

Quality Management Performance Measures

For Acute-care Contractors and

The Division of Developmental Disabilities

Measurement Period Ending September 30, 2007

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Arizona Health Care Cost Containment System

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INTRODUCTION

Overview

This is the annual report on quality management performance measures by the Arizona Health Care Cost Containment System (AHCCCS). The report includes data on preventive health services provided to members enrolled with nine publicly and privately operated managed care organizations (MCOs) that contract with AHCCCS (referred to as Contractors). These MCOs provide services under the AHCCCS Acute-care program. Data for services provided through the Department of Economic Security's Division of Developmental Disabilities (DES/DDD) is included in an appendix.

These results should be viewed as *indicators* of utilization of services, rather than absolute rates. These data allow AHCCCS and its Contractors to identify areas for improvement and implement interventions to increase the use of preventive services.

This report includes performance measurement data from nine publicly and privately operated managed care organizations (MCOs)

Methodology

AHCCCS used Healthcare Effectiveness Data and Information Set (HEDIS®) 2007 specifications to collect and report results of 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 HEDIS requirements for selecting members to be included in the measures is that they are continuously enrolled for a minimum period of time with one Contractor. Thus, members included in the measures represent only a portion of the AHCCCS acute-care population.

This report includes results for the contract year ending September 30, 2007. Results are reported for Contractors overall and by individual health plan. Data also are analyzed by race or ethnicity and county. The report indicates whether changes in rates overall or by Contractor are statistically significant, when compared with rates in the previous measurement. Changes from the previous measurement are described as increases or decreases only when analysis using the Pearson chi-square test yields a statistically significant value ($p \leq .05$); that is, the probability of obtaining a difference by chance is relatively low.

National HEDIS averages for managed care health plans also are included in this report. However, it should be noted that some HEDIS measures may be calculated using data extracted from medical records, as well as claims for services (this is known as a hybrid data collection methodology). The use of medical records may reflect more complete data (and thus higher rates) than claims alone. Because national averages include data reported by health plans using the hybrid data collection methodology, they may not be directly comparable to rates reported by AHCCCS, which does not currently use a hybrid methodology to collect data for these measures.

In addition, some health plans in other states report HEDIS rates based on combined data for Medicaid members and those eligible under the State Children's Health Insurance Program (SCHIP), known in Arizona as KidsCare. In Arizona, rates for these measures are typically higher among members covered under KidsCare. However, because the populations differ in terms of socioeconomic status, Arizona reports rates for these eligibility groups separately. The difference in reporting Medicaid rates separately from KidsCare rates may also limit comparisons between Arizona and national HEDIS rates.

Data Sources

AHCCCS uses an 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 encounter data (records of services provided and related claims paid by Contractors) in PMMIS. The numerator data reported here are based on encounters for professional services, primarily physician office and clinic visits.

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Data Validation

AHCCCS conducts annual data validation studies of encounters. Based on the most recent data validation study by AHCCCS, approximately 90 percent of all encounters for acute-care professional services are complete when compared with corresponding medical records. Approximately 85 percent are fully accurate, compared with services documented in members' medical records.

Data Limitations

The data reported here are subject to at least three limitations. First, because rates are based on encounter data, they may be negatively affected if Contractors have not submitted complete and accurate encounters to AHCCCS.

Second, data for both race and ethnicity (i.e., whether or not a person is of Hispanic or Latino origin) is limited by the way these data are stored by AHCCCS. Race and ethnicity data are collected according to current U.S. Census Bureau classifications when members apply for AHCCCS. However, the PMMIS system was designed long before the current federal standards for collecting race and ethnicity were issued in 1997, and does not accommodate both data fields at this time. After applicants become eligible, data for race and ethnicity are merged into one field and loaded into PMMIS. AHCCCS has developed a hierarchy for merging race and ethnicity data (Appendix A), so they are still useful in evaluating member demographics and possible trends. But, while people of Hispanic origin may be of any race, the hierarchy does not allow AHCCCS to identify the race of members who are classified as Hispanic. Thus, people of Hispanic origin are reported separately, and are not included in any race category.

Third, despite the limitations of storing race and ethnicity data, people whose racial makeup includes more than one race may identify themselves as "other". In addition, members who do not identify their race and/or ethnicity on the AHCCCS application are placed in the "unknown/unspecified category." Thus, race or ethnicity of some members included in this measurement can only be described as unknown, unspecified or other.

Deviations from Previous Methodology

The HEDIS methodology used for data collection in the current measurement differs from the methodology used for the previous measurement as follows:

- ***Adults' Access to Preventive/Ambulatory Health Services*** – NCQA deleted the exclusion of mental health and chemical dependency services; however, this may not have had a significant effect on the AHCCCS results, since most behavioral health services for children and adults in the acute-care program are provided through a "carve-out" arrangement with the Arizona Department of Health Services/Division of Behavioral Health Services, rather than through the Acute-care health plans.
- ***Annual Dental Visits –*** In 2006, NCQA lowered the age limit for children included in the measure from 4 years old to 2 years old at the end of the measurement period. This is the first year that AHCCCS has reported a rate of annual dental visits for members 2 to 21 years. Because annual dental visits for children were previously recommended beginning at 3 years of age, the inclusion of younger children in this measure may have affected the overall rate.
- ***Cervical Cancer Screening*** – NCQA raised the lower age limit to 21 years (24 years at the end of the measurement period) from 18 years (21 years at the end of the measurement period).
- ***Children's and Adolescents' Access to Primary Care Practitioners (PCPs)*** – NCQA deleted the exclusion of mental health and chemical dependency services; however, this may not have had a significant effect on the AHCCCS results, since most behavioral health services for children and adults in the acute-care program are provided through a "carve-out" arrangement with the Arizona Department of Health Services/Division of Behavioral Health Services, rather than through the Acute-care health plans.
- ***All measures*** – NCQA allows dual-eligible members who have Medicare Fee-For-Service or unknown Medicare coverage, in addition to their Medicaid coverage, to be excluded from the HEDIS measures. For this measurement, AHCCCS excluded some dual-eligible members who were enrolled in Medicare MCOs or who had fee-for-service Medicare coverage. AHCCCS members who were enrolled in a Medicare plan that is aligned with their Medicaid plan (i.e., operated by or contracted with the same organization). In the previous AHCCCS measurement, all dual-eligible members were included as long as they met the eligible population criteria.

Because complete data on services provided to dual-eligible members may not be available; particularly those services that are paid for by Medicare, the exclusion of some of these members may have positively affected rates for some measures.

Also for this measurement, AHCCCS included denied encounters, which are claims that health plans receive but have denied payment for such reasons as the claim was not submitted in a timely manner or the service was not rendered by a contracted provider. However, since services were provided, HEDIS allows these encounters to be counted toward the measures.

Highlights of the Data

Measures in 10 areas of access to care and use of preventive services are reported. Age groups for Children's and Adolescents' Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services are reported separately. In addition, Medicaid and KidsCare rates for each of the child and adolescent measures are reported as separate measures. Results include the following:

- ***Children's Access to PCPs*** – The overall rate for Medicaid-eligible members, as well as rates in all four age groups, improved over the previous measurement. For KidsCare members, the overall rate and rates for two age groups also improved, while two other age groups did not show statistically significant changes.
- ***Well-Child Visits in the First 15 Months of Life*** – While the rate for Medicaid-eligible children did not show a statistically significant change, it remains above the national HEDIS Medicaid mean. The rate for KidsCare members also did not change significantly from the previous year, and continues to exceed the national Medicaid mean.
- ***Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life –*** Overall rates for both Medicaid and KidsCare members increased, and the rate for KidsCare members exceeds the national Medicaid mean.
- ***Adolescent Well-Care Visits*** – Overall rates for both Medicaid and KidsCare members increased, and the rate for KidsCare members remains slightly above the national Medicaid mean.
- ***Annual Dental Visits*** – Overall rates for both Medicaid and KidsCare populations decreased from the previous year, likely due to lowering of the age range from 4 to 2 years old. However, rates for both populations remain well above the national Medicaid mean.
- ***Adults' Access to Preventive/Ambulatory Health Services*** – The overall rate, as well as rates for both age groups, increased from the previous measurement, and continue to exceed national Medicaid means. The current rate includes fewer members, with the removal of some dual-eligible members.

- ***Breast Cancer Screening*** – The rate for this measure increased from the previous year. The current rate includes fewer members, with the removal of some dual-eligible members.
- ***Cervical Cancer Screening*** – This rate also increased from the previous measurement. The current rate includes fewer members, with the removal of some dual-eligible members.
- ***Chlamydia Screening*** – The overall rate for this measurement showed a statistically significant decrease. The current rate includes slightly fewer members, with the removal of some dual-eligible members.
- ***Timeliness of Prenatal Care*** – The rate for this measure was statistically unchanged from the previous measurement.

AHCCCS rates for several measures exceeded HEDIS national Medicaid means

Using multivariate analysis, data for each measure were analyzed for members identified as Hispanic, Native American, and non-Hispanic Black, compared with non-Hispanic White members. Data also are collected for members identified as Asian/Pacific Islander or Cuban/Haitian; however, these groups generally were not large enough to be analyzed separately. In addition, a significant portion of members do not specify their race or ethnicity.

For the current measurement, there were disparities in the Medicaid population by race/ethnicity in nearly all measures. In many of the measures, members of Hispanic ethnicity were more likely than non-Hispanic Whites, Blacks, and Native Americans to have a service. Native American members often appeared to be less likely than non-Hispanic whites to have a service; however, this may be due in part to incomplete data for those members, as they may obtain care outside the AHCCCS program. There were fewer disparities by race/ethnicity among KidsCare members. These disparities are discussed in the sections on the specific measures.

Rates for Medicaid-eligible members by county and rural vs. urban areas also are compared for each measure (KidsCare rates are not analyzed by county because some counties do not have enough members in this eligibility group to yield valid results). In general, there were significant differences in utilization of services between members in urban counties and those in rural counties. These findings also are described in the measure-specific sections.

Contractor Performance Standards and Improvement

Contractor rates are compared to Minimum Performance Standards, as specified in the AHCCCS CYE 2008 contracts with health plans. The following table shows the AHCCCS Minimum Performance Standard (MPS) for each measure included in this report, as well as the AHCCCS benchmark, or long-range goal for the measure. Interim goals also are specified for each measure, which Contractors should strive to meet if they already are meeting the MPS for any measure.

Acute-care Performance Standards

Performance Measure	Minimum Performance Standard	Goal	Benchmark (Healthy People Goals)
Children's Dental Visits 2 to 21*	51%	57%	57%
Well-child Visits 15 Months	70%	72%	90%
Well-child Visits 3 - 6 Years*	56%	58%	80%
Adolescent Well-care Visit*	37%	38%	50%
Children's Access to PCPs 12-24 Months*	85%	86%	97%
Children's Access to PCPs 25 months-6 Years*	78%	80%	97%
Children's Access to PCPs 7-11 Years*	77%	79%	97%
Children's Access to PCPs 12-19 Years*	79%	81%	97%
Cervical Cancer Screening	57%	60%	90%
Breast Cancer Screening	50%	52%	70%
Adult Preventive/Ambulatory Care 20-44 Years	78%	80%	96%
Adult Preventive/Ambulatory Care 45-64 Years	83%	84%	96%
Timeliness of Prenatal Care	70%	72%	90%
Chlamydia Screening	43%	45	62%

* Medicaid and KidsCare populations for these measures are evaluated separately against the AHCCCS contractual standards, and are thus counted as two separate measures.

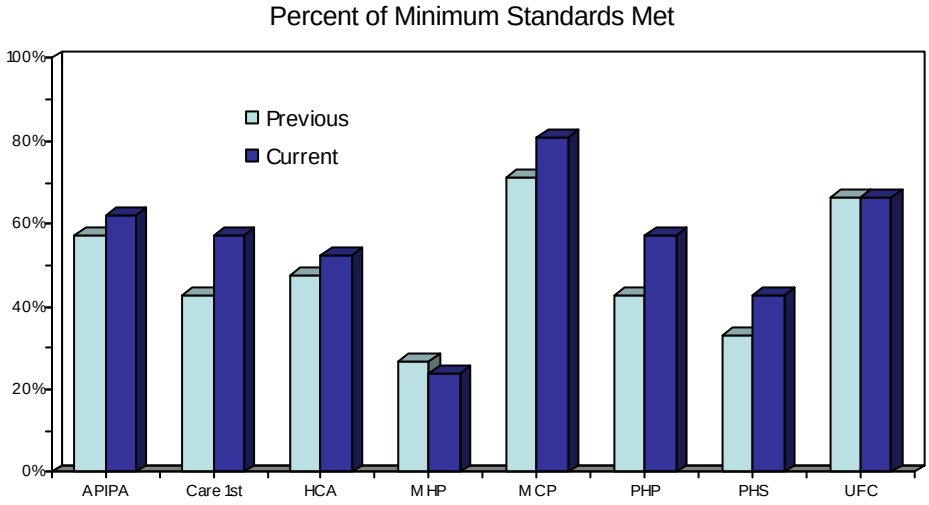
The following table shows the number of measures reported for each Contractor and the number for which the Contractor met the AHCCCS MPS in the current measurement. Because of the unique population it serves, the Department of Economic Security's Comprehensive Medical and Dental Program (CMDP), a health plan for children and adolescents in foster care, this Contractor has fewer performance standards than other Acute-care Contractors. In addition, CMDP has too few KidsCare members to measure this population separately.

Contractor Performance

Contractor	Number of Measures in Which Contractor was Included	Number of Measures for Which MPS was Met
Mercy Care Plan	21	17
University Family Care	21	14
Arizona Physicians IPA	21	13
Care 1st Healthplan of Arizona	21	12
Phoenix Health Plan	21	12
Health Choice Arizona	21	11
Pima Health System	21	10
Maricopa Health Plan	21	5
DES/CMDP	7	7

Figure 1 shows the percentage of these measures for which each Contractor met the AHCCCS MPS for the current measurement and the previous measurement.

Figure 1. Contractor Performance, Current and Previous Measurements



Note: CMDP is not included in this figure because it has fewer acute-care performance measures; however, it met the MPS for all seven measures in both the current and previous measurements.

Contractors that did not meet the MPS for any measure will be required to implement corrective action plans (CAPs) or revise existing CAPs to bring their rates up to compliance with AHCCCS contractual standards. If Contractors already have CAPs in place as a result of the previous measurement, they will have to demonstrate that they have evaluated the effectiveness of interventions to improve rates and are implementing new or revised actions for improvement. Based on the current measurement, financial sanctions will be assessed against Contractors.

Finally, the data reported here indicate disparities in rates of service between racial and ethnic groups. For several measures, Blacks and Native Americans are less likely to receive services. It should be noted, however, that data for Native American members may be incomplete because these members may receive services through either Indian Health Service (IHS) or AHCCCS-contracted health plans. Claims for services provided by IHS may not be included in AHCCCS encounter data.

Any disparities must be reduced in order to improve rates overall. AHCCCS has implemented a Performance Improvement Project (PIP) for all Acute-care Contractors to address racial/ethnic disparities in one of the measures, Adolescent Well Care Visits, and may consider other PIPs for specific measures in the future.

Children's and Adolescent's Access to Primary Care Practitioners

Access to primary care services by children and adolescents is critical to preventing the premature onset of disease and disability. Research suggests that lack of access to primary care practitioners (PCPs) may result in unnecessary hospitalizations.[1,2] In addition, routine primary and preventive care helps support healthy development and the ability to learn.[3-5]

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

Description

AHCCCS measured the percentage of children and adolescents who:

- were at least 12 months but not older than 19 years during the measurement period (October 1, 2006, through September 30, 2007), and
- had one or more visits with PCPs (pediatricians, general or family practitioners, internists, physician's assistants, nurse practitioners or obstetrician/gynecologists) during the measurement period.

To be included in the denominator, members in the age groups of 12 to 24 months and 25 months to 6 years had to be continuously enrolled with the same Contractor during the measurement year (one break in enrollment was allowed if the gap did not exceed one member-month). To be counted in the numerator, these members would have had one or more PCP visits during the measurement year. Members 7 to 11 years and 12 to 19 years were included in the denominator if they were continuously enrolled with the same Contractor during the measurement year and the previous year (one break in enrollment was allowed per year if the gap did not exceed one member-month). These members were counted in the numerator if they had at least one PCP visit during the two-year period.

Results for members who were eligible under Medicaid and the State Children's Health Insurance Program (SCHIP), known as KidsCare, were calculated separately, by age group.

Performance Goals

AHCCCS has adopted Minimum Performance Standards and Goals for both Medicaid and KidsCare members for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives. These are shown in the following table:

AHCCCS Performance Standards for Children's and Adolescents' Access to PCPs

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
12 – 24 Months	85%	86%	97%
25 Mos – 6 Years	78%	80%	97%
7 – 11 Years	77%	79%	97%
12 – 19 Years	79%	81%	97%

Results Overall and by Age Group

In the current period, the total rate (all age groups combined) for Medicaid members was 76.7 percent, an increase from the previous rate of 75.8 percent in the previous year ($p<.001$). The total rate for KidsCare members was 83.2 percent, an increase from 82.2 percent in the previous year ($p<.004$).

Rates for all age groups in the Medicaid population increased from the previous measurement. KidsCare rates for two age groups increased, while rates for two other age groups remained at the same level.

Rates for all age groups in the Medicaid population increased

Children 12 to 24 Months: The overall rate for Medicaid-eligible children in this age group (Table 1) increased to 82.6 percent from 81.0 percent in the previous year ($p<.001$). The rate for children eligible under KidsCare (Table 2) increased to 92.7 percent from 90.8 percent in the previous year ($p<.048$).

Children 25 months to 6 Years: The overall rate for Medicaid-eligible children in this age group was 76.1 percent, an increase from the previous rate of 75.4 percent ($p<.001$). The rate for children eligible under KidsCare increased to 80.7 percent from 79.0 percent in the previous year ($p<.005$).

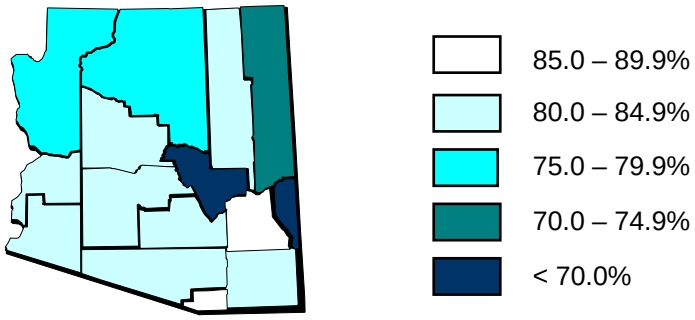
Children 7 to 11 Years: The overall rate for Medicaid-eligible children in this age group increased to 75.2 percent from 74.1 percent in the previous year ($p<.001$). The overall rate for children eligible under KidsCare remained stable at 83.5 percent, compared with 83.0 percent in the previous year ($p=.465$).

Children 12 to 19 Years: The overall rate for Medicaid-eligible members increased to 76.7 percent from 75.9 percent in the previous year ($p<.007$). The rate for children eligible under KidsCare remained stable at 84.2 percent, compared with 83.7 percent in the previous year ($p=.406$).

Results by County

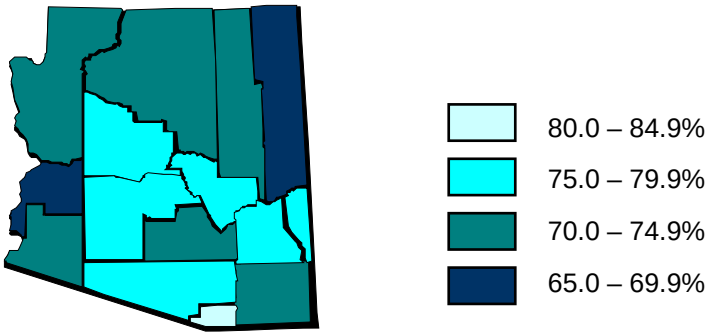
12 to 24 Months: Current rates by county for Medicaid-eligible members ranged from 56.6 percent in Greenlee County to 89.9 percent in Santa Cruz County (it should be noted that there were only 18 members in Greenlee County in this age group who met the continuous enrollment criteria for this measure, so those results should be interpreted with caution). Figure 2 shows relative rates by county for Medicaid members.

Figure 2. Children's and dolescents' Access to PCPs by County, 12 – 24 Months, Medicaid Members



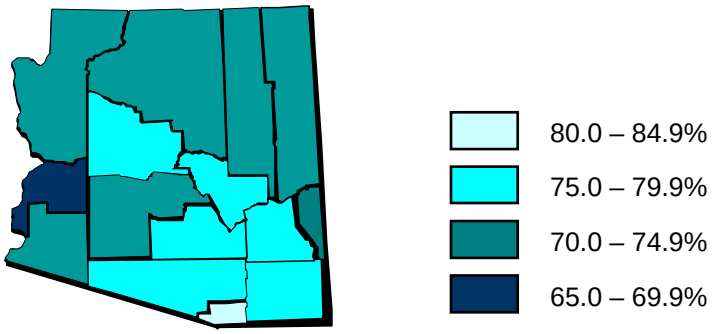
25 Months to 6 Years: Current rates by county for Medicaid-eligible members ranged from 69.5 percent in both Apache and La Paz counties to 81.9 percent in Santa Cruz County. Figure 3 shows relative rates by county for Medicaid members.

Figure 3. Children's and Adolescents' Access to PCPs by County, 25 Months – 6 Years, Medicaid Members



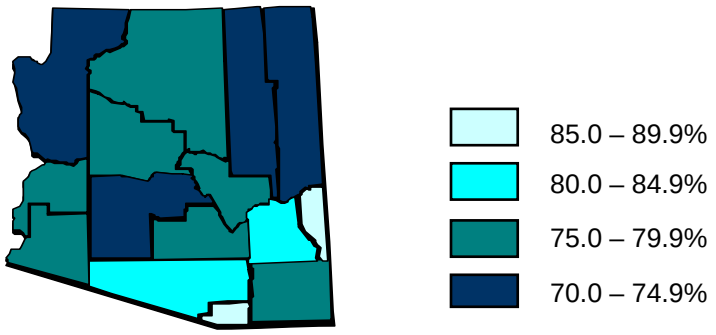
7 to 11 Years: Current rates by county for Medicaid-eligible members ranged from 66.9 percent in La Paz County to 83.5 percent in Santa Cruz County. Figure 4 shows relative rates by county for Medicaid members.

Figure 4. Children's and Adolescents' Access to PCPs by County, 7– 11 Years, Medicaid Members



12 to 19 Years: Current rates for individual counties for Medicaid-eligible members ranged from 72.0 percent in Apache County to 85.9 percent in Greenlee County. Figure 5 shows relative rates by county for Medicaid members.

Figure 5. Children's and Adolescents' Access to PCPs by County, 12 – 19 Years, Medicaid Members



When rates were analyzed by rural and urban counties, Medicaid-eligible members 12 to 24 months and 25 months to 6 years in urban counties (i.e., Maricopa and Pima counties) were more likely to have PCP visits than those in rural counties ($p<.001$ for both groups). Medicaid-eligible rural members 12 to 19 years were more likely to have PCP visits than urban members ($p=.001$), and there was no significant difference among members 7 to 11 years old ($p=.611$).

Among KidsCare members, the only significant difference was in the age group of 25 months to 6 years, with urban members more likely to have PCP visits than members in rural areas ($p<.001$).

Results by Race or Ethnicity

Overall, Native American Medicaid-eligible members were less likely than non-Hispanic Whites to have PCP visits, with a relative risk (RR) of 0.90 (95% CI 0.88, 0.91). Black members overall also were less likely to have visits, with RR of 0.96 (95% CI 0.95, 0.97) overall; which is attributable to disparities in all age groups except 12 to 24 months.

Among children and adolescents covered under KidsCare, only Native American members 12 to 19 years old were less likely than non-Hispanic white members to have PCP visits, with RR of 0.89 (95% CI 0.81, 0.99).

Comparison with National Benchmarks

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, as follows:

AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
12 – 24 Months	82.6%	92.7%	94.1%	97.0%
25 Mos – 6 Years	76.1%	80.7%	84.9%	89.3%
7 – 11 Years	75.2%	83.5%	85.9%	89.2%
12 – 19 Years	76.7%	84.2%	83.2%	86.6%

AHCCCS Medicaid rates for all age groups were lower than the most recent national HEDIS means for Medicaid health plans. Rates for KidsCare members also were lower than the national Medicaid means, except for members 12 to 19 years old. It should be noted that, for the next measurement period, AHCCCS has raised its Minimum Performance Standards to reflect the most current HEDIS Medicaid means available when contracts were developed. The higher standards, coupled with potential financial sanctions, should drive Contractor and overall improvement.

Discussion

Children 24 months and younger typically have a higher rate of primary care visits because they are receiving immunizations that must be given at specific intervals, and are screened for developmental milestones during this period of rapid growth. After these “baby shots” are completed and children’s growth and development begins to slow, they are less likely to have PCP visits, unless they are ill or have other specific needs. Thus, rates for this measure are highest for children 12 to 24 months.

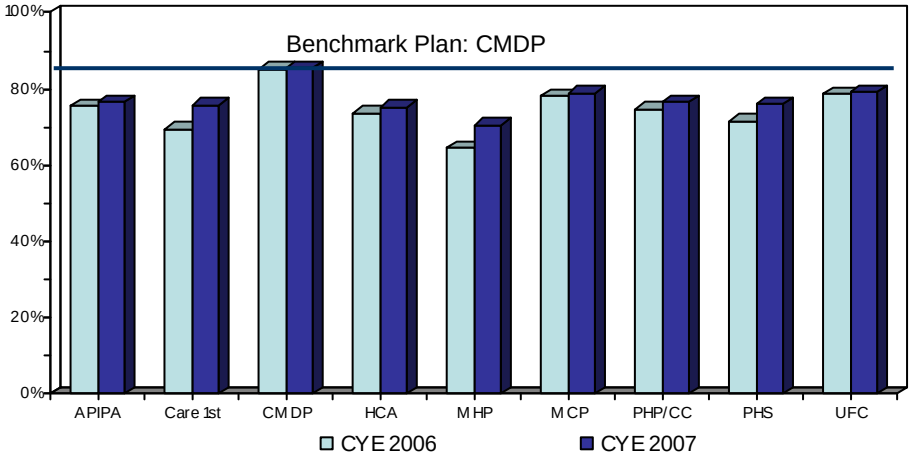
Consistent with previous measurements, children enrolled with AHCCCS Contractors through KidsCare have higher overall rates of preventive services than those enrolled under Medicaid. Parents of KidsCare members pay premiums for coverage and thus may be more likely to ensure that their children receive services such as well-care visits. These parents also may have a higher level of education and a better understanding of the value of preventive health care services.

Data obtained through this measurement indicate that Native American children and adolescents enrolled with AHCCCS health plans may have the lowest rate of access to PCPs relative to members identified as White. However, Native American members also may receive primary care through Indian Health Service (IHS) facilities. Data for services provided by IHS facilities is not included in these data, unless a health plan paid for the service.

In the current measurement, only DES/CMDP met the Minimum Performance Standard for all age groups for Medicaid-eligible members. Mercy Care Plan and University Family Care each met the MPS for two age groups. While Contractors are evaluated on their rates by age group, Figure 6 shows Contractor performance when all age groups are combined.

Figure 6. Rates by Contractor, Children's Access to PCPs among Medicaid Members, All Age Groups Combined

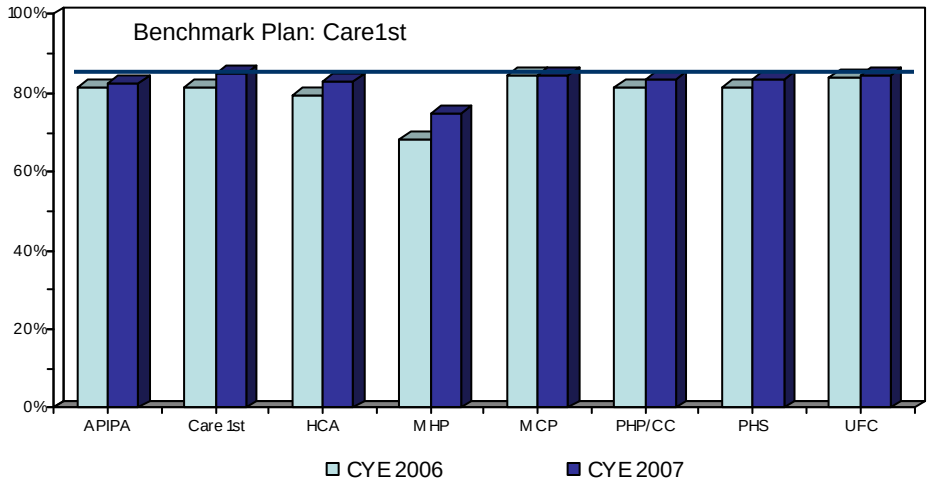
CYE 2006 and CYE 2007



As shown above, the Comprehensive Medical and Dental Program (CMDP) had the highest rate of access to PCPs among Medicaid-eligible members for all age groups combined (85.5 percent). CMDP is a special needs health plan operated by the state Department of Economic Security (DES) for children and adolescents in foster care. when these children and adolescents are taken into custody by the state, case managers work to ensure that they have a medical visit as soon as possible.

Figure 7. Rates by Contractor, Children's Access to PCPs among KidsCare Members, All Age Groups Combined

CYE 2006 and CYE 2007



For KidsCare members, most Contractors met the AHCCCS MPS for all age groups. Care1st Healthplan recorded the highest overall rate for KidsCare members (85.0 percent), while Mercy Care Plan and University Family Care were only slightly lower (84.7 percent and 84.4 percent, respectively).

Adults' Access to Preventive and Ambulatory Health Services

Behavioral risk factors such as smoking, poor diet, physical inactivity, and excessive drinking are linked to the leading causes of death in the United States. Controlling these behavioral risk factors and using preventive health services (e.g., influenza vaccinations and cholesterol screenings) can substantially reduce disease and premature death among U.S. adults.[6]

Smoking and other unhealthy behaviors often worsen the complications of chronic diseases, and increase the risk of developing other serious illnesses. A recent survey of AHCCCS acute-care health plan members found that 44 percent of adults have smoked 100 or more cigarettes in their lifetimes and, of those, 62 percent still smoke either sometimes or every day (current smokers). [7] National data for 2006 show an estimated 20.8 percent of U.S. adults are current cigarette smokers, and the rate increases to 30.6 percent among adults living below the federal poverty level. [8]

Access to routine ambulatory medical services for adults is essential to the early diagnosis and treatment of disease. Regular health care visits also provide opportunities for clinicians to educate and counsel patients on smoking cessation, diet, exercise and other healthy behaviors. Yet, the estimated rate of adults who had a recent routine checkup ranges from 45 to 81 percent depending on the state or area. A survey by the Centers for Disease Control and Prevention in 2006 found that 65.5 percent of Arizona adults had visited a doctor for a routine checkup in the preceding 12 months. [6]

Description

AHCCCS measured the percentage of Medicaid members who:

- were ages 20 through 44 and 45 through 64 years at the end of the measurement period (October 1, 2006, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment was allowed if the gap did not exceed one member-month), and
- had one or more preventive/ambulatory visits, including encounters with primary care physicians, specialists, physician's assistants, nurse practitioners, ophthalmologists and optometrists.

Performance Goals

AHCCCS has adopted Minimum Performance Standards and Goals for Adults' Access to Preventive/Ambulatory Health Services for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives. These are shown in the following table:

AHCCCS Performance Standards for Adults' Access to Preventive/Ambulatory Health Services

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
20 – 44 Years	78%	84%	96%
45 – 64 Years	83%	72%	90%

Rates for both age groups increased, and exceed the national Medicaid means

Results Overall and by Age Group

The total rate of both age groups combined (Table 3) increased in the current measurement, to 81.7 percent from 79.5 percent in the previous year ($p<.001$).

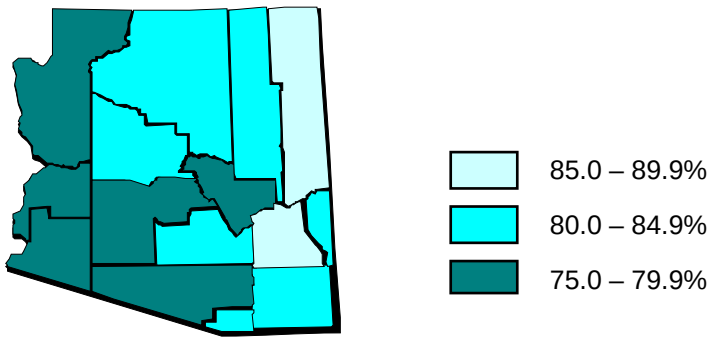
20 to 44 Years: In the current measurement, 79.9 percent of adults 20 to 44 years old had a preventive or ambulatory care visit during the year, an increase from 77.3 percent in the previous year $p<.001$).

45 to 64 Years: This rate also showed a statistically significant increase, to 85.6 percent from 84.1 percent in the previous year ($p<.001$).

Results by County

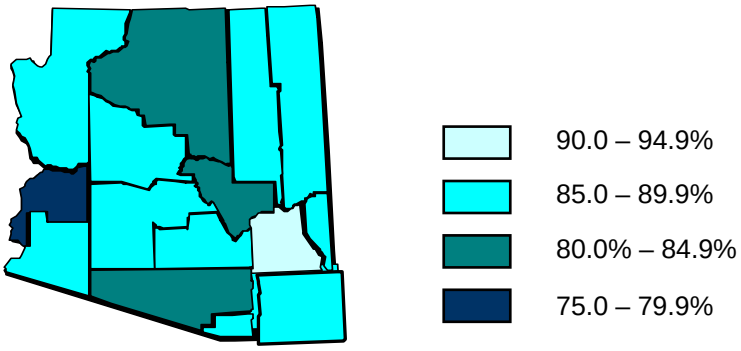
20 to 44 Years: Rates by county ranged from 78.1 percent in Yuma County to 85.2 percent in Apache County. Figure 8 shows relative rates by county.

Figure 8. Adults' Access to Preventive/Ambulatory Health Services by County, 20 – 44 Years, Medicaid Members



45 to 64 Years: Rates by county ranged from 77.4 percent in La Paz County to 92.1 percent in Graham County. Figure 9 shows relative rates by county.

Figure 9. Adults' Access to Preventive/Ambulatory Health Services by County, 45 – 44 Years, Medicaid Members



When rates were analyzed by rural and urban counties, rural members in both age groups (20 to 44 years and 45 to 64 years) were more likely to have a preventive or ambulatory care visit than those living in urban counties ($p=.009$ and $p<.001$, respectively).

Results by Race or Ethnicity

Black members in both age groups were less likely than non-Hispanic Whites to have a preventive or ambulatory care visit, with RR at 0.97 (95% CI 0.96, 0.99) overall.

Comparison with National Benchmarks

AHCCCS rates for both age groups are higher than the most recent national HEDIS means for Medicaid health plans.

AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
20 – 44 Years	79.9%	78.2%	93.1%
45 – 64 Years	85.6%	83.1%	95.1%

Discussion

Ensuring that adult members use preventive services is challenging. This may be due to lack of awareness among members about when and what types of routine preventive health services are recommended, skepticism about the effectiveness of prevention or avoidance — especially if a person is engaging in unhealthy behaviors like smoking. In addition, medical professionals no longer recommend that adults have an annual checkup.

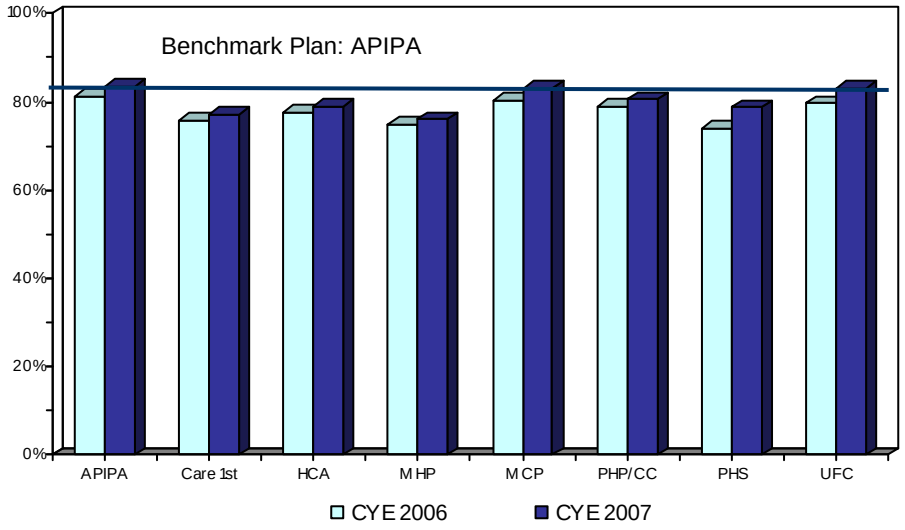
However, given the risks associated with smoking alone and the substantial portion of members who use tobacco, yearly preventive health care visits may be an important service for AHCCCS members.

Nationally, African American and Hispanic patients have fewer primary care visits and lower rates of preventive care, which are associated with poverty, namely income and low educational attainment.[9] Other data show that Blacks have higher rates of hypertension, smoking and leisure-time physical inactivity.[6] Thus, the significantly lower rates of annual preventive/ambulatory health visits among members who are African American should be addressed by Contractors.

Four Contractors — Arizona Physicians IPA (APIPA), Mercy Care Plan, Phoenix Health Plan and University Family Care — met the MPS for both age groups. While Contractors are evaluated on their rates by age group, Figure 10 shows Contractor performance when both age groups are combined.

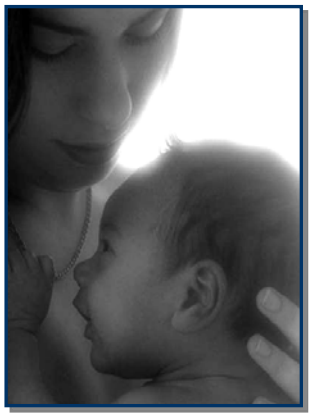
Figure 10. Rates by Contractor, Both Age Groups of Adults Combined, Medicaid Members

CYE 2006 and CYE 2007



APIPA had the highest rate (83.3 percent) for Adults' Access to Preventive/Ambulatory Health Services when both age groups were combined, while Mercy Care Plan and University Family Care were only slightly lower (83.0 percent and 83.1 percent, respectively).

Well Child Visits in the First 15 Months of Life



The most dramatic growth during childhood – physical, cognitive, social and emotional – occurs during infancy. In the first year of life, an infant's birth weight triples, his length increases by almost 50 percent, and he achieves most of his brain growth.[10]

During this time, health care providers help ensure that children are adequately protected against infectious diseases by vaccinating them and screening for physical illness or developmental delays, which can be minimized with early intervention. This also is an ideal time to counsel parents about infant care, nutrition, sleep position and injury prevention.

Description

AHCCCS measured the percentage of children who:

- turned 15 months old during the measurement period (October 1, 2006, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor from 31 days of age through their 15-month birthdays (one break in enrollment, not exceeding one member-month, was allowed), and
- had six or more well-child visits during the first 15 months of life.

Performance Goals

AHCCCS has adopted Minimum Performance Standards and Goals for both Medicaid and KidsCare members for this measure in the current period, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives. These are shown in the following table:

AHCCCS Performance Standards for Well Child Visits in the First 15 Months of Life

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
Well-Child Visits, 15 Months	70%	72%	90%

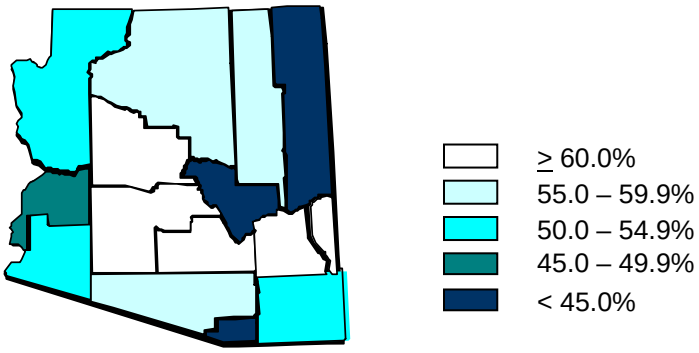
Overall Results

The overall rate for Medicaid members (Table 4) remained unchanged, at 58.6 percent, compared with 58.0 percent in the previous measurement (p=.325). The overall rate for KidsCare members also remained at the same level, with a rate of 68.7 percent, compared with 72.5 percent in the previous measurement (p=.111). This report does not include a table of results by individual health plan for KidsCare members for this measure because several Contractors had population sizes that were too small to make valid statistical comparisons.

Results by County

Rates by county for Medicaid members ranged from 37.7 percent in Gila County to 71.4 percent in Greenlee County (although there were only eight members in the denominator for that county). Figure 11 shows relative rates by county for Medicaid members.

Figure 11. Well-Child Visits in the First 15 months of Life, by County, Medicaid Members



The AHCCCS rates exceed the national Medicaid mean

When rates were analyzed by rural and urban counties, Medicaid-eligible children living in urban counties were more likely to have six well-child visits than those living in rural counties (p=.001).

Results by Race or Ethnicity

For Medicaid members, Black and Native American children were significantly less likely than non-Hispanic White members to have six well-child visits. Native Americans had the greatest disparity with Whites for this measure, with a RR of 0.71 (95% CI 0.60, 0.83); RR for Black members was 0.85 (95% CI 0.77, 0.93).

Comparison with National Benchmarks

The AHCCCS overall rates for six well child visits exceed the most recent national HEDIS means for Medicaid health plans.

AHCCCS Rates Compared with 2007 National HEDIS Means

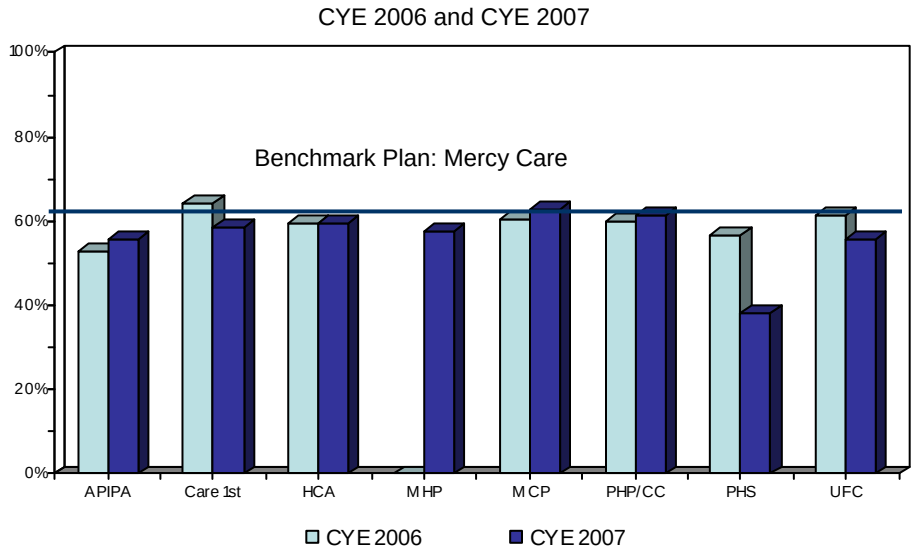
Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Six Well Child Visits by 15 Months of Age	58.6%	68.7%	55.6%	72.9%

Discussion

While the AHCCCS overall rate for Well-Child Visits in the First 15 Months of Life among Medicaid members is above the national mean, there is still room for improvement in this rate, given the goal that AHCCCS has established.

The rate for Native American children may lag behind other groups as many of these members are able to receive care through Indian Health Services, as well as through AHCCCS health plan providers. This bears further investigation, to ensure that these children are receiving all necessary preventive services.

Figure 12. Rates by Contractor, Well-Child Visits in the First 15 Months of Life, Medicaid Members



Mercy Care Plan had the highest rate for this measure in the current period (62.6 percent).

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

Children who are healthy are better able to learn and develop.[11,12] Well-child visits during the preschool and early school years are important in helping children reach their full potential and become productive, healthy adults. These visits allow any medical, behavioral or developmental problems to be detected and addressed.

Health care providers also can administer any needed vaccines and educate parents about adequate nutrition, oral health and injury prevention during well-child visits. Evidence shows that provider counseling can increase the use of seat belts, child safety seats and bicycle helmets, especially when directed at the parents.

Description

AHCCCS measured the percentage of members who:

- were ages 3 through 6 years at the end of the measurement period (October 1, 2006, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment was allowed if the gap did not exceed one member-month), and
- had at least one well-child visit during the measurement period.

Performance Goals

AHCCCS has adopted the following Minimum Performance Standard and Goal for both Medicaid and KidsCare members for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives.

AHCCCS Performance Standards for Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
Well-Child Visits, 3 through 6 Years	56%	58%	80%

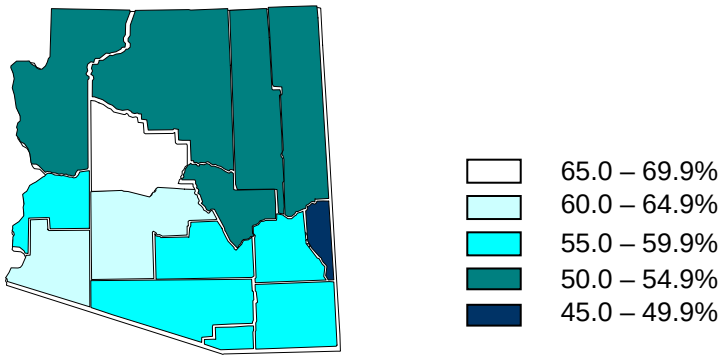
Overall Results

The overall rate for Medicaid members (Table 5) increased to 61.3 percent from 58.5 percent in the previous measurement ($p<.001$). The rate for KidsCare members (Table 6) also increased, to 67.9 percent from 64.0 percent in the previous year ($p<.001$).

Results by County

Rates by county for Medicaid members ranged from 46.2 percent in Greenlee County to 65.2 percent in Yavapai County. Figure 13 shows relative rates by county for these members. Rates for KidsCare members ranged from 40.0 percent in La Paz County to 75.0 percent in Greenlee County, although both counties had very small denominators.

Figure 13. Well-Child Visits in the Third through Sixth Years of Life, By County, Medicaid Members



The rate for KidsCare members exceeds the national means for Medicaid and commercial health plans

When analyzed by rural and urban county groups, Medicaid-eligible members in urban counties were more likely to have well-child visits than members in rural areas ($p<.001$). The same was true for KidsCare members ($p<.001$).

Results by Race or Ethnicity

For Medicaid members, Native Americans were less likely than non-Hispanic Whites to have well child visits, with RR of 0.85 (95% CI 0.81, 0.89), as were Blacks, with RR of 0.95 (95% CI 0.92, 0.98). Hispanic members were more likely to have visits, with RR of 1.04 (95% CI 1.02, 1.05). Among KidsCare members, Hispanics also were slightly more likely to have well child visits, with RR of 1.07 (95% CI 1.02, 1.11), compared to non-Hispanic white members.

Comparison with National Benchmarks

The AHCCCS rate for KidsCare members exceeds the most recent national HEDIS means for both Medicaid and commercial health plans, while the AHCCCS rate for Medicaid members is slightly below both national means.

AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
3 through 6 Years	61.3%	67.9%	66.8%	66.7%

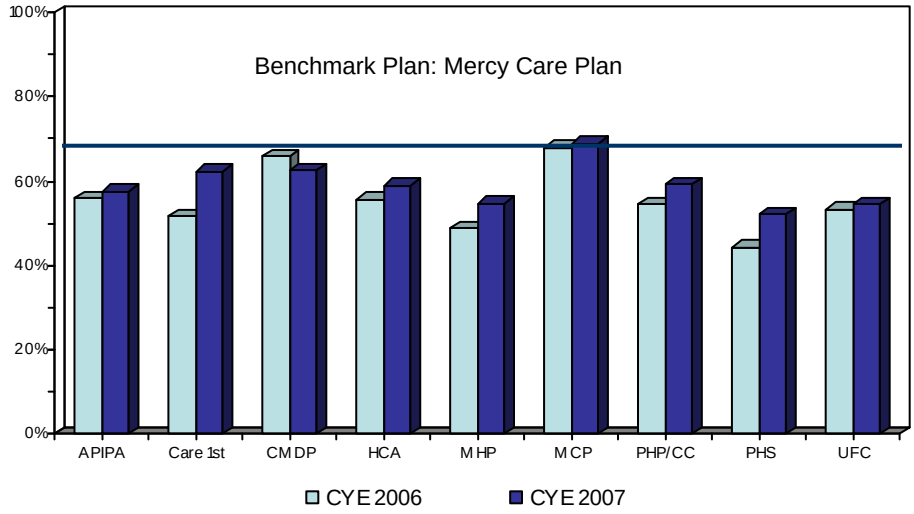
Discussion

In the first two years of life, children are receiving immunizations that must be given at specific intervals, and are screened for developmental milestones during this period of rapid growth. After these "baby shots" are completed and children's growth and development begins to slow, they are less likely to have primary care visits, unless they are ill or have other specific needs. Targeted efforts to educate parents about the value of preventive care visits for children in this age range are needed to improve the rate for this measure.

As seen in the measure of Well-Child Visits in the First 15 Months of Life, Native American children may have lower rates because they are receiving services through IHS, but this bears further investigation to ensure that they are receiving the necessary services for optimum health and development.

Figure 14. Rates by Contractor, Well-Child Visits in Third through Sixth Years of Life, Medicaid Members

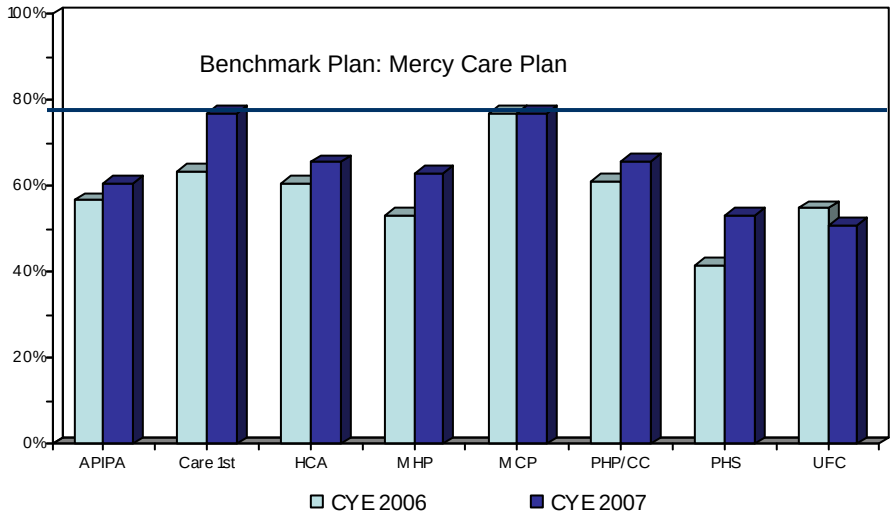
CYE 2005 and CYE 2006



As seen in Figure 14, Mercy Care Plan had the highest rate of well-child visits for Medicaid members in this age group in the current period (68.8 percent). Six Contractors met the MPS for Medicaid-eligible children.

Figure 15. Rates by Contractor, Well-Child Visits in the Third through Sixth Years of Life, KidsCare Members

CYE 2006 and CYE 2007



Mercy Care Plan also had the highest rate for KidsCare members in the current period (77.0 percent), although Care1st Healthplan was only 0.1 percentage point lower (76.9 percent). Six Contractors met the AHCCCS MPS for this population.

Adolescent Well-Care Visits

Adolescence generally is characterized by good health. However, data indicate that many teenagers are involved in unhealthy behaviors, including alcohol and drug use, tobacco use, unprotected sex, driving without seat belts and speeding, poor diet and inadequate physical activity. Nationally and in Arizona, the major causes of death in adolescents are motor vehicle accidents, homicide, suicide, malignant neoplasms (cancer) and disease of the heart.[6,13]

Many of these unhealthy behaviors and other medical problems can lead to chronic health conditions that last throughout life. In recent years, obesity has become a major cause of adolescent morbidity, contributing to a dramatic increase in the number of youth with type 2 diabetes mellitus.[14] Several national studies show higher rates of overweight, low fitness, and diabetes among Hispanic and Black adolescents, compared with White adolescents.[15]

Since most of the factors that contribute to adolescent morbidity and mortality are preventable or may be minimized with medical treatment, it is crucial to identify early signs of unhealthy behaviors or physical problems. Regular well-care visits that address the psychological, behavioral and physical aspects of health are very important in helping adolescents become healthy adults.

Description

This indicator measured the percentage of members who:

- were ages 12 to 21 years if eligible under Medicaid or 12 to 19 years if eligible under KidsCare at the end of the measurement period (October 1, 2006, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment, not exceeding one member-month, was allowed), and
- had at least one well care visit during the measurement year.

Performance Goals

AHCCCS has adopted the following Minimum Performance Standard and Goal for both Medicaid and KidsCare members for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives.

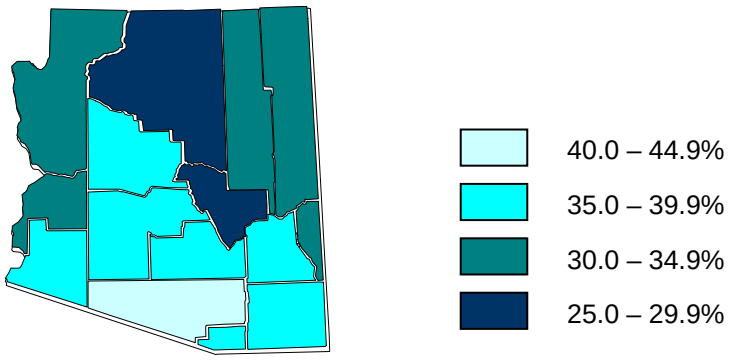
AHCCCS Performance Standards for Adolescent Well Care Visits

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
Adolescent Well-Care Visits	37%	38%	50%

Overall Results
The overall rate for this measure also was unchanged from the previous period (Table 7). The rate for Medicaid-eligible adolescents was 32.8 percent, compared with from 33.1 percent in the previous period (p=.201). The rate for KidsCare members (Table 8) also did not show a statistically significant change, at 39.5 percent, compared with 40.3 percent in the previous period (p=.221).

Results by County
Rates for Medicaid members by county ranged from 29.3 percent in Coconino County to 40.1 percent in Pima County. Figure 16 shows relative rates by county for these members. Rates for KidsCare members ranged from 29.3 percent in La Paz County (which had only 41 members in this eligibility group) to 49.6 percent in Pima County.

Figure 16. Adolescent Well-Care Visits, by County, Medicaid Members



The rate for KidsCare members exceeds the national means for Medicaid and commercial health plans

When analyzed by rural and urban county groups, Medicaid-eligible adolescents in urban counties were more likely to have a well-care visit (p<.001). This also was true of adolescents covered under KidsCare (p=.001).

Results by Race or Ethnicity
Among Medicaid members, Native Americans were less likely to have well care visits than non-Hispanic White members, with RR of 0.80 (95% CI 0.75, 0.85). Hispanic members were more likely to have visits, with RR of 1.02 (95% CI 1.00, 1.05). Among KidsCare members, Native Americans also were less likely to have well care visits, with RR of 0.72 (95% CI 0.59, 0.86), while Hispanics were more likely to have visits, with RR of 1.08 (95% CI 0.92, 0.98).

Comparison with National Benchmarks
The AHCCCS overall rate for Medicaid members is lower than the most recent national mean for Medicaid health plans reported by NCQA. However, the overall rate for KidsCare members exceeds both the HEDIS national Medicaid and commercial means.

AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Adolescent Well Care Visits	36.3%	43.8%	43.6%	40.3%

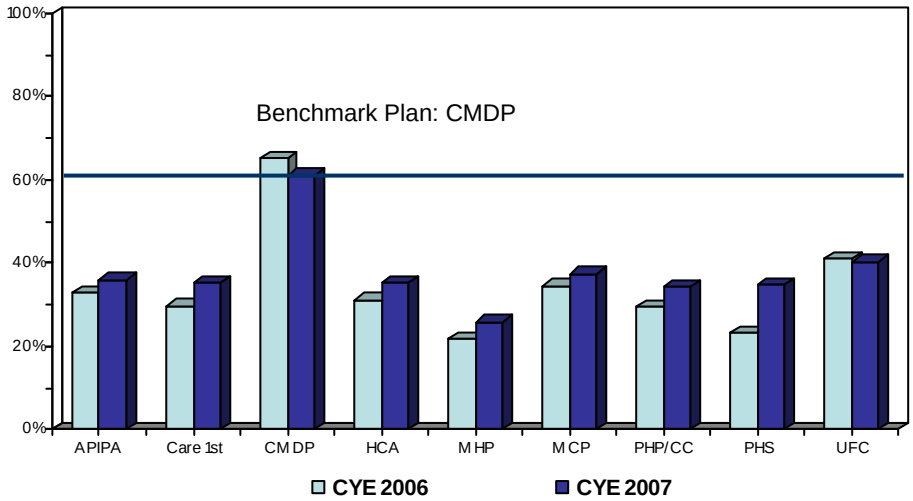
Discussion

The relatively low rates for adolescent preventive care visits, both nationally and among AHCCCS health plans, demonstrates the difficulty in getting adolescents to do something they may not think is worthwhile, and parents not taking them to the doctor unless they are sick. However, the rate in Pima County is encouraging and warrants exploration of strategies used to get these members in for well visits.

The low rate among Native American youth may be affected by data collection issues, as previously noted (i.e., if services are obtained through IHS, they will not be encountered in this measurement). It also may be that this population is even less likely to obtain health care services when they perceive no need. Given that the death rate in Arizona for Native American adolescents is twice that of non-Hispanic White teens,[12] it is important that health plans pay attention to this population to try to reduce their risk of disease and premature death.

Figure 17. Rates by Contractor, Adolescent Well-Care Visits, Medicaid Members

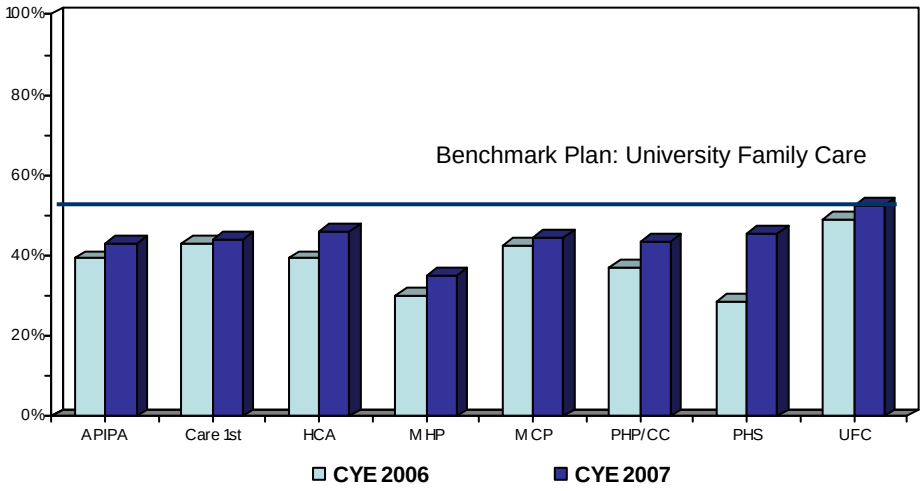
CYE 2006 and CYE 2007



As shown in Figure 17 above, CMDP had the highest rate of Adolescent Well Care visits among the Medicaid population (61.0 percent). Three Contractors met the MPS for Medicaid members in the current measurement.

Figure 18. Rates by Contractor, Adolescent Well-Care Visits, KidsCare Members

CYE 2006 and CYE 2007



University Family Care had the highest rate for the KidsCare population (52.6 percent), as shown in Figure 18. Six Contractors met the AHCCCS minimum standard for this population.

Annual Dental Visits

Oral health is inseparable from overall health status. A child's ability to learn and function well can be affected by problems of the teeth and gums. Dental disease results in children's failure to thrive, impaired speech development, absence from and inability to concentrate in school and reduced self-esteem. Even though most oral diseases are preventable, tooth decay is one of the most common health problems among children today. [16,17]

Brushing, flossing and other oral health practices can reduce the risk of developing diseases of the teeth and gums. Regular professional dental care, in combination with these practices, is important. Preventive services, such as the application of topical fluorides, are known to reduce the rate of tooth decay and other oral diseases in children.[17] Routine dental visits also serve to educate individuals about dental hygiene and preventive measures. The American Association of Pediatric Dentistry recommends that dental visits being by age 1.

Description

AHCCCS measured the percentage of children and adolescents who:

- were ages 2 through 21 years if eligible under Medicaid, or 2 through 19 years if eligible under KidsCare, at the end of the measurement period (October 1, 2006, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment, not exceeding one member-month, was allowed), and
- had at least one dental visit during the measurement year.

Performance Goals

AHCCCS has adopted the following Minimum Performance Standard and Goal for both Medicaid and KidsCare members for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives.

AHCCCS Performance Standards for Annual Dental Visits

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
Annual Dental Visits, 2 through 21 Years	51%	57%	57%

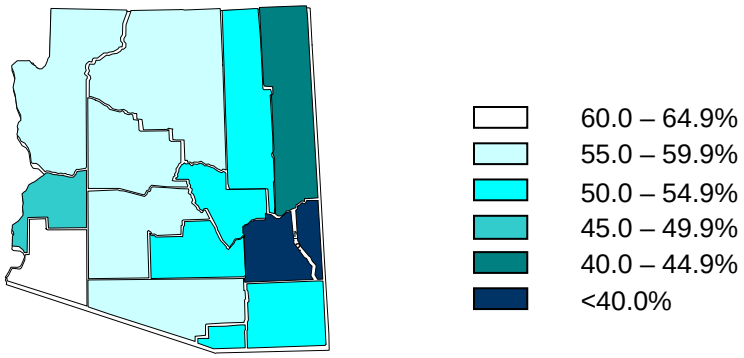
Overall Results

Among Medicaid members (Table 9), the overall rate dropped to 57.5 percent from 59.6 percent in the previous year (p<.001); however, this is likely due to the lowering of the age range for annual dental visits. Children as young as 2 years old at the end of the measurement are now included, while the previous measurement included children starting at 4 years old. Among KidsCare members (Table 10), the rate also dropped, to 68.6 percent from 71.0 percent in the previous year (p<.001).

Results by County

For Medicaid members, the lowest rate was in Graham County, at 31.9 percent, and the highest rate was in Yuma County, at 60.2 percent. Figure 19 shows relative rates by county for these members. KidsCare rates ranged from 37.7 percent in Graham County to 70.0 percent in Maricopa County.

Figure 19. Annual Dental Visits, by County, Medicaid Members



Rates for both Medicaid and KidsCare are in the 90th percentile for Medicaid health plans nationally

When analyzed by rural and urban county groups, both Medicaid and KidsCare members in urban counties were more likely to have a dental visit than those in rural areas (p<.001 for both populations).

Results by Race or Ethnicity

Among Medicaid members, Native Americans were somewhat less likely to have dental visits, with RR of 0.92 (95% CI 0.92, 0.95), as were Blacks, with RR of 0.94 (95% CI 0.93, 0.96). Hispanics were more likely to have visits, with RR of 1.05 (95% CI 1.04, 1.06). Among KidsCare members, Native Americans also were less likely to have dental visits, with RR of 0.87 (95% CI 0.81, 0.93), while Hispanics were more likely to have visits with RR of 1.06 (95% CI 1.04, 1.08).

Comparison with National Benchmarks

The AHCCCS overall rate for both Medicaid and KidsCare members is substantially higher than the most recent national mean for Medicaid health plans reported by NCQA. The AHCCCS rates for both populations are in the 90th percentile of Medicaid plans nationally. The HEDIS measure does not apply to commercial health plans because dental services are usually provided through a separate organization.

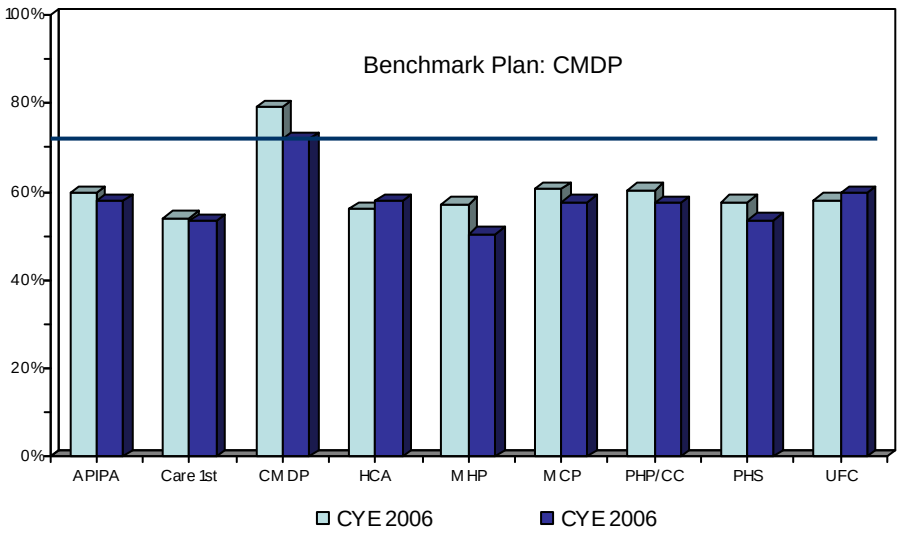
AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	Medicaid 90th Percentile
Annual Dental Visits, 2 through 21 Years	57.5%	68.6%	42.5%	57.3%

Discussion

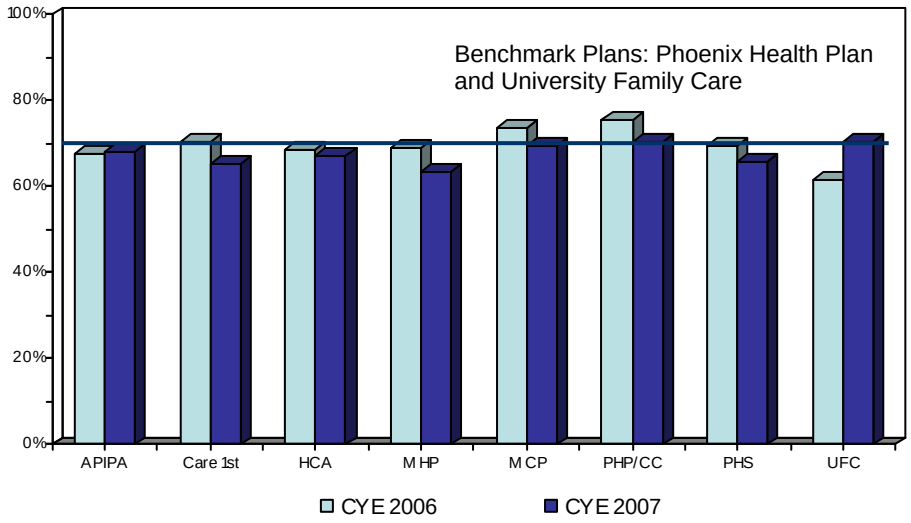
Over the last several years, AHCCCS has focused much attention on improving rates of dental services among enrolled children and adolescents. In 2003, the Agency implemented a Performance Improvement Project (PIP), which required all Acute-care Contractors to show statistically significant improvement in rates of annual dental visits. This PIP and other previous initiatives appear to have had a very positive effect on improving the rate of annual dental visits. While this is a service area in which AHCCCS excels nationally, more work needs to be done to ensure that children and adolescents who are Native American or Black have regular dental check ups.

Figure 20. Rates by Contractor, Annual Dental Visits, Medicaid Members
CYE 2006 and CYE 2007



As shown in Figure 20 above, CMDP had the highest rate of Annual Dental Visits for Medicaid members in the current measurement (71.8 percent). While the rate overall and among most Contractors declined somewhat, one Contractor — Health Choice Arizona – improved its rate with the addition of a younger group of children in the measurement. All Contractors met the MPS for this measure.

Figure 21. Rates by Contractor, Annual Dental Visits, KidsCare Members
CYE 2006 and CYE 2007

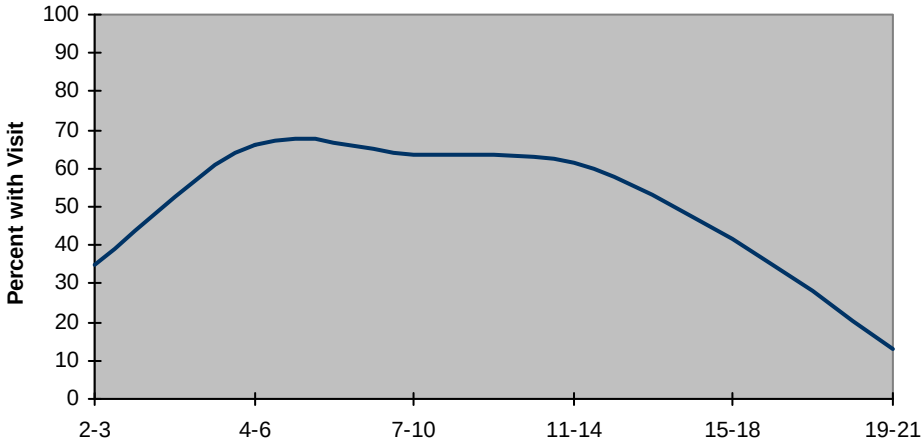


For the KidsCare population, Phoenix Health Plan and University Family Care achieved the highest rates (70.5 percent for both), with University Family Care improving its rate from the previous measurement. All Contractors achieved the AHCCCS minimum standard for dental visits.

As previously noted, HEDIS specifications now include children who are 2 and 3 years old at the end of the measurement period. This is the first measurement of annual dental visits by AHCCCS that includes members in this age group; prior measurements included children and adolescents from 4 through 21 years at the end of the measurement period. When children 2 and 3 years old are excluded from the current measurement, the total rate for Medicaid members 4 through 21 years is 66.2 percent, compared with 59.6 percent in the previous measurement.

In addition to a total rate for members 2 through 21 years old, HEDIS criteria requires managed care organizations to report rates by specific age stratifications. When current data for annual dental visits among Medicaid members are analyzed by age group, the rate is lowest for 19- to 21-year-olds, at 13.1 percent, followed by 2- and 3-year-olds, at 34.7 percent. The following figure shows relative rates by age group for Contractors overall.

Figure 22. Annual Dental Visits by Age Group,
CYE 2007



Data by age and Contractor will be shared with Contractors to assist them in focusing efforts on members in those age groups least likely to have annual dental visits.

Breast Cancer Screening

Breast cancer is the second leading cause of cancer death among North American women. Approximately 1 in 8 women will receive a diagnosis of breast cancer during her lifetime, and 1 in 30 will die of the disease. Breast cancer incidence increases with age, and although significant progress has been made in identifying risk factors, more than 50 percent of cases occur in women without known major predictors.[18]

According to the Centers for Disease Control and Prevention, more than 180,000 women are diagnosed with breast cancer each year, and more than 41,000 women die of the disease.[19] On average, nearly 700 Arizona women die of breast cancer each year.[20]

In the last decade, the overall death rate from female breast cancer has declined. 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.[21]

Screening mammography is an important tool in the early detection of breast cancer. Studies have demonstrated that screening mammography may reduce mortality from the disease by up to 30 percent.[19,22,23] However, results from a recent study of managed care plan members showed declining screening rates from 1999 to 2002.[19]

Description

AHCCCS measured the percentage of members who:

- were ages 52 through 69 years at the end of the measurement period (October 1, 2005, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment per year was allowed if each gap did not exceed one member-month), and
- had a mammogram in the two-year period.

Performance Goals

AHCCCS has adopted Minimum Performance Standards and Goals for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives. These are shown in the following table:

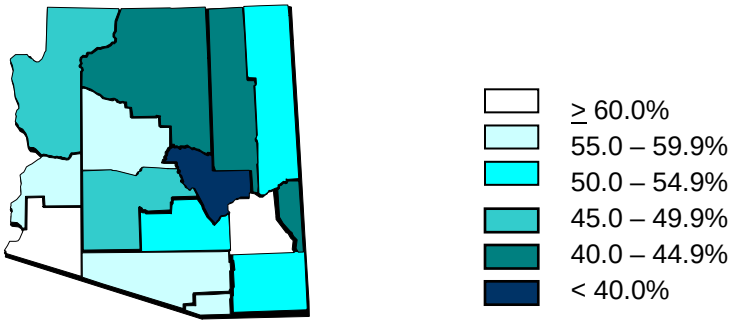
AHCCCS Performance Standards for Breast Cancer Screening

	Minimum Performance Standard (MPS)	Goal	Benchmark
Breast Cancer Screening, 52 – 69 Years	50%	52%	70%

Overall Results
In the current period, the overall rate for breast cancer screening (Table 11) among women 52 to 69 years of age was 51.8 percent, an increase from the previous rate of 49.7 percent (p=.002).

Results by County
Current rates by county ranged from 30.0 percent in Gila County to 72.2 percent in Yuma County. Figure 23 shows relative rates by county for Medicaid members.

Figure 23. Breast Cancer Screening by County, 52 – 69 Years, Medicaid Members



The AHCCCS rate increased, but was lower than the national means for Medicaid and commercial health plans

When rates were analyzed by rural and urban counties, there was no significant difference in members receiving mammograms between rural and urban counties (p=.183).

Results by Race or Ethnicity
Hispanic members were somewhat more likely than other groups to have mammograms for breast cancer screening, with RR of 1.10 (95% CI 1.10, 1.15).

Comparison with National Benchmarks
The AHCCCS rate was lower than the most recent national HEDIS means for Medicaid and commercial health plans. It should be noted that, for the next measurement period, AHCCCS has raised its Minimum Performance Standard to reflect the most current HEDIS mean available when contracts were developed. The higher standard, coupled with potential financial sanctions, should drive Contractor and overall improvement.

AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Breast Cancer Screening, 52 – 69 Years	51.8%	54.8%	71.9%

Discussion

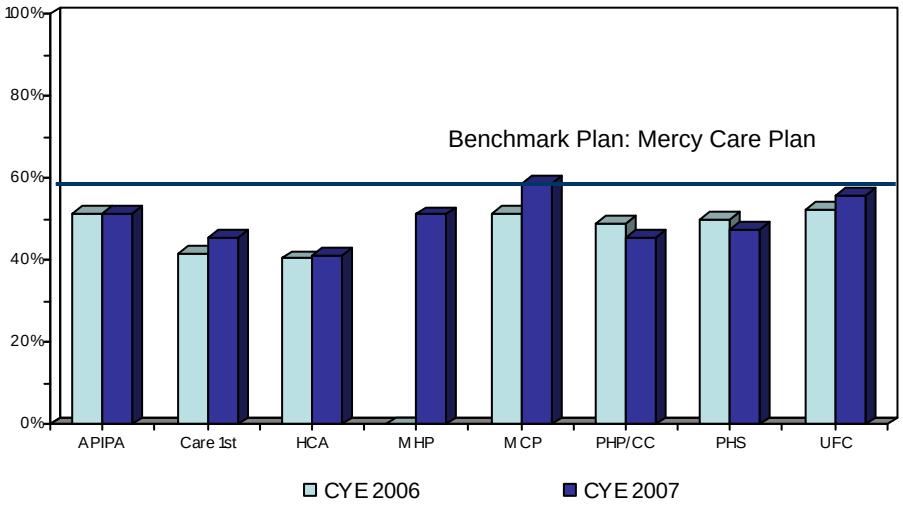
The identification of tumors while they are still localized and potentially curable can significantly reduce breast cancer mortality.[24] However, many women do not obtain mammograms at the recommended one- to two-year intervals. A significant percentage of women responding to a recent National Cancer 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.[24] Women of certain racial or ethnic groups may be especially reluctant to obtain mammograms because of embarrassment or the belief that one can do little to alter the future.[25,26]

Data obtained through this measurement indicate that Native American women enrolled with AHCCCS health plans may be receiving mammograms at a rate well below women of other races; however, Native American women may receive these services through Indian Health Service facilities on a fee-for-service basis even though they are enrolled with AHCCCS health plans. In these cases, the services may not be captured in AHCCCS encounter data unless a health plan paid for them.

Possible underreporting of services for Native American women may have contributed to lower rates in some counties, such as Coconino and Navajo, where many of these women live. Native Americans may obtain services through IHS, and these services may not be reported to AHCCCS.

Figure 24. Rates by Contractor, Breast Cancer Screening among Medicaid Members

CYE 2006 and CYE 2007



As shown above, Mercy Care Plan (MCP) had the highest rate of breast cancer screening (58.9 percent). Four Contractors met the AHCCCS minimum standard for this measure.

Cervical Cancer Screening

The American Cancer Society predicts that there will be about 11,070 new cases of invasive cervical cancer in the United States in 2008, and that about 3,870 women will die from the disease during the year. Approximately half of these deaths occur in women who were not screened at timely intervals.[28]

Cytologic screening through the use of the Papanicolaou (Pap) test has led to an 80-percent reduction in the incidence of cervical cancer. The Pap test can detect precancerous conditions and infection with the human papilloma virus (HPV). Certain types of HPV are strongly associated with cervical cancer.[23] While a vaccine is now available to protect teens and young women against HPV, women should continue to be screened for cervical cancer at regular intervals.

The American College of Obstetricians and Gynecologists, the American Cancer Society and the U.S. Preventive Services Task Force recommend that adolescents and other 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.

Description

AHCCCS measured the percentage of members who:

- were ages 21 through 64 (or 24 through 64 years at the end of the measurement period, October 1, 2006, through September 30, 2007),
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment was allowed if the gap did not exceed one member-month), and
- had a Pap test in the measurement period or in either of the two preceding years.

Performance Goals

AHCCCS has adopted Minimum Performance Standards and Goals for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives. These are shown in the following table:

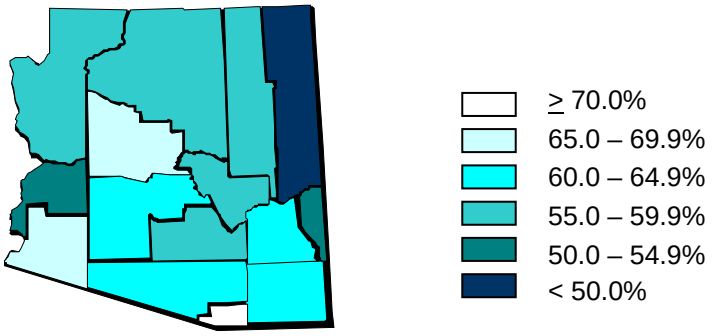
AHCCCS Performance Standards for Cervical Cancer Screening

	Minimum Performance Standard (MPS)	Goal	Benchmark
Cervical Cancer Screening	57%	60%	90%

Overall Results
The overall rate of cervical cancer screening (Table 12) increased in the current measurement, to 62.2 percent from 57.6 percent in the previous year (p<.001).

Results by County
Rates by county ranged from 78.1 percent in Yuma County to 85.2 percent in Apache County. Figure 25 shows relative rates by county.

Figure 25. Cervical Cancer Screening by County, 21 – 69 Years, Medicaid Members



When rates were analyzed by rural and urban counties, urban members were more likely to have a Pap test than those living in rural counties (p<.001).

The AHCCCS rate increased, but was lower than the national means for Medicaid and commercial health plans

Results by Race or Ethnicity
Hispanic members were more likely than non-Hispanic Whites to have a Pap test, with RR of 1.07 (95% CI 1.05, 1.08), while Native American members were less likely, with RR of 0.93 (95% CI 0.90, 0.97).

Comparison with National Benchmarks
The AHCCCS rate was lower than the most recent national HEDIS means for Medicaid and commercial health plans. It should be noted that, for the next measurement period, AHCCCS has raised its Minimum Performance Standard to reflect the most current HEDIS mean available when contracts were developed. The higher standard, coupled with potential financial sanctions, should drive Contractor and overall improvement.

AHCCCS Rates Compared with 2007 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Cervical Cancer Screening	62.2%	65.7%	81.0%

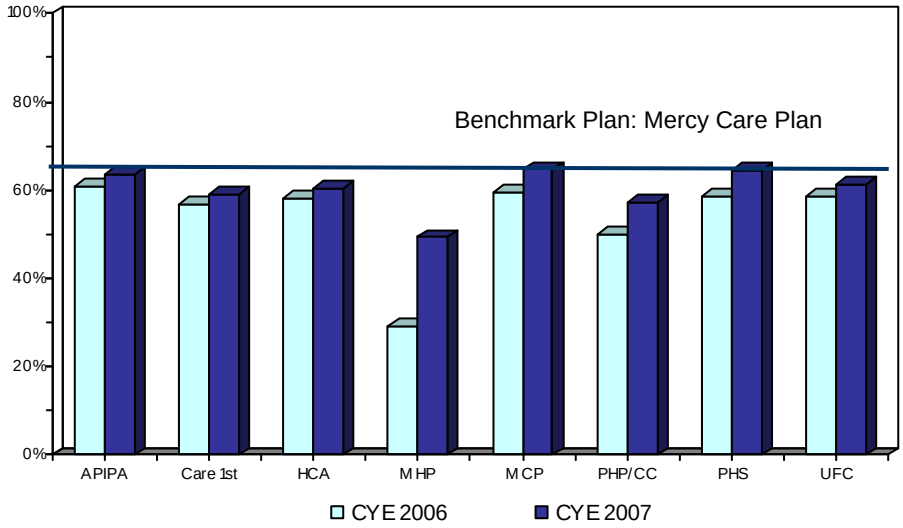
Discussion

As with breast cancer screening, many women may not have Pap tests at recommended intervals because they are not aware they are due for such screening, embarrassment or cultural factors and beliefs.[25,26]

Data obtained through this measurement indicate that Native American women enrolled with AHCCCS health plans may Pap tests at a lower rate than women of other races. However, as in the case of mammograms, Native American women enrolled with health plans may receive these services through Indian Health Service facilities on a fee-for-service basis. Thus, data on these services may not be captured in AHCCCS health plan encounter data. Contractors should try to reach these members and identify whether they have been screened for cervical cancer according to recommendations.

Figure 26. Rates by Contractor, Cervical Cancer Screening among Medicaid Members

CYE 2006 and CYE 2007



Mercy Care Plan (MCP) had the highest rate (64.6 percent) for Cervical Cancer Screening, while Pima Health System's rate was only 0.1 percent lower (64.3 percent). Seven Contractors met the AHCCS Minimum Performance Standard for this measure.

Chlamydia Screening

Chlamydia is one of the most commonly reported sexually transmitted diseases (STDs) in the United States, infecting an estimated 2.8 million people each year. Yet, it often is undetected because up to 80 percent of women and 50 percent of men infected with the *chlamydia trachomatis* bacteria have no symptoms. It is estimated that, by age 30, half of sexually active women have had chlamydia.[29]

If untreated, chlamydia infection can cause serious reproductive and other health problems. The infection can result in pelvic inflammatory disease, which in turn can lead to infertility, an ectopic or tubal pregnancy, or chronic pelvic pain. In pregnant women, chlamydia infections may lead to premature delivery and babies born to infected mothers can have eye infections or pneumonia.

Because chlamydia is most prevalent among women in their late teens and early 20s — and is often without symptoms — the U.S. Preventive Services Task Force has recommended that all sexually active females 25 and younger be tested for the infection at least once a year. This can be done as part of a routine gynecologic examination.

Description

AHCCCS measured the percentage of female members who:

- were ages 16 through 25 years at the end of the measurement period (October 1, 2006, through September 30, 2007),
- were identified as sexually active, based on specific gynecological services received during the measurement period,
- were continuously enrolled with one acute-care Contractor during the measurement period (one break in enrollment was allowed if the gap did not exceed one member-month), and
- were screened for chlamydia infection during the measurement period.

Performance Goals

AHCCCS has adopted Minimum Performance Standards and Goals for this measure in the current period, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives. These are shown in the following table:

AHCCCS Performance Standards for Chlamydia Screening

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
Chlamydia Screening, 16 – 25 Years	43%	45%	62%

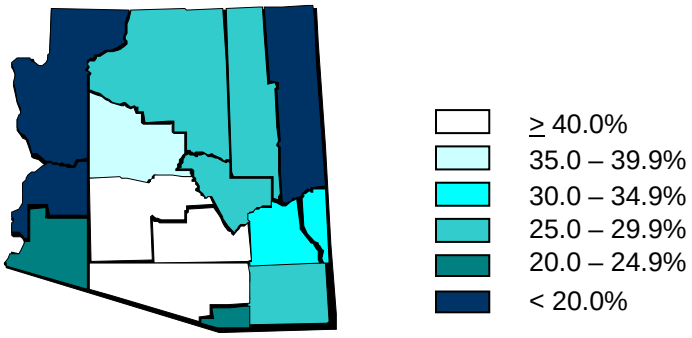
Overall Results

The overall rate for Medicaid members (Table 13) declined to 39.0 percent from 43.6 percent in the previous measurement (p<.001).

Results by County

Rates by county ranged from 13.6 percent in Apache County to 43.3 percent in Maricopa County. Figure 27 shows relative rates by county for Medicaid members.

Figure 27. Chlamydia Screening, Members 16 – 25 Years, by County, Medicaid Members



The AHCCCS rate was lower than the national Medicaid mean, but exceeded the commercial mean

When rates were analyzed by rural and urban counties, members living in urban counties were much more likely to be screened for chlamydia than those living in rural counties (p<.001).

Results by Race or Ethnicity

Members who are Hispanic were more likely to be screened for chlamydia, with RR of 1.09 (95% CI 1.04, 1.13), as were members who are Black, with RR of 1.21 (95% CI 1.14, 1.29). Native American members were less likely to have this service, with RR of 0.84 (95% CI 0.74, 0.96).

Comparison with National Benchmarks

The AHCCCS overall rate fell short of the most recent national HEDIS means for Medicaid health plans; however, it did exceed the commercial health plan mean. The MPS for this measure also has been increased substantially for the next measurement period, to encourage Contractor improvement.

AHCCCS Rates Compared with 2007 National HEDIS Means

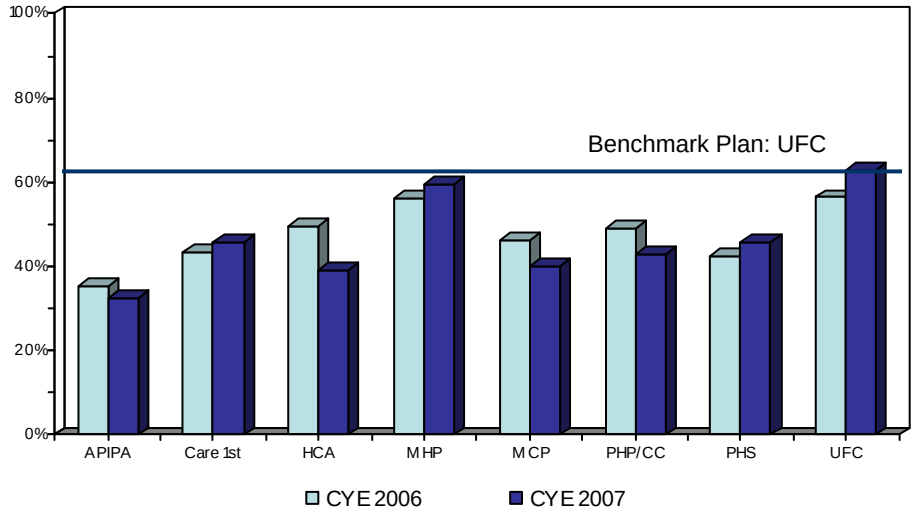
Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Chlamydia Screening, 16 – 25 Years	39.0%	52.4%	37.3%

Discussion

The current recommendation for chlamydia screening for all sexually active females ages 16 through 25 was made by the U.S. Preventive Services Task Force in 2001, but it appears that providers have not fully implemented this recommendation. Physicians are sometimes reluctant to discuss such screening with their patients because of the stigma associated with STDs.[30]

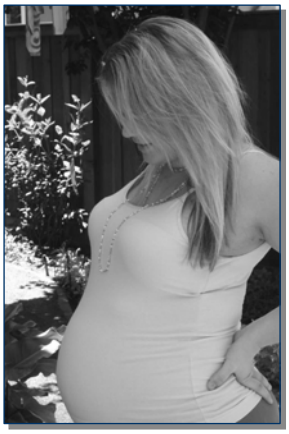
Many women probably do not seek testing because they are not aware of the seriousness of chlamydia infection or are embarrassed about possibly having a sexually transmitted disease. The often asymptomatic nature of the infection also presents a major barrier to testing.

Figure 28. Rates by Contractor, Chlamydia Screening, Medicaid Members
CYE 2006 and CYE 2007



University Family Care (UFC) had the highest rate for this measure in the current period (62.9 percent), exceeding both the HEDIS Medicaid and commercial means. Four Contractors met the AHCCCS minimum standard for this measure.

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.[31-35] Babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care.[36]

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.

According to the Arizona Department of Health Services, 68.5 percent of births covered by AHCCCS in 2007 (including those covered through health plans or on a fee-for-service basis) were to mothers who began care in their first trimester of pregnancy, while 77.6 percent of all mothers in Arizona began care in the first trimester. AHCCCS covers the deliveries of about half of all babies born in the state.[37]

Description

AHCCCS measured the percentage of female members who:

- had a live birth during the measurement period (October 1, 2006, through September 30, 2007).
- 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.

Performance Goals

AHCCCS has adopted the following Minimum Performance Standard and Goal for the current measurement, as well as Benchmarks, or long-range goals based on national Healthy People 2010 objectives.

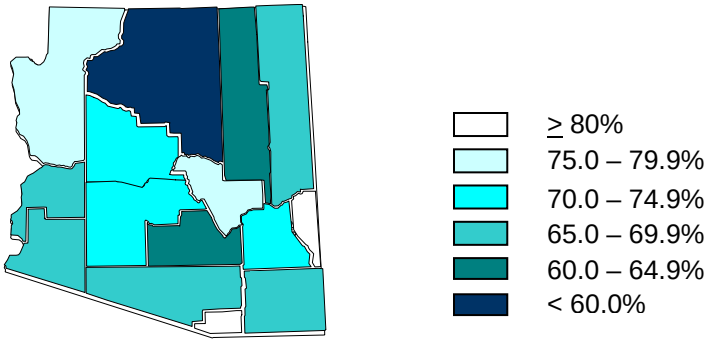
AHCCCS Performance Standards for Timeliness of Prenatal Care

Age Group	Minimum Performance Standard (MPS)	Goal	Benchmark
Timeliness of Prenatal Care	70%	72%	90%

Overall Results
The overall rate for Medicaid members (Table 14) remained at the same level, with a rate of 70.9 percent in the current measurement, compared with 71.8 percent in the previous measurement (p=.063).

Results by County
Rates by county for Medicaid members ranged from 57.2 percent in Coconino County to 87.2 percent in Santa Cruz County. Figure 29 shows relative rates by county.

Figure 29. Timeliness of Prenatal Care, By County, Medicaid Members



The AHCCCS rate was lower than the national Medicaid and commercial means

When analyzed by rural and urban county groups, members in urban counties were much more likely to have timely prenatal care than members in rural areas (p<.001).

Results by Race or Ethnicity
Hispanic, Black and Native American members all were less likely than non-Hispanic Whites to have timely prenatal care visits. for Hispanics, RR was 0.97 (95% CI 0.95, 0.99); for Blacks, RR was 0.94 (95% CI 0.91, 0.98), and for Native Americans, RR was 0.88 (95% CI (0.84, 0.93).

Comparison with National Benchmarks
The AHCCCS rate is well below the most recent national HEDIS means for both Medicaid and commercial health plans. AHCCCS has raised its Minimum Performance Standard for the next measurement period, to reflect the most current HEDIS means available when contracts were developed. The higher standards, coupled with potential financial sanctions, should drive Contractor and overall improvement.

AHCCCS Rates Compared with 2007 National HEDIS Means

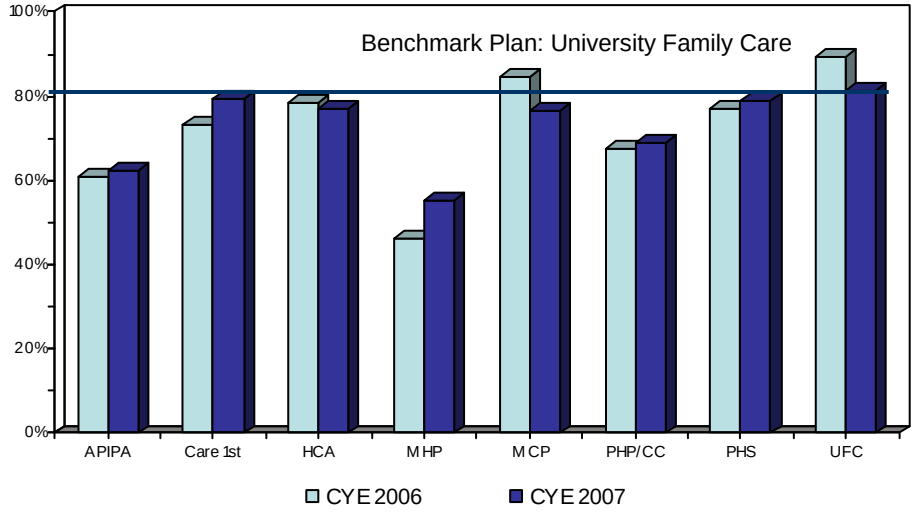
Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Timeliness of Prenatal Care	39.0%	81.2%	90.7%

Discussion

Prenatal, delivery and postpartum services provided through AHCCCS health plans typically are paid for under a "global" fee. Providers may not have reported all dates of prenatal visits when billing for OB services, which likely has resulted in underreporting of rates for this measure. AHCCCS has been working with Contractors to ensure more complete reporting, and some health plans are focusing significant efforts on this area.

Figure 30. Rates by Contractor, Timeliness of Prenatal Care, Medicaid Members

CYE 2006 and CYE 2007



As seen in Figure 30, University Family Care (UFC) had the highest rate for Timeliness of Prenatal Care (81.1 percent). Five Contractors met the MPS for this measure. While it met the MPS, Mercy Care Plan (MCP) experienced a significant decline in its rate. As a large health plan, its poor performance affected the overall AHCCCS rate.

Acute-care Measures for DES/DDD

Overview

The Arizona Department of Economic Security's Division of Developmental Disabilities (DDD) provides needed supports to Arizona residents who are at risk of having a developmental disability if younger than 6 years or, if older, have a diagnosis of epilepsy, cerebral palsy, cognitive disability (such as mental retardation) or autism that was made prior to the age of 18 years, and have substantial functional limitations in at least three major areas, such as self-care, learning and mobility. Many of DDD's clients are dependent on ventilators to breathe.

More than 60 percent of Arizonans served by DDD also are covered under Medicaid through the Arizona Long Term Care System (ALTCS), a program of the Arizona Health Cost Containment System (AHCCCS). In addition to long-term care and supportive services provided through DDD, these members also receive primary and acute medical services through subcontracts with health plans, most of which also serve AHCCCS Acute-care members.

Performance Standards

Under its contract with DDD, AHCCCS has established Performance Standards for primary and preventive care provided to children and adolescents. These standards measure the extent to which DDD ensures that these members receive necessary health services and screenings, including well-child visits and regular dental care. These measures are collected according to HEDIS methodology in the same way as Performance Measures for Acute-care Contractors. This section reports DDD's performance in four of the following measures:

AHCCCS Performance Standards for the Division of Developmental Disabilities (DDD)

	Minimum Performance Standard (MPS)	Goal	Benchmark
Children's Access to PCPs (All Ages Combined)	73%	75%	97%
Well-Child Visits 3 – 6 Yrs	42%	46%	80%
Adolescent Well-Care Visits	31%	33%	50%
Annual Dental Visits, 4 – 21 Yrs	39%	41%	56%

Eligibility for ALTCS members, including those with developmental disabilities, differs from eligibility for Acute-care Contractors in that medical and functional criteria are considered, along with a different set of financial criteria. Thus, as many as two-thirds of DDD members with AHCCCS coverage also have other insurance coverage. Because services may be provided through other insurers, AHCCCS not does not have encounters for those services. The above Performance Standards reflect the limitation in collecting complete data for DDD members.

In addition to the four measures above, AHCCCS also attempted to collect data for Well-Child Visits in the First 15 Months of Life for DDD members. However, there were too few DDD members in that age group who met the HEDIS enrollment criteria for a valid measurement.

Children's and Adolescents' Access to PCPs

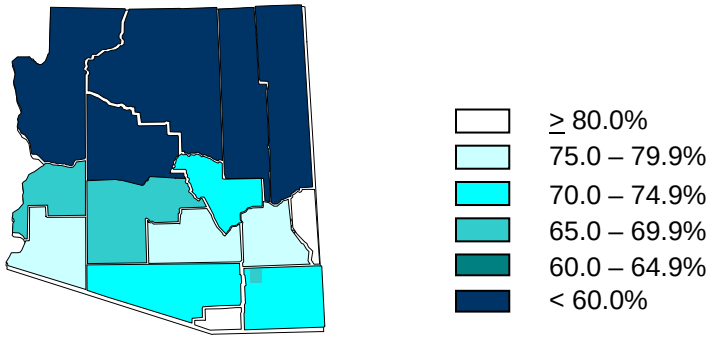
As with the Acute-care population, this measure looks at visits to pediatricians, family physicians and other primary care practitioners as a way to gauge general access to care for children and adolescents with developmental disabilities.

In the current measurement, there were no significant changes in rates by age group and overall (Table 15). The rate for the 12-to-24-month group was 85.7 percent, compared with the previous year's rate of 77.6 percent (p=.233). The rate for members 25 months to 6 years was 65.5 percent, compared with the previous rate of 67.7 percent (p=.069). The rate for members 7 to 11 years was 67.9 percent in the current year, compared with the previous rate of 67.6 percent (p=.815). The rate for members 12 to 19 years was 67.2 percent, compared with 68.8 percent in the previous year (p=.157). The overall rate (all age groups combined) was 67.0 percent in the current measurement, compared with the previous rate of 68.1 percent (p=.103).

With the exception of children 12 to 24 months, there were significant disparities in rates for racial/ethnic subgroups compared with non-Hispanic white members. Among members in the three other age groups — 25 months to 6 years, 7 to 11 years and 12 to 19 years — Native Americans were less likely than non-Hispanic whites to have a PCP visit, while Hispanic children were more likely to have a visit. Overall, RR for Hispanics was 1.11 (95% CI 1.08, 1.15); for Native Americans RR was 0.72 (95% CI 1.08, 1.15).

Rates by county for all ages combined are shown in the following figure. Several counties did not have large enough denominators to analyze rates for individual age groups.

Figure 31. Children's Access to PCPs, All Ages Combined, By County, DDD Members



Rates by county ranged from 24.3 percent in Apache County to 100 percent in Greenlee County, which had only six members in the denominator.

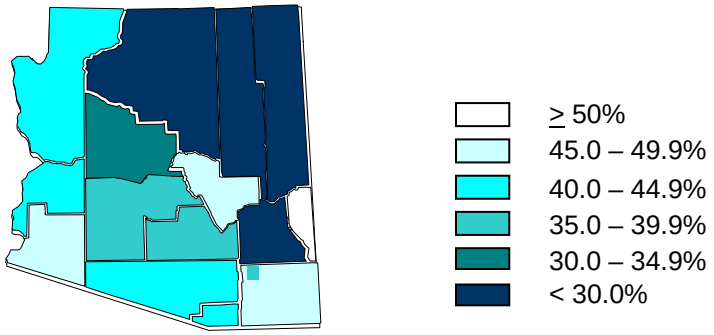
Well-Child Visits in the Third through Sixth Years of Life

Like all children, those with special health care needs require preventive health care services. In addition to early intervention services and therapies to help support optimal development, children with disabilities should have well-child checkups at regular intervals to monitor and improve their health.

In the current measurement, 36.1 percent of children had an annual well-care visit (Table 16), a decrease from 43.8 percent in the previous year ($p<.001$).

Hispanic children in this age group were more likely to have a well-care visit than non-Hispanic whites, with RR of 1.29 (95% CI 1.15, 1.44).

Figure 32. Well Child Visits in the Third through Sixth Years of Life, By County, DDD Members



Rates by county ranged from 7.4 percent in Navajo County, which had only 27 members in the denominator, to 55.6 percent in Gila County, which had only nine members. Several other rural counties had small denominators, so these results should be interpreted with caution.

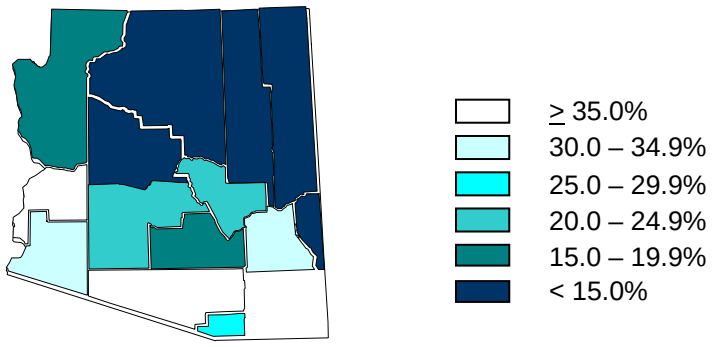
Adolescent Well-Care Visits

Many children and adolescents with developmental disabilities have comorbid physical conditions, such as asthma, cerebral palsy and diabetes. They also suffer from emotional and behavioral problems, and adolescents in particular are more likely to need mental health services than younger children with special health care needs.[38] Adolescent well-care visits enable providers to focus on the special needs of these members, so that they may experience the best possible health.

In the current measurement, 27.1 percent of adolescents had a well-care visit (Table 17), which was unchanged from the previous year's rate of 28.8 percent (p=.080).

Native Americans were about half as likely to have a well care visit as non-Hispanic whites, with RR of 0.58 (95% CI 0.43, 0.79). Hispanics were more likely to have a well care visit, with RR of 1.22 (95% CI 1.09, 1.36), as were Black members, with RR of 1.23 (95% CI 1.01, 1.50).

Figure 33. Adolescent Well Child Visits, By County, DDD Members



Rates by county ranged from 4.6 percent in Apache County to 40.0 percent in La Paz County, which had only 15 members in the denominator. These results also should be interpreted with caution, as several other rural counties had small denominators.

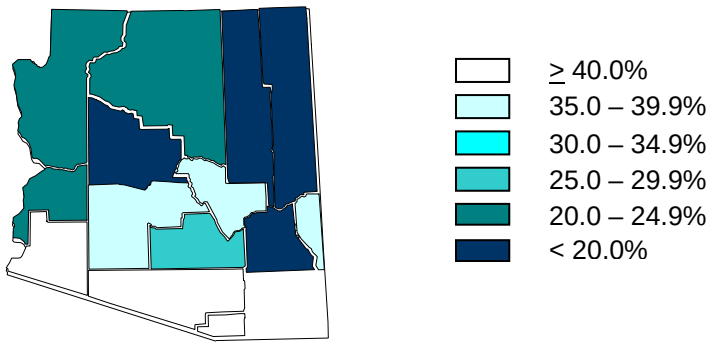
Annual Dental Visits

In general, people with developmental disabilities have poorer oral health and oral hygiene than those without such disabilities. Data indicate that people who have mental retardation have more untreated caries and a higher prevalence of gingivitis and other periodontal diseases than the general population. Medications, malocclusion, multiple disabilities, and poor oral hygiene combine to increase the risk of dental disease in people with developmental disabilities.[39]

The rate of annual dental visits (Table 18) decreased in the current measurement, to 36.4 percent from 40.7 percent in the previous year ($p<.001$).

Native Americans were less likely to have a dental visit than non-Hispanic whites, with RR of 0.65 (95% CI 0.55, 0.77), while Hispanic members were more likely to have a dental visit, with RR of 1.18 (95% CI 1.12, 1.25).

Figure 34. Annual Dental Visits, By County, DDD Members



Rates by county ranged from 10.5 percent in Graham County to 52.7 percent in Yuma County. Greenlee and La Paz counties had small denominators.

Discussion

Overall performance for DDD was disappointing, as two rates showed significant declines from the previous year and two others were unchanged, and appear to be moving downward. The Division did not meet the Minimum Performance Standard for any of the measures.

The effect of third party insurance as the primary payer for many of these children may have resulted in artificially low rates

Native American children and adolescents enrolled in DDD displayed significantly lower rates of service in nearly all measures. As with the Acute-care population, these members may show lower rates of visits because they are receiving services through Indian Health Service, which are not encountered by AHCCCS. However, this requires further investigation to determine if these members are receiving important preventive health care services, especially given their special needs status and increased risk of physical complications.

Overall, the effect of third party insurance as the primary payer for many of these children also may have resulted in artificially low rates of primary and preventive care. Yet children in some counties appear to fare much better when it comes to utilization of these services. In general, rates were lowest in the northern part of the state, while southern counties had higher rates. DDD must address the issues that lead to low rates and/or underreporting of services.

CONCLUSION

Overall Results

The data reported here indicate that children and adults enrolled with AHCCCS have a relatively high degree of access to the health care system, as evidenced by the use of several preventive care services. Compared with Medicaid managed care plans nationally, AHCCCS excels in rates of Annual Dental Visits, with rates for Adults' Access to Preventive/Ambulatory Health Services and Well-Child Visits in the First 15 months of Life also above national Medicaid means.

KidsCare members, in particular, have higher rates of utilization than Medicaid and Children's Health Insurance Program beneficiaries nationally. KidsCare rates for four measures — Well-Child Visits in the First 15 months of Life, Adolescents' Access to PCPs at 12 through 19 Years, Adolescent Well Care Visits and Annual Dental Visits — are above the most recent HEDIS national Medicaid means, which includes members in this beneficiary group.

Contracted health plans must focus resources on increasing rates of children's and adolescent' access to primary care and well-care visits among Medicaid members. It should be noted that, when non-PCP providers (i.e., specialists) are included in the access measures, rates of medical visits are significantly higher; thus, some members may be receiving primary care services in settings other than PCP offices. Health plans should explore whether this is the case and ensure that members received services in the most appropriate setting.

Use of preventive services such as mammograms, Pap tests and chlamydia screening by women also is of concern.

Disparities by Race and Ethnicity

Analysis of data indicates lower rates of service among Native Americans for several measures, as well as lower rates for Black and Hispanic members for some measures

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American Indians and Alaska Natives are more likely to live in poverty and have less than a high school education than non-Hispanic Whites, both of which indicate less access to primary care and preventive services. A recent report from several leading cancer organizations found that more Native Americans than non-Hispanic Whites reported being obese; and that screening rates for breast, colorectal, prostate and cervical cancers were lower among Native Americans than Whites. The report also notes high rates of smoking among Native Americans.[40]

Some Contractors have demonstrated through focused efforts that rates can be improved significantly

Other national data show that racial and ethnic minorities are more likely to rate their health as fair or poor, compared with non-Hispanic White persons: Native Americans are about twice as likely to rate their health as fair or poor, and Blacks and Hispanics also are more likely to rate their health as such. In addition Black and Mexican-American children generally have higher rates of obesity and untreated dental decay, [41] problems that could be addressed with regular medical and dental care.

Research suggests that Native American populations experience more perceived barriers to care than their White counterparts. Many Native Americans indicate that work or family responsibilities, lack of transportation, and inconvenient clinic/office hours of operation are common barriers to care. Native Americans also perceive more issues of racial and economic discrimination by providers. Others have indicated a lack of trust and confidence in their child's provider.[42] Other studies have shown that Hispanic parents identify language differences, transportation difficulties, and long waiting times as major barriers to health care for their children.[43]

General Strategies for Improvement

These trends underscore the disparities in use of services among racial/ethnic subgroups, as indicated by this analysis of AHCCCS Performance Measure data. Strategies to reduce disparities and improve Performance Measure rates may include:[44-48]

- Utilizing community lay health workers, who encourage members or parents of children to receive preventive services.
- Conducting one-on-one outreach to educate and motivate patients.
- Seeking member feedback to strengthen commitment and adherence to medical regimens.
- Ensuring the diversity and cultural competency of providers through provider and staff education so that members feel comfortable seeing them.
- Encouraging expanded clinic hours among providers to make it easier for members to receive services.
- Using incentives, either with providers or members, to increase rates of preventive care visits.

While AHCCCS health plans may be using some of these approaches, and the program overall has a strong cultural competency focus, Contractors should consider whether these and other approaches could be better used to improve rates among specific groups of members. Contracted health plans also should try to determine if Native Americans enrolled in their plans are receiving services through IHS or not at all.

Strategies for Specific Measures

Research has demonstrated effective interventions for some specific services, including:

Well Child Visits

- Partner with other community programs to reach AHCCCS-enrolled members, such Head Start, which serves low-income children 3 to 6 years old and Early Head Start, which focuses on pregnant women and younger children. This may include taking services to the community, at venues such as health fairs or other settings, as long as Contractors can identify whether children are members of their health plan and providers can bill for those services, so they may be reported as encounters to AHCCCS.
- Target high-volume PCP offices to improve their rates of well child visits. One successful initiative by a Medicaid health plan held quarterly quality improvement forums with PCP offices to promote use of the Bright Futures system from the American Academy of Pediatrics. The plan's Medical Director sent letters to the top 40 PCP practices (by volume) with a Bright futures Pocket Toolkit to assist providers in making appropriate decisions regarding preventive care services and had follow -up meetings with 25 of those offices to address improving well-child visits. The health plan also implemented an incentive program that provided an additional $15 per visit for preventive care visits. [45]
- Another Medicaid health based at a federally qualified community health center offered incentives to office staff of the center. The health plan generated lists of members due/overdue for EPSDT visits for staff to contact. Office staff names were entered into a raffle for each appointment scheduled and drawings were held weekly for gift certificates.

It should be noted that all Contractors send initial and reminder notices when children are due or overdue for well child and other preventive services to both parents/caregivers and their assigned PCPs. Greater effort to follow up with families and providers on members who do not have visits after the second notice may be warranted. Because addresses for members may not be current, follow up by cell phone or text messaging may be more effective.

Adolescent Well Care Visits

- Successful efforts to improve adolescent preventive services in a Medicaid health plan include identifying "teen-friendly" physicians and assigning adolescent members to those practices, as well as providing incentives to members, such as movie tickets for a completed well visit.[46]

- Initiatives that stress confidentiality of services for adolescents also have proven effective. This approach was coupled with continuing education opportunities for providers and targeted feedback about the quality preventive services after medical chart review.[47]
- The use of community health centers and encouraging adolescents to use services in those settings also may be an effective strategy, since low-income patients are more likely to use these centers for other services.[48] All providers should identify opportunities to offer well care services when adolescent members present for other reasons.

Breast and Cervical Cancer Screening

- One managed care organization targeted women 50 to 79 years old who were due to receive a mammogram and did not schedule one after receiving a reminder letter. These women received a reminder postcard, a reminder telephone call or a "motivational" telephone call that provided an opportunity for them to ask questions and discuss concerns about mammography with a knowledgeable person who had received special training in this type of intervention. Health plan staff also had the ability to schedule an appointment at the time of the intervention call. Women who received the reminder or motivational telephone calls were more likely to get a mammogram than those who received the reminder postcard. Such one-on-one telephone counseling has been employed successfully by several other health plans.[49]
- Community based outreach, including small-group educational and motivational sessions in neighborhoods, coupled with culturally relevant patient education materials also has proven successful among some populations.[50-51]

Chlamydia Screening

- One health plan used a multifaceted approach to improve screening for chlamydia that included interventions with providers and members. The health plan created a "Provider Health Toolkit" that covered women's health issues, including chlamydia screening, and focused on clinical guidelines for screening in a provider newsletter. It also included specific education about screening in member materials. In addition, the health plan adopted a new coding system that allowed providers to bill separately for chlamydia screening, so it was able to better capture data showing that the service was provided.[52]
- Another managed care organization also used an effective combination of interventions that included one-on-one physician training with a focus on chlamydia and infertility, letters to physicians with names of assigned members who were eligible for screening, tracking screening rates and reporting those back to individual physicians, and educational materials for members 19 and older or parents, if younger. The health plan also received laboratory results directly from its contracted lab vendor. [30]

In July 2007, AHCCCS advised Acute-care Contractors that they would face financial sanctions in the next couple of years if they do not increase rates to meet Minimum Performance Standards. In order to avoid these financial sanctions, Contractors should choose to direct more resources, including staff effort, to improving Performance Measure rates.

AHCCCS is providing recommendations for possible quality improvement strategies to Contractors. Data from this measurement may further guide interventions to improve performance, particularly in specific geographic areas or among certain populations.

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Appendix A

PMMIS Race/Ethnicity Hierarchy

	DES Field Coded with "Y"		AHCCCS Conversion
AI	American Indian (Native American)	NA	Native American
HI	Hispanic or Latino	HS	Hispanic
BL	Black	BL	Black
AS	Asian	AS	Asian/Pacific Islander
NH	Native Hawaiian/Pacific Islander	AS	Asian/Pacific Islander
WH	White (Caucasian)	CW	Caucasian/White
UD	Unable to Determine (Other)	UN	Unknown/Unspecified
RA	Refused to Answer	UN	Unknown/Unspecified