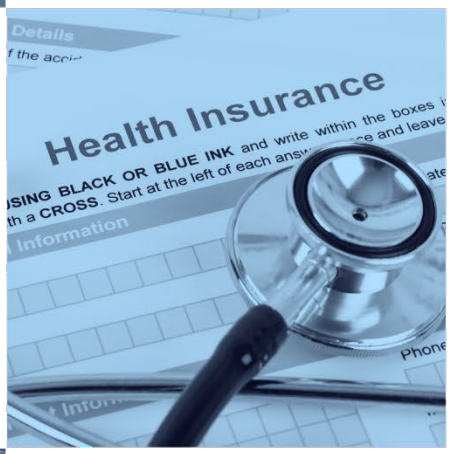

Office of Public Insurance Counsel

2024-25 Guide to Texas HMO Quality

(Measurement Year 2023 Data)

This report is brought to you through the combined efforts of the State of Texas, the Office of Public Insurance Counsel, and the Texas Department of State Health Services Center for Health Statistics.

For inquiries:

Office of Public Insurance Counsel
Barbara Jordan Building
1601 Congress Ave., Suite 3.500
Austin, Texas 78701
(512) 322-4143 | toll-free at (877) 611-6742
help@opic.texas.gov | https://www.opic.texas.gov

Texas Health Care Information Collection
Department of State Health Services
Center for Health Statistics, MC 1898
1100 West 49th Street, Ste M-660
Austin, Texas 78756
P. O. Box 149347
Austin, Texas 78714-9347
(512) 776-7261
thcichelp@dshs.texas.gov | https://www.dshs.texas.gov/texas-health-care-information-collection

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Section 1: Introduction and Summary

Introduction

About the Report

The Office of Public Insurance Counsel (OPIC) is an independent state agency established by the Texas Legislature to represent the interests of Texas consumers, as a class, in insurance matters. OPIC produces and publishes this report through a joint Memorandum of Understanding with the Department of State Health Services (DSHS) Center for Health Statistics. The *Guide to Texas HMO Quality 2024-2025* reports Health Maintenance Organization (HMO) performance based on Healthcare Effectiveness Data and Information Set (HEDIS®)[1] quality of care measures. Consumers can use the publication to evaluate HMOs based on their own needs.

Section 1 of the report provides summary tables depicting HMO performance in specific categories. Section 2 details performance measures for Effectiveness of Care. This section includes a narrative with an overview of each measure followed by bar charts that graphically depict the performance for all HMOs. Section 3 details performance measures for Access and Availability of Care. Section 4 provides Utilization and Risk-Adjusted Utilization measures. Section 5 provides discussion on data reporting methods and statistical matters.

About the Data

HEDIS® is a set of standardized performance measures used to compare the quality of care of managed care organizations. The National Committee for Quality Assurance (NCQA), a private non-profit organization, develops and maintains HEDIS®. Each year NCQA convenes national health care experts to guide the selection and development of HEDIS® measures. The performance measures reflect many significant public health issues such as cancer, heart disease, smoking, diabetes, and the care of children and pregnant women. Texas law requires basic service HMOs to report HEDIS® measures each year to DSHS.[2] For more information about the data or methodology used in this report, please consult Section 5 at the end of this report.

Interpret the results in this publication with care. The data used in this report do not control for underlying differences in plan population characteristics like age or health status. For some measures, the difference between HMOs may represent differences in quality of care while others may simply represent a different mix of member enrollment. It is more meaningful to compare health plans across a group of related measures than any single measure.

Using the Report

OPIC encourages you to consider the information in this report in relation to your specific needs. For example, if your family has young children, you may be interested in an HMO that performs well on childhood immunizations. If you are middle-aged, you may consider a plan that hires providers, such as doctors, who routinely screen for diseases for which you are at higher risk.

This guide is only one tool for comparing HMOs. You should consider other factors such as the service area, benefits, cost, availability of providers, and consumer satisfaction. Much of this information is available directly from the HMOs. You can find consumer satisfaction information in OPIC's publication *Comparing Texas HMOs*, available at https://www.opic.texas.gov/-hmo-report-cards. For more information on HEDIS®, please see the NCQA website at https://www.ncqa.org/hedis/.

Summary Tables

The summary tables provided in this section reflect HMO performance on specific measures in relation to the Texas state average. The table summarizes plan performance as follows:

+ Plan performed better than the Texas average

= Plan performance equivalent to the Texas average

- Plan performance lower than the Texas average

The summary tables provide a quick tool to compare plan performance. The results should be interpreted with care. For some measures, the difference between HMOs may represent differences in quality of care, while others may simply represent a different mix of member enrollment. It is more meaningful to compare health plans across a group of related measures than any single measure. For detailed information on the statistical tests used in this publication, please consult Section 5 at the end of this report.

Summary Table 1: Prevention and Screening

Health Plan	Childhood Immunization Status - DTaP	Childhood Immunization Status - IPV	Childhood Immunization Status - MMR	Childhood Immunization Status - HiB	Breast Cancer Screening	Cervical Cancer Screening	Colorectal Cancer Screening (Total)	Chlamydia Screening in Women - Total
Aetna Health Inc. (Texas)	-	=	-	-	-	-	-	+
Cigna HealthCare of Texas, Inc.	=	=	=	=	+	+	+	+
Blue Cross and Blue Shield of Texas (Houston)	=	+	+	+	-	-	-	+
Blue Cross and Blue Shield of Texas (DFW)	=	=	=	=	+	-	-	=
Humana Health Plan of Texas (Austin)	-	-	-	-	=	+	+	=
Humana Health Plan of Texas (Houston)	=	-	=	-	-	=	=	=
Humana Health Plan of Texas (Corpus Christi)	NA	NA	NA	NA	=	=	=	=
Humana Health Plan of Texas (San Antonio)	-	-	=	-	-	+	+	=
Scott and White Health Plan	=	+	=	+	+	+	+	-
Community First Health Plans	+	+	+	+	=	=	=	=
UnitedHealthcare of Texas (Austin/San Antonio)	=	=	=	=	-	=	=	=
CHRISTUS Health	-	-	-	-	=	+	+	-
UnitedHealthcare of Texas (Houston/Corpus Christi)	=	=	=	=	-	-	-	=
UnitedHealthcare of Texas (DFW)	=	=	=	=	=	=	=	=
Memorial Hermann Commercial Health Plan	NA	NA	NA	NA	-	-	-	-
Blue Cross and Blue Shield of Texas (Austin)	=	=	=	=	-	+	+	-
Blue Cross and Blue Shield of Texas (RGV)	=	=	=	=	-	-	-	=
Blue Cross and Blue Shield of Texas (San Antonio)	=	=	=	=	-	-	-	=
Blue Cross and Blue Shield of Texas (ETX)	+	=	=	=	=	-	-	=
Blue Cross and Blue Shield of Texas (Abilene)	=	+	=	+	-	-	-	-

+ Higher than Texas Average = Equivalent to Texas Average - Lower than Texas Average
NA – Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR – Not Reported. The organization chose not to report the measure.
NQ – Not Required. The organization was not required to report the measure.
** Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Summary Table 2: Respiratory Conditions

Health Plan	Appropriate Testing for Pharyngitis (Total)
Aetna Health Inc. (Texas)	-
Cigna HealthCare of Texas, Inc.	-
Blue Cross and Blue Shield of Texas (Houston)	-
Blue Cross and Blue Shield of Texas (DFW)	+
Humana Health Plan of Texas (Austin)	+
Humana Health Plan of Texas (Houston)	-
Humana Health Plan of Texas (Corpus Christi)	-
Humana Health Plan of Texas (San Antonio)	=
Scott and White Health Plan	+
Community First Health Plans	-
UnitedHealthcare of Texas (Austin/San Antonio)	-
CHRISTUS Health	-
UnitedHealthcare of Texas (Houston/Corpus Christi)	-
UnitedHealthcare of Texas (DFW)	=
Memorial Hermann Commercial Health Plan	-
Blue Cross and Blue Shield of Texas (Austin)	+
Blue Cross and Blue Shield of Texas (RGV)	-
Blue Cross and Blue Shield of Texas (San Antonio)	=
Blue Cross and Blue Shield of Texas (ETX)	-
Blue Cross and Blue Shield of Texas (Abilene)	+

+ Higher than Texas Average = Equivalent to Texas Average - Lower than Texas Average
NA – Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
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NQ – Not Required. The organization was not required to report the measure.
** Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Summary Table 3: Cardiovascular Conditions

Health Plan	Controlling High Blood Pressure	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy
Aetna Health Inc. (Texas)	+	+
Cigna HealthCare of Texas, Inc.	-	+
Blue Cross and Blue Shield of Texas (Houston)	=	=
Blue Cross and Blue Shield of Texas (DFW)	+	=
Humana Health Plan of Texas (Austin)	=	=
Humana Health Plan of Texas (Houston)	-	=
Humana Health Plan of Texas (Corpus Christi)	-	=
Humana Health Plan of Texas (San Antonio)	+	=
Scott and White Health Plan	+	=
Community First Health Plans	+	+
UnitedHealthcare of Texas (Austin/San Antonio)	+	=
CHRISTUS Health	+	-
UnitedHealthcare of Texas (Houston/Corpus Christi)	+	NA
UnitedHealthcare of Texas (DFW)	+	=
Memorial Hermann Commercial Health Plan	+	NA
Blue Cross and Blue Shield of Texas (Austin)	+	=
Blue Cross and Blue Shield of Texas (RGV)	-	=
Blue Cross and Blue Shield of Texas (San Antonio)	-	=
Blue Cross and Blue Shield of Texas (ETX)	-	=
Blue Cross and Blue Shield of Texas (Abilene)	=	=

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Summary Table 4: Diabetes Care

Health Plan	Hemoglobin A1c Control for Patients With Diabetes	Eye Exam for Patients With Diabetes	Kidney Health Evaluation for Patients With Diabetes (Total)	Blood Pressure Control for Patients With Diabetes	Statin Therapy for Patients With Diabetes - Received Statin Therapy
Aetna Health Inc. (Texas)	+	+	+	+	=
Cigna HealthCare of Texas, Inc.	+	+	+	-	+
Blue Cross and Blue Shield of Texas (Houston)	-	-	-	=	=
Blue Cross and Blue Shield of Texas (DFW)	+	=	+	+	=
Humana Health Plan of Texas (Austin)	=	+	-	=	=
Humana Health Plan of Texas (Houston)	=	+	=	-	=
Humana Health Plan of Texas (Corpus Christi)	+	=	-	-	=
Humana Health Plan of Texas (San Antonio)	+	=	-	+	=
Scott and White Health Plan	=	+	+	=	-
Community First Health Plans	+	+	-	+	-
UnitedHealthcare of Texas (Austin/San Antonio)	+	=	=	+	=
CHRISTUS Health	+	+	-	+	=
UnitedHealthcare of Texas (Houston/Corpus Christi)	=	+	=	+	=
UnitedHealthcare of Texas (DFW)	+	+	+	+	=
Memorial Hermann Commercial Health Plan	=	=	=	+	=
Blue Cross and Blue Shield of Texas (Austin)	=	+	-	+	=
Blue Cross and Blue Shield of Texas (RGV)	-	-	-	=	-
Blue Cross and Blue Shield of Texas (San Antonio)	-	-	-	-	-
Blue Cross and Blue Shield of Texas (ETX)	-	-	-	-	-
Blue Cross and Blue Shield of Texas (Abilene)	-	-	-	=	-

+ Higher than Texas Average = Equivalent to Texas Average - Lower than Texas Average
NA – Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
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NQ – Not Required. The organization was not required to report the measure.
** Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Summary Table 5: Behavioral Health

Health Plan	Antidepressant Medication Management - Effective Acute Phase Treatment	Antidepressant Medication Management - Effective Continuation Phase Treatment	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	Follow-Up Care for Children Prescribed ADHD Medication - Cont. and Maint. Phase	Follow-Up After Hospitalization For Mental Illness - 7 days (Total)	Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)	Diagnosed Mental Health Disorders (Total)	Follow-Up After Emergency Department Visit for Substance Abuse - 7 days (Total)	Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)
Aetna Health Inc. (Texas)	=	=	-	=	=	NA	-	NA	NA
Cigna HealthCare of Texas, Inc.	-	-	=	=	+	=	-	=	NA
Blue Cross and Blue Shield of Texas (Houston)	=	=	NR	NR	=	=	=	=	=
Blue Cross and Blue Shield of Texas (DFW)	=	+	NR	NR	=	=	+	=	=
Humana Health Plan of Texas (Austin)	=	=	=	=	NA	NA	-	NA	NA
Humana Health Plan of Texas (Houston)	=	=	=	=	NA	NA	-	NA	NA
Humana Health Plan of Texas (Corpus Christi)	=	=	=	=	NA	NA	-	NA	NA
Humana Health Plan of Texas (San Antonio)	=	=	=	=	=	NA	-	NA	NA
Scott and White Health Plan	-	=	=	=	=	=	=	NA	NA
Community First Health Plans	+	+	=	=	=	NA	+	NA	NA
UnitedHealthcare of Texas (Austin/San Antonio)	=	=	=	=	NA	NA	=	NA	NA
CHRISTUS Health	+	=	=	=	NA	NA	+	NA	NA
UnitedHealthcare of Texas (Houston/Corpus Christi)	=	=	=	=	NA	NA	-	NA	NA
UnitedHealthcare of Texas (DFW)	=	=	=	=	NA	NA	-	NA	NA
Memorial Hermann Commercial Health Plan	NA	NA	=	=	NA	NA	-	NA	NA
Blue Cross and Blue Shield of Texas (Austin)	=	+	NR	NR	=	=	+	=	=
Blue Cross and Blue Shield of Texas (RGV)	=	-	NR	NR	NA	NA	-	NA	NA
Blue Cross and Blue Shield of Texas (San Antonio)	=	=	NR	NR	=	NA	=	NA	NA
Blue Cross and Blue Shield of Texas (ETX)	=	=	NR	NR	=	=	+	NA	NA
Blue Cross and Blue Shield of Texas (Abilene)	=	=	NR	NR	=	NA	-	NA	NA

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NQ – Not Required. The organization was not required to report the measure.
** Plans reporting HMO/POS membership combined. Others are HMO membership only.*

Summary Table 6: Adult Access to Preventative Care, Prenatal and Postpartum

Health Plan	Prenatal and Postpartum Care - Timeliness of Prenatal Care	Prenatal and Postpartum Care - Postpartum Care
Aetna Health Inc. (Texas)	+	-
Cigna HealthCare of Texas, Inc.	-	-
Blue Cross and Blue Shield of Texas (Houston)	=	=
Blue Cross and Blue Shield of Texas (DFW)	-	=
Humana Health Plan of Texas (Austin)	=	=
Humana Health Plan of Texas (Houston)	=	=
Humana Health Plan of Texas (Corpus Christi)	=	=
Humana Health Plan of Texas (San Antonio)	=	=
Scott and White Health Plan	+	+
Community First Health Plans	+	+
UnitedHealthcare of Texas (Austin/San Antonio)	+	+
CHRISTUS Health	NA	NA
UnitedHealthcare of Texas (Houston/Corpus Christi)	+	+
UnitedHealthcare of Texas (DFW)	+	+
Memorial Hermann Commercial Health Plan	=	=
Blue Cross and Blue Shield of Texas (Austin)	=	+
Blue Cross and Blue Shield of Texas (RGV)	=	=
Blue Cross and Blue Shield of Texas (San Antonio)	=	=
Blue Cross and Blue Shield of Texas (ETX)	=	-
Blue Cross and Blue Shield of Texas (Abilene)	-	=

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

Section 2: Effectiveness of Care

Prevention and Screening Measures

Childhood Immunization Status: Diphtheria, Tetanus, and Acellular Pertussis (DTaP)

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

Diphtheria is a bacterial respiratory infection characterized by a sore throat, low-grade fever, a coating in the back of the throat, and a swollen neck. The disease is spread by coughing and sneezing. Complications include breathing problems, paralysis, heart failure, and death.[3]

Tetanus (lockjaw) is a bacterial infection caused by exposure through cuts in the skin. The disease causes painful tightening of the muscles and can cause the jaw to "lock" closed. Tetanus leads to death in about 1 in 10 cases.[4]

Pertussis (whooping cough) is a highly contagious bacterial respiratory disease spread by coughing and sneezing. The patient experiences severe spasms of coughing that often lasts minutes. Between coughing spells, the patient may gasp for air with a characteristic "whooping" sound. If left untreated, pertussis may lead to pneumonia (a lung infection), seizures, encephalopathy (brain degeneration), vomiting, weight loss, breathing difficulties, and possibly death.[5]

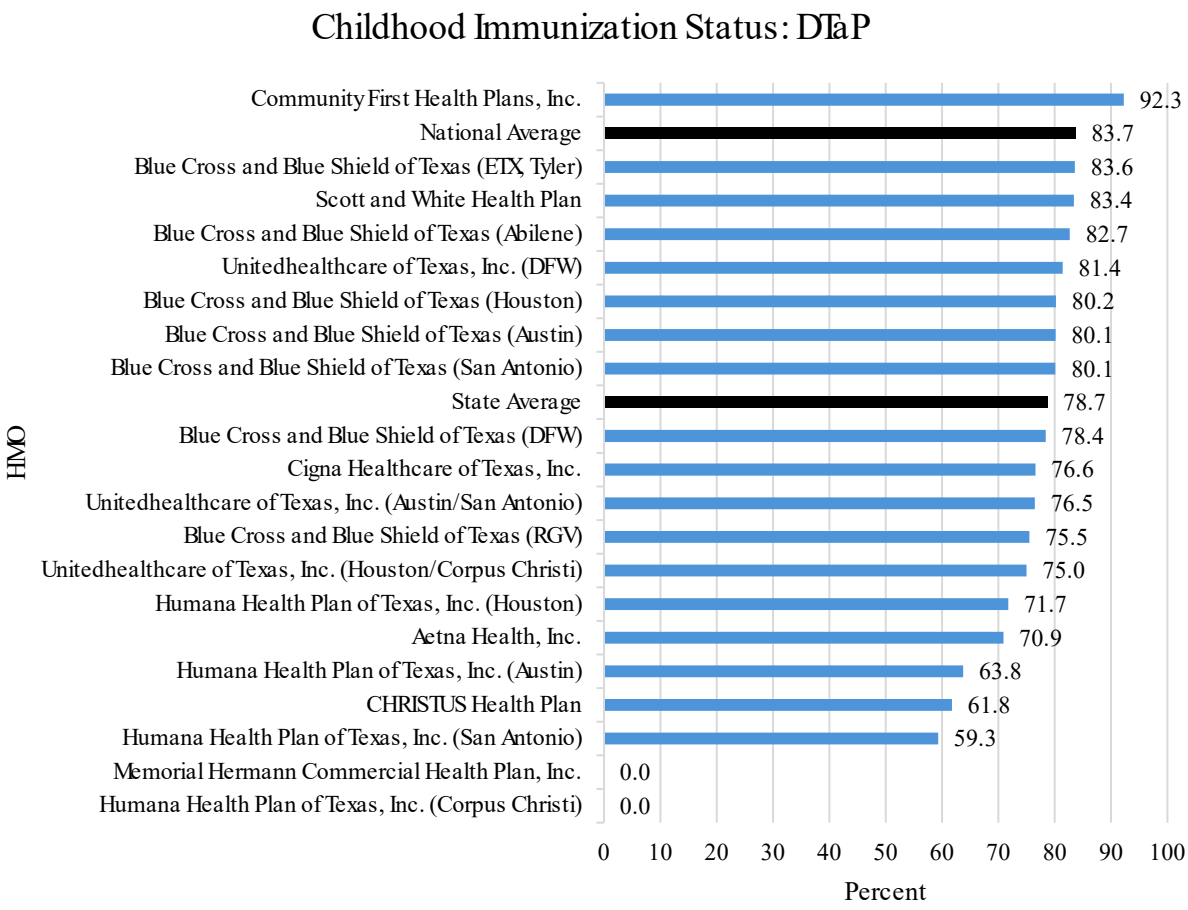
Four combination vaccines prevent diphtheria, tetanus, and acellular pertussis: DTaP, Tdap, DT, and Td. Children under seven get DTaP and DT. Tdap and Td are given to adolescents and adults. DT and Td are given to individuals who cannot receive the pertussis vaccine. Upper-case letters indicate full-strength doses of diphtheria and pertussis in child formulas and lower-case letters indicate reduced doses given in the adolescent/adult formulas. The lowercase "a" indicates that the pertussis vaccine is "acellular."[6]

Table 1: Childhood Immunization Status: DTaP

Childhood Immunization Status: DTaP					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	78.0%	73.8%	*	*	78.7%
NCQA's Quality Compass®[7] **	85.8%	86.3%	*	*	83.7%

* Data not analyzed for these years.
** Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA. Quality Compass® is a registered trademark of NCQA.

Chart 1: Childhood Immunization Status: DTaP



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Polio (IPV)

Definition: The percentage of children using the HMO who received at least three doses of the Inactivated Polio Vaccine (IPV) by the age of two.

Polio is a viral disease that lives in the throat and intestinal tract. It typically spreads through contact with the stool of an infected person but may also spread through oral/nasal secretions. Before the vaccine was introduced in 1955, polio caused paralysis in thousands of people in the U.S. each year. Most people infected with the polio virus have no symptoms. About 4-8% of those infected experience flu-like symptoms that resolve without causing permanent injury. Approximately 1-2% of infected individuals experience stiffness of the neck, back, or legs. Fewer than 1% of the total cases result in paralysis which can lead to permanent disability or death.[8]

Table 2: Childhood Immunization Status: Polio (IPV)

Childhood Immunization Status: Polio (IPV)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	85.4%	79.7%	*	*	86.8%
NCQA's Quality Compass®	91.3%	91.3%	*	*	89.5%

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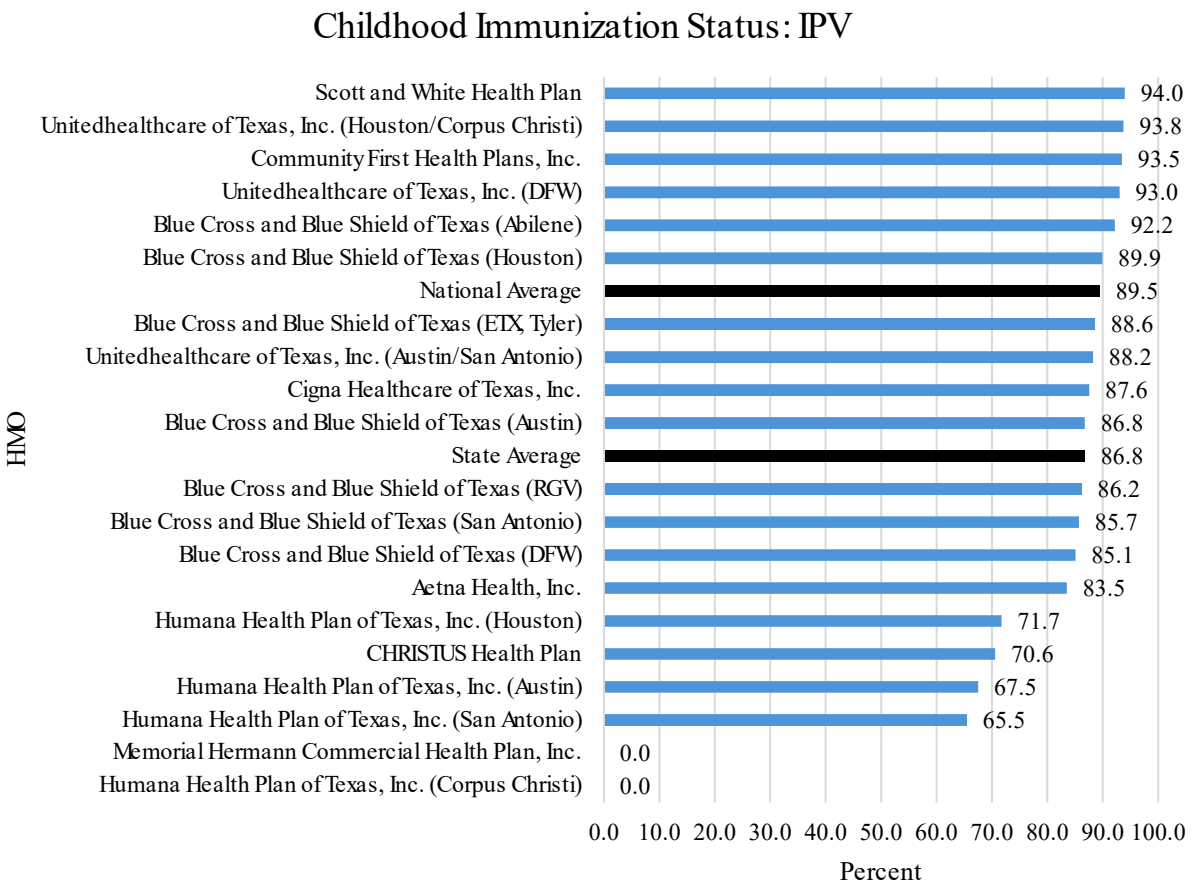
* Data not analyzed for these years.

Chart 2: Childhood Immunization Status: Polio (IPV)



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

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

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

Measles is a highly contagious viral disease that causes rash, cough, runny nose, eye irritation, and fever. Complications include ear infection, pneumonia (a lung infection), seizures, brain damage, or death. Measles infection was nearly universal before a vaccine was available.

Mumps is a viral disease that causes fever, headache, and swollen salivary glands. It can cause serious complications like hearing loss, encephalitis (inflammation of the brain), and meningitis (inflammation of the coverings of the brain and spinal cord).

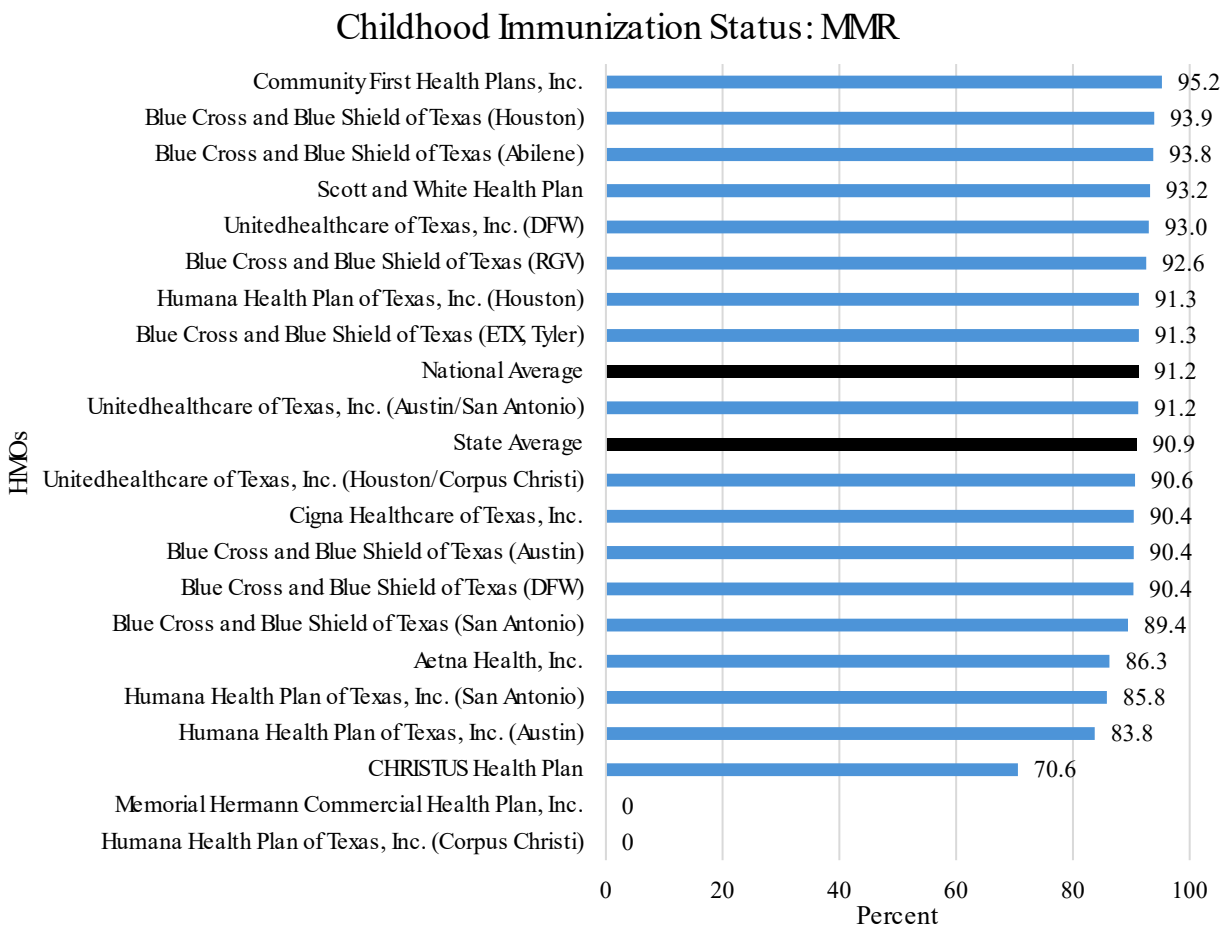
Rubella (German Measles) is a viral disease that causes rash, mild fever, and arthritis. The disease is typically mild in children and young adults. However, a woman who contracts rubella during pregnancy may spread the disease to the fetus. The condition, Congenital Rubella Syndrome (CRS), can result in miscarriage, stillbirth, or severe birth defects. The most common birth defects are blindness, deafness, heart damage, and intellectual disabilities.

Table 3: Childhood Immunization Status: MMR

Childhood Immunization Status: MMR					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	90.8%	90.2%	*	*	90.9%
NCQA's Quality Compass®	92.3%	92.6%	*	*	91.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 3: Childhood Immunization Status: MMR



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Childhood Immunization Status: Haemophilus Influenzae Type B (HiB)

Definition: The percentage of children using the HMO who received at least three doses of the Haemophilus influenzae type B (HiB) vaccine by the age of two.

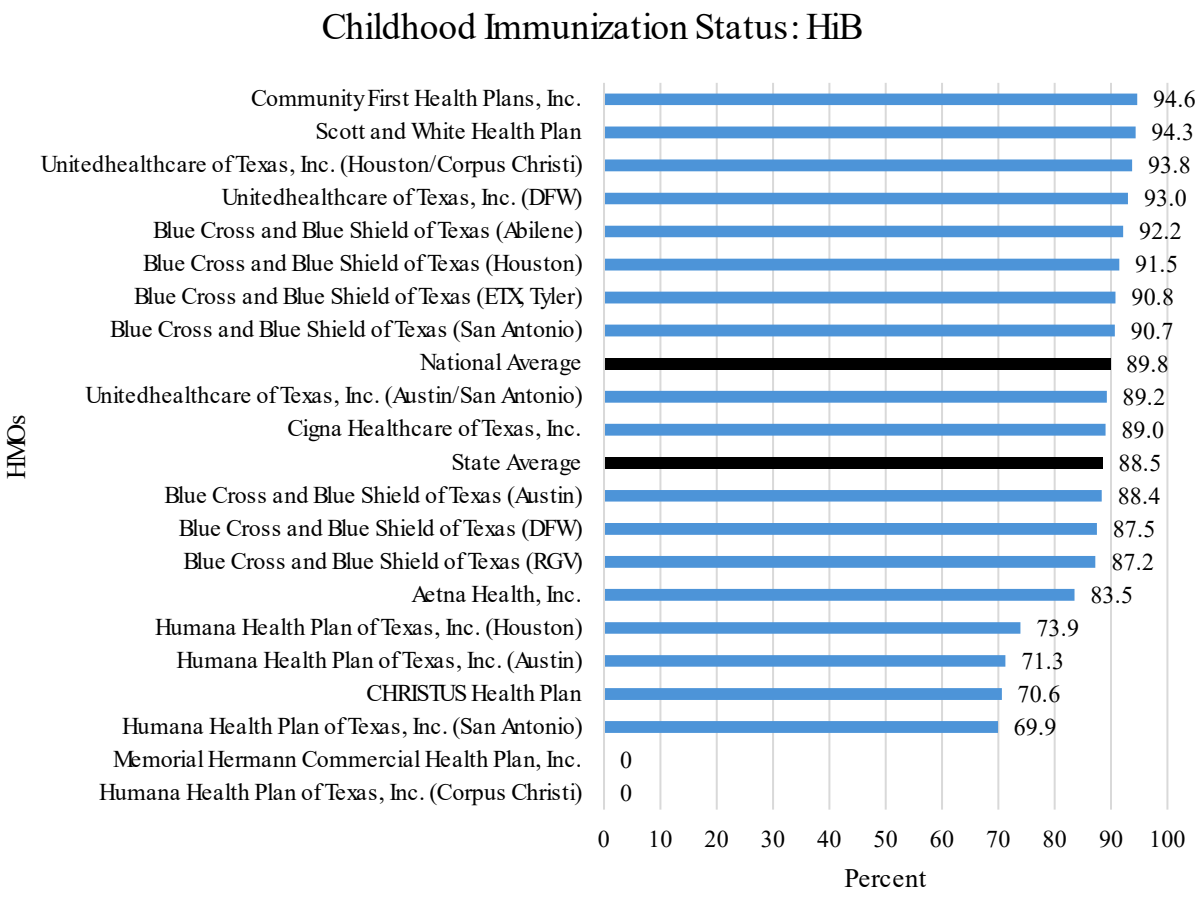
HiB is a bacterial infection that can cause meningitis (an infection of the covering of the brain and spinal cord), pneumonia (a lung infection), epiglottitis (a severe throat infection), and other life-threatening conditions. HiB was the leading cause of bacterial meningitis and other invasive bacterial disease among children younger than five before the introduction of effective vaccines in the mid-1980s. Prior to the development of vaccines, approximately two-thirds of all HiB cases occurred among children younger than 18 months. The routine use of the HiB conjugate vaccine has reduced the incidence of HiB in infants and young children by 99% since the introduction of the vaccine.[9]

Table 4: Childhood Immunization Status: HiB

Childhood Immunization Status: HiB					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	87.2%	82.6%	*	*	88.5%
NCQA's Quality Compass®	91.4%	91.7%	*	*	89.8%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 4: Childhood Immunization Status: HiB



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Breast Cancer Screening

Definition: The percentage of women 50-74 years of age who received a mammogram to screen for breast cancer.

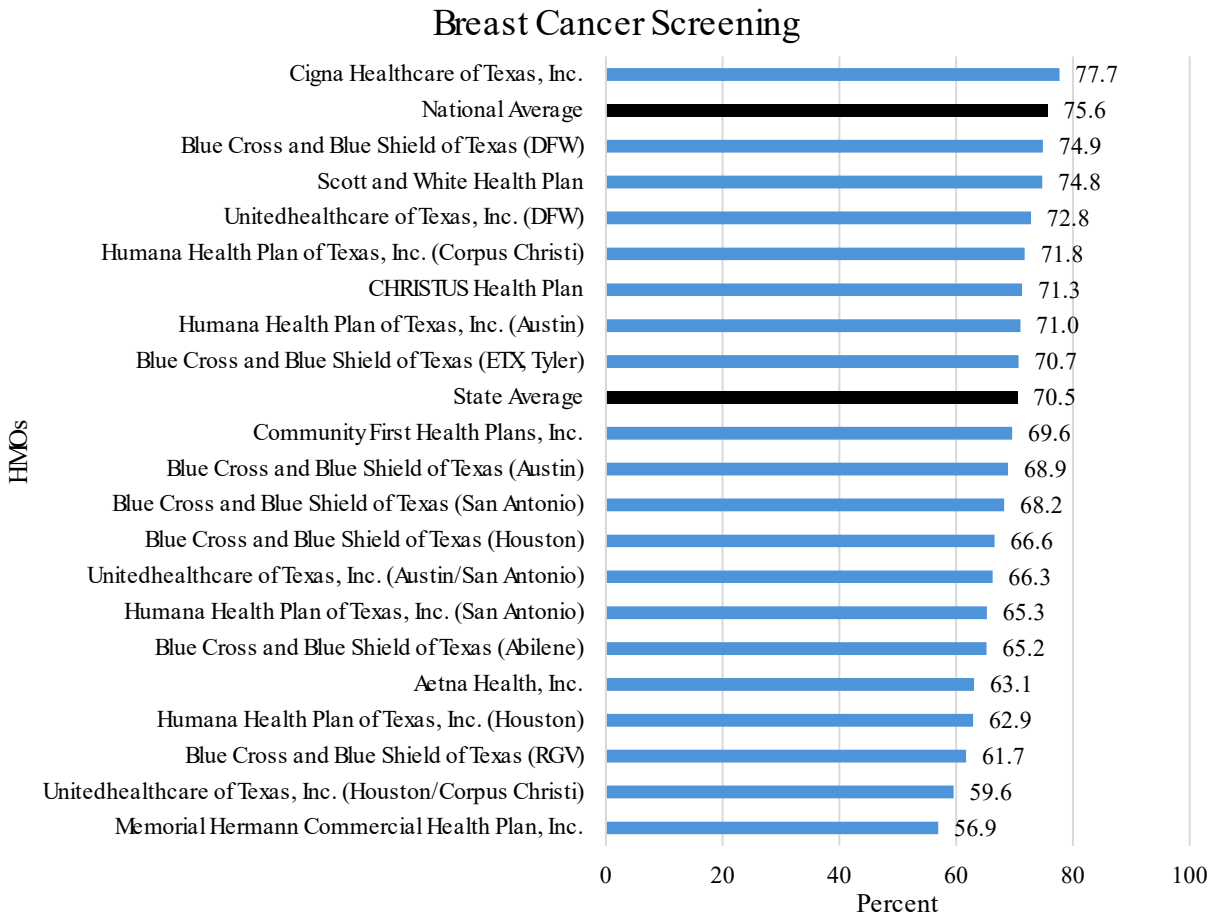
A **mammogram**, an x-ray of the tissues inside the breast, can detect breast cancer before a woman has signs or symptoms of the disease. Early detection of breast cancer often leads to a greater range of treatment options, including less-invasive options. A mammogram will not detect all breast cancers, and some breast cancers may still have poor prognosis. However, regular mammograms in women over the age of 40 can reduce the risk of a woman dying from breast cancer.[10]

Table 5: Breast Cancer Screening

Breast Cancer Screening					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	71.3%	72.0%	*	*	70.5%
NCQA's Quality Compass®	73.5%	73.7%	*	*	75.6%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 5: Breast Cancer Screening



Cervical Cancer Screening

Definition: The percentage of women 21-64 years of age who received 1 or more Pap tests to screen for cervical cancer during the previous 3 years.

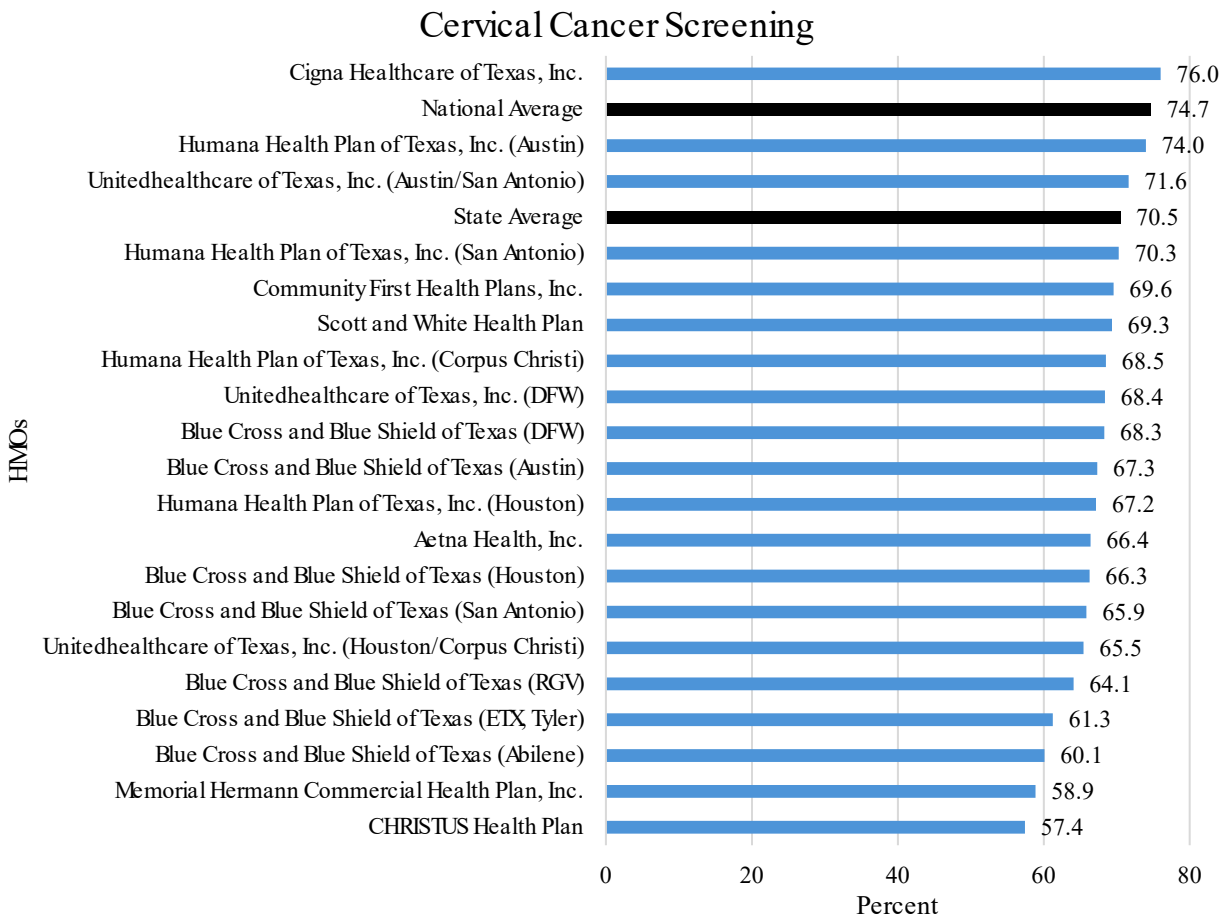
Cervical cancer often has no recognizable symptoms until it reaches an advanced stage. Regular Pap tests can detect cervical cancer before symptoms are present. A Pap test uses cells collected from the cervix to detect cancerous and precancerous cells. The test can also detect noncancerous conditions such as infection and inflammation.[11] Early detection and treatment of cancer through Pap screening has reduced the rate of deaths from cervical cancer by 50%.[12] The American College of Obstetricians and Gynecologists (ACOG)[13] and the American Cancer Society (ACS)[14] recommend Pap testing every 3 years for women 21-65.

Table 6: Cervical Cancer Screening

Cervical Cancer Screening					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	73.2%	73.3%	*	*	70.5%
NCQA's Quality Compass®	75.2%	76.2%	*	*	74.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 6: Cervical Cancer Screening



Colorectal Cancer Screening

Definition: The percentage of adult members 46-75 years of age who had an appropriate screening for colorectal cancer.

Colorectal cancer (CRC) is the third leading cause of cancer-related deaths in the U.S. CRC typically develops from a noncancerous polyp and grows slowly over a period of 10-15 years. Systematic screening can identify polyps before cancer develops or detect cancer in its early stages when treatment is most effective and least invasive.[15]

The incidence of CRC increases with age. Approximately 90% of new cases occur in adults over the age of 50.[16] This measure reports the percentage of adults 46-75 years of age who have received an appropriate screening for CRC. "Appropriate screening" is defined as one of the following:

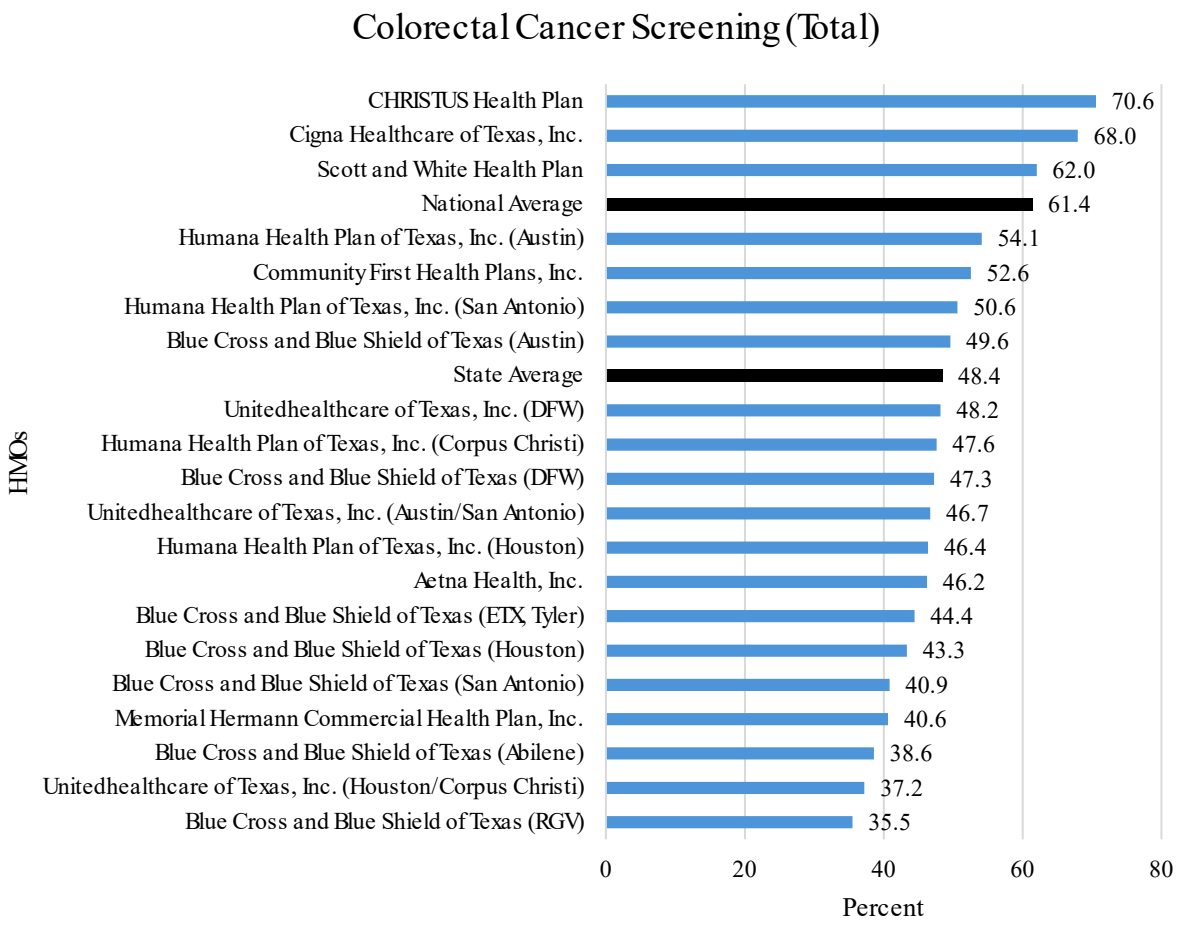
- a fecal occult blood test (FOBT) during the measurement year;
- a flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year;
- a double contrast barium enema (DCBE) during the measurement year or the 4 years prior to the measurement year; or
- a colonoscopy during the measurement year or the 9 years prior to the measurement year.

Table 7: Colorectal Cancer Screening (Total)

Colorectal Cancer Screening (Total)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	52.9%	53.2%	*	*	48.4%
NCQA's Quality Compass®	64.1%	65.0%	*	*	61.4%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 7: Colorectal Cancer Screening (Total)



Chlamydia Screening in Women

Definition: The percentage of women 16-20 or 21-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

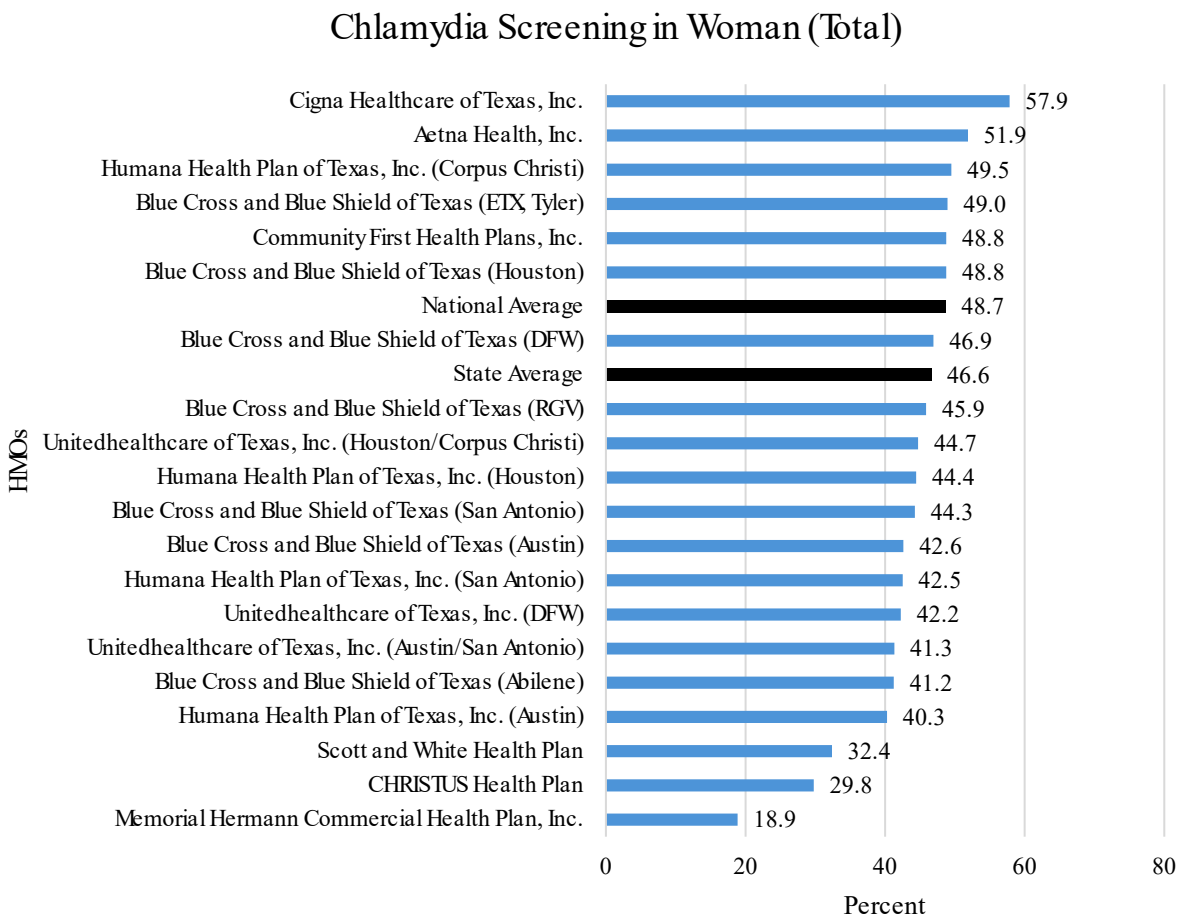
Chlamydia is a sexually transmitted bacterial infection. The Centers for Disease Control and Prevention (CDC) estimates that nearly 3 million chlamydia infections occur in the U.S. each year. The majority of infected people do not have symptoms. In women, an untreated chlamydia infection can cause damage to the reproductive system, chronic pelvic pain, and ectopic pregnancy. Sexually active adolescent and young adult women may be more susceptible to infection because the cervix has not fully matured. Antibiotics can treat and cure chlamydia.[17]

Chart 8: Chlamydia Screening in Women (Total)

Chlamydia Screening in Women: Total					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	45.8%	47.2%	*	*	46.9%
NCQA's Quality Compass®	50.6%	51.5%	*	*	48.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 8: Chlamydia Screening in Women: Ages (Total)



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Respiratory Condition Measures

Appropriate Testing for Children with Pharyngitis

Definition: The percentage of members 3-17 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

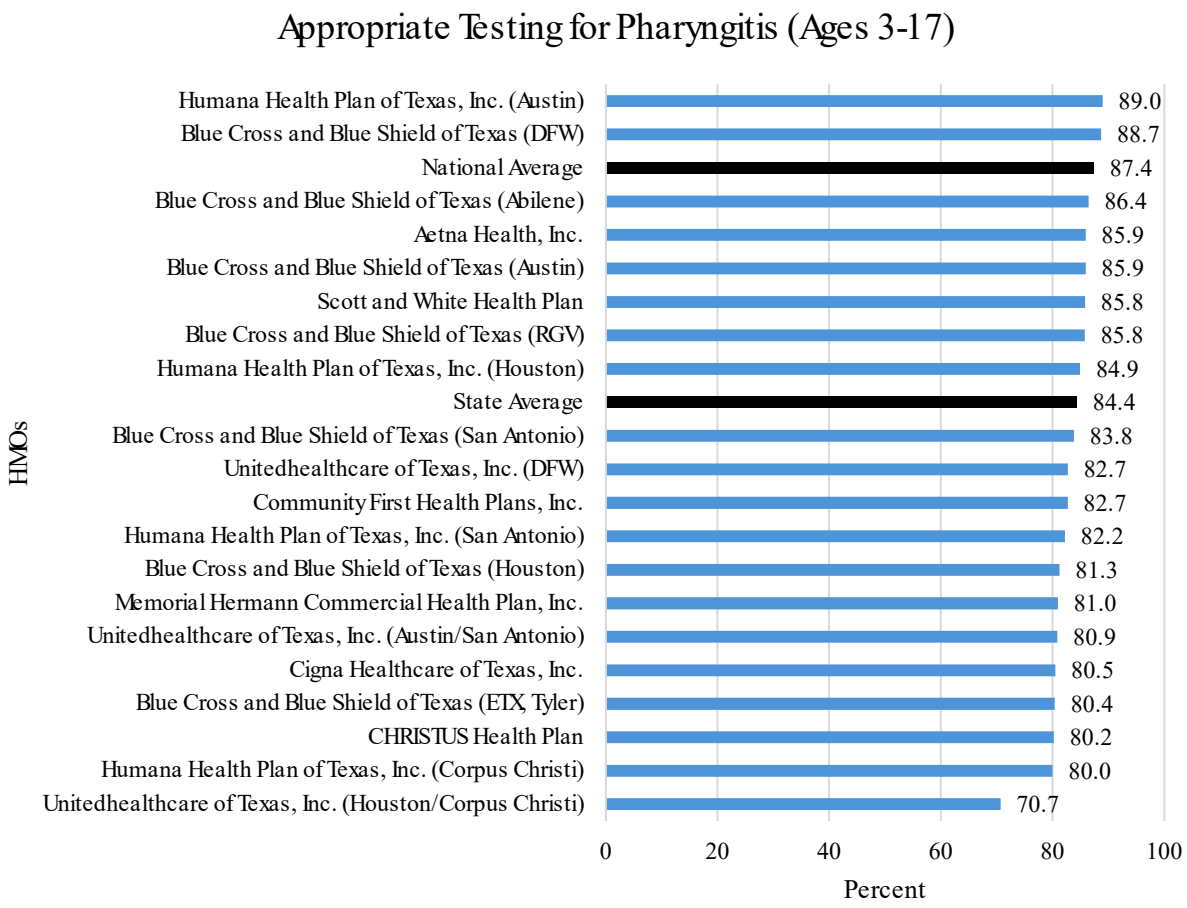
Pharyngitis (sore throat) can be caused by a virus or bacteria and a physician can definitively confirm the diagnosis with a lab test. Antibiotics can effectively treat diseases caused by bacteria, but most upper respiratory infections (URIs) are caused by viruses and cannot be treated with antibiotics.
Antibiotic use to treat pharyngitis can serve as an important indicator of appropriate antibiotic use in children because pediatric clinical practice guidelines recommend only treating children diagnosed with group A streptococcus pharyngitis (strep throat) with antibiotics.[18]

Table 9: Appropriate Testing for Children with Pharyngitis (Ages 3-17)

Appropriate Testing for Children with Pharyngitis (Ages 3-17)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	85.4%	83.9%	*	*	84.4%
NCQA's Quality Compass®	87.3%	86.2%	*	*	87.4%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 9: Appropriate Testing for Children with Pharyngitis (Ages 3-17)



Cardiovascular Condition Measures

Controlling High Blood Pressure

Definition: The percentage of members 18-85 years of age diagnosed with hypertension (high blood pressure), whose blood pressure was adequately controlled during the measurement year.

Adequate control is based on the following criteria: the member was 18-59 years of age whose blood pressure was <140/90 mm Hg; the member was 60-85 years of age with a diagnosis of diabetes whose blood pressure was <140/90 mm Hg; or the member was 60-85 years of age without a diagnosis of diabetes whose blood pressure was <150/90 mm Hg.

High blood pressure is a common condition that approximately 80 million American adults have according to the American Heart Association (AHA). High blood pressure (greater than 140/90 mm Hg) usually has no specific symptoms and no early warning signs. If left untreated, it increases an individual's risk for heart disease, stroke, congestive heart failure, and kidney disease.[19]

Table 10: Controlling High Blood Pressure

Controlling High Blood Pressure					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	14.5%	13.5%	*	*	36.8%
NCQA's Quality Compass®	61.3%	62.1%	*	*	62.5%

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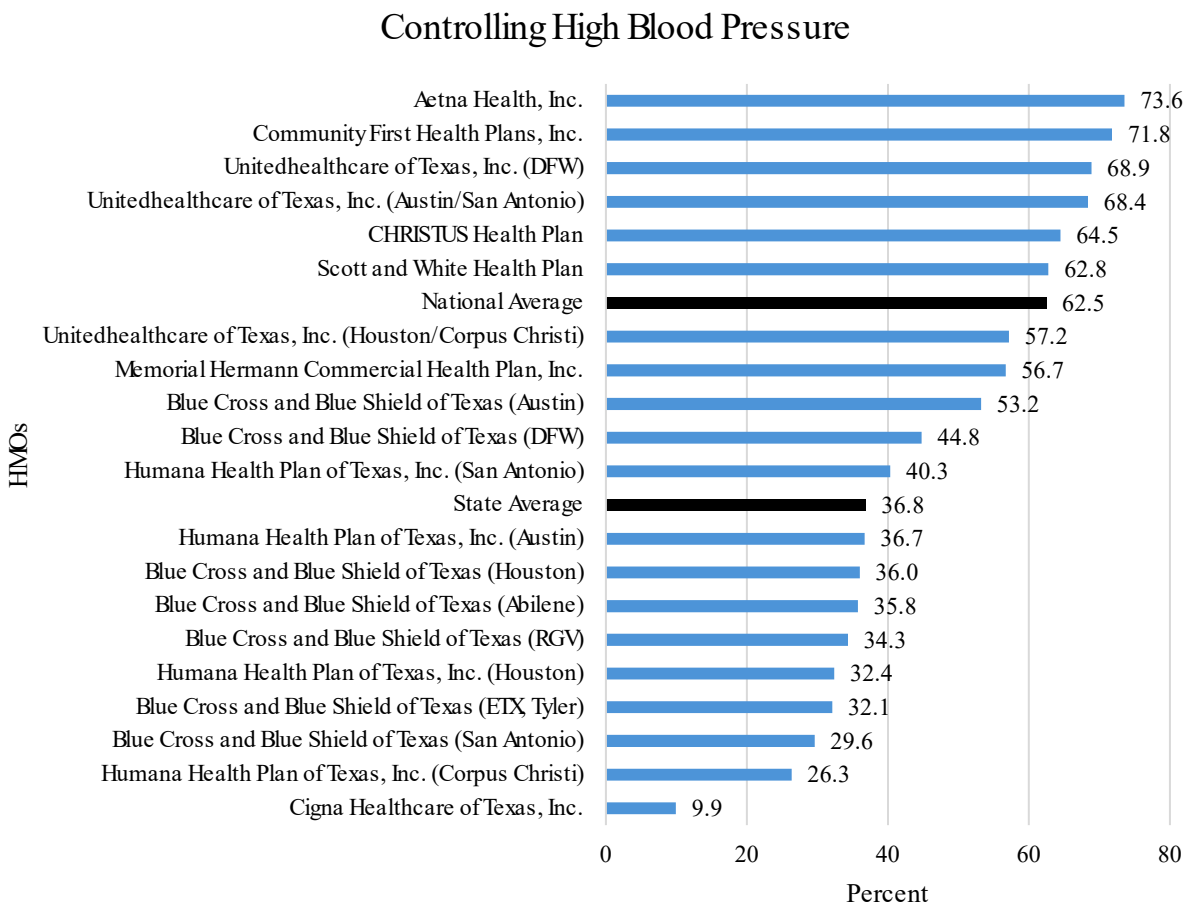
* Data not analyzed for these years.

Chart 10 Controlling High Blood Pressure



Statin Therapy for Patients with Cardiovascular Disease

Definition: The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rate is reported: Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.

Statins (HMG CoA reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by preventing the formation of cholesterol, thus lowering the amount of cholesterol in the blood.[20] Statins are most effective in lowering low-density lipoprotein cholesterol (LDL-C). The amount of cholesterol-lowering effect is based on statin intensity, which is classified as either high, moderate, or low.

Table 11: Statin Therapy for Patients with Cardiovascular Disease (Total)

Statin Therapy for Patients with Cardiovascular Disease (Total)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	77.8%	79.1%	*	*	80.8%
NCQA's Quality Compass®	80.7%	81.9%	*	*	82.5%

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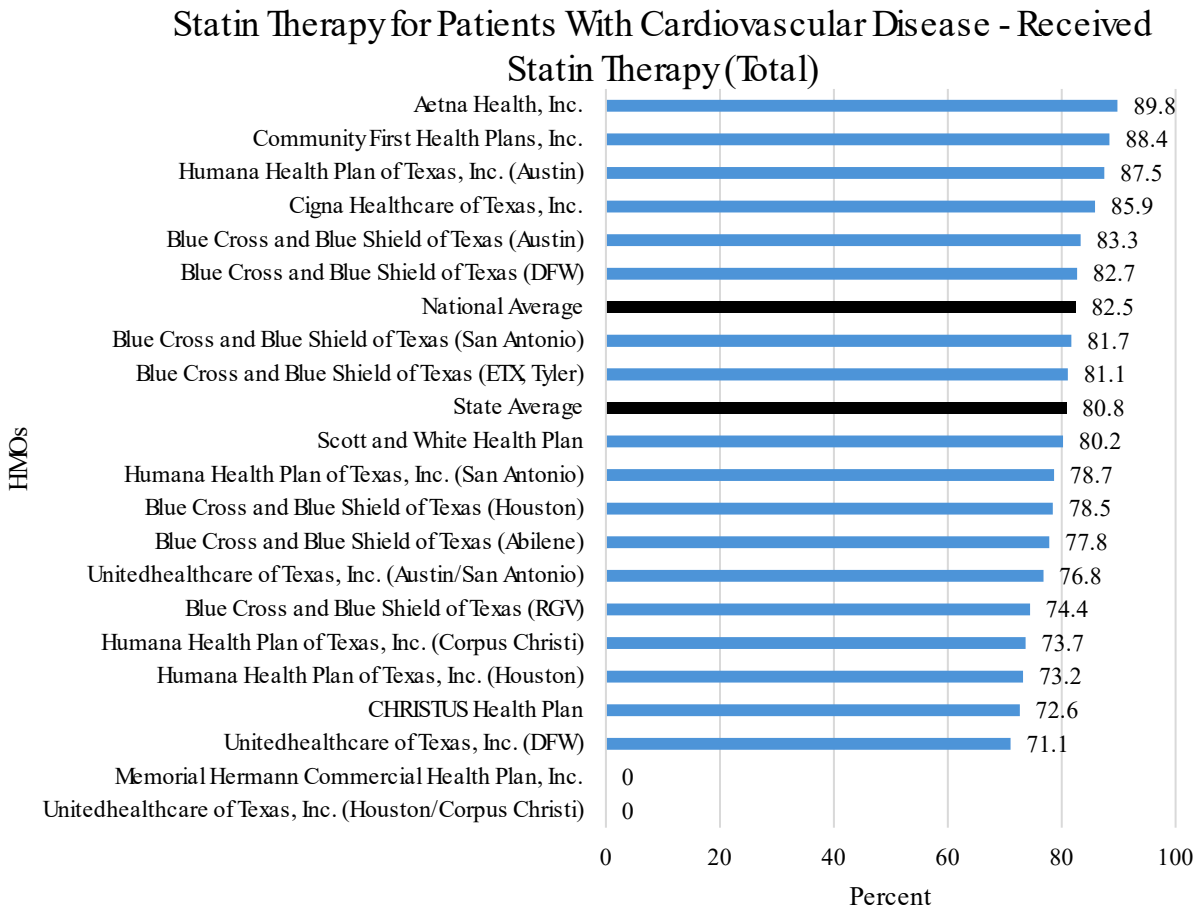
* Data not analyzed for these years.

Chart 11: Statin Therapy for Patients with Cardiovascular Disease (Total)



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Diabetes Measures

Hemoglobin A1c Control for Patients with Diabetes

Definition: The percentage of members 18-75 years of age with Type 1 or Type 2 Diabetes who had one or more hemoglobin A1c (HbA1c) tests conducted within the past year.

Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.

The HbA1c test is one of the tests used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under 7% have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of 8% or higher.[21] The American Diabetes Association (ADA) recommends a therapeutic goal of 7% and encourages physicians to reevaluate treatment regimes in patients with levels consistently above 8%. HbA1c levels over 9% indicate poorly controlled diabetes.[22]

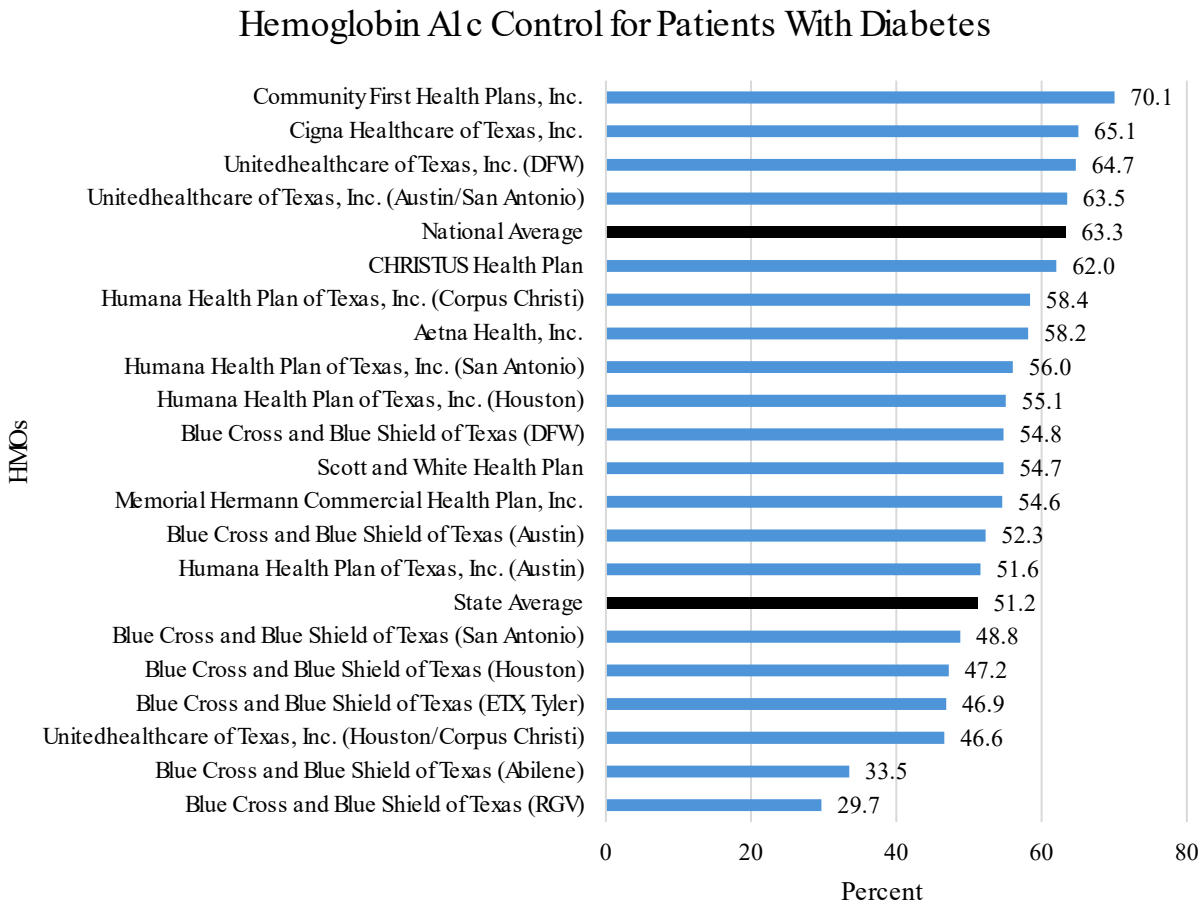
ADA recommends that an individual diagnosed with diabetes have this test performed at least twice a year. An individual with diabetes should continue to perform daily self-tests to monitor day-to-day blood glucose control.[23]

Table 12: Hemoglobin A1c Control for Patients with Diabetes

Hemoglobin A1c Control for Patients with Diabetes					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	*	*	*	*	51.2%
NCQA's Quality Compass®	*	*	*	*	63.3%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 12: Hemoglobin A1c Control for Patients with Diabetes



Blood Pressure Control for Patients with Diabetes

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

Adults with diabetes are 2-4 times more likely to have cardiovascular disease (heart disease or stroke) than individuals without diabetes. Blood pressure control can reduce the risk of heart attack and stroke as well as other diabetes related complications such as retinopathy (damage to the blood vessels in the retina) and nephropathy (damage to blood vessels in the kidneys).[24] The National Institutes of Health (NIH) recommends that individuals with diabetes maintain their blood pressure below 130/80 mm Hg.[25]

Table 13: Blood Pressure Control for Patients with Diabetes

Blood Pressure Control for Patients with Diabetes					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	22.3%	21.3%	*	*	52.9%
NCQA's Quality Compass®	64.2%	65.0%	*	*	64.6%

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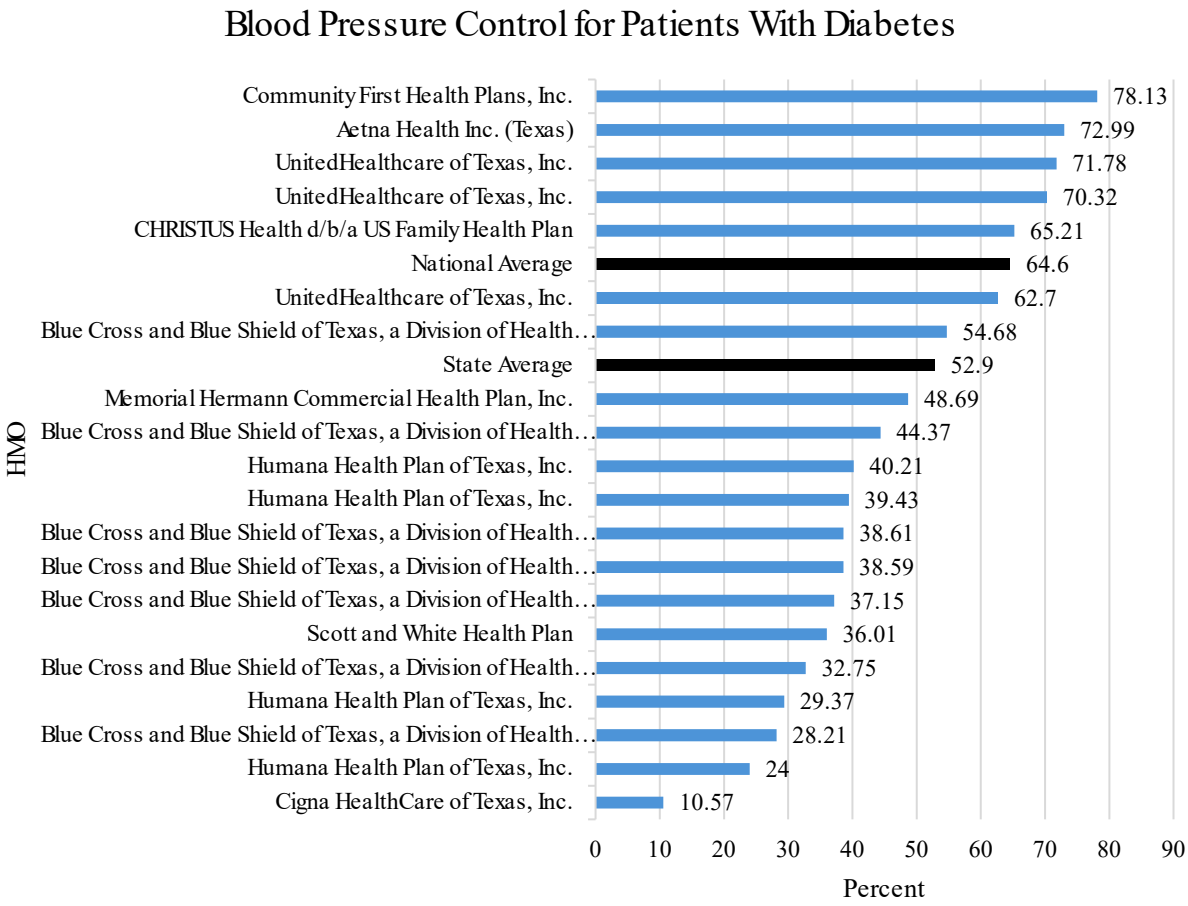
* Data not analyzed for these years.

Chart 13: Blood Pressure Control for Patients with Diabetes



Eye Exam for Patients with Diabetes

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

Diabetic retinopathy is caused by changes in the blood vessels in the retina. It is the most common diabetic eye disease and a leading cause of blindness in American adults. In some people with diabetic retinopathy, blood vessels swell and leak fluid. In others, abnormal new blood vessels grow on the surface of the retina. Between 40-45% of Americans diagnosed with diabetes have some stage of diabetic retinopathy. Individuals with proliferative retinopathy can reduce their risk of blindness by 95% with timely treatment and appropriate follow-up care.[26]

Table 14: Eye Exam for Patients with Diabetes

Eye Exam for Patients with Diabetes					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	33.1%	33.4%	*	*	30.4%
NCQA's Quality Compass®	55.9%	55.1%	*	*	51.8%

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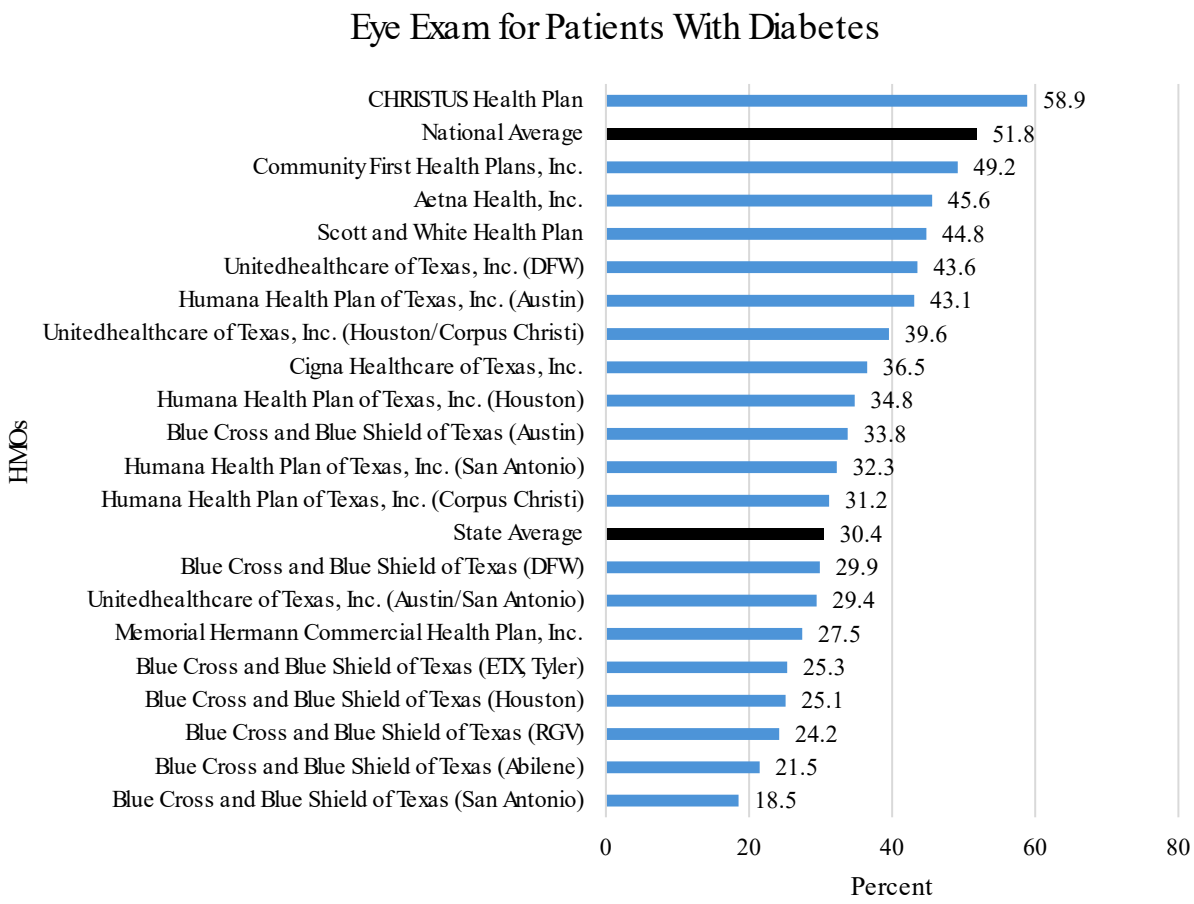
* Data not analyzed for these years.

Chart 14: Eye Exam for Patients with Diabetes



Statin Therapy for Patients with Diabetes

Definition: The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and received statin therapy, defined as being dispensed at least one statin medication of any intensity during the measurement year.

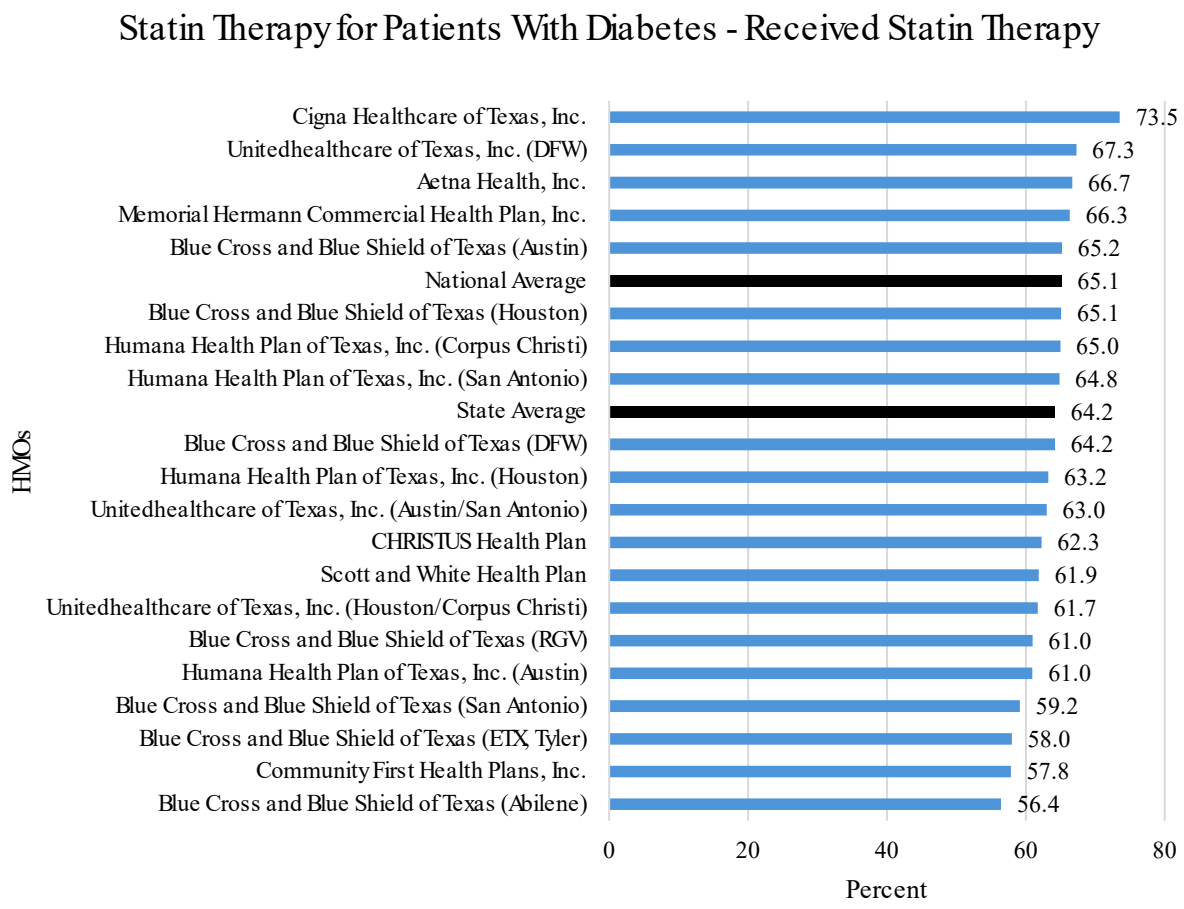
Statins (HMG CoA reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by preventing the formation of cholesterol, thus lowering the amount of cholesterol in the blood.[27] Statins are most effective in lowering low-density lipoprotein cholesterol (LDL-C). The amount of cholesterol-lowering effect is based on statin intensity, which is classified as either high, moderate, or low.

Table 15: Statin Therapy for Patients with Diabetes

Statin Therapy for Patients with Diabetes (Total)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	62.2%	64.0%	*	*	64.2%
NCQA's Quality Compass®	63.0%	64.0%	*	*	65.1%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 15: Statin Therapy for Patients with Diabetes: Received Statin Therapy



Kidney Health Evaluation for Patients With Diabetes

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

Diabetic nephropathy, or kidney disease, is a frequent complication of diabetes. Diabetic nephropathy is a progressive disease that develops over several years. In healthy individuals, many tiny vessels (nephrons) in the kidneys filter waste, chemicals, and excess water from the blood. When an individual has diabetic nephropathy, the nephrons become damaged, leaky, and eventually quit working. The stress on the remaining nephrons damages them as well. When the filtration system breaks down, the kidneys fail to function causing end-stage renal disease (ESRD). An individual with ESRD will require dialysis or a kidney transplant to survive.[28]

Table 16: Kidney Health Evaluation for Patients With Diabetes (Total)

Kidney Health Evaluation for Patients With Diabetes (Total)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	91.0%	91.0%	*	*	51.1%
NCQA's Quality Compass®	90.3%	90.1%	*	*	49.3%

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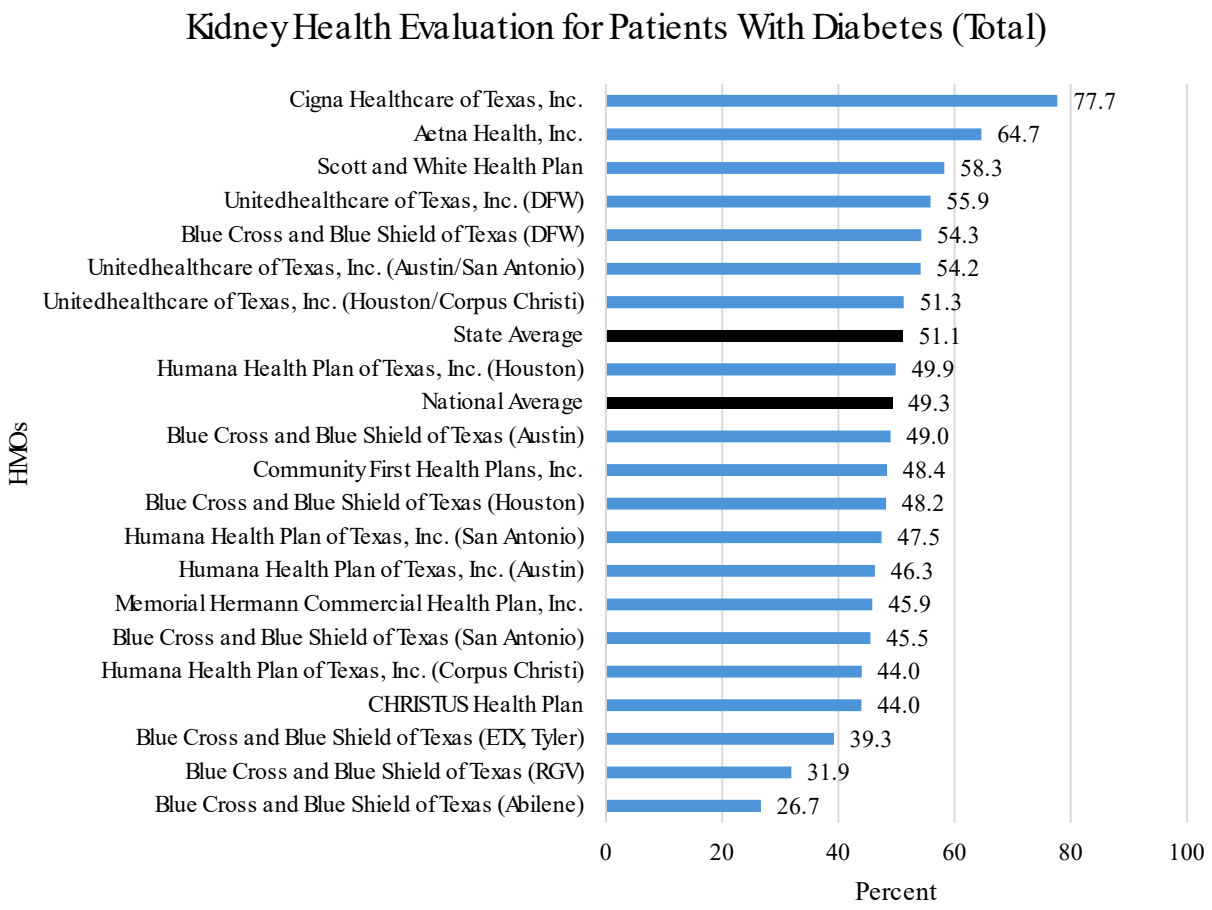
* Data not analyzed for these years.

Table 16: Kidney Health Evaluation for Patients With Diabetes (Total)



Behavioral Health Measures

Diagnosed Mental Health Disorders

Definition: The percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.

In 2022, it was estimated that 23.1%—or more than 1 in 5 adults—had had a mental illness in the past year.[29] Mental illness can be defined as mental, behavioral or emotional disorders (excluding substance use) that meet duration and other diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders. Among individuals with any mental illness in the past year (59.3 million), approximately half received mental health treatment.[30] Untreated mental illness can result in unnecessary disability, loss of productivity, serious health problems and decreased quality of life overall.2

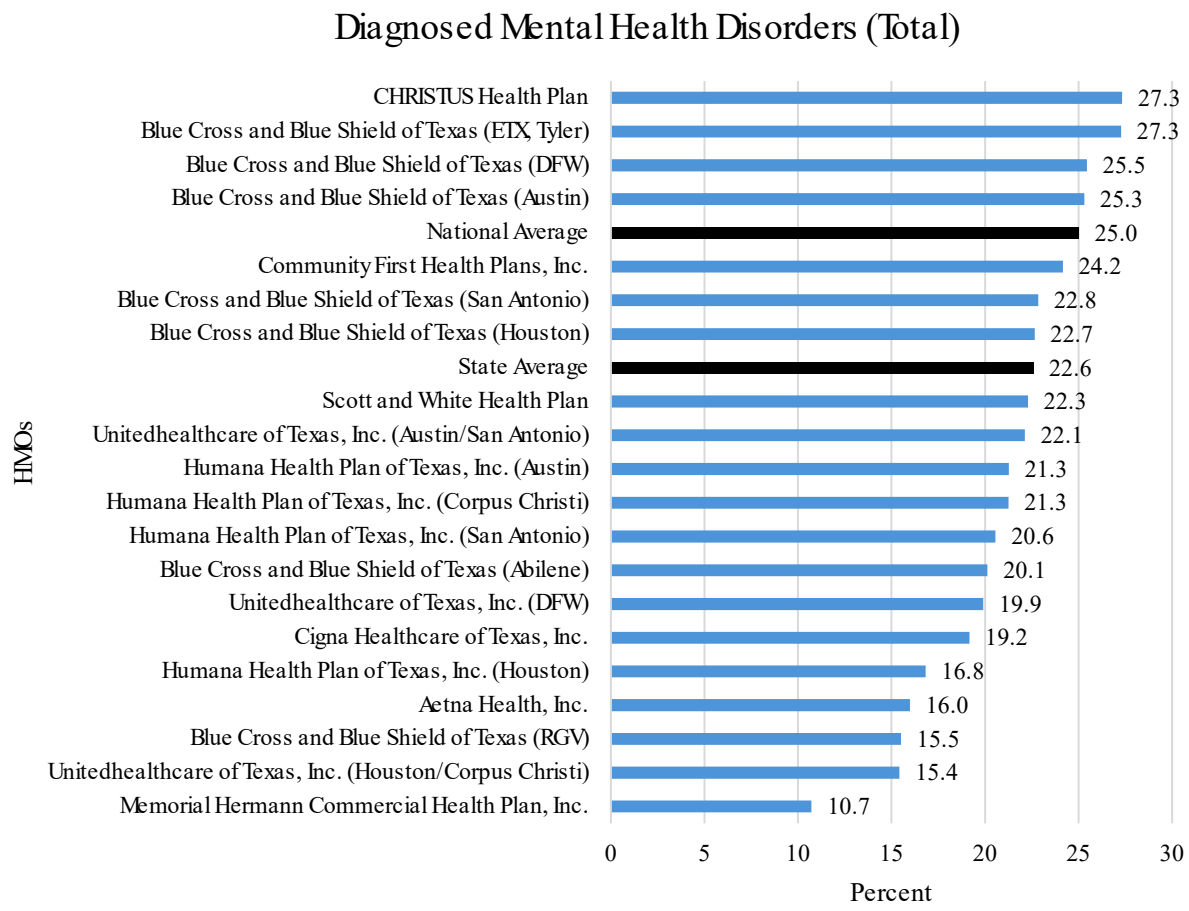
Note: The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.

Table 17: Diagnosed Mental Health Disorders (Total)

Diagnosed Mental Health Disorders (Total)					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	*	*	*	*	22.6%
NCQA's Quality Compass®	*	*	*	*	25.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 17: Diagnosed Mental Health Disorders (Total)



Note: The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.

Antidepressant Medication Management: Effective Acute Phase Treatment

Definition: The percentage of members 18 or older who were diagnosed with major depression, treated with antidepressant medication, and who remained on an antidepressant medication during the entire 84-day (12-week) Acute Phase Treatment.

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year.[31][32] Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[33]

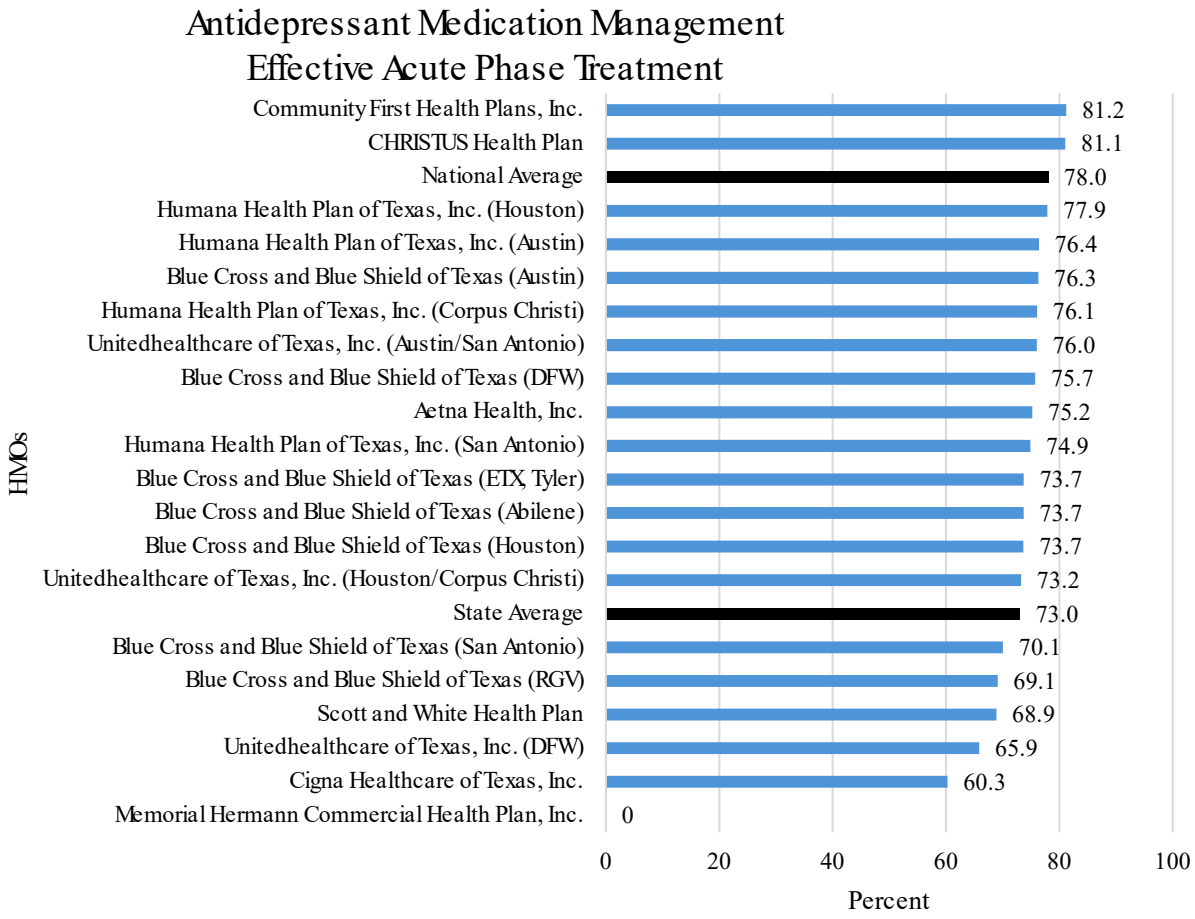
Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.

Table 18: Antidepressant Medication Management: Effective Acute Phase Treatment

Antidepressant Medication Management: Effective Acute Phase Treatment					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	66.0%	69.0%	*	*	73.0%
NCQA's Quality Compass®	69.2%	69.4%	*	*	78.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 18: Antidepressant Medication Management: Effective Acute Phase Treatment



Antidepressant Medication Management: Effective Continuation Phase Treatment

Definition: The percentage of members 18 or older who were diagnosed with major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year.[34][35] Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[36]

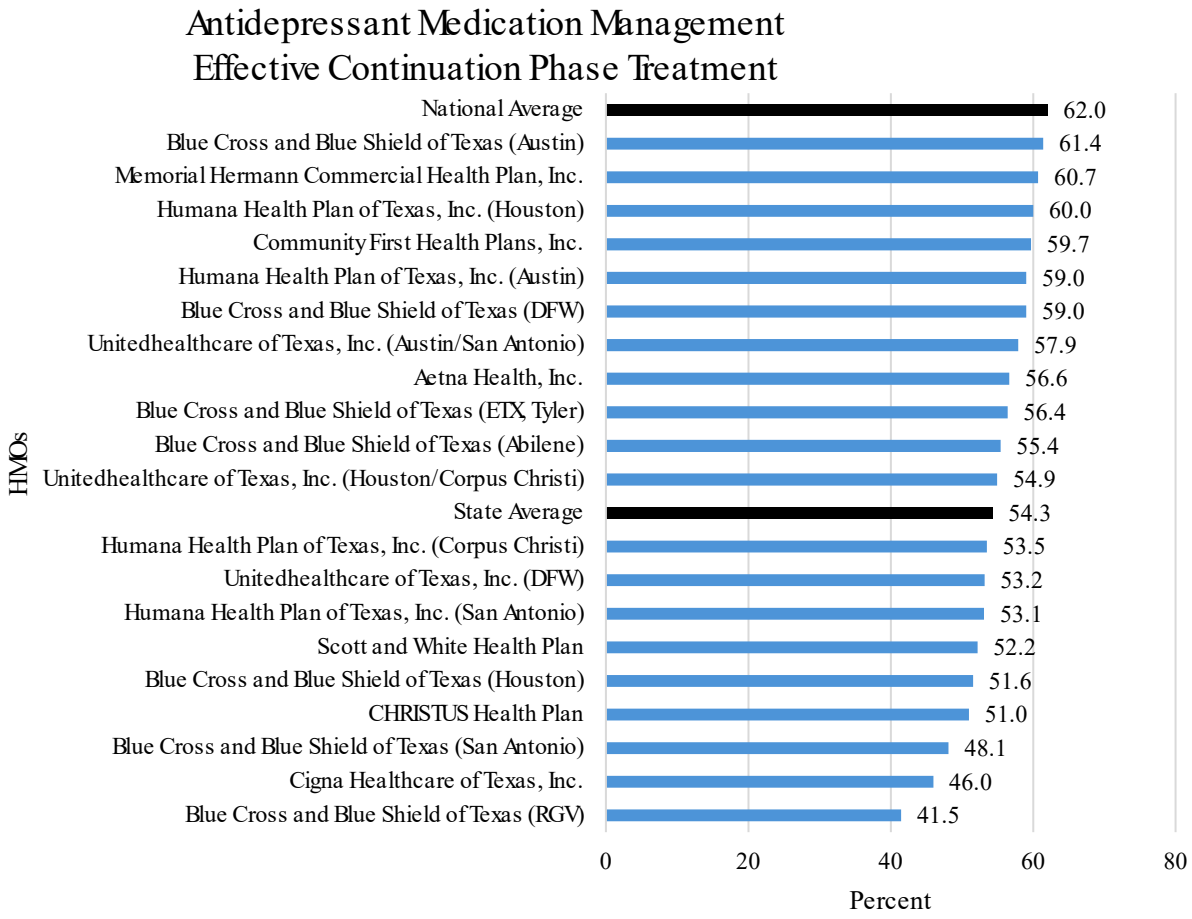
Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.

Table 19: Antidepressant Medication Management: Effective Continuation Phase Treatment

Antidepressant Medication Management: Effective Continuation Phase Treatment					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	49.8%	51.1%	*	*	54.3%
NCQA's Quality Compass®	52.9%	53.1%	*	*	62.0%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 19: Antidepressant Medication Management: Effective Continuation Phase Treatment



Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase

Definition: The percentage of children 6-12 years of age, newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

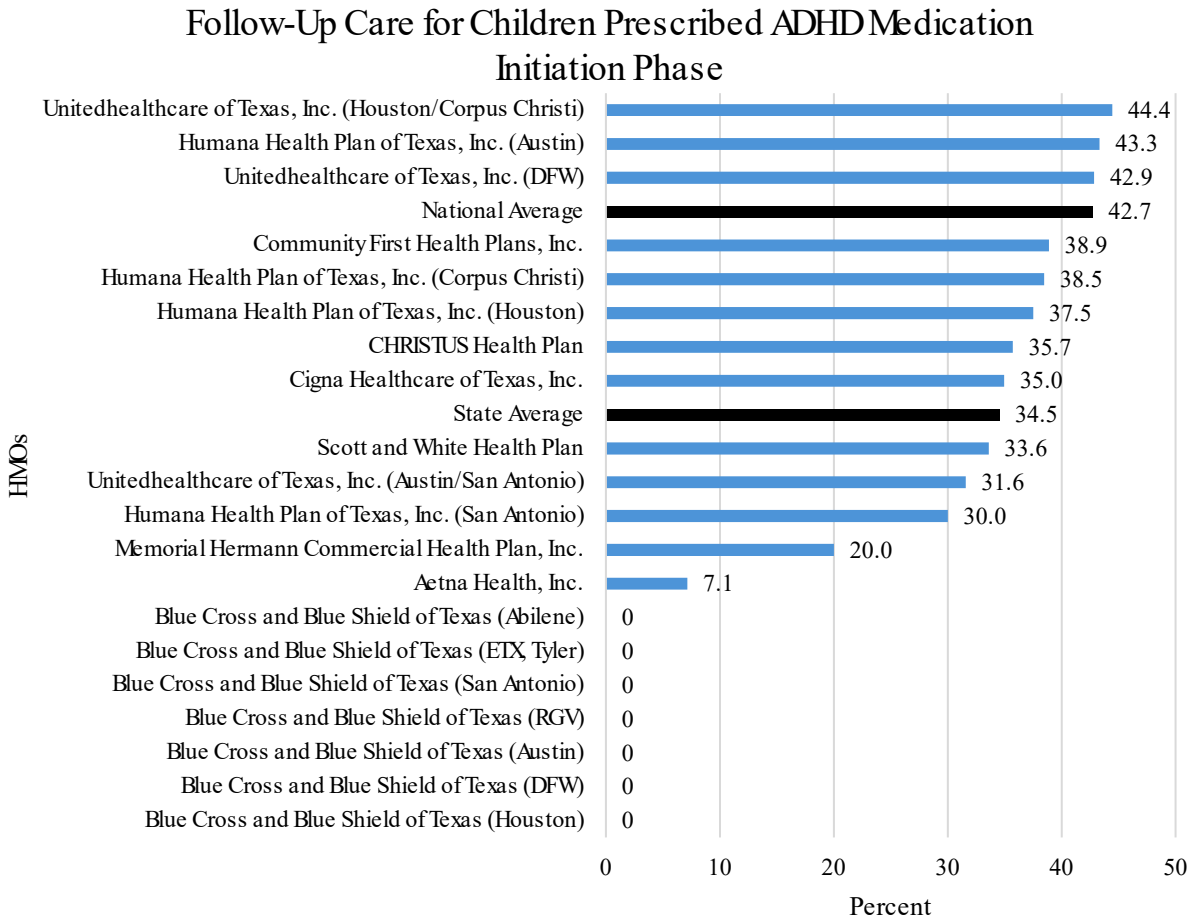
ADHD is a condition that can cause children to experience significant functional problems such as school difficulties, strained relationships with family members and peers, and behavioral problems.[37] The American Academy of Pediatrics (AAP) guidelines recommend that a child receive follow-up appointments at least once a month until the symptoms have stabilized. After that, the child should have an office visit once every 3-6 months to assess learning and behavior.[38]

Table 20: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase

Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	30.8%	33.8%	*	*	34.5%
NCQA's Quality Compass®	40.6%	40.7%	*	*	42.7%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 20: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

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

Definition: The percentage of children, 6-12 years of age, newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 9 months after the Initiation Phase.

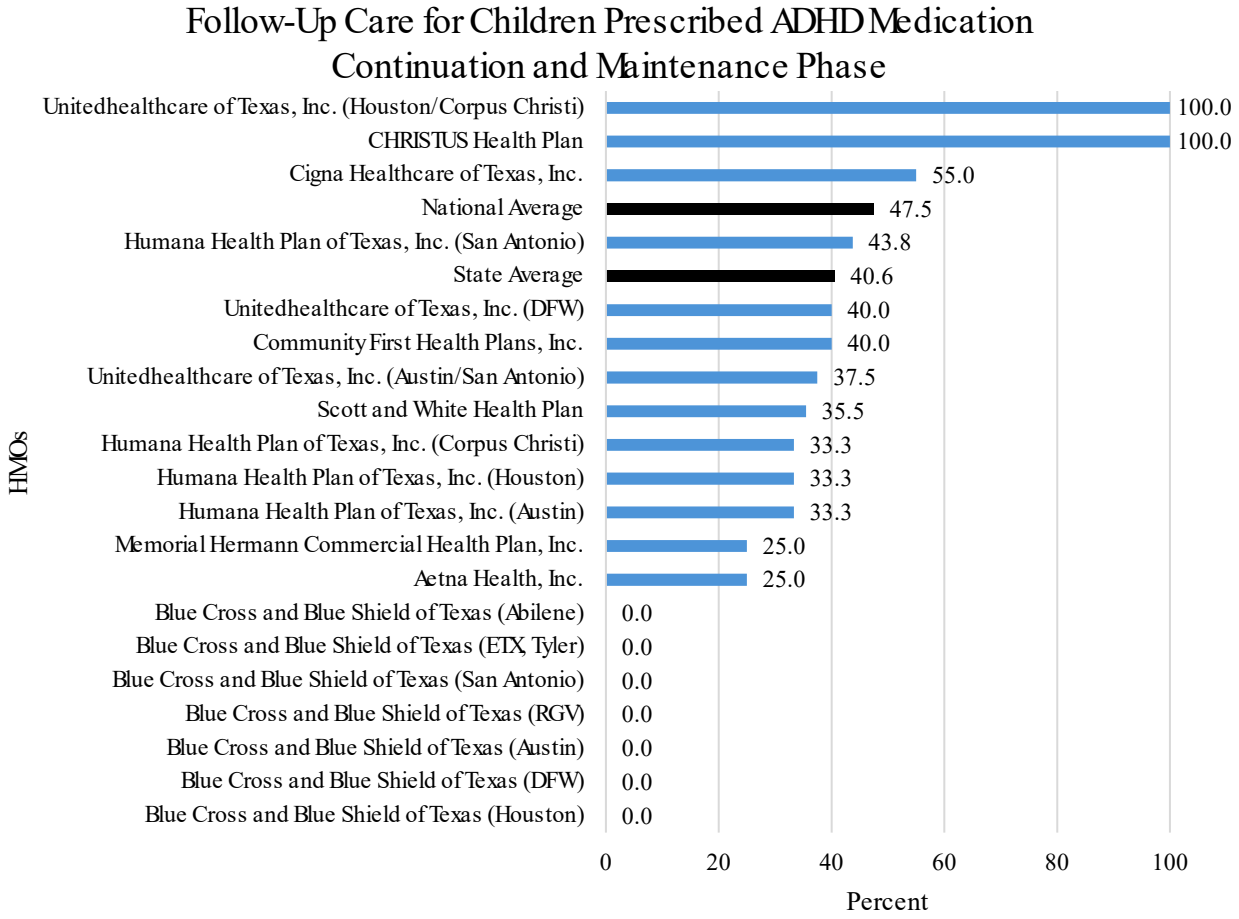
ADHD is a condition that can cause children to experience significant functional problems such as school difficulties, strained relationships with family members and peers, and behavioral problems.[39] The American Academy of Pediatrics (AAP) guidelines recommend that a child receive follow-up appointments at least once a month until the symptoms have stabilized. After that, the child should have an office visit once every 3-6 months to assess learning and behavior.[40]

Table 21: Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase

Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	42.6%	46.1%	*	*	40.6%
NCQA's Quality Compass®	49.7%	47.0%	*	*	47.5%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 21: Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

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 one of the following follow-up services: 1) an outpatient visit with a mental health practitioner; 2) an intensive outpatient encounter; or 3) partial hospitalization. The measure reports the percentage of members who received follow-up care within 7 days of discharge.

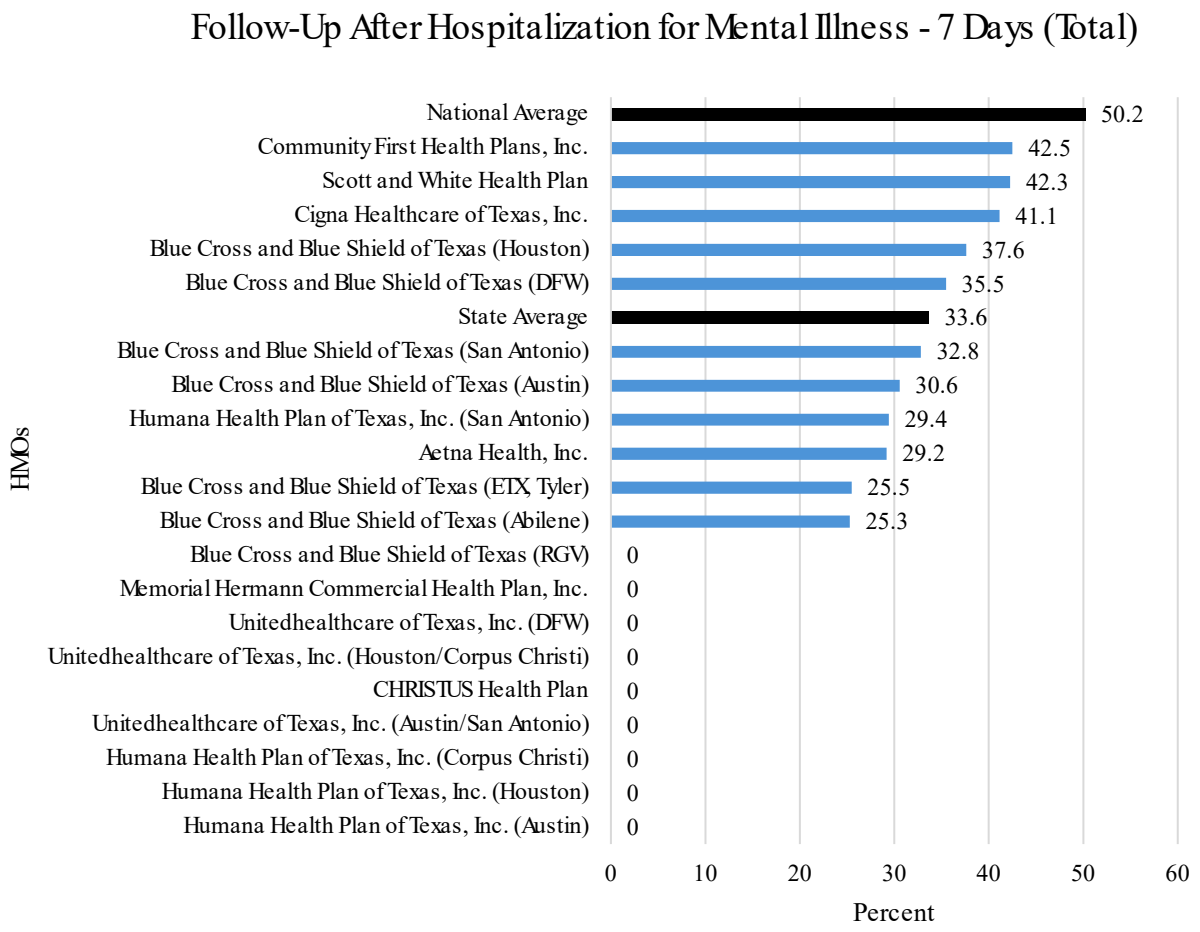
Individuals who have follow-up services after an inpatient hospitalization for mental illness are less likely to be readmitted and more likely to make a successful transition back to home and work. Follow-up visits also help healthcare providers provide effective continuation of care. The American Psychiatric Association (APA)[41] and the American Academy of Child and Adolescent Psychiatry (AACAP)[42] both encourage timely follow-up services.

Table 22: Follow-Up After Hospitalization for Mental Illness Within 7 Days

Follow-Up After Hospitalization for Mental Illness Within 7 Days					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	35.6%	33.9%	*	*	33.6%
NCQA's Quality Compass®	45.6%	46.2%	*	*	50.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 22: Follow-Up After Hospitalization for Mental Illness Within 7 Days



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After Emergency Department Visit for Mental Illness

Definition: This measure assesses the percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7 days of the emergency department visit (8 total days).

Although ED visits are common among patients suffering from mental illness, many may be avoidable. Research suggests that for people with a serious mental illness, both low-intensity interventions, such as appointment reminders, and high-intensity interventions, such as assertive community treatment, can be effective following an ED visit, to encourage follow-up care in the outpatient setting.[43]

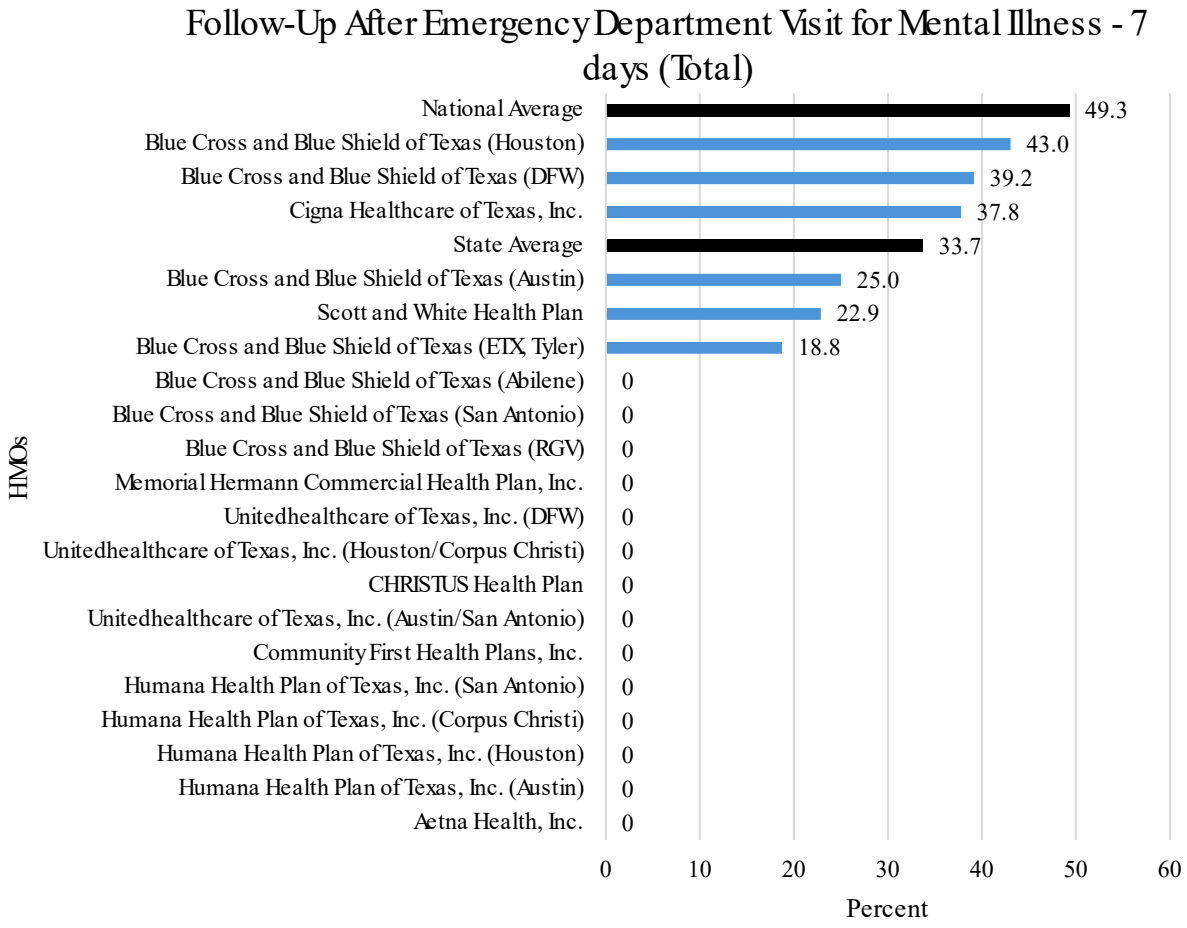
This measure was added to the Texas Subset beginning with HEDIS® 2018.

Table 23: Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days

Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	33.0%	29.4%	*	*	33.7%
NCQA's Quality Compass®	45.6%	46.8%	*	*	49.3%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Table 23: Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After High Intensity Care for Substance Use Disorder

Definition: The percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. The rate reported is the percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

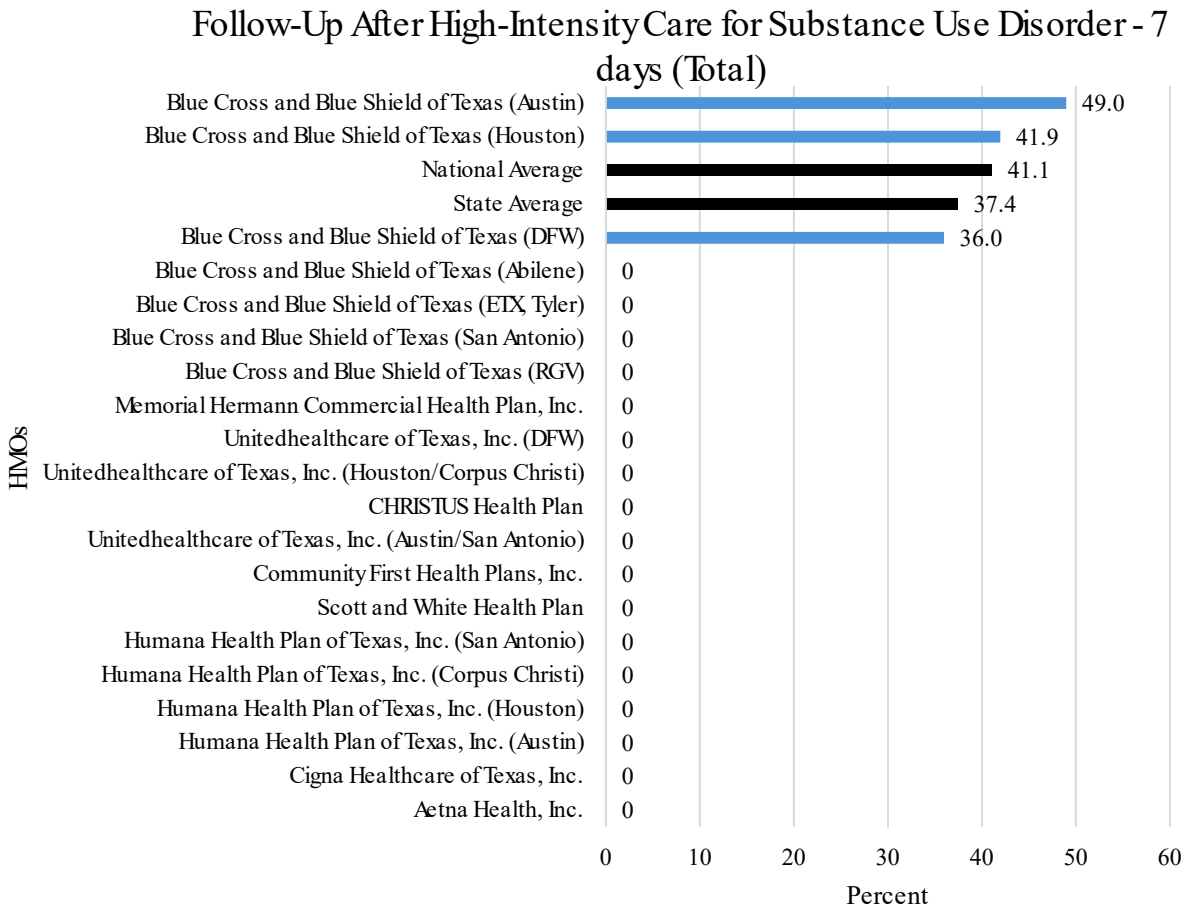
In 2020, 40.3 million Americans 12 and older (about 14.5% of the population) were classified as having an SUD, including alcohol use disorder and illicit drug use disorder.[44] Individuals with SUD have higher utilization of high-intensity care treatment such as inpatient hospitalizations.[45] Timely follow-up care after treatment for SUD is critical to reduce negative health outcomes such as disengagement from the health care system and substance use relapse.[4647]

Table 24: Follow-Up After High-Intensity Care for Substance Use Disorder Within 7 Days

Follow-Up After High-Intensity Care for Substance Use Disorder Within 7 Days					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	*	*	*	*	37.4%
NCQA's Quality Compass®	*	*	*	*	41.1%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 24: Follow-Up After High-Intensity Care for Substance Use Disorder After Within 7 Days



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Follow-Up After Emergency Department Visit for Substance Use

Definition: This measure assesses the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. The rate reported is the percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

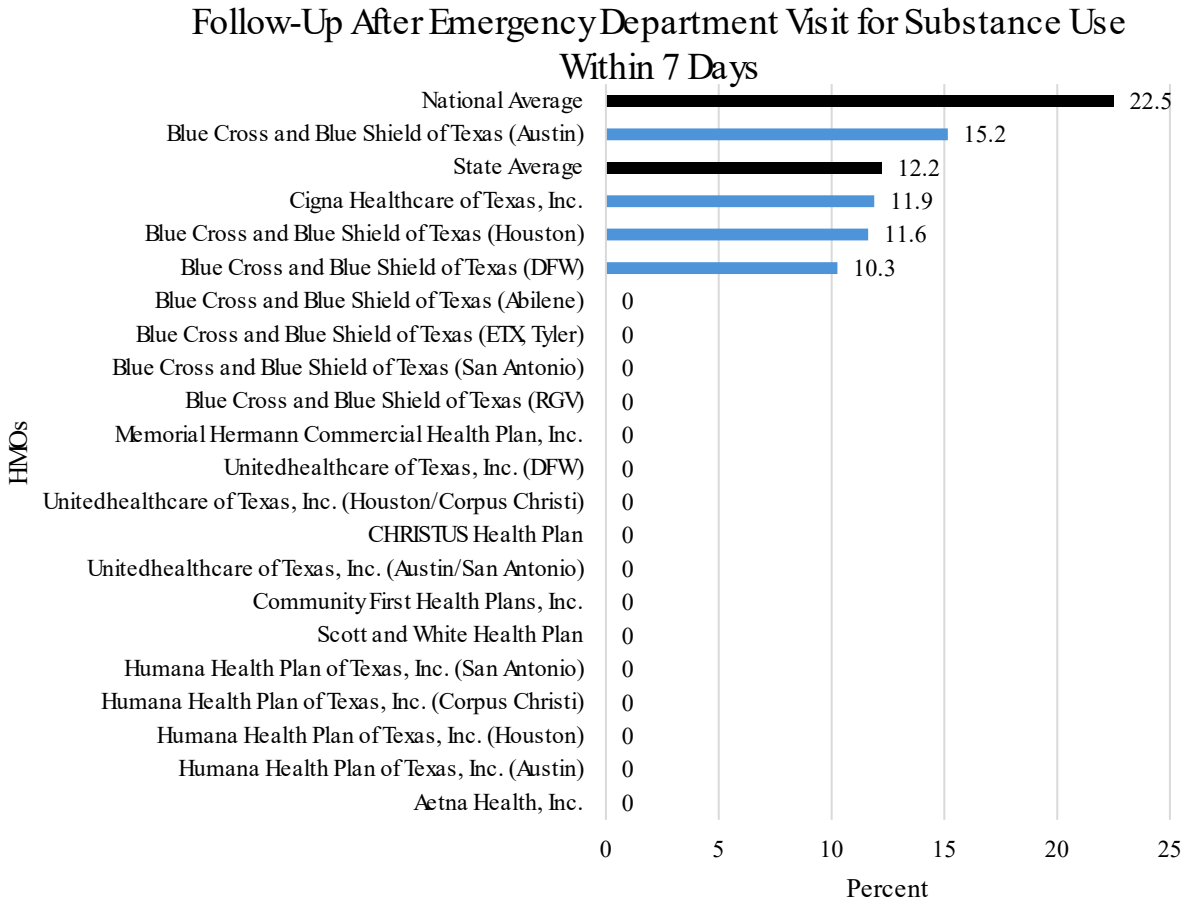
In 2022, 48.7 million Americans over 12 years of age (about 17.3% of the population) were classified as having an SUD.[48] Between 2018 and 2021, the use of ED services for substance use increased 39%, and the rate of ED visits related to substance use went up from 74.4 to 103.8 visits per 10,000 individuals.[49] The ED plays a crucial role in helping individuals with substance use by providing immediate care and timely diagnosis, and connecting individuals to further care.[50] This measure focuses on making sure that people leaving the ED after a high-risk substance use event get coordinated care, because they might be at a higher risk of losing touch with the health care system.

Table 25: Follow-Up After Emergency Department Visit for Substance Use Within 7 Days

Follow-Up After Emergency Department Visit for Substance Use Within 7 Days					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	5.1%	4.0%	*	*	12.2%
NCQA's Quality Compass®	11.3%	11.3%	*	*	22.5%

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 25: Follow-Up After Emergency Department Visit for Substance Use Within 7 Days



0 = Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Section 3: Access/Availability of Care

Prenatal and Postpartum Care Measures

Prenatal and Postpartum Care: Timeliness of Prenatal Care

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

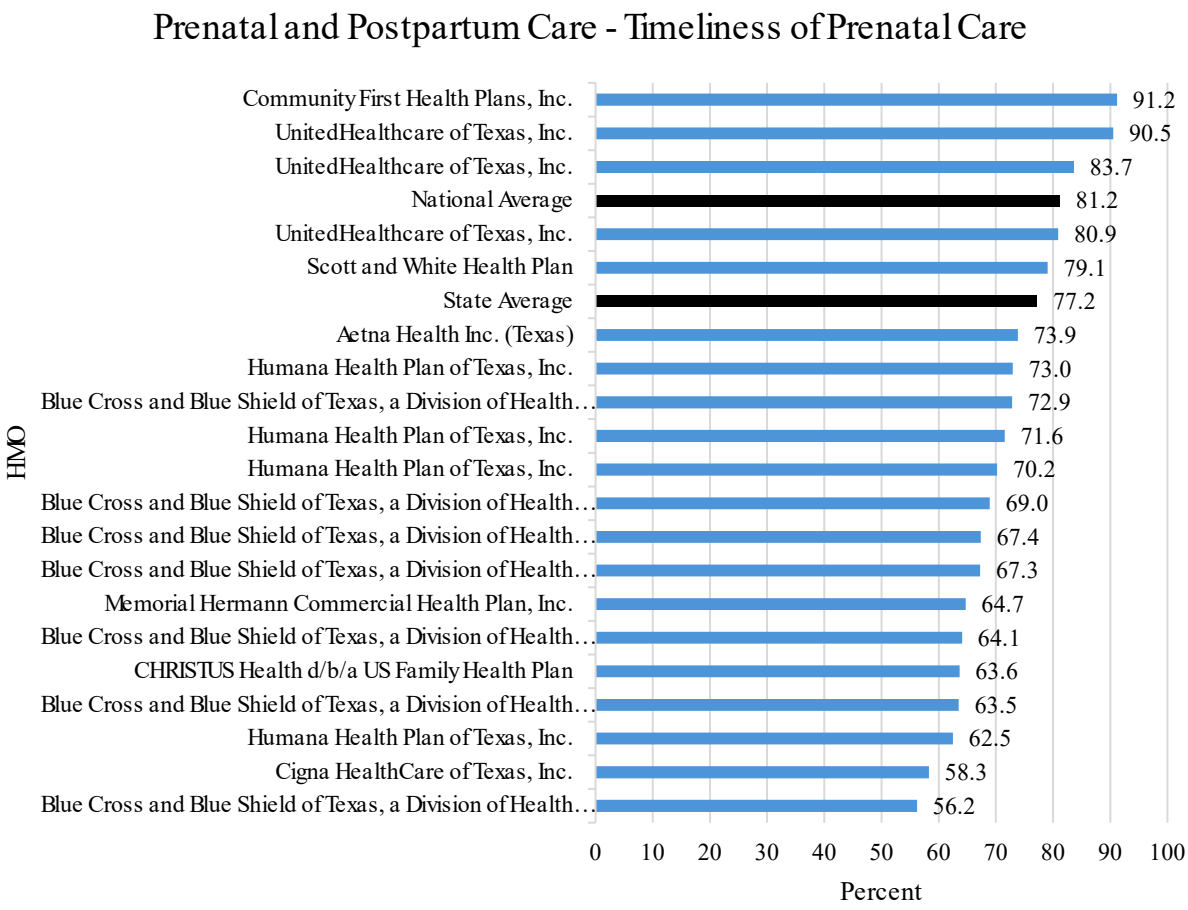
Early prenatal care is an essential part of a healthy pregnancy. Doctors can identify and treat health problems early when they see pregnant women regularly. Doctors can also advise pregnant women about healthy choices during pregnancy to provide their babies a healthy start to life. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy.[51]

Table 26: Prenatal and Postpartum Care: Timeliness of Prenatal Care

Timeliness of Prenatal Care					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	72.0%	63.3%	*	*	77.2%
NCQA's Quality Compass®	85.7%	85.8%	*	*	81.2%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 26: Prenatal and Postpartum Care: Timeliness of Prenatal Care



Prenatal and Postpartum Care: Postpartum Care

Definition: The percentage of deliveries where the mother had a postpartum visit 21-56 days after delivery.

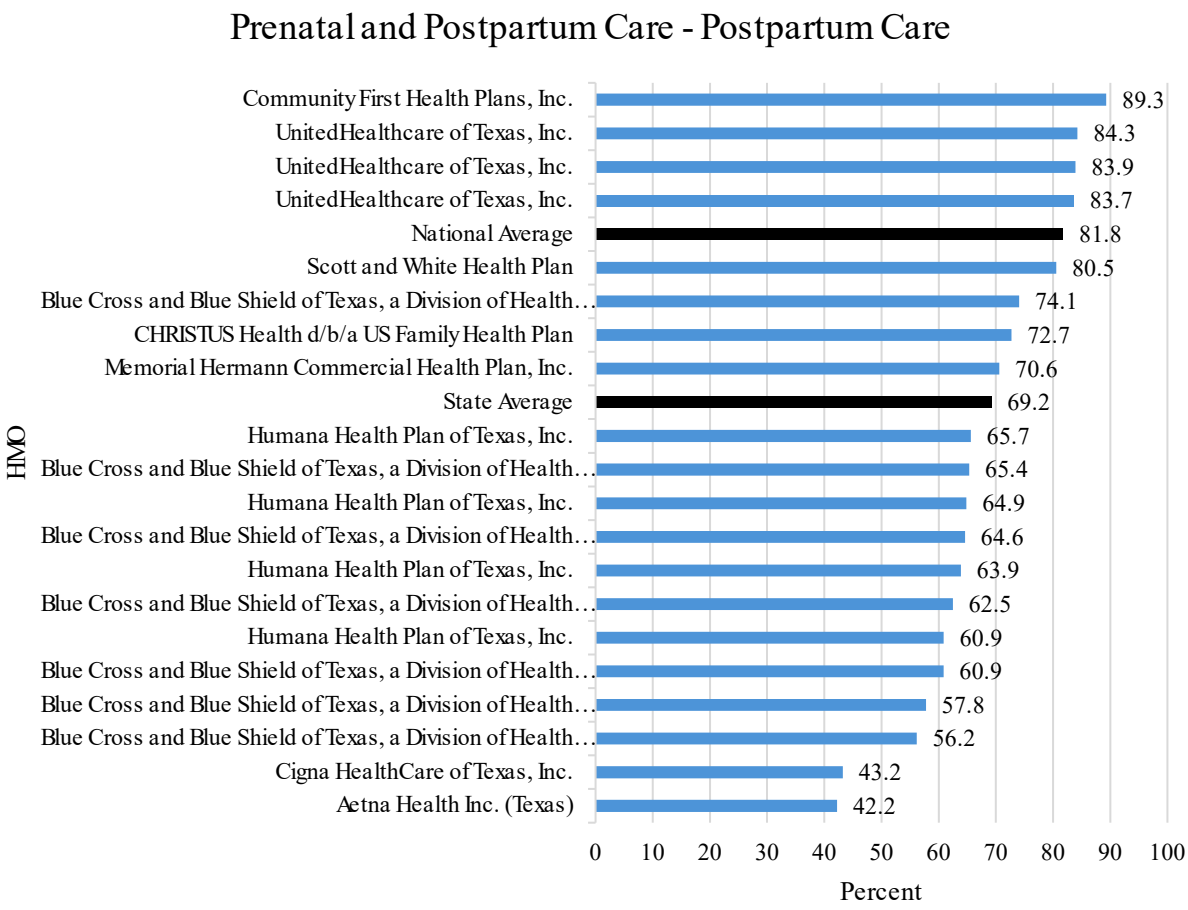
The American College of Obstetricians and Gynecologists (ACOG) recommends that a woman see her health care provider at least once 4-6 weeks after giving birth. The first postpartum visit should include a physical examination and is also an opportunity for the health care practitioner to answer questions, give family planning guidance, and counsel on nutrition.[52]

Table 27: Prenatal and Postpartum Care: Postpartum Care

Prenatal and Postpartum Care: Postpartum Care					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	59.1%	65.1%	*	*	69.2%
NCQA's Quality Compass®	74.9%	80.7%	*	*	81.8%

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for these years.

Chart 27: Prenatal and Postpartum Care: Postpartum Care



Section 4: Utilization and Risk Adjusted Utilization

Risk Adjusted Utilization Measures

Acute Hospital Utilization

Definition: For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.

In 2019, 5.9% of people had had a hospital stay in the past year.[53] Hospital care accounts for 31% of health spending in the U.S.[54] A study found that inpatient admission costs account for 21% of total Medicare benefit payments.[55] Hospital and inpatient hospitalizations put patients at risk for adverse events and prolonged inpatient stays.[56] [57] One in 25 hospitalized individuals are affected by a health care-associated infection.[58] Older patients are particularly at increased risk for delirium, falls and depressed psycho-physiologic functioning while hospitalized.[59] [60] Some hospitalizations can be avoided with improved access to care, timely delivery of care and appropriate care coordination.

This measure was added to the Texas Subset beginning with HEDIS® 2020.

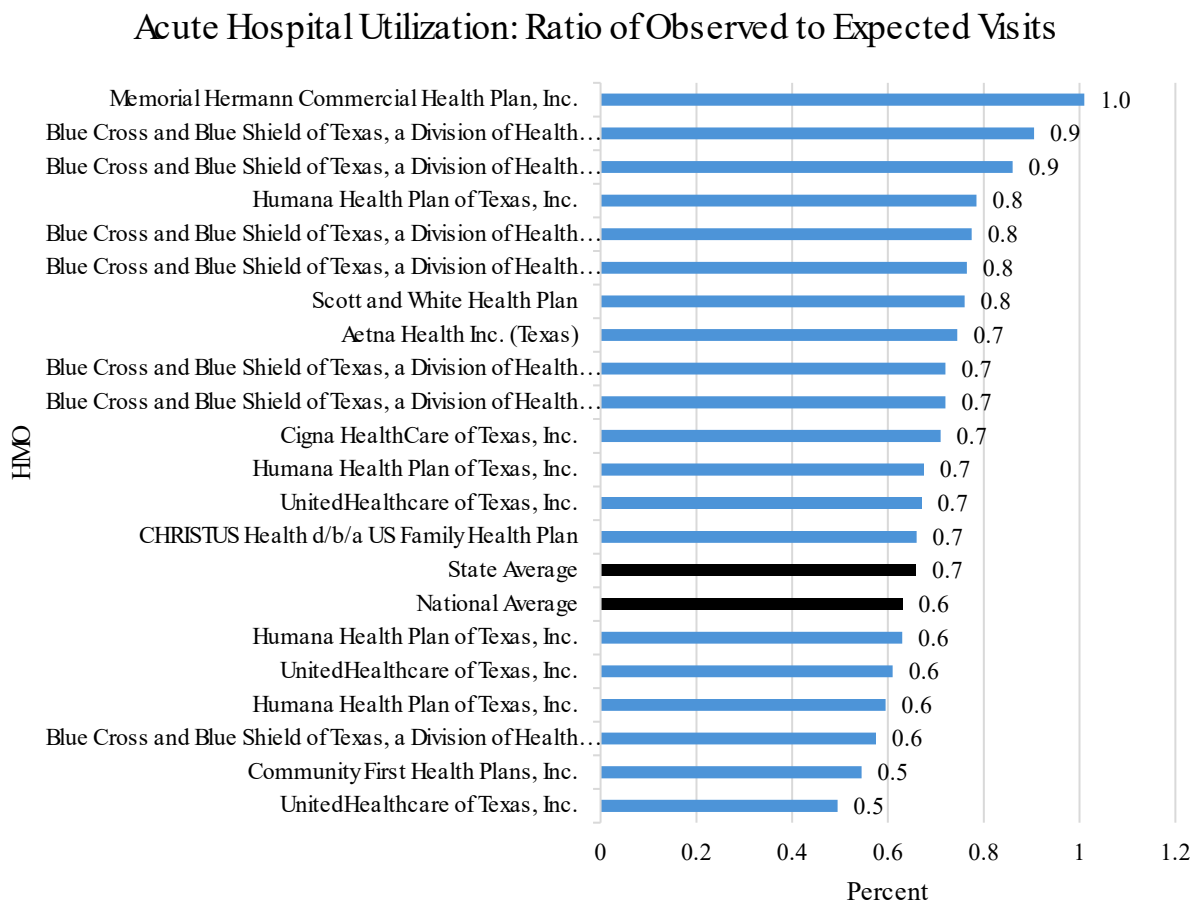
Note: Lower rates indicate better performance for this measure.

Table 28: Acute Hospital Utilization: Ratio of Observed to Expected Visits

Acute Hospital Utilization: Ratio of Observed to Expected Visits					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	**	1.15	*	*	0.70
NCQA's Quality Compass®	**	1.08	*	*	0.60

Quality Compass® (QC) is a national database of health plan-specific performance information voluntarily reported to the NCQA.
* Data not analyzed for this year.
**Value not established or not obtained.

Chart 28: Acute Hospital Utilization: Ratio of Observed to Expected Visits



Note: Lower rates indicate better performance for this measure.

Emergency Department Utilization

Definition: For members 18 years of age and older, this measure assesses the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.

ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED events may be attributed to preventable or treatable conditions. A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented.[61] [62] Plans can ensure that members receive appropriate, coordinated primary care to address preventable ED visits.

Note: Lower rates indicate better performance for this measure.

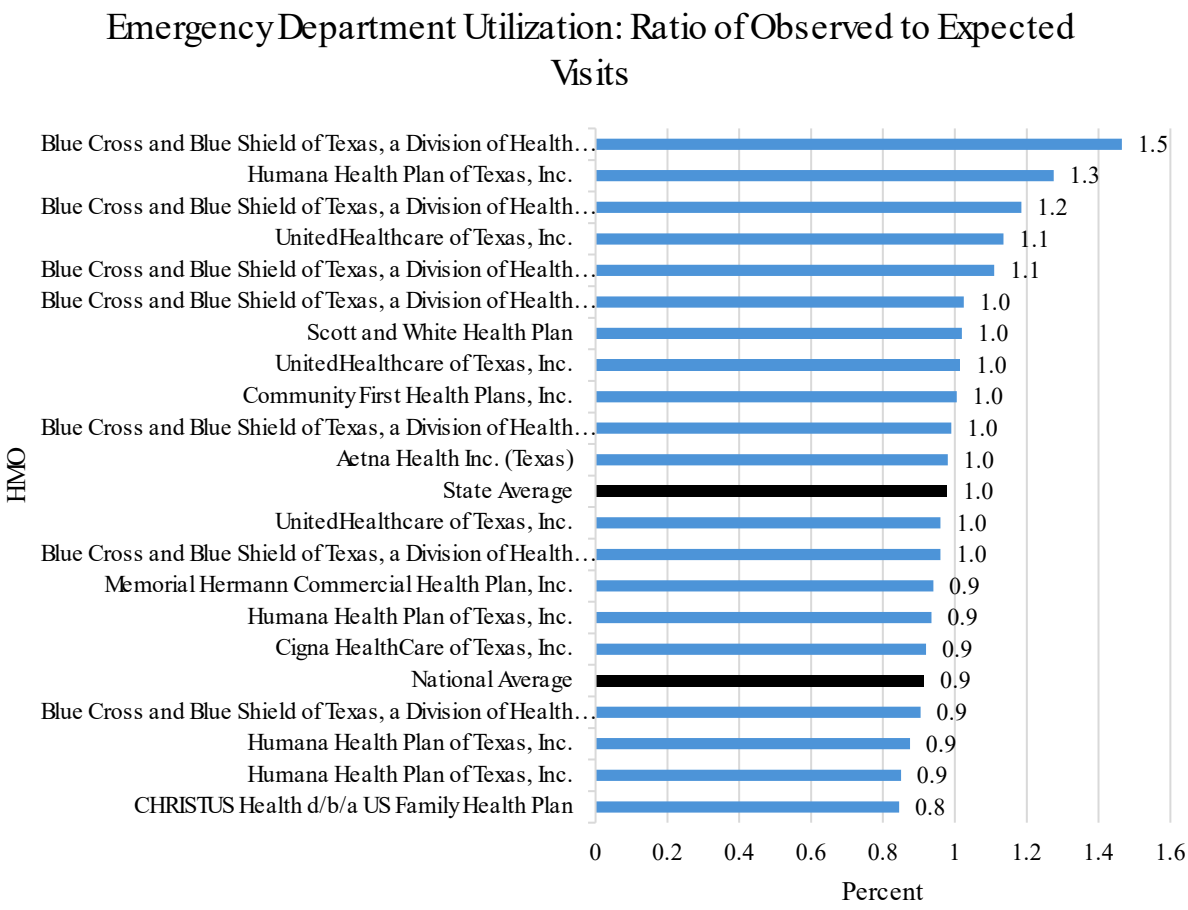
This measure was added to the Texas Subset beginning with HEDIS® 2018.

Table 29: Emergency Department Visits: Ratio of Observed to Expected Visits

Emergency Department Visits: Ratio of Observed to Expected Visits					
	2019	**2020**	**2021**	**2022**	**2023**
Texas Average	1.06	1.06	*	*	1.0
NCQA's Quality Compass®	1.05	1.04	*	*	0.90

Quality Compass® is a national database of health plan-specific performance information voluntarily reported to the NCQA.
**Value not established or not obtained.

Chart 29: Emergency Department Visits: Ratio of Observed to Expected Visits



Note: Lower rates indicate better performance for this measure.

Section 5: Additional Information

Methods and Statistical Issues

About

The Healthcare Effectiveness Data and Information Set (HEDIS®) consists of standardized performance measures used to compare the quality of care of managed care organizations. The National Committee for Quality Assurance (NCQA), a private, nonprofit organization— developed and maintains HEDIS®. NCQA convenes national healthcare experts to guide the selection and development of HEDIS® measures based on three primary criteria: relevance, scientific soundness, and feasibility. The performance measures reflect many current public health issues affecting Americans, including cancer, heart disease, smoking, diabetes, and the care of children and pregnant women.

Texas law requires basic service HMOs to report HEDIS® measures to the Department of State Health Services (DSHS) through the Texas Health Care Information Collection (THCIC) on an annual basis.[63] THCIC is a part of the Center for Health Statistics (CHS) division of the DSHS.

Each year THCIC collects a subset of HEDIS® measures in Texas. THCIC uses the following principles to guide its recommendations:

- The measures must reflect the types of plans and products currently available in the Texas marketplace.
- The measures must translate into meaningful information for Texas residents.
- Sufficient encounter information must be available. If a majority of plans cannot report a specific measure due to a low number of members qualifying for the measure, the measure is not required to be reported.
- The reporting requirements must minimize duplication in reporting to other state agencies.
- The reporting requirements and technical specifications must be consistent with those of NCQA.

Reporting Methods

To accommodate differences in HMO data systems and technical capabilities, HEDIS® gives plans a choice of two methods to calculate performance measures: 1) an administrative records method or 2) a hybrid method. The administrative records approach involves three steps. First, all records in a health plan's administrative database are queried to determine the eligible population for a certain measure. This becomes the denominator for the measure. Second, the selected records are reviewed to identify the members who utilized the service/ procedure. This number is included in the numerator. Third, the members with a contraindication to the service/ procedure are excluded from the denominator. The hybrid method utilizes a random sample of enrollees for the denominator. The selected records are reviewed to identify the individuals who use the service. NCQA has developed a systematic sampling scheme for health plans who choose to use the hybrid method.

A third data gathering and analysis method, survey research, is used for the "Medical Assistance with Smoking and Tobacco Use Cessation" and "Flu Vaccinations for Adults 18-64" measures in the Effectiveness of Care domain. The standardized survey instrument employed for HEDIS® is the Consumer Assessment of Healthcare Providers and Systems, Version 5.1 (CAHPS® 5.1H)[64]. The survey asks consumers to score various aspects of their experience with their health plan. Health plans must contract with independent survey vendors certified by NCQA to administer the survey. A report on the

survey measures, *Comparing Texas HMOs*, is available on OPIC's website at: https://www.opic.texas.gov/-hmo-report-cards.

Data Usage

Plan members must be continuously enrolled to be counted for rate denominators. Continuous enrollment criteria typically require an individual to be 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 enrollment.

NCQA developed the sampling methodology using established practices, however there is a small chance that the sample does not represent the underlying population. When interpreting data, keep in mind that many HEDIS® 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.

Certified auditors review HEDIS® results using a process designed by NCQA. Data not certified through this process, or not submitted as required by NCQA, are denoted as “NR” (not reportable). Data that may meet NCQA audit standards but are calculated from fewer than 30 denominator observations are designated as “NA” (not applicable). Plans that fail to report a measure by service area as statutorily required are designated as “FTR” (failure to report).

Measures from Effectiveness of Care and Utilization domains were tested using a 95% confidence interval to determine if they differ significantly from the average of all HMOs in Texas.

For ease of computation, the formula for calculating the 95% confidence interval around an organization’s HEDIS® rate is:

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

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

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:

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

$$\text{lower} = .52 - 1.96\sqrt{\frac{.52(1-.52)}{96} - \frac{1}{192}} = 41.5\%$$

$$\text{upper} = .52 + 1.96\sqrt{\frac{.52(1-.52)}{96} + \frac{1}{192}} = 62.5\%$$

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

The user can be 95% certain that the organization's true Pap test rate is between 41.5% and 62.5%.

The summary tables (pages 8-16) report plan performance on specific measures in relation to the Texas state average. Plan performance is "equivalent" to the state average if it 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 plan's performance is reported as either better (+) or worse (-) than the state average.

Caveats

Results of HEDIS® statistical significance testing should be interpreted with care. Statistical tests account only for random or chance variations in measurement. HEDIS® does not control for underlying differences in plan population characteristics such as age or health status. For some measures, the difference between HMOs may represent differences in quality of care, while others may represent a different mix of member enrollment.

This publication reports benchmarks from NCQA's National Quality Compass®. NCQA's national averages are based on HEDIS® data voluntarily reported to NCQA by hundreds of health plans throughout the country.

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Questions or Comments

For inquiries:

Office of Public Insurance Counsel
Barbara Jordan Building
1601 Congress Ave., Suite 3.500
Austin, Texas 78701
(512) 322-4143 | toll-free at (877) 611-6742
help@opic.texas.gov | https://www.opic.texas.gov

Endnotes

[1] HEDIS® - The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.
[2] 25 Tex. Admin. Code § 421.22 (2004)
[3] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Quality Compass® is a registered trademark of NCQA.
[8] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. *Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.
[9] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. *Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th ed. Washington, D.C.: Public Health Foundation, 2015.
[10] American Cancer Society. *Breast Cancer Facts and Figures 2015-2016*. Atlanta, GA: American Cancer Society, 2015.
[11] National Cancer Institute. *Pap and HPV Testing Fact Sheet*. Washington, D.C.: National Institutes of Health, 2016.
[12] National Cancer Institute. *A Snapshot of Cervical Cancer*. Washington, D.C.: National Institutes of Health, 2014.
[13] American College of Obstetricians and Gynecologists. *Cervical Cancer Screening*. Washington, D.C.: American College of Obstetricians and Gynecologists, 2016.
[14] Saslow, Debbie. "Screening Guidelines for the Prevention and Early Detection of Cervical Cancer." CA: *A Cancer Journal for Clinicians*. Atlanta, GA: American Cancer Society, 2012.
[15] American Cancer Society. *Cancer Facts and Figures 2016*. Atlanta, GA: American Cancer Society, 2016.
[16] Ibid.
[17] Centers for Disease Control and Prevention. *Chlamydia - CDC Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2016.
[18] Centers for Disease Control and Prevention. "Office Related Antibiotic Prescribing for Persons Aged < 14 Years - United States, 1993-1994 to 2007-2008." *Morbidity and Mortality Weekly Report*. 60: 1153- 1156 (2011).
[19] Mozaffarian, Dariush, et al. on behalf of the American Heart Association's Statistics Committee and Stroke Statistics Subcommittee. "Heart Disease and Stroke Statistics - 2016 Update: A Report from the American Heart Association." Circulation: *Journal of the American Heart Association*. 133: e38-e360 (2016).
[20] American Heart Association (AHA). 2014. "Drug Therapy for Cholesterol." https://www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Drug-Therapy-for-Cholesterol_%20UCM_305632_Article.jsp
[21] Centers for Disease Control and Prevention. *2014 National Diabetes Statistics Report*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[22] American Diabetes Association. *Living with Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[23] Ibid.
[24] American Diabetes Association. *Living with Diabetes: High Blood Pressure (Hypertension).* Alexandria, VA: American Diabetes Association, 2014.
[25] National Heart, Lung, and Blood Institute. *Health Topics: High Blood Pressure*. Bethesda, MD: National Institutes of Health, 2015.
[26] National Eye Institute. *Facts About Diabetic Eye Disease*. Bethesda, MD: National Eye Institute, 2015.

[27] American Heart Association (AHA). 2014. "Drug Therapy for Cholesterol." https://www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Drug-Therapy-for-Cholesterol_UCM

[28] National Institute of Diabetes and Digestive and Kidney Disease. *Glomerular Diseases*. Bethesda, MD: National Institutes of Health, 2014.

[29] Substance Abuse and Mental Health Services Administration. 2022. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health." HHS, PEP22-07-01–005(NSDUH Series H-57). https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf

[30] Center for Behavioral Health Statistics and Quality. 2023. "Results from the 2022 National Survey on Drug Use and Health: Detailed Tables." Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-table

[31] National Alliance on Mental Illness. 2013. "Major Depression Fact Sheet: What is Major Depression?"

[32] Centers for Disease Control and Prevention. 2012. "Suicide Facts at a Glance 2012."

[33] Birnbaum, H.G., R.C. Kessler, D. Kelley, R. Ben-Hamadi, V.N. Joish, P.E. Greenberg. 2010. "Employer burden of mild, moderate, and severe major depressive disorder: Mental health services utilization and costs, and work performance." Depression and Anxiety; 27(1) 78–89.

[34] National Alliance on Mental Illness. 2013. "Major Depression Fact Sheet: What is Major Depression?"

[35] Centers for Disease Control and Prevention. 2012. "Suicide Facts at a Glance 2012."

[36] Birnbaum, H.G., R.C. Kessler, D. Kelley, R. Ben-Hamadi, V.N. Joish, P.E. Greenberg. 2010. "Employer burden of mild, moderate, and severe major depressive disorder: Mental health services utilization and costs, and work performance." Depression and Anxiety; 27(1) 78–89.

[37] American Academy of Pediatrics. *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*. Pediatrics. 128(5): 1007-22 (2011).

[38] Ibid.

[39] American Academy of Pediatrics. *Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*. Pediatrics. 128(5): 1007-22 (2011).

[40] Ibid.

[41] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006*. Arlington, VA: American Psychiatric Association, 2006.

[42] American Academy of Child and Adolescent Psychiatry. *Policy Statement: Inpatient Hospital Treatment of Children and Adolescents.* Washington, D.C.: American Academy of Child and Adolescent Psychiatry, 1989.

[43] Krevenbuhl, J., I. Nossel, L. Dixon. 2009. "Disengagement from Mental Health Treatment among Individuals with Schizophrenia and Strategies for Facilitating Connections to Care: A Review of the literature." *Schizophrenia Bulletin*. 35: 696-703.

[44] Substance Abuse and Mental Health Services Administration. 2021. Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[45] Gryczynski, J., R. Schwartz, et al. 2016. "Understanding Patterns Of High-Cost Health Care Use Across Different Substance User Groups." Health Aff (Millwood). January; 35(1): 12–19.

[46] National Institute on Drug Abuse (NIDA). 2018. Drugs, Brains, and Behavior: The Science of Addiction. July 2018. https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.

[47] Proctor, S., P. Herschman. 2014. "The Continuing Care Model of Substance Use Treatment: What Works, and When Is 'Enough,' Enough?" Psychiatry Journal. Volume 2014, Article ID 692423, 16 pages.

[48] Substance Abuse and Mental Health Services Administration. 2023. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health." HHS Publication No. PEP23-07-01-006, NSDUH Series H-58. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

[49] Centers for Disease Control and Prevention (CDC). 2023. "Rate of Emergency Department Visits for Substance Use Disorders Among Adults Aged ≥18 Years, by Age Group—National Hospital Ambulatory Medical Care Survey, United States, 2018–2019 and 2020–2021." *MMWR Morb Mortal Wkly Rep* 72:1073. DOI: http://dx.doi.org/10.15585/mmwr.mm7239a6

[50] Samuels, E.A., K. Dwyer, M.J. Mello, J. Baird, A.R. Kellogg, & E. Bernstein. 2016. "Emergency Department-Based Opioid Harm Reduction: Moving Physicians from Willing to Doing." *Academic Emergency Medicine* 23(4), 455–65

[51] U.S. Department of Health and Human Services, Office on Women's Health. *Prenatal Care Fact Sheet*. Washington, D.C.: U.S. Department of Health and Human Services, 2012.

[52] American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*. 7th ed. Washington, D.C.: American College of Obstetricians and Gynecologists, 2012.

[53] Centers for Disease Control and Prevention. 2021. *Hospitalization—Health, United States*. National Center for Health Statistics. https://www.cdc.gov/nchs/hus/topics/hospitalization.htm

[54] California Heath Care Foundation. 2021. "Health Care Costs 101, 2021: US Spending Growth Outpaces Economy." *California Health Care Almanac*.

[55] Kaiser Family Foundation. *An Overview of Medicare*. https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/

[56] Covinsky, K.E., E. Pierluissi, & C.B. Johnston. 2011. "Hospitalization-Associated Disability." *JAMA: The Journal of the American Medical Association* 306(16), 1782–

[57] Schimmel, E. 2003. "The Hazards of Hospitalization." *Quality and Safety in Health Care* 12(1), 58–63.

[58] Magill, S.S., J.R. Edwards, W. Bamberg, et al. 2014. "Multistate Point-Prevalence Survey of Health Care–Associated Infections." *New England Journal of Medicine* 370:1198–208.

[59] Gillick, M.R., N.A. Serrell & L.S. Gillick. 1982. "Adverse Consequences of Hospitalization in the Elderly." *Social Science & Medicine* 16(10), 1033–8.

[60] Lang, V.J., N.S. Clark, et al. 2008. "Hazards of Hospitalization: Hospitalists and Geriatricians Educating Medical Students About Delirium and Falls in Geriatric Inpatients." *Gerontology & Geriatrics Education* 28(4): 94–104.

[61] Dowd, B., M. Karmarker, T. Swenson, et al. 2014. "Emergency department utilization as a measure of physician performance." American Journal of Medical Quality 29 (2), 135–43. http://ajm.sagepub.com/content/29/2/135.long

[62] Agency for Healthcare Research and Quality. 2015. Measures of Care Coordination: Preventable Emergency Department Visits. Accessed at https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html

[63] 25 Tex. Admin. Code § 421.22 (2004)

[64] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).