Measuring the Quality of Maryland HMOs and POS Plans

2007/2008 STATE EMPLOYEE GUIDE
### Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 State Employee Guide

The Skipjack shown on the cover is the state boat of Maryland. Designed for dredging oysters from shallow water, Maryland has committed to preserve the Chesapeake Bay skipjack fleet because of its historic and early economic importance to the state. Today, only a few remain and represent the last working boats under sail in North America.

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<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Company</th>
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</thead>
<tbody>
<tr>
<td>Reverend Robert L. Conway</td>
<td>Retired Teacher and Principal, Calvert County Public School System</td>
</tr>
<tr>
<td>Sharon Krumm, Ph.D., R.N.</td>
<td>Administrator and Director of Nursing, The Sidney Kimmel Cancer Center @ Johns Hopkins</td>
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<tr>
<td>Robert Moffit, Ph.D.</td>
<td>Heritage Foundation</td>
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<tr>
<td>Robert E. Nicolay, C.P.A.</td>
<td>Retired, Exxon Mobil Corporation</td>
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<tr>
<td>Debra Herring Risher</td>
<td>President and Owner, Belair Engineering and Service Co., Inc.</td>
</tr>
<tr>
<td>Sheri D. Sensabaugh</td>
<td>Small Business Owner, ACT Personnel Service Inc.</td>
</tr>
<tr>
<td>Clifton Toulson, Jr., MBA, M.P.A</td>
<td>CEO and Owner, Toulson Enterprises</td>
</tr>
<tr>
<td>Garret A. Falcone, NHA</td>
<td>Senior Administrator, Erickson Retirement Communities</td>
</tr>
<tr>
<td>Jeffrey D. Lucht FSA, MAAA</td>
<td>Aetna Health Inc.</td>
</tr>
<tr>
<td>Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc.</td>
<td>President PH RockWood Corporation</td>
</tr>
<tr>
<td>Andrew N. Pollak, M.D.</td>
<td>Associate Professor, Orthopaedics, University of Maryland School of Medicine</td>
</tr>
<tr>
<td>Constance Row</td>
<td>Partner, Row Associates</td>
</tr>
<tr>
<td>Nevins W. Todd, Jr., M.D.</td>
<td>Cardiothoracic and General Surgery, Peninsula Regional Medical Center</td>
</tr>
</tbody>
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Phone: 410-764-3460; Fax: 410-358-1236; Toll-Free: 877-245-1762; TDD: 800-735-2258  
Web site: [http://mhcc.maryland.gov](http://mhcc.maryland.gov)  
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ABOUT THIS GUIDE
Choosing your health plan is an important decision. Because not all health plans are the same, the one you select can make a difference in the quality of your health care. *Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 State Employee Guide* compares measures of quality care that managed care plans in Maryland provide to their members. The information in this Guide will help you choose a health plan that works best for you, especially when used to complement cost and benefit information available in the *2007 State of Maryland Summary of Health Benefits* book supplied by the Office of Personnel’s Employee Benefit division.

Be an informed consumer when it comes to your health care!

USE THIS GUIDE AS A TOOL TO
- Learn more about how health insurance works and compare measures of quality care that plans provide to their members
- See how your plan compares to others in Maryland

INFORMATION IN THIS GUIDE INCLUDES
- Contact information for Health Maintenance Organizations (HMOs) and Point of Service (POS) plans available to Maryland State employees
- Steps to guide you in choosing a health plan
- An explanation of what plan quality means and its importance
- Plan members’ survey responses about their health plan and services they receive
- Plans’ performance on providing important health care services, tests, and treatments
- Who to contact if you disagree with your plan’s decision to limit or deny services to you

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MARYLAND HEALTH PLANS IN THIS GUIDE
This Guide reports on three HMOs and two POS plans available to Maryland State employees. The table below gives you some important information about each plan. See page 4 for tips on how to use this information when choosing a health plan.

Plan Service Area and Contact Information
The table lists the plans’ service areas and contact information. Use it to:
• Find a plan where you live or work
• Get more information directly from the plan’s customer service department or visit its Web site

Enrollment
The table shows the combined number of HMO and POS members enrolled in each plan.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Customer Service Information</th>
<th>Enrollment (HMO/POS)</th>
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<tbody>
<tr>
<td>HMO</td>
<td></td>
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</table>
| CareFirst BlueChoice, Inc. (BlueChoice)

  866-520-6099
  8:00 am–6:00 pm, Monday–Friday
  9:00 am–2:00 pm, Saturday
  www.carefirst.com

  560,134 |

| Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente)

  800-777-7902 or 301-468-6000
  For the hearing and speech impaired: 301-879-6380
  7:30 am–5:30 pm, Monday–Friday
  www.kaiserpermanente.org

  443,566 |

| Optimum Choice, Inc. (OCI)

  800-709-7604
  24 Hours, 7 Days
  www.mamsiunitedHealthcare.com

  504,786 |

| POS         |                              |                      |
|-------------|------------------------------|                      |
| Aetna Health Inc.- Maryland, DC and Virginia (Aetna)

  800-323-9930
  8:00 am–6:00 pm, Monday–Friday
  www.aetna.com

  312,769 |

| MD-Individual Practice Association, Inc. (M.D. IPA)

  800-709-7604
  24 Hours, 7 Days
  www.mamsiunitedHealthcare.com

  234,488 |

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aBlueChoice, a for-profit HMO, operates under a holding company called CareFirst.
bKaiser Permanente’s performance in this Guide relates to HMO members only. It is the only non-profit HMO operating in Maryland.
cTwo for-profit HMOs, M.D. IPA and OCI, are owned and operated by Mid-Atlantic Medical Services, LLC. (MAMSI), a regional holding company and subsidiary of UnitedHealthGroup, Inc.
Quality information on the CareFirst BlueCross BlueShield POS plan, *Maryland Point of Service*, is not reported in this Guide. MHCC does not require CareFirst BlueCross BlueShield to submit quality information on the POS plan it administers for State employees due to the plan’s licensing arrangement, which makes it exempt from reporting.

### Health Plan Accreditation

Accreditation is a way of assessing health plan quality. It lets you know that an independent organization has checked how well a health plan provides the health services you need. All plans listed in this Guide are accredited by the National Committee for Quality Assurance ([www.ncqa.org](http://www.ncqa.org)) or by the American Accreditation Healthcare Commission ([www.urac.org](http://www.urac.org)).

<table>
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<th>Health Plan</th>
<th>Plan Service Areas Each Maryland region is described below</th>
<th>Baltimore Metro Area</th>
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<td>Aetna Health Inc.- Maryland, DC and Virginia (Aetna)</td>
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<td>✔</td>
<td>Cecil, Kent, Queen Anne’s, Talbot, Wicomico</td>
<td>✔</td>
<td>Frederick, Washington</td>
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**Regi**

**Baltimore Metropolitan Area**: Baltimore City, Baltimore, Carroll, Harford, Howard, Anne Arundel

**Washington D.C. Metropolitan Area**: Montgomery, Prince George’s

**Eastern Shore**: Caroline, Cecil, Dorchester, Kent, Queen Anne’s, Somerset, Talbot, Wicomico, Worcester

**Southern Maryland**: Calvert, Charles, St. Mary’s

**Western Maryland**: Allegany, Frederick, Garrett, Washington
Maryland Health Care Commission

**Steps to Choosing a Health Plan**

**STEP 1: DECIDE WHAT MATTERS TO YOU MOST. SOME IMPORTANT THINGS TO THINK ABOUT ARE:**

- **Choice of providers.**
  Decide if you prefer few limits on your choice of providers or if you think you will have enough choices using the group of providers working with the plan (known as “in-network”). POS plans give you the option of seeing doctors outside of the plan’s group of doctors.

  **A Note About POS Plans…**
  Though POS plans expand your choice of doctors through their out-of-network services, usually there is higher cost to use them. With a POS plan, you may have to pay higher fees (deductible, coinsurance, or co-payment) each time you see an out-of-network doctor. You might also have to pay more for your prescription drugs and pay higher premiums.

- **Easy access to care and a range of services that you need.**
  If you have specific needs for medical or behavioral health care, you should use information from the 2007 State of Maryland Summary of Health Benefits booklet, the health plan, and this Guide to decide if the plan covers the services you will need by giving you enough choices of doctors, convenient locations, and quality care.

- **Members’ satisfaction with the plan (see pages 6–9 for member opinions about the HMO and POS plans offered to State employees).**

- **Learn what activities the plan has to help you and your family stay healthy.**
  HMO plans make an effort to “manage” your care by designing programs that are intended to promote health and prevent illnesses. Read the Manage Your Health Care sections in this Guide (pages 10–17) to learn what activities Maryland plans have in place to “manage” plan members’ care.*

**STEP 2: REVIEW THE RESULTS ON PAGES 10–17 TO COMPARE PLAN PERFORMANCE AND MEMBER SATISFACTION.**

This Guide gives you results of how each plan did in both of these areas.

**STEP 3: SELECT A PLAN.**

When you have finished Steps 1 and 2, use the information to complement cost information from the 2007 State of Maryland Summary of Health Benefits booklet.

**Joining the Health Plan…**

There are two different ways to get health insurance. You can enroll in a health plan offered by the State or you can purchase individual coverage (“individual” means the insurance is not obtained through an employer, such as the State).

- **State employee coverage.** There are two times when you can enroll in a health plan. The first is when you are newly hired and you enroll in a plan for the first time; the second is during the “open enrollment period” that happens once a year in the spring. During open enrollment, you can join a new plan or make changes to your existing plan benefits such as adding or removing coverage for prescription drugs, or you can change the dependents included on your plan. Before selecting a plan, decide what changes you would like to make and review your personalized benefit statement, which contains information about you and your benefit options for the current benefit year. Contact the Agency Benefits Coordinator in your Personnel Office if you have not received this statement or have never enrolled in any State health benefit plan.

  If you do not make changes to your plan benefits during the open enrollment period, you will keep the same benefits that you currently have.

- **Individual coverage.** To find out whether the plans listed in this Guide offer coverage directly to individuals and to get enrollment information, contact the plan’s customer service department. See page 2 for contact information.

*Each program highlight is an example of how the health plan attempts to improve the quality of care delivered to its members. It does not represent an endorsement of the plan. Other health plans may have a similar program.
Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 State Employee Guide

Health Plan Quality Measurement

ABOUT HEALTH PLAN QUALITY
Health plan quality is important because when your plan offers the best possible care, you are more likely to get the best possible results. This Guide covers some quality measures that are important for you to know about when selecting a health plan. It is not possible to measure everything about a health plan, but this Guide will give you a lot of useful information. Two nationally accepted quality measurement tools were used to collect the information in this Guide to gather results that can help you decide whether you are getting quality health care; the first evaluates member experiences and the second evaluates service results. Health plans report results of their evaluation of how often they provided recommended health care services. An independent organization verified the accuracy of the collection methods used by these health plans.

DATA SOURCES
Maryland plans gathered information from their records and members and reported it to the State for this Guide. Data (rates) included here are not specific to Maryland State employees, but reflect the care provided to and the opinions of a sample of all members enrolled in the plans.

Member Survey: This symbol means that information was gathered from health plan members using a survey that asked about their experiences with the plan. An independent company hired by Maryland conducted the survey of 1,100 members from each plan.a

Health Plan Records: This symbol means that the information was gathered from plans’ records using a uniform system for collecting and reporting clinical information. All plans gathered information in the same way and an independent company hired by Maryland checked their methods for accuracy.b

The scores for every plan include the combined data for HMO and POS members, except Kaiser Permanente, whose ratings show HMO data only.

SUMMARY OF PLANS’ PERFORMANCE
Above-average scores for all of the areas measured are added together to give a snapshot of each plan’s high performance for 2006 and 2004–2006 (Star Performer).c

The Maryland average for each performance standard is based on the results reported by the seven plans required to submit reports to MHCC.

<table>
<thead>
<tr>
<th>HEALTH PLAN</th>
<th>NUMBER OF TIMES ABOVE AVERAGE</th>
<th>NUMBER OF TIMES STAR PERFORMER</th>
</tr>
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<tr>
<td>MD IPA</td>
<td>6</td>
<td>3</td>
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</tbody>
</table>

LOOK FOR THESE SYMBOLS

☀☀☀☀ This symbol stands for Star Performer. It means that the plan’s performance was better than the Maryland average for three years in a row (2004–2006).

☀☀☀ This symbol means that the plan’s performance was better than the 2006 Maryland average.

☀★ This symbol means that the plan’s performance was equal to the 2006 Maryland average.

★ This symbol means that the plan’s performance was worse than the 2006 Maryland average.

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a The survey is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 3.0H. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

b Health plans report data using a system called the Health Plan Employer Data and Information Set (HEDIS®). HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

c Health plans get a Star Performer designation on measures in this Guide for which they demonstrate high performance for three years in a row.
MEMBER OPINIONS MAKE QUALITY CHANGES HAPPEN
What members think about the service they get from their health plans and the care given by their doctors is important for improving the quality of care for everyone. Health plans use the comments to identify the need for new services and to improve the services already offered to give you the best care possible. Just as important, you likely want to know if members had good or bad experiences with the plan or its doctors.

Where does this information come from? A group of randomly selected members from each health plan answered questions sent to them in a survey. Their answers, as a group, are shown on the next page for each plan.

Manage Your Health Care—How CareFirst BlueChoice Uses Member Feedback to Improve Customer Services
CareFirst BlueChoice introduced the “First-Call Resolution” program in 2004. The program’s goal is to quickly address member concerns and provide accurate information so that members do not have to call back a second time. Surveys of BlueChoice members show improvement in first-call resolution.

BlueChoice reviewed its service processes and tools to learn where it could make changes. As a result, BlueChoice

• Provides “Customer Experience Training” for customer service representatives.
• Installed new tools to help customer service representatives access member information.
• Increased the number of customer service representatives available to help members.

The customer satisfaction survey used to measure health plan quality asks about members’ experiences with the plan’s customer service. Survey data from 2006 show an increase of seven percentage points (from 2004) in the proportion of members who reported that they had no problems getting help from customer service.

This program is an example of how CareFirst BlueChoice sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.
The charts on this page summarize how members rated the services they received. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

**Rating of Health Plan**
The percentage of members who rated their health plan “9 or 10” on a scale of 0–10, with 10 being the “best health plan possible.”

<table>
<thead>
<tr>
<th>HMO</th>
<th>BlueChoice</th>
<th>Kaiser Permanente</th>
<th>OCI</th>
<th>POS Plan</th>
<th>Aetna</th>
<th>M.D. IPA</th>
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<td>Rating</td>
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<td>36</td>
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</table>

MD Plan Average = 38%

**Recommending Plan to Friends/Family**
The percentage of members who said “definitely yes” when asked about whether they would recommend their health plan to friends or family.

<table>
<thead>
<tr>
<th>HMO</th>
<th>BlueChoice</th>
<th>Kaiser Permanente</th>
<th>OCI</th>
<th>POS Plan</th>
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<td>39</td>
<td>43</td>
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</table>

MD Plan Average = 40%

**Few Consumer Complaints**
The percentage of members who said they “did not call or write their health plan with a complaint or problem.”

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<thead>
<tr>
<th>HMO</th>
<th>BlueChoice</th>
<th>Kaiser Permanente</th>
<th>OCI</th>
<th>POS Plan</th>
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<td>83</td>
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</table>

MD Plan Average = 85%

**Health Plan Customer Service**
The percentage of members who said it was “not a problem” finding or understanding their plan’s information, getting help from their plan’s customer service department, and filling out paperwork.

<table>
<thead>
<tr>
<th>HMO</th>
<th>BlueChoice</th>
<th>Kaiser Permanente</th>
<th>OCI</th>
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<td>70</td>
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MD Plan Average = 70%

Data Source: Member Survey

Performance

- **Star Performer:** Above Average for three years (2004–2006)
- **★★★★** Above Average in 2006
- **★★★** Average in 2006
- **★** Below Average in 2006

Stars show statistically significant differences between each plan’s score and the Maryland average. “Statistically significant” means scores varied by more than could be accounted for by chance.
MEMBERS GRADE THE CARE THEY GET
Each year, Americans spend more for health care. Recently, U. S. health care spending reached $1.9 trillion. For the money you and your employer spend, does the quality of the care and services provide you with good value? Getting the right care is a good start to getting value for your health care dollars. That means seeing your doctor for check-ups, following the plan of care recommended for you, and using your primary doctor to coordinate tests and visits to other doctors. By using referrals from your doctor or health plan, you will save money, too, from lower copays and by using the best source for the care you need. For example, if you become sick or hurt when your doctor cannot see you, he or she may refer you to an urgent care clinic rather than a hospital emergency department. Going to an urgent care clinic should reduce the amount of time you wait and the amount of money you pay.

Where does this information come from? A group of randomly selected members from each health plan answered questions sent to them in a survey. Their answers, as a group, are shown on the next page for each plan.

Manage Your Health Care—What You Can Do to Improve the Quality of Your Health Care Experience

Getting Care When Your Doctor Can’t See You
There might be times when you are injured or become ill and your doctor is not available. In cases of serious sickness or injury, an emergency department (ED) at a hospital may be the best place to get treatment. In most other cases, problems are best diagnosed and treated by your attending physician or urgent care center. Emergency rooms are much more costly and in a non-emergency situation, you will likely find yourself facing a long and frustrating wait, since patients with more serious problems will receive care first.

Your doctor or health plan can advise you before you go to the ED, if you feel unsure about whether or not you need emergency care. Before a situation like this occurs, ask your plan about:
• How to get care for non-life threatening conditions after normal business hours;
• What to do if you need to go to the emergency department; and
• What to do if you are admitted to the hospital as a result of the emergency.

Getting Care When You Are Too Sick to Communicate
An accident or illness can take away your ability to make health care choices. You can take steps now to make sure your wishes are carried out if this happens by creating a set of instructions known as an “advance directive.” An advance directive lets you choose someone you trust to make health care decisions for you if you cannot, and documents your treatment wishes, particularly about treatments needed to keep you alive.

You can choose anyone who is 18 or older and who is not involved with the health care facility where you are receiving care. You can prepare by talking to your doctor, hospital, or nursing home, and family or friends who you want to know about your wishes. For more information on advance directives and your rights under Maryland law, go to Maryland’s Web site at http://www.oag.state.md.us/healthpol/AdvanceDirectives.htm.
The charts on this page summarize how members view their health care and how easy it is for them to get care. 

Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

| Data Source: Member Survey |

### Getting Needed Care
The percentage of members who said it was “not a problem” choosing a personal doctor or nurse, seeing a specialist, getting necessary care, and getting quick approval for care.

- **HMO**
  - BlueChoice: **
  - Kaiser Permanente: *
  - OCI: **
  - POS Plan: **
  - Aetna: **
  - M.D. IPA: **

** MD Plan Average = 76%

### Getting Care Quickly
The percentage of members who said they “always” got help when they called their doctor during office hours, got needed care for illness or injury when they wanted, got timely appointments for routine care, and waited no longer than 15 minutes past their appointment time.

- **HMO**
  - BlueChoice: **
  - Kaiser Permanente: *
  - OCI: **
  - POS Plan: **
  - Aetna: **
  - M.D. IPA: **

** MD Plan Average = 41%

### How Well Doctors Communicate
The percentage of members who said that their provider “always” listened to them, explained things clearly, showed them respect, and spent enough time with them.

- **HMO**
  - BlueChoice: **
  - Kaiser Permanente: *
  - OCI: **
  - POS Plan: **
  - Aetna: *
  - M.D. IPA: **

** MD Plan Average = 59%

### Rating of Health Care
The percentage of members who rated their overall care “9 or 10” on a scale of 0–10, with 10 being the “best health care possible.”

- **HMO**
  - BlueChoice: ****
  - Kaiser Permanente: *
  - OCI: **
  - POS Plan: **
  - Aetna: **
  - M.D. IPA: **

** MD Plan Average = 47%
BABY STEPS TO A HEALTHY LIFE

Every baby follows its own path in developing movement (motor) skills and relating to the world. How and when your child reaches milestone during the first two years will vary. Your baby’s doctor is a good source to help you decide when a variation might be a cause for concern. The American Academy of Pediatrics recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age. Regular check-ups for children during the early teen years can make parents aware of physical, emotional, behavioral, and social problems.

Health plans are rated on how well they provide preventive services—such as immunizations and regular check-ups—to children and adolescents. Most immunizations are given by the time children become 2 years old, but others are given during adolescence. For example, shots are given by age 13 to protect against hepatitis B.

Where does this information come from? For this group of members, each health plan checked its records to see which members received recommended care. For instance, did each child get the recommended check-ups and vaccines that prevent polio and other childhood diseases?

Managing Your Health Care—How Doctors in Maryland Help to Prevent Illness in Children

Keeping track of which shots your child needs can be difficult. Maryland doctors can keep your child’s shots up to date using ImmuNet. ImmuNet is a computer system that helps doctors track immunizations given to children. Your information is kept private and safe. Although only doctors can access this system, there are many benefits to you and your child.

ImmuNet helps your doctor keep your child healthy by:

- Making sure that your child receives correct and timely immunizations
- Providing Maryland doctors access to your child’s complete shot history so that if you move your new doctor will have the information
- Tracking your child’s shot records from different doctors so your child does not get a shot more often than needed
- Sending you a reminder when your child is due for a shot

For additional information on ImmuNet, visit the registry Web site at www.mdimmunet.org.
The charts on this page summarize how plans provided children with important preventive care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

**Immunizations for Children**
The percentage of children who received vaccines for measles, mumps and rubella (MMR); polio; influenza (flu) type b; hepatitis B; chicken pox (VZV); and diphtheria, tetanus, and pertussis (DTaP/DT) by age two.

- MD Plan Average = 81%

**Immunizations for Adolescents**
The percentage of adolescents who received vaccines for MMR, hepatitis B, and chicken pox by age 13.

- MD Plan Average = 60%

**Well-Child Visits for Infants and Children**
The combined percentages of infants who had six or more visits by age 15 months and children ages 3–6 years who had at least one visit to a primary care provider during 2005.

- MD Plan Average = 72%

**Well-Care Visits for Adolescents**
The percentage of adolescents ages 12–21 who had at least one visit to a primary care provider during 2005.

- MD Plan Average = 39%
PREVENTION—A KEY TO HEALTHY LIVING

Preventing diseases or detecting them early keeps you healthy. Breast cancer screening is one example of a preventive service that health plans provide. When breast cancer is caught early, women have less of a chance of needing surgery and a better chance for survival. Women should start getting breast cancer screening from age 40 (or from a younger age, for women with high risk).

In Maryland, the National Breast and Cervical Cancer Early Detection Program provides breast cancer screening to low-income women. For more information about this program, call 800-477-9774 or visit www.fha.state.md.us/cancer/html/bc_scrn.html

Health plans rate differently on how well they provide their members with various preventive care services. The data on the next page show how well health plans performed in different preventive care areas in 2006. Information like this can help health plans decide which preventive services they need to improve.

Where does this information come from? For this group of members, each health plan checked its records to examine which members got the recommended screening service; for example, whether women age 50 and older got breast cancer screening at least once during 2004 or 2005.

Managing Your Health Care—How Kaiser Permanente Improved Colorectal Cancer Screening for its Members

Kaiser Permanente decided to improve its colorectal cancer screening program after reviewing the 2005 results. The plan decided to create a new telephone outreach program, using interactive voice technology, to educate members on the importance of colorectal cancer screening, to identify and address barriers that prevent some people from getting the screening, and to encourage follow up with members’ physicians after screening. The program also allowed members to request home test kits for detecting blood in the stool. The presence of blood in the stool is a symptom of colorectal cancer, as well as other factors, so members with this result are asked to have further tests, such as a colonoscopy.

The first telephone calls to members began in October 2005 and ended in December 2005. Members between the ages of 50–80 were contacted, regardless of the length of their enrollment.

Fifty percent of members (9,600 people) who completed the call asked for a home test kit, and approximately 16 percent of those members returned their kits for analysis, as instructed. The 2006 colorectal cancer screening results for Kaiser Permanente showed that the number of members who were screened increased from 50 percent to 53 percent.

This program is an example of how Kaiser Permanente sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.
The charts on this page summarize how well plans provided their adult members with important preventive services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

**Performance**
- 🌟🌟🌟 Star Performer: Above Average for three years (2004–2006)
- 🌟🌟 Above Average in 2006
- 🌟 Average in 2006
- 🌟 Below Average in 2006

*Stars show statistically significant differences between each plan’s score and the Maryland average. “Statistically significant” means scores varied by more than could be accounted for by chance.*

### Screening for Breast Cancer
The percentage of women ages 50–69 who had a mammogram in 2004 or 2005.

- **HMO**
  - BlueChoice: 71
  - Kaiser Permanente: 78
  - OCI: 68
  - Aetna: 68
  - M.D. IPA: 73

MD Plan Average = 71%

### Screening for Chlamydia
The percentage of women ages 16–25 who received a test for chlamydia, a sexually transmitted bacterial infection.

- **HMO**
  - BlueChoice: 35
  - Kaiser Permanente: 76
  - OCI: 37
  - Aetna: 41
  - M.D. IPA: 41

MD Plan Average = 43%

### Screening for Colorectal Cancer
The percentage of adults ages 50–80 who received a test that screens for colon cancer.

- **HMO**
  - BlueChoice: 54
  - Kaiser Permanente: 53
  - OCI: 53
  - Aetna: 52
  - M.D. IPA: 59

MD Plan Average = 55%

### Advising Smokers to Quit
The percentage of smokers 18 years of age and older who were seen by a provider in 2005 and received advice to quit smoking.

- **HMO**
  - BlueChoice: 75
  - Kaiser Permanente: 76
  - OCI: 67
  - Aetna: 67
  - M.D. IPA: 76

MD Plan Average = 73%

*Data Source: Member Survey*
MANAGING ONGOING MEDICAL PROBLEMS
If you already have a persistent (chronic) disease such as diabetes, having a health plan that provides quality services to manage the disease makes a difference. Doctors can control your diabetes by checking and controlling your blood sugar and cholesterol levels, making sure that you get routine eye exams, and testing your kidneys for kidney disease.

As reported in 2006, 49 percent of Maryland plan members had a cholesterol level less than 100mg/dL and 72 percent had a cholesterol level less than 130mg/dL. In addition, 71 percent of plan members had their blood sugar (HbA1c) level controlled. Only 22 percent of Maryland plan members received comprehensive diabetes care; individual rates varied widely between plans, from 15 percent to 43 percent. Looking at these numbers can help you decide which health plans can provide you quality diabetes care, if you or a loved one needs it.

Where does this information come from? For this group of members, each health plan checked its records to examine which members got the recommended service for managing certain chronic conditions. For example, the plans checked to see whether each member with diabetes got recommended regular eye exams.

Chronic Care
MANAGING ONGOING MEDICAL PROBLEMS

Aetna’s Healthy Outlook Diabetes Disease Management program has been in place since the early 1990s and remains a top priority. As of 2005, 7 percent of Aetna members in Maryland had diabetes, accounting for 62,000 doctor visits annually; it is first among all reported common chronic illnesses. Successful management requires frequent monitoring by physicians and patients to avoid complications including blindness and major organ failure. Implementation of the following activities showed overall improvements across diabetes measurements for each of the last three years:

• Use of detailed records and tools by Aetna clinical staff to track and flag the potential need for outreach
• Physician education, including online classes, incentives for good performance, and charting tools and reminders about when patients need certain diabetes care and services
• Member education that emphasizes ways to stay healthy, with schedules for monitoring important lab values and ongoing systems that send reminders to patients to come in for screenings

This program is an example of how Aetna sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.
The charts on this page summarize how well plans provided their adult members with important health care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

Persistence of Beta-Blocker Treatment after a Heart Attack
The percentage of members ages 35 and older who were hospitalized due to a heart attack and received a beta-blocker medication for six months after discharge.

- **HMO**
  - BlueChoice: ★
  - Kaiser Permanente: ★★★★
  - OCI: ★★
  - POS Plan: ★★
  - Aetna: ★★
  - M.D. IPA: ★★

MD Plan Average = 68%

Controlling High Blood Pressure
The percentage of members with high blood pressure ages 46–85 who had controlled levels of pressure (no higher than 140mm Hg systolic and 90mm Hg diastolic) during 2005.

- **HMO**
  - BlueChoice: ★★
  - Kaiser Permanente: ★★
  - OCI: ★★
  - POS Plan: ★★
  - Aetna: ★★
  - M.D. IPA: ★★

MD Plan Average = 73%

Eye Exams
The percentage of adult members with diabetes who had an eye screening for retinal disease in 2005 (or in 2004, if the retinal exam was normal).

- **HMO**
  - BlueChoice: ★★
  - Kaiser Permanente: ★★★★★
  - OCI: ★
  - POS Plan: ★★★
  - Aetna: ★★★
  - M.D. IPA: ★★★

MD Plan Average = 57%

Monitoring for Kidney Disease (Diabetic Nephropathy)
The percentage of adult members with diabetes who were checked or treated for kidney disease, known as diabetic nephropathy.

- **HMO**
  - BlueChoice: ★★
  - Kaiser Permanente: ★★★★★
  - OCI: ★★★
  - POS Plan: ★★
  - Aetna: ★
  - M.D. IPA: ★★★

MD Plan Average = 56%
IMPROVING PRIMARY CARE PROGRAMS TO TREAT THE MIND AND THE BODY

The physical symptoms of mental illness or the occurrence of mental illness along with a physical condition can lead people to seek care from their primary care doctors for physical complaints. Often the primary care doctor is the first point of contact for a patient, giving the primary care setting an important role in identifying someone with an undiagnosed mental disorder.

In 2000, the U. S. Surgeon General met with consumers and experts to discuss ways to improve mental health care in the primary care setting. Barriers participants identified are:

- Lack of training for primary care providers to identify mental disorders and little guidance about when it is appropriate to treat disorder in the primary care setting
- Lack of sufficient time to treat mental disorders
- Lack of adequate funding from payers unsure about “integrated” programs

When you feel you might be depressed, you should talk to your primary care doctor. Let your doctor know your symptoms and ask about what treatment options might work for you.

Where does this information come from? For this group of members, each health plan checked its records to examine which members got the recommended behavioral health service. For example, the plans checked to see whether each member who was diagnosed with depression took their prescribed antidepressant medication for the recommended amount of time.

Manage Your Health Care—How M.D. IPA and OCI Focus on Improving the Health of Members with Depression

Since 2004, M.D. IPA and OCI have offered a depression management program. The program helps patients with major depression learn the benefits of completing their cycle of treatment by offering them advice and information on treatment and recovery programs.

It has been shown that patients’ symptoms are more likely to improve when their treatment lasts through the acute and continuous phases of therapy. To encourage them to complete both phases of therapy, patients receive educational materials that include information on symptoms, treatment, recovery, and prevention of a relapse. Printed materials are mailed to patients or are available online. These include a log for monitoring medication side effects and an interactive form that identifies symptoms of depression, with coping mechanisms to reduce the symptoms. Patients may also receive case management services. Since the program began, the percentage of patients completing both the acute and continuous phases of antidepressant medication therapy has increased.

This program is an example of how M.D. IPA and OCI sought to address one quality of care issue in their program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.
The charts on this page summarize how well plans provided behavioral health services to their members. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Antidepressant Medication Management
The percentage of members who saw a primary care or mental health practitioner at least three times within the first three months of being diagnosed with depression.

- **HMO**
  - BlueChoice
  - Kaiser Permanente
  - OCI
  - POS Plan
  - Aetna
  - M.D. IPA

- **MD Plan Average = 20%**

Antidepressant Medication Treatment
The percentage of members diagnosed with depression who took their antidepressant medication for at least six months.

- **MD Plan Average = 44%**

Follow-Up After Hospitalization
The percentage of members ages 6 and older who were hospitalized for a mental disorder and were seen at least once by a mental health provider within 30 days of leaving the hospital.

- **MD Plan Average = 75%**

Initiation of Alcohol and Other Drug Treatment
The percentage of members with alcohol or other drug dependence who started treatment through an inpatient admission or outpatient services within 14 days of diagnosis.

- **MD Plan Average = 46%**
Other Useful Information for State Employees

OBTAINING AUTHORIZATION FOR BEHAVIORAL HEALTH CARE

State Employees Enrolled in POS and PPO Plans
State employees who select a POS (Aetna or M.D. IPA) or PPO plan (CareFirst BlueCross BlueShield PPO or MAMSI MLH-Eagle PPO) receive behavioral health services from APS Healthcare, Inc. The State contracts separately with APS to provide behavioral health services for employees who choose one of these plan options for their health care. If you are enrolled in one of these plans, you should contact APS to obtain authorization for behavioral health services and referrals.

State Employees Enrolled in an HMO Plan
State employees who select an HMO plan (BlueChoice, Kaiser, or OCI) receive behavioral services through either the MBHO network selected by the health plan or directly from the health plan's network of providers. You should contact Kaiser** and OCI directly to obtain authorization for behavioral health services and referrals. State employees enrolled in BlueChoice should contact the plan's MBHO, Magellan at 800-245-7013 for referral and authorization.

Insurance Complaints and Appeals
You have the right to disagree and ask your health plan to change a decision to deny, limit, or not cover a medical service. This is called a “grievance.” You can also ask a government agency to decide if the plan’s final decision is fair (a “complaint”). The type of plan you have makes a difference in what steps you should take. Ask Employee Benefits or refer to the next section to learn if your plan is fully-insured or self-insured.

Fully-Insured Health Plans—State Regulated
Contracts between the State of Maryland and HMOs stipulate that the HMO fully insures all members. The State of Maryland regulates these plans through the Maryland Insurance Administration (MIA); therefore, as a member of BlueChoice, Kaiser Permanente, or OCI you may file a grievance or a complaint after exhausting your plan's internal process*. You can find out more information about filing a grievance by contacting the Consumer Protection Division of the Maryland Attorney General’s Office at 877-261-8807. To file a complaint, call the MIA at 800-492-6116.

Self-Insured Health Plans—Federally Regulated
The State of Maryland is primarily self-insured for members belonging to POS plans included in this Guide, Maryland Point of Service, administered by BlueCross BlueShield Maryland (not in this Guide), and PPOs offered to State employees. Members of these plans must first exhaust their plan's internal process*. A federal law known as ERISA regulates these plans. You may file an appeal to the U.S. Department of Labor (call 866-4-USA-DOL) regarding problems that cannot be resolved with your plan or obtain assistance from a mediator from the Consumer Protection Division of the Maryland Attorney General’s Office (877-261-8807).

PERFORMANCE REPORTS
For an electronic version of this Guide and additional information on health plan quality and performance, visit the MHCC Web site at http://mhcc.maryland.gov/consumerinfo/.

- Measuring the Quality of Maryland HMOs and POS Plans: 2006/2007 Consumer Guide. Contains similar information as this Guide, but covers all seven HMOs and POS plans operating in the State of Maryland.
- Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland. Contains more plan-specific rates on HEDI (clinical) and CAHPS (survey) measures.
- Maryland Commercial HMOs & POS Plans: Report to Policy Makers. Compares the performance of commercial HMOs and POS plans in Maryland, as a group, to their counterparts in the region and nation.

Publications on the performance of health care facilities are available on the MHCC Web site at http://mhcc.maryland.gov/consumerinfo/. This site includes three Web-based, interactive Guides:

- Maryland Hospital Performance Evaluation Guide. Compares the quality of care provided by Maryland hospitals.
- Maryland Ambulatory Surgery Facility Consumer Guide. Compares descriptive information about ambulatory surgery facilities and their services.
- Maryland Nursing Home Performance Evaluation Guide. Compares comprehensive nursing care facilities and continuing care retirement communities in Maryland on age or functional ability of residents and on measures of quality.

*Members of HMO, POS, and PPO plans having a problem that cannot be resolved through the internal process can send their appeal to the Benefits Review Committee. The committee considers appeals on a monthly basis, for which it has received all documentation from the member’s provider and plan. Send appeals to: State of Maryland Benefits Review Committee, c/o Employee Benefits Division, 301 W. Preston Street, Rm 510, Baltimore, MD 21201.
Nationally, health care premiums increased an average of 9.2 percent in 2005, down from the 11.2 percent average in 2004. With the rate of increase of health care costs outpacing that of growth in wages and other business expenses, more employers are stepping up their cost-containment efforts. Employer strategies range from educational efforts to creative cost sharing methods.

Employees becoming better health care consumers
Employees may not realize that how they use the health care system affects health care cost. Some employers are using educational initiatives to inform their employees about how to navigate the system at a lower cost; for example, choosing a generic over a brand-name drug, seeing a primary care provider instead of a specialist, or using an urgent care center instead of a hospital emergency room.

Promoting employee health
Employees whose medical conditions are well managed are more productive and absent less often than employees whose medical conditions are poorly controlled. The Commonwealth Fund (2005) reports that absenteeism and “presenteism” cost U.S. employers $260 billion in 2003. In an effort to promote employee wellness, some employers offer health promotion programs. Some include onsite fitness programs; full or discounted membership to gyms; and even financial rewards for exercising, dieting, and other “good” health behaviors.

Employee cost-sharing
Some employers are targeting cost-sharing strategies at employees who practice unhealthy behaviors (e.g., smoking) in an effort to improve health and lower health care costs. The estimated additional premium that employers charge employees who smoke ranges, on average, from $20 to $50 a month. The National Business Group on Health (http://www.wbgh.org/) estimates that employees who smoke add an additional $3,856 a year to a company’s health care costs.

Health Information Technology
Health information technology (HIT) is broadly thought of as using computers to store, retrieve, and share health information, data, and other information needed for decision-making purposes. Concerns about preventable medical errors, inconsistency in the quality of care, and fragmented communication among health care providers involved in treating patients have all emerged as key drivers toward wider adoption and use of HIT.

Electronic medical records contain medical information that, when authorized by the patient, can securely bridge information sharing between health care providers and create the possibility of patients not needing to fill out any forms when arriving at a physician’s office or hospital.

Interest is growing among many health care providers and consumers because of the potential efficiencies. Electronic medical records contain confidential patient information ranging from name and address to a patient’s medical history.

Achieving the promise of a more efficient and effective health care system requires more than simply acquiring technology and applying it to existing processes and practices. Large organizations such as Dell, IBM, General Motors, Kodak, and Kaiser Permanente have taken the lead in using HIT to enable employees to take greater responsibility for their own health care by securely maintaining an electronic record of their health information.
ABOUT THE MARYLAND HEALTH CARE COMMISSION (MHCC)

The MHCC is a public, regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary charge of the Commission is to evaluate and publish findings on the quality and performance of commercial HMOs, hospitals, nursing homes, and ambulatory surgery facilities that operate in Maryland. MHCC produces this Guide annually with the cooperation of Maryland HMOs and their members. Additionally, MHCC coordinates efforts with the Office of Personnel’s Employee Benefits Division to provide this Guide to State employees. These annual performance reports are the only source of objective, independently audited information on the quality of Maryland commercial HMOs. More information about MHCC and performance reports is available at http://mhcc.maryland.gov.