

2009

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**GUIDE TO TEXAS HMO QUALITY: 2009**

*Through a combined effort of the*  
**STATE OF TEXAS**  
**OFFICE OF PUBLIC INSURANCE COUNSEL**  
*and the*  
**DEPARTMENT OF STATE HEALTH SERVICES**  
**CENTER FOR HEALTH STATISTICS**

**NOVEMBER 2009**

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# Introduction

## **A. Healthcare Effectiveness Data and Information Set (HEDIS®)**

The Healthcare Effectiveness Data and Information Set (HEDIS®) consists of standardized performance measures designed for comparing the quality of care of managed care organizations. As reported by the *State of Health Care Quality (2009)*, this tool is used by a total of 979 health plans. These plans cover 116 million Americans, or 2 in 5 people. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA), a private non-profit organization committed to assessing, reporting and improving the quality of care provided by organized health care delivery systems. NCQA convenes national health care experts to guide the selection and development of HEDIS® measures using three primary criteria: relevance, scientific soundness, and feasibility. The performance measures reflect many significant U.S. public health issues such as cancer, heart disease, smoking, diabetes, and the care of pregnant women and children.

## **B. Texas Subset of HEDIS®**

Basic service HMOs with 5,000 or more members are required under Texas law (Chapter 108 of the Texas Health and Safety Code) to report HEDIS® measures annually to the Texas Health Care Information Collection (THCIC) of the Center for Health Statistics (CHS) division of the Texas Department of State Health Services.

THCIC has elected to collect a subset of HEDIS® 2009 in Texas, rather than the entire set of measures developed by NCQA. The process for determining Texas' annual subset of HEDIS® begins the year prior. THCIC has adopted the following principles to guide their recommendations:

- Advice is in direct relation to the types of plans and products currently available in the Texas marketplace.
- Measures collected must be translatable into meaningful information to Texas residents.
- There must be reason to believe that there is sufficient encounter information to make the analysis valuable. If a majority of plans cannot report a specific measure due to a low number of members qualifying for the measure, then that measure is not required to be reported.
- Minimize duplication in reporting to other state agencies.
- All reporting requirements and technical specifications will be consistent with those of NCQA.

The Office of Public Insurance Counsel (OPIC) produces and publishes this guide through a joint memorandum of understanding with the THCIC.

## **C. Making Use of This Report**

In using this report, we encourage health plan purchasers and consumers to think about the relevance each HEDIS® measure has to their own needs. For instance, the fact that one HMO performs well on childhood immunization may be more important to a family with young children than to one without. Likewise, a middle-aged couple might prefer a plan that hires providers who routinely screen for diseases for which their age makes them a higher risk.

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

In the same way that HEDIS<sup>®</sup> measures undergo constant review and have evolved over time, techniques for communicating the importance and the results of HEDIS<sup>®</sup> measures have also been changing. This report groups performance measures in meaningful *categories-of-care* as organized in the annual Quality Compass<sup>®</sup> report published by NCQA.

Each measure begins with a general introduction followed by bar charts that graphically display the performance for all HMOs. The bar charts depicting individual Texas HMO performance are presented in both alphabetical and rank order. The health plan names include the service area, shown in parentheses, which is usually the city from which the plan is administered.

The narrative provides detail on what data points were included in the measure and in most cases presents two additional points of reference for comparing a given plan's performance: the statewide average of all plan's performances, and the nationwide average of more than 250 health plans participating in NCQA's Quality Compass<sup>®</sup> project.

The summary section (beginning on page 5) includes tables that depict whether a plan's performance is significantly higher (+), lower ( - ) or equal (=) to the state average. Calculations for this table are provided in the Methods and Statistical Issues section.

Readers wishing to have a greater understanding of HEDIS<sup>®</sup> data collection and auditing methodology are directed to NCQA's Technical Specifications for HEDIS<sup>®</sup> 2009, which can be found via NCQA's website: [www.ncqa.org](http://www.ncqa.org).

#### **D. Data Limitations**

Since the HEDIS<sup>®</sup> results are not risk adjusted, the data in this document, like most health care statistical reporting, must be interpreted with recognition of variables that may influence the data. For example, differences between individual HMOs may represent different levels of HMO performance or they may represent demographic and other differences among the recipients served by the HMOs.

Although the development of sampling methodology was based upon state-of-the-art practice, and determined by highly qualified professionals in the field, there is still a small chance that the sample does not represent the underlying population. However, the likelihood of this random error occurring is extremely small. It is important to note that HEDIS<sup>®</sup> is a set of measures, and many of the measures are best understood in the context of others. It is always more meaningful to compare health plans across a group of related measures than any single measure.

#### **E. Verification of Data**

In order to achieving its full potential, NCQA and CHS require that all HEDIS<sup>®</sup> and CAHPS<sup>®</sup> measures reported by HMOs be audited according to the certified audit program- the HEDIS Compliance Audit<sup>™</sup>. All HEDIS<sup>®</sup> data contained in this report has passed a HEDIS Compliance Audit<sup>™</sup>.

## **F. Consumer Satisfaction Survey**

For additional information on health plan quality, see the Office of Public Insurance Counsel's annual report ***Comparing Texas HMOs***, at [www.opic.state.tx.us](http://www.opic.state.tx.us). This report reflects the experience of Texans in HMO during 2008. The first section of the report illustrates the results of the Consumer Assessment of Healthcare Providers and Systems, Version 4.0H (CAHPS™ 4.0H). The sections following the survey results contain complaint data, market share, and other statewide information collected by the Texas Department of Insurance.

## Summary Tables

The summary tables on the following pages reflect the results of statistical tests comparing each plan's rate to the state average of all plans in Texas. The table uses the following symbols:

- + Plan performed better than the Texas average
- = Plan performance equivalent to the Texas average
- Plan performed lower than the Texas average

Results of the comparisons provided in the tables in this section should be interpreted carefully. Tests of statistical significance account only for random or chance variations in measurements. The size of the denominator (sample size) on which the HMO reports its rates, influences the confidence interval. A large denominator provides more power to the test and demonstrates a more precise estimation of true population rate. For example, on a certain measure, if two plans have equally higher rates than the state average, the plan with higher sample size may get an "above average" designation, where as the plan with lower sample size may be termed as "equal to state average".

HEDIS<sup>®</sup> does not adjust for differences in plan population characteristics such as age or health status. For some HEDIS<sup>®</sup> measures this lack of risk adjustment could lead readers to mistakenly believe that superior or inferior plan performance is due to quality of care when, in fact, it may be due to case mix differences in the member populations of the plans.

Not all HEDIS<sup>®</sup> measures lend themselves to this statistical test. Results are shown for all the measures in Effectiveness of Care Domain, the Well Child Visits in the First 15 Months and 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> years of life and Adolescent Well-Care Visits. For a more detailed description of the statistical test used, please refer to the Methods and Statistical Issues section of this guide.

## Summary Table

Health Plan Name	Childhood Immunization, DTaP	Childhood Immunization, IPV	Childhood Immunization, MMR	Childhood Immunization, Hib	Childhood Immunization, HepB	Childhood Immunization, VZV	Childhood Immunization, Pneumo-coccal Conjugate	Childhood Immunization, CMBO 2	Childhood Immunization, CMBO 3
*Aetna U.S. Healthcare (Austin)	=	=	=	=	=	=	=	=	=
*Aetna U.S. Healthcare (Dallas/Fort Worth)	=	=	=	+	NR	=	=	+	NR
*Aetna U.S. Healthcare (El Paso)	-	-	-	-	=	=	-	=	=
*Aetna U.S. Healthcare (Houston)	-	-	=	=	=	-	-	-	-
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	-	-	=	=	NR	=	=	+	NR
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	+	+	+	+	+	+	+	+	+
FIRSTCARE (Abilene)	+	+	+	+	+	+	+	+	+
FIRSTCARE (Amarillo)	+	+	+	+	+	=	+	+	+
FIRSTCARE (Lubbock)	+	+	=	+	+	=	+	+	+
FIRSTCARE (Waco)	+	+	=	=	+	=	=	+	+
HMO Blue Texas (Austin)	+	+	=	+	+	=	+	+	+
HMO Blue Texas (Dallas/Fort Worth)	=	+	=	+	-	=	=	-	-
HMO Blue Texas (East/West/South Texas)	=	=	=	=	=	=	=	=	=
HMO Blue Texas (Houston)	=	=	=	+	=	=	=	=	=
Humana Health Plan of Texas (Austin)	+	+	+	+	+	+	+	+	+
Humana Health Plan of Texas (Houston)	+	+	+	+	+	+	+	+	+
Humana Health Plan of Texas (San Antonio/Corpus Christi)	+	+	+	+	+	+	+	+	+
Mercy Health Plans (Laredo)	=	=	=	=	+	=	=	=	=
PacificCare of Texas (Dallas/Austin)	+	+	+	+	+	=	+	+	+
PacificCare of Texas (San Antonio/Houston)	+	+	+	+	+	+	+	+	+
Scott and White Health Plan (Central Texas)	+	+	+	+	+	+	+	+	+
UNICARE Health Plans (Southeast Texas)	+	+	+	+	+	=	+	+	+
*UnitedHealthcare of Texas (Austin/San Antonio)	-	-	-	-	-	=	-	-	-
*UnitedHealthcare of Texas (Dallas)	-	-	-	-	-	-	-	-	-
*UnitedHealthcare of Texas (Houston/Corpus Christi)	-	-	-	-	-	-	-	-	-
Valley Baptist Health Plans (Harlingen)	+	+	+	+	+	+	=	+	+

+ Better than Texas Average

= Equivalent to Texas Average

- Lower than Texas Average

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.

FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Summary Table

Health Plan Name	Colorectal Cancer Screening	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women	Controlling High Blood Pressure	Persistence of Beta-Blocker Treatment After Heart Attack	Cholesterol Management: LDL-C Screening After Heart Attack	Diabetes Care, HbA1c testing	Diabetes Care, HbA1c poorly controlled
*Aetna U.S. Healthcare (Austin)	=	-	-	+	NR	NA	=	=	NR
*Aetna U.S. Healthcare (Dallas/Fort Worth)	+	+	+	-	NR	+	=	+	NR
*Aetna U.S. Healthcare (El Paso)	-	=	=	=	NR	NA	=	=	NR
*Aetna U.S. Healthcare (Houston)	=	-	+	=	NR	=	=	+	NR
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	=	-	=	+	NR	NA	=	-	NR
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	-	-	-	+	=	NA	=	=	-
FIRSTCARE (Abilene)	=	=	-	=	=	NA	=	=	-
FIRSTCARE (Amarillo)	-	=	-	=	-	NA	=	+	-
FIRSTCARE (Lubbock)	=	=	-	=	-	NA	+	+	-
FIRSTCARE (Waco)	=	-	-	=	-	NA	-	+	-
HMO Blue Texas (Austin)	=	+	+	+	NR	NA	=	+	+
HMO Blue Texas (Dallas/Fort Worth)	=	-	+	+	NR	NA	=	+	-
HMO Blue Texas (East/West/South Texas)	+	=	=	=	NR	NA	=	=	=
HMO Blue Texas (Houston)	+	-	-	-	NR	=	-	-	+
Humana Health Plan of Texas (Austin)	+	=	+	+	=	NA	+	+	-
Humana Health Plan of Texas (Houston)	-	-	-	+	-	NA	+	=	-
Humana Health Plan of Texas (San Antonio/Corpus Christi)	+	=	-	=	+	=	+	+	-
Mercy Health Plans (Laredo)	=	=	+	=	=	NA	NA	+	-
PacifiCare of Texas (Dallas/Austin)	+	=	=	=	=	NA	=	+	-
PacifiCare of Texas (San Antonio/Houston)	=	-	-	=	+	NA	+	+	-
Scott and White Health Plan (Central Texas)	+	+	+	+	=	=	+	+	-
UNICARE Health Plans (Southeast Texas)	-	-	-	=	+	NA	=	+	-
*UnitedHealthcare of Texas (Austin/San Antonio)	-	+	+	=	NR	=	=	=	NR
*UnitedHealthcare of Texas (Dallas)	-	=	+	-	NR	=	=	+	NR
*UnitedHealthcare of Texas (Houston/Corpus Christi)	-	-	+	=	NR	=	-	=	NR
Valley Baptist Health Plans (Harlingen)	-	-	-	=	=	NA	=	+	-

+ Better than Texas Average

= Equivalent to Texas Average

- Lower than Texas Average

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.

FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Summary Table

Health Plan Name	Diabetes Care, eye examination	Diabetes Care, LDL-C screening	Diabetes Care, LDL-C control	Diabetes Care Medical Attention for Nephropathy	Diabetes Care Blood Pressure Control <130/80 mm HG	Diabetes Care Blood Pressure Control <140/90 mm HG	Medications for Asthma 5-9 Yr	Medications for Asthma 10-17 Yr	Medications for Asthma 18-56 Yr
*Aetna U.S. Healthcare (Austin)	+	=	NR	=	NR	NR	NA	NA	=
*Aetna U.S. Healthcare (Dallas/Fort Worth)	+	+	+	-	NR	NR	=	=	+
*Aetna U.S. Healthcare (El Paso)	=	=	=	-	NR	NR	NA	NA	NA
*Aetna U.S. Healthcare (Houston)	=	+	-	-	NR	NR	=	=	=
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	+	=	+	-	NR	NR	=	=	=
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	+	=	+	=	=	=	+	+	+
FIRSTCARE (Abilene)	+	=	+	-	=	-	NA	NA	-
FIRSTCARE (Amarillo)	+	+	=	=	=	+	NA	NA	+
FIRSTCARE (Lubbock)	+	=	=	=	=	-	=	=	=
FIRSTCARE (Waco)	+	=	+	=	-	-	NA	NA	=
HMO Blue Texas (Austin)	=	+	-	+	NR	NR	=	=	=
HMO Blue Texas (Dallas/Fort Worth)	=	+	+	+	NR	NR	=	=	=
HMO Blue Texas (East/West/South Texas)	=	+	+	-	NR	NR	NA	NA	=
HMO Blue Texas (Houston)	-	-	-	+	NR	NR	=	=	=
Humana Health Plan of Texas (Austin)	+	+	+	+	=	=	NA	NA	=
Humana Health Plan of Texas (Houston)	=	=	+	+	=	=	NA	NA	=
Humana Health Plan of Texas (San Antonio/Corpus Christi)	+	=	+	+	+	+	=	=	=
Mercy Health Plans (Laredo)	=	+	=	-	=	-	NA	NA	NA
PacifiCare of Texas (Dallas/Austin)	+	+	+	+	=	=	NA	NA	=
PacifiCare of Texas (San Antonio/Houston)	+	+	+	=	=	=	NA	NA	NA
Scott and White Health Plan (Central Texas)	+	+	+	+	=	=	-	=	-
UNICARE Health Plans (Southeast Texas)	+	+	+	+	=	=	NA	NA	=
*UnitedHealthcare of Texas (Austin/San Antonio)	=	=	NR	=	NR	NR	+	=	=
*UnitedHealthcare of Texas (Dallas)	=	=	NR	+	NR	NR	=	=	=
*UnitedHealthcare of Texas (Houston/Corpus Christi)	-	=	NR	=	NR	NR	=	=	+
Valley Baptist Health Plans (Harlingen)	+	+	=	+	=	=	NA	NA	+

+ Better than Texas Average

= Equivalent to Texas Average

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\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Summary Table

Health Plan Name	Medications for Asthma Total	Follow-up: Hosp. for Mental Illness, 7-days	Follow-up: Hosp. for Mental Illness, 30-day	Antidepressant Medication Management, acute phase	Antidepressant Medication Management, continuation phase	Well Child Visits: First 15 Months of Life	Well Child Visits: 3rd, 4th, 5th & 6th Years	Adolescent Well-Care Visits
*Aetna U.S. Healthcare (Austin)	=	=	=	=	=	-	+	+
*Aetna U.S. Healthcare (Dallas/Fort Worth)	+	=	+	+	=	-	+	+
*Aetna U.S. Healthcare (El Paso)	=	NA	NA	NA	NA	-	-	-
*Aetna U.S. Healthcare (Houston)	=	=	=	-	=	-	-	+
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	=	=	=	=	=	-	-	-
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	+	=	=	=	=	-	-	-
FIRSTCARE (Abilene)	-	-	-	=	=	=	-	-
FIRSTCARE (Amarillo)	=	=	=	=	=	+	-	-
FIRSTCARE (Lubbock)	-	=	=	=	=	=	-	-
FIRSTCARE (Waco)	=	-	=	=	=	+	-	-
HMO Blue Texas (Austin)	=	+	=	=	=	+	+	+
HMO Blue Texas (Dallas/Fort Worth)	=	+	+	=	=	+	=	=
HMO Blue Texas (East/West/South Texas)	=	=	=	=	=	=	=	-
HMO Blue Texas (Houston)	=	=	=	=	=	=	=	=
Humana Health Plan of Texas (Austin)	=	=	=	=	=	+	+	+
Humana Health Plan of Texas (Houston)	=	=	=	=	=	=	=	=
Humana Health Plan of Texas (San Antonio/Corpus Christi)	=	=	=	=	=	=	=	-
Mercy Health Plans (Laredo)	NA	NA	NA	NA	NA	NA	=	-
PacifiCare of Texas (Dallas/Austin)	=	NA	NA	=	=	=	=	=
PacifiCare of Texas (San Antonio/Houston)	=	NA	NA	NA	NA	=	+	=
Scott and White Health Plan (Central Texas)	-	-	=	+	+	+	-	+
UNICARE Health Plans (Southeast Texas)	=	NA	NA	=	=	=	=	+
*UnitedHealthcare of Texas (Austin/San Antonio)	=	=	=	=	=	+	+	+
*UnitedHealthcare of Texas (Dallas)	=	+	=	=	=	+	+	+
*UnitedHealthcare of Texas (Houston/Corpus Christi)	=	-	-	-	-	+	-	+
Valley Baptist Health Plans (Harlingen)	+	NA	NA	NA	NA	=	=	-

+ Better than Texas Average

= Equivalent to Texas Average

- Lower than Texas Average

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.

FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Childhood Immunization Status: Diphtheria, Tetanus, Pertussis (DTaP)

Definition: The percentage of children using the HMO who received at least four Diphtheria, Tetanus, Acellular Pertussis (DTaP) vaccines by two years of age.

Diphtheria, a bacterial respiratory infection characterized by a sore throat, low-grade fever, heart, and nerve problems, is a communicable disease spread by coughing and sneezing.<sup>1</sup>

Tetanus (lockjaw) is a serious disease that causes painful tightening of the muscles, usually all over the body. It can lead to "locking" of the jaw so the child cannot open his or her mouth or swallow. Tetanus leads to death in about 1 in 10 cases.<sup>2</sup>

Pertussis, or whooping cough, is a highly contagious respiratory disease spread by coughing and sneezing. The disease is named for the severe spasms of coughing that often last minutes. Between coughing spells, the child may gasp for air with a characteristic "whooping" sound. If left unattended, Pertussis may lead to hospitalization with pneumonia, seizures, encephalopathy (brain degeneration), vomiting, weight loss, breathing difficulties, and possibly death.<sup>3</sup>

Four doses of DTaP vaccine are recommended to prevent illness from Diphtheria, Tetanus, and Pertussis. The DTaP vaccine is preferred over the older DTP vaccine because it produces fewer side effects. Regardless of which vaccine series a child receives, most children will be protected from these diseases throughout childhood if immunized.

Childhood Immunization: DTaP rates					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	61.0%	54.4%	63.2%	56.4%	57.1%
<b>NCQA's Quality Compass®</b>	85.9%	86.1%	87.2%	73.1%	87.2%

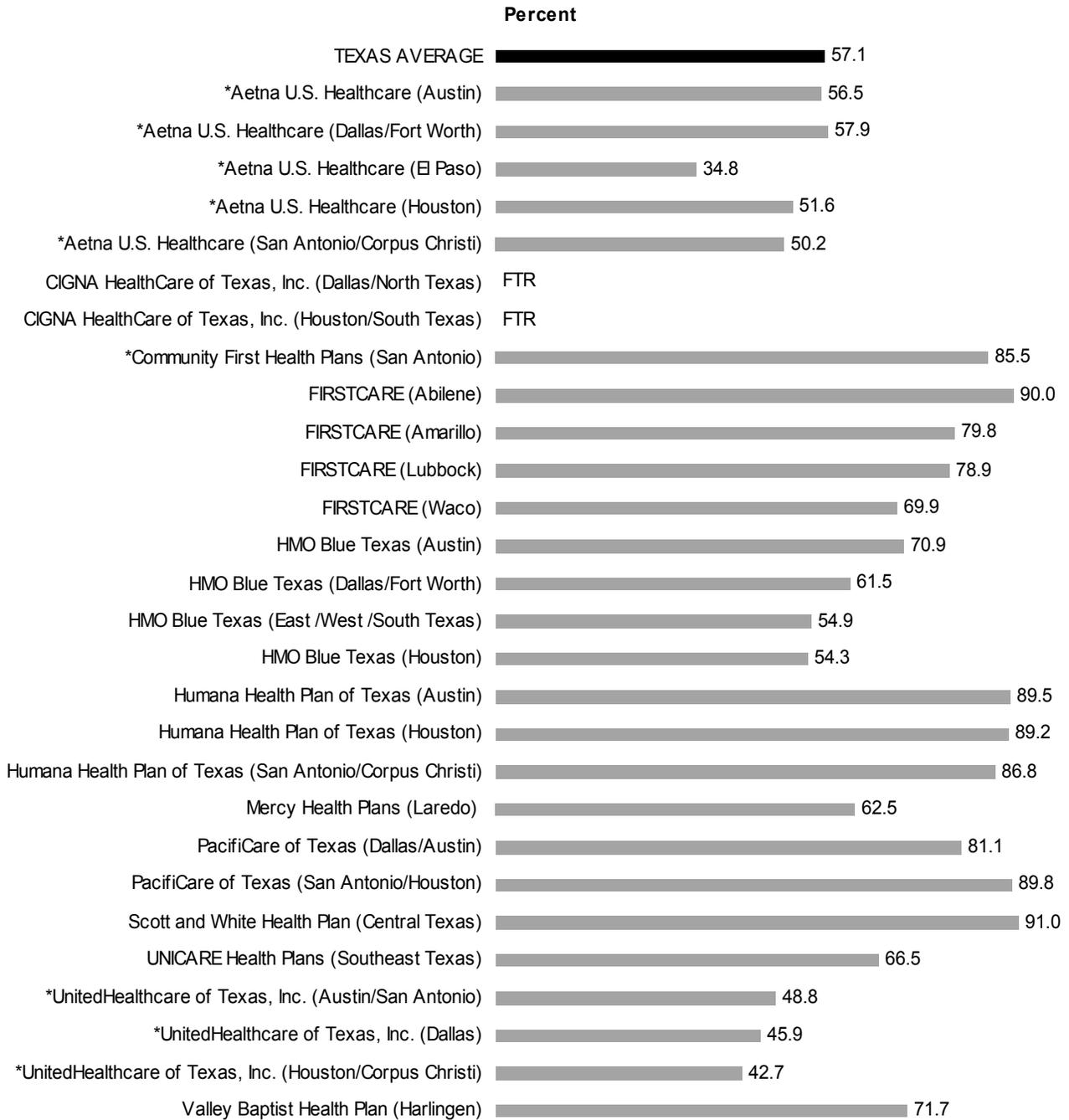
Quality Compass® is a national database of health plan specific performance information voluntarily reported to the National Committee for Quality Assurance (NCQA).

<sup>1</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, Diphtheria Vaccination, 2009

<sup>2</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, Tetanus (Lockjaw) Vaccination, 2009

<sup>3</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, Pertussis (Whooping Cough) Vaccination, 2009

## Childhood Immunization: DTaP



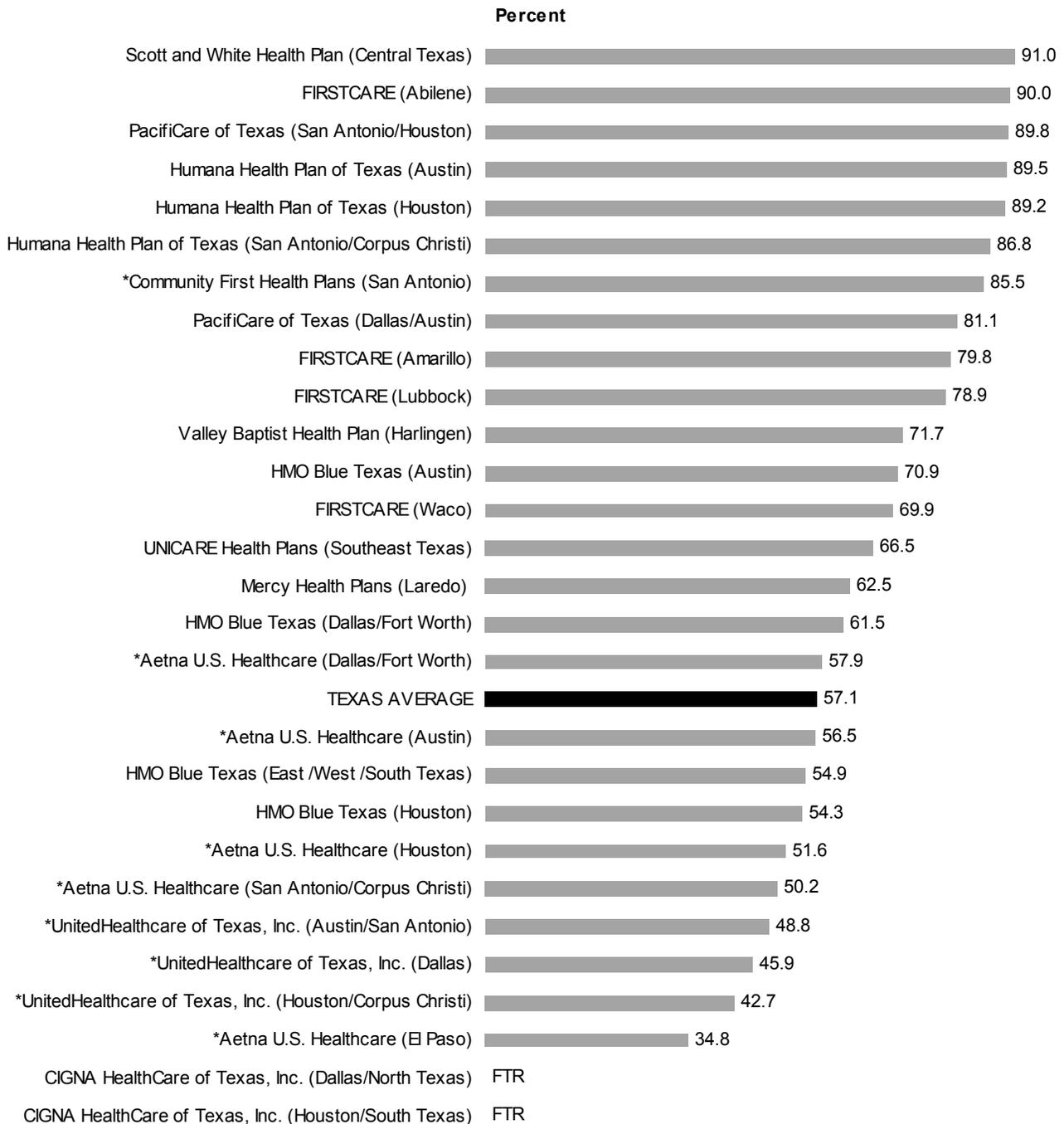
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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Childhood Immunization: DTaP



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## Childhood Immunization Status: Polio (IPV)

Definition: The percentage of children using the HMO who received at least three Polio vaccinations (IPV) by two years of age

Polio is an infectious disease caused by a virus that lives in the throat and intestinal tract. It is most often spread through person-to-person contact with the stool of an infected person and may also be spread through oral/nasal secretions. Polio used to be very common in the United States and caused severe illness in thousands of people each year before the Polio vaccine was introduced in 1955. Most people infected with the Polio virus have no symptoms, however for the less than 1% who develop paralysis it may result in permanent disability and even death.

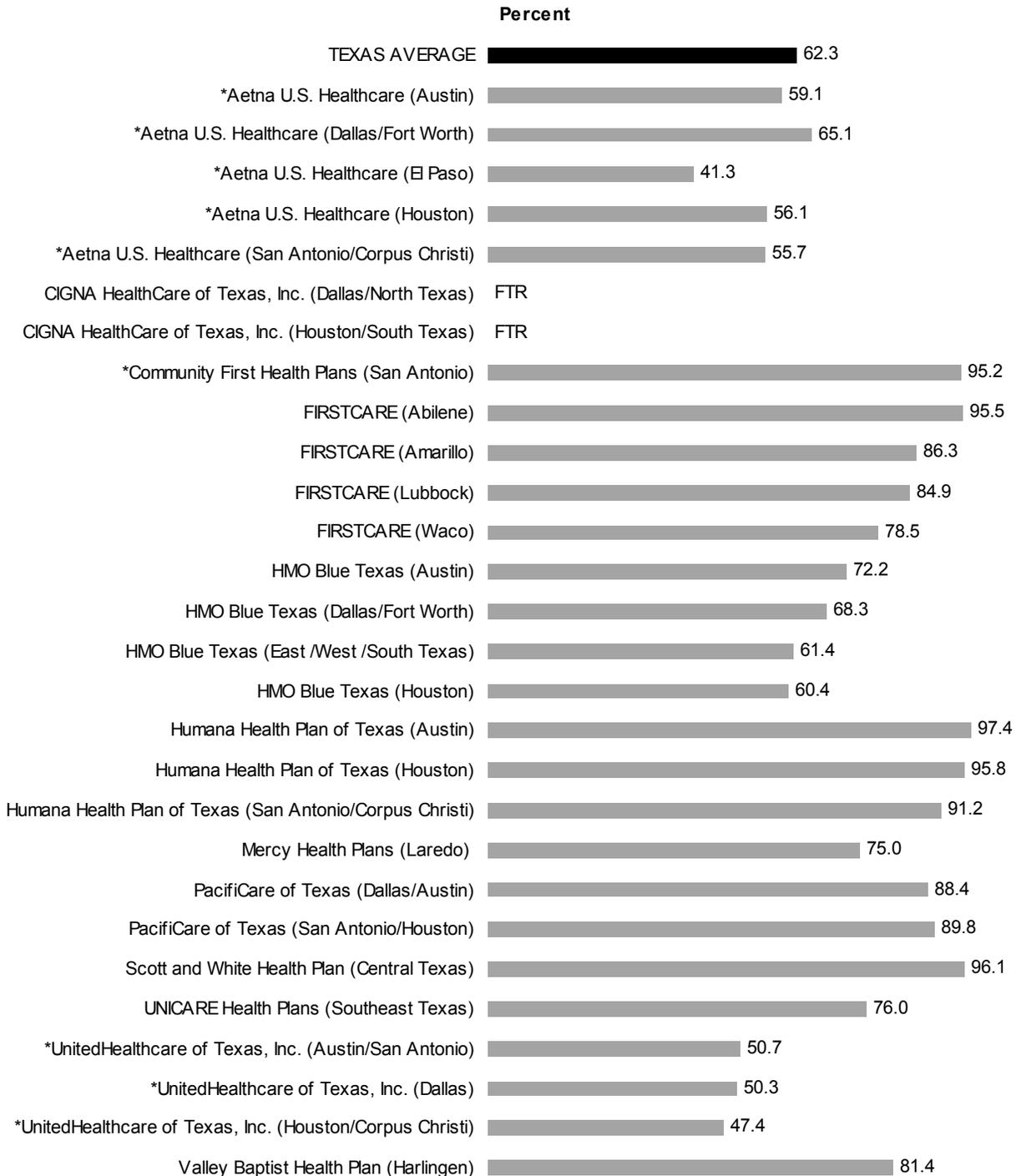
There are two types of vaccine that protect against Polio: Inactivated Polio Vaccine (IPV) and Oral Polio Vaccine (OPV). IPV, used in the U.S. since 2000, is given as an injection in the leg or arm, depending on age.<sup>1</sup>

Childhood Immunization Status: IPV rates					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	65.7%	63.3%	67.9%	61.9%	62.3%
<b>NCQA's Quality Compass®</b>	90.1%	90.3%	91.4%	77.9%	92.1%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, Polio Vaccination, 2009

## Childhood Immunization Status: IPV (Polio)



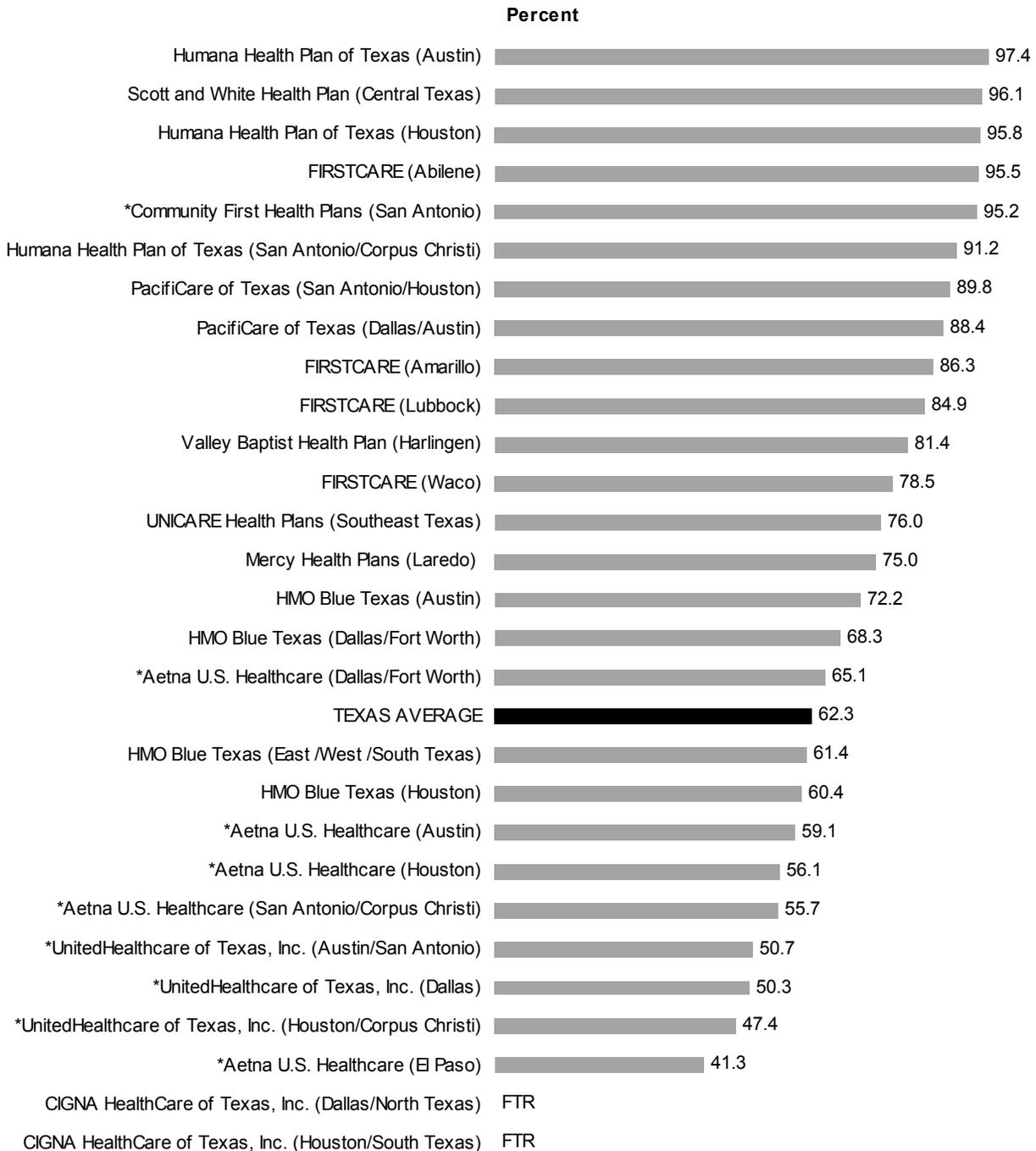
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## Childhood Immunization Status: IPV (Polio)



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## Childhood Immunization Status: Measles, Mumps, Rubella (MMR)

Definition: The percentage of children using the HMO who received one dose of the Measles, Mumps, Rubella (MMR) vaccine by two years of age.

Measles is a viral disease that causes rash, cough, runny nose, eye irritation, and fever. In severe cases, it can lead to ear infection, pneumonia, seizures, brain damage, and death.<sup>1</sup>

Mumps is a highly contagious viral disease that affects one or more of the salivary glands. These glands are located on either side of the face, below the ears. Though the usual symptoms are fever, headache, and swollen glands, it can cause serious complications like hearing loss, inflammation of the brain (encephalitis), and inflammation of the coverings of the brain and spinal cord (meningitis).<sup>2</sup>

Rubella, or German Measles, is a mild but very contagious viral disease that causes rash, mild fever, and arthritis. It is not usually a serious disease in children, but it can be very serious if a pregnant woman becomes infected. When a woman gets Rubella during pregnancy, the infection is likely to spread to the fetus and cause Congenital Rubella Syndrome (CRS). CRS can result in miscarriage, stillbirth, and severe birth defects. The most common birth defects are blindness, deafness, heart damage, and mental retardation.<sup>3</sup>

Childhood Immunization Status: MMR Rates					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	86.7%	87.1%	88.2%	85.5%	86.0%
<b>NCQA's Quality Compass®</b>	92.3%	93.0%	93.6%	88.2%	93.5%

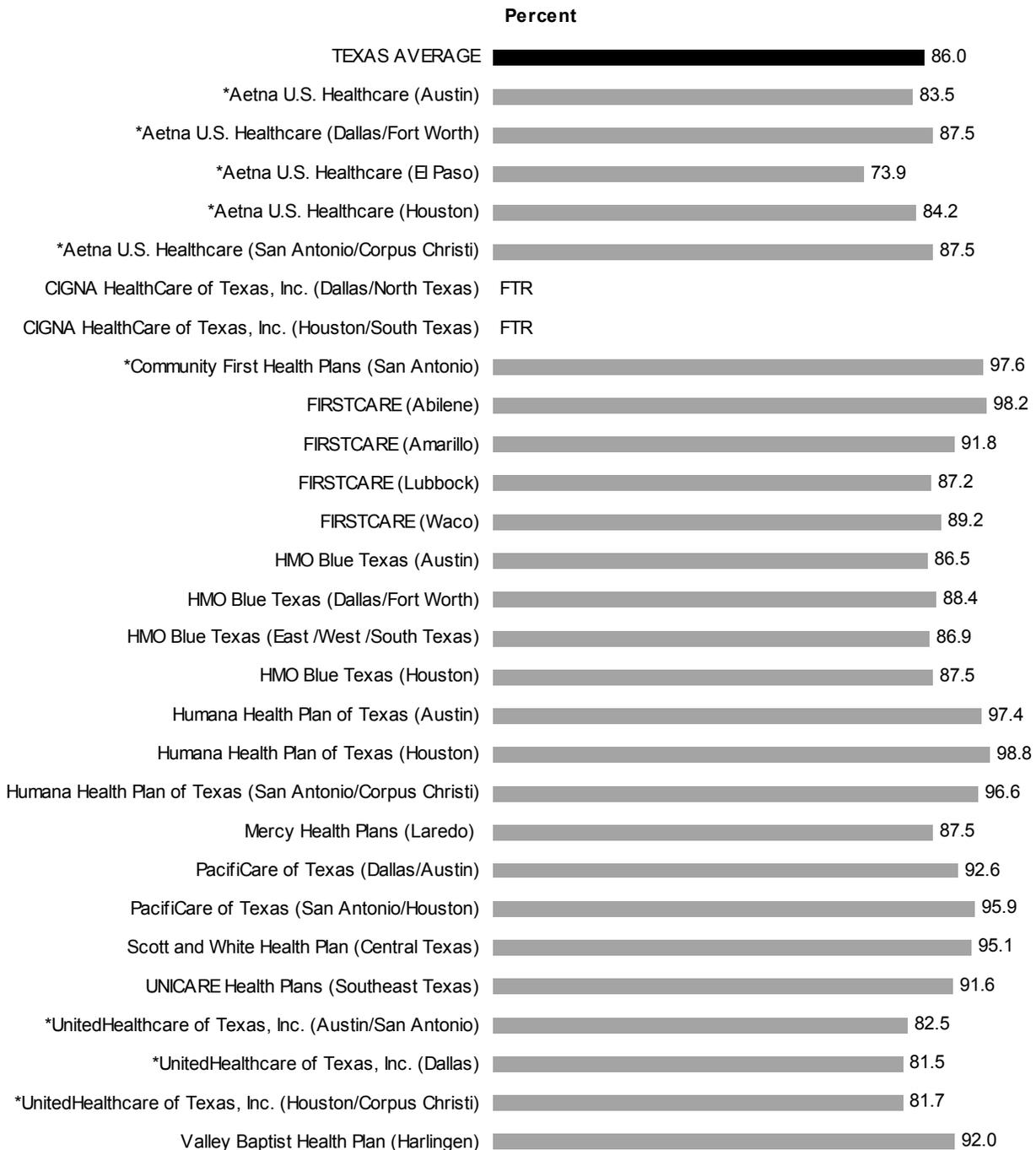
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<sup>1</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, MMR Vaccines Questions and Answers, 2009

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

## Childhood Immunization Status: MMR



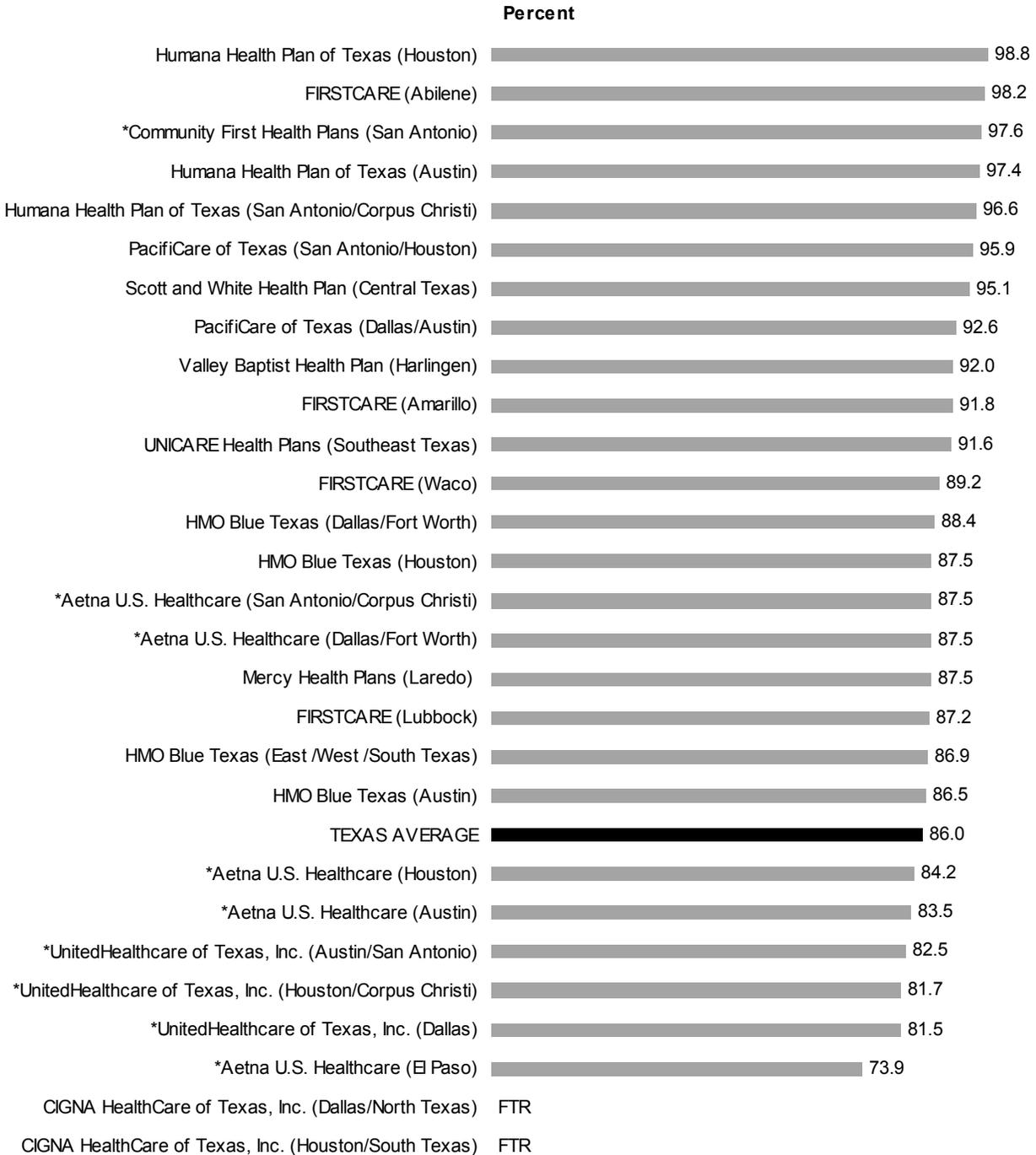
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## Childhood Immunization Status: MMR



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## Childhood Immunization Status: H Influenza Type B (HiB)

Definition: The percentage of children using the HMO who received at least *two H influenza type B (HiB) vaccines* by two years of age.

Note: Due to the HiB shortage, only two of the three doses are required for HEDIS 2009.

*Haemophilus influenzae* type B vaccine prevents meningitis (an infection of the covering of the brain and spinal cord), pneumonia (lung infection), epiglottitis (a severe throat infection), and other serious infections caused by a type of bacteria called *Haemophilus influenzae* type B. It is recommended for all children under 5 years old in the United States, and it is usually given to infants starting at two months old.<sup>1</sup>

Due to routine use of the HiB conjugate vaccine since 1990, the incidence of HiB disease in infants and young children has decreased by 99% to fewer than 1 case per 100,000 children under 5 years of age.<sup>2</sup>

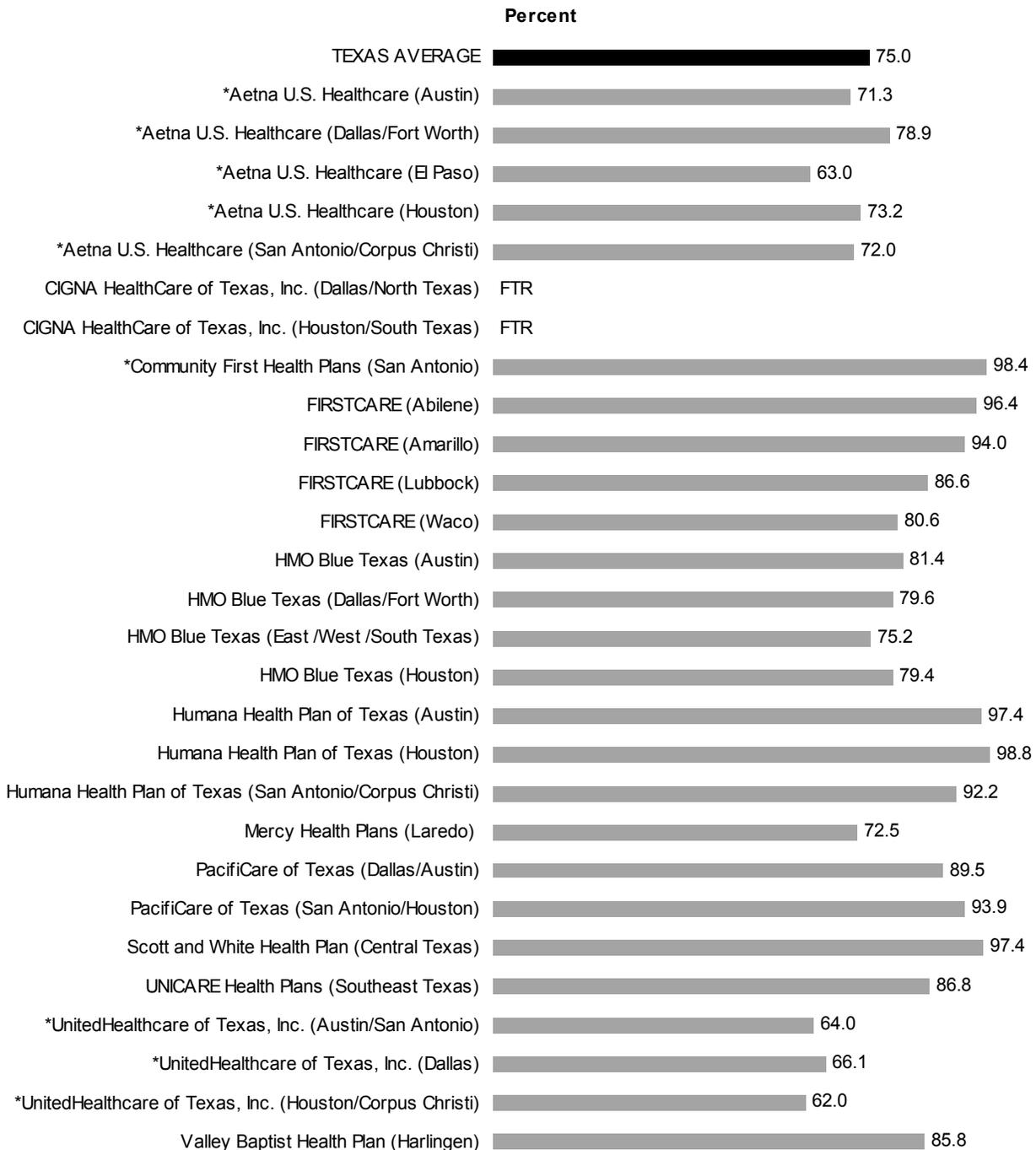
Childhood Immunization Status: HiB Rates					
	2005	2006	2007	2008	2009
Texas Average	66.8%	69.6%	70.0%	66.9%	75.0%
NCQA's Quality Compass®	87.7%	92.9%	93.4%	80.9%	94.8%

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<sup>1</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, HiB Vaccination, 2009

<sup>2</sup> Centers for Disease Control and Prevention, *Haemophilus influenzae* Serotype b (HiB) Disease, 2008

## Childhood Immunization Status: HiB



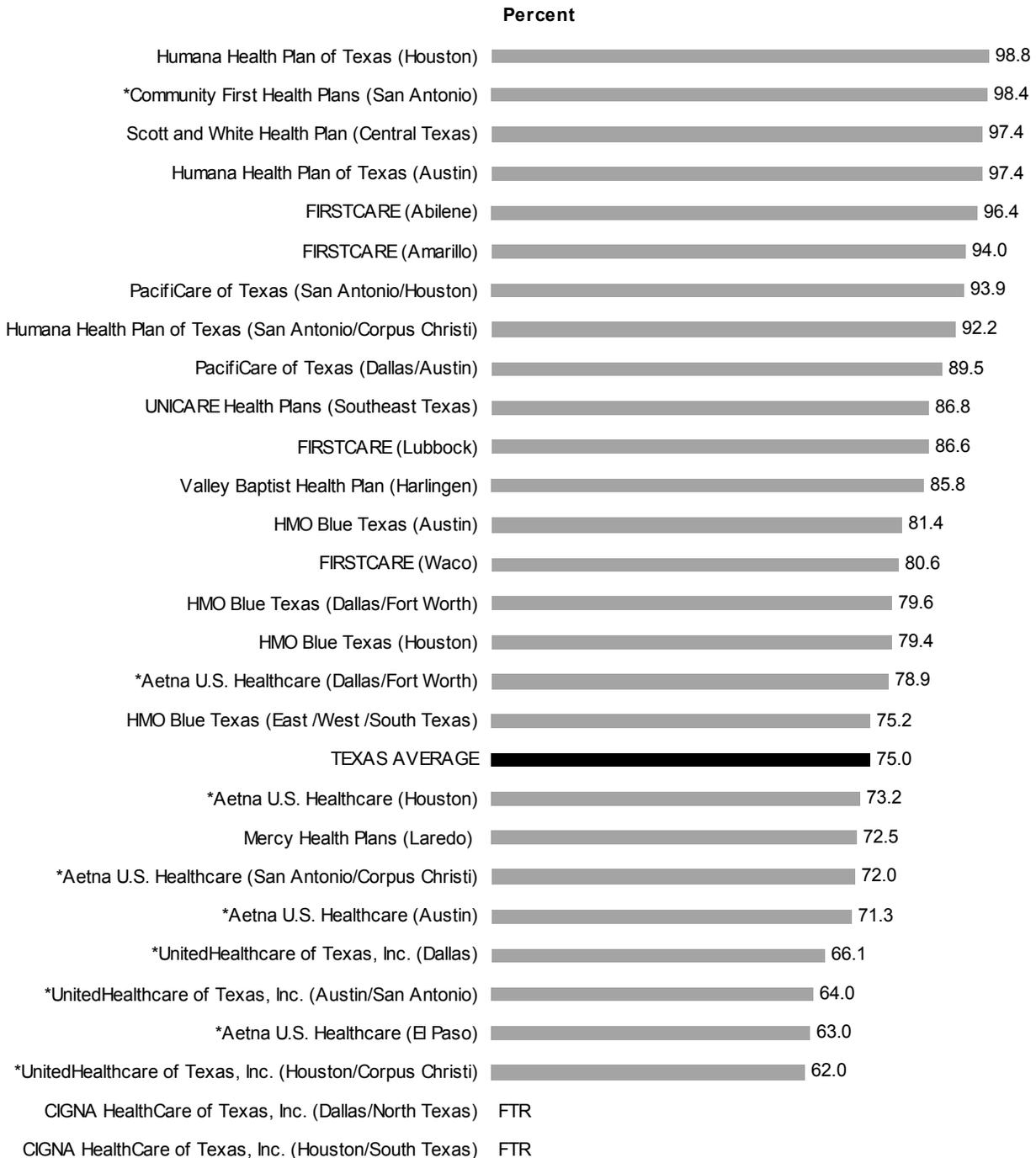
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## Childhood Immunization Status: HiB



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## Childhood Immunization Status: Hepatitis B

Definition: The percentage of children using the HMO who received three Hepatitis B vaccinations by two years of age.

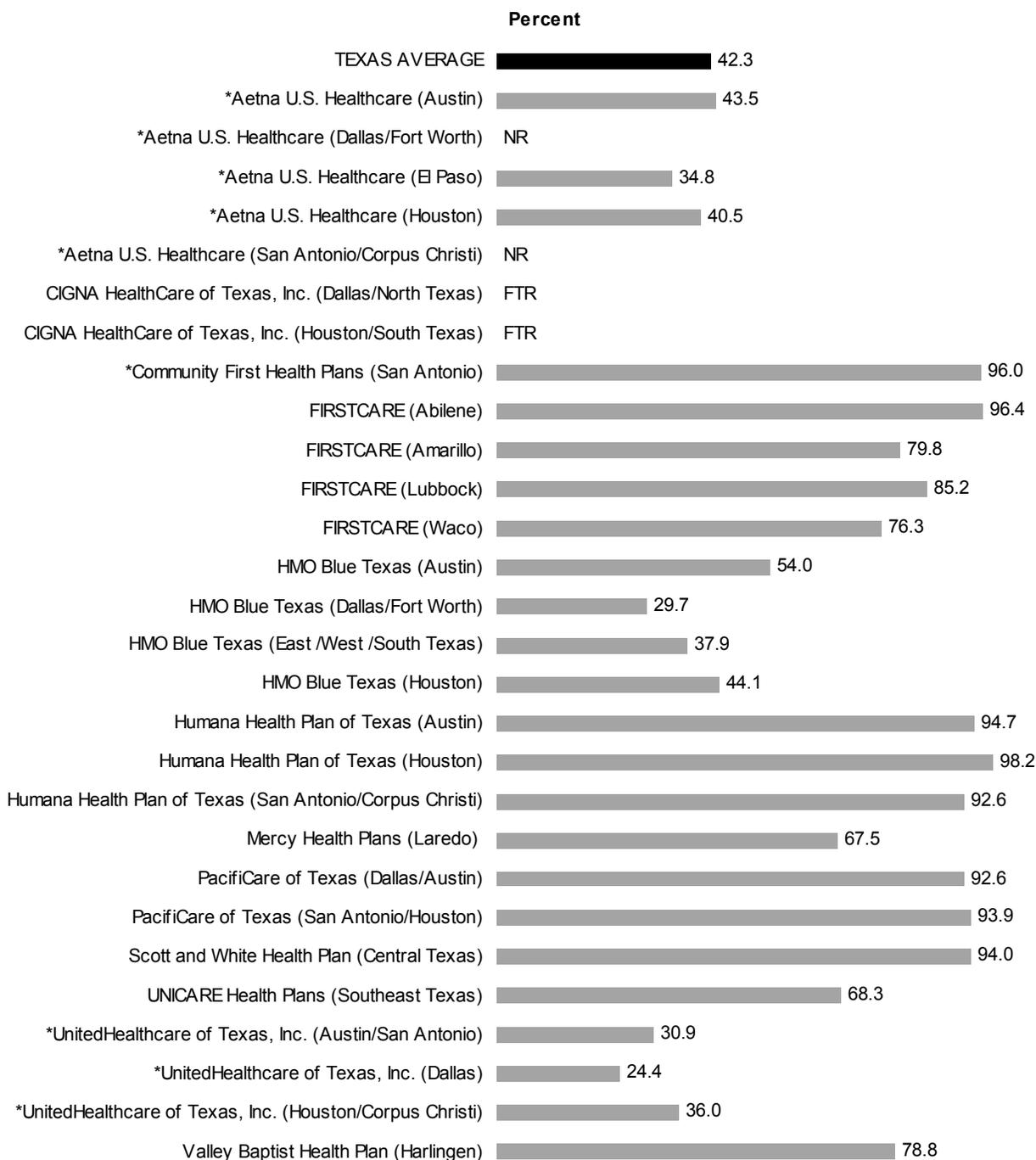
Hepatitis B is a virus that spreads through contact with an infected person's body fluids. Signs and symptoms include jaundice (yellow coloration of skin and eye), fatigue, abdominal pain, loss of appetite, nausea, vomiting and joint pain. Though symptoms are less marked in children, they are more likely to develop chronic liver disease. Approximately 90% of infants and 25%–50% of children aged 1–5 years will remain chronically infected with Hepatitis B throughout their lives. Other complications of Hepatitis B infection include liver damage (cirrhosis) and liver cancer. Vaccination for Hepatitis B by age two reduces or eliminates the risk of contracting the disease.<sup>1</sup>

Childhood Immunization Status: Hepatitis B Rates					
	2005	2006	2007	2008	2009
Texas Average	47.8%	46.8%	50.1%	44.2%	42.3%
NCQA's Quality Compass®	87.2%	90.0%	91.0%	74.6%	91.8%

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<sup>1</sup> Centers for Disease Control and Prevention, FAQs for Health Professionals – Hepatitis B, 2009

## Childhood Immunization Status: Hepatitis B



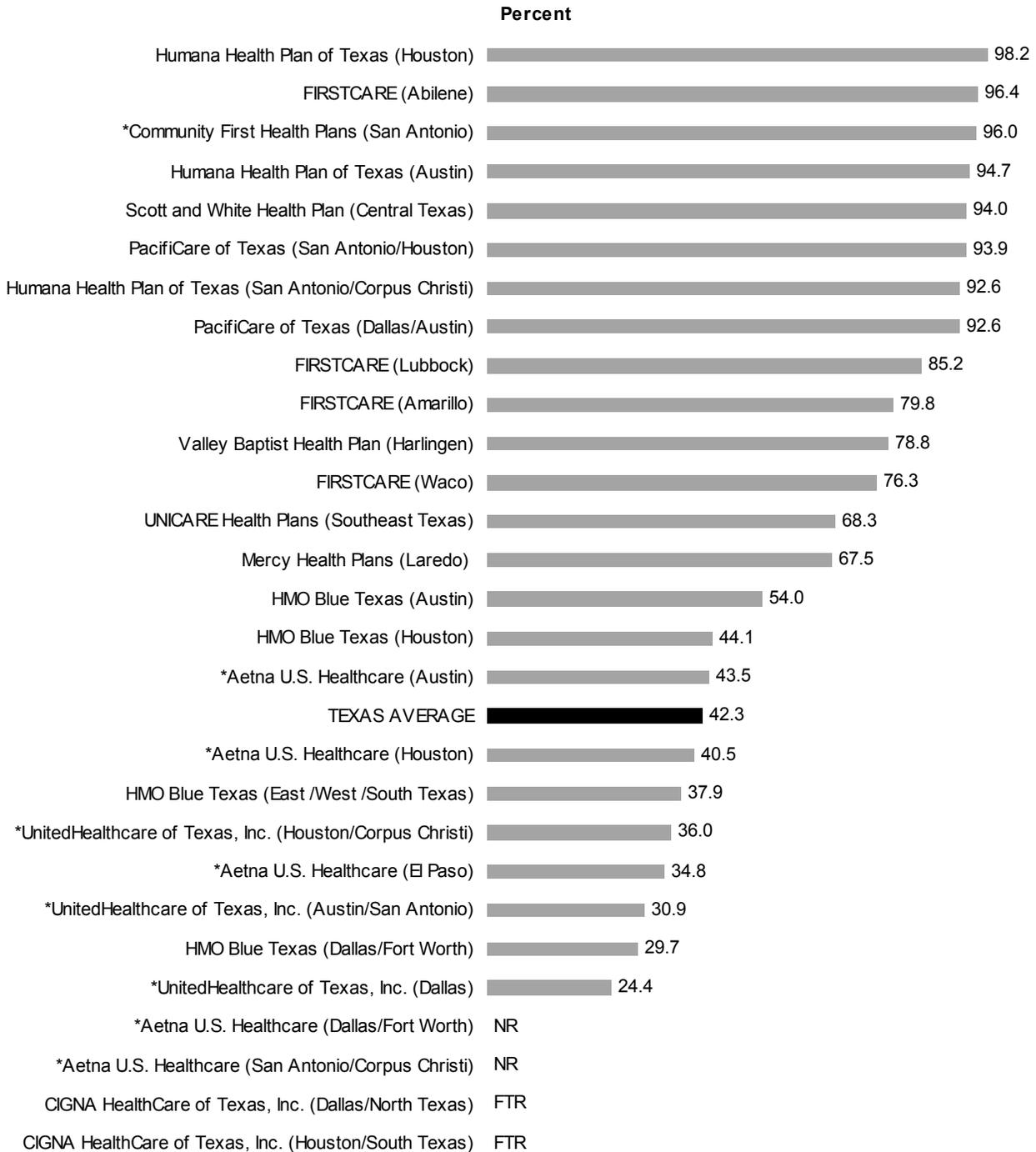
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## Childhood Immunization Status: Hepatitis B



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## Childhood Immunization Status: Chickenpox (VZV)

Definition: The percentage of children using the HMO who received at least one Chickenpox (VZV) vaccine by two years of age.

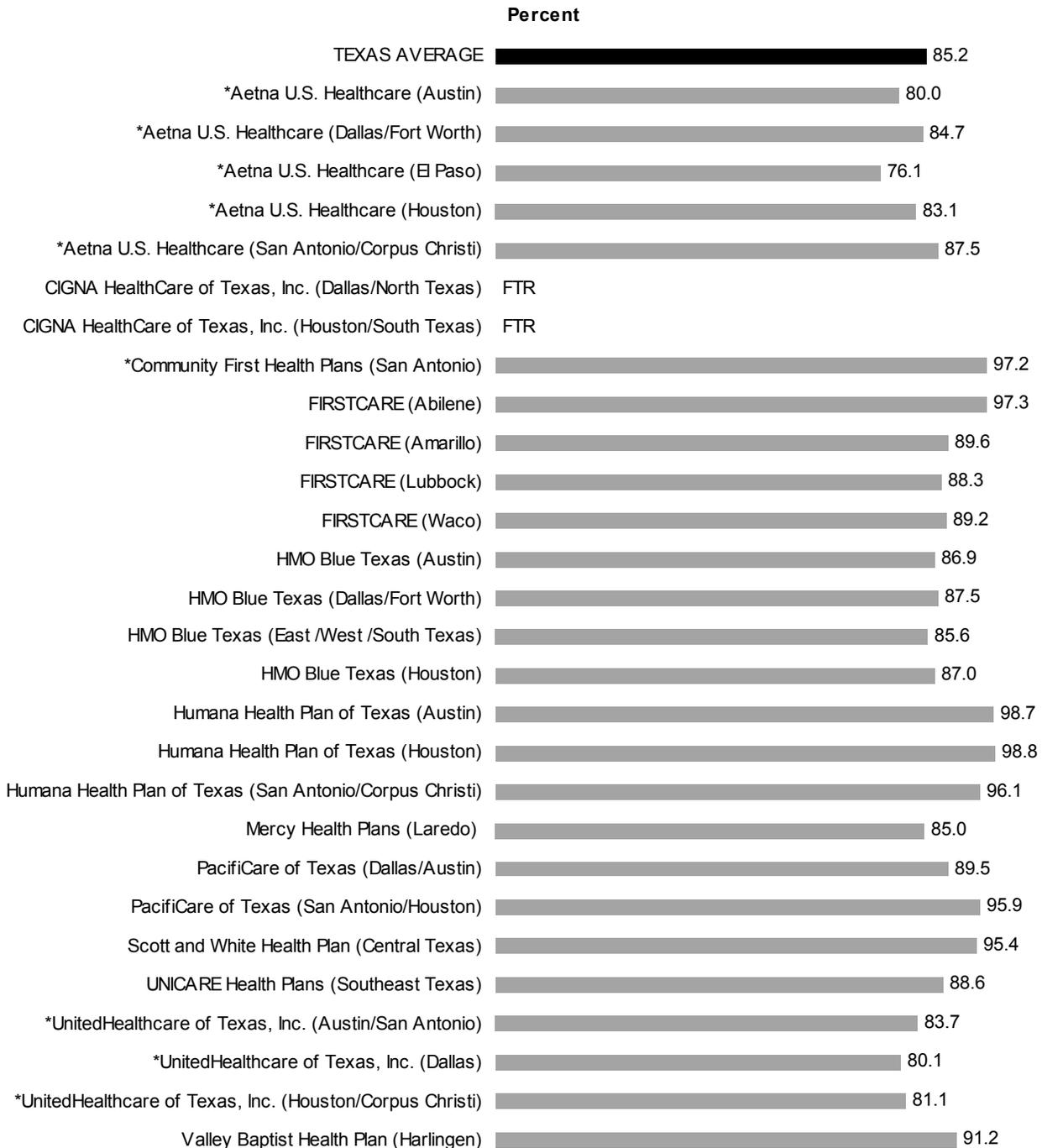
The Varicella vaccine is the best way to prevent chickenpox. Vaccination not only protects vaccinated children, it also reduces the risk for exposure in the community for persons unable to be vaccinated because of illness or other conditions, including those who may be at greater risk for severe disease. While no vaccine is 100% effective in preventing disease, the chickenpox vaccine is very effective: about 8 to 9 of every 10 people who are vaccinated are completely protected from chickenpox. In addition, the vaccine almost always prevents against severe disease. If a vaccinated person does get chickenpox, it is usually a very mild case lasting only a few days and involving fewer skin lesions (usually less than 50), mild or no fever, and few other symptoms.<sup>1</sup>

Childhood Immunization Status: VZV Rates					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	84.5%	85.5%	86.7%	84.6%	85.2%
<b>NCQA's Quality Compass®</b>	87.5%	89.9%	90.9%	86.5%	92.0%

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<sup>1</sup> Centers for Disease Control and Prevention, Vaccines and Preventable Diseases, Varicella (Chickenpox) Vaccination, 2009

## Childhood Immunization Status: VZV (Chickenpox)



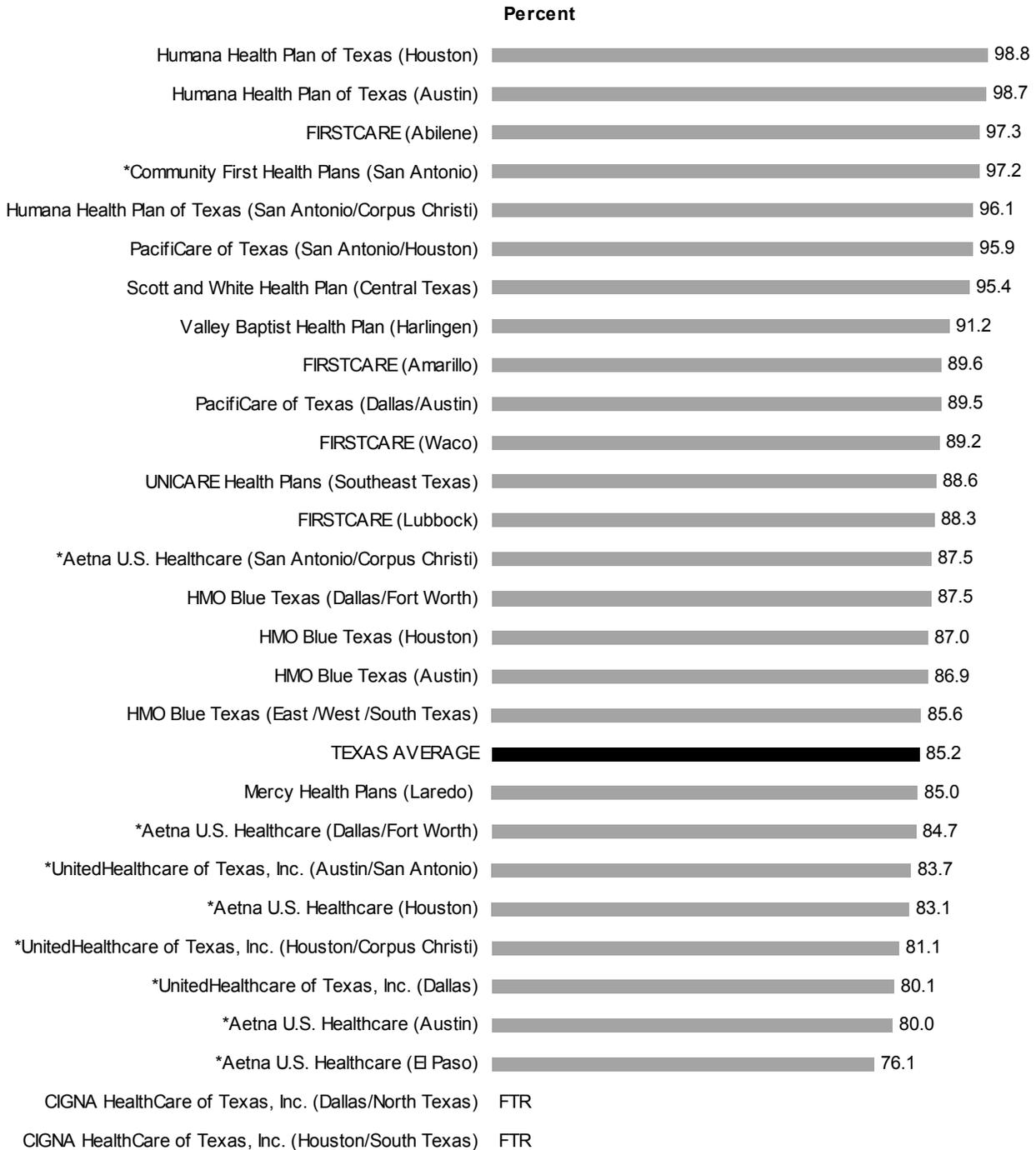
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## Childhood Immunization Status: VZV (Chickenpox)



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# Childhood Immunization Status: Pneumococcal Conjugate

Definition: The percentage of children using the HMO who received four Pneumococcal Conjugate vaccines by two years of age.

Infection with *Streptococcus pneumoniae* bacteria can cause serious illness and death. Invasive pneumococcal disease is responsible for about 200 deaths each year among children under 5 years old. It is the leading cause of bacterial meningitis (Meningitis is an infection of the covering of the brain) in the United States. Pneumococcal infection causes severe disease in children under five years old. Before the vaccine was available, each year pneumococcal infection caused: over 700 cases of meningitis, 13,000 blood infections, and about 5 million ear infections.<sup>1</sup>

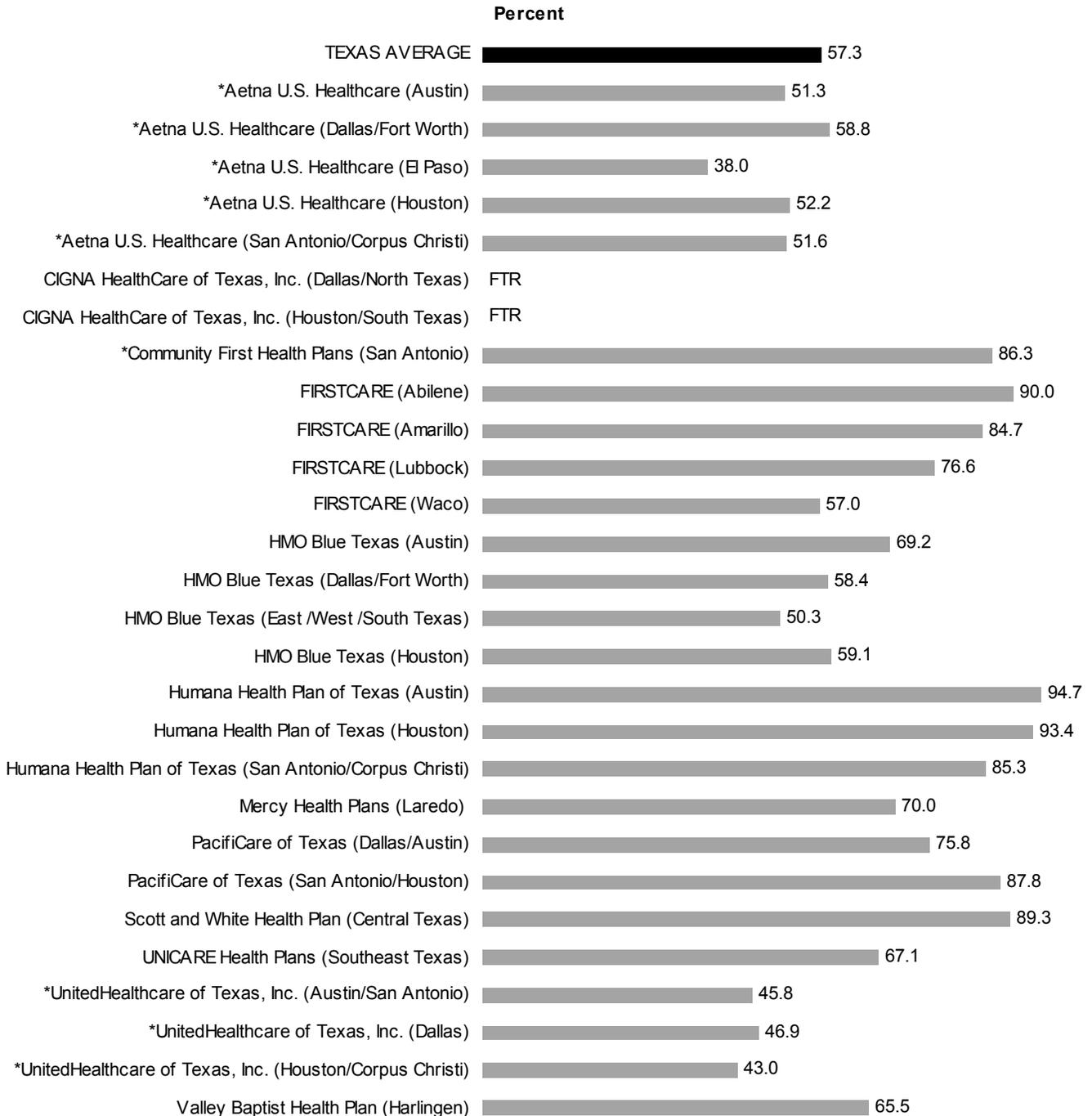
Childhood Immunization Status: Pneumococcal Conjugate Rates				
	2006	2007	2008	2009
Texas Average	*	53.5%	56.6%	57.3%
NCQA's Quality Compass®	*	72.8%	70.9%	84.8%

This measure was added to the Texas Subset beginning with HEDIS® 2006

\* Value not established or not obtained.  
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<sup>1</sup> Centers for Disease Control and Prevention, Vaccine Information Statement, Pneumococcal Conjugate Vaccine, 2002

## Childhood Immunization Status: Pneumococcal Conjugate



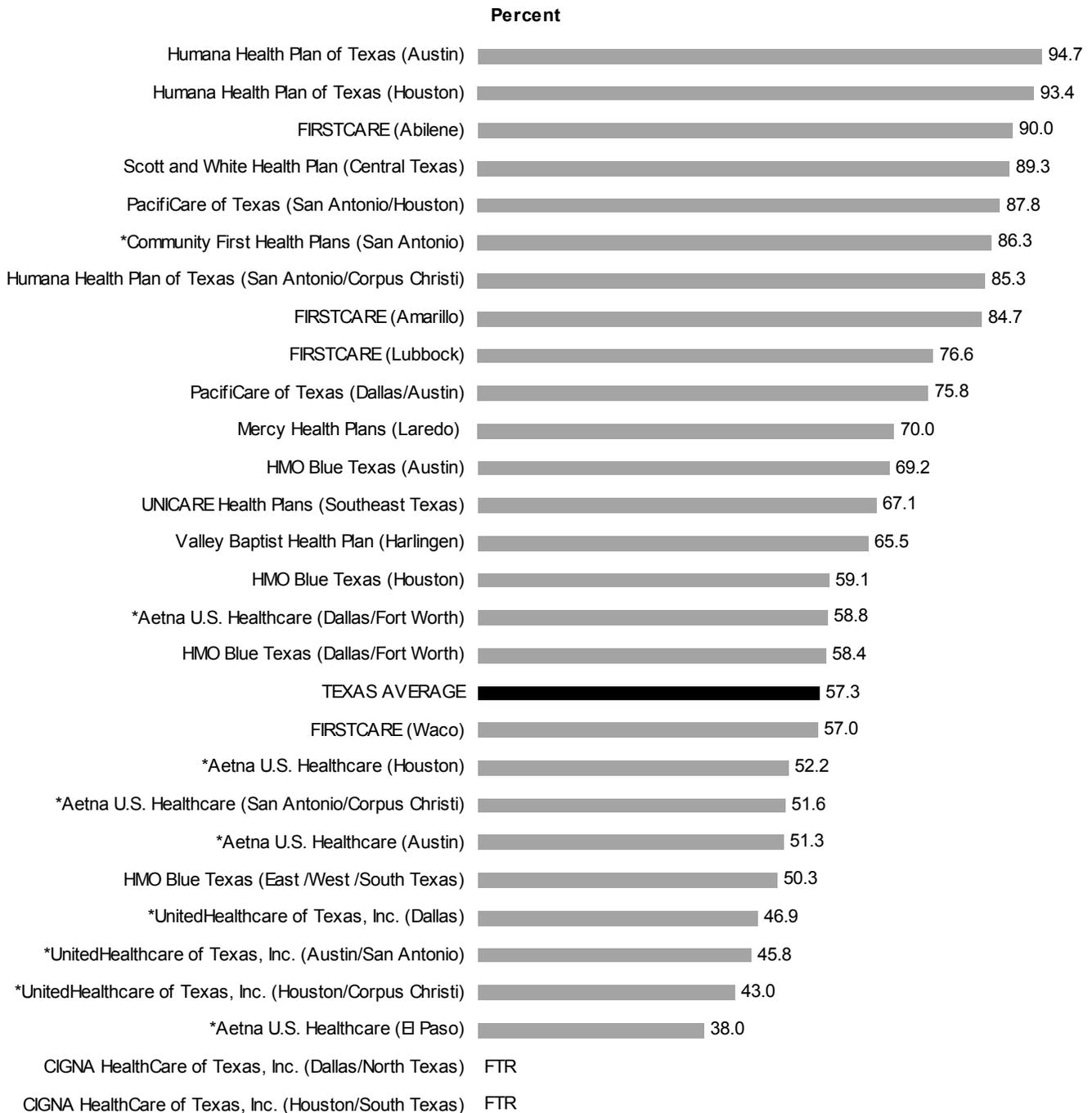
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## Childhood Immunization Status: Pneumococcal Conjugate



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## Childhood Immunization Status: Combination 2

Definition: The percentage of children using the HMO who received all Combination 2 vaccinations [4 Diphtheria, Tetanus, Pertussis (DTaP), 3 Polio, 3 Hepatitis B, 1 Measles, Mumps, Rubella (MMR), 3 H Influenza type B (HiB), and 1 Chickenpox (VZV)] by two years of age.

A basic method for prevention of illness is immunization. Childhood immunizations help prevent serious illnesses such as Polio, Tetanus and Hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like Mumps and Measles. Even preventing “mild” diseases saves hundreds of lost school days and work days and millions of dollars.<sup>1</sup>

The American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians (AAFP) all recommend the following immunization schedule for children under two years of age:

- Hepatitis B - three vaccines (one from birth to 2 months, one from 1 to 4 months, and one from 6 to 18 months)
- Diphtheria, Tetanus, Pertussis - four vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 15 to 18 months)
- *Haemophilus Influenzae* type B (HiB)- four vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 12 to 15 months)
- Inactivated Polio - three vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 12 to 15 months)
- Pneumococcal Conjugate - four vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 12 to 15 months)
- Measles, Mumps, Rubella - one vaccine (one from 12 to 15 months), and
- Varicella - one vaccine (one from 12 to 18 months).

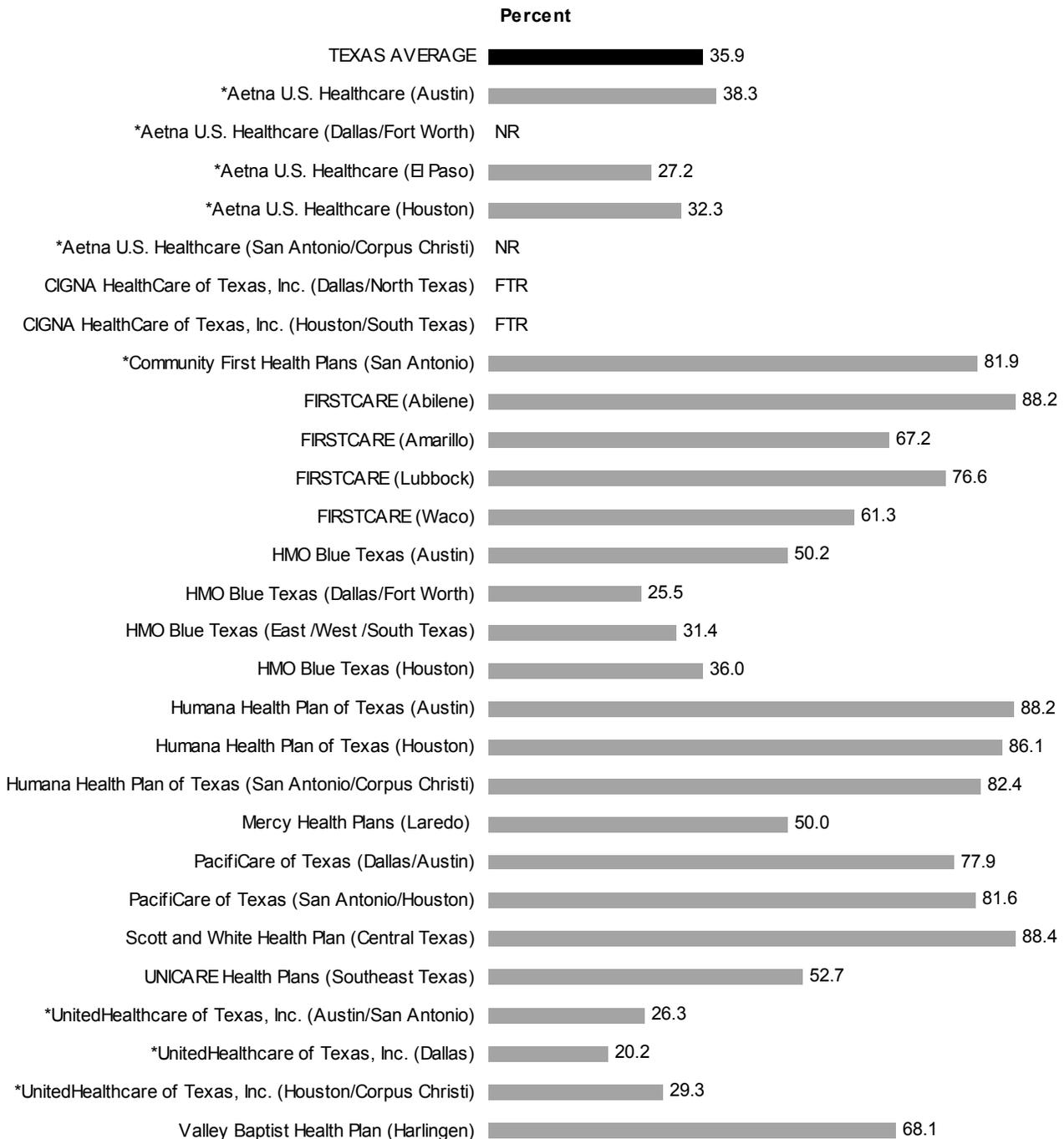
The Combination 2 measure does not include the Pneumococcal Conjugate vaccine.

Childhood Immunization Status: Combination 2 Rates					
	2005	2006	2007	2008	2009
Texas Average	39.8%	37.0%	42.6%	37.0%	35.9%
NCQA's Quality Compass®	72.5%	77.7%	79.8%	66.9%	81.2%

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Childhood Immunization Status: Combination 2



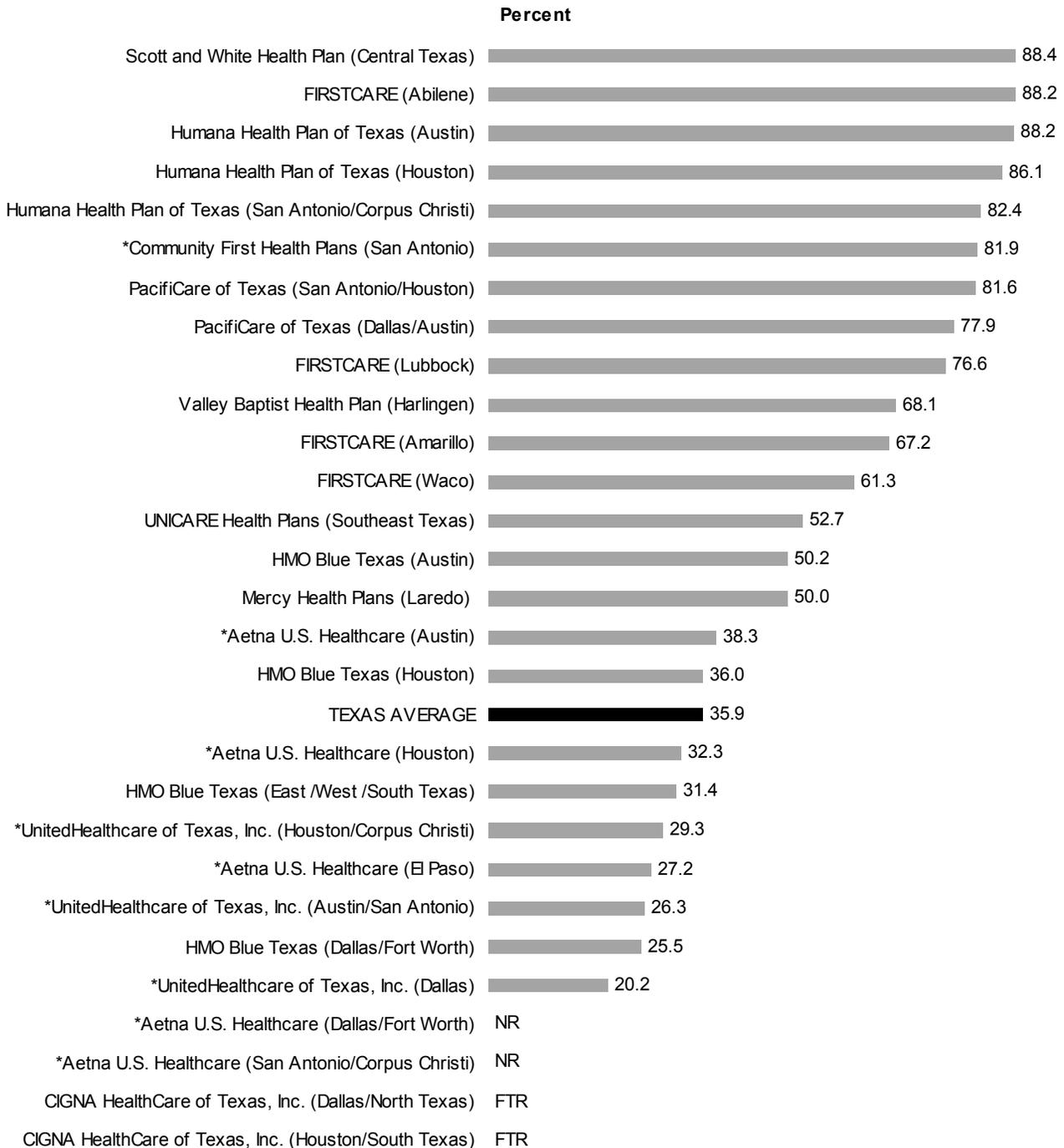
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## Childhood Immunization Status: Combination 2



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## Childhood Immunization Status: Combination 3

Definition: The percentage of children using the HMO who received all Combination 3 vaccinations [4 Diphtheria, Tetanus, Pertussis (DTaP), 3 Polio, 3 Hepatitis B, 1 Measles, Mumps, Rubella (MMR), 3 H Influenza type B (HiB), 1 Chickenpox, and 4 Pneumococcal Conjugate] by two years of age.

The American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians (AAFP) all recommend the following immunization schedule for children under two years of age:

- Hepatitis B - three vaccines (one from birth to 2 months, one from 1 to 4 months, and one from 6 to 18 months)
- Diphtheria, Tetanus, Pertussis - four vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 15 to 18 months)
- *Haemophilus Influenzae* type B (HiB)- four vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 12 to 15 months)
- Inactivated Polio - three vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 12 to 15 months)
- Pneumococcal Conjugate - four vaccines (one at 2 months, one at 4 months, one at 6 months, and one from 12 to 15 months)
- Measles, Mumps, Rubella - one vaccine (one from 12 to 15 months), and
- Varicella - one vaccine (one from 12 to 18 months).

The Combination 3 measure most closely reflects the number of immunizations recommended by AAP, ACIP and AAFP for children under two years of age.

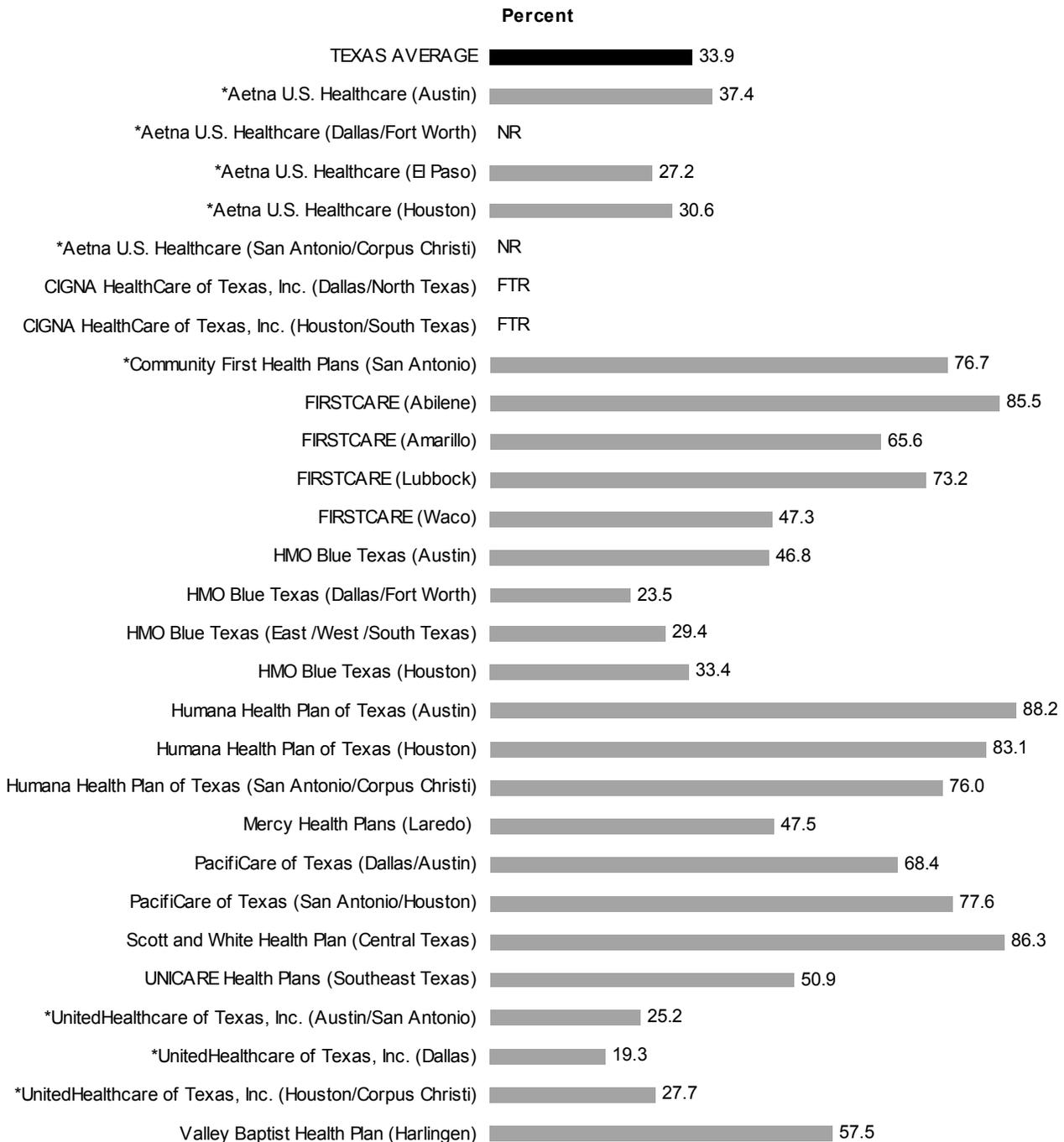
Childhood Immunization Status: Combination 3 Rates				
	2006	2007	2008	2009
Texas Average	*	33.6%	34.9%	33.9%
NCQA's Quality Compass®	*	65.7%	62.3%	76.6%

This measure was added to the Texas Subset beginning with HEDIS® 2006

\* Value not established or not obtained.

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## Childhood Immunization Status: Combination 3



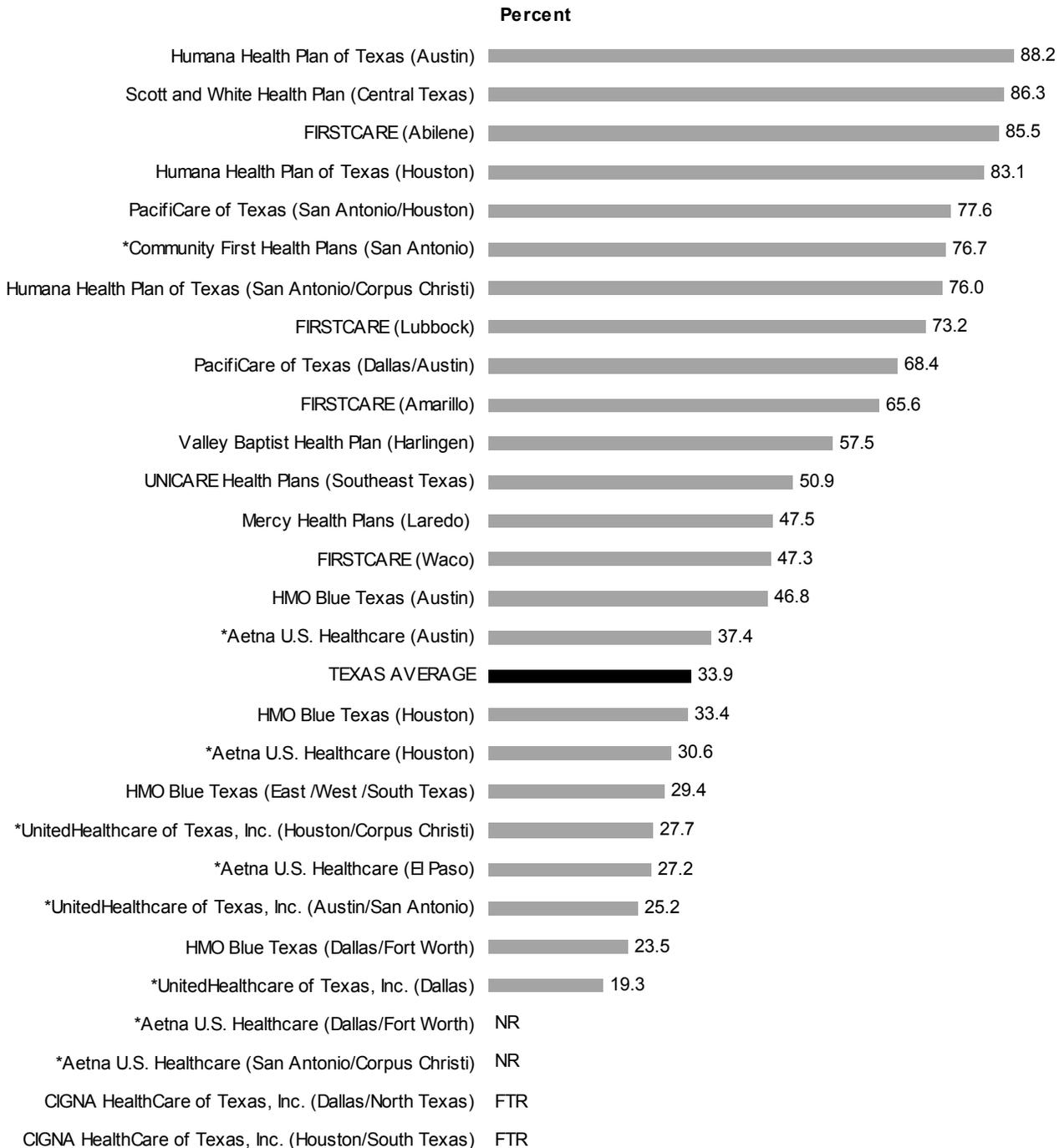
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## Childhood Immunization Status: Combination 3



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## Colorectal Cancer Screening

Definition: The percentage of adults 50 to 80 years of age using the HMO who had an appropriate screening for colorectal cancer.

Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States.<sup>1</sup> It places significant economic burden on society, with treatment costing over \$6.5 billion per year. Unlike other screening tests that only detect disease, some methods of CRC screening can detect premalignant polyps and guide their removal, which in theory can prevent the cancer from developing.<sup>2</sup>

This measure assesses whether adults 50–80 years of age have had appropriate screening for CRC. “Appropriate screening” is defined by meeting any one of the four criteria below.<sup>3</sup>

- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year

Compelling evidence gathered during the past decade shows that systematic screening can reduce mortality from colorectal cancer. Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective.<sup>4</sup>

Colorectal Cancer Screening Rates			
	2007	2008	2009
Texas Average	45.3%	43.3%	46.4%
NCQA's Quality Compass®	54.5%	51.3%	58.7%

This measure was added to the Texas Subset beginning with HEDIS® 2007.

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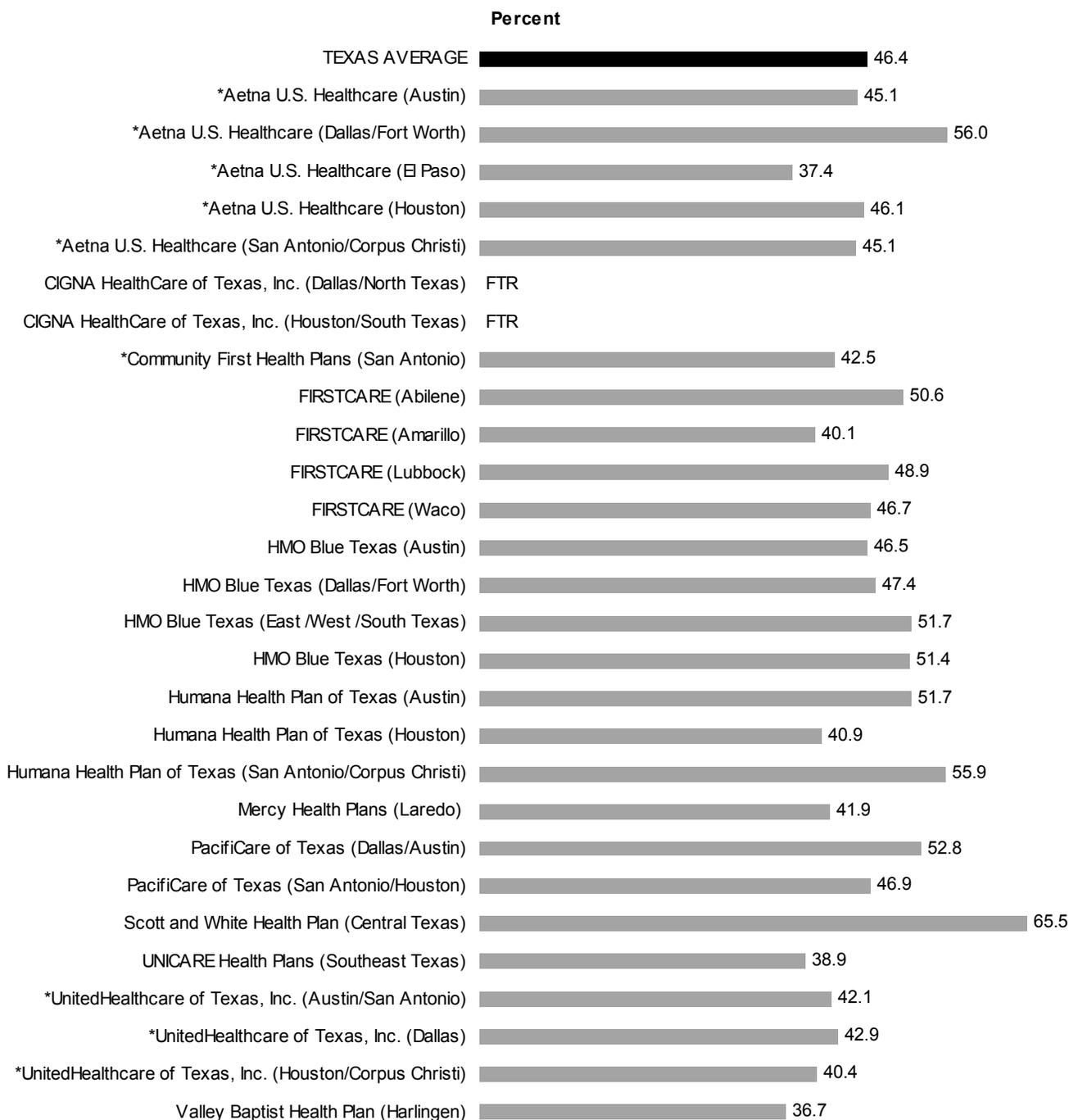
<sup>1</sup> American Cancer Society, Cancer Facts and Figures 2007, 2007

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>3</sup> *ibid.*

<sup>4</sup> Kavanagh, A., E. Giovannucci, C. Fuchs, et al. 1998. Screening endoscopy and risk of colorectal cancer in United States men. *Cancer Causes Control* 9:455-462.

## Colorectal Cancer Screening Rate



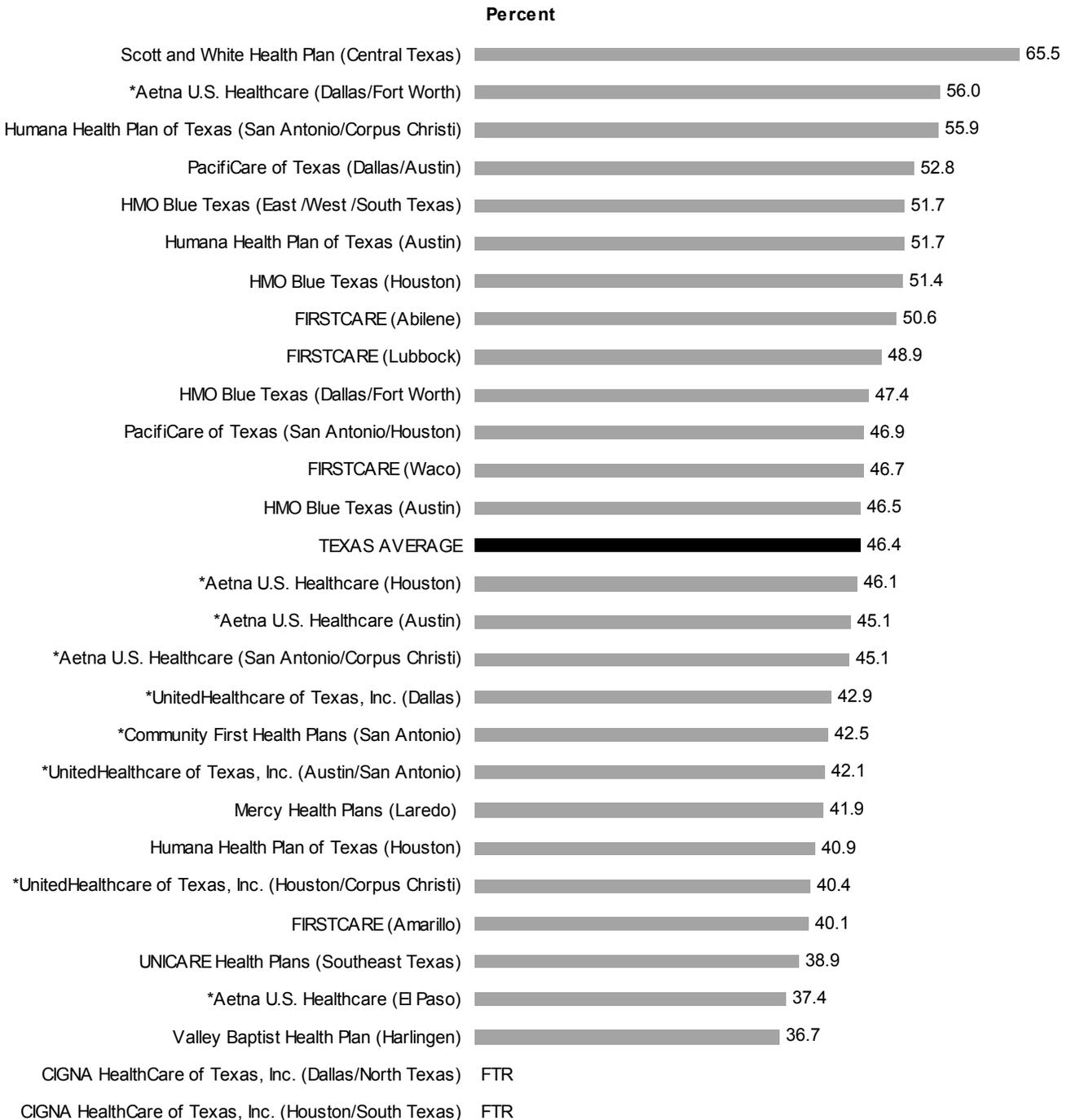
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Colorectal Cancer Screening Rate



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## Breast Cancer Screening

Definition: The percentage of women 40 through 69 years of age using the HMO who received a mammogram to screen for breast cancer.

Breast cancer is the second most common form of cancer among American women. More than 190,000 women are diagnosed each year with breast cancer.<sup>1</sup> The earlier breast cancer is found, the better the chance for successful treatment. A mammogram is one of the best ways to detect breast cancer at an early stage. A mammogram is an X-ray of the breast that identifies tumors that are too small to be detected by self-examination. Several large studies conducted around the world show that breast cancer screening with mammograms reduces the number of deaths from breast cancer for women ages 40 to 69, especially for those over age 50.<sup>2</sup>

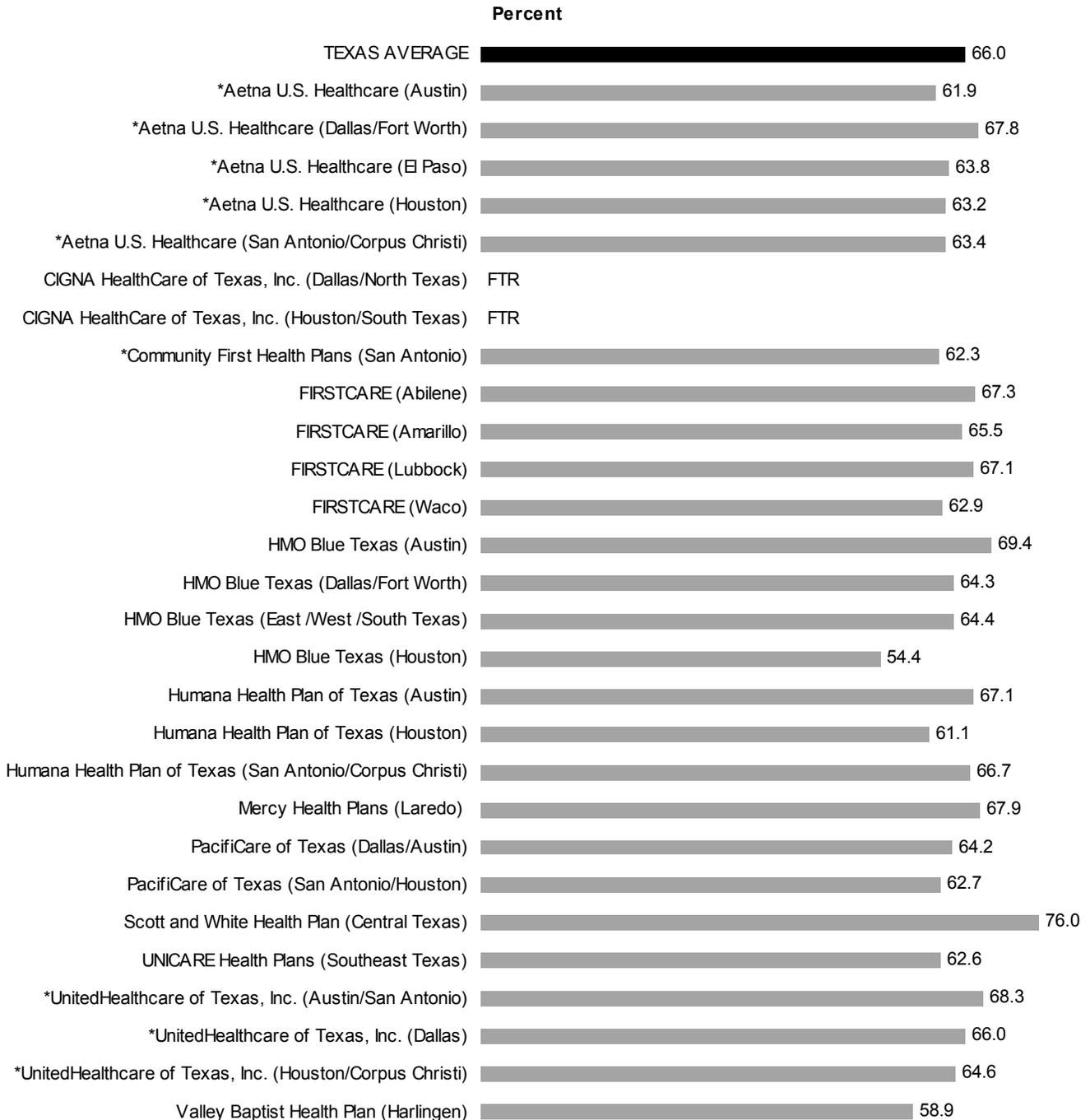
Breast Cancer Screening Rates					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	67.6%	66.1%	63.3%	65.2%	66.0%
<b>NCQA's Quality Compass®</b>	73.4%	72.0%	68.9%	67.3%	70.2%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Cancer Institute, Cancer Topics, Breast Cancer, 2009

<sup>2</sup> National Cancer Institute, Fact Sheet, Mammograms, 2009

## Breast Cancer Screening Rate



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Breast Cancer Screening Rate



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Cervical Cancer Screening

Definition: The percentage of women 21 through 64 years of age using the HMO who received one or more Pap tests to screen for cervical cancer.

Cervical cancer often has no recognizable symptoms until it is at an advanced stage. However, when detected early, cervical cancer can almost always be cured. In 2009, an estimated 11,200 cases of cervical cancer were expected to occur with about 4,000 women dying from this disease.<sup>1</sup> Most of these deaths could have been prevented by a routine Pap smear. Early detection, through Pap screening, has dramatically reduced the incidence and mortality from invasive cervical cancer. Over the last three decades, cervical cancer incidence and mortality rates have declined approximately 50 percent in the United States.<sup>2</sup>

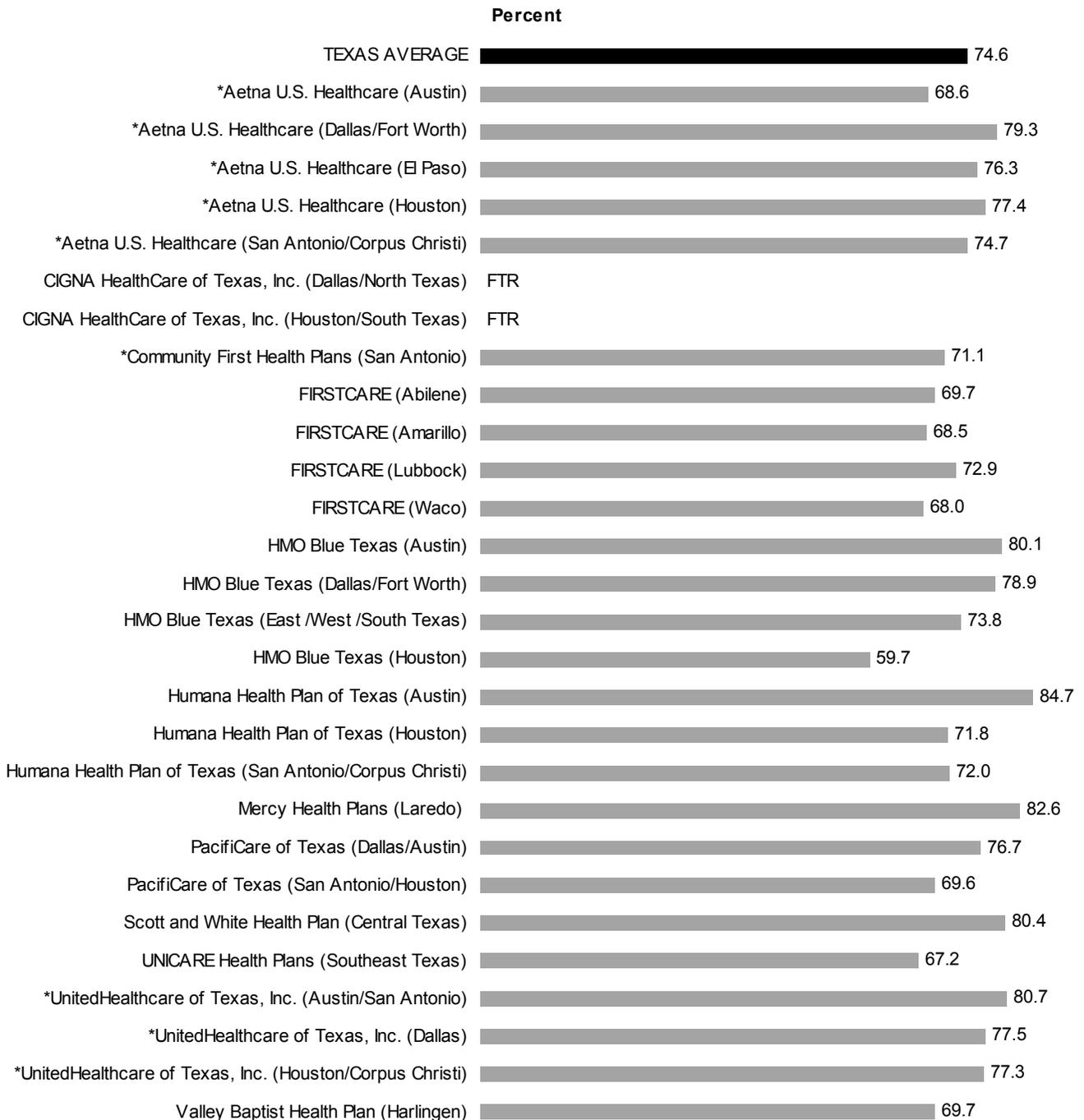
Cervical Cancer Screening					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	76.6%	77.1%	74.7%	76.2%	74.6%
<b>NCQA's Quality Compass®</b>	80.9%	81.8%	81.0%	78.4%	80.8%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Cancer Institute, Cervical Cancer, 2009

<sup>2</sup> National Cancer Institute, A Snapshot of Cervical Cancer, September 2008

## Cervical Cancer Screening Rate



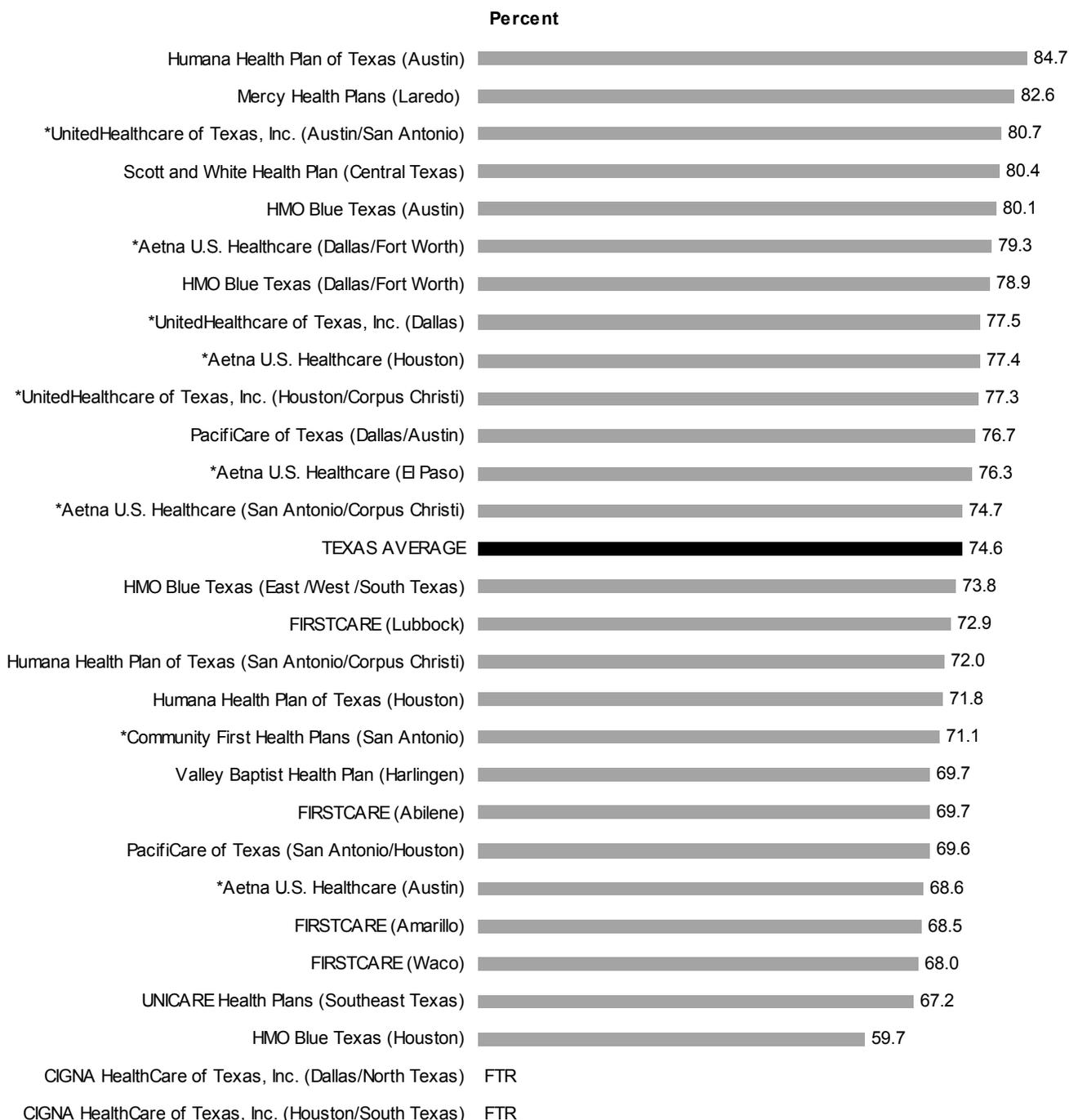
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## Cervical Cancer Screening Rate



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## Chlamydia Screening in Women

Definition: The percentage of women 16 to 24 years of age using the HMO who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States. The CDC estimates that approximately three million people are infected with chlamydia each year. Risk factors associated with becoming infected with chlamydia are the same as risks for contracting other STDs (e.g., multiple sex partners). Chlamydia is more prevalent among adolescent (15–19) and young adult (20–24) women.<sup>1</sup>

This measure assesses the percentage of sexually active women 16–24 years of age who were screened for chlamydia. Screening for chlamydia is essential because the majority of women who have the condition do not experience symptoms. The main objective of chlamydia screening is to prevent pelvic inflammatory disease (PID), infertility and ectopic pregnancy, all of which have very high rates of occurrence among women with untreated chlamydial infection.<sup>2</sup>

Chlamydia Screening Rates			
	2007	2008	2009
Texas Average	34.0%	33.1%	38.2%
NCQA's Quality Compass <sup>®</sup>	37.3%	36.4%	41.7%

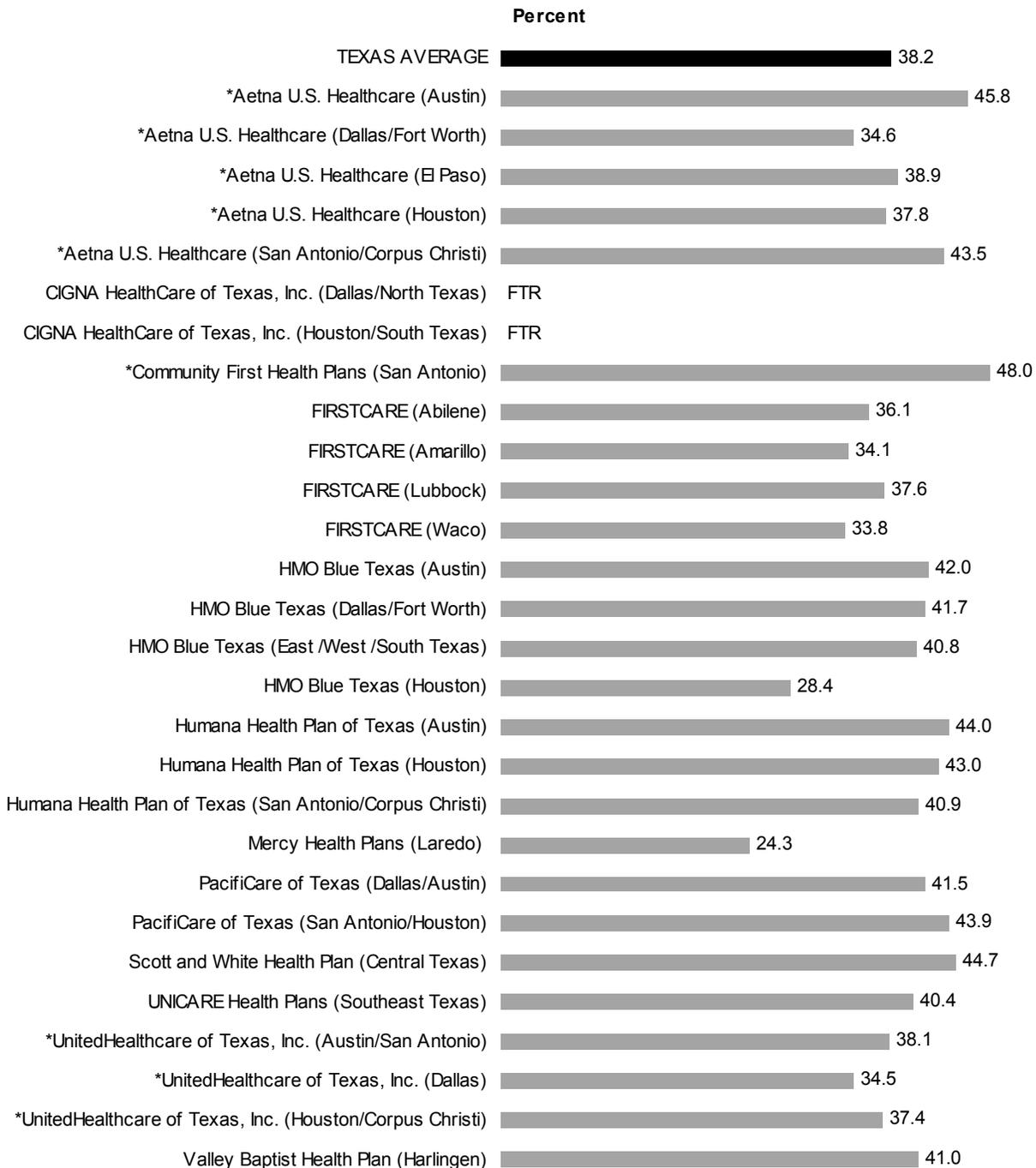
This measure was added to the Texas Subset beginning with HEDIS<sup>®</sup> 2007.

Quality Compass<sup>®</sup> is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS<sup>®</sup> 2009 Volume 1 Narrative, 2008

<sup>2</sup> United States Preventive Services Task Force (USPSTF), Screening for Chlamydial Infection, 2001

## Chlamydia Screening Rate



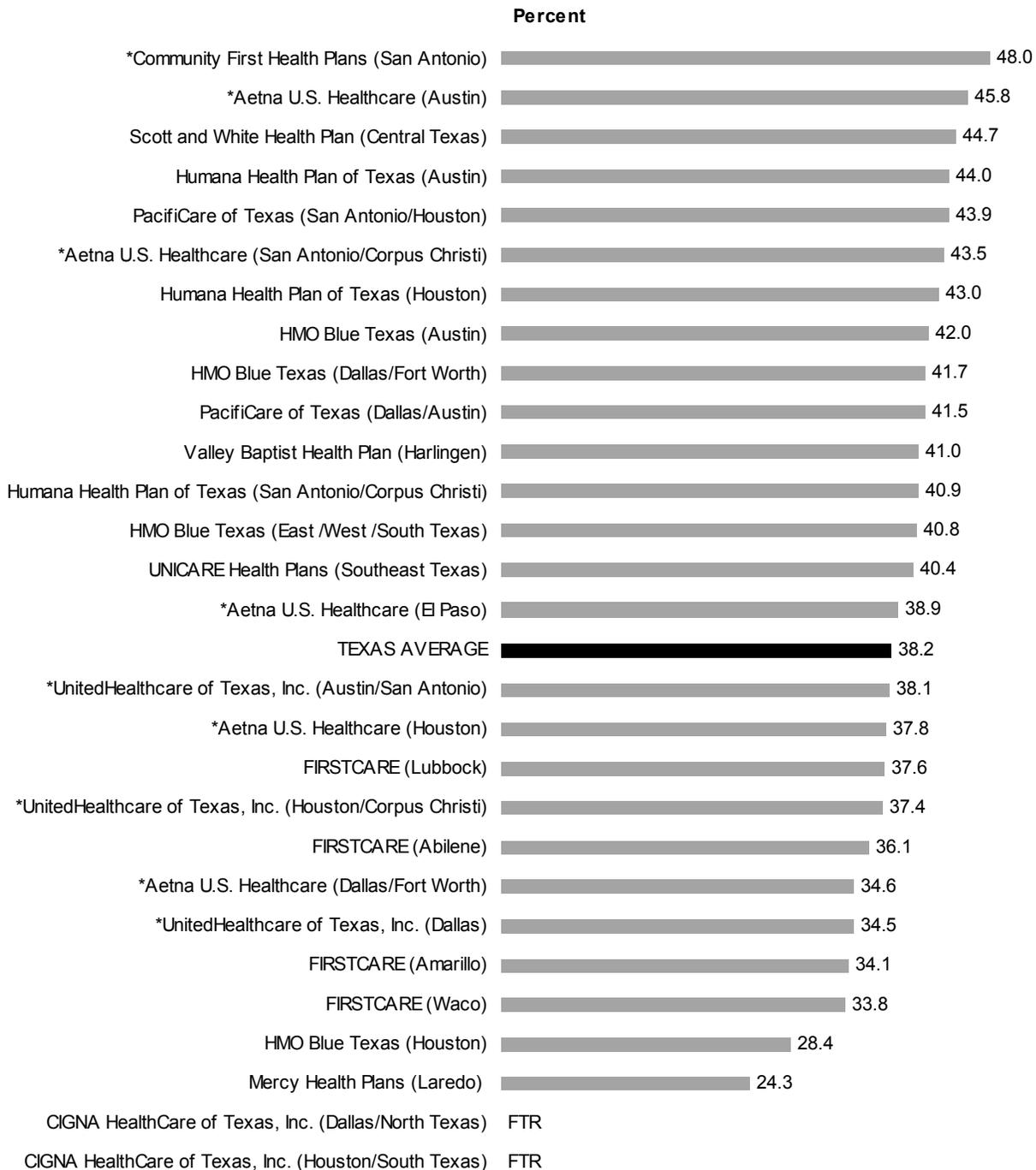
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## Chlamydia Screening Rate



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FTR– Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Controlling High Blood Pressure

Definition: The percentage of members age 18 through 85 years diagnosed with hypertension (high blood pressure), whose blood pressure was adequately controlled during the measurement year. Adequate control was demonstrated by a blood pressure reading below 140 mm Hg systolic and 90 mm Hg diastolic.

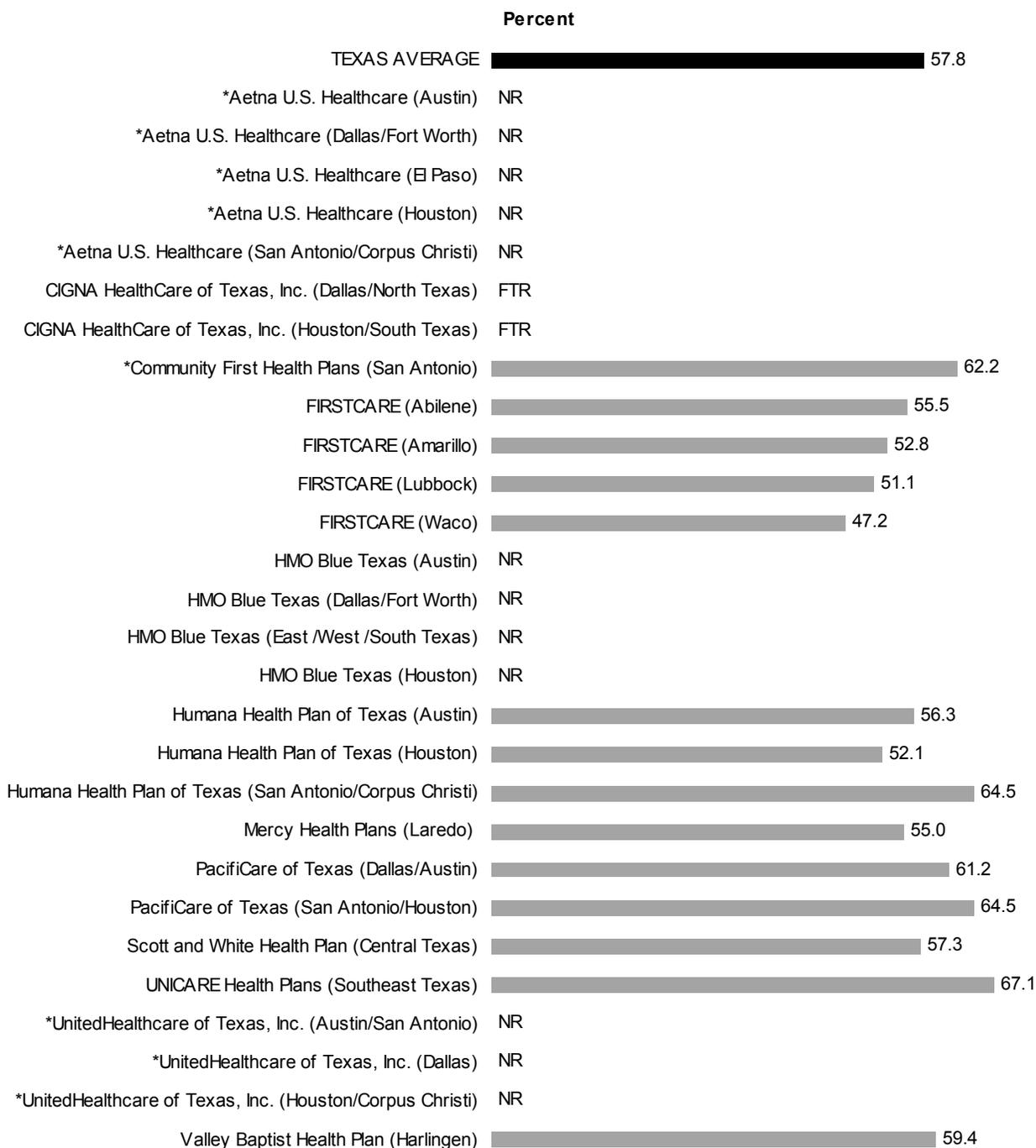
According to the American Heart Association about 74 million Americans have high blood pressure. High blood pressure killed 57,400 Americans in 2005 and was a secondary mortality factor in 319,000 additional deaths.<sup>1</sup> Studies have shown that of those with hypertension age 20 and older, 78.7 percent were aware of their condition, 69.1 percent were under current treatment, 45.4 percent had it under control, and 54.6 percent did not have it controlled. High blood pressure usually has no specific symptoms and no early warning signs. It's truly a "silent killer". Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke, and renal failure.

Controlling High Blood Pressure					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	64.5%	64.5%	57.7%	59.9%	57.8%
<b>NCQA's Quality Compass®</b>	66.8%	68.8%	59.7%	62.2%	63.4%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> American Heart Association, Heart Disease and Stroke Statistics, 2009

## Controlling High Blood Pressure



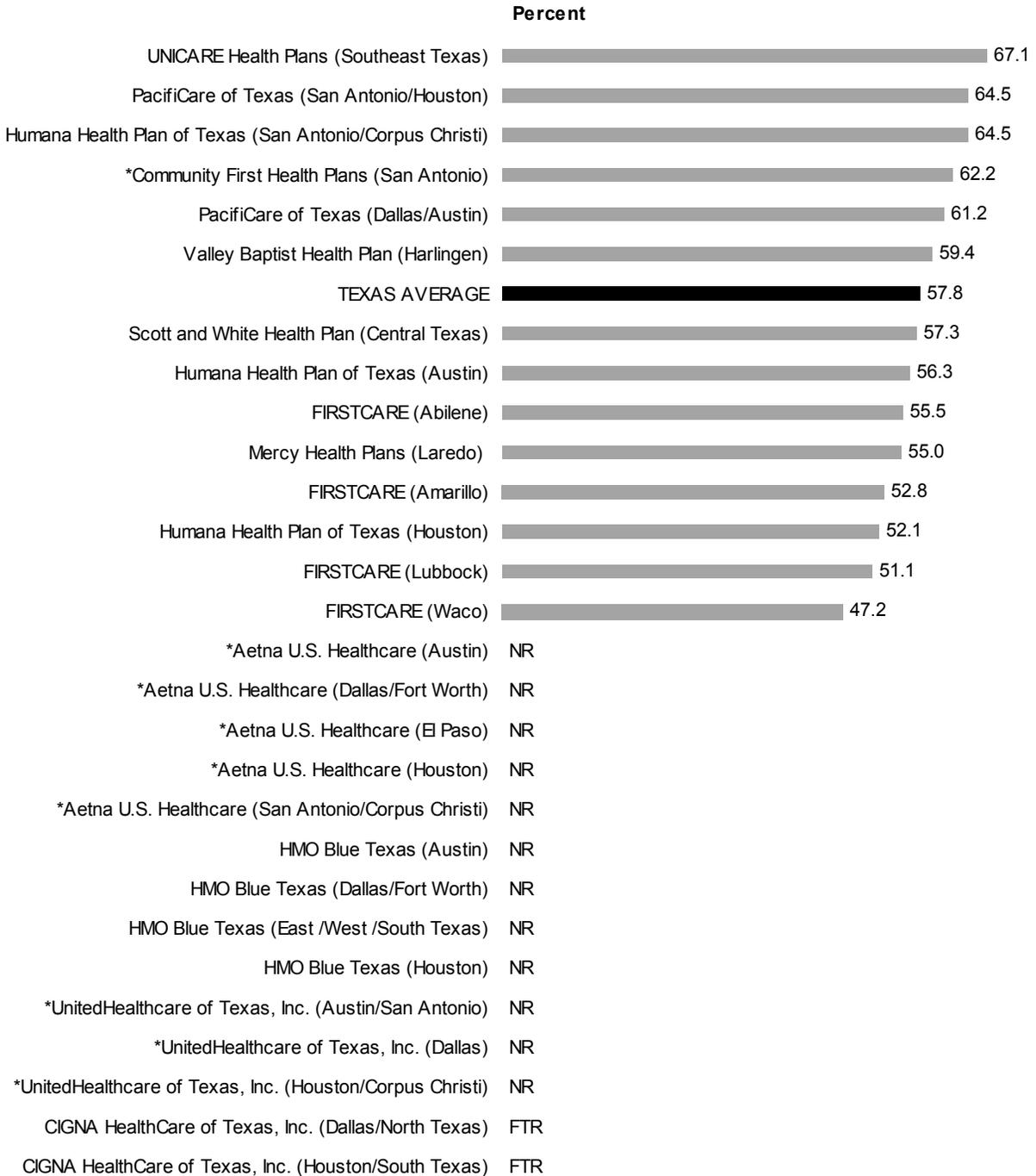
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## Controlling High Blood Pressure



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## Persistence of Beta-Blocker Treatment After a Heart Attack

Definition: The percentage of members age 18 years and older who were hospitalized during the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received six months of beta-blocker treatment after discharge. Members who have a valid medical reason not to take the drug are excluded.

A number of HMOs have been assigned “NA” (not applicable) for this measure because they had too small eligible member population (less than 30) to report a statistically valid rate. Please note that the lower age limit changed from 35 years of age to 18 years of age beginning with HEDIS® 2008.

The National Health and Nutrition Examination Survey shows that coronary heart disease (CHD) or heart attack is the single leading cause of death in America.<sup>1</sup> One of every five deaths is due to heart attack and an estimated 6,400,000 people in the United States suffer from angina (chest pain due to coronary heart disease).<sup>2</sup> Heart attack can reduce the heart's ability to pump effectively (ejection fraction) and this may increase the risk for a subsequent attack and sudden cardiac death (SCD).

Beta-blockers, properly known as beta-adrenergic blocking drugs, interfere with actions of the sympathetic nervous system, which controls involuntary muscle movement. They slow the heart rate, relax pressure in blood vessel walls, and decrease the force of heart contractions.

Treatment with beta blockers has been shown to lower the risk of subsequent heart attacks, because the medication reduces how hard the heart has to work and also lowers blood pressure. The American Heart Association and The American College of Cardiology recommend the immediate infusion of beta-blockers upon diagnosis of AMI.<sup>3</sup>

Beta Blocker Treatment After a Heart Attack				
	2006	2007	2008	2009
<b>Texas Average</b>	63.9%	70.4%	61.9%	68.7%
<b>NCQA's Quality Compass®</b>	70.3%	72.5%	68.3%	75.0%

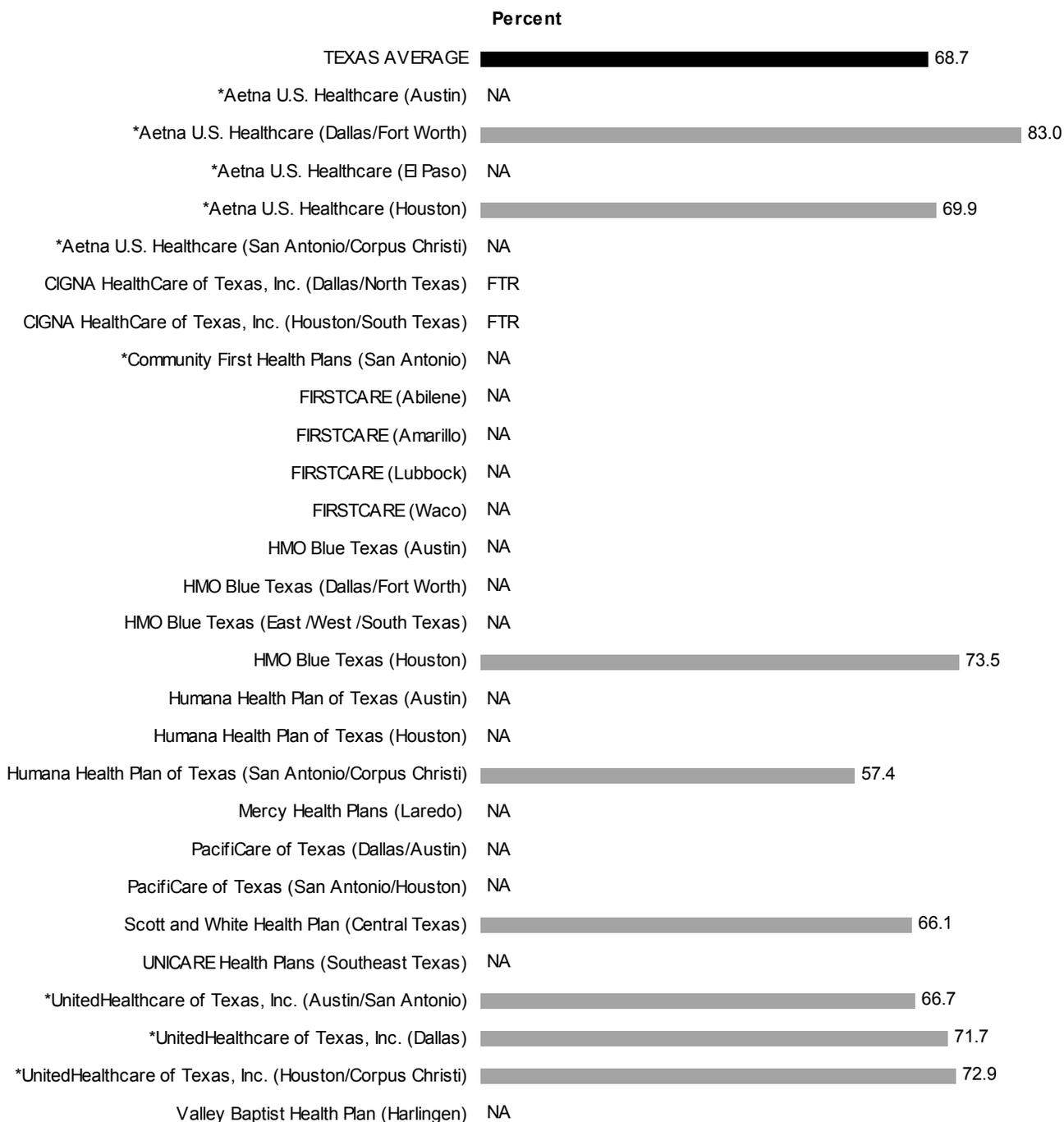
Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

## Persistence of Beta Blocker Treatment After a Heart Attack



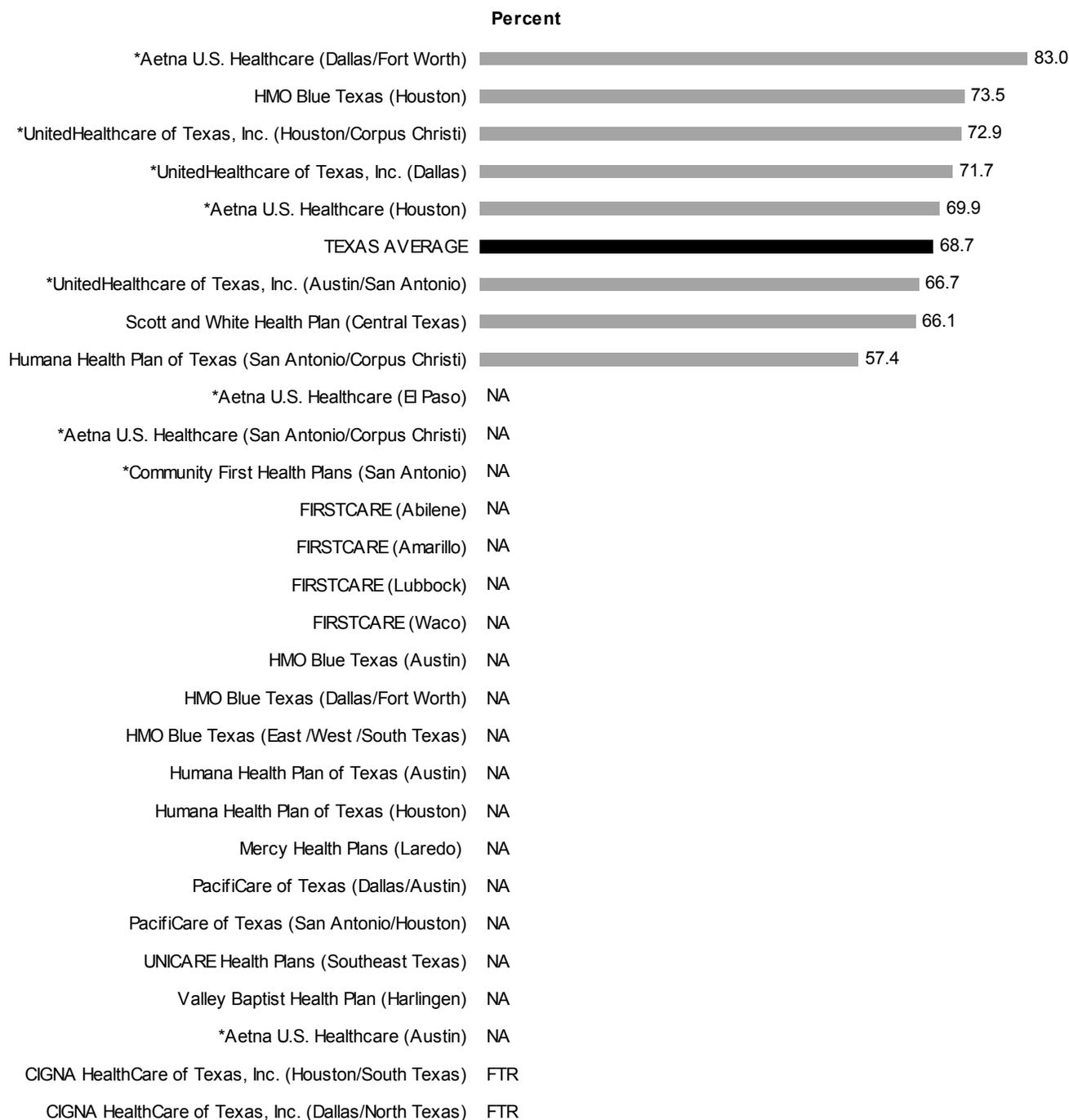
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## Persistence of Beta Blocker Treatment After a Heart Attack



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## Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening

Definition: The percentage of members age 18 through 75 years of age who had an LDL-C (low density lipoprotein-cholesterol) screening during the measurement year and the year prior, after discharge for an acute cardiovascular event.

Total blood cholesterol is directly related to the development of coronary artery disease and coronary heart disease, with most of the risk associated with LDL cholesterol. When LDL-C levels are high, cholesterol can build up within the walls of the arteries and cause atherosclerosis, a build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke.<sup>1</sup>

Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40 percent. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of  $\leq 100$  mg/dL for such patients.<sup>2</sup>

Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	79.4%	75.6%	82.3%	83.6%	84.4%
<b>NCQA's Quality Compass®</b>	81.8%	*	87.5%	82.7%	88.9%

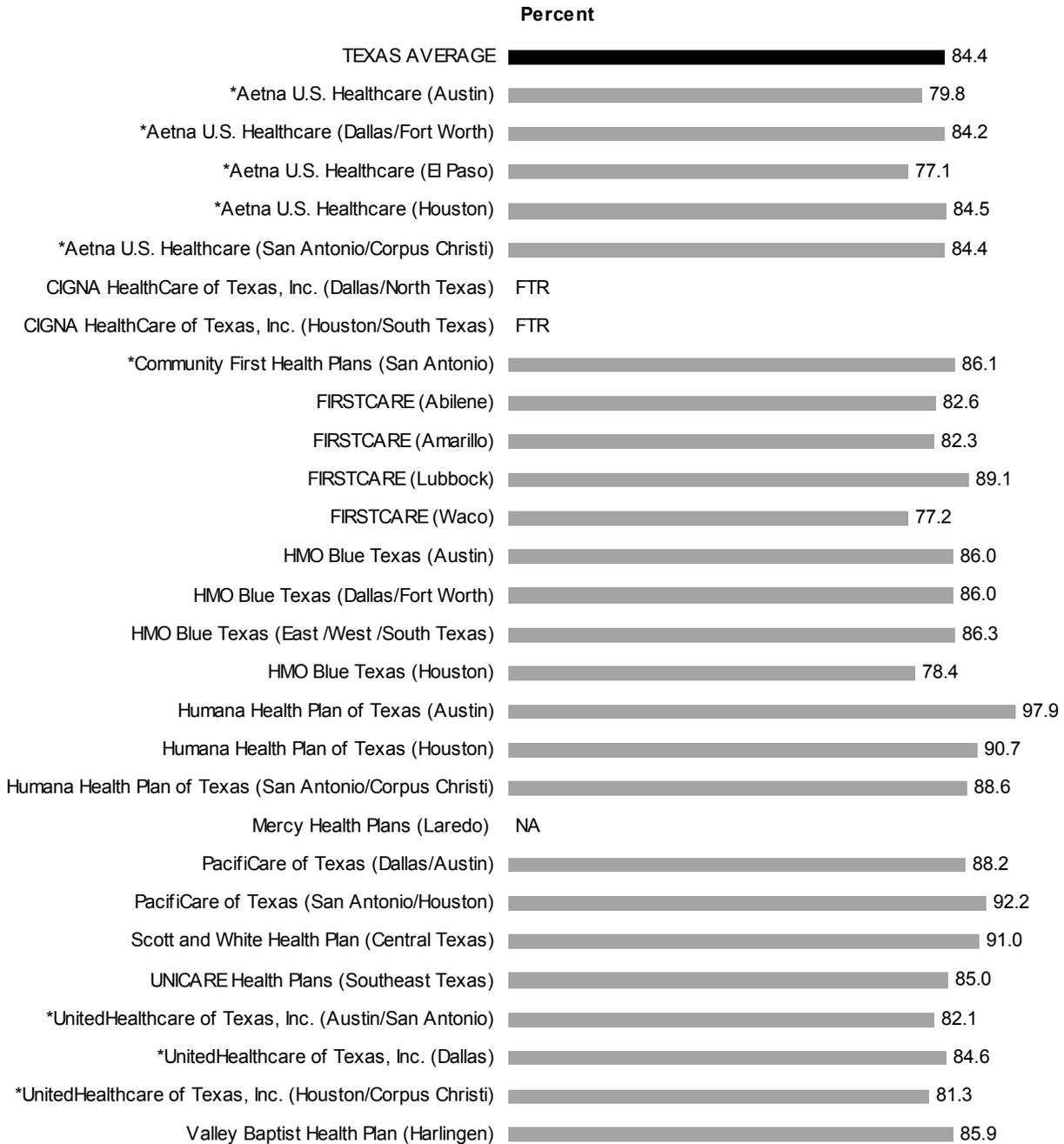
\* Value not established or not obtained.

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> National Heart, Lung, and Blood Institute Health Information Network, NCEP Guidelines, 2009

## Cholesterol Management: LDL-C Level Screening After Acute Cardiovascular Event



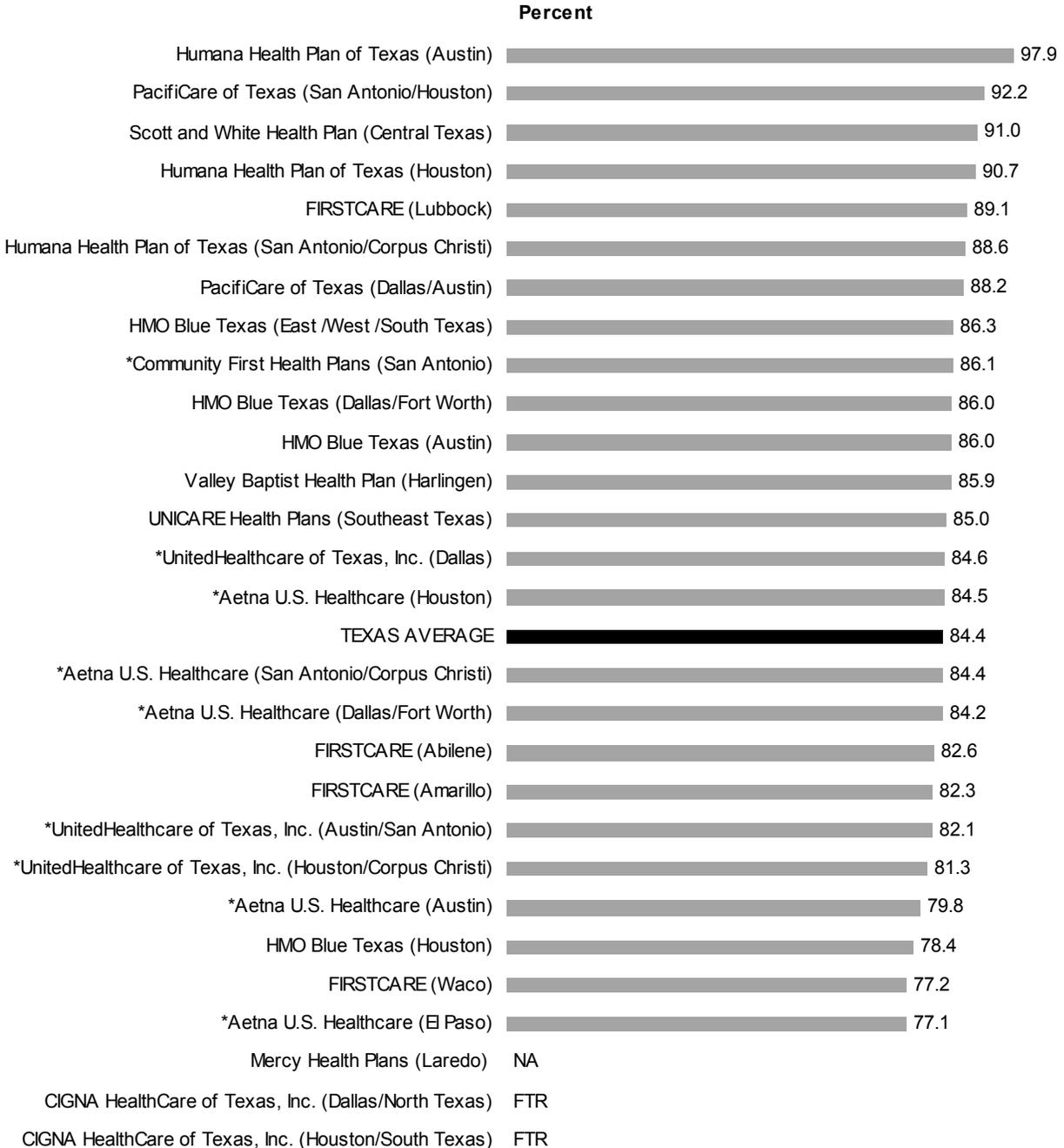
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## Cholesterol Management: LDL-C Level Screening After Acute Cardiovascular Event



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## Comprehensive Diabetes Care: HbA1cTesting

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had one or more HbA1c tests conducted within the past year.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed.<sup>1</sup> Complications from the disease cost the country nearly \$100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in persons over 25. Many complications, such as amputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages.<sup>2</sup>

The glycosylated hemoglobin (HbA1c) test is a simple lab test that measures the average amount of sugar (glucose) that has been in a person's blood over the last three months. The test shows if a person's blood sugar is under control.

It is recommended that people with diabetes should have a Hemoglobin A1c test at least twice a year.<sup>3</sup>

Comprehensive Diabetes Care: HbA1cTesting					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	82.1%	82.5%	78.2%	79.2%	81.7%
<b>NCQA's Quality Compass®</b>	86.5%	87.5%	87.5%	83.2%	89.0%

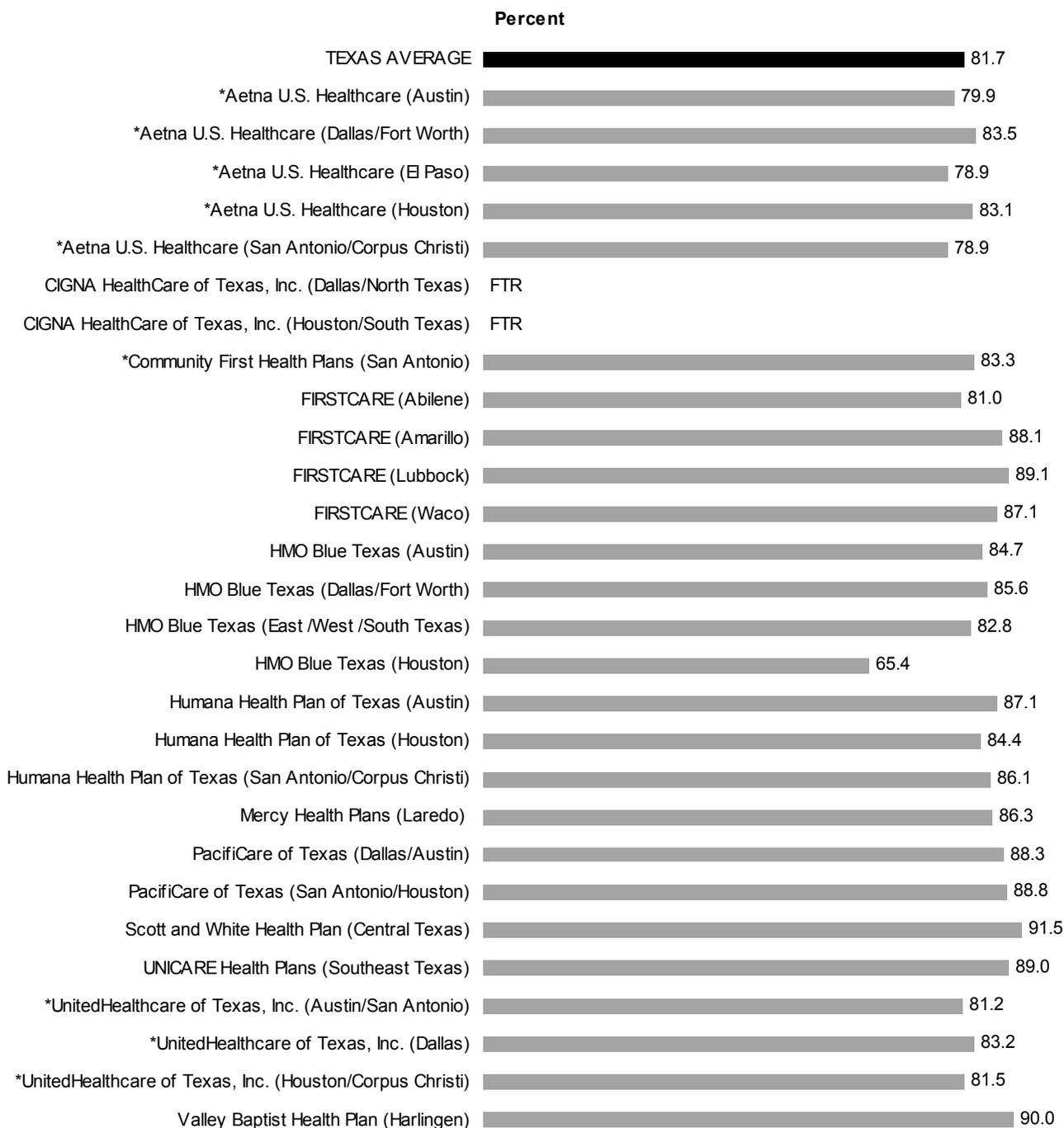
Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> Centers for Disease Control and Prevention, National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>3</sup> American Diabetes Association, A1c Test, 2009

## Comprehensive Diabetes Care: HbA1c Testing



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## Comprehensive Diabetes Care: HbA1c Testing



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**Note - Lower rates indicate better performance for this measure.**

## **Comprehensive Diabetes Care: Poor HbA1c Control (>9.0%)**

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had their most recent HbA1c level greater than 9.0 percent during the past year.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed.<sup>1</sup> Complications from the disease cost the country nearly \$100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in persons over 25. Many complications, such as amputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages.<sup>2</sup>

Diabetics who keep their HbA1c levels close to seven percent have a much better chance of delaying or preventing problems that affect the eyes, kidneys, and nerves than do diabetics with levels eight percent or higher. The American Diabetes Association recommends that the goal of therapy should be an HbA1c level of less than seven percent and that physicians should reevaluate the treatment regimes in patients with HbA1c levels consistently above eight percent.<sup>3</sup>

Comprehensive Diabetes Care: Poor HbA1c Control					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	56.6%	57.0%	55.8%	70.3%	56.0%
<b>NCQA's Quality Compass®</b>	30.7%	29.7%	29.6%	43.4%	28.4%

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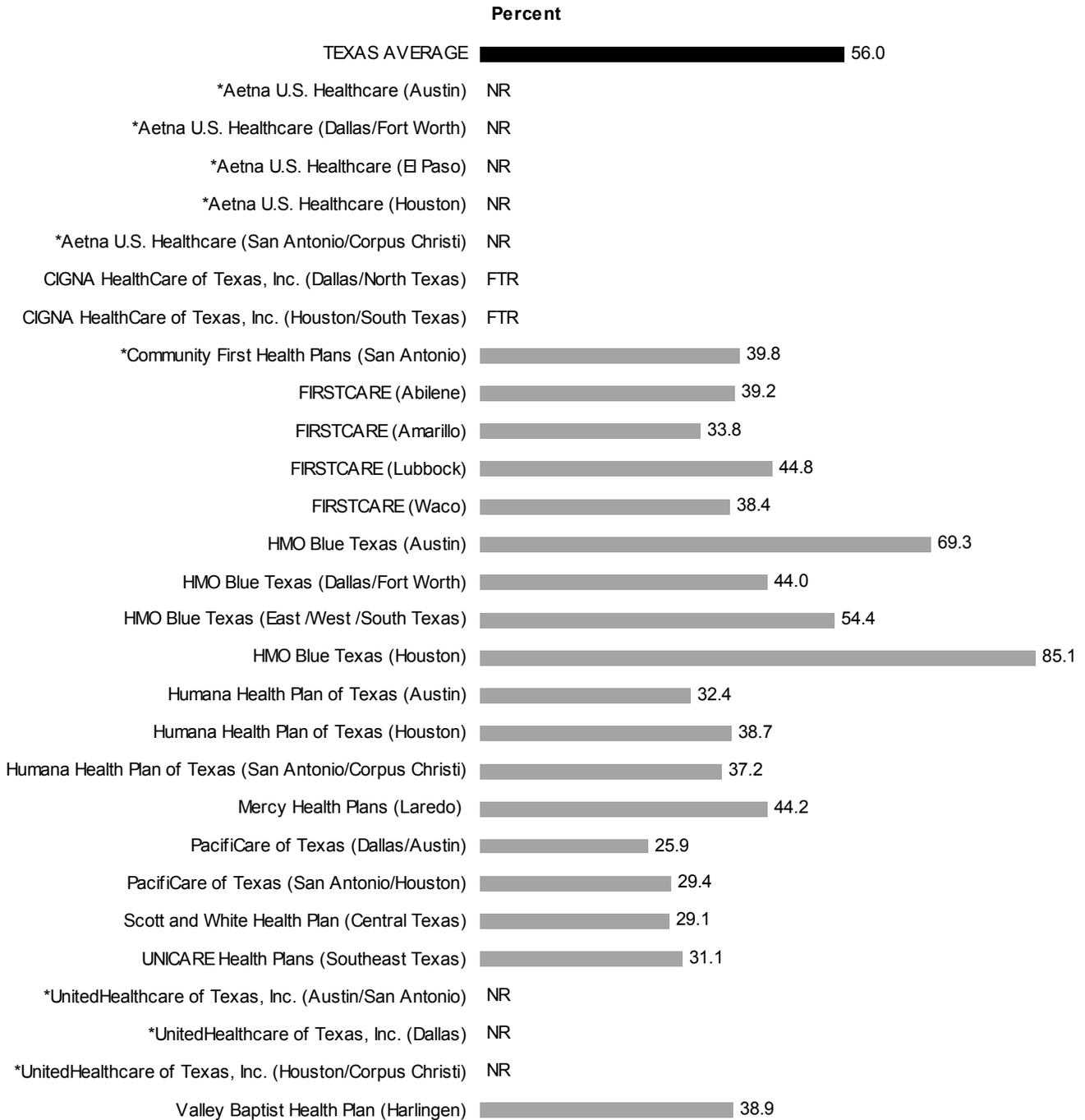
<sup>1</sup> Centers for Disease Control and Prevention, National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>3</sup> American Diabetes Association, Checking Your Blood Glucose, 2009

**Note - Lower rates indicate better performance for this measure.**

## Comprehensive Diabetes Care: Poor HbA1c Control



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

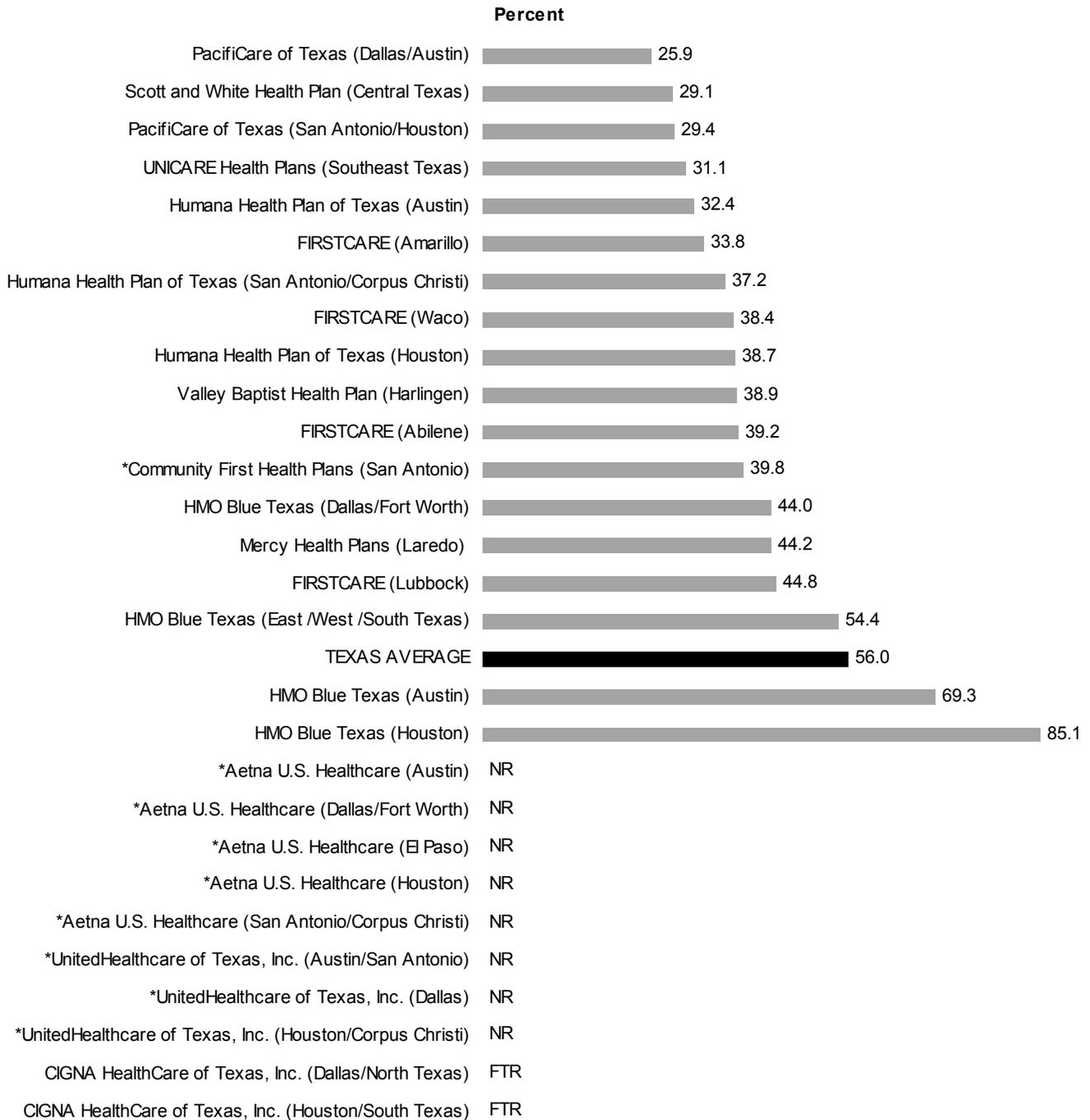
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**Note - Lower rates indicate better performance for this measure.**

## Comprehensive Diabetes Care: Poor HbA1c Control



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## Comprehensive Diabetes Care: Eye Exam

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had an eye screening for diabetic retinal disease within the past year, or a negative retinal exam the year prior.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed.<sup>1</sup> Complications from the disease cost the country nearly \$100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in persons over 25. Many complications, such as amputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages.<sup>2</sup>

Diabetic retinopathy is the most common diabetic eye disease and a leading cause of blindness in American adults. It is caused by changes in the blood vessels of the retina. In some people with diabetic retinopathy, blood vessels may swell and leak fluid. In other people, abnormal new blood vessels grow on the surface of the retina. Between 40 to 45 percent of Americans diagnosed with diabetes have some stage of diabetic retinopathy. People with proliferative retinopathy can reduce their risk of blindness by 95 percent with timely treatment and appropriate follow-up care.<sup>3</sup>

Comprehensive Diabetes Care: Eye Exam					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	35.0%	35.5%	33.8%	32.2%	32.1%
<b>NCQA's Quality Compass®</b>	60.0%	54.8%	54.7%	46.9%	56.5%

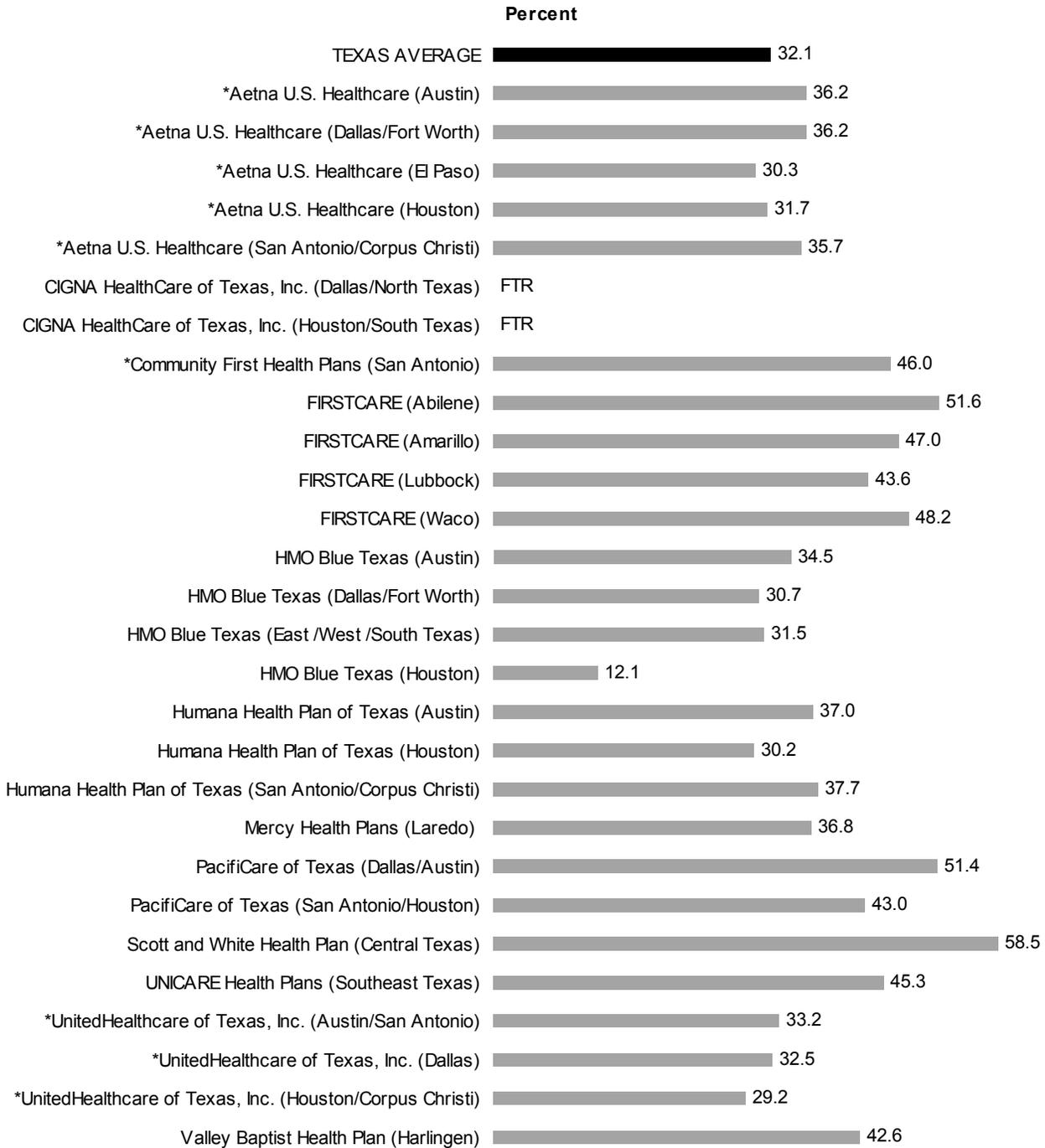
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<sup>1</sup> Centers for Disease Control and Prevention, National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>3</sup> National Eye Institute, National Institutes of Health, Diabetic Retinopathy, 2009

## Comprehensive Diabetes Care: Eye Exam



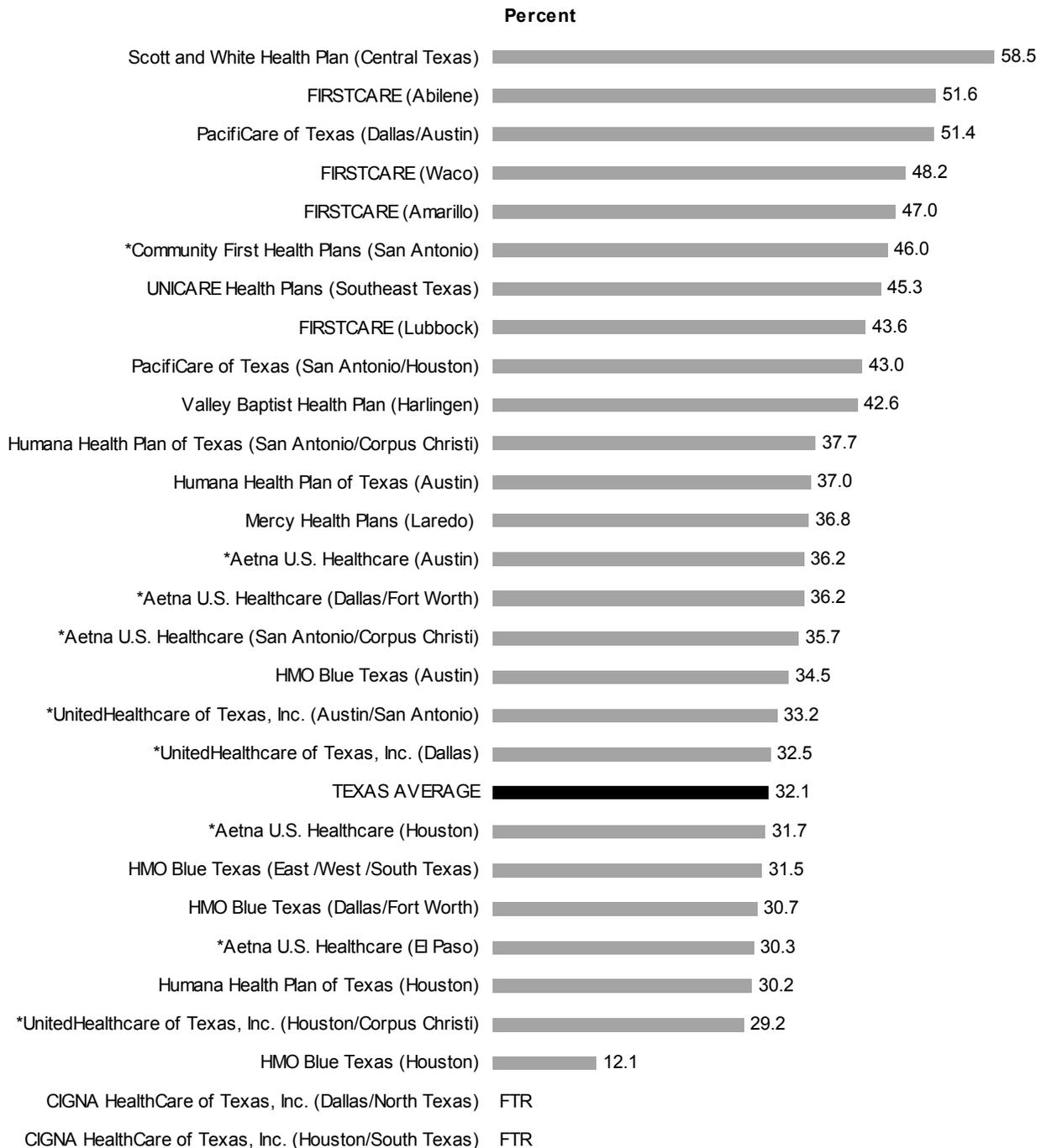
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## Comprehensive Diabetes Care: Eye Exam



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## Comprehensive Diabetes Care: LDL-C Screening

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had a LDL-C test done within the last two years.

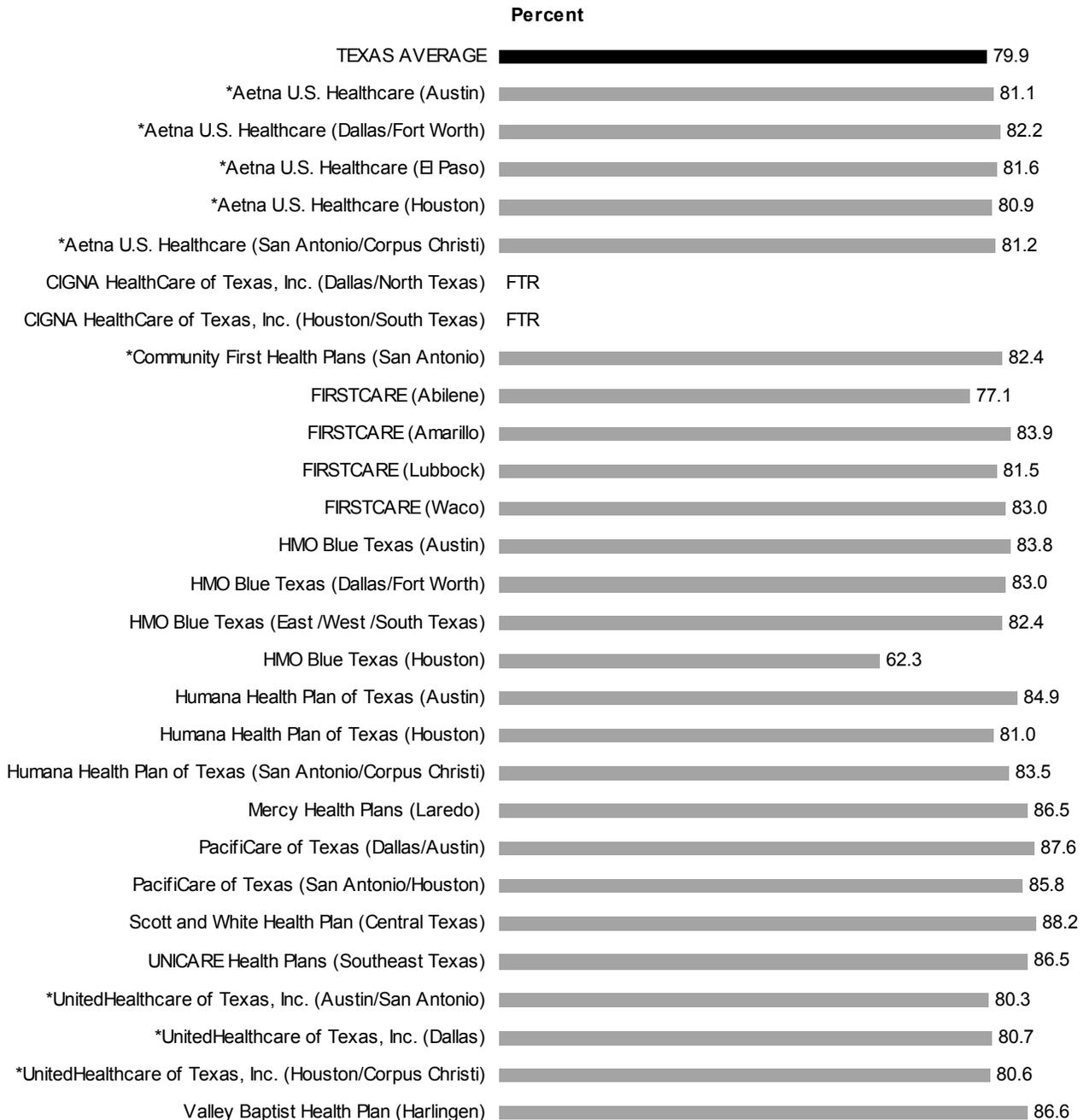
Lipid profiles can help predict a person's risk of cardiovascular disease, the leading cause of death among people with diabetes in the United States. A lipid profile consists of measurements of total cholesterol, total triglycerides, and high-density lipoproteins (HDLs). Low-density lipoproteins (LDLs) can either be tested separately or calculated by a formula involving the measurements of the other three items. High levels of LDLs in the blood may cause plaque to deposit on the walls of the arteries causing atherosclerosis, which can restrict or obstruct blood flow to the heart. The American Diabetes Association recommends that adults with diabetes have their lipid profiles checked every year.<sup>1</sup>

Comprehensive Diabetes Care: LDL-C Screening					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	89.1%	88.6%	75.4%	77.2%	79.9%
<b>NCQA's Quality Compass®</b>	91.0%	92.3%	83.4%	79.5%	84.8%

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<sup>1</sup> American Diabetes Association, Treating High Cholesterol in People with Diabetes, 2009

## Comprehensive Diabetes Care: LDL-C Screening



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## Comprehensive Diabetes Care: LDL-C Screening



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## Comprehensive Diabetes Care: LDL-C Control (<100 mg/dL)

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had a LDL-C test done with a level reading of less than 100 mg/dL during the last year.

Lipid profiles can help predict a person's risk of cardiovascular disease, the leading cause of death among people with diabetes in the United States. A lipid profile consists of measurements of total cholesterol, total triglycerides, and high-density lipoproteins (HDLs). Low-density lipoproteins (LDLs) can either be tested separately or calculated by a formula involving the measurements of the other three items. High levels of LDLs in the blood may cause plaque to deposit on the walls of the arteries causing atherosclerosis, which can restrict or obstruct blood flow to the heart. The American Diabetes Association recommends that adults with diabetes have their lipid profiles checked every year.<sup>1</sup>

Annual cholesterol testing and a treatment plan to keep LDL levels below 100 mg/dl can lower the risk of heart attack or stroke in patients with diabetes.

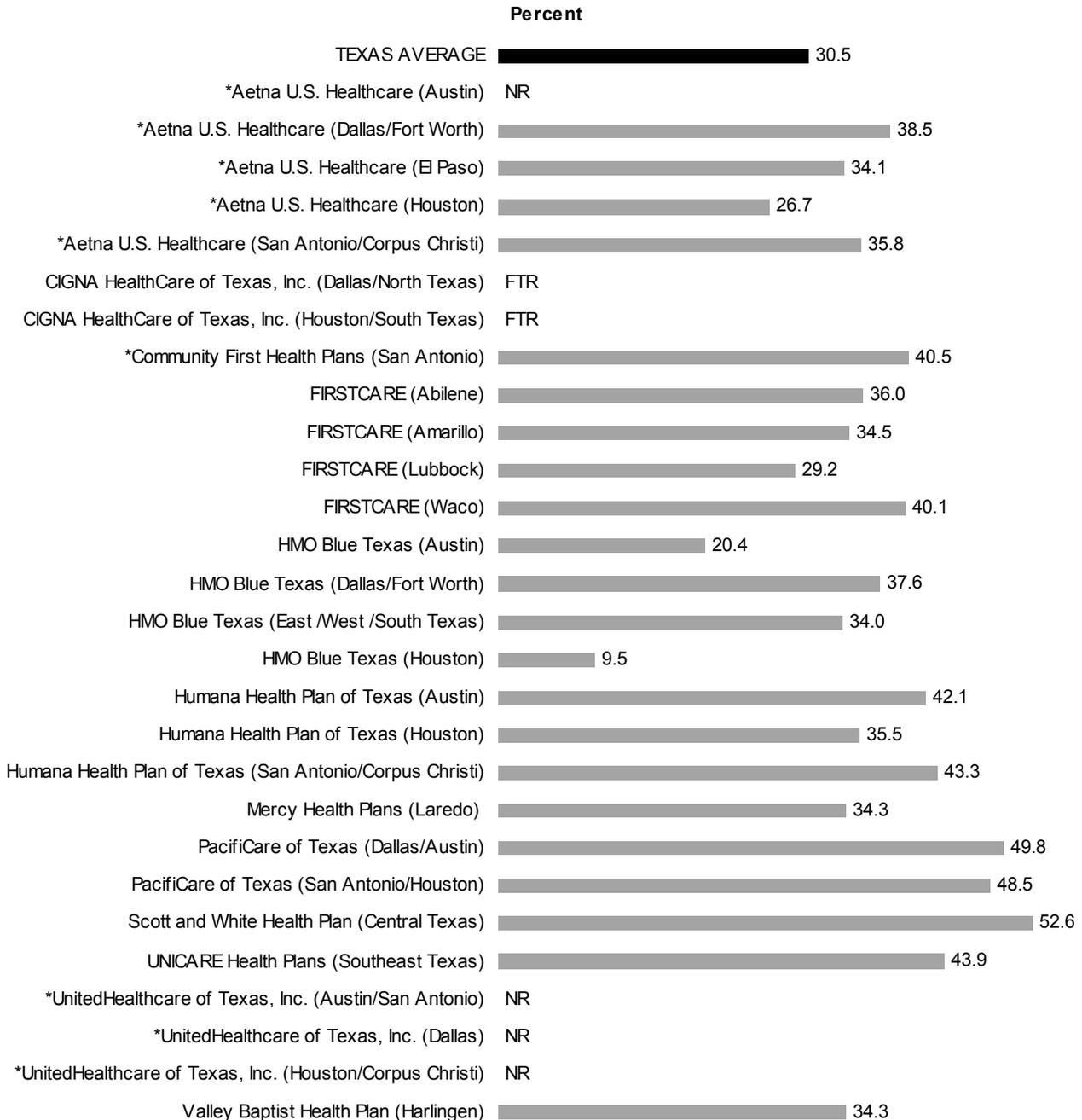
Comprehensive Diabetes Care: LDL-C Control (<100 mg/dL)		
	2008	2009
Texas Average	22.2%	30.5%
NCQA's Quality Compass®	35.0%	45.5%

This measure is an addition to the Texas Subset for HEDIS® 2008.

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> American Diabetes Association, Treating High Cholesterol in People with Diabetes, 2009

## Comprehensive Diabetes Care: LDL-C Control (<100 mg/dL)



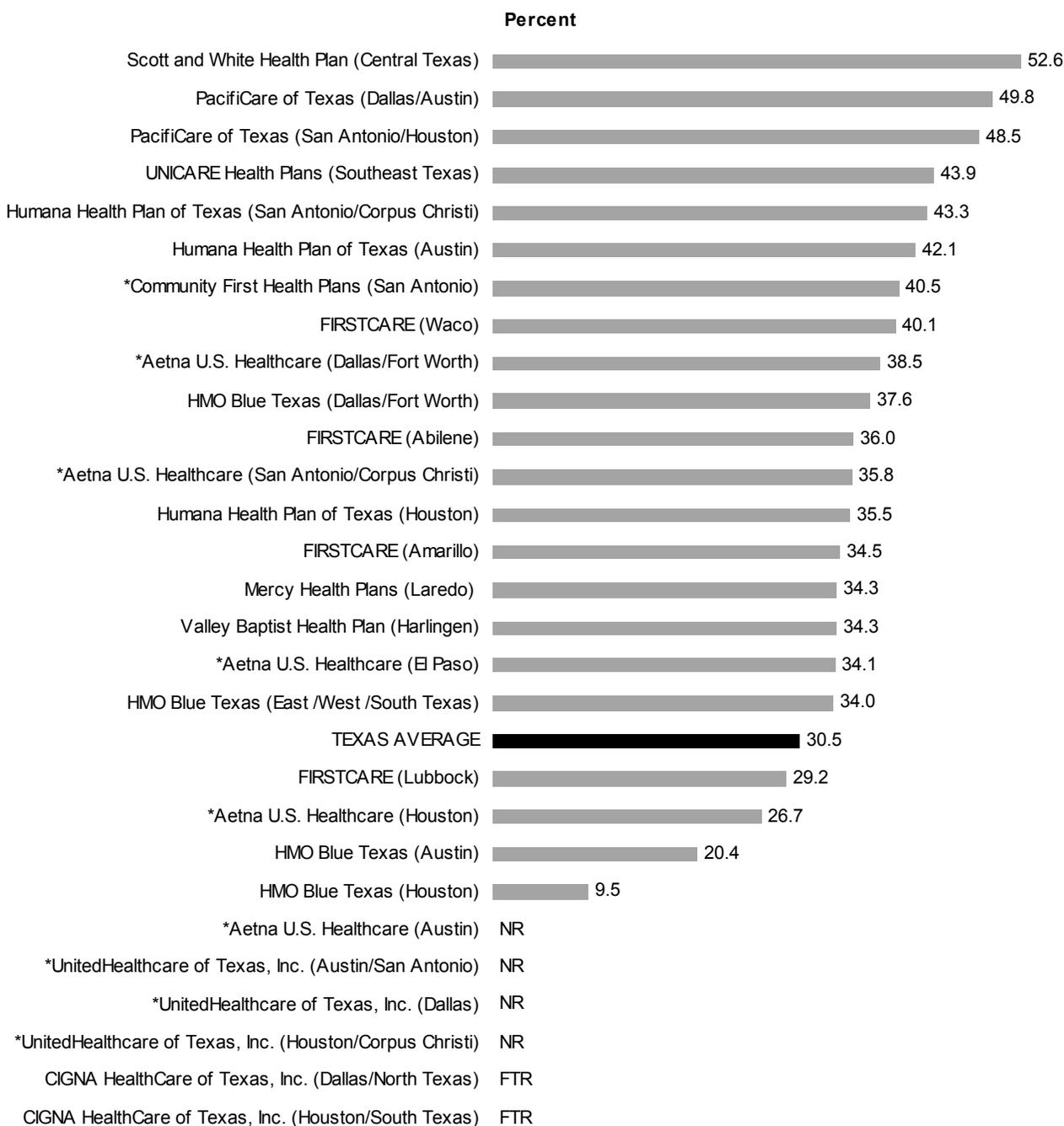
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## Comprehensive Diabetes Care: LDL-C Control (<100 mg/dL)



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## Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy (Kidney Disease)

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who received medical attention for nephropathy or evidence of already having nephropathy within the past year.

Nephropathy, or kidney disease, is a frequent complication of diabetes and often ends in kidney failure or end-stage renal disease. Diabetic nephropathy is a progressive disease that develops over several years. Among healthy individuals, many tiny vessels (nephrons) in the kidney act as filters to remove wastes, chemicals, and excess water from the blood. In diabetic nephropathy, these nephrons are damaged, becoming leaky, and protein eventually spills into the urine. Eventually, the damaged nephrons are destroyed, putting more stress on the remaining “filters” and causing them to become damaged. When the entire filtration system breaks down, the kidneys fail to function causing end-stage renal disease (ESRD). ESRD is a condition where the patient requires dialysis or a kidney transplant in order to survive.<sup>1</sup>

The key to preventing diabetes-related kidney problems begins with good control of blood glucose levels, control of blood pressure, and regular screening by health care professionals.<sup>2</sup>

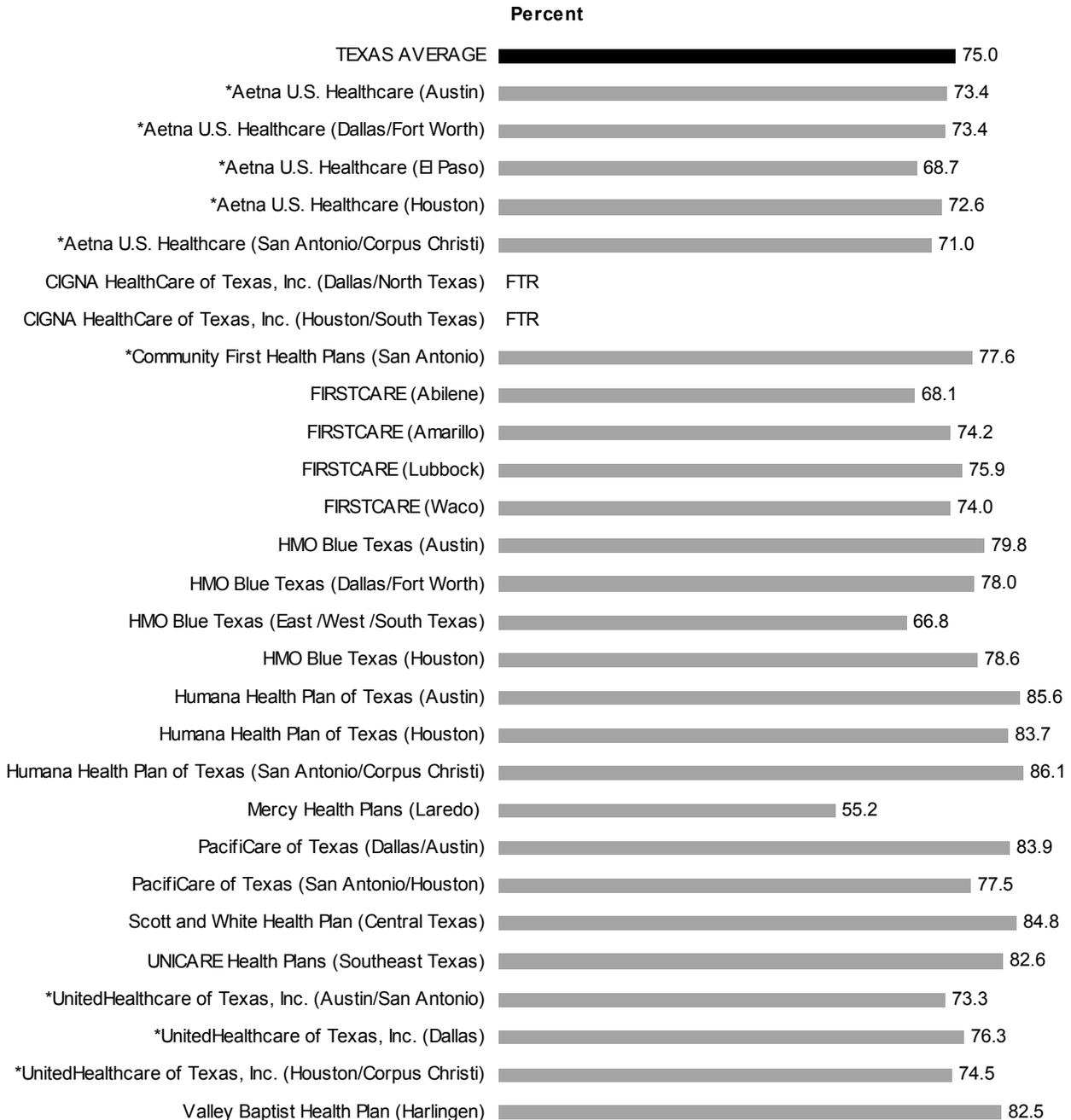
Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	45.6%	45.8%	71.2%	71.9%	75.0%
<b>NCQA's Quality Compass®</b>	52.0%	55.1%	79.7%	74.1%	82.4%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA

<sup>1</sup> American Diabetes Association, Kidney Disease, 2009

<sup>2</sup> Ibid.

## Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy (Kidney Disease)



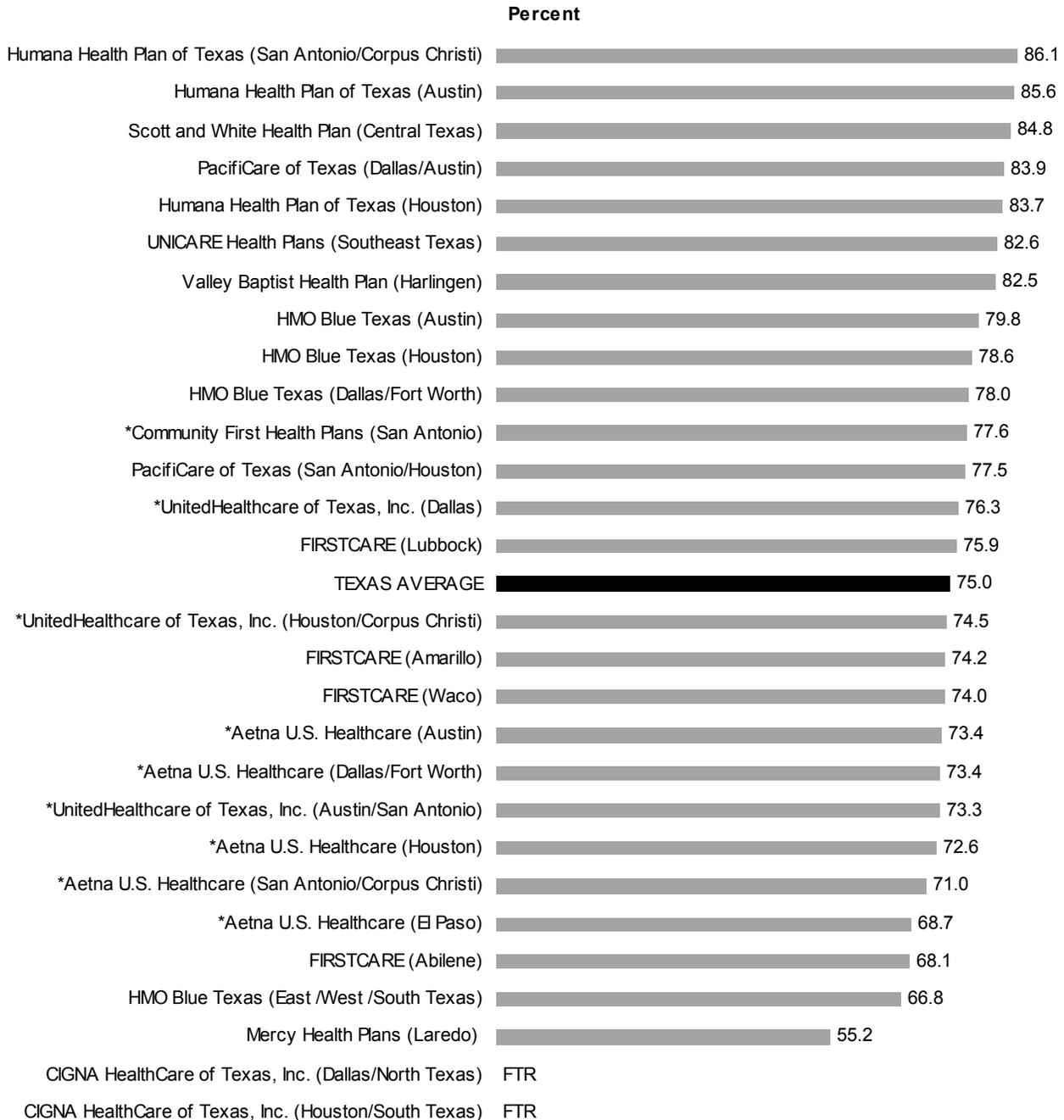
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy (Kidney Disease)



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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Comprehensive Diabetes Care: Blood Pressure Control (<130/80 mm Hg)

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had their most recent blood pressure reading at less than 130 mm Hg systolic and 80 mm Hg diastolic during the past year.

Controlling blood pressure in people with diabetes is especially important because high blood pressure is a major risk factor for disease and increases the risk for heart attack, stroke, and other complications such as retinopathy (damage to blood vessels in the retina) and nephropathy (damage to blood vessels in the kidneys).<sup>1</sup>

This measure is an indication of the percentage of people using the HMO who have been diagnosed for Diabetes and have a blood pressure reading in the normal to prehypertension range.

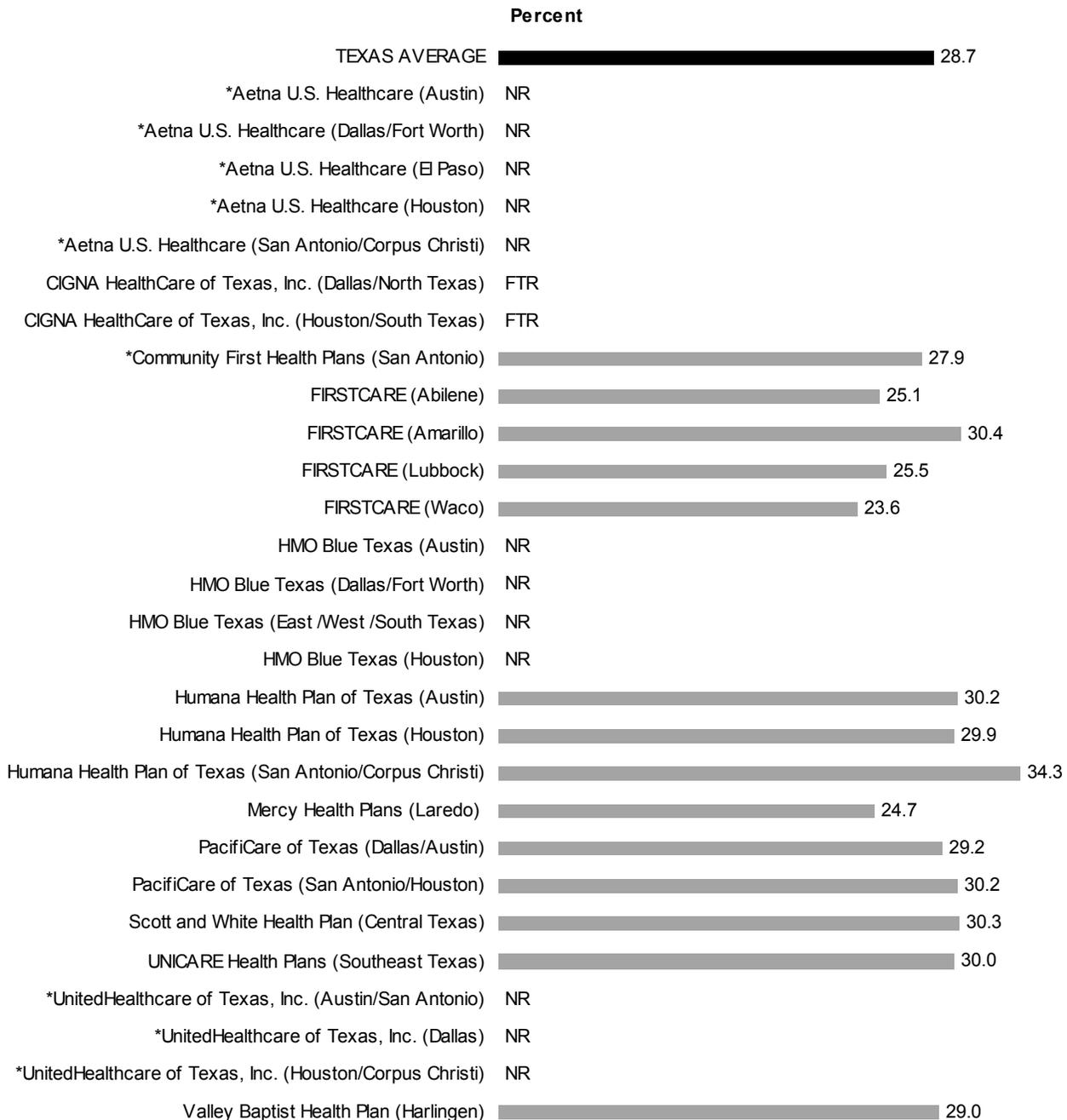
Comprehensive Diabetes Care: Blood Pressure Control (<130/80 mm Hg)		
	2008	2009
Texas Average	28.5%	28.7%
NCQA's Quality Compass®	28.5%	33.4%

This measure is an addition to the Texas Subset for HEDIS® 2008.

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> American Heart Association, Diabetes and High Blood Pressure, 2009

## Comprehensive Diabetes Care: Blood Pressure Control (<130/80 mm Hg)



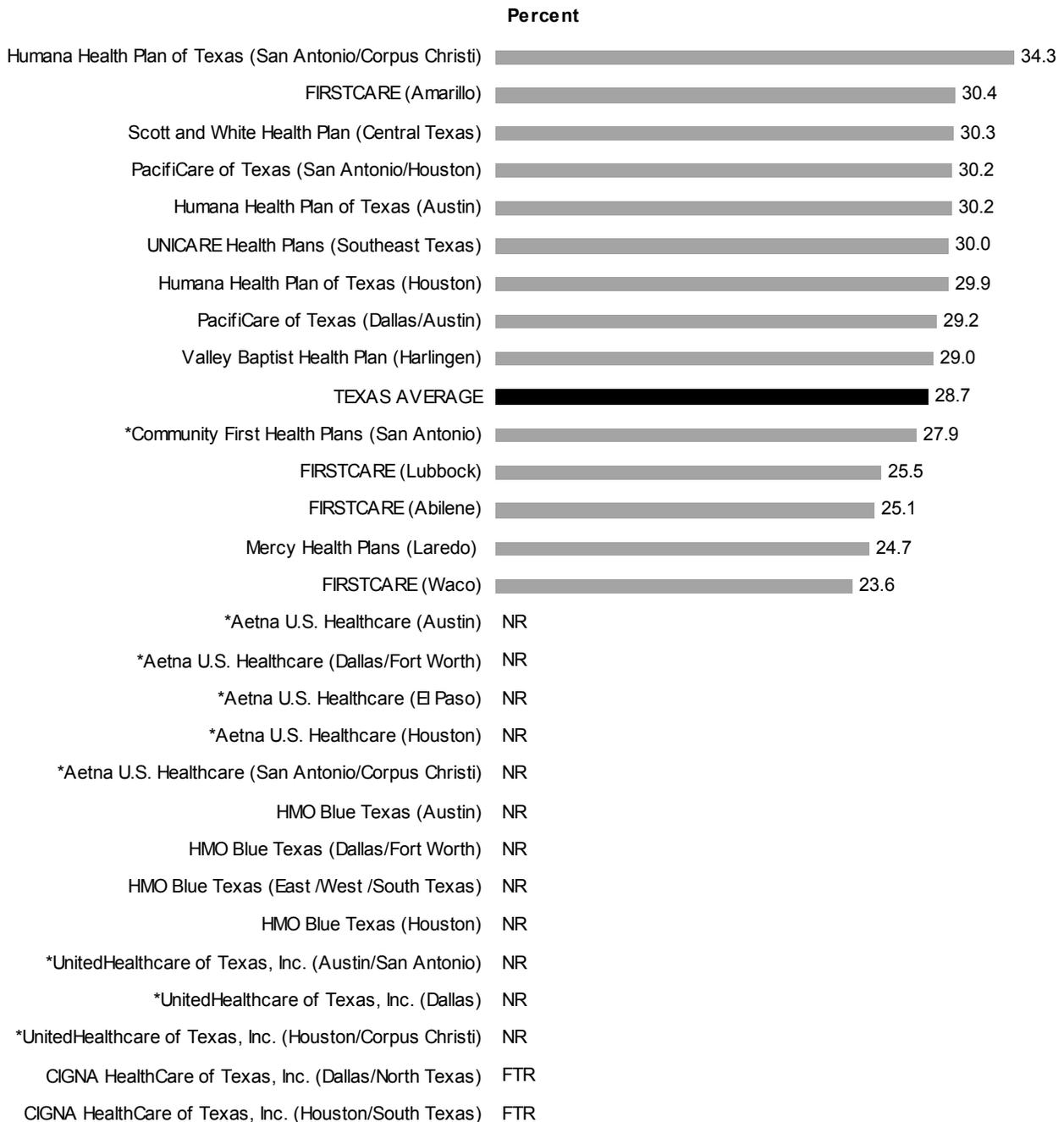
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## Comprehensive Diabetes Care: Blood Pressure Control (<130/80 mm Hg)



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)

Definition: The percentage of members 18 through 75 years of age with Type 1 or Type 2 Diabetes using the HMO who had their most recent blood pressure reading at less than 140 mm Hg systolic and 90 mm Hg diastolic during the past year.

Controlling blood pressure in people with diabetes is especially important because high blood pressure is a major risk factor for disease and increases the risk for heart attack, stroke, and other complications such as retinopathy (damage to blood vessels in the retina) and nephropathy (damage to blood vessels in the kidneys).<sup>1</sup>

This measure is an indication of the percentage of people using the HMO who have been diagnosed for Diabetes and have a blood pressure reading which puts them into the Hypertension category as defined by the American Heart Association.

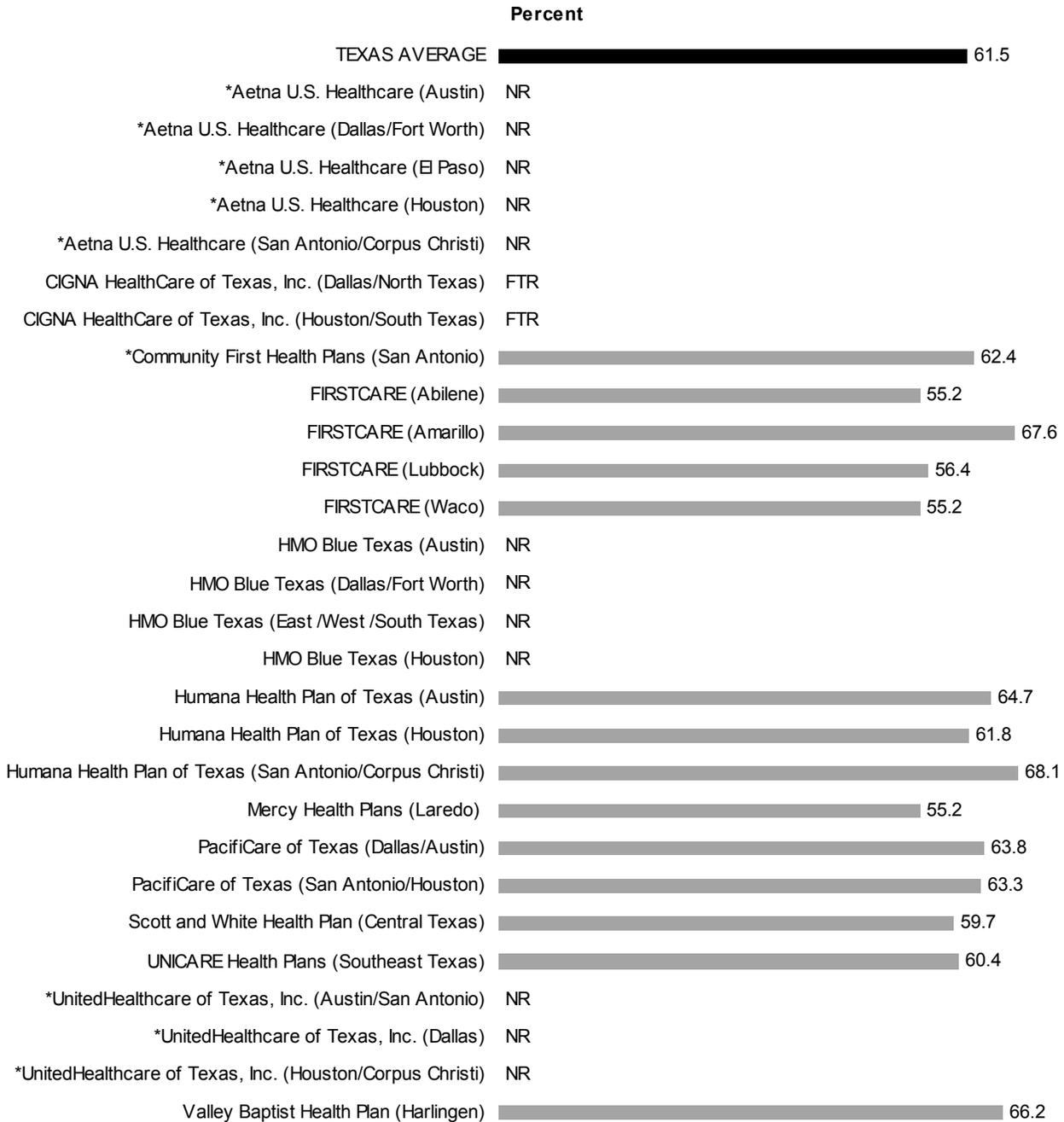
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)		
	2008	2009
Texas Average	61.3%	61.5%
NCQA's Quality Compass®	56.8%	65.6%

This measure is an addition to the Texas Subset for HEDIS® 2008.

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> American Heart Association, Diabetes and High Blood Pressure, 2009

## Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)



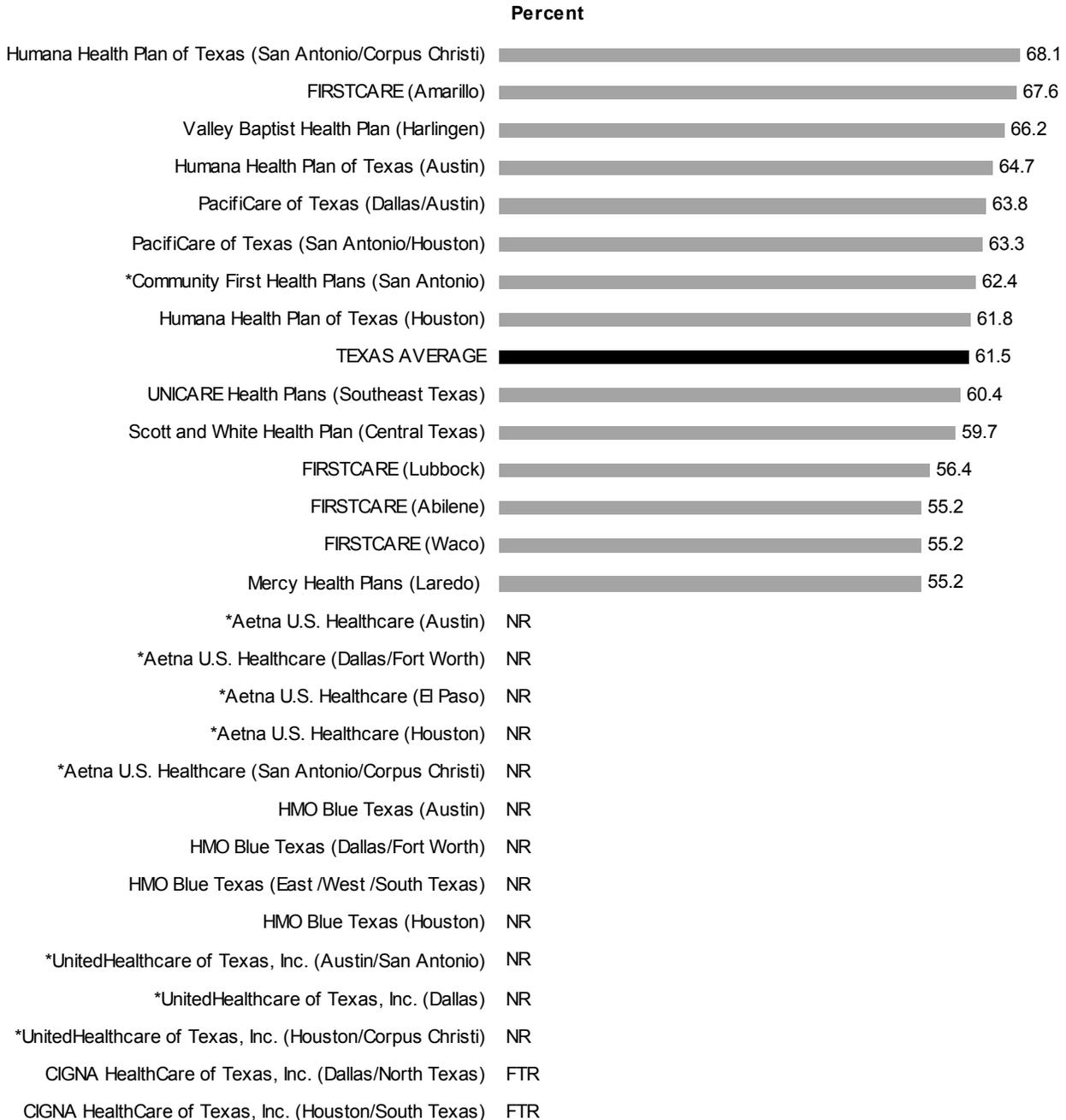
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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
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 NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.  
 FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Use of Appropriate Medications for People with Asthma

Definition: Percentage of members 5 through 56 years of age with persistent asthma who were being prescribed medications acceptable as primary therapy for long-term control of asthma.

The rates are presented in three age stratifications, 5-9, 10-17, and 18-56, and a combined rate for all ages.

Asthma is an obstructive lung disease, caused by an increased reaction of the airways to various stimuli. It is estimated that 23 million people have been diagnosed with asthma by a health professional; 6.8 million are children under 18 years of age. Asthma accounts for 13 million lost school days annually.<sup>1</sup> Much of the deaths and morbidity associated with asthma is avoidable. Successful management of asthma can be achieved for most asthmatics if they take medications that provide long-term control.

Asthma-related suffering, cost and death can be greatly reduced through effective treatment with long-term controller medications. In addition, patient education regarding medication use, symptom management and avoidance of asthma attack triggers can greatly reduce the impact of the disease. Organizations must continue to focus efforts on this condition to ensure that treatment is available to all who might benefit from improved medication management.<sup>2</sup>

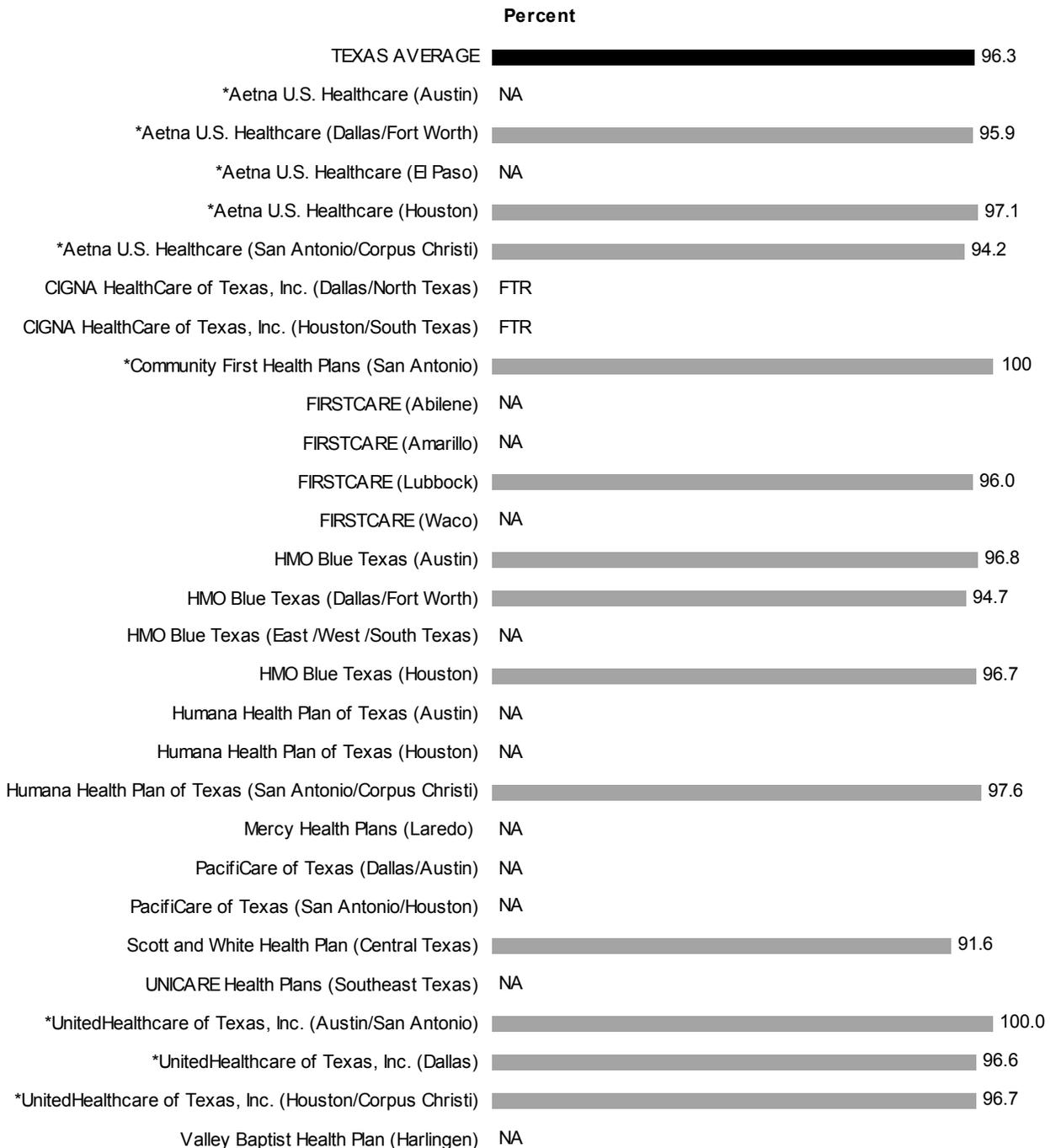
Use of Appropriate Medications for People with Asthma (5-56 Years)					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	71.8%	90.6%	91.4%	92.2%	92.2%
<b>NCQA's Quality Compass®</b>	72.9%	89.9%	91.6%	92.5%	92.4%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> Environmental Protection Agency, Asthma Facts, January 2009.

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Medication for People with Asthma: 5-9 Years



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.

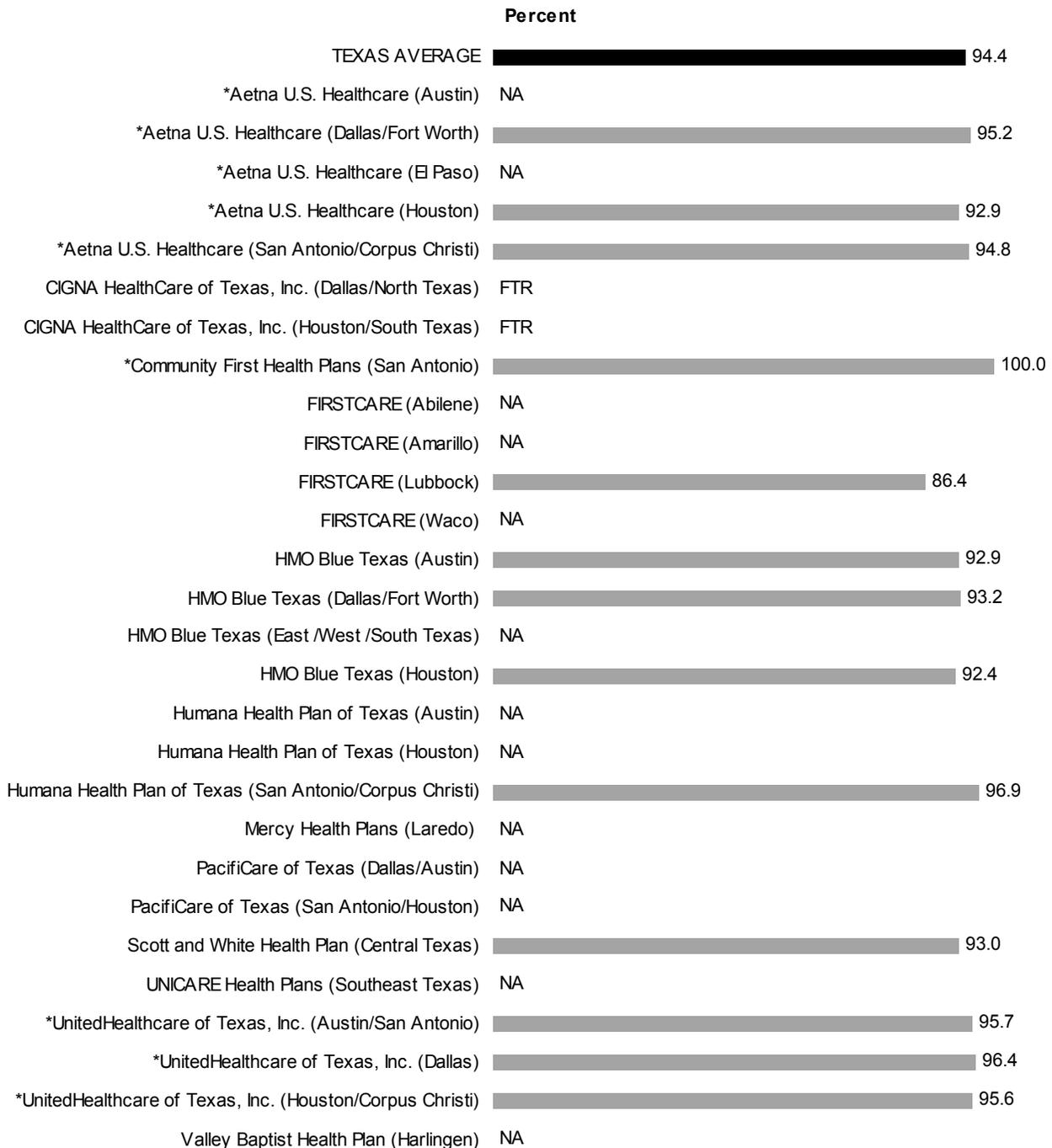
FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Medication for People with Asthma: 5-9 Years

	Percent	
*UnitedHealthcare of Texas, Inc. (Austin/San Antonio)	97.6	100.0
*Community First Health Plans (San Antonio)	97.6	100.0
Humana Health Plan of Texas (San Antonio/Corpus Christi)	97.6	
*Aetna U.S. Healthcare (Houston)	97.1	
HMO Blue Texas (Austin)	96.8	
*UnitedHealthcare of Texas, Inc. (Houston/Corpus Christi)	96.7	
HMO Blue Texas (Houston)	96.7	
*UnitedHealthcare of Texas, Inc. (Dallas)	96.6	
TEXAS AVERAGE	96.3	
FIRSTCARE (Lubbock)	96.0	
*Aetna U.S. Healthcare (Dallas/Fort Worth)	95.9	
HMO Blue Texas (Dallas/Fort Worth)	94.7	
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	94.2	
Scott and White Health Plan (Central Texas)	91.6	
*Aetna U.S. Healthcare (Austin)	NA	
*Aetna U.S. Healthcare (El Paso)	NA	
FIRSTCARE (Abilene)	NA	
FIRSTCARE (Amarillo)	NA	
FIRSTCARE (Waco)	NA	
HMO Blue Texas (East /West /South Texas)	NA	
Humana Health Plan of Texas (Austin)	NA	
Humana Health Plan of Texas (Houston)	NA	
Mercy Health Plans (Laredo)	NA	
PacifiCare of Texas (Dallas/Austin)	NA	
PacifiCare of Texas (San Antonio/Houston)	NA	
UNICARE Health Plans (Southeast Texas)	NA	
Valley Baptist Health Plan (Harlingen)	NA	
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
 NA- The plan did not have a large enough sample to report a valid rate.

## Medication for People with Asthma: 10-17 Years



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Medication for People with Asthma: 10-17 Years

	<b>Percent</b>	
*Community First Health Plans (San Antonio)	100.0	
Humana Health Plan of Texas (San Antonio/Corpus Christi)	96.9	
*UnitedHealthcare of Texas, Inc. (Dallas)	96.4	
*UnitedHealthcare of Texas, Inc. (Austin/San Antonio)	95.7	
*UnitedHealthcare of Texas, Inc. (Houston/Corpus Christi)	95.6	
*Aetna U.S. Healthcare (Dallas/Fort Worth)	95.2	
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	94.8	
<b>TEXAS AVERAGE</b>	<b>94.4</b>	
HMO Blue Texas (Dallas/Fort Worth)	93.2	
Scott and White Health Plan (Central Texas)	93.0	
*Aetna U.S. Healthcare (Houston)	92.9	
HMO Blue Texas (Austin)	92.9	
HMO Blue Texas (Houston)	92.4	
FIRSTCARE (Lubbock)	86.4	
*Aetna U.S. Healthcare (Austin)	NA	
*Aetna U.S. Healthcare (El Paso)	NA	
FIRSTCARE (Abilene)	NA	
FIRSTCARE (Amarillo)	NA	
FIRSTCARE (Waco)	NA	
HMO Blue Texas (East /West /South Texas)	NA	
Humana Health Plan of Texas (Austin)	NA	
Humana Health Plan of Texas (Houston)	NA	
Mercy Health Plans (Laredo)	NA	
PacifiCare of Texas (Dallas/Austin)	NA	
PacifiCare of Texas (San Antonio/Houston)	NA	
UNICARE Health Plans (Southeast Texas)	NA	
Valley Baptist Health Plan (Harlingen)	NA	
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	

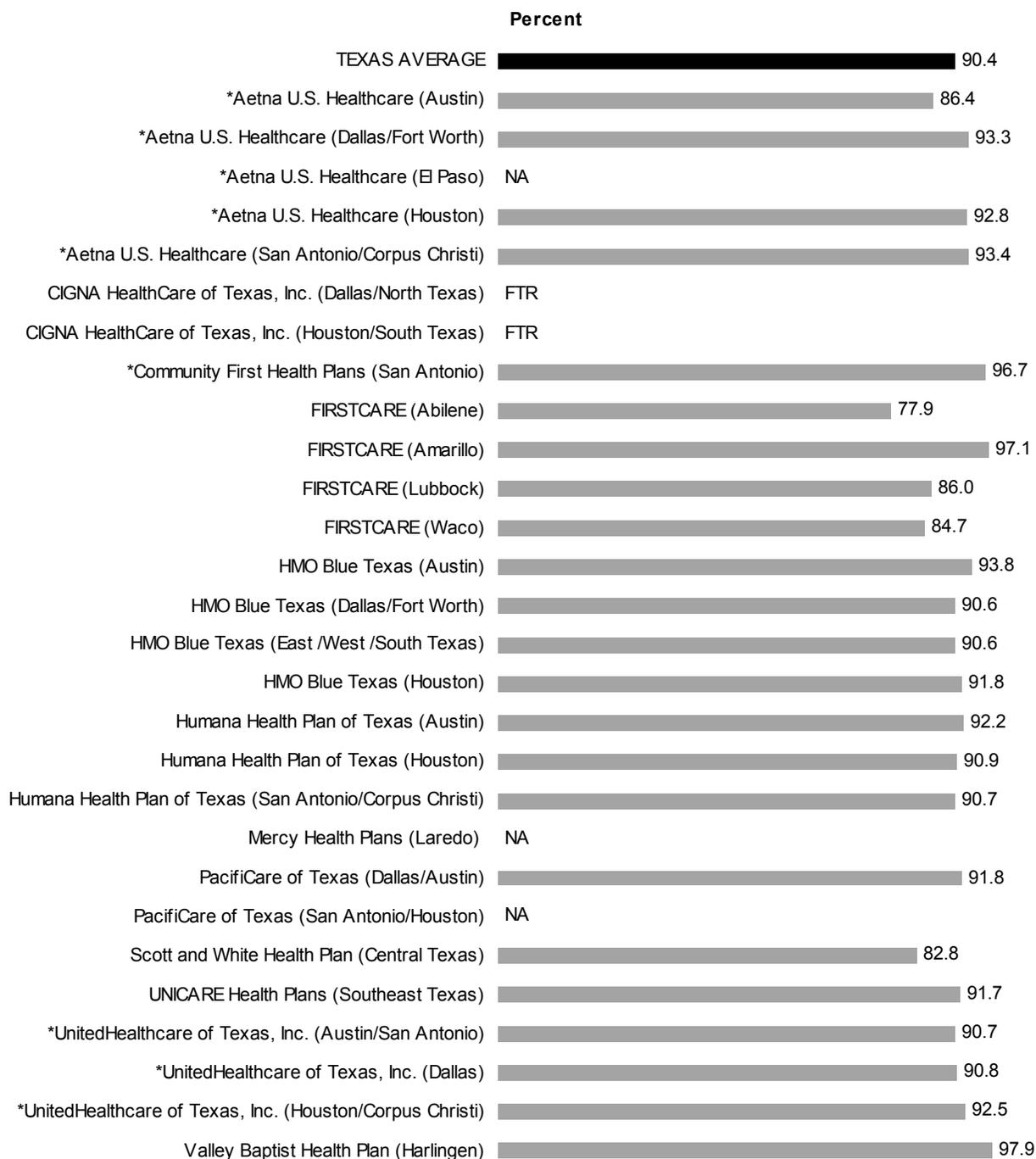
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## Medication for People with Asthma: 18-56 Years



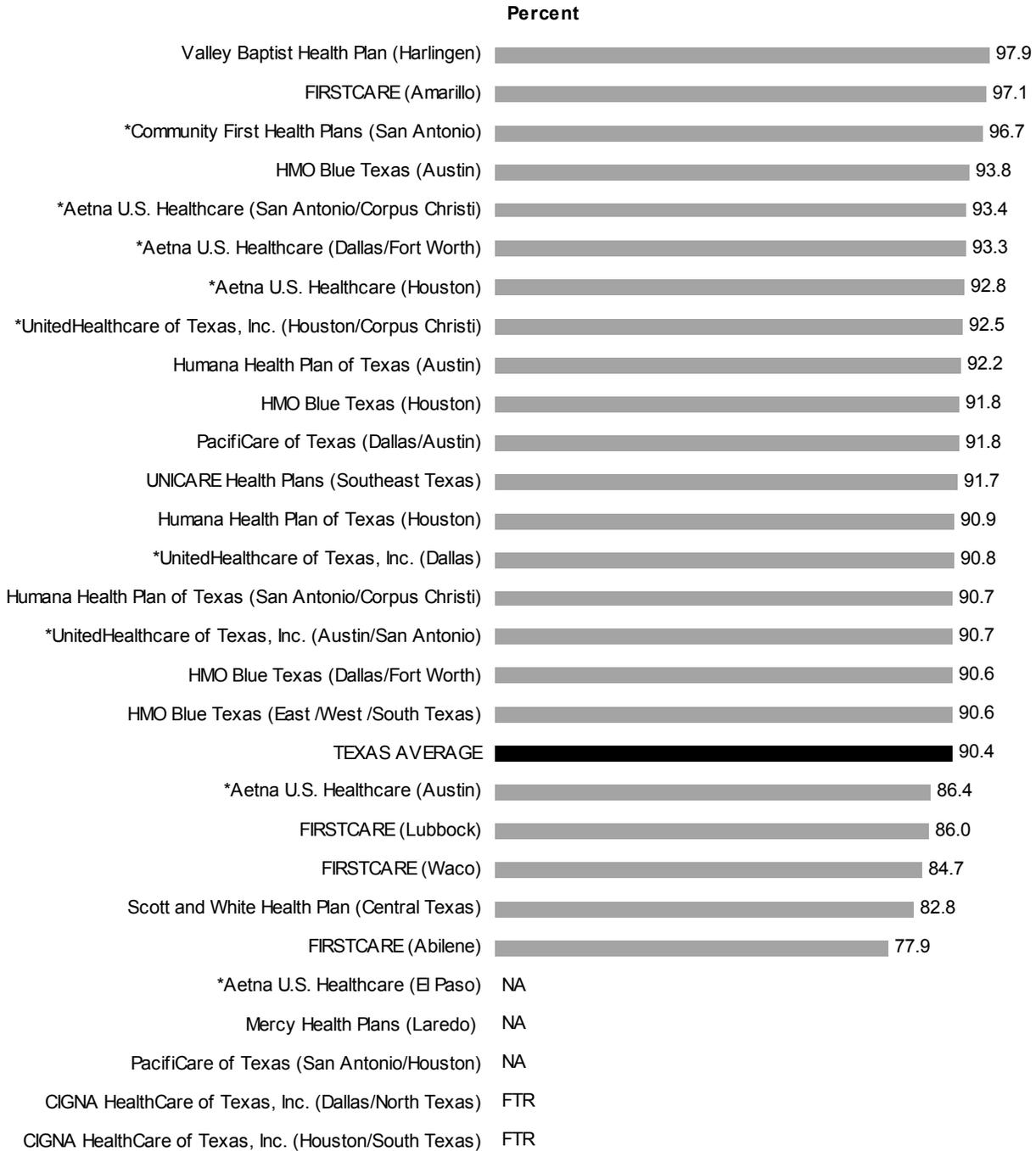
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## Medication for People with Asthma: 18-56 Years



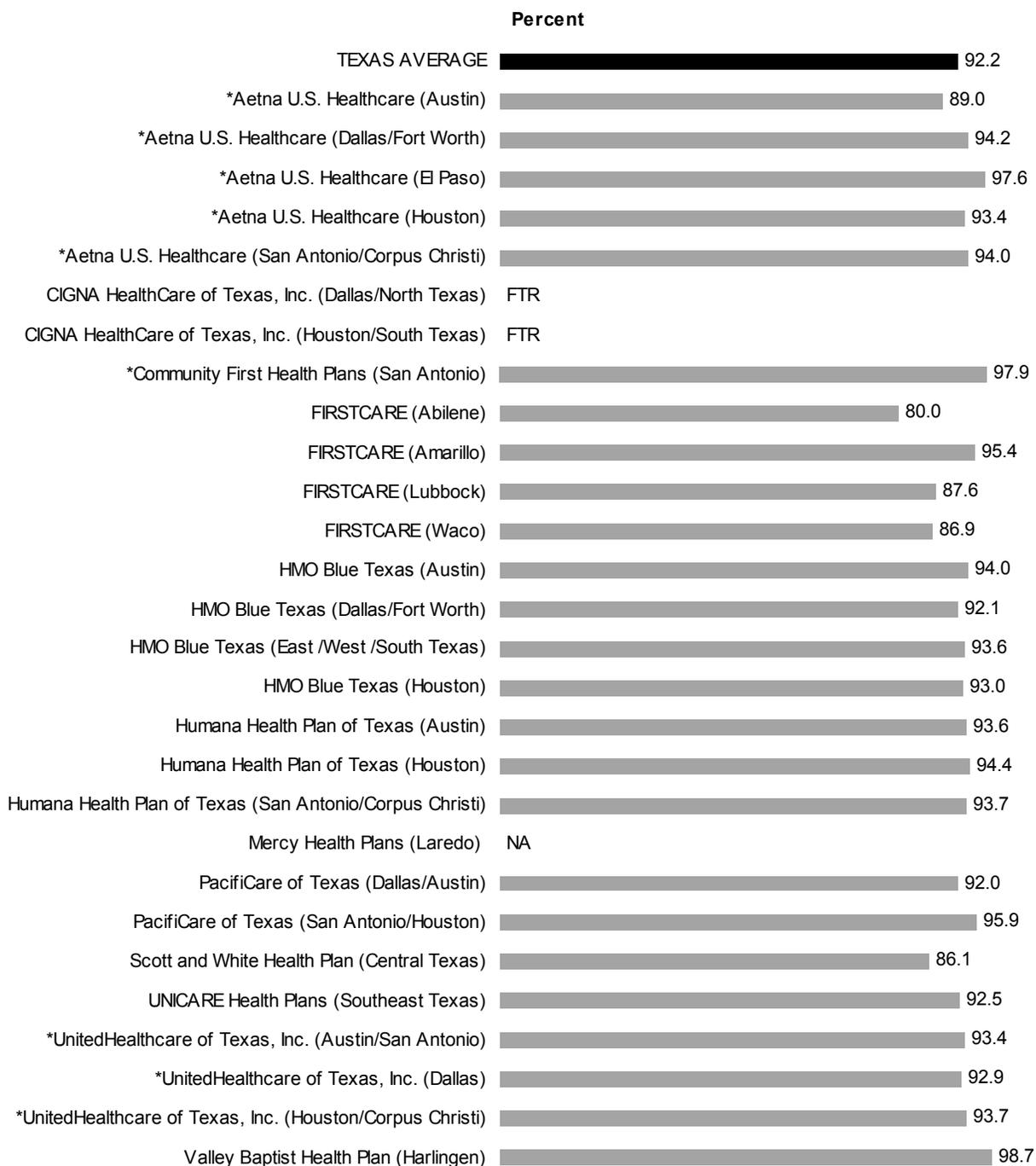
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## Medication for People with Asthma: Total (5-56 Years)



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## Medication for People with Asthma: Total (5-56 Years)



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## Follow-up After Hospitalization for Mental Illness

Definition: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days, or within 7 days after their discharge from the hospital.

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.<sup>1</sup> According to a guideline developed by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, there is a need for regular and timely assessments and documentation of the patient's response to all treatments.<sup>2</sup>

This measure looks at continuity of care for mental illness. It measures the percentage of organization members 6 years of age and older who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 30 days, or within 7 days after their discharge from the hospital. The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.<sup>3</sup>

Follow-up After Hospitalization for Mental Illness					
	2005	2006	2007	2008	2009
<b>Texas Average (within 7 days)</b>	48.7%	47.6%	50.6%	46.5%	46.3%
<b>NCQA's Quality Compass<sup>®</sup> (within 7 days)</b>	55.9%	55.8%	56.7%	49.9%	57.2%
<b>Texas Average (within 30 days)</b>	71.1%	72.3%	72.9%	65.7%	67.0%
<b>NCQA's Quality Compass<sup>®</sup> (within 30 days)</b>	76.0%	75.9%	75.8%	69.6%	76.1%

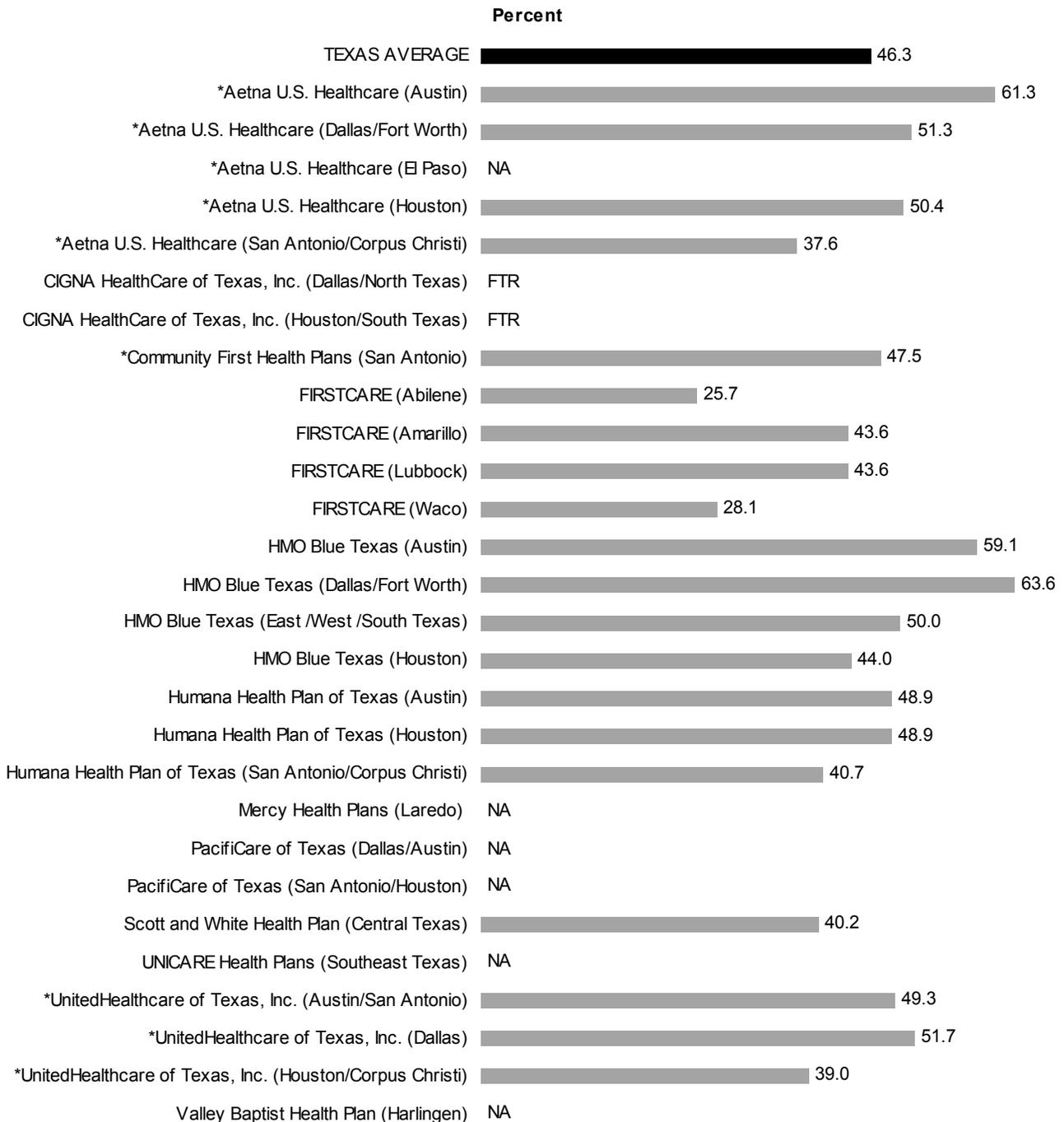
Quality Compass<sup>®</sup> is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS<sup>®</sup> 2009 Volume 1 Narrative, 2008

<sup>2</sup> American Academy of Child and Adolescent Psychiatry, American Psychiatric Association. 1997. *Criteria for Short-Term Treatment of Acute Psychiatric Illness*. [http://www.psych.org/psych\\_pract/criteria121503.pdf](http://www.psych.org/psych_pract/criteria121503.pdf). (August 2, 2005)

<sup>3</sup> National Committee for Quality Assurance (NCQA), HEDIS<sup>®</sup> 2009 Volume 1 Narrative, 2008

## Hospitalization for Mental Illness: 7 Day Follow-up



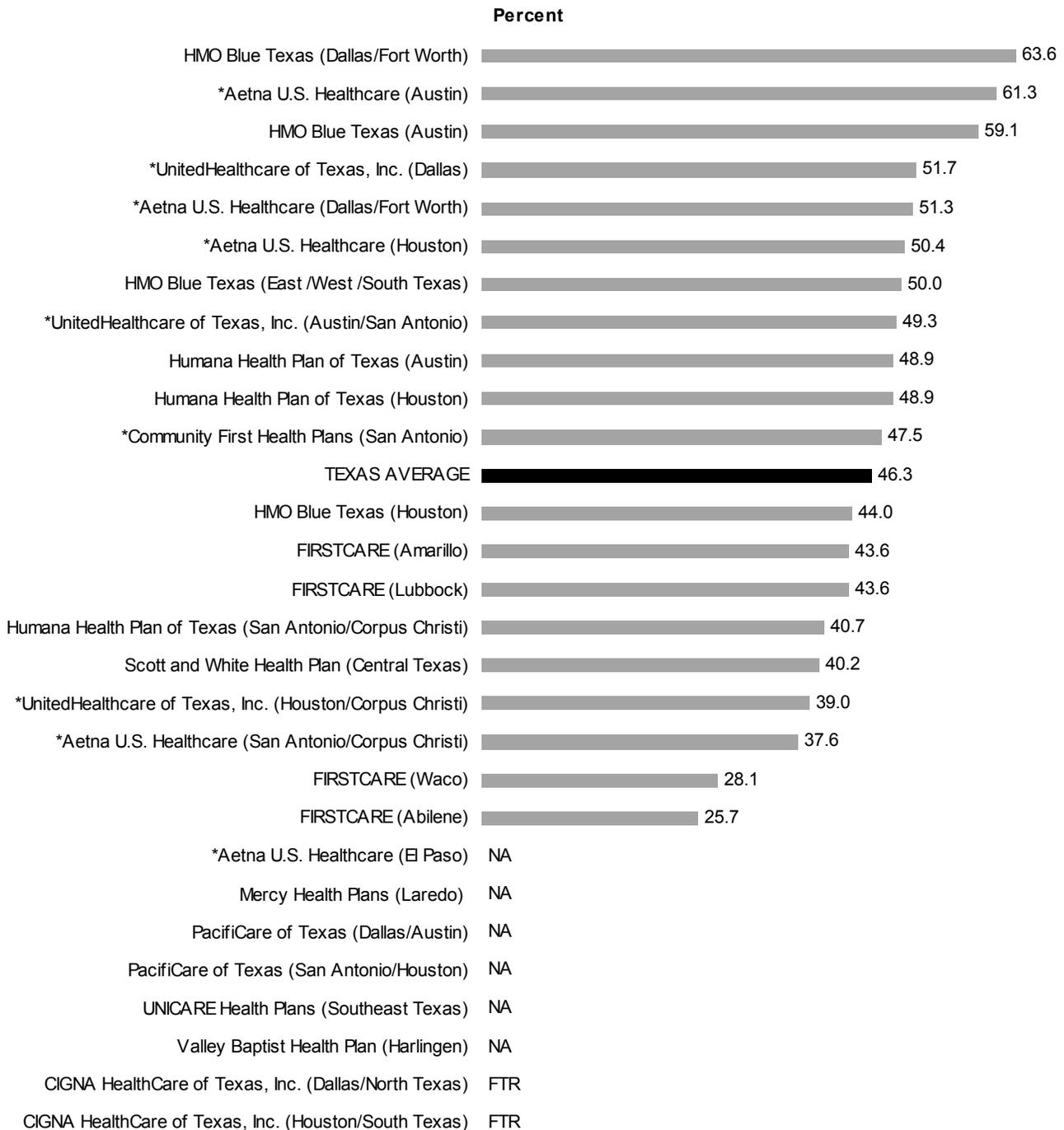
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## Hospitalization for Mental Illness: 7 Day Follow-up



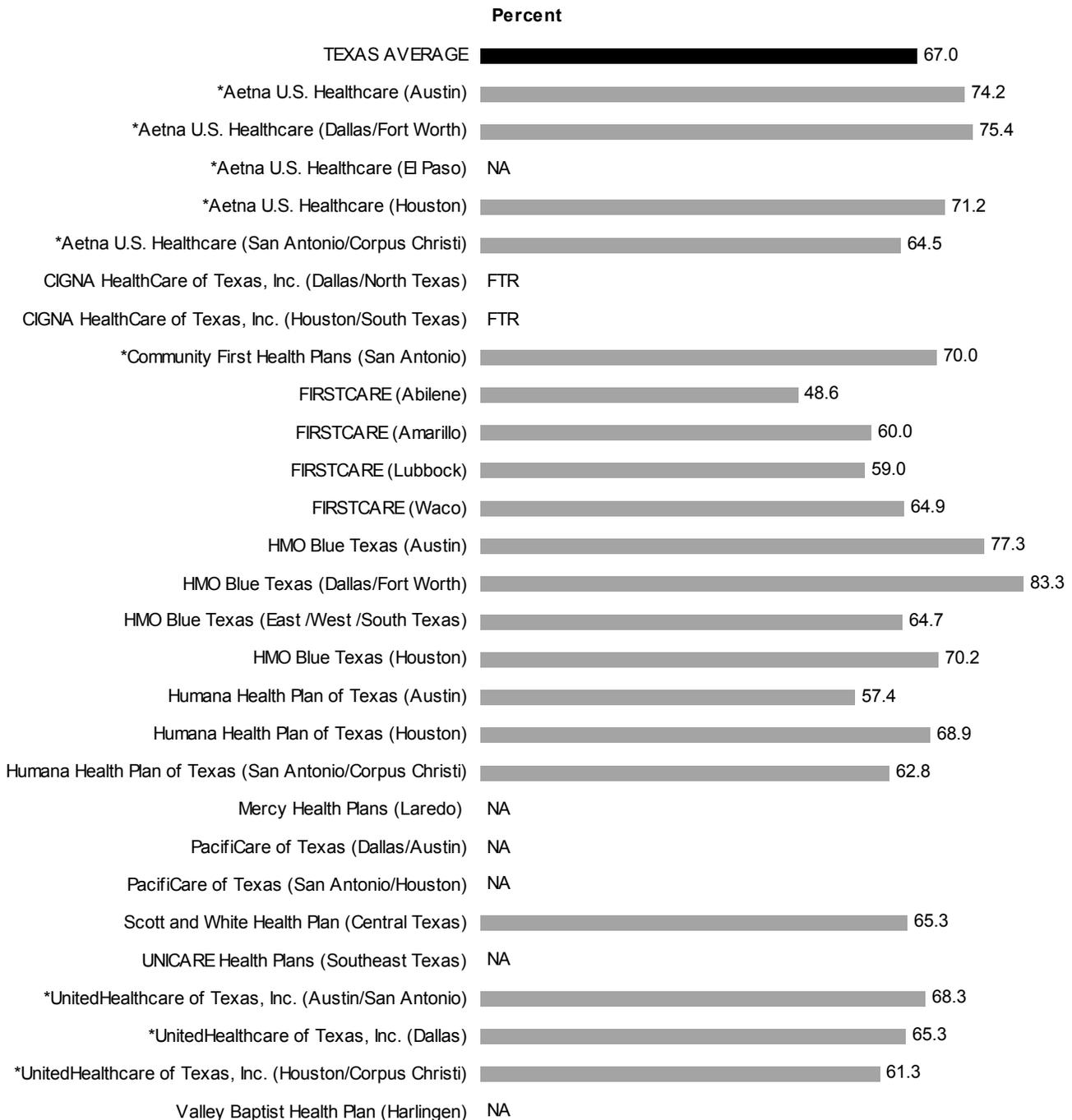
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## Hospitalization for Mental Illness: 30 Day Follow-up



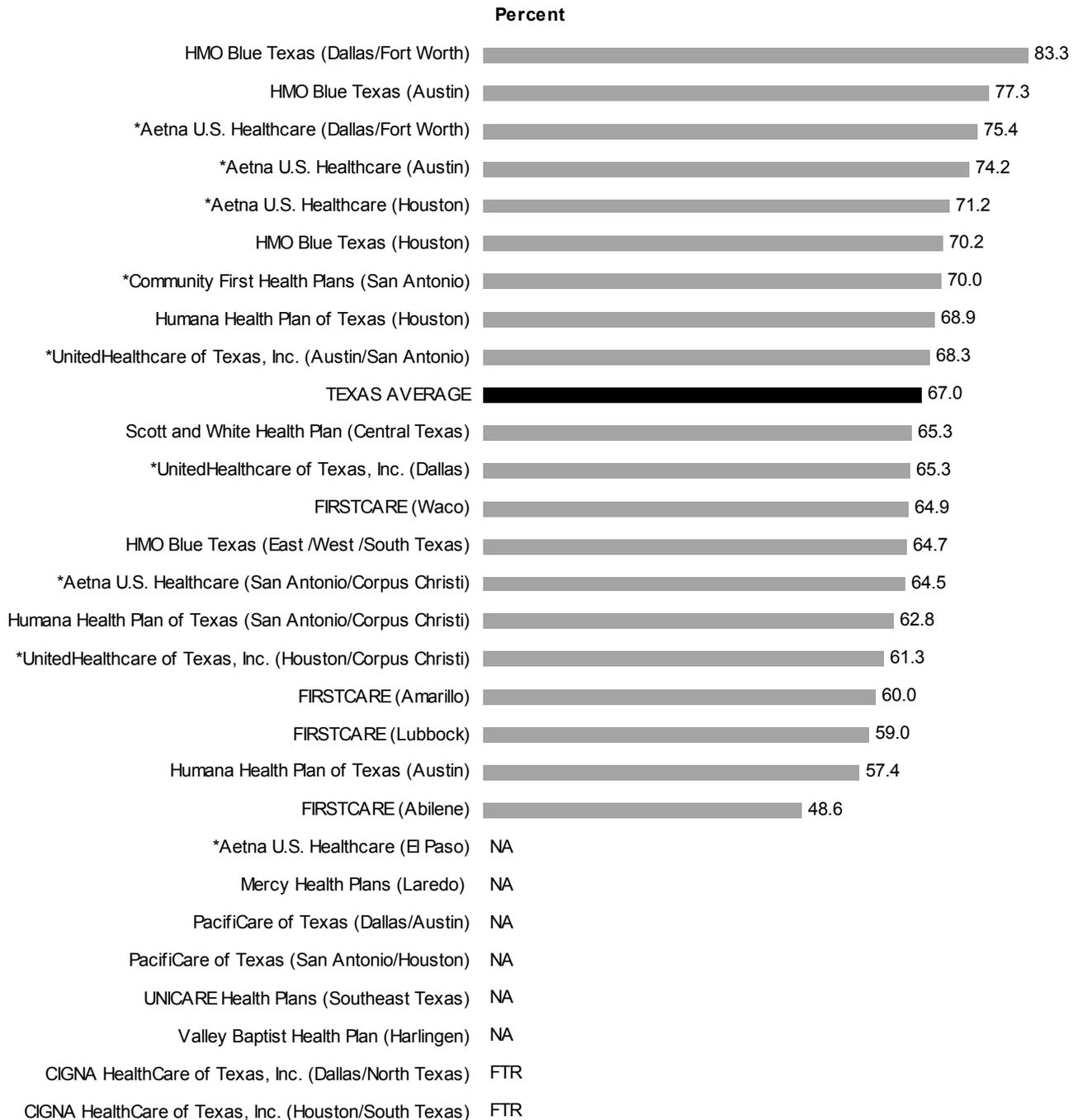
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## Hospitalization for Mental Illness: 30 Day Follow-up



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## Antidepressant Medication Management: Effective Acute Phase Treatment

Definition: The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication during the entire 12 week Acute Treatment Phase.

In a given year, an estimated 20.9 million American adults suffer from a depressive disorder or depression.<sup>1</sup> Without treatment, symptoms associated with these disorders can last for years, and can eventually lead to death by suicide or other causes. Fortunately, many people can improve through treatment with appropriate medications.<sup>2</sup>

According to the American Psychiatric Association<sup>3</sup>, successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans.

This measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimes by determining whether adult members completed a period of treatment adequate for defining a recovery according to guidelines published by the Agency for Healthcare Research and Quality (AHRQ).

Antidepressant Medication Management: Effective Acute Phase Treatment					
	2005	2006	2007	2008	2009
Texas Average	53.7%	56.5%	56.9%	58.3%	59.6%
NCQA's Quality Compass®	60.9%	61.4%	61.1%	63.2%	63.1%

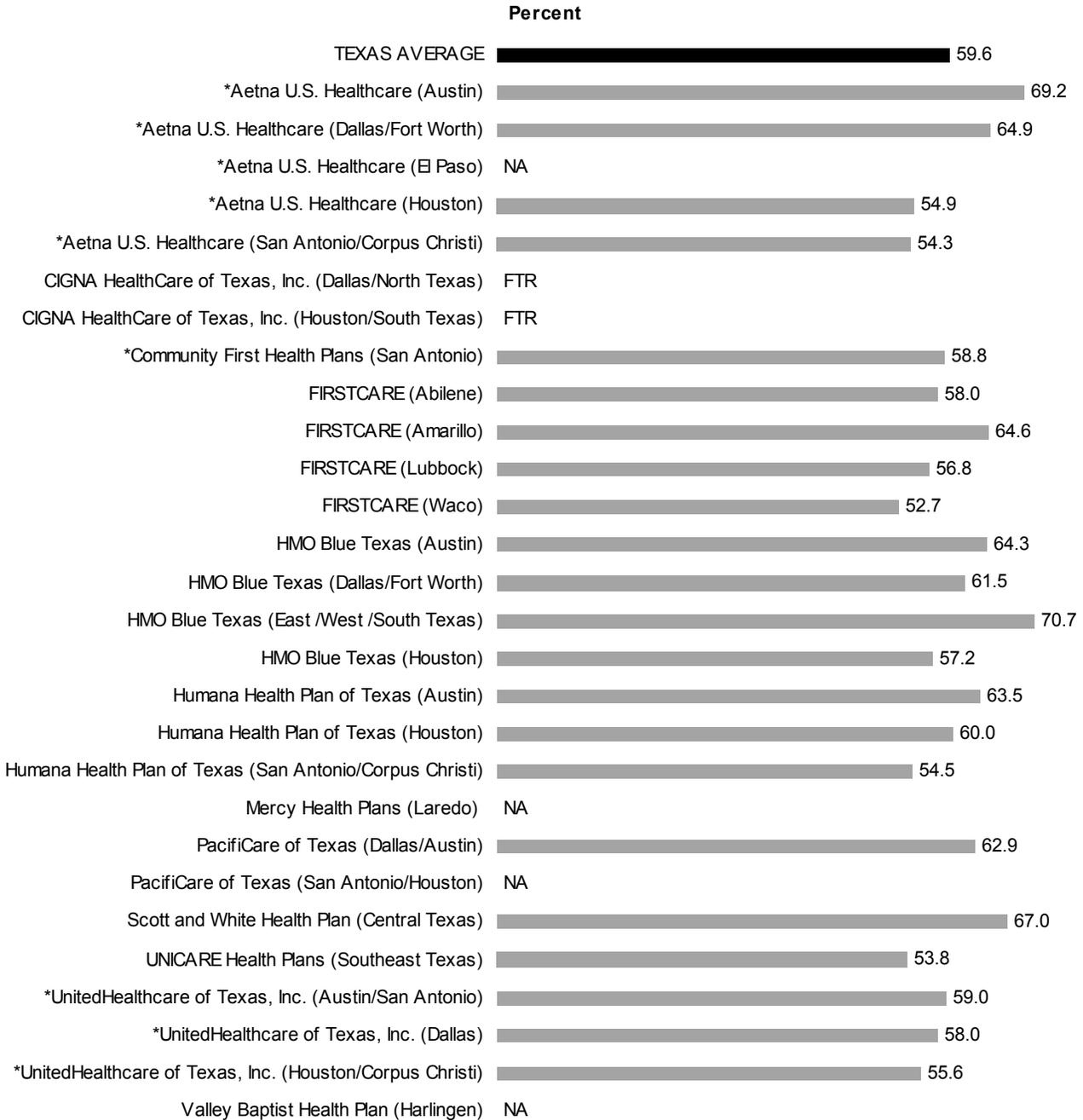
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<sup>1</sup> National Institute of Mental Health, Depression, 2006

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>3</sup> American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2000.

## Antidepressant Medication Management: Effective Acute Phase Treatment



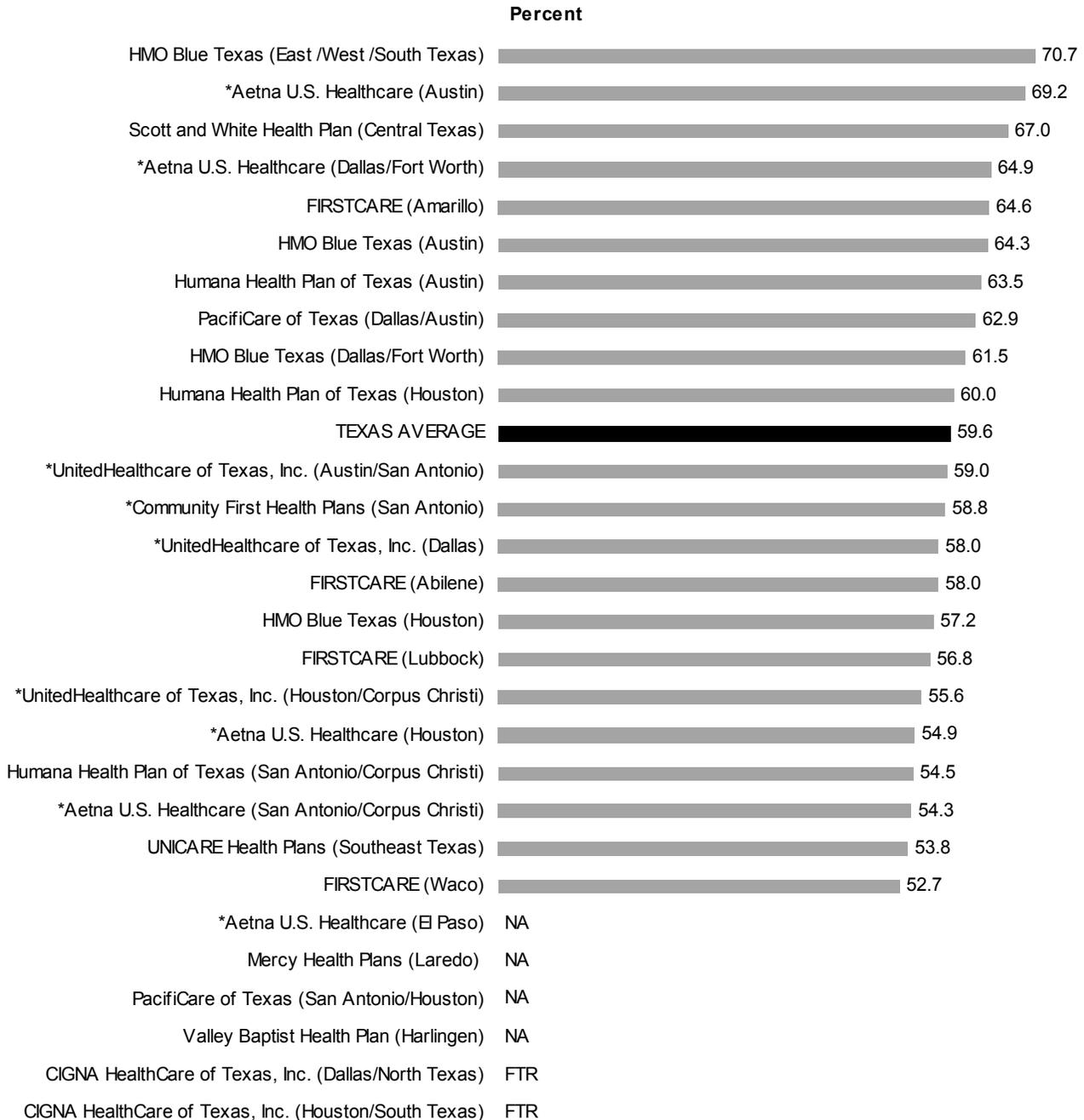
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## Antidepressant Medication Management: Effective Acute Phase Treatment



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FTR– Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Antidepressant Medication Management: Effective Continuation Phase Treatment

Definition: The percentage of members 18 years of age and older using the HMO who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant drug for at least 180 days.

In a given year, an estimated 20.9 million American adults suffer from a depressive disorder or depression.<sup>1</sup> Without treatment, symptoms associated with these disorders can last for years, and can eventually lead to death by suicide or other causes. Fortunately, many people can improve through treatment with appropriate medications.<sup>2</sup>

According to the American Psychiatric Association,<sup>3</sup> successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans.

This measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimes by determining whether adult members completed a period of treatment adequate for defining a recovery according to guidelines published by the Agency for Healthcare Research and Quality (AHRQ).

Antidepressant Medication Management: Effective Continuation Phase Treatment					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	37.6%	39.7%	41.5%	40.2%	41.9%
<b>NCQA's Quality Compass®</b>	44.3%	45.0%	45.1%	46.7%	46.3%

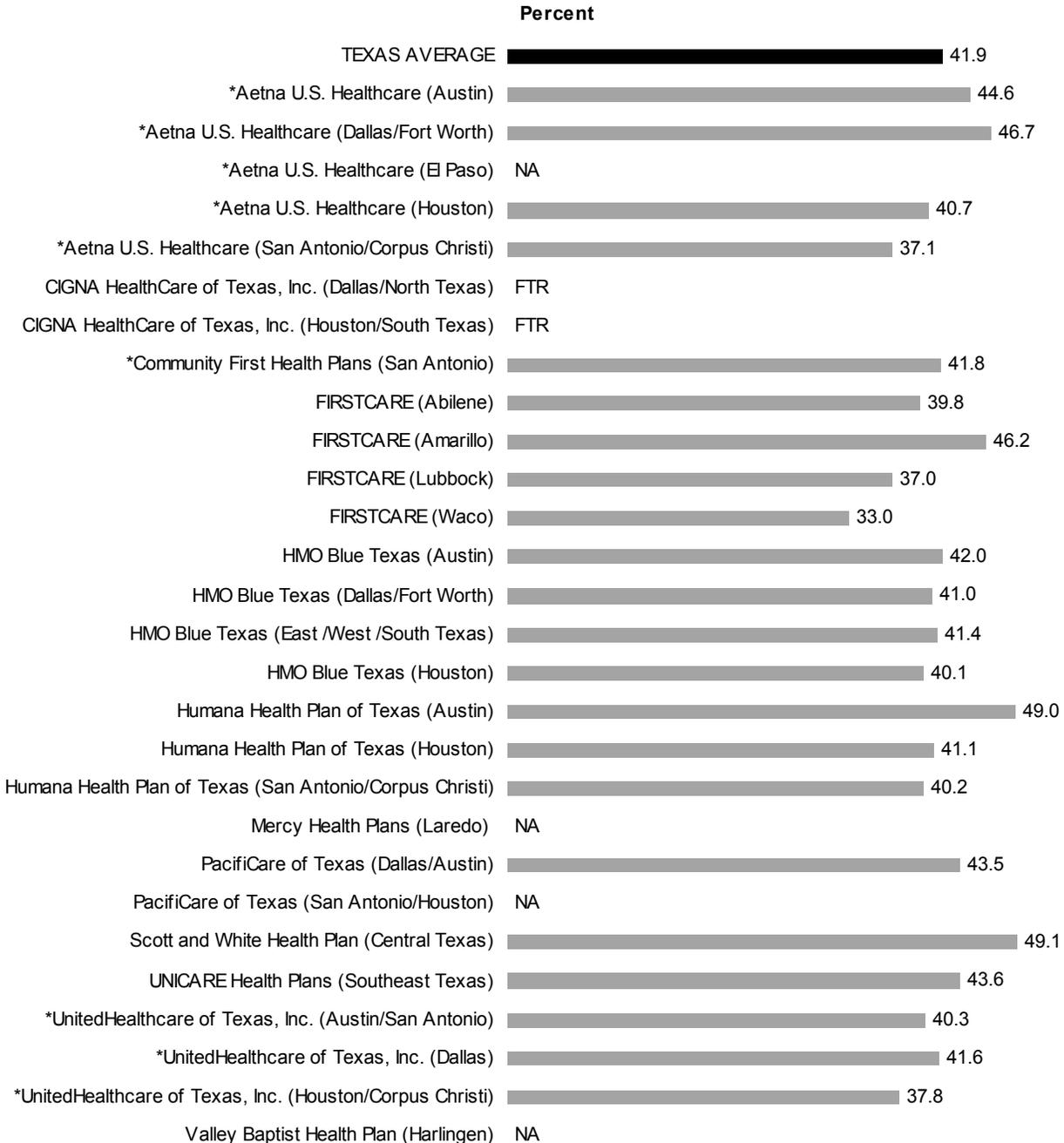
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<sup>1</sup> National Institute of Mental Health, Depression, 2006

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>3</sup> American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2000

## Antidepressant Medication Management: Effective Continuation Phase Treatment



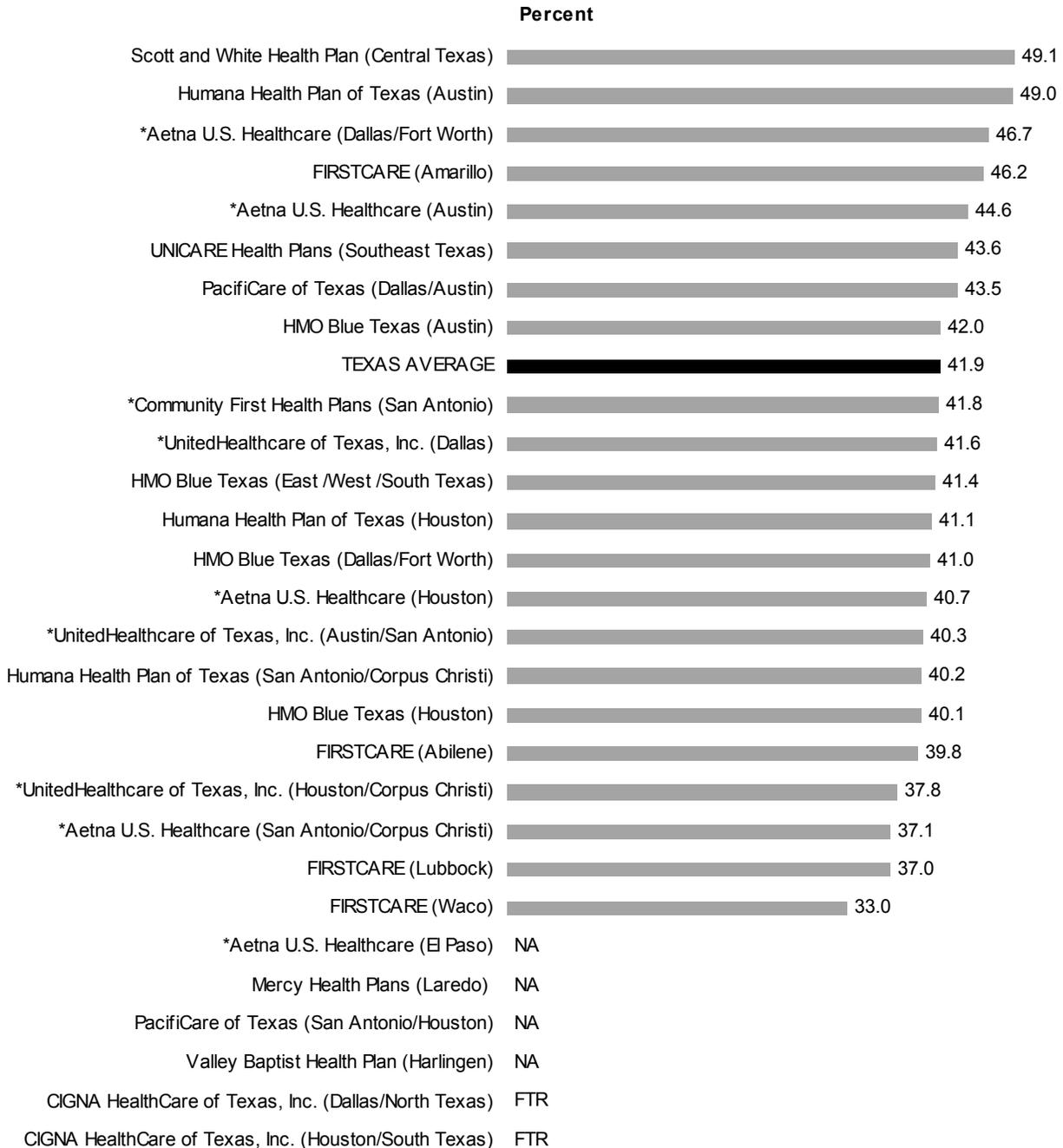
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Antidepressant Medication Management: Effective Continuation Phase Treatment



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 FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Medical Assistance with Smoking Cessation

Definition: This is a three-part survey measure that looks at the percentage of members 18 years of age and older who were current smokers or recent quitters, who were seen by a medical practitioner and received advice to quit smoking, discussed smoking cessation medications, and discussed smoking cessation strategies.

Smoking is the leading preventable cause of death in the United States, contributing to more than 430,700 deaths each year. Over 47 million Americans smoke, despite the risks. Seventy percent of smokers are interested in stopping smoking completely; smokers report that they would be more likely to stop smoking if a doctor advised them to quit.<sup>1</sup> A number of clinical trials have demonstrated the effectiveness of clinical quit-smoking programs. Getting even brief advice to quit is associated with a 30 percent increase in the number of people who quit.<sup>2</sup>

This three-part survey measure looks at the health care provider's role in curbing tobacco use and focuses on health care providers' efforts to help members quit smoking by evaluating the following components.<sup>3</sup>

- *Advising Smokers to Quit.* The percentage of members 18 years of age and older who are current smokers and who received advice to quit smoking from their practitioner.
- *Discussing Smoking Cessation Medications.* The percentage of members 18 and older who are current smokers and whose practitioner discussed smoking cessation medications.
- *Discussing Smoking Cessation Strategies.* The percentage of members 18 and older who are current smokers and whose practitioner discussed smoking cessation strategies.

Quitting smoking reduces the risk of lung and other cancers, heart attack, stroke and chronic lung disease. Women who stop smoking before pregnancy or during the first three months of pregnancy reduce their risk of having a low-birth-weight baby to the same risk as women who never smoked. The excess risk of coronary artery disease is reduced by about half one year after quitting, and continues to decline gradually.<sup>4</sup>

Medical Assistance with Smoking Cessation					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	61.3%	65.7%	71.3%	*	*
<b>NCQA's Quality Compass®</b>	69.6%	71.2%	73.8%	75.3%	76.7%

\*Value not established or not obtained.

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> CDC. Cigarette Smoking Among Adults—United States 2003. *MMWR* May 27, 2005; 54(20):509-513.

<sup>2</sup> Fiore, M.C., W.C. Bailey, S.J. Cohen, et al. 2000. *Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians.* Rockville, Md: Public Health Service, U.S. Department of Health and Human Services.

<sup>3</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>4</sup> USPSTF. *Counseling: Tobacco Use.* Release Date: November 2003. <http://www.ahrq.gov/clinic/uspstf/uspstbac.htm>.

## Medical Assistance with Smoking Cessation: Advising Smokers to Quit

	Percent
TEXAS AVERAGE	NA
*Aetna U.S. Healthcare (Austin)	NA
*Aetna U.S. Healthcare (Dallas/Fort Worth)	NA
*Aetna U.S. Healthcare (El Paso)	NA
*Aetna U.S. Healthcare (Houston)	NA
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	NA
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR
*Community First Health Plans (San Antonio)	NA
FIRSTCARE (Abilene)	NA
FIRSTCARE (Amarillo)	NA
FIRSTCARE (Lubbock)	NA
FIRSTCARE (Waco)	44.2
HMO Blue Texas (Austin)	NA
HMO Blue Texas (Dallas/Fort Worth)	NA
HMO Blue Texas (East /West /South Texas)	NA
HMO Blue Texas (Houston)	NA
Humana Health Plan of Texas (Austin)	NA
Humana Health Plan of Texas (Houston)	NA
Humana Health Plan of Texas (San Antonio/Corpus Christi)	NA
Mercy Health Plans (Laredo)	NA
PacifiCare of Texas (Dallas/Austin)	NA
PacifiCare of Texas (San Antonio/Houston)	NA
Scott and White Health Plan (Central Texas)	NA
UNICARE Health Plans (Southeast Texas)	NA
*UnitedHealthcare of Texas, Inc. (Austin/San Antonio)	NA
*UnitedHealthcare of Texas, Inc. (Dallas)	NA
*UnitedHealthcare of Texas, Inc. (Houston/Corpus Christi)	NA
Valley Baptist Health Plan (Harlingen)	NA

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR– Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Medical Assistance with Smoking Cessation: Advising Smokers to Quit

	<b>Percent</b>	
FIRSTCARE (Waco)	44.2	
TEXAS AVERAGE	NA	
*Aetna U.S. Healthcare (Austin)	NA	
*Aetna U.S. Healthcare (Dallas/Fort Worth)	NA	
*Aetna U.S. Healthcare (El Paso)	NA	
*Aetna U.S. Healthcare (Houston)	NA	
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	NA	
*Community First Health Plans (San Antonio)	NA	
FIRSTCARE (Abilene)	NA	
FIRSTCARE (Amarillo)	NA	
FIRSTCARE (Lubbock)	NA	
HMO Blue Texas (Austin)	NA	
HMO Blue Texas (Dallas/Fort Worth)	NA	
HMO Blue Texas (East /West /South Texas)	NA	
HMO Blue Texas (Houston)	NA	
Humana Health Plan of Texas (Austin)	NA	
Humana Health Plan of Texas (Houston)	NA	
Humana Health Plan of Texas (San Antonio/Corpus Christi)	NA	
Mercy Health Plans (Laredo)	NA	
PacifiCare of Texas (Dallas/Austin)	NA	
PacifiCare of Texas (San Antonio/Houston)	NA	
Scott and White Health Plan (Central Texas)	NA	
UNICARE Health Plans (Southeast Texas)	NA	
*UnitedHealthcare of Texas, Inc. (Austin/San Antonio)	NA	
*UnitedHealthcare of Texas, Inc. (Dallas)	NA	
*UnitedHealthcare of Texas, Inc. (Houston/Corpus Christi)	NA	
Valley Baptist Health Plan (Harlingen)	NA	
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	

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## Flu Shots for Adults Ages 50-64

Definition: The percentage of members 50-64 years of age and older who received an influenza vaccination.

The disease burden for influenza is large, and the potential for prevention is high. Influenza infections result in significant health care expenditures each year, and vaccination is safe and effective. This measure facilitates the achievement of national goals to increase the demand for adult vaccination by improving provider and public awareness to effectively deliver vaccines to adults and to monitor and improve the performance of the nation's immunization program.<sup>1</sup>

Specifications are consistent with current recommendations from the Advisory Committee on Immunization Practices (ACIP), which recommends yearly influenza vaccinations for persons aged 50–64 years<sup>2</sup> because this group has an increased prevalence of persons with high-risk medical conditions and age-specific strategies have been more successful to increase vaccine coverage than those based on medical conditions.

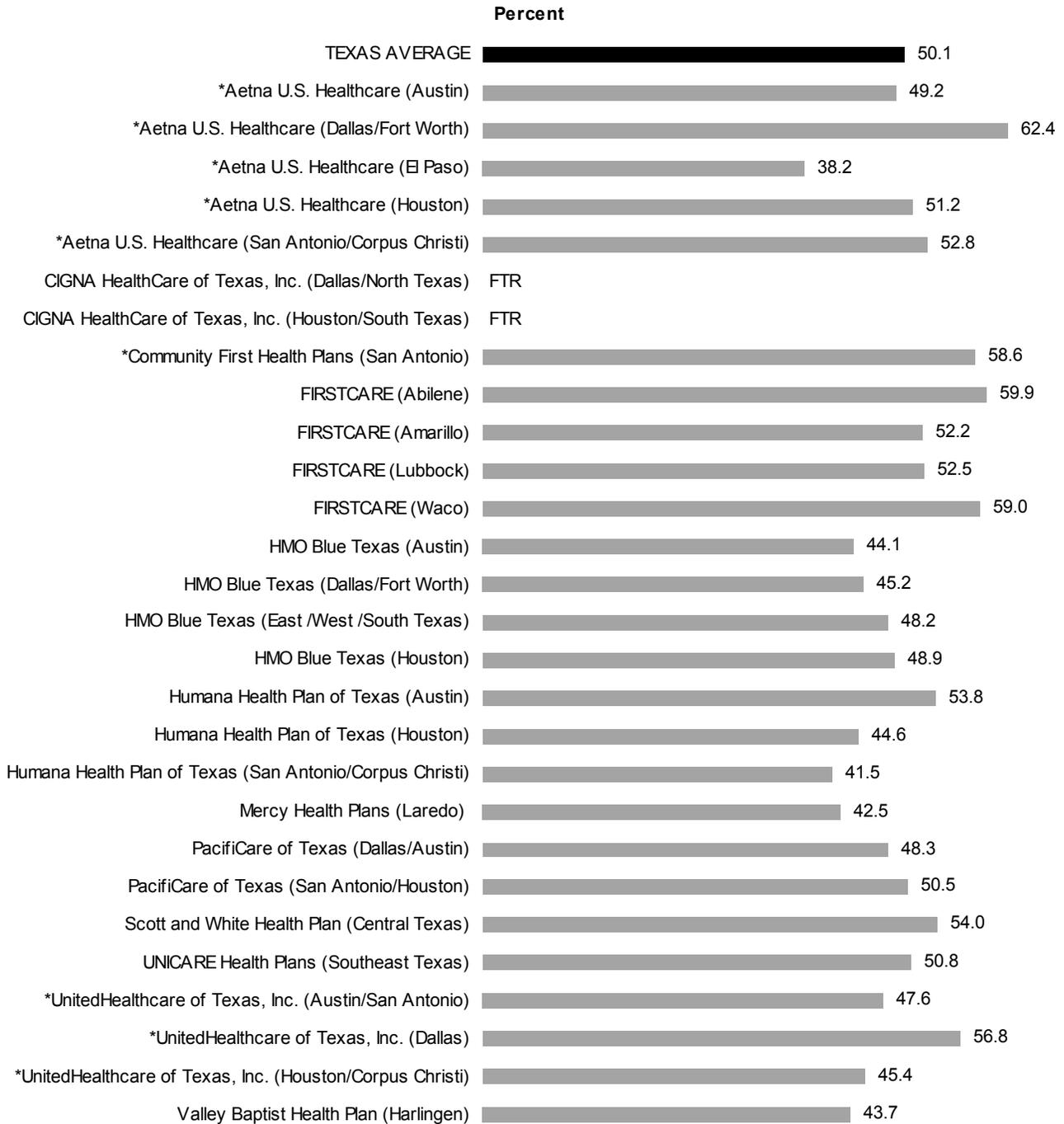
Flu Shots for Adults Ages 50-64					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	39.5%	34.9%	45.2%	49.9%	50.1%
<b>NCQA's Quality Compass®</b>	38.9%	36.3%	45.6%	48.4%	49.8%

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> Advisory Committee on Immunization Practices (ACIP), Adult Immunization Recommendations, 2006

## Flu Shots for Adults Ages 50-64



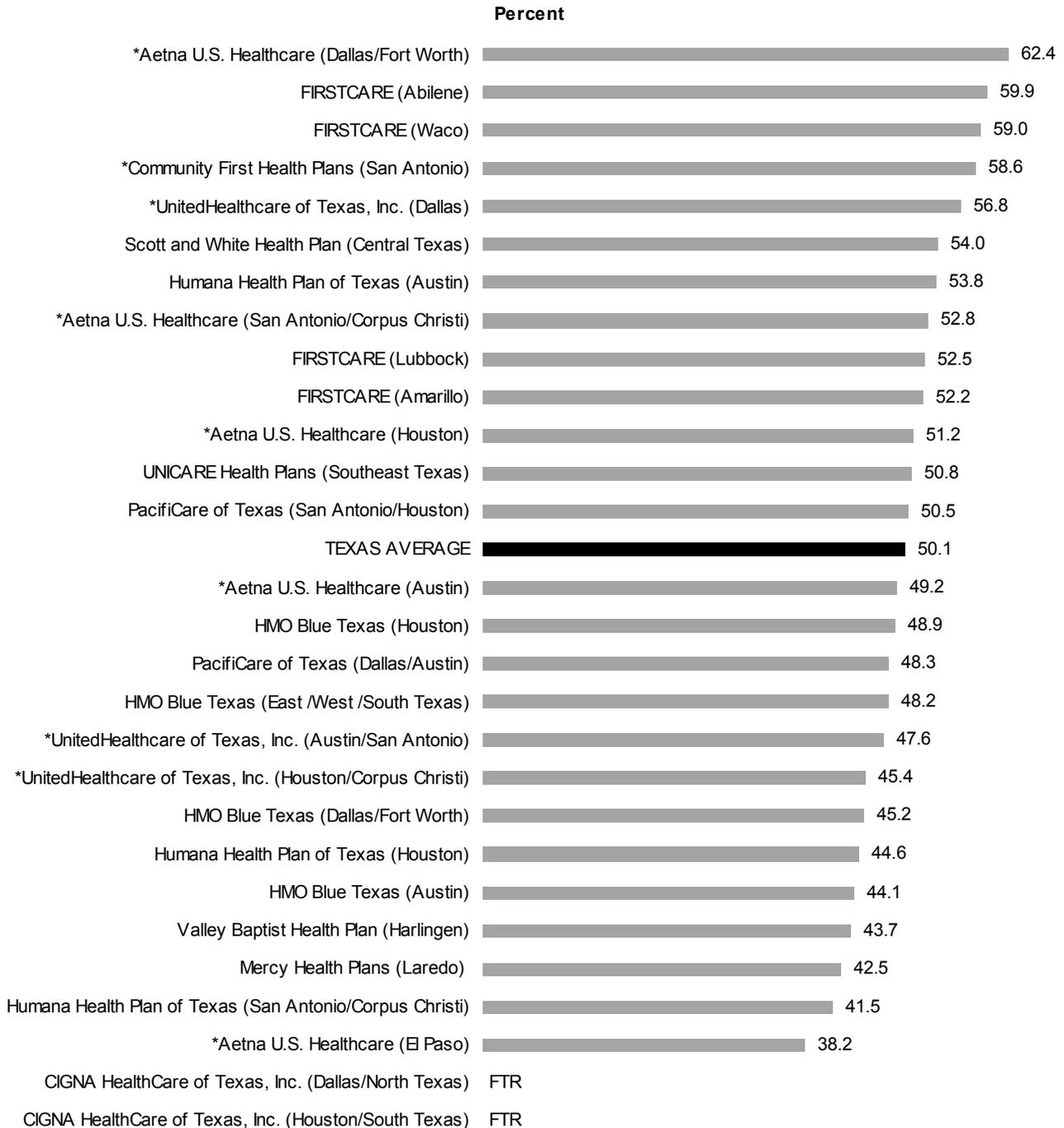
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## Flu Shots for Adults Ages 50-64



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## Prenatal and Postpartum Care: Timeliness of Prenatal Care

Definition: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Preventive medicine is fundamental to prenatal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion must occur early in pregnancy to have a maximum impact on outcome. Poor outcomes include spontaneous abortion, low-birth-weight babies, large-for-gestational-age babies and neonatal infection.<sup>1</sup>

Early prenatal care is also an essential part of helping a pregnant woman prepare to become a mother. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy.<sup>2</sup>

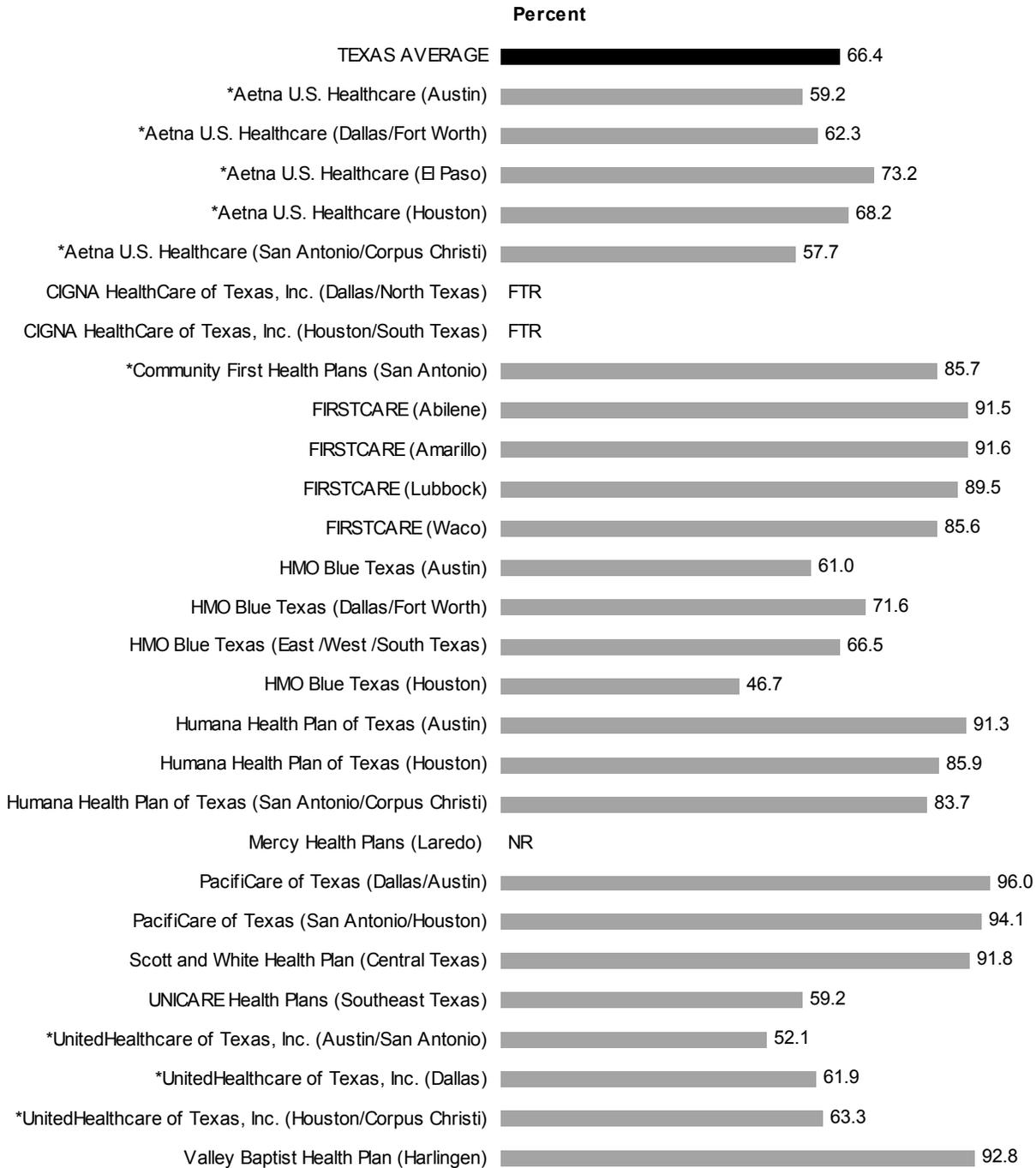
Timeliness of Prenatal Care					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	68.4%	71.5%	65.6%	68.6%	66.4%
<b>NCQA's Quality Compass®</b>	90.8%	91.8%	90.6%	77.5%	92.4%

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> Ibid.

## Timeliness of Prenatal Care



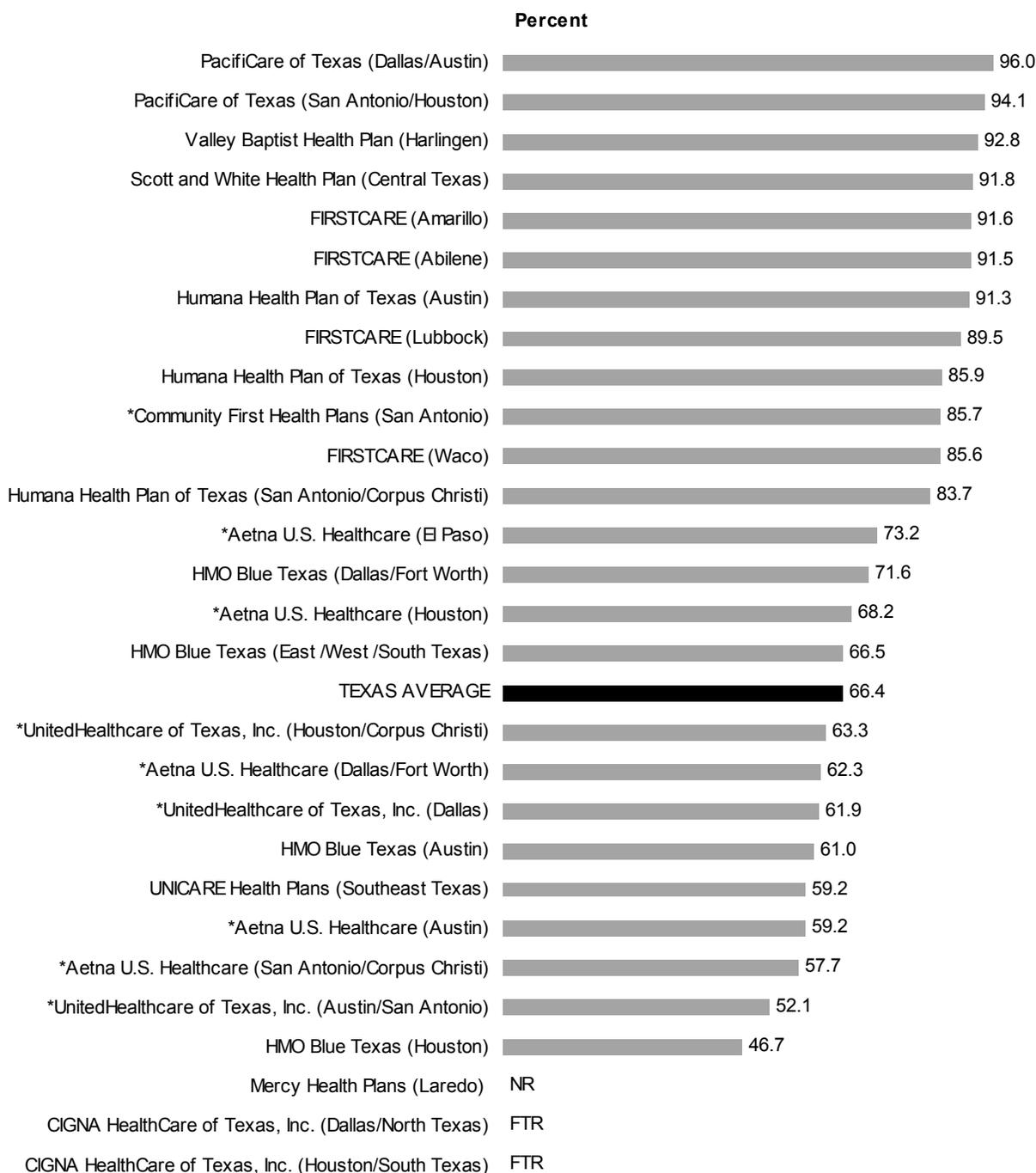
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## Timeliness of Prenatal Care



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## Prenatal and Postpartum Care: Postpartum Care

Definition: The percentage of deliveries that had a postpartum visit on or between 21 days and 56 days after delivery.

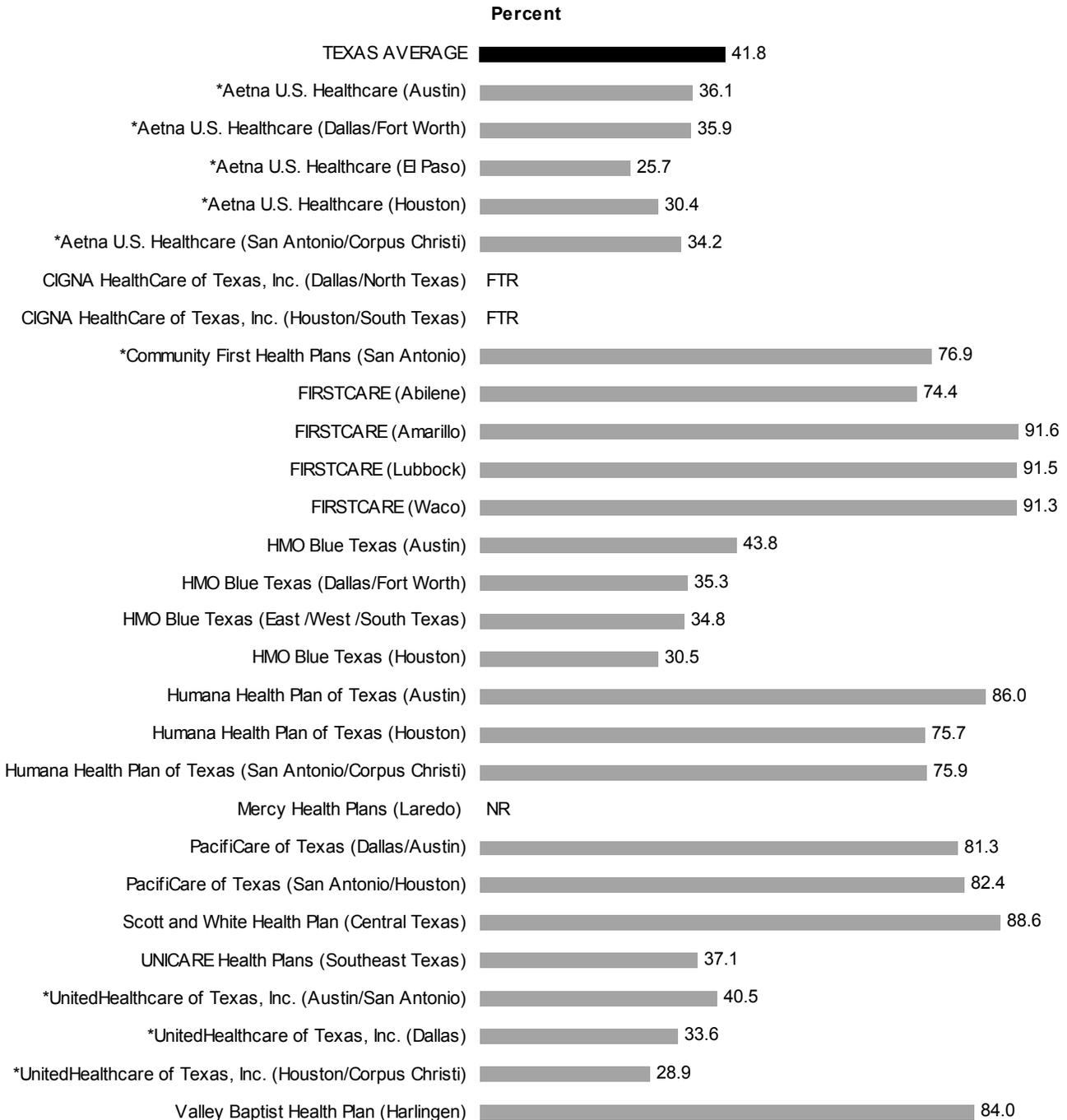
The American College of Obstetricians and Gynecologists<sup>1</sup> recommends that women see their health care provider at least once between four and six weeks after giving birth. The first postpartum visit should include a physical examination and is an opportunity for the health care practitioner to answer parents' questions, give family planning guidance and counsel on nutrition.

Postpartum Care					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	47.0%	48.0%	41.0%	44.1%	41.8%
<b>NCQA's Quality Compass®</b>	80.7%	81.5%	79.9%	69.0%	82.8%

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<sup>1</sup>American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care* (5th Edition). October 2002.

## Postpartum Care



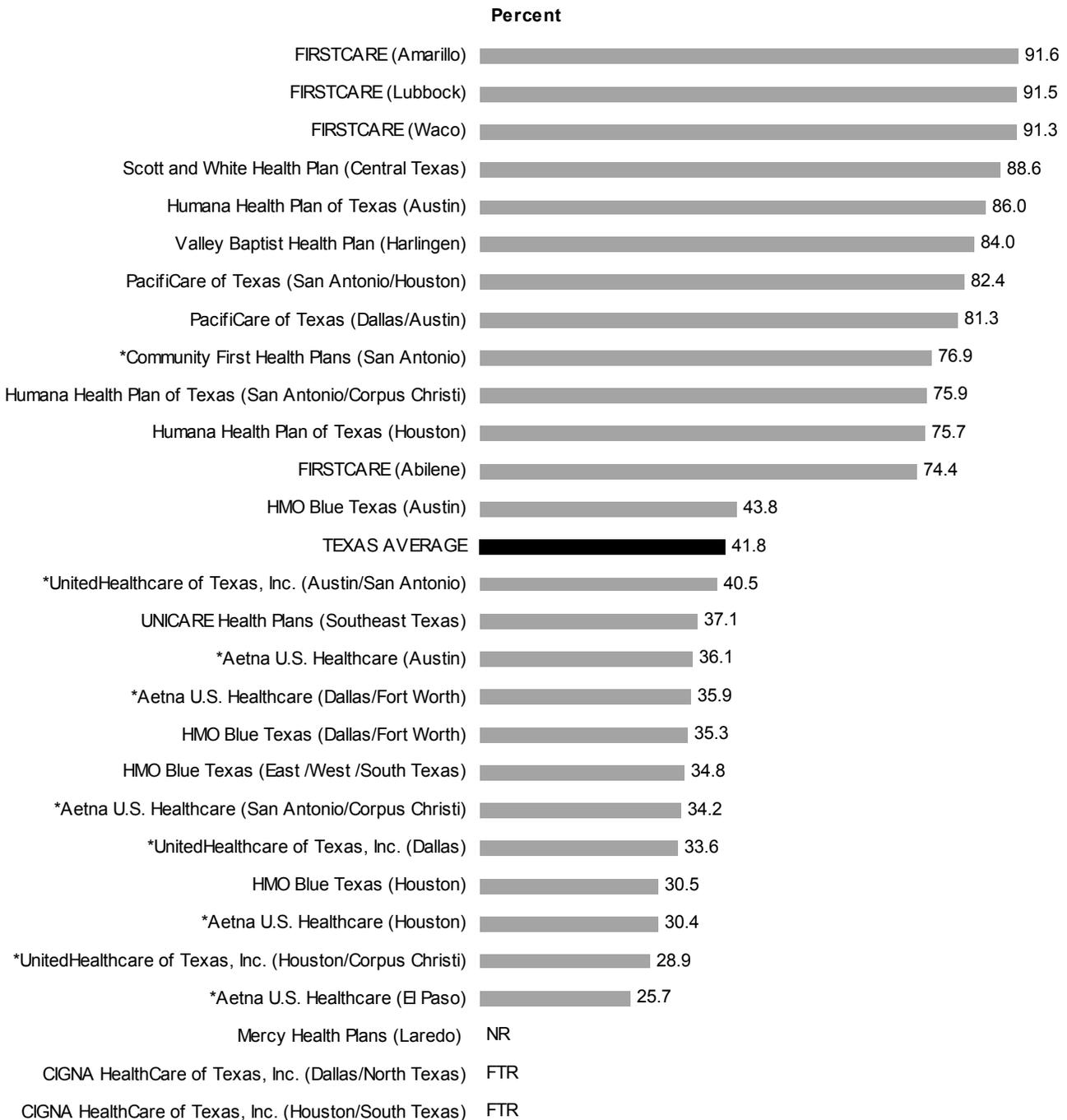
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## Postpartum Care



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## Initiation of Alcohol and Other Drug Dependence Treatment

Definition: The percentage of members diagnosed with alcohol and other drug dependence (AOD) who initiate treatment during the measurement year through either an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system.<sup>1</sup>

This measure assesses the degree to which the organization initiates members identified with a need for AOD dependence services and the degree to which members initiate and continue treatment once the need has been identified.

Identifying individuals with alcohol and other drug (AOD) disorders is an important first step in the process of care, but identification often does not lead to initiation of care.<sup>2</sup> Reasons an individual may not initiate treatment include the social stigma associated with AOD disorder, denial of the problem, noncompliance with treatment or lack of immediately available treatment services.<sup>3</sup> This measure is designed to ensure that treatment is initiated once the need has been identified, and will permit comparison of effectiveness in initiating care.<sup>4</sup>

Initiation of Alcohol and Other Drug Dependence Treatment				
	2006	2007	2008	2009
<b>Texas Average</b>	47.6%	44.6%	47.5%	41.8%
<b>NCQA's Quality Compass®</b>	44.5%	43.2%	45.1%	42.4%

This measure was added to the Texas Subset beginning with HEDIS® 2006.

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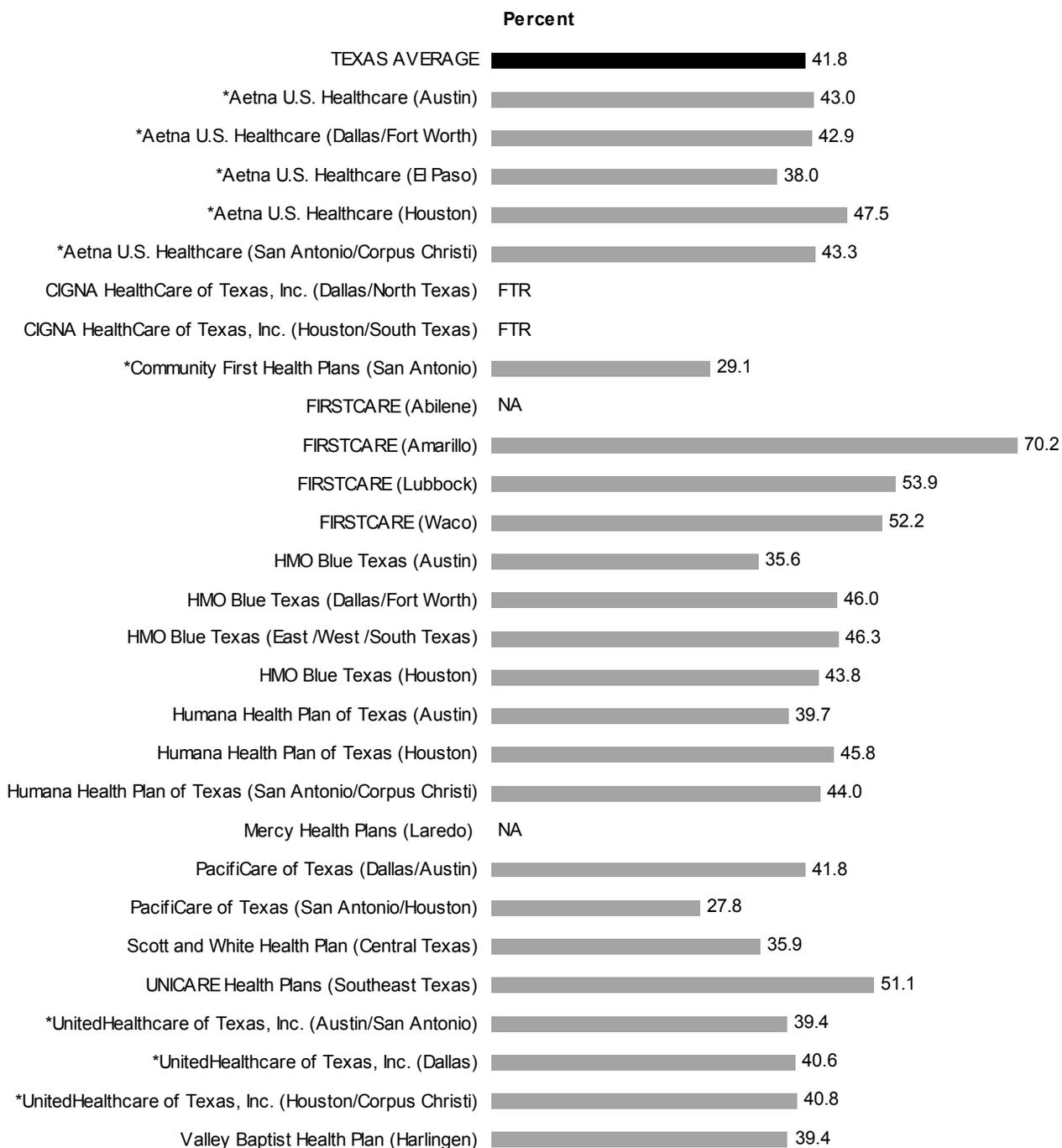
<sup>1</sup> Schneider Institute for Health Policy, Brandeis University. 2001. *Substance Abuse: The Nation's Number One Health Problem*, Robert Wood Johnson Foundation, Princeton, New Jersey

<sup>2</sup> McCorry, F., Garnick, D., Bartlett, J., Cotter, F., Chalk, M. Nov. 2000. Developing Performance Measures for Alcohol and Other Drug Services in Managed Care Plans. *Joint Commission Journal on Quality Improvement* 26 (11): 633-643.

<sup>3</sup> Institute of Medicine (IOM). 1990a. *Broadening the Base of Treatment for Alcohol Problems*. Washington, DC: National Academy Press.

<sup>4</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Initiation of Alcohol and Other Drug Dependence Treatment



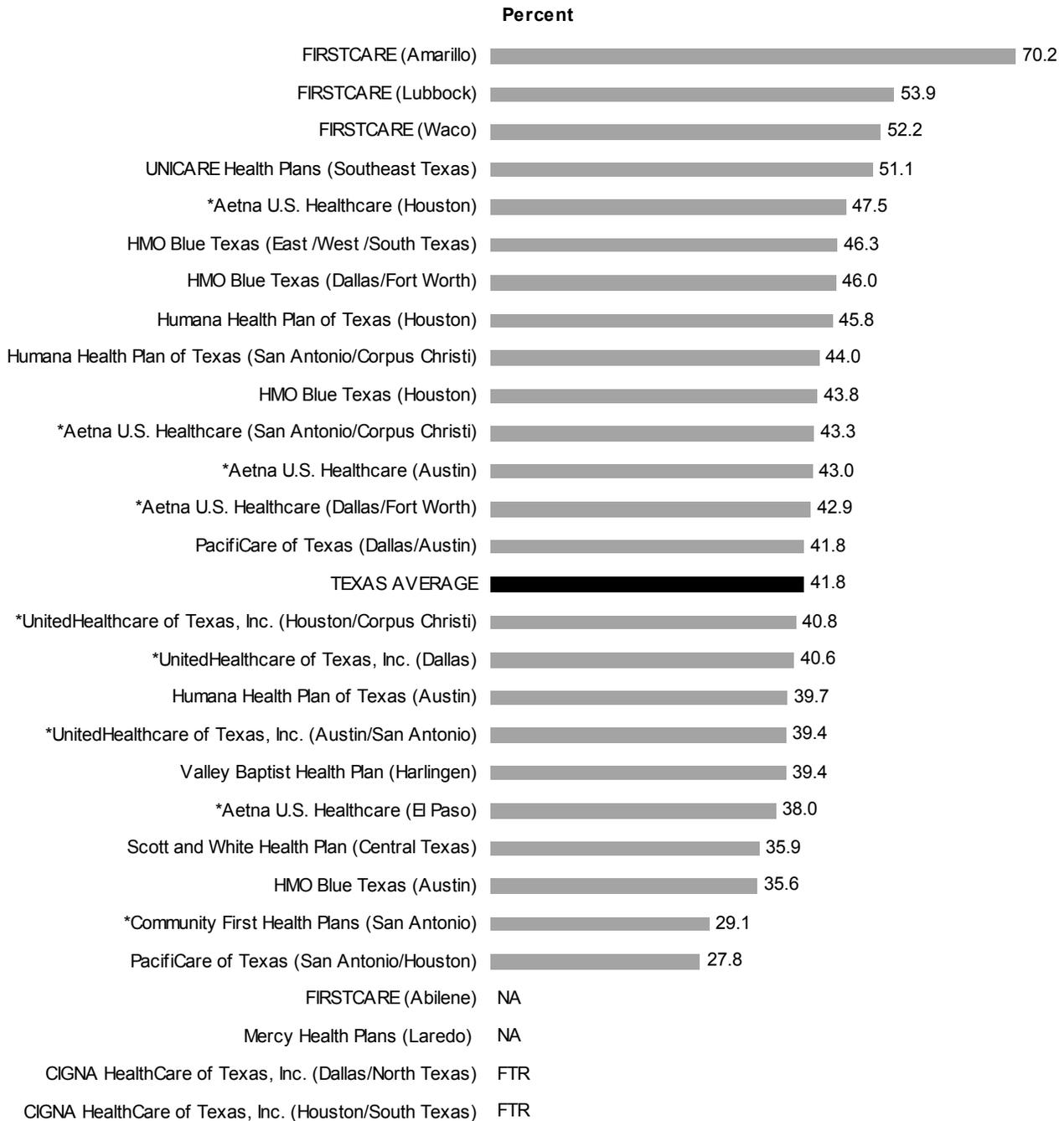
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## Initiation of Alcohol and Other Drug Dependence Treatment



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## Engagement of Alcohol and Other Drug Dependence Treatment

Definition: The percentage of members diagnosed with alcohol and other drug dependence (AOD) who undergo initiation treatment with two additional AOD services within 30 days of the initiation visit.

Engagement of AOD Treatment is an intermediate step between initially accessing care (initiation treatment) and completing a full course treatment.

Treatment engagement is an intermediate step between initially accessing care (the first visit) and completing a full course of treatment. Numerous studies indicate that individuals who remain in treatment for a longer duration of time have improved outcome, but the 1990 Drug Service Research Survey suggested that many clients (52 percent) with AOD disorders leave treatment prematurely.<sup>1</sup> This measure is an important intermediate indicator, closely related to outcome. In fact, studies have tied frequency and intensity of engagement as important in treatment outcome and in reducing drug-related illnesses.<sup>2</sup>

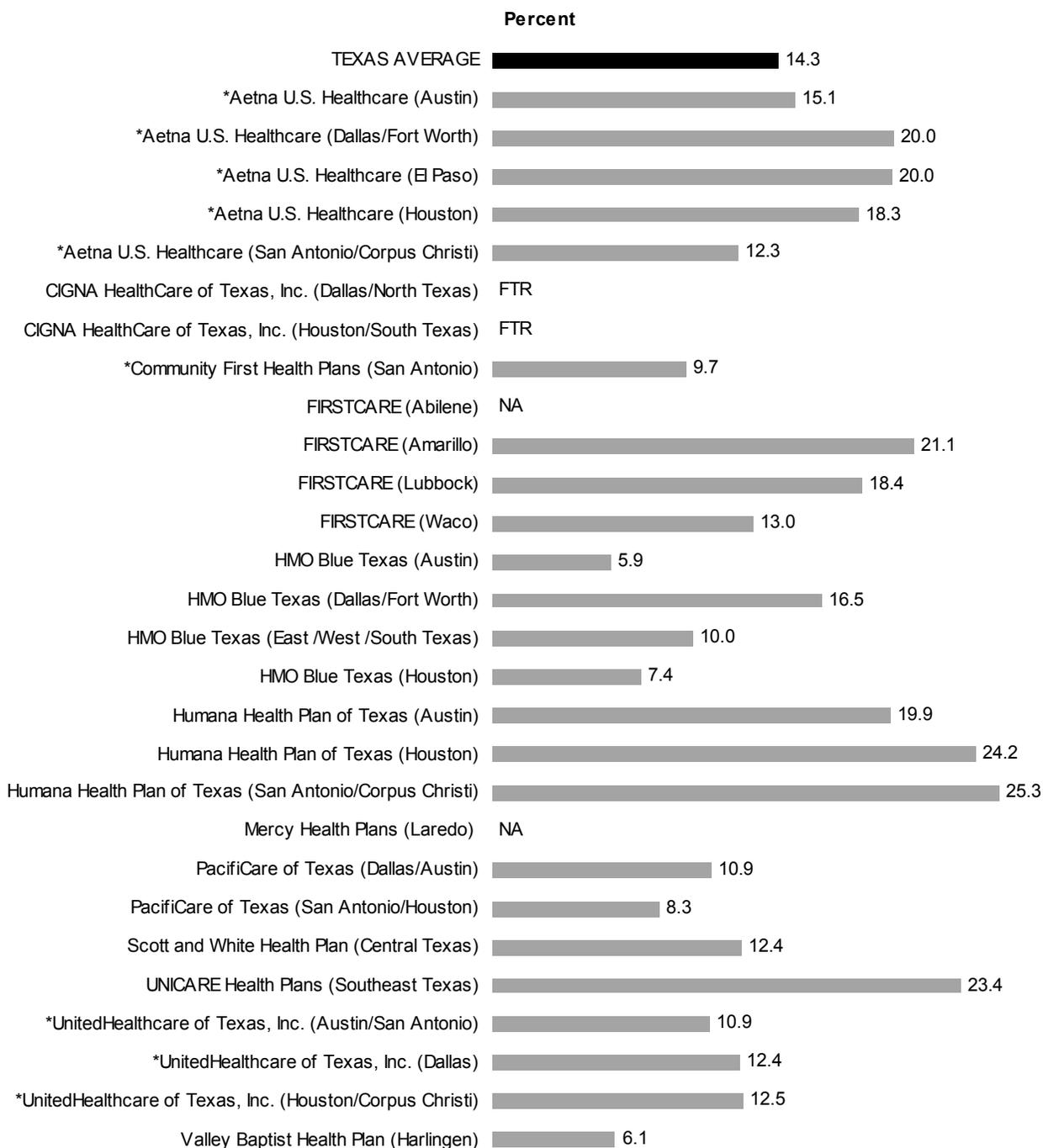
Engagement of Alcohol and Other Drug Dependence Treatment				
	2006	2007	2008	2009
<b>Texas Average</b>	12.4%	12.1%	10.9%	14.3%
<b>NCQA's Quality Compass®</b>	14.1%	13.8%	15.2%	16.2%

This measure was added to the Texas Subset beginning with HEDIS® 2006.

<sup>1</sup>Barten, H., et. al. 1992. Drug Service Research Survey. *Final Report: Phase II*. Submitted by the Bigel Institute for Health Policy, Brandeis University to the National Institute on Drug Abuse. Waltham, Massachusetts.

<sup>2</sup>McLellan, A., et. al. 1997. Evaluating effectiveness of addiction treatments: Reasonable expectations, appropriate comparisons. In Egertson, A., D. Fox, A. Leshner (eds): *Treating Drug Abusers Effectively*. Malden, MA: Blackwell Publishers.

## Engagement of Alcohol and Other Drug Dependence Treatment



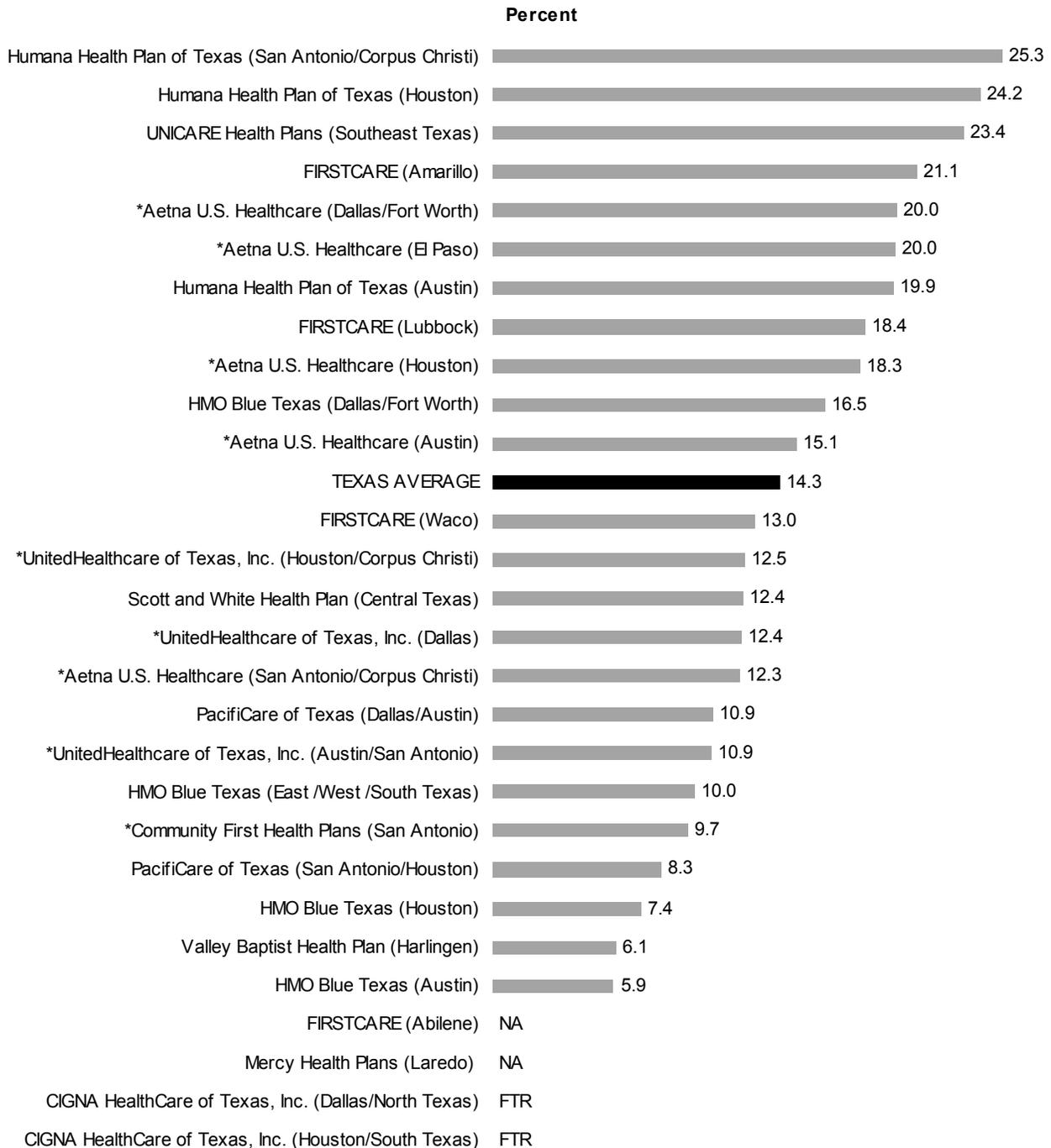
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## Engagement of Alcohol and Other Drug Dependence Treatment



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## Well-Child Visits in the First 15 Months of Life: Six or More Visits

Definition: The percentage of children using the HMO who turned 15 months old during the measurement year and received six or more well-child visits during those 15 months.

Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.<sup>1</sup>

This measure looks at the adequacy of well-child care for infants. It measures the percentage of children who had 1, 2, 3, 4, 5, 6 or more well-child visits by the time they turned 15 months of age.

These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9 and 12 months of age.<sup>2</sup>

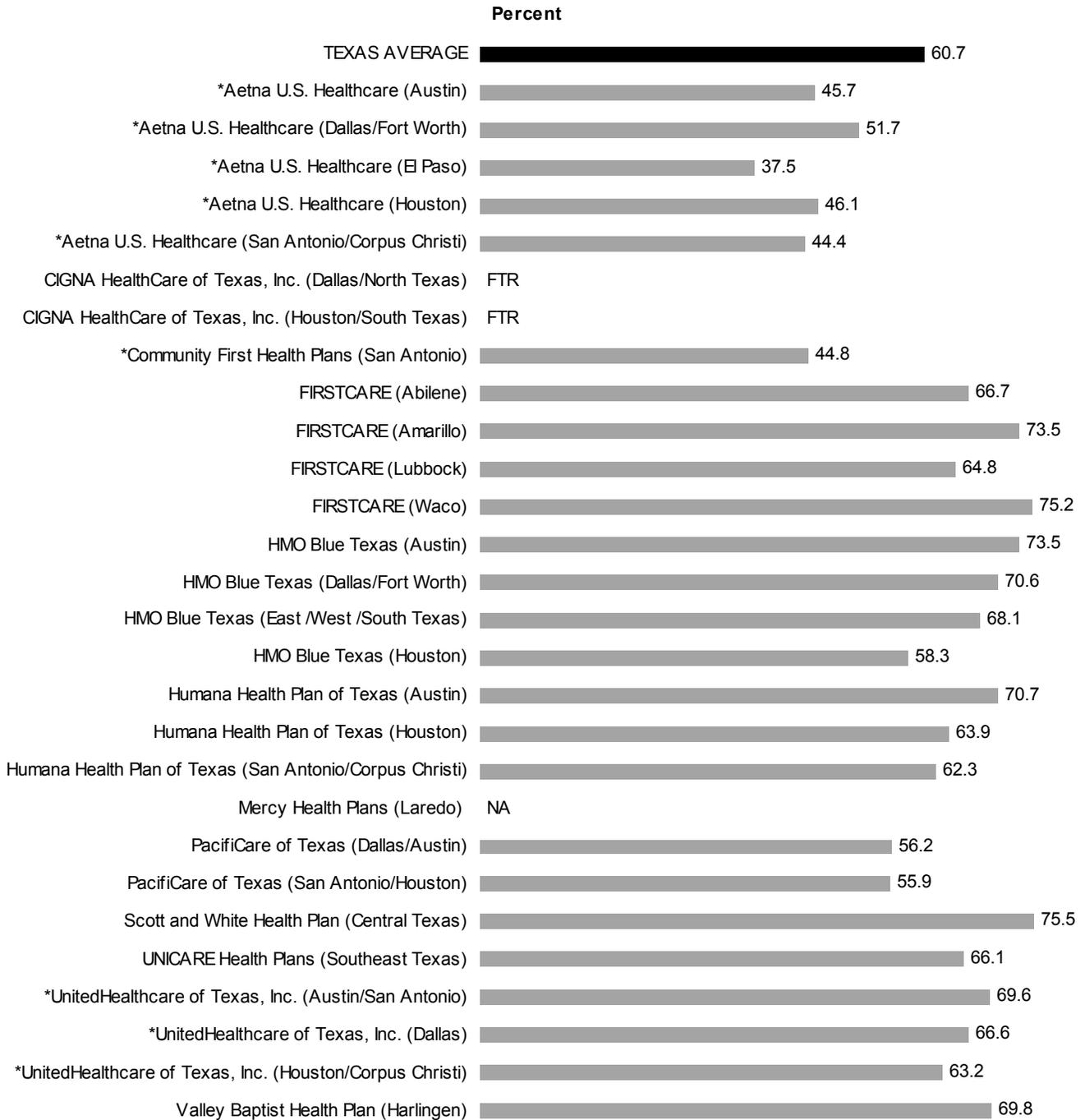
Well-Child Visits in the First 15 Months of Life: Six or More Visits					
	2005	2006	2007	2008	2009
Texas Average	54.0%	51.8%	55.7%	58.0%	60.7%
NCQA's Quality Compass®	68.7%	71.1%	72.9%	69.0%	75.2%

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> American Academy of Pediatrics. 2000. Committee on Practice and Ambulatory Medicine: Recommendations for Preventive Pediatric Health Care. *Pediatrics* 105: 645-646.

## Well-Child Visits in First 15 Months of Life



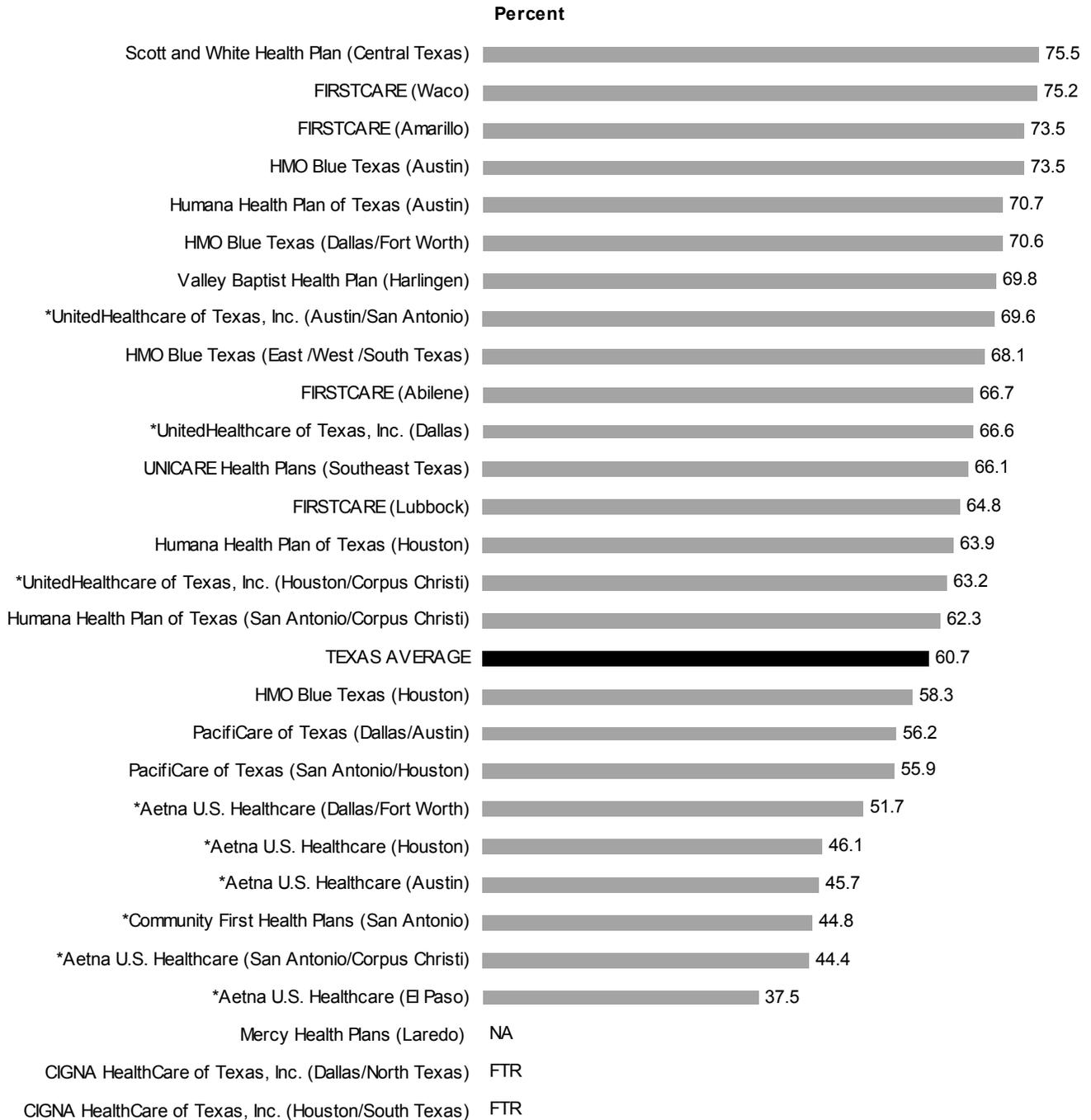
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## Well-Child Visits in First 15 Months of Life



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

Definition: The percentage of children using the HMO between three and six years of age that received one or more well-child visits with a primary care practitioner during the measurement year.

Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems.<sup>1</sup>

This measure looks at the use of routine check-ups by preschool and early school-age children. It assesses the percentage of children 3, 4, 5 and 6 years of age who received at least one well-child visit with a primary care practitioner during the measurement year.

The American Academy of Pediatrics (AAP) recommends at least one annual well-child visit for 2–6 year-olds.<sup>2</sup>

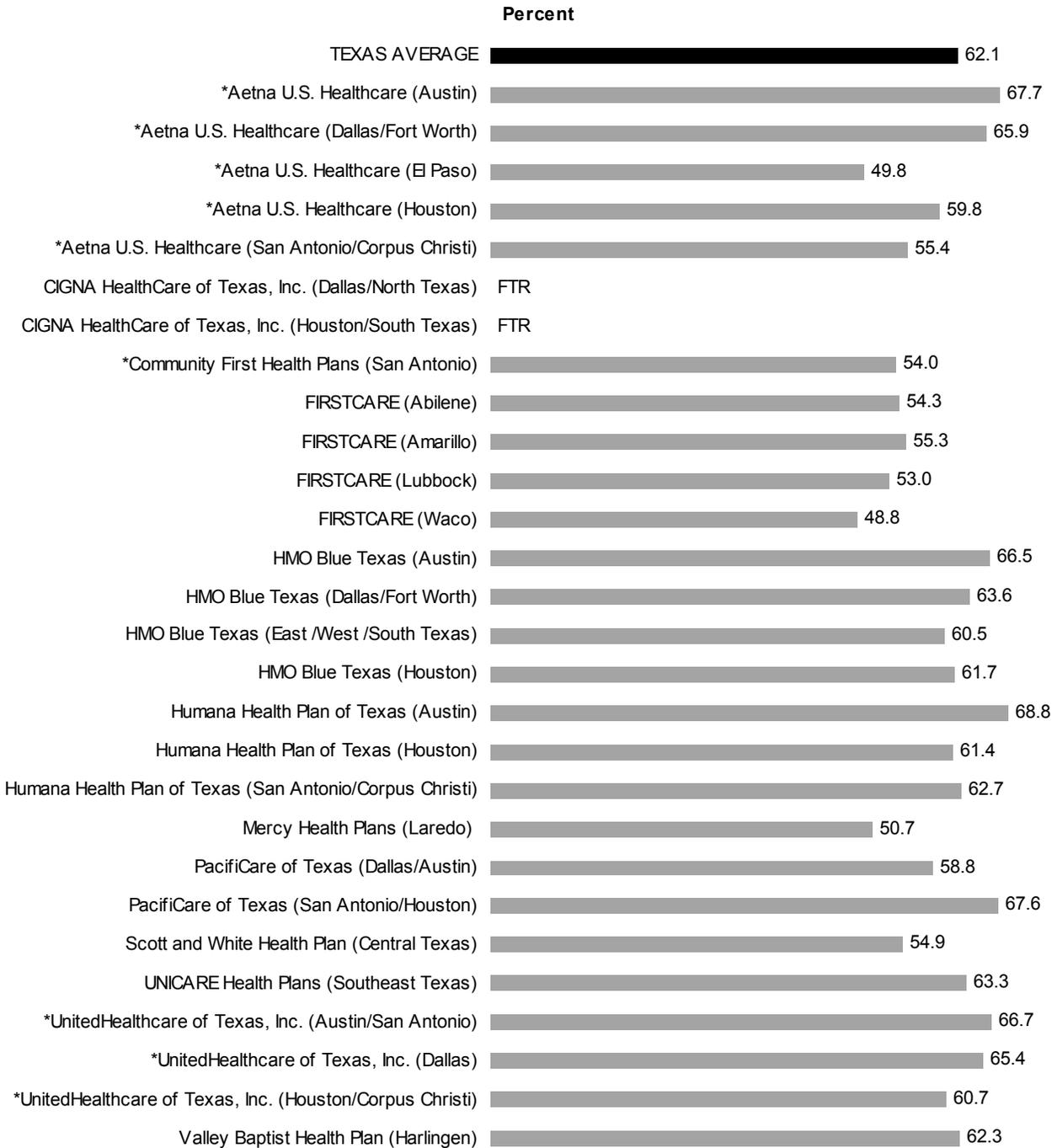
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
	2005	2006	2007	2008	2009
<b>Texas Average</b>	53.2%	56.4%	59.2%	61.0%	62.1%
<b>NCQA's Quality Compass®</b>	64.3%	65.6%	66.7%	65.0%	69.8%

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> American Academy of Pediatrics. 2000. Committee on Practice and Ambulatory Medicine: Recommendations for Preventive Pediatric Health Care. *Pediatrics* 105: 645-646.

## Well-Child Visits in 3rd, 4th, 5th and 6th Year of Life



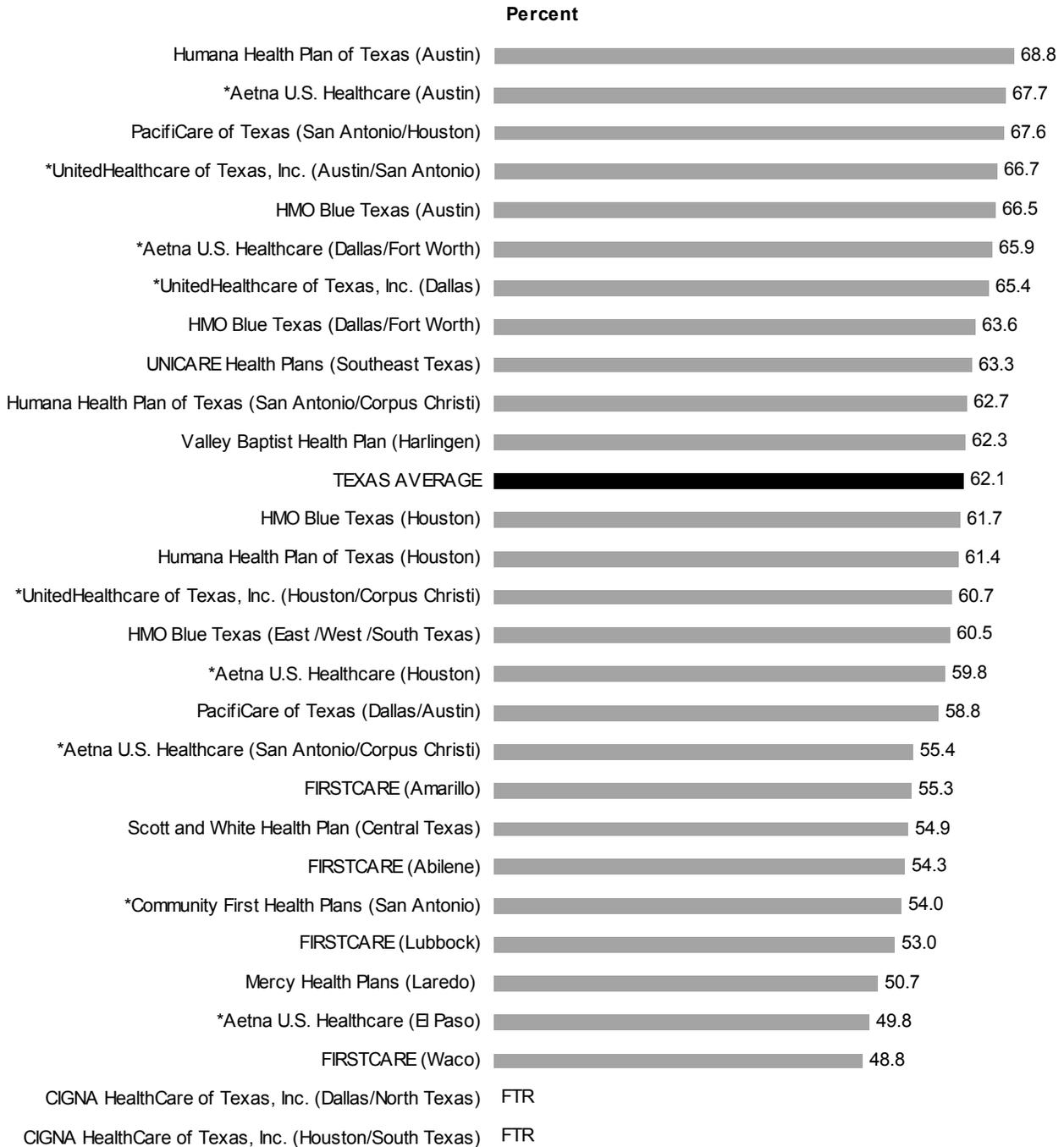
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## Well-Child Visits in 3rd, 4th, 5th and 6th Year of Life



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## Adolescent Well-Care Visits

Definition: The percentage of enrolled members 12 through 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an OB/GYN practitioner during the measurement year.

Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of—or result from—physical, emotional and social adolescent problems. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health.<sup>1</sup>

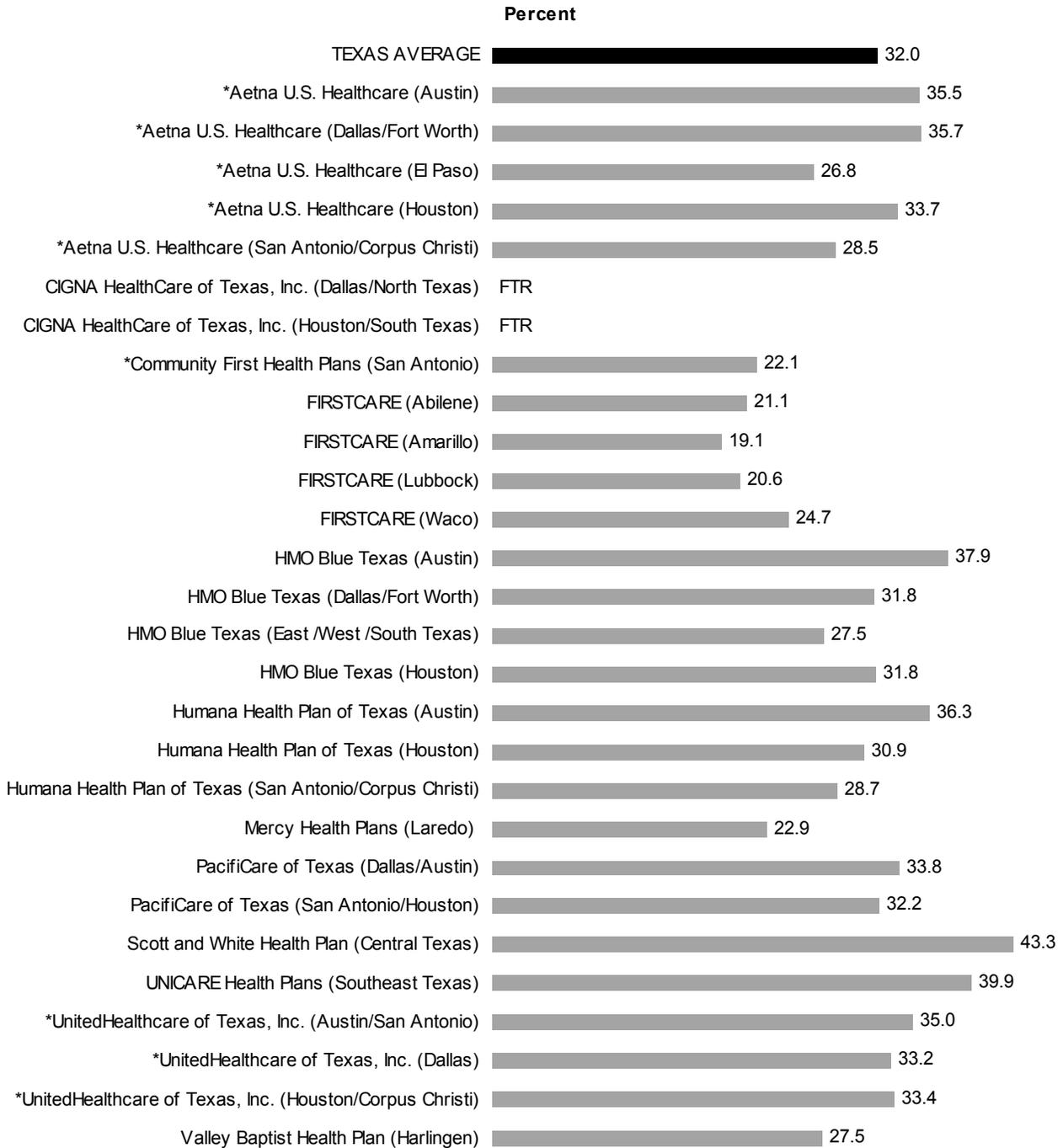
Adolescent Well-Care Visit				
	2006	2007	2008	2009
<b>Texas Average</b>	28.5%	30.8%	32.4%	32.0%
<b>NCQA's Quality Compass®</b>	38.8%	40.3%	39.0%	42.9%

This measure was added to the Texas Subset beginning with HEDIS® 2006.

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Adolescent Well-Child Visits



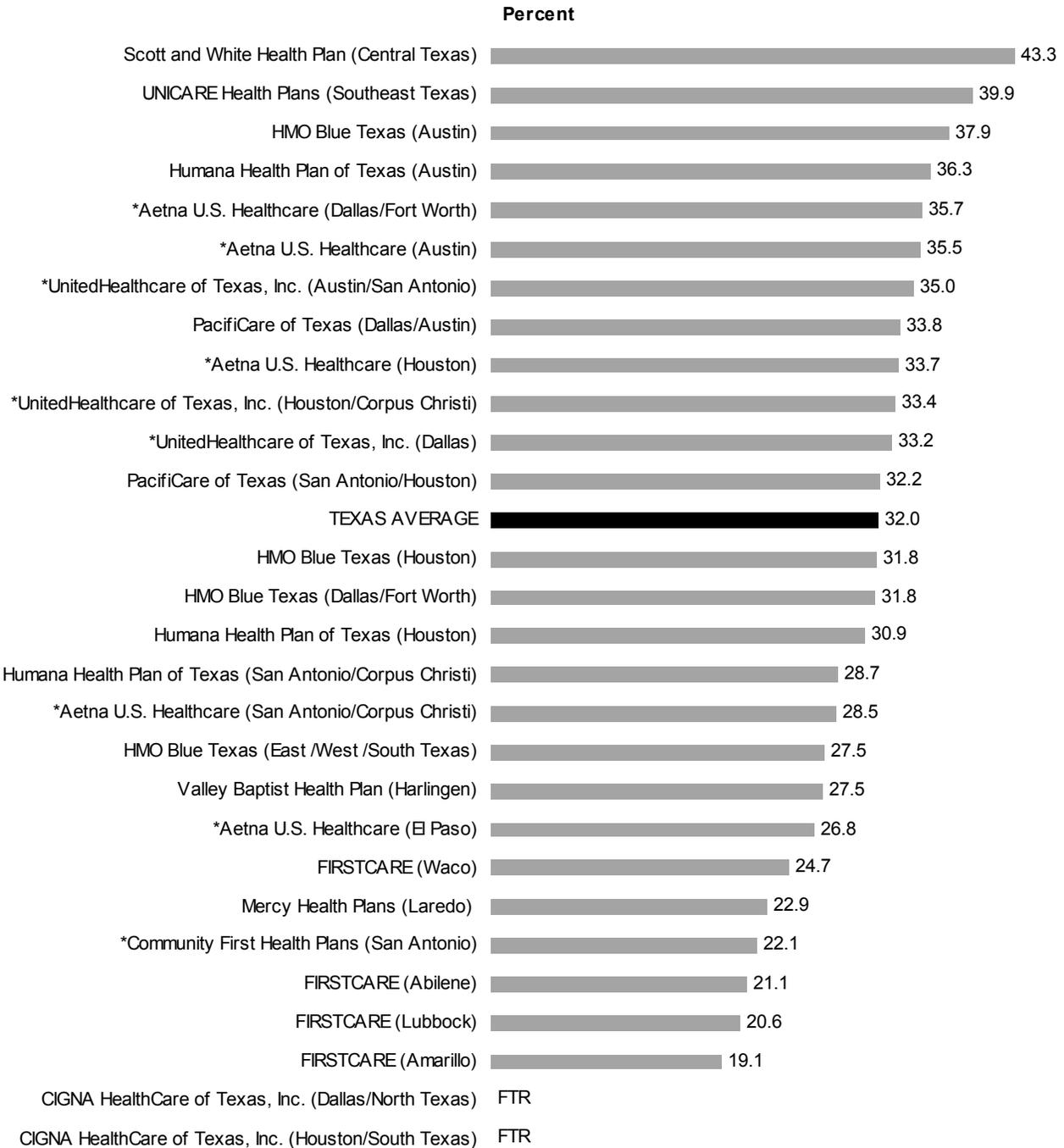
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## Adolescent Well-Child Visits



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## Inpatient Utilization – General Hospital/Acute Care: Total

Definition: Discharges per 1,000 members per year and average length of stay for all inpatient acute care services.

The bar charts show 1) the total number of discharges (DIS) per 1,000 members per year in each HMO and, 2) the average length of stay (ALOS) for total inpatient utilization.

HMO members are hospitalized for a variety of reasons. Whether for a planned delivery, a corrective surgery, or a life-threatening emergency. Hospitalization remains one of the largest contributors to overall health care costs. Total Inpatient Utilization estimates the extent that plan members receive inpatient hospital services for any reason other than non-acute care, mental health and chemical dependency, and newborn care.<sup>1</sup>

Inpatient Utilization – General Hospital/Acute Care: Total										
	2005		2006		2007		2008		2009	
	DIS	ALOS								
<b>TX Average</b>	65.9	3.8	61.4	3.7	58.6	3.8	58.7	3.7	56.3	3.8
<b>NCQA's Quality Compass</b>	58.7	3.7	57.4	3.6	56.7	3.6	56.2	3.5	57.0	3.7

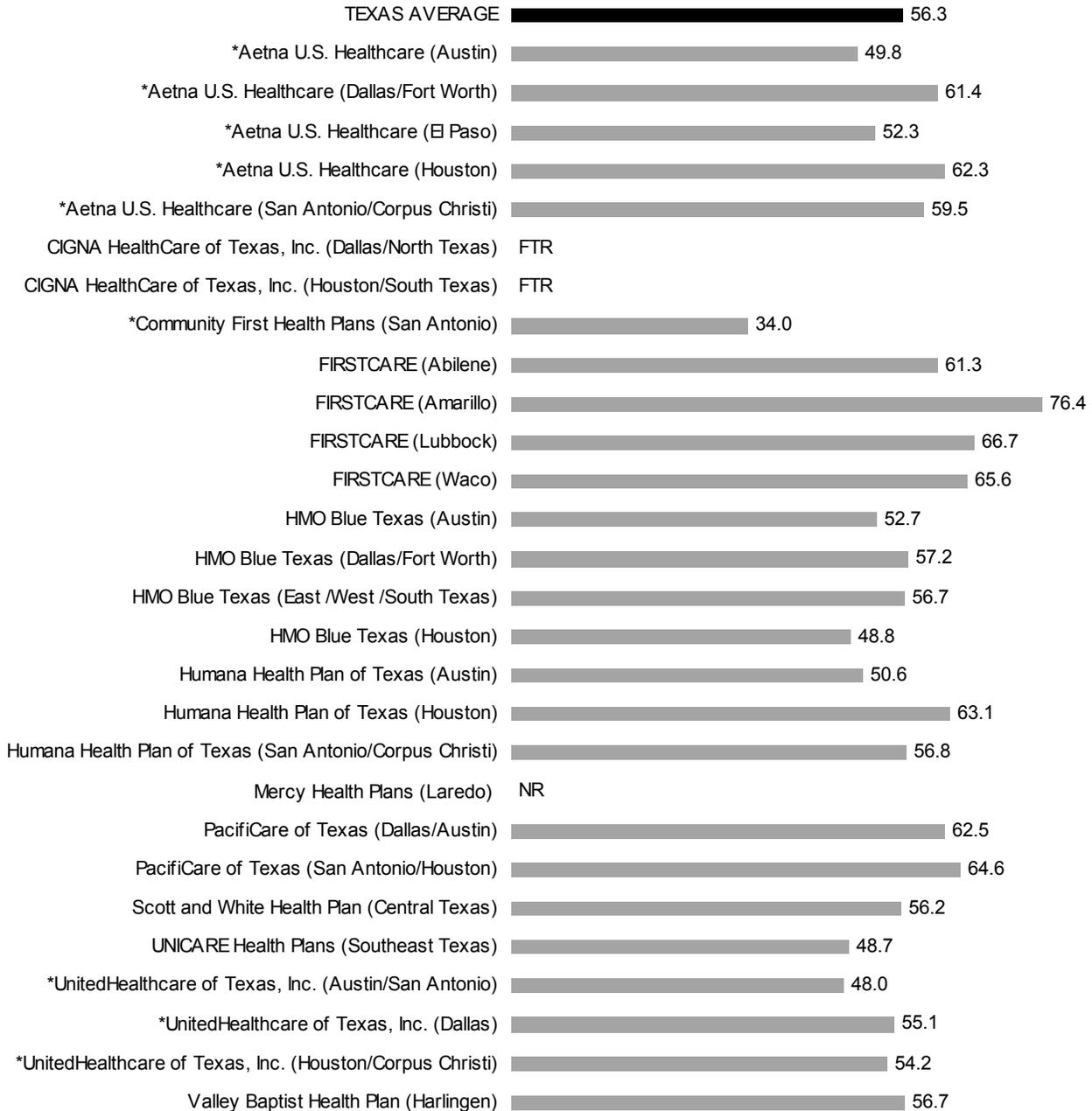
DIS - Discharges per 1,000 members per year  
ALOS - Average length of stay in days

Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Inpatient Utilization - Acute Care: Total Discharge

**Per 1,000 Members Per Year**



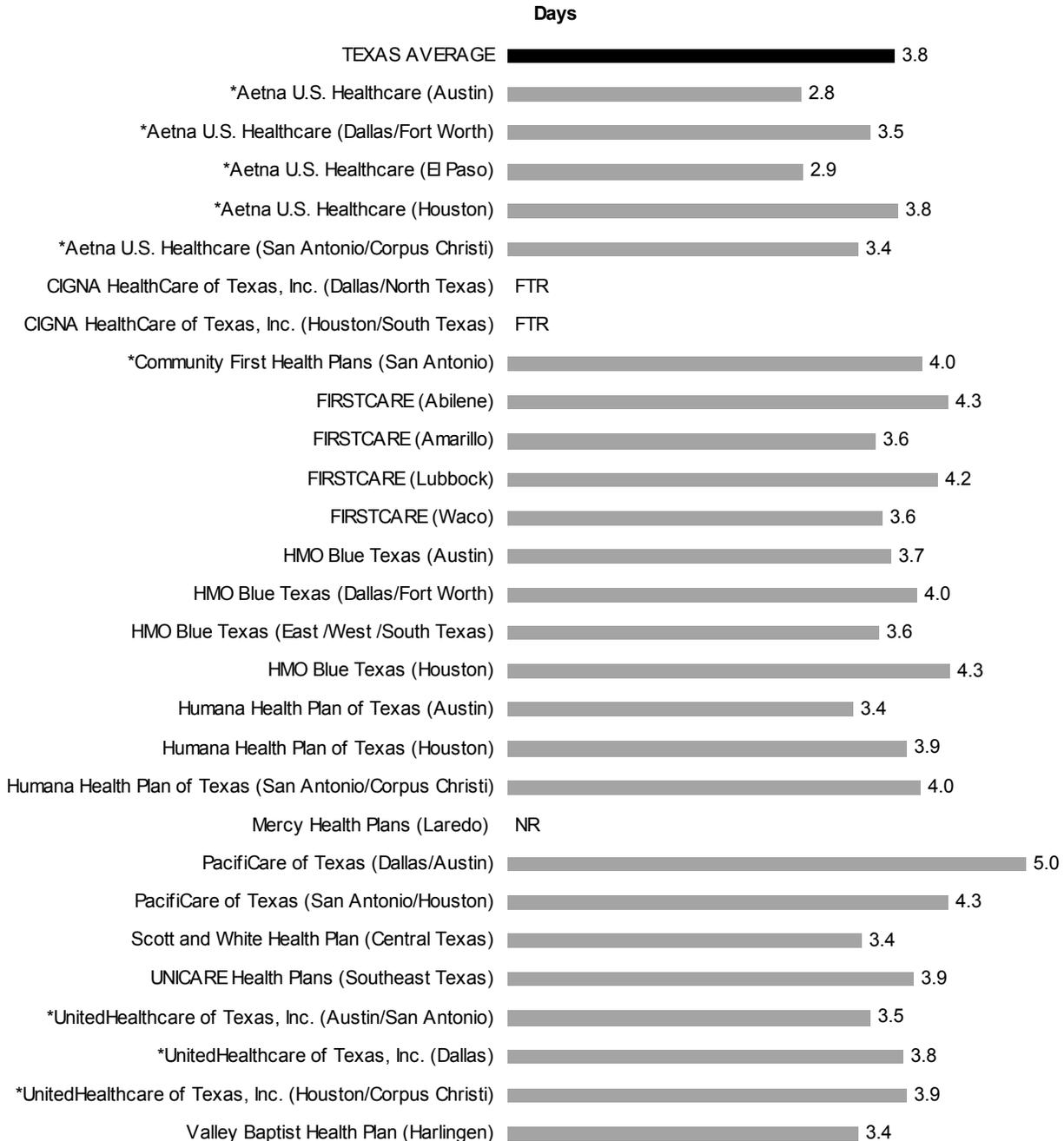
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## Inpatient Utilization - Acute Care: Total Average Length of Stay



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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Inpatient Utilization - General Hospital/Acute Care: Medicine

Definition: Discharges per 1,000 members per year and average length of stay for medicine acute care services.

This measure reports the extent to which health plan members received inpatient hospital services for non-surgical medical treatment. When interpreting this information, it is important to remember that these results are not risk-adjusted for the demographic characteristics of HMO members and use of outpatient alternatives.<sup>1</sup>

Inpatient Utilization – General Hospital/ Acute Care: Medicine										
	2005		2006		2007		2008		2009	
	DIS	ALOS								
<b>TX Average</b>	26.9	3.9	24.1	3.6	22.7	3.8	23.0	3.8	21.7	3.9
<b>NCQA's Quality Compass</b>	24.9	3.7	23.5	3.5	23.0	3.5	23.2	3.5	23.7	3.6

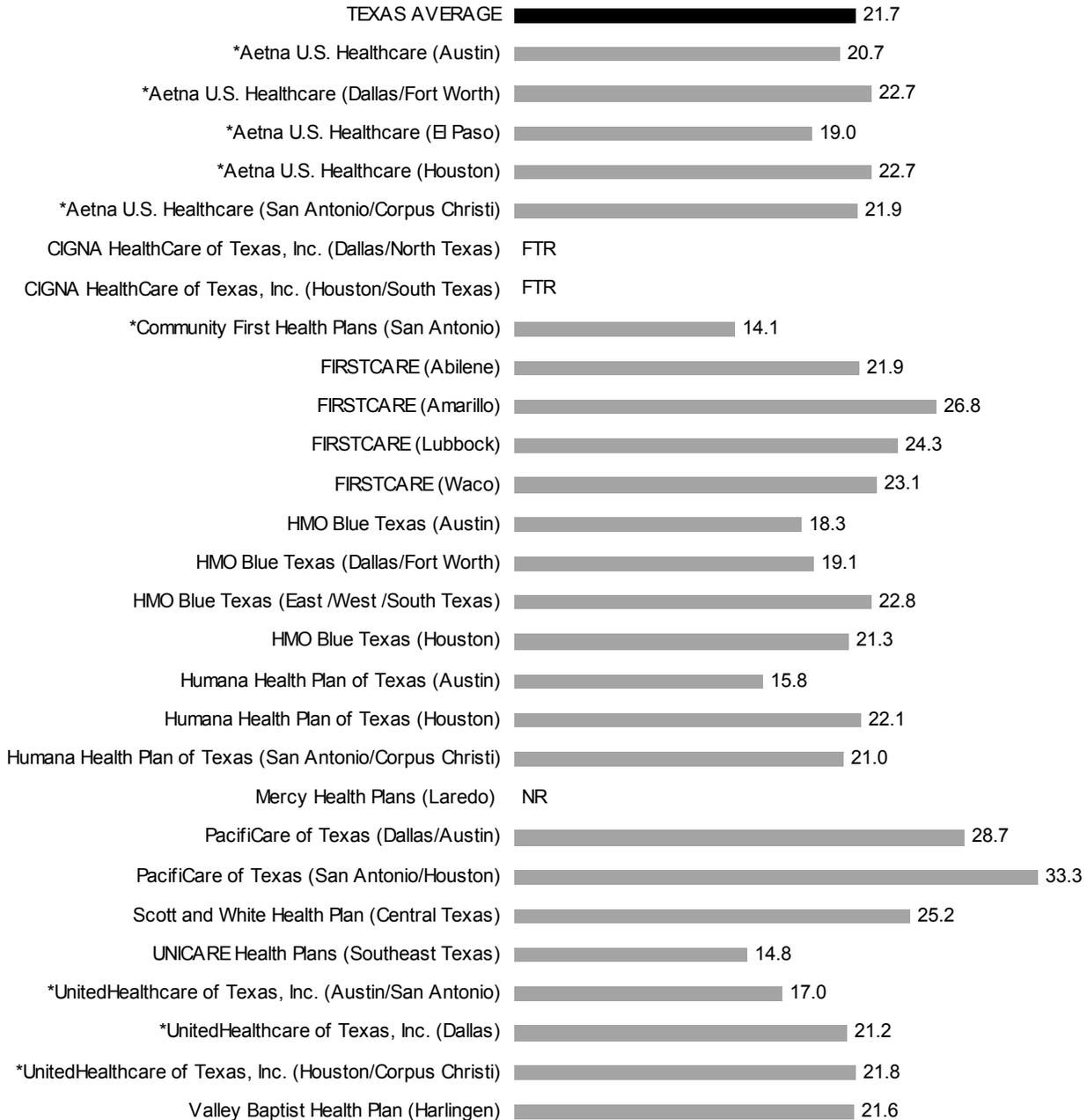
DIS - Discharges per 1,000 members per year  
ALOS - Average length of stay in days

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Inpatient Utilization - Acute Care: Medicine Discharge

**Per 1,000 Members Per Year**



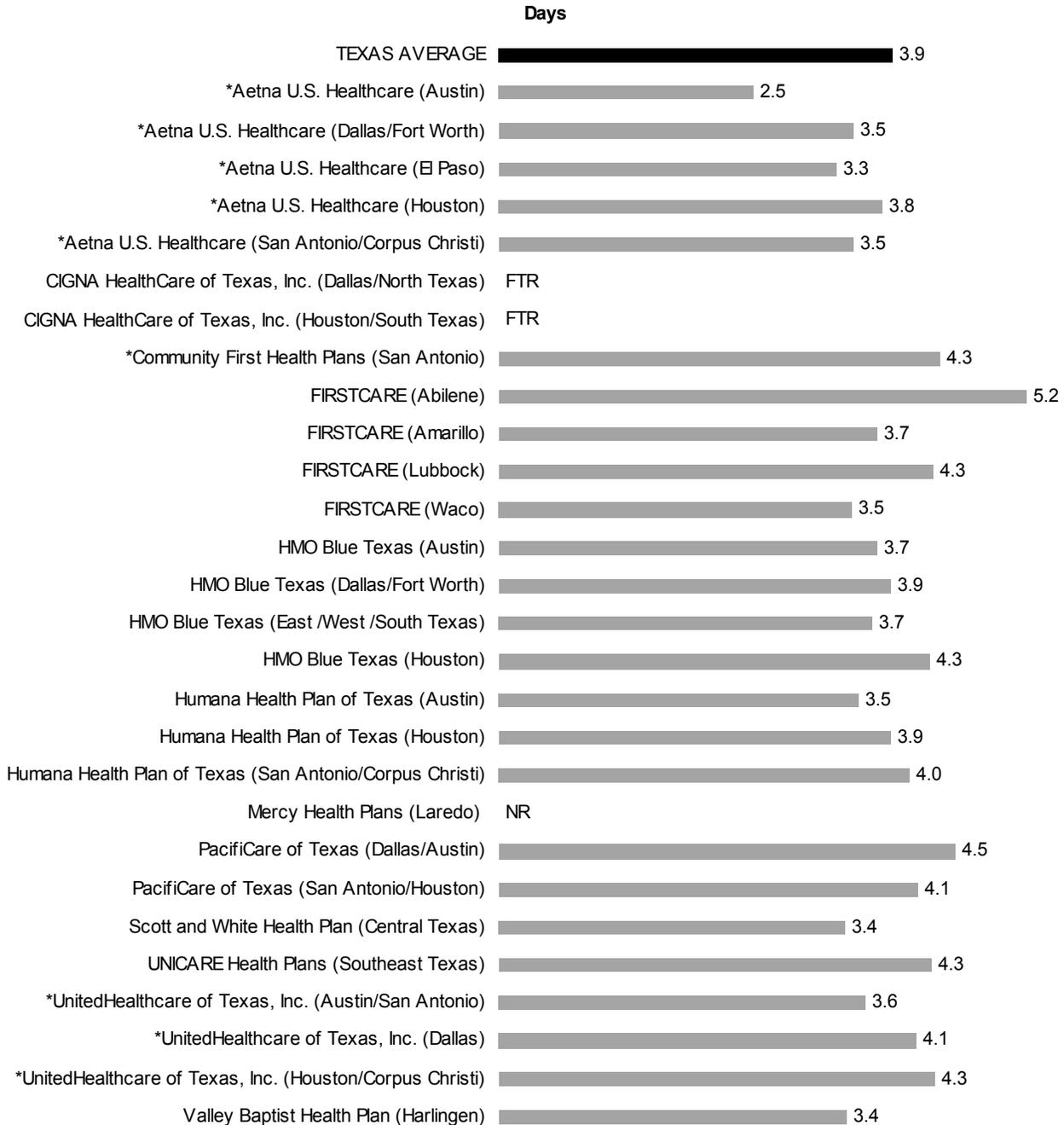
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## Inpatient Utilization - Acute Care: Medicine Average Length of Stay



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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Inpatient Utilization - General Hospital/Acute Care: Surgery

Definition: Discharges per 1,000 members per year, and average length of stay for all surgical acute care services.

This measure reports the extent to which health plan members received surgical inpatient hospital services. When interpreting this information, it is important to remember that these results are not risk-adjusted for the demographic characteristics of HMO members and their use of outpatient alternatives.<sup>1</sup>

Inpatient Utilization – General Hospital/Acute Care: Surgery										
	2005		2006		2007		2008		2009	
	DIS	ALOS								
<b>TX Average</b>	21.9	4.6	21.0	4.4	20.1	4.5	20.0	4.4	19.7	4.3
<b>NCQA's Quality Compass</b>	19.7	4.4	19.8	4.6	20.0	4.3	19.8	4.2	20.4	4.3

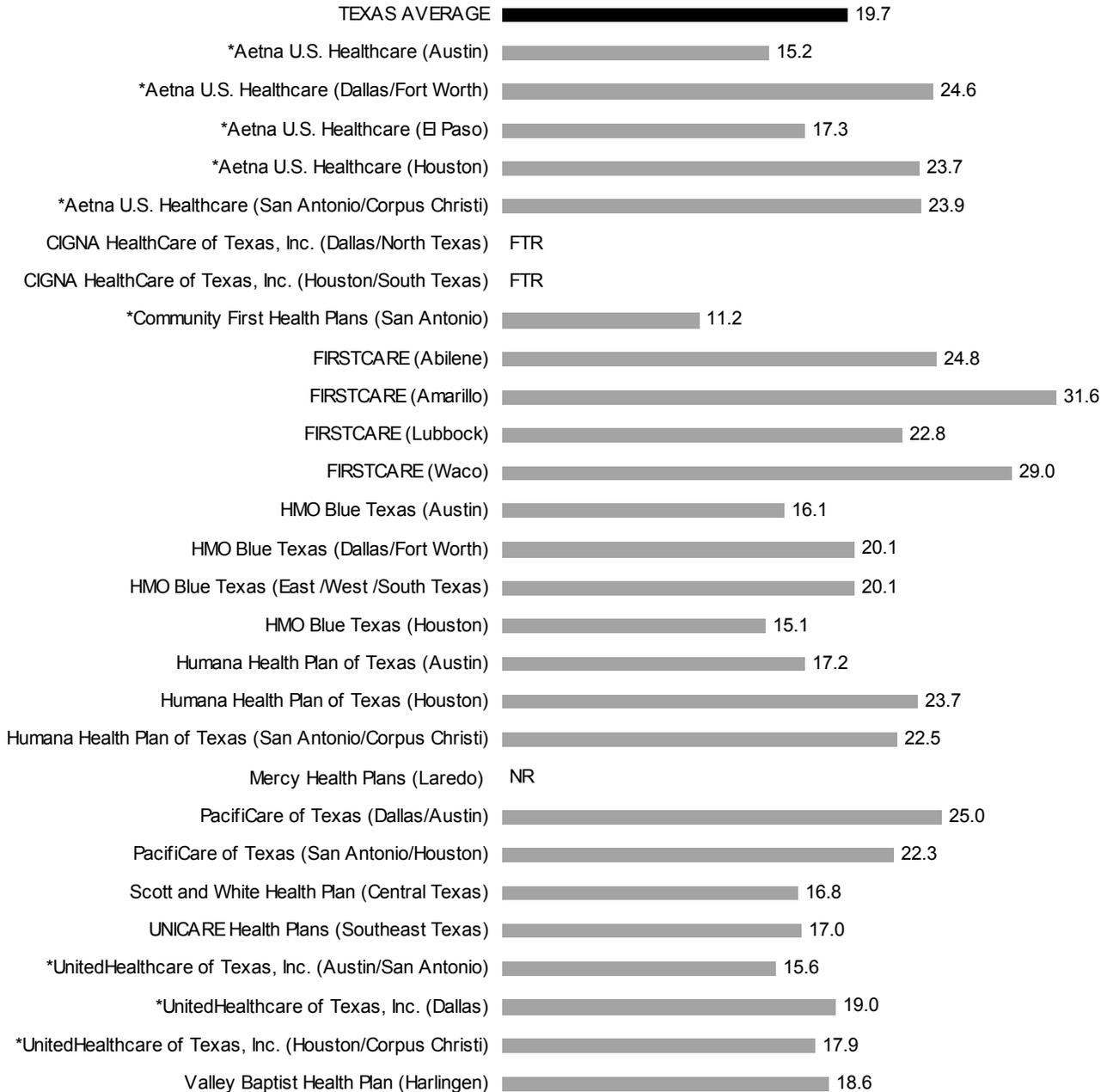
DIS - Discharges per 1,000 members per year  
ALOS - Average length of stay in days

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Inpatient Utilization - Acute Care: Surgery Discharge

**Per 1,000 Members Per Year**



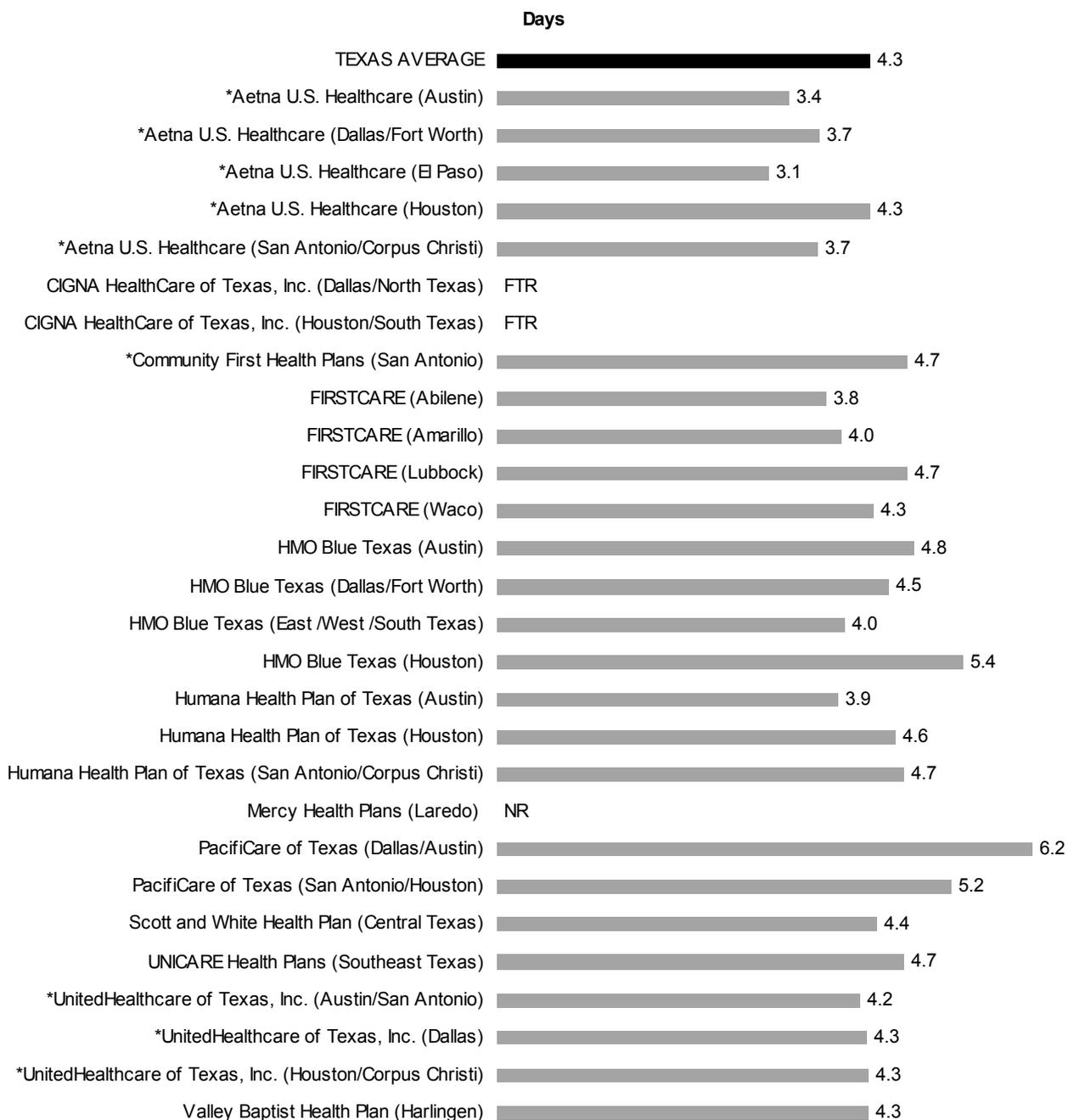
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## Inpatient Utilization - Acute Care: Surgery Average Length of Stay



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## Inpatient Utilization - General Hospital/Acute Care: Maternity

Definition: Discharges per 1,000 members per year, and average length of stay for maternity acute care services.

This measure reports the extent to which health plan members received inpatient care for maternity related services. When interpreting this information, it is important to remember that these results are not risk-adjusted for demographic characteristics such as age of the mother.<sup>1</sup>

Inpatient Utilization – General Hospital/Acute Care: Maternity										
	2005		2006		2007		2008		2009	
	DIS	ALOS								
<b>TX Average</b>	17.0	2.8	16.8	2.8	18.6	2.8	18.3	2.7	14.9	2.8
<b>NCQA's Quality Compass</b>	16.1	2.7	16.8	2.7	16.0	2.7	15.5	2.7	15.1	2.8

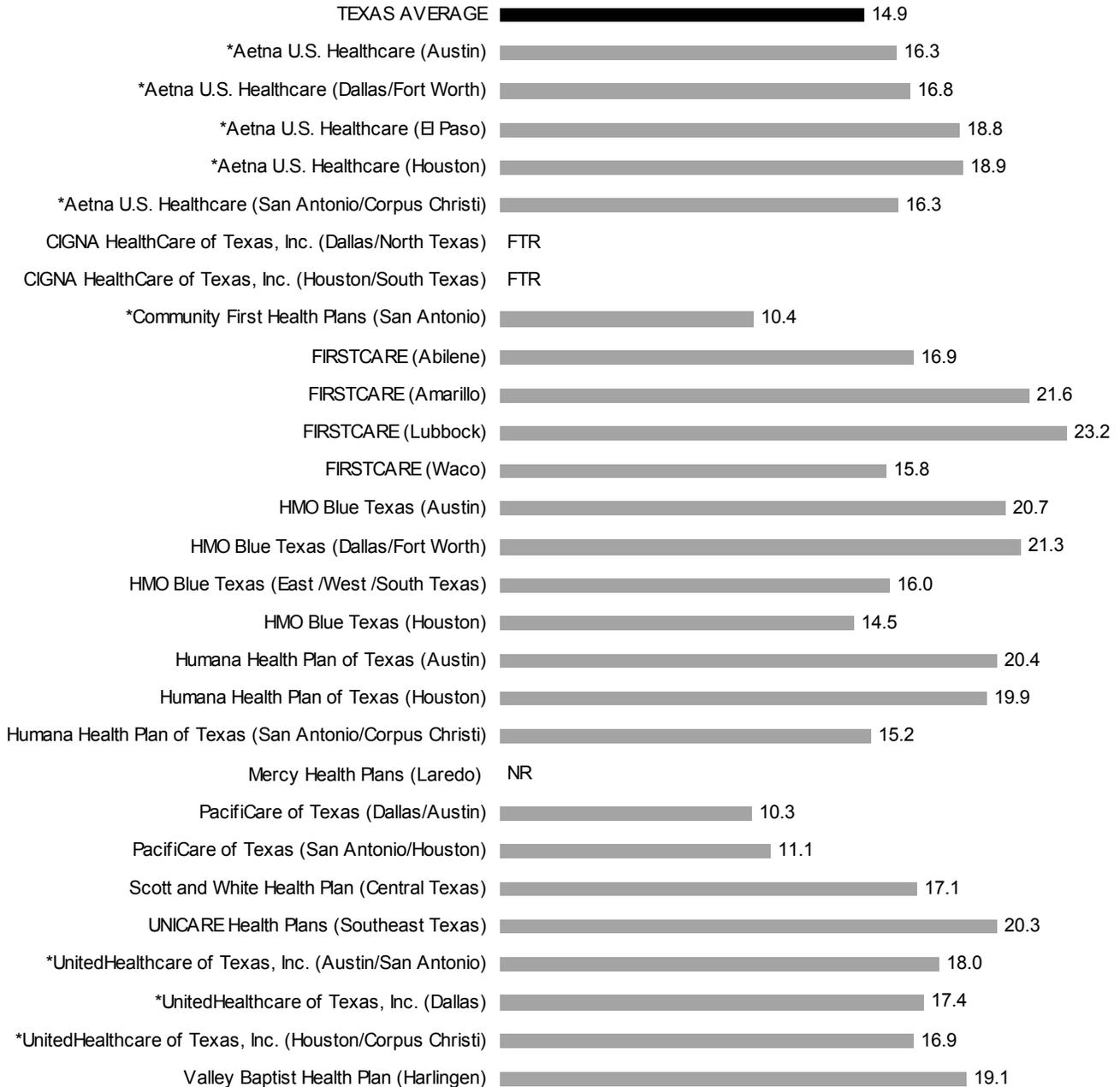
DIS - Discharges per 1,000 members per year  
ALOS - Average length of stay in days

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<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Inpatient Utilization - Acute Care: Maternity Discharge

**Per 1,000 Members Per Year**



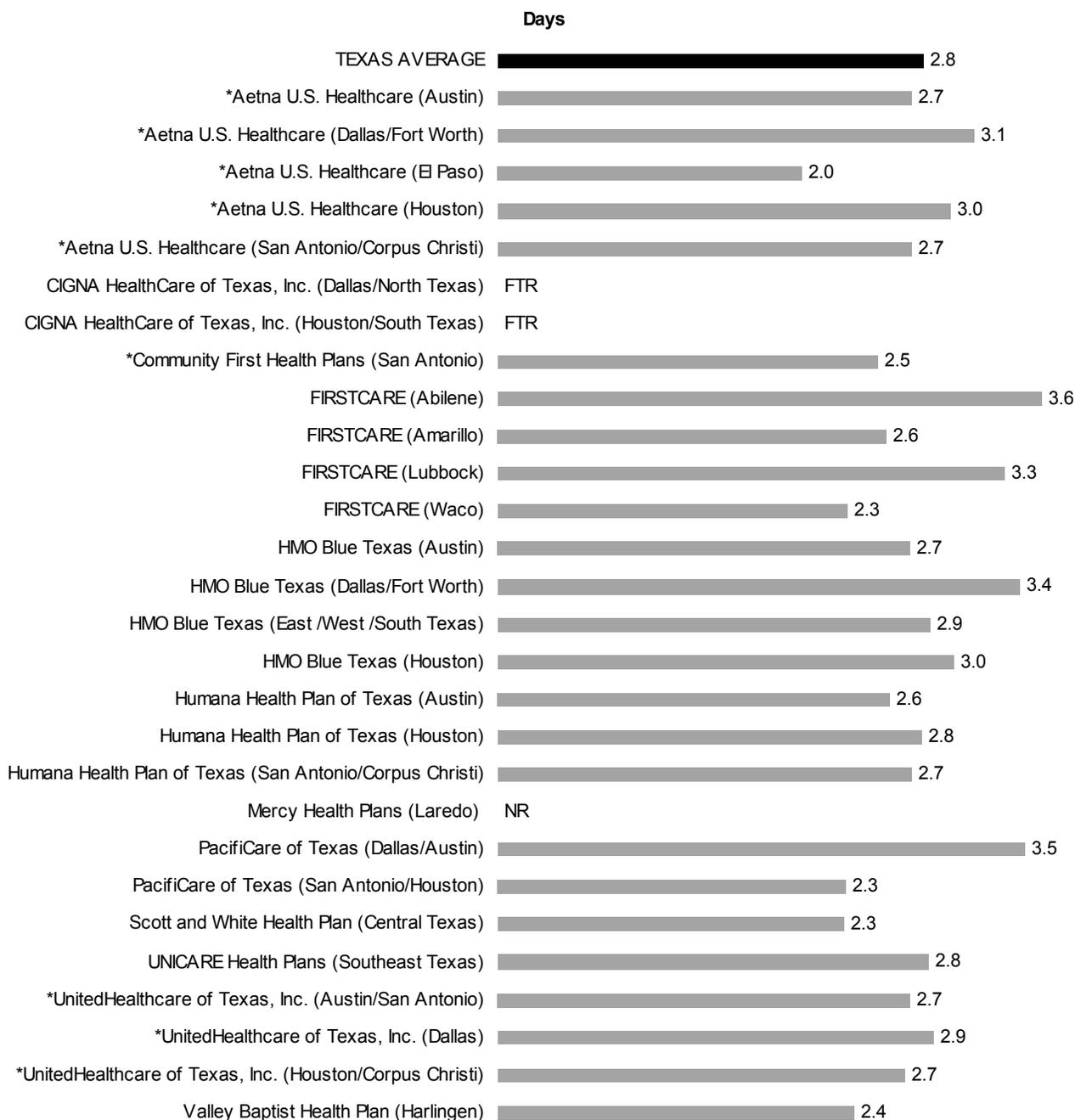
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## Inpatient Utilization - Acute Care: Maternity Average Length of Stay



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## Ambulatory Care

Definition: The number of ambulatory care services per 1,000 members per year. Ambulatory services are divided into the following categories: 1) Outpatient Visits, 2) Emergency Department Visits, 3) Ambulatory Surgery/Procedures performed in hospital, outpatient facilities or freestanding surgical centers, and 4) Observatory Room Stays that result in discharge.

**Outpatient Visits:** This category reports face-to-face encounters between the practitioner and patient for office visits or routine visits to hospital outpatient departments. It provides a reasonable proxy for professional ambulatory encounters.

**Emergency Department Visits:** This category reports the use of emergency department services, which are sometimes used as a substitute for ambulatory clinic encounters. The decision to use an emergency department rather than a clinic or physician's office may be the result of insufficient access to primary care, rather than a patient's behavior. However emergency department visits are often more costly than outpatient visits. Therefore, it is important to note unusual trends in emergency department utilization.

**Ambulatory Surgery/Procedures:** This category reports only ambulatory surgery/ procedures performed at a hospital outpatient facility or at a freestanding surgical center. Office-based surgeries/procedures are not included in this measure but are reported under Outpatient Visits.

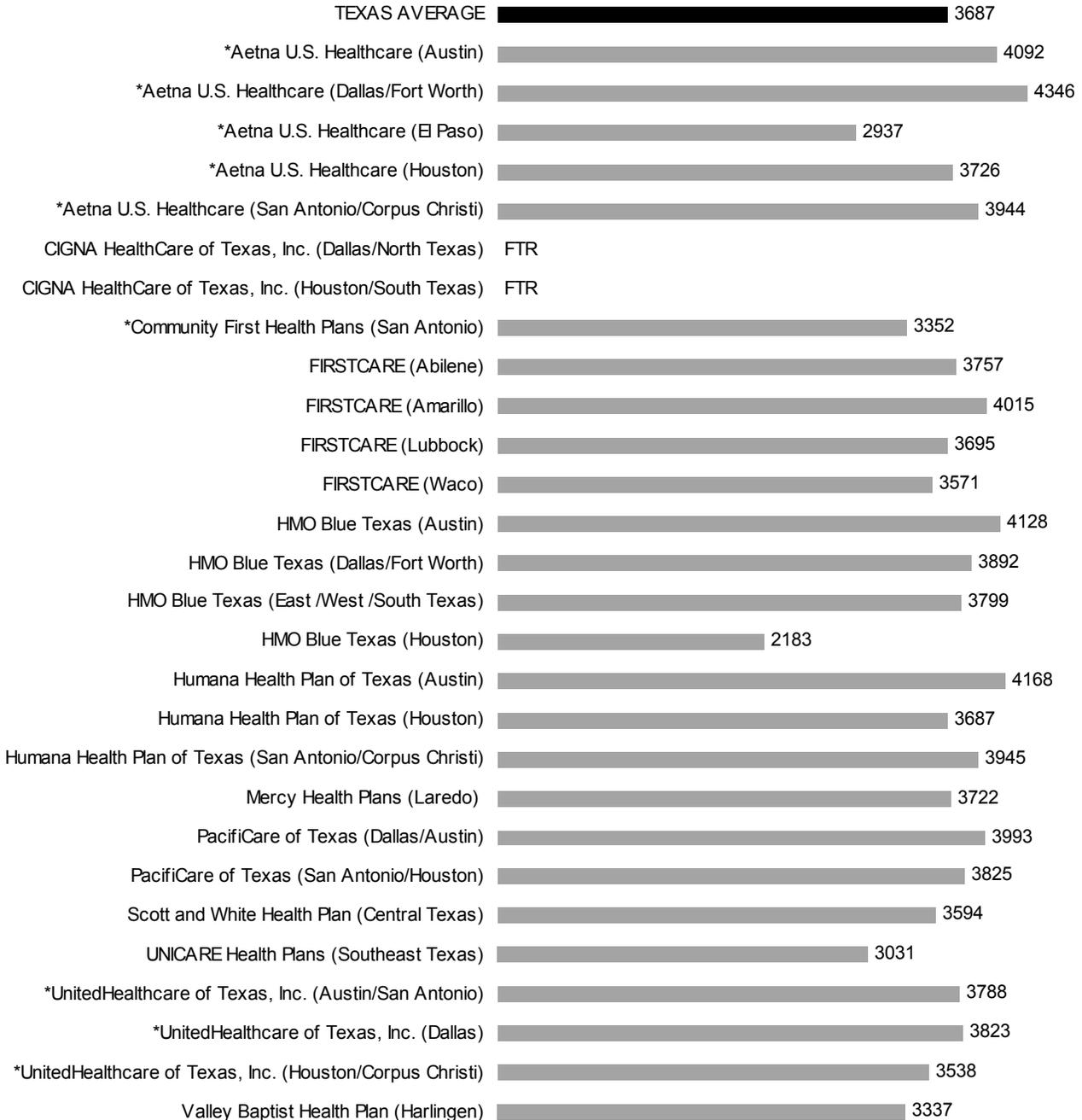
**Observation Room Stays:** This category reports observation room stays resulting in discharge of the patient. The observation room is generally part of the outpatient department of a hospital where patients stay for observation until the physician can determine whether inpatient admission is necessary.

Ambulatory care services per 1,000 members per year										
Average Rates	2005		2006		2007		2008		2009	
	Texas	QC								
Outpatient Visits	3636	3604	3629	3720	3376	3561	3336	3627	3687	3932
ED Visits	166	177	172	188	172	201	171	197	179	195
Ambulatory Surgery/ Procedures	109	114	117	119	118	126	109	124	144	151
Observation Room Stays	14	10	14	10	15	10	12	10	11	9

QC- Quality Compass<sup>®</sup>- a national database of health plan specific performance information voluntarily reported to NCQA.

## Ambulatory Care: Outpatient Visits

**Per 1,000 Members Per Year**



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

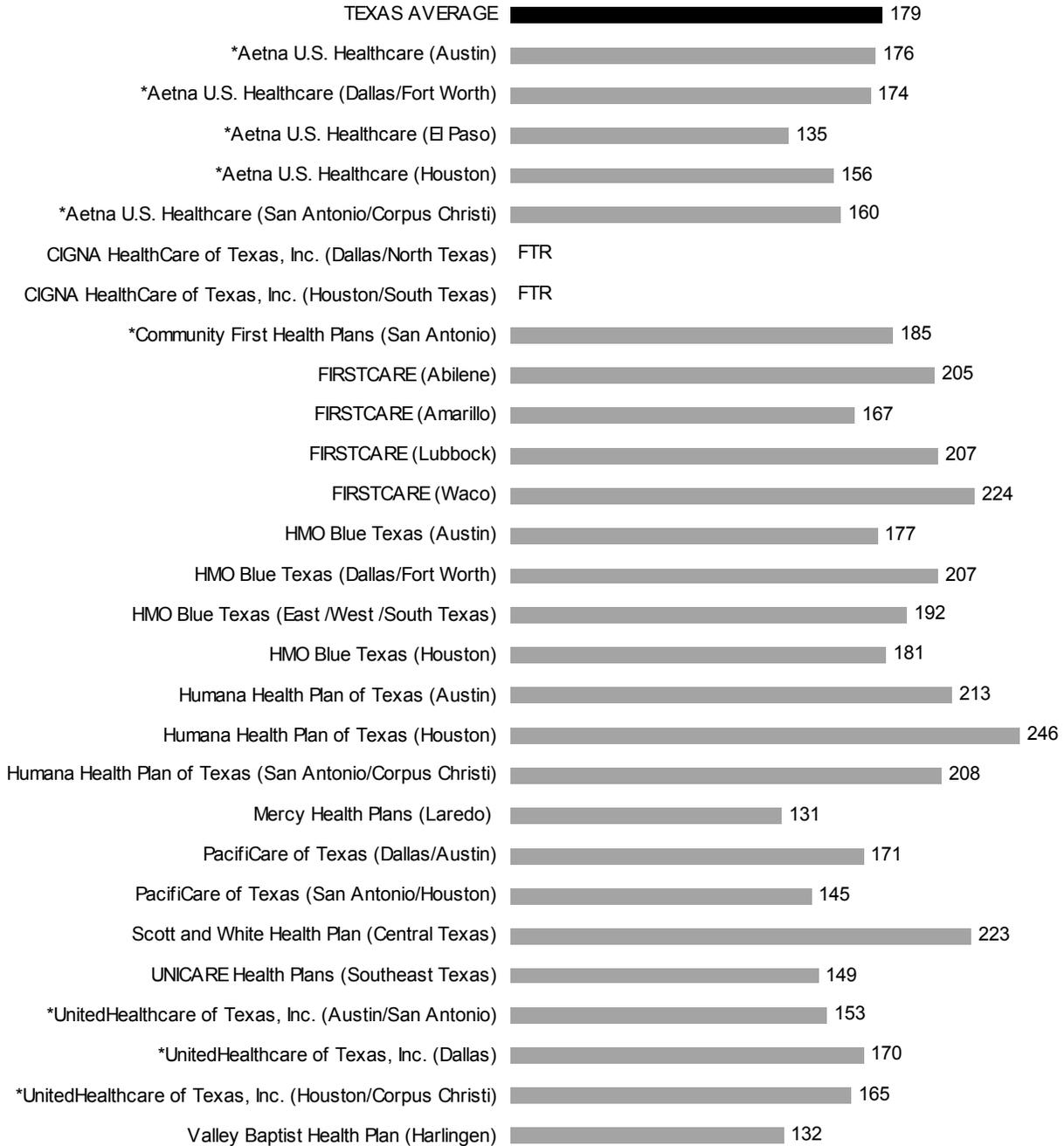
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## Ambulatory Care: Emergency Department Visits

**Per 1,000 Members Per Year**



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

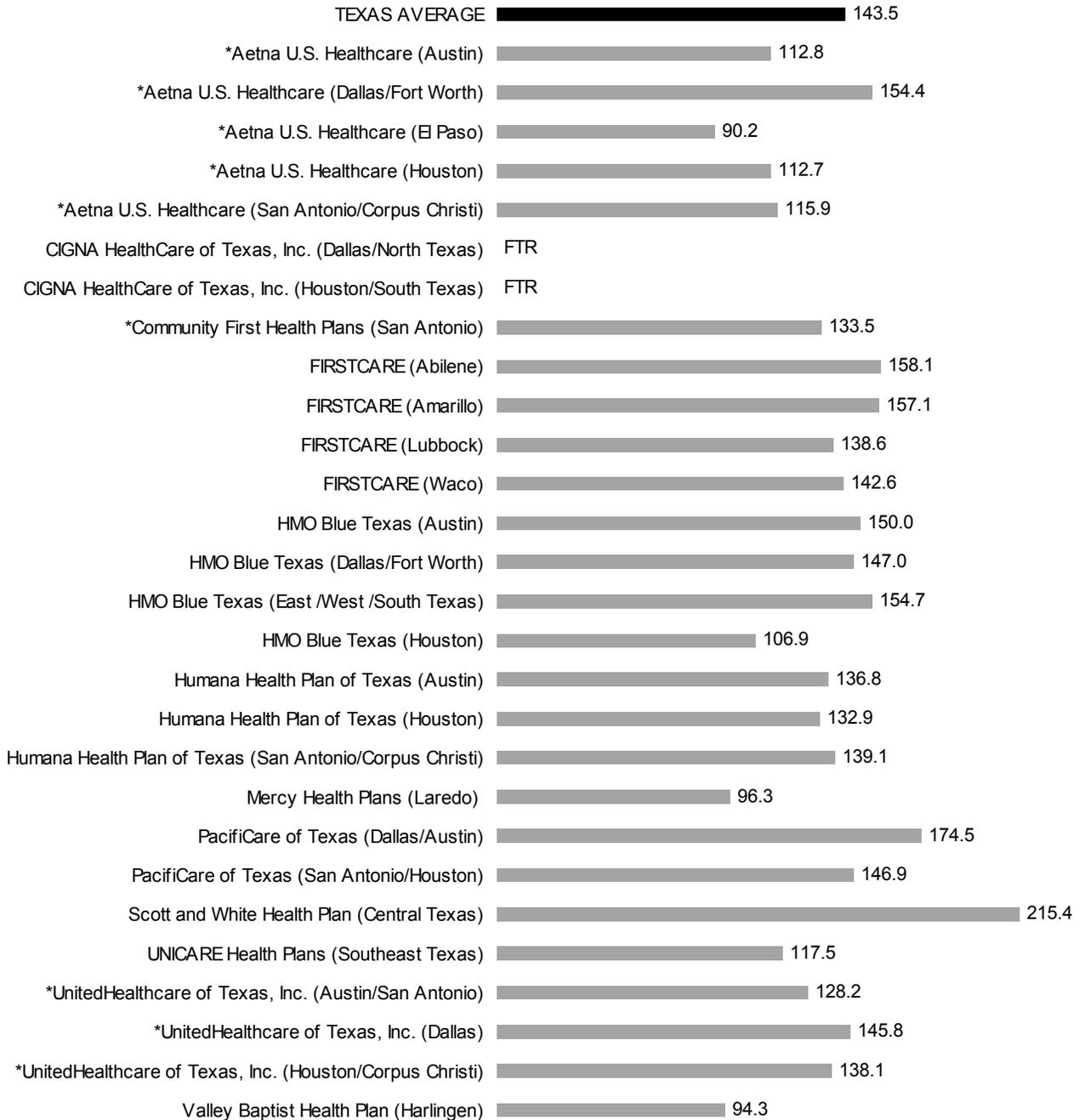
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## Ambulatory Care: Ambulatory Surgery/Procedures

**Per 1,000 Members Per Year**



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

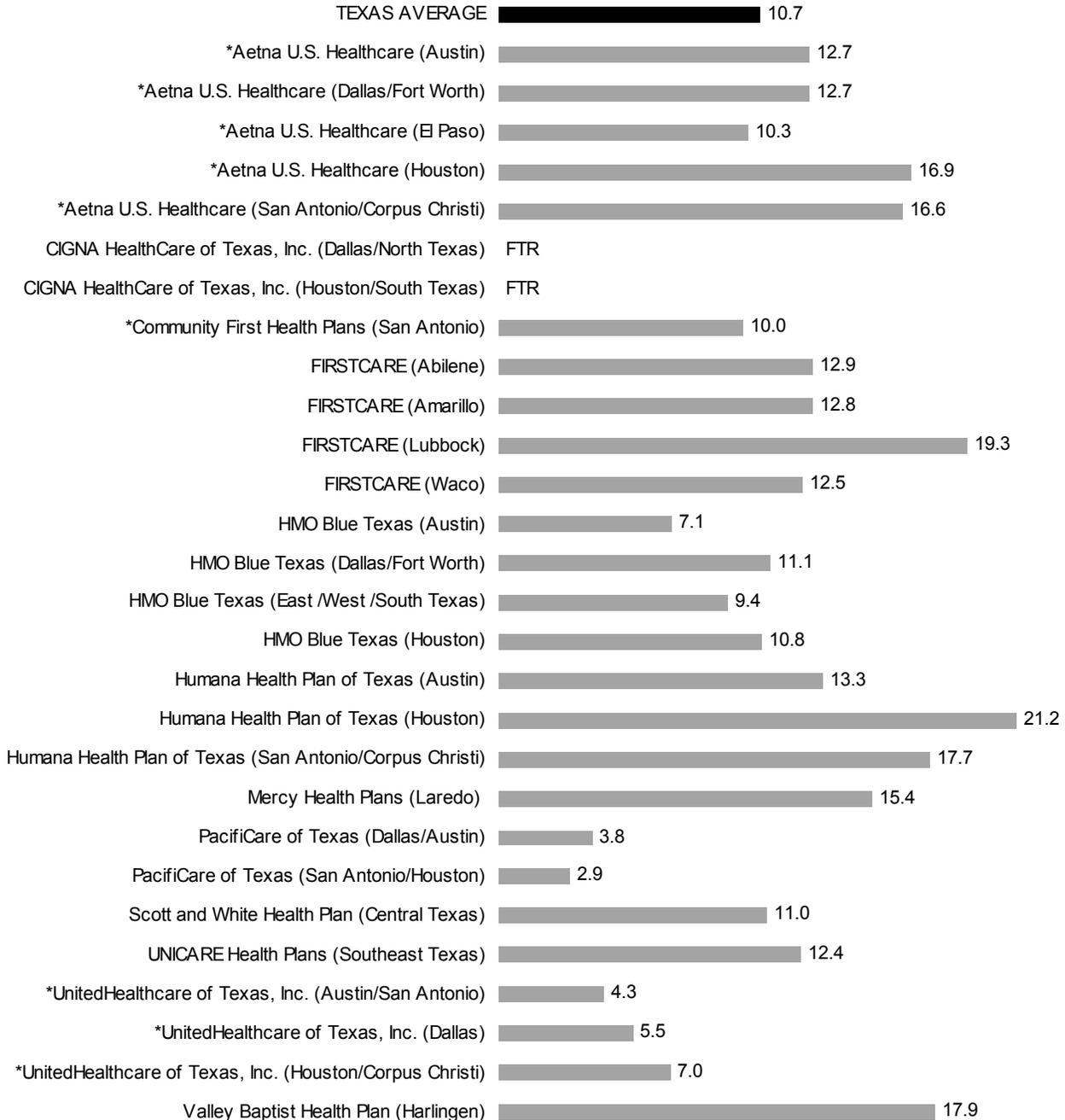
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## Ambulatory Care: Observation Room Stays

**Per 1,000 Members Per Year**



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## Mental Health Utilization: Percentage of Members Receiving Mental Health Services

Definition: The percentage of members with a mental health benefit receiving any mental health services (inpatient, intensive outpatient or partial hospitalization, or outpatient and emergency department mental health services).

It is estimated that 22.1 percent of American adults suffer from a diagnosable mental disorder.<sup>1</sup> Federal legislation defines serious mental illness as “a mental disorder that substantially interferes with one’s life activities and ability to function.” Given this definition, it is estimated that 5.4 percent of the adult population in the United States is affected by serious mental illness each year.<sup>2</sup> Approximately half of those receive some form of treatment. Overall, 15 percent of adults and 21 percent of children ages 9–17 receive some type of mental health services in any one year<sup>3</sup>, though very few of those treated receive adequate treatment.

Mental Health Utilization – Percentage of Members Receiving Inpatient, Intensive outpatient or partial hospitalization, and Outpatient or emergency department services.								
Mental Health Services Received	2006		2007		2008		2009	
	Texas	QC	Texas	QC	Texas	QC	Texas	QC
Any	4.1	5.6	4.2	5.8	4.0	5.5	4.2	5.8
Inpatient	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2
Intensive Outpatient or Partial Hospitalization	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Outpatient or Emergency Department	4.1	5.6	4.2	5.7	4.0	5.4	4.1	5.8

This measure was added to the Texas Subset beginning with HEDIS® 2006.

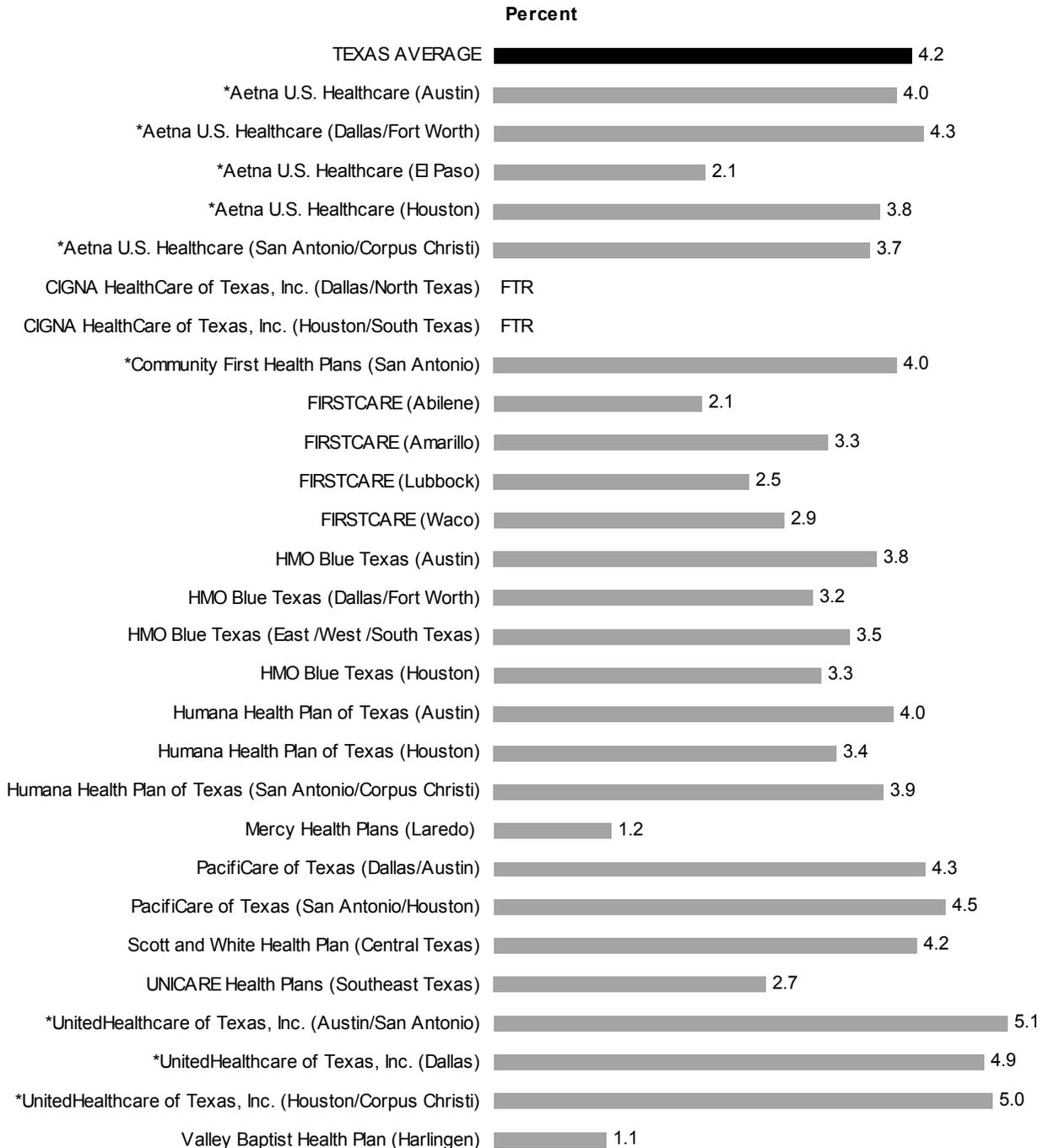
QC- Quality Compass®, a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

<sup>2</sup> Wang, P., O. Demler, R. Kessler. 2002. Adequacy of Treatment for Serious Mental Illness in the United States. *American Journal of Public Health* 92: 92-98.

<sup>3</sup> U.S. Public Health Service. 1999. *Mental Health: A Report of the Surgeon General*. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

## Mental Health Utilization: Members Receiving Any Services



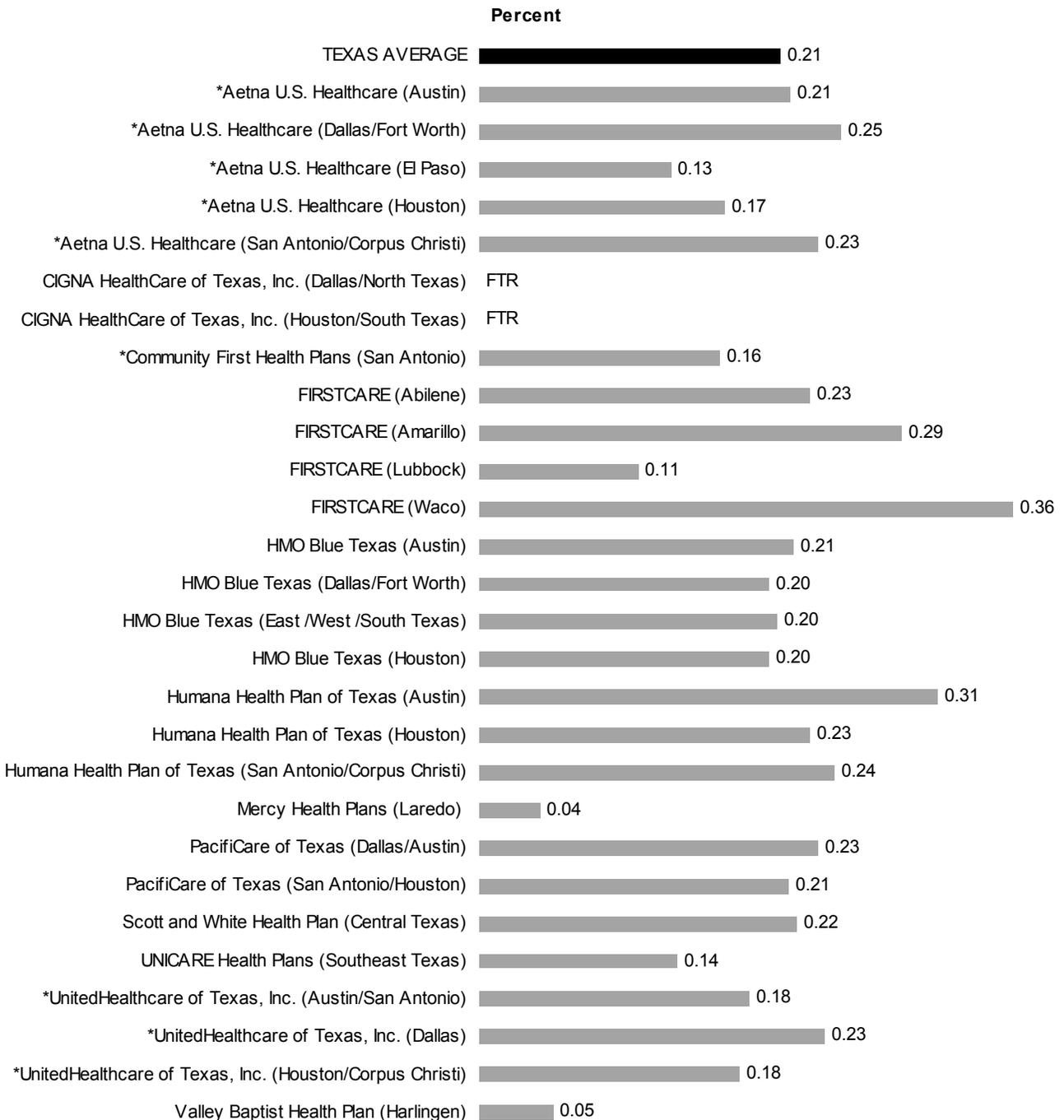
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## Mental Health Utilization: Members Receiving Inpatient Services



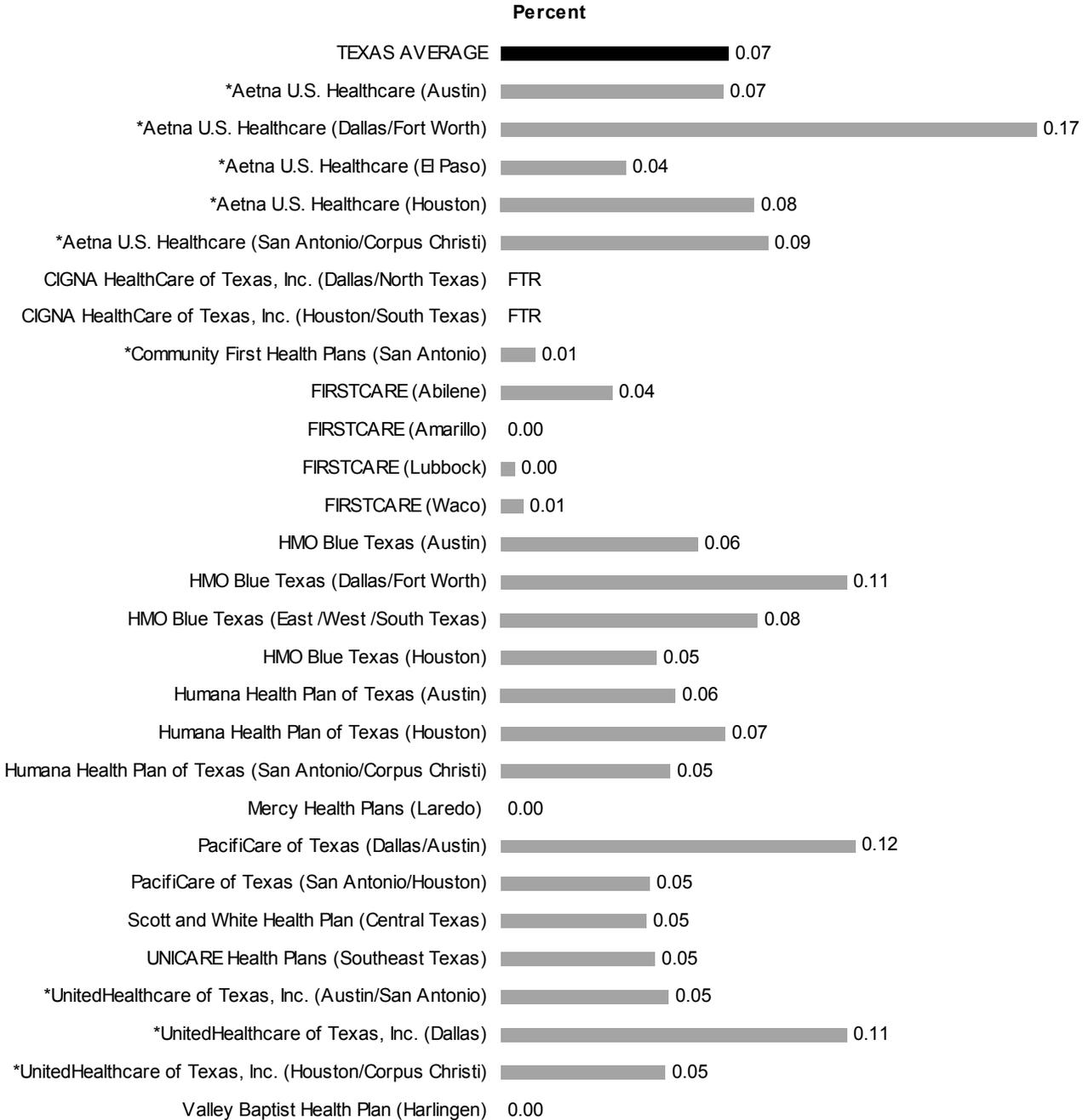
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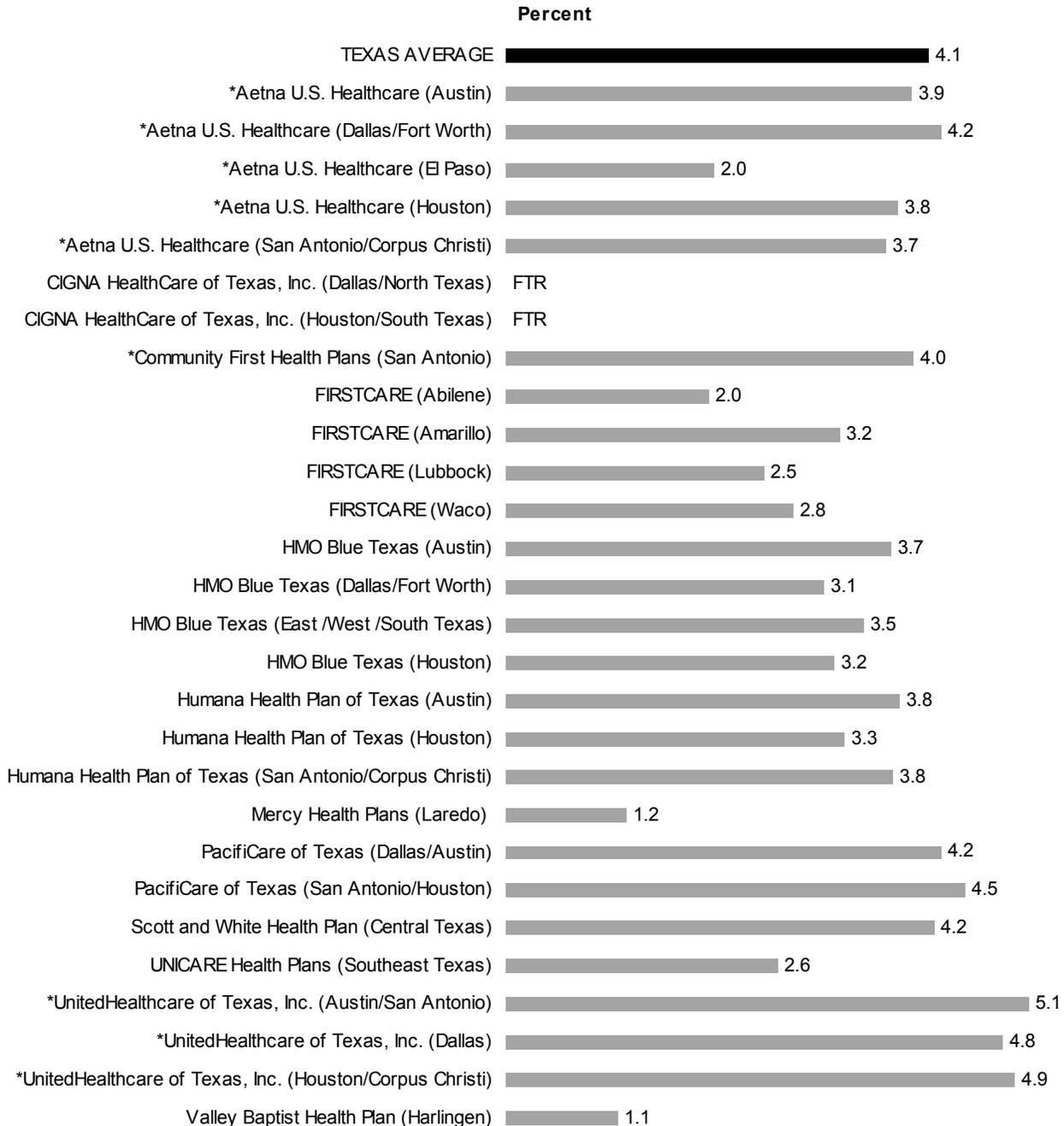
FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Mental Health Utilization: Members Receiving Intensive Outpatient or Partial Hospitalization Services



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## Mental Health Utilization: Members Receiving Outpatient or Emergency Department Services



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## Antibiotic Utilization

Definition: The average number of antibiotic prescriptions per member per year (PMPY), the average days supplied for all antibiotic prescriptions, the average number of antibiotic prescriptions (PMPY) for antibiotics of concern and the percentage of antibiotics of concern prescribed during the measurement year for outpatient utilization.

Utilization of antibiotic drugs is of particular concern due to increased antibiotic resistance complications resulting from drug resistance; increased risk of adverse drug events from unnecessary medications; and evidence in the literature of misuse and overuse of antibiotics for a number of conditions, especially common respiratory conditions such as Upper Respiratory Infections (URI) or acute bronchitis.<sup>1,2,3</sup>

There is a need to reduce overall antibiotic utilization and improve appropriate antibiotic use.<sup>4</sup> The National Ambulatory Medical Care Survey shows rates of inappropriate antibiotic prescription for uncomplicated URI at about 52 percent, and acute bronchitis at 80 percent. Reporting utilization of antibiotics for an organization's total population provides an overall and comprehensive picture of trends in antibiotic prescribing.<sup>5</sup>

Antibiotic Utilization: Outpatient Utilization of Antibiotic Prescriptions				
Outpatient Antibiotic Utilization	2008		2009	
	Texas	QC	Texas	QC
Average Number of Antibiotic Prescriptions PMPY	1.02	*	0.98	*
Average Days Supplied for All Antibiotic Prescriptions	9.4	*	9.9	*
Average Number of Prescriptions PMPY for Antibiotics of Concern**	0.56	*	0.56	*
Percentage of Antibiotics of Concern For All Antibiotic Prescriptions	54.7%	*	57.0%	*

This measure was added to the Texas Subset beginning with HEDIS® 2008.

QC- Quality Compass®, a national database of health plan specific performance information voluntarily reported to NCQA.

\* Value not established or not obtained.

\*\* Certain classes of antibiotics determined by NCQA to be "of concern" because of inappropriate usage and/or contributing to antibiotic drug resistance.

<sup>1</sup> Cunha, B.A. Antibiotic side-effects. 2001. *Medical Clinics of North America* 85(1):149-185.

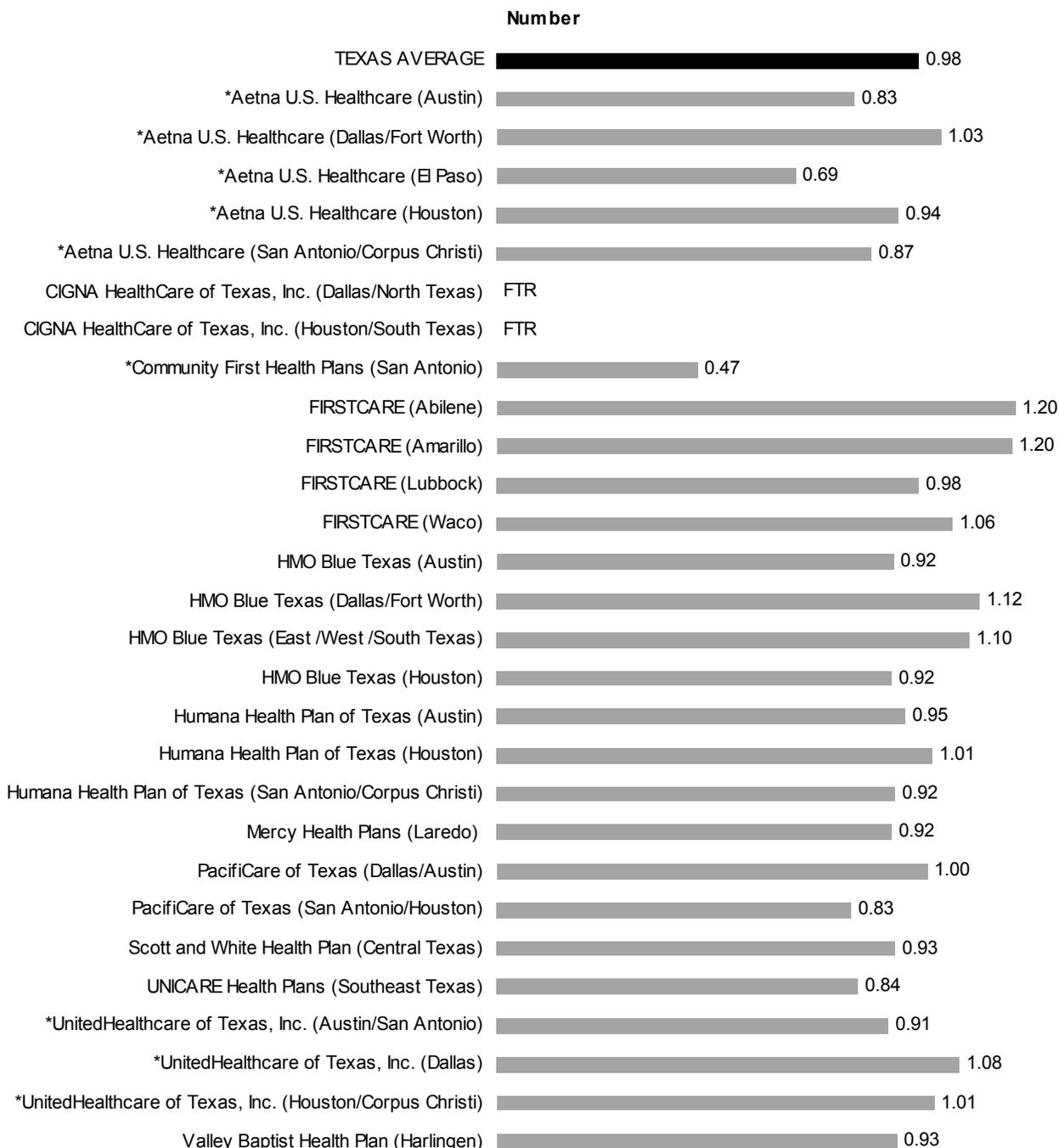
<sup>2</sup> Feikin, D.R., A. Schuchat, M. Kolczak, N.L. Barrett, L.H. Harrison, L. Lefkowitz, et al. 2000. Mortality from invasive pneumococcal pneumonia in the era of antibiotic resistance, 1995–1997. *American Journal of Public Health* 90(2):223-229.

<sup>3</sup> Watanabe, H., S. Sato, K. Kawakami, K. Watanabe, K. Oishi, N. Rikitomi, et al. 2000. A comparative clinical study of pneumonia by penicillin-resistant and sensitive *Streptococcus pneumoniae* in a community hospital. *Respirology*.

<sup>4</sup> Zebrowska-Lupina, I., G. Szymczyk, A. Wrobel. 2000. Adverse effects of interactions of antibiotics with other drugs. *Pol Merkuriusz Lek.* 9 (51):623-626.

<sup>5</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Antibiotic Utilization: Average Number of Prescriptions PMPY



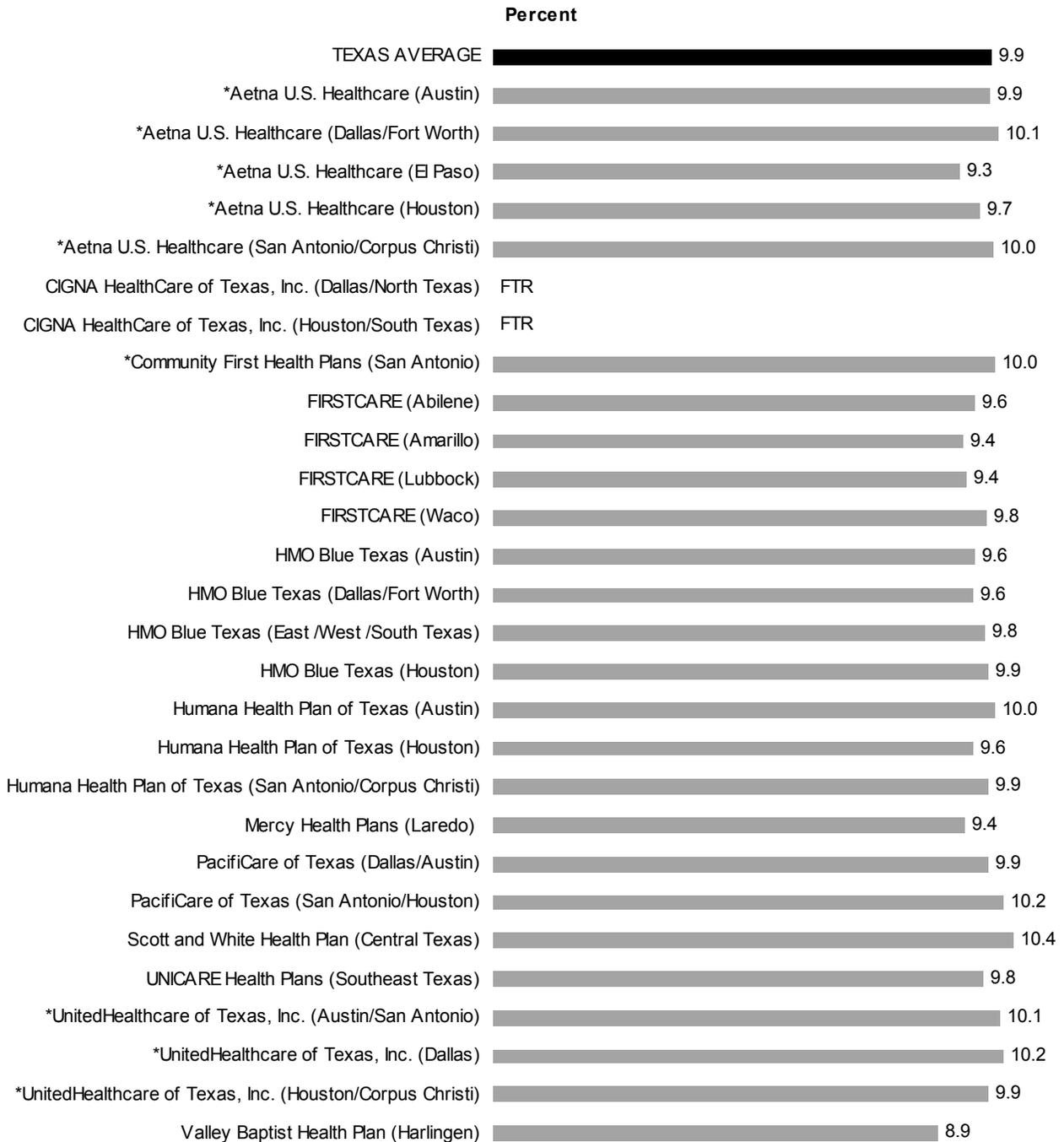
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## Antibiotic Utilization: Average Days Supplied Per Antibiotic Prescription



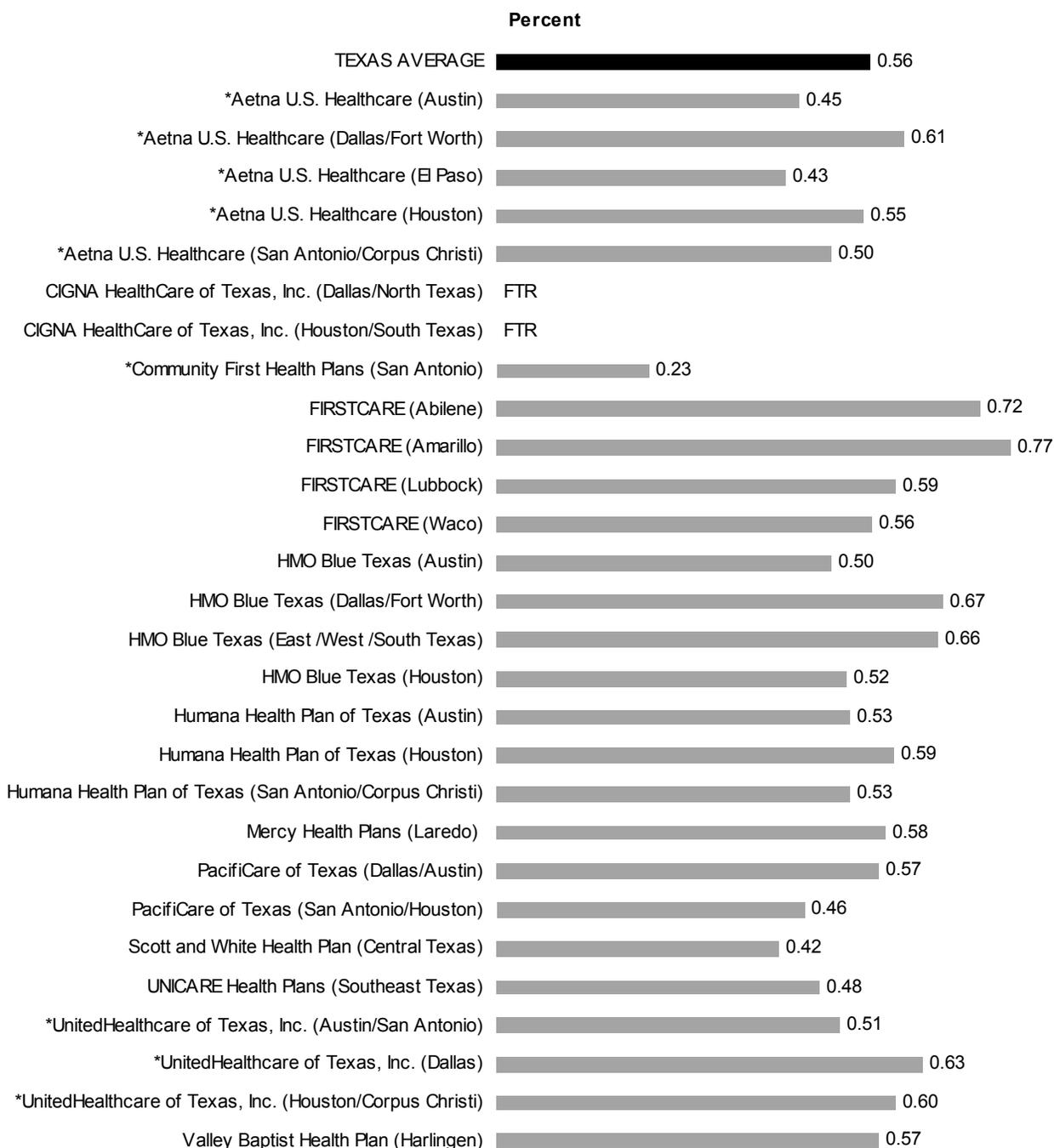
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## Antibiotic Utilization: Ave. Number of Prescriptions for Antibiotics of Concern PMPY



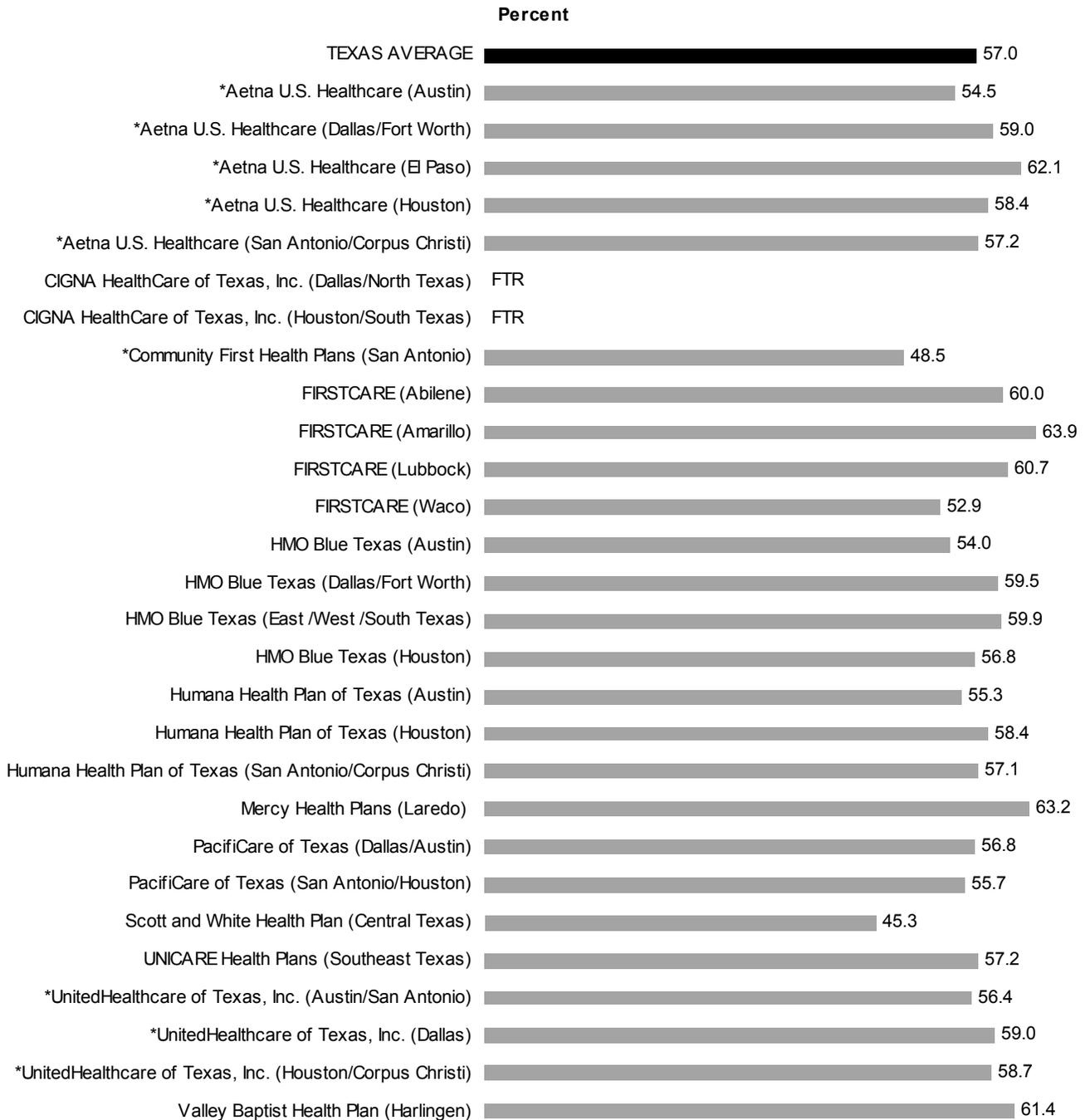
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## Antibiotic Utilization: Percent Antibiotics of Concern for All Antibiotic Prescriptions



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## Identification of Alcohol and Other Drug Services

Definition: The percentage of members with a chemical dependency benefit with a diagnosis of alcohol and other drug abuse or dependence receiving any chemical dependency services (includes inpatient, intensive outpatient or partial hospitalization, and outpatient or emergency department services).

There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance use and abuse places a huge burden on the health care system.<sup>1</sup>

This measure provides an overview of members with an alcohol and other drug (AOD) dependence diagnosis and the extent to which the different levels of chemical dependency services are used. It reports the number and percentage of members with an AOD claim (i.e., containing a diagnosis of AOD abuse or dependence and a specific AOD-related service during the measurement year) in the following categories.

- Any Service
- Inpatient Services
- Intensive Outpatient or Partial Hospitalization Services
- Outpatient or ED Services

In each category, the organization reports by age and sex the number of members with an AOD diagnosis who received the service and the percentage that received the service out of all members with a chemical dependency benefit.<sup>2</sup>

Identification of Alcohol and Other Drug Services: Percent Receiving Services									
Chemical Dependency Services Received	2006		2007		2008		2009		
	Texas	QC	Texas	QC	Texas	QC	Texas	QC	
<b>Any</b>	0.5	0.8	0.6	0.8	0.7	0.9	0.7	1.0	
<b>Inpatient</b>	0.2	0.2	0.2	0.3	0.2	0.3	0.2	0.3	
<b>Intensive Outpatient or Partial Hospitalization</b>	0.1	0.04	0.00	0.04	0.09	0.09	0.10	0.09	
<b>Outpatient or Emergency Department</b>	0.4	0.6	0.4	0.7	0.6	0.7	0.5	0.8	

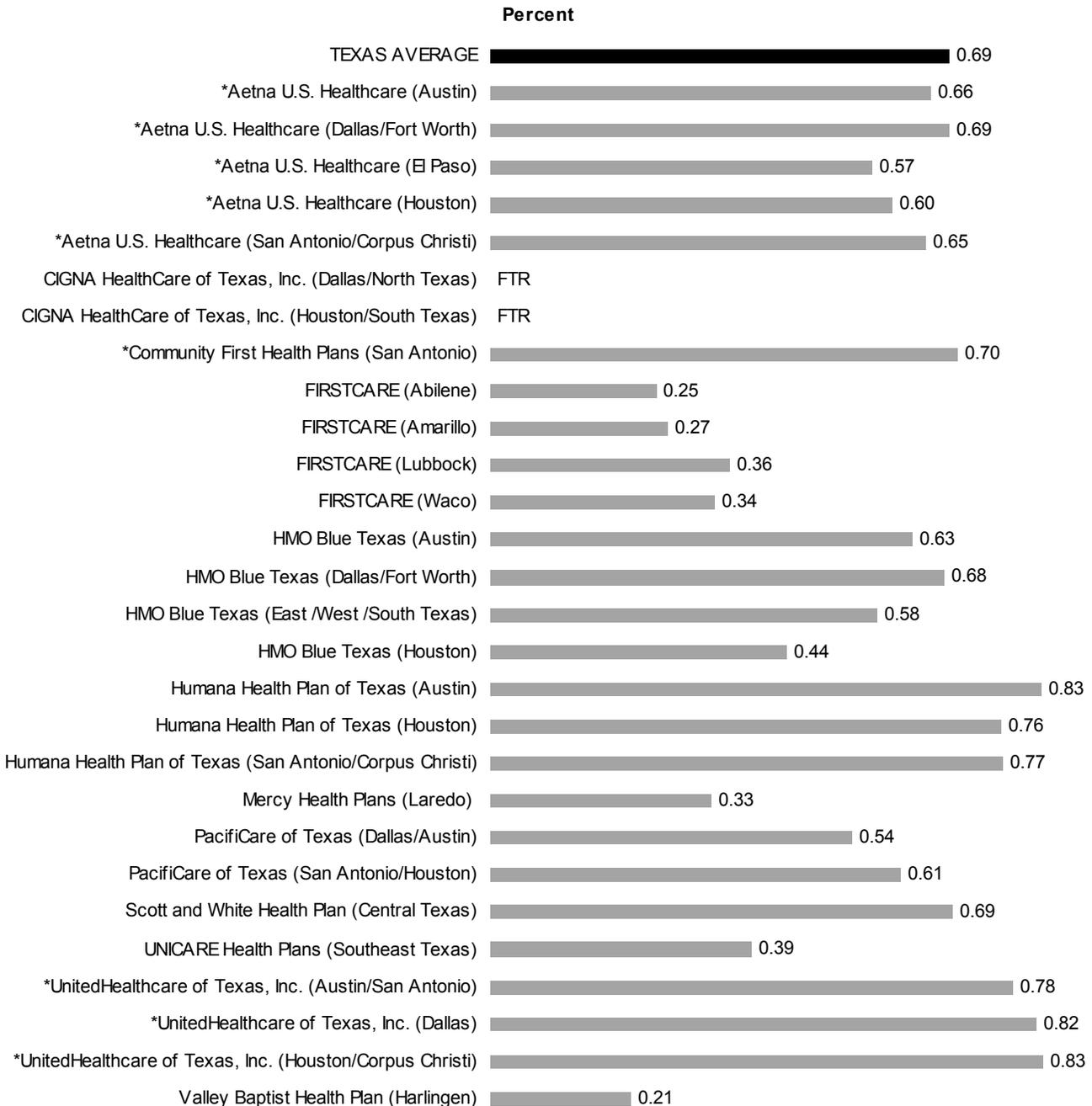
This measure was added to the Texas Subset beginning with HEDIS® 2006.

QC- Quality Compass®, a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> Schneider Institute for Health Policy, Brandeis University. 2001. Substance Abuse: The Nation's Number One Health Problem, Robert Wood Johnson Foundation, Princeton, New Jersey.

<sup>2</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008

## Alcohol and Other Drug Services: Members Receiving Any Services



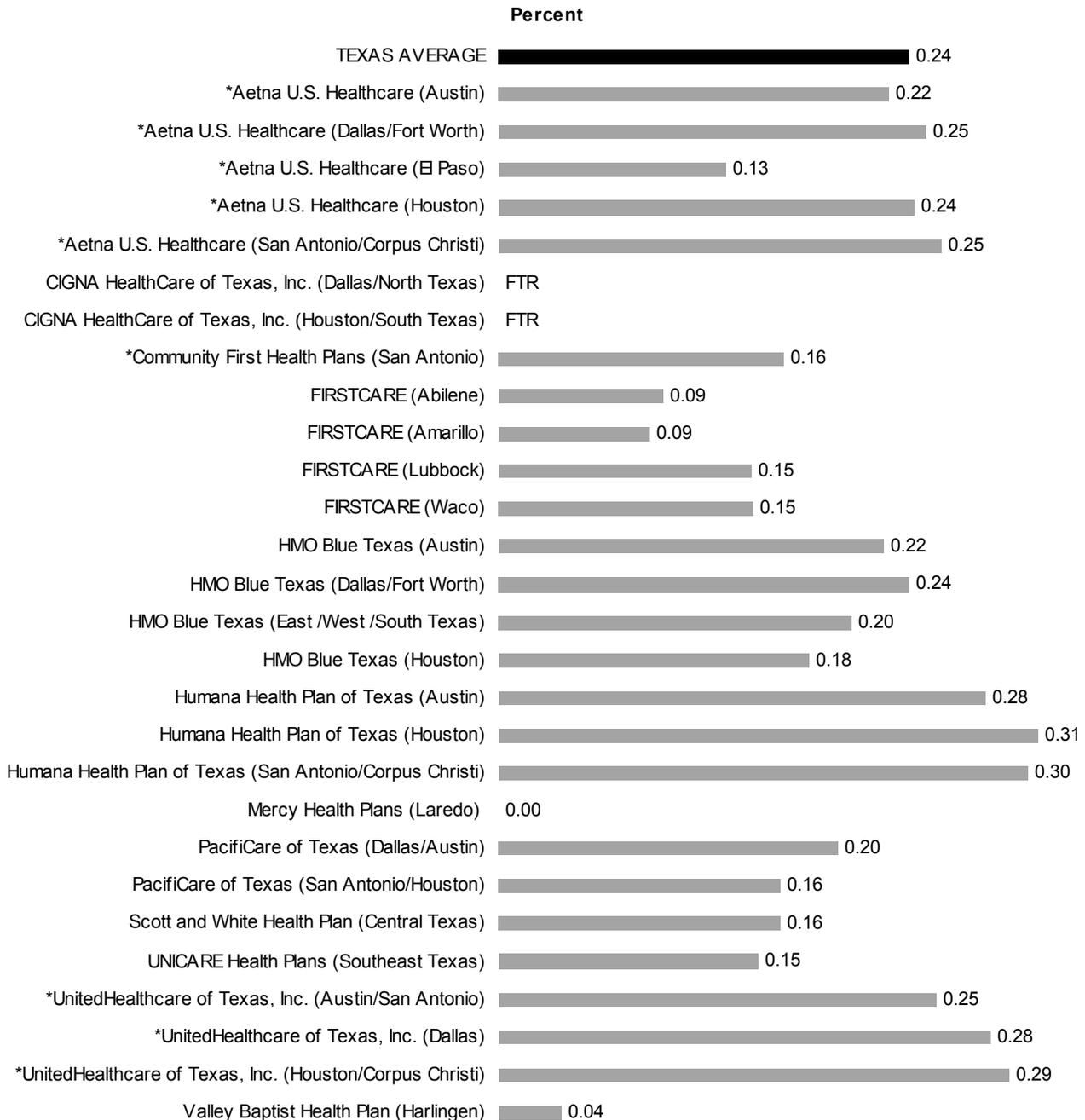
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## Alcohol and Other Drug Services: Members Receiving Inpatient Services



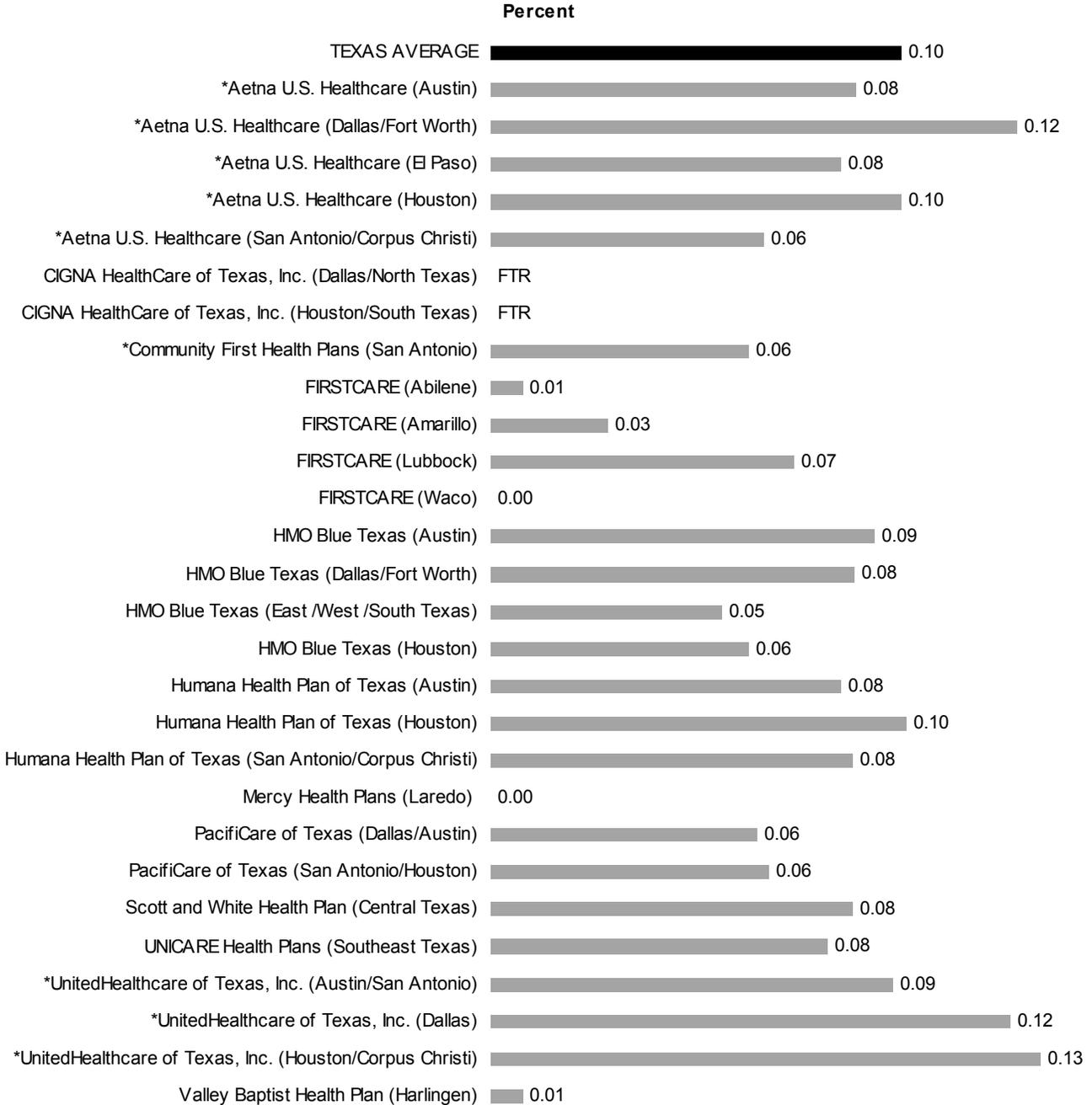
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## Alcohol and Other Drug Services: Members Receiving Intensive Outpatient & Partial Hospitalization



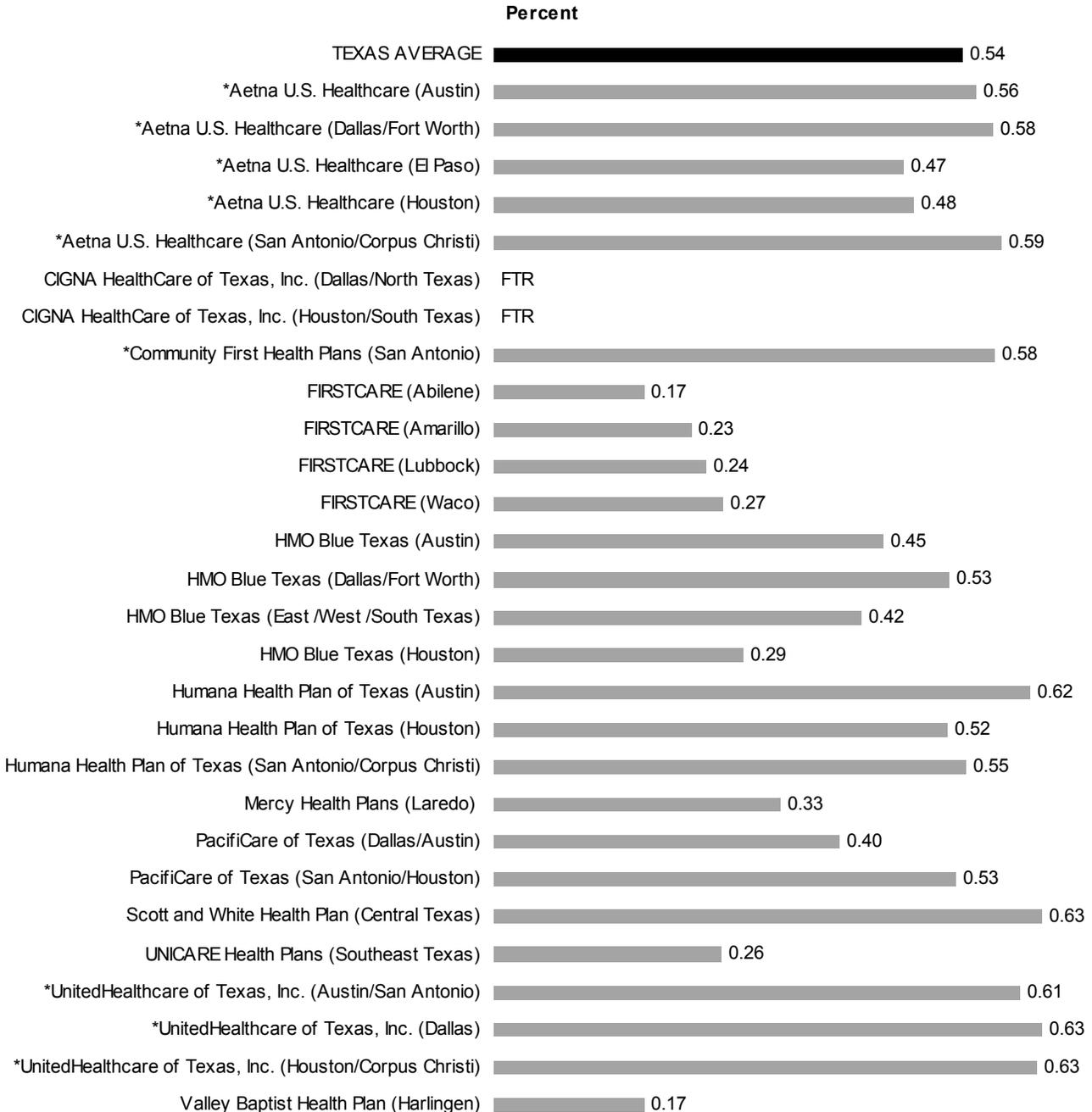
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## Alcohol and Other Drug Services: Members Receiving Outpatient and ED



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.

FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Outpatient Drug Utilization

Definition: The average cost of prescriptions per member per month (PMPM) and the average number of prescriptions per member per year (PMPY) during the measurement year for outpatient utilization of drug prescriptions.

Expenditures for prescription drugs in the U.S. continues to be the fastest growing component of health care. As measured by various research groups and by the federal government, prescription drug spending has risen 15 percent or more per year over the past several years.<sup>1,2</sup> Managing the cost of prescription medications is only one aspect of managing utilization. Formulary development and compliance help reduce unnecessary variation in prescribing habits, but may be unnecessarily restrictive to practicing clinicians. Use of a less-effective drug may result in unnecessary hospitalization or in a patient whose quality of life is eroded by unacceptable side effects. A total disease management approach avoids focusing on one component of care that might result in poor outcome and increased total cost of care.<sup>3</sup>

This measure provides information for members with a pharmacy benefit and reports information on the following data.

- Total cost of prescriptions
- Average cost of prescriptions per member per month (PMPM)
- Total number of prescriptions
- Average number of prescriptions per member per year (PMPY)

Outpatient Drug Utilization								
	2006		2007		2008		2008	
	Texas	QC	Texas	QC	Texas	QC	Texas	QC
<b>Average Cost of Prescriptions PMPM</b>	\$36.70	\$49.82	\$57.34	\$53.89	\$53.81	\$52.97	\$58.26	\$59.22
<b>Average Number of Prescriptions PMPY</b>	11.1	11.1	11.3	11.6	11.9	11.7	11.3	12.1

This measure was added to the Texas Subset beginning with HEDIS® 2006.

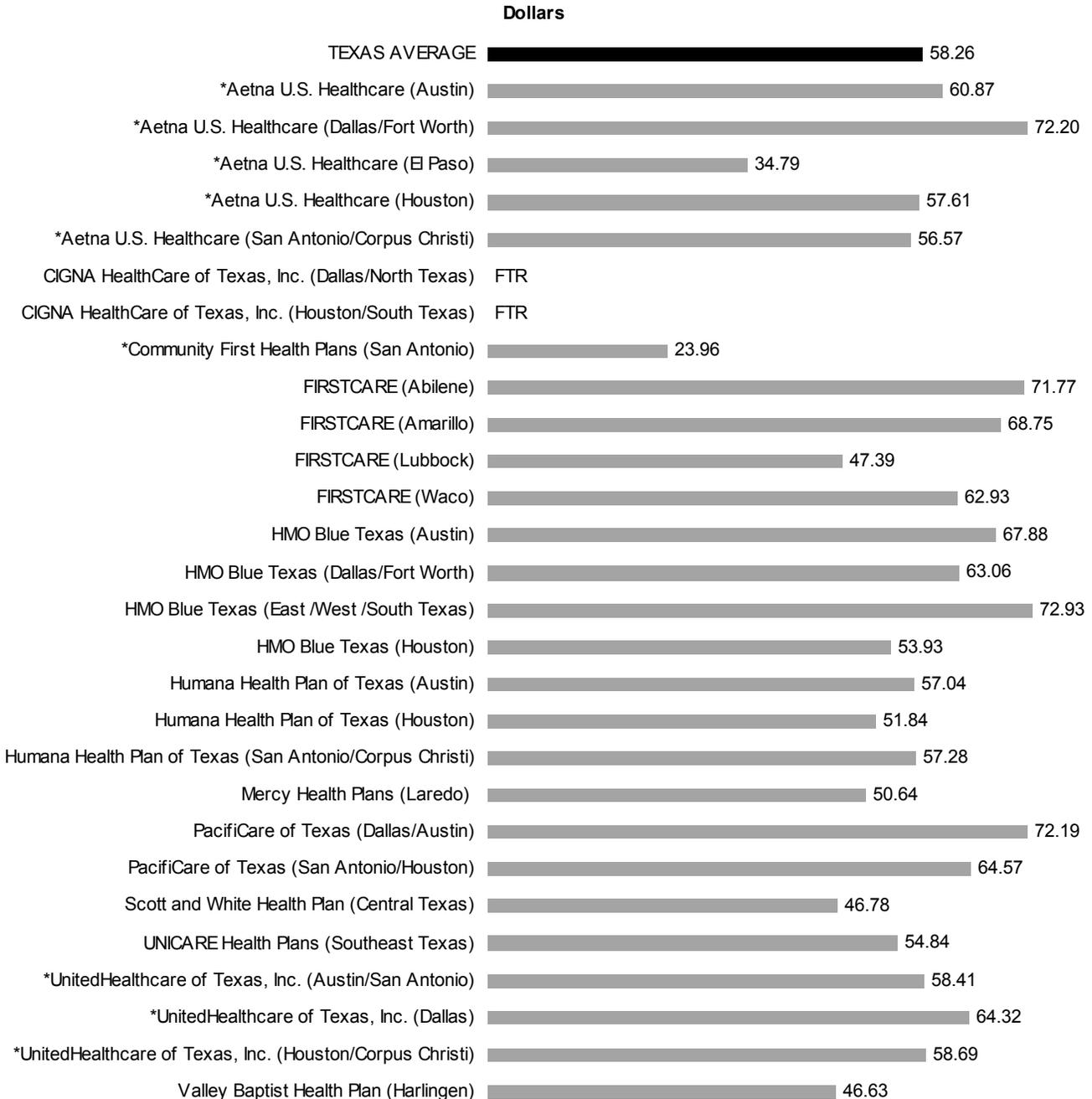
QC- Quality Compass®, a national database of health plan specific performance information voluntarily reported to NCQA.

<sup>1</sup> Katharine Levit et al. 2002. Inflation Spurs Health Spending in 2000. *Health Affairs* 21(1):172-181.

<sup>2</sup> Strunk, B.C., et al. 2001. Tracking Health Care Costs. *Health Affairs* Web Exclusive. [www.healthaffairs.org](http://www.healthaffairs.org).

<sup>3</sup> National Committee for Quality Assurance (NCQA), HEDIS® 2009 Volume 1 Narrative, 2008.

## Outpatient Drug Utilization: Average Cost of Prescriptions PMPM



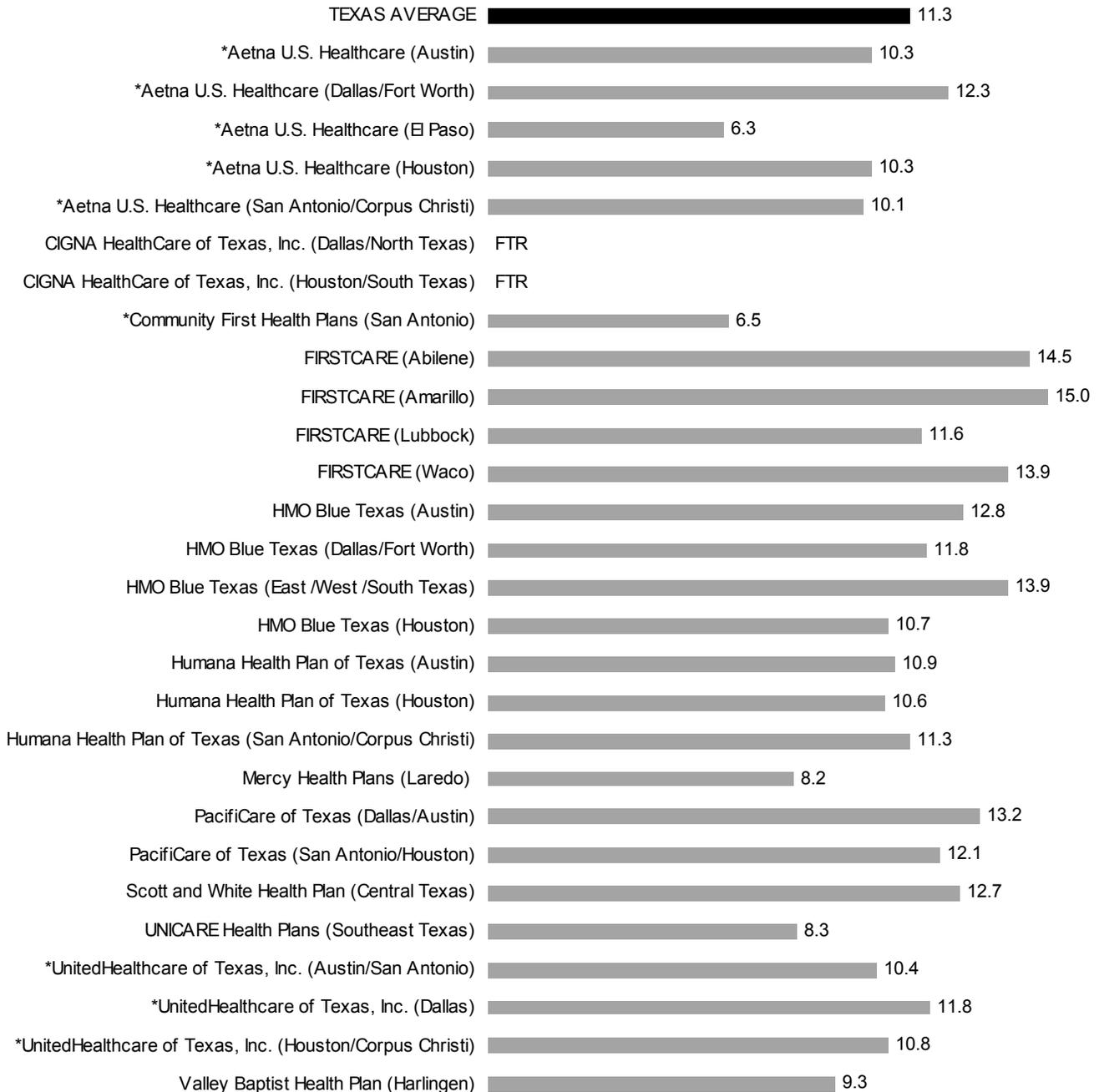
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Outpatient Drug Utilization: Average Number of Prescriptions PMPY



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

NA- The plan did not have a large enough sample to report a valid rate.

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## Board Certification

Definition: The percentage of physicians whose board certification is active as of December 31st of the measurement year.

Board certification provides information on the credentials of the physicians who belong to the plan. If physicians are board certified, it means they have completed residency training and a certification program in their specific field of practice. The percentage of board certified physicians in each plan does not directly measure the quality of every doctor in the plan. It provides basic information about the credentials of the plan's physicians.

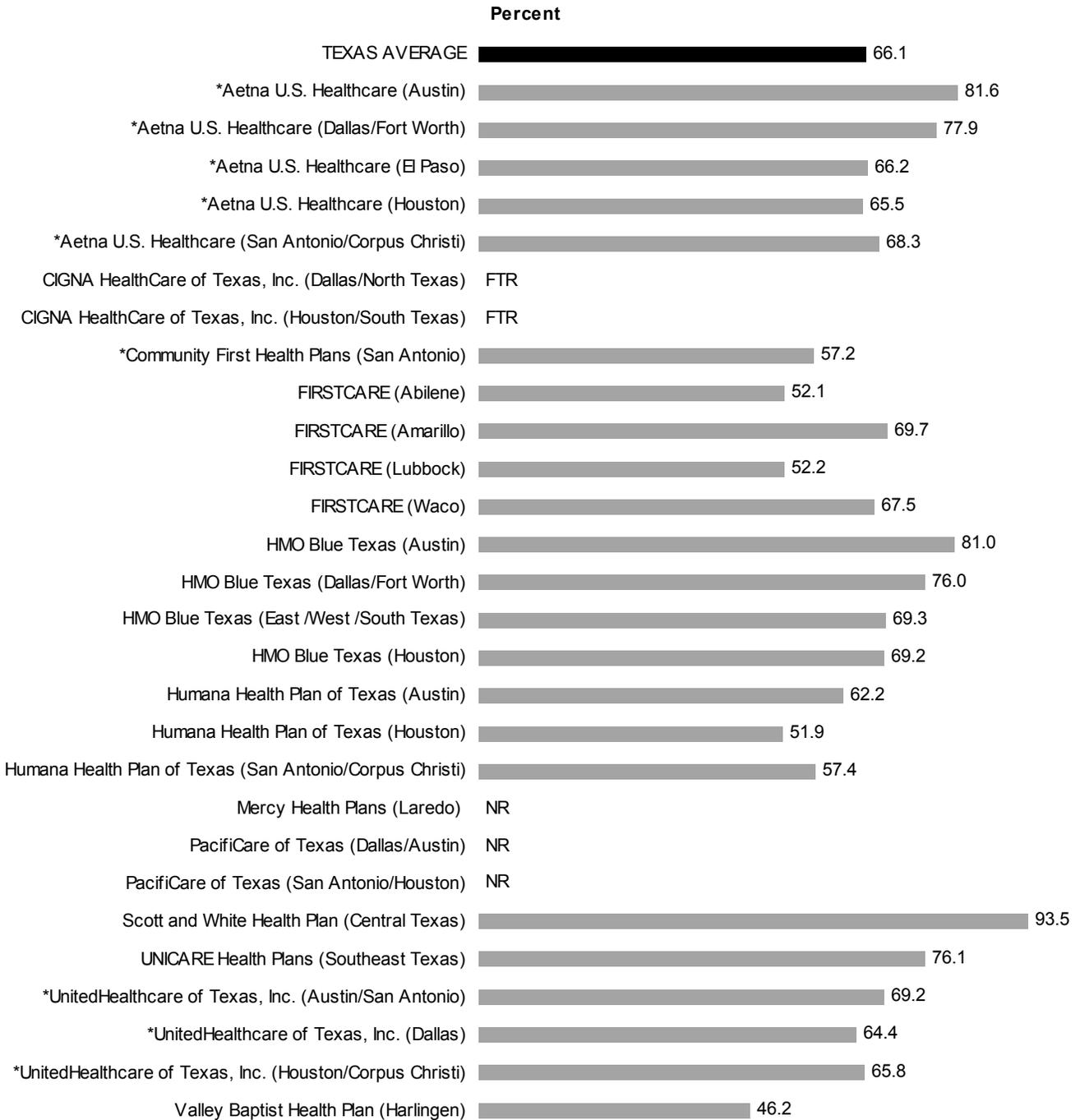
For 2008, Primary Care Practitioners was replaced with Family Medicine Physicians and Internal Medicine Physicians categories.

Percent of Physicians with Board Certification										
	2005		2006		2007		2008		2009	
	Texas	QC								
<b>Family Medicine Physicians</b>	*	*	*	*	*	*	63.7	75.0	66.1	77.5
<b>Internal Medicine Physicians</b>	*	*	*	*	*	*	61.8	77.0	69.8	79.9
<b>OB/GYNs</b>	80.4	81.2	77.5	81.5	74.9	80.1	64.2	73.6	67.8	76.1
<b>Pediatricians</b>	80.1	78.2	69.7	76.4	61.7	74.1	72.4	79.2	74.7	82.0
<b>Geriatricians</b>	76.8	74.6	66.9	72.6	57.3	71.6	48.9	67.5	44.9	68.8
<b>Other Physician Specialists</b>	78.2	81.1	77.8	80.6	74.5	79.1	66.8	74.3	68.9	77.2

\* Value not established or not obtained.

QC- Quality Compass<sup>®</sup> is a national database of health plan specific performance information voluntarily reported to NCQA.

## Board Certification Rate: Family Medicine Physicians



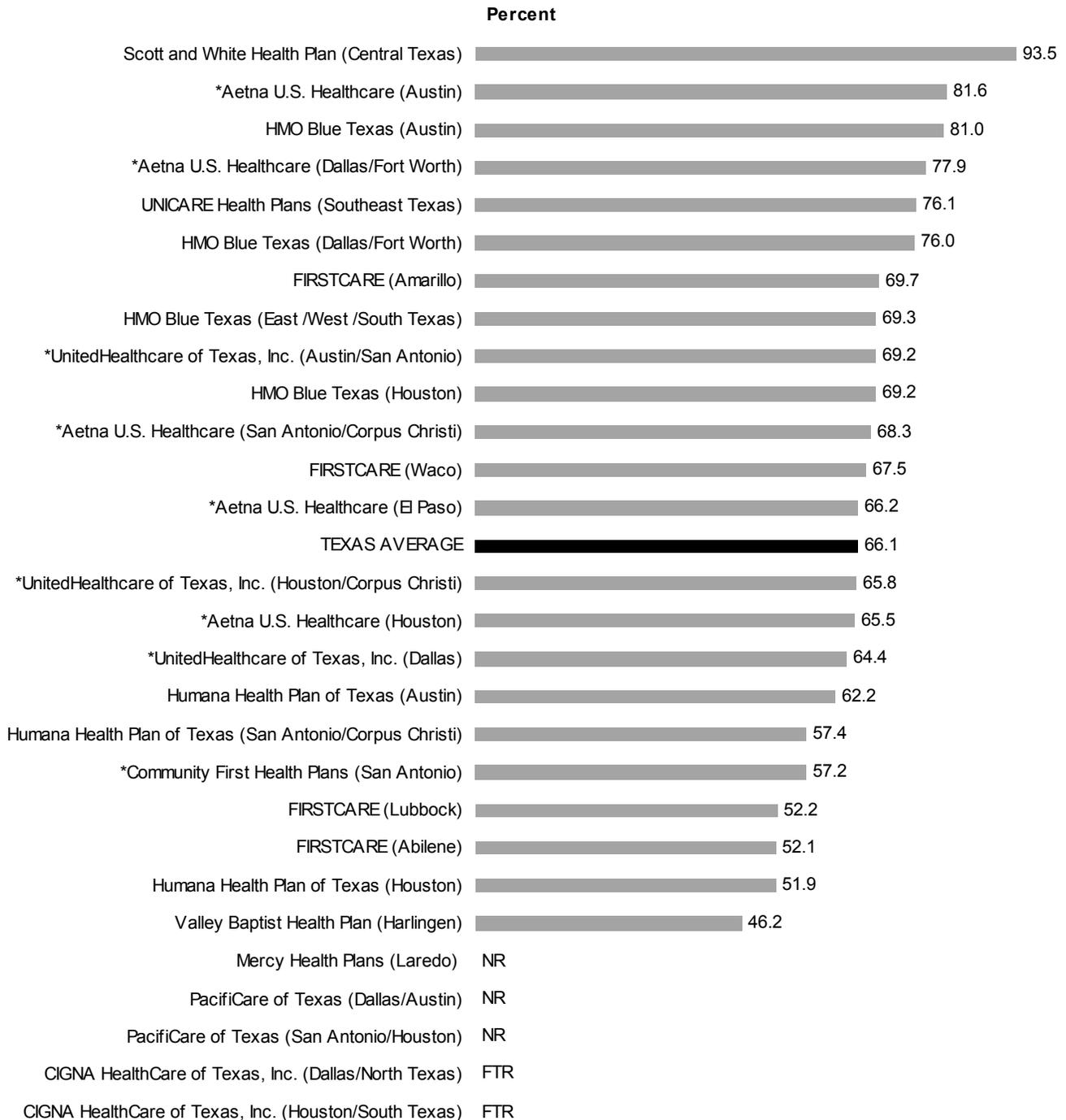
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Board Certification Rate: Family Medicine Physicians



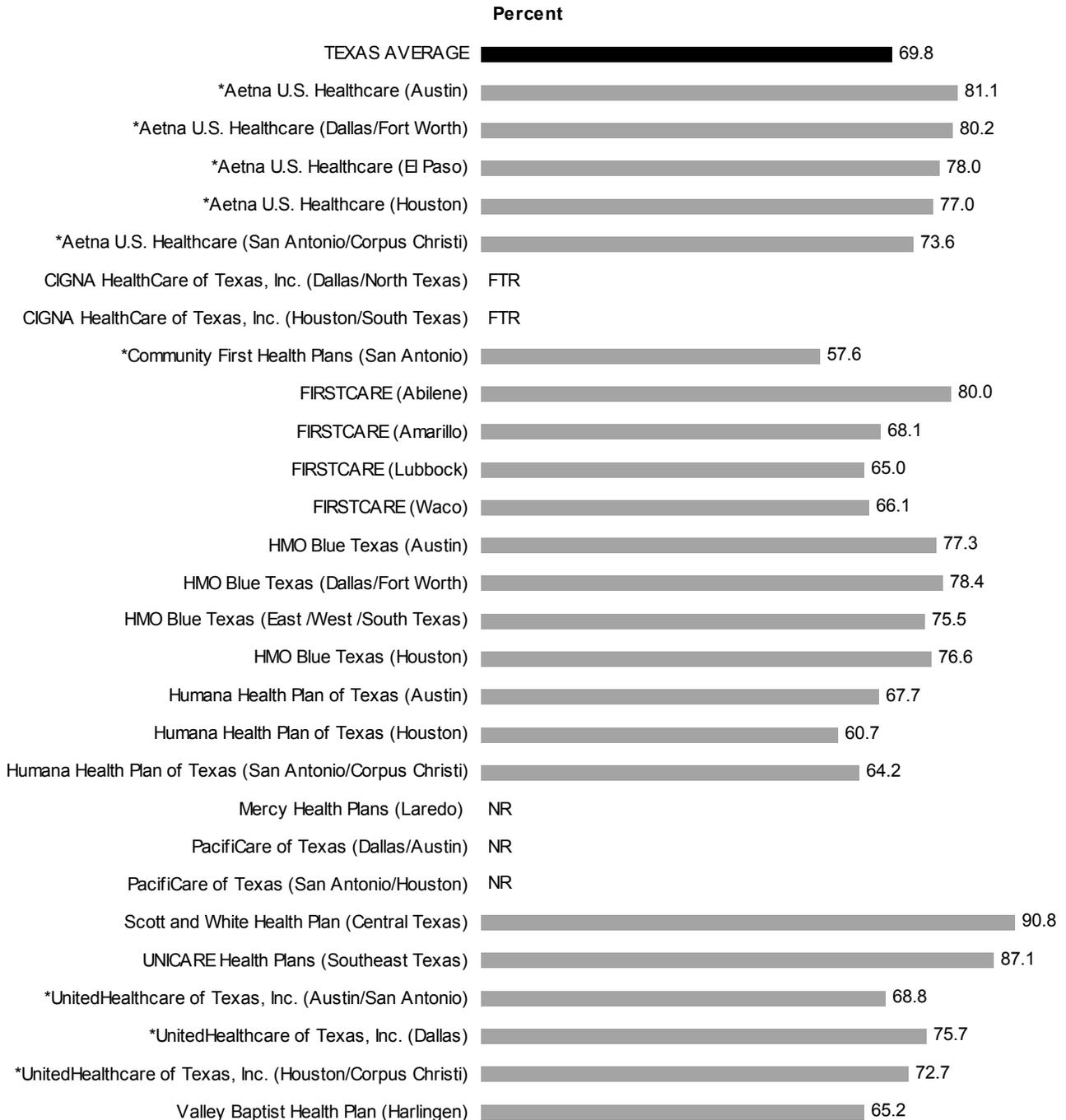
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR– Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: Internal Medicine Physicians



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: Internal Medicine Physicians



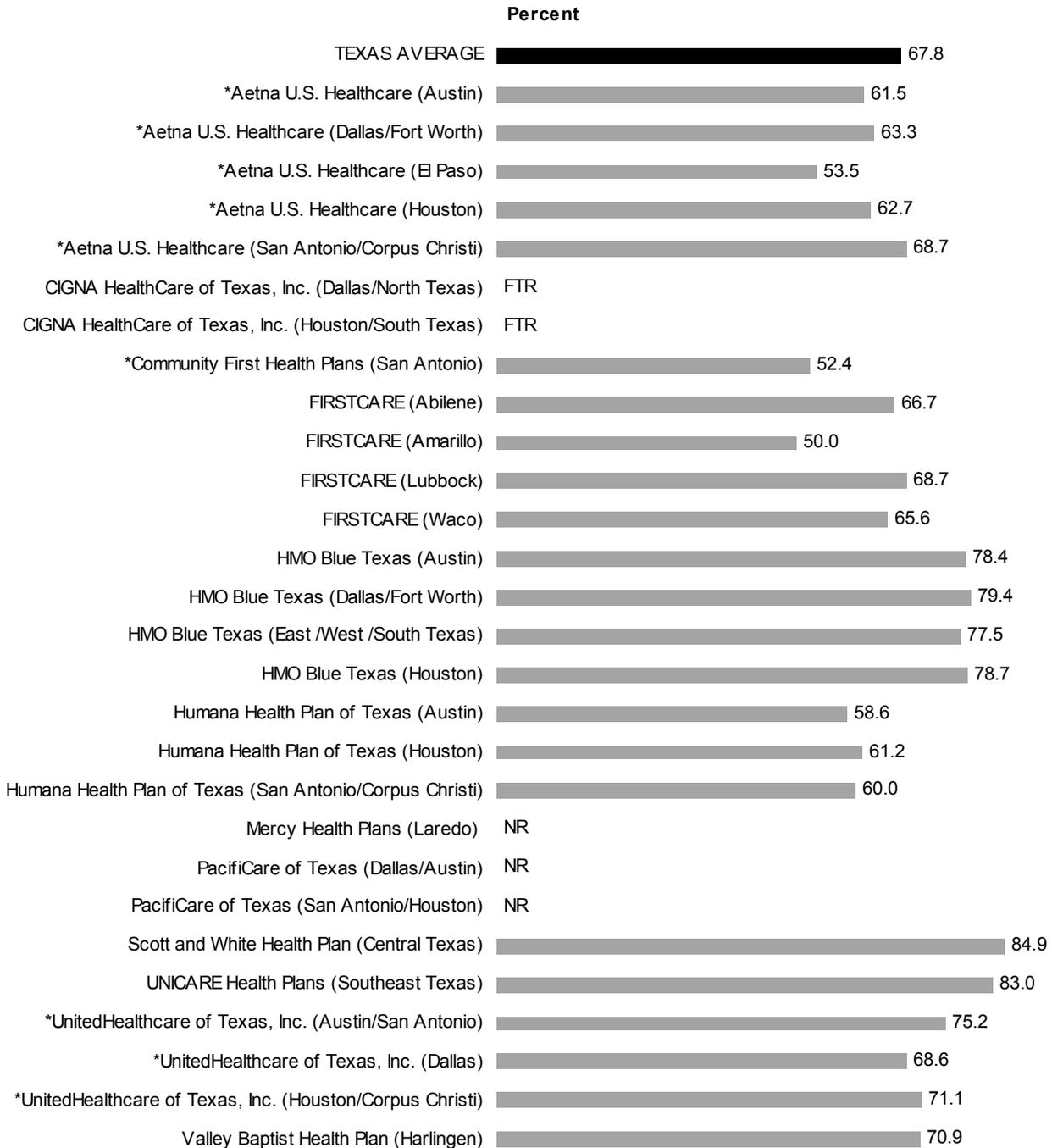
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: OB/GYN Physicians



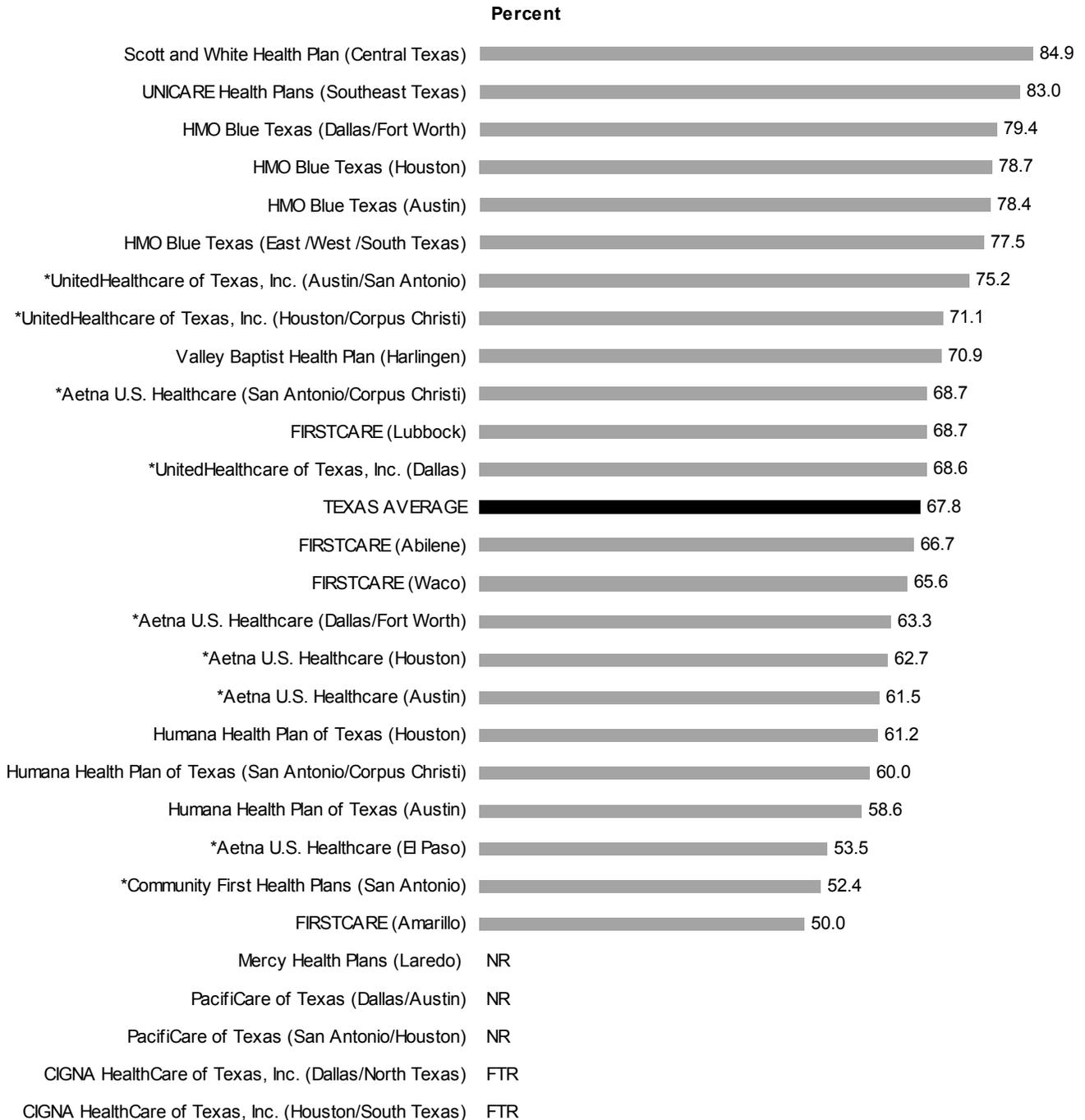
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Board Certification Rate: OB/GYN Physicians



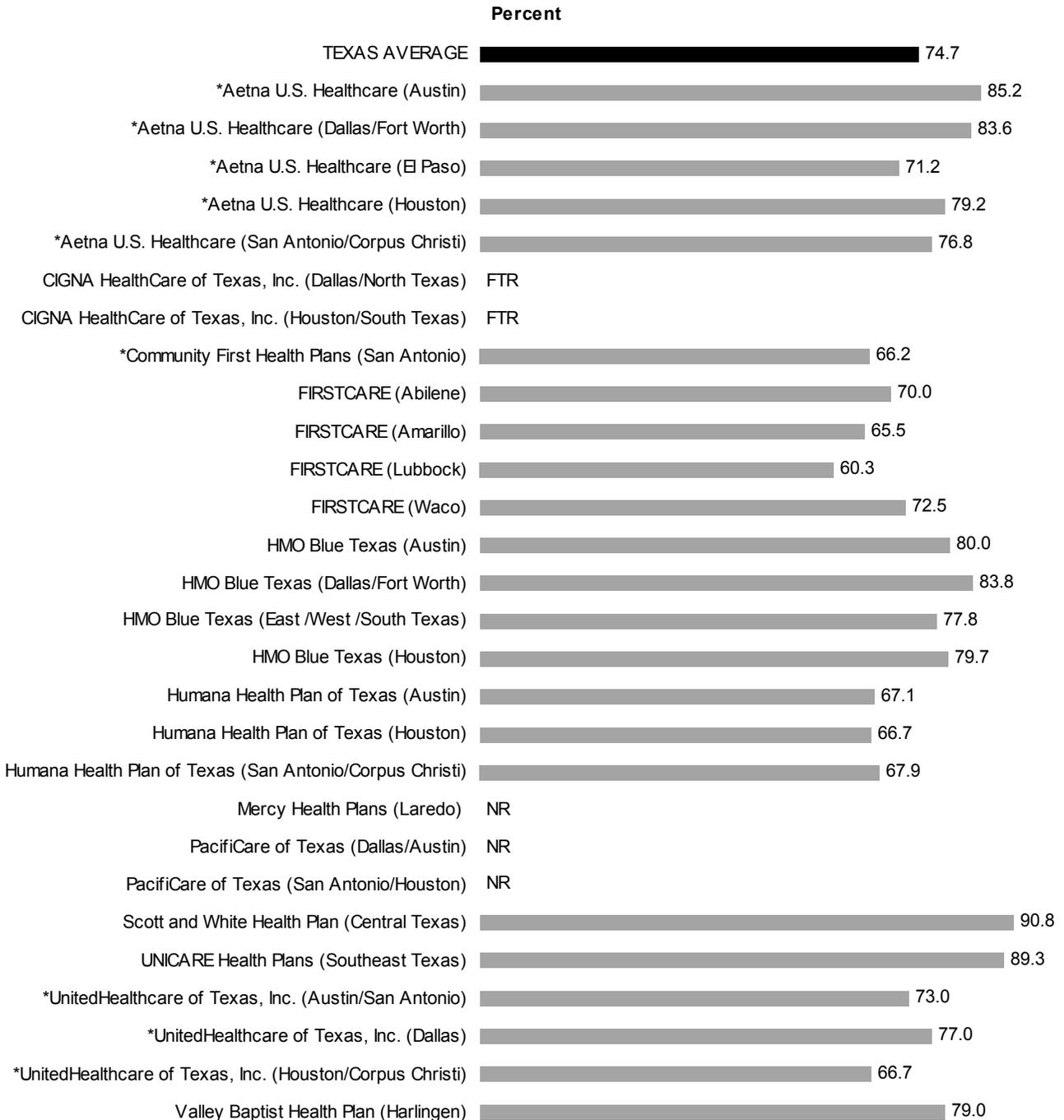
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FTR– Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: Pediatricians



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Board Certification Rate: Pediatricians



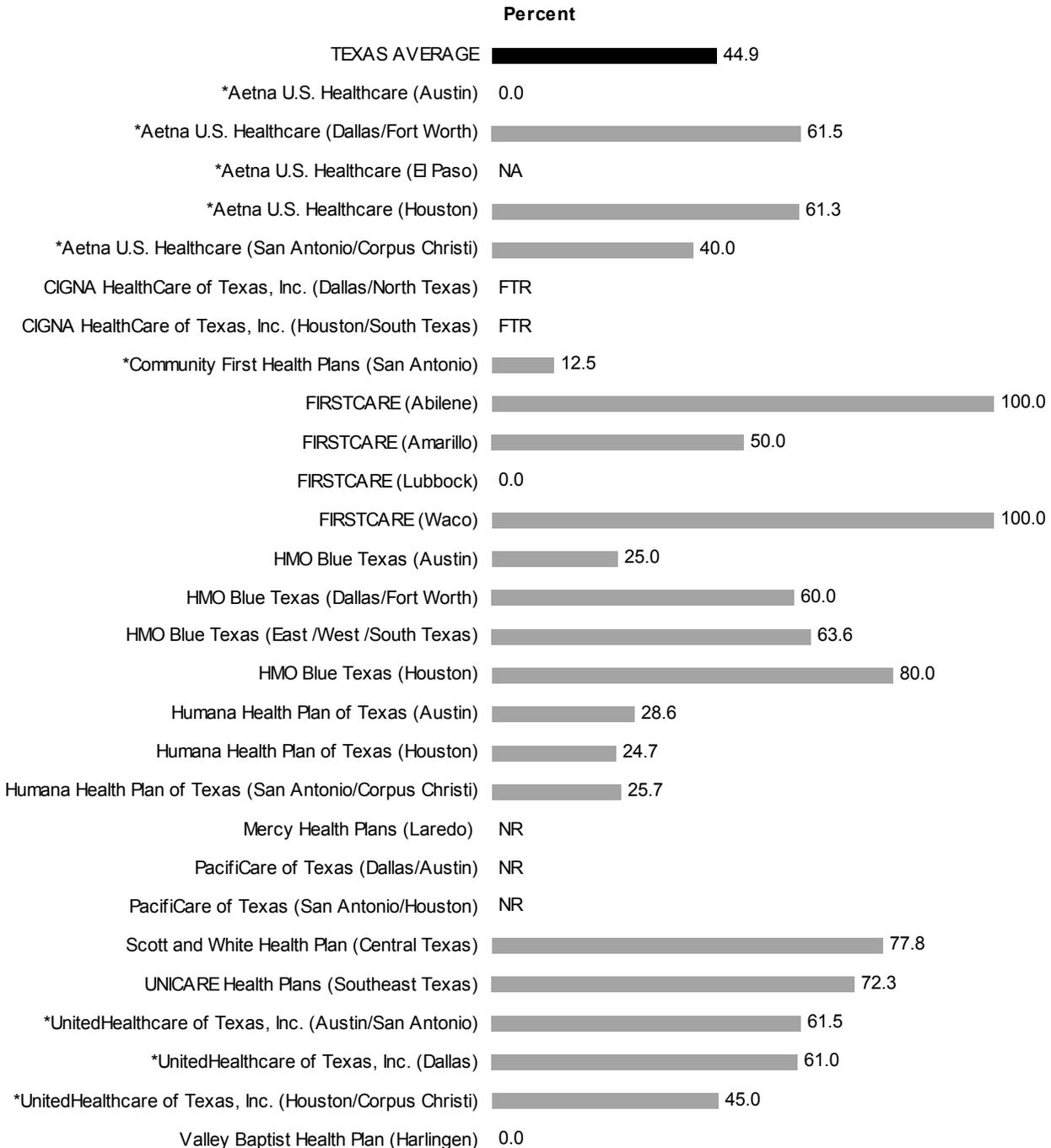
\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.

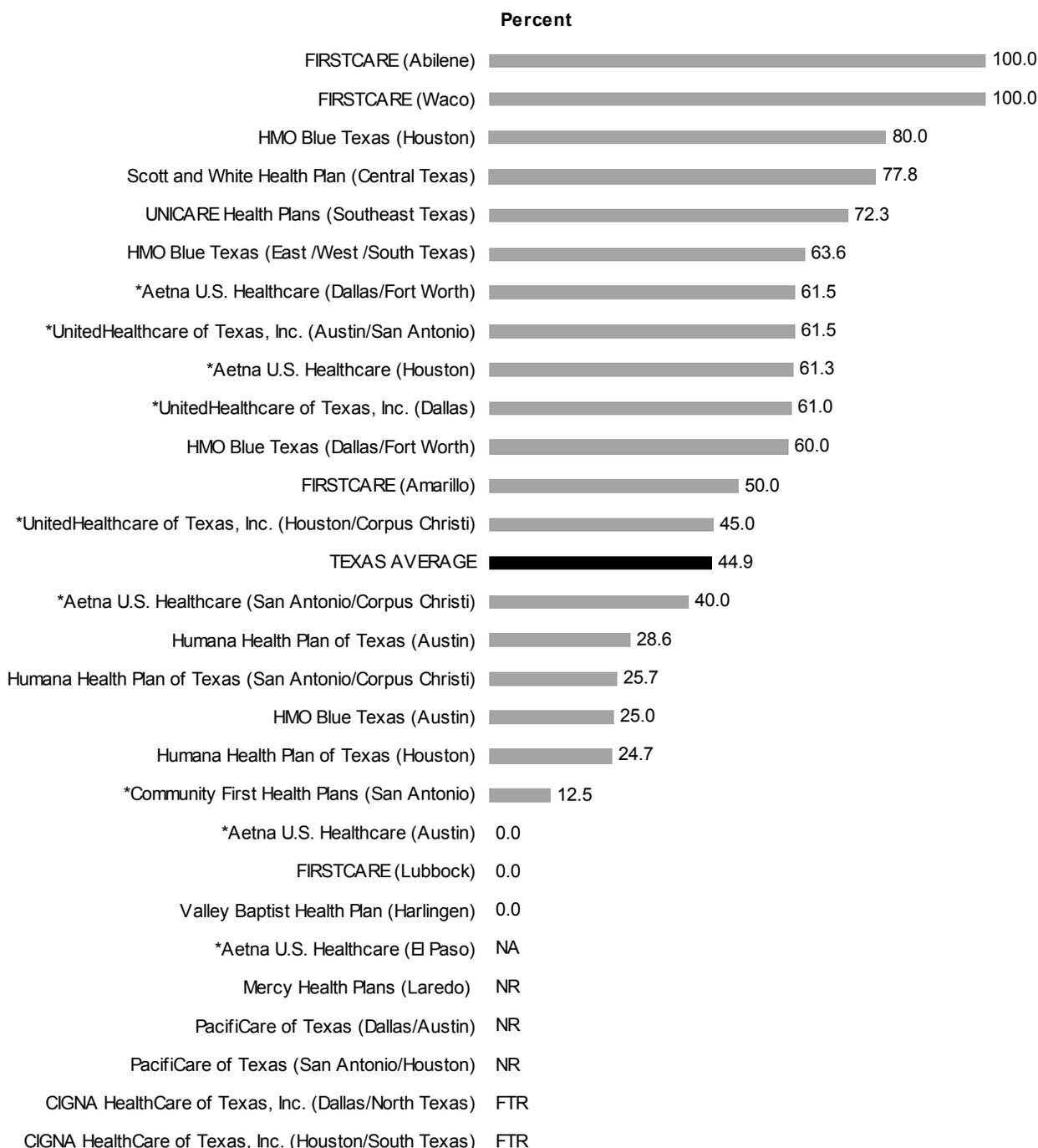
FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: Geriatricians



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
 NA- The plan did not have a large enough sample to report a valid rate.  
 NR- Plan failed to submit the required data or data not certified by an NCQA licensed auditor.  
 FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: Geriatricians



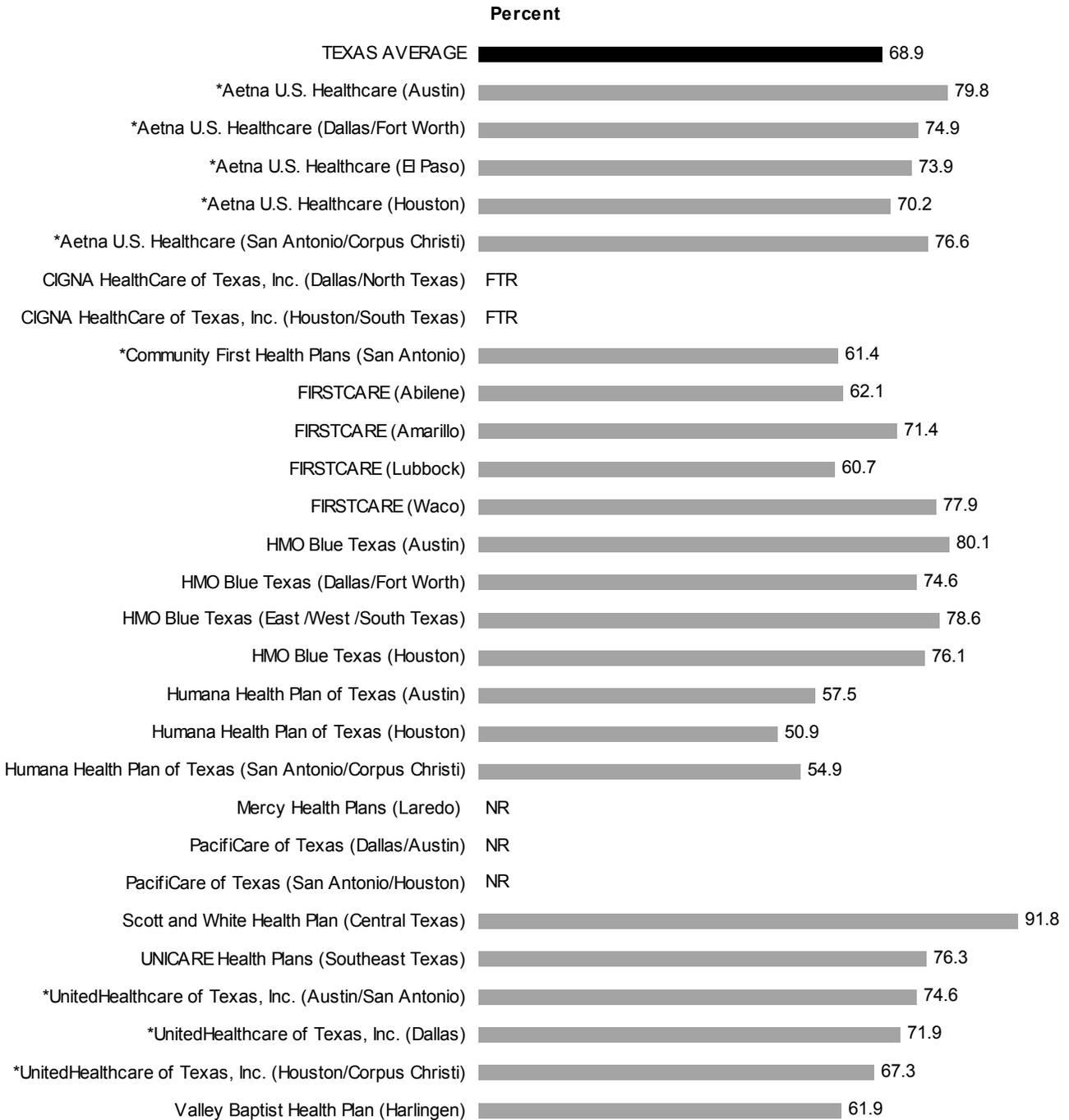
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FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Board Certification Rate: Other Physician Specialists



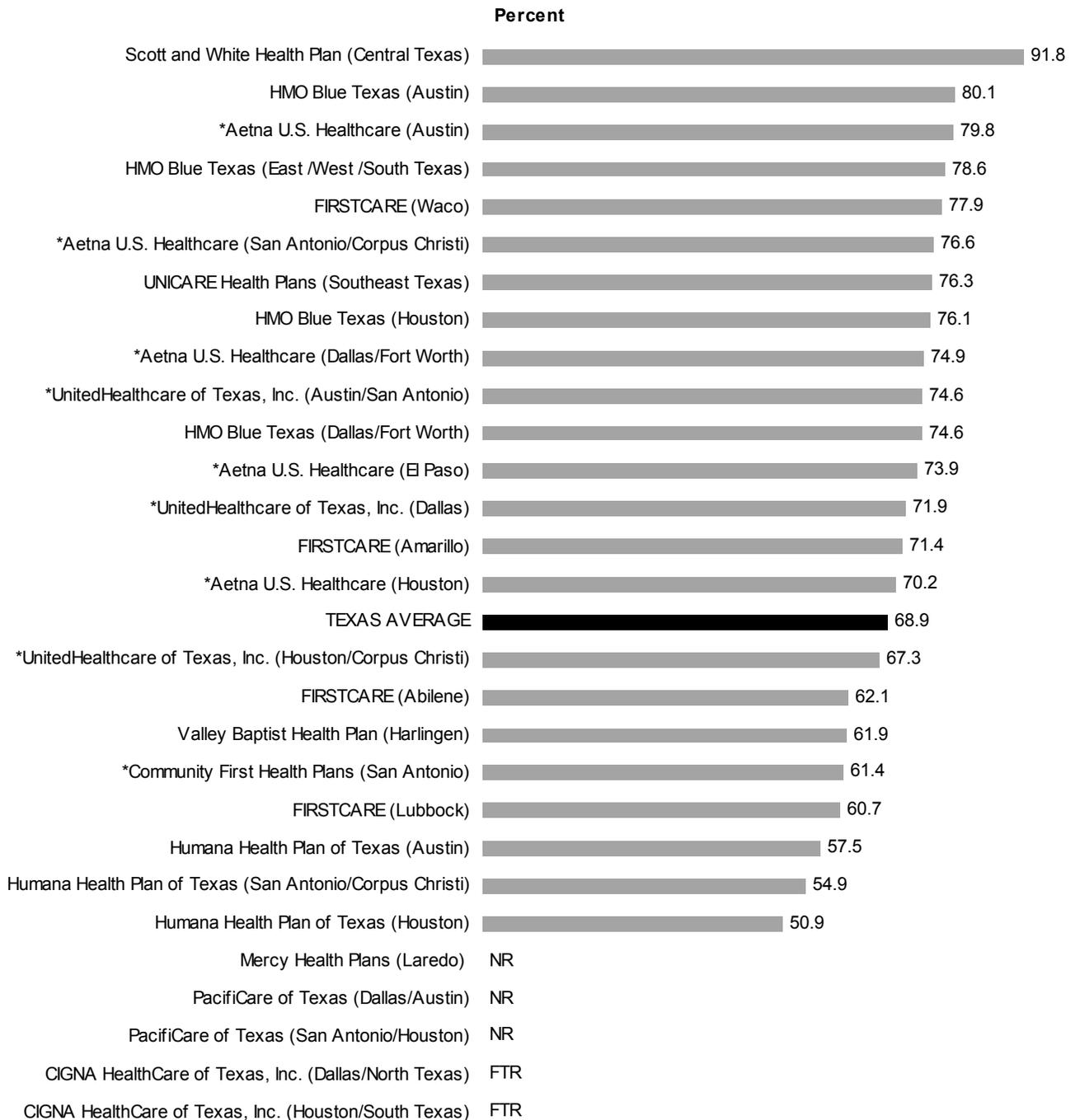
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## Board Certification Rate: Other Physician Specialists



\* Plans reporting HMO/POS membership combined. Others are HMO membership only.

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## Total Enrollment by Percentage

Definition: The percentage of plan members enrolled by product line.

Generally speaking, there are four product lines offered by Texas HMOs: Commercial, Medicare, Medicaid, and Self-insured. While this report only compares HEDIS<sup>®</sup> data on commercial members, the following tables show what proportion of the HMO's total business is represented in each product line, and percentage of members enrolled in different types of managed care plans, e.g. HMO, PPO, and POS.

Commercial members may be enrolled through an employer group policy or through an individual policy. Medicare members are enrolled through a contract between the Centers for Medicare and Medicaid Services (CMS) and the health plan. Medicaid members are enrolled through a contract between the state Medicaid agency (Texas Health and Human Services Commission) and the health plan.

These product line percentages provide information on which populations are insured by a specific plan. This information gives a sense of member demographics by plan. For example, commercial members generally fall between 18-64 (plus their under-age dependents). Medicaid members are primarily women and children. Medicare members are generally 65 and older.

Percentage of plan's members enrolled in an HMO by product line

Health Plan Name	Commercial %	Medicaid %	Medicare %	Others %
*Aetna U.S. Healthcare (Austin)	100	NR	NR	NR
*Aetna U.S. Healthcare (Dallas/Fort Worth)	100	NR	NR	NR
*Aetna U.S. Healthcare (El Paso)	100	NR	NR	NR
*Aetna U.S. Healthcare (Houston)	100	NR	NR	NR
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	100	NR	NR	NR
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	100	0	0	0
FIRSTCARE (Abilene)	78	20	1	0
FIRSTCARE (Amarillo)	78	20	1	NR
FIRSTCARE (Lubbock)	78	20	1	NR
FIRSTCARE (Waco)	78	20	1	NR
HMO Blue Texas (Austin)	100	0	0	0
HMO Blue Texas (Dallas/Fort Worth)	100	0	0	0
HMO Blue Texas (East/West /South Texas)	100	0	0	0
HMO Blue Texas (Houston)	100	0	0	0
Humana Health Plan of Texas (Austin)	100	0	0	0
Humana Health Plan of Texas (Houston)	100	0	0	0
Humana Health Plan of Texas (San Antonio/Corpus Christi)	71	0	29	0
Mercy Health Plans (Laredo)	100	NR	NR	NR
PacifiCare of Texas (Dallas/Austin)	8	0	92	0
PacifiCare of Texas (San Antonio/Houston)	5	0	95	0
Scott and White Health Plan (Central Texas)	88	0	12	0
UNICARE Health Plans (Southeast Texas)	100	NR	NR	NR
*UnitedHealthcare of Texas (Austin/San Antonio)	11	0	89	0
*UnitedHealthcare of Texas (Dallas)	8	0	92	0
*UnitedHealthcare of Texas (Houston/Corpus Christi)	28	0	72	0
Valley Baptist Health Plans (Harlingen)	100	NR	NR	NR

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
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 FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

Percentage of members enrolled by product type

Health Plan Name	HMO %	PPO %	POS %
*Aetna U.S. Healthcare (Austin)	77	NR	23
*Aetna U.S. Healthcare (Dallas/Fort Worth)	85	NR	15
*Aetna U.S. Healthcare (El Paso)	56	NR	44
*Aetna U.S. Healthcare (Houston)	80	NR	20
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	73	NR	27
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	42	0	58
FIRSTCARE (Abilene)	99	NR	1
FIRSTCARE (Amarillo)	99	NR	1
FIRSTCARE (Lubbock)	99	NR	1
FIRSTCARE (Waco)	99	NR	1
HMO Blue Texas (Austin)	4	86	10
HMO Blue Texas (Dallas/Fort Worth)	4	86	10
HMO Blue Texas (East/West /South Texas)	4	86	10
HMO Blue Texas (Houston)	4	86	10
Humana Health Plan of Texas (Austin)	100	0	0
Humana Health Plan of Texas (Houston)	100	0	0
Humana Health Plan of Texas (San Antonio/Corpus Christi)	100	0	0
Mercy Health Plans (Laredo)	100	NR	NR
PacifiCare of Texas (Dallas/Austin)	100	0	0
PacifiCare of Texas (San Antonio/Houston)	100	0	0
Scott and White Health Plan (Central Texas)	100	0	0
UNICARE Health Plans (Southeast Texas)	100	NR	NR
*UnitedHealthcare of Texas (Austin/San Antonio)	18	0	82
*UnitedHealthcare of Texas (Dallas)	7	0	93
*UnitedHealthcare of Texas (Houston/Corpus Christi)	9	0	91
Valley Baptist Health Plans (Harlingen)	100	NR	NR

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
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## Enrollment by Product Line: Commercial

Definition: The percentage of total members stratified by gender and age for the commercial product line.

Membership data by gender and age can be used by purchasers and consumers to learn the enrollment characteristics of the health plan. The gender and age breakdowns can help explain differences in the type of care provided and the total volume of services provided.

The following tables show the percentage of members in the plan by the following age group and gender categories:

Males Age 0 - 19  
Males Age 20 - 44  
Males Age 45 - 64  
Males Age 65+

Females Age 0 - 19  
Females Age 20 - 44  
Females Age 45 - 64  
Females Age 65+

Table Showing percentage of **Male** members (commercial product) by age group

Health Plan Name	0-19 Years %	20-44 Years %	45-64 Years %	65+ Years %
*Aetna U.S. Healthcare (Austin)	28.3	41.7	28.1	1.8
*Aetna U.S. Healthcare (Dallas/Fort Worth)	30.6	35.0	32.0	2.3
*Aetna U.S. Healthcare (El Paso)	31.1	42.1	25.5	1.3
*Aetna U.S. Healthcare (Houston)	32.4	37.0	28.4	2.2
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	31.9	37.9	28.1	2.1
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	36.6	37.0	24.2	2.1
FIRSTCARE (Abilene)	30.1	32.2	34.0	3.7
FIRSTCARE (Amarillo)	33.5	32.7	29.6	4.2
FIRSTCARE (Lubbock)	32.9	35.7	28.9	2.5
FIRSTCARE (Waco)	31.8	30.1	33.6	4.6
HMO Blue Texas (Austin)	28.9	37.7	33.1	0.3
HMO Blue Texas (Dallas/Fort Worth)	33.1	41.8	24.7	0.4
HMO Blue Texas (East/West /South Texas)	32.0	34.6	32.9	0.5
HMO Blue Texas (Houston)	31.7	35.1	32.7	0.5
Humana Health Plan of Texas (Austin)	26.3	45.7	26.9	1.0
Humana Health Plan of Texas (Houston)	28.3	41.4	29.0	1.4
Humana Health Plan of Texas (San Antonio/Corpus Christi)	28.1	36.7	33.6	1.6
Mercy Health Plans (Laredo)	27.3	44.0	27.4	1.3
PacifiCare of Texas (Dallas/Austin)	30.9	28.8	35.3	4.9
PacifiCare of Texas (San Antonio/Houston)	29.5	26.2	36.1	8.2
Scott and White Health Plan (Central Texas)	31.5	35.3	29.5	3.7
UNICARE Health Plans (Southeast Texas)	32.7	39.2	25.8	2.3
*UnitedHealthcare of Texas (Austin/San Antonio)	26.3	45.5	26.7	1.5
*UnitedHealthcare of Texas (Dallas)	26.0	43.2	29.0	1.8
*UnitedHealthcare of Texas (Houston/Corpus Christi)	26.1	42.9	29.2	1.8
Valley Baptist Health Plans (Harlingen)	31.4	39.6	27.4	1.7

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
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Table Showing percentage of **Female** members (commercial product) by age group

Health Plan Name	0-19 Years %	20-44 Years %	45-64 Years %	65+ Years %
*Aetna U.S. Healthcare (Austin)	26.2	43.0	29.1	1.7
*Aetna U.S. Healthcare (Dallas/Fort Worth)	28.9	37.9	31.5	1.7
*Aetna U.S. Healthcare (El Paso)	25.6	48.6	24.9	0.9
*Aetna U.S. Healthcare (Houston)	27.6	41.8	29.2	1.5
*Aetna U.S. Healthcare (San Antonio/Corpus Christi)	27.8	41.1	29.4	1.7
CIGNA HealthCare of Texas, Inc. (Dallas/North Texas)	FTR	FTR	FTR	FTR
CIGNA HealthCare of Texas, Inc. (Houston/South Texas)	FTR	FTR	FTR	FTR
*Community First Health Plans (San Antonio)	27.2	41.4	29.0	2.4
FIRSTCARE (Abilene)	24.3	36.4	36.4	2.8
FIRSTCARE (Amarillo)	26.2	37.5	33.3	3.0
FIRSTCARE (Lubbock)	26.5	40.9	30.8	1.8
FIRSTCARE (Waco)	22.8	36.3	37.4	3.5
HMO Blue Texas (Austin)	19.7	44.6	35.3	0.4
HMO Blue Texas (Dallas/Fort Worth)	29.5	44.9	25.2	0.4
HMO Blue Texas (East/West /South Texas)	27.8	38.8	33.1	0.3
HMO Blue Texas (Houston)	32.0	36.1	31.4	0.5
Humana Health Plan of Texas (Austin)	25.6	46.1	27.5	0.8
Humana Health Plan of Texas (Houston)	25.7	44.5	29.0	0.9
Humana Health Plan of Texas (San Antonio/Corpus Christi)	24.3	39.4	34.7	1.6
Mercy Health Plans (Laredo)	26.7	48.0	24.6	0.7
PacifiCare of Texas (Dallas/Austin)	28.2	31.3	36.1	4.4
PacifiCare of Texas (San Antonio/Houston)	28.3	26.9	36.5	8.3
Scott and White Health Plan (Central Texas)	27.5	37.8	31.6	3.1
UNICARE Health Plans (Southeast Texas)	28.1	43.2	27.3	1.4
*UnitedHealthcare of Texas (Austin/San Antonio)	25.6	46.2	27.2	1.1
*UnitedHealthcare of Texas (Dallas)	25.9	43.1	29.6	1.4
*UnitedHealthcare of Texas (Houston/Corpus Christi)	27.3	42.8	28.6	1.2
Valley Baptist Health Plans (Harlingen)	21.9	46.7	30.5	1.0

\* Plans reporting HMO/POS membership combined. Others are HMO membership only.  
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 FTR- Failure to report by service areas as required by Chapter 108.009 (o) of the Texas Health and Safety Code.

## Methods and Statistical Issues

In order to accommodate differences in HMO data systems and technical capabilities, HEDIS® 2009 gives plans a choice to use either an administrative records or a hybrid method to calculate many of the performance measures reported in this publication. The administrative records approach involves the following steps:

- All records in a health plan's administrative database are queried to determine the eligible population for a certain measure, and this becomes the denominator for the measure.
- The selected records are reviewed to identify the members who availed the service/procedure and are included in the numerator.
- The members with contra-indication to the service/procedure are excluded from the denominator.
- A rate is calculated.

The hybrid method, on the other hand, is sample driven and requires random selection of enrollees to form the denominator followed by examination of administrative and medical records for evidence of a numerator event. NCQA has specified a systematic sampling scheme for those who chose to use the hybrid method. Proper utilization and implementation of this methodology ensures high integrity of HEDIS® data.

A third data gathering and analysis method, survey research, is used for the Satisfaction with the Experience of Care domain, Advising Smokers to Quit, and Flu Shots for Adults measures presented in the Effectiveness of Care domain. The standardized survey instrument employed for HEDIS® 2009 is the Consumer Assessment of Healthcare Providers and Systems, Version 4.0 (CAHPS® 4.0H). This survey is administered through the mail with a telephone follow-up to members not responding by mail. It asks consumers to score various aspects of their experience with their health plan. Health plans are required to contract with independent survey vendors certified by NCQA to administer the survey. A report on the survey measures, **Comparing Texas HMOs**, may be viewed at our agency website <http://www.opic.state.tx.us/health.php>

HEDIS® 2009 requires continuous enrollment of members in order to be counted for rate denominators. Continuous enrollment criteria are measure specific, but typically this condition is satisfied when an individual is an active plan member for the duration of time under review, usually one year. One break in enrollment of up to 45 days per year is usually allowed to account for a change in employment.

HEDIS® measures reported in this publication meet rigorous standards for public release. All health plan data submissions are required to be reviewed by an NCQA licensed auditor. Data not certified through this process are denoted with an "NR" (Not Reportable). Other data may meet NCQA audit standards but are suppressed due to statistical considerations. These situations, which include rates calculated from less than 30 denominator observations, are designated as "NA" (Not Applicable). Plans which failed to report by service area as required by Chapter 108.009 (o) of the Texas Health and Safety Code are designated as "FTR" (Failure to Report).

Measures from Effectiveness of Care, Health Plan Stability, Health Plan Descriptive and Use of Services domains were tested using a 95% confidence interval to determine if they differ significantly from the average of all HMOs in the State.

NCQA suggests the following formula for statistical significance testing on HEDIS<sup>®</sup> measures:

$$(\text{Plan rate} - \text{*Stateavg}) \pm 1.96 \sqrt{(\text{SE plan})^2 + (\text{SE *Stateavg})^2}$$

Where:

Planrate = rate reported for the plan

\*Stateavg = unweighted mean for all plans in Texas minus the comparison plan

SE plan = standard error for the plan

SE \*Stateavg = standard error for the average for all plans in Texas minus the comparison plan

The equation for a plan standard error (SE plan) is as follows:

$$\sqrt{\frac{p(1-p)}{m-1}}$$

Where:

$m$  = number of members in the sample

$p$  = plan rate

The standard error for all plans in Texas minus the comparison plan (SE \*Stateavg) is calculated like this:

$$\sqrt{\frac{1}{n^2} \sum_i^n \frac{1}{m_i - 1} p_i(1 - p_i)}$$

Where:

$n$  = number of plans with valid rates minus 1

$i$  = a plan

$m$  = number of members in the sample

$p$  = plan rate

Rates are considered statistically significant if the interval produced by the above test does not include zero.

For ease of computation, the formula for calculating the 95 percent confidence interval around an organization's HEDIS<sup>®</sup> rate is:

$$\text{lower} = p - 1.96 \sqrt{\frac{p(1-p)}{n}} - \frac{1}{2n}$$

$$\text{upper} = p + 1.96 \sqrt{\frac{p(1-p)}{n}} + \frac{1}{2n}$$

Where  $p$  = the organization's rate and  $n$  = the sample size.

For example, suppose the organization has a sample size of 96 eligible women for its *Cervical Cancer Screening* rate. Of these, 50 receive a Pap test during the year. The calculation would proceed as follows:

$$p = \frac{50}{96} = 52\%$$

$$\text{lower} = .52 - 1.96 \sqrt{\frac{.52(1-.52)}{96}} - \frac{1}{196} = 41.5\%$$

$$\text{upper} = .52 + 1.96 \sqrt{\frac{.52(1-.52)}{96}} + \frac{1}{196} = 62.5\%$$

Thus, the user can be 95 percent certain that the organization's true Pap test rate is between 41.5 percent and 62.5 percent.<sup>1</sup>

The summary section (pages 6-9) reports measures with an “=” sign when plan performance is not rated as statistically different from the average of all plans in the state (i.e. the interval includes the state average). Otherwise, the performance of the measure is reported as either better (+) or worse (-) than the state average.

Results of HEDIS<sup>®</sup> statistical significance testing should be interpreted carefully as should any conclusions drawn from direct comparisons of plans. Statistical tests account only for random or chance variations in measurement. HEDIS<sup>®</sup> does not control for underlying differences in plan population characteristics such as age or health status. For some HEDIS<sup>®</sup> measures this lack of risk adjustment could lead readers to erroneously accept the proposition that apparent superior or inferior performance is due to quality of care when in fact it derives from a positive or negative case mix in member enrollment.

This publication reports benchmarks from NCQA's National Summary Statistics. NCQA's national averages are based on HEDIS<sup>®</sup> data voluntarily reported to NCQA by more than 250 health plans throughout the country.

NCQA intends its HEDIS<sup>®</sup> database to serve primarily as a decision and management support tool for benefits managers, consultants, policy makers, and health plans.

<sup>1</sup> National Committee for Quality Assurance (NCQA), HEDIS<sup>®</sup> 2009 Volume 2 Technical Specification, 2008

## Texas Subset of HEDIS® Commercial 2009 Measures

### Effectiveness of Care Domain

- Childhood Immunization Status
- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Persistence of Beta Blocker Treatment After a Heart Attack
- Cholesterol Management for Patients with Cardiovascular Conditions
- Comprehensive Diabetes Care
- Use of Appropriate Medication for People with Asthma
- Follow-Up after Hospitalization for Mental Illness
- Antidepressant Medication Management
- Medical Assistance with Smoking Cessation
- Flu Shots for Adults Ages 18-64

### Access/Availability of Care

- Prenatal and Postpartum Care
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

### Satisfaction with the Experience of Care Domain

- CAHPS® 4.0H Adult Survey  
(Results of the survey are published in “Comparing Texas HMOs 2009.”  
It is published by the State of Texas Office of Public Insurance Counsel and is available via our website [www.opic.state.tx.us/health.php](http://www.opic.state.tx.us/health.php))

### Health Plan Stability Domain

- Years in Business/Total Membership

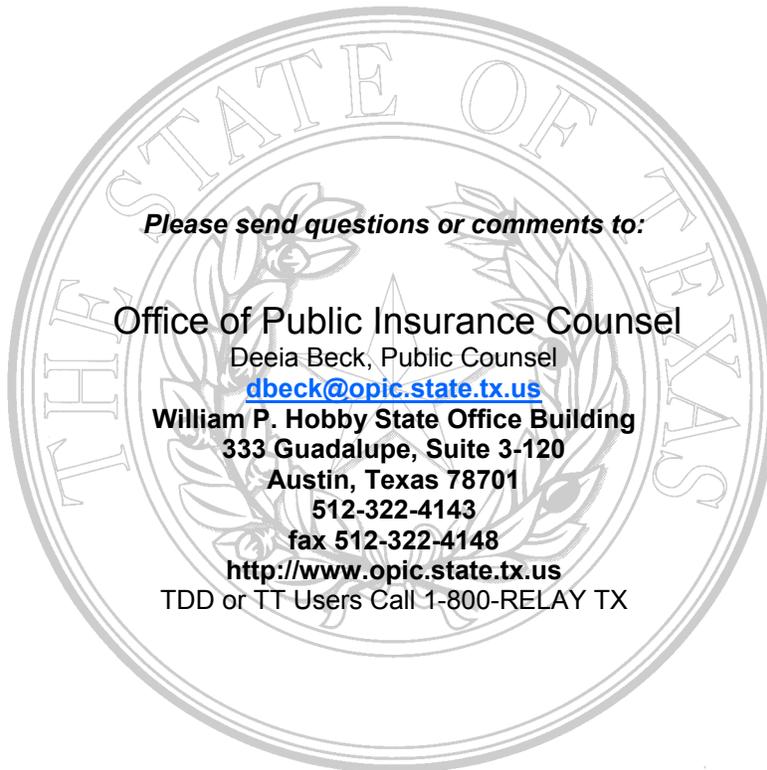
### Use of Services Domain

- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life
- Adolescent Well-Care Visits
- Inpatient Utilization – General Hospital/Acute Care
- Ambulatory Care
- Mental Health Utilization – Percentage of Members Receiving Inpatient and Intermediate Care and Ambulatory Services
- Identification of Alcohol and Other Drug Services
- Antibiotic Utilization
- Outpatient Drug Utilization

### Health Plan Descriptive Information

- Board Certification
- Enrollment by Product Line
- Total Enrollment by Percentage





*Please send questions or comments to:*

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