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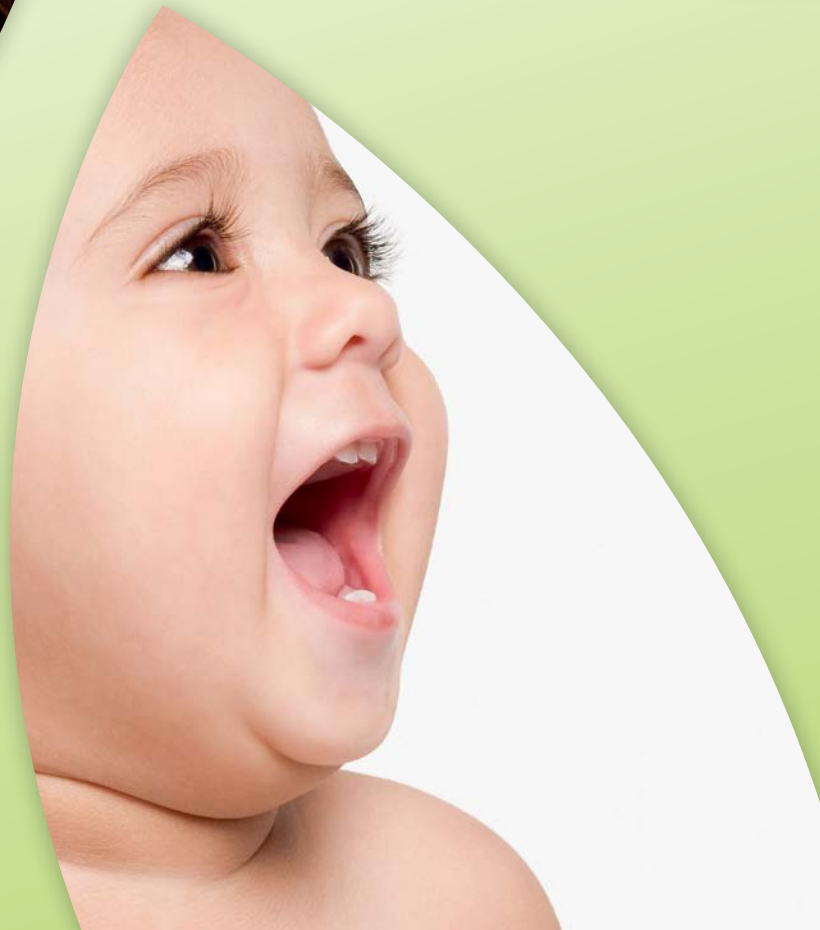
Quality Report 2015



Comparing the Quality and Performance of Qualified Health Plans available through the Maryland Health Connection

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Maryland Health Connection Quality Report

Welcome to the 2015 Maryland Health Connection Quality Report. This report provides a summary of quality and performance information on medical plans offered on Maryland Health Connection, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) plans, and exclusive provider organizations (EPOs). Individuals, families, employers, and employees can use this report to compare qualified health plans on performance measures that are specific to their health care needs and closely linked to high quality, value-based care.

To make it easier for Marylanders to make more informed choices, each qualified health plan being offered on the Maryland Health Connection is assigned a five star rating, with more stars indicating higher quality. The five star rating reflects overall quality of healthcare services provided, satisfaction of enrollees, quality improvement activities performed within the organization, and the organization's ability to provide services to diverse populations.

The quality information collected from commercial health benefit plans is based on performance data for 2014, the most recent year for which complete data is available. Since qualified health plans do not have significant numbers of enrollees in 2014 for many of the quality measures being assessed, parallel health benefit plan data is used as a proxy for qualified health plans offered on Maryland Health Connection. The quality information has been assembled and audited by the Maryland Health Care Commission (MHCC). MHCC is a trusted source of information on health care quality and cost in Maryland government having published performance information on commercial health insurance companies for the past 19 years. Maryland Health Connection is the marketplace for individuals, families and small businesses to compare and enroll in health insurance. Both MHCC and Maryland Health Connection have worked together to develop the 2015 Maryland Health Connection Quality Report as part of Maryland's efforts to implement the Patient Protection and Affordable Care Act.

Shopping for health insurance is an important and often challenging process for individuals, families and small businesses. We hope that you find this report and the five star rating system informative as you make your health insurance purchasing decision.

Sincerely,

Carolyn Quattrocki
Executive Director
Maryland Health Benefit Exchange

Ben Steffen
Executive Director
Maryland Health Care Commission

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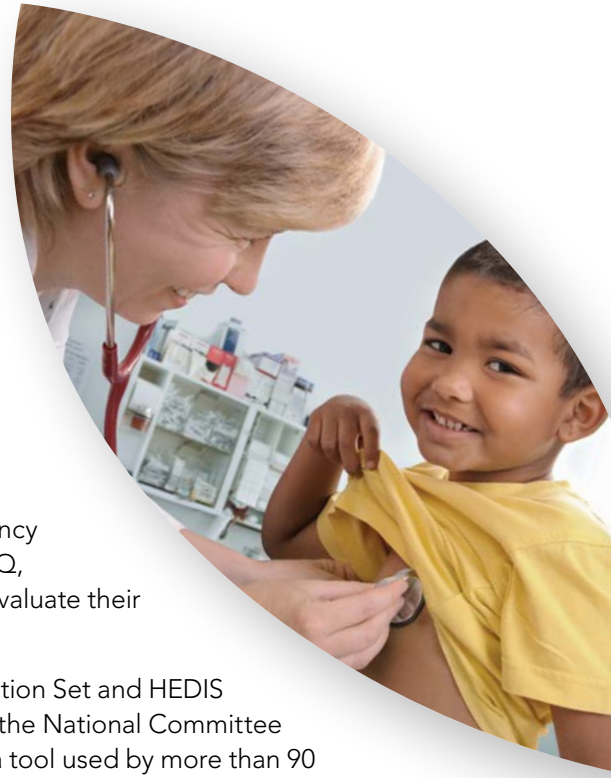
General Information

Acknowledgement

Maryland Health Benefit Exchange would like to extend appreciation and acknowledgement to the Maryland Healthcare Commission for their contributions to this annual Quality Report and for access to information on qualified health plan quality and performance.



Trademarks

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). According to AHRQ, CAHPS® surveys ask consumers and patients to report on and evaluate their experiences with health care.

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and HEDIS Compliance Audit®, both of which are registered trademarks of the National Committee for Quality Assurance (NCQA). According to NCQA, HEDIS® is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

RELICC™ refers to the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment and is a trademark of the Maryland Health Care Commission (MHCC). According to MHCC, RELICC™ is a quality measurement tool designed specifically to address a core State priority which is to reduce and ultimately eliminate health care disparities. RELICC™ was created for the State of Maryland by the Mid-Atlantic Business Group on Health (MABGH) with support from the National Business Coalition on Health (NBCH).

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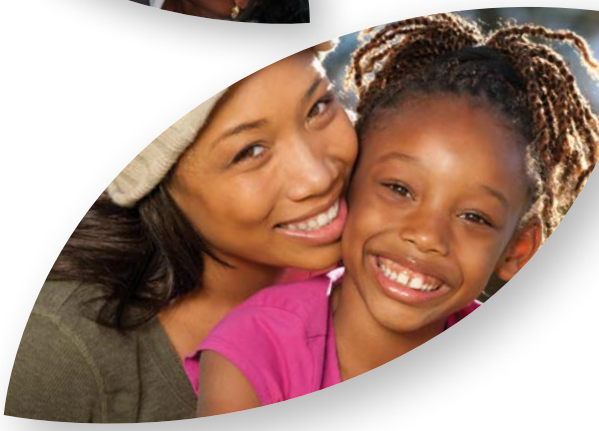
Federal Legislation that Created Maryland Health Connection

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 ACA requires each state to establish a health insurance marketplace starting January 1, 2014. The Maryland Health Connection is Maryland's health insurance marketplace. Through the marketplace Marylanders can shop for and compare insurance plans based on price, benefits options, out-of-pocket costs and quality.

Follow-up State Legislation

The Maryland Health Progress Act of 2013, signed by Governor Martin O'Malley on May 2, 2013, adopted plan certification requirements that include meeting standards and providing data related to quality. Insurance Article § 31-115(k)(2)(v) Annotated Code of Maryland. In addition, the Maryland Health Benefit Exchange Carrier and Qualified Plan Certification Interim Procedures adopted by the MHBE Board on October 23, 2013, require that the "carrier will provide quality data and RELICC data, as specified by the Maryland Health Benefit Exchange, to the Maryland Health Care Commission." The Interim Procedures also state that carriers must provide the quality data at least on an annual basis.



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About Maryland Health Connection

The Maryland Health Connection Board of Directors developed policies for operating the core functions of Maryland's marketplace and adopted seven principles to ensure the health care needs of Maryland individuals, families, employers and employees would be met. These principles continue to guide the policy development and implementation decisions for Maryland Health Connection:

1. **Accessibility**—Maryland Health Connection should reduce the number of Marylanders without health insurance and improve access for all Marylanders.
2. **Affordability**—The affordability of coverage, within the exchange and within the state, is essential to improving Maryland's health care system and economy.
3. **Sustainability**—Maryland Health Connection will need to be sustainable in order to succeed in the long run.
4. **Stability**—Maryland Health Connection should promote solutions that respect existing strengths of our state's health care system and promote stability within the Exchange.
5. **Health Equity**—Maryland Health Connection should work to address longstanding, unjust disparities in health access and health outcomes in Maryland.
6. **Flexibility**—Maryland Health Connection should be nimble and flexible in responding to the quickly changing insurance market, health care delivery system, and general economic conditions in Maryland, while being sensitive and responsive to consumer demands.
7. **Transparency**—Maryland Health Connection is accountable to the public, and its activities should be transparent, its services easily available, and its information easily understandable by the populations it assists.

The ACA requires that all small group and individual health benefit plans must cover a core set of "essential health benefits" as defined by the U.S. Department of Health and Human Services (HHS). Health benefit plans offered on Maryland Health Connection are referred to as Qualified Health Plans (QHPs) and must go through a rigorous review process to ensure the requirements of the ACA are met. Only authorized insurance companies that are approved by the State of Maryland can offer insurance coverage through Maryland Health Connection.

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About Maryland Health Connection Quality Report 2015

For consumers shopping on Maryland Health Connection, 2014 quality and performance data from similar plans that were offered by each insurance company is used to evaluate qualified health plan (QHP) performance. Plan quality scores are displayed in a five-star rating format. The five-star rates are based on information published in the Maryland Health Care Commission Comprehensive Quality Report 2015, which employs the following quality measurement instruments:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Health care Providers and Systems (CAHPS®)
- Maryland Behavioral Health Assessment (BHA)
- Maryland Health Plan Quality Profile (QP)
- Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency (RELICC™)

Using the quality and performance data from similar plans, each QHP has been assigned a score up to five stars. The results are displayed on Maryland Health Connection so consumers can see this information when they are shopping for a qualified health plan. It should be noted that quality data is not yet available for some plans, however a lack of quality data does NOT indicate a poor quality rating. All insurance companies listed on Maryland Health Connection have met all necessary requirements to offer plans to consumers in Maryland. This report outlines the development of the star rating system, components used in the rating system, and the final star rating of QHPs that are offered on Maryland Health Connection.

Consumers interested in viewing the detailed quality and performance information which forms the basis for the star ratings in this report, will need to view a copy of the Maryland Health Care Commission Comprehensive Quality Report 2015. This report is produced annually by the Maryland Health Care Commission and details the quality and performance of various medical plans licensed to operate in Maryland, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service plans (POSs), and exclusive provider organizations (EPOs). The Maryland Health Care Commission Comprehensive Quality Report 2015 can be found using the following link: **http://mhcc.maryland.gov/mhcc/pages/CQM_HPQ_2015_Comprehensive_Quality_Report_RPT_20151015.pdf**.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

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Qualified Health Plan Information and Overview

Health Benefit Plan Delivery Systems

Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plans, Point-Of-Service (POS) plans, and Exclusive Provider Organization (EPO) plans, all have distinct features. These features are summarized in the table on the right, and typically fall into three main categories that are of importance to consumers: (1) Primary Care Providers, (2) Referrals to specialty care providers, and (3) Out-of-pocket costs, which includes annual premium and cost sharing.

It should be noted that 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 benefits package linked to their contract. These behavioral health care services include mental health services as well as services for mood, behavioral and addictive disorders.

Features of the Various Types of Qualified Health 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).	Depending on the plan, members may need to 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.

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Features of the Various Types of Qualified Health Plan Delivery Systems continued

Topic		HMO	POS	PPO	EPO
Out-of-pocket costs	**Annual premiums**	Annual premiums tend to be lower than POS and PPO plans.	Annual premiums tend to fall between HMO and PPO plans.	Annual premiums tend to be higher than HMO and POS plans.	Annual premiums tend to be lower than PPO plans.
	Cost sharing	*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.	*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.	*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.	*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

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Qualified Plans in Maryland Health Connection

2016 Qualified Health Plans (QHPs)

Only authorized insurance companies (also referred to as "insurance carriers") can offer health insurance plans through the Maryland Health Connection. Most of these insurance carriers have a history of being evaluated and rated in the State of Maryland on the basis of quality and value. All insurance carriers must meet the same requirements to offer plans on Maryland Health Connection but all insurance carriers do not have a history of being rated on quality metrics in the State. If any insurance carriers do not have a quality rating, this does not mean the carrier offers low quality plans. This simply means Maryland does not yet have data to be able to provide a quality score for the given insurance carrier's qualified health plans.

Following is a list of the 2016 Qualified Health Plans (QHPs). For additional help in enrolling with a QHP, please contact the appropriate insurance carrier using the information provided in the table below:

Health Insurance Carrier Legal Name	Plan Type	Report Name	Contact Information
HMO			
CareFirst BlueChoice	HMO/POS	CareFirst BlueChoice Marketplace HMO/POS	1-855-444-3121 Monday through Friday, 8:00 AM–6:00 PM www.carefirst.com
Evergreen Health Cooperative	HMO/POS	Evergreen Health Co-Op Marketplace HMO/POS	410-844-0701 or 855-475-0990
Kaiser Permanente	HMO	Kaiser Permanente Marketplace HMO	1-800-759-0584 24 hours a day, 7 days a week www.kaiserpermanente.org
UnitedHealthcare of the Mid-Atlantic	HMO	UnitedHealthcare Marketplace HMO	1-866-633-2446 TTY: 711 (Maryland only) 24 hours a day, 7 days a week www.uhc.com

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2016 Qualified Health Plans (QHPs) continued

Health Insurance Carrier Legal Name	Plan Type	Report Name	Contact Information
PPO			
CareFirst of Maryland, Inc.	PPO	CareFirst CFMI Marketplace PPO	1-855-444-3121 7 days a week, 7:00 AM–7:00 PM www.carefirst.com
(CareFirst's) Group Hospitalization and Medical Services, Inc.	PPO	CareFirst GHMSI Marketplace PPO	1-855-444-3121 7 days a week, 7:00 AM–7:00 PM www.carefirst.com
Cigna Health and Life Insurance Company	PPO	Cigna Marketplace PPO	1-866-GET-Cigna (1-866-438-2446) 24 hours a day, 7 days a week www.cigna.com
EPO			
All-Savers UnitedHealthcare	EPO	All-Savers Marketplace EPO	800-980-5213

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2016 Qualified Dental Plans (QDPs)

For the Maryland Health Connection, a number of dental carriers have been authorized to offer plans on Maryland Health Connection. At this time, the state of Maryland is not collecting quality data for these carriers. Because of this, no performance data is available on these carriers.

Dental Plan Name	Dental Carrier Report Name	Dental Plan Type
DeltaCare USA Preferred Plan for Families	Alpha Dental Programs, Inc.	DHMO
DeltaCare USA Basic Plan for Families	Alpha Dental Programs, Inc.	DHMO
BlueDental Preferred High	CareFirst of Maryland, Inc.	DPPO
BlueDental Preferred Low	CareFirst of Maryland, Inc.	DPPO
Delta Dental PPO Preferred Plan for Families	Delta Dental of Pennsylvania	DPPO
Delta Dental PPO Basic Plan for Families	Delta Dental of Pennsylvania	DPPO
DentaQuest EPO Pediatric High	DentaQuest Mid-Atlantic, Inc.	DEPO
DentaQuest EPO Family High	DentaQuest Mid-Atlantic, Inc.	DEPO
DentaQuest EPO Family Low	DentaQuest Mid-Atlantic, Inc.	DEPO
Dentegra Dental PPO Family Basic Plan	Dentegra Insurance Company	DPPO
Select Plan Basic Kids	Dominion Dental Services, Inc.	DHMO
Select Plan Basic	Dominion Dental Services, Inc.	DHMO
Select Plan Premium Kids	Dominion Dental Services, Inc.	DHMO
Select Plan Premium	Dominion Dental Services, Inc.	DHMO
PPO Elite Premium Kids	Dominion Dental Services, Inc.	DPPO
PPO Elite Basic	Dominion Dental Services, Inc.	DPPO
PPO Elite Basic Kids	Dominion Dental Services, Inc.	DPPO
PPO Elite Premium	Dominion Dental Services, Inc.	DPPO
BlueDental Preferred High	CareFirst GHMSI	DPPO
BlueDental Preferred Low	CareFirst GHMSI	DPPO

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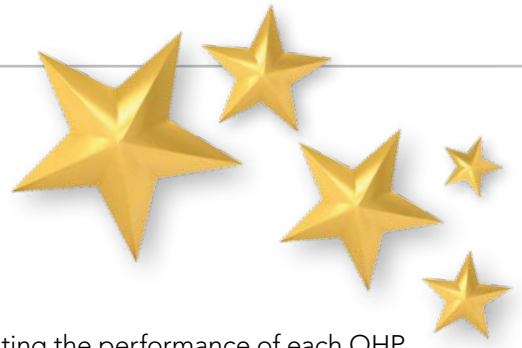
Qualified Health Plan (QHP) Performance Ratings



Rationale for HDC 5-Star™

Maryland Health Connection uses a simple method for rating the performance of each QHP that was developed by HealthcareData Company, LLC (HDC). The rating method provides a visual representation of overall plan quality and performance so that consumers can more easily make comparisons among health plans.

The HDC 5-Star™ Quality and Performance Rating System uses performance measures and indicators currently reported by the insurance carriers to the Maryland Health Care Commission. Each measure and indicator is assigned a weight in order to take account of how important the particular measure or indicator is presumed to be to consumers. For example, an insurance carrier's performance on health care quality clinical measures and indicators are given a greater weight than their performance on measures and indicators that relate to a consumer satisfaction survey of their members. Insurance carriers are evaluated on each of the weighted performance measures and indicators they report on and are then awarded an overall star rating of 1 to 5 stars, with 5 stars being the highest. It should be noted that this overall star rating is rounded up to the nearest half-star increment.

Consideration should be made when comparing carriers by star rating. A carrier with less than 5 stars is not below standard. When compared to the national average a carrier may have strengths and weaknesses, that same carrier may be providing excellent service when compared with carriers outside of Maryland. It is best to compare those areas that address your individual concerns to ensure the level of care you desire.

> *The rating method provides a visual representation of overall plan quality and performance so that consumers can more easily make comparisons among health plans.*

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Description for HDC 5-Star™

Please refer to Appendix 1 for a diagram of the 5-star rating process.

Three steps are used to produce a star rating for each Qualified Health Plan. The following outline presents how the star rating system works:

Given: 2014 health benefit plan quality and performance data is being used as a "proxy" or close substitute for quality and performance data of similar qualified health plans (QHPs) *and* quality and performance measures and indicators have been weighted to account for their level of importance.

Step 1: The **Basic Star Score** is determined by comparing plan performance on the selected measure or indicator to the national average benchmark for the same measure or indicator. Each QHP reports on many clinical measures and indicators plus some non-clinical measures. The performance score for each clinical measure and indicator is compared to percentile rankings produced by the National Committee for Quality Assurance (NCQA). Basic Star Scores are assigned to each of these measures and indicators based on QHP performance against the national average benchmark and according to the following percentile schedule:

0 to 10th percentile	★
11th to 25th percentile	★★
26th to 50th percentile	★★★
51st to 75th percentile	★★★★
Above the 75th percentile	★★★★★

Please refer to Appendix 1 for a listing of the clinical and non-clinical measures and indicators.

Step 2: The **Weighted Star Score** is determined by multiplying the Basic Star Score from Step 1 by the weight assigned to the same individual measure or indicator.

Please refer to Appendix 2 for more information on weighting of measures and indicators.

Step 2a: The **HEDIS® Category Weighted Star Score** is determined by calculating the sum of Weighted Star Scores for individual measures and indicators within each of the eight categories of clinical measures and indicators with a fixed weight of 0.90% for each measure and indicator.

Step 2b: The **Member Experience and Satisfaction Category Weighted Star Score** is determined by repeating steps 1 and 2, then calculating the sum of the Weighted Star Scores for measures within each of the fourteen categories of non-clinical measures with a fixed weight of 0.50% for each CAHPS® category.

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Step 2c: The **Maryland Specific Performance Areas Weighted Star Score** is determined by the comprehensiveness of the non-clinical measure being reported. One star is assigned if insufficient or no information is reported for these measures and five stars if the measure is completely reported. If five stars, then each non-clinical measure is assigned a maximum value. This includes performance on the Maryland Health Plan Quality Profile and the Maryland Plan Behavioral Health Assessment (2.4%) plus a fixed weight of 4.9% for performance on the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment.

Step 3: The final **5-STAR™ Rate** for each QHP is then determined by calculating the sum of the Category Weighted Star Scores from steps 2a, 2b, and 2c, then rounding up to the nearest half-star increment.

Performance Measures Used in Scoring

Please refer to Appendix 1 for a detailed listing of all performance measures/indicators used in calculating the star rating.

Assignment of Weights and Measure Contributions

Please refer to Appendix 2 for a detailed listing of the major performance areas used in the star rating.

Sample of Scoring

For a sample of scoring using the HDC 5-Star™ Performance Evaluation System, please refer to Appendix 3 for a table depicting the star rating process.

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Co-Insurance varies—The percent of a members co-insurance charges varies based on whether health or dental services are rendered by in-network or out-of-network provider(s); base co-insurance will be displayed if provided*

HSA—Health Services Account established by individuals to pay for qualified health care expenses

HRA—Healthcare Reimbursement Account used by employers to reimburse employees' health care expenses

Performance Rating Table for Maryland QHPs

Report-Level Name	QHP Name ($–Annual Individual Deductible/%–Co-Insurance)	Carrier	Plan Type	Embedded Pediatric Dental Only or Embedded Adult and Pediatric Dental	Overall Star Rating
HMO					
CareFirst BlueChoice	BlueChoice HMO Silver ($2,000/Copay Plan)	CareFirst BlueChoice Inc.	HMO	Pediatric	★★★★
	BlueChoice HMO Young Adult ($6,850/Copay Plan)	CareFirst BlueChoice Inc.	HMO	Pediatric	★★★★
	BlueChoice HMO HSA Silver ($1,350/Copay Plan)	CareFirst BlueChoice Inc.	HMO/HSA	Pediatric	★★★★
	BlueChoice HMO HSA Bronze ($6,000 /Copay Plan)	CareFirst BlueChoice Inc.	HMO/HSA	Pediatric	★★★★
	BlueChoice HMO HSA Bronze ($6,550/Copay Plan)	CareFirst BlueChoice Inc.	HMO/HSA	Pediatric	★★★★
	BlueChoice Plus Silver ($2,500/Copay Plan)	CareFirst BlueChoice Inc.	POS	Pediatric	★★★★
	BlueChoice Plus Bronze ($5,500 /Copay Plan)	CareFirst BlueChoice Inc.	HMO/HSA	Pediatric	★★★★
	HealthyBlue HMO Gold ($250/Copay Plan)	CareFirst BlueChoice Inc.	HMO	Pediatric	★★★★
	HealthyBlue HMO Gold ($1,000/Copay Plan)	CareFirst BlueChoice Inc.	HMO	Pediatric	★★★★
	HealthyBlue Plus Gold ($750/Copay Plan)	CareFirst BlueChoice Inc.	POS	Pediatric	★★★★
Evergreen Health Cooperative	Evergreen Health HMO Open-Access Platinum ($350/10 Co-insurance)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available
	Evergreen Health HMO Open-Access Gold ($1,100/20% Co-Insurance)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available
	Evergreen Health HMO Open-Access Silver ($3,000/20% Co-Insurance)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available
	Evergreen Health HMO Open Access Silver HSA ($2,000/25% Co-Insurance)	Evergreen Health Cooperative	HMO/HSA	Pediatric	2014 Quality Data Not Available
	Evergreen Health HMO Open-Access Bronze HSA ($6,200/40% Co-Insurance)	Evergreen Health Cooperative	HMO/HSA	Pediatric	2014 Quality Data Not Available
	Evergreen Health HMO Open-Access The Basics ($6,850/Co-Insurance varies*)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available
	Evergreen Health POS Gold ($900/20% Co-Insurance)	Evergreen Health Cooperative	POS	Pediatric	2014 Quality Data Not Available
	Evergreen Health POS Gold HSA ($1,400/20% Co-Insurance)	Evergreen Health Cooperative	POS/HSA	Pediatric	2014 Quality Data Not Available
	Evergreen Health POS Silver ($4,850/30% Co-Insurance)	Evergreen Health Cooperative	POS	Pediatric	2014 Quality Data Not Available
	Evergreen Health POS Bronze ($6,200/40% Co-Insurance)	Evergreen Health Cooperative	POS	Pediatric	2014 Quality Data Not Available
	Evergreen Health Select Platinum ($250/10% Co-Insurance)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available
	Evergreen Health Select Gold ($1,100/20% Co-Insurance)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available
	Evergreen Health Select Silver ($4,400/30% Co-Insurance)	Evergreen Health Cooperative	HMO	Pediatric	2014 Quality Data Not Available

Co-Insurance varies—The percent of a members co-insurance charges varies based on whether health or dental services are rendered by in-network or out-of-network provider(s); base co-insurance will be displayed if provided*

HSA—Health Services Account established by individuals to pay for qualified health care expenses

HRA—Healthcare Reimbursement Account used by employers to reimburse employees' health care expenses

Performance Rating Table for Maryland QHPs continued

Report-Level Name	QHP Name ($–Annual Individual Deductible/%–Co-Insurance)	Carrier	Plan Type	Embedded Pediatric Dental Only or Embedded Adult and Pediatric Dental	Overall Star Rating
HMO					
Kaiser Permanente	KP MD Platinum ($0/20% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
	KP MD Gold ($0/20% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
	KP MD Gold ($1,000/20% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
	KP MD Silver ($1,500/30% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
	KP MD Silver ($2,500/30% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
	KP MD Bronze ($4,500/50% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
	KP MD Silver ($2,750/20% Co-Insurance)/HSA	Kaiser Permanente	HMO/HSA	Pediatric/Adult	★★★★½
	KP MD Bronze ($5,000/50% Co-Insurance)/HSA	Kaiser Permanente	HMO/HSA	Pediatric/Adult	★★★★½
	KP MD Bronze ($6,000/20% Co-Insurance)/HSA	Kaiser Permanente	HMO/HSA	Pediatric/Adult	★★★★½
	KP MD Catastrophic ($6,850/0% Co-Insurance)	Kaiser Permanente	HMO	Pediatric/Adult	★★★★½
United-Healthcare of the Mid-Atlantic	Gold Compass ($0/30% Co-Insurance)	UnitedHealthcare of the Mid-Atlantic	HMO	Pediatric	★★½
	Gold Compass ($1,000/20% Co-Insurance)	UnitedHealthcare of the Mid-Atlantic	HMO	Pediatric	★★½
	Silver Compass ($4,500/Co-Insurance varies*)	UnitedHealthcare of the Mid-Atlantic	HMO	Pediatric	★★½
	Bronze Compass ($6,500/40% Co-Insurance)	UnitedHealthcare of the Mid-Atlantic	HMO	Pediatric	★★½
	Silver Compass HSA ($2,000/Co-Insurance varies*)	UnitedHealthcare of the Mid-Atlantic	HMO/HSA	Pediatric	★★½
	Bronze Compass HSA ($5,500/Co-Insurance varies*)	UnitedHealthcare of the Mid-Atlantic	HMO/HSA	Pediatric	★★½

Co-Insurance varies—The percent of a members co-insurance charges varies based on whether health or dental services are rendered by in-network or out-of-network provider(s); base co-insurance will be displayed if provided*

HSA—Health Services Account established by individuals to pay for qualified health care expenses

HRA—Healthcare Reimbursement Account used by employers to reimburse employees' health care expenses

Performance Rating Table for Maryland QHPs continued

Report-Level Name	QHP Name ($–Annual Individual Deductible/%–Co-Insurance)	Carrier	Plan Type	Embedded Pediatric Dental Only or Embedded Adult and Pediatric Dental	Overall Star Rating
PPO					
CareFirst of Maryland, Inc.	BlueCross BlueShield Preferred ($500/Copay Plan)	CareFirst of Maryland, Inc.	PPO	Pediatric	★★★★
	BlueCross BlueShield Preferred ($1600/30% Co-Insurance)	CareFirst of Maryland, Inc.	PPO/HSA	Pediatric	★★★★
	BluePreferred PPO HSA Bronze ($4,500/Copay Plan)	CareFirst of Maryland, Inc.	PPO/HSA	Pediatric	★★★★
Cigna Health and Life Insurance Company	Cigna Access Flex Gold ($1,000/15% Co-Insurance)	Cigna Health and Life Insurance Company	PPO	Pediatric	★★★★½
	Cigna Access HSA Silver ($2,750/15% Co-Insurance)	Cigna Health and Life Insurance Company	PPO	Pediatric	★★★★½
	Cigna Access HSA Bronze ($6,000/30% Co-Insurance)	Cigna Health and Life Insurance Company	PPO	Pediatric	★★★★½
CareFirst's GHMSI	BlueCross BlueShield Preferred ($500/Copay Plan)	Group Hospitalization and Medical Services, Inc.	PPO	Pediatric	★★★★
	BlueCross BlueShield Preferred ($1,600/30% Co-Insurance)	Group Hospitalization and Medical Services, Inc.	PPO/HSA	Pediatric	★★★★
	BluePreferred PPO HSA Bronze ($4,500/Copay Plan)	Group Hospitalization and Medical Services, Inc.	PPO/HSA	Pediatric	★★★★
EPO					
All-Savers United-Healthcare	Silver Choice HSA ($3,650/Co-Insurance varies*)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Bronze Choice HSA ($6,350/Co-Insurance varies*)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Gold Choice ($1,500/20% Co-Insurance)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Silver Choice ($2,500/20% Co-Insurance)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Silver Choice ($3,000/20% Co-Insurance)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Silver Choice ($4,400/20% Co-Insurance)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Bronze Choice ($6,350/20% Co-Insurance)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available
	Catastrophic Choice ($6,850/Co-Insurance varies*)	All-Savers Insurance Company	EPO	Pediatric	2014 Quality Data Not Available

Information on Key Reporting Methodologies

Plan Rating Method – HEDIS®

Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool developed by the National Committee for Quality Assurance (NCQA) to gather information on how well health plans provide a standard set of services. The set of services are called HEDIS® measures. Ratings based on the HEDIS® measures help consumers compare health plans' performance on each measure or indicator.

The Maryland Health Care Commission contracted with a licensed HEDIS® audit firm, HealthcareData Company, LLC to audit all of Maryland Health Connection plans based on 2015 HEDIS® measures. The audit reviewed how well each insurance company collected data on its benefit services, and how well each company performed on the measures.

HEDIS® software is used to evaluate each health plan's data. Health plans gather and report on several types of data:

1. Administrative data from patient claims, visits, encounters, and even pharmacy or behavior health encounters
2. Supplemental data from immunization registries, lab results, case management files and medical records
3. Medical record data from paper or electronic medical records

The percentages of data obtained from one data source versus another vary widely among 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. The performance scores presented in this report reflect only measures deemed "Reportable" by the HEDIS® auditor.

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Plan Rating Method – Member Experience And Satisfaction (CAHPS® & HEDIS®)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a set of surveys overseen by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ). These surveys capture patient, health plan member and consumer satisfaction about their healthcare experiences. The Maryland Health Care Commission (MHCC) used *CAHPS® Health Plan Survey 5.0H Adult Version*.

The core of the CAHPS® survey is a set of questions used to measure satisfaction with the experience of care and includes questions that reflect overall satisfaction and multi-question composites that summarize responses in key areas. Respondents are asked to use various scales (e.g., 1–10, Yes/No, or Usually/Always) to rate or evaluate their doctors, specialists, experience with all health care, and their health benefit plan.

MHCC contracted with WBA 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 WBA Research randomly drew from the sample and administered the survey. Survey data collection began in mid-February 2015 and lasted into May 2015. Summary-level data files generated by NCQA were distributed in June 2015 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.

Included in the Member Experience and Satisfaction is one HEDIS® measure reported outside of the CAHPS® survey—Call Answer Timeliness. This measure calculates the percentage of calls received by the organization's member services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds. The rationale for inclusion is that healthcare providers, organization members, and purchasers increasingly recognize the importance of customer service as a factor in patient satisfaction. The collected data provides opportunities for organization comparisons, as well as quality improvement initiatives.

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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 2014 measurement year. They also had to be continuously enrolled in the commercial health benefit plan for at least 11 of the 12 months of 2014, and remain enrolled in the health benefit plan in 2015. 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.

RELICC™

The Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment™, or RELICC™, is a quality and performance measurement tool customized for the State of Maryland by the MidAtlantic Business Group on Health/National Business Coalition on Health. The tool focuses on how plans are working to eliminate health disparities in the State of Maryland by targeting issues surrounding race/ethnicity, language, interpreter need, and cultural competency.

Quality Profile

The Maryland Health Plan Quality Profile is also a Maryland-specific quality tool that offers a summary of current quality improvement initiatives implemented by each carrier. The Maryland initiatives described by carriers focus on a core theme of "understanding and addressing health care disparities." Many of the initiatives include a focus on actions taken by each organization toward implementing progressive programs that respond to improving methods for collecting and reporting RELICC™-related information and promoting continuous quality improvement.

Behavioral Health Assessment

The Maryland Plan Behavioral Health Assessment is another Maryland-specific quality tool that details the plan's behavioral health care provider network. Information provided in the tool includes total members with behavioral health benefits, Maryland counties where plan operates, total behavioral health providers available, accreditation status of behavioral health vendor, and percentage of psychiatrists who are board certified.

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Appendices

Appendix 1 – Example of Scoring Using the HDC 5-Star™ Performance Evaluation System

Code	Measures	Rate %	Stars 1–5	Weight	Value	Notes
	Primary Care and Wellness for Children and Adolescents					
CAP	Children and Adolescent's Access to Primary Care Providers: **STEP 1**					**STEP 2**
	• 12–24 months	96.76%	2	x 0.00903	= 0.01807	
	• 25 months–6 years	91.84%	3	0.00903	0.02710	
	• 7–11 years	92.64%	3	0.00903	0.02710	
	• 12–19 years	89.89%	3	0.00903	0.02710	
	STEP 2a			**Category Total**		0.75877
	Child Respiratory Conditions					
				Category Total		0.36132
	Women's Health					
				Category Total		0.21679
	Primary Care for Adults					
				Category Total		1.12912
	Behavioral Health					
				Category Total		0.22582
	Member Experience and Satisfaction With Health Benefit Plan					
CAT	Call Answer Timeliness	74.75%	2	0.00500	0.01000	
rgnc	Getting Needed Care Composite	84.22%	3	0.00500	0.01500	
rgcq	Getting Care Quickly Composite	82.32%	3	0.00500	0.01500	
rdoc	How Well Doctors Communicate Composite	94.11%	3	0.00500	0.01500	
rsvc	Customer Service Composite	85.85%	3	0.00500	0.01500	
				Category Total		0.28000
	(Special Emphasis Areas: HEDIS Measures) Wellness & Prevention					
				Category Total		0.30712
	(Special Emphasis Areas: HEDIS Measures) Chronic Diseases					
	STEP 2b			**Category Total**		0.32519
	Maryland Plan Behavioral Health Assessment					
	Reported	100.00%	5	0.02450	0.1225	
				Category Total		0.12250
	Maryland Health Plan Quality Profile					
	Reported **STEP 2c**	100.00%	5	0.02450	0.1225	
				Category Total		0.12250
	Qualified Health Plan Focus on Cultural and Ethnic Diversity of Membership (RELICC)					
	Reported	100.00%	5	0.04900	0.245	
				Category Total		0.24500
	STEP 3			**Value Total**		4.09413

Given: 2014 health benefit plan quality and performance data is being used as a "proxy" or close substitute for quality and performance data of similar qualified health plans (QHPs) *and* quality and performance measures and indicators have been weighted to account for their level of importance.

STEP 1: Basic Star Score is based on QHP performance against the national average benchmark—2 stars here

STEP 2: Weighted Star Score is based on multiplying the Basic Star Score by the weight of the measure or indicator—about 0.018 of a star here

STEP 2a: HEDIS® Category Weighted Star Score is based on the sum of the Weighted Star Scores in each of eight HEDIS categories—about 0.758 of a star here…plus 7 more category totals

STEP 2b: CAHPS® Category Weighted Star Score is based on the sum of the Weighted Star Scores in each of five CAHPS categories—about 0.280 of a star here…all category totals (5 shown here)

STEP 2c: Sufficiency Category Weighted Star Score is based on the sufficient completion of the 3 Maryland-specific quality tools—about 0.12, 0.12 & 0.25 of a star here… for the 3 category totals

STEP 3: 5-STAR Rate for each QHP is based on the sum of the Category Weighted Star Scores—about 4.09 stars here

Appendix 2 – Assignment of Weights and Measure Contributions

1. Each HEDIS® measure is assigned a weight of 0.90%. *(Note: Some measures have multiple components; each component is assigned a weight of 0.90%.)*
2. These measures, of which 15% are "Special Emphasis" measures selected in consultation with Maryland state government officials who identified the areas of interest listed below.
3. The percentages by HEDIS® category are:
   - **Primary Care and Wellness for Children and Adolescents** **18%**
   - **Child Respiratory Conditions** **9%**
   - **Women's Health** **5%**
   - **Primary Care and Wellness for Adults** **5%**
   - **Chronic Disease for Adults** **23%**
   - **Behavioral Health** **7%**
   - **"Special Emphasis" on Wellness and Prevention** **7%**
   - **"Special Emphasis" on Chronic Diseases** **8%**
4. The 13 CAHPS® categories and HEDIS® measures in the Member Experience and Satisfaction category account for a total of 8% of the scoring. See complete list of all fourteen CAHPS® categories in Appendix 3.
5. In total, the HEDIS® and CAHPS® measures account for 90% of the total scoring.
6. Performance on the Maryland Health Plan Quality Profile and the Maryland Plan Behavioral Health Assessment account for 2.5% of the total scoring—and the scoring is based on the sufficiency of QHP's completion of the two quality tools.
7. Performances on the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment™ (RELICC™) is assigned a weight of 5% of the total scoring—and this scoring is based on the sufficiency of QHP's submission of a completed RELICC™ assessment evaluation instrument.

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Appendix 3 – Performance Measures Used in Star Rating Scoring

Primary Care and Wellness for Children and Adolescents

- Children and Adolescent's Access to Primary Care Providers
  - *4 Age Groups*
    - 12–24 months
    - 25 months–6 years
    - 7–11 years
    - 12–19 years
- Well Child Visits in the First 15 Months of Life—0 visits with a PCP
- Well Child Visits Age 3, 4, 5, 6 Years of Age
- Childhood Immunization Services—Combo 10
- Adolescent Well Care Visits
- Immunization for Adolescents—Combo 1
- Human Papillomavirus Vaccine for Female Adolescents
- Non-recommended Cervical Cancer Screening in Adolescent Females
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - *3 Indicators—Two age groups per indicator (3–11 years, 12–17 years)*
    - BMI Percentile
    - Counseling for Nutrition
    - Counseling for Physical Activity

Child Respiratory Conditions

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Follow-up Care For Children Prescribed ADHD Medications
  - *2 Indicators*
    - Initiation Phase
    - Continuation Phase
- Use of Appropriate Medications for People with Asthma**

*** Note: Two age groups reported for each measure: 19–50 years and 51–64 years*

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Child Respiratory Conditions continued

- Asthma Medication Ratio**
- Medication Management for People with Asthma (2 rates for each age group—50%, 75%)**

Women's Health

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Prenatal and Postpartum Care—Prenatal Visit
- Prenatal and Postpartum Care—Postpartum Visit

Primary Care and Wellness for Adults

- Adults' Access to Preventive/Ambulatory Health Services
  - *3 Age Groups*
    - 20–44 years
    - 45–64 years
    - 65 years +
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Use of Imaging Services for Low Back Pain
- Adult Body Mass Index Assessment
- Colorectal Cancer Screening
- Annual Monitoring for Patients on Anticonvulsants
- Medical Assistance With Smoking and Tobacco Use Cessation
  - Advising Smokers and Tobacco Users to Quit
  - Discussing Cessation Medications
  - Discussing Cessation Strategies

*** Note: Two age groups reported for each measure: 0–11 years and 12–18 years*

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Chronic Diseases for Adults

Asthma

- Use of Appropriate Medications for People with Asthma**
- Asthma Medication Ratio**
- Medication Management for People with Asthma (2 rates for each age group—50%, 75%)**

Cardiovascular Conditions

- Persistence of Beta Blocker Treatment after Heart Attack
- Annual Monitoring for Patients on
  - Digoxin
  - Angiotensin receptor blockers
  - Diuretics

COPD

- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation

  2 Indicators
  - Corticosteroid
  - Bronchodilator

Diabetes

- Comprehensive Diabetes Care

  7 Indicators
  - Hemoglobin HbA1c testing
  - HbA1c Poor Control > 9
  - HbA1c control < 8
  - HbA1c control < 7 for a selected population
  - Exam Performed
  - Medical Attention for Nephropathy
  - BP Control < 140/90

*** Note: Two age groups reported for each measure: 19–50 years and 51–64 years*

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Chronic Diseases for Adults continued

Hypertension

- Controlling High Blood Pressure

Behavioral Health

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - *4 Indicators*
    - Initiation: Age Groups 13–17 and 18+
    - Engagement: Age Groups 13–17 and 18+
- Antidepressant Medication Management
  - *2 Indicators*
    - 84 days medication coverage
    - 180 days medication coverage
- Follow-up After Hospitalization for Mental Illness
  - *2 Indicators*
    - Follow-up within 7 days of discharge
    - Follow-up within 30 days of discharge

Member Experience & Satisfaction (CAHPS® and HEDIS® Measures)

- Rating of Health Plan
- Customer Service Composite
- Getting Care Quickly Composite
- Getting Needed Care Composite
- How Well Doctors Communicate Composite
- Claims Processing
- Shared Decision Making
- Plan Information on Costs
- Health Promotion and Education
- Coordination of Care
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Call Answer Timeliness
- Aspirin Use and Discussion
- Flu Vaccination for Adults Age 18–64

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Special Emphasis Areas:

Wellness & Prevention—HEDIS® Measures

- Well child visits in the first 15 months of life—0 visits with a PCP
- Well child visits age 3, 4, 5, 6 years of age
- Childhood immunization services—combo 10
- Adolescent well care visits
- Immunization for adolescents—combo 1
- Children and adolescent's access to primary care providers—age group 12 to 19 years
- Adults' access to preventive/ambulatory health services—age group 20 to 44 years
- Percent of members who rated their QHP at 8, 9 or 10 (where 10 is the highest score)

Chronic Diseases—HEDIS® Measures

- Asthma (3 measures—use Total Rate for each measure)
- Cardiovascular Conditions (1 measure)
- COPD (2 measures)
- Diabetes (1 measure)—use HbA1c < 7
- Hypertension (1 measure)

Maryland Specific Performance Measures

- **Qualified Health Plan quality initiatives**
- **Qualified Health Plan focus on cultural and ethnic diversity of membership (RELICC™)**

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