2016

GUIDE TO TEXAS HMO QUALITY: 2016

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

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Guide to Texas HMO Quality

Table of Contents

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About the Report

The Office of Public Insurance Counsel (OPIC) is an independent state agency that advocates on behalf of insurance consumers as a class in the state of Texas. OPIC produces and publishes this report through a joint Memorandum of Understanding with the Department of State Health Services Center for Health Statistics. The *Guide to Texas HMO Quality* reports Health Maintenance Organization (HMO) performance based on quality of care measures. Consumers can use the publication to evaluate HMOs based on their own needs.

Section one of the report provides summary tables depicting HMO performance across specific measures. Section two details performance measures for each category 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 three provides health plan descriptive information, including physician board certification and plan enrollment figures. The report concludes with a section on methods and statistical issues.

About the Data

The Healthcare Effectiveness Data and Information Set (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, developed and maintains HEDIS®. Each year NCQA convenes national healthcare 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 pregnant women and children. Texas law requires basic service HMOs to report HEDIS® measures each year to the Department of State Health Services. For more information about the data or methodology used in this report, please consult the Methods and Statistical Issues section 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 HEDIS® measures 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 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 www.opic.texas.gov.

Types of Health Plans

	HMO *Health Maintenance Organization*	PPO *Preferred Provider Organization*	EPO *Exclusive Provider Organization*	HMO/POS *Health Maintenance Organization with Point-of-Service Option*	FFS *Fee-for-Service (Traditional insurance)*
Type of Network	Closed You must use network doctors, hospitals, and specialists.	Open You may use in-network doctors, hospitals, and specialists or go outside the network.	Closed You must use in-network doctors, hospitals, and specialists.	Open You may use network doctors, hospitals, and specialists or go outside the network.	No Network You may use any doctor, hospital, or specialist you choose.
Limits on your choice of doctors	HMO plans typically require you to choose a primary care physician (PCP) from the HMO's network. With some exceptions, you must obtain a referral from your PCP before seeing other doctors in the network.	Many PPOs permit you to see any doctor in the network without a referral. However, some PPOs do require you to choose a PCP and obtain a referral before seeing other doctors in the PPO's network. Verify referral requirements with the PPO before making an appointment.	Some EPOs permit you to see any doctor in the network without a referral, others require a referral. Verify referral requirements with the EPO before making an appointment.	An HMO/POS will typically require you to choose a PCP and obtain a referral from that doctor before making an appointment with other doctors in the network.	No limitations.
Incentives to use network doctors	Except in limited circumstances (such as an emergency), an HMO will not cover services provided by non-network providers.	A PPO will typically reimburse a higher percentage of the cost of your health care services if you use in-network providers.	Except in limited circumstances (such as an emergency), an EPO will not cover services provided by out-of-network providers.	An HMO/POS will typically reimburse a higher percentage of the cost of your health care services if you use network providers.	Not applicable.
Payment for services	When you access the HMO network, you will pay designated copays for covered services. Some plans require you to meet a deductible before they start paying for services. Typically, you will not pay coinsurance. A network provider cannot bill you for any remaining balance after you meet your copay.	When you access the PPO network, you typically pay a copay for covered services. You may also pay a percentage of the overall cost of the service. When you use an out-of-network provider, you will be responsible for your deductible, coinsurance, and any remaining balance charged by the health care provider.	When you access the EPO network, you may pay copays or coinsurance for covered services. Many plans require you to meet a deductible before they start paying for services. When you use an out-of-network provider, you will typically pay the entire cost of the service.	When you access the HMO network, you will pay designated copays. Some plans require you to meet a deductible before they start paying for services. When you use a non-network provider, you will be responsible for your deductible, coinsurance, and any remaining balance charged by the health care provider.	FFS insurance plans partially pay for the medical services you receive. You will be responsible for coinsurance plus any remaining balance charged by the health care provider.

Summary Tables

The summary tables provided in this section reflect a plan's performance on specific measures in relation to the Texas state average. The tables summarize plan performance as follows:

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

The summary tables provide a quick tool to compare plan performance. However, 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 the Methods and Statistical Issues section at the end of this report.

Summary Tables

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, HepA	Childhood Immunization, Rotavirus	Childhood Immunization, Influenza	Childhood Immunization, Combo 2	Childhood Immunization, Combo 3
Aetna Health, Inc. (Austin)*	NR	NR	=	NR	NR	=	NR	=	NR	=	NR	NR
Aetna Health, Inc. (Dallas/Ft Worth)*	NR	NR	=	NR	NR	=	NR	=	-	=	NR	NR
Aetna Health, Inc. (Houston)*	NR	NR	=	NR	NR	=	NR	+	NR	=	NR	NR
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Allegian Health Plans, Inc. (Harlingen)	=	=	=	=	=	-	=	-	=	-	=	=
CIGNA HealthCare of Texas, Inc. (South Texas)*	=	+	=	+	=	=	=	=	=	=	-	-
Community First Health Plans (San Antonio)*	+	+	+	+	+	+	+	+	+	+	+	+
FIRSTCARE (Abilene)	=	+	=	+	+	=	=	=	+	=	+	+
FIRSTCARE (Amarillo)	=	=	=	=	+	=	=	-	=	-	=	=
FIRSTCARE (Lubbock)	=	+	=	+	+	=	+	=	=	-	+	=
FIRSTCARE (Waco)	=	+	=	+	+	=	=	=	=	=	=	=
HMO Blue Texas (Dallas/Ft Worth)	+	+	+	+	=	+	+	=	=	=	=	=
HMO Blue Texas (East/South/West Texas)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	=
HMO Blue Texas (Houston)	=	=	=	=	-	=	=	=	=	=	-	-
Humana Health Plan of Texas (Austin)*	+	+	=	+	+	=	+	=	+	+	+	+
Humana Health Plan of Texas (Corpus Christi)*	+	+	+	+	+	+	+	+	+	=	+	+
Humana Health Plan of Texas (Houston)*	+	+	=	+	+	=	+	=	=	=	+	+
Humana Health Plan of Texas (San Antonio)*	+	+	=	+	+	+	+	=	+	=	+	+
Scott and White Health Plan (Central TX)*	+	+	=	+	+	=	+	=	+	+	+	+

+ Better than Texas Average **=** Equivalent to Texas Average **-** Lower than Texas Average

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Summary Tables

Health Plan Name	Childhood Immunization, Combo 4	Childhood Immunization, Combo 5	Childhood Immunization, Combo 6	Childhood Immunization, Combo 7	Childhood Immunization, Combo 8	Childhood Immunization, Combo 9	Childhood Immunization, Combo 10	Breast Cancer Screening	Cervical Cancer Screening	Non-Recommended Cervical Cancer Screening in Adolescent Females	Colorectal Cancer Screening	Chlamydia Screening, Women Age 16–20
Aetna Health, Inc. (Austin)*	NR	NR	NR	NR	NR	NR	NR	-	=	=	NR	=
Aetna Health, Inc. (Dallas/Ft Worth)*	NR	NR	NR	NR	NR	NR	NR	-	-	+	=	=
Aetna Health, Inc. (Houston)*	NR	NR	NR	NR	NR	NR	NR	-	=	=	NR	=
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA	NA	NA	NA	NA	NA	NA	-	-	=	=	+
Allegian Health Plans, Inc. (Harlingen)	=	=	-	=	-	-	-	-	-	NQ	-	=
CIGNA HealthCare of Texas, Inc. (South Texas)*	-	-	-	-	-	-	-	+	+	-	+	+
Community First Health Plans (San Antonio)*	+	+	+	+	+	+	+	-	-	-	=	=
FIRSTCARE (Abilene)	+	+	+	+	+	+	+	-	-	=	-	-
FIRSTCARE (Amarillo)	=	=	=	=	=	=	=	-	=	=	-	=
FIRSTCARE (Lubbock)	=	=	=	=	=	=	=	-	-	=	=	-
FIRSTCARE (Waco)	=	=	=	=	=	=	=	-	-	=	-	=
HMO Blue Texas (Dallas/Ft Worth)	=	=	=	=	=	=	=	=	+	=	+	=
HMO Blue Texas (East/South/West Texas)	NA	NA	NA	NA	NA	NA	NA	-	-	=	-	=
HMO Blue Texas (Houston)	=	-	-	=	-	-	-	=	-	=	=	+
Humana Health Plan of Texas (Austin)*	+	+	+	+	+	+	+	-	=	+	=	=
Humana Health Plan of Texas (Corpus Christi)*	+	+	=	+	+	=	=	=	=	+	=	=
Humana Health Plan of Texas (Houston)*	+	+	+	+	+	+	+	-	=	+	=	=
Humana Health Plan of Texas (San Antonio)*	+	+	+	+	+	+	+	-	=	=	=	=
Scott and White Health Plan (Central TX)*	+	+	+	+	+	+	+	+	=	-	+	-

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* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.
NQ– The plan was not required to report the measure.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Summary Tables

Health Plan Name	Chlamydia Screening, Women Age 21–24	Chlamydia Screening, Women Age Total	Controlling High Blood Pressure	Persistence of Beta-Blocker Treatment After Heart Attack	Diabetes Care, HbA1c testing	Diabetes Care, HbA1c >9.0%	Diabetes Care, HbA1c <8.0%	Diabetes Care, HbA1c <7.0%	Diabetes Care, eye examination	Diabetes Care, Medical Attention for Nephropathy	Diabetes Care, Blood Pressure <140/90 mm HG	Testing for Children with Pharyngitis
Aetna Health, Inc. (Austin)*	=	=	NR	NA	-	NR	NR	NR	+	-	NR	+
Aetna Health, Inc. (Dallas/Ft Worth)*	=	-	NR	NA	-	NR	+	NR	+	=	NR	+
Aetna Health, Inc. (Houston)*	=	=	NR	NA	=	NR	NR	=	=	-	NR	+
Aetna Health, Inc. (San Antonio/Corpus Christi)*	=	+	NR	NA	=	NR	NR	NR	=	=	NR	NA
Allegian Health Plans, Inc. (Harlingen)	=	=	-	NA	-	=	-	NQ	=	=	+	-
CIGNA HealthCare of Texas, Inc. (South Texas)*	+	+	NR	=	+	+	-	NR	-	+	-	=
Community First Health Plans (San Antonio)*	=	=	+	NA	=	-	+	BR	+	=	+	-
FIRSTCARE (Abilene)	-	-	=	NA	=	-	+	+	=	-	+	=
FIRSTCARE (Amarillo)	-	-	-	NA	=	=	=	-	=	=	+	-
FIRSTCARE (Lubbock)	-	-	-	NA	=	-	+	=	=	=	+	-
FIRSTCARE (Waco)	-	-	-	NA	=	-	+	=	=	=	+	-
HMO Blue Texas (Dallas/Ft Worth)	=	=	NR	NA	=	-	+	NA	=	=	-	+
HMO Blue Texas (East/South/West Texas)	=	=	NR	NA	-	+	-	NA	-	=	-	=
HMO Blue Texas (Houston)	=	+	NR	NA	=	+	-	NA	-	=	-	=
Humana Health Plan of Texas (Austin)*	-	-	+	NA	=	-	+	=	=	-	+	+
Humana Health Plan of Texas (Corpus Christi)*	=	=	=	NA	-	-	+	=	+	-	+	-
Humana Health Plan of Texas (Houston)*	=	=	=	NA	-	-	+	-	=	=	+	+
Humana Health Plan of Texas (San Antonio)*	=	=	+	=	=	-	+	+	+	=	+	=
Scott and White Health Plan (Central TX)*	=	-	+	=	+	-	+	+	+	=	+	+

+ Better than Texas Average **=** Equivalent to Texas Average **-** Lower than Texas Average

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
BR– The calculated rate was materially biased.
NA–The plan did not have a large enough sample to report a valid rate.
NQ– The plan was not required to report the measure.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Summary Tables

Health Plan Name	Treatment for Children with Upper Respiratory Infection	Avoidance of Antibiotic Treatment In Adults with Acute Bronchitis	Med Management for Asthma, on meds for 50% of treatment period, Age 5-11	Med Management for Asthma, on meds for 50% of treatment period, Age 12-18	Med Management for Asthma, on meds for 50% of treatment period, Age 19-50	Med Management for Asthma, on meds for 50% of treatment period, Age 51-64	Med Management for Asthma, on meds for 50% of treatment period, Age 65-85	Med Management for Asthma, on meds for 50% of treatment period, Total	Med Management for Asthma, on meds for 75% of treatment period, Age 5-11	Med Management for Asthma, on meds for 75% of treatment period, Age 12-18	Med Management for Asthma, on meds for 75% of treatment period, Age 19-50	Med Management for Asthma, on meds for 75% of treatment period, Age 51-64
Aetna Health, Inc. (Austin)*	=	=	NA	NA	NA	NA	NA	=	NA	NA	NA	NA
Aetna Health, Inc. (Dallas/Ft Worth)*	=	=	NA	NA	=	+	NA	+	NA	NA	=	+
Aetna Health, Inc. (Houston)*	=	+	NA	NA	=	NA	NA	=	NA	NA	=	NA
Aetna Health, Inc. (San Antonio/Corpus Christi)*	=	=	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Allegian Health Plans, Inc. (Harlingen)	=	=	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
CIGNA HealthCare of Texas, Inc. (South Texas)*	=	-	=	-	=	=	NA	-	=	-	-	=
Community First Health Plans (San Antonio)*	+	=	=	+	=	+	NA	+	=	=	=	=
FIRSTCARE (Abilene)	-	=	NA	NA	NA	NA	NA	+	NA	NA	NA	NA
FIRSTCARE (Amarillo)	-	=	NA	NA	NA	NA	NA	+	NA	NA	NA	NA
FIRSTCARE (Lubbock)	-	-	NA	NA	+	NA	NA	+	NA	NA	+	NA
FIRSTCARE (Waco)	-	-	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HMO Blue Texas (Dallas/Ft Worth)	=	=	NA	NA	NA	NA	NA	=	NA	NA	NA	NA
HMO Blue Texas (East/South/West Texas)	=	=	NA	NA	NA	NA	NA	=	NA	NA	NA	NA
HMO Blue Texas (Houston)	=	-	NA	NA	NA	NA	NA	=	NA	NA	NA	NA
Humana Health Plan of Texas (Austin)*	+	+	=	-	-	-	NA	-	=	=	-	-
Humana Health Plan of Texas (Corpus Christi)*	-	=	NA	NA	NA	NA	NA	-	NA	NA	NA	NA
Humana Health Plan of Texas (Houston)*	=	=	=	NA	=	=	NA	=	=	NA	=	=
Humana Health Plan of Texas (San Antonio)*	+	+	-	=	-	=	NA	-	-	=	-	=
Scott and White Health Plan (Central TX)*	+	=	=	=	=	=	=	=	=	=	=	=

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

Summary Tables

Health Plan Name	Med Management for Asthma, on meds for 75% of treatment period, Age 65-85	Med Management for Asthma, on meds for 75% of treatment period, Total	Antidepressant Medication Management, acute phase	Antidepressant Medication Management, continuation phase	Follow-Up Care: Children Prescribed ADHD Meds: Initiation Phase	Follow-Up Care: Children Prescribed ADHD Meds: Continuation & Maintenance	7-Day Follow-up After Hosp. for Mental Illness	30-Day Follow-up After Hosp. for Mental Illness	Well Child Visits, First 15 Months of Life	Well Child Visits, Age 3–6	Adolescent Well-Care Visits
Aetna Health, Inc. (Austin)*	NA	=	=	=	NA	NA	NA	NA	=	+	=
Aetna Health, Inc. (Dallas/Ft Worth)*	NA	+	=	=	=	NA	=	=	=	=	=
Aetna Health, Inc. (Houston)*	NA	=	=	+	=	NA	NA	NA	=	=	=
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA	NA	=	=	NA	NA	NA	NA	NA	=	=
Allegian Health Plans, Inc. (Harlingen)	NA	NA	=	-	NA	NA	NA	NA	-	-	-
CIGNA HealthCare of Texas, Inc. (South Texas)*	NA	-	-	-	=	=	=	=	=	=	+
Community First Health Plans (San Antonio)*	NA	=	=	-	=	NA	=	=	=	=	-
FIRSTCARE (Abilene)	NA	+	+	+	NA	NA	NA	NA	=	-	-
FIRSTCARE (Amarillo)	NA	+	+	+	NA	NA	NA	NA	=	-	-
FIRSTCARE (Lubbock)	NA	+	+	+	=	NA	NA	NA	=	-	-
FIRSTCARE (Waco)	NA	NA	+	+	NA	NA	NA	NA	=	-	-
HMO Blue Texas (Dallas/Ft Worth)	NA	=	=	=	NA	NA	NA	NA	+	+	+
HMO Blue Texas (East/South/West Texas)	NA	=	=	=	NA	NA	NA	NA	NA	=	=
HMO Blue Texas (Houston)	NA	=	=	-	=	NA	NA	NA	=	=	+
Humana Health Plan of Texas (Austin)*	NA	-	=	=	=	NA	=	=	+	+	+
Humana Health Plan of Texas (Corpus Christi)*	NA	-	-	-	=	NA	NA	NA	=	=	-
Humana Health Plan of Texas (Houston)*	NA	-	=	=	=	NA	=	=	=	+	+
Humana Health Plan of Texas (San Antonio)*	NA	-	-	-	=	NA	=	=	+	+	=
Scott and White Health Plan (Central TX)*	=	=	+	+	=	=	=	=	=	=	-

+ Better than Texas Average **=** Equivalent to Texas Average **-** Lower than Texas Average

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Childhood Immunization Status

Immunization is a basic method of preventing illness. Childhood immunizations help prevent serious illnesses like polio, measles, and tetanus. Even immunizing children for relatively "mild" illnesses like chickenpox (VZV) prevents lost school and work days and saves millions of dollars in health care costs each year. Immunization of healthy individuals also protects those who cannot receive vaccinations due to age or medical conditions.

The first part of this section reports the percentage of children using the HMO who received all age appropriate doses of a specific vaccine by two years of age—i.e., the percentage of children who received at least four doses of the diphtheria, tetanus, and acellular pertussis (DTaP) vaccine. The second part of the section reports the percentage of children using the HMO who received all age appropriate doses for the immunization combinations recommended by the Advisory Committee on Immunization Practices (ACIP).

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 two years of age.

Four combination vaccines prevent diphtheria, tetanus, and acellular pertussis: DTaP, Tdap, DT, and Td. Two of these (DTaP and DT) are given to children under seven years of age, and two (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."[1]

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.[2]

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.[3]

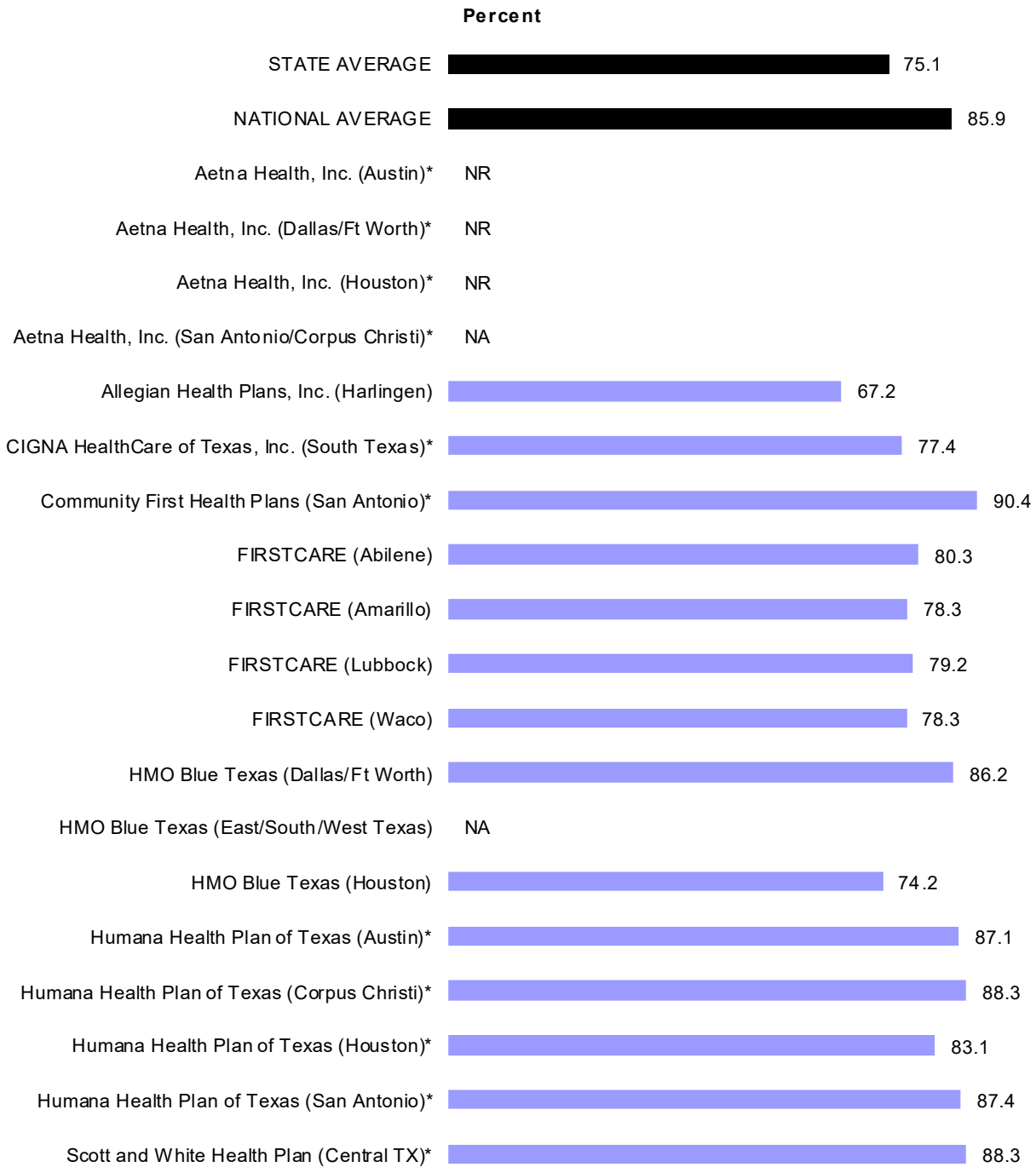
Pertussis (whooping cough) is a highly contagious bacterial respiratory disease spread by coughing and sneezing. The patient experiences severe spasms of coughing that often last minutes. Between coughing spells, the patient may gasp for air with a characteristic "whooping" sound. If left untreated, pertussis may lead to pneumonia, seizures, encephalopathy (brain degeneration), vomiting, weight loss, breathing difficulties, and possibly death.[4]

Childhood Immunization: DTaP					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	70.0%	79.8%	81.3%	83.1%	75.1%
NCQA's Quality Compass®	86.5%	87.2%	86.7%	87.3%	85.9%

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

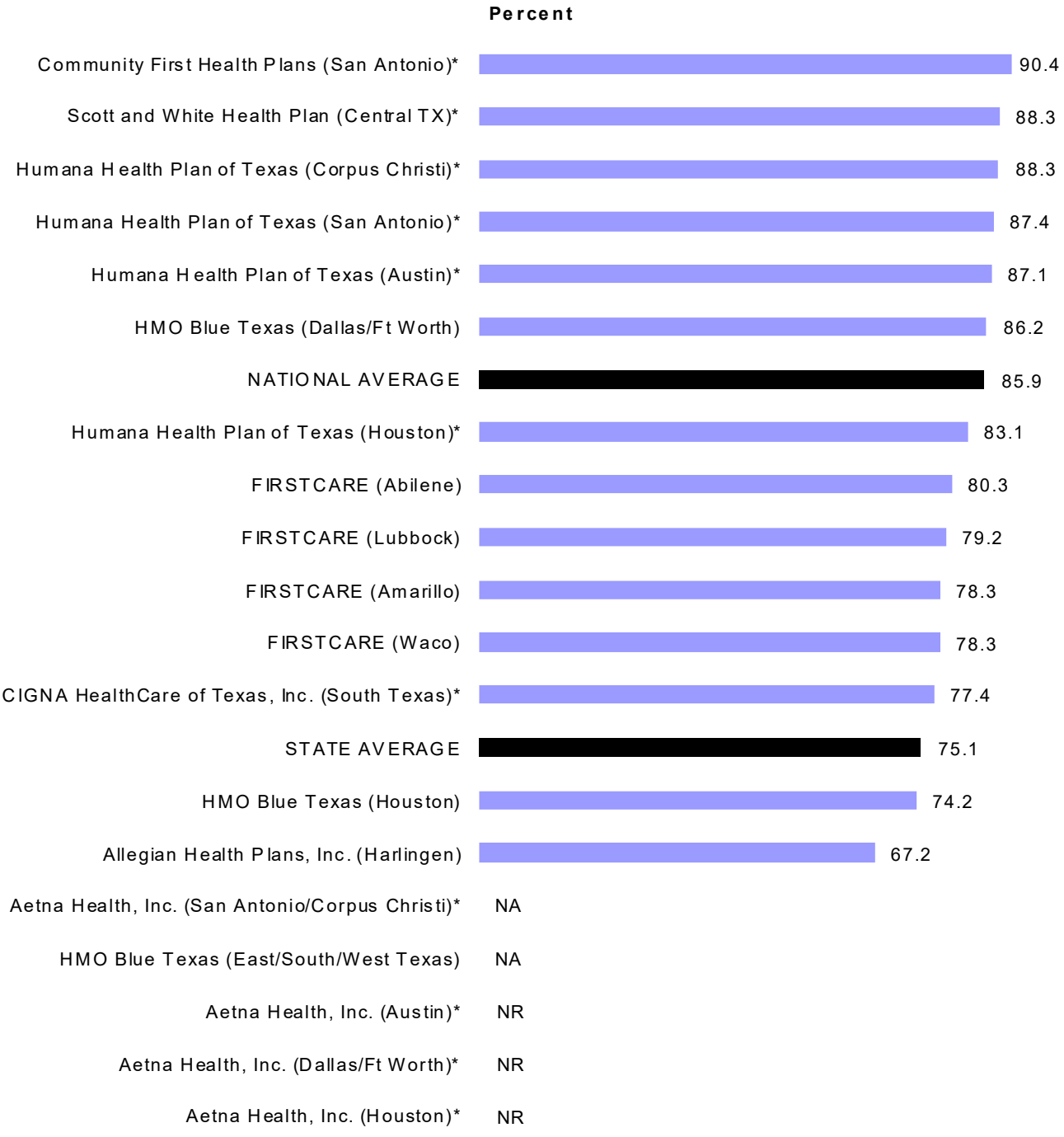
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.
[2] Ibid.
[3] Ibid.
[4] Ibid.

Childhood Immunization: DTaP



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Childhood Immunization: DTaP



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Childhood Immunization Status: Polio (IPV)

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

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 United States 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.[1]

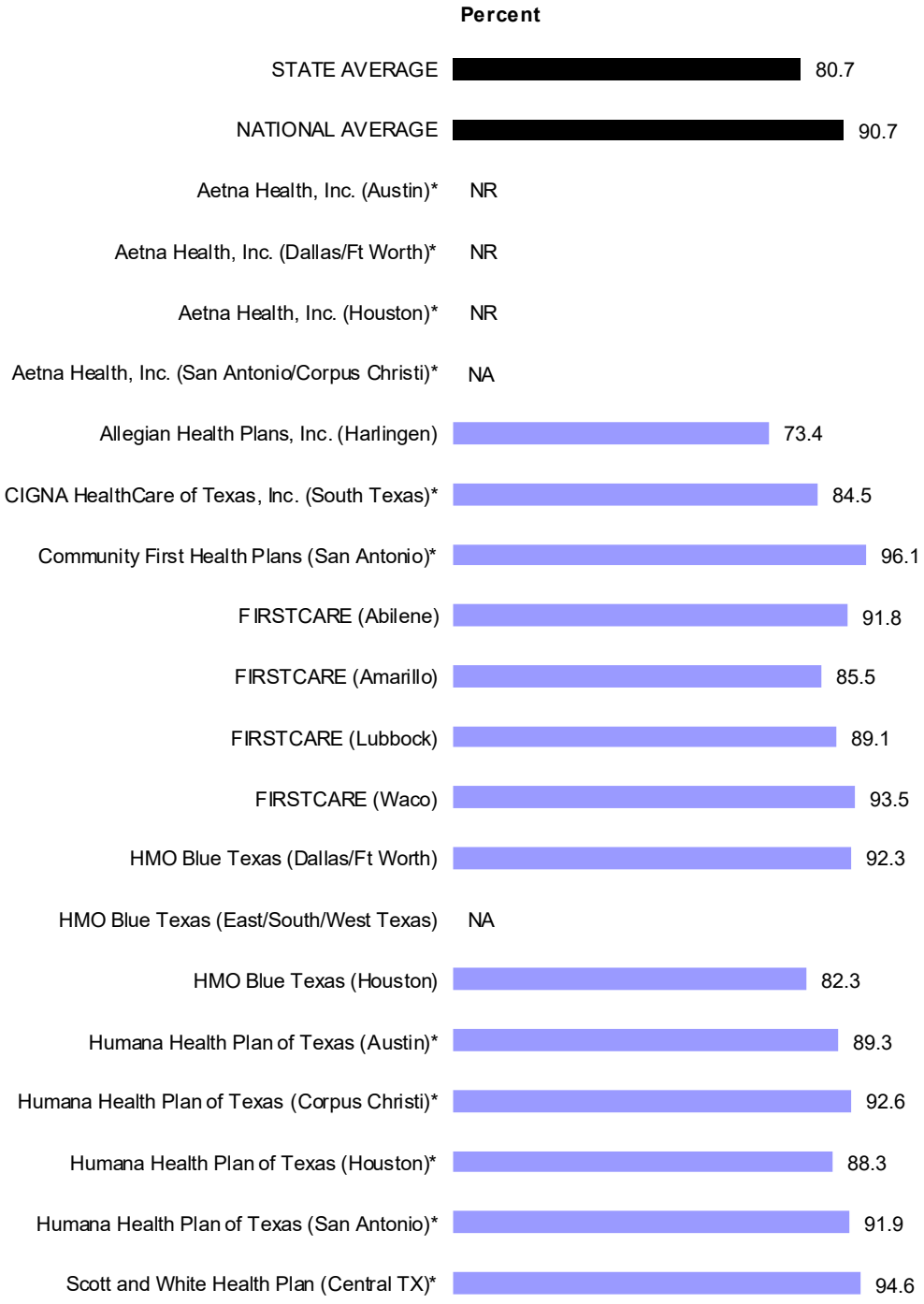
Two types of vaccines protect against polio: Inactivated Polio Vaccine (IPV) and Oral Polio Vaccine (OPV). IPV was administered in the U.S. from 1955 until the early 1960s when the OPV vaccine was licensed. OPV provides greater protection against the wild polio virus than IPV, and its widespread use led to the eradication of the wild polio virus in the U.S. by the late 1970s. However, OPV is a live vaccine and has been associated with isolated cases of vaccine-associated paralytic polio (VAPP) in unvaccinated individuals. To prevent VAPP transmission, IPV replaced OPV in the U.S. in 2000.[2]

Childhood Immunization Status: IPV					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	77.4%	86.8%	88.0%	89.6%	80.7%
NCQA's Quality Compass®	92.4%	92.8%	92.2%	92.4%	90.7%

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

[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.
[2] Ibid.

Childhood Immunization Status: IPV (Polio)



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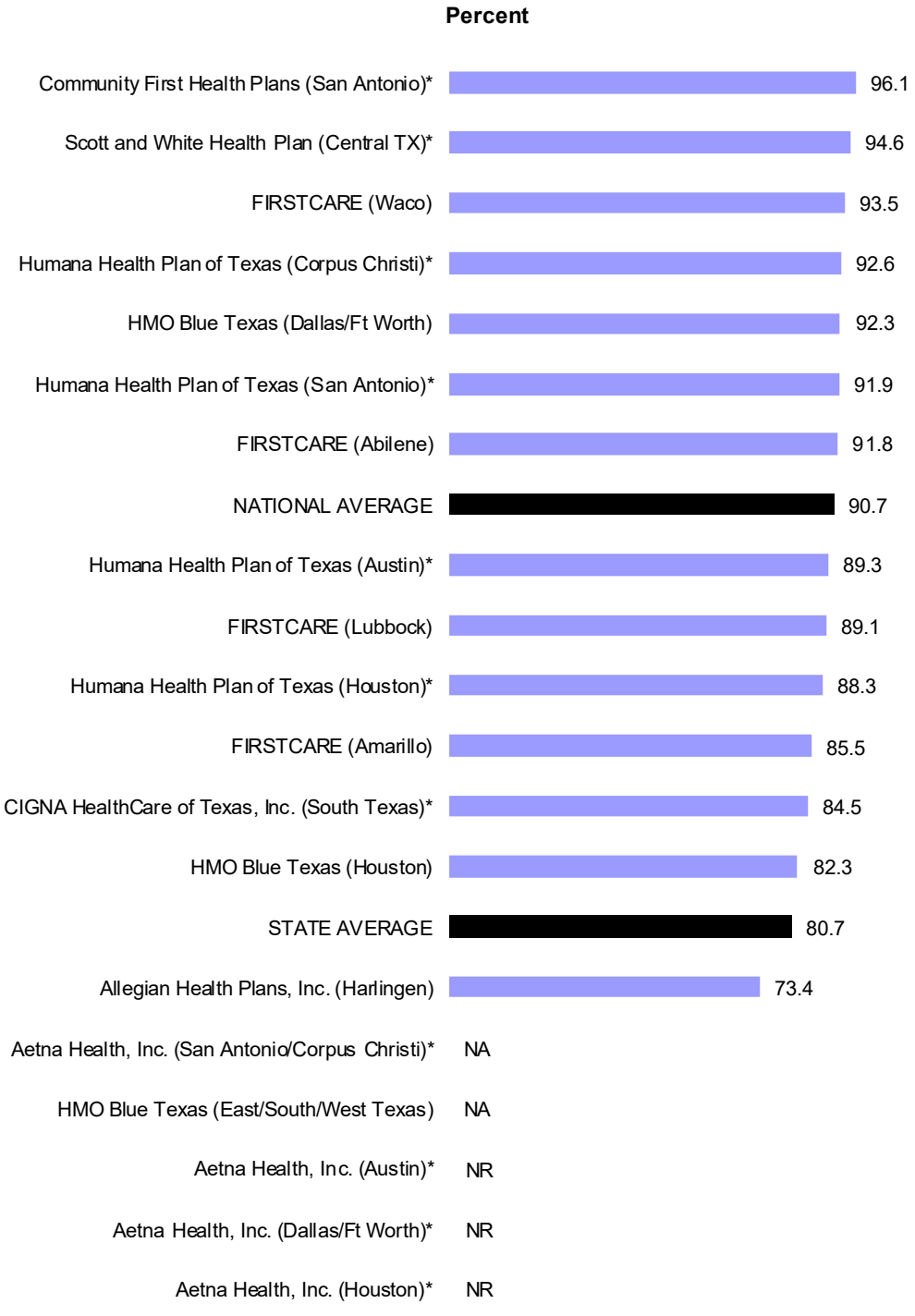
Childhood Immunization Status: IPV (Polio)



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

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

Measles is a highly contagious viral disease that causes rash, cough, runny nose, eye irritation, and fever. Complications include ear infection, pneumonia, seizures, brain damage, or death. In 1963, the first live attenuated vaccine was licensed for use in the United States. Measles infection was nearly universal before a vaccine was available. Measles is still a common and often fatal disease in developing countries with an estimated 145,700 deaths worldwide in 2013.[1]

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). The first mumps vaccine was introduced in the United States in 1967.[2]

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. The first rubella vaccines were licensed in 1969.[3]

Childhood Immunization Status: MMR					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	89.0%	91.2%	91.4%	92.3%	92.7%
NCQA's Quality Compass®	91.5%	91.8%	91.5%	92.1%	93.0%

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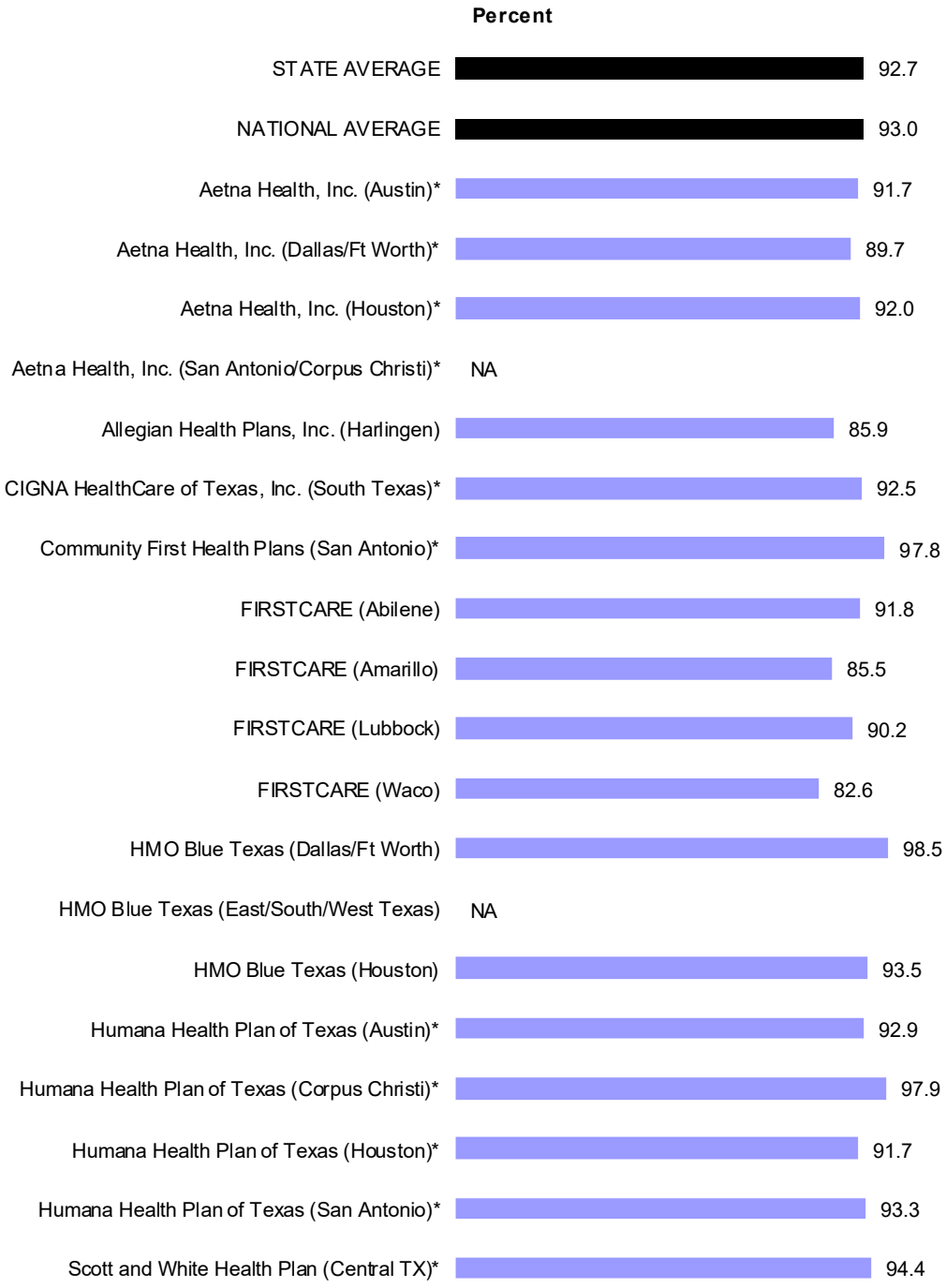
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.
[2] Ibid.
[3] Ibid.

Childhood Immunization Status: MMR



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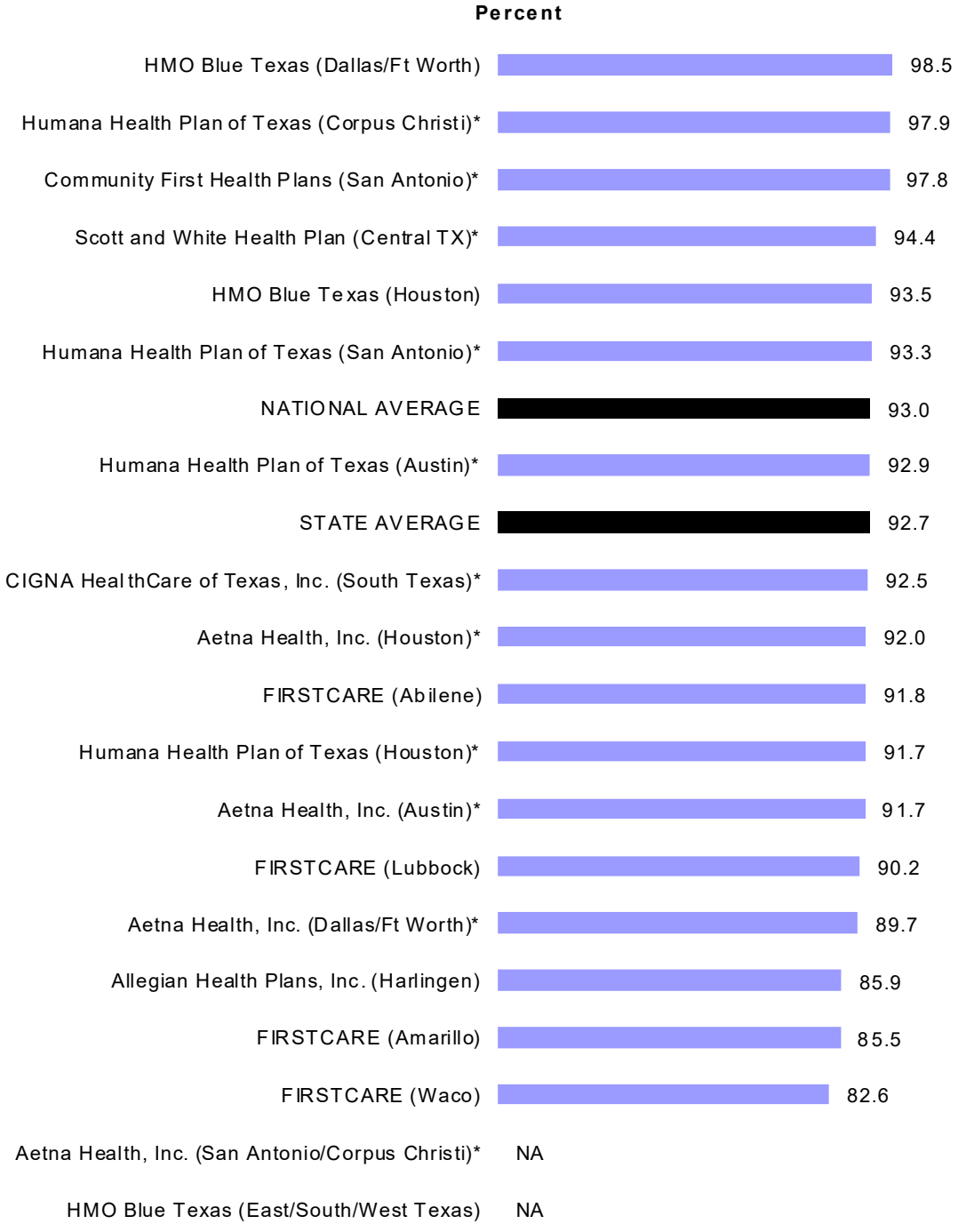
Childhood Immunization Status: MMR



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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 two years of age.

Haemophilus influenzae type B (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 5 years of age before the introduction of effective vaccines in the mid-1980s. Approximately two-thirds of all HiB cases occurred among children younger than 18 months of age. 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.[1]

Childhood Immunization Status: HiB					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	81.5%	89.5%	90.4%	91.9%	82.6%
NCQA's Quality Compass®	94.1%	94.3%	93.5%	93.7%	91.9%

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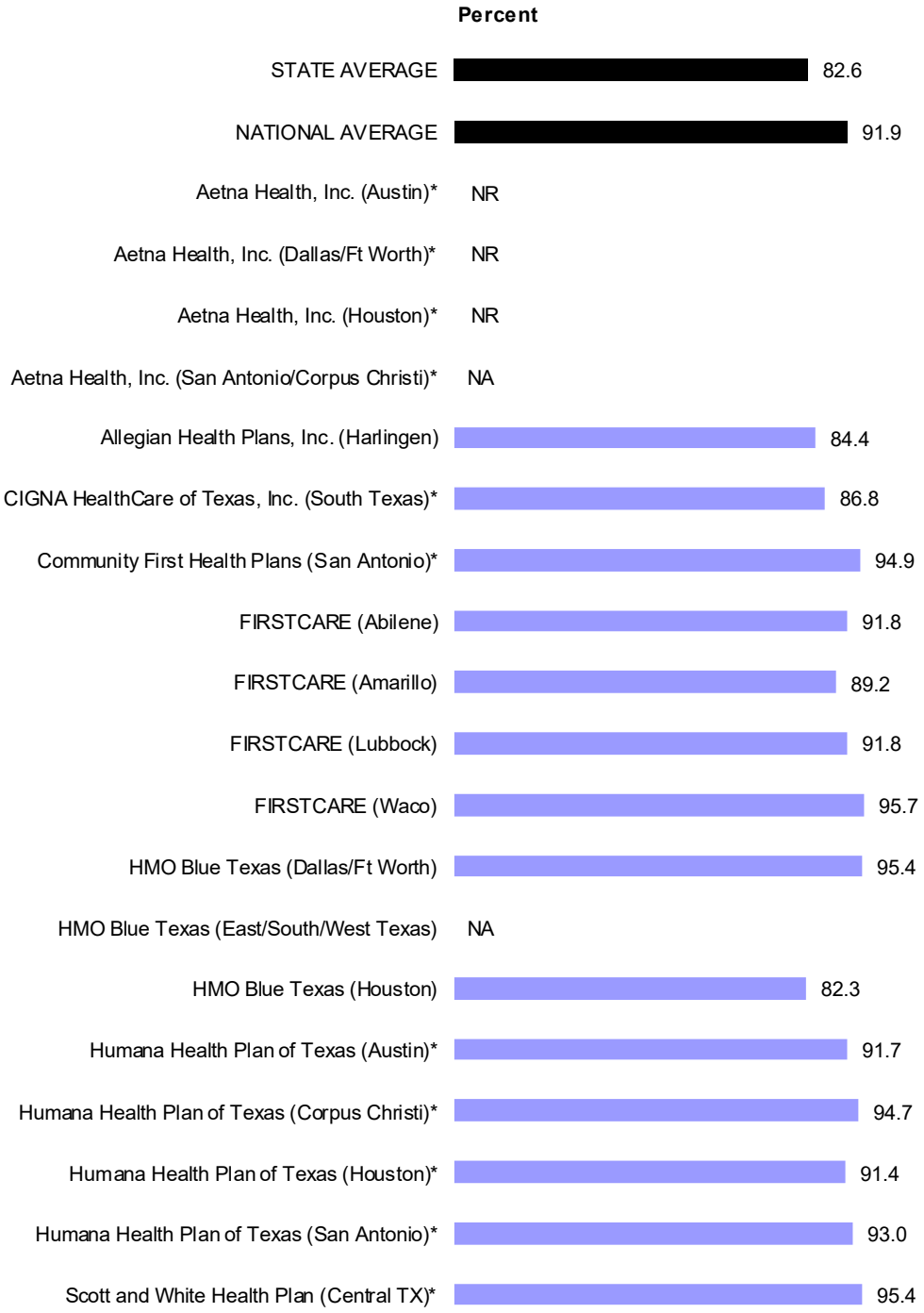
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.

Childhood Immunization Status: HiB



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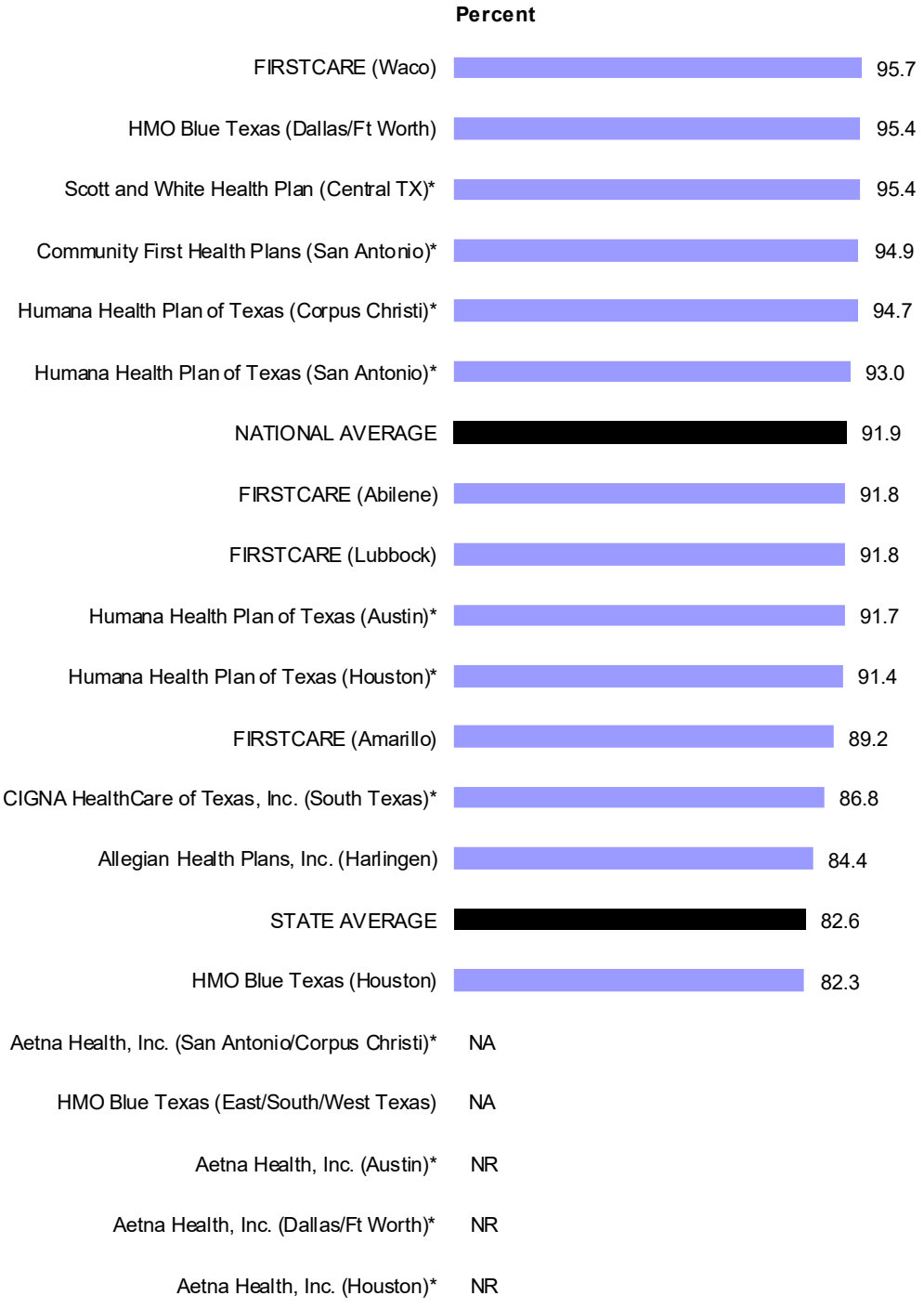
Childhood Immunization Status: HiB



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Childhood Immunization Status: Hepatitis B (HBV)

Definition: The percentage of children using the HMO who received three doses of the Hepatitis B (HBV) vaccine by two years of age.

Hepatitis B (HBV) is a virus that spreads through contact with an infected person's body fluids. Symptoms of HBV include jaundice (yellow coloration of the skin and eyes), fatigue, abdominal pain, loss of appetite, nausea, vomiting, and joint pain. Complications include liver damage (cirrhosis) and liver cancer. Once infected, children are less likely than adults to experience severe symptoms associated with acute HBV infection, but they are more likely to experience chronic infection. Complications are more likely with chronic infection. Approximately 90% of infants and 30–50% of children under five years of age will remain chronically infected. Vaccination for HBV reduces or eliminates the risk of contracting the disease for at least twenty years in healthy individuals vaccinated after 6 months of age.[1]

Childhood Immunization Status: Hepatitis B					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	51.3%	73.7%	78.1%	70.5%	75.6%
NCQA's Quality Compass®	87.9%	89.2%	88.1%	88.9%	86.5%

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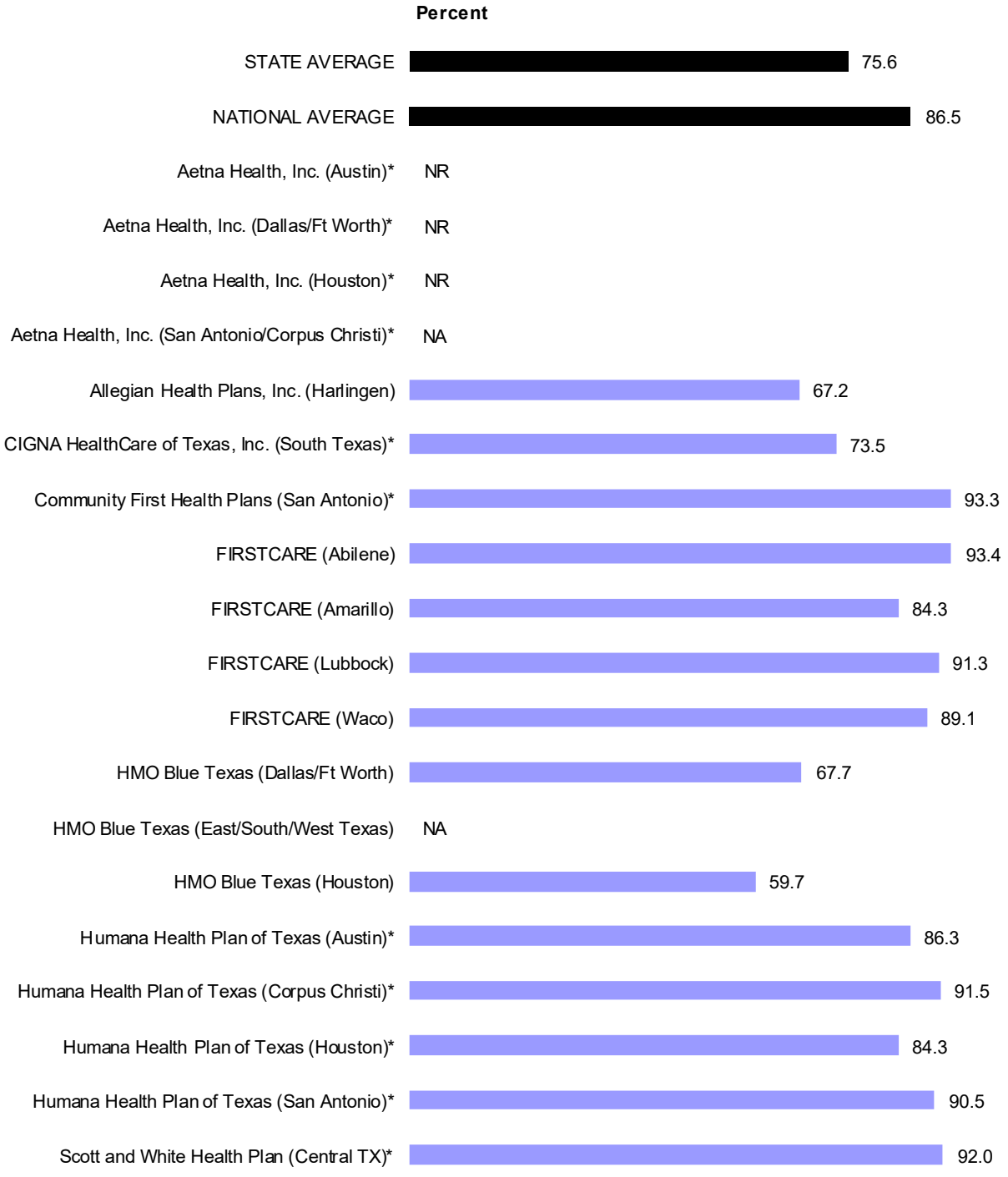
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.

Childhood Immunization Status: Hepatitis B



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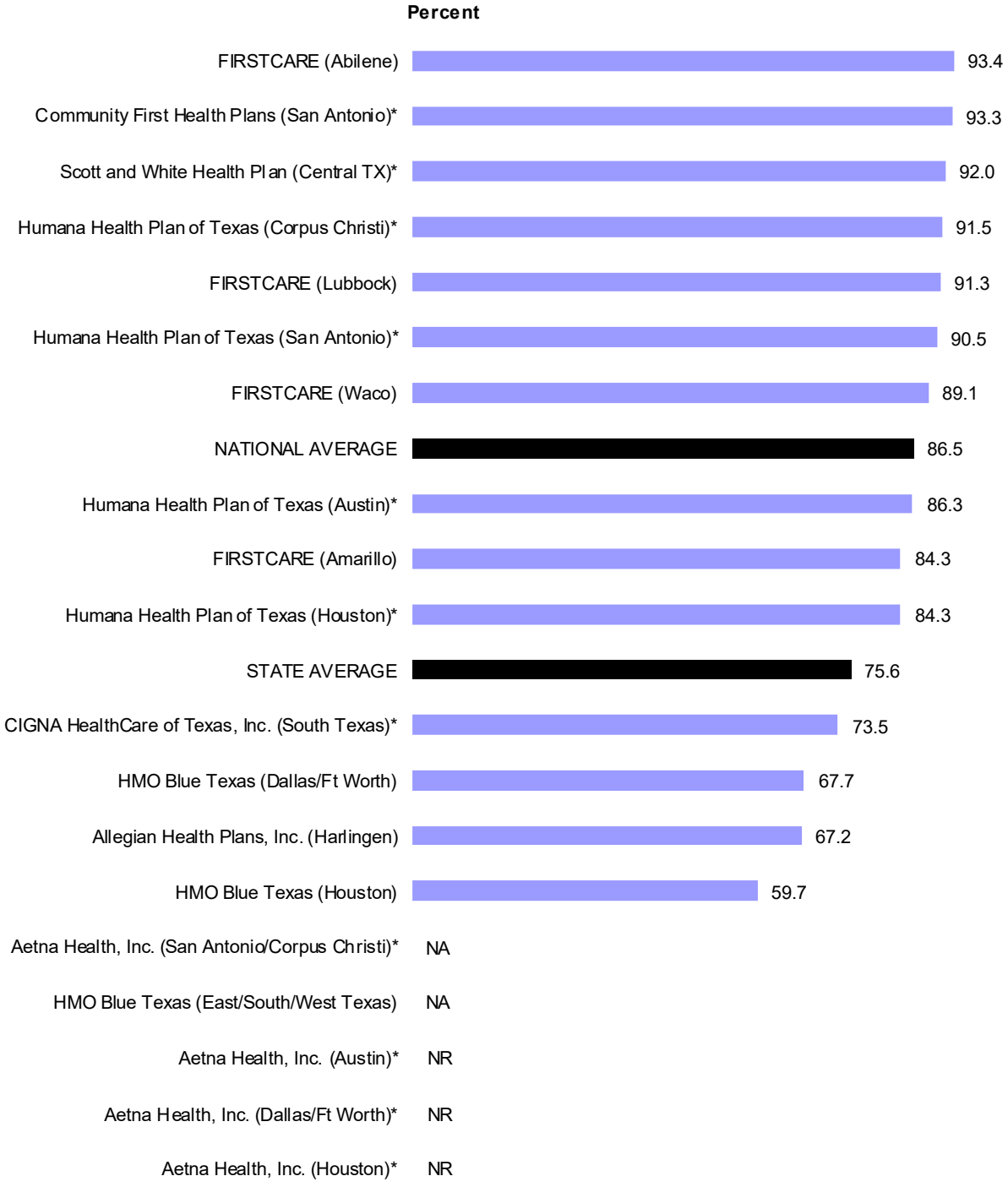
Childhood Immunization Status: Hepatitis B



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Childhood Immunization Status: Chickenpox (VZV)

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

Chickenpox (VZV) is a virus that causes fever and rash. Complications include skin infection, encephalitis (inflammation of the brain), and pneumonia. Adolescents and adults who contract the disease have a greater risk of complications. The vaccine completely protects 80–90% of individuals from the disease. Those who receive the vaccine but are not completely immune typically experience a milder version of the illness.[1]

Childhood Immunization Status: VZV					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	88.9%	90.6%	91.7%	92.0%	92.3%
NCQA's Quality Compass®	91.3%	91.6%	91.5%	92.0%	91.9%

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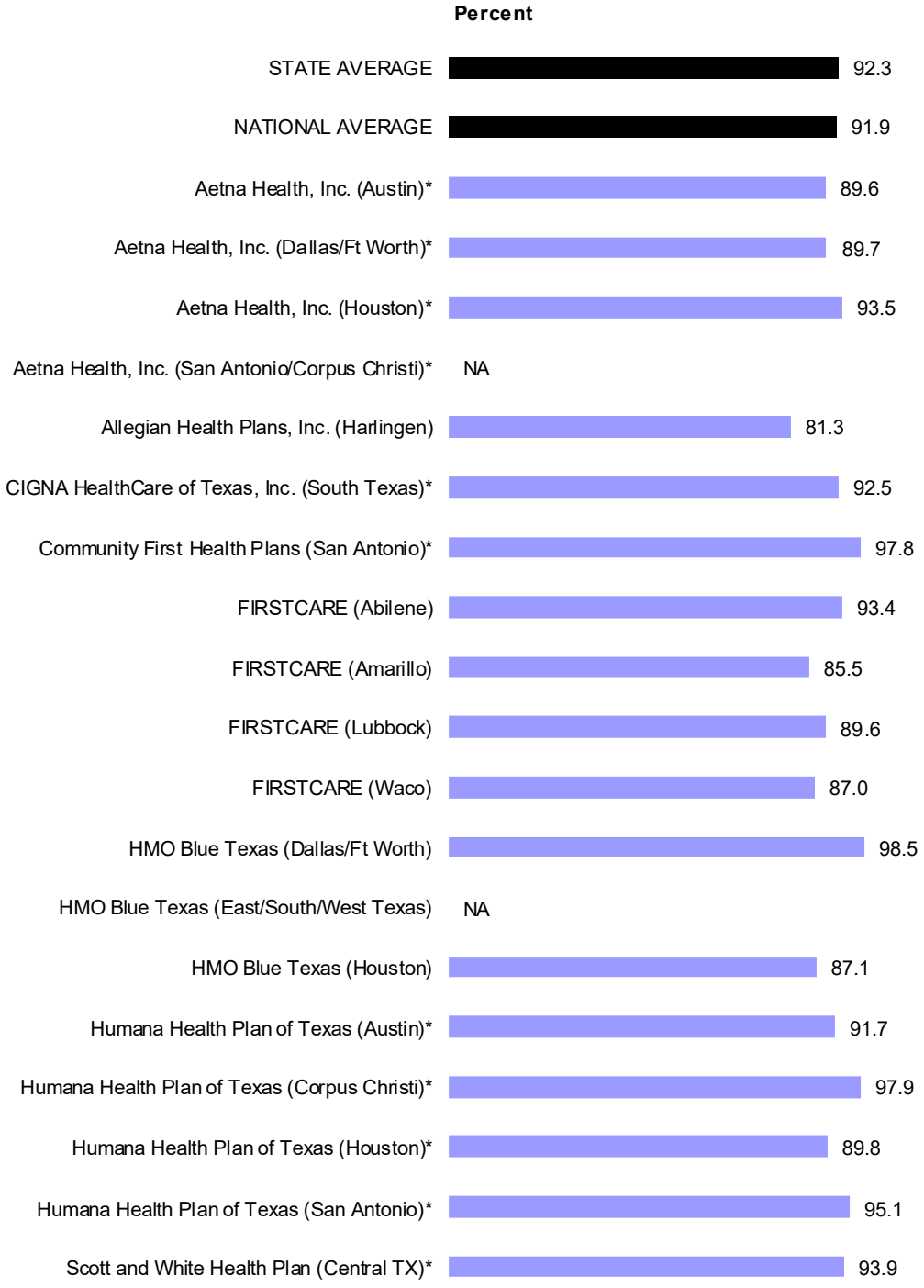
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.

Childhood Immunization Status: VZV (Chicken Pox)



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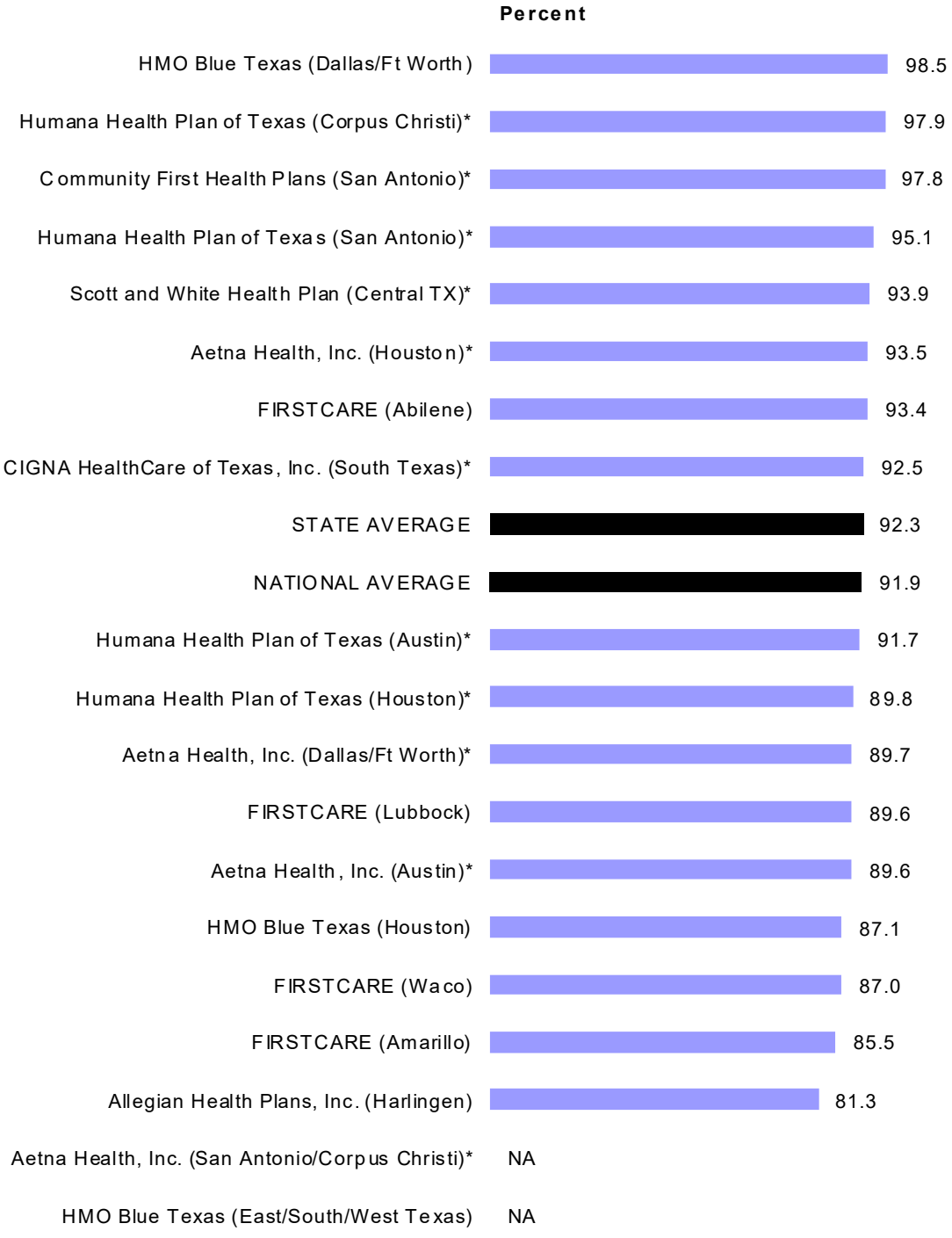
Childhood Immunization Status: VZV (Chicken Pox)



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

Childhood Immunization Status: Pneumococcal Conjugate

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

Pneumococcal disease is a bacterial infection caused by *Streptococcus pneumonia.* The disease can present in several ways including pneumococcal pneumonia, bacteremia (a blood stream infection), meningitis (an infection of the covering of the brain), and otitis media (a middle ear infection). Complications can include brain damage, hearing loss, and death. Pneumococcal disease is the leading cause of meningitis in the United States. Before the conjugate vaccine was available in 2000, pneumococcal infection caused over 700 cases of meningitis, 13,000 blood infections, and about five million ear infections each year.[1]

Childhood Immunization Status: Pneumococcal Conjugate					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	71.0%	78.8%	80.9%	83.7%	74.9%
NCQA's Quality Compass®	87.0%	86.7%	87.0%	87.5%	85.9%

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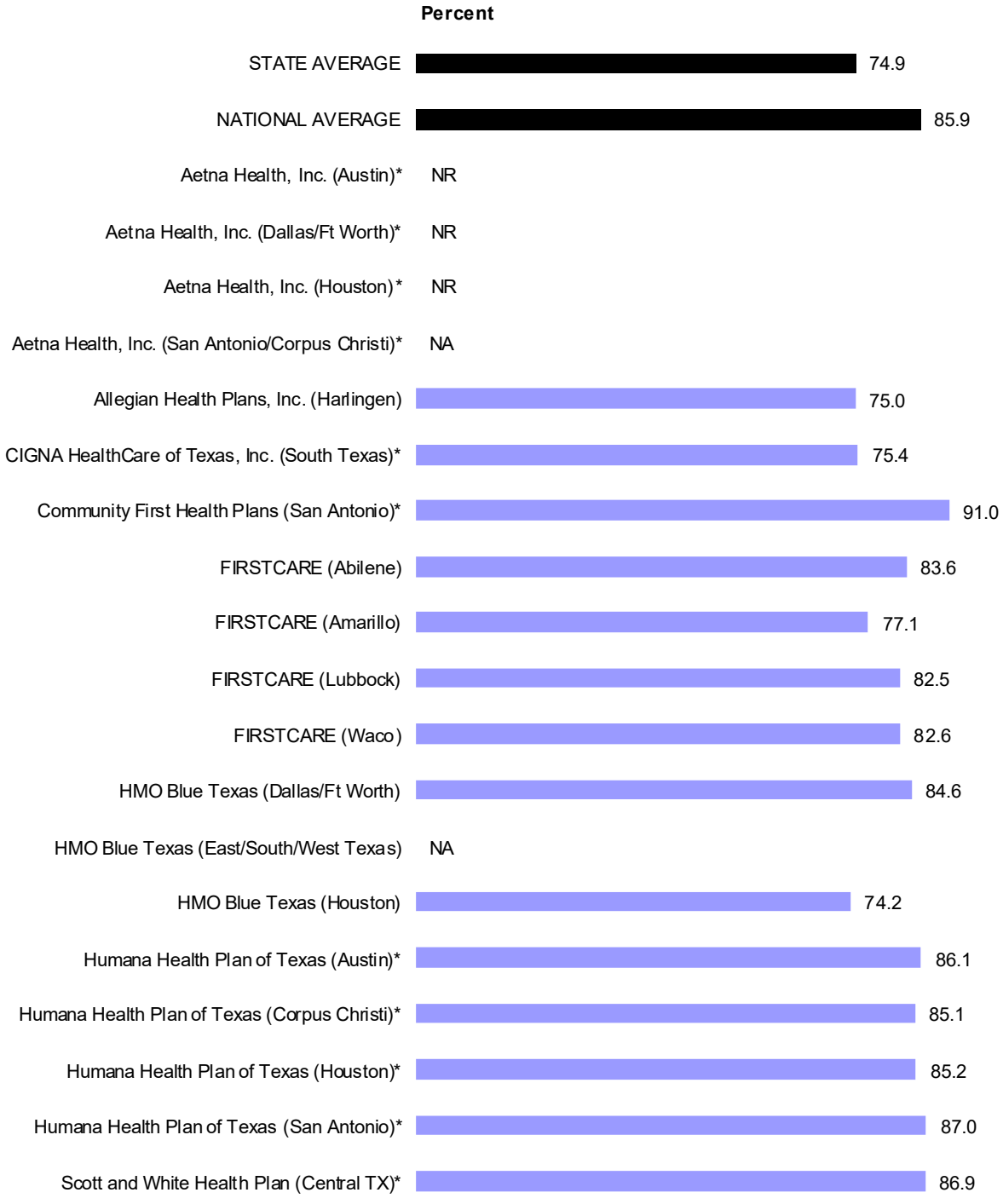
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 13th ed. Washington, DC: Public Health Foundation, 2015.

Childhood Immunization Status: Pneumococcal conjugate



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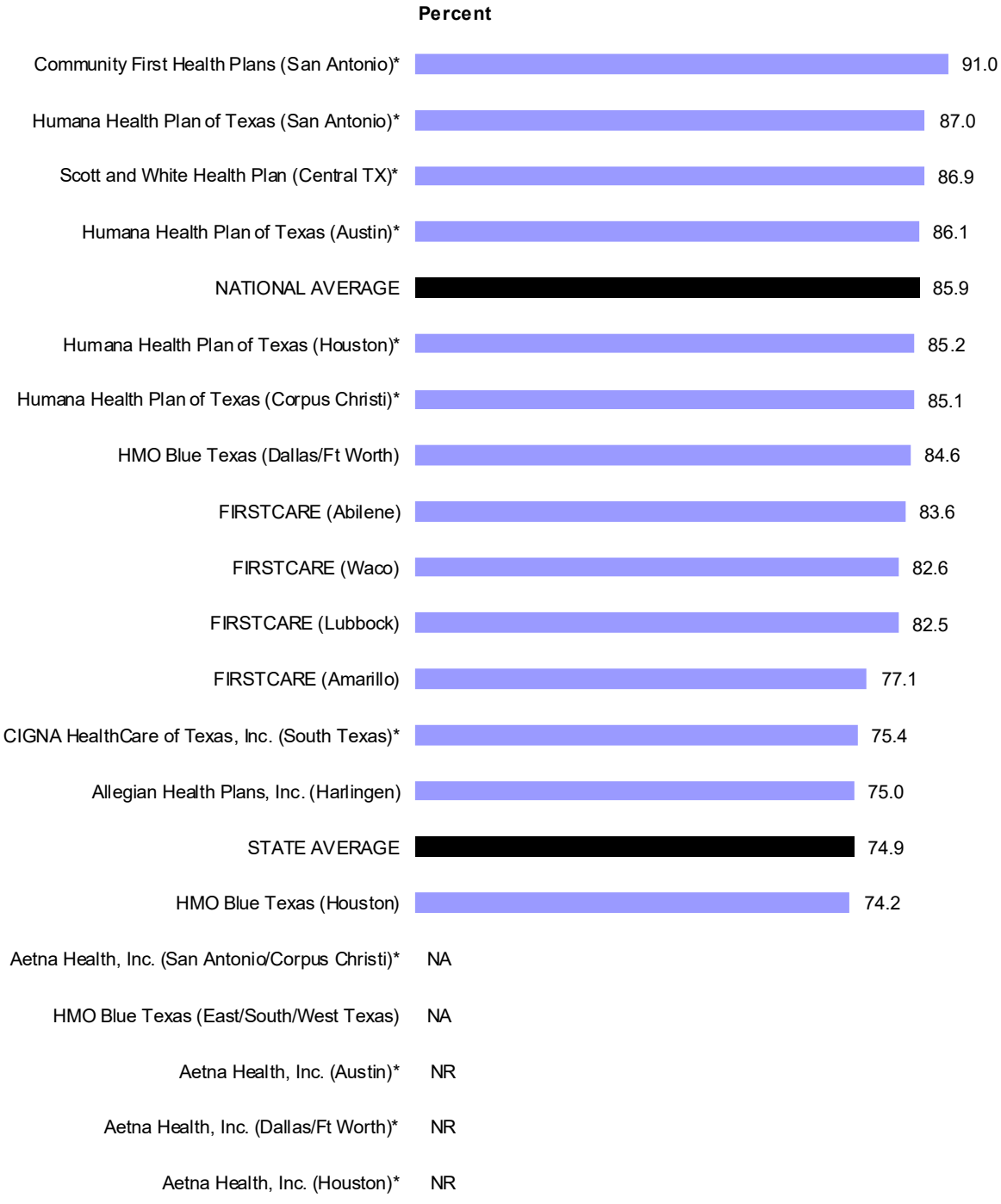
Childhood Immunization Status: Pneumococcal conjugate



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Childhood Immunization Status: Hepatitis A (HAV)

Definition: The percentage of children using the HMO who received one dose of the Hepatitis A (HAV) vaccine by two years of age.

Hepatitis A (HAV) is a contagious viral disease that affects the liver. Symptoms include jaundice, fever, and nausea. The disease typically spreads through contact with objects, food, or drinks contaminated with the stool of an infected person. It can range in severity from a mild illness lasting a few weeks to a severe illness lasting several months. Unlike Hepatitis B and C, HAV is not a chronic illness.[1]

Childhood Immunization Status: Hepatitis A					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	34.4%	83.6%	88.6%	89.2%	90.4%
NCQA's Quality Compass®	39.0%	65.5%	82.5%	83.7%	85.5%

Please note that the target vaccine dosage decreased from two doses to one dose with HEDIS® 2013.

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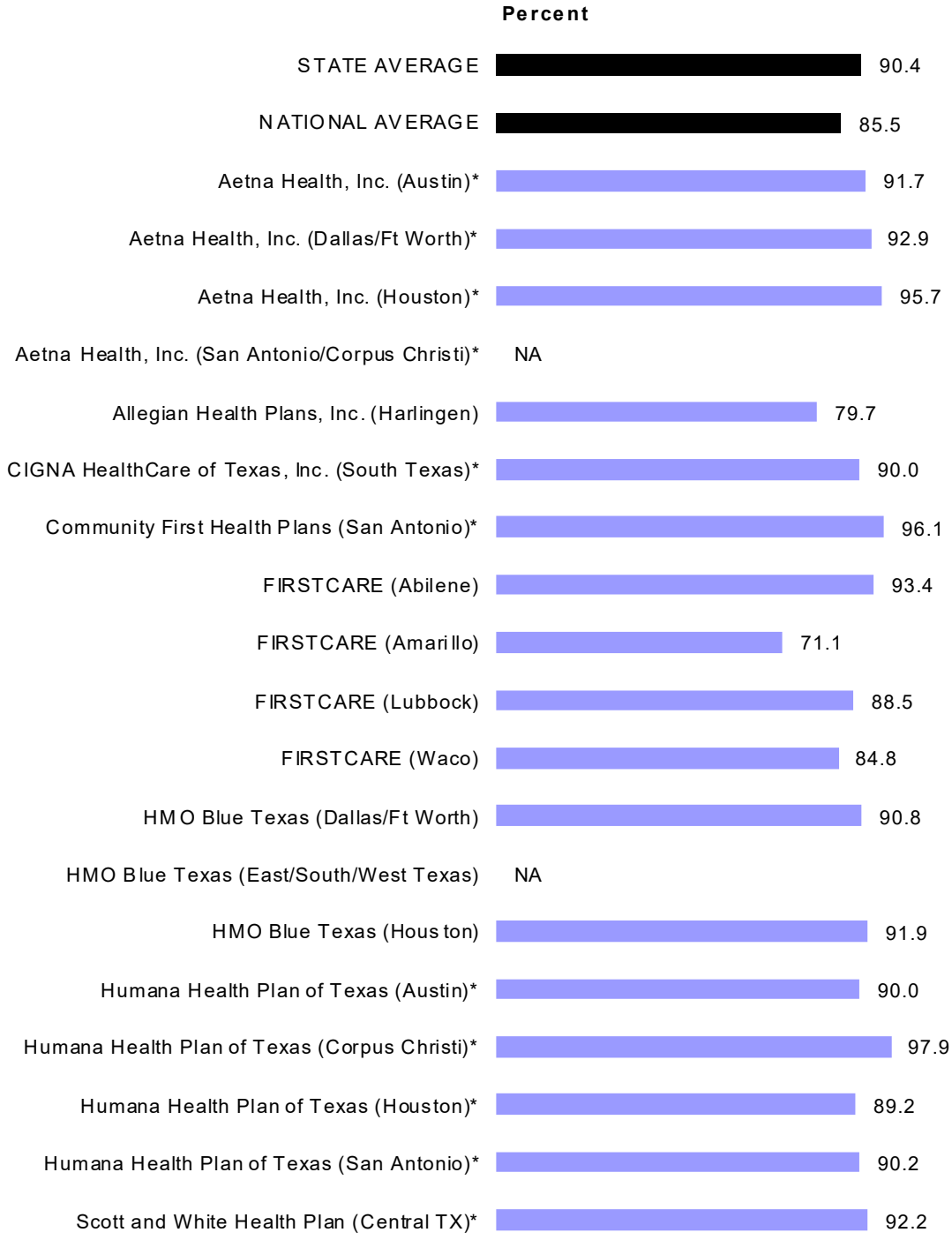
Childhood Immunization Status: Hepatitis A



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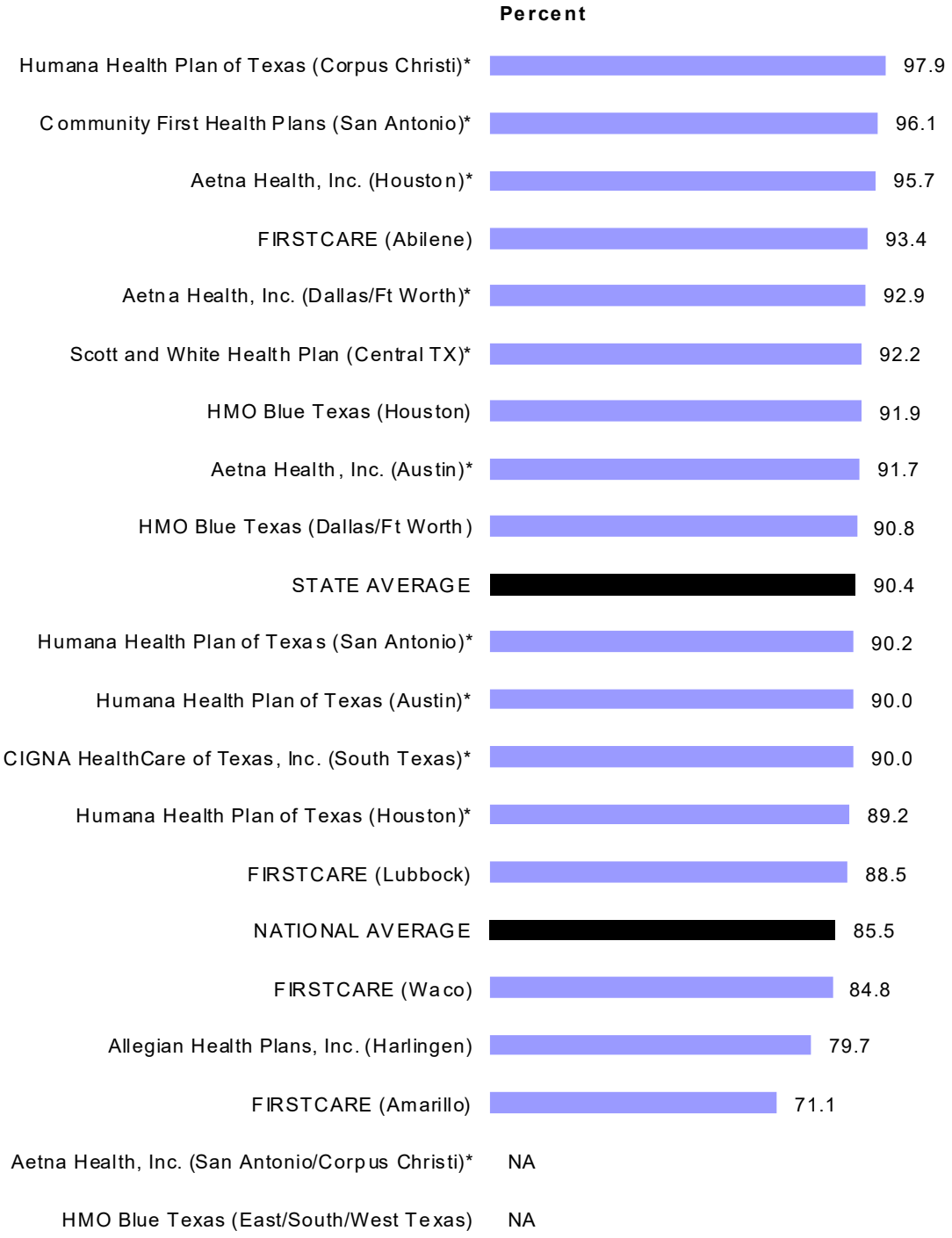
Childhood Immunization Status: Hepatitis A



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

Childhood Immunization Status: Rotavirus

Definition: The percentage of children using the HMO who received the required doses of the Rotavirus vaccine. There is a two-dose schedule and a three-dose schedule.

Rotavirus causes gastroenteritis (inflammation of the stomach and intestines). Symptoms include severe watery diarrhea, often accompanied by vomiting, fever, and abdominal pain. In babies and young children, the virus can lead to life-threatening dehydration. Rotavirus is the leading cause of severe diarrhea in infants and young children worldwide. Globally, it causes more than half a million deaths each year in children younger than five years of age.[1]

Rotavirus was the leading cause of severe diarrhea in American infants and young children before the introduction of the vaccine in 2006. In the prevaccine era, almost all children in the U.S. were infected with rotavirus before the age of five. The disease was responsible for more than 400,000 doctor visits, more than 200,000 emergency room visits, 55,000 to 70,000 hospitalizations, and twenty to sixty deaths in children under five years of age each year.[2]

Childhood Immunization Status: Rotavirus					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	65.6%	73.8%	77.8%	79.8%	74.6%
NCQA's Quality Compass®	75.1%	76.7%	79.9%	80.8%	80.2%

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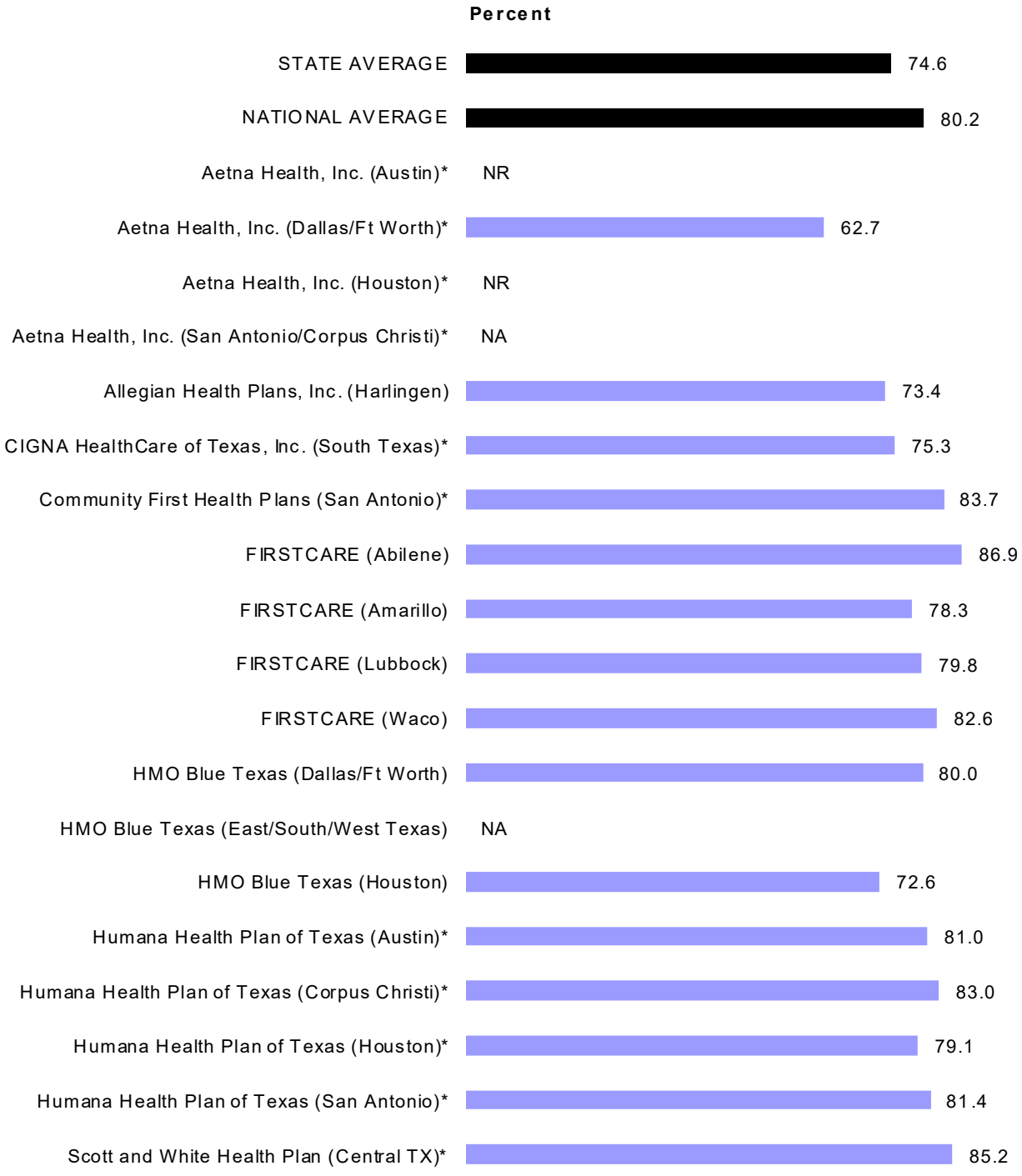
[2] Ibid.

Childhood Immunization Status: Rotovirus



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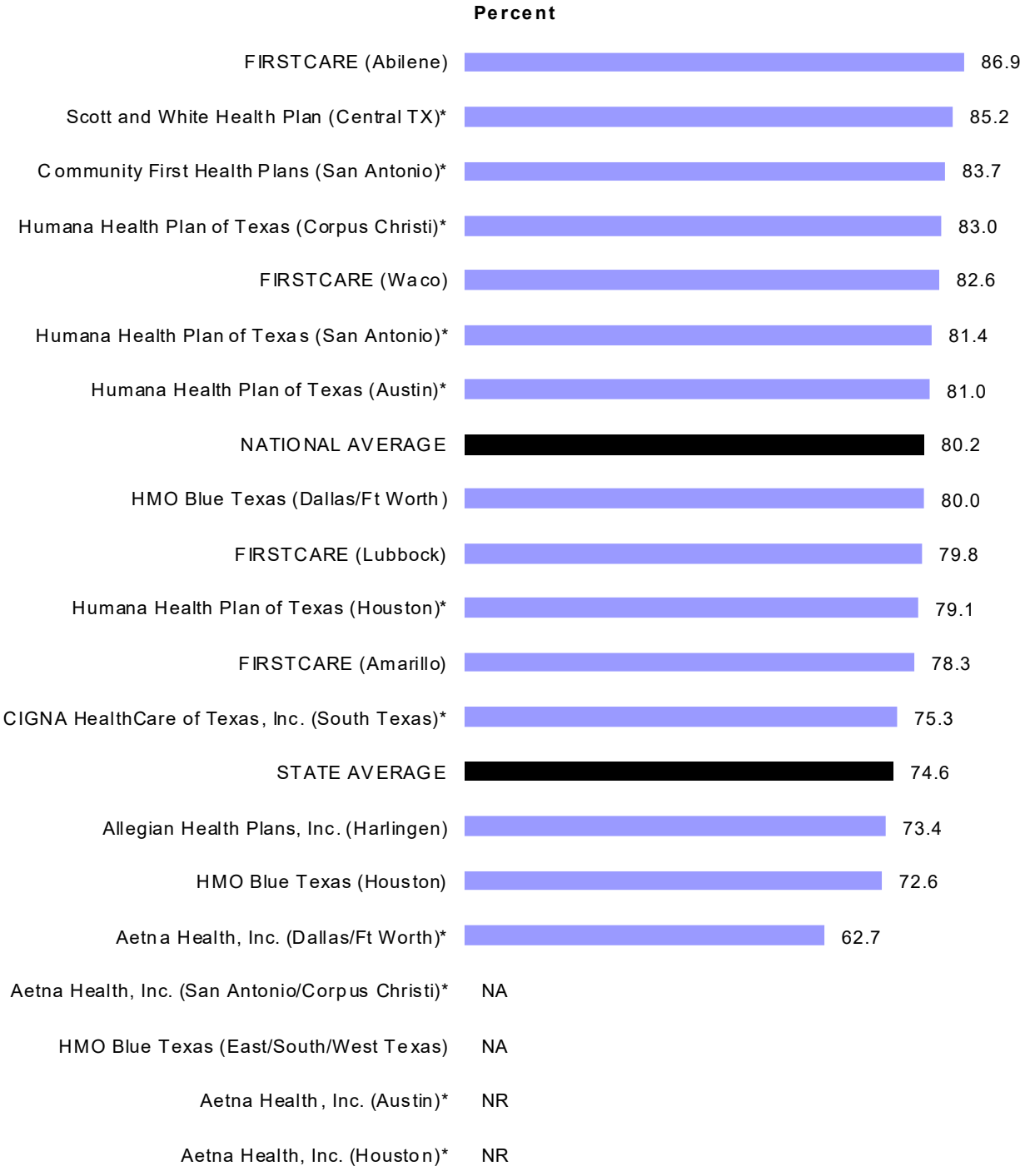
Childhood Immunization Status: Rotovirus



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Childhood Immunization Status: Influenza

Definition: The percentage of children using the HMO who received two doses of the Influenza vaccine by two years of age.

Influenza (flu) is a highly contagious viral illness. Symptoms can include fever, sore throat, headache, cough, and sore muscles. Complications can include pneumonia, myocarditis (inflammation of the heart), and death. Young children, adults over sixty-five, and individuals with underlying medical conditions have the highest risk of complications and death from the flu. On average, more than 200,000 individuals are hospitalized per year for influenza related symptoms.[1]

The Advisory Committee on Immunization Practices (ACIP) recommends yearly influenza vaccinations for all individuals over the age of six months, but emphasizes the importance of yearly vaccinations in vulnerable populations.[2]

Childhood Immunization Status: Influenza					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	55.1%	60.1%	62.4%	64.5%	60.8%
NCQA's Quality Compass®	61.1%	63.3%	65.4%	66.6%	64.8%

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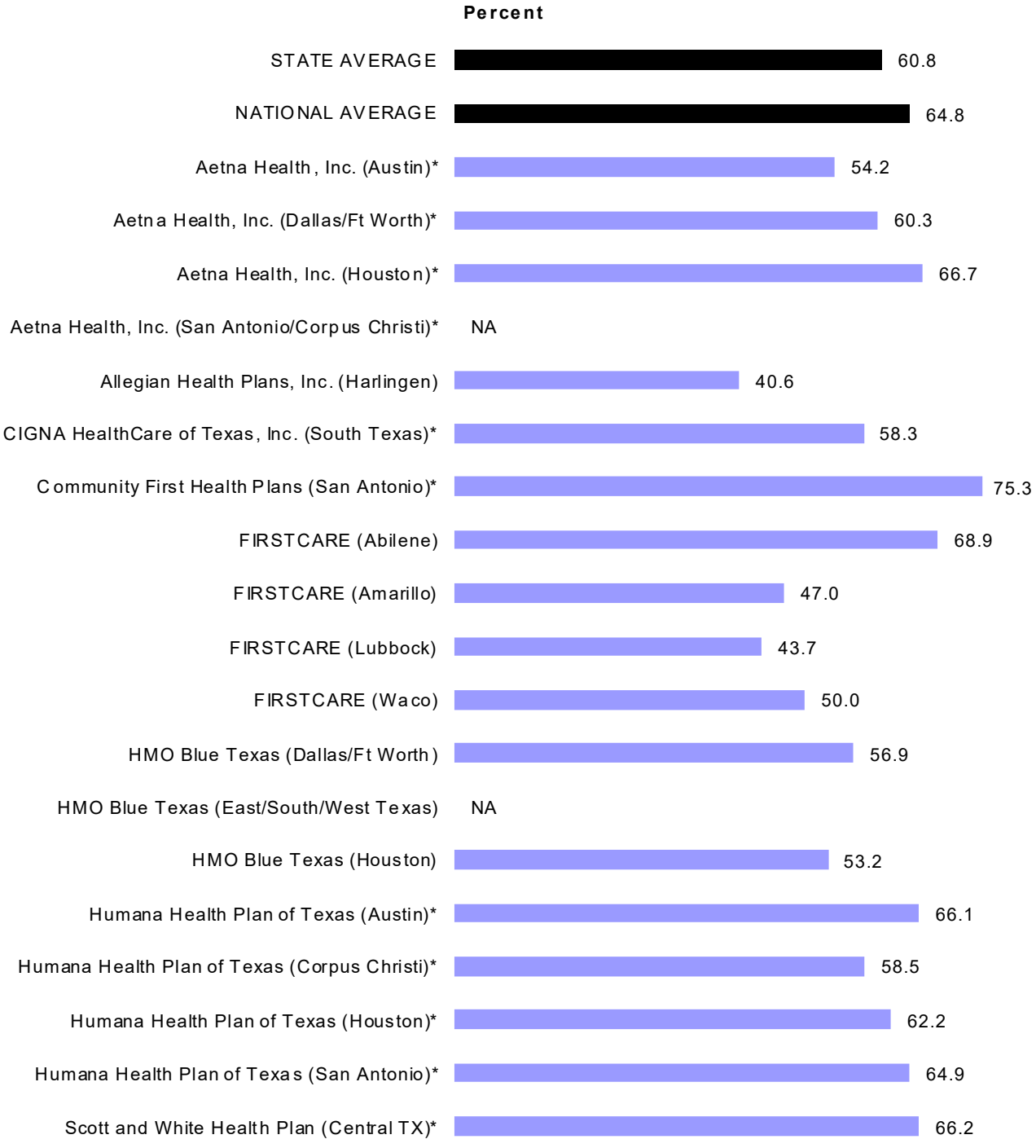
[2] Ibid.

Childhood Immunization Status: Influenza



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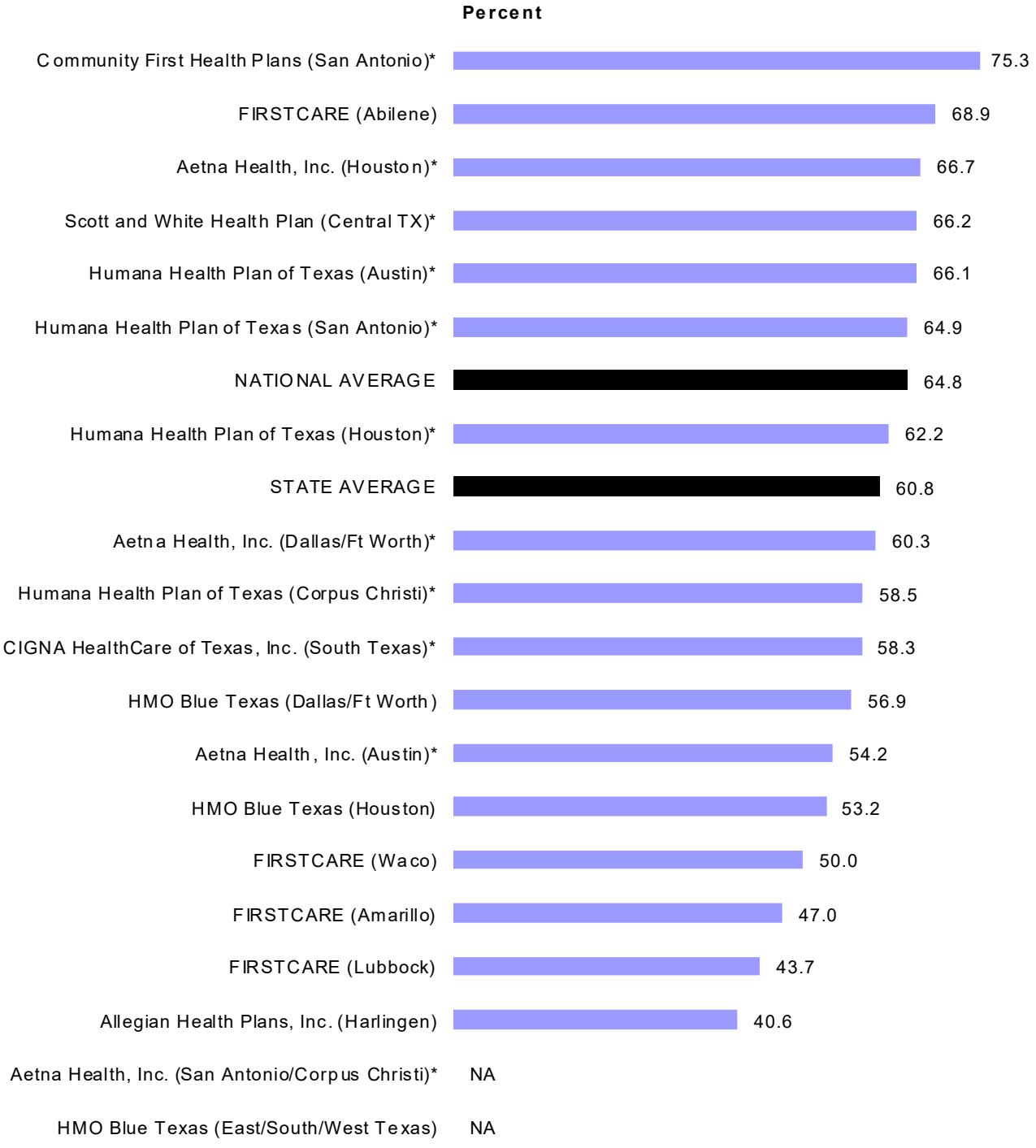
Childhood Immunization Status: Influenza



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Childhood Immunization Status: Combination 2

Definition: The percentage of children using the HMO who received all doses of the Combination 2 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose

Childhood Immunization Status: Combination 2					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	44.1%	63.9%	69.5%	63.3%	66.7%
NCQA's Quality Compass®	78.0%	79.7%	78.8%	80.1%	78.4%

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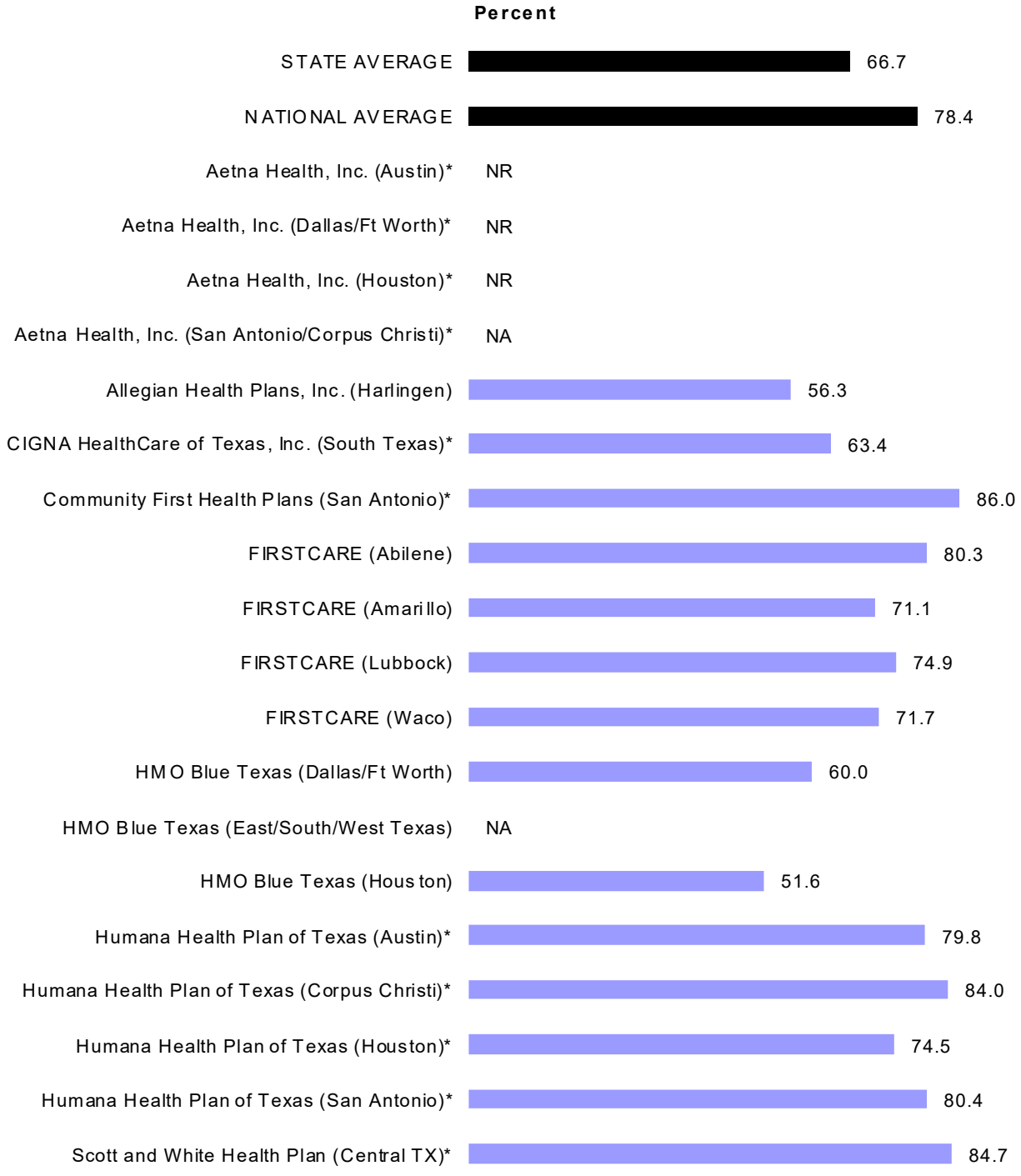
Childhood Immunization Status: Combination 2



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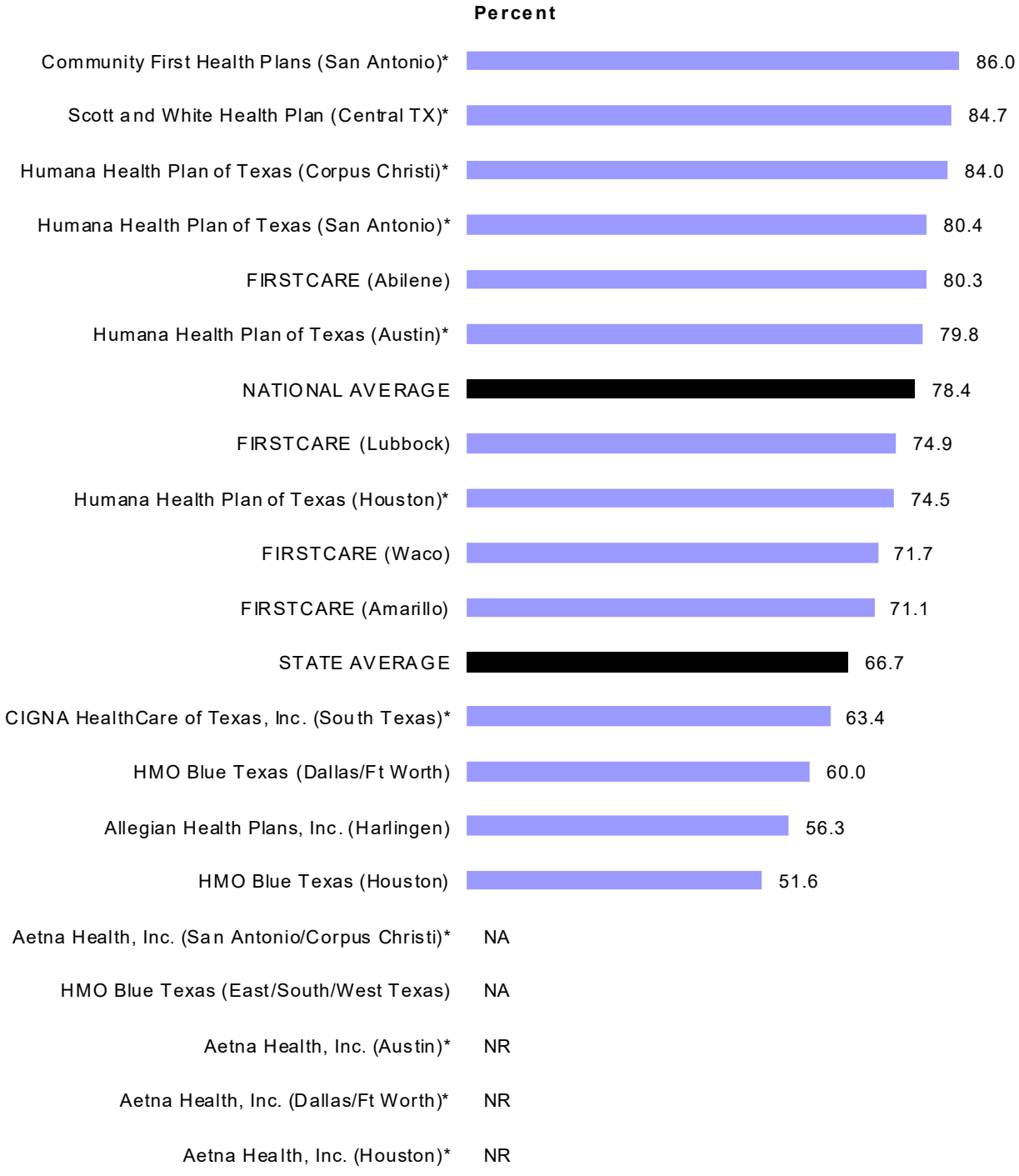
Childhood Immunization Status: Combination 2



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Childhood Immunization Status: Combination 3

Definition: The percentage of children using the HMO who received all doses of the Combination 3 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses

Childhood Immunization Status: Combination 3					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	42.6%	60.8%	66.8%	61.4%	64.0%
NCQA's Quality Compass®	75.7%	76.8%	76.6%	78.0%	76.3%

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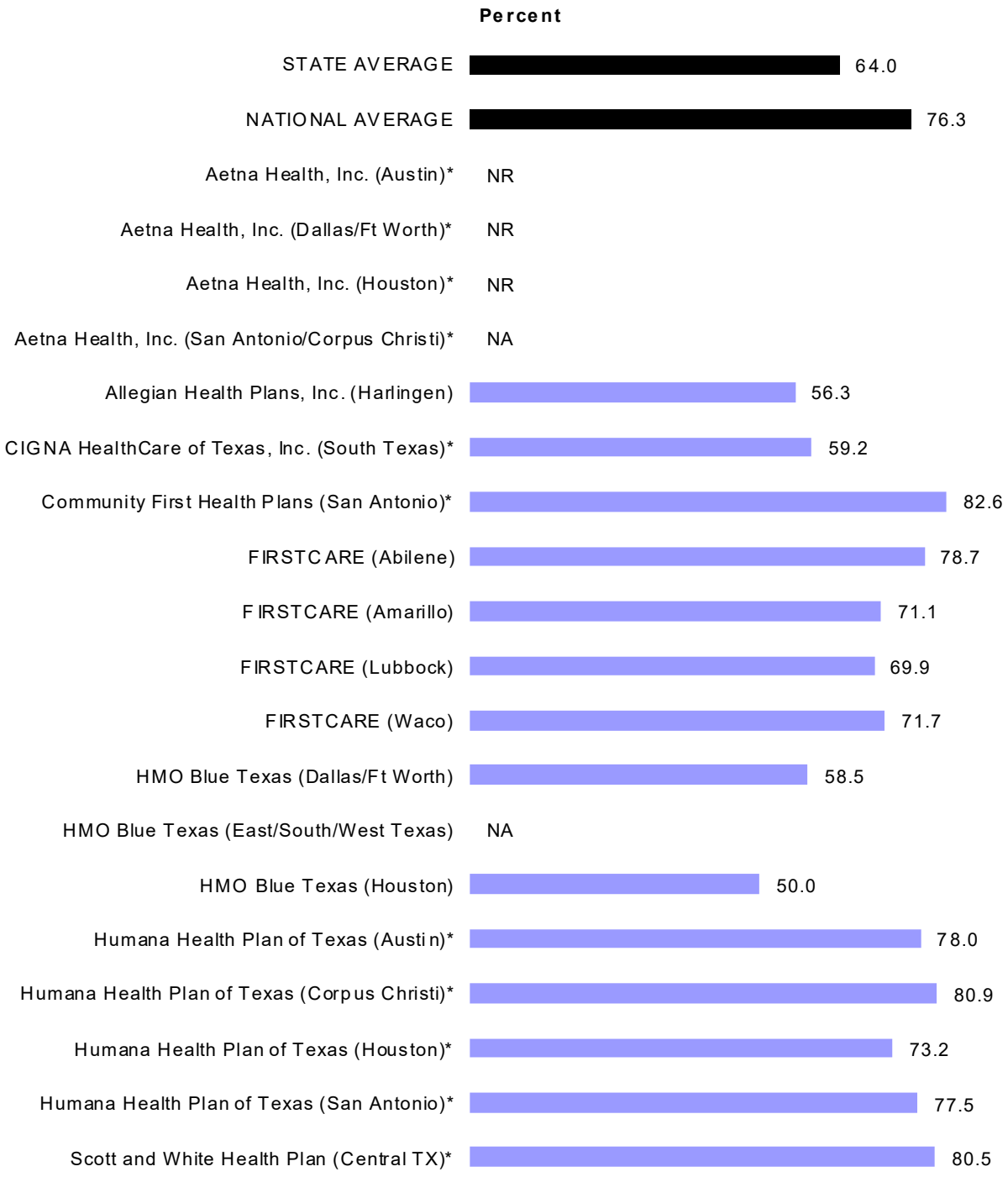
Childhood Immunization Status: Combination 3



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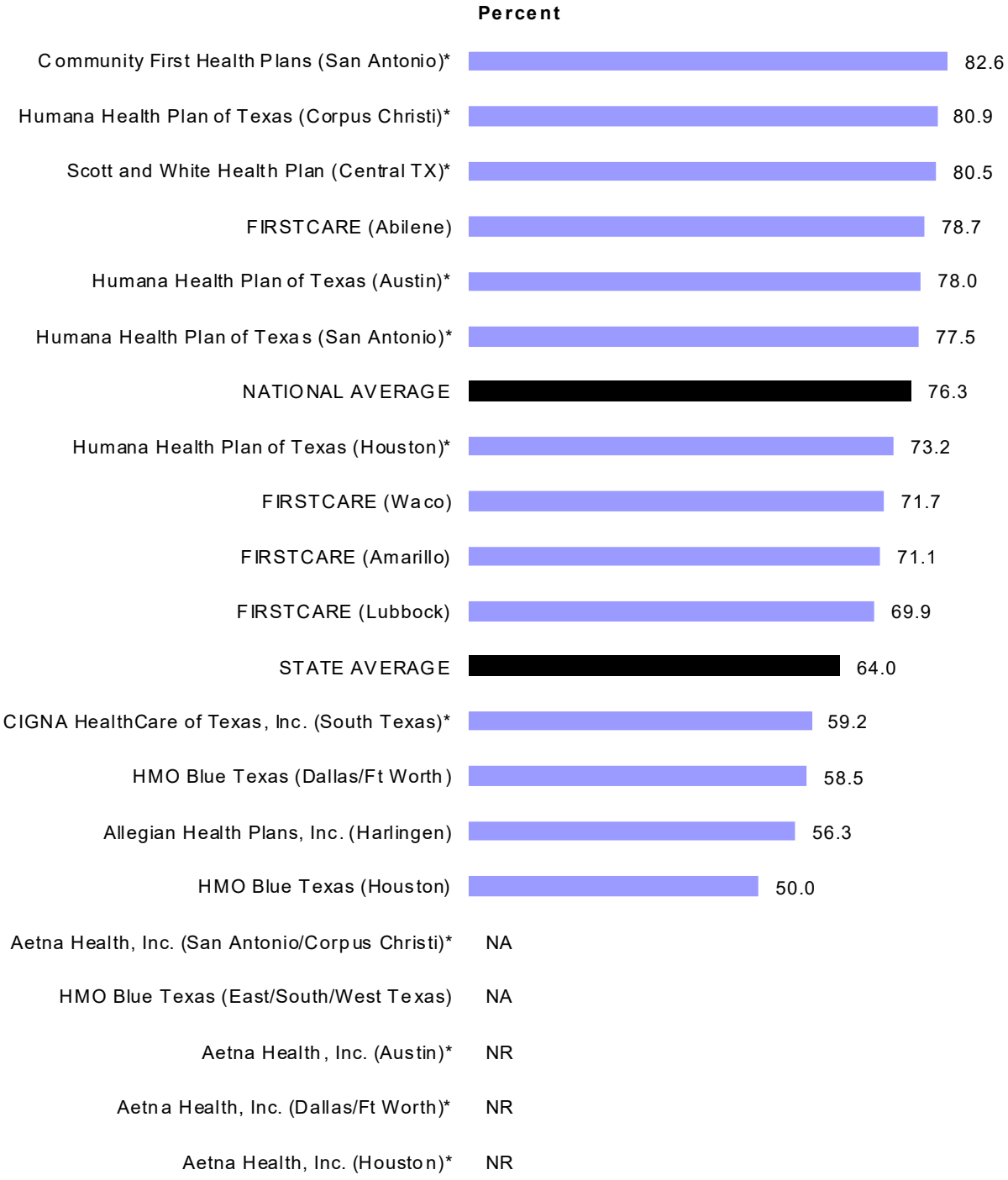
Childhood Immunization Status: Combination 3



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Childhood Immunization Status: Combination 4

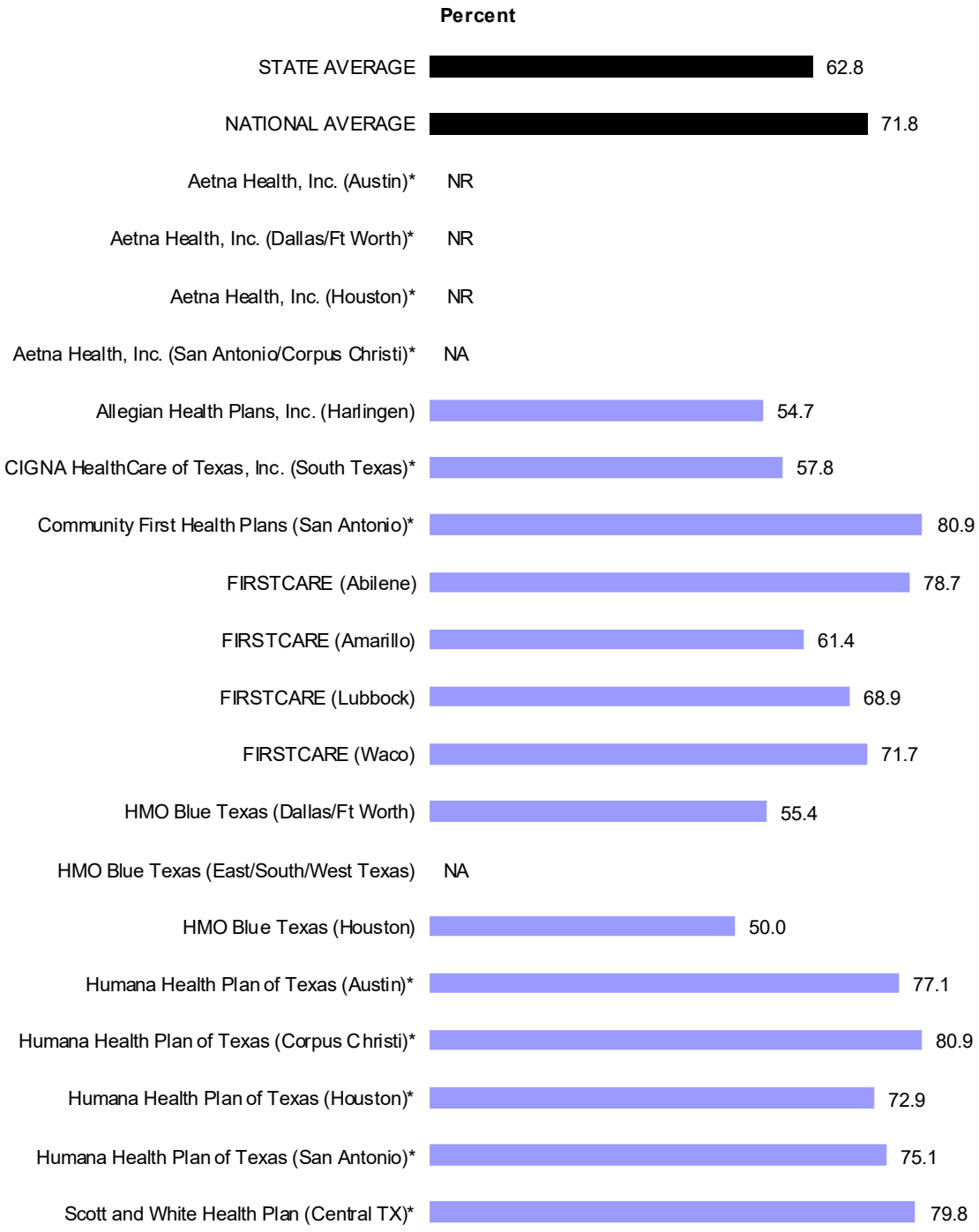
Definition: The percentage of children using the HMO who received all doses of the Combination 4 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Hepatitis A (HAV)—one dose

Childhood Immunization Status: Combination 4					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	20.5%	55.3%	64.5%	59.4%	62.8%
NCQA's Quality Compass®	34.6%	55.9%	69.7%	71.8%	71.8%

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

Childhood Immunization Status: Combination 4



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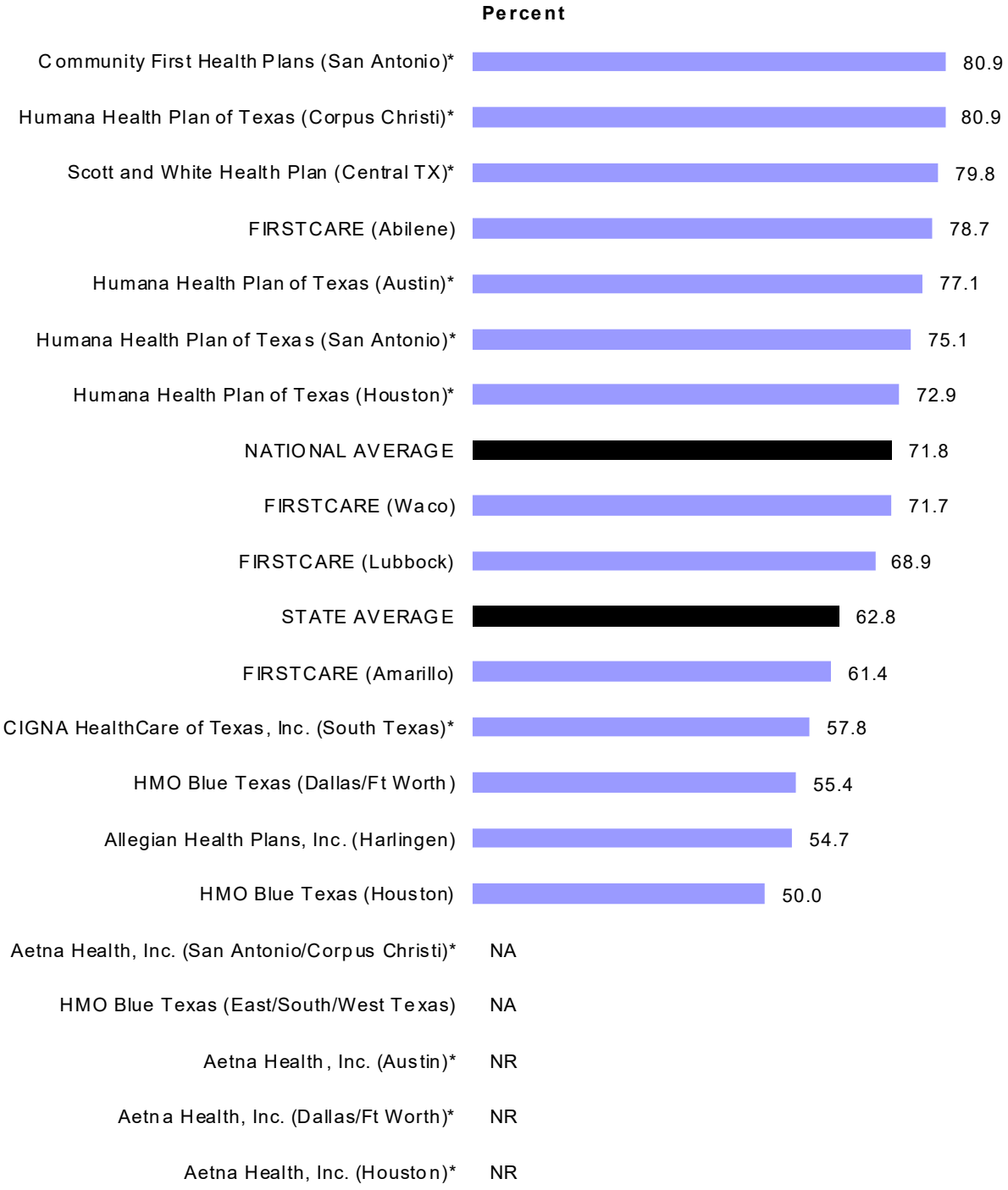
NA–The plan did not have a large enough sample to report a valid rate.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Childhood Immunization Status: Combination 4



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NA–The plan did not have a large enough sample to report a valid rate.
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Childhood Immunization Status: Combination 5

Definition: The percentage of children using the HMO who received all doses of the Combination 5 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Rotavirus—two or three doses

Childhood Immunization Status: Combination 5					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	37.1%	53.5%	60.9%	56.1%	58.8%
NCQA's Quality Compass®	63.6%	65.6%	68.5%	70.2%	69.5%

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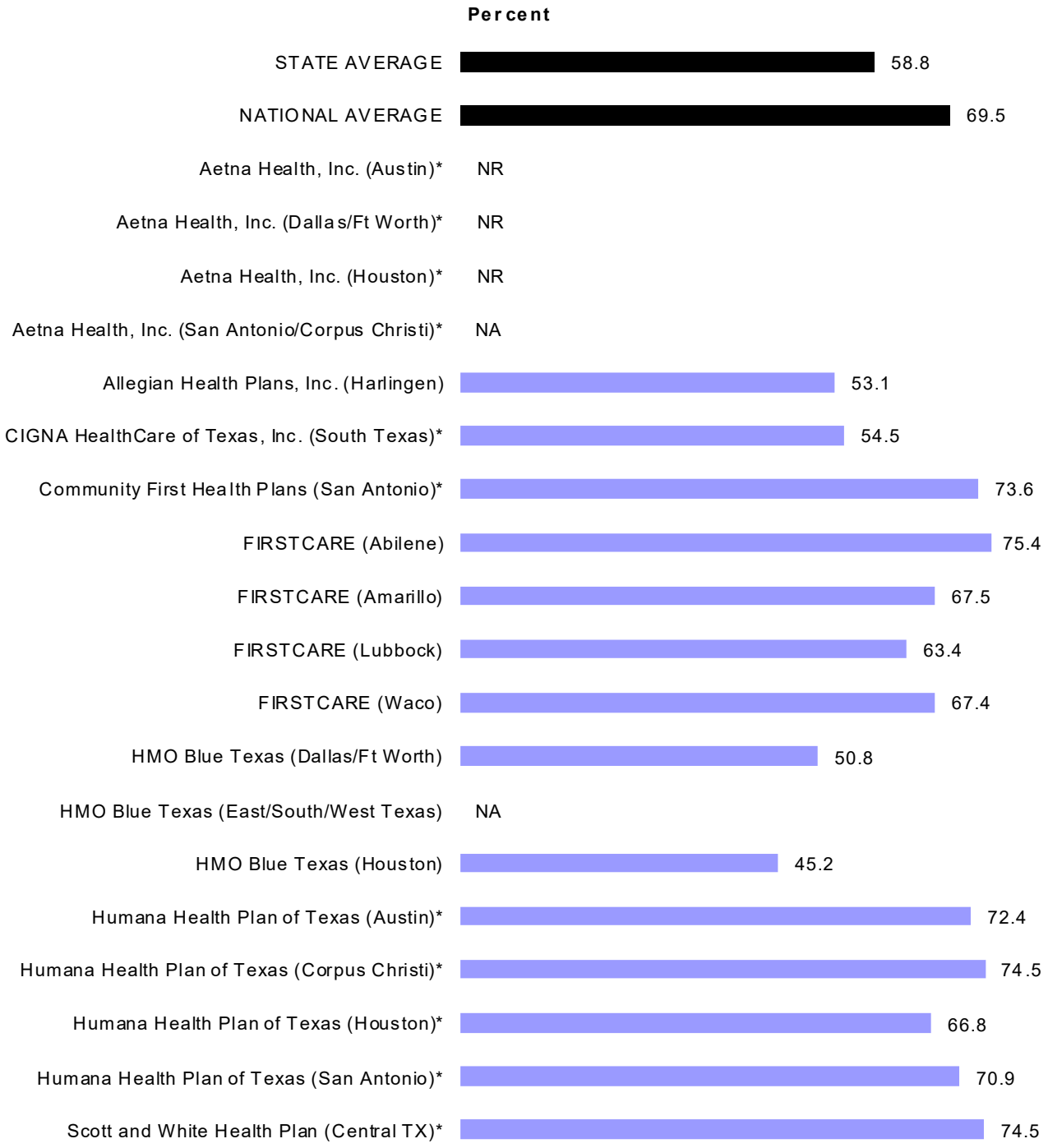
Childhood Immunization Status: Combination 5



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
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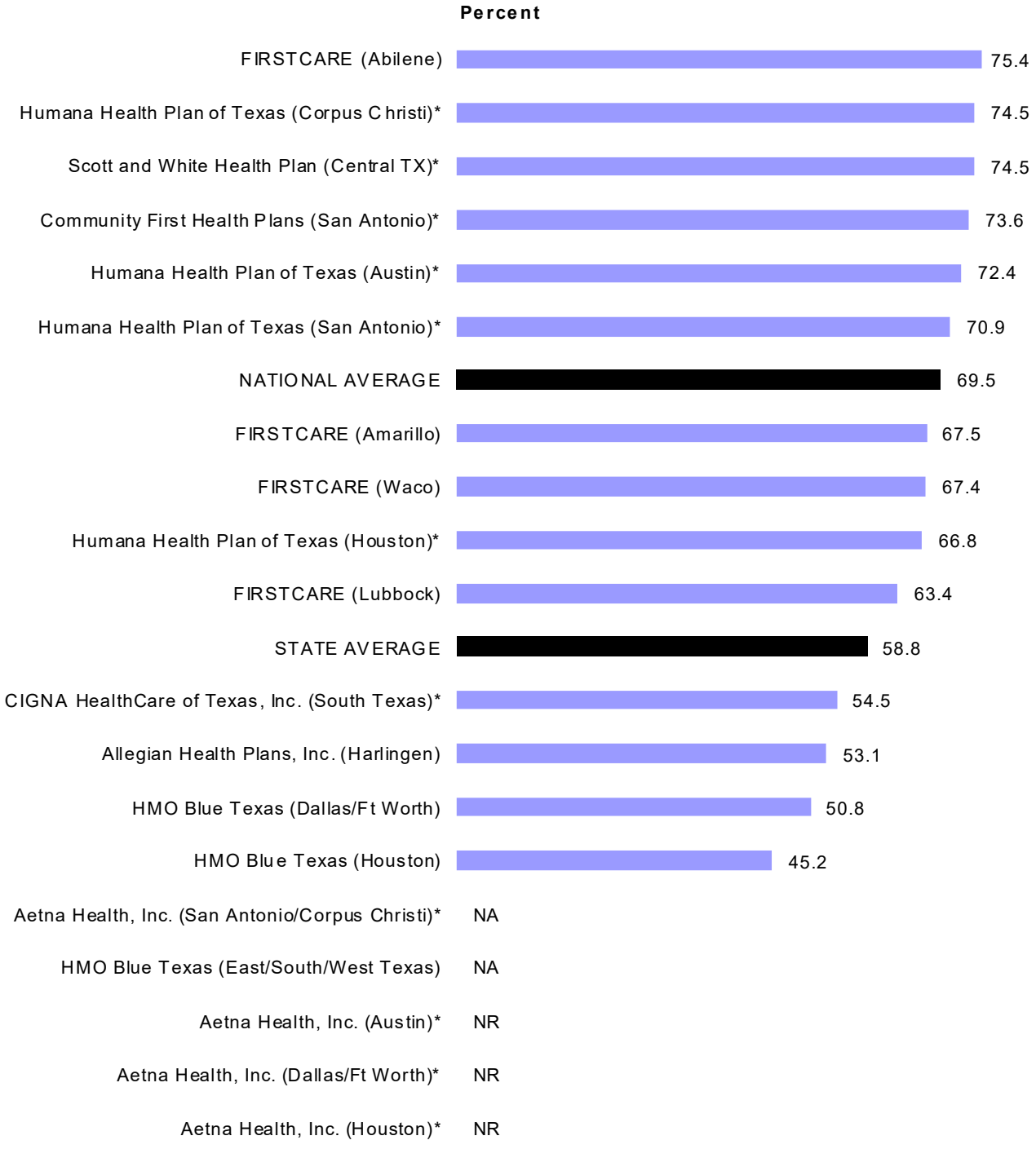
Childhood Immunization Status: Combination 5



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Childhood Immunization Status: Combination 6

Definition: The percentage of children using the HMO who received all doses of the Combination 6 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Influenza—two doses

Childhood Immunization Status: Combination 6					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	26.7%	42.9%	48.1%	45.0%	45.1%
NCQA's Quality Compass®	52.1%	54.8%	56.9%	58.6%	56.6%

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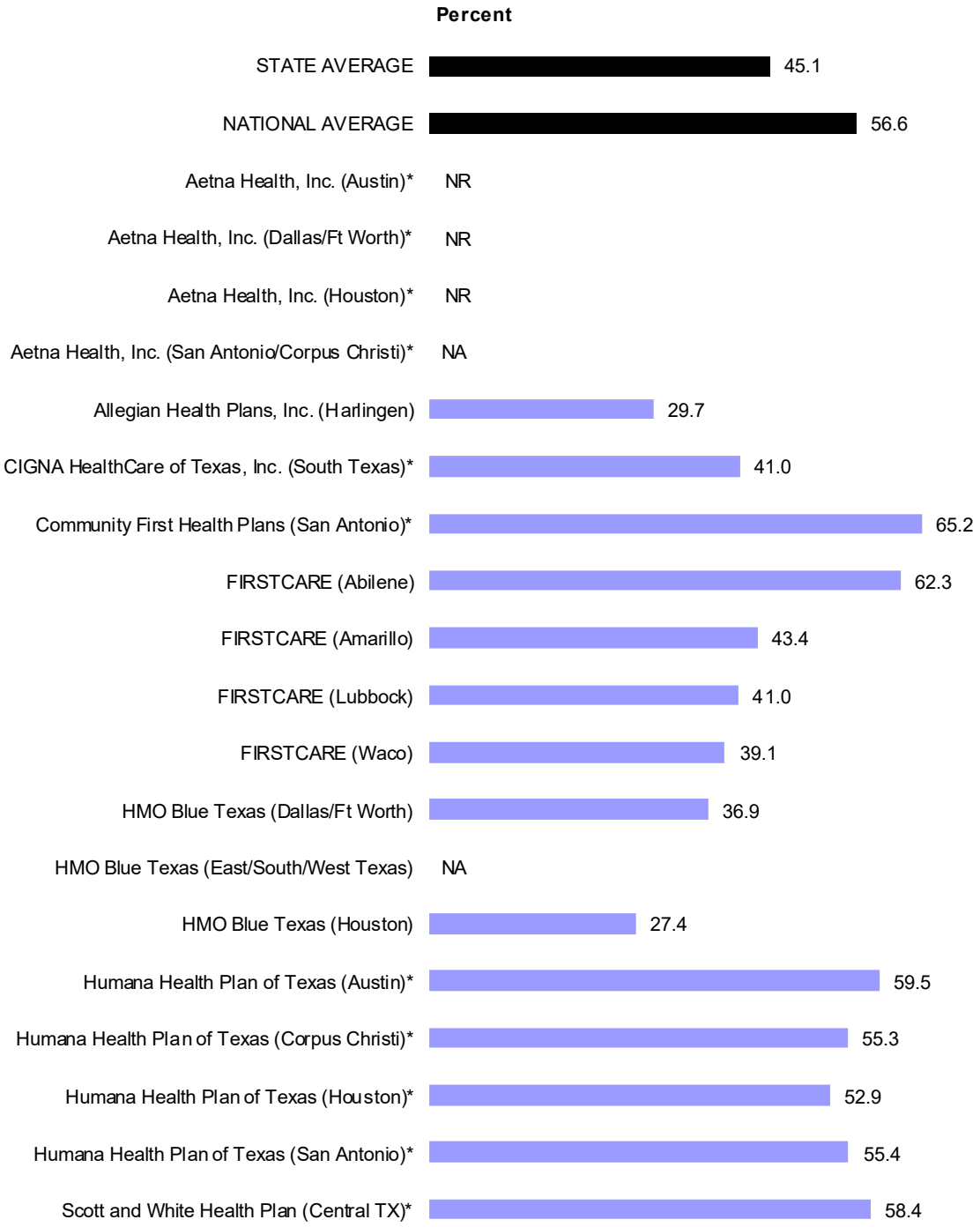
Childhood Immunization Status: Combination 6



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
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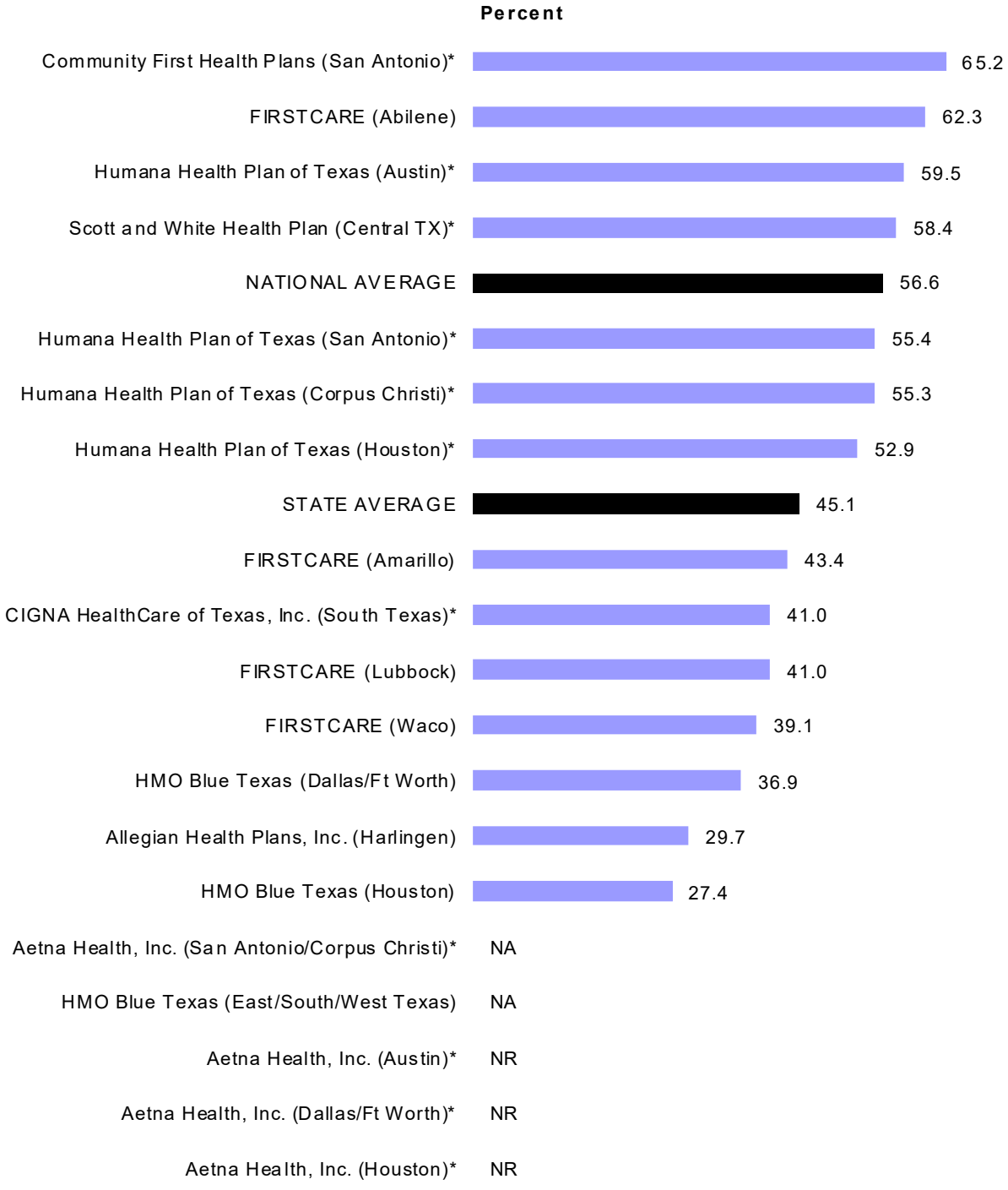
Childhood Immunization Status: Combination 6



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NA–The plan did not have a large enough sample to report a valid rate.
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Childhood Immunization Status: Combination 7

Definition: The percentage of children using the HMO who received all doses of the Combination 7 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Hepatitis A (HAV)—one dose
- Rotavirus—two or three doses

Childhood Immunization Status: Combination 7					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	17.9%	49.3%	59.0%	54.4%	58.0%
NCQA's Quality Compass®	30.8%	49.8%	63.7%	65.8%	66.2%

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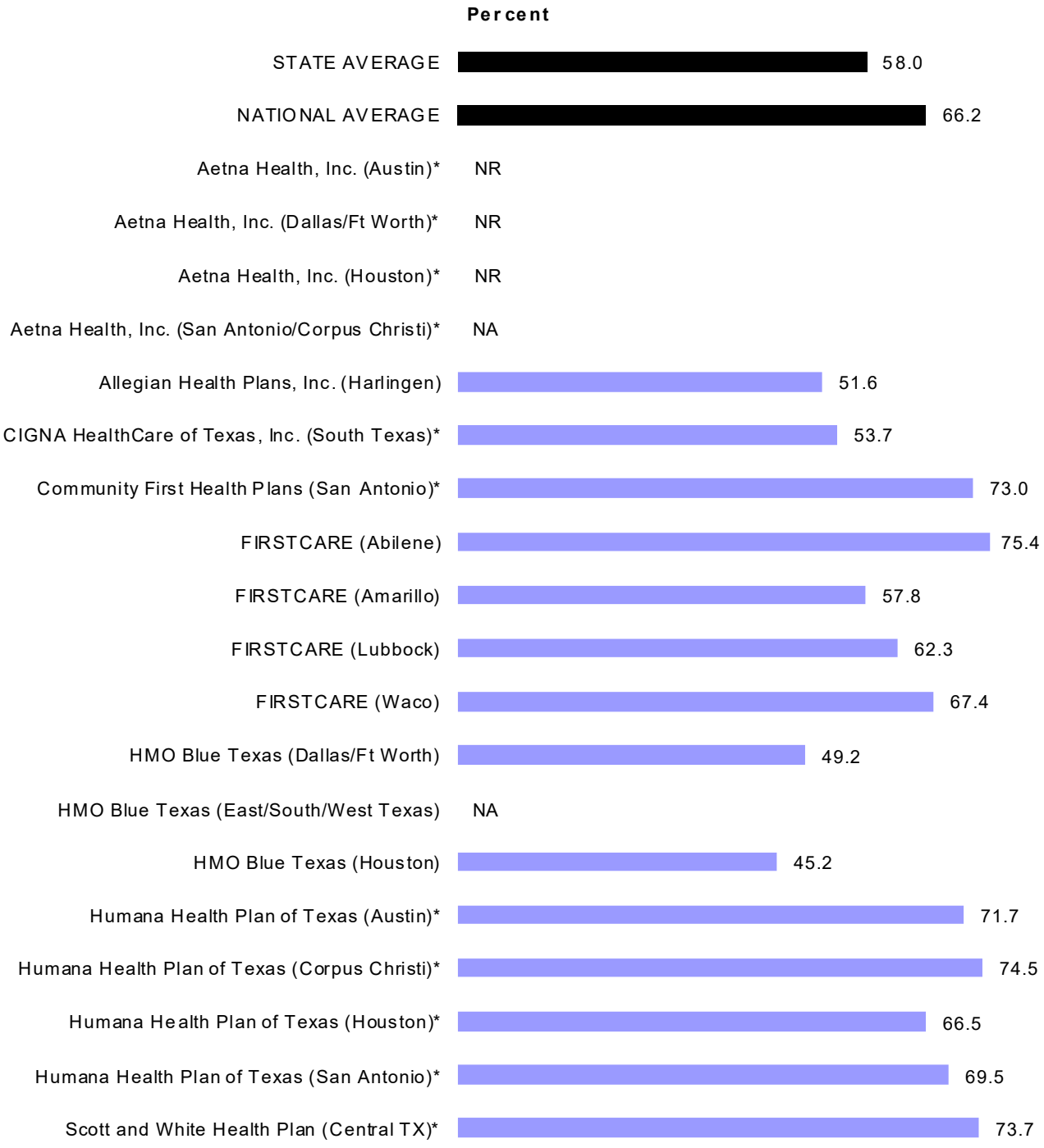
Childhood Immunization Status: Combination 7



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
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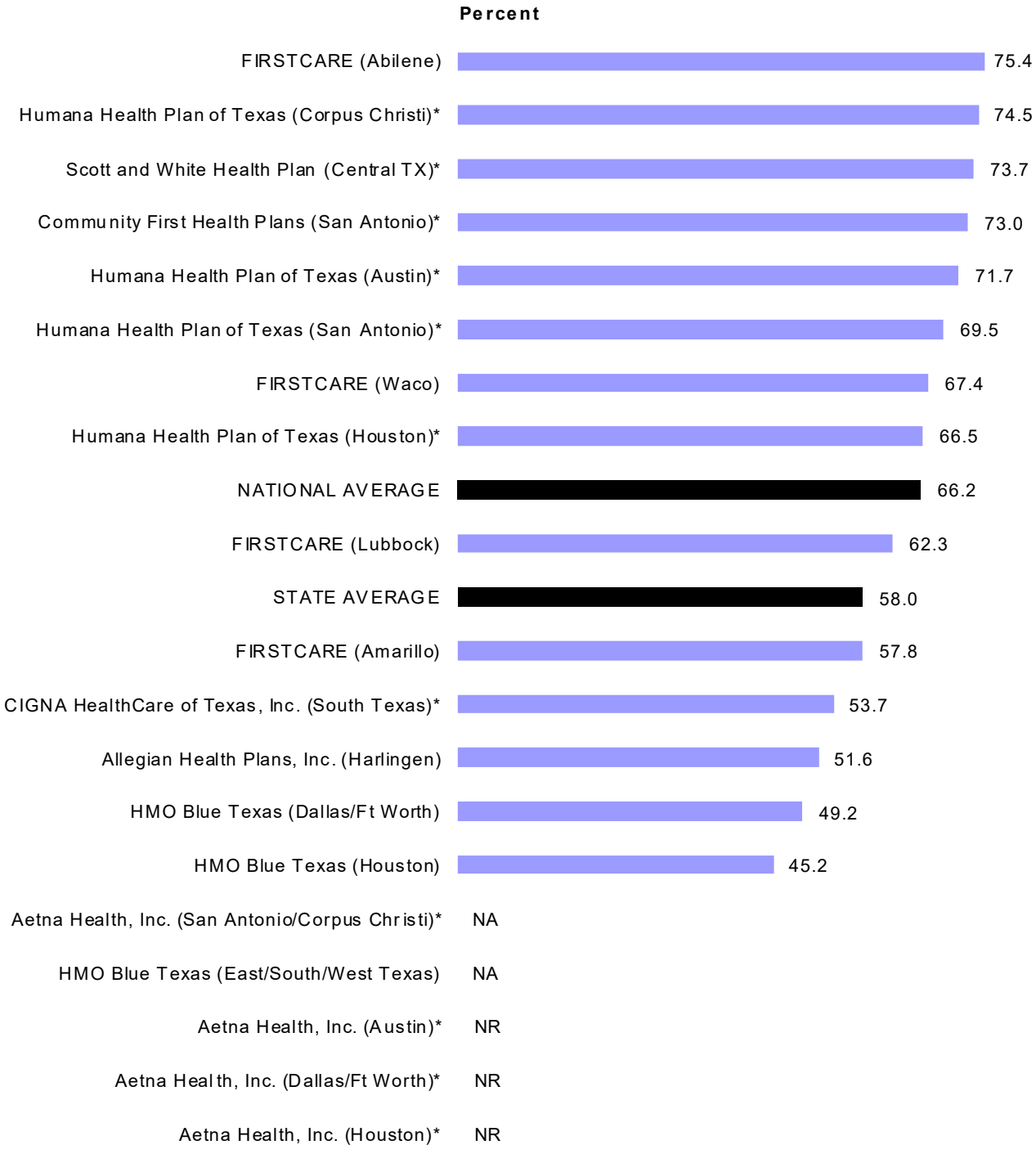
Childhood Immunization Status: Combination 7



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NA–The plan did not have a large enough sample to report a valid rate.
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Childhood Immunization Status: Combination 8

Definition: The percentage of children using the HMO who received all doses of the Combination 8 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Hepatitis A (HAV)—one dose
- Influenza—two doses

Childhood Immunization Status: Combination 8					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	14.1%	39.9%	46.7%	43.8%	44.3%
NCQA's Quality Compass®	25.3%	41.5%	52.9%	55.1%	54.1%

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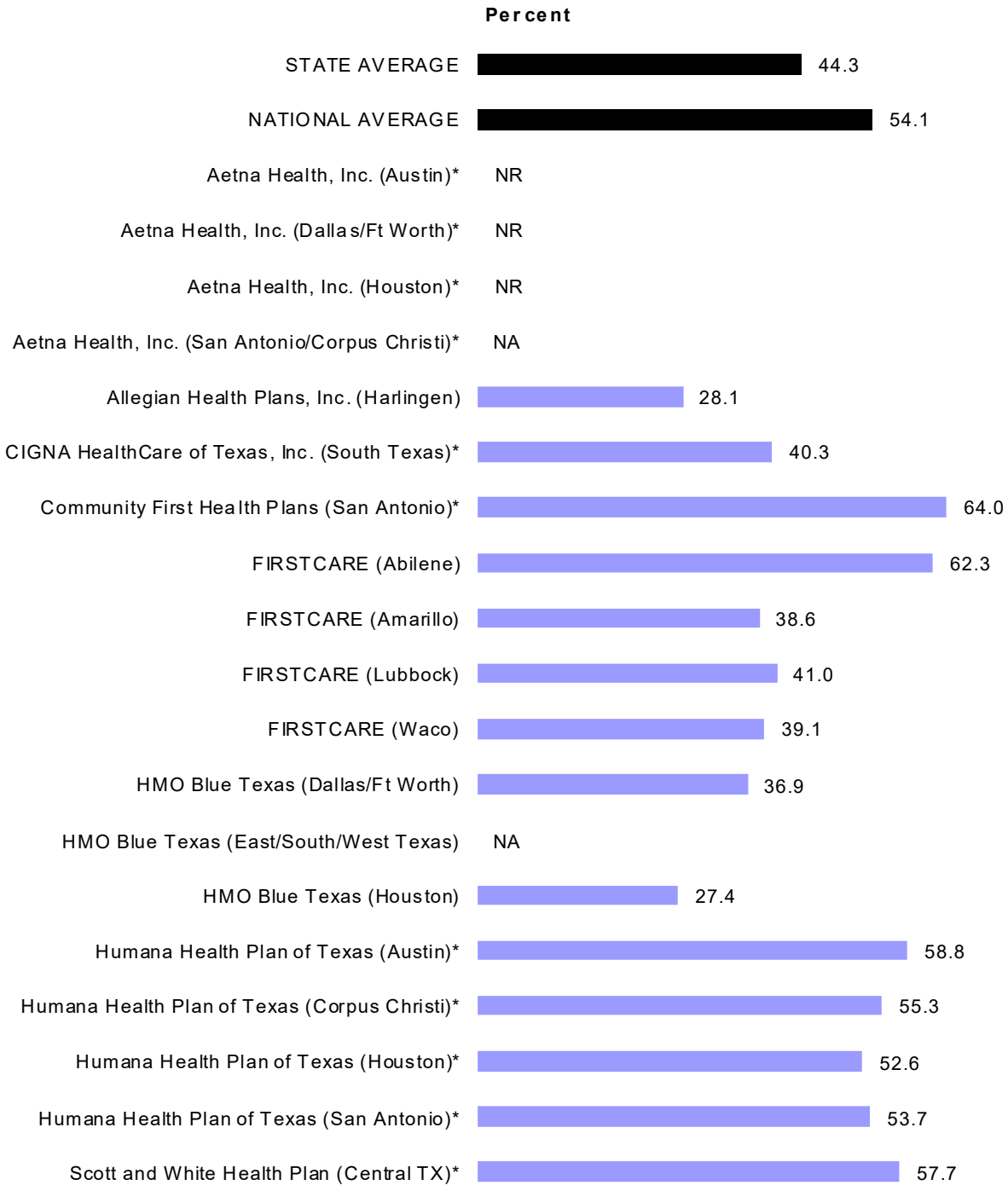
Childhood Immunization Status: Combination 8



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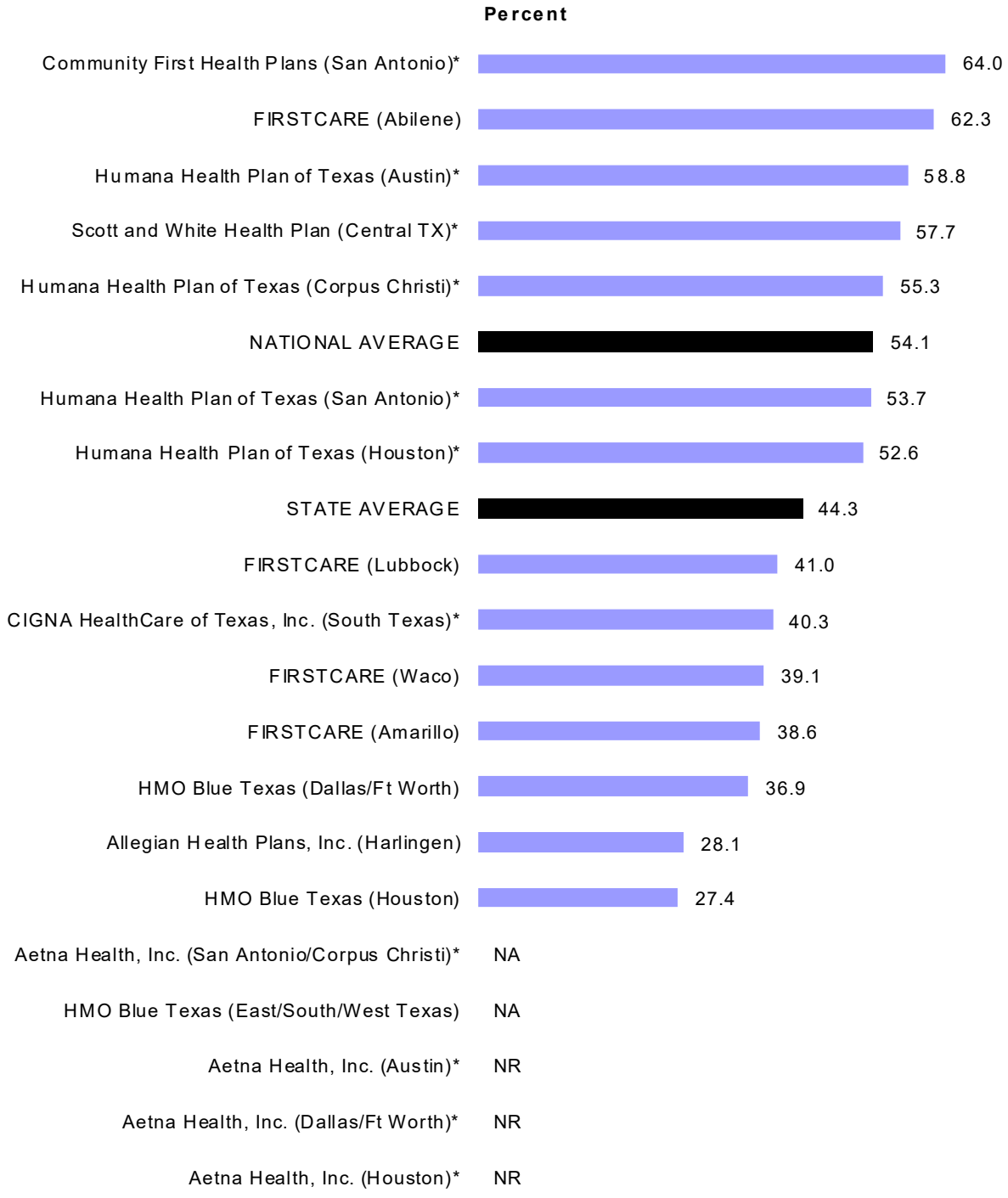
Childhood Immunization Status: Combination 8



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Childhood Immunization Status: Combination 9

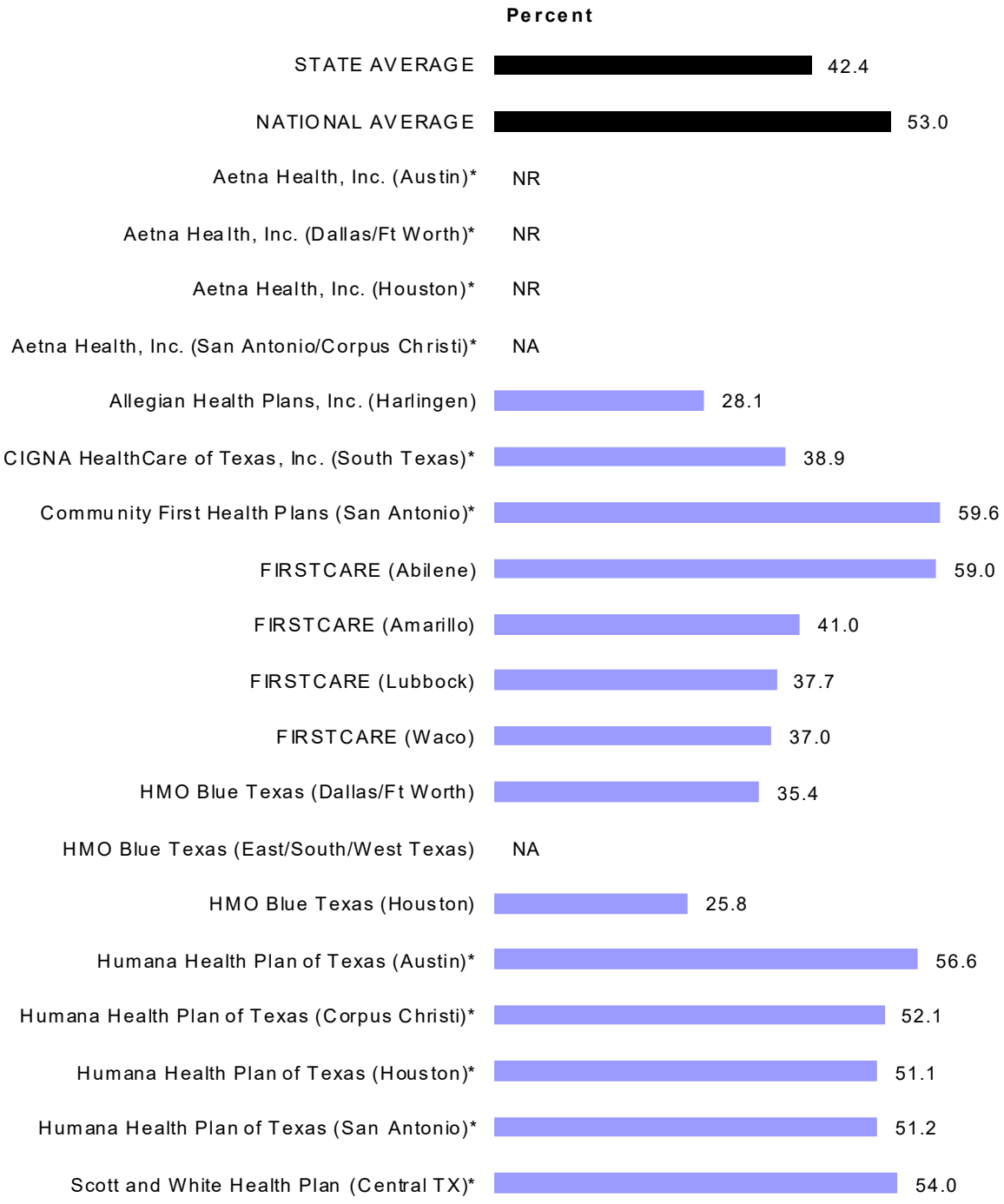
Definition: The percentage of children using the HMO who received all doses of the Combination 9 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Influenza—two doses
- Rotavirus—two or three doses

Childhood Immunization Status: Combination 9					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	25.3%	38.8%	45.0%	42.3%	42.4%
NCQA's Quality Compass®	45.7%	48.9%	52.3%	54.3%	53.0%

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

Childhood Immunization Status: Combination 9



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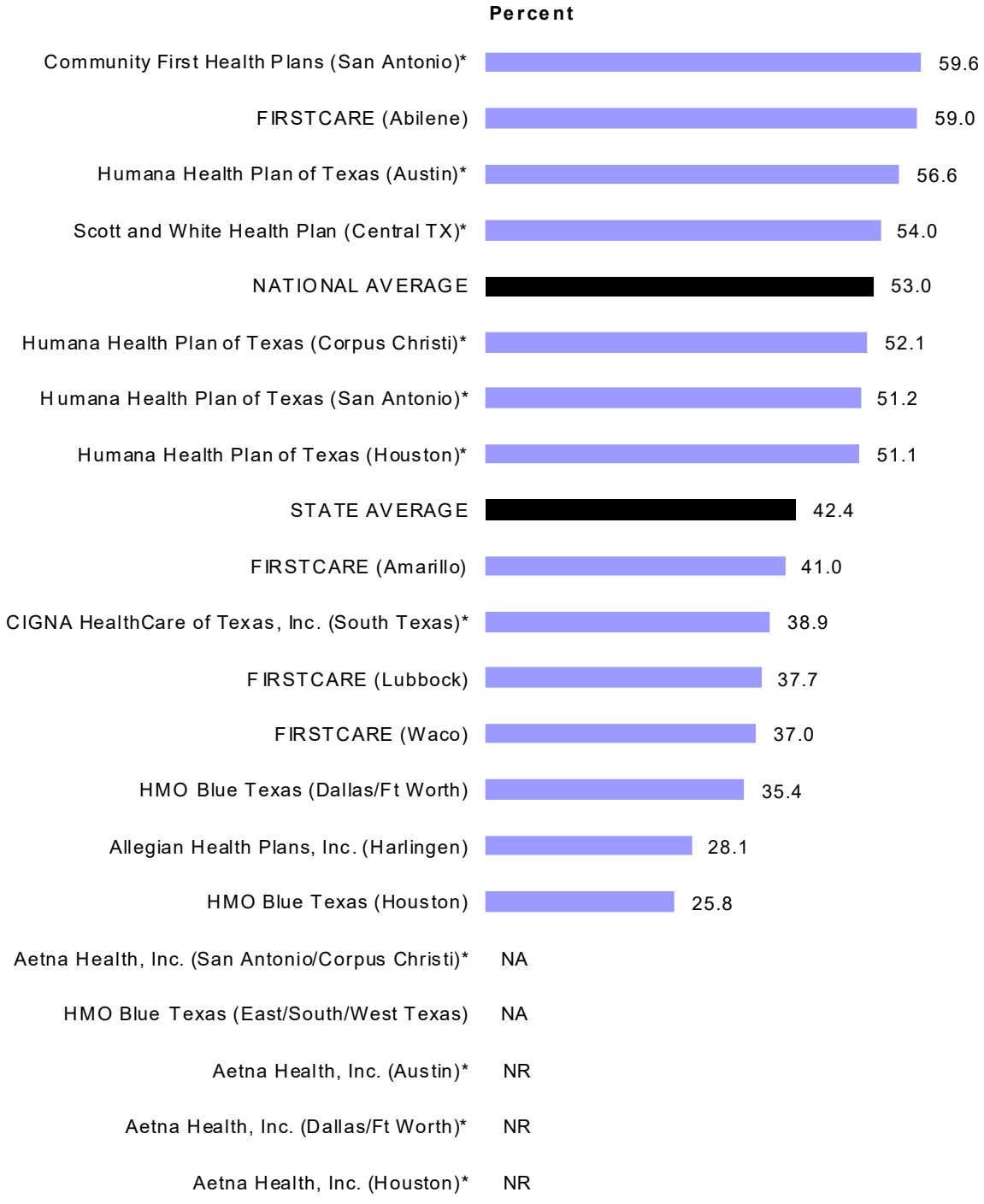
Childhood Immunization Status: Combination 9



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Childhood Immunization Status: Combination 10

Definition: The percentage of children using the HMO who received all doses of the Combination 10 vaccinations by two years of age.

- Diphtheria, Tetanus, acellular Pertussis (DTaP)—four doses
- Polio (IPV)—three doses
- Hepatitis B (HBV)—three doses
- Measles, Mumps, Rubella (MMR)—one dose
- *Haemophilus Influenzae* type B (HiB)—three doses
- Chickenpox (VZV)—one dose
- Pneumococcal Conjugate—four doses
- Hepatitis A (HAV)—one dose
- Rotavirus—two or three doses
- Influenza—two doses

Childhood Immunization Status: Combination 10					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	12.9%	36.4%	43.8%	41.2%	42.0%
NCQA's Quality Compass®	22.9%	37.9%	49.3%	51.5%	51.0%

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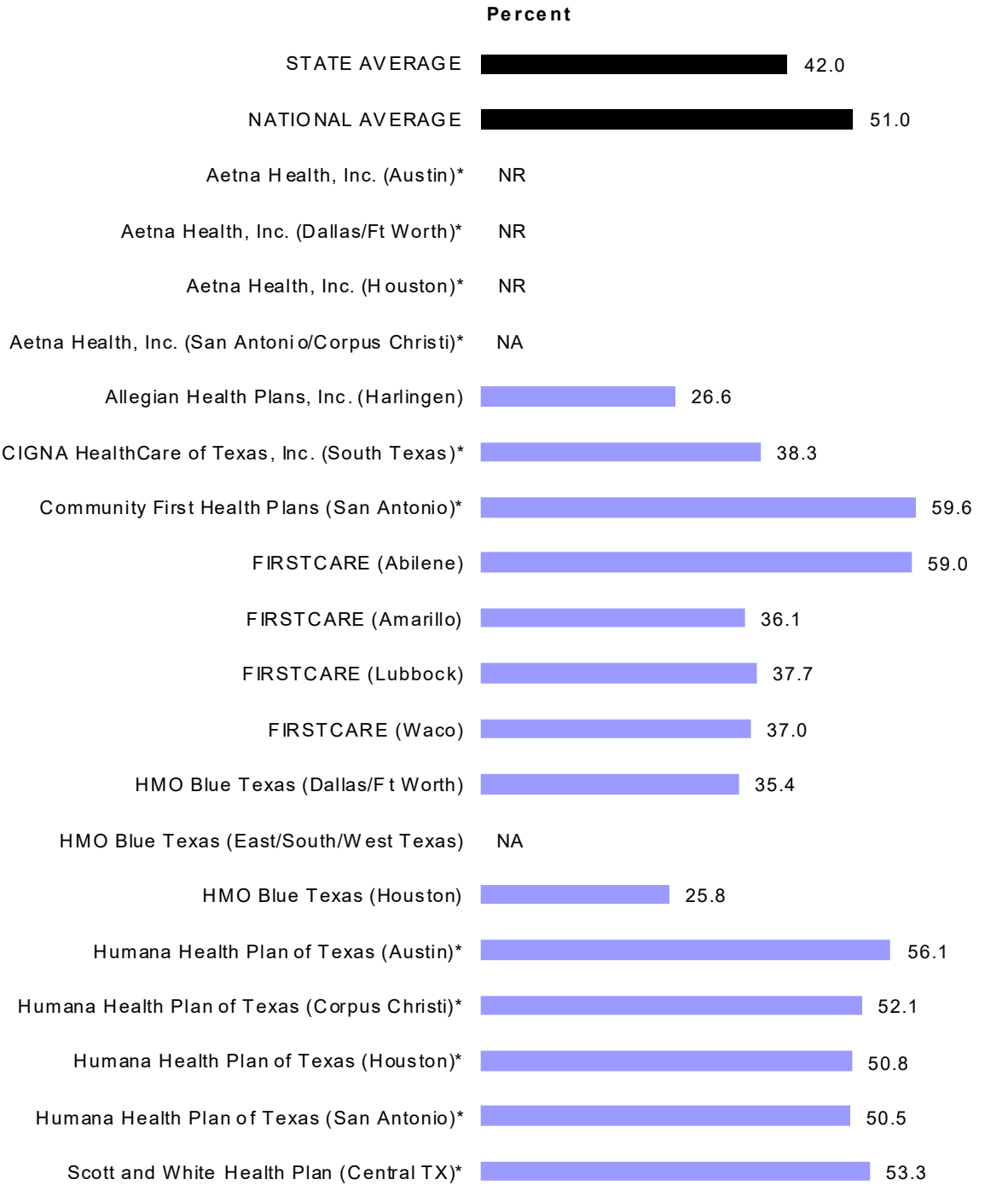
Childhood Immunization Status: Combination 10



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
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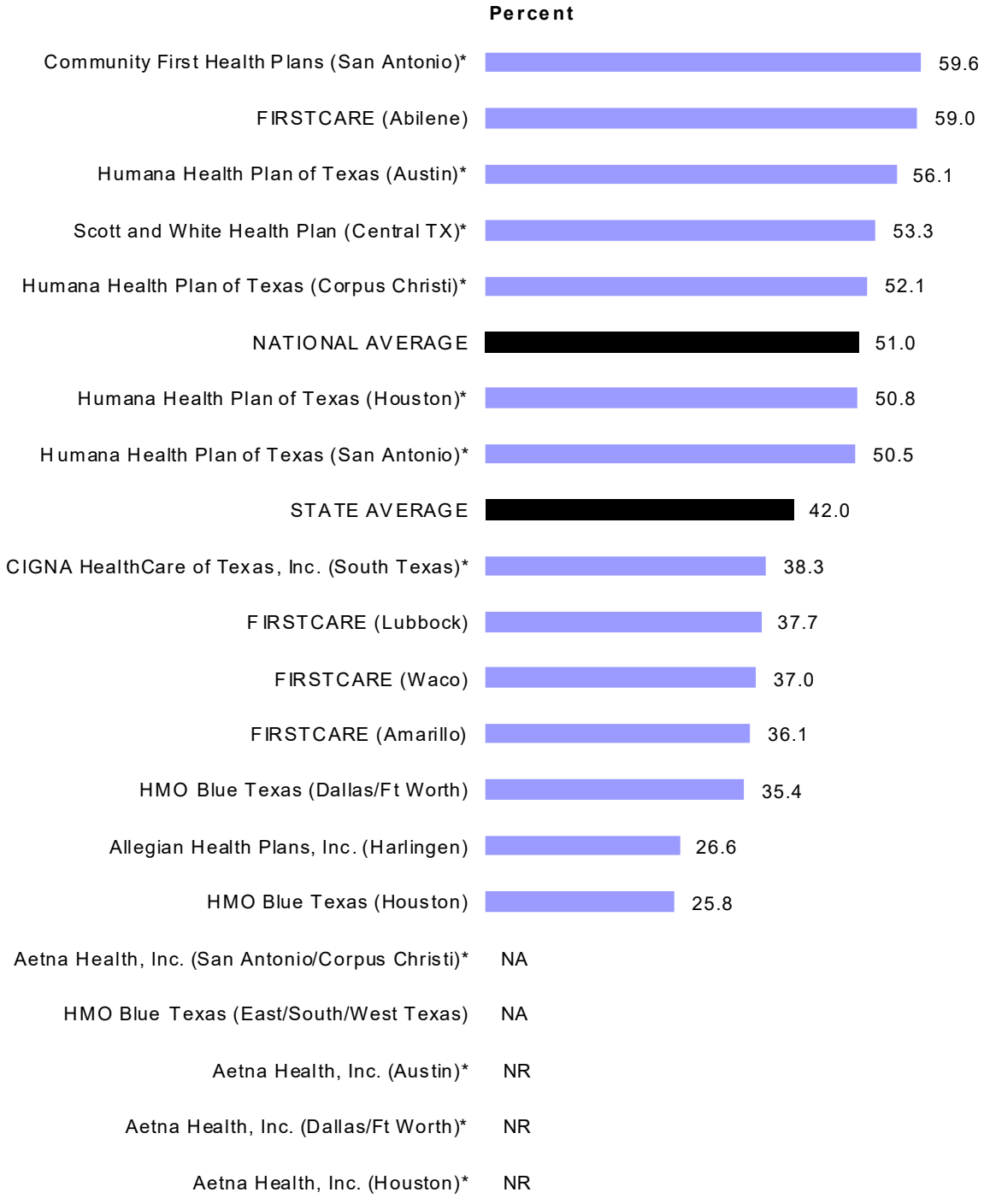
Childhood Immunization Status: Combination 10



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NA–The plan did not have a large enough sample to report a valid rate.
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Breast Cancer Screening

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

The American Cancer Society estimates that an estimated 231,840 new cases of invasive breast cancer will be diagnosed among US women in 2015, as well as an estimated 60,290 additional cases of in situ breast cancer. In addition, approximately 40,290 US women died from breast cancer. Only lung cancer accounts for more cancer deaths in women.

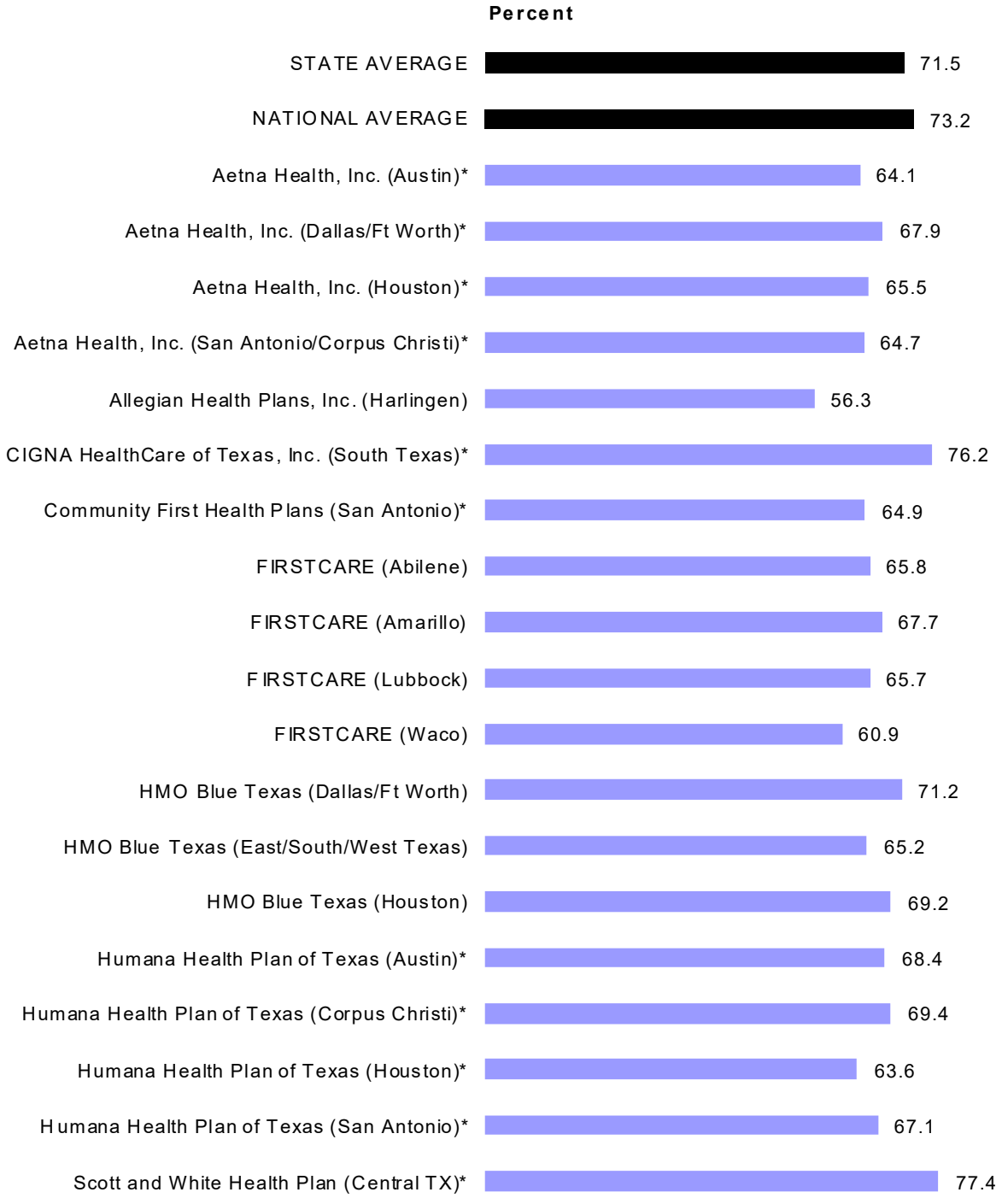
A mammogram—an x-ray of the tissues inside the breast—can detect breast cancer before a woman has signs or symptoms of the disease. Early detection of breast cancer often leads to a greater range of treatment options, including less-invasive options. Mammography does have limitations. A mammogram will 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.[1]

Breast Cancer Screening					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	66.6%	65.9%	71.7%	71.1%	71.5%
NCQA's Quality Compass®	70.5%	70.3%	74.3%	73.8%	73.2%

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

[1] American Cancer Society. *Breast Cancer Facts and Figures 2015-2016*. Atlanta, GA: American Cancer Society, 2015.
[2] Ibid.

Breast Cancer Screening Rate



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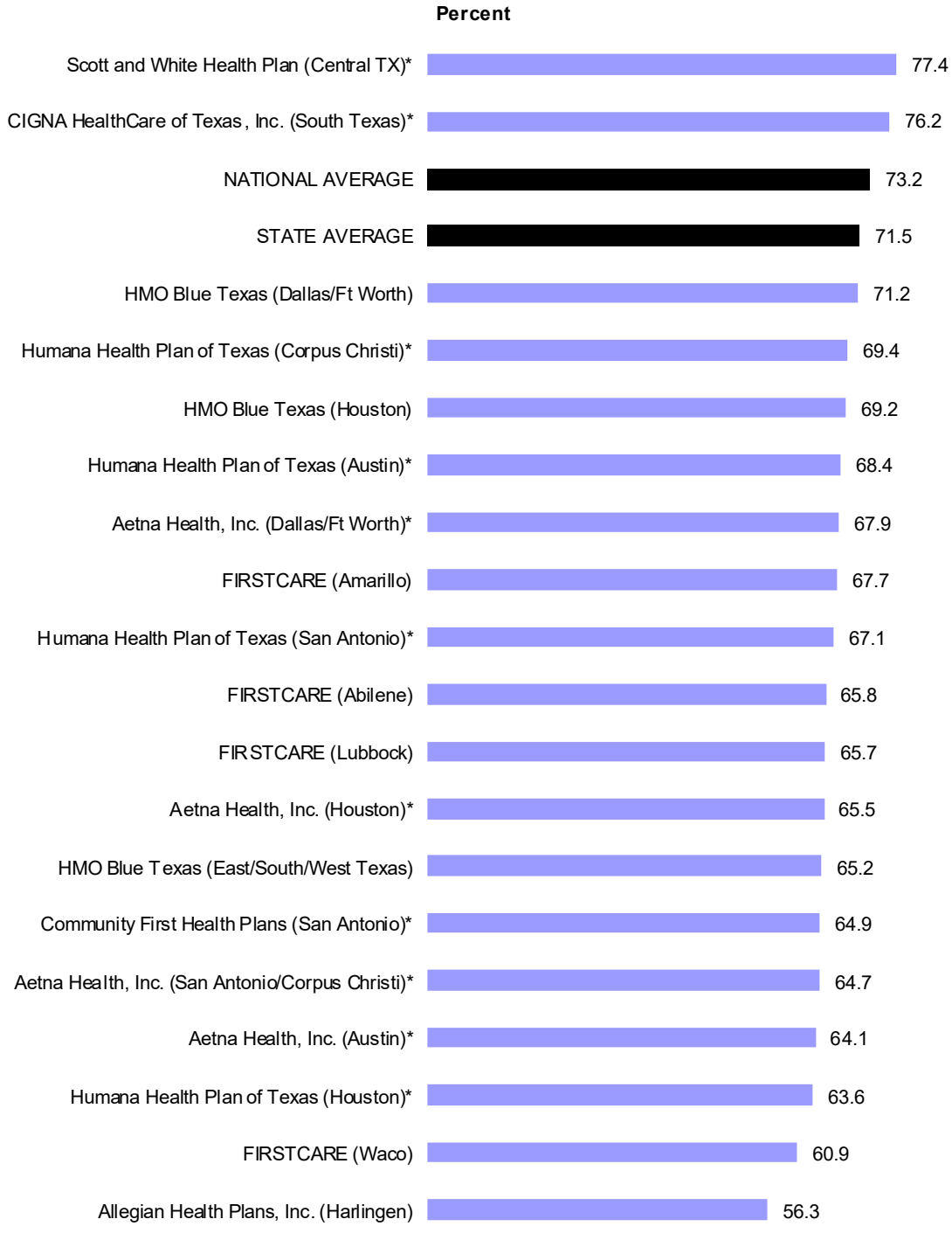
Breast Cancer Screening Rate



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Cervical Cancer Screening

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

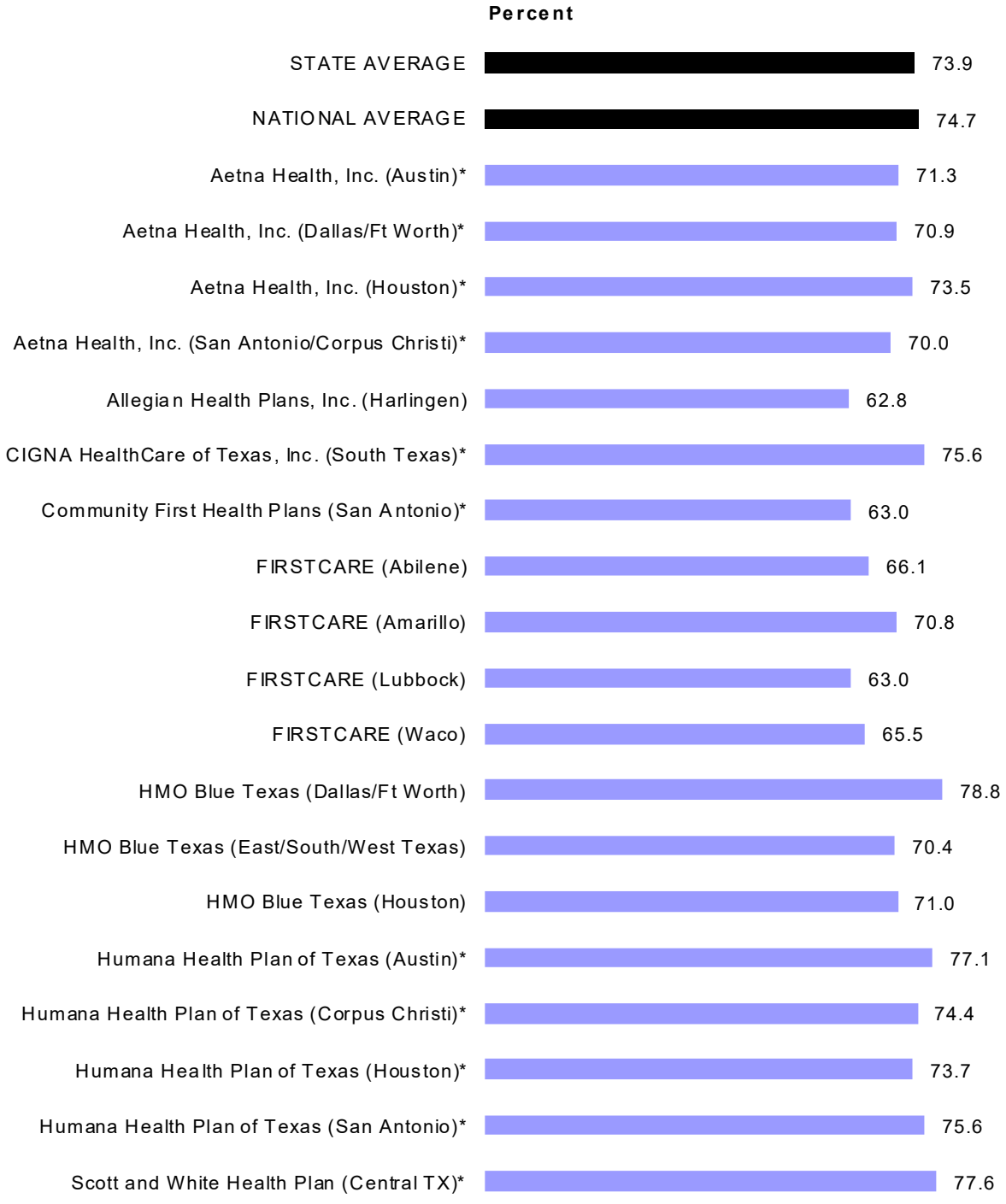
Cervical cancer often has no recognizable symptoms until it reaches an advanced stage. Regular Pap tests can detect cervical cancer before symptoms are present. A Pap test uses cells collected from the cervix to detect cancerous and precancerous cells. The test can also detect noncancerous conditions such as infection and inflammation.[1] Early detection and treatment of cancer through Pap screening has reduced the rate of deaths from cervical cancer by fifty percent over the last thirty years.[2] The American College of Obstetricians and Gynecologists (ACOG)[3] and the American Cancer Society (ACS)[4] recommend Pap testing every three years for women between 21 and 65.

Cervical Cancer Screening					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	73.5%	73.8%	**	73.4%	73.9%
NCQA's Quality Compass®	76.5%	75.5%	**	76.3%	74.7%

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

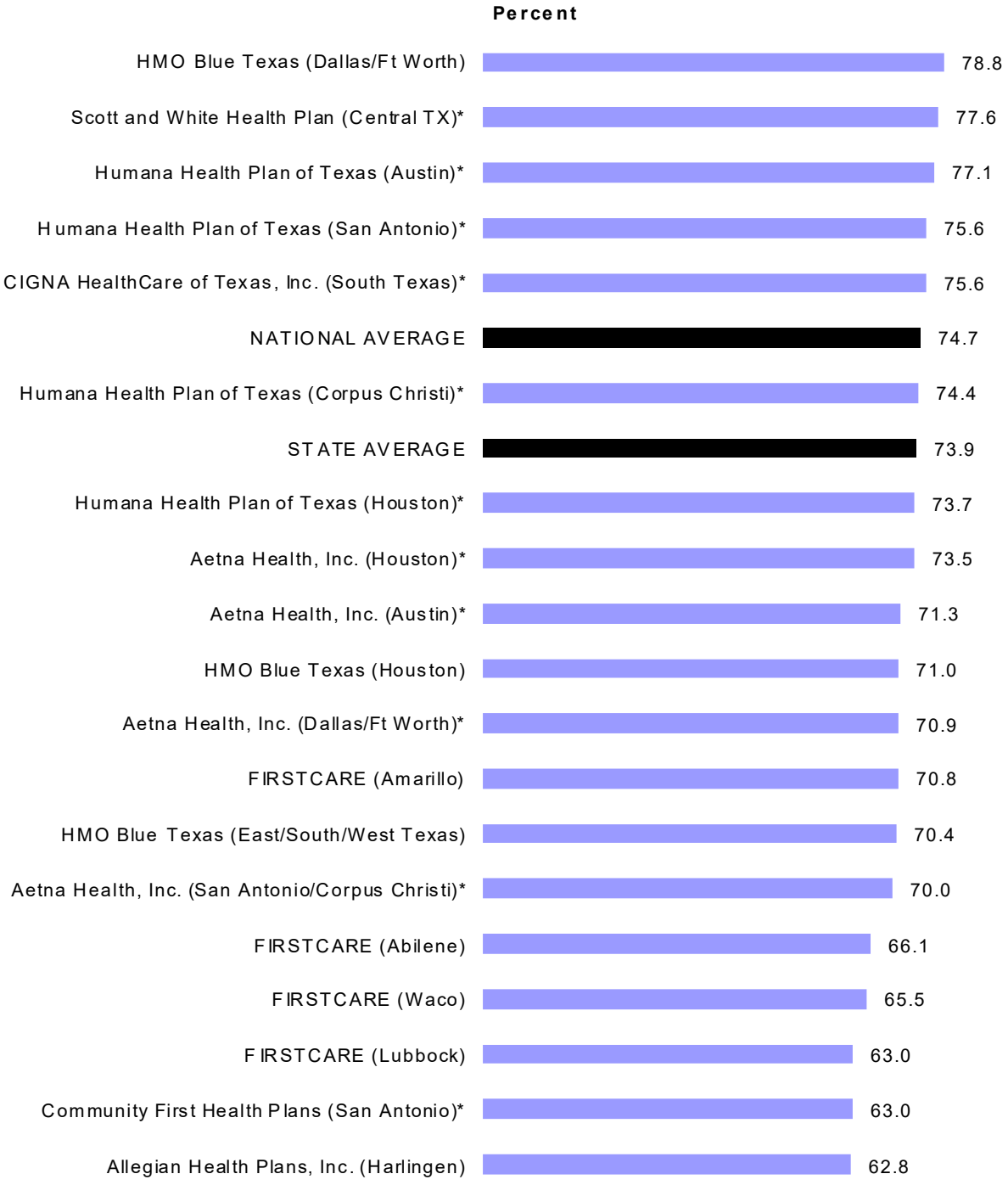
[1] National Cancer Institute. *Pap and HPV Testing Fact Sheet.* Washington, DC: National Institutes of Health, 2016.
[2] National Cancer Institute. *A Snapshot of Cervical Cancer.* Washington, DC: National Institutes of Health, 2014.
[3] American College of Obstetricians and Gynecologists. *Cervical Cancer Screening*. Washington, DC: American College of Obstetricians and Gynecologists, 2016.
[4] 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.

Cervical Cancer Screening Rate



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Cervical Cancer Screening Rate



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Note—Lower rates indicate better performance for this measure.

Non-Recommended Cervical Cancer Screening in Adolescent Females

Definition: The percentage of young women 16–20 years of age who were unnecessarily screened for cervical cancer.

Many organizations, including the American College of Obstetricians and Gynecologists (ACOG)[1] and the American Cancer Society (ACS)[2] recommend against cervical cancer screening for women under 21 years of age. However, many clinicians still over-screen for cervical cancer in this population. While screening is highly effective for women in the 21–65 year old age group, the U.S. Preventive Services Task Force (USPSTF) found evidence that screening women in the younger age group leads to more harm than benefit.[3] For example, cervical cancer is rare in women under 21 and most abnormal test results in women under 21 are likely to be transient and to resolve on their own. In addition, treatment may have an adverse effect on future child-bearing.

Non-Recommended Cervical Cancer Screening in Adolescent Females		
	2015	**2016**
Texas Average	4.0%	2.7%
NCQA's Quality Compass®	3.4%	2.3%

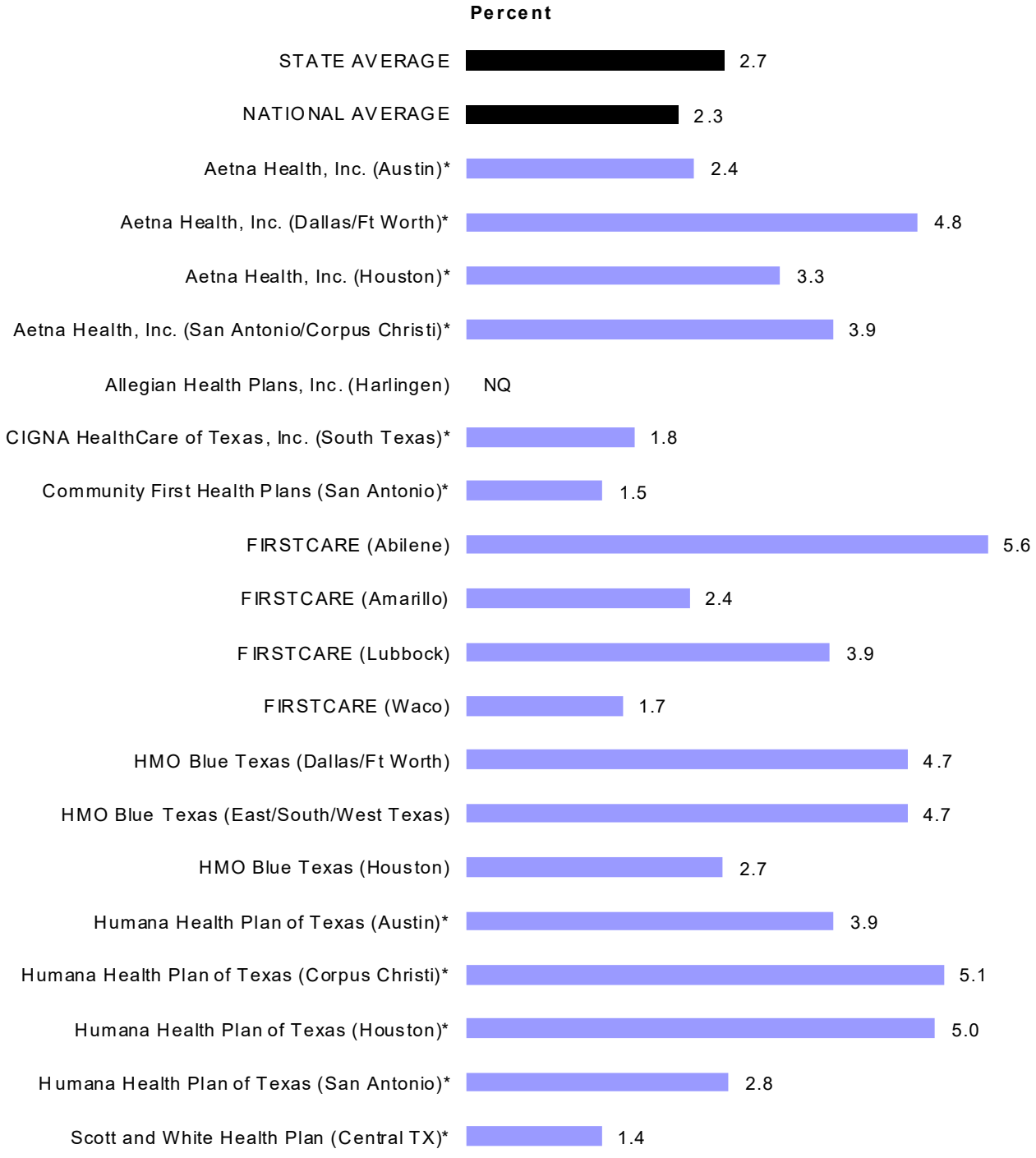
This measure was added to the Texas Subset beginning with HEDIS® 2015.

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

[1] American College of Obstetricians and Gynecologists. Cervical Cancer Screening. Washington, DC: American College of Obstetricians and Gynecologists, 2016.
[2] 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.
[3] Moyer, Virginia A., U.S. Preventive Services Task Force. "Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation statement." *Annals of Internal Medicine.* 156: 880-891 (2012).

Note—Lower rates indicate better performance for this measure.

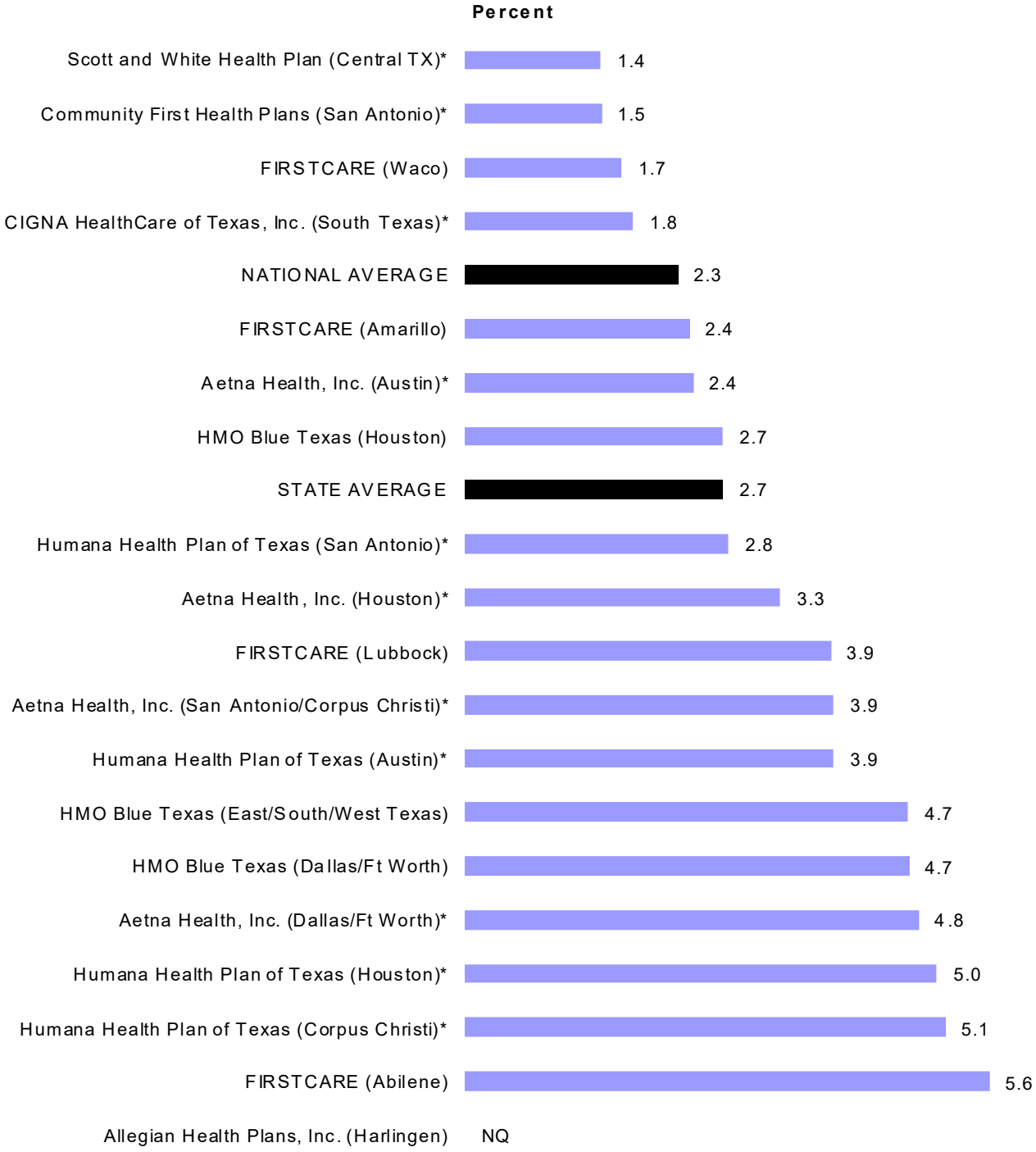
Non-Recommended Cervical Cancer Screening Rate



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NQ– The plan was not required to report the measure.

Note—Lower rates indicate better performance for this measure.

Non-Recommended Cervical Cancer Screening Rate



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NQ– The plan was not required to report the measure.

Colorectal Cancer Screening

Definition: The percentage of adult members 50–75 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 United States. CRC typically develops from a noncancerous polyp and grows slowly over a period of ten to fifteen years. Systematic screening can identify polyps before cancer develops or detect cancer in its early stages when treatment is most effective and least invasive.[1]

The incidence of CRC increases with age. Approximately ninety percent of new cases occur in adults over the age of fifty.[2] This measure reports the percentage of adults 50–75 years of age who have received an appropriate screening for CRC. "Appropriate screening" is defined as one of the following:

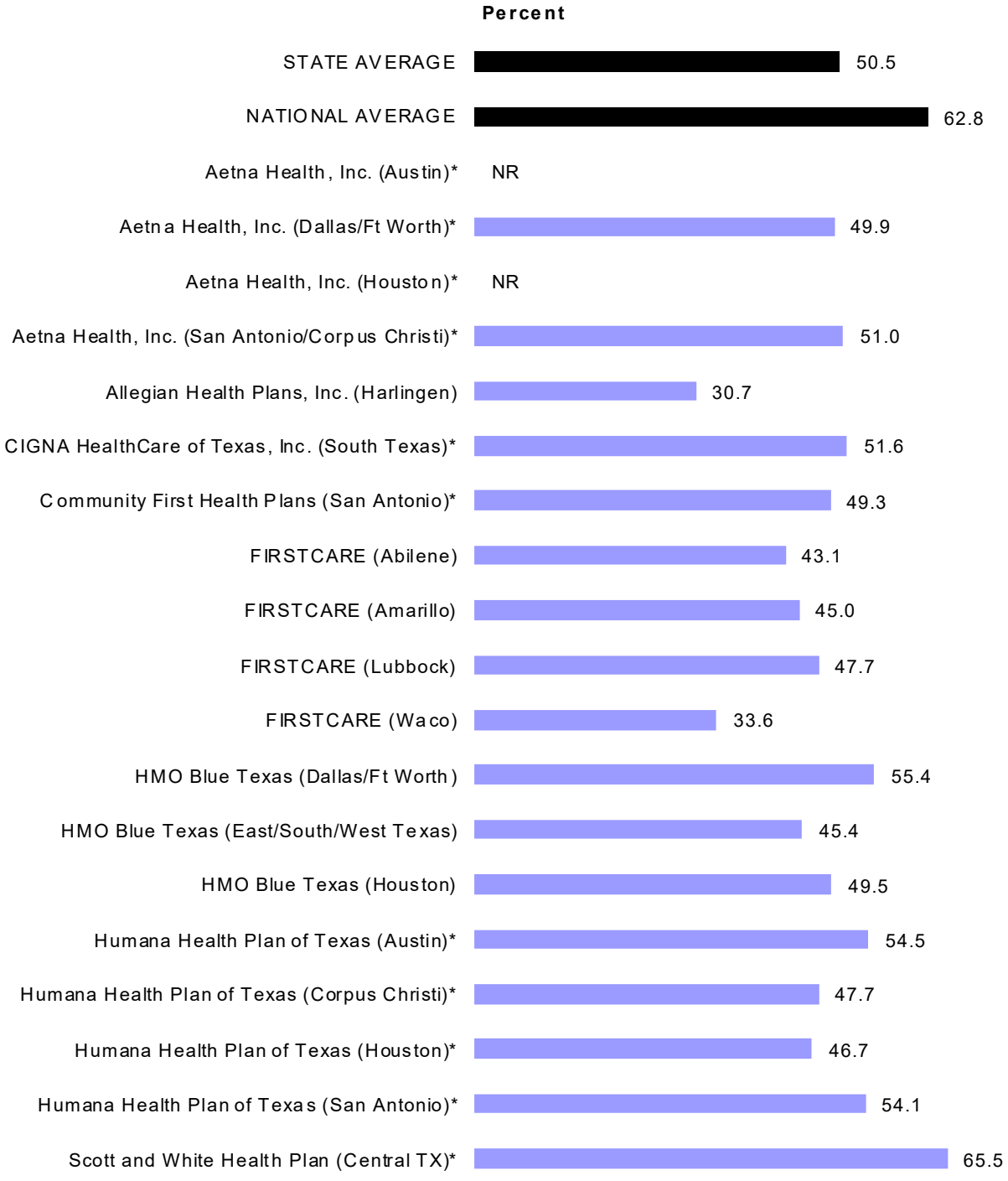
- a fecal occult blood test (FOBT) during the measurement year
- a flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- a double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year
- a colonoscopy during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

Colorectal Cancer Screening					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	52.3%	49.9%	47.6%	48.7%	50.5%
NCQA's Quality Compass®	62.4%	63.3%	63.3%	64.4%	62.8%

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

[1] American Cancer Society. *Cancer Facts and Figures 2016*. Atlanta, GA: American Cancer Society, 2016.
[2] Ibid.

Colorectal Cancer Screening Rate



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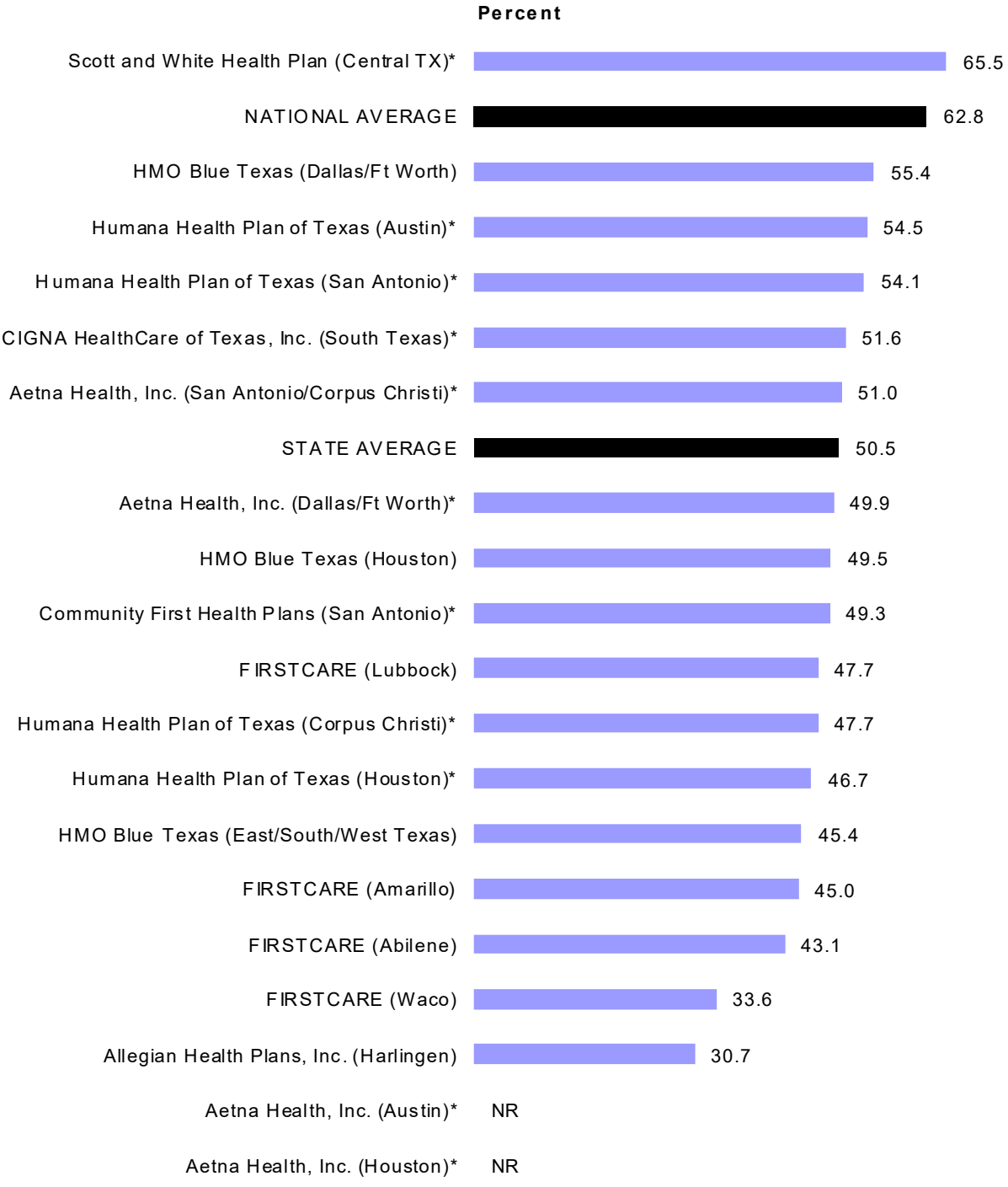
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Colorectal Cancer Screening Rate



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Chlamydia Screening in Women

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

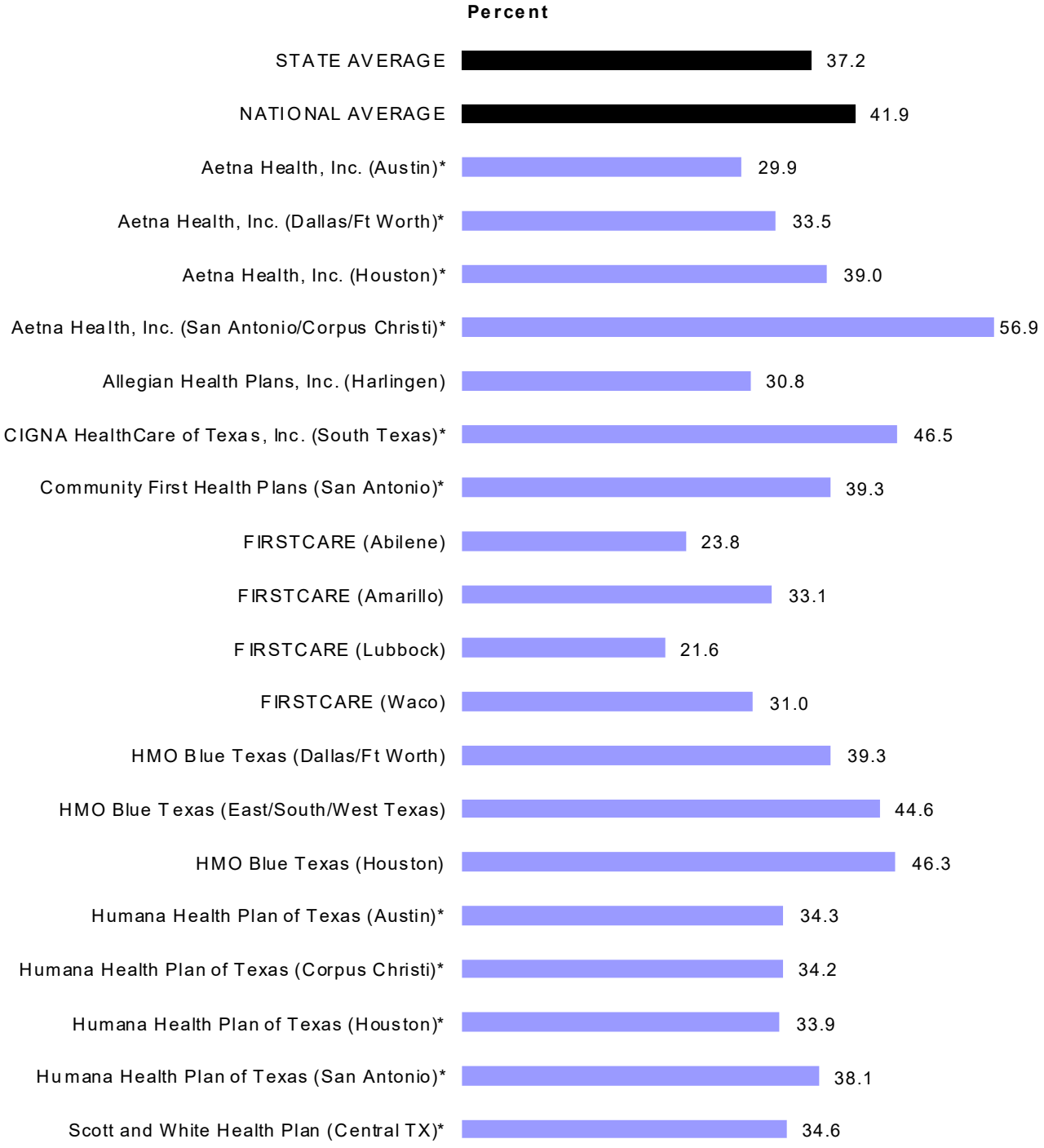
The CDC estimates that nearly three million chlamydia infections occur in the U.S. each year. The majority of infected people do not have symptoms. In women, an untreated chlamydia infection can cause damage to the reproductive system, chronic pelvic pain, and ectopic pregnancy. Sexually active adolescent and young adult women may be more susceptible to infection because the cervix has not fully matured. Antibiotics can easily treat and cure chlamydia.[1]

Chlamydia Screening: Total					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	42.3%	42.5%	44.8%	44.5%	44.3%
NCQA's Quality Compass®	45.0%	45.1%	46.2%	47.0%	47.4%

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

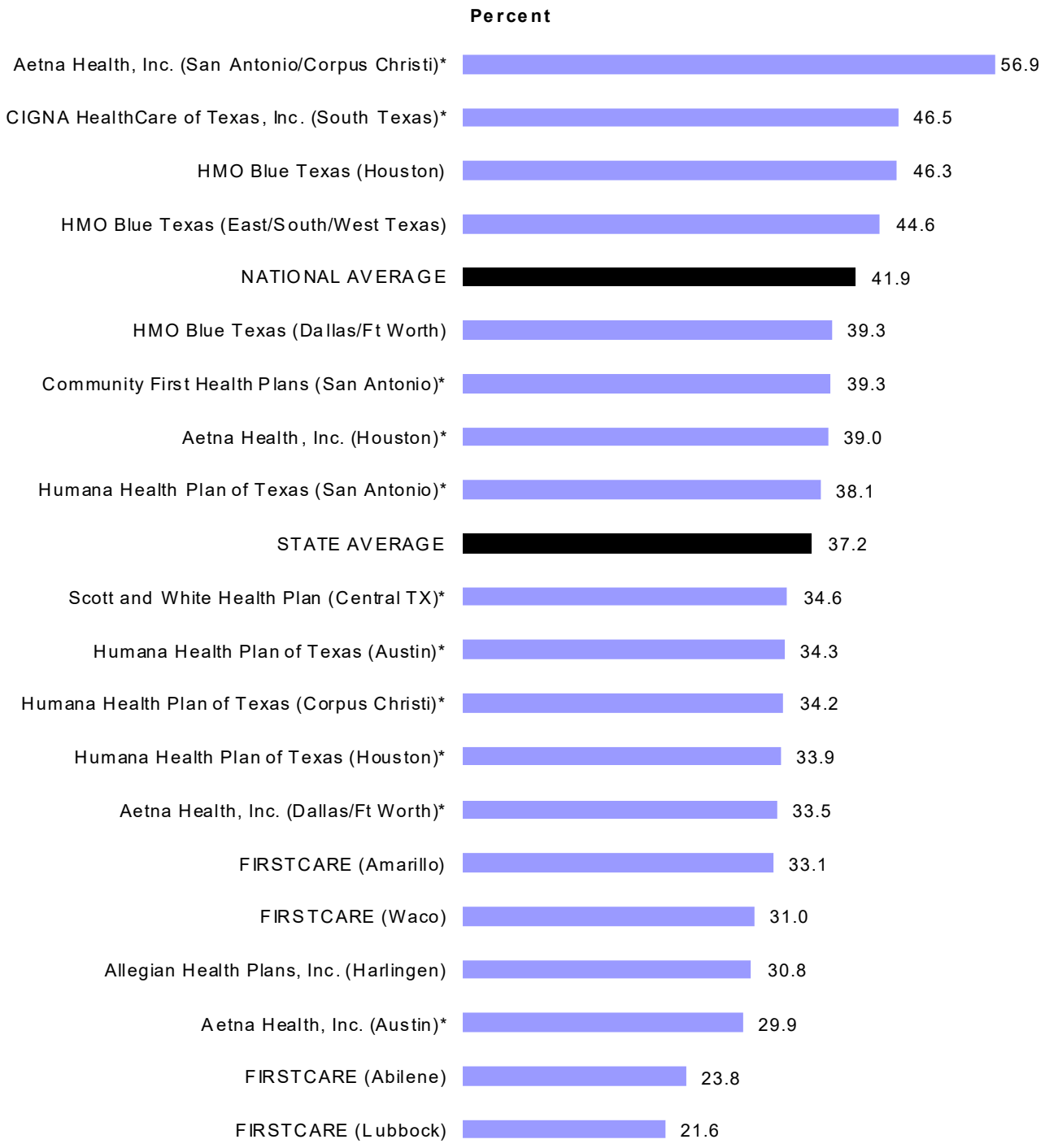
[1] Centers for Disease Control and Prevention. *Chlamydia—CDC Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2016.

Chlamydia Screening Rate: Age 16 to 20



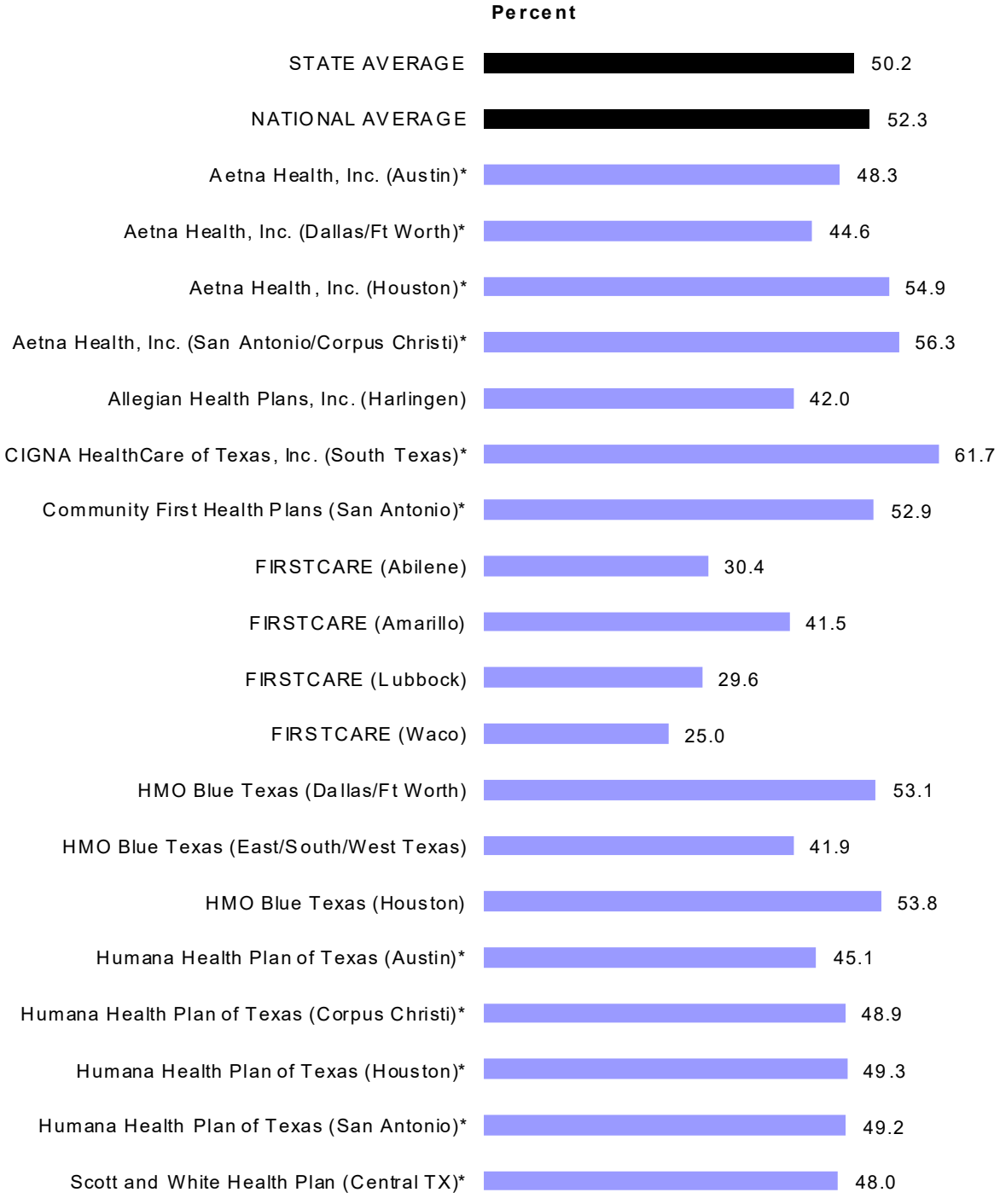
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Chlamydia Screening Rate: Age 16 to 20



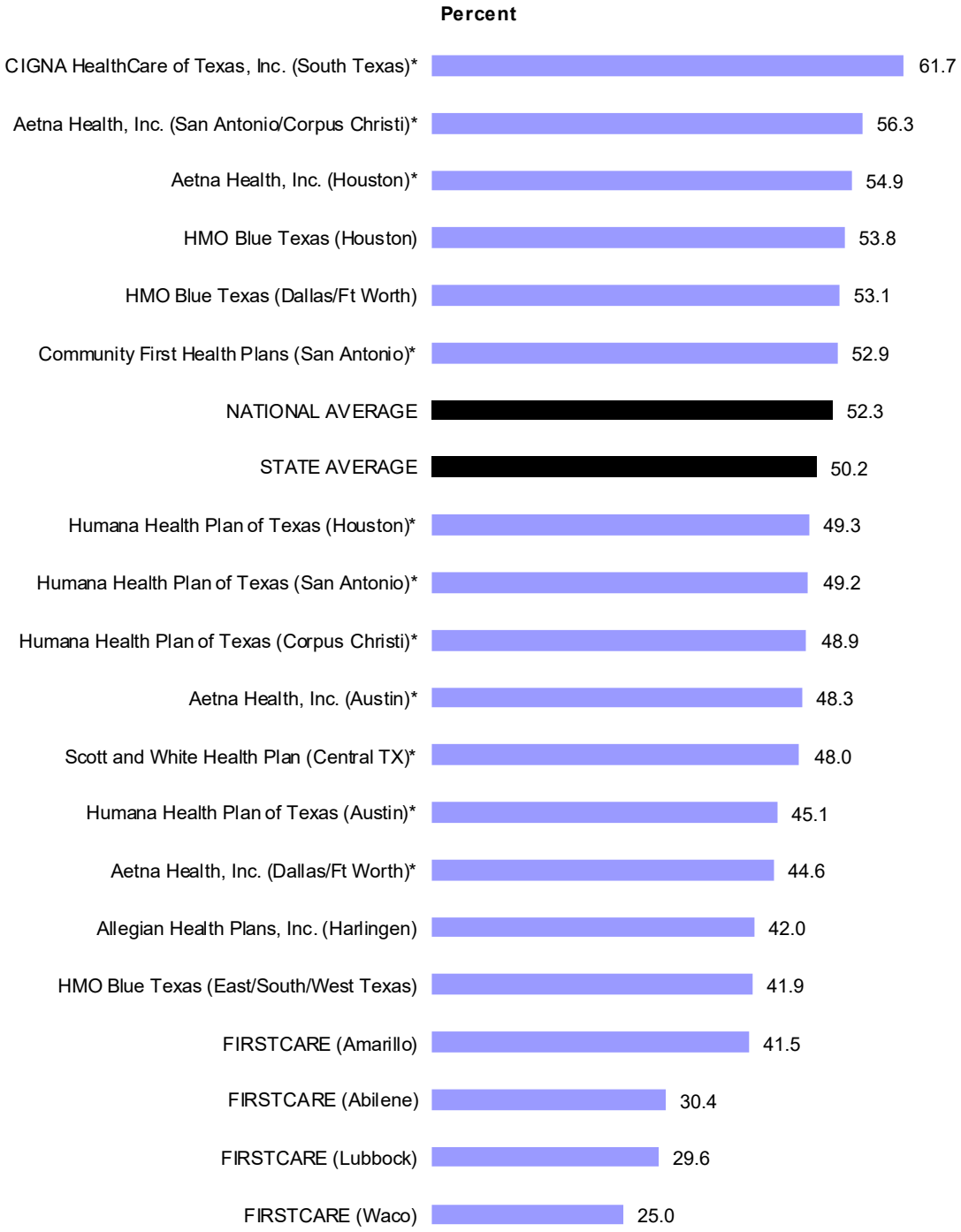
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Chlamydia Screening Rate: Age 21 to 24



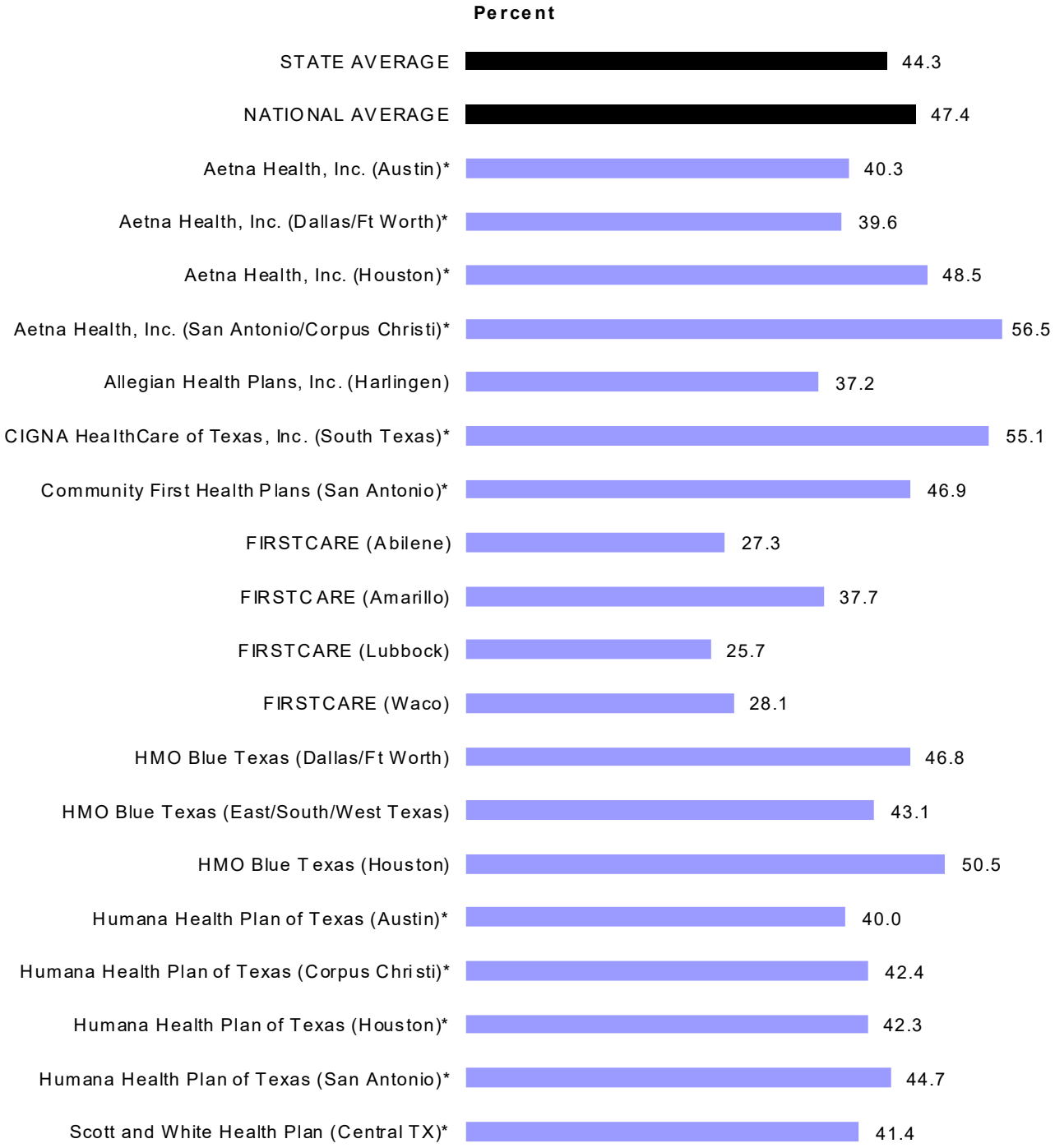
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Chlamydia Screening Rate: Age 21 to 24



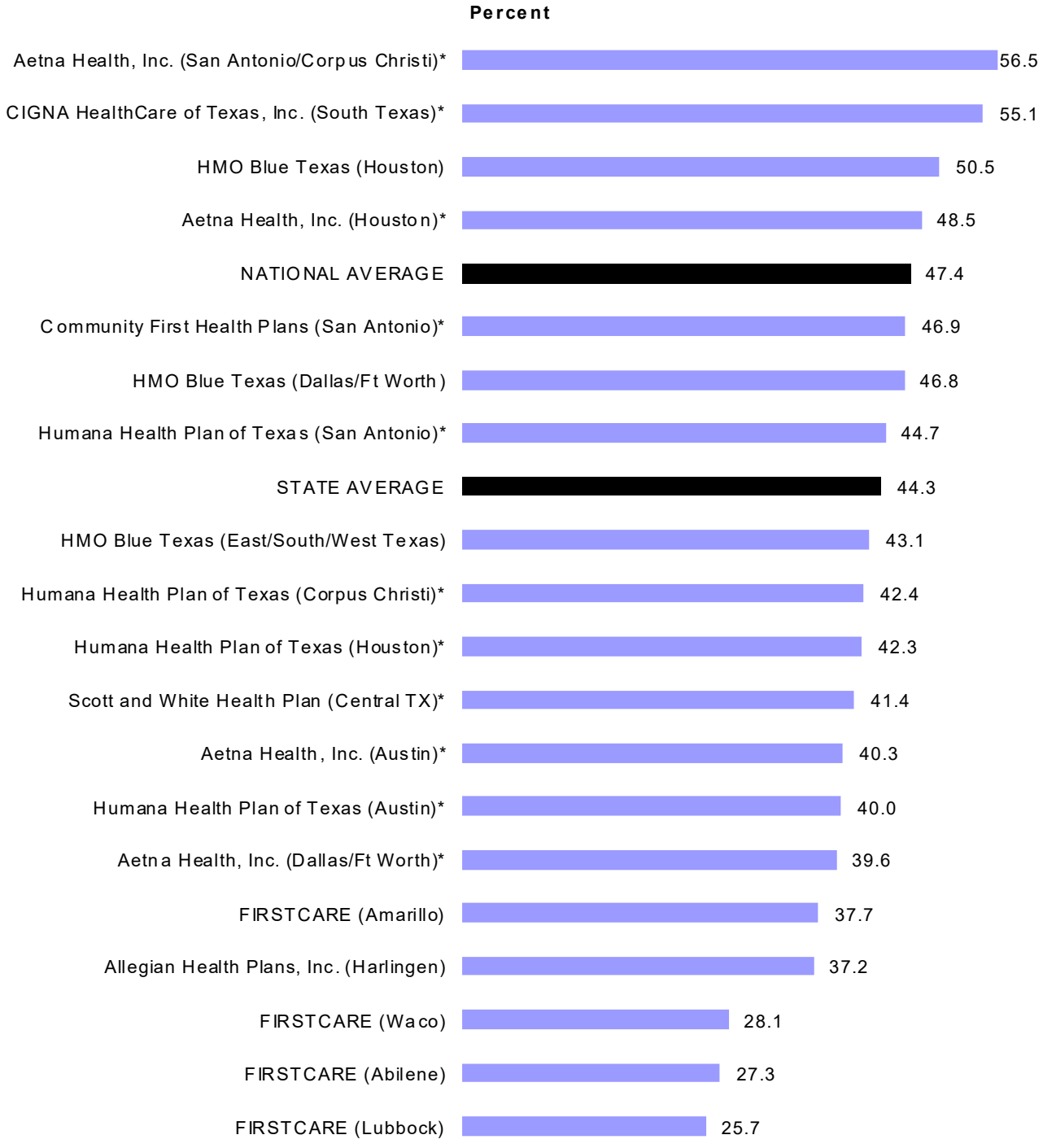
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Chlamydia Screening Rate: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Chlamydia Screening Rate: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Controlling High Blood Pressure

Definition: The percentage of members age 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 is 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.

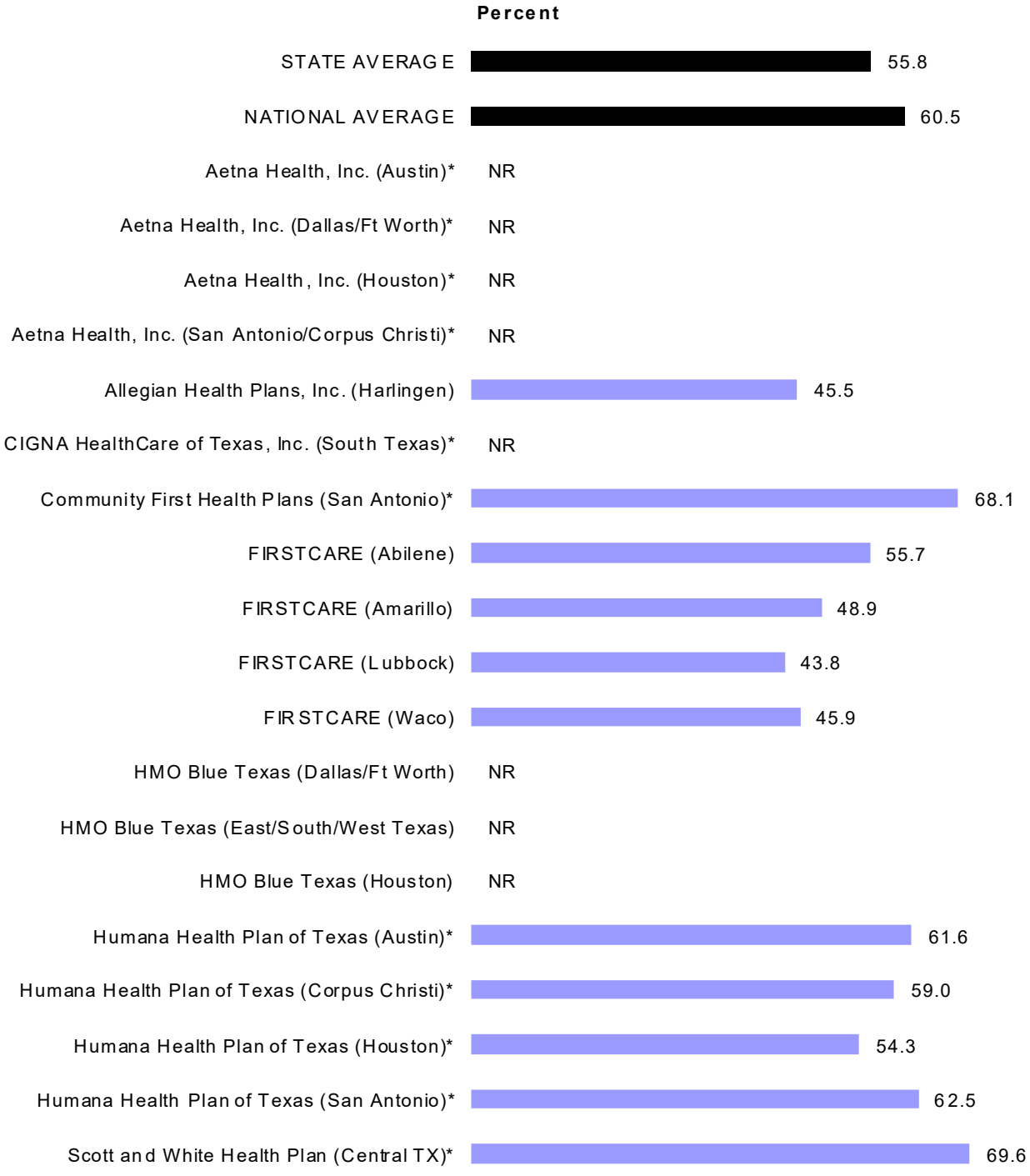
According to the American Heart Association, approximately 80 million American adults have high blood pressure. The disease killed nearly 72,000 Americans in 2013 and contributed to over 405,000 additional deaths. High blood pressure (greater than 140/90 mm Hg) usually has no specific symptoms and no early warning signs. If left untreated, it increases an individual's risk for heart disease, stroke, congestive heart failure, and kidney disease.[1]

Controlling High Blood Pressure					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	55.4%	55.2%	55.2%	53.7%	55.8%
NCQA's Quality Compass®	65.4%	63.0%	64.4%	64.0%	60.5%

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

[1] 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).

Controlling High Blood Pressure



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
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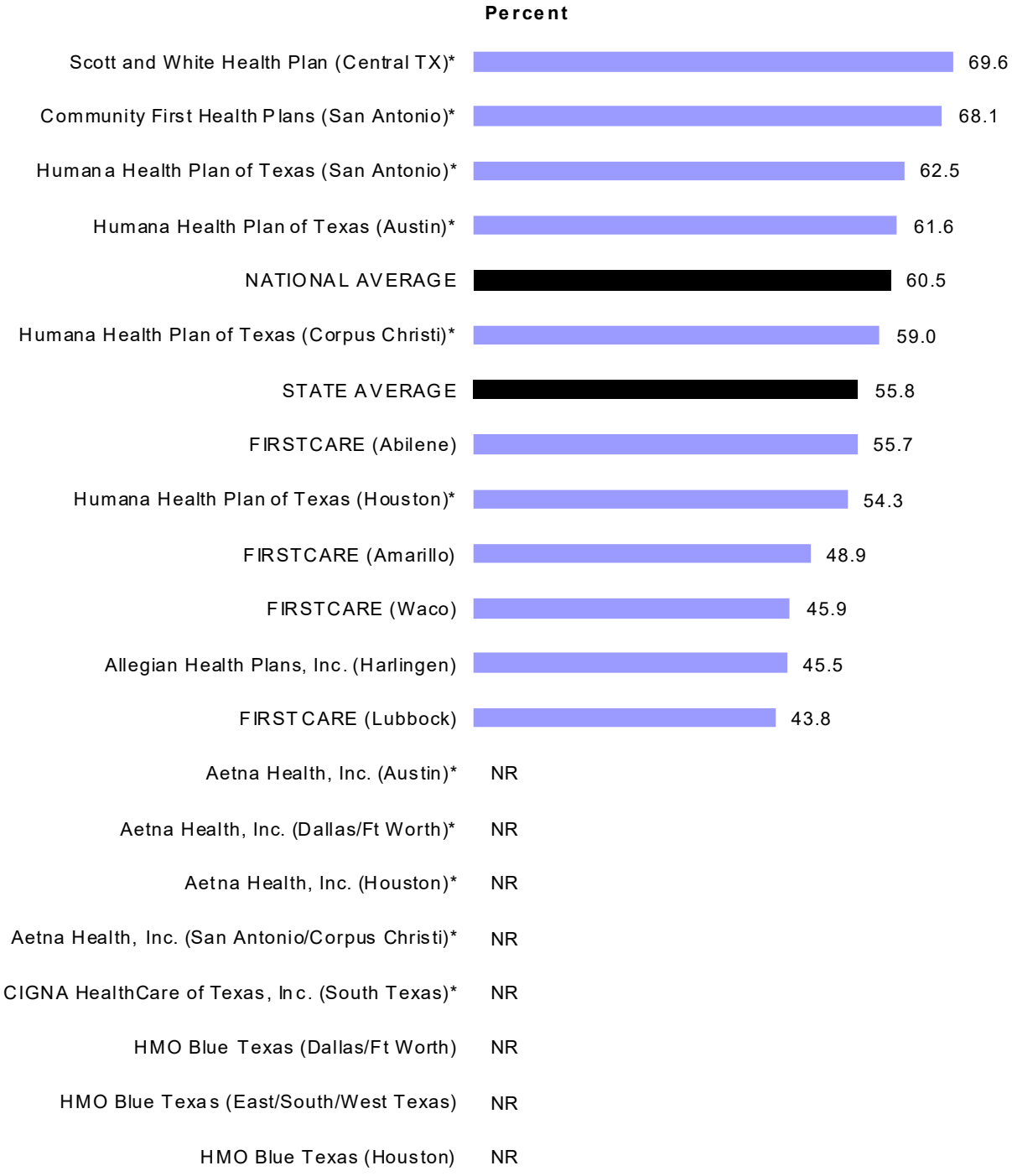
Controlling High Blood Pressure



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Persistence of Beta-Blocker Treatment After a Heart Attack

Definition: The percentage of members 18 years of age 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.

Acute myocardial infarction (AMI)—also known as a heart attack—is a leading cause of death in the United States. Often a blood clot that blocks one of the coronary arteries and starves the heart of oxygen-rich blood. The slow buildup of plaque in the walls of the coronary arteries narrows blood vessels and increases the risk of blockage.[1]

Beta-adrenergic blocking drugs—also known as beta-blockers—reduce nerve impulses to the heart and blood vessels. This slows the heart rate, relaxes pressure in the blood vessel walls, and decreases the force of heart contractions.[2] Treatment with beta-blockers has been shown to lower the risk of a subsequent AMI by reducing the heart's workload and lowering blood pressure. The American Heart Association and the American College of Cardiology recommend the use of beta-blockers after a heart attack to reduce the risk of a subsequent heart attack.[3]

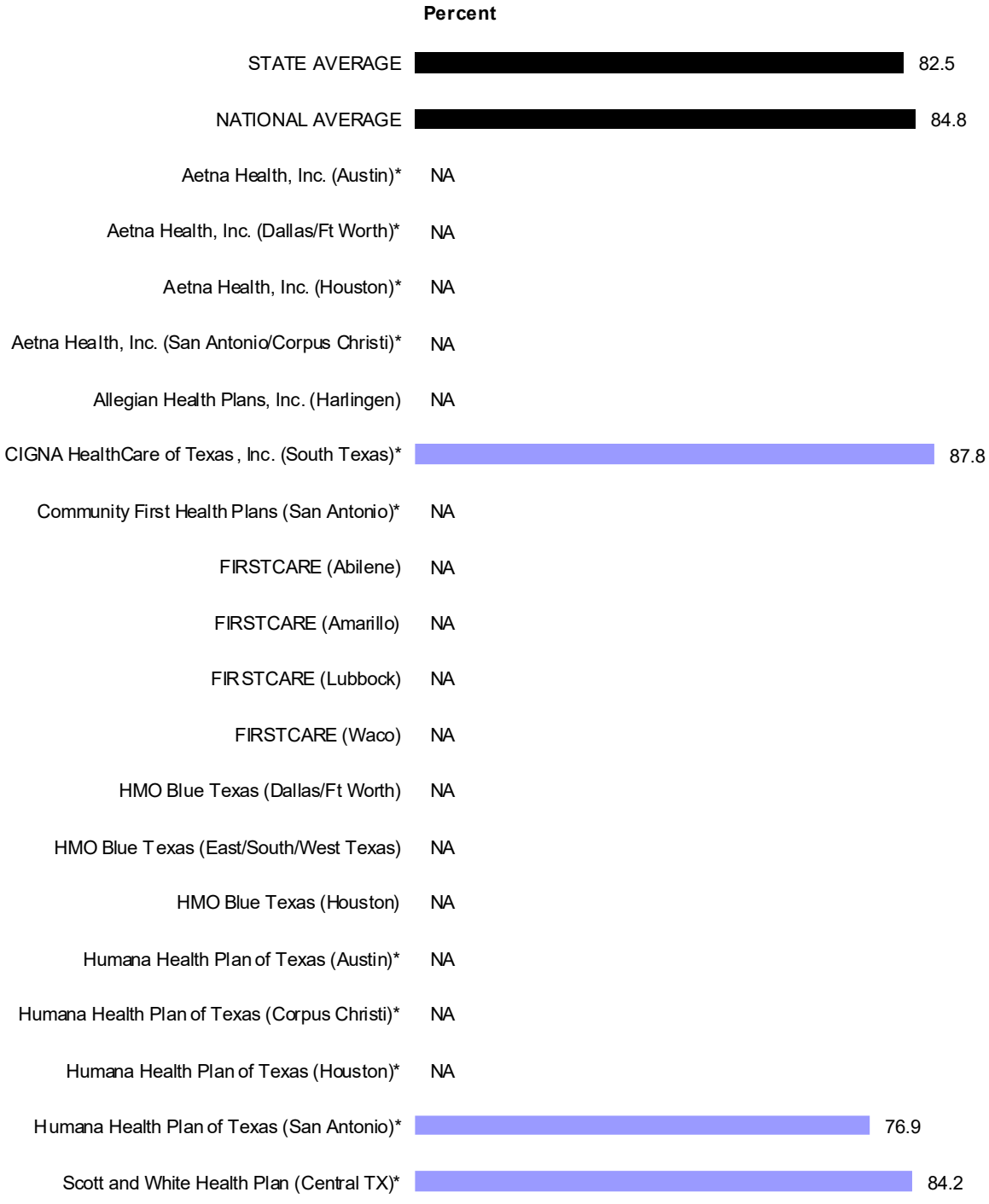
An "NA" (not applicable) designation for this measure indicates the eligible member population was too small (less than 30) to report a statistically valid rate.

Persistence of Beta Blocker Treatment After a Heart Attack					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	74.2%	73.8%	82.4%	84.3%	82.5%
NCQA's Quality Compass®	81.3%	83.9%	83.9%	84.4%	84.8%

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

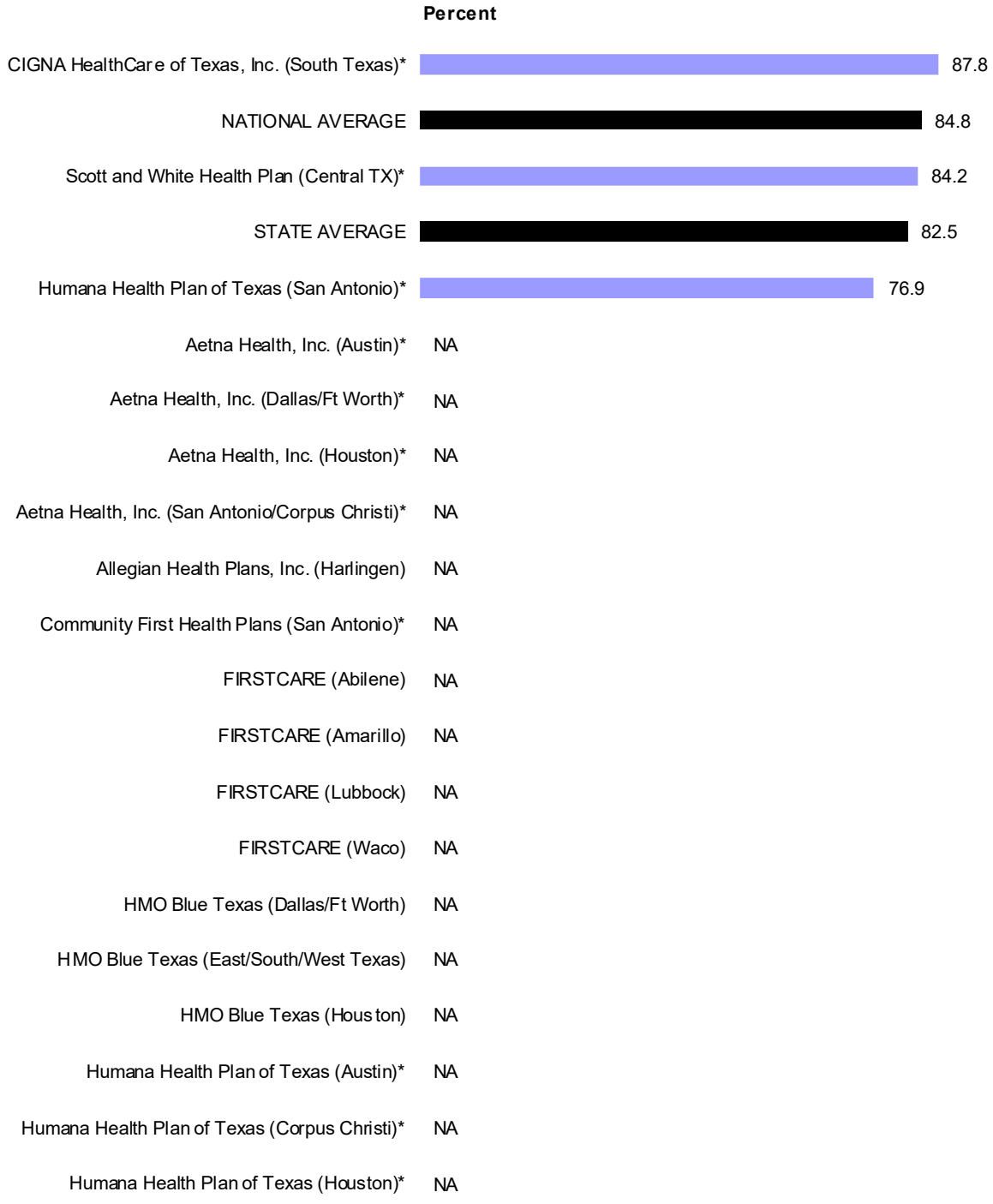
[1] National Heart, Lung, and Blood Institute. *Health Topics: Heart Attack*. Bethesda, MD: National Heart, Lung, and Blood Institute, 2015.
[2] Ibid.
[3] Yancy, Clyde, et al. "2013 ACCF/AHA Guideline for the Management of Heart Failure." *Journal of the American College of Cardiology*. 62: e147–e239 (2013).

Persistence of Beta Blocker Treatment After a Heart Attack



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Persistence of Beta Blocker Treatment After a Heart Attack



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Comprehensive Diabetes Care: HbA1cTesting

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

The Centers for Disease Control and Prevention estimates that in 2012, 29.1 million Americans (9.3% of the population) have diabetes. Of these cases, 21.0 million individuals have been diagnosed and an estimated 8.1 million individuals have diabetes but have not been diagnosed. Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.[1]

The HbA1c test is one test used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under seven percent have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of eight percent or higher.[2] The American Diabetes Association recommends a therapeutic goal of seven percent and encourages physicians to reevaluate treatment regimes in patients with levels consistently above eight percent. HbA1c levels over nine percent indicate poorly controlled diabetes.[3]

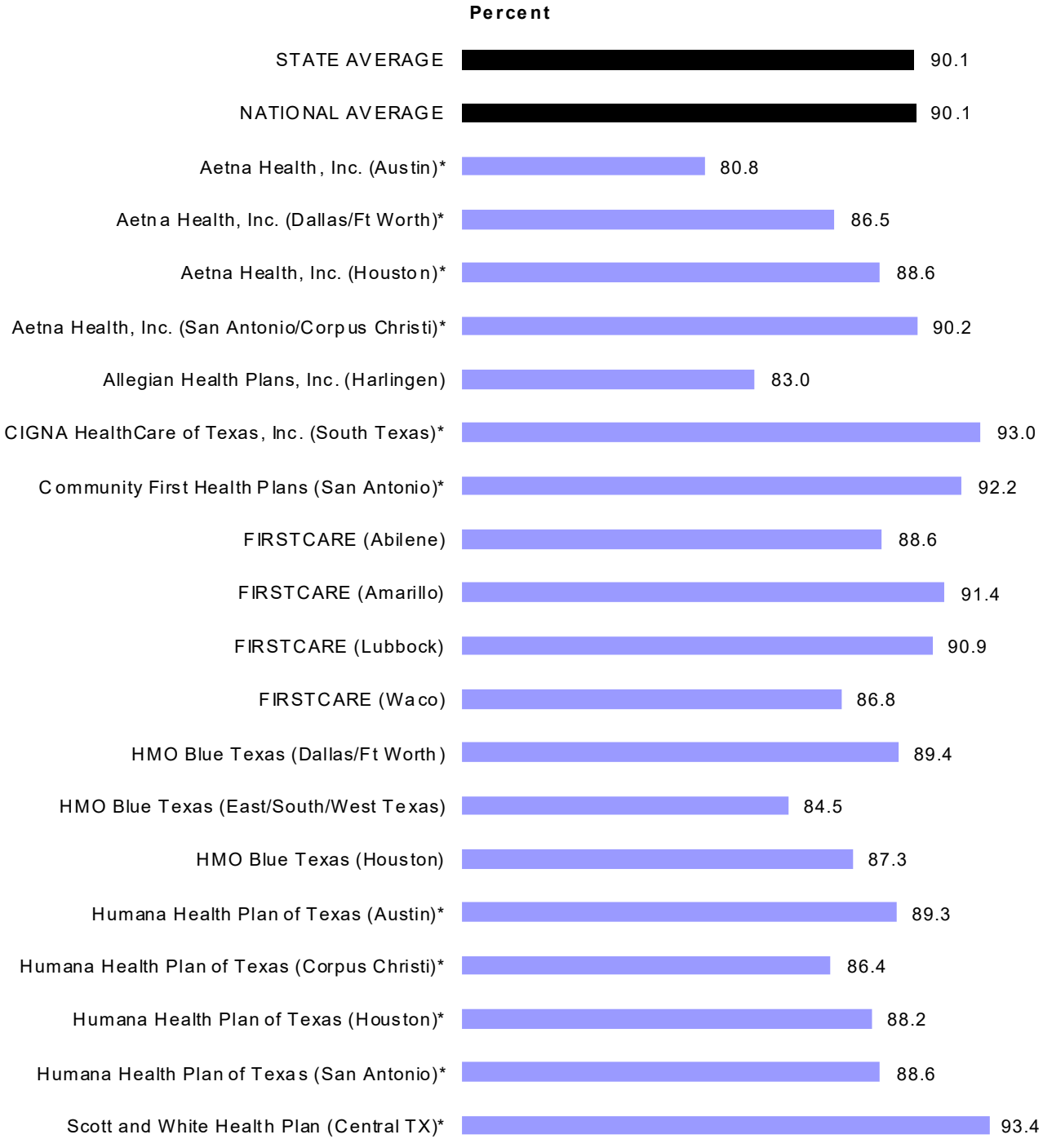
The American Diabetes Association recommends that an individual diagnosed with diabetes have this test performed at least twice a year. An individual with diabetes should continue to perform daily self-tests to monitor day-to-day blood glucose control.[4]

Comprehensive Diabetes Care: HbA1cTesting					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	86.8%	86.2%	87.0%	90.1%	90.1%
NCQA's Quality Compass®	90.0%	90.1%	89.9%	90.5%	90.1%

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

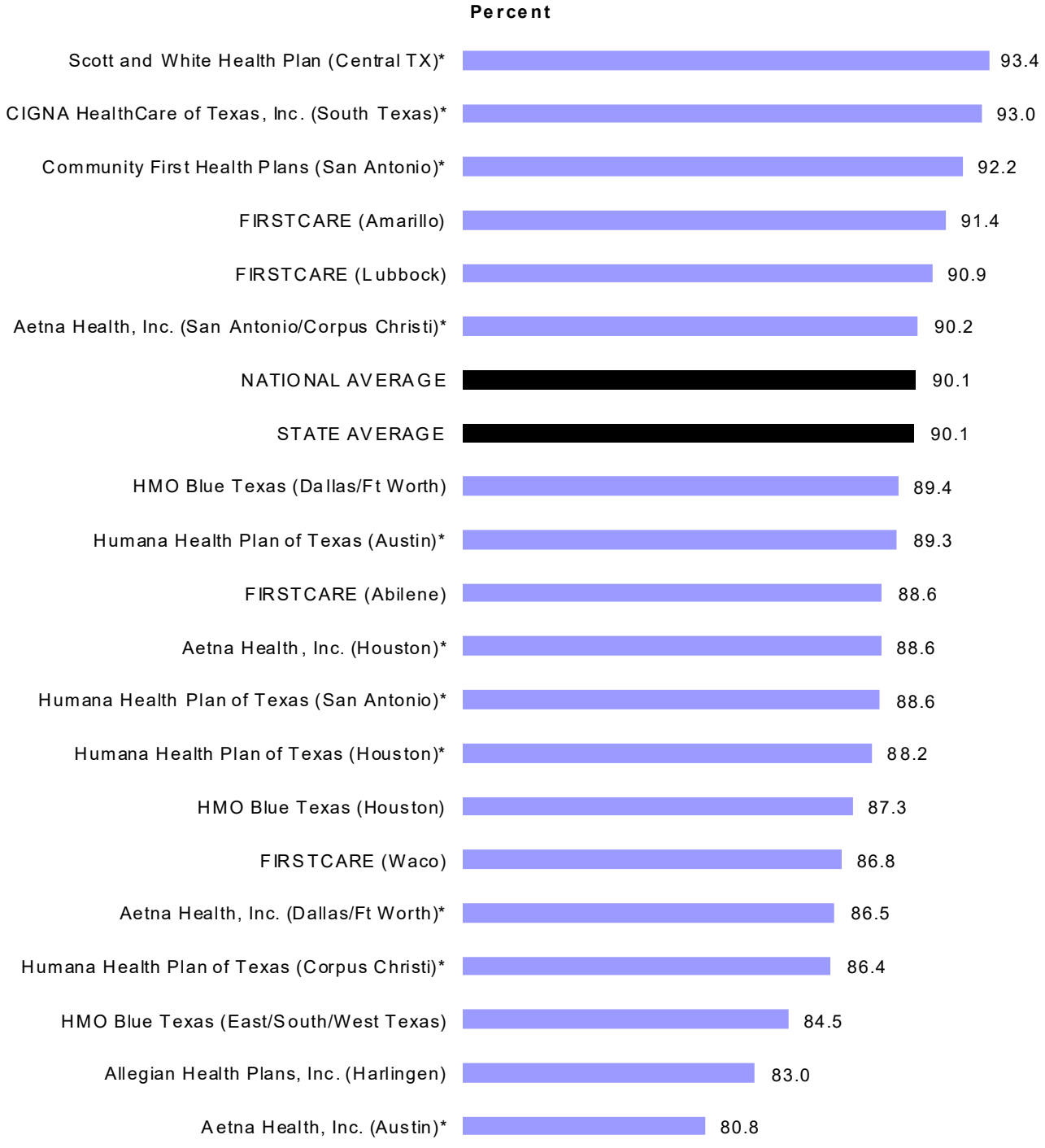
[1] Centers for Disease Control and Prevention, *2014 National Diabetes Statistics Report*, Atlanta, GA: Centers for Disease Control and Prevention, 2014.
Centers for Disease Control and Prevention. *National Diabetes Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2011.
[2] American Diabetes Association. *Living With Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[3] Ibid.

Comprehensive Diabetes Care: HbA1c Testing



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Comprehensive Diabetes Care: HbA1c Testing



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Note—Lower rates indicate better performance for this measure.

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

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

The Centers for Disease Control and Prevention estimates that in 2012, 29.1 million Americans (9.3% of the population) have diabetes. Of these cases, 21.0 million individuals have been diagnosed and an estimated 8.1 million individuals have diabetes but have not been diagnosed. Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.[1]

The HbA1c test is one test used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under seven percent have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of eight percent or higher.[2] The American Diabetes Association recommends a therapeutic goal of seven percent and encourages physicians to reevaluate treatment regimes in patients with levels consistently above eight percent. HbA1c levels over nine percent indicate poorly controlled diabetes.[3]

The American Diabetes Association 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.[4]

Comprehensive Diabetes Care: Poor HbA1c Control					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	44.4%	47.8%	49.2%	45.4%	56.8%
NCQA's Quality Compass®	28.3%	28.5%	30.5%	31.2%	33.8%

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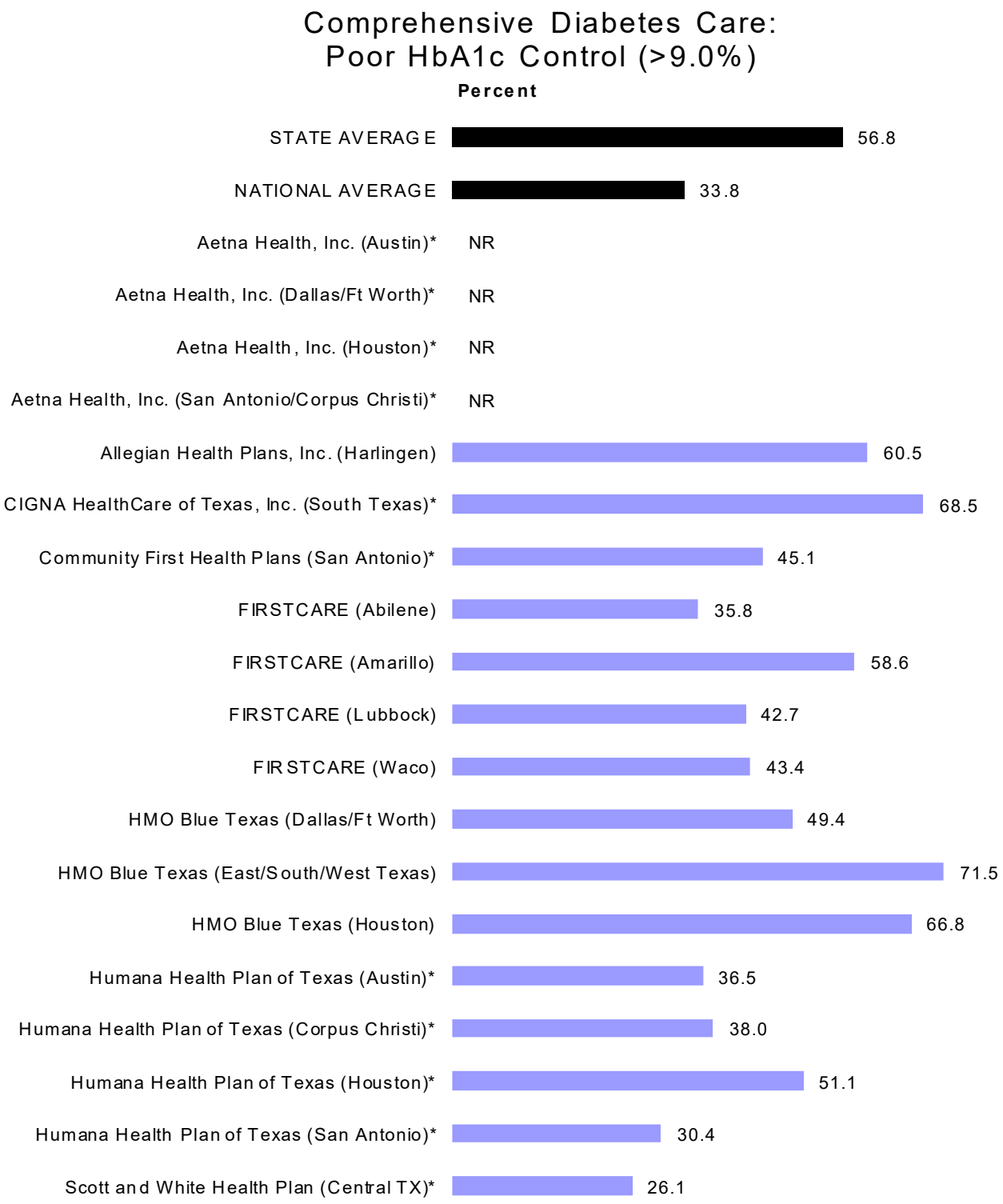
[1] Centers for Disease Control and Prevention, *2014 National Diabetes Statistics Report*, Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] Centers for Disease Control and Prevention. *National Diabetes Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2011.
[3] American Diabetes Association. *Living With Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[4] Ibid.

Note—Lower rates indicate better performance for this measure.



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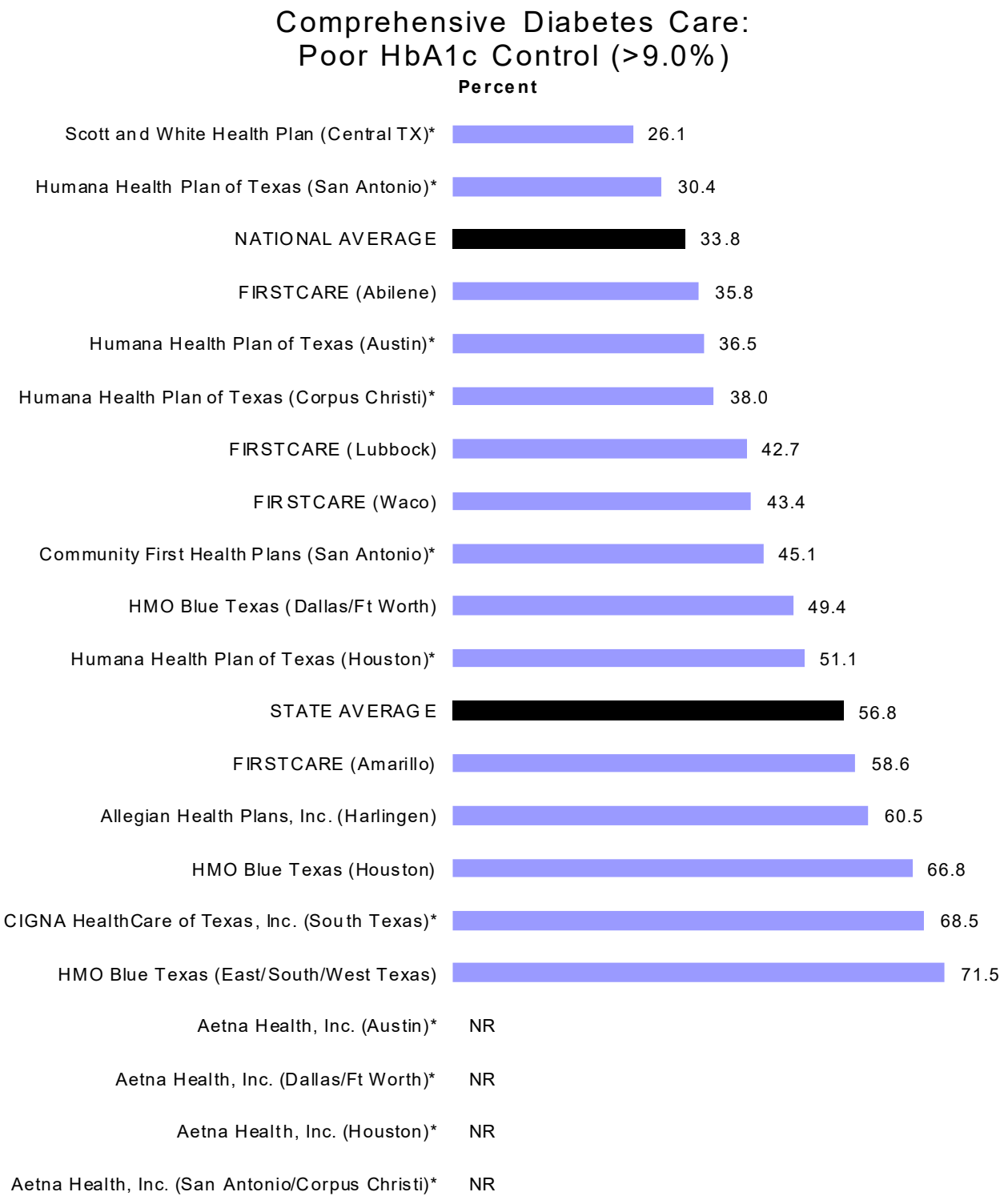
Note—Lower rates indicate better performance for this measure.



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NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Comprehensive Diabetes Care: HbA1c Control (<8.0%)

Definition: The percentage of members 18–75 years of age with Type 1 or Type 2 Diabetes who had their most recent HbA1c level less than 8.0 percent during the past year.

The Centers for Disease Control and Prevention estimates that in 2012, 29.1 million Americans (9.3% of the population) have diabetes. Of these cases, 21.0 million individuals have been diagnosed and an estimated 8.1 million individuals have diabetes but have not been diagnosed. Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.[1]

The HbA1c test is one test used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under seven percent have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of eight percent or higher.[2] The American Diabetes Association recommends a therapeutic goal of seven percent and encourages physicians to reevaluate treatment regimes in patients with levels consistently above eight percent. HbA1c levels over nine percent indicate poorly controlled diabetes.[3]

The American Diabetes Association 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.[4]

Comprehensive Diabetes Care: HbA1c Control (<8.0%)					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	36.4%	40.7%	42.0%	44.1%	35.9%
NCQA's Quality Compass®	61.2%	61.3%	58.9%	57.5%	55.3%

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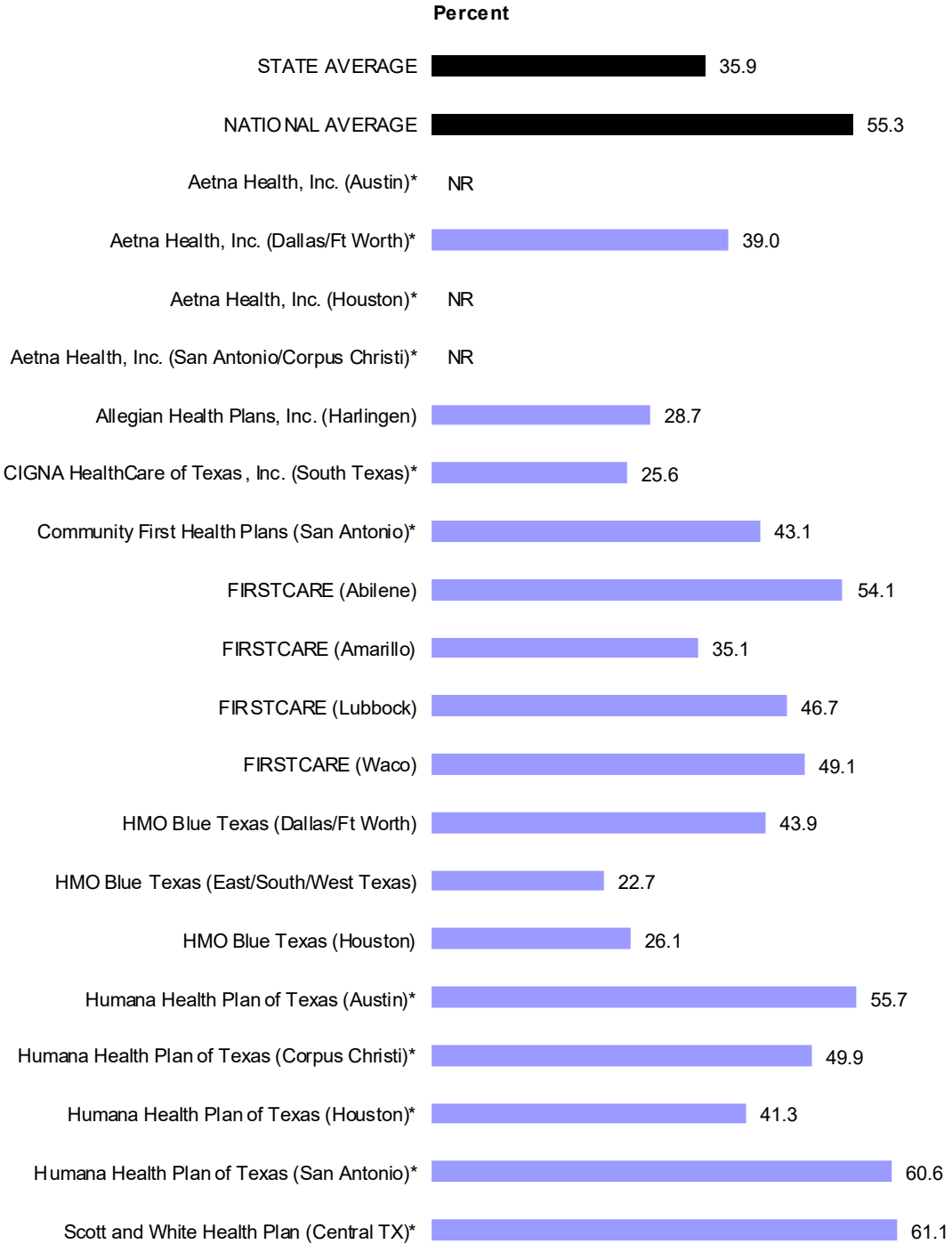
[1] Centers for Disease Control and Prevention, *2014 National Diabetes Statistics Report*, Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] Centers for Disease Control and Prevention. *National Diabetes Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2011.
[3] American Diabetes Association. *Living With Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[4] Ibid.

Comprehensive Diabetes Care: HbA1c Control (<8.0%)



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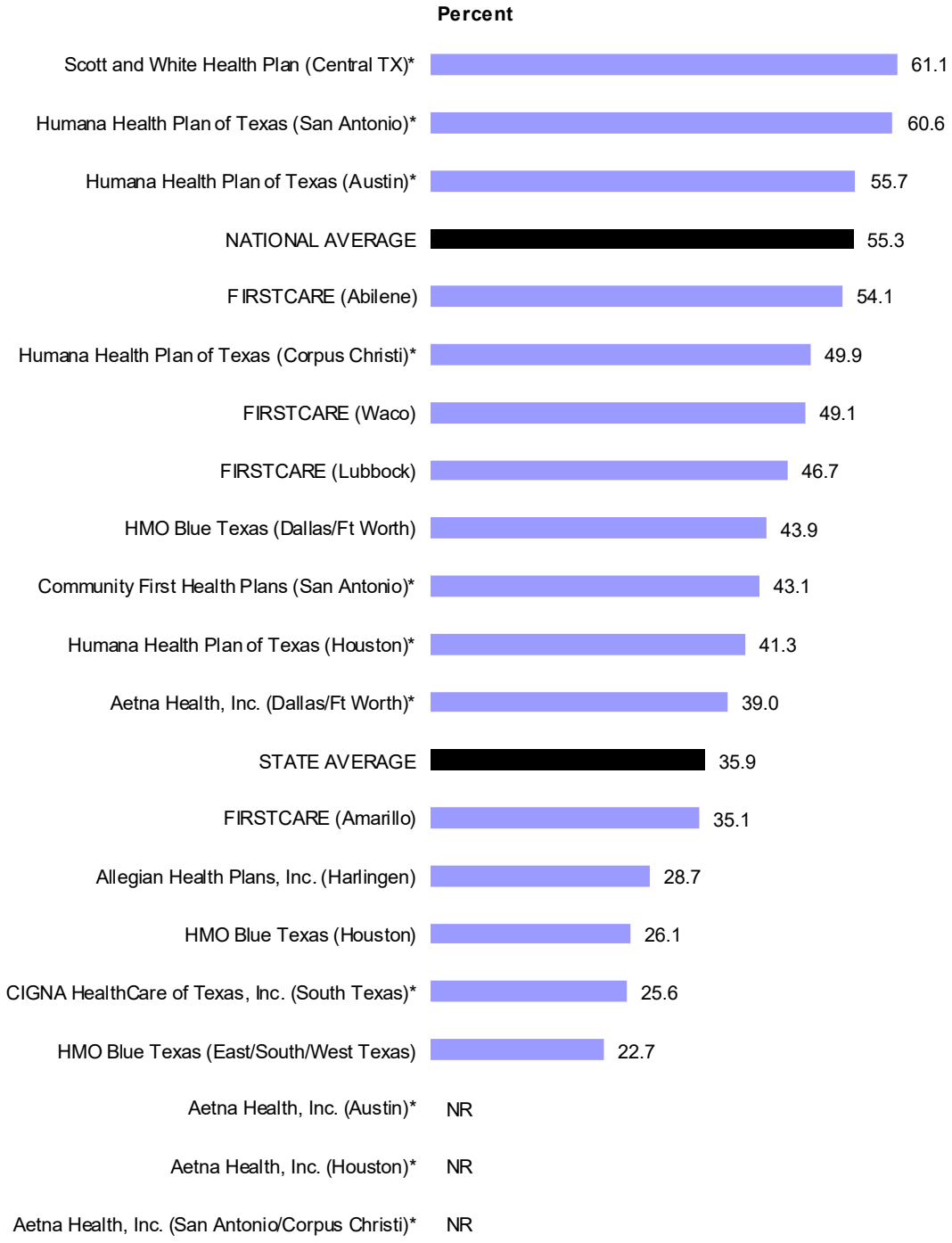
Comprehensive Diabetes Care: HbA1c Control (<8.0%)



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
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Comprehensive Diabetes Care: HbA1c Control (<7.0%)

Definition: The percentage of members 18–75 years of age with Type 1 or Type 2 Diabetes who had their most recent HbA1c level less than 7.0 percent during the past year.

The Centers for Disease Control and Prevention estimates that in 2012, 29.1 million Americans (9.3% of the population) have diabetes. Of these cases, 21.0 million individuals with diabetes have been diagnosed and an estimated 8.1 million individuals with diabetes have not been diagnosed. Diabetes is associated with serious complications, including heart disease and stroke, blindness, kidney failure, and lower-limb amputation.[1]

The HbA1c test is one test used to monitor individuals with diabetes. It measures average blood glucose control during the previous months. Diabetics who maintain HbA1c levels under seven percent have a much better chance of delaying or preventing complications that affect the eyes, kidneys, and nerves than diabetics with levels of eight percent or higher.[2] The American Diabetes Association recommends a therapeutic goal of seven percent and encourages physicians to reevaluate treatment regimes in patients with levels consistently above eight percent. HbA1c levels over nine percent indicate poorly controlled diabetes.[3]

The American Diabetes Association 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.[4]

Comprehensive Diabetes Care: HbA1c Control (<7.0%)					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	26.6%	27.3%	29.7%	28.6%	30.4%
NCQA's Quality Compass®	42.2%	43.2%	39.8%	39.0%	36.7%

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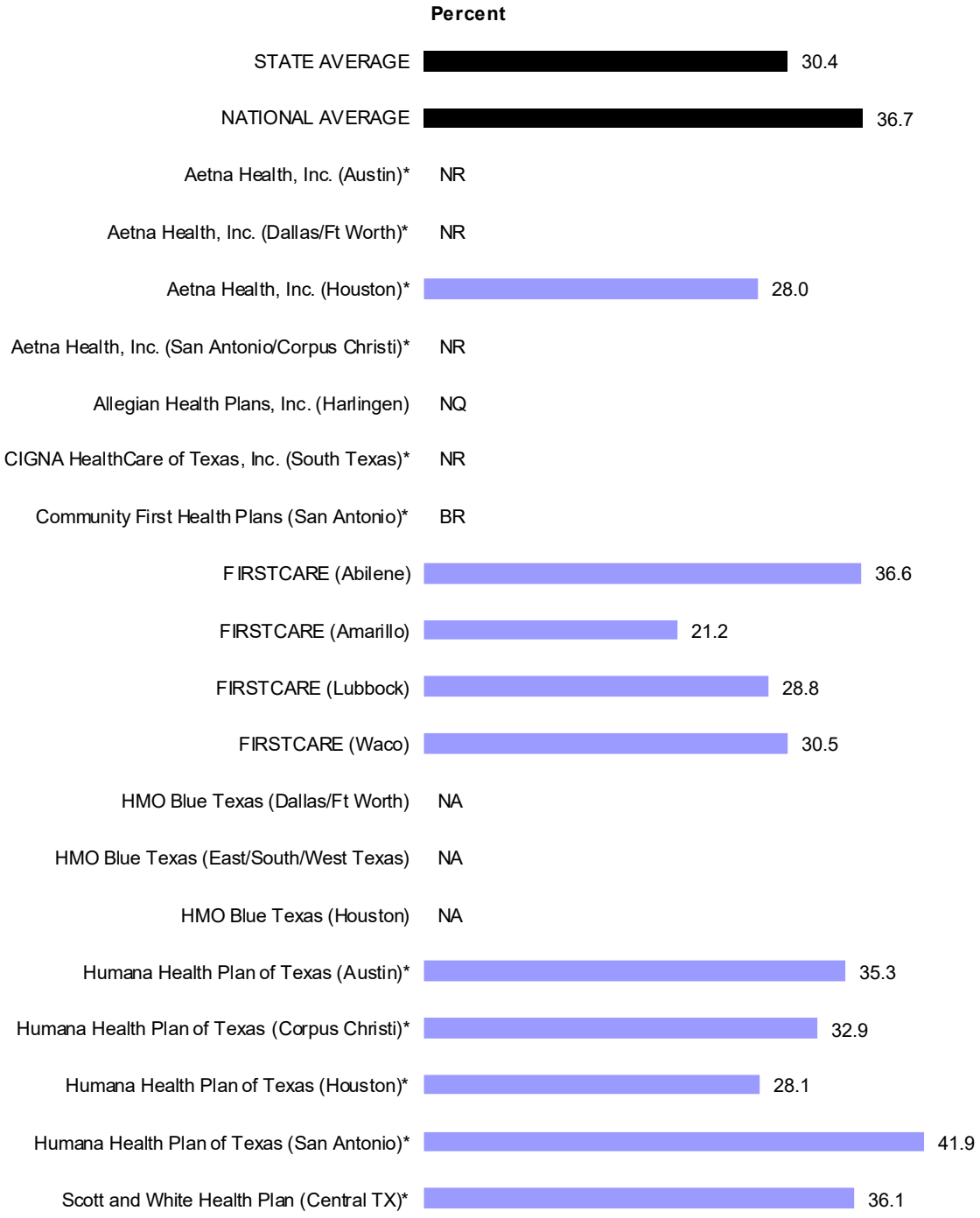
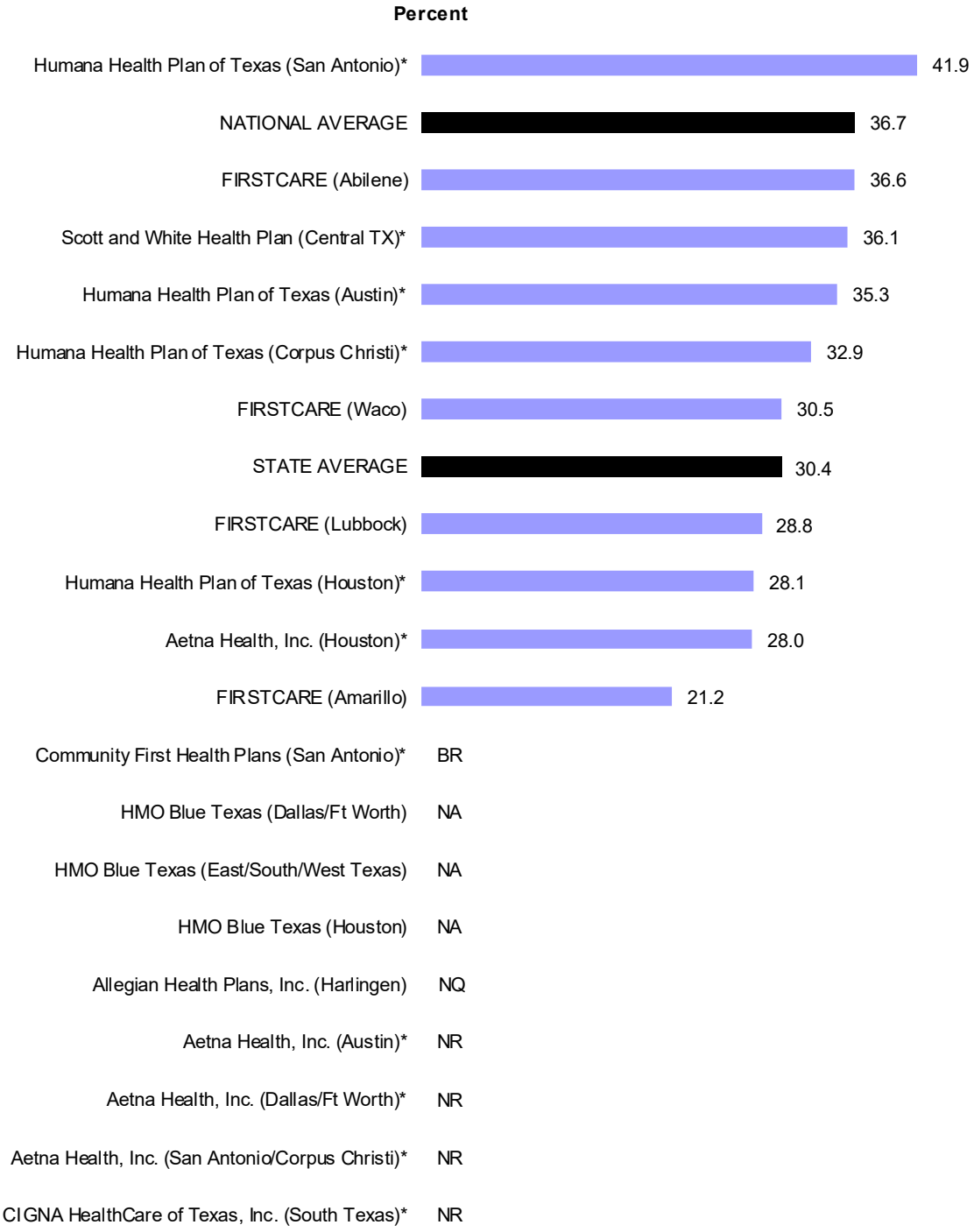
[1] Centers for Disease Control and Prevention, *2014 National Diabetes Statistics Report*, Atlanta, GA: Centers for Disease Control and Prevention, 2014.
[2] Centers for Disease Control and Prevention. *National Diabetes Fact Sheet*. Atlanta, GA: Centers for Disease Control and Prevention, 2011.
[3] American Diabetes Association. *Living With Diabetes: A1c and eAG*. Alexandria, VA: American Diabetes Association, 2014.
[4] Ibid.

Comprehensive Diabetes Care: HbA1c Control (<7.0%)



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
BR– The calculated rate was materially biased.
NA–The plan did not have a large enough sample to report a valid rate.
NQ– The plan was not required to report the measure.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Comprehensive Diabetes Care: HbA1c Control (<7.0%)



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NQ– The plan was not required to report the measure.
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Comprehensive Diabetes Care: Eye Exam

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.

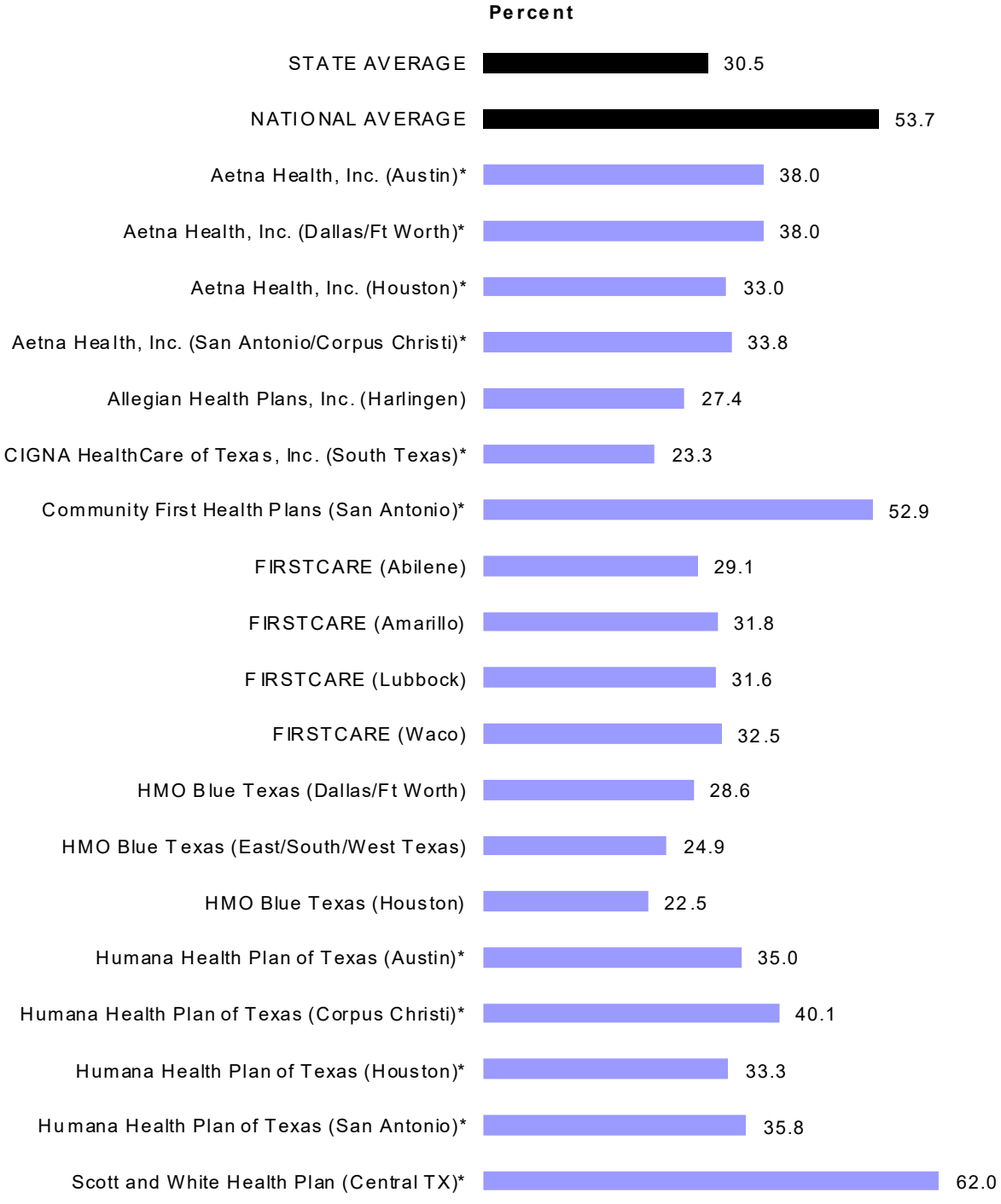
Diabetic retinopathy is the most common diabetic eye disease and a leading cause of blindness in American adults. Changes in the blood vessels in the retina cause the disease. In some people with diabetic retinopathy, blood vessels swell and leak fluid. In others, abnormal new blood vessels grow on the surface of the retina. Between 40 and 45 percent of Americans diagnosed with diabetes have some stage of diabetic retinopathy. Individuals with proliferative retinopathy can reduce their risk of blindness by 95 percent with timely treatment and appropriate follow-up care.[1]

Comprehensive Diabetes Care: Eye Exam					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	34.4%	33.2%	34.4%	36.4%	30.5%
NCQA's Quality Compass®	56.9%	56.8%	55.7%	56.2%	53.7%

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

[1] National Eye Institute. *Facts About Diabetic Eye Disease*. Bethesda, MD: National Eye Institute, 2015.

Comprehensive Diabetes Care: Eye Exam



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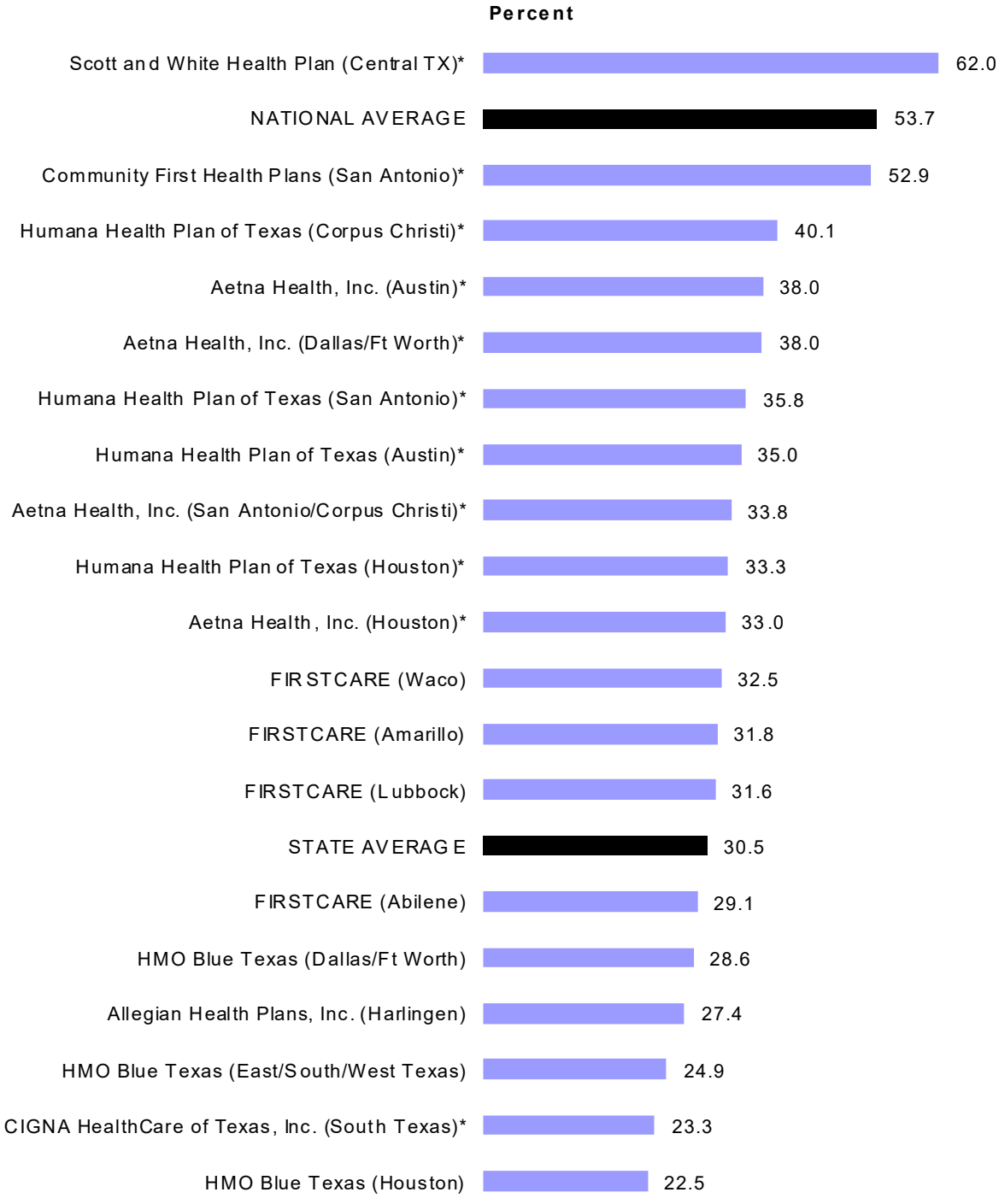
Comprehensive Diabetes Care: Eye Exam



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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

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.

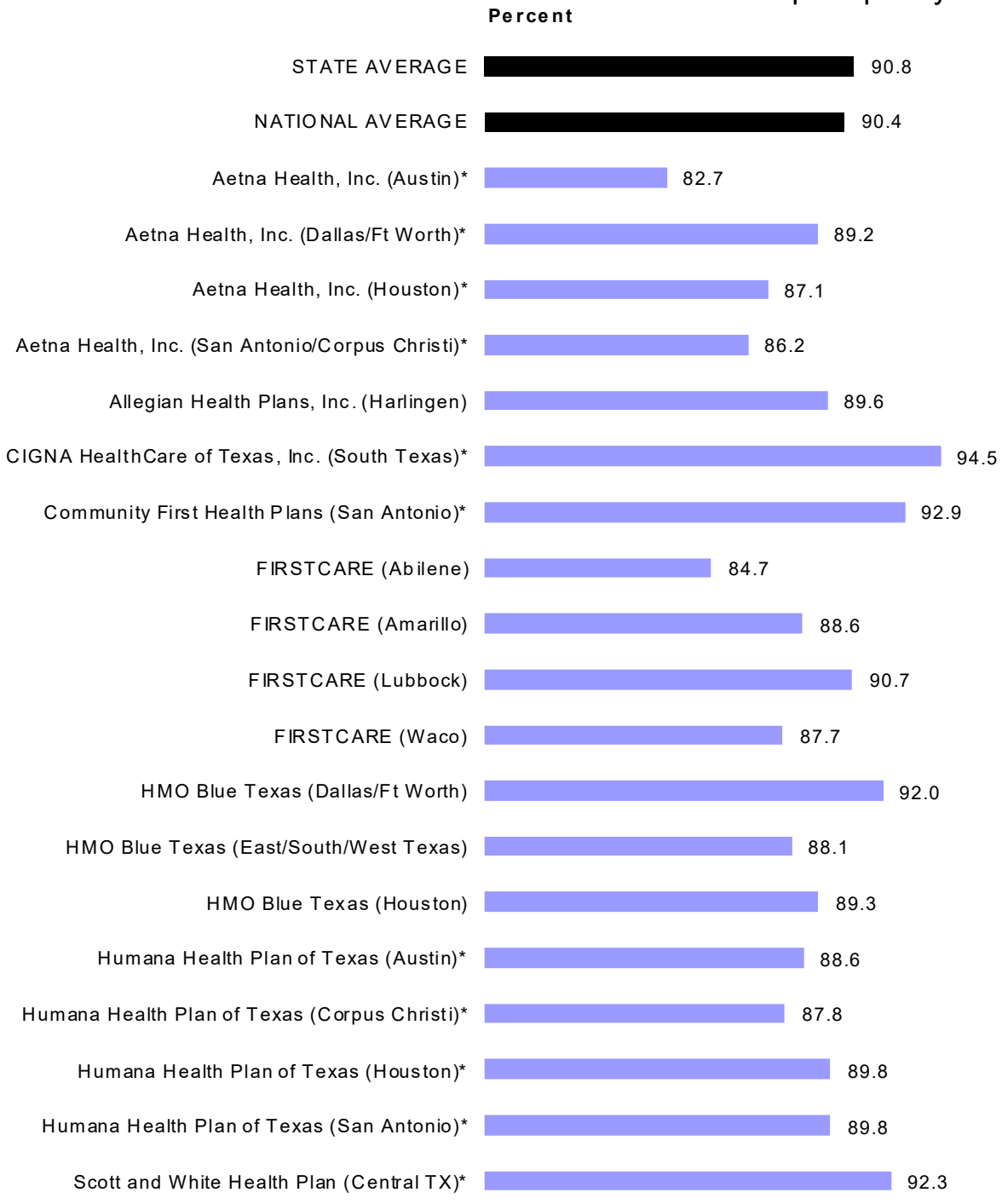
Nephropathy, or kidney disease, is a frequent complication of diabetes. Diabetic nephropathy is a progressive disease that develops over several years. In healthy individuals, many tiny vessels (nephrons) in the kidneys filter wastes, chemicals, and excess water from the blood. When an individual has 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 in order to survive.[1]

Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	78.0%	81.7%	82.6%	85.2%	90.8%
NCQA's Quality Compass®	83.9%	84.3%	84.5%	85.4%	90.4%

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

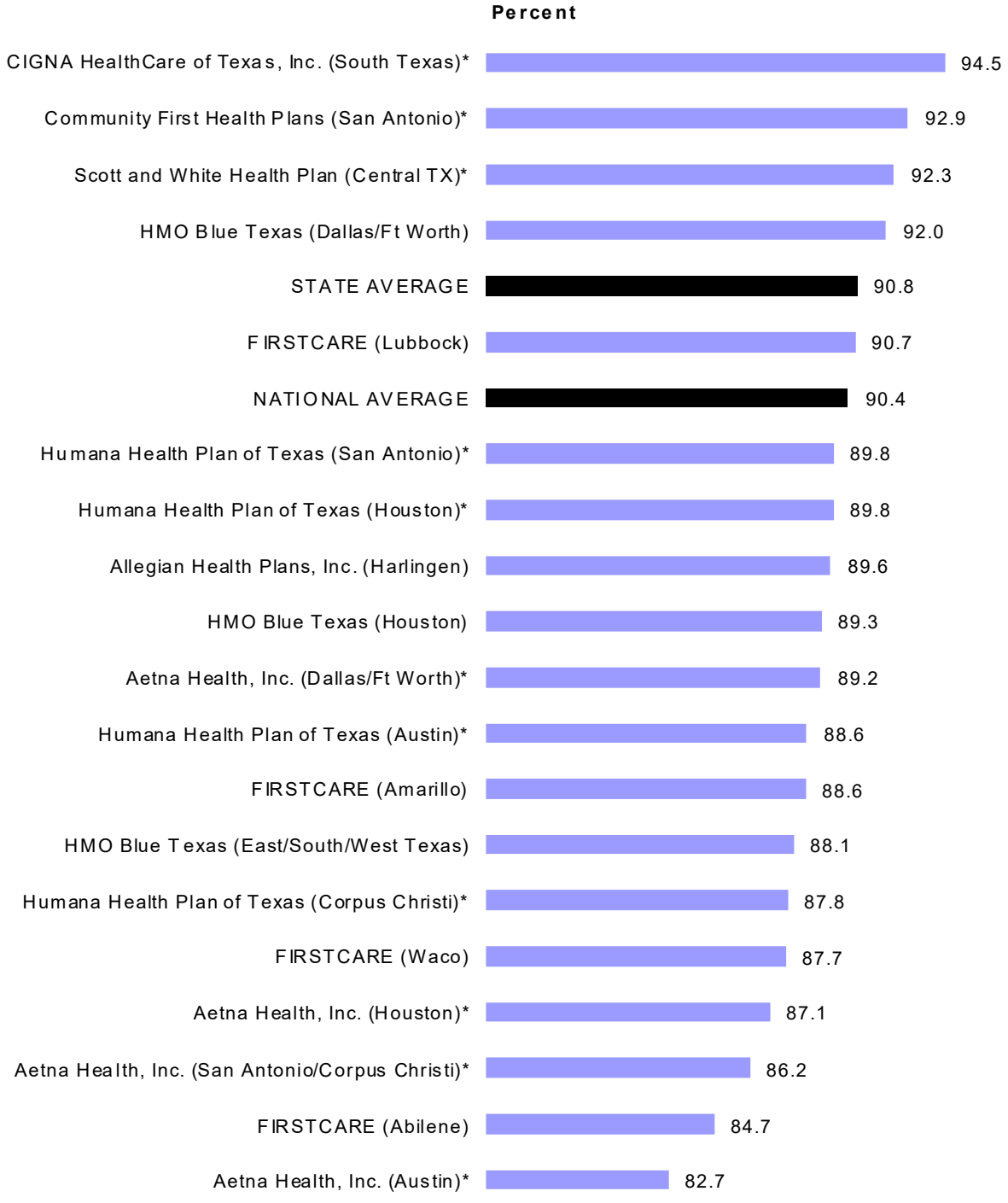
[1] National Institute of Diabetes and Digestive and Kidney Disease. *Glomerular Diseases*. Bethesda, MD: National Institutes of Health, 2014.

Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Comprehensive Diabetes Care: Medical Attention for Diabetic Nephropathy



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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

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.

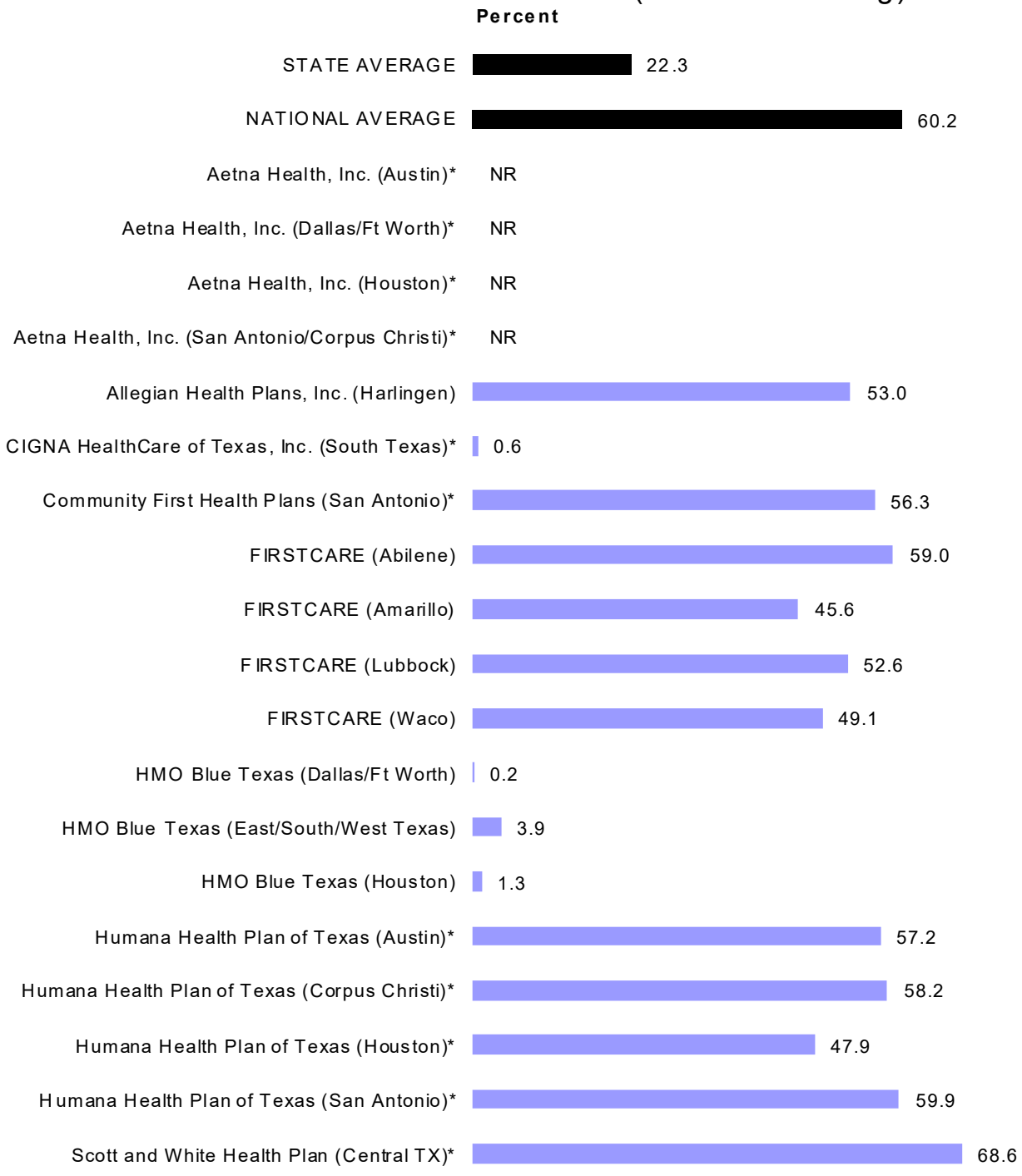
Adults with diabetes are two to four times more likely to have cardiovascular disease—heart disease or stroke—than individuals without diabetes. Blood pressure control can reduce the risk of heart attack and stroke as well as other diabetes related complications such as retinopathy (damage to the blood vessels in the retina) and nephropathy (damage to blood vessels in the kidneys).[1] The National Institutes of Health[2] recommends that individuals with diabetes maintain their blood pressure below 130/80 mm Hg.

Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	45.0%	47.4%	33.8%	42.8%	22.3%
NCQA's Quality Compass®	65.8%	66.5%	65.0%	64.6%	60.2%

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

[1] American Diabetes Association. *Living with Diabetes: High Blood Pressure (Hypertension).* Alexandria, VA: American Diabetes Association, 2014.
[2] National Heart, Lung, and Blood Institute. *Health Topics: High Blood Pressure*. Bethesda, MD: National Institutes of Health, 2015.

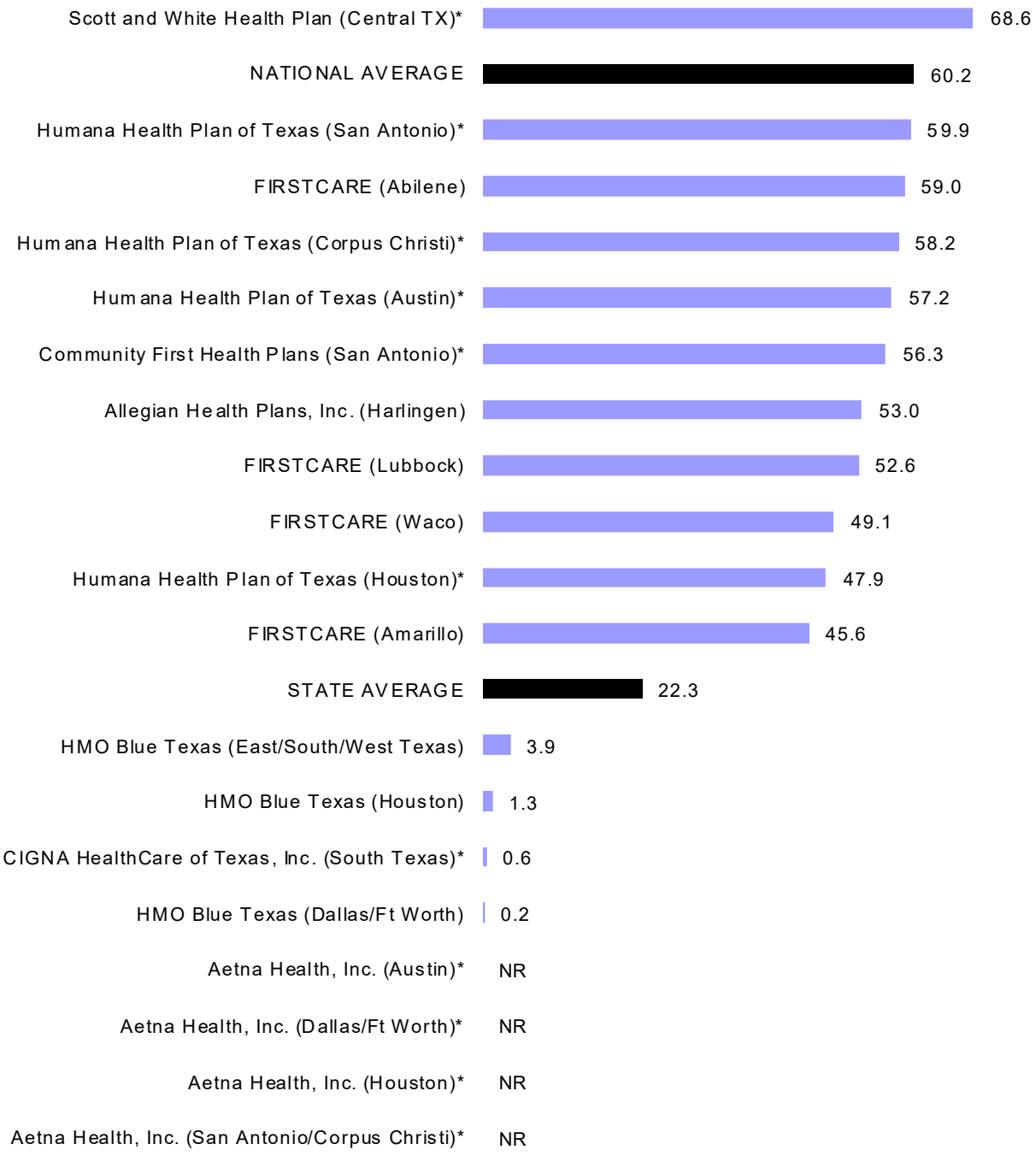
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

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

Percent



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Appropriate Testing for Children with Pharyngitis

Definition: Percentage of members 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Antibiotics can effectively treat diseases caused by bacteria, but not those caused by viruses. The overuse of antibiotics has increased bacterial resistance. In 1995, the Centers for Disease Control and Prevention began a campaign to educate physicians and patients on appropriate antibiotic use. While inappropriate antibiotic use has decreased, it still remains high.[1]

Most upper respiratory infections (URIs) are caused by viruses and cannot be treated with antibiotics. However, some physicians still prescribe antibiotics for these conditions. Pharyngitis (sore throat) can be caused by a virus or bacteria and a physician can definitively confirm the diagnosis with a lab test. Pediatric clinical practice guidelines recommend only treating children diagnosed with group A streptococcus pharyngitis (strep throat) with antibiotics.[2]

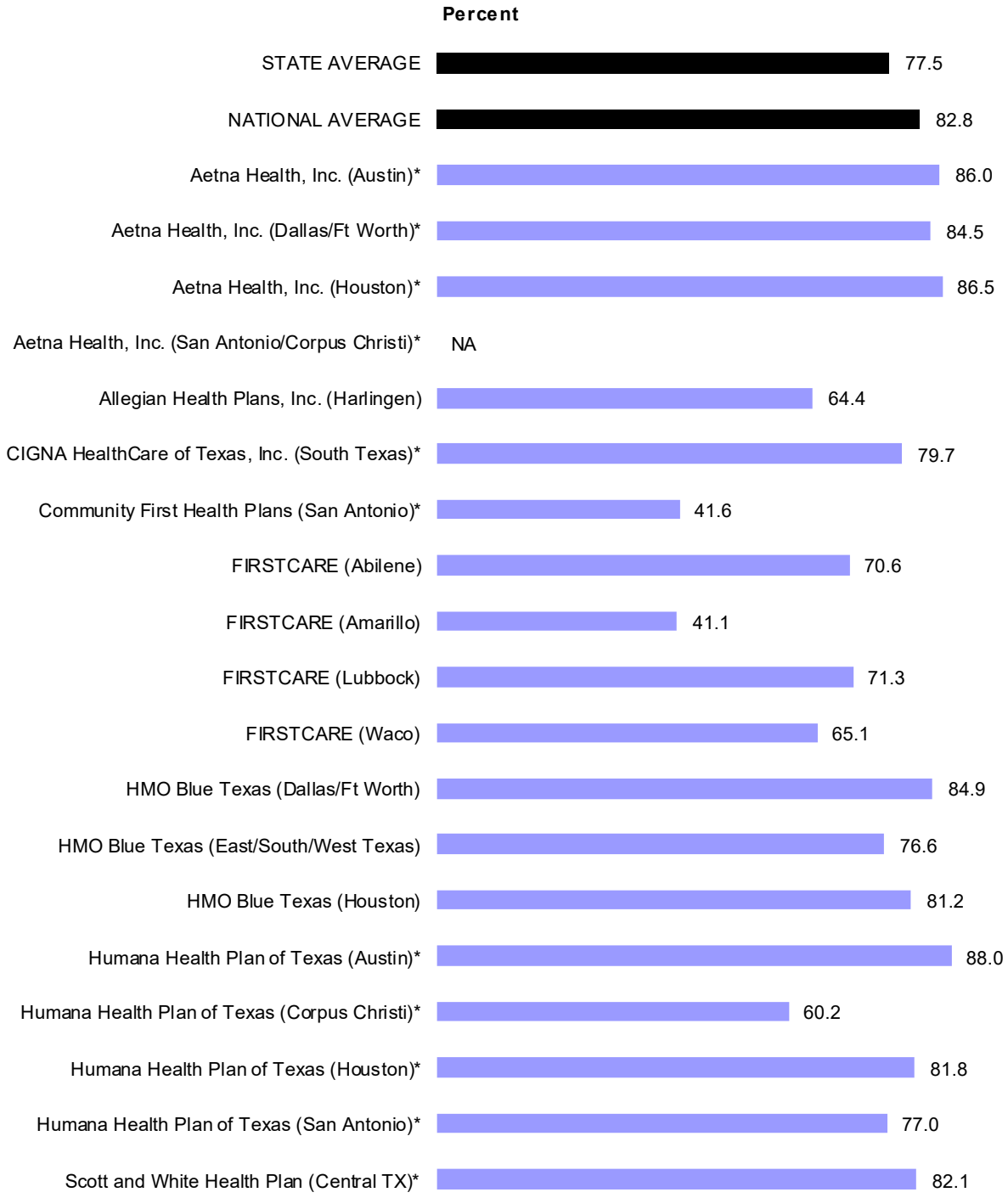
Antibiotic use to treat pharyngitis can serve as an important indicator of appropriate antibiotic use in children.

Appropriate Testing for Children with Pharyngitis					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	74.7%	75.3%	76.1%	76.4%	77.5%
NCQA's Quality Compass®	80.2%	80.2%	80.7%	82.4%	82.8%

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

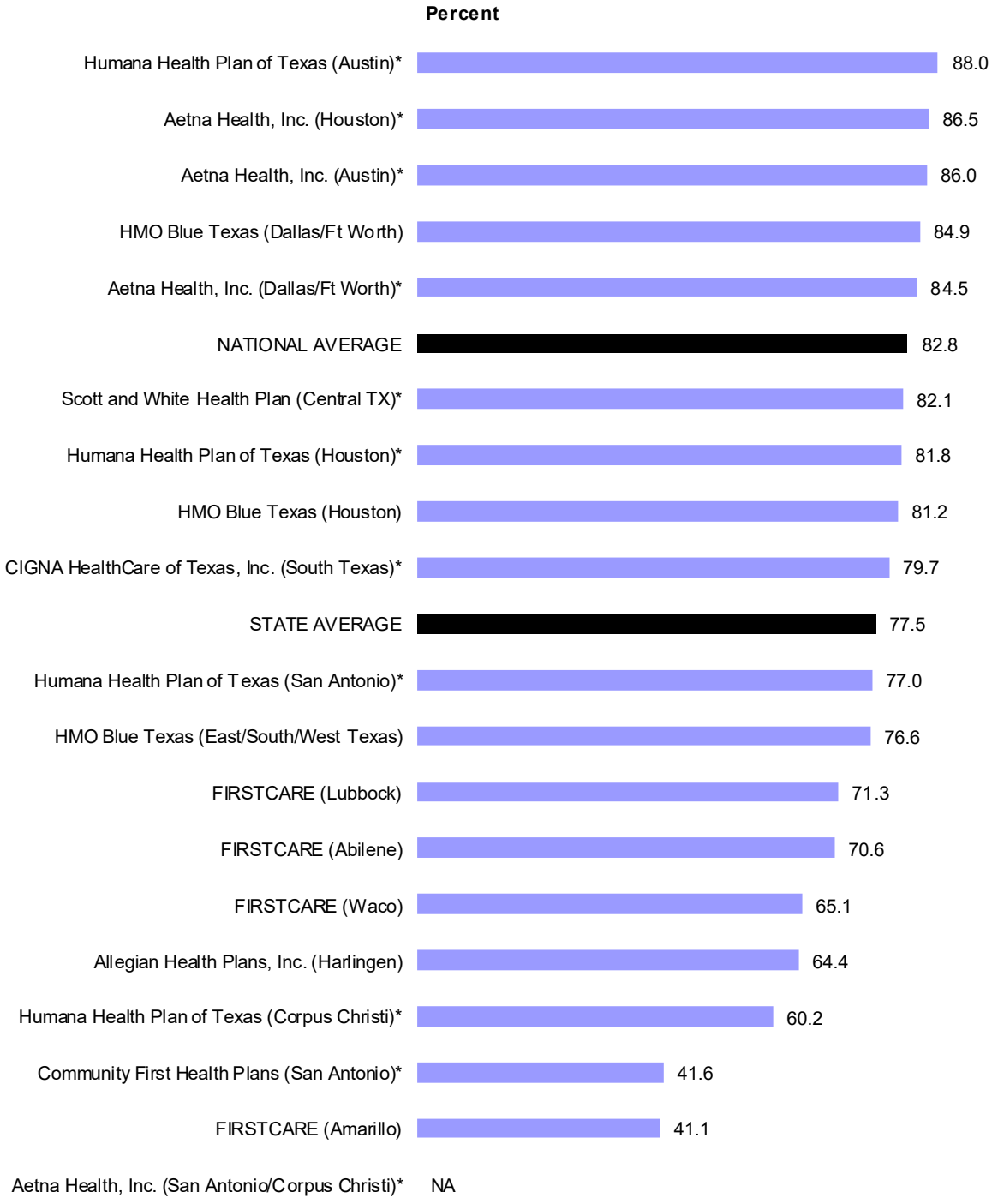
[1] Centers for Disease Control and Prevention. "Office Related Antibiotic Prescribing for Persons Aged ≤ 14 Years—United States, 1993–1994 to 2007–2008." *Morbidity and Mortality Weekly Report.* 60: 1153–1156 (2011).
[2] Ibid.

Appropriate Testing for Children with Pharyngitis



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Appropriate Testing for Children with Pharyngitis



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Appropriate Treatment for Children with Upper Respiratory Infection

Definition: Percentage of members 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Antibiotics can effectively treat diseases caused by bacteria, but not those caused by viruses. The overuse of antibiotics has increased bacterial resistance. In 1995, the Centers for Disease Control and Prevention began a campaign to educate physicians and patients on appropriate antibiotic use. While inappropriate antibiotic use has decreased, it still remains high.[1]

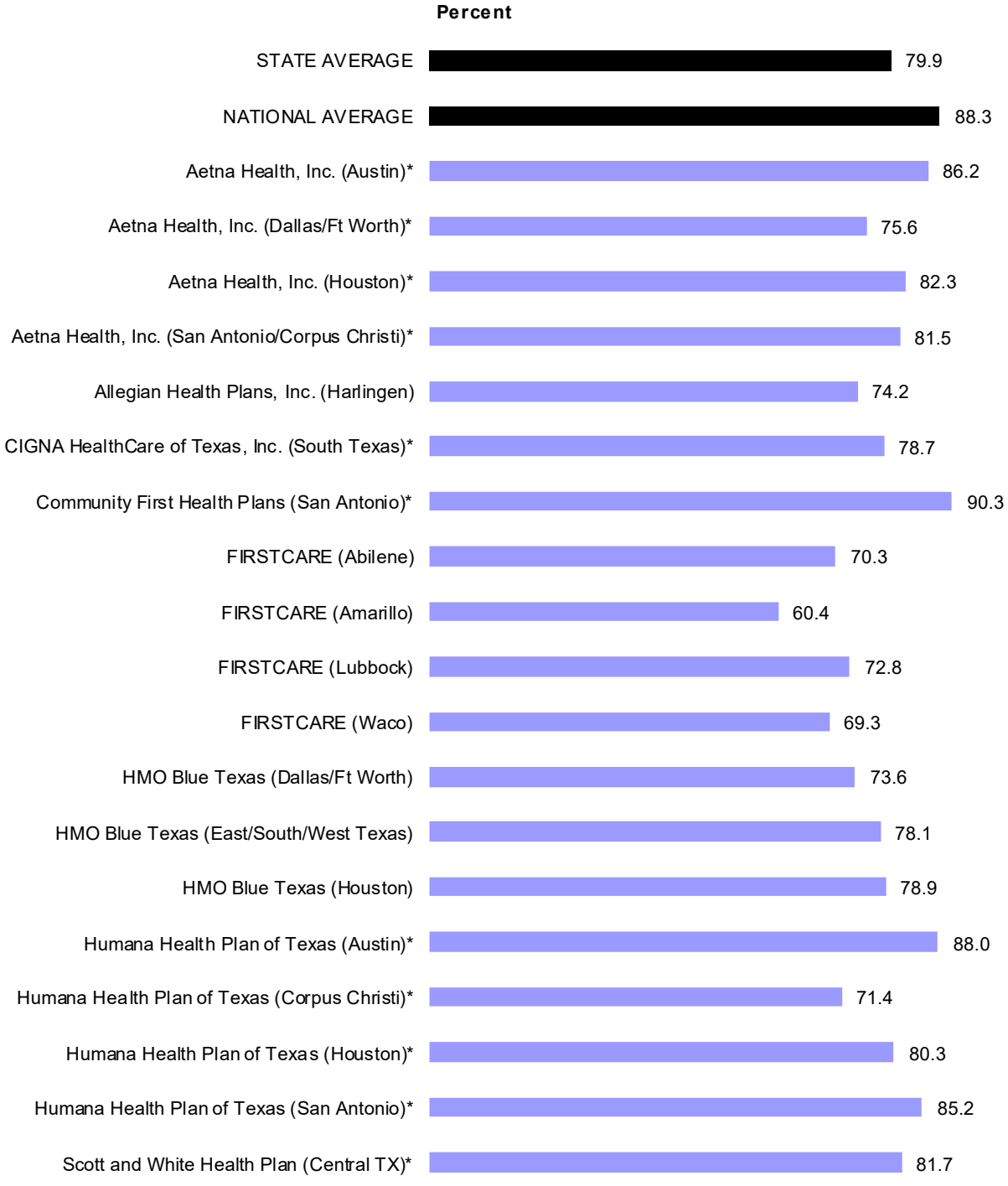
Most upper respiratory infections (URIs) are caused by viruses and cannot be treated with antibiotics. However, some physicians still prescribe antibiotics for these conditions, including the common cold (non-specific URI).[2] The incidence of antibiotic use to treat the common cold can serve as an important indicator of appropriate antibiotic use in children.

Appropriate Treatment for Children with Upper Respiratory Infection					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	74.6%	76.1%	75.9%	78.0%	79.9%
NCQA's Quality Compass®	83.9%	84.0%	85.2%	87.1%	88.3%

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

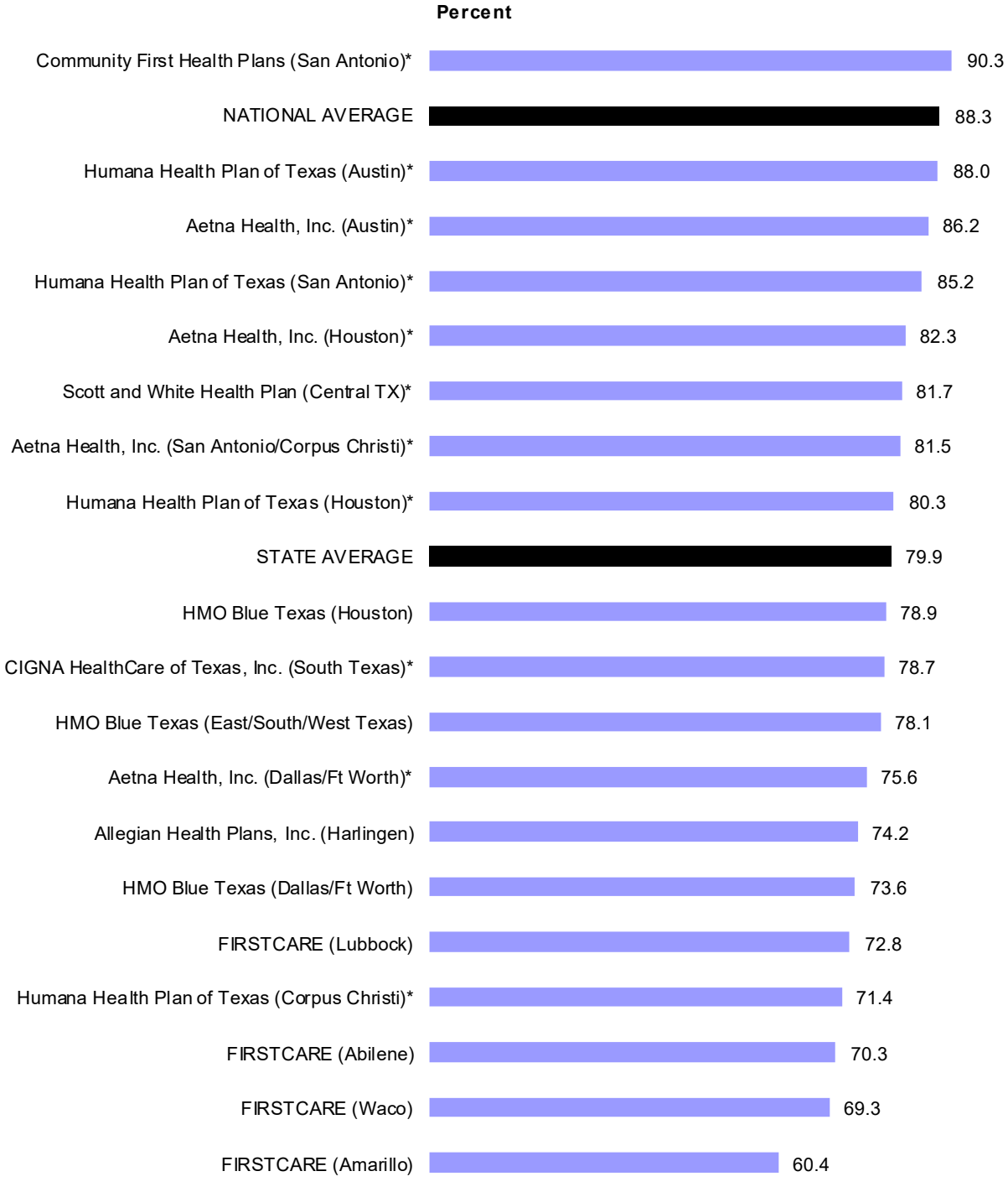
[1] Centers for Disease Control and Prevention. "Office Related Antibiotic Prescribing for Persons Aged ≤ 14 Years—United States, 1993–1994 to 2007–2008." *Morbidity and Mortality Weekly Report.* 60: 1153–1156 (2011).
[2] Ibid.

Appropriate Treatment for Children with Upper Respiratory Infection



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Appropriate Treatment for Children with Upper Respiratory Infection



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Definition: Percentage of members 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

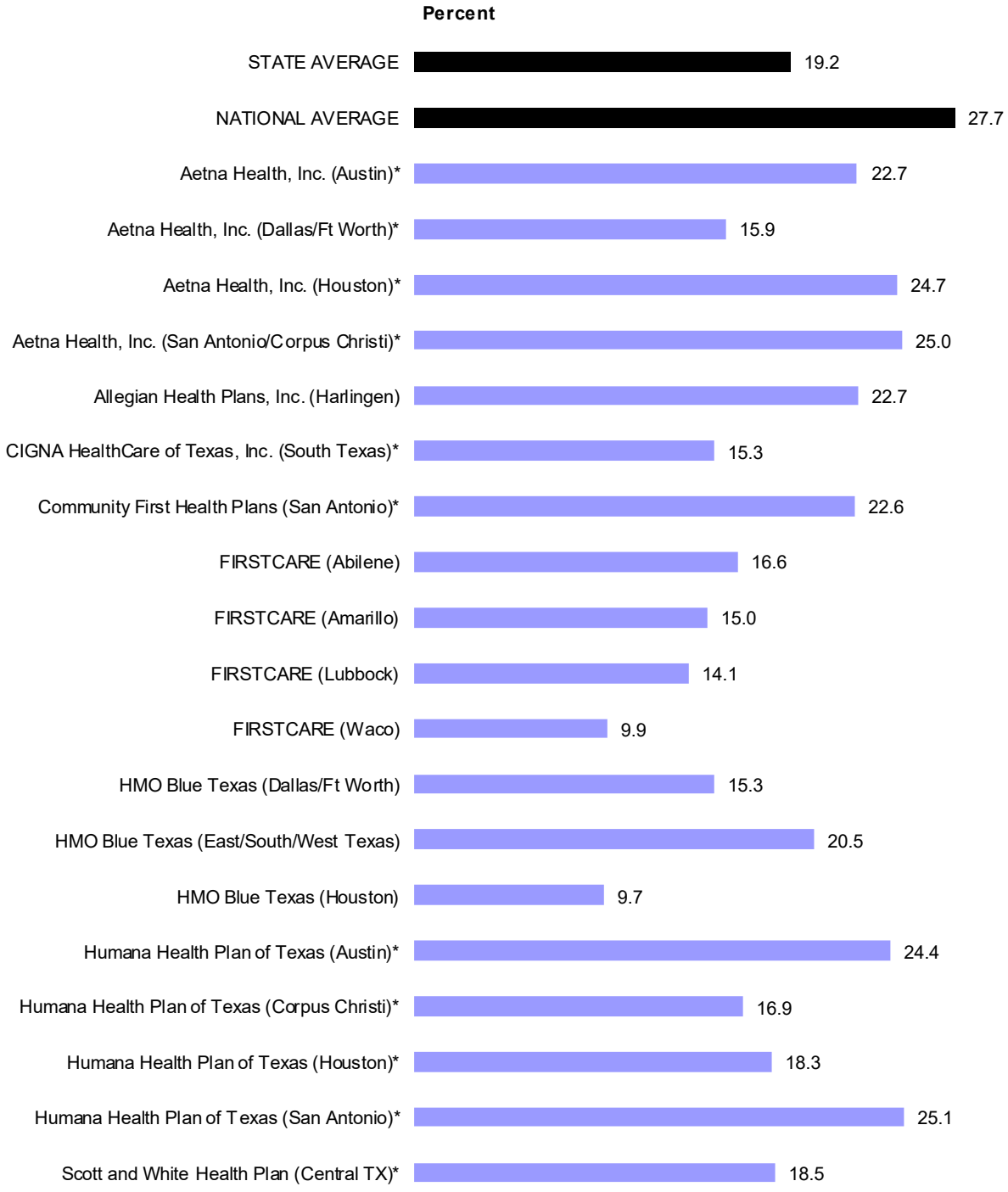
Acute bronchitis (chest cold) occurs when the bronchial tubes in the lungs become inflamed. The swelling often occurs after an upper respiratory illness like a cold. The symptoms include soreness in the chest, coughing, and low-grade fever. More than ninety percent of acute bronchitis cases are caused by a virus and should not be treated with an antibiotic.[1] The incidence of antibiotic use to treat acute bronchitis can serve as an important indicator of appropriate antibiotic use in adults.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	20.0%	19.6%	19.4%	19.1%	19.2%
NCQA's Quality Compass®	23.6%	24.6%	26.1%	27.7%	27.7%

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

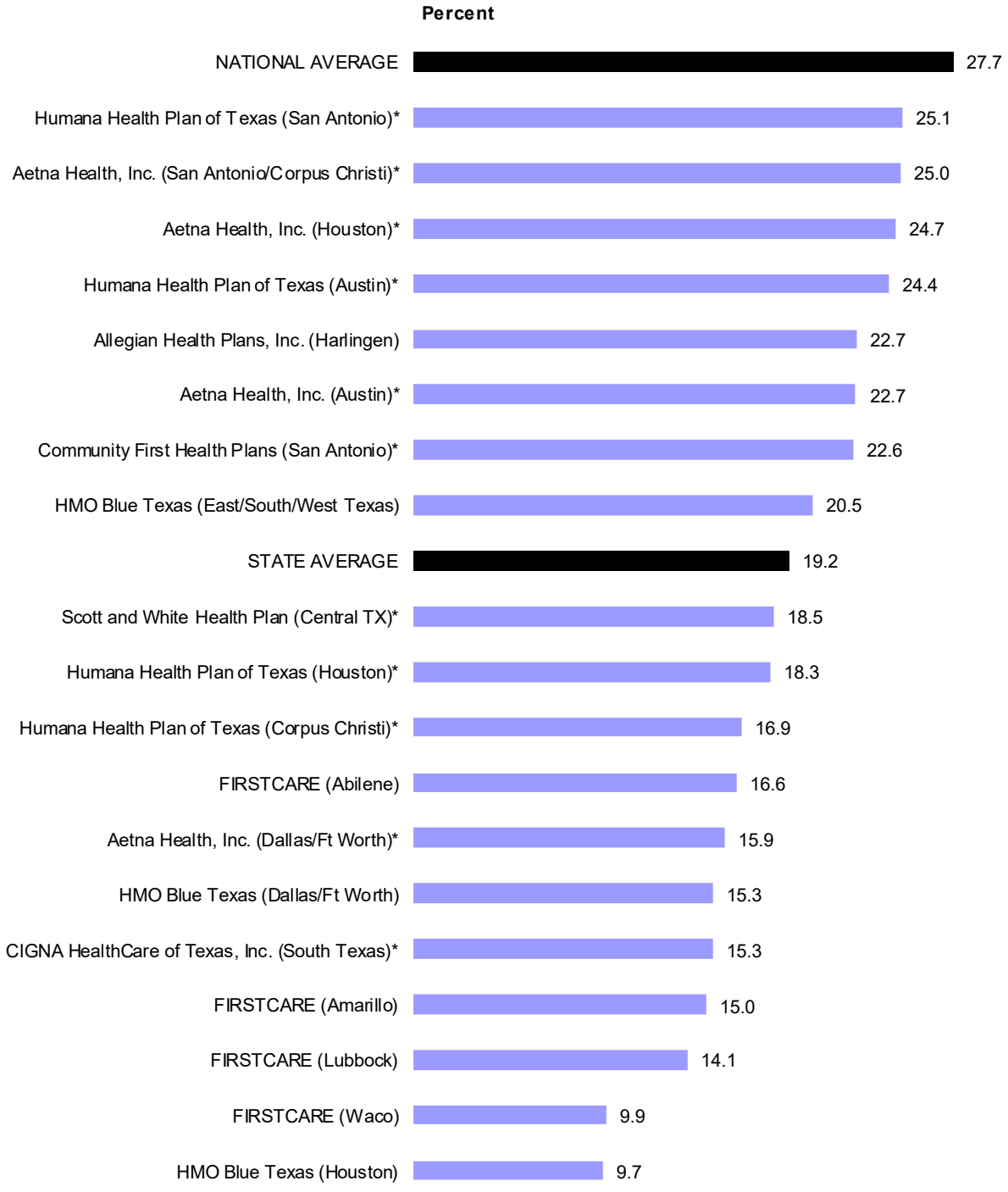
[1] Centers for Disease Control and Prevention. *Acute Cough Illness (Acute Bronchitis): Physician Information Sheet (Adults).* Atlanta, GA: Centers for Disease Control and Prevention, 2015.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Medication Management for People with Asthma: On Asthma Controller Medication for at Least 50% of Their Treatment Period

Definition: Percentage of members 5–85 years of age with persistent asthma who were dispensed appropriate medications who remained on an asthma controller medication for at least 50% of their treatment period.

Asthma is an obstructive lung disease caused by an increased reaction of the airways to various stimuli. Over 25 million Americans have asthma. About seven million are children under 18 years of age. Asthma accounts for millions of lost school and work days each year. Most individuals with asthma can manage the disease with long-term controller medications. Patient education regarding medication use, symptom management, and trigger avoidance can reduce the impact of the disease.[1]

This section reports the use of appropriate medications for people with asthma in the following groups: ages 5–11, ages 12–18, ages 19–50, ages 51–64, ages 65-85 and a combined rate for all ages.

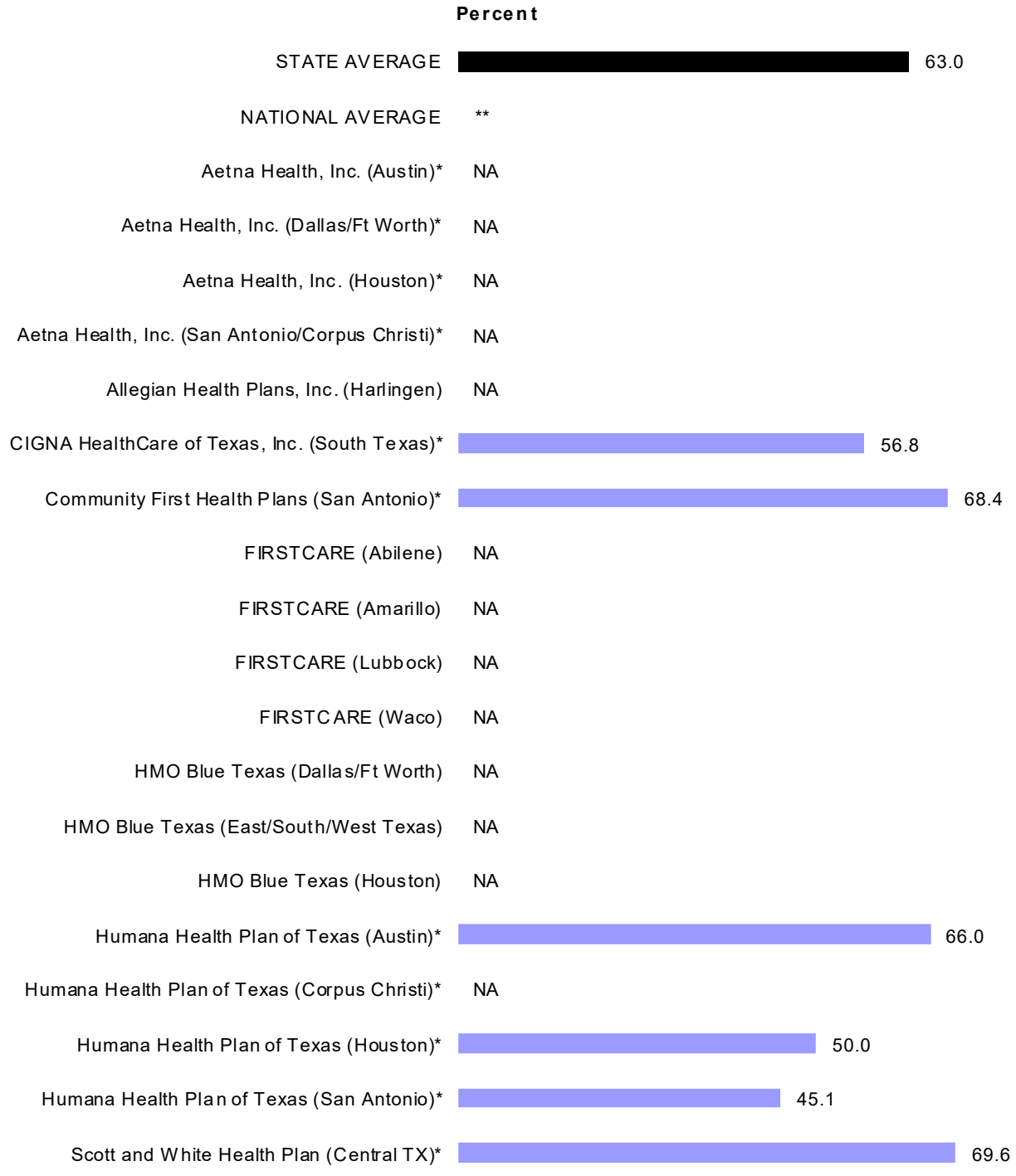
Medication Management for People with Asthma: Total		
	2015	**2016**
Texas Average	64.4%	69.8%
NCQA's Quality Compass®	**	**

This measure was added to the Texas Subset beginning with HEDIS® 2015.

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

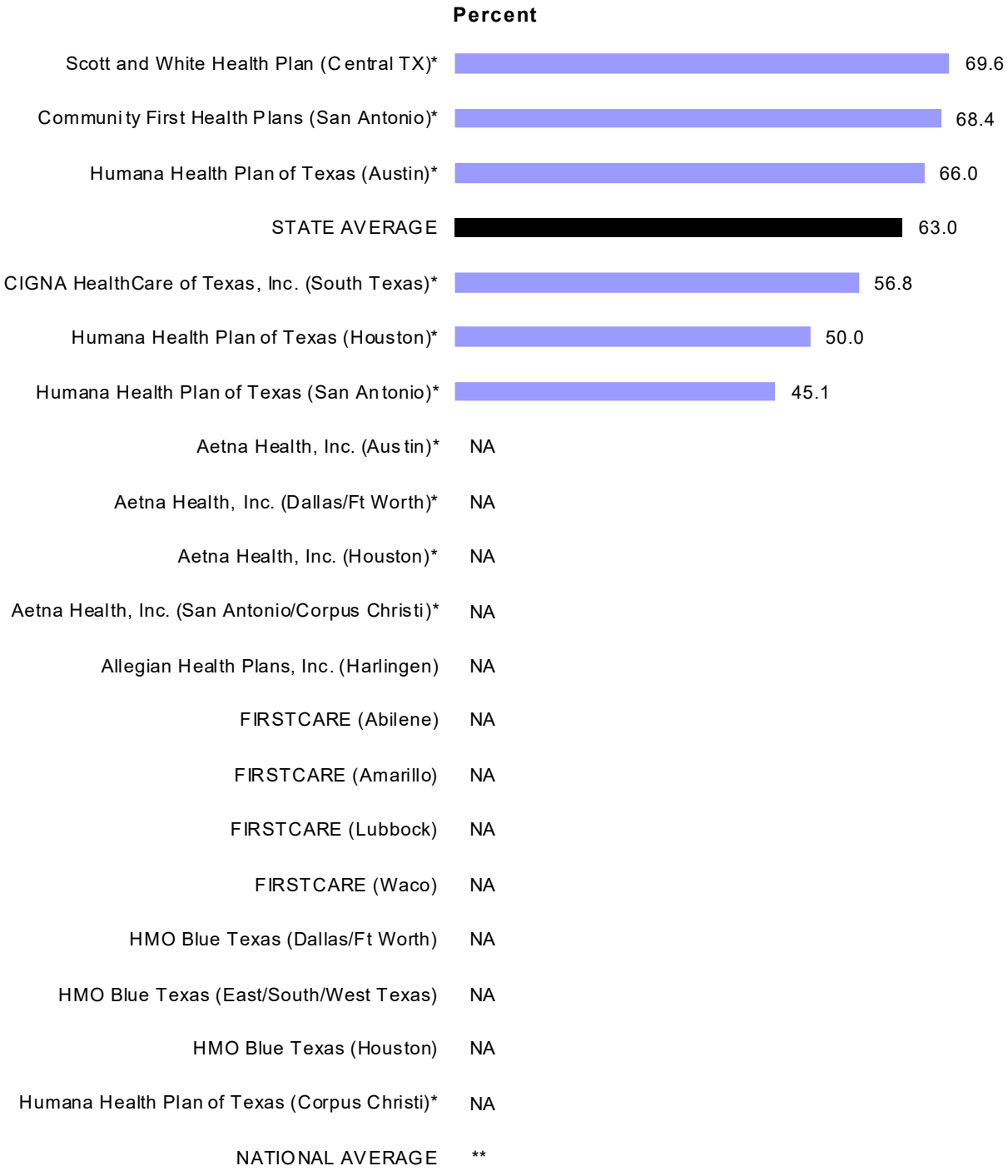
[1] National Heart, Lung, and Blood Institute. *Health Topics: Asthma.* Washington, DC: National Institutes of Health, 2014.

Medication Management for People with Asthma: 5-11



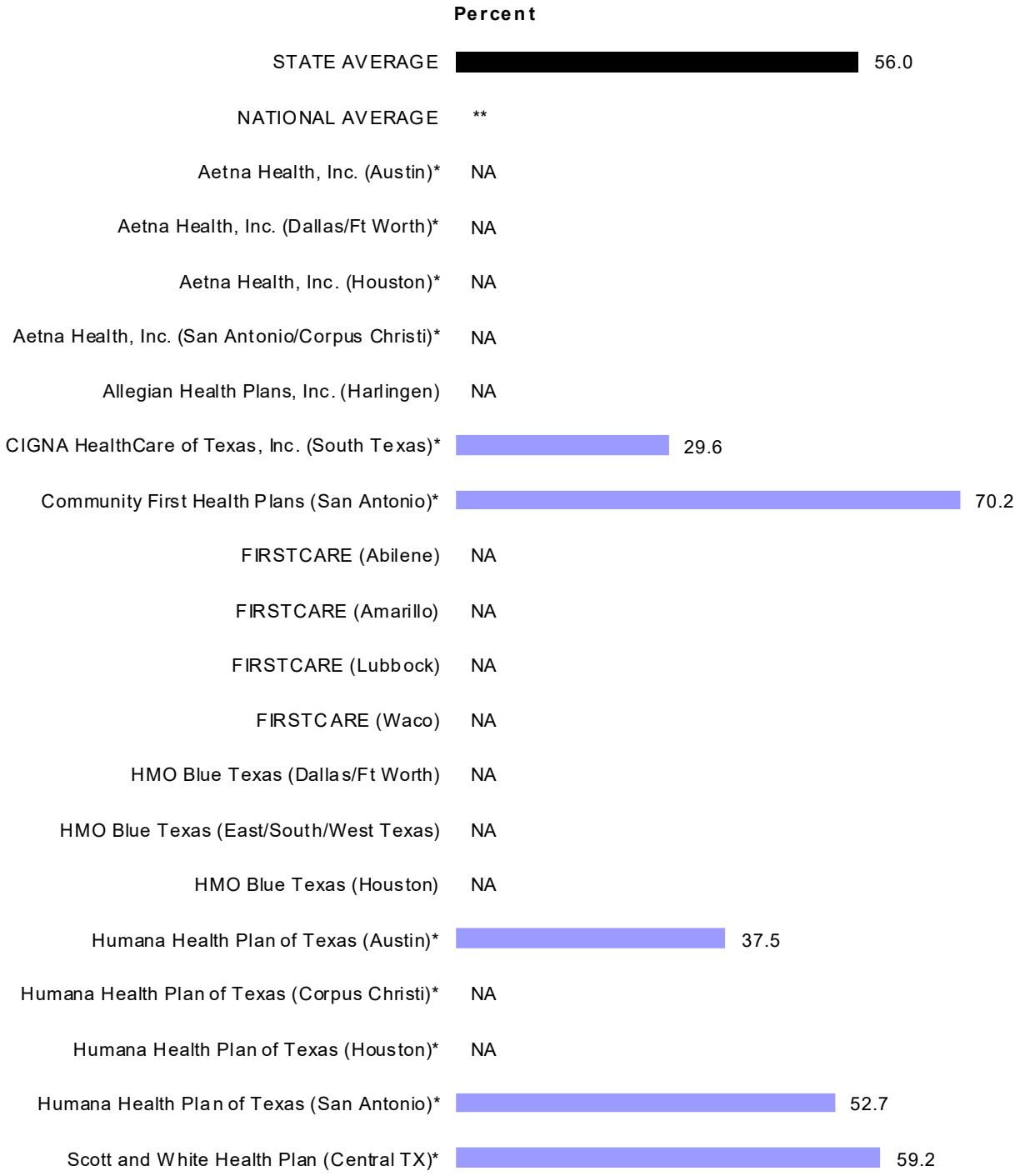
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 5-11



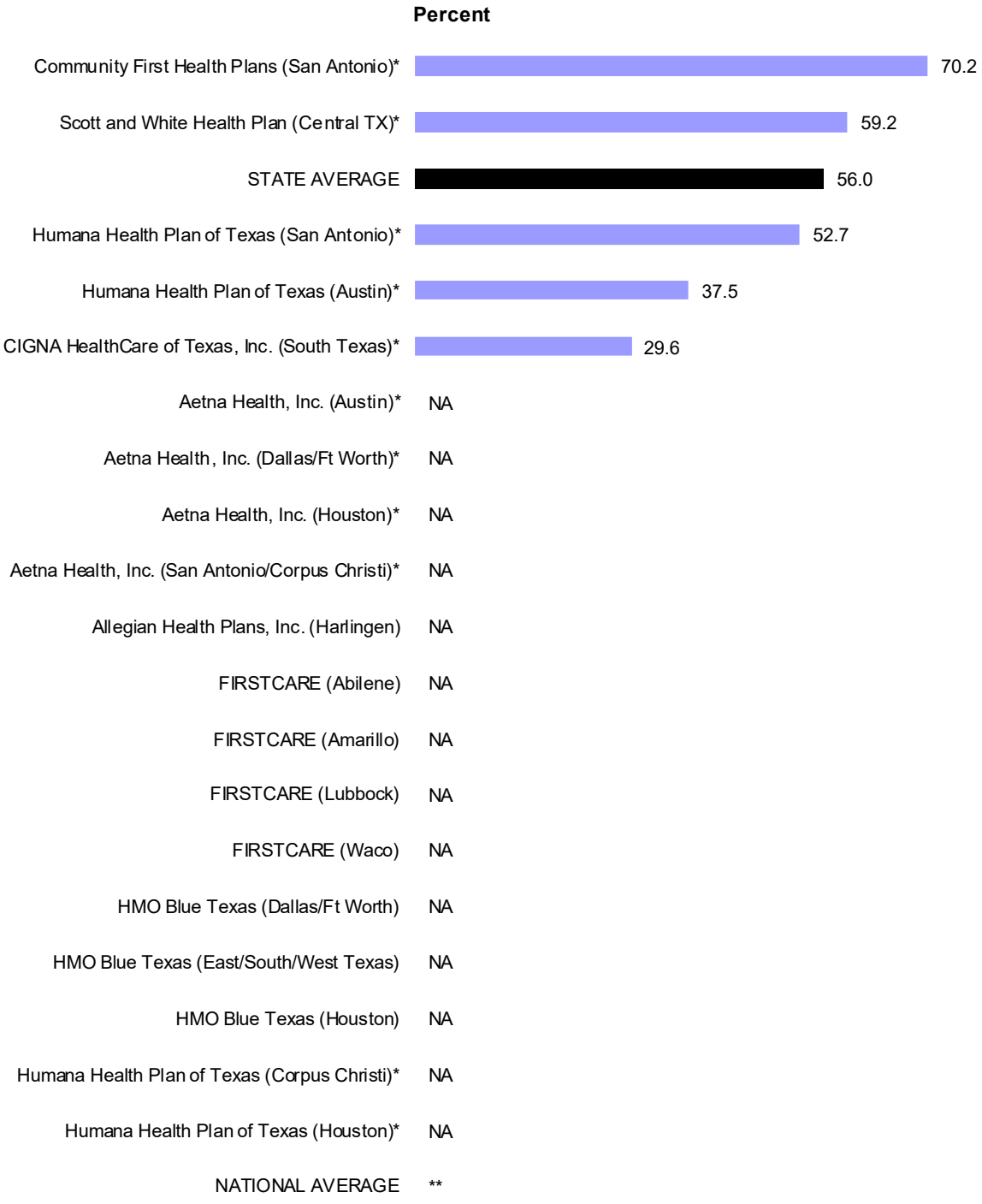
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 12-18



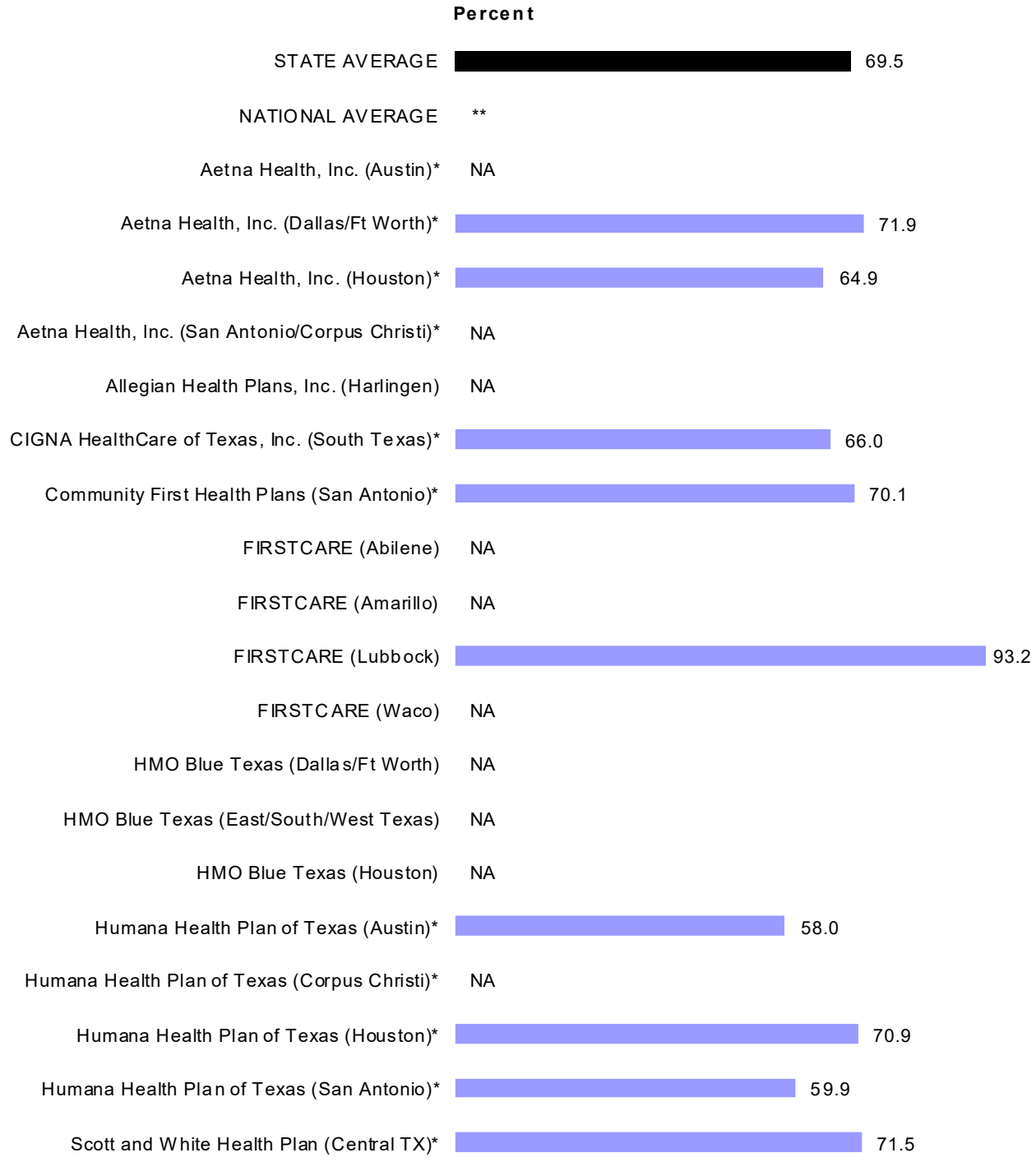
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 12-18



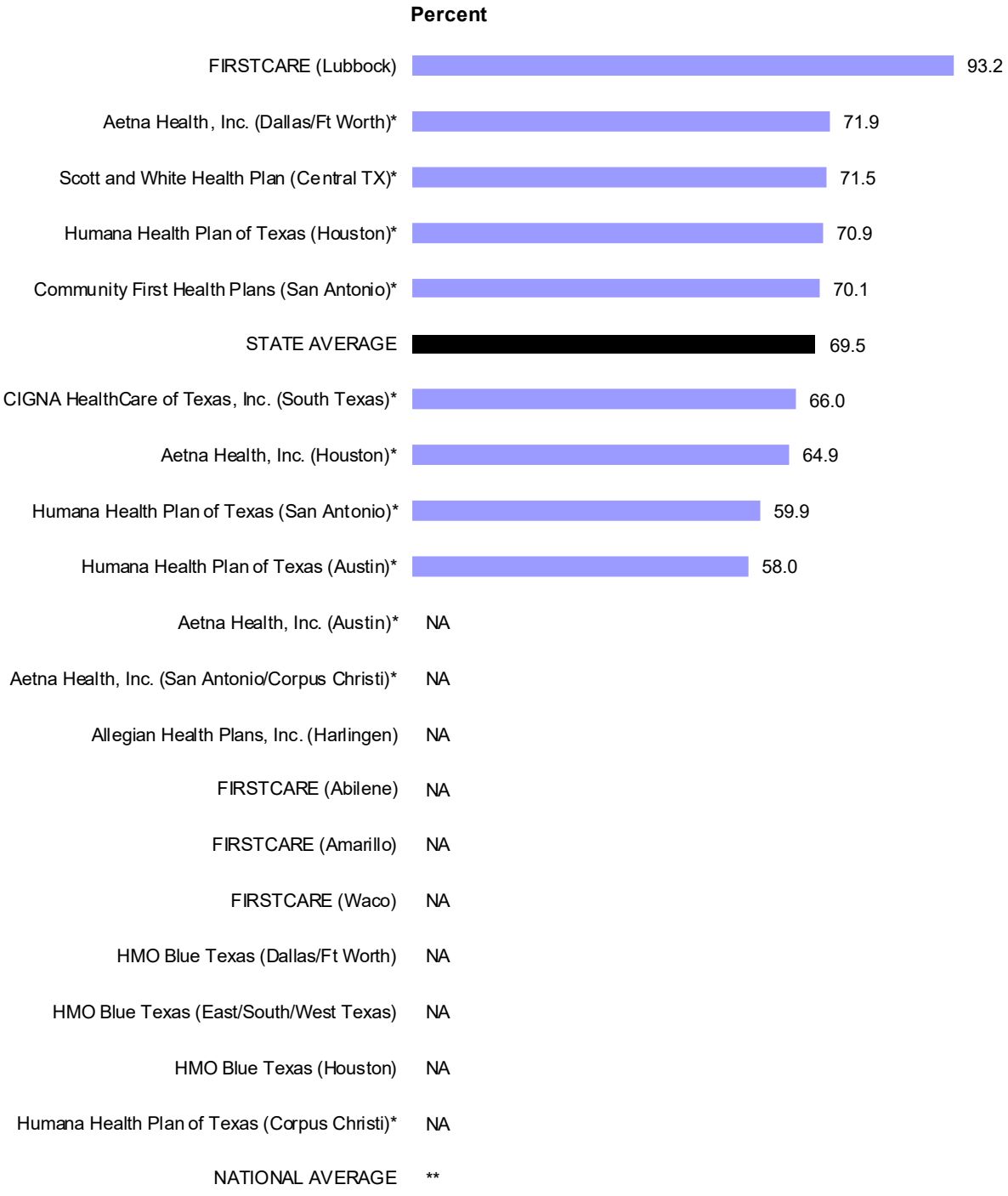
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 19-50



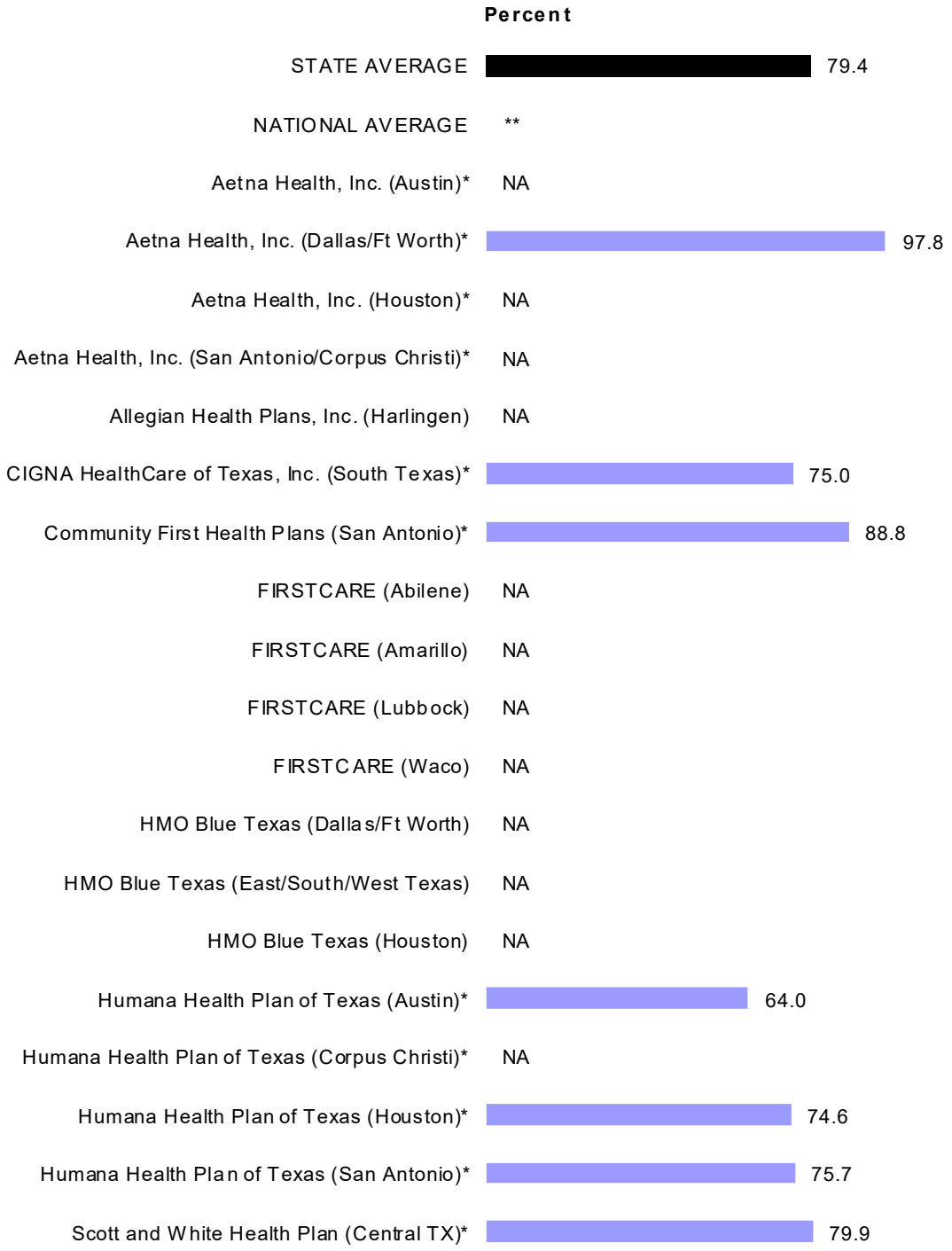
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 19-50



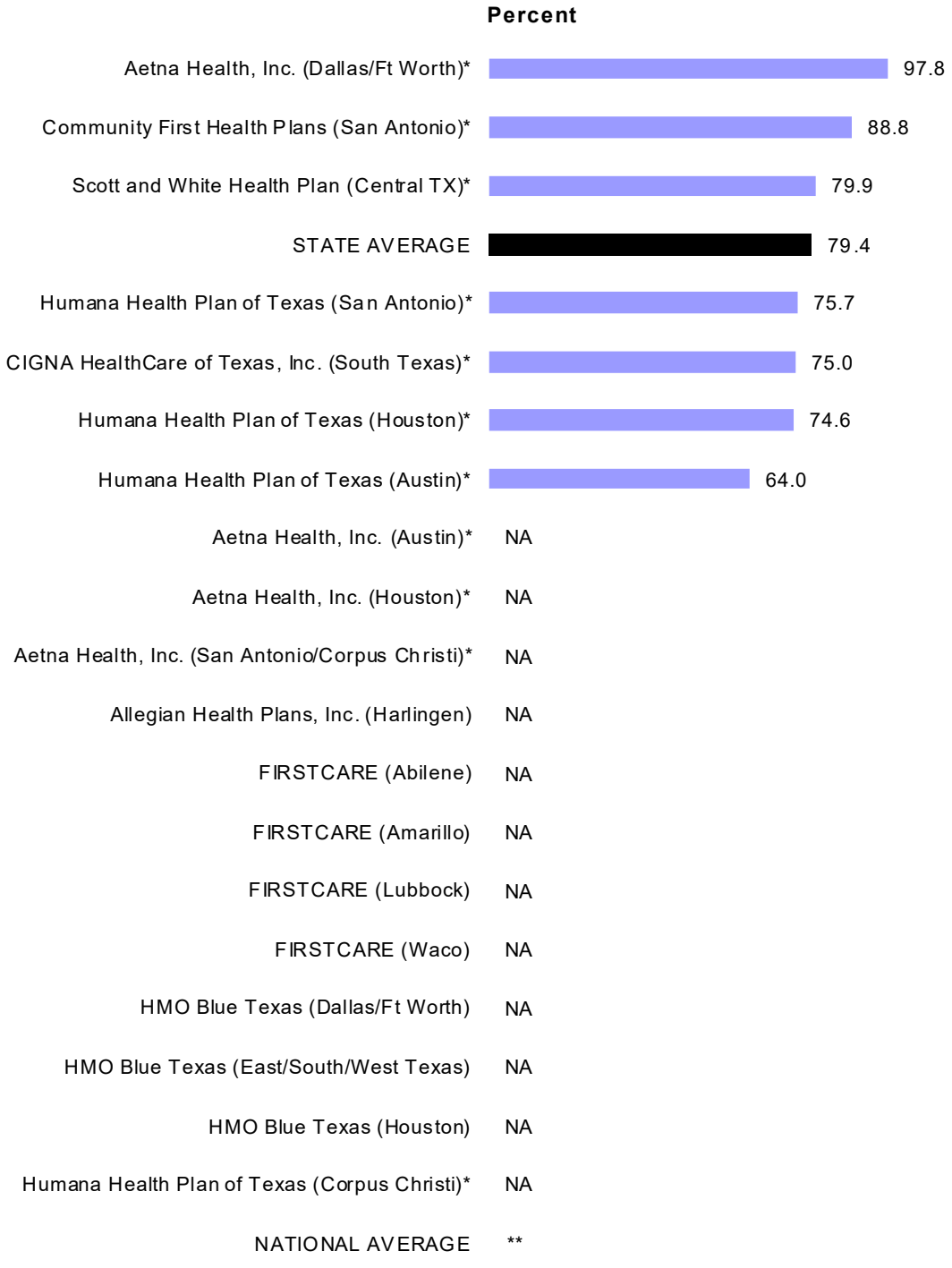
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 51-64



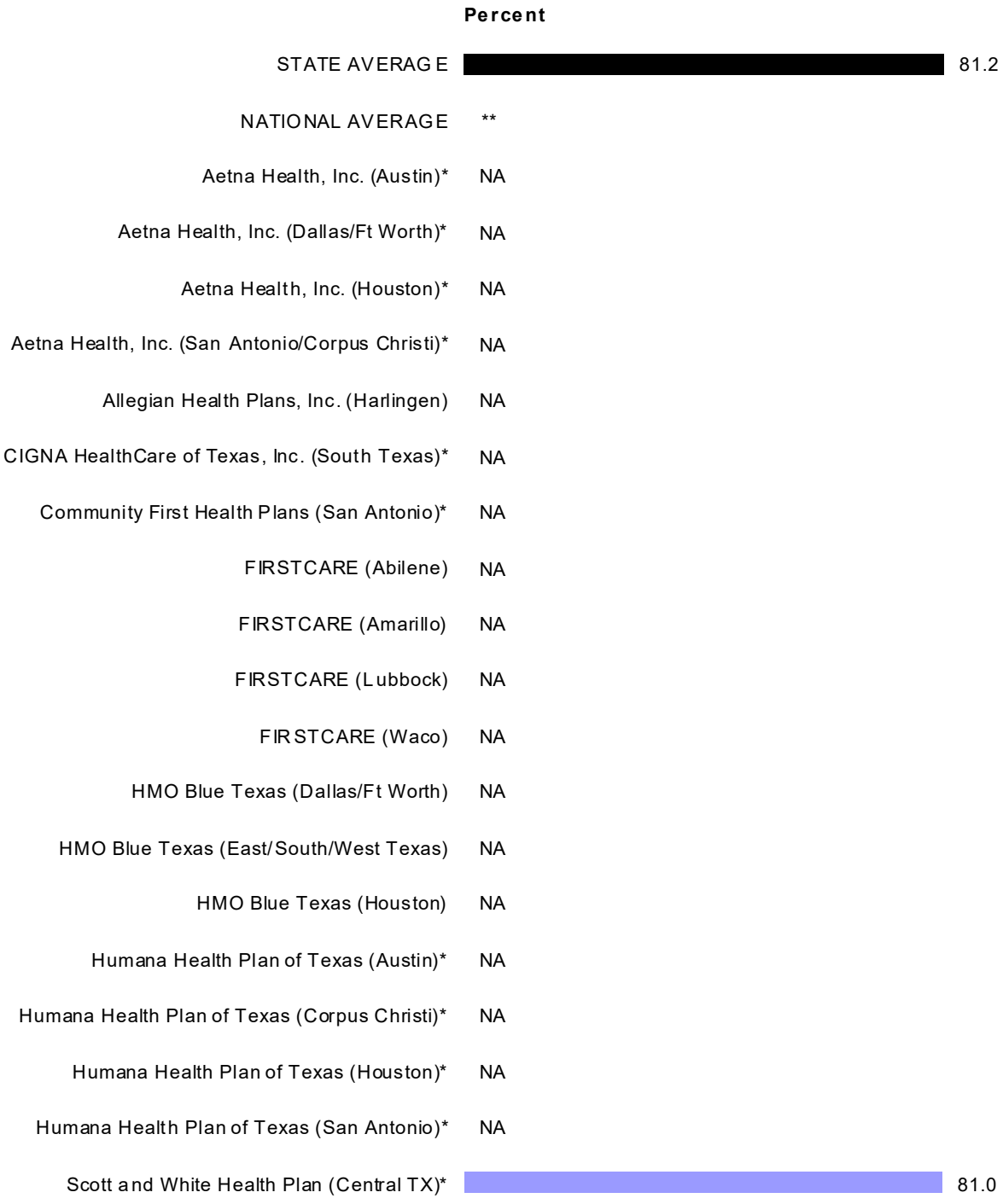
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 51-64



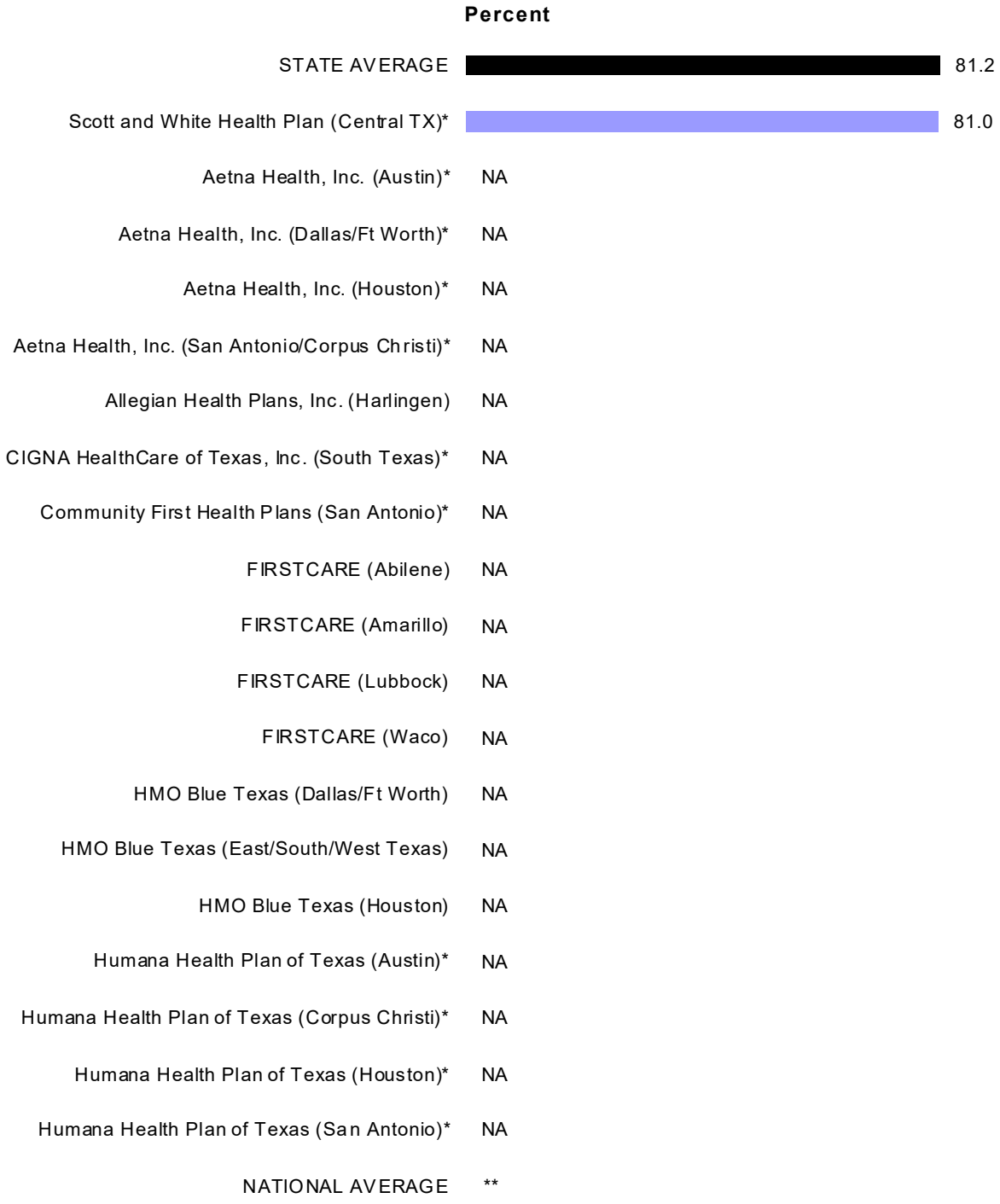
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 65-85



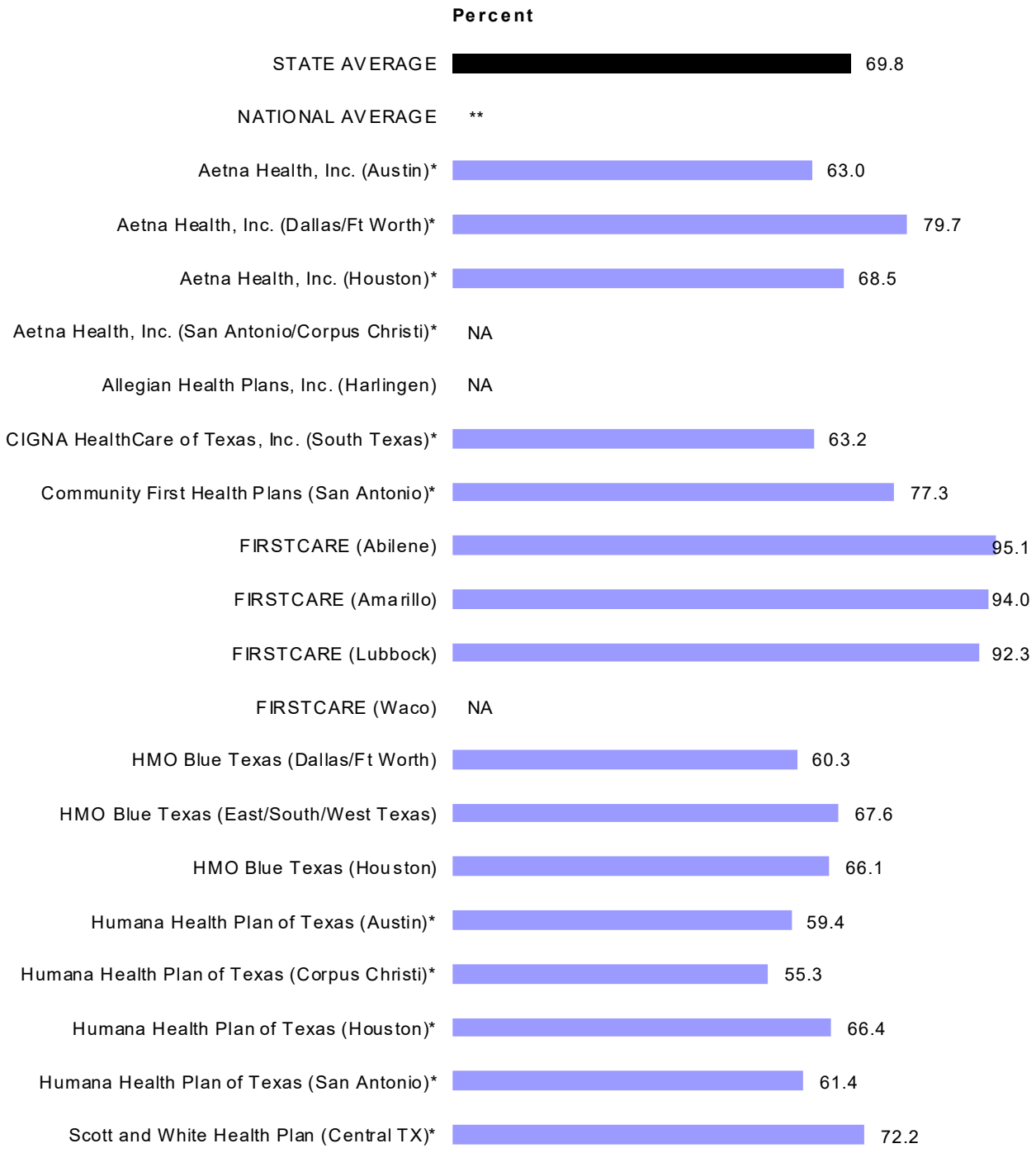
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 65-85



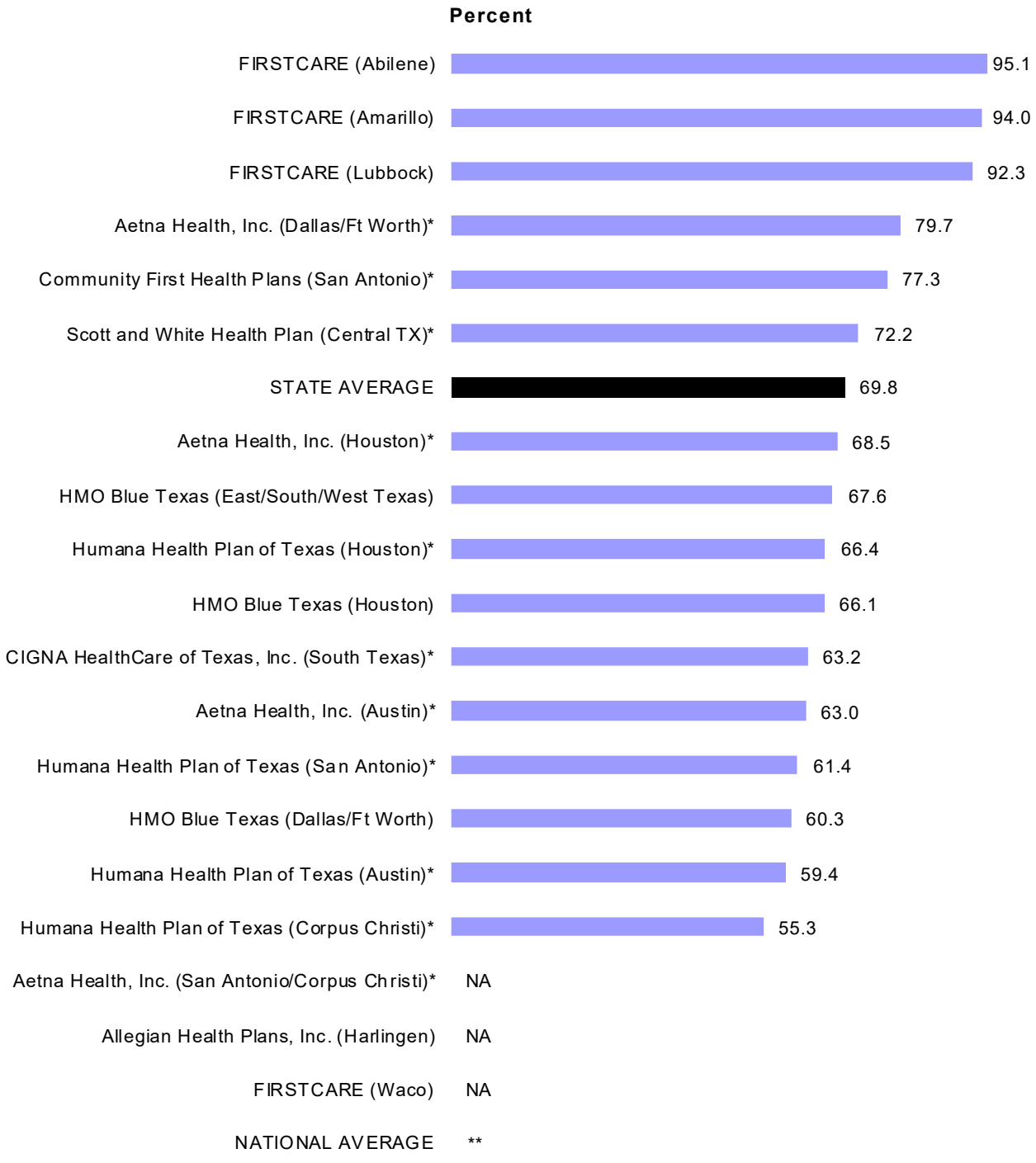
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: On Asthma Controller Medication for at Least 75% of Their Treatment Period

Definition: Percentage of members 5–85 years of age with persistent asthma who were dispensed appropriate medications who remained on an asthma controller medication for at least 75% of their treatment period.

Asthma is an obstructive lung disease caused by an increased reaction of the airways to various stimuli. Over 25 million Americans have asthma. About seven million are children under 18 years of age. Asthma accounts for millions of lost school and work days each year. Most individuals with asthma can manage the disease with long-term controller medications. Patient education regarding medication use, symptom management, and trigger avoidance can reduce the impact of the disease.[1]

This section reports the use of appropriate medications for people with asthma in the following groups: ages 5–11, ages 12–18, ages 19–50, ages 51–64, ages 65-85 and a combined rate for all ages.

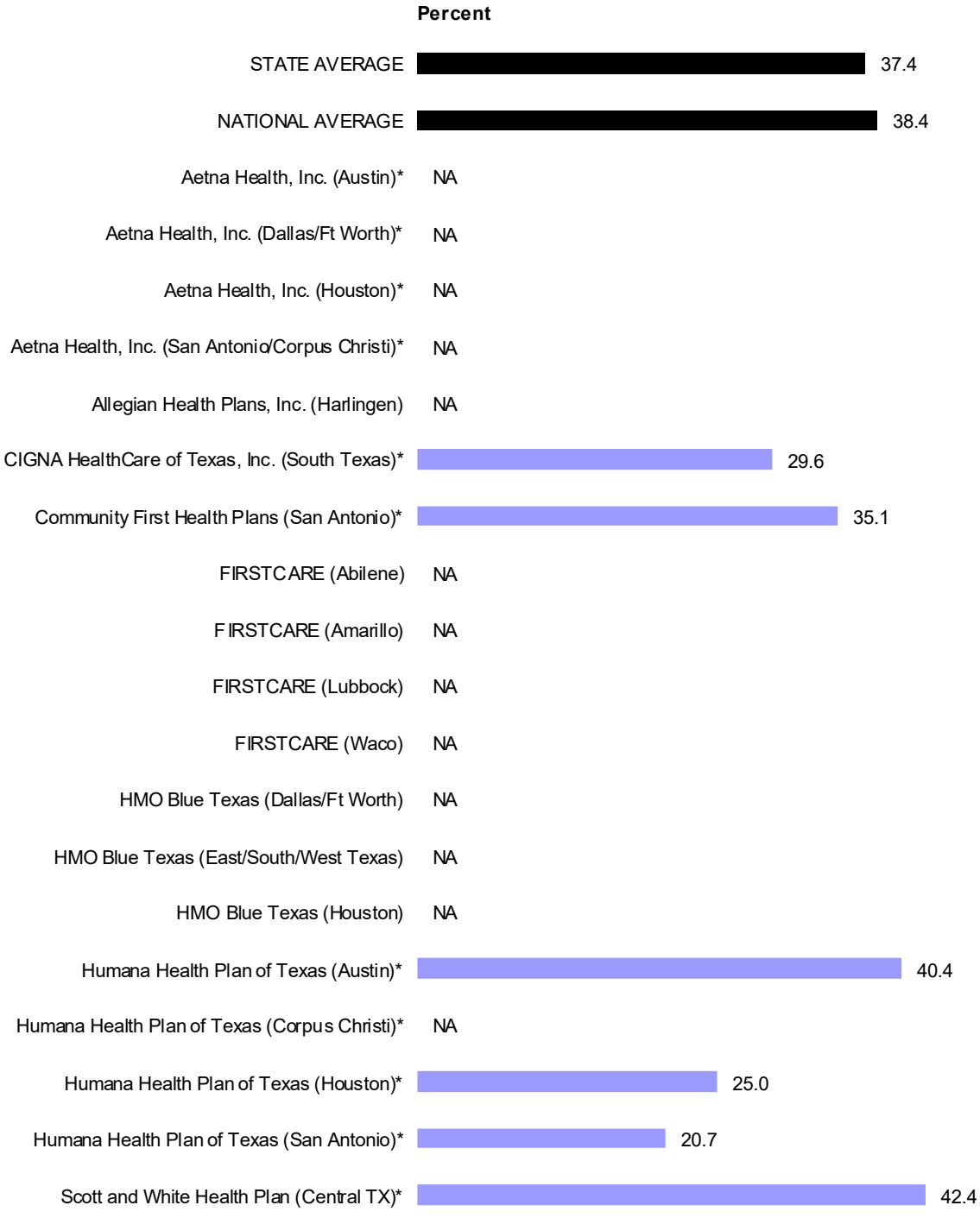
Medication Management for People with Asthma: Total		
	2015	**2016**
Texas Average	40.2%	46.3%
NCQA's Quality Compass®	44.6%	46.3%

This measure was added to the Texas Subset beginning with HEDIS® 2015.

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

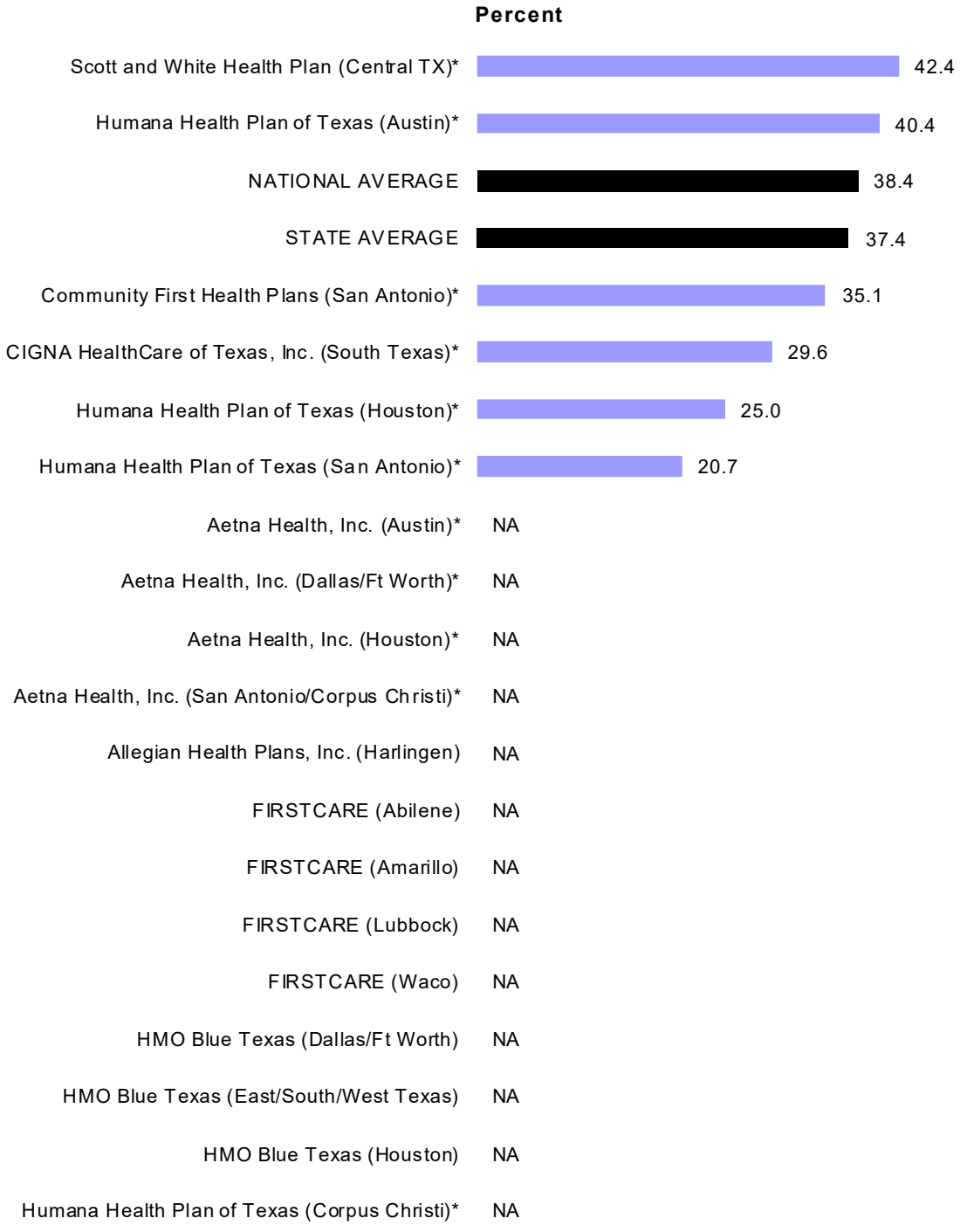
[1] National Heart, Lung, and Blood Institute. *Health Topics: Asthma.* Washington, DC: National Institutes of Health, 2014.

Medication Management for People with Asthma: 5-11



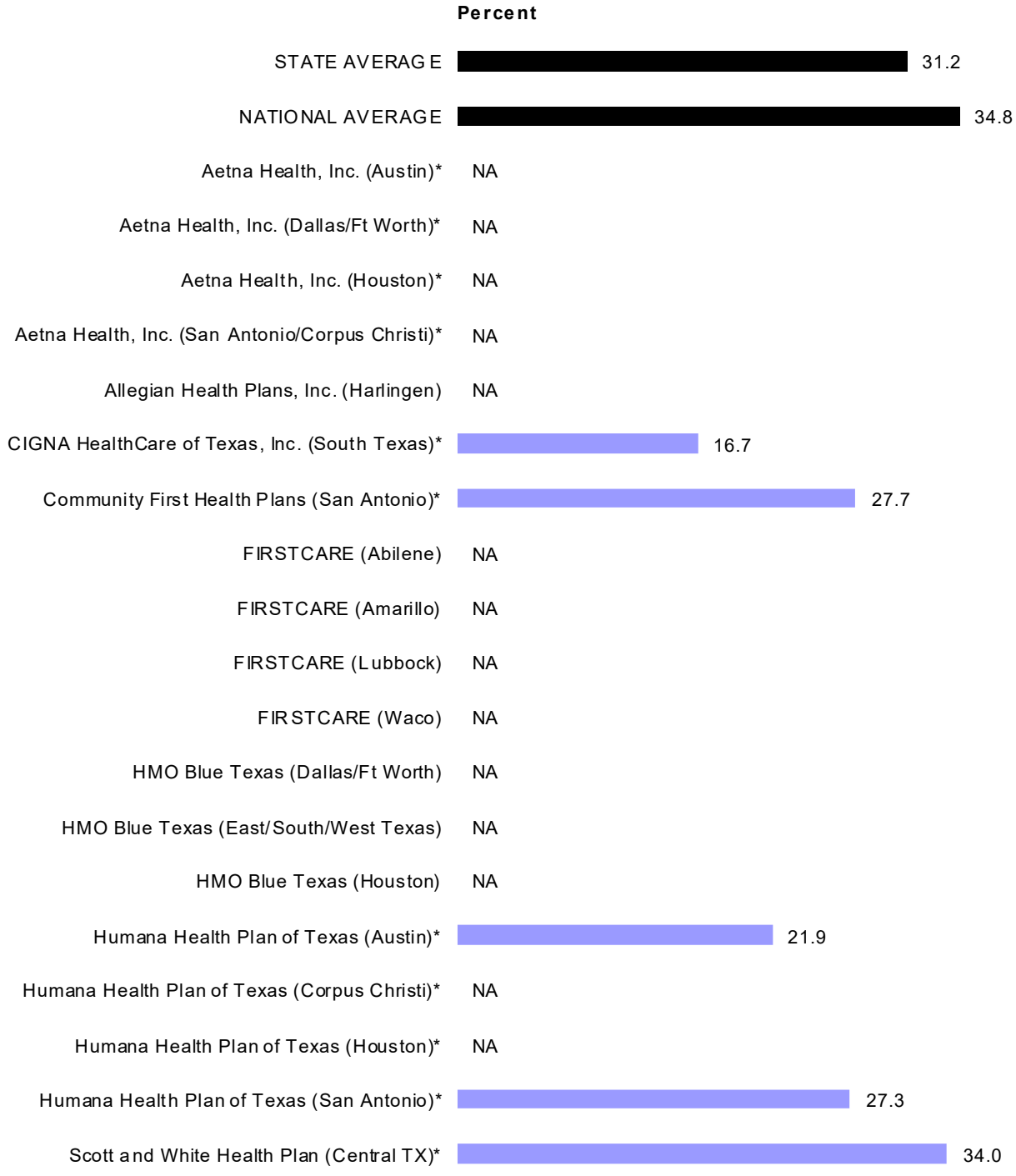
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 5-11



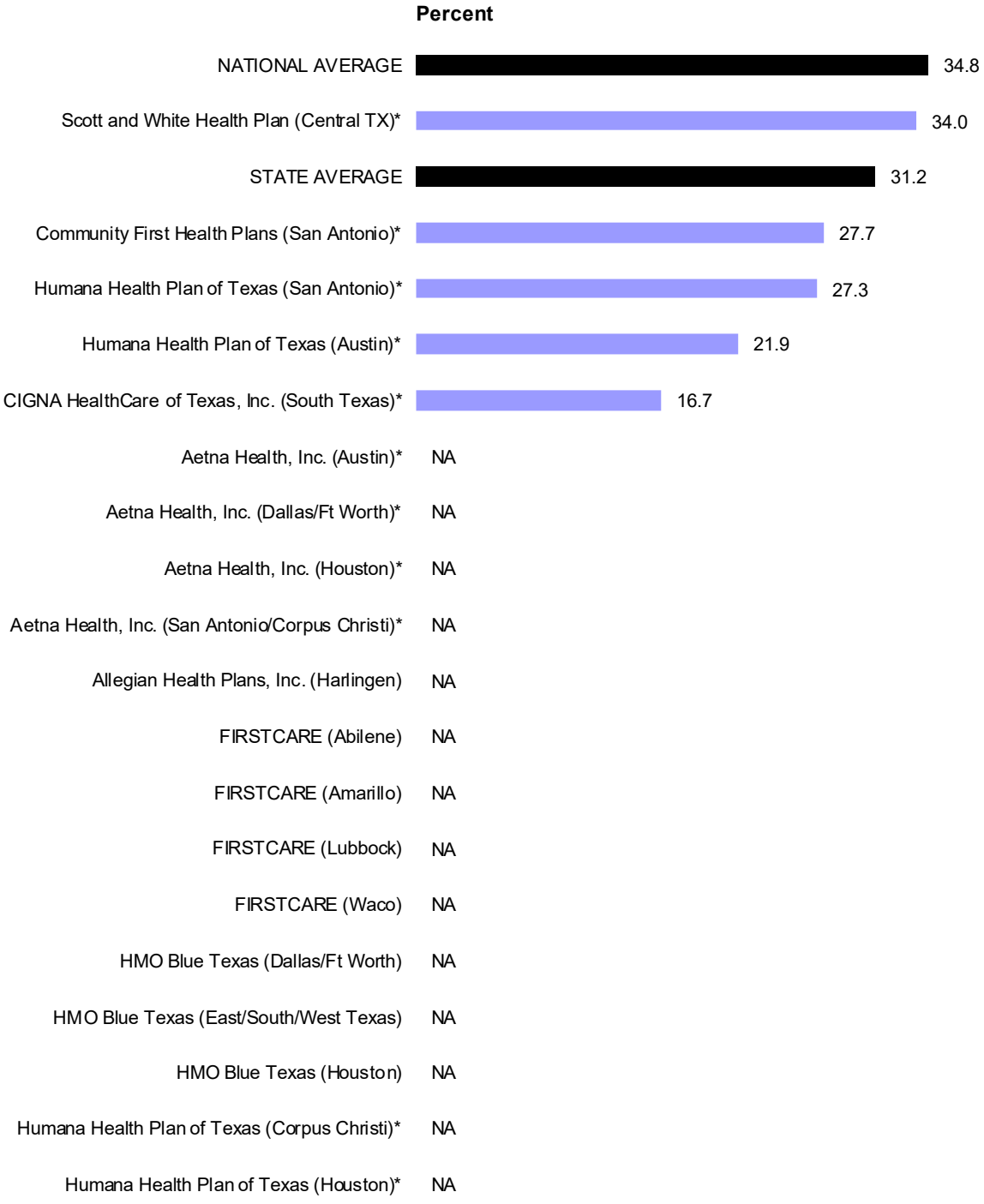
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 12-18



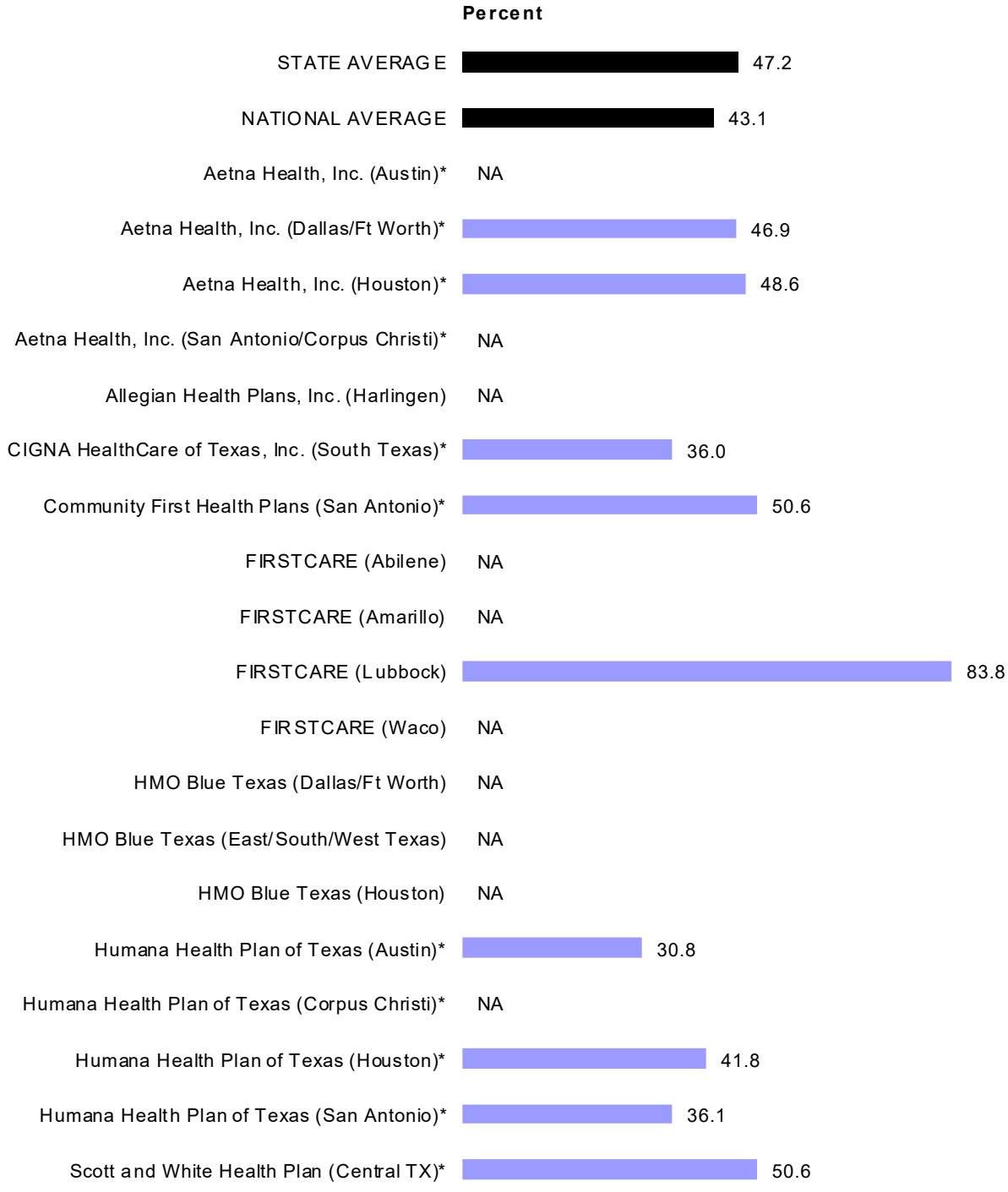
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 12-18



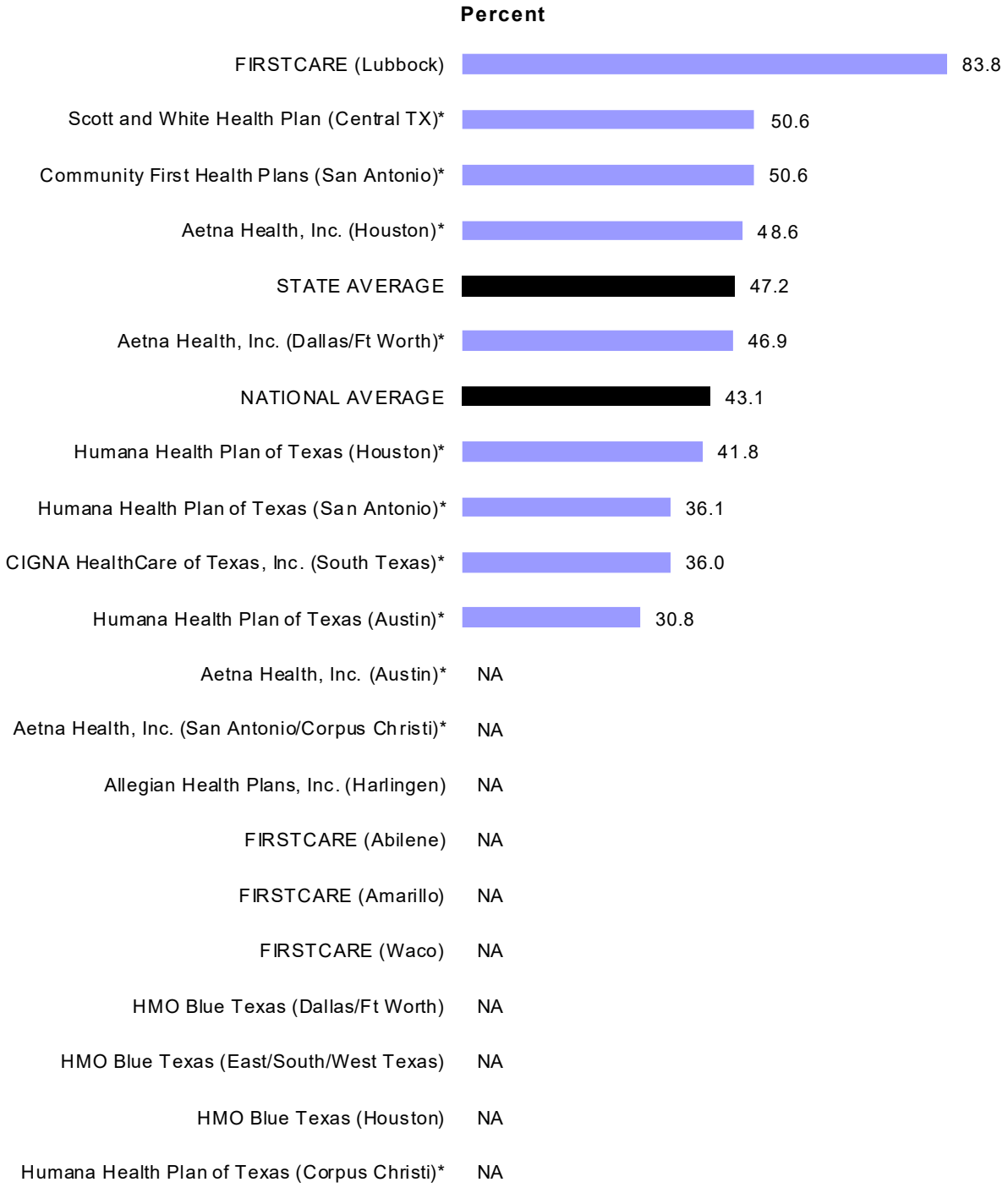
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 19-50



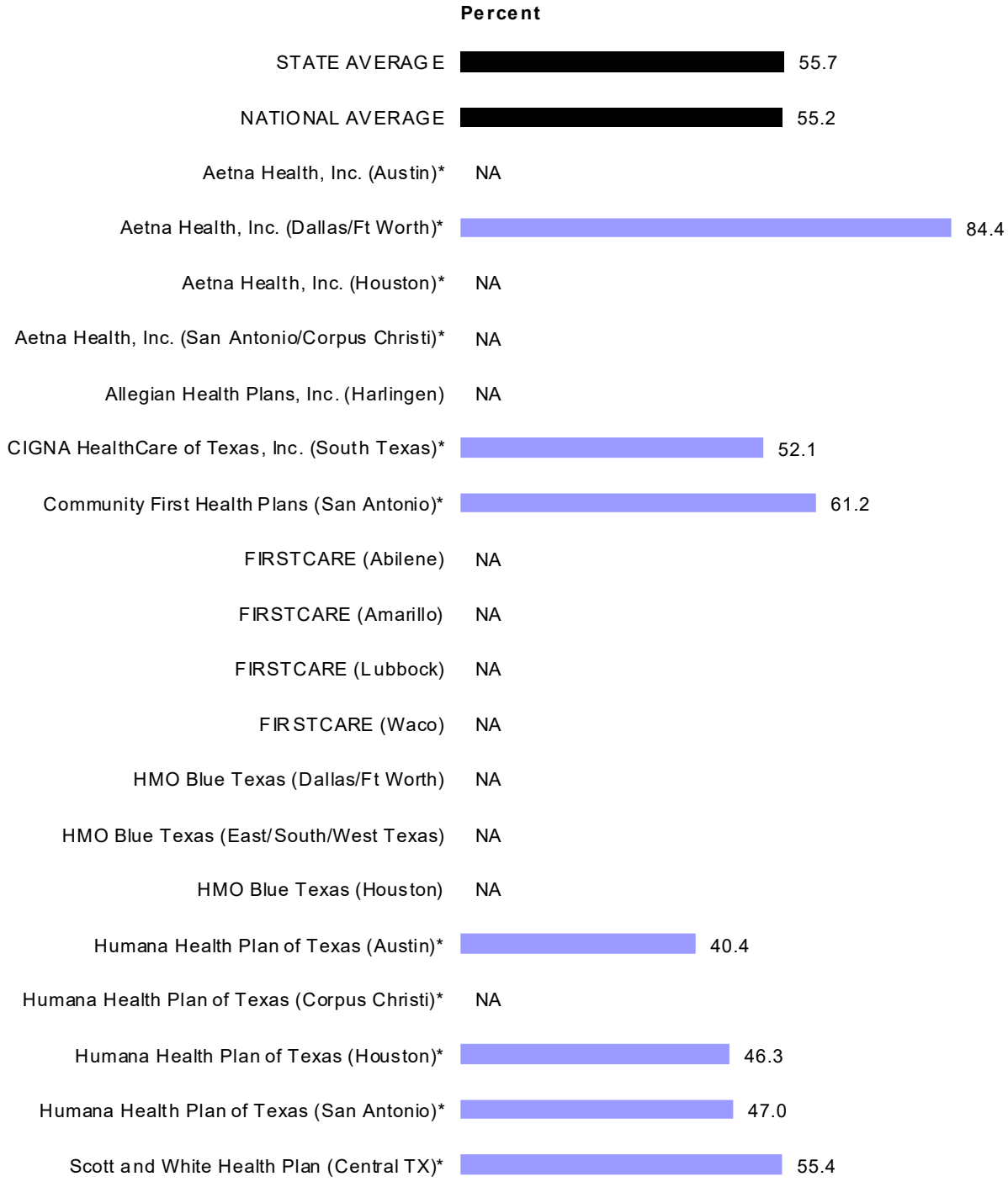
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 19-50



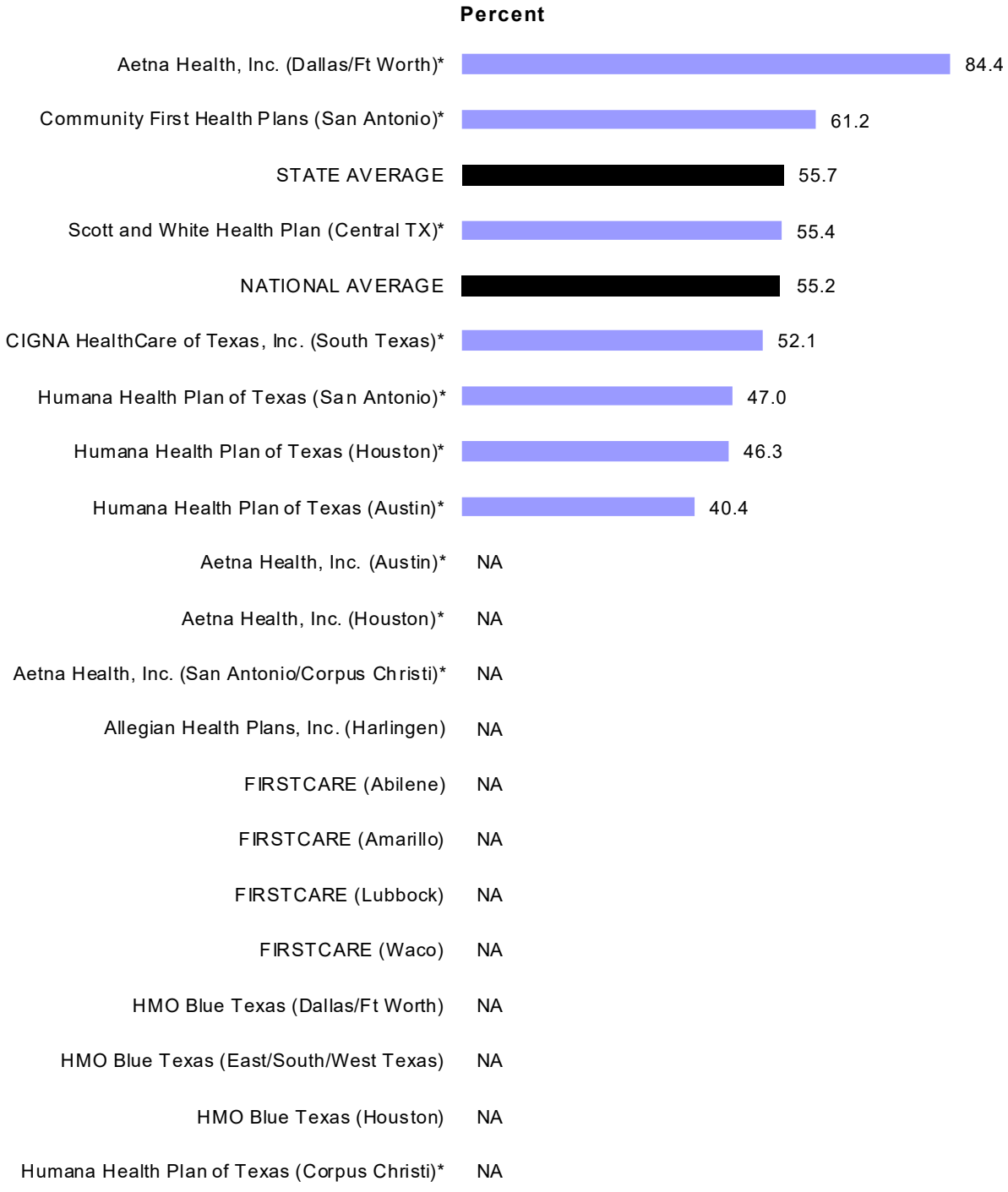
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 51-64



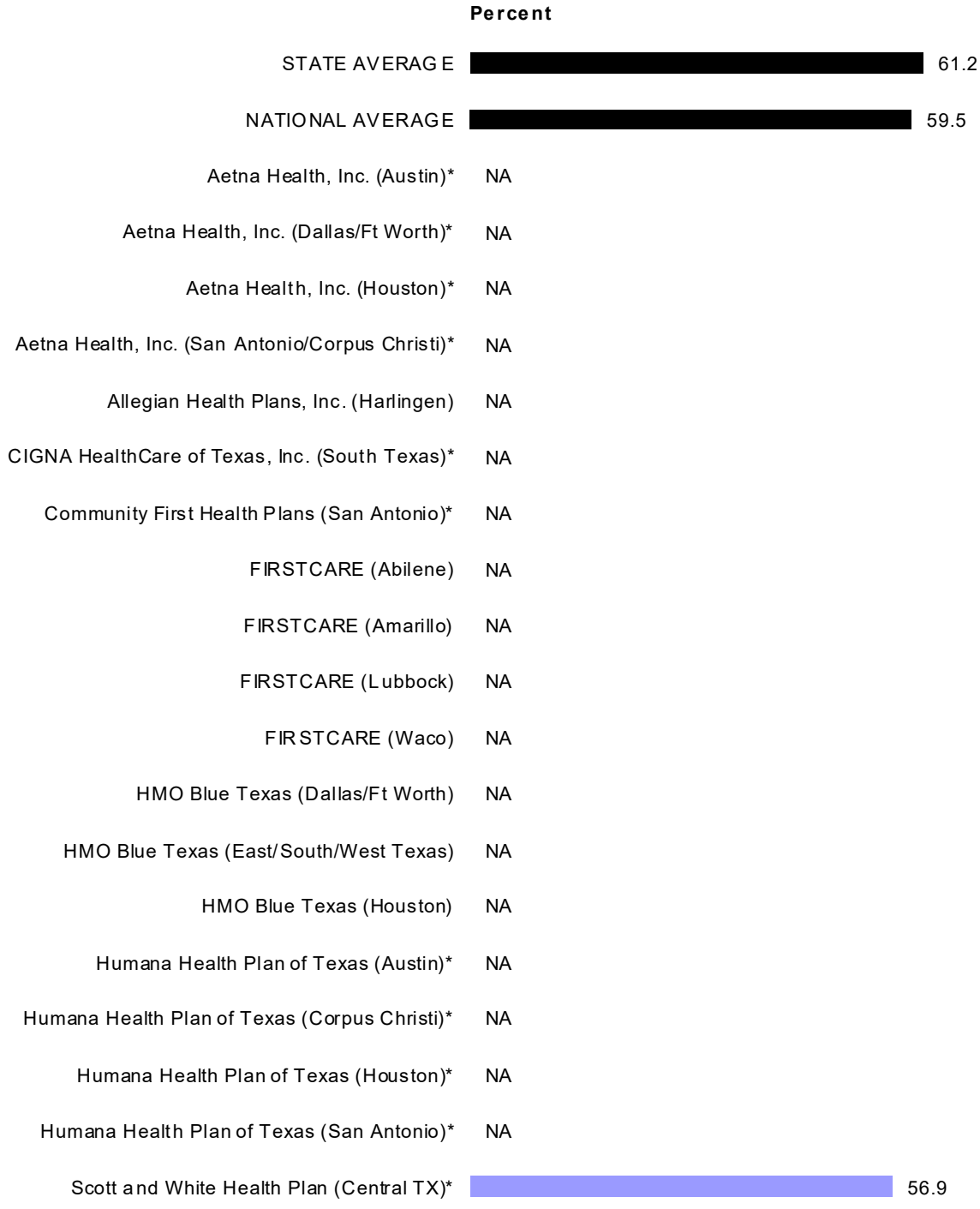
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 51-64



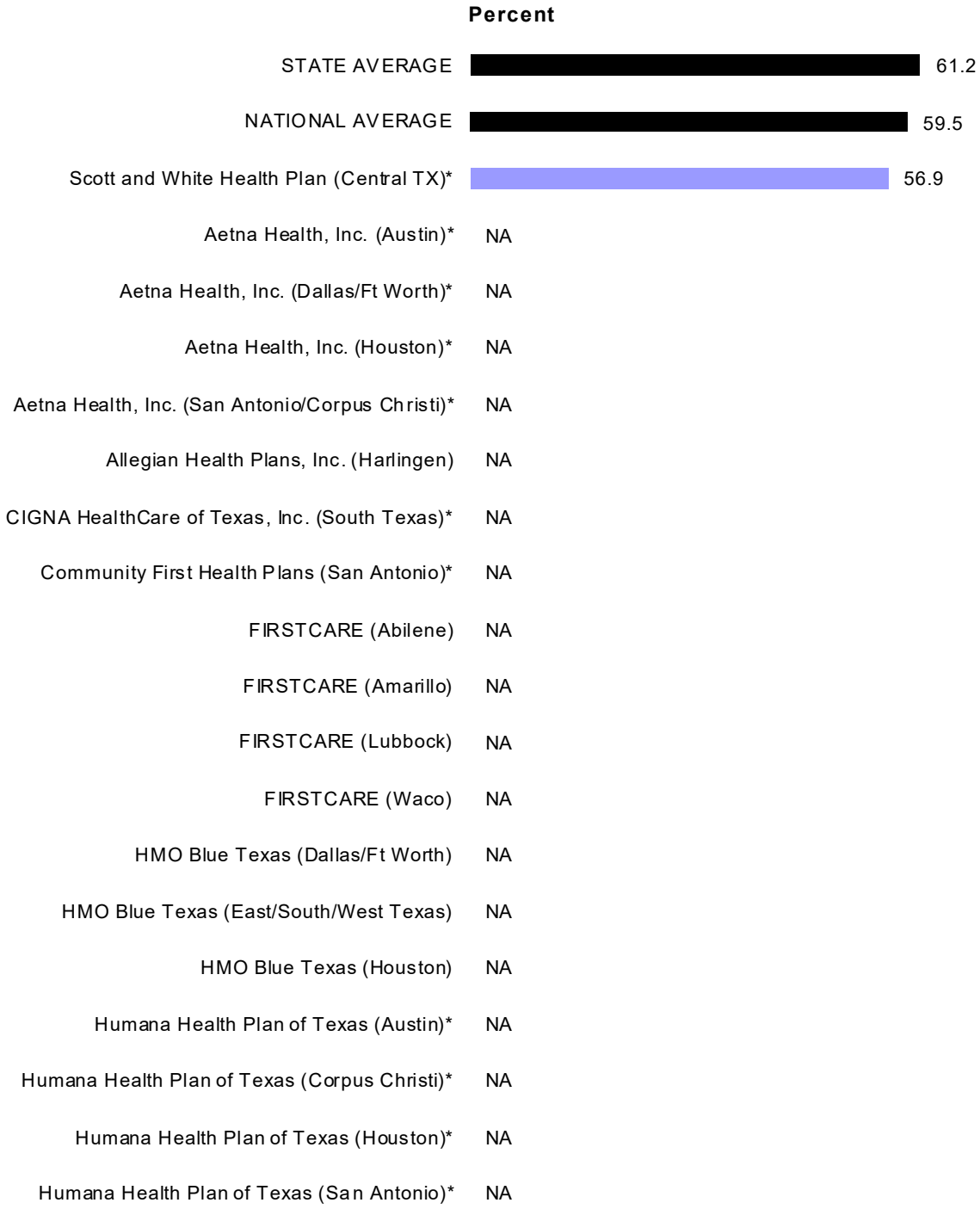
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 65-85



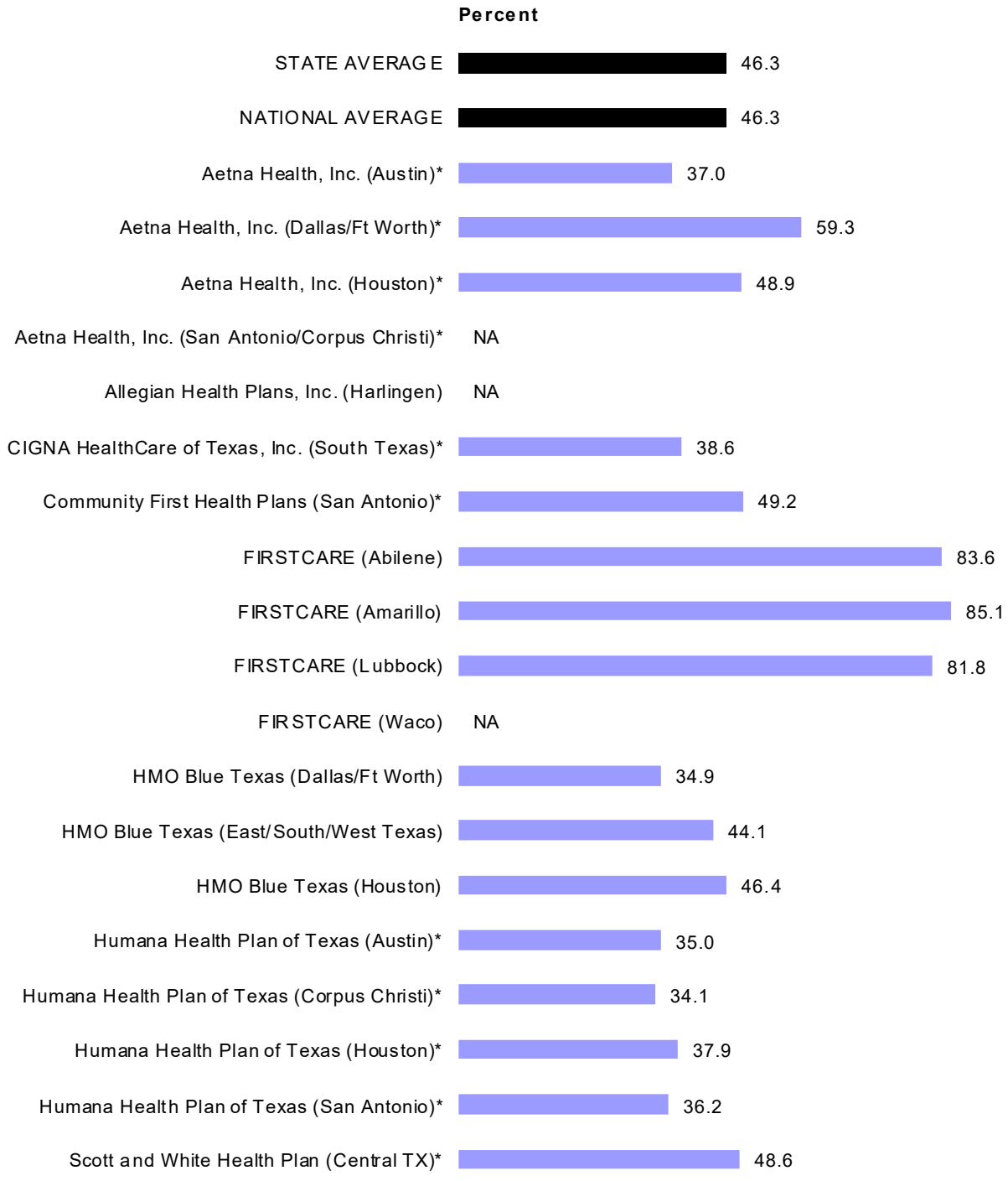
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: 65-85



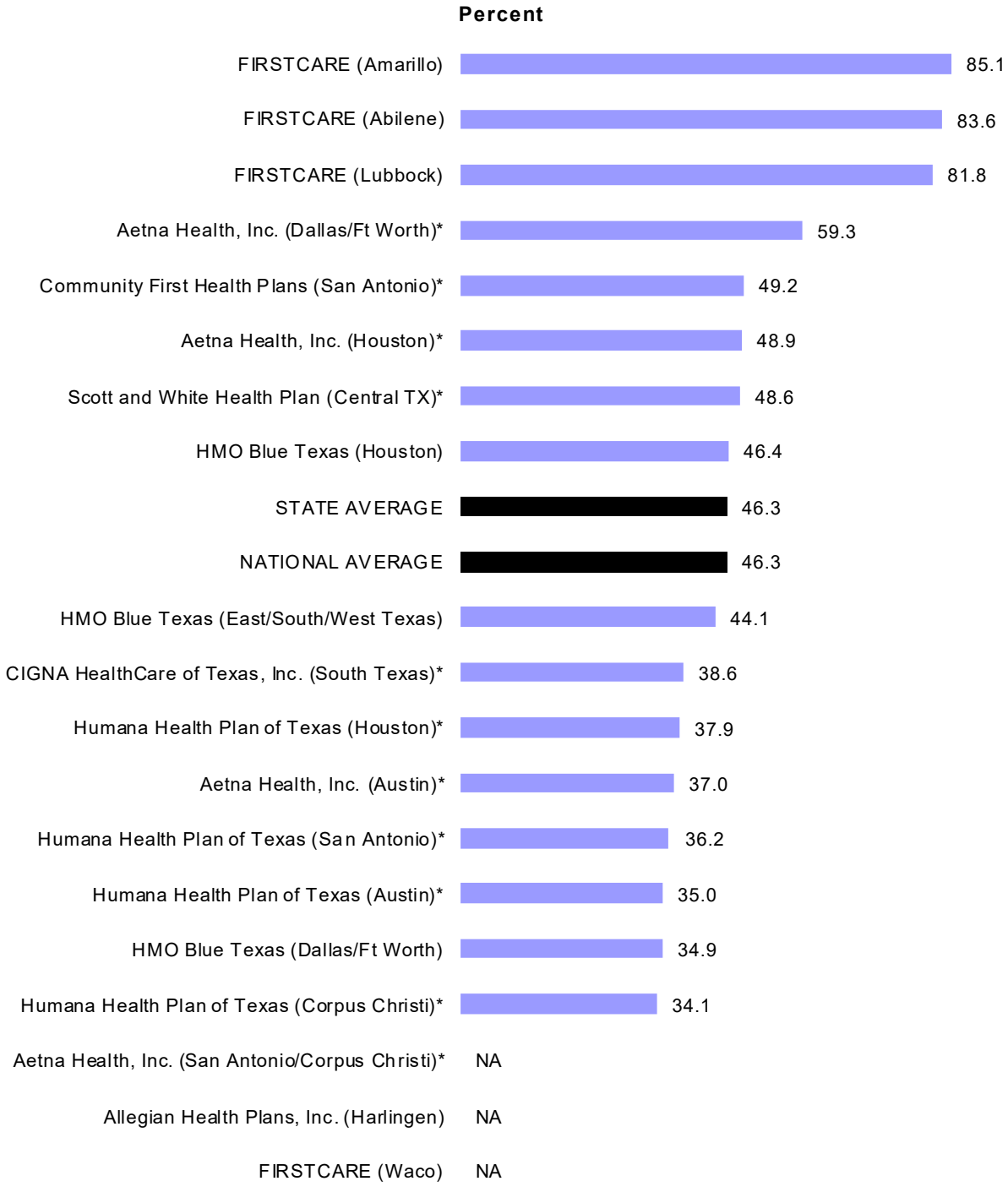
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Medication Management for People with Asthma: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Antidepressant Medication Management: Effective Acute Phase Treatment

Definition: The percentage of members 18 years of age and 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.

Millions of American adults suffer from major depressive disorder. The disorder is characterized by a combination of symptoms that interfere with an individual's ability to work, sleep, study, and enjoy once-pleasurable activities. Some individuals experience only one episode within a lifetime, others experience multiple episodes. Antidepressant medications are often prescribed to individuals diagnosed with major depressive disorder as a part of a comprehensive treatment plan.[1]

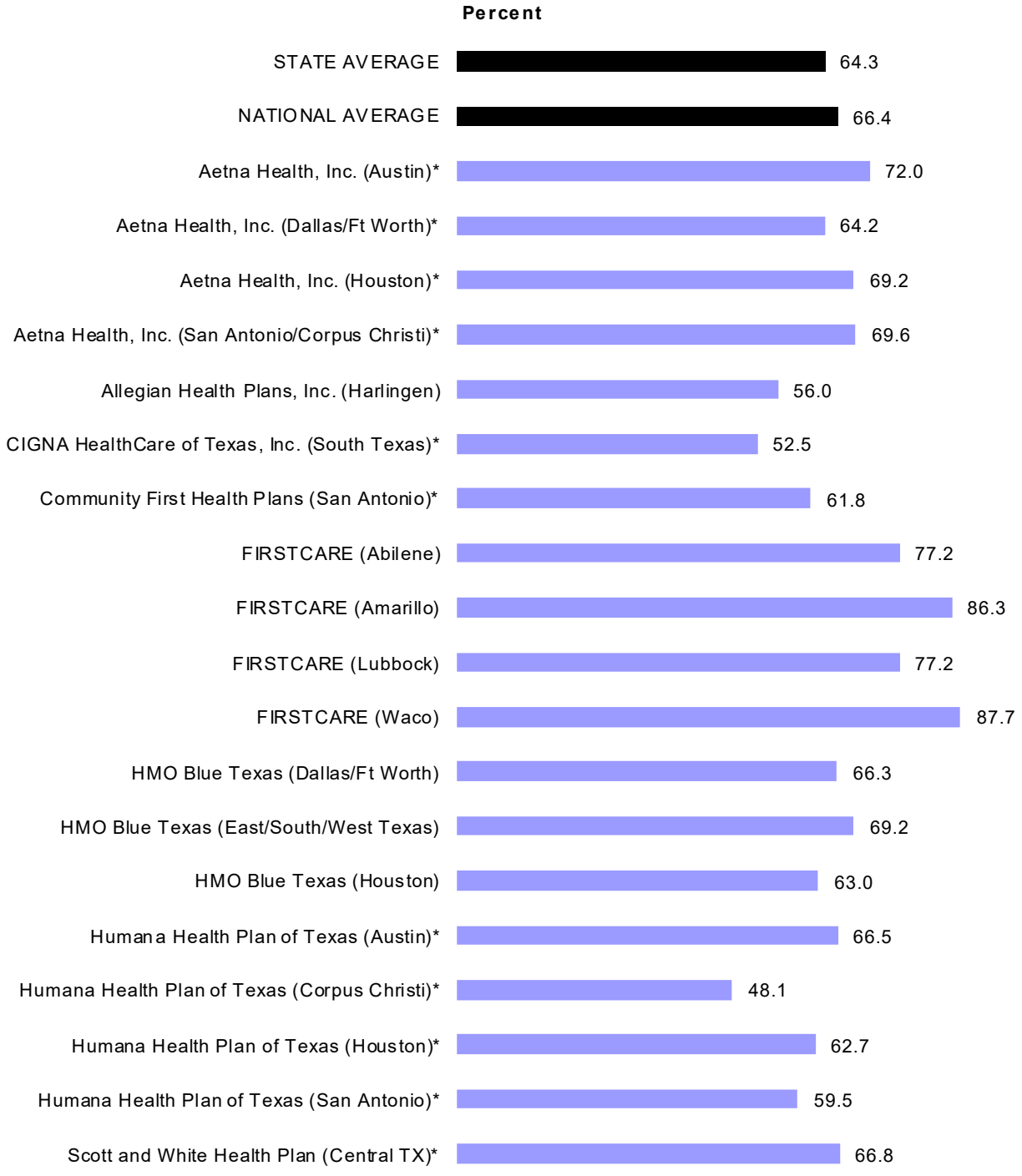
The American Psychiatric Association contends that a thorough assessment of the patient and close adherence to treatment plans promotes successful treatment of patients with major depressive disorder.[2]

Antidepressant Medication Management: Effective Acute Phase Treatment					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	61.0%	65.1%	59.9%	61.7%	64.3%
NCQA's Quality Compass®	65.6%	69.2%	64.4%	66.2%	66.4%

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

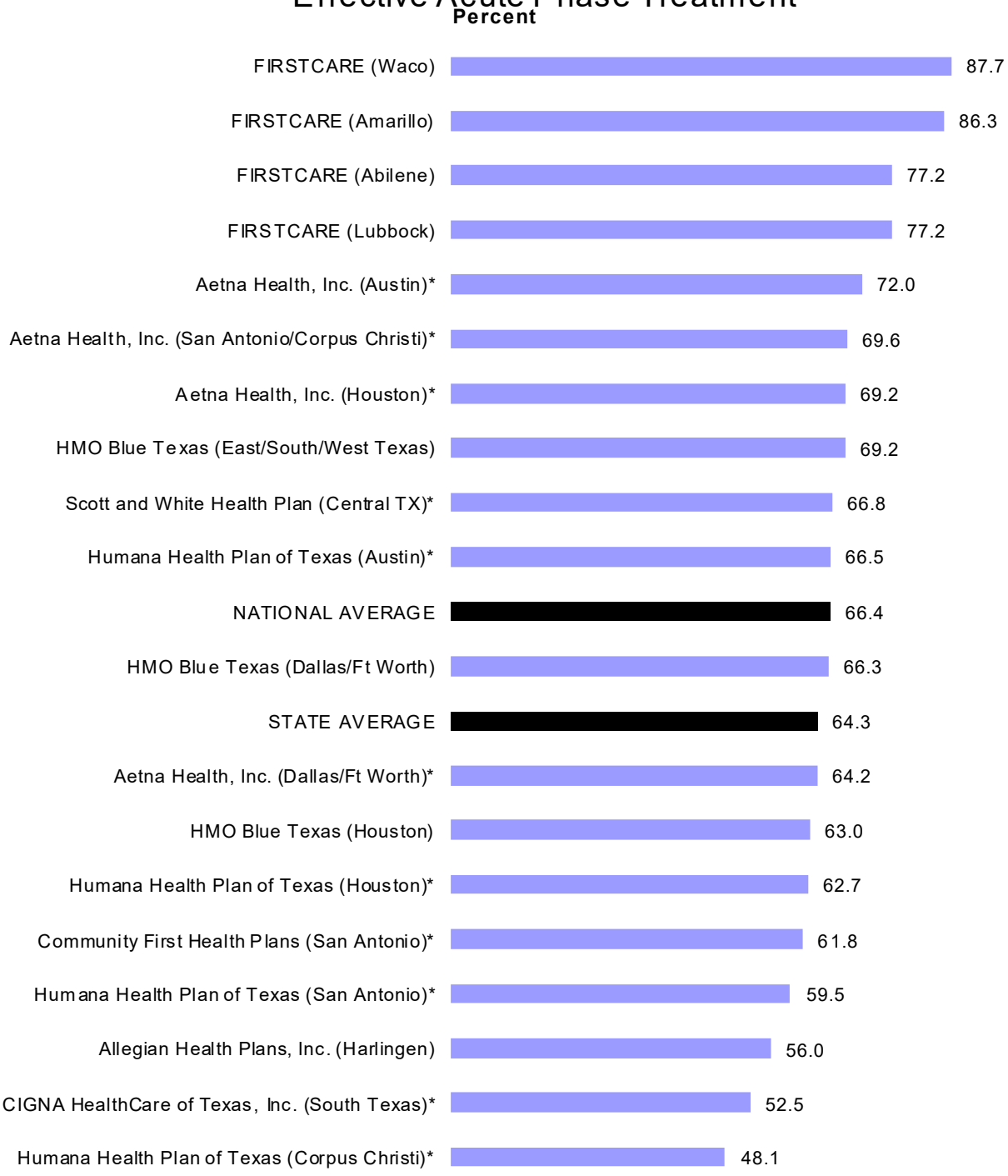
[1] National Institute of Mental Health. *Health Topics: Depression*. Washington, DC: National Institutes of Health, 2016.
[2] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006.* Arlington, VA: American Psychiatric Association, 2006.

Antidepressant Medication Management: Effective Acute Phase Treatment



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Antidepressant Medication Management: Effective Acute Phase Treatment



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Antidepressant Medication Management: Effective Continuation Phase Treatment

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

Millions of American adults suffer from major depressive disorder. The disorder is characterized by a combination of symptoms that interfere with an individual's ability to work, sleep, study, and enjoy once-pleasurable activities. Some individuals experience only one episode within a lifetime, others experience multiple episodes. Antidepressant medications are often prescribed to individuals diagnosed with major depressive disorder as a part of a comprehensive treatment plan.[1]

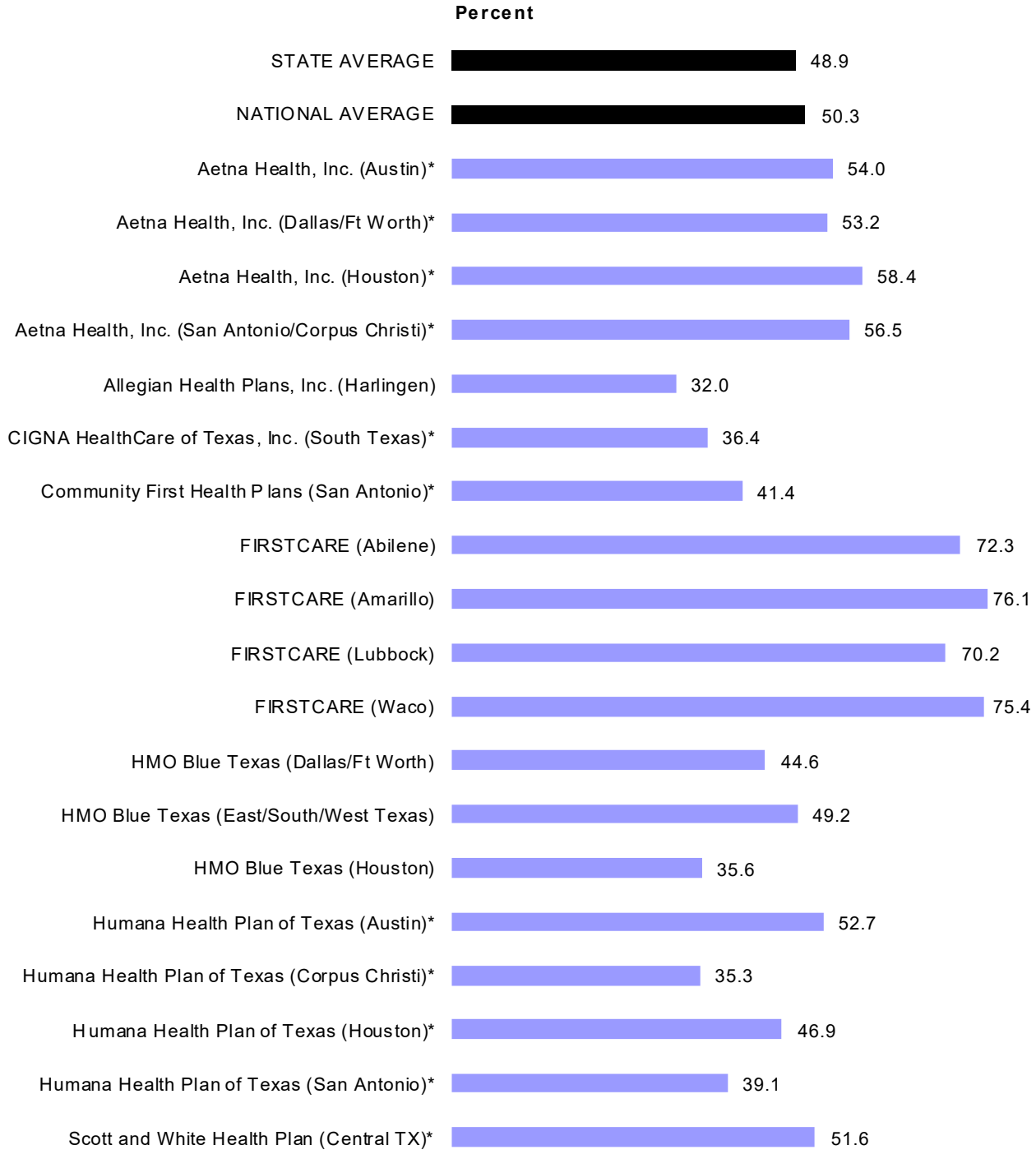
The American Psychiatric Association contends that a thorough assessment of the patient and close adherence to treatment plans promotes successful treatment of patients with major depressive disorder.[2]

Antidepressant Medication Management: Effective Continuation Phase Treatment					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	43.4%	48.3%	42.5%	45.2%	48.9%
NCQA's Quality Compass®	49.4%	53.6%	47.4%	50.0%	50.3%

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

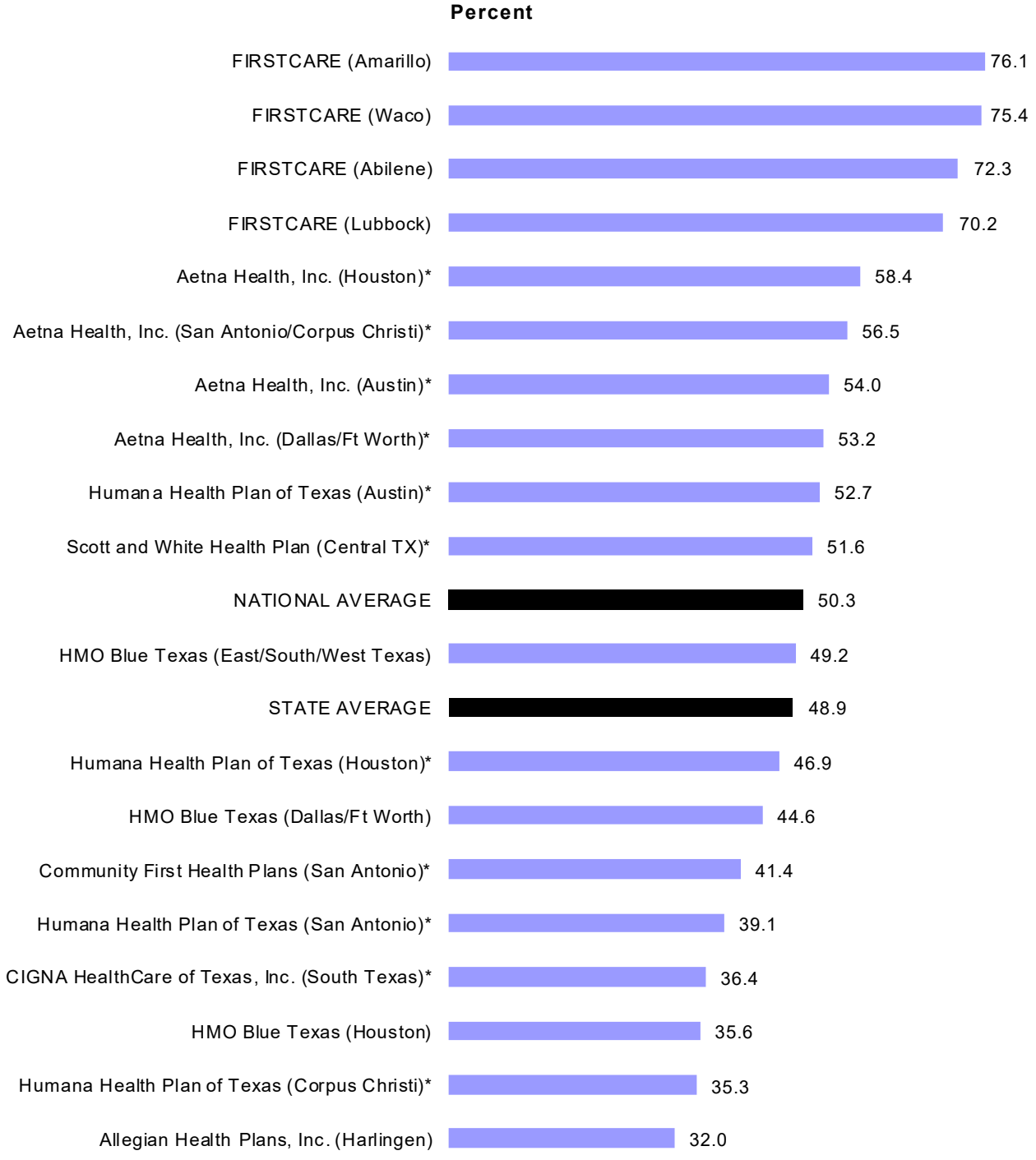
[1] National Institute of Mental Health. *Health Topics: Depression*. Washington, DC: National Institutes of Health, 2016.
[2] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006.* Arlington, VA: American Psychiatric Association, 2006.

Antidepressant Medication Management: Effective Continuation Phase Treatment



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Antidepressant Medication Management: Effective Continuation Phase Treatment



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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

Definition: The percentage of children 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 affects approximately 8 percent of adolescents. Children with ADHD can experience significant functional problems such as school difficulties, strained relationships with family members and peers, and behavioral problems.[1] 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 three to six months to assess learning and behavior.

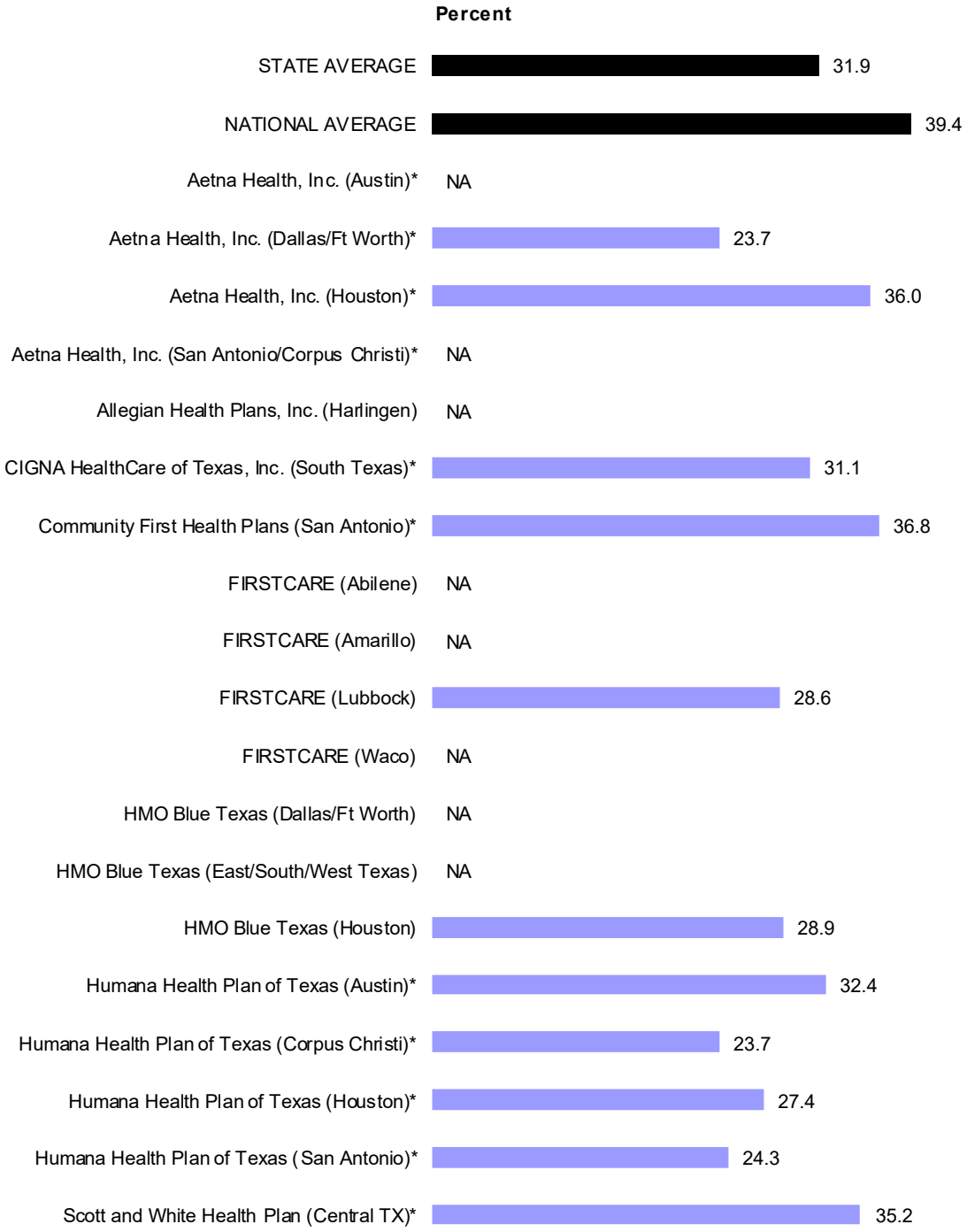
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase		
	2015	**2016**
Texas Average	33.2%	31.9%
NCQA's Quality Compass®	38.2%	39.4%

This measure was added to the Texas Subset beginning with HEDIS® 2015.

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

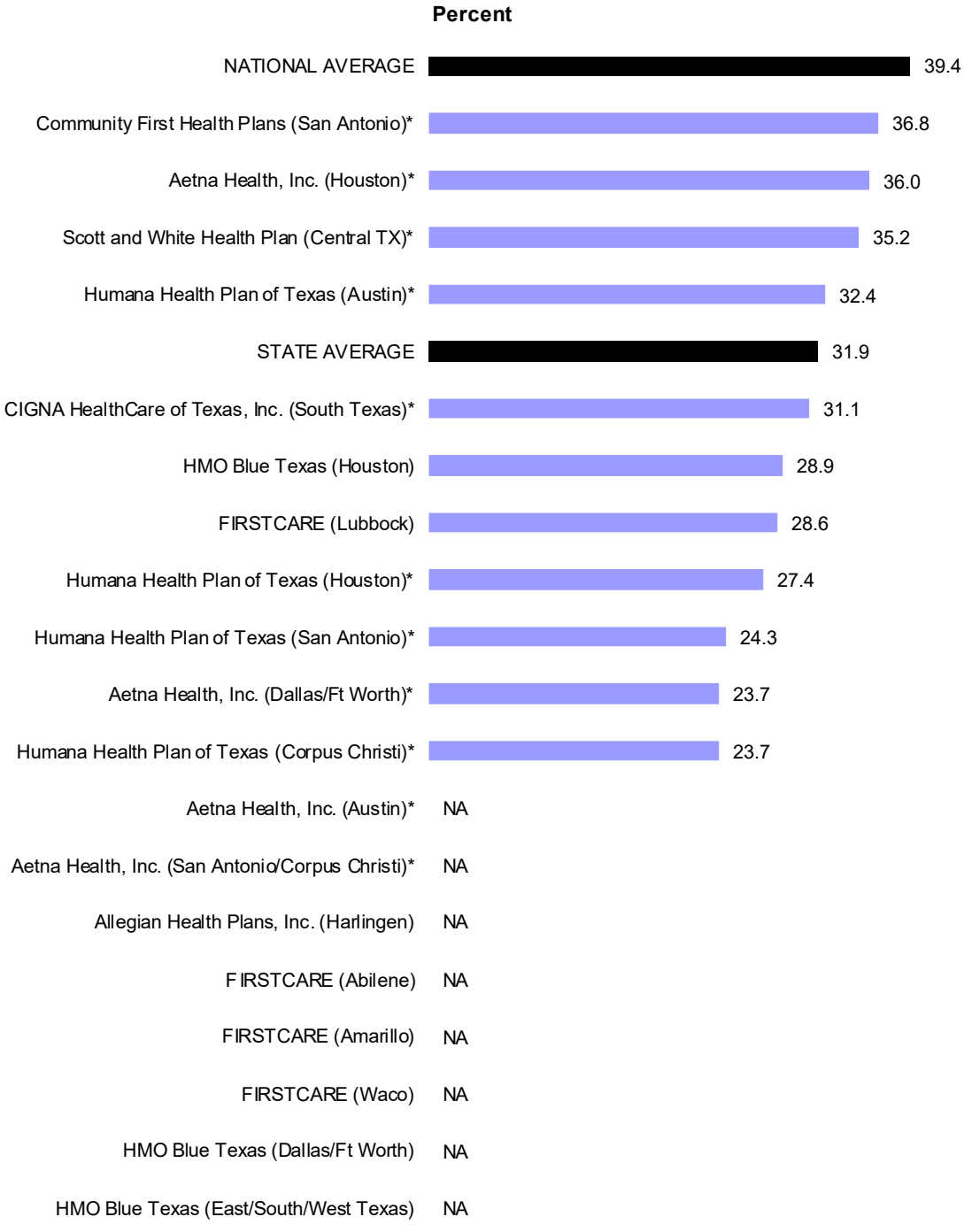
[1] American Academy of Pediatrics. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*.128(5):1007–22 (2011).

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



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

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



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

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

Definition: The percentage of children 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 270 days (9 months) after the Initiation Phase ended.

ADHD affects approximately 8 percent of adolescents. Children with ADHD can experience significant functional problems such as school difficulties, strained relationships with family members and peers, and behavioral problems.[1] 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 three to six months to assess learning and behavior.[2]

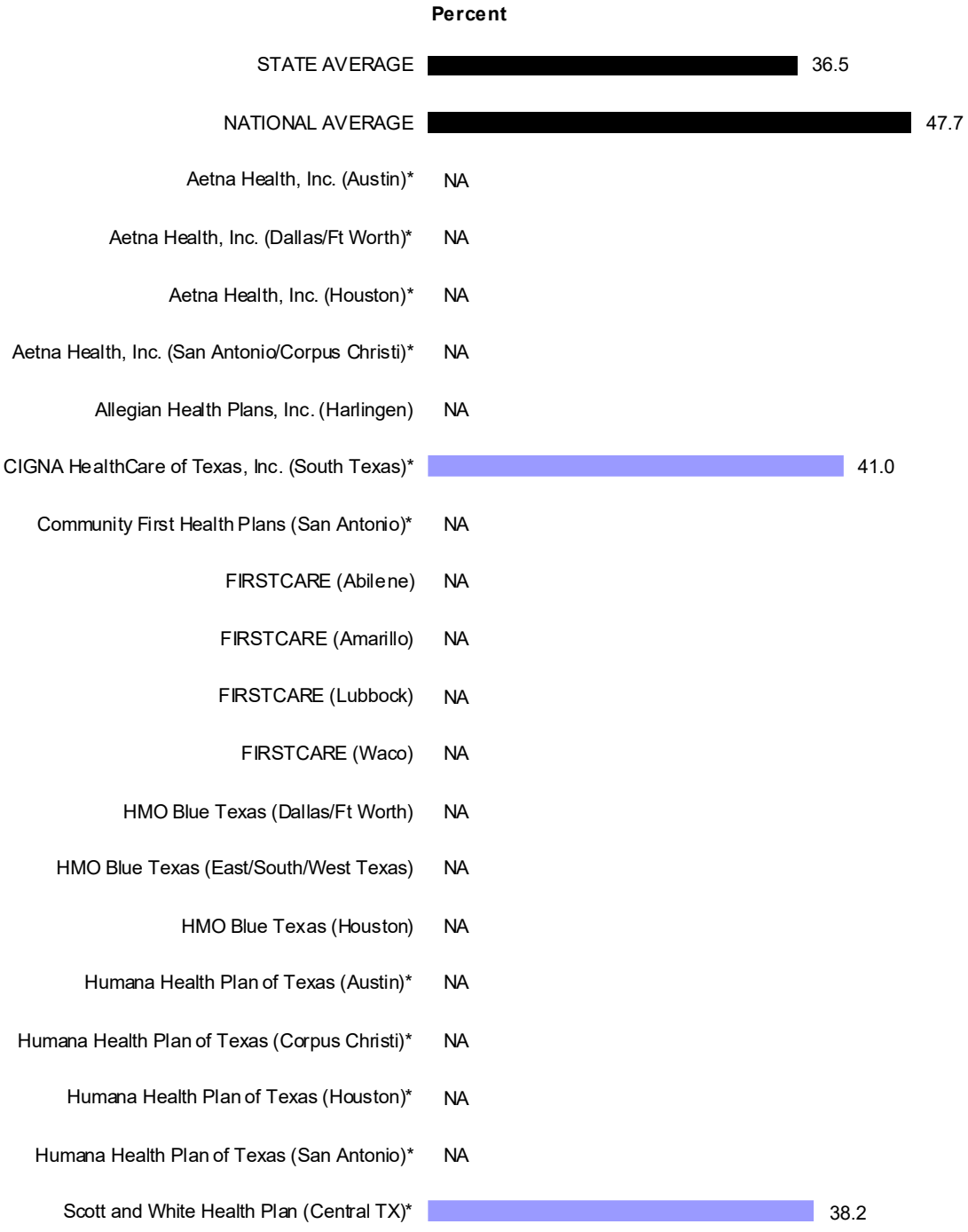
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase		
	2015	**2016**
Texas Average	38.1%	36.5%
NCQA's Quality Compass®	46.5%	47.7%

This measure was added to the Texas Subset beginning with HEDIS® 2015.

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

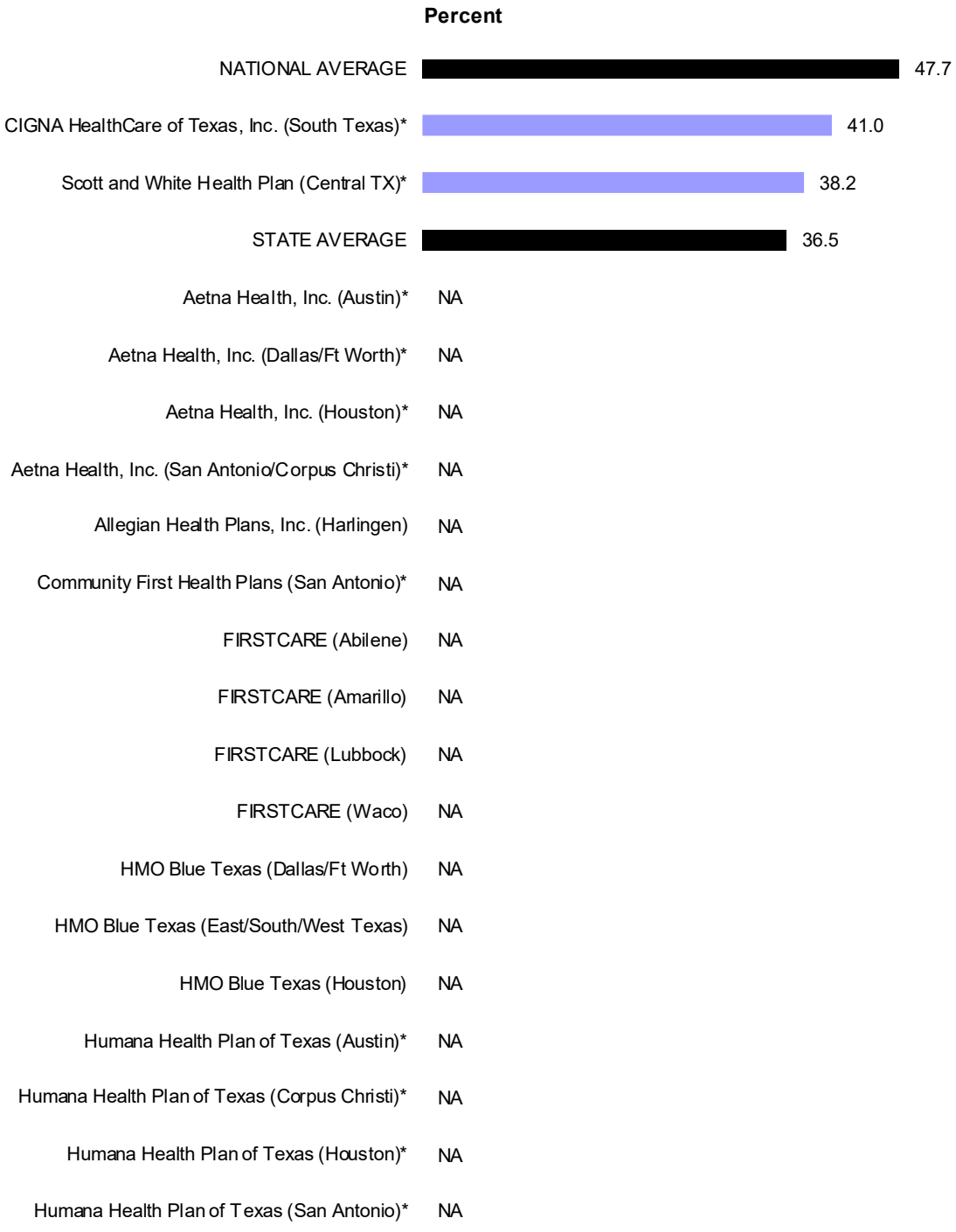
[1] American Academy of Pediatrics. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*.128(5):1007–22 (2011).
[2] Ibid.

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



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

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



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample 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: an outpatient visit with a mental health practitioner, an intensive outpatient encounter, or partial hospitalization. The measure reports the percentage of members who received follow-up care within 7 days of discharge and 30 days of discharge.

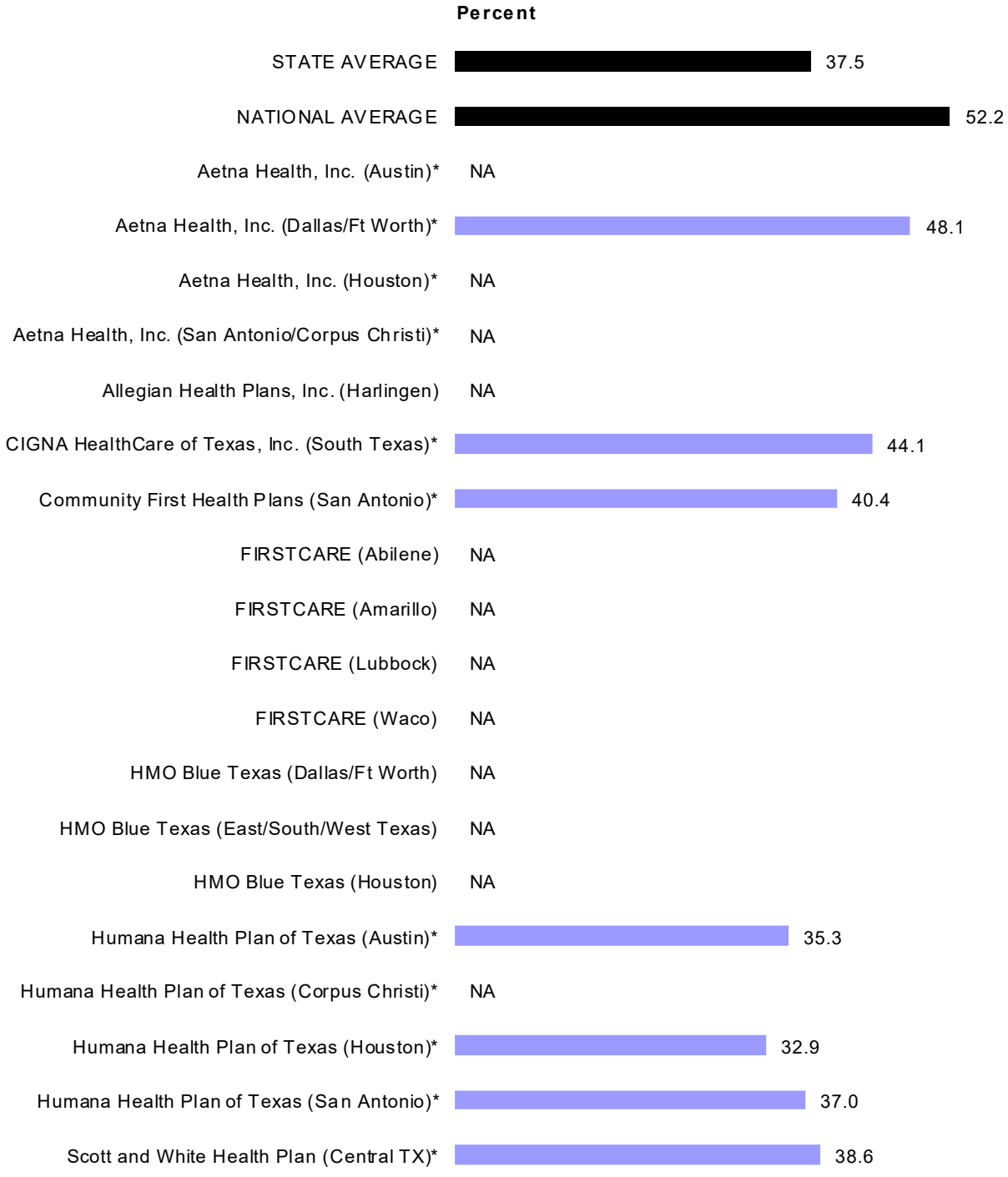
Individuals who utilize follow-up services after an inpatient hospitalization for mental illness are less likely to be readmitted and more likely to make a successful transition back to home and work. Follow-up visits also help health care providers provide effective continuation of care. Both the American Psychiatric Association[1] and the American Academy of Child and Adolescent Psychiatry[2] encourage timely follow-up services.

Follow-up After Hospitalization for Mental Illness					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average (within 7 days)	48.2%	44.7%	44.0%	38.1%	37.5%
NCQA's Quality Compass® (within 7 days)	58.9%	57.9%	54.6%	53.0%	52.2%
Texas Average (within 30 days)	68.5%	63.2%	64.8%	61.9%	57.9%
NCQA's Quality Compass® (within 30 days)	76.5%	76.0%	72.8%	71.0%	70.8%

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

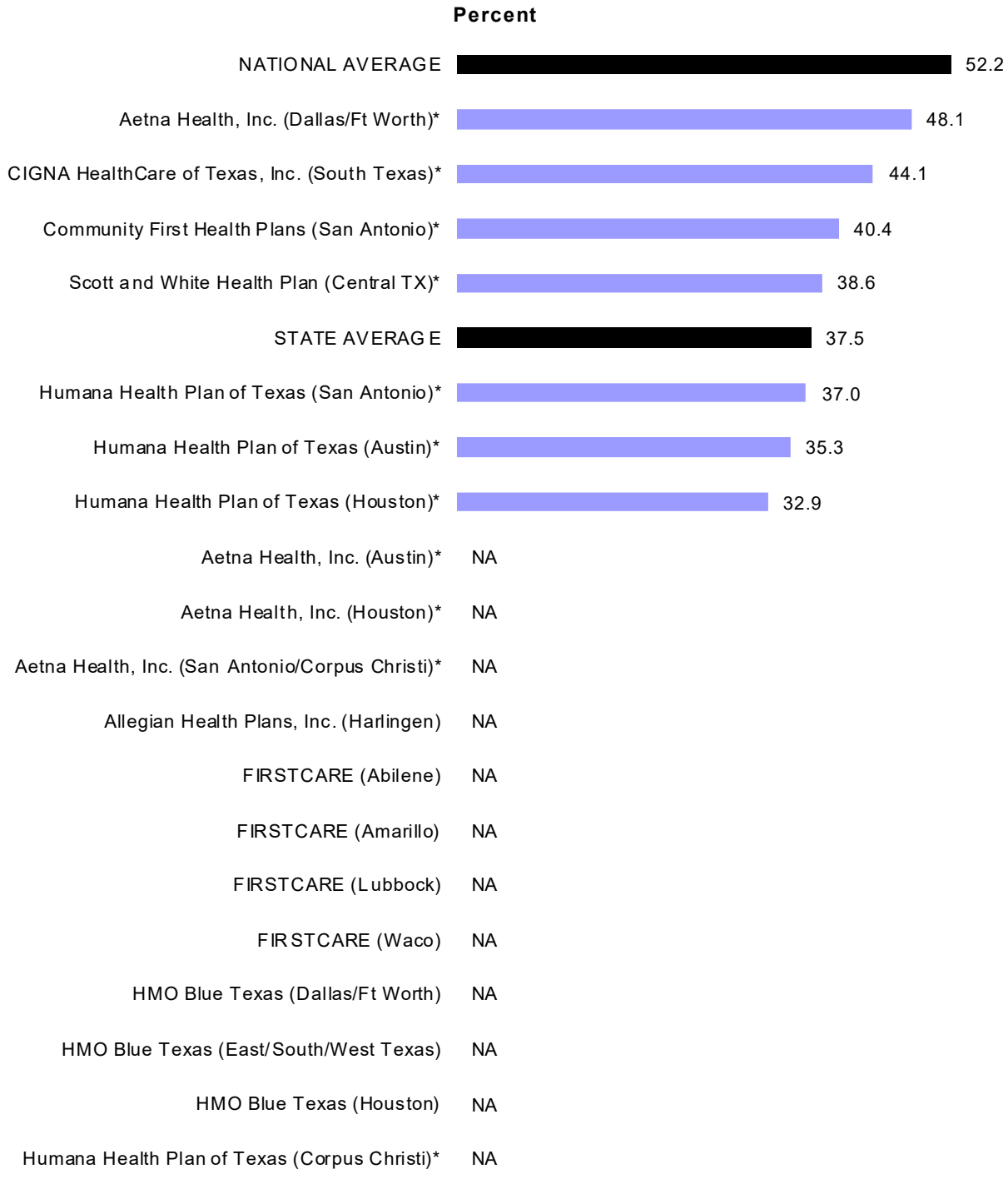
[1] American Psychiatric Association. *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006.* Arlington, VA: American Psychiatric Association, 2006.
[2] American Academy of Child and Adolescent Psychiatry. *Policy Statement: Inpatient Hospital Treatment of Children and Adolescents.* Washington, DC: American Academy of Child and Adolescent Psychiatry, 1989.

Hospitalization for Mental Illness: 7 Day Follow-up



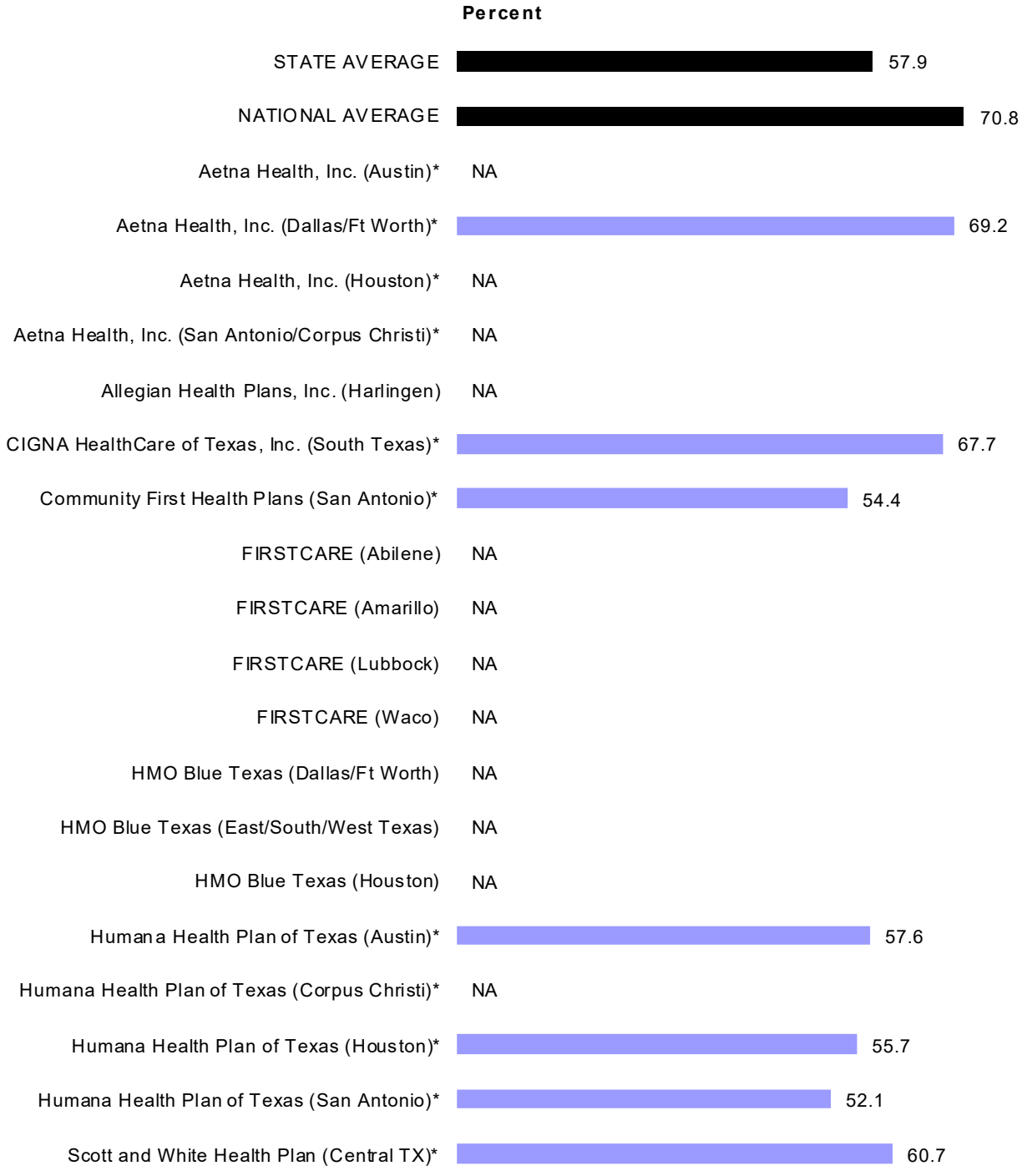
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Hospitalization for Mental Illness: 7 Day Follow-up



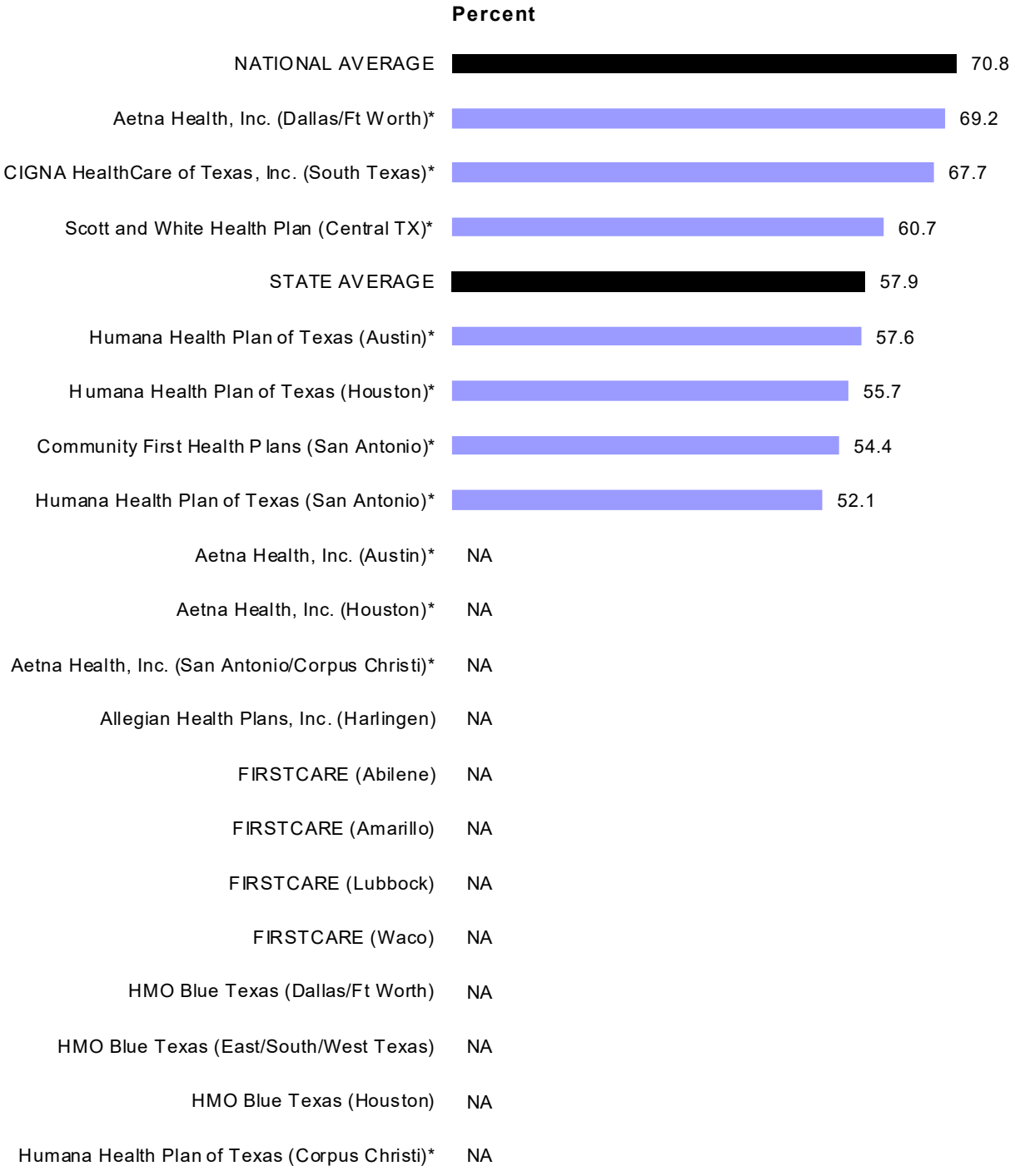
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Hospitalization for Mental Illness: 30 Day Follow-up



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Hospitalization for Mental Illness: 30 Day Follow-up



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Flu Vaccinations for Adults Ages 18–64

Definition: The percentage of members 18–64 years of age who received an influenza vaccination.

Influenza (flu) is a highly contagious viral illness. Symptoms can include fever, sore throat, headache, cough, and sore muscles. Complications can include pneumonia and myocarditis (inflammation of the heart).[1] Children under five and adults over fifty have a higher risk of complications and death from the disease. The Advisory Committee on Immunization Practices (ACIP) recommends yearly influenza vaccinations for all individuals over the age of six months.[2]

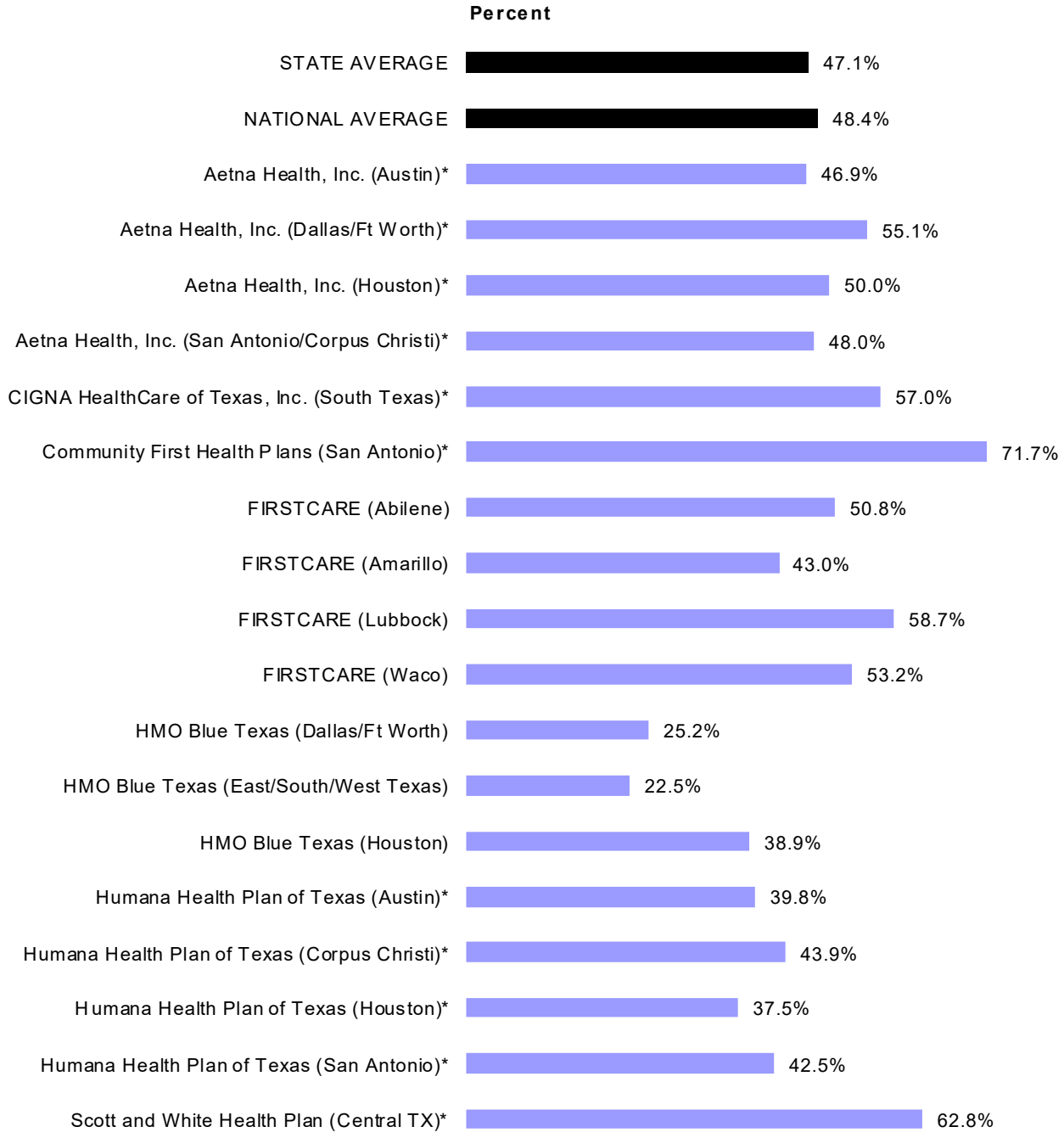
Flu Vaccinations for Adults Ages 18–64					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	53.5%	55.0%	50.0%	51.8%	47.1%
NCQA's Quality Compass®	53.3%	55.3%	50.3%	50.0%	48.4%

Please note that the lower end of the age range changed from 50 years of age to 18 years of age beginning with HEDIS 2014.

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

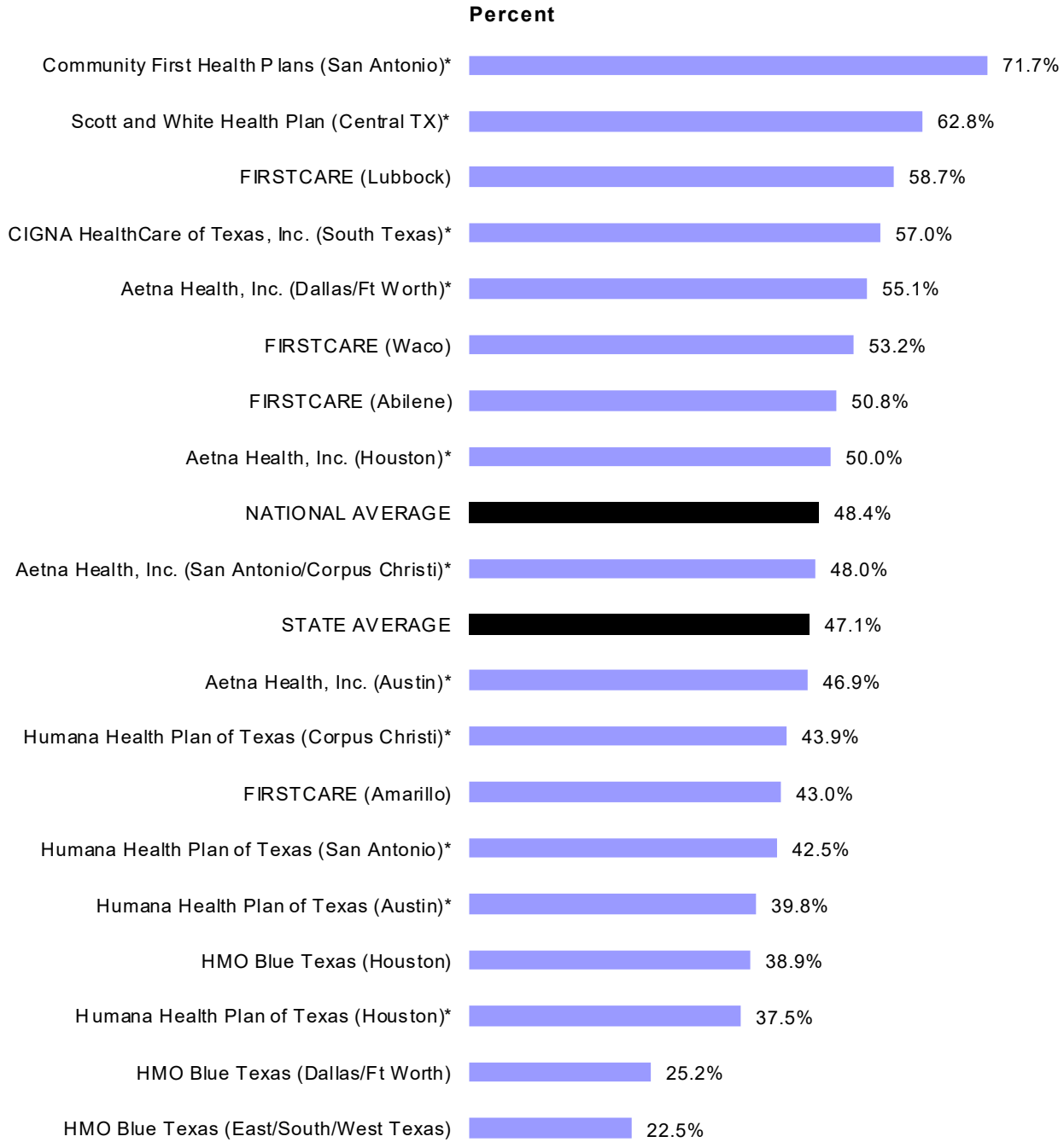
[1] Hamborsky, Jennifer, Andrew Kroger, and Charles Wolfe, eds. Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. 13th ed. Washington, DC: Public Health Foundation, 2015.
[2] Centers for Disease Control and Prevention. *Recommended Adult Immunization Schedule, by Vaccine and Age Group.* Atlanta, GA: Centers for Disease Control and Prevention, 2016.

Flu Vaccinations for Adults Ages 18-64



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Flu Vaccinations for Adults Ages 18-64



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Medical Assistance with Smoking and Tobacco Use Cessation

Definition: This three-part survey measure examines the percentage of members 18 years of age and older who were current smokers or tobacco users or recent quitters, were seen by a medical practitioner, and (1) received advice from the practitioner to quit, (2) discussed cessation medications with the practitioner, or (3) discussed cessation strategies with the practitioner.

Smoking cessation reduces the risk of lung and other cancers, heart attack, stroke, and chronic lung disease. Nearly 70% percent of smokers are interested in smoking cessation and report that they would be more likely to stop smoking if a doctor advised them to quit. However, less than 50% of smokers report that a health care professional advised them to quit.[2]

This three-part survey measure examines the health care provider's role in curbing tobacco use and focuses on health care providers' efforts to help members quit smoking or tobacco use by evaluating the following components:

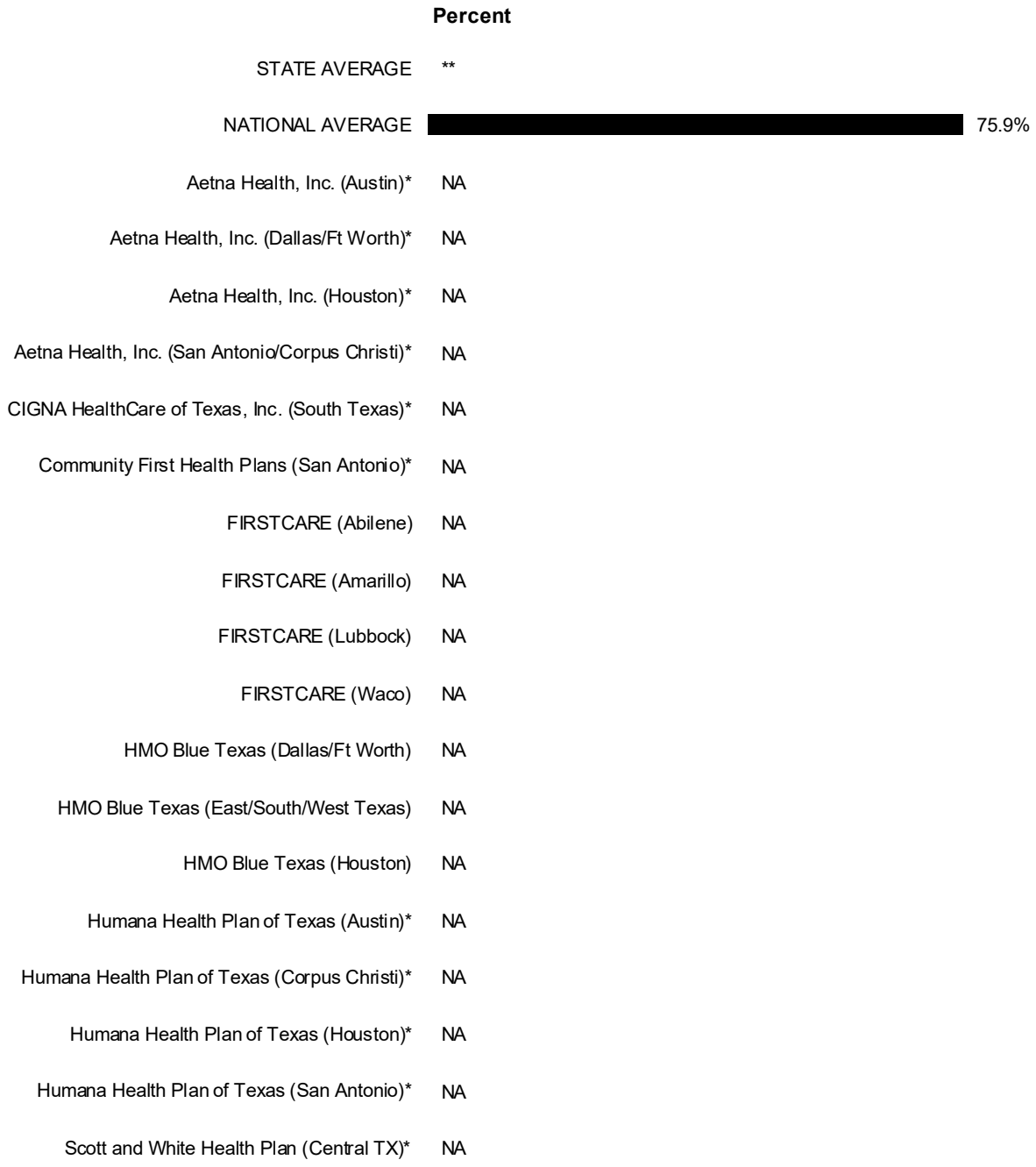
- *Advising Smokers and Tobacco Users to Quit.* The percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice from their practitioner.
- *Discussing Cessation Medications.* The percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were recommended cessation medications.
- *Discussing Cessation Strategies.* The percentage of members 18 years of age and older who are current smokers or tobacco users whose discussed or were provided cessation methods or strategies during.

Medical Assistance with Smoking and Tobacco Use Cessation										
	2012		2013		2014		2015		2016	
	Texas	QC	Texas	QC	Texas	QC	Texas	QC	Texas	QC
Advising to Quit	**	77.6%	**	77.8%	**	77.3%	**	77.0%	**	75.9%
Discussing Cessation Medications	**	53.1%	**	52.9%	**	51.7%	**	51.8%	**	50.3%
Discussing Cessation Strategies	**	47.6%	**	47.9%	**	46.5%	**	47.0%	**	45.8%

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

[1] Centers for Disease Control and Prevention. "Quitting Smoking Among Adults—United States, 2001–2010." *Morbidity and Mortality Weekly Report*. 60: 1513–1519 (2011).

Medical Assitance with Smoking and Tobacco Use Cessation: Advising to Quit



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medical Assitance with Smoking and Tobacco Use Cessation: Advising to Quit

Percent

NATIONAL AVERAGE	75.9%
Aetna Health, Inc. (Austin)*	NA
Aetna Health, Inc. (Dallas/Ft Worth)*	NA
Aetna Health, Inc. (Houston)*	NA
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA
CIGNA HealthCare of Texas, Inc. (South Texas)*	NA
Community First Health Plans (San Antonio)*	NA
FIRSTCARE (Abilene)	NA
FIRSTCARE (Amarillo)	NA
FIRSTCARE (Lubbock)	NA
FIRSTCARE (Waco)	NA
HMO Blue Texas (Dallas/Ft Worth)	NA
HMO Blue Texas (East/South/West Texas)	NA
HMO Blue Texas (Houston)	NA
Humana Health Plan of Texas (Austin)*	NA
Humana Health Plan of Texas (Corpus Christi)*	NA
Humana Health Plan of Texas (Houston)*	NA
Humana Health Plan of Texas (San Antonio)*	NA
Scott and White Health Plan (Central TX)*	NA
STATE AVERAGE	**

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medical Assitance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications

	Percent
STATE AVERAGE	**
NATIONAL AVERAGE	50.3%
Aetna Health, Inc. (Austin)*	NA
Aetna Health, Inc. (Dallas/Ft Worth)*	NA
Aetna Health, Inc. (Houston)*	NA
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA
CIGNA HealthCare of Texas, Inc. (South Texas)*	NA
Community First Health Plans (San Antonio)*	NA
FIRSTCARE (Abilene)	NA
FIRSTCARE (Amarillo)	NA
FIRSTCARE (Lubbock)	NA
FIRSTCARE (Waco)	NA
HMO Blue Texas (Dallas/Ft Worth)	NA
HMO Blue Texas (East/South/West Texas)	NA
HMO Blue Texas (Houston)	NA
Humana Health Plan of Texas (Austin)*	NA
Humana Health Plan of Texas (Corpus Christi)*	NA
Humana Health Plan of Texas (Houston)*	NA
Humana Health Plan of Texas (San Antonio)*	NA
Scott and White Health Plan (Central TX)*	NA

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

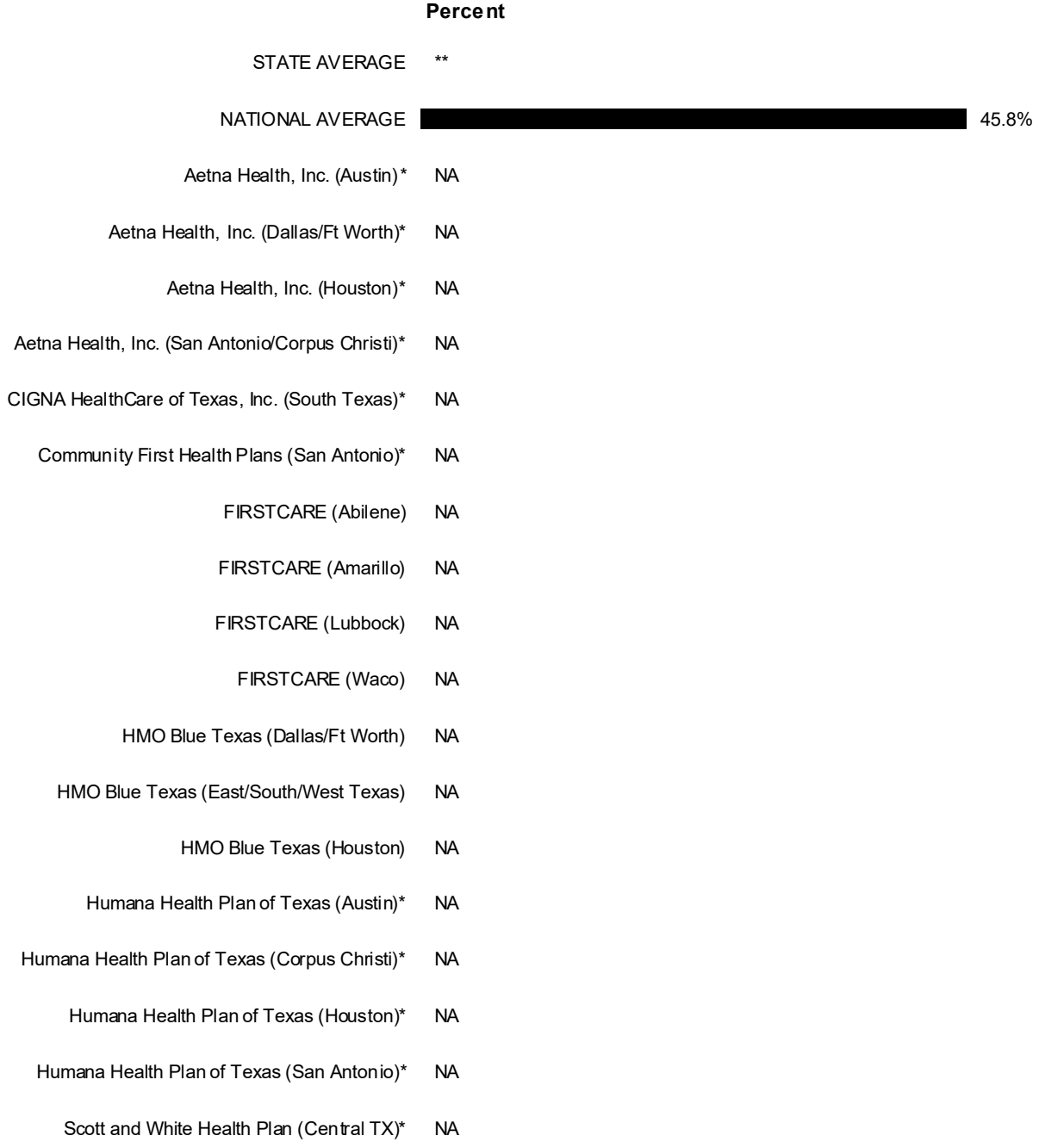
Medical Assitance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications

Percent

NATIONAL AVERAGE	50.3%
Aetna Health, Inc. (Austin)*	NA
Aetna Health, Inc. (Dallas/Ft Worth)*	NA
Aetna Health, Inc. (Houston)*	NA
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA
CIGNA HealthCare of Texas, Inc. (South Texas)*	NA
Community First Health Plans (San Antonio)*	NA
FIRSTCARE (Abilene)	NA
FIRSTCARE (Amarillo)	NA
FIRSTCARE (Lubbock)	NA
FIRSTCARE (Waco)	NA
HMO Blue Texas (Dallas/Ft Worth)	NA
HMO Blue Texas (East/South/West Texas)	NA
HMO Blue Texas (Houston)	NA
Humana Health Plan of Texas (Austin)*	NA
Humana Health Plan of Texas (Corpus Christi)*	NA
Humana Health Plan of Texas (Houston)*	NA
Humana Health Plan of Texas (San Antonio)*	NA
Scott and White Health Plan (Central TX)*	NA
STATE AVERAGE	**

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medical Assitance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Medical Assitance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

Percent

NATIONAL AVERAGE	45.8%
Aetna Health, Inc. (Austin)*	NA
Aetna Health, Inc. (Dallas/Ft Worth)*	NA
Aetna Health, Inc. (Houston)*	NA
Aetna Health, Inc. (San Antonio/Corpus Christi)*	NA
CIGNA HealthCare of Texas, Inc. (South Texas)*	NA
Community First Health Plans (San Antonio)*	NA
FIRSTCARE (Abilene)	NA
FIRSTCARE (Amarillo)	NA
FIRSTCARE (Lubbock)	NA
FIRSTCARE (Waco)	NA
HMO Blue Texas (Dallas/Ft Worth)	NA
HMO Blue Texas (East/South/West Texas)	NA
HMO Blue Texas (Houston)	NA
Humana Health Plan of Texas (Austin)*	NA
Humana Health Plan of Texas (Corpus Christi)*	NA
Humana Health Plan of Texas (Houston)*	NA
Humana Health Plan of Texas (San Antonio)*	NA
Scott and White Health Plan (Central TX)*	NA
STATE AVERAGE	**

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.

Adults' Access to Preventative/Ambulatory Health Services

Definition: The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

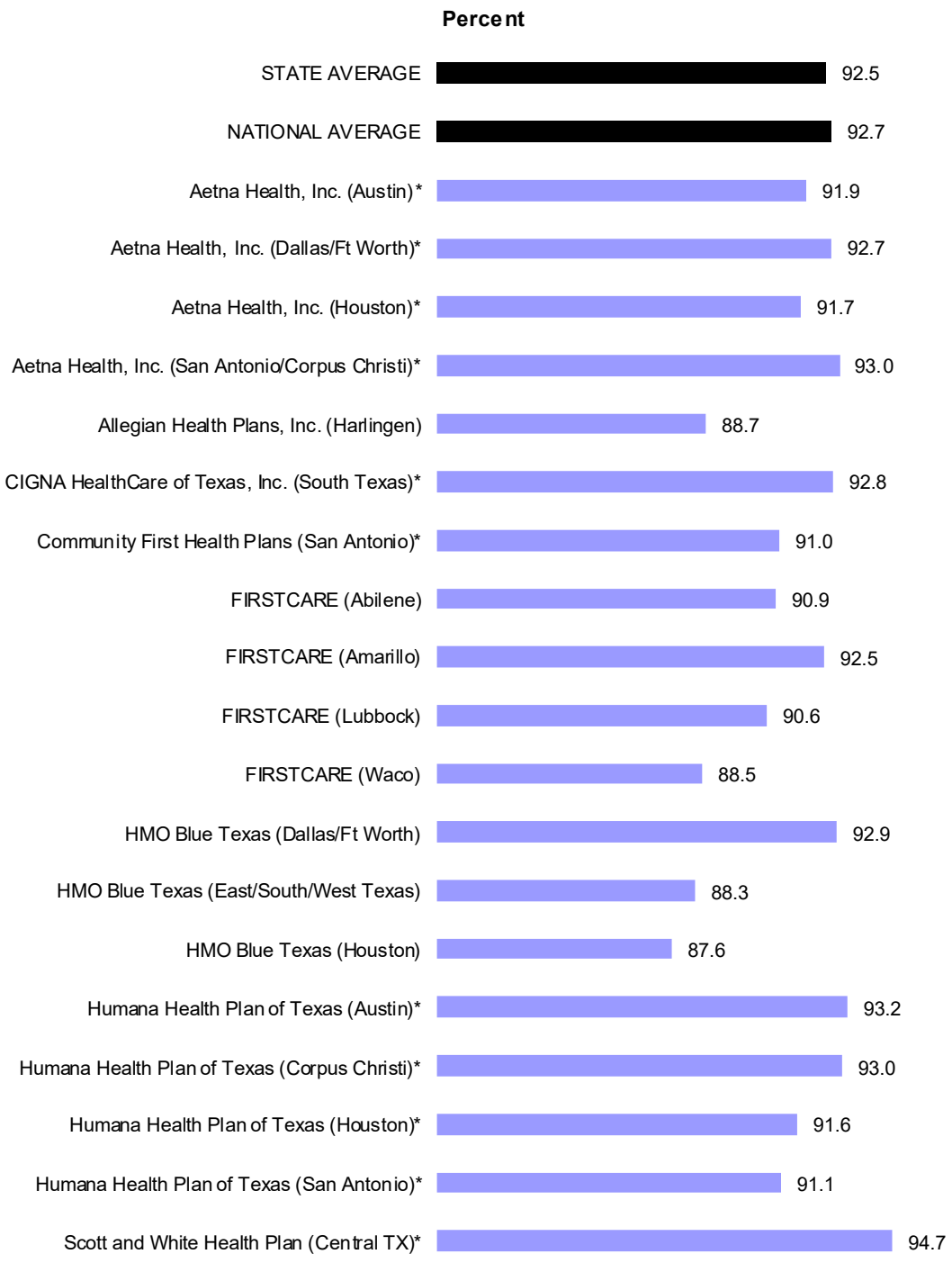
This measure looks at members' ability to obtain basic services they require from their HMO. Specifically, this measure indicates the percentage of members who have had a preventive or ambulatory visit to their physician. This measure indicates not only the percentage of members who do access care, but can also indicate barriers to care in the HMO. Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care.

Adults' Access to Preventative/Ambulatory Health Services: Total		
	2015	**2016**
Texas Average	94.5%	94.4%
NCQA's Quality Compass®	94.7%	94.6%

This measure was added to the Texas Subset beginning with HEDIS® 2015.

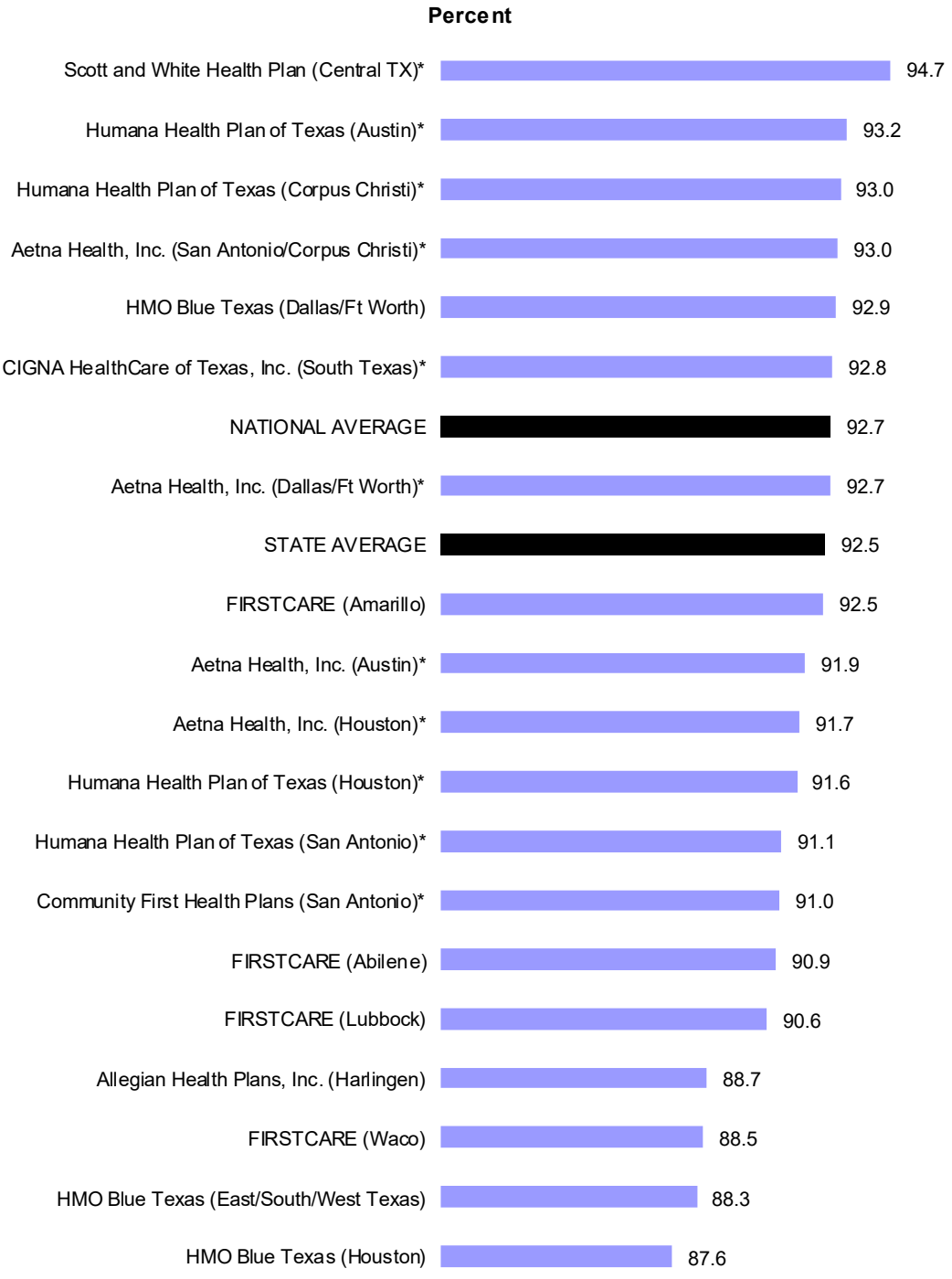
Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.

Access to Preventative/Ambulatory Services: 20-44 years



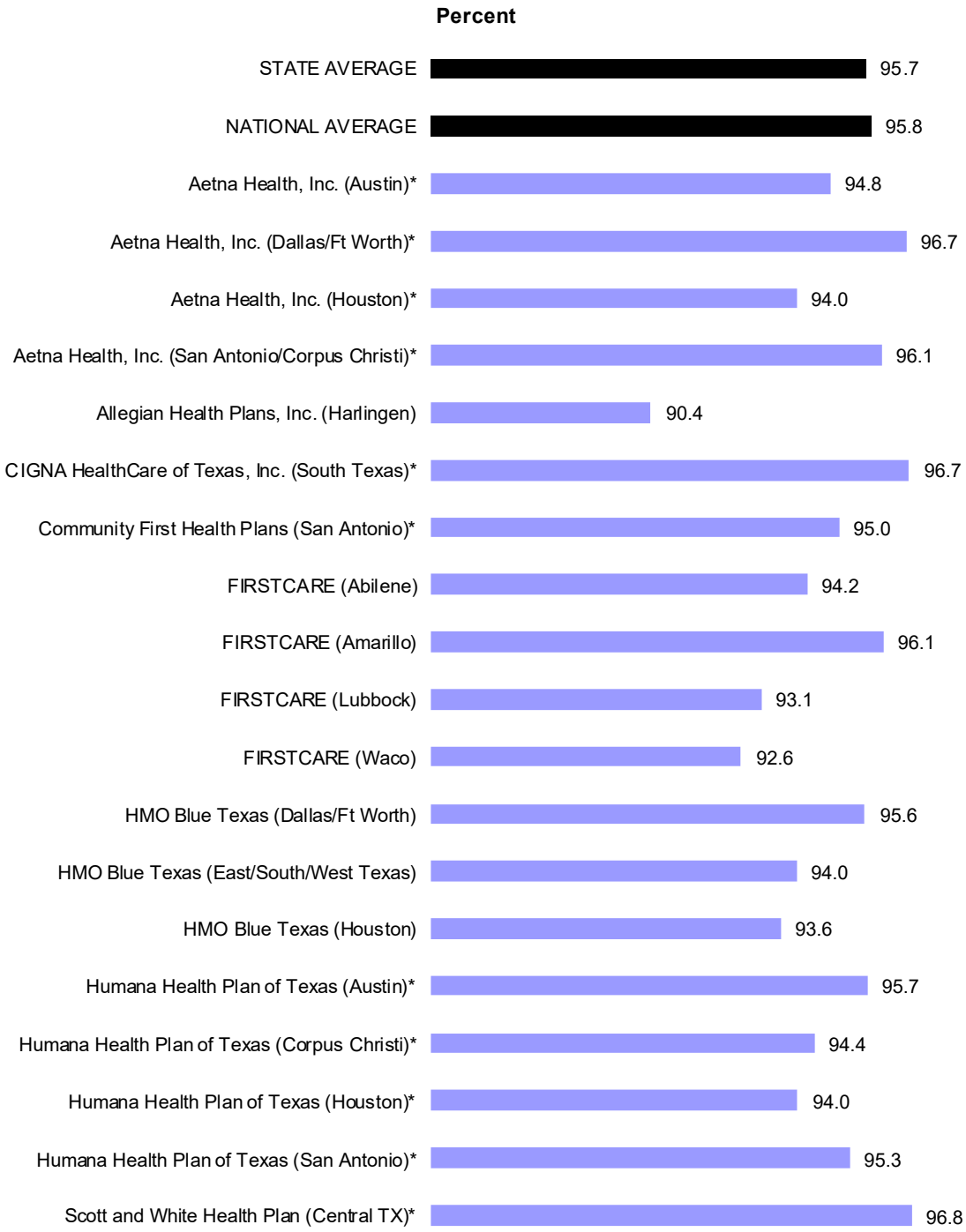
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: 20-44 years



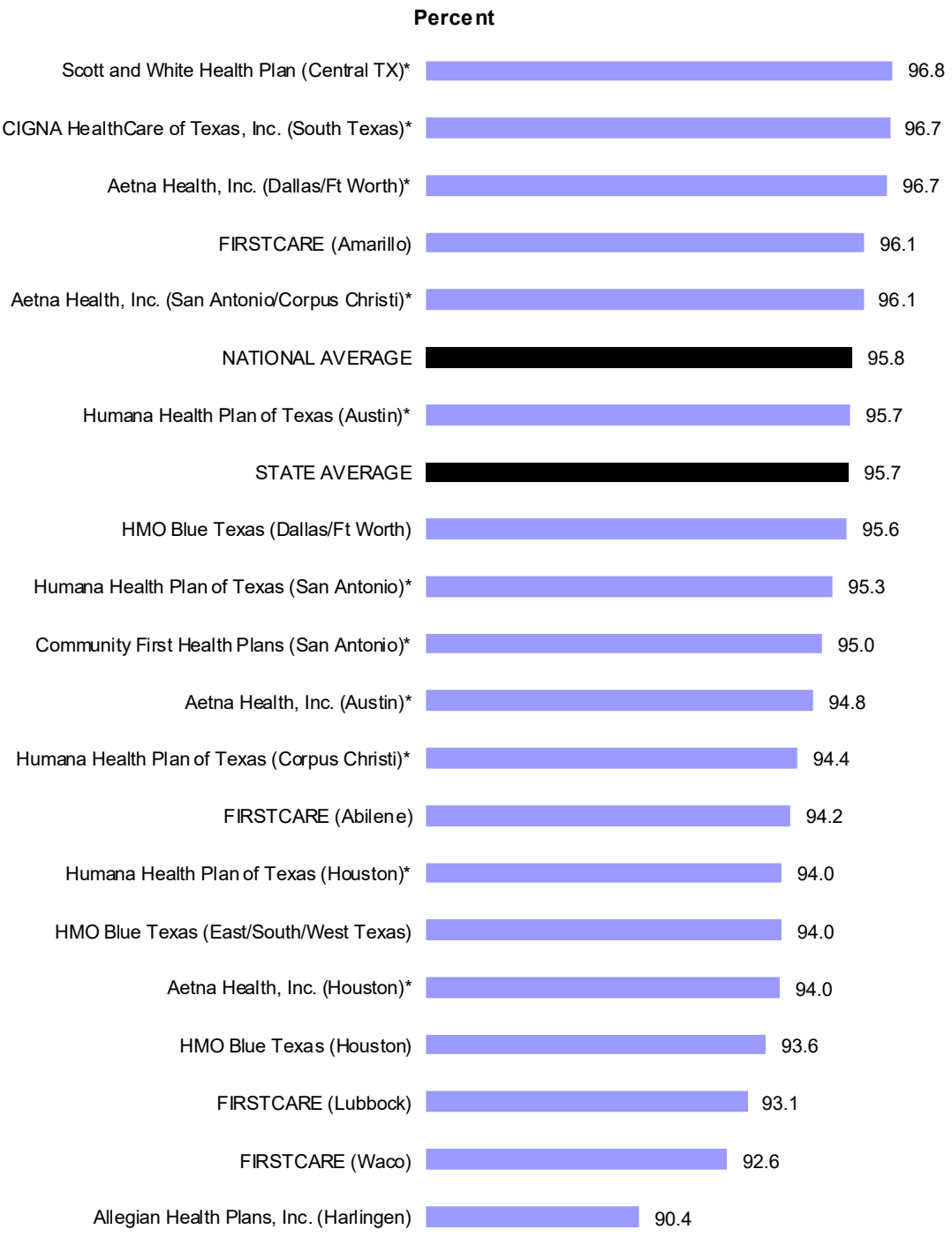
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: 45-64 years



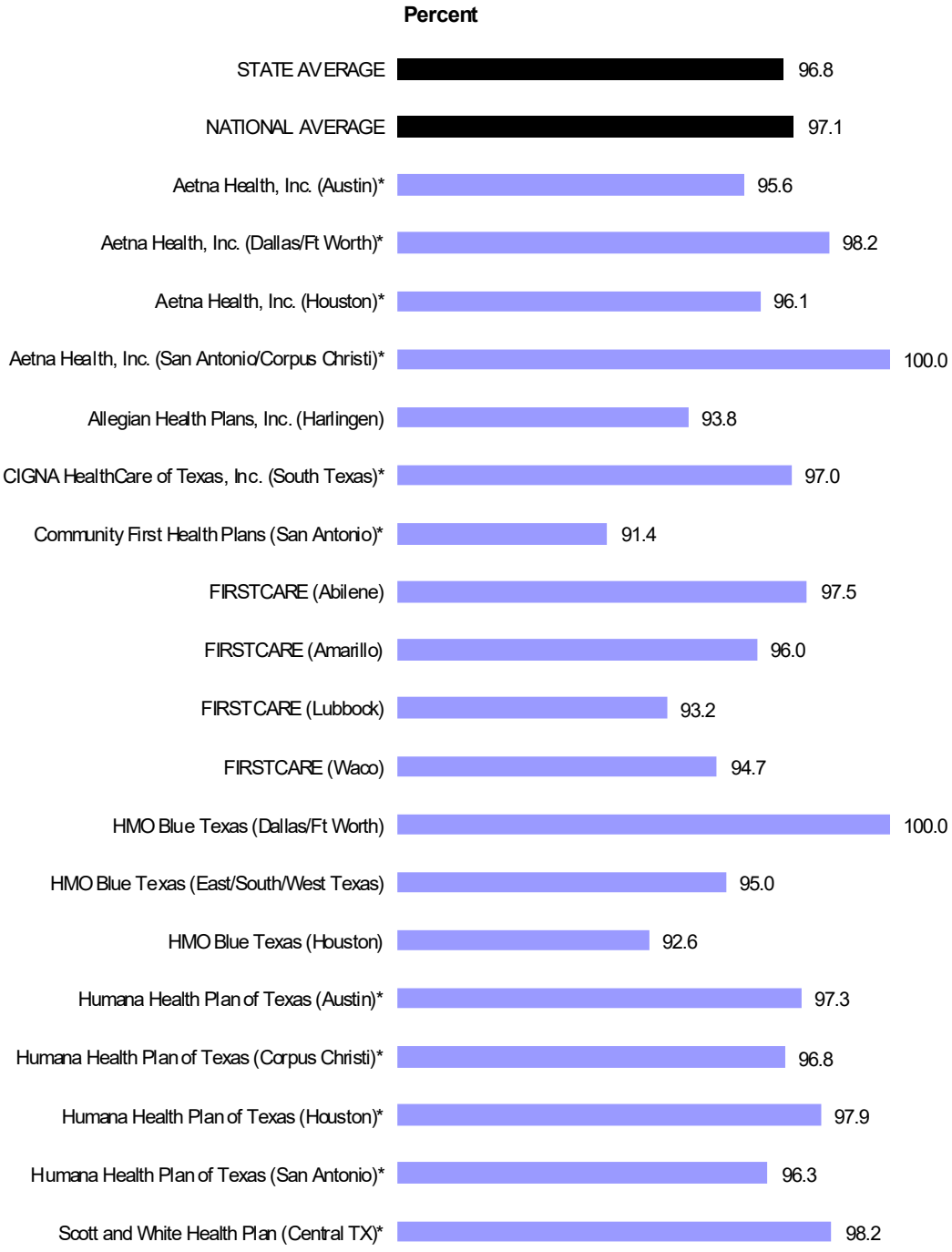
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: 45-64 years



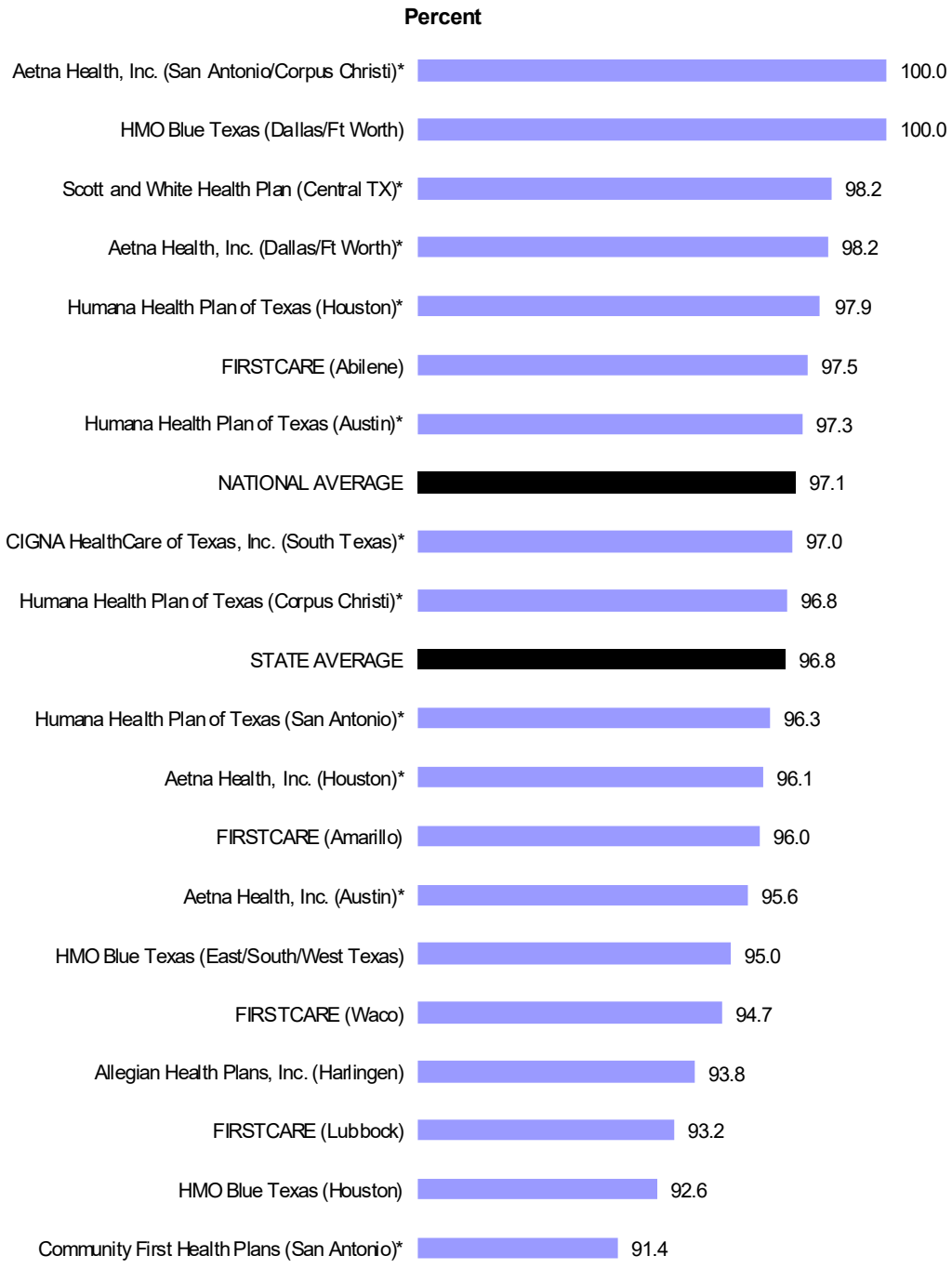
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: 65 years and older



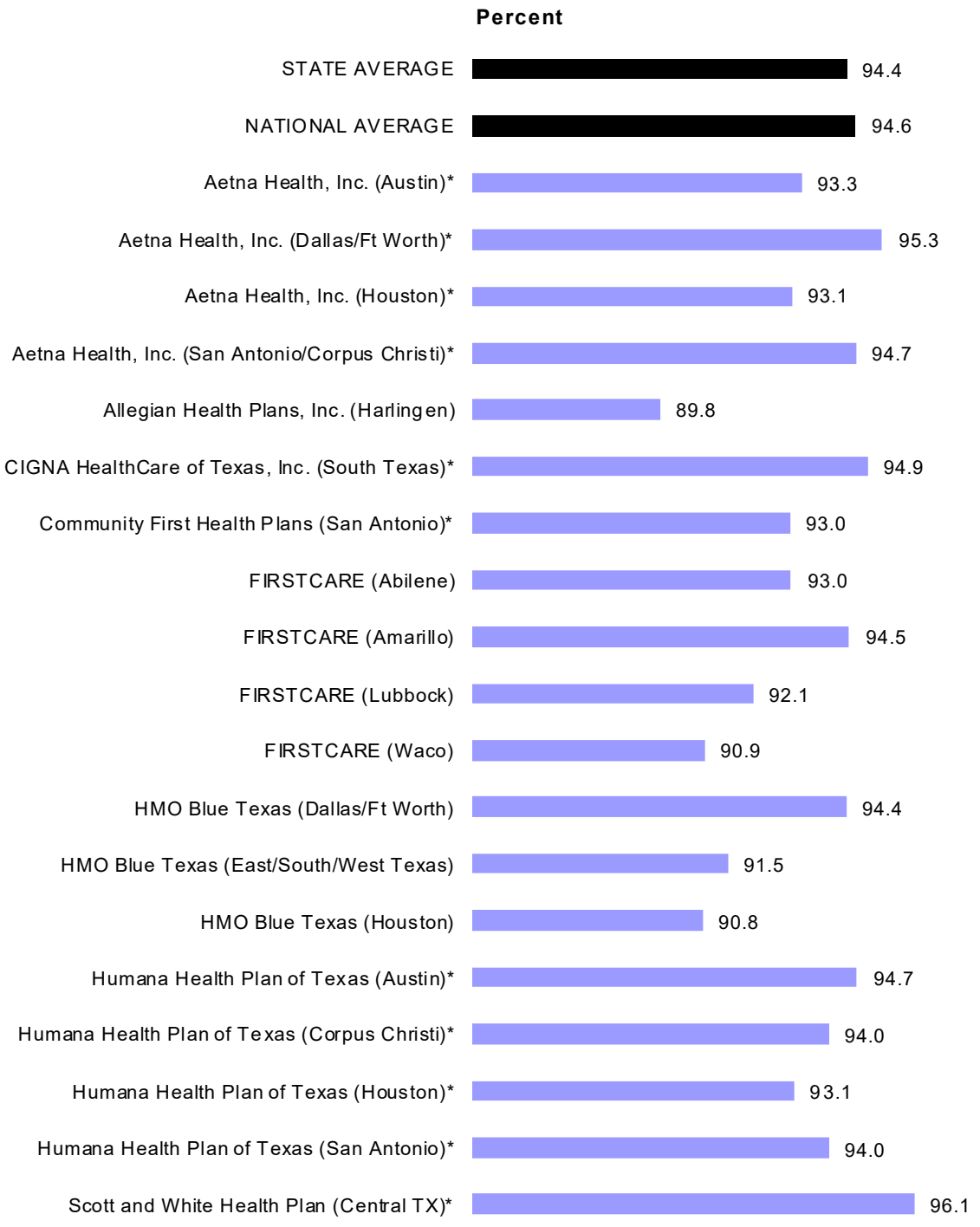
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: 65 years and older



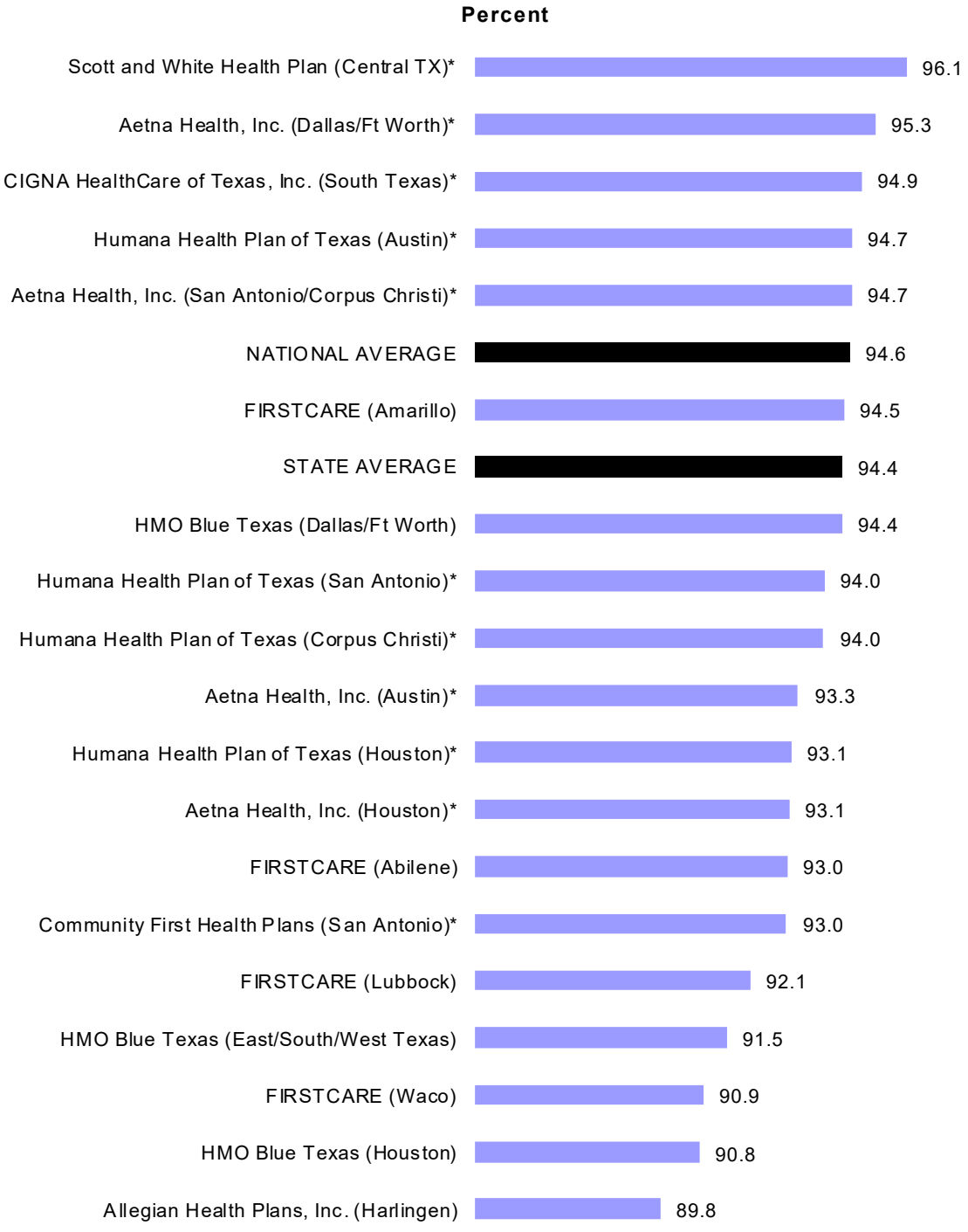
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Access to Preventative/Ambulatory Services: Total



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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.

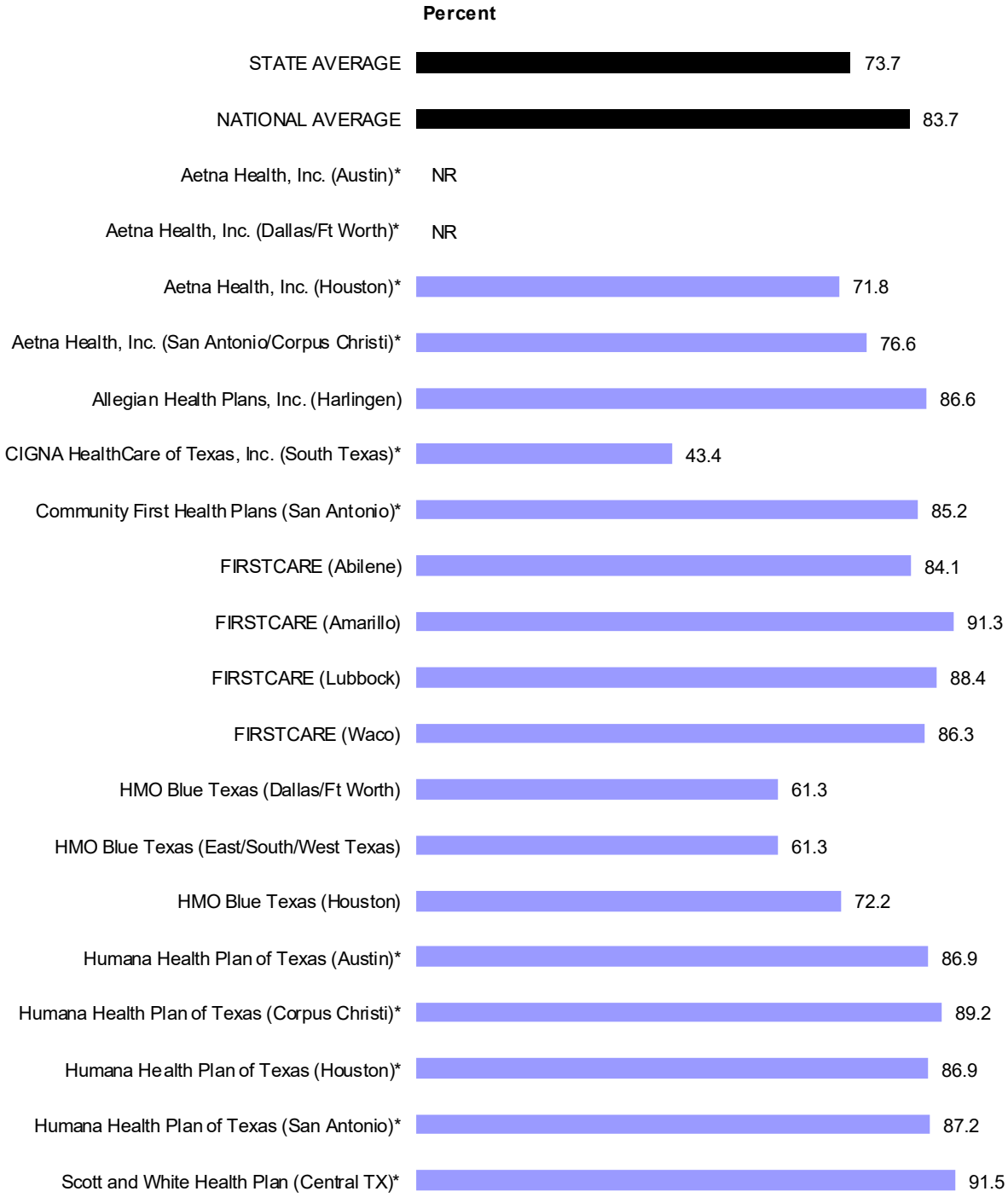
Early prenatal care is an essential part of a healthy pregnancy. Babies of mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die in infancy than those born to mothers who did receive care. Doctors can identify and treat health 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.[1]

Timeliness of Prenatal Care					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	77.3%	78.7%	81.4%	83.7%	73.7%
NCQA's Quality Compass®	91.0%	89.6%	90.9%	87.5%	83.7%

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

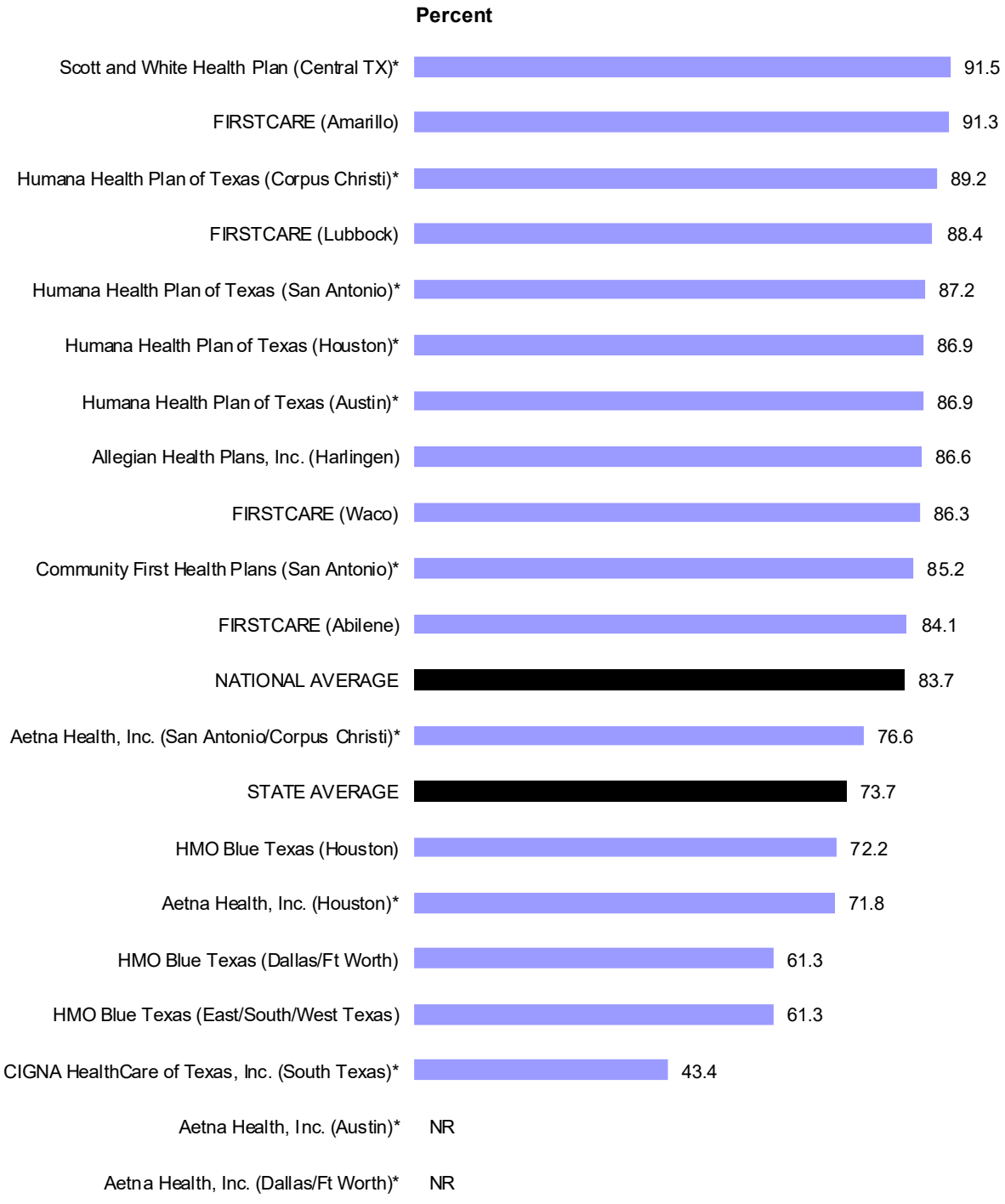
[1] U.S. Department of Health and Human Services, Office on Women's Health. *Prenatal Care Fact Sheet.* Washington, DC: U.S. Department of Health and Human Services, 2012.

Timeliness of Prenatal Care



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Timeliness of Prenatal Care



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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 recommends that a woman see her health care provider at least once four to six weeks after giving birth. The first postpartum visit should include a physical examination. The visit is also an opportunity for the health care practitioner to answer questions, give family planning guidance, and counsel on nutrition.[1]

Postpartum Care					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	52.9%	52.0%	54.8%	71.7%	60.0%
NCQA's Quality Compass®	80.6%	80.1%	80.7%	76.9%	70.3%

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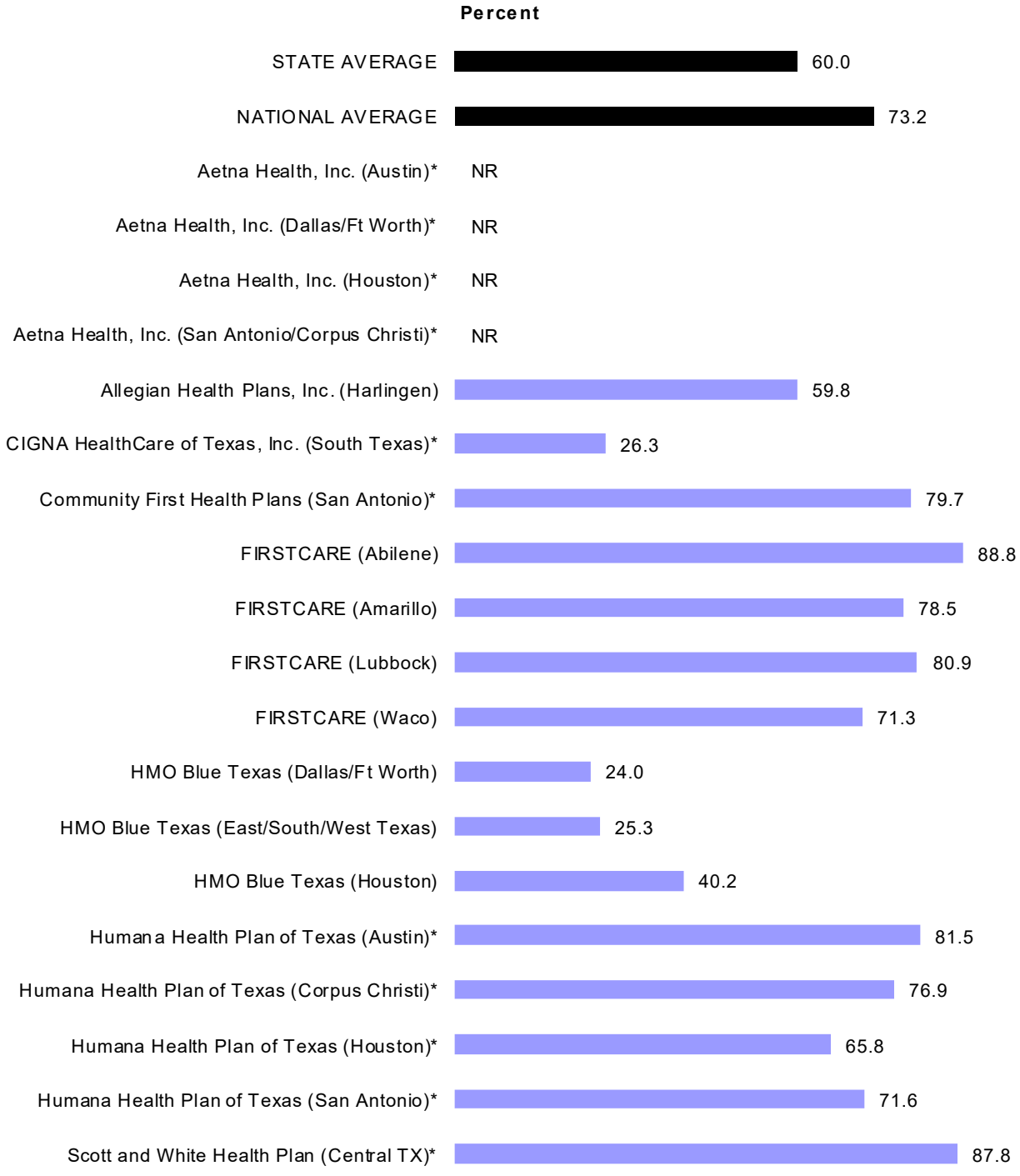
[1] American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care.* 7th ed. Washington, DC: American College of Obstetricians and Gynecologists, 2012.

Postpartum Care



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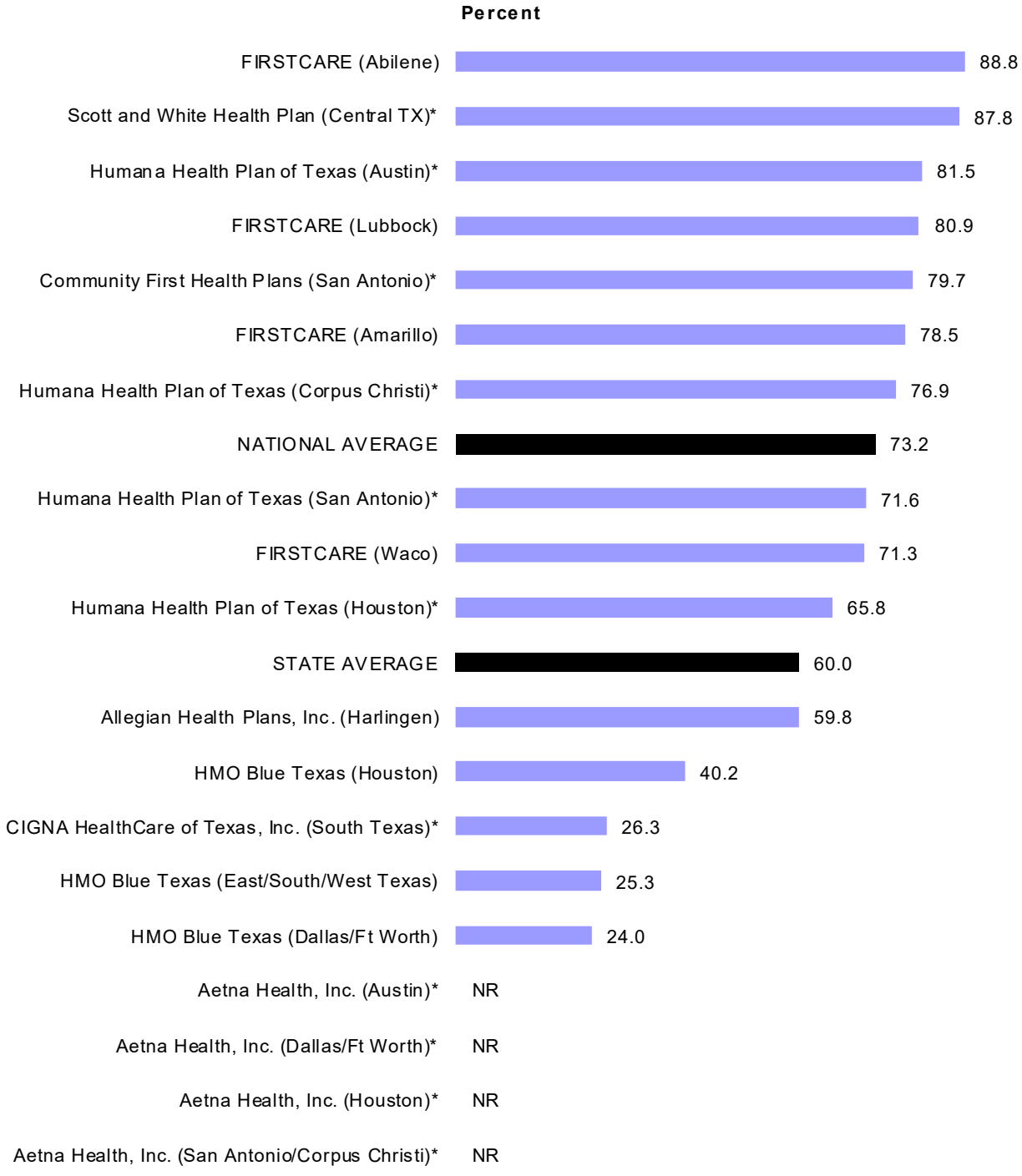
Postpartum Care



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

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

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

During the first year of life an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination, and social and emotional growth. Regular check-ups allow the clinician to detect and address physical, developmental, behavioral, and emotional problems in children. It also provides an opportunity for the clinician to offer guidance and counseling to the parents. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life: one within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age.[1]

Well-Child Visits in the First 15 Months of Life: Six or More Visits					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	67.1%	66.9%	66.5%	62.1%	67.7%
NCQA's Quality Compass®	78.0%	78.2%	79.0%	78.1%	78.3%

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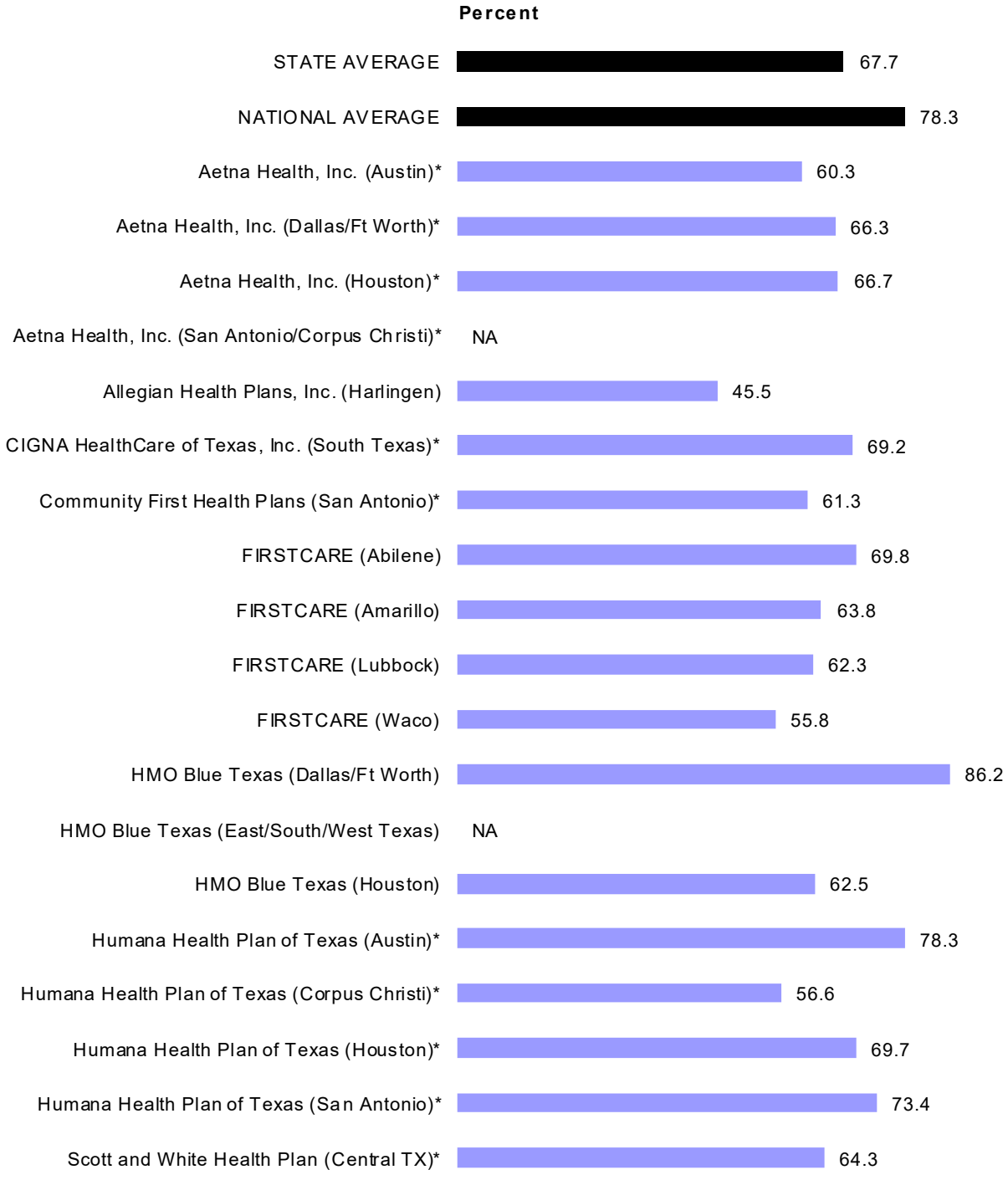
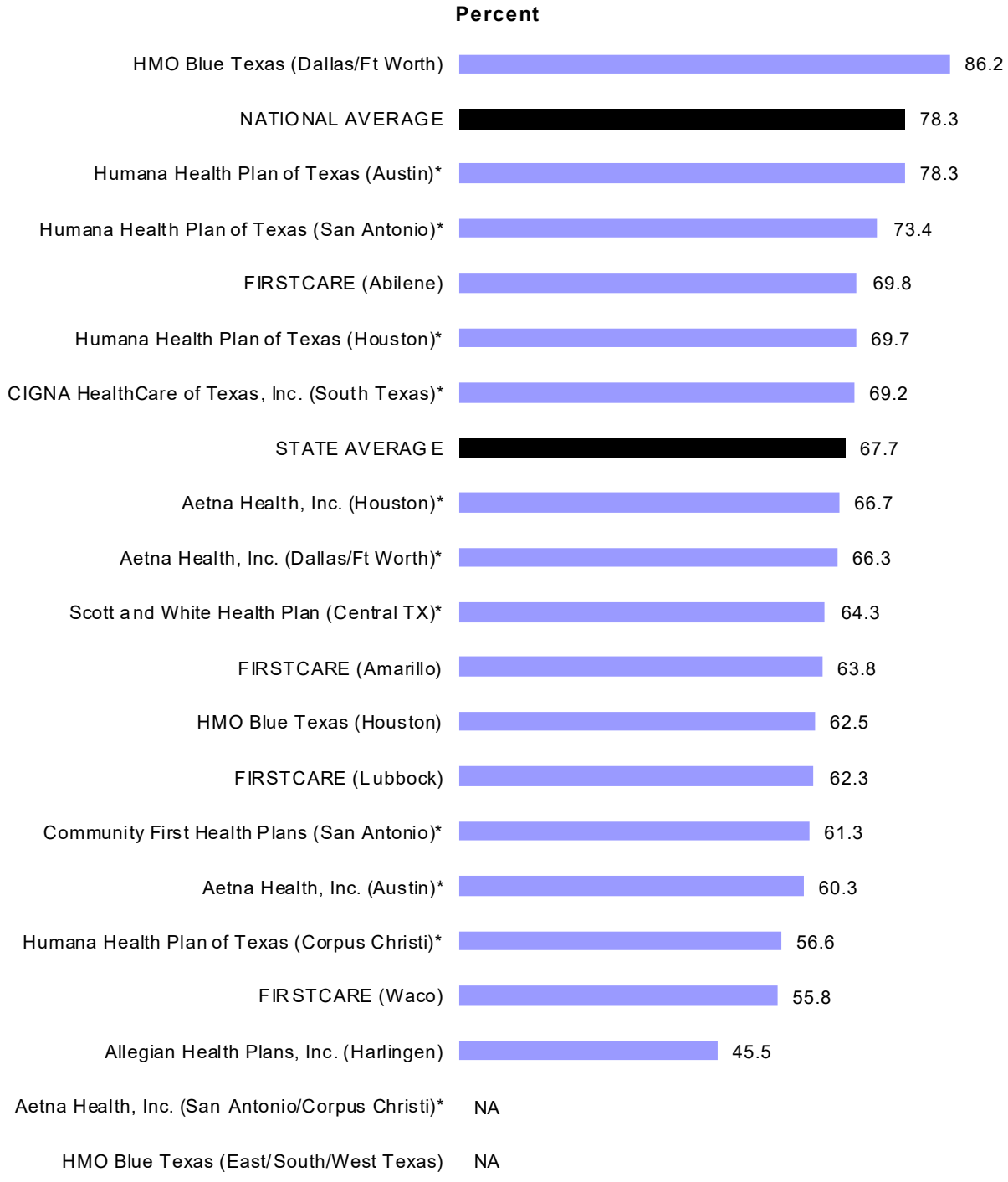
[1] Hagen, Joseph F., Judith S. Shaw, and Paula M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

Well-Child Visits in First 15 Months of Life



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

Well-Child Visits in First 15 Months of Life



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NA–The plan did not have a large enough sample to report a valid rate.

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

Definition: The percentage of children 3–6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.

Regular well-child visits during the preschool and early school years allow a clinician to detect vision, speech, and language problems. Early diagnosis and treatment can improve a child's communication skills and identify language and learning problems. The American Academy of Pediatrics (AAP) recommends at least one annual well-child visit for children 2–6 years of age.[1]

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	63.0%	64.2%	66.0%	67.2%	68.5%
NCQA's Quality Compass®	72.5%	72.9%	74.3%	75.6%	76.3%

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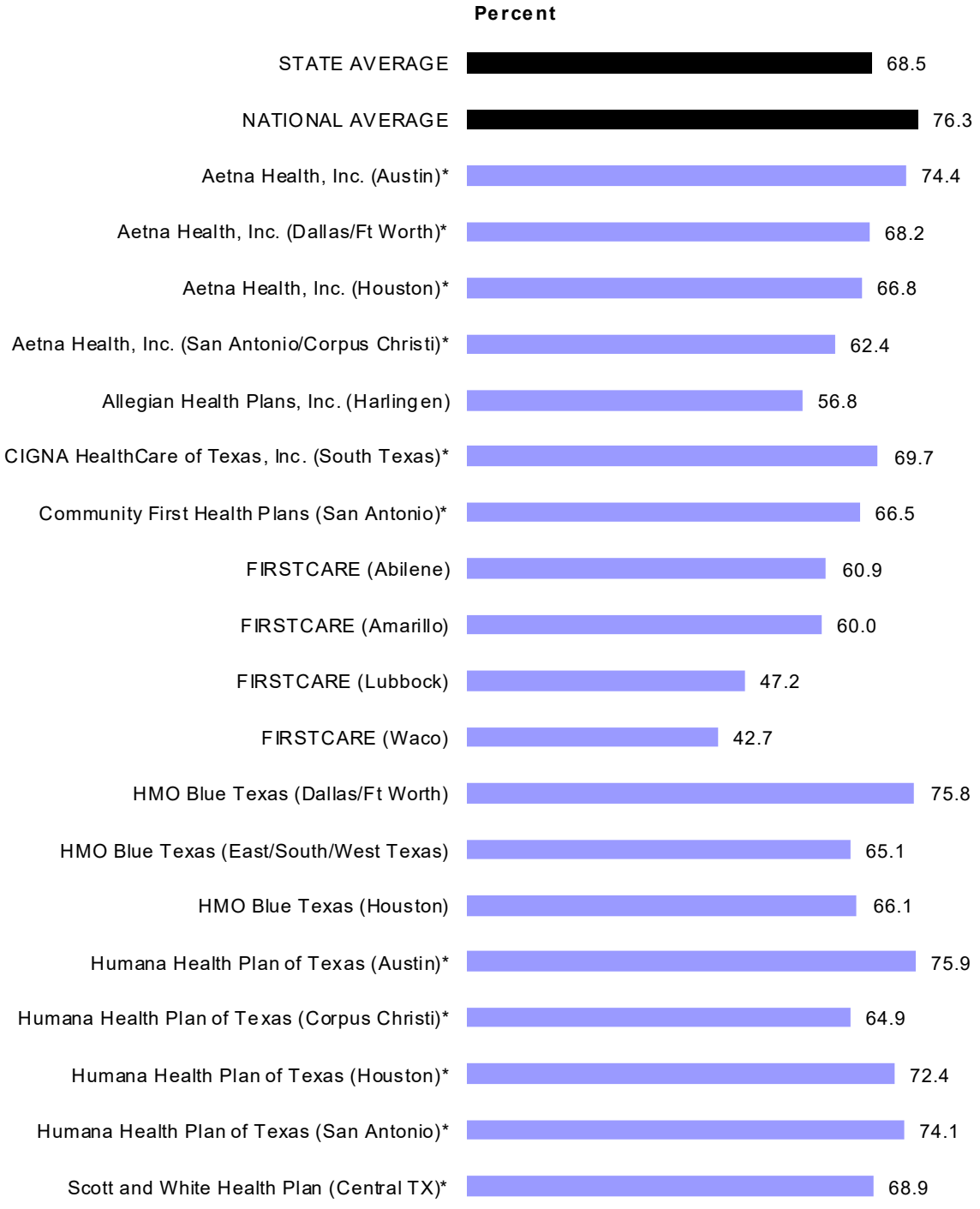
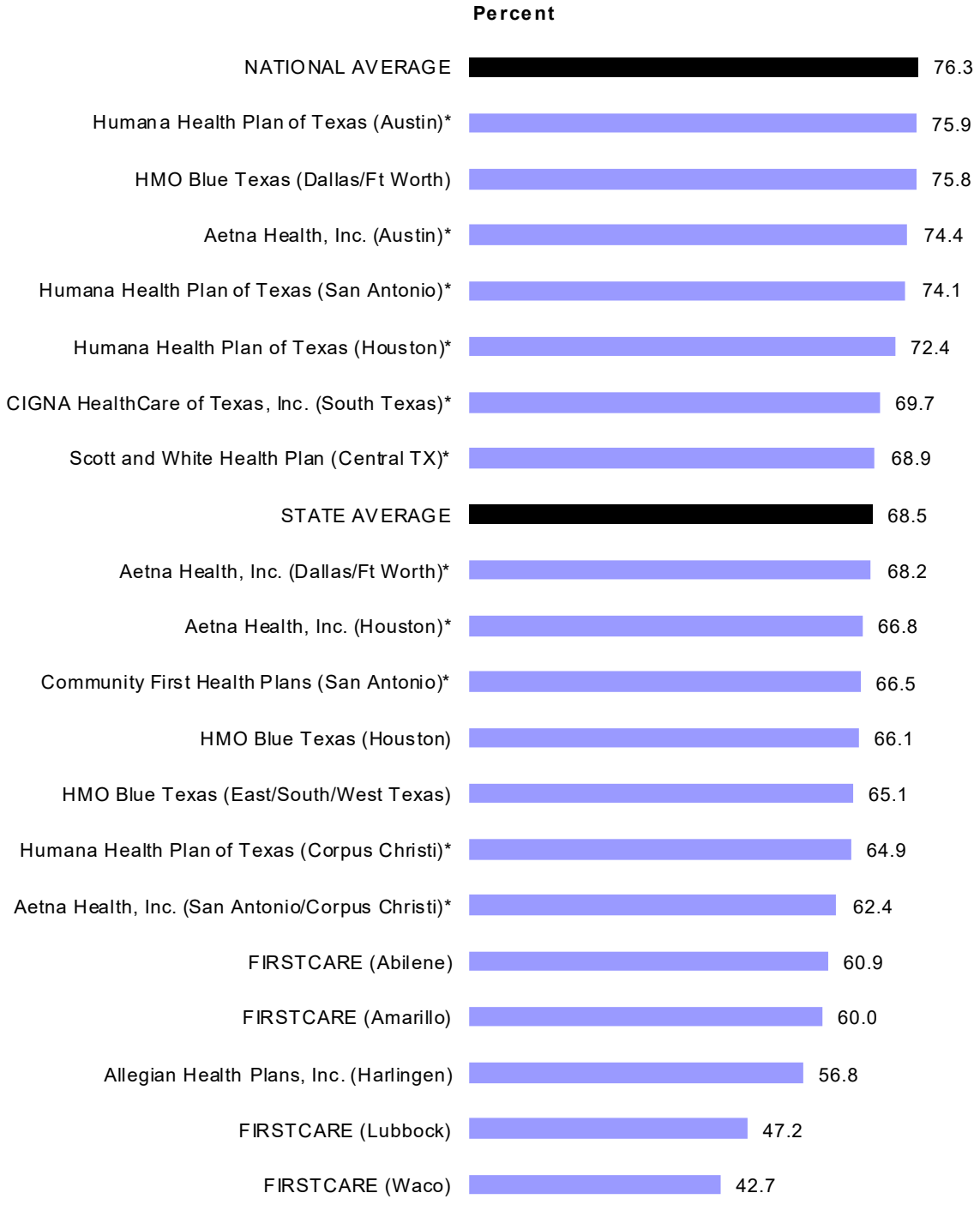
[1] Hagen, Joseph F., Judith S. Shaw, and Paula M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

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



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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 12–21 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. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional, and social aspects of their health. The American Academy of Pediatrics (AAP) recommends at least one annual well-care visit for healthy adolescents 12–21 years of age.[1]

Adolescent Well-Care Visit					
	2012	**2013**	**2014**	**2015**	**2016**
Texas Average	34.7%	36.8%	36.9%	37.7%	37.8%
NCQA's Quality Compass®	43.2%	43.3%	44.5%	45.8%	46.6%

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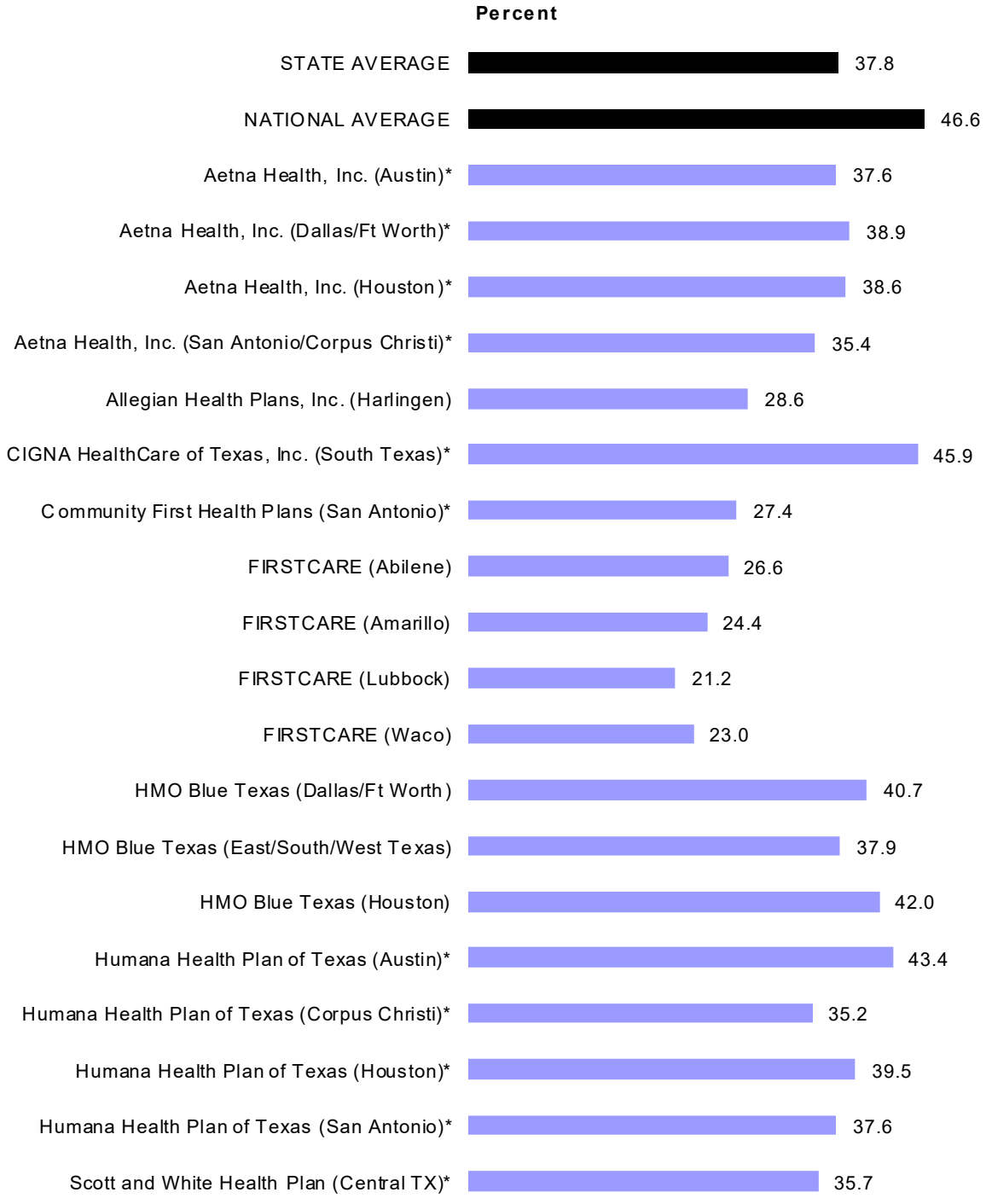
[1] Hagen, Joseph F., Judith S. Shaw, and Paula M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

Adolescent Well-Child Visits



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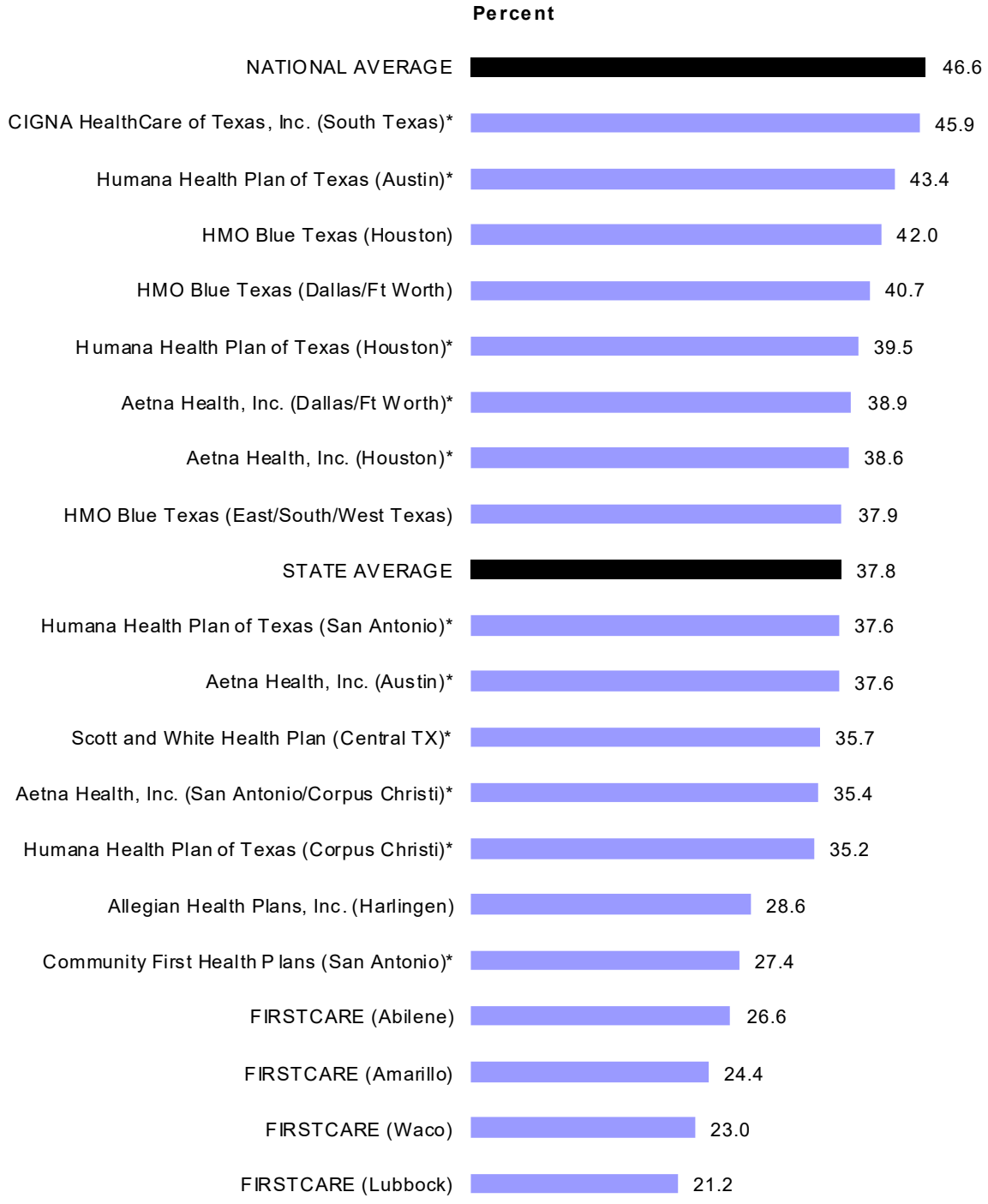
Adolescent Well-Child Visits



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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 and (2) Emergency Department Visits.

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.

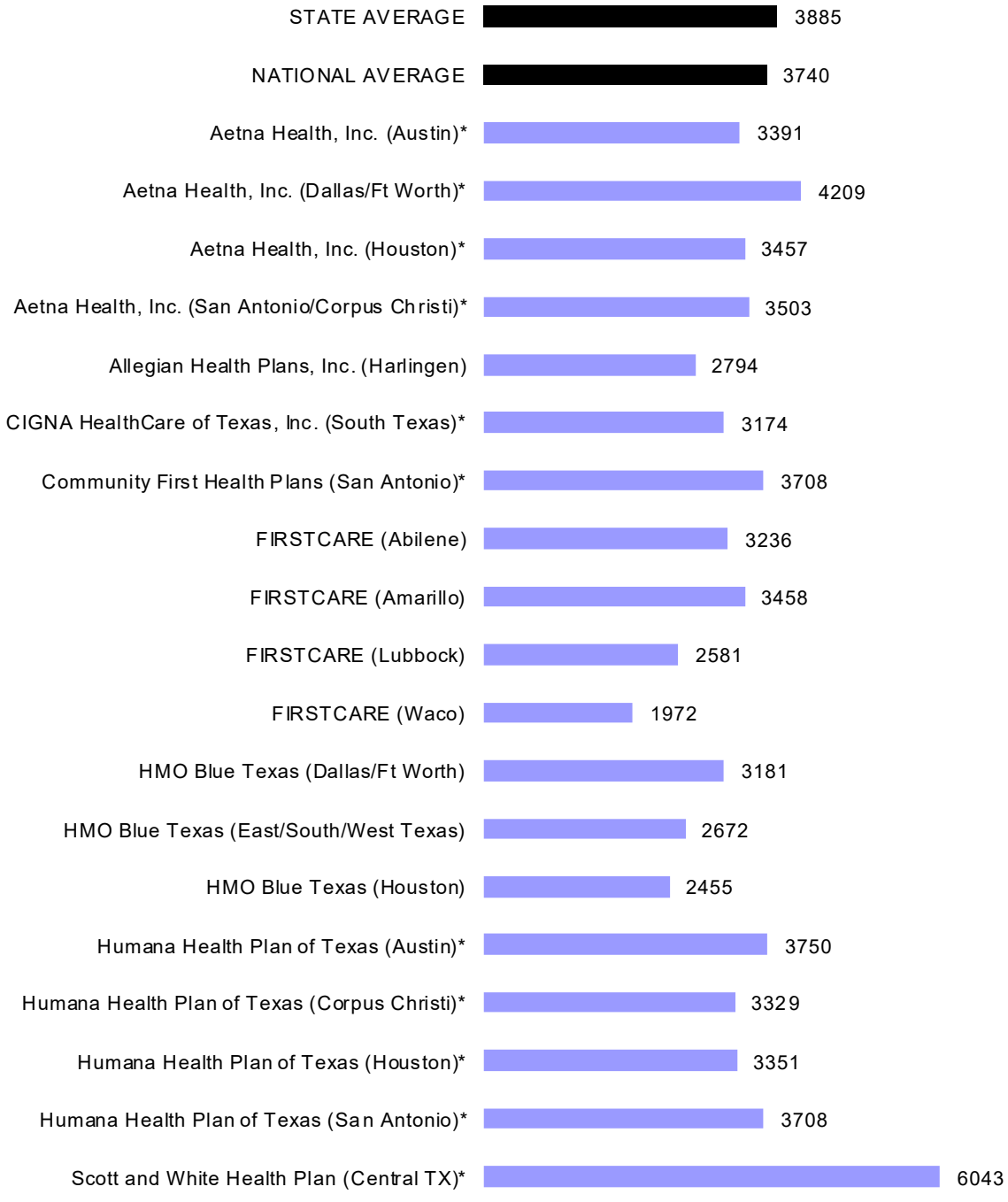
Emergency Department Visits: This category reports the use of emergency department services, which are sometimes used as a substitute for ambulatory clinic encounters. The decision to use an emergency department rather than a clinic or physician's office may be the result of insufficient access to primary 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 care services per 1,000 members per year										
	2012		2013		2014		2015		2016	
Average	Texas	QC	Texas	QC	Texas	QC	Texas	QC	Texas	QC
Outpatient Visits	3940	3914	4258	3880	4119	3812	3956	3794	3885	3740
ED Visits	181	193	190	196	187	193	196	196	201	198

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

Ambulatory Care: Outpatient Visits

Per 1,000 Members Per Year



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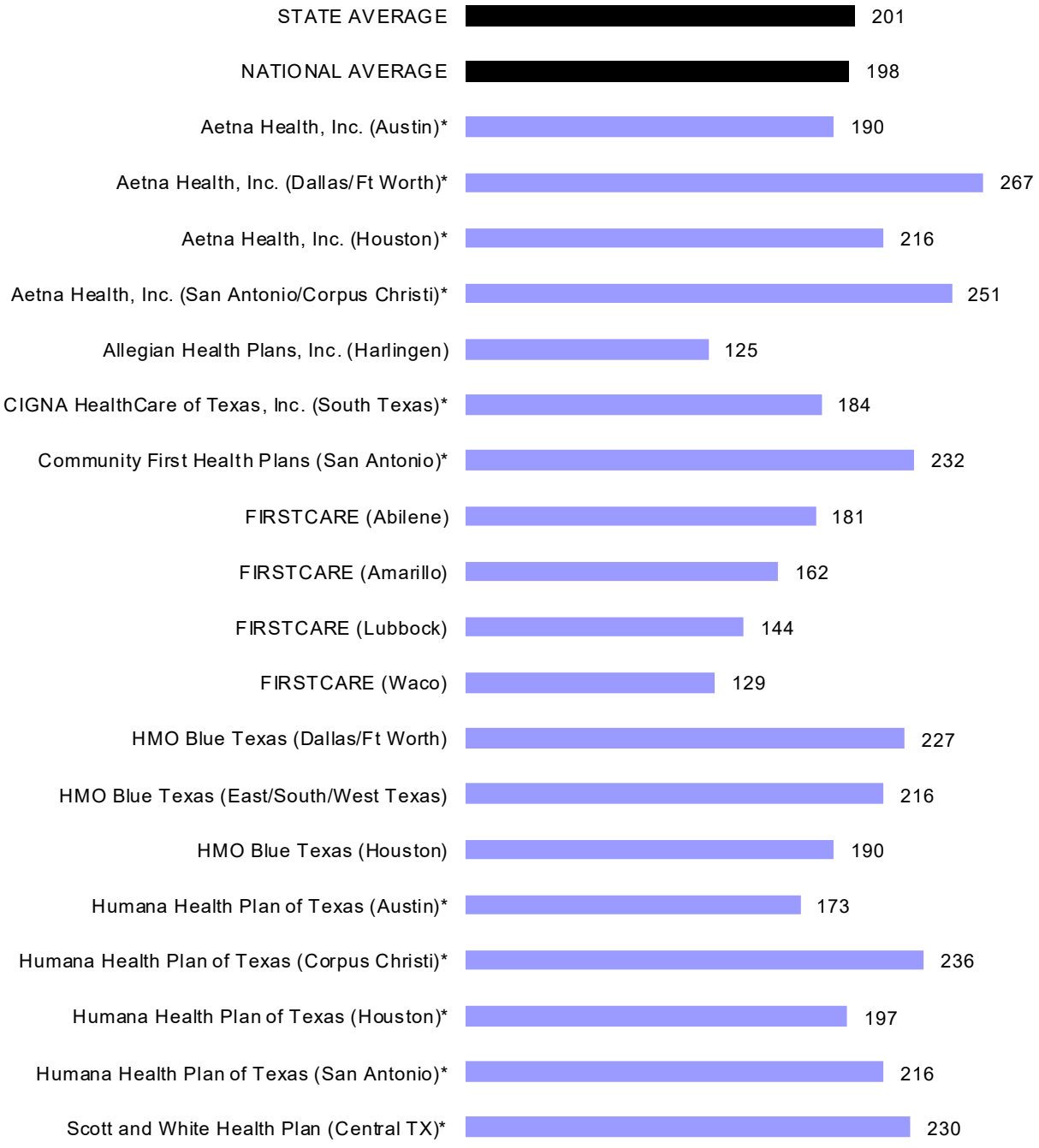
Ambulatory Care: Emergency Department Visits

Per 1,000 Members Per Year



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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.

Hospitalization is one of the largest contributors to overall healthcare costs. This measure reports plan member use of inpatient hospital services for surgical, medical, and maternity admissions. The measure excludes non-acute care, mental health, chemical dependency, and newborn care admissions.

Inpatient Utilization–General Hospital/Acute Care: Total										
	2012		2013		2014		2015		2016	
	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS
TX Average	50.9	3.9	50.1	3.9	56.0	3.5	46.7	3.8	46.4	4.6
NCQA's Quality Compass®	52.9	3.8	51.6	3.8	49.7	3.8	47.8	3.9	45.9	3.9

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

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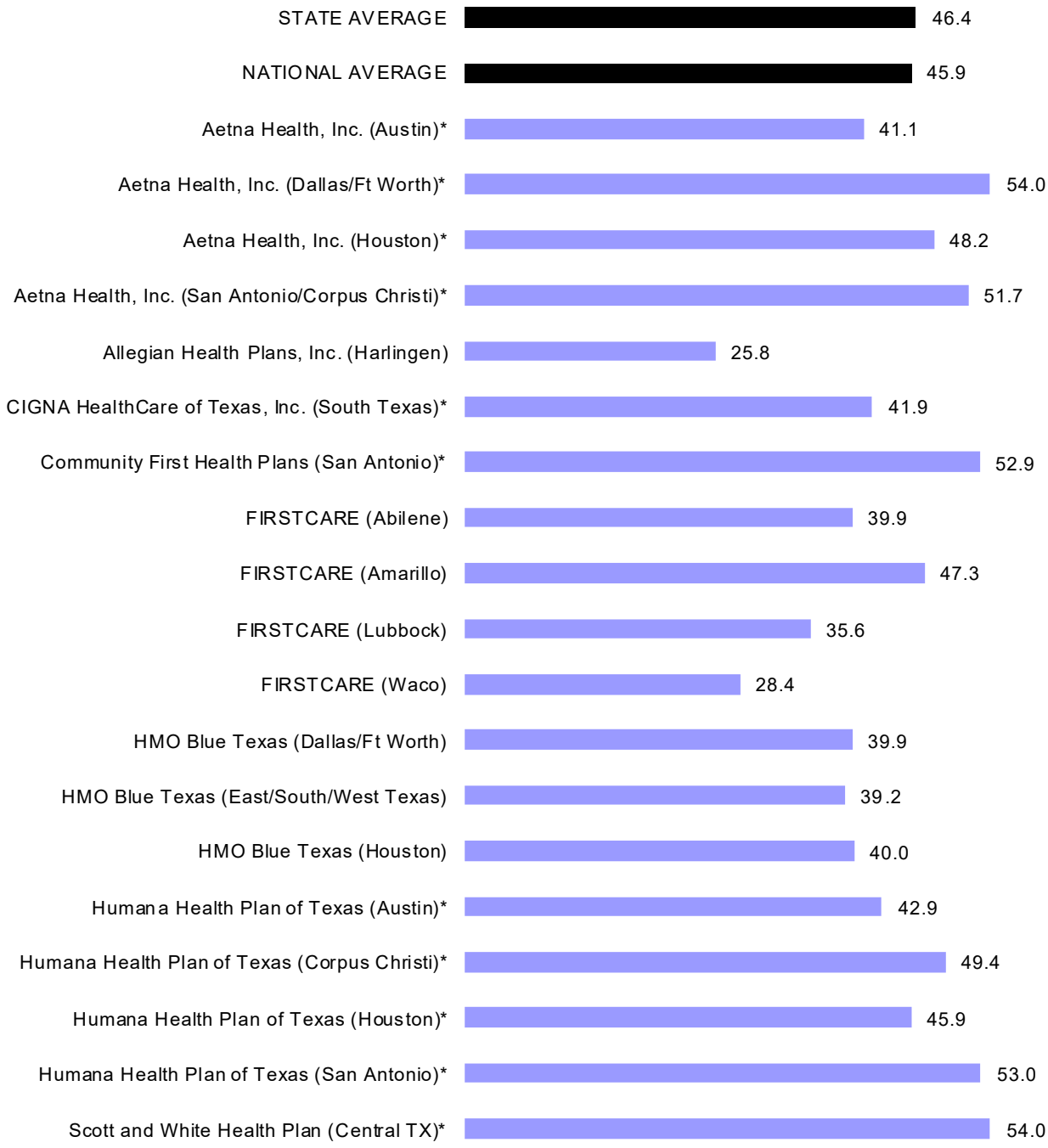
Inpatient Utilization - Acute Care: Total Discharge

Per 1,000 Members Per Year



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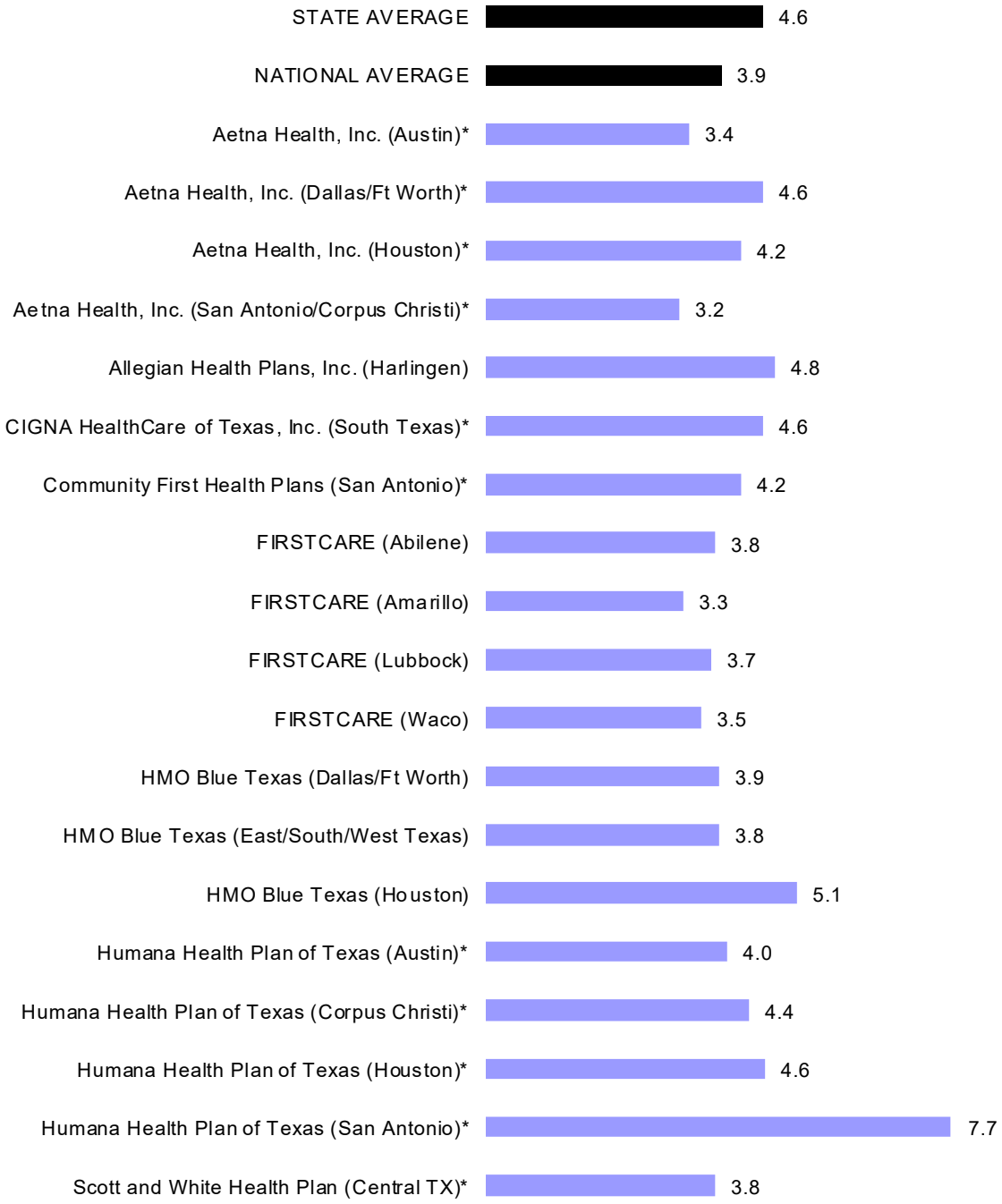
Inpatient Utilization - Acute Care: Total Average Length of Stay

Days



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Inpatient Utilization—General Hospital/Acute Care: Medicine

Definition: Discharges per 1,000 members per year and average length of stay for inpatient hospital services for non-surgical medical treatment.

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 or use of outpatient alternatives.

Inpatient Utilization – General Hospital/ Acute Care: Medicine										
	2012		2013		2014		2015		2016	
	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS
TX Average	21.0	4.2	20.5	4.0	26.2	3.4	19.3	4.0	19.3	4.6
NCQA's Quality Compass®	22.5	3.8	22.4	3.8	21.3	3.8	20.4	3.9	19.2	4.0

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

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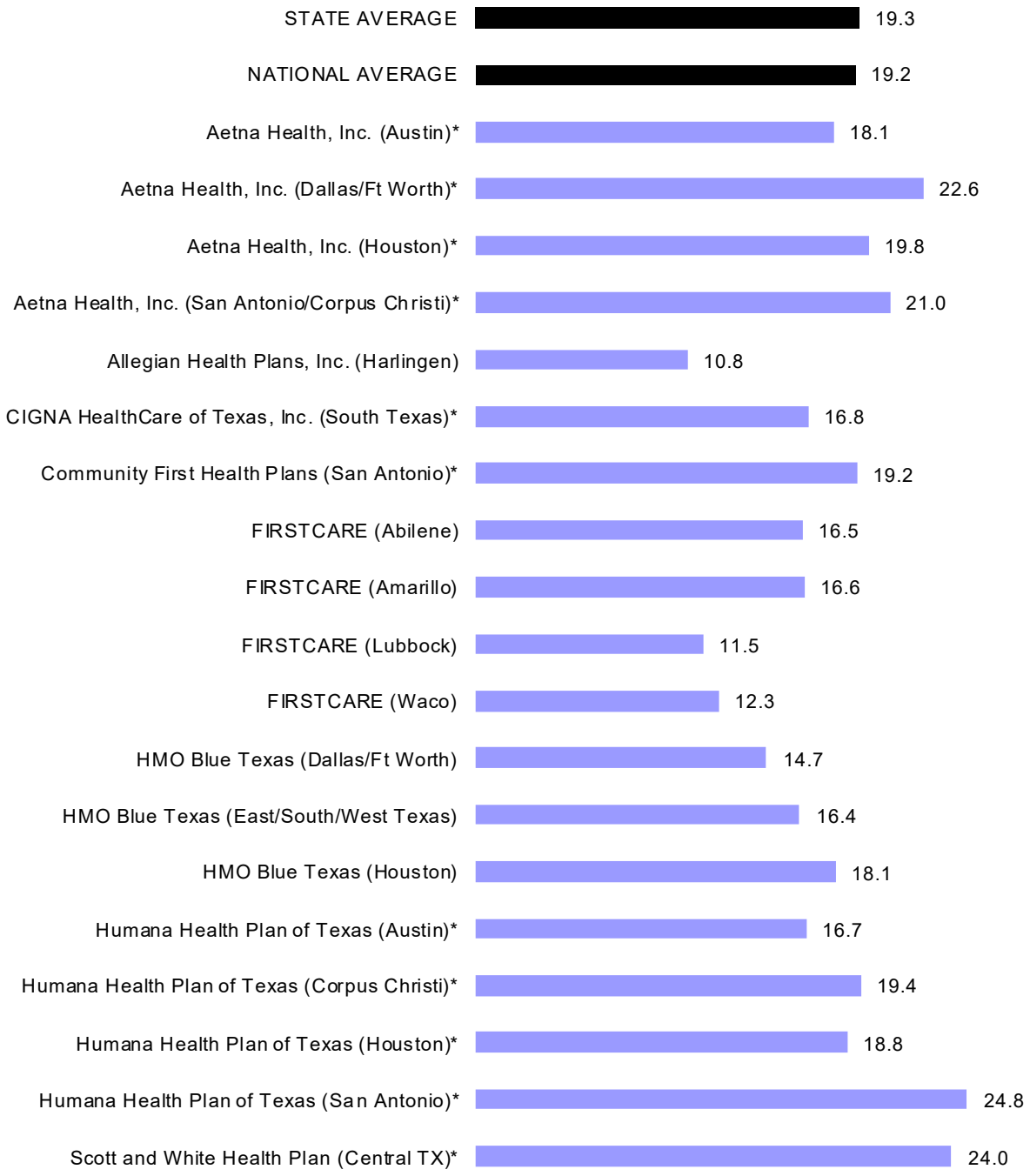
Inpatient Utilization - Acute Care: Medicine Discharge

Per 1,000 Members Per Year



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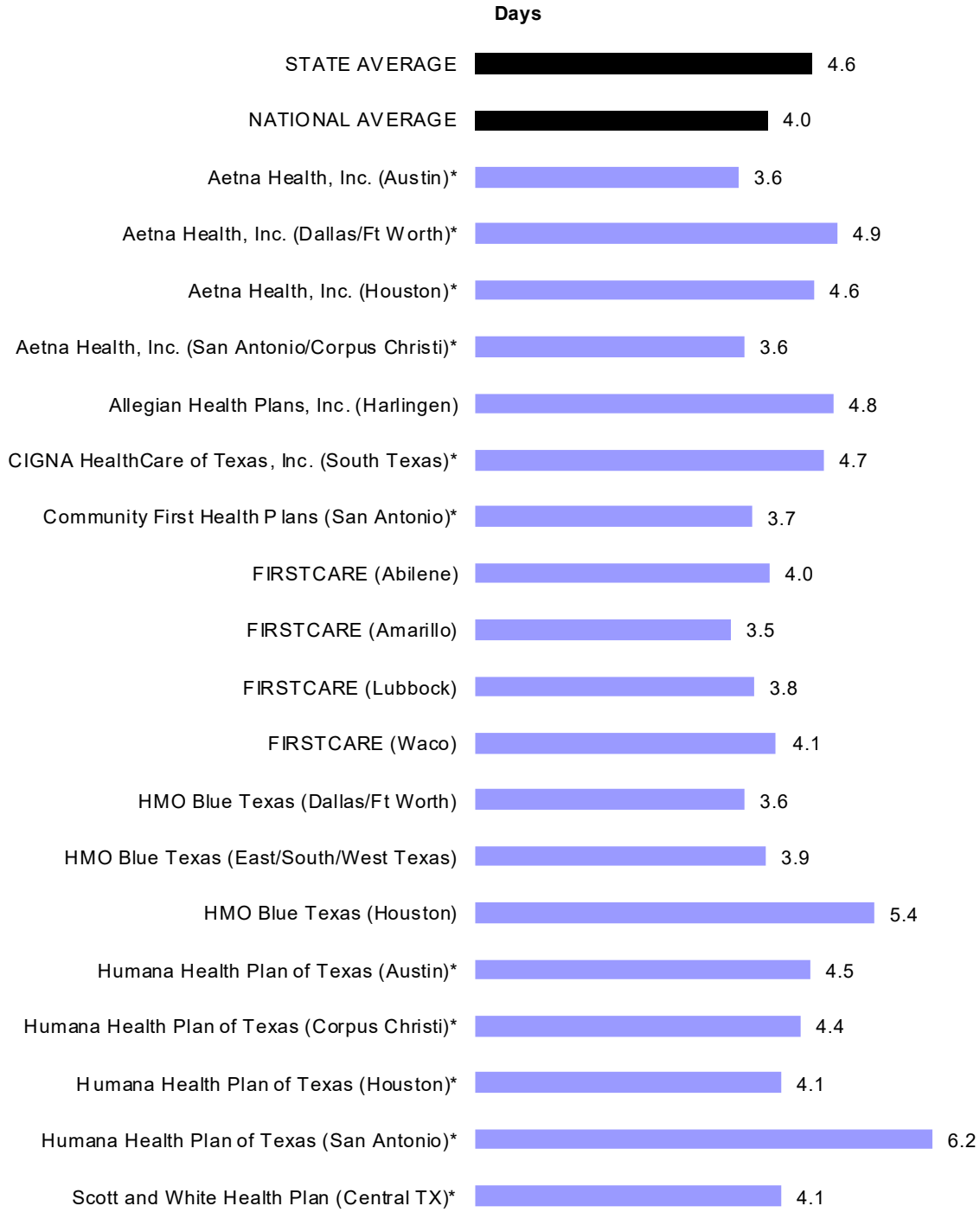
Inpatient Utilization - Acute Care: Medicine Average Length of Stay



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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 or use of outpatient alternatives.

Inpatient Utilization – General Hospital/Acute Care: Surgery										
	2012		2013		2014		2015		2016	
	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS
TX Average	16.4	4.6	16.1	4.7	15.6	4.7	14.3	4.8	14.1	6.2
NCQA's Quality Compass®	18.5	4.4	17.5	4.5	16.7	4.5	15.9	4.7	15.3	4.7

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

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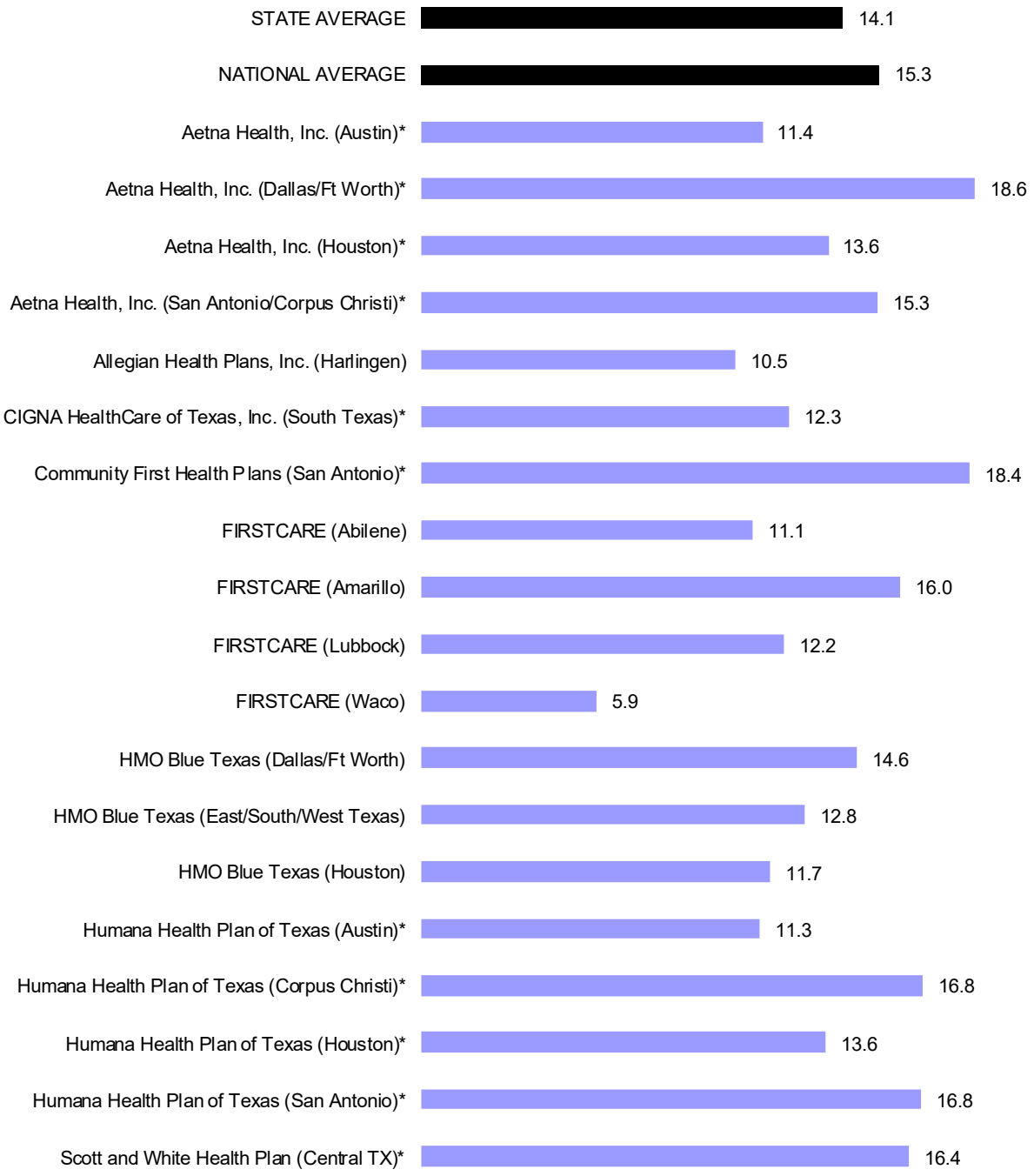
Inpatient Utilization - Acute Care: Surgery Discharge

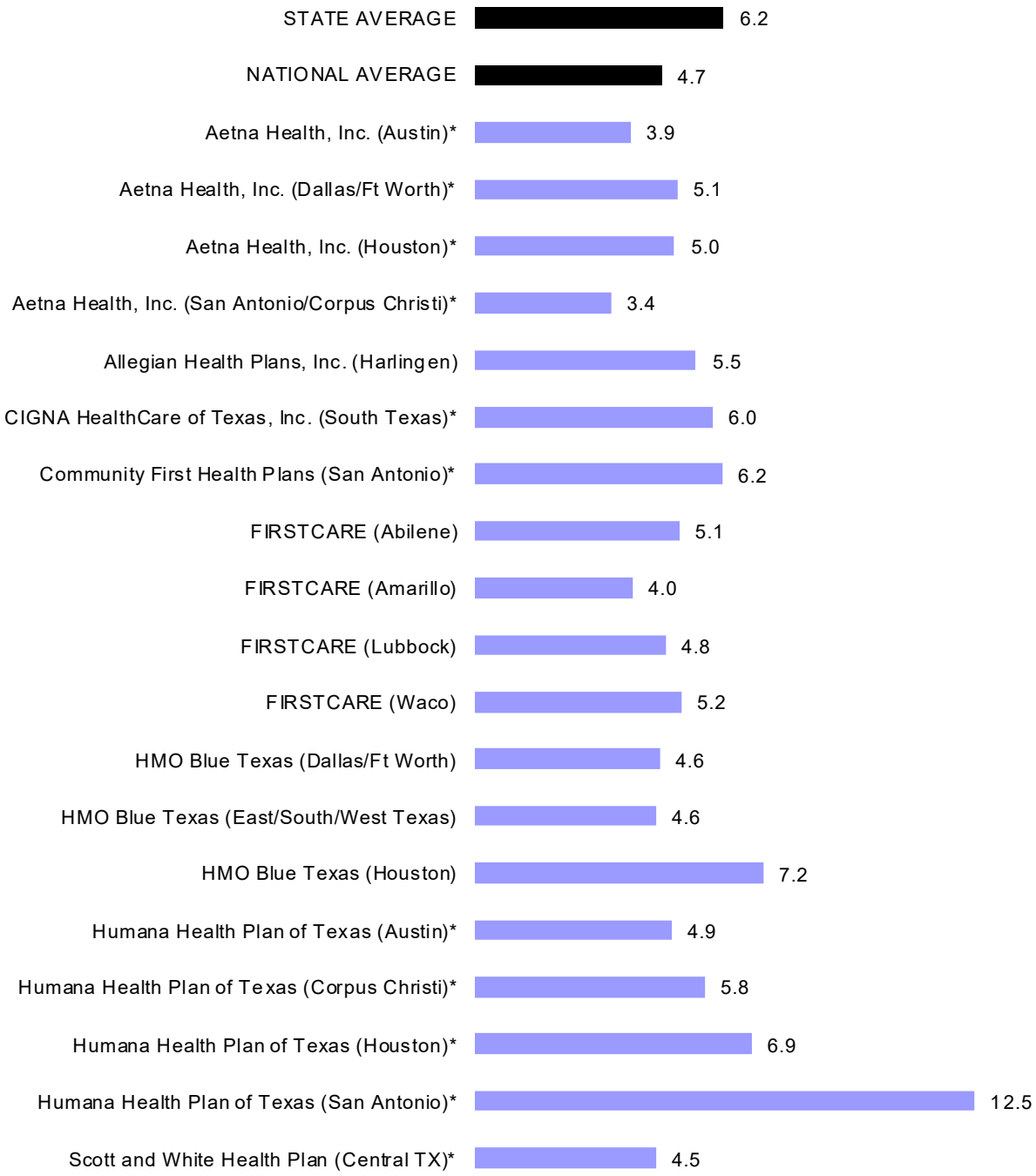
Per 1,000 Members Per Year



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Inpatient Utilization - Acute Care: Surgery Average Length of Stay

Days



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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.

Inpatient Utilization – General Hospital/Acute Care: Maternity										
	2012		2013		2014		2015		2016	
	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS	DIS	ALOS
TX Average	13.5	2.7	13.5	2.7	14.1	2.5	13.1	2.5	12.8	2.8
NCQA's Quality Compass®	13.8	2.8	13.7	2.7	13.3	2.7	13.3	2.7	13.1	2.7

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

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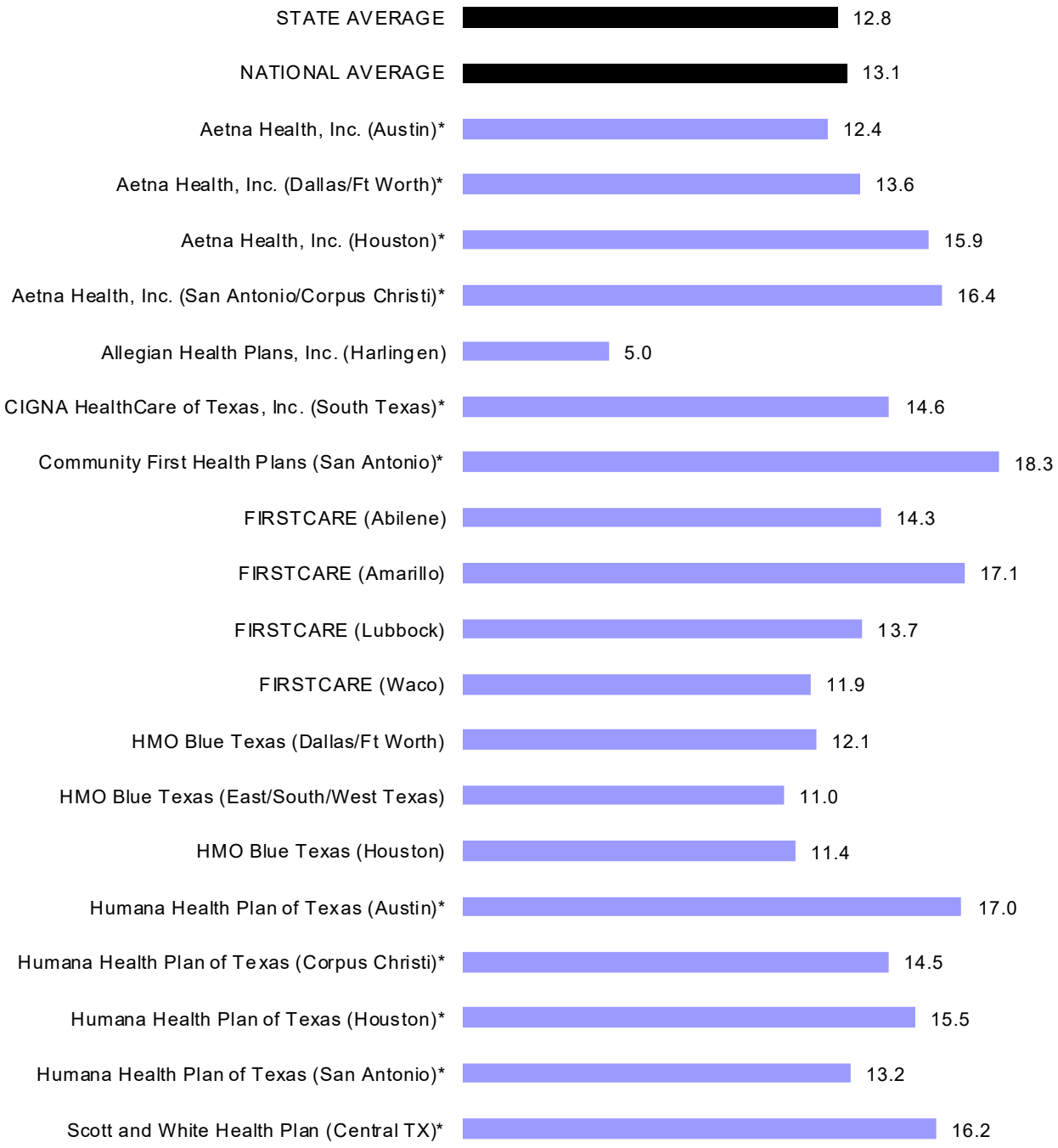
Inpatient Utilization - Acute Care: Maternity Discharge

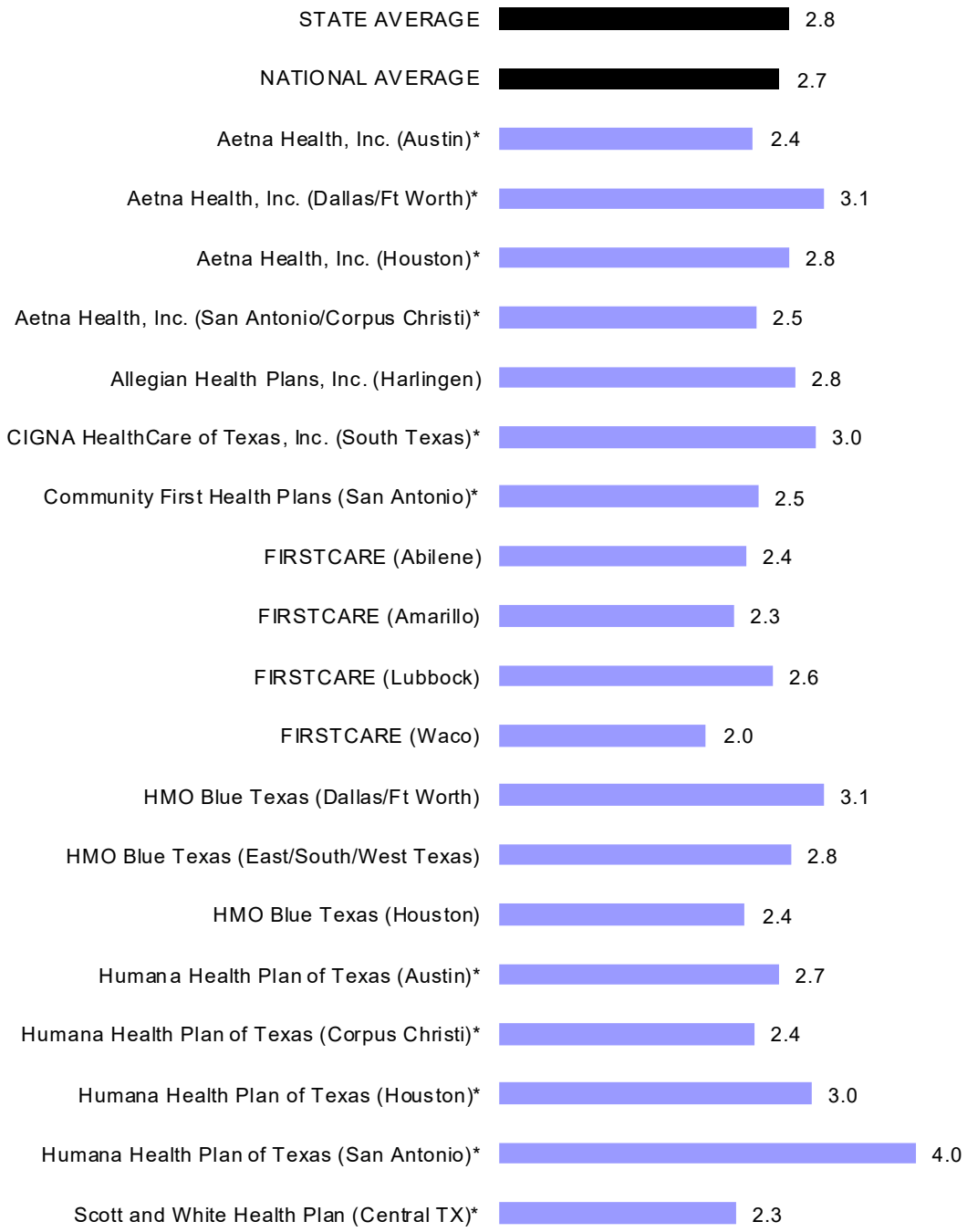
Per 1,000 Members Per Year



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Inpatient Utilization - Acute Care: Maternity Average Length of Stay

Days



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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).

In 2014, there were an estimated 43.6 million adults aged 18 or older in the U.S. with a diagnosis of any mental illness in the past year. This represented 18.1 percent of all U.S. adults.[1] Mental illness can range in impact from mild impairment to significantly disabling impairment, such as in individuals with serious mental illness. Serious mental illness is defined as individuals with a mental disorder with serious functional impairment which substantially interferes with or limits one or more major life activities. In 2008, 13.4 percent of adults in the United States received treatment for a mental health problem.[2] This includes all adults who received care in inpatient or outpatient settings and/or used prescription medication for mental or emotional problems.

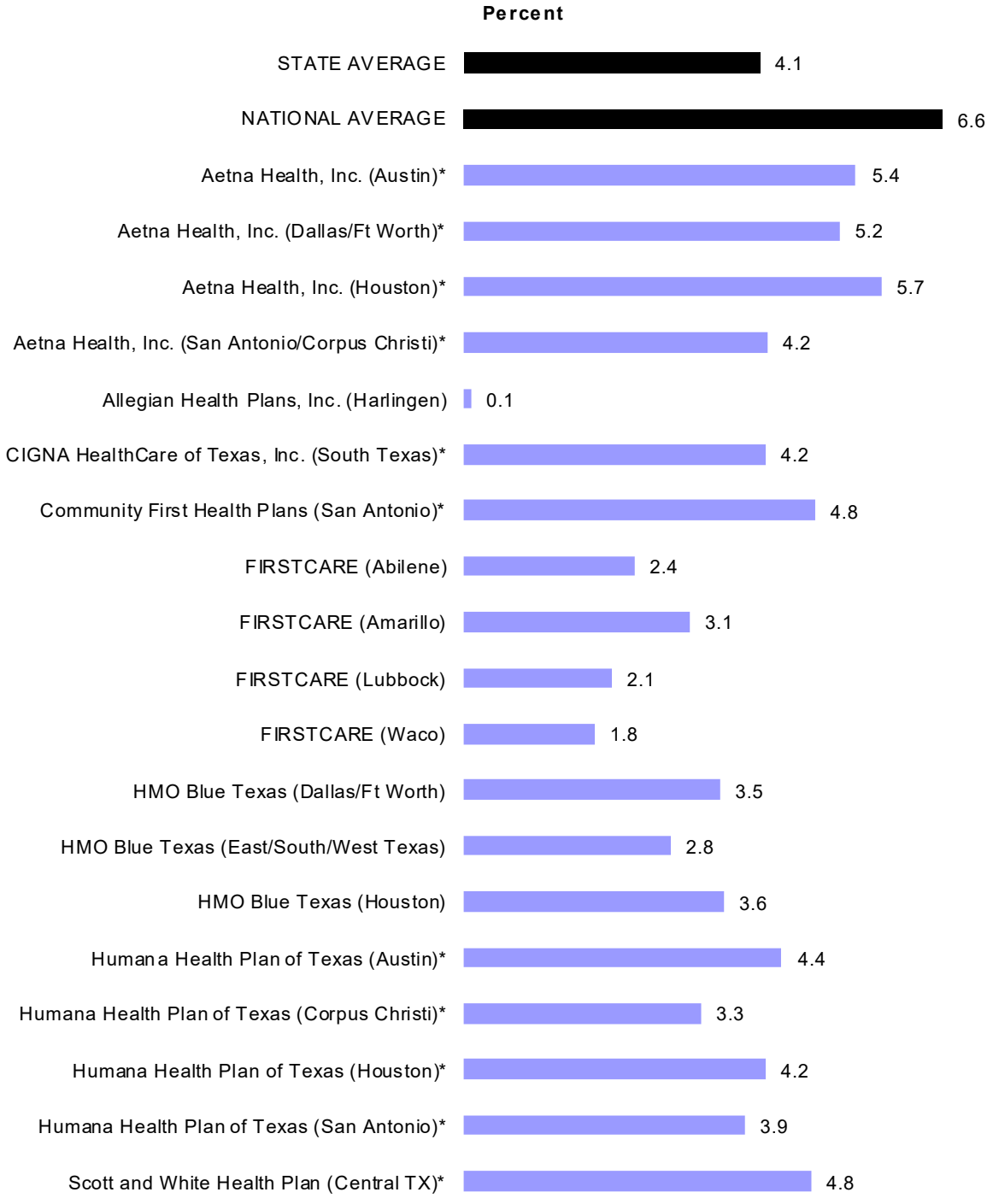
Mental Health Utilization – Percentage of Members Receiving Inpatient, Intensive outpatient or partial hospitalization, and Outpatient or emergency department services.				
	2015		2016	
Mental Health Services Received	Texas	QC	Texas	QC
Any	4.7%	6.8%	4.1%	6.6%
Inpatient	0.19%	0.25%	0.19%	0.24%
Intensive Outpatient or Partial Hospitalization	0.14%	0.18%	0.09%	0.18%
Outpatient or Emergency Department	4.7%	6.7%	4.0%	6.5%

This measure was added to the Texas Subset beginning with HEDIS® 2015.

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

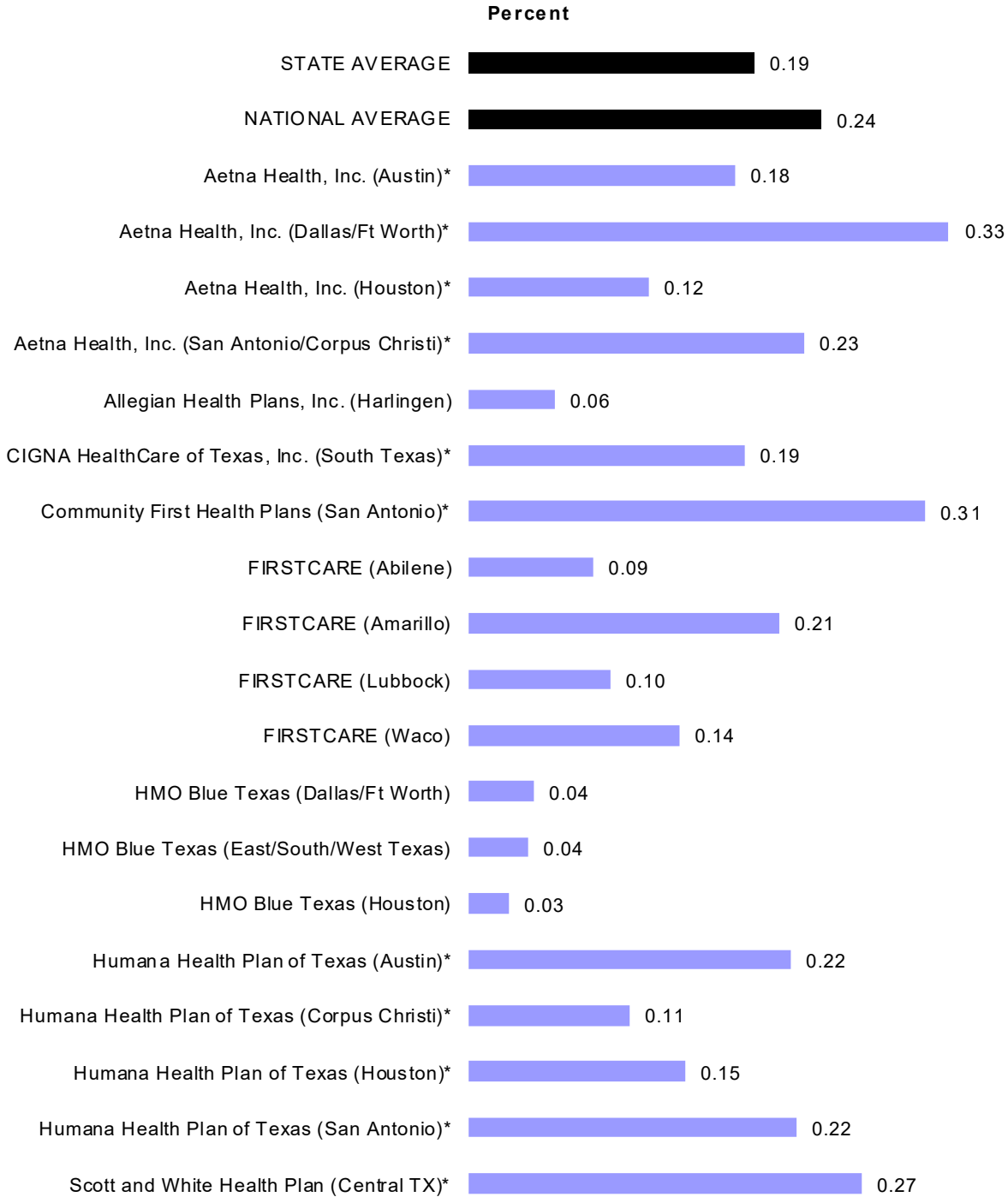
[1] National Institutes of Health, National Institute of Mental Health. *Any Disorder Among Adults.* Bethesda, MD: National Institutes of Health, 2016.
[2] National Institutes of Health, National Institute of Mental Health. *Use of Mental Health Services and Treatment Among Adults.* Bethesda, MD: National Institutes of Health, 2015.

Mental Health Utilization: Any Service



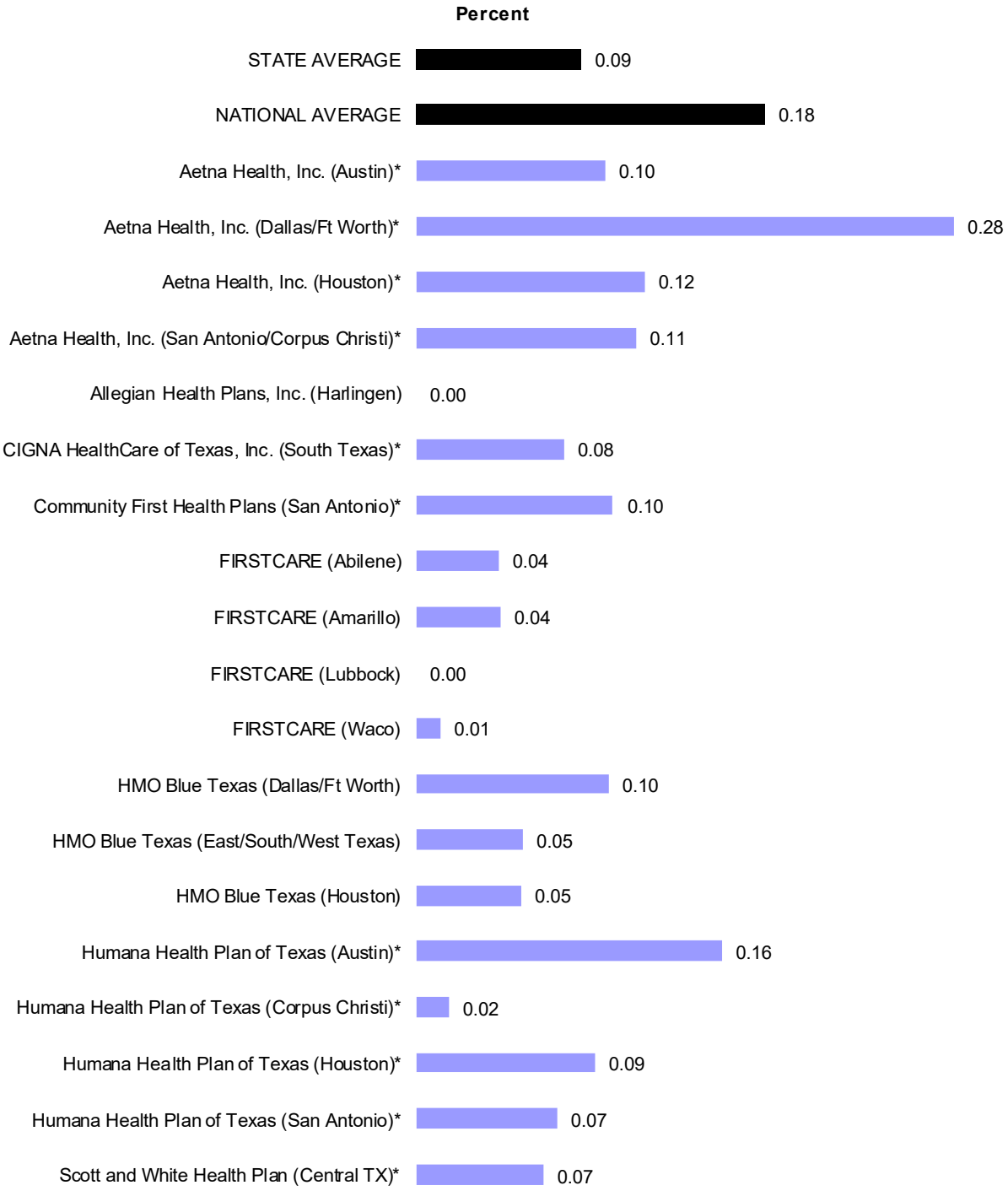
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Mental Health Utilization: Inpatient Services



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

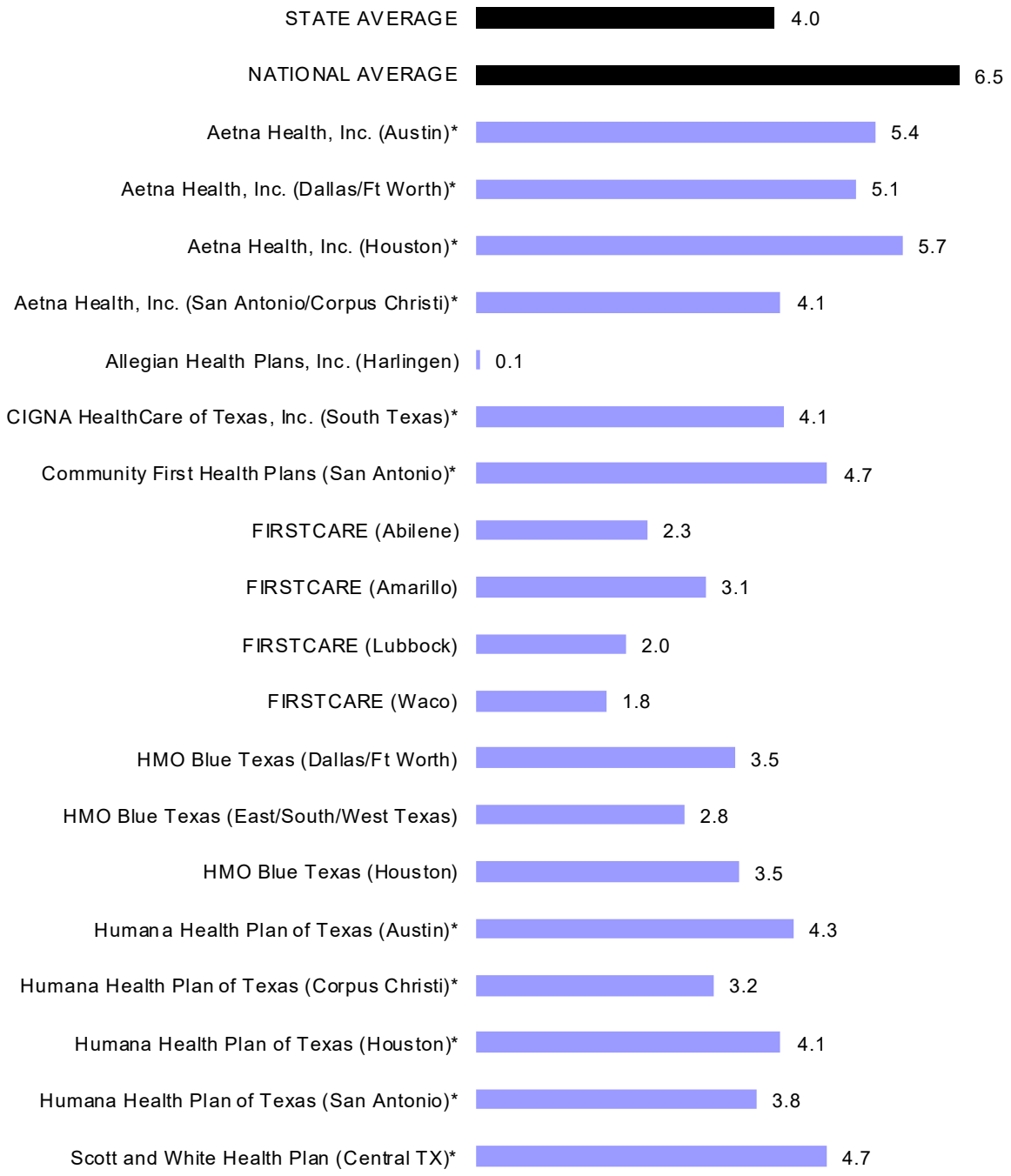
Mental Health Utilization: Intensive Outpatient or Partial Hospitalization



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Mental Health Utilization: Outpatient or Emergency Department

Percent



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

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.

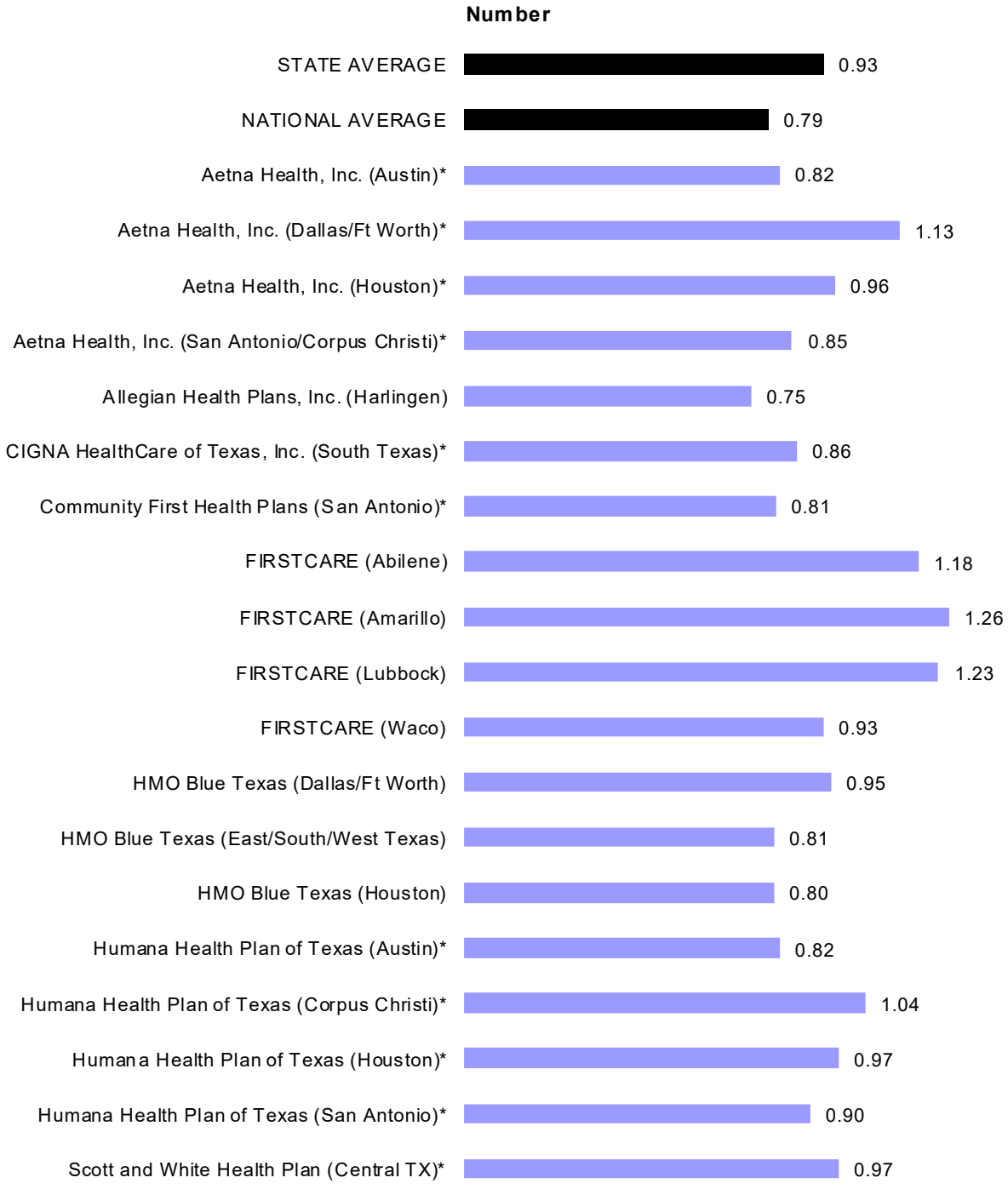
Antibiotics can effectively treat diseases caused by bacteria, but not those caused by viruses. The overuse of antibiotics has increased bacterial resistance. In 1995, the Centers for Disease Control and Prevention began a campaign to educate physicians and patients on appropriate antibiotic use. While inappropriate antibiotic use has decreased, it still remains high.[1] Utilization of antibiotics for an organization's total population provides a comprehensive picture of trends in antibiotic prescribing.

Antibiotic Utilization: Outpatient Utilization of Antibiotic Prescriptions										
	2012		2013		2014		2015		2016	
Outpatient Antibiotic Utilization	**Texas**	**QC**	**Texas**	**QC**	**Texas**	**QC**	**Texas**	**QC**	**Texas**	**QC**
Average Number of Antibiotic Prescriptions PMPY	0.97	**	1.00	**	0.96	0.81	0.90	0.78	0.93	0.79
Average Days Supplied for All Antibiotic Prescriptions	10.0	**	9.9	**	10.0	10.5	9.8	10.4	9.7	10.2
Average Number of Prescriptions PMPY for Antibiotics of Concern* **	0.51	**	0.54	**	0.51	0.41	0.48	0.39	0.49	0.39
Percentage of Antibiotics of Concern For All Antibiotic Prescriptions	53.0%	**	54.2%	**	53.5%	49.6%	53.4%	48.9%	52.9%	49.4%

QC–Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.
** Value not established or not obtained.
*** NCQA classifies certain antibiotics as "antibiotics of concern" because of the drug's more prolific role in antibiotic drug resistance.

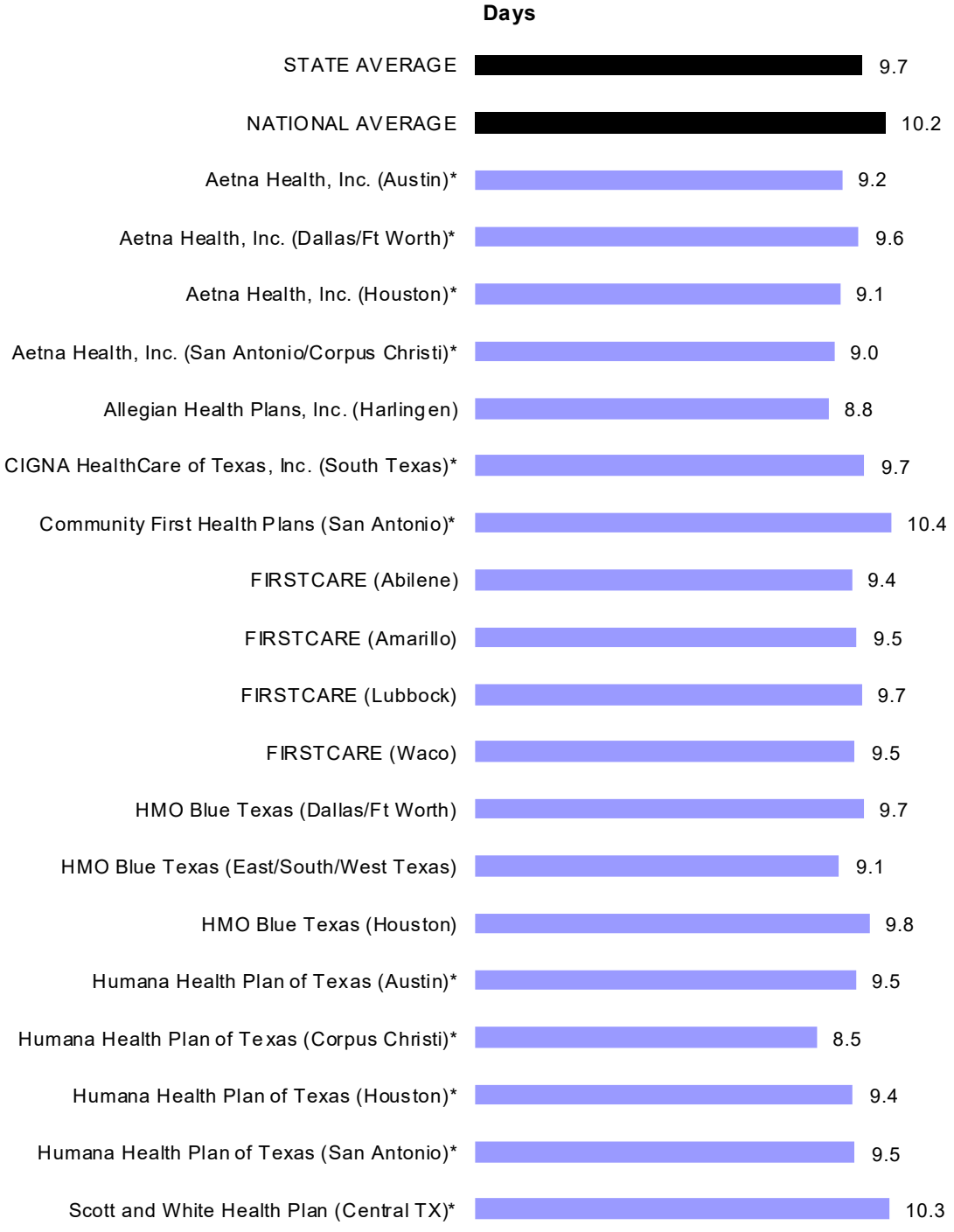
[1] Centers for Disease Control and Prevention. "Office-Related Antibiotic Prescribing for Persons Aged ≤ 14 Years—United States, 1993–1994 to 2007–2008." *Morbidity and Mortality Weekly Report.* 60: 1153–1156 (2011).

Antibiotic Utilization:
Average Number of Prescriptions PMPY



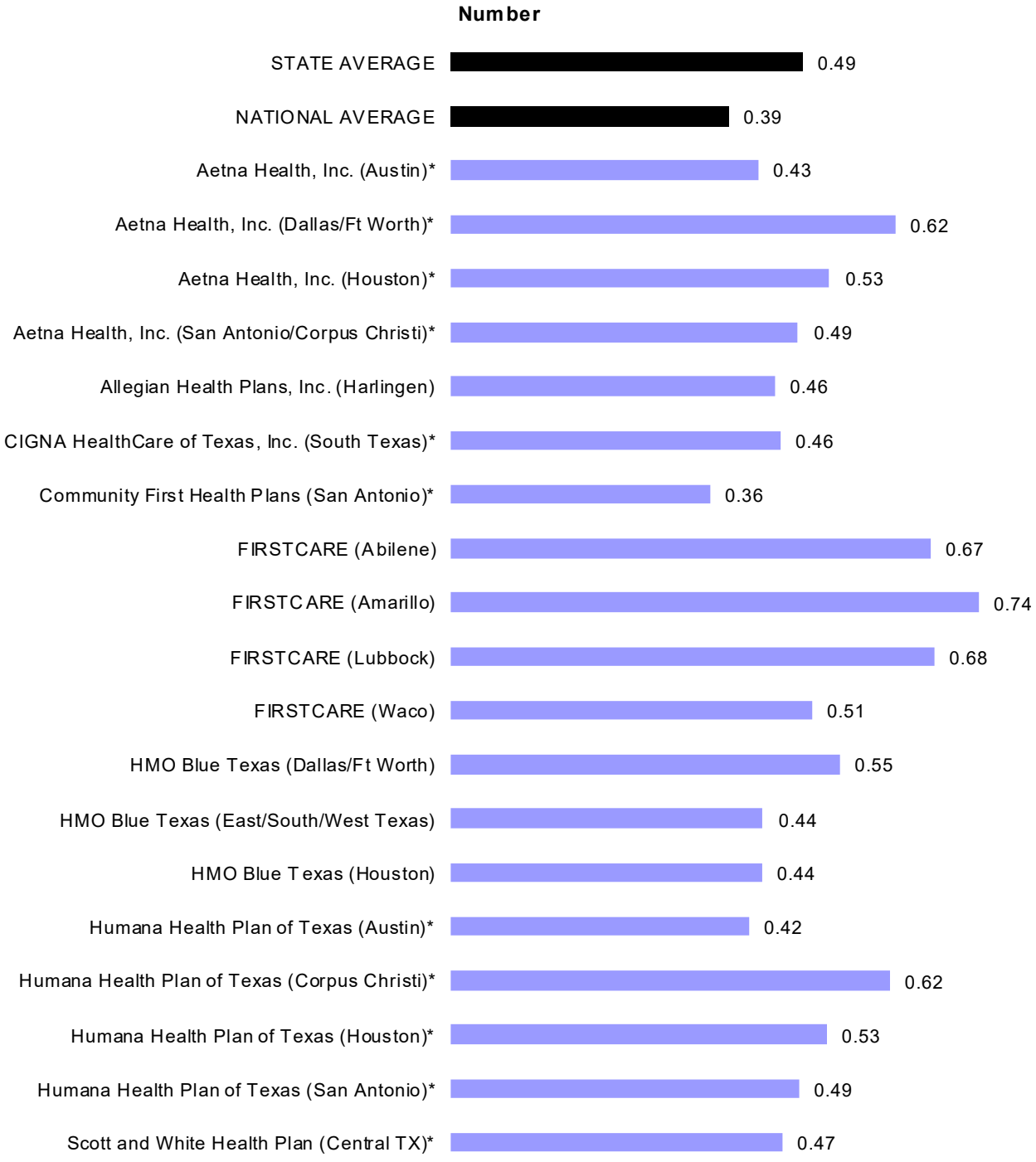
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Antibiotic Utilization:
Average Days Supplied Per Antibiotic Prescription



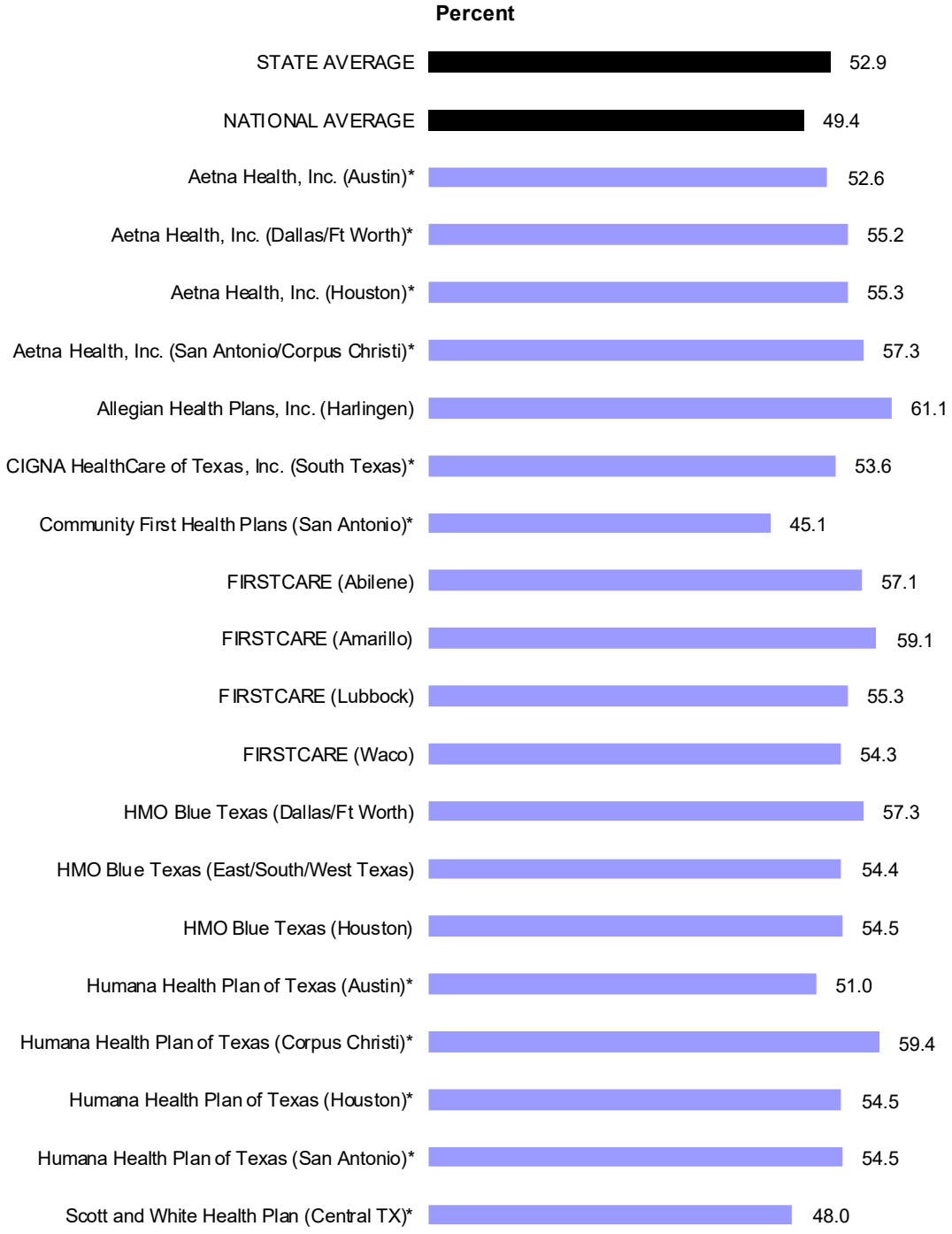
* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Antibiotic Utilization: Average Number of Prescriptions for Antibiotics of Concern PMPY



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Antibiotic Utilization:
Percent Antibiotics of Concern for All Antibiotic Prescriptions



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** The reported number is clearly incorrect. A correct number from the plan was not available at time of publication.

Board Certification

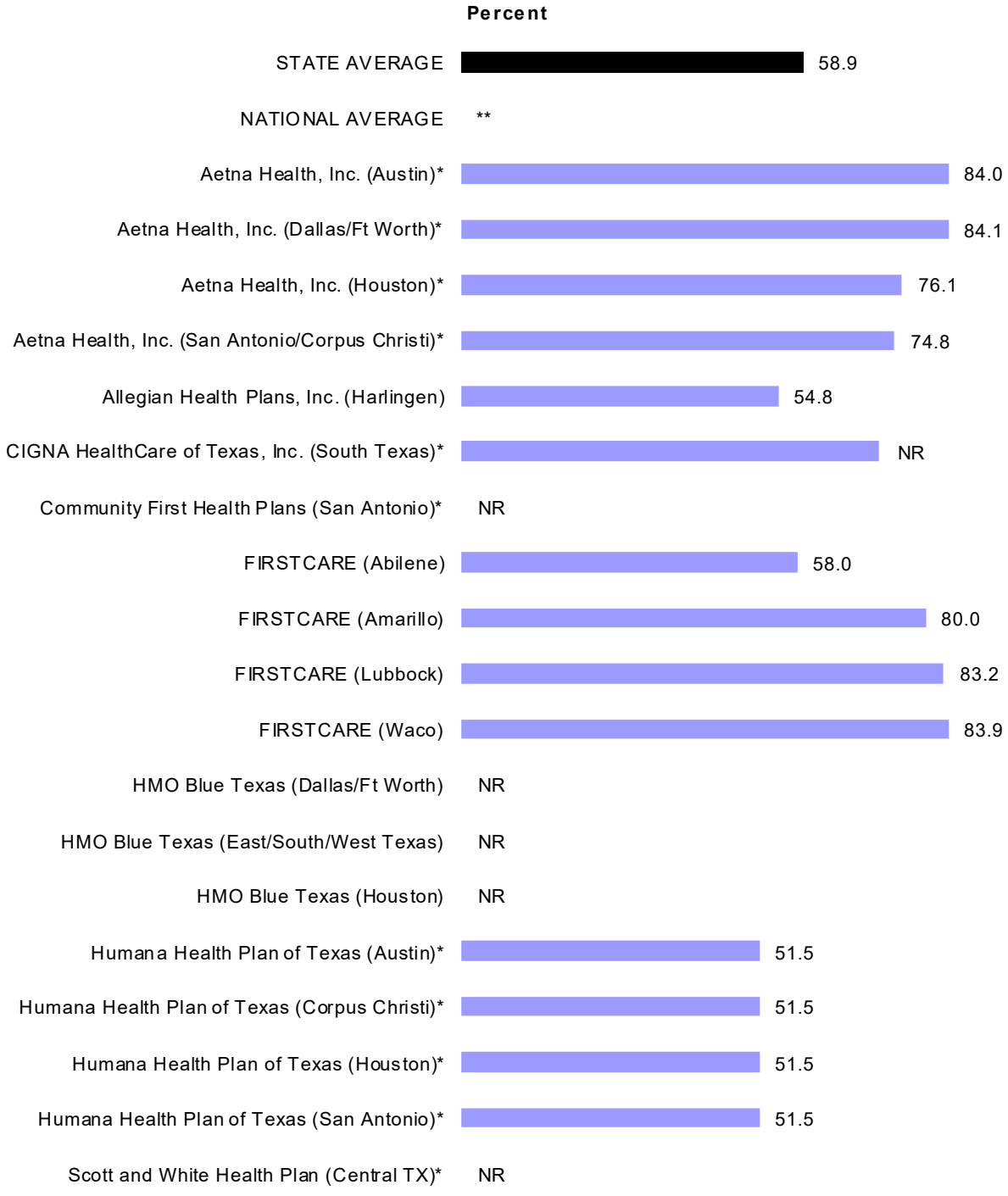
Definition: The percentage of physicians whose board certification is active as of December 31st of the measurement year.

Board certified physicians 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. However, it does provide basic information about the credentials of the plan's physicians.

Physicians with Board Certification										
	2012		2013		2014		2015		2016	
	Texas	QC	Texas	QC	Texas	QC	Texas	QC	Texas	QC
Family Medicine Physicians	73.2%	79.4%	74.3%	78.6%	72.1%	77.9%	61.4%	78.8%	58.9%	**
Internal Medicine Physicians	76.5%	80.8%	76.3%	80.3%	74.0%	79.1%	67.5%	79.4%	67.9%	**
OB/GYNs	78.4%	80.6%	79.5%	80.3%	75.8%	78.1%	74.5%	80.1%	74.8%	**
Pediatricians	81.6%	84.2%	83.7%	84.6%	81.5%	82.2%	78.0%	84.3%	78.2%	**
Geriatricians	52.7%	66.5%	49.3%	66.0%	49.5%	64.1%	29.7%	65.5%	26.9%	**
Other Physician Specialists	69.0%	78.1%	71.9%	77.4%	72.0%	77.1%	65.8%	79.2%	66.5%	**

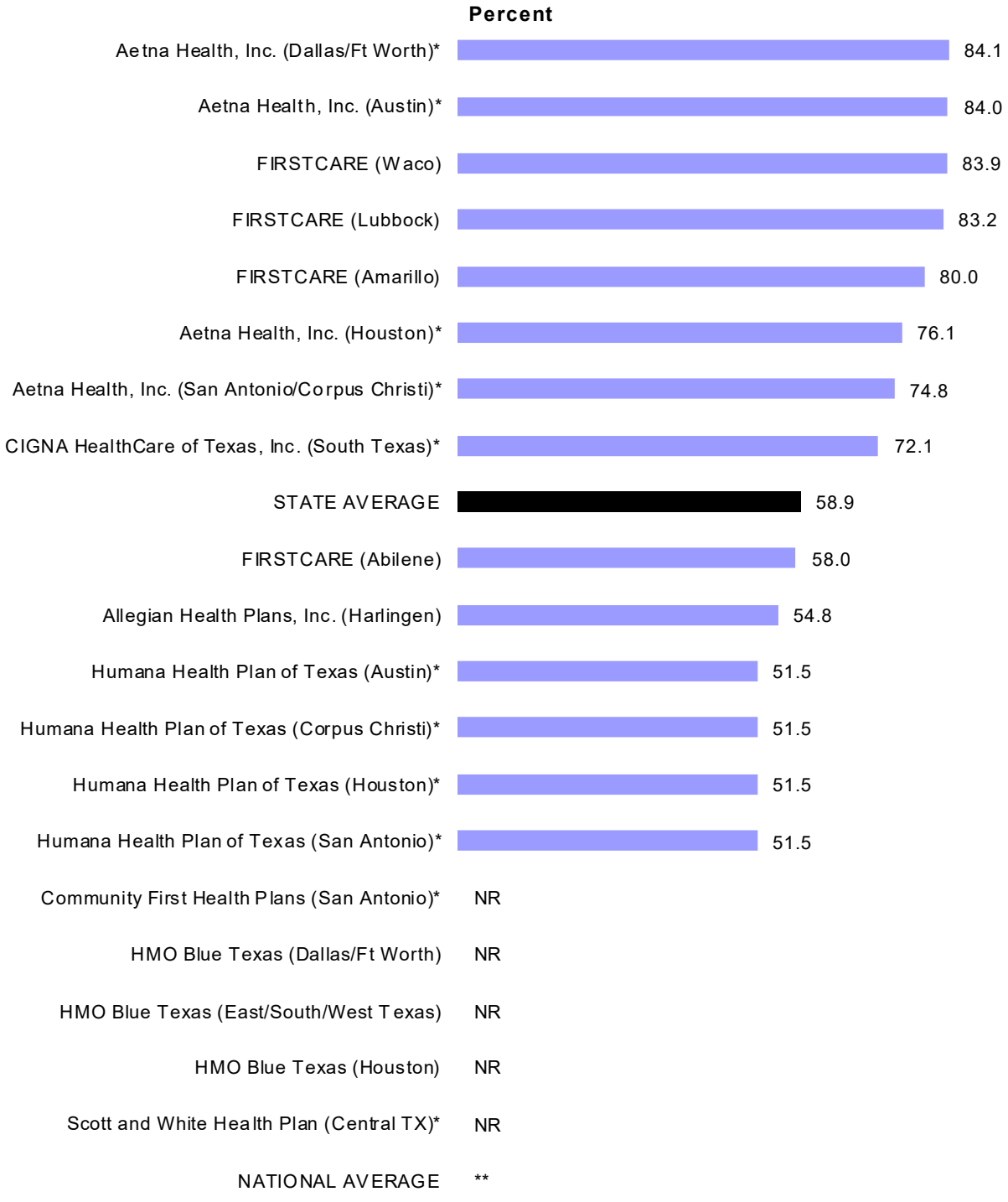
QC–Quality Compass® is a national database of health plan specific performance information voluntarily reported to NCQA.
** Value not established or not obtained.

Board Certification Rate: Family Medicine Physicians



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Board Certification Rate: Family Medicine Physicians



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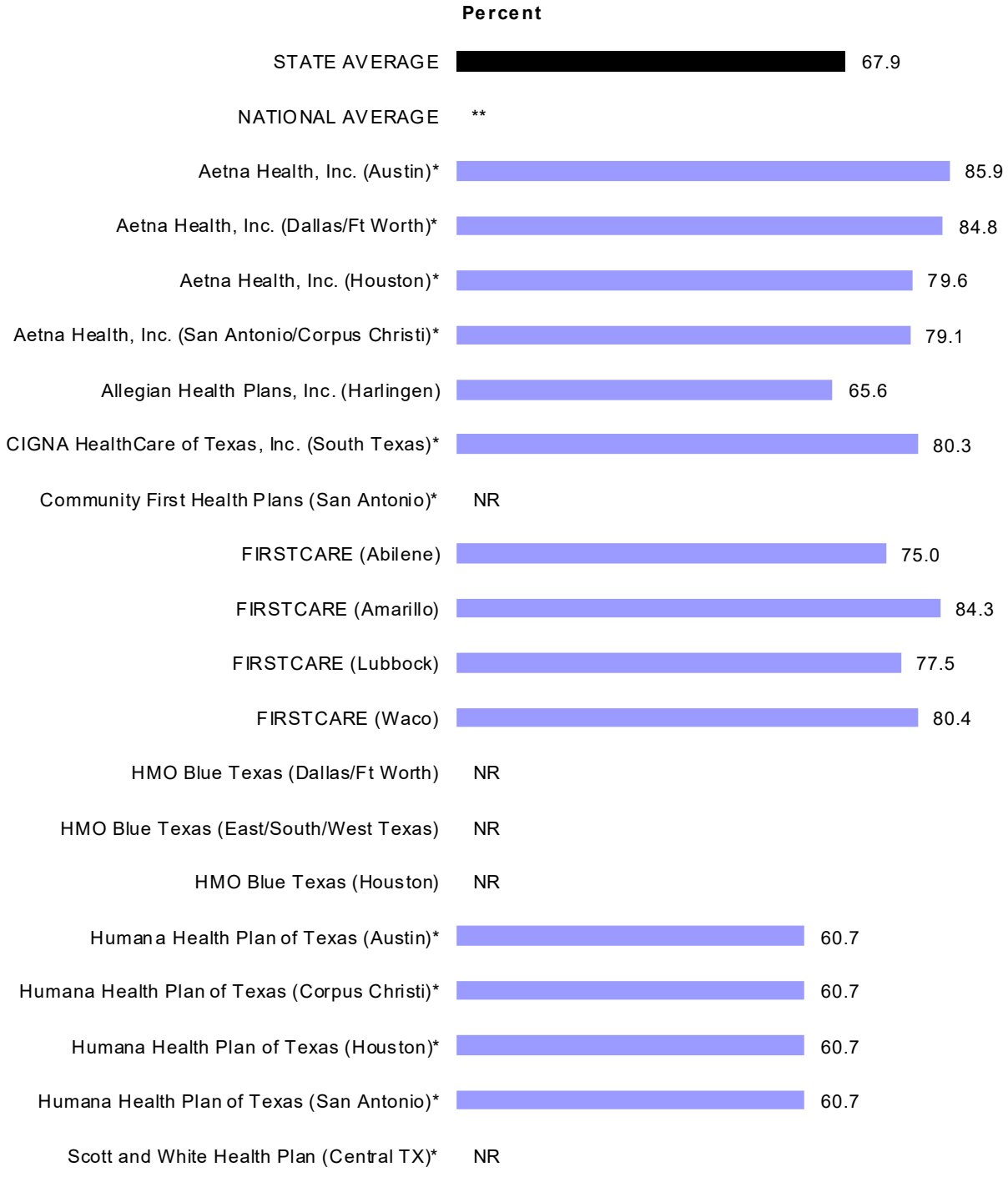
Board Certification Rate: Internal Medicine Physicians



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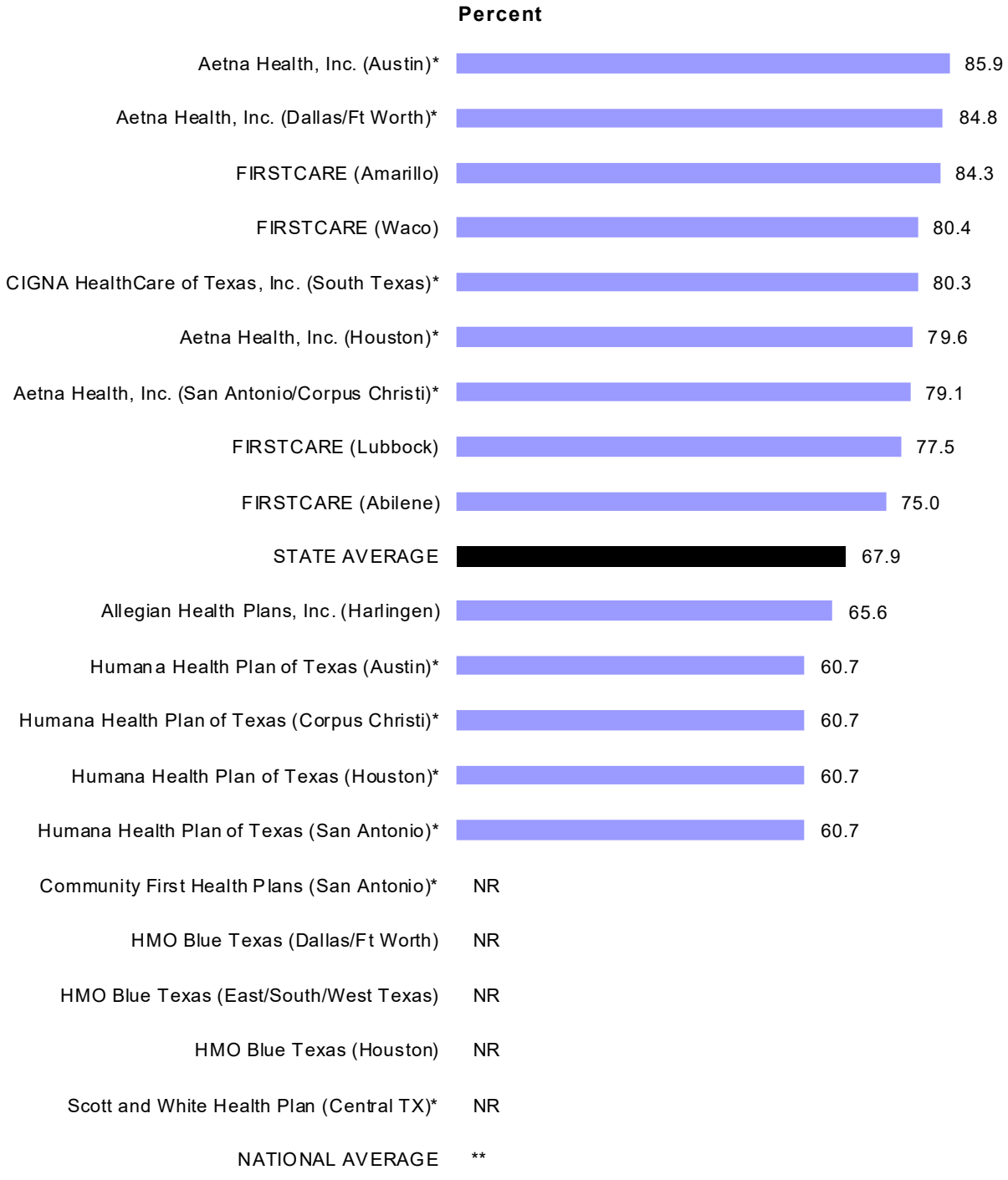
Board Certification Rate: Internal Medicine Physicians



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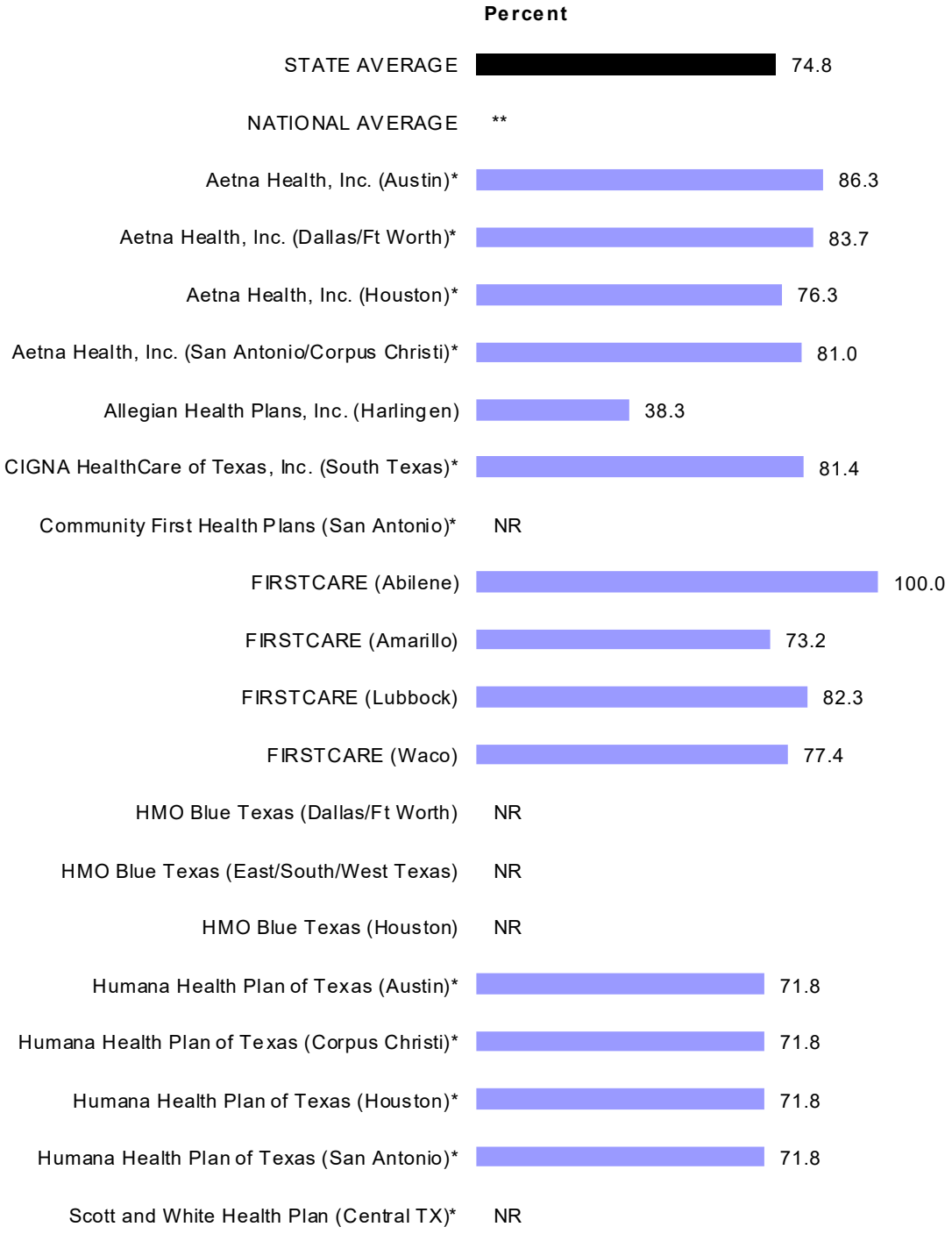
Board Certification Rate: OB/GYN Physicians



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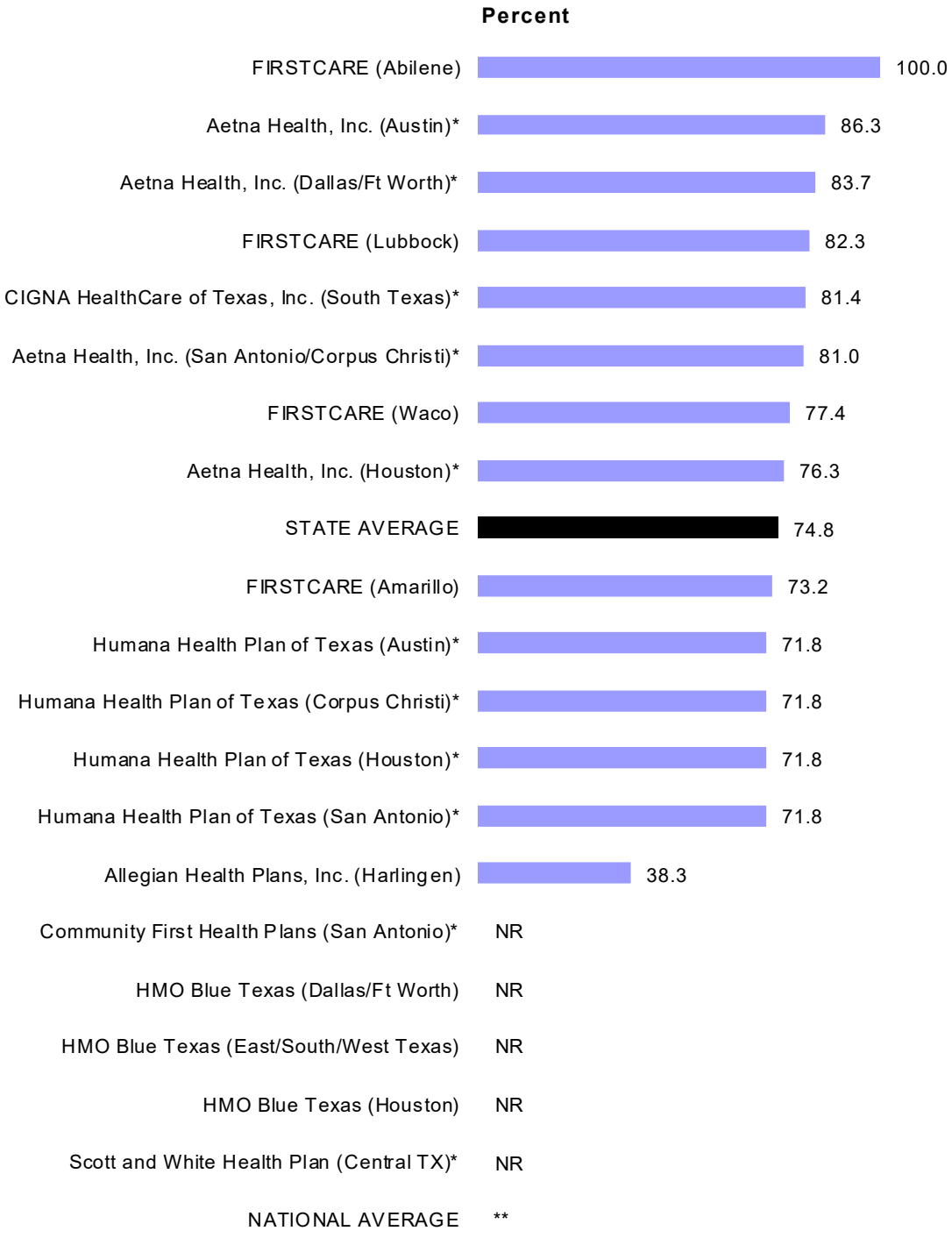
Board Certification Rate: OB/GYN Physicians



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** Value not established or not obtained.
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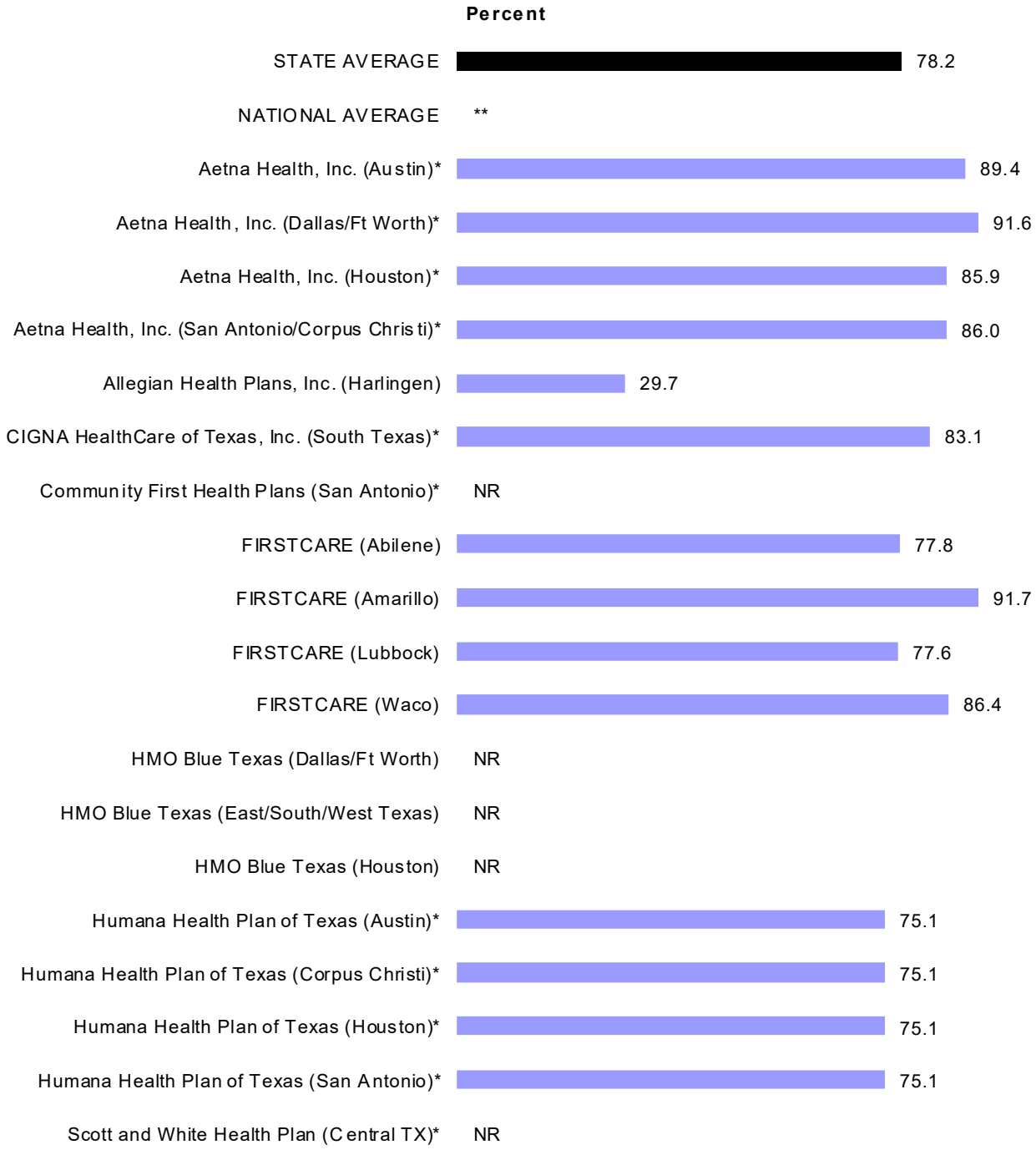
Board Certification Rate: Pediatricians



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** Value not established or not obtained.
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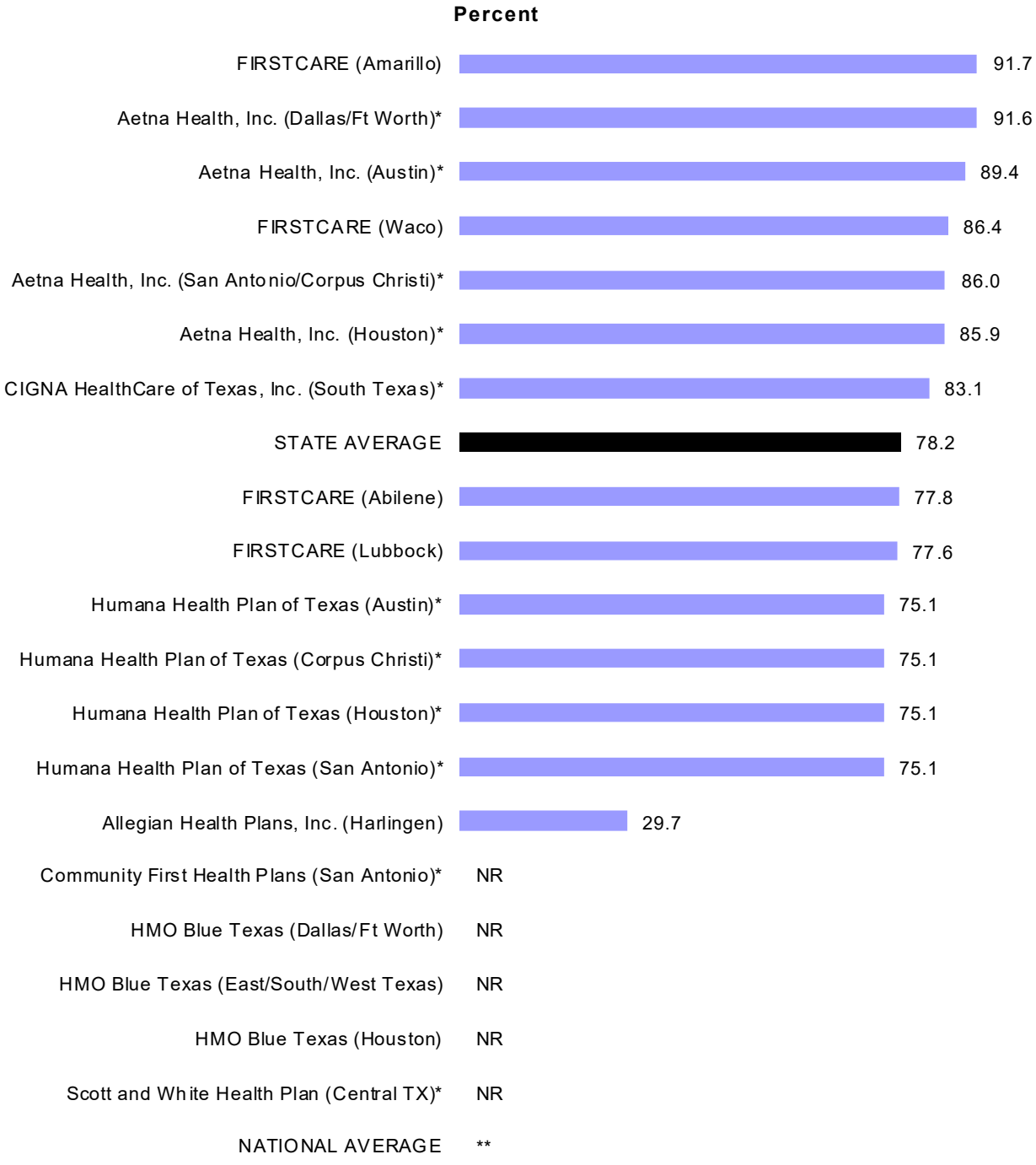
Board Certification Rate: Pediatricians



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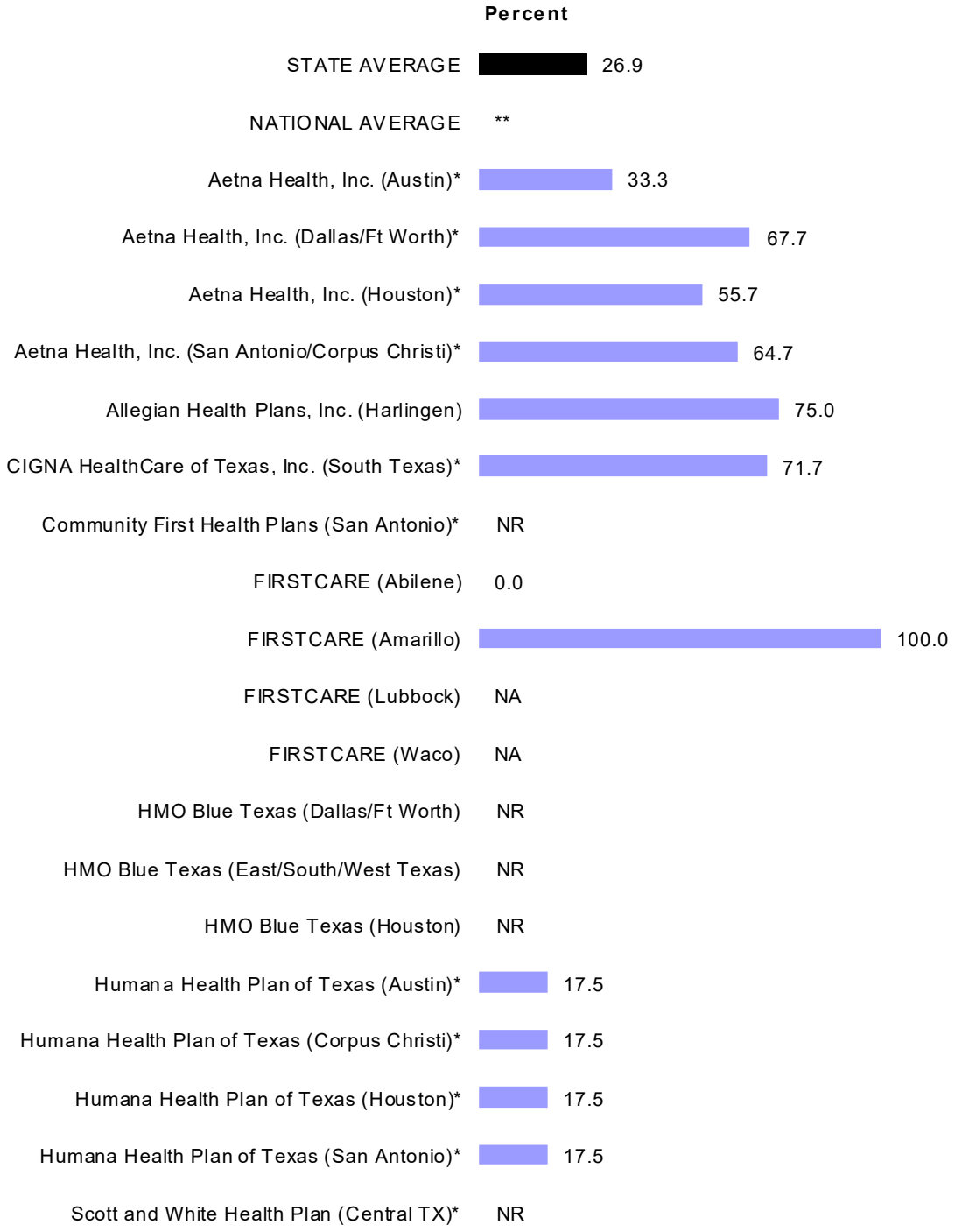
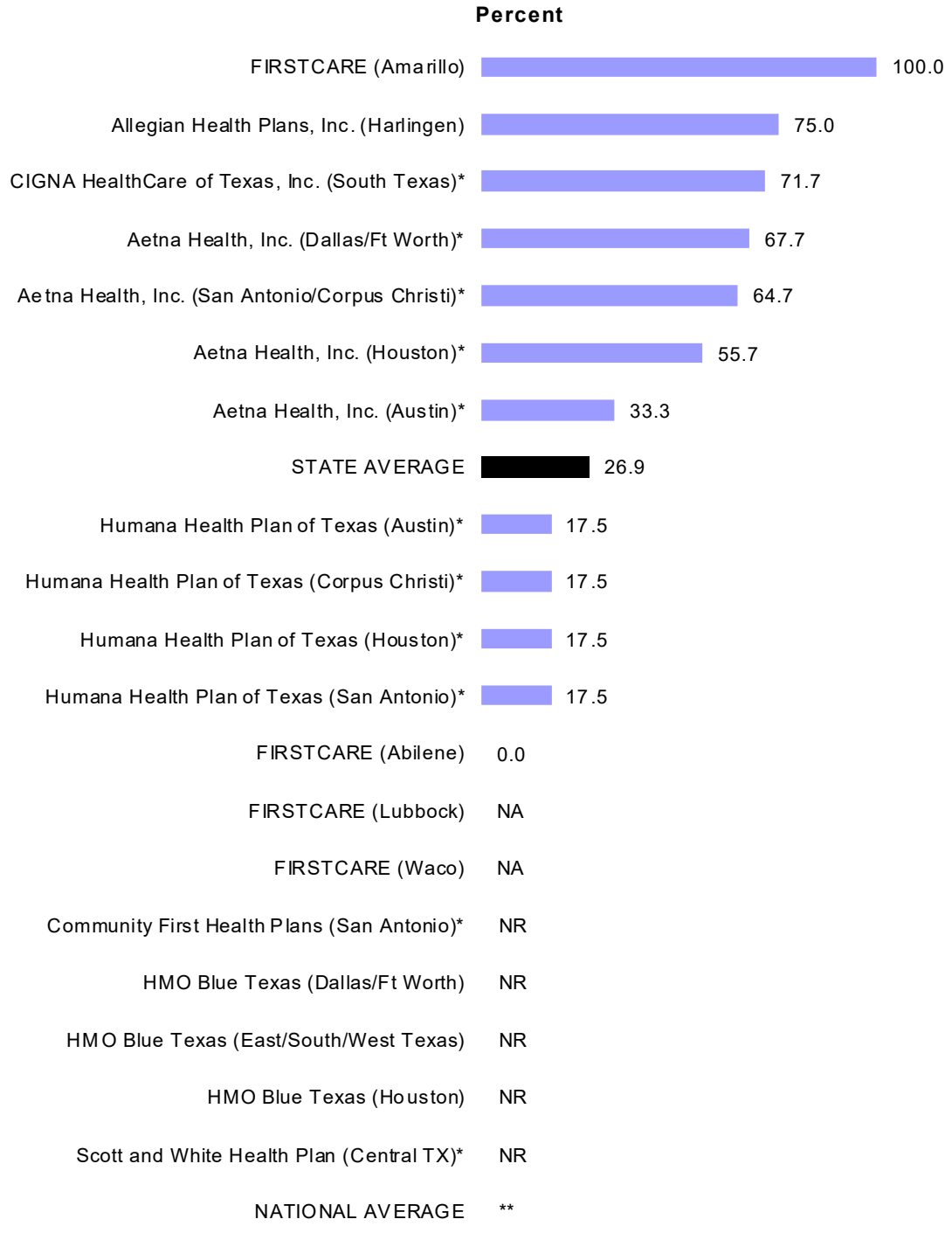
Board Certification Rate: Geriatricians



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Board Certification Rate: Geriatricians



* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
** Value not established or not obtained.
NA–The plan did not have a large enough sample to report a valid rate.
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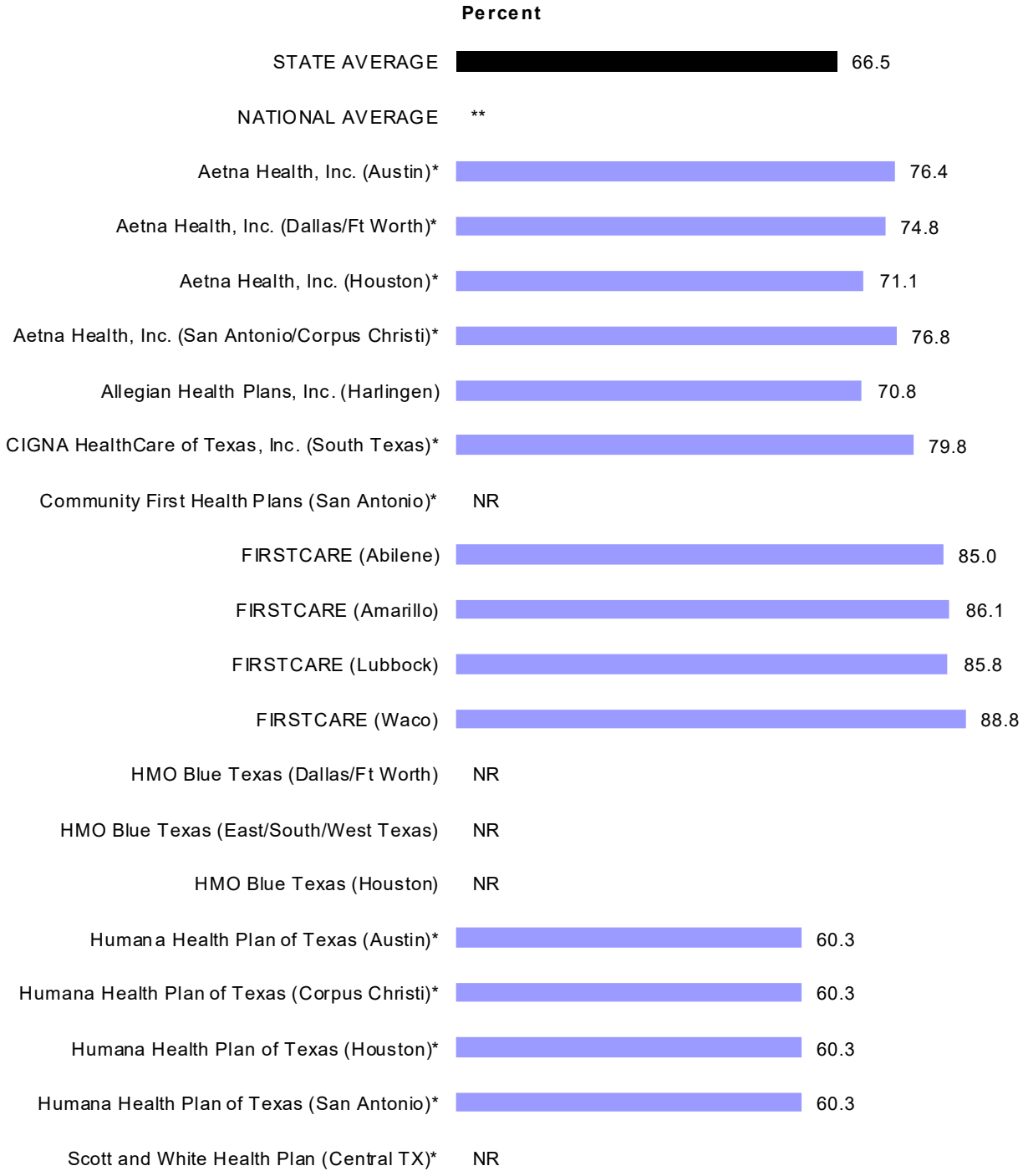
Board Certification Rate: Other Physician Specialists



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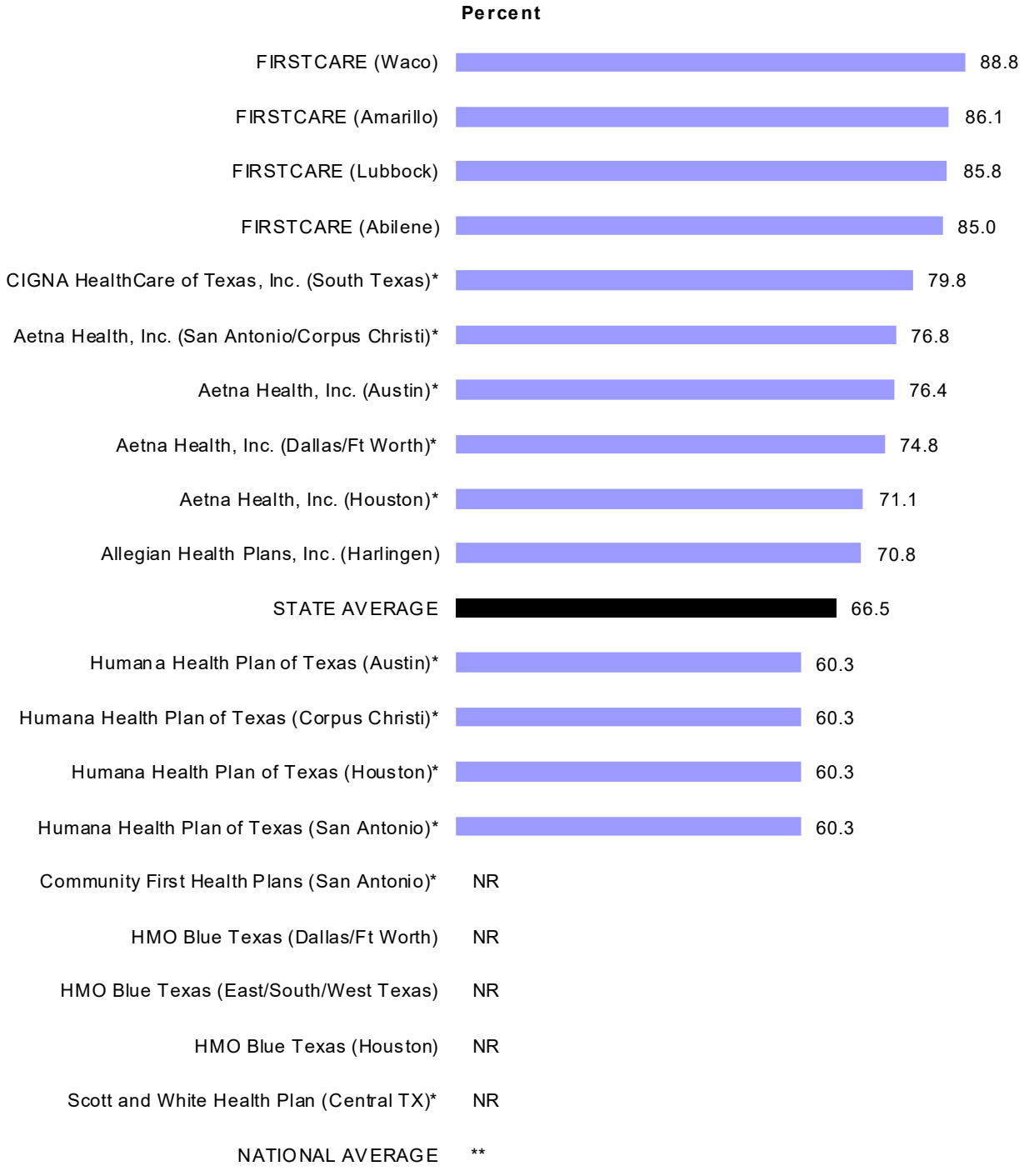
Board Certification Rate: Other Physician Specialists



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NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Total Membership by product line and product type

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

Texas HMOs offer five product lines (Commercial, Medicare, Medicaid, Marketplace, and Self-Insured) and five product types (HMOs, PPOs, POS, EPOs, and FFS). The following tables report the percentage of consumers enrolled in an HMO by product line and in any health plan by product type. 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 and the health plan. Medicaid members are enrolled through a contract between the Texas Health and Human Services Commission and the health plan.

Product line percentages provide a sense of member demographics by providing information on which populations a specific plan insurers. 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	Marketplace	Others
Aetna Health, Inc. (Austin)*	100%	NR	NR	NR	NR
Aetna Health, Inc. (Dallas/Ft Worth)*	100%	NR	NR	NR	NR
Aetna Health, Inc. (Houston)*	100%	NR	NR	NR	NR
Aetna Health, Inc. (San Antonio/Corpus Christi)*	100%	NR	NR	NR	NR
Allegian Health Plans, Inc. (Harlingen)	100%	NR	NR	NR	NR
CIGNA HealthCare of Texas, Inc. (South Texas)*	100%	0%	0%	0%	0%
Community First Health Plans (San Antonio)*	10%	89%	0%	1%	0%
FIRSTCARE (Abilene)	100%	NR	NR	NR	NR
FIRSTCARE (Amarillo)	100%	NR	NR	NR	NR
FIRSTCARE (Lubbock)	100%	NR	NR	NR	NR
FIRSTCARE (Waco)	100%	NR	NR	NR	NR
HMO Blue Texas (Dallas/Ft Worth)	100%	0%	0%	0%	0%
HMO Blue Texas (East/South/West Texas)	100%	0%	0%	0%	0%
HMO Blue Texas (Houston)	100%	0%	0%	0%	0%
Humana Health Plan of Texas (Austin)*	13%	17%	70%	0%	0%
Humana Health Plan of Texas (Corpus Christi)*	13%	17%	70%	0%	0%
Humana Health Plan of Texas (Houston)*	13%	17%	70%	0%	0%
Humana Health Plan of Texas (San Antonio)*	13%	17%	70%	0%	0%
Scott and White Health Plan (Central TX)*	100%	0%	0%	0%	0%

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Percentage of Members Enrolled by Product Type

Health Plan Name	HMO	PPO	POS	FFS	EPO
Aetna Health, Inc. (Austin)*	100%	NR	0%	NR	NR
Aetna Health, Inc. (Dallas/Ft Worth)*	100%	NR	0%	NR	NR
Aetna Health, Inc. (Houston)*	100%	NR	0%	NR	NR
Aetna Health, Inc. (San Antonio/Corpus Christi)*	100%	NR	0%	NR	NR
Allegian Health Plans, Inc. (Harlingen)	100%	NR	NR	NR	NR
CIGNA HealthCare of Texas, Inc. (South Texas)*	93%	0%	7%	0%	0%
Community First Health Plans (San Antonio)*	97%	0%	3%	0%	0%
FIRSTCARE (Abilene)	100%	NR	NR	NR	NR
FIRSTCARE (Amarillo)	100%	NR	NR	NR	NR
FIRSTCARE (Lubbock)	100%	NR	NR	NR	NR
FIRSTCARE (Waco)	100%	NR	NR	NR	NR
HMO Blue Texas (Dallas/Ft Worth)	100%	0%	0%	0%	0%
HMO Blue Texas (East/South/West Texas)	100%	0%	0%	0%	0%
HMO Blue Texas (Houston)	100%	0%	0%	0%	0%
Humana Health Plan of Texas (Austin)*	37%	42%	18%	3%	0%
Humana Health Plan of Texas (Corpus Christi)*	37%	42%	18%	3%	0%
Humana Health Plan of Texas (Houston)*	37%	42%	18%	3%	0%
Humana Health Plan of Texas (San Antonio)*	37%	42%	18%	3%	0%
Scott and White Health Plan (Central TX)*	100%	0%	0%	0%	0%

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)
NR–The plan failed to submit the required data or the data was not certified by an NCQA licensed auditor.

Enrollment by Product Line: Commercial

Definition: The percentage of total members organized 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 demographic data 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	Females Age 0–19
Males Age 20–44	Females Age 20–44
Males Age 45–64	Females Age 45–64
Males Age 65+	Females Age 65+

Percentage of Male Members (Commercial Product) by Age Group

Health Plan Name	0-19 Years	20-44 Years	45-64 Years	65+ Years
Aetna Health, Inc. (Austin)*	25.2%	46.5%	27.1%	1.1%
Aetna Health, Inc. (Dallas/Ft Worth)*	25.4%	35.0%	35.3%	4.3%
Aetna Health, Inc. (Houston)*	23.5%	42.7%	31.3%	2.5%
Aetna Health, Inc. (San Antonio/Corpus Christi)*	25.1%	41.3%	32.5%	1.1%
Allegian Health Plans, Inc. (Harlingen)	22.8%	43.5%	32.3%	1.4%
CIGNA HealthCare of Texas, Inc. (South Texas)*	30.4%	36.8%	30.9%	1.9%
Community First Health Plans (San Antonio)*	32.5%	37.3%	26.1%	4.1%
FIRSTCARE (Abilene)	31.8%	33.6%	33.4%	1.2%
FIRSTCARE (Amarillo)	36.8%	33.8%	28.0%	1.5%
FIRSTCARE (Lubbock)	27.9%	37.7%	32.4%	2.0%
FIRSTCARE (Waco)	34.5%	36.7%	27.6%	1.3%
HMO Blue Texas (Dallas/Ft Worth)	26.8%	43.7%	28.4%	1.1%
HMO Blue Texas (East/South/West Texas)	20.7%	47.0%	31.3%	1.0%
HMO Blue Texas (Houston)	24.7%	42.4%	31.9%	1.0%
Humana Health Plan of Texas (Austin)*	24.1%	44.5%	29.5%	1.9%
Humana Health Plan of Texas (Corpus Christi)*	21.0%	42.0%	34.3%	2.7%
Humana Health Plan of Texas (Houston)*	22.7%	42.3%	32.6%	2.4%
Humana Health Plan of Texas (San Antonio)*	20.9%	39.8%	33.3%	5.9%
Scott and White Health Plan (Central TX)*	29.8%	34.5%	31.5%	4.3%

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Percentage of Female Members (Commercial Product) by Age Group

Health Plan Name	0-19 Years	20-44 Years	45-64 Years	65+ Years
Aetna Health, Inc. (Austin)*	26.5%	47.2%	25.5%	0.9%
Aetna Health, Inc. (Dallas/Ft Worth)*	24.3%	38.4%	33.9%	3.4%
Aetna Health, Inc. (Houston)*	22.5%	44.8%	30.4%	2.3%
Aetna Health, Inc. (San Antonio/Corpus Christi)*	26.0%	44.2%	28.8%	1.1%
Allegian Health Plans, Inc. (Harlingen)	20.2%	45.3%	33.3%	1.2%
CIGNA HealthCare of Texas, Inc. (South Texas)*	29.3%	38.3%	30.9%	1.5%
Community First Health Plans (San Antonio)*	23.5%	41.7%	30.1%	4.8%
FIRSTCARE (Abilene)	22.3%	38.9%	36.8%	2.0%
FIRSTCARE (Amarillo)	24.6%	39.2%	34.2%	2.0%
FIRSTCARE (Lubbock)	24.0%	40.9%	33.2%	1.9%
FIRSTCARE (Waco)	24.7%	43.8%	30.0%	1.5%
HMO Blue Texas (Dallas/Ft Worth)	27.0%	42.9%	29.1%	1.0%
HMO Blue Texas (East/South/West Texas)	21.7%	48.7%	28.8%	0.9%
HMO Blue Texas (Houston)	26.3%	42.8%	30.2%	0.6%
Humana Health Plan of Texas (Austin)*	22.1%	46.3%	29.9%	1.7%
Humana Health Plan of Texas (Corpus Christi)*	20.8%	43.3%	33.9%	2.0%
Humana Health Plan of Texas (Houston)*	23.5%	43.0%	31.8%	1.8%
Humana Health Plan of Texas (San Antonio)*	20.3%	41.1%	33.0%	5.6%
Scott and White Health Plan (Central TX)*	24.6%	38.0%	33.6%	3.7%

* Plans reporting HMO/POS membership combined. Others are HMO membership only. (See page 3 for explanation.)

Methods and Statistical Issues

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 pregnant women and children.

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

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.

To accommodate differences in HMO data systems and technical capabilities, HEDIS® 2016 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 used 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 Cessation and Flu Shots for Adults measures in the Effectiveness of Care domain. The standardized survey instrument employed for HEDIS® 2016 is the Consumer Assessment of Healthcare Providers and Systems, Version 5.0 (CAHPS 5.0H). 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 http://www.opic.texas.gov/health/comparing-texas-hmos.

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, 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 Texas. NCQA suggests the following formula for statistical significance testing on HEDIS® measures:

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

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® 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:

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

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

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

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

The summary tables (pages 5–10) 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.

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 Summary Statistics. NCQA's national averages are based on HEDIS® data voluntarily reported to NCQA by hundreds of health plans throughout the country.

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

Texas Subset of HEDIS® Commercial 2016 Measures

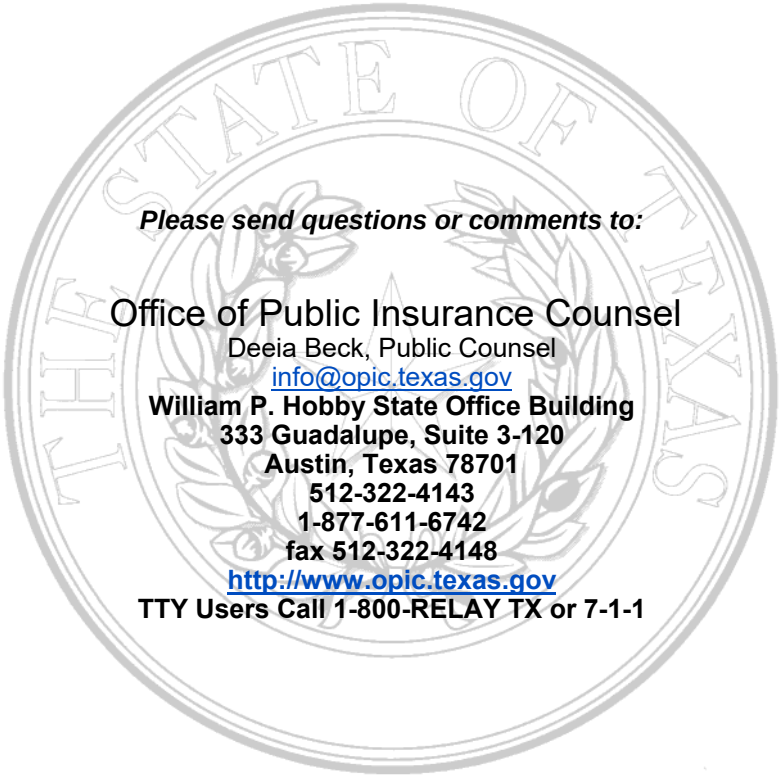
Effectiveness of Care
- **Prevention and Screening**
  - Childhood Immunization Status
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Non-Recommended Cervical Cancer Screening in Adolescent Females
  - Colorectal Cancer Screening
  - Chlamydia Screening in Women
- **Cardiovascular Conditions**
  - Controlling High Blood Pressure
  - Persistence of Beta Blocker Treatment After a Heart Attack
- **Diabetes**
  - Comprehensive Diabetes Care
- **Respiratory Conditions**
  - Appropriate Testing for Children With Pharyngitis
  - Appropriate Treatment for Children With Upper Respiratory Infection
  - Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
  - Medication Management for People With Asthma
- **Behavioral Health**
  - Antidepressant Medication Management
  - Follow-Up Care for Children Prescribed ADHD Medication
  - Follow-Up After Hospitalization for Mental Illness
- **Measures Collected Through the CAHPS Health Plan Survey**
  - Flu Vaccinations for Adults Ages 18–64
  - Medical Assistance With Smoking and Tobacco Use Cessation

Access/Availability of Care
- Adults' Access to Preventative/Ambulatory Health Services
- Prenatal and Postpartum Care

Experience of Care
- CAHPS® Health Plan Survey 5.0H, Adult Version
  - (A report on the survey measures, ***Comparing Texas HMOs 2016*** is available on OPIC's website at http://www.opic.texas.gov/health/comparing-texas-hmos)

Utilization and Relative Resource Use
- **Utilization**
  - 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
  - Ambulatory Care
  - Inpatient Utilization–General Hospital/Acute Care
  - Mental Health Utilization
  - Antibiotic Utilization

Health Plan Descriptive Information
- Board Certification
- Total Membership
- Enrollment by Product Line



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