

**Quality Management Performance Measures  
For Acute-care Contractors and  
The Division of Developmental Disabilities**

**Measurement Period Ending Sept. 30, 2008**

**Prepared by the Division of Health Care Management**



**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. In addition, data for services provided through the Department of Economic Security's Division of Developmental Disabilities (DES/DDD) are 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.

### Methodology

AHCCCS used Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) 2009 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 Sept. 30, 2008. Results are reported for Contractors overall and by individual health plan. The report also indicates whether changes in rates 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 Medicaid and commercial managed care 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.

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

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In addition, some health plans in other states report HEDIS rates based on combined data for members eligible under Medicaid (Title XIX of the Social Security Act) and those eligible under the Children’s Health Insurance Program (CHIP, or Title XXI), 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.

### **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 two 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.

In addition, members may receive health care services through other programs, such as Indian Health Service, Medicare, other medical coverage, or free/low-cost community providers. Thus, they may have received a service being measured, but it is not counted because it was not paid for under Medicaid or CHIP.

To minimize the impact of limited data available for Medicare beneficiaries who also are enrolled in AHCCCS, dual-eligible members who are enrolled in Medicare MCOs or who have fee-for-service Medicare coverage are excluded from the measurement. AHCCCS members who are enrolled in a Medicare plan that is aligned with their Medicaid plan (i.e., operated by or contracted with the same organization) are included.

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The numerator data are based on encounters for professional services, primarily physician office and clinic visits

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Second, data for both race and ethnicity (i.e., whether or not a person is of Hispanic or Latino origin) are collected according to current U.S. Census Bureau classifications when members apply for AHCCCS; however, the PMMIS system was designed long before current federal standards for collecting race and ethnicity were issued, and does not accommodate both data fields at this time. Data for race and ethnicity are merged into one field when 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. It also should be noted that people of Hispanic origin may be of any race, but they are reported as a separate racial category.

And, 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 added codes to identify some services for the numerators (nursing facility discharge day management). In addition, AHCCCS added Place of Service (POS) codes to better identify hospital emergency department and inpatient services, which should be excluded from the numerator for this measure.
- ***Breast Cancer Screening*** – NCQA added codes to include diagnostic, as well as screening, mammograms in the numerator.
- ***Cervical Cancer Screening*** – NCQA deleted a code that was used to identify a pelvic and clinical breast exam, which was previously counted toward the numerator, and added codes to exclude women who had laproscopic hysterectomies from the denominator.
- ***Children’s and Adolescent’s Access to Primary Care Practitioners; Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; and Adolescent Well-Care Visits*** – AHCCCS added Place of Service (POS) codes to better identify hospital emergency department and inpatient services, which should be excluded from the numerators for these measures. AHCCCS also added more codes to identify services provided by physicians’ assistants and nurse practitioners for inclusion in the numerators.
- ***Chlamydia Screening*** – NCQA decreased the upper age limit from 25 to 24 years and added codes to identify sexually active women for the denominator.

- **Timeliness of Prenatal Care** – NCQA added more codes to identify live births and prenatal services.

In addition to these changes, NCQA updates its methodology annually to add or delete codes that have been added or retired from standardized coding sets used by providers, such as Current Procedural Terminology (CPT) and International Classification of Diseases, Ninth Revision (ICD-9) coding. AHCCCS makes these coding changes as well.

It also should be noted that denominators for these measures increased from the previous year’s measurement, reflecting significant growth in the AHCCCS program. Some of the growth also may be attributed to the inclusion of more members who are covered under health plans’ Acute-care contracts (contract type A); primarily adults who are eligible under expanded eligibility up to 100 percent of the federal poverty level.

## HIGHLIGHTS OF THE DATA

### Results and Analysis

Measures of access to care and use of preventive services are included in this report. 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 three age groups also improved, while another age group did not show a statistically significant change. KidsCare rates for all age groups exceeded HEDIS national Medicaid means.
- **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 continues to exceed the national HEDIS Medicaid mean. The rate for KidsCare members also did not change significantly from the previous year, and is well above the national mean for Medicaid health plans.
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life** – Overall rates for both Medicaid and KidsCare members increased, with the rate for both Medicaid and KidsCare members exceeding the national Medicaid mean. The KidsCare rate also exceeds the national HEDIS commercial mean.
- **Adolescent Well-Care Visits** – Overall rates for both Medicaid and KidsCare members increased, and the rate for KidsCare members continues to exceed national Medicaid and commercial means.

- **Annual Dental Visits** – Overall rates for both Medicaid and KidsCare populations increased from the previous year and remain well above the national Medicaid mean, with the rate for KidsCare members in the 90th percentile of Medicaid plans nationally.
- **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 the national Medicaid means.
- **Breast Cancer Screening** – NCQA changed this measure to report a total rate for women ages 42 to 69; previously, separate rates were reported for women ages 42 to 51 and 52 to 69, as well as a total rate. AHCCCS continues to report only the age group of 52 to 69 with this measurement period. The rate for this measure increased from the previous year and exceeds the Medicaid mean reported for this age group in the previous year.
- **Cervical Cancer Screening** – This rate also increased from the previous measurement.
- **Chlamydia Screening** – The overall rate for this measurement increased over the previous year.
- **Timeliness of Prenatal Care** – This measure was the only one to show a decrease from the previous measurement.

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Nearly all AHCCCS rates showed significant increases and most exceeded HEDIS national Medicaid means

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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.

As with the previous measurement, there were some disparities in the Medicaid population by race/ethnicity in most measures, with members of Hispanic ethnicity often 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. 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) and tribal health programs or AHCCCS-contracted health plans. Claims for all services provided by IHS or tribal health care providers may not be included in AHCCCS encounter data. African-American members also appear to be less likely than non-Hispanic Whites to have some types of services. There were fewer disparities by race/ethnicity among KidsCare members.

For nearly all measures, rates were higher in urban areas of the state compared with rural areas. The exception was the measure of prenatal care, in which the rate in rural areas was significantly higher. Rates by county also were analyzed, although clear trends were not identified.

### Contractor Performance Standards and Improvement

Contractor rates are compared to Minimum Performance Standards, as specified in the AHCCCS CYE 2009 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 Goal for the measure. Minimum standards are based on the most recent HEDIS national Medicaid mean available from NCQA when the CYE 2009 contract was developed in late 2007 or, if the AHCCCS statewide average already was above the HEDIS mean, a rate slightly above the current rate (note that national HEDIS means have increased since the CYE 2009 contracts were awarded to health plans). The AHCCCS Goal is based on a national “Healthy People 2010” objective set by the U.S. Department of Health and Human Services several years ago.

#### Acute-care Performance Standards

Performance Measure	Minimum Performance Standard	Goal
Children’s Dental Visits 2 to 21*	55%	57%
Well-child Visits 15 Months*	65%	90%
Well-child Visits 3 - 6 Years*	64%	80%
Adolescent Well-care Visit*	41%	50%
Children’s Access to PCPs 12-24 Months*	93%	97%
Children’s Access to PCPs 25 months-6 Years*	83%	97%
Children’s Access to PCPs 7-11 Years*	83%	97%
Children’s Access to PCPs 12-19 Years*	81%	97%
Cervical Cancer Screening	65%	90%
Breast Cancer Screening	50%	70%
Adult Preventive/Ambulatory Care 20-44 Years	78%	96%
Adult Preventive/Ambulatory Care 45-64 Years	85%	96%
Timeliness of Prenatal Care	80%	90%
Chlamydia Screening	51%	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, has fewer performance standards than most other Acute-care Contractors. In addition, CMDP has too few KidsCare members to measure this population separately. Pima Health System also has fewer performance measures because it serves primarily Medicare-Medicaid dual-eligible adults and any eligible family members who wish to enroll in the plan under its Acute-care contract with AHCCCS.

### Contractor Performance

Contractor	Number of Measures in Which Contractor was Included	Number of Measures for Which MPS was Met	Percent of Measures for Which MPS was Met
Phoenix Health Plan	22	17	77.3
Mercy Care Plan	22	16	72.3
Care 1st Healthplan of Arizona	22	13	59.1
Arizona Physicians IPA	22	11	50.0
Maricopa Health Plan	22	11	50.0
Health Choice Arizona	22	8	36.7
University Family Care*	20	13	65.0
DES/CMDP	7	5	71.4
Pima Health System	4	2	50.0

\* University Family Care did not have enough KidsCare members who met the eligible population criteria for two measures.

Overall rates for nearly all measures increased because of significant increases demonstrated by several Contractors, despite the fact that AHCCCS raised most Minimum Performance Standards in the CYE 2009 contract, which applies to this measurement period. In July 2007, AHCCCS advised Contractors that it would levy financial sanctions if Contractors did not improve their performance, and this action appears to have encouraged health plans to implement interventions and apply the resources necessary to increase rates.

AHCCCS will request corrective action plans (CAPs) from Contractors to bring their rates up to compliance with minimum standards when Minimum Performance Standards are not met. 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 and are implementing new or revised actions to improve rates.

## CHILDREN'S AND ADOLESCENTS' 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.<sup>1,2</sup> In addition, routine primary and preventive care helps support healthy development and the ability to learn.<sup>3-5</sup>

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 (Oct. 1, 2007, through Sept. 30, 2008), 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 a Minimum Performance Standards by age group, which apply to both Medicaid and KidsCare members, for the current measurement, based on the most recent national Medicaid means reported by NCQA. AHCCCS also has set 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**

<b>Age Group</b>	<b>Minimum Performance Standard (MPS)</b>	<b>Goal</b>
12 – 24 Months	93%	97%
25 Months – 6 Years	83%	97%
7 – 11 Years	83%	97%
12 – 19 Years	81%	97%

**Results**

Rates for all age groups in the Medicaid population increased from the previous measurement (Table 1). KidsCare rates for three age groups increased, while the rate for one age group did not significantly change (Table 2).

In the current period, the total rate (all age groups combined) for Medicaid members was 80.8 percent, an increase from the previous rate of 76.7 percent in the previous year ( $p < .001$ ). The total rate for KidsCare members was 87.2 percent, an increase from 83.2 percent in the previous year ( $p < .001$ ). (you don’t have a “total rate” in the table above which makes this somewhat confusing.)

When total rates were analyzed by rural and urban counties, both Medicaid-and KidsCare-eligible members 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). However, there was no significant difference among Medicaid members 7 to 11 years old ( $p = .073$ ). Among KidsCare members, there was no significant difference between urban and rural areas among Medicaid-eligible 7 to 11 years of age and 12 to 19 years of age ( $p = .933$  and  $p = .892$ ).

Overall, Native American and Black Medicaid-eligible members were less likely than non-Hispanic Whites to have PCP visits (refer to Appendix A for detailed analysis by race/ethnicity). These results are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. AHCCCS Medicaid and KidsCare rates compare to the national means as follows:

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Rates for Medicaid members in all four age groups increased, while rates for KidsCare members in three age groups increased

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### AHCCCS Rates Compared with 2008 National HEDIS Means

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commerci al Mean
12 – 24 Months	85.0%	93.7%	93.4%	96.9%
25 Mos – 6 Years	81.6%	87.5%	84.3%	89.4%
7 – 11 Years	78.4%	86.2%	85.8%	89.5%
12 – 19 Years	80.0%	86.4%	82.6%	86.9%

#### **Discussion**

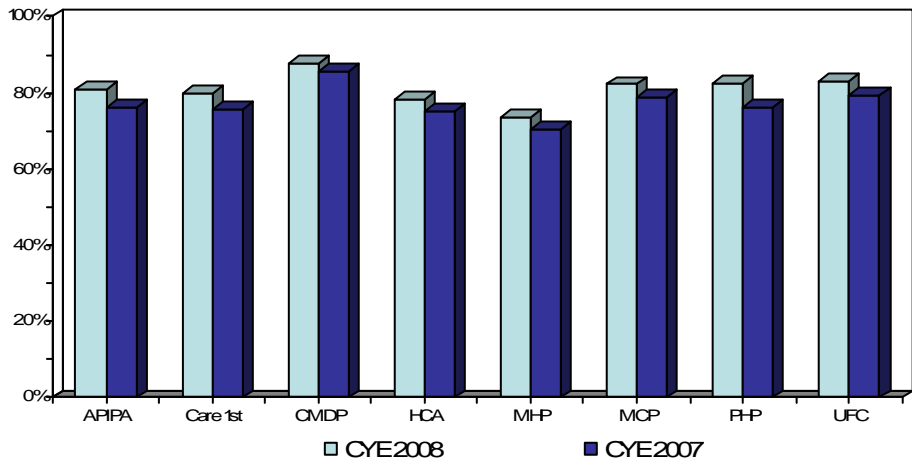
Children 24 months and younger typically have a higher rate of primary care visits because they are receiving immunizations that must be given at specific intervals, and are screened for developmental milestones during this period of rapid growth. After these “baby shots” are completed and children’s 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 Children’s and Adolescents’ Access to PCPs are highest for children 12 to 24 months.

Consistent with previous measurements, children enrolled with AHCCCS Contractors through KidsCare have higher 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 need for 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 non-Hispanic 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.

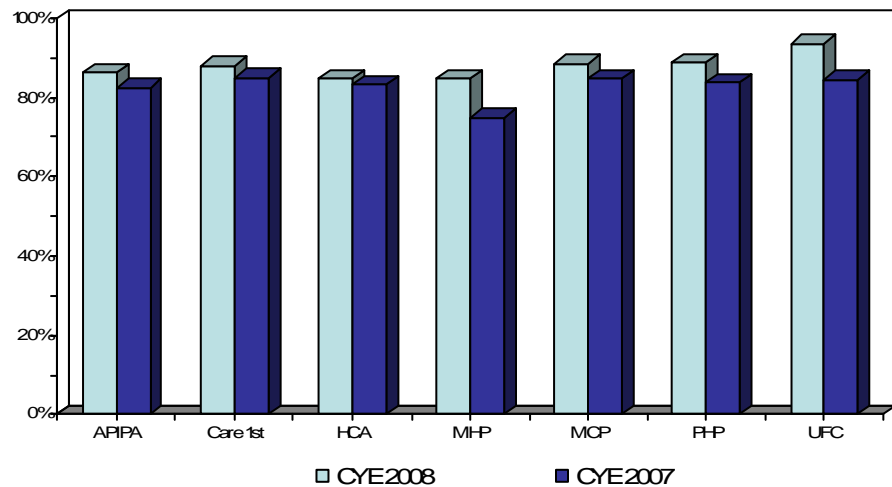
In the current measurement, DES/CMDP met the Minimum Performance Standard (MPS) for three of four age groups for Medicaid-eligible members. No other Contractor met as many minimum standards for that population. Three Contractors — Maricopa Health Plan, Mercy Care Plan and Phoenix Health Plan — each met the MPS for all four age groups among KidsCare members. While Contractors are evaluated on their rates by age group, Figures 1 and 2 show Contractor performance when all age groups are combined.

**Figure 1. Rates by Contractor, Children's Access to PCPs among Medicaid Members, All Age Groups Combined**  
 CYE 2008 compared with 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 (87.5 percent). CMDP is a 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 2. Rates by Contractor, Children's Access to PCPs among KidsCare Members, All Age Groups Combined**  
 CYE 2008 compared with CYE 2007



For KidsCare members, University Family Care recorded the highest total rate (93.6 percent).

















## 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.<sup>6</sup>

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).<sup>7</sup> The most recent national data, for 2007, show an estimated 19.8 percent of Arizona adults are current cigarette smokers.<sup>8</sup> Rates of smoking increase as income falls below the federal poverty level.<sup>7</sup>

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, a survey by the Centers for Disease Control and Prevention found that only 65.5 percent of Arizona adults had visited a doctor for a routine checkup in the preceding 12 months.<sup>6</sup>

### **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 (Oct. 1, 2007, through Sept. 30, 2008),
- 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 by age group for Adults' Access to Preventive/Ambulatory Health Services for the current measurement, based on the most recent national Medicaid means reported by NCQA. AHCCCS also has set 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
20 – 44 Years	78%	96%
45 – 64 Years	85%	96%

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

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**Results**

The total rate of both age groups combined increased in the current measurement, to 83.0 percent from 81.7 percent in the previous year (p<.001). Rates for both age groups also showed statistically significant increases (Table 3).

When total rates were analyzed by rural and urban counties, members in both age groups and overall who resided in urban counties were more likely to have preventive and ambulatory visits than those in rural counties (p<.001 for both groups and overall).

Among members 20 to 44 years of age and overall, non-Hispanic Whites were more likely to have visits than other racial or ethnic groups (refer to Appendix A for detailed analysis by race/ethnicity). There were no significant differences in the age group 45 to 64 years old. In the previous measurement, only Black members were less likely to have visits than non-Hispanic Whites.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. The AHCCCS rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
20 – 44 Years	81.0%	76.8%	93.0%
45 – 64 Years	86.7%	82.4%	95.1%

**Discussion**

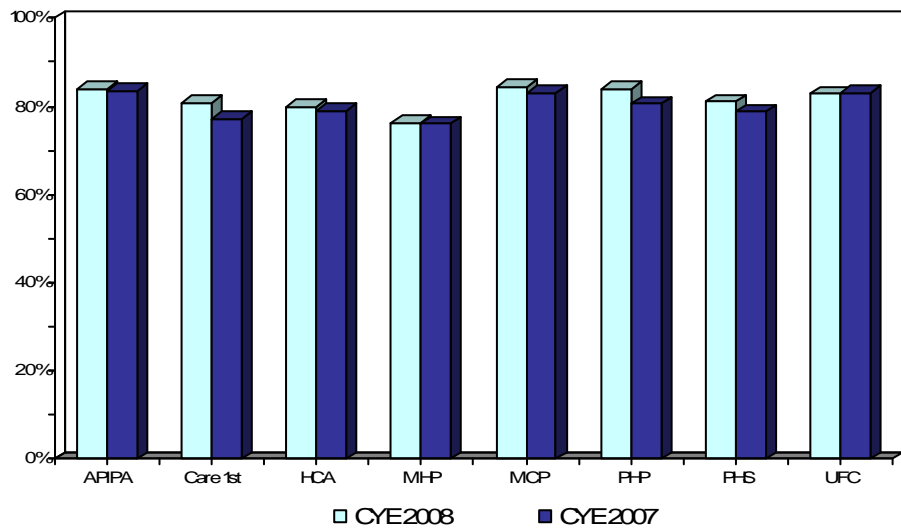
Ensuring that adult members use preventive services is challenging. This may be due to lack of awareness among members about when and what types of routine preventive health services are recommended, skepticism about the effectiveness of prevention or avoidance — especially if a person is engaging in 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.

Five Contractors — Arizona Physicians IPA, Care1st Healthplan, 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 3 shows Contractor performance when both age groups are combined.

**Figure 3. Rates by Contractor, Both Age Groups of Adults Combined, Medicaid Members**

CYE 2008 compared with CYE 2007

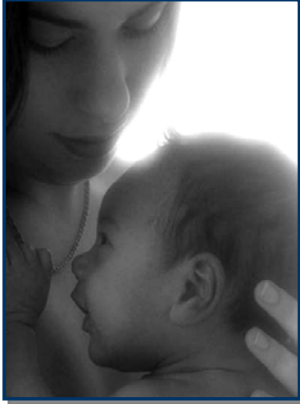


Mercy Care Plan showed the highest rate (84.2 percent) for Adults' Access to Preventive/Ambulatory Health Services when both age groups were combined.





## 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.<sup>9</sup>

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 (Oct. 1, 2007, through Sept. 30, 2008),
- 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 a Minimum Performance Standard that applies to both Medicaid and KidsCare members for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal 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
Well-Child Visits, 15 Months	65%	90%

### Results

The overall rate for Medicaid members (Table 4) was unchanged, at 59.5 percent, compared with 59.4 percent in the previous measurement (p=.857). The overall rate for KidsCare members (Table 5) did not show a statistically significant increase, with a rate of 71.3 percent, compared with 68.6 percent in the previous measurement (p=.221).

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). Rates between urban and rural counties for KidsCare members did not show a statistically significant difference (p=.057).

Overall, Native American and Black Medicaid-eligible members were less likely than non-Hispanic Whites to have visits (refer to Appendix A for detailed analysis by race/ethnicity). These results are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. AHCCCS Medicaid and KidsCare rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commerci al Mean
Six Well Child Visits by 15 Months of Age	59.5%	71.3%	53.0%	72.8%

**Discussion**

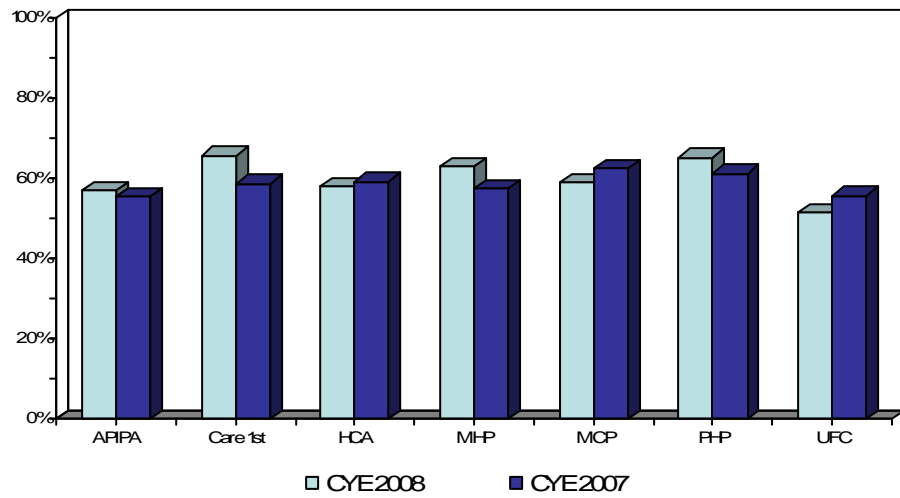
While the AHCCCS overall rate for Well Child Visits in the First 15 Months of Life among Medicaid members is above the national mean, there is still room for improvement in this rate, given the goal that AHCCCS has established.

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, as part of Contractors’ efforts to ensure that all members receive necessary preventive services in the first 15 months of life.

Care1st Healthplan and Phoenix Health Plan met the Minimum Performance Standard for Medicaid-eligible children, while all Contractors met the MPS for the KidsCare population.

**Figure 4. Rates by Contractor, Well-Child Visits in the First 15 Months of Life, Medicaid Members**

CYE 2008 compared with CYE 2007



Care1st Healthplan had the highest rate for this measure in the current period (65.8 percent). Rates by Contractor for KidsCare members are not compared with the previous measurement, as individual Contractor rates for CYE 2007 were not reported for this population.

**Table 4**  
**Arizona Health Care Cost Containment System**  
**WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER MEDICAID**  
**Measurement Period: Oct. 1, 2007, to Sept. 30, 2008**

**Minimum Performance Standard:**

**65**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number with 6+ Visits	Percent with 6+ Visits	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	5,150	2,937	57.0%	2.8%	p=.187
AZ Physicians IPA	2795	1551	55.5%		
<b>Care1st Healthplan</b>	758	499	<b>65.8%</b>	12.1%	p=.014
Care1st Healthplan	431	253	58.7%		
<b>Health Choice AZ</b>	2,752	1,596	58.0%	-2.2%	p=.408
Health Choice AZ	1,494	886	59.3%		
<b>Maricopa Health Plan</b>	835	526	63.0%	9.7%	p=.052
Maricopa Health Plan	444	255	57.4%		
<b>Mercy Care Plan</b>	6,011	3,545	59.0%	-5.7%	p=.001
Mercy Care Plan	3,230	2,021	62.6%		
<b>Phoenix Health Plan</b>	2,315	1,511	<b>65.3%</b>	6.6%	p=.016
Phoenix Health Plan	1,263	773	61.2%		
<b>University Family Care</b>	95	49	51.6%	-7.5%	p=.611
University Family Care	61	34	55.7%		
<b>TOTAL</b>	17,916	10,663	59.5%	0.2%	p=.857
TOTAL	9,718	5,773	59.4%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

**Table 5**  
**Arizona Health Care Cost Containment System**  
**WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER KIDSCARE**  
**Measurement Period: Oct. 1, 2007, to Sept. 30, 2008**

**Minimum Performance Standard:** **65**  
Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number with 6+ Visits	Percent with 6+ Visits	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	467	322	<b>69.0%</b>	11.2%	p=.070
AZ Physicians IPA	221	137	62.0%		
<b>Care1st Healthplan</b>	81	59	<b>72.8%</b>	8.1%	p=.516
Care1st Healthplan	46	31	67.4%		
<b>Health Choice AZ</b>	282	184	<b>65.2%</b>	-8.7%	p=.251
Health Choice AZ	105	75	71.4%		
<b>Maricopa Health Plan</b>	85	63	<b>74.1%</b>	61.7%	p=.009
Maricopa Health Plan	24	11	45.8%		
<b>Mercy Care Plan</b>	620	453	<b>73.1%</b>	-0.7%	p=.858
Mercy Care Plan	307	226	73.6%		
<b>Phoenix Health Plan</b>	244	187	<b>76.6%</b>	4.6%	p=.507
Phoenix Health Plan	101	74	73.3%		
<b>TOTAL</b>	1,779	1,268	<b>71.3%</b>	3.4%	p=.221
TOTAL	804	554	68.9%		

Notes:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

University Family Care did not have enough KidsCare members in this age group who met the criteria for the eligible population to be included in the measurement

## WELL CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE



Children who are healthy are better able to learn and develop.<sup>10,11</sup> 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 (Oct. 1, 2007, through Sept. 30, 2008),
- 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 a Minimum Performance Standard that applies to both Medicaid and KidsCare members for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on national Healthy People 2010 objectives. These are shown in the following table:

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

Age Group	Minimum Performance Standard (MPS)	Goal
Well-Child Visits, 3 through 6 Years	64%	80%

### Results

The overall rate for Medicaid members (Table 6) increased to 66.2 percent from 61.6 percent in the previous measurement ( $p < .001$ ). The rate for KidsCare members (Table 7) also increased, to 73.4 percent from 68.2 percent in the previous year ( $p < .001$ ).

---

Rates for both Medicaid and KidsCare members exceed the national means for Medicaid plans, and the KidsCare rate exceeds the commercial health plan mean

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When analyzed by rural and urban county groups, Medicaid-eligible members in urban counties were more likely to have visits than members in rural areas (p<.001). The same was true for KidsCare members (p<.001). These results are consistent with the previous measurement.

For Medicaid members, Native Americans were less likely than non-Hispanic Whites to have well child visits, while Hispanic members were more likely to have visits (refer to Appendix A for detailed analysis by race/ethnicity). These results also are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. AHCCCS Medicaid and KidsCare rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Well-Child Visits, 3 through 6 Years	66.2%	73.4%	65.3%	67.8%

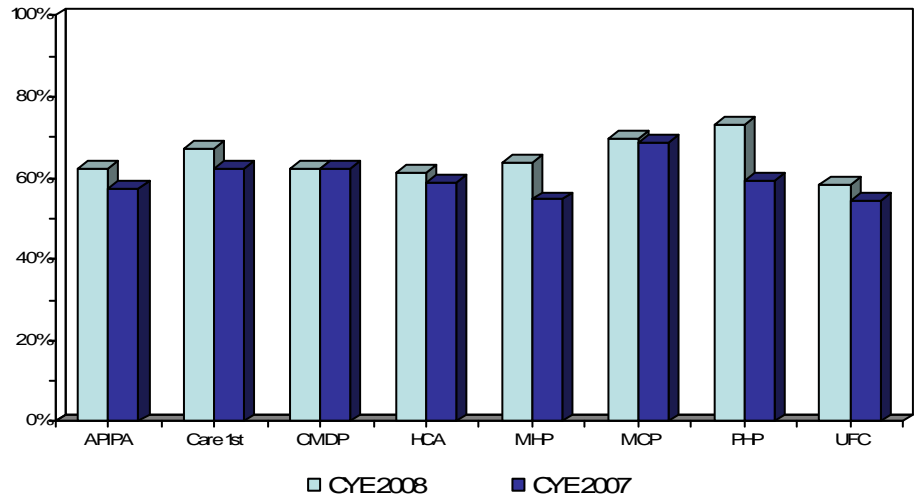
**Discussion**

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.

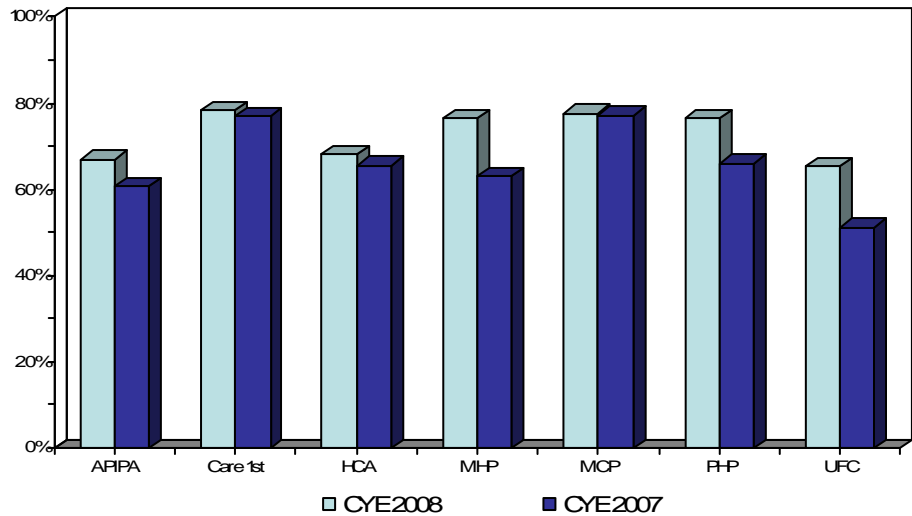
Care1st Healthplan, Mercy Care Plan and Phoenix Health Plan met the Minimum Performance Standard for Medicaid-eligible children, while all Contractors met the MPS for the KidsCare population.

**Figure 5. Rates by Contractor, Well-Child Visits in Third through Sixth Years of Life, Medicaid Members**  
 CYE 2008 compared with CYE 2007



Phoenix Health Plan had the highest rate of well-child visits for Medicaid members in this age group in the current period (73.0 percent). Six Contractors met the MPS for Medicaid-eligible children.

**Figure 6. Rates by Contractor, Well-Child Visits in the Third through Sixth Years of Life, KidsCare Members**  
 CYE 2008 compared with CYE 2007



Care1st Healthplan had the highest rate for KidsCare members in the current period (78.4 percent). Six Contractors met the AHCCCS MPS for this population.

**Table 6**  
**Arizona Health Care Cost Containment System**  
**WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER MEDICAID**  
**Measurement Period: Oct. 1, 2007, through Sept. 30, 2008**

**Minimum Performance Standard:**

**64**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number with 1+ Visits	Percent with 1+ Visits	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	22,087	13,795	62.5%	8.5%	p<.001
AZ Physicians IPA	21,516	12,385	57.6%		
<b>Care1st Healthplan</b>	2,837	1,911	<b>67.4%</b>	7.9%	p<.001
Care1st Healthplan	2,400	1,498	62.4%		
<b>DES/CMDP</b>	1,084	678	62.5%	0.0%	p=.995
DES/CMDP	1,097	686	62.5%		
<b>Health Choice AZ</b>	11,045	6,777	61.4%	3.9%	p=.001
Health Choice AZ	9,782	5,776	59.0%		
<b>Maricopa Health Plan</b>	3,297	2,102	63.8%	16.6%	p<.001
Maricopa Health Plan	3,355	1,835	54.7%		
<b>Mercy Care Plan</b>	23,938	16,647	<b>69.5%</b>	1.1%	p=.089
Mercy Care Plan	21,693	14,926	68.8%		
<b>Phoenix Health Plan</b>	9,700	7,085	<b>73.0%</b>	23.4%	p<.001
Phoenix Health Plan	8,906	5,273	59.2%		
<b>University Family Care</b>	600	351	58.5%	7.6%	p=.128
University Family Care	765	416	54.4%		
<b>TOTAL</b>	74,588	49,346	66.2%	7.5%	p<.001
TOTAL	69,514	42,795	61.6%		

Note:

Results of previous measurement period (Oct. 1, 2006 through Sept. 30, 2007) shown in shaded rows.

**Table 7**  
**Arizona Health Care Cost Containment System**  
**WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER KIDSCARE**  
**Measurement Period Oct. 1, 2007, to Sept. 30, 2008**

**Minimum Performance Standard:**

**64**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number with 1+ Visits	Percent with 1+ Visits	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	2,200	1,475	<b>67.0%</b>	10.7%	p<.001
AZ Physicians IPA	2,286	1,385	60.6%		
<b>Care1st Healthplan</b>	375	294	<b>78.4%</b>	2.0%	p=.634
Care1st Healthplan	307	236	76.9%		
<b>Health Choice AZ</b>	1,123	764	<b>68.0%</b>	3.7%	p=.229
Health Choice AZ	1,014	665	65.6%		
<b>Maricopa Health Plan</b>	423	323	<b>76.4%</b>	21.5%	p<.001
Maricopa Health Plan	463	291	62.9%		
<b>Mercy Care Plan</b>	2,840	2,204	<b>77.6%</b>	0.8%	p=.596
Mercy Care Plan	2,758	2,124	77.0%		
<b>Phoenix Health Plan</b>	1,537	1,176	<b>76.5%</b>	16.1%	p<.001
Phoenix Health Plan	1,578	1,040	65.9%		
<b>University Family Care</b>	26	17	<b>65.4%</b>	27.9%	p=.243
University Family Care	45	23	51.1%		
<b>TOTAL</b>	8,524	6,253	<b>73.4%</b>	7.6%	p<.001
<b>TOTAL</b>	8,451	5,764	<b>68.2%</b>		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

## 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.<sup>6,12</sup>

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.<sup>13</sup> Several national studies show higher rates of overweight, low fitness, and diabetes among Hispanic and Black adolescents, compared with White adolescents.<sup>14</sup>

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 (Oct. 1, 2007, through Sept. 30, 2008),
- 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 a Minimum Performance Standard that applies to both Medicaid and KidsCare members for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on national Healthy People 2010 objectives. These are shown in the following table:

**AHCCCS Performance Standards for Adolescent Well Care Visits**

Age Group	Minimum Performance Standard (MPS)	Goal
Adolescent Well-Care Visits	41%	50%

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

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**Results**

The overall Medicaid rate for this measure (Table 8) improved to 41.6 percent from 36.3 percent in the previous period (p<.001). The rate for KidsCare members (Table 9) also improved, to 51.6 percent from 43.7 percent in the previous period (p<.001).

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). These results are consistent with the previous measurement period.

Among Medicaid members, Native Americans were less likely to have well care visits than non-Hispanic White members, while Hispanic and African-American members were more likely to have visits (refer to Appendix A for detailed analysis by race/ethnicity).

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. AHCCCS Medicaid and KidsCare rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

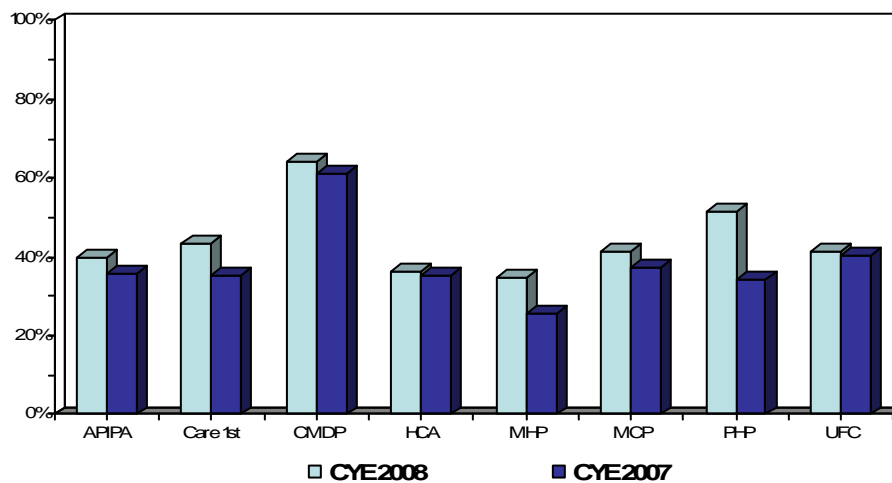
Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Adolescent Well Care Visits	41.6%	51.6%	42.0%	41.8%

**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 rates achieved by some Contractors are encouraging and warrant exploration of strategies used to get these members in for well visits.

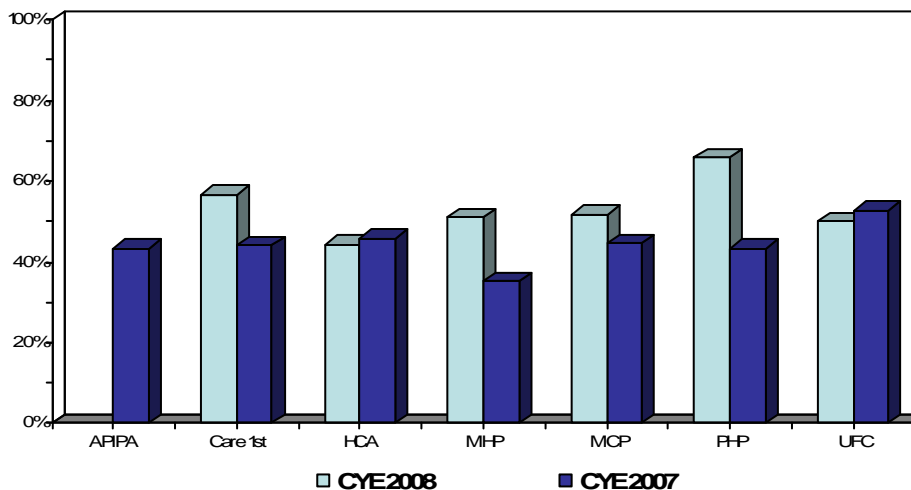
The low rate among Native American youth may be affected by data collection issues, as previously noted (i.e., if services are obtained through IHS, they will not be encountered in this measurement). It also may be that this population is even less likely to obtain health care services when they perceive no need. Given that the death rate in Arizona for Native American adolescents is twice that of non-Hispanic White teens,<sup>11</sup> it is important that health plans pay attention to this population to try to reduce their risk of disease and premature death.

**Figure 7. Rates by Contractor, Adolescent Well-Care Visits, Medicaid Members**  
 CYE 2008 compared with CYE 2007



CMDP had the highest rate of Adolescent Well Care visits among the Medicaid population (64.3 percent).

**Figure 8. Rates by Contractor, Adolescent Well-Care Visits, KidsCare Members**  
 CYE 2008 compared with CYE 2007



Phoenix Health Plan had the highest rate for the KidsCare population (65.8 percent), as shown in Figure 18.

Five Contractors met the Minimum Performance Standard for Medicaid members in the current measurement, and all Contractors met the MPS for the KidsCare population.

**Table 8**  
**Arizona Health Care Cost Containment System**  
**ADOLESCENT WELL-CARE VISITS BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER MEDICAID**  
**Measurement Period: Oct. 1, 2007 through Sept. 30, 2008**

**Minimum Performance Standard:**

**41**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number with 1+ Visits	Percent with 1+ Visits	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	31,969	12,732	39.8%	10.7%	p<.001
AZ Physicians IPA	27,693	9,964	36.0%		
<b>Care1st Healthplan</b>	2,419	1,050	<b>43.4%</b>	23.4%	p<.001
Care1st Healthplan	2,058	724	35.2%		
<b>DES/CMDP</b>	1,700	1,093	<b>64.3%</b>	5.5%	p=.043
DES/CMDP	1,757	1,071	61.0%		
<b>Health Choice AZ</b>	11,762	4,264	36.3%	2.4%	p=.207
Health Choice AZ	9,442	3,344	35.4%		
<b>Maricopa Health Plan</b>	3,579	1,242	34.7%	34.5%	p<.001
Maricopa Health Plan	3,163	816	25.8%		
<b>Mercy Care Plan</b>	26,628	11,072	<b>41.6%</b>	11.3%	p<.001
Mercy Care Plan	21,075	7,876	37.4%		
<b>Phoenix Health Plan</b>	10,238	5,275	<b>51.5%</b>	50.3%	p<.001
Phoenix Health Plan	8,480	2,907	34.3%		
<b>University Family Care</b>	1,296	539	<b>41.6%</b>	3.1%	p=.514
University Family Care	1,319	532	40.3%		
<b>Total</b>	89,591	37,267	<b>41.6%</b>	14.5%	p<.001
Total	74,987	27,234	36.3%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

**Table 9**  
**Arizona Health Care Cost Containment System**  
**ADOLESCENT WELL-CARE VISITS BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER KIDSCARE**  
**Measurement Period: Oct. 1, 2007 through Sept. 30, 2008**

**Minimum Performance Standard: 41**  
Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number with 1+ Visits	Percent with 1+ Visits	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	4,330	2,066	<b>47.7%</b>	10.4%	p<.001
AZ Physicians IPA	4,493	1,942	43.2%		
<b>Care1st Healthplan</b>	344	195	<b>56.7%</b>	28.9%	p=.001
Care1st Healthplan	341	150	44.0%		
<b>Health Choice AZ</b>	1,488	660	<b>44.4%</b>	-3.1%	p=.454
Health Choice AZ	1,311	600	45.8%		
<b>Maricopa Health Plan</b>	548	279	<b>50.9%</b>	45.2%	p<.001
Maricopa Health Plan	502	176	35.1%		
<b>Mercy Care Plan</b>	3,669	1,894	<b>51.6%</b>	15.6%	p<.001
Mercy Care Plan	3,582	1,599	44.6%		
<b>Phoenix Health Plan</b>	1,868	1,229	<b>65.8%</b>	51.8%	p<.001
Phoenix Health Plan	1,804	782	43.3%		
<b>University Family Care</b>	94	47	<b>50.0%</b>	-4.9%	p=.691
University Family Care	154	81	52.6%		
<b>Total</b>	12,341	6,370	<b>51.6%</b>	18.0%	p<.001
Total	12,187	5,330	43.7%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

## 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.<sup>15,16</sup>

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.<sup>16</sup> Routine dental visits also serve to educate individuals about dental hygiene and preventive measures. The American Association of Pediatric Dentistry recommends that dental visits begin 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 (Oct. 1, 2007, through Sept. 30, 2008),
- 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 a Minimum Performance Standard that applies to both Medicaid and KidsCare members for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on national Healthy People 2010 objectives. These are shown in the following table:

**AHCCCS Performance Standards for Annual Dental Visits**

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

Rates for both Medicaid and KidsCare are well above the national mean for Medicaid health plans

**Results**

Among Medicaid members (Table 10), the overall rate increased to 60.9 percent from 57.6 percent in the previous year (p<.001). Among KidsCare members (Table 11), the rate also increased, to 71.8 percent from 68.6 percent in the previous year (p<.001).

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). These results are consistent with the previous measurement.

Among Medicaid members, Native American and Black members were less likely to have dental visits, while Hispanic members were more likely to have visits (refer to Appendix A for detailed analysis of results by race/ethnicity). These results also are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid health plans, based on the 2008 measurement year. The HEDIS measure does not apply to commercial health plans because dental services are usually provided through a separate organization. Because AHCCCS Medicaid and KidsCare rates compare favorably to the 90th percentile of Medicaid plans nationally, that rate is also shown. AHCCCS Medicaid and KidsCare rates compare to national means as follows:

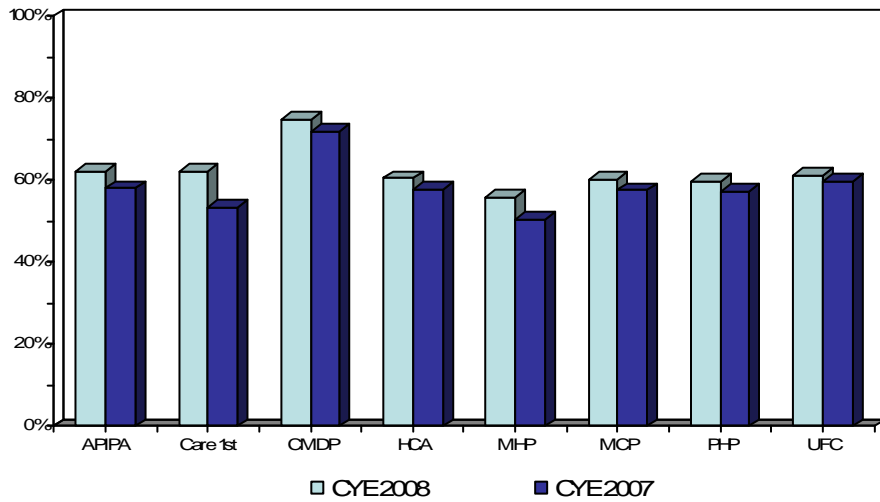
**AHCCCS Rates Compared with 2007 National HEDIS Means**

Measure/ Age Group	AHCCCS Medicaid Rate	AHCCCS KidsCare Rate	HEDIS Medicaid Mean	Medicaid 90th Percentile
Annual Dental Visits, 2 through 21 Years	60.9%	71.8%	43.5%	61.3%

**Discussion**

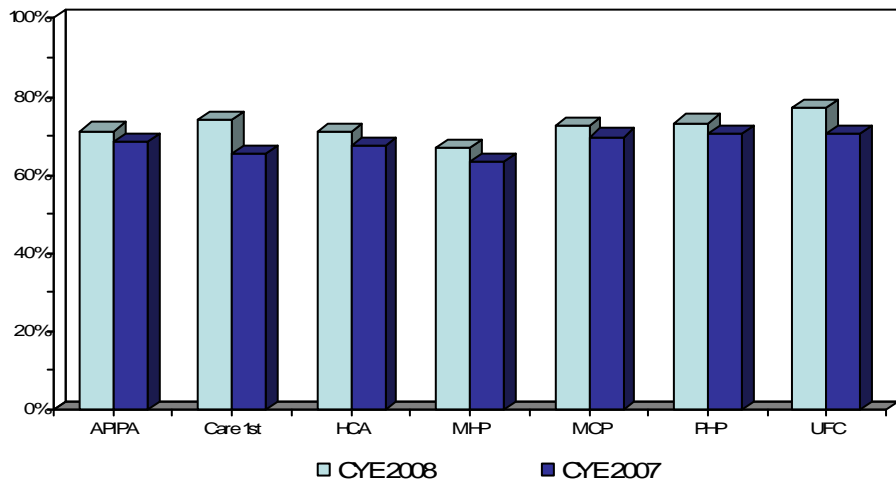
Over the last several years, AHCCCS has focused much attention on improving rates of dental services among enrolled children and adolescents. In 2003, the Agency implemented a Performance Improvement Project (PIP), which required all Acute-care Contractors to show statistically significant improvement in rates of annual dental visits. This PIP and other 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, the rate of annual dental visits is lower than some other preventive services. More work needs to be done to ensure that children and adolescents, particularly those that are Native American or Black, have regular dental checkups.

**Figure 9. Rates by Contractor, Annual Dental Visits, Medicaid Members**  
 CYE 2008 compared with CYE 2007



CMDP had the highest rate of Annual Dental Visits for Medicaid members in the current measurement (74.9 percent). All Contractors met the Minimum Performance Standard.

**Figure 10. Rates by Contractor, Annual Dental Visits, KidsCare Members**  
 CYE 2008 compared with CYE 2007



For the KidsCare population, University Family Care achieved the highest rate (77.0 percent). All Contractors achieved the AHCCCS MPS for this population as well.

**Table 10**  
**Arizona Health Care Cost Containment System**  
**ANNUAL DENTAL VISITS, AGES 2-21, BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER MEDICAID**  
**Measurement Period: Oct. 1, 2007, through Sept. 30, 2008**

**Minimum Performance Standard:**

**55**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Number of Members</b>	<b>Number Receiving Dental Services</b>	<b>Percent Receiving Dental Services</b>	<b>Relative Percent Change from Previous Year</b>	<b>Statistical Significance</b>
<b>AZ Physicians IPA</b>	83,757	52,050	<b>62.1%</b>	7.2%	p<.001
AZ Physicians IPA	77,404	44,868	58.0%		
<b>Care1st Healthplan</b>	8,040	5,004	<b>62.2%</b>	16.5%	p<.001
Care1st Healthplan	7,182	3,837	53.4%		
<b>DES/CMDP</b>	4,118	3,083	<b>74.9%</b>	4.3%	p=.002
DES/CMDP	4,260	3,059	71.8%		
<b>Health Choice AZ</b>	36,075	21,829	<b>60.5%</b>	4.4%	p<.001
Health Choice AZ	31,038	17,983	57.9%		
<b>Maricopa Health Plan</b>	10,945	6,113	<b>55.9%</b>	10.7%	p<.001
Maricopa Health Plan	10,324	5,207	50.4%		
<b>Mercy Care Plan</b>	79,538	47,851	<b>60.2%</b>	4.4%	p<.001
Mercy Care Plan	68,166	39,277	57.6%		
<b>Phoenix Health Plan</b>	31,572	18,821	<b>59.6%</b>	3.8%	p<.001
Phoenix Health Plan	28,161	16,174	57.4%		
<b>University Family Care</b>	2,876	1,763	<b>61.3%</b>	2.8%	p=.186
University Family Care	3,166	1,888	59.6%		
<b>TOTAL</b>	256,921	156,514	<b>60.9%</b>	5.8%	p<.001
<b>TOTAL</b>	229,701	132,293	57.6%		

Notes:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

**Table 11**  
**Arizona Health Care Cost Containment System**  
**ANNUAL DENTAL VISITS, AGES 2-19, BY CONTRACTOR**  
**MEMBERS ELIGIBLE UNDER KIDSCARE**  
**Measurement Period: Oct. 1, 2007, through Sept. 30, 2008**

**Minimum Performance Standard:**

**55**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Number of Members</b>	<b>Number Receiving Dental Services</b>	<b>Percent Receiving Dental Services</b>	<b>Relative Percent Change from Previous Year</b>	<b>Statistical Significance</b>
<b>AZ Physicians IPA</b>	10,760	7,672	<b>71.3%</b>	4.4%	p<.001
AZ Physicians IPA	11,019	7,523	68.3%		
<b>Care1st Healthplan</b>	1,120	828	<b>73.9%</b>	13.4%	p<.001
Care1st Healthplan	1,095	714	65.2%		
<b>Health Choice AZ</b>	4,497	3,188	<b>70.9%</b>	5.3%	p<.001
Health Choice AZ	4,038	2,718	67.3%		
<b>Maricopa Health Plan</b>	1,709	1,145	<b>67.0%</b>	5.8%	p=.026
Maricopa Health Plan	1,628	1,031	63.3%		
<b>Mercy Care Plan</b>	10,998	7,965	<b>72.4%</b>	4.1%	p<.001
Mercy Care Plan	10,850	7,550	69.6%		
<b>Phoenix Health Plan</b>	5,937	4,344	<b>73.2%</b>	3.8%	p=.001
Phoenix Health Plan	6,001	4,232	70.5%		
<b>University Family Care</b>	183	141	<b>77.0%</b>	9.3%	p=.118
University Family Care	288	203	70.5%		
<b>TOTAL</b>	35,204	25,283	<b>71.8%</b>	4.6%	p<.001
<b>TOTAL</b>	34,919	23,971	68.6%		

Notes:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

## 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.<sup>17</sup>

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.<sup>18</sup> On average, nearly 700 Arizona women die of breast cancer each year.<sup>19</sup>

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.<sup>20</sup>

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.<sup>17,21,22</sup> However, results from a recent study of managed care plan members showed declining screening rates from 1999 to 2002.<sup>18</sup>

### **Description**

AHCCCS measured the percentage of members who:

- were ages 52 through 69 years at the end of the two-year measurement period (Oct. 1, 2006, through Sept. 30, 2008),
- 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 a Minimum Performance Standard for Breast Cancer Screening for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on a comparable national Healthy People 2010 objective. These are shown in the following table:

**AHCCCS Performance Standards for Breast Cancer Screening**

	<b>Minimum Performance Standard (MPS)</b>	<b>Goal</b>
Breast Cancer Screening, 52 – 69 Years	54%	70%

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The AHCCCS rate increased, and exceeds the national mean for Medicaid health plans

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**Results**

In the current period, the overall rate for breast cancer screening (Table 12) among women 52 to 69 years of age was 62.3 percent, an increase from the previous rate of 51.8 percent (p<.001).

When rates were analyzed by rural and urban counties, there was no significant difference in members receiving mammograms between rural and urban counties (p=.683). These results are consistent with the previous measurement.

Hispanic members were somewhat more likely than other groups to have mammograms for breast cancer screening, with no other differences based on race/ethnicity (refer to Appendix A for detailed analysis of results by race/ethnicity). These results also are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. The AHCCCS rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

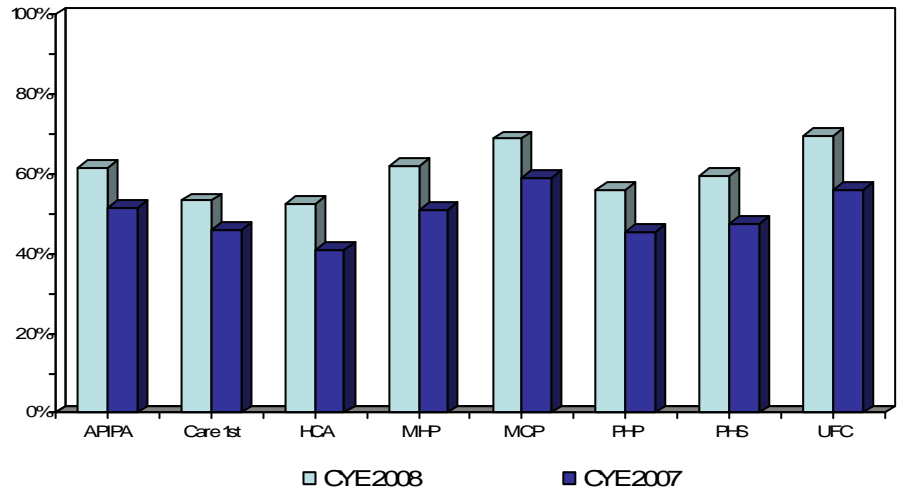
<b>Measure/ Age Group</b>	<b>AHCCCS Medicaid Rate</b>	<b>HEDIS Medicaid Mean</b>	<b>HEDIS Commercial Mean</b>
Breast Cancer Screening, 52 – 69 Years	62.3%	54.8%	71.6%

**Discussion**

Identification of tumors while they are still localized and potentially curable can significantly reduce breast cancer mortality.<sup>23</sup> However many women do not obtain mammograms at the recommended one- to two-year intervals. A significant percentage of women responding to a National Cancer Institute survey said they did not have a mammogram because they did not know they needed one or their doctor had not recommended one.<sup>23</sup> Women of some 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.<sup>24-26</sup>

**Figure 11. Rates by Contractor, Breast Cancer Screening among Medicaid Members**

CYE 2008 compared with CYE 2007



University Family Care had the highest rate of breast cancer screening (69.6percent). Six Contractors met the AHCCCS minimum standard for this measure.

**Table 12**  
**Arizona Health Care Cost Containment System**  
**BREAST CANCER SCREENING, AGES 52-69 YEARS, BY CONTRACTOR**  
**Measurement Period: Oct. 1, 2006, through Sept. 30, 2008**

**Minimum Performance Standard:**

**54**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number Receiving Mammograms	Percent Receiving Mammograms	Relative Percent Change from Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	6,663	4,101	<b>61.5%</b>	19.3%	p<.001
	3,637	1,876	51.6%		
<b>Care1st Healthplan</b>	503	268	53.3%	16.3%	p=.047
	275	126	45.8%		
<b>Health Choice AZ</b>	2,024	1,062	52.5%	27.5%	p<.001
	1,123	462	41.1%		
<b>Maricopa Health Plan</b>	612	380	<b>62.1%</b>	21.2%	p=.001
	410	210	51.2%		
<b>Mercy Care Plan</b>	5,862	4,033	<b>68.8%</b>	16.9%	p<.001
	3,060	1,801	58.9%		
<b>Phoenix Health Plan</b>	1,584	886	<b>55.9%</b>	23.1%	p<.001
	1,034	470	45.5%		
<b>Pima Health System</b>	635	378	<b>59.5%</b>	25.7%	p<.001
	321	152	47.4%		
<b>University Family Care</b>	339	236	<b>69.6%</b>	24.2%	p=.001
	232	130	56.0%		
<b>TOTAL</b>	18,222	11,344	<b>62.3%</b>	20.2%	p<.001
	10,092	5,227	51.8%		

Notes:

Results of the previous measurement period (Oct. 1, 2005, through Sept. 30, 2007) shown in shaded rows

## CERVICAL CANCER SCREENING



The American Cancer Society estimates that more than 11,000 new cases of invasive cervical cancer were diagnosed in the United States in 2009, and that more than 4,000 women died from the disease last year. Approximately half of deaths due to cervical cancer occur in women who were not screened at timely intervals.<sup>27</sup>

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.<sup>24</sup> 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, Oct. 1, 2007, through Sept. 30, 2008),
- 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 a Minimum Performance Standard for Cervical Cancer Screening for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on a comparable national Healthy People 2010 objective. These are shown in the following table:

**AHCCCS Performance Standards for Cervical Cancer Screening**

	Minimum Performance Standard (MPS)	Goal
Cervical Cancer Screening	65%	90%

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

**Results**

The overall rate of cervical cancer screening (Table 13) increased in the current measurement, to 63.2 percent from 62.2 percent in the previous year (p<.001).

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). These results are consistent with the previous measurement.

Hispanic and Black members were more likely than non-Hispanic Whites to have a Pap test, while Native American members were less likely (refer to Appendix A for detailed analysis of results by race/ethnicity). In the previous measurement, only Hispanic members were more like to have Pap tests, while Native Americans still lagged behind non-Hispanic white members in the rate of Pap tests.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. The AHCCCS rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

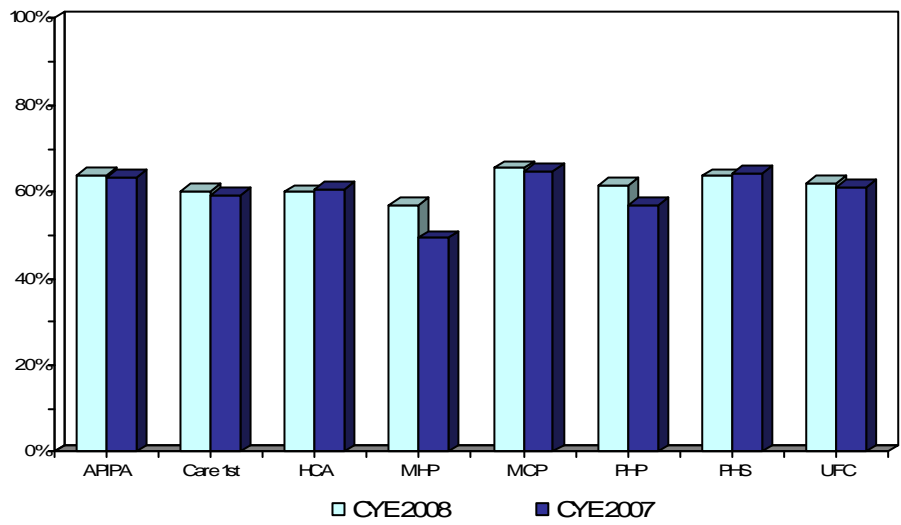
Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Cervical Cancer Screening	63.2%	64.8%	81.7%

**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.<sup>26,27</sup>

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 12. Rates by Contractor, Cervical Cancer Screening among Medicaid Members**  
CYE 2008 compared with CYE 2007



Mercy Care Plan (MCP) had the highest rate (65.4 percent) and was the only Contractor that met the AHCCS Minimum Performance Standard for this measure.

**Table 13**  
**Arizona Health Care Cost Containment System**  
**CERVICAL CANCER SCREENING BY CONTRACTOR**  
**Measurement Period: Oct. 1, 2007, through Sept. 30, 2008**

**Minimum Performance Standard:**

**65**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Number of Members</b>	<b>Number Receiving Pap Tests</b>	<b>Percent Receiving Pap Tests</b>	<b>Relative Percent Change From Previous Year</b>	<b>Statistical Significance</b>
<b>AZ Physicians IPA</b>	31,631	20,186	63.8%	0.7%	p=.302
AZ Physicians IPA	20,742	13,145	63.4%		
<b>Care1st</b>	2,861	1,720	60.1%	1.5%	p=.551
Care1st	1,860	1,102	59.2%		
<b>Health Choice AZ</b>	12,424	7,437	59.9%	-1.1%	p=.331
Health Choice AZ	7,764	4,701	60.5%		
<b>Maricopa Health Plan</b>	2,521	1,437	57.0%	15.7%	p<.001
Maricopa Health Plan	1,756	865	49.3%		
<b>Mercy Care Plan</b>	29,041	18,992	<b>65.4%</b>	1.2%	p=.083
Mercy Care Plan	18,214	11,769	64.6%		
<b>Phoenix Health Plan</b>	8,793	5,427	61.7%	8.1%	p<.001
Phoenix Health Plan	5,986	3,418	57.1%		
<b>Pima Health System</b>	3,428	2,181	63.6%	-1.0%	p=.635
Pima Health System	1,948	1,252	64.3%		
<b>University Family Care</b>	1,117	690	61.8%	0.9%	p=.804
University Family Care	908	556	61.2%		
<b>TOTAL</b>	91,816	58,070	63.2%	1.7%	p<.001
TOTAL	59,178	36,808	62.2%		

Results of previous measurement period (Oct. 1, 2006 through Sept. 30, 2007) shown in shaded rows.

## 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.<sup>28</sup>

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 24 years at the end of the measurement period (Oct. 1, 2007, through Sept. 30, 2008),
- 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 a Minimum Performance Standard for Chlamydia Screening for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on the 90th percentile rate reported for Medicaid health plans nationally. These are shown in the following table:

**AHCCCS Performance Standards for Chlamydia Screening**

Age Group	Minimum Performance Standard (MPS)	Goal
Chlamydia Screening, 16 – 24 Years	43%	62%

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The AHCCCS rate increased and exceeded the national mean for commercial health plans but was lower than the Medicaid health plan mean

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**Results**

The overall rate for Medicaid members (Table 14) improved to 39.9 percent from 38.7 percent in the previous measurement (p=.022).

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).

Members who are Hispanic or Black were more likely to be screened for Chlamydia, while Native American members were less likely to have this service (refer to Appendix A for detailed analysis of results by race/ethnicity). These results are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. The AHCCCS rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

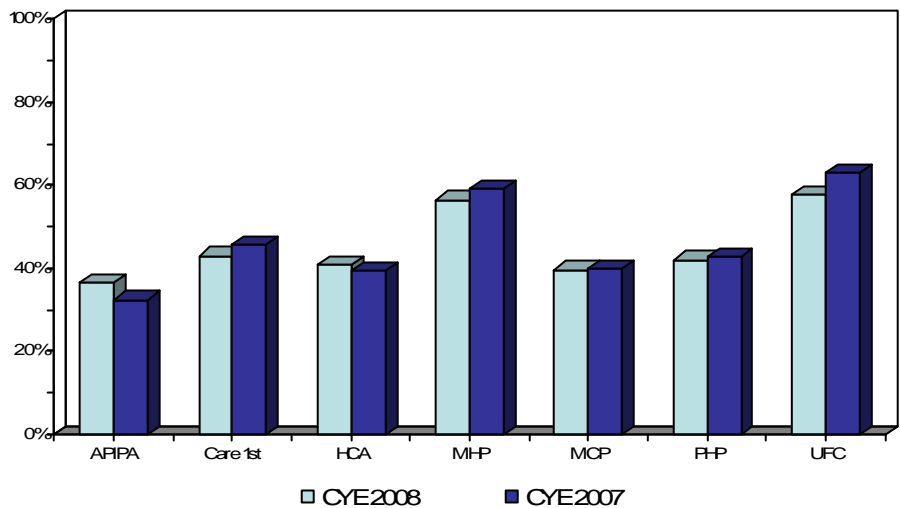
Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Chlamydia Screening, 16 – 24 Years	39.9%	50.8%	38.1%

**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.<sup>29</sup>

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.<sup>29</sup>

**Figure 13. Rates by Contractor, Chlamydia Screening, Medicaid Members  
CYE 2008 compared with CYE 2007**



University Family Care (UFC) had the highest rate for this measure in the current period (57.7 percent), exceeding both the HEDIS Medicaid and commercial means. Two Contractors, UFC and Maricopa Health Plan, met the AHCCCS Minimum Performance Standard for this measure.

**Table 14**  
**Arizona Health Care Cost Containment System**  
**CHLAMYDIA SCREENING, AGES 16-24, BY CONTRACTOR**  
**Measurement Period: Oct. 1, 2007, through Sept. 30, 2008**

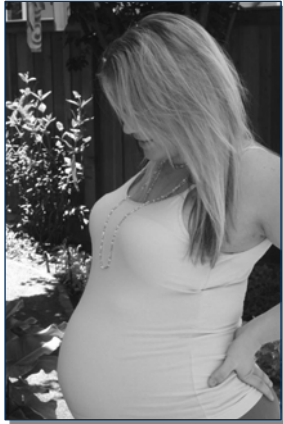
**Minimum Performance Standard: 51**  
Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

Contractor	Number of Members	Number of Members Receiving Chlamydia Screening	Percent of Members Receiving Chlamydia Screening	Relative Percent Change From Previous Year	Statistical Significance
<b>AZ Physicians IPA</b>	7,395	2,706	36.6%	12.7%	p<.001
AZ Physicians IPA	5,577	1,810	32.5%		
<b>Care1st HealthPlan</b>	833	359	43.1%	-5.8%	p=.328
Care1st HealthPlan	544	249	45.8%		
<b>Health Choice AZ</b>	3,268	1,333	40.8%	3.7%	p=.274
Health Choice AZ	2,389	940	39.3%		
<b>Maricopa Health Plan</b>	648	366	<b>56.5%</b>	-4.7%	p=.360
Maricopa Health Plan	454	269	59.3%		
<b>Mercy Care Plan</b>	7,470	2,961	39.6%	-0.9%	p=.675
Mercy Care Plan	5,299	2,120	40.0%		
<b>Phoenix Health Plan</b>	2,563	1,076	42.0%	-1.9%	p=.584
Phoenix Health Plan	1,829	783	42.8%		
<b>University Family Care</b>	234	135	<b>57.7%</b>	-8.3%	p=.237
University Family Care	251	158	62.9%		
<b>TOTAL</b>	22,411	8,936	39.9%	3.0%	p=.022
TOTAL	16,343	6,329	38.7%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

## 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.<sup>30-34</sup> 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.<sup>35</sup>

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, 52.5 percent of deliveries in the state, including those covered by health plans or on a fee-for-service basis, were paid for through AHCCCS in 2008 (it should be noted that more than 17,000 fee-for-service deliveries were to women who were undocumented immigrants and did not qualify for coverage of prenatal care through AHCCCS). In 2008, 71.4 percent of AHCCCS births were to mothers who began care in their first trimester of pregnancy, while 91.5 percent of all mothers covered by private insurance began care in the first trimester.<sup>36</sup>

### **Description**

AHCCCS measured the percentage of female members who:

- had a live birth during the measurement period (Oct. 1, 2007, through Sept. 30, 2008).
- 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 immediately preceding delivery.

### **Performance Goals**

AHCCCS has adopted a Minimum Performance Standard for Timeliness of Prenatal Care for the current measurement, based on the most recent national Medicaid mean reported by NCQA. AHCCCS also has set a Goal based on a comparable national Healthy People 2010 objective. These are shown in the following table:

**AHCCCS Performance Standards for  
Timeliness of Prenatal Care**

Age Group	Minimum Performance Standard (MPS)	Goal
Timeliness of Prenatal Care	80%	90%

**Results**

The overall rate for Medicaid members (Table 15) declined to 67.1 percent from a rate of 70.7 percent in the previous measurement (p<.001).

When analyzed by rural and urban county groups, members in rural counties were more likely to have timely prenatal care than members in urban areas (p<.001). This finding contrasts with other measures, in which members in urban areas are more likely to have services.

Hispanic, Black and Native American members all were less likely than non-Hispanic Whites to have timely prenatal care visits (see Appendix A for detailed analysis of results by race/ethnicity). These results are consistent with the previous measurement.

**Comparison with National Benchmarks**

NCQA has reported national HEDIS means (averages) for Medicaid and commercial health plans, based on the 2008 measurement year. The AHCCCS rates compare to the national means as follows:

**AHCCCS Rates Compared with 2008 National HEDIS Means**

Measure/ Age Group	AHCCCS Medicaid Rate	HEDIS Medicaid Mean	HEDIS Commercial Mean
Timeliness of Prenatal Care	67.1%	81.4%	91.9%

**Discussion**

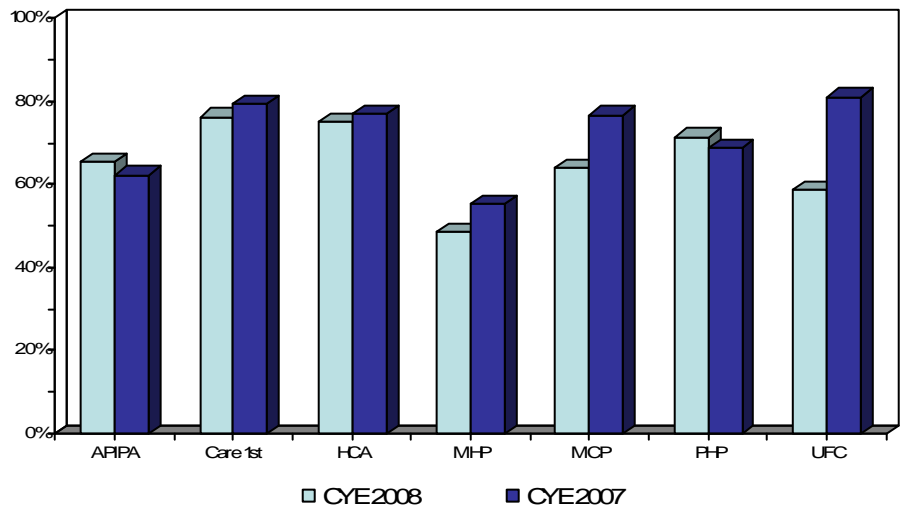
Prenatal, delivery and postpartum services provided through AHCCCS health plans typically are paid for under a “global” fee. Providers may not have reported all dates of prenatal visits when billing for OB services, which likely has resulted in underreporting of rates for this measure. AHCCCS has been working with Contractors to ensure more complete reporting, and expects to convene a work group with health plans to address collection of more complete data for this measure and any additional member outreach efforts needed in this area.

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

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**Figure 14. Rates by Contractor, Timeliness of Prenatal Care,  
Medicaid Members**  
CYE 2008 compared with CYE 2007



Care1st Healthplan had the highest rate for Timeliness of Prenatal Care (76.3 percent). No Contractors met the Minimum Performance Standard for this measure.

**Table 15**  
**Arizona Health Care Cost Containment System**  
**TIMELINESS OF PRENATAL CARE BY CONTRACTOR**  
**Measurement Period: Oct. 1, 2007, through Sept. 30, 2008**

**Minimum Performance Standard:**

**80**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Number of Members</b>	<b>Number with Prenatal Visits</b>	<b>Percent</b>	<b>Relative Percent Change from Previous Year</b>	<b>Statistical Significance</b>
<b>AZ Physicians IPA</b>	7,713	5,052	65.5%	5.2%	p<.001
AZ Physicians IPA	6,096	3,796	62.3%		
<b>Care1st Health Plan</b>	987	753	76.3%	-3.8%	p=.160
Care1st HealthPlan	637	505	79.3%		
<b>Health Choice AZ</b>	3,956	2,968	75.0%	-2.6%	p=.067
Health Choice AZ	2,516	1,938	77.0%		
<b>Maricopa Health Plan</b>	583	283	48.5%	-12.4%	p=.038
Maricopa Health Plan	368	204	55.4%		
<b>Mercy Care Plan</b>	9,731	6,237	64.1%	-16.5%	p<.001
Mercy Care Plan	6,244	4,791	76.7%		
<b>Phoenix Health Plan</b>	2,930	2,092	71.4%	3.6%	p=.063
Phoenix Health Plan	1,986	1,369	68.9%		
<b>University Family Care</b>	148	87	58.8%	-27.5%	p<.001
University Family Care	95	77	81.1%		
<b>TOTAL</b>	26,048	17,472	67.1%	-5.1%	p<.001
TOTAL	17,942	12,680	70.7%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

## 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). DDD provides long-term care and supportive services to these members, as well as primary and acute medical services through subcontracts with health plans, most of which also serve AHCCCS Acute-care members. This measurement includes DDD members who are enrolled with ALTCS.

### Performance Standards

Under its contract with DDD, AHCCCS has established Performance Measures and Standards for primary and preventive health care provided to children and adolescents. Performance Standards are designed to drive improvement in DDD’s performance toward Goals that are based on Healthy People 2010 objectives.

This section reports DDD’s performance in the following measures:

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

	Minimum Performance Standard (MPS)	Goal
Children’s Access to PCPs – 12 to 24 Months	78%	97%
Children’s Access to PCPs – 25 Months to 6 Years	70%	97%
Children’s Access to PCPs – 7 to 11 Years	70%	97%
Children’s Access to PCPs – 12 to 19 Years	70%	97%
Well-Child Visits 3 – 6 Yrs	44%	80%
Adolescent Well-Care Visits	31%	50%
Annual Dental Visits, 2 – 21 Yrs	41%	57%

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 financial criteria that are different than for non-DDD Medicaid members. Thus, many DDD members with AHCCCS coverage often have other medical coverage; recent data show that nearly 40 percent of DDD members also are covered by Medicare and/or private insurance. Because services can be provided through other insurers, AHCCCS may not have complete encounters for those services. The above Performance Standards reflect the limitation in collecting complete data for DDD members.

Performance Measures are collected according to HEDIS methodology in the same way as Performance Measures for Acute-care Contractors.

### **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, rates for three age groups and overall showed significant increases (Table 16). The rate for the 12-to-24-month group was statistically unchanged, at 84.3 percent compared with 85.7 percent in the previous measurement ( $p=.831$ ). The rate for members 25 months to 6 years increased to 76.6 percent from the previous rate of 65.5 percent ( $p<.001$ ). The rate for members 7 to 11 years increased to 72.2 percent from the previous rate of 67.9 percent ( $p<.001$ ). The rate for members 12 to 19 years increased to 72.0 percent from 67.2 percent in the previous year ( $p<.001$ ). The overall rate (all age groups combined) increased to 73.5 percent from 67.0 percent in the current measurement ( $p<.001$ ).

### **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, 46.9 percent of children had an annual well-care visit (Table 17), an increase from 36.1 percent in the previous year ( $p<.001$ ).

### 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.<sup>37</sup> 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, 35.3 percent of adolescents had a well-care visit (Table 18), an increase from the previous year's rate of 26.7 percent (p<.001).

### Annual Dental Visits

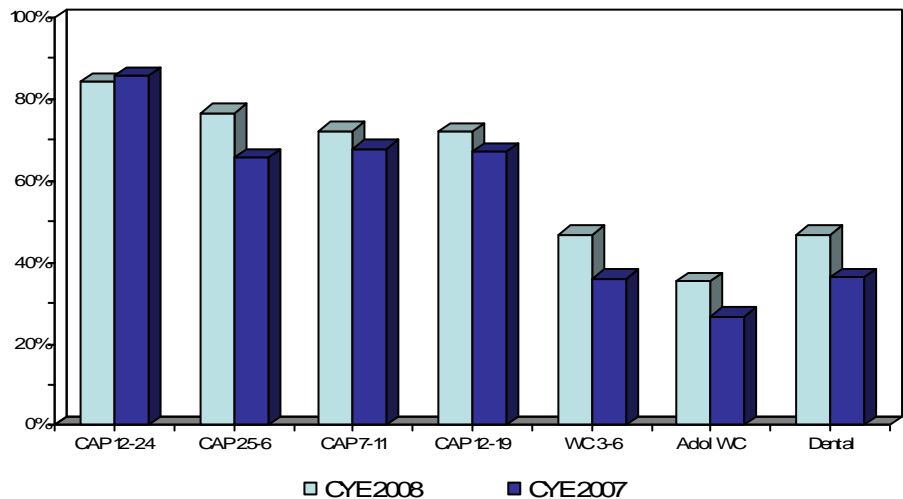
In general, people with developmental disabilities have poorer oral health and oral hygiene than those without such disabilities. Data indicate that people who have mental retardation have more untreated caries and a higher prevalence of gingivitis and other periodontal diseases than the general population. Medications, malocclusion, multiple disabilities, and poor oral hygiene combine to increase the risk of dental disease in people with developmental disabilities.<sup>38</sup>

The rate of annual dental visits (Table 19) increased in the current measurement, to 46.9 percent from 36.4 percent in the previous year (p<.001).

### Discussion

In the current measurement, DDD showed statistically significant improvement in all but one performance measure. The Division met the Minimum Performance Standards for all of the measures reported here.

**Figure 15. DDD Performance Measure Rates**  
CYE 2008 compared with CYE 2007



**Table 16**  
**Arizona Health Care Cost Containment System**  
**CHILDREN'S ACCESS TO PRIMARY CARE PRACTITIONERS**  
**MEMBERS ELIGIBLE UNDER DES/DDD**  
**Measurement Period Oct. 1, 2007, to Sept. 30, 2008**

<b>Minimum Performance Standards:</b>	<b>12-24 Months</b>	<b>78</b>
Rates in bold face denote the Contractor met	<b>25 Months - 6 Years</b>	<b>70</b>
the AHCCCS Minimum Performance Standard	<b>7-11 Years</b>	<b>70</b>
	<b>12-19 Years</b>	<b>70</b>

Contractor	Age	Number of Members	Number with 1+ Visits	Percent with 1+ Visits	Relative Percent Change From Previous Year	Statistical Significance
DES/DDD	12-24 mos.	51	43	<b>84.3%</b>	-1.6%	p=.831
	25 mos. - 6 yrs	3,055	2,341	<b>76.6%</b>	17.1%	p<.001
	7 - 11 yrs.	3,284	2,370	<b>72.2%</b>	6.3%	p<.001
	12 -19 yrs.	3,785	2,727	<b>72.0%</b>	7.3%	p<.001
	Total	10,175	<b>7,481</b>	<b>73.5%</b>	9.7%	p<.001
DES/DDD	12-24 mos.	70	60	85.7%		
	25 mos. - 6 yrs	2,930	1,918	65.5%		
	7 - 11 yrs.	3,003	2,038	67.9%		
	12 -19 yrs.	3,465	2,327	67.2%		
	Total	9,468	6,343	67.0%		

Notes:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

**Table 17**  
**Arizona Health Care Cost Containment System**  
**WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE**  
**MEMBERS ELIGIBLE UNDER DES/DDD**  
**Measurement Period: October 1, 2007, through September 30, 2008**

**Minimum Performance Standard: 44**  
 Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Number of Members</b>	<b>Number with 1+ Visits</b>	<b>Percent with 1+ Visits</b>	<b>Relative Percent Change From Previous Year</b>	<b>Statistical Significance</b>
<b>DES/DDD</b>	<b>2,854</b>	<b>1,338</b>	<b>46.9%</b>	<b>30.0%</b>	<b>p&lt;.001</b>
DES/DDD	2,725	983	36.1%		

Notes:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

**Table 18**  
**Arizona Health Care Cost Containment System**  
**ADOLESCENT WELL-CARE VISITS**  
**MEMBERS ELIGIBLE UNDER DES/DDD**  
**Measurement Period: October 1, 2007 through September 30, 2008**

**Minimum Performance Standard:**

**31**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Total Number of Members</b>	<b>Number with 1+ Visits</b>	<b>Percent with 1+ Visits</b>	<b>Relative Percent Change From Previous Year</b>	<b>Statistical Significance</b>
<b>DES/DDD *</b>	<b>4,708</b>	<b>1,664</b>	<b>35.3%</b>	<b>32.6%</b>	<b>p&lt;.001</b>
DES/DDD	4,374	1,166	26.7%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

**Table 19**  
**Arizona Health Care Cost Containment System**  
**ANNUAL DENTAL VISITS, AGES 2-21 YEARS**  
**MEMBERS ELIGIBLE UNDER DES/DDD**  
**Measurement Period: October 1, 2007 to September 30, 2008**

**Minimum Performance Standard: 41**

Rates in bold face denote the Contractor met the AHCCCS Minimum Performance Standard

<b>Contractor</b>	<b>Total Number of Members</b>	<b>Total Dental Services</b>	<b>Percent Dental Services</b>	<b>Relative Percent Change from Previous Year</b>	<b>Statistical Significance</b>
<b>DES/DDD</b>	11,343	5,320	<b>46.9%</b>	28.9%	p<.001
<b>DES/DDD</b>	10,593	3,855	36.4%		

Note:

Results of previous measurement period (Oct. 1, 2006, through Sept. 30, 2007) shown in shaded rows.

## CONCLUSION



### **Overall Results**

Despite increase in AHCCCS Minimum Performance Standards for these measures in the current period, Contractors significantly improved rates of primary and preventive care services, as measured under HEDIS.

In July 2007, AHCCCS advised Acute-care Contractors that they would face significant financial sanctions in the next couple of years if they do not increase rates to meet Minimum Performance Standards. Facing these financial sanctions, Contractors directed resources to improve Performance Measure rates, and these efforts appear to have had a significant impact. Contractors should continue improvement efforts, focusing on areas where they perform poorly.

The data reported here indicate that, overall, 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, the AHCCCS rate of Annual Dental Visits compares to or exceeds the 90th percentile of Medicaid health plans nationally, with rates for several other measures 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 measures such as Well-Child Visits in the First 15 months of Life, Adolescent Well Care Visits and Annual Dental Visits are well above the most recent HEDIS national Medicaid means, which includes members in this beneficiary group, and some exceed comparable national means for commercial health plans.

However, Contractors' rates for Children's and Adolescents' Access to PCPs still lag behind national means. AHCCCS-contracted health plans must focus resources on increasing rates for this measure. Use of preventive services such as Pap tests, Chlamydia screening and prenatal care by women also is of concern, and Contractors must ensure that women are receiving these services and complete data are being captured. AHCCCS expects to convene work groups in CYE 2010 to address one or more of these measures.

### **Disparities by Race and Ethnicity**

Analysis of data continues to indicate 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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Contractors directed resources to improve rates, and these efforts appear to have had a significant impact

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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.<sup>40</sup>

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,<sup>41</sup> 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.<sup>42</sup> 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.<sup>43</sup>

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. AHCCCS also will seek to work with Contractors and others, such as Indian Health Service, to explore mechanisms for collecting more complete data.

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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

### Multivariate Analysis of Performance Measures by Race/Ethnicity

The following tables include results of multivariate analysis of data by race/ethnicity for each performance measure. This analysis was conducted to identify disparities in utilization of health care services among racial/ethnic minorities relative to utilization of services by non-Hispanic White members.

Highlighted rows indicate disparities between the racial/ethnic subgroup and non-Hispanic whites included in the measurements (these disparities may be either positive or negative). RR equals relative risk: if the value in this column is  $\geq 1.0$ , members in this group are more likely than non-Hispanic white members to have the particular service being measured (these rows are highlighted in aqua); if the value is  $< 1.0$ , members of this group are less likely to have the service (these rows are highlighted in yellow).

Note: For purposes of this analysis, the “Other” category includes Asian/Pacific Islanders and Cuban/Haitians, as these groups generally did not have large enough population sizes to be analyzed separately, as well as members for whom race was unknown or unspecified.

Prenatal Care											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	7174	10191	70.40%		7856	11914	65.9%	0.9619	0.0180	0.9447	0.9794
Black	7174	10191	70.40%		1230	2022	60.8%	0.9155	0.0372	0.8821	0.9502
Native American	7174	10191	70.40%		780	1232	63.3%	0.9384	0.0443	0.8977	0.9809

Dental Care 2-21 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	36275	62225	58.30%		97423	152853	63.7%	1.0570	0.0076	1.0489	1.0651
Black	36275	62225	58.30%		10520	19509	53.9%	0.9513	0.0146	0.9375	0.9652
Native American	36275	62225	58.30%		4647	9216	50.4%	0.9102	0.0213	0.8910	0.9298

Breast Cancer Screening 52-69 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	4879	8389	58.16%		4282	6017	71.2%	1.1306	0.0243	1.1036	1.1584
Black	4879	8389	58.16%		552	973	56.7%	0.9843	0.0578	0.9291	1.0429
Native American	4879	8389	58.16%		130	261	49.8%	0.9042	0.1231	0.7994	1.0226

Cervical Cancer Screening											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	24496	40533	60.43%		24395	35806	68.1%	1.0757	0.0106	1.0644	1.0872
Black	24496	40533	60.43%		4486	7011	64.0%	1.0358	0.0192	1.0161	1.0560
Native American	24496	40533	60.43%		1498	2721	55.1%	0.9426	0.0349	0.9103	0.9760

Chlamydia Screening All Age Groups											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	3150	8169	38.56%		4496	11085	40.6%	1.0369	0.0355	1.0008	1.0743
Black	3150	8169	38.56%		917	1901	48.2%	1.1693	0.0540	1.1078	1.2342
Native American	3150	8169	38.56%		236	854	27.6%	0.7780	0.1119	0.6956	0.8702

Adult Access 45-64 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	26704	30791	86.73%		16464	18992	86.7%	0.9998	0.0071	0.9927	1.0069
Black	26704	30791	86.73%		3359	3950	85.0%	0.9895	0.0138	0.9759	1.0032
Native American	26704	30791	86.73%		898	1089	82.5%	0.9730	0.0277	0.9464	1.0004

Adult Access 20-44 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	39801	48088	82.77%		36609	45794	79.9%	0.9810	0.0061	0.9750	0.9871
Black	39801	48088	82.77%		7151	8958	79.8%	0.9803	0.0112	0.9694	0.9913
Native American	39801	48088	82.77%		3074	3919	78.4%	0.9707	0.0169	0.9544	0.9872

Adult Access All Age Groups											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	66505	78879	84.31%		53073	64786	81.9%	0.9844	0.0047	0.9798	0.9890
Black	66505	78879	84.31%		10510	12908	81.4%	0.9811	0.0088	0.9725	0.9897
Native American	66505	78879	84.31%		3972	5008	79.3%	0.9669	0.0145	0.9530	0.9810

Children and Adolescents Access to Care 12-24 Months											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	4223	4958	85.18%		12088	14140	85.5%	1.0020	0.0135	0.9886	1.0155
Black	4223	4958	85.18%		993	1230	80.7%	0.9711	0.0297	0.9427	1.0004
Native American	4223	4958	85.18%		475	635	74.8%	0.9303	0.0466	0.8880	0.9747

Children and Adolescents Access to Care 2-6 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	15831	19470	81.31%		49895	60374	82.6%	1.0090	0.0077	1.0013	1.0167
Black	15831	19470	81.31%		4397	5698	77.2%	0.9712	0.0156	0.9562	0.9866
Native American	15831	19470	81.31%		2058	2985	68.9%	0.9100	0.0250	0.8875	0.9330

Children and Adolescents Access to Care 7-11 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	8647	10943	79.02%		24480	30911	79.2%	1.0012	0.0112	0.9901	1.0125
Black	8647	10943	79.02%		2754	3698	74.5%	0.9670	0.0212	0.9467	0.9877
Native American	8647	10943	79.02%		1099	1589	69.2%	0.9263	0.0342	0.8951	0.9585

Children and Adolescents Access to Care 12-19 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	11771	14600	80.62%		24343	30044	81.0%	1.0027	0.0097	0.9931	1.0125
Black	11771	14600	80.62%		3911	5107	76.6%	0.9716	0.0171	0.9551	0.9884
Native American	11771	14600	80.62%		1401	1993	70.3%	0.9248	0.0296	0.8978	0.9526

Children and Adolescents Access to Care All Age Groups											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	40472	49971	80.99%		110806	135469	81.8%	1.0055	0.0049	1.0005	1.0104
Black	40472	49971	80.99%		12055	15733	76.6%	0.9695	0.0096	0.9602	0.9788
Native American	40472	49971	80.99%		5033	7202	69.9%	0.9193	0.0157	0.9049	0.9339

Adolescents Well Care											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	9904	25593	38.70%		20873	47460	44.0%	1.0948	0.0185	1.0748	1.1152
Black	9904	25593	38.70%		3443	8206	42.0%	1.0593	0.0298	1.0283	1.0913
Native American	9904	25593	38.70%		1057	3590	29.4%	0.8152	0.0529	0.7732	0.8596

Well Child Visits 15 Months of Life											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	2489	4083	60.96%		7148	11963	59.8%	0.9876	0.0286	0.9597	1.0163
Black	2489	4083	60.96%		517	1028	50.3%	0.8836	0.0655	0.8275	0.9434
Native American	2489	4083	60.96%		210	488	43.0%	0.7944	0.1050	0.7152	0.8823

Well Child Visits 3rd-6th Years of Life											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	9596	15633	61.38%		33411	48453	69.0%	1.0730	0.0138	1.0583	1.0879
Black	9596	15633	61.38%		2801	4624	60.6%	0.9918	0.0264	0.9660	1.0183
Native American	9596	15633	61.38%		1190	2412	49.3%	0.8686	0.0423	0.8326	0.9061

Dental Care 2-19 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	5622	8331	67.48%		16211	21865	74.1%	1.0567	0.0168	1.0390	1.0746
Black	5622	8331	67.48%		595	865	68.8%	1.0114	0.0473	0.9647	1.0604
Native American	5622	8331	67.48%		414	729	56.8%	0.8989	0.0651	0.8423	0.9594

Children and Adolescents Access to Care 12-24 Months											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	462	496	93.15%		987	1046	94.4%	1.0067	0.0281	0.9788	1.0354
Black	462	496	93.15%		38	48	79.2%	0.9162	0.1471	0.7909	1.0614
Native American	462	496	93.15%		43	49	87.8%	0.9692	0.1073	0.8706	1.0789

Children and Adolescents Access to Care 2-6 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	1796	2117	84.84%		6121	6909	88.6%	1.0235	0.0199	1.0033	1.0441
Black	1796	2117	84.84%		181	204	88.7%	1.0243	0.0521	0.9723	1.0791
Native American	1796	2117	84.84%		144	192	75.0%	0.9337	0.0836	0.8588	1.01519

Children and Adolescents Access to Care 7-11 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	1420	1687	84.17%		4304	4946	87.0%	1.0181	0.0233	0.9946	1.0421
Black	1420	1687	84.17%		117	135	86.7%	1.0159	0.0693	0.9478	1.0888
Native American	1420	1687	84.17%		79	109	72.5%	0.9194	0.1175	0.8175	1.0341

Children and Adolescents Access to Care 12-19 Years of Age											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	1952	2250	86.76%		3953	4563	86.6%	0.9992	0.0198	0.9797	1.0192
Black	1952	2250	86.76%		205	236	86.9%	1.0007	0.0522	0.9498	1.0543
Native American	1952	2250	86.76%		119	164	72.6%	0.9052	0.0955	0.8227	0.9959

Children and Adolescents Access to Care All Age Groups											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	5630	6550	85.95%		15365	17464	88.0%	1.0125	0.0112	1.0012	1.0240
Black	5630	6550	85.95%		541	623	86.8%	1.0055	0.0321	0.9737	1.0383
Native American	5630	6550	85.95%		385	514	74.9%	0.9265	0.0510	0.8804	0.9750

Adolescents Well Care											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	1544	3405	45.35%		3878	6999	55.4%	1.1428	0.0424	1.0953	1.1923
Black	1544	3405	45.35%		206	405	50.9%	1.0807	0.1026	0.9753	1.1974
Native American	1544	3405	45.35%		109	313	34.8%	0.8279	0.1560	0.7083	0.9677

Well Child Visits 15 Months of Life											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	360	500	72.00%		752	1071	70.2%	0.9854	0.0672	0.9214	1.0539
Black	360	500	72.00%		19	28	67.9%	0.9657	0.2607	0.7441	1.2534
Native American	360	500	72.00%		41	55	74.5%	1.0203	0.1638	0.8661	1.2019

Well Child Visits 3rd-6th Years of Life											
	n	Total	%		n	Total	%	RR	Std. Err	Lower Limit	Upper Limit
Hispanic	1127	1695	66.49%		4327	5677	76.2%	1.0830	0.0368	1.0439	1.1236
Black	1127	1695	66.49%		117	176	66.5%	0.9999	0.1102	0.8955	1.1164
Native American	1127	1695	66.49%		81	161	50.3%	0.8381	0.1572	0.7162	0.9808