MARYLAND HEALTH CARE COMMISSION

2009 COMPREHENSIVE PERFORMANCE REPORT

Commercial HMO, POS, and PPO Plans in Maryland

Maryland Health Care Commission

The Maryland Health Care Commission (MHCC) is a public regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary function of the commission is to evaluate and publish findings on the quality and performance of commercial managed care plans that operate in Maryland. MHCC produces the annual comparative reports with the cooperation of the health plans and their members. These annual performance reports are the only source of objective, comprehensive, independently audited information on health care quality. More information about MHCC and reports it produces is available at **http://mhcc.maryland.gov**.

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INTRODUCTION

Overview

The Maryland Health Care Commission (MHCC) is committed to promoting improvements in health care by reporting on the performance of Maryland managed care organizations (MCO). This year, MHCC continues its 13-year history of advancing health care quality by reporting on the performance of health maintenance organizations (HMO) and point-of-service (POS) health plans. For the second year, this report includes the performance results for preferred provider organizations (PPO) that collaborated voluntarily with the state to make health care quality a priority. The *2009 Comprehensive Performance Report: Commercial HMO, POS, and PPO Plans in Maryland* gives plans, providers, researchers, and other interested individuals detailed, plan-specific and Maryland-wide indicators of performance.

The *Comprehensive Report* incorporates three years of data, collected most recently in 2009, using the Health Plan Effectiveness Data and Information Set (HEDIS®[1]) measurement tool, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) 4.0H survey, and the National Business Coalition on Health's eValue8™[3] evaluation tool. The measures included in the report cover clinical quality, member satisfaction, plan descriptive features, utilization information, and cost-effectiveness.

The *Comprehensive Report* is designed to help plans, purchasers, and policymakers assess the relative quality of services delivered by managed care plans operating in Maryland. This information can affect purchasing and enrollment decisions, marketplace changes, and quality initiatives implemented by commercial health plans.

Report Organization

The *Comprehensive Report* organizes measurement results into four domains of related information: Screening and Preventive Care; Treatment and Management Care; Satisfaction With the Experience of Care; and Cost, Efficiency, and Utilization. Maryland plans followed the guidelines in *HEDIS 2009 Volume 2: Technical Specifications* when developing their rates.

Plans are listed alphabetically in tables that display individual plan rates and the Maryland average rate.

The *Comprehensive Report* includes the following sections.

Methodology covers data sources, statistical methods, and general considerations for interpreting the data in this report.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[3]eValue8 is a copyright of the National Business Coalition on Health.

Measure Domains provide the following information.

- **Key findings** highlight salient performance results across the domain.
- **Performance rating summary tables** display the number of measures that are above average, average, or below average for each HMO/POS plan.
- **Measure definitions** as specified in *HEDIS 2009 Volume 2: Technical Specifications;* including a summary of any applicable measure specification changes that may affect the ability to trend results.
- **Data tables** containing three years of results that show plan rates (e.g., percentages, rates per 1,000 members), significant changes in rates from 2007–2009, and relative rates (i.e., designation above, equivalent to, or below the Maryland average).

Appendix A: Health Plan Descriptive and Accreditation Information presents enrollment data, board certification information and the accreditation status of each plan. In Maryland, accreditation is voluntary (i.e., not required by law). Information on the various organizations that accredit managed behavioral healthcare organizations (MBHO) is included in this section, as well.

Appendix B: Methodology for Audit of HEDIS 2009 Rates from Maryland HMO, POS, and PPO Plans summarizes the 2009 audit methodology used to verify that Maryland health plans followed the specifications of the NCQA HEDIS Compliance Audit™ [4] when they calculated rates for each measure.

Appendix C: Methodology for Administering CAHPS 4.0H Survey to Maryland HMO, POS, and PPO Plans summarizes the survey methodology used to collect and calculate the CAHPS 4.0H 2009 survey results.

Appendix D: Methods for Data Analyses describes the method used to compare plan performance and rates across years for HEDIS and CAHPS 4.0H survey measures.

Companion Maryland HMO/POS and PPO Performance Reports

Measuring the Quality of Maryland Commercial Managed Care Plans: 2009/2010 Performance Report communicates the performance of a subset of measures for each Maryland plan, along with the combined average performance compared to commercial plans in the region and nation. This user-friendly report serves employers, consumers, and policymakers.

Measuring the Quality of Maryland Commercial Managed Care Plans: State Employee Guide, Spring Edition, presents the same content and format as the *2009/2010 Performance Report,* but includes only health plans available to employees of the State of Maryland.

[4] HEDIS Compliance Audit™ is a trademark of NCQA.

Quality Evaluation and Reporting

Health General Article, Section 19-135 (c) charges the Maryland Health Care Commission with establishing and implementing a system for objective, comparative evaluation of the quality of care and performance of HMOs. The purpose of the system is twofold:

1. Help improve quality of care by establishing a common set of performance measures.
2. Disseminate findings to consumers, purchasers, managed care plans, and other interested parties.

A public-private partnership formed in 2006 between MHCC and the major health insurance carriers to broaden the positive effects of quality measurement. Aetna, CareFirst, CIGNA, Coventry, Kaiser, and United Healthcare were early collaborators with MHCC to test the feasibility of performance measurement and reporting by PPOs. Through these significant voluntary contributions, quality evaluation and reporting has expanded to include comparisons of the breadth of managed care products—HMO, POS, and PPO—in a single, independent source.

Maryland Health Plans in This Report

This report includes HMO, POS, and PPO plans that primarily serve the commercially insured population and receive over 1 million dollars in Maryland premiums.

Figure 1 lists the health plans reporting performance measures in 2009.

HMOs and POS

Health plans have the option of reporting combined performance results for their HMO and POS products, but only if POS plans operate under the licenses of their HMO. With the exception of Kaiser Permanente, each plan chose that option. Thus, references to "HMOs" and "HMO members" throughout this report should be understood to include POS members for six of the seven plans. The number of plans reporting to MHCC remained the same for 2007–2009.

PPOs

For the second year, the comparative data that health plans voluntarily collected on their PPO products are included in the state's health plan performance reports. According to the American Association of Preferred Provider Organizations, 69 percent of Americans who have health insurance are enrolled in a PPO. This report includes performance results for three PPO plans that operate in Maryland, one fewer than what we reported last year.

Figure 1: Health Plans Reporting in 2009

HMO/POS PLANS	PPO PLANS
Aetna Health, Inc.—Maryland, DC, and Virginia (Aetna)	Aetna Life Insurance Company (Aetna PPO)
Care First BlueChoice, Inc. (BlueChoice)	BluePreferred (BluePreferred)
CIGNA HealthCare Mid-Atlantic, Inc. (CIGNA)	Connecticut General Life Insurance Company (CGLIC)
Coventry Health Care of Delaware, Inc. (Coventry)	
Kaiser Family Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente)	
MD Individual Practice Association, Inc. (M.D. IPA)	
Optimum Choice, Inc. (OCI)	

Below is a brief overview of the plans' operating structures.

Aetna and **CIGNA**, for-profit HMOs and PPOs; **Coventry**, a for-profit HMO; and **Kaiser Permanente**, the only non-profit HMO operating in Maryland, represent national health care insurers in Maryland.

BlueChoice and **BluePreferred** are for-profit and operate under a holding company called CareFirst. CareFirst, Inc. is the not-for-profit parent company of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., affiliates that do business as CareFirst BlueCross BlueShield.

M.D. IPA and **OCI,** for-profit HMOs, are owned and operated by Mid Atlantic Medical Services, LLC (MAMSI), a regional holding company and subsidiary of UnitedHealth Group, Inc.

Figure 2 shows the percentage of members enrolled in the plans' HMO and POS products. PPOs did not report enrollment numbers. See Appendix A for more descriptive information on each health plan.

Figure 2: Maryland HMO/POS Enrollment 2009

Health Plan	Number of Plan Members	% of Members Enrolled in HMO	% of Members Enrolled in POS
Aetna	292,313	84%	16%
BlueChoice	671,859	68%	32%
CIGNA	183,895	60%	40%
Coventry	102,428	80%	20%
Kaiser Permanente	424,423	95%	5%
M.D. IPA	189,748	85%	15%
OCI	207,588	81%	19%

METHODOLOGY

This section describes the data and statistical methods used to determine relative plan performance and the statistical significance of trends. This report presents results collected using HEDIS, CAHPS, and eValue8 from seven HMO/POS plans and three PPO Maryland plans. PPOs were not required to submit data for all measures included in this report. Measures are grouped in four domains of health care.

1. Screening and Preventive Care
2. Treatment and Management Care
3. Satisfaction With the Experience of Care
4. Cost, Efficiency, and Utilization of Care

Data Sources

Data reported in the *Comprehensive Report* are drawn primarily from three sources: HEDIS performance measures, the CAHPS 4.0H survey, and the eValue8 tool.

HEDIS Measures

HEDIS is a standard set of performance measures developed by the National Committee for Quality Assurance (NCQA), with assistance from experts representing many fields. NCQA is a not-for-profit organization that assesses, accredits, and reports on the quality of MCOs, including HMOs, POS plans, and PPOs.

Rates reported for HEDIS 2009 measurement set reflect services delivered during the 2008 calendar year (CY). Similarly, 2008 and 2007 results presented in this report for trending purposes reflect performance experiences from CY 2007 and CY 2006, respectively. Based on the state's reporting requirements, the MHCC required plans to report 46 HEDIS measures for reporting year 2009. In addition, Maryland plans were asked to provide specific data and information about their behavioral health networks.

HEDIS measurement processes and results collected by plans for MHCC have been audited by certified auditors according to the NCQA HEDIS Compliance Audit™ protocol. The audit program, established by NCQA, is a standardized methodology that enables organizations to compare plan results for HEDIS performance measures directly. The audit is a two-part process that comprises an assessment of overall information systems capabilities, followed by an evaluation of the plan's ability to comply with HEDIS specifications. HealthcareData Company, LLC, performed the HEDIS audit functions on site at participating plans that submitted the data displayed throughout this report, under a separate, competitively-bid contract with the MHCC. See Appendix B for more information about the audit process.

Data Collection Methodology

To capture representative results effectively, HEDIS gives HMO/POS plans the choice of using the Administrative Method or the Hybrid Method of data collection. The Hybrid Method allows health plans to supplement rates typically calculated from administrative data systems that gather information from member medical records. By using the Hybrid Method, health plans can produce rates that reflect actual performance better. Twelve measures are eligible for the Hybrid Method (Figure 3).

For HEDIS 2009, only HMO and POS plans have the option to report eligible measures using the Hybrid Method. NCQA's protocol requires PPOs to report all HEDIS measures using the Administrative Method, since their presence in multistate service areas presents a barrier to accessing medical records. MHCC will confer with the participating health plans and certified audit firm about annual assessment of the feasibility of using the Hybrid Method to collect data on eligible measures.

Briefly, the basic steps of the two methods are as follows:

- ***Administrative Method:*** After identifying the eligible member population for a measure, health plans search their administrative database (claims and encounter systems) for evidence of the service. For some measures, rates calculated using the Administrative Method might be slightly lower than rates calculated for the same measure using the Hybrid Method.

- ***Hybrid Method:*** After selecting a random sample of eligible members for a measure, health plans search their administrative database for evidence that each individual in the sample received the service. If the administrative database does not contain the information, plans consult medical records to confirm that the individuals received the service.

Plans that use only administrative data to generate rates eligible for hybrid collection are indicated by a superscript "m" (^{m}) in the results tables.

Figure 3: Plans Use of the Hybrid (H) Method vs. Administrative (A) Method

	Aetna	Blue Choice	CIGNA	Coventry	Kaiser	M.D. IPA	OCI
Adult BMI Assessment	H	H	A	H	A	A	A
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	H	H	A	H	A	A	A
Childhood Immunization Status	H	H	H	H	H	H	H
Cervical Cancer Screening	A	H	H	H	A	H	A
Colorectal Cancer Screening	H	H	H	H	A	H	H
Cholesterol Management for Patients With Cardiovascular Conditions	A	H	H	A	A	H	H
Controlling High Blood Pressure	H	H	H	H	H	H	H
Comprehensive Diabetes Care	H	H	H	H	H	H	H
Prenatal and Postpartum Care	H	H	H	H	H	H	H
Well-Child Visits in the First 15 Months of Life	A	A	A	A	A	H	H
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	A	A	A	A	A	H	H
Adolescent Well-Care Visits	A	A	A	A	A	H	H

ROTATION OF MEASURES

NCQA allows health plans to *rotate* data collection for selected HEDIS measures. For eligible measures, data may be collected once and reported for two consecutive years. Measures that NCQA selects for rotation have the potential to impose a substantial burden for health plans to collect, have been part of the HEDIS measurement set for at least two years, and have had no significant changes to the methods used to collect and report data. Since this is the second year Maryland is publicly reporting on PPO performance, PPOs reported results for a limited measurement set that included only measures collected using the Administrative Method; therefore, measure rotation does not apply to rates submitted in 2009.

If a health plan rotates a measure, valid results reported to MHCC in 2008 are also shown as 2009 results in this report. Figure 4 indicates the measures that each HMO/POS plan rotated and the collection method used for hybrid collection-eligible measures.

Plans that rotate the measure are identified by a superscript "r" (^{r}) in the results tables.

Figure 4: Plan Use of Rotated Measure Results

	Aetna	Blue Choice	CIGNA	Coventry	Kaiser	M.D. IPA	OCI
Childhood Immunization Status	R	R	R	R	R	R	R
Comprehensive Diabetes Care			R*				
Cholesterol Management for Patients With Cardiovascular Conditions			R	R		R	
Adolescent Well-Care Visits						R	R
Well-Child Visits in the First 15 Months of Life							R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						R	R
Colorectal Cancer Screening			R	R		R	

*All measures composing *Comprehensive Diabetes Care* were rotated, except for HbA1c Screening, HbA1c Poor Control, and HbA1c Good Control <8.

"NOT REPORT" AND "NOT APPLICABLE" DESIGNATIONS

Plans must report a rate for each measure included in the MHCC performance reporting set; they do not have the option of choosing not to calculate or not report rates for these measures. Therefore, each *Not Report (NR)*[5] designation that appears in the Maryland health plan performance reports means that the plan did not pass the audit for that measure.

When a plan can accurately generate a rate but the denominator (the number of members who meet criteria for a measure) is less than 30, its rate is reported as *Not Applicable (NA)*. NCQA's guidelines set 30 as the lower acceptable limit for denominators. If fewer than 30 people constitute the population undergoing comparison, the statistical validity and measure meaningfulness is compromised.

[5] According to NCQA guidelines, measures are assigned *NR* if they meet the following criteria: 1.) The plan chose not to report the rate; or 2.) The plan calculated the measure but the rate was materially biased. For measures reported as a rate (e.g., *Effectiveness of Care*) and for the three service measures, "materially biased" is an error that causes a ±5 percentage point difference in the reported rate. For non-rate measures (e.g., *Use of Services* and survey measures), materially biased is an error that causes a ±10 percent change in the reported rate.

CAHPS 4.0H Survey Measures

The *Satisfaction With Experience of Care* section of this report contains survey results from health plan members. The CAHPS survey (included in the HEDIS measurement set) has been administered to randomly selected samples of Maryland health plan members enrolled in commercial products.

The survey contains questions covering such topics as enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and respondent demographics.

MHCC contracted with WB&A Market Research to administer the CAHPS 4.0H survey to the adult, commercial HMO/POS, and PPO populations. A random sample of 1,210 members from each health plan was surveyed in 2009. The survey was administered according to the protocol outlined by NCQA in *HEDIS 2009, Volume 3: Specifications for Survey Measures*. See Appendix C for additional information regarding survey methodology.

EValue8

Evalue8 is a tool designed to assess key components of a health plan's system. It helps consumers understand the plan's role and determine the efficiency and effectiveness of its programs. The National Business Coalition on Health (NBCH) produced the eValue8 tool to assess health plans at the program level. Results gathered from the tool provide an in-depth analysis in seven essential categories:

- Prevention and Health Promotion
- Chronic Disease Management
- Consumer Engagement
- Provider Measurement
- Prescription Management
- Behavioral Health Care
- Plan Profile

MHCC obtained the most current eValue8 results from the Mid-Atlantic Business Group on Health (MABGH), the local NBCH affiliate for Maryland employers. MABGH invited several major health plans in the region to submit information on their plan management and quality programs using the eValue8 tool. Of those invited, three plans completed the tool: Aetna, CareFirst BlueChoice, and Kaiser Permanente.

Statistical Analysis

Calculation of Relative Rates

This report contains Maryland HMO/POS averages for each measure, and conducts a comparison analysis between individual plan averages and the state average. State averages and a comparison analysis were not calculated for PPOs because PPO participation and reporting is voluntary, and too few PPOs reported in 2009. Regional PPO averages are included in the place of state averages.

All HMO/POS plans contribute equally to the state average rate of performance (i.e., the average rate for HMO/POS plans is determined by adding the rate for each HMO/POS plan and dividing by seven); then individual plan rates are compared to the un-weighted average rate of performance for all seven HMO/POS Maryland plans. If the difference between a plan's rate and the Maryland

HMO/POS average is statistically significant, the plan is assigned to the "above average" or "below average" category, accordingly. To determine the statistical significance of differences between the two values, a modified t-test is conducted to account for potential random errors in measurement of the individual plan's rate and in measurement of the Maryland HMO/POS average. A 95 percent degree of confidence is used to determine whether the difference between rates is statistically significant. See Appendix D for a detailed description of this methodology.

The tables in this report use the following symbols to denote relative comparisons.

★★★ The plan performed significantly better than the Maryland HMO/POS average.

★★ The plan's performance is equivalent to the Maryland HMO/POS average.

★ The plan performed significantly worse than the Maryland HMO/POS average.

In some situations, two plans with the same rate are classified into two different performance rating categories; this is the result of the data collection methodology used by the plans. Plans that use the Administrative Method tend to have smaller confidence intervals because the entire eligible population for the measure is used as the measure denominator, rather than a sample of the population. This results in a larger denominator, which allows a more precise estimation of the true rate. In statistical terms, the confidence interval around the rate is smaller. *This means that statistical examination of two plans with the same percentage rate can result in two different performance strata.* For example, Plan A and Plan B both report a rate of 85 percent for a given measure. The Maryland HMO/POS average for this example is 80 percent. Plan A used the Hybrid Method and its performance is designated as "average" because of its larger confidence interval, when compared with the state average for all seven plans. Plan B used the Administrative Method and its performance is designated as "above average," since its narrower confidence interval excludes the Maryland HMO/POS average. Additionally, plans with the same rate could be designated as performing at two different levels because statistical tests were conducted using entire numbers without rounding. Rates were rounded for display in this report.

Understanding Data Comparisons and Changes From 2007–2009

Comparison over time provides an assessment of the quality of services offered by plans and an opportunity to look at trends toward improved performance. The HMO/POS tables contain a column titled "Change 2007–2009," which indicates whether a change in a plan's actual rate from 2007–2009 is statistically significant and, if so, the direction of the change. It is an indicator of the consistency of a plan's performance over time rather than its performance in relation to other plans.

The tables use the following symbols.

↑ Plan rate increased significantly from 2007–2009.

⇔ Plan rate did not change significantly from 2007–2009.

↓ Plan rate decreased significantly from 2007–2009.

Because this indicator shows whether a plan's actual rate improved over time, it is independent of the plan's relative rating. To illustrate how this indicator differs from the relative rating indicator, a plan's rate may have changed from 65 percent in 2007 to 75 percent in 2009—a significant increase that

would be identified with the "↑" symbol. However, it is possible for the relative ranking to remain unchanged, or even decline, if the Maryland HMO/POS average changed from 60 percent in 2007 to 80 percent in 2009. In this example, the plan's relative rating may have been above average in 2007 but below average in 2009 because of the upward shift in the Maryland HMO/POS average. Over time, the plan shows a statistically significant increase in its performance, but it increased less significantly than the Maryland HMO/POS average over the same period.

The three columns titled "Comparison of Relative Rates" show how each HMO/POS plan performed in relation to the other plans that reported each year. The relative score is an indicator of the plan's performance (above average or below average) relative to the Maryland HMO/POS average.

Percentiles

NCQA annually releases Quality Compass®[6], which contains HEDIS rates and averages obtained from hundreds of HMOs across the country. These data are used to construct scores by quartile and for the top (90th percentile) and bottom (10th percentile) deciles. A score in the top decile is higher than the scores of at least 90 percent of the HMOs that report to Quality Compass; a score in the bottom decile is a score that is lower than the scores of at least 90 percent of the HMO scores in Quality Compass.

Rates and averages that are in the top and bottom deciles in the *Cost, Efficiency, and Utilization of Care* section of this report are indicated by the following symbols.

- ▲ Plan rate is higher than 90 percent of other plans nationally
- ▼ Plan rate is lower than 90 percent of other plans nationally

[6] Quality Compass® is a registered trademark of NCQA.

General Considerations for Interpreting Information

PPOs Voluntarily Reporting

Participating PPOs voluntarily submitted data for public reporting on 14 HEDIS measures and all CAHPS measures. Because this is the second year that PPOs have voluntarily submitted and reported performance information to Maryland, trend data are not available. This year only three PPOs voluntarily participated, therefore state PPO averages and comparison analysis are not included in this report.

PPOs were required to collect data using the Administrative Method only. There is the chance that this limited the opportunity to report more precise rates through medical record abstraction, which the Hybrid Method allows.

Data Completeness

A plan may not have complete data on all services rendered to its members because:

- In plan mergers or acquisitions, the surviving health plan must integrate all data from predecessor plans for future HEDIS reporting. Administrative data system conversions can be complex and can lead to data loss. Even if a system conversion has not taken place, creating HEDIS measures from multiple systems can raise data integration issues that may lead to data loss.
- For some HMO providers, payment is capitated and is not associated with each service rendered to enrollees; therefore, providers may not always submit the encounter information to the HMO, even though care was provided.
- Many HMOs do not receive complete patient data from contractual vendors that provide laboratory, radiology, pharmacy, and mental health services. Plans have improved data transfers from vendors, however, by implementing incentive programs and making this requirement part of their contracts.

These factors, along with the choice of the Administrative Method vs. the Hybrid Method of data collection, can cause either underreporting or over reporting of HEDIS results that is not attributable to differences in performance. Although plans continually work to improve their data for use in performance measurement and quality improvement, demonstrating the effects of these factors on final HEDIS rates is extremely difficult.

Performance Measurement Issues

Health plan performance assessment methods are under continual development. Each year, HEDIS measures are refined and new measures are added to create a reliable and valid means of evaluation. Factors to consider when interpreting results are highlighted throughout this report, when applicable. In addition to differences in quality, the following issues can cause variation in HEDIS results.

- HEDIS measures collected using the Hybrid or Administrative Method are calculated from samples of a plan's eligible population. Even if the plan's sampling methods conform to statistical methods, there is a small chance that the sample does not represent the underlying population. The likelihood of this random error occurring is small, but the estimate obtained with a sample may produce a result that exceeds the 5 percent error tolerance set by HEDIS specifications.

- For health plans choosing to rotate data collection for eligible measures, statistical testing over the reporting years (2007–2009) is not a true reflection of change over three years. When exercising the rotation option, health plans use valid results from the previous year for the current reporting year; therefore, the change in rate may only be a reflection of plan results over two years.

- Some measures allow optional exclusions. This means that health plans are allowed to exclude certain members from the denominator if they are identified as having had a certain procedure or comorbidity (e.g., women who have had a bilateral mastectomy may be excluded from the *Breast Cancer Screening* measure). The health plan is not required to make these exclusions, but may do so to improve the accuracy of its rates.

- HEDIS results are not risk adjusted, which may account for variation in rates for some measures, such as those in the *Frequency of Selected Procedures* measure. There may be differences in plan populations that cause rate variation, even when the quality of health care delivered is the same. For example, Plan A may have a sicker population than Plan B. Although both plans may provide the same quality of care, Plan A may have higher utilization rates for some services because its members need more medical care than the healthier members of Plan B do. Consequently, results are not caused by differences in performance.

SCREENING AND PREVENTIVE CARE

Health care practices emphasize disease prevention and reducing the effects of disease. This means undergoing screenings for life-threatening or chronic illness and taking prophylactic measures to reduce the risk of infectious diseases such as the flu. The measures in this section indicate the percentage of people who received recommended screening and preventive care services. Measures in this domain are:

- **Flu Shots for Adults Ages 50–64**
- **Childhood Immunization Status**
- **Well-Child Visits in the First 15 Months of Life**
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**
- **Adolescent Well-Care Visits**
- **Prenatal and Postpartum Care**
- **Breast Cancer Screening†**
- **Colorectal Cancer Screening**
- **Cervical Cancer Screening†**
- **Chlamydia Screening in Women**
- **Appropriate Testing for Children With Pharyngitis†**
- **Use of Spirometry Testing in the Assessment and Diagnosis of COPD†**
- **Medical Assistance With Smoking and Tobacco Use Cessation**
- **Adult BMI Assessment *(new measure)***
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents *(new measure)***

†Results include comparative data for PPO plans.

Screening and Prevention Key Findings

HMO/POS Plans

- Figure 5 provides a summary of plan performance, listing the number of measures where plan performance was above average, average and below average compared to the Maryland average.
- Most HMO/POS plans in Maryland demonstrated average performance for screening and prevention measures. Three plans did not perform above average on any measures in this domain (Figure 5).
- *Childhood Immunization Status Combination 2* exhibited the highest Maryland average (83 percent) among measures in this domain (Table 6). The *Appropriate Testing for Children With Pharyngitis* and *Cervical Cancer Screening* measures followed closely with Maryland averages of 82 and 81 percent, respectively (Tables 15 and 18).
- For the *Chlamydia Screening* measure, the variation in performance was relatively large, ranging from 72 percent to a low of 33 percent (Table 17).
- Use of *Spirometry Testing in the Assessment and Diagnosis of COPD* had the lowest Maryland average with a score of 38 percent (Table 20).
- Five plans showed significant improvement between 2007 and 2009 on the *Chlamydia Screening* and *Appropriate Testing For Children with Pharyngitis* measures (Tables 17 and 18).
- The Discussing Smoking Cessation Medications measure showed the largest positive change (10 percentage points) in performance from 2007 to 2009 (Table 23). Although three measures demonstrated no change from 2007 to 2009 (Tables 9, 11 and 15); no measures in this domain had a negative change in performance.
- Plan rates were under 50 percent in 2009 for *Adolescent Well-Care Visits* (Table 10), *Chlamydia Screening in Women* (Table 17), *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (Table 20), and *Discussing Smoking Cessation Medications and Strategies* (Tables 23 and 24).

PPO Plans

- Variation in PPO plan performance was largest for the *Cervical Cancer Screening* measure. PPO plan rates ranged from 54 percent–77 percent (Table 16).
- All PPO plans' *Breast Cancer Screening* absolute rates and *Appropriate Testing for Children With Pharyngitis* absolute rates were higher in 2009 (Tables 12 and 19).
- All three PPOs scored higher than the regional average for the *Appropriate Testing for Children With Pharyngitis* measure (Table 19).
- PPO rates were lowest for the *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure (Table 21).

Figure 5: HMO/POS* Summary of Performance Ratings for Screening and Preventive Care

	Above-Average Performance ★★★	Average Performance ★★	Below-Average Performance ★
Aetna	—	8	4
BlueChoice	2	11	2
CIGNA	5	6	1
Coventry	—	10	5
Kaiser Permanente	8	4	—
M.D. IPA	2	9	1
OCI	—	7	5

*A state average cannot be calculated for PPO plans because participation is voluntary and too few plans elected to participate in 2009. A summary of performance for PPO plans in Maryland is not included.

Screening and Prevention Measure Results

Flu Shots for Adults Ages 50–64

Percent of members 50–64 years of age as of September 1, 2008, who received an influenza vaccination between September 2008 and the date on which the CAHPS 4.0H Adult Survey was completed. Tables 1 and 3 display the percentage of members enrolled in a HMO or PPO plan and received an influenza vaccination. Tables 2 and 4 display the reasons why members did not receive an influenza vaccination during the reporting year.

Table 1: Flu Shots for Adults Ages 50-64, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**46%**	**49%**	**51%**	**5%**			
Aetna	41%	46%	48%	⇔	★★	★★	★★
BlueChoice	46%	43%	47%	⇔	★★	★	★★
CIGNA	45%	52%	50%	⇔	★★	★★	★★
Coventry	42%	47%	49%	⇔	★★	★★	★★
Kaiser Permanente	55%	57%	57%	⇔	★★★	★★★	★★★
M.D. IPA	49%	52%	55%	⇔	★★	★★	★★★
OCI	42%	44%	48%	⇔	★★	★★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Table 2: Reasons for Not Getting a Flu Shot, 2009 HMO/POS Results					
	Didn't Ask	Refused	Ineligible	Unavailable	Other
Maryland HMO/POS Average	**57%**	**20%**	**1%**	**2%**	**21%**
Aetna	58%	20%	0%	2%	21%
BlueChoice	64%	15%	0%	1%	20%
CIGNA	51%	24%	2%	2%	22%
Coventry	57%	19%	1%	1%	22%
Kaiser Permanente	57%	22%	1%	1%	21%
M.D. IPA	60%	20%	1%	2%	18%
OCI	57%	18%	1%	2%	21%

Table 3: Flu Shots for Adults Ages 50–64, PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	*****	**51%**
Aetna PPO	50%	51%
Blue Preferred	52%	59%
CGLIC	NA	44%

*A regional result for this measure was not calculated for 2008.

Table 4: Reasons for Not Getting a Flu Shot, 2009 PPO Results					
	Didn't Ask	Refused	Ineligible	Unavailable	Other
Aetna PPO	52%	22%	1%	1%	24%
BluePreferred	56%	22%	1%	4%	19%
CGLIC	51%	24%	0%	2%	23%

Screening and Prevention Measure Results

Childhood Immunization Status

Percent of 2-year-old children that received the recommended vaccines listed in Table 5. The measure calculates a rate for each vaccine and two separate combination rates. The 2009 specifications changed the required number of doses for the HiB vaccine; therefore, for the Combo 2 and Combo 3 indicators, trending performance with prior years should be considered with caution.

Table 5: Childhood Immunization Status, HMO/POS Results

Percentage of Children Immunized																		
	Combo 2		Combo 3		DTaP		IPV		MMR		HiB		Hep B		VZV		PCV	
Maryland HMO/POS Average	83%		77%		89%		93%		95%		94%		92%		94%		84%	
Aetna[r]	85%	★★	77%	★★	91%	★★	94%	★★	96%	★★	98%	★★★	93%	★★	95%	★★	83%	★★
BlueChoice[r]	82%	★★	73%	★	87%	★★	92%	★★	94%	★★	93%	★★	90%	★★	93%	★★	79%	★
CIGNA [r]	87%	★★★	82%	★★★	90%	★★	93%	★★	96%	★★	95%	★★	94%	★★	96%	★★★	87%	★★★
Coventry[r]	81%	★★	76%	★★	87%	★★	91%	★★	97%	★★★	93%	★★	91%	★★	96%	★★	84%	★★
Kaiser Permanente[r]	86%	★★	81%	★★	89%	★★	94%	★★	95%	★★	90%	★	95%	★★★	95%	★★	86%	★★
M.D. IPA[r]	82%	★★	76%	★★	88%	★★	94%	★★	94%	★★	96%	★★	91%	★★	93%	★★	84%	★★
OCI[r]	81%	★★	76%	★★	89%	★★	92%	★★	93%	★★	93%	★★	88%	★	92%	★★	83%	★★

Legend

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.
★★ Plan performed equivalent to the Maryland HMO/POS average.
★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.
[r]This measure was eligible for rotation in 2009 and the plan elected to resubmit 2008 data in 2009. See page 12 for more information about measure rotation.

Table 6: Childhood Immunization Status Combination 2, HMO/POS Results*

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**81%**	**83%**	**83%**	**3%**			
Aetna[r]	84%	85%	85%	⇔	★★	★★	★★
BlueChoice[r]	80%	82%	82%	⇔	★★	★★	★★
CIGNA[r]	85%	87%	87%	⇔	★★★	★★★	★★★
Coventry[rm]	77%	81%	81%	⇔	★	★★	★★
Kaiser Permanente[r]	86%	86%	86%	⇔	★★★	★★	★★
M.D. IPA[r]	79%	82%	82%	⇔	★★	★★	★★
OCI[r]	75%	81%	81%	⇔	★	★★	★★

Table 7: Childhood Immunization Status Combination 3, HMO/POS Results*

	Comparison of Relative Rates		*Comparison of Relative Rates*	
	2008	2009	2008	2009
Maryland HMO/POS Average	**77%**	**77%**		
Aetna[r]	77%	77%	★★	★★
BlueChoice[r]	73%	73%	★	★
CIGNA[rm]	82%	82%	★★★	★★★
Coventry[r]	76%	76%	★★	★★
Kaiser Permanente[r]	81%	81%	★★	★★
M.D. IPA[r]	76%	76%	★★	★★
OCI[r]	76%	76%	★★	★★

*The 2009 specifications changed the required number of doses for the HiB vaccine; therefore, for the Combo 2 and Combo 3 indicators, trending performance with prior years should be considered with caution.

Legend

Change 2007–2009

↑ Plan rate increased significantly from 2007 to 2009.
⇔ Plan rate *did not* change significantly from 2007 to 2009.
↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.
★★ Plan performed equivalent to the Maryland HMO/POS average.
★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.
[r]This measure was eligible for rotation in 2009 and the plan elected to resubmit 2008 data in 2009. See page 12 for more information about measure rotation.

Screening and Prevention Measure Results

Well-Child Visits in the First 15 Months of Life

Percent of children who turned 15 months old during 2008 and received six or more well-child visits by the time they reached 15 months of age.

Table 8: Well-Child Visits in the First 15 Months of Life, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**78%**	**79%**	**79%**	**2%**			
Aetna[m]	69%	64%	65%	⇔	★	★	★
BlueChoice[m]	77%	77%	78%	⇔	★★	★	★★
CIGNA[m]	82%	82%	83%	⇔	★★★	★★★	★★★
Coventry[m]	82%	80%	77%	⇔	★★★	★★	★★
Kaiser Permanente[m]	78%	81%	81%	⇑	★★	★★★	★★★
M.D. IPA	76%	85%	90%	⇑	★★	★★★	★★★
OCI[r]	80%	81%	81%	⇔	★★	★★	★★

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.
[r]This measure was eligible for rotation in 2009 and the plan elected to resubmit 2008 data in 2009. See page 12 for more information about measure rotation.

Screening and Prevention Measure Results

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

Percent of children 3–6 years of age in 2008 who received one or more well-child visits with a primary care physician during the measurement year.

Table 9: Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**74%**	**73%**	**74%**	**0%**			
Aetna[m]	76%	75%	75%	⇔	★★	★★★	★★
BlueChoice[m]	74%	75%	76%	🡅	★★	★★★	★★★
CIGNA[m]	72%	74%	74%	🡅	★	★★★	★★
Coventry[m]	74%	73%	76%	⇔	★★	★★	★★
Kaiser Permanente[m]	70%	68%	74%	🡅	★	★	★★
M.D. IPA[r]	79%	72%	72%	🡇	★★★	★★	★★
OCI[r]	73%	72%	72%	⇔	★★	★★	★★

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.

[r]This measure was eligible for rotation in 2009 and the plan elected to resubmit 2008 data in 2009. See page 12 for more information about measure rotation.

Screening and Prevention Measure Results

Adolescent Well Care Visits

Percent of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a primary care physician or an OB/GYN practitioner during the measurement year.

Table 10: Adolescent Well-Care Visits, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**45%**	**44%**	**45%**	**1%**			
Aetna[m]	48%	43%	44%	⇔	★★	★	★★
BlueChoice[m]	46%	45%	46%	↑	★★	★★	★★★
CIGNA[m]	42%	44%	44%	↑	★	★★	★★
Coventry[m]	42%	44%	44%	↑	★	★★	★
Kaiser Permanente[m]	41%	42%	45%	↑	★	★	★★
M.D. IPA[r]	45%	45%	45%	⇔	★★	★★	★★
OCI[r]	49%	48%	48%	⇔	★★★	★★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.
[r]This measure was eligible for rotation in 2009 and the plan elected to resubmit 2008 data in 2009. See page 12 for more information about measure rotation.

Screening and Prevention Measure Results

Breast Cancer Screening

Percent of women 40–69 years of age who had a mammogram to screen for cancer.

Table 11: Breast Cancer Screening, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**69%**	**68%**	**69%**	**0%**			
Aetna	66%	66%	68%	↑	★	★	★
BlueChoice	67%	65%	68%	↑	★	★	★
CIGNA	66%	68%	69%	↑	★	★★	★★
Coventry	70%	68%	69%	↓	★★★	★★	★★
Kaiser Permanente	77%	75%	78%	↑	★★★	★★★	★★★
M.D. IPA	69%	68%	65%	↓	★★	★★	★
OCI	65%	64%	64%	⇔	★	★	★

Table 12: Breast Cancer Screening, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**64%**	**65%**
Aetna PPO	65%	68%
Blue Preferred	58%	65%
CGLIC	63%	66%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Screening and Prevention Measure Results

Colorectal Cancer Screening

Percent of adults 50–80 years of age who had appropriate screening for colorectal cancer.

Table 13: Colorectal Cancer Screening, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**57%**	**58%**	**62%**	**5%**			
Aetna	54%	56%	59%	⇔	★★	★	★★
BlueChoice[r]	55%	58%	58%	⇔	★★	★★	★★
CIGNA[r]	64%	68%	68%	⇔	★★★	★★★	★★★
Coventry	57%	45%	57%	⇔	★★	★	★
Kaiser Permanente[m]	58%	61%	71%	↑	★★	★★★	★★★
M.D. IPA[r]	59%	61%	61%	⇔	★★★	★★	★★
OCI	53%	56%	57%	⇔	★	★★	★

Table 14: Colorectal Cancer Screening, PPO Results

	Comparison of Absolute Rates
	2009
Regional PPO Average	**51%**
Aetna PPO	53%
Blue Preferred	47%
CGLIC	53%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.

[r]This measure was eligible for rotation in 2009 and the plan elected to resubmit 2008 data in 2009. See page 12 for more information about measure rotation.

Screening and Prevention Measure Results

Cervical Cancer Screening

Percent of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.

Table 15: Cervical Cancer Screening, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**81%**	**82%**	**81%**	**0%**			
Aetna[m]	79%	79%	79%	⇔	★	★	★
BlueChoice	79%	83%	82%	⇔	★	★★	★★
CIGNA	84%	84%	86%	⇔	★★	★★	★★★
Coventry	80%	80%	77%	⇔	★★	★★	★
Kaiser Permanente[m]	82%	82%	82%	⇔	★★★	★★	★★★
M.D. IPA	83%	83%	84%	⇔	★★	★★	★★
OCI[m]	78%	78%	77%	🡻	★	★	★

Table 16: Cervical Cancer Screening, PPO Results

	Comparison of Absolute Rates
	2009
Regional PPO Average	**74%**
Aetna PPO	77%
Blue Preferred	54%
CGLIC	77%

Legend

Change 2007–2009

- 🡹 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡻 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate the rate in 2009. See page 12 for more information about the Administrative Method.

Screening and Prevention Measure Results

Chlamydia Screening in Women

Percent of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Table 17: Chlamydia Screening Combined Ages 16–24, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**44%**	**43%**	**47%**	**3%**			
Aetna	41%	39%	33%	↓	★	★	★
BlueChoice	38%	43%	47%	↑	★	★★	★★
CIGNA	38%	40%	44%	↑	★	★	★
Coventry	39%	40%	42%	↑	★	★	★
Kaiser Permanente	72%	71%	72%	⇔	★★★	★★★	★★★
M.D. IPA	40%	37%	46%	↑	★	★	★★
OCI	36%	35%	43%	↑	★	★	★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Screening and Prevention Measure Results

Appropriate Testing for Children With Pharyngitis

Percent of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e. appropriate testing).

Table 18: Appropriate Testing for Children With Pharyngitis, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**78%**	**82%**	**82%**	**4%**			
Aetna	76%	81%	82%	↑	★	★★	★★
BlueChoice	73%	80%	82%	↑	★	★	★★
CIGNA	78%	83%	83%	↑	★★	★★★	★★
Coventry	72%	76%	74%	⇔	★	★	★
Kaiser Permanente	93%	92%	93%	⇔	★★★	★★★	★★★
M.D. IPA	77%	80%	84%	↑	★★	★	★★
OCI	75%	80%	81%	↑	★	★	★

Table 19: Appropriate Testing for Children With Pharyngitis, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**75%**	**76%**
Aetna PPO	82%	84%
Blue Preferred	81%	82%
CGLIC	83%	87%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Screening and Prevention Measure Results

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Percent of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who and received spirometry testing to confirm this diagnosis.

Table 20: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**35%**	**36%**	**38%**	**3%**			
Aetna	33%	37%	39%	⇑	★★	★★	★★
BlueChoice	36%	35%	36%	⇔	★★	★★	★★
CIGNA	35%	39%	39%	⇔	★★	★★	★★
Coventry	35%	33%	35%	⇔	★★	★★	★★
Kaiser Permanente	36%	36%	42%	⇑	★★	★★	★★★
M.D. IPA	36%	36%	38%	⇔	★★	★★	★★
OCI	34%	36%	35%	⇔	★★	★★	★★

Table 21: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, PPO Results

	Comparison of Absolute Rates
	2009
Regional PPO Average	**38%**
Aetna PPO	37%
Blue Preferred	40%
CGLIC	39%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Screening and Prevention Measure Results

Medical Assistance With Smoking and Tobacco Use Cessation

Three components make up the CAHPS 4.0 *Medical Assistance With Smoking and Tobacco Use Cessation* survey measure. For each component, members 18 years of age and older who are current smokers were asked about specific guidance from their practitioners.

1. **Advising Smokers and Tobacco Users to Quit** shows the percent of members whose practitioner advised them to quit smoking or using tobacco products.
2. **Discussing Smoking Cessation Medications** shows the percent of members whose practitioner recommended or discussed smoking or tobacco use cessation medications.
3. **Discussing Smoking Cessation Strategies** shows the percent of members whose practitioner recommended or discussed smoking or tobacco use cessation methods or strategies.

Table 22: Advising Smokers to Quit, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**75%**	**78%**	**77%**	**1%**			
Aetna	NA	NA	NA	NA	NA	NA	NA
BlueChoice	73%	80%	79%	⇔	★★	★★	★★
CIGNA	73%	NA	NA	NA	★★	NA	NA
Coventry	79%	76%	78%	⇔	★★	★★	★★
Kaiser Permanente	78%	NA	72%	⇔	★★	★	★★
M.D. IPA	NA	NA	NA	NA	NA	NA	NA
OCI	73%	NA	NA	NA	★★	NA	NA

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Table 23: Discussing Smoking Cessation Medications, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**40%**	**47%**	**49%**	**10%**			
Aetna	NA	NA	NA	NA	NA	NA	NA
BlueChoice	41%	48%	52%	⇔	★★	★★	★★
CIGNA	39%	NA	NA	NA	★★	★	NA
Coventry	39%	47%	52%	🡅	★★	★★	★★
Kaiser Permanente	43%	NA	44%	⇔	★★	NA	★★
M.D. IPA	NA	NA	NA	NA	NA	NA	NA
OCI	37%	NA	NA	NA	★★	NA	NA

Table 24: Discussing Smoking Cessation Strategies, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**38%**	**47%**	**45%**	**7%**			
Aetna	NA	NA	NA	NA	NA	NA	NA
BlueChoice	37%	48%	47%	⇔	★★	★★	★★
CIGNA	34%	NA	NA	NA	★★	NA	NA
Coventry	44%	46%	46%	⇔	★★	★★	★★
Kaiser Permanente	43%	NA	44%	⇔	★★	NA	★★
M.D. IPA	NA	NA	NA	NA	NA	NA	NA
OCI	32%	NA	NA	NA	★★	NA	NA

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Screening and Prevention New Measures

Adult BMI Assessment and the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were introduced in HEDIS 2009 as first-year measures. Plan-level rates are not publicly reported during the first year of measurement, and data for these measures are not included in this report.

Adult BMI Assessment

Percent of members 18–74 years of age who had an outpatient visit and had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.

HMO/POS First-Year Results:
The Maryland HMO/POS plan average for members who had an outpatient visit and had their BMI documented during 2007 or 2008 was 22 percent.

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

Percent of members 2–17 years of age who had an outpatient visit with a primary care physician or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

HMO/POS First-Year Results:
The Maryland HMO/POS plan average was 21 percent for child/adolescent members 2–17 years of age who had a BMI documented in 2008. The Maryland average plan performance was 21 percent for members receiving nutrition counseling and 19 percent for members receiving physical activity counseling.

TREATMENT AND MANAGEMENT OF CARE

The affects of chronic illnesses can lead to poorer quality of life, disability, and reduced ability to perform daily activities. Appropriate treatment and management of diseases are important for both the individual and the health care system; receiving timely care can help improve outcomes by keeping diseases and related side effects under control. The measures in this section are designed to illustrate a plan's delivery of clinical services in accordance with established and widely accepted guidelines. Measures in this domain are:

- **Comprehensive Diabetes Care†**
- **Controlling High Blood Pressure**
- **Persistence of Beta-Blocker Treatment After a Heart Attack†**
- **Cholesterol Management for Patients With Cardiovascular Conditions†**
- **Appropriate Treatment for Children With Upper Respiratory Infection†**
- **Pharmacotherapy Management of COPD Exacerbation**
- **Use of Appropriate Medications for People With Asthma†**
- **Disease Modifying Anti-Rheumatic Drug Therapy**
- **Annual Monitoring for Patients on Persistent Medications**
- **Follow-Up After Hospitalization for Mental Illness†**
- **Antidepressant Medication Management†**
- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
- **Follow-Up Care for Children Prescribed ADHD Medication**

†Results include comparative data for PPO plans.

Treatment and Management Key Findings

HMO/POS Plans

Figure 6 provides a summary of plan performance, listing the number of measures where plan performance was above average, average and below average compared to the Maryland average.

- Most HMO/POS plans in Maryland demonstrated average performance for treatment and management care measures. Two plans had more below average scores than average or above average scores (Figure 6).
- For the *Comprehensive Diabetes Care, Cholesterol (LDL-C) <100 mg/dL Control* measure the variation in performance for 2009 was relatively large, ranging from a high of 75 percent to a low of 45 percent (Table 29).
- Although all seven HMO/POS plans continued to score below 50 percent on the *Comprehensive Diabetes Care, Blood Pressure Control <130/80 mm Hg* measure, three plans demonstrated significant increases from 2007 to 2009 (Table 34). Trend data show that this measure, along with the *Comprehensive Diabetes Care, Blood Pressure Control <140/90 mm Hg* measure, had the largest increase (6 percentage points) in performance over time for measures in this domain (Tables 34 and 35).
- For the *Controlling High Blood Pressure* measures, five of the seven plans demonstrated below average performance. The two remaining plans scored above average. Trend data show that performance improved for four of the seven plans (Table 37).
- *Use of Appropriate Medications for People with Asthma* measures had a Maryland average ranging between 92 percent and 97 percent, which represent the highest average scores among all measures in this domain (Tables 47, 49, 51, 53, 55 and 57).
- *Among all measures in this domain, Annual Monitoring for Patients on Persistent Medications Total Rate* showed the largest decrease (5 percentage points) in performance from 2007 to 2009. The Maryland average was 81percent in 2007 and dropped to 76 percent in 2009 (Table 60).
- The *Initiation and Engagement of Alcohol and Other Drug Treatment* measure exhibited the lowest Maryland average (17 percent) among measures in this domain. However, with a 6 percentage point change from 2007 to 2009, this measure is among two other measures (*Comprehensive Diabetes Blood Pressure Control* mentioned above) showing the largest gain in performance over time. Five of the seven HMO/POS plans' rates increased significantly from 2007 to 2009 (Table 70).
- All seven plans scored below 50 percent on the *Initiation of Follow Up Care for Children Prescribed ADHD Medication* measure in 2009; two plans showed significant increases from 2007 to 2009 (Table 71). For the *Continuation of Follow-Up Care for Children Prescribed ADHD Medication* measure, the variation in performance in 2009 was relatively large, ranging from a high of 83 percent to a low of 32 percent (Table 72).

PPO Plans

- The variation in performance for 2009 for the *Comprehensive Diabetes Care, Medical Attention for Diabetic Nephropathy* measure was relatively large, ranging from a high of 73 percent to a low of 32 percent (Table 32).
- For the *Cholesterol Management, Cholesterol (LDL-C) Screening* measure the variation in performance for 2009 was relatively large, ranging from a high of 76 percent to a low of 34 percent (Table 41).

- All PPO plans scored above 90 percent on the *Use of Appropriate Medications for People With Asthma* measures (Tables 48, 50, 52, 54, 56 and 58).
- From 2008 to 2009 the absolute rates for the *Follow-Up After Hospitalization for Mental Illness* measures were higher for all PPOs (Tables 62 and 64).
- For the *Antidepressant Medication Management* measure, scores decreased from 2008 to 2009 for all PPOs (Table 68).

Figure 6: HMO/POS* Summary of Performance Ratings for Treatment and Management Care **

	Above-Average Performance ★★★	Average Performance ★★	Below-Average Performance ★
Aetna	1	18	7
BlueChoice	9	7	10
CIGNA	11	14	1
Coventry	—	12	14
Kaiser Permanente	8	14	4
M.D. IPA	3	16	7
OCI	5	15	6

*A state average cannot be calculated for PPO plans because participation is voluntary and too few plans elected to participate in 2009. A summary of performance for PPO plans in Maryland is not included.

**For the *Use of Appropriate Medications for People With Asthma,* the summary of ratings table above only includes the combined rate indicator; age-band indicators for this measure are omitted in the summary table.

Treatment and Management Measure Results

Comprehensive Diabetes Care

Percent of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: hemoglobin A1c (HbA1c) testing, HbA1c poor control (>9%), HbA1c good control (<8%); eye exam (retinal) performed; LDL-C screening, LDL-C control (<100mg/dL); medical attention for nephropathy; blood pressure control <130/80 and blood pressure control <140/90 mm Hg.

Table 25: Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**86%**	**85%**	**87%**	**1%**			
Aetna	85%	84%	87%	⇔	★★	★★	★★
BlueChoice	88%	84%	87%	⇔	★★	★★	★★
CIGNA	93%	93%	94%	⇔	★★★	★★★	★★★
Coventry	84%	85%	86%	⇔	★★	★★	★★
Kaiser Permanente	87%	83%	89%	⇔	★★	★★	★★
M.D. IPA	85%	83%	85%	⇔	★★	★★	★★
OCI	80%	83%	83%	⇔	★	★★	★

Table 26: Comprehensive Diabetes Care HbA1c Testing, 2009 PPO Results

	Comparison of Absolute Rates
	2009
Regional PPO Average	**77%**
Aetna PPO	77%
Blue Preferred	45%
CGLIC	78%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Table 27: Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**70%**	**70%**	**74%**	**4%**			
Aetna	66%	67%	72%	⇔	★★	★★	★★
BlueChoice	76%	77%	79%	⇔	★★★	★★★	★★★
CIGNA	76%	78%	80%	⇔	★★★	★★★	★★★
Coventry	68%	67%	69%	⇔	★★	★★	★
Kaiser Permanente	73%	65%	73%	⇔	★★	★	★★
M.D. IPA	69%	68%	73%	⇔	★★	★★	★★
OCI	63%	69%	70%	↑	★	★★	★★

Table 28: Comprehensive Diabetes Care, Cholesterol (LDL-C) Screening, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**83%**	**83%**	**85%**	**2%**			
Aetna	82%	82%	86%	⇔	★★	★★	★★
BlueChoice	86%	82%	84%	⇔	★★	★★	★★
CIGNA[r]	87%	90%	90%	⇔	★★★	★★★	★★★
Coventry	81%	83%	82%	⇔	★★	★★	★
Kaiser Permanente	84%	81%	87%	⇔	★★	★★	★★
M.D. IPA	84%	81%	83%	⇔	★★	★★	★★
OCI	80%	79%	84%	⇔	★★	★★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Table 29: Comprehensive Diabetes Care, Cholesterol (LDL-C) <100 mg/dL Control, HMO/POS Results							
	Comparison of Actual Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**48%**	**46%**	**51%**	**4%**			
Aetna	45%	43%	53%	↑	★★	★★	★★
BlueChoice	56%	65%	75%	↑	★★★	★★★	★★★
CIGNA[r]	46%	47%	47%	⇔	★★	★★	★
Coventry	50%	45%	49%	⇔	★★	★★	★★
Kaiser Permanente	47%	41%	45%	⇔	★★	★	★
M.D. IPA	45%	41%	45%	⇔	★★	★	★
OCI	44%	41%	47%	⇔	★★	★	★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Table 30: Comprehensive Diabetes Care, Eye Exams, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**56%**	**56%**	**56%**	**0%**			
Aetna[r]	51%	58%	58%	↑	★	★★	★★
BlueChoice	53%	48%	44%	↓	★★	★	★
CIGNA[r]	55%	58%	58%	⇔	★★	★★	★★
Coventry	54%	49%	48%	⇔	★★	★	★
Kaiser Permanente	64%	63%	68%	⇔	★★★	★★★	★★★
M.D. IPA	62%	64%	63%	⇔	★★★	★★★	★★★
OCI	52%	51%	55%	⇔	★★	★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Table 31: Comprehensive Diabetes Care, Medical Attention for Diabetic Nephropathy, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**79%**	**80%**	**83%**	**4%**			
Aetna	79%	80%	86%	↑	★★	★★	★★
BlueChoice	76%	73%	77%	⇔	★★	★	★
CIGNA[r]	80%	83%	83%	⇔	★★	★★	★★
Coventry	78%	82%	79%	⇔	★★	★★	★
Kaiser Permanente	89%	91%	93%	↑	★★★	★★★	★★★
M.D. IPA	80%	77%	82%	⇔	★★	★★	★★
OCI	74%	76%	81%	↑	★	★	★★

Table 32: Comprehensive Diabetes Care, Medical Attention for Diabetic Nephropathy, 2009 PPO Results	
	Comparison of Absolute Rates
	2009
Regional PPO Average	**63%**
Aetna PPO	58%
Blue Preferred	32%
CGLIC	73%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Comprehensive Diabetes Care, Continued

Table 33: Comprehensive Diabetes Care Good HbA1c Control (<8.0%), HMO/POS Results*

	Comparison of Absolute Rates			*Comparison of Relative Rates*		
	2007	2008	2009	2007	2008	2009
Maryland HMO/POS Average	**42%**	**45%**	**65%**			
Aetna	39%	42%	63%	★★	★★	★★
BlueChoice	45%	56%	71%	★★	★★★	★★★
CIGNA	45%	53%	71%	★★	★★★	★★★
Coventry	44%	42%	60%	★★	★★	★
Kaiser Permanente	38%	32%	60%	★★	★	★
M.D. IPA	45%	44%	65%	★★	★★	★★
OCI	41%	43%	64%	★★	★★	★★

*For HEDIS 2009, MHCC requires an HbA1c good control indicator of <8.0%. This is different from HEDIS 2008 and 2007, when the good control indicator was <7.0%; therefore, results for this measure cannot be trended with previous years' results.

Table 34: Comprehensive Diabetes Care, Blood Pressure Control <130/80 mm Hg, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**27%**	**30%**	**34%**	**6%**			
Aetna	25%	25%	26%	⇔	★★	★	★
BlueChoice	29%	40%	44%	🡅	★★	★★★	★★★
CIGNA[r]	30%	41%	41%	🡅	★★	★★★	★★★
Coventry	30%	25%	29%	⇔	★★	★	★
Kaiser Permanente	33%	34%	36%	⇔	★★★	★★★	★★
M.D. IPA	18%	20%	28%	🡅	★	★	★
OCI	26%	25%	31%	⇔	★★	★	★★

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Table 35: Comprehensive Diabetes Care, Blood Pressure Control <140/90 mm Hg, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**57%**	**59%**	**64%**	**6%**			
Aetna	53%	54%	60%	⇔	★	★★	★
BlueChoice	63%	57%	65%	⇔	★★★	★★	★★
CIGNA[r]	68%	76%	76%	↑	★★★	★★★	★★★
Coventry	60%	58%	62%	⇔	★★	★★	★★
Kaiser Permanente	65%	63%	65%	⇔	★★★	★★★	★★
M.D. IPA	42%	51%	56%	↑	★	★	★
OCI	51%	52%	63%	↑	★	★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Comprehensive Diabetes Care, Continued

Table 36: Comprehensive Diabetes Care, 2009 HMO/POS Results																		
	Blood Glucose (HbA1c) Testing		Blood Glucose (HbA1c) Control		Cholesterol Screening		Cholesterol Control <100 mg/dL		Eye Exams		Medical Attention for Diabetic Nephropathy		Good HbA1c Control (<8.0%)		BP Control <130/80 mm HG		BP Control <140/90 mm HG	
Maryland HMO/POS Average	**87%**		**74%**		**85%**		**51%**		**56%**		**83%**		**65%**		**34%**		**64%**	
Aetna	87%	★★	72%	★★	86%	★★	53%	★★	58%	★★	86%	★★	63%	★★	26%	★	60%	★
BlueChoice	87%	★★	79%	★★★	84%	★★	75%	★★★	44%	★	77%	★	71%	★★★	44%	★★★	65%	★★
CIGNA[r]	94%	★★★	80%	★★★	90%	★★★	47%	★	58%	★★	83%	★★	71%	★★★	41%	★★★	76%	★★★
Coventry	86%	★★	69%	★	82%	★	49%	★★	48%	★	79%	★	60%	★	29%	★	62%	★★
Kaiser Permanente	89%	★★	73%	★★	87%	★★	45%	★	68%	★★★	93%	★★★	60%	★	36%	★★	65%	★★
M.D. IPA	85%	★★	73%	★★	83%	★★	45%	★	63%	★★★	82%	★★	65%	★★	28%	★	56%	★
OCI	83%	★	70%	★★	84%	★★	47%	★	55%	★★	81%	★★	64%	★★	31%	★★	63%	★★

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Treatment and Management Measure Results

Controlling High Blood Pressure

Percent of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

Table 37: Controlling High Blood Pressure, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**59%**	**63%**	**62%**	**3%**			
Aetna	51%	60%	57%	↑	★	★	★
BlueChoice	68%	68%	70%	↑	★★★	★★★	★★★
CIGNA	76%	76%	76%	⇔	★★★	★★★	★★★
Coventry	61%	61%	54%	↓	★★★	★	★
Kaiser Permanente	65%	65%	61%	↓	★★★	★★★	★
M.D. IPA	48%	54%	58%	↑	★	★	★
OCI	46%	57%	60%	↑	★	★	★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

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Treatment and Management Measure Results

Persistence of Beta-Blocker Treatment After a Heart Attack

Percent of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI), and who received persistent beta-blocker treatment for six months after discharge.

Table 38: Persistence of Beta-Blocker Treatment After Heart Attack, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**75%**	**73%**	**77%**	**2%**			
Aetna	65%	66%	74%	⇔	★	★	★★
BlueChoice	65%	71%	68%	⇔	★	★★	★
CIGNA	74%	67%	84%	⇔	★★	★★	★★
Coventry	82%	78%	76%	⇔	★★	★★	★★
Kaiser Permanente	76%	76%	81%	⇔	★★	★★	★★
M.D. IPA	81%	78%	78%	⇔	★★	★★	★★
OCI	80%	76%	76%	⇔	★★	★★	★★

Table 39: Persistence of Beta-Blocker Treatment After a Heart Attack, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**68%**	**69%**
Aetna PPO	59%	58%
Blue Preferred	68%	76%
CGLIC	74%	80%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Cholesterol Management for Patients With Cardiovascular Conditions

Percent of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had each of the following during the measurement year: LDL-C screening and LDL-C control <100 mg/dL.

Table 40: Cholesterol Management, Cholesterol (LDL-C) Screening, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**85%**	**85%**	**87%**	**2%**			
Aetna	82%	83%	86%	⇔	★★	★★	★★
BlueChoice	78%	81%	86%	🡅	★	★	★★
CIGNA[r]	90%	92%	92%	⇔	★★★	★★★	★★★
Coventry[r]	83%	82%	82%	⇔	★★	★★	★
Kaiser Permanente	84%	88%	90%	🡅	★★	★★	★★★
M.D. IPA[r]	87%	85%	85%	⇔	★★	★★	★★
OCI	87%	84%	87%	⇔	★★	★★	★★

Table 41: Cholesterol Management, Cholesterol (LDL-C) Screening, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**74%**	**74%**
Aetna PPO	73%	74%
Blue Preferred	63%	34%
CGLIC	76%	76%

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Table 42: Cholesterol Management, Cholesterol (LDL-C) <100 mg/dL Control, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**58%**	**58%**	**62%**	**4%**			
Aetna	58%	54%	62%	⇔	★★	★★	★★
BlueChoice	46%	46%	67%	↑	★	★	★★★
CIGNA[r]	59%	68%	68%	↑	★★	★★★	★★★
Coventry[r]	63%	56%	56%	↓	★★★	★★	★
Kaiser Permanente	58%	62%	66%	↑	★★	★★	★★
M.D. IPA[r]	61%	58%	58%	⇔	★★	★★	★
OCI	60%	60%	57%	⇔	★★	★★	★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

[r]This measure was eligible for rotation in 2009 and this plan elected to resubmit 2008 data in 2009. See page 12 for an explanation of measure rotation.

Treatment and Management Measure Results

Appropriate Treatment for Children With Upper Respiratory Infection

Percent of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription (i.e., appropriate treatment as antibiotics were not prescribed).

Table 43: Appropriate Treatment for Children With Upper Respiratory Infection, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**84%**	**85%**	**86%**	**2%**			
Aetna	84%	87%	88%	↑	★★	★★★	★★★
BlueChoice	81%	81%	81%	⇔	★	★	★
CIGNA	84%	86%	87%	↑	★★	★★★	★★
Coventry	81%	78%	83%	⇔	★	★	★
Kaiser Permanente	94%	93%	94%	⇔	★★★	★★★	★★★
M.D. IPA	85%	84%	85%	⇔	★★	★★	★★
OCI	82%	83%	84%	↑	★	★	★

Table 44: Appropriate Treatment for Children With Upper Respiratory Infection, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**84%**	**86%**
Aetna PPO	89%	87%
Blue Preferred	83%	83%
CGLIC	86%	87%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Pharmacotherapy Management of COPD Exacerbation

Percent of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) encounter between January 1–November 30 of the measurement year and were dispensed appropriate medications. Two rates are reported.

1. Dispensed a systemic corticosteroid within 14 days of the event
2. Dispensed a bronchodilator within 30 days of the event

Table 45: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid, HMO/POS 2009 Results*

	Comparison of Absolute Rates	*Comparison of Relative Rates*
Maryland HMO/POS Average	**61%**	
Aetna	59%	★★
BlueChoice	46%	★
CIGNA	65%	★★
Coventry	61%	★★
Kaiser Permanente	67%	★★
M.D. IPA	63%	★★
OCI	65%	★★

*Plan specific rates are being reported for the first time in 2009; therefore, trend data are not available.

Table 46: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator, HMO/POS 2009 Results*

	Comparison of Absolute Rates	*Comparison of Relative Rates*
Maryland HMO/POS Average	**72%**	
Aetna	76%	★★
BlueChoice	54%	★
CIGNA	68%	★★
Coventry	65%	★★
Kaiser Permanente[m]	80%	★★★
M.D. IPA	78%	★★
OCI	83%	★★★

*Plan specific rates are being reported for the first time in 2009; therefore, trend data are not available.

Legend

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.

★★ Plan performed equivalent to the Maryland HMO/POS average.

★ Plan performed significantly worse than the Maryland HMO/POS average.

[m]This plan used the Administrative Method to calculate this rate in 2009. See page 9 for an explanation of the Administrative Method.

Treatment and Management Measure Results

Use of Appropriate Medications for People With Asthma

Percent of members 5–56 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.

Table 47: Use of Appropriate Medications for People With Asthma—Ages 5–9, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**96%**	**97%**	**97%**	**1%**			
Aetna	93%	98%	97%	↑	★	★★	★★
BlueChoice	96%	97%	96%	⇔	★★	★★	★
CIGNA	97%	99%	99%	⇔	★★	★★★	★★★
Coventry	98%	97%	98%	⇔	★★	★★	★★
Kaiser Permanente	97%	96%	97%	⇔	★★	★★	★★
M.D. IPA	96%	97%	96%	⇔	★★	★★	★★
OCI	96%	97%	98%	⇔	★★	★★	★★

Table 48: Use of Appropriate Medications for People With Asthma—Ages 5–9, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**97%**	**96%**
Aetna PPO	99%	97%
Blue Preferred	96%	98%
CGLIC	92%	97%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Table 49: Use of Appropriate Medications for People With Asthma—Ages 10–17, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**93%**	**95%**	**94%**	**1%**			
Aetna	90%	94%	93%	⇔	★	★★	★★
BlueChoice	93%	92%	93%	⇔	★★	★	★★
CIGNA	95%	96%	97%	⇔	★★	★★	★★★
Coventry	96%	94%	98%	⇔	★★	★★	★★★
Kaiser Permanente	95%	96%	91%	↓	★★	★★	★
M.D. IPA	91%	93%	93%	⇔	★★	★★	★★
OCI	92%	97%	94%	⇔	★★	★★★	★★

Table 50: Use of Appropriate Medications for People With Asthma—Ages 10–17, PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**96%**	**94%**
Aetna PPO	94%	94%
Blue Preferred	97%	98%
CGLIC	94%	93%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Use of Appropriate Medications for People With Asthma, Continued

Table 51: Use of Appropriate Medications for People With Asthma—Ages 5–17, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**95%**	**96%**	**96%**	**1%**			
Aetna	91%	96%	95%	⇑	★	★★	★★
BlueChoice	94%	94%	94%	⇔	★★	★★★	★
CIGNA	96%	98%	98%	⇑	★★	★★	★★★
Coventry	97%	96%	98%	⇔	★★	★★	★★★
Kaiser Permanente	96%	96%	94%	⇓	★★	★★	★
M.D. IPA	94%	95%	94%	⇔	★★	★★	★★
OCI	94%	97%	96%	⇔	★★	★	★★

Table 52: Use of Appropriate Medications for People With Asthma—Ages 5–17, PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	*	**95%**
Aetna PPO	97%	95%
Blue Preferred	97%	98%
CGLIC	93%	95%

*A regional result for this measure was not calculated for 2008.

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Use of Appropriate Medications for People With Asthma, Continued

Table 53: Use of Appropriate Medications for People With Asthma - Ages 18-56, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**93%**	**93%**	**92%**	**-1%**			
Aetna	90%	91%	93%	↑	★	★★	★★
BlueChoice	93%	92%	91%	↓	★★	★★	★
CIGNA	91%	91%	93%	⇔	★★	★★	★★
Coventry	95%	93%	91%	⇔	★★	★★	★★
Kaiser Permanente	96%	97%	93%	↓	★★★	★★★	★★
M.D. IPA	93%	92%	93%	⇔	★★	★★	★★
OCI	92%	92%	93%	⇔	★★	★★	★★

Table 54: Use of Appropriate Medications for People With Asthma—Ages 18–56 PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**92%**	**93%**
Aetna PPO	92%	94%
Blue Preferred	95%	95%
CGLIC	94%	94%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Table 55: Use of Appropriate Medications for People With Asthma—Combined Age Groups, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**94%**	**94%**	**93%**	**0%**			
Aetna	90%	93%	94%	↑	★	★★	★★
BlueChoice	94%	93%	92%	↓	★★	★	★
CIGNA	93%	93%	95%	⇔	★★	★★	★★★
Coventry	96%	94%	93%	⇔	★★★	★★	★★
Kaiser Permanente	96%	96%	93%	↓	★★★	★★★	★★
M.D. IPA	93%	93%	94%	⇔	★★	★★	★★
OCI	93%	94%	94%	⇔	★★	★★	★★

Table 56: Use of Appropriate Medications for People With Asthma—Combined Age Groups,, PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**94%**	**94%**
Aetna PPO	93%	95%
Blue Preferred	95%	96%
CGLIC	94%	94%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Use of Appropriate Medications for People With Asthma, Continued

Table 57: Use of Appropriate Medications for People With Asthma, HMO/POS 2009 Results								
	Ages 5–9		Ages 10–17		Ages 5–17		Ages 18–56	
Maryland HMO/POS Average	97%		94%		96%		92%	
Aetna	97%	★★	93%	★★	95%	★★	93%	★★
BlueChoice	96%	★	93%	★★	94%	★	91%	★
CIGNA	99%	★★★	97%	★★★	98%	★★★	93%	★★
Coventry	98%	★★	98%	★★★	98%	★★★	91%	★★
Kaiser Permanente	97%	★★	91%	★	94%	★	93%	★★
M.D. IPA	96%	★★	93%	★★	94%	★★	93%	★★
OCI	98%	★★	94%	★★	96%	★★	93%	★★

Table 58: Use of Appropriate Medications for People With Asthma, PPO 2009 Results				
	Ages 5–9	Ages 10–17	Ages 5–17	Ages 18–56
Regional PPO Average	96%	94%	95%	93%
Aetna PPO	97%	94%	95%	94%
Blue Preferred	98%	98%	98%	95%
CGLIC	97%	93%	95%	94%

Legend

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.

★★ Plan performed equivalent to the Maryland HMO/POS average.

★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Disease Modifying Anti-Rheumatic Drug Therapy

Percent of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

Table 59: Disease Modifying Anti-Rheumatic Therapy in Rheumatoid Arthritis, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**83%**	**84%**	**84%**	**1%**			
Aetna	81%	80%	81%	⇔	★★	★	★★
BlueChoice	78%	81%	79%	⇔	★	★	★
CIGNA	86%	87%	92%	🡅	★★	★★	★★★
Coventry	91%	89%	78%	🡇	★★★	★★	★
Kaiser Permanente	76%	85%	85%	🡅	★	★★	★★
M.D. IPA	86%	89%	85%	⇔	★★★	★★★	★★
OCI	83%	80%	88%	🡅	★★	★	★★★

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Annual Monitoring for Patients on Persistent Medications

Percent of members 18 years of age and older who received at least a 180-day supply of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. The following drugs are reported as a combined total rate.

ACE/ARBs

Digoxins

Diuretics

Anticonvulsants

Table 60: Annual Monitoring for Patients on Persistent Medications Combined, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**81%**	**78%**	**76%**	**-5%**			
Aetna	78%	79%	66%	🡻	★	★★★	★
BlueChoice	77%	81%	76%	🡻	★	★★★	★★
CIGNA	71%	80%	80%	🡹	★	★★★	★★★
Coventry	74%	75%	74%	⇔	★	★	★
Kaiser Permanente	74%	75%	75%	⇔	★	★	★
M.D. IPA	98%	79%	80%	🡻	★★★	★★★	★★★
OCI	97%	77%	80%	🡻	★★★	★	★★★

Legend

Change 2007–2009

- 🡹 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡻 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Follow-Up After Hospitalization for Mental Illness

Percent of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. Two rates are reported.

1. Percent of members who received follow-up within 7 days of discharge
2. Percent of members who received follow-up within 30 days of discharge

Table 61: Follow-Up After Hospitalization for Mental Illness—7 Days, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**57%**	**54%**	**57%**	**1%**			
Aetna	53%	48%	51%	⇔	★	★	★
BlueChoice	60%	59%	59%	⇔	★★★	★★★	★★
CIGNA	60%	48%	54%	⇔	★★	★	★★
Coventry	50%	46%	48%	⇔	★	★	★
Kaiser Permanente	69%	68%	65%	⇔	★★★	★★★	★★★
M.D. IPA	54%	56%	60%	⇔	★★	★★	★★
OCI	51%	54%	64%	⇑	★	★★	★★★

Table 62: Follow-Up After Hospitalization for Mental Illness—7 Days, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**48%**	**53%**
Aetna PPO	45%	53%
Blue Preferred	43%	47%
CGLIC	46%	51%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Follow-Up After Hospitalization for Mental Illness, Continued

Table 63: Follow-Up After Hospitalization for Mental Illness—30 Days, HMO/POS Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**74%**	**73%**	**76%**	**2%**			
Aetna	72%	67%	71%	⇔	★★	★	★
BlueChoice	76%	78%	78%	⇔	★★	★★★	★★
CIGNA	77%	69%	72%	⇔	★★	★★	★★
Coventry	69%	69%	67%	⇔	★	★★	★
Kaiser Permanente	76%	80%	80%	⇔	★★	★★★	★★★
M.D. IPA	74%	72%	79%	⇔	★★	★★	★★
OCI	73%	73%	85%	⇑	★★	★★	★★★

Table 64: Follow-Up After Hospitalization for Mental Illness—30 Days, PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**67%**	**73%**
Aetna PPO	63%	71%
Blue Preferred	56%	64%
CGLIC	71%	73%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Antidepressant Medication Management

Percent of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* Percent of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks)
2. *Effective Continuation Phase Treatment.* Percent of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months)

Table 65: Antidepressant Medication Management, Effective Acute Phase Treatment, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**63%**	**64%**	**66%**	**3%**			
Aetna	67%	67%	64%	⇔	★★★	★★	★★
BlueChoice	68%	69%	70%	⇔	★★★	★★★	★★★
CIGNA	61%	64%	66%	⇔	★★	★★	★★
Coventry	61%	64%	69%	🡅	★★	★★	★★
Kaiser Permanente	56%	62%	66%	🡅	★	★	★★
M.D. IPA	63%	60%	64%	⇔	★★	★	★★
OCI	65%	64%	63%	⇔	★★	★★	★★

Table 66: Antidepressant Medication Management, Effective Acute Phase Treatment, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**66%**	**64%**
Aetna PPO	66%	62%
Blue Preferred	66%	64%
CGLIC	68%	65%

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Antidepressant Medication Management, Continued

Table 67: Antidepressant Medication Management, Continuation Phase Treatment, PPO Results							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**47%**	**48%**	**48%**	**1%**			
Aetna	49%	50%	46%	⇔	★★	★★	★★
BlueChoice	52%	54%	52%	⇔	★★★	★★★	★★★
CIGNA	49%	48%	47%	⇔	★★	★★	★★
Coventry	48%	46%	51%	⇔	★★	★★	★★
Kaiser Permanente	38%	46%	49%	⇑	★	★	★★
M.D. IPA	46%	46%	45%	⇔	★★	★★	★
OCI	48%	46%	46%	⇔	★★	★★	★★

Table 68: Antidepressant Medication Management, Continuation Phase Treatment, PPO Results		
	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**50%**	**46%**
Aetna PPO	51%	48%
Blue Preferred	55%	47%
CGLIC	55%	48%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Percent of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

1. *Initiation of AOD Treatment*. Percent of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
2. *Engagement of AOD Treatment*. Percent of members who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

Table 69: Initiation of Alcohol and Other Drug Dependence Treatment, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**42%**	**49%**	**44%**	**2%**			
Aetna	49%	50%	42%	🡻	★★★	★★	★★
BlueChoice	23%	35%	33%	🡹	★	★	★
CIGNA	46%	47%	41%	⇔	★★★	★★	★★
Coventry	46%	48%	43%	⇔	★★★	★★	★★
Kaiser Permanente	45%	68%	70%	🡹	★★★	★★★	★★★
M.D. IPA	44%	46%	44%	⇔	★★	★★	★★
OCI	41%	43%	35%	🡻	★★	★	★

Table 70: Engagement of Alcohol and Other Drug Treatment, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**11%**	**17%**	**17%**	**6%**			
Aetna	15%	16%	16%	⇔	★★★	★	★★
BlueChoice	9%	24%	21%	🡹	★	★★★	★★★
CIGNA	11%	18%	18%	🡹	★★	★★	★★
Coventry	8%	13%	15%	🡹	★	★	★★
Kaiser Permanente	13%	22%	17%	🡹	★★★	★★★	★★
M.D. IPA	10%	13%	14%	🡹	★★	★	★
OCI	14%	18%	17%	⇔	★★★	★★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Treatment and Management Measure Results

Follow-Up Care for Children Prescribed ADHD Medication

Percent of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. Percent of members 6–12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase

2. *Continuation and Maintenance (C&M) Phase*. Percent of members 6–12 years of age as of the Index Prescription Episode Start Date, with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended

Table 71: Initiation of Follow-Up Care for Children Prescribed ADHD Medication, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**32%**	**32%**	**36%**	**4%**			
Aetna	31%	37%	37%	↑	★★	★★★	★★
BlueChoice	34%	29%	28%	↓	★★	★	★
CIGNA	29%	32%	38%	↑	★★	★★	★★
Coventry	29%	25%	39%	⇔	★★	★	★★
Kaiser Permanente	27%	28%	29%	⇔	★	★	★
M.D. IPA	39%	39%	45%	⇔	★★★	★★★	★★★
OCI	36%	36%	38%	⇔	★★★	★★★	★★

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Table 72: Continuation of Follow-Up Care for Children Prescribed ADHD Medication, HMO/POS Results*				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2008	2009	2008	2009
Maryland HMO/POS Average	**45%**	**50%**		
Aetna	39%	39%	★★	★
BlueChoice	87%	83%	★★★	★★★
CIGNA	32%	49%	★	★★
Coventry	23%	32%	★	★
Kaiser Permanente	43%	43%	★★	★★
M.D. IPA	51%	56%	★★	★★
OCI	41%	45%	★★	★★

*In 2007, the age and eligible population criteria were clarified for the C*ontinuation and Maintenance (C&M) Phase* numerator. Changes to the measure specification may have had an impact on rates; therefore, the C&M *Phase* plan-specific results were not reported in 2007.

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

SATISFACTION WITH THE EXPERIENCE OF CARE

This section contains results for the 2009 CAHPS measures that MHCC required Maryland commercial HMO/POS plans to report and which PPOs voluntarily reported. Member satisfaction data can be a valuable decision-making tool for perspective members. CAHPS surveys provide an opportunity to assess how well current members feel their plan meets their needs. The CAHPS measures in this section evaluate Maryland residents' experience with their health plans, customer service, doctors, and decision making. Measures in this domain are:

- **Rating of Health Plan†**
- **Health Plan Customer Service†**
- **Getting Needed Care†**
- **Getting Care Quickly†**
- **How Well Doctors Communicate†**
- **Rating of Health Care†**
- **Shared Decision Making†**
- **Health Promotion and Education†**
- **Coordination of Care†**

†Results include comparative data for PPO plans.

Satisfaction With the Experience of Care Key Findings

HMO/POS Plans

Figure 7 provides a summary of plan performance, listing the number of measures where plan performance was above average, average and below average compared to the Maryland average.

- The majority of plans demonstrated average performance for Satisfaction With the Experience of Care measures. One plan had more below average scores than average or above average scores (Figure 7). In 2009, plans scored at or below 50 percent on five of nine measures (Tables 73, 77, 83, 87 and 89). On average, the plans scored lowest on the *Rating of Health Plan* measure (35 percent) and the *Health Promotion and Education* measure (27 percent) (Tables 73 and 87).
- Trend data show that the Maryland average decreased for six of the nine measures in this domain: *Health Plan Customer Service, How Well Doctors Communicate, Rating of Health Care, Shared Decision Making, Health Promotion and Education, and Coordination of Care* (Tables 75, 81, 83, 85, 87, and 89).
- *Health Plan Customer Service* measure showed the largest percentage decrease (6 percentage points) in performance over time for measures in this domain (Table 75).

PPO Plans

- In 2009, PPOs scored below 50 percent on five of nine measures (Tables 74, 78, 84, 88 and 90). The plans scored lowest on the *Rating of Health Plan* measure (41 percent to 31 percent) and the *Health Promotion and Education* measure (22 percent to 27 percent) (Tables 74 and 88).
- In 2009, PPOs achieved the highest scores for the *How Well Doctors Communicate* measure, with all PPOs scoring 68 percent (Table 82).

Figure 7: HMO/POS* Summary of Performance Ratings for Satisfaction With the Experience of Care

	Above-Average Performance ★★★	Average Performance ★★	Below-Average Performance ★
Aetna	—	4	5
BlueChoice	1	7	1
CIGNA	1	8	—
Coventry	1	8	—
Kaiser Permanente	1	7	1
M.D. IPA	1	8	—
OCI	—	9	—

*A state average cannot be calculated for PPO plans because participation is voluntary and too few plans elected to participate in 2009. A summary of performance for PPO plans in Maryland is not included.

Satisfaction With Experience of Care Measure Results

Rating of Health Plan

The *Rating of Health Plan* measure asked the following question.

"Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"

Table 73: Rating of Health Plan, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**34%**	**33%**	**35%**	**0%**			
Aetna	31%	25%	31%	⇔	★★	★	★★
BlueChoice	37%	36%	37%	⇔	★★	★★	★★
CIGNA	33%	38%	38%	⇔	★★	★★★	★★
Coventry	34%	30%	31%	⇔	★★	★★	★★
Kaiser Permanente	36%	33%	39%	⇔	★★	★★	★★★
M.D. IPA	38%	34%	34%	⇔	★★	★★	★★
OCI	32%	33%	32%	⇔	★★	★★	★★

Table 74: Rating of Health Plan, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**32%**	**37%**
Aetna PPO	29%	31%
Blue Preferred	48%	41%
CGLIC	29%	33%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Health Plan Customer Service

The *Health Plan Customer Service* measure is a composite of the following survey questions.

- *"In the last 12 months, how often did your health plan's customer service give you the information or help you needed?"*
  - Only respondents who called their health plan's Customer Service Department for information or help in the last 12 months were asked this question.
- *"In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?"*
  - Only respondents who called their health plan's Customer Service Department for information or help in the last 12 months were asked this question.
- *"In the last 12 months, did your health plan give you any forms to fill out,"* ***or*** *"In the last 12 months, how often were the forms from your health plan easy to fill out?"*
  - *Respondents* who had no experience with paperwork for their health plan in the last 12 months were considered to have never had a problem filling out paperwork.

Table 75: Health Plan Customer Service, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**56%**	**51%**	**50%**	**-6%**			
Aetna	51%	54%	52%	⇔	★	★★	★★
BlueChoice	56%	41%	40%	🡻	★★	★	★
CIGNA	54%	52%	56%	⇔	★★	★★	★★
Coventry	58%	54%	54%	⇔	★★	★★	★★
Kaiser Permanente	55%	45%	48%	⇔	★★	★	★★
M.D. IPA	64%	55%	52%	🡻	★★★	★★★	★★
OCI	55%	52%	52%	⇔	★★	★★	★★

Table 76: Health Plan Customer Service, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**51%**	**54%**
Aetna PPO	47%	48%
Blue Preferred	55%	52%
CGLIC	49%	57%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Getting Needed Care

The *Getting Needed Care* measure is a composite of the following survey questions.

- *"In the last 12 months, how often was it easy to get appointments with specialists?"*
  - Only respondents who needed to see a specialist in the last 12 months were asked this question.
- *"In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?"*
  - Only respondents who thought they needed care, tests, or treatment in the last 12 months were asked this question.

Table 77: Getting Needed Care, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**46%**	**45%**	**47%**	**1%**			
Aetna	42%	43%	44%	⇔	★★	★★	★★
BlueChoice	47%	46%	49%	⇔	★★	★★	★★
CIGNA	48%	45%	46%	⇔	★★	★★	★★
Coventry	54%	52%	50%	⇔	★★★	★★★	★★
Kaiser Permanente	41%	41%	46%	⇔	★	★★	★★
M.D. IPA	46%	43%	48%	⇔	★★	★★	★★
OCI	44%	45%	44%	⇔	★★	★★	★★

Table 78: Getting Needed Care, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**46%**	**51%**
Aetna PPO	46%	49%
Blue Preferred	48%	48%
CGLIC	41%	48%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.

★★ Plan performed equivalent to the Maryland HMO/POS average.

★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Getting Care Quickly

The *Getting Care Quickly* measure is a composite of the following survey questions.

- *"In the last 12 months, when you needed care right away how often did you get care as soon as you thought you needed?"*
  - Only respondents who thought they needed care right away in the last 12 months were asked this question.
- *"In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?"*
  - Only respondents who made an appointment for health care they did not need right away in the last 12 months were asked this question.

Table 79: Getting Care Quickly, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**56%**	**51%**	**56%**	**0%**			
Aetna	58%	49%	51%	⇔	★★	★★	★★
BlueChoice	56%	50%	58%	⇔	★★	★★	★★
CIGNA	57%	57%	61%	⇔	★★	★★★	★★
Coventry	65%	54%	56%	⇓	★★★	★★	★★
Kaiser Permanente	48%	45%	48%	⇔	★	★	★
M.D. IPA	55%	49%	62%	⇑	★★	★★	★★★
OCI	55%	52%	55%	⇔	★★	★★	★★

Table 80: Getting Care Quickly, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**57%**	**57%**
Aetna PPO	52%	58%
Blue Preferred	61%	52%
CGLIC	49%	53%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.

★★ Plan performed equivalent to the Maryland HMO/POS average.

★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

How Well Doctors Communicate

The *How Well Doctors Communicate* measure is a composite of several questions. Only respondents who had been to a doctor's office or clinic to get care for themselves in the last 12 months were asked the following survey questions.

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

Table 81: How Well Doctors Communicate, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**69%**	**65%**	**67%**	**-2%**			
Aetna	68%	65%	61%	⇔	★★	★★	★
BlueChoice	67%	66%	68%	⇔	★★	★★	★★
CIGNA	65%	64%	67%	⇔	★★	★★	★★
Coventry	77%	69%	72%	⇔	★★★	★★	★★★
Kaiser Permanente	69%	63%	69%	⇔	★★	★★	★★
M.D. IPA	67%	65%	66%	⇔	★★	★★	★★
OCI	68%	62%	67%	⇔	★★	★★	★★

Table 82: How Well Doctors Communicate, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**70%**	**71%**
Aetna PPO	64%	68%
Blue Preferred	70%	68%
CGLIC	60%	68%

Legend

Change 2007–2009

- ⇑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ⇓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.

★★ Plan performed equivalent to the Maryland HMO/POS average.

★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Rating of Health Care

The *Rating of Health Care* measure asked the following question.

- *"Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"*

Table 83: Rating of Health Care, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**43%**	**39%**	**43%**	**-1%**			
Aetna	44%	40%	36%	⇔	★★	★★	★
BlueChoice	46%	43%	47%	⇔	★★	★★	★★
CIGNA	40%	40%	48%	🡅	★★	★★	★★★
Coventry	52%	45%	46%	⇔	★★★	★★★	★★
Kaiser Permanente	38%	36%	41%	⇔	★	★★	★★
M.D. IPA	44%	38%	43%	⇔	★★	★★	★★
OCI	40%	33%	38%	⇔	★★	★	★★

Table 84: Rating of Health Care, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**44%**	**47%**
Aetna PPO	36%	42%
Blue Preferred	46%	47%
CGLIC	35%	44%

Legend

Change 2007–2009

- 🡅 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡇 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Shared Decision Making

The *Shared Decision Making* measure is a composite of two questions.

- *"In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?"*
- *"In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice was best for you?"*

Table 85: Shared Decision Making, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**59%**	**56%**	**57%**	**-2%**			
Aetna	64%	55%	50%	🡻	★★	★★	★
BlueChoice	57%	53%	61%	⇔	★★	★★	★★
CIGNA	63%	55%	60%	⇔	★★	★★	★★
Coventry	65%	60%	59%	⇔	★★	★★	★★
Kaiser Permanente	51%	54%	55%	⇔	★	★★	★★
M.D. IPA	57%	55%	55%	⇔	★★	★★	★★
OCI	55%	60%	57%	⇔	★★	★★	★★

Table 86: Shared Decision Making, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**56%**	**58%**
Aetna PPO	52%	54%
Blue Preferred	56%	55%
CGLIC	47%	61%

Legend

Change 2007–2009

- 🡹 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡻 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Health Promotion and Education

The *Health Promotion and Education* measure asked the following question.

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

Table 87: Health Promotion and Education, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**30%**	**25%**	**27%**	**-3%**			
Aetna	34%	26%	22%	🡻	★★	★★	★
BlueChoice	28%	24%	28%	⇔	★★	★★	★★
CIGNA	32%	27%	31%	⇔	★★	★★	★★
Coventry	30%	26%	25%	⇔	★★	★★	★★
Kaiser Permanente	31%	24%	28%	⇔	★★	★★	★★
M.D. IPA	24%	22%	27%	⇔	★	★★	★★
OCI	27%	27%	27%	⇔	★★	★★	★★

Table 88: Health Promotion and Education, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**27%**	**27%**
Aetna PPO	26%	27%
Blue Preferred	31%	22%
CGLIC	21%	26%

Legend

Change 2007–2009

- 🡹 Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- 🡻 Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

Satisfaction With Experience of Care Measure Results

Coordination of Care

The *Care Coordination* measure asked the following question.

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

Table 89: Coordination of Care, HMO/POS Results

	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2007	2008	2009	Change 2007-2009	2007	2008	2009
Maryland HMO/POS Average	**45%**	**41%**	**42%**	**-3%**			
Aetna	43%	37%	33%	⇔	★★	★★	★
BlueChoice	48%	42%	49%	⇔	★★	★★	★★★
CIGNA	35%	38%	42%	⇔	★	★★	★★
Coventry	52%	48%	45%	⇔	★★	★★★	★★
Kaiser Permanente	53%	42%	47%	⇔	★★★	★★	★★
M.D. IPA	42%	39%	42%	⇔	★★	★★	★★
OCI	46%	43%	39%	⇔	★★	★★	★★

Table 90: Coordination of Care, PPO Results

	Comparison of Absolute Rates	
	2008	2009
Regional PPO Average	**43%**	**45%**
Aetna PPO	36%	41%
Blue Preferred	44%	36%
CGLIC	36%	38%

Legend

Change 2007–2009

- ↑ Plan rate increased significantly from 2007 to 2009.
- ⇔ Plan rate *did not* change significantly from 2007 to 2009.
- ↓ Plan rate decreased significantly from 2007 to 2009.

Relative Rates

- ★★★ Plan performed significantly better than the Maryland HMO/POS average.
- ★★ Plan performed equivalent to the Maryland HMO/POS average.
- ★ Plan performed significantly worse than the Maryland HMO/POS average.

COST, EFFICIENCY, AND UTILIZATION

A fair appraisal of health plan quality measurement should include an assessment of how often members receive recommended care, and the associated costs of that care. This section includes data from the eValue8 tool and Relative Resource Use and Utilization measures. The evalue8 tool provides an in-depth analysis of plan processes to evaluate the system as a whole; Relative Resource Use measures address the issue of health care quality when cost of care is taken into consideration; and Utilization measures are a way to identify variations in the use of health care services. Measures in this domain are:

- **eValue8 Measures**
  - **Prevention and Health Promotion**
  - **Chronic Disease Management**
  - **Consumer Engagement**
  - **Provider Measurement**
  - **Prescription Management**
  - **Behavioral Healthcare**
- **Relative Resource Use Measures**
  - **RRU for People With Diabetes**
  - **RRU for People With Asthma**
  - **RRU for People With Cardiovascular Conditions**
  - **RRU for People With Uncomplicated Hypertension**
  - **RRU for People With COPD**
- **Utilization Measures**
  - **Ambulatory Care**
  - **Antibiotic Utilization**
  - **Frequency of Selected Procedures**
  - **Inpatient Utilization—General Hospital/Acute Care**
  - **Inpatient Utilization—Nonacute Care**
  - **Outpatient Drug Utilization**
  - **Identification and Engagement of Alcohol and Other Drug Services**

Cost, Efficiency, and Utilization Key Findings

eValue8

- Wide variation in plan scores exist for all measures (Tables 91-96). *Prescription Management* showed the largest gap--46 percentage points; rates ranged from 85 percent to 39 percent (Table 94). *Consumer Engagement* showed a similarly wide range in performance with 45 percentage points between the highest (85 percent) and lowest (40 percent) scores (Table 91). *Provider Measurement* showed the smallest gap (18 points), with rates ranging from 54 percent to 36 percent (Table 96).
- Among all measures, the scores for *Behavioral Health Care* were highest on average, ranging from 91 percent to 65 percent (Table 95). The scores were lowest on average for *Provider Measurement*, ranging from 54 percent to 36 percent (Table 96).
- For each of the six measures, one plan achieved the same level of performance as the regional benchmark (Tables 91–96).
- Over the past three years, all plans showed a decrease in absolute scores in the area of *Disease Management*. The largest drop in performance was 15 percentage points, which is the same decrease seen in the regional benchmark between 2007 and 2009. (Table 93).

Relative Resource Use

- For people with diabetes, the 2009 average expected medical cost was $267.30 nationally and $309.72 regionally. Regionally, the observed to expected ratio was 1.00, this indicates that in the region health plans used the same amount of resources as expected (Table 97).
- For people with asthma or COPD, the regional observed-to-expected ratio for total medical and total pharmacy was below 1.00. This indicates that for total medical and total pharmacy, health plans in the region used fewer resources than expected (Tables 98 and 101).
- In 2009, the expected total medical cost for people with cardiovascular conditions was $585.12 nationally and $607.00 regionally. Nationally, health plans used 3 percent more resources than expected; regionally, plans used 6 percent more resources than expected (Table 99).
- The average expected total medical cost in 2009 for people with uncomplicated hypertension was $168.59 nationally and $183.15 regionally. Nationally, health plans used 8 percent more resources than expected; regionally, plans used 3 percent more resources than expected (Table 100).

Utilization Measures

- The Maryland HMO/POS average of ED visits continued its eight-year increase, reaching 207 visits per 1,000 members (Figure 8).
- The average total number of antibiotics prescribed by Maryland HMO/POS providers declined from an average 231,909 dispensing events in 2008 to 213,382 in 2009 (Table 103).
- The Maryland HMO/POS average for both the acute and non-acute inpatient Utilization measures increased from 2008 to 2009. In 2008, inpatient utilization—acute care discharges per 1,000 members was 52.9 and the average length of stay (ALOS) was 3.6 days. In 2009, discharges per1,000 members was 56.2 and the ALOS was 3.7 days. In 2008, non-acute care discharges per 1,000 members was 1.9 and the ALOS was 13.9. In 2009, the rates were 2.1 and 14.8, respectively (Tables 110 and 111).

Cost, Efficiency, and Utilization Results

eValue8 Measures

Consumer Engagement

Assesses how the plan provides members with tools and strategies to help them manage their health benefits. Examples include Web-based practitioner directories, electronic personal health records, and cost estimation tools for medical services and prescription drugs.

Table 91: eValue8 Consumer Engagement Results			
	2007	2008	2009
Regional Benchmark	**54%**	**84%**	**85%**
Aetna	54%	84%	85%
CareFirst BlueChoice	38%	40%	40%
Kaiser Permanente	50%	70%	60%

Preventive Care

Assesses availability and types of programs offered by the plan to screen for cancer, promote health education, and support healthier birth outcomes. HEDIS rates are included in the overall score as a measure of the effectiveness of immunization and cancer screening programs.

Table 92: eValue8 Preventive Care Results			
	2007	2008	2009
Regional Benchmark	**78%**	**90%**	**82%**
Aetna	55%	57%	61%
CareFirst BlueChoice	57%	52%	58%
Kaiser Permanente	78%	90%	82%

Disease Management

Assesses the breadth of the plan's DM programs, with specific emphasis on diabetes and coronary artery disease. To determine the effectiveness of member and practitioner support programs, HEDIS rates for the two disease conditions are used to measure program performance.

Table 93: eValue8 Disease Management Results			
	2007	2008	2009
Regional Benchmark	**91%**	**83%**	**76%**
Aetna	63%	60%	57%
CareFirst BlueChoice	71%	65%	62%
Kaiser Permanente	91%	83%	76%

Cost, Efficiency, and Utilization Results

Prescription Management

Assesses the plan's programs to manage and monitor issues of overuse, underuse, and misuse of prescription drugs. Examples include how the plan monitors and acts on prescribing conflicts and how it manages the outpatient pharmacy network to ensure quality and safety.

Table 94: eValue8 Prescription Management Results			
	2007	2008	2009
Regional Benchmark	**98%**	**89%**	**85%**
Aetna	42%	50%	49%
CareFirst BlueChoice	54%	45%	39%
Kaiser Permanente	98%	89%	85%

Behavioral Healthcare

Assesses the plan's programs to manage depression, screening for alcohol overuse, and other behavioral health services. HEDIS rates are included in the overall score as a measure of the programs' effectiveness at managing alcohol abuse and depression.

Table 95: eValue8 Behavioral Health Care Results			
	2007	2008	2009
Regional Benchmark	**77%**	**84%**	**91%**
Aetna	77%	73%	76%
BlueChoice	65%	71%	65%
Kaiser Permanente	64%	84%	91%

Provider Measurement

Assesses how the plan measures, differentiates, and rewards provider performance.

Table 96: eValue8 Provider Measurement Results			
	2007	2008	2009
Regional Benchmark	**47%**	**60%**	**54%**
Aetna	47%	58%	54%
BlueChoice	31%	34%	36%
Kaiser Permanente	33%	60%	41%

Cost, Efficiency, and Utilization Results

Relative Resource Use Measures

The Relative Resource Use (RRU) measures focus on six high-cost conditions: diabetes, asthma, acute low back pain, cardiovascular conditions, uncomplicated hypertension, and COPD. The populations included in the RRU measures represent eligible populations in current HEDIS quality measures; health care consumers can consider a plan's HEDIS quality and RRU measures together. Additionally, health plans and providers may find RRU and quality measure results useful for evaluating their own effectiveness at managing chronic illnesses and improving the health status of their members. ***Note:*** *The RRU low back pain measure requires further analysis before conclusions can be drawn; therefore this measure is not presented in this report.*

Health plans use Standardized Price Tables to calculate and report total standardized costs and utilization rates across several health condition categories. NCQA calculates an expected (E) total standard cost for each chronic and acute condition by plan type (e.g., commercial) and product line (e.g., HMO). Resource use is adjusted for the composition of a plan's eligible population as it pertains to age, gender, and presence of comorbidities. This case-mix adjustment method allows comparison of utilization performance and eliminates the influences of other factors, such as having a large number of older members or having members with a greater burden of illness, which could be a disadvantage for a plan in this type of assessment. An expected cost for each health plan is based on national norms after adjusting for the plan's mix of conditions and members. ***Note:*** *This same method applies when calculating national and regional costs.*

Observed (O) amounts represent the plan's experience. Health plans submit their cost or utilization data for each measure's eligible population by following HEDIS specifications, including applying the NCQA standardized prices to each unit of heath service included in the measures. Data are displayed as per member per month (PMPM) for the Cost of Services category.

Finally, NCQA calculates an RRU index that is based on standard costs, eligible members, and services, and which serves as the basis for O/E ratio development. The O/E ratio compares health plan results with the average national or regional eligible population. For example, for the clinical condition of diabetes, a ratio result of 1.00 indicates that a health plan spent or used the same level of resources to treat its diabetic population as other plans did to treat their members with diabetes. A ratio of 1.12 indicates that a health plan used 12 percent more resources than the national average; a ratio of 0.73 indicates that a plan used 27 percent fewer resources than average. ***Note:*** *The results tables provide expected standard costs that represent the average operating national or regional plan. The O/E Ratio for the nation (or region) reflects the resource experience across all plans submitting data in relation to the expected costs for the eligible population.*

In 2009, RRU data were reported at the national and regional levels. Regional-level data included in this report are from The U.S. Department of Health and Human Services Region 3—Philadelphia: Maryland, Delaware, Pennsylvania, Virginia, West Virginia, and the District of Columbia. NCQA does not publicly report plan-level data because these measures require further analysis before definitive conclusions can be drawn.

Cost, Efficiency, and Utilization Results

Relative Resource Use for People With Diabetes

Assesses the plan's relative resource use for adult members with diabetes.

Table 97: Relative Resource Use for People With Diabetes, 2009 Results

		N	Mean	P10	P90
National Total—Medical	Expected	204	$267.30	$241.66	$290.80
	Ratio Results O/E	202	1.04	0.74	1.27
Regional Total—Medical	Expected	24	$309.72	$287.29	$330.08
	Ratio Results O/E	24	1.00	0.74	1.18
National Total—Pharmacy	Expected	204	$223.44	$208.00	$238.10
	Ratio Results O/E	203	1.07	0.86	1.26
Regional Total—Pharmacy	Expected	24	$240.26	$228.18	$252.64
	Ratio Results O/E	24	1.02	0.84	1.20

Relative Resource Use for People With Asthma

Assesses the plan's relative resource use for members with asthma.

Table 98: Relative Resource Use for People With Asthma, 2009 Results

		N	Mean	P10	P90
National Total—Medical	Expected	205	$122.65	$111.68	$133.88
	Ratio Results O/E	203	1.03	0.74	1.36
Regional Total—Medical	Expected	24	$131.78	$116.80	$147.77
	Ratio Results O/E	24	0.96	0.63	1.31
National Total—Pharmacy	Expected	205	$181.75	$168.14	$197.44
	Ratio Results O/E	204	1.07	0.90	1.19
Regional Total—Pharmacy	Expected	24	$190.19	$175.66	$208.62
	Ratio Results O/E	24	0.99	0.89	1.13

Legend

N Number of HMO/POS plans reporting
P10 10th percentile
P90 90th percentile
O/E Observed/Expected

Notes

- Regional data are from Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, they may not have submitted data for the full combination of service categories. Only plans submitting data for all service categories for the selected condition were included when determining *observed-to-expected ratio results*.
- Ratio Results Observed-to-Expected (O/E) = The plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

Cost, Efficiency, and Utilization Results

Relative Resource Use for People With Cardiovascular Conditions

Assesses the plan's relative resource use for members with cardiovascular conditions.

Table 99: Relative Resource Use for People With Cardiovascular Conditions, 2009 Results

		N	Mean	P10	P90
National Total—Medical	Expected	204	$585.12	$538.09	$635.74
	Ratio Results O/E	202	1.03	0.77	1.37
Regional Total—Medical	Expected	24	$607.00	$565.33	$646.65
	Ratio Results O/E	24	1.06	0.79	1.51
National Total—Pharmacy	Expected	204	$261.06	$246.91	$272.53
	Ratio Results O/E	203	1.06	0.83	1.20
Regional Total—Pharmacy	Expected	24	$275.75	$267.65	$283.41
	Ratio Results O/E	24	1.01	0.85	1.17

Legend

N Number of HMO/POS plans reporting
P10 10th percentile
P90 90th percentile
O/E Observed/Expected

Notes

- Regional data are from Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, they may not have submitted data for the full combination of service categories. Only plans submitting data for all service categories for the selected condition were included when determining *observed-to-expected ratio results*.
- Ratio Results Observed-to-Expected (O/E) = The plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

Cost, Efficiency, and Utilization Results

Relative Resource Use for People With Uncomplicated Hypertension

Assesses the plan's relative resource use for members with uncomplicated hypertension.

Table 100: Relative Resource Use for People With Uncomplicated Hypertension, 2009 Results

		N	Mean	P10	P90
National Total—Medical	Expected	199	$168.59	$164.02	$172.98
	Ratio Results O/E	197	1.08	0.84	1.37
Regional Total—Medical	Expected	24	$183.15	$178.98	$187.06
	Ratio Results O/E	24	1.03	0.86	1.39
National Total—Pharmacy	Expected	199	$105.21	$100.98	$109.03
	Ratio Results O/E	198	1.10	0.86	1.26
Regional Total—Pharmacy	Expected	24	$112.47	$108.60	$116.37
	Ratio Results O/E	24	1.02	0.89	1.18

Relative Resource Use for People With COPD

Assesses the plan's relative resource for members with chronic obstructive pulmonary disease (COPD).

Table 101: Relative Resource Use for People With COPD, 2009 Results

		N	Mean	P10	P90
National Total—Medical	Expected	204	$572.57	$529.80	$617.85
	Ratio Results O/E	202	1.01	0.76	1.31
Regional Total—Medical	Expected	24	$672.13	$614.15	$708.96
	Ratio Results O/E	24	0.97	0.76	1.23
National Total—Pharmacy	Expected	204	$225.64	$206.49	$240.00
	Ratio Results O/E	203	1.06	0.86	1.29
Regional Total—Pharmacy	Expected	24	$239.53	$218.61	$254.05
	Ratio Results O/E	24	0.99	0.82	1.19

Legend

N Number of HMO/POS plans reporting
P10 10th percentile
P90 90th percentile
O/E Observed/Expected

Notes

- Regional data are from Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the District of Columbia.
- "N" differs for the *expected* and *ratio results* because although a given number of plans submitted data used in calculating the expected value for a condition, they may not have submitted data for the full combination of service categories. Only plans submitting data for all service categories for the selected condition were included when determining *observed-to-expected ratio results*.
- Ratio Results Observed-to-Expected (O/E) = The plan submitted (observed) data divided by the NCQA risk adjusted (expected) data.

Cost, Efficiency, and Utilization Results

Utilization Measures

This section presents descriptive indicators and rates related to facility utilization; including information on inpatient discharge, average length of stay (ALOS), and ambulatory care.

Although there are no Utilization measure standards, plans can use these results for initial verification of outlier rates. Outlier rates indicate that something unusual is occurring with the plan, its providers, or its members, or that the plan's data collection system is flawed. The concept behind collecting these data is that HMO/POS plans can target identified areas for further study or improvement.

For Frequency of Use measures, rates of utilization are often expressed as rates of service used per 1,000 member months, or they may be converted to rates of service used per year. Unlike Screening and Preventive Care and Treatment and Management measures, continuous enrollment criteria do not factor into most of these rate calculations. The number of member months is the sum of the months when a member is enrolled in the plan each year. For plans with stable memberships, the reported number of member years is close to the number of members enrolled at any point during the year. This comparison may not apply to plans with growing or declining enrollment.

Several factors complicate interpretation of the Utilization measures. Readers should consider the following.

- Utilization can be significantly influenced by a population's member characteristics (e.g., age) or health care access alternatives. HEDIS rates are not risk adjusted, so variation in plan results may be affected by real differences in member health, race, education, socioeconomic status or outpatient alternatives. These differences may be most obvious in rates of use for various procedures. *Rates that are three standard deviations from the mean are not included.*

- Standards or accepted targets for these rates do not exist. High rates *could* indicate overutilization, while low rates *could* indicate underutilization.

- Health plans do not always measure utilization using the same method as HEDIS specifications, which means that plans do not have comparable internal rates to determine how reasonable their results are.

Because of these factors, relative rates (i.e., above/below average scores) *are not* presented for rates of procedures. Interplan comparison is not appropriate. In addition, given the large number of these measures, only 2009 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for the year of interest.

Cost, Efficiency, and Utilization Results

Ambulatory Care

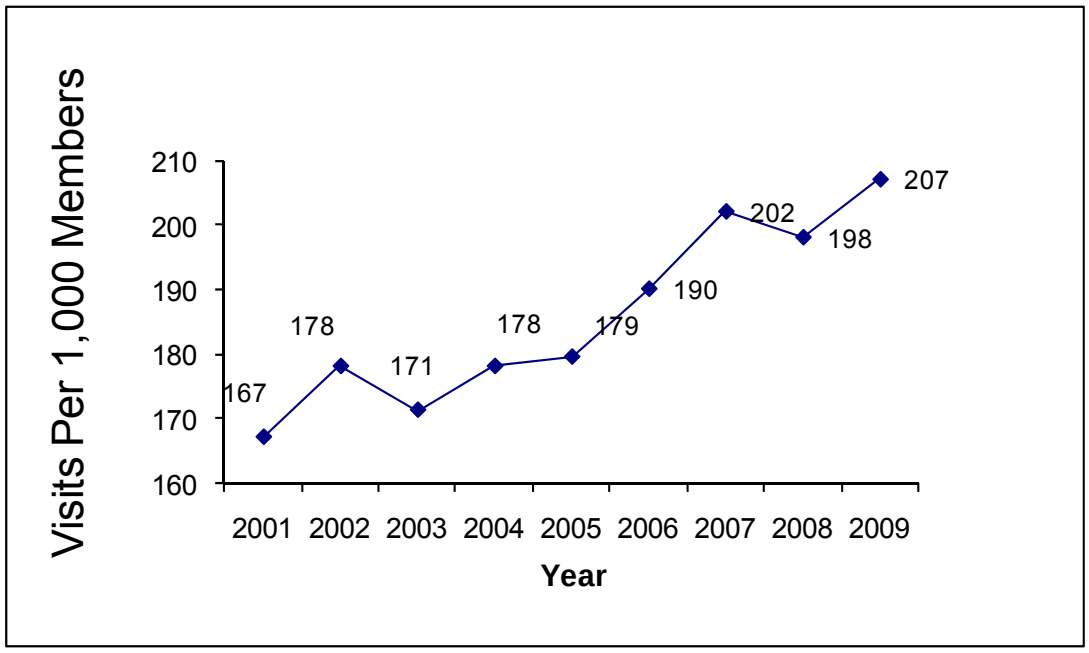
Summarizes member use of ambulatory services, including outpatient visits, ED visits, and ambulatory surgeries/procedures. Rates are per 1,000 members.

Table 102: Ambulatory Care, 2009 Results			
Visits/1,000 Members			
	Outpatient Visits	ED Visits	Ambulatory Surgery/Procedure
Maryland HMO/POS Average	**3,993**	**207**	**131**
Aetna	4,139	216	133
BlueChoice	3,871	266 ▲	65 ▼
CIGNA	4,213	199	126
Coventry	3,520	177	172
Kaiser Permanente	3,922	145	67 ▼
M.D. IPA	4,399	217	187
OCI	3,890	226	165

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Figure 8: Emergency Department, Trending



Cost, Efficiency, and Utilization Results

Antibiotic Utilization

Summarizes data on outpatient utilization of antibiotic prescriptions on the following.

- Total number of antibiotic prescriptions
- Average number of antibiotic prescriptions per member per year (PMPY)
- Total days supplied for all antibiotic prescriptions
- Average number of days supplied per antibiotic prescription
- Total number of prescriptions PMPY for antibiotics of concern
- Average number of prescriptions PMPY for antibiotics of concern
- Average number of antibiotics PMPY reported by drug class:
  - For selected "antibiotics of concern"
  - For all other antibiotics
- Percentage of antibiotics of concern of total antibiotic prescriptions
- During the measurement year, stratified by age and gender and reported for each product

Table 103 presents the total number of antibiotic prescriptions dispensed in 2009; all other indicators are not presented in this report.

Table 103: Total Antibiotic Dispensing Events, 2009 Results	
Maryland HMO/POS Average	213,382
Aetna	201,648
BlueChoice	485,548
CIGNA	112,349
Coventry	97,928
Kaiser Permanente	296,699
M.D. IPA	146,108
OCI	153,397

Cost, Efficiency, and Utilization Results

Frequency of Selected Procedures

Assesses the plan's utilization rates for the following procedures.

- *Myringotomy:* Incision of the eardrum to allow insertion of ventilating tubes to treat chronic ear infections.
- *Tonsillectomy/Tonsillectomy and Adenoidectomy:* Surgical removal of the tonsils or tonsils and adenoids.
- *Nonobstetric Dilation and Curettage (D&C):* Dilation and surgical cleansing of the surface of the uterus.
- *Hysterectomy:* Surgical removal of the uterus.
- *Cholecystectomy, open:* Surgical removal of the gallbladder through an abdominal incision.
- *Cholecystectomy, closed (laparoscopic):* Surgical removal of the gallbladder with a laparoscope.
- *Angioplasty:* Repairing or replacing damaged blood vessels using lasers or tiny inflatable balloons at the end of a catheter that is inserted into the vessels.
- *Cardiac Catheterization:* Procedure used to diagnose the severity and extent of coronary artery disease.
- *Coronary Artery Bypass Graft (CABG):* Surgical procedure used to treat coronary heart disease by grafting a portion of a vein from the patient to replace the portion of the damaged or blocked coronary artery.
- *Prostatectomy:* Surgical removal of the prostate gland.
- *Back Surgery:* Spinal fusions and disc surgeries, including laminectomies with and without disc removal.
- *Mastectomy:* Surgical removal of all or most of the breast.
- *Lumpectomy:* Surgical removal of a small tumor from the breast.

Table 104: Frequency of Myringotomies and Tonsillectomies, 2009 Results				
	Procedures/1,000 Applicable Population			
	MYR 0-4 years M&F	MYR 5-19 years M&F	TA 0-9 years M&F	TA 10-19 years M&F
Maryland HMO/POS Average	**41.2**	**3.1**	**7.7**	**3.3**
Aetna	41.7	3.4	7.0	2.6
BlueChoice	19.5 ▼	2.0	7.6	3.7
CIGNA	62.4	4.4	8.4	3.1
Coventry	54.7	4.1	8.8	5.1
Kaiser Permanente	18.0 ▼	1.6 ▼	5.4	1.7 ▼
M.D. IPA	45.8	2.6	7.8	3.5
OCI	46.3	3.6	8.8	3.5

Notes

MYR Myringotomy
TA Tonsillectomy or Tonsillectomy and Adenoidectomy
M&F Male and Female

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Table 105: Frequency of D&Cs and Hysterectomies, 2009 Results						
	Procedures/1,000 Female Applicable Population					
	D&C 15-44 yrs	D&C 45-64 yrs	HYS-ab 15-44 yrs	HYS-ab 45-64 yrs	HYS-vag 15-44 yrs	HYS-vag 45-64 yrs
Maryland HMO/POS Average	**2.8**	**3.7**	**3.4**	**5.3**	**1.7**	**2.5**
Aetna	2.9	4.5	3.5	6.1	2.0	3.2
BlueChoice	3.3	4.4	2.9	5.5	1.7	3.1
CIGNA	2.7	3.1	3.4	5.1	1.8	3.0
Coventry	4.4 ▲	4.9	4.7	5.1	2.1	2.6
Kaiser Permanente	0.4 ▼	0.8	2.7	5.8	0.4 ▼	0.9 ▼
M.D. IPA	3.0	4.1	3.4	4.6	1.9	2.4
OCI	3.1	4.0	3.1	5.1	2.1	2.5

Notes

D&C Dilation & Curettage
HYS-ab Hysterectomy—Abdominal
HYS-vag Hysterectomy—Vaginal

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Table 106: Frequency of Cholecystectomies, 2009 Results						
	Procedures/1,000 Applicable Population					
	Chol-o 30-64 yrs Male	Chol-o 15-44 yrs Female	Chol-o 45-64 yrs Female	Chol-c 30-64 yrs Male	Chol-c 15-44 yrs Female	Chol-c 45-64 yrs Female
Maryland HMO/POS Average	**0.3**	**0.2**	**0.3**	**2.2**	**4.6**	**5.2**
Aetna	0.3	0.2	0.4	1.8	3.8	4.8
BlueChoice	0.3	0.2	0.3	2.2	4.7	5.6
CIGNA	0.3	0.2	0.5	2.7	5.0	6.4
Coventry	0.3	0.2	0.2	2.9	5.6	5.0
Kaiser Permanente	0.2	0.1	0.3	1.2 ▼	3.0 ▼	3.7
M.D. IPA	0.3	0.2	0.3	2.5	4.3	5.3
OCI	0.3	0.1	0.3	2.4	5.7	5.9

Notes
Chol-o Cholecystectomy—Open
Chol-c Cholecystectomy—Closed

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Table 107: Frequency of Back Surgeries, 2009 Results				
	Procedures/1,000 Eligible Population			
	Back Surgery 20-44 yrs Male	Back Surgery 20-44 yrs Female	Back Surgery 45-64 yrs Male	Back Surgery 45-64 yrs Female
Maryland HMO/POS Average	**2.4**	**2.1**	**5.5**	**4.9**
Aetna	2.2	2.1	4.8	4.1
BlueChoice	2.6	2.4	5.0	4.9
CIGNA	3.2	2.6	6.5	5.5
Coventry	2.6	2.4	6.7	6.2
Kaiser Permanente	1.0 ▼	1.2	4.3	3.7
M.D. IPA	2.1	1.5	6.4	4.5
OCI	3.0	2.5	5.1	5.5

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Table 108: Frequency of Cardiac Procedures, 2009 Results						
	Procedures/1,000 Eligible Population					
	Ang 45-64 yrs Male	Ang 45-64 yrs Female	CC 45-64 yrs Male	CC 45-64 yrs Female	CABG 45-64 yrs Male	CABG 45-64 yrs Female
Maryland HMO/POS Average	**6.5**	**2.5**	**9.1**	**6.9**	**2.2**	**0.7**
Aetna	6.3	2.9	10.8	7.3	1.8	0.5
BlueChoice	6.8	1.8	8.7	6.0	1.8	0.5
CIGNA	5.8	1.8	9.8	7.4	2.7	0.6
Coventry	8.6	3.6 ▲	10.4	7.6	2.6	0.9
Kaiser Permanente	4.0 ▼	1.9	5.2 ▼	3.9	1.8	0.6
M.D. IPA	7.2	2.3	10.2	8.7	1.9	0.9
OCI	7.1	3.1	8.8	7.1	2.9	0.7

Notes

Ang Angioplasty
CC Cardiac Catheterization
CABG Coronary Artery Bypass Graft

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Table 109: Frequency of Mastectomies, Lumpectomies, and Prostatectomies, 2009 Results					
	Procedures/1,000 Eligible Population				
	Mastectomy		Lumpectomy		Prostatectomy
	15-44 yrs Female	45-64 yrs Female	15-44 yrs Female	45-64 yrs Female	45-64 yrs Male
Maryland HMO/POS Average	**0.5**	**1.9**	**2.8**	**7.0**	**3.0**
Aetna	0.8	1.7	2.9	7.1	2.9
BlueChoice	0.4	1.7	2.9	6.6	2.8
CIGNA	0.4	1.9	2.6	7.7	3.5
Coventry	0.7	2.1	3.3	7.8	3.2
Kaiser Permanente	0.3	1.6	2.0	5.7	2.5
M.D. IPA	0.5	1.9	2.9	7.3	2.9
OCI	0.6	2.0	2.9	6.8	3.3

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Cost, Efficiency, and Utilization Results

Inpatient Utilization—General Hospital/Acute Care

Reports general hospital rates of utilization for treatment of acute conditions and average length of stay (ALOS). Three separate rates are reported: all patients (Total), medical patients (Medicine), and surgical patients (Surgery).

Table 110: Inpatient Utilization—General Hospital/Acute Care, 2009 Results

	Discharges/1,000 Members			ALOS (Days)		
	Total	Medical	Surgical	Total	Medical	Surgical
Maryland HMO/POS Average	**56.2**	**25.7**	**19.0**	**3.7**	**3.4**	**4.5**
Aetna	61.4	27.9	20.7	3.3	2.9 ▼	4.0
BlueChoice	60.4	21.7	23.3	3.4	2.9 ▼	4.2
CIGNA	52.9	21.9	18.2	3.9	3.8	4.6
Coventry	65.7	31.7 ▲	22.5	3.3	3.0	3.9
Kaiser Permanente	55.3	28.2	14.9 ▼	4.0	4.0	4.9 ▲
M.D. IPA	57.4	29.4	19.0	3.9	3.8	4.7
OCI	40.5 ▼	19.1	14.2 ▼	3.8	3.4	4.9 ▲

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Cost, Efficiency, and Utilization Results

Inpatient Utilization-Non-acute Care

Reports rates of utilization and average length of stay (ALOS) for inpatient, non-acute care. Inpatient, nonacute care includes inpatient care received in the following facilities: hospice, nursing home, rehabilitation, skilled nursing facilities, transitional, and respite care. Mental health and chemical dependency facilities are excluded. Rates are per 1,000 members.

Table 111: Inpatient Utilization—Non-acute Care, 2009 Results

	Discharges/ 1,000 Members	ALOS (Days)
Maryland HMO/POS Average	**2.1**	**14.8**
Aetna	1.7	16.4
BlueChoice	1.3	15.9
CIGNA	2.0	16.5
Coventry	1.8	15.6
Kaiser Permanente	4.3 ▲	13.6
M.D. IPA	2.4	13.5
OCI	1.3	11.9

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Outpatient Drug Utilization

Reports the number of prescriptions dispensed per member per year (PMPY) and the average cost of prescriptions per member per month (PMPM). Only members whose benefits include prescription drug coverage through their HMO/POS plans are included and only prescriptions covered by the plan are included; drugs given in the hospital are excluded. Because many employers "carve out" drug benefits from their contracts with health plans, data do not reflect a true picture of prescription drug use by all plan members.

Table 112: Outpatient Drug Utilization, 2009 Results

	Prescriptions/ PMPY	Cost of Prescriptions/ PMPM
Maryland HMO/POS Average	**11.9**	**61.3**
Aetna	10.2	60.1
BlueChoice	11.1	63.9
CIGNA	12.6	68.6
Coventry	12.2	57.3
Kaiser Permanente	12.1	40.2 ▼
M.D. IPA	13.3	73.2 ▲
OCI	12.0	65.5

▲ Plan rate is higher than 90% of other plans, nationally.

▼ Plan rate is lower than 90% of other plans, nationally.

Identification and Engagement of Alcohol and Other Drug Services

This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services.

Any services

Inpatient

Intensive outpatient or partial hospitalization

Outpatient or ED

Table 113: Identification of Alcohol and Other Drug Services—Percentage of Members Receiving Services, 2009 Results

	Any Services		Inpatient Services		Intermediate Services		Ambulatory Services	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**33,499**	**0.95%**	**9,869**	**0.28%**	**3,511**	**0.11%**	**27,262**	**0.78%**
Aetna	26,088	0.78%	8,916	0.27%	3,084	0.09%	23,628	0.70%
BlueChoice	81,444	1.01%	26,268	0.33%	10,608	0.13%	60,156	0.75%
CIGNA	10,428	0.66%	2,508	0.16%	1,296	0.08%	8,808	0.55%
Coventry	15,828	1.29%	4,836	0.39%	2,076	0.17%	12,240	1.00%
Kaiser Permanente	63,852	1.25%	16,500	0.32%	2,640	0.05%	55,968	1.10%
M.D. IPA	14,988	0.77%	5,376	0.27%	1,644	0.08%	11,316	0.58%
OCI	21,864	0.88%	4,680	0.19%	3,228	0.13%	18,720	0.76%

APPENDIX A—HEALTH PLAN DESCRIPTIVE AND ACCREDITATION INFORMATION

HEALTH PLAN DESCRIPTIVE INFORMATION

This section contains results for the HEDIS 2009 Health Plan Descriptive Information measures that MHCC required Maryland commercial HMO/POS plans to report in 2009. It includes information on health plan structure, staffing, and enrollment. The following measures address these issues.

- Board certification
- Total enrollment by state and by product

Board Certification

The *Board Certification* measure reports the percentage of the following *physician* practitioners who are board certified.

- Family medicine practitioners
- Internal medicine practitioners
- OB/GYN practitioners
- Pediatricians
- Psychiatrists
- All other practitioner specialists

"Board certification" refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association. In 2009, NCQA clarified which physicians should be included in this measure and how to report general practitioners.

Table A-1: Board Certification, 2009 Results

	Family Medicine		Internal Medicine		OB/GYN		Pediatrician		Other Specialist	
Maryland HMO/POS Average	**77%**		**79%**		**72%**		**79%**		**72%**	
Aetna	77%	★★	81%	★★★	65%	★	83%	★★★	74%	★★★
BlueChoice	80%	★★★	80%	★★★	72%	★★	83%	★★★	79%	★★★
CIGNA	76%	★	79%	★★	66%	★	82%	★★★	78%	★★★
Coventry	86%	★★★	79%	★★	71%	★★	86%	★★★	76%	★★★
Kaiser Permanente	83%	★★★	86%	★★★	81%	★★★	74%	★	59%	★
M.D. IPA	71%	★	74%	★	75%	★★★	75%	★	69%	★
OCI	68%	★	73%	★	74%	★★★	73%	★	68%	★

Legend

Relative Rates

★★★ Plan performed significantly better than the Maryland HMO/POS average.
★★ Plan performed equivalent to the Maryland HMO/POS average.
★ Plan performed significantly worse than the Maryland HMO/POS average.

Total Enrollment

Enrollment by Product Line

The *Enrollment by Product Line* measure shows the aggregate number of member years contributed to the health plan during 2008. Member years are closely associated with the number of members in a health plan. Enrollment figures are for each plan's entire population, stratified by age and gender. Figures include Maryland residents and may include members residing in service areas of Washington, D.C., regions of Virginia, Delaware, southern New Jersey, southeastern Pennsylvania, and West Virginia, depending on the geographic configuration of the HMO.

Enrollment by State

Enrollment by State is a third-year measure that shows the number of members enrolled any time during 2008, by state.

Enrollment figures for all plans except Kaiser Permanente include membership in HMO and POS products. Kaiser reports HEDIS rates based on the HMO product alone.

Table A-2: Enrollment by Product Line (Member Years) in 2009														
	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total	Total
Maryland HMO/POS Average	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	2009	2008
	42,042	40,621	82,663	52,887	61,257	114,144	43,385	47,702	91,087	4,249	3,894	8,143	296,037	324,677
Maryland Total	294,292	284,350	578,642	370,209	428,802	799,011	303,696	333,912	637,608	29,743	27,256	56,999	2,072,260	2,272,741
Aetna	45,015	43,808	88,823	49,601	60,250	109,851	39,772	45,176	84,948	4,333	4,360	8,693	292,315	300,543
BlueChoice	90,108	86,987	177,095	135,530	159,057	294,587	90,829	99,379	190,208	5,482	4,487	9,969	671,859	619,482
CIGNA	27,410	26,637	54,047	31,406	35,481	66,887	29,362	29,996	59,358	1,940	1,664	3,604	183,896	227,346
Coventry	12,898	12,148	25,046	21,649	19,341	40,990	17,118	15,954	33,072	1,867	1,454	3,321	102,429	122,778
Kaiser Permanente	59,091	56,983	116,074	69,525	83,497	153,022	64,361	75,864	140,225	7,699	7,403	15,102	424,423	454,507
M.D. IPA	30,126	28,981	59,107	24,092	30,439	54,531	30,581	34,814	65,395	5,476	5,241	10,717	189,750	205,793
OCI	29,644	28,806	58,450	38,406	40,737	79,143	31,673	32,729	64,402	2,946	2,647	5,593	207,588	342,292

Table: A-3 Enrollment by State, 2009									
	Maryland	Delaware	D.C.	New Jersey	Pennsylvania	Virginia	West Virginia	Other	Total
Maryland HMO/POS Average	57.59%	5.53%	4.50%	0.15%	1.36%	29.41%	1.11%	0.46%	100%
Total State Enrollment	1,248,051	42,861	111,464	1,498	20,446	573,275	17,048	11,381	2,026,024
Aetna	57.45%	0.12%	8.41%	0.11%	0.47%	32.90%	0.22%	0.32%	282,604
BlueChoice	77.75%	0.23%	4.66%	0.02%	1.26%	14.78%	0.46%	0.84%	660,451
CIGNA	33.25%	0.03%	2.10%	0.04%	0.33%	61.43%	2.08%	0.73%	174,365
Coventry	58.77%	34.99%	0.06%	0.85%	4.91%	0.20%	0.07%	0.14%	100,186
Kaiser Permanente	52.06%	0.03%	8.95%	0.02%	0.27%	38.33%	0.33%	0.53%	444,989
M.D. IPA	64.89%	0.29%	4.92%	0.01%	0.89%	27.47%	1.17%	0.38%	186,984
OCI	58.94%	3.01%	2.40%	0.02%	1.39%	30.77%	3.47%	0.25%	173,661

HEALTH PLAN ACCREDITATION INFORMATION

Accreditation is another way of assessing health plan quality; it is an independent, external assessment of quality by a review organization. The National Committee for Quality Assurance (NCQA) and the American Accreditation Healthcare Commission (URAC) accredit the health plans and managed behavioral healthcare organizations (MBHO) in this report.

Each health plan and MBHO in this report has voluntarily obtained accreditation through NCQA, URAC, or both. In Maryland, accreditation is not required for health plans or MBHOs.

NCQA Health Plan Accreditation

NCQA Accreditation evaluates how well a health plan manages its delivery system—physicians, hospitals, other providers, and administrative services—for continuous improvement of health care it delivers to members. A team of physicians and managed care experts conducts onsite and offsite evaluations. The team reviews grievance procedures, physician evaluation and care management processes, preventive health efforts, medical record keeping, quality improvement, and performance on key aspects of clinical care, such as immunization rates. In 2009, NCQA's Accreditation program required plans to report performance results for 20 clinical care measures and 9 satisfaction measures.

A national Review Oversight Committee (ROC) of physicians analyzes the team's findings and assigns an accreditation level based on a plan's performance on selected HEDIS measures, relative to NCQA standards and to other plans.

NCQA Accreditation Levels

NCQA assigns one of five possible accreditation levels based on a plan's performance.

- ***Excellent:*** Highest accreditation status, awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results in the highest range of national or regional performance.
- ***Commendable:*** Awarded to plans demonstrating levels of service and clinical quality that meet NCQA's requirements for consumer protection and quality improvement.
- ***Accredited:*** Awarded to health plans meeting most of NCQA's basic requirements for consumer protection and quality improvement.
- ***Provisional:*** Awarded to health plans that meet some, but not all, of NCQA's basic requirements for consumer protection and quality improvement.
- ***Denied:*** Indicates that a health plan did not meet NCQA's requirements.

Pharmacy Management Standards

Maryland plans accredited by NCQA have met NCQA standards for pharmaceutical management, including formulary development. To help ensure that plan drug formularies are fair and valid, formulary policies are reviewed under the pharmaceutical management standards for health plans

that choose to be accredited by NCQA. NCQA standards require a plan's formulary to meet the following criteria.

- The formulary is based on sound clinical evidence.
- There is annual review of the formulary, with updates at least annually.
- There is involvement of appropriate, actively practicing practitioners, including pharmacists, in the development and updating of the formulary.
- There is a policy of giving practitioners a copy of the formulary and notifying them of changes.
- There are policies that consider medically necessary exceptions to the formulary.

The following health plans are accredited by NCQA and meet the pharmaceutical management standards described above: Aetna, Aetna PPO, BlueChoice, BluePreferred, CIGNA, CGLIC PPO, Kaiser Permanente, M.D. IPA, and OCI.

URAC Health Plan Accreditation

URAC's health plan accreditation standards provide a comprehensive assessment of health plan performance and apply to health care systems that provide a full range of health care services, such as HMOs and fully integrated PPOs. Standards include key quality benchmarks for network management, provider credentialing, utilization management, quality improvement, and consumer protection.

Organizations applying for accreditation participate in a review process involving several phases. The initial phase of the accreditation process consists of completing the application forms and supplying supporting documentation. The remaining three phases cover a period of approximately four to six months:

Desktop Review: During the review process, the reviewer conducts an analysis of the applicant's documentation in relation to URAC standards.

Onsite Review: The accreditation review team conducts an onsite review after completing the desktop review, to verify compliance with the standards.

Committee Review: The last phase of review, leading to a recommendation regarding the application, involves examination by two URAC committees that comprise professionals from health care and other industry experts.

Following these reviews, an accreditation recommendation is provided to URAC's Executive Committee, which makes the final accreditation decision.

URAC Accreditation Levels

URAC assigns one of three possible accreditation levels based on a plan's performance.

- ***Full:*** Awarded 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:*** Awarded 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 follow a plan to demonstrate full compliance and move to Full Accreditation status within six months.

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

Organizations unable to meet URAC standards may be placed on corrective action status, may be denied accreditation, or may withdraw.

Table A-4: Health Plan Accreditation Status

Health Plan	Organization	Accreditation* Status	Expiration Date
Aetna	NCQA	Excellent	1/11
Aetna PPO	NCQA	Full	12/10
BlueChoice	NCQA	Excellent	12/10
BluePreferred PPO	NCQA	Full	12/10
CIGNA	NCQA	Excellent	09/09
CGLIC	NCQA	Excellent	12/10
Coventry	URAC	Full Accreditation	06/10
Kaiser Permanente	NCQA	Excellent	06/10
M.D. IPA	NCQA	Excellent	03/12
OCI	NCQA	Commendable	03/12

*Accreditation status as of July 2009.
Visit www.ncqa.org and www.urac.org for the most current information on accreditation status.

NCQA MBHO Accreditation

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

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

URAC MBHO Accreditation

Like other integrated health care delivery systems, MBHOs may choose to undergo a full review of their operations or have individual components reviewed for accreditation. URAC's accreditation Standards program assesses an organization and assigns an accreditation level based on performance regarding defined standards. This process consists of the same multi-phase review described in the previous section, *Health Plan Accreditation*. A range of accreditation programs is available through URAC, permitting review of a segment of the operations. The Health Utilization Management and Case Management standards are examples of accreditation modules that MCOs (such as MBHOs) select to demonstrate that they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

To satisfy legislative, task force, and MHCC requirements, plans report on MHCC-specific measures related to behavioral health. Table A-5 presents the accreditation status and the percentage of health plan members with behavioral health benefit which is a MHCC-specific measure that HMO and POS plans were required to report.

Table A-5: MBHO Accreditation Status and Behavioral Health Benefit

Health Plan	MBHO	Accrediting Body	Accreditation Status: Expiration Date*	Percentage of Members With Behavioral Health Benefit
Aetna	Aetna Behavioral Health	NCQA	Full: Expires 01/11	99.17%
BlueChoice	Magellan Behavioral Health—Mid-Atlantic Service Center	NCQA	Full: Expires 12/11	100%
		URAC (Health Utilization Management and Case Management)	Full: UM Expires 6/10 and CM Expires 9/10	
CIGNA	CIGNA Behavioral Health—Chesapeake	NCQA	Full: Expires 12/11	72.08%
		URAC (Health Utilization Management)	Full: Expires 11/09	
Coventry	MHNet Behavioral Health	NCQA	Full: Expires 10/09	97.68%
		URAC (Health Utilization Management)	Full: Expires 01/12	
Kaiser Permanente	APS Healthcare Bethesda, Inc (APS)	URAC (Health Utilization Management)	Accredited: 11/10	100%
M.D. IPA	United Behavioral Health—Philadelphia	NCQA	Full: 6/10	85.86%
		URAC	Full: 2/11	
OCI	United Behavioral Health—Philadelphia	NCQA	Full: 6/10	99.42%
		URAC (Health Utilization Management)	Full: 2/11	

*Accreditation Status as of July 2009.
Visit www.ncqa.org and www.urac.org for the most current information on accreditation status.

APPENDIX B—METHODS FOR DATA ANALYSES

METHODS FOR DATA ANALYSES

Methodology to Compare Plan Performance

For each HEDIS measure, CAHPS question, and CAHPS composite, a score is computed for each plan, and the mean value is computed for all of the plans as a group. Each score or mean is expressed as a percentage, with higher values representing more favorable performance.

Plan ratings for each measure are based on the difference between the plan score and the unweighted group mean. The statistical significance of each difference is determined by computing a 95 percent confidence interval (CI) around it. If the lower limit of the CI is greater than zero, then the plan score is significantly above the mean. If the upper limit of the CI is less than zero, then the plan score is significantly below the mean. Plans with scores significantly above or below the mean at the 95 percent significance level usually received the highest and lowest designations, respectively. All remaining plans received the middle designation.

The specific formula for calculating the CI for each measure is as follows.

For a given HEDIS measure or CAHPS individual question and plan k, let the difference d_k = plan k score – group mean. Then the formula for the 95 percent CI is $d_k \pm 1.96\sqrt{Var(d_k)}$ where $Var(d_k)$= Variance of d_k is estimated as:

$$\frac{P(P-2)}{P^2} * \frac{p_k(1-p_k)}{n_k} + \frac{1}{P^2}\sum_{k=1}^{P}\frac{p_k(1-p_k)}{n_k}$$

and p_k = plan k score

P = total number of plans

n_k = the measure denominator for plan k

For a CAHPS composite, the variance formula is modified by substituting the plan composite global proportion variance ($CGPV_k$) for the $p_k(1\text{-}p_k)/n_k$ terms where $CGPV_k = \frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$

and j = 1,…,m questions in the composite measure

i = 1,…,n_j members responding to question j

x_{ij} = response of member i to question j (0 or 1)

$\bar{x}_j$ = plan mean for question j

N = Members responding to at least one question in the composite.

Alternatively, the CI formula can be rearranged to compute the test statistic $\frac{d_k^2}{Var(d_k)}$.

For $d_i > 0$, the lower limit of the CI is > 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

For $d_i < 0$, the upper limit of the CI is < 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

Comparing Rates Across Years

For determining the statistical significance of the trend in a plan score between 2007 and 2009, first compute the difference in plan scores between the two years. This difference *d* can be written as $p_{2007} - p_{2009}$ where p_{200x} is the plan score for year 200x on a given measure. Then compute a 95% CI around the difference. If the lower limit of the CI is greater than zero then the trend is significantly upward. If the upper limit of the CI is less than zero then the trend is significantly downward.

The formula for the CI around *d* is: $d \pm 1.96\sqrt{Var(d)}$

where $Var(d) = \hat{p}(1-\hat{p})\left(\frac{1}{n_{2007}} + \frac{1}{n_{2009}}\right)$

and $\hat{p} = \frac{p_{2007}n_{2007} + p_{2009}n_{2009}}{n_{2007} + n_{2009}}$

and n_{200x} is the measure denominator for year 200x.

APPENDIX C—METHODOLOGY FOR AUDIT OF HEDIS 2009 RATES FROM MARYLAND HMO, POS, AND PPO PLANS

METHODOLOLGY FOR AUDIT OF HEDIS 2009 RATES FROM MARYLAND HMO, POS, AND PPO PLANS

HEDIS Compliance Audit™

NCQA's HEDIS Compliance Audit has a standardized methodology that enables organizations to make direct comparison of plan rates for HEDIS performance measures. Maryland hired HealthcareData Company, LLC (HDC), an NCQA licensed organization, to conduct a full audit of the Maryland commercial health plans as prescribed by *HEDIS 2009, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*, published by NCQA. In addition, HDC reviewed non-HEDIS data that the MHCC required plans to report in 2009.

A major objective of the audit is to determine the reasonableness and accuracy of how each plan collects data for performance reporting in Maryland. In addition to ensuring that publicly reported rates are accurate and comparable, the audit also satisfies a requirement of NCQA Health Plan Accreditation.

HEDIS is a standardized set of key performance measures designed to gather information that purchasers and consumers need for reliable comparison of managed care plan performance. By using a standardized methodology to collect data and calculate measure results, consumers, government agencies, employers, and health plans can more accurately evaluate and trend plan performance and compare plans with each other. NCQA Certified HEDIS Compliance auditors focus on two areas when evaluating each health plan, specifically: an assessment of the plan's overall information system (IS) capabilities and an evaluation of the plan's ability to comply with HEDIS specifications for individual measures.

Audit Implementation

The audit process itself is divided into three phases: audit preparation; onsite visit; and post-onsite and reporting activities. During these phases, auditors focus on a number of performance areas, including information practices and control procedures, sampling methods, data integrity and analytic file production, algorithmic compliance with measurement specifications, reporting, and documentation. A detailed description of the well-defined phases of the audit appears in NCQA's *HEDIS 2009, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*.

Phase 1: Audit Preparation

The initial phase consists of various supporting tasks or activities defined by NCQA. A key activity critical to the audit's success is each organization's completion of the Baseline Assessment Tool (BAT) in a timely manner prior to the onsite visit, followed by a review of the completed tool by auditors and MHCC staff. The BAT is a comprehensive instrument designed by NCQA to collect information from the health plan regarding its structure, information processing (e.g., claim/encounter, medical record review, membership data, provider data), and HEDIS reporting procedures (e.g., measure programming/determinations, reporting functions).

For organizations not using an NCQA certified software vendor, auditors also perform the key task of selecting a core set of measures for each plan. The protocol requires a minimum number of 15 measures (plus the CAHPS survey sample frame). Auditors use the core set to evaluate all measures

within the various HEDIS domains; review findings are then extrapolated to the full set of HEDIS measures to make a final determination of reportability. As needed, the measure set can be expanded based on any finding or issue that surfaces during the onsite audit. Each auditor uses a variety of criteria to select the core set, which includes, but is not limited to:

- Measures revised by NCQA from the prior year
- New measures being reported
- Measures calculated by vendors or by outside third parties
- Issues identified from review of the BAT that could impact code development
- Internal processes affecting data collection
- Problems experienced by the organization in prior audits.

Source-code review for measures in the core set starts during Phase 1, beginning with review of the source code associated with the CAHPS sample frame programming.

Phase 2: Onsite Visit

During Phase 2, auditors conduct in-person interviews and record examination at the office of each plan. The onsite portion comprises a number of critical activities that fall into two broad categories: an assessment of compliance with NCQA's standards for IS capabilities and an evaluation of compliance with HEDIS measure specifications.

1. IS Standards Assessment: Auditors determine the impact of various IS practices on the HEDIS reporting process. The key to accurate reporting is collecting comprehensive and accurate data. Auditors do not attempt to evaluate the overall effectiveness of the health plan's management of IS; rather, they determine whether the health plan's automated systems, information management practices, and data control procedures ensure that all information required for HEDIS reporting is adequately captured, translated, stored, analyzed, and reported.
2. HEDIS Measure Determination Standards: Each measure has a detailed set of specifications that describe both its purpose and method of calculation. In this activity, auditors determine whether the processes used to produce each HEDIS measure comply with HEDIS specifications and yield reportable results. If issues or discrepancies are identified, the health plan is given the opportunity to make corrections and resubmit corrected code until the auditors are satisfied that all specifications are met.

Phase 3: Post-Onsite and Reporting Activities

In Phase 3, auditors work closely with plan representatives to ensure that they understand all unresolved issues and deficiencies, as well as the potential effects of these matters on HEDIS data collection and reporting. When indicated, additional questions are presented to each plan about its software, programming, manual processing, and data input and output. Additionally, follow-up may become necessary to examine the effect of significant events, such as system conversion. Each plan is

given a final review and the opportunity to correct unresolved items before a final determination on reportability is issued for each HEDIS measure. Key activities accomplished during this phase are as follows.

1. Initial Report of Findings. Within 10 working days of the onsite visit, the audit team prepares an initial report on its visit. The report is returned to the health plan and includes the following components.
    - A detailed list of any outstanding issues
    - A list of all materials/documentation not yet received
    - An assessment of whether each measure tested meets specific data requirements
    - A list of all problem areas that require follow-up action before the final audit report is issued
    - Potential problems with measure rate integrity
    - Notes about any measures that, based on current findings, would receive a *Not Report (NR)* designation if no further action is taken to correct identified deficiencies
2. Medical Record Review Validation. In this portion of the audit, auditors complete their evaluation of the health plan's medical record review process. They begin by reviewing all training materials and internal oversight policies established by the plan for medical record review. Next, auditors verify the accuracy of the health plan's findings in which a numerator-positive event was identified (i.e., the plan's reviewer determined whether the criteria for the measure were met and the designated medical service was delivered). Auditors select two measures for each plan and request 30 charts for each measure.
3. IDSS Review. Health plans use the Interactive Data Submission System (IDSS) to electronically record all HEDIS results and calculations submitted to NCQA and MHCC. Maryland-specific data are submitted on an MHCC-specific data submission tool. The IDSS review consists of two phases. First, the plan submits results to NCQA, where data are subjected to a series of rules and guidelines that help identify potential problem areas for correction. After passing this level of review, plans inform the auditor of their readiness for final review. Auditors compare plan results to established NCQA benchmarks and the plan's rates from the previous year. Rates that vary by 10 percent or more between years are flagged, as are rates below the 10th and above the 90th percentiles, in comparison with NCQA benchmarks. Any problems detected are evaluated to determine whether additional analysis and review are necessary.
4. Audit Designations. After reviewing all relevant documentation and processes, the auditor issues a designation of *Report (R)* or *Not Report (NR)* for each measure included in the audit. Determination for each measure is based on the rationales described here.

    Report (R)

    (R) indicates that the measure is fully or substantially compliant with HEDIS specifications or has only minor deviations that do not significantly bias the reported rate. Under NCQA guidelines, it is possible for subcomponents of a measure to fail the audit and be designated NR without resulting in an NR rating for the entire measure. An example of this is the *Ambulatory Care* measure, which comprises four subcategories: outpatient visits, ED visits, ambulatory surgery, and observation room stays. One of these subcategories could be

designated NR, but because the measure is a composite of three other reportable subcategories, it would be deemed R. A measure designation of R may also be assigned where the denominator for the measure is too small to report a valid rate or where the plan did not offer a health benefit for the measure being reported. In these cases, the rate is designated in the Maryland publications as *Not Applicable (NA)*.

Not Report (NR)

In compliance with guidelines established by the State of Maryland, the NR designation indicates that the rate submitted by a plan did not pass the audit. In other words, the auditor determined that the results produced by the plan were significantly biased and did not reflect the plan's true performance. NCQA has broader categories for the NR designation, but in Maryland, health plans may not voluntarily accept an NR designation in place of a rate. Plans are required to calculate and report all HEDIS measures that are part of the state's mandated performance-reporting process, unless the measure is designated NR by the auditor.

5. Audit Findings. HDC summarizes its audit findings in a plan-specific Final Audit Report that is submitted to the plan and to MHCC. The report includes recommendations for improvement and change in future audits.

APPENDIX D—METHODOLOGY FOR ADMINISTERING THE CAHPS 4.0H SURVEY TO MARYLAND HMO, POS, AND PPO PLAN MEMBERS

METHODOLOLGY FOR ADMINISTERING THE CAHPS 4.0H SURVEY TO MARYLAND HMO, POS, and PPO PLAN MEMBERS

Background

MHCC contracted with WB&A Market Research, an NCQA certified survey vendor specializing in health care and other consumer satisfaction surveys, to conduct research on the satisfaction of plan members following standard CAHPS[7] procedures. In addition, MHCC contracted with the NCQA licensed audit firm, HealthcareData Company, LLC, to review programming code used to create the list of eligible members for the survey and to validate the integrity of the sample frame before WB&A drew the sample and administered the survey. Survey data collection began in mid-February 2009 and lasted into May 2009. Summary-level data files generated by NCQA were distributed in June to each plan for their review of data prior to signing their attestations.

Sample sizes remained stable in 2009, based on analysis of 2008 data. The sample size is set to achieve the minimum number of completed surveys necessary to obtain reportable results (411).

The core CAHPS survey consists of 59 questions. There are 10 additional supplemental questions specifically for Maryland plans. The core of the CAHPS survey, which changed from the 3.0H version to the 4.0H version in 2008, is a set of 13 measures used to measure satisfaction with the experience of care, which include 4 ratings questions that reflect overall satisfaction and 7 multi-question composites that summarize responses in key areas. Respondents are asked to rate their doctor, their specialist, their experience with all care, and their health plan on a 0–10 scale. Responses are summarized into 3 categories: a rating of "9 or 10" belongs in the top category, a rating of "7 or 8" belongs in the second category, and the remaining ratings fall into the third category.

Seven composite scores are generated from individual respondent-level data: *Claims Processing, Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Plan Information On Costs,* and *Shared Decision Making*. In addition, question summary rates are reported individually for two items summarizing health promotion and education and coordination of care.

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

Health plan members who are eligible to participate in the CAHPS 4.0H Adult Commercial Survey had to be 18 years of age or older as of December 31 of the measurement year (2008). They also had to be continuously enrolled in the commercial plan for at least 11 of the 12 months of 2008, and remain enrolled in the plan in 2009. Enrollment data sets submitted to the CAHPS vendor are sets of all eligible members—the relevant population. All health plans are required to have their CAHPS data set (sample frame) audited by the licensed HEDIS auditor prior to sending it to the survey vendor.

[7] CAHPS originally stood for the *Consumer Assessment of Health Plans Study*, but as the products evolved beyond health plans, the name changed to *Consumer Assessment of Healthcare Providers and Systems* to capture the full range of survey products and tools.

The standard sample size for 2009 administration (2008 measurement year) was 1,210 and included a 10 percent oversample. To reach the maximum number of selected members, sample files were sent to a National Change of Address (NCOA) look-up and telephone matching service. Updated addresses and phone numbers were merged into the sample files.

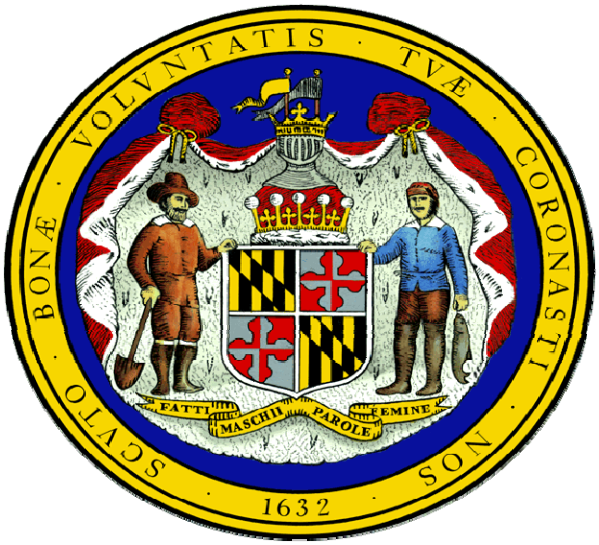
Survey Protocol

The CAHPS survey protocol employs a rigorous, multistage contact protocol that features a mixed-mode methodology consisting of a four-wave mail process (two questionnaires and two reminder postcards), with at least six telephone follow-up attempts. This protocol is designed both to maximize response rates and to 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, male, and healthier; mail responders are more likely to be older, better educated, and less healthy. The mail-only methodology is an option under the CAHPS protocol, but MHCC chose to use the mixed-mode methodology.

Response Rates

As directed by NCQA, the response rate is calculated by dividing the number of completed surveys by the number in the original sample and subtracting the ineligible respondents (completes/total sample—ineligibles). A survey is classified as a valid completion if the member appropriately responds to one or more questions. Ineligible respondents are those who are no longer enrolled in the health plan, cannot respond to the survey in the language in which it is administered, are deceased, or are mentally or physically incapacitated.

There is no minimum required response rate, but there is a required minimum denominator of 100 responses to achieve a reportable rate. In 2009, the average response rate of the seven HMO plans was 38.5 percent; the highest response rate was 45.7 percent and the lowest was 33.1 percent. The average response rate of the four PPO plans was 36.1 percent; the highest response rate was 41.5 percent, and the lowest was 29.6 percent.



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