2015

COMPREHENSIVE QUALITY REPORT

Comparing Performance Trends of Maryland's Commercial Health Benefit Plans

MHCC | MARYLAND HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

COMPREHENSIVE QUALITY REPORT 2015

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

Maryland Health Care Commission
Comprehensive Quality Report 2015

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

Letter From the Chair and Executive Director

Dear Fellow Marylanders,

Thank you for helping to make 2015 another remarkable year! Together with your support, the Maryland Health Care Commission (MHCC) continues to increase transparency and improve the overall quality of health benefit plans in Maryland through an expansion of public reporting on quality.

Two decades ago, the State Legislature recognized that for Marylanders to make informed purchasing decisions related to the competing health maintenance organization (HMO) products in the health insurance market, there needed to be an additional source of information beyond the carriers' list of plan benefits and corresponding premiums. As a result, the Maryland Health Care Commission was charged with the responsibility to measure and report on the quality of competing commercial HMO plans, driving Maryland to become the first state to produce a performance report on the quality of health benefit plans. In the ensuing years, other delivery systems were developed, including point of service (POS) plans, preferred provider organization (PPO) plans and exclusive provider organization (EPO) plans. Foreseeing a continued evolution of new delivery systems over time, the Legislature chose to categorize each current and future type of health insurance product as a health benefit plan (HBP), regardless of the type of delivery system.

Today, the annual health benefit plan Comprehensive Quality Report has been designed for use by small businesses to large self-insured employers, employees, individuals, and families when purchasing a health benefit plan. The report allows users to compare the different types of health benefit plans on the basis of quality and value, rather than having to compare health benefit plans on the basis of the price for coverage alone. To ensure the report is widely accessible and responsive to the needs of its diverse users, a web-based navigable Comprehensive Quality Report is currently under way and is scheduled to be rolled out by October 2015, in time for the open enrollment period for the State as well as for many Maryland employers.

The Commissioners and staff remain committed to continuous health care quality improvement through public reporting and to providing Marylanders the breadth and depth of information that they need in order to make more informed choices when selecting a health benefit plan that is right for them. To that end, we hope you find this report helpful and encourage you to forward your suggestions on how we can improve the report to better meet your needs.

Sincerely,

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

Ben Steffen
Executive Director
Maryland Health
Care Commission

CONTENTS

I. GENERAL INFORMATION

Maryland Health Care Commission (MHCC)

Maryland Health Care Commission (MHCC) is a public regulatory agency whose commissioners are appointed by the Governor with the advice and consent of the Maryland Senate. A core function of the Commission is to evaluate and publish findings on the quality and performance of commercial health benefit plans that operate in Maryland. MHCC publishes this Comprehensive Quality Report as an annual comparative report with the cooperation of the health benefit plans. The annual quality report is a source of objective, comprehensive, independently audited information on health benefit plan quality and performance in Maryland. For more information about MHCC and the reports it produces, visit **http://mhcc.dhmh.maryland.gov**. For MHCC contact information, please see the back page of this report.

Reporting on Health Benefit Plan Quality and Performance

Maryland Health Care Commission (MHCC) is committed to promoting improvements in health care by reporting on the quality and performance of health benefit plans operating in the State of Maryland. This year, MHCC continues its long 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, MHCC is legislatively charged with establishing and implementing a system of quality and performance measurement and with disseminating findings to consumers, employees, health benefit plans, and other interested parties. Assessing the performance of Maryland's 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. The availability of consumer-friendly 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 MHCC Comprehensive Quality Report 2015 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 MHCC's Center for Quality Measurement and Reporting

The **Health Benefit Plan Quality and Performance** division is committed to promoting improvements in health care by fulfilling its legislative charge to establish and maintain a Quality and Performance Evaluation System of measurement and reporting for managed care plans operating in the State of Maryland. Health benefit plan disclosure of information using reliable, audited, standardized quality measures and indicators helps consumers and employers evaluate specific areas of interest and overall performance of health benefit plans. The Division is tasked with:

- Management of the Health Benefit Plan Quality and Performance Evaluation System, which uses a variety of quality tools to measure the performance of commercial health benefit plans in the State of Maryland.
- Leading the development and implementation of the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC™) tool that is being used by MHCC and the Maryland Health Benefit Exchange to evaluate and report on commercial health benefit plans' and qualified health plans' initiatives to address disparities.
- Production of comparative public reports, including the Consumer Edition of the Maryland Health Care Commission Quality Report 2015, the Maryland Health Care Commission Comprehensive Quality Report 2015, and the Maryland Health Connection Quality Report 2015, all of which are typically used by employers, individuals and the State Employee Benefits program to assist Marylanders in their choice of a health benefit plan while shopping for health insurance.

The division of **Long Term Care Quality and Performance** focuses on improving long-term and community-based care through collection and report of performance and quality measures for services. An interactive web-based consumer guide is the platform for presenting information about Maryland long term care (LTC) service providers. The *Maryland Guide to Long Term Care Services* provides users an easy way to locate and compare nursing homes, assisted living residences, home health agencies, adult day care, and hospice programs on services offered and quality and performance measures where available.

- LTC quality measures include: results of the Office of Health Care Quality (OHCQ) annual licensing and complaint surveys; staff influenza vaccination rates, results of Experience of Care surveys for nursing homes and home health agencies, and outcome and process measures on various aspects of care.
- Division staff works with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum (NQF) to ensure that the quality measures reported within the *Maryland Guide to LTC Services* are reliable, validated, and suitable for public reporting. This work also follows national trends in LTC quality to keep quality and performance measures in Maryland on the "cutting edge."

The **Hospital Quality and Performance** division is responsible for providing meaningful information to consumers, practitioners, and policymakers about the quality and outcomes of care provided in all Maryland acute care hospitals. The division is responsible for producing the Maryland Health Care Quality Reports, a web-based resource, which contains both general information and specific quality and performance measures. Key priorities of the division include:

- Reporting on the hospital adherence to evidence based standards of care
- Reporting on the patients' assessment of the care provided during their hospital stay
- Reporting on the most common conditions treated in Maryland hospitals, including maternity and newborn care
- Reporting the rates of key hospital acquired infections and related initiatives
- Auditing the data to ensure the accuracy and completeness of the information displayed on the website that hosts the Maryland Health Care Quality Reports
- Reporting on hospital charges for common conditions identified using Diagnosis Related Groups
- Enhancements as part of the Commission's price transparency initiative are underway
- A system for reporting on hospital performance related to specialized cardiac services is under development

The division works closely with the Health Services Cost Review Commission (HSCRC), Maryland's hospital rate setting agency, to support the data requirements associated with the Quality-Based Reimbursement initiative and the Medicare Waiver Project.

I. GENERAL INFORMATION

Acknowledgements

Maryland Health Care Commission would like to extend appreciation and acknowledgement to the following state agencies for their contributions to this annual Quality Report and for helping ensure good availability of information on health benefit plan quality and performance:

- Maryland Department of Legislative Services
- Maryland Department of Planning
- Maryland Health Benefit Exchange
- Maryland Department of Budget and Management

Trademarks

I. GENERAL INFORMATION

About This Report

The MHCC Comprehensive Quality Report 2015 allows Marylanders to compare health benefit plans on key quality measures from seven categories of health benefit plan quality and performance comparisons. These seven categories include 1. Carrier Disparities Initiatives, 2. Primary Care and Wellness for Children and Adolescents, 3. Child Respiratory Conditions, 4. Women's Health, 5. Primary Care for Adults, 6. Behavioral Health, and 7. Member Experience and Satisfaction with Health Benefit Plan. The measure specific quality ratings show a health benefit plan's ability to deliver high-quality care to its members.

All quality data included in this report are collected from health insurance carriers operating in the State of Maryland who meet pre-defined criteria requiring them to report on the performance of their various health benefit plans operating under several types of health care delivery systems. These delivery systems primarily include health maintenance organization (HMO) plans and preferred provider organization (PPO) plans; however, point-of-service (POS) plans, exclusive provider organization (EPO) plans, and other types of health benefit plan 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, performance rates on each measure and indicator are determined for each health benefit plan. Three comparison points are provided for each measure or indicator when available: the Maryland Average Benchmark (MAB), the National Average Benchmark (NAB) and the National Top Performers (NTP) benchmark. A relative rate comparison for the Maryland Average Benchmark is also presented for each measure and indicator through a three-star rating system, with more stars indicating a better performance for the individual health benefit plan. Specifically, health benefit plans that perform significantly better than the Maryland average achieve three stars. Those that perform at a level equivalent to the Maryland average achieve two stars, and those that perform worse achieve only one star.

As you read this report, you may notice some health benefit plans with a Not Applicable or "NA" designation. When the total eligible population for a clinical measure is less than 30 members, or when the total number of responses for a member experience survey measure is fewer than 100 responses, a performance score of NA is assigned because it is impossible to produce a statistically significant rate with such a small amount of member participation. Rarely, a measure may receive a No Benefit or "NB" designation when the health benefit plan does not offer a particular health benefit to members. Additionally, some measures may receive a Not Reportable or "NR" designation when the auditor deems the rate to be biased due to incomplete data. When producing the Maryland Average Benchmark, National Average Benchmark or National Top Performers benchmark, any measure with a NA, NB, or NR assigned designation was not included in the benchmark calculations.

Using the detailed performance information, as well as information on Maryland and National benchmarks, plus the consumer-friendly three-star rating system presented in this report, supports consumers as they make more informed health choices, particularly in the selection of a health benefit plan with the best quality of care specific to their needs. The consumer can select the appropriate category of quality and performance comparisons based on individual criteria and level of importance. For example, a parent 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."

Helpful information on managing chronic conditions and maintaining wellness is also included and can bring multiple benefits, including a longer lifespan, fewer illnesses and an overall improved quality of life. As with all reports, caution needs to be applied in interpreting the performance results, especially when the interpretation of a health benefit plan's quality is based on areas of importance to the reader.

II. HEALTH BENEFIT 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 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).	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.
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

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

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), URAC (formerly known as the Utilization Review and Accreditation Commission) and Accreditation Association of Ambulatory Health Care (AAAHC) all accredit the health benefit plans and managed behavioral healthcare organizations (MBHOs) in this report. Each health benefit plan and MBHO in this report voluntarily obtained one or more types of accreditation through NCQA, URAC or AAAHC.

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/Full: NCQA awards a status of Accredited/Full 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 structures 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.

NCQA MBHO Accreditation

The NCQA Managed Behavioral Healthcare Organization (MBHO) accreditation program is closely aligned with the NCQA health benefit plan accreditation program and has four levels of accreditation: Full, One-Year, Provisional, and Denied. In 2014, MBHO standards were revised for better coordination with physical health and accountability through performance measurement in order to reduce fragmented care, especially for people with special needs, and to support overall quality improvement. 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 and Research (1994). This publication lists a number of illustrative preventive interventions for the various age and population categories.

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 include key quality and performance benchmarks for network management, provider credentialing, utilization management, quality and performance improvement, as well as 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.

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

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 multi-phase 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.

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Health Benefit Plan Accreditation Information (continued)

AAAHC Accreditation

The Accreditation Association for Ambulatory Health Care (AAAHC) health benefit plan accreditation standards outline expectations for health benefit plans that include key areas of member rights, responsibilities, and protection; governance and administration; network adequacy and credentialing; care and case management; quality improvement programs including benchmarking and risk management; clinical record-keeping; health education and promotion; and environment of care and safety. The standards highlight the expectations and requirements and include specific review guidelines that outline how the health benefit plan can ensure its ability to meet the standard.

The survey process includes submission of an application that provides details about the health benefit plan and its lines of business, an on-site evaluation of organizational processes and programs, site visits to selected provider locations determined in conjunction with the health benefit plan to showcase delivery processes, and committee evaluation to determine accreditation status.

Each accreditation survey is tailored to the type, complexity, and range of services offered by the organization seeking accreditation. The five types of accreditation surveys include the following:

Initial Accreditation Surveys: Initial accreditation surveys are conducted for organizations that are not currently accredited by AAAHC.

Re-Accreditation Surveys: Re-accreditation surveys are conducted for organizations that are currently AAAHC-accredited and seek continuation of accreditation.

Interim Surveys: Interim surveys are conducted for organizations that are currently AAAHC-accredited and for which oversight is required to assess ongoing compliance with the accreditation standards. The organization will be informed of the need for an interim survey following review of the Plan For Improvement (PFI).

Random Surveys: To support ongoing AAAHC quality improvement initiatives, an accredited organization may be selected for a random survey from nine to thirty months after an accreditation survey. Organizations are selected to participate in unannounced random surveys on a proportionate basis across settings and geographic areas.

Discretionary Surveys: Discretionary surveys are conducted "for cause," when concerns have been raised about an accredited organization's continued compliance with the standards. An accredited organization may undergo a discretionary survey at any time, without advance notice, and at the discretion of AAAHC.

The length of the on-site visit and the number of surveyors sent to conduct an accreditation survey is based on size of health benefit plan membership, the number of lines of business, and a review of the information provided in the Application for Survey and supporting documents submitted by the organization. Plans meeting all AAAHC accreditation standards will be awarded a three-year accreditation certificate. At any time during this three year period, the accreditation status can be revoked or revised based on the results from an interim, random or discretionary survey that may occur.

Full Accreditation: AAAHC awards a Full Accreditation status for a period of three years to organizations that successfully meet all requirements.

Provisional Accreditation: AAAHC awards a Provisional Accreditation status to any organization that fails to meet all minimum requirements for accreditation. Any organization with a Provisional Accreditation is required to comply with a follow-up survey that includes an additional on-site evaluation. The follow-up survey is required either six months or one year after the initial survey. A PFI may be required from the health benefit plan.

AAAHC MBHO Accreditation

The AAAHC health plan accreditation program provides for accreditation of behavioral health plans and dental health plans through the application of additional specific behavioral health or dental standards and review guidelines. AAAHC's evaluation process evaluates the MBHO's performance based on five levels (fully, substantially, partially, minimally, and non-compliant) and accreditation awards include fully accredited or accredited with a required PFI and follow-up survey. Plans meeting all AAAHC accreditation standards will be awarded a three-year accreditation certificate. At any time during this three year period, the accreditation status can be revoked or revised based on the results from an interim, random or discretionary survey that may occur.

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Performance Summary Against Maryland and National Benchmarks

Quality and Performance Measure Summaries

The table below provides a summary of clinical performance measures and indicators, as well as an account of how many of the Maryland health benefit plans had quality and performance scores equivalent to or better than the Maryland average, performance scores at or better than the National average, and performance scores at or better than the top ten percent nationally. 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 seven HMOs and authorized HMO combinations such as HMO/POS plan combinations and eight 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 (e.g., <30 members, or <100 survey respondents) to calculate a rate; **NB**, indicating No Benefit offered by the health benefit plan; or **NR**, indicating Not Reportable performance results due to bias in the data; then the NA, NB and NR performance results 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 5th, 10th, 25th, 50th, 75th, 90th, and 95th 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 2014.

National Top Performers (NTP) Benchmark: The National Top Performers benchmark represents one of the highest performance levels that can be achieved by health benefit plans. When all of the performance scores reported to NCQA for a particular measure are compared, the NTP marks the bar where eighty-nine percent of the health benefit plans had a lower score and ten percent had a higher score. The NTP is different from the MAB and NAB, which are averages calculated from all reported performance scores. The NTP represents a specific placeholder of all scores reported when they are sorted from lower to higher performance score. It serves as a clear indication and comparison of the health benefit plan's performance in comparison to peers reporting the same product without regard to size of health benefit plan or geographic service area. A health benefit plan is to be applauded if they meet or exceed the NTP benchmark.

Note: Due to NCQA licensing restrictions, the numeric NAB and NTP percentile is not displayed but represented by a line in each of the report's graphs.

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Carrier Information and Provider Network						
Carrier Information and Provider Network Information	No Maryland or National Benchmark Comparisons					

continued

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Performance Summary Against Maryland and National Benchmarks (continued)

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Health Care Disparities						
Member Information Sources, page 48	6	6	6	6	2	3
Information on Physicians, Physician Office Staff, and Plan Personnel, page 49	3	4	2	3	0	0
Using the Data, page 50	6	7	6	7	2	3
Supporting the Needs of Members With Limited English Proficiency, page 51	6	3	2	2	1	1
Assuring That Culturally Competent Health Care is Delivered, page 52	6	5	6	7	1	2
Evaluating and Measuring the Impact of Language Assistance, page 53	4	4	1	2	1	2
Information Available Through the Online Provider Directory, page 54	6	7	6	7	0	0
Interactive Selection Features for Members Selecting a Physician Online, page 55	5	4	7	8	0	0
Health Assessment Programming, page 56	3	3	7	8	3	3
Primary Care and Wellness for Children and Adolescents						
Children and Adolescents Access to Primary Care Providers (12 to 24 months), page 58	5	4	2	4	1	0
Children and Adolescents Access to Primary Care Providers (25 months to 6 years), page 59	6	4	6	7	0	0
Children and Adolescents Access to Primary Care Providers (7 to 11 years), page 60	6	6	7	8	0	1
Children and Adolescents Access to Primary Care Providers (12 to 19 years), page 61	5	5	5	8	0	0
Well-Child Visits in the First 15 Months of Life (0 visits), page 62	5	4	5	6	1	0
Well-Child Visits in the First 15 Months of Life (6+ visits), page 63	5	5	5	5	1	1
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, page 65	6	5	7	7	0	0
Childhood Immunization Status (10 Required Immunizations), page 66	6	6	5	6	2	1
Adolescent Well-Care Visits (1+ Visits), page 67	5	5	7	8	0	0
Immunizations for Adolescents (2 Required Immunizations), page 68	6	5	6	6	1	0
Human Papillomavirus Vaccine for Female Adolescents, page 69	6	5	2	0	2	0

continued

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Performance Summary Against Maryland and National Benchmarks (continued)

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Primary Care and Wellness for Children and Adolescents continued						
Non-Recommended Cervical Cancer Screening in Adolescent Females, page 70	5	4	4	7	1	1
Weight Assessment and Counseling For Nutrition and Physical Activity for Children and Adolescents (Body Mass Index), page 71	6	7	3	7	1	2
Weight Assessment and Counseling For Nutrition and Physical Activity for Children and Adolescents (Nutrition), page 72	6	7	6	7	1	2
Weight Assessment and Counseling For Nutrition and Physical Activity for Children and Adolescents (Physical Activity), page 73	6	7	6	7	1	3
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase), page 74	5	3	1	2	1	0
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase), page 75	3	3	2	1	0	1
Child Respiratory Conditions						
Appropriate Testing for Children With Pharyngitis, page 77	6	5	7	8	2	8
Appropriate Treatment for Children With Upper Respiratory Infection, page 78	6	5	6	7	1	0
Use of Appropriate Medications for Children With Asthma (5 to 11 years), page 79	3	4	0	1	0	0
Use of Appropriate Medications for Children With Asthma (12 to 18 years), page 80	3	4	3	3	0	0
Asthma Controller Medication Ratio Among Children ≥50% (5 to 11 years), page 81	3	3	1	1	0	0
Asthma Controller Medication Ratio Among Children ≥50% (12 to 18 years), page 82	3	4	2	3	0	0
Medication Management for Children With Asthma (5 to 11 years, 50% treatment period compliance), page 83	3	3	3	3	0	0
Medication Management for Children With Asthma (12 to 18 years, 50% treatment period compliance), page 84	3	3	2	3	0	1
Medication Management for Children With Asthma (5 to 11 years, 75% treatment period compliance), page 85	3	3	3	3	0	0
Medication Management for Children With Asthma (12 to 18 years, 75% treatment period compliance), page 86	3	2	2	2	0	0

continued

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Performance Summary Against Maryland and National Benchmarks (continued)

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Women's Health						
Prenatal Care, page 88	6	5	1	5	0	0
Postpartum Care, page 89	6	5	1	4	0	0
Breast Cancer Screening (52 to 74 years), page 90	6	5	1	6	1	0
Cervical Cancer Screening (21 to 64 years), page 91	6	5	2	5	1	3
Chlamydia Screening (16 to 24 years), page 92	6	6	6	7	1	0
Primary Care for Adults – *General Health*						
Adult's Access to Preventive/Ambulatory Health Services (20 to 44 years), page 94	5	7	2	4	0	1
Adult's Access to Preventive/Ambulatory Health Services (45 to 64 years), page 95	6	7	2	7	0	0
Adult's Access to Preventive/Ambulatory Health Services (65+ years), page 96	6	6	4	5	0	1
Adult Body Mass Index (BMI) Assessment, page 97	6	6	1	6	1	0
Colorectal Cancer Screening, page 98	5	6	3	6	2	0
Primary Care for Adults – *Respiratory Conditions*						
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, page 100	7	4	1	2	1	0
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease, page 101	4	5	3	5	1	1
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Systemic Corticosteroid), page 102	4	3	4	1	0	0
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator), page 103	4	3	2	1	1	1
Use of Appropriate Medications for Adults With Asthma (19 to 50 years), page 104	4	3	2	4	1	3
Use of Appropriate Medications for Adults With Asthma (51 to 64 years), page 105	4	4	2	5	1	3
Asthma Controller Medication Ratio Among Adults ≥50% (19 to 50 years), page 106	4	4	2	4	0	2

continued

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Primary Care for Adults – *Respiratory Conditions* continued						
Asthma Controller Medication Ratio Among Adults ≥50% (51 to 64 years), page 107	3	3	0	5	0	1
Medication Management for Adults With Asthma (19 to 50 years, 50% treatment period compliance), page 108	3	3	3	3	0	0
Medication Management for Adults With Asthma (51 to 64 years, 50% treatment period compliance), page 109	4	3	1	3	0	1
Medication Management for Adults With Asthma (19 to 50 years, 75% treatment period compliance), page 110	4	3	3	3	0	0
Medication Management for Adults With Asthma (51 to 64 years, 75% treatment period compliance), page 111	4	3	3	3	0	1
Primary Care for Adults – *Cardiovascular Conditions and Diabetes*						
Controlling High Blood Pressure, page 113	6	4	2	4	1	2
Persistence of Beta-Blocker Treatment After a Heart Attack, page 114	3	3	3	5	0	0
Comprehensive Diabetes Care (HbA1c Testing), page 115	5	7	1	2	1	0
Comprehensive Diabetes Care (Poor HbA1c Control >9.0%), page 116	5	6	2	6	0	0
Comprehensive Diabetes Care (Good HbA1c Control <8.0%), page 117	6	6	2	6	0	0
Comprehensive Diabetes Care (Tight HbA1c Control <7.0%), page 118	5	6	0	6	0	0
Comprehensive Diabetes Care (Dilated Eye Exam – Retina), page 119	4	5	3	8	1	1
Comprehensive Diabetes Care (Medical Attention for Nephropathy), page 120	6	6	2	7	1	2
Comprehensive Diabetes Care (Good BP Control <140/90 mm Hg), page 121	6	4	1	4	1	0

continued

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Performance Summary Against Maryland and National Benchmarks (continued)

Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Primary Care for Adults – *Musculoskeletal Disease and Medication Management*						
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis, page 123	4	3	1	2	0	0
Use of Imaging Studies for Low Back Pain, page 124	6	5	3	1	0	0
Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs), page 125	5	7	3	7	1	1
Annual Monitoring for Patients on Persistent Mediations (Digoxin), page 126	4	4	1	0	0	0
Annual Monitoring for Patients on Persistent Medications (Diuretics), page 127	5	6	3	5	0	1
Behavioral Health						
Antidepressant Medication Management (Effective Acute Phase), page 129	5	5	7	7	1	1
Antidepressant Medication Management (Effective Continuation Phase), page 130	6	4	6	7	0	1
Follow-Up After Hospitalization for Mental Illness (7 days), page 131	4	3	2	5	0	0
Follow-Up After Hospitalization for Mental Illness (30 days), page 132	4	3	3	4	0	0
Initiation of Alcohol and Other Drug Dependence Treatment (13 to 17 years), page 133	3	3	2	1	0	0
Initiation of Alcohol and Other Drug Dependence Treatment (18+ years), page 134	6	4	0	2	0	0
Engagement of Alcohol and Other Drug Dependence Treatment (13 to 17 years), page 135	3	4	1	2	0	1
Engagement of Alcohol and Other Drug Dependence Treatment (18+ years), page 136	6	4	2	4	0	2

continued

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Performance Summary Against Maryland and National Benchmarks (continued)

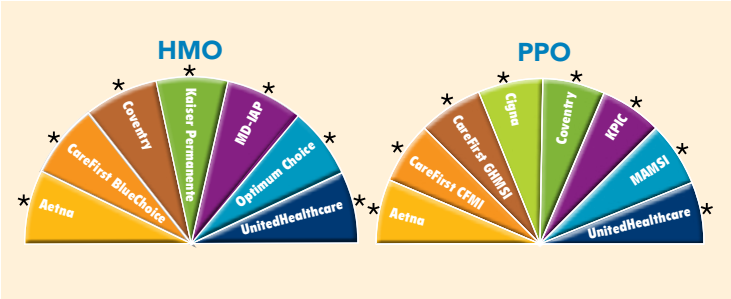
Measures and Indicators	Number of Health Benefit Plans Scoring Equivalent To or Better Than the Maryland Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the National Average (7-HMO/8-PPO)		Number of Health Benefit Plans Scoring At or Better Than the Top 10% Nationally (7-HMO/8-PPPO)	
	HMO	PPO	HMO	PPO	HMO	PPO
Member Experience and Satisfaction With Health Benefit Plan						
Aspirin Discussion, page 138	4	6	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Flu Vaccinations for Adults (18 to 64 years), page 139	5	5	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Call Answer Timeliness, page 140	6	6	5	4	0	3
Getting Needed Care, page 141	5	5	1	2	0	0
Getting Care Quickly, page 142	6	5	1	0	0	0
How Well Doctors Communicate, page 143	6	7	0	2	0	1
Customer Service, page 144	3	NA	0	0	0	0
Claims Processing, page 145	4	4	1	3	0	1
Shared Decision-Making, page 146	3	3	No Benchmark*	No Benchmark*	No Benchmark*	No Benchmark*
Plan Information on Costs, page 147	5	3	2	3	0	1
Health Promotion and Education, page 148	5	6	3	6	1	1
Coordination of Care, page 149	5	4	1	3	0	0
Rating of All Health Care (Good Overall), page 150	5	5	1	5	0	0
Rating of Personal Doctor (Good Overall), page 151	5	5	2	2	0	0
Rating of Specialist Seen Most Often (Good Overall), page 152	4	4	1	2	0	0
Rating of Health Benefit Plan (Good Overall), page 153	4	5	2	5	0	3

No Benchmark* – No national benchmark available due to significant specification changes for this measure

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Understanding the Dashboard Displays (on Pages 17-22)

The dashboards included in this section contain displays that resemble a multi-colored radius for HMO and PPO health benefit plan categories. Each radius 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 III, Health Benefit Plan Quality and Performance Comparisons. Page numbers are referenced at the bottom of each dashboard display. When interpreting the displays, the reader should pay attention to the health plan benefit plans listed on the radius in color with an asterisk, which indicates performance at or better than the National Average Benchmark. There are a total of seven HMOs and authorized HMO combination health benefit plans, as well as eight PPOs and authorized PPO combination health benefit plans. Below is a display that depicts what a dashboard would look like if all health benefit plans are performing at or better than the National Average Benchmark.



Understanding the Graphic Data Displays (on Pages 48-153)

Contained in this report are graphs that track the health benefit plans' 2015 performance on each quality measure. Along with individual plan performance rates, each graph depicts Maryland and National benchmarks, plus relative performance rates that use a three-star rating system. A legend is also included on each graph (see example below). The health benefit plan quality and performance information will assist consumers in making informed choices, particularly in the selection of a health benefit plan that could provide care specific to their needs. For example, a parent may be more concerned with plan performance in the category of Primary Care and Wellness for Children and Adolescents. A single consumer may focus on other areas of importance to their continued health and wellbeing, such as Women's Health, or Primary Care for Adults - Cardiovascular Conditions and Diabetes. If the consumer is interested in plan performance over time on a particular measure or measures, Appendix B of this report contains up to three years of performance data as a reference.

PERFORMANCE RATING

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

More stars indicate better health benefit plan performance.

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

NR – Performance results are **not reported** due to bias in the data from the health benefit plan

NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Excellent Performance Areas

Maryland's health benefit plans are maintaining a track record of good performance across many of the measures and indicators being evaluated. However, out of the five categories of clinical performance measures and indicators [1) Primary Care and Wellness for Children and Adolescents, 2) Child Respiratory Conditions, 3) Women's Health, 4) Primary Care for Adults, and 5) Behavioral Health], Maryland's health benefit plans demonstrate excellent performance on several measures within four categories:

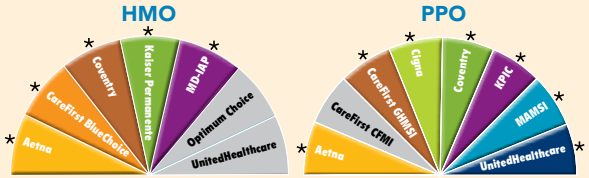
1. In the category **Primary Care and Wellness for Children and Adolescents**, the results show that health benefit plans are maintaining a focus on services to children and adolescents. Children 25 months to 11 years of age have good access to primary care providers. In addition, children 3 to 6 years of age, as well as adolescents and young adults 12 to 21 years of age, receive at least one well-child visit each year. The results also show that the majority of plans ensure children and adolescents receive appropriate counseling for nutrition and physical activity.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Maryland Health Benefit Plans Performing At or Better Than the National Average Benchmark (Displayed in color, with asterisk).

Primary Care and Wellness for Children and Adolescents

Children and Adolescents Access to Primary Care Providers (25 months to 6 years)



Children aged 25 months to 6 years in 2014 who had a visit with a primary care provider during 2014

See details on page 62

Adolescent Well-Care Visits (1+ Visits)

Adolescents and young adults aged 12 to 21 years in 2014 who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist (OB/GYN) during 2014

See details on page 67

Children and Adolescents Access to Primary Care Providers (7 to 11 years)

Children aged 7 to 11 years in 2014 who had a visit with a primary care provider during 2014 or 2013

See details on page 68

Counseling for Nutrition

Children and adolescents aged 3 to 17 years in 2014 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose counseling for nutrition was documented in 2014

See details on page 72

Well-Child Visits In 3, 4, 5, 6 Years of Life (1+ Visits)

Children aged 3 to 6 years in 2014 who received one or more well-child visits with a primary care provider during 2014

See details on page 65

Counseling for Physical Activity

Children and adolescents aged 3 to 17 years in 2014 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose counseling for physical activity was documented in 2014

See details on page 73

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Excellent Performance Areas (continued)

2. In the category **Child Respiratory Conditions**, the results show that health benefit plans are appropriately using strep testing to diagnose and treat children with pharyngitis and are not inappropriately prescribing antibiotics for upper respiratory infections which are typically not bacterial in nature.
3. In the category **Women's Health**, the results show that the majority of the health benefit plans are appropriately screening women for chlamydia infection which can lead to infertility if left untreated.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Maryland Health Benefit Plans Performing At or Better Than the National Average Benchmark (Displayed in color, with asterisk).

Child Respiratory Conditions

Appropriate Testing for Children With Pharyngitis

Children and adolescents aged 2 to 18 years in 2014 who received a group-A streptococces (strep) test before being diagnosed with pharyngitis and then being given an appropriate prescription for an antibiotic during 2014

See details on page 77

Appropriate Treatment for Children With Upper Respiratory Infection

Infants, children, and adolescents aged 3 months to 18 years in 2014 who were given a diagnosis of upper respiratory infection, and were appropriately not given an antibiotic prescription within 3 days of their visit

See details on page 78

Women's Health

Chlamydia Screening

Women aged 16 to 24 years in 2014 who were identified as sexually active and who had a least one test for chlamydia during 2014

See details on page 92

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Excellent Performance Areas (continued)

4. In the category **Behavioral Health**, the results show that health benefit plans are doing more to ensure that adults, age 18 and older who are diagnosed with depression are appropriately prescribed antidepressant medications for at least 12 weeks and, where required, continued on the medication for at least 6 months.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Maryland Health Benefit Plans Performing At or Better Than the National Average Benchmark (Displayed in color, with asterisk).

Behavioral Health

Antidepressant Medication Management (Effective Acute Phase)

Adults aged 18 years and over in 2014 with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 12 weeks

See details on page 129

Antidepressant Medication Management (Effective Continuation Phase)

Adults aged 18 years and over in 2014 with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 6 months

See details on page 130

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Areas That Need Improvement

Overall, the health benefit plans continue to perform well when compared to the national average. However, there are several items within four out of the five categories of clinical performance measures and indicators [1) Primary Care and Wellness for Children and Adolescents, 2) Child Respiratory Conditions, 3) Women's Health, 4) Primary Care for Adults, and 5) Behavioral Health], where Maryland's health benefit plans demonstrate poor performance and improvement is needed on several measures within four categories.

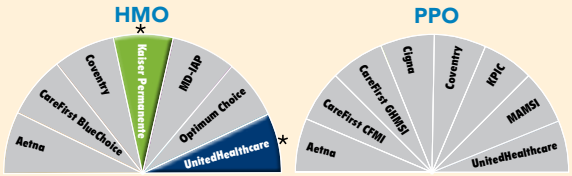
1. In the category **Primary Care and Wellness for Children and Adolescents**, the results show that health benefit plans need to focus more on conducting human papillomavirus vaccination for female adolescents and on providing appropriate follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication.
2. In the category **Child Respiratory Conditions**, the results show that health benefit plans need to improve care for children with asthma, particularly with regard to asthma medications and treatment compliance.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Maryland Health Benefit Plans Performing At or Better Than the National Average Benchmark (Displayed in color, with asterisk).

Primary Care and Wellness for Children and Adolescents

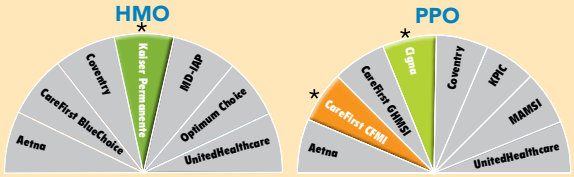
Human Papillomavirus Vaccine for Female Adolescents



Female adolescents, who turned 13 years of age during 2014 and who had three doses of the human papillomavirus (HPV) vaccine by their thirteenth birthday

See details on page 69

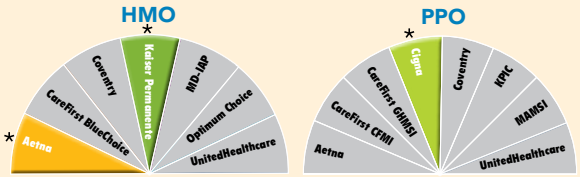
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)



Children aged 6 to 12 years that were newly prescribed ADHD medication who also had one follow-up visit during the initial 30 days of when the first ADHD medication was prescribed

See details on page 74

Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase)

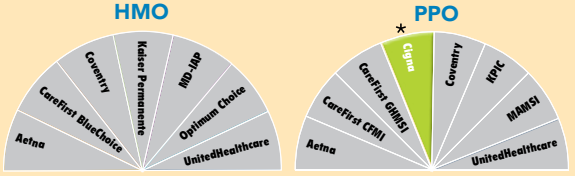


Children aged 6 to 12 years that were newly prescribed ADHD medication, who remained on the medication for at least a seven month period and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits within 9 months after the 30-day Initiation Phase ended

See details on page 75

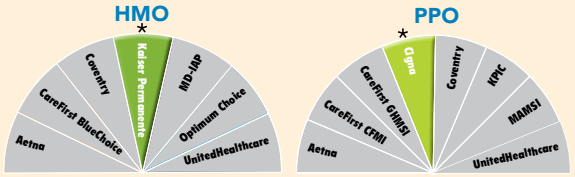
Child Respiratory Conditions

Use of Appropriate Medications for Children With Asthma (5 to 11 years)



Children aged 5 to 11 years in 2014 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/rescue medication during 2014 *See details on page 79*

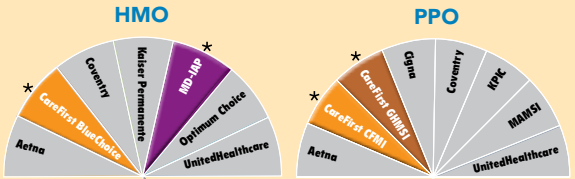
Asthma Controller Medication Ratio Among Children ≥50% (5 to 11 years)



Children aged 5 to 11 years in 2014 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during 2014

See details on page 81

Medication Management for Children With Asthma (12 to 18 years, 75% treatment compliance)



Adolescents aged 12 to 18 years in 2014 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 percent of the remaining days in 2014 *See details on page 86*

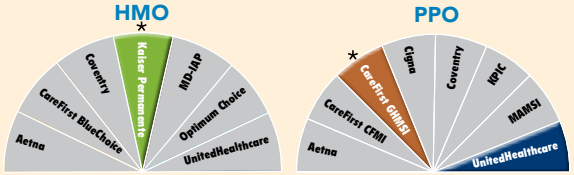
3. In the category **Primary Care for Adults**, the results show that health benefit plans have room to improve on specific measures related to respiratory conditions, cardiovascular conditions and diabetes, as well as musculoskeletal disease and medication management. Central to the management of members with diabetes, health benefit plans not only need to closely monitor blood sugar levels through HbA1c testing but they also need to achieve good blood pressure control among members with diabetes.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Maryland Health Benefit Plans Performing At or Better Than the National Average Benchmark (Displayed in color, with asterisk).

Primary Care for Adults–Respiratory Conditions

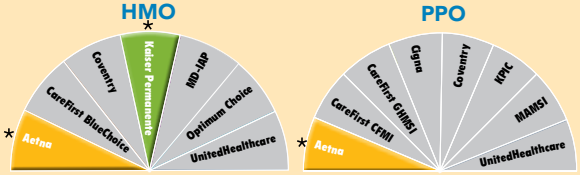
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



Adults aged 18 to 64 years in 2014 with a diagnosis of acute bronchitis who were appropriately not given an antibiotic prescription unless needed

See details on page 100

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator)

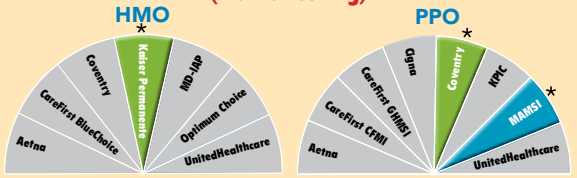


Adults aged 40 years and over in 2014 who had an acute inpatient discharge or emergency department encounter for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation on or between January 1st and November 30th, 2014, and who were given a prescription for a bronchodilator within 30 days of the COPD event

See details on page 103

Primary Care for Adults–Cardiovascular Conditions and Diabetes

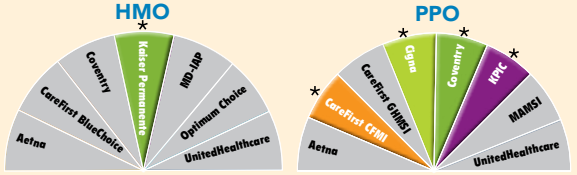
Comprehensive Diabetes Care (HbA1c Testing)



Adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had an HbA1c test during 2014

See details on page 115

Comprehensive Diabetes Care (Good BP Control <140/90 mm Hg)



Adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had their blood pressure assessed and demonstrated good blood pressure control <140/90 mm Hg, during 2014

See details on page 121

II. HEALTH BENEFIT PLAN INFORMATION AND OVERVIEW

Areas That Need Improvement (continued)

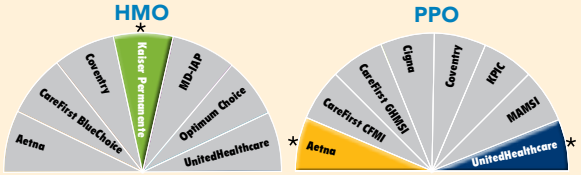
4. In the category Behavioral Health, the results show that health benefit plans must do better to meet the needs of adolescent and adult members requiring treatment for alcohol and other drug dependence.

NOTE: Maximum score is 7 for the HMOs and authorized HMO combination health benefit plans and 8 for the PPOs and authorized PPO combination health benefit plans.

Maryland Health Benefit Plans Performing At or Better Than the National Average Benchmark (Displayed in color, with asterisk).

Primary Care for Adults–Musculoskeletal Disease and Medication Management

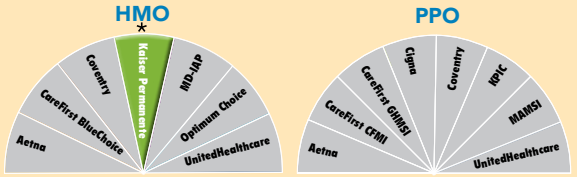
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis



Adults aged 18 years and over in 2014 who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one Disease Modifying anti-Rheumatic Drug (DMARD) in 2014. DMARDs are medications proven effective in slowing or preventing joint damage as opposed to just relieving pain and inflammation.

See details on page 123

Annual Monitoring for Patients on Persistent Medications (Digoxin)

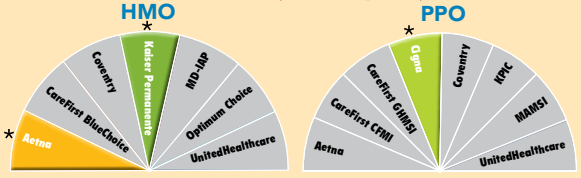


Adults aged 18 years and over in 2014 who received at least 180 treatment days of ambulatory medication therapy with digoxin during 2014 and had at least one therapeutic monitoring event for the digoxin agent in 2014

See details on page 126

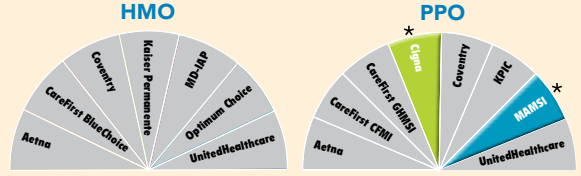
Behavioral Health

Initiation of Alcohol and Other Drug Dependence Treatment (13 to 17 years)



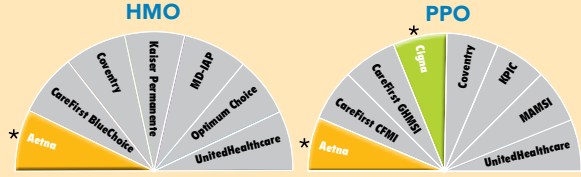
Adolescents aged 13 to 17 years in 2014 with a new episode of Alcohol and Other Drug (AOD) dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis *See details on page 133*

Initiation of Alcohol and Other Drug Dependence Treatment (18+ years)



Adults aged 18 years and over in 2014 with a new episode of Alcohol and Other Drug (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 *See details on page 134*

Engagement of Alcohol and Other Drug Dependence Treatment (13 to 17 years)



Adolescents aged 13 to 17 years in 2014 with a new episode of Alcohol and Other Drug (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 *See details on page 135*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network

Several major commercial health insurance carriers operating in Maryland are required to annually report on their health benefit plans' quality and performance results to the Maryland Health Care Commission. For reporting purposes, all plans fall into one of two categories, either Health Maintenance Organization (HMO) plans or Preferred Provider Organization (PPO) plans. Also, a carrier with multiple health benefit plans may be authorized to combine their plan reporting depending on how the plan is licensed and structured, and how services are delivered to members. These plans may be structured according to any of a number of delivery systems, not only HMO and PPO, but also Point of Service (POS) plans, Exclusive Provider Organization (EPO) plans, or other plans offered through any other type of delivery system. Following is a list of Maryland's reporting plans with the delivery systems they are authorized to combine:

Health Maintenance Organizations (HMOs)

- Aetna (HMO/POS)
- CareFirst BlueChoice (HMO/POS)
- Coventry (HMO/POS)
- Kaiser Permanente (HMO/POS)
- MD-IPA (HMO/POS)
- Optimum Choice (HMO/POS)
- UnitedHealthcare (HMO)

Preferred Provider Organizations (PPOs)

- Aetna (PPO/EPO)
- CareFirst CFMI (PPO/EPO)
- CareFirst GHMSI (PPO)
- Cigna (PPO/POS)
- Coventry (PPO)
- KPIC (PPO)
- MAMSI (PPO)
- UnitedHealthcare (PPO/POS/EPO)

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network

aetna

PLAN OVERVIEW	
Plan Name	HMO: Aetna (HMO/POS Combined) PPO: Aetna (PPO/EPO Combined)
Legal Name	HMO: Aetna Health, Inc. (Pennsylvania) – Maryland PPO: Aetna Life Insurance Company (MD/DC)
MHBO Name	Aetna Behavioral Health Pennsylvania
Contact Information	1-800-US-AETNA (1-800-872-3862) 7 days a week, 7:00 am–7:00 pm **www.aetna.com**
Tax Status and Ownership	Aetna HMO is a for-profit HMO with POS Aetna PPO is a for-profit PPO and EPO
Accreditation Status	HMO: "Accredited" NCQA Accreditation (exp. 2015) PPO: "Accredited" NCQA Accreditation (exp. 2017) HMO & PPO: "Full" NCQA MBHO Accreditation (exp. 2016)
Wellness Quality Initiatives	Check out Aetna's "Healthier Living Resources" under the "Individuals & Families" tab. **www.aetna.com**

TOTAL BEHAVIORAL HEALTH CARE PROVIDERS (MARYLAND)	Aetna (HMO)	Aetna (PPO)
Psychiatrists	623	637
Physicians, Certified in Addiction Medicine	3	2
Psychologists	459	461
Social Workers	1,420	1,447
Licensed Social Work Associates	0	0
Nurse Psycho-therapists	123	130
Nurse Practitioners	0	0
Registered Nurses	0	0
Licensed Therapists and Counselors	861	912
Alcohol and Drug Counselors	31	32
TOTAL BEHAVIORAL HEALTH CARE PROVIDERS	**3,520**	**3,621**

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

aetna

Aetna: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Aetna – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	1	100%	13	69%	4	100%	3	67%	2	100%	4	100%	54	83%	5	0%
Anne Arundel	470	83%	613	73%	172	99%	258	90%	8	88%	46	83%	3,104	82%	440	0%
Baltimore	636	87%	1,497	76%	300	100%	257	88%	49	84%	219	80%	8,300	80%	820	0%
Baltimore City	354	89%	1,896	74%	405	99%	646	83%	54	63%	291	76%	8,419	75%	381	0%
Calvert	21	67%	76	70%	18	100%	17	82%	1	100%	9	89%	673	84%	86	0%
Caroline	6	100%	0	0%	0	0%	0	0%	0	0%	0	0%	24	88%	1	0%
Carroll	73	93%	88	48%	48	96%	41	85%	2	50%	28	68%	1,422	81%	203	0%
Cecil	48	77%	25	84%	23	100%	21	86%	0	0%	10	70%	146	68%	81	0%
Charles	93	83%	104	66%	18	100%	47	72%	1	100%	3	67%	553	80%	69	0%
Dorchester	1	100%	3	100%	4	100%	3	100%	0	0%	9	100%	43	70%	8	0%
Frederick	106	91%	99	65%	64	89%	161	95%	2	100%	41	83%	1,018	77%	180	0%
Garrett	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	16	88%	1	0%
Harford	165	84%	218	74%	48	100%	92	84%	2	100%	25	92%	1,907	80%	247	0%
Howard	109	86%	308	69%	100	99%	91	87%	7	71%	68	87%	1,707	76%	325	0%
Kent	3	100%	17	88%	5	100%	2	100%	0	0%	0	0%	274	82%	13	0%
Montgomery	295	78%	750	74%	432	97%	358	89%	7	86%	107	85%	3,809	81%	561	0%
Prince George's	192	65%	587	69%	213	98%	193	80%	8	100%	48	69%	2,561	78%	335	0%
Queen Anne's	17	94%	12	50%	15	100%	22	100%	0	0%	5	80%	183	85%	45	0%
Saint Mary's	33	70%	77	86%	8	100%	38	92%	0	0%	9	78%	238	82%	43	0%
Somerset	0	0%	1	100%	9	100%	4	100%	0	0%	2	50%	10	70%	18	0%
Talbot	19	100%	30	87%	10	90%	15	100%	0	0%	6	83%	206	79%	41	0%
Washington	56	84%	86	66%	19	100%	47	83%	0	0%	36	83%	454	79%	143	0%
Wicomico	8	88%	54	76%	30	100%	33	85%	0	0%	16	50%	269	78%	94	0%
Worcester	6	100%	35	54%	0	0%	0	0%	1	100%	2	100%	99	77%	6	0%
TOTAL	**2,712**		**6,589**		**1,945**		**2,349**		**144**		**984**		**35,489**		**4,146**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

aetna

Aetna: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Aetna – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	16	50%	50	74%	13	100%	16	75%	3	100%	9	67%	150	79%	50	0%
Anne Arundel	483	83%	621	72%	176	99%	262	89%	10	80%	47	83%	3,093	82%	436	0%
Baltimore	646	87%	1,495	76%	302	100%	258	89%	53	85%	219	81%	8,193	81%	816	0%
Baltimore City	354	89%	1,909	74%	407	100%	658	82%	58	62%	293	76%	8,477	75%	382	0%
Calvert	24	71%	76	70%	18	100%	17	82%	1	100%	9	78%	668	84%	86	0%
Caroline	18	72%	2	100%	1	100%	1	100%	0	0%	0	0%	26	88%	2	0%
Carroll	74	93%	87	49%	46	100%	41	85%	2	50%	27	67%	1,383	81%	206	0%
Cecil	48	77%	24	83%	24	100%	21	86%	0	0%	10	70%	149	68%	81	0%
Charles	95	83%	110	68%	20	100%	47	72%	1	100%	3	67%	554	80%	72	0%
Dorchester	10	90%	13	54%	6	100%	4	100%	0	0%	11	100%	69	72%	20	0%
Frederick	109	89%	108	68%	63	94%	160	96%	2	100%	42	81%	1,036	76%	180	0%
Garrett	19	84%	4	100%	0	0%	0	0%	2	0%	1	0%	35	86%	5	0%
Harford	170	85%	222	74%	48	100%	96	84%	2	100%	24	92%	1,893	80%	244	0%
Howard	110	86%	301	71%	99	100%	91	88%	9	67%	62	87%	1,705	76%	315	0%
Kent	3	100%	19	89%	6	100%	2	100%	1	0%	0	0%	273	81%	13	0%
Montgomery	306	79%	777	75%	449	98%	392	89%	9	67%	106	84%	4,069	80%	564	0%
Prince George's	198	66%	609	70%	223	99%	194	80%	13	54%	49	69%	2,690	78%	334	0%
Queen Anne's	17	94%	11	45%	15	100%	22	100%	0	0%	5	80%	189	84%	45	0%
Saint Mary's	32	72%	79	85%	8	100%	38	92%	0	0%	8	63%	246	79%	43	0%
Somerset	1	100%	4	75%	9	100%	6	83%	0	0%	2	50%	13	77%	22	0%
Talbot	25	96%	29	86%	10	100%	15	100%	0	0%	6	83%	215	78%	40	0%
Washington	58	84%	88	67%	19	100%	49	84%	0	0%	38	84%	457	79%	143	0%
Wicomico	8	88%	56	75%	30	100%	36	86%	0	0%	16	50%	277	78%	93	0%
Worcester	33	94%	42	69%	4	100%	2	0%	1	100%	3	67%	118	77%	28	0%
TOTAL	**2,857**		**6,736**		**1,996**		**2,428**		**167**		**990**		**35,978**		**4,220**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

CareFirst

PLAN OVERVIEW	
Plan Name	HMO: CareFirst BlueChoice (HMO/POS Combined) PPO: CareFirst CFMI (PPO/EPO Combined) PPO: CareFirst GHMSI (PPO)
Legal Name	HMO: CareFirst BlueChoice, Inc. PPO: CareFirst of Maryland, Inc. PPO: Group Hospitalization and Medical Services, Inc.
MHBO Name	HMO: Magellan Healthcare, Inc. PPOs: Magellan Tristate Care Management Center
Contact Information	1-888-432-4380 7 days a week, 7:00 am–7:00 pm **www.carefirst.com**
Tax Status and Ownership	HMO: CareFirst BlueChoice is a for-profit HMO PPO: CareFirst CFMI is a non-profit PPO with EPO PPO: CareFirst GHMSI is a non-profit PPO
Accreditation Status	HMO: "Accredited" NCQA Accreditation (exp. 2016) PPO: "Commendable" NCQA Accreditation (exp. 2016) HMO & PPOs: "Full" NCQA MBHO Accreditation (exp. 2016) HMO & PPOs: "Full" URAC Health Utilization Management and Case Management Accreditation (exp. 2016)
Wellness Quality Initiatives	Check out CareFirst's "Health and Wellness" information under the "individuals" tab. **www.carefirst.com**

TOTAL BEHAVIORAL HEALTH CARE PROVIDERS (MARYLAND)	BlueChoice (HMO)	CFMI (PPO)	GHMSI (PPO)
Psychiatrists	507	656	656
Physicians, Certified in Addiction Medicine	2	0	0
Psychologists	463	731	731
Social Workers	1,489	1,902	1,902
Licensed Social Work Associates	0	0	0
Nurse Psycho-therapists	36	94	94
Nurse Practitioners	1,875	1,585	1,585
Registered Nurses	49	0	0
Licensed Therapists and Counselors	935	1,023	1,023
Alcohol and Drug Counselors	0	1	1
TOTAL BEHAVIORAL HEALTH CARE PROVIDERS	**3,548**	**5,992**	**5,992**

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

CareFirst

CareFirst: Specialty by County – Frequency in Maryland

County/ Jurisdiction	CareFirst BlueChoice – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	22	86%	49	90%	7	86%	17	82%	8	100%	8	75%	71	89%	42	0%
Anne Arundel	263	91%	493	90%	107	71%	266	92%	21	100%	31	84%	786	87%	282	0%
Baltimore	331	88%	866	90%	145	77%	163	85%	35	91%	132	78%	1,385	86%	567	0%
Baltimore City	197	82%	1,391	87%	234	62%	510	88%	47	94%	50	72%	2,618	74%	278	0%
Calvert	16	100%	81	94%	14	79%	14	79%	7	100%	8	75%	120	91%	54	0%
Caroline	5	100%	2	100%	0	0%	1	100%	0	0%	0	0%	1	100%	2	0%
Carroll	28	96%	99	96%	22	73%	39	90%	3	67%	25	92%	190	92%	145	0%
Cecil	28	89%	43	93%	7	57%	9	100%	2	100%	4	75%	78	92%	59	0%
Charles	57	88%	91	88%	15	93%	22	86%	5	100%	3	100%	146	84%	48	0%
Dorchester	8	100%	17	88%	1	100%	1	100%	0	0%	9	100%	23	96%	24	0%
Frederick	71	93%	99	92%	30	83%	161	93%	12	67%	24	79%	250	88%	134	0%
Garrett	7	100%	1	100%	0	0%	0	0%	0	0%	0	0%	8	63%	2	0%
Harford	130	92%	154	90%	36	86%	74	89%	2	100%	11	64%	293	85%	191	0%
Howard	132	91%	223	90%	39	69%	100	95%	5	100%	42	79%	403	83%	254	0%
Kent	7	100%	21	100%	1	100%	2	100%	1	100%	1	100%	23	96%	11	0%
Montgomery	198	91%	706	93%	266	88%	487	95%	31	77%	69	77%	1,344	88%	418	0%
Prince George's	86	87%	459	93%	106	78%	156	90%	19	95%	35	71%	787	89%	216	0%
Queen Anne's	10	90%	9	89%	15	60%	13	85%	0	0%	3	100%	75	91%	46	0%
Saint Mary's	13	77%	76	95%	6	83%	18	89%	9	100%	8	75%	118	91%	30	0%
Somerset	1	100%	3	100%	8	75%	7	86%	0	0%	3	33%	3	100%	21	0%
Talbot	12	100%	45	96%	5	80%	11	100%	0	0%	7	100%	97	89%	33	0%
Washington	42	95%	92	96%	14	71%	48	94%	3	100%	18	83%	174	89%	93	0%
Wicomico	9	100%	64	92%	21	90%	37	89%	4	100%	15	73%	145	91%	69	0%
Worcester	15	100%	49	100%	3	100%	5	100%	1	100%	1	100%	90	92%	22	0%
TOTAL	**1,688**		**5,133**		**1,102**		**2,161**		**215**		**507**		**9,228**		**3,041**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

CareFirst

CareFirst: Specialty by County – Frequency in Maryland

County/ Jurisdiction	CareFirst CFMI/GHMSI – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	33	94%	76	87%	7	86%	24	92%	9	100%	26	42%	109	80%	89	0%
Anne Arundel	310	90%	622	90%	135	67%	253	90%	27	100%	73	56%	966	88%	561	1%
Baltimore	422	86%	1,044	91%	197	76%	213	87%	53	94%	204	64%	1,759	85%	985	2%
Baltimore City	267	82%	1,787	86%	302	55%	576	87%	71	87%	360	63%	3,435	74%	931	6%
Calvert	23	96%	91	92%	14	79%	22	82%	10	100%	7	29%	150	89%	96	0%
Caroline	8	100%	4	100%	0	0%	1	100%	0	0%	0	0%	2	100%	5	0%
Carroll	44	91%	112	94%	31	87%	37	92%	3	67%	24	54%	220	90%	214	1%
Cecil	40	88%	58	93%	9	67%	10	100%	3	100%	14	71%	110	93%	132	0%
Charles	68	87%	111	93%	19	95%	27	89%	8	100%	5	40%	164	83%	103	1%
Dorchester	6	100%	21	86%	2	100%	4	100%	0	0%	29	76%	39	90%	58	7%
Frederick	99	97%	113	92%	39	90%	185	88%	15	73%	35	69%	332	89%	262	3%
Garrett	11	100%	1	100%	0	0%	0	0%	0	0%	4	75%	15	80%	8	0%
Harford	160	89%	203	89%	40	83%	86	90%	5	100%	21	38%	382	82%	302	1%
Howard	165	91%	265	89%	55	75%	115	92%	10	90%	90	68%	504	82%	423	2%
Kent	7	100%	22	95%	3	100%	3	100%	1	100%	0	0%	37	92%	21	0%
Montgomery	257	91%	844	92%	319	85%	514	95%	43	84%	182	77%	1,789	88%	1,003	4%
Prince George's	125	90%	540	94%	127	79%	190	90%	31	97%	82	56%	922	87%	510	2%
Queen Anne's	21	95%	17	94%	19	68%	17	82%	0	0%	8	63%	101	86%	66	0%
Saint Mary's	25	80%	97	99%	8	88%	29	83%	12	100%	16	63%	152	88%	81	5%
Somerset	1	100%	6	100%	11	73%	7	86%	0	0%	5	20%	6	50%	23	9%
Talbot	12	100%	56	95%	10	70%	11	100%	0	0%	10	80%	131	89%	49	4%
Washington	67	96%	97	96%	22	73%	61	95%	3	100%	36	58%	228	84%	187	3%
Wicomico	11	100%	87	93%	28	86%	37	86%	3	100%	17	53%	186	88%	116	4%
Worcester	22	100%	59	100%	3	100%	6	100%	2	100%	3	67%	111	89%	34	0%
TOTAL	**2,204**		**6,333**		**1,400**		**2,428**		**309**		**1,251**		**11,850**		**6,259**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

Cigna

PLAN OVERVIEW	
Plan Name	PPO: Cigna (PPO/POS Combined)
Legal Name	PPO: Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company
MHBO Name	PPO: Cigna Behavioral Health, Inc.
Contact Information	1-866-GET-Cigna 7 days a week, 24 hours a day **www.cigna.com**
Tax Status and Ownership	Connecticut General Life Insurance Company is doing business as Cigna and is a for-profit PPO and POS
Accreditation Status	PPO: "Commendable" NCQA Accreditation (exp. 2018) PPO: "Full" NCQA MBHO Accreditation (exp. 2017)
Wellness Quality Initiatives	Check out Cigna's "Health & Wellness" information under the "Personal" tab. **www.cigna.com**

TOTAL BEHAVIORAL HEALTH CARE PROVIDERS (MARYLAND)	Cigna (PPO)
Psychiatrists	373
Physicians, Certified in Addiction Medicine	11
Psychologists	348
Social Workers	879
Licensed Social Work Associates	0
Nurse Psycho-therapists	99
Nurse Practitioners	0
Registered Nurses	0
Licensed Therapists and Counselors	495
Alcohol and Drug Counselors	12
TOTAL BEHAVIORAL HEALTH CARE PROVIDERS	**2,217**

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

Cigna: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Cigna – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	11	55%	23	83%	6	100%	10	70%	0	0%	7	86%	72	72%	24	0%
Anne Arundel	65	68%	176	86%	75	72%	76	74%	2	100%	32	78%	452	79%	276	0%
Baltimore	79	61%	347	82%	101	80%	114	70%	9	67%	136	81%	869	76%	556	0%
Baltimore City	43	63%	276	83%	66	71%	64	69%	5	60%	46	65%	805	72%	175	0%
Calvert	11	73%	29	76%	8	63%	7	71%	0	0%	14	100%	65	68%	47	0%
Caroline	10	80%	2	100%	0	0%	0	0%	0	0%	0	0%	0	0%	2	0%
Carroll	24	50%	35	57%	10	80%	18	44%	0	0%	18	61%	90	73%	145	0%
Cecil	20	60%	11	73%	6	67%	6	17%	0	0%	8	63%	52	85%	31	0%
Charles	17	29%	38	79%	16	81%	21	52%	0	0%	3	67%	92	75%	43	0%
Dorchester	3	67%	7	71%	0	0%	0	0%	0	0%	6	100%	16	88%	12	0%
Frederick	37	51%	46	59%	9	78%	31	68%	3	67%	27	67%	191	82%	123	0%
Garrett	13	77%	3	100%	1	0%	0	0%	2	50%	0	0%	19	79%	0	0%
Harford	25	52%	49	80%	14	93%	29	72%	2	50%	15	87%	121	72%	144	0%
Howard	27	74%	74	80%	20	80%	38	66%	3	33%	54	80%	227	75%	192	0%
Kent	10	70%	5	100%	3	100%	1	0%	0	0%	0	0%	16	81%	9	0%
Montgomery	139	50%	337	77%	155	72%	211	71%	5	60%	98	84%	1,111	77%	401	0%
Prince George's	115	37%	212	73%	58	74%	80	53%	4	75%	40	58%	579	74%	150	0%
Queen Anne's	4	75%	8	63%	1	100%	1	100%	0	0%	2	100%	7	57%	37	0%
Saint Mary's	7	71%	8	88%	4	100%	7	43%	0	0%	5	80%	29	62%	27	0%
Somerset	3	67%	4	100%	1	0%	1	100%	0	0%	2	50%	7	43%	3	0%
Talbot	10	80%	20	90%	9	89%	8	100%	0	0%	4	50%	62	89%	16	0%
Washington	39	62%	39	59%	10	80%	25	52%	0	0%	15	93%	158	80%	31	0%
Wicomico	8	50%	33	67%	13	77%	16	56%	0	0%	7	71%	118	86%	23	0%
Worcester	8	50%	10	70%	0	0%	1	100%	0	0%	1	100%	19	74%	10	0%
TOTAL	**728**		**1,792**		**586**		**765**		**35**		**540**		**5,177**		**2,477**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

COVENTRY Health Care

PLAN OVERVIEW	
Plan Name	HMO: Coventry (HMO/POS Combined) PPO: Coventry (PPO)
Legal Name	HMO: Coventry Health Care of Delaware, Inc. PPO: Coventry Health and Life Insurance Company
MHBO Name	HMO: MHNet Behavioral Health PPO: MHNet Behavioral Health
Contact Information	1-800-833-7423 Monday–Friday, 8:00 am–5:00 pm (EST) **www.coventryhealthcare.com**
Tax Status and Ownership	Coventry Health Care of Delaware, Inc. is a for-profit HMO Coventry Health and Life Insurance Company is a for-profit PPO
Accreditation Status	HMO: "Accredited" NCQA Accreditation (exp. 2016) PPOs: "Accredited" NCQA Accreditation (exp. 2016) HMO & PPO: "Full" NCQA MBHO Accreditation (exp. 2015)
Wellness Quality Initiatives	Check out Coventry's "Wellness Resources" information on the Home page. **www.chcdelaware.coventryhealthcare.com**

TOTAL BEHAVIORAL HEALTH CARE PROVIDERS (MARYLAND)	Coventry (HMO)	Coventry (PPO)
Psychiatrists	188	188
Physicians, Certified in Addiction Medicine	0	0
Psychologists	123	123
Social Workers	451	451
Licensed Social Work Associates	1	1
Nurse Psycho-therapists	0	0
Nurse Practitioners	0	0
Registered Nurses	1	1
Licensed Therapists and Counselors	245	245
Alcohol and Drug Counselors	0	0
TOTAL BEHAVIORAL HEALTH CARE PROVIDERS	**1,009**	**1,009**

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

COVENTRY Health Care

Coventry: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Coventry – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	8	38%	7	71%	3	100%	10	90%	1	100%	0	0%	27	63%	8	0%
Anne Arundel	88	85%	114	82%	56	77%	70	87%	1	100%	13	15%	252	85%	121	0%
Baltimore	116	84%	282	80%	126	76%	126	89%	13	77%	82	17%	679	85%	192	0%
Baltimore City	69	78%	206	83%	148	66%	91	85%	19	68%	27	33%	1,734	81%	102	0%
Calvert	9	78%	17	82%	3	33%	4	100%	1	100%	0	0%	49	80%	15	0%
Caroline	6	50%	2	100%	0	0%	1	100%	0	0%	0	0%	0	0%	1	0%
Carroll	33	85%	28	54%	19	89%	21	86%	2	50%	7	0%	89	84%	29	0%
Cecil	20	80%	6	67%	9	89%	5	100%	1	100%	6	33%	43	84%	44	0%
Charles	18	78%	17	65%	11	73%	18	56%	0	0%	0	0%	46	89%	2	0%
Dorchester	8	75%	3	67%	2	100%	1	100%	0	0%	5	60%	19	89%	14	0%
Frederick	55	84%	11	36%	19	63%	33	91%	1	100%	8	13%	90	83%	32	0%
Garrett	4	100%	1	100%	0	0%	0	0%	0	0%	0	0%	2	100%	0	0%
Harford	41	83%	39	74%	21	71%	34	85%	0	0%	4	75%	126	80%	56	0%
Howard	38	76%	47	85%	37	81%	40	85%	1	100%	9	11%	153	84%	46	0%
Kent	6	83%	5	100%	1	100%	1	100%	0	0%	3	33%	12	83%	10	0%
Montgomery	61	74%	119	80%	97	67%	113	73%	2	100%	1	0%	475	84%	38	0%
Prince George's	71	66%	106	75%	59	78%	55	76%	2	50%	5	40%	262	77%	23	0%
Queen Anne's	11	64%	5	60%	1	100%	5	100%	0	0%	1	100%	13	100%	12	0%
Saint Mary's	15	60%	18	89%	5	80%	11	91%	0	0%	0	0%	50	82%	4	0%
Somerset	2	50%	4	100%	6	50%	4	75%	0	0%	2	0%	1	100%	6	0%
Talbot	12	92%	6	100%	6	83%	9	89%	0	0%	5	40%	66	92%	22	0%
Washington	28	89%	17	71%	14	79%	20	95%	1	100%	1	100%	71	86%	12	0%
Wicomico	5	100%	23	78%	10	80%	16	88%	0	0%	9	11%	91	89%	38	0%
Worcester	18	89%	9	78%	3	67%	3	67%	0	0%	0	0%	32	88%	13	0%
TOTAL	**742**		**1,092**		**656**		**691**		**45**		**188**		**4,382**		**840**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

COVENTRY Health Care

Coventry: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Coventry – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	8	38%	7	71%	3	100%	10	90%	1	100%	0	0%	27	63%	8	0%
Anne Arundel	88	85%	114	82%	56	77%	70	87%	1	100%	13	15%	252	85%	121	0%
Baltimore	116	84%	282	80%	126	76%	126	89%	13	77%	82	17%	679	85%	192	0%
Baltimore City	69	78%	206	83%	148	66%	91	85%	19	68%	27	33%	1,734	81%	102	0%
Calvert	9	78%	17	82%	3	33%	4	100%	1	100%	0	0%	49	80%	15	0%
Caroline	6	50%	2	100%	0	0%	1	100%	0	0%	0	0%	0	0%	1	0%
Carroll	33	85%	28	54%	19	89%	21	86%	2	50%	7	0%	89	84%	29	0%
Cecil	20	80%	6	67%	9	89%	5	100%	1	100%	6	33%	43	84%	44	0%
Charles	18	78%	17	65%	11	73%	18	56%	0	0%	0	0%	46	89%	2	0%
Dorchester	8	75%	3	67%	2	100%	1	100%	0	0%	5	60%	19	89%	14	0%
Frederick	55	84%	11	36%	19	63%	33	91%	1	100%	8	13%	90	83%	32	0%
Garrett	4	100%	1	100%	0	0%	0	0%	0	0%	0	0%	2	100%	0	0%
Harford	41	83%	39	74%	21	71%	34	85%	0	0%	4	75%	126	80%	56	0%
Howard	38	76%	47	85%	37	81%	40	85%	1	100%	9	11%	153	84%	46	0%
Kent	6	83%	5	100%	1	100%	1	100%	0	0%	3	33%	12	83%	10	0%
Montgomery	61	74%	119	80%	97	67%	113	73%	2	100%	1	0%	475	84%	38	0%
Prince George's	71	66%	106	75%	59	78%	55	76%	2	50%	5	40%	262	77%	23	0%
Queen Anne's	11	64%	5	60%	1	100%	5	100%	0	0%	1	100%	13	100%	12	0%
Saint Mary's	15	60%	18	89%	5	80%	11	91%	0	0%	0	0%	50	82%	4	0%
Somerset	2	50%	4	100%	6	50%	4	75%	0	0%	2	0%	1	100%	6	0%
Talbot	12	92%	6	100%	6	83%	9	89%	0	0%	5	40%	66	92%	22	0%
Washington	28	89%	17	71%	14	79%	20	95%	1	100%	1	100%	71	86%	12	0%
Wicomico	5	100%	23	78%	10	80%	16	88%	0	0%	9	11%	91	89%	38	0%
Worcester	18	89%	9	78%	3	67%	3	67%	0	0%	0	0%	32	88%	13	0%
TOTAL	**742**		**1,092**		**656**		**691**		**45**		**188**		**4,382**		**840**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

KAISER PERMANENTE®

PLAN OVERVIEW	
Plan Name	HMO: Kaiser Permanente (HMO/POS Combined) PPO: KPIC (POS)
Legal Name	HMO: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. PPO: Kaiser Permanente Insurance Company
MHBO Name	HMO: Kaiser Permanente Health Plan of the Mid-Atlantic States PPO: Kaiser Permanente Health Plan of the Mid-Atlantic States
Contact Information	1-800-245-3181 7 days a week, 24 hours a day **www.kaiserpermanente.org**
Tax Status and Ownership	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. Kaiser Permanente Insurance Company is a for-profit POS.
Accreditation Status	HMO: "Excellent" NCQA Accreditation (exp. 2016) HMO: "Excellent" NCQA MBHO Accreditation* (exp. 2016) * MBHO Accreditation by NCQA is through the health plan itself, which operates under a staff model to also address members' behavioral health needs.
Wellness Quality Initiatives	Check out Kaiser Permanente's "Health & Wellness" tab on the Home page. **www.kaiserpermanente.org**

TOTAL BEHAVIORAL HEALTH CARE PROVIDERS (MARYLAND)	Kaiser (HMO)	KPIC (PPO)
Psychiatrists	348	635
Physicians, Certified in Addiction Medicine	1	1
Psychologists	262	523
Social Workers	456	910
Licensed Social Work Associates	0	0
Nurse Psycho-therapists	23	23
Nurse Practitioners	0	0
Registered Nurses	0	0
Licensed Therapists and Counselors	159	407
Alcohol and Drug Counselors	4	7
TOTAL BEHAVIORAL HEALTH CARE PROVIDERS	**1,253**	**2,506**

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

KAISER PERMANENTE®

Kaiser: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Kaiser Permanente – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%
Anne Arundel	54	85%	100	80%	51	86%	28	89%	4	100%	14	100%	244	87%	82	17%
Baltimore	69	78%	330	85%	92	84%	53	91%	7	100%	169	88%	679	86%	205	17%
Baltimore City	39	82%	463	83%	186	70%	175	87%	27	96%	193	85%	2,118	87%	95	13%
Calvert	10	70%	10	70%	3	67%	8	88%	2	100%	2	100%	23	83%	15	40%
Caroline	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Carroll	6	100%	11	73%	0	0%	6	100%	0	0%	8	75%	35	89%	39	23%
Cecil	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Charles	11	73%	23	78%	2	100%	8	63%	2	100%	2	100%	29	93%	25	24%
Dorchester	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Frederick	7	100%	24	63%	19	89%	2	100%	0	0%	14	71%	69	94%	56	5%
Garrett	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Harford	9	78%	22	59%	5	80%	18	83%	1	100%	2	100%	80	80%	43	16%
Howard	23	91%	91	85%	49	84%	21	95%	1	100%	44	89%	161	86%	104	20%
Kent	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Montgomery	48	85%	280	87%	123	89%	62	94%	5	100%	54	93%	540	91%	191	21%
Prince George's	58	88%	194	84%	41	76%	42	88%	7	100%	31	100%	353	90%	102	27%
Queen Anne's	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	6	83%	1	0%
Saint Mary's	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%	5	60%	1	0%
Somerset	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Talbot	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	4	75%	0	0%
Washington	0	0%	2	100%	11	91%	0	0%	0	0%	0	0%	9	78%	0	0%
Wicomico	0	0%	0	0%	0	0%	4	50%	0	0%	2	50%	7	100%	1	0%
Worcester	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
TOTAL	**335**		**1,553**		**582**		**427**		**56**		**535**		**4,363**		**960**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

KAISER PERMANENTE®

Kaiser: Specialty by County – Frequency in Maryland

County/ Jurisdiction	KPIC – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	7	57%	15	73%	6	67%	9	89%	0	0%	3	100%	21	81%	2	0%
Anne Arundel	138	85%	205	82%	82	78%	96	89%	4	100%	26	81%	519	87%	163	9%
Baltimore	180	82%	591	84%	212	82%	177	90%	15	100%	198	88%	1,289	86%	359	10%
Baltimore City	103	79%	817	83%	339	72%	364	84%	56	93%	347	87%	4,388	86%	268	4%
Calvert	14	71%	32	78%	10	60%	17	88%	3	100%	4	100%	70	84%	45	13%
Caroline	6	100%	2	100%	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%
Carroll	35	91%	39	69%	12	83%	19	89%	0	0%	10	70%	102	83%	88	10%
Cecil	18	78%	4	100%	2	100%	5	80%	0	0%	2	50%	16	81%	44	0%
Charles	32	69%	48	75%	11	64%	26	62%	2	100%	4	75%	75	92%	45	13%
Dorchester	5	80%	6	67%	0	0%	1	100%	0	0%	5	60%	5	100%	2	0%
Frederick	59	93%	47	66%	39	85%	32	91%	0	0%	17	76%	178	93%	89	3%
Garrett	6	67%	1	100%	0	0%	0	0%	0	0%	0	0%	7	86%	0	0%
Harford	38	92%	71	72%	19	89%	52	90%	1	100%	9	89%	176	82%	102	7%
Howard	59	88%	155	86%	91	82%	63	90%	2	50%	51	86%	301	88%	180	12%
Kent	7	86%	4	100%	0	0%	1	100%	0	0%	0	0%	3	100%	3	0%
Montgomery	146	87%	491	87%	258	87%	216	91%	5	100%	86	86%	1,201	89%	308	14%
Prince George's	112	81%	310	83%	74	81%	106	78%	7	100%	44	98%	633	89%	172	16%
Queen Anne's	9	100%	2	100%	1	100%	1	100%	0	0%	1	100%	7	86%	9	0%
Saint Mary's	15	80%	19	89%	8	88%	13	62%	0	0%	0	0%	61	82%	4	0%
Somerset	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%
Talbot	11	82%	7	100%	4	100%	10	100%	0	0%	1	100%	76	84%	4	0%
Washington	40	88%	36	81%	27	78%	15	93%	0	0%	9	89%	80	88%	26	0%
Wicomico	0	0%	3	100%	2	100%	11	64%	0	0%	4	75%	85	88%	11	0%
Worcester	11	91%	5	100%	2	100%	0	0%	0	0%	1	0%	23	96%	1	0%
TOTAL	**1,051**		**2,910**		**1,199**		**1,235**		**95**		**822**		**9,316**		**1,926**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

UnitedHealthcare

PLAN OVERVIEW	
Plan Name	HMO: MD-IPA (HMO/POS Combined) HMO: Optimum Choice (HMO/POS Combined) HMO: UnitedHealthcare (HMO) PPO: MAMSI (PPO) PPO: UnitedHealthcare (PPO/POS/EPO Combined)
Legal Name	HMO: Maryland Individual Practice Association, Inc. HMO: Optimum Choice, Inc. HMO: UnitedHealthcare of the Mid-Atlantic, Inc. PPO: MAMSI Life and Health Insurance Company PPO: UnitedHealthcare Insurance Company (Maryland)
MHBO Name	HMOs: United Behavioral Health PPOs: United Behavioral Health
Contact Information	1-800-307-7820 TTY: 711 (Maryland only) 7 days a week, 24 hours a day **www.uhc.com**
Tax Status and Ownership	MD-IPA and Optimum Choice, Inc., for-profit HMOs, are owned and operated by a regional holding company and are subsidiaries of UnitedHealth Group, Inc. UnitedHealthcare of the Mid-Atlantic, Inc. is a for-profit HMO plan and a subsidiary of UnitedHealth Group, Inc. MAMSI Life and Health Insurance Company and UnitedHealthcare Insurance Company (Maryland) are both for-profit PPO plans subsidiaries of UnitedHealth Group, Inc.
Accreditation Status	MD-IPA HMO: "Commendable" NCQA Accreditation (exp. 2017) Optimum Choice & UnitedHealthcare HMO: "Accredited" NCQA Accreditation (exp. 2017) MAMSI PPO (Marketplace only): "Accredited" NCQA Accreditation (exp. 2018) UnitedHealthcare PPO: "Commendable" NCQA Accreditation (exp. 2015) HMOs & PPOs: "Full" NCQA MBHO Accreditation (exp. 2017) UnitedHealthcare HMO & PPO: "Full" URAC Health Utilization Management Accreditation (exp. 2017)
Wellness Quality Initiatives	Check out UnitedHealthcare's "Healthy Living" information under the "Individuals and Families" tab. **www.uhc.com**

TOTAL BEHAVIORAL HEALTH CARE PROVIDERS (MARYLAND)	MD-IPA (HMO)	Optimum Choice (HMO)	United-Healthcare (HMO)	MAMSI (PPO)	United-Healthcare (PPO)
Psychiatrists	472	472	471	472	472
Physicians, Certified in Addiction Medicine	4	4	4	4	4
Psychologists	476	476	476	476	476
Social Workers	1,080	1,080	1,076	1,080	1,080
Licensed Social Work Associates	0	0	0	0	0
Nurse Psycho-therapists	122	122	122	122	122
Nurse Practitioners	10	10	10	10	10
Registered Nurses	2	2	2	2	0
Licensed Therapists and Counselors	494	494	492	494	494
Alcohol and Drug Counselors	0	0	0	0	0
TOTAL BEHAVIORAL HEALTH CARE PROVIDERS	**2,660**	**2,660**	**2,658**	**2,660**	**2,658**

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

UnitedHealthcare

UnitedHealthcare: Specialty by County – Frequency in Maryland

County/ Jurisdiction	MD-IPA – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	11	55%	33	73%	8	100%	11	91%	1	100%	4	100%	84	64%	2	50%
Anne Arundel	115	83%	192	78%	73	85%	95	85%	3	33%	10	70%	463	85%	10	10%
Baltimore	129	78%	589	83%	174	89%	194	86%	25	88%	30	90%	1,166	82%	22	14%
Baltimore City	99	67%	884	85%	156	78%	332	85%	43	70%	15	80%	1,937	79%	10	0%
Calvert	18	78%	34	82%	8	75%	14	93%	2	100%	6	83%	79	73%	2	100%
Caroline	9	67%	1	100%	0	0%	1	100%	0	0%	0	0%	0	0%	1	0%
Carroll	43	70%	63	65%	21	90%	30	87%	2	50%	3	100%	167	83%	7	14%
Cecil	25	76%	19	53%	8	75%	10	90%	1	100%	3	100%	54	74%	7	0%
Charles	18	67%	46	74%	13	69%	22	64%	2	50%	0	0%	91	81%	2	0%
Dorchester	8	63%	4	50%	4	75%	1	100%	0	0%	3	100%	15	67%	0	0%
Frederick	61	84%	45	60%	20	90%	45	93%	2	50%	9	100%	193	87%	10	0%
Garrett	12	92%	1	100%	3	0%	0	0%	1	0%	0	0%	10	90%	1	0%
Harford	45	82%	87	74%	25	84%	49	90%	3	33%	1	0%	216	82%	3	0%
Howard	41	78%	105	76%	54	89%	65	92%	4	25%	16	94%	263	83%	16	6%
Kent	8	63%	10	70%	3	100%	2	100%	0	0%	0	0%	22	91%	2	0%
Montgomery	129	74%	384	79%	174	89%	202	92%	16	69%	43	91%	1,151	86%	51	2%
Prince George's	93	59%	210	75%	53	83%	90	84%	4	75%	11	100%	444	77%	7	0%
Queen Anne's	20	90%	13	100%	9	100%	11	91%	0	0%	0	0%	50	88%	1	0%
Saint Mary's	17	59%	27	78%	9	89%	18	78%	1	100%	2	100%	55	89%	2	0%
Somerset	2	100%	3	100%	12	75%	7	86%	0	0%	0	0%	5	80%	0	0%
Talbot	8	100%	16	81%	6	100%	9	100%	0	0%	0	0%	71	87%	2	50%
Washington	42	81%	60	70%	24	92%	17	88%	2	100%	9	67%	152	87%	6	0%
Wicomico	13	85%	54	80%	8	88%	17	88%	2	50%	5	40%	91	81%	3	33%
Worcester	18	94%	25	72%	4	100%	2	100%	0	0%	0	0%	85	89%	0	0%
TOTAL	**984**		**2,905**		**869**		**1,244**		**114**		**170**		**6,864**		**167**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

UnitedHealthcare

UnitedHealthcare: Specialty by County – Frequency in Maryland

County/ Jurisdiction	Optimum Choice – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	11	55%	33	73%	8	100%	11	91%	1	100%	4	100%	84	64%	2	50%
Anne Arundel	116	83%	192	78%	73	85%	97	86%	3	33%	10	70%	458	85%	10	10%
Baltimore	129	78%	588	83%	173	89%	194	86%	25	88%	30	90%	1,161	82%	22	14%
Baltimore City	98	67%	884	85%	156	78%	331	85%	43	70%	15	80%	1,936	79%	10	0%
Calvert	18	78%	35	80%	8	75%	14	93%	2	100%	6	83%	78	73%	2	100%
Caroline	9	67%	1	100%	0	0%	1	100%	0	0%	0	0%	0	0%	1	0%
Carroll	43	70%	64	66%	21	90%	30	87%	2	50%	3	100%	169	82%	7	14%
Cecil	25	76%	18	50%	8	75%	10	90%	1	100%	3	100%	53	75%	7	0%
Charles	18	67%	46	74%	13	69%	22	64%	2	50%	0	0%	91	81%	2	0%
Dorchester	8	63%	4	50%	4	75%	1	100%	0	0%	3	100%	15	67%	0	0%
Frederick	61	84%	45	60%	20	90%	45	93%	2	50%	9	100%	194	87%	10	0%
Garrett	12	92%	1	100%	3	0%	0	0%	1	0%	0	0%	10	90%	1	0%
Harford	45	82%	87	74%	25	84%	49	90%	3	33%	1	0%	215	83%	3	0%
Howard	41	78%	105	76%	54	89%	68	93%	4	25%	16	94%	264	83%	16	6%
Kent	8	63%	10	70%	3	100%	2	100%	0	0%	0	0%	22	91%	2	0%
Montgomery	128	75%	382	79%	175	89%	201	92%	17	65%	43	91%	1,151	86%	51	2%
Prince George's	94	60%	212	75%	53	83%	90	84%	4	75%	11	100%	450	76%	7	0%
Queen Anne's	20	90%	13	100%	9	100%	11	91%	0	0%	0	0%	49	88%	1	0%
Saint Mary's	17	59%	27	78%	9	89%	18	78%	1	100%	2	100%	55	89%	2	0%
Somerset	2	100%	3	100%	12	75%	7	86%	0	0%	0	0%	4	75%	0	0%
Talbot	8	100%	16	81%	6	100%	9	100%	0	0%	0	0%	71	87%	2	50%
Washington	42	81%	60	70%	25	92%	17	88%	2	100%	9	67%	149	87%	6	0%
Wicomico	12	83%	54	80%	8	88%	17	88%	2	50%	5	40%	89	81%	3	33%
Worcester	18	94%	25	72%	4	100%	2	100%	0	0%	0	0%	85	89%	0	0%
TOTAL	**983**		**2,905**		**870**		**1,247**		**115**		**170**		**6,853**		**167**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

UnitedHealthcare

UnitedHealthcare: Specialty by County – Frequency in Maryland

County/ Jurisdiction	UnitedHealthcare – HMO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	0	0%	0	0%	0	0%	0	0%	0	0%	4	100%	3	67%	2	50%
Anne Arundel	3	100%	7	71%	6	100%	4	75%	0	0%	10	70%	63	84%	10	10%
Baltimore	9	67%	11	64%	21	90%	4	50%	0	0%	30	90%	44	82%	22	14%
Baltimore City	1	0%	12	75%	4	75%	4	100%	0	0%	15	80%	39	82%	10	0%
Calvert	18	78%	35	80%	8	75%	14	93%	2	100%	6	83%	77	73%	2	100%
Caroline	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%
Carroll	2	0%	2	50%	4	100%	4	100%	0	0%	3	100%	9	56%	7	14%
Cecil	0	0%	0	0%	0	0%	0	0%	0	0%	3	100%	0	0%	7	0%
Charles	9	44%	39	77%	10	80%	21	62%	2	50%	0	0%	81	83%	2	0%
Dorchester	0	0%	1	0%	0	0%	0	0%	0	0%	3	100%	0	0%	0	0%
Frederick	2	100%	2	50%	20	90%	2	100%	0	0%	9	100%	36	94%	10	0%
Garrett	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Harford	2	100%	2	100%	4	50%	0	0%	0	0%	1	0%	10	60%	3	0%
Howard	4	75%	10	60%	7	100%	11	82%	0	0%	16	94%	65	80%	16	6%
Kent	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2	0%
Montgomery	116	71%	355	79%	170	89%	191	93%	16	69%	43	91%	1,045	87%	51	2%
Prince George's	81	60%	195	75%	43	84%	84	83%	4	75%	11	100%	381	76%	7	0%
Queen Anne's	0	0%	1	100%	1	100%	0	0%	0	0%	0	0%	2	100%	1	0%
Saint Mary's	16	56%	26	77%	9	89%	17	76%	1	100%	2	100%	49	88%	2	0%
Somerset	0	0%	0	0%	1	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Talbot	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	100%	2	50%
Washington	1	100%	4	100%	8	88%	1	100%	0	0%	9	67%	26	88%	6	0%
Wicomico	1	100%	3	100%	0	0%	1	100%	0	0%	5	40%	0	0%	3	33%
Worcester	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	2	100%	0	0%
TOTAL	**266**		**705**		**316**		**358**		**25**		**170**		**1,933**		**166**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

UnitedHealthcare

UnitedHealthcare: Specialty by County – Frequency in Maryland

County/ Jurisdiction	MAMSI – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	11	55%	33	73%	8	100%	11	91%	1	100%	4	100%	84	64%	2	50%
Anne Arundel	115	83%	192	78%	73	85%	95	85%	3	33%	10	70%	463	85%	10	10%
Baltimore	129	78%	589	83%	174	89%	194	86%	25	88%	30	90%	1,166	82%	22	14%
Baltimore City	99	67%	884	85%	156	78%	332	85%	43	70%	15	80%	1,937	79%	10	0%
Calvert	18	78%	34	82%	8	75%	14	93%	2	100%	6	83%	79	73%	2	100%
Caroline	9	67%	1	100%	0	0%	1	100%	0	0%	0	0%	0	0%	1	0%
Carroll	43	70%	63	65%	21	90%	30	87%	2	50%	3	100%	167	83%	7	14%
Cecil	25	76%	19	53%	8	75%	10	90%	1	100%	3	100%	54	74%	7	0%
Charles	18	67%	46	74%	13	69%	22	64%	2	50%	0	0%	91	81%	2	0%
Dorchester	8	63%	4	50%	4	75%	1	100%	0	0%	3	100%	15	67%	0	0%
Frederick	61	84%	45	60%	20	90%	45	93%	2	50%	9	100%	193	87%	10	0%
Garrett	12	92%	1	100%	3	0%	0	0%	1	0%	0	0%	10	90%	1	0%
Harford	45	82%	87	74%	25	84%	49	90%	3	33%	1	0%	216	82%	3	0%
Howard	41	78%	105	76%	54	89%	65	92%	4	25%	16	94%	263	83%	16	6%
Kent	8	63%	10	70%	3	100%	2	100%	0	0%	0	0%	22	91%	2	0%
Montgomery	129	74%	384	79%	174	89%	202	92%	16	69%	43	91%	1,151	86%	51	2%
Prince George's	93	59%	210	75%	53	83%	90	84%	4	75%	11	100%	444	77%	7	0%
Queen Anne's	20	90%	13	100%	9	100%	11	91%	0	0%	0	0%	50	88%	1	0%
Saint Mary's	17	59%	27	78%	9	89%	18	78%	1	100%	2	100%	55	89%	2	0%
Somerset	2	100%	3	100%	12	75%	7	86%	0	0%	0	0%	5	80%	0	0%
Talbot	8	100%	16	81%	6	100%	9	100%	0	0%	0	0%	71	87%	2	50%
Washington	42	81%	60	70%	24	92%	17	88%	2	100%	9	67%	152	87%	6	0%
Wicomico	13	85%	54	80%	8	88%	17	88%	2	50%	5	40%	91	81%	3	33%
Worcester	18	94%	25	72%	4	100%	2	100%	0	0%	0	0%	85	89%	0	0%
TOTAL	**984**		**2,905**		**869**		**1,244**		**114**		**170**		**6,864**		**167**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Information and Provider Network (continued)

UnitedHealthcare

UnitedHealthcare: Specialty by County – Frequency in Maryland

County/ Jurisdiction	UnitedHealthcare – PPO*															
	Family Medicine		Internal Medicine		OB/GYN Physicians		Pediatricians		Geriatricians		Psychiatrists		Other Physician Specialists (non BH)		Behavioral Health Specialists (non MD)	
Allegany	11	55%	33	73%	8	100%	11	91%	1	100%	4	100%	84	64%	2	50%
Anne Arundel	115	83%	192	78%	73	85%	95	85%	3	33%	10	70%	463	85%	10	10%
Baltimore	129	78%	593	83%	174	89%	197	86%	25	88%	30	90%	1,166	82%	22	14%
Baltimore City	100	67%	885	85%	156	78%	332	85%	43	70%	15	80%	1,937	79%	10	0%
Calvert	18	78%	34	82%	8	75%	14	93%	2	100%	6	83%	79	73%	2	100%
Caroline	9	67%	1	100%	0	0%	1	100%	0	0%	0	0%	0	0%	1	0%
Carroll	43	70%	63	65%	21	90%	30	87%	2	50%	3	100%	167	83%	7	14%
Cecil	25	76%	19	53%	8	75%	10	90%	1	100%	3	100%	54	74%	7	0%
Charles	19	63%	46	74%	14	71%	22	64%	2	50%	0	0%	91	81%	2	0%
Dorchester	8	63%	4	50%	4	75%	1	100%	0	0%	3	100%	15	67%	0	0%
Frederick	61	84%	45	60%	20	90%	45	93%	2	50%	9	100%	193	87%	10	0%
Garrett	12	92%	1	100%	3	0%	0	0%	1	0%	0	0%	10	90%	1	0%
Harford	45	82%	87	74%	25	84%	49	90%	3	33%	1	0%	216	82%	3	0%
Howard	41	78%	105	76%	54	89%	65	92%	4	25%	16	94%	263	83%	16	6%
Kent	8	63%	10	70%	3	100%	2	100%	0	0%	0	0%	22	91%	2	0%
Montgomery	130	73%	386	79%	175	89%	202	92%	17	71%	43	91%	1,151	86%	51	2%
Prince George's	93	59%	211	75%	53	83%	90	84%	4	75%	11	100%	444	77%	7	0%
Queen Anne's	20	90%	13	100%	9	100%	11	91%	0	0%	0	0%	50	88%	1	0%
Saint Mary's	18	61%	27	78%	9	89%	18	78%	1	100%	2	100%	55	89%	2	0%
Somerset	2	100%	3	100%	12	75%	7	86%	0	0%	0	0%	5	80%	0	0%
Talbot	8	100%	16	81%	6	100%	9	100%	0	0%	0	0%	71	87%	2	50%
Washington	42	81%	60	70%	24	92%	17	88%	2	100%	9	67%	152	87%	6	0%
Wicomico	13	85%	53	79%	8	88%	17	88%	2	50%	5	40%	91	81%	3	33%
Worcester	18	94%	25	72%	4	100%	2	100%	0	0%	0	0%	85	89%	0	0%
TOTAL	**988**		**2,912**		**871**		**1,247**		**115**		**170**		**6,864**		**167**	

HMO/PPO*: Left column contains the Number of Providers and the Right column contains the Percent of Providers that are Board Certified. Also note that providers with office locations in multiple jurisdictions are counted separately in each jurisdiction where they maintain a practice.*

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Health Care Disparities

Addressing health and health care disparities requires cooperation across the health care system, from individuals, health care providers, hospitals and health centers, health benefit plans, and government agencies. There is growing evidence to suggest that improving data collection strategies across the health care system by incorporating key data, particularly data on race, ethnicity and language, is likely to have a beneficial effect on reducing health care disparities and improving overall health care quality. "While a range of health and health care entities collect data, the data do not flow among these entities in a cohesive or standardized way. Entities within the health care system face challenges when collecting race, ethnicity, and language data from patients, enrollees, members, and respondents. Explicitly expressing the rationale for the data collection and training staff, organizational leadership, and the public to appreciate the need to use valid collection mechanisms may improve the situation. Nevertheless, some entities face health information technology (Health IT) constraints and internal resistance. Indirect estimation techniques, when used with an understanding of the probabilistic nature of the data, can supplement direct data collection efforts."

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Improving Data Collection Across the Health Care System

Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, 2014

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Background to Maryland Demographics

Share of State Population

Maryland ranks nineteenth nationally in terms of population, with approximately 5.9 million people. Over 80% of State residents live centrally within the Baltimore and National Capital regions.

The 24 jurisdictions, including 23 Maryland counties and the jurisdiction of Baltimore City, are divided into the following five regions:

Western Maryland – Garrett, Allegany and Washington counties

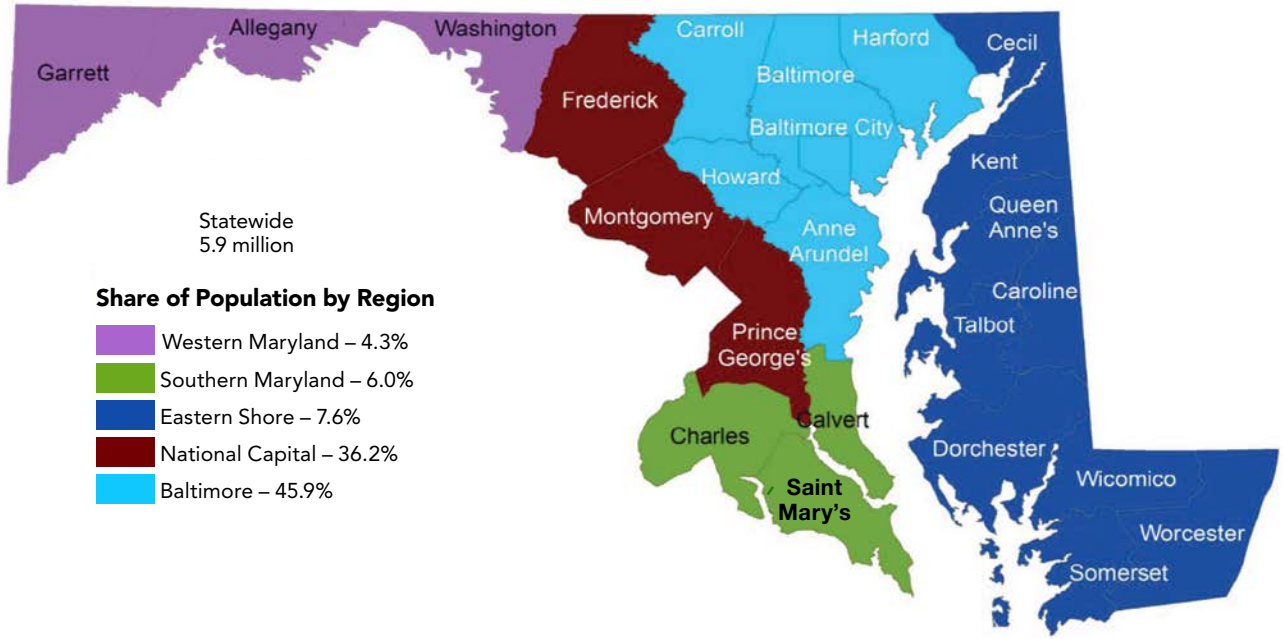
Southern Maryland – Calvert, Charles and Saint Mary's counties

Eastern Shore – Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Worcester, and Somerset counties

National Capital – Frederick, Montgomery and Prince George's counties

Baltimore – Carroll, Howard, Anne Arundel, Baltimore, and Harford counties and Baltimore City

Share of Population by Region (2013)



Prepared by: Maryland Department of Legislative Services
Source: U.S. Census Bureau
Updated: 2014

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Background to Maryland Demographics (continued)

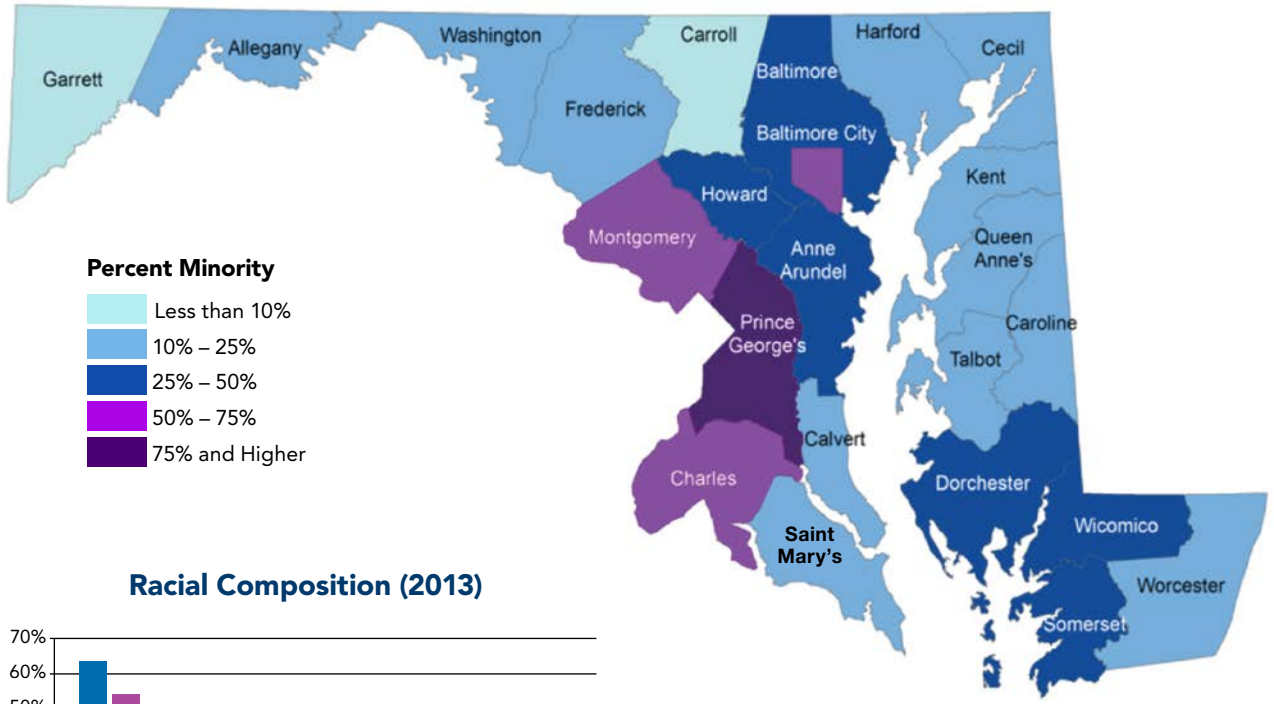
Maryland Racial Composition

Four of Maryland's jurisdictions have a majority minority population; they are Baltimore City, as well as Montgomery, Prince George's and Charles counties.

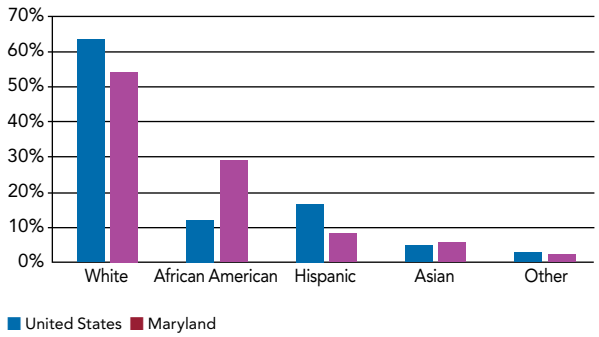
Racial minorities comprise 46.7% of the State's population compared to 37.4% nationally.

African Americans are the largest racial minority in Maryland comprising 29.2% of the State's population; whereas Hispanics account for 9.0%, followed by Asians at 6.0%.

Racial Composition by County – All Ages (2013)



Racial Composition (2013)



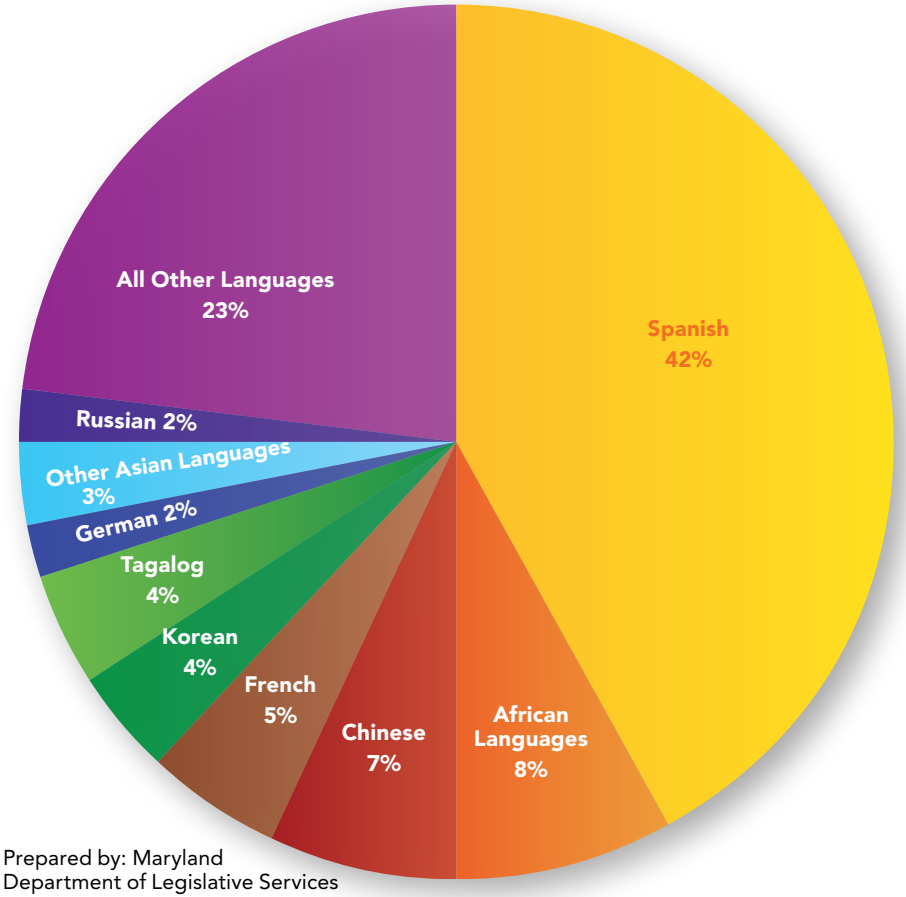
Prepared by: Maryland Department of Legislative Services
Source: U.S. Census Bureau
Updated: 2014

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Background to Maryland Demographics (continued)

Languages Spoken at Home, Other than English (2013)

Maryland remains one of the most diverse states with people from approximately 160 different countries speaking over one hundred languages. Nationally, Maryland has the tenth highest percentage of residents who are foreign-born. 14.2% of Maryland residents are foreign-born compared to 13.1% at the national level.



Prepared by: Maryland Department of Legislative Services
Source: U.S. Census Bureau
Updated: 2014

Language	Number of speakers	Spoke English less than "Very Well"
Spanish	395,706	43.3%
African languages	72,420	26.5%
Chinese	65,212	46.7%
French	51,661	25.4%
Korean	38,547	54.9%
Tagalog	34,660	26.5%
German	16,126	10.9%
Other Asian Languages	28,498	23.1%
Russian	18,715	40.7%
Other Indic languages	22,368	38.0%
Vietnamese	19,194	54.4%
Hindi	14,845	18.0%
Arabic	20,236	23.7%
Italian	8,924	24.7%
Urdu	20,755	26.4%
Greek	11,708	28.8%
French Creole	13,324	38.7%
Persian	13,650	38.4%
Other Indo-European languages	8,747	22.3%
Portuguese	10,273	31.1%
Hebrew	9,106	9.9%
Gujarati	9,160	31.2%
Japanese	4,518	32.9%
Polish	3,142	33.0%
Other Slavic languages	5,368	18.0%
Other Pacific Island languages	3,813	46.9%
Thai	4,118	38.1%
Hungarian	2,270	34.5%
Scandinavian languages	1,983	5.9%
Mon-Khmer, Cambodian	1,615	47.2%
Other and unspecified languages	883	28.4%
Serbo-Croatian languages	2,983	33.1%
Armenian	728	26.5%
Yiddish	600	19.5%
Other Native North American languages	2,927	5.8%
Laotian	1,692	49.3%
Navajo	453	0%

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives

Member Information Sources

DESCRIPTION

The percentage of meaningful member information sources and information being proactively captured by the health benefit plan, and also being used to identify RELICC™ data elements, including race/ethnicity, languages spoken other than English, interpreter need, and cultural characteristics of their enrolled members.

Maryland plans were recently permitted to begin gathering RELICC™ data directly from members in order to better address their health care needs. As a result, plans are in various stages with regard to RELICC™ data completeness.

For this measure, a higher percentage is better, which means that the plan is taking steps to gather RELICC™ data directly and proactively from members in order to better address their health care needs.

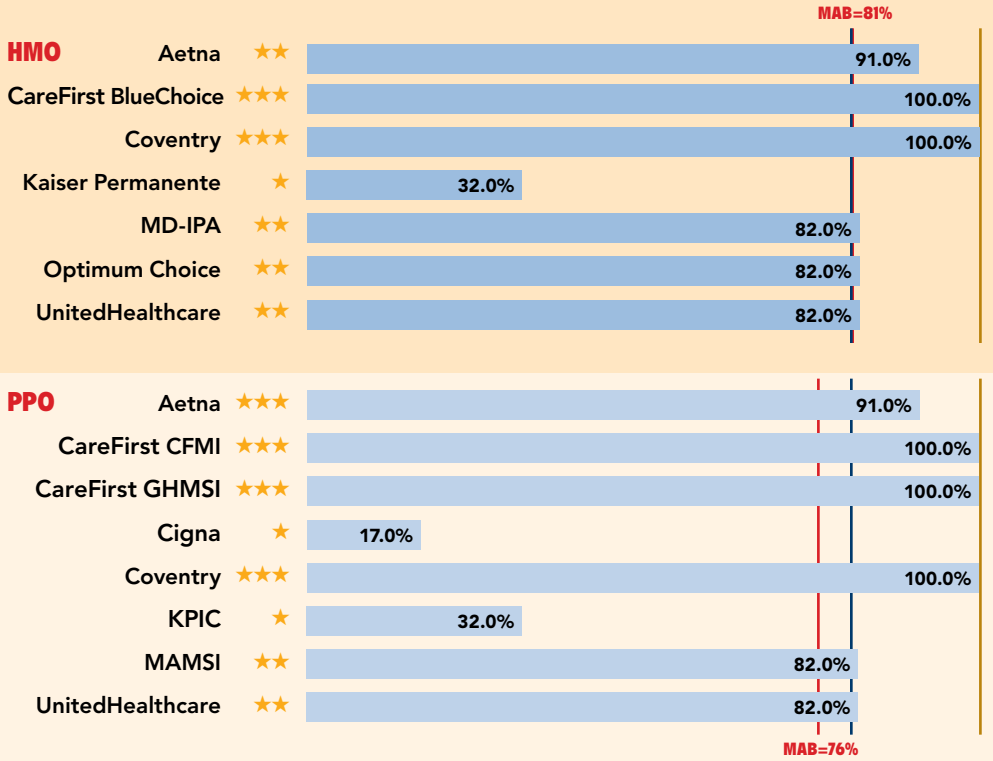
RATIONALE

According to population projections by the U.S. Census Bureau, the number of minorities living in the United States is projected to increase to about one in two by 2050. In spite of the many advances in health care, race and ethnicity remains a significant factor in determining whether an individual has adequate access to health care, receives high quality health care, and has positive health outcomes.

Not all Maryland plans proactively collect RELICC™ information directly from members. Those plans that do, use enrollment forms, clinical visits, and surveys. Several plans improved their capture of Race/Ethnicity from 2014, and others announced long-term plans to improve their sources of information. Included this year, plans were also asked whether they capture information on members' education level.

I.U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, 1996

IS THE PLAN GETTING ACCURATE RELICC™ MEMBER INFORMATION?



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Data Source: RELICC™ Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Information on Physicians, Physician Office Staff, and Plan Personnel

DESCRIPTION

The percentage of network physicians, provider office staff and health benefit plan personnel for which the plan has identified RELICC™ data elements, including race/ethnicity and languages spoken other than English.

For this measure a higher percentage is better, which means that RELICC™ data elements have been identified for the provider network, provider office staff and plan personnel.

NOTE: Each RELICC™ data element is weighted differently, thus scores do not reflect a one-to-one relationship. For example, a plan with a score of 47% on this measure does not necessarily indicate the plan has 47% of the RELICC™ data on their provider network, office staff and plan personnel.

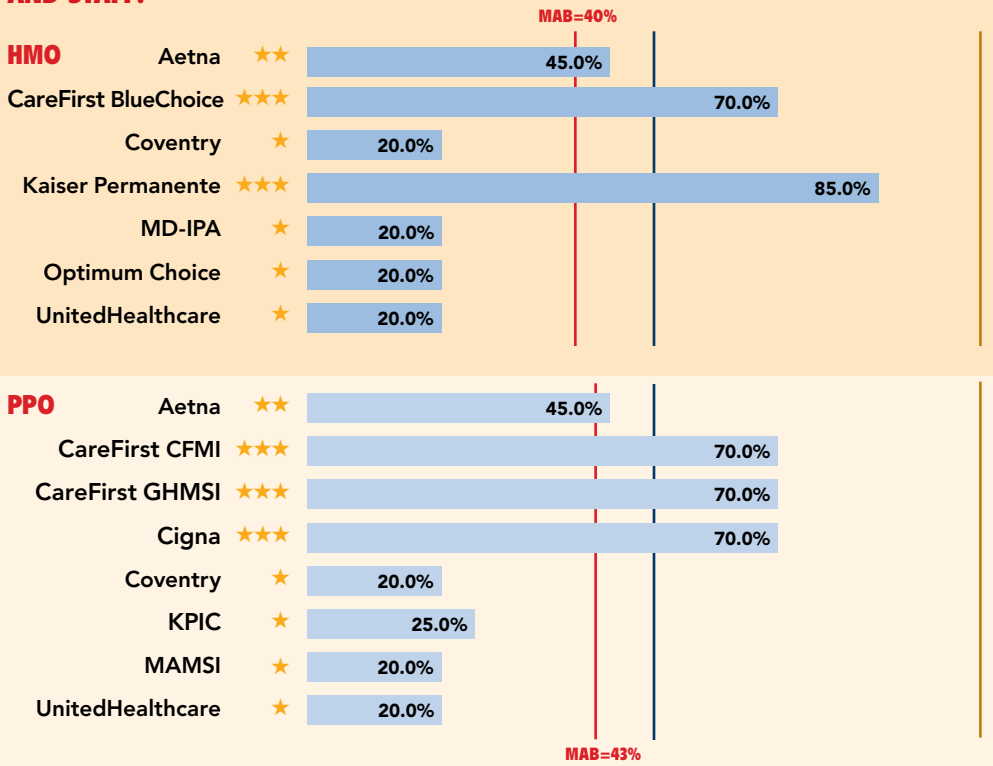
RATIONALE

"Clear communication [between patients and providers] is the foundation for patients to be able to understand and act on health information." In order to provide useful support materials and to connect patients with concordant or similar health providers if desired, health benefit plans should have information on RELICC™ characteristics, not only of their members, but also of their provider network and provider office staff.

Maryland plan performance remains inconsistent for this measure. About half the plans have identified Race/Ethnicity for a significant number of network physicians, but few for the physician's office staff. Almost all know the languages spoken by network physicians, but no plans have identified languages spoken by physicians' office staff. Plans are improving in their knowledge of RELICC™ information of their own staff.

U.S. Department of Health and Human Services, Indian Health Services, Patient-Provider Communication Toolkit

DOES THE PLAN KNOW THE RELICC™ INFORMATION FOR THEIR DOCTORS AND STAFF?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Using the Data

DESCRIPTION

The percentage of meaningful ways the health benefit plan uses RELICC™ data elements of their enrolled members, network providers, and their own plan customer service personnel, as well as organizational RELICC™ related programming data, to eliminate disparities.

For this measure, a higher percentage is better, which means the plan is using the RELICC™ data elements of their members, network providers and plan personnel in meaningful ways to eliminate disparities.

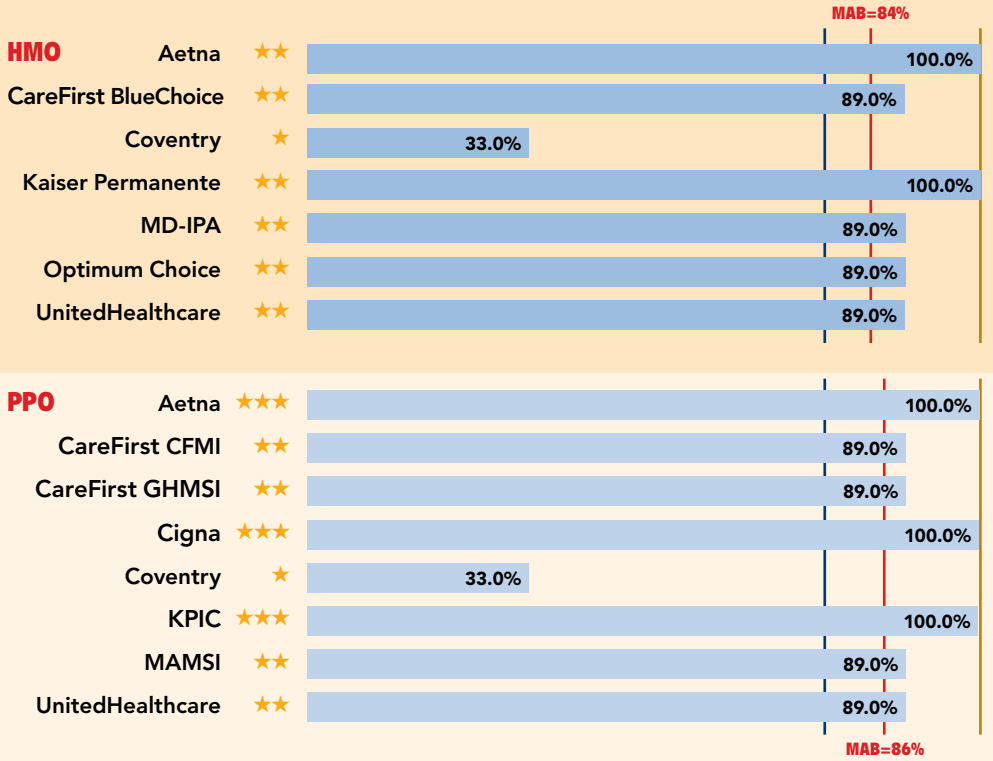
RATIONALE

The National Prevention Council advises that health benefit plans can take action to eliminate disparities by training and hiring "more qualified staff from underrepresented racial and ethnic minorities and people with disabilities."

Maryland plans continue to do a good job with the RELICC™ data they have. Plans use the data to improve language support activities; focus quality improvement efforts; assess the adequacy of language assistance to meet members' needs; and create culturally sensitive disease management, health education and health promotion programs. However, few plans are sharing the data with their provider networks, using the data to incentivize providers to reduce disparities, or using the data to analyze their own disenrollment patterns to address disparities.

U.S. Department of Health and Human Services, Office of the Surgeon General, National Prevention Council

DOES THE PLAN USE THE DATA TOWARD ELIMINATING DISPARITIES?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Supporting the Needs of Members With Limited English Proficiency

DESCRIPTION

The percentage of meaningful ways the health benefit plan supports the language needs of members with limited English proficiency (including users of Deaf American Sign Language).

For this measure, a higher percentage is better, which means the plan is employing multiple effective language needs strategies to assist their members whose primary language is not English.

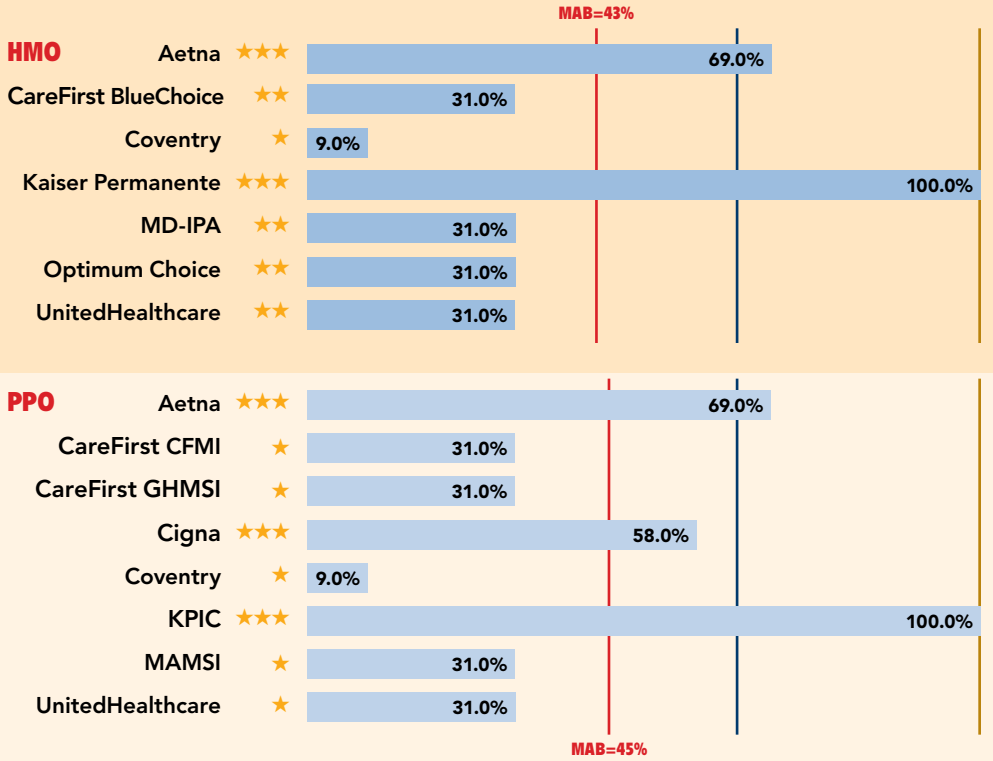
RATIONALE

Health literacy is defined as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions." It is crucial to identify and implement successful communication strategies for all members, including those with limited English proficiency (LEP).

Maryland plans remain inconsistent in meeting the needs of LEP members, though improvements were made. Most plans are testing and certifying the proficiency of interpreters, and about half pay for these services used by their networks. Up from 2014, more plans are testing or verifying the proficiency of bilingual non-clinical plan staff and of bilingual clinicians. However, few plans provide or pay for foreign language training.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015

HOW WELL DOES THE PLAN HELP MEMBERS WITH LANGUAGE CHALLENGES?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Assuring That Culturally Competent Health Care is Delivered

DESCRIPTION

The percentage of meaningful ways the health benefit plan assures that culturally competent health care is delivered.

For this measure, a higher percentage is better, which means the plan is finding ways to assure that culturally competent health care is delivered.

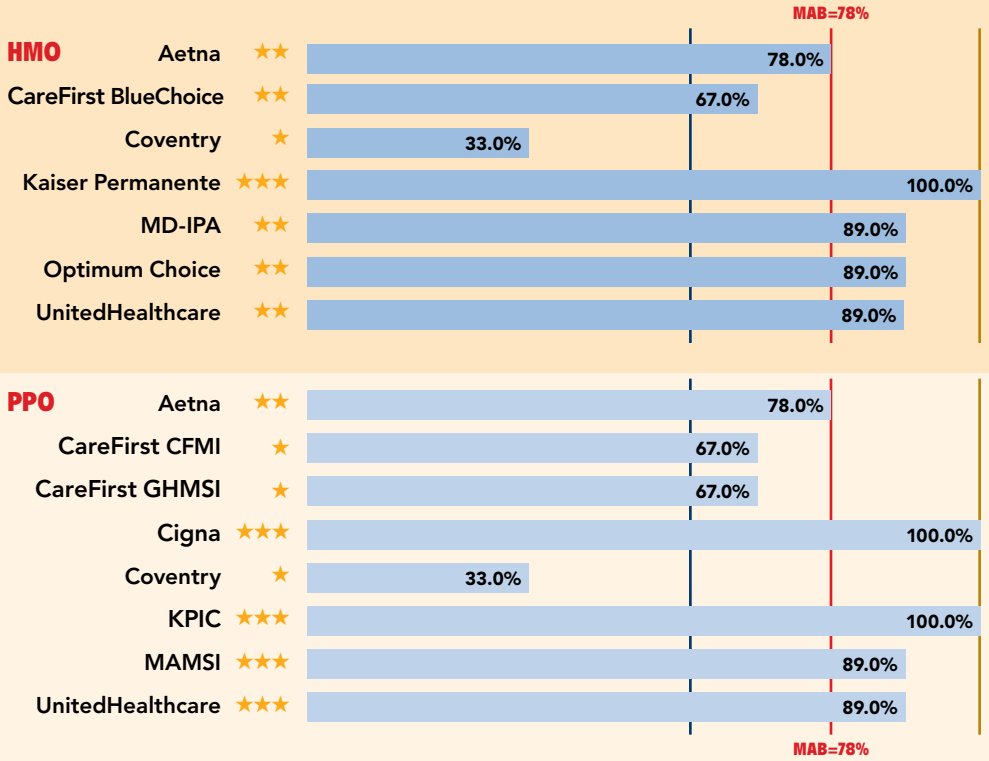
RATIONALE

"… Prevention communications should take the culture (e.g., language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups) of the target population into consideration to be effective."

Maryland plans improved their efforts to assure the delivery of culturally competent care. The plans assess members' needs, tailor health promotion and disease management messaging to particular cultural groups, and involve the community by seeking advice from Community Advisory Boards and other community-based organizations, plus collaborating with medical associations focused on cultural competency issues. Some plans have added extensive cultural competence training programs. Still, few plans conduct a cultural competence assessment of physician offices, nor do they employ cultural and linguistic services coordinators or specialists.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity, 2013

DOES THE PLAN SUPPORT THE COMPLETE CULTURAL HEALTH NEEDS OF MEMBERS?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Evaluating and Measuring the Impact of Language Assistance

DESCRIPTION

The percentage of meaningful results from the health benefit plan's evaluation and measurement of the impact of language assistance programs or initiatives aimed at better serving the needs of their enrolled members, network providers and their office staff, as well as the plan's own customer service personnel.

For this measure, a higher percentage is better, which means the plan is effectively evaluating and measuring the impact of language assistance programs and initiatives to ensure that members in need of language assistance are provided with high quality language services, using certified medical interpreters or trained staff.

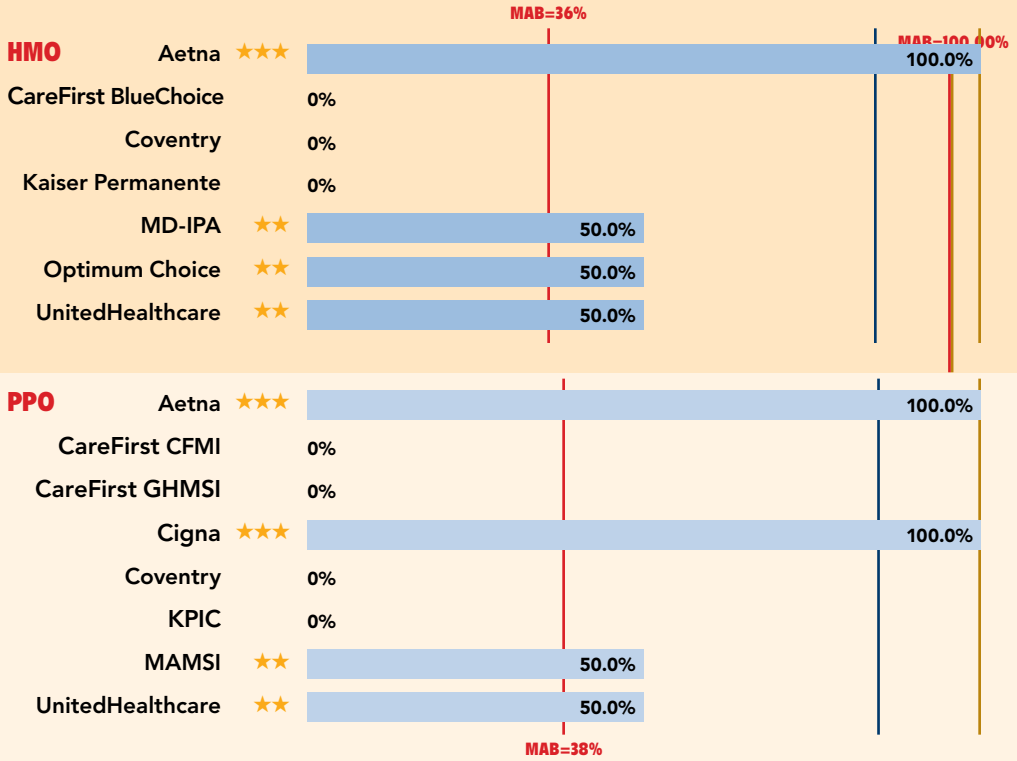
RATIONALE

Studies show that when offered a choice, minority patients are more likely to select a provider of a similar race/ethnicity, and have a higher degree of patient satisfaction. Several reasons for this include the removal of language barriers, the ability to communicate more effectively, and the assumption that similar cultural beliefs and values will be shared.

Although all health benefit plans are taking steps to meet the language needs of their members, strict evaluation of this measure beginning in 2015 show that about half of Maryland plans measure the impact of their language assistance programs and initiatives. Some plans limit their measurement to the number of members accessing language assistance, and satisfaction with those services. Some plans have expanded to investigate the impact of culturally related interventions on drug adherence and associated reduction in adverse events.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, National Center for Biotechnology Information, 2010

HOW WELL DOES THE PLAN CRITIQUE THEIR OWN LANGUAGE ASSISTANCE EFFORTS?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Information Available Through the Online Provider Directory

DESCRIPTION

The percentage of meaningful ways RELICC™ information on the health benefit plan's provider network is made available to members through the online provider directory.

For this measure, a higher percentage is better, which means the plan is effectively using their online provider directory in order to share providers' RELICC™-related characteristics which are important to their members.

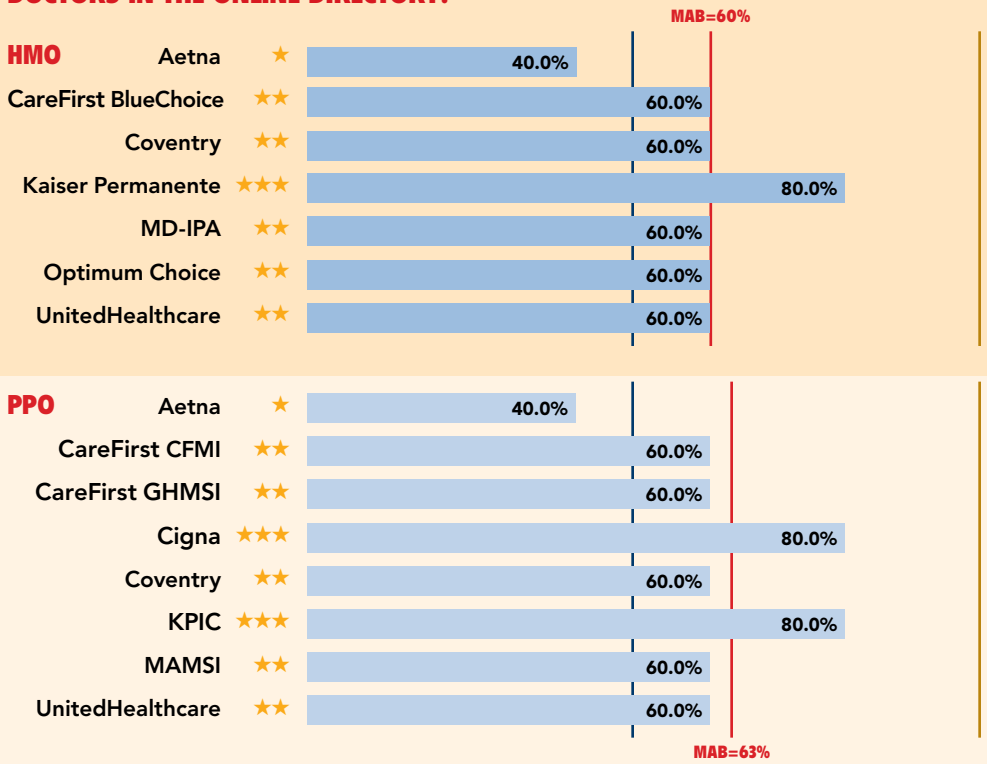
RATIONALE

To make informed provider selections, plan members should have access to relevant information on the provider network. Also, to process and pay claims correctly, plans need to maintain accurate information on network providers. "Member Services are also part of a provider network [thus directories include]… both entity information and individual provider information."

Maryland plans improved their searchable physician information this year. With the addition of new capabilities, almost all plans offer the ability to search by facility privileges, and almost all can search by languages spoken. Although some added this feature, only about half can be searched by years in practice, and almost no plans offer the ability to search by office hours. In addition to the basic information noted above, dynamic provider directories also include degree and residency information, licensing information, hospital and group affiliations, and whether providers are accepting new patients.

U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, 2012

CAN MEMBERS PRIORITIZE SEARCH CRITERIA TO FIND DOCTORS IN THE ONLINE DIRECTORY?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Interactive Selection Features for Members Selecting a Physician Online

DESCRIPTION

The percentage of meaningful ways members can interact with the health benefit plan's online physician selection tool to select provider features that are of importance to them as members.

For this measure, a higher percentage is better, which means the plan is effectively maintaining a highly interactive online provider directory in order to share providers' professional features and other RELICC™-related characteristics which are important to their members.

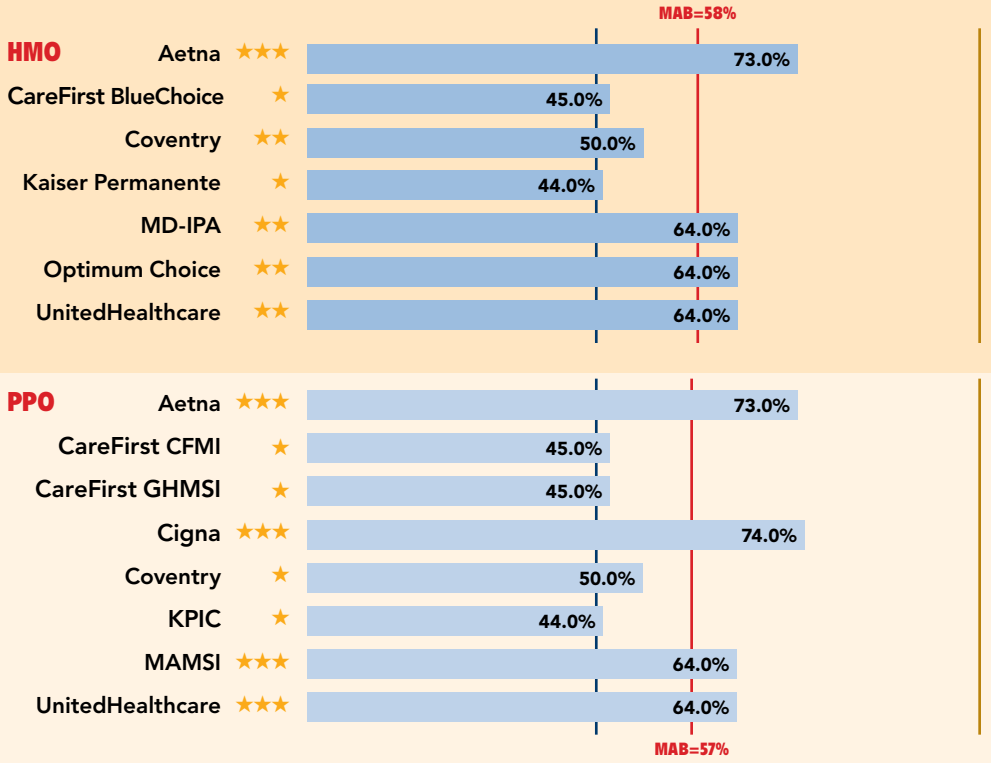
RATIONALE

Health benefit plan members often rely on technology to help them find culturally concordant or similar health care providers. Provider directories can be important sources for this information. Some directories are more sophisticated than others and are structured to allow convenient searches according to a member's preference for one or more provider categories such as gender, location, etc. Better directories guide members to the right doctor for them.

Almost all Maryland plans support members in searching for providers by treatment or condition and by culture. Improved for this year, almost all provide the user with guidance about physician choice, questions to ask physicians, and questions to ask the carrier. However, few plans in Maryland provide a photo for at least 50% of their physicians.

U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, 2015

DOES THE PLAN WEBSITE HELP MEMBERS WITH THE RIGHT GUIDANCE?



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Carrier Disparities Initiatives (continued)

Health Assessment Programming

DESCRIPTION

The percentage of meaningful ways the health benefit plan engages their members in Health Assessment completion and subsequent activities that reduce their members' health risk.

For this measure, a higher percentage is better, which means the plan is effectively reaching out to their members to facilitate completion of the plan's Health Assessment (HA), and that the HA content is comprehensive.

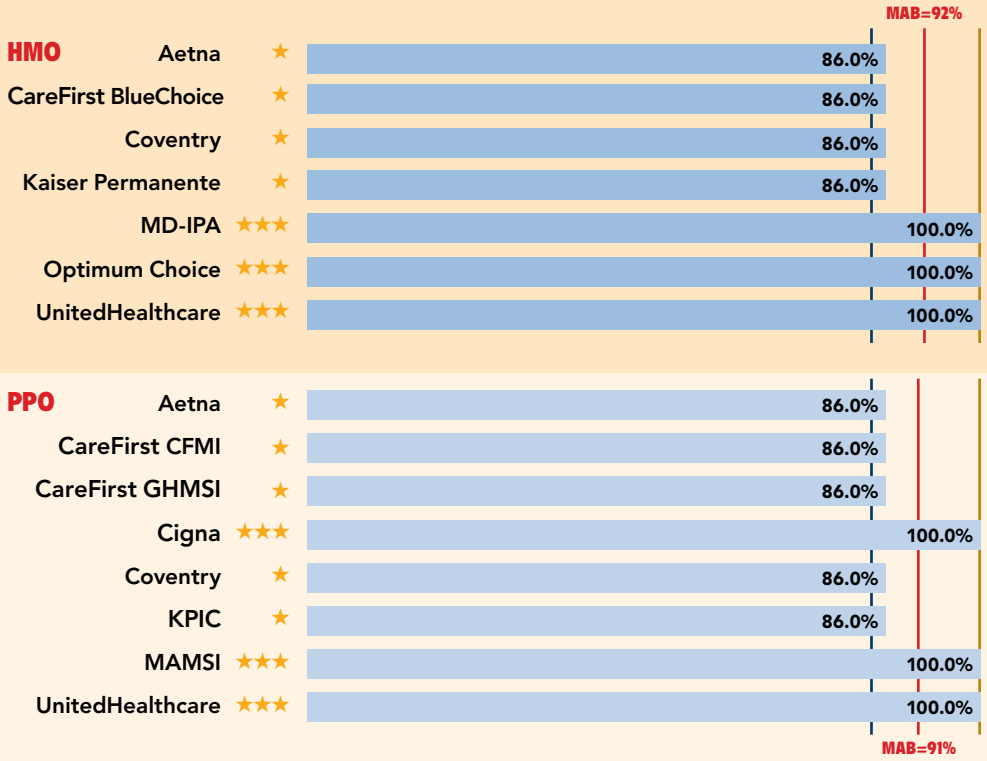
RATIONALE

Health Assessments (HAs), sometimes known as Health Risk Appraisals, help members understand their current health status and what their unique health risks might be, as well as guide members to resources that can improve their health. RELICC™- related issues play a strong role in making HAs user-friendly and helping members understand their unique health profile.

All Maryland plans have personal HAs available to members, providing the tool online and in print, and in multiple language options. Most plans provide member-specific behavior change recommendations that reduce risk at HA completion, though again this year, few offer such messaging at the point of the member risk response (i.e., at point member indicates that they are a smoker). Again this year, no plans provide access to the HAs through an Interactive Voice Recognition system or telephone interview with a live person.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity and Obesity, 2010

DOES THE PLAN HELP MEMBERS ADDRESS THEIR HEALTH RISKS?



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III. 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.

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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 aged 12 to 24 months in 2014 who had a visit with a primary care provider during the 2014 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.

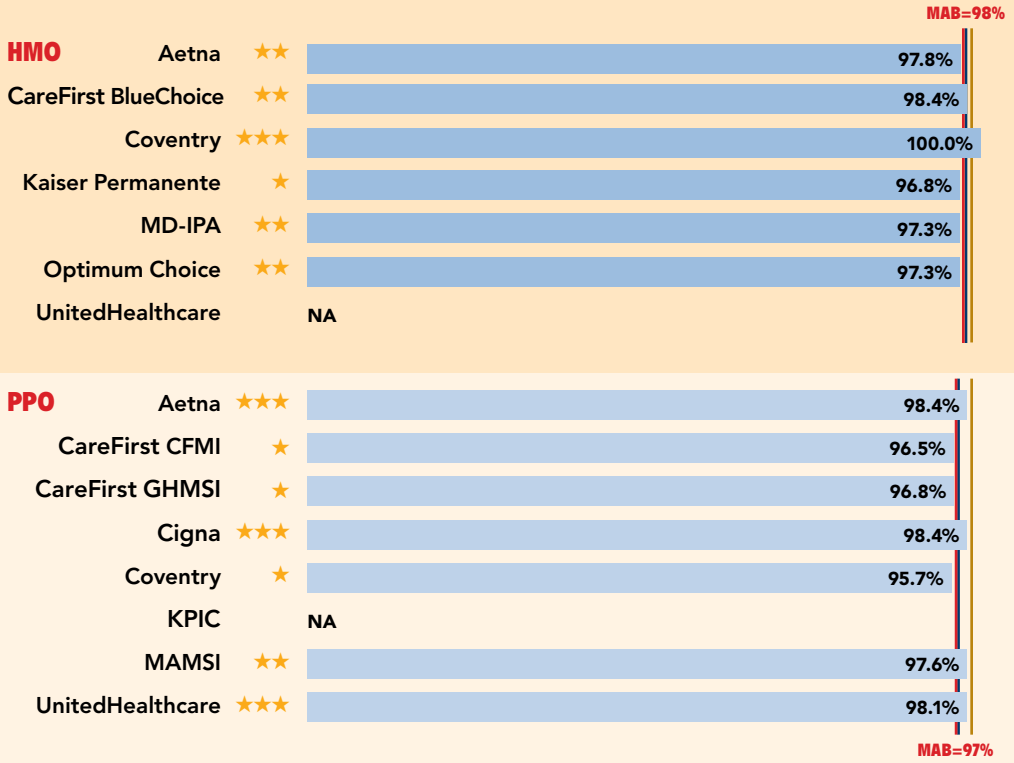
RATIONALE

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. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

PRIMARY CARE VISIT 12 TO 24 MONTHS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

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NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

Data Source: HEDIS® Submission or Health Benefit Plan Records

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

2. The percentage of children aged 25 months to 6 years in 2014 who had a visit with a primary care provider during the 2014 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.

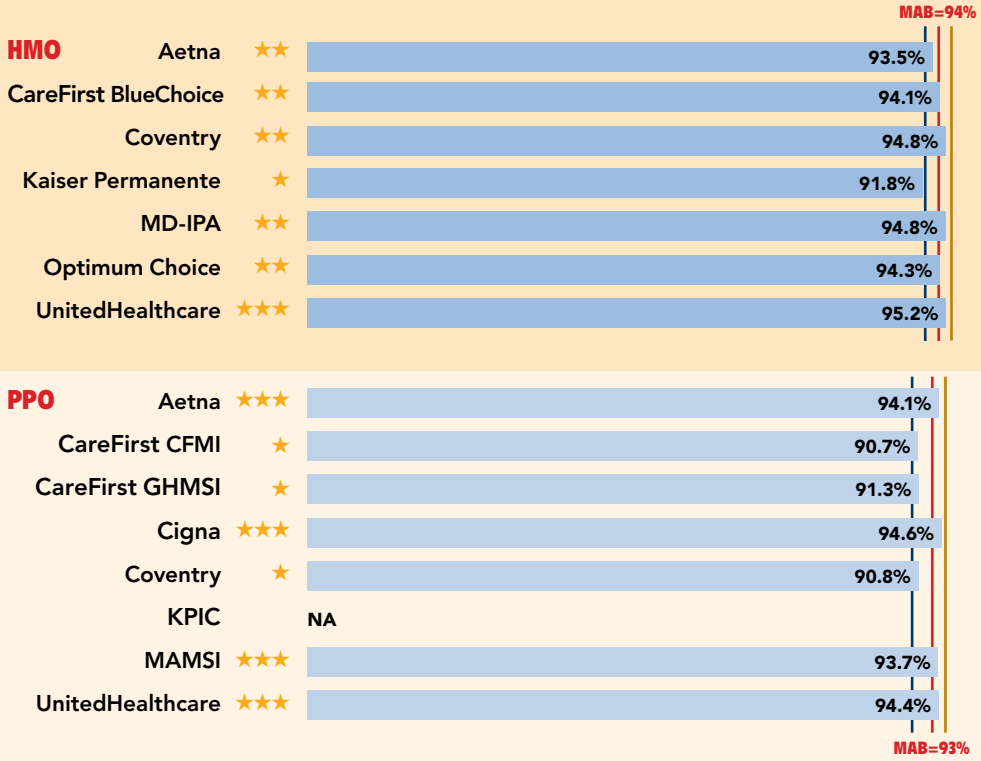
RATIONALE

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. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

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



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

3. The percentage of children aged 7 to 11 years in 2014 who had a visit with a primary care provider during the 2014 measurement year or the year prior.

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

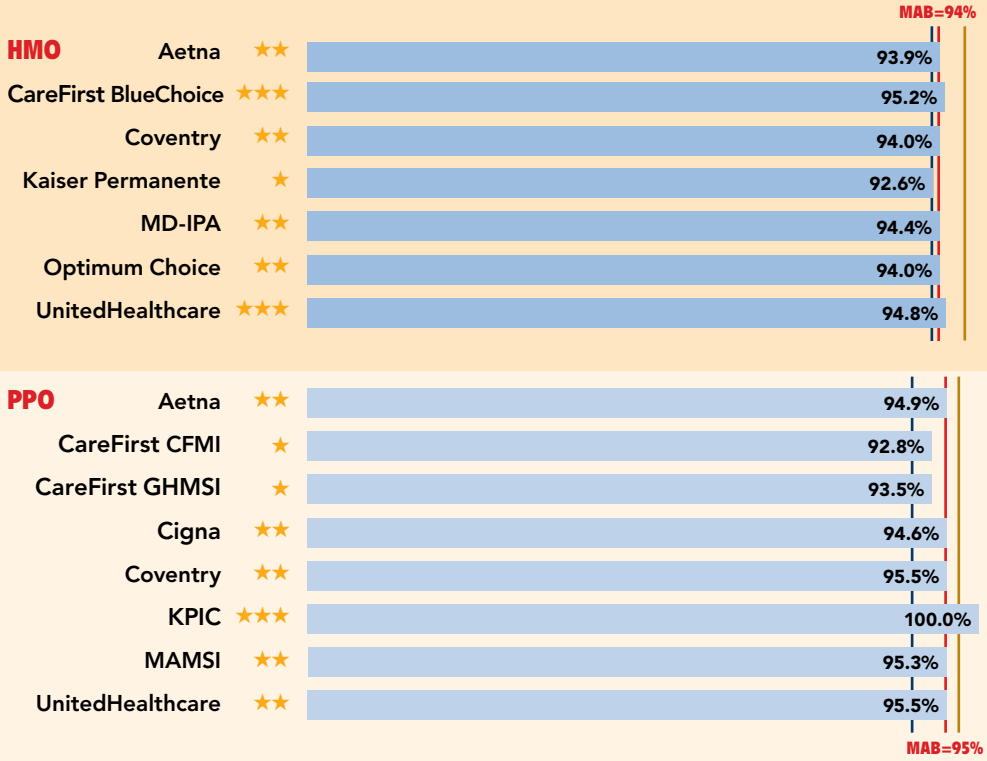
RATIONALE

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. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

1 PRIMARY CARE VISIT – 7 TO 11 YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Children and Adolescents Access to Primary Care Providers continued

DESCRIPTION

4. The percentage of children aged 12 to 19 years in 2014 who had a visit with a primary care provider during the 2014 measurement year or the year prior.

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

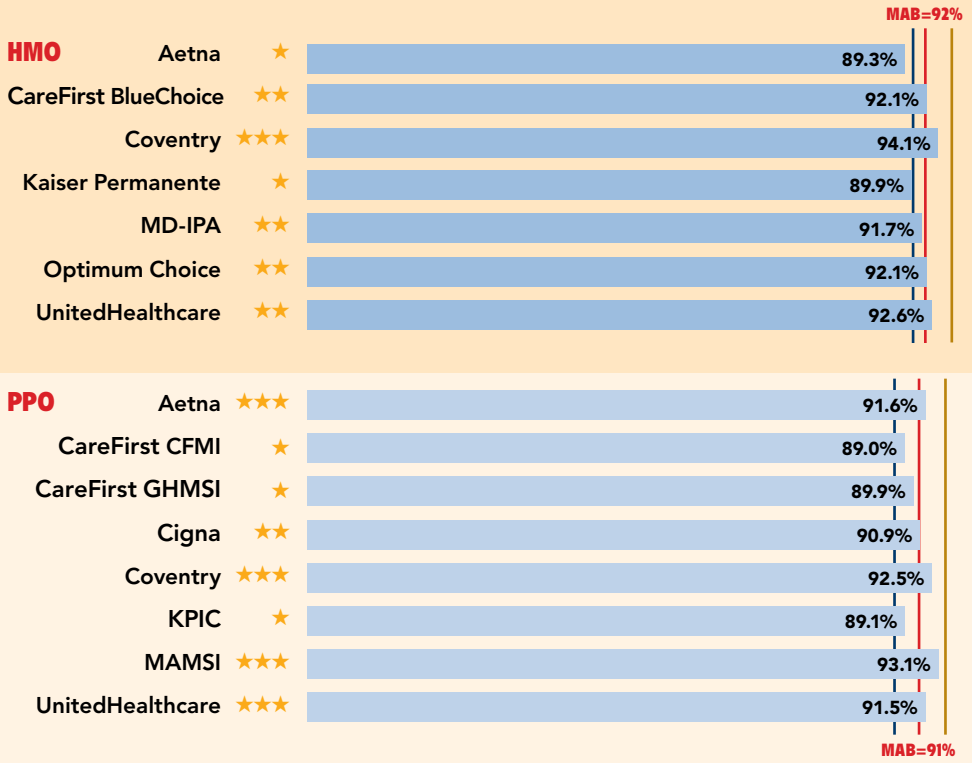
RATIONALE

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. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

1 PRIMARY CARE VISIT – 12 TO 19 YEARS OF AGE



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PERFORMANCE RATING

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

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QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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 of age during 2014 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.

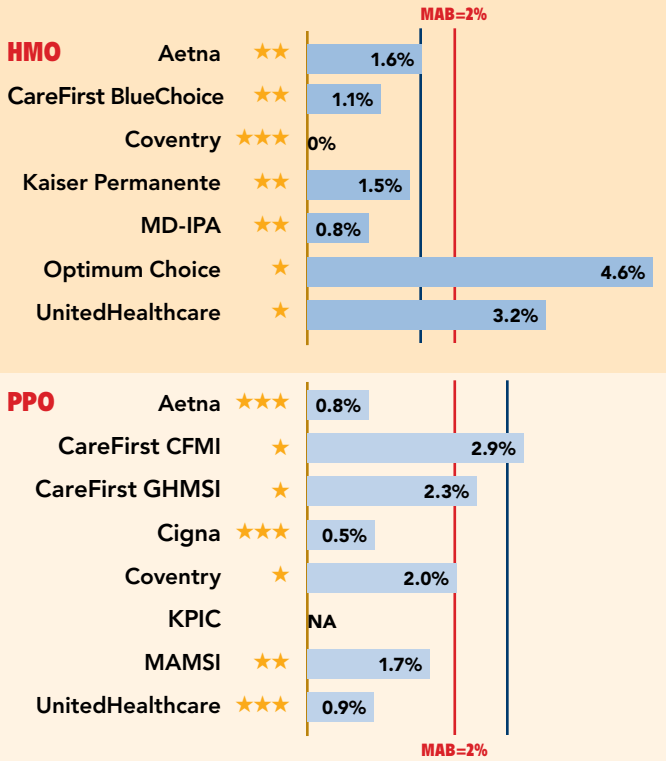
RATIONALE

Regular well-child checkups are one of the best ways to monitor growth and development in order to find and prevent health problems. They also provide an opportunity for the health care provider to offer guidance and counseling to the parents. These visits are of particular importance during early childhood, when infants and toddlers undergo rapid growth and change. Well-child visits are important even for healthy children because of the focus on wellness and preventive health care measures that keep children healthy.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, 2013

NOTE: For this performance indicator, a lower percentage is better

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



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PERFORMANCE RATING

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BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
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Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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

DESCRIPTION

2. The percentage of children who turned 15 months of age during 2014 who had six or more well-child visits with a primary care provider during their first 15 months of life.

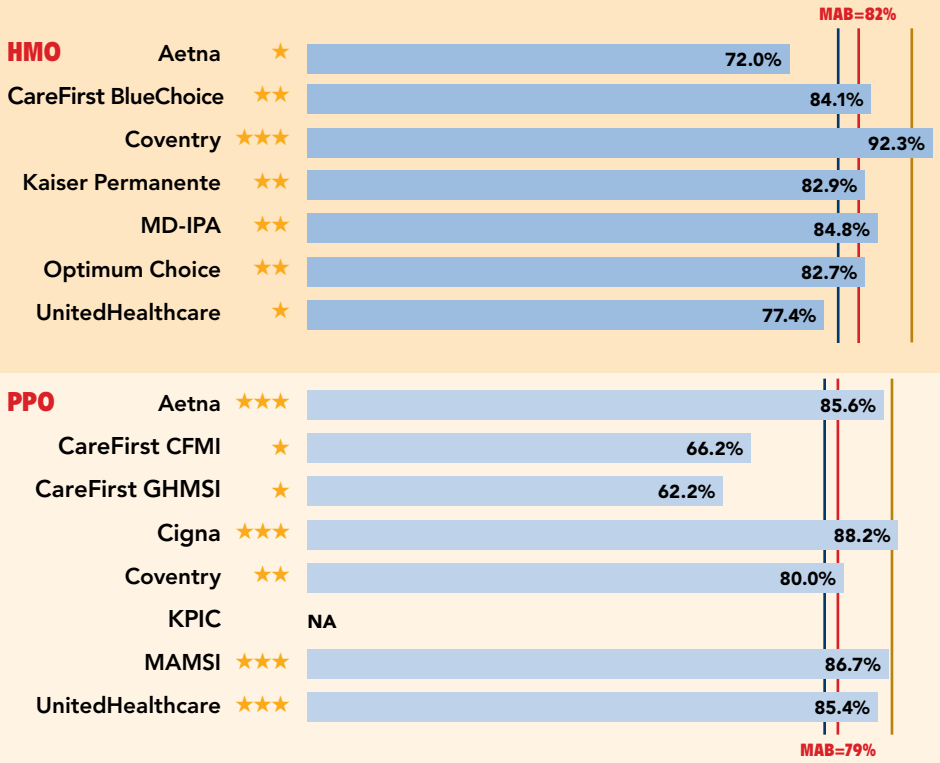
For this performance indicator, a higher percentage is better, which means that more infants and toddlers did have six or more well-child visits with a primary care provider, which is desirable, and fewer infants and toddlers had only five visits or less.

RATIONALE

Regular well-child checkups are one of the best ways to monitor growth and development in order to find and prevent health problems. They also provide an opportunity for the health care provider to offer guidance and counseling to the parents. These visits are of particular importance during early childhood, when infants and toddlers undergo rapid growth and change. Well-child visits are important even for healthy children because of the focus on wellness and preventive health care measures that keep children healthy.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, 2013

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



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

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

DESCRIPTION

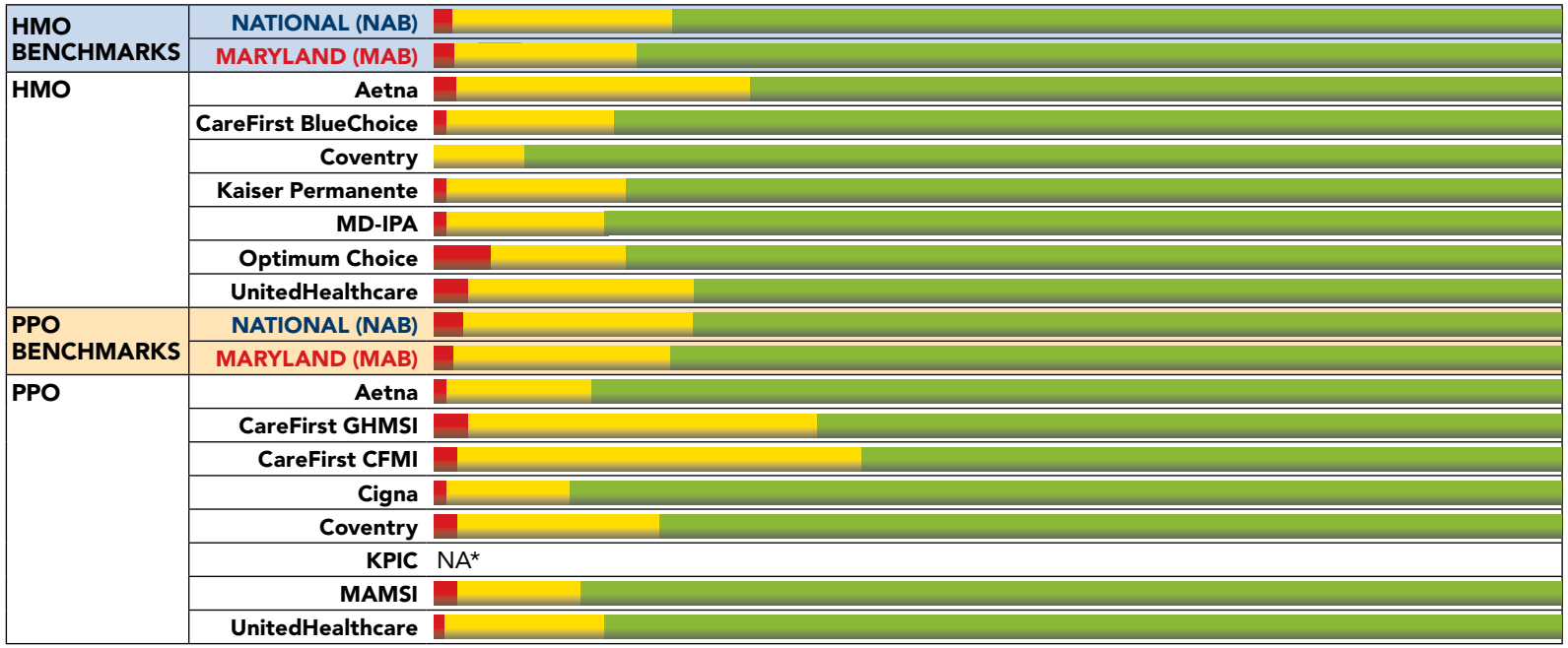
3. The percentage of children who turned 15 months of age during 2014 who had zero, one to five, or six or more well-child visit(s) with a primary care provider during their first 15 months of life.

NOTE: 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. 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 yellow
6+ Visits	Desirable goal for this measure; performance is displayed in green

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.



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

Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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

DESCRIPTION

The percentage of children aged 3 to 6 years in 2014 who received one or more well-child visits with a primary care provider during the 2014 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.

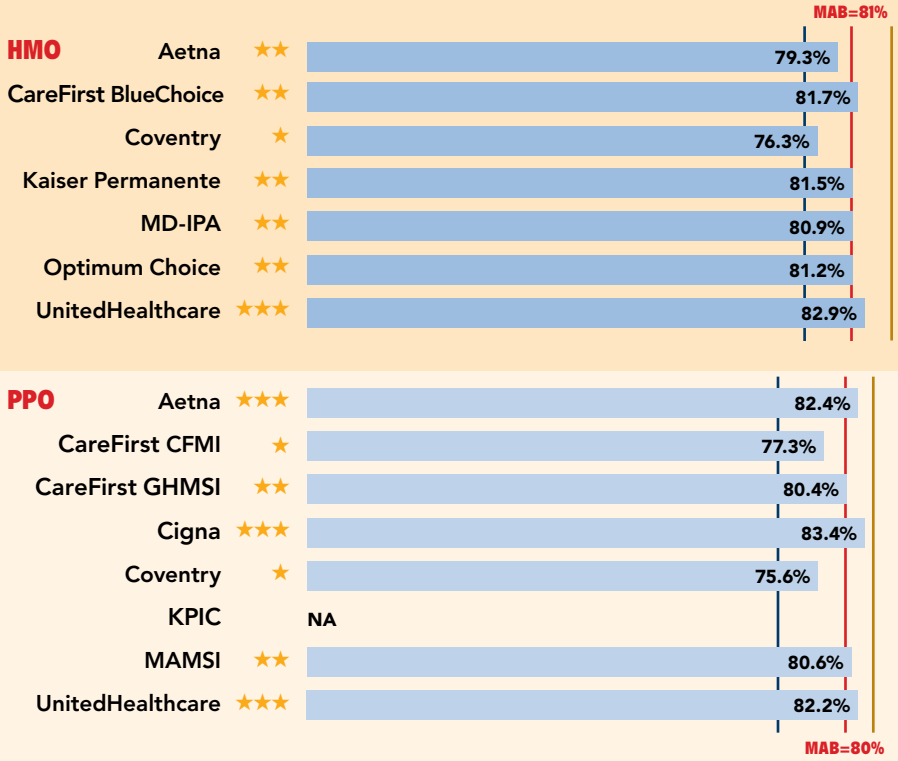
RATIONALE

Well-child visits are more than just a time for kids to get their immunizations. It is also a great time for parents to get valuable information that optimizes the health of their child. Parents should expect to get answers to questions or concerns about "normal development, nutrition, sleep, safety, diseases that are 'going around,' and other important topics."

One important topic involves vision, speech and language problems. Early intervention here can improve communication skills and avoid or reduce language and learning problems.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, 2013

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



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Childhood Immunization Status

DESCRIPTION

The percentage of children who turned 2 years of age during 2014 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. (See page 173 for more information)

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

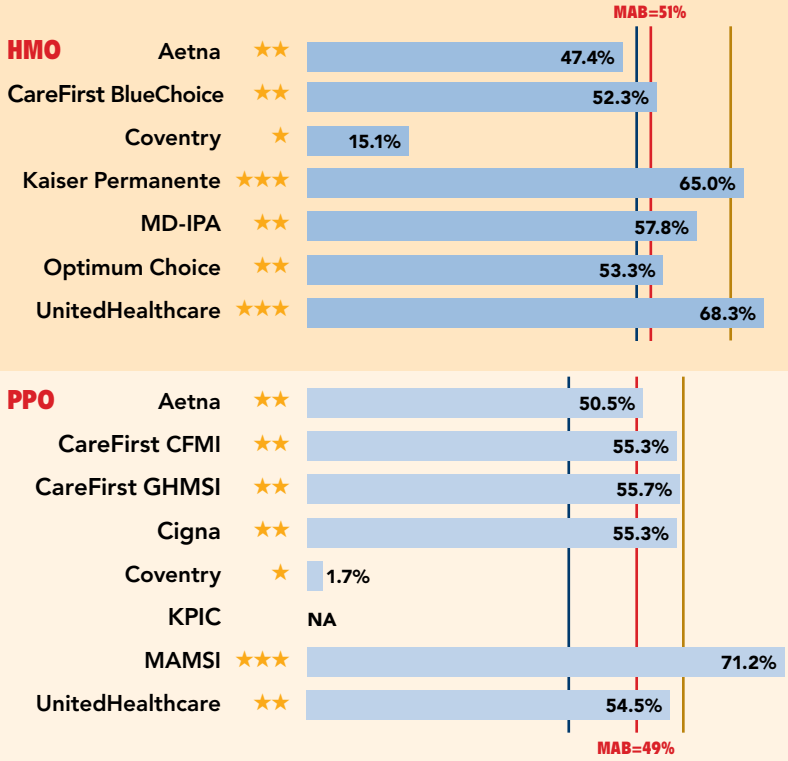
NOTE: There are nineteen separate indicators in this measure category, including individual and combination immunizations. Only the total percentage of members with documented immunizations for Combo 10, which includes all the immunizations that are required for children by age 2, is represented in the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

RATIONALE

Routine vaccinations help the body build immunity to over a dozen diseases without getting sick first. The Centers for Disease Control and Prevention publishes immunization schedules that summarize recommendations for routine vaccines for children. These schedules (see Appendix A) have been approved by the American Academy of Family Physicians and the American Academy of Pediatrics. The immunization schedules outline the best times to get each of the immunizations and also account for times when getting a particular immunization is not recommended. For example, children shouldn't receive measles vaccine until they are at least one year old because if it is given earlier the vaccination might not work as well.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, 2015

10 REQUIRED IMMUNIZATIONS – 2 YEARS OF AGE



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PERFORMANCE RATING

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Adolescent Well-Care Visits

DESCRIPTION

The percentage of adolescents and young adults aged 12 to 21 years in 2014 who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist (OB/GYN) during the 2014 measurement year.

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

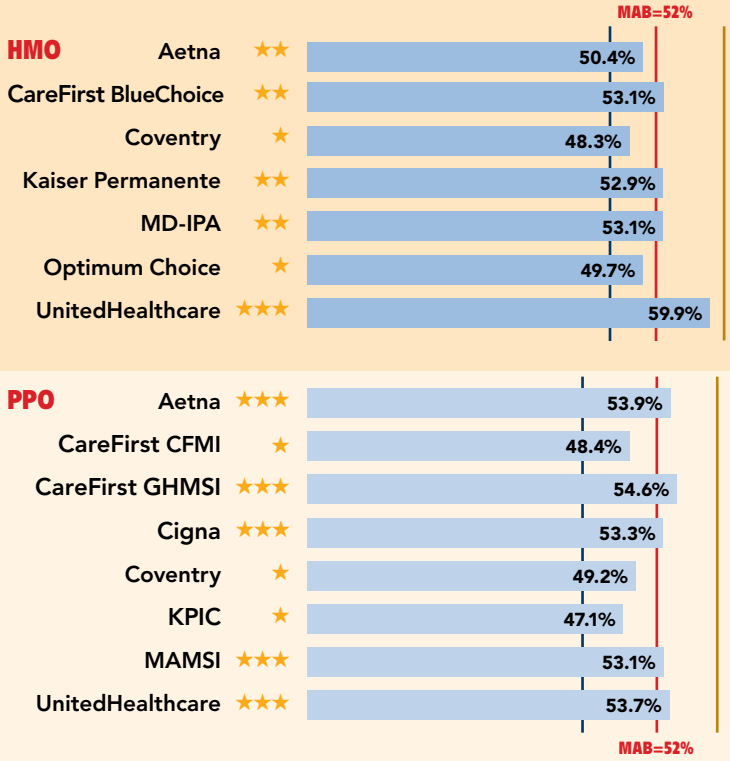
RATIONALE

Well-care visits are more than just a time for adolescents and young adults to get their immunizations. It is also a good opportunity to get valuable information that optimizes their health. Topics that can be covered during well-care visits include questions and concerns about "normal development, nutrition, sleep, safety, diseases that are 'going around,' and other important topics."

One important topic involves emotional and social aspects of 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.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, 2013

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



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PERFORMANCE RATING

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Immunizations for Adolescents

DESCRIPTION

The percentage of adolescents who turned 13 years of age during 2014 who had the two 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 dose of tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one dose of tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday. (See page 173 for more information)

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

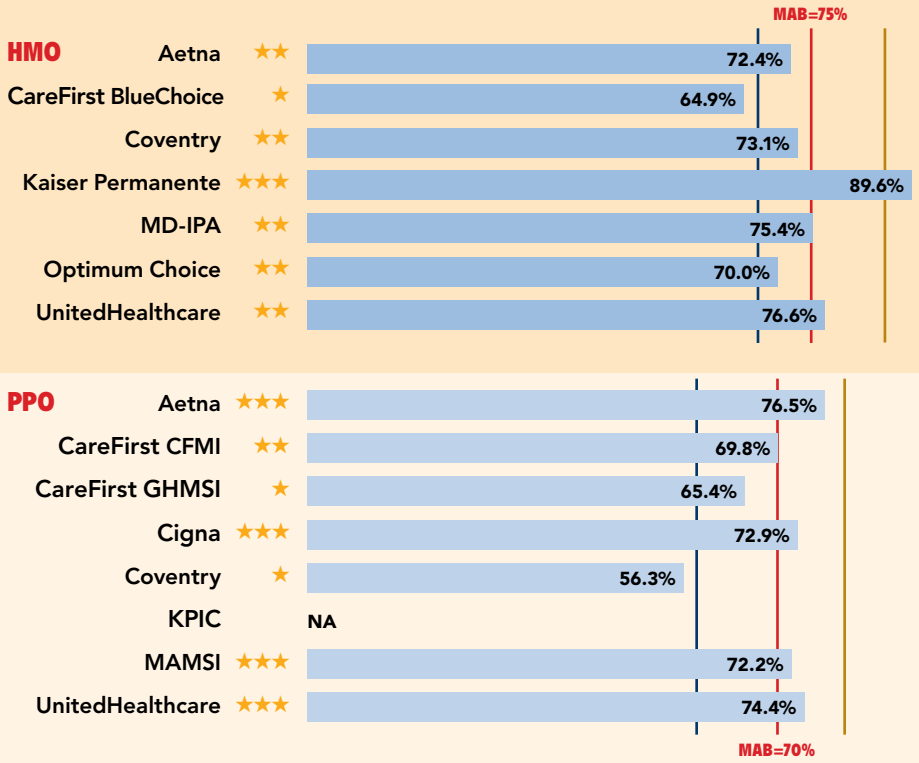
NOTE: There are three separate indicators in this measure category, including MCV, Tdap or Td, and a total of both MCV and Tdap or Td immunizations. Only the total percentage of members with documented immunizations for Combo 1, which includes all the immunizations that are required for adolescents by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

RATIONALE

"Preteens and teens are at risk for diseases and need the protection of vaccines to keep them healthy. The vaccines for preteens and teens are important because as kids get older, protection from some childhood vaccines begins to wear off and some vaccines work better when given during adolescence. There are many opportunities for vaccination, so take advantage of health check-ups, sports, or camp physicals to ensure teens receive the recommended vaccines."

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, 2015

2 REQUIRED IMMUNIZATIONS – 13 YEARS OF AGE



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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Human Papillomavirus Vaccine for Female Adolescents

DESCRIPTION

The percentage of female adolescents who turned 13 years of age during 2014 and who had three doses of the human papillomavirus (HPV) vaccine by their thirteenth birthday.

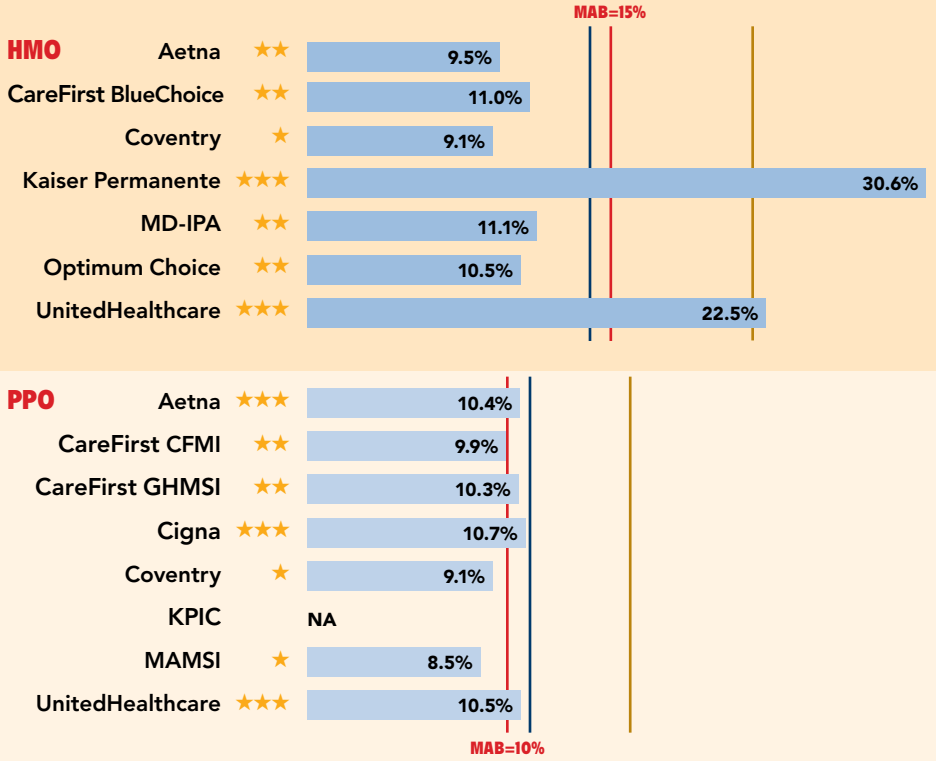
For this measure, a higher percentage is better, which means that more parents/guardians for female adolescents who turned 13 years of age during the measurement year not only authorized the optional HPV vaccination, but also followed through with attending two additional visits in order to complete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

RATIONALE

Genital human papillomavirus (HPV) is the most common sexually transmitted infection in the United States. According to the Centers for Disease Control and Prevention, approximately 79 million Americans are currently infected with HPV. In fact, it is so common that "most sexually-active men and women will get at least one type of HPV at some point in their lives." Genital warts and cervical cancer are two common health problems related to HPV. The HPV vaccine can offer protection against contracting the viral infection, which could reduce the need for medical care, biopsies and invasive procedures associated with follow-up from abnormal Pap tests and thereby reduce health care costs.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013

RECOMMENDED HPV IMMUNIZATION – 13 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

Non-Recommended Cervical Cancer Screening in Adolescent Females

DESCRIPTION

The percentage of adolescent females aged 16 to 20 years in 2014 who were screened unnecessarily for cervical cancer during the 2014 measurement.

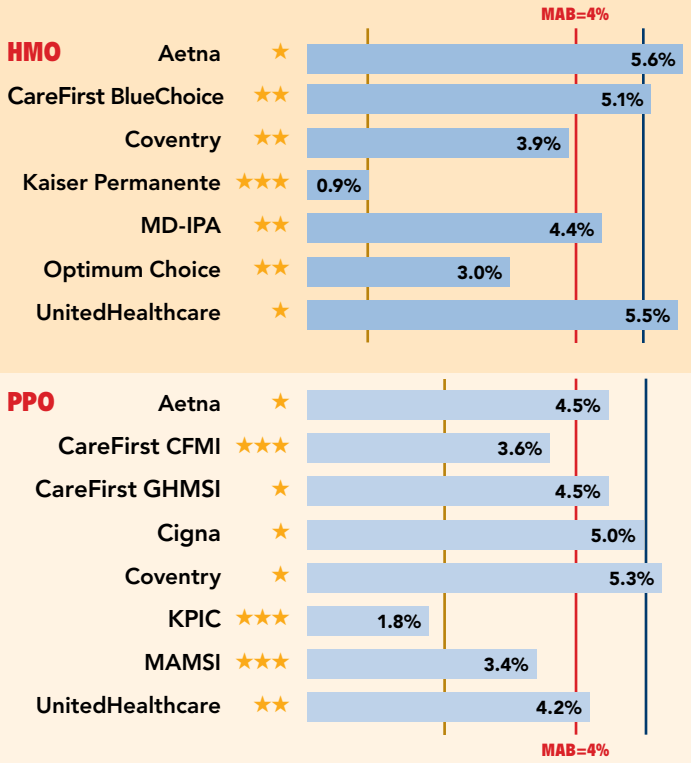
For this measure, a lower percentage is better, which means that there were fewer adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer whether with a Pap test or HPV co-test.

RATIONALE

Experts "recommend against cervical cancer screening in a general population of females under 21 years of age" because there is evidence that screening in this age group [regardless of sexual history] does not reduce the incidence of new cases of cervical cancer, nor does it reduce mortality from cervical cancer, compared with beginning screening at age 21. It should be noted that screening has been shown to be very effective at reducing cervical cancer incidence and mortality among women 21 to 65 years of age.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality

UNNECESSARY CERVICAL CANCER SCREENING – 16 TO 20 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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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 children and adolescents aged 3 to 17 years in 2014 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose weight and body mass index (BMI) was assessed and documented in the 2014 measurement year.

For this performance indicator, 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 primary care provider or OB/GYN.

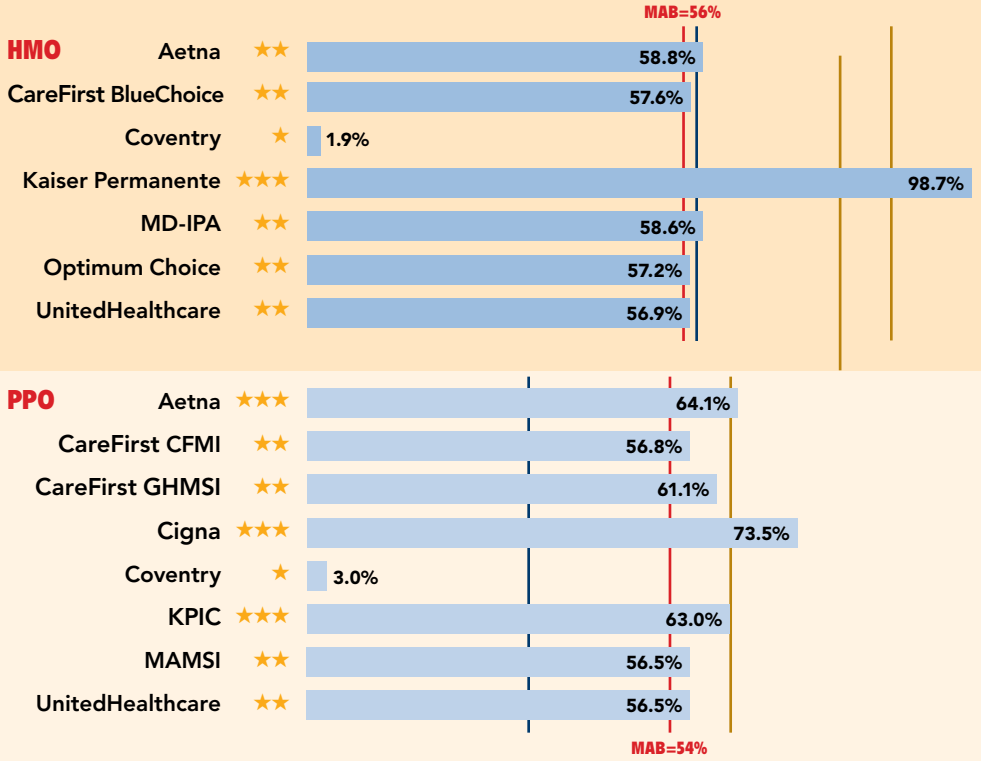
NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3 to 11 years, 12 to 17 years and 3 to 17 years. Only the total percentage of children and adolescents with documented BMI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

RATIONALE

Childhood obesity can have a harmful effect on the body in a variety of ways. Children who have obesity are more likely to have high blood pressure and high cholesterol, which are risk factors for cardiovascular disease, increased risk of impaired glucose tolerance (insulin resistance and type 2 diabetes), breathing problems (sleep apnea and asthma), musculoskeletal discomfort, fatty liver disease, gallstones, and gastro-esophageal reflux (heartburn), psychological stress such as depression, behavioral problems, and issues in school. Obese children are more likely to become obese adults, and the obesity in adulthood is likely to be more severe. A goal for overall good health should be to reach and maintain a healthy weight.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity, 2015

BODY MASS INDEX – 3 TO 17 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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

continued

DESCRIPTION

2. The percentage of children and adolescents aged 3 to 17 years in 2014 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose counseling for nutrition was documented in the 2014 measurement year.

For this performance indicator, 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 primary care provider or OB/GYN.

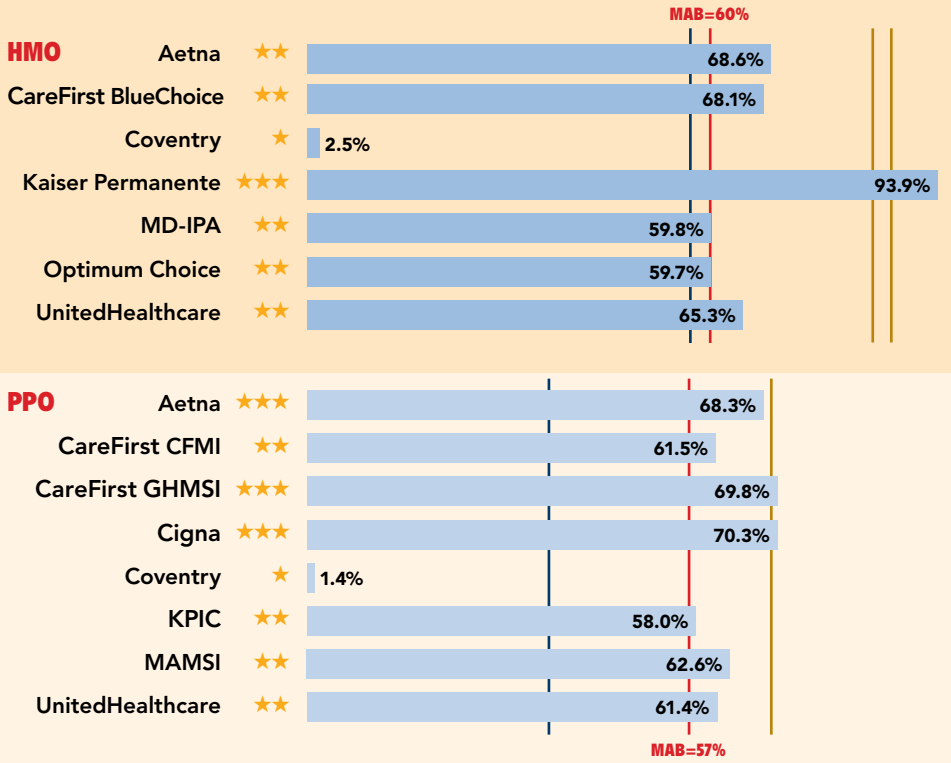
NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3 to 11 years, 12 to 17 years and 3 to 17 years. Only the total percentage of children and adolescents with documented nutrition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

RATIONALE

Childhood obesity can have a harmful effect on the body in a variety of ways. Children who have obesity are more likely to have high blood pressure and high cholesterol, which are risk factors for cardiovascular disease, increased risk of impaired glucose tolerance (insulin resistance and type 2 diabetes), breathing problems (sleep apnea and asthma), musculoskeletal discomfort, fatty liver disease, gallstones, and gastro-esophageal reflux (heartburn), psychological stress such as depression, behavioral problems, and issues in school. Obese children are more likely to become obese adults, and the obesity in adulthood is likely to be more severe. A goal for overall good health should be to reach and maintain a healthy weight.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity, 2015

NUTRITION COUNSELING – 3 TO 17 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care and Wellness for Children and Adolescents (continued)

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

continued

DESCRIPTION

3. The percentage of children and adolescents aged 3 to 17 years in 2014 who had an outpatient visit with a primary care provider or obstetrician/gynecologist (OB/GYN) and whose counseling for physical activity was documented in the 2014 measurement year.

For this performance indicator, 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 primary care provider or OB/GYN.

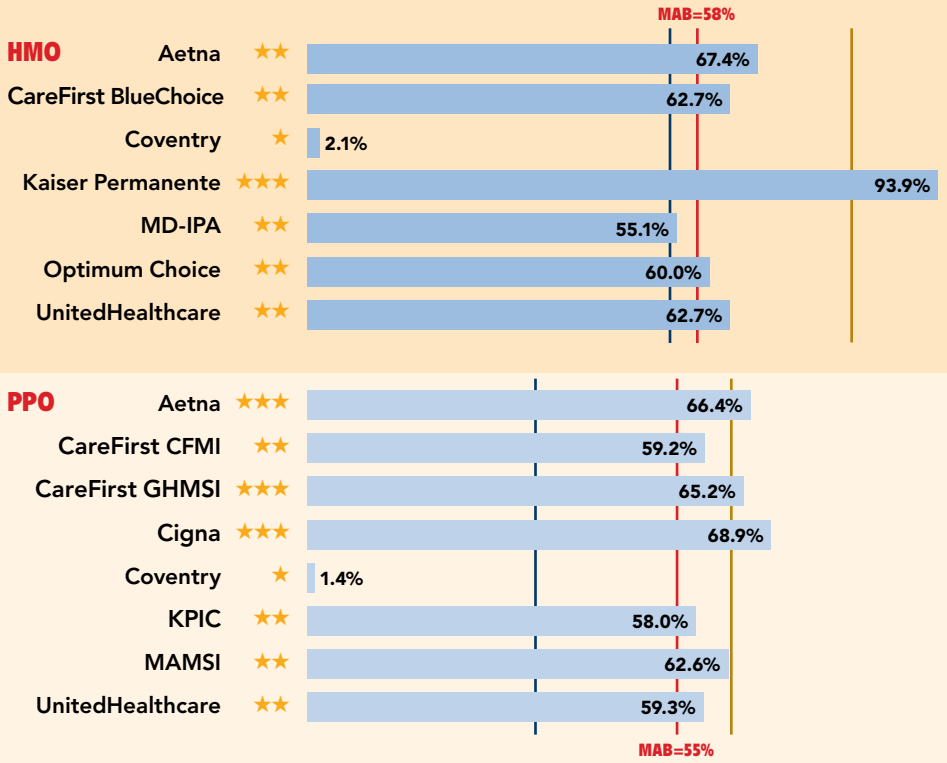
NOTE: There are nine separate indicators in this measure category, including body mass index, nutrition counseling and physical activity counseling for each of three age groupings, 3 to 11 years, 12 to 17 years and 3 to 17 years. Only the total percentage of children and adolescents with documented counseling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

RATIONALE

Childhood obesity can have a harmful effect on the body in a variety of ways. Children who have obesity are more likely to have high blood pressure and high cholesterol, which are risk factors for cardiovascular disease, increased risk of impaired glucose tolerance (insulin resistance and type 2 diabetes), breathing problems (sleep apnea and asthma), musculoskeletal discomfort, fatty liver disease, gallstones, and gastro-esophageal reflux (heartburn), psychological stress such as depression, behavioral problems, and issues in school. Obese children are more likely to become obese adults, and the obesity in adulthood is likely to be more severe. A goal for overall good health should be to reach and maintain a healthy weight.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity, 2015

PHYSICAL ACTIVITY COUNSELING – 3 TO 17 YEARS OF AGE



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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 children aged 6 to 12 years during the intake period from March 1, 2013 to February 28, 2014 that were newly prescribed attention deficit/hyperactivity disorder (ADHD) medication, who also had one follow-up visit with a practitioner with prescribing authority during the initial 30 days of when the first ADHD medication was prescribed (Index Prescription Start Date).

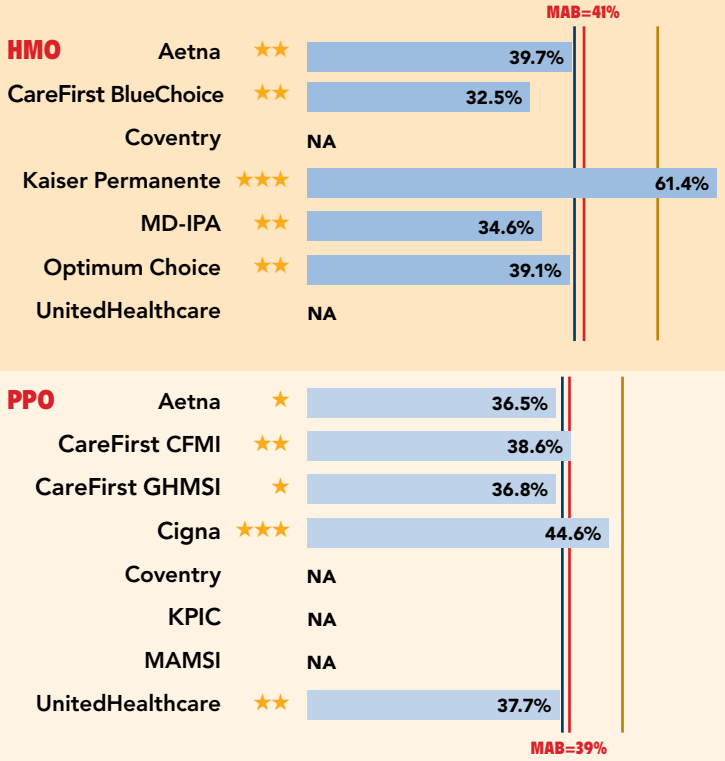
For this performance indicator, a higher percentage is better, which means that more children 6 to 12 years of age did have a follow-up visit during the 30-day Initiation Phase.

RATIONALE

Currently, there is no cure for attention deficit/hyperactivity disorder (ADHD), but it can be successfully managed, usually with a combination of behavior therapy and medication. A good treatment plan includes close monitoring and follow-up care through which parents and doctors "work closely with everyone involved in the child's treatment—teachers, coaches, therapists, and other family members."

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development, 2015

INITIATION PHASE – 6 TO 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 children aged 6 to 12 years during the intake period from March 1, 2013 to February 28, 2014 that were newly prescribed attention deficit/hyperactivity disorder (ADHD) medication, who remained on the medication for at least a 7-month period (210 days) and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner with prescribing authority within 9 months (270 days) after the 30-day Initiation Phase ended.

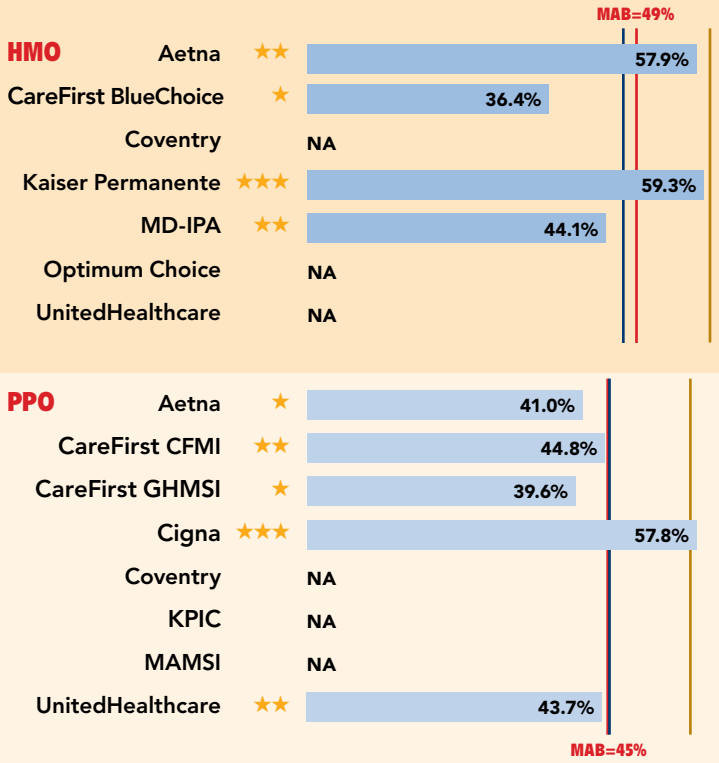
For this performance indicator, a higher percentage is better, which means that more children 6 to 12 years of age did have at least two additional follow-up visits over the 9 month period following the end of the 30-day Initiation Phase.

RATIONALE

Currently, there is no cure for attention deficit/hyperactivity disorder (ADHD), but it can be successfully managed, usually with a combination of behavior therapy and medication. A good treatment plan includes close monitoring and follow-up care through which parents and doctors "work closely with everyone involved in the child's treatment—teachers, coaches, therapists, and other family members."

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development, 2015

CONTINUATION & MAINTENANCE PHASE – 6 TO 12 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions

The excess use of antibiotics in the treatment of children with upper respiratory infections and the under use of controller medications in the treatment of children with asthma can lead to an overall lowering of quality of life and an increase in health care costs. Within the last decade, a push toward responsible antibiotic stewardship is helping to curb the nation's excess use of antibiotics which leads to the shared problem of antibiotic resistance. In addition, a push toward the appropriate use of asthma controller medications, which in turn decrease the need for use of emergency medications for asthma, are helping to control the rising cost of care.

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions (continued)

Appropriate Testing for Children With Pharyngitis

DESCRIPTION

The percentage of children and adolescents aged 2 to 18 years in 2014 who received a group-A streptococcus (strep) test before being diagnosed with pharyngitis and then being given an appropriate prescription for an antibiotic during the 2014 measurement year.

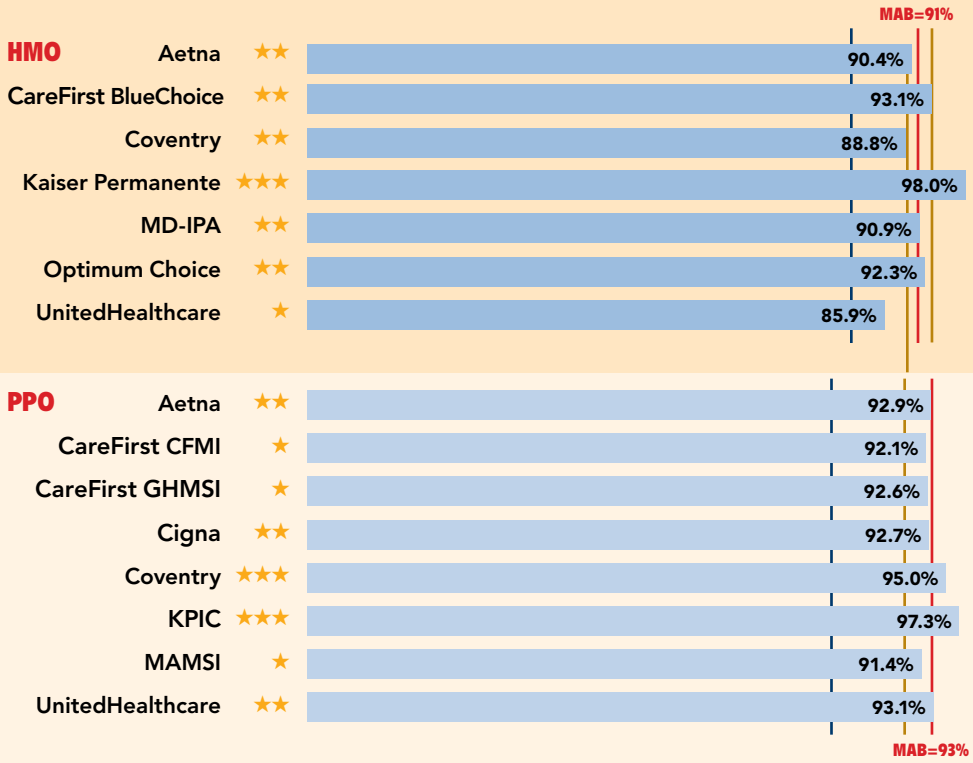
For this measure, a higher percentage is better, which means that more children and adolescents 2 to 18 years of age received appropriate strep testing before beginning antibiotic treatment for pharyngitis.

RATIONALE

The definitive diagnosis of pharyngitis, commonly referred to as strep throat, should not be made without simple laboratory testing. Commonly used laboratory tests for diagnosing strep throat include the rapid antigen detection test (RADT), which takes only minutes to get results, and the throat culture, which can take a day or two to get results. Clinical practice guidelines recommend that antibiotics are prescribed only when the diagnosis of group-A strep pharyngitis is based on the RADT or throat culture laboratory tests.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, 2014

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



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions (continued)

Appropriate Treatment for Children With Upper Respiratory Infection

DESCRIPTION

The percentage of infants, children and adolescents aged 3 months to 18 years in 2014 who were given a diagnosis of 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 to treat an URI.

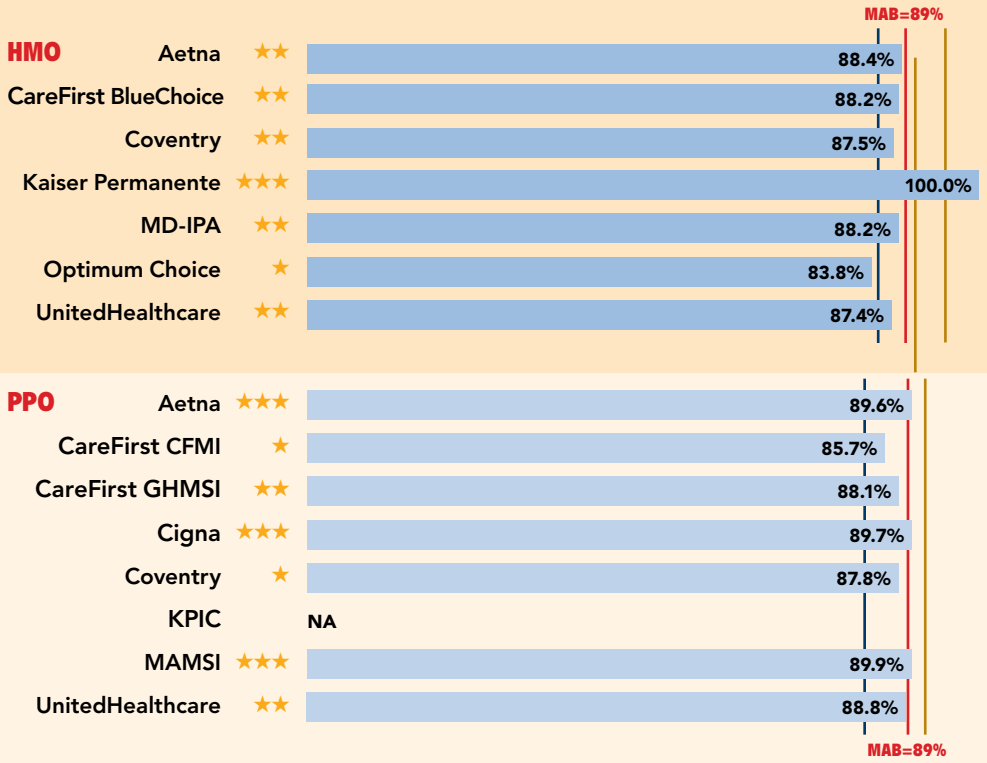
RATIONALE

The common cold is an upper respiratory infection (URI) that is a frequent reason for children visiting the doctor's office. Existing clinical practice guidelines do not support the use of antibiotics for the majority of upper respiratory infections including the common cold due to the viral cause of many of these infections.

The prevalence of inappropriate antibiotic prescribing in clinical practice raises awareness of the importance of reducing inappropriate antibiotic use in order to combat antibiotic resistance in the community.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, 2013

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



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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 children aged 5 to 11 years in 2014 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 to 11 years of age with asthma were appropriately prescribed asthma medications.

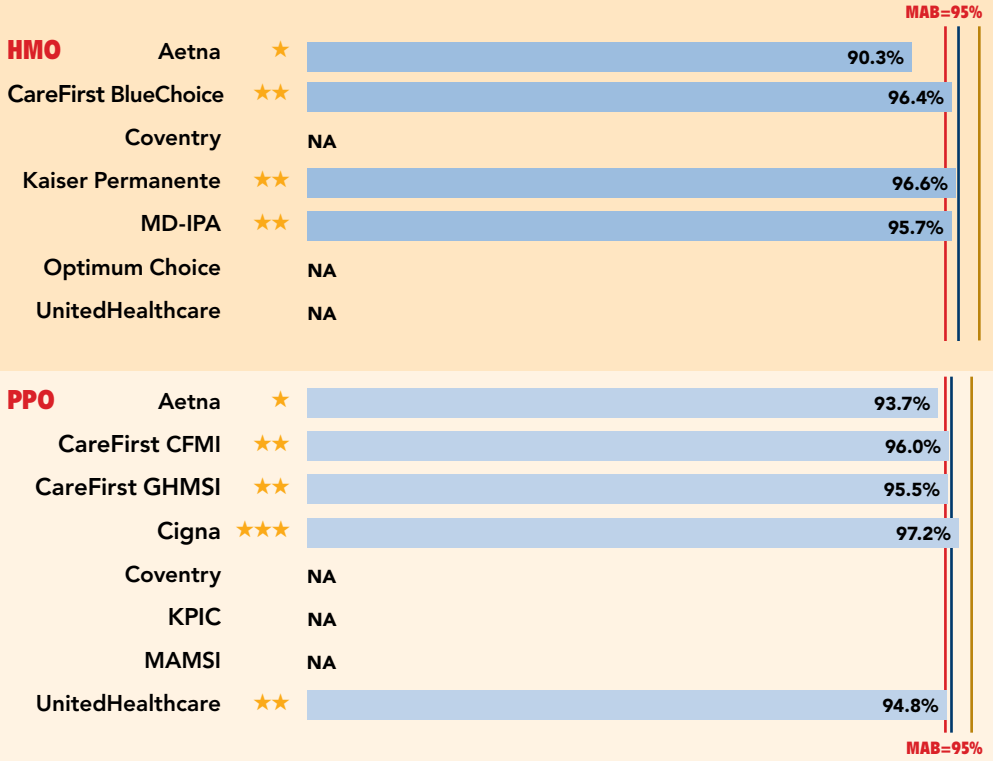
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is a chronic disease that affects the airways and may cause wheezing, coughing, chest tightness, and trouble breathing, especially early in the morning or at night. About 20 million people in the United States have asthma, and nearly 9 million of them are children. Asthma is especially serious among children, who have smaller airways than adults. Asthma medicines can be taken in pill form or by injection, but most are taken using a device called an inhaler, which deliver the medicine directly to the lungs. You can work with your child's health care provider to create a treatment plan that is right for your child. The plan also will explain when to call the health care provider and when to go to the emergency room.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, MedlinePlus, 2015

APPROPRIATE ASTHMA MEDICATIONS – 5 TO 11 YEARS OF AGE



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Use of Appropriate Medications for Children With Asthma continued

DESCRIPTION

2. The percentage of adolescents aged 12 to 18 years in 2014 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/ rescue medications during the measurement year.

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

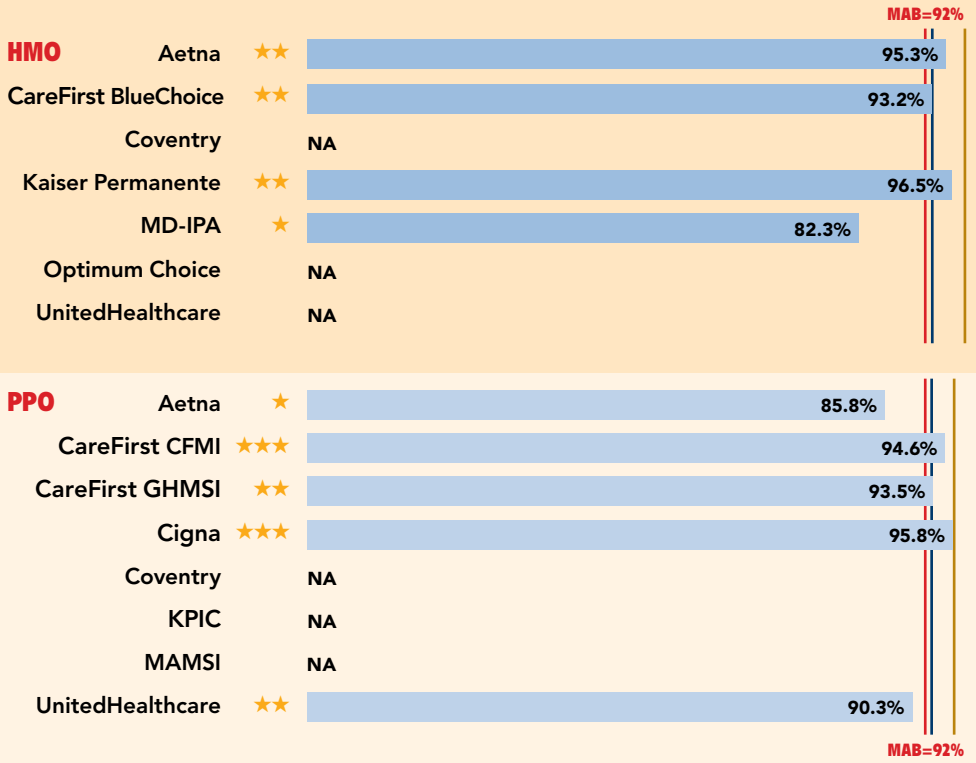
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Asthma is a chronic disease that affects the airways and may cause wheezing, coughing, chest tightness, and trouble breathing, especially early in the morning or at night. About 20 million people in the United States have asthma, and nearly 9 million of them are children. Asthma is especially serious among children, who have smaller airways than adults. Asthma medicines can be taken in pill form or by injection, but most are taken using a device called an inhaler, which deliver the medicine directly to the lungs. You can work with your child's health care provider to create a treatment plan that is right for your child. The plan also will explain when to call the health care provider and when to go to the emergency room.

U.S. Department of Health and Human Services, National Institutes of Health, U.S. National Library of Medicine, MedlinePlus, 2015

APPROPRIATE ASTHMA MEDICATIONS – 12 TO 18 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions (continued)

Asthma Medication Ratio Among Children

DESCRIPTION

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

1. The percentage of children aged 5 to 11 years in 2014 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2014 measurement year.

For this performance indicator, a higher percentage is better, which means that more children 5 to 11 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications.

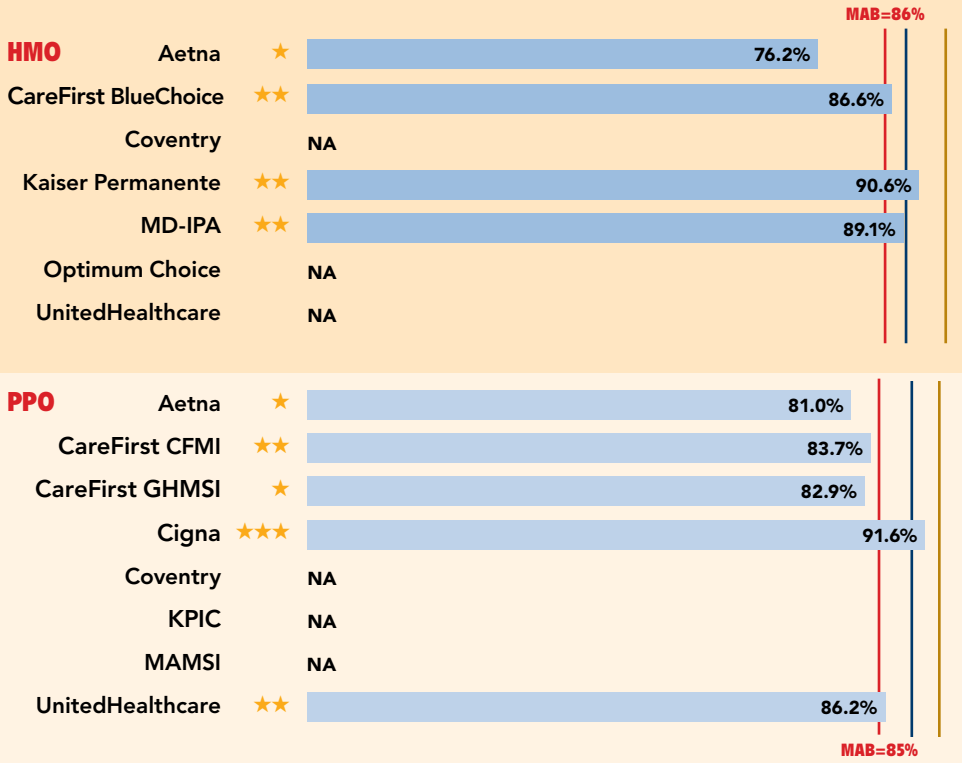
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

"Most people who have asthma need to take long-term control medicines daily to help prevent symptoms. The most effective long-term medicines reduce airway inflammation, which helps prevent symptoms from starting. These medicines don't give you quick relief from symptoms…Asthma treatment for certain groups of people – such as children, older adults, pregnant women, or those for whom exercise brings on asthma symptoms – will be adjusted to meet their special needs."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 5 TO 11 YEARS OF AGE



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PERFORMANCE RATING

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★★ EQUIVALENT TO MARYLAND AVERAGE
★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Asthma Medication Ratio Among Children continued

DESCRIPTION

2. The percentage of adolescents aged 12 to 18 years in 2014 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2014 measurement year.

For this performance indicator, a higher percentage is better, which means that more adolescents 12 to 18 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications.

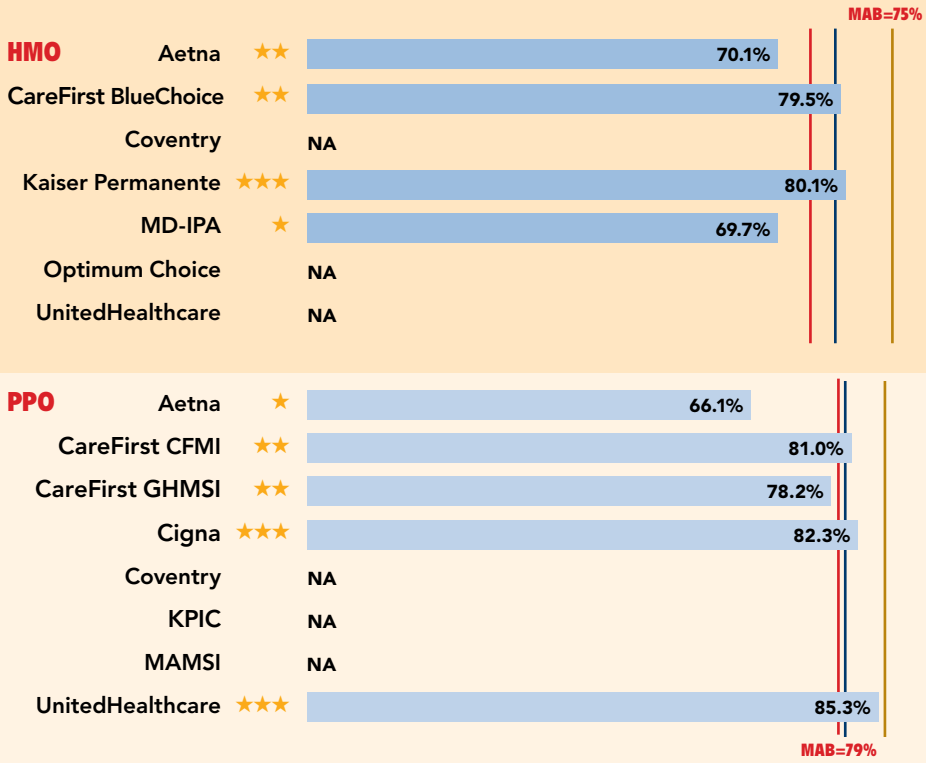
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

"Most people who have asthma need to take long-term control medicines daily to help prevent symptoms. The most effective long-term medicines reduce airway inflammation, which helps prevent symptoms from starting. These medicines don't give you quick relief from symptoms…Asthma treatment for certain groups of people – such as children, older adults, pregnant women, or those for whom exercise brings on asthma symptoms – will be adjusted to meet their special needs."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 12 TO 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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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Child Respiratory Conditions (continued)

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 children aged 5 to 11 years in 2014 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 percent of the remaining days in 2014.

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

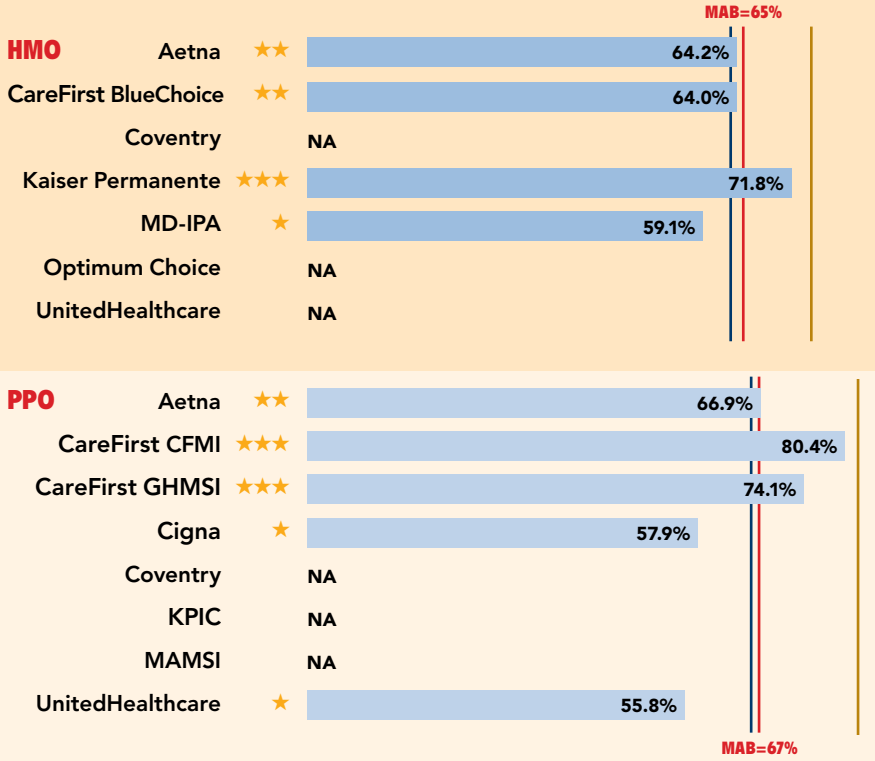
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Most people with asthma, including many children, need to take inhaled corticosteroids or other long-term control medicines daily to help reduce airway inflammation and prevent symptoms from starting. "If your doctor prescribes a long-term control medicine, take it every day to control your asthma. Your asthma symptoms will likely return or get worse if you stop taking your medicine." All people with asthma need quick-relief medicines to help relieve asthma flare ups. Inhaled short-acting beta2-agonists are the preferred medicine for quick relief; however, these medicines don't reduce airway inflammation. "If you use this medicine more than two days a week, talk with your doctor about your asthma control."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

50% TREATMENT COMPLIANCE – 5 TO 11 YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Children With Asthma
continued

DESCRIPTION

2. The percentage of adolescents aged 12 to 18 years in 2014 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 percent of the remaining days in 2014.

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

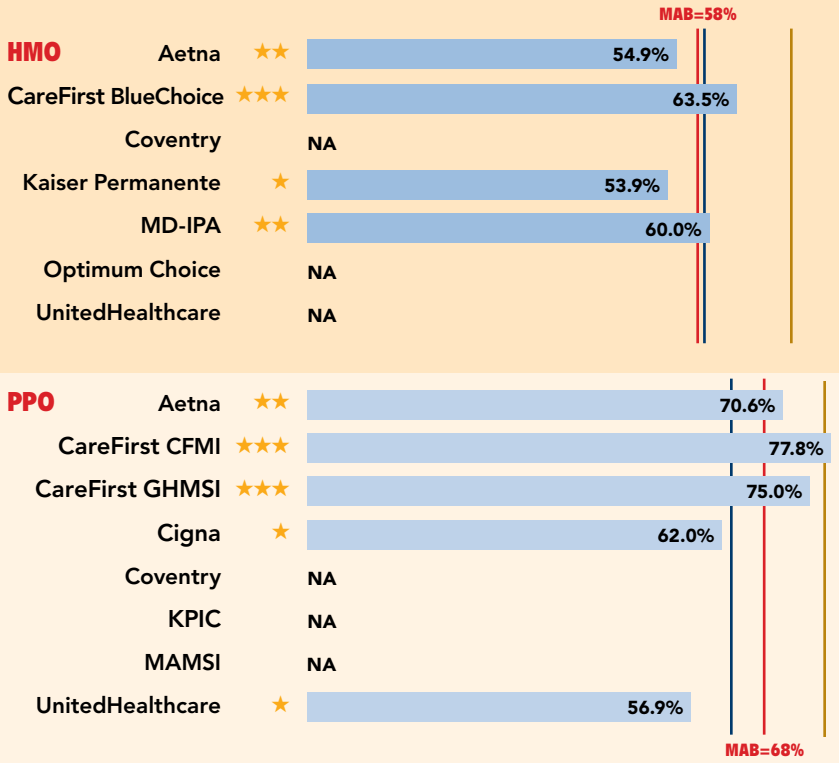
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Most people with asthma, including many children, need to take inhaled corticosteroids or other long-term control medicines daily to help reduce airway inflammation and prevent symptoms from starting. "If your doctor prescribes a long-term control medicine, take it every day to control your asthma. Your asthma symptoms will likely return or get worse if you stop taking your medicine." All people with asthma need quick-relief medicines to help relieve asthma flare ups. Inhaled short-acting beta2-agonists are the preferred medicine for quick relief; however, these medicines don't reduce airway inflammation. "If you use this medicine more than two days a week, talk with your doctor about your asthma control."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

50% TREATMENT COMPLIANCE – 12 TO 18 YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Children With Asthma
continued

DESCRIPTION

3. The percentage of children aged 5 to 11 years in 2014 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 percent of the remaining days in 2014.

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

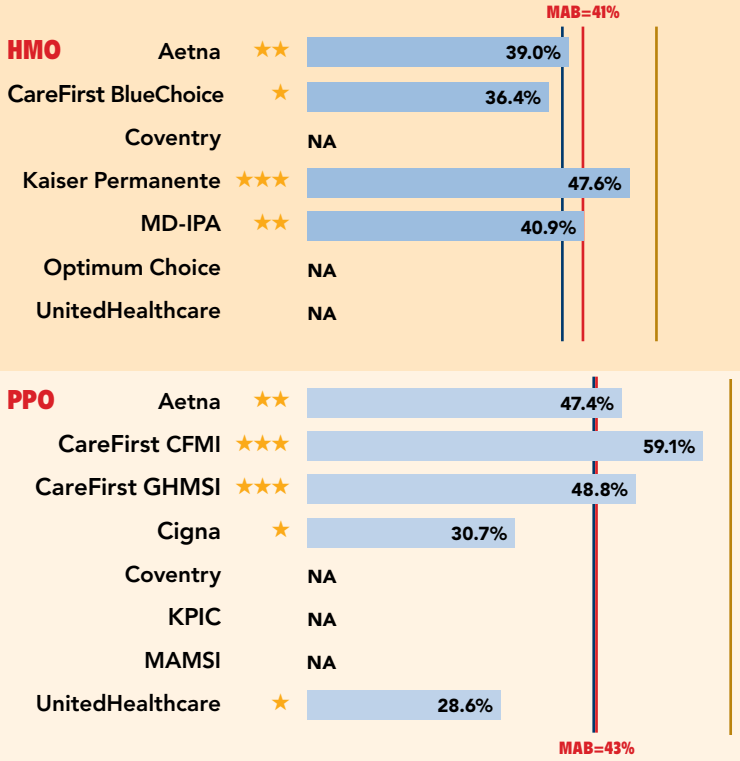
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Most people with asthma, including many children, need to take inhaled corticosteroids or other long-term control medicines daily to help reduce airway inflammation and prevent symptoms from starting. "If your doctor prescribes a long-term control medicine, take it every day to control your asthma. Your asthma symptoms will likely return or get worse if you stop taking your medicine." All people with asthma need quick-relief medicines to help relieve asthma flare ups. Inhaled short-acting beta2-agonists are the preferred medicine for quick relief; however, these medicines don't reduce airway inflammation. "If you use this medicine more than two days a week, talk with your doctor about your asthma control."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

75% TREATMENT COMPLIANCE – 5 TO 11 YEARS OF AGE



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Medication Management for Children With Asthma
continued

DESCRIPTION

4. The percentage of adolescents aged 12 to 18 years in 2014 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 percent of the remaining days in 2014.

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

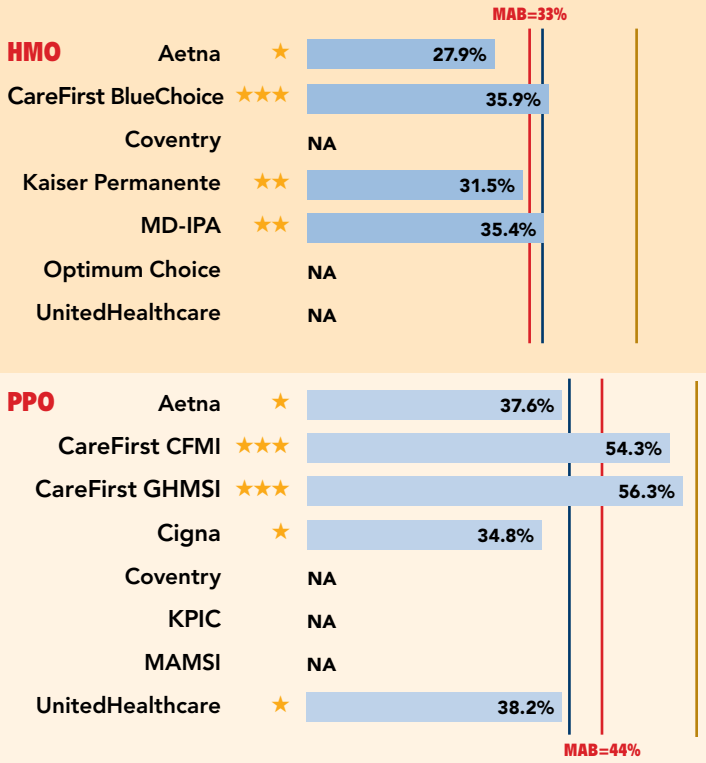
NOTE: Please find the quality measure for adults 19 to 50 and 51 to 64 years of age in the Primary Care for Adults – Respiratory Conditions section.

RATIONALE

Most people with asthma, including many children, need to take inhaled corticosteroids or other long-term control medicines daily to help reduce airway inflammation and prevent symptoms from starting. "If your doctor prescribes a long-term control medicine, take it every day to control your asthma. Your asthma symptoms will likely return or get worse if you stop taking your medicine." All people with asthma need quick-relief medicines to help relieve asthma flare ups. Inhaled short-acting beta2-agonists are the preferred medicine for quick relief; however, these medicines don't reduce airway inflammation. "If you use this medicine more than two days a week, talk with your doctor about your asthma control."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

75% TREATMENT COMPLIANCE – 12 TO 18 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health

Prevention and early detection of illness lead to the availability of more treatment choices and better health outcomes for patients as well as lower overall costs of 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.

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health (continued)

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 a live birth delivery during the treatment period between November 6th, 2013 and November 5th, 2014, who had a prenatal care visit in their first trimester of pregnancy or within 42 days of enrollment in the health benefit plan.

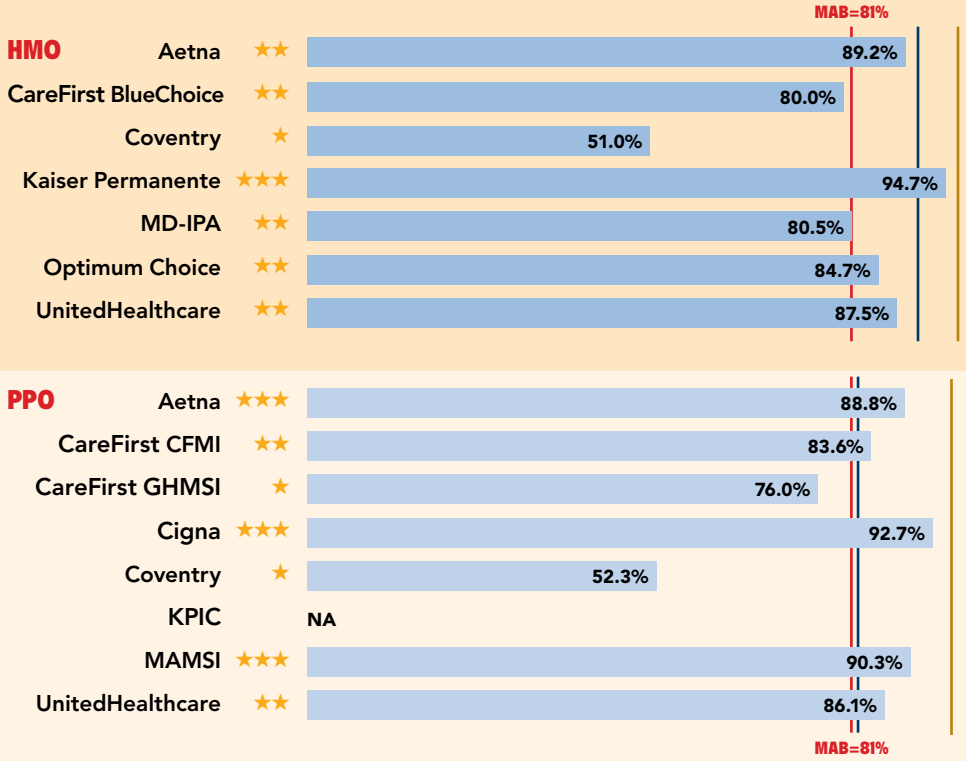
For this performance indicator, a higher percentage is better, which means that more women with live birth deliveries did receive timely prenatal care.

RATIONALE

Beginning prenatal care early in a pregnancy and continuing care at regular intervals throughout pregnancy helps to promote healthy moms and babies. Through effective prenatal care, women can not only receive screenings and management of risk factors for various health conditions, but also can receive education and counseling on nutrition, physical activity and breastfeeding during and after pregnancy. "Women should schedule a prenatal visit as soon as they know or suspect that they are pregnant, ideally within the first trimester of pregnancy (12 weeks). Monthly visits are recommended thereafter that increase to biweekly visits at 28 weeks and weekly visits after 36 weeks. More frequent care may be necessary for women with certain conditions and risk factors."

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Child Health USA 2014.

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



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PERFORMANCE RATING

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health (continued)

Prenatal and Postpartum Care continued

DESCRIPTION

2. Timeliness of Postpartum Care: The percentage of women with a live birth delivery during the treatment period between November 6th, 2013 and November 5th, 2014, who had an appropriate follow-up visit for postpartum care between 21 to 56 days after the live birth delivery.

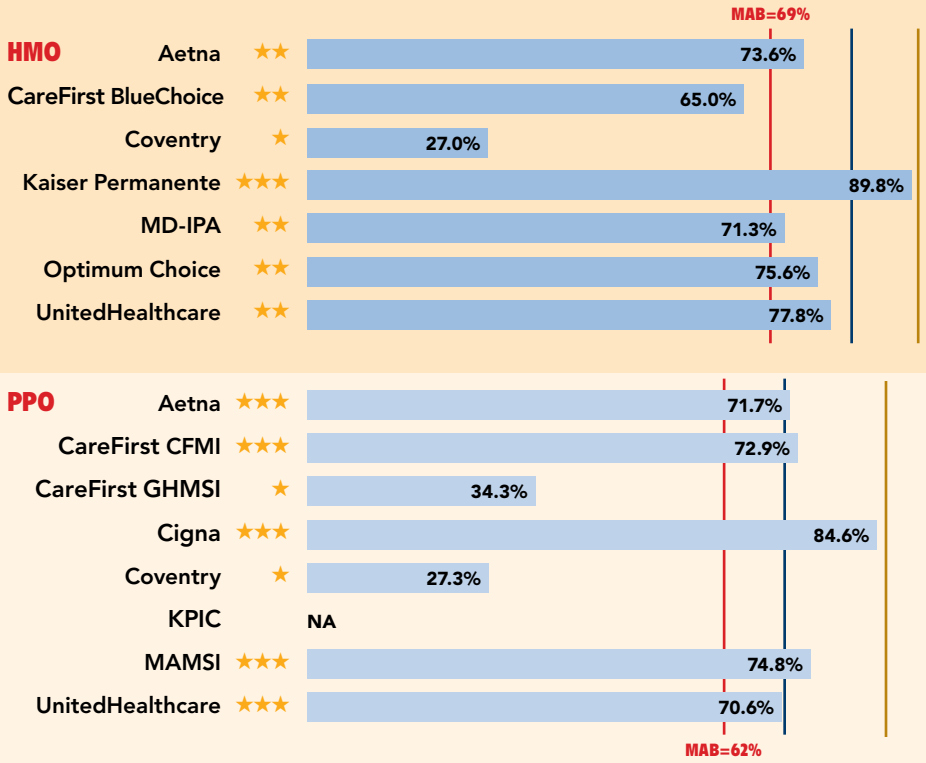
For this performance indicator, a higher percentage is better, which means that more women with live birth deliveries did receive timely postpartum care.

RATIONALE

Care for the mother continues during the postpartum period immediately following the birth of her baby(ies). During this postpartum period, it is important for the health care provider to evaluate the mother's current physical health, including the status of any pregnancy-related conditions such as gestational diabetes. In addition, mothers are screened for postpartum depression and are given helpful information on infant care, breastfeeding, breast self-examination, and family planning. Additional screening and referrals for the management of chronic conditions may also be necessary.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Child Health USA 2013

TIMELY POSTPARTUM CARE – 21 TO 56 DAYS AFTER DELIVERY



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PERFORMANCE RATING

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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health (continued)

Breast Cancer Screening

DESCRIPTION

The percentage of women aged 52 to 74 years in 2014 who were continuously enrolled with the health benefit plan from October 1, 2012 through December 31, 2014, who also had at least one mammogram to screen for breast cancer during the same time period.

For this measure, a higher percentage is better, which means that more women 52 to 74 years of age did get a mammogram within the required timeframe.

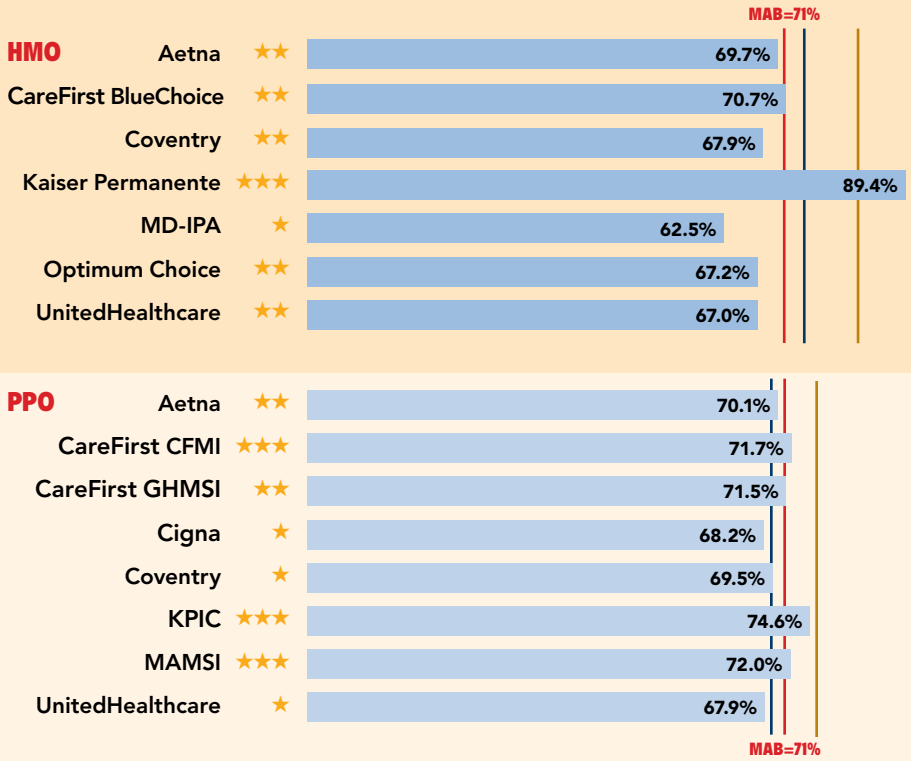
NOTE: Some of the quality measures related to women's health are subject to revision and update based on current research and clinical guidelines. The Breast Cancer Screening measure is one quality measure that is being considered for revision by the National Committee for Quality Assurance, due to recent findings concerning the recommended frequency for mammograms and the age groups most impacted.

RATIONALE

Breast cancer is the second leading cause of death from cancer among American women. Women whose breast cancer is detected early, through a mammogram or other breast exam, have more treatment choices and better chances for survival. Clinical guidelines previously indicated that women should begin annual mammogram screening at the age of 40. Currently, not all organizations agree about when mammogram screening should begin or how frequently it should be conducted. Therefore, it is recommended that women discuss the benefits and risks with their health care provider, and together decide the right course of action.

U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2014

1+ MAMMOGRAM – 52 TO 74 YEARS OF AGE



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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health (continued)

Cervical Cancer Screening

DESCRIPTION

Health benefit plans report their performance for this measure using either of two appropriate cervical cancer screening methods:

- The percentage of women aged 21 to 64 years in 2014 who were continuously enrolled with the plan during the 2014 measurement year and the two years prior, who also received one or more Pap smear tests to screen for cervical cancer during the three year period.
- The percentage of women aged 30 to 64 years in 2014 who were continuously enrolled with the plan during the 2014 measurement year and the four years prior, who also received one or more Pap smear and HPV co-tests to screen for cervical cancer during the five year period.

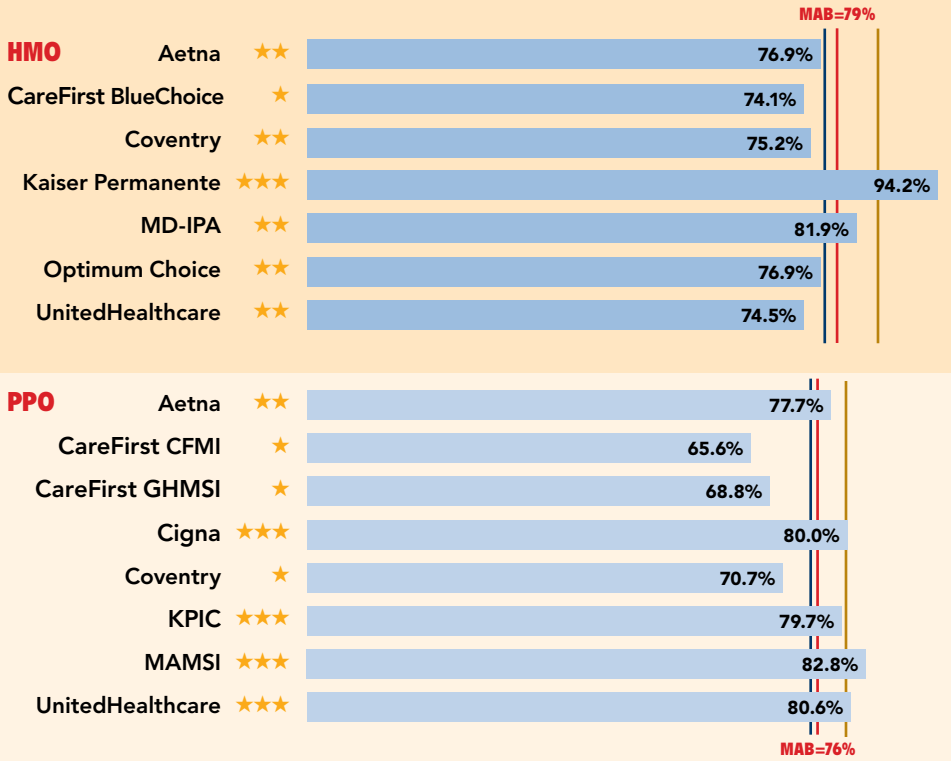
For this measure, a higher percentage is better, which means that more women 21 to 64 years of age did get the recommended Pap smear or HPV co-testing performed.

RATIONALE

All women are at risk for the easiest gynecologic cancer to prevent, cervical cancer. It occurs most often in women over age 30 and is usually caused by the common human papillomavirus (HPV) that is passed from one person to another during sex. At least half of sexually active people will have HPV at some point in their lives, but with regular screening tests and follow-up, few women will get cervical cancer. "The Pap test is recommended for all women between the ages of 21 and 65 years old, and can be done in a doctor's office or clinic…If you are 30 years old or older, you may choose to have an HPV test along with the Pap test." Talk with your health care provider about whether the Pap test alone or the HPV co-test is right for you.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, 2014

1+ CERVICAL CANCER SCREENING – 21 TO 64 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Women's Health (continued)

Chlamydia Screening

DESCRIPTION

The percentage of women aged 16 to 24 years in 2014 who were identified as sexually active and who had at least one test for chlamydia during the 2014 measurement year.

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

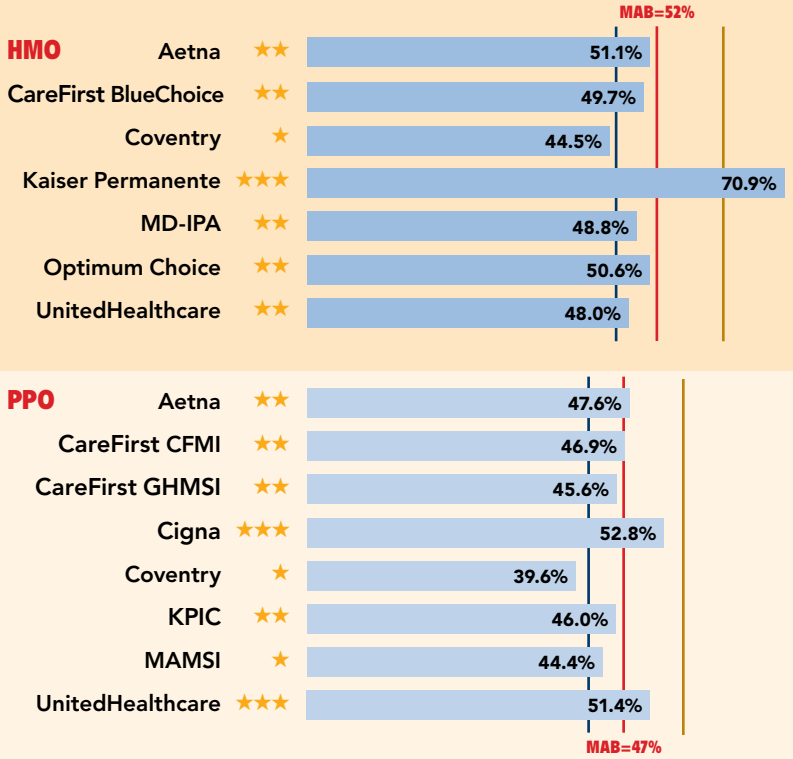
NOTE: There are three separate indicators in this measure category including chlamydia screening among women 16 to 20 years, 21 to 24 years and 16 to 24 years of age. Only the total percentage of women screened among the 16 to 24 years of age group is represented in the associated graph.

RATIONALE

Chlamydia is a common bacterial sexually transmitted disease (STD). Chlamydia is more prevalent among adolescents and young adults aged 14 to 24 years. Most infected people do not have any symptoms and therefore do not realize they have the infection and require treatment. 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.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of STD Prevention, CDC Fact Sheet – Chlamydia, 2014

1+ CHLAMYDIA SCREENING – 16 TO 24 YEARS OF AGE



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III. 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 improved health outcomes. The evaluation of developing risk factors as well as preventive health screenings can contribute greatly to a higher quality of life for individuals and lower health care costs for the community.

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health (continued)

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 adults aged 20 to 44 years in 2014 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2014 measurement year or the two years prior.

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

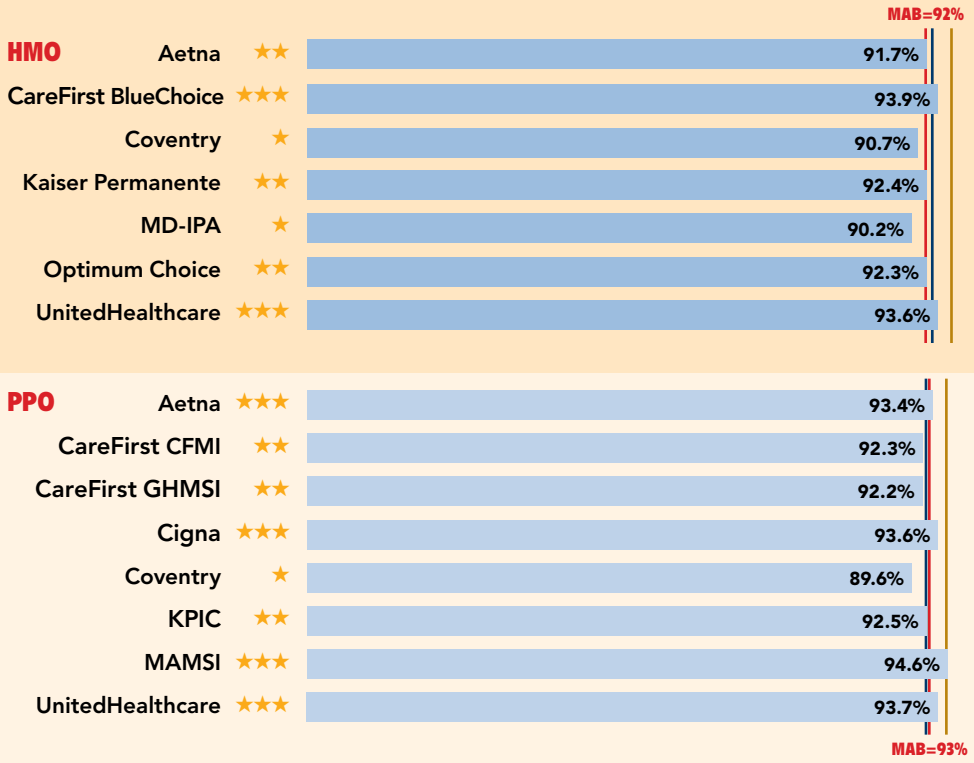
RATIONALE

Access to primary care providers such as pediatricians, family medicine doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

1+ OUTPATIENT VISITS – 20 TO 44 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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health (continued)

Adults' Access to Preventive/Ambulatory Health Services
continued

DESCRIPTION

2. The percentage of adults aged 45 to 64 years in 2014 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2014 measurement year or the two years prior.

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

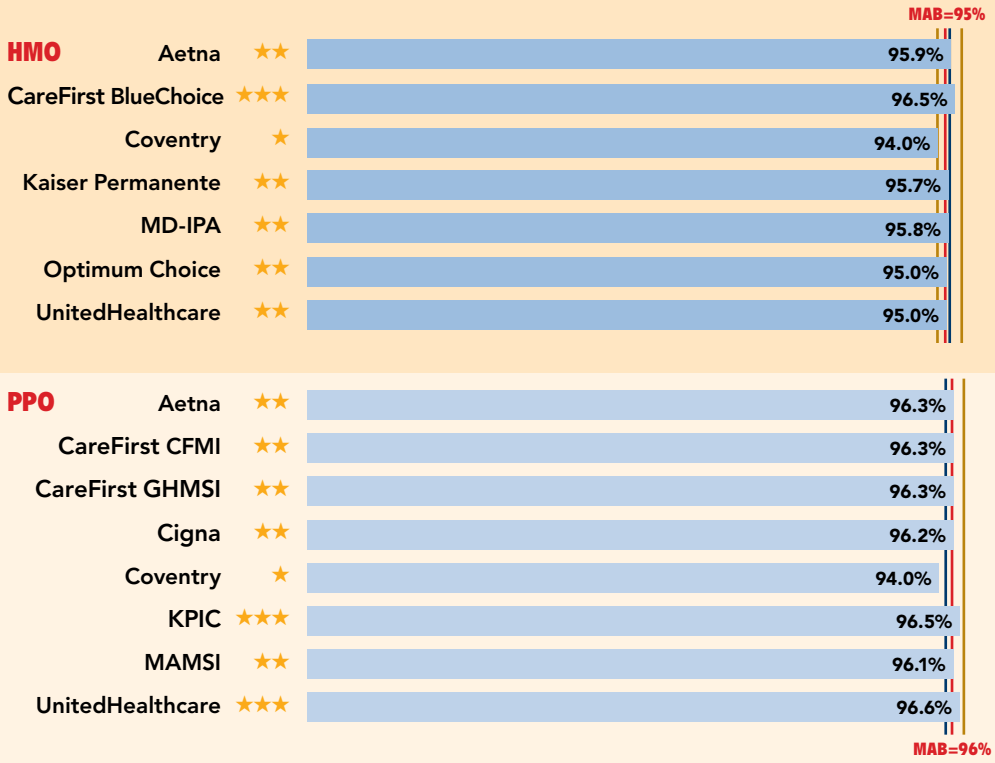
RATIONALE

Access to primary care providers such as pediatricians, family medicine doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

1+ OUTPATIENT VISITS – 45 TO 64 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
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NTP NATIONAL TOP PERFORMERS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Adults' Access to Preventive/Ambulatory Health Services
continued

DESCRIPTION

3. The percentage of adults aged 65 years and older in 2014 who had at least one outpatient visit, including an ambulatory or preventive care visit during the 2014 measurement year or the two years prior.

For this performance indicator, a higher percentage is better, which means that more adults 65 years of age and older did have at least one ambulatory or preventive care visit.

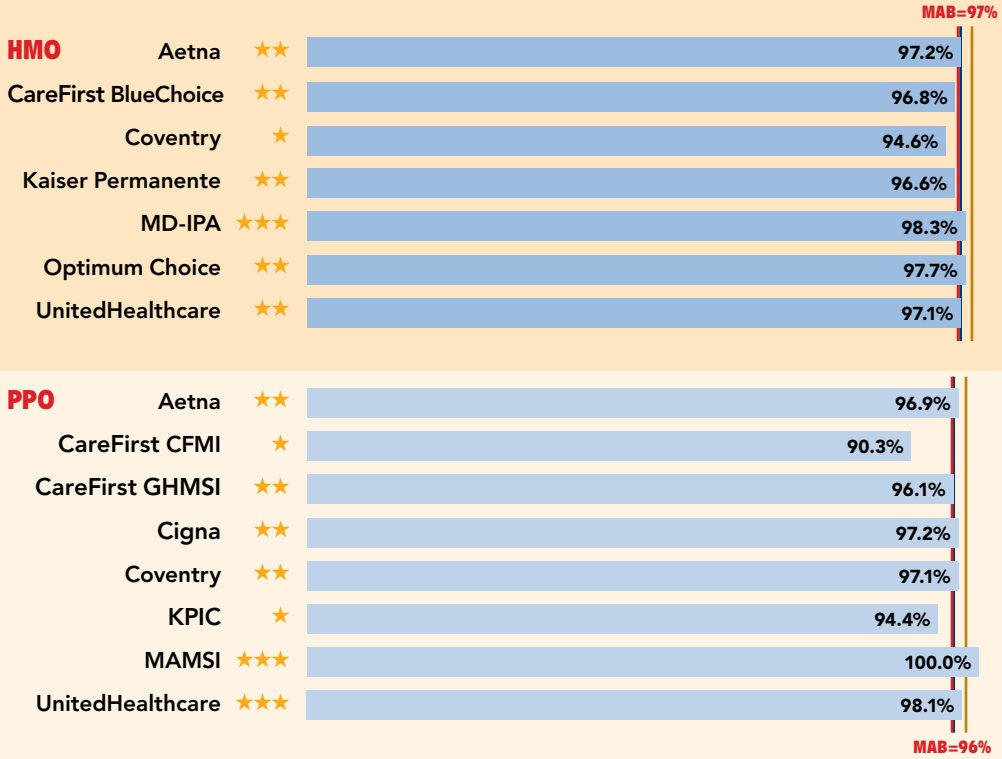
RATIONALE

Access to primary care providers such as pediatricians, family medicine doctors, nurse practitioners, and other providers improves opportunities for appropriate use of prevention and wellness services and the proper screening for communicable diseases. Access to health services encompasses four areas of importance:

- Coverage – lack of adequate health insurance coverage makes it difficult for people to get the health care they need
- Services – in addition to primary care and preventive services, access to emergency medical services is a crucial link in the chain of care
- Timeliness – the ability to access care quickly after a need is recognized is associated with improved patient satisfaction and health outcomes
- Workforce – to improve the nation's health, it is important to increase the number of practicing primary care providers across all communities

U.S. Department of Health and Human Services, Healthy People 2020

1+ OUTPATIENT VISITS – 65+ YEARS OF AGE



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PERFORMANCE RATING

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health (continued)

Adult Body Mass Index (BMI) Assessment

DESCRIPTION

The percentage of adults aged 18 to 74 years in 2014 who had an outpatient visit and whose weight was assessed and body mass index (BMI) was documented during the 2014 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 to 74 years, rather than an absolute BMI value.

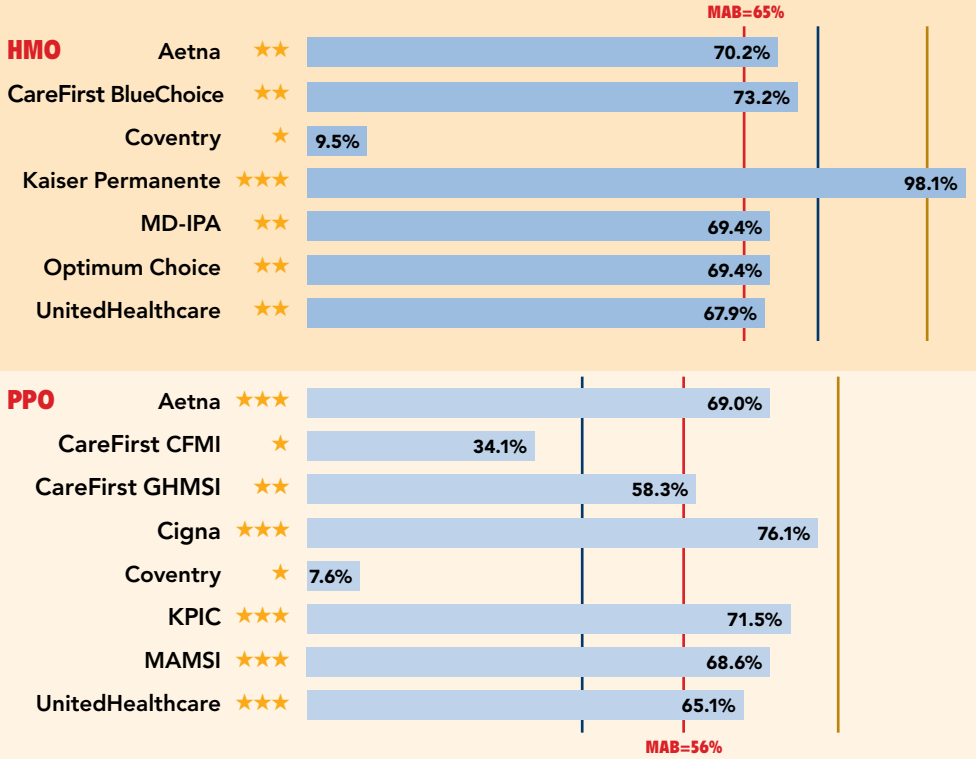
For this measure, a higher percentage is better, which means that more adults 18 to 74 years of age did have an outpatient visit, which included having their BMI calculated and documented.

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 the risk of developing additional conditions such as diabetes, coronary heart disease and cancer. Body mass index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable way to screen for weight categories that may lead to health problems.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2014

BODY MASS INDEX – 18 TO 74 YEARS OF AGE



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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – General Health (continued)

Colorectal Cancer Screening

DESCRIPTION

The percentage of adults aged 50 to 75 years in 2014 who had at least one appropriate type of screening for colorectal cancer during the appropriate time based on the screening method used:

- Fecal occult blood test during the 2014 measurement year
- Flexible sigmoidoscopy test during 2014 or four years prior
- Colonoscopy test during 2014 or nine years prior

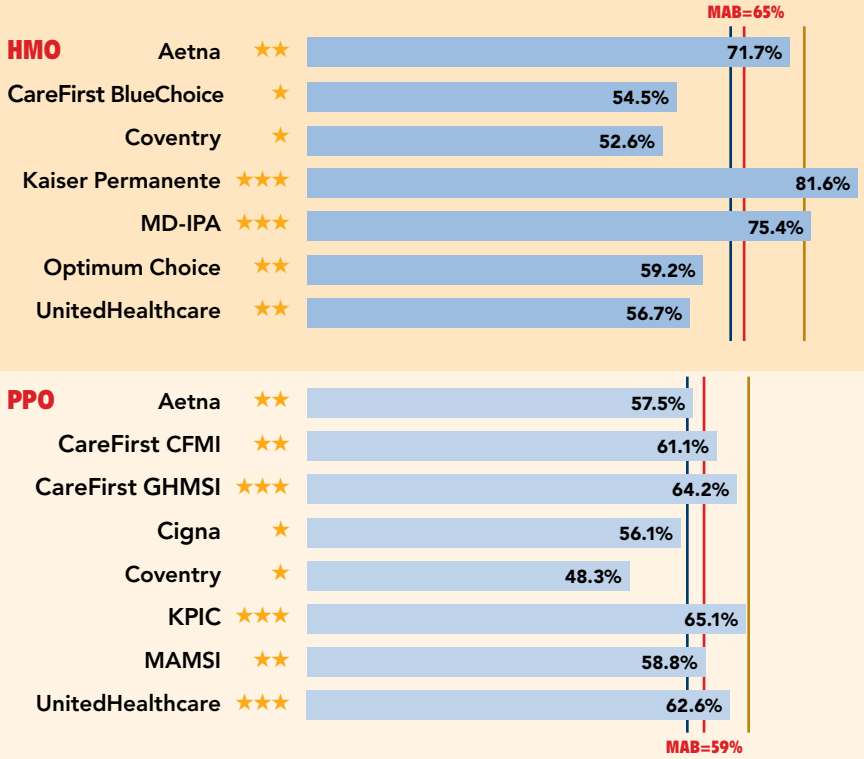
For this measure, a higher percentage is better, which means that more adults 50 to 75 years of age did get screened for colorectal cancer.

RATIONALE

Colorectal cancer is the second leading cause of cancer death in the United States. Unlike other screening tests that only detect disease, some methods of colorectal cancer 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. Most experts generally recommend colorectal cancer screening tests such as a high-sensitivity fecal occult blood test, sigmoidoscopy and standard or optical colonoscopy.

U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2014

1+ COLORECTAL CANCER SCREENING – 50 TO 75 YEARS OF AGE



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Primary Care for Adults – Respiratory Conditions

Primary care medicine is vitally important in the diagnosis and treatment of adults with respiratory conditions such as acute bronchitis, chronic obstructive pulmonary disease (COPD) and asthma. Through proper testing, medical treatment and education, patients continue to learn and become more effective participants in the management of their respiratory conditions.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

DESCRIPTION

The percentage of adults aged 18 to 64 years in 2014 with a diagnosis of acute bronchitis who were appropriately not given an antibiotic prescription unless needed during the treatment period between January 1st and December 24th of the 2014 measurement year.

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

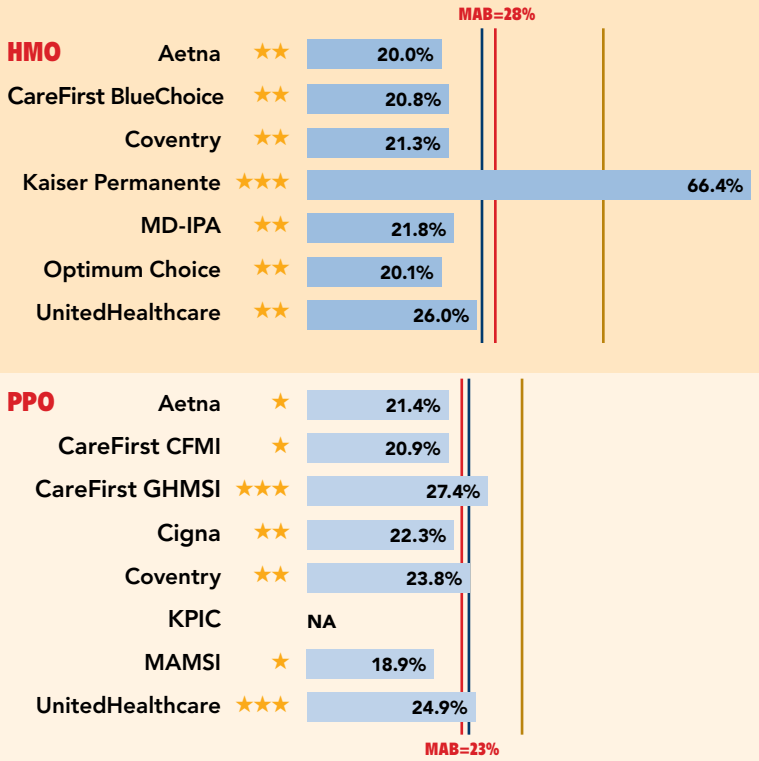
RATIONALE

"Acute bronchitis, or chest cold, is a condition that occurs when the bronchial tubes in the lungs become inflamed." Since acute bronchitis is most often caused by a virus, taking antibiotics will not make it better.

Inappropriate antibiotic treatment of adults with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics leads to antibiotic drug resistance. Acute bronchitis can be prevented by quitting smoking and avoiding second hand smoke, good hand hygiene, and keeping up-to-date with recommended immunizations.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, 2013

APPROPRIATELY NOT GIVEN ANTIBIOTICS – 18 TO 64 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Respiratory Conditions (continued)

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

DESCRIPTION

The percentage of adults aged 40 years or older in 2014 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 2014 measurement year.

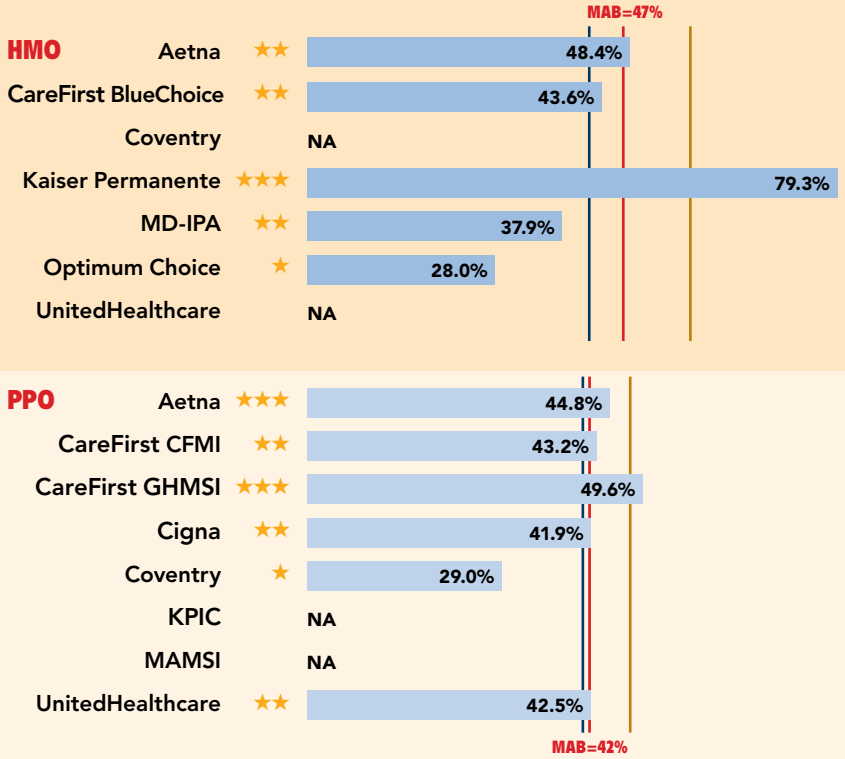
For this measure, a higher percentage is better, which means that more adults 40 years of age and over with COPD did get the best diagnostic test for COPD, a lung function test called spirometry.

RATIONALE

Chronic Obstructive Pulmonary Disease (COPD) refers to a group of diseases that cause airflow blockage and breathing problems. It includes chronic bronchitis, emphysema and in some cases, asthma. In the United States, tobacco smoke is a key factor in the development and progression of COPD. 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.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2013

SPIROMETRY TEST – 40+ YEARS OF AGE



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

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NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Respiratory Conditions (continued)

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 adults aged 40 years and over in 2014 who had an acute inpatient discharge or emergency department encounter for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation on or between January 1st and November 30th of the 2014 measurement year, and who were given a prescription for a systemic corticosteroid within 14 days of the COPD event.

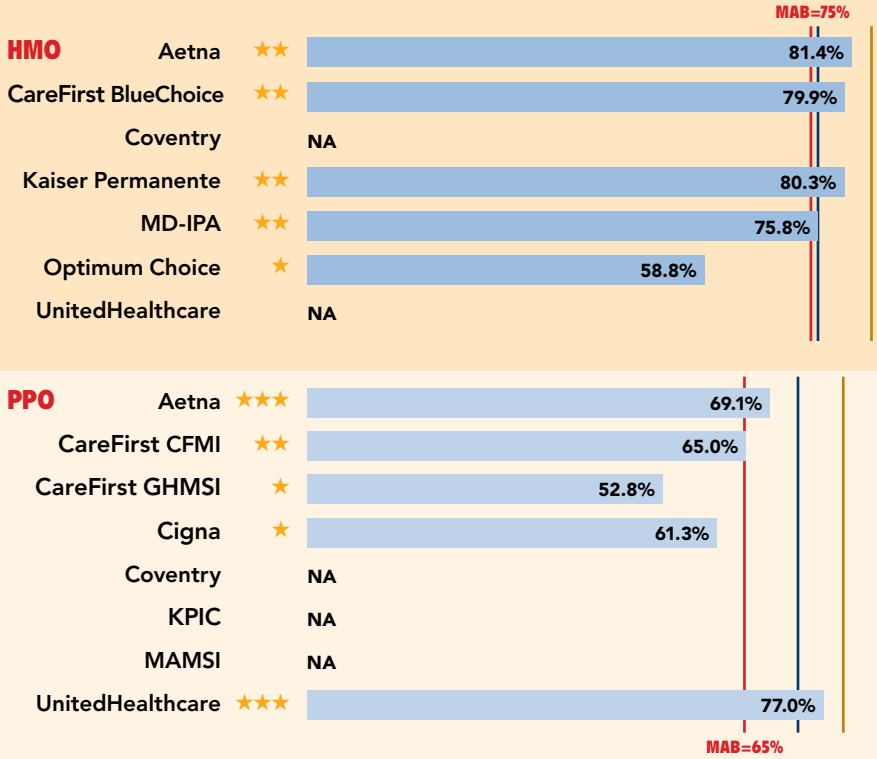
For this performance indicator, a higher percentage is better, which means that more adults 40 years of age and older did get a timely prescription for a systemic corticosteroid.

RATIONALE

Most people with Chronic Obstructive Pulmonary Disease (COPD) have both emphysema and chronic bronchitis. Common medications used in mild to moderate COPD treatment include short or long-acting bronchodilators that relax the muscles around the airways, helping to open the airways and making it easier to breathe. Combination bronchodilators and oral or inhaled Glucocorticosteroids (also called glucocorticoids, corticosteroids or steroids) are often used to treat more severe COPD and to prevent COPD flare-ups.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2013

SYSTEMIC CORTICOSTEROID WITHIN 14 DAYS – 40+ YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation continued

DESCRIPTION

2. The percentage of adults aged 40 years and over in 2014 who had an acute inpatient discharge or emergency department encounter for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation on or between January 1st and November 30th of the 2014 measurement year, and who were given a prescription for a bronchodilator within 30 days of the COPD event.

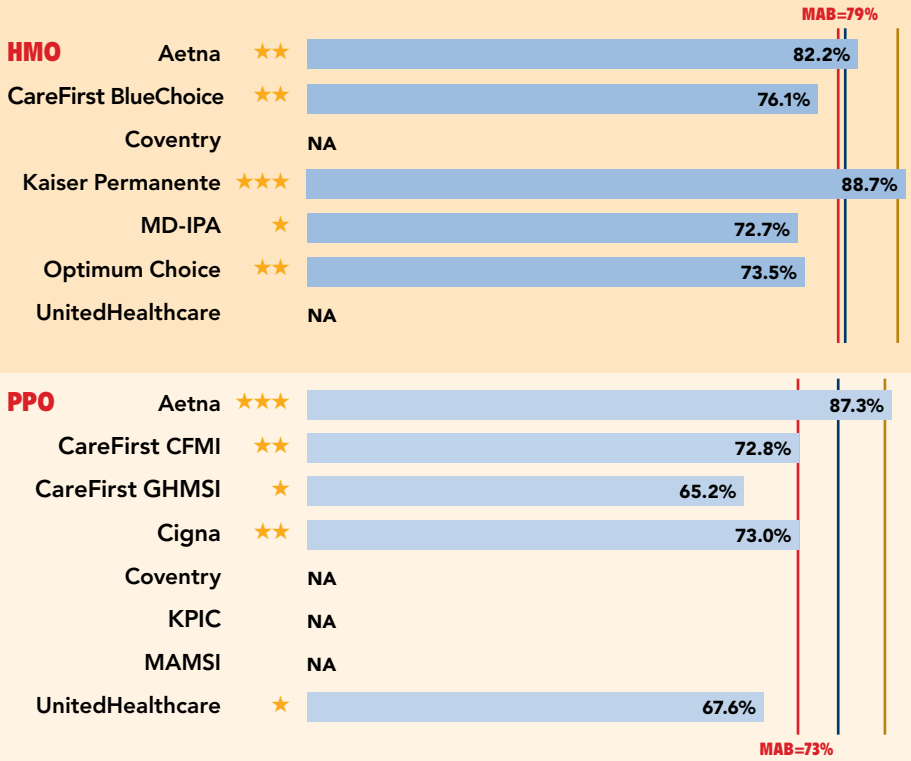
For this performance indicator, a higher percentage is better, which means that more adults 40 years of age and over did get a timely prescription for a bronchodilator.

RATIONALE

Most people with Chronic Obstructive Pulmonary Disease (COPD) have both emphysema and chronic bronchitis. Common medications used in mild to moderate COPD treatment include short or long-acting bronchodilators that relax the muscles around the airways, helping to open the airways and making it easier to breathe. Combination bronchodilators and oral or inhaled Glucocorticosteroids (also called glucocorticoids, corticosteroids or steroids) are often used to treat more severe COPD and to prevent COPD flare-ups.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2013

BRONCHODILATOR WITHIN 30 DAYS – 40+ YEARS OF AGE



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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 adults aged 19 to 50 years in 2014 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/ rescue medication during the 2014 measurement year.

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

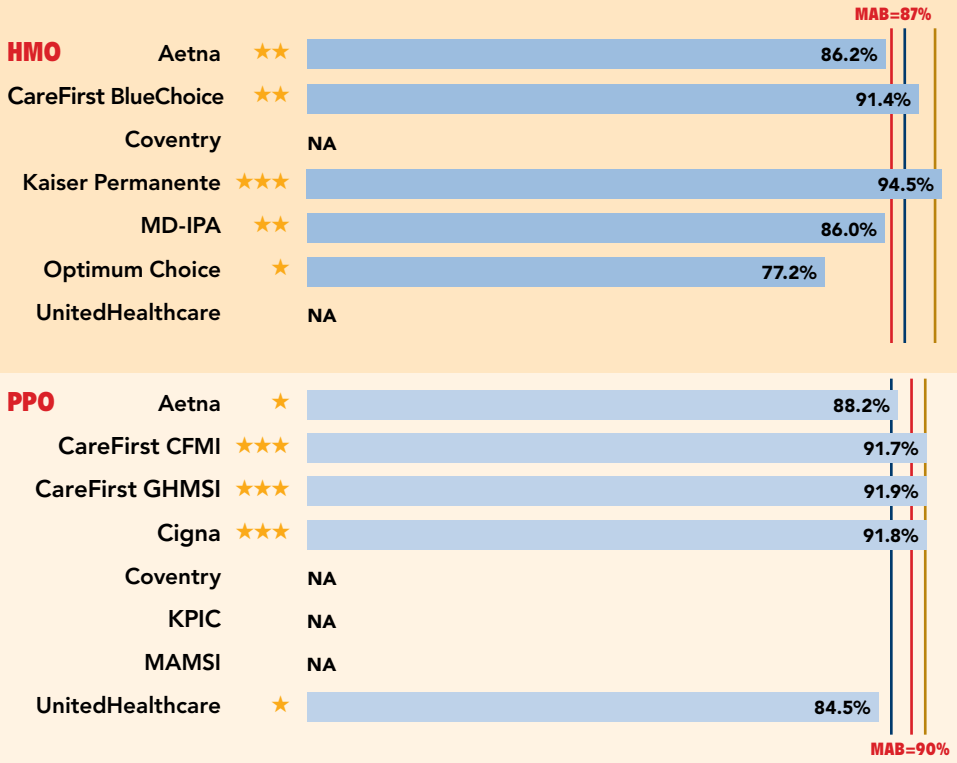
NOTE: Please find the quality measure for children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Many things are taken into consideration when deciding which asthma medicines are right for the individual patient being treated. Asthma medicines can be taken in pill form or by injection, but most are taken using a device called an inhaler, which deliver the medicine directly to the lungs. A medicine or dosage may be initially prescribed to determine its effectiveness. Then, the same medicine or dosage can be adjusted as needed for optimal effectiveness. "Doctors may need to adjust asthma treatment for older adults who take certain other medicines, such as beta blockers, aspirin and other pain relievers, and anti-inflammatory medicines. These medicines can prevent asthma medicines from working well and may worsen asthma symptoms…Older adults may develop weak bones from using inhaled corticosteroids, especially at high doses. Talk with your doctor about taking calcium and vitamin D pills, as well as other ways to help keep your bones strong."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

APPROPRIATE ASTHMA MEDICATIONS – 19 TO 50 YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Use of Appropriate Medications for Adults With Asthma
continued

DESCRIPTION

2. The percentage of adults aged 51 to 64 years in 2014 who were identified as having persistent asthma and who were appropriately prescribed asthma controller or reliever/ rescue medication during the 2014 measurement year.

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

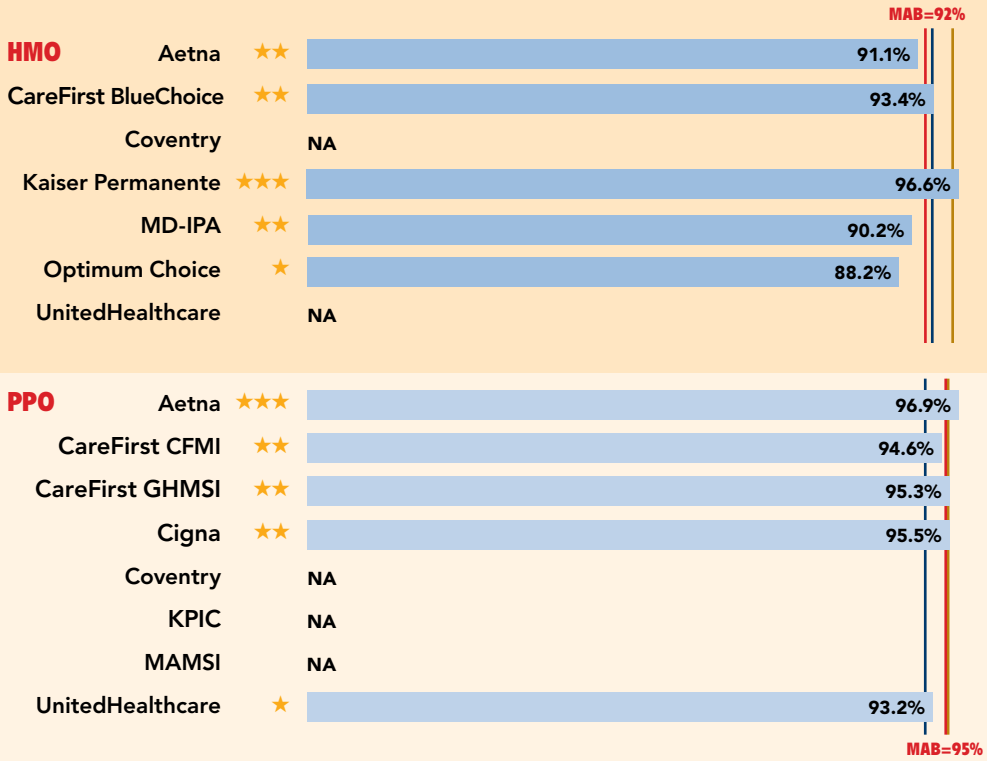
NOTE: Please find the quality measure for children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

Many things are taken into consideration when deciding which asthma medicines are right for the individual patient being treated. Asthma medicines can be taken in pill form or by injection, but most are taken using a device called an inhaler, which deliver the medicine directly to the lungs. A medicine or dosage may be initially prescribed to determine its effectiveness. Then, the same medicine or dosage can be adjusted as needed for optimal effectiveness. "Doctors may need to adjust asthma treatment for older adults who take certain other medicines, such as beta blockers, aspirin and other pain relievers, and anti-inflammatory medicines. These medicines can prevent asthma medicines from working well and may worsen asthma symptoms…Older adults may develop weak bones from using inhaled corticosteroids, especially at high doses. Talk with your doctor about taking calcium and vitamin D pills, as well as other ways to help keep your bones strong."

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

APPROPRIATE ASTHMA MEDICATIONS – 51 TO 64 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Respiratory Conditions (continued)

Asthma Medication Ratio

DESCRIPTION

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

1. The percentage of adults aged 19 to 50 years in 2014 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2014 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 19 to 50 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications, thereby demonstrating that asthma is being well controlled with fewer asthmatic emergencies that require reliever/rescue medications.

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

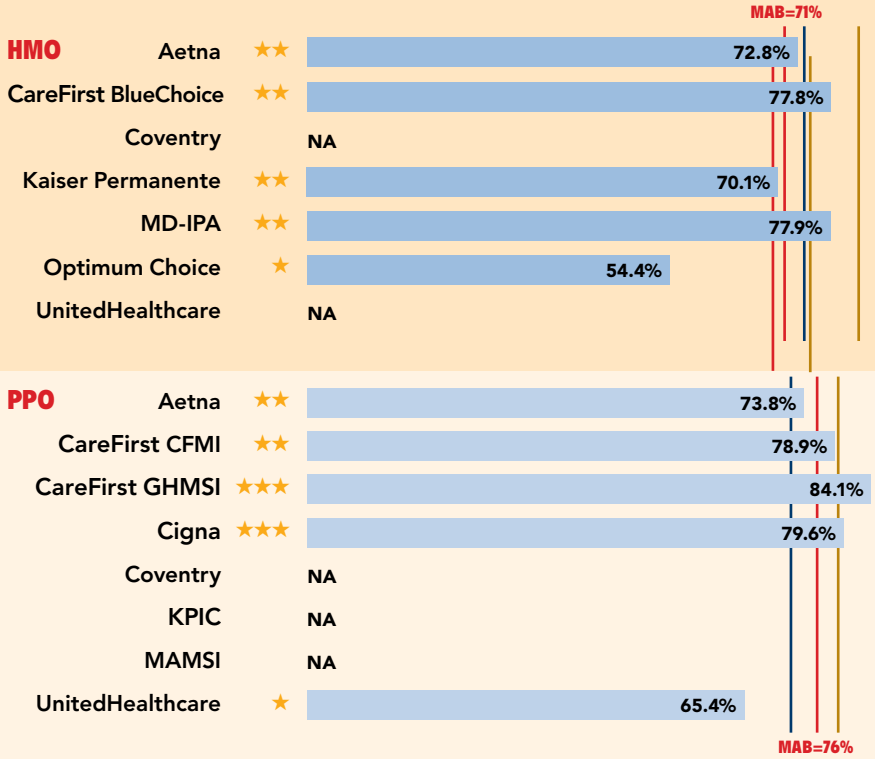
RATIONALE

The goal of care in treating asthma is to have good control over the disease. Treatment involves the use of two types of medicines, long-term control medicines that reduce airway inflammation and prevent asthma symptoms, and quick-relief or "rescue" medicines that relieve asthma symptoms during a flare up. Good asthma control will:

- Reduce the need for quick-relief medicines
- Help maintain good lung function
- Maintain normal activity level and allow sleep through the night
- Prevent asthma attacks that could result in an emergency room visit or hospital stay

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 19 TO 50 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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

NR – Performance results are **not reported** due to bias in the data from the health benefit plan

NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Respiratory Conditions (continued)

Asthma Medication Ratio continued

DESCRIPTION

2. The percentage of adults aged 51 to 64 years in 2014 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the 2014 measurement year.

For this performance indicator, a higher percentage is better, which means that more adults 51 to 64 years of age with asthma were prescribed asthma controller medications at least as often as reliever/rescue medications, thereby demonstrating that asthma is being well controlled with fewer asthmatic emergencies that require reliever/rescue medications.

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

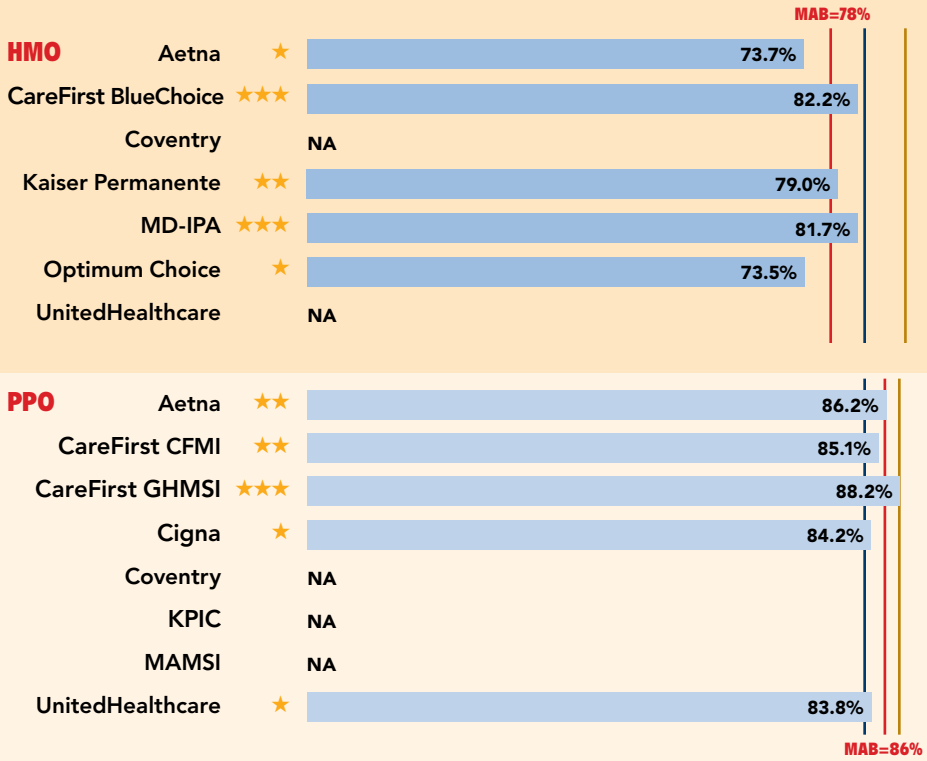
RATIONALE

The goal of care in treating asthma is to have good control over the disease. Treatment involves the use of two types of medicines, long-term control medicines that reduce airway inflammation and prevent asthma symptoms, and quick-relief or "rescue" medicines that relieve asthma symptoms during a flare up. Good asthma control will:

- Reduce your need for quick-relief medicines
- Help you maintain good lung function
- Let you maintain your normal activity level and sleep through the night
- Prevent asthma attacks that could result in an emergency room visit or hospital stay

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

ASTHMA CONTROLLER MEDICATION RATIO ≥50% – 51 TO 64 YEARS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

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NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Respiratory Conditions (continued)

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 adults aged 19 to 50 years in 2014 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 2014.

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

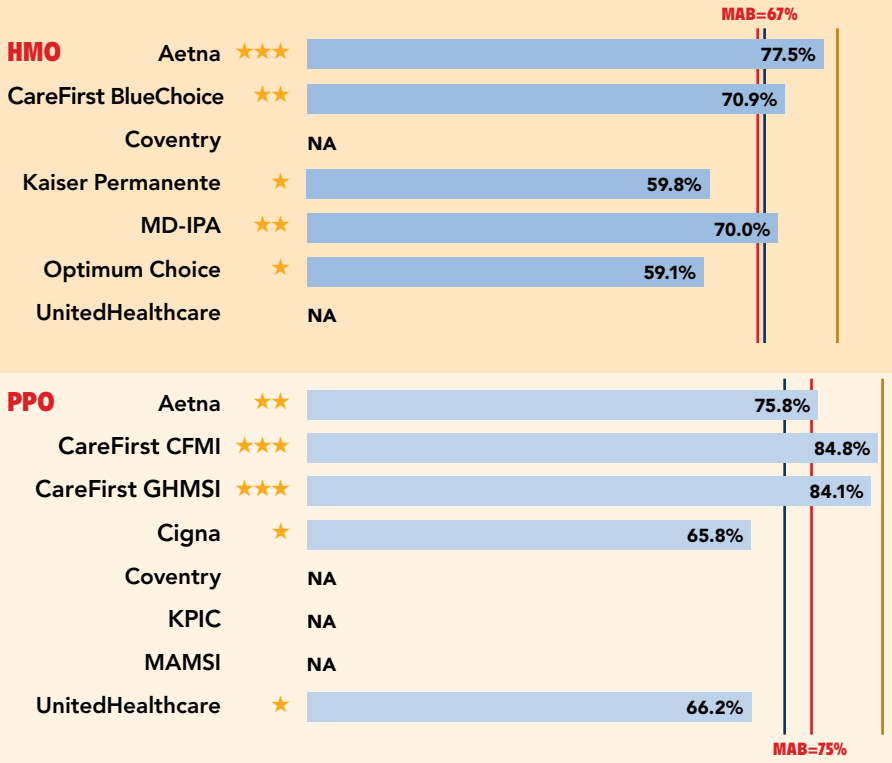
NOTE: Please find the quality measure for children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

"Most people who have asthma need to take long-term control medicines [such as inhaled corticosteroids] daily to help prevent symptoms. The most effective long-term medicines reduce airway inflammation, which helps prevent symptoms from starting. These medicines don't give you quick relief from symptoms." Asthma treatment for certain groups of people will be adjusted to meet their special needs. This includes children, older adults, pregnant women, or those for whom exercise brings on asthma symptoms.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

50% TREATMENT COMPLIANCE – 19 TO 50 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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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NB – No benefit is being offered by the health benefit plan for the given measure

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Adults With Asthma
continued

DESCRIPTION

2. The percentage of adults aged 51 to 64 years in 2014 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 2014.

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

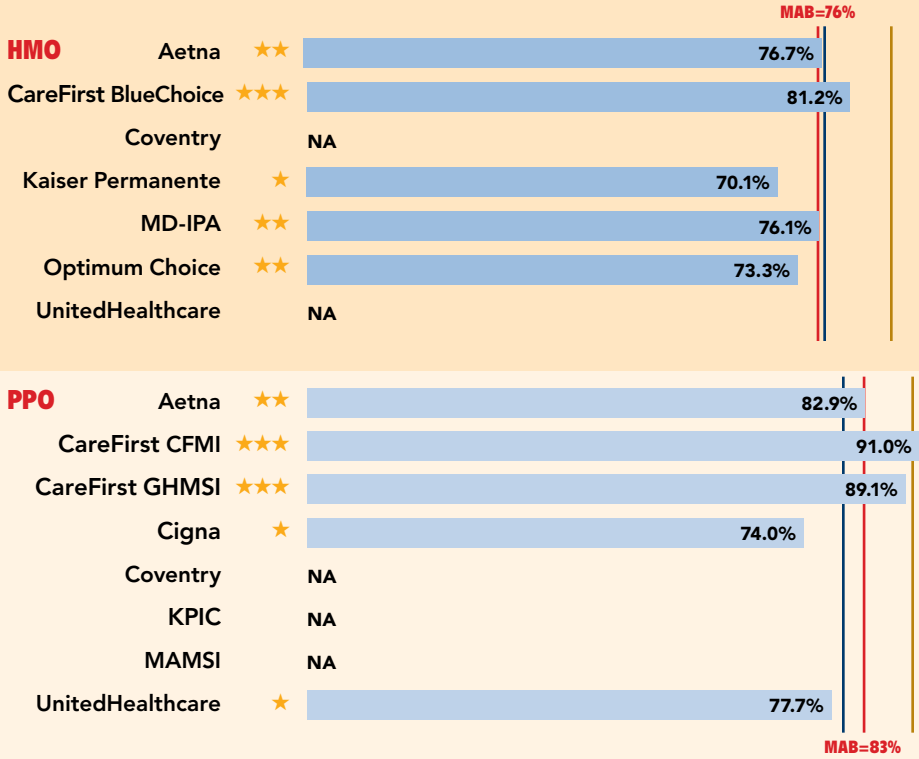
NOTE: Please find the quality measure for children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

"Most people who have asthma need to take long-term control medicines [such as inhaled corticosteroids] daily to help prevent symptoms. The most effective long-term medicines reduce airway inflammation, which helps prevent symptoms from starting. These medicines don't give you quick relief from symptoms." Asthma treatment for certain groups of people will be adjusted to meet their special needs. This includes children, older adults, pregnant women, or those for whom exercise brings on asthma symptoms.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

50% TREATMENT COMPLIANCE – 51 TO 64 YEARS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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NB – No benefit is being offered by the health benefit plan for the given measure

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NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

Medication Management for Adults With Asthma
continued

DESCRIPTION

3. The percentage of adults aged 19 to 50 years in 2014 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 2014.

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

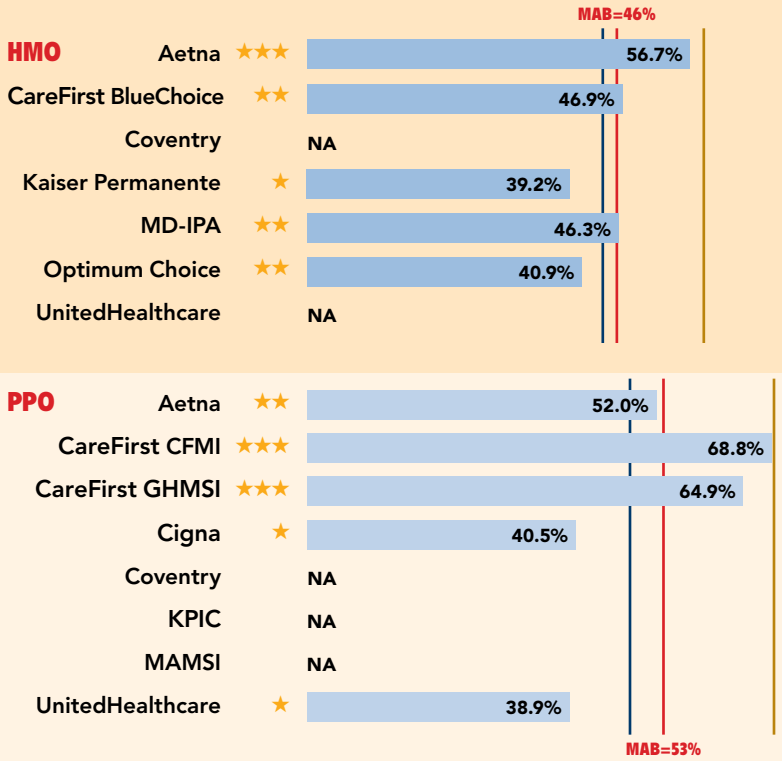
NOTE: Please find the quality measure for children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

"Most people who have asthma need to take long-term control medicines [such as inhaled corticosteroids] daily to help prevent symptoms. The most effective long-term medicines reduce airway inflammation, which helps prevent symptoms from starting. These medicines don't give you quick relief from symptoms." Asthma treatment for certain groups of people will be adjusted to meet their special needs. This includes children, older adults, pregnant women, or those for whom exercise brings on asthma symptoms.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

75% TREATMENT COMPLIANCE – 19 TO 50 YEARS OF AGE



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PERFORMANCE RATING

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

BENCHMARKS

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NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Medication Management for Adults With Asthma
continued

DESCRIPTION

4. The percentage of adults aged 51 to 64 years in 2014 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 2014.

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

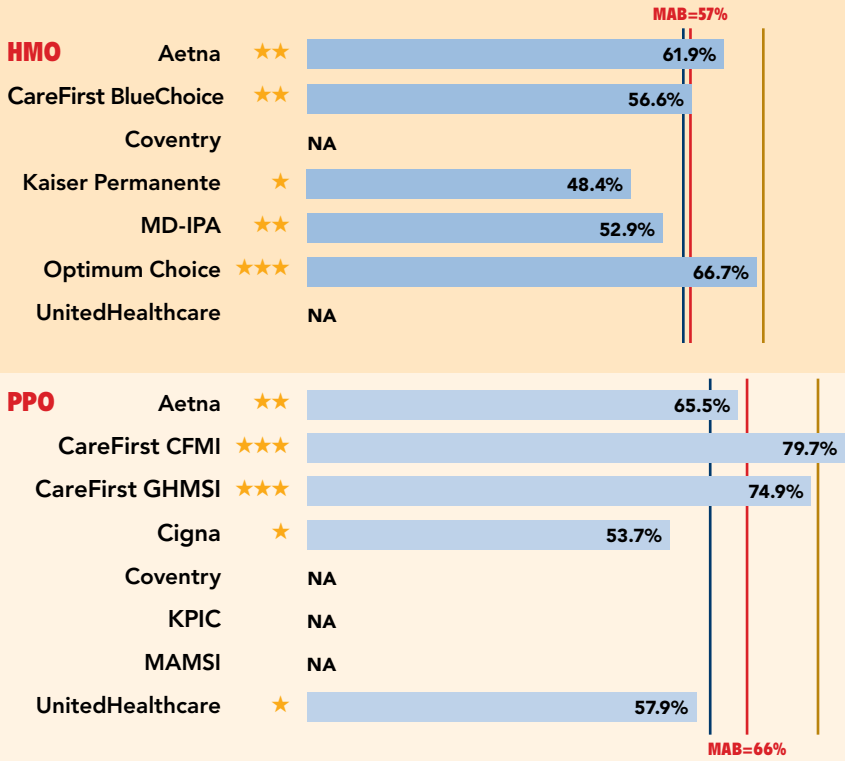
NOTE: Please find the quality measure for children 5 to 11 and 12 to 18 years of age in the Child Respiratory Conditions section.

RATIONALE

"Most people who have asthma need to take long-term control medicines [such as inhaled corticosteroids] daily to help prevent symptoms. The most effective long-term medicines reduce airway inflammation, which helps prevent symptoms from starting. These medicines don't give you quick relief from symptoms." Asthma treatment for certain groups of people will be adjusted to meet their special needs. This includes children, older adults, pregnant women, or those for whom exercise brings on asthma symptoms.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

75% TREATMENT COMPLIANCE – 51 TO 64 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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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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Primary Care for Adults – Cardiovascular Conditions and Diabetes

Many people with diabetes are at risk for developing cardiovascular disease, also referred to as heart and blood vessel disease. A comprehensive approach to care is therefore required, and consists of a strong program that targets prevention as well as treatment. Lifestyle changes such as diet, exercise, stress management and quitting smoking are key preventive health care efforts. Medications to control blood sugar, blood pressure and cholesterol levels, as well as other medications, therapies, monitoring, and testing are important health care treatment efforts that optimize health and wellness while controlling health care costs.

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes (continued)

Controlling High Blood Pressure

DESCRIPTION

The percentage of members aged 18 to 85 years who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:

- Members 18 to 59 years of age whose BP was <140/90 mm Hg.
- Members 60 to 85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60 to 85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

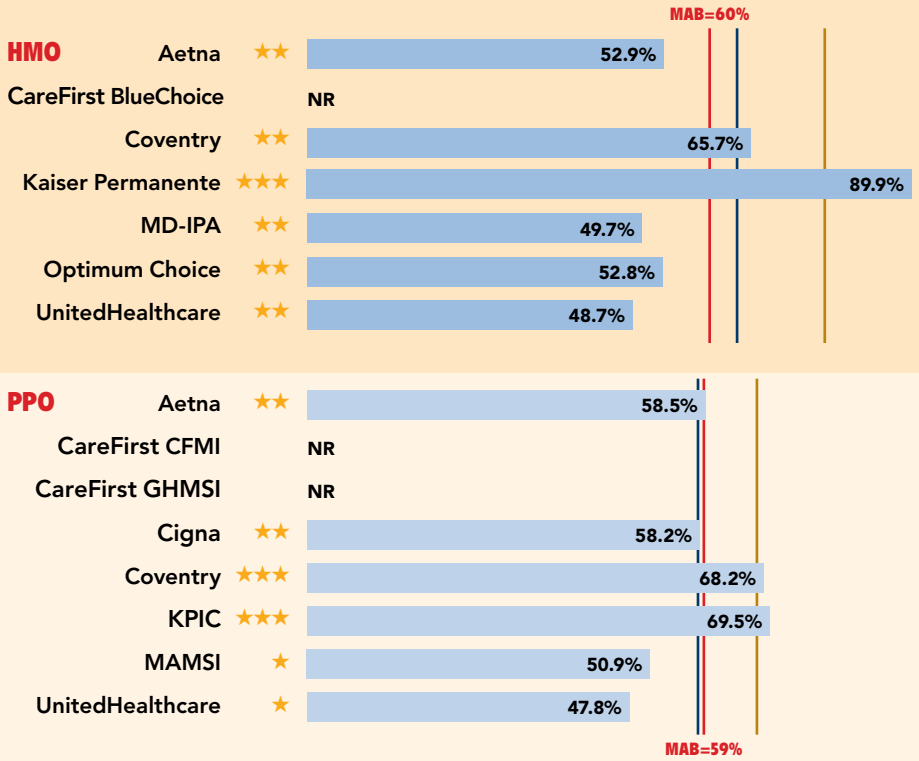
For this measure, a higher percentage is better, which means that more adults 18 to 85 years of age with hypertension did get adequate control of their blood pressure.

RATIONALE

"Blood pressure normally rises and falls throughout the day. But if it stays high for a long time, it can damage your heart and lead to [serious] health problems." Since there are no warning signs of the disease, it is important to have your blood pressure measured and make healthy choices that keep it in a healthy range. When a healthy lifestyle is not enough, one or more types of high blood pressure medication may be needed to achieve blood pressure control.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2013

ADEQUATE BLOOD PRESSURE CONTROL (CARDIOVASCULAR) – 18 TO 85 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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes (continued)

Persistence of Beta-Blocker Treatment After a Heart Attack

DESCRIPTION

The percentage of adults aged 18 years and older in 2014 who were hospitalized and discharged alive from July 1, 2013 through June 30, 2014, with a diagnosis of heart attack or acute myocardial infarction and who received persistent beta-blocker treatment (a class of drugs commonly used to treat the heart) for six months after discharge.

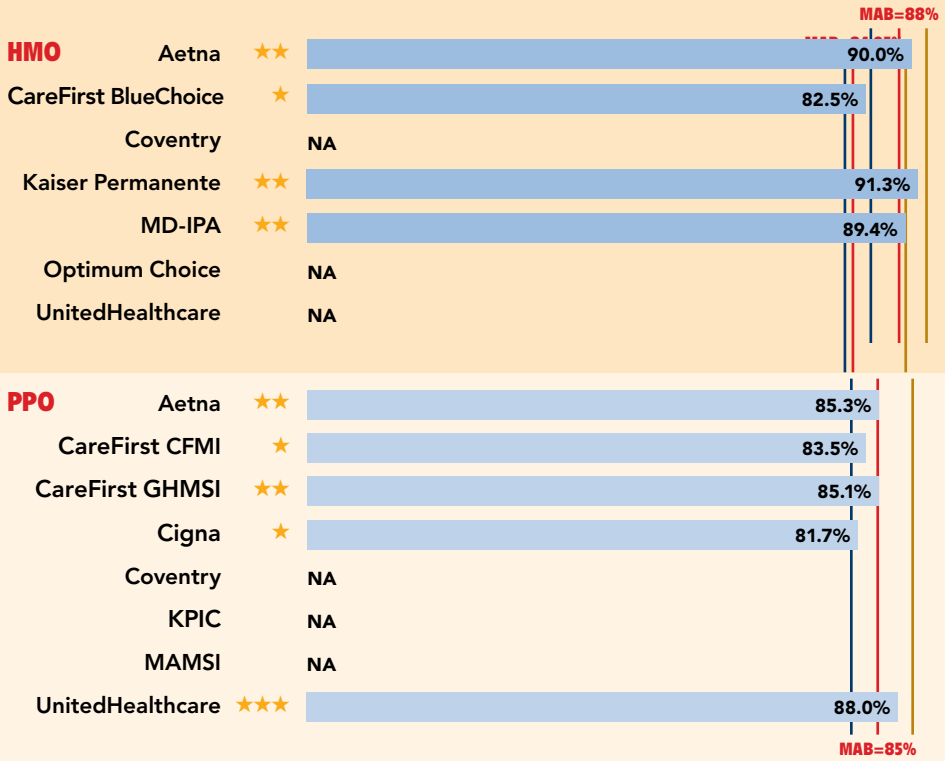
For this measure, a higher percentage is better, which means that more adults 18 years of age and over with a history of having a heart attack did get at least six months of beta-blocker treatment.

RATIONALE

To prevent a repeat heart attack, beta blockers are a common class of medication that is used to decrease the workload of the heart by slowing down the heart rate. Despite their benefits, underutilization of beta blockers continues today. This underutilization may be attributed, in part, to some of the medication's side effects, including headache, depression and sexual dysfunction. After starting beta blocker therapy, it is important not to stop taking the medication suddenly because sudden withdrawal may worsen chest pain or even bring about another heart attack.

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2014

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
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BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes (continued)

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 adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had an HbA1c test during the 2014 measurement year.

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

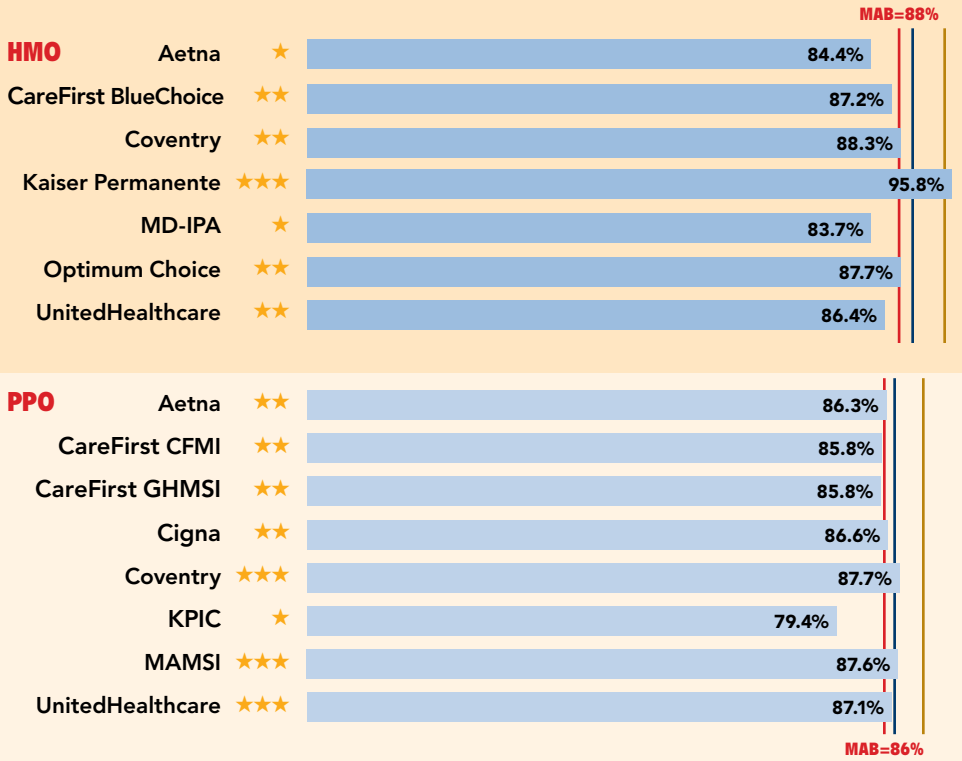
RATIONALE

Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

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



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PERFORMANCE RATING

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BENCHMARKS

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Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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NB – No benefit is being offered by the health benefit plan for the given measure

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Comprehensive Diabetes Care continued

DESCRIPTION

2. Hemoglobin A1c (HbA1c) Poor Control >9.0%: The percentage of adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had an HbA1c test during the 2014 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 to 75 years of age exhibited poor control of their HbA1c level, thereby indicating better diabetes management.

RATIONALE

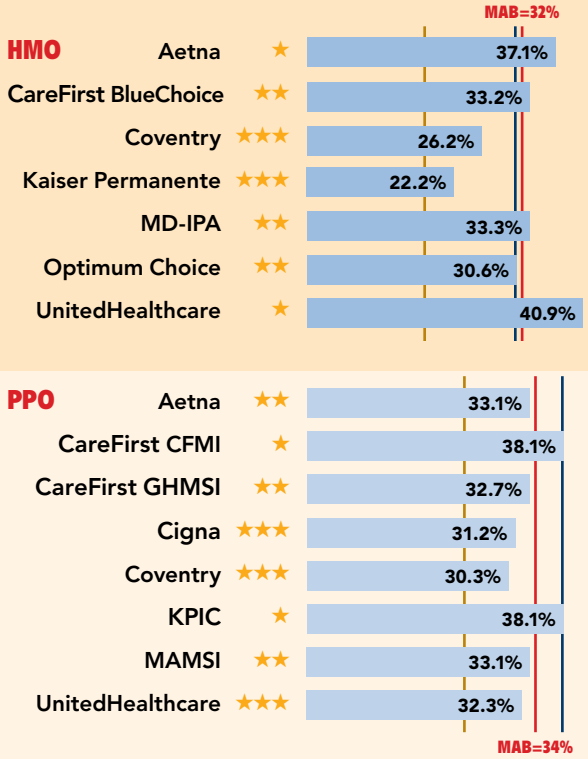
Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

NOTE: For this performance indicator, a lower percentage is better

POOR HbA1c CONTROL (DIABETES) >9.0% – 18 TO 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

MAB MARYLAND AVERAGE BENCHMARK
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NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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NR – Performance results are **not reported** due to bias in the data from the health benefit plan

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Comprehensive Diabetes Care continued

DESCRIPTION

3. Hemoglobin A1c (HbA1c) Good Control <8.0%: The percentage of adults 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had an HbA1c test during the 2014 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 to 75 years of age exhibited good control of their HbA1c level, thereby indicating better diabetes management.

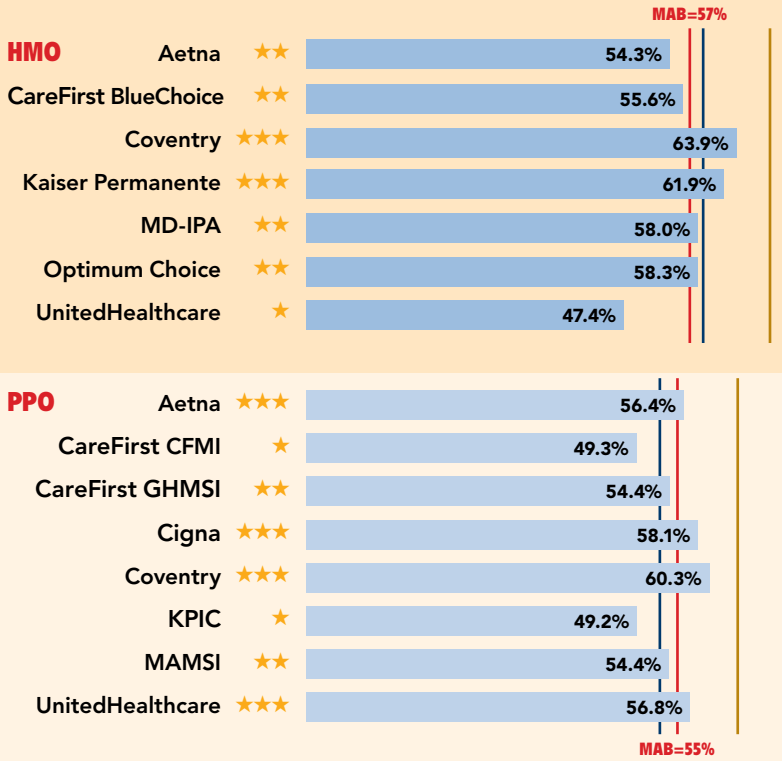
RATIONALE

Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

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



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes (continued)

Comprehensive Diabetes Care continued

DESCRIPTION

4. Hemoglobin A1c (HbA1c) Tight Control <7.0%: The percentage of adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had an HbA1c test during the 2014 measurement year and also had exhibited tight HbA1c control <7.0%.

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

NOTE: Additional exclusion criteria may apply (e.g., members aged 65 years and over as of December 31 of the 2014 measurement year, discharged alive for coronary artery bypass graft procedure during the 2014 measurement year or the year prior, etc.).

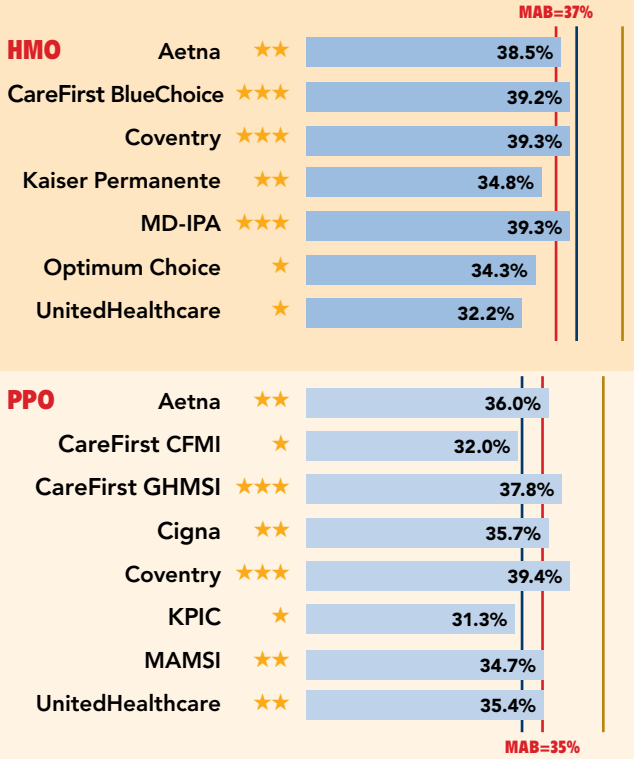
RATIONALE

Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

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



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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Cardiovascular Conditions and Diabetes (continued)

Comprehensive Diabetes Care continued

DESCRIPTION

5. Dilated Eye Exam (Retina) Performed: The percentage of adults 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had a retinal eye exam during the 2014 measurement year.

For this performance indicator, a higher percentage is better, which means that more diabetic adults 18 to 75 years of age did get appropriate retinal examination of the eyes to look for signs of retinopathy, or damage to the blood vessels in the retina, located in the back of the eye.

NOTE: If a patient is negative for retinopathy, they are considered to be at low risk and are not required to have a dilated eye exam by a specialist until the second year after the exam that produced the negative result.

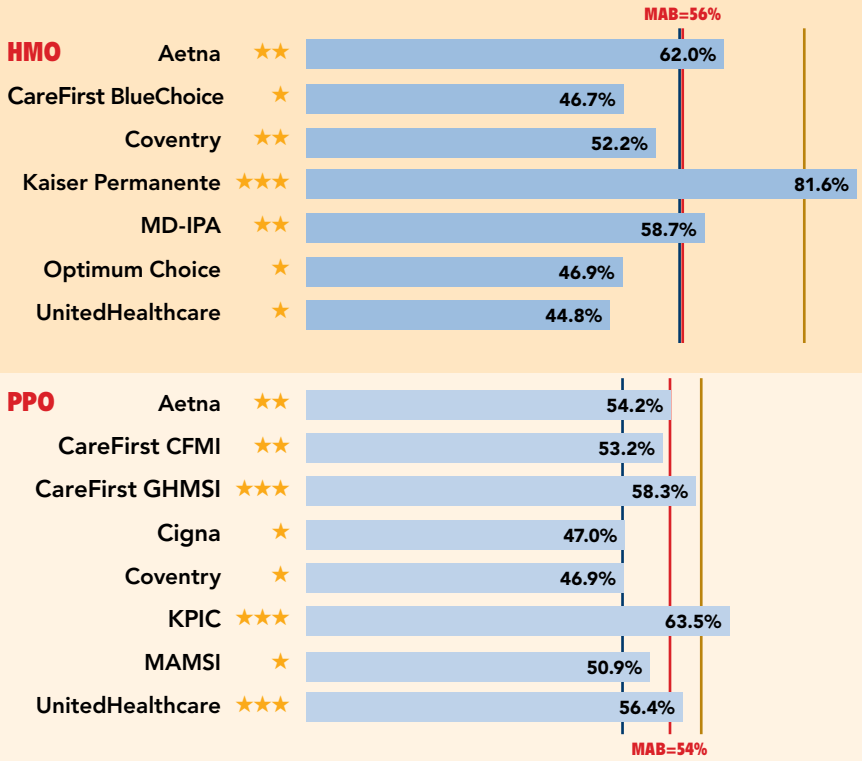
RATIONALE

Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
- Cholesterol Test – measures the amount of lipids (fats) in your blood; high levels can lead to blocked arteries
- Urine and Blood Tests – used to check for developing problems in the kidneys
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

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



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Comprehensive Diabetes Care continued

DESCRIPTION

6. Medical Attention for Nephropathy: The percentage of adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had medical attention for nephropathy or kidney disease during the 2014 measurement year.

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

RATIONALE

Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

- Dilated Eye Exam – inspects the delicate retina in the back of the eye for diabetes-related damage
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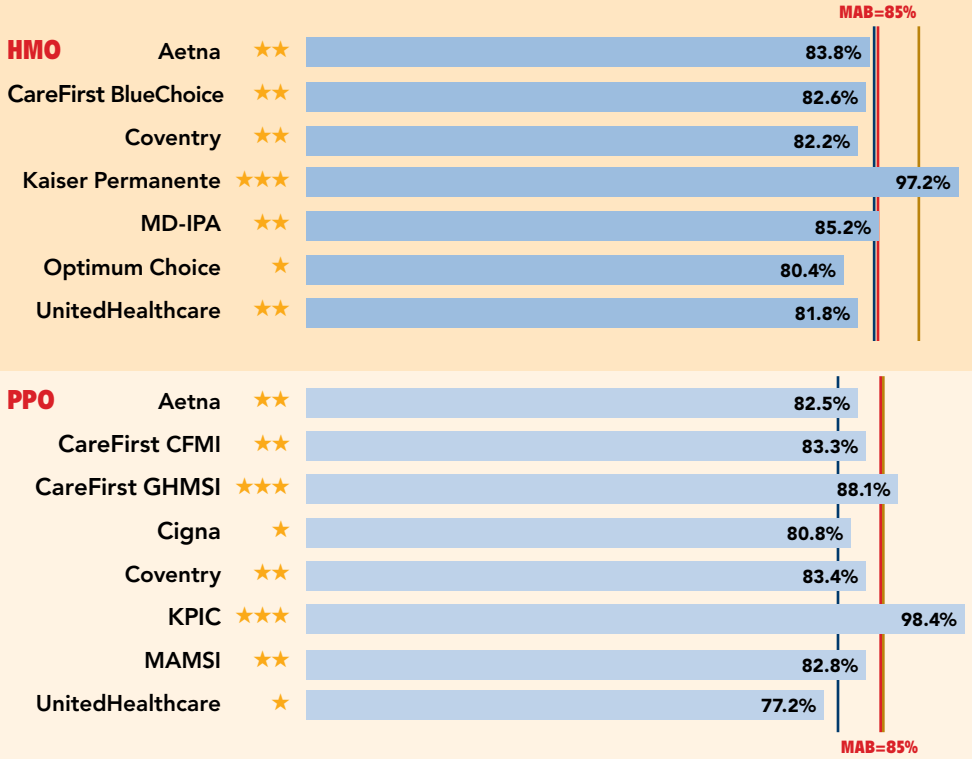
- Blood Pressure Check – measures pressure in your arteries; high blood pressure can lead to heart disease or stroke
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

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



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Comprehensive Diabetes Care continued

DESCRIPTION

7. Good Blood Pressure Control <140/90 mm Hg: The percentage of adults aged 18 to 75 years in 2014 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 2014 measurement year.

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

RATIONALE

Diabetes is a serious disease in which the body's level of blood glucose (sugar) is too high. Two main types of diabetes include type 1, where the body does not make the insulin needed to convert glucose to energy, and type 2, which is more common and occurs when the body does not make enough insulin or can not use its own insulin as well as it should. This causes sugar to build up in your blood and can lead to serious health complications. Important tools to gain control over diabetes include:

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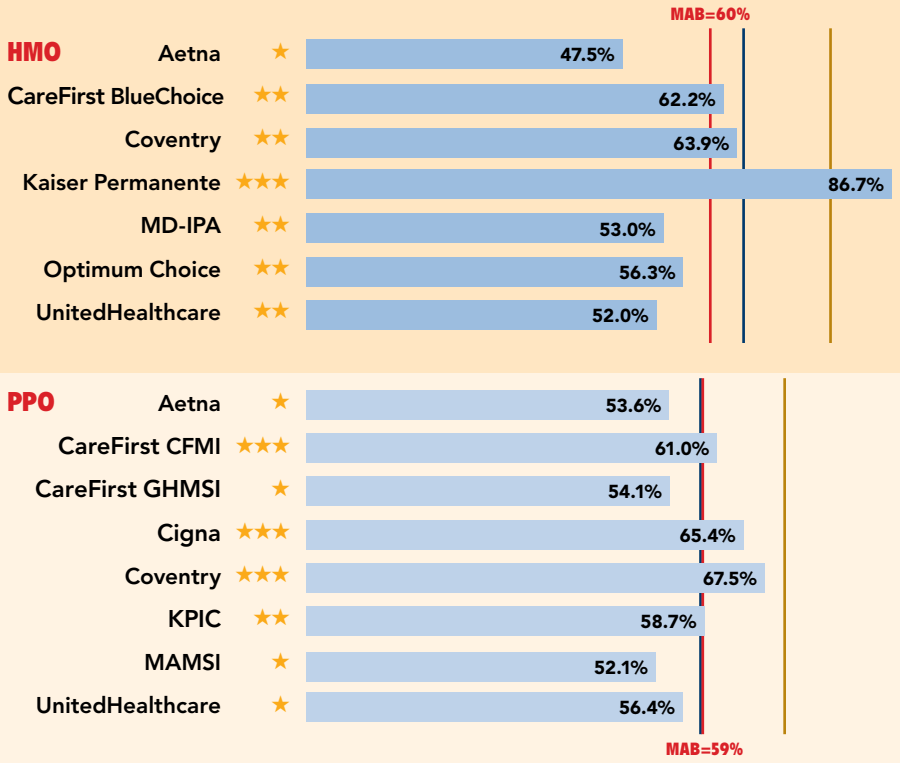
- Healthy lifestyle choices, plus foot and dental exams, as well as annual flu and pneumonia vaccines are also important

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2015

GOOD BLOOD PRESSURE CONTROL (DIABETES) – 18 TO 75 YEARS OF AGE



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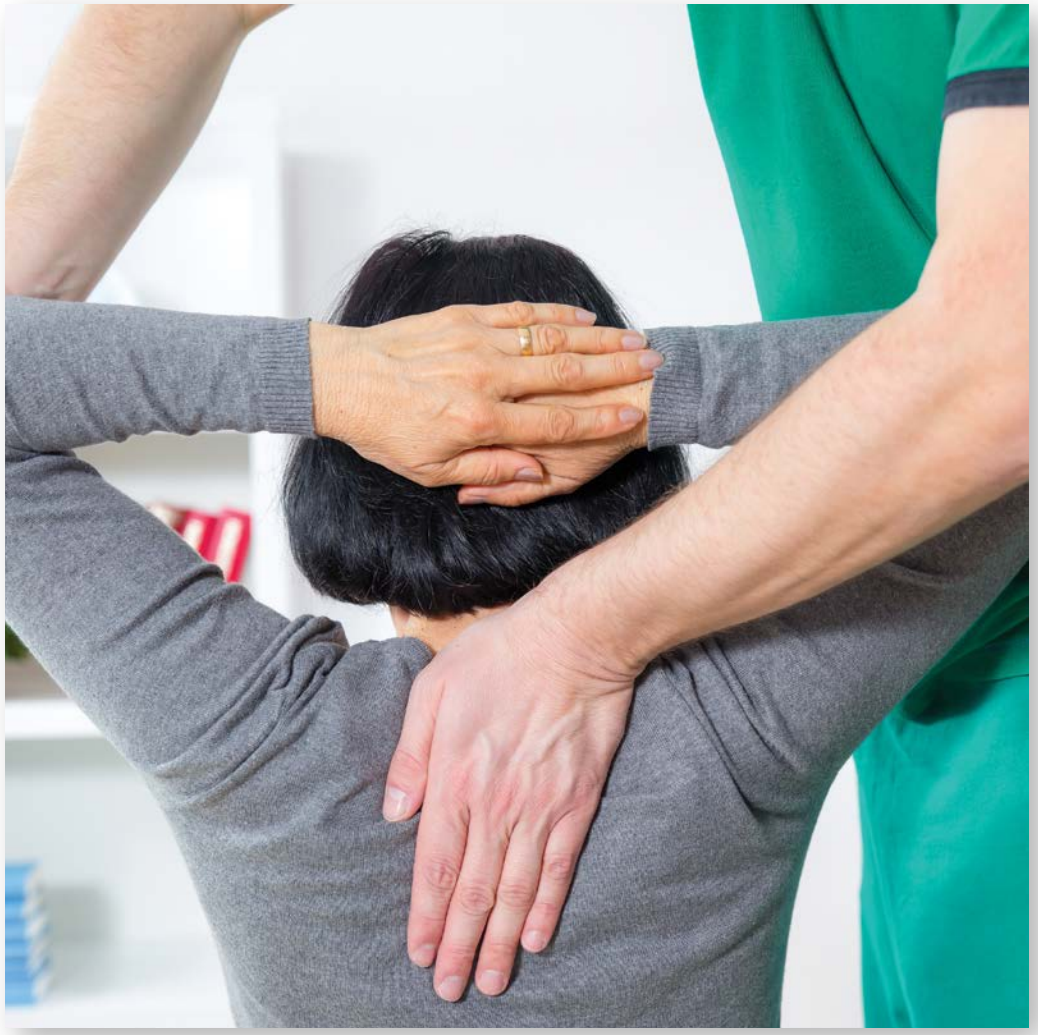
Primary Care for Adults – Musculoskeletal Disease and Medication Management

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.



Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

DESCRIPTION

The percentage of adults aged 18 years and over in 2014 who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one Disease Modifying anti-Rheumatic Drug (DMARD) in 2014. DMARDs are medications proven effective in slowing or preventing joint damage as opposed to just relieving pain and inflammation.

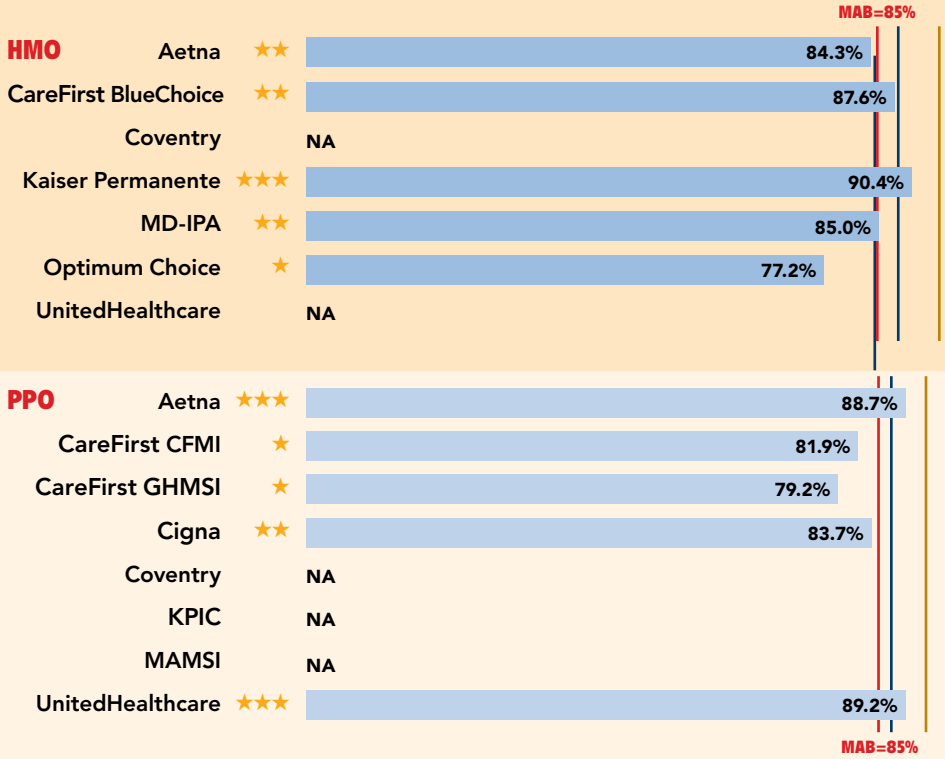
For this measure, a higher percentage is better, which means that more adults 18 years of age and over did get DMARD treatment for their RA.

RATIONALE

The autoimmune condition, rheumatoid arthritis (RA), is a systemic, chronic inflammatory disease that primarily affects the membrane lining of multiple joints, but can also affect organs in the body. The inflamed membrane tissues surrounding affected joints can cause joint redness, swelling, pain, and even joint deformity. There is no cure for RA. The goal is to start treatment early, including medications, therapy and exercise, in order to slow or stop disease progression. Newer non-biologic and biologic Disease Modifying anti-Rheumatic Drugs (DMARDs) help relieve pain, prevent joint destruction and maintain functional capacity. Ideally, DMARD therapy should be started within 3 months of diagnosis.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012

DMARD THERAPY – 18+ YEARS OF AGE



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PERFORMANCE RATING

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Musculoskeletal Disease and Medication Management (continued)

Use of Imaging Studies for Low Back Pain

DESCRIPTION

The percentage of adults aged 18 to 50 years in 2014 with a primary diagnosis of low back pain who did not have an imaging study (x-ray, MRI or CT scan) within 28 days after the diagnosis.

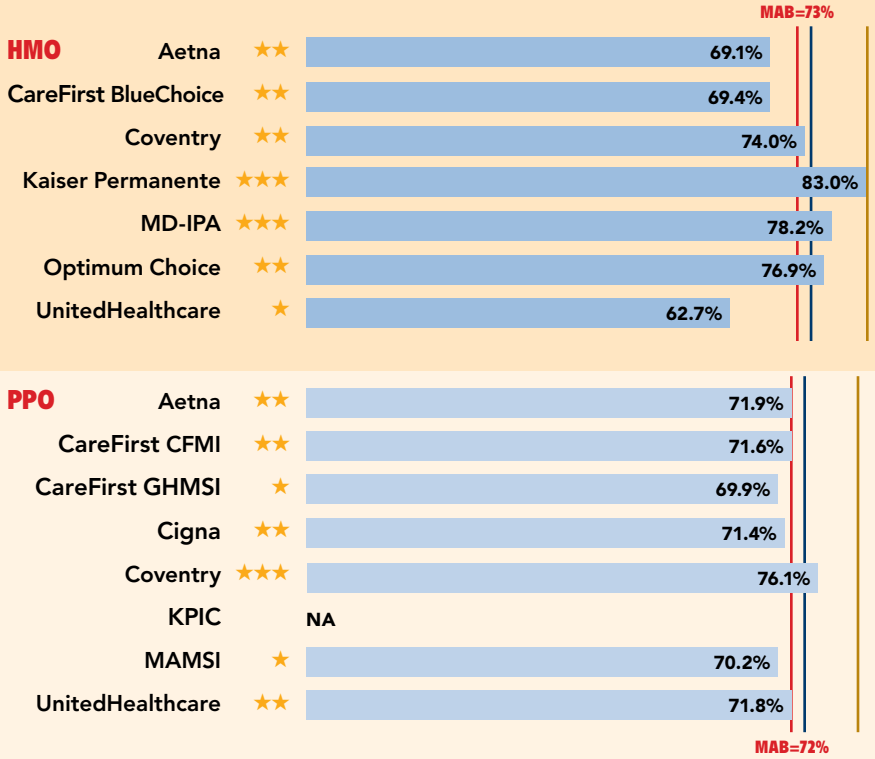
For this measure, a higher percentage is better, which means that more adults 18 to 50 years of age with low back pain appropriately did not get an imaging study, as imaging studies are often overused.

RATIONALE

Low back pain is common, affecting about 80 percent of adults at some point in their lives. "Most low back pain is acute, or short term, and lasts a few days to a few weeks. It tends to resolve on its own with self-care and there is no residual loss of function. The majority of acute low back pain is mechanical in nature, meaning that there is a disruption in the way the components of the back (the spine, muscle, intervertebral discs, and nerves) fit together and move." Imaging studies such as X-ray, CT scan or MRI are not necessary in most cases of low back pain. However, under certain circumstances, imaging may be ordered to rule out specific causes of pain, including fracture, infection, tumor, and spinal stenosis.

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Neurological Disorders and Stroke, 2015

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



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Musculoskeletal Disease and Medication Management (continued)

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 Patients on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs): The percentage of adults aged 18 years and over in 2014 who received at least 180 treatment days of ambulatory medication therapy with ACE inhibitors or ARBs during 2014 and had at least one therapeutic monitoring event for the ACE inhibitor or ARB agent in 2014.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on ACE inhibitors or ARBs are being appropriately monitored and did get at least one annual therapeutic monitoring event.

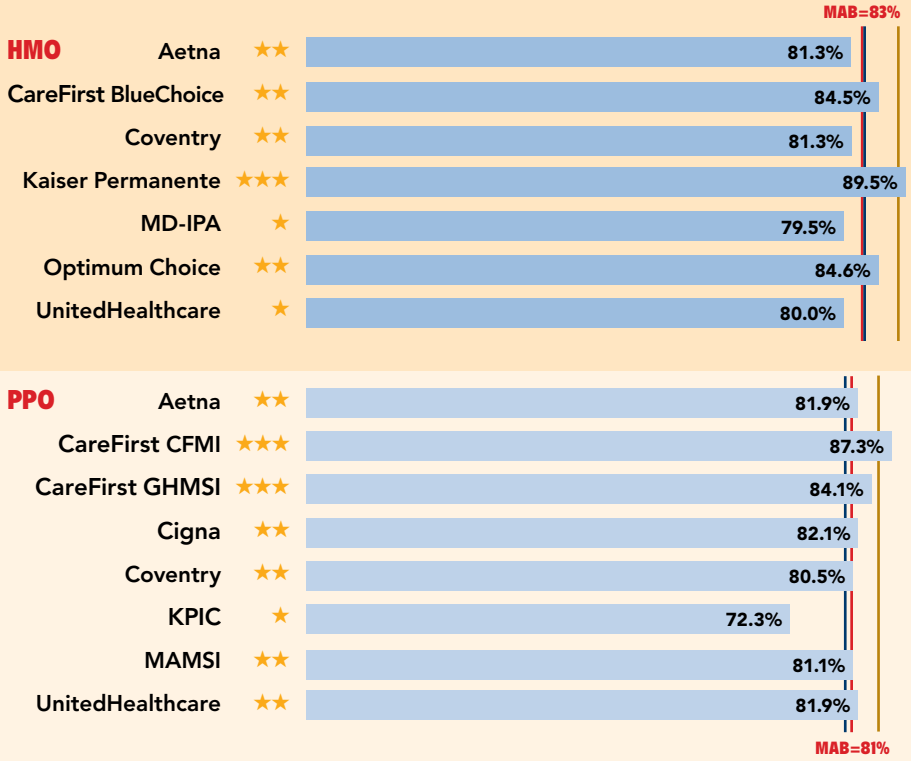
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Healthcare Quality Promotion, 2012

ACE INHIBITORS OR ARBS – 18+ YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Primary Care for Adults – Musculoskeletal Disease and Medication Management (continued)

Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

2. Annual Monitoring for Patients on Digoxin: The percentage of adults aged 18 years and over in 2014 who received at least 180 treatment days of ambulatory medication therapy with digoxin during 2014 and had at least one therapeutic monitoring event for the digoxin agent in 2014.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on digoxin are being appropriately monitored and did get at least one annual therapeutic monitoring event.

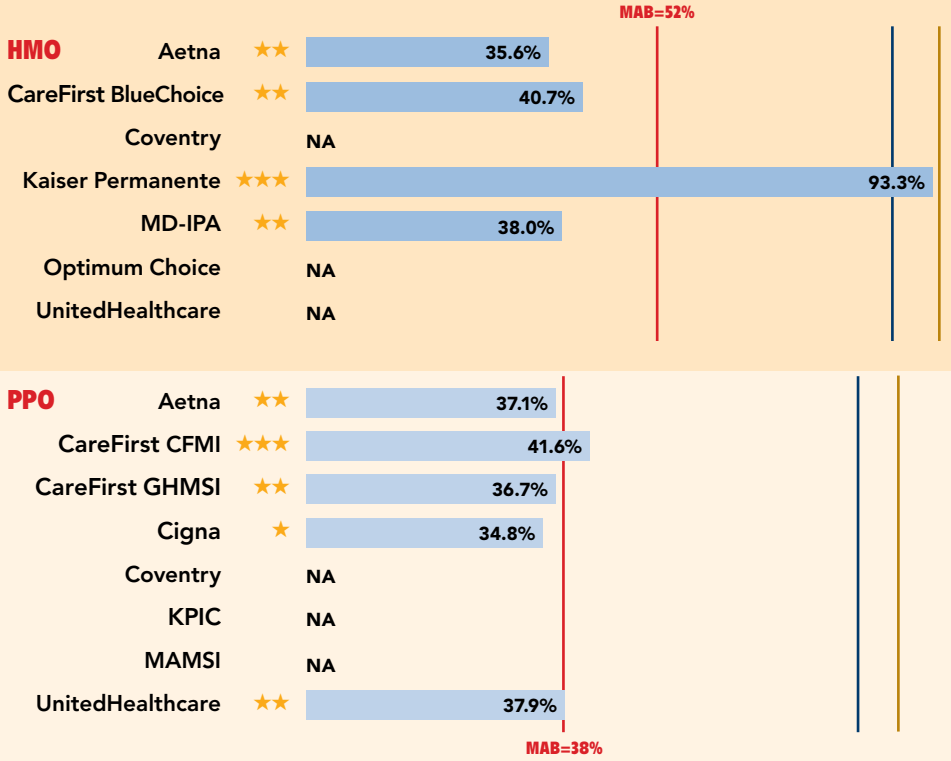
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Healthcare Quality Promotion, 2012

DIGOXIN – 18+ YEARS OF AGE



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Annual Monitoring for Patients on Persistent Medications continued

DESCRIPTION

3. Annual Monitoring for Patients on Diuretics: The percentage of adults aged 18 years and over in 2014 who received at least 180 treatment days of ambulatory medication therapy with diuretics during 2014 and had at least one therapeutic monitoring event for the diuretic agent in 2014.

For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over on diuretics are being appropriately monitored and did get at least one annual therapeutic monitoring event.

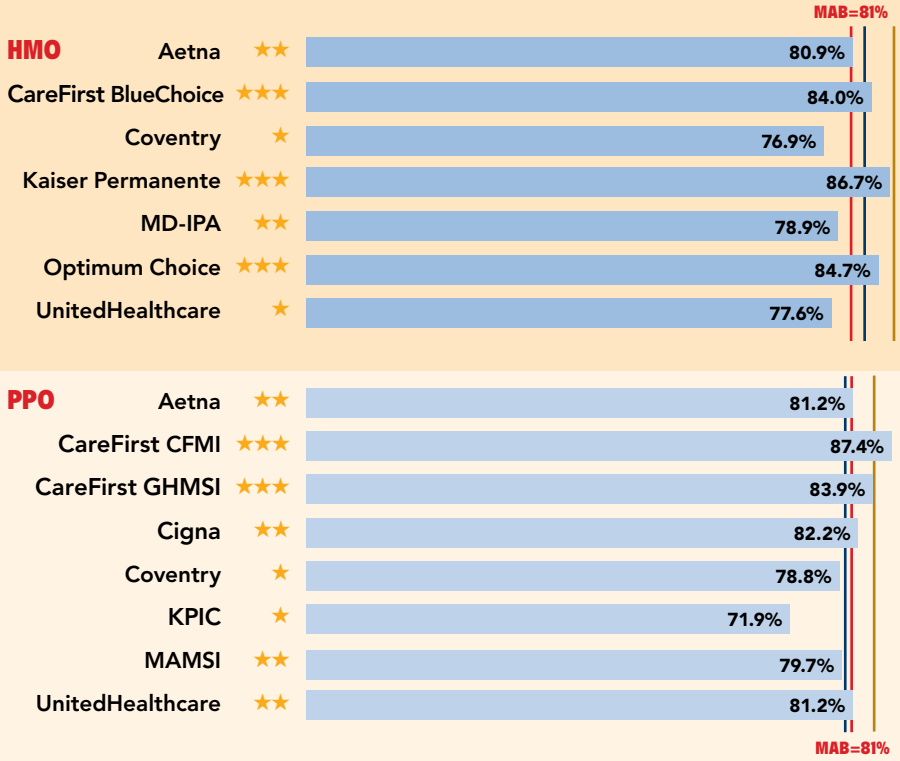
RATIONALE

ACE inhibitors, ARBs, digoxin, diuretics, and anticonvulsants are taken by thousands of patients and are proven to be safe classes of medications. However, over 700,000 emergency department visits each year are due to adverse drug events. The risk of having an adverse drug event is increased among older adults who typically take more medicines. Some medicines that require regular monitoring include:

- Blood thinners (e.g., warfarin)
- Diabetes medicines (e.g., insulin)
- Seizure/Anticonvulsant medicines (e.g., phenytoin, carbamazepine)
- Heart medicine (e.g., digoxin)
- Blood pressure medicines (e.g., ACE inhibitors, ARBs and diuretics

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Healthcare Quality Promotion, 2012

DIURETICS – 18+ YEARS OF AGE



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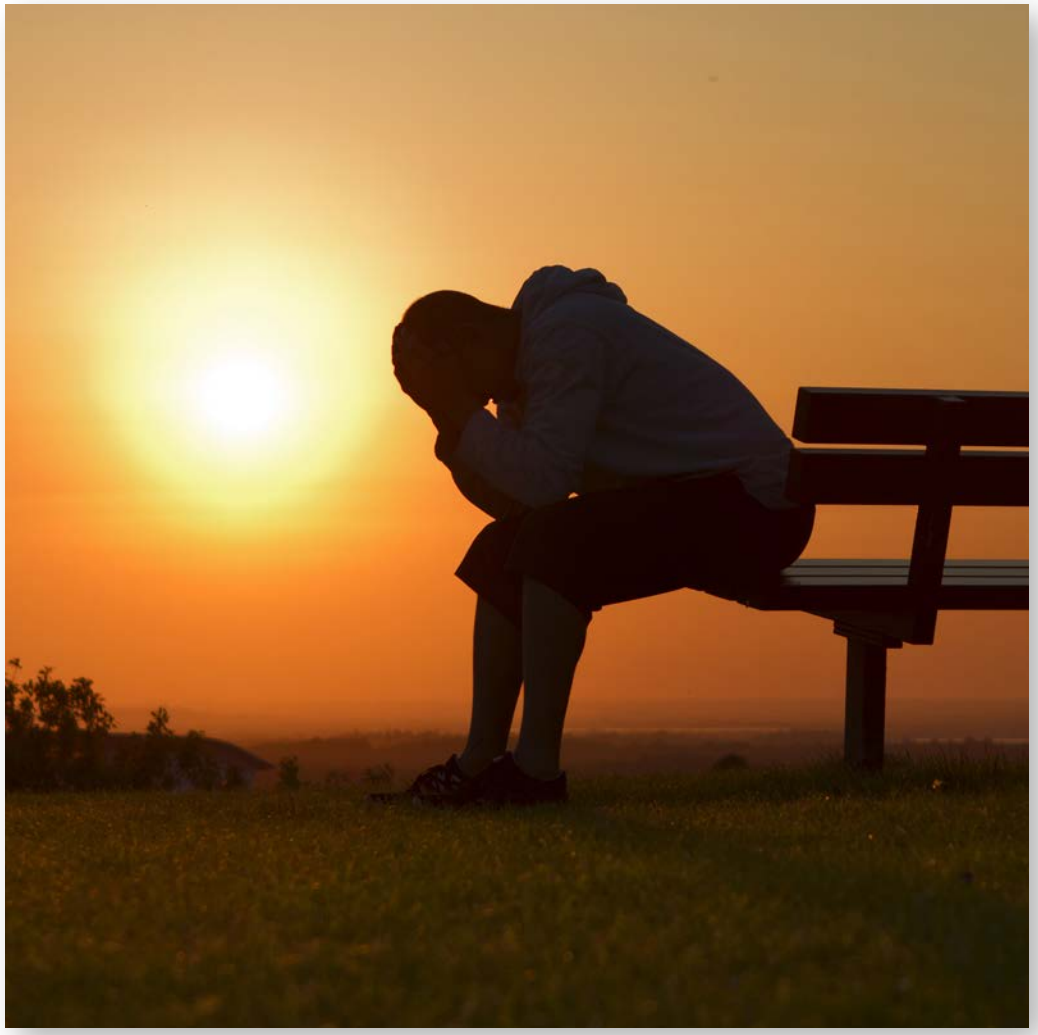
Behavioral Health

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



III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Behavioral Health (continued)

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 adults aged 18 years and over in 2014 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 over with depression were effectively treated with 12 weeks of antidepressant medication during the acute phase of treatment.

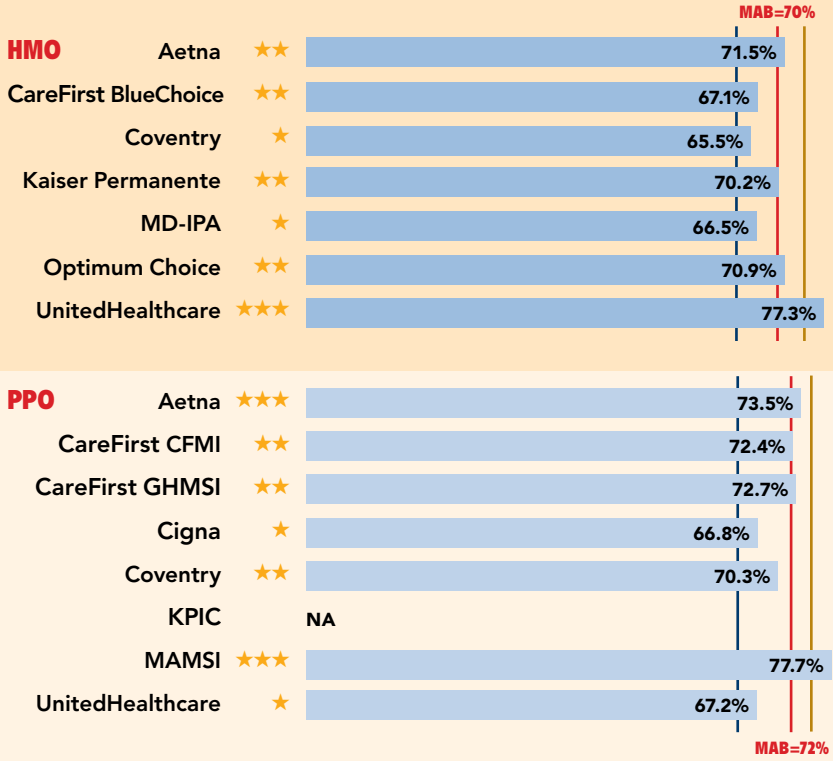
RATIONALE

Antidepressant medications work to balance some of the natural chemicals in the brain that affect mood and emotional responses.

The most popular types of antidepressants do not have as many side effects as older classes of antidepressants and include a class of medicines called selective serotonin reuptake inhibitors (SSRIs) and a similar class called serotonin and norepinephrine reuptake inhibitors (SNRIs). Another antidepressant that is commonly used is bupropion, which is unique in that it does not fit into any specific drug class. Older classes of antidepressants include tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs). For some people, these older classes of antidepressants may be the best medications. Patients of all ages taking any class of antidepressant medications should be closely monitored for possible side effects including "depression that gets worse, suicidal thinking or behavior, or any unusual changes in behavior such as trouble sleeping, agitation, or withdrawal from normal social situations."

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, 2015

EFFECTIVE 12 WEEK ACUTE PHASE – 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

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

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Antidepressant Medication Management continued

DESCRIPTION

2. Effective Continuation Phase Treatment: The percentage of adults aged 18 years and over in 2014 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).

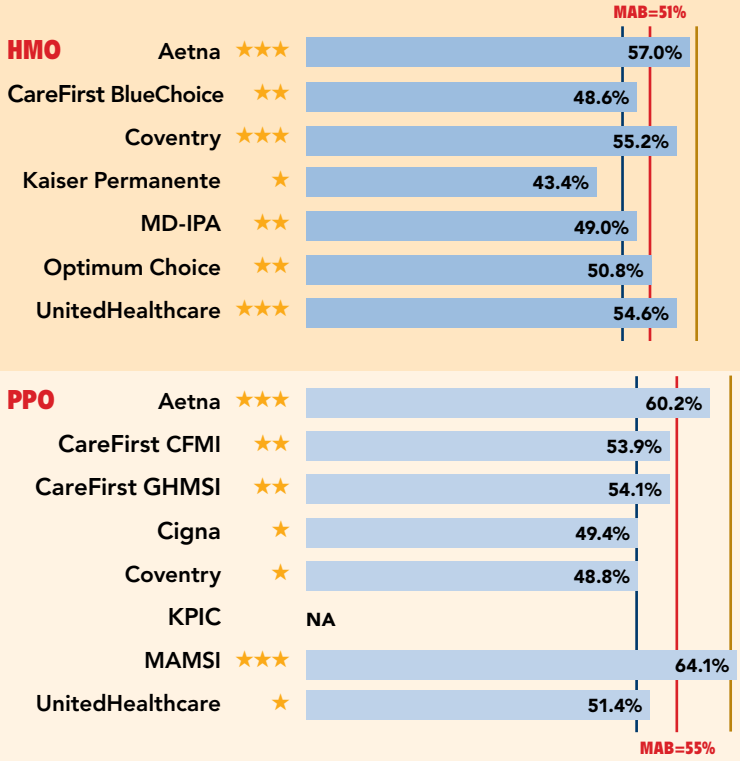
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over with depression were effectively treated with at least 6 months of antidepressant medication during the continuation phase of treatment.

RATIONALE

Antidepressant medications work to balance some of the natural chemicals in the brain that affect mood and emotional responses. The most popular types of antidepressants do not have as many side effects as older classes of antidepressants and include a class of medicines called selective serotonin reuptake inhibitors (SSRIs) and a similar class called serotonin and norepinephrine reuptake inhibitors (SNRIs). Another antidepressant that is commonly used is bupropion, which is unique in that it does not fit into any specific drug class. Older classes of antidepressants include tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs). For some people, these older classes of antidepressants may be the best medications. Patients of all ages taking any class of antidepressant medications should be closely monitored for possible side effects including "depression that gets worse, suicidal thinking or behavior, or any unusual changes in behavior such as trouble sleeping, agitation, or withdrawal from normal social situations."

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, 2015

EFFECTIVE 6 MONTH CONTINUATION PHASE – 18+ YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Behavioral Health (continued)

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 aged 6 years and over in 2014 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 over who were hospitalized for treatment of selected mental health disorders received timely follow-up within 7 days of discharge.

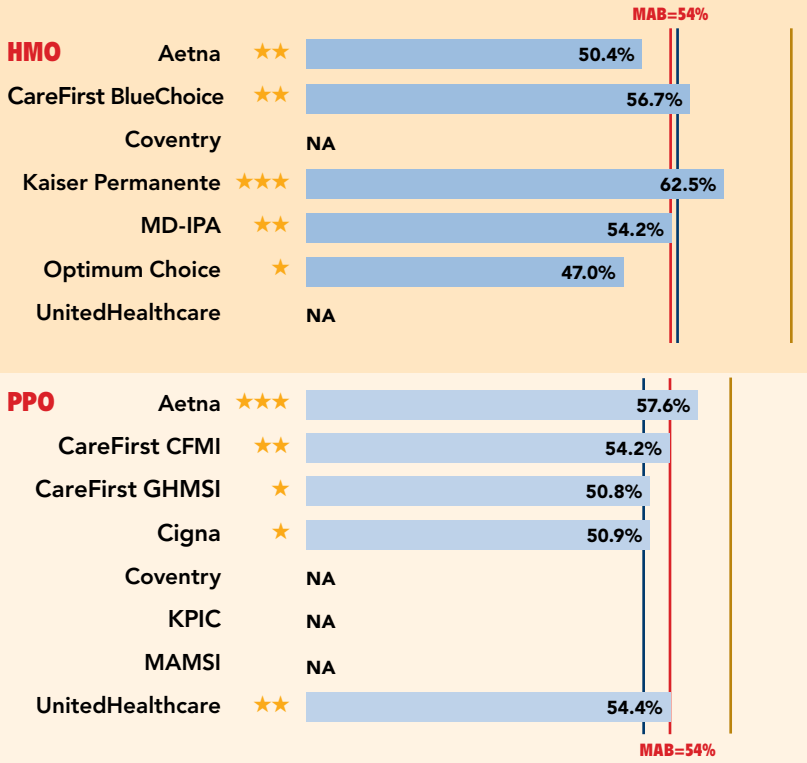
RATIONALE

Studies show that many patients who do not have timely follow-up care after being hospitalized for a mental illness, are often re-hospitalized within 12 months. Making and keeping appointments for early follow-up visits with a mental health provider are recommended in order to:

- Support the transition to home/work
- Ensure that gains made during hospitalization are not lost following discharge
- Monitor for negative reactions to medications or treatments
- Provide continuing care and treatment
- Reduce hospital readmissions and significantly lower costs to the health care system

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Effective Health Care Program, 2014

FOLLOW-UP WITHIN 7 DAYS – 6+ YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Behavioral Health (continued)

Follow-Up After Hospitalization for Mental Illness

continued

DESCRIPTION

2. Follow-Up Within 30 Days of Discharge: The percentage of members aged 6 years and over in 2014 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 over 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.

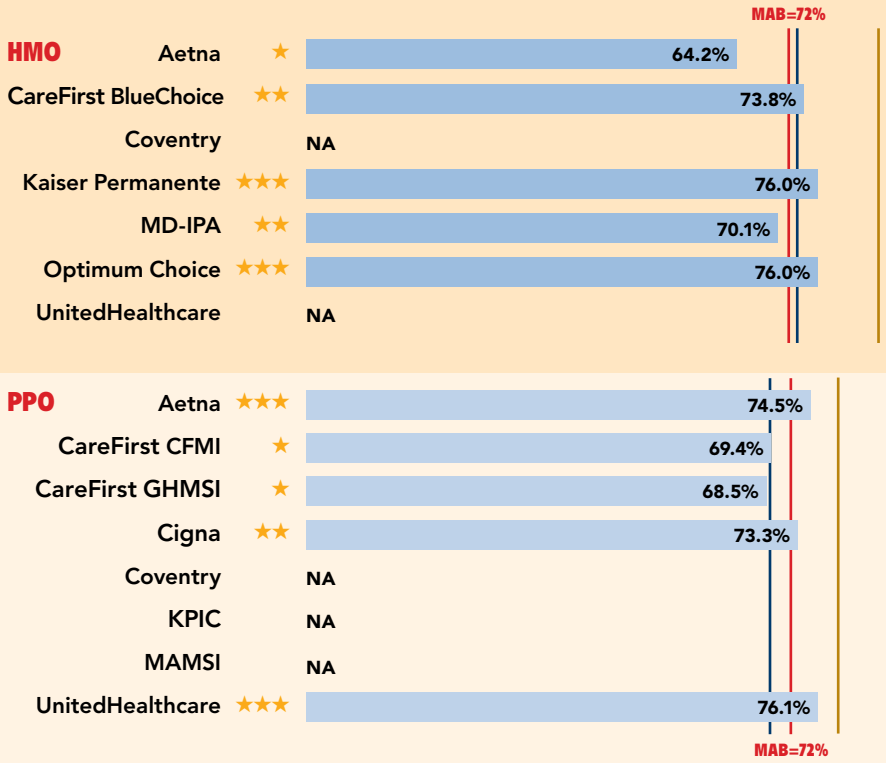
RATIONALE

Studies show that many patients who do not have timely follow-up care after being hospitalized for a mental illness, are often re-hospitalized within 12 months. Making and keeping appointments for early follow-up visits with a mental health provider are recommended in order to:

- Support the transition to home/work
- Ensure that gains made during hospitalization are not lost following discharge
- Monitor for negative reactions to medications or treatments
- Provide continuing care and treatment
- Reduce hospital readmissions and significantly lower costs to the health care system

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Effective Health Care Program, 2014

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 adolescents aged 13 to 17 years in 2014 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.

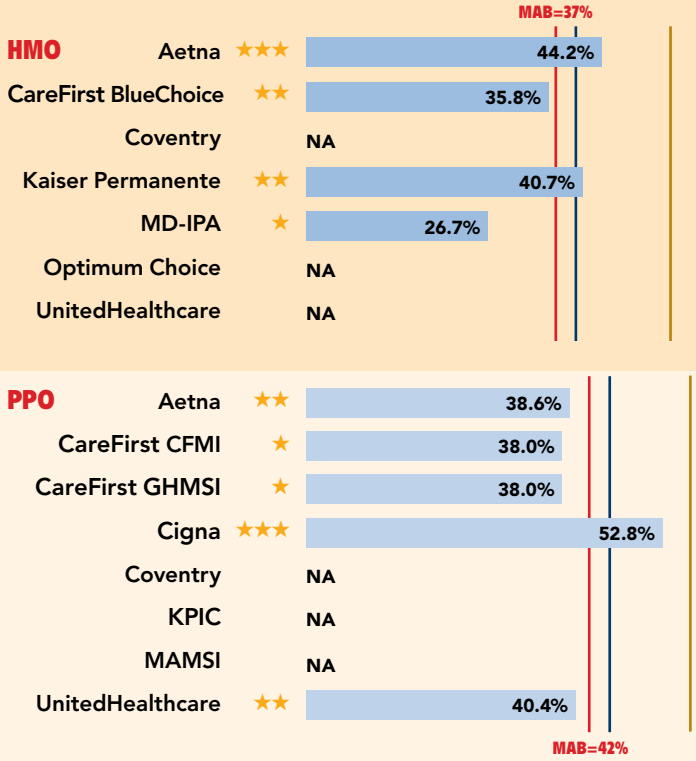
For this performance indicator, a higher percentage is better, which means that more adolescents 13 to 17 years of age who were diagnosed with AOD dependence received treatment within 14 days of diagnosis.

RATIONALE

Many Americans still go without needed behavioral health treatment and supportive services for alcohol and other drug dependence. "Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs. For many people with behavioral health problems the most effective approach often involves a combination of counseling and medication. Supportive services, such as case or care management, can also play an important role in promoting health and recovery."

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014

INITIATION WITHIN 14 DAYS – 13 TO 17 YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

2. Initiation of Alcohol and Other Drug (AOD) Treatment-Adults: The percentage of adults aged 18 years and over in 2014 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.

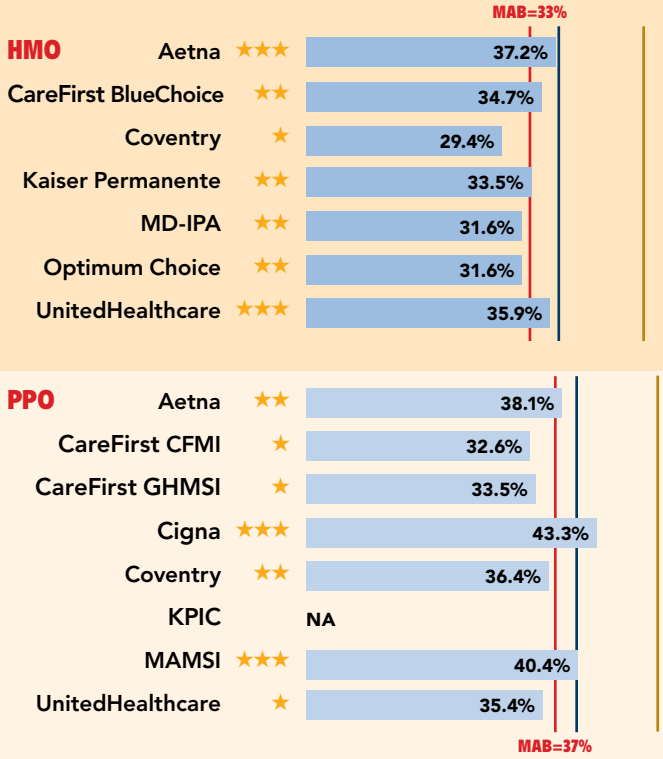
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over who were diagnosed with AOD dependence received treatment within 14 days of diagnosis.

RATIONALE

Many Americans still go without needed behavioral health treatment and supportive services for alcohol and other drug dependence. "Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs. For many people with behavioral health problems the most effective approach often involves a combination of counseling and medication. Supportive services, such as case or care management, can also play an important role in promoting health and recovery."

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014

INITIATION WITHIN 14 DAYS – 18+ YEARS OF AGE



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Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

3. Engagement of Alcohol and Other Drug (AOD) Treatment-Adolescents: The percentage of adolescents aged 13 to 17 years in 2014 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.

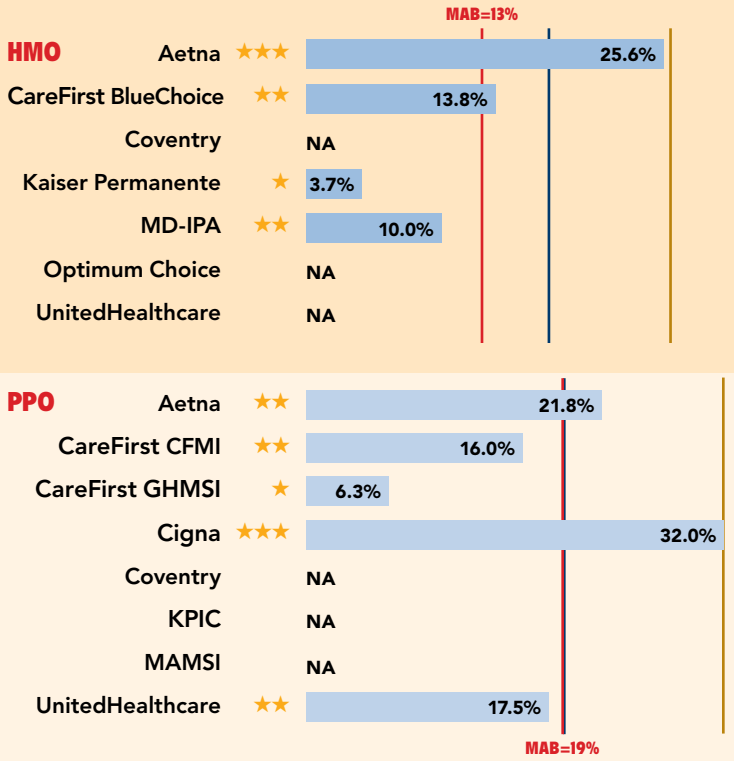
For this performance indicator, a higher percentage is better, which means that more adolescents 13 to 17 years of age who were diagnosed with AOD dependence received two or more additional follow-up treatments within 30 days of their initial visit.

RATIONALE

Many Americans still go without needed behavioral health treatment and supportive services for alcohol and other drug dependence. "Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs. For many people with behavioral health problems the most effective approach often involves a combination of counseling and medication. Supportive services, such as case or care management, can also play an important role in promoting health and recovery."

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014

ENGAGEMENT WITHIN 30 DAYS – 13 TO 17 YEARS OF AGE



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PERFORMANCE RATING

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Data Source: HEDIS® Submission or Health Benefit Plan Records

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment continued

DESCRIPTION

4. Engagement of Alcohol and Other Drug (AOD) Treatment-Adults: The percentage of adults aged 18 years and over in 2014 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.

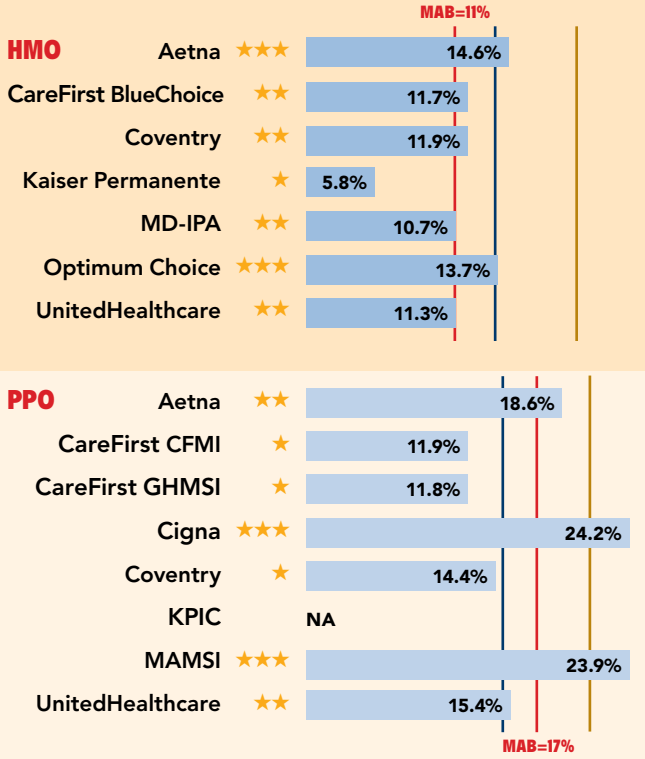
For this performance indicator, a higher percentage is better, which means that more adults 18 years of age and over who were diagnosed with AOD dependence received two or more additional follow-up treatments within 30 days of their initial visit.

RATIONALE

Many Americans still go without needed behavioral health treatment and supportive services for alcohol and other drug dependence. "Individual paths to recovery differ, and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs. For many people with behavioral health problems the most effective approach often involves a combination of counseling and medication. Supportive services, such as case or care management, can also play an important role in promoting health and recovery."

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014

ENGAGEMENT WITHIN 30 DAYS – 18+ YEARS OF AGE



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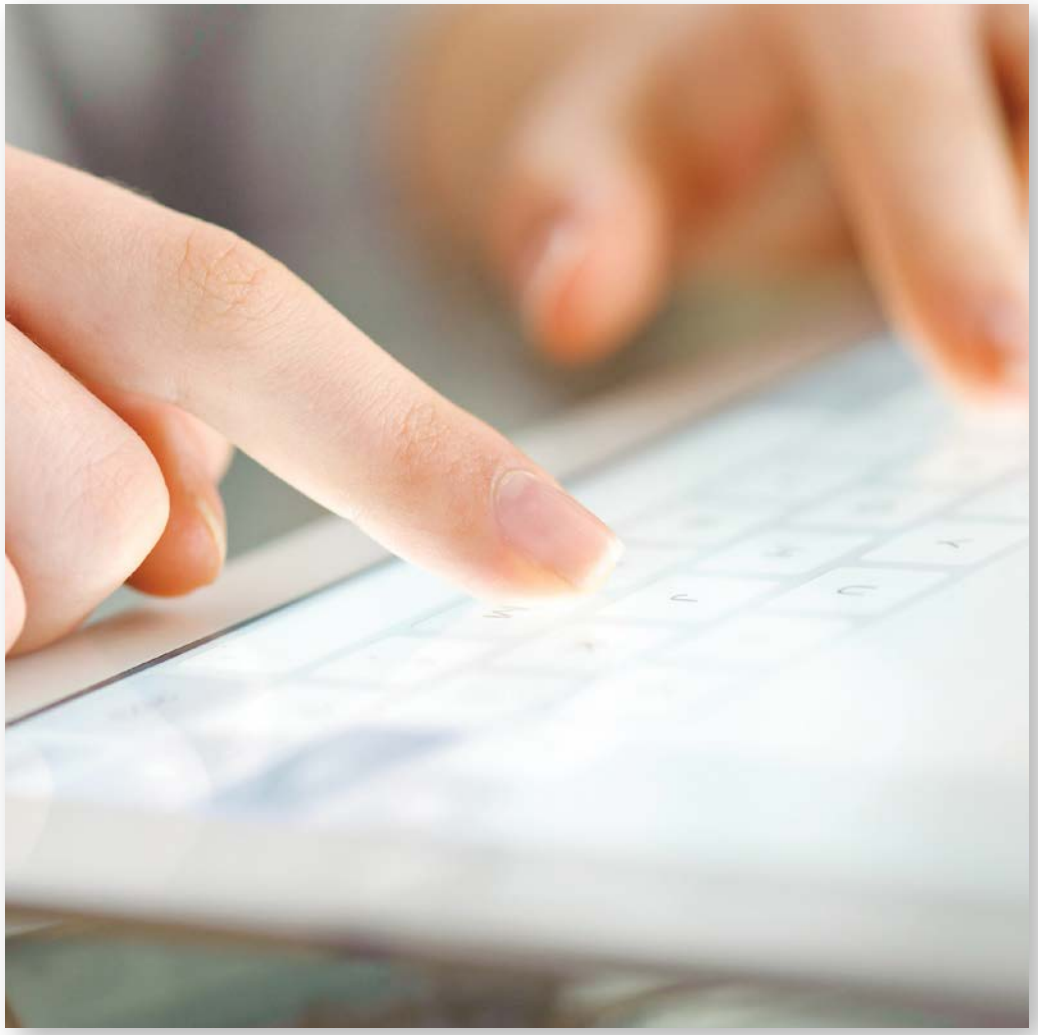
Member Experience and Satisfaction With Health Benefit Plan

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey program is trademarked and overseen by the United States Department of Health and Human Services – Agency For Healthcare Research and Quality (AHRQ). Maryland Health Care Commission has implemented use of the CAHPS® 5.0H, Adult Health Plan Survey as part of the Health Benefit Plan Quality and Performance Evaluation System. The CAHPS® Surveys each include a myriad of survey questions designed to capture health benefit plan member perspectives on health care quality.



III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Aspirin Discussion

DESCRIPTION

The percentage of adults 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 aged 56 to 79 years, regardless of risk factors
- Men aged 46 to 79 years, regardless of risk factors

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

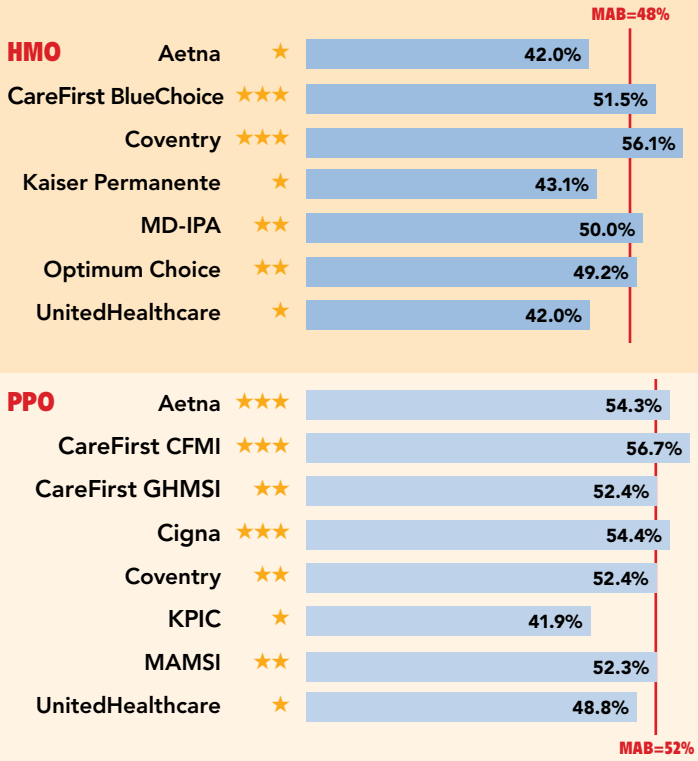
NOTE: No National benchmarks (NAB and NTP) available

RATIONALE

Shared decision making between a patient and their health care provider is a collaborative process that honors the expert knowledge of the provider, as well as the values and preferences of the patient. Shared decision making about the risks and benefits of aspirin therapy should be used especially among patients at an increased risk for a heart attack or stroke. "Risk assessment and discussion should probably be held at least every 5 years with middle-aged and older people or when CVD [cardiovascular disease] risk factors are detected." Modifiable CVD risk factors that can be controlled include hypertension, diabetes, high cholesterol, tobacco use, physical inactivity, unhealthy diet, and obesity. Non-modifiable risk factors include advanced age, family history of CVD as well as men over 45 years of age and post-menopausal women.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Using Aspirin for the Primary Prevention of Cardiovascular Disease, 2009

ASPIRIN DISCUSSION – WOMEN 56 TO 79 AND MEN 46 TO 79 YEARS OF AGE



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PERFORMANCE RATING

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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Flu Vaccinations for Adults

DESCRIPTION

The percentage of surveyed adults aged 18 to 64 years who received an influenza vaccination (Flu shot) between July 1 of the 2014 measurement year and the date when the CAHPS® 5.0H Commercial Adult survey was completed.

For this measure, a higher percentage is better, which means that more adults 18 to 64 years of age did receive an annual Flu shot after July 1 of the 2014 measurement year.

NOTE: No National benchmarks (NAB and NTP) available

RATIONALE

The flu vaccine is safe and effective and **recommended for everyone 6 months of age and older**. Flu season starts in the fall and can occur as late as May. Each year, get a flu vaccine as soon as it is available in your area.

Trivalent vaccines protect against 3 strains of the flu, A/H3N2, A/H1N1, and influenza B. Trivalent vaccines are available in:

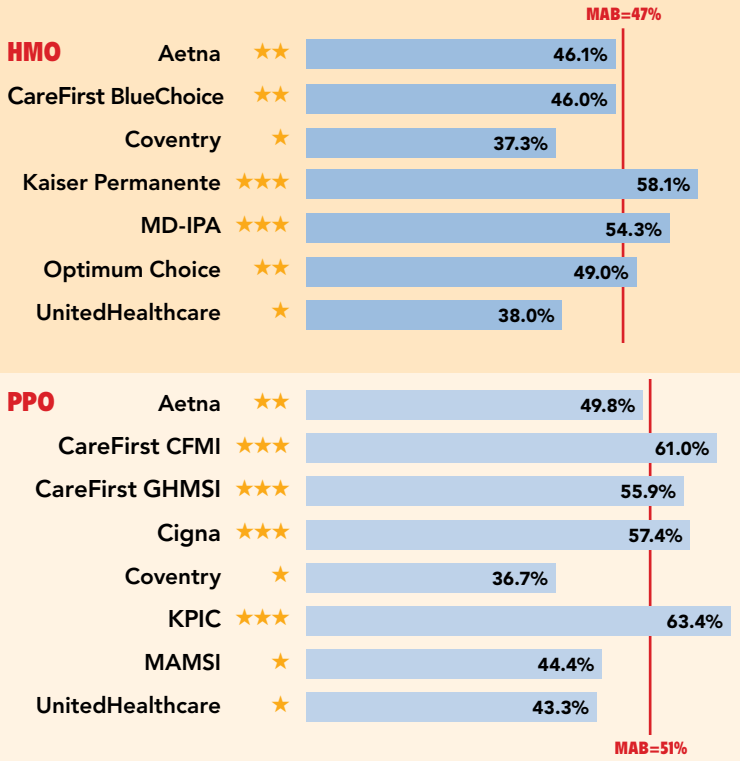
- Traditional flu shots, approved for anyone 6 months and older
- Intradermal shots, which use a shorter needle, approved for anyone 18 to 64 years
- High dose shots approved for people over 65 years
- Cell based shots created using viruses grown in animal cells and approved for anyone over 18 years
- Recombinant shots created using DNA technology, approved for people 18 to 49 years with severe egg allergies

Quadrivalent vaccines protect against 4 strains of the flu, A/H3N2, A/H1N1, and 2 strains of influenza B. Quadrivalent vaccines are available in:

- Traditional flu shots, approved for anyone 6 months and older
- Nasal spray, approved for healthy people from 2 to 49 years, except pregnant women

U.S. Department of Health & Human Services, 2015

FLU SHOTS – 18 TO 64 YEARS OF AGE



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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Call Answer Timeliness

DESCRIPTION

The percentage of calls received by the organization's Member Services call centers during operating hours in 2014 that were answered by a live voice within 30 seconds.

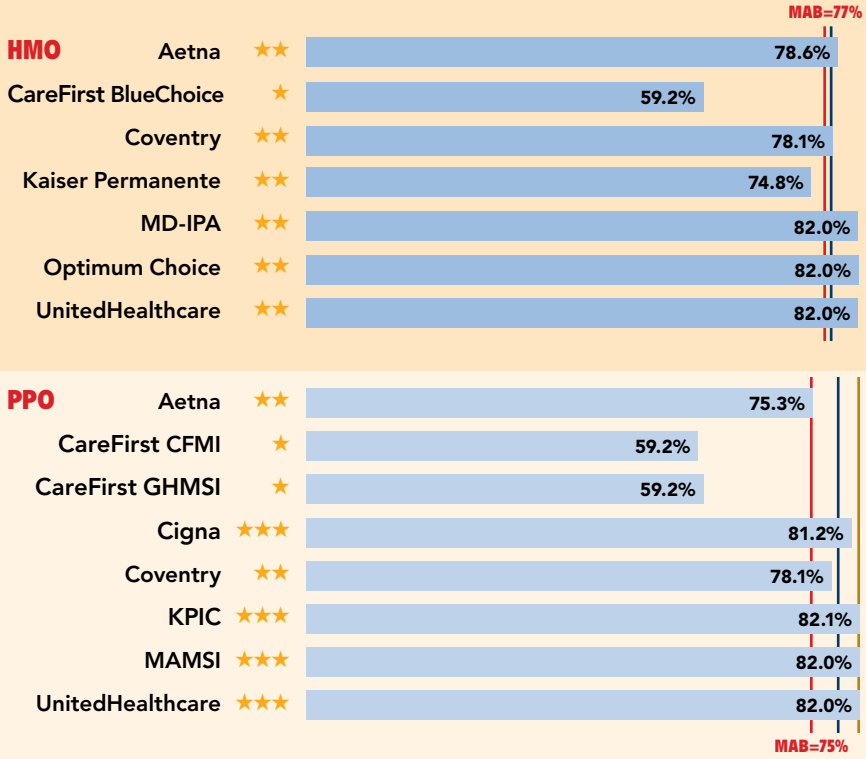
For this measure, a higher percentage is better, which means more members' calls to the organization's Member Services call centers were timely answered by a live voice within 30 seconds.

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 a health benefit plan through their customer service call center and talk to a live person in a timely manner is the first step toward ensuring that the health benefit plan 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.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, National Quality Measures Clearinghouse, National Committee for Quality Assurance Health Care Effectiveness Data and Information Set (HEDIS®), 2015

CALL ANSWERED WITHIN 30 SECONDS – BY A LIVE VOICE



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★ WORSE THAN MARYLAND AVERAGE

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: HEDIS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

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NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Getting Needed Care

DESCRIPTION

A composite measure that assesses member experiences with getting needed care. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?
- **Q2.** In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

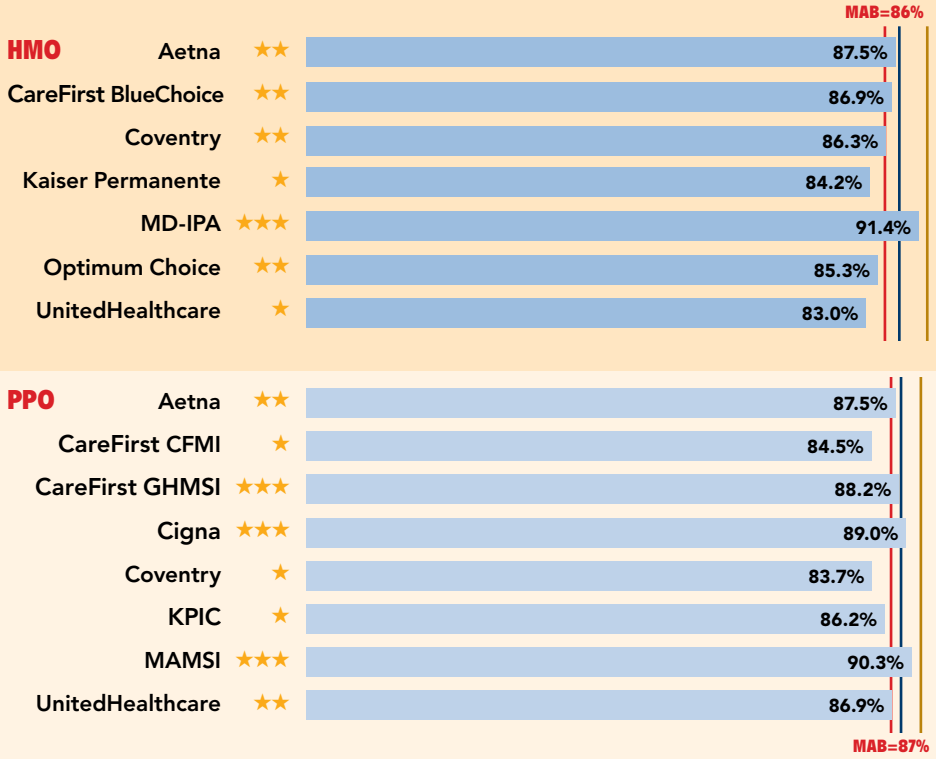
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always got the care they needed.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

CARE, TESTS, TREATMENTS, AND TIMELY SPECIALIST APPOINTMENTS – USUALLY OR ALWAYS



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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: CAHPS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Getting Care Quickly

DESCRIPTION

A composite measure that assesses member experiences with getting care quickly. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?
- **Q2.** In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

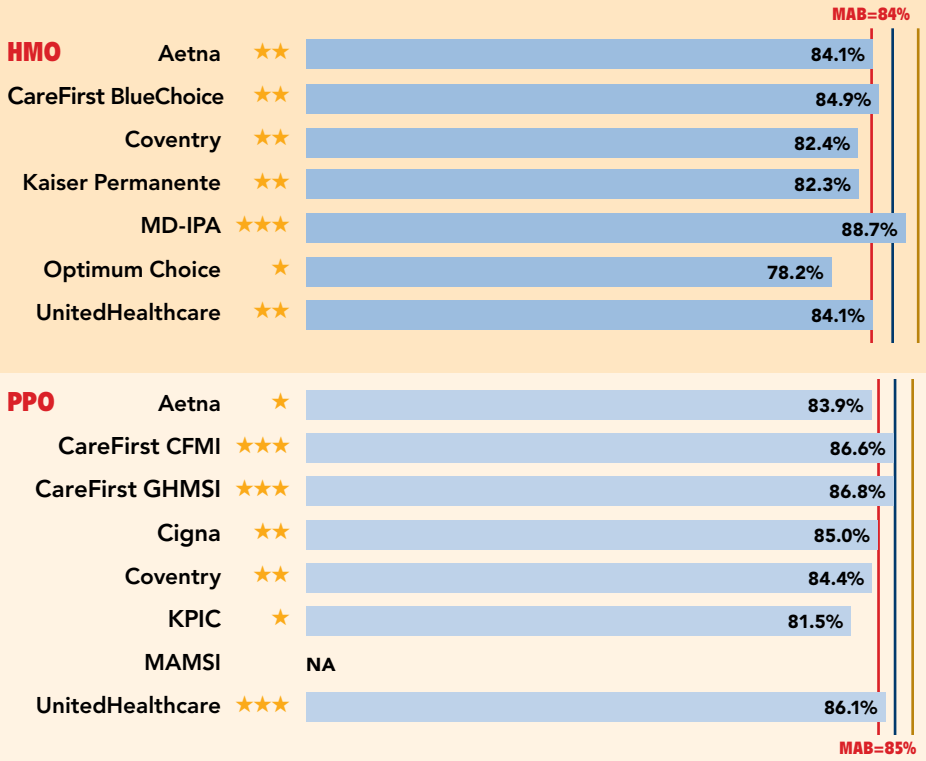
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always got care quickly.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

TIMELY CARE AND TIMELY ROUTINE APPOINTMENTS – USUALLY OR ALWAYS



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: CAHPS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

How Well Doctors Communicate

DESCRIPTION

A composite measure that assesses member experiences with how well doctors communicate. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following four related questions:

- **Q1.** In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?
- **Q2.** In the last 12 months, how often did your personal doctor listen carefully to you?
- **Q3.** In the last 12 months, how often did your personal doctor show respect for what you had to say?
- **Q4.** In the last 12 months, how often did your personal doctor spend enough time with you?

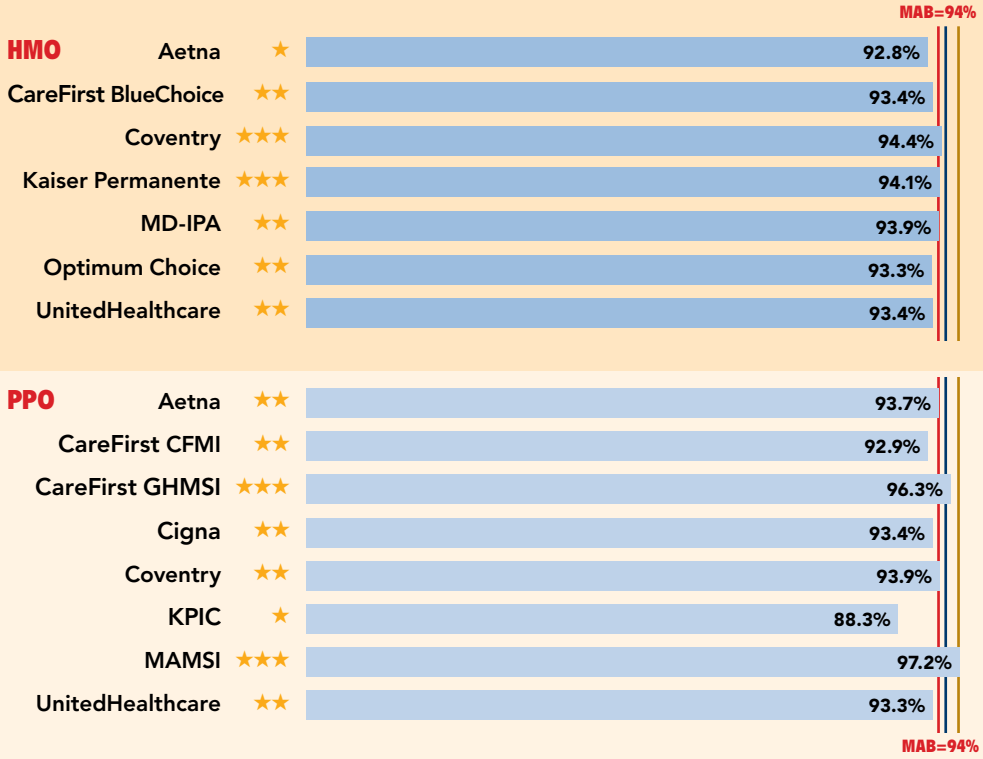
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel their personal doctor usually or always communicated well.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

GOOD COMMUNICATION BY PERSONAL DOCTOR – USUALLY OR ALWAYS



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: CAHPS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Customer Service

DESCRIPTION

A composite measure that assesses member experiences with customer service. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often did your health plan's customer service staff give you the information or help you needed?
- **Q2.** In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

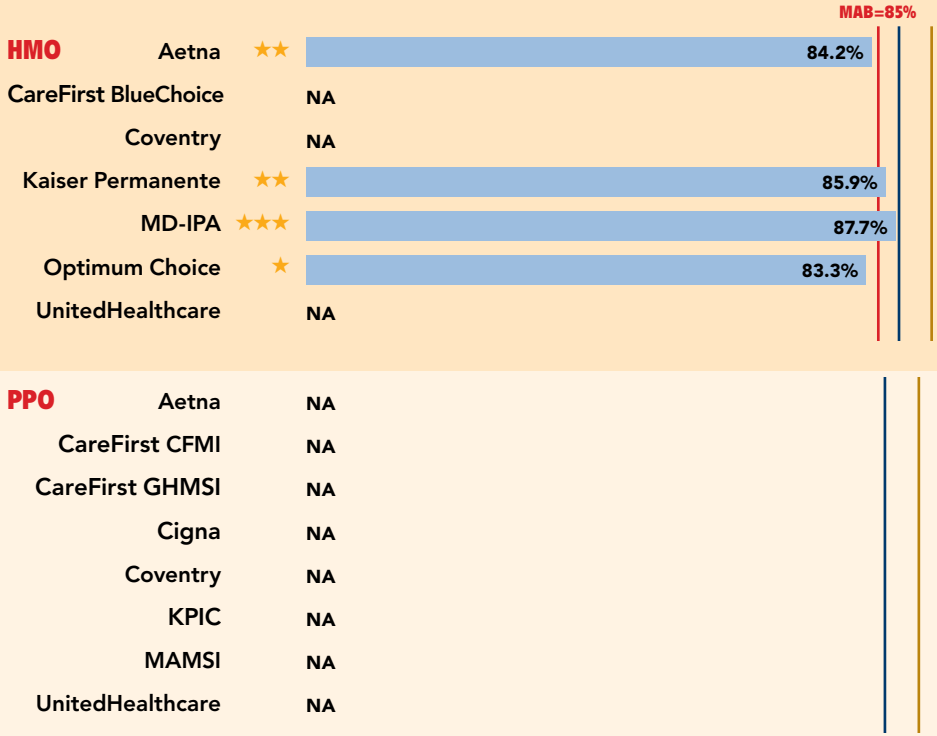
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always had a positive interaction with customer service.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

INFORMED, HELPFUL, COURTEOUS, AND RESPECTFUL CUSTOMER SERVICE – USUALLY OR ALWAYS



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: CAHPS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Claims Processing

DESCRIPTION

A composite measure that assesses member experiences with claims processing. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often did your health plan handle your claims quickly?
- **Q2.** In the last 12 months, how often did your health plan handle your claims correctly?

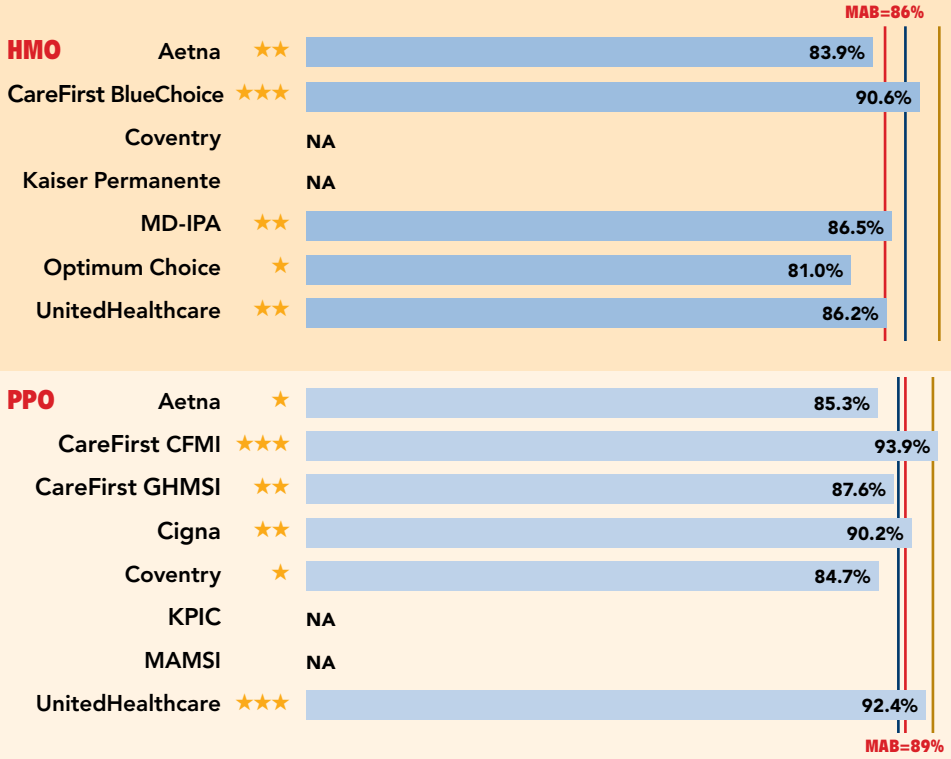
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always had a positive interaction with claims processing.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

FAST AND ACCURATE CLAIMS PROCESSING – USUALLY OR ALWAYS



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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: CAHPS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Shared Decision-Making

DESCRIPTION

A composite measure that assesses member experiences with shared decision-making. The composite score represents the percentage of survey participants who responded with "Yes" for the following three related questions:

- **Q1.** Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
- **Q2.** Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
- **Q3.** Did you and a doctor or other health provider ask you what you thought was best for you?

For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they had a role in the decision making process with their doctor or other health provider.

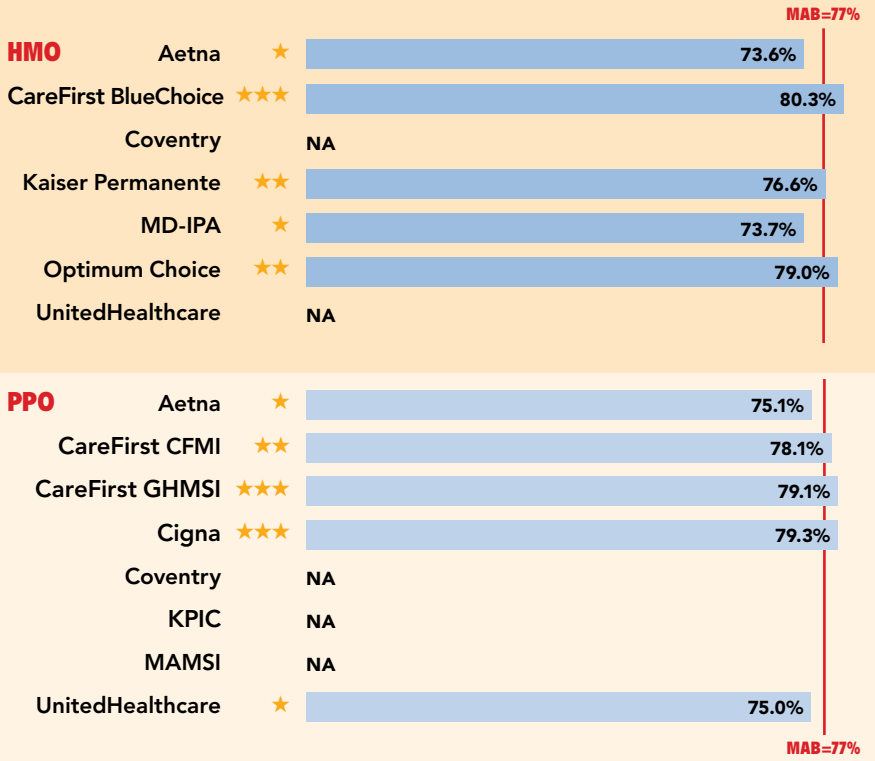
NOTE: No National benchmarks (NAB and NTP) available

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

HEALTH PROVIDER FEEDBACK CONCERNING STARTING OR STOPPING A MEDICINE – YES



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: CAHPS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Plan Information on Costs

DESCRIPTION

A composite measure that assesses member experiences with plan information on costs. The composite score represents the percentage of survey participants who responded with "Usually" or "Always" for the following two related questions:

- **Q1.** In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?
- **Q2.** In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

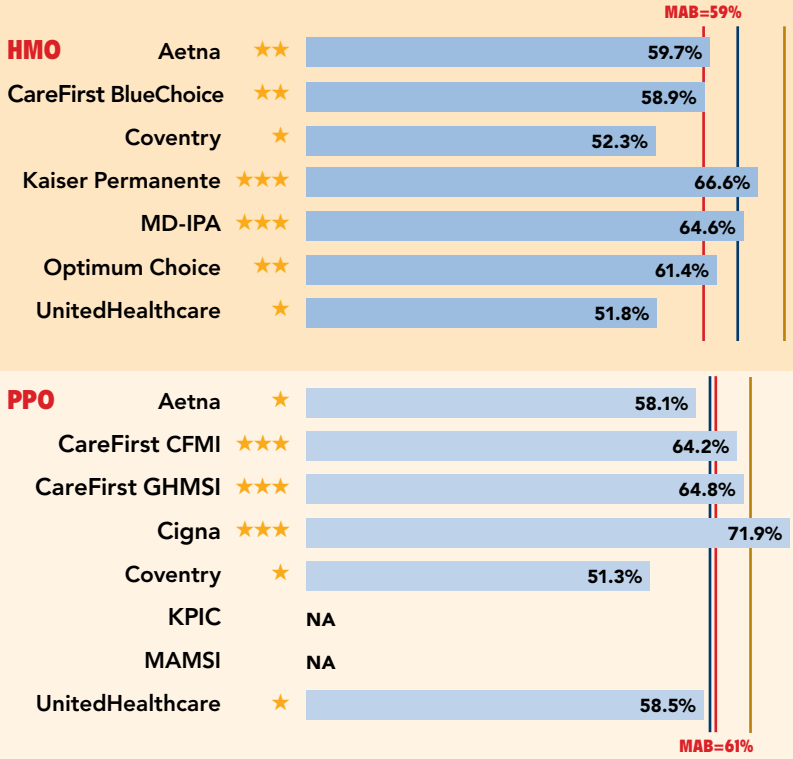
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel they usually or always were able to find information from their plan on costs.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

INFORMATION AVAILABLE ON OUT-OF-POCKET COSTS – USUALLY OR ALWAYS



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
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NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

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Data Source: CAHPS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Health Promotion and Education

DESCRIPTION

A standard measure that assesses member experiences with health promotion and education. The standard score represents the percentage of survey participants who responded with "Yes" for the following question:

- **Q1.** In the last 12 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

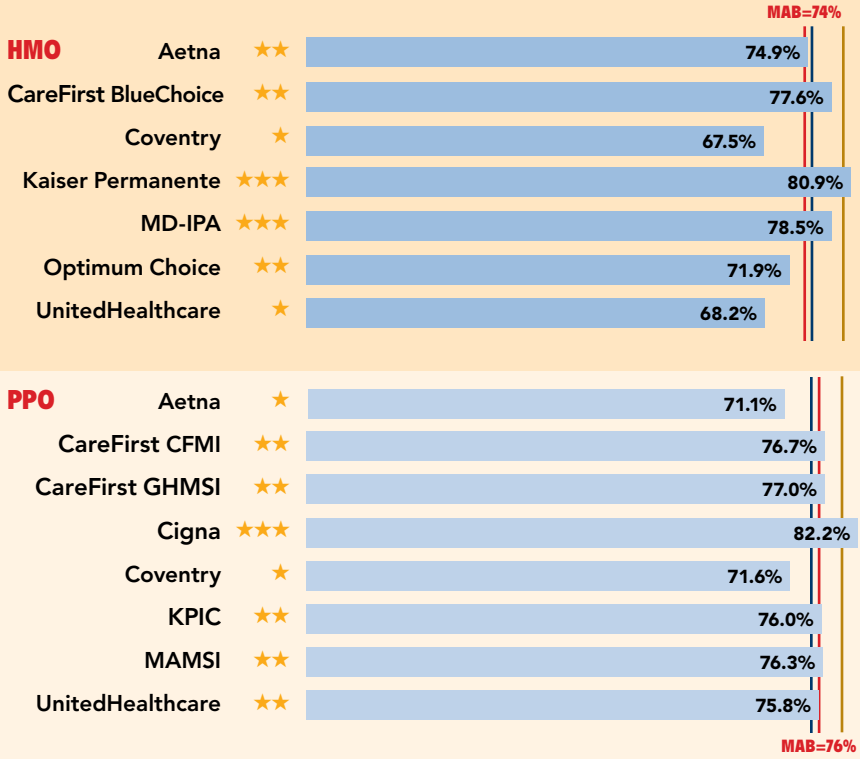
For this measure, a higher percentage is better and represents the proportion of survey respondents who spoke with their doctor or other health provider about preventative care.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

ILLNESS PREVENTION DISCUSSION WITH HEALTH PROVIDER – YES



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PERFORMANCE RATING

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

BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

Data Source: CAHPS® Submission or Health Benefit Plan Records

QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Coordination of Care

DESCRIPTION

A standard measure that assesses member experiences with coordination of care. The standard score represents the percentage of survey participants who responded with "Usually" or "Always" for the following question:

- **Q1.** In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these [other] doctors or other health providers?

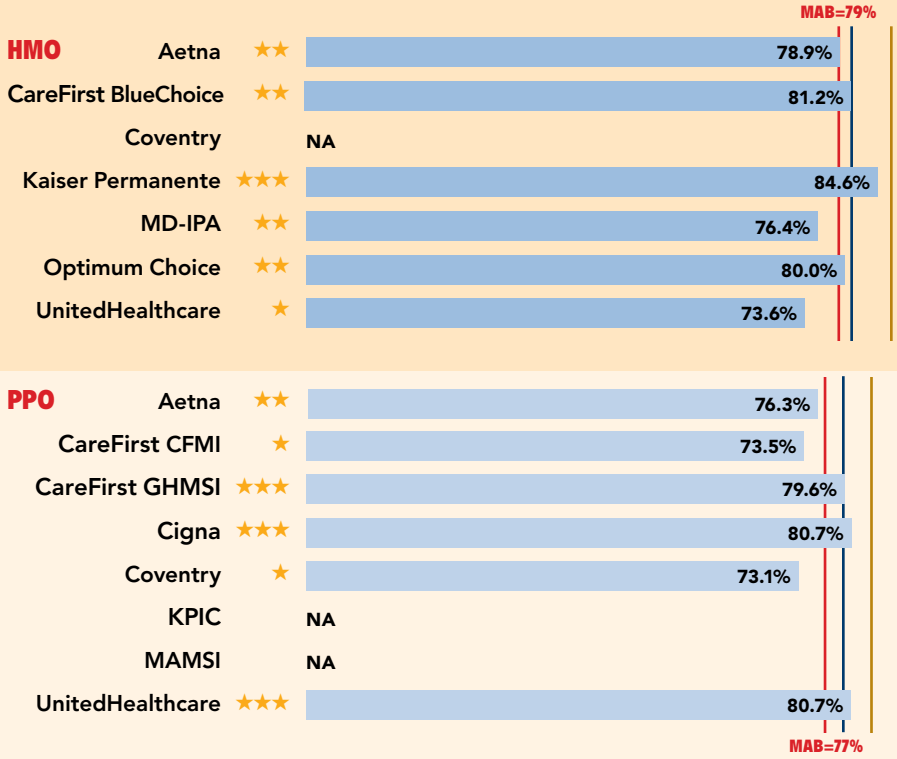
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel their doctor usually or always coordinated care with other doctors or health providers.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

WELL INFORMED PERSONAL DOCTOR – USUALLY OR ALWAYS



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Rating of All Health Care

DESCRIPTION

A standard measure that assesses member experiences with and rating of all health care. The standard score represents the percentage of survey participants who rated their health care an 8, 9 or 10 on a scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible.

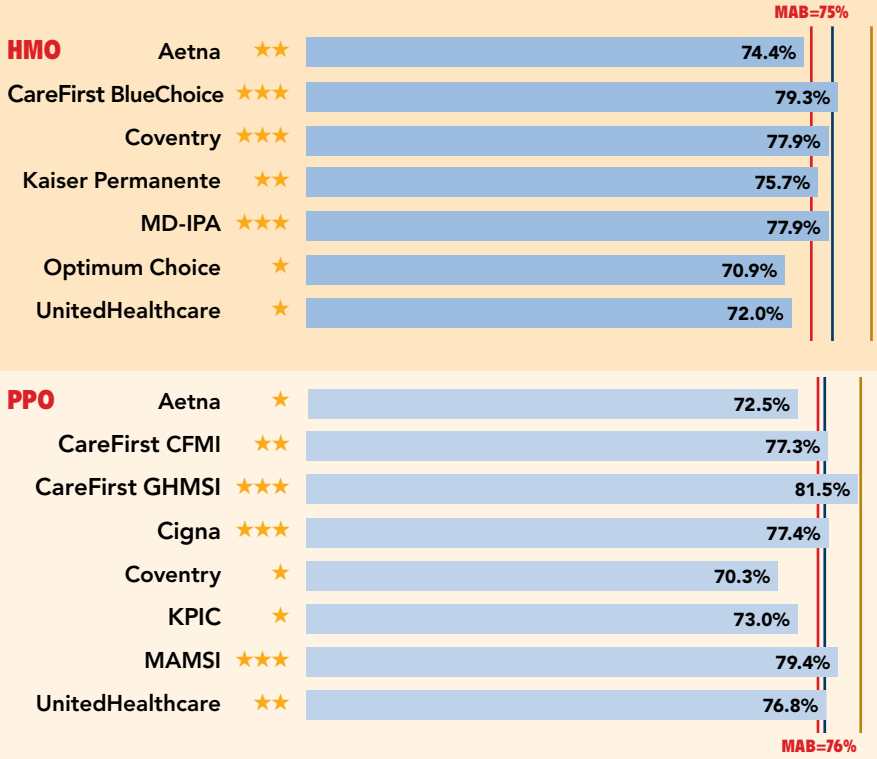
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the health care they receive is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

GOOD OVERALL RATING OF ALL HEALTH CARE – 8, 9, OR 10, OUT OF 10



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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
★★ EQUIVALENT TO MARYLAND AVERAGE
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BENCHMARKS

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NTP NATIONAL TOP PERFORMERS

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QUALITY MEASURE DESIGNATIONS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Rating of Personal Doctor

DESCRIPTION

A standard measure that assesses member experiences with and rating of their personal doctor. The standard score represents the percentage of survey participants who rated their personal doctor an 8, 9 or 10 on a scale of 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible.

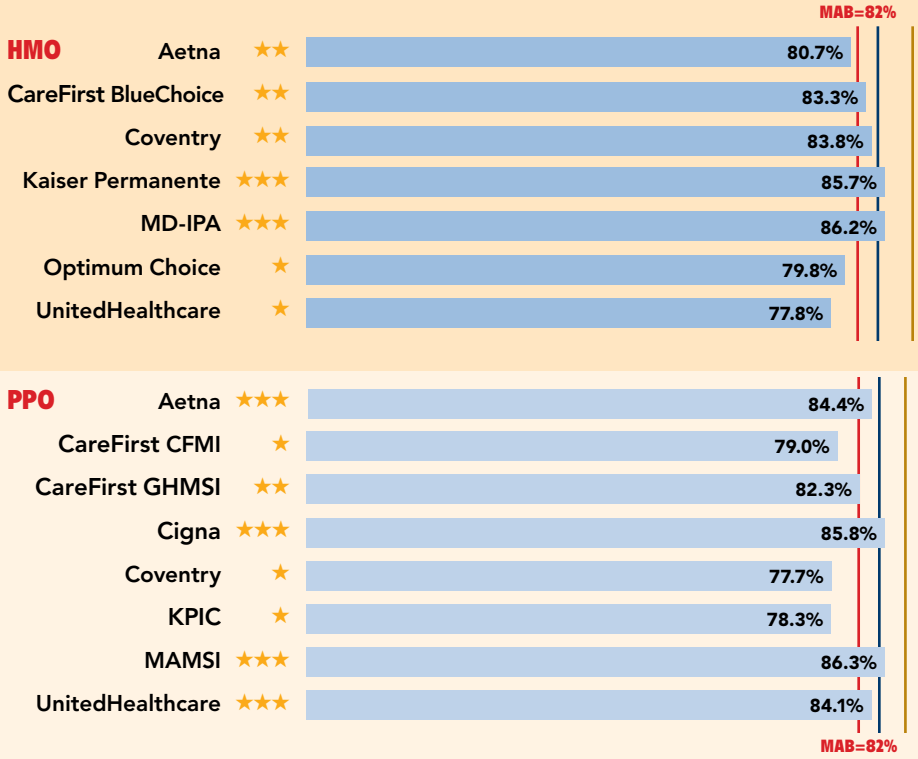
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the care they receive from their personal doctor is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

GOOD OVERALL RATING OF PERSONAL DOCTOR – 8, 9, OR 10, OUT OF 10



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PERFORMANCE RATING

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

BENCHMARKS

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III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Rating of Specialist Seen Most Often

DESCRIPTION

A standard measure that assesses member experiences with and rating of their specialist seen most often. The standard score represents the percentage of survey participants who rated their specialist seen most often an 8, 9 or 10 on a scale from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible.

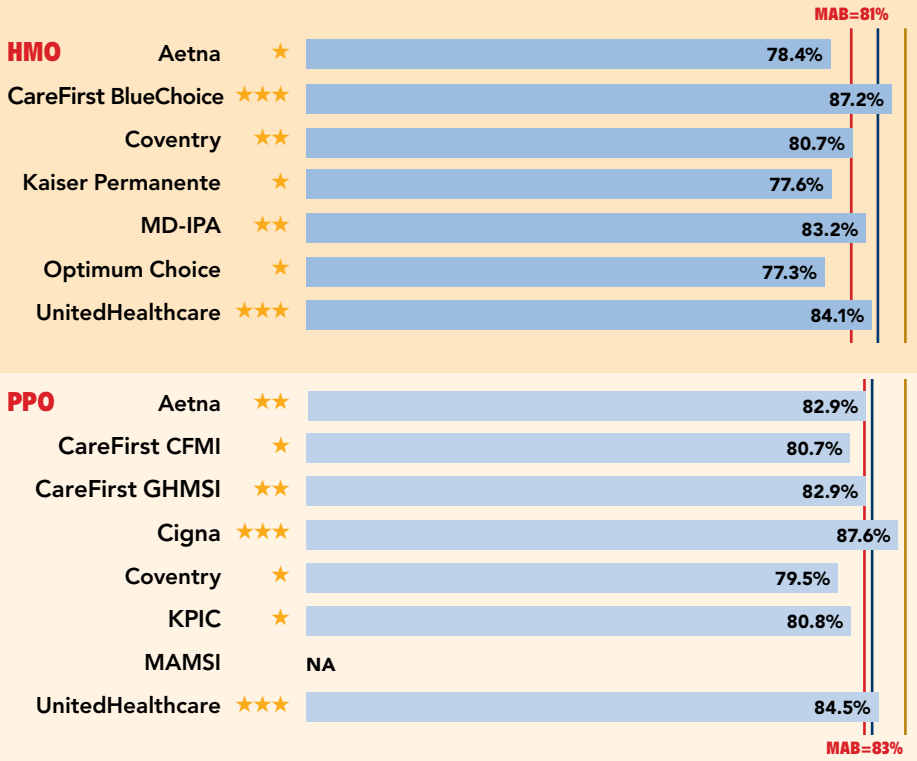
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the care they receive from their specialist is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

GOOD OVERALL RATING OF SPECIALIST SEEN MOST OFTEN – 8, 9, OR 10, OUT OF 10



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

MAB MARYLAND AVERAGE BENCHMARK
NAB NATIONAL AVERAGE BENCHMARK
NTP NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

NR – Performance results are **not reported** due to bias in the data from the health benefit plan

NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year

Data Source: CAHPS® Submission or Health Benefit Plan Records

III. HEALTH BENEFIT PLAN QUALITY AND PERFORMANCE COMPARISONS

Member Experience and Satisfaction With Health Benefit Plan (continued)

Rating of Health Benefit Plan

DESCRIPTION

A standard measure that assesses member experiences with and rating of their health benefit plan. The standard score represents the percentage of survey participants who rated their health benefit plan an 8, 9, or 10 on a scale from 0 to 10, where 0 is the worst health benefit plan possible and 10 is the best health benefit plan possible.

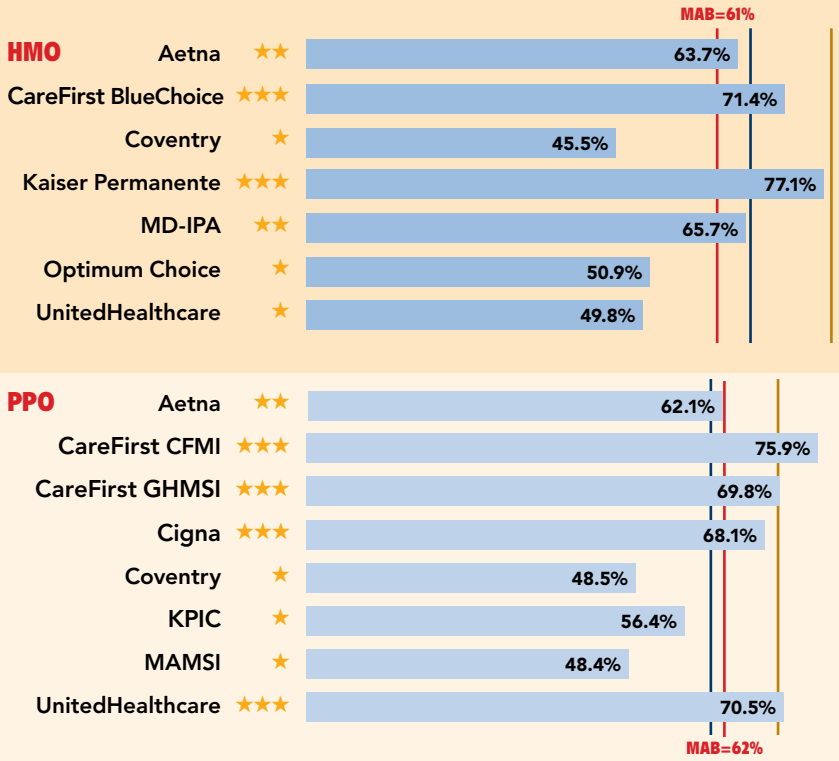
For this measure, a higher percentage is better and represents the proportion of survey respondents who feel the care they receive through their health benefit plan is good overall.

RATIONALE

The CAHPS® 5.0H Adult Health Plan Survey is a national survey designed to capture valuable information from consumers about their experiences with health care through their health benefit plan. The survey includes a core set of questions, with some questions grouped into composite areas of health care. A few additional questions were included for health benefit plans operating in the State of Maryland. Survey results give health benefit plans the opportunity for continuous improvement in member care.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2015

GOOD OVERALL RATING OF HEALTH BENEFIT PLAN – 8, 9, OR 10, OUT OF 10



More stars indicate better health benefit plan performance.

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PERFORMANCE RATING

★★★ BETTER THAN MARYLAND AVERAGE
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BENCHMARKS

MAB MARYLAND AVERAGE BENCHMARK
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Data Source: CAHPS® Submission or Health Benefit Plan Records

IV. STATE AND FEDERAL HEALTH BENEFIT PROGRAMS

Information for State of Maryland Employees and Retirees

2016 Health Care Coverage

1. Effective January 1, 2016, the State of Maryland's Employee and Retiree Health and Welfare Benefits Program (the Program), will offer the following:
   - CareFirst Blue Cross Blue Shield EPO plan
   - CareFirst Blue Cross Blue Shield PPO plan
   - CareFirst POS plan (for SLEOLA* members only)
   - Kaiser Permanente Integrated Health Model (IHM)
     - Kaiser Permanente has a regional network and is not available to individuals outside their service area or to those who are eligible for Medicare.
   - United Healthcare EPO plan
   - United Healthcare PPO plan
   - Prescription Drug Plan
   - Delta Dental DHMO plan
   - United Concordia DPPO plan
   - Dependent Day Care Flexible Spending Account
   - Health Care Flexible Spending Account
   - Term Life Insurance
   - Accidental Death and Dismemberment plan
   - Long Term Care Insurance

   *State Law Enforcement Officers Labor Alliance
2. The mental health and substance abuse benefit is offered as a part of the medical plan.
3. The Program offers a Wellness Program to help State employee and retiree participants:
   - get healthy or stay healthy
   - stay on track with treatment compliance by making services more affordable
   - have a better quality of life
4. This Wellness Program includes weight management, nutrition education and tobacco cessation programs, provided at no cost for employees.
5. All lab services and x-rays connected to chronic conditions are covered at 100%, with no copay or coinsurance when an in-network provider is used.
6. Employees, retirees and covered spouses who complete the healthy activities requirements for each year are eligible for wellness rewards.
7. Subsidized medical and prescription coverage is offered at 75% for contractual/variable hour employees who work more than 30 hours/week or 130 hours/month. Dental coverage is not subsidized however individuals can elect coverage assuming 100% of the cost. Accidental Death and Dismemberment as well as Life insurance coverage options are offered at 100% of the cost to active employees.

IV. STATE AND FEDERAL HEALTH BENEFIT PROGRAMS

Information for State of Maryland Employees and Retirees (continued)

Wellness Program*

The Program will continue to include a Wellness Program for all State employees, retirees and enrolled spouses that began January 1, 2015. Our goal is to encourage and educate our members to continue "moving forward to better health." The Wellness Program will require employees, retirees and enrolled spouses (not enrolled children) to complete healthy activities throughout the calendar year. If these activities are completed, enrollees will enjoy enhanced benefits such as waiving copays for all Primary Care Physician (PCP) visits. For each individual (employee, retiree, and covered spouse) who does not complete all of the healthy activities for that year, a surcharge will be deducted from the employee's or retiree's biweekly or monthly check/pension allowance.

Year 2016: Healthy Activity Requirements	
Participants not identified for participation in the Disease Management Program	**Participants with a chronic condition identified for participation in the Disease Management Program**
▶ Employees, retirees, and covered spouses are required to complete a Nutrition Education or Stress Management program sponsored by your medical carrier.	▶ Employees, retirees and covered spouses are required to actively participate in the disease management program sponsored by your medical carrier and follow all treatment guidelines of the care manager or complete the disease management program recommended.
▶ Employees, retirees and covered spouses are required to complete the health risk assessment which can be obtained on your plan's website or by calling your medical plan. Each employee and covered spouse must personally review their health risk assessment with their selected PCP. PCP must sign-off confirming review.	▶ Employees, retirees and covered spouses are required to complete the health risk assessment which can be obtained on your plan's website or by calling your medical plan. Each employee and covered spouse must personally review their health risk assessment with their selected PCP. PCP must sign-off confirming review.
▶ Employees, retirees, and covered spouses are required to complete all recommended age/gender specific preventive screenings and discuss results with your PCP.	▶ Employees, retirees, and covered spouses are required to complete all recommended age/gender specific preventive screenings and discuss results with your PCP.
Rewards for meeting the 2016 Healthy Activity Requirements:	PCP copayments waived for employees, retirees and covered spouses.
Penalties for not meeting the 2016 Healthy Activity Requirements:	▶ For each individual, the employee and retiree will have a $50 surcharge which will be deducted from your bi-weekly ($2.08) or monthly ($4.16) pay starting January 1, 2017. ▶ If you are identified as having a chronic condition you must engage with the plan's nurse and follow the recommended treatment plan. If you do not, an additional $250 surcharge will be deducted from your bi-weekly ($10.42) or monthly ($20.84) pay starting January 1, 2017.

* Wellness Program does not apply to SLEOLA members.

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

For more information on State of Maryland employee and retiree benefits, please go to Maryland's State Employee and Retiree Health and Welfare Benefits Program website at: **www.dbm.maryland.gov/benefits**

IV. STATE AND FEDERAL HEALTH BENEFIT PROGRAMS

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 required 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 Health Benefit Exchange model is a state-based marketplace called Maryland Health Connection. As a state-based exchange, Maryland is responsible for the development and operation of the following core functions:

- Consumer support for coverage decisions
- Approval of participating carriers
- Certification of plans as Qualified Health Plans (QHPs)
- Eligibility determinations for individuals and calculations of cost sharing reductions and tax subsidies
- Enrollment in qualified health plans (QHPs) and qualified dental plans (QDPs)

The ACA requires that QHPs meet all applicable federal and state laws in order to be certified. 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. 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 2015, for consumer use during open enrollment beginning on November 1, 2015. Each QHP's 5-star rate will also be displayed on the Maryland Health Connection website. Carriers new to the individual market in Maryland will not be assigned a 5-star rate.

Quality is just one of the plan selection tools that consumers may utilize on Maryland Health Connection. Other plan selection tools include a provider search, a Summary of Benefits and Coverage (SBC) for each plan, side-by-side plan comparison, icons that indicate whether or not a plan includes dental benefits for children or adults, and the ability to sort on premium price, annual cost, and carrier.

Individual consumers may shop for health insurance coverage using Maryland Health Connection. Open enrollment to buy a plan for 2015 ended. Open enrollment for 2016 runs from November 1, 2015 to January 31, 2016. Individuals may enroll outside of Open Enrollment if they experience a qualifying life event, such as a change in household composition or a change in income.

For more information about how to enroll, visit the Maryland Health Connection website at **http://www.marylandhealthconnection.gov**. Here you will find many enrollment resources as well as the eligibility and enrollment portal. In order to speak directly to a Customer Service Representative, please call the Consumer Support Center at 1-855-642-8572 or 1-855-642-8573 (TTY services for deaf and hard of hearing).

You may also visit any Connector Entity for in-person assistance: **http://marylandhealthconnection.gov/health-insurance-in-maryland/help-with-health-insurance/health-insurance-support/connector-organizations/**.

For more information about the Maryland Health Benefit Exchange, such as policy documents and information on public meetings, visit the stakeholder website at **http://marylandhbe.com**.

IV. STATE AND FEDERAL HEALTH BENEFIT PROGRAMS

Medicaid, Maryland Children's Health Program (MCHP), and MCHP Premium

Medicaid is a joint state-federal program. Each state establishes its own eligibility standards, benefits package, provider requirements, payment rates, and program administration under broad federal guidelines. In Maryland, Medicaid (also called Medical Assistance or "MA") is administered by the Department of Health and Mental Hygiene. Maryland Medicaid provides free or low-cost benefits for an average of more than 1.2 million people—approximately one in six Marylanders. The program provides health coverage, long term care, and supplemental assistance with Medicare costs (e.g., payment of Medicare premiums and cost sharing).

Most individuals can apply for benefits using Maryland Health Connection, including:

- low-income children;
- adults without dependent children;
- parents and caretaker relatives; and
- pregnant women.

Individuals who qualify due to one of the circumstances listed below can apply at a Local Department of Social Services (LDSS) or using **www.marylandsail.org**:

- the aged, blind, and disabled;
- the medically needy; and
- populations for whom income is not an eligibility factor, such as foster care children.

Adults under 65 with income under 138% of the federal poverty level (FPL) qualify for Medicaid. Pregnant women are covered up to 250% FPL. Coverage for children is available through either Medicaid or the Maryland Children's Health Program (MCHP) up to 300% FPL. MCHP provides access to health insurance for higher income uninsured children up to age 19, under 200% FPL through the Maryland Managed Care Program, HealthChoice. MCHP does not require the payment of a premium.

Maryland Children's Health Program Premium (MCHP Premium) is low-cost health insurance for higher-income children up to age 19 between 200% FPL and 300% FPL. MCHP Premium provides access to health insurance for eligible uninsured children through the Maryland Managed Care Program, HealthChoice, for a modest monthly premium.

The premium amount charged for MCHP Premium is assessed per family, not per child. The 2015 premium amounts are:

- Premium for families between 200-250% FPL: $53 per month
- Premium for families between 250-300% FPL: $66 per month
- American Indians do not have to pay a monthly premium to enroll in MCHP Premium.

Most individuals can qualify for Medicaid/MCHP through Maryland Health Connection. Enrollment in Medicaid/MCHP is not subject to an open enrollment period and is therefore offered year-round. Individuals can apply for Medicaid/MCHP at any time. Once an applicant is found eligible for Medicaid/MCHP, coverage will be effective back to the first day of the month in which the person applied.

Most recipients qualify for Maryland Medicaid's Managed Care Program, HealthChoice, a statewide mandatory managed care program. Eligible Medicaid/MCHP/MCHP Premium participants enroll in a Managed Care Organization (MCO) of their choice and select a primary care provider (PCP) to oversee their medical care.

IV. STATE AND FEDERAL HEALTH BENEFIT PROGRAMS

Medicaid, Maryland Children's Health Program (MCHP), and MCHP Premium

MCOs must provide or arrange for a comprehensive range of health care services; some services, however, are carved out of the MCO benefit package and are offered through the Medicaid fee-for-service (FFS) system (e.g., dental, behavioral health, and substance use disorder services).

The following MCOs currently participate in HealthChoice:

- AMERIGROUP Community Care – **www.amerigroupcorp.com**
- Jai Medical Systems – **www.jaimedicalsystems.com**
- Kaiser Permanente– **www.kp.org/medicaid/md**
- Maryland Physicians Care – **www.marylandphysicianscare.com**
- MedStar Family Choice – **www.medstarfamilychoice.net**
- Priority Partners – **www.ppmco.org**
- Riverside Health of Maryland – **http://www.myriversidehealth.com**
- UnitedHealthcare – **www.uhccommunityplan.com**

Maryland specific benefits and guidance can be found at: **https://mmcp.dhmh.maryland.gov/SitePages/Home.aspx**.

Application information and enrollment help can be found at: **https://www.marylandhealthconnection.gov/medicaid-basics-benefits/**, or through SAIL at **https://www.marylandsail.org**.

Individuals who are already enrolled and have questions about their coverage can call the HealthChoice Enrollee Help Line at **1-800-284-4510**.

IV. STATE AND FEDERAL HEALTH BENEFIT PROGRAMS

Medicare

Medicare is a health insurance program for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

PART A INSURANCE for hospital services and skilled nursing facilities – Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

PART B INSURANCE for doctors' services and outpatient care – Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

PART C MEDICARE ADVANTAGE PLANS – These plans are sometimes called "Part C" or "MA Plans," and are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. You'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not Original Medicare. Medicare Advantage Plans cover all Medicare services. Medicare Advantage Plans may also offer extra coverage. Medicare pays a fixed amount for your care each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care). These rules can change each year.

Some Part C Medicare Advantage Plans will cover prescription drugs but if not, you will be required to obtain Part D coverage.

PART D INSURANCE for prescription drug coverage – Most people will pay a monthly premium for this coverage. Medicare prescription drug coverage is available to everyone with Medicare. Coverage may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

MEDICARE SUPPLEMENTAL INSURANCE (Medigap) policy, sold by private companies, can help pay some of the health care costs that *Original Medicare* doesn't cover, like copayments, coinsurance, and deductibles.

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care **when you travel outside the U.S.** If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

A Medigap policy is different from a **Medicare Advantage Plan**. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits.

More information about the Medicare Program can be obtained from the Centers for Medicare and Medicaid Services at:
http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html

Additional information about Medicare Supplemental Insurance or Medigap policies can be obtained from the Centers for Medicare and Medicaid Services at:
http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html

V. INFORMATION ON CHRONIC DISEASES

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. 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 Obesity, Cardiovascular Disease, Diabetes, Asthma, and Chronic Obstructive Pulmonary Disease (COPD).

V. INFORMATION ON CHRONIC DISEASES

"The key to achieving and maintaining a healthy weight isn't about short-term dietary changes. It's about a lifestyle that includes healthy eating, regular physical activity, and balancing the number of calories you consume with the number of calories your body uses."

Centers for Disease Control and Prevention

Obesity

What is Obesity?

When we say someone is obese, what does it mean? It means the person has too much body fat. It is different from being overweight, which means weighing too much. The weight may come from more than just fat. Both mean that a person weighs more than what we think is healthy for his or her height. Obesity happens as a person eats more calories than he or she uses. Each person is different in the amount of calories they need and how many are too much. Things that might affect your weight include your genes, overeating, eating high-fat foods, and not getting enough exercise. Being obese increases your risk of diabetes, heart disease, stroke, arthritis, some cancers, and other problems you don't want to have.

How do I know if I'm obese?

Are your clothes getting tight? Does the scale show you are gaining weight? Are you feeling fatter around your waist? There are tools you can use to get some idea of where you are. Visit the web pages of the National Heart, Lung, and Blood Institute. There is information there on tools such as body mass index (BMI). See your doctor to check all of this and to determine your health risk.

What can I do about it?

If you need to lose weight, remember to set realistic goals that you can meet. You also should plan to lose the weight slowly. A pound or two a week is realistic for most adults. You also want to focus on lifestyle changes so you eat fewer calories and get more exercise. Medicine and surgery are options for people who just can't lose the weight through lifestyle changes.

Sources and additional information:

MedLinePlus
http://www.nlm.nih.gov/medlineplus/obesity.html

National Heart, Lung, and Blood Institute
http://www.nhlbi.nih.gov/health/health-topics/topics/obe

Centers for Disease Control and Prevention
http://www.cdc.gov/healthyweight/index.html
http://www.cdc.gov/obesity/index.html

V. INFORMATION ON CHRONIC DISEASES

"In the United States, someone has a heart attack every 43 seconds. Each minute, someone in the United States dies from a heart disease-related event."

Centers for Disease Control and Prevention

Cardiovascular Disease

What is cardiovascular disease?

Cardiovascular disease is a name given to a group of problems with the heart and the blood vessels. The World Health Organization says that cardiovascular disease is the number 1 cause of death in the world today. The list of cardiovascular diseases includes:

- **Coronary heart disease** – disease of the blood vessels carrying blood to the heart muscle
- **Cerebrovascular disease** – disease of the blood vessels carrying blood to the brain
- **Peripheral artery disease** – disease of the blood vessels carrying blood to the arms and/or the legs
- **Rheumatic heart disease** – damage to the heart caused by rheumatic fever
- **Congenital heart disease** – problems with the heart that a person had at birth
- **Deep vein thrombosis and pulmonary embolism** – blood clots in the legs that can move to the heart and lungs

Heart attacks and strokes may occur suddenly and can be life-threatening emergencies. They are often caused by fat that builds up inside the blood vessels and stops the blood from getting to the heart or the brain.

What increases the risk?

The risk of heart disease and stroke is increased by unhealthy behavior. Eating an unhealthy diet, not getting enough exercise, using tobacco, and harmful use of alcohol can all increase your risk.

Medications can be used to help reduce the risk. However, there are things you can do as well to reduce your risk. Don't use tobacco in any form. Try to reduce the amount of salt you eat. Eat plenty of fresh fruits and vegetables. Get plenty of exercise. Watch how much alcohol you drink and keep it from getting out of control.

Talk to your doctor about ways you can reduce your risk and about any treatment you need.

Source: World Health Organization
http://www.who.int/mediacentre/factsheets/fs317/en/

V. INFORMATION ON CHRONIC DISEASES

"Today and every day, strive to balance your food, physical activity, and medicine. Test your own blood glucose (also called blood sugar) to see how this balance is working out. Then make choices that help you feel well every day to protect your health."

Centers for Disease Control and Prevention

Diabetes

What is Diabetes?

Diabetes is a disease where you have too much blood glucose (blood sugar). You get glucose from the food you eat. Insulin is something in your body that helps your cells get energy from the glucose. With type 1 diabetes, your body isn't able to make insulin. With type 2 diabetes, the more common type, your body isn't able to make or to use insulin well. Without enough insulin, the glucose stays in your blood and that can cause some very serious problems. If you have more sugar in your blood than normal, but not enough to call it diabetes, you have what's called pre-diabetes and that can put you at higher risk for getting type 2 diabetes. There is also a type called gestational diabetes that affects pregnant women, but that goes away after the baby is born.

Some of the problems caused over time by too much glucose in the blood include:

- Damage to your eyes, kidneys, and nerves
- Heart disease
- Stroke
- Loss of a limb

It's very important to remember that losing weight and getting enough exercise can delay or prevent type 2 diabetes.

How can I tell if I have Diabetes?

Common signs and symptoms of diabetes are:

- being very thirsty
- urinating often
- feeling very hungry
- feeling very tired
- losing weight without trying
- sores that heal slowly
- dry, itchy skin
- feelings of pins and needles in your feet
- losing feeling in your feet
- blurry eyesight

However, you will need a blood test to see if you might have diabetes so you need to see your doctor.

What can I do if I have diabetes?

Be sure to follow all the instructions given by your healthcare team including your diet plan. Take the medicines as your doctor tells you to take them. Be sure to get plenty of exercise. Watch your weight.

Sources:

US National Library of Medicine – MedLinePlus
http://www.nlm.nih.gov/medlineplus/diabetes.html

National Institute of Diabetes and Digestive and Kidney Disease
http://www.niddk.nih.gov/health-information/health-topics/Diabetes/your-guide-diabetes/Pages/index.aspx#what

National Diabetes Education Program
http://ndep.nih.gov/i-have-diabetes/ManageYourDiabetes.aspx

V. INFORMATION ON CHRONIC DISEASES

"Remember – *you can control your asthma.* With your healthcare provider's help, make your own asthma action plan. Decide who should have a copy of your plan and where he or she should keep it. Take your long-term control medicine even when you don't have symptoms."

Centers for Disease Control and Prevention

Asthma

What is Asthma?

Asthma is a disease that makes people short of breath. It can cause a wheezing or whistling noise when the person with it tries to breathe. The person's chest might feel tight and it may cause that person to cough. These breathing problems happen because the airways, the tubes that carry air in and out of the lungs, become narrower so air can't flow through them as well as it normally flows. The airways become narrow because asthma makes them inflamed so they become swollen and sensitive. In that condition, they react strongly to certain things that a person may inhale. That can make the muscles around them contract making the airways even more narrow. It can get even worse if all this causes the airways to have more mucus in them. Anyone with asthma can have problems anytime the airways are inflamed.

Who Gets Asthma?

Though it usually starts at childhood, asthma can affect anyone at any age. Sometimes, the person with asthma has a mild case that goes away on its own or with a little treatment. When problems don't go away and continue to get worse, they cause asthma attacks. These attacks can cause an emergency and can be deadly.

What Can Be Done?

There is no cure for asthma. If you have asthma, it's very important to treat the symptoms as soon as you are aware of them to try to avoid a severe asthma attack. That means it's very important to work with your doctor and others taking care of you to make sure you have a way to treat the problem. There are things they can do to help you manage asthma since with the treatments available today, people with asthma can have a normal life!

Source:

National Heart, Lung, and Blood Institute
http://www.nhlbi.nih.gov/health/health-topics/topics/asthma

V. INFORMATION ON CHRONIC DISEASES

"Tobacco use is the primary cause of COPD in the United States, but air pollutants at home (such as secondhand smoke and some heating fuels) and at work (such as dusts, gases, and fumes), and genetic predisposition also can cause COPD."

Centers for Disease Control and Prevention

Chronic Obstructive Pulmonary Disease (COPD)

What is COPD?

Chronic Obstructive Pulmonary Disease (COPD) is a disease that makes it hard to breathe. It is a life-threatening condition. You may have heard people call it emphysema or chronic bronchitis. The primary cause of COPD is tobacco smoke. It could be because the person with it smoked or it could be due to second-hand smoke. It can also come from breathing other toxic chemicals in the air. Its symptoms include chronic coughing that some people refer to as smoker's cough. Other symptoms include feeling like you can't breathe and excess sputum (a mix of saliva and mucus).

What puts me at risk for COPD?

COPD is commonly found in people over 40 who smoke or have smoked, since smoking is the most common cause of COPD. However, smoking is not the only cause. COPD can also come from exposure to anything that irritates your lungs. For example, dust and toxic fumes in the workplace, second-hand smoke, or air pollution can be causes, so try to protect yourself from them. There is also a genetic condition that causes COPD.

How do I know if I have COPD?

The common symptoms of COPD include shortness of breath, a chronic cough, frequent respiratory infections, blue lips or fingernail beds, having a lot of mucus, and wheezing.

There is a test called spirometry that measures how much and how fast you can breathe. Since COPD generally takes a long time to develop, people are usually at least 40 when they are diagnosed with COPD. See your doctor to see if you need this and other tests.

Be sure not to just write off your shortness of breath to age or being out of shape. See your doctor so that you can get the right treatment for your symptoms.

Sources:

National Heart, Lung, and Blood Institute
http://www.nhlbi.nih.gov/health/educational/copd/what-is-copd/index.htm

World Health Organization
http://www.who.int/mediacentre/factsheets/fs315/en/

American Lung Association
http://www.lung.org/lung-disease/copd/about-copd/symptoms-diagnosis-treatment.html

VI. CONSUMER RESOURCES

Links to MHCC Resources

Publications on the performance of health care facilities are available on the MHCC website, 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.maryland.gov/mhcc/pages/plr/plr_Insurance/documents/CQM_SGM_2010_ConsumerGuide_Getting_Keeping_Health_Insurance_GUID_20100701.pdf

Maryland Guide to Long Term Care Services 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

Maryland Health Care Quality Reports compares information on hospital characteristics, patient satisfaction ratings, quality scores, and selected health care associated infections (HAI) information. The site features a pricing guide and other information about hospital services in Maryland. In addition, the site also includes informtion on physician services, long term care, health benefit plans, and surgery centers.
http://healthcarequality.mhcc.maryland.gov

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/

VI. CONSUMER RESOURCES

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
https://www.marylandhealthconnection.gov/

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/webmga/frm1st.aspx?tab=home

Maryland Links

Maryland Department of Health and Mental Hygiene
http://dhmh.maryland.gov

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/

VI. CONSUMER RESOURCES

Links to Additional Information and Assistance (continued)

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/StateHealthInsuranceProgram.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.cms.hhs.gov/HospitalQualityInits/33_HospitalQualityAlliance.asp

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/

VI. CONSUMER RESOURCES

Links to Additional Information and Assistance (continued)

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

VII. 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 7, because there are 7 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 8, because there are 8 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, NB, or NR result instead of a performance rate, are excluded from the calculation of the MAB for the appropriate HMO or PPO category. These three results reflect unique situations where the denominator or eligible population for the measure is too small to statistically support the performance rate (NA), there is no benefit or service offered by the health benefit plan (NB), or the measure results were biased due to incomplete data and could not be published (NR). 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 better than the Maryland average**

When the difference between a health benefit plan's rate and the MAB for the appropriate HMO or PPO category is statistically significant and the health benefit plan's rate is "above" the Maryland average, the health benefit plan is assigned to the "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 MAB for the appropriate HMO or PPO category 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 worse than the Maryland average**

When the difference between a health benefit plan's rate and the MAB for the appropriate HMO or PPO category is statistically significant and the health benefit plan's rate is "below" the Maryland average, the health benefit plan is assigned to the "worse than" the Maryland average category and receives 1 star.

VII. INFORMATION ON METHODOLOGIES

RELICC™ Methodology

In support of the Maryland Health Improvement and Disparities Reduction Act of 2012, Maryland Health Care Commission (MHCC) expanded the standardized collection and reporting of health benefit plan quality data related to disparities issues by developing and implementing the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC)™, a quality measurement instrument for use by health insurance carriers to assist in identifying, and ultimately eliminating health disparities. A major objective of RELICC™ is to determine if carriers gather appropriate information on their membership and their provider network in order to ensure that members are engaged and that culturally sensitive and appropriate care is delivered. The new tool was developed in collaboration with Maryland Health Benefit Exchange (MHBE), and with the participation and feedback of representatives from many of Maryland's health insurance carriers. The Mid-Atlantic Business Group on Health (MABGH) through the National Business Coalition on Health (NBCH), created the customized, quality measurement tool, based largely on the "Addressing Language and Health Literacy Needs" section of the proprietary eValue8™ Request For Information (RFI) tool. RELICC™ is an internet-based application securely administered by the application vendor, ProposalTech.

Credit is assigned to plan *responses* based on:

- Methods used to capture information on race/ethnicity, languages spoken and interpreter need of membership
- Knowledge of network and staff demographics and capabilities to support membership
- Whether information is captured proactively and directly rather than reactively (when member calls) or indirectly (imputed using zip code analysis, etc.)
- Breadth and depth in using data collected to meet member's needs (from language and culture perspective)
- Measurement of impact of language assistance activities
- Whether tools are provided that consider language and cultural needs (such as physician photo, if health assessment offered in different languages and via multiple ways including phone)

Upon completion by the health plan, the reviewer summarizes responses, marks certain questions for follow-up and assesses the attachments provided. If the follow-up responses and documents do not validate the plan's response(s), the response is changed in ProposalTech. Trained scorers conduct each review to ensure the following criteria are met:

1. Plan responses, including responses from nationally based health plans with multiple market locations, must only reflect services provided in Maryland.
2. Responses should be provided for a plan's commercial member population only. Medicaid or Medicare member data, initiatives or programs shall not be included in responses, except where explicitly requested.
3. Plans may delegate certain functions to an external vendor (disease management, pharmacy benefit management, behavioral health, or administrative services). If a plan fully delegates or collaborates with a vendor for any services, the plan should coordinate their Maryland RELICC Assessment™ responses with the vendor where appropriate.
4. In some health plans, varying degrees of delegation to provider groups or Independent Practice Associations (IPAs) exist. In recognition of plan models where providers accept a significant amount of delegation such as in generating performance reports, plans are asked to report approximate percentages of membership where provider groups generate patient-specific or performance reports and where the plan or a vendor may generate such reports.
5. All attachments to the Maryland RELICC Assessment™ must be labeled and submitted electronically. Requested attachments will be used to verify Maryland RELICC Assessment™ responses. Attachment examples include web screen shots and relevant newsletter articles.
6. All responses must be for 2014 data.

VII. INFORMATION ON METHODOLOGIES

Maryland BHA and QP Methodologies

Maryland Plan Behavioral Health Assessment

The Maryland Plan Behavioral Health Assessment (BHA) is another Maryland-specific quality measurement instrument that details the health benefit plan's behavioral health care provider network. Information provided by the tool includes the following:

- Total counts of members with behavioral health benefits
- Maryland counties and jurisdictions where the health benefit plan operates and services are offered
- Total counts of practicing primary care and behavioral health care providers
- Accreditation status for the behavioral health care services program
- Percentage of psychiatrists that are board certified

Maryland Health Plan Quality Profile

The Maryland Health Plan Quality Profile (QP) is a Maryland-specific quality measurement instrument from which each health insurance carrier offers a summary of current Maryland initiatives implemented by the health benefit plans. 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's leaders toward developing and implementing progressive programs that respond to changes in demographics, required services, and patient and provider expectations. All initiatives promote programs that respond to improving methods for collecting and reporting RELICC™-related information, ultimately promoting continuous quality improvement within each health benefit plan.

VII. 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.

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 2015, 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 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® 2015, 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 or "Not Reportable." 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.

VII. 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. Maryland Health Care Commission (MHCC) 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 questions that reflect overall satisfaction and multi-question composites that summarize responses in key areas. Survey respondents are also asked to use a scale of 0 to 10 to rate their doctor, their specialist, their 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.

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 Maryland residents 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.

APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

According to the Centers for Disease Control and Prevention (CDC), vaccine-preventable disease levels in the United States are at or near record lows. Vaccination against preventable disease protects children from unnecessary illness, disability and death. Supporting information is provided below for two quality measures on childhood immunization found earlier in this report.

Childhood Immunization Status (see page 66)

COMBINATION 10 IMMUNIZATION SERIES – 2 YEARS OF AGE:

Combo 10	Diphtheria, 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	Influenza
Inoculations ("Doses")	4	3	1	3	3	1	4	1	2 or 3	2

DTaP – At least four DTaP vaccinations, on different dates

IPV – At least three IPV vaccinations, on different dates

MMR – Any of the following:

- At least one MMR vaccination
- At least one measles and rubella vaccination and at least one mumps vaccination
- At least one measles vaccination and at least one mumps vaccination and at least one rubella vaccination

HiB – At least three HiB vaccinations, on different dates

HepB – Either of the following:

- At least three HepB vaccinations, on different dates
- History of hepatitis

VZV – At least one VZV vaccination

PCV – At least four PCV vaccinations, on different dates

HepA – At least one HepA vaccination

RV – Any of the following:

- At least two doses of the two-dose RV vaccine, on different dates
- At least three doses of the three-dose RV vaccine, on different dates
- At least one dose of the two-dose RV vaccine and at least two doses of the three-dose RV vaccine, on different dates

Influenza – At least two influenza vaccinations, on different dates

Immunizations for Adolescents (see page 68)

COMBINATION 1 IMMUNIZATION SERIES – 13 YEARS OF AGE:

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

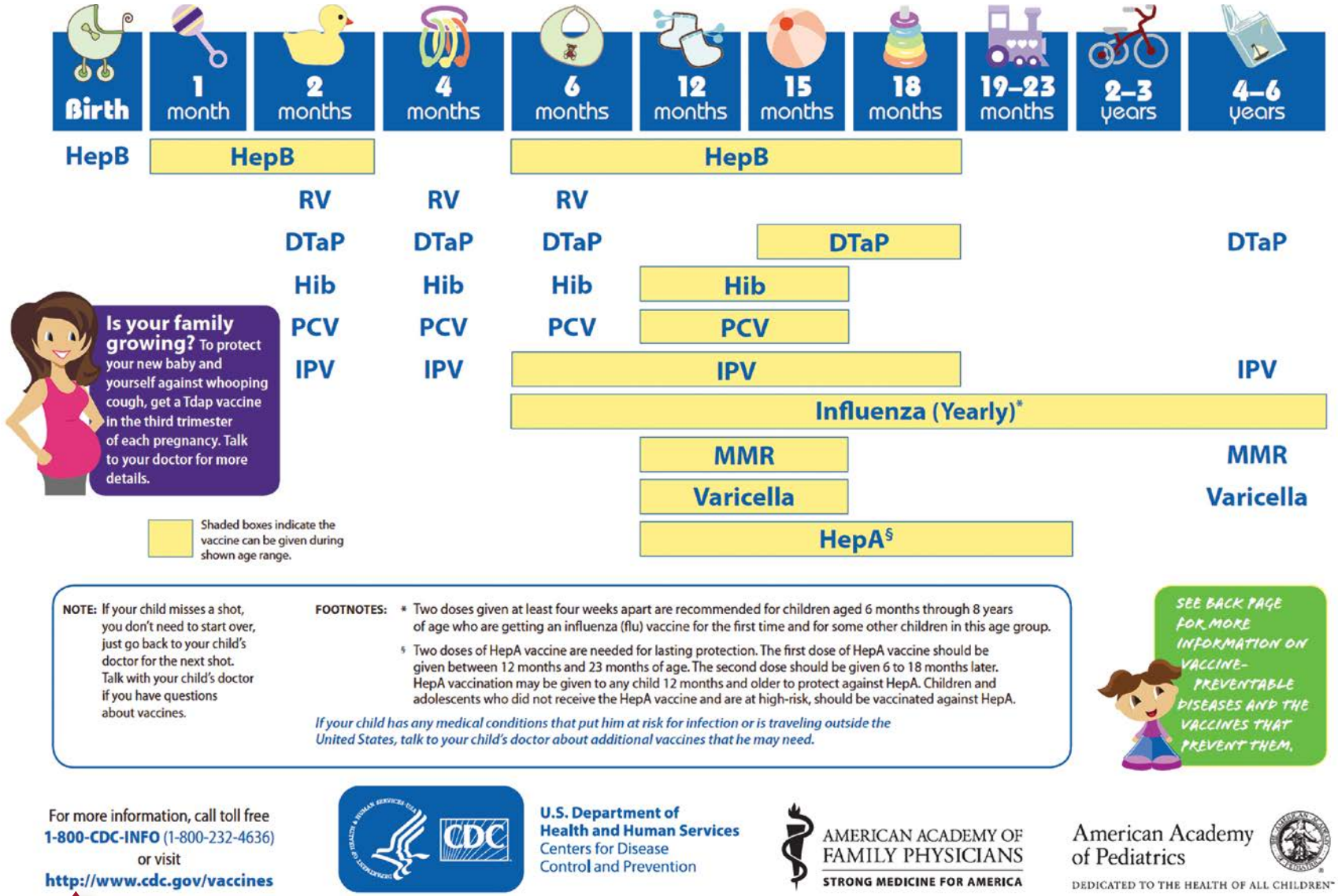
MCV – At least one MCV or meningococcal polysaccharide vaccine, on a date on or between the member's 11th and 13th birthdays

Tdap/Td – Any of the following on a date on or between the member's 10th and 13th birthdays:

- At least one Tdap vaccine
- At least one Td vaccine
- At least one tetanus vaccine and at least one diphtheria vaccine, on the same or different dates

APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

2015 Recommended Immunizations for Children from Birth Through 6 Years Old



NOTE: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

For more information, call toll free
1-800-CDC-INFO (1-800-232-4636)
or visit
http://www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

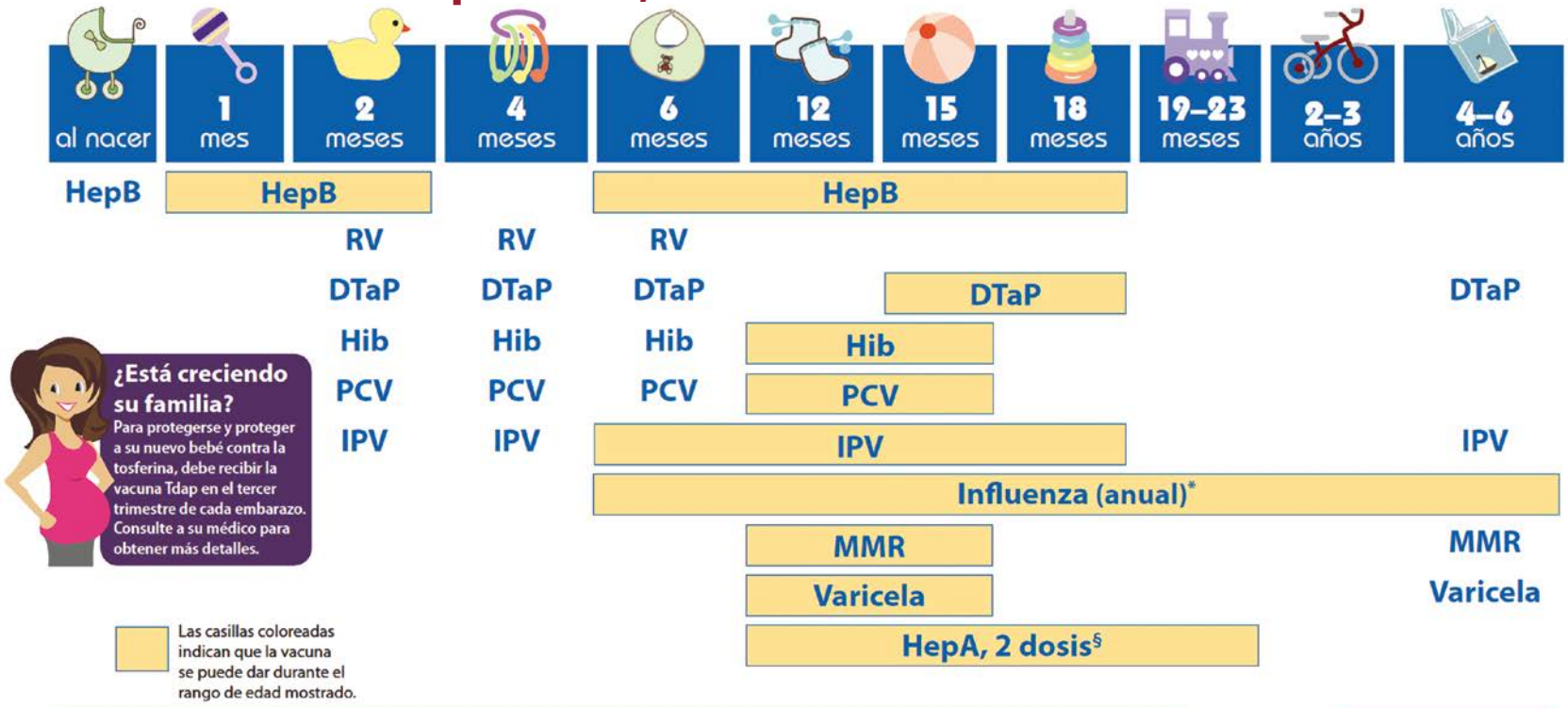
Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Flu	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated January 26, 2015 • CS245366-A -

APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

2015 Vacunas recomendadas para niños, desde el nacimiento hasta los 6 años de edad



NOTA:
Si su hijo no recibió una de las dosis, no se necesita volver a empezar, solo llévelo al pediatra para que le apliquen la siguiente. Consulte al médico de su hijo si tiene preguntas sobre las vacunas.

NOTAS A PIE DE PÁGINA:

* Se recomiendan dos dosis con un intervalo de por lo menos cuatro semanas para los niños de 6 meses a 8 años que reciben por primera vez la vacuna contra la influenza y para otros niños en este grupo de edad.

§ Se requieren 2 dosis de la vacuna HepA para brindar una protección duradera. La primera dosis de la vacuna HepA se debe administrar durante los 12 y los 23 meses de edad. La segunda dosis se debe administrar 6 a 18 meses después. La vacuna HepA se puede administrar a todos los niños de 12 meses de edad o más para protegerlos contra la hepatitis A. Los niños y adolescentes que no recibieron la vacuna HepA y tienen un riesgo alto, deben vacunarse contra la hepatitis A.

Si su niño tiene alguna afección que lo pone en riesgo de contraer infecciones o si va a viajar al extranjero, consulte al pediatra sobre otras vacunas que pueda necesitar.

MÁS INFORMACIÓN AL REVERSO SOBRE ENFERMEDADES PREVENIBLES CON LAS VACUNAS Y LAS VACUNAS PARA PREVENIRLAS.

Para más información, llame a la línea de atención gratuita
1-800-CDC-INFO (1-800-232-4636)
o visite
http://www.cdc.gov/vaccines

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APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

Enfermedades prevenibles con las vacunas y vacunas para prevenirlas

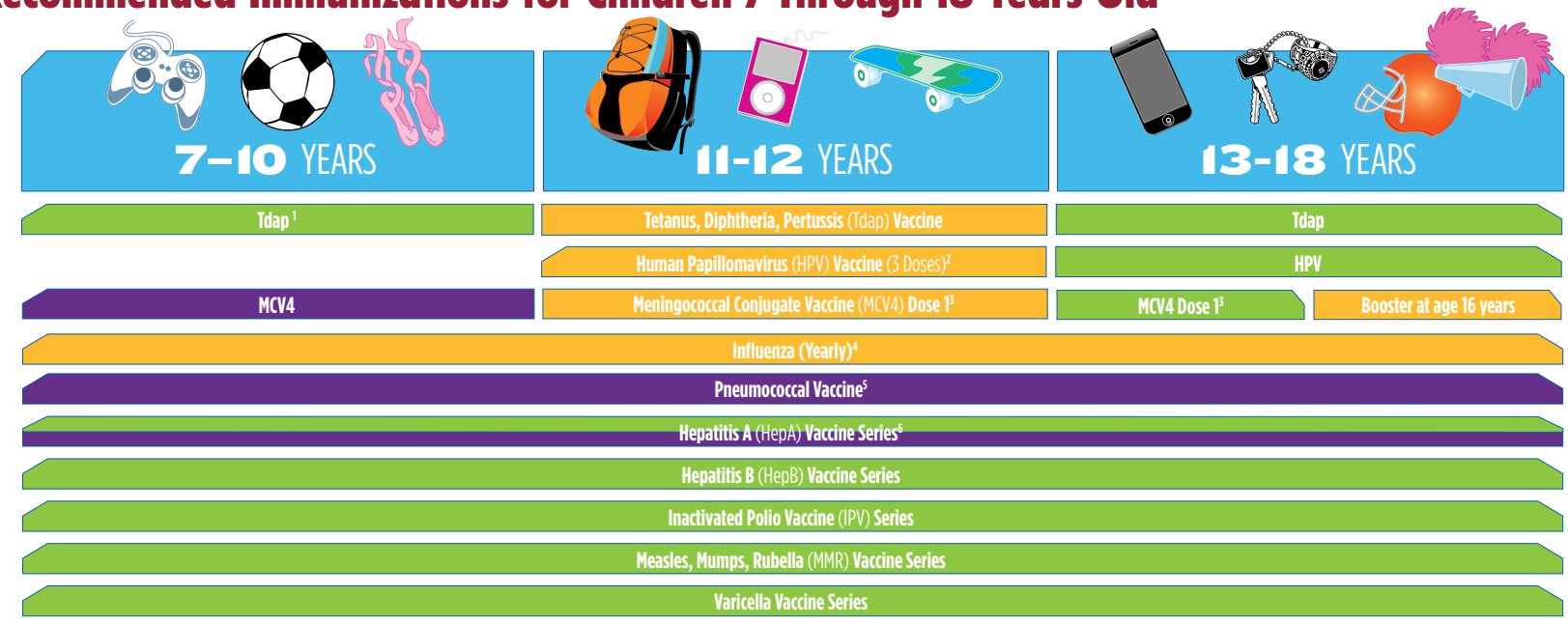
Enfermedad	Vacuna	Enfermedad transmitida por	Signos y síntomas de la enfermedad	Complicaciones de la enfermedad
Varicela	Vacuna contra la varicela.	Aire, contacto directo	Sarpullido, cansancio, dolor de cabeza, fiebre	Ampollas infectadas, trastornos hemorrágicos, encefalitis (inflamación del cerebro), neumonía (infección en los pulmones)
Difteria	La vacuna DTaP* protege contra la difteria.	Aire, contacto directo	Dolor de garganta, fiebre moderada, debilidad, inflamación de los ganglios del cuello	Inflamación del músculo cardiaco, insuficiencia cardiaca, coma, parálisis, muerte
Hib	La vacuna contra la Hib protege contra *Haemophilus influenzae* serotipo b.	Aire, contacto directo	Puede no causar síntomas a menos que la bacteria entre en la sangre	Meningitis (infección en las membranas que recubren el cerebro y la médula espinal), discapacidad intelectual, epiglotitis (infección que puede ser mortal en la que se bloquea la tráquea y origina graves problemas respiratorios) y neumonía (infección en los pulmones), muerte
Hepatitis A	La vacuna HepA protege contra la hepatitis A.	Contacto directo, comida o agua contaminada	Puede no causar síntomas, fiebre, dolor de estómago, pérdida del apetito, cansancio, vómito, ictericia (coloración amarilla de la piel y los ojos), orina oscura	Insuficiencia hepática, artralgia (dolor en las articulaciones), trastorno renal, pancreático y de la sangre
Hepatitis B	La vacuna HepB protege contra la hepatitis B.	Contacto con sangre o líquidos corporales	Puede no causar síntomas, fiebre, dolor de cabeza, debilidad, vómito, ictericia (coloración amarilla de los ojos y la piel) dolor en las articulaciones	Infección crónica del hígado, insuficiencia hepática, cáncer de hígado
Influenza (gripe)	La vacuna influenza protege contra la gripe o influenza.	Aire, contacto directo	Fiebre, dolor muscular, dolor de garganta, tos, cansancio extremo	Neumonía (infección en los pulmones)
Sarampión	La vacuna MMR** protege contra el sarampión.	Aire, contacto directo	Sarpullido, fiebre, tos, moqueo, conjuntivitis	Encefalitis (inflamación del cerebro), neumonía (infección en los pulmones), muerte
Paperas	La vacuna MMR**protege contra las paperas.	Aire, contacto directo	Inflamación de glándulas salivales (debajo de la mandíbula), fiebre, dolor de cabeza, cansancio, dolor muscular	Meningitis (infección en las membranas que recubren el cerebro y la médula espina), encefalitis (inflamación del cerebro), inflamación de los testículos o los ovarios, sordera
Tosferina	La vacuna DTaP* protege contra la tosferina (*pertussis*).	Aire, contacto directo	Tos intensa, moqueo, apnea (interrupción de la respiración en los bebés)	Neumonía (infección en los pulmones), muerte
Poliomielitis	La vacuna IPV protege contra la poliomielitis.	Aire, contacto directo, por la boca	Puede no causar síntomas, dolor de garganta, fiebre, náuseas, dolor de cabeza	Parálisis, muerte
Infección neumocócica	La vacuna PCV protege contra la infección neumocócica.	Aire, contacto directo	Puede no causar síntomas, neumonía (infección en los pulmones)	Bacteriemia (infección en la sangre), meningitis (infección en las membranas que recubren el cerebro y la médula espinal), muerte
Rotavirus	La vacuna RV protege contra el rotavirus.	Por la boca	Diarrea, fiebre, vómito	Diarrea intensa, deshidratación
Rubéola	La vacuna MMR** protege contra la rubéola.	Aire, contacto directo	Los niños infectados por rubéola a veces presentan sarpullido, fiebre y ganglios linfáticos inflamados	Muy grave en las mujeres embarazadas: puede causar aborto espontáneo, muerte fetal, parto prematuro, defectos de nacimiento
Tétano	La vacuna DTaP* protege contra el tétano.	Exposición a través de cortaduras en la piel	Rigidez del cuello y los músculos abdominales, dificultad para tragar, espasmos musculares, fiebre	Fractura de huesos, dificultad para respirar, muerte

* La vacuna DTaP combina la protección contra la difteria, el tétano y la tosferina.
** La vacuna MMR combina la protección contra el sarampión, las paperas y la rubéola.

Última actualización 01/26/2015 • CS245366-D -

APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

2015 Recommended Immunizations for Children 7 Through 18 Years Old



These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health conditions that put them at high risk for serious diseases. Note that healthy children **can** get the HepA series[6]. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

FOOTNOTES

[1] Tdap vaccine is recommended at age 11 or 12 to protect against tetanus, diphtheria and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don't know if your child has received these shots, your child needs a single dose of Tdap when they are 7 -10 years old. Talk to your child's health care provider to find out if they need additional catch-up vaccines.

[2] All 11 or 12 year olds – both girls *and* boys – should receive 3 doses of HPV vaccine to protect against HPV-related disease. The full HPV vaccine series should be given as recommended for best protection.

[3] Meningococcal conjugate vaccine (MCV) is recommended at age 11 or 12. A booster shot is recommended at age 16. Teens who received MCV for the first time at age 13 through 15 years will need a one-time booster dose between the ages of 16 and 18 years. If your teenager missed getting the vaccine altogether, ask their health care provider about getting it now, especially if your teenager is about to move into a college dorm or military barracks.

[4] Everyone 6 months of age and older—including preteens and teens—should get a flu vaccine every year. Children under the age of 9 years may require more than one dose. Talk to your child's health care provider to find out if they need more than one dose.

[5] Pneumococcal Conjugate Vaccine (PCV13) and Pneumococcal Polysaccharide Vaccine (PPSV23) are recommended for some children 6 through 18 years old with certain medical conditions that place them at high risk. Talk to your healthcare provider about pneumococcal vaccines and what factors may place your child at high risk for pneumococcal disease.

[6] Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. HepA vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against HepA. Talk to your healthcare provider about HepA vaccine and what factors may place your child at high risk for HepA.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit http://www.cdc.gov/vaccines/teens

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Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccine)

Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the diptheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, low-grade fever, and swollen glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In severe cases, the illness can cause coma, paralysis, and even death.

Hepatitis A (Can be prevented by HepA vaccine)

Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms include fever, tiredness, loss of appetite, nausea, abdominal discomfort, dark urine, and jaundice (yellowing of the skin and eyes). An infected person may have no symptoms, may have mild illness for a week or two, or may have severe illness for several months that requires hospitalization. In the U.S., about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccine)

Hepatitis B is an infection of the liver caused by hepatits B virus. The virus spreads through exchange of blood or other body fluids, for example, from sharing personal items, such as razors or during sex. Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. The virus stays in the liver of some people for the rest of their lives and can result in severe liver diseases, including fatal cancer.

Human Papillomavirus (Can be prevented by HPV vaccine)

Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. It is the major cause of cervical cancer in women and genital warts in women and men. The strains of HPV that cause cervical cancer and genital warts are spread during sex.

Influenza (Can be prevented by annual flu vaccine)

Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccine)

Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by MCV vaccine)

Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children. The bacteria are spread through the exchange of nose and throat droplets, such as when coughing, sneezing or kissing. Symptoms include nausea, vomiting, sensitivity to light, confusion and sleepiness. Meningococcal disease also causes blood infections. About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccine)

Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object, like a toy. The mumps virus causes fever, headaches, painful swelling of the salivary glands under the jaw, fever, muscle aches, tiredness, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the covering of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely can lead to sterility in men.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccine)

Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. Pertussis is most serious for babies, who can get pneumonia, have seizures, become brain damaged, or even die. About two-thirds of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease

(Can be prevented by Pneumococcal vaccine)

Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. This bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the covering around the brain and spinal cord), bacteremia and sepsis (blood stream infection). Sinus and ear infections are usually mild and are much more common than the more severe forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage, hearing loss and limb loss. Pneumococcal disease spreads when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by IPV vaccine)

Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the feces (stool) of an infected person and through droplets from a sneeze or cough. Symptoms typically include sudden fever, sore throat, headache, muscle weakness, and pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, up to 5% of children may die because they become unable to breathe.

Rubella (German Measles) (Can be prevented by MMR vaccine)

Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccine)

Tetanus is caused by bacteria found in soil. The bacteria enters the body through a wound, such as a deep cut. When people are infected, the bacteria produce a toxin (poison) in the body that causes serious, painful spasms and stiffness of all muscles in the body. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. Complete recovery from tetanus can take months. Three of ten people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccine)

Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child's vaccines, talk to your healthcare provider.

Last updated on 02/02/2015 • *CS254242-A*

APPENDIX A: CHILDHOOD IMMUNIZATION INFORMATION FOR CONSUMERS

2015 Vacunas recomendadas para niños de los 7 años hasta los 18 años de edad

7–10 AÑOS	11-12 AÑOS	13-18 AÑOS	
La vacuna Tdap[1]	Tetanus, Diphtheria, Pertussis (Tdap) Vaccine	La vacuna Tdap[1]	
	La vacuna VPH (3 dosis)[2]	La vacuna VPH	
MCV4	La vacuna meningocócica conjugada (MCV4) 1 dosis[3]	Dosis de la vacuna MCV4[3]	Vacuna de refuerzo a los 16 años
Influenza (anual)[4]			
La vacuna neumocócica[5]			
La serie de vacunas contra la hepatitis A (HepA)[6]			
La serie de vacunas contra la hepatitis B (HepB)			
La serie de vacunas inactivadas contra la polio (IPV)			
La serie de vacunas contra el sarampión, las paperas y la rubéola (MMR)			
La serie de vacunas contra la varicela			

Los casilleros sombreados de este color indican cuándo se recomienda la vacuna para todos los niños, a menos que su médico le indique que a su hijo no se le puede administrar la vacuna de manera segura.

Los casilleros sombreados de este color indican que se esta vacuna se le debe poner a los niños que se están poniendo al día con las vacunas que no se ha puesto.

Los casilleros sombreados de este color indican que la vacuna se recomienda para los niños que tienen ciertas afecciones de salud que los ponen en alto riesgo de contagiarse de enfermedades graves. Tenga en cuenta que los niños sanos se pueden poner la serie de las vacunas HepA6 Vea las recomendaciones específicas para cada vacuna en: **www.cdc.gov/vaccines/pubs/ACIP-list.htm**.

NOTAS A PIE DE PÁGINA

1. La vacuna Tdap se recomienda a los 11 o 12 años de edad para proteger contra el tétanos, la difteria y la pertusis. Si a su hijo no le han puesto ninguna vacuna de la serie DTaP, o si usted no sabe si a su niño le han puesto estas vacunas, su hijo necesita una sola dosis de la vacuna Tdap cuando tiene entre 7 a 10 años de edad. Converse con el proveedor médico de su niño para ver si necesita vacunas de actualización.
2. A todos los niños de 11 o 12 años de edad, tanto varones como mujeres, se les debe poner 3 dosis de la vacuna HPV para protegerlos contra enfermedades relacionadas con el HPV [Virus del papiloma humano]. Para la mejor protección, todos deben recibir la serie completa de vacuna HPV (de acuerdo con las recomendaciones).
3. La vacuna meningocócica conjugada (MCV) se recomienda a la edad de 11 o 12 años. A los 16 años de edad se recomienda una vacuna de refuerzo. A los adolescentes que se les puso la vacuna MCV por primera vez entre los 13 y 15 años de edad se les tiene que poner una dosis de refuerzo entre los 16 y 18 años de edad. Si su adolescente no sepuso la vacuna, pídale a su proveedor de salud que se la ponga ahora, especialmente si su adolescente está por mudarse a una residencia universitaria o barracas militares.
4. Todas las personas de 6 meses de edad en adelante, entre ellos, los preadolescentes y los adolescentes, deben ponerse una vacuna contra la influenza todos los años. Los niños menores de 9 años de edad podrían necesitar ponerse más de una dosis. Hable con el proveedor de salud de su niño para saber si necesita ponerse más de una dosis.
5. La vacuna antineumocócica conjugada 13-valente (PVC13) y la vacuna antineumocócica polisacárida 23-valente (PPSV23) están recomendadas para algunos niños de entre 6 y 18 años que poseen ciertas afecciones médicas que los ponen en riesgo de contraer esta enfermedad. Consulte a su proveedor de atención médica sobre las vacunas antineumocócicas y qué factores pueden poner en riesgo a su hijo de contraer una enfermedad neumocócica.
6. La vacuna contra la hepatitis A se recomienda para los niños mayores que tienen ciertas condiciones médicas que los ponen en mayor riesgo. La vacuna HepA está autorizada, es segura y eficaz para niños de todas las edades. Incluso si su niño no se encuentra en alto riesgo de contagiarse de esta enfermedad, usted podría desear proteger a su hijo contra la HepA. Converse con su proveedor médico sobre la vacuna HepA y sobre qué factores podrían poner a su niño en mayor riesgo de contraer la HepA.

Para obtener mayor información, llame gratuitamente al 1-800-CDC-INFO (1-800-232-4636) o visite el sitio web: http://www.cdc.gov/vaccines/teens

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Enfermedades que se pueden prevenir con vacunas y las vacunas que las previenen

La difteria (Se puede prevenir con la vacuna Tdap)

La difteria es una enfermedad muy contagiosa producida por una bacteria que afecta al sistema respiratorio, incluso los pulmones. La bacteria de la difteria se puede propagar de una persona a otra a través del contacto directo con las micro-gotas de la tos o el estornudo de una persona infectada. Cuando las personas están infectadas, la bacteria de la difteria produce una toxina (veneno) en el cuerpo que puede causar debilidad, dolor de la garganta, fiebre baja e inflamación de las glándulas en el cuello. Los efectos de esta toxina también pueden conllevar inflamación del músculo del corazón y, en algunos casos, falla cardíaca. En los casos graves, la enfermedad puede causar coma, parálisis y hasta la muerte.

La hepatitis A (Se puede prevenir con la vacuna HepA)

La hepatitis A es una infección del hígado causada por el virus de la hepatitis A. El virus se transmite principalmente de persona a persona a través de la ruta fecal-oral. En otras palabras, el virus se recibe por la boca a partir del contacto con objetos, alimentos o bebidas contaminadas por las heces (excremento) de una persona infectada. Entre los síntomas se encuentran: fiebre, cansancio, pérdida del apetito, náuseas, malestar abdominal, orine de color oscuro e ictericia (color amarillento de la piel y los ojos). Una persona infectada por el virus puede no tener síntomas, puede tener un caso leve de la enfermedad por una semana o dos, o puede tener un caso grave de la enfermedad por varios meses que requiere de hospitalización. En los Estados Unidos, alrededor de 100 personas al año mueren a consecuencia de la hepatitis A.

La hepatitis B (Se puede prevenir con la vacuna HepB)

La hepatitis B es una infección del hígado causada por el virus de la B. El virus se transmite a través del intercambio de sangre u otros fluidos corporales, como por ejemplo, el intercambio de artículos personales, tales como navajas de afeitar o mediante el contacto sexual (coito). La hepatitis B causa una enfermedad parecida a la gripe, con pérdida del apetito, náuseas, vómitos, sarpullidos, dolor de las articulaciones e ictericia. El virus se aloja en el hígado de algunas personas por el resto de sus vidas y puede resultar en enfermedades hepáticas graves, entre ellas, el cáncer fatal.

El virus del papiloma humano (Se puede prevenir con la vacuna VPH)

El virus del papiloma humano es un virus bastante común. El VPH es más común en las personas durante los años de la adolescencia y principios de sus 20 años. Es la causa principal del cáncer del cuello del útero en las mujeres y de las verrugas genitales tanto en las mujeres como en los hombres. Las cepas del VPH que causan cáncer del cuello del útero y verrugas genitales se transmiten por contacto sexual (coito).

La influenza (Se puede prevenir con la vacuna anual contra la influenza)

La influenza es una infección viral de la nariz, la garganta y los pulmones altamente contagiosa. El virus se transmite fácilmente a través de las micro-gotas de la tos o el estornudo de una persona infectada y puede causar una enfermedad que oscila de leve a grave. Entre los síntomas típicos se encuentran: fiebre alta repentina, escalofríos, tos seca, dolor de cabeza, secreción nasal, dolor de garganta y dolores musculares y de las articulaciones. La fatiga aguda puede durar de varios días a semanas. La influenza puede conllevar a la hospitalización o hasta causar la muerte, incluso en niños que anteriormente hayan sido sanos.

El sarampión (Se puede prevenir con la vacuna MMR)

El sarampión es una de las enfermedades virales más contagiosas que existen. El virus del sarampión se transmite mediante el contacto directo con las micro-gotas respiratorias suspendidas en el aire de una persona infectada. El sarampión es tan contagioso que el tan solo estar en la misma habitación en la que haya estado una persona con sarampión puede resultar en una infección. Entre los síntomas comunes se encuentran: sarpullido, fiebre, tos y ojos enrojecidos y llorosos. La fiebre puede ser persistente, el sarpullido puede durar hasta una semana y la tos puede durar alrededor de 10 días. El sarampión paperas también puede causar neumonía, convulsiones, daños cerebrales o la muerte.

La enfermedad meningocócica (Se puede prevenir con la vacuna MCV)

La enfermedad meningocócica es causada por una bacteria y es la causa principal de la meningitis bacteriana (la infección de las membranas que cubren el cerebro y la espina dorsal) en los niños. Las bacterias se transmiten a través del intercambio de micro-gotas nasales y de la garganta al toser, estornudar y besarse. Entre los síntomas se encuentran: náuseas, vómitos, sensibilidad a la luz, confusión y somnolencia. La enfermedad meningocócica también causa infecciones sanguíneas. Alrededor de una de cada diez personas que contrae la enfermedad muere a consecuencia de ella. Los sobrevivientes de la enfermedad meningocócica pueden perder los brazos o las piernas, quedarse sordos, tener problemas en el sistema nervioso, tener discapacidades del desarrollo, o sufrir convulsiones o derrames cerebrales (apoplejías).

Las paperas (Se pueden prevenir con la vacuna MMR)

Las paperas son una enfermedad infecciosa causada por el virus de las paperas, el cual se transmite por el aire cuando una persona infectada tose o estornuda. Un niño también puede infectarse con las paperas al estar en contacto con un objeto contaminado por el virus, como un juguete por ejemplo. Las paperas causan fiebre, dolores de cabeza, inflamación dolorosa de las glándulas salivares debajo de mandíbula, fiebre, dolores musculares, cansancio y pérdida del apetito. Las complicaciones graves para los niños que tienen paperas son poco comunes, pero pueden incluir meningitis (infección de las membranas que cubren el cerebro y la espina dorsal), encefalitis (inflamación del cerebro), pérdida auditiva permanente, o inflamación de los testículos, que en raras ocasiones puede generar esterilidad en los hombres.

La pertusis (tos ferina) (Se puede prevenir con la vacuna Tdap)

La pertusis es una enfermedad causada por una bacteria que se transmite a través del contacto directo con las micro-gotas respiratorias de una persona infectada al toser o estornudar. Al principio, los síntomas de la tos ferina son similares a los del resfrío común, entre ellos: secreción nasal, estornudos y tos. Después de 1 a 2 semanas, la tos ferina puede causar períodos violentos de tos y ahogo, que dificultan respirar, beber o comer. Esta tos puede durar semanas. La pertusis es una enfermedad muy grave para los bebés, quienes pueden tener neumonía, convulsiones, daños cerebrales, e incluso, morir. Alrededor de dos tercios de los niños menores de 1 año de edad que se contagian de la tos ferina tienen que ser hospitalizados.

La enfermedad neumocócica (Se puede prevenir con la vacuna neumocócica)

La neumonía es una infección de los pulmones que puede ser causada por la bacteria llamada neumococo. Esta bacteria también puede causar otros tipos de infecciones tales como infecciones del oído, infecciones de los senos nasales, meningitis (infección de las membranas que cubren el cerebro y la espina dorsal), bacteriemia y sepsis (infección del torrente sanguíneo). Las infecciones de los senos nasales y del oído normalmente son leves y son mucho más comunes que las formas más graves de la enfermedad neumocócica. No obstante, en algunos casos la enfermedad neumocócica puede ser fatal o traer consigo problemas de largo plazo tales como daños cerebrales, pérdida de la audición y de las extremidades. La enfermedad neumocócica se transmite cuando las personas infectadas tosen o estornudan. Sin embargo, muchas personas tienen la bacteria en la nariz o la garganta en un momento u otro sin estar enfermas, eso se conoce por el nombre de ser portador de la enfermedad.

La polio (Se puede prevenir con la vacuna IPV)

La polio es una enfermedad causada por un virus que vive en la garganta o los intestinos de una persona infectada. Se transmite a través del contacto con las heces (excremento) de una persona infectada y a través de las micro-gotas de un estornudo o tos. Entre los síntomas más comunes se encuentran: fiebre repentina, dolor de garganta, dolor de cabeza, debilidad y dolor muscular. En alrededor del 1% de los casos, la polio puede causar parálisis. Entre las personas que resultan paralizadas, hasta el 5% de los niños pueden morir porque no pueden respirar.

La rubéola (Sarampión alemán) (Se puede prevenir con la vacuna MMR)

La rubéola es una enfermedad causada por un virus que se transmite a través de la tos y el estornudo. En los niños, la rubéola normalmente causa una enfermedad leve con fiebre, inflamación de las glándulas y un sarpullido que dura alrededor de 3 días. La rubéola raras veces causa una enfermedad grave o complicaciones en los niños, pero puede ser muy grave para un bebé en el vientre. Si una mujer embarazada se contagia de la enfermedad, el resultado de la misma en el bebé puede ser devastador, entre ellos: aborto espontáneo, defectos cardíacos graves, retardo mental y pérdida de la audición y de la vista.

El tétanos (Trismo) (Se puede prevenir con la vacuna Tdap)

El tétanos es una enfermedad causada por bacterias que se encuentran en la tierra. La bacteria ingresa al cuerpo a través de una herida, tal como una cortadura profunda. Cuando las personas se infectan, la bacteria produce una toxina (veneno) en el cuerpo que causa espasmos graves y rigidez dolorosa de todos los músculos del cuerpo. Esto puede conllevar al "cierre y bloqueo" de la mandíbula de modo que la persona no puede abrir la boca, ni tragar, ni respirar. La recuperación total del tétanos puede tomar meses. Tres de cada diez personas que tienen tétanos mueren a consecuencia de la enfermedad.

La varicela (Se puede prevenir con la vacuna contra la varicela)

La varicela es una enfermedad causada por el virus de la varicela-zóster. La varicela es altamente contagiosa y se transmite con mucha facilidad a partir de las personas infectadas. El virus se puede transmitir a partir de la tos o el estornudo. También se puede transmitir a partir de las ampollas en la piel, ya sea al tocarlas o al respirar estas partículas virales. Entre los síntomas más comunes de la varicela se encuentran: sarpullido con picazón y ampollas, cansancio, dolor de cabeza y fiebre. Normalmente, la varicela es una enfermedad leve, pero puede conllevar a infecciones de la piel graves, neumonía, encefalitis (inflamación del cerebro) o incluso, la muerte.

Si tiene alguna pregunta acerca de las vacunas de su niño, hable con su proveedor médico.

Last updated on 02/02/2015 • *CS254242-B*

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Contained in Appendix B are tables that track three years of performance for each Health Benefit Plan on individual quality measures. In addition, 2015 health benefit plan performance is compared against the Maryland Average Benchmark, the National Average Benchmark and the National Top Performers Benchmark. These comparisons are presented as easy to interpret "arrows" to indicate whether the individual health benefit plan's performance is above, equivalent to, or below the Maryland and National Benchmarks. Consumers should be aware that reporting on Health Care Disparities measures began in 2014, therefore only two years of performance data for these measures is available for all health benefit plans. Also, required reporting on all quality measures by the health benefit plan KPIC was implemented in 2014, therefore only two years of performance data for this plan is available on all quality measures.

BENCHMARKS

- **MAB** MARYLAND AVERAGE BENCHMARK
- **NAB** NATIONAL AVERAGE BENCHMARK
- **NTP** NATIONAL TOP PERFORMERS

QUALITY MEASURE DESIGNATIONS

NA – Not applicable due to insufficient eligible members (fewer than 30) to calculate a rate for a HEDIS® measure, or insufficient survey responses (fewer than 100) to calculate a rate for a CAHPS® measure

NB – No benefit is being offered by the health benefit plan for the given measure

NR – Performance results are **not reported** due to bias in the data from the health benefit plan

NDA – No data available for the year specified due to the measure not being required for quality reporting in the given year; the measure specifications changing in the year(s) following the year specified; the measure not existing in the year specified; or the health benefit plan not being required to participate in quality reporting for the year specified.

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Carrier Disparities Initiatives									
Member Information Source	Is the Plan Getting Accurate RELICC™ Member Information? [Page 48]	HMO	Aetna (HMO)	NDA	92%	91%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	NDA	0%	100%	⇧	⇧	⇔
			Coventry (HMO)	NDA	86%	100%	⇧	⇧	⇔
			Kaiser Permanente (HMO)	NDA	58%	32%	⇩	⇩	⇩
			MD-IPA (HMO)	NDA	83%	82%	⇔	⇔	⇩
			Optimum Choice (HMO)	NDA	83%	82%	⇔	⇔	⇩
			UnitedHealthcare (HMO)	NDA	83%	82%	⇔	⇔	⇩
		PPO	Aetna (PPO)	NDA	92%	91%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	0%	100%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	0%	100%	⇧	⇧	⇔
			Cigna (PPO)	NDA	17%	17%	⇩	⇩	⇩
			Coventry (PPO)	NDA	86%	100%	⇧	⇧	⇔
			KPIC (PPO)	NDA	58%	32%	⇩	⇩	⇩
			MAMSI (PPO)	NDA	83%	82%	⇧	⇔	⇩
			UnitedHealthcare (PPO)	NDA	83%	82%	⇧	⇔	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Carrier Disparities Initiatives (continued)									
Information on Physicians, Physician Office Staff, and Plan Personnel	Does the Plan Know the RELICC™ Information for Their Doctors and Staff? [Page 49]	HMO	Aetna (HMO)	NDA	45%	45%	⇧	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	35%	70%	⇧	⇧	⇩
			Coventry (HMO)	NDA	10%	20%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	50%	85%	⇧	⇧	⇩
			MD-IPA (HMO)	NDA	10%	20%	⇩	⇩	⇩
			Optimum Choice (HMO)	NDA	10%	20%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	10%	20%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	45%	45%	⇧	⇩	⇩
			CareFirst CFMI (PPO)	NDA	35%	70%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	35%	70%	⇧	⇧	⇩
			Cigna (PPO)	NDA	70%	70%	⇧	⇧	⇩
			Coventry (PPO)	NDA	10%	20%	⇩	⇩	⇩
			KPIC (PPO)	NDA	25%	25%	⇩	⇩	⇩
			MAMSI (PPO)	NDA	10%	20%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	NDA	10%	20%	⇩	⇩	⇩
Using the Data	Does the Plan Use the Data Toward Eliminating Disparities? [Page 50]	HMO	Aetna (HMO)	NDA	100%	100%	⇧	⇧	⇔
			CareFirst BlueChoice (HMO)	NDA	67%	89%	⇧	⇧	⇩
			Coventry (HMO)	NDA	44%	33%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	100%	100%	⇧	⇧	⇔
			MD-IPA (HMO)	NDA	100%	89%	⇧	⇧	⇩
			Optimum Choice (HMO)	NDA	100%	89%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	NDA	100%	89%	⇧	⇧	⇩
		PPO	Aetna (PPO)	NDA	100%	100%	⇧	⇧	⇔
			CareFirst CFMI (PPO)	NDA	67%	89%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	67%	89%	⇧	⇧	⇩
			Cigna (PPO)	NDA	100%	100%	⇧	⇧	⇔
			Coventry (PPO)	NDA	44%	33%	⇩	⇩	⇩
			KPIC (PPO)	NDA	100%	100%	⇧	⇧	⇔
			MAMSI (PPO)	NDA	100%	89%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	NDA	100%	89%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Carrier Disparities Initiatives (continued)									
Supporting the Needs of Members With Limited English Proficiency	How Well Does the Plan Help Members With Language Challenges? [Page 50]	HMO	Aetna (HMO)	NDA	42%	69%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	NDA	31%	31%	⇩	⇩	⇩
			Coventry (HMO)	NDA	9%	9%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	84%	100%	⇧	⇧	⇔
			MD-IPA (HMO)	NDA	31%	31%	⇩	⇩	⇩
			Optimum Choice (HMO)	NDA	31%	31%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	31%	31%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	42%	69%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	31%	31%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	31%	31%	⇩	⇩	⇩
			Cigna (PPO)	NDA	53%	58%	⇧	⇩	⇩
			Coventry (PPO)	NDA	9%	9%	⇩	⇩	⇩
			KPIC (PPO)	NDA	84%	100%	⇧	⇧	⇔
			MAMSI (PPO)	NDA	31%	31%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	NDA	31%	31%	⇩	⇩	⇩
Assuring That Culturally Competent Health Care is Delivered	Does the Plan Support the Complete Cultural Health Needs of Members? [Page 52]	HMO	Aetna (HMO)	NDA	78%	78%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	NDA	67%	67%	⇩	⇧	⇩
			Coventry (HMO)	NDA	33%	33%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	100%	100%	⇧	⇧	⇔
			MD-IPA (HMO)	NDA	89%	89%	⇧	⇧	⇩
			Optimum Choice (HMO)	NDA	89%	89%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	NDA	89%	89%	⇧	⇧	⇩
		PPO	Aetna (PPO)	NDA	78%	78%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	67%	67%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	67%	67%	⇩	⇧	⇩
			Cigna (PPO)	NDA	100%	100%	⇧	⇧	⇔
			Coventry (PPO)	NDA	33%	33%	⇩	⇩	⇩
			KPIC (PPO)	NDA	100%	100%	⇧	⇧	⇔
			MAMSI (PPO)	NDA	89%	89%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	NDA	89%	89%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Carrier Disparities Initiatives (continued)									
Evaluating and Measuring the Impact of Language Assistance	How Well Does the Plan Critique Their Own Language Assistance Efforts? [Page 53]	HMO	Aetna (HMO)	NDA	NDA	100%	⇧	⇧	⇔
			CareFirst BlueChoice (HMO)	NDA	NDA	0%	⇩	⇩	⇩
			Coventry (HMO)	NDA	NDA	0%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	NDA	0%	⇩	⇩	⇩
			MD-IPA (HMO)	NDA	NDA	50%	⇧	⇩	⇩
			Optimum Choice (HMO)	NDA	NDA	50%	⇧	⇩	⇩
			UnitedHealthcare (HMO)	NDA	NDA	50%	⇧	⇩	⇩
		PPO	Aetna (PPO)	NDA	NDA	100%	⇧	⇧	⇔
			CareFirst CFMI (PPO)	NDA	NDA	0%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	NDA	0%	⇩	⇩	⇩
			Cigna (PPO)	NDA	NDA	100%	⇧	⇧	⇔
			Coventry (PPO)	NDA	NDA	0%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NDA	0%	⇩	⇩	⇩
			MAMSI (PPO)	NDA	NDA	50%	⇧	⇩	⇩
			UnitedHealthcare (PPO)	NDA	NDA	50%	⇧	⇩	⇩
Information Available Through the Online Provider Directory	Can Members Prioritize Search Criteria to Find Doctors in the Online Directory? [Page 54]	HMO	Aetna (HMO)	NDA	20%	40%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	60%	60%	⇔	⇧	⇩
			Coventry (HMO)	NDA	60%	60%	⇔	⇧	⇩
			Kaiser Permanente (HMO)	NDA	40%	80%	⇧	⇧	⇩
			MD-IPA (HMO)	NDA	60%	60%	⇔	⇧	⇩
			Optimum Choice (HMO)	NDA	60%	60%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	NDA	60%	60%	⇔	⇧	⇩
		PPO	Aetna (PPO)	NDA	20%	40%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	60%	60%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	60%	60%	⇩	⇧	⇩
			Cigna (PPO)	NDA	60%	80%	⇧	⇧	⇩
			Coventry (PPO)	NDA	60%	60%	⇩	⇧	⇩
			KPIC (PPO)	NDA	40%	80%	⇧	⇧	⇩
			MAMSI (PPO)	NDA	60%	60%	⇩	⇧	⇩
			UnitedHealthcare (PPO)	NDA	60%	60%	⇩	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Carrier Disparities Initiatives (continued)									
Interactive Selection Features for Members Selecting a Physician Online	Does the Plan Website Help Members With the Right Guidance? [Page 55]	HMO	Aetna (HMO)	NDA	68%	73%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	NDA	45%	45%	⇩	⇧	⇩
			Coventry (HMO)	NDA	44%	50%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	NDA	37%	44%	⇩	⇧	⇩
			MD-IPA (HMO)	NDA	64%	64%	⇧	⇧	⇩
			Optimum Choice (HMO)	NDA	64%	64%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	NDA	64%	64%	⇧	⇧	⇩
		PPO	Aetna (PPO)	NDA	68%	73%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	45%	45%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	45%	45%	⇩	⇧	⇩
			Cigna (PPO)	NDA	94%	74%	⇧	⇧	⇩
			Coventry (PPO)	NDA	44%	50%	⇩	⇧	⇩
			KPIC (PPO)	NDA	37%	44%	⇩	⇧	⇩
			MAMSI (PPO)	NDA	64%	64%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	NDA	64%	64%	⇧	⇧	⇩
Health Assessment Programming	Does the Plan Help Members Address Their Health Risks? [Page 56]	HMO	Aetna (HMO)	NDA	100%	86%	⇩	⇧	⇩
			CareFirst BlueChoice (HMO)	NDA	86%	86%	⇩	⇧	⇩
			Coventry (HMO)	NDA	86%	86%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	NDA	86%	86%	⇩	⇧	⇩
			MD-IPA (HMO)	NDA	100%	100%	⇧	⇧	⇔
			Optimum Choice (HMO)	NDA	100%	100%	⇧	⇧	⇔
			UnitedHealthcare (HMO)	NDA	100%	100%	⇧	⇧	⇔
		PPO	Aetna (PPO)	NDA	100%	86%	⇩	⇧	⇩
			CareFirst CFMI (PPO)	NDA	86%	86%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	86%	86%	⇩	⇧	⇩
			Cigna (PPO)	NDA	100%	100%	⇧	⇧	⇔
			Coventry (PPO)	NDA	86%	86%	⇩	⇧	⇩
			KPIC (PPO)	NDA	86%	86%	⇩	⇧	⇩
			MAMSI (PPO)	NDA	100%	100%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	NDA	100%	100%	⇧	⇧	⇔

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents									
Children and Adolescents Access to Primary Care Providers	1 Primary Care Visit – 12 to 24 Months of Age [Page 58]	HMO	Aetna (HMO)	99%	99%	98%	⇔	⇔	⇩
			CareFirst BlueChoice (HMO)	96%	98%	98%	⇔	⇔	⇩
			Coventry (HMO)	99%	99%	100%	⇧	⇧	⇔
			Kaiser Permanente (HMO)	96%	96%	97%	⇩	⇩	⇩
			MD-IPA (HMO)	99%	98%	97%	⇔	⇔	⇩
			Optimum Choice (HMO)	98%	98%	97%	⇔	⇔	⇩
			UnitedHealthcare (HMO)	100%	98%	NA	NA	NA	NA
		PPO	Aetna (PPO)	98%	99%	98%	⇧	⇧	⇔
			CareFirst CFMI (PPO)	NDA	94%	96%	⇔	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	97%	97%	⇔	⇔	⇩
			Cigna (PPO)	98%	99%	98%	⇧	⇧	⇔
			Coventry (PPO)	100%	100%	96%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	96%	97%	98%	⇔	⇔	⇩
			UnitedHealthcare (PPO)	98%	99%	98%	⇔	⇔	⇔
Children and Adolescents Access to Primary Care Providers	1 Primary Care Visit – 25 Months to 6 Years of Age [Page 59]	HMO	Aetna (HMO)	94%	94%	93%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	90%	94%	94%	⇔	⇧	⇩
			Coventry (HMO)	96%	96%	95%	⇔	⇧	⇩
			Kaiser Permanente (HMO)	91%	90%	92%	⇩	⇔	⇩
			MD-IPA (HMO)	93%	95%	95%	⇔	⇧	⇩
			Optimum Choice (HMO)	93%	94%	94%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	94%	94%	95%	⇧	⇧	⇩
		PPO	Aetna (PPO)	94%	94%	94%	⇧	⇧	⇔
			CareFirst CFMI (PPO)	NDA	90%	91%	⇩	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	92%	91%	⇩	⇧	⇩
			Cigna (PPO)	94%	94%	95%	⇧	⇧	⇔
			Coventry (PPO)	94%	93%	91%	⇩	⇔	⇩
			KPIC (PPO)	NDA	90%	NA	NA	NA	NA
			MAMSI (PPO)	94%	94%	94%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	94%	94%	94%	⇧	⇧	⇔

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Children and Adolescents Access to Primary Care Providers	1 Primary Care Visit – 7 to 11 Years of Age [Page 60]	HMO	Aetna (HMO)	95%	95%	94%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	92%	95%	95%	⇧	⇧	⇩
			Coventry (HMO)	95%	93%	94%	⇔	⇧	⇩
			Kaiser Permanente (HMO)	92%	92%	93%	⇩	⇔	⇩
			MD-IPA (HMO)	95%	95%	94%	⇔	⇧	⇩
			Optimum Choice (HMO)	95%	93%	94%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	92%	94%	95%	⇔	⇧	⇩
		PPO	Aetna (PPO)	94%	95%	95%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	89%	93%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	91%	93%	⇩	⇧	⇩
			Cigna (PPO)	95%	95%	95%	⇔	⇧	⇩
			Coventry (PPO)	93%	95%	95%	⇔	⇧	⇩
			KPIC (PPO)	NDA	92%	100%	⇧	⇧	⇧
			MAMSI (PPO)	98%	96%	95%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	95%	95%	95%	⇔	⇧	⇩
Children and Adolescents Access to Primary Care Providers	1 Primary Care Visit – 12 to 19 Years of Age [Page 61]	HMO	Aetna (HMO)	89%	90%	89%	⇩	⇔	⇩
			CareFirst BlueChoice (HMO)	88%	92%	92%	⇔	⇧	⇩
			Coventry (HMO)	92%	93%	94%	⇧	⇧	⇩
			Kaiser Permanente (HMO)	89%	89%	90%	⇩	⇔	⇩
			MD-IPA (HMO)	91%	92%	92%	⇔	⇧	⇩
			Optimum Choice (HMO)	90%	91%	92%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	92%	92%	93%	⇔	⇧	⇩
		PPO	Aetna (PPO)	90%	91%	92%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	84%	89%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	86%	90%	⇩	⇧	⇩
			Cigna (PPO)	91%	91%	91%	⇔	⇧	⇩
			Coventry (PPO)	90%	93%	93%	⇧	⇧	⇩
			KPIC (PPO)	NDA	93%	89%	⇩	⇧	⇩
			MAMSI (PPO)	96%	94%	93%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	91%	92%	92%	⇔	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Well-Child Visits In the First 15 Months of Life	0 Well-Child Visits – 0 to 15 Months of Age [Page 62] NOTE: For this performance indicator, a lower percentage is better.	HMO	Aetna (HMO)	1%	1%	2%	⇔	⇔	⇧
			CareFirst BlueChoice (HMO)	3%	1%	1%	⇔	⇔	⇧
			Coventry (HMO)	2%	0%	0%	⇧	⇧	⇧
			Kaiser Permanente (HMO)	2%	1%	1%	⇔	⇔	⇧
			MD-IPA (HMO)	0%	0%	1%	⇧	⇔	⇧
			Optimum Choice (HMO)	2%	2%	5%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	0%	2%	3%	⇩	⇩	⇔
		PPO	Aetna (PPO)	1%	1%	1%	⇔	⇧	⇧
			CareFirst CFMI (PPO)	NDA	5%	3%	⇩	⇔	⇧
			CareFirst GHMSI (PPO)	NDA	3%	2%	⇔	⇔	⇧
			Cigna (PPO)	1%	1%	0%	⇧	⇧	⇧
			Coventry (PPO)	1%	1%	2%	⇔	⇔	⇧
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	0%	4%	2%	⇔	⇔	⇧
			UnitedHealthcare (PPO)	1%	1%	1%	⇔	⇧	⇧
Well-Child Visits In the First 15 Months of Life	6+ Well-Child Visits – 0 to 15 Months of Age [Page 63]	HMO	Aetna (HMO)	77%	74%	72%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	81%	84%	84%	⇧	⇧	⇩
			Coventry (HMO)	84%	87%	92%	⇧	⇧	⇧
			Kaiser Permanente (HMO)	82%	83%	83%	⇔	⇧	⇩
			MD-IPA (HMO)	86%	89%	85%	⇧	⇧	⇩
			Optimum Choice (HMO)	80%	86%	83%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	88%	81%	77%	⇩	⇩	⇩
		PPO	Aetna (PPO)	83%	85%	86%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	65%	66%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	69%	62%	⇩	⇩	⇩
			Cigna (PPO)	84%	88%	88%	⇧	⇧	⇧
			Coventry (PPO)	86%	86%	80%	⇔	⇧	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	84%	80%	87%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	86%	88%	85%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Well-Child Visits In the Third, Fourth, Fifth and Sixth Years of Life	1+ Well-Child Visits – 3 to 6 Years of Age [Page 63]	HMO	Aetna (HMO)	80%	80%	79%	⇩	⇧	⇩
			CareFirst BlueChoice (HMO)	75%	80%	82%	⇧	⇧	⇩
			Coventry (HMO)	82%	83%	76%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	77%	77%	81%	⇔	⇧	⇩
			MD-IPA (HMO)	78%	82%	81%	⇔	⇧	⇩
			Optimum Choice (HMO)	77%	79%	81%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	80%	81%	83%	⇧	⇧	⇩
		PPO	Aetna (PPO)	80%	81%	82%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	75%	77%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	81%	80%	⇔	⇧	⇩
			Cigna (PPO)	79%	80%	83%	⇧	⇧	⇩
			Coventry (PPO)	81%	82%	76%	⇩	⇧	⇩
			KPIC (PPO)	NDA	32%	NA	NA	NA	NA
			MAMSI (PPO)	78%	83%	81%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	80%	82%	82%	⇧	⇧	⇩
Childhood Immunization Status	10 Required Immunizations – 2 Years of Age [Page 64]	HMO	Aetna (HMO)	45%	47%	47%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	38%	46%	52%	⇔	⇧	⇩
			Coventry (HMO)	35%	18%	15%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	59%	63%	65%	⇧	⇧	⇧
			MD-IPA (HMO)	34%	54%	58%	⇧	⇧	⇩
			Optimum Choice (HMO)	46%	52%	53%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	59%	65%	68%	⇧	⇧	⇧
		PPO	Aetna (PPO)	51%	49%	50%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	48%	55%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	49%	56%	⇧	⇧	⇔
			Cigna (PPO)	52%	55%	55%	⇧	⇧	⇩
			Coventry (PPO)	33%	23%	2%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	41%	47%	71%	⇧	⇧	⇧
			UnitedHealthcare (PPO)	37%	53%	54%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To 2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Adolescent Well-Care Visits	1+ Well-Care Visits – 12 to 21 Years of Age [Page 67]	HMO	Aetna (HMO)	48%	50%	50%	⇩	⇧	⇩
			CareFirst BlueChoice (HMO)	46%	51%	53%	⇔	⇧	⇩
			Coventry (HMO)	49%	52%	48%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	48%	50%	53%	⇔	⇧	⇩
			MD-IPA (HMO)	50%	52%	53%	⇔	⇧	⇩
			Optimum Choice (HMO)	46%	49%	50%	⇩	⇧	⇩
			UnitedHealthcare (HMO)	49%	54%	60%	⇧	⇧	⇩
		PPO	Aetna (PPO)	50%	52%	54%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	45%	48%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	51%	55%	⇧	⇧	⇩
			Cigna (PPO)	49%	50%	53%	⇧	⇧	⇩
			Coventry (PPO)	50%	54%	49%	⇩	⇧	⇩
			KPIC (PPO)	NDA	50%	47%	⇩	⇧	⇩
			MAMSI (PPO)	56%	57%	53%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	50%	52%	54%	⇧	⇧	⇩
Immunizations for Adolescents	2 Required Immunizations – 13 Years of Age [Page 68]	HMO	Aetna (HMO)	56%	63%	72%	⇩	⇧	⇩
			CareFirst BlueChoice (HMO)	57%	62%	65%	⇩	⇩	⇩
			Coventry (HMO)	49%	64%	73%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	79%	83%	90%	⇧	⇧	⇧
			MD-IPA (HMO)	58%	65%	75%	⇔	⇧	⇩
			Optimum Choice (HMO)	43%	60%	70%	⇩	⇧	⇩
			UnitedHealthcare (HMO)	54%	63%	77%	⇧	⇧	⇩
		PPO	Aetna (PPO)	59%	62%	76%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	59%	70%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	63%	65%	⇩	⇧	⇩
			Cigna (PPO)	59%	65%	73%	⇧	⇧	⇩
			Coventry (PPO)	39%	59%	56%	⇩	⇩	⇩
			KPIC (PPO)	NDA	45%	NA	NA	NA	NA
			MAMSI (PPO)	61%	62%	72%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	51%	64%	74%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To 2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Human Papillomavirus Vaccine for Female Adolescents	Recommended HPV Immunization – 13 Years of Age [Page 69]	HMO	Aetna (HMO)	8%	9%	9%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	6%	10%	11%	⇩	⇩	⇩
			Coventry (HMO)	7%	11%	9%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	10%	17%	31%	⇧	⇧	⇧
			MD-IPA (HMO)	10%	13%	11%	⇩	⇩	⇩
			Optimum Choice (HMO)	8%	11%	10%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	5%	6%	22%	⇧	⇧	⇔
		PPO	Aetna (PPO)	6%	8%	10%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	9%	10%	⇔	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	10%	10%	⇔	⇔	⇩
			Cigna (PPO)	7%	8%	11%	⇔	⇔	⇩
			Coventry (PPO)	5%	6%	9%	⇔	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	7%	0%	9%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	7%	9%	10%	⇔	⇔	⇩
Non-Recommended Cervical Cancer Screening in Adolescent Females	Unnecessary Cervical Cancer Screening – 16 to 20 Years of Age [Page 70]	HMO	Aetna (HMO)	NDA	NDA	6%	⇩	⇔	⇧
			CareFirst BlueChoice (HMO)	NDA	NDA	5%	⇩	⇔	⇧
			Coventry (HMO)	NDA	NDA	4%	⇔	⇧	⇧
			Kaiser Permanente (HMO)	NDA	NDA	1%	⇧	⇧	⇧
			MD-IPA (HMO)	NDA	NDA	4%	⇔	⇔	⇧
			Optimum Choice (HMO)	NDA	NDA	3%	⇧	⇧	⇧
			UnitedHealthcare (HMO)	NDA	NDA	5%	⇩	⇔	⇧
		PPO	Aetna (PPO)	NDA	NDA	4%	⇔	⇔	⇧
			CareFirst CFMI (PPO)	NDA	NDA	4%	⇔	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	NDA	5%	⇔	⇔	⇧
			Cigna (PPO)	NDA	NDA	5%	⇔	⇔	⇧
			Coventry (PPO)	NDA	NDA	5%	⇩	⇔	⇧
	NOTE: For this performance measure, a lower percentage is better.		KPIC (PPO)	NDA	NDA	2%	⇧	⇧	⇧
			MAMSI (PPO)	NDA	NDA	3%	⇔	⇧	⇧
			UnitedHealthcare (PPO)	NDA	NDA	4%	⇔	⇧	⇧

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Body Mass Index – 3 to 17 Years of Age [Page 71]	HMO	Aetna (HMO)	42%	55%	59%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	44%	39%	58%	⇧	⇔	⇩
			Coventry (HMO)	3%	8%	2%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	89%	96%	99%	⇧	⇧	⇧
			MD-IPA (HMO)	45%	54%	59%	⇧	⇔	⇩
			Optimum Choice (HMO)	35%	45%	57%	⇧	⇔	⇩
			UnitedHealthcare (HMO)	41%	42%	57%	⇧	⇔	⇩
		PPO	Aetna (PPO)	48%	52%	64%	⇧	⇧	⇔
			CareFirst CFMI (PPO)	NDA	41%	57%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	43%	61%	⇧	⇧	⇩
			Cigna (PPO)	50%	57%	73%	⇧	⇧	⇧
			Coventry (PPO)	2%	8%	3%	⇩	⇩	⇩
			KPIC (PPO)	NDA	47%	63%	⇧	⇧	⇔
			MAMSI (PPO)	0%	45%	57%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	37%	44%	56%	⇧	⇧	⇩
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Nutrition Counseling – 3 to 17 Years of Age [Page 72]	HMO	Aetna (HMO)	54%	62%	69%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	54%	56%	68%	⇧	⇧	⇩
			Coventry (HMO)	4%	16%	2%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	75%	96%	94%	⇧	⇧	⇧
			MD-IPA (HMO)	54%	66%	60%	⇔	⇧	⇩
			Optimum Choice (HMO)	53%	55%	60%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	54%	63%	65%	⇧	⇧	⇩
		PPO	Aetna (PPO)	55%	65%	68%	⇧	⇧	⇔
			CareFirst CFMI (PPO)	NDA	58%	61%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	51%	70%	⇧	⇧	⇧
			Cigna (PPO)	74%	61%	70%	⇧	⇧	⇧
			Coventry (PPO)	4%	14%	1%	⇩	⇩	⇩
			KPIC (PPO)	NDA	44%	58%	⇧	⇧	⇩
			MAMSI (PPO)	0%	64%	63%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	57%	64%	61%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Physical Activity Counseling – 3 to 17 Years of Age [Page 73]	HMO	Aetna (HMO)	52%	59%	67%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	45%	50%	63%	⇧	⇧	⇩
			Coventry (HMO)	3%	15%	2%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	75%	96%	94%	⇧	⇧	⇧
			MD-IPA (HMO)	50%	58%	55%	⇩	⇧	⇩
			Optimum Choice (HMO)	47%	52%	60%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	50%	62%	63%	⇧	⇧	⇩
		PPO	Aetna (PPO)	48%	60%	66%	⇧	⇧	⇧
			CareFirst CFMI (PPO)	NDA	51%	59%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	44%	65%	⇧	⇧	⇧
			Cigna (PPO)	72%	50%	69%	⇧	⇧	⇧
			Coventry (PPO)	3%	14%	1%	⇩	⇩	⇩
			KPIC (PPO)	NDA	43%	58%	⇧	⇧	⇩
			MAMSI (PPO)	0%	59%	63%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	48%	60%	59%	⇧	⇧	⇩
Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase – 6 to 12 Years of Age [Page 74]	HMO	Aetna (HMO)	32%	35%	40%	⇩	⇔	⇩
			CareFirst BlueChoice (HMO)	34%	34%	33%	⇩	⇩	⇩
			Coventry (HMO)	40%	26%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	26%	54%	61%	⇧	⇧	⇧
			MD-IPA (HMO)	39%	41%	35%	⇩	⇩	⇩
			Optimum Choice (HMO)	33%	29%	39%	⇩	⇔	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	35%	34%	36%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	27%	39%	⇔	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	37%	37%	⇩	⇩	⇩
			Cigna (PPO)	46%	43%	45%	⇧	⇧	⇩
			Coventry (PPO)	30%	39%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	40%	36%	38%	⇩	⇔	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care and Wellness for Children and Adolescents (continued)									
Follow-Up Care for Children Prescribed ADHD Medication	Continuation & Maintenance Phase – 6 to 12 Years of Age [Page 75]	HMO	Aetna (HMO)	32%	42%	58%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	36%	41%	36%	⇩	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	21%	29%	59%	⇧	⇧	⇔
			MD-IPA (HMO)	43%	43%	44%	⇩	⇩	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	44%	38%	41%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	33%	45%	⇔	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	43%	40%	⇩	⇩	⇩
			Cigna (PPO)	52%	49%	58%	⇧	⇧	⇔
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	47%	37%	44%	⇩	⇩	⇩
Child Respiratory Conditions									
Appropriate Testing for Children With Pharyngitis	Group-A Strep Test – 2 to 18 Years of Age [Page 76]	HMO	Aetna (HMO)	83%	88%	90%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	90%	92%	93%	⇧	⇧	⇔
			Coventry (HMO)	85%	89%	89%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	94%	96%	98%	⇧	⇧	⇧
			MD-IPA (HMO)	87%	90%	91%	⇔	⇧	⇩
			Optimum Choice (HMO)	89%	89%	92%	⇔	⇧	⇔
			UnitedHealthcare (HMO)	88%	87%	86%	⇩	⇧	⇩
		PPO	Aetna (PPO)	89%	92%	93%	⇔	⇧	⇧
			CareFirst CFMI (PPO)	NDA	91%	92%	⇩	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	91%	93%	⇔	⇧	⇧
			Cigna (PPO)	90%	91%	93%	⇔	⇧	⇧
			Coventry (PPO)	88%	84%	95%	⇧	⇧	⇧
			KPIC (PPO)	NDA	NA	97%	⇧	⇧	⇧
			MAMSI (PPO)	88%	94%	91%	⇩	⇧	⇧
			UnitedHealthcare (PPO)	91%	92%	93%	⇔	⇧	⇧

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Child Respiratory Conditions (continued)									
Appropriate Treatment for Children With Upper Respiratory Infection	Appropriately Not Prescribed Antibiotics – 3 Months to 18 Years of Age [Page 77]	HMO	Aetna (HMO)	82%	82%	88%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	81%	84%	88%	⇔	⇧	⇩
			Coventry (HMO)	82%	76%	88%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	99%	100%	100%	⇧	⇧	⇧
			MD-IPA (HMO)	80%	85%	88%	⇔	⇧	⇩
			Optimum Choice (HMO)	82%	88%	84%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	81%	82%	87%	⇩	⇧	⇩
		PPO	Aetna (PPO)	84%	87%	90%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	80%	86%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	87%	88%	⇔	⇧	⇩
			Cigna (PPO)	86%	85%	90%	⇧	⇧	⇩
			Coventry (PPO)	76%	81%	88%	⇔	⇧	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	79%	89%	90%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	85%	85%	89%	⇔	⇧	⇩
Use of Appropriate Medications for Children With Asthma	Appropriate Asthma Medications – 5 to 11 Years of Age [Page 78]	HMO	Aetna (HMO)	92%	96%	90%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	95%	97%	96%	⇧	⇔	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	97%	94%	97%	⇧	⇔	⇩
			MD-IPA (HMO)	92%	90%	96%	⇔	⇩	⇩
			Optimum Choice (HMO)	95%	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	93%	95%	94%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	97%	96%	⇔	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	94%	96%	⇔	⇔	⇩
			Cigna (PPO)	93%	96%	97%	⇧	⇧	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	93%	93%	95%	⇔	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Child Respiratory Conditions (continued)									
Use of Appropriate Medications for Children With Asthma	Appropriate Asthma Medications – 12 to 18 Years of Age [Page 80]	HMO	Aetna (HMO)	93%	97%	95%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	92%	92%	93%	⇧	⇔	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	94%	95%	96%	⇧	⇧	⇩
			MD-IPA (HMO)	88%	93%	82%	⇩	⇩	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	96%	91%	86%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	93%	95%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	95%	93%	⇧	⇔	⇩
			Cigna (PPO)	95%	97%	96%	⇧	⇧	⇔
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	91%	95%	90%	⇩	⇩	⇩
Asthma Controller Medication Ratio Among Children	Asthma Controller Medication Ratio ≥50% – 5 to 11 Years of Age [Page 81]	HMO	Aetna (HMO)	NDA	90%	76%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	93%	87%	⇔	⇩	⇩
			Coventry (HMO)	NDA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	NDA	89%	91%	⇧	⇧	⇩
			MD-IPA (HMO)	NDA	88%	89%	⇧	⇔	⇩
			Optimum Choice (HMO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NDA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	NDA	84%	81%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	92%	84%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	86%	83%	⇩	⇩	⇩
			Cigna (PPO)	NDA	91%	92%	⇧	⇧	⇩
			Coventry (PPO)	NDA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	89%	86%	⇧	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Child Respiratory Conditions (continued)									
Asthma Controller Medication Ratio Among Children	Asthma Controller Medication Ratio ≥50% – 12 to 18 Years of Age [Page 82]	HMO	Aetna (HMO)	NDA	80%	70%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	85%	80%	⇧	⇔	⇩
			Coventry (HMO)	NDA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	NDA	78%	80%	⇧	⇧	⇩
			MD-IPA (HMO)	NDA	76%	70%	⇩	⇩	⇩
			Optimum Choice (HMO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NDA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	NDA	73%	66%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	82%	81%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	84%	78%	⇔	⇩	⇩
			Cigna (PPO)	NDA	86%	82%	⇧	⇧	⇩
			Coventry (PPO)	NDA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	84%	85%	⇧	⇧	⇔
Medication Management for Children With Asthma	50% Treatment Compliance – 5 to 11 Years of Age [Page 83]	HMO	Aetna (HMO)	56%	76%	64%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	NR	63%	64%	⇔	⇧	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	58%	71%	72%	⇧	⇧	⇩
			MD-IPA (HMO)	46%	66%	59%	⇩	⇩	⇩
			Optimum Choice (HMO)	57%	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	53%	77%	67%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	64%	80%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	59%	74%	⇧	⇧	⇩
			Cigna (PPO)	56%	62%	58%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	54%	63%	56%	⇩	⇩	⇩

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Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Child Respiratory Conditions (continued)									
Medication Management for Children With Asthma	50% Treatment Compliance – 12 to 18 Years of Age [Page 84]	HMO	Aetna (HMO)	58%	71%	55%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NR	56%	64%	⇧	⇧	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	62%	61%	54%	⇩	⇩	⇩
			MD-IPA (HMO)	48%	49%	60%	⇧	⇔	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	55%	75%	71%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	54%	78%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	56%	75%	⇧	⇧	⇩
			Cigna (PPO)	62%	60%	62%	⇩	⇔	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	56%	64%	57%	⇩	⇩	⇩
Medication Management for Children With Asthma	75% Treatment Compliance – 5 to 11 Years of Age [Page 5]	HMO	Aetna (HMO)	31%	52%	39%	⇩	⇔	⇩
			CareFirst BlueChoice (HMO)	NR	37%	36%	⇩	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	41%	48%	48%	⇧	⇧	⇩
			MD-IPA (HMO)	21%	37%	41%	⇔	⇧	⇩
			Optimum Choice (HMO)	40%	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	32%	60%	47%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	39%	59%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	32%	49%	⇧	⇧	⇩
			Cigna (PPO)	31%	39%	31%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	29%	36%	29%	⇩	⇩	⇩

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Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Child Respiratory Conditions (continued)									
Medication Management for Children With Asthma	75% Treatment Compliance – 12 to 18 Years of Age [Page 86]	HMO	Aetna (HMO)	31%	52%	28%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NR	31%	36%	⇧	⇔	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	40%	37%	32%	⇩	⇩	⇩
			MD-IPA (HMO)	23%	21%	35%	⇧	⇔	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	32%	54%	38%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	35%	54%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	35%	56%	⇧	⇧	⇩
			Cigna (PPO)	40%	42%	35%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	28%	39%	38%	⇩	⇔	⇩
Women's Health									
Prenatal and Postpartum Care	Timely Prenatal Care – 1st Trimester of Pregnancy or 0 to 42 Days of Enrollment [Page 88]	HMO	Aetna (HMO)	89%	88%	89%	⇧	⇩	⇩
			CareFirst BlueChoice (HMO)	88%	76%	80%	⇩	⇩	⇩
			Coventry (HMO)	82%	63%	51%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	90%	93%	95%	⇧	⇧	⇩
			MD-IPA (HMO)	88%	80%	81%	⇔	⇩	⇩
			Optimum Choice (HMO)	87%	85%	85%	⇧	⇩	⇩
			UnitedHealthcare (HMO)	96%	74%	88%	⇧	⇩	⇩
		PPO	Aetna (PPO)	89%	92%	89%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	82%	84%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	81%	76%	⇩	⇩	⇩
			Cigna (PPO)	95%	95%	93%	⇧	⇧	⇩
			Coventry (PPO)	86%	55%	52%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	96%	81%	90%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	91%	87%	86%	⇧	⇧	⇩

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Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Women's Health (continued)									
Prenatal and Postpartum Care	Timely Postpartum Care – 21 to 56 Days After Delivery [Page 89]	HMO	Aetna (HMO)	77%	76%	74%	⇧	⇩	⇩
			CareFirst BlueChoice (HMO)	73%	37%	65%	⇩	⇩	⇩
			Coventry (HMO)	76%	54%	27%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	82%	92%	90%	⇧	⇧	⇔
			MD-IPA (HMO)	79%	61%	71%	⇧	⇩	⇩
			Optimum Choice (HMO)	77%	73%	76%	⇧	⇩	⇩
			UnitedHealthcare (HMO)	82%	71%	78%	⇧	⇩	⇩
		PPO	Aetna (PPO)	75%	76%	72%	⇧	⇔	⇩
			CareFirst CFMI (PPO)	NDA	65%	73%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	64%	34%	⇩	⇩	⇩
			Cigna (PPO)	80%	82%	85%	⇧	⇧	⇩
			Coventry (PPO)	77%	48%	27%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	81%	75%	75%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	82%	69%	71%	⇧	⇔	⇩
Breast Cancer Screening	1+ Mammogram – 52 to 74 Years of Age [Page 890]	HMO	Aetna (HMO)	70%	72%	70%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	67%	71%	71%	⇔	⇩	⇩
			Coventry (HMO)	69%	73%	68%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	85%	89%	89%	⇧	⇧	⇧
			MD-IPA (HMO)	68%	67%	62%	⇩	⇩	⇩
			Optimum Choice (HMO)	63%	67%	67%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	67%	72%	67%	⇩	⇩	⇩
		PPO	Aetna (PPO)	67%	70%	70%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	72%	72%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	72%	71%	⇔	⇧	⇩
			Cigna (PPO)	66%	68%	68%	⇩	⇩	⇩
			Coventry (PPO)	67%	74%	69%	⇩	⇔	⇩
			KPIC (PPO)	NDA	72%	75%	⇧	⇧	⇩
			MAMSI (PPO)	71%	73%	72%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	69%	69%	68%	⇩	⇩	⇩

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Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Women's Health (continued)									
Cervical Cancer Screening	1+ Cervical Cancer Screening – 21 to 64 Years of Age [Page 91]	HMO	Aetna (HMO)	NDA	78%	77%	⇩	⇔	⇩
			CareFirst BlueChoice (HMO)	NDA	75%	74%	⇩	⇩	⇩
			Coventry (HMO)	NDA	77%	75%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	92%	94%	⇧	⇧	⇧
			MD-IPA (HMO)	NDA	79%	82%	⇧	⇧	⇩
			Optimum Choice (HMO)	NDA	75%	77%	⇩	⇔	⇩
			UnitedHealthcare (HMO)	NDA	77%	74%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	77%	78%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	70%	66%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	76%	69%	⇩	⇩	⇩
			Cigna (PPO)	NDA	77%	80%	⇧	⇧	⇔
			Coventry (PPO)	NDA	76%	71%	⇩	⇩	⇩
			KPIC (PPO)	NDA	85%	80%	⇧	⇧	⇔
			MAMSI (PPO)	NDA	79%	83%	⇧	⇧	⇧
			UnitedHealthcare (PPO)	NDA	75%	81%	⇧	⇧	⇔
Chlamydia Screening	1+ Chlamydia Screening – 16 to 24 Years of Age [Page 92]	HMO	Aetna (HMO)	52%	52%	51%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	49%	49%	50%	⇩	⇧	⇩
			Coventry (HMO)	51%	44%	45%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	73%	75%	71%	⇧	⇧	⇧
			MD-IPA (HMO)	49%	48%	49%	⇩	⇧	⇩
			Optimum Choice (HMO)	51%	50%	51%	⇩	⇧	⇩
			UnitedHealthcare (HMO)	42%	47%	48%	⇩	⇧	⇩
		PPO	Aetna (PPO)	48%	48%	48%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	49%	47%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	47%	46%	⇩	⇧	⇩
			Cigna (PPO)	52%	53%	53%	⇧	⇧	⇩
			Coventry (PPO)	41%	44%	40%	⇩	⇩	⇩
			KPIC (PPO)	NDA	60%	46%	⇔	⇧	⇩
			MAMSI (PPO)	42%	43%	44%	⇩	⇧	⇩
			UnitedHealthcare (PPO)	51%	52%	51%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — General Health									
Adult's Access to Preventive/ Ambulatory Health Services	1+ Outpatient Visits – 20 to 44 Years of Age [Page 94]	HMO	Aetna (HMO)	93%	93%	92%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	94%	94%	94%	⇧	⇔	⇩
			Coventry (HMO)	90%	91%	91%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	93%	92%	92%	⇔	⇔	⇩
			MD-IPA (HMO)	92%	91%	90%	⇩	⇩	⇩
			Optimum Choice (HMO)	92%	93%	92%	⇔	⇔	⇩
			UnitedHealthcare (HMO)	94%	94%	94%	⇧	⇔	⇩
		PPO	Aetna (PPO)	93%	93%	93%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	92%	92%	⇔	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	92%	92%	⇔	⇔	⇩
			Cigna (PPO)	94%	94%	94%	⇔	⇧	⇩
			Coventry (PPO)	90%	91%	90%	⇩	⇩	⇩
			KPIC (PPO)	NDA	88%	92%	⇔	⇔	⇩
			MAMSI (PPO)	93%	94%	95%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	94%	94%	94%	⇔	⇧	⇔
Adult's Access to Preventive/ Ambulatory Health Services	1+ Outpatient Visits – 45 to 64 Years of Age [Page 5]	HMO	Aetna (HMO)	96%	96%	96%	⇔	⇔	⇩
			CareFirst BlueChoice (HMO)	96%	96%	96%	⇧	⇔	⇩
			Coventry (HMO)	94%	95%	94%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	96%	96%	96%	⇔	⇔	⇩
			MD-IPA (HMO)	96%	96%	96%	⇔	⇔	⇩
			Optimum Choice (HMO)	95%	95%	95%	⇔	⇔	⇩
			UnitedHealthcare (HMO)	95%	95%	95%	⇔	⇔	⇩
		PPO	Aetna (PPO)	96%	96%	96%	⇔	⇧	⇔
			CareFirst CFMI (PPO)	NDA	96%	96%	⇔	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	96%	96%	⇔	⇧	⇔
			Cigna (PPO)	96%	96%	96%	⇔	⇔	⇔
			Coventry (PPO)	95%	94%	94%	⇩	⇩	⇩
			KPIC (PPO)	NDA	92%	97%	⇔	⇧	⇔
			MAMSI (PPO)	97%	97%	96%	⇔	⇔	⇔
			UnitedHealthcare (PPO)	96%	97%	97%	⇔	⇧	⇔

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — General Health (continued)									
Adult's Access to Preventive/ Ambulatory Health Services	1+ Outpatient Visits – 65+ Years of Age [Page 96]	HMO	Aetna (HMO)	98%	98%	97%	⇔	⇔	⇩
			CareFirst BlueChoice (HMO)	97%	96%	97%	⇔	⇔	⇩
			Coventry (HMO)	97%	96%	95%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	97%	97%	97%	⇔	⇔	⇩
			MD-IPA (HMO)	98%	98%	98%	⇧	⇧	⇔
			Optimum Choice (HMO)	97%	98%	98%	⇔	⇔	⇩
			UnitedHealthcare (HMO)	95%	95%	97%	⇔	⇔	⇩
		PPO	Aetna (PPO)	97%	97%	97%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	89%	90%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	96%	96%	⇔	⇔	⇩
			Cigna (PPO)	97%	98%	97%	⇔	⇔	⇔
			Coventry (PPO)	98%	100%	97%	⇔	⇔	⇩
			KPIC (PPO)	NDA	93%	94%	⇩	⇩	⇩
			MAMSI (PPO)	97%	98%	100%	⇧	⇧	⇧
			UnitedHealthcare (PPO)	98%	98%	98%	⇧	⇧	⇔
Adult Body Mass Index (BMI) Assessment	Body Mass Index – 18 to 74 Years of Age [Page 97]	HMO	Aetna (HMO)	61%	65%	70%	⇧	⇩	⇩
			CareFirst BlueChoice (HMO)	45%	66%	73%	⇧	⇩	⇩
			Coventry (HMO)	6%	8%	9%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	93%	95%	98%	⇧	⇧	⇧
			MD-IPA (HMO)	58%	64%	69%	⇧	⇩	⇩
			Optimum Choice (HMO)	62%	67%	69%	⇧	⇩	⇩
			UnitedHealthcare (HMO)	56%	62%	68%	⇧	⇩	⇩
		PPO	Aetna (PPO)	56%	62%	69%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	62%	34%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	59%	58%	⇧	⇧	⇩
			Cigna (PPO)	52%	64%	76%	⇧	⇧	⇩
			Coventry (PPO)	7%	5%	8%	⇩	⇩	⇩
			KPIC (PPO)	NDA	66%	72%	⇧	⇧	⇩
			MAMSI (PPO)	2%	63%	69%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	55%	64%	65%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — General Health (continued)									
Colorectal Cancer Screening	1+ Colorectal Cancer Screening – 50 to 75 Years of Age [Page 98]	HMO	Aetna (HMO)	66%	69%	72%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	50%	55%	55%	⇩	⇩	⇩
			Coventry (HMO)	49%	49%	53%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	75%	80%	82%	⇧	⇧	⇧
			MD-IPA (HMO)	74%	73%	75%	⇧	⇧	⇔
			Optimum Choice (HMO)	60%	61%	59%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	52%	55%	57%	⇩	⇩	⇩
		PPO	Aetna (PPO)	64%	60%	57%	⇩	⇔	⇩
			CareFirst CFMI (PPO)	NDA	63%	61%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	66%	64%	⇧	⇧	⇔
			Cigna (PPO)	65%	58%	56%	⇩	⇔	⇩
			Coventry (PPO)	41%	46%	48%	⇩	⇩	⇩
			KPIC (PPO)	NDA	66%	65%	⇧	⇧	⇔
			MAMSI (PPO)	62%	61%	59%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	59%	68%	63%	⇧	⇧	⇩
Primary Care for Adults — Respiratory Conditions									
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Appropriately Not Given Antibiotics – 18 to 64 Years of Age [Page 100]	HMO	Aetna (HMO)	18%	17%	20%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	19%	22%	21%	⇩	⇩	⇩
			Coventry (HMO)	18%	18%	21%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	66%	53%	66%	⇧	⇧	⇧
			MD-IPA (HMO)	17%	17%	22%	⇩	⇩	⇩
			Optimum Choice (HMO)	16%	19%	20%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	21%	23%	26%	⇩	⇔	⇩
		PPO	Aetna (PPO)	22%	24%	21%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	21%	21%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	23%	27%	⇧	⇧	⇩
			Cigna (PPO)	20%	21%	22%	⇔	⇩	⇩
			Coventry (PPO)	18%	15%	24%	⇔	⇔	⇩
			KPIC (PPO)	NDA	26%	NA	NA	NA	NA
			MAMSI (PPO)	15%	23%	19%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	19%	23%	25%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Respiratory Conditions (continued)									
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	Spirometry Test – 40+ Years of Age [Page 101]	HMO	Aetna (HMO)	43%	47%	48%	⇔	⇧	⇩
			CareFirst BlueChoice (HMO)	45%	45%	44%	⇩	⇧	⇩
			Coventry (HMO)	39%	32%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	59%	72%	79%	⇧	⇧	⇧
			MD-IPA (HMO)	49%	41%	38%	⇩	⇩	⇩
			Optimum Choice (HMO)	49%	38%	28%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	45%	47%	45%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	44%	43%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	55%	50%	⇧	⇧	⇧
			Cigna (PPO)	42%	46%	42%	⇔	⇔	⇩
			Coventry (PPO)	NA	NA	29%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	43%	45%	42%	⇔	⇧	⇩
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation	Systemic Corticosteroid Within 14 Days – 40+ Years of Age [Page 102]	HMO	Aetna (HMO)	77%	71%	81%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	81%	81%	80%	⇧	⇧	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	67%	71%	80%	⇧	⇧	⇩
			MD-IPA (HMO)	66%	69%	76%	⇔	⇔	⇩
			Optimum Choice (HMO)	NA	70%	59%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	NA	69%	69%	⇧	⇩	⇩
			CareFirst CFMI (PPO)	NDA	69%	65%	⇔	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	72%	53%	⇩	⇩	⇩
			Cigna (PPO)	55%	73%	61%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	67%	71%	77%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Respiratory Conditions (continued)									
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation	Bronchodilator Within 30 Days – 40+ Years of Age [Page 103]	HMO	Aetna (HMO)	80%	82%	82%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	82%	76%	76%	⇩	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	74%	85%	89%	⇧	⇧	⇧
			MD-IPA (HMO)	82%	89%	73%	⇩	⇩	⇩
			Optimum Choice (HMO)	NA	70%	74%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	NA	80%	87%	⇧	⇧	⇧
			CareFirst CFMI (PPO)	NDA	75%	73%	⇔	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	77%	65%	⇩	⇩	⇩
			Cigna (PPO)	72%	81%	73%	⇔	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	73%	82%	68%	⇩	⇩	⇩
Use of Appropriate Medications for Adults With Asthma	Appropriate Asthma Medications – 19 to 50 Years of Age [Page 104]	HMO	Aetna (HMO)	86%	89%	86%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	89%	90%	91%	⇧	⇧	⇩
			Coventry (HMO)	87%	85%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	94%	93%	94%	⇧	⇧	⇔
			MD-IPA (HMO)	85%	89%	86%	⇩	⇩	⇩
			Optimum Choice (HMO)	84%	80%	77%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	93%	97%	NA	NA	NA	NA
		PPO	Aetna (PPO)	90%	91%	88%	⇩	⇧	⇩
			CareFirst CFMI (PPO)	NDA	91%	92%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	92%	92%	⇧	⇧	⇔
			Cigna (PPO)	92%	91%	92%	⇧	⇧	⇔
			Coventry (PPO)	88%	87%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	91%	86%	85%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Respiratory Conditions (continued)									
Use of Appropriate Medications for Adults With Asthma	Appropriate Asthma Medications – 51 to 64 Years of Age [Page 105]	HMO	Aetna (HMO)	93%	93%	91%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	94%	94%	93%	⇧	⇔	⇩
			Coventry (HMO)	94%	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	96%	95%	97%	⇧	⇧	⇔
			MD-IPA (HMO)	93%	91%	90%	⇩	⇩	⇩
			Optimum Choice (HMO)	92%	85%	88%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	97%	96%	97%	⇧	⇧	⇧
			CareFirst CFMI (PPO)	NDA	93%	95%	⇔	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	95%	95%	⇔	⇧	⇔
			Cigna (PPO)	94%	95%	95%	⇔	⇧	⇔
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	94%	92%	93%	⇩	⇧	⇩
Asthma Medication Ratio	Asthma Controller Medication Ratio ≥50% – 19 to 50 Years of Age [Page 106]	HMO	Aetna (HMO)	NDA	77%	73%	⇧	⇔	⇩
			CareFirst BlueChoice (HMO)	NDA	76%	78%	⇧	⇧	⇩
			Coventry (HMO)	NDA	70%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	NDA	68%	70%	⇔	⇩	⇩
			MD-IPA (HMO)	NDA	76%	78%	⇧	⇧	⇩
			Optimum Choice (HMO)	NDA	60%	54%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	80%	NA	NA	NA	NA
		PPO	Aetna (PPO)	NDA	74%	74%	⇩	⇧	⇩
			CareFirst CFMI (PPO)	NDA	81%	79%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	82%	84%	⇧	⇧	⇧
			Cigna (PPO)	NDA	81%	80%	⇧	⇧	⇔
			Coventry (PPO)	NDA	72%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	72%	65%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Respiratory Conditions (continued)									
Asthma Medication Ratio	Asthma Controller Medication Ratio ≥50% – 51 to 64 Years of Age [Page 107]	HMO	Aetna (HMO)	NDA	84%	74%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	89%	82%	⇧	⇔	⇩
			Coventry (HMO)	NDA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	NDA	77%	79%	⇔	⇩	⇩
			MD-IPA (HMO)	NDA	89%	82%	⇧	⇩	⇩
			Optimum Choice (HMO)	NDA	82%	74%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	NDA	86%	86%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	88%	85%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	89%	88%	⇧	⇧	⇔
			Cigna (PPO)	NDA	85%	84%	⇩	⇧	⇩
			Coventry (PPO)	NDA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	84%	84%	⇩	⇔	⇩
Medication Management for Adults With Asthma	50% Treatment Compliance – 19 to 50 Years of Age [Page 108]	HMO	Aetna (HMO)	69%	79%	77%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	NR	71%	71%	⇧	⇧	⇩
			Coventry (HMO)	69%	72%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	60%	63%	60%	⇩	⇩	⇩
			MD-IPA (HMO)	67%	66%	70%	⇧	⇧	⇩
			Optimum Choice (HMO)	57%	56%	59%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	68%	84%	76%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	71%	85%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	71%	84%	⇧	⇧	⇔
			Cigna (PPO)	72%	67%	66%	⇩	⇩	⇩
			Coventry (PPO)	53%	65%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	67%	70%	66%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Respiratory Conditions (continued)									
Medication Management for Adults With Asthma	50% Treament Compliance – 51 to 64 Years of Age [Page 109]	HMO	Aetna (HMO)	77%	87%	77%	⇧	⇔	⇩
			CareFirst BlueChoice (HMO)	NR	81%	81%	⇧	⇧	⇩
			Coventry (HMO)	68%	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	69%	72%	70%	⇩	⇩	⇩
			MD-IPA (HMO)	78%	75%	76%	⇔	⇩	⇩
			Optimum Choice (HMO)	82%	74%	73%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	80%	86%	83%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	83%	91%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	79%	89%	⇧	⇧	⇩
			Cigna (PPO)	74%	70%	74%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	82%	80%	78%	⇩	⇩	⇩
Medication Management for Adults With Asthma	75% Treatment Compliance – 19 to 50 Years of Age [Page 110]	HMO	Aetna (HMO)	43%	65%	57%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	NR	46%	47%	⇔	⇧	⇩
			Coventry (HMO)	44%	44%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	41%	41%	39%	⇩	⇩	⇩
			MD-IPA (HMO)	42%	41%	46%	⇔	⇧	⇩
			Optimum Choice (HMO)	36%	38%	41%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	43%	65%	52%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	48%	69%	⇧	⇧	⇔
			CareFirst GHMSI (PPO)	NDA	46%	65%	⇧	⇧	⇩
			Cigna (PPO)	43%	41%	40%	⇩	⇩	⇩
			Coventry (PPO)	39%	48%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	43%	44%	39%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To 2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Respiratory Conditions (continued)									
Medication Management for Adults With Asthma	75% Treatment Compliance – 51 to 64 Years of Age [Page 111]	HMO	Aetna (HMO)	54%	70%	62%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	NR	57%	57%	⇔	⇔	⇩
			Coventry (HMO)	48%	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	50%	50%	48%	⇩	⇩	⇩
			MD-IPA (HMO)	49%	52%	53%	⇩	⇩	⇩
			Optimum Choice (HMO)	73%	56%	67%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	59%	73%	65%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	64%	80%	⇧	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	60%	75%	⇧	⇧	⇩
			Cigna (PPO)	52%	54%	54%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	59%	56%	58%	⇩	⇩	⇩
Primary Care for Adults — Cardiovascular Conditions and Diabetes									
Controlling High Blood Pressure	Adequate Blood Pressure Control (Cardiovascular) – 18 to 85 Years of Age [Page 113]	HMO	Aetna (HMO)	NDA	NDA	53%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	NDA	NR	NR	NR	NR
			Coventry (HMO)	NDA	NDA	66%	⇧	⇧	⇩
			Kaiser Permanente (HMO)	NDA	NDA	90%	⇧	⇧	⇧
			MD-IPA (HMO)	NDA	NDA	50%	⇩	⇩	⇩
			Optimum Choice (HMO)	NDA	NDA	53%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	NDA	49%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	NDA	59%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	NDA	NR	NR	NR	NR
			CareFirst GHMSI (PPO)	NDA	NDA	NR	NR	NR	NR
			Cigna (PPO)	NDA	NDA	58%	⇔	⇔	⇩
			Coventry (PPO)	NDA	NDA	68%	⇧	⇧	⇔
			KPIC (PPO)	NDA	NDA	69%	⇧	⇧	⇧
			MAMSI (PPO)	NDA	NDA	51%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	NDA	NDA	48%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Cardiovascular Conditions and Diabetes (continued)									
Persistence of Beta Blocker Treatment After a Heart Attack	Beta-Blocker For 6 Months After Discharge – 18+ Years of Age [Page 114]	HMO	Aetna (HMO)	85%	90%	90%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	86%	86%	83%	⇩	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	82%	74%	91%	⇧	⇧	⇔
			MD-IPA (HMO)	81%	88%	89%	⇧	⇧	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	79%	89%	85%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	81%	83%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	84%	85%	⇔	⇧	⇩
			Cigna (PPO)	83%	93%	82%	⇩	⇔	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	84%	87%	88%	⇧	⇧	⇩
Comprehensive Diabetes Care	HbA1c Testing (Diabetes) – 18 to 75 Years of Age [Page 115]	HMO	Aetna (HMO)	85%	82%	84%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	83%	86%	87%	⇔	⇩	⇩
			Coventry (HMO)	87%	86%	88%	⇔	⇩	⇩
			Kaiser Permanente (HMO)	94%	95%	96%	⇧	⇧	⇧
			MD-IPA (HMO)	87%	85%	84%	⇩	⇩	⇩
			Optimum Choice (HMO)	88%	87%	88%	⇔	⇩	⇩
			UnitedHealthcare (HMO)	86%	85%	86%	⇩	⇩	⇩
		PPO	Aetna (PPO)	88%	86%	86%	⇔	⇩	⇩
			CareFirst CFMI (PPO)	NDA	90%	86%	⇔	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	87%	86%	⇔	⇩	⇩
			Cigna (PPO)	92%	86%	87%	⇔	⇔	⇩
			Coventry (PPO)	84%	84%	88%	⇧	⇔	⇩
			KPIC (PPO)	NDA	92%	79%	⇩	⇩	⇩
			MAMSI (PPO)	86%	86%	88%	⇧	⇔	⇩
			UnitedHealthcare (PPO)	86%	87%	87%	⇧	⇔	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Cardiovascular Conditions and Diabetes (continued)									
Comprehensive Diabetes Care	Poor HbA1c Control (Diabetes) >9.0% – 18 to 75 Years of Age [Page 116] NOTE: For this performance indicator, a lower percentage is better.	HMO	Aetna (HMO)	34%	38%	37%	⇩	⇩	⇧
			CareFirst BlueChoice (HMO)	51%	55%	33%	⇩	⇩	⇧
			Coventry (HMO)	28%	29%	26%	⇧	⇧	⇧
			Kaiser Permanente (HMO)	25%	22%	22%	⇧	⇧	⇧
			MD-IPA (HMO)	29%	31%	33%	⇩	⇩	⇧
			Optimum Choice (HMO)	30%	33%	31%	⇧	⇔	⇧
			UnitedHealthcare (HMO)	30%	34%	41%	⇩	⇩	⇔
		PPO	Aetna (PPO)	37%	36%	33%	⇔	⇧	⇧
			CareFirst CFMI (PPO)	NDA	49%	38%	⇩	⇔	⇧
			CareFirst GHMSI (PPO)	NDA	58%	33%	⇔	⇧	⇧
			Cigna (PPO)	25%	32%	31%	⇧	⇧	⇧
			Coventry (PPO)	36%	39%	30%	⇧	⇧	⇧
			KPIC (PPO)	NDA	27%	38%	⇩	⇔	⇧
			MAMSI (PPO)	33%	35%	33%	⇔	⇧	⇧
			UnitedHealthcare (PPO)	29%	35%	32%	⇧	⇧	⇧
Comprehensive Diabetes Care	Good HbA1c Control (Diabetes) <8.0% – 18 to 75 Years of Age [Page 117]	HMO	Aetna (HMO)	58%	54%	54%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	42%	38%	56%	⇩	⇩	⇩
			Coventry (HMO)	62%	60%	64%	⇧	⇧	⇩
			Kaiser Permanente (HMO)	61%	63%	62%	⇧	⇧	⇩
			MD-IPA (HMO)	61%	60%	58%	⇔	⇔	⇩
			Optimum Choice (HMO)	61%	57%	58%	⇧	⇔	⇩
			UnitedHealthcare (HMO)	59%	57%	47%	⇩	⇩	⇩
		PPO	Aetna (PPO)	55%	55%	56%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	44%	49%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	33%	54%	⇔	⇧	⇩
			Cigna (PPO)	64%	58%	58%	⇧	⇧	⇩
			Coventry (PPO)	52%	53%	60%	⇧	⇧	⇩
			KPIC (PPO)	NDA	66%	49%	⇩	⇩	⇩
			MAMSI (PPO)	59%	53%	54%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	61%	58%	57%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Cardiovascular Conditions and Diabetes (continued)									
Comprehensive Diabetes Care	Tight HbA1c Control (Diabetes) <7.0% – 18 to 75 Years of Age [Page 118]	HMO	Aetna (HMO)	44%	35%	39%	⇧	⇩	⇩
			CareFirst BlueChoice (HMO)	36%	33%	39%	⇧	⇔	⇩
			Coventry (HMO)	NR	41%	39%	⇧	⇔	⇩
			Kaiser Permanente (HMO)	37%	38%	35%	⇩	⇩	⇩
			MD-IPA (HMO)	42%	40%	39%	⇧	⇔	⇩
			Optimum Choice (HMO)	39%	37%	34%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	46%	40%	32%	⇩	⇩	⇩
		PPO	Aetna (PPO)	38%	40%	36%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	36%	32%	⇩	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	27%	38%	⇧	⇧	⇩
			Cigna (PPO)	43%	43%	36%	⇔	⇧	⇩
			Coventry (PPO)	37%	37%	39%	⇧	⇧	⇩
			KPIC (PPO)	NDA	56%	31%	⇩	⇩	⇩
			MAMSI (PPO)	40%	33%	35%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	44%	45%	35%	⇔	⇧	⇩
Comprehensive Diabetes Care	Dilated Eye Exam – Retina (Diabetes) – 18 to 75 Years of Age [Page 119]	HMO	Aetna (HMO)	61%	60%	62%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	42%	48%	47%	⇩	⇩	⇩
			Coventry (HMO)	49%	52%	52%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	75%	81%	82%	⇧	⇧	⇧
			MD-IPA (HMO)	58%	56%	59%	⇧	⇧	⇩
			Optimum Choice (HMO)	46%	44%	47%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	41%	46%	45%	⇩	⇩	⇩
		PPO	Aetna (PPO)	54%	50%	54%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	52%	53%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	51%	58%	⇧	⇧	⇔
			Cigna (PPO)	52%	48%	47%	⇩	⇔	⇩
			Coventry (PPO)	40%	46%	47%	⇩	⇔	⇩
			KPIC (PPO)	NDA	67%	63%	⇧	⇧	⇧
			MAMSI (PPO)	46%	48%	51%	⇩	⇧	⇩
			UnitedHealthcare (PPO)	52%	54%	56%	⇧	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Cardiovascular Conditions and Diabetes (continued)									
Comprehensive Diabetes Care	Medical Attention for Nephropathy (Diabetes) – 18 to 75 Years of Age [Page 120]	HMO	Aetna (HMO)	84%	84%	84%	⇔	⇔	⇩
			CareFirst BlueChoice (HMO)	74%	84%	83%	⇩	⇩	⇩
			Coventry (HMO)	82%	82%	82%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	94%	96%	97%	⇧	⇧	⇧
			MD-IPA (HMO)	85%	86%	85%	⇔	⇔	⇩
			Optimum Choice (HMO)	86%	76%	80%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	80%	82%	82%	⇩	⇩	⇩
		PPO	Aetna (PPO)	77%	78%	82%	⇩	⇧	⇩
			CareFirst CFMI (PPO)	NDA	80%	83%	⇩	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	81%	88%	⇧	⇧	⇧
			Cigna (PPO)	87%	83%	81%	⇩	⇧	⇩
			Coventry (PPO)	81%	81%	83%	⇩	⇧	⇩
			KPIC (PPO)	NDA	90%	98%	⇧	⇧	⇧
			MAMSI (PPO)	81%	83%	83%	⇩	⇧	⇩
			UnitedHealthcare (PPO)	79%	76%	77%	⇩	⇩	⇩
Comprehensive Diabetes Care	Good Blood Pressure Control <140/90 mm Hg (Diabetes) – 18 to 75 Years of Age [Page 121]	HMO	Aetna (HMO)	55%	46%	47%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	52%	52%	62%	⇧	⇩	⇩
			Coventry (HMO)	62%	66%	64%	⇧	⇩	⇩
			Kaiser Permanente (HMO)	77%	81%	87%	⇧	⇧	⇧
			MD-IPA (HMO)	59%	46%	53%	⇩	⇩	⇩
			Optimum Choice (HMO)	58%	54%	56%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	61%	59%	52%	⇩	⇩	⇩
		PPO	Aetna (PPO)	61%	52%	54%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	56%	61%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	40%	54%	⇩	⇩	⇩
			Cigna (PPO)	78%	65%	65%	⇧	⇧	⇩
			Coventry (PPO)	59%	60%	68%	⇧	⇧	⇩
			KPIC (PPO)	NDA	71%	59%	⇔	⇔	⇩
			MAMSI (PPO)	55%	53%	52%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	61%	50%	56%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Musculoskeletal Disease and Medication Management									
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	DMARD Therapy – 18+ Years of Age [Page 122]	HMO	Aetna (HMO)	84%	81%	84%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	85%	86%	88%	⇧	⇔	⇩
			Coventry (HMO)	90%	85%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	89%	88%	90%	⇧	⇧	⇩
			MD-IPA (HMO)	86%	85%	85%	⇔	⇩	⇩
			Optimum Choice (HMO)	85%	78%	77%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	88%	84%	89%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	83%	82%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	85%	79%	⇩	⇩	⇩
			Cigna (PPO)	84%	90%	84%	⇔	⇩	⇩
			Coventry (PPO)	95%	86%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	85%	84%	89%	⇧	⇧	⇩
Use of Imaging Studies for Low Back Pain	No Imaging Within 28 Days After Diagnosis – 18 to 50 Years of Age [Page 123]	HMO	Aetna (HMO)	74%	71%	69%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	70%	70%	69%	⇩	⇩	⇩
			Coventry (HMO)	73%	73%	74%	⇔	⇩	⇩
			Kaiser Permanente (HMO)	83%	83%	83%	⇧	⇧	⇔
			MD-IPA (HMO)	79%	83%	78%	⇧	⇧	⇩
			Optimum Choice (HMO)	79%	77%	77%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	71%	71%	63%	⇩	⇩	⇩
		PPO	Aetna (PPO)	71%	70%	72%	⇔	⇩	⇩
			CareFirst CFMI (PPO)	NDA	69%	72%	⇔	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	69%	70%	⇩	⇩	⇩
			Cigna (PPO)	71%	70%	71%	⇔	⇩	⇩
			Coventry (PPO)	71%	77%	76%	⇧	⇧	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	71%	66%	70%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	70%	71%	72%	⇔	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To 2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Musculoskeletal Disease and Medication Management (continued)									
Annual Monitoring for Patients on Persistent Medications	ACE Inhibitors or ARBs – 18+ Years of Age [Page 124]	HMO	Aetna (HMO)	81%	82%	81%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	82%	84%	85%	⇧	⇧	⇩
			Coventry (HMO)	80%	81%	81%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	89%	91%	89%	⇧	⇧	⇧
			MD-IPA (HMO)	81%	80%	80%	⇩	⇩	⇩
			Optimum Choice (HMO)	84%	84%	85%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	84%	82%	80%	⇩	⇩	⇩
		PPO	Aetna (PPO)	82%	82%	82%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	73%	87%	⇧	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	79%	84%	⇧	⇧	⇔
			Cigna (PPO)	79%	83%	82%	⇔	⇧	⇩
			Coventry (PPO)	77%	80%	81%	⇔	⇔	⇩
			KPIC (PPO)	NDA	86%	72%	⇩	⇩	⇩
			MAMSI (PPO)	80%	81%	81%	⇔	⇔	⇩
			UnitedHealthcare (PPO)	81%	82%	82%	⇔	⇧	⇩
Annual Monitoring for Patients on Persistent Medications	Digoxin – 18+ Years of Age [Page 125]	HMO	Aetna (HMO)	89%	85%	36%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	83%	88%	41%	⇩	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	98%	98%	93%	⇧	⇧	⇩
			MD-IPA (HMO)	81%	78%	38%	⇩	⇩	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	79%	76%	37%	⇔	⇩	⇩
			CareFirst CFMI (PPO)	NDA	77%	42%	⇧	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	88%	37%	⇔	⇩	⇩
			Cigna (PPO)	77%	83%	35%	⇩	⇩	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	84%	84%	38%	⇔	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To 2015 MAB	2015 NAB	2015 NTP
Primary Care for Adults — Musculoskeletal Disease and Medication Management (continued)									
Annual Monitoring for Patients on Persistent Medications	Diuretics – 18+ Years of Age [Page 126]	HMO	Aetna (HMO)	81%	81%	81%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	82%	84%	84%	⇧	⇧	⇩
			Coventry (HMO)	80%	80%	77%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	83%	89%	87%	⇧	⇧	⇔
			MD-IPA (HMO)	81%	80%	79%	⇩	⇩	⇩
			Optimum Choice (HMO)	83%	83%	85%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	83%	80%	78%	⇩	⇩	⇩
		PPO	Aetna (PPO)	81%	82%	81%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	74%	87%	⇧	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	78%	84%	⇧	⇧	⇔
			Cigna (PPO)	79%	82%	82%	⇧	⇧	⇩
			Coventry (PPO)	76%	79%	79%	⇩	⇩	⇩
			KPIC (PPO)	NDA	85%	72%	⇩	⇩	⇩
			MAMSI (PPO)	79%	81%	80%	⇩	⇔	⇩
			UnitedHealthcare (PPO)	81%	82%	81%	⇔	⇧	⇩
Behavioral Health									
Antidepressant Medication Management	Effective 12 Week Acute Phase – 18+ Years of Age [Page 129]	HMO	Aetna (HMO)	79%	75%	71%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	72%	68%	67%	⇩	⇧	⇩
			Coventry (HMO)	78%	73%	66%	⇩	⇧	⇩
			Kaiser Permanente (HMO)	72%	62%	70%	⇔	⇧	⇩
			MD-IPA (HMO)	69%	66%	66%	⇩	⇧	⇩
			Optimum Choice (HMO)	67%	64%	71%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	75%	71%	77%	⇧	⇧	⇧
		PPO	Aetna (PPO)	76%	75%	73%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	72%	72%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	71%	73%	⇧	⇧	⇩
			Cigna (PPO)	71%	61%	67%	⇩	⇧	⇩
			Coventry (PPO)	79%	75%	70%	⇩	⇧	⇩
			KPIC (PPO)	NDA	69%	NA	NA	NA	NA
			MAMSI (PPO)	84%	65%	78%	⇧	⇧	⇧
			UnitedHealthcare (PPO)	70%	64%	67%	⇩	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Behavioral Health (continued)									
Antidepressant Medication Management	Effective 6 Month Continuation Phase – 18+ Years of Age [Page 130]	HMO	Aetna (HMO)	65%	60%	57%	⇧	⇧	⇔
			CareFirst BlueChoice (HMO)	55%	48%	49%	⇩	⇧	⇩
			Coventry (HMO)	60%	54%	55%	⇧	⇧	⇩
			Kaiser Permanente (HMO)	45%	37%	43%	⇩	⇩	⇩
			MD-IPA (HMO)	51%	49%	49%	⇩	⇧	⇩
			Optimum Choice (HMO)	52%	45%	51%	⇔	⇧	⇩
			UnitedHealthcare (HMO)	62%	51%	55%	⇧	⇧	⇩
		PPO	Aetna (PPO)	62%	64%	60%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	56%	54%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	55%	54%	⇔	⇧	⇩
			Cigna (PPO)	58%	36%	49%	⇩	⇔	⇩
			Coventry (PPO)	62%	55%	49%	⇩	⇔	⇩
			KPIC (PPO)	NDA	53%	NA	NA	NA	NA
			MAMSI (PPO)	68%	48%	64%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	55%	49%	51%	⇩	⇧	⇩
Follow-Up After Hospitalization for Mental Illness	Follow-Up Within 7 Days – 6+ Years of Age [Page 131]	HMO	Aetna (HMO)	47%	48%	50%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	59%	56%	57%	⇧	⇧	⇩
			Coventry (HMO)	56%	53%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	55%	64%	62%	⇧	⇧	⇩
			MD-IPA (HMO)	62%	55%	54%	⇔	⇔	⇩
			Optimum Choice (HMO)	67%	57%	47%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	55%	56%	58%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	50%	54%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	55%	51%	⇩	⇧	⇩
			Cigna (PPO)	51%	53%	51%	⇩	⇧	⇩
			Coventry (PPO)	53%	56%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	61%	NA	NA	NA	NA
			UnitedHealthcare (PPO)	65%	61%	54%	⇔	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Behavioral Health (continued)									
Follow-Up After Hospitalization for Mental Illness	Follow-Up Within 30 Days – 6+ Years of Age [Page 130]	HMO	Aetna (HMO)	68%	66%	64%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	74%	75%	74%	⇧	⇧	⇩
			Coventry (HMO)	74%	70%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	70%	79%	76%	⇧	⇧	⇩
			MD-IPA (HMO)	77%	69%	70%	⇩	⇩	⇩
			Optimum Choice (HMO)	80%	70%	76%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	72%	74%	74%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	66%	69%	⇩	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	73%	68%	⇩	⇔	⇩
			Cigna (PPO)	74%	74%	73%	⇔	⇧	⇩
			Coventry (PPO)	69%	71%	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	64%	NA	NA	NA	NA
			UnitedHealthcare (PPO)	80%	77%	76%	⇧	⇧	⇩
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation Within 14 Days – 13 to 17 Years of Age [Page 133]	HMO	Aetna (HMO)	42%	35%	44%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	40%	40%	36%	⇩	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	36%	30%	41%	⇧	⇔	⇩
			MD-IPA (HMO)	49%	NA	27%	⇩	⇩	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	47%	51%	39%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	31%	38%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	30%	38%	⇩	⇩	⇩
			Cigna (PPO)	41%	42%	53%	⇧	⇧	⇩
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	48%	43%	40%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Behavioral Health (continued)									
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation Within 14 Days – 18+ Years of Age [Page 134]	HMO	Aetna (HMO)	53%	52%	37%	⇧	⇔	⇩
			CareFirst BlueChoice (HMO)	32%	33%	35%	⇧	⇩	⇩
			Coventry (HMO)	30%	35%	29%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	33%	34%	33%	⇔	⇩	⇩
			MD-IPA (HMO)	41%	33%	32%	⇩	⇩	⇩
			Optimum Choice (HMO)	39%	36%	32%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	32%	29%	36%	⇧	⇩	⇩
		PPO	Aetna (PPO)	51%	50%	38%	⇧	⇩	⇩
			CareFirst CFMI (PPO)	NDA	30%	33%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	36%	34%	⇩	⇩	⇩
			Cigna (PPO)	39%	45%	43%	⇧	⇧	⇩
			Coventry (PPO)	29%	33%	36%	⇔	⇩	⇩
			KPIC (PPO)	NDA	43%	NA	NA	NA	NA
			MAMSI (PPO)	42%	38%	40%	⇧	⇔	⇩
			UnitedHealthcare (PPO)	41%	36%	35%	⇩	⇩	⇩
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Engagement Within 30 Days – 13 to 17 Years of Age [Page 135]	HMO	Aetna (HMO)	8%	32%	26%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	19%	19%	14%	⇔	⇩	⇩
			Coventry (HMO)	NA	NA	NA	NA	NA	NA
			Kaiser Permanente (HMO)	14%	11%	4%	⇩	⇩	⇩
			MD-IPA (HMO)	19%	NA	10%	⇩	⇩	⇩
			Optimum Choice (HMO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (HMO)	NA	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	21%	22%	22%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	17%	16%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	10%	6%	⇩	⇩	⇩
			Cigna (PPO)	22%	24%	32%	⇧	⇧	⇔
			Coventry (PPO)	NA	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	18%	17%	18%	⇩	⇩	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Behavioral Health (continued)									
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Engagement Within 30 Days – 18+ Years of Age [Page 136]	HMO	Aetna (HMO)	16%	11%	15%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	14%	15%	12%	⇔	⇩	⇩
			Coventry (HMO)	8%	19%	12%	⇔	⇩	⇩
			Kaiser Permanente (HMO)	9%	10%	6%	⇩	⇩	⇩
			MD-IPA (HMO)	12%	11%	11%	⇔	⇩	⇩
			Optimum Choice (HMO)	13%	14%	14%	⇧	⇔	⇩
			UnitedHealthcare (HMO)	15%	14%	11%	⇔	⇩	⇩
		PPO	Aetna (PPO)	18%	18%	19%	⇧	⇧	⇩
			CareFirst CFMI (PPO)	NDA	13%	12%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	17%	12%	⇩	⇩	⇩
			Cigna (PPO)	18%	25%	24%	⇧	⇧	⇧
			Coventry (PPO)	10%	13%	14%	⇩	⇔	⇩
			KPIC (PPO)	NDA	17%	NA	NA	NA	NA
			MAMSI (PPO)	19%	19%	24%	⇧	⇧	⇧
			UnitedHealthcare (PPO)	17%	16%	15%	⇩	⇔	⇩
Member Experience and Satisfaction With Health Benefit Plan									
Aspirin Discussion	Aspirin Discussion – Women 56 to 79 and Men 46 to 79 Years of Age [Page 138]	HMO	Aetna (HMO)	42%	44%	42%	⇩	*	*
			CareFirst BlueChoice (HMO)	NA	51%	52%	⇧	*	*
			Coventry (HMO)	53%	57%	56%	⇧	*	*
			Kaiser Permanente (HMO)	39%	42%	43%	⇩	*	*
			MD-IPA (HMO)	54%	51%	50%	⇧	*	*
			Optimum Choice (HMO)	44%	44%	49%	⇧	*	*
			UnitedHealthcare (HMO)	46%	45%	42%	⇩	*	*
		PPO	Aetna (PPO)	51%	54%	54%	⇧	*	*
			CareFirst CFMI (PPO)	NDA	70%	57%	⇧	*	*
			CareFirst GHMSI (PPO)	NDA	55%	52%	⇔	*	*
			Cigna (PPO)	48%	56%	54%	⇧	*	*
			Coventry (PPO)	46%	52%	52%	⇔	*	*
			KPIC (PPO)	NDA	45%	42%	⇩	*	*
			MAMSI (PPO)	48%	52%	52%	⇔	*	*
			UnitedHealthcare (PPO)	52%	50%	49%	⇩	*	*

*No National Benchmarks Available

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Flu Vaccinations for Adults	Flu Shots – 18 to 64 Years of Age [Page 139] *No National Benchmarks Available	HMO	Aetna (HMO)	NDA	49%	46%	⇔	*	*
			CareFirst BlueChoice (HMO)	NDA	40%	46%	⇔	*	*
			Coventry (HMO)	NDA	38%	37%	⇩	*	*
			Kaiser Permanente (HMO)	NDA	50%	58%	⇧	*	*
			MD-IPA (HMO)	NDA	51%	54%	⇧	*	*
			Optimum Choice (HMO)	NDA	41%	49%	⇧	*	*
			UnitedHealthcare (HMO)	NDA	37%	38%	⇩	*	*
		PPO	Aetna (PPO)	NDA	46%	50%	⇩	*	*
			CareFirst CFMI (PPO)	NDA	55%	61%	⇧	*	*
			CareFirst GHMSI (PPO)	NDA	56%	56%	⇧	*	*
			Cigna (PPO)	NDA	50%	57%	⇧	*	*
			Coventry (PPO)	NDA	37%	37%	⇩	*	*
			KPIC (PPO)	NDA	60%	63%	⇧	*	*
			MAMSI (PPO)	NDA	51%	44%	⇩	*	*
			UnitedHealthcare (PPO)	NDA	47%	43%	⇩	*	*
Call Answer Timeliness	Calls Answered Within 30 Seconds – By A Live Voice [Page 140]	HMO	Aetna (HMO)	78%	80%	79%	⇧	⇧	⇩
			CareFirst BlueChoice (HMO)	73%	64%	59%	⇩	⇩	⇩
			Coventry (HMO)	79%	83%	78%	⇧	⇔	⇩
			Kaiser Permanente (HMO)	83%	82%	75%	⇩	⇩	⇩
			MD-IPA (HMO)	82%	81%	82%	⇧	⇧	⇩
			Optimum Choice (HMO)	78%	81%	82%	⇧	⇧	⇩
			UnitedHealthcare (HMO)	78%	81%	82%	⇧	⇧	⇩
		PPO	Aetna (PPO)	79%	82%	75%	⇔	⇩	⇩
			CareFirst CFMI (PPO)	NDA	64%	59%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	64%	59%	⇩	⇩	⇩
			Cigna (PPO)	76%	81%	81%	⇧	⇧	⇔
			Coventry (PPO)	79%	83%	78%	⇧	⇔	⇩
			KPIC (PPO)	NDA	85%	82%	⇧	⇧	⇔
			MAMSI (PPO)	78%	81%	82%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	78%	81%	82%	⇧	⇧	⇔

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Getting Needed Care	Care, Tests, Treatments and Timely Specialist Appointments – Usually or Always [Page 141]	HMO	Aetna (HMO)	85%	87%	88%	⇧	⇔	⇩
			CareFirst BlueChoice (HMO)	86%	85%	87%	⇔	⇩	⇩
			Coventry (HMO)	84%	87%	86%	⇔	⇩	⇩
			Kaiser Permanente (HMO)	85%	85%	84%	⇩	⇩	⇩
			MD-IPA (HMO)	91%	89%	91%	⇧	⇧	⇔
			Optimum Choice (HMO)	85%	84%	85%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	87%	83%	83%	⇩	⇩	⇩
		PPO	Aetna (PPO)	87%	88%	88%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	87%	84%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	86%	88%	⇧	⇔	⇩
			Cigna (PPO)	87%	89%	89%	⇧	⇔	⇩
			Coventry (PPO)	79%	84%	84%	⇩	⇩	⇩
			KPIC (PPO)	NDA	84%	86%	⇔	⇩	⇩
			MAMSI (PPO)	87%	86%	90%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	88%	91%	87%	⇔	⇩	⇩
Getting Care Quickly	Timely Care and Timely Routine Appointments – Usually or Always [Page 142]	HMO	Aetna (HMO)	94%	87%	84%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	83%	83%	85%	⇧	⇩	⇩
			Coventry (HMO)	87%	85%	82%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	82%	88%	82%	⇩	⇩	⇩
			MD-IPA (HMO)	88%	88%	89%	⇧	⇧	⇩
			Optimum Choice (HMO)	83%	87%	78%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	84%	83%	84%	⇔	⇩	⇩
		PPO	Aetna (PPO)	86%	89%	84%	⇔	⇩	⇩
			CareFirst CFMI (PPO)	NDA	92%	87%	⇧	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	85%	87%	⇧	⇔	⇩
			Cigna (PPO)	86%	92%	85%	⇔	⇩	⇩
			Coventry (PPO)	77%	84%	84%	⇔	⇩	⇩
			KPIC (PPO)	NDA	88%	81%	⇩	⇩	⇩
			MAMSI (PPO)	85%	88%	NA	NA	NA	NA
			UnitedHealthcare (PPO)	86%	88%	86%	⇧	⇔	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
How Well Doctors Communicate	Good Communication By Personal Doctor – Usually or Always [Page 143	HMO	Aetna (HMO)	93%	93%	93%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	92%	95%	93%	⇔	⇩	⇩
			Coventry (HMO)	95%	94%	94%	⇔	⇔	⇩
			Kaiser Permanente (HMO)	94%	93%	94%	⇔	⇔	⇩
			MD-IPA (HMO)	94%	93%	94%	⇔	⇩	⇩
			Optimum Choice (HMO)	89%	94%	93%	⇔	⇩	⇩
			UnitedHealthcare (HMO)	91%	91%	93%	⇔	⇩	⇩
		PPO	Aetna (PPO)	96%	95%	94%	⇔	⇩	⇩
			CareFirst CFMI (PPO)	NDA	96%	93%	⇔	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	94%	96%	⇧	⇧	⇔
			Cigna (PPO)	93%	93%	93%	⇔	⇩	⇩
			Coventry (PPO)	92%	95%	94%	⇔	⇩	⇩
			KPIC (PPO)	NDA	93%	88%	⇩	⇩	⇩
			MAMSI (PPO)	95%	94%	97%	⇧	⇧	⇔
			UnitedHealthcare (PPO)	94%	94%	93%	⇔	⇩	⇩
Customer Service	Informed, Helpful, Courteous, and Respectful Customer Service – Usually or Always [Page 144]	HMO	Aetna (HMO)	85%	88%	84%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NA	NA	NA	NA	NA	NA
			Coventry (HMO)	85%	85%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	88%	89%	86%	⇔	⇩	⇩
			MD-IPA (HMO)	86%	93%	88%	⇧	⇔	⇩
			Optimum Choice (HMO)	83%	84%	83%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	84%	NA	NA	NA	NA	NA
		PPO	Aetna (PPO)	81%	81%	NA	NA	NA	NA
			CareFirst CFMI (PPO)	NDA	NA	NA	NA	NA	NA
			CareFirst GHMSI (PPO)	NDA	NA	NA	NA	NA	NA
			Cigna (PPO)	88%	89%	NA	NA	NA	NA
			Coventry (PPO)	80%	NA	NA	NA	NA	NA
			KPIC (PPO)	NDA	79%	NA	NA	NA	NA
			MAMSI (PPO)	NA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	86%	85%	NA	NA	NA	NA

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Claims Processing	Fast and Accurate Claims Processing – Usually or Always [Page 145]	HMO	Aetna (HMO)	NDA	83%	84%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	94%	91%	⇧	⇧	⇩
			Coventry (HMO)	NDA	87%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	NDA	NA	NA	NA	NA	NA
			MD-IPA (HMO)	NDA	91%	87%	⇔	⇩	⇩
			Optimum Choice (HMO)	NDA	84%	81%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	82%	86%	⇔	⇩	⇩
		PPO	Aetna (PPO)	NDA	88%	85%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	88%	94%	⇧	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	91%	88%	⇩	⇔	⇩
			Cigna (PPO)	NDA	90%	90%	⇧	⇧	⇩
			Coventry (PPO)	NDA	87%	85%	⇩	⇩	⇩
			KPIC (PPO)	NDA	NA	NA	NA	NA	NA
			MAMSI (PPO)	NDA	NA	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	85%	92%	⇧	⇧	⇔
Shared Decision-Making	Health Provider Feedback Concerning Starting or Stopping A Prescription Medicine – Yes [Page 146]	HMO	Aetna (HMO)	NDA	NDA	74%	⇩	*	*
			CareFirst BlueChoice (HMO)	NDA	NDA	80%	⇧	*	*
			Coventry (HMO)	NDA	NDA	NA	NA	*	*
			Kaiser Permanente (HMO)	NDA	NDA	77%	⇔	*	*
			MD-IPA (HMO)	NDA	NDA	74%	⇩	*	*
			Optimum Choice (HMO)	NDA	NDA	79%	⇧	*	*
			UnitedHealthcare (HMO)	NDA	NDA	NA	NA	*	*
		PPO	Aetna (PPO)	NDA	NDA	75%	⇩	*	*
			CareFirst CFMI (PPO)	NDA	NDA	78%	⇔	*	*
			CareFirst GHMSI (PPO)	NDA	NDA	79%	⇧	*	*
			Cigna (PPO)	NDA	NDA	79%	⇧	*	*
			Coventry (PPO)	NDA	NDA	NA	NA	*	*
			KPIC (PPO)	NDA	NDA	NA	NA	*	*
			MAMSI (PPO)	NDA	NDA	NA	NA	*	*
			UnitedHealthcare (PPO)	NDA	NDA	75%	⇩	*	*
	*No National Benchmarks Available								

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Plan Information on Costs	Information Available On Out-Of-Pocket Costs – Usually or Always [Page 147]	HMO	Aetna (HMO)	NDA	64%	60%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	58%	59%	⇔	⇩	⇩
			Coventry (HMO)	NDA	57%	52%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	NDA	66%	67%	⇧	⇧	⇩
			MD-IPA (HMO)	NDA	65%	65%	⇧	⇔	⇩
			Optimum Choice (HMO)	NDA	56%	61%	⇧	⇩	⇩
			UnitedHealthcare (HMO)	NDA	54%	52%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	61%	58%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	NA	64%	⇧	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	64%	65%	⇧	⇧	⇔
			Cigna (PPO)	NDA	NA	72%	⇧	⇧	⇧
			Coventry (PPO)	NDA	54%	51%	⇩	⇩	⇩
			KPIC (PPO)	NDA	53%	NA	NA	NA	NA
			MAMSI (PPO)	NDA	57%	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	60%	59%	⇩	⇩	⇩
Health Promotion and Education	Illness Prevention Discussion With Health Provider – Yes [Page 148]	HMO	Aetna (HMO)	78%	78%	75%	⇔	⇔	⇩
			CareFirst BlueChoice (HMO)	75%	78%	78%	⇧	⇧	⇩
			Coventry (HMO)	72%	76%	68%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	79%	82%	81%	⇧	⇧	⇔
			MD-IPA (HMO)	76%	83%	78%	⇧	⇧	⇩
			Optimum Choice (HMO)	71%	70%	72%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	68%	66%	68%	⇩	⇩	⇩
		PPO	Aetna (PPO)	74%	79%	71%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	81%	77%	⇔	⇧	⇩
			CareFirst GHMSI (PPO)	NDA	79%	77%	⇧	⇧	⇩
			Cigna (PPO)	81%	81%	82%	⇧	⇧	⇧
			Coventry (PPO)	67%	71%	72%	⇩	⇩	⇩
			KPIC (PPO)	NDA	78%	76%	⇔	⇧	⇩
			MAMSI (PPO)	75%	74%	76%	⇔	⇧	⇩
			UnitedHealthcare (PPO)	81%	78%	76%	⇔	⇧	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

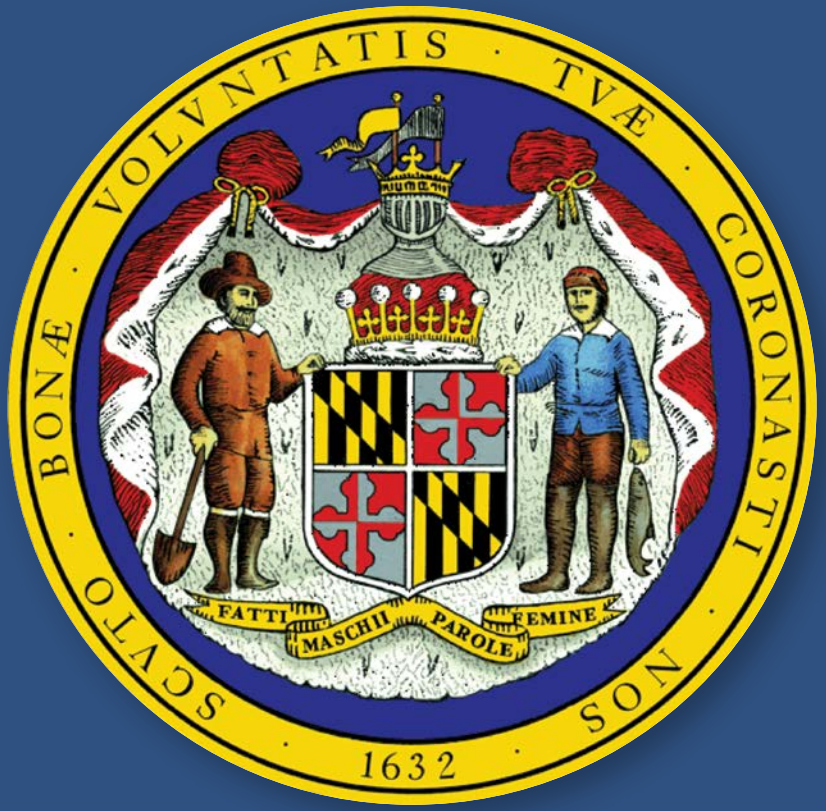
Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Coordination of Care	Well Informed Personal Doctor – Usually or Always [Page 149]	HMO	Aetna (HMO)	75%	72%	79%	⇔	⇩	⇩
			CareFirst BlueChoice (HMO)	79%	79%	81%	⇧	⇔	⇩
			Coventry (HMO)	83%	79%	NA	NA	NA	NA
			Kaiser Permanente (HMO)	82%	85%	85%	⇧	⇧	⇩
			MD-IPA (HMO)	79%	82%	76%	⇩	⇩	⇩
			Optimum Choice (HMO)	74%	75%	80%	⇔	⇩	⇩
			UnitedHealthcare (HMO)	69%	77%	74%	⇩	⇩	⇩
		PPO	Aetna (PPO)	77%	73%	76%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	83%	74%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	76%	80%	⇧	⇔	⇩
			Cigna (PPO)	77%	80%	81%	⇧	⇧	⇩
			Coventry (PPO)	72%	82%	73%	⇩	⇩	⇩
			KPIC (PPO)	NDA	81%	NA	NA	NA	NA
			MAMSI (PPO)	81%	69%	NA	NA	NA	NA
			UnitedHealthcare (PPO)	77%	82%	81%	⇧	⇧	⇩
Rating of All Health Care	Good Overall Rating of All Health Care – 8, 9, or 10, Out of 10 [Page 150]	HMO	Aetna (HMO)	NDA	75%	74%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	83%	79%	⇧	⇧	⇩
			Coventry (HMO)	NDA	73%	78%	⇧	⇔	⇩
			Kaiser Permanente (HMO)	NDA	81%	76%	⇔	⇩	⇩
			MD-IPA (HMO)	NDA	81%	78%	⇧	⇔	⇩
			Optimum Choice (HMO)	NDA	74%	71%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	69%	72%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	76%	73%	⇩	⇩	⇩
			CareFirst CFMI (PPO)	NDA	83%	77%	⇧	⇔	⇩
			CareFirst GHMSI (PPO)	NDA	74%	82%	⇧	⇧	⇔
			Cigna (PPO)	NDA	78%	77%	⇧	⇔	⇩
			Coventry (PPO)	NDA	64%	70%	⇩	⇩	⇩
			KPIC (PPO)	NDA	66%	73%	⇩	⇩	⇩
			MAMSI (PPO)	NDA	76%	79%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	NDA	81%	77%	⇔	⇔	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Rating of Personal Doctor	Good Overall Rating of Personal Doctor – 8, 9, 10, Out of 10 [Page 151]	HMO	Aetna (HMO)	NDA	85%	81%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	87%	83%	⇔	⇩	⇩
			Coventry (HMO)	NDA	85%	84%	⇧	⇩	⇩
			Kaiser Permanente (HMO)	NDA	85%	86%	⇧	⇔	⇩
			MD-IPA (HMO)	NDA	84%	86%	⇧	⇧	⇩
			Optimum Choice (HMO)	NDA	80%	80%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	79%	78%	⇩	⇩	⇩
		PPO	Aetna (PPO)	NDA	82%	84%	⇧	⇔	⇩
			CareFirst CFMI (PPO)	NDA	85%	79%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	81%	82%	⇔	⇩	⇩
			Cigna (PPO)	NDA	82%	86%	⇧	⇧	⇩
			Coventry (PPO)	NDA	81%	78%	⇩	⇩	⇩
			KPIC (PPO)	NDA	80%	78%	⇩	⇩	⇩
			MAMSI (PPO)	NDA	85%	86%	⇧	⇧	⇩
			UnitedHealthcare (PPO)	NDA	85%	84%	⇧	⇔	⇩
Rating of Specialist Seen Most Often	Good Overall Rating of Specialist – 8, 9, 10, Out of 10 [Page 152]	HMO	Aetna (HMO)	NDA	83%	78%	⇩	⇩	⇩
			CareFirst BlueChoice (HMO)	NDA	80%	87%	⇧	⇧	⇩
			Coventry (HMO)	NDA	82%	81%	⇔	⇩	⇩
			Kaiser Permanente (HMO)	NDA	86%	78%	⇩	⇩	⇩
			MD-IPA (HMO)	NDA	81%	83%	⇧	⇩	⇩
			Optimum Choice (HMO)	NDA	86%	77%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	NDA	79%	84%	⇧	⇔	⇩
		PPO	Aetna (PPO)	NDA	76%	83%	⇔	⇔	⇩
			CareFirst CFMI (PPO)	NDA	89%	81%	⇩	⇩	⇩
			CareFirst GHMSI (PPO)	NDA	83%	83%	⇔	⇔	⇩
			Cigna (PPO)	NDA	81%	88%	⇧	⇧	⇩
			Coventry (PPO)	NDA	79%	79%	⇩	⇩	⇩
			KPIC (PPO)	NDA	73%	81%	⇩	⇩	⇩
			MAMSI (PPO)	NDA	78%	NA	NA	NA	NA
			UnitedHealthcare (PPO)	NDA	86%	85%	⇧	⇔	⇩

APPENDIX B: TRENDED HEALTH BENEFIT PLAN PERFORMANCE DATA (2013-2015)

Measure	Indicator/Description	Type	Plan Name	2013 Rate	2014 Rate	2015 Rate	Plan Performance Compared To		
							2015 MAB	2015 NAB	2015 NTP
Member Experience and Satisfaction With Health Benefit Plan (continued)									
Rating of Health Benefit Plan	Good Overall Rating of Health Benefit Plan – 8, 9, or 10, Out of 10 [Page 153]	HMO	Aetna (HMO)	66%	66%	64%	⇧	⇩	⇩
			CareFirst BlueChoice (HMO)	66%	74%	71%	⇧	⇧	⇩
			Coventry (HMO)	50%	51%	46%	⇩	⇩	⇩
			Kaiser Permanente (HMO)	83%	81%	77%	⇧	⇧	⇩
			MD-IPA (HMO)	68%	68%	66%	⇧	⇔	⇩
			Optimum Choice (HMO)	51%	58%	51%	⇩	⇩	⇩
			UnitedHealthcare (HMO)	53%	55%	50%	⇩	⇩	⇩
		PPO	Aetna (PPO)	61%	64%	62%	⇔	⇧	⇩
			CareFirst CFMI (PPO)	NDA	80%	76%	⇧	⇧	⇧
			CareFirst GHMSI (PPO)	NDA	73%	70%	⇧	⇧	⇔
			Cigna (PPO)	67%	69%	68%	⇧	⇧	⇩
			Coventry (PPO)	41%	42%	49%	⇩	⇩	⇩
			KPIC (PPO)	NDA	67%	56%	⇩	⇩	⇩
			MAMSI (PPO)	56%	53%	48%	⇩	⇩	⇩
			UnitedHealthcare (PPO)	65%	69%	71%	⇧	⇧	⇔



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