2013

HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE REPORT

MEASURING THE QUALITY AND PERFORMANCE OF MARYLAND'S COMMERCIAL HEALTH BENEFIT PLANS

MHCC | MARYLAND HEALTH CARE COMMISSION

2013 HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE REPORT

On Commercial HMOs, PPOs, POSs, EPOs, and Other Types of Health Benefit Plans in Maryland

MHCC | MARYLAND HEALTH CARE COMMISSION

2013 Health Benefit Plan Quality and Performance Report

* For MHCC contact information please see the back cover of this report.

Letter From the Chair and the Executive Director

Thank you for your interest in the *2013 Health Benefit Plan Quality and Performance Report: Measuring the Quality and Performance of Commercial Health Benefit Plans In Maryland.* This annual report provides an array of quality and performance information on health insurance carriers and authorized combinations of their different types of health benefit plan delivery systems including health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service plans (POSs), and exclusive provider organizations (EPOs). The report also shares important health care quality improvement work being done by Maryland's commercial health insurance carriers and is a valuable resource for individuals, employers and employees to compare health benefit plans on 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 MHCC 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.

We are proud to be driving continuous health care quality improvement in the State of Maryland through publicly reporting information on health benefit plan quality and performance. We hope you find this report to be a valuable resource that presents information in an easy to understand way. As this is a dynamic report, we invite you to send us suggestions on how the report could be improved for 2014.

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

Maryland Health Care Commission

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 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. For more information about the MHCC and the reports it produces, visit **http://mhcc.dhmh.maryland.gov**. For MHCC contact information, please see the back page of this report.

Measuring and Reporting on Health Care Quality and Performance

The Maryland Health Care Commission (MHCC) is committed to promoting improvements in health care by reporting on the quality and performance of managed care plans operating in the State of Maryland. This year, MHCC continues its 17-year history of advancing health care quality through its leadership in the evaluation and public reporting of commercial health benefit plan quality and performance information. 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).

To help improve the quality of health care in Maryland, the MHCC is legislatively charged with establishing and implementing a system of quality and performance measurement and with disseminating findings to consumers, health benefit plans, and other interested parties. Assessing the performance of Maryland commercial health benefit plans is a critical component of ensuring the availability of quality health care for its residents. Health benefit plan disclosure of quality information using reliable, audited, standardized measures and indicators helps consumers and employers evaluate specific areas and overall performance of health benefit plans. A consistent finding by key organizations such as the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), and the National Committee for Quality Assurance (NCQA) is that health benefit plans that publicly report performance data perform significantly better than those that do not publicly report. Using quality and performance information supports informed health choices, and aids in the selection and purchase of the best quality of care specific to the needs of each consumer, whether the consumer is an individual, a family or an employer. Public reporting of standardized quality and performance measures and indicators promotes competition among health insurance carriers and stimulates health benefit plans' efforts toward continuous quality and performance improvement activities that target consumer 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.

The 2013 Health Benefit Plan Quality and Performance Report provides detailed, health benefit plan specific indicators of quality and performance based on measures that include: health care effectiveness through 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.

I. GENERAL INFORMATION

About This Report

The 2013 Health Benefit Plan Quality and Performance Report allows Marylanders to compare health benefit plans on key quality measures regarding the effectiveness of health care delivery and member satisfaction with their experience of care. 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 health care delivery systems. These delivery systems primarily include health maintenance organizations (HMOs) and preferred provider organizations (PPOs); however point-of-service plans (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 HMO or PPO, 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 on managing chronic conditions and maintaining wellness, which can bring multiple benefits, including a longer lifespan, fewer illnesses and an 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 highlights 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 among delivery systems, demographic information on the health benefit plans and behavioral health plans, and board certification status of the provider networks.

Section IV of the report provides an introduction to several new performance areas. First, there is a short discussion on the development of RELICC, a quality and performance measurement tool which focuses on race/ethnicity, language, interpreters, and cultural competency issues. Next are vignettes prepared by each carrier which provide a summary of initiatives related to this year's theme, *"Leadership Actions In Health Care Delivery."* The theme focuses on actions taken by each organization's leaders toward progressive programs that respond to the Affordable Care Act, changes in demographics, required services, and patient expectations.

Section V presents the results of each individual health benefit plan across multiple quality and performance measures and indicators, which are divided into the following six key measurement categories: 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 comparison for the Maryland Average Benchmark is presented for each measure and indicator through a 3-star rating system, with more stars indicating a better performance for the individual health benefit plan. The reader can choose the appropriate category based on 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." Section V also includes a portrayal of member experience and satisfaction with

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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 is dedicated to State of Maryland employees with information on the specific 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 health care initiatives, such as the Maryland Multi-Payer Patient Centered Medical Home program, the Million Hearts® initiative, the Maryland Health Information Exchange, as well as the Maryland Health Benefit Exchange.

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 briefly explained along with helpful hints for disease management. Finally, 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?

- Individuals and families 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
- 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 who want to stay informed on current health benefit plan quality and performance issues

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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 a national average and whether that ranking would make a difference in the choice of a 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 Average Benchmark 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 Average 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 HMOs and authorized HMO combination health benefit plans as well as six PPOs and authorized PPO combination health benefit plans. When looking at the HMO results in a measure, if the needle is on 7, it means that 7 of the HMOs and authorized HMO combination health benefit plans are better than the National Average Benchmark 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. Seven of the eight HMOs and authorized HMO combination health benefit plans and all six of the PPOs and authorized PPO combination health benefit plans performed better than the National Average Benchmark. 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 Benchmark and highlight a potential area for improvement. Again, the maximum score would be eight HMOs and authorized HMO combination health benefit plans as well as six PPOs and authorized PPO combination health benefit plans that could be better than the National Average Benchmark. The position of the needle on the display indicates how many health benefit plans scored better than the National Average Benchmark.

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.

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 [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], Maryland's health benefit plans demonstrate excellent performance on several measures within three categories:

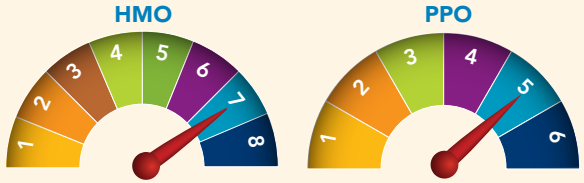
1. In the category **Primary Care and Wellness for Children and Adolescents**, the results clearly show that health benefit plans are focusing on services to children and adolescents. Newborns are being provided the required number of well-child visits before they turn 15 months old, plus children 3–6 years of age and adolescents 12–21 years of age receive at least one well-child visit each year. The results also show that the majority of plans ensure children receive access to care and adequate preventive health care through appropriate vaccination.

Note: Maximum score is 8 for the HMOs and authorized HMO combination health benefit plans and 6 for the PPOs and authorized PPO combination health benefit plans.

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

Primary Care and Wellness for Children and Adolescents

Well-Child Visits in the First 15 Months of Life



Children who during their first months of life had 6+ office visits with their primary care provider

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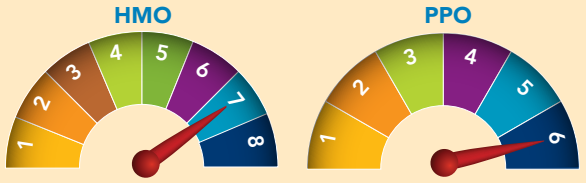
Childhood Immunization Status



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)

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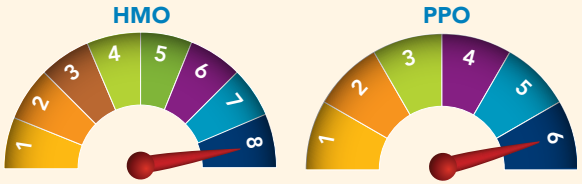
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



Children 3, 4, 5, or 6 years of age who had at least one well-child visit with their primary care provider during 2012

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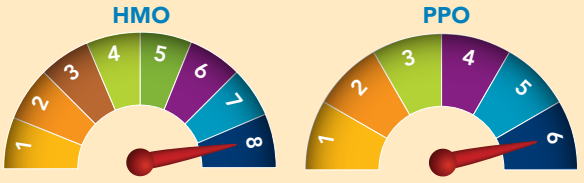
Adolescent Well-Care Visits



Adolescents 12–21 years of age who had at least one well-child visit with their primary care provider during 2012

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Maryland's health benefit plans demonstrate excellent performance in three categories.

2. In the category **Child Respiratory Conditions**, all of the health benefit plans are appropriately treating children with antibiotics and a strep test when diagnosed with pharyngitis.
3. In the category **Behavioral Health**, the results show that all health benefit plans appropriately manage members diagnosed with major depression with medication, and the majority of plans continue this medication treatment at least 6 months after the initial diagnosis and screening.

Note: Maximum score is 8 for the HMOs and authorized HMO combination health benefit plans and 6 for the PPOs and authorized PPO combination health benefit plans.

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

Child Respiratory Conditions

Appropriate Testing for Children with Pharyngitis

Children who received appropriate testing when diagnosed with pharyngitis during 2012

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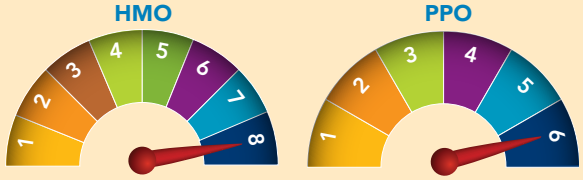
Behavioral Health

Antidepressant Medication Management



Members who received appropriate medication treatment associated with major depression during 2012

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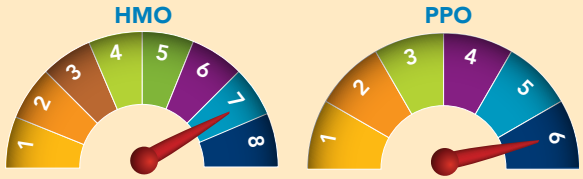
Continuing Antidepressant Medication Management



Members who received appropriate medication treatment for at least 6 months after initial diagnosis

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Potential Areas for Improvement

Overall, the health benefit plans continue to perform well when compared to the national average. However, there are several items within five out of the six categories of measures and indicators previously listed [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], where improvement is dictated but perhaps influenced to some degree by member expectations on services that should be provided.

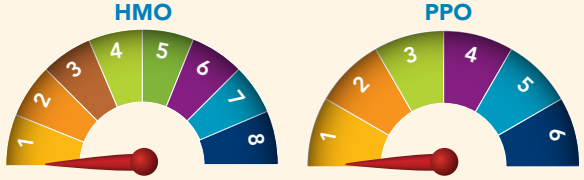
1. In the category **Primary Care and Wellness for Children and Adolescents**, the results clearly show that all the health benefit plans need to focus more on conducting human papillomavirus vaccination for female adolescents.
2. In the category **Child Respiratory Conditions**, the results show that health benefit plans need to improve care for all children with asthma, particularly children 5-11 years of age.

Note: Maximum score is 8 for the HMOs and authorized HMO combination health benefit plans and 6 for the PPOs and authorized PPO combination health benefit plans.

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

Primary Care and Wellness for Children and Adolescents

Human Papillomavirus Vaccine for Female Adolescents



Female adolescents who received the complete vaccination for human papillomavirus during 2012

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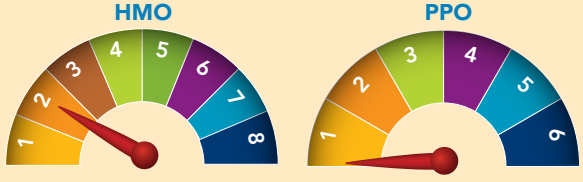
Child Respiratory Conditions

Medication Management for Children with Asthma (5–11 years, 50% treatment period compliance)



Children 5–11 years of age with asthma who achieved 50% treatment period compliance during 2012

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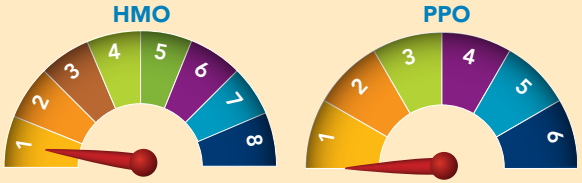
Child Respiratory Conditions

Use of Appropriate Medications for Children with Asthma (5–11 years)



Children 5–11 years of age who received appropriate medication for asthma during 2012

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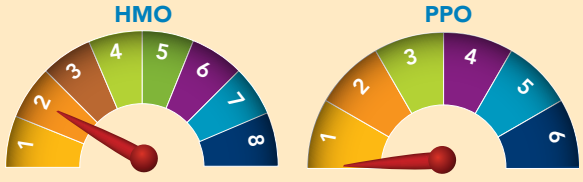
Child Respiratory Conditions

Medication Management for Children with Asthma (5–11 years, 75% treatment period compliance)



Children 5–11 years of age with asthma who achieved 75% treatment period compliance during 2012

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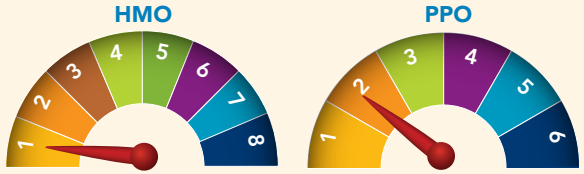
3. In the category **Primary Care for Adults – Respiratory Conditions**, the results show that many health benefit plan members are routinely prescribed antibiotics for acute bronchitis when perhaps antibiotics are not necessary. In addition, members 51–64 years of age with asthma, as well as members with chronic obstructive pulmonary disease (COPD) can benefit from improved medication management activities.

Note: Maximum score is 8 for the HMOs and authorized HMO combination health benefit plans and 6 for the PPOs and authorized PPO combination health benefit plans.

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

Primary Care for Adults – Respiratory Conditions

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



Adults with acute bronchitis who were prescribed antibodics only when needed

See details on page 72

Pharmacotheraphy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Systemic Corticosteriod)

Adults with COPD who were prescribed systemic corticosteroids to control bronchial inflammation

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Medication Management for Adults with Asthma (51–64 years, 75% treatment period compliance)

Adults 51-64 years of age who remained on asthma medication for at least 75% of the treatment period

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Pharmacotheraphy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator)

Adults with COPD who were prescribed "rescue" medications that provide quick, temporary relief from bronchial inflammation

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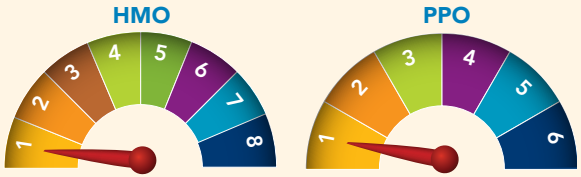
4. In the category **Primary Care for Adults – Cardiovascular Conditions and Diabetes**, the results show that controlling members' high blood pressure and providing hemoglobin A1c (HbA1c) testing for diabetics also need greater focus for improvement by the majority of health benefit plans.
5. In the category **Behavioral Health**, results indicate that improvement is again needed when it comes to providing appropriate follow-up after being discharged from the hospital due to a mental health disorder.

Note: Maximum score is 8 for the HMOs and authorized HMO combination health benefit plans and 6 for the PPOs and authorized PPO combination health benefit plans.

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

Primary Care for Adults – Cardiovascular Conditions and Diabetes

Controlling High Blood Pressure



Adults who had blood pressure appropriately controlled after initial diagnosis

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Comprehensive Diabetes Care (HbA1c Testing)

Adults who received HbA1c lab testing, showing whether they have active control of their diabetes

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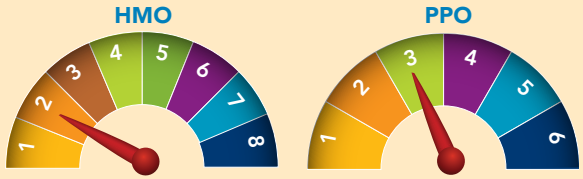
Behavioral Health

Follow-Up After Hospitalization for Mental Illness (7 days)



Members who had follow-up within 7 days of discharge from the hospital for a mental health disorder

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Follow-Up After Hospitalization for Mental Illness (30 days)

Members who had follow-up within 30 days of discharge from the hospital for a mental health disorder

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III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plan Delivery System

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 within the network and 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.

Features of the Various Health Benefit Plan Delivery Systems

Topic	HMO	POS	PPO	EPO
Primary Care Providers (PCPs)	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 to manage their care. Members may choose an in-network PCP or out-of-network PCP to manage their care.	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.	Referrals may be needed to seek care from specialists or other providers. Members may choose between PCP referral to an 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. Other than physician office visits and emergency care, services must usually be authorized by the PPO before members receive them.	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. As long as you see your PCP or have an authorized referral to another provider, your out-of-pocket cost is usually a relatively small copayment per visit. But if you choose to go to another provider without a referral—whether or not the providers are in the HMO network—you'll have to pay 100% of the provider's bills. The exceptions are true emergency situations for which you are covered by the plan.	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; higher costs associated with out-of-network services. You pay least when you receive services from your PCP or through an authorized referral to another in-network provider. But unlike an HMO, you may opt out of the network. If you opt out you'll be responsible for paying a higher percent of the provider's bill.	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. A PPO plan encourages you to choose doctors, hospitals, and other providers that participate in the plan. They do this by increasing the portion of the bill they pay if you stay "in-network." You may choose to go "out-of-network" at any time, but if you do, you'll have to pay a higher percent of the provider's bill.	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. In choosing an EPO, it is important to make sure that the program includes enough providers to match your needs. In most EPO plans, as with an HMO, if you choose to go out-of-network, you'll have to pay 100% of the provider's bills.

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

III. HEALTH BENEFIT PLAN INFORMATION

Health Benefit Plans in Maryland Reporting in 2013

Abbreviated health benefit plan report-level names are used in this report.

Health Benefit Plan 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	1-800-US-AETNA (1-800-872-3862) 7 days a week, 7:00 AM–7:00 PM **www.aetna.com**	Aetna is a for-profit HMO with POS, PPO and EPO
Aetna Life Insurance Company (MD/DC)	Aetna PPO	PPO/EPO Combined		
CareFirst BlueChoice, Inc.	BlueChoice HMO	HMO/POS Combined	1-888-432-4380 7 days a week, 7:00 AM–7:00 PM **www.carefirst.com**	CareFirst BlueChoice is a not-for-profit HMO
CareFirst of Maryland, Inc.	BluePreferred PPO	PPO/EPO Combined		CareFirst BluePreferred, Inc. is a for-profit PPO with EPO
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company	Cigna HMO	HMO/POS Combined	1-866-GET-Cigna (1-866-438-2446) 24 hours a day, 7 days a week **www.cigna.com**	Connecticut General Life Insurance Company is doing business as Cigna and is a for-profit HMO with POS and PPO
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company	Cigna PPO	PPO		
Coventry Health Care of Delaware, Inc.	Coventry HMO	HMO/POS Combined	1-800-833-7423 Monday–Friday, 8:00 AM–5:00 PM **www.coventryhealthcare.com**	Coventry Health Care of Delaware, Inc. is a for-profit HMO and has a for-profit PPO offered by Coventry Health and Life Insurance Company
Coventry Health and Life Insurance Company	Coventry PPO	PPO		

continued

III. HEALTH BENEFIT PLAN INFORMATION

HEALTH BENEFIT PLANS IN MARYLAND REPORTING IN 2013

Health Benefit Plan 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/POS Combined	1-800-245-3181 24 hours a day, 7 days a week **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.
(United Healthcare) Maryland Individual Practice Association, Inc.	MD–IPA HMO	HMO/POS Combined	1-800-307-7820 24 hours a day, 7 days a week TTY: 711 (Maryland only) **www.myuhc.com**	MD–IPA and OCI, for-profit HMOs, are owned and operated by a regional holding company and are subsidiaries of UnitedHealth Group, Inc.
(United Healthcare) Optimum Choice, Inc.	OCI HMO	HMO/POS Combined		
(UnitedHealthcare) MAMSI Life and Health Insurance Company	MAMSI PPO	PPO	1-800-307-7820 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		
UnitedHealthcare Insurance Company (Maryland)	United PPO	PPO/POS/EPO Combined		UnitedHealthcare Insurance Company (Maryland) and MAMSI Life and Health Insurance Company are both for-profit PPO plans and subsidiaries of UnitedHealth Group, Inc.

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III. HEALTH BENEFIT PLAN INFORMATION

Managed Behavioral Healthcare Organizations (MBHO)

Behavioral health care services include mental health services as well as services for mood, behavioral, and addictive disorders such as the abuse of alcohol or other substances. Behavioral health care services are provided through the health benefit plan's own provider network or through a contractual arrangement with a behavioral health care 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 health care services for each health benefit plan.

Name of MBHO Providing Behavioral Health Care Services	
HMO	**Name of MBHO**
Aetna Health, Inc. (Pennsylvania) – Maryland	Aetna Behavioral Health Pennsylvania
CareFirst BlueChoice, Inc.	Magellan Health Services
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company (Cigna HMO)	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
(UnitedHealthcare) Maryland Individual Practice Association, Inc.	United Behavioral Health
(UnitedHealthcare) 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 of Maryland, Inc. (BluePreferred)	CareFirst's regional provider network Magellan Health Services – for utilization and care management services
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company (Cigna PPO)	Cigna Behavioral Health, Inc.
Coventry Health and Life Insurance Company	MHNet Behavioral Health
(UnitedHealthcare) MAMSI Life and Health Insurance Company	United Behavioral Health
UnitedHealthcare Insurance Company (Maryland)	United Behavioral Health

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III. HEALTH BENEFIT PLAN INFORMATION

Total Behavioral Health Care 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	547	1	413	1239	0	84	0	0	674	0	19	3008
CareFirst BlueChoice, Inc.	509	4	508	1499	0	119	0	0	848	3	0	3490
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company (Cigna HMO)	368	9	273	764	0	55	0	0	396	10	7	1882
Coventry Health Care of Delaware, Inc.	237	5	214	732	0	41	20	4	375	6	0	1634
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	376	1	256	497	0	29	6	0	142	6	0	1313
(UnitedHealthcare) Maryland Individual Practice Association, Inc.	460	5	464	1018	0	110	12	1	393	0	0	2463
(UnitedHealthcare) Optimum Choice, Inc.	460	5	464	1018	0	110	12	1	393	0	0	2463
UnitedHealthcare of the Mid-Atlantic, Inc.	460	5	464	1018	0	110	12	1	393	0	0	2463
PPO												
Aetna Life Insurance Company (MD/DC)	563	1	417	1267	0	86	0	0	688	20	31	3073
CareFirst of Maryland, Inc. (BluePreferred)	799	0	831	2083	0	109	0	0	1019	0	0	4841
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company (Cigna PPO)	368	9	273	763	0	55	0	0	396	10	7	1881
Coventry Health and Life Insurance Company	237	5	214	732	0	41	20	4	375	6	0	1634
(UnitedHealthcare) MAMSI Life and Health Insurance Company	460	5	464	1018	0	110	12	1	393	0	0	2463
UnitedHealthcare Insurance Company (Maryland)	460	5	464	1018	0	110	12	1	393	0	0	2463

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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 via an independent, external assessment of quality and performance by a review organization. National Committee for Quality Assurance (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 commercial health benefit plans or MBHOs.

NCQA Accreditation

The NCQA accreditation 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 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 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 a 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 health care systems which provide a full range of health care services, such as HMO health benefit plans and fully integrated PPO health benefit plans. Standards

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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 and include a desktop review phase, on-site review phase, plus a committee review phase. 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 site that participates in the 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 within six months.

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 health care and improve coordination among medical and behavioral health professionals.

The MBHO accreditation program requires MBHOs to annually monitor and evaluate at least two preventive behavioral health care 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 plans (such as MBHOs) select to demonstrate that they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

III. HEALTH BENEFIT PLAN INFORMATION

HEALTH BENEFIT PLAN ACCREDITATION INFORMATION

Health Benefit Plan Accreditation Status

HMO	Organization	Accreditation Status	Expiration Year	Name of MBHO or Accredited Segment of Health Plan	NCQA MBHO Accreditation Status: Expiration Year	URAC Health Utilization Management Accreditation	URAC Case Management Accreditation
Aetna Health, Inc. (Pennsylvania) – Maryland	NCQA	Excellent	2014	Aetna Behavioral Health Pennsylvania	Full; 2014		
CareFirst BlueChoice, Inc.	NCQA	Commendable	2013	Magellan Tristate Care Management Center	Full; 2013	Full; 2013	Full; 2013
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company (Cigna HMO)	NCQA	Excellent	2014	Cigna Behavioral Health, Inc.	Full; 2014		
Coventry Health Care of Delaware, Inc.	URAC	Full Accreditation	2013	MHNet Behavioral Health	Full; 2015	Full; 2015	
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	NCQA	Excellent	2013	Kaiser Permanente Health Plan of the Mid-Atlantic States	Excellent; 2013		
(UnitedHealthcare) Maryland Individual Practice Association, Inc.	NCQA	Commendable	2015	United Behavioral Health	Full; 2013	Full; 2014	
(UnitedHealthcare) Optimum Choice, Inc.	NCQA	Commendable	2015	United Behavioral Health	Full; 2013	Full; 2014	
UnitedHealthcare of the Mid-Atlantic, Inc.	NCQA	Commendable	2015	United Behavioral Health	Full; 2013	Full; 2014	
PPO							
Aetna Life Insurance Company (MD/DC)	NCQA	Excellent	2013	Aetna Behavioral Health Pennsylvania	Full; 2014		
CareFirst of Maryland, Inc. (BluePreferred)	NCQA	Commendable	2013	Magellan Tristate Care Management Center	Full; 2013	Full; 2013	Full; 2013
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company (Cigna PPO)	NCQA	Commendable	2014	Cigna Behavioral Health, Inc.	Full; 2014		
				ValueOptions, Inc.		Full; 2013	
Coventry Health and Life Insurance Company	NCQA	Commendable	2013	MHNet Behavioral Health	Full; 2015	Full; 2015	
(UnitedHealthcare) MAMSI Life and Health Insurance Company	NCQA	Commendable	2013	United Behavioral Health	Full; 2013	Full; 2014	
UnitedHealthcare Insurance Company (Maryland)	NCQA	Excellent	2015	United Behavioral Health	Full; 2013	Full; 2014	

HEDIS and HEDIS Compliance Audits are trademarks of the National Committee for Quality Assurance (NCQA)

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

* 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

One of MHCC's functions is to address and report on public health issues of particular importance to the State of Maryland. In this regard, MHCC continues to work closely with carriers, employers, and others to improve upon the State's system for commercial health benefit plan quality and performance measurement and reporting. As a result, health benefit plans are required to report on health and wellness initiatives specifically targeted for their Maryland members. A special theme is published for each reporting year. For 2013, the theme established by MHCC is *"Leadership Actions In Health Care Delivery."* The theme focuses on actions taken by each organization's leaders toward progressive programs that respond to the Affordable Care Act, changes in demographics, required services, and patient expectations.

In addition, in response to Lt. Governor Anthony Brown's Maryland Health Improvement and Disparities Reduction Act of 2012, a new measurement tool, the Maryland RELICC Assessment (RELICC), was developed and recently implemented. RELICC focuses on how commercial health benefit plans are working to reduce health disparities in the State by targeting race/ethnicity, language, interpreter need, and cultural competency issues. Use of the new RELICC tool and other efforts on quality and performance measurement and reporting in this area are just starting; therefore, performance results are not included in this report. Subsequent editions of the annual Health Benefit Plan Quality and Performance Report will contain information on how Maryland's health benefit plans are helping to eradicate health care disparities.

Information on carrier-specific leadership actions in health care delivery, including health and wellness initiatives specific to each carrier, is provided in this section.

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IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES | aetna

Aetna

Aetna Health Inc. and Aetna Life Insurance Company are committed to changing health care. All our efforts are toward a single end: To provide improved access to quality health care services for all Americans. We put information and helpful resources to work for our members to help them make better-informed decisions about their health care. We work hard to improve health care in America and want to make sure health care is affordable and of good quality for all.

Emerging Technologies

By providing online tools to maintain a personal health record, estimate medical out of pocket costs, research health topics, and ask questions concerning care and service, Aetna provides members opportunities for an interactive role in their own health management. Further efforts have been made to provide social, mobile, and fun/educational tools to support member needs for engagement and interaction.

Accountable Care Solutions

As part of an enhanced experience, members are provided with services including motivational interviewing in combination with care management to provide a more member engaged result to health outcomes and satisfaction. In addition, there are flexible saving, spending, and reimbursement accounts to allow less stressful access to care when needed.

Services are provided throughout a broad care network that allow better access to services, tools, and other resources that promote more diverse and thorough care quality. Further, services are offered connecting members to health and wellness resources that enable members to have an active role in managing a healthier lifestyle.

These member oriented services are combined with reimbursement incentives, care based member satisfaction, and technology enhancements that allow care providers greater access to the means to provide the best individualized care to members.

Member Programs

Directory services provide members assistance in efficiently finding providers within the Aetna network. Additionally, web based tools allow access to detailed provider information, minimizing the stress involved with finding the best care for member needs. Providers and clinicians also receive member details and clinical performance scoring to best prepare them to treat members ensuring the best match between member and care provider.

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IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES | CareFirst

CareFirst

CareFirst BlueCross BlueShield, including CareFirst BlueChoice and CareFirst BluePreferred, believes that improving health care quality and reducing costs should be complementary – not contradictory – concepts. Specifically, we believe that coordination of care is best done under the guidance of a primary care physician, who, in turn, should have a strong incentive to closely track the needs of patients with multiple chronic health conditions. This requires the integration of financial incentives to providers, infrastructure support and data analytics that track members, and groupings of members over time and care settings.

Patient Centered Medical Home (PCMH) Program

The PCMH Program is now one of the largest in the nation, with more than 3,600 primary care providers (PCPs) – physicians and nurse practitioners – serving nearly 1 million CareFirst subscribers. The PCMH Program provides strong financial incentives as well as a variety of other supports to PCPs to assure that care coordination and risk reduction strategies are applied to member care to help prevent chronic conditions from developing into even more serious health issues.

Focused Initiatives

It is essential that all aspects of coverage, including hospital care, professional services, drug coverage and home based and ancillary services, be coordinated. For the most critically ill, specialty case management is used to coordinate the complex needs of these members. Similarly, a well-focused wellness program is essential to maintaining the health of the vast majority of members.

CareFirst initiatives, including admission review, complex case management, chronic care management and an array of other support programs are geared toward patient specific management/care coordination.

Wellness Services

CareFirst also offers an extensive list of wellness services, such as Health Assessments, online coaching, and telephone health advice targeted to specific risks identified in a member's health assessment. In addition to addressing critical conditions such as Chronic Obstructive Pulmonary Disorder (COPD), diabetes, asthma, etc., these health coaches also discuss options for healthy lifestyle practices with members.

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IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES | Cigna

Cigna

Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company (Cigna HMO, Cigna PPO), shows a commitment to the Affordable Care Act by working with customers, health care professionals, and business and policy leaders to attend to the health, well-being, and sense of security of the people we serve. As a health care insurance provider, we make this happen through a broad range of integrated health care and related plans and services, and proven health and well-being programs that are targeted to the unique needs of our customers.

Quality, Affordable Health Care for All Americans

Cigna has been creating Collaborative Accountable Care Programs with the goal of improving quality and lowering cost. Cigna's programs are built on services that focus on the health care needs of the whole person. The programs strive to improve doctor performance and reward high quality, affordable care, and patient satisfaction. Cigna has about 52 active Collaborative Accountable Care programs with the goal to expand to 100 programs by 2014.

Prevention of Chronic Disease and Improving Public Health

Cigna takes advantage of HEDIS and other tools to effectively measure performance on important levels of care and service, compare health improvement outcomes to standards within the industry, and look for ways to improve. These clinical measures are also used to determine the results of many of Cigna's clinical activities. Activities by Cigna quality staff are monitored in order to promote health and wellness. Some of these activities include: asthma screening and monitoring, cervical cancer screening, breast cancer screening, and childhood immunizations. Cigna also promotes prevention through a variety of efforts, including direct to customer correspondence and partnering with customers and doctors.

Transparency and Program Integrity

Cigna's Centers of Excellence program shows customers those hospitals that have achieved the highest score for Patient Outcomes and Cost Efficiency for a particular procedure or condition. Each hospital is scored by procedure or condition and a hospital may be a Center of Excellence for one or more procedures.

Cigna Care Designation identifies high quality and cost efficient doctors in about 22 of the most common specialty areas, including primary care doctors. Cigna evaluates doctor quality and cost-efficiency information using an approach consistent with national standards providing customers with further information to aid in health care decision-making. Quality measures are used to identify those doctors who show improvement in patient outcomes. Doctors that earn the Cigna Care Designation are identified with the Cigna Tree of Life icon displayed next to their name in the Cigna directory on **my.cigna.com**.

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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 broad range member care through member based initiatives within the company structure. Aetna acquired Coventry Health Care, Inc. on May 7, 2013. As a combined company we now serve an estimated 22 million medical members in the U.S. and around the world. As we work to bring our companies together, we will continue to provide the high-quality service you have come to expect. For the time being, you won't see any major changes. We will continue to provide current Aetna and Coventry products and services. As we move through the integration process, our products and services will continue to evolve and members will be kept informed of any changes that impact them.

Member Outreach Call Centers

Coventry has created member outreach call centers to implement live calls, interactive voice response calls, and correspondence to provide member reminder materials and member and provider incentive projects. Using member demographics to more clearly define customers' base needs, Coventry not only updates member demographic data on every call, but also combines new processes to prevent incorrect overwriting, while updating demographics. In maintaining updated demographic data, the Customer Service Organization can view gaps in care of members and educate the member on services needed when the member calls in.

Prevention and Education

To support breast cancer screening, Coventry continues to send the Women's Health Brochure to female members between the ages of 18 to 65 with topical information on prevention of women's health issues and reminders of annual breast cancer screening. Reinforcing comprehensive diabetes care, Coventry provides educational articles published in the Member newsletter regarding Diabetes and the CHCDE Preventive Health Guidelines are distributed to members and physicians annually. Supporting the importance of childhood immunizations, monthly education and care reminder mailings are sent to the parents of all one-year-olds from January through December. Articles are also published in both the Member and Provider newsletters regarding childhood immunizations.

Back to Basics Program

Coventry has implemented 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.

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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. Preventive care is at the core of our value system. Empowering people to take an active role in their health, and to collaborate with their primary care physician and care team, has been our model since we began providing care in Maryland in 1980. At Kaiser Permanente we believe that the path to a healthy mind, body, and spirit begins with care that's personal, convenient, and connected.

Mobile Health Vehicle

Kaiser Permanente of the Mid-Atlantic States offers a new generation of mobile health services in the form of a state-of-the-art Mobile Health Vehicle, designed to mirror a small medical center on wheels. Equipped with two exam rooms, areas for patient intake and health education, and computers, our physicians and staff can access and coordinate patient information and care with services such as blood pressure checks, body mass index (BMI) calculation, glucose, and cholesterol monitoring, as well as depression screening, immunizations, health education, and some chronic disease management. Clinical staff onboard are able to order prescriptions or follow-up care. Also having a phlebotomist onboard makes lab testing quick and convenient.

Mental Health Care

Kaiser Permanente primary care physicians are empowered to recognize the symptoms of depression, anxiety, and other conditions and are provided with tools and resources to help screen at-risk members. These primary care physician teams work closely with Kaiser Permanente behavioral health clinicians, who provide assistance and support with treatment options and medication management, and are often in the same building as the primary care offices.

Member Diversity Programs, Outreach and Education

Programs established a decade ago and guided by our National Diversity Agenda support the diversity of Kaiser Permanente membership in both the development of a diverse workforce and of leading edge tools and resources for improved linguistic access. Kaiser Permanente aims to deliver health care that acknowledges and understands cultural diversity in health beliefs, practices, and communication. In addition, all members receive information about classes and programs through direct outreach via their care teams. More than 20 classes are offered in Kaiser Permanente medical centers to help members maintain their wellness. Members have access to 11 online programs on **healthy.kaiserpermanente.org**. Health education content is built into the electronic medical record, Kaiser Permanente HealthConnect, and routinely provided to members as part of their after visit summary. During their birthday month, members are sent a tailored journal that addresses his/her health care gaps. The journal provides detailed information about the care, when it was last provided and the result, when the care is due next, and whether the result is normal.

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IV. HEALTH BENEFIT PLAN HEALTH AND WELLNESS INITIATIVES | UnitedHealthcare

UnitedHealthcare/MAMSI/ MD – IPA/Optimum Choice

UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare Insurance Company, Mid-Atlantic Medical Services, LLC (MAMSI), Maryland Individual Practice Association (MD-IPA), and Optimum Choice, Inc. are all focused on helping people live healthier lives. Our family of companies delivers innovative products and services to approximately 70 million Americans. We strive to improve the quality and effectiveness of health care for all Americans; to enhance access to health benefits; to create products and services that make health care more affordable; and to use technology to make the health care system easier to navigate. We continue using the power of information and innovative thinking to help employers, doctors and individuals make better health care decisions.

Rewards and Inspiration

The member-tested interface and website, **MyUHC.com**, collects and organizes health information for a personalized experience, supports members through a prioritized health action plan, and keeps members engaged through rewards and inspiration. **MyUHC.com** trackers and tools provide preventive care reminders and health and wellness discounts which help members with many of their needs, from managing their chronic conditions and making informed choices about living a healthy lifestyle, to finding answers to questions about smoking cessation.

Education Tools and Resources

A member's Health Assessment consists of 57 questions that stratify high risk individuals to care management tracks and enable a predictor of future health care costs. A member's personalized report includes an overall wellness score offering the top three areas for focus while also identifying health measures for the member to target in order to help establish personal health goals and to achieve overall health improvement.

Behavior Support

Online Health Coach Programs provide easy navigation, clear direction, and progress status on program options including Asthma, Back Pain, High Blood Pressure, Diabetes Lifestyle, Heart Health Lifestyle, Exercise, Nutrition, Weight Management, Tobacco Cessation, Stress Management, Pregnancy, and Preventive Care.

myNurseLine℠ is an American Health Care Commission/URAC accredited source of health information and support for a wide variety of concerns. Nurses are available 24 hours a day, seven days a week, providing advice, general health information and education, other information on member services or provider referrals, and access to a health information library.

The Health Care Cost Estimator is an intuitive tool that supports consumer decisions with consistently reliable cost estimates which helps members make the best personal value choice based on price, quality, and convenience.

UnitedHealth Allies is a health discount program that provides discounts on health and wellness related products and services not covered under the medical plan. Popular discounts include gym discounts, tobacco cessation, fitness apparel, Lasik surgery, Jenny Craig weight loss programs, and complementary care. Discounts also exist for dental care, long-term care services, infertility treatment, and hearing devices.

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Summary of Scores vs. Maryland Average Benchmark and National Average Benchmark

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 and authorized HMO combinations such as HMO/POS plan combinations and six PPOs and authorized PPO combinations such as PPO/EPO plan combinations. If a health benefit plan reported NA, indicating Not Applicable due to an insufficient eligible population (<30 members) to calculate a rate, or NR, indicating erroneous or 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 NABs used here are based on quality and performance reported in 2012.

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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	PPO	HMO	PPO
Primary Care and Wellness for Children and Adolescents				
Children and Adolescents Access to Primary Care Providers (12–24 months)	6	5	5	4
Children and Adolescents Access to Primary Care Providers (25 months–6 years)	6	5	6	5
Children and Adolescents Access to Primary Care Providers (7–11 years)	5	5	8	5
Children and Adolescents Access to Primary Care Providers (12–19 years)	6	5	6	5
Well-Child Visits in the First 15 Months of Life (0 visits)	5	5	4	5

continued

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

SUMMARY OF SCORES VS. MARYLAND AVERAGE BENCHMARK AND NATIONAL AVERAGE BENCHMARK

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	PPO	HMO	PPO
Primary Care and Wellness for Children and Adolescents continued				
Well-Child Visits in the First 15 Months of Life (6+ visits)	6	5	7	5
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	6	5	8	6
Childhood Immunization Status (Combo 10 – all vaccines/antigens)	7	4	7	6
Adolescent Well-Care Visits	6	5	8	6
Immunizations for Adolescents (Combo 1)	6	4	1	5
Human Papillomavirus Vaccine for Female Adolescents	6	4	0	0
Weight Assessment and Body Mass Index (BMI) Assessment for Children and Adolescents	6	4	2	4
Counseling for Nutrition for Children and Adolescents	6	4	6	4
Counseling for Physical Activity for Children and Adolescents	6	4	6	4
Follow-Up Care for Children Prescribed ADHD Medication (Initiation phase)	5	3	1	2
Follow-Up Care for Children Prescribed ADHD Medication (Continuation phase)	3	3	0	2
Child Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis	6	4	8	6
Appropriate Treatment for Children with Upper Respiratory Infection	8	3	1	3
Use of Appropriate Medications for Children with Asthma (5–11 years)	3	2	1	0
Use of Appropriate Medications for Children with Asthma (12–18 years)	3	3	2	2
Medication Management for Children with Asthma (5–11 years, 50% treatment period compliance)	3	2	2	0

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

SUMMARY OF SCORES VS. MARYLAND AVERAGE BENCHMARK AND NATIONAL AVERAGE BENCHMARK

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	PPO	HMO	PPO
Child Respiratory Conditions continued				
Medication Management for Children with Asthma (12–18 years, 50% treatment period compliance)	2	1	2	1
Medication Management for Children with Asthma (5–11 years, 75% treatment period compliance)	3	2	2	0
Medication Management for Children with Asthma (12–18 years, 75% treatment period compliance)	2	2	1	1
Women's Health				
Prenatal Care	6	4	1	6
Postpartum Care	7	4	2	6
Breast Cancer Screening	7	3	1	4
Cervical Cancer Screening	7	4	3	3
Chlamydia Screening in Women (16–24 years)	7	4	7	4
Primary Care for Adults – *General Health*				
Adults Access to Preventive/Ambulatory Health Services (20–44 years)	7	4	2	4
Adults Access to Preventive/Ambulatory Health Services (45–64 years)	6	3	5	6
Adults Access to Preventive/Ambulatory Health Services (65+ years)	7	5	4	5
Adult Body Mass Index (BMI) Assessment	6	4	5	4
Colorectal Cancer Screening	5	4	3	4

continued

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

SUMMARY OF SCORES VS. MARYLAND AVERAGE BENCHMARK AND NATIONAL AVERAGE BENCHMARK

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	PPO	HMO	PPO
Primary Care for Adults – *Respiratory Conditions*				
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	8	4	1	2
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	5	2	5	4
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Systemic Corticosteroid)	3	2	2	1
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator)	3	1	2	1
Use of Appropriate Medications for Adults with Asthma (19–50 years)	5	3	2	4
Use of Appropriate Medications for Adults with Asthma (51–64 years)	5	2	3	4
Medication Management for Adults with Asthma (19–50 years, 50% treatment period compliance)	3	3	3	3
Medication Management for Adults with Asthma (51–64 years, 50% treatment period compliance)	3	2	3	2
Medication Management for Adults with Asthma (19–50 years, 75% treatment period compliance)	4	3	4	3
Medication Management for Adults with Asthma (51–64 years, 75% treatment period compliance)	5	2	2	2

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

SUMMARY OF SCORES VS. MARYLAND AVERAGE BENCHMARK AND NATIONAL AVERAGE BENCHMARK

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	PPO	HMO	PPO
Primary Care for Adults – *Cardiovascular Conditions and Diabetes*				
Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening)	6	3	1	5
Cholesterol Management for Patients with Cardiovascular Conditions (LDL level)	6	5	2	5
Controlling High Blood Pressure	7	3	1	1
Persistence of Beta-Blocker Treatment After a Heart Attack	3	3	3	4
Comprehensive Diabetes Care (HbA1c Testing)	6	4	1	2
Comprehensive Diabetes Care (HbA1c Poor Control >9.0%)	6	5	2	3
Comprehensive Diabetes Care (HbA1c Good Control <8.0%)	6	4	2	3
Comprehensive Diabetes Care (HbA1c Tight Control <7.0% selected population)	6	4	2	6
Comprehensive Diabetes Care (Eye Examination - Retina)	5	4	3	3
Comprehensive Diabetes Care (LDL Screening)	7	3	1	4
Comprehensive Diabetes Care (LDL Control < 100 mg/dL)	6	4	2	4
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	6	4	4	5
Comprehensive Diabetes Care (Good BP Control < 140/90 mm Hg)	7	4	1	3
Comprehensive Diabetes Care (Excellent BP Control < 140/80 mm Hg)	7	3	1	3

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

SUMMARY OF SCORES VS. MARYLAND AVERAGE BENCHMARK AND NATIONAL AVERAGE BENCHMARK

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	PPO	HMO	PPO
Primary Care for Adults – *Musculoskeletal Disease and Medication Management*				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	5	2	2	2
Use of Imaging Studies for Low Back Pain	6	5	3	0
Annual Monitoring for Patients on ACE Inhibitors or ARBs	5	4	4	4
Annual Monitoring for Patients on Digoxin	3	2	2	2
Annual Monitoring for Patients on Diuretics	5	4	5	4
Annual Monitoring for Patients on Anticonvulsants	5	2	1	1
Behavioral Health				
Antidepressant Medication Management (Effective–Acute Phase)	5	4	8	6
Antidepressant Medication Management (Effective–Continuation Phase)	6	4	7	6
Follow-Up After Hospitalization for Mental Illness (7 days)	5	3	2	3
Follow-Up After Hospitalization for Mental Illness (30 days)	4	3	2	2
Initiation of Alcohol and Other Drug Dependence Treatment (13-17 years)	3	2	2	3
Initiation of Alcohol and Other Drug Dependence Treatment (18+ years)	7	4	2	3
Engagement of Alcohol and Other Drug Dependence Treatment (13-17 years)	3	3	2	3
Engagement of Alcohol and Other Drug Dependence Treatment (18+ years)	6	4	3	4
Member Experience and Satisfaction				
Aspirin Discussion	5	5	2	3
Flu Shots for Adults Ages 50-64	6	5	5	3
Call Answer Timeliness	6	4	6	4

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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents

Effective primary care and wellness practices assist with the prevention or early detection of childhood conditions that may prove detrimental to healthy development. These same wellness practices can assist to develop a health-centered child who in turn is likely to develop into a healthy adult and potentially minimize overall health costs throughout life.

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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 in 2012 who had a visit with a primary care provider during the 2012 measurement year.

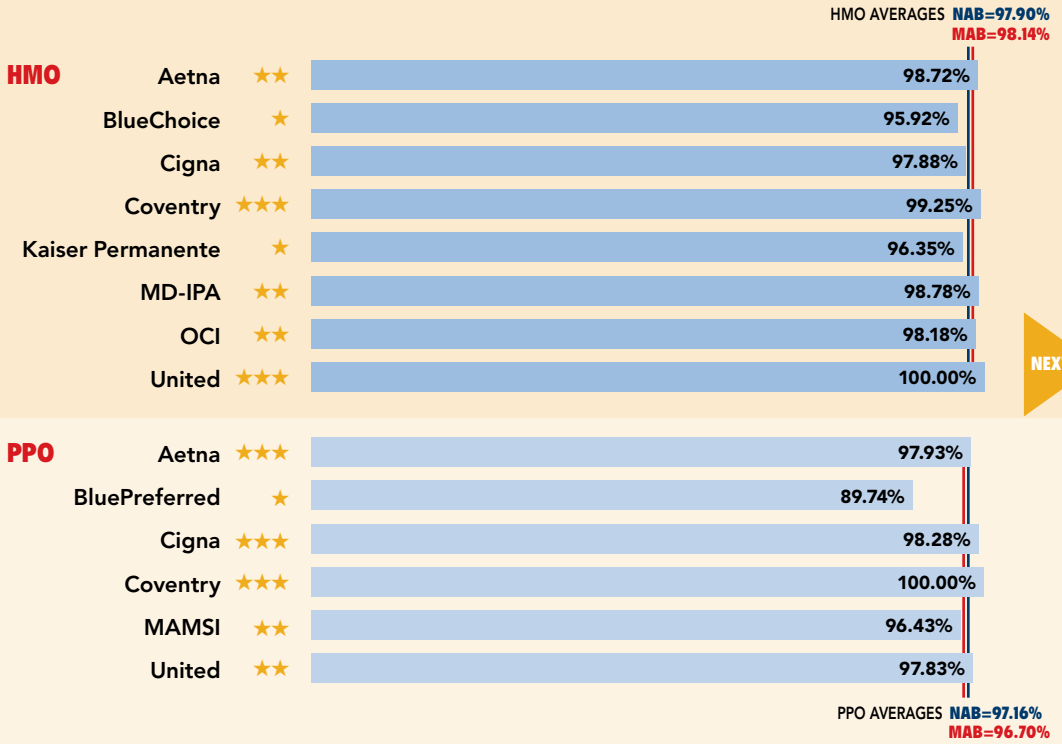
For this performance indicator, a higher percentage is better, which means that more toddlers did have a visit to a primary care provider.

RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. A consistent pattern among children and adolescents who receive appropriate primary care is that these children and adolescents have reduced medical costs associated with emergency care and have better health outcomes.

(The State of Health Care Quality 2012. National Committee for Quality Assurance)

1 PRIMARY CARE VISIT – 12-24 MONTHS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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 in 2012 who had a visit with a primary care provider during the 2012 measurement year.

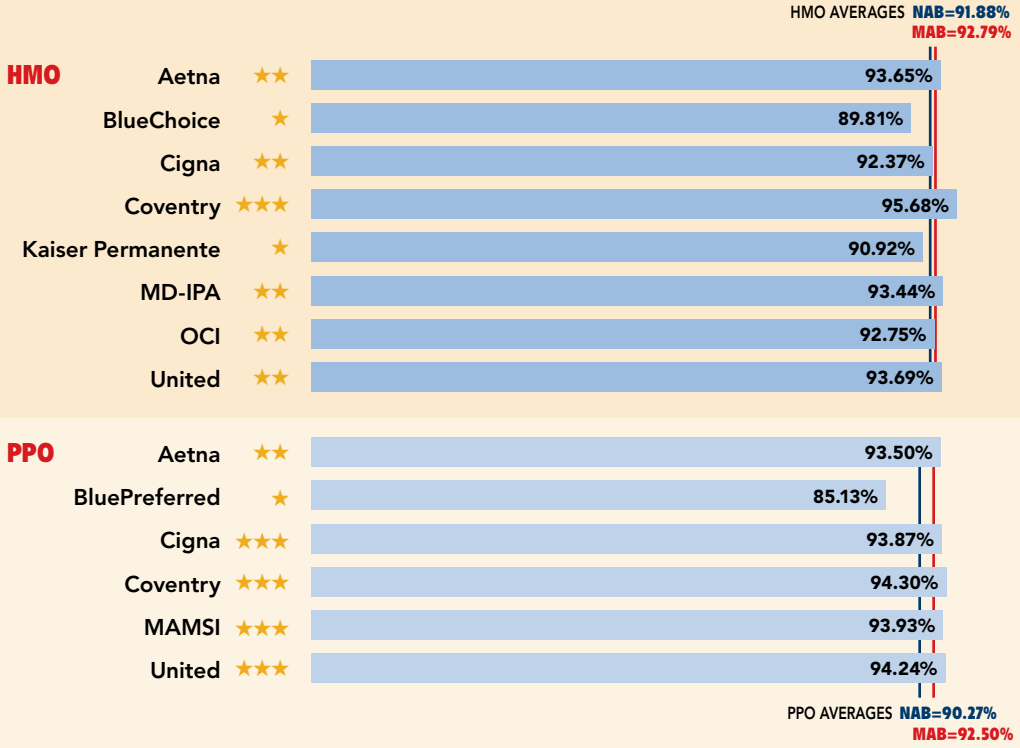
For this performance indicator, a higher percentage is better, which means that more young children did have a visit to a primary care provider.

RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. A consistent pattern among children and adolescents who receive appropriate primary care is that these children and adolescents have reduced medical costs associated with emergency care and have better health outcomes.

(The State of Health Care Quality 2012. National Committee for Quality Assurance)

1 PRIMARY CARE VISIT – 25 MONTHS-6 YEARS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

3. The percentage of children 7–11 years in 2012 who had a visit with a primary care provider during the 2012 measurement year or the prior year.

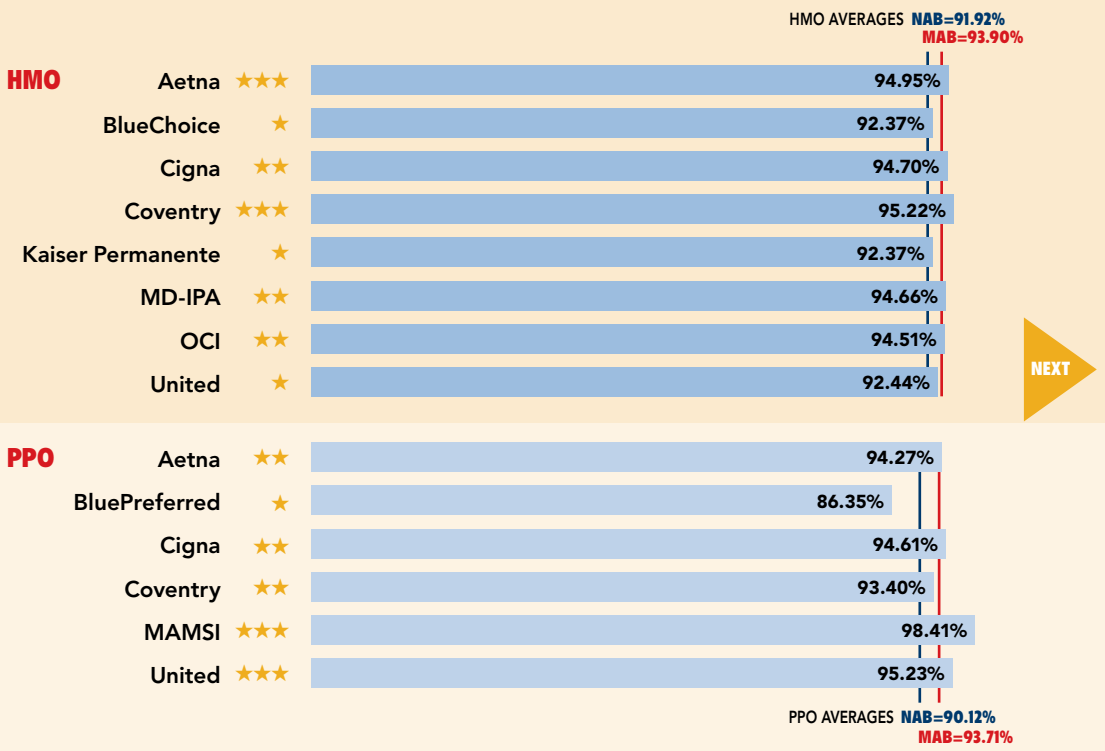
For this performance indictor, a higher percentage is better, which means that more older children did have a visit to a primary care provider.

RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. A consistent pattern among children and adolescents who receive appropriate primary care is that these children and adolescents have reduced medical costs associated with emergency care and have better health outcomes.

(The State of Health Care Quality 2012. National Committee for Quality Assurance)

1 PRIMARY CARE VISIT – 7-11 YEARS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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 in 2012 who had a visit with a primary care provider during the 2012 measurement year or the prior year.

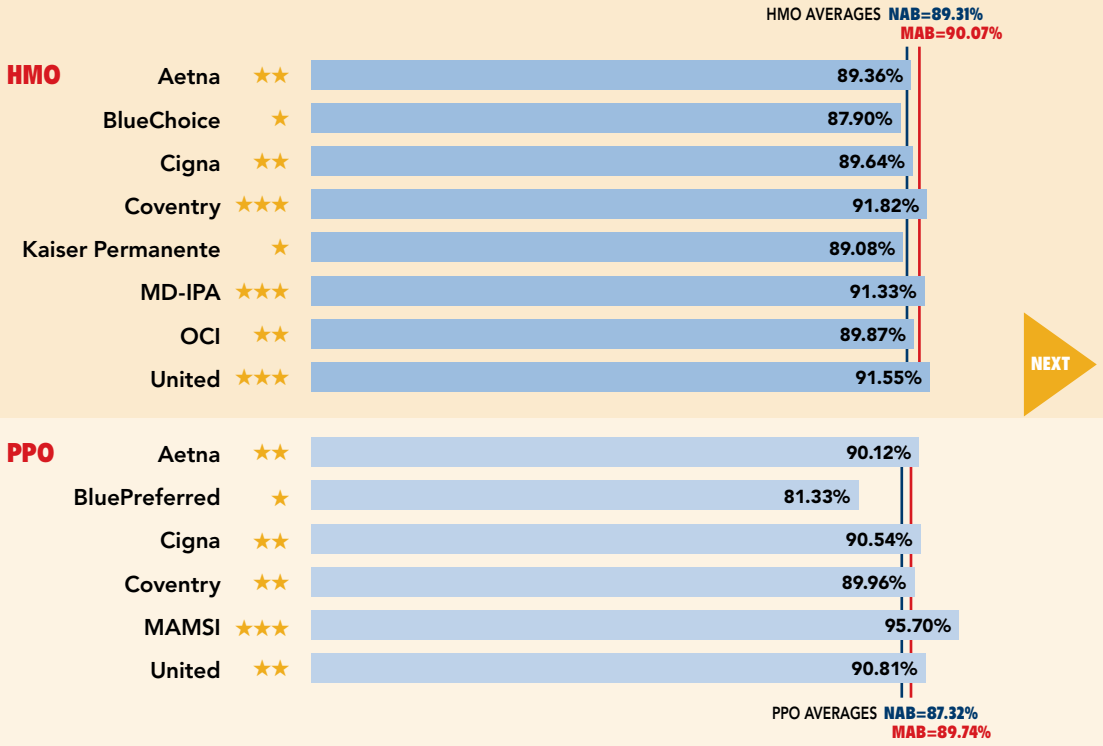
For this performance indicator, a higher percentage is better, which means that more adolescents did have a visit to a primary care provider.

RATIONALE

Access to primary care providers such as pediatricians, family doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. A consistent pattern among children and adolescents who receive appropriate primary care is that these children and adolescents have reduced medical costs associated with emergency care and have better health outcomes.

(The State of Health Care Quality 2012. National Committee for Quality Assurance)

1 PRIMARY CARE VISIT – 12-19 YEARS OF AGE



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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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. Seven separate indicators include:

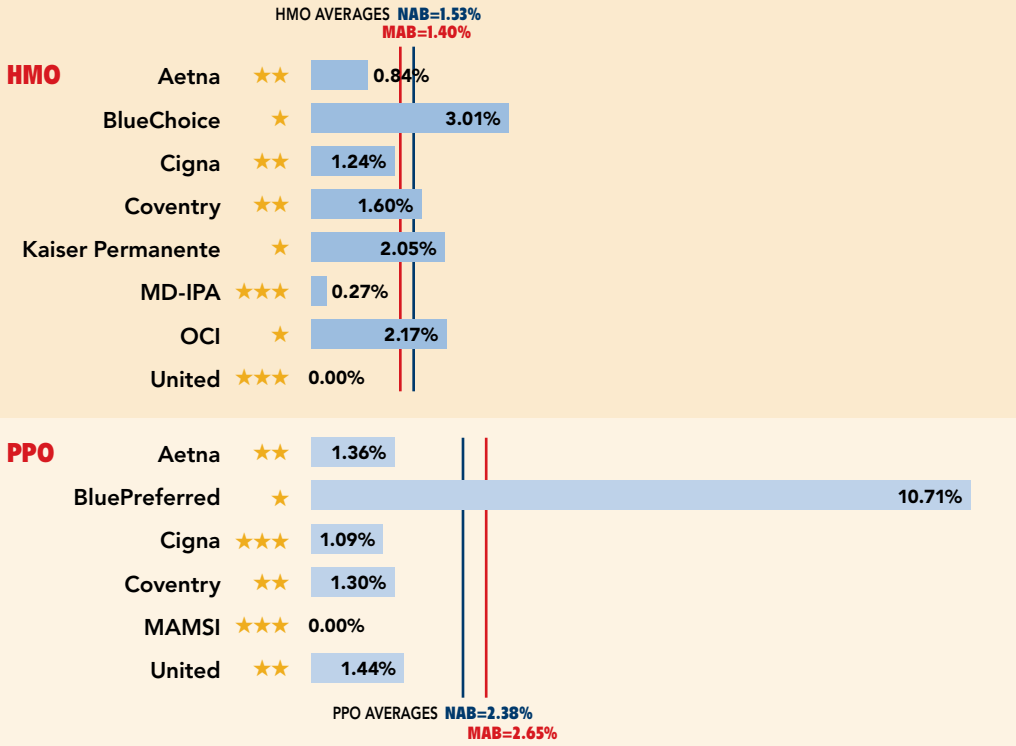
1. The percentage of children who turned 15 months old during the 2012 measurement year who had no well-child visits with a primary care provider during their first 15 months of life.

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

RATIONALE

This group of indicators looks at the adequacy of well-child care for infants and toddlers. Regular checkups 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 infants and toddlers undergo substantial changes in cognitive and motor skills, including hand-eye coordination, as well as physical, social and emotional growth.

0 WELL-CHILD VISITS – 0-15 MONTHS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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

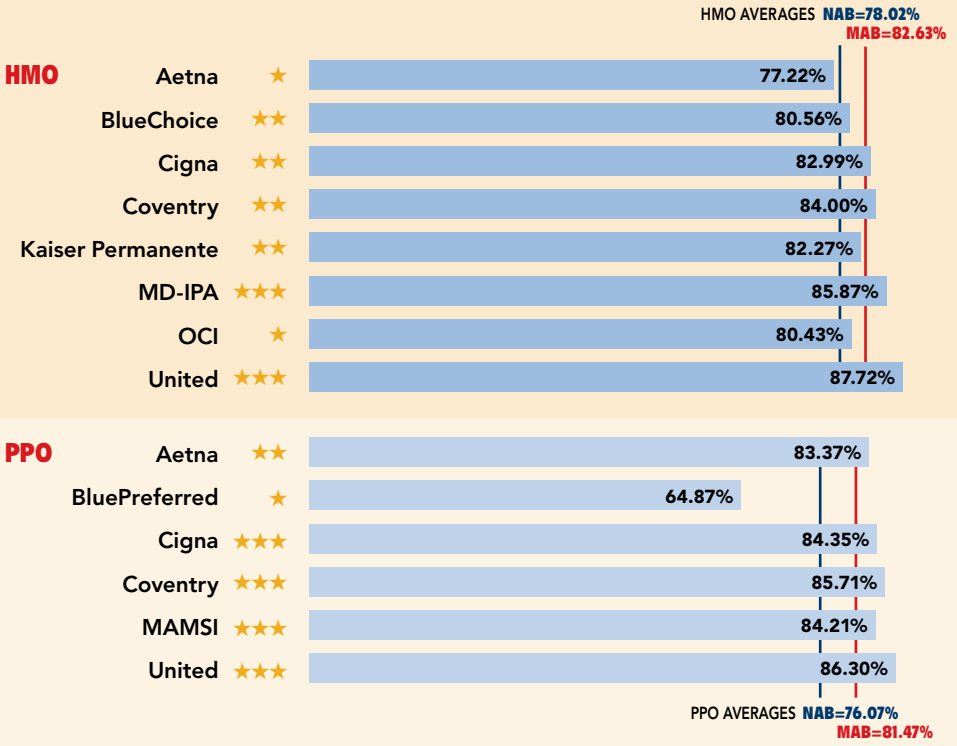
2. The percentage of children who turned 15 months old during the 2012 measurement year who had six or more well-child visits with a primary care provider during their first 15 months of life.

For this performance indicator, a higher percentage is better, which means that more infants and toddlers did have six or more visits with a primary care provider, which is desirable, and fewer infants and toddlers had only five visits or less.

RATIONALE

This group of indicators looks at the adequacy of well-child care for infants and toddlers. Regular checkups 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 infants and toddlers undergo substantial changes in cognitive and motor skills, including hand-eye coordination, as well as physical, social and emotional growth.

6+ WELL-CHILD VISITS – 0-15 MONTHS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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

DESCRIPTION

3. The percentage of children who turned 15 months old during the 2012 measurement year, who had either zero, one, two, three, four, five, or six or more well-child visit(s) with a primary care provider during their first 15 months of life.

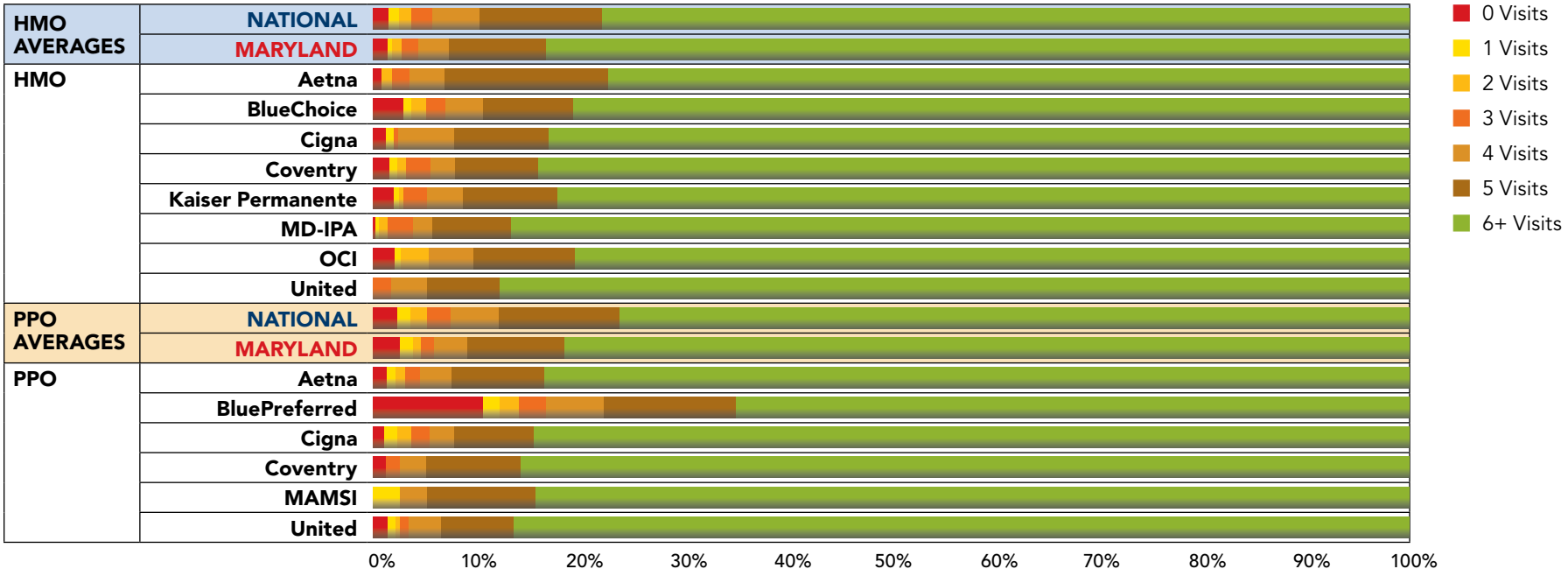
RATIONALE

The schedule for well-child care should be individualized based on the patient's age, health status, including health risks, previously received services, and the desired outcome of care as determined jointly by the health care practitioner and family. The goal for an adequate schedule includes at least six well child visits before the child reaches 15 months of age. However, conflicting demands on the parent[s] results in mixed ability of health benefit plans to achieve the goal of six or more visits.

NOTE: The graph below provides a summary of what the health benefit plans achieved in providing the following:

0 Visits	Undesirable; performance is displayed in red
1–5 Visits	Not necessarily good or bad; no judgment is made as to the overall performance score, no star rating is assigned and performance is displayed in shades of yellow
6+ Visits	Desirable goal for this measure; performance is displayed in green

When evaluating health benefit plan performance, the graph below should be considered in conjunction with the prior graphs for zero visits and six or more visits.



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

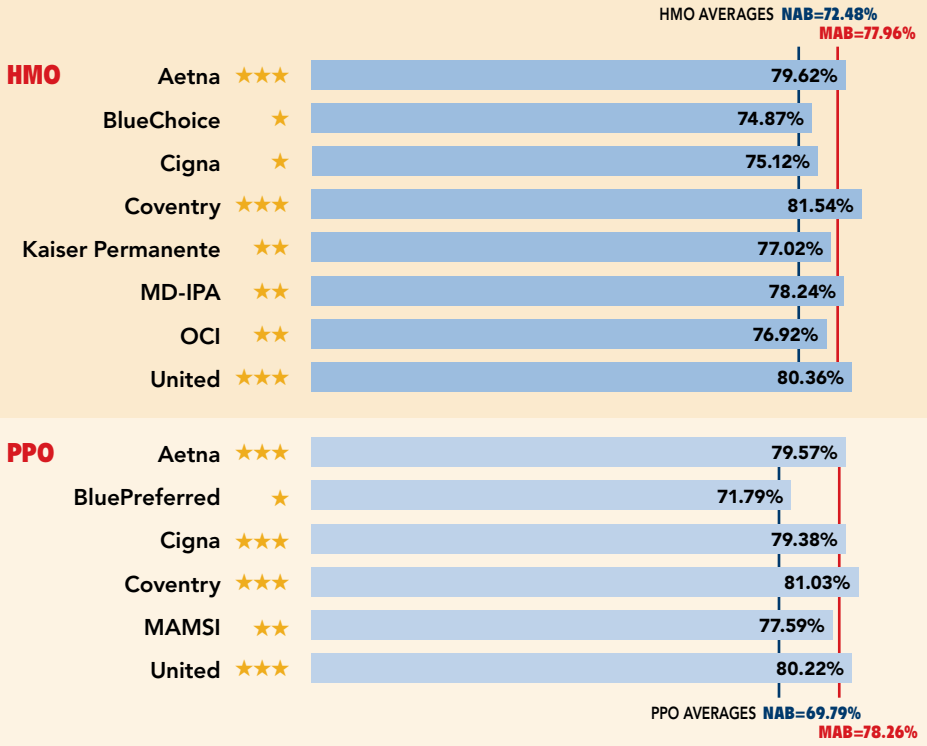
The percentage of children 3–6 years of age in 2012 who received one or more well-child visits with a primary care provider during the 2012 measurement year.

For this measure, a higher percentage is better, which means that more young children did have one or more well-child visits to a primary care provider, which is desirable, and fewer young children had zero visits.

RATIONALE

This measure looks at the use of routine check-ups by young, 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.

1+ WELL-CHILD VISITS – 3-6 YEARS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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 2 years of age during the 2012 measurement year who had all the required ten immunizations by their second birthday. The measure calculates a rate for those children who had all the required doses for immunization against several communicable diseases, including four DTaP, three IPV, one MMR, three HIB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two Influenza vaccines by their second birthday.

For this measure, a higher percentage is better, which means that more infants and 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.

NOTE: There are nineteen separate indicators in this measure category, including individual and combination immunizations. Only the total percentage of members with documented immunizations for Combo 10, which includes all the immunizations that are required for children by age 2, is represented in the associated graph.

COMBINATION 10 IMMUNIZATION SERIES:

Combo 10	Diptheria, Tetanus and acellular Pertussis	Inactivated Polio Virus	Measles, Mumps and Rubella	Haemophilus Influenza type B	Hepatitis B	Varicella (Chicken Pox) Zoster Virus	Pneumococcal Conjugate Virus	Hepatitis A	Rotavirus	Influenza
Abbreviation	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influ-enza
Inoculations ("Doses")	4	3	1	3	3	1	4	1	2 or 3	2

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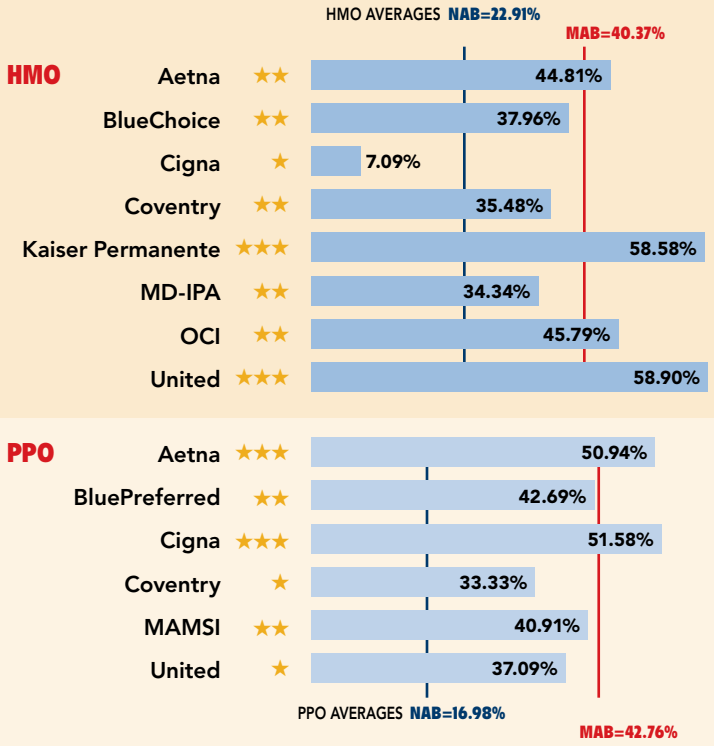
10 REQUIRED IMMUNIZATIONS – 2 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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 2012 who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) during the 2012 measurement year.

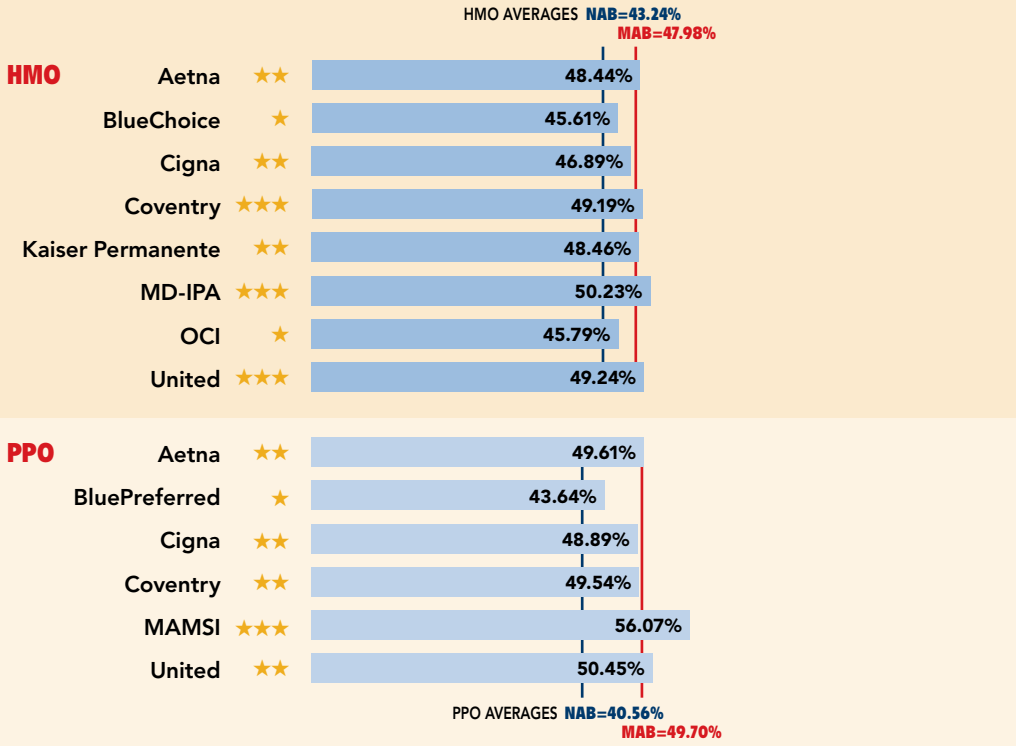
For this measure, a higher percentage is better, which means that more adolescents and young adults 12 to 21 years of age did have one or more well-care visits to a PCP or an OB/GYN.

RATIONALE

Adolescents and young adults benefit from an annual preventive health care visit that addresses the physical, emotional, and social aspects of their health. Not only are accidents, homicides and suicides among the leading causes of adolescent and young adult deaths, but sexually transmitted diseases, substance abuse, pregnancies, and antisocial behaviors are also important causes of, or result from, physical, emotional, and social adolescent problems.

(National Vital Statistics Reports, October 26, 2012)

1+ WELL-CARE VISITS – 12-21 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Immunizations for Adolescents

DESCRIPTION

The percentage of children who turned 13 years of age during the 2012 measurement year who had both the required immunizations for adolescents by their thirteenth birthday. The measure calculates a rate for those adolescents who had one dose of meningococcal conjugate vaccine (MCV) and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday.

For this measure, a higher percentage is better, which means that more children who turned 13 years of age during the measurement year got 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.

NOTE: There are three separate indicators in this measure category, including MCV, Tdap or Td, and a total of both MCV and Tdap or Td immunizations. Only the total percentage of members with documented immunizations for Combo 1, which includes all the immunizations that are required for adolescents by age 13, is represented in the associated graph.

COMBINATION 1 IMMUNIZATION SERIES:

Combo 1	Meningococcal Conjugate Vaccine	Tetanus, Diptheria toxoids, and acellular Pertussis OR Tetanus diphtheria toxoids
Abbreviation	MCV	Tdap or Td
Inoculations ("Doses")	1	1

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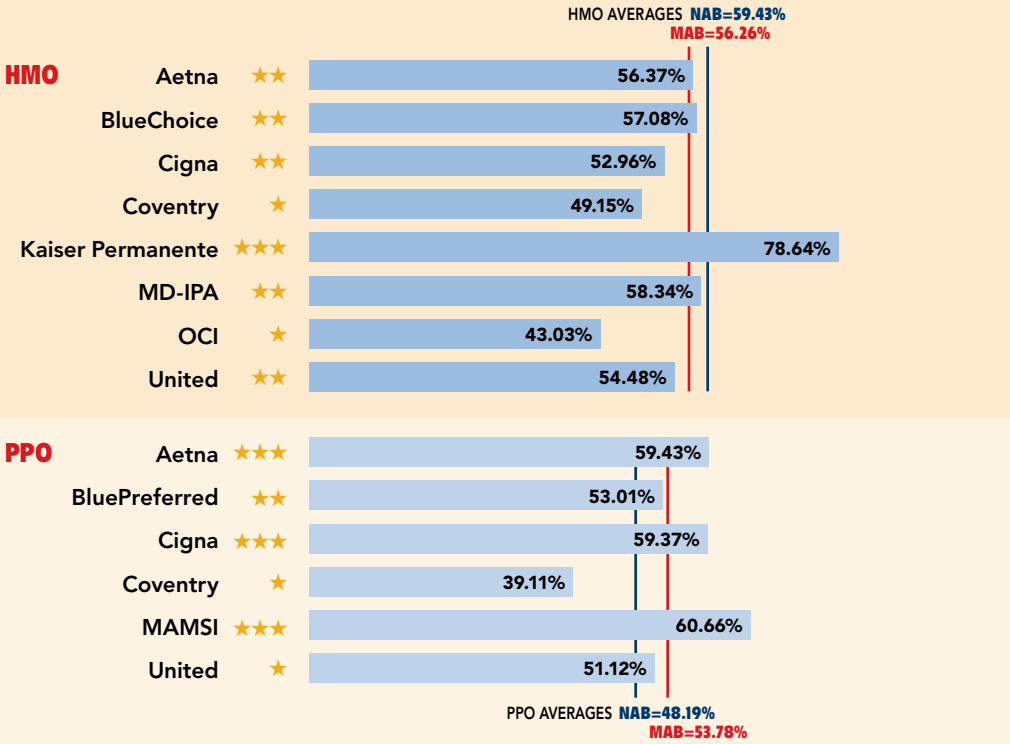
2 REQUIRED IMMUNIZATIONS – 13 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Human Papillomavirus Vaccine for Female Adolescents

DESCRIPTION

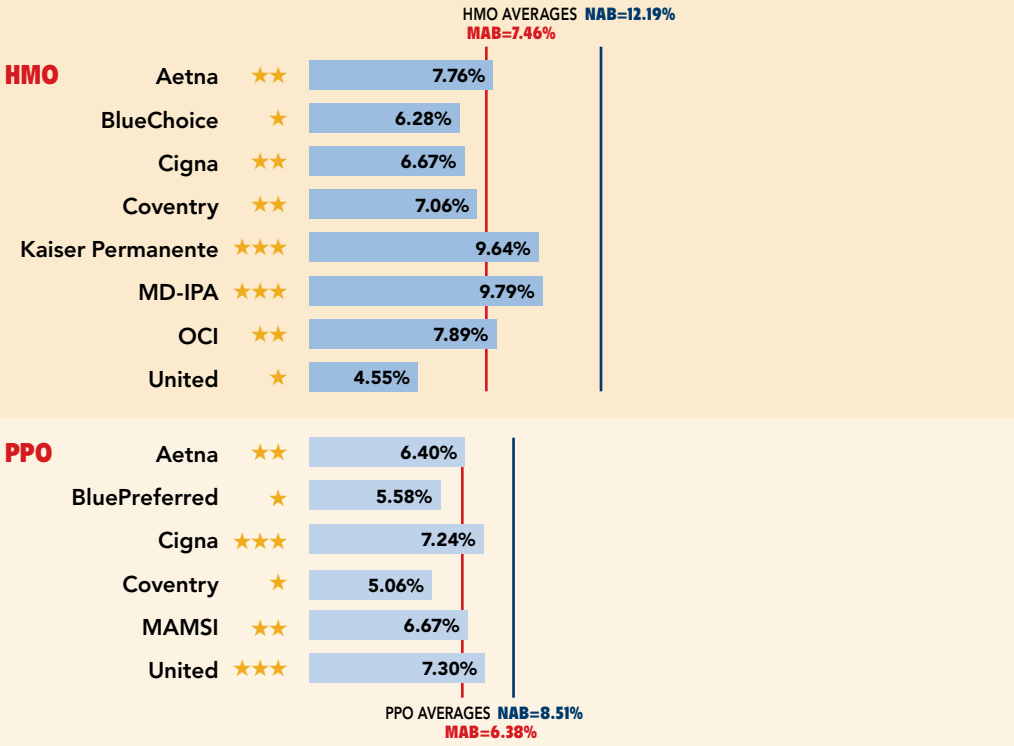
The percentage of female children who turned 13 years of age during the 2012 measurement year who had three doses of the human papillomavirus (HPV) vaccine by their thirteenth birthday.

For this measure, a higher percentage is better, which means that more guardians for female children who turned 13 years of age during the measurement year not only authorized the optional HPV vaccination, but also followed through with attending two additional visits in order to complete the three-shot 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.

RECOMMENDED HPV IMMUNIZATION – 13 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE AND WELLNESS FOR CHILDREN AND ADOLESCENTS

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

DESCRIPTION

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

1. The percentage of members 3–17 years of age in 2012 who had an outpatient visit with a PCP or OB/GYN and whose weight was assessed and body mass index (BMI) was documented during the 2012 measurement year. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed for a group aged between 3 and 17 years, rather than an absolute BMI value.

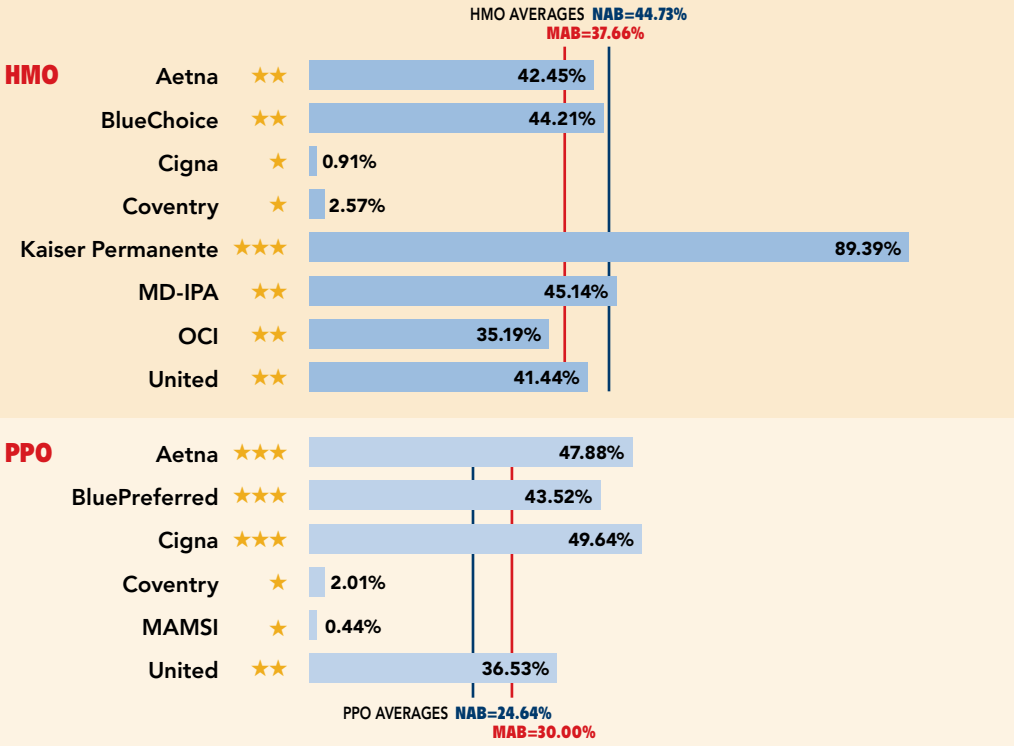
For this measure, a higher percentage is better, which means that more children and adolescents 3 to 17 years of age did have their BMI calculated and documented during a visit with their PCP or OB/GYN.

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 obesity begins in the PCP'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.

NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3–11 years, 12–17 years and 3–17 years. Only the total percentage of children and adolescents with documented BMI among the 3–17 years of age group is represented in the associated graph.

BODY MASS INDEX – 3-17 YEARS OF AGE



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Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
continued

DESCRIPTION

2. The percentage of members 3–17 years of age in 2012 who had an outpatient visit with a PCP or OB/GYN and who had counseling for nutrition during the 2012 measurement year.

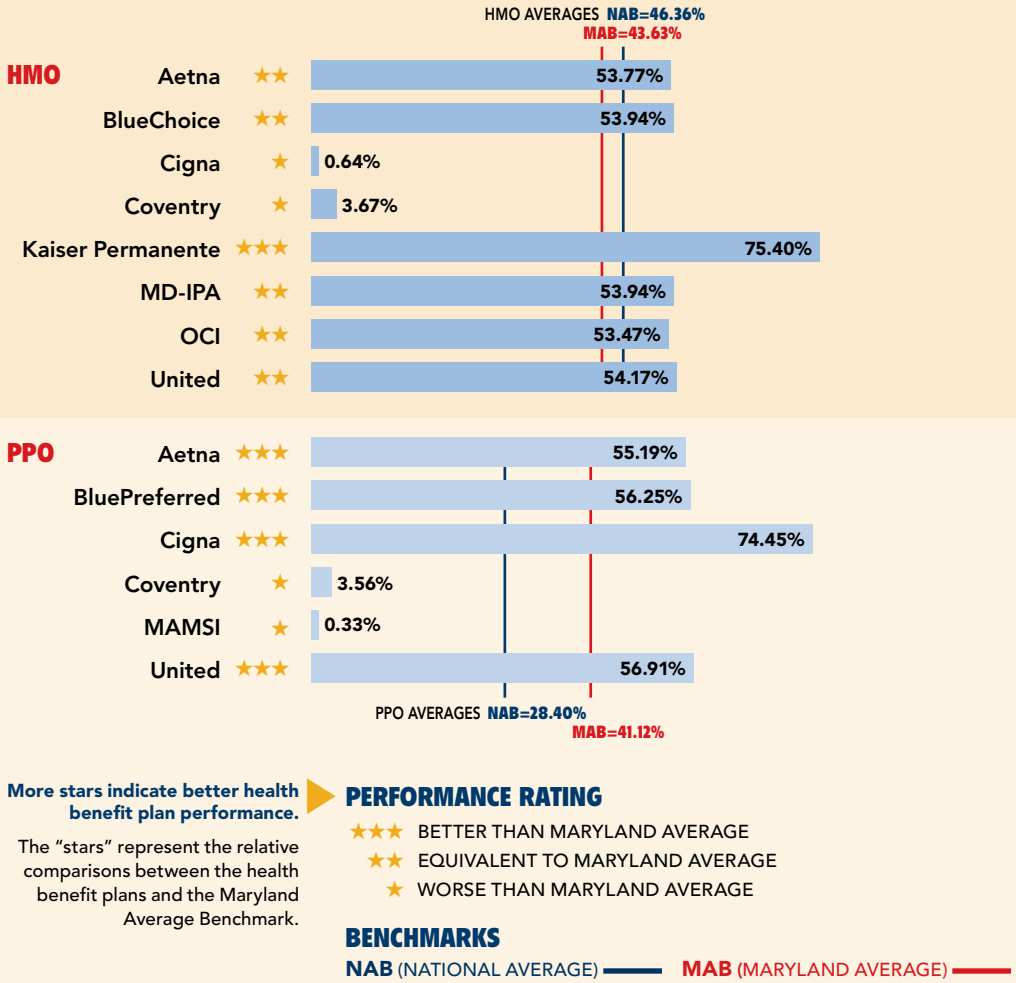
For this measure, a higher percentage is better, which means that more children and adolescents 3 to 17 years of age did receive counseling for nutrition during a visit with their PCP or OB/GYN.

NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3–11 years, 12–17 years and 3–17 years. Only the total percentage of children and adolescents with documented nutrition counseling among the 3–17 years of age group is represented in the associated graph.

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 obesity begins in the primary care 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.

NUTRITION COUNSELING – 3-17 YEARS OF AGE



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Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

continued

DESCRIPTION

3. The percentage of members 3–17 years of age in 2012 who had an outpatient visit with a PCP or OB/GYN and who had counseling for physical activity during the 2012 measurement year.

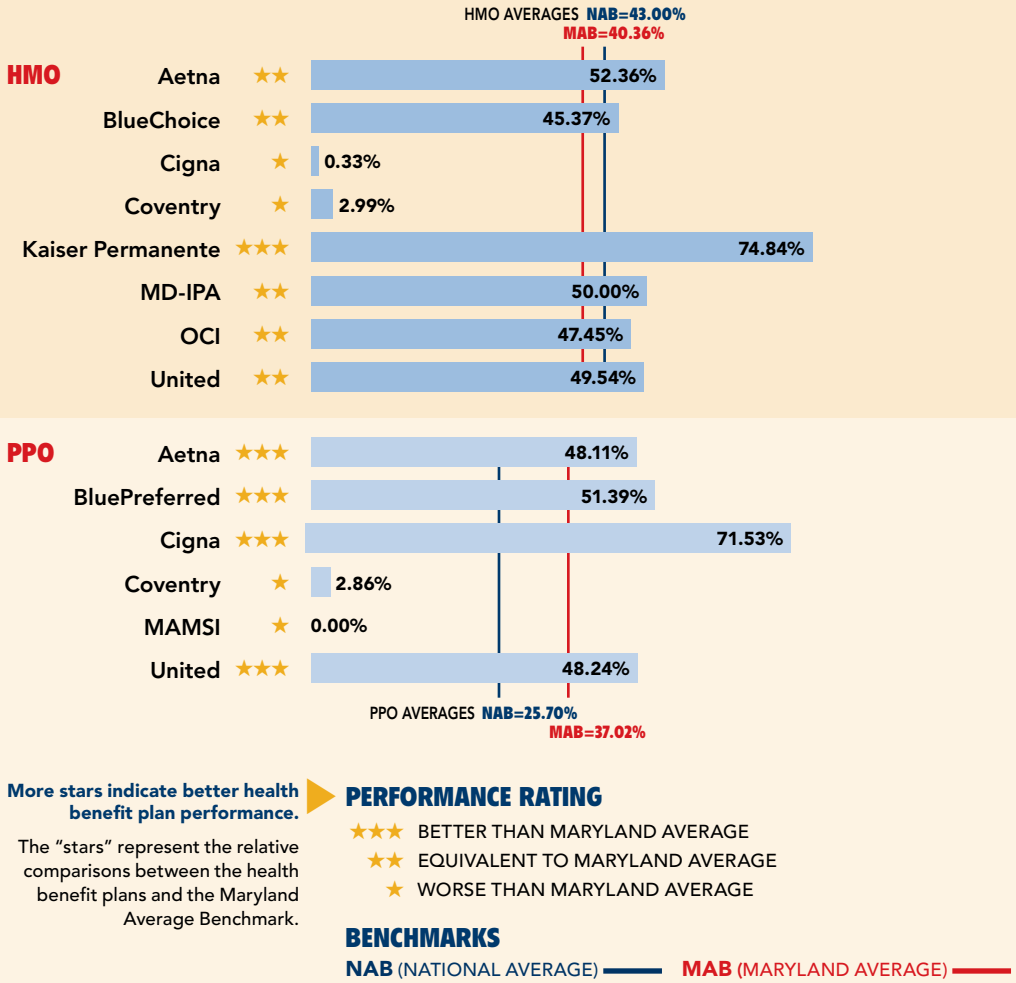
For this measure, a higher percentage is better, which means that more children and adolescents 3 to 17 years of age did receive counseling for physical activity during a visit with their PCP or OB/GYN.

NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3–11 years, 12–17 years and 3–17 years. Only the total percentage of children and adolescents with documented physical activity counseling among the 3–17 years of age group is represented in the associated graph.

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 obesity begins in the primary care 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.

PHYSICAL ACTIVITY COUNSELING – 3-17 YEARS OF AGE



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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. Two separate indicators include:

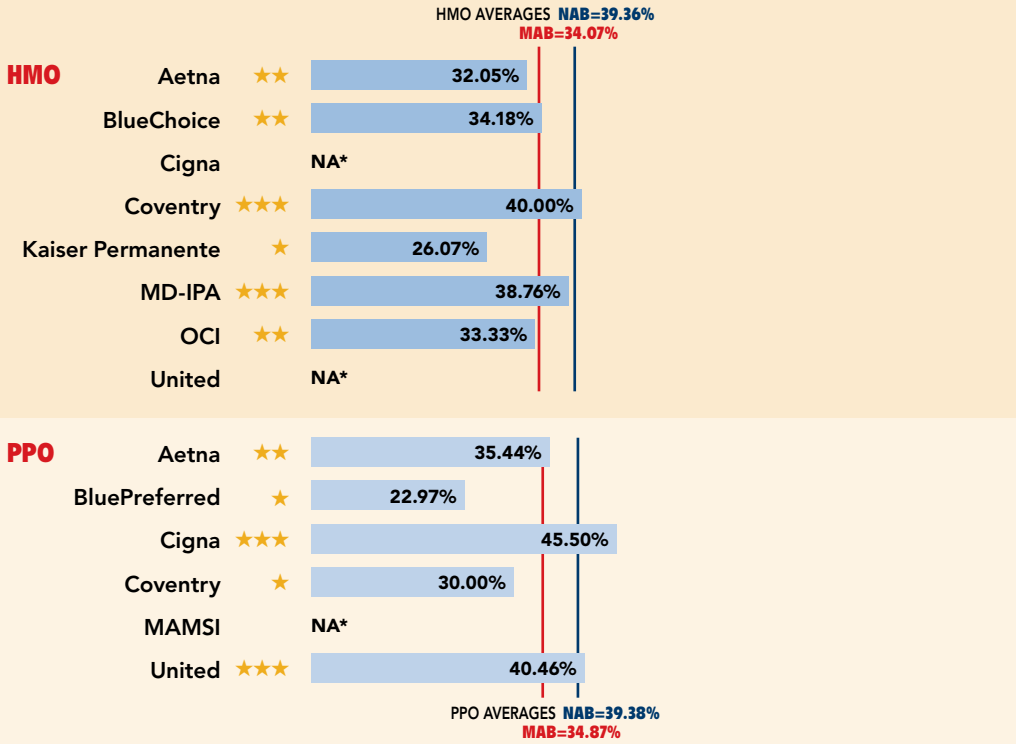
1. Initiation phase. The percentage of pre-teen children 6–12 years of age during the intake period from March 1st, 2012 to February 28th, 2013, that were newly prescribed attention deficit/hyperactivity disorder (ADHD) medication, who also had one follow-up care visit with a practitioner with prescribing 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 more children 6–12 years of age 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 monthly follow-up visits should be scheduled until a 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.

INITIATION PHASE – 6-12 YEARS OF AGE



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Follow-Up Care for Children Prescribed ADHD Medication continued

DESCRIPTION

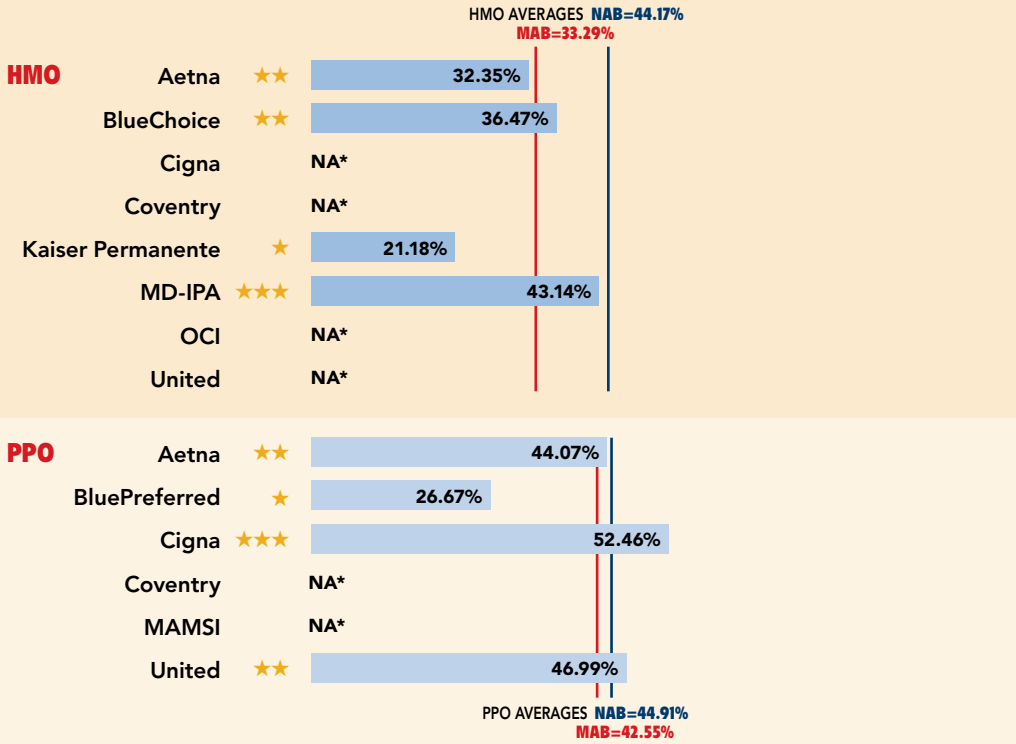
2. Continuation and maintenance phase. The percentage of pre-teen children 6–12 years of age during the intake period from March 1st, 2012 to February 28th, 2013, that were newly prescribed attention deficit/ hyperactivity disorder (ADHD) medication who, in addition to the visit in the Initiation phase, also remained on the ADHD medication for at least a 7–month period (210 days) and who had at least two additional follow-up care visits with a practitioner with prescribing authority within the 9–month period (270 days) after the 1–month (30–day) Initiation phase ended.

For this performance indicator, a higher percentage is better, which means that more children 6–12 years of age did have at least two additional follow-up care 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 monthly follow-up visits should be scheduled until a 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.

CONTINUATION & MAINTENANCE PHASE – 6-12 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

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 controlling medications which decrease the need for use of emergency medications by people with respiratory conditions, like asthma, are helping to control the rising cost of care.

BACK

NEXT

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Appropriate Testing for Children with Pharyngitis

DESCRIPTION

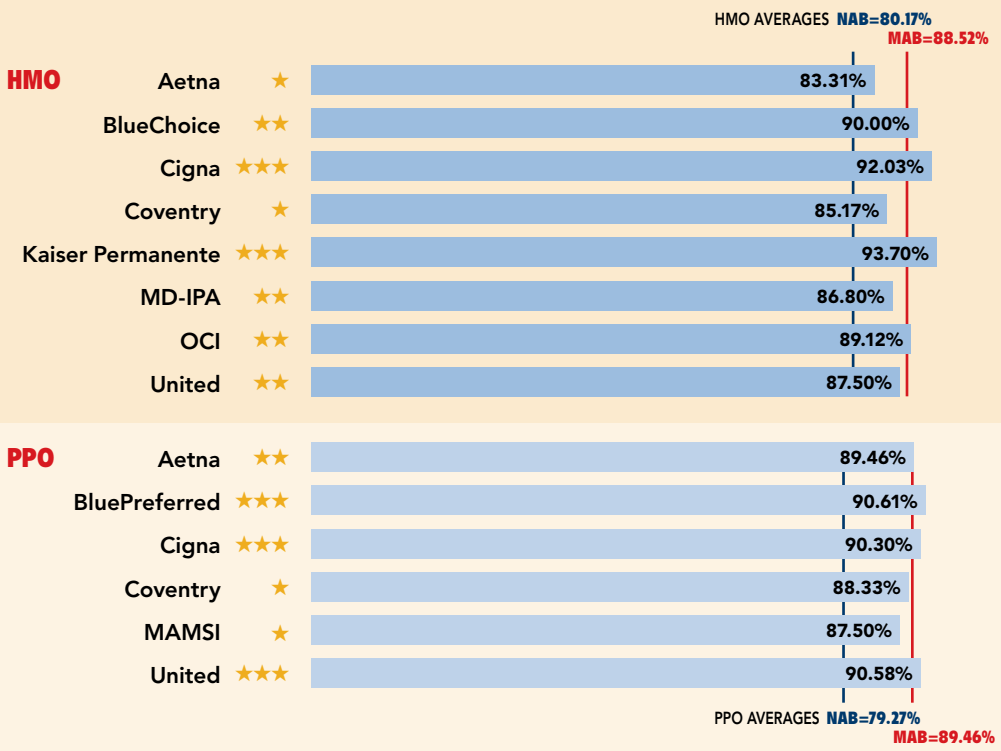
The percentage of members 2–18 years of age during the 2012 measurement year who, after receiving a group-A streptococcus (strep) test, were diagnosed with pharyngitis and then given an appropriate prescription for an antibiotic.

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

RATIONALE

Excess use of antibiotics is highly prevalent for pharyngitis, an upper respiratory tract infection (URI). Pharyngitis is the only condition among 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 patients with 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.

GROUP-A STREP TEST – 2-18 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

CHILD RESPIRATORY CONDITIONS

Appropriate Treatment for Children with Upper Respiratory Infection

DESCRIPTION

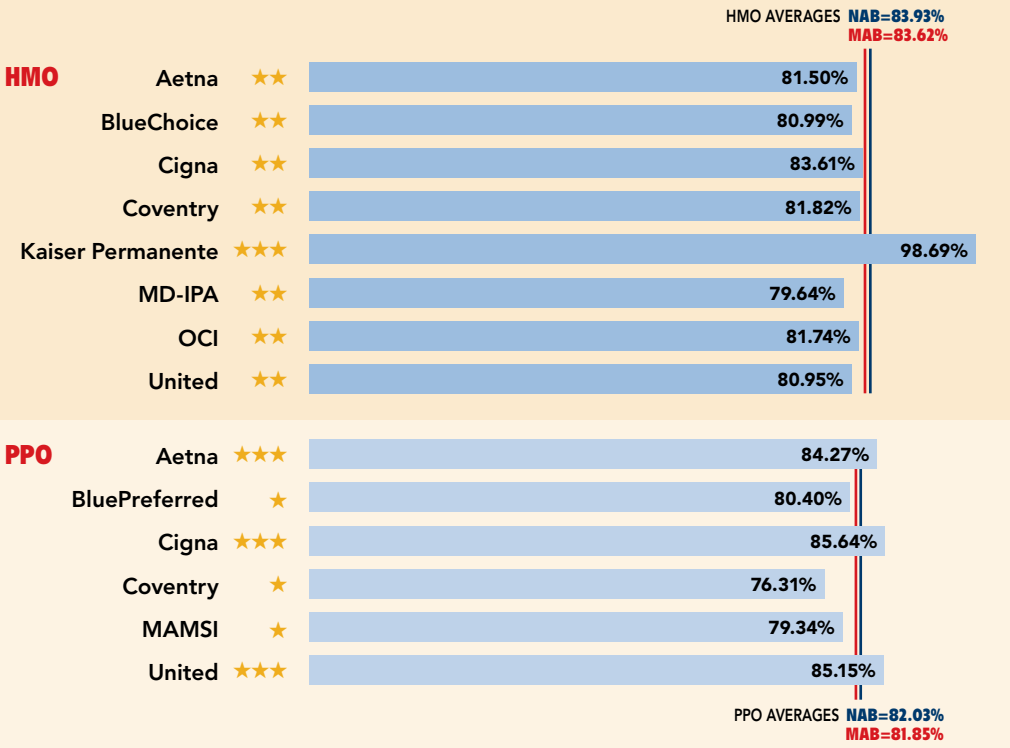
The percentage of members 3 months to 18 years of age during the 2012 measurement year who were identified as having an upper respiratory infection (URI) and were appropriately not given an antibiotic prescription within three days of their visit.

For this measure, a higher percentage is better, which means that more infants, children and adolescents 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, patients are often prescribed 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.

APPROPRIATELY NOT PRESCRIBED ANTIBIOTICS – 3 MONTHS-18 YEARS OF AGE



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BACK NEXT

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. Two separate indicators include:

1. The percentage of members 5–11 years of age in 2012 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during the measurement year.

For this performance indicator, a higher percentage is better, which means that more children 5–11 years of age with asthma were appropriately prescribed asthma medications.

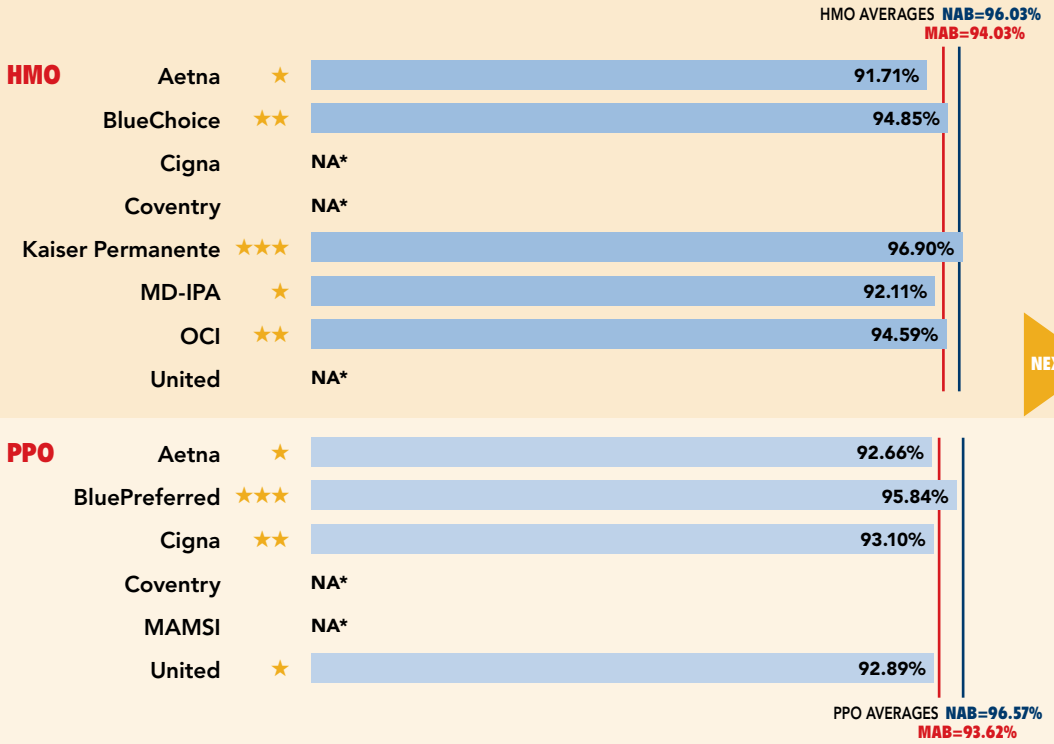
NOTE: Please find adult 19–50 and 51–64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 Americans die of it (CDC, 2011). 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.

(National Center for Health Statistics. Centers for Disease Control and Prevention CDC FastStats: Asthma)

APPROPRIATE ASTHMA MEDICATIONS – 5-11 YEARS OF AGE



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BACK NEXT

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 during the 2012 measurement year who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medications.

For this performance indicator, a higher percentage is better, which means that more children 12–18 years of age with asthma were appropriately prescribed asthma medications.

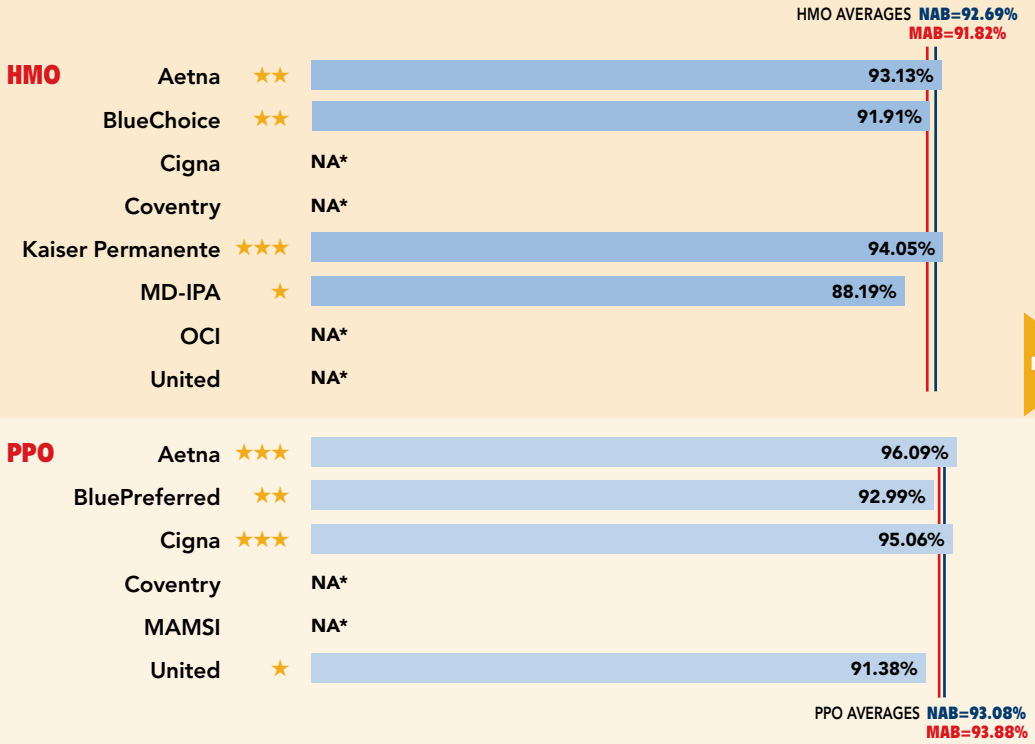
NOTE: Please find adult 19–50 and 51–64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is one of the nation's most costly and widespread diseases affecting children and adults alike. Approximately 7 million children have been diagnosed with asthma and each year more than 3,000 Americans die of it (CDC, 2011). 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.

(National Center for Health Statistics. Centers for Disease Control and Prevention CDC FastStats: Asthma)

APPROPRIATE ASTHMA MEDICATIONS – 12-18 YEARS OF AGE



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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. Four separate indicators include:

1. The percentage of members 5–11 years of age during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50% of the remaining days in 2012.

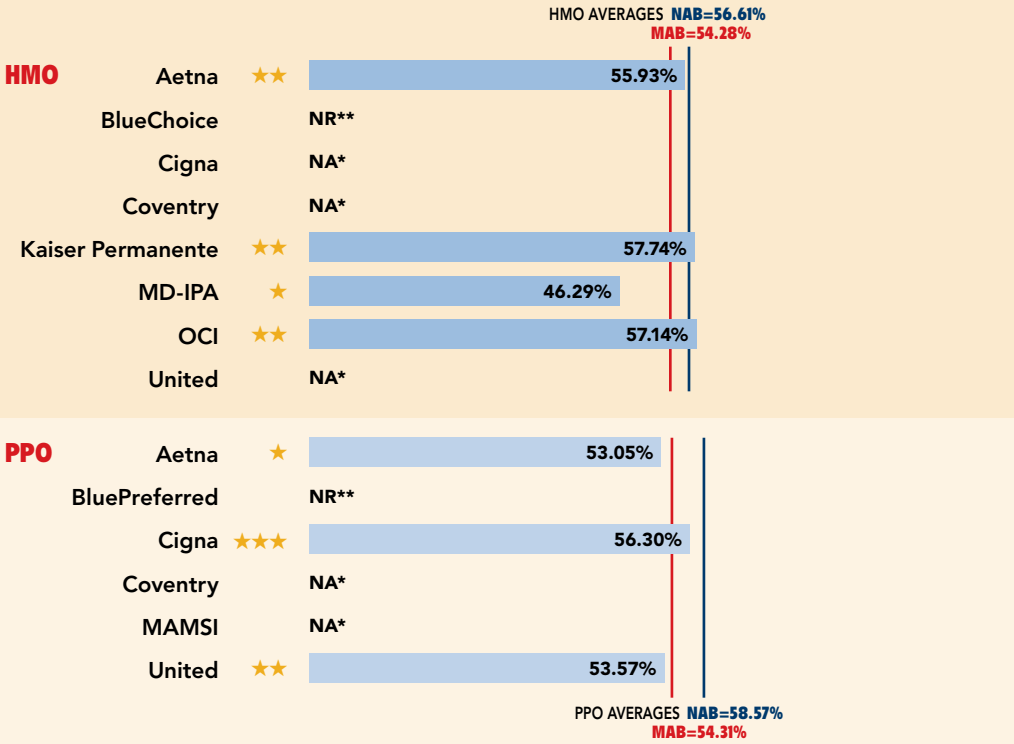
For this performance indicator, a higher percentage is better, which means that more children 5–11 years of age with asthma remained compliant on their asthma medication for at least 50% of the treatment period.

NOTE: Please find adult 19–50 and 51–64 years of age in the Primary Care for Adults – Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

50% TREATMENT COMPLIANCE – 5-11 YEARS OF AGE



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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

NA* – Insufficient eligible members (fewer than 30) to calculate rate
NR** – Bias in results (erroneous or "Not Reportable" data)

Data Source: Health Benefit Plan Records or Member Survey

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 during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50% of the remaining days in 2012.

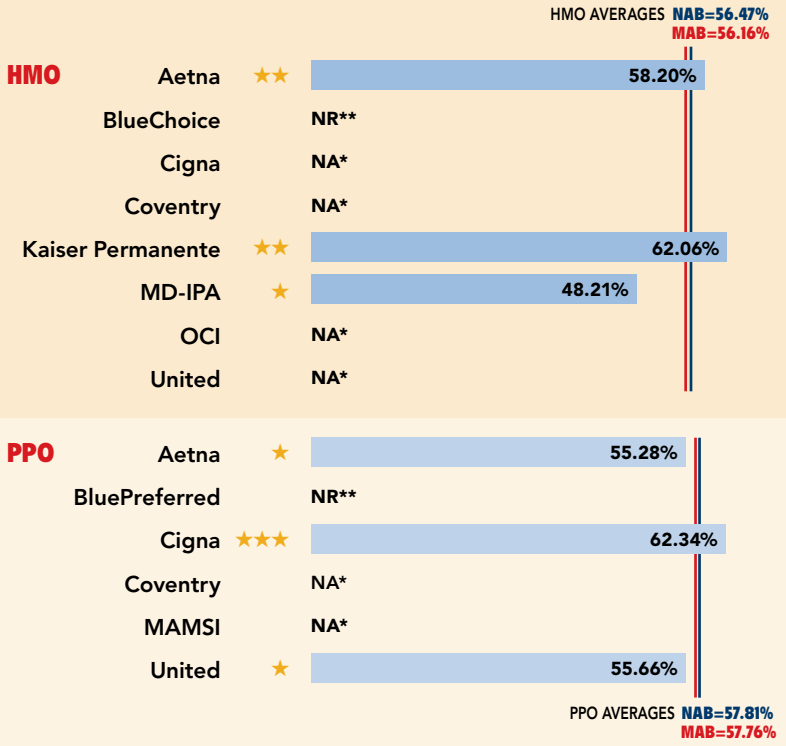
For this performance indicator, a higher percentage is better, which means that more children 12–18 years of age with asthma remained compliant on their asthma medication for at least 50% of the treatment period.

NOTE: Please find adult 19–50 and 51–64 years of age in the Primary Care for Adults – Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

50% TREATMENT COMPLIANCE – 12-18 YEARS OF AGE



More stars indicate better health benefit plan performance.

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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BACK NEXT

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 during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75% of the remaining days in 2012.

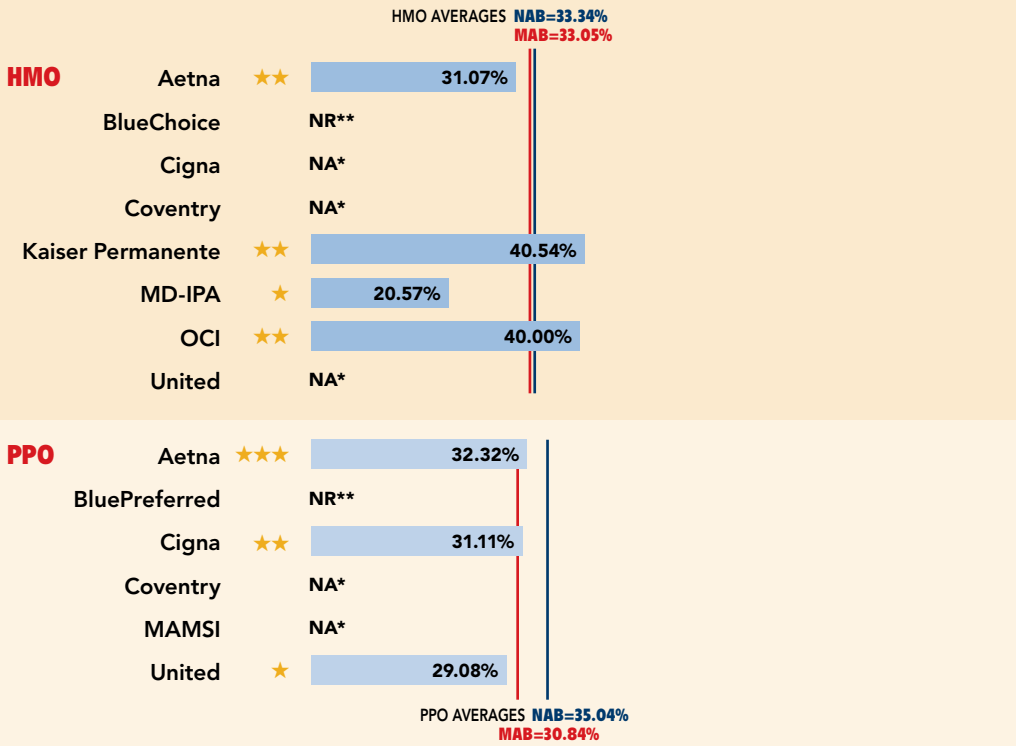
For this performance indicator, a higher percentage is better, which means that more children 5–11 years of age with asthma remained compliant on their asthma medication for at least 75% of the treatment period.

NOTE: Please find adult 19–50 and 51–64 years of age in the Primary Care for Adults - Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

75% TREATMENT COMPLIANCE – 5-11 YEARS OF AGE



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BACK NEXT

Medication Management for Children with Asthma continued

DESCRIPTION

4. The percentage of members 12–18 years of age during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75% of the remaining days in 2012.

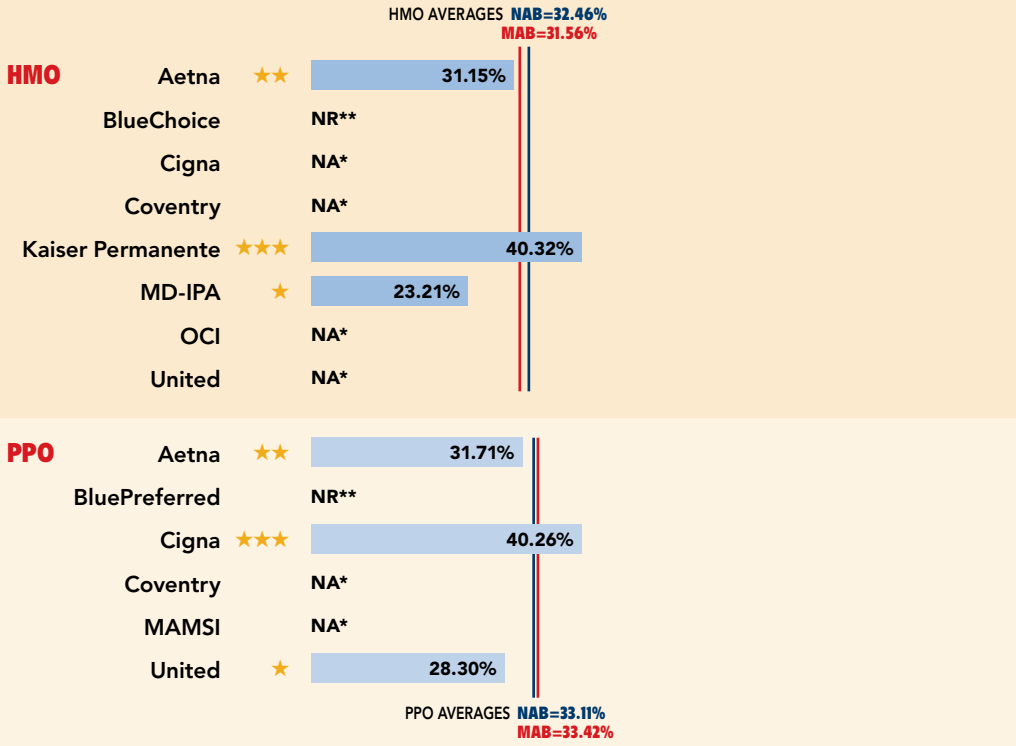
For this performance indicator, a higher percentage is better, which means that more children 12–18 years of age with asthma remained compliant on their asthma medication for at least 75% of the treatment period.

NOTE: Please find adult 19–50 and 51–64 years of age in the Primary Care for Adults – Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

75% TREATMENT COMPLIANCE – 12-18 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

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. Preventive 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.

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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. Two separate indicators include:

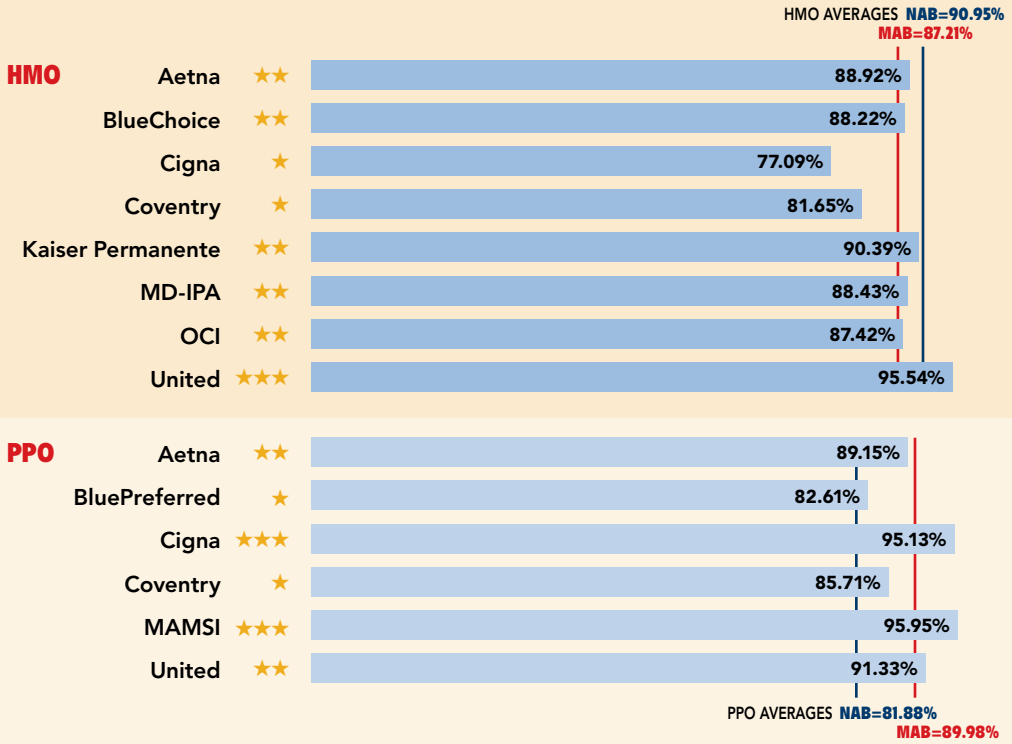
1. Timeliness of prenatal care. The percentage of women with live birth deliveries during the treatment period between November 6th, 2011 and November 5th, 2012, who had a prenatal care visit in their first trimester of pregnancy or within 42 days of enrollment in the health benefit plan.

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

RATIONALE

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.

TIMELY PRENATAL CARE – 1ST TRIMESTER OF PREGNANCY OR 0-42 DAYS OF ENROLLMENT



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

WOMEN'S HEALTH

Prenatal and Postpartum Care continued

DESCRIPTION

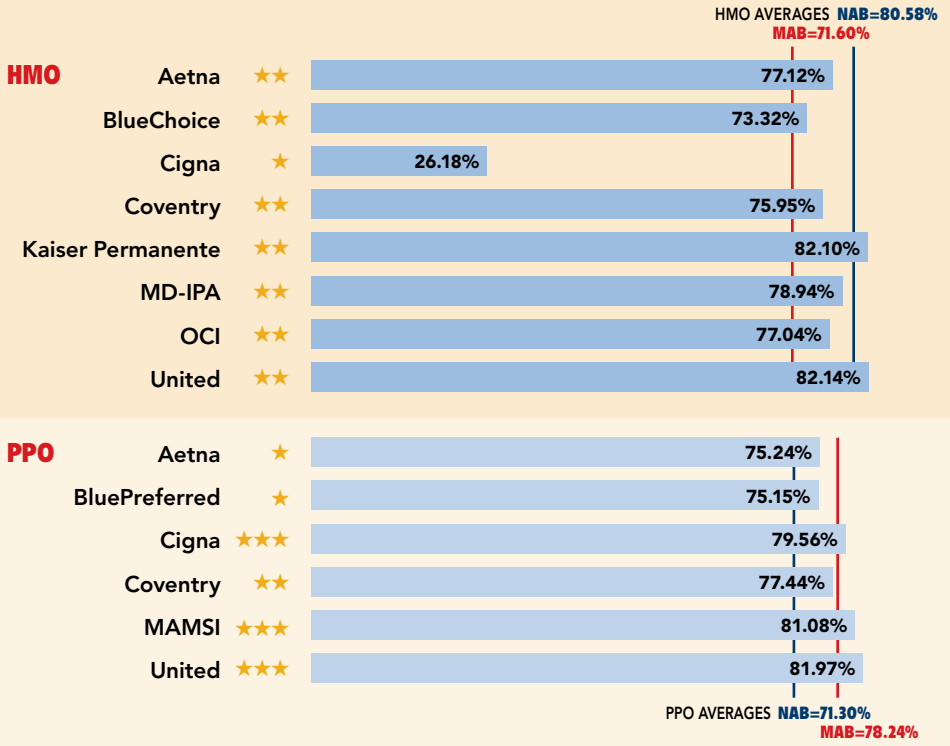
2. Timeliness of postpartum care. The percentage of women with live birth deliveries during the treatment period between November 6th, 2011 and November 5th, 2012, who had a postpartum care visit on or between 21 to 56 days after a live birth delivery.

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

RATIONALE

The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once between 21 to 56 days after giving birth. The first postpartum visit should include a physical examination and an opportunity for the health care practitioner to answer parents' questions and give family planning guidance and counseling on nutrition.

TIMELY POSTPARTUM CARE – 21-56 DAYS AFTER DELIVERY



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

WOMEN'S HEALTH

Breast Cancer Screening

DESCRIPTION

The percentage of women 42–69 years of age in 2012 who were continuously enrolled with the plan during the 2012 measurement year and the prior year, who also had a mammogram to screen for breast cancer during the 2012 measurement year or the prior year.

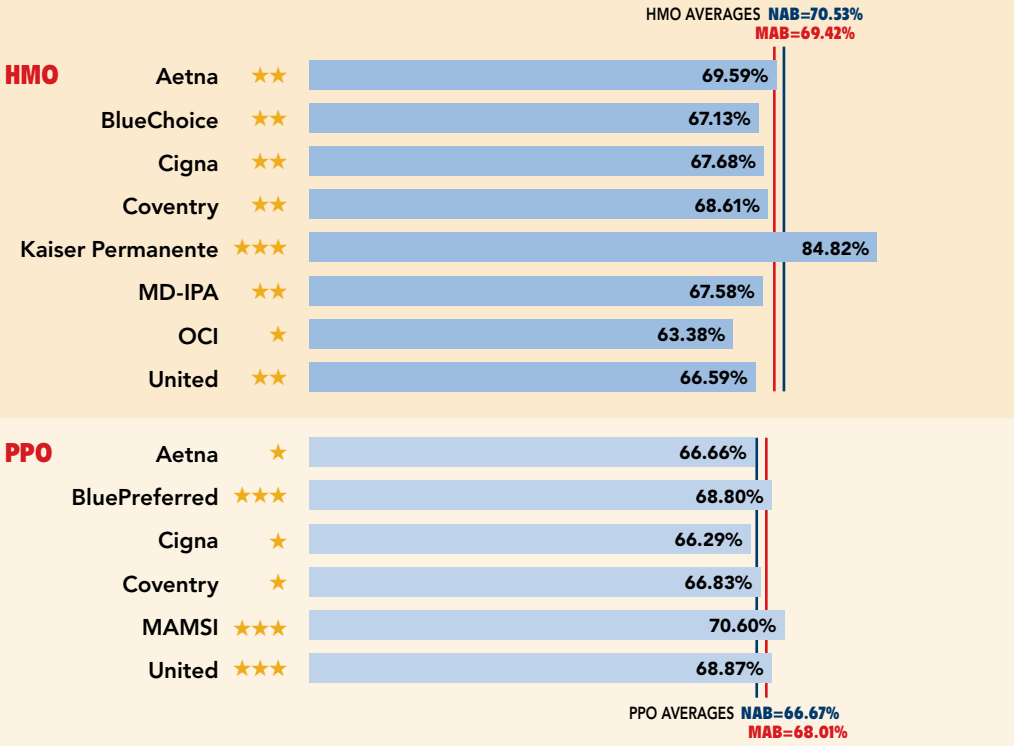
For this measure, a higher percentage is better, which means that more women did get a mammogram within the required timeframe.

RATIONALE

Breast cancer is the most common type of cancer among American women, with approximately 232,340 new cases estimated for 2013. 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.

(American Cancer Society)

MAMMOGRAM – 42-69 YEARS OF AGE



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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 2012 who were continuously enrolled with the plan during the 2012 measurement year and the two years prior, who also received one or more Pap smear tests to screen for cervical cancer during the 2012 measurement year.

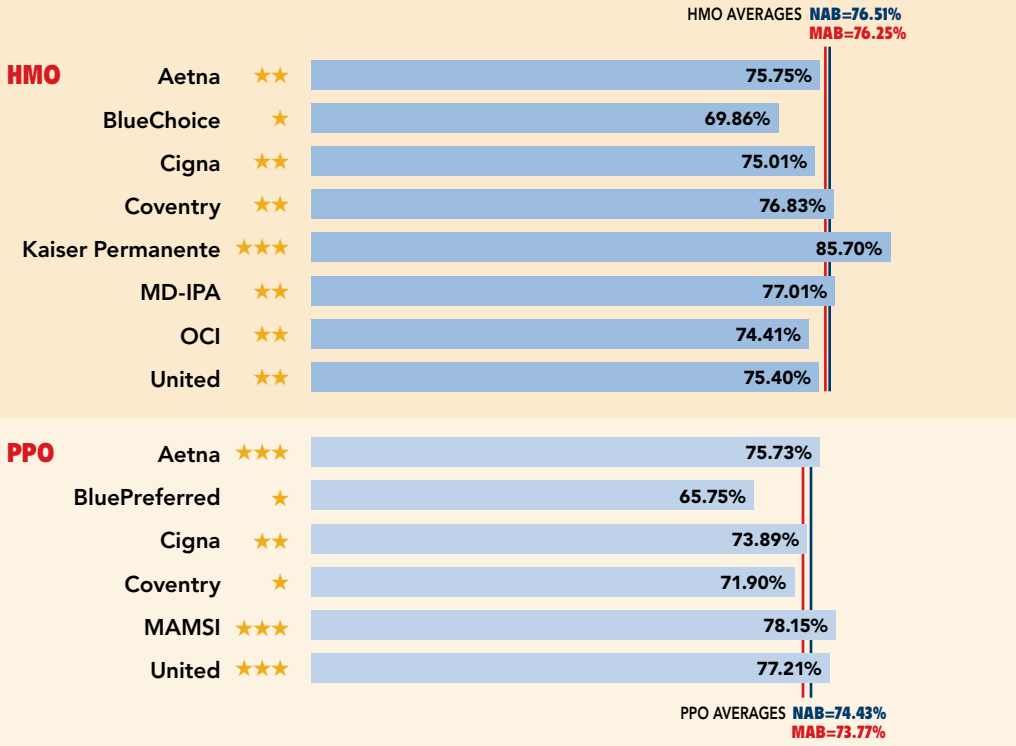
For this measure, a higher percentage is better, which means that more women did get at least one Pap smear test.

RATIONALE

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.

(Agency for Healthcare Research and Quality)

1+ PAP SMEAR TEST – 21-64 YEARS OF AGE



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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 2012 who were identified as sexually active and who had at least one test for Chlamydia during the 2012 measurement year.

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

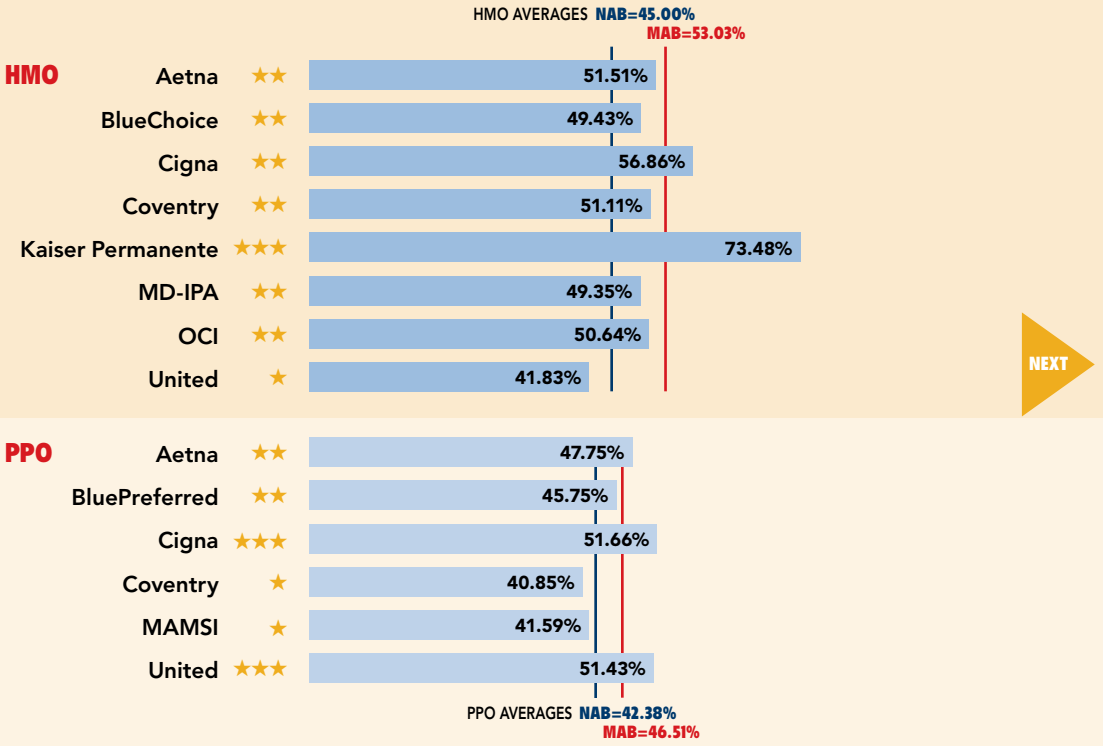
NOTE: There are three separate indicators in this measure category including Chlamydia screening among women 16–20 years, 21–24 years and 16–24 years. Only the total percentage of women screened among the 16–24 years age group is represented in the associated graph.

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.

(Centers for Disease Control and Prevention CDC Fact Sheet – Chlamydia)

1+ CHLAMYDIA TEST – 16-24 YEARS OF AGE



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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. The evaluation of developing risk factors as well as preventive health screenings can contribute greatly to a higher quality of life for a patient and lower health care costs.

BACK

NEXT

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – GENERAL HEALTH

Adults' Access to Preventive/ Ambulatory Health Services

DESCRIPTION

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

1. The percentage of members 20–44 years of age in 2012 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2012 measurement year or the two years prior.

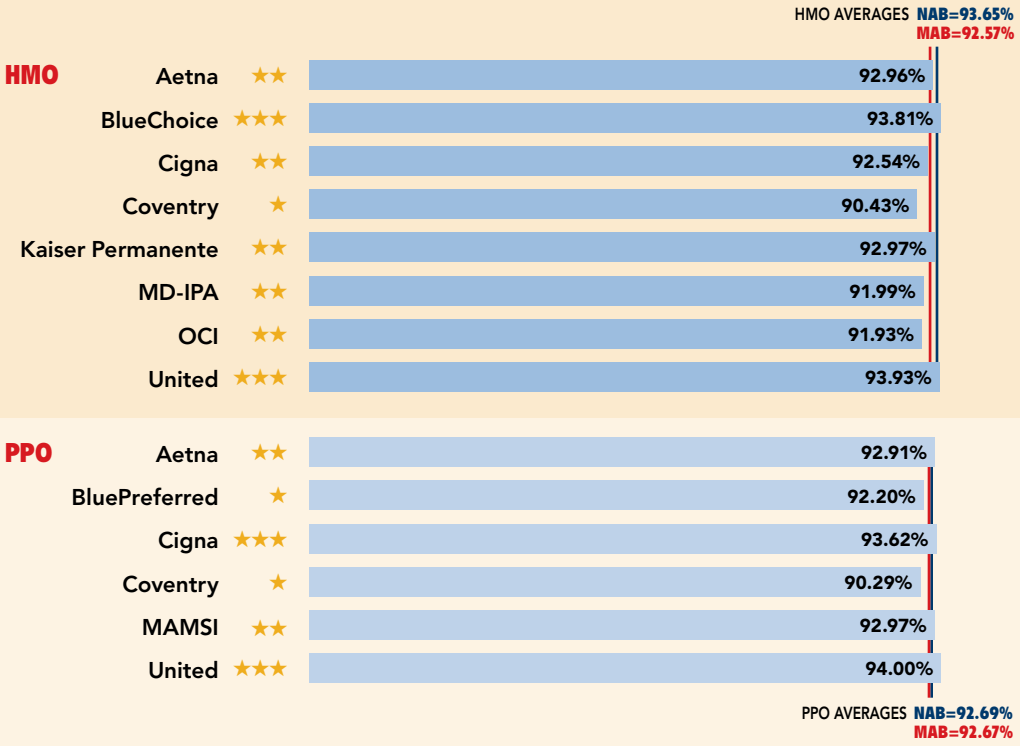
For this measure, a higher percentage is better, which means that more adults 20–44 years of age did have at least one ambulatory or preventive care visit.

RATIONALE

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

(Centers for Disease Control and Prevention)

OUTPATIENT VISIT – 20-44 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – GENERAL HEALTH

Adults' Access to Preventive/ Ambulatory Health Services continued

DESCRIPTION

2. The percentage of members 45–64 years of age in 2012 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2012 measurement year or the two years prior.

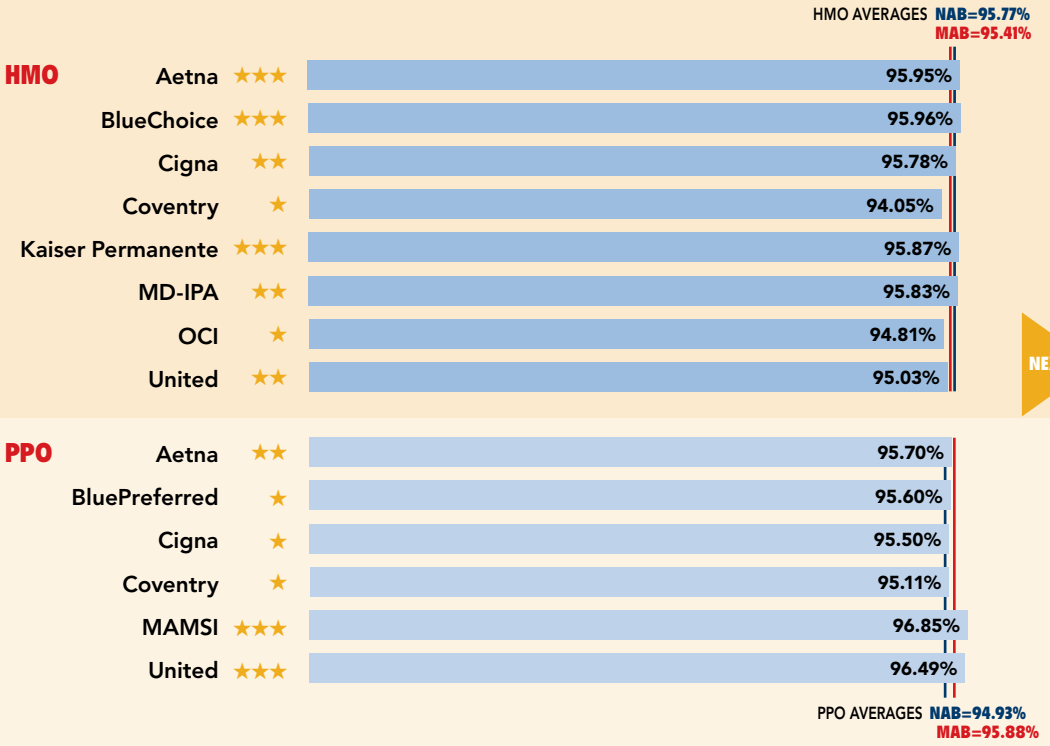
For this measure, a higher percentage is better, which means that more adults 45–64 years of age did have at least one ambulatory or preventive care visit.

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 health care provider to evaluate and treat or arrange for the future evaluation and treatment of a patient's risk factors.

(Centers for Disease Control and Prevention)

OUTPATIENT VISIT – 45-64 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – GENERAL HEALTH

Adults' Access to Preventive/ Ambulatory Health Services continued

DESCRIPTION

3. The percentage of members 65 years of age and older in 2012 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2012 measurement year or the two years prior.

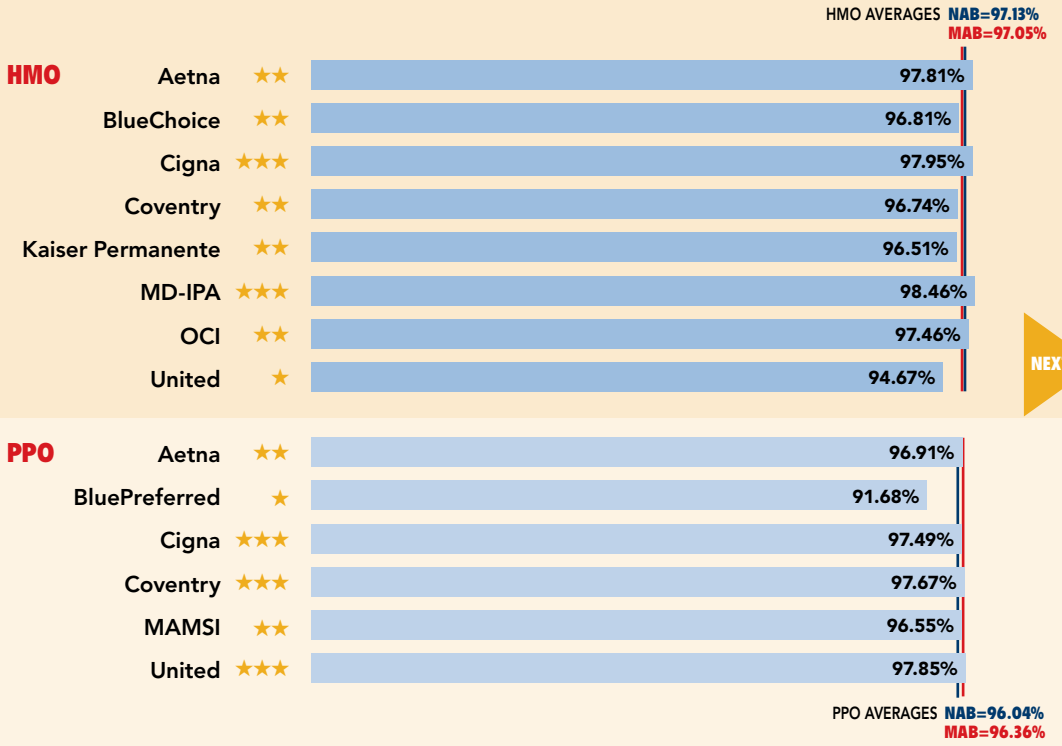
For this measure, a higher percentage is better, which means that more seniors did have at least one ambulatory or preventive care visit.

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 health care provider to evaluate and treat or arrange for the future evaluation and treatment of a patient's risk factors.

(Centers for Disease Control and Prevention)

OUTPATIENT VISIT – 65+ YEARS OF AGE



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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 2012 who had an outpatient visit and whose weight was assessed and body mass index (BMI) was documented during the 2012 measurement year or the prior year. Because BMI norms vary with age and gender, this measure evaluates whether BMI percentile is assessed for a group aged between 18 and 74 years, rather than an absolute BMI value.

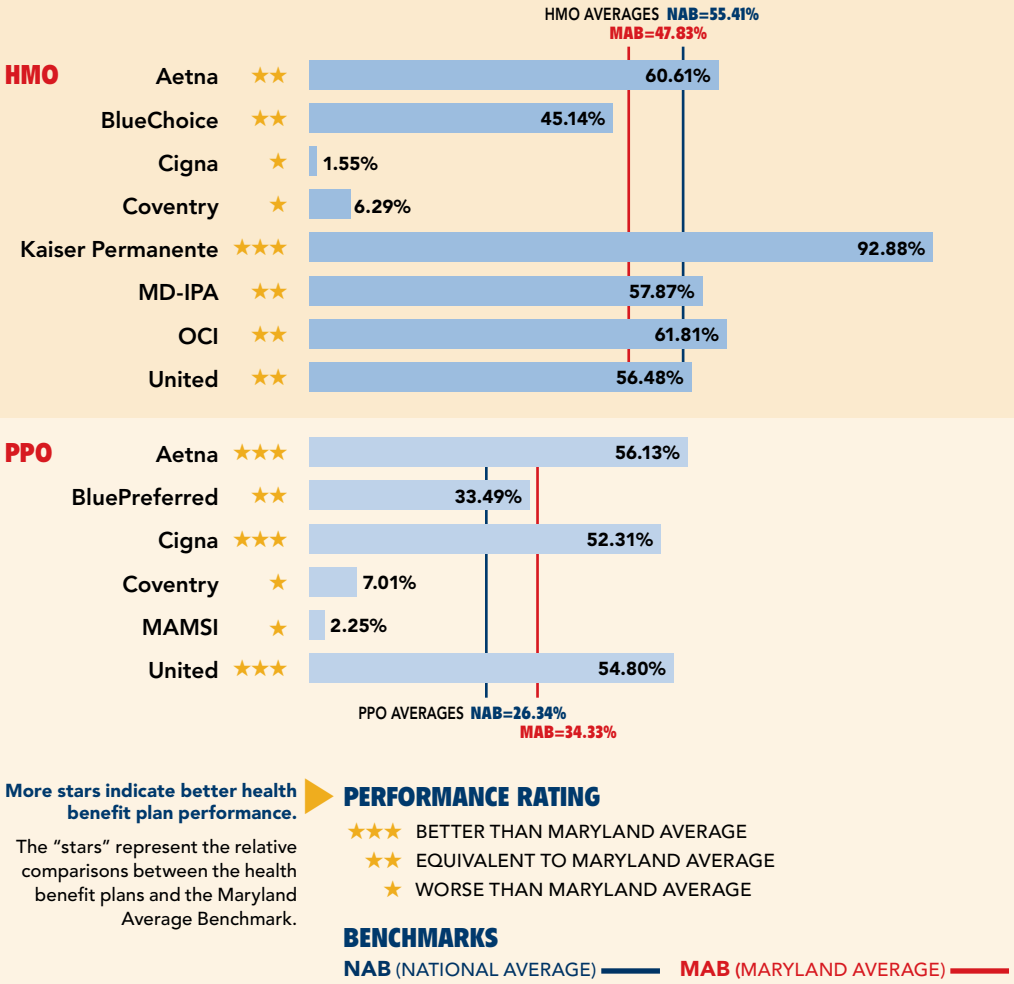
For this measure, a higher percentage is better, which means that more adults 18–74 years of age did have an outpatient visit, which included having their BMI calculated and documented.

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.

(Journal of the American Medical Association, March 2004 – Vol. 291, No. 10)

BODY MASS INDEX – 18-74 YEARS OF AGE



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BACK NEXT

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 2012 who had an appropriate screening for colorectal cancer during the 2012 measurement year and the prior year.

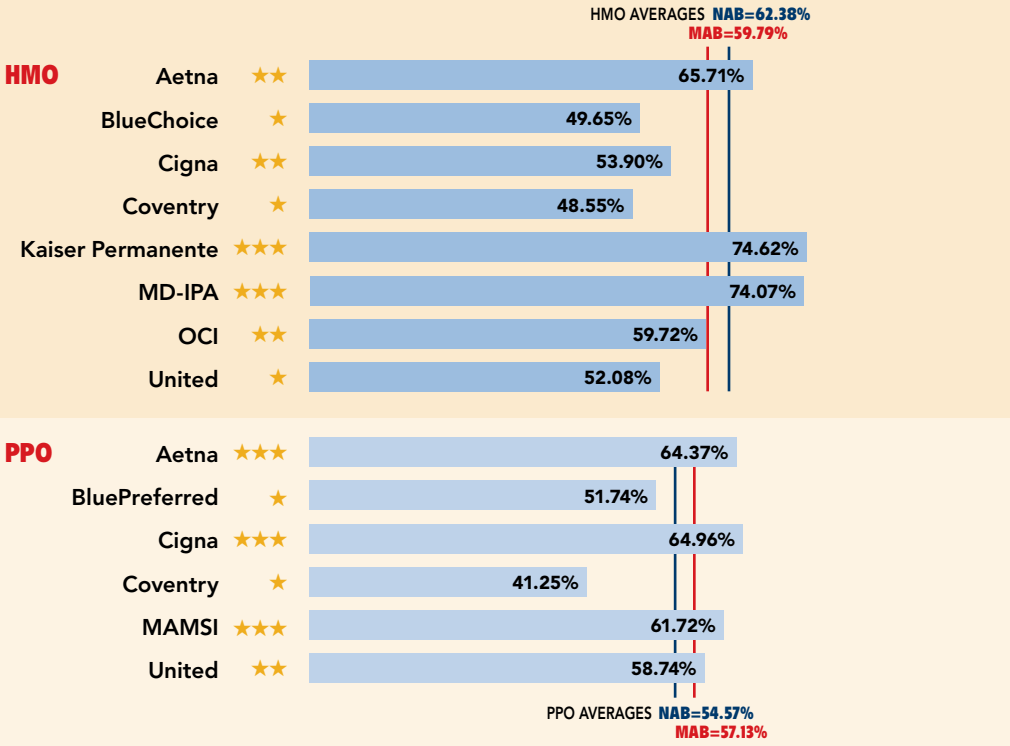
For this measure, a higher percentage is better, which means that more adults 50–75 years of age did get screened for colorectal cancer.

RATIONALE

Colorectal cancer (CRC) is the fifth 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.

(American Cancer Society, 2013)

COLORECTAL CANCER SCREENING – 50-75 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

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, medical treatment and education, patients continue to learn and become more effective participants in the management of their respiratory conditions.

BACK

NEXT

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

DESCRIPTION

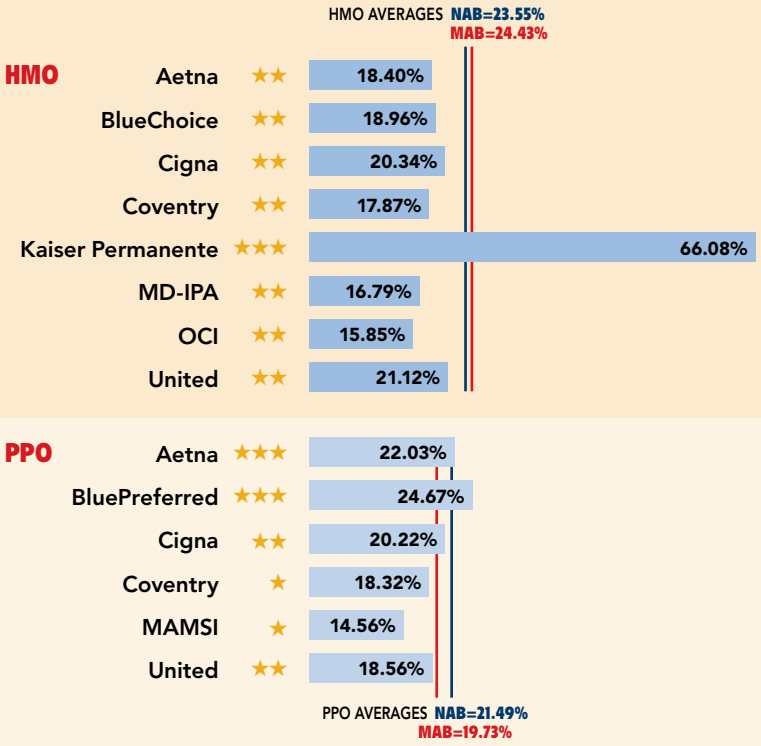
The percentage of members 18–64 years of age in 2012 with a diagnosis of acute bronchitis who were not given an antibiotic prescription during the treatment period between January 1st and December 24th of the 2012 measurement year.

For this measure, a higher percentage is better, which means that more 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.

NOT GIVEN ANTIBIOTICS – 18-64 YEARS OF AGE



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BACK NEXT

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 2012 with a new diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis during the 2012 measurement year.

For this measure, a higher percentage is better, which means that more adults 40 years of age 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. COPD defines a group of diseases characterized by airflow obstruction, and includes chronic bronchitis and emphysema. COPD afflicts nearly 13 million adults in the U.S. COPD is the third 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. Although 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.

(American Lung Association, 2013)

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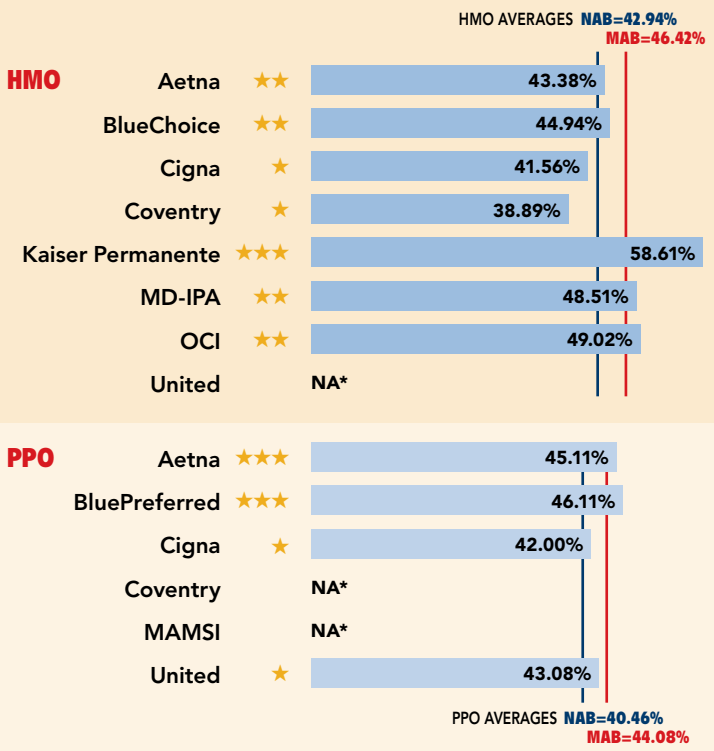
SPIROMETRY TEST – 40+ YEARS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) **MAB** (MARYLAND AVERAGE)

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

Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation

DESCRIPTION

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

1. The percentage of Chronic Obstructive Pulmonary Disease (COPD) exacerbations for members 40 years of age and older in 2012 who had an acute inpatient discharge or emergency department encounter on or between January 1st and November 30th of the 2012 measurement year, and who were given a prescription for a systemic corticosteroid within 14 days of the COPD event.

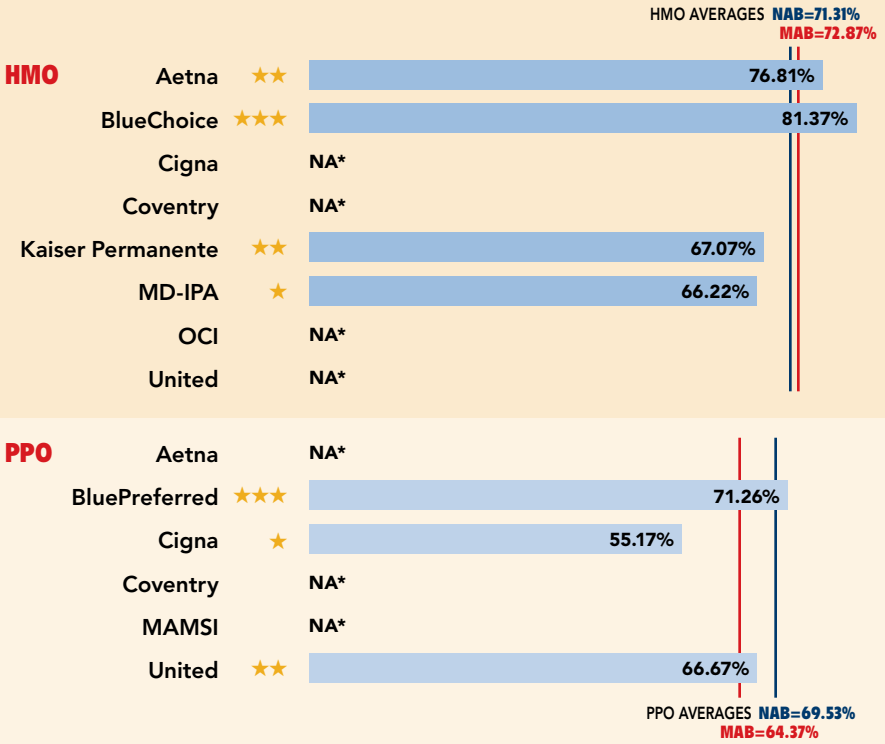
For this performance indicator, a higher percentage is better, which means that more adults 40 years of age ond older did get a timely prescription for a systemic corticosteroid.

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. However, studies have shown that proper management of exacerbations may have the greatest potential to reduce the clinical, social and economic impact of the disease.

(Expert Review of Pharmaco-economics and Research 2012; 12(6))

SYSTEMIC CORTICOSTEROID WITHIN 14 DAYS – 40+ YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

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Data Source: Health Benefit Plan Records or Member Survey

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Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation

continued

DESCRIPTION

2. The percentage of Chronic Obstructive Pulmonary Disease (COPD) exacerbations for members 40 years of age and older in 2012 who had an acute inpatient discharge or emergency department encounter on or between January 1st and November 30th of the 2012 measurement year, and who were given a prescription for a bronchodilator within 30 days of the event.

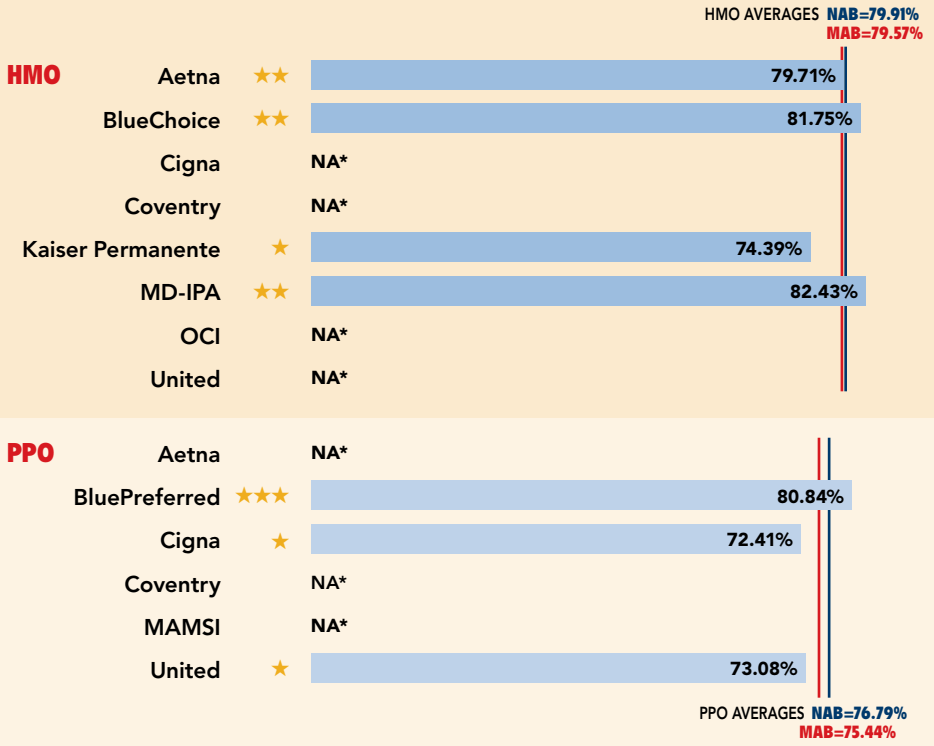
For this performance indicator, a higher percentage is better, which means that more adults 40 years of age and over did get a timely prescription for a bronchodilator.

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. However, studies have shown that proper management of exacerbations may have the greatest potential to reduce the clinical, social and economic impact of the disease.

(Expert Review of Pharmaco-economics and Research 2012; 12(6))

BRONCHODILATOR WITHIN 30 DAYS – 40+ YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Use of Appropriate Medications for Adults with Asthma

DESCRIPTION

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

1. The percentage of members 19–50 years of age in 2012 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during the 2012 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 19–50 years of age with asthma were appropriately prescribed asthma medications.

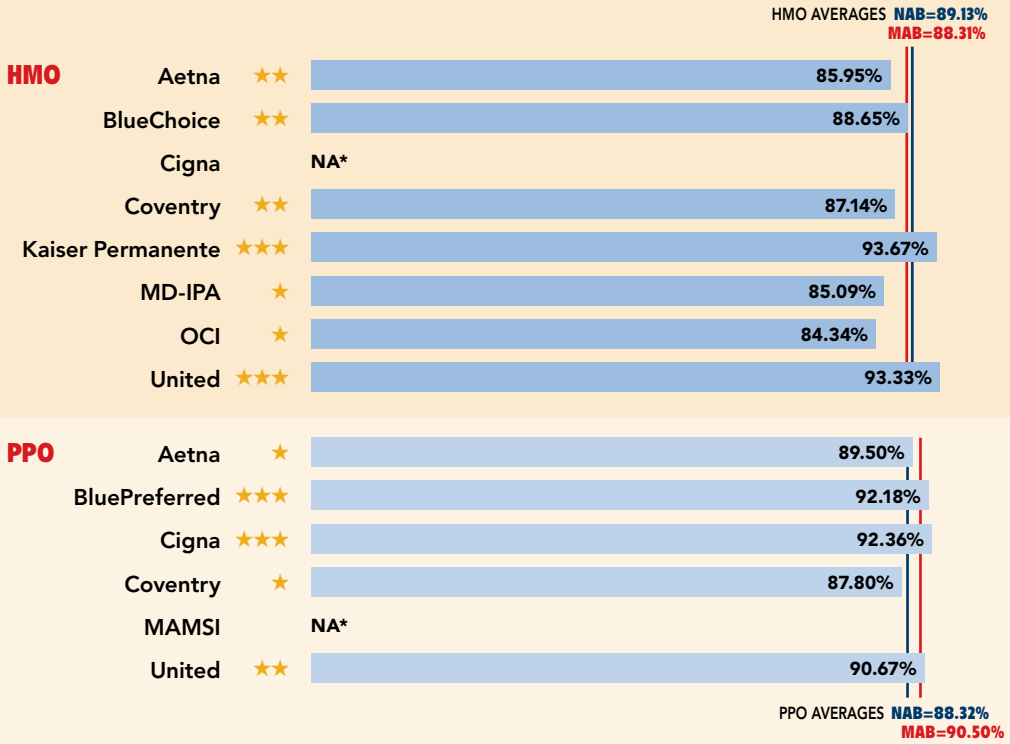
NOTE: Please find children 5–11 and 12–18 years of age in the Child Respiratory Conditions section.

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 more than 3,000 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.

(National Center for Health Statistics. Centers for Disease Control and Prevention CDC FastStats: Asthma)

APPROPRIATE ASTHMA MEDICATIONS – 19-50 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Use of Appropriate Medications for Adults with Asthma continued

DESCRIPTION

2. The percentage of members 51–64 years of age in 2012 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during the 2012 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 51–64 years of age with asthma were appropriately prescribed asthma medications.

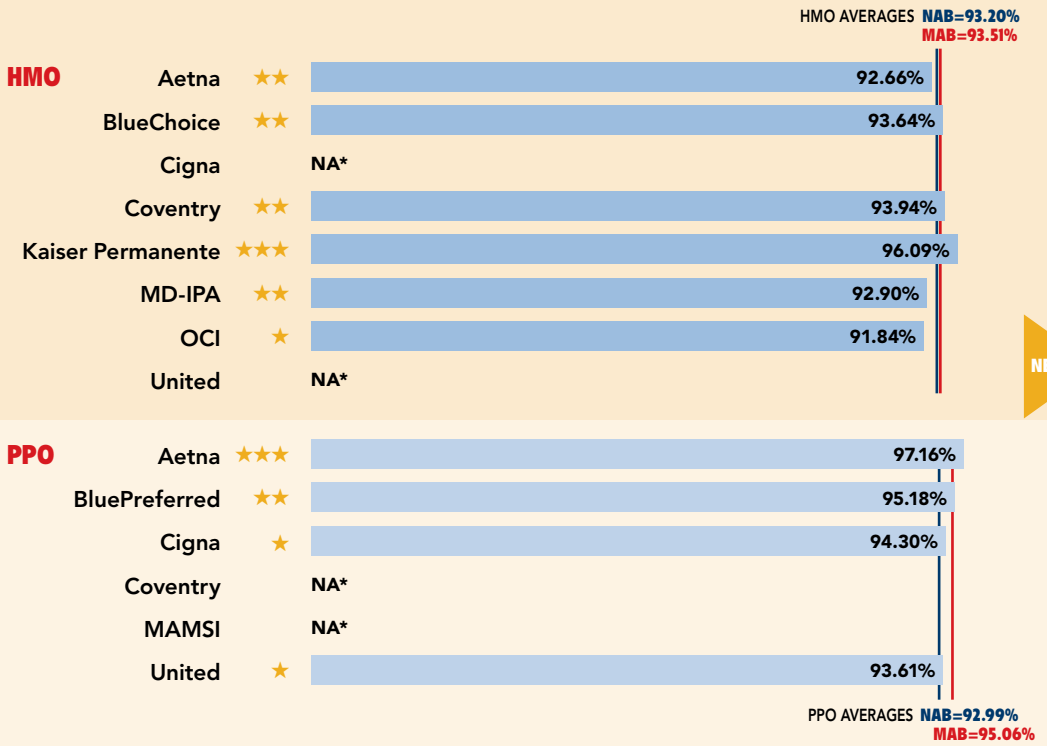
NOTE: Please find children 5–11 and 12–18 years of age in the Child Respiratory Conditions section.

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 more than 3,000 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.

(National Center for Health Statistics. Centers for Disease Control and Prevention CDC FastStats: Asthma)

APPROPRIATE ASTHMA MEDICATIONS – 51-64 YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – RESPIRATORY CONDITIONS

Medication Management for Adults with Asthma

DESCRIPTION

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

1. The percentage of members 19–50 years of age during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50% of the remaining days in 2012.

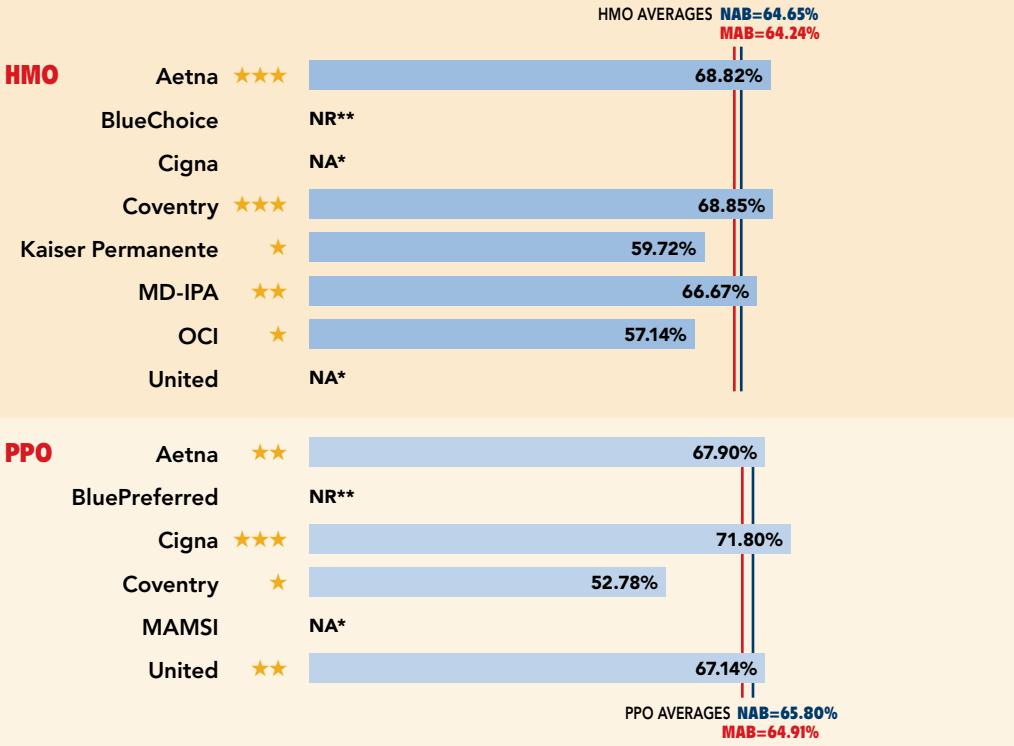
For this performance indicator, a higher percentage is better, which means that more adults 19–50 years of age with asthma remained compliant on their asthma medication for at least 50% of the treatment period.

NOTE: Please find children 5–11 and 12–18 years of age in the Child Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

50% TREATMENT COMPLIANCE – 19-50 YEARS OF AGE



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NR** – Bias in results (erroneous or "Not Reportable" data)

Data Source: Health Benefit Plan Records or Member Survey

Medication Management for Adults with Asthma
continued

DESCRIPTION

2. The percentage of members 51–64 years of age during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 50% of the remaining days in 2012.

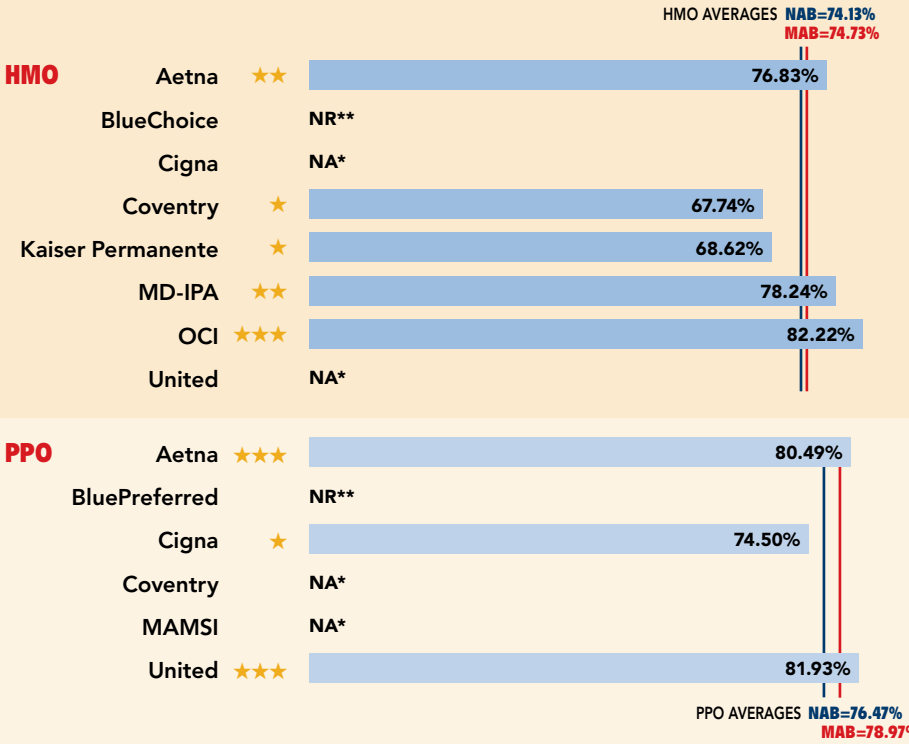
For this performance indicator, a higher percentage is better, which means that more adults 51–64 years of age with asthma remained compliant on their asthma controller medication for at least 50% of the treatment period.

NOTE: Please find children 5–11 and 12–18 years of age in the Child Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

50% TREATMENT COMPLIANCE – 51-64 YEARS OF AGE



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Data Source: Health Benefit Plan Records or Member Survey

Medication Management for Adults with Asthma
continued

DESCRIPTION

3. The percentage of members 19–50 years of age during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75% of the remaining days in 2012.

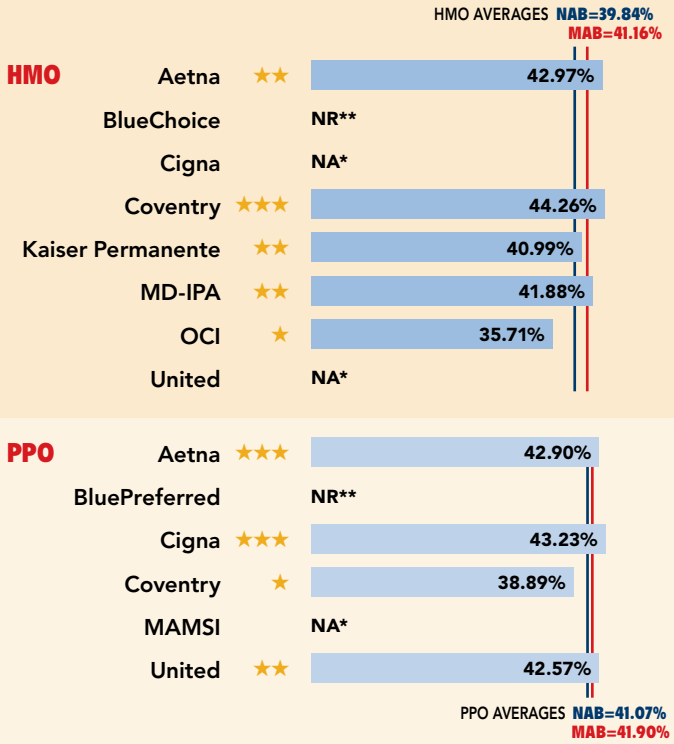
For this performance indicator, a higher percentage is better, which means that more adults 19–50 years of age with asthma remained compliant on their asthma medication for at least 75% of the treatment period.

NOTE: Please find children 5–11 and 12–18 years of age in the Child Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

75% TREATMENT COMPLIANCE – 19-50 YEARS OF AGE



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BENCHMARKS

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Data Source: Health Benefit Plan Records or Member Survey

Medication Management for Adults with Asthma
continued

DESCRIPTION

4. The percentage of members 51–64 years of age during the 2012 measurement year who were identified as having persistent asthma, were given a prescription for an appropriate medication including an asthma controller or reliever/rescue medication, and who remained on that medication for at least 75% of the remaining days in 2012.

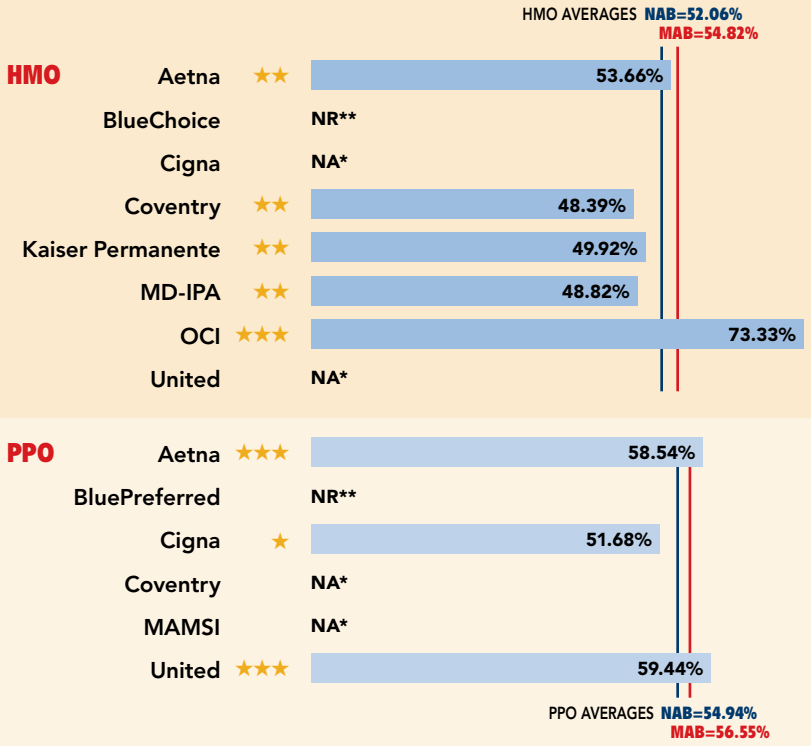
For this performance indicator, a higher percentage is better, which means that more adults 51–64 years of age with asthma remained compliant on their asthma controller medication for at least 75% of the treatment period.

NOTE: Please find children 5–11 and 12–18 years of age in the Child Respiratory Conditions section.

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 treat, prevent and control asthma symptoms, and improve quality of life by reducing the frequency and severity of asthma exacerbations and reversing airflow obstruction.

75% TREATMENT COMPLIANCE – 51-64 YEARS OF AGE



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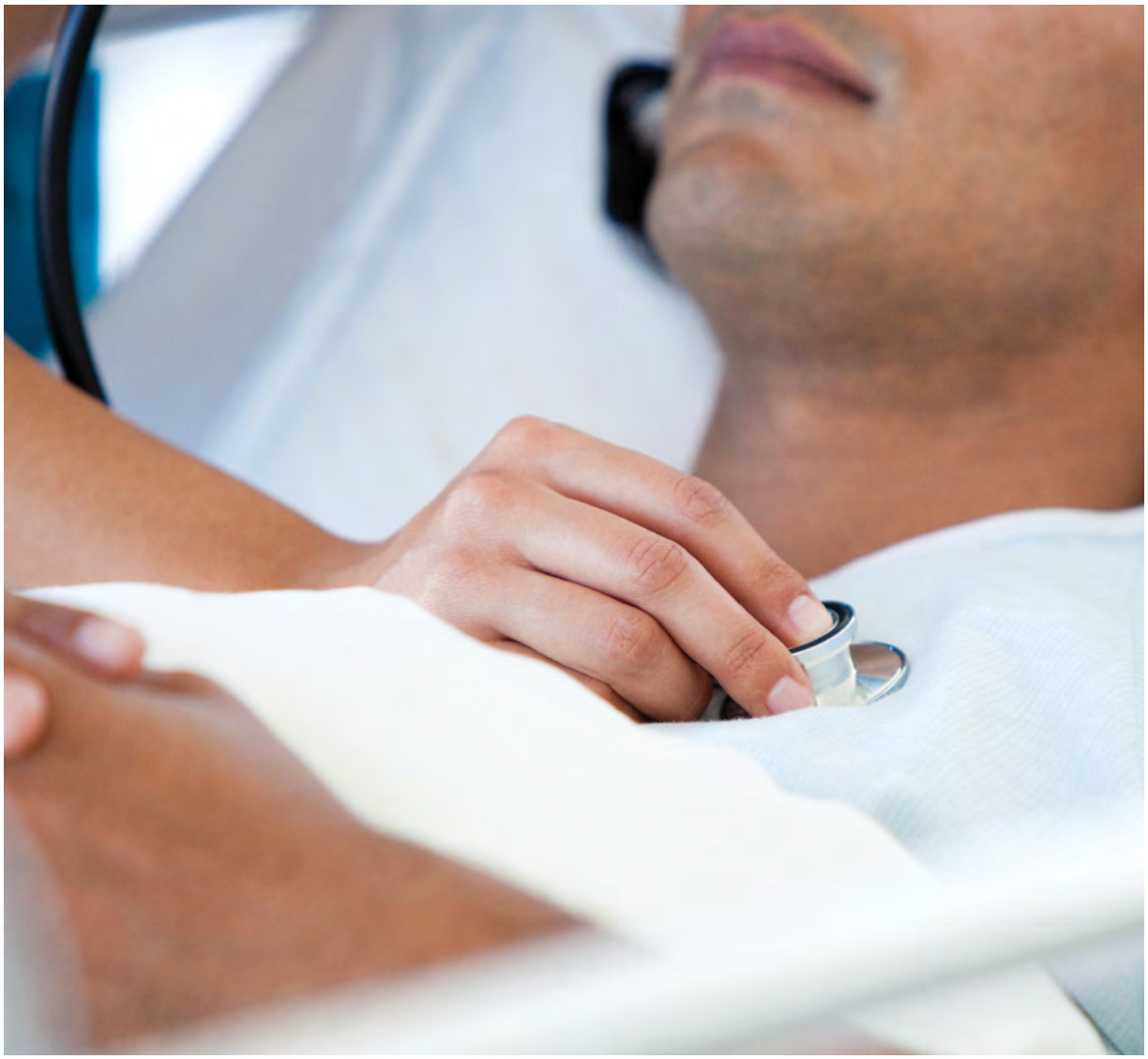
Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes

Many people with diabetes are at risk for developing mild cardiovascular disease. Therefore, a comprehensive approach to care is required and consists of a strong program that targets prevention as well as treatment and involves lifestyle changes such as diet, exercise, stress management and quitting smoking; medications to control blood sugar, blood pressure and cholesterol levels; and other medications, treatments, monitoring and testing.

(Cardiovascular Angiography and Interventions, 2012)



BACK

NEXT

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Cholesterol Management for Patients with Cardiovascular Conditions

DESCRIPTION

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

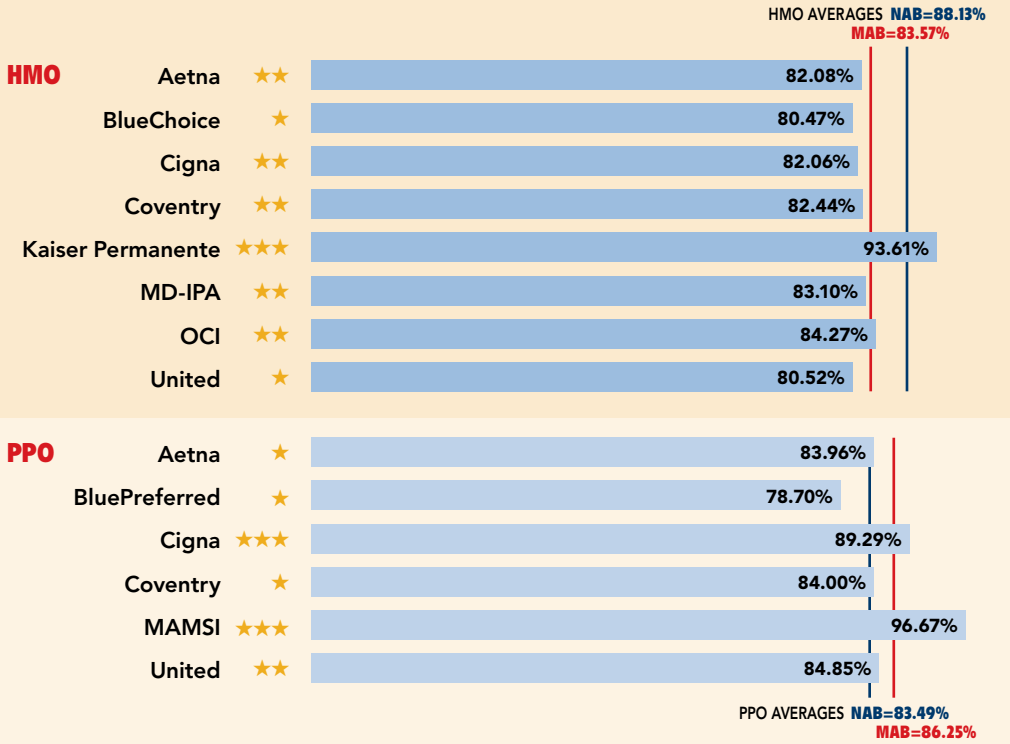
1. Low-Density Lipoprotein Cholesterol (LDL-C) screening: The percentage of members 18–75 years of age who were discharged alive for a heart attack or acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) commonly known as angioplasty or stent procedure, from January 1–November 1 of the year prior to the measurement year (2011), or who had a diagnosis of ischemic vascular disease (IVD) during the 2012 measurement year and the prior year.

For this performance indicator, a higher percentage is better, which means that more adults 18–75 years of age, at increased risk for cardiovascular events, did get appropriate LDL 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 an LDL-C goal of less than 100 mg/dL.

LDL CHOLESTEROL SCREENING (CARDIOVASCULAR) – 18-75 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

Data Source: Health Benefit Plan Records or Member Survey

Cholesterol Management for Patients with Cardiovascular Conditions continued

DESCRIPTION

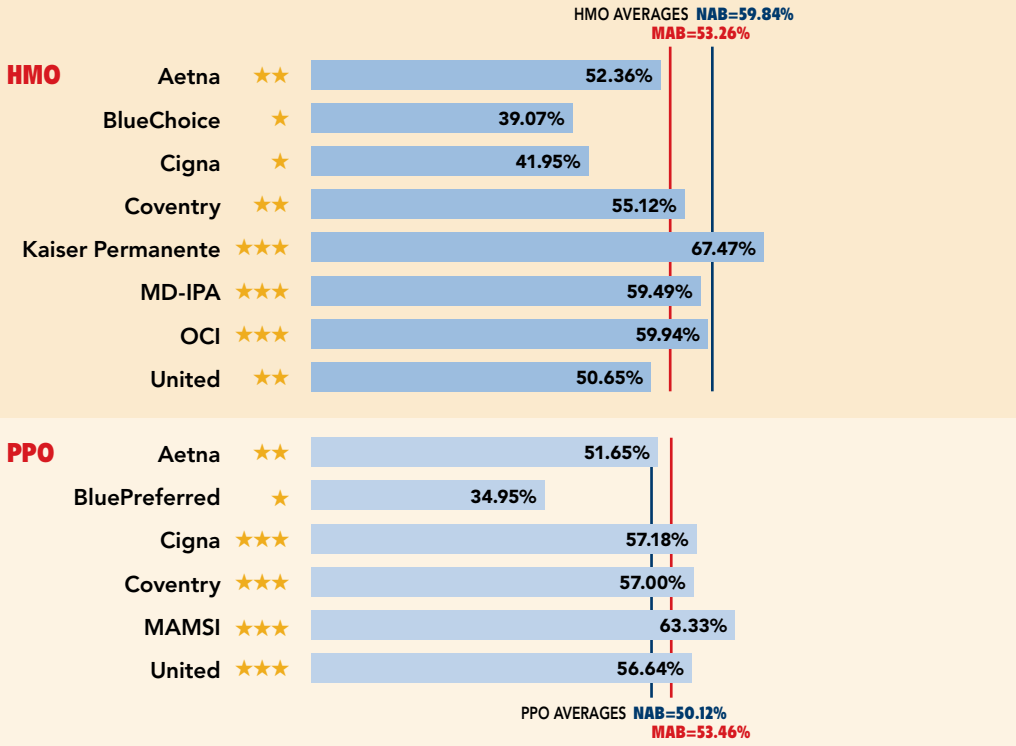
2. Low-Density Lipoprotein Cholesterol (LDL-C) control: The percentage of members 18–75 years of age who were discharged alive for a heart attack or acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) commonly known as angioplasty or stent procedure, from January 1–November 1 of the year prior to the measurement year (2011), or who had a diagnosis of ischemic vascular disease (IVD) during the 2012 measurement year and the prior year, who also had a level less than 100 mg/dL on their LDL-C Screening.

For this performance indicator, a higher percentage is better, which means that more adults 18–75 years of age, at increased risk for cardiovascular events, did achieve good cholesterol control with an LDL-C level below 100 mg/dL.

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 an LDL-C goal of less than 100 mg/dL.

LDL CHOLESTEROL CONTROL < 100 MG/DL (CARDIOVASCULAR) – 18-75 YEARS OF AGE



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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

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 2012 who had a confirmed diagnosis of hypertension and through proper disease management, had blood pressure that was adequately controlled (<140/90 mm Hg) during the 2012 measurement year.

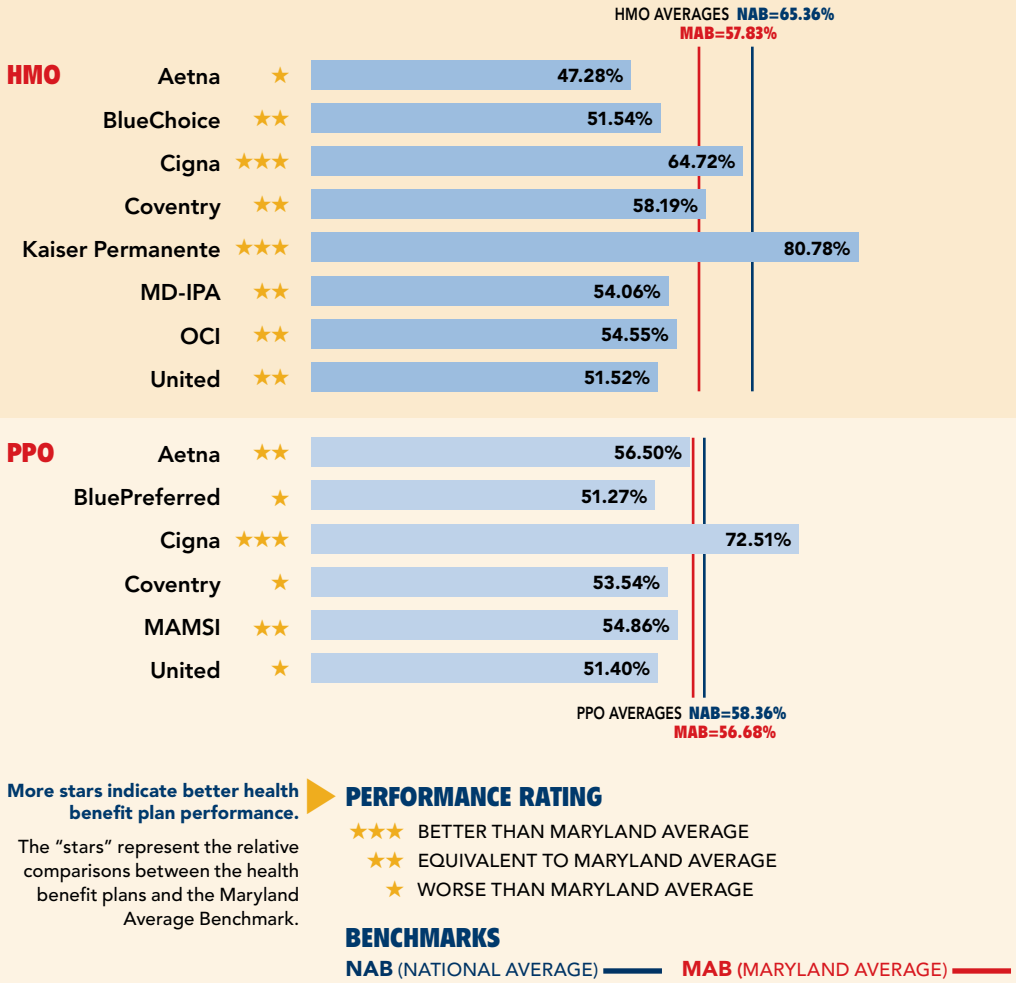
For this measure, a higher percentage is better, which means that more adults 18–85 years of age with hypertension did get adequate control of their blood pressure.

RATIONALE

Having high blood pressure puts you at risk for heart disease and stroke, the leading causes of death in the United States. People of all ages and backgrounds can develop high blood pressure. Fortunately, it's mostly preventable. Of the American adult population, 67 million (31%) have high blood pressure or 1 in every 3 American adults. In the same population, 69% of people who have a first heart attack, 77% of people who have a first stroke, and 74% of people with chronic heart failure also have high blood pressure. In addition, high blood pressure is a major risk factor for kidney disease. Overall, more than 348,000 American deaths in 2009 included high blood pressure as a primary or contributing cause.

(CDC, High Blood Pressure, Facts and Statistics, 2013)

BLOOD PRESSURE CONTROL <140/90 MM Hg (CARDIOVASCULAR) – 18-85 YEARS OF AGE



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BENCHMARKS

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Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Persistence of Beta-Blocker Treatment After a Heart Attack

DESCRIPTION

The percentage of members 18 years of age and older during the 2012 measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year (2011) to June 30 of the measurement year (2012) 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 more adults 18 years of age and over with a history of having a heart attack did get at least six months of beta-blocker treatment.

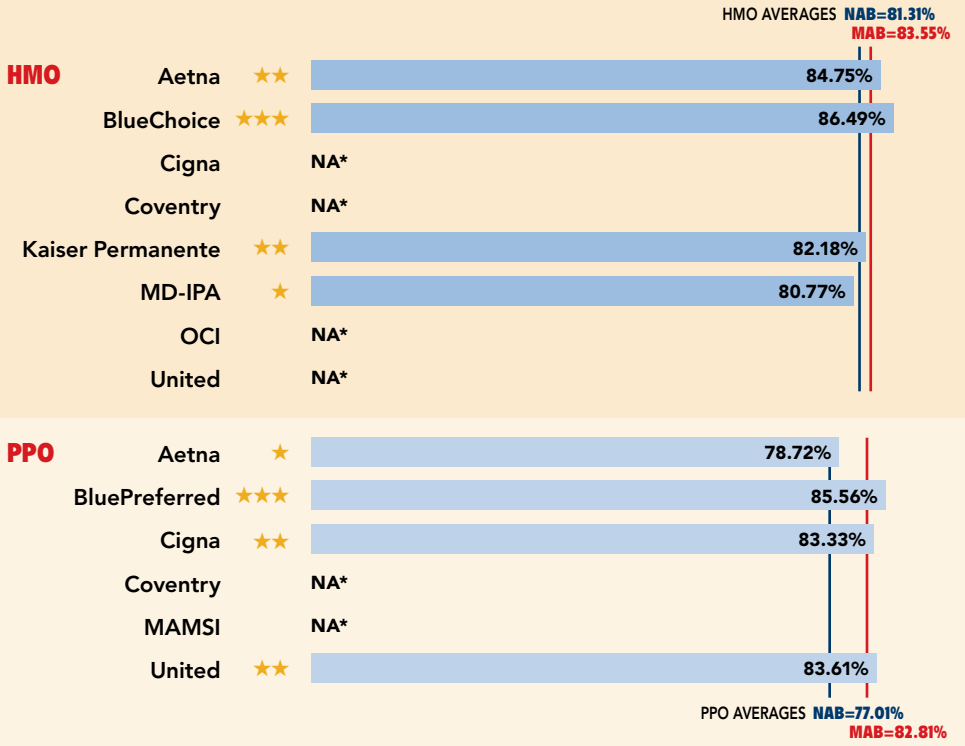
RATIONALE

Although beta-blockers can significantly reduce mortality after a heart attack, these agents are prescribed to only a minority of patients. Underutilization of beta-blockers may be attributed, in part, to fear of adverse effects, especially in the elderly and in patients with disorders such as diabetes or heart failure. However, studies have shown that such patients are precisely the ones who derive the greatest benefit from beta blockade. Advancing age or the presence of potentially complicating disease states is usually not a justification for withholding beta-blocker therapy.

The American Heart Association and the American College of Cardiology emphasize the importance of beta blockade in their current treatment guidelines for myocardial infarction. On the basis of these guidelines, the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) have identified beta-blocker therapy after myocardial infarction as a critical marker for quality of care. CMS and NCQA now include beta-blocker use after infarction in profiles of hospitals and managed care plans.

(American Academy of Family Physicians, American Family Physician; 2000 Oct 15; 62(8):1853-1860)

BETA-BLOCKER FOR 6 MONTHS AFTER DISCHARGE – 18+ YEARS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

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

Data Source: Health Benefit Plan Records or Member Survey

HEDIS and HEDIS Compliance Audits are trademarks of the National Committee for Quality Assurance (NCQA)

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Comprehensive Diabetes Care

DESCRIPTION

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

1. Hemoglobin A1c (HbA1c) testing: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during the 2012 measurement year.

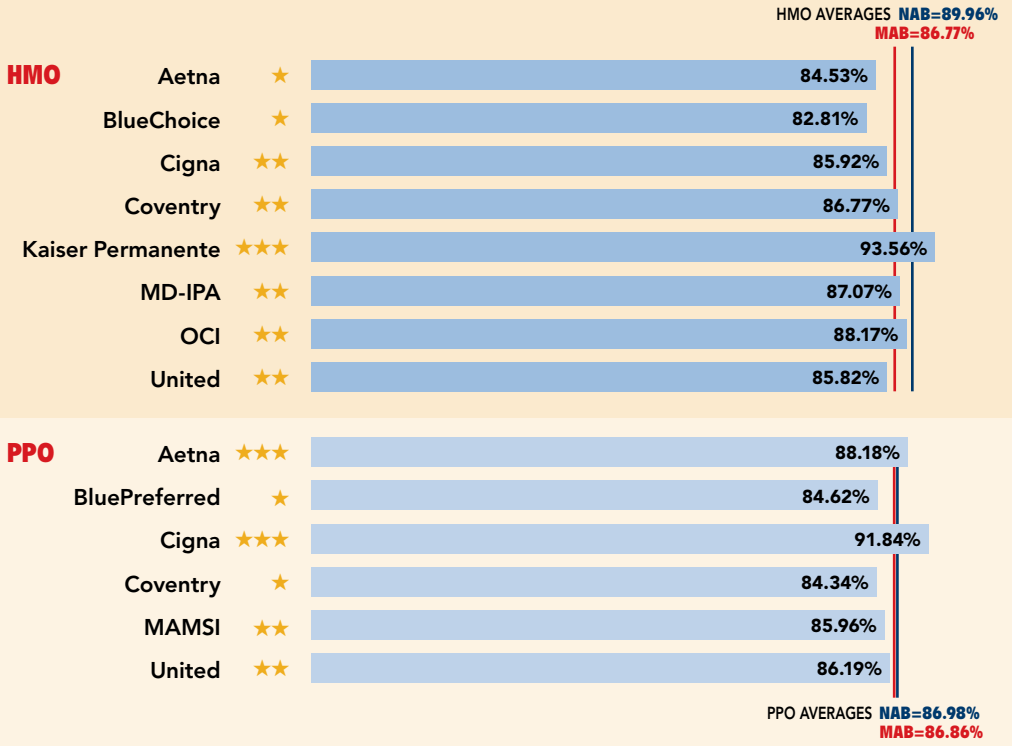
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age did get appropriate HbA1c testing.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

HbA1c TESTING (DIABETES) – 18-75 YEARS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

Data Source: Health Benefit Plan Records or Member Survey

Comprehensive Diabetes Care continued

DESCRIPTION

2. Hemoglobin A1c (HbA1c) poor control >9.0%: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during the 2012 measurement year and also had exhibited poor HbA1c control > 9.0%.

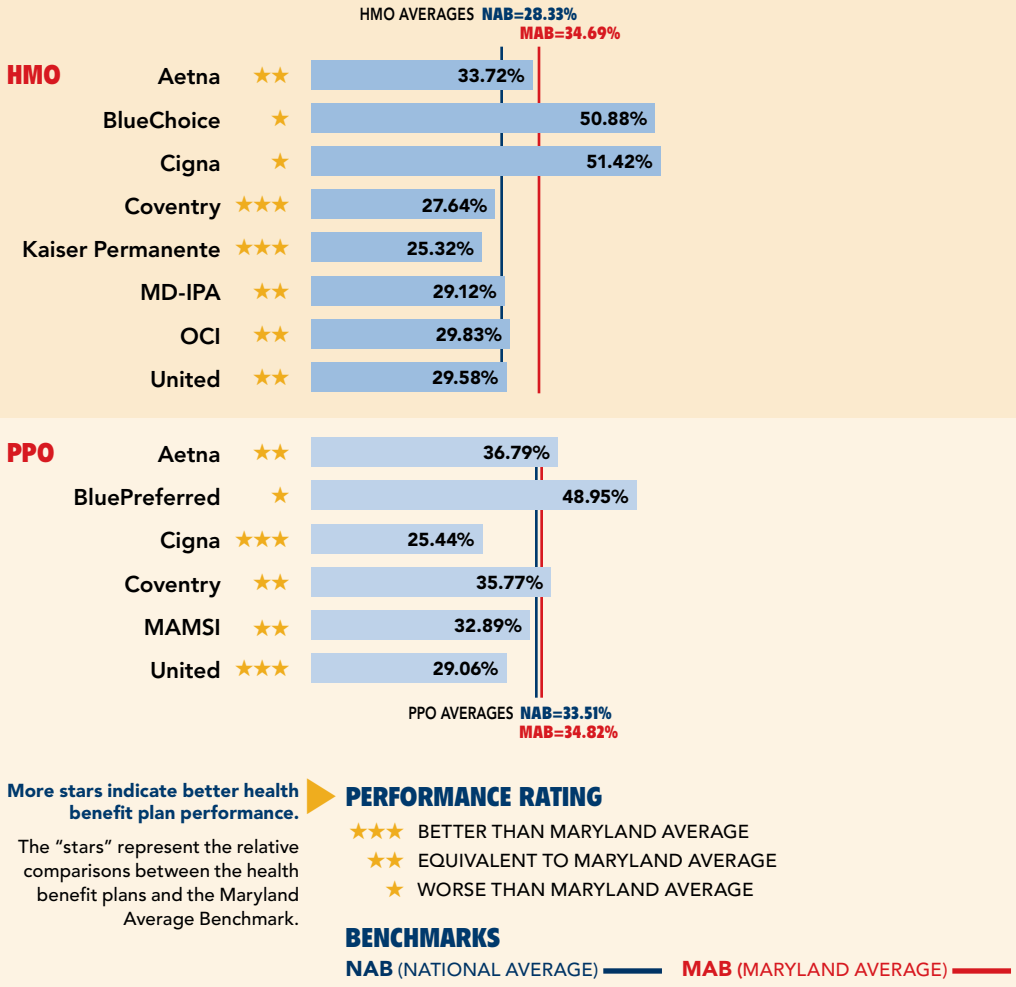
For this performance indicator, a lower percentage indicates better performance, which means that fewer diabetic adults 18–75 years of age exhibited poor control of their HbA1c level, thereby indicating better diabetes management.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

HbA1c POOR CONTROL (DIABETES) >9.0% – 18-75 YEARS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

Comprehensive Diabetes Care continued

DESCRIPTION

3. Hemoglobin A1c (HbA1c) good control <8.0%: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during the 2012 measurement year and also had exhibited good HbA1c control < 8.0%.

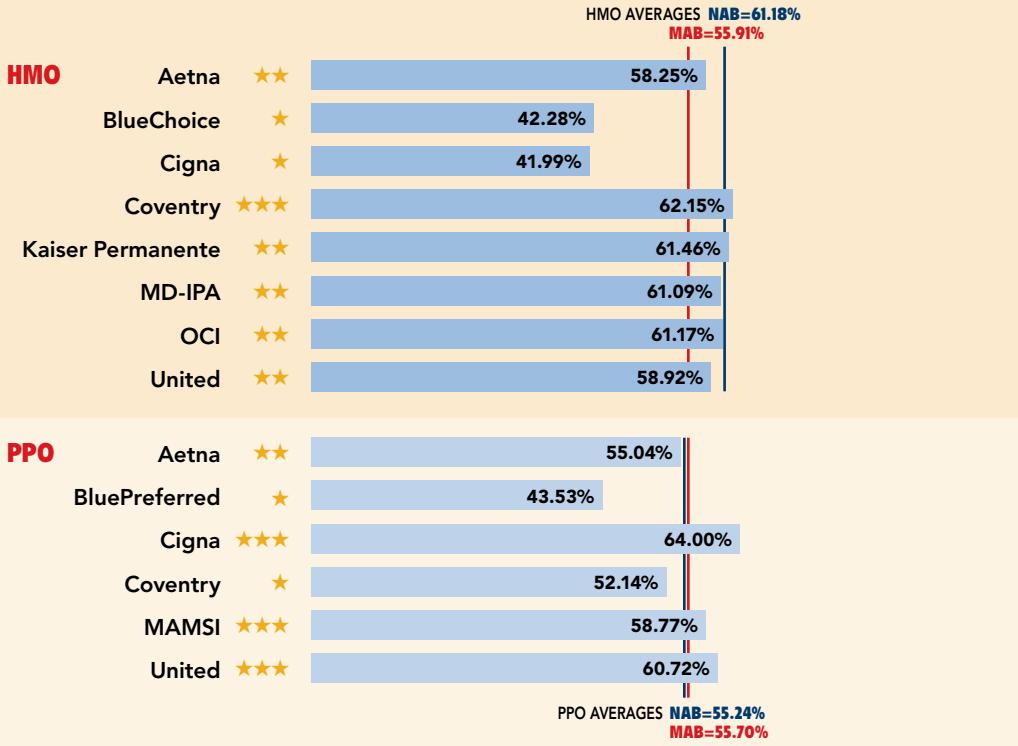
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age exhibited good control of their HbA1c level, thereby indicating better diabetes management.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

HbA1c GOOD CONTROL (DIABETES) <8.0% – 18-75 YEARS OF AGE



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PERFORMANCE RATING

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★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

BACK NEXT

Comprehensive Diabetes Care continued

DESCRIPTION

4. Hemoglobin A1c (HbA1c) tight control <7.0%: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during the 2012 measurement year and also had exhibited tight HbA1c control < 7.0%. It should be noted that this indicator also uses additional eligible population criteria (e.g., removing members with required exclusions).

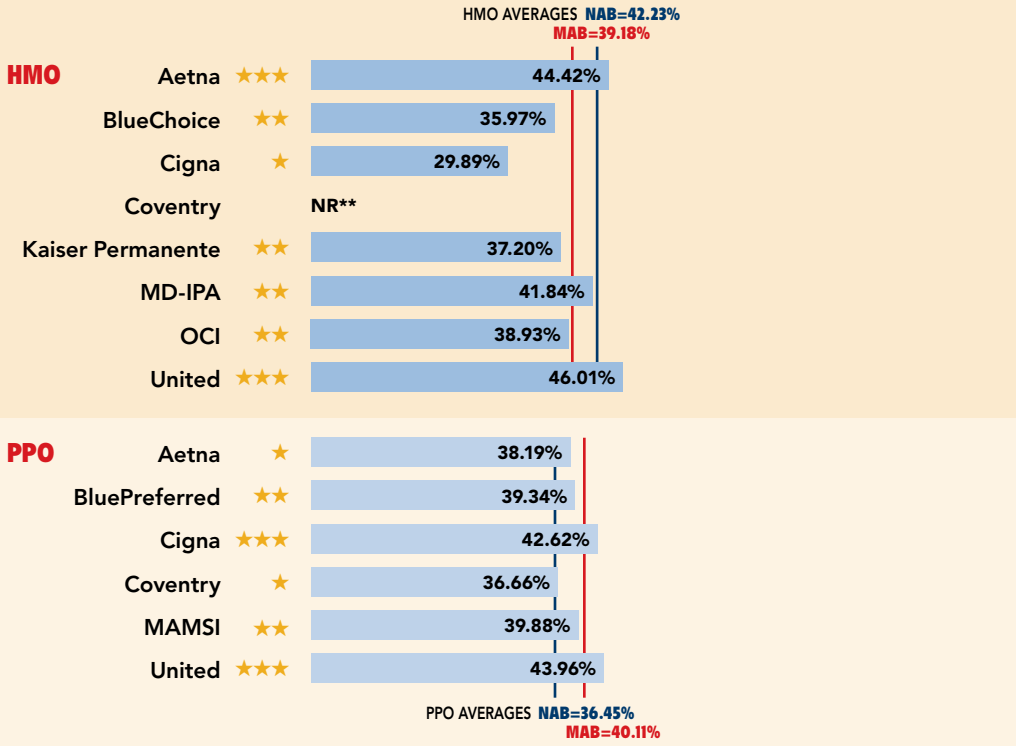
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age exhibited tight control of their HbA1c level, thereby indicating better diabetes management.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

HbA1c TIGHT CONTROL (DIABETES) <7.0% – 18-75 YEARS OF AGE



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PERFORMANCE RATING

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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

NR** – Bias in results (erroneous or "Not Reportable" data

Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Comprehensive Diabetes Care continued

DESCRIPTION

5. Eye exam (retina) performed: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a retinal exam of the eyes during the 2012 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age did get appropriate retinal examination of the eyes.

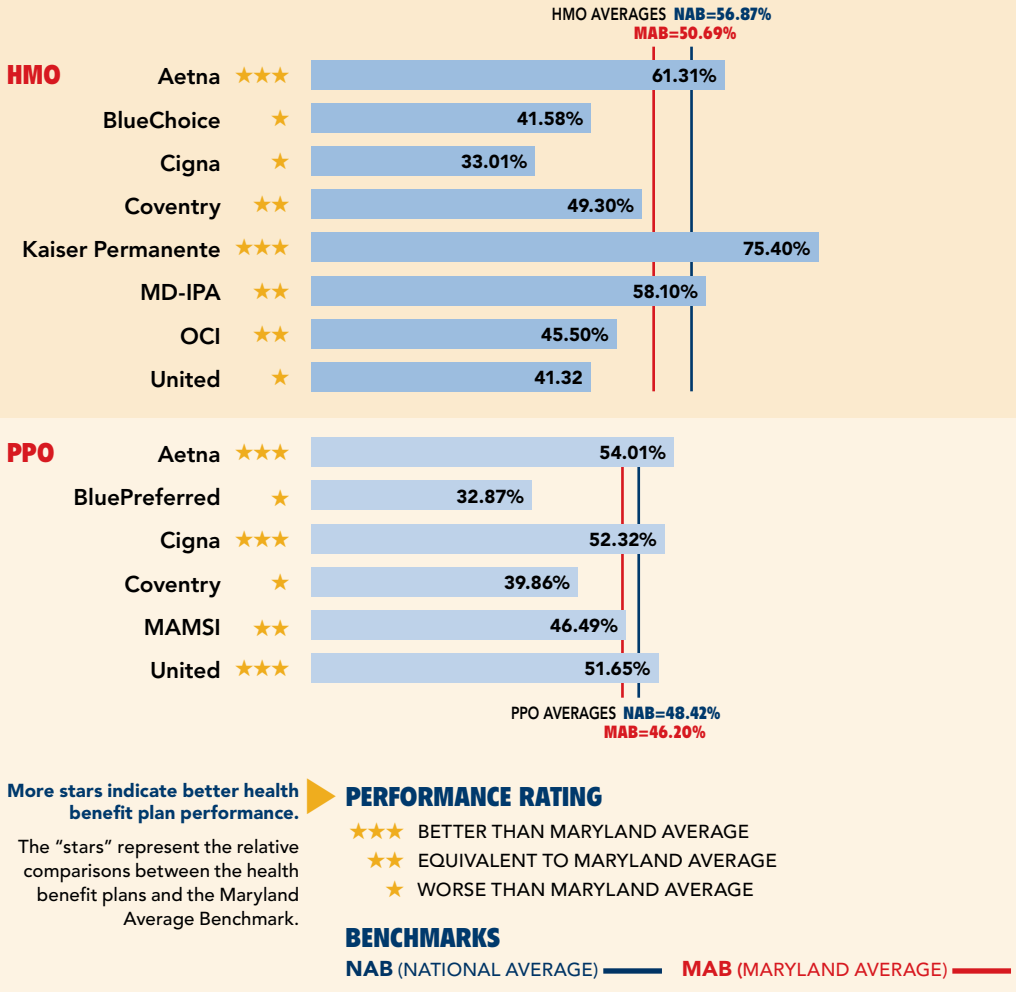
It should be noted that if a patient is negative for retinopathy, they are considered to be at low risk and are not required to have a retinal examination of the eyes by a specialist until the second year after the examination that produced the negative result.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

EYE EXAM - RETINA (DIABETES) – 18-75 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

BACK NEXT

Comprehensive Diabetes Care continued

DESCRIPTION

6. Low-Density Lipoprotein Cholesterol (LDL-C) screening: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an LDL-C screening during the 2012 measurement year.

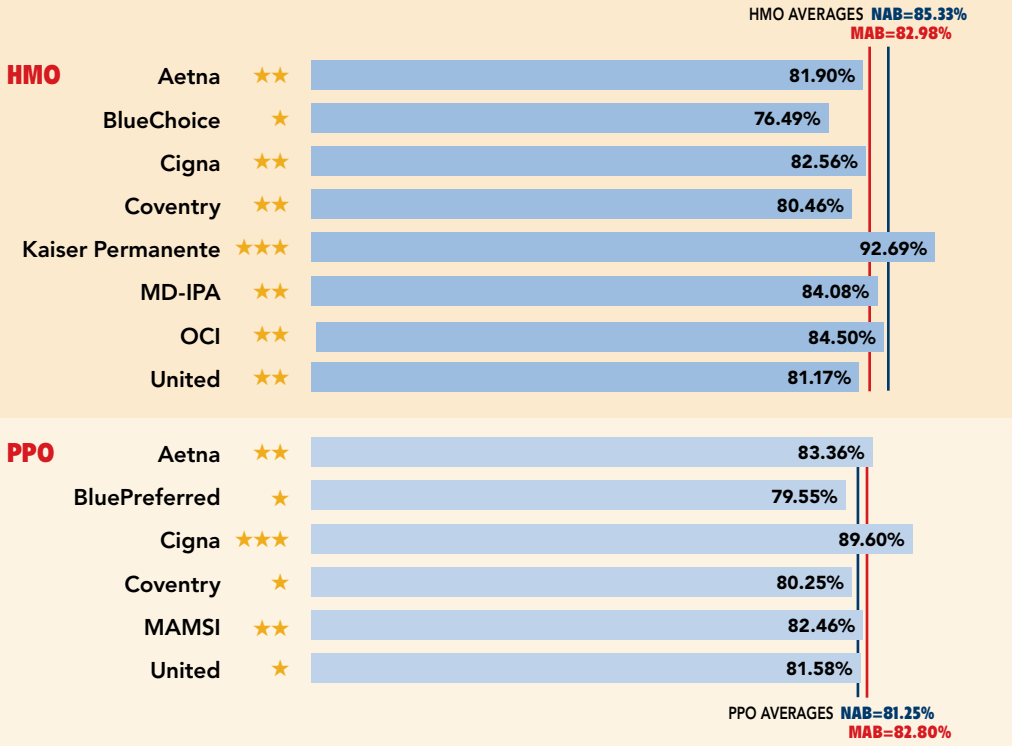
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age did get appropriate LDL cholesterol screening.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

LDL CHOLESTEROL SCREENING (DIABETES) – 18-75 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

Data Source: Health Benefit Plan Records or Member Survey

Comprehensive Diabetes Care continued

DESCRIPTION

7. Low-Density Lipoprotein Cholesterol (LDL-C) control <100 mg/dL: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an LDL-C screening during the 2012 measurement year, and who also had a level less than 100 mg/dL on their LDL-C screening.

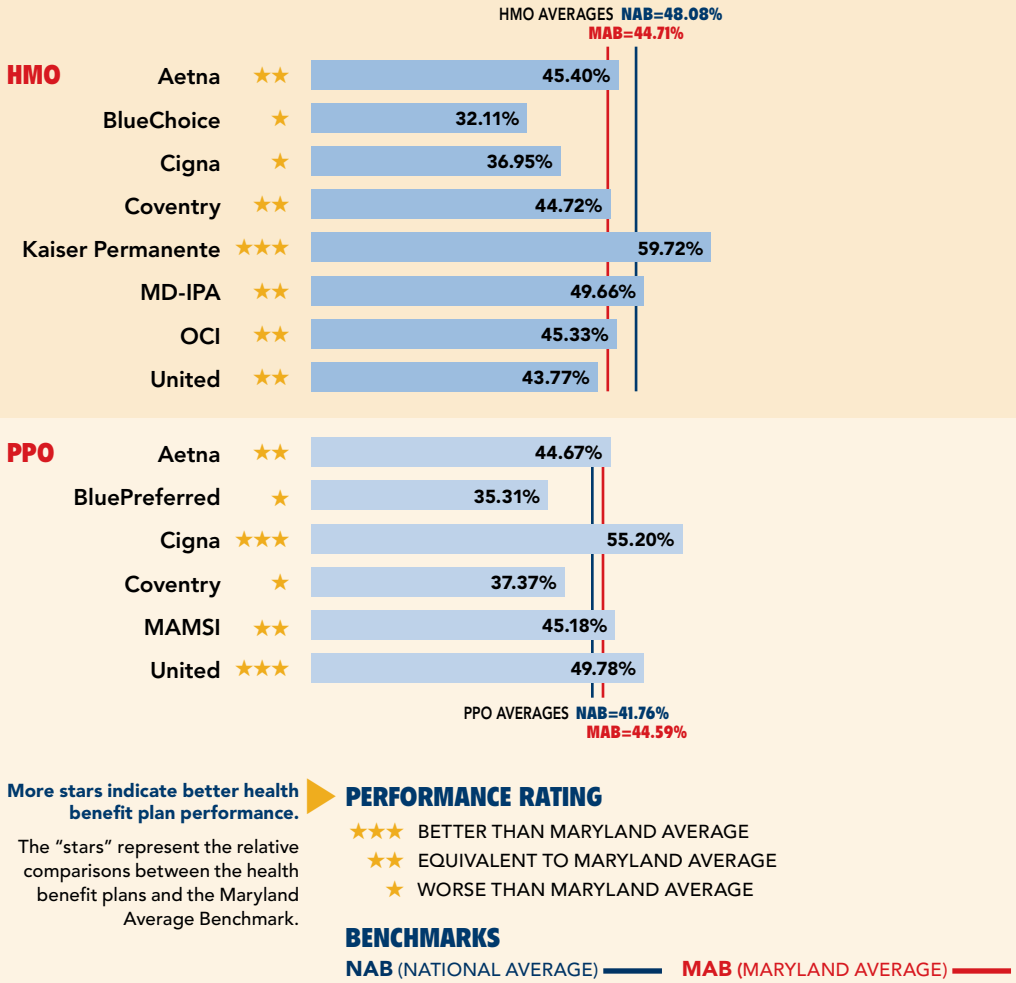
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age do have good control of their cholesterol level.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

LDL CHOLESTEROL CONTROL <100 MG/DL (DIABETES) – 18-75 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

BACK NEXT

Comprehensive Diabetes Care continued

DESCRIPTION

8. Medical attention for nephropathy: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy or kidney disease during the 2012 measurement year.

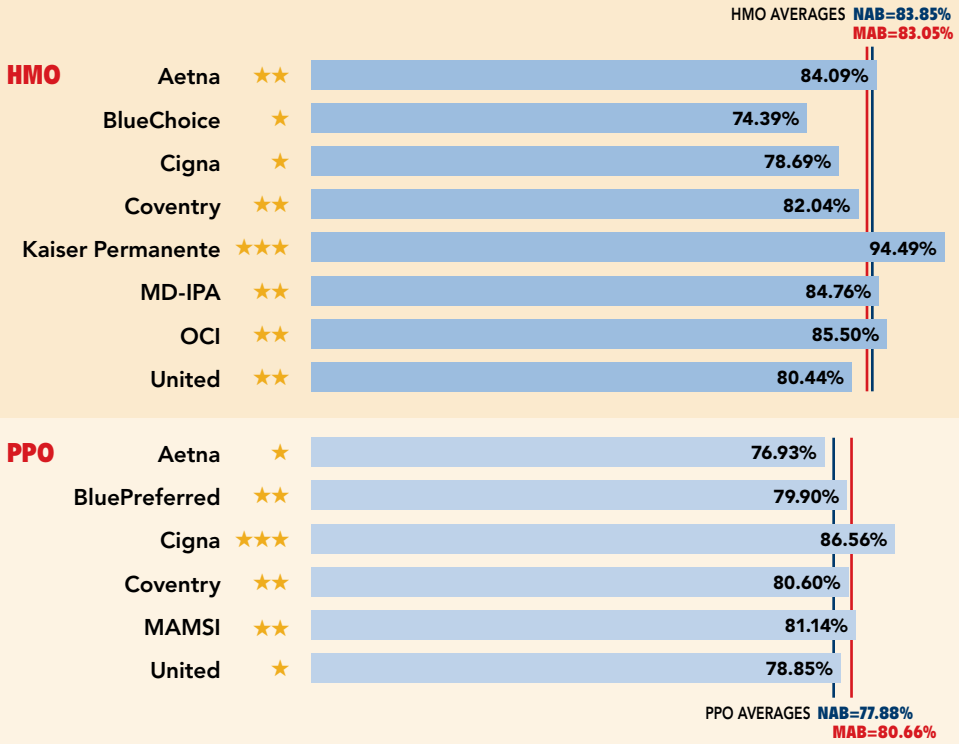
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age did get appropriate screening and care for nephropathy.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

MEDICAL ATTENTION FOR NEPHROPATHY (DIABETES) – 18-75 YEARS OF AGE



More stars indicate better health benefit plan performance.

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PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

Comprehensive Diabetes Care continued

DESCRIPTION

9. Blood pressure control <140/90 mm Hg: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had their blood pressure assessed and demonstrated good blood pressure control < 140/90 mm Hg, during the 2012 measurement year.

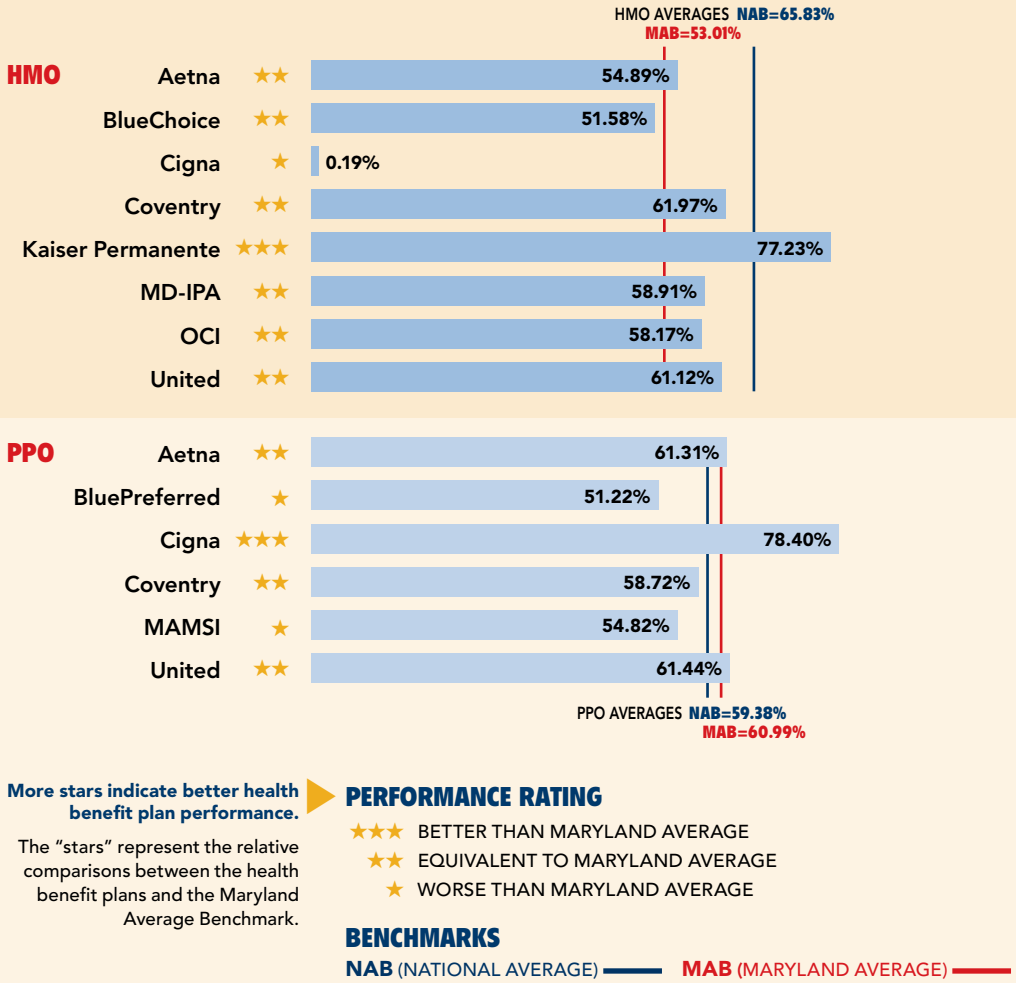
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age do have good blood pressure control.

RATIONALE

Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

GOOD BLOOD PRESSURE CONTROL <140/90 MM HG (DIABETES) – 18-75 YEARS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – CARDIOVASCULAR CONDITIONS AND DIABETES

Comprehensive Diabetes Care continued

DESCRIPTION

10. Excellent blood pressure control <140/80 mm Hg: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had their blood pressure assessed and demonstrated excellent blood pressure control <140/80 mm Hg, during the 2012 measurement year.

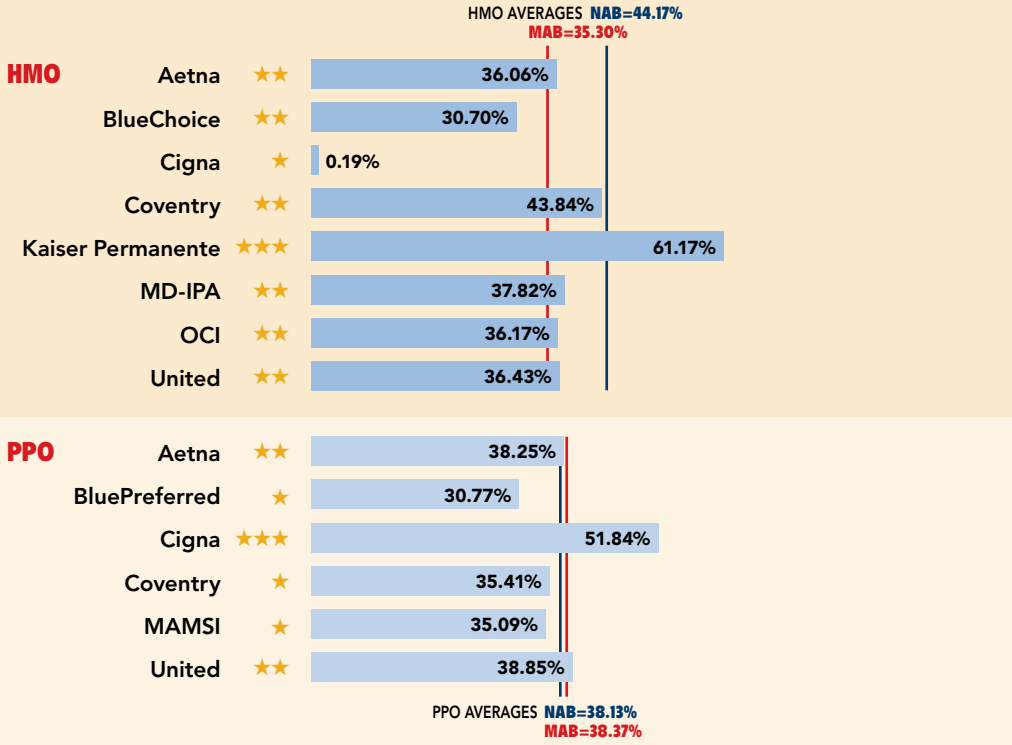
For this performance indicator, a higher percentage is better, which means that more diabetic adults 18–75 years of age do have excellent blood pressure control.

RATIONALE

Good management of Good management of blood glucose levels can reduce symptoms related to diabetes and reduce the risk of both acute and chronic complications. Factors such as life expectancy, risk of hypoglycemia and the presence of advanced diabetes complications, or other medical conditions need to be taken into account when deciding which target values are most appropriate for an individual. Major benefits include reductions in eye, nerve, kidney, and heart complications with reducing the number of cardiovascular disease events by more than 50% in people with diabetes.

(U.S. Department of Health and Human Services, National Diabetes Education Program. 2009)

EXCELLENT BLOOD PRESSURE CONTROL <140/80 MM HG (DIABETES) – 18-75 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Musculoskeletal Disease and Medication Management

Musculoskeletal diseases and disorders affect the muscles, tendons and ligaments, as well as 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.

BACK

NEXT

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 2012 who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one disease modifying anti-rheumatic drug (DMARD) in 2012. 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 more adults 18 years of age and older did get DMARD treatment for their RA.

RATIONALE

Arthritis and other rheumatic conditions are the leading cause of disability among adults in the United States. RA is a chronic autoimmune disorder that affects approximately 2.5 million Americans, disproportionately women. There is no cure; consequently, the goal of treatment is to slow the progression of disease and thereby delay or prevent joint destruction, relieve pain and maintain functional capacity. Long-term pain management is often most effectively managed with Disease Modifying Anti-Rheumatic Drugs (DMARDs), but analgesics and anti-inflammatory drugs also have an important place.

All patients with RA are candidates for DMARD therapy, and the majority of the newly diagnosed should be started on DMARD therapy within three months of diagnosis.

(National Committee for Quality Assurance, HEDIS V2, 2006)

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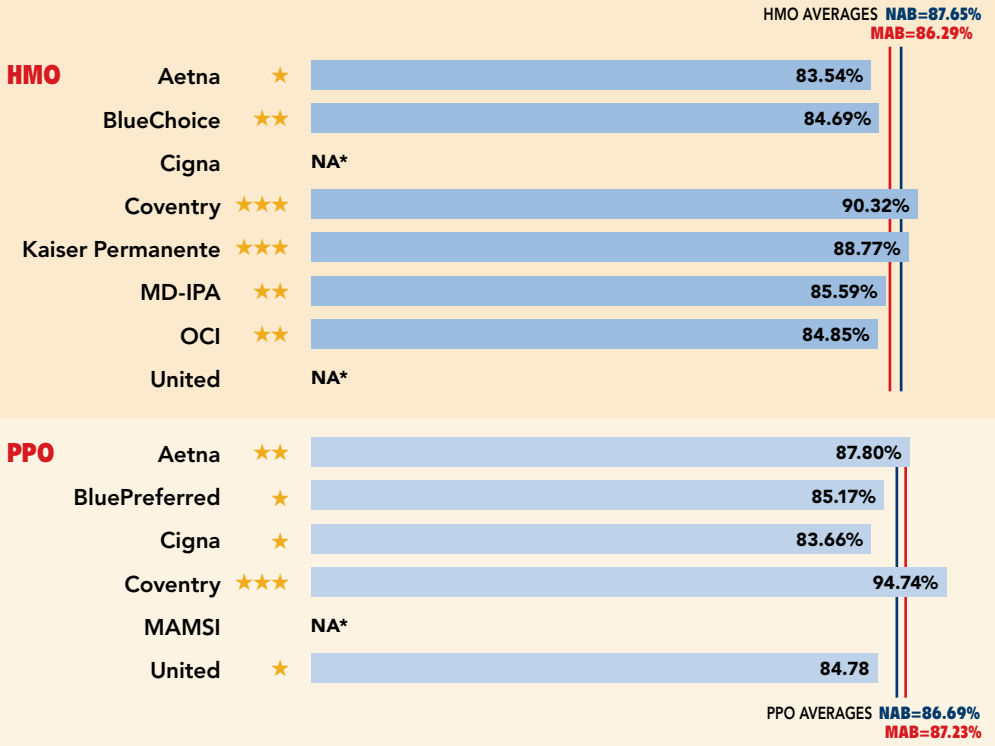
DMARD THERAPY – 18+ YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

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

Data Source: Health Benefit Plan Records or Member Survey

BACK NEXT

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 2012 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 more adults 18 to 50 years of age with low back pain appropriately did not get an imaging study, as imaging studies are often overused.

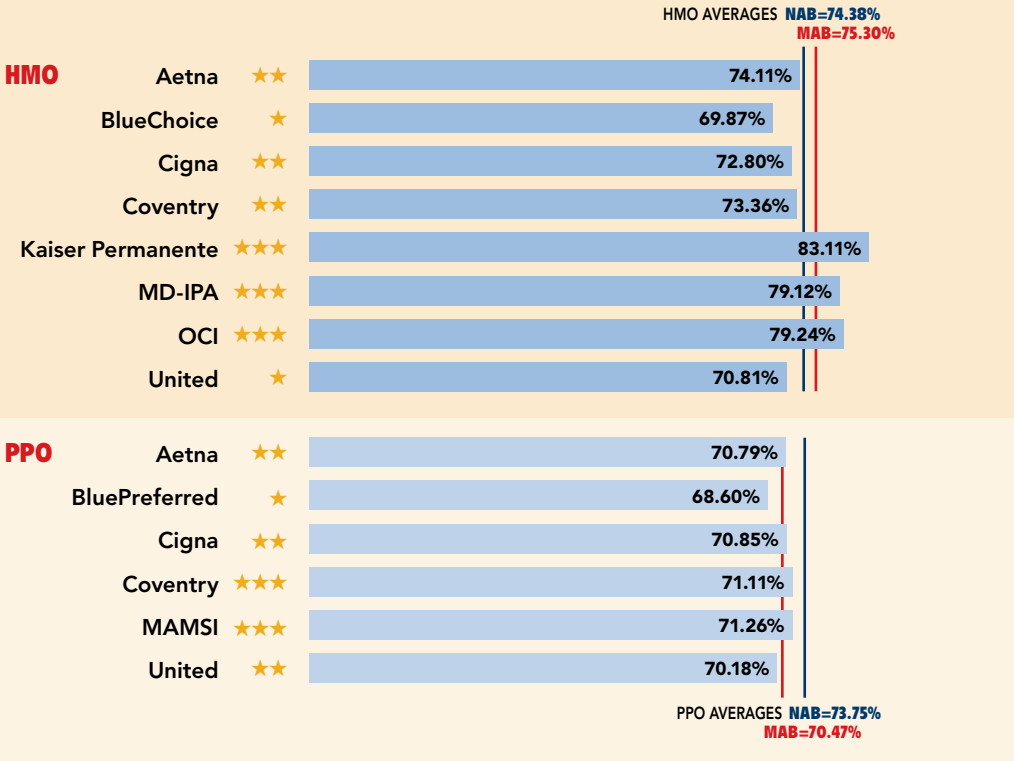
RATIONALE

Low back pain is a pervasive problem that affects two thirds of adults at some time in their lives. Back problems are second only to cough among symptoms of people who seek medical care at physician offices, outpatient departments or emergency rooms.

Evidence suggests that plain x-rays are rarely useful in evaluating or guiding treatment of adult acute lower back pain in the absence of red flags. Small cumulative doses of ionizing radiation are believed to present minimal or no risks, but risk increases with lumbar x-rays which expose the male and female reproductive organs to larger doses of ionizing radiation through routine use of oblique views or repeated exposures.

(National Committee for Quality Assurance, HEDIS V2, 2005)

NO IMAGING WITHIN 28 DAYS AFTER DIAGNOSIS – 18-50 YEARS OF AGE



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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

PRIMARY CARE FOR ADULTS – MUSCULOSKELETAL DISEASE AND MEDICATION MANAGEMENT

Annual Monitoring for Patients on Persistent Medications

DESCRIPTION

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

1. Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs): The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy with ACE inhibitors or ARBs during 2012 and had at least one therapeutic monitoring event for the ACE inhibitor or ARB agent in 2012.

For this measure, a higher percentage is better, which means that more adults 18 years of age and older on ACE inhibitors or ARBs are being appropriately monitored and 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. The medications included in this measure also have more serious effects in the elderly. Some harmful effects associated with these medications include:

- Potential damage to liver function from statins
- Drug toxicity from anticonvulsants
- Drug-induced hypothyroidism from valproic acid
- Physiologic and electrolyte imbalances from drugs that affect potassium levels and potentially affect heart function

Although there are no clinical guideline recommendations on the frequency of monitoring, annual monitoring represents a conservative standard of care and is supported by FDA drug labeling recommendations for each drug.

(National Committee for Quality Assurance, HEDIS V2, 2006)

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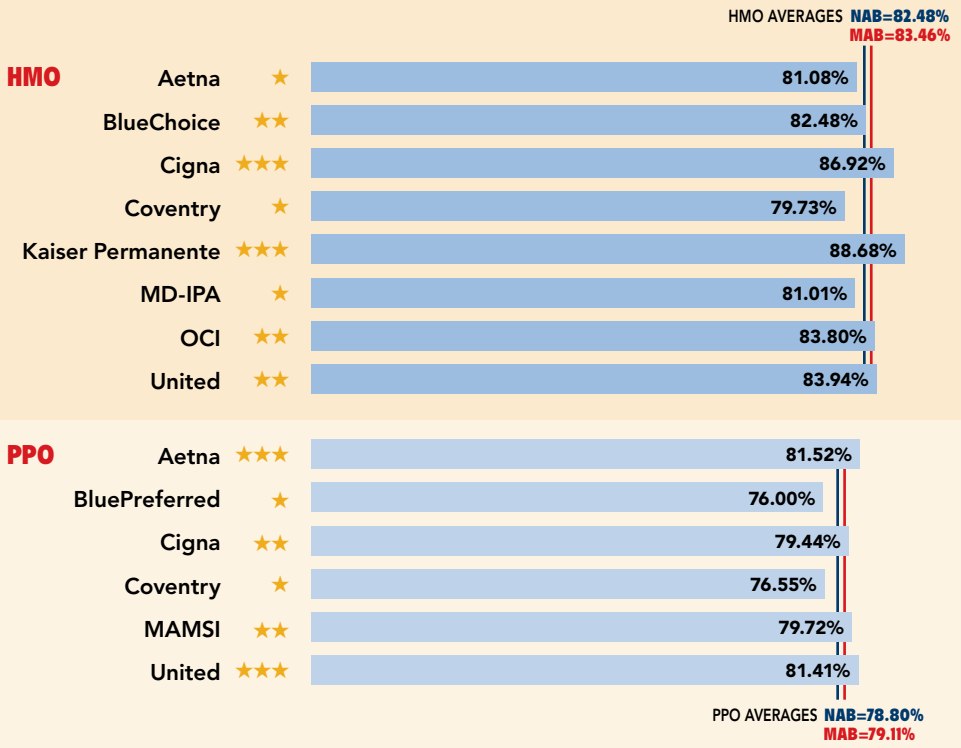
ACE INHIBITORS OR ARBS – 18+ YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

Data Source: Health Benefit Plan Records or Member Survey

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

2. Annual monitoring for members on Digoxin: The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy with Digoxin during 2012 and had at least one therapeutic monitoring event for the Digoxin agent in 2012.

For this measure, a higher percentage is better, which means that more adults 18 years of age and older on Digoxin are being appropriately monitored and 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. The medications included in this measure also have more serious effects in the elderly. Some harmful effects associated with these medications include:

- Potential damage to liver function from statins
- Drug toxicity from anticonvulsants
- Drug-induced hypothyroidism from valproic acid
- Physiologic and electrolyte imbalances from drugs that affect potassium levels and potentially affect heart function

Although there are no clinical guideline recommendations on the frequency of monitoring, annual monitoring represents a conservative standard of care and is supported by FDA drug labeling recommendations for each drug.

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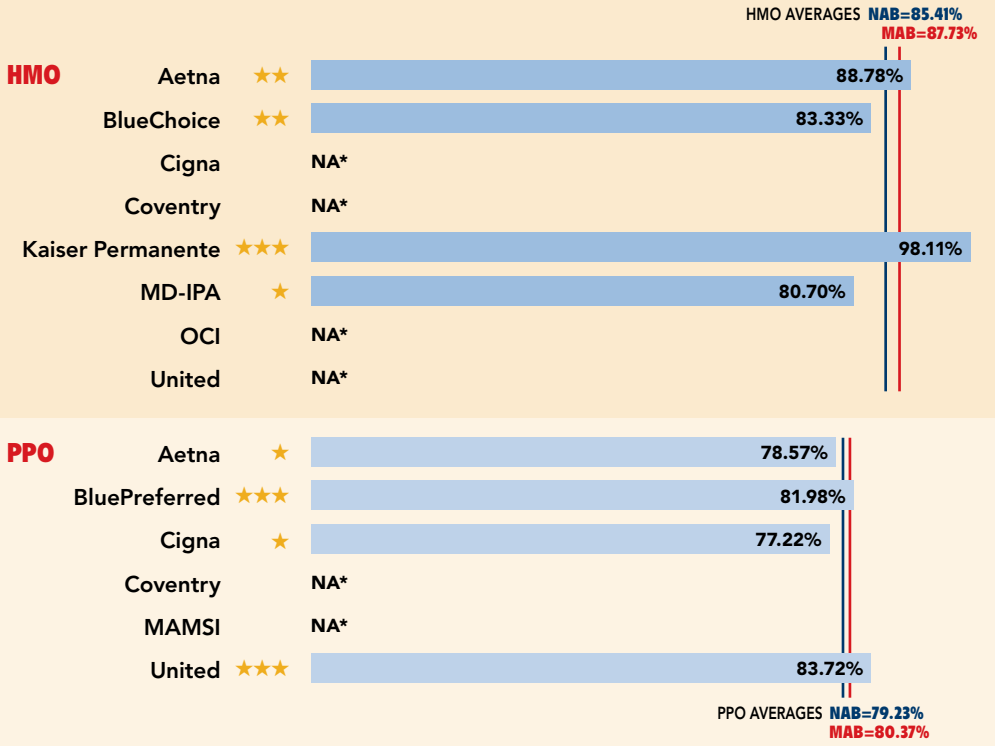
DIGOXIN 18+ YEARS OF AGE



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PERFORMANCE RATING

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★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

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

Data Source: Health Benefit Plan Records or Member Survey

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

3. Annual monitoring for members on diuretics: The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy with diuretics during 2012 and had at least one therapeutic monitoring event for the diuretic agent in 2012.

For this measure, a higher percentage is better, which means that more adults 18 years of age and older on diuretics are being appropriately monitored and 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. The medications included in this measure also have more serious effects in the elderly. Some harmful effects associated with these medications include:

- Potential damage to liver function from statins
- Drug toxicity from anticonvulsants
- Drug-induced hypothyroidism from valproic acid
- Physiologic and electrolyte imbalances from drugs that affect potassium levels and potentially affect heart function

Although there are no clinical guideline recommendations on the frequency of monitoring, annual monitoring represents a conservative standard of care and is supported by FDA drug labeling recommendations for each drug.

(National Committee for Quality Assurance, HEDIS V2, 2006)

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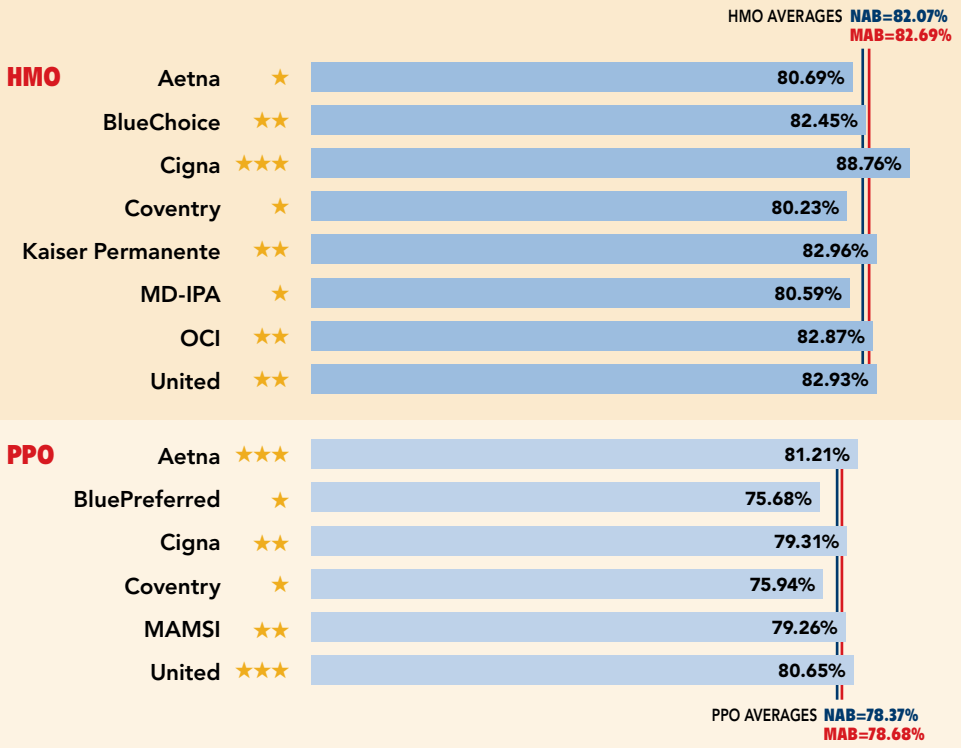
DIURETICS – 18+ YEARS OF AGE



More stars indicate better health benefit plan performance.

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

PERFORMANCE RATING

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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

Data Source: Health Benefit Plan Records or Member Survey

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

4. Annual monitoring for members on anticonvulsants: The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy with anticonvulsants during 2012 and had at least one therapeutic monitoring event for the anticonvulsant agent in 2012.

For this measure, a higher percentage is better, which means that more adults 18 years of age and older on anticonvulsants are being appropriately monitored and 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. The medications included in this measure also have more serious effects in the elderly. Some harmful effects associated with these medications include:

- Potential damage to liver function from statins
- Drug toxicity from anticonvulsants
- Drug-induced hypothyroidism from valproic acid
- Physiologic and electrolyte imbalances from drugs that affect potassium levels and potentially affect heart function

Although there are no clinical guideline recommendations on the frequency of monitoring, annual monitoring represents a conservative standard of care and is supported by FDA drug labeling recommendations for each drug.

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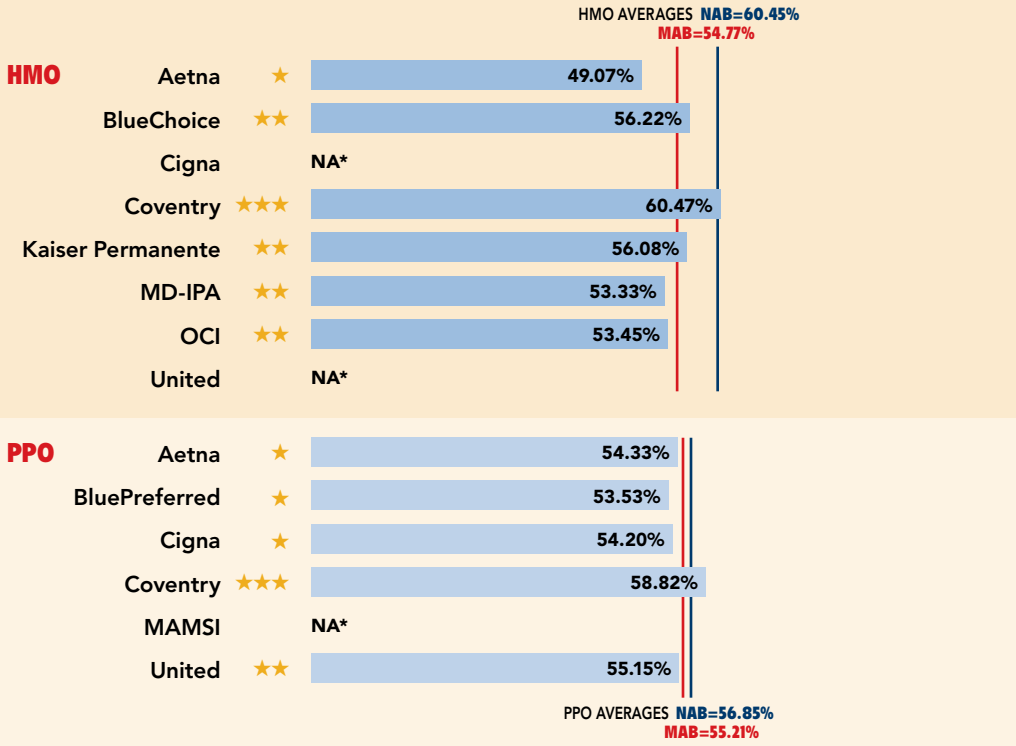
ANTICONVULSANTS – 18+ YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

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, but when it is, a patient should be made aware of the short and long term effects.

BACK

NEXT

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

BEHAVIORAL HEALTH

Antidepressant Medication Management

DESCRIPTION

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

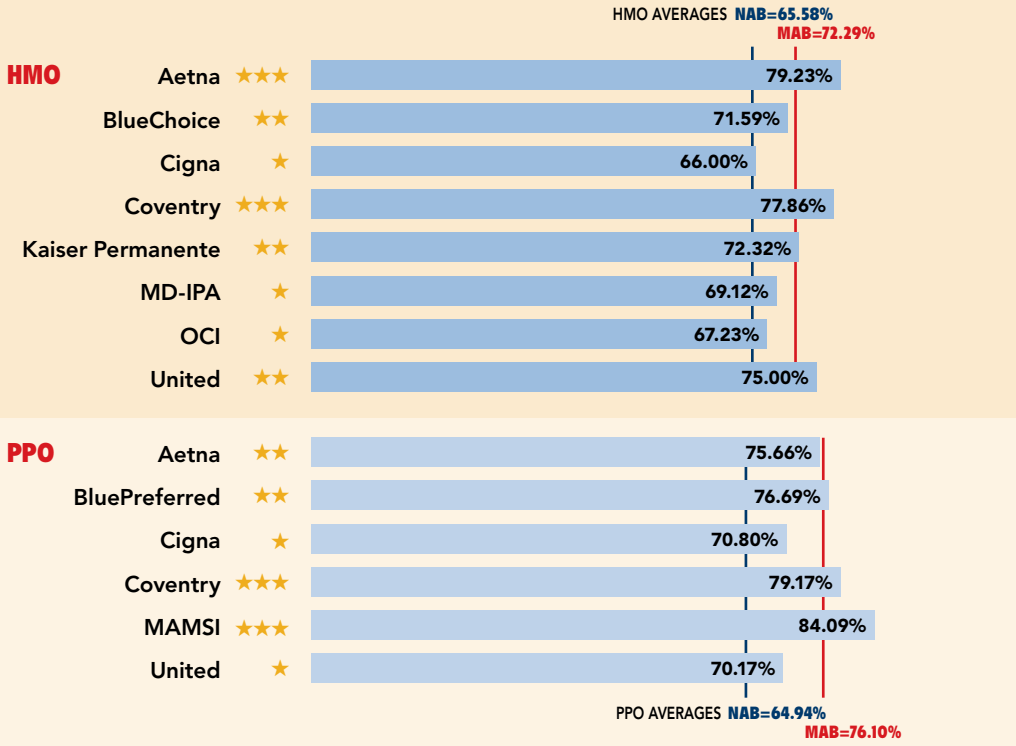
1. Effective acute phase treatment: The percentage of members 18 years of age and older in the 2012 measurement year with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (12 weeks).

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

RATIONALE

Many people with depression suffer in silence. Without treatment, a depressive disorder or depression symptoms can last for years, or can even lead to death by suicide or other cause. Fortunately, many people can improve through treatment with behavioral health therapy and/or appropriate medication. 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 medication safety and efficacy as well as the emergence of side effects. 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. According to the American Psychiatric Association, successful treatment is promoted by a thorough assessment of the patient and close adherence to treatment plans.

EFFECTIVE 12 WEEK ACUTE PHASE – 18+ YEARS OF AGE



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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE)

Data Source: Health Benefit Plan Records or Member Survey

Antidepressant Medication Management continued

DESCRIPTION

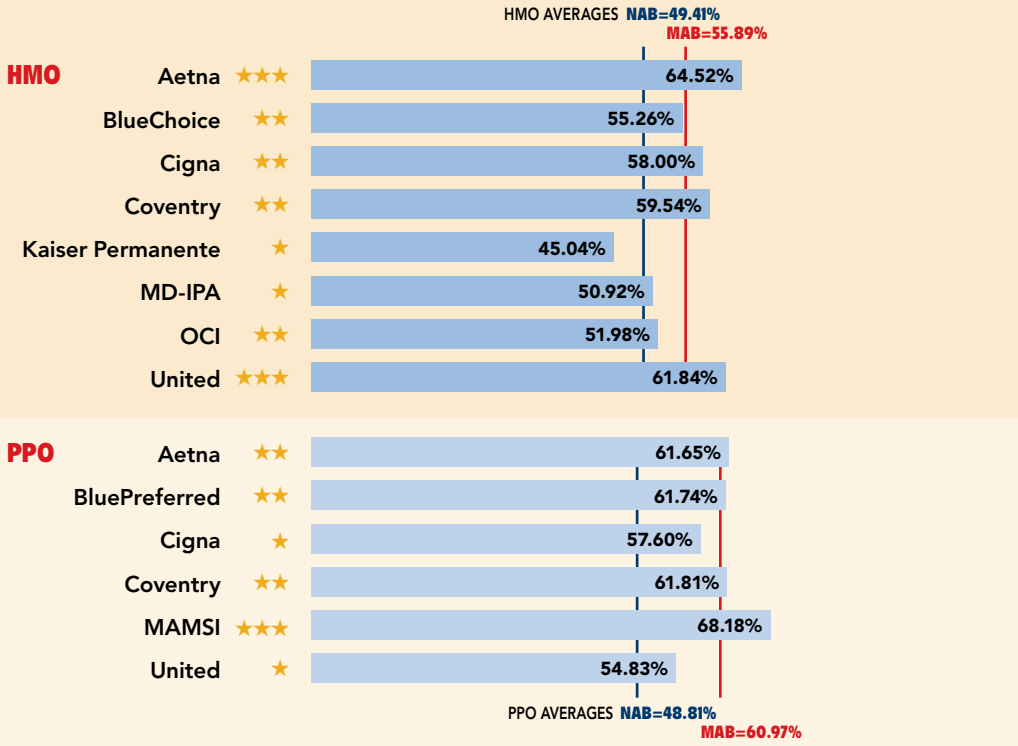
2. Effective continuation phase treatment: The percentage of members 18 years of age and older in the 2012 measurement year with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and older with depression were effectively treated with at least 6 months of antidepressant medication during the continuation phase of treatment.

RATIONALE

Many people with depression suffer in silence. Without treatment, a depressive disorder or depression symptoms can last for years, or can even lead to death by suicide or other cause. Fortunately, many people can improve through treatment with behavioral health therapy or appropriate medication. 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 medication safety and efficacy as well as the emergence of side effects. 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. According to the American Psychiatric Association, successful treatment is promoted by a thorough assessment of the patient and close adherence to treatment plans.

EFFECTIVE 6 MONTH CONTINUATION PHASE – 18+ YEARS OF AGE



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BENCHMARKS

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Data Source: Health Benefit Plan Records or Member Survey

BACK
NEXT

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. Two separate indicators include:

1. Follow-up within 7 days of discharge: The percentage of members 6 years of age and older in 2012 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 for which the member received follow-up within 7 days of discharge.

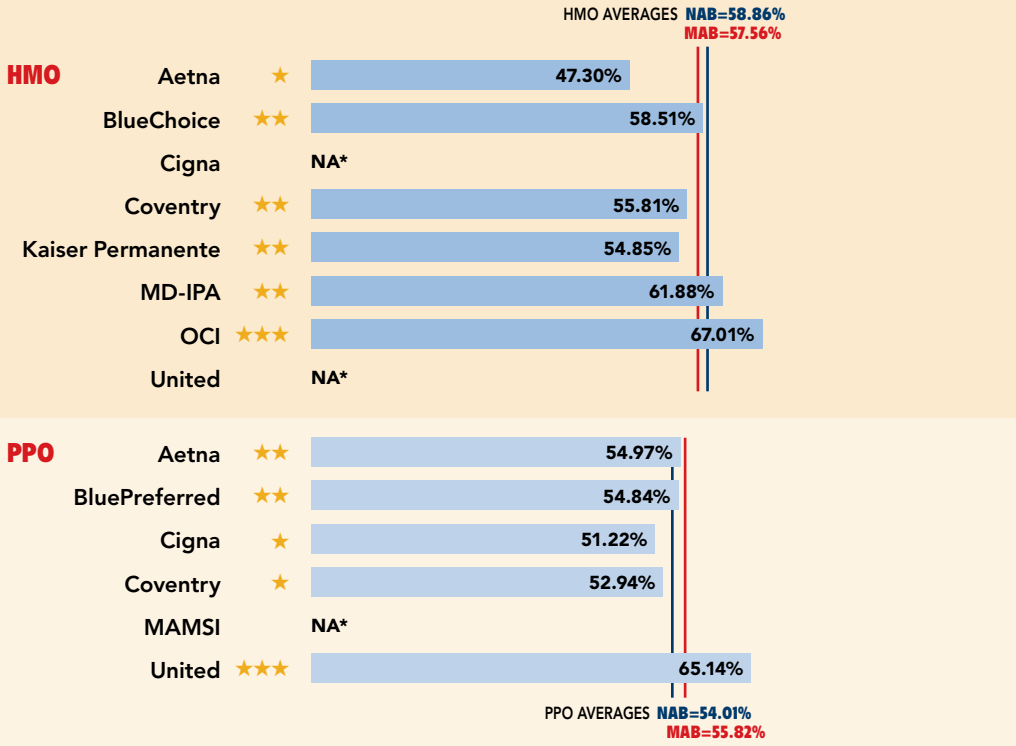
For this performance indicator, a higher percentage is better, which means that more members 6 years of age and older who were hospitalized for treatment of selected mental health disorders received timely follow up within 7 days of discharge.

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 health care 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 7 DAYS – 6+ YEARS OF AGE



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V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

BEHAVIORAL HEALTH

Follow-Up After Hospitalization for Mental Illness
continued

DESCRIPTION

2. Follow-up within 30 days of discharge: The percentage of members 6 years of age and older in 2012 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 for which the member received follow-up within 30 days of discharge.

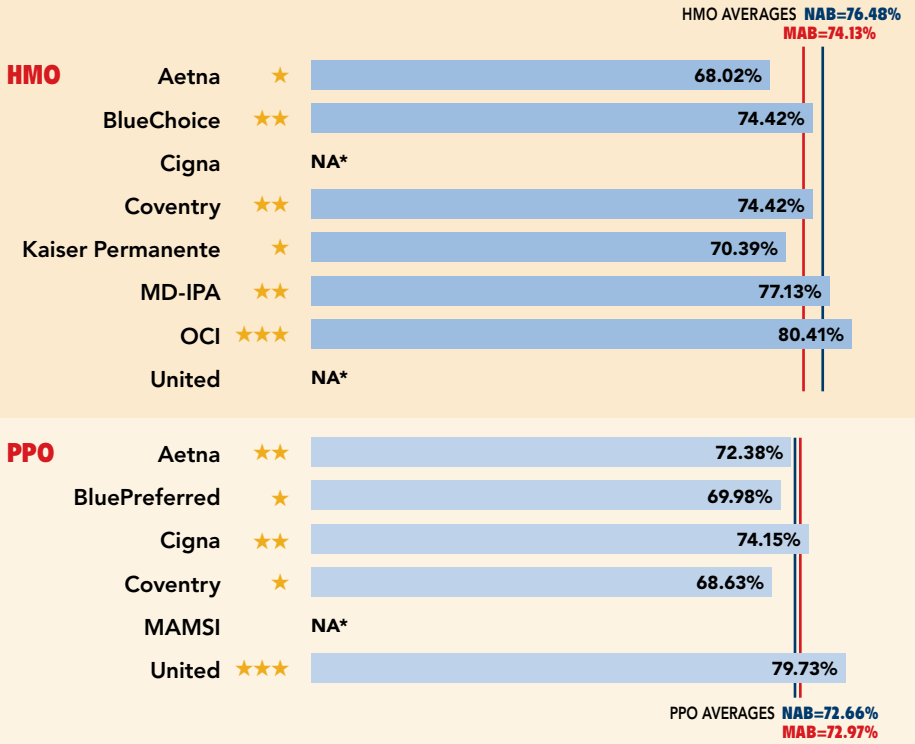
For this performance indicator, a higher percentage is better, which means that more members 6 years of age and older who were hospitalized for treatment of selected mental health disorders received timely follow up within 30 days of discharge. This measure includes those members who also received timely 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 health care 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 OF AGE



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Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

DESCRIPTION

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

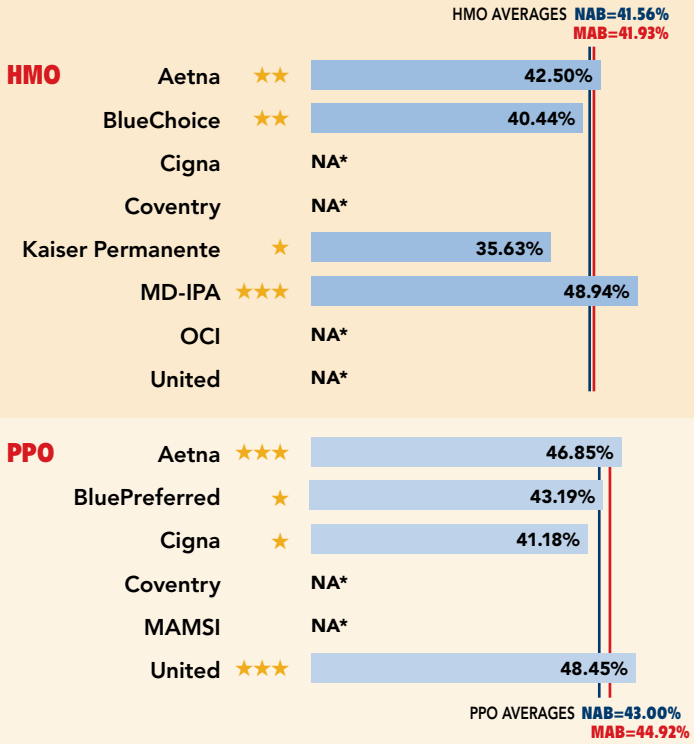
1. Initiation of alcohol and other drug (AOD) treatment-adolescents: The percentage of members, 13–17 years of age, with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

For this performance indicator, a higher percentage is better, which means that more members 13–17 years of age who were diagnosed with AOD dependence received treatment within 14 days of diagnosis.

RATIONALE

There are more illnesses, disabilities and deaths from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system. Identifying people with AOD disorders is an important first step in the process of care, but identification often does not lead to initiation of care. Someone may not initiate treatment because of the social stigma associated with AOD disorder, denial of the problem or lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and permits comparison of effectiveness in initiating care.

INITIATION WITHIN 14 DAYS – 13-17 YEARS OF AGE



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Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

BEHAVIORAL HEALTH

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

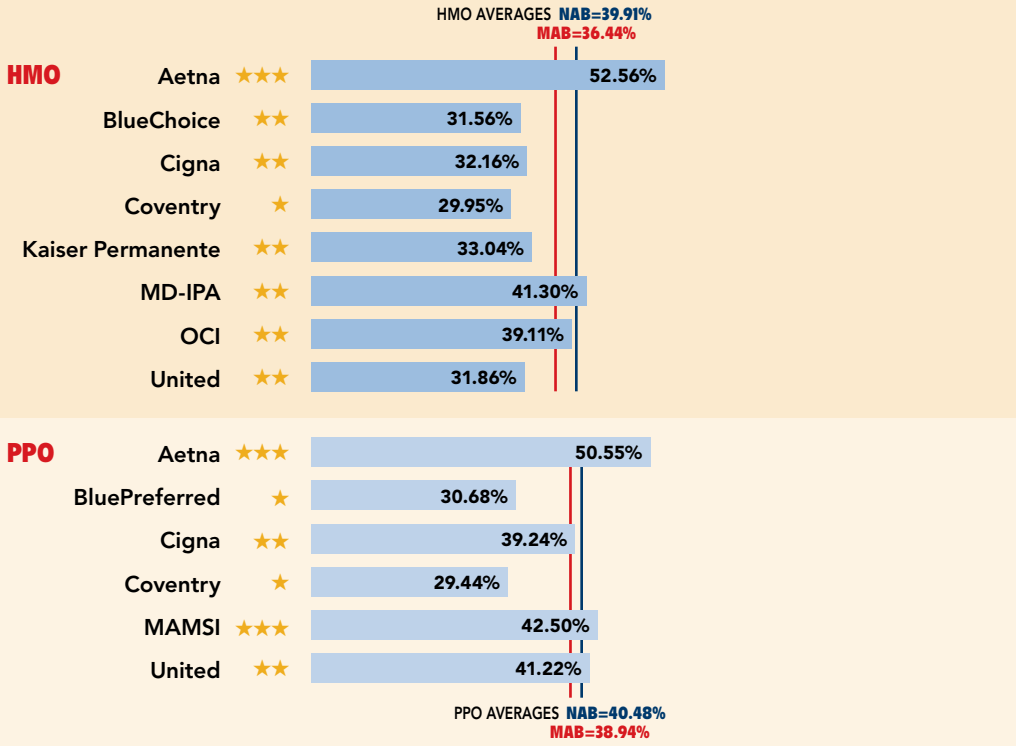
2. Initiation of AOD treatment-adults: The percentage of members, 18 years of age and older, with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

For this performance indicator, a higher percentage is better, which means that more members 18 years of age and older who were diagnosed with AOD dependence received treatment within 14 days of diagnosis.

RATIONALE

There are more illnesses, disabilities and deaths from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system. Identifying people with AOD disorders is an important first step in the process of care, but identification often does not lead to initiation of care. Someone may not initiate treatment because of the social stigma associated with AOD disorder, denial of the problem or lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and permits comparison of effectiveness in initiating care.

INITIATION WITHIN 14 DAYS – 18+ YEARS OF AGE



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Data Source: Health Benefit Plan Records or Member Survey

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Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

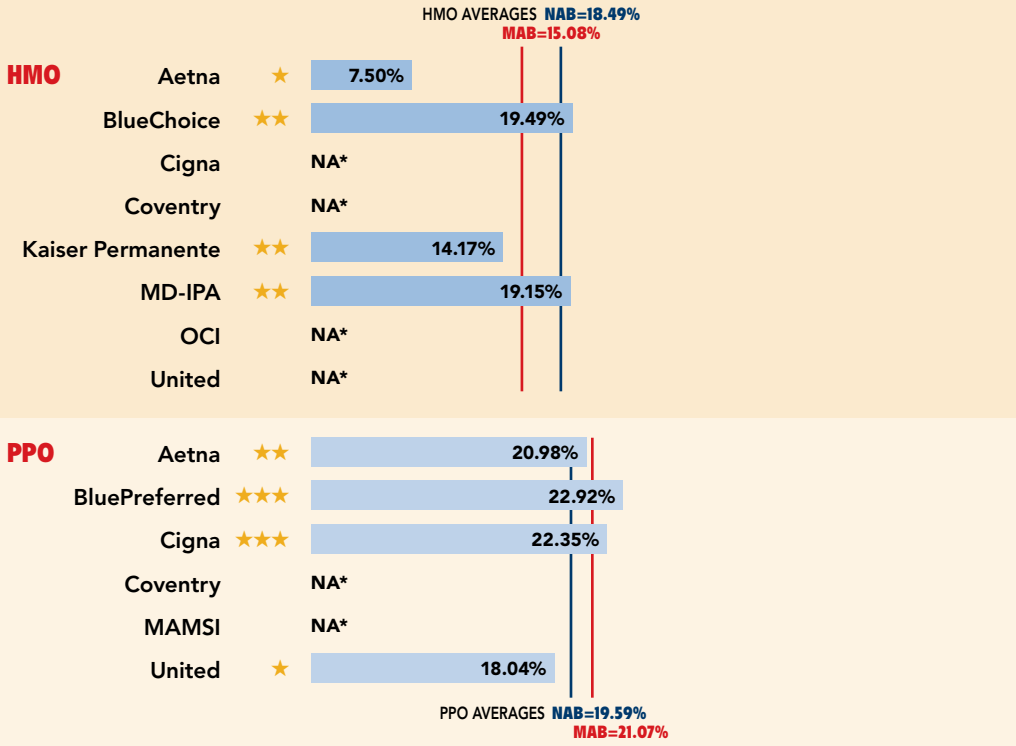
3. Engagement of AOD treatment-adolescents: The percentage of members, 13–17 years of age, with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who had two or more additional services within 30 days of the initiation visit.

For this performance indicator, a higher percentage is better, which means that more members 13–17 years of age who were diagnosed with AOD dependence received two or more additional follow-up treatments within 30 days of their initial visit.

RATIONALE

There are more illnesses, disabilities and deaths from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system. Identifying people with AOD disorders is an important first step in the process of care, but identification often does not lead to initiation of care. Someone may not initiate treatment because of the social stigma associated with AOD disorder, denial of the problem or lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and permits comparison of effectiveness in initiating care.

ENGAGEMENT WITHIN 30 DAYS – 13-17 YEARS OF AGE



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Data Source: Health Benefit Plan Records or Member Survey

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

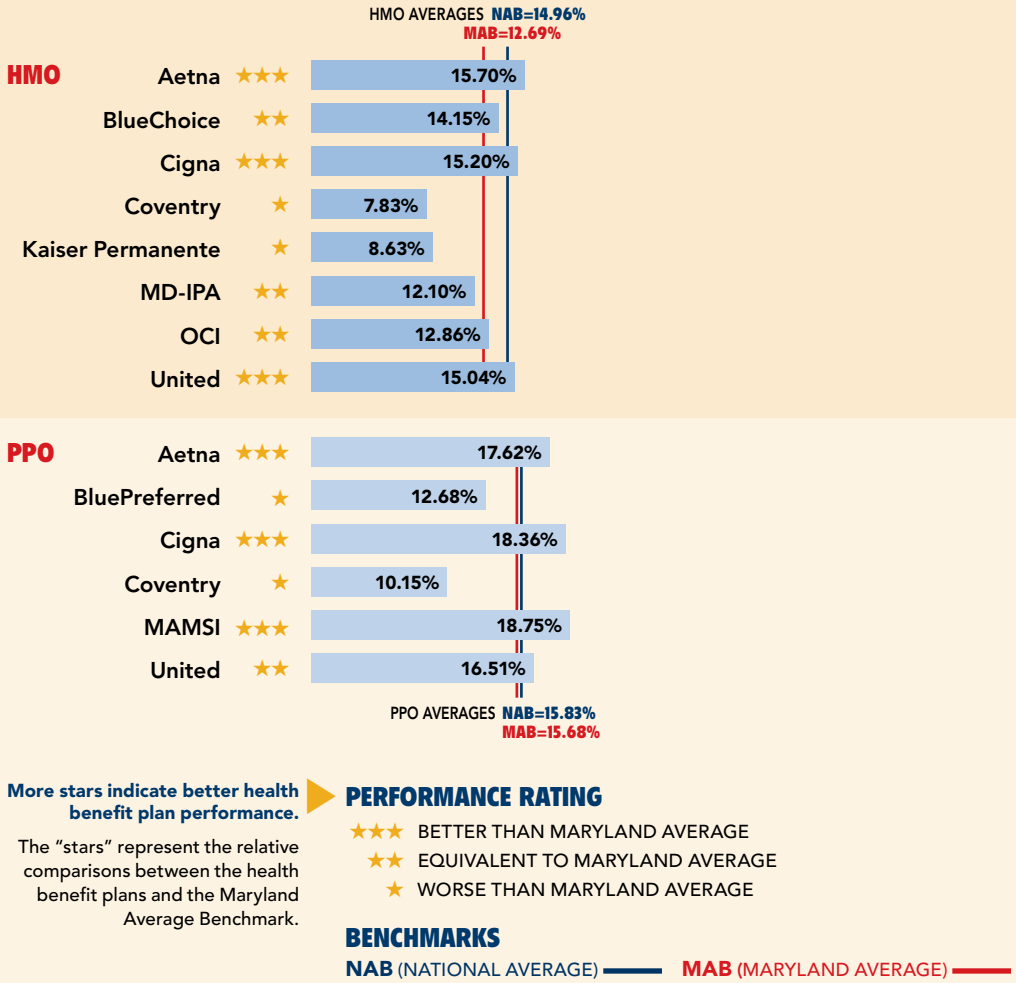
4. Engagement of AOD treatment-adults: The percentage of members, 18 years of age and older, with a new episode of AOD dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who had two or more additional services within 30 days of the initiation visit.

For this performance indicator, a higher percentage is better, which means that more members 18 years of age and older who were diagnosed with AOD dependence received two or more additional follow-up treatments within 30 days of their initial visit.

RATIONALE

There are more illnesses, disabilities and deaths from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system. Identifying people with alcohol and other drug (AOD) disorders is an important first step in the process of care, but identification often does not lead to initiation of care. Someone may not initiate treatment because of the social stigma associated with AOD disorder, denial of the problem or lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and permits comparison of effectiveness in initiating care.

ENGAGEMENT WITHIN 30 DAYS – 18+ YEARS OF AGE



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BENCHMARKS

NAB (NATIONAL AVERAGE) — **MAB** (MARYLAND AVERAGE) —

Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction

Unlike the previous subsections that report performance on clinical measures and indicators, this subsection reports on health benefit plan member ratings of their experience with care and their satisfaction with the health care services they received. This additional information can serve as a source of information to help consumers make more informed choices about their health care, since members in commercial health benefit plans have wants, needs and expectations that continue to evolve quickly.

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION

Aspirin Discussion

DESCRIPTION

Aspirin discussion: The percentage of members in the target population who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported for the target population below:

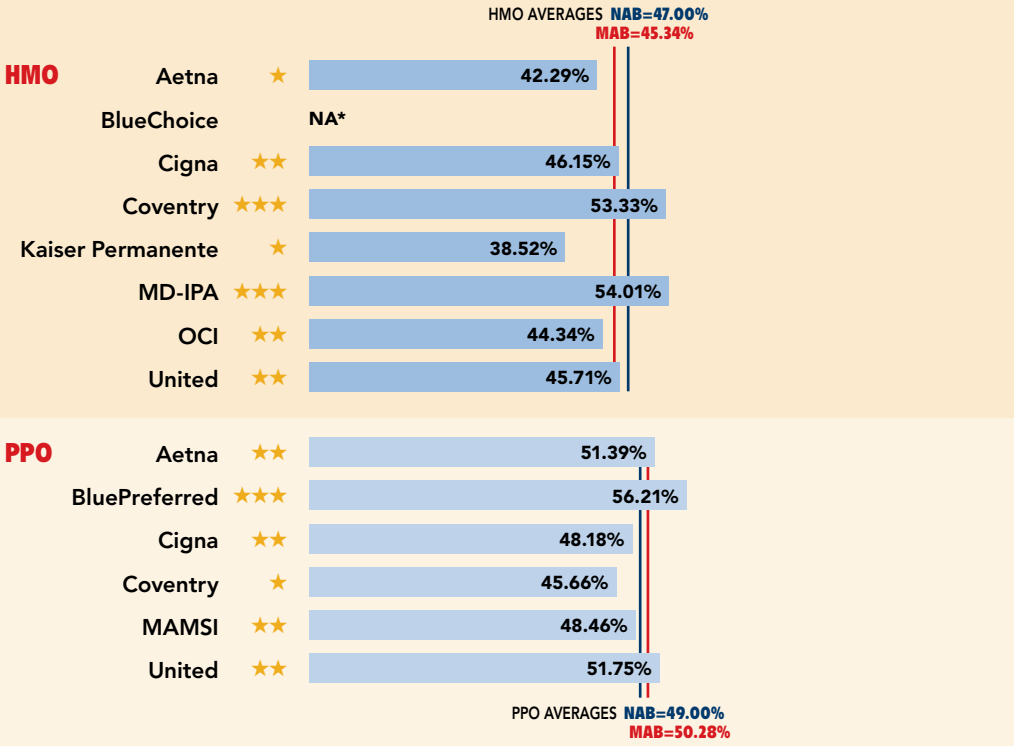
- Women 56–79 years of age, regardless of risk factors
- Men 46–79 years of age, regardless of risk factors

For this performance indicator, a higher percentage is better, which means more members in the target population did discuss the risks and benefits of using aspirin as part of their treatment regimen.

RATIONALE

The United States Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (five-year risk ≥ 3%) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy. The American Diabetes Association (ADA) encourages the use of aspirin therapy (75-162 mg/day) as a primary prevention strategy in patients with type 1 or type 2 diabetes who are at increased cardiovascular risk, including those who are 40 years of age and older or who have additional risk factors (e.g., family history of cardiovascular disease [CVD], hypertension, smoking, dyslipidemia, albuminuria).

ASPIRIN DISCUSSION – MIXED AGES



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Data Source: Health Benefit Plan Records or Member Survey

Flu Shots for Older Adults

DESCRIPTION

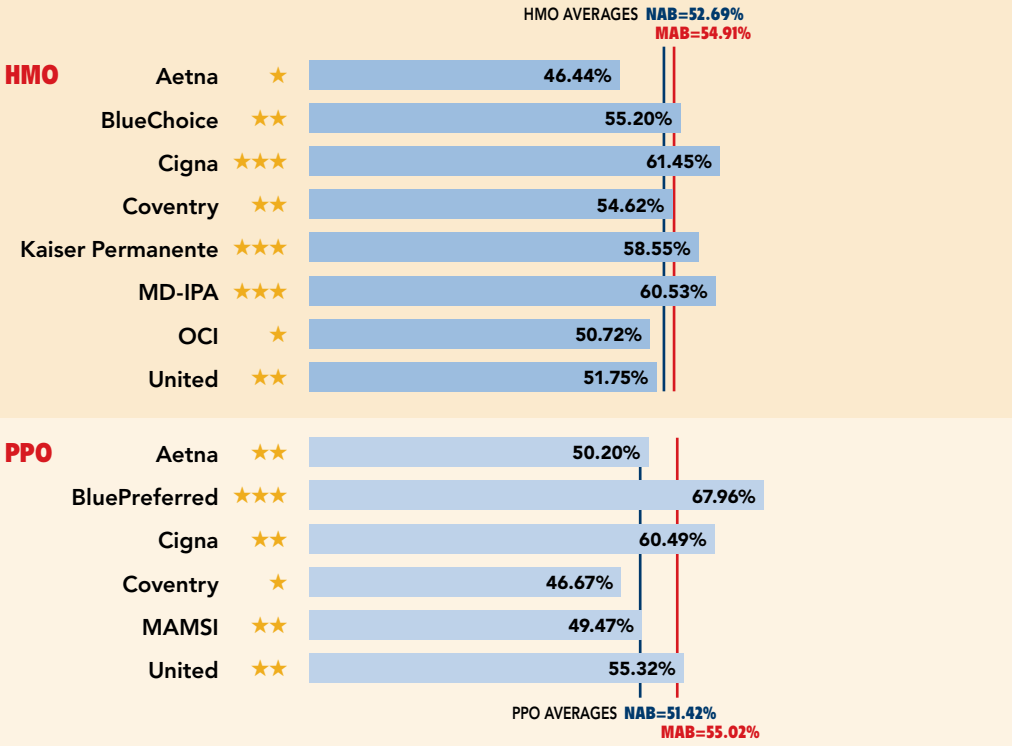
The percentage of members surveyed (CAHPS 5.0H survey) who were 50 to 64 years of age and who received an influenza vaccination (Flu shot) between September 1 of the 2012 measurement year and the date when the survey was completed.

For this measure, a higher percentage is better, which means that more members 50 to 64 years of age who are at greater risk of contracting the Flu and developing complications, did receive an annual Flu shot after September 1 of the 2012 measurement year.

RATIONALE

Influenza (the Flu) infections result in significant health care expenditures each year, and the vaccine to prevent the Flu is safe and effective. The Advisory Committee on Immunization Practices (ACIP) recommends yearly influenza vaccinations for people 50 to 64 years of age. This group has an increased prevalence of people with high-risk medical conditions, and age-specific strategies have been more successful to increase vaccine coverage than those based on medical conditions. Healthy people in any age group and even those without any high-risk conditions can also benefit from getting their annual Flu shot, as they can experience a reduced number of illnesses, physician visits, missed work/school days, and reduced disease transmission, especially to loved ones who may be at a higher risk of getting infected.

FLU SHOTS – 50-64 YEARS OF AGE



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BENCHMARKS

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Data Source: Health Benefit Plan Records or Member Survey

V. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

MEMBER EXPERIENCE AND SATISFACTION

Call Answer Timeliness

DESCRIPTION

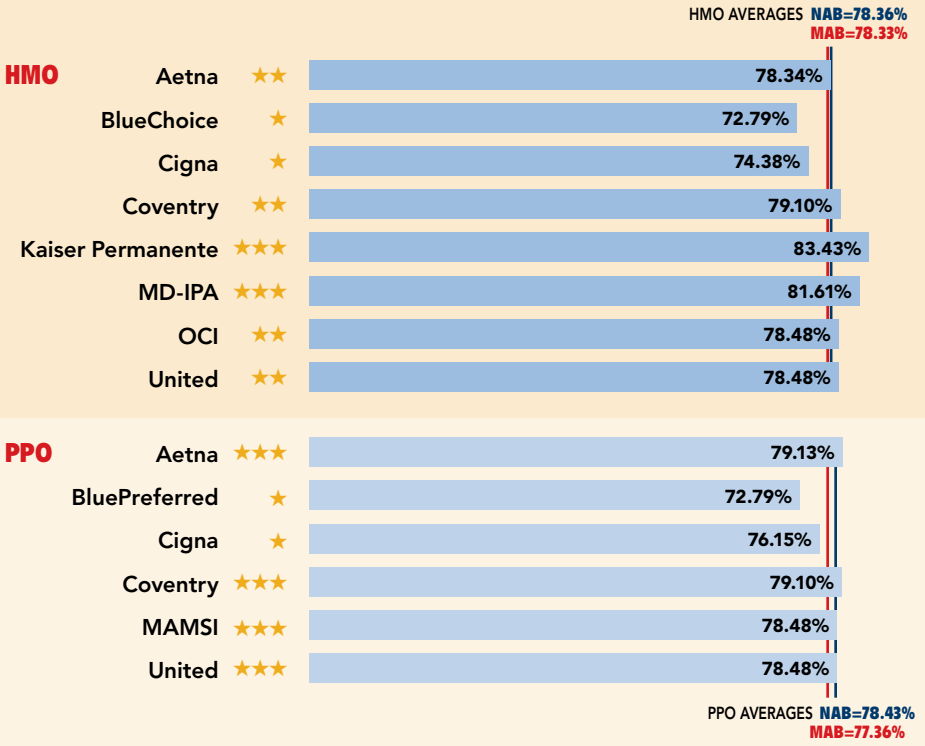
The percentage of calls received by the organization's Member Services call centers (during operating hours) during the 2012 measurement year that were answered by a live voice within 30 seconds.

For this performance indicator, a higher percentage is better, which means more members' calls that were received by the organization's Member Services call centers (during operating hours) during the 2012 measurement year were answered by a live voice within 30 seconds.

RATIONALE

Customer service continues to gain importance as health benefit plan members and employers demand improvements in the health care experience. A member's ability to reach out to an organization through their customer service call center and talk to a live person in a timely manner is the first step toward ensuring that a health insurance organization is meeting the needs of their customers. High performance on this measure by a carrier's health benefit plan(s) should improve health benefit plan member satisfaction.

CALL ANSWERED WITHIN 30 SECONDS – BY A LIVE VOICE



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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 5.0H, 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 Service

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 Percentage who selected 8, 9 or 10
Aetna	66.25%
BlueChoice	66.37%
Cigna	60.92%
Coventry	50.00%
Kaiser Permanente	83.15%
MD-IPA	67.69%
OCI	51.42%
United	52.58%
PPO	
Aetna	60.70%
BluePreferred	66.22%
Cigna	66.76%
Coventry	41.40%
MAMSI	56.00%
United	64.56%

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

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

HMO	Coordination of Care	How Well Doctors Communicate	Health Promotion and Education
	Percentage who selected Always or Usually		Percentage who selected Yes
Aetna	75.46%	92.51%	78.31%
BlueChoice	78.81%	92.45%	74.50%
Cigna	82.81%	94.12%	77.85%
Coventry	82.80%	95.06%	71.58%
Kaiser Permanente	81.97%	93.54%	78.90%
MD-IPA	78.71%	93.71%	76.20%
OCI	73.91%	89.39%	71.43%
United	69.41%	91.14%	67.91%
PPO			
Aetna	76.85%	95.54%	73.75%
BluePreferred	71.79%	94.86%	74.64%
Cigna	77.01%	93.13%	80.92%
Coventry	71.70%	91.76%	66.89%
MAMSI	81.25%	95.18%	75.00%
United	76.96%	94.12%	81.29%

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Member Satisfaction with Getting Care Quickly and Getting Needed Care

Description: The percentage of adult members who said they "always" or "usually" 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
	Percentage who selected Always or Usually	
Aetna	93.91%	84.67%
BlueChoice	82.99%	86.43%
Cigna	85.63%	83.39%
Coventry	86.93%	84.35%
Kaiser Permanente	81.83%	84.51%
MD-IPA	88.05%	90.56%
OCI	83.39%	84.67%
United	83.74%	87.20%
PPO		
Aetna	86.22%	86.74%
BluePreferred	85.12%	87.57%
Cigna	85.65%	86.93%
Coventry	77.15%	79.13%
MAMSI	85.14%	86.84%
United	85.75%	88.01%

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Overall Customer Service

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

HMO	Customer Service
	Percentage who selected Always or Usually
Aetna	84.97%
BlueChoice	NA*
Cigna	88.06%
Coventry	85.32%
Kaiser Permanente	88.44%
MD-IPA	86.04%
OCI	82.68%
United	84.21%
PPO	
Aetna	81.21%
BluePreferred	82.49%
Cigna	88.20%
Coventry	80.35%
MAMSI	NA*
United	86.47%

NA* – Insufficient responses (fewer than 100) to calculate a rate

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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 following table 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 health care 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

Eligibility for Behavioral Health Coverage

Behavioral Health benefits are available to all individuals and their dependents enrolled in medical plan coverage with the State of Maryland. This coverage is automatic when you enroll in a medical plan, and you pay no additional premium. There is no coverage for behavioral health if you do not enroll in a medical plan. Your behavioral health benefits vary depending on the medical plan you choose.

PPO and POS Medical Plans: If you are enrolled in a PPO or POS medical plan, APS Healthcare administers your behavioral health benefits. The State currently offers CareFirst (BCBS) PPO and POS, United Healthcare PPO and POS, and Aetna POS.

EPO Medical Plan: If you are enrolled in an EPO medical plan, all of your behavioral health benefits will be provided by your EPO medical plan.

APSHelpLink: This State-provided benefit through APS is available to all State of Maryland employees, retirees and dependents. APSHelpLink provides online consumer information, interactive self-help and life management tools to help you address issues that impact your health, quality of life and well being. APSHelpLink offers an online provider locator to assist you in choosing in-network providers so you receive the highest level of benefits. You can also print a temporary ID card or order a new one if needed. You can access the APS link from the Department of Budget and Management Health Benefits webpage **www.dbm.maryland.gov/benefits** or by typing **www.apshelplink.com** into your web browser. In either case, you will need to enter your company code **SOM2002**.

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			
TOPIC	**POS**	**PPO**	**EPO**
Primary Care	***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.	***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.
Referrals to specialists	***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.*	Members **do not** need a referral to see an in-network specialist or other health care provider.
Out-of-network care	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.*	**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.

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* For co-pay and out-of-network deductible amounts, see the State of Maryland 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) *Choice POS II* *Select EPO*	800-501-9837 TTY/TDD: 800-501-9837	**www.aetnamd.com**	***Aetna Choice POS II*** performance information is reported as part of the ***Aetna HMO*** quality information. ***Open Access Aetna Select EPO*** performance information is reported as part of the ***Aetna PPO*** quality information.
CareFirst BlueCross BlueShield (regional only) *POS* *PPO* *EPO*	**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 Maryland POS*** performance information is reported as part of the ***BlueChoice HMO*** quality information. ***CareFirst PPO*** performance information is reported as part of the ***BluePreferred PPO*** quality information. ***CareFirst EPO*** performance information is reported as part of the ***BluePreferred PPO*** quality information.
UnitedHealthcare (nationwide) *Choice Plus POS* *Options PPO* *Select EPO*	800-382-7513 TTY: 711 (Maryland only)	**www.uhcmaryland.com**	***UnitedHealthcare Choice Plus POS***, ***UnitedHealthcare Options PPO***, and ***UnitedHealthcare Select EPO*** performance information are reported as part of the ***United PPO*** quality information.

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 HEALTH CARE INITIATIVES

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 encourages 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 Maryland Multi-Payer Patient Centered Medical Home (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/**.

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VII. MARYLAND STATEWIDE HEALTH CARE INITIATIVES

Million Hearts® Initiative

The Maryland Department of Health and Mental Hygiene (DHMH) supports the Million Hearts® Initiative. Million Hearts® is a national initiative that was launched by the Department of Health and Human Services in September 2011 to prevent 1 million heart attacks and strokes in the United States by 2017.

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
- 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 health care 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 the Million Hearts® Initiative 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 Centers for Disease Control and Prevention 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 was used to expand Maryland's Million Hearts® activities to Baltimore City, and Baltimore, Montgomery, Prince George's, and Anne Arundel counties. The CTG and PHHS Grants together 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**.

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VII. MARYLAND STATEWIDE HEALTH CARE INITIATIVES

Maryland Health Enterprise Zones (HEZ) Initiative

On April 10, 2012, with the support of the Maryland General Assembly, Governor Martin O'Malley signed the Maryland Health Improvement and Disparities Reduction Act into law. Implementation of this landmark legislation is under the leadership of Lt. Governor Anthony Brown. The Act seeks to address unacceptable health disparities that impact the lives of many Marylanders. The law establishes a process through which the Secretary of the Department of Health and Mental Hygiene (DHMH), in collaboration with the Community Health Resources Commission (CHRC), designates Health Enterprise Zones (HEZ). The purpose of establishing these zones is to target State resources in order to save lives and health care dollars. Resources are aimed at reducing health disparities among racial and ethnic groups and geographic areas; improving health care access and health outcomes in underserved areas; and reducing health care costs and hospital admissions and readmissions.

The Act also requires the Maryland Health Care Commission (MHCC) to establish and incorporate a standard set of measures regarding racial and ethnic variations in quality and outcomes and track health insurance carriers' and hospitals' efforts to combat disparities and to provide culturally appropriate educational materials. To this end, a chief priority for the MHCC has been the recent development and implementation of the Maryland RELICC Assessment, which is a health insurance carriers' quality and performance measurement tool that focuses on race/ethnicity, language, interpreter need, and cultural competency issues among Maryland's health insurance carriers. In addition, the Act requires state institutions of higher education that train health care professionals to report to the Governor and General Assembly on their actions aimed at reducing health disparities. Additional efforts by state institutions of higher education also remain ongoing.

The HEZ Initiative is a four-year pilot program with a budget of $4 million per year. A steering committee led by Secretary Joshua Sharfstein continues to guide the implementation of the HEZ Initiative. To receive designation as a HEZ, community organizations and local health departments applied to DHMH and CHRC identifying a comprehensive plan to address disparities in a contiguous geographic area, defined by zip code boundaries, with a documented population of at least 5,000, which is thought to be small enough to allow incentives to have a significant impact. Each applicant organization was also required to demonstrate economic disadvantage and poor health outcomes, with documented evidence of health disparities.

Maryland's first five HEZ are in the following locations:

- Capitol Heights in Prince George's County
- Greater Lexington Park in St. Mary's County
- Dorchester and Caroline Counties
- West Baltimore
- Annapolis

Several possible incentives that can be utilized to address disparities within the HEZ include the following:

- Loan assistance repayment
- State income tax credits
- Hiring tax credits
- Priority to enter the Maryland Patient Centered Medical Home Program
- Grant funding for capital improvements and medical/dental equipment
- Priority for receiving funds for establishing electronic health records

To see the January 24, 2013 DHMH press release announcing Maryland's first five HEZ, visit **http://dhmh.maryland.gov/newsroom1/Pages/Health-Enterprise-Zones.aspx**

For more information on HEZs, visit **http://dhmh.maryland.gov/healthenterprisezones/SitePages/Home.aspx**

VII. MARYLAND STATEWIDE HEALTH CARE INITIATIVES

Maryland Health Information Exchange (HIE)

A health information exchange (HIE) is a conduit for transmitting electronic health information safely and efficiently across providers and systems. A 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.

To learn more about Maryland's HIE, visit **http://mhcc.dhmh.maryland.gov/hit/hie/Pages/hie_main.aspx**

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VII. MARYLAND STATEWIDE HEALTH CARE INITIATIVES

Maryland Health Benefit Exchange (MHBE)

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama. A key provision of the law requires all states to participate in health insurance exchanges beginning January 1, 2014. A health insurance exchange is a marketplace to help individuals, families and small businesses shop for coverage through easy comparison of available plan options based on price, benefits and services, and quality.

Maryland's model is a state-based marketplace. In a letter dated October 9, 2012 to U.S. Secretary of Health and Human Services, Kathleen Sebelius, Governor Martin O'Malley formally declared the State of Maryland's intention to establish a state-based health insurance marketplace. In December 2012, the State of Maryland received conditional approval to operate its exchange, Maryland Health Connection. As a state-based exchange, Maryland is responsible for the development and operation of all core functions including:

- Consumer support for coverage decisions
- Eligibility determinations for individuals
- Enrollment in qualified health plans
- Approval of participating carriers
- Certification of plans as Qualified Health Plans (QHPs)
- Operation of a Small Business Health Options Program (SHOP)

The ACA further requires that QHPs meet all applicable federal and state laws in order to be certified as QHPs. Additionally, all QHPs operating via Maryland Health Connection and available to consumers must offer a core set of "essential health benefits" as defined by the U.S. Department of Health and Human Services (HHS). The State of Maryland performs a review to ensure compliance with all areas required in the ACA.

To assist consumers with plan selection when they shop for plans on Maryland Health Connection, MHCC and MHBE have an agreement that enables MHBE to utilize quality data from carriers in this report as a proxy for quality data by the same carrier with similar product offerings inside the exchange. Each carrier's aggregated results from this report form the basis of a 5-star rate for each QHP in the Maryland Health Connection Quality Report 2013, for consumer use during open enrollment beginning on October 1, 2013. Each QHP's 5-star rate will also be displayed on the Maryland Health Connection website.

To learn more about MHBE, visit **http://marylandhbe.com**

To learn more about Maryland Health Connection, visit **http://www.marylandhealthconnection.gov**

A health insurance exchange is a marketplace to help individuals, families and small businesses shop for coverage through easy comparison of available plan options based on price, benefits and services, and quality.

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VIII. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

Chronic diseases or conditions are prolonged illnesses that usually last more than six months, are not able to be spread to others like an infection, require treatment because they do not resolve on their own, and are rarely cured completely. They affect people of all ages and ethnicities but are more common among older adults, especially those belonging to ethnic minority groups. Empowering patients to appropriately manage their chronic conditions is a leading health priority for the State of Maryland and there is mounting evidence that a comprehensive approach to care management can save tremendous costs and unnecessary suffering. Five chronic conditions impacting Maryland residents include Heart Disease, Diabetes, Hypertension, Asthma, and Chronic Obstructive Pulmonary Disease (COPD).

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VIII. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

Coronary heart disease–often simply called heart disease–is the main form of heart disease. It is a disorder of the blood vessels of the heart that can lead to heart attack. A heart attack happens when an artery becomes blocked, preventing oxygen and nutrients from getting to the heart. Heart disease is one of several cardiovascular diseases, which are diseases of the heart and blood vessel system. Other cardiovascular diseases include stroke, high blood pressure, angina (chest pain), and rheumatic heart disease.

(National Institutes of Health, 2012)

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 health care 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-attack/DS00094/DSECTION=coping-and-support

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VIII. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

Diabetes mellitus refers to a group of diseases that affect how your body uses blood glucose, commonly called blood sugar. Glucose is vital to your health because it's an important source of energy for the cells that make up your muscles and tissues. It's also your brain's main source of fuel.

If you have diabetes, no matter what type, it means you have too much glucose in your blood, although the reasons may differ. Too much glucose can lead to serious health problems.

(Mayo Clinic, 2013)

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 access to 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/

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VIII. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

High blood pressure is a common condition in which the force of the blood against your artery walls is high enough that it may eventually cause health problems, such as heart disease.

Blood pressure is determined by the amount of blood your heart pumps and the amount of resistance to blood flow in your arteries. The more blood your heart pumps and the narrower your arteries, the higher your blood pressure. You can have high blood pressure (hypertension) for years without any symptoms. Uncontrolled high blood pressure increases your risk of serious health problems, including heart attack and stroke.

(Mayo Clinic, 2013)

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 health care 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

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VIII. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

Asthma is a chronic (long-term) lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing (a whistling sound when you breathe), chest tightness, shortness of breath, and coughing. The coughing often occurs at night or early in the morning.

Asthma affects people of all ages, but it most often starts during childhood. In the United States, more than 25 million people are known to have asthma. About 7 million of these people are children.

Asthma has no cure. Even when you feel fine, you still have the disease and it can flare up at any time. However, with today's knowledge and treatments, most people who have asthma are able to manage the disease. They have few, if any, symptoms. They can live normal, active lives and sleep through the night without interruption from asthma.

(National Institutes of Health, 2012)

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 can 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 with a contagious illness. Asthma is a treatable disease that with monitoring and proper medication 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/

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VIII. FIVE CHRONIC DISEASES IMPACTING MARYLAND RESIDENTS

COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. COPD can cause coughing that produces large amounts of mucus, wheezing, shortness of breath, chest tightness, and other symptoms.

COPD develops slowly. Symptoms often worsen over time and can limit your ability to do routine activities. Severe COPD may prevent you from doing even basic activities like walking, cooking, or taking care of yourself.

COPD has no cure yet, and doctors don't know how to reverse the damage to the airways and lungs. However, treatments and lifestyle changes can help you feel better, stay more active, and slow the progress of the disease.

(National Institutes of Health, 2013)

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 to 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 of developing COPD and raise awareness about the ease of diagnosis and the testing for COPD. More than 12 million people are diagnosed with COPD nationally 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 the prevention of developing COPD. 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 for smokers 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

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IX. CONSUMER RESOURCES

Links to MHCC Resources

Publications on the performance of health care 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

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, adult day care facilities, and hospice programs. Users can sort by services offered and by county or zip code; view recent results from Maryland Office of Health Care Quality's health and safety inspections; annual 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

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Links to Additional Information and Assistance

Inquiries and Complaints About Health Care Facilities and Practitioners

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://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/vaccines-for-children-program.aspx

Inquiries and Complaints About Health Insurance for Consumers

Maryland Health Connection
http://www.marylandhealthconnection.gov/resources/consumer-assistance/

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

Maryland Health Benefit Exchange
http://marylandhbe.com

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/Licensee%20Directory.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/

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Maryland Links continued

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

Maryland Pharmacy Board
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/SeniorHealthInsurance_Program.html

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 Health Care Organizations
http://www.jointcommission.org

Hospital Quality Alliance
http://www.hospitalqualityalliance.org/

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/index.aspx

Assisted Living Facilities Organization
http://www.assistedlivingfacilities.org/

IX. CONSUMER RESOURCES | LINKS TO MHCC RESOURCES

Federal Links

CMS Nursing Home Compare
http://www.medicare.gov/nursinghomecompare/search.html

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

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

Medicare
http://www.medicare.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/consumer/HSAGuide.cfm

http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx

Data Sources

The Common Wealth Fund
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
http://whynotthebest.org/maps

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X. INFORMATION ON METHODOLOGIES

Star Rating Methodology

Calculation of Relative Rates Using a 3-Star Rating System

Each performance measure and indicator included in this report contains health benefit plan performance rates for Maryland's individual and authorized combinations of HMO and PPO health benefit plans. Benchmark performance rates are also calculated in order to compare health benefit plan performance to overall State and national performance on each measure and indicator. The Maryland Average Benchmark (MAB) rate calculates a State average for each measure and indicator being reported. The National Average Benchmark (NAB) rate calculates a national average for each measure and indicator being reported.

The MAB rate forms the basis for the 3-Star rating system depicting relative performance of each health benefit plan on each measure and indicator being reported. All individual and authorized combinations of HMO and PPO health benefit plans contribute equally to the MAB for the HMO and PPO health benefit plan categories respectively. For the HMO category, the MAB is determined by adding the performance rate for each HMO and authorized HMO combination, and dividing by eight, because there are eight health benefit plans being reported upon in the HMO category. For the PPO category, the MAB is determined by adding the performance rate for each PPO and authorized PPO combination, and dividing by six, because there are six health benefit plans being reported upon in the PPO category. Health benefit plans in the HMO or PPO category for any performance measure or indicator with an NA or NR result instead of a performance rate, are excluded from the calculation of the MAB for the appropriate HMO or PPO category. Then, if the difference between a health benefit plan's actual performance rate (percent score) and the MAB is statistically significant, the health benefit plan is assigned one of three possible relative rates. Following are the symbols and a brief explanation of the three possible relative rates:

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

*When the difference between a health benefit plan's rate and the MAB 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 and receives 3 stars.*

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

When the difference between a health benefit plan's rate and the Maryland average benchmark for HMOs is statistically equivalent to the Maryland average, the health benefit plan is assigned to the "equivalent to" the Maryland average category and receives 2 stars.

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

*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 "below" the Maryland average, the* health benefit plan is assigned to the significantly "worse than" the Maryland average category and receives 1 star.

X. INFORMATION ON METHODOLOGIES

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 2013, 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 2013, 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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X. INFORMATION ON METHODOLOGIES

CAHPS Methodology

CAHPS 5.0H 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 5.0H, 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 2013 and lasted into May 2013. Summary-level data files generated by NCQA were distributed in June 2013 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 5.0H, Adult Version* had to be 18 years of age or older as of December 31 of the 2012 measurement year. They also had to be continuously enrolled in the commercial health benefit plan for at least 11 of the 12 months of 2012, and remain enrolled in the health benefit plan in 2013. 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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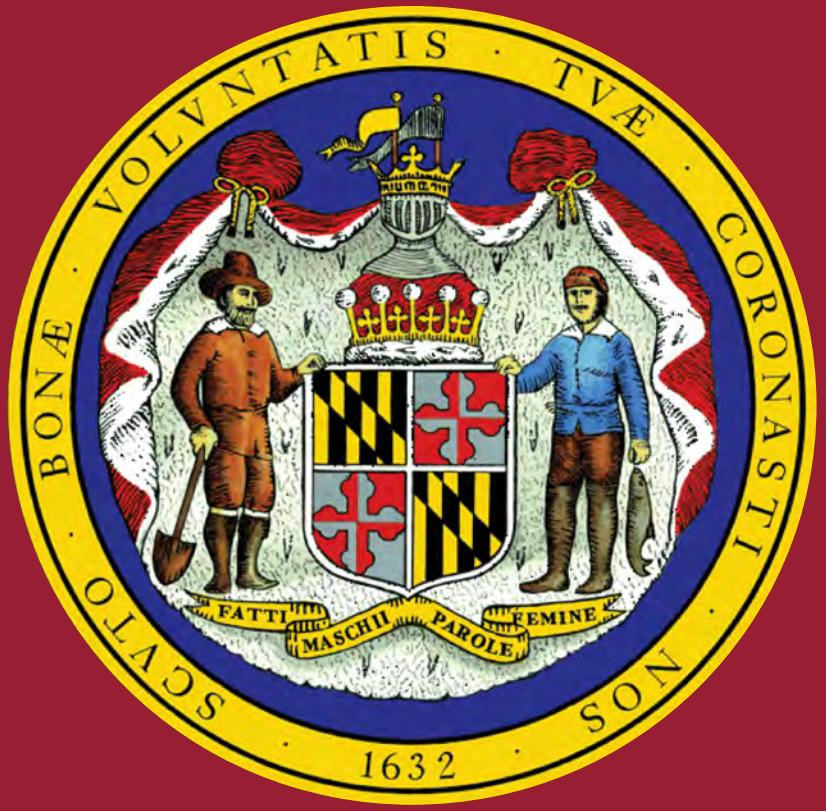

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