Arizona Health Care Cost Containment System

Quality Management Performance Measures for Acute-care Contractors

Measurement Period Ending September 30, 2003

Prepared by the Division of Health Care Management
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OVERVIEW

This report includes information on performance measures for preventive health care services provided to members enrolled with acute-care health plans that contract with the Arizona Health Care Cost Containment System (AHCCCS). These members are eligible for AHCCCS under Medicaid or the State Children's Health Insurance Program (SCHIP), known as KidsCare.

The report includes data from seven publicly and privately operated health plans (known as Contractors). In addition, data for the Comprehensive Medical and Dental Program (CMDP), a health plan operated by the Arizona Department of Economic Security (DES) for children and adolescents in foster care, is reported for one measure.

The results reported here should be viewed as *indicators* of utilization of services, rather than absolute rates for how successfully AHCCCS and/or its Contractors provide care. Many factors affect whether AHCCCS members use services. By analyzing trends over time, AHCCCS and its Contractors can identify areas for improvement and implement interventions to increase access to, and use of, services.

Methodology

AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®) as a guide in determining the methodology for these measures. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry.

One of the criteria for selecting members to be included in the analyses is that they be continuously enrolled for a minimum period of time with one Contractor. Thus, members included in the results of each measure represent only a portion of AHCCCS members, rather than the entire acute-care population.

This report includes data for the contract year ending September 30, 2003 (some measures count health services provided in a previous contract year). Results are reported in aggregate by Maricopa, Pima and the combined rural counties, and by individual Contractor. The report also indicates whether an increase or decrease in a rate is statistically significant; that is, whether the change is not merely due to chance. Where available, national averages for Medicaid managed care plans reported by NCQA are compared with AHCCCS overall rates.

Data Sources and Quality

AHCCCS uses a statewide, automated managed care data system known as the Prepaid Medical Management Information System (PMMIS). Members included in the denominator for each measure are selected from the Recipient Subsystem of PMMIS.

Numerators, and therefore rates, for each measure are based on AHCCCS encounter data; i.e., records of medically necessary services provided and the related claims paid by Contractors. AHCCCS conducts data validation studies to evaluate the completeness, accuracy and timeliness of encounter data. From the latest data validation results, it is estimated that overall encounter data is approximately 85 percent accurate. Through ongoing review and analysis of encounter submission trends and data quality, AHCCCS develops ways to continually improve the accuracy of encounter data.

It should be noted that data collection issues related to one Contractor may have affected its rates for some measures. Problems with Maricopa Health Plan's claims processing system have resulted in a major lag in submitting encounter data to AHCCCS during CYE 2003, and the likelihood that the plan's rates are artificially low. However, it does not appear that Maricopa Health Plan's rates had a substantial effect on AHCCCS overall rates because the health plan represents a relatively small percentage of the acute-care population. Maricopa Health Plan has taken actions to correct its encounter-submission problems.

Rotation of Measures

In 2000, NCQA began to "rotate" reporting of measures, and AHCCCS adopted a similar rotation schedule in 2003. This rotation schedule alternates most measures on a biennial basis, allowing Contractors an "intervention year" between measures; thus, providing adequate time to focus activities on improving specific rates.

Three measures are reported annually. These include Children's Access to Primary Care Practitioners (PCPs) – Medicaid Members, Children's Access to PCPs – KidsCare Members, and Adults' Access to Preventive/Ambulatory Health Services.

Highlights of the Data

Results of the six AHCCCS acute-care measures reported here were mixed in the most recent period. Three measures showed no statistically significant change:

- Children's Access to PCPs – KidsCare Members,
- Adults' Access to Preventive/Ambulatory Health Services, and
- Breast Cancer Screening.

One measure, Cervical Cancer Screening, improved and one measure, Children's Access to PCPs – Medicaid Members, declined slightly. Another measure, Timeliness of Prenatal Care, is based on new methodology and is being reported by AHCCCS for the first time.

When analyzed by area, rates for all measures were highest in Pima County.

For some measures, AHCCCS rates were higher than the most recent national HEDIS means (averages) reported by NCQA for Medicaid health plans. As in years past, the AHCCCS rates for Children's Access to PCPs among members in two age groups, 1 year and 2 through 6 years, was better than the NCQA means for those groups. This was true of both Medicaid-eligible members and KidsCare members.

The AHCCCS rate for Adults' Access to Preventive/Ambulatory Health Services for members ages 21 to 44 years is slightly under the NCQA mean, but the AHCCCS rate for members 45 to 64 years exceeds the NCQA average.

However, the AHCCCS rate for Cervical Cancer Screening is well below the HEDIS mean, despite a significant improvement in the AHCCCS rate.

Individual Contractor performance varied widely. One Contractor, Mercy Care Plan, met or exceeded the AHCCCS Minimum Performance Standard in five of six measures. Three Contractors – Health Choice Arizona, Pima Health System and University Family Care – met or exceeded the minimum standard in four measures. Three other Contractors – Arizona Physicians IPA, Maricopa Health Plan and Phoenix Health Plan/Community Connection – met or exceeded the minimum standard in only two measures. CMDP exceeded the minimum standard for its measure, Children's Access to PCPs – Medicaid Members.

Performance Improvement

AHCCCS will require corrective action plans from Contractors that did not meet the Minimum Performance Standard for any measure, or that showed statistically significant declines in their rates, even if they met the minimum standard. Contractors that fail to show improvement may be subject to sanctions in the future.

AHCCCS will continue to provide technical assistance, such as identifying new interventions or enhancements to existing efforts, to help Contractors improve their performance. This data also may be used in developing future Performance Improvement Projects by Contractors.

It should be noted that, as of October 1, 2003, Care 1st Healthplan of Arizona has contracted with AHCCCS to provide services to Medicaid and KidsCare members. However, the health plan did not have enough members who met the continuous enrollment criteria to be included in this report.

Feedback

For questions or comments about this report, please contact:

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Children's Access to Primary Care Practitioners (Medicaid and KidsCare)

Children's access to primary care services is critical in helping to prevent the premature onset of disease and disability. Lack of access to primary care practitioners (PCPs) may result in unnecessary hospitalizations.[1,2]

PCPs can address physical, nutritional, developmental and behavioral health needs, and make referrals to specialists or to services such as nutritional support and parenting classes. If members are receiving these general health care services through a PCP, they likely have access to other levels of the health care system.

Indicator Description

Two separate indicators measured the percentage of children and adolescents who:

- were 1 through 20 years of age if eligible under Medicaid, or 1 through 18 years of age if eligible under KidsCare, at the end of the measurement period (October 1, 2002, through September 30, 2003),
- were continuously enrolled with one acute-care Contractor during the measurement period,
- had no more than one break in enrollment, not exceeding 31 days, and
- had one or more visits with PCPs, including pediatricians, general or family practice physicians, internal medicine physicians, physician's assistants, nurse practitioners or obstetrician/gynecologists, during the measurement period.

Performance Goals

AHCCCS has adopted a Minimum Performance Standard that Contractors achieve a rate of 77 percent for both measures. If Contractors have already achieved this rate for either group, they should strive for the AHCCCS Goal of 80 percent.

National Comparisons

The National Committee for Quality Assurance (NCQA) has reported national averages for Medicaid health plans by age group for Children's Access to PCPs. In calendar year 2002, the most recent year for which national data are available, the averages were:

1 year	90.9 percent
2 through 6 years	79.9 percent
7 through 11 years	80.2 percent

NCQA did not report an average for children 12 through 20 years old.

Current Results and Trends

Children's Access to PCPs – Medicaid

AHCCCS overall rates for Medicaid-eligible children were: 96.5 percent for members 1 year old, 83.3 percent for members 2 through 6 years, 66.9 percent for members 7 through 11 years, and 67.7 percent for members 12 through 20 years (Table 1). The AHCCCS total rate was 75.7 percent, a decline from the previous measurement period, when the rate was 76.6 percent ($p<.001$).

Total rates by Contractor ranged from 52.7 percent to 80.7 percent. Five of eight Contractors met or exceeded the AHCCCS Minimum Performance Standard and one exceeded the AHCCCS Goal.

Rates for Medicaid-eligible children were higher in Pima County and the combined rural counties, at 78.6 percent and 77.9 percent, respectively. The rate for Maricopa County was 73.5 percent.

Children's Access to PCPs – KidsCare

Overall rates for KidsCare members were 95.1 percent for members 1 year old, 87.3 percent for members 2 through 6 years, 73.7 percent for members 7 through 11 years, and 74.1 percent for members 12 through 18 (Table 2). The AHCCCS total rate for KidsCare members was 77.7 percent, compared with 78.4 percent in the previous measurement period. However, the change was not statistically significant (p=.089).

Total rates by Contractor ranged from 54.5 percent to 81.7 percent. Six of seven Contractors met or exceeded the AHCCCS Minimum Performance Standard and four met or exceeded the AHCCCS Goal.

Rates for KidsCare members were highest in Pima County, at 80.4 percent, followed by the combined rural counties and Maricopa County, at 77.9 percent and 76.6 percent, respectively

The AHCCCS overall rate for children's access to PCPs among Medicaid-eligible members has remained above 70 percent since 1998, and was at its highest point in CYE 2002, at approximately 77 percent. The overall rate among KidsCare members was 60 percent in 1999, when the rate for this group was first measured, and reached the highest point in the current measurement period.

Fig. 1: Children's Access to PCPs, 1998-2003

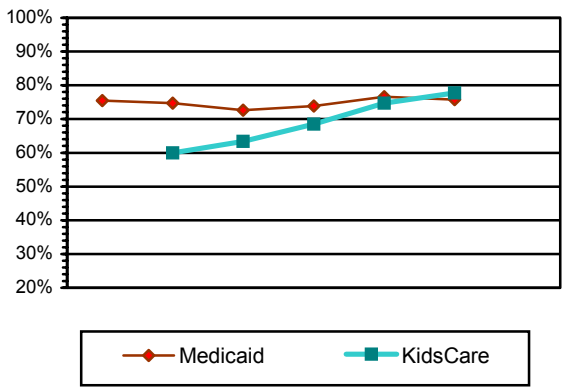

Table 1

Arizona Health Care Cost Containment System

CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS BY CONTRACTOR

MEMBERS ELIGIBLE UNDER MEDICAID

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
University Family Care *	**1**	**472**	**460**	**97.5%**		
	2	**383**	**367**	**95.8%**		
	3-6	**1,494**	**1,284**	**85.9%**		
	7-11	**1,614**	**1,213**	**75.2%**		
	12-20	**2,113**	**1,581**	**74.8%**		
	Total	**6,076**	**4,905**	**80.7%**	**-0.1%**	**p=.927**
Universtiy Family Care	1	473	458	96.8%		
	2	378	361	95.5%		
	3-6	1,267	1,095	86.4%		
	7-11	1,530	1,131	73.9%		
	12-20	1,710	1,284	75.1%		
	Total	5,358	4,329	80.8%		
Pima Health System *	**1**	**424**	**406**	**95.8%**		
	2	**314**	**297**	**94.6%**		
	3-6	**842**	**712**	**84.6%**		
	7-11	**1,049**	**767**	**73.1%**		
	12-20	**1,348**	**975**	**72.3%**		
	Total	**3,977**	**3,157**	**79.4%**	**0.6%**	**p.=633**
Pima Health System	1	365	355	97.3%		
	2	240	231	96.3%		
	3-6	675	544	80.6%		
	7-11	917	686	74.8%		
	12-20	1,072	764	71.3%		
	Total	3,269	2,580	78.9%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

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MEMBERS ELIGIBLE UNDER MEDICAID

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Mercy Care Plan *	**1**	**6,426**	**6,230**	**96.9%**		
	2	**4,948**	**4,618**	**93.3%**		
	3-6	**15,044**	**12,553**	**83.4%**		
	7-11	**14,458**	**10,262**	**71.0%**		
	12-20	**16,733**	**11,943**	**71.4%**		
	Total	**57,609**	**45,606**	**79.2%**	**1.2%**	**p<.001**
Mercy Care Plan	1	5,986	5,766	96.3%		
	2	3,786	3,475	91.8%		
	3-6	12,350	10,103	81.8%		
	7-11	11,984	8,277	69.1%		
	12-20	12,965	9,196	70.9%		
	Total	47,071	36,817	78.2%		
CMDP *	**1**	**245**	**228**	**93.1%**		
	2	**216**	**189**	**87.5%**		
	3-6	**629**	**532**	**84.6%**		
	7-11	**678**	**517**	**76.3%**		
	12-20	**1,678**	**1,261**	**75.1%**		
	Total	**3,446**	**2,727**	**79.1%**	**-5.4%**	**p<.001**
CMDP	1	205	198	96.6%		
	2	177	161	91.0%		
	3-6	539	476	88.3%		
	7-11	625	489	78.2%		
	12-20	1,506	1,230	81.7%		
	Total	3,052	2,554	83.7%		

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MEMBERS ELIGIBLE UNDER MEDICAID

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Health Choice AZ *	**1**	**2,228**	**2,148**	**96.4%**		
	2	**1,726**	**1,598**	**92.6%**		
	3-6	**5,294**	**4,393**	**83.0%**		
	7-11	**4,696**	**3,097**	**65.9%**		
	12-20	**4,838**	**3,253**	**67.2%**		
	Total	**18,782**	**14,489**	**77.1%**	**2.2%**	**p<.001**
Health Choice AZ	1	2,159	2,066	95.7%		
	2	1,527	1,403	91.9%		
	3-6	4,468	3,519	78.8%		
	7-11	4,098	2,653	64.7%		
	12-20	3,856	2,512	65.1%		
	Total	16,108	12,153	75.4%		
AZ Physicians IPA	**1**	**6,529**	**6,302**	**96.5%**		
	2	**5,152**	**4,737**	**91.9%**		
	3-6	**18,798**	**15,457**	**82.2%**		
	7-11	**19,979**	**13,707**	**68.6%**		
	12-20	**23,088**	**15,877**	**68.8%**		
	Total	**73,546**	**56,080**	**76.3%**	**-1.0%**	**p=.001**
AZ Physicians IPA	1	6,230	6,008	96.4%		
	2	4,580	4,202	91.7%		
	3-6	16,391	13,424	81.9%		
	7-11	17,678	12,264	69.4%		
	12-20	18,633	13,004	69.8%		
	Total	63,512	48,902	77.0%		

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Table 1

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MEMBERS ELIGIBLE UNDER MEDICAID

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Phoenix Health Plan/CC	**1**	**2,663**	**2,587**	**97.1%**		
	2	**1,833**	**1,688**	**92.1%**		
	3-6	**6,394**	**5,105**	**79.8%**		
	7-11	**6,006**	**3,883**	**64.7%**		
	12-20	**6,315**	**4,116**	**65.2%**		
	Total	**23,211**	**17,379**	**74.9%**	**-1.3%**	**p=.018**
Phoenix Health Plan/CC	1	2,243	2,154	96.0%		
	2	1,538	1,408	91.5%		
	3-6	5,373	4,341	80.8%		
	7-11	5,005	3,316	66.3%		
	12-20	5,176	3,450	66.7%		
	Total	19,335	14,669	75.9%		
Maricopa Health Plan	**1**	**1,372**	**1,277**	**93.1%**		
	2	**1,147**	**939**	**81.9%**		
	3-6	**3,462**	**1,963**	**56.7%**		
	7-11	**3,507**	**1,321**	**37.7%**		
	12-20	**3,583**	**1,388**	**38.7%**		
	Total	**13,071**	**6,888**	**52.7%**	**-20.2%**	**p<.001**
Maricopa Health Plan	1	1,387	1,324	95.5%		
	2	915	800	87.4%		
	3-6	3,014	2,167	71.9%		
	7-11	3,092	1,653	53.5%		
	12-20	2,880	1,513	52.5%		
	Total	11,288	7,457	66.1%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

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Table 1

Arizona Health Care Cost Containment System

CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS BY CONTRACTOR

MEMBERS ELIGIBLE UNDER MEDICAID

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
TOTAL	**1**	**20,359**	**19,638**	**96.5%**		
	2	**15,719**	**14,433**	**91.8%**		
	3-6	**51,957**	**41,999**	**80.8%**		
	7-11	**51,987**	**34,767**	**66.9%**		
	12-20	**59,696**	**40,394**	**67.7%**		
	Total	**199,718**	**151,231**	**75.7%**	**-1.2%**	**p<.001**
TOTAL	1	**19,048**	**18,329**	96.2%		
	2	**13,141**	**12,041**	91.6%		
	3-6	**44,077**	**35,669**	80.9%		
	7-11	**44,929**	**30,469**	67.8%		
	12-20	**47,798**	**32,953**	68.9%		
	Total	**168,993**	**129,461**	76.6%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

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Statistically significant changes from the previous period are highlighted in yellow.

Table 2

Arizona Health Care Cost Containment System

CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS BY CONTRACTOR

MEMBERS ELIGIBLE UNDER KIDSCARE

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Health Choice AZ *	**1**	**12**	**12**	**100.0%**		
	2	**88**	**83**	**94.3%**		
	3-6	**390**	**354**	**90.8%**		
	7-11	**550**	**423**	**76.9%**		
	12-18	**489**	**377**	**77.1%**		
	Total	**1,529**	**1,249**	**81.7%**	**1.7%**	**p=.335**
Health Choice AZ	1	35	34	97.1%		
	2	141	134	95.0%		
	3-6	408	351	86.0%		
	7-11	564	425	75.4%		
	12-18	459	347	75.6%		
	Total	1,607	1,291	80.3%		
University Family Care *	**1**	**5**	**5**	**100.0%**		
	2	**37**	**36**	**97.3%**		
	3-6	**113**	**95**	**84.1%**		
	7-11	**277**	**222**	**80.1%**		
	12-18	**401**	**322**	**80.3%**		
	Total	**833**	**680**	**81.6%**	**-0.7%**	**p=.752**
University Family Care	1	11	11	100.0%		
	2	43	42	0.0%		
	3-6	120	107	89.2%		
	7-11	280	230	82.1%		
	12-18	390	304	77.9%		
	Total	844	694	82.2%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

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Table 2

Arizona Health Care Cost Containment System

CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS BY CONTRACTOR

MEMBERS ELIGIBLE UNDER KIDSCARE

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Mercy Care Plan *	**1**	**70**	**66**	**94.3%**		
	2	**336**	**314**	**93.5%**		
	3-6	**1,215**	**1,060**	**87.2%**		
	7-11	**2,060**	**1,590**	**77.2%**		
	12-18	**2,018**	**1,597**	**79.1%**		
	Total	**5,699**	**4,627**	**81.2%**	**1.8%**	**p=.063**
Mercy Care Plan	1	76	72	94.7%		
	2	314	296	94.3%		
	3-6	1,120	972	86.8%		
	7-11	1,947	1,511	77.6%		
	12-18	1,891	1,416	74.9%		
	Total	5,348	4,267	79.8%		
Pima Health System *	**1**	**2**	**2**	**100.0%**		
	2	**20**	**20**	**100.0%**		
	3-6	**34**	**33**	**97.1%**		
	7-11	**109**	**80**	**73.4%**		
	12-18	**126**	**97**	**77.0%**		
	Total	**291**	**232**	**79.7%**	**-4.0%**	**p=.318**
Pima Health System	1	2	2	0.0%		
	2	14	14	100.0%		
	3-6	38	34	0.0%		
	7-11	105	85	81.0%		
	12-18	95	76	80.0%		
	Total	254	211	83.1%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

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Table 2

Arizona Health Care Cost Containment System

CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS BY CONTRACTOR

MEMBERS ELIGIBLE UNDER KIDSCARE

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
AZ Physicians IPA *	**1**	**79**	**75**	**94.9%**		
	2	**320**	**303**	**94.7%**		
	3-6	**1,344**	**1,171**	**87.1%**		
	7-11	**2,704**	**2,002**	**74.0%**		
	12-18	**2,928**	**2,162**	**73.8%**		
	Total	**7,375**	**5,713**	**77.5%**	**-0.4%**	**p=.669**
AZ Physicians IPA	1	114	113	99.1%		
	2	381	356	93.4%		
	3-6	1,439	1,257	87.4%		
	7-11	2,801	2,077	74.2%		
	12-18	2,867	2,108	73.5%		
	Total	7,602	5,911	77.8%		
Phoenix Health Plan/CC *	**1**	**40**	**37**	**92.5%**		
	2	**146**	**135**	**92.5%**		
	3-6	**650**	**559**	**86.0%**		
	7-11	**942**	**687**	**72.9%**		
	12-18	**771**	**537**	**69.6%**		
	Total	**2,549**	**1,955**	**76.7%**	**-2.4%**	**p=.107**
Phoenix Health Plan/CC	1	38	38	100.0%		
	2	153	145	94.8%		
	3-6	594	523	88.0%		
	7-11	910	669	73.5%		
	12-18	694	503	72.5%		
	Total	2,389	1,878	78.6%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

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MEMBERS ELIGIBLE UNDER KIDSCARE

Measurement Period October 1, 2002, to September 30, 2003

Contractor	Age	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Maricopa Health Plan	**1**	**16**	**16**	**100.0%**		
	2	**88**	**73**	**83.0%**		
	3-6	**294**	**192**	**65.3%**		
	7-11	**435**	**214**	**49.2%**		
	12-18	**305**	**125**	**41.0%**		
	Total	**1,138**	**620**	**54.5%**	**-20.9%**	**p<.001**
Maricopa Health Plan	1	22	21	95.5%		
	2	84	72	85.7%		
	3-6	314	261	83.1%		
	7-11	458	282	61.6%		
	12-18	281	162	57.7%		
	Total	1,159	798	68.9%		
TOTAL	**1**	**224**	**213**	**95.1%**		
	2	**1,035**	**964**	**93.1%**		
	3-6	**4,040**	**3,464**	**85.7%**		
	7-11	**7,077**	**5,218**	**73.7%**		
	12-18	**7,038**	**5,217**	**74.1%**		
	Total	**19,414**	**15,076**	**77.7%**	**-0.9%**	**p=.089**
TOTAL	1	298	291	97.7%		
	2	1,130	1,059	93.7%		
	3-6	4,033	3,505	86.9%		
	7-11	7,065	5,279	74.7%		
	12-18	6,677	4,916	73.6%		
	Total	19,203	15,050	78.4%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

Adults' Access to Preventive/Ambulatory Health Services

Three behaviors – tobacco use, poor nutrition and lack of physical activity – are major contributors to this country's leading killers, cardiovascular disease and cancer. These behaviors often worsen the complications of chronic diseases, such as diabetes, and increase the risk of developing other serious illnesses.[3]

Access to routine ambulatory medical services for adults is essential to the early diagnosis and treatment of diseases. Regular health care visits also provide opportunities for clinicians to educate and counsel patients on smoking cessation, diet, exercise and other healthy behaviors.

Indicator Description

The indicator for this measure was the percentage of members who:

- were ages 21 through 64 years at the end of the measurement period (October 1, 2002, through September 30, 2003),
- were continuously enrolled with one acute-care Contractor during the measurement period,
- had no more than one break in enrollment, not exceeding 31 days, and
- had at least one preventive/ambulatory visit during the measurement period, including encounters with primary care physicians, specialists, physician's assistants, nurse practitioners, ophthalmologists and optometrists.

Results were analyzed by two age groups: 21 through 44 and 45 through 64 years.

Performance Goals

AHCCCS has adopted a Minimum Performance Standard that Contractors achieve a total rate of at least 78 percent for this indicator. If Contractors have already achieved this rate, they should strive for an AHCCCS-established Goal of 80 percent.

National Comparisons

The National Committee for Quality Assurance (NCQA) has reported national averages for Medicaid health plans by age group for this measure. In calendar year 2002, the most recent year for which national data are available, the rates were:

20 to 44 years	75.3 percent
45 to 64 years	81.6 percent

Current Results and Trend

Overall, AHCCCS rates were 74.1 percent for members 21 to 44 years and 82.1 percent for members 45 to 64 years. The AHCCCS total rate remained unchanged from the previous measurement period, at 76.2 percent. Total rates by Contractor ranged from 63.2 percent to 78.4 percent. One of seven Contractors met the AHCCCS Minimum Performance Standard (Table 3).

The overall rate for this measure was slightly higher in Pima County, at 77.6 percent, compared with the combined rural counties and Maricopa County, at 76.4 percent and 75.5 percent, respectively.

The AHCCCS overall rate for this measure was at its highest point in CYE 1999, at 78.7 percent, and has declined slightly since then.

Fig. 2: Adults' Access to Care, 1998-2003

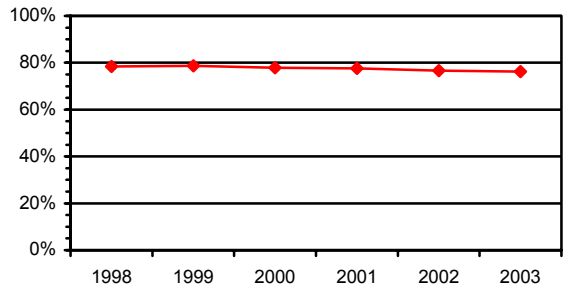

Table 3

Arizona Health Care Cost Containment System

ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES BY CONTRACTOR

Measurement Period: October 1, 2002, through September 30, 2003

Contractor	Ages	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Mercy Care Plan *	**21-44**	**22,474**	**17,136**	**76.2%**		
	45-64	**8,007**	**6,774**	**84.6%**		
	Total	**30,481**	**23,910**	**78.4%**	**0.4%**	**p=.345**
Mercy Care Plan	21-44	16,416	12,518	76.3%		
	45-64	5,311	4,450	83.8%		
	Total	21,727	16,968	78.1%		
University Family Care	**21-44**	**2,486**	**1,854**	**74.6%**		
	45-64	**1,111**	**916**	**82.4%**		
	Total	**3,597**	**2,770**	**77.0%**	**-2.5%**	**p=.065**
University Family Care	21-44	1,918	1,488	77.6%		
	45-64	786	647	82.3%		
	Total	2,704	2,135	79.0%		
AZ Physicians IPA	**21-44**	**28,821**	**21,374**	**74.2%**		
	45-64	**10,214**	**8,414**	**82.4%**		
	Total	**39,035**	**29,788**	**76.3%**	**-0.2%**	**p=.622**
AZ Physicians IPA	21-44	21,979	16,332	74.3%		
	45-64	7,145	5,940	83.1%		
	Total	29,124	22,272	76.5%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

Table 3

Arizona Health Care Cost Containment System

ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES BY CONTRACTOR

Measurement Period: October 1, 2002, through September 30, 2003

Contractor	Ages	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Health Choice AZ	**21-44**	**6,443**	**4,796**	**74.4%**		
	45-64	**2,159**	**1,740**	**80.6%**		
	Total	**8,602**	**6,536**	**76.0%**	**3.2%**	**p=.001**
Health Choice AZ	21-44	4,918	3,544	72.1%		
	45-64	1,660	1,297	78.1%		
	Total	6,578	4,841	73.6%		
Pima Health System	**21-44**	**1,692**	**1,245**	**73.6%**		
	45-64	**724**	**589**	**81.4%**		
	Total	**2,416**	**1,834**	**75.9%**	**1.6%**	**p=.370**
Pima Health System	21-44	1,221	875	71.7%		
	45-64	558	454	81.4%		
	Total	1,779	1,329	74.7%		
Phoenix Health Plan/CC	**21-44**	**7,121**	**5,267**	**74.0%**		
	45-64	**2,440**	**1,962**	**80.4%**		
	Total	**9,561**	**7,229**	**75.6%**	**-0.7%**	**p=.443**
Phoenix Health Plan/CC	21-44	5,451	4,040	74.1%		
	45-64	1,902	1,557	81.9%		
	Total	7,353	5,597	76.1%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

Table 3

Arizona Health Care Cost Containment System

ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES BY CONTRACTOR

Measurement Period: October 1, 2002, through September 30, 2003

Contractor	Ages	Number of Members	Number with ≥1 Visits	Percent with ≥1 Visits	Relative Percent Change from Previous Period	Statistical Significance
Maricopa Health Plan	**21-44**	**3,220**	**1,873**	**58.2%**		
	45-64	**1,703**	**1,236**	**72.6%**		
	Total	**4,923**	**3,109**	**63.2%**	**-10.7%**	**p<.001**
Maricopa Health Plan	21-44	2,470	1,643	66.5%		
	45-64	1,436	1,118	77.9%		
	Total	3,906	2,761	70.7%		
TOTAL	**21-44**	**72,257**	**53,545**	**74.1%**		
	45-64	**26,358**	**21,631**	**82.1%**		
	Total	**98,615**	**75,176**	**76.2%**	**-0.2%**	**p=.416**
TOTAL	21-44	54,373	40,440	74.4%		
	45-64	18,798	15,463	82.3%		
	Total	73,171	55,903	76.4%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

Breast Cancer Screening

In the last decade, the overall death rate from female breast cancer declined from 23 deaths per 100,000 women in 1990 to 18.8 deaths per 100,000 in 1998. However, the rates of decline for Hispanic and black women were lower than for white, non-Hispanic women, and the rates for Asians, Pacific Islanders, American Indians and Alaska Natives were virtually unchanged.[4]

Breast cancer is the second most commonly diagnosed cancer among women, after skin cancer.[5] The Centers for Disease Control and Prevention estimates that 216,000 new cases of invasive breast cancer will occur in the United States this year, and more than 40,000 women will die of the disease.[5,6] Data from the Arizona Department of Health Services indicates that approximately 670 women in the state died of breast cancer in 2003.[7]

Screening mammography is an important tool in the early detection of breast cancer. Studies have demonstrated that screening mammography may reduces mortality from the disease by up to 30 percent.[8,9]

Indicator Description

The indicator for this measure was the percentage of women who:

- were ages 52 through 64 years as of September 30, 2003,
- were continuously enrolled with one Contractor for two years (October 1, 2001, through September 30, 2003),
- had no more than one break in enrollment, not exceeding 31 days per year, and
- had a mammogram in the two-year period.

Performance Goals

AHCCCS has adopted a Minimum Performance Standard that Contractors achieve a rate of at least 55 percent for this measure. If Contractors have already achieved this rate, they should strive for the AHCCCS Goal of 60 percent.

National Comparison

NCQA has reported a national average of 55.9 percent for Medicaid health plans for this measure in calendar year 2003.

Current Results and Trend

The AHCCCS overall rate for the current measurement period was unchanged from the previous period, at 54.6 percent. Individual Contractor rates ranged from 51.3 percent to 62.2 percent. Four of seven Contractors met or exceeded the AHCCCS Minimum Performance Standard and two exceeded the AHCCCS Goal (Table 4).

Rates were higher in Pima County and the combined rural counties, at 58.1 percent and 57 percent, respectively. The rate for Maricopa County was 51.2 percent.

The AHCCCS overall rate for breast cancer screening has increased from 49.7 percent in CYE 1995, and was at its highest point in CYE 1998, at 57.3 percent.

Fig. 3: Breast Cancer Screening, 1995-2003

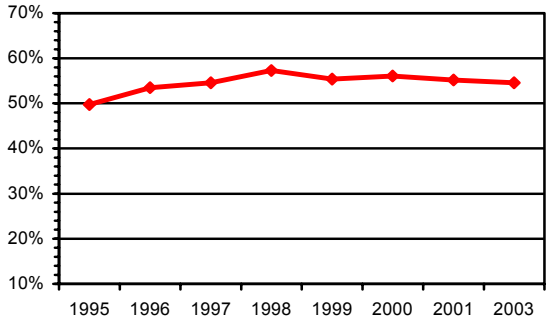

Table 4
Arizona Health Care Cost Containment System
BREAST CANCER SCREENING RATES BY CONTRACTOR
Measurement Period October 1, 2001, through September 30, 2003

Contractor	Number of Members	Number Screened	Percent Screened	Relative Percent Change From Previous Period	Statistical Significance
Pima Health System *	**225**	**140**	**62.2%**	**-5.6%**	**p=.454**
Pima Health System	170	112	65.9%		
Maricopa Health Plan *	**470**	**283**	**60.2%**	**16.8%**	**p=.009**
Maricopa Health Plan	423	218	51.5%		
University Family Care *	**271**	**159**	**58.7%**	**1.5%**	**p=.863**
University Family Care	166	96	57.8%		
Mercy Care Plan *	**1,759**	**973**	**55.3%**	**-2.4%**	**p=.476**
Mercy Care Plan	1,133	642	56.7%		
AZ Physicians IPA	**2,250**	**1,196**	**53.2%**	**-0.5%**	**p=.866**
AZ Physicians IPA	1,529	817	53.4%		
Health Choice AZ	**466**	**239**	**51.3%**	**-5.1%**	**p=.426**
Health Choice AZ	370	200	54.1%		
Phoenix Health Plan/CC	**591**	**303**	**51.3%**	**-9.0%**	**p=.094**
Phoenix Health Plan/CC	506	285	56.3%		
TOTAL	**6,032**	**3,293**	**54.6%**	**-1.0%**	**p=.571**
TOTAL	4,297	2,370	55.2%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

Cervical Cancer Screening

According to the American Cancer Society, an estimated 10,520 new cases of invasive cervical cancer will be diagnosed in 2004, and nearly 4,000 women will die of the disease.[6] Many of these deaths could be prevented with timely screening.

Since the introduction of the Papanicolaou (Pap) test, death from cervical cancer has declined by 70 percent. The Pap test can detect human papillomavirus (HPV) infection and precancerous conditions. Treatment of these problems can stop cervical cancer before it fully develops.[10,11]

The American College of Obstetricians and Gynecologists, the American Cancer Society and the U.S. Preventive Services Task Force recommend that women have a Pap test and pelvic examination when they become sexually active or at age 18, whichever occurs first. Annual Pap tests are recommended until three consecutive Pap tests are interpreted as being normal. Following this, Pap tests can be performed every three years, at the discretion of a woman's health care provider.

Indicator Description

This indicator for this measure was the percentage of members who:

- were ages 16 through 64 years as of October 1, 2002,
- were continuously enrolled with one Contractor during a one-year period (October 1, 2002, through September 30, 2003),
- had no more than one break in enrollment, not exceeding 31 days, and
- had at least one Pap test within a three-year period (October 1, 2000, through September 30, 2003).

Performance Goals

AHCCCS has adopted a Minimum Performance Standard that Contractors achieve a rate of at least 57 percent for this measure. If Contractors have already achieved this rate, they should strive for an AHCCCS-established Goal of 60 percent.

National Comparison

NCQA has reported a national average of 64.0 percent for Medicaid health plans for this measure in calendar year 2003.

Current Results and Trend

The AHCCCS overall rate for the current measurement period increased to 53.2 percent from 50.5 percent in the previous period ($p<.001$). Individual Contractor rates ranged from 44.1 percent to 57.6 percent. One of seven Contractors met the AHCCCS Minimum Performance Standard; however, four others showed statistically significant increases (Table 5).

Rates were slightly higher in Pima County, at 55.5 percent, compared with 53.0 percent in Maricopa County and 52.0 percent in the combined rural counties.

The AHCCCS overall rate for cervical cancer screening has decreased from approximately 57.2 percent in CYE 1999.

Fig. 4: Cervical Cancer Screening, 1999-2003

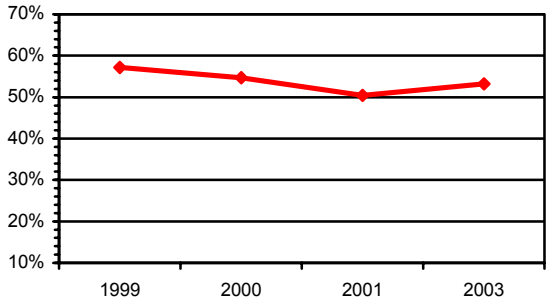

Table 5

Arizona Health Care Cost Containment System

CERVICAL CANCER SCREENING RATES BY CONTRACTOR

Measurement Period: October 1, 2000, through September 30, 2003

Contractor	Number of Members	Number Screened	Percent Screened	Relative Percent Change From Previous Period	Statistical Significance
Health Choice AZ *	**8,135**	**4,682**	**57.6%**	**8.4%**	**p<.001**
Health Choice AZ	3,725	1,977	53.1%		
Mercy Care Plan	**28,833**	**16,259**	**56.4%**	**-0.6%**	**p=.565**
Mercy Care Plan	11,583	6,569	56.7%		
University Family Care	**3,588**	**1,981**	**55.2%**	**9.9%**	**p<.001**
University Family Care	1,585	796	50.2%		
AZ Physicians IPA	**36,224**	**19,034**	**52.5%**	**8.7%**	**p<.001**
AZ Physicians IPA	15,812	7,644	48.3%		
Pima Health System	**2,459**	**1,281**	**52.1%**	**13.9%**	**p<.001**
Pima Health System	1,141	522	45.7%		
Phoenix Health Plan /CC	**9,158**	**4,234**	**46.2%**	**-3.6%**	**p=.066**
Phoenix Health Plan /CC	4,070	1,952	48.0%		
Maricopa Health Plan	**4,682**	**2,066**	**44.1%**	**18.4%**	**p<.001**
Maricopa Health Plan	2,471	921	37.3%		
TOTAL	**93,079**	**49,537**	**53.2%**	**5.5%**	**p<.001**
TOTAL	40,387	20,381	50.5%		

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

Shaded rows show totals and percentages from the previous measurement period.

Statistically significant changes from the previous period are highlighted in yellow.

Timeliness of Prenatal Care

Women who receive early and ongoing prenatal care are more likely to have better pregnancy outcomes than women who receive little or no prenatal care.[12,13,14,15]

Adverse outcomes such as low birth weight, preterm delivery and cognitive impairment of newborns can be prevented by modifying maternal behaviors.[16] Prenatal care affords physicians and other health care practitioners opportunities to address risk factors such as smoking, alcohol use and improper diet, as well as treat medical complications that can negatively affect the health of mother and baby. In addition, prenatal care provides opportunities to educate pregnant women, especially first-time mothers, on childbirth and infant care.

Arizona continues to lag behind the national average for women receiving prenatal care in the first trimester. In 2003, 75.5 percent of all Arizona women who had live births started prenatal care in the first trimester, compared with 83.8 percent nationally.[17]

Indicator Description

The indicator for this measure was the percentage of women who:

- had a live birth during the measurement period (October 1, 2002, through September 30, 2003).
- were continuously enrolled with the same acute-care Contractor for 43 days or more prior to delivery, and
- had a prenatal care visit during their first trimester of pregnancy or within 42 days of enrollment, depending on the date of enrollment with the Contractor and any gaps in enrollment during the pregnancy.

Performance Goals

AHCCCS has adopted a Minimum Performance Standard that Contractors achieve a rate of at least 59 percent for this measure. If Contractors have already achieved this rate, they should strive for the AHCCCS Goal of 65 percent.

National Comparison

NCQA has reported a national average of 76.5 percent for Medicaid health plans for this measure in calendar year 2003.

Current Results

The AHCCCS overall rate for the current measurement period was 73.7 percent. All eight Contractors met the AHCCCS Minimum Performance Standard for this measure and six met the AHCCCS Goal (Table 6).

Rates were slightly higher in Pima County, at 74.6 percent, compared with 73.2 percent in Maricopa County and 71.4 percent in the combined rural counties.

AHCCCS further analyzed rates by the length of time women were enrolled. The rate of women who were continuously enrolled with a Contractor and had a prenatal care visit in the first trimester was 86.5 percent. Among women who were enrolled later in pregnancy or had gaps in enrollment, the rate of prenatal visits within 42 days of enrollment was 68.5 percent.

This is the first year AHCCCS has measured timeliness of prenatal care using the current methodology, so comparisons with previous rates cannot be made.

Table 6

Arizona Health Care Cost Containment System

TIMELINESS OF PRENATAL CARE

Measurement Period: October 1, 2002, through September 30, 2003

Contractor	Visits within the First Trimester			Visits within 42 days of Enrollment			Total		
	Members	With Visits	Percent	Members	With Visits	Percent	Members	With Visits	Percent
Mercy Care Plan *	2,731	2,447	89.6%	6,106	4,741	77.6%	8,837	7,188	81.3%
AZ Physicians IPA *	2,367	2,080	87.9%	6,441	4,308	66.9%	8,808	6,388	72.5%
University Family Care *	234	201	85.9%	499	309	61.9%	733	510	69.6%
Health Choice AZ *	838	706	84.2%	1,883	1,135	60.3%	2,721	1,841	67.7%
Phoenix Health Plan/CC *	777	631	81.2%	1,999	1,196	59.8%	2,776	1,827	65.8%
Maricopa Health Plan *	150	105	70.0%	409	232	56.7%	559	337	60.3%
Pima Health System *	115	70	60.9%	442	256	57.9%	557	326	58.5%
TOTAL	**7,212**	**6,240**	**86.5%**	**17,779**	**12,177**	**68.5%**	**24,991**	**18,417**	**73.7%**

* Indicates the Contractor met or exceeded the AHCCCS Minimum Performance Standard.

DISCUSSION

The data reported here indicate that children – especially those in the youngest age groups – and adults enrolled with AHCCCS have a high degree of access to the health care system. However, many adults are reluctant to use preventive services. This may be due to lack of knowledge or confusion about what services or tests are needed and when, language barriers, cultural beliefs, and skepticism about the effectiveness of prevention.[18]

For example, a significant percentage of women responding to a recent National Cancer Institute survey said that they did not have a mammogram because they did not know they needed one or their doctor had not recommended one.[19] Women of certain racial or ethnic groups may be reluctant to obtain mammograms or Pap tests because of embarrassment about reproductive health issues and fatalistic attitudes that an individual can do little to alter the future, or they may believe that the needs of the group are more important than their own needs.[20,21]

Overcoming Barriers to Care

Routine reminders that it's time for members to get a particular service may not be enough to improve rates of preventive health services. For instance, AHCCCS Contractors should emphasize how the benefits of mammography in detecting cancer early outweigh the discomfort and any perceived risks associated with the procedure. They also should remind women who have no special risk factors for breast cancer that they need regular mammograms to detect possible tumors.

Personal outreach coupled with culturally relevant education materials may be effective in improving rates of breast and cervical cancer screening, especially among some racial or ethnic groups.

Pima Health System, which had the highest rates of breast cancer screening in the last two measurement periods, has combined personal outreach and education for a variety of ages and health needs when case managers make home visits to families with newborns. Since several family members may be enrolled with the health plan, they check to see if other members of the household are due for preventive visits and use the opportunity to encourage them to receive services. Case managers may assist in making appointments for family members who are enrolled in the health plan and arranging for transportation.

Provider-focused Strategies

Some strategies to improve rates of preventive care are aimed at providers. At a minimum, most Contractors periodically send providers lists of members who are due or overdue for a particular service. Other provider interventions include distributing profiles to individual practitioners that show their rates for a particular service compared with their peers, recognition of providers who meet certain quality criteria, and "pay-for-performance" arrangements that reward providers with the highest rates. Several Contractors are using or considering these mechanisms for improvement.

These strategies may be tied together. Feedback in the form of provider profiles helps physicians, hospitals and other providers improve their performance. Health plans may recognize providers that perform at a certain level; e.g. in provider or member information materials, and those that meet specific criteria may receive extra payment.

Conclusion

AHCCCS will continue to work with Contractors, especially those with the lowest rates, and their actions to improve performance for these measures.

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APPENDIX

Methodology and Technical Specifications for Acute-care Performance Measures For Measurement Periods Ending September 30, 2003

I. CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS (MEDICAID AND KIDSCARE MEMBERS)

Population
Members were selected from the acute-care population only.

Sample Frame
AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®), 2002 version, as a guide in developing the methodology for this measure.

Enrollment criteria

Acute-care members who:
- were ages 1 through 20 years if eligible under the Medicaid program or 1 through 18 years old if eligible under the KidsCare program,
- were continuously enrolled with the same acute-care Contractor during the measurement period, and
- had no more than one break in enrollment, not to exceed 31 days in the contract year

Service selection criteria

Acute-care members who:
- met the enrollment criteria and
- had at least one visit with a health plan PCP during the measurement period.

Sample Selection
All members who met the sample frame criteria were included in this measure.

Population Stratification
The sample frame was stratified for both the Medicaid and KidsCare populations by:
- Maricopa, Pima and Rural counties, and
- acute-care Contractor or the Comprehensive Medical and Dental Program (CMDP) managed by the Department of Economic Security (DES).

Population Exclusions
This measure did not include children who were enrolled in Arizona Long-term Care System (ALTCS), the Division of Developmental Disabilities (DDD) managed by the Department of Economic Security (DES), Indian Health Services (IHS), Emergency Services Program (ESP) and Fee For Service (FFS). In addition, this measure excluded any members who also were Medicare recipients.

Data Sources
- Recipient enrollment data were used to identify members who met the denominator criteria.
- Encounter data were used to identify the number of members who had PCP visits.

Data Collection
The Information Services Division (ISD) of AHCCCS extracted administrative data from the Prepaid Medical Management Information System (PMMIS). No outside data were collected.

Data Validation
Data validation was performed to ensure that all data received from the Information Services Division (ISD) were from the appropriate service records and met this measure's service selection criteria, and that all recipients selected met the proper enrollment criteria.

The Data Analysis and Research Unit (DA&R) in the Division of Health Care Management (DHCM) developed a Quality Control (QC) process based on the measure methodology. DA&R verified that members selected met the sample frame criteria. The QC report provided by ISD was used to complete data validation.

Denominator
The number of members who met the sample frame criteria for enrollment

Numerator
The number of members who met the sample frame criteria for service selection

Comparative Analysis
For the Medicaid and KidsCare populations separately:
- the total rate for all Contractors was compared to the total for the previous measurement period.
- totals for Maricopa, Pima and the combined rural counties were compared to each other and to totals for the previous measurement period.
- individual Contractor rates were compared to their rates for the previous year.
- individual Contractor rates were compared to the AHCCCS Minimum Performance Standard and Goal.
- if available, the total rate for all Contractors was compared to the national average for this measure as reported by the National Committee for Quality Assurance (NCQA).

Deviations from HEDIS
This measure differs from HEDIS 2002 in the following areas:
- the HEDIS measure includes only members ages 1 through 11 years. The AHCCCS measure includes ages 1 through 20 for the Medicaid population and ages 1 through 18 for the KidsCare population.
- The HEDIS measure uses a one-year enrollment for ages 1-6 years and two-year enrollment period for members ages 7 through 11 years. AHCCCS used the one-year enrollment period for all ages.
- The HEDIS measure includes PCP visits in the two-year enrollment period for ages 7 through 11 years. AHCCCS selected services in the one-year measurement period only.

- The AHCCCS measure uses CPT codes 99384, 99385, 99394 and 99395 to collect preventive medicine visits by members 12 and older. HEDIS does not use these codes because members older than 11 are not included in the measure.
- The HEDIS measures uses codes 99341 to 99350 for services provided in a private residence. The AHCCCS measure uses only codes 99341 to 99345 for these services.
- AHCCCS uses Evaluation and Management codes in conjunction with ICD-9 diagnosis codes to identify some PCP visits. HEDIS used both the CPT and ICD-9 codes independently to identify visits.

Recipient Subsystem Requirements

- Members must have been 1 through 20 years of age, or 1 through 18 years of age if eligible under KidsCare, as of September 30 of the measurement period.
- Members must have been continuously enrolled during the measurement period and on September 30 of the measurement period.
- Members must have been enrolled with the same acute-care, capitated Contractor for the entire measurement period.
- Prior Period Coverage (PPC) was not considered part of continuous enrollment and was treated as a break in acute enrollment.
- A member with one single enrollment gap, not to exceed 31 days, was considered to have continuous enrollment and was included in the population; however, the gap could not occur at the beginning or the end of the continuous enrollment period.
- Change of county-service-area with the same Contractor without any gap of enrollment was not considered a break in enrollment.
- For those members who stayed with the same Contractor but moved to a different county during the measurement period, the member was assigned to the last county of residence.
- Any enrollment that changed from an acute-care Contractor to a Contractor for the Arizona Long Term Care System (ALTCS) and back to an acute-care Contractor within 31 days was treated as a break in acute enrollment instead of enrollment with more than one capitated Contractor during the measurement period.
- Any member enrolled with the following Contractors was excluded:

000850 - State Emergency Services	000950 - Federal Emergency Services
000960 - Family Planning Services	003335 - Permanent Fee-For-Service
008690 - Temporary Fee-For-Service	010174 - Maricopa LTC, Residual
010182 - Pima LTC, Residual	999998 - Indian Health Services
888886 - Fee-For-Service LTC, residual	079873 - DHS
110007 - DES/DDD	550005 - DES/VD

- Members with rate codes 45XX were excluded.
- Members with Medicare Part A and/or Part B during the measurement period were excluded.

Note:
A data file containing the information for each member was created and used to identify services received.

Encounter Subsystem Requirements

Utilizing data from the Recipient Subsystem:

- All encounters selected (Form 1500 and UB 82/92) for the numerator were based on the service selection criteria listed below.
- Encounters were included if the begin-date of service fell within the measurement period.
- Encounters from the Arizona Department of Health Services/Children's Rehabilitative Services (CRS) and ADHS/Behavioral Health Services (BHS) who also were enrolled with another Contractor were included in the other Contractor's data.
- All services for the member were reported under the member's last county of residence in the measurement period.
- The selected encounters were sorted by member primary ID.
- All members from the denominator who did not meet the selection criteria and who had encounters matching the service exclusionary criteria listed below were excluded from the numerator.

Service Selection Criteria

CPT-4 Codes for Preventive Medicine Services (UB82/92 or HCFA 1500)

99381 - 99385	New Patient (ages 1 - 39 years)
99391 - 99395	Established Patient (ages 1 - 39 years)
99401 - 99404	Preventive medicine, individual counseling
99411 - 99412	Preventive medicine, group counseling
99420	Administration and interpretation of health risk assessment instrument
99429	Unlisted preventive medicine service

The following CPT-4 codes were used in conjunction with ICD-9 codes

CPT-4 Codes for Evaluation and Management (UB82/92 or HCFA 1500)

99201 - 99205	New Patient
99211 - 99215	Established patient
99241 - 99245	Office or other outpatient consultations
99341 - 99345	Home services
99499	Unlisted evaluation and management service

In Conjunction with ICD-9 Diagnosis Codes:

V20.2	Routine infant or child health check
V70.0	Routine general medical examination at health care facility
V70.3	Other general medical examination
V70.5 - V70.6	Health examination
V70.7	Examination for normal comparison or control in clinical research
V70.8 - V70.9	Other specified and unspecified general medical examination.

Exclusions

Form Type = "I"
Form type = "O" with revenue code = 450 (Emergency Room)
Form Type = "A" with place of service = 23= (Emergency Room), 21= (Inpatient Hospital).
If principal/first-listed diagnosis codes ICD-9 290-316
If principal/first-listed diagnosis codes ICD-9 960-979 with a secondary diagnosis of chemical dependency codes ICD-9-CM 303.xx and 304.xx.
CPT Procedure Codes 90801-90899

OR

ICD-9 Procedure Codes
94.26, 94.27, and 94.6

In conjunction with the following ICD-9 Diagnosis Codes:

V20.2	Routine infant or child health check
V70.0	Routine general medical examination at health care facility.
V70.3	Other general medical examination
V70.5 - V70.6	Health examination
V70.7	Examination for normal comparison or control in clinical research
V70.8 - V70.9	Other specified and unspecified general medical examination.

II. ADULTS' ACCESS TO PREVENTIVE/AMBULATORY CARE SERVICES

Population
Members were selected from the acute-care population only.

Sample Frame
AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®), 2002 version, as a guide in developing the methodology for this measure.

Enrollment criteria
The enrollment criteria for sample frame included acute-care members who:
- were ages 21 through 64 years,
- were continuously enrolled with the same acute-care Contractor during the measurement period, and
- had no more than one break in enrollment, not to exceed 31 days in the contract year

Prior period coverage (PPC) was not considered part of continuous enrollment and was treated as a break in acute enrollment.

- Service selection criteria
- The service selection criteria for sample frame included acute-care members who:
- met the enrollment criteria and
- had at least one preventive or ambulatory care visit during the measurement period

Sample Selection
All members who met the sample frame criteria were included in this measure.

Population Stratification
The sample frame was stratified by:
- Maricopa, Pima and Rural counties, and
- acute-care Contractor or the Comprehensive Medical and Dental Program (CMDP) managed by the Department of Economic Security (DES).

Population Exclusions
This measure did not include members enrolled in the Arizona Long-term Care System (ALTCS), the Division of Developmental Disabilities (DDD) managed by the Department of Economic Security (DES), Indian Health Services (IHS), Emergency Services Program (ESP) and Fee For Service (FFS). In addition, this measure excluded any members who also were Medicare recipients.

Data Sources
- Recipient enrollment data were used to identify members who met the denominator criteria.
- Encounter data were used to identify the number of members who received preventive or ambulatory care visits.

Data Collection
The Information Services Division (ISD) of AHCCCS extracted administrative data from the Prepaid Medical Management Information System (PMMIS). There was no outside data collected.

Data Validation
Data validation was performed to ensure that all data received from the Information Services Division (ISD) were from the appropriate service records and met this measure's service selection criteria, and that all recipients selected met the proper enrollment criteria.

The Data Analysis and Research Unit (DA&R) in the Division of Health Care Management (DHCM) developed a Quality Control (QC) process based on the measure methodology. DA&R verified that the members selected met the sample frame criteria. The QC report provided by ISD was used to complete data validation.

Denominator
The number of members who met the sample frame criteria for enrollment

Numerator
The number of members who met the sample frame criteria for service selection.

Note:
A member was included in the numerator only once under the number of visits received.

Comparative Analysis
- The total rate for all Contractors was compared to the total for the previous measurement period.
- Totals for Maricopa, Pima and the combined rural counties were compared to each other and to totals for the previous measurement period.
- Individual Contractor rates were compared to their rates for the previous year.
- Individual Contractor rates were compared to the AHCCCS Minimum Performance Standard and Goal.
- If available, the total rate for all Contractors was compared to the national average for this measure as reported by the National Committee for Quality Assurance (NCQA).

Deviations from HEDIS
This measure differs from HEDIS 2002 in the following area:
- The HEDIS measure includes members who are age 20 years and older. The AHCCCS measure includes only members 21 through 64 years.
- AHCCCS used Revenue codes 770 (General Classification/Preventive Care Services), 771 (Vaccine Administration) and 779 (Other Preventive Care Services) to identify preventive/ambulatory care visits. HEDIS does not use these codes.

Recipient Subsystem Requirements:

- Members selected must have been 21 through 64 years old as of September 30 of the measurement period.
- Members must have been continuously enrolled during the measurement period and as of September 30 of the measurement period.
- Members must have been enrolled with one acute-care, capitated Contractor for the entire measurement period.
- Prior Period Coverage (PPC) was not considered part of continuous enrollment and was treated as a break in acute enrollment.
- A member with one single enrollment gap per contract year, not exceeding 31 days, was considered to have continuous enrollment and was included in the population.
- A change of county-service-area with the same Contractor without any gap in enrollment was not considered a break in enrollment.
- For those members who stayed with the same Contractor but moved to a different county during the reporting period, the member was assigned to the last county of residence.
- Any enrollment that changed from an acute-care Contractor to a Contractor for the Arizona Long Term Care System (ALTCS) and back to an acute-care Contractor within 31 days was treated as a break in acute enrollment instead of enrollment with more than one Contractor during the measurement period.
- Any member enrolled with the following Contractors was excluded:

000850 – State Emergency Services	000950 – Federal Emergency Services
000960 – Family Planning Services	003335 – Permanent Fee-For-Service
008690 – Temporary Fee-For-Service	010174 – Maricopa LTC, Residual
010182 – Pima LTC, Residual	999998 – Indian Health Services
888886 – Fee-For-Service LTC, Residual	079873 – DHS
110007 – DES/DDD	550005 – DES/VD

- Members with Medicare Part A and/or Part B during the measurement period were excluded.
- Members with rate codes 45XX and 46XX were excluded.

Note:
A data file was created containing the information for each member that was to be used to identify the services received.

Encounter Subsystem Requirements:
Utilizing data from Recipient Subsystem:

- All encounters (using Form 1500 and UB 82/92) for the selected members were based on the service selection criteria listed below.
- Encounters were included if the begin-date of service fell within the measurement period.
- Encounters from the Arizona Department of Health Services (ADHS)/Behavioral Health Services (BHS) were excluded.
- All services for the member were reported under the member's last county of residence in the measurement period.
- All selected encounters were sorted by members' primary identification numbers.
- All members from the denominator who did not meet the selection criteria and who had encounters matching the service exclusionary criteria listed below were excluded from the numerator.

Service Selection Criteria

CPT-4 Codes for Preventive Medicine Services (UB82/92 or HCFA 1500)

99385 – 99387	New Patient
99395 – 99397	Established Patient
99401 – 99404	Preventive medicine, individual counseling
99411 – 99412	Preventive medicine, group counseling
99420	Administration and interpretation of health risk assessment instrument
99429	Unlisted preventive medicine service

OR

CPT-4 Codes for Evaluation and Management (UB82/92 or HCFA 1500)

99201 – 99205	New Patient
99211 – 99215	Established patient
99241 – 99245	Office or other outpatient consultations
99301 – 99303	Comprehensive nursing facility assessments
99311 – 99313	Subsequent nursing facility care
99321 – 99323	Domiciliary, rest home, or custodial care services, new patient
99331 – 99333	Domiciliary, rest home, or custodial care services, established patient
99341 – 99350	Home services
99499	Unlisted evaluation and management service

OR

CPT-4 Codes for Ophthalmology and Optometry (UB82/92 or HCFA 1500)

92002 – 92004	General ophthalmological services, new patient
92012 – 92014	General ophthalmological services, established patient

OR

Revenue Codes(UB 82/92)

510	Clinic
511	Chronic pain clinic
514	OB/GYN clinic
516	Urgent clinic
517	Family clinic
519	Other clinic
520	Freestanding clinic
521	Rural clinic
522	Rural / home
523	Family practice clinic
526	Freestanding urgent care clinic

529	Other freestanding clinic
530	Osteopath services
531	Osteopath Rx
539	Other Osteopath services
770	General Classification/Preventative Care Services
771	Vaccine Administration
779	Other Preventative Care Services
982	Professional fees, outpatient services
983	Professional fees, clinic

Exclusions

Form Type = "I"
Form type = "O" with revenue code = 450 (Emergency Room)
Form Type = "A" with place of service = 23= (Emergency Room), 21= (Inpatient Hospital).
If principal/first-listed diagnosis codes ICD-9 290-316
If principal/first-listed diagnosis codes ICD-9 960-979 with a secondary diagnosis of chemical dependency codes ICD-9-CM 303.xx and 304.xx.
CPT Procedure Codes 90801-90899

OR

ICD-9 Procedure Codes

94.26, 94.27, and 94.6

In conjunction with the following ICD-9 Diagnosis Codes:

V20.2	Routine infant or child health check
V70.0	Routine general medical examination at health care facility.
V70.3	Other general medical examination
V70.5 - V70.6	Health examination
V70.7	Examination for normal comparison or control in clinical research
V70.8 - V70.9	Other specified and unspecified general medical examination.

III. BREAST CANCER SCREENING

Population
All members selected were from the acute-care population exclusively.

Sample Frame
AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®), 2002 version, as a guide in developing the methodology for this measure.

Enrollment criteria
Acute-care members who:
- were ages 52 to 64 years old at the end of the measurement period,
- were continuously enrolled with one acute-care Contractor for two years, and
- had no more than one break in enrollment, not exceeding 31 days, per year.

Prior Period Coverage (PPC) was not considered part of continuous enrollment and was treated as a break in acute enrollment.

Service selection criteria
Acute-care members who:
- met the enrollment criteria and
- had a mammogram within the two-year measurement period.

Sample Selection
All members who met the sample frame criteria were included in this measure.

Population Stratification
The sample frame was stratified by:
- Maricopa, Pima and the combined rural counties, and
- acute-care Contractor.

Population Exclusions
This measure did not include members enrolled in the Arizona Long Term Care system (ALTCS) or the fee-for-service program (i.e., Indian Health Services and Emergency Services Program). In addition, this measure excluded any members who also were Medicare recipients.

Data Sources
- Recipient enrollment data were used to identify members who met the denominator criteria.
- Encounter data were used to identify the number of members who received mammograms.

Data Collection
The Information Services Division (ISD) of AHCCCS extracted administrative data from the Prepaid Medical Management Information System (PMMIS). No outside data were collected.

Data Validation
Data validation was performed to ensure that all data received from the Information Services Division (ISD) were from the appropriate service records and met this measure's service selection criteria, and that all recipients selected met the proper enrollment criteria.

The Data Analysis and Research Unit (DA&R) in the Division of Health Care Management (DHCM) developed a Quality Control (QC) process based on the measure methodology. DA&R verified that the members selected met the sample frame criteria. The QC report provided by ISD was used to complete data validation.

Denominator
The number of members who met the sample frame criteria for enrollment

Numerator
The number of members in the sample frame who met the criteria for service selection

Comparative Analysis
- The total for all Contractors was compared to results for the previous measurement period.
- The average results for Maricopa, Pima and the combined rural counties were compared to each other and to results for the previous measurement period.
- Individual Contractor rates were compared to their rates for the previous year.
- Individual Contractor rates were compared to the AHCCCS Minimum Performance Standard and AHCCCS goal.
- If available, the total rate for all Contractors was compared to the national average for this measure as reported by the National Committee for Quality Assurance (NCQA).

Deviations from HEDIS
This measure differs from HEDIS 2002 in the following area:
- HEDIS criteria include searching for evidence of a bilateral mastectomy as far back as possible in the patient's history, through either administrative data or medical record review. AHCCCS only searched for evidence of a bilateral mastectomy during the measurement period.

Recipient Subsystem Requirements
- Only female members were selected.
- Members selected must have been 52 through 64 years old as of September 30 of the measurement period.
- Members must have been continuously enrolled during the measurement period, and as of September 30 of the measurement period.
- Members selected must have been enrolled with one acute-care Contractor for the entire measurement period.
- Prior Period Coverage (PPC) was not considered as part of continuous enrollment and was treated as a break in acute enrollment.
- A member with one single enrollment gap, not exceeding 31 days per contract year, was considered to have continuous enrollment and was included in the sample frame.

- A change of county service area while enrolled with the same Contractor without any gap of enrollment was not considered a break in enrollment.
- For those members who stayed with the same acute-care Contractor but moved to a different county during the measurement period, the member was assigned to the last county of residence.
- Any enrollment that changed from an acute-care Contractor to a Contractor for the Arizona Long Term Care System (ALTCS) and back to an acute-care Contractor within 31 days was treated as a break in acute enrollment instead of enrollment with more than one Contractor during the measurement period.
- Members enrolled with the following Contractors were not selected:

000850 - State Emergency Services	000950 - Federal Emergency Services
000960 - Family Planning Services	003335 - Permanent Fee-For-Service
008690 - Temporary Fee-For-Service	010174 - Maricopa LTC, Residual
010182 - Pima LTC, Residual	999998 - Indian Health Services
888886 - Fee-For-Service LTC, residual	079873 - DHS
110007 - DES/DDD	550005 - DES/VD

- Members with Medicare Part A and/or Part B during the measurement period were excluded.
- Members with rate codes 45XX and 46XX were excluded.

Note:
A data file containing the information for each member was created and used to identify the services received.

Encounter Subsystem Requirements
Utilizing data from Recipient Subsystem:
- All encounters selected (using Form 1500 or UB 82/92) for the selected members were based on the service selection criteria listed below.
- Encounters were included if the begin-date of service fell within the measurement period.
- Encounters from the ADHS/Behavioral Health Services (BHS) were excluded.
- All services for the member were reported under the member's last county of residence in the measurement period.
- The selected encounters were sorted by members' primary identification numbers.
- All members from the denominator who did not meet the selection criteria and who had encounters matching the service exclusionary criteria listed below were excluded from the numerator.

Service Selection Criteria

CPT-4 Procedure Codes (HCFA 1500 or UB 82/92)

76090 Mammography – unilateral
76091 Mammography – bilateral
76092 Screening mammography, bilateral

OR

ICD-9 Diagnostic Codes (HCFA 1500 or UB 82/92)
V76.11 Screening mammogram for high-risk patient
V76.12 Other screening mammogram

OR

ICD-9 Procedure Codes (UB 82/92)
87.36 Xerography of breast
87.37 Other mammography

OR

Revenue Codes (UB 82/92)
401 Mammography
403 Screen mammography

Service Exclusionary Criteria

ICD-9 Procedure Codes (UB 82/92)
85.44 Bilateral extended simple mastectomy
85.46 Bilateral radical mastectomy
85.48 Bilateral extended radical mastectomy

OR

CPT-4 Procedure Codes (HCFA 1500 or UB 82/92)
19200 Mastectomy, radical, including pectoral muscles, an axillary lymph nodes
19220 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes
19240 Mastectomy, modified radical, including axillary lymph nodes with or without pectoralis minor muscle, but excluding pectoralis major muscle

In conjunction with modifier code:
50 Bilateral procedure

IV. CERVICAL CANCER SCREENING

Population
Members were selected from the acute-care population exclusively.

Sample Frame
AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®), 2002 version, as a guide in developing the methodology for this measure.

Enrollment criteria
Acute-care members who:
- were ages 16 to 64 at the end of the measurement period,
- were continuously enrolled with one acute-care Contractor during the measurement period, and
- had no more than one break in enrollment, not exceeding 31 days, during the measurement period

Prior Period Coverage (PPC) was not considered part of continuous enrollment and was treated as a break in acute enrollment.

Service selection criteria
Acute-care members who:
- met the enrollment criteria and
- who received one or more Pap tests within the measurement period or two previous years

Sample Selection
All members who met the sample frame were included in this measure.

Population Stratification
The sample frame was stratified by:
- Maricopa, Pima and the combined rural counties, and
- acute-care Contractor.

Population Exclusions
This measure did not include members enrolled in KidsCare, the Arizona Long Term Care system (ALTCS), or the fee-for-service program (i.e., Indian Health Services and Emergency Services Program). In addition, this measure excluded any members who also were Medicare recipients.

Members who had a hysterectomy with no residual cervix during the measurement period also were excluded.

Data Sources
- Recipient enrollment data were used to identify members who met the denominator criteria.
- Encounter data were used to identify the number of members who received a Pap test.

Data Collection
The Information Services Division (ISD) of AHCCCS extracted administrative data from the Prepaid Medical Management Information System (PMMIS). No outside data were collected.

Data Validation
Data validation was performed to ensure that all data received from the Information Services Division (ISD) were from the appropriate service records and met this measure's service selection criteria, and that all recipients selected met the proper enrollment criteria.

The Data Analysis and Research Unit (DA&R) in the Division of Health Care Management (DHCM) developed a Quality Control (QC) process based on the measure methodology. DA&R verified that the members selected met the sample frame criteria. The QC report provided by ISD was used to complete data validation.

Denominator
The number members who met the sample frame criteria for enrollment

Numerator
The number of members in the sample frame who met the criteria for service selection

Comparative Analysis
- The total for all Contractors was compared to results for the previous measurement period.
- The average results for Maricopa, Pima and the combined rural counties were compared to each other and to results for the previous measurement period.
- Individual Contractor rates were compared to their rates for the previous year.
- Individual Contractor rates were compared to the AHCCCS Minimum Performance Standard and AHCCCS goal.
- If available, the total rate for all Contractors was compared to the national average for this measure as reported by the National Committee for Quality Assurance (NCQA).

Deviations from HEDIS
This measure differs from HEDIS 2002 in the following areas:
- The HEDIS measure uses the age range 21 through 69 years. The AHCCCS measure used the age range 16 through 64 years.
- The AHCCCS measure used additional HCPCS codes P3000, P3001 and Q0091, and revenue code 311.
- The AHCCCS measure used additional CPT codes 88143, 88144, 88145, 88147, 88148, 88153, 88154, 88164, 88165, 88166, and 88167.
- The HEDIS measure gives Contractors the option of using cervical cancer screening exclusionary codes for those women identified as having had a hysterectomy with no residual cervix at any time. The AHCCCS measure only included the exclusionary codes if they occurred during the measurement period.

Recipient Subsystem Requirements

- Only female members were selected.
- Members selected must have been 16 through 64 years old as of September 30 of the measurement period.
- Members selected must have been continuously enrolled during the measurement period and as of September 30 of the measurement period.
- Members selected must have been enrolled with one acute-care Contractor for the entire measurement year.
- Prior Period Coverage (PPC) was not considered as part of continuous enrollment and was treated as a break in acute enrollment.
- A member with one single enrollment gap, not exceeding 31 days, was considered to have continuous enrollment and was included in the sample frame.
- A change of county service area while enrolled with the same acute-care Contractor without any gap of enrollment was not considered a break in enrollment.
- For those members who stayed with the same acute-care Contractor but moved to a different county during the measurement period, the member was assigned to the last county of residence.
- The member's enrollment-begin date was the beginning date of the measurement period. The enrollment-end date was the ending date of the measurement period. If the allowable gap appeared at the beginning of the measurement period, then the member's enrollment begin-date was the first enrollment date after the gap.
- Because only acute-care Contractors were evaluated, any enrollment that changed from an acute- care Contractor to a Contractor for the Arizona Long Term Care System (ALTCS) and back to an acute-care Contractor within 31 days was treated as a break in acute enrollment instead of enrollment with more than one Contractor during the measurement period.
- Members enrolled with the following Contractors were not selected:

000850 - State Emergency Services	000950 - Federal Emergency Services
000960 - Family Planning Services	003335 - Permanent Fee-For-Service
008690 - Temporary Fee-For-Service	010174 - Maricopa LTC, Residual
010182 - Pima LTC, Residual	999998 - Indian Health Services
888886 - Fee-For-Service LTC, residual	079873 - DHS
110007 - DES/DDD	550005 - DES/VD

- Members with Medicare Part A and/or Part B during the measurement period were excluded.
- Members with rate codes 45XX and 46XX were excluded.

Note:
A data file containing the information for each member was created and used to identify the services received.

Encounter Subsystem Requirements

Utilizing data from Recipient Subsystem:

- All encounters selected (Form 1500 and UB 82/92) for the selected members were based on the service selection criteria listed below.
- Encounters were included if the begin-date of service fell within the measurement period.

- Encounters from the Arizona Department of Health Services/Children's Rehabilitative Services (CRS) and ADHS/Behavioral Health Services (BHS) were excluded. Children receiving services through CRS or BHS who also were enrolled with another Contractor were included in the other Contractor's data.
- All services for the member were reported under the member's last county of residence in the measurement period.
- The selected encounters were sorted by member primary ID.
- All members from the denominator who did not meet the selection criteria and who had encounters matching the service exclusionary criteria listed below were excluded from the numerator.

Service Selection Criteria

CPT-4 codes (UB82/92 or HCFA 1500)

88141 Cytopathology, cervical or vaginal, requiring interpretation by physician
88142 Cytopathology, cervical or vaginal, collected in preservative fluid, manual screening
88143 Cytopathology, cervical or vaginal, collected in preservative fluid, manual screening and rescreening
88144 Cytopathology, cervical or vaginal, collected in preservative fluid, manual screening and computer-assisted rescreening
88145 Cytopathology, cervical or vaginal, collected in preservative fluid, manual screening and computer-assisted rescreening using cell selection
88147 Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148 Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision, with manual rescreening
88150 Cytopathology, slides, cervical or vaginal, manual screening
88151 Cytopathology, slides, cervical or vaginal
88152 Cytopathology, slides, cervical or vaginal, manual screening and computer-assisted rescreening
88153 Cytopathology, slides, cervical or vaginal, manual screening and rescreening
88154 Cytopathology, slides, cervical or vaginal, manual screening and computer-assisted rescreening using cell selection
88155 Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation
88156 Cytopathology, slides, cervical or vaginal
88157 Cytopathology, slides, cervical or vaginal
88158 Cytopathology, slides, cervical or vaginal, with manual screening
88164 Cytopathology, slides, cervical or vaginal (the Bethesda System), manual screening
88165 Cytopathology, slides, cervical or vaginal (the Bethesda System), manual screening and rescreening
88166 Cytopathology, slides, cervical or vaginal (the Bethesda System), manual screening and computer-assisted rescreening

88167 Cytopathology, slides, cervical or vaginal (the Bethesda System), manual screening and computer-assisted rescreening using cell selection

OR

HCPCS Codes (UB82/92 or HCFA 1500):

P3000 Screening Papanicolaou smear, cervical or vaginal
P3001 Screening Papanicolaou smear, cervical or vaginal
Q0091 Screening Papanicolaou smear; obtaining, preparing and conveyance
G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system, manual rescreening
G0143 Screening cytopathology smears, cervical or vaginal (any reporting system), collected in preservative fluid, manual screening and rescreening
G0144 Screening cytopathology smears, cervical or vaginal (any reporting system), collected in preservative fluid, manual screening and computer-assisted rescreening
G0145 Screening cytopathology smears, cervical or vaginal (any reporting system), collected in preservative fluid, manual screening and computer-assisted rescreening using cell selection
G0147 Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148 Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision, manual rescreening

OR

ICD-9 Procedure Code (UB 82/92):

91.46 Cell block and Papanicolaou smear

OR

ICD-9 Diagnostic Code (UB 82/92 or HCFA 1500):

V76.2 Screening for malignant neoplasms of cervix

NOT in conjunction with HCPCS codes:

AXXXX	Medical and surgical supplies
DXXXX	Dental procedures
G0001 to G0132	Procedures and professional services

AND

NOT in conjunction with CPT-4 codes:

80029 to 88140	Laboratory and pathology (not cytopathology, cervical or vaginal)
88230 to 89399	Laboratory and pathology (not cytopathology, cervical or vaginal)

OR

Revenue Codes (UB82/92):

923 Cervical cancer screening

OR

Revenue Codes (UB82/92):

300 Laboratory
310 Pathology Lab
311 Pathology /cytology

In conjunction with ICD-9 Diagnosis codes:

180.X Malignant neoplasm of cervix
233.1 Carcinoma in situ of cervix
236.0 Neoplasm of uncertain behavior, uterus
622.X Non-inflammatory disorders of cervix
795.0 Nonspecific abnormal Papanicolaou smear of cervix
795.1 Nonspecific abnormal Papanicolaou smear of other site

Service Exclusionary Criteria

ICD-9 Procedure Codes (UB 82/92):

68.4 Total abdominal hysterectomy
68.5 Vaginal hysterectomy
68.6 Radical abdominal hysterectomy
68.7 Radical vaginal hysterectomy
68.8 Pelvic evisceration

OR

CPT-4 Procedure Codes (HCFA 1500 or UB 82/92)

56308 Laparoscopy, surgical, with vaginal hysterectomy
58150 Total abdominal hysterectomy (corpus and cervix)
58152 Total abdominal hysterectomy (corpus and cervix), with colpo-urethrocystopexy
58200 Total abdominal hysterectomy, including partial vaginectomy
58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy
58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy
58260 Vaginal hysterectomy
58262 Vaginal hysterectomy, with removal of tube(s) and/or ovary(ies)
58263 Vaginal hysterectomy, with removal of tube(s) and/or ovary(ies), with repair of enterocele
58267 Vaginal hysterectomy, with colpo-urethrocystopexy
58270 Vaginal hysterectomy, with repair of enterocele
58275 Vaginal hysterectomy, with total or partial colpectomy

58280 Vaginal hysterectomy, with total or partial colpectomy, with repair of enterocele
58285 Vaginal hysterectomy, radical
59135 Surgical treatment of interstitial, uterine pregnancy requiring total hysterectomy

V. TIMELINESS OF PRENATAL CARE

Population
Members were selected from the acute-care population only.

Sample Frame
AHCCCS used the Health Plan Employer Data and Information Set (HEDIS®), 2003 version, as a guide in developing the methodology for this measure.

Enrollment criteria
Members who:
- had a live birth during the measurement period
- were continuously enrolled with the same acute-care Contractor for 43 days or more prior to delivery

For this measure, Prior Period Coverage (PPC) was excluded when determining the start of enrollment or was considered a break in enrollment.

Service selection criteria
Members who:
- met the enrollment criteria and
- had a prenatal care visit in the first trimester (176 to 280 days prior to delivery) if enrolled 280 or more days prior to enrollment.
- had a prenatal care visit in the first trimester if continuously enrolled 176 or more days but less than 280 prior to enrollment.
- did not have a prenatal care visit during the first trimester but, had a prenatal care visit within 42 days of being enrolled in a health plan and were continuously enrolled for 43 or more prior to delivery.

Sample Selection
All members who met the sample frame criteria were included in this measure.

Population Stratification
The sample frame was stratified by:
- Maricopa, Pima and the combined rural counties, and
- acute-care Contractor.

Population Exclusions
This measure did not include:
- Members who were enrolled in the Arizona Long Term Care System (ALTCS), the Department of Economic Security (DES) Division of Developmental Disabilities (DDD), Indian Health Services (IHS), Emergency Services Program (ESP) and Fee For Service (FFS) program. Any members who also were Medicare recipients were excluded.
- Women who had live births but were not continuously enrolled for at least 43 days prior to delivery.

- Women whose pregnancies did not result in a live birth (i.e., miscarriage or stillbirth) were excluded.
- Women whose single pregnancy resulted in multiple live births wree counted only once for this measure. Women who had two separate deliveries (different dates of service) within the measurement period were counted twice.

Data Sources
- Recipient data were used to identify members who meet the enrollment selection criteria.
- Encounter data were used to identify enrolled women who had live births during the measurement period and dates of prenatal visits.

Data Collection
The Information Service Division (ISD) of AHCCCS collected administrative data from the Prepaid Medical Management Information System (PMMIS). No outside data were collected.

Data Validation
Data Validation was performed to ensure that all data received from the Information Services Division (ISD) were from the appropriate service records and met this measure's service selection criteria, and that all recipients selected met the proper enrollment criteria.

The Data Analysis and Research Unit (DAR) in the Division of Health Care Management (DHCM) has developed a Quality Control (QC) process based on the measure methodology. DAR verified that members selected met the sample frame criteria. A QC report provided by ISD was used to complete data validation.

Denominator
The number of members who met the sample frame criteria for enrollment

Numerator
The number of members who met the sample frame criteria for service selection

Comparative Analysis
- The total for all Contractors was compared to results for the previous measurement period.
- Results for Maricopa, Pima and the combined rural counties were compared to each other and to results for the previous measurement period.
- Individual Contractor rates were compared to their rates for the previous year.
- Individual Contractor rates were compared to the AHCCCS Minimum Performance Standard and Goal.
- If available, the total rate for all Contractors was compared to the national average for this measure as reported by the National Committee for Quality Assurance (NCQA).

Deviations from HEDIS

This measure differed from HEDIS 2003 in the following area:

- AHCCCS does not measure the number or percentage of women who had a postpartum visit, as HEDIS does. Because postpartum visits are not measured, AHCCCS requires only a minimum of 43 days of continuous enrollment prior to delivery. The HEDIS measure requires that women included in the denominator be enrolled continuously from 43 days prior to delivery to 56 days after delivery.

Recipient Subsystem Requirements

- Only female members were selected.
- Members must have been continuously enrolled for more than 43 days prior to the delivery date.
- Member must have been enrolled with one acute capitated Contractor for the entire enrollment period through the delivery date.
- Members must have delivered during the measurement period.
- The PPC period was considered a break in determining start of enrollment.
- A member with one single enrollment gap, not exceeding 31 days, was considered to have continuous enrollment.
- A change of county-service-area with the same Contractor without any gap of enrollment is not considered a break in enrollment.
- For those members who stayed with the same Contractor but moved to a different county during the measurement period, the member was assigned to the last county of residence.
- The enrollment begin-date for the member was the first date of enrollment prior to the start of the prenatal period (280 days prior to delivery), and the enrollment end-date was the delivery date.
- Any member enrolled with the following acute-care Contractors was <u>included:</u>

  010083 Maricopa Health Plan
  010124 Pima Health System
  010158 Arizona Physicians IPA
  010166 DES CMDP
  010306 Mercy Care Plan
  010299 Phoenix Health Plan
  010497 Health Choice Arizona
  010314 University Health Plan
  010545 Community Connection

- Any member with Medicare Part A and/or Part B during the measurement period is to be excluded.

<u>Note:</u>

A data file containing the information for each member was created and used to identify the services received.

Encounter Subsystem Requirements

Utilizing data from Recipient Subsystem:

- All encounters (Form 1500 and UB 82/92) were selected for members in the denominator based on the service selection criteria listed below.

- Encounters from the Arizona Department of Health Services/Children's Rehabilitative Services (CRS) and ADHS/Behavioral Health Services (BHS) were excluded. Children receiving services through CRS or BHS who also were enrolled with another Contractor were included in the other Contractor's data.The selected encounters are sorted by member primary ID.
- All services for the member were reported under the member's last county of residence in the measurement period.

Identifying live births

The following codes were used to identify deliveries and verify live births:

ICD-9 Codes: 74.0-74.2*, 74.4*, 74.99*, 640.x1, 641.x1, 642.x2, 643.x1, 644.21, 645.11, 645.21, 646.x1, 646.12, 646.22, 646.42, 646.52, 646.62, 646.82, 647.x1, 647.x2, 648.x1, 648.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.02, 654.12, 654.32, 654.42, 654.52, 654.62, 654.72, 654.82, 654.92, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.01, 665.11, 665.22, 665.31, 665.41, 665.51, 665.61, 665.71, 665.72, 665.81, 665.82, 665.91, 665.92, 666.x2, 667.x2, 668.x1, 668.x2, 669.01, 669.02, 669.11, 669.12, 669.21, 669.22, 669.32, 669.41, 669.42, 669.51, 669.61, 669.71, 669.81, 669.82, 669.91, 669.92, 670.02, 671.01, 671.02, 671.11, 671.12, 671.21, 671.22, 671.31, 671.42, 671.51, 671.52, 671.81, 671.82, 671.91, 671.92, 672.02, 673.x1, 673.x2, 674.01, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2

CPT codes: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 and 59622.

Codes used to identify deliveries not resulting in a live birth: 656.4**, v27.1**, v27.4**, v27.7**

Service Selection Criteria to Identify Prenatal Visits

Decision Rule 1: Prenatal care visit to an OB practitioner, midwife or family practitioner with documentation of when prenatal care was initiated

Service provider		HCFA1500
Provider –type: 09 – Certified Nurse-midwife 05 – Clinic **Or** **Provider type 08 (Physician) w/ following specialty** 089 – OB/GYN 091 – OB 092 – Maternal & Fetal Medicine 095– Women's HC OB/GYN NP	**AND**	**59400 Routine obstetric care including antepartum care and postpartum care** 59510 Routine obstetric care including antepartum care, cesarean delivery and postpartum care 59610 Routine obstetric care including antepartum care, vaginal delivery and postpartum care, after previous cesarean delivery 59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care following attempted vaginal delivery after previous cesarean delivery 59425 Antepartum care only; 4-6 visits 59426 Antepartum care only; 7 or more visits

Decision Rule 2: Any visit to an OB practitioner or midwife

Service provider		HCFA1500/UB 92
Provider type: 09 – Certified Nurse-midwife 05 – Clinic **OR** **Provider type 08 (Physician) with the following specialty**: 089 – OB/GYN 091 – OB 092 – Maternal & Fetal Medicine 095 – Women's HC OB/GYN NP	**AND**	**Administrative Codes:** 99201 – 99205 New Patient 99211 – 99215 Established Patient or Revenue code 514 **WITH EITHER** **One of the following laboratory or radiology services:** CPT Codes – Procedure based: 76805 Echography, pregnant uterus complete 76810 Echography, pregnant uterus complete, first trimester 76815 Echography, pregnant uterus limited 76816 Echography, pregnant uterus follow-up or repeat 76818 Fetal Biophysical profile with non-stress test 80055 Obstetric panel 80090 TORCH antibody panel 86762 Antibody; rubella with 86900 Blood typing; ABO or 86901 Blood typing; Rh (D) **OR** **One of the following ICD-9 diagnosis codes:** 640.0X – 648.9X, 651.0X – 659.9X, where fifth digit is 3 V22.X Normal pregnancy V23.X Supervision of high-risk pregnancy V28.X Antenatal screening

Decision Rule 3: Any visit to family practitioner or other primary care practitioner

		HCFA1500/UB 92
Provider type: 08 – Physician 05 – Clinic	**AND**	**Administrative Codes:** 99201 – 99205 New Patient 99211 – 99215 Established Patient or Revenue code 514 **WITH BOTH** **One of the following laboratory or radiology services:** CPT Codes – Procedure based: 76805 Echography, pregnant uterus complete 76810 Echography, pregnant uterus complete, first trimester 76815 Echography, pregnant uterus limited 76816 Echography, pregnant uterus follow-up or repeat 76818 Fetal Biophysical profile with non-stress test 80055 Obstetric panel 80090 TORCH antibody panel 86762 Antibody; rubella with 86900 Blood typing; ABO or 86901 Blood typing; Rh (D) **AND** **One of the following ICD-9 diagnosis codes:** 640.0X – 648.9X, 651.0X – 659.9X, where fifth digit is 3 V22.X Normal pregnancy V23.X Supervision of high-risk pregnancy V28.X Antenatal screening

Decision Rule 4: Any visit to an OB/GYN, family practitioner or other primary care practitioner with either an ultrasound or principal diagnosis of pregnancy

Service provider		HCFA1500/UB 92
Provider type: 09 – Certified Nurse-midwife 05 – Clinic **OR** **Provider type 08 (Physician) with the following specialty**: 089 – OB/GYN 091 – OB 092 – Maternal & Fetal Medicine 095 – Women's HC OB/GYN NP	**AND**	**59400 Routine obstetric care including antepartum care and postpartum care** 59510 Routine obstetric care including antepartum care, cesarean delivery and postpartum care 59610 Routine obstetric care including antepartum care, vaginal delivery and postpartum care, after previous cesarean delivery 59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care following attempted vaginal delivery after previous cesarean delivery 59425 Antepartum care only; 4-6 visits 59426 Antepartum care only; 7 or more visits or Revenue code 514 **WITH EITHER** **One of the following laboratory or radiology services:** CPT Codes – Procedure based: 76805 Echography, pregnant uterus complete 76810 Echography, pregnant uterus complete, first trimester 76815 Echography, pregnant uterus limited 76816 Echography, pregnant uterus follow-up or repeat 76818 Fetal Biophysical profile with non-stress test **OR** **One of the following ICD-9 diagnosis codes:** 640.0X – 648.9X, 651.0X – 659.9X, where fifth digit is 3 V22.X Normal pregnancy V23.X Supervision of high-risk pregnancy V28.X Antenatal screening