of their various health benefit plans operating under several types of managed healthcare delivery systems. These delivery systems largely include health maintenance organizations (HMOs) and preferred provider organizations (PPOs); however point-of-service organizations (POSs), exclusive provider organizations (EPOs), and other types of delivery systems may be reporting on their quality and performance metrics in combination with either their parent HMOs or PPOs, depending on the licensure and structure of the delivery system.

This report highlights areas of health care where health benefit plans had average and above-average performance, and areas that need improvement. In addition to this year's quality and performance ratings, the report includes information about how to maintain wellness, which can bring multiple benefits, including a longer lifespan, fewer illnesses and a resulting overall improved quality of life. Wellness can be defined as the process of becoming aware of, taking responsibility for, and making choices that directly contribute to well-being.

Section I of the report provides the reader with general information about the report and includes information about who should read this report.

Section II provides an overview that summarizes several excellent performance areas as well as potential areas for health benefit plan improvement.

Section III of the report provides a wide array of information including the differences between delivery systems, demographic information on the health benefit plans and behavioral health plans, and board certification status of the provider networks.

In **Section IV**, each carrier has been given the opportunity to briefly highlight their wellness initiatives. It should be noted that information on many of these wellness initiatives are offered to health benefit plan enrollees in a multi-language format.

Section V presents the results of the individual health benefit plan across multiple quality and performance measures and indicators, which are divided into six key measurement categories. The six categories include: 1) Primary Care and Wellness for Children and Adolescents, 2) Child Respiratory Conditions, 3) Women's Health, 4) Primary Care for Adults, 5) Behavioral Health, and 6) Member Experience and Satisfaction With Health Benefit Plan. Two comparison points are provided when available: the Maryland average benchmark and the national average benchmark. In addition, a relative rate in comparison to the Maryland average benchmark

This report highlights areas of health care where health benefit plans had average and above-average performance, and areas that need improvement.

I. GENERAL INFORMATION

About This Report

is presented for each measure and indicator through a star rating system, with more stars indicating better performance for the individual health benefit plan. The reader can choose the appropriate category based on their individual criteria and level of importance. For example, a mother with adolescent children may find the category of “Primary Care and Wellness for Children and Adolescents” to be more important than “Primary Care for Adults.” Finally, Section V also includes a portrayal of member experience and satisfaction with their health benefit plan. These scores were derived from the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which includes a myriad of survey questions designed to collect consumer and patient perspectives on health care quality. Additional information on the CAHPS survey method is discussed in Section X of the report.

Section VI provides State of Maryland employees with information on the various types of health benefit plans offered to them. Key differences among the plans are summarized and contact information for the plans are provided. Each health benefit plan offers a national network of health care providers and has different rules for how members use the plan’s benefits.

Section VII provides a summary of select State of Maryland quality and performance initiatives, such as the Million Hearts™ Campaign, the Maryland Multi-Payer Patient Centered Medical Home program, the Maryland Health Information Exchange, as well as links to other resources provided by MHCC.

Section VIII provides a summary of the five major chronic diseases that impact Maryland residents, including heart disease, diabetes, hypertension, asthma, and chronic obstructive pulmonary disease (COPD). Each disease is fully explained along with resources available to each resident. Finally, helpful hints and things you should know are listed so that you can discuss any issues with your health care provider.

Section IX provides a compendium of various resources available to consumers who might want to make inquiries on various programs or seek additional information.

Section X provides information to readers regarding the methodology behind the calculation of star ratings as well as performance rates for HEDIS and CAHPS.

Who Should Read This Report?

- Maryland consumers who want to choose a new health benefit plan or examine their current plan’s performance on the measures of care and service highlighted in this report
- Maryland employers who want to consider quality when making decisions about health care purchasing so they can get the best value (health outcome for dollars spent) for their employees and their company
- Health insurance carriers who want to identify areas where they require competitive performance improvement
- Policy makers, media, and academic researchers

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II. OVERVIEW

This report demonstrates a commitment by the MHCC to promote continuous quality improvement among Maryland's health benefit plans. All plans meeting the reporting criteria are required to report on the types of services offered and how well these services are provided for each of their health benefit plan products.

In addition, this report recognizes unique health and wellness initiatives offered to Maryland residents by health benefit plans and the State. This report contains performance measures and indicators reported by health benefit plans, of which only a portion may be deemed significant to the reader. As with all reports, caution and close attention is urged in (1) determining what area is most important to the reader and (2) the interpretation of some results. Conversely, it is important to understand the rankings of individual plans compared to national benchmarks and whether that ranking would make a difference in an individual's choice in health benefit plan.

As you read this report, you may notice some plans with a Not Applicable or "NA" rating. When the total eligible population for a measure is less than 30 members, a performance score of NA is assigned because it is impossible to produce a statistically significant rate with such a small membership. Additionally, some measures may receive a Not Reportable or "NR" rating when the auditor deems the rate to be biased due to incomplete data. When producing the Maryland or National Average Benchmark, any measure with an NA or NR assigned rate was not included.

The dashboard included in this section contains displays that resemble gas gauges and provides a quick summary of health benefit plan performance across selected measures as compared to national benchmarks. Detailed descriptions to fully explain the measure or indicator and the rationale for why it is important are provided in Section V. Page numbers are referenced at the bottom of each display. The first set of displays focuses on measures related to Primary Care and Wellness for Children and Adolescents and shows excellent performance. When interpreting the displays, the reader should pay attention to where the "needle" is on the gauge. There are a total of eight HMO and six PPO health benefit plans. When looking at the HMO results in a measure, if the needle is on 7, it means that 7 of the health benefit plans are better than the national average for that measure. For example, one display presents information on the number of children who received all of their required vaccines of the various antigens before they turned two years old. All eight of the HMO health benefit plans and five of the PPO health benefit plans performed better than the national average. In addition to showing measures in which health benefit plans demonstrate excellent performance, there are several measures where the health benefit plans are performing worse than the national average and highlight a potential area for improvement. Again, the maximum score would be eight HMO and six PPO health benefit plans that could be better than the national average. The position of the needle on the display indicates how many health benefit plans scored better than the national average.

This report demonstrates a commitment by the MHCC to promote continuous quality improvement among Maryland's health benefit plans.

II. OVERVIEW

Excellent Performance Areas

Maryland's health benefit plans are maintaining a track record of good performance across many of the measures and indicators being evaluated. However, out of the six categories of measures and indicators previously listed (at the bottom of page 2), Maryland's health benefit plans demonstrate excellent performance in two categories:

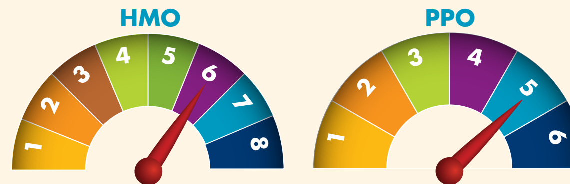
1. In the category Primary Care and Wellness for Children and Adolescents, the majority of plans performed better than the national average benchmark on measures that relate to access to care and adequate preventive healthcare through appropriate vaccination.

Note: Maximum score is 8 for the HMO/POS type of health benefit plan and 6 for the PPO type of health benefit plan.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmarks

Primary Care and Wellness for Children and Adolescents

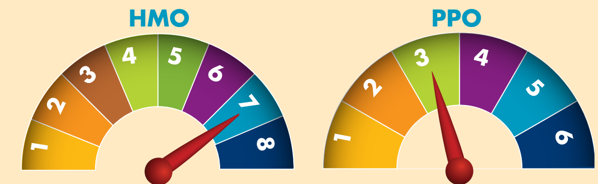
Children and Adolescents Access to Primary Care Providers



Children and adolescents age 12–19 years of age who had a visit with a primary care provider during 2011

See details on page 31

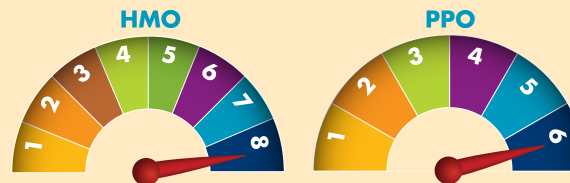
Well-Child Visits in the First 15 Months of Life



Children who during their first months of life had no office visit with their primary care provider

See details on page 32

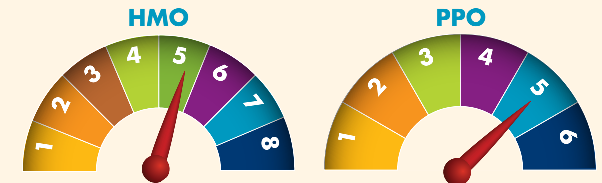
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Children age 3, 4, 5, or 6 who had a well child visit with their primary care provider during 2011

See details on page 35

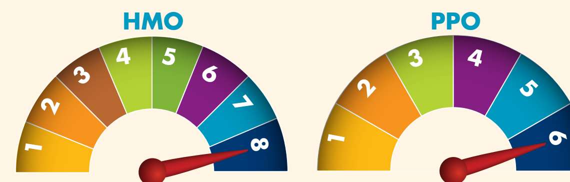
Childhood Immunization Status



Number of children who received all of their required vaccines before they turned 2 years old (immunization/ vaccination based on the American Academy of Pediatrics)

See details on page 36

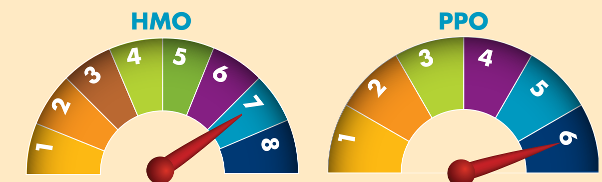
Adolescent Well-Care Visits



Number of adolescents who received a well child visit in 2011

See details on page 37

Immunizations for Adolescents



Number of adolescents who received their required number of vaccines before their 13th birthday

See details on page 38

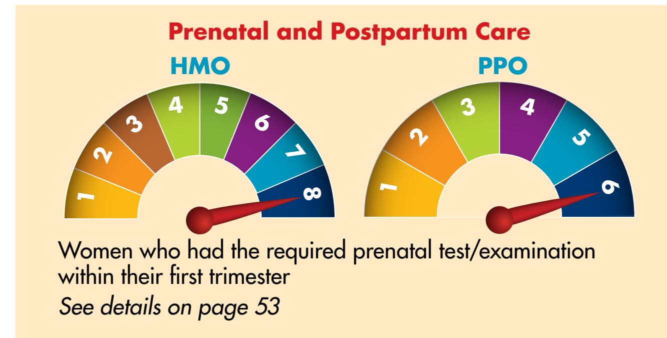
II. OVERVIEW

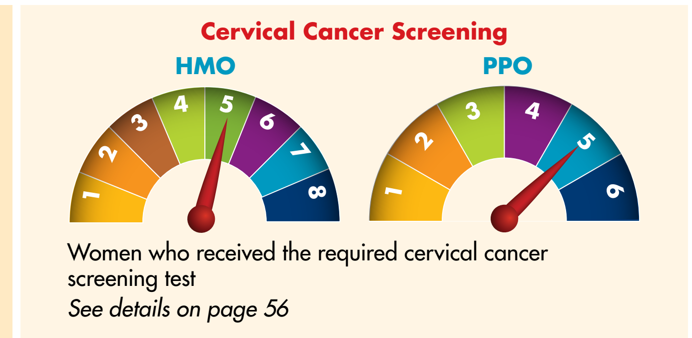
Excellent Performance Areas

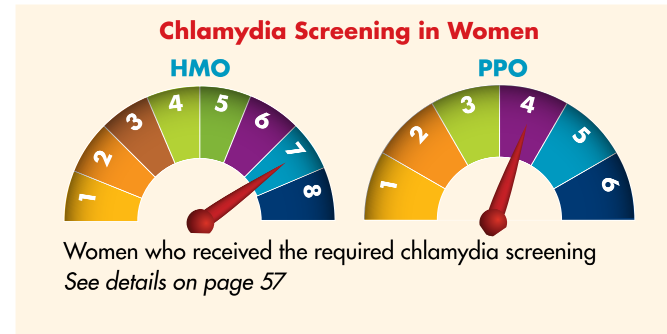
2. In the category Women's Health, the majority of plans performed better than the national average benchmark on measures that relate to prevention and screening.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmarks

Women's Health







Note: Maximum score is 8 for the HMO/POS type of health benefit plan and 6 for the PPO type of health benefit plan.

II. OVERVIEW

Potential Areas for Improvement

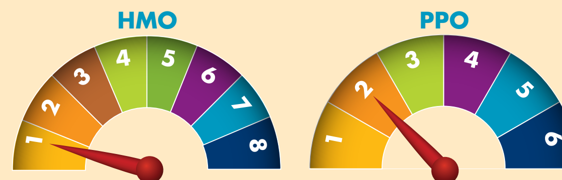
Overall, the health benefit plans continue to perform well when compared to national average benchmarks. However, there are several areas where improvement is dictated but perhaps mitigated to some degree by member expectations on services that should be provided.

When interpreting these measures, the description below the display provides additional information. For example, one display entitled Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis indicates only 2 out of 8 HMOs and 1 out of 6 PPOs succeeded in performing better than the national average benchmark in increasing the number of adults, within the health benefit plan, who were not provided an antibiotic for bronchitis. Therefore, the remaining 6 HMOs and 5 PPOs routinely prescribe antibiotics when perhaps contraindicated.

Number of Maryland Health Benefit Plans Performing Better Than the National Average Benchmarks

Primary Care and Wellness for Children and Adolescents

Follow-Up Care for Children Prescribed ADHD Medication – *Continuation Phase*

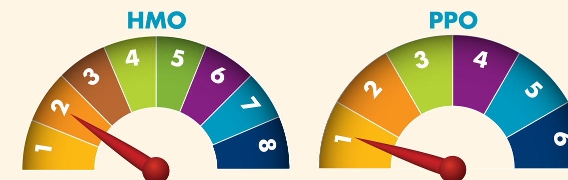


Children diagnosed with ADHD who, after their initial treatment, had two follow up visits and remained on medication for 120 days

See details on page 42

Primary Care for Adults – Respiratory Conditions

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

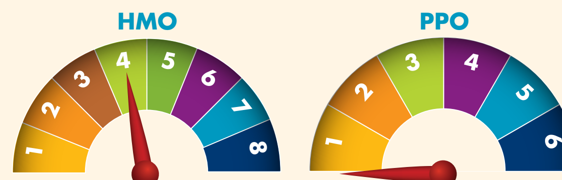


Number of adults who were not prescribed an antibiotic for acute bronchitis

See details on page 63

Primary Care for Adults – Musculoskeletal Disease and Medication Management

Use of Imaging Studies for Low Back Pain

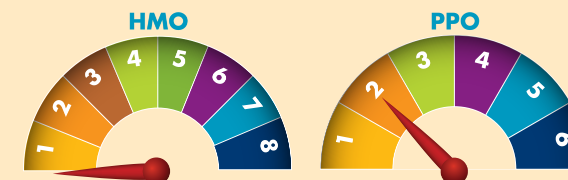


Number of adults who did not receive an X-ray or similar imaging study for low back pain

See details on page 80

Behavioral Health

Follow-Up After Hospitalization for Mental Illness



Number of members discharged after a hospitalization for a mental illness who did not have a follow-up visit within 30 days of their discharge

See details on page 85

Note: Maximum score is 8 for the HMO/POS type of health benefit plan and 6 for the PPO type of health benefit plan.

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Delivery Systems

Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service Organization (POS), and Exclusive Provider Organization (EPO) plans all have distinct features. Both HMO and POS plans use a Primary Care Provider (PCP), who is responsible for coordinating a patient's care. Traditionally, a key difference among HMO, PPO, and POS plans is that PPO and POS plan members do not need a referral from a PCP to see a specialist and may select a provider who is not in the plan's network of providers—although members' out-of-pocket costs are lower when they use an in-network provider.

Some employers have begun to offer EPO plans. An EPO is a relatively new type of hybrid health benefit plan with features of both an HMO and a PPO. There is usually no designated primary care provider and usually no need to obtain a referral for services with an EPO. Benefits are available for in-network office visits and hospital care, including inpatient and outpatient surgery; however, there is no coverage for out-of-network services. State of Maryland employees have an option to select an EPO plan.

Health Benefit Plan Features

Topic	HMO	POS	PPO	EPO
Primary care	Members must choose an in-network PCP to manage their care For some plans the PCP and all medical personnel work directly for the HMO at one of its medical facilities; so it is necessary to live or work in close proximity to the medical facility(ies)	Members must choose an in-network PCP to manage their care	Members are not required to have a PCP manage their care Members may choose in-network or out-of-network primary care providers	Depending on the plan, members may need to choose an in-network PCP to manage their care
Referrals to specialty care providers	Members need a referral from their PCP to see a specialist and other providers, although some HMOs no longer require referrals	Members may choose between PCP referral to in-network specialist or they may choose to see an out-of-network specialist	No referrals are needed to seek care from specialists or other health care providers	Referrals may be needed to seek care from specialists or other in-network providers Members must choose in-network providers if they have a need for a specialist Some plans may allow referrals to out-of-network providers in emergency situations
Out-of-pocket costs	Annual premiums tend to be lower than POS and PPO plans *Cost sharing:* Fixed co-payments with no annual deductible or coinsurance	Annual premiums tend to fall between HMO and PPO plans *Cost sharing:* Fixed co-payments for in-network services; deductibles and coinsurance may apply to in-network services and out-of-network services	Annual premiums tend to be higher than HMO and POS plans *Cost sharing*: Fixed co-payments for in-network services; deductibles and coinsurance may apply to in-network services and out-of-network services	Annual premiums tend to be lower than PPO plans *Cost sharing:* Fixed co-payments for in-network services; deductibles and coinsurance may apply to in-network services and out-of-network services, if allowed

Sources: Maryland Department of Budget and Management Health Benefits, National Association of Insurance Commissioners and **Healthcare.gov**.

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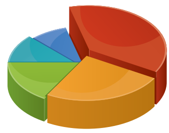


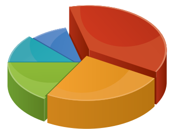
III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plans in Maryland Reporting in 2012

Health benefit plan abbreviated names used in this report

Health Benefit Plan Provider Information				
Health Plan Name	**Report-Level Name**	**Product Type**	**Contact Information**	**Tax Status and Ownership**
Aetna Health, Inc. (Pennsylvania) – Maryland	Aetna HMO	HMO/POS Combined	800-694-3258 Monday–Friday, 8:00 AM–5:00 PM **www.aetna.com**	Aetna is a for-profit HMO with a PPO.
Aetna Life Insurance Company (MD/DC)	Aetna PPO	PPO		
CareFirst BlueChoice, Inc.	BlueChoice HMO	HMO/POS Combined	866-520-6099 Monday–Friday, 7:00 AM–7:00 PM, Saturday, 8:00 AM–1:00 PM **www.carefirst.com**	CareFirst BlueChoice is a not-for-profit HMO.
CareFirst, Inc. (BluePreferred)	BluePreferred PPO	PPO		CareFirst BluePreferred, Inc. is a for-profit PPO.
Cigna HealthCare Mid-Atlantic, Inc.	Cigna HMO	HMO/POS Combined	800-Cigna24 (800-244-6224) 24 hours a day, 7 days a week **www.Cigna.com**	Cigna (Cigna HMO) is a for-profit HMO.
Connecticut General Life Insurance Company (MD/DC)	CGLIC PPO	PPO		CGLIC (Cigna PPO) is a for-profit PPO offered by Connecticut General Life Insurance Company.
Coventry Health Care of Delaware, Inc.	Coventry HMO	HMO/POS Combined	800-833-7423 Monday–Friday, 8:00 AM–5:00 PM **www.coventryhealthcare.com**	Coventry is a for-profit HMO.
Coventry Health and Life Insurance Company	Coventry PPO	PPO		Coventry Health Care of Delaware, Inc. is a for-profit PPO offered by Coventry Health and Life Insurance Company.

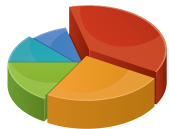
continued



III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plans in Maryland Reporting in 2012

Health Benefit Plan Provider Information (continued)				
Health Plan Name	**Report-Level Name**	**Product Type**	**Contact Information**	**Tax Status and Ownership**
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Kaiser Permanente HMO	HMO	301-468-6000 (metro area) 800-777-7902 (Outside metro area: toll free) Monday–Friday 7:30 AM–5:00 PM Medical advice/appointments numbers for members 800-777-7904 or 703-359-7878, 24 hours a day, 7 days a week. For hearing and speech impaired: 301-879-6380 **www.kaiserpermanente.org**	Each independent Kaiser Permanente Medical Group in Maryland operates as a separate for-profit HMO plan and is primarily funded by reimbursements from the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
MD – Individual Practice Association, Inc.	MD – IPA HMO	HMO/POS Combined	Members should call the number on the back of their card, or 866-633-2446, 24 hours a day, 7 days a week TTY: 711 (Maryland only) **www.myuhc.com**	M.D. IPA and OCI, for-profit HMOs, are owned and operated by a regional holding company and are subsidiaries of UnitedHealth Group, Inc.
Optimum Choice, Inc.	OCI HMO	HMO/POS Combined		
MAMSI Life and Health Insurance Company	MAMSI PPO	PPO	800-815-8958, TTY: 711 (Maryland only) 24 hours a day, 7 days a week **www.uhc.com**	UnitedHealthcare of the Mid-Atlantic, Inc. is a for-profit HMO/POS plan and a subsidiary of UnitedHealth Group, Inc.
UnitedHealthcare of the Mid-Atlantic, Inc.	United HMO	HMO/POS Combined		
UnitedHealthcare Insurance Company (MD)	United PPO	PPO/POS Combined		UnitedHealthcare Insurance Company (Maryland) and MAMSI Life and Health Insurance Company are both for-profit PPO plans and subsidiaries of UnitedHealth Group, Inc.



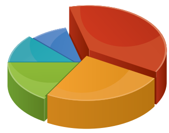
III. HEALTH BENEFIT PLAN INFORMATION

Managed Behavioral Healthcare Organizations (MBHO)

Behavioral healthcare services are provided through the health benefit plan's own provider network or through a contractual arrangement with a behavioral healthcare services vendor. Members have access to these services based on the benefit package linked to their contract. These charts provide information on who is providing the behavioral healthcare services for each health benefit plan and the percentage of members covered by these services.

Name of MBHO Providing Behavioral Healthcare Services

HMO	Name of MBHO
Aetna Health, Inc. (Pennsylvania) – Maryland	Aetna Behavioral Health Pennsylvania
CareFirst BlueChoice, Inc.	Magellan Health Services
Cigna HealthCare Mid-Atlantic, Inc.	Cigna Behavioral Health, Inc.
Coventry Health Care of Delaware, Inc.	MHNet Behavioral Health
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Kaiser Permanente Health Plan of the Mid-Atlantic States
MD – Individual Practice Association, Inc.	United Behavioral Health
Optimum Choice, Inc.	United Behavioral Health
UnitedHealthcare of the Mid-Atlantic, Inc.	United Behavioral Health
PPO	**Name of MBHO**
Aetna Life Insurance Company (MD/DC)	Aetna Behavioral Health Pennsylvania
CareFirst, Inc. (BluePreferred)	CareFirst's regional provider network Magellan Health Services – for utilization and care management services
Connecticut General Life Insurance Company (MD, DC)	Cigna Behavioral Health, Inc.
Coventry Health and Life Insurance Company	MHNet Behavioral Health
MAMSI Life and Health Insurance Company	United Behavioral Health
UnitedHealthcare Insurance Company (MD)	United Behavioral Health



III. HEALTH BENEFIT PLAN INFORMATION

Managed Behavioral Healthcare Organizations (MBHO)

Total Behavioral Healthcare Providers (Maryland)

HMO	Psychiatrist	Physician, certified in addiction medicine	Psychologist	Social Worker	Licensed Social Work Associate	Nurse Psycho-therapist	Nurse Practitioner	Registered Nurse	Licensed Therapists and Counselors	Alcohol and Drug Counselors	Other Professional Titles: Applied Behavioral Analyst – Autism Treatment	All Professionals (TOTAL)
Aetna Health, Inc. (Pennsylvania) – Maryland	529	3	415	1146	0	70	0	0	610	0	12	2785
CareFirst BlueChoice, Inc.	485	4	451	1352	0	111	0	0	745	3	0	3151
Cigna HealthCare Mid-Atlantic Inc.	365	9	239	672	0	47	0	0	319	10	2	1663
Coventry Health Care of Delaware, Inc.	276	3	210	686	0	35	0	0	16	0	0	1226
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	361	1	252	534	0	11	7	4	150	9	0	1329
MD – Individual Practice Association, Inc.	447	4	453	980	0	93	13	1	354	0	0	2345
Optimum Choice, Inc.	447	4	453	980	0	93	13	1	354	0	0	2345
UnitedHealthcare of the Mid-Atlantic, Inc.	447	4	453	980	0	93	13	1	354	0	0	2345
PPO												
Aetna Life Insurance Company (MD/DC)	545	1	420	1177	0	74	0	0	609	14	12	2852
CareFirst, Inc. (BluePreferred)	766	0	820	1970	0	98	27	0	941	0	0	4622
Connecticut General Life Insurance Company (MD/DC)	838	15	587	1411	0	87	0	11	595	17	17	3578
Coventry Health and Life Insurance Company	276	3	210	686	0	35	0	0	16	0	0	1226
MAMSI Life and Health Insurance Company	447	4	453	980	0	93	13	1	354	0	0	2345
UnitedHealthcare Insurance Company (MD)	447	4	453	980	0	93	13	1	354	0	0	2345

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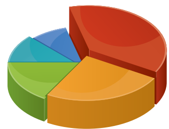

III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Accreditation Information

Accreditation is another way of assessing health benefit plan quality and performance; it is an independent, external assessment of quality and performance by a review organization. The NCQA and URAC accredit the health benefit plans and managed behavioral healthcare organizations (MBHO) in this report. Each health benefit plan and MBHO in this report voluntarily obtained accreditation through NCQA, URAC, or both. In Maryland, accreditation is not currently required for health benefit plans or MBHOs.

NCQA Accreditation

The program evaluates how well an organization manages its delivery system—physicians, hospitals, other providers, and administrative services—for continuous improvement of the health care it delivers to members. A team of physicians and managed care experts conducts on site and off site evaluations. The team reviews grievance procedures, physician evaluation and care management processes, preventive health efforts, medical record keeping, quality and performance improvement, and quality and performance on key aspects of clinical care, such as immunization rates.

NCQA assigns one of the following five accreditation levels, based on an organization's quality and performance:

Excellent: NCQA awards its highest accreditation status of Excellent to organizations with programs for service and clinical quality and performance that meet or exceed rigorous requirements for consumer protection and quality and performance improvement. HEDIS and CAHPS results are in the highest range of national quality and performance.

Commendable: NCQA awards a status of Commendable to organizations with well-established programs for service and clinical quality and performance that meet rigorous requirements for consumer protection and quality and performance improvement.

Accredited: NCQA awards an accreditation status of Accredited to organizations with programs for service and clinical quality and performance that meet basic requirements for consumer protection and quality and performance improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.

Provisional: NCQA awards a status of Provisional to organizations with programs for service and clinical quality and performance that meet some, but not all, basic requirements for consumer protection and quality and performance improvement. Organizations awarded this status need to take significant action to improve their processes and achieve a higher accreditation status.

Interim: NCQA awards a status of Interim to organizations with basic structure and processes in place to meet expectations for consumer protection and quality improvement. Organizations awarded this status will need to undergo a new review within 18 months to demonstrate they have executed those processes effectively.

Denied: NCQA denies accreditation to organizations whose programs for service and clinical quality and performance did not meet NCQA requirements during the accreditation survey.

URAC Accreditation

URAC's accreditation standards provide a comprehensive assessment of organization quality and performance that applies to healthcare systems which provide a full range of health care services, such as HMO health benefit plans and fully integrated PPO health benefit plans. Standards include key quality and performance benchmarks for network management, provider credentialing, utilization management, quality and performance improvement, and consumer protection.

Organizations applying for accreditation participate in a review process involving several phases. The initial phase of the accreditation process consists of completing the application forms and supplying supporting documentation. The remaining three phases cover a period of approximately four to six months. During the review process, the reviewer analyzes the applicant's documentation with regard to URAC standards.

URAC assigns one of the following three accreditation levels based on an organization's quality and performance:

Full: URAC awards an accreditation status of Full to organizations that successfully meet all requirements. Full accreditation is for two years. An accreditation certificate is issued to each company that participates in the

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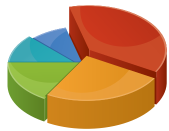


III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Accreditation Information

accreditation review. As a condition of accreditation, organizations awarded Full accreditation must remain compliant with URAC standards during the two-year accreditation cycle.

Conditional: URAC awards an accreditation status of Conditional to organizations that have appropriate documentation but did not completely implement certain policies or procedures before achieving full compliance. URAC requires organizations with Conditional accreditation to demonstrate full compliance and move to Full accreditation status within six months.

Provisional: URAC awards an accreditation status of Provisional to organizations that complied with all standards but had not been in operation long enough (less than six months) at the time of the onsite review to demonstrate full compliance. URAC requires organizations with Provisional accreditation to demonstrate full compliance of standards to meet Full accreditation status.

Organizations that cannot meet URAC standards may be placed on corrective action status, may be denied accreditation, or may withdraw.

NCQA MBHO Accreditation

MBHO and NCQA Accreditation Programs are closely aligned with nearly identical sets of standards that apply to both types of organizations. Both programs seek to promote access to behavioral healthcare and improve coordination between medical and behavioral health professionals.

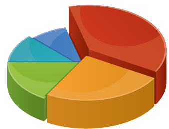
The MBHO accreditation program requires MBHOs to annually monitor and evaluate at least two preventive behavioral healthcare screenings and educational interventions offered to their covered population. The categories of preventive interventions listed in the standards are adapted from the Institute of Medicine's Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research (1994). This publication lists a number of illustrative preventive interventions for the various age and population categories.

URAC MBHO Accreditation

Like other integrated health care delivery systems, MBHOs may undergo a full review of their operations or have individual components reviewed for accreditation. URAC's accreditation standards assess an organization and assign an accreditation level based on quality and performance on defined standards. The accreditation process consists of the multiphase review described in the previous section. A range of accreditation programs is available through URAC, permitting review of a segment of organization operations. The Health Utilization Management and Case Management standards are examples of accreditation modules that Managed Care Organizations (such as MBHOs) select to demonstrate that they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

Health Benefit Plan Accreditation Status

HMO	Organization	Accreditation Status	Expiration Date (mm/yy)
Aetna Health, Inc. (Pennsylvania) – Maryland	NCQA	Excellent	01/14
CareFirst BlueChoice, Inc.	NCQA	Commendable	11/13
Cigna Healthcare Mid-Atlantic, Inc.	NCQA	Excellent	12/14
Coventry Health Care of Delaware, Inc.	URAC	Full Accreditation	06/13
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	NCQA	Excellent	08/13
MD – Individual Practice Association, Inc.	NCQA	Commendable	03/15
Optimum Choice, Inc.	NCQA	Commendable	03/15
UnitedHealthcare of the Mid-Atlantic, Inc.	NCQA	Commendable	03/15
PPO			
Aetna Life Insurance Company (MD/DC)	NCQA	Excellent	12/13
CareFirst, Inc. (BluePreferred)	NCQA	Commendable	11/13
Connecticut General Life Insurance Company (MD/DC)	NCQA	Commendable	12/14



III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Accreditation Information

MBHO Accreditation Status				
HMO	**Name of MBHO or Accredited Segment of Health Plan**	**NCQA MBHO Accreditation**	**URAC Health Utilization Management Accreditation**	**URAC Case Management Accreditation**
Aetna Health, Inc. (Pennsylvania) – Maryland	Aetna Behavioral Health Pennsylvania	Full; 1/7/2014		
CareFirst BlueChoice, Inc.	Magellan Tristate Care Management Center	Full; 7/19/2013	Full; 6/1/2013	Full; 9/1/2013
Cigna Healthcare Mid-Atlantic, Inc.	Cigna Behavioral Health, Inc.	Full; 12/16/2014		
Coventry Health Care of Delaware, Inc.	MHNet Behavioral Health	Full; 8/17/2015	Full; 1/1/2015	
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Kaiser Permanente Health Plan of the Mid-Atlantic States	Excellent; 6/1/2013		
MD – Individual Practice Association, Inc.	United Behavioral Health	Full; 6/10/2013	Full; 2/1/2014	
Optimum Choice, Inc.	United Behavioral Health	Full; 6/10/2013	Full; 2/1/2014	
UnitedHealthcare of the Mid-Atlantic, Inc.	United Behavioral Health	Full; 6/10/2013	Full; 2/1/2014	
PPO				
Aetna Life Insurance Company (MD/DC)	Aetna Behavioral Health Pennsylvania	Full; 1/7/2014		
CareFirst, Inc. (BluePreferred)	Magellan Tristate Care Management Center	Full; 7/19/2013	Full; 6/1/2013	Full; 9/1/2013
Connecticut General Life Insurance Company (MD/DC)	Cigna Behavioral Health, Inc.	Full; 12/16/2014		
	ValueOptions, Inc.		Full; 3/1/2013	
Coventry Health and LIfe Insurance Company	MHNet Behavioral Health	Full; 8/17/2015	Full; 1/1/2015	
MAMSI Life and Health Insurance Company	United Behavioral Health	Full; 6/10/2013	Full; 2/1/2014	
UnitedHealthcare Insurance Company (MD)	United Behavioral Health	Full; 6/10/2013	Full; 2/1/2014	

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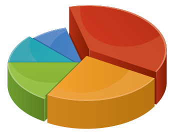


III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Accreditation Information

Board Certification Status of Provider Network*							
HMO	**Geriatrician**	**Internal Medicine**	**OB/GYN**	**Family Medicine**	**Pediatrician**	**Psychiatrist**	**Other Specialists**
Aetna Health, Inc. (Pennsylvania) – Maryland	65.4%	80.6%	77.1%	74.6%	84.5%	72.6%	87.0%
CareFirst BlueChoice, Inc.	78.0%	82.9%	69.7%	72.2%	82.1%	79.6%	86.4%
Cigna Healthcare Mid-Atlantic, Inc.	73.8%	83.4%	82.0%	71.2%	78.9%	91.0%	83.9%
Coventry Health Care of Delaware, Inc.	73.4%	76.4%	73.7%	81.2%	83.8%	24.6%	86.7%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	93.8%	87.9%	85.2%	83.2%	90.8%	86.1%	90.4%
MD – Individual Practice Association, Inc.	67.7%	79.3%	84.9%	80.6%	78.7%	79.0%	85.8%
Optimum Choice, Inc.	67.9%	78.9%	84.5%	80.3%	76.9%	79.0%	84.7%
UnitedHealthcare of the Mid-Atlantic, Inc.	67.3%	79.3%	84.9%	80.6%	78.7%	79.0%	85.8%
PPO	**Geriatrician**	**Internal Medicine**	**OB/GYN**	**Family Medicine**	**Pediatrician**	**Psychiatrist**	**Other Specialists**
Aetna Life Insurance Company (MD/DC)	66.7%	80.9%	75.9%	74.9%	83.8%	73.8%	87.1%
CareFirst, Inc. (BluePreferred)	64.4%	77.8%	59.0%	59.0%	76.1%	62.1%	76.6%
Connecticut General Life Insurance Company (MD/DC)	77.8%	82.2%	80.5%	69.7%	75.5%	84.4%	83.6%
Coventry Health and Life Insurance Company	73.4%	76.4%	73.7%	81.5%	83.8%	24.6%	86.7%
MAMSI Life and Health Insurance Company	68.7%	79.1%	83.1%	79.0%	73.6%	79.0%	84.7%
UnitedHealthcare Insurance Company (MD)	68.4%	79.0%	83.1%	79.0%	73.8%	79.0%	84.7%

* Percentage of Board Certified Physicians – a provider who is board certified and credentialed to work in multiple disciplines will be counted in each relevant discipline in the chart.

IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES

Aetna

Aetna Health Inc. and Aetna Life Insurance Company focus on the whole person relating to physical, nutritional, and emotional well being. Programs implemented toward this focus include:

Stress Reduction Pilot Program

A study on Mind-Body Stress Reduction – testing two innovative mind-body approaches, mindfulness meditation, and therapeutic yoga against a control group on a selection of 239 employees. Employees experienced improvements in perceived stress with decreases in stress levels as compared to the control, as well as a decrease in sleep difficulties and current pain levels.

Member Population Health

Life Style groups and group coaching (in person) combine to facilitate behavior and lifestyle changes, identifying risk and contributing to the overall health of the population. Activities are supported through virtual social engagement, face-to-face community programs, biometric screenings, informed wellness coordination, and a health telephone hotline.

Targeted Health Reminders

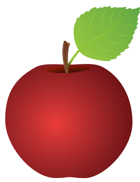
Diabetes management, childhood immunization, and cancer screening reminders are customized for members and member groups regarding quality improvement compliance initiatives and group specific needs. In addition, healthy lifestyle information addressing eating habits, exercise and weight management, and talking with the doctor, as well as a *Member Essentials eNewsletter* with educational articles designed to prompt members to take action applicable to their wellness needs.

Provider/Member Focused Initiatives/Outreach

Member rosters and claims data are used to identify provider gaps in appropriate testing or related care in the previous year and to identify the effectiveness of current mailings to member groups. Providers are also supplied with results of quality and performance reporting by healthcare providers within their networks/states for comparative analysis. New outreach efforts target members according to their specific health risks and provide members with related educational and healthy lifestyle information customized for specific age groups. New efforts are being directed toward Interactive Voice Response (IVR) calls as additional reminder tools.

Behavioral Health Quality Initiatives

Aetna behavioral health operational staff now report to medical staff; the logic is that you cannot separate mind from body; the goal is to identify behavioral health issues as early as possible and intervene quickly to get the biggest impact. Performance on key behavioral health measures are selected and barriers to improved performance are identified. Opportunities for improvement are selected and strategies for implementation of these opportunities are developed. Where possible, member input is solicited to identify barriers from the member's perspective.



IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES

CareFirst

CareFirst BlueChoice and CareFirst BluePreferred have implemented a series of risk management assessments and patient centered programs including:

Patient Centered Medical Home Program

This program is built on a new set of incentives for primary care physicians that reinforce their role in helping to manage their patients' health risks and guiding their patients' care when they experience major illness, including those with one or more chronic illnesses. Local Care Coordinators assist the primary care providers in identifying patients with an illness burden, coordinating care for those patients, as well as identifying and closing gaps in care.

Disease Management Program

Members who have diabetes, coronary artery disease, asthma, COPD and similar chronic diseases receive communications based on the severity of the illness to assist in the management of the condition and to achieve and maintain control of their wellness.

CareFirst Great Beginnings

This program places an emphasis on prenatal and postpartum visits by women during and after pregnancy. Both prenatal and postpartum visits are designed to supplement the care and education from the physician. The visits are intended to identify health risks specific to the individual member and provide additional resources including call reminders regarding the importance of a postpartum visit.

HealthyBlue

HealthyBlue is a member incentive program rewarding members for their healthy choices through a variety of incentives, and partnering with primary care physicians to evaluate the wellness of their members.

Overall Programs

Additional programs create partnerships with health and fitness vendors for weight management programs in order to provide more robust services for at-risk members. CareFirst programs strive to identify and address the core needs of the population being managed, and optimize the use of web portals for information sharing, continuously updating contact information and encouraging use of patient centered medical homes while also assisting providers in creating an action plan for improvement.

Cigna

Cigna Healthcare of the Mid-Atlantic, Inc. and Connecticut General Life Insurance Company center on the individual, with a personalized approach to total health including behavioral health, stress management and personal health risk appraisal. Programs implemented at the organizations include:

"Go You" Campaign

This campaign puts the focus on inspiring and championing the individual to make healthier choices for an overall healthy lifestyle which in turn leads to optimal health and wellness.

Colorectal Cancer Screening Disparities

An ongoing collaborative evaluation focused on finding the most effective intervention methods to increase the colorectal cancer screening rate for a target (at-risk) population within Cigna's membership.

Breast, Cervical, Colorectal Cancer Screening Program

A collaborative regional level program with the American Cancer Society to provide health fairs, special benefit coverage mailers and incentives aligned with member and organizational needs.

Physician Collaborative Efforts

A collaborative effort with the physician network to evaluate the impact of the physician's influence on a patient's decision to obtain appropriate screening for colorectal cancer and for a diabetic patient's decision to obtain an appropriate retinal eye examination. The diabetic eye exam program has built upon the success of the colorectal cancer initiative and uses the same provider network.

Funded Study Examining Health Disparities

Over a 12-month period, patient financial incentives versus educational materials were analyzed to test the associated improvement in physician visits. Results did not affect the total number of visits; however, analyses of two patient subgroups suggested that newly diagnosed individuals and those who had not seen a physician in more than a year are responsive to both financial incentives and educational materials that promote a visit to the physician. Ongoing analysis continues to identify additional subgroups that are responsive.

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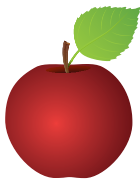


IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES

Coventry

Coventry Health Care of Delaware, Inc. (CHCDE) and Coventry Health and Life Insurance Company focus on the whole person relating to physical, nutritional and emotional well being. Programs implemented at the organization include:

Women's Health Focus

During the month of their birth, female members between the ages of 18 and 65 receive educational materials regarding breast, cervical and colon cancer screening, as well as osteoporosis, menopause, chlamydia, prenatal care, and smoking cessation.

Member Outreach

Call centers implement national and local live calls, interactive voice response calls and a variety of educational campaign calls to members. Individualized health check-up reminders for mammography and other preventive health measures are made available via links on the CHCDE website.

Back to Basics Program

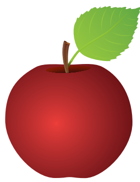
A quality assurance and quality improvement program involving data collection and reporting of various clinical quality measures. This program allows for intensive oversight of health benefit plans in order to promote continuous quality improvement among plans.

Maternity Case Management Program

A program designed to improve birth outcomes, with registered nurses and providers partnering to identify high risk members through Prenatal Risk Assessment. In addition, an educational prenatal magazine is sent to all expectant mothers reviewing the importance of prenatal care and testing.

Member Focused Initiatives

Member incentive programs are established to encourage program participation in prenatal and well child areas. Internal reviews are conducted to identify member-specific data gaps and organizational hurdles that impact overall health benefit plan performance. In addition, use of electronic medical records are encouraged among healthcare providers and a pilot program with Walgreens is underway to capture relevant member-specific clinical data.



IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES

Kaiser Permanente

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has ongoing programs focused on wellness management and total health awareness including:

Women's Health Focus

Regional Health Education, Health Promotion and Women's Health programs support education. In addition, online self-management tools and resources deliver service to all members.

National Program to Address Domestic Abuse

Current projects in place for reducing intimate partner violence and collaboration on a national level to address domestic abuse through provider education and member education.

Thrive Campaign

Thrive is a targeted wellness campaign promoting individualized wellness activities that allow members to adopt healthier practices that meet their personal, cultural and regional needs.

Disease Management Program

This program is centered on developing processes and practices to identify members and adopt practice guidelines that document and meet standard performance measures. Management of chronic conditions such as asthma, diabetes, and behavioral health conditions receive the most focus.

Population Care Management Program

This focused program centers around five major goals that guide the activities of the organization.

Goal 1: Ensure Compliance with Accreditation and Regulatory Standards particularly for chronic disease management (NCQA Standard QI 8 – Disease Management)

Goal 2: Ensure Compliance with Accreditation and Regulatory Standards particularly for clinical practice guidelines (NCQA Standard QI 9 – Clinical Practice Guidelines)

Goal 3: Demonstrate Clinical Quality Improvement as evidenced by improving performance scores on HEDIS, Crossing the Quality Chasm, and Medicare STARS

Goal 4: Support the Delivery System Physicians and Staff in their effort to do the right thing, on time, for every patient

Goal 5: Demonstrate the Value of Population Care Management to Kaiser Permanente employers and employees

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UnitedHealthcare/ MAMSI/MD – IPA/ Optimum Choice

UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare Insurance Company, MAMSI, Maryland Individual Practice Association, and Optimum Choice, Inc. are all focused on the individual member taking control of their health, providing supports and programs that give the member focused actions and the employer proactive initiatives including:

Individualized Wellness Supports

Awareness, education, and behavior support tools provide access to personalized health assessments and health records. Worksite wellness programs for screenings as well as counseling and online health coach reminders, trackers, and tools are also available for use by members.

MyUHC.com

This website is an online health coaching tool that is customized according to members' needs. MyUHC.com helps members with many of their needs, from managing their diabetes or making informed choices about a heart healthy lifestyle, to finding answers to questions about nutrition and weight loss or managing stress. The site also provides information and assistance with smoking cessation.

Cultural Specific Programs

Cultural and ethnic backgrounds can affect a member's health risk and wellness lifestyle. These programs focus on providing culturally specific wellness resources for African American, Latino, and Asian American members including health history mapping, recipes and finding a culturally similar doctor.

Worksite Solutions

Periodic onsite screening of cholesterol, blood pressure, glucose, and body mass index to identify personal health risk factors are offered. Solutions are also provided to the employer for reporting capabilities, wellness website tools, videos and podcasts, incentive solutions, and health rewards.

Member Focused Engagement Tools

A variety of tools are made available to members. Some of these include:

- Health Assessment using a University of Michigan assessment tool
- Online Health Coaching focused on diabetes, exercise, nutrition, weight loss, etc.
- Nurse Line with access to a nurse 24 hours a day to answer questions
- Employer tools such as wellness initiatives, behavior modification, Dr. Oz video clips, etc.

Summary of Scores vs. Maryland and National Benchmarks

Quality and Performance Measure Summaries

The table below provides a summary of clinical performance measures and indicators, as well as an account of how many of the Maryland health benefit plans had quality and performance scores equivalent to or better than the Maryland average and/or better than the National average. Notes specific to each measure, where appropriate, are provided.

Maryland Average Benchmark (MAB):
The Maryland average benchmark is an average of the rates as reported to NCQA for the health benefit plans in this report. The average is calculated for eight HMOs, including HMO/POS and six PPOs including PPO/POS plans. If a health benefit plan reported NA, indicating Non Applicable due to an insufficient eligible population (<30 members) to calculate a rate, or NR, indicating Not Reportable due to bias in the results, then the NA and NR were not included in the calculation of the Maryland average benchmark.

National Average Benchmark (NAB):
The National average benchmark is an average of the rates as reported to NCQA for all of the health benefit plans across the United States and its territories. A mean value of each reported rate is taken from NCQA's HEDIS Audit Means, Percentiles and Ratios – Commercial HMO/POS and Commercial PPO plans, which is released to the public each year. The NCQA data set gives prior-year rates for each measure displayed as the mean rate and the rate at the 10th, 25th, 50th, 75th, and 90th percentiles. NCQA averages the rates of all organizations submitting HEDIS performance results gathered through the administrative, supplemental or hybrid methods. Therefore, the method for calculating the NAB is the same as that used for calculating the MAB, but on a larger scale. The national average benchmarks used here are based on quality and performance reported in 2011.

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (8-HMO/6-PPO)		Number of Health Benefit Plans Scoring Better Than the National Average (8-HMO/6-PPO)	
	HMO/POS	PPO	HMO/POS	PPO
Primary Care and Wellness for Children and Adolescents				
Children and Adolescents Access to Primary Care Providers (12–24 months)	6	5	4	5
Children and Adolescents Access to Primary Care Providers (25 months–6 years)	6	4	8	6
Children and Adolescents Access to Primary Care Providers (7–11 years)	6	4	8	6
Children and Adolescents Access to Primary Care Providers (12–19 years)	6	4	6	5
Well-Child Visits in the First 15 Months of Life (0 visits)	7	3	7	3
Well-Child Visits in the First 15 Months of Life (1–4 visits)	7	3	0	1
Well-Child Visits in the First 15 Months of Life (5+ visits)	6	4	8	4

continued

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Summary of Scores vs. Maryland and National Benchmarks

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (8-HMO/6-PPO)		Number of Health Benefit Plans Scoring Better Than the National Average (8-HMO/6-PPO)	
	HMO/POS	PPO	HMO/POS	PPO
Primary Care and Wellness for Children and Adolescents continued				
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	6	4	8	6
Childhood Immunization Status (Combo 10 – all vaccines/antigens)	7	2	5	5
Adolescent Well-Care Visits	7	3	8	6
Immunizations for Adolescents (Combo 1)	7	4	7	6
Human Papillomavirus Vaccine for Female Adolescents	3	1	**	**
Counseling for Physical Activity for Children and Adolescents	5	3	5	3
Follow-Up Care for Children Prescribed ADHD Medication (Initiation phase)	5	3	3	1
Follow-Up Care for Children Prescribed ADHD Medication (Continuation phase)	5	2	1	2
Child Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis	7	4	8	6
Appropriate Treatment for Children with Upper Respiratory Infection	7	5	3	3
Use of Appropriate Medications for Children with Asthma (5–11 years)	6	3	2	1
Use of Appropriate Medications for Children with Asthma (12–18 years)	6	3	**	**
Medication Management for Children with Asthma (5–11 years, 50% treatment period compliance)	3	1	**	**
Medication Management for Children with Asthma (12–18 years, 50% treatment period compliance)	3	1	**	**
Medication Management for Children with Asthma (5–11 years, 75% treatment period compliance)	3	1	**	**
Medication Management for Children with Asthma (12–18 years, 75% treatment period compliance)	3	1	**	**

** No benchmarks available except Maryland average

continued

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Summary of Scores vs. Maryland and National Benchmarks

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (8-HMO/6-PPO)		Number of Health Benefit Plans Scoring Better Than the National Average (8-HMO/6-PPO)	
	HMO/POS	PPO	HMO/POS	PPO
Women's Health				
Prenatal Care	6	3	8	6
Postpartum Care	5	4	4	6
Breast Cancer Screening	7	4	1	4
Cervical Cancer Screening	7	5	5	5
Chlamydia Screening in Women (16–24 years)	7	4	6	4
Primary Care for Adults – *General Health*				
Adults Access to Preventive/Ambulatory Health Services (20–44 years)	6	5	2	4
Adult Body Mass Index (BMI) Assessment	5	3	5	3
Colorectal Cancer Screening	4	5	4	6
Primary Care for Adults – *Respiratory Condition*				
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	8	3	2	1
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	7	2	7	4
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Systemic Corticosteroid)	5	2	4	1
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator)	6	2	3	2
Use of Appropriate Medications for People with Asthma (19–50 years)	6	2	**	**
Use of Appropriate Medications for People with Asthma (51–64 years)	6	2	**	**
Medication Management for People with Asthma (19–50 years, 50% treatment period compliance)	3	1	**	**

** No benchmarks available except Maryland average

continued

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Summary of Scores vs. Maryland and National Benchmarks

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (8-HMO/6-PPO)		Number of Health Benefit Plans Scoring Better Than the National Average (8-HMO/6-PPO)	
	HMO/POS	PPO	HMO/POS	PPO
Primary Care for Adults – *Respiratory Condition* continued				
Medication Management for People with Asthma (51–64 years, 50% treatment period compliance)	3	1	**	**
Medication Management for People with Asthma (19–50 years, 75% treatment period compliance)	4	1	**	**
Medication Management for People with Asthma (51–64 years, 75% treatment period compliance)	3	1	**	**
Primary Care for Adults – *Cardiovascular Conditions and Diabetes*				
Cholesterol Management for Patients with Cardiovascular Conditions (LDL level)	6	3	2	5
Controlling High Blood Pressure	7	3	3	3
Persistence of Beta-Blocker Treatment After a Heart Attack	3	2	5	4
Retinal Examination for Diabetics	5	5	3	5
Primary Care for Adults – *Musculoskeletal Disease and Medication Management*				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	5	4	1	1
Use of Imaging Studies for Low Back Pain	5	5	4	0
Annual Monitoring for Patients on Digoxin	4	1	3	1
Behavioral Health				
Antidepressant Medication Management (Effective–Acute Phase)	6	4	5	6
Antidepressant Medication Management (Effective–Continuation Phase)	6	3	4	6
Follow-Up After Hospitalization for Mental Illness (7 days)	6	4	1	1
Follow-Up After Hospitalization for Mental Illness (30 days)	6	3	0	2

** No benchmarks available except Maryland average

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Primary Care and Wellness for Children and Adolescents

Maintaining available access, encouraging preventive care, and evaluation can all contribute to better overall health and the detection of childhood and adolescent conditions that can be detrimental to future adult health. This type of wellness management can also assist in lowering hospital utilization, detecting developing speech, vision, and language problems, and reducing the need for further health expenditures.

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Children and Adolescents Access to Primary Care Providers

DESCRIPTION

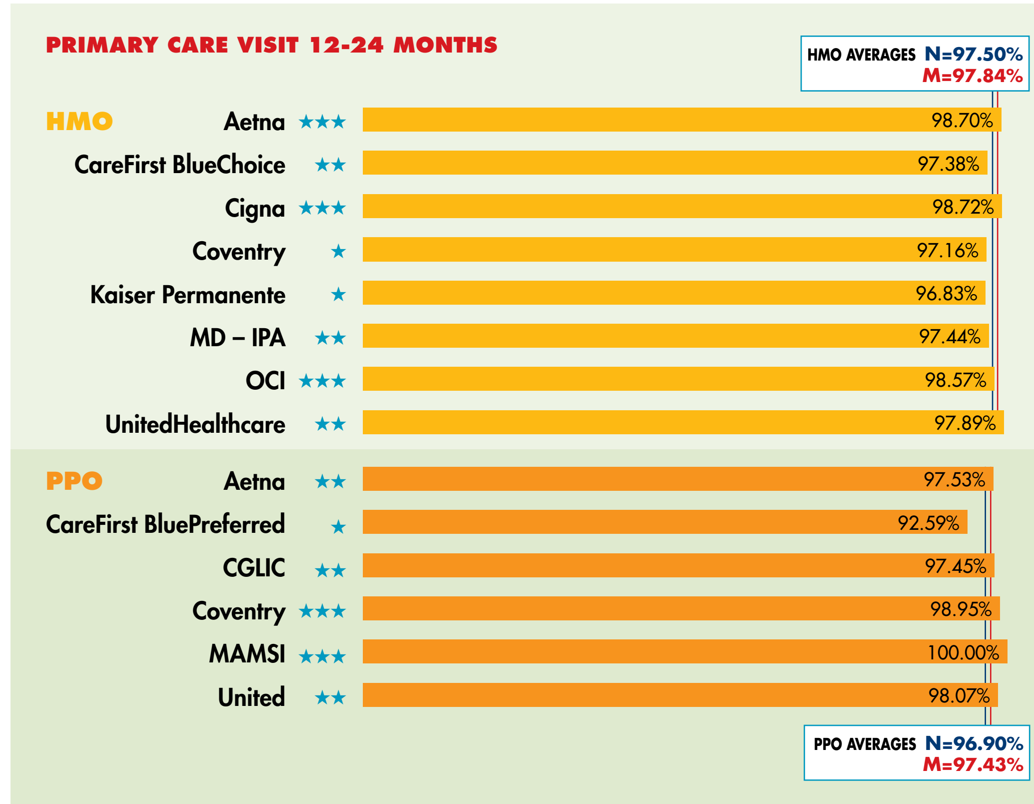
Each health benefit plan reports on multiple indicators under this measure. Four separate indicators include:

1. The percentage of children 12–24 months who had a visit with a primary care provider during the measurement year (2011).

For this performance indicator, a higher percentage is better, which means that toddlers did have a visit to a primary care provider.

RATIONALE

Although access to primary care has been shown to correlate with reduced hospital use while preserving quality and performance (Bodenheimer 2005), this group of indicators does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality and performance of care delivered.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL —— MARYLAND ——

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Children and Adolescents Access to Primary Care Providers continued

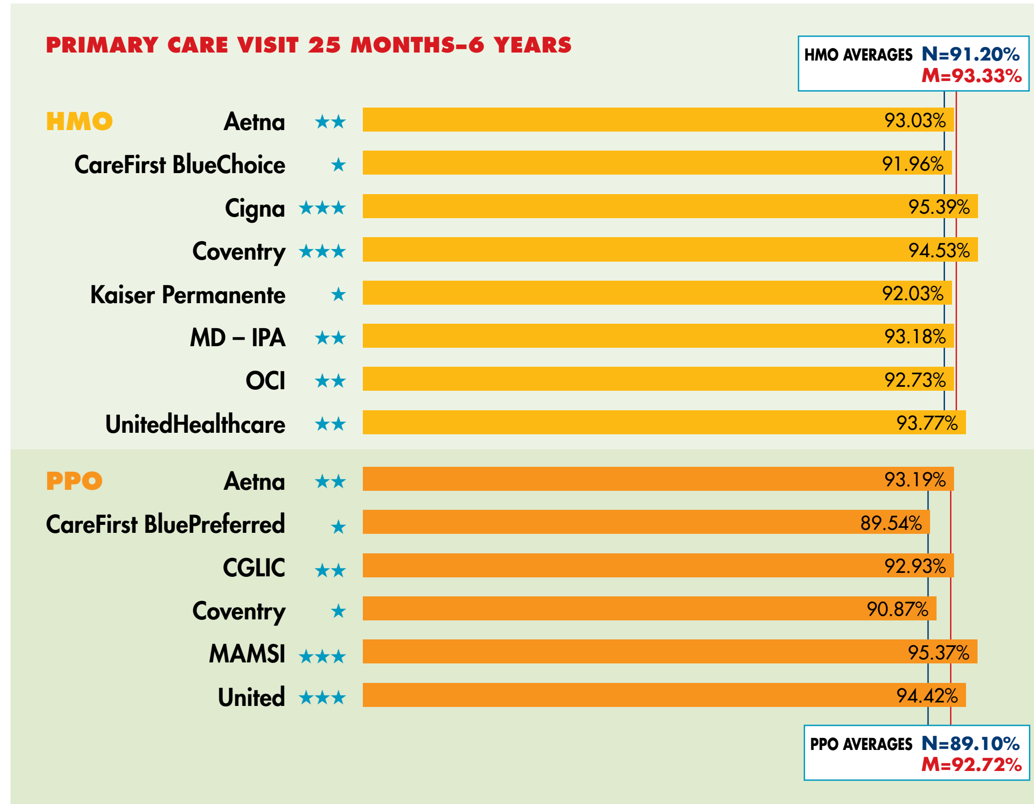
DESCRIPTION

2. The percentage of children 25 months–6 years who had a visit with a primary care provider during the measurement year (2011).

For this performance indicator, a higher percentage is better, which means that young children did have a visit to a primary care provider.

RATIONALE

Although access to primary care has been shown to correlate with reduced hospital use while preserving quality and performance (Bodenheimer 2005), this group of indicators does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality and performance of care delivered.



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Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE

★★ EQUIVALENT TO MARYLAND AVERAGE

★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL —— MARYLAND ——

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Children and Adolescents Access to Primary Care Providers continued

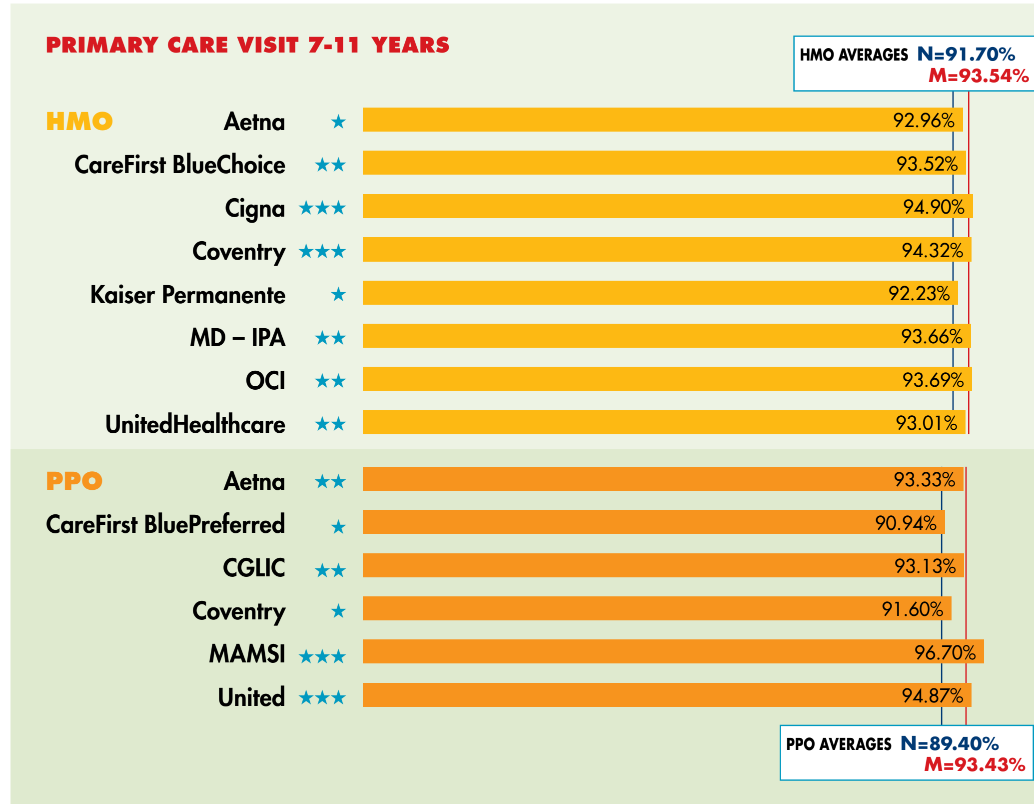
DESCRIPTION

3. The percentage of children 7–11 years who had a visit with a primary care provider during the measurement year (2011) or the year prior to the measurement year (2010).

For this performance indictor, a higher percentage is better, which means that older children did have a visit to a primary care provider.

RATIONALE

Although access to primary care has been shown to correlate with reduced hospital use while preserving quality and performance (Bodenheimer 2005), this group of indicators does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality and performance of care delivered.



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Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
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AVERAGES

NATIONAL — MARYLAND —

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Children and Adolescents Access to Primary Care Providers continued

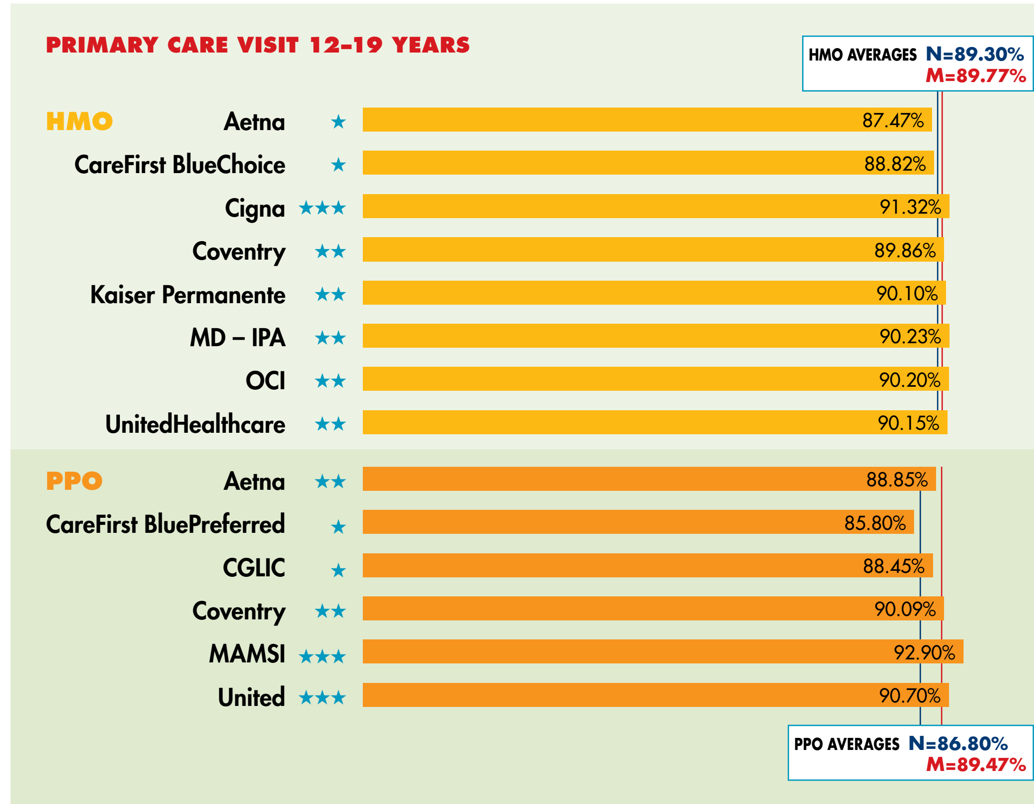
DESCRIPTION

4. The percentage of adolescents 12–19 years who had a visit with a primary care provider during the measurement year (2011) or the year prior to the measurement year (2010).

For this performance indicator, a higher percentage is better, which means that adolescents did have a visit to a primary care provider.

RATIONALE

Although access to primary care has been shown to correlate with reduced hospital use while preserving quality and performance (Bodenheimer 2005), this group of indicators does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality and performance of care delivered.



More stars mean better health benefit plan performance.

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Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL — MARYLAND —

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Well-Child Visits in the First 15 Months of Life

DESCRIPTION

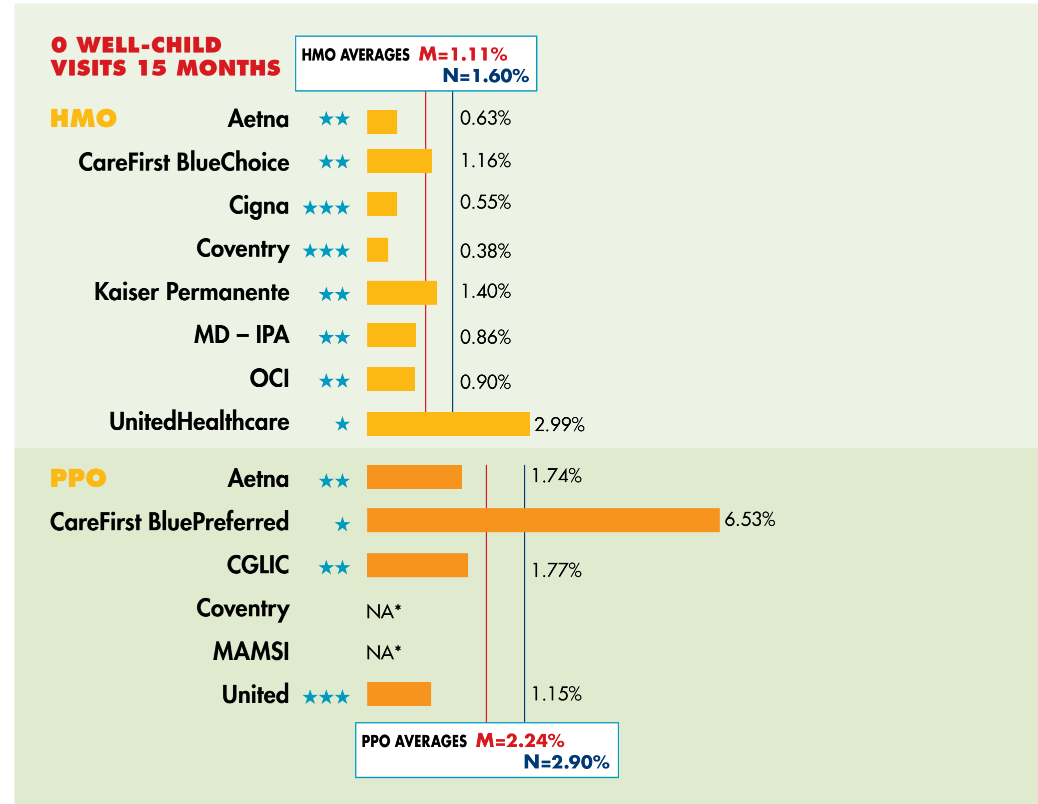
Each health benefit plan reports on multiple indicators under this measure. Three separate indicators include:

1. The percentage of members who turned 15 months old during the measurement year (2011) who had no well-child visits with a primary care provider during their first 15 months of life.

For this performance indicator, a lower percentage is better, which means that more children did have a well-child visit with a primary care provider and fewer children had zero visits, which is desirable.

RATIONALE

This group of indicators looks at the adequacy of well-child care for infants. Regular check-ups are one of the best ways to detect physical, developmental, behavioral, and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents. These visits are of particular importance during the first two years of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination, as well as social and emotional growth.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL — MARYLAND —

*NA – Insufficient eligible members (fewer than 30) to calculate rate

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

Well-Child Visits in the First 15 Months of Life continued

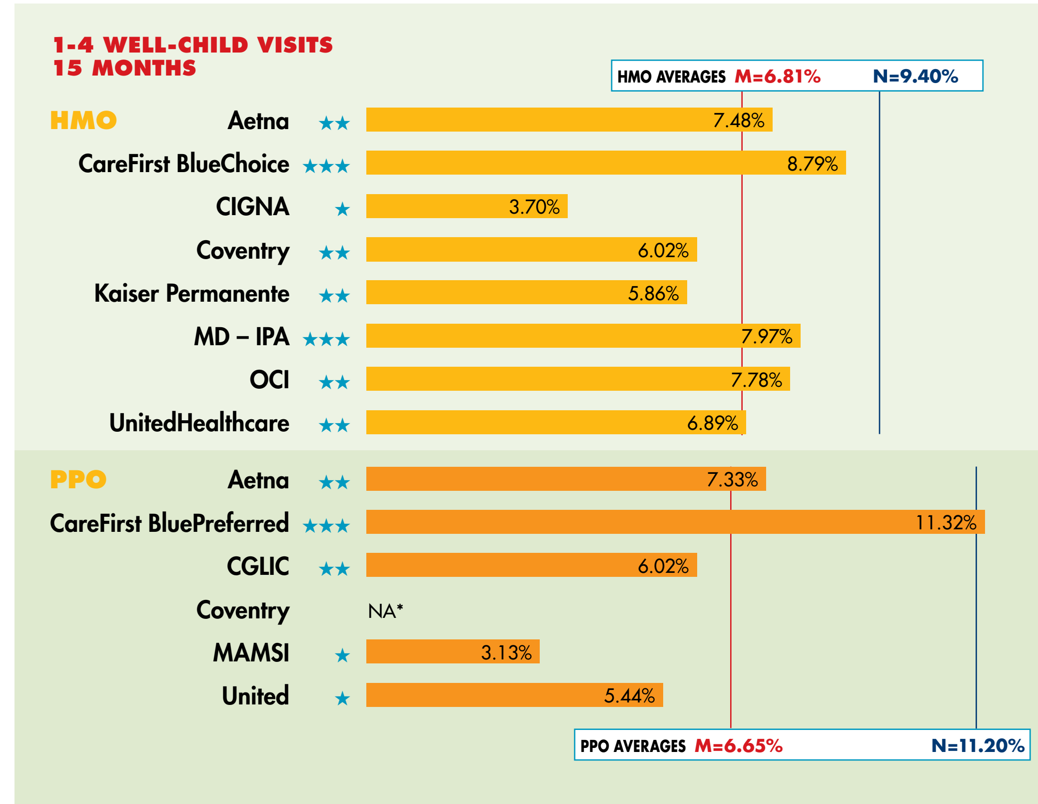
DESCRIPTION

2. The percentage of members who turned 15 months old during the measurement year (2011) who had one to four well-child visits with a primary care provider during their first 15 months of life.

For this performance indicator, a higher percentage is better, which means that the children did have one to four visits to a primary care provider.

RATIONALE

This group of indicators looks at the adequacy of well-child care for infants. Regular check-ups are one of the best ways to detect physical, developmental, behavioral, and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents. These visits are of particular importance during the first two years of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination, as well as social and emotional growth.



More stars mean better health benefit plan performance. ▶

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL —— MARYLAND ——

*NA – Insufficient eligible members (fewer than 30) to calculate rate

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Well-Child Visits in the First 15 Months of Life continued

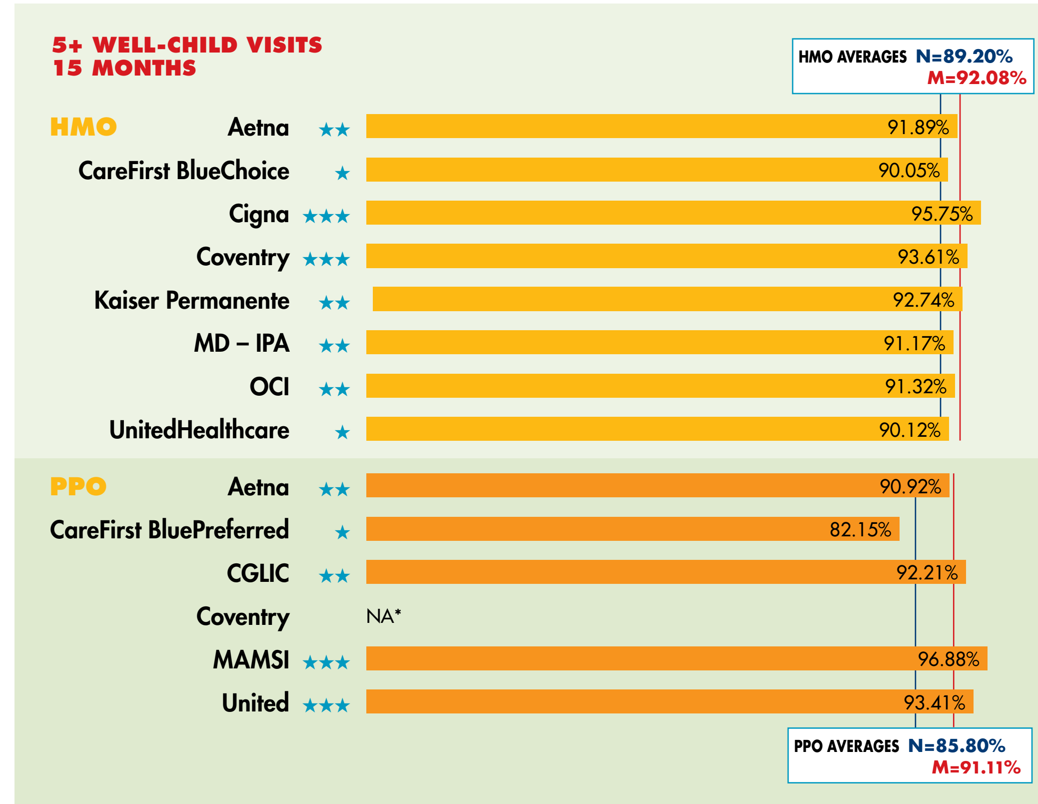
DESCRIPTION

3. The percentage of members who turned 15 months old during the measurement year (2011) who had five or more well-child visits with a primary care provider during their first 15 months of life.

For this performance indicator, a higher percentage is better, which means that the children did have five or more visits to a primary care provider.

RATIONALE

This group of indicators looks at the adequacy of well-child care for infants. Regular check-ups are one of the best ways to detect physical, developmental, behavioral, and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents. These visits are of particular importance during the first two years of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination, as well as social and emotional growth.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL — MARYLAND —

*NA – Insufficient eligible members (fewer than 30) to calculate rate

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

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

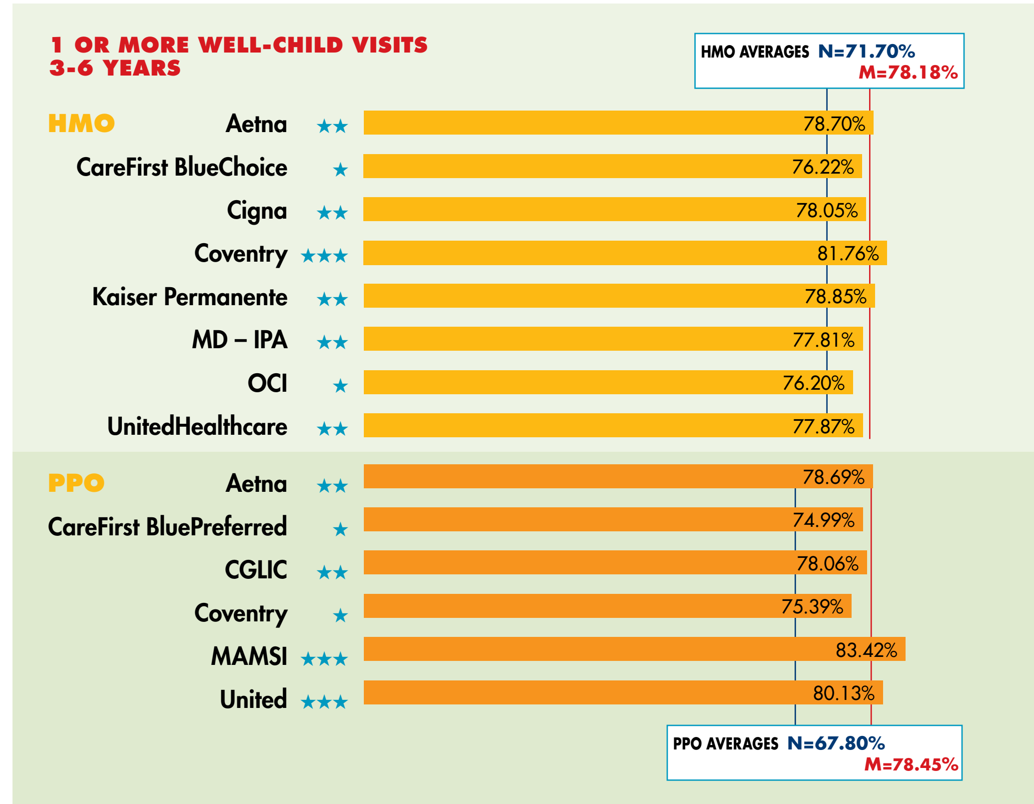
DESCRIPTION

The percentage of members 3–6 years of age who received one or more well-child visits with a primary care provider during the measurement year (2011).

For this measure, a higher percentage is better, which means that the children did have one or more well-child visits to a primary care provider.

RATIONALE

This measure looks at the use of routine check-ups by preschool and early school-age children. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems.



More stars mean better health benefit plan performance.

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Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL — MARYLAND —

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

Childhood Immunization Status

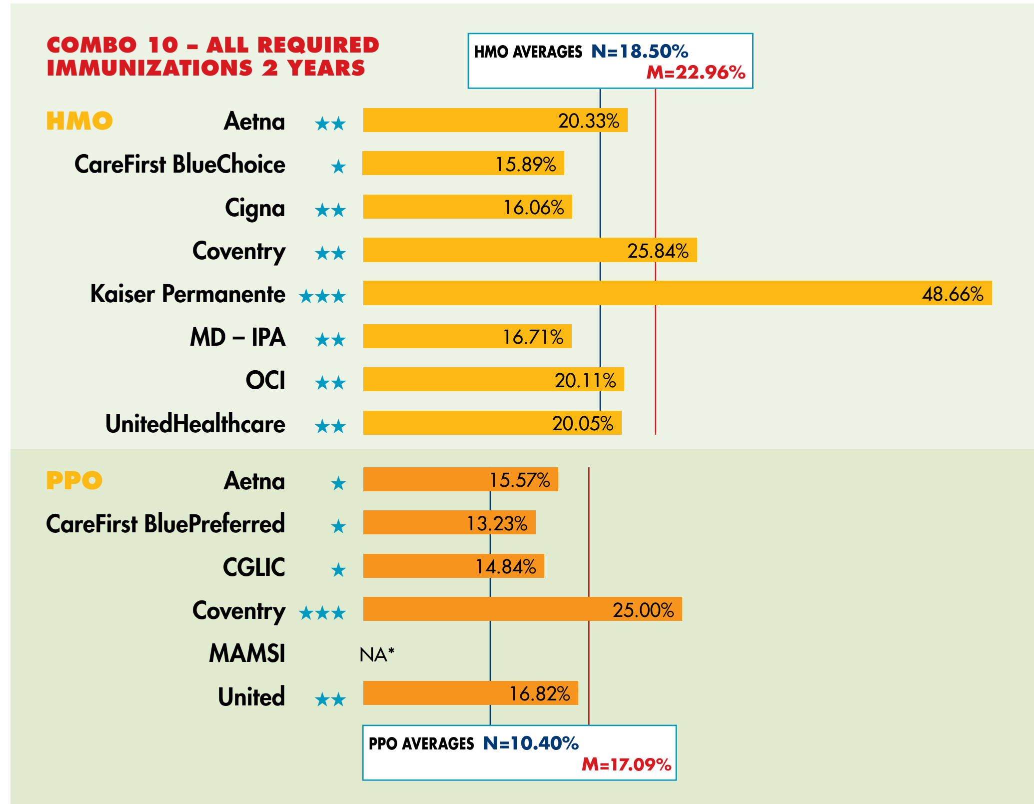
DESCRIPTION

The percentage of children who turned two years of age in 2011, that had all of the required immunizations before turning age two. These immunizations include those listed as Combination 10 in the table below. The measure calculates a rate for each of the following immunizations: four diphtheria, tetanus, and acellular pertussis (DTaP); three inactivated polio virus (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four Pneumococcal Conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza vaccines. The measure calculates one rate for each vaccine and nine separate combination rates.

For this measure, a higher percentage is better, which means that the toddlers did get all their required immunizations.

RATIONALE

Childhood immunizations help prevent the spread of serious communicable illnesses such as polio, tetanus, and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
- ★★★ BETTER THAN MARYLAND AVERAGE
- ★★ EQUIVALENT TO MARYLAND AVERAGE
- ★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL —— MARYLAND ——

*NA – Insufficient eligible members (fewer than 30) to calculate rate

	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 2	X	X	X	X	X	X				
Combination 3	X	X	X	X	X	X	X			
Combination 4	X	X	X	X	X	X	X	X		
Combination 5	X	X	X	X	X	X	X		X	
Combination 6	X	X	X	X	X	X	X			X
Combination 7	X	X	X	X	X	X	X	X	X	
Combination 8	X	X	X	X	X	X	X	X		X
Combination 9	X	X	X	X	X	X	X		X	X
Combination 10	X	X	X	X	X	X	X	X	X	X

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Adolescent Well-Care Visits

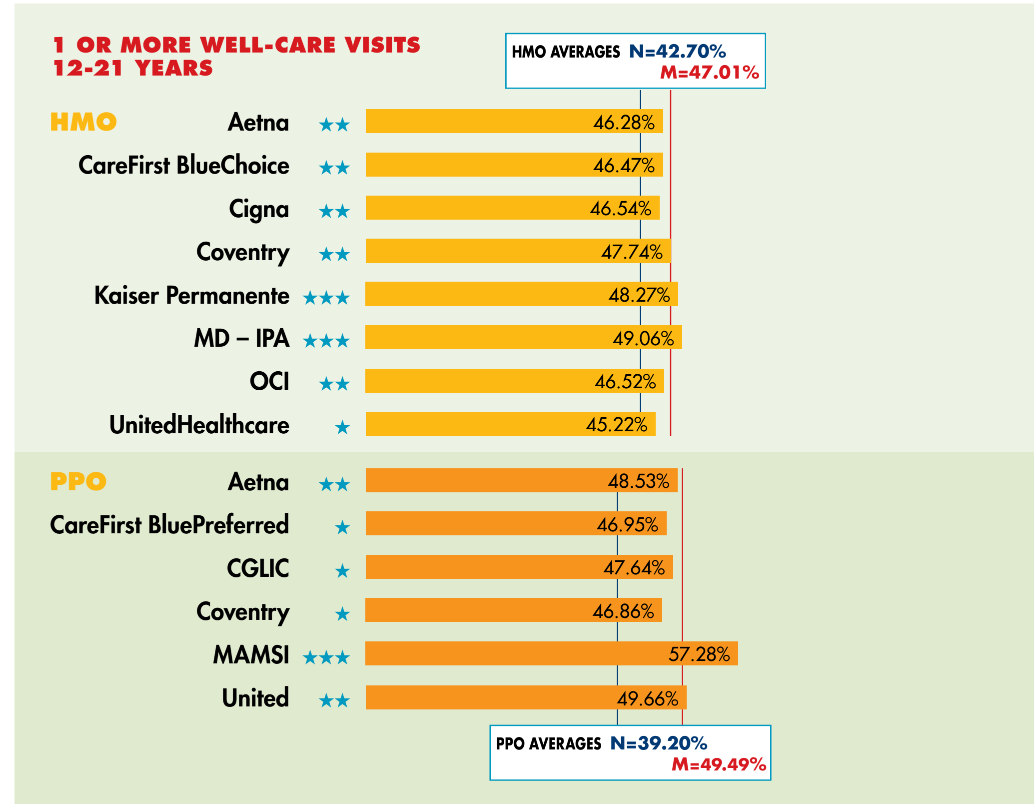
DESCRIPTION

The percentage of members 12–21 years of age in 2011, who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year (2011).

For this measure, a higher percentage is better, which means that adolescents did have one or more well-care visits to a PCP or an OB/GYN.

RATIONALE

This measure looks at the use of regular check-ups by adolescents. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional, and social aspects of their health. Not only are accidents, homicide and suicide the leading causes of adolescent deaths, but sexually transmitted diseases, substance abuse, pregnancy, and antisocial behavior are also important causes of, or result from, physical, emotional, and social adolescent problems.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL — MARYLAND —

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

Immunizations for Adolescents

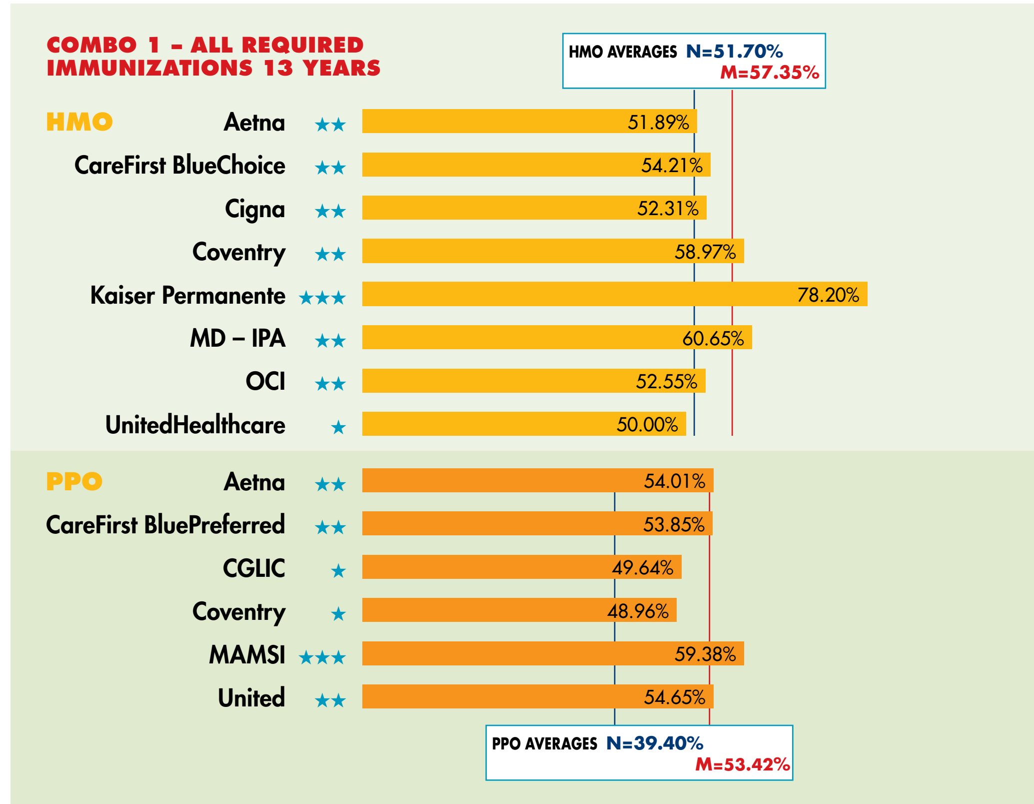
DESCRIPTION

The percentage of adolescents who turned 13 years of age in 2011, who had all required immunizations by their 13th birthday. These immunizations include one dose of meningococcal vaccine and one tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td). The measure calculates a rate for each vaccine and one combination rate. Only the combination rate is reported.

For this measure, a higher percentage is better, which means that adolescents did get all their required immunizations.

RATIONALE

Low immunization rates among adolescents have the potential to cause outbreaks of preventable diseases and to establish reservoirs of disease in adolescents that can affect other susceptible populations with lower levels of immunity, including infants, the elderly and individuals with chronic conditions.



More stars mean better health benefit plan performance. ▶

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL —— MARYLAND ——

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

Human Papillomavirus Vaccine for Female Adolescents

DESCRIPTION

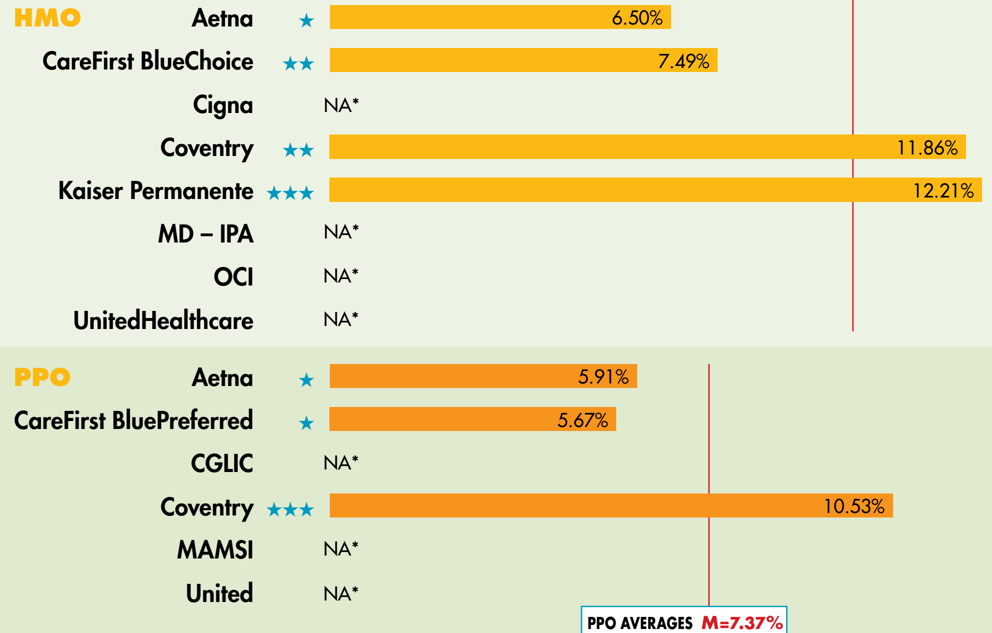
The percentage of female adolescents 13 years of age in 2011, who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

There is no national average benchmark for this measure as this is a first-year measure in 2012 and data for this measure is not publicly reported at the national level.

For this measure, a higher percentage is characterized as better, which means that the guardians for these female minors not only authorized the HPV vaccination, but also followed through with two additional visits in order to complete the three-shot optional vaccination series.

RATIONALE

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. According to the Centers for Disease Control and Prevention (CDC), approximately 20 million Americans are infected with genital HPV, which is responsible for nearly 70 percent of cases of cervical cancer and 90 percent of cases of anogenital warts. Administering widespread vaccination for HPV could reduce cervical cancer deaths around the world by as much as two-thirds if all young, sexually active women received the vaccination and if protection turns out to be long-term. The HPV vaccine could reduce the need for medical care, biopsies, and invasive procedures associated with follow-up from abnormal Pap tests, thereby reducing health care costs from abnormal Pap tests and follow-up procedures.



More stars mean better health benefit plan performance.

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Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL —— MARYLAND ——

*NA – Insufficient eligible members (fewer than 30) to calculate rate

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

Counseling for Physical Activity for Children and Adolescents

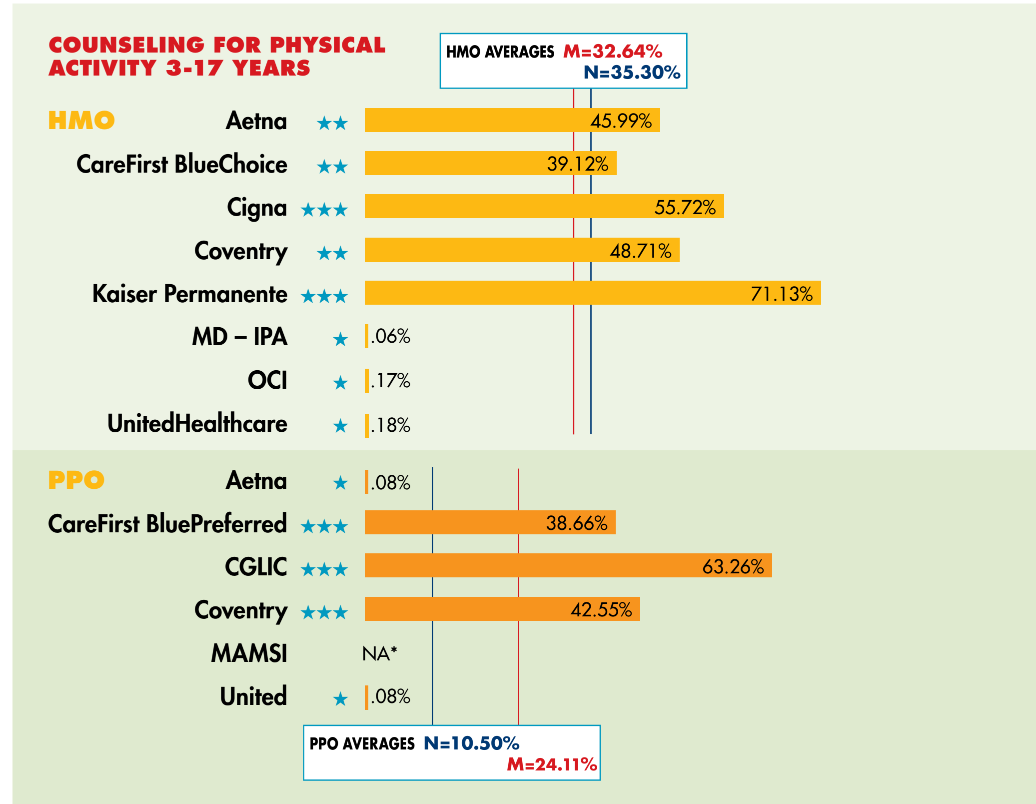
DESCRIPTION

The percentage of members 3–17 years of age in 2011, who had an outpatient visit with a primary care provider (PCP) or obstetrician/gynecologist (OB/GYN) practitioner and who had evidence of counseling for physical activity during the measurement year (2011).

For this measure, a higher percentage is better, which means that children did receive counseling for physical activity during a visit to their PCP or OB/GYN.

RATIONALE

The Centers for Disease Control and Prevention (CDC) states that overweight children and adolescents are more likely to become obese as adults. Screening for overweight or obesity begins in the provider's office with the calculation of body mass index. Medical evaluations should include investigation into possible causes of obesity that may be responsive to treatment such as thyroid gland dysfunction or other issues. Medical evaluations should also include counseling for nutrition and physical activity as well as identification of any obesity-related health complications.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL ▬ MARYLAND ▬

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care and Wellness for Children and Adolescents

Follow-Up Care for Children Prescribed ADHD Medication

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of children 6–12 years of age during the intake period from March 1st, 2011 to February 29th, 2012, that were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication, who also had at least three follow-up care visits within a 10-month period.

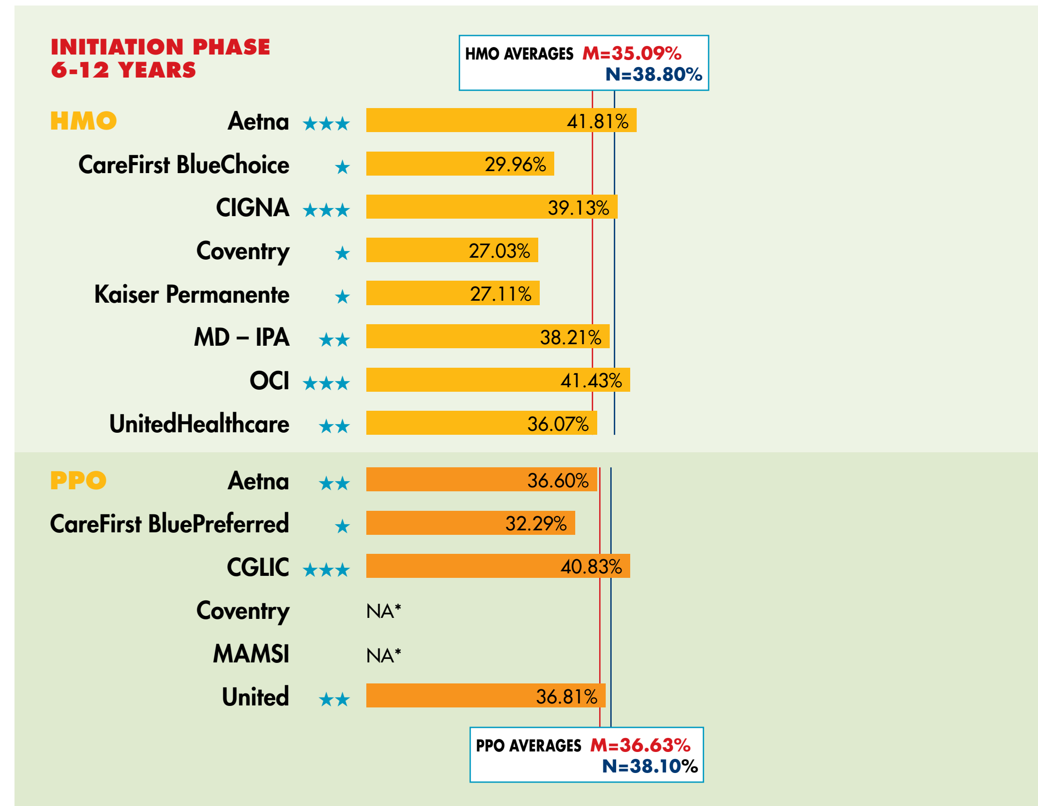
Two rates are reported for this measure:

1. *Initiation Phase.* The percentage of pre-teen children 6–12 years of age with a prescription for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the initial 30 days of when the first ADHD medication was prescribed [Index Prescription Start Date (IPSD)].

For this performance indicator, a higher percentage is better, which means that children did have a follow-up visit during the 30-day Initiation Phase.

RATIONALE

Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic conditions. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems. Effective medications are available to treat ADHD. The American Academy of Pediatrics (AAP) guidelines recommend that once a child is stable on ADHD medication, an office visit every three to six months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized. It should be noted that while not measured, there have also been some reported "drug holidays" from ADHD medications taken by children when the child is out of school for extended periods, such as during the summer.



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PERFORMANCE RATING
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AVERAGES
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Follow-Up Care for Children Prescribed ADHD Medication continued

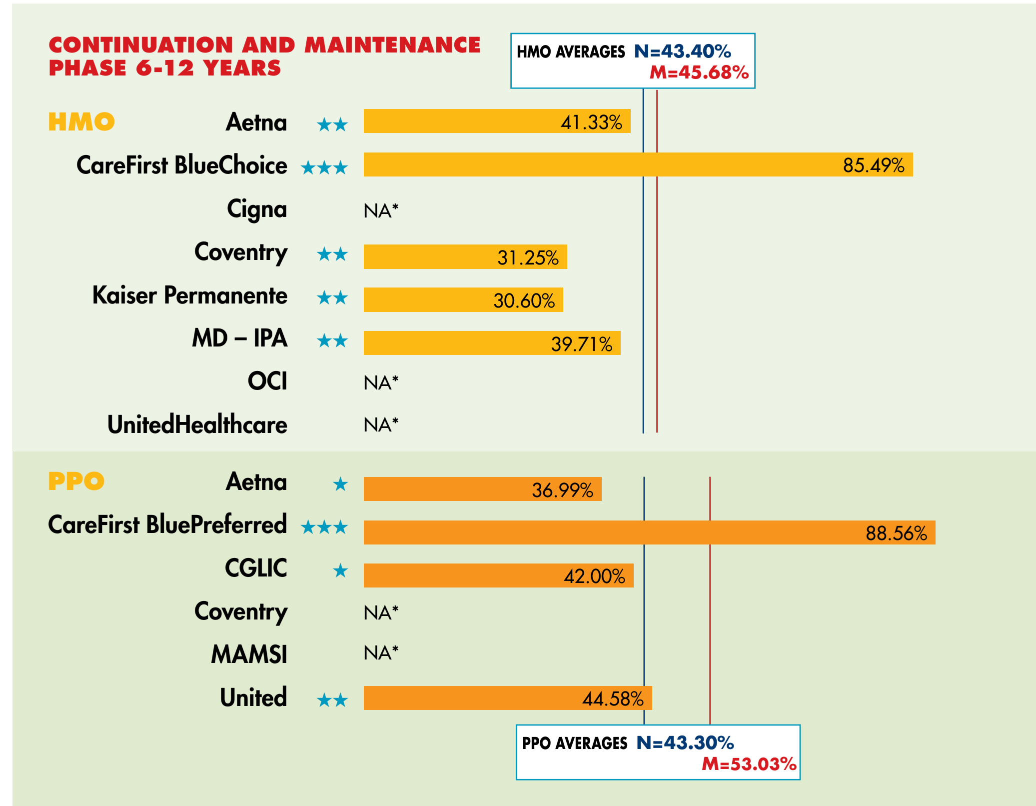
DESCRIPTION continued

2. *Continuation and Maintenance (C&M) Phase.* The percentage of pre-teen children 6–12 years of age with a prescription for ADHD medication, who remained on the medication for at least 210 days (7 months) and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner with prescribing authority within the next 270 days (9 months) after the Initiation Phase ended.

For this performance indicator, a higher percentage is better, which means that children did have at least two follow-up visits over the nine month period following the end of the 30-day Initiation Phase.

RATIONALE

Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic conditions. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems. Effective medications are available to treat ADHD. The American Academy of Pediatrics (AAP) guidelines recommend that once a child is stable on ADHD medication, an office visit every three to six months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized. It should be noted that while not measured, there have also been some reported "drug holidays" from ADHD medications taken by children when the child is out of school for extended periods, such as during the summer.



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Child Respiratory Conditions

The excess use of antibiotics and the under use of controlling medications for respiratory conditions can lead to an overall lowering of quality of life and an increase in health care costs. A recent push toward responsible antibiotic stewardship is helping to curb the nation's excess use of antibiotics. In addition, a push toward the appropriate use of medications, particularly controlling medications for people with respiratory conditions like asthma, is helping to control the rising cost of care.

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Child Respiratory Conditions

Appropriate Testing for Children with Pharyngitis

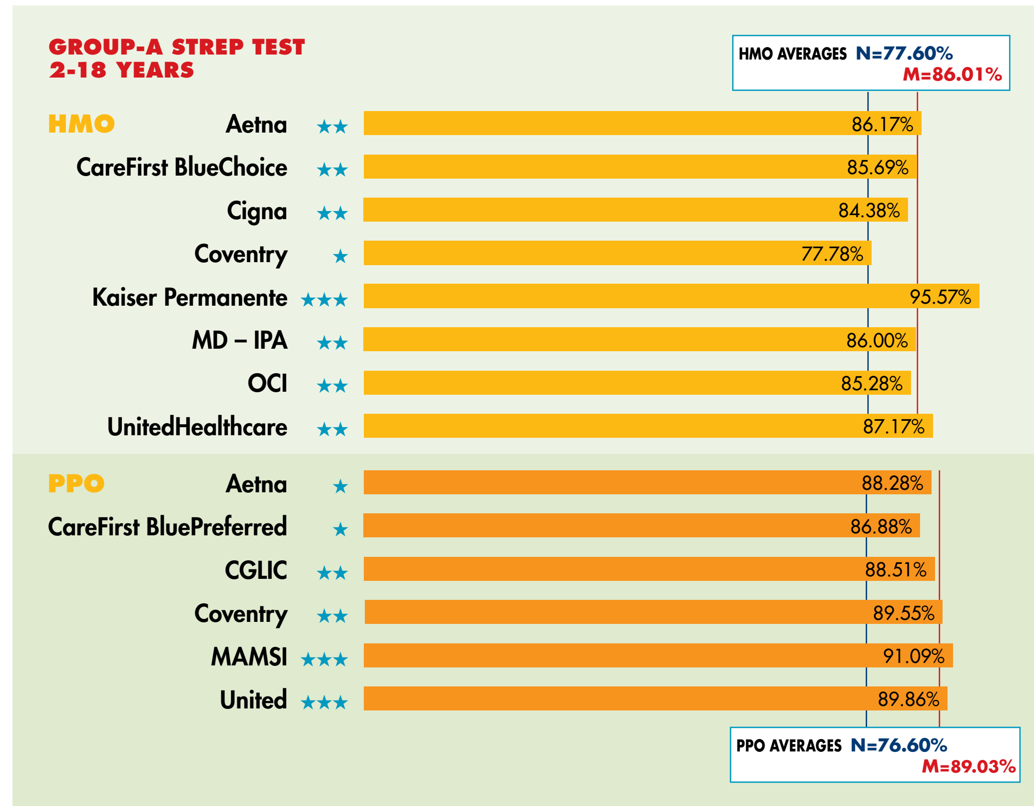
DESCRIPTION

The percentage of members 2–18 years of age in 2011, who after receiving a group-A streptococcus (strep) test, were diagnosed with pharyngitis and then given a prescription for an antibiotic.

For this measure, a higher percentage is better, which means that children 2-18 years of age did appropriately receive a strep test before getting an antibiotic prescription to treat pharyngitis.

RATIONALE

Pharyngitis is the only condition among upper respiratory infections (URIs) where diagnosis is easily and objectively validated through administrative and laboratory data, and can serve as an important indicator of appropriate antibiotic use among respiratory tract infections. Pediatric clinical practice guidelines recommend that only children with diagnosed group-A strep pharyngitis based on appropriate lab tests be treated with antibiotics. A strep test (rapid assay or throat culture) is the definitive test of group-A strep pharyngitis. Excess use of antibiotics is highly prevalent for pharyngitis.



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AVERAGES

NATIONAL —— MARYLAND ——

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Child Respiratory Conditions

Appropriate Treatment for Children with Upper Respiratory Infection

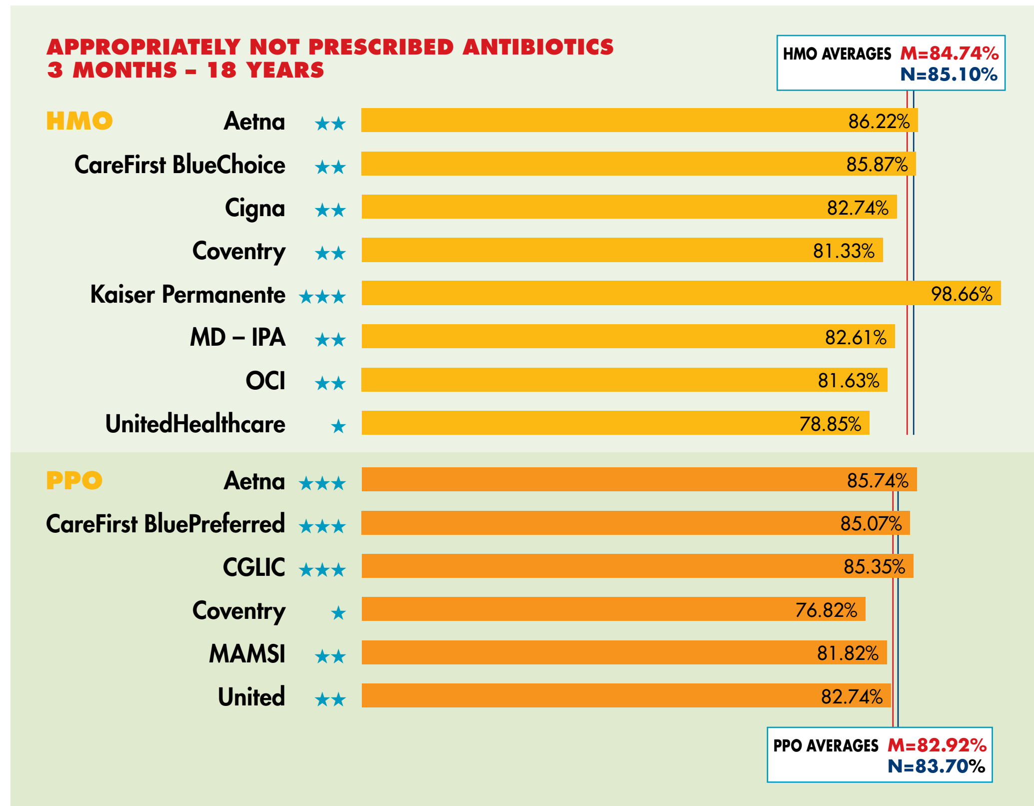
DESCRIPTION

The percentage of members 3 months to 18 years of age in 2011, who were identified as having an upper respiratory infection (URI) and were appropriately not given an antibiotic prescription within three days of their visit.

For this measure, a higher percentage is better, which means that children 3 months to 18 years of age appropriately did not get an antibiotic prescription.

RATIONALE

The common cold is an upper respiratory infection (URI) that is a frequent reason for children visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Pediatric clinical practice guidelines do not recommend antibiotics for a majority of upper respiratory infections due to the viral cause of many of these infections, including the common cold. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

Use of Appropriate Medications for Children with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of members 5–11 and 12–18 years of age during the measurement year (2011) who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. Please find adult ages 19-50 and 51-64 years in the Primary Care for Adults – Respiratory Conditions section.

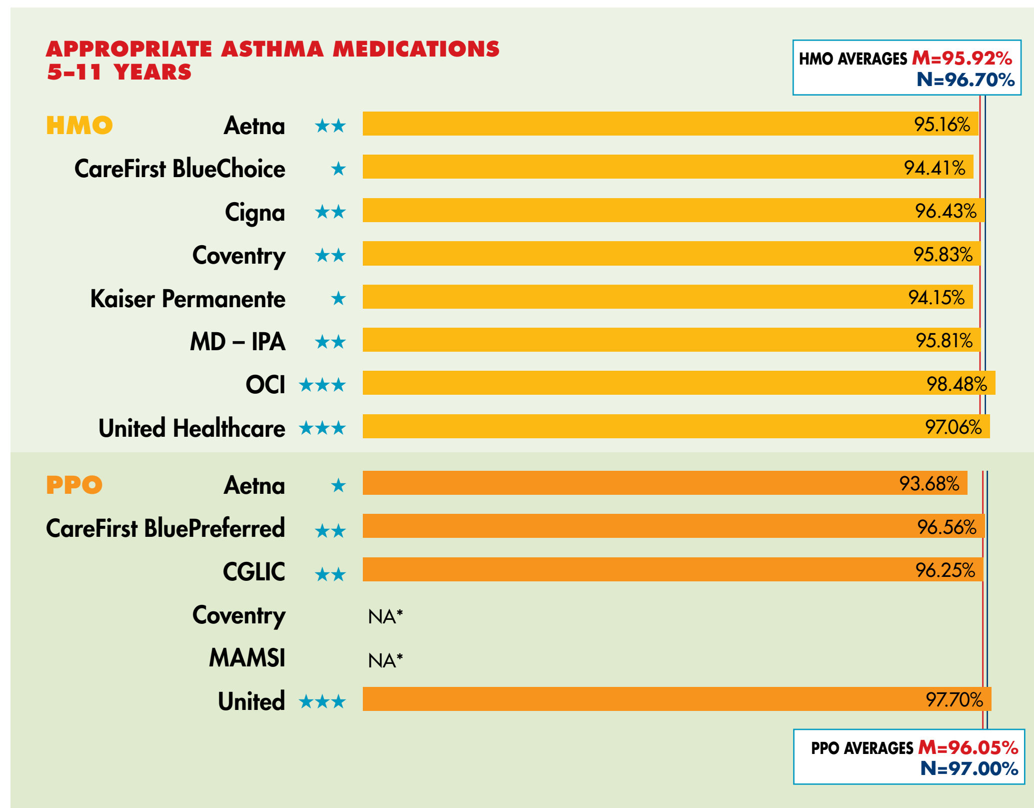
Two rates are reported for this measure:

1. The percentage of members 5–11 years of age, appropriately prescribed asthma controller medications.

For this performance indicator, a higher percentage is better, which means that young children with asthma were appropriately prescribed asthma medications.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 34.1 million Americans have been diagnosed with asthma and each year nearly 5,000 Americans die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.



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AVERAGES

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

Use of Appropriate Medications for Children with Asthma continued

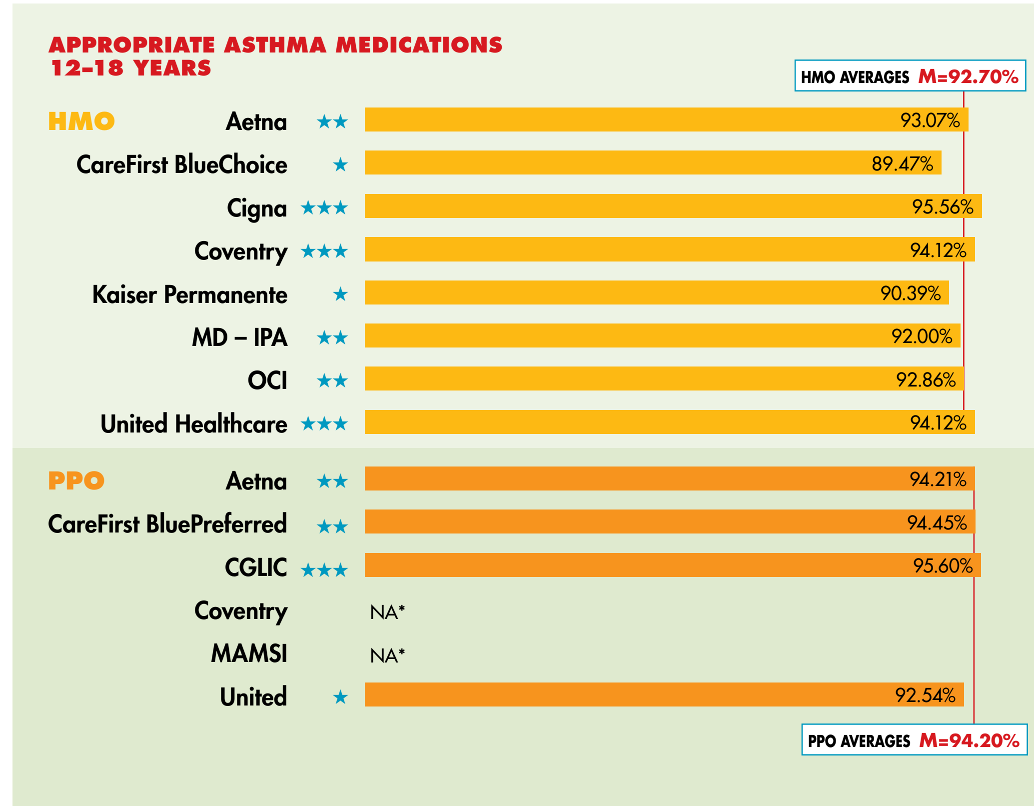
DESCRIPTION

2. The percentage of members 12–18 years of age, appropriately prescribed asthma controller medications.

For this performance indicator, a higher percentage is better, which means that older children with asthma were appropriately prescribed asthma medications.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 34.1 million Americans have been diagnosed with asthma and each year nearly 5,000 Americans die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Child Respiratory Conditions

Medication Management for Children with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of members 5–11 and 12–18 years of age during the measurement year (2011) who were identified as having persistent asthma, were given a prescription for an appropriate medication and who remained on that medication during the treatment period, for at least 50-75% of the remaining days in 2011. Please find adult ages 19–50 and 51–64 years in the Primary Care for Adults – Respiratory Conditions section.

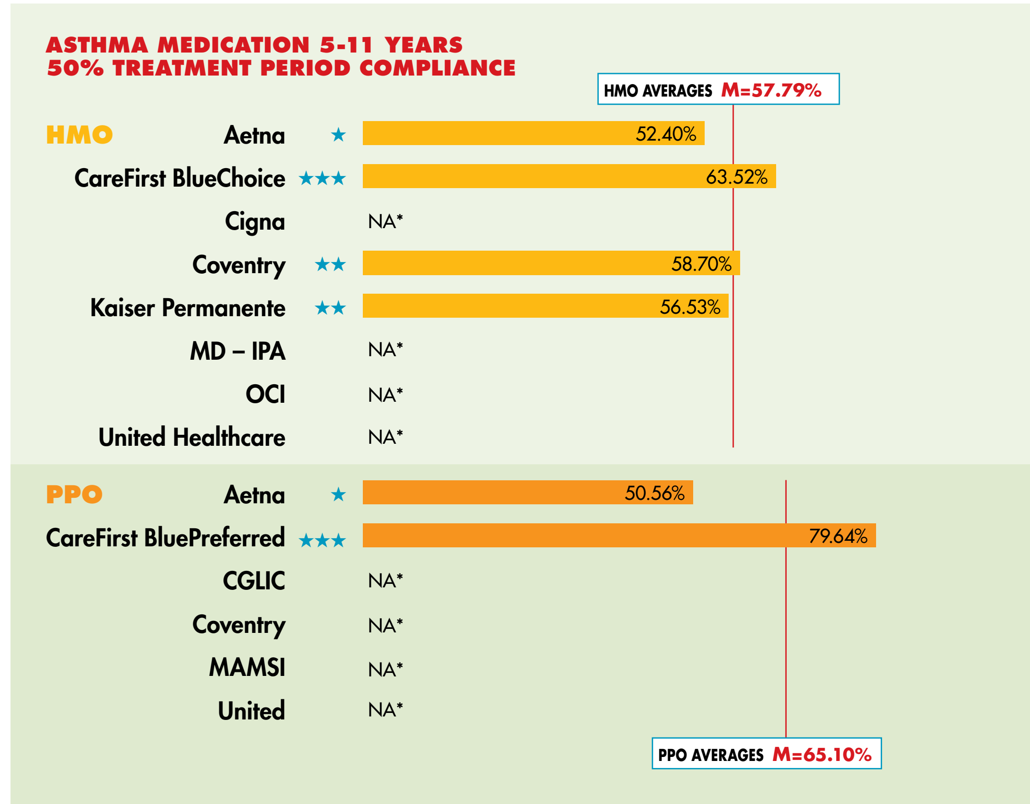
Four rates are reported for this measure:

1. The percentage of members 5–11 years of age, who remained on an asthma controller medication for at least 50 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that young children with asthma remained compliant on their asthma controller medication for at least 50% of the treatment period.

RATIONALE

Appropriate asthma medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered “not well controlled” or “very poorly controlled” as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

Medication Management for Children with Asthma continued

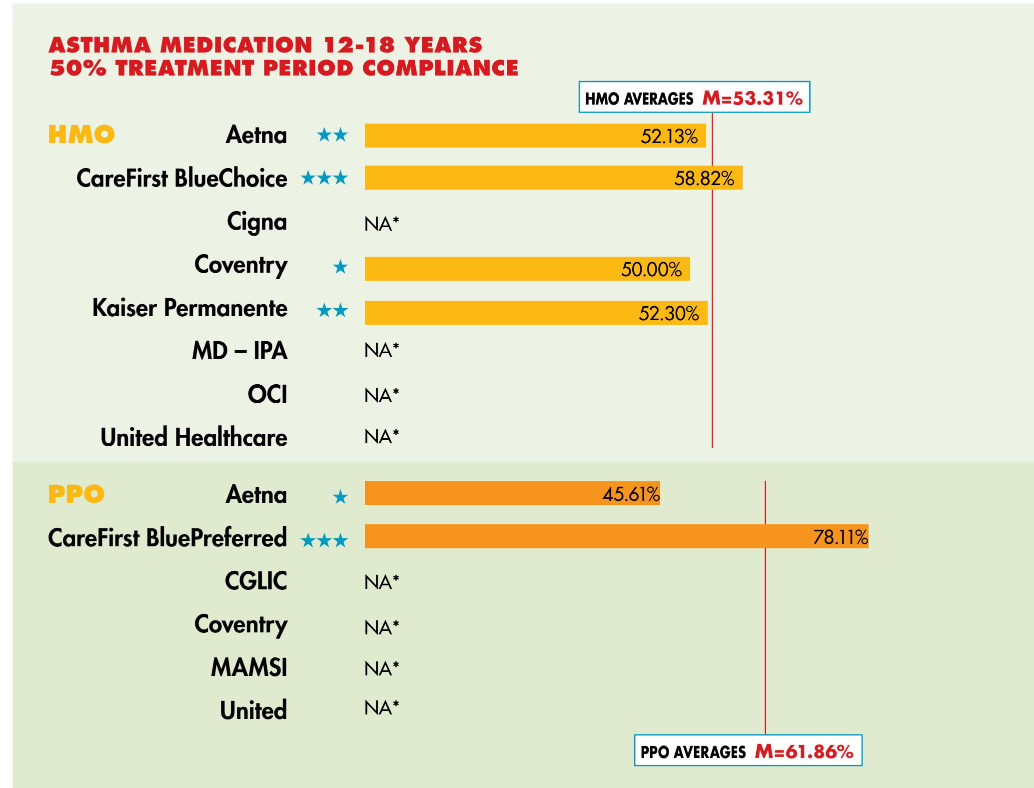
DESCRIPTION

2. The percentage of members 12–18 years of age, who remained on an asthma controller medication for at least 50 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that older children with asthma remained compliant on their asthma controller medication for at least 50% of the treatment period.

RATIONALE

Appropriate asthma medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

Medication Management for Children with Asthma continued

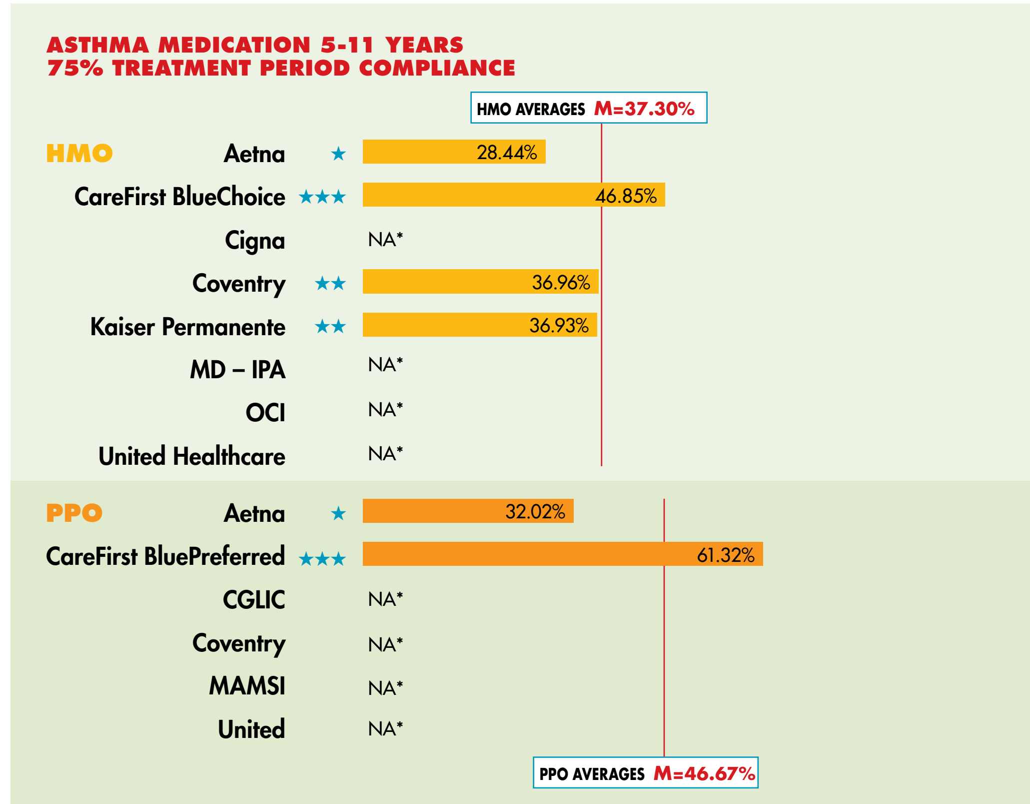
DESCRIPTION

3. The percentage of members 5-11 years of age, who remained on an asthma controller medication for at least 75 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that younger children with asthma remained compliant on their asthma controller medication for at least 75% of the treatment period.

RATIONALE

Appropriate asthma medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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PERFORMANCE RATING

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AVERAGES

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

Medication Management for Children with Asthma continued

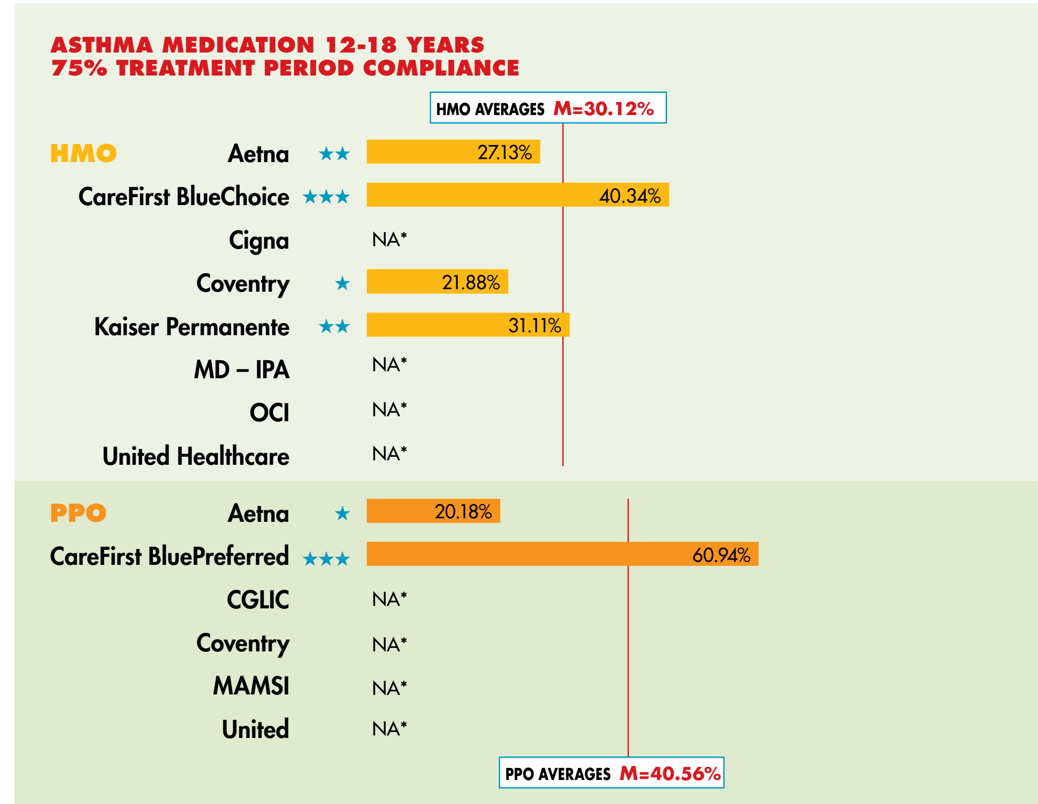
DESCRIPTION

4. The percentage of members 12–18 years of age, who remained on an asthma controller medication for at least 75 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that older children with asthma remained compliant on their asthma controller medication for at least 75% of the treatment period.

RATIONALE

Appropriate asthma medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered “not well controlled” or “very poorly controlled” as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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Women's Health

Prevention and early detection of illness lead to more treatment choices and better health outcomes for patients as well as lower overall costs for care. Preventative care, such as prenatal and postpartum care for women, as well as early detection programs including screenings for cancer and other illnesses can lead to a higher probability of survival for affected women and a healthier infant population.

Note: Some of the women's measures are subject to revision and update based on current research and clinical guidelines. The Breast Cancer Screening measure is one that is being considered for revision, based on recent findings concerning the recommended frequency for mammograms and the age groups most impacted.

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Women's Health

Prenatal and Postpartum Care

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of women who had deliveries of live births between November 6 of the year prior to the measurement year (2010) and November 5 of the measurement year (2011).

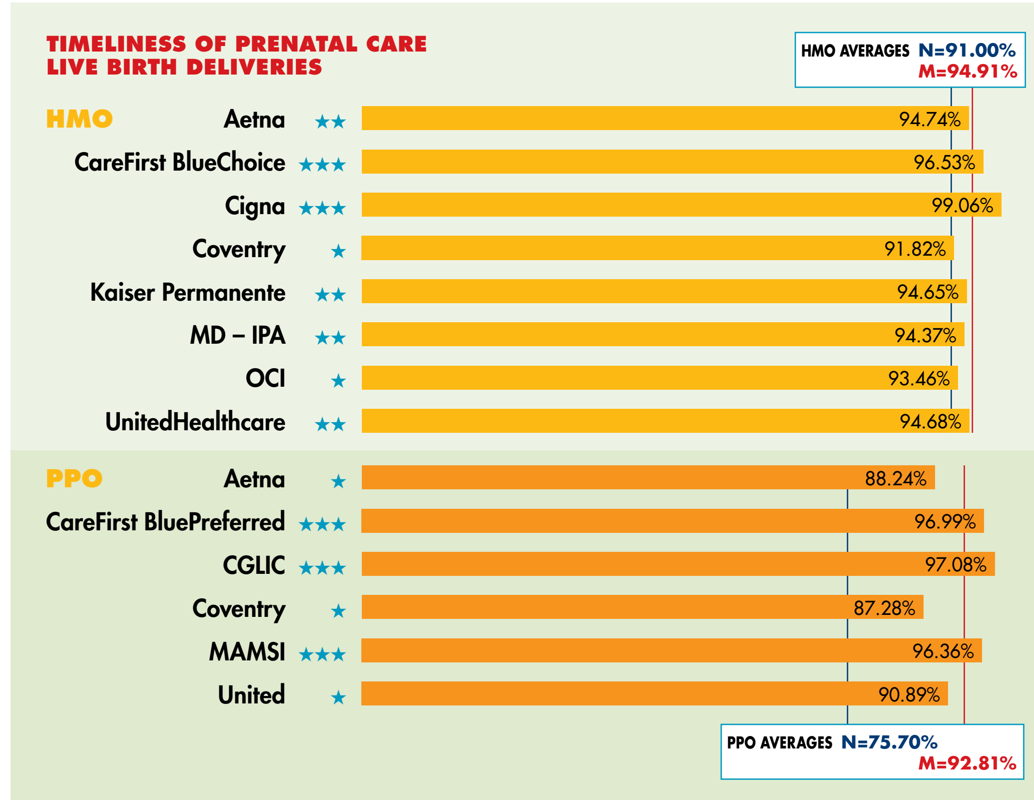
For these women, the measure assesses the following two facets of prenatal and postpartum care:

1. *Timeliness of Prenatal Care:* The percentage of women with live birth deliveries during the treatment period, who received a prenatal care visit in the first trimester or within 42 days of enrollment in the health benefit plan.

For this performance indicator, a higher percentage is better, which means that women with live birth deliveries did receive timely prenatal care.

RATIONALE

Timeliness of Prenatal Care: Preventive medicine is fundamental to prenatal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion must occur early in pregnancy to have an optimal effect on outcome. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Prenatal and Postpartum Care continued

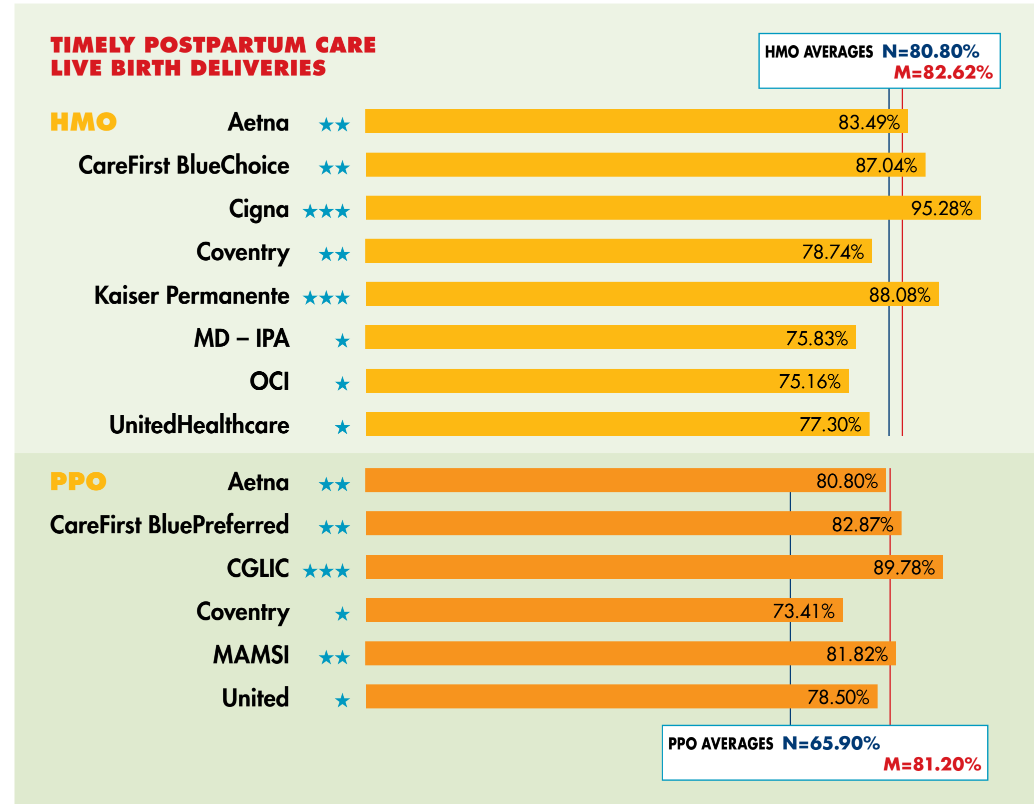
DESCRIPTION

2. *Postpartum Care:* The percentage of women with live birth deliveries during the treatment period who had a postpartum visit on or between 21 and 56 days after delivery.

For this performance indicator, a higher percentage is better, which means that women with live birth deliveries did receive timely postpartum care.

RATIONALE

Postpartum Care: The American College of Obstetricians and Gynecologists recommends that women see their healthcare provider at least once between four and six weeks after giving birth. The first postpartum visit should include a physical examination and an opportunity for the healthcare practitioner to answer parents' questions and give family planning guidance and counseling on nutrition.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Women's Health

Breast Cancer Screening

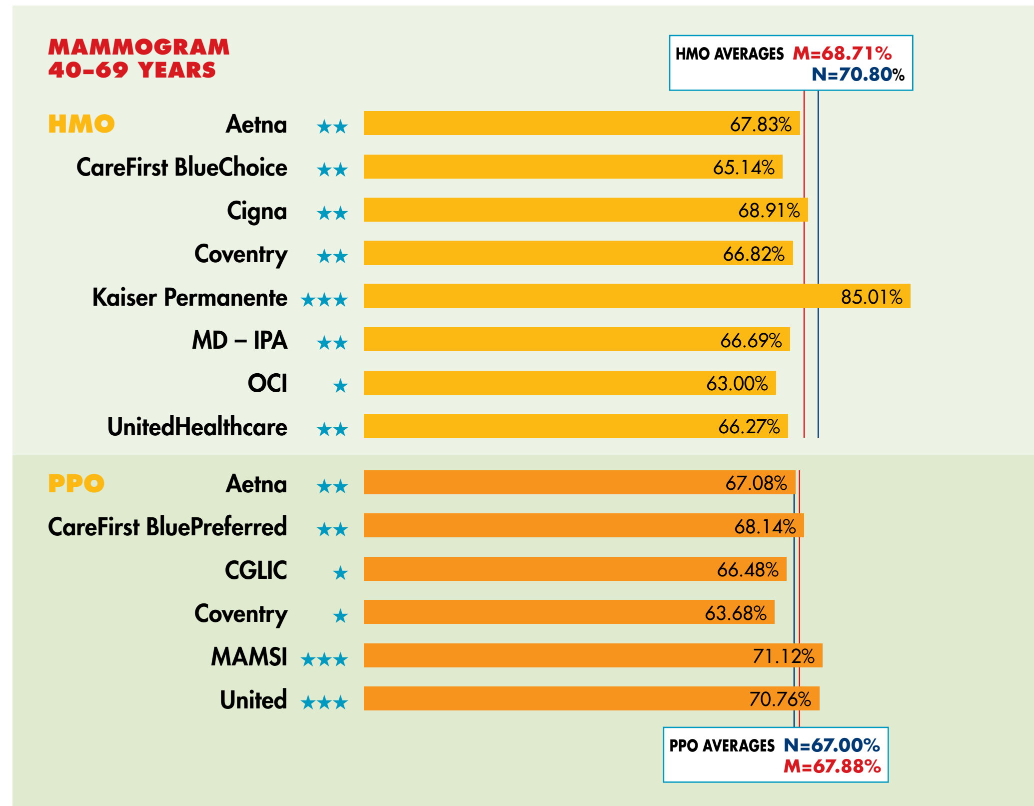
DESCRIPTION

The percentage of women 40–69 years of age in 2011 who had a mammogram within the required timeframe to screen for breast cancer.

For this measure, a higher percentage is better, which means that women did get a mammogram.

RATIONALE

As reported by the Agency for Healthcare Research and Quality, breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20 percent to 30 percent among women 40 and older. Mammography screening for women ages 50 to 69 can reduce breast cancer mortality up to 35 percent.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health

Cervical Cancer Screening

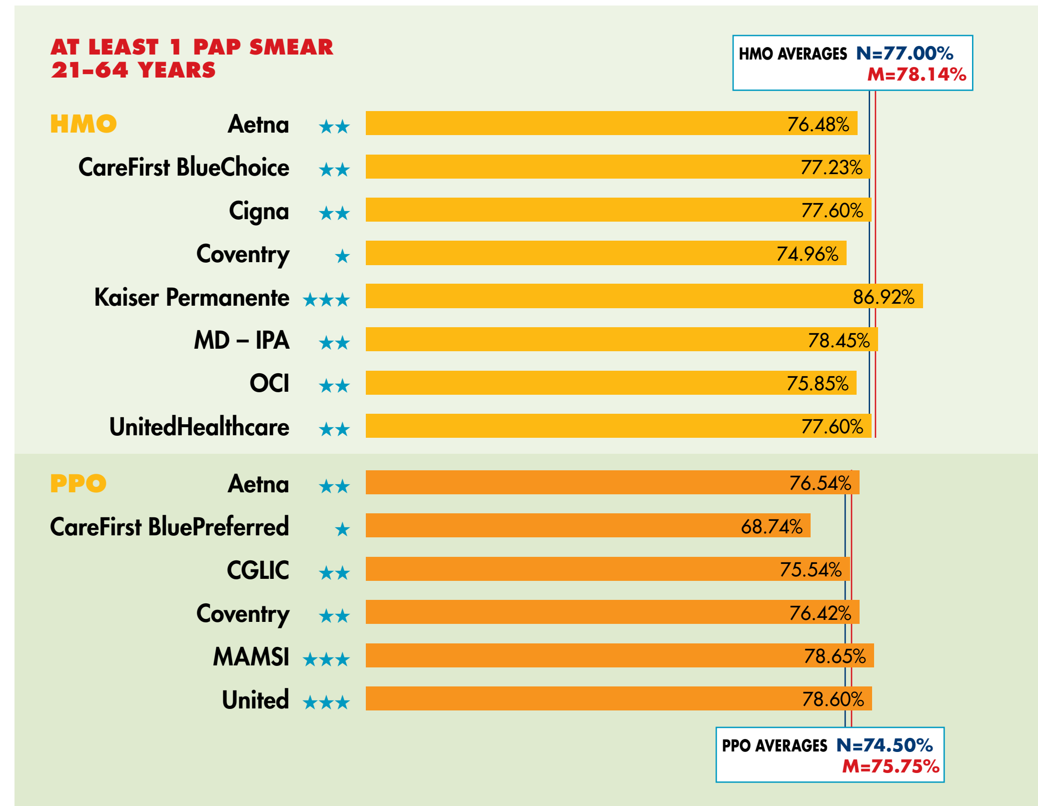
DESCRIPTION

The percentage of women 21–64 years of age in 2011 who received one or more Pap smear tests within the required timeframe to screen for cervical cancer.

For this measure, a higher percentage is better, which means that women did get at least one Pap smear.

RATIONALE

As reported by the Agency for Healthcare Research and Quality, cervical cancer is the second most common type of cancer among women worldwide and the third leading cause of cancer-related deaths in women. Although rates of cervical cancer in the U.S. have decreased, it remains the tenth leading cause of cancer in females in the U.S. Most importantly, when detected and treated early, cervical cancer is one of the most treatable cancers. For women under 50 with the disease, cervical cancer is diagnosed in the early stages 62 percent of the time.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health

Chlamydia Screening in Women

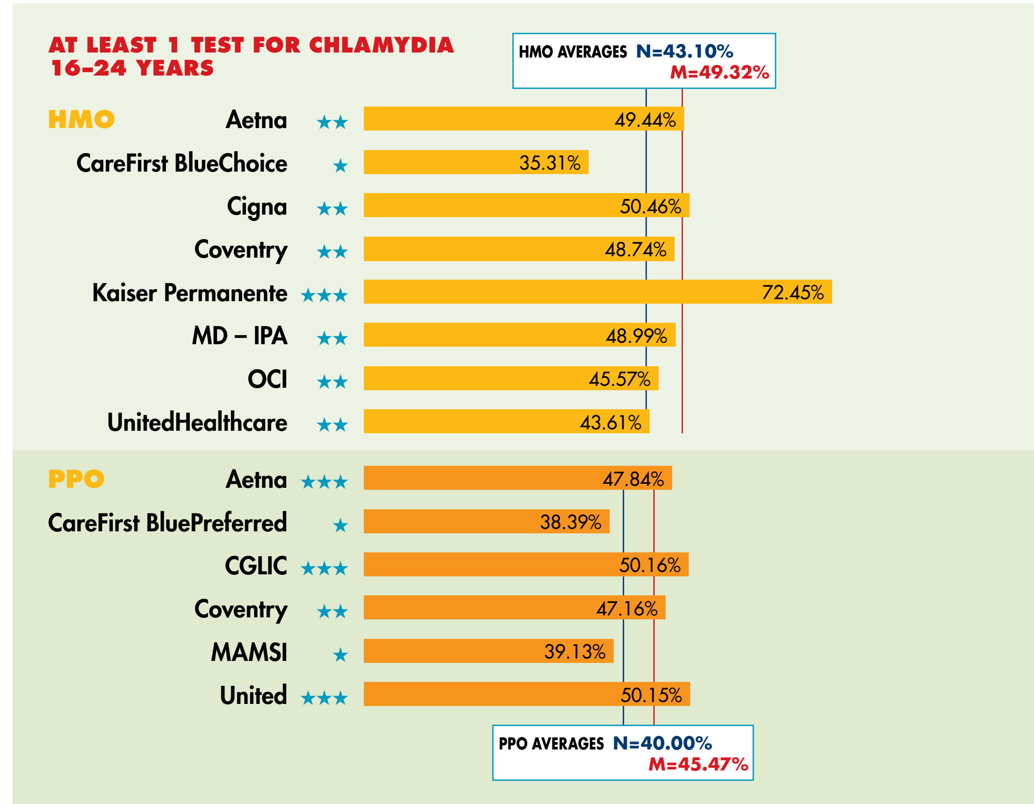
DESCRIPTION

The percentage of women 16–24 years of age in 2011 who were identified as sexually active and who had at least one test for chlamydia during the measurement year (2011).

For this measure, a higher percentage is better, which means that women 16–24 years of age did get at least one chlamydia screening test.

RATIONALE

Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States. Chlamydia is more prevalent among adolescent (15 to 19) and young adult (20–24) women. Three-fourths of infected women do not realize they have the infection, as there are no symptoms until one to three weeks after infection. Pregnant women who have a chlamydial infection can pass the disease to the infant during childbirth, and it is a leading cause of conjunctivitis (pink eye) and pneumonia in newborns. Untreated chlamydia can damage a woman's reproductive organs, possibly causing permanent and irreversible damage to the fallopian tubes and uterus, leading to infertility.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health

The general health of adult patients is significantly impacted by their access to and receipt of adequate primary care assessments, preventive services and routine evaluations, which all contribute to lower mortality rates. Evaluation of developing risk factors as well as preventive health screenings contribute greatly to a higher quality of life for a patient and lower healthcare costs.

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Adults Access to Preventive/ Ambulatory Health Services

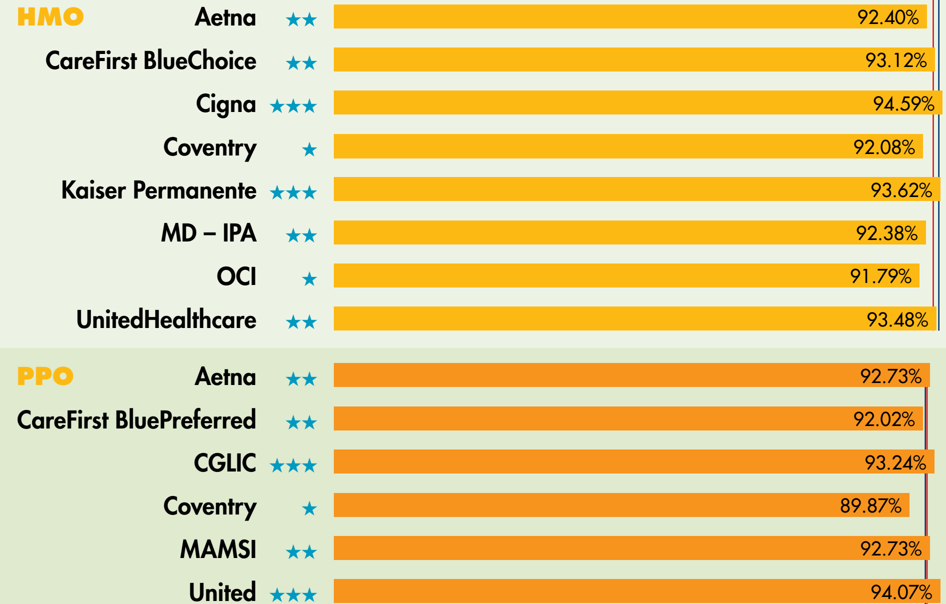
DESCRIPTION

The percentage of members 20–44 years of age in 2011 who had at least one outpatient visit, including an ambulatory or preventive care visit during the measurement year (2011) or the year prior to the measurement year (2010).

For this measure, a higher percentage is better, which means that adults did have at least one ambulatory or preventive care visit.

RATIONALE

Access to care, especially preventive services (e.g., screening tests, counseling interventions, immunizations, etc.) has been identified as an important national priority. Any type of visit (emergent, urgent, or routine) is an opportunity for a healthcare provider to evaluate and treat or arrange for the future evaluation and treatment of a patient's risk factors.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

- ★★★ BETTER THAN MARYLAND AVERAGE
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AVERAGES

NATIONAL — MARYLAND —

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health

Adult Body Mass Index (BMI) Assessment

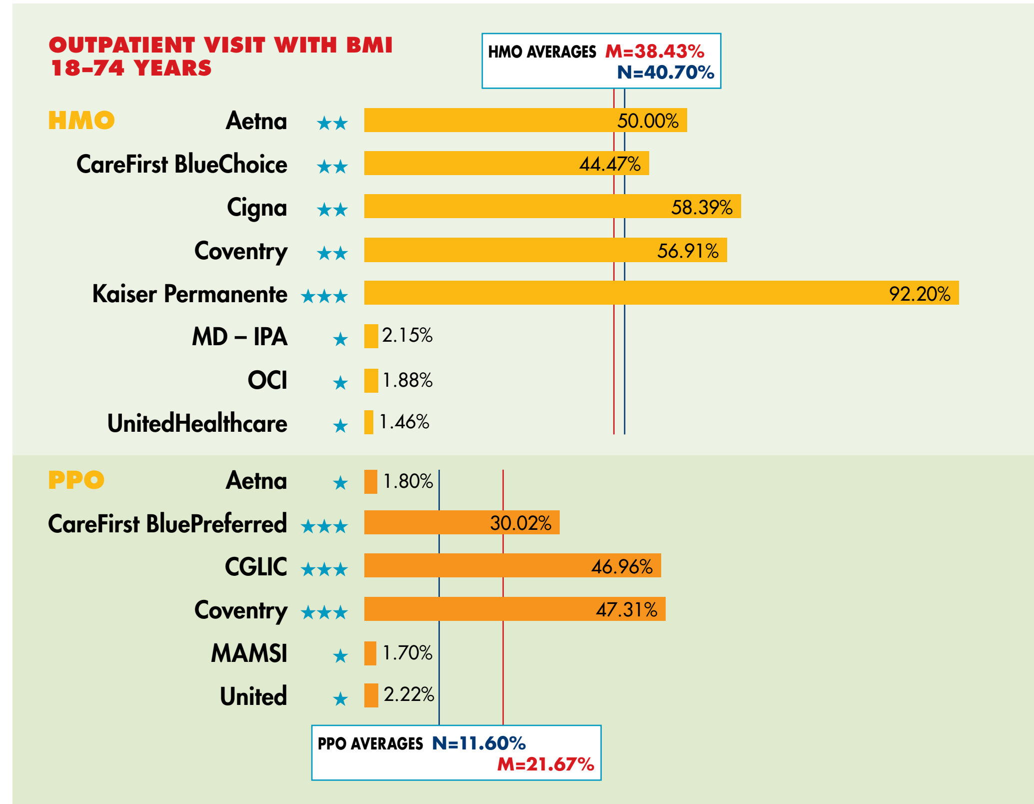
DESCRIPTION

The percentage of members 18–74 years of age in 2011 who had an outpatient visit and whose body mass index (BMI) was documented during the year prior to the measurement year (2010) or the measurement year (2011).

For this measure, a higher percentage is better, which means that adults did have an outpatient visit, which included a calculation of their BMI.

RATIONALE

Obesity is the second leading cause of preventable death in the United States. Obesity often increases the severity of other illnesses and also increases mortality rates. In addition, obesity increases the risk of developing additional conditions such as diabetes, coronary heart disease and cancer. It has a substantial negative effect on longevity, reducing the length of life of people who are severely obese by an estimated 5–20 years. BMI is considered the most efficient and effective method for assessing excess body fat; it is a starting point for assessing the relationship between weight and height.



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PERFORMANCE RATING

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AVERAGES

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health

Colorectal Cancer Screening

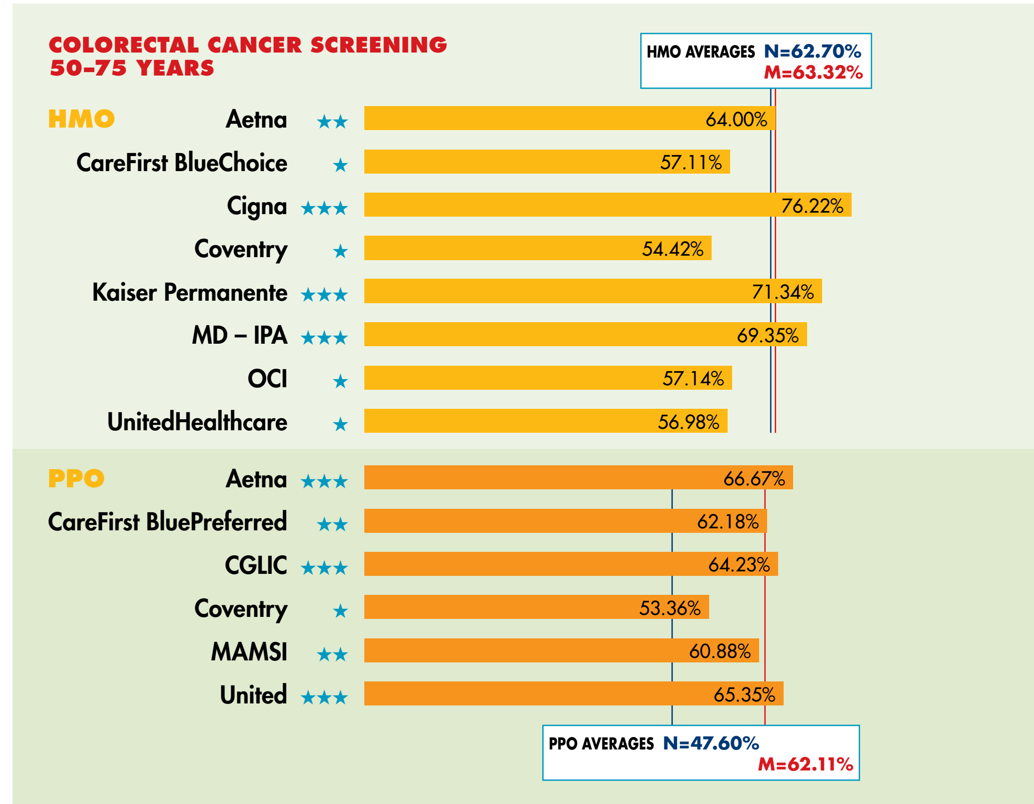
DESCRIPTION

The percentage of members 50–75 years of age in 2011 who had appropriate screening for colorectal cancer.

For this measure, a higher percentage is better, which means that adults 50–75 years of age, did get screened for colorectal cancer.

RATIONALE

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the U.S. Unlike other screening tests that only detect disease, some methods of CRC screening can detect premalignant polyps and guide their removal, which, in theory, can prevent the cancer from developing. Colorectal cancer screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective.



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Primary Care for Adults – Respiratory Conditions

Primary care medicine is vitally important in the diagnosis and treatment of adults with respiratory conditions such as acute bronchitis, chronic obstructive pulmonary disease (COPD) and asthma. Through proper testing and the right medical treatment, patients continue to learn about the value in avoiding treatments that are ineffective and how to better manage their respiratory conditions.

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Respiratory Conditions*

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

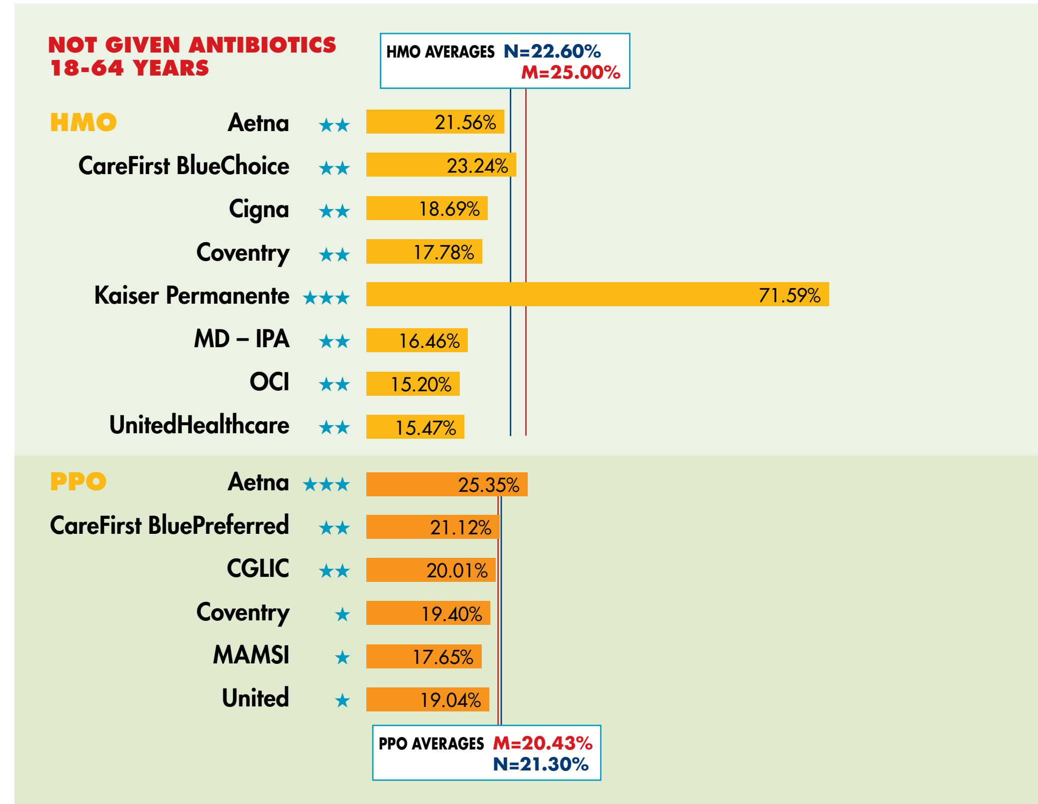
DESCRIPTION

The percentage of members 18–64 years of age in 2011 with a diagnosis of acute bronchitis who were not given an antibiotic prescription. A higher rate indicates appropriate treatment with no antibiotic prescribed.

For this measure, a higher percentage is better, which means that adults 18–64 years of age with acute bronchitis were appropriately treated and not given an antibiotic prescription as part of their treatment.

RATIONALE

Antibiotics are most often inappropriately prescribed for adults with acute bronchitis. Antibiotics are not indicated in clinical guidelines for treating adults with acute bronchitis who do not have a comorbidity or other infection for which antibiotics may be appropriate. Inappropriate antibiotic treatment of adults with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. The vast majority of acute bronchitis cases (more than 90 percent) have a nonbacterial cause; therefore, antibiotics would be an ineffective treatment choice for these cases. However, antibiotics are prescribed 65 percent to 80 percent of the time.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Respiratory Conditions*

Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease

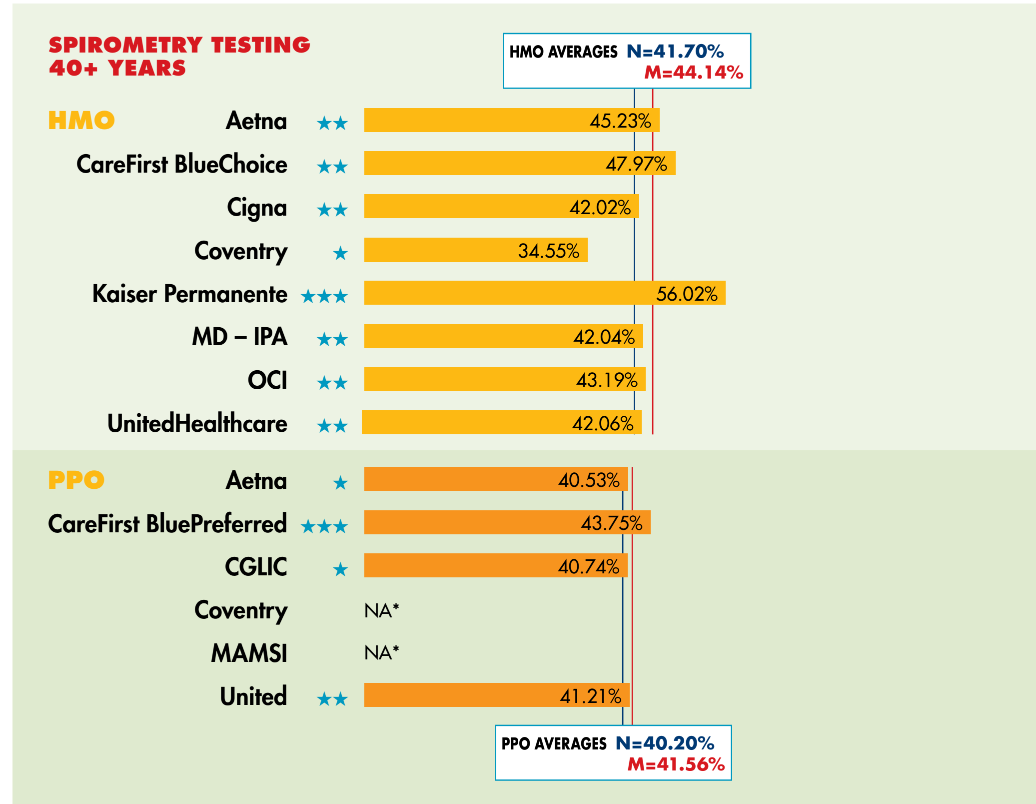
DESCRIPTION

The percentage of members 40 years of age or older in 2011 with a new diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

For this measure, a higher percentage is better, which means that adults 40 and over with COPD, did get the best diagnostic test for COPD, a lung function test called spirometry.

RATIONALE

Chronic Obstructive Pulmonary Disease (COPD) is a major cause of chronic morbidity and mortality throughout the world and in the United States (U.S.). COPD defines a group of diseases characterized by airflow obstruction, and includes chronic bronchitis and emphysema. COPD afflicts nearly 16 million adults in the U.S. COPD is the fourth leading cause of death in the U.S. Spirometry is a simple test that measures the amount of air a person can breathe out and the amount of time it takes to do so. Both symptomatic and asymptomatic patients suspected of COPD should have spirometry testing performed to establish airway limitation and severity. Though several scientific guidelines and specialty societies recommend use of spirometry testing to confirm COPD diagnosis and determine severity of airflow limitation, spirometry tests are largely underutilized.



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AVERAGES

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Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of Chronic Obstructive Pulmonary Disease (COPD) exacerbations for members 40 years of age and older in 2011 who had an acute inpatient discharge or emergency department encounter on or between January 1 and November 30 of the measurement year (2011) and who were given a prescription for appropriate medications.

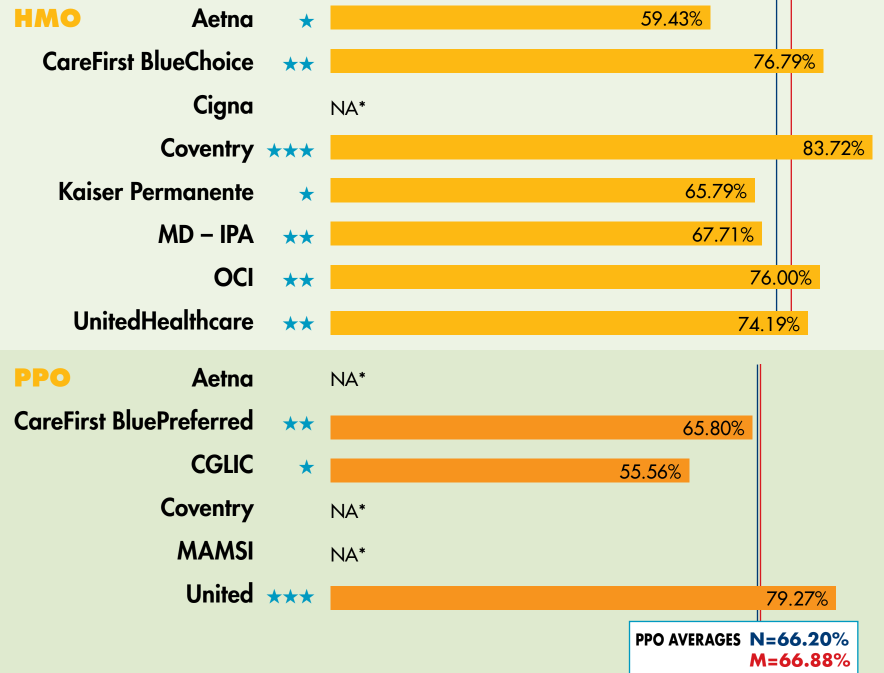
Two rates are reported for this measure:

1. Members given a prescription for a systemic corticosteroid within 14 days of the event.

For this performance indicator, a higher percentage is better, which means that adults did get a timely prescription for a systemic corticosteroid.

RATIONALE

Chronic Obstructive Pulmonary Disease (COPD) is characterized by airflow limitation that is not fully reversible, is usually progressive and is associated with an abnormal inflammatory response of the lung to noxious particles or gases. The disease results in high direct and indirect costs. Exacerbations of COPD account for the greatest burden on the health care system, though studies have shown that proper management of exacerbations may have the greatest potential to reduce the clinical, social and economic impact of the disease.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care for Adults – *Respiratory Conditions*

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation
continued

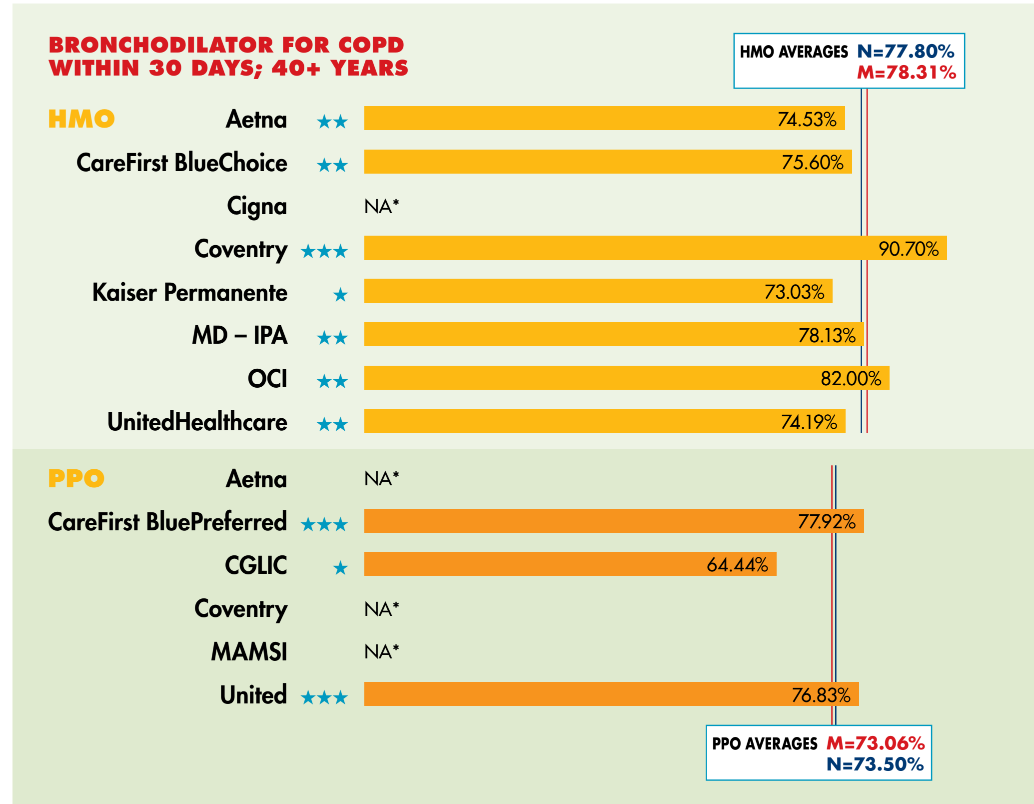
DESCRIPTION

2. Members given a prescription for a bronchodilator within 30 days of the event.

For this performance indicator, a higher percentage is better, which means that adults 40 and over did get a timely prescription for a bronchodilator.

RATIONALE

Chronic Obstructive Pulmonary Disease (COPD) is characterized by airflow limitation that is not fully reversible, is usually progressive and is associated with an abnormal inflammatory response of the lung to noxious particles or gases. The disease results in high direct and indirect costs. Exacerbations of COPD account for the greatest burden on the health care system, though studies have shown that proper management of exacerbations may have the greatest potential to reduce the clinical, social and economic impact of the disease.



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NATIONAL — MARYLAND —

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care for Adults – *Respiratory Conditions*

Use of Appropriate Medications for People with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of members 19–50 and 51–64 years of age during the measurement year (2011), who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. Please find child ages 5–11 and 12–18 years in the Child Respiratory Conditions section.

Two rates are reported for this measure:

1. The percentage of members 19-50 years of age, appropriately prescribed asthma medications.

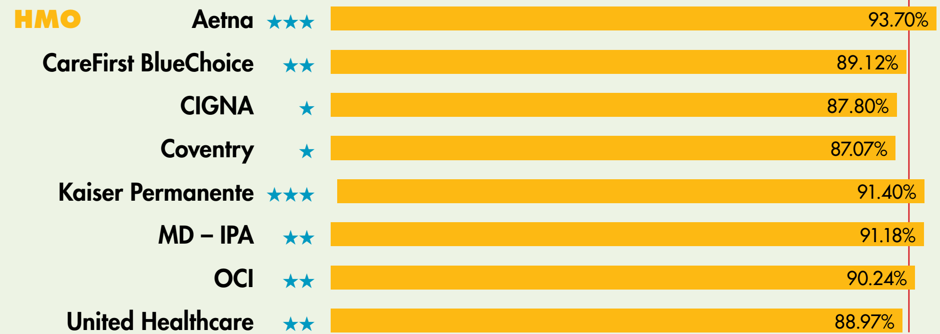
For this performance indicator, a higher percentage is better, which means that younger adults with asthma were appropriately prescribed asthma medications.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 34.1 million Americans have been diagnosed with asthma and each year nearly 5,000 Americans die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

USE OF APPROPRIATE ASTHMA MEDICATIONS AGES 19-50 YEARS

HMO AVERAGES M=89.94%



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NATIONAL —— MARYLAND ——

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Respiratory Conditions*

Use of Appropriate Medications for People with Asthma continued

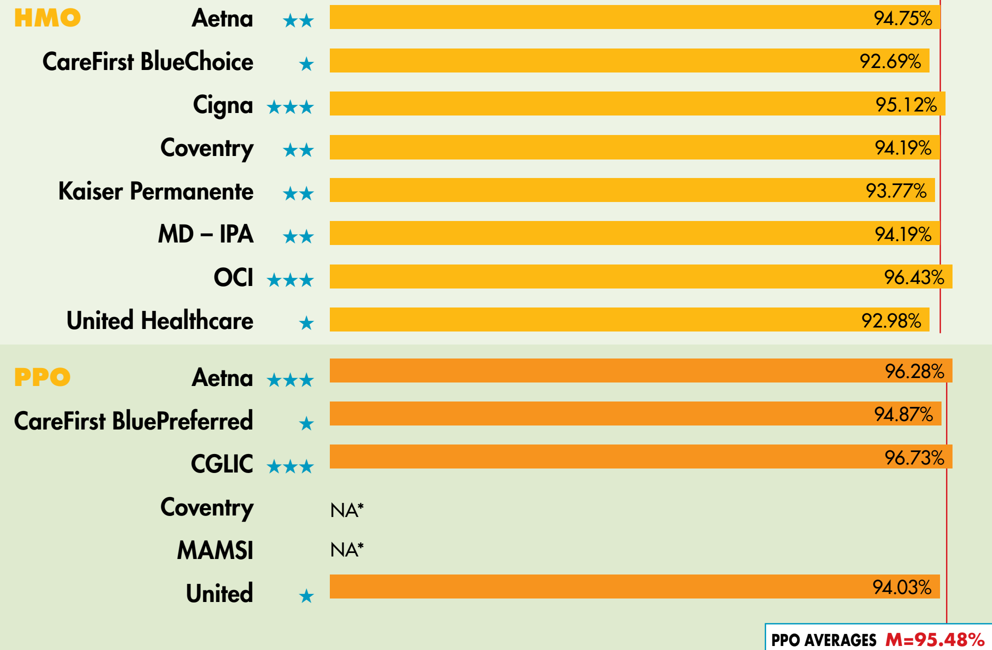
DESCRIPTION

2. The percentage of members 51–64 years of age, appropriately prescribed asthma medications.

For this performance indicator, a higher percentage is better, which means that older adults with asthma were appropriately prescribed asthma medications.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 34.1 million Americans have been diagnosed with asthma and each year nearly 5,000 Americans die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Appropriate medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Respiratory Conditions*

Medication Management for People with Asthma

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of members 19–50 and 51–64 years of age during the measurement year (2011) who were identified as having persistent asthma, were given a prescription for an appropriate medication and who remained on that medication during the treatment period, for a least 50-75% of the remaining days in 2011. Please find child ages 5–11 and 12–18 years in the Child Respiratory Conditions section.

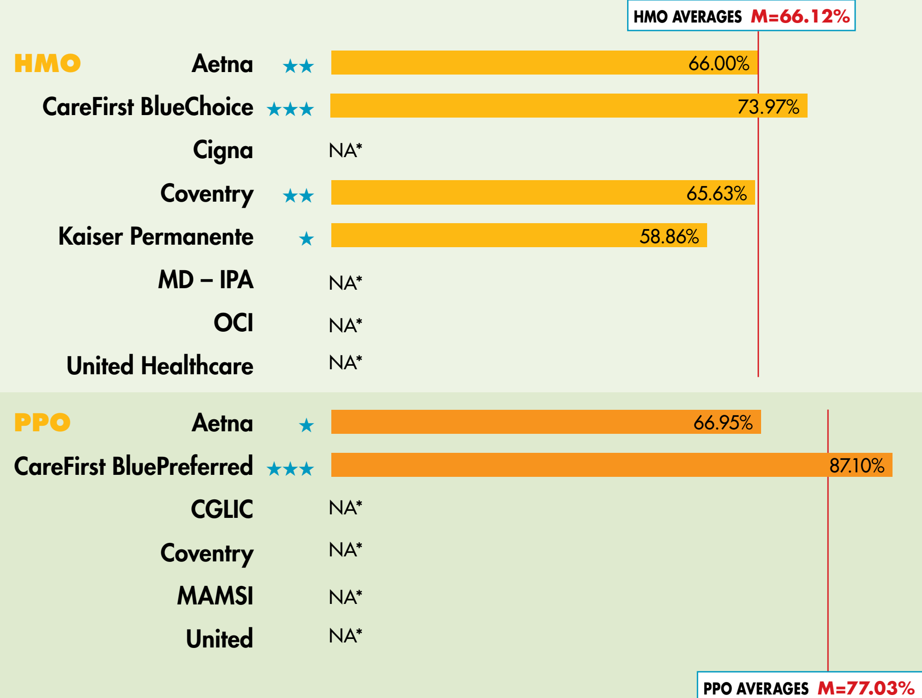
Four rates are reported for this measure:

1. The percentage of members 19–50 years of age, who remained on an asthma controller medication for at least 50 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that younger adults with asthma remained compliant on their asthma controller medication for at least 50% of the treatment period.

RATIONALE

Appropriate asthma medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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AVERAGES

NATIONAL — MARYLAND —

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Respiratory Conditions*

Medication Management for People with Asthma continued

DESCRIPTION

2. The percentage of members 51–64 years of age, who remained on an asthma controller medication for at least 50 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that older adults with asthma remained compliant on their asthma controller medication for at least 50% of the treatment period.

RATIONALE

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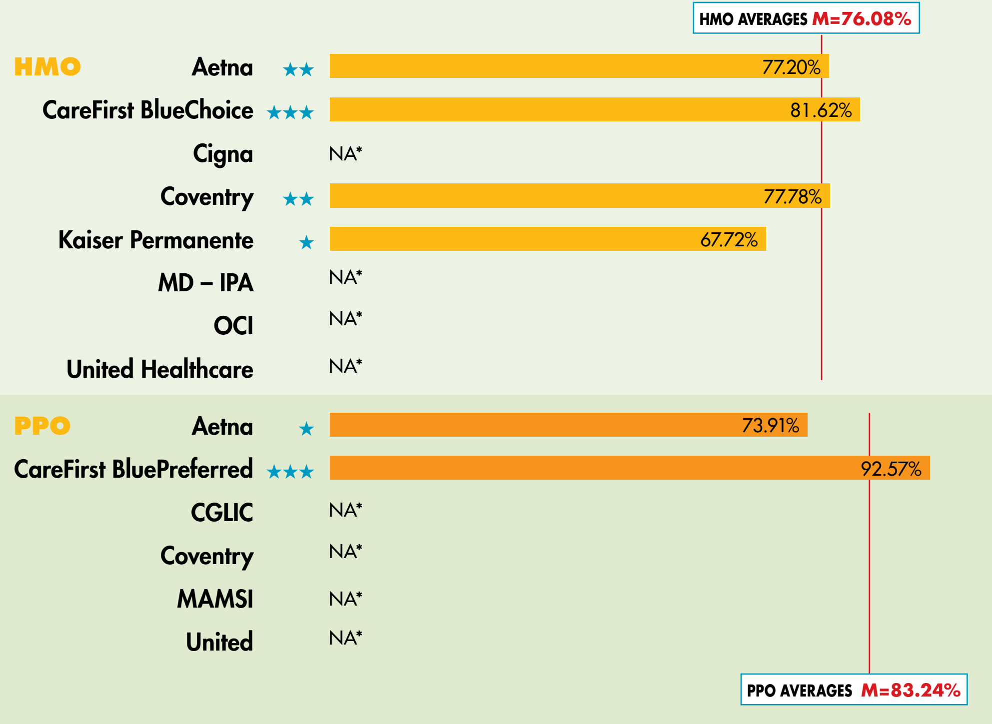

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NATIONAL — MARYLAND —

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Medication Management for People with Asthma continued

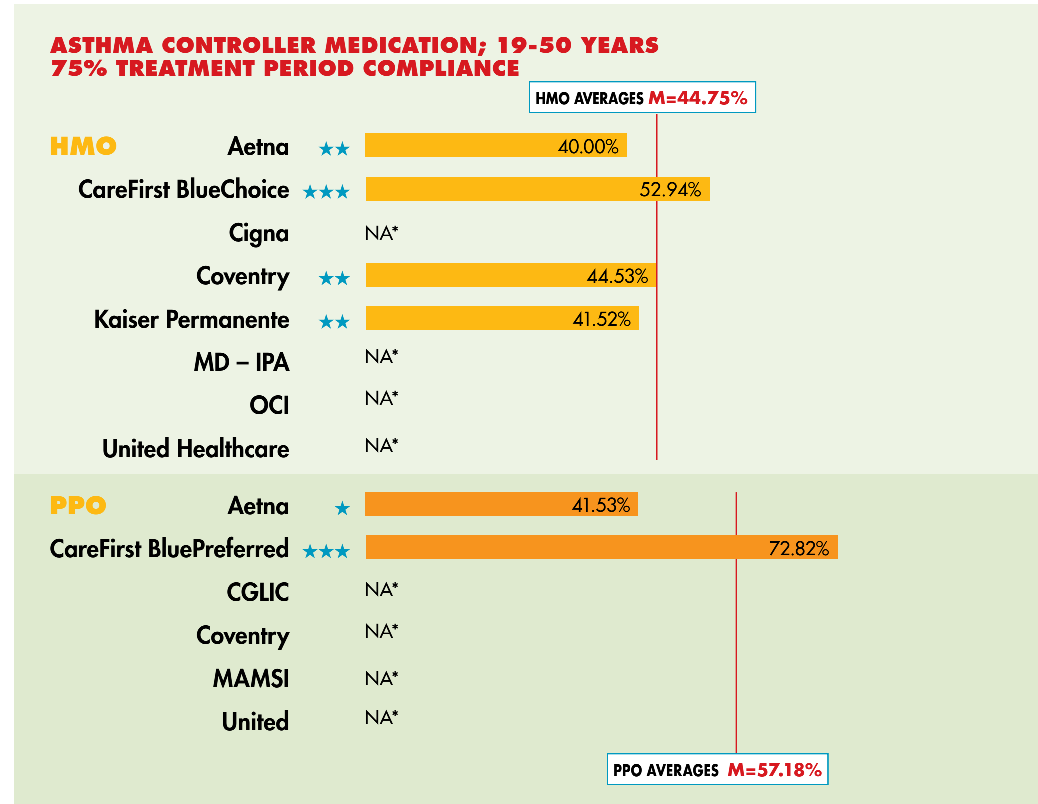
DESCRIPTION

3. The percentage of members 19–50 years of age, who remained on an asthma controller medication for at least 75 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that younger adults with asthma remained compliant on their asthma controller medication for at least 75% of the treatment period.

RATIONALE

Appropriate asthma medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care for Adults – *Respiratory Conditions*

Medication Management for People with Asthma continued

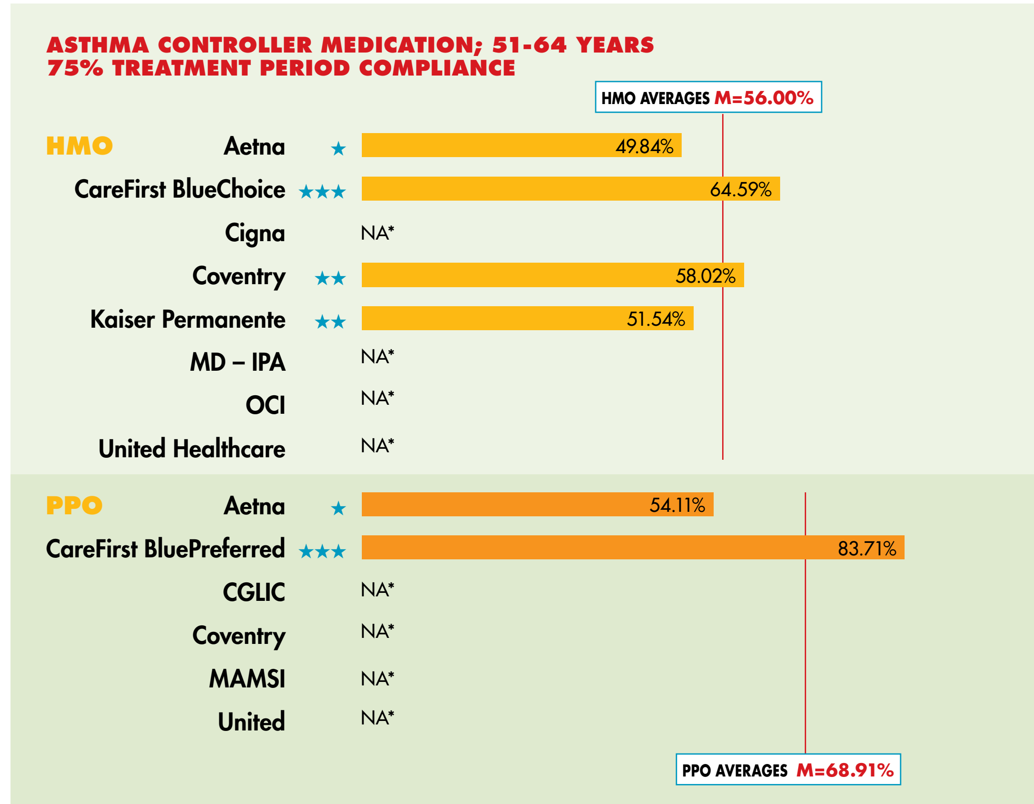
DESCRIPTION

4. The percentage of members 51–64 years of age, who remained on an asthma controller medication for at least 75 percent of their treatment period in 2011.

For this performance indicator, a higher percentage is better, which means that older adults with asthma remained compliant on their asthma controller medication for at least 75% of the treatment period.

RATIONALE

Appropriate medication adherence can reduce the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines. Medications are used to prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.



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NATIONAL —— MARYLAND ——

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Primary Care for Adults – Cardiovascular Conditions and Diabetes

Appropriate treatment of cardiovascular conditions helps prevent development of further coronary diseases, reduce mortality rates for related diseases and, with proper medications and treatment, can reduce coronary events.

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Cardiovascular Conditions and Diabetes*

Cholesterol Management for Patients with Cardiovascular Conditions

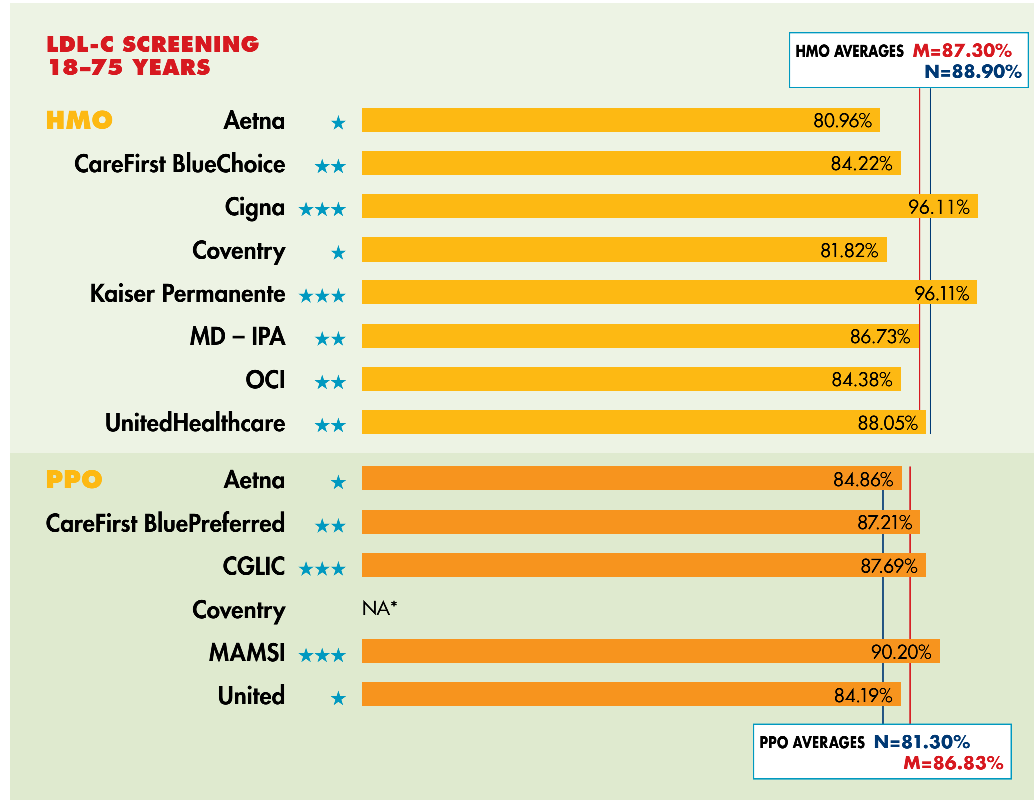
DESCRIPTION

The percentage of members 18 to 75 years of age in 2011 who were hospitalized and discharged alive for a "heart attack" or acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 to November 1 of the year prior to the measurement year (2010), or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year (2011) and the year prior to the measurement year (2010), who also had proper cholesterol management with a low-density lipoprotein cholesterol (LDL-C) screening in 2011.

For this measure, a higher percentage is better, which means that adults 18-75 years of age at increased risk for cardiovascular events, did get appropriate LDL-C cholesterol screening.

RATIONALE

Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol plaques can build up within the walls of the arteries, causing atherosclerosis. Reducing cholesterol in patients with known heart disease is critically important, as treatment can not only reduce the risk for heart attack and stroke, but also can reduce mortality by as much as 40 percent. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease, establishing the need for close monitoring of LDL cholesterol in patients with coronary heart disease and targeting for LDL-C goal of less than or equal to 100 mg/dL.



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Cardiovascular Conditions and Diabetes*

Controlling High Blood Pressure

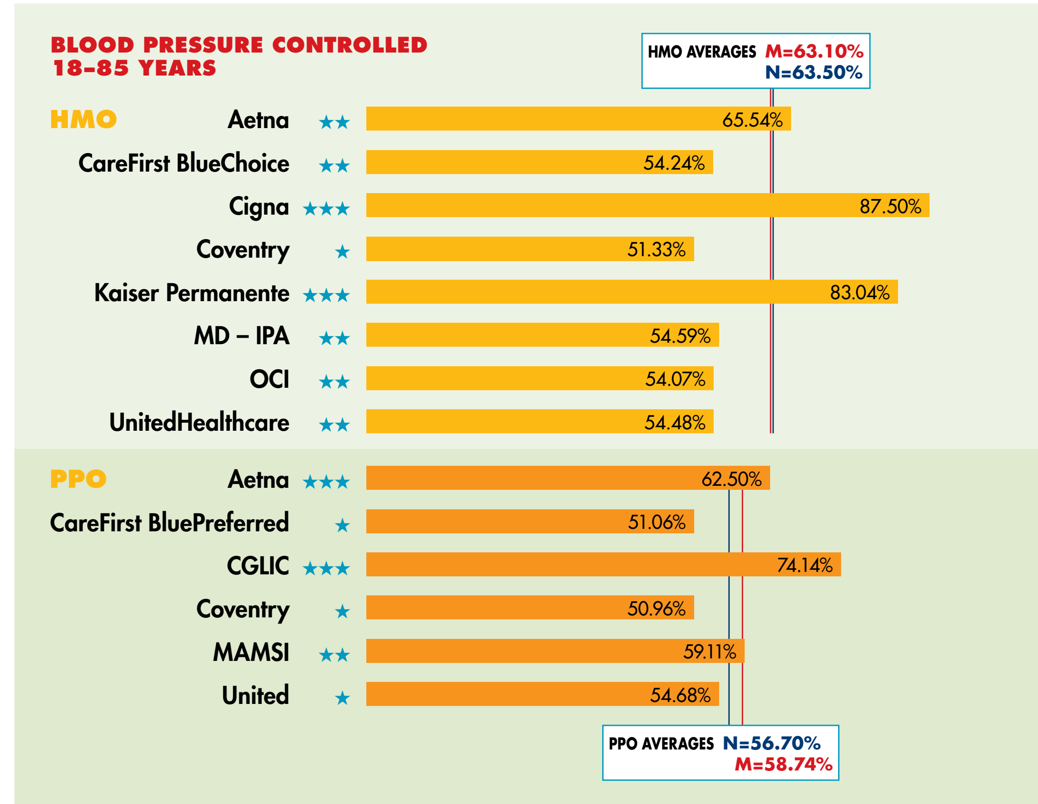
DESCRIPTION

The percentage of members 18 to 85 years of age in 2011 who had a confirmed diagnosis of hypertension and through proper disease management, whose blood pressure was adequately controlled (<140/90) during the measurement year (2011).

For this measure, a higher percentage is better, which means that adults 18-85 years of age with hypertension did get adequate control of their disease.

RATIONALE

Approximately 76.4 million, or 33.5 percent, of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and kidney failure; results are particularly striking in elderly hypertensive patients, who are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 to 20 percent reduction in mortality from coronary heart disease. Literature from clinical trials indicates that only 53 to 75 percent of people under treatment achieved control of their blood pressure.



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Persistence of Beta-Blocker Treatment After a Heart Attack

DESCRIPTION

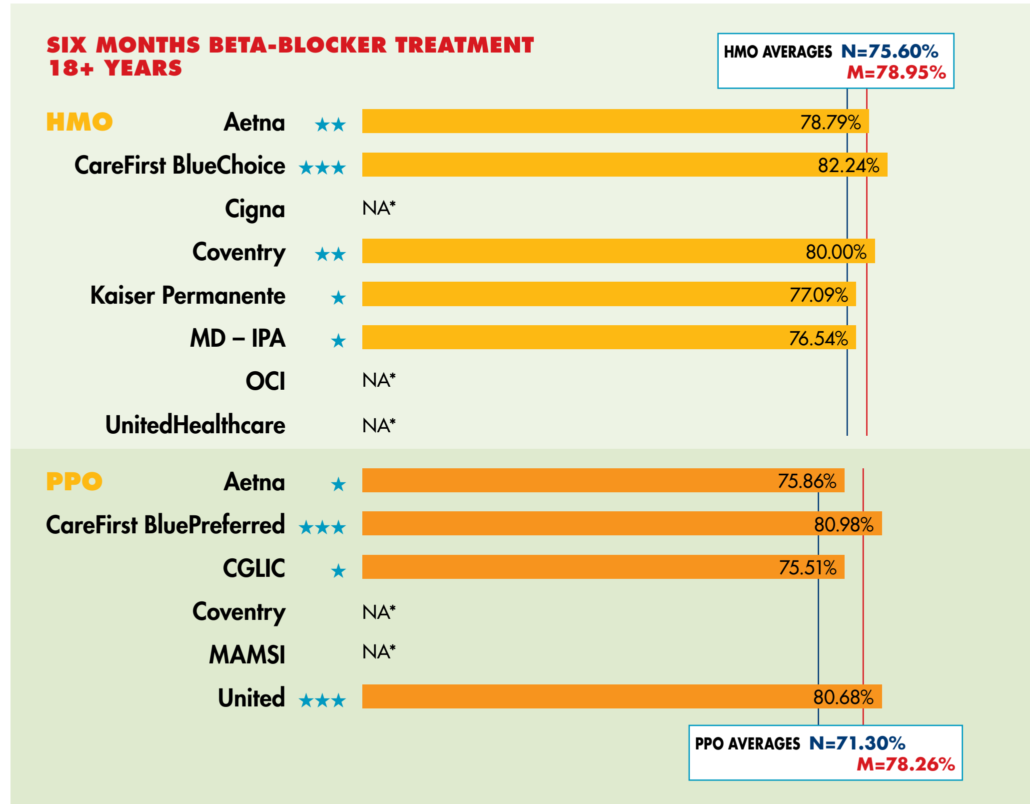
The percentage of members 18 years of age and older during the measurement year (2011) who were hospitalized and discharged alive from July 1 of the year prior to the measurement year (2010) to June 30 of the measurement year (2011) with a diagnosis of "heart attack" or acute myocardial infarction (AMI) and who received persistent beta-blocker treatment (a class of drugs commonly used to treat the heart) for six months after discharge.

For this measure, a higher percentage is better, which means that adults 18 and over with a history of having a heart attack did get at least six months of beta-blocker treatment.

RATIONALE

According to results of large-scale clinical trials, beta-blockers consistently reduce subsequent coronary events, cardiovascular mortality, and all–cause mortality by 20 to 30 percent after an AMI when taken indefinitely. Literature suggests that adherence to beta-blocker treatment declines significantly within the first year.

About half of AMI survivors who are eligible for beta-blocker therapy do not receive it, indicating significant underutilization of beta-blockers.



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AVERAGES

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*NA – Insufficient eligible members (fewer than 30) to calculate rate

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care for Adults – *Cardiovascular Conditions and Diabetes*

Retinal Examination for Diabetics

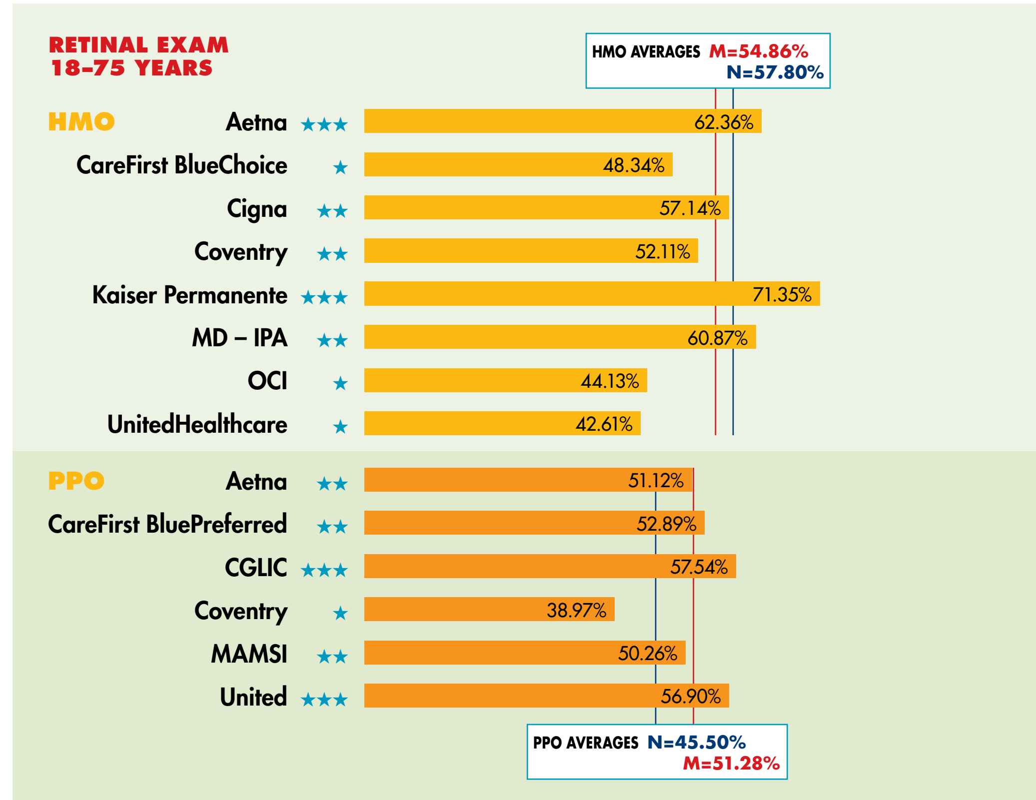
DESCRIPTION

The percentage of members 18 to 75 years of age in 2011, with diabetes (type 1 and type 2), who received a retinal or dilated eye exam by an optometrist or ophthalmologist during the measurement year (2011), or received a retinal or dilated eye exam by an optometrist or ophthalmologist during the year prior to the measurement year (2010) which was negative for retinopathy.

For this measure, a higher percentage is better, which means that diabetic adults 18-75 years of age did get appropriate retinal examination of the eyes. It should be noted that if a patient is negative for retinopathy, they are considered to be at low risk and are not required to have a retinal examination of the eyes by a specialist until the second year after the examination that produced the negative result.

RATIONALE

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as blindness, amputation and kidney failure, can be prevented if diabetes is detected and addressed in the early stages.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL —— MARYLAND ——

Primary Care for Adults – Musculoskeletal Disease and Medication Management

Musculoskeletal diseases and disorders affect the muscles, tendons and ligaments along with the bones. Often, musculoskeletal disorders are due to minor illness or injury and short-term medications are used to relieve pain while the problem gets better. However, more serious diseases and disorders may cause persistent pain, discomfort or disability, and long-term medications are needed to adequately control symptoms and manage the disease or disorder.

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care for Adults – *Musculoskeletal Disease and Medication Management*

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

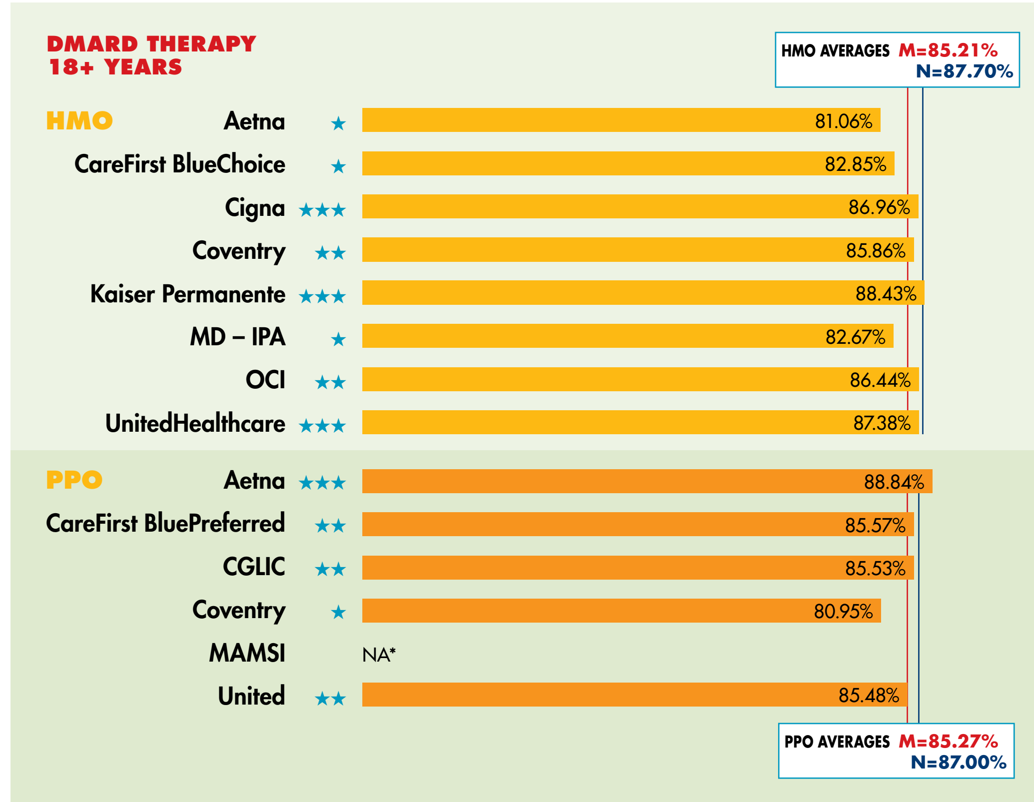
DESCRIPTION

The percentage of members 18 years of age and older in 2011 who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one disease modifying anti-rheumatic drug (DMARD) in 2011. DMARDs are proven effective in slowing or preventing joint damage as opposed to just relieving pain and inflammation.

For this measure, a higher percentage is better, which means that adults 18 and over did get DMARD treatment for their RA.

RATIONALE

Rheumatoid arthritis (RA) is a chronic inflammatory disease in which the immune system attacks healthy joints. It causes joint destruction, bone erosion and damage to muscles, kidneys and other organs. RA affects 1.5 million Americans. There is no cure; consequently, the goal of treatment is to slow the progression of the disease and thereby delay or prevent joint destruction, relieve pain, and maintain functional capacity. Disease modifying anti-rheumatic drugs (DMARDs) modify the disease course of RA through attenuation of progression of bony erosions, and reduction of inflammation and long-term structural damage. The utilization of DMARDs is also expected to provide improvement in functional status.



DMARD THERAPY 18+ YEARS

Plan type	Plan	Rating	Rate
HMO	Aetna	★	81.06%
	CareFirst BlueChoice	★	82.85%
	Cigna	★★★	86.96%
	Coventry	★★	85.86%
	Kaiser Permanente	★★★	88.43%
	MD – IPA	★	82.67%
	OCI	★★	86.44%
	UnitedHealthcare	★★★	87.38%
PPO	Aetna	★★★	88.84%
	CareFirst BluePreferred	★★	85.57%
	CGLIC	★★	85.53%
	Coventry	★	80.95%
	MAMSI		NA*
	United	★★	85.48%

HMO AVERAGES M=85.21% N=87.70%

PPO AVERAGES M=85.27% N=87.00%

More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL —— MARYLAND ——

*NA – Insufficient eligible members (fewer than 30) to calculate rate

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – *Musculoskeletal Disease and Medication Management*

Use of Imaging Studies for Low Back Pain

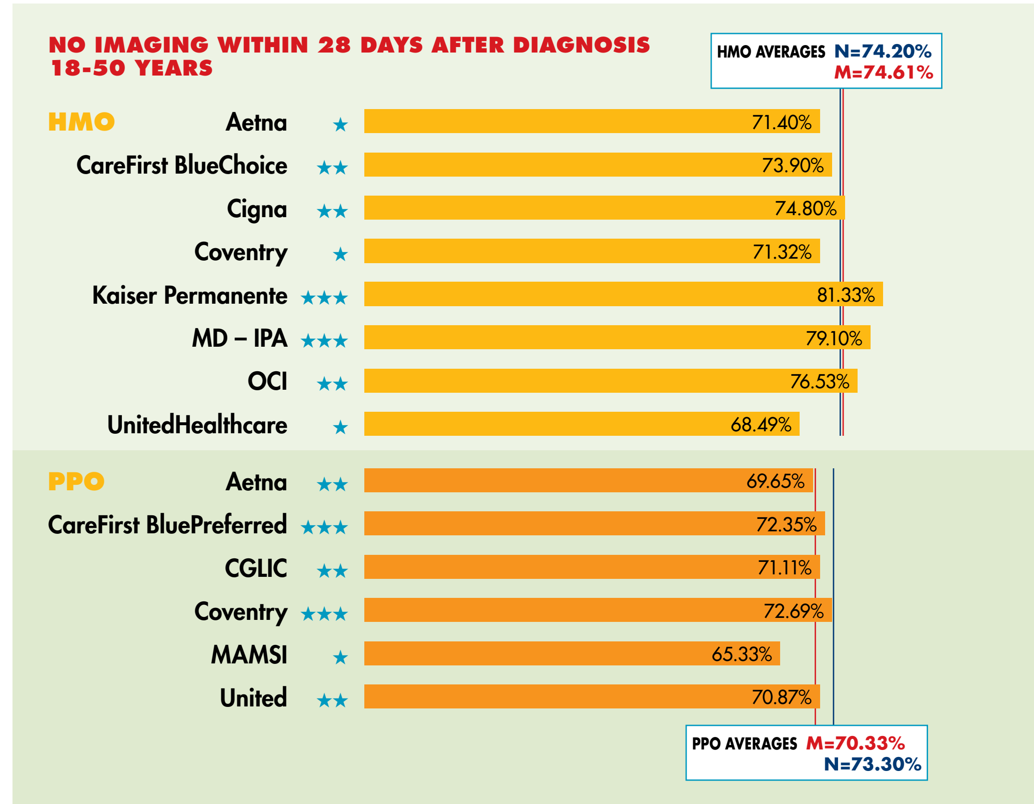
DESCRIPTION

The percentage of members 18 to 50 years of age in 2011 with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days after the diagnosis.

For this measure, a higher percentage is better, which means that adults 18 to 50 years of age with low back pain appropriately did not get an imaging study, as imaging studies are often overused.

RATIONALE

Low back pain ranks among the top 10 reasons for adult patients to visit an internist (physician specializing in Internal Medicine) and is the most common and expensive reason for work disability in the U.S., afflicting approximately 31 million Americans. Persistent pain that lasts beyond 3 to 6 months occurs in only 5 to 10 percent of patients with low back pain. According to the American College of Radiology, uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The majority of these patients are back to their usual activities in 30 days. There is no compelling evidence to justify substantial deviation from the diagnostic strategy published in clinical guidelines, which indicate that for most patients with acute low back pain, diagnostic imaging is usually unnecessary.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

- ★★★ BETTER THAN MARYLAND AVERAGE
- ★★ EQUIVALENT TO MARYLAND AVERAGE
- ★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL — MARYLAND —

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

▶ Primary Care for Adults – *Musculoskeletal Disease and Medication Management*

Annual Monitoring for Patients on Digoxin

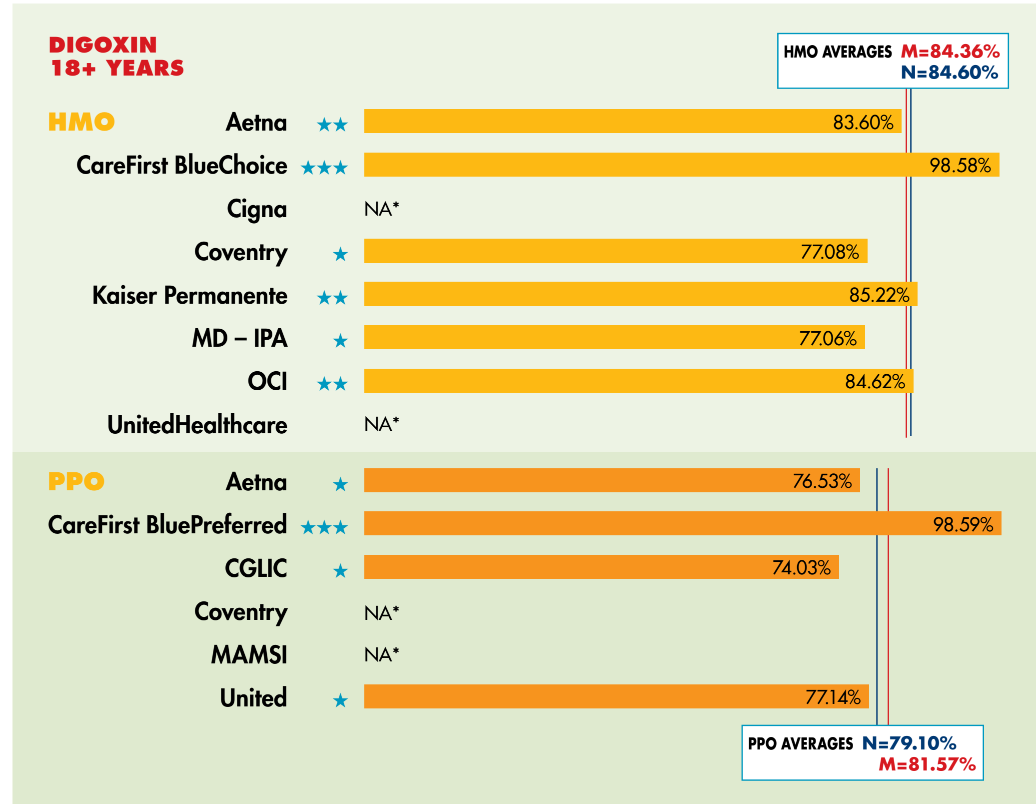
DESCRIPTION

The percentage of members 18 years of age and older in 2011 who received prescriptions for at least 180 treatment days of a prescription for a heart medication called Digoxin and at least one therapeutic monitoring event for the drug during the measurement year (2011). Digoxin is commonly used to treat congestive heart failure and to slow the heart rate in patients with abnormal heart rhythms (arrhythmias).

For this measure, a higher percentage is better, which means that adults 18 and over on Digoxin did get at least one annual therapeutic monitoring event.

RATIONALE

Patient safety is highly important, especially for patients at increased risk of adverse drug events from long-term medication use. Persistent use of drugs like Digoxin warrants close monitoring and follow-up by the prescribing physician to assess for harmful side effects, adjust drug dosage and implement other therapeutic decisions accordingly. The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. The total costs of drug-related problems due to misuse of drugs in the ambulatory setting has been estimated to exceed $76 billion annually.



More stars mean better health benefit plan performance. ▶

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES

NATIONAL ▬ MARYLAND ▬

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Behavioral Health

The intent of these measures is to maintain functionality for a patient, to appropriately utilize health care resources and to protect a patient on long term medication from harmful use. Treatment and medication is not required in every case, and when it is a patient should be made aware of long term effects.

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Antidepressant Medication Management

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of members 18 years of age and older in 2011 with a diagnosis of major depression, who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Two rates are reported for this measure:

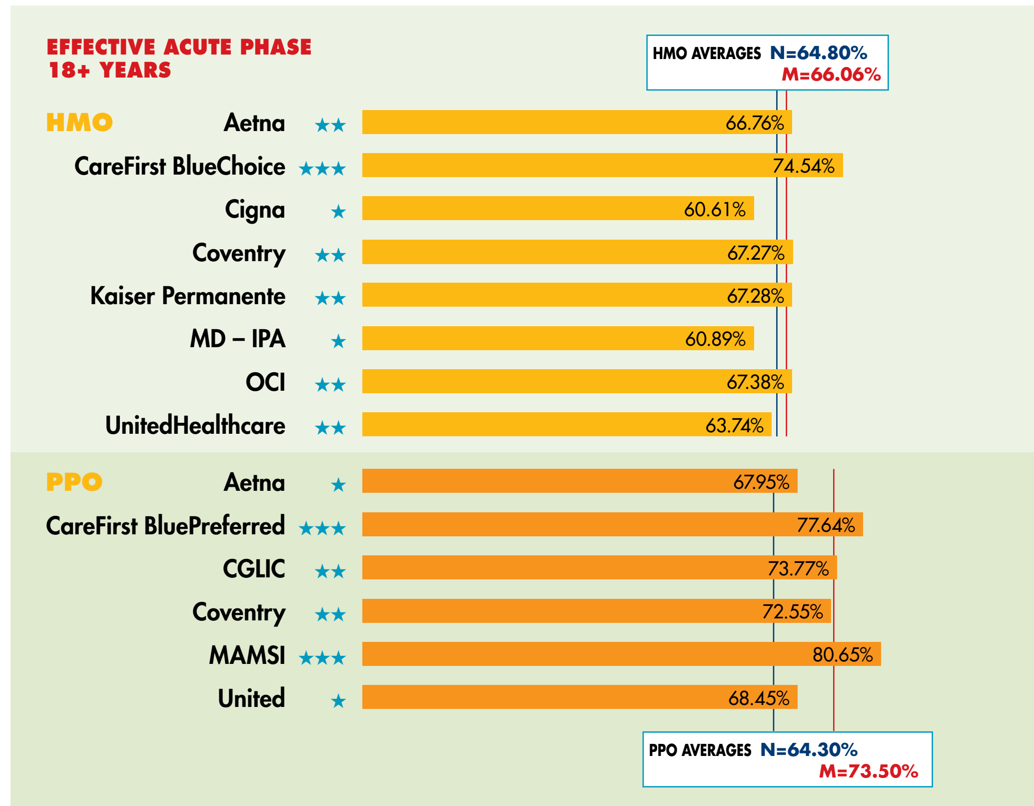
1. *Effective Acute Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

For this performance indicator, a higher percentage is better, which means that adults 18 and over with depression were effectively treated with 12 weeks of antidepressant medication during the acute phase of treatment.

RATIONALE

Without treatment, a depressive disorder or depression symptoms can last for years, or can eventually lead to death by suicide or other cause. Fortunately, many people can improve through treatment with appropriate medications.

According to the American Psychiatric Association, successful treatment is promoted by a thorough assessment of the patient and close adherence to treatment plans.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL —— MARYLAND ——

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Antidepressant Medication Management
continued

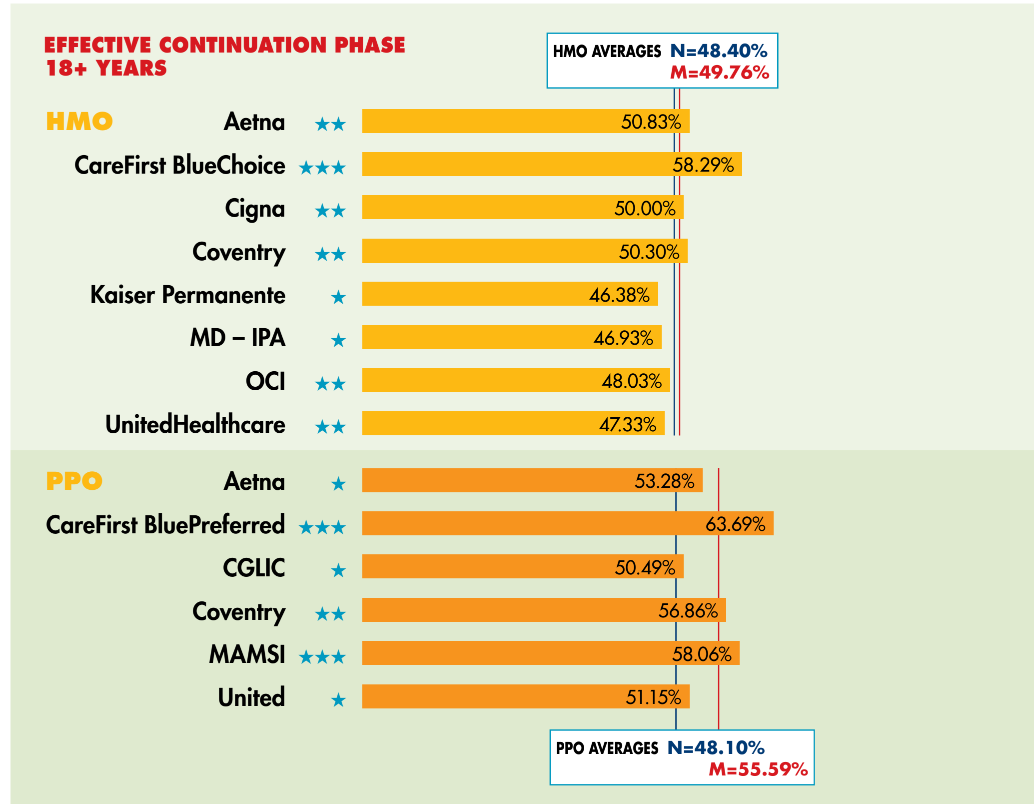
DESCRIPTION

2. *Effective Continuation Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

For this performance indicator, a higher percentage is better, which means that adults with depression were effectively treated with at least 6 months of antidepressant medication.

RATIONALE

When medication is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to medication as well as the emergence of side effects, clinical conditions and safety. In practice, the frequency of monitoring during the acute phase can vary from once a week in routine cases to multiple times per week in more complex cases. Patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse.



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The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL — MARYLAND —

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Behavioral Health

Follow-Up After Hospitalization for Mental Illness

DESCRIPTION

Each health benefit plan reports on multiple indicators under this measure. This measure describes the percentage of discharges for members 6 years of age and older in 2011 who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.

Two rates are reported for this measure:

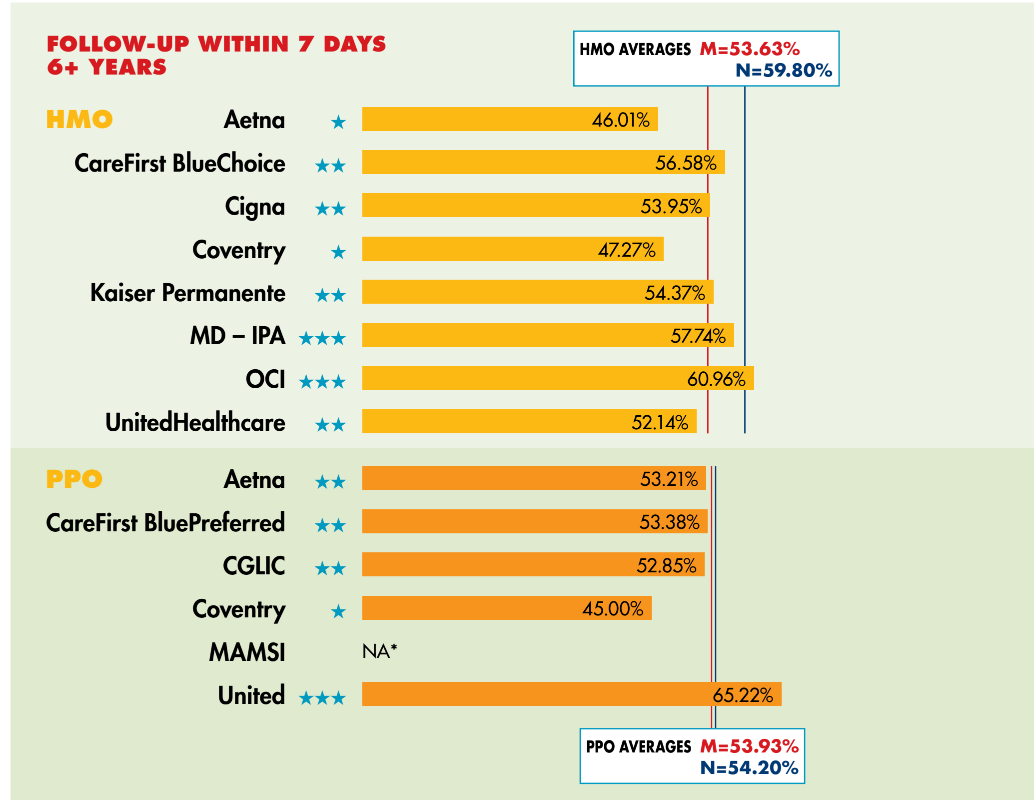
1. The percentage of discharges for which the member received follow-up within 7 days of discharge.

For this performance indicator, a higher percentage is better, which means that members 6 years and older with depression did get timely follow up within 7 days of discharge.

RATIONALE

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a behavioral healthcare provider after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide appropriate interventions.

The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.



More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
- ★★★ BETTER THAN MARYLAND AVERAGE
- ★★ EQUIVALENT TO MARYLAND AVERAGE
- ★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL — MARYLAND —

*NA – Insufficient eligible members (fewer than 30) to calculate rate

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Behavioral Health

Follow-Up After Hospitalization for Mental Illness continued

DESCRIPTION

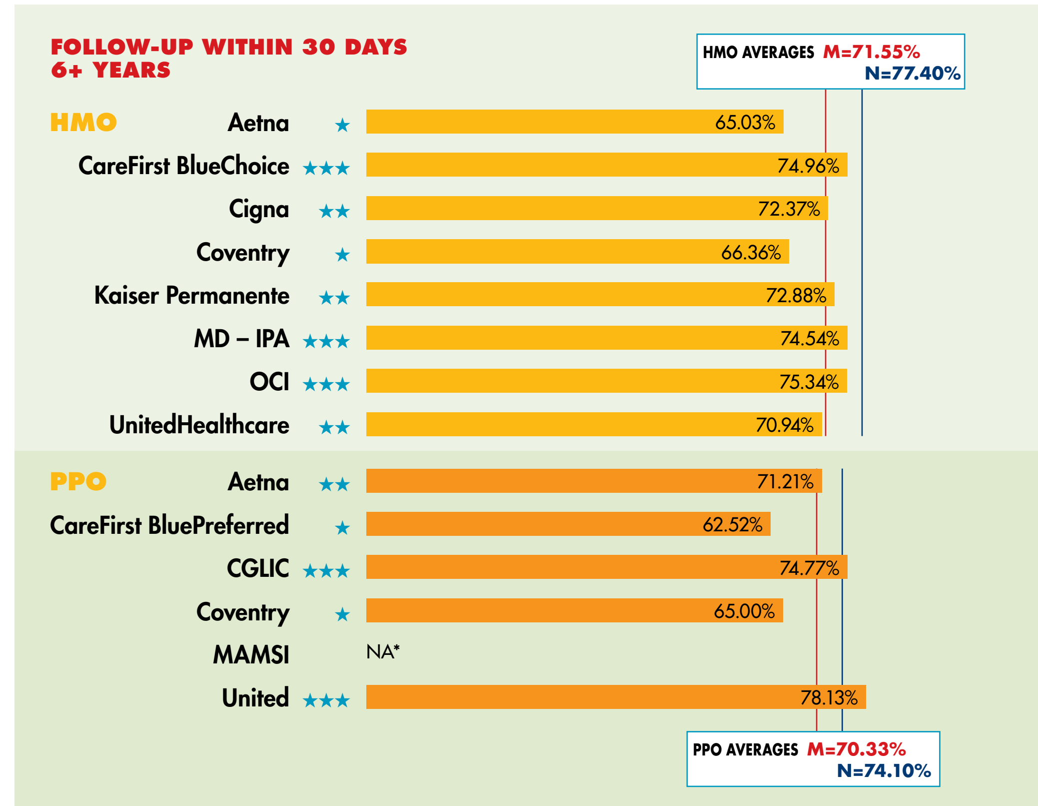
2. The percentage of discharges for which the member received follow-up within 30 days of discharge.

For this indicator, a higher percentage is better, which means that members 6 years and over with depression did get timely follow-up within 30 days of discharge.

RATIONALE

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a behavioral healthcare provider after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide appropriate interventions.

The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.



FOLLOW-UP WITHIN 30 DAYS 6+ YEARS

Plan type	Plan	Rating	Rate
HMO	Aetna	★	65.03%
	CareFirst BlueChoice	★★★	74.96%
	Cigna	★★	72.37%
	Coventry	★	66.36%
	Kaiser Permanente	★★	72.88%
	MD – IPA	★★★	74.54%
	OCI	★★★	75.34%
	UnitedHealthcare	★★	70.94%
PPO	Aetna	★★	71.21%
	CareFirst BluePreferred	★	62.52%
	CGLIC	★★★	74.77%
	Coventry	★	65.00%
	MAMSI		NA*
	United	★★★	78.13%

HMO AVERAGES M=71.55% N=77.40%

PPO AVERAGES M=70.33% N=74.10%

More stars mean better health benefit plan performance.

The "stars" represent the relative comparisons between the health benefit plans and the Maryland Average Benchmark.

Data Source: Health Benefit Plan Records or Member Survey

PERFORMANCE RATING
★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

AVERAGES
NATIONAL — MARYLAND —

*NA – Insufficient eligible members (fewer than 30) to calculate rate

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction with Health Benefit Plan

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey program is overseen by the United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ) and includes a myriad of survey products designed to capture consumer, patient and health benefit plan member perspectives on health care quality. The Maryland Health Care Commission has implemented use of the *CAHPS Health Plan Survey 4.0H, Adult Version* as part of the Health Benefit Plan Quality and Performance Evaluation System.

The following tables reflect health benefit plan member responses in four key areas:

- Overall Rating of Health Benefit Plan
- Coordination of Care and Communication with Doctors
- Overall Member Satisfaction with Getting Needed Care
- Overall Customer Satisfaction

Rating of Health Benefit Plan

Description: The percentage of adult members who rated their health benefit plan "8, 9 or 10" on a scale of 0–10, with 10 being the "best health benefit plan possible."

HMO	Rating of Health Benefit Plan
Aetna Health, Inc. (Pennsylvania) – Maryland	64.59%
CareFirst BlueChoice, Inc.	63.09%
Cigna Healthcare Mid-Atlantic, Inc.	71.05%
Coventry Health Care of Delaware, Inc.	55.45%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	77.80%
MD – Individual Practice Association, Inc.	86.11%
Optimum Choice, Inc.	59.15%
UnitedHealthcare of the Mid-Atlantic, Inc.	51.70%
PPO	
Aetna Life Insurance Company (MD/DC)	60.22%
CareFirst, Inc. (BluePreferred)	64.42%
Connecticut General Life Insurance Company (MD/DC)	61.90%
Coventry Health and Life Insurance Company	43.93%
MAMSI Life and Health Insurance Company	49.08%
UnitedHealthcare Insurance Company (MD)	67.78%

Coordination of Care, Communication with Doctors and Health Promotion/Education

Description: The percentage of members who replied "usually" and "always" in evaluating the overall coordination of care, the effectiveness of communication with doctors and the general promotion and education of the member's health.

HMO	Coordination of Care	How Well Doctors Communicate	Health Promotion and Education
Aetna Health, Inc. (Pennsylvania) – Maryland	73.42%	92.89%	54.34%
CareFirst BlueChoice, Inc.	71.05%	91.50%	49.81%
Cigna Healthcare Mid-Atlantic, Inc.	69.57%	92.58%	57.38%
Coventry Health Care of Delaware, Inc.	78.15%	92.68%	55.02%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	80.00%	93.20%	62.15%
MD – Individual Practice Association, Inc.	80.63%	92.28%	51.52%
Optimum Choice, Inc.	72.15%	91.38%	50.76%
UnitedHealthcare of the Mid-Atlantic States, Inc.	79.34%	91.10%	51.33%
PPO			
Aetna Life Insurance Company (MD/DC)	76.97%	92.25%	61.63%
CareFirst, Inc. (BluePreferred)	68.63%	92.16%	50.59%
Connecticut General Life Insurance Company (MD/DC)	81.25%	92.92%	60.80%
Coventry Health and Life Insurance Company	70.92%	93.41%	50.38%
MAMSI Life and Health Insurance Company	81.15%	94.05%	48.40%
UnitedHealthcare Insurance Company (MD)	81.21%	93.94%	55.59%

Member Satisfaction with Getting Care Quickly and Getting Needed Care

Description: The percentage of adult members who said they "usually" and "always" get needed care and timely appointments at a doctor's office or with specialists and get the care, tests, or treatment they thought they needed through their health benefit plan.

HMO	Getting Care Quickly	Getting Needed Care
Aetna Health, Inc. (Pennsylvania) – Maryland	84.05%	84.52%
CareFirst BlueChoice, Inc.	87.26%	84.29%
Cigna Healthcare Mid-Atlantic, Inc.	87.65%	81.52%
Coventry Health Care of Delaware, Inc.	86.08%	81.85%
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	85.42%	84.65%
MD – Individual Practice Association, Inc.	88.05%	83.49%
Optimum Choice, Inc.	83.47%	80.95%
UnitedHealthcare of the Mid-Atlantic, Inc.	83.51%	83.10%
PPO		
Aetna Life Insurance Company (MD/DC)	88.28%	85.68%
CareFirst, Inc. (BluePreferred)	89.40%	84.05%
Connecticut General Life Insurance Company (MD/DC)	86.35%	86.51%
Coventry Health and Life Insurance Company	81.65%	78.17%
MAMSI Life and Health Insurance Company	86.21%	83.33%
UnitedHealthcare Insurance Company (MD)	89.52%	88.60%

Overall Customer Satisfaction

Description: The percentage of members who said they "usually" and "always" are satisfied with the overall customer service of the health benefit plan.

HMO	Customer Service
Aetna Health, Inc. (Pennsylvania) – Maryland	81.60%
CareFirst BlueChoice, Inc.	NA*
Cigna Healthcare Mid-Atlantic, Inc.	87.23%
Coventry Health Care of Delaware, Inc.	NA*
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	83.51%
MD – Individual Practice Association, Inc.	86.11%
Optimum Choice, Inc.	87.82%
UnitedHealthcare of the Mid-Atlantic, Inc.	NA*
PPO	
Aetna Life Insurance Company (MD/DC)	84.82%
CareFirst, Inc. (BluePreferred)	NA*
Connecticut General Life Insurance Company (MD/DC)	88.64%
Coventry Health and Life Insurance Company	73.40%
MAMSI Life and Health Insurance Company	NA*
UnitedHealthcare Insurance Company (MD)	NA*

* NA—Insufficient responses to calculate a percentage

VI. HEALTH BENEFIT PLAN CHOICES FOR STATE OF MARYLAND EMPLOYEES

State of Maryland employees continue to have the option of EPO, POS, and PPO health benefit plans. The table below compares the various types of health benefit plans offered to State of Maryland employees. Key differences include whether health benefit plan members must select a primary care provider and whether they must obtain a referral before seeing a specialist. Members will typically have higher costs when using out-of-network providers. Each health benefit plan offers a national network of health care providers and has different rules for how members use the plan's benefits. Contact a health benefit plan for more details.

Help Resolving Issues

State of Maryland employees who have a problem with the care or service provided by a state health benefit plan must first use the plan's internal process for resolving issues. If the problem cannot be resolved through the internal appeals process, the employee can request an external review of the denial by the Maryland Insurance Administration (MIA). If an external review is requested, the MIA will review and provide a final, written determination. If the MIA decides to overturn the insurance carrier's decision, the MIA will instruct the insurance carrier to provide coverage or payment for the healthcare item or service. If a claim is denied because the service was not a covered service and therefore not eligible for an independent, external review, the employee may contact the Adverse Determinations Department of the Employee Benefits Division.

Contacts:

Maryland Insurance Administration
Attn: Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Telephone: (410) 468-2000
Toll-free: 1-800-492-6116
Facsimile: (410) 468-2270
TTY: 1-800-735-2258

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510
Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-307-8283
Facsimile: (410) 333-7104

Managed Behavioral Healthcare Organizations

State of Maryland employees automatically receive behavioral health coverage, but benefits vary by health benefit plan. If you are enrolled in an EPO plan, your behavioral health benefits are provided by your plan's MBHO. Refer to **Behavioral Health Services** (page 11) for information on behavioral healthcare networks.

Comparison of the Various Types of Health Benefit Plans Offered to State of Maryland Employees

TOPIC	EPO	POS	PPO
Primary Care	*Aetna Select EPO* and *UnitedHealthcare Select EPO* **do** require members to choose an in-network PCP to manage their care. *CareFirst EPO* **does not** require members to choose a PCP.	*Aetna Choice POS II* and *UnitedHealthcare ChoicePlus POS* **do not** require members to choose a PCP. Members choosing *CareFirst Maryland POS* **must** choose an in-network PCP.	*CareFirst PPO* and *UnitedHealthcare Options PPO* **do not** require members to choose a PCP.
Referrals to specialists	Members **do not** need a referral to see an in-network specialist or other health care provider.	*Aetna Choice POS II* and *UnitedHealthcare ChoicePlus POS* **do not** require members to get a referral for in-network or out-of-network services.* *CareFirst Maryland POS* members **must** use a PCP referral for in-network providers or may opt to use an out-of-network provider **without** a referral.*	Members **do not** need a referral to see an in-network or out-of-network specialist or other health care provider.*

continued

VI. HEALTH BENEFIT PLAN CHOICES FOR STATE OF MARYLAND EMPLOYEES

Comparison of the Various Types of Health Benefit Plans Offered to State of Maryland Employees continued			
	EPO	**POS**	**PPO**
Out-of-network care	**There are no benefits for out-of-network services.** Members are responsible for the full charge billed by the out-of-network provider or facility.	For all plans, members may receive services from out-of-network providers without obtaining a referral. (This is called "self-referral.")*	Members may receive services by out-of-network providers, but are responsible for the entire fee when they receive such services and must submit a claim for reimbursement for out-of-network provider fees.*

* For co-pay and out-of-network deductible amounts, see the State employee benefit booklet produced and distributed by the Employee Benefits Division of the Department of Budget and Management. To access the booklet online go to **http://dbm.maryland.gov/benefits/Pages/HBHome.aspx**

State of Maryland Employee Health Benefit Plan Choices			
Health Benefit Plans	**Phone**	**Website**	**Where to Find the Plan in This Guide**
Aetna (nationwide) *Select EPO* *Choice POS II*	800-501-9837 TTY/TDD: 800-501-9837	**www.aetnamd.com**	***Open Access Aetna Select EPO*** performance information is not represented in this report. Please refer to ***Aetna's HMO/POS*** for comparable quality information. ***Aetna Choice POS II*** performance information is reported as part of ***Aetna's HMO/POS*** quality information.
CareFirst BlueCross BlueShield (regional only) *EPO* *POS* *PPO*	State Operations Center: (Baltimore); 410-581-3601 (outside Baltimore) 800-225-0131 (Maryland only); TTY: 711 (outside Maryland) 800-735-2258	**www.carefirst.com/statemd**	***CareFirst EPO*** performance information is not represented in this report. Please refer to ***CareFirst's HMO/POS*** for comparable quality information. ***CareFirst Maryland POS*** performance information is reported as part of ***CareFirst's HMO/POS*** quality information. ***CareFirst PPO*** is represented in this guide.
UnitedHealthcare (nationwide) *Select EPO* *Choice Plus POS* *Options PPO*	800-382-7513 TTY: 711 (Maryland only)	**www.uhcmaryland.com**	***UnitedHealthcare Select EPO***, ***UnitedHealthcare Choice Plus POS***, and ***UnitedHealthcare Options PPO*** performance information are not reported in this guide.

Note: For additional information regarding health benefit plan options for State of Maryland employees, visit the Employee Benefits Division of the Department of Budget and Management. To access the booklet online, go to **http://dbm.maryland.gov/benefits/Pages/HBHome.aspx**

VII. MARYLAND STATEWIDE QUALITY AND PERFORMANCE INITIATIVES

Million Hearts™ Campaign

The Maryland Department of Health and Mental Hygiene (DHMH) supports the Million Hearts™ Initiative of the U.S. Department of Health and Human Services, which aims to prevent one million heart attacks and strokes in the United States over the next five years.

Heart disease and stroke are among the top causes of death in Maryland, responsible for one out of three deaths. Heart disease accounted for 24.9 percent of deaths, and stroke accounted for 5.2 percent of total deaths in 2010. In Maryland, 37.4 percent of adults reported high cholesterol and 30.1 percent of adults reported high blood pressure in 2009, and 15.2 percent of adults were current smokers in 2010. We also know that members of minority communities in Maryland experience these risk factors at even higher rates. Most risk factors for heart disease and stroke – specifically high blood pressure, high cholesterol, diabetes, smoking, and obesity – are preventable and controllable. Controlling these risk factors can reduce the risk of heart attack or stroke by more than 80 percent.

Maryland's commitment to the Million Hearts™ Initiative has five core components: improving clinical care, strengthening tobacco control, promoting a healthy diet, encouraging workplace wellness, and incentivizing local public health action. Maryland's Million Hearts™ activities are a central component of an overall health reform strategy that aims to expand access to high quality healthcare for all Marylanders and maximize wellness and prevention to optimize the value of the state's investment in health. Progress will be tracked through StateStat, a performance-measurement and management tool implemented by Governor Martin O'Malley to improve state government efficiency and accountability. DHMH recently added to its StateStat reporting a template specific to Million Hearts™ that tracks data with the goal of controlling blood pressure, improving control of diabetes and reducing cardiovascular mortality. The template can be found at: **http://www.dhmh.maryland.gov/statestat/SitePages/Home.aspx**.

Maryland's Million Hearts™ strategies align with Maryland's recent award of a $9.7 million CDC Community Transformation Grant (CTG) to expand the Healthiest Maryland efforts in "making the healthiest choice the easiest choice" for all Marylanders, particularly for Marylanders with existing heart disease and stroke risk factors. From May 2012 to September 2013, the Preventive Health and Health Services (PHHS) Grant will be used to expand Maryland's Million Hearts™ activities to Baltimore City, Baltimore, Montgomery, Prince George's, and Anne Arundel counties. The CTG and PHHS Grants together will allow for a statewide reach and measurable impact by reducing tobacco use; enhancing the physical activity and food environment (including reducing sodium and eliminating trans fat in the food supply); and providing community-clinical linkages to improve control of blood pressure and cholesterol.

To learn more about the Million Hearts™ Initiative, visit **http://millionhearts.hhs.gov/index.html**.

Maryland's Million Hearts™ activities are a central component of an overall health reform strategy that aims to expand access to high quality healthcare for all Marylanders and maximize wellness and prevention to optimize the value of the state's investment in health.

Maryland Multi-Payer Patient Centered Medical Home (MMPP)

The Patient-Centered Medical Home (PCMH) is a model of primary care delivery designed to strengthen the patient-clinician relationship by replacing episodic care with coordinated care and a long-term healing relationship. It can lower costs of care through a focus on patient self-management and engagement, rather than on disease. PCMH encourages teamwork and coordination among clinicians and support staff to give patients better access to care, and encourage patients to take a greater role in making care decisions. Key PCMH components include understanding patients' preferences and culture, shared decision making between patient and clinician, and patients' willingness to establish and work toward personal health goals.

PCMH concepts endorsed in the Joint Principles of the Patient-Centered Medical Home have been adopted by national organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians and the American College of Physicians, and by many business and consumer organizations across the United States. For Maryland patients, the Maryland Multi-Payer Patient Centered Medical Home (MMPP) offers:

- Integrated care plans for ongoing medical care in partnership with patients and their families
- Chronic disease management, with the help of specialized care coordinators
- Medication reconciliation for every visit
- Increased access to a primary care provider through a "24-7" telephone response system
- Same-day appointments for urgent care
- Enhanced modes of care communication, such as e-mail.

For Maryland employers, the MMPP offers the type of health care benefits that they seek for their employees: a strong emphasis on primary care services and lowering the costs of care, while improving the health of their workforce through expanded access to primary care clinicians, reduced health care disparities, and better coordination of care.

Maryland began a three-year program to test this new model of care in 2011, with 53 primary and multi-specialty practices and federally-qualified health centers (FQHC) located across the state. Although Maryland law requires the five major carriers of fully insured health benefit products (Aetna, CareFirst, CIGNA, Coventry, and UnitedHealthcare) to participate in the MMPP, the Federal Employees Health Benefits Program (FEHBP), the Maryland State Employee and Retiree Health and Welfare Benefits Program, TRICARE, and private employers such as Maryland hospital systems, voluntarily elected to offer this program to their employees. Program participants are collaborating with the University of Maryland Department of Family Medicine, Johns Hopkins Community Physicians, Kaiser Foundation Health Plan of the Mid-Atlantic, Inc., and the program management staff at the Maryland Health Care Commission, Community Health Resources Commission, and Department of Health and Mental Hygiene to encourage more than 300 primary care clinicians throughout Maryland to adopt these advanced principles of primary care. If you would like to receive care from a clinician offering this innovative model of primary care, ask your employer's health benefits plan manager for more information or visit the Maryland Health Care Commission's PCMH Program page at **http://mhcc.maryland.gov/pcmh/**.

VII. MARYLAND STATEWIDE QUALITY AND PERFORMANCE INITIATIVES

Maryland Health Information Exchange

A health information exchange (HIE) is a conduit for transmitting electronic health information safely and efficiently across providers and systems. An HIE facilitates access to and retrieval of health data, encouraging timely and efficient patient-centered care, and can also support research, public health, emergency response, and quality improvement. Maryland is committed to building a safe, secure network for exchanging health information, using input from various stakeholders such as medical and technical experts, providers, and patients.

The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) are collaborating to implement an interoperable, statewide HIE that enables the exchange of health information (rather than collecting data for a repository) to allow providers access to patient health data from hospitals, laboratories, provider practices, pharmacies, and long term care facilities.

The MHCC is collaborating with stakeholders to build patient trust in the HIE through comprehensive privacy and security policies. Using $10 million in State funds allocated for this purpose, along with a federal grant of approximately $10.9 million, Maryland is developing a "citizen-centric," statewide HIE that allows providers to exchange patient information electronically, using a system that maximizes security and patient privacy.

Links to Other MHCC Resources

Publications on the performance of healthcare facilities are available on the MHCC Web site, including the following Web-based, interactive guides:

A Consumer's Guide to Getting and Keeping Health Insurance in Maryland is a 45-page guide that explains rights and protections that apply to health insurance coverage in Maryland. Information is provided for individuals who buy their own health insurance or who get coverage through an employer, or for small business owners who offer health insurance to their employees. **http://mhcc.dhmh.maryland.gov/smallgroup/Pages/smallemployer.aspx**

Maryland Health Insurance Partnership for Small Businesses is a premium subsidy program available to very small businesses that currently do not offer group insurance to their employees, if the average wage of the business is less than a specified amount. The site includes a subsidy calculator, the maximum subsidy table, and a downloadable application for subsidy support. **http://mhcc.maryland.gov/partnership/**

VIRTUAL COMPARE is a Web portal that provides important information about selected health benefit plans available to small employers in Maryland and allows a side-by-side comparison of benefits, premiums, and out-of-pocket costs for up to four health plans at a time. **https://virtualcompare.benefitfocus.com/Platform/Default.aspx?ApplicationID=MarketplaceProto&PageID=Home%20page&TenantID=MHCC**

Maryland Hospital Performance Evaluation Guide compares information on hospital characteristics, patient satisfaction ratings, quality scores, and selected health care associated infections (HAI) information. The site also features a pricing guide and other information about hospital services in Maryland. **http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm**

Maryland Ambulatory Surgery Facility Consumer Guide provides useful information for selecting an ambulatory surgery center. Users can find a surgical center by name, zip code, or medical specialty; download a checklist of questions to consider when having surgery in an outpatient center; and find information on what to do if they have a complaint. **http://mhcc.maryland.gov/consumerinfo/amsurg/index.htm**

Maryland Consumer Guide to Long Term Care helps consumers locate and compare Maryland long-term care services: nursing homes, assisted-living residences, home health agencies, and hospice programs. Users can sort by services offered and by county or zip code; view results from recent health and safety inspections and family satisfaction surveys; and find Internet links to many resources of interest to seniors, such as preparing for long term care needs. **http://mhcc.maryland.gov/consumerinfo/longtermcare/Default.aspx**

Heart disease describes a range of diseases that affect your heart, including diseases of blood vessels, such as coronary artery disease, arrhythmias and heart infections.

Heart Disease

Understanding the Disease

Heart disease describes a range of diseases that affect your heart, including diseases of blood vessels, such as coronary artery disease, arhythmias and heart infections. The term “heart disease” is often used interchangeably with “cardiovascular disease.” Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Many forms of heart disease can be prevented with healthy lifestyle choices.

Source: Mayo Clinic
http://www.mayoclinic.com/health/heart-disease/DS01120

Resources/Helpful Hints

Some risk factors for heart disease cannot be helped such as age, sex, and heredity. Older people, men more than women, and children of parents with heart disease are all at increased risk of developing heart disease. However, many risk factors can be managed to reduce or control risk. Tobacco smokers’ risk for developing coronary heart disease is two to four times that of nonsmokers. High cholesterol, when combined with additional risk factors (especially those that cannot be modified) increases the likelihood even more. Physical inactivity, obesity and excess body fat, poor nutrition and high stress levels are all factors that contribute to heart disease that, when managed, can lead to improved overall health.

Source: The American Heart Association
http://www.heart.org/HEARTORG/Conditions/Conditions_UCM_001087_SubHomePage.jsp

Things You Need to Know

Here are 7 easy tips to discuss with your healthcare provider to improve overall heart health:

1. Quit smoking
2. Control other health conditions, such as high blood pressure, high cholesterol and diabetes
3. Exercise at least 30 minutes a day on most days of the week (Ask your doctor if you are healthy enough for physical activity)
4. Eat a diet that’s low in salt and saturated fat
5. Maintain a healthy weight
6. Reduce and manage stress
7. Practice good hygiene

Source: The Mayo Clinic
http://www.mayoclinic.com/health/heart-disease/DS01120/DSECTION=coping-and-support

Diabetes is a group of diseases characterized by high blood glucose levels that result from defects in the body's ability to produce and/or use insulin.

Diabetes

Understanding the Disease

Diabetes is a group of diseases characterized by high blood glucose levels that result from defects in the body's ability to produce and/or use insulin. There are three types of diabetes:

- **Type 1**, previously known as juvenile diabetes as it is usually diagnosed in childhood
- **Type 2**, the increasingly common type in adults
- **Type 3**, also known as gestational diabetes, in which a pregnant woman can develop diabetes for the duration of her pregnancy but will recover soon after delivery.

Diabetes is a serious but manageable disease; it causes more deaths per year than breast cancer and AIDS combined. Having gestational diabetes can increase a woman's risk of developing Type 2 diabetes later in life. In addition, having family members with diabetes, injury or diseases of the pancreas, hypertension, and obesity are also risk factors in the development of diabetes.

Sources: The American Diabetes Association **http://www.diabetes.org/diabetes-basics/?loc=GlobalNavDB**

The National Library of Medicine. **http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001898/**

Resources/Helpful Hints

As with all chronic diseases, it's important to know your risk. Age, family history, weight, and nutrition can all contribute to your risk of developing Type 2 or gestational diabetes. Talk to your doctor about lessening your risk through improving your diet, i.e. reducing your sugar intake. The American Diabetes Association provides recipes, lifestyle tips and an online community that provides a support network for getting involved and knowing your rights within the community and at the work place.

Source: American Diabetes Association **http://www.diabetes.org/living-with-diabetes/connect-with-others/**

Things You Need to Know

Type 1 diabetes is caused by genetics and unknown factors that trigger the onset of the disease. Type 2 diabetes is caused by genetics, which you cannot change, and lifestyle factors, which you can. Research has shown that drinking sugary drinks is linked to Type 2 diabetes. The American Diabetes Association recommends that people should limit their intake of sugar-sweetened beverages to help prevent diabetes. Sugar-sweetened beverages include beverages like regular soda, fruit punch/drinks, sports/energy drinks, and sweet tea.

Source: The American Diabetes Association **http://www.diabetes.org/diabetes-basics/diabetes-myths/**

Hypertension, commonly known as high blood pressure or HBP, is a serious disease that can lead to heart attack or stroke.

Hypertension

Understanding the Disease

Hypertension, commonly known as high blood pressure or HBP, is a serious disease that can lead to heart attack or stroke. More than 75 million American adults have been diagnosed with high blood pressure. Blood pressure is measured by two forces within your body. They are the two numbers a doctor gives you when he/she reads your blood pressure. The first, systolic, is the pressure your heart uses to push the blood into your arteries and the second "force" is created as the heart rests between beats, known as diastolic. You will most often see these two numbers written with the systolic number above and the diastolic number below. Your genetics and family history as well as your lifestyle play key roles in the development of hypertension. You should always consult your doctor before beginning a treatment routine.

Source: The American Heart Association
http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/AboutHighBloodPressure/About-High-Blood-Pressure_UCM_002050_Article.jsp

Resources/Helpful Hints

As with many diseases, there are ways to control your risk and symptoms once you have been diagnosed with hypertension. These include: a heart healthy diet (reducing salt intake), regular exercise, maintaining a healthy body weight, reducing and managing stress, avoiding tobacco use and secondhand smoke, limiting alcohol intake, and complying with medication prescriptions. Though the symptoms are difficult to recognize, the disease is simple to detect. Once diagnosed it can be very helpful to your healthcare provider if you monitor your blood pressure at home. Recording your results will allow your provider to see a time-lapse picture of your blood pressure and it can also prevent false readings caused by anxiety when measured at a doctor's office. Home monitoring is not recommended for all patients with hypertension so it is important to consult with your doctor.

Source: The American Heart Association
http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/SymptomsDiagnosisMonitoringofHighBloodPressure/Symptoms-Diagnosis-Monitoring-of-High-Blood-Pressure_UCM_002053_Article.jsp

Things You Need to Know

Hypertension and high blood pressure are difficult to recognize within your own body. If you have risk factors and have experienced symptoms like fatigue and dizziness, consult with your doctor. Educate yourself, change detrimental lifestyle habits and improve your overall health. Simple changes like sticking to a heart healthy nutritional plan can have a great effect.

Source: The American Heart Association
http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/Prevention-Treatment-of-High-Blood-Pressure_UCM_002054_Article.jsp

Asthma creates swollen and red (or inflamed) airways in the lungs. People with asthma become sensitive to environmental and/or everyday asthma "triggers."

Asthma

Understanding the Disease

Asthma creates swollen and red (or inflamed) airways in the lungs. People with asthma become sensitive to environmental and/or everyday asthma "triggers." A trigger could be a cold or respiratory infection, the weather, or things in the environment, such as dust, chemicals, smoke, and pet dander. When a person with asthma breathes in a trigger, the insides of the airways make extra mucus and swell even more. This narrows the space for the air to move in and out of the lungs, making it difficult to breathe.

Source: American Lung Association
http://www.lung.org/lung-disease/asthma/learning-more-about-asthma/

Resources/Helpful Hints

Though some risk factors, like your genetics or family history, cannot be modified, many risk factors can be managed. Take care of your lungs, avoid secondhand smoke and limit your exposure to chemicals. Avoid outdoor activities on bad air quality days. It is important to treat colds and respiratory infections quickly and as directed by your doctor. Protect yourself against contagions during the cold and flu season, practice good oral hygiene (protecting your mouth from germs), get vaccinated against influenza, and protect others by staying home from work or school when you get sick. Asthma is a treatable disease that with monitoring can allow you to live a normal and productive life. Check your local air quality at **www.stateoftheair.org** before engaging in an outdoor activity. It's important for everyone, not just those who live with asthma.

Source: American Lung Association
http://www.lung.org/your-lungs/protecting-your-lungs/

Things You Need to Know

Although the exact cause of asthma is not known, the following factors play an important role in the development and worsening or exacerbation of asthma:

- **Genetics.** Asthma tends to run in families.
- **Allergies.** Some people are more likely to develop allergies than others, especially if your parents had allergies. Certain allergies are linked to people who get asthma.
- **Respiratory Infections.** As the lungs develop in infancy and early childhood, certain respiratory infections have been shown to cause inflammation and damage the lung tissue.
- **Environment.** Contact with allergens, certain irritants, or exposure to viral infections as an infant or in early childhood when the immune system is developing have been linked to developing asthma. Irritants and air pollution may also play a significant role in adult-onset asthma.

Source: American Lung Association
http://www.lung.org/lung-disease/asthma/

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases that block airflow as you exhale; if left untreated COPD can cause serious, long term disability.

Chronic Obstructive Pulmonary Disease (COPD)

Understanding the Disease

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases that blocks airflow as you exhale; if left untreated COPD can cause serious, long term disability. Often, symptoms are mistaken by patients as normal results of aging or simply being out of shape. COPD is the third leading cause of death in the United States; however, it is treatable and preventable. Damage to the airways is most often caused by long-term tobacco smoke use or exposure (like secondhand smoke), but can also be caused by exposure to harmful chemicals and/or air pollution.

Source: American Lung Association
http://www.lung.org/lung-disease/copd/living-with-copd/life-change.html

Resources/Helpful Hints

COPD is highly preventable and very easy to diagnose with a simple breathing test. The National Heart Lung and Blood Institute's (NHLBI) campaign *COPD: Learn More Breathe Better*, is meant to educate those at risk and raise awareness about the ease of diagnosis and the testing of COPD. More than 12 million people are diagnosed with COPD and another estimated 12 million may have it and not know it. Your doctor can provide you with the best tools for coping with your condition.

Source: National Heart Lung and Blood Institute
http://www.nhlbi.nih.gov/health/public/lung/copd/

Prevention and Assistance

Unlike some diseases, COPD typically has a clear path to the cause and as a result to prevention. Most cases are directly related to cigarette smoking so the best way to prevent it is to never smoke or quit smoking as soon as possible. It's critical to find a tobacco-cessation program that will help you quit for good and give you the best chance for preventing damage to your lungs.

Source: National Heart Lung and Blood Institute
http://www.nhlbi.nih.gov/health/public/lung/copd/am-i-at-risk/index.htm

Things You Need to Know

Occupational exposure to chemical fumes and dust are other risk factors for COPD. Educate yourself on the best ways to stay protected (wearing a mask when necessary) to prevent lung damage.

Source: The Mayo Clinic
http://www.mayoclinic.com/health/copd/DS00916

IX. CONSUMER RESOURCES

Links to Additional Information and Assistance

Inquiries and Complaints About Healthcare Facilities

Assisted Living, Hospice, Hospitals, Labs, Nursing Homes –
Contact the Office of Health Care Quality
410-402-8000
http://dhmh.maryland.gov/ohcq/SitePages/Home.aspx

Physicians – *Contact the Board of Physicians*
410-764-4777
http://www.mbp.state.md.us/

Vaccinations

Local Health Department
http://msa.maryland.gov/msa/mdmanual/01glance/html/healloc.html

Vaccines for Children Program
http://ideha.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/about-vaccine-for-children.aspx

Inquiries and Complaints About Health Insurance for Consumers

Maryland Health Insurance Plan *(for residents without health insurance)*
http://www.marylandhealthinsuranceplan.state.md.us/

Maryland Insurance Administration
1-800-492-6116 or 410-468-2000
http://www.mdinsurance.state.md.us

Children's Health Insurance Program (CHIP)
1-800-456-8900
http://mmcp.dhmh.maryland.gov/chp/SitePages/Home.aspx

Has your health benefit plan refused to cover a medical procedure or pay for a medical service that has already been provided? – *Contact the Maryland Attorney General's Health Education and Advocacy Unit*
1-410-528-1840
http://www.oag.state.md.us/consumer/heau.htm

Bill Information/legislative/budget/statute questions? – *Contact the Maryland General Assembly*
http://mgaleg.maryland.gov

Maryland Links

Medicaid Waivers
http://mmcp.dhmh.maryland.gov/waiverprograms/SitePages/Home.aspx

Maryland Office of Health Care Quality
http://dhmh.maryland.gov/ohcq/SitePages/Home.aspx

Maryland Licensed Health Care Facilities
http://dhmh.maryland.gov/ohcq/SitePages/Home.aspx

Maryland Children's Health Programs
http://mmcp.dhmh.maryland.gov/chp/SitePages/Home.aspx

Maryland Local Health Departments
http://msa.maryland.gov/msa/mdmanual/01glance/html/healloc.html

Maryland Health Insurance Plan *(for residents without health insurance)*
http://www.marylandhealthinsuranceplan.state.md.us/

Maryland Insurance Administration
http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp

Maryland Board of Physicians
http://www.mbp.state.md.us/

Maryland Board of Nursing
http://www.mbon.org/main.php

Maryland Pharmacy Board
Number is 410-764-4755
http://dhmh.maryland.gov/pharmacy/SitePages/Home.aspx

Maryland State Board of Dental Examiners
http://dhmh.maryland.gov/dental/SitePages/Home.aspx

Maryland Department of Aging
http://www.aging.maryland.gov/

Senior Health Insurance Assistance Program (SHIP)
http://www.aging.maryland.gov/senior.html

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IX. CONSUMER RESOURCES

Maryland Health Services Cost Review Commission
http://www.hscrc.state.md.us/

Maryland Vital Records (birth, death, marriage, divorce certificates)
http://dhmh.maryland.gov/vsa/SitePages/Home.aspx

Long Term Care Provider Contacts

Health Facilities Association of Maryland
http://www.hfam.org

LifeSpan Network
http://www.lifespan-network.org

Maryland Association for Adult Day Services
http://www.maads.org

Maryland National Capital Homecare Association
http://www.mncha.org

The Hospice & Palliative Care Network of Maryland
http://www.hnmd.org

COMAR Online

Title 10 – Department of Health and Mental Hygiene
http://www.dsd.state.md.us/comar/searchtitle.aspx?scope=10

Patient Safety

Maryland Patient Safety Center
http://www.marylandpatientsafety.org

Hospital Information

Maryland Hospital Association
http://www.mhaonline.org

CMS Hospital Compare
http://www.hospitalcompare.hhs.gov/

Joint Commission on Accreditation of Healthcare Organizations
http://www.jointcommission.org

Hospital Quality Alliance (HQA)
http://www.hospitalqualityalliance.org/

Federal Links

Medicaid
http://www.cms.hhs.gov/home/medicaid.asp

Medicare
http://www.medicare.gov

Assisted Living Information
Assisted Living Federation of America: http://www.alfa.org/alfa/Consumer_Corner.asp
National Center for Assisted Living: http://www.ahcancal.org/ncal/Pages/default.aspx
Assisted Living Facilities Organization: http://www.assistedlivingfacilities.org/

CMS Nursing Home Compare
http://www.medicare.gov/NHCompare

Department of Health and Human Services Administration on Aging
http://www.aoa.gov/

U.S. Department of Health and Human Services
http://www.hhs.gov/

U.S. Bureau of the Census
http://www.census.gov

National Links

American Association of Homes and Services for the Aging
http://www.leadingage.org/

Health Savings Accounts
http://www.nahu.org/index.cfm
http://www.ustreas.gov

Data Sources

Maps with county-level and hospital referral region statistics, quality measures, health information technology adoption, population health, utilization & costs, readmission rates, mortality rates, as well as prevention and inpatient quality indicators (The Commonwealth Fund)
http://whynotthebest.org/maps

Star Rating Methodology

Comparison of Health Benefit Plan Rates to the Maryland Average

This report contains Maryland HMO/POS and PPO plan averages for each measure, and presents a comparison analysis between individual health benefit plan averages and the Maryland average benchmark. All HMO/POS and PPO health benefit plans contribute equally to the Maryland average benchmark rate of performance for the HMO and PPO categories of plans respectively. The Maryland average benchmark rate for HMO/POS plans is determined by adding the rate for each HMO/POS plan and dividing by eight. Then individual health benefit plan rates for the HMO category are compared to the unweighted average rate of performance for all eight HMO/POS Maryland plans. When the difference between a health benefit plan's rate and the Maryland average benchmark for HMOs is statistically significant and the health benefit plan's rate is "above" the Maryland average, the health benefit plan is assigned to the significantly "better than" the Maryland average category; accordingly, if the health benefit plan's rate is "below" the Maryland average benchmark for HMOs, the health benefit plan is assigned to the significantly "worse than" the Maryland average category. In some situations, two health benefit plans with the same rate could be classified into two different performance rating categories for a measure. This possibility is related to the width of a confidence interval around the difference between the health benefit plan and the Maryland average benchmark. The width of a confidence interval is inversely related to the size of the denominator. A health benefit plan with a relatively small denominator will have a wider confidence interval than a health benefit plan with a large denominator. The wider the confidence interval, the more likely it is to contain the Maryland HMO/POS average. If the Maryland HMO/POS average lies within the confidence interval, the plan is assigned to the significantly "equivalent to" the Maryland average benchmark for HMOs. Conversely, the narrower the confidence interval, the less likely it is to contain the Maryland HMO/POS average. Therefore, the health benefit plan with the larger denominator is less likely to be classified with an "equivalent to" the Maryland average benchmark for HMOs category.

The same method was applied to calculation of relative rates for PPOs except that the Maryland average benchmark rate for PPO plans is determined by adding the rate for each PPO plan and dividing by six.

The report uses the following symbols to denote the relative comparisons between the individual health benefit plan and the Maryland average:

★★★ The health benefit plan's performance is significantly better than the Maryland average

★★ The health benefit plan's performance is equivalent to the Maryland average

★ The health benefit plan's performance is significantly worse than the Maryland average

HEDIS Methodology

The NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) is a proprietary health benefit plan performance evaluation tool that uses a standardized set of key performance measures and indicators to gather information from health benefit plans. This information, once audited and validated, is then able to be publicly reported so that consumers, employers and others can make direct comparisons of health benefit plan performance rates for each measure and indicator being reported.

The Maryland Health Care Commission contracted with HealthcareData Company, LLC (HDC), a licensed HEDIS firm, to conduct a full audit of the Maryland commercial health benefit plans as prescribed by HEDIS 2012, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures, published by NCQA.

A major objective of the audit is to determine the reasonableness and accuracy of how each health benefit plan collects data for performance reporting in Maryland.

The compliance audit focuses on two areas when evaluating each organization: an assessment of the organization's overall information system (IS) capabilities and an evaluation of its ability to comply with HEDIS specifications for individual performance measures.

The HEDIS-reporting organization follows guidelines for data collection and specifications for measure calculation described in HEDIS 2012 Volume 2: Technical Specifications. For data collection, the health benefit plan pulls together all data sources, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. Three approaches may be taken for data collection:

1. **Administrative data:** Data from transaction systems (claims, encounters, enrollment, practitioner) provide the majority of administrative data. Organizations may receive encounter files from pharmacy, laboratory, vision, and behavioral health vendors.
2. **Supplemental data:** NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and medical record-derived databases.
3. **Medical record data:** Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid method. HEDIS specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. Use of the hybrid method is optional.

The percentages of data obtained from one data source versus another vary widely between health benefit plans, making it inappropriate to make across-the-board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data collection systems.

Upon completion, the auditor approves the rate/result of each measure included in the HEDIS report. If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of NR. Bias is based on the degree of error or data completeness for the data collection method used. NCQA defines four bias determination rules, applied to specific measures. The performance scores presented in this report reflect only measures deemed "Reportable" by the HEDIS auditor.

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CAHPS Methodology

CAHPS 4.0H Survey: Background

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey program is overseen by the United States Department of Health and Human Services—Agency for Healthcare Research and Quality (AHRQ) and includes a myriad of survey products designed to capture consumer, patient and health benefit plan member perspectives on health care quality. The Maryland Health Care Commission has implemented use of the *CAHPS Health Plan Survey 4.0H, Adult Version* as part of the Health Benefit Plan Quality and Performance Evaluation System.

The core of the CAHPS survey is a set of questions used to measure satisfaction with the experience of care and includes four questions that reflect overall satisfaction and seven multi-question composites that summarize responses in key areas. Respondents are asked to use a scale of 0–10 to rate their doctor, their specialist, their experience with all health care, and their health benefit plan.

MHCC contracted with WB&A Market Research, a survey vendor specializing in health care and other consumer satisfaction surveys, to administer the survey to members of the various health benefit plans included in this report.

In addition, MHCC contracted with a licensed HEDIS audit firm, HealthcareData Company, LLC, to review programming codes used to create the list of eligible members to take part in the survey and to validate the integrity of the sample frame of those members before WB&A Market Research randomly drew from the sample and administered the survey.

Survey data collection began in mid-February 2012 and lasted into May 2012. Summary-level data files generated by NCQA were distributed in June 2012 to each health benefit plan for a review of data before the authorized health benefit plan representative signed off attesting to the accuracy of the data pertaining to their health benefit plan that are now included in this public report.

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

Health benefit plan members who are eligible to participate in the *CAHPS Health Plan Survey 4.0H, Adult Version* had to be 18 years of age or older as of December 31 of the measurement year (2011). They also had to be continuously enrolled in the commercial health benefit plan for at least 11 of the 12 months of 2011, and remain enrolled in the health benefit plan in 2012. Enrollment data sets submitted to the CAHPS vendor are sets of all eligible members—the relevant population. All health benefit plans are required to have their CAHPS data set (sample frame) audited by the licensed HEDIS auditor before the data is sent to the survey vendor.

Survey Protocol

The CAHPS survey employs a rigorous, multistage contact protocol that features a mixed-mode methodology consisting of a mail process and telephone follow-up attempts. This protocol is designed to maximize response rates and give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, healthier, and male.

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