Arizona Health Care Cost Containment System (AHCCCS)
AHCCCS Complete Care (ACC)/KidsCare, Children's Medical and Dental Program (CMDP), and Division of Developmental Disabilities (DDD)
Performance Improvement Project:

Back to Basics

Creation Date: October 2018
Implementation Date: October 1, 2018
Updated: January 2021

Background:
Well-care and annual dental visits for children and adolescents aim to promote optimal health and development. Ensuring that children and adolescents receive regular well-care and dental visits is critical in disease prevention, early detection, and treatment. It is equally important in evaluating a child's developmental milestones, addressing parental concerns, and assessing a child or adolescent's psychological and social development.

There are many benefits of well-child/well-care visits. Well-child visits benefits include disease prevention, tracking growth and development, raising concerns, and establishing a team approach to assist with the development of optimal physical, mental, and social health of a child[1]. Adolescence is a critical stage of development during which physical, intellectual, emotional, and psychological changes occur[2]. Adolescence is generally considered a healthy stage of life; however, during this stage, individuals begin making lifestyle choices and develop behaviors that can impact their current and future health. Adolescent well-care visits assist with the promotion of healthy choices and behaviors, preventing risky behaviors, and the early detection of conditions that can inhibit an adolescent's development.

Maintaining good oral health is an essential component in the overall health of infants, children, and adolescents. Oral health addresses several disease prevention and health promotion topics including dental caries, tooth decay, and periodontal health. Tooth decay (or cavities) is one of the most common chronic conditions of childhood in the United States[3]. If untreated, tooth decay can lead to pain and infections that cause children and adolescents to experience problems with playing, learning, eating, and speaking. About 1 in 5 children aged 5 to 11 years old have at least one untreated decayed tooth, and 1 in 7 adolescents aged 12 to 19 years old have at least one untreated decayed tooth[3]
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Due to a decline in the rates between CYE 2015 and CYE 2016 for the Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV) performance measures, AHCCCS has identified these measures as areas of opportunity and improvement for the overall well being of children and adolescents. Increasing the rates for these measures also impacts other measures and focus areas including, but not limited to, childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings.

Purpose:
The purpose of this performance improvement project is to increase the number of child and adolescent well-child/well-care visits, as well as increase the number of children and adolescents receiving annual dental visits.

AHCCCS Goal:
The goal is to demonstrate a statistically significant increase in the number and percentage of child and adolescent well-child/well-care visits, as well as a statistically significant increase in the number and percentage of children and adolescents receiving an annual dental visit, followed by sustained improvement for one consecutive year.

Measurement Period:

Baseline Measurement	October 1, 2018 through September 30, 2019
Intervention Year 1	January 1, 2020 through December 31, 2020
Intervention Year 2	January 1, 2021 through December 31, 2021
First Re-measurement	January 1, 2022 through December 31, 2022
Second Re-measurement	January 1, 2023 through December 31, 2023

Study Question:
What is the number and percent, overall and by Contractor, of AHCCCS enrolled children and adolescents receiving well-child visits and children and adolescents receiving at least one annual dental visit?

Eligible Population:
- Children and adolescents who are continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement period

Population Exclusions:
- Children and adolescents who do not meet the continuous enrollment criteria as described in the indicator's associated technical specifications
- Children and adolescents with more than one gap in enrollment during the measurement period
- Children and adolescents with a gap in enrollment of more than 45 days during the measurement period
- Children and adolescents enrolled in hospice or utilizing hospice services

Population Stratification:
Not Applicable

Sample Frame:
All members that meet the eligibility criteria at the Contractor-specific level will be evaluated to determine the indicator rate(s).

Sample Selection:
Not Applicable

Indicator Criteria:

Indicator 1: Well-Child Visits in the First 30 Months of Life (W30 Rate 1)

Indicator 1: Percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life. (*Not applicable for CMDP or DDD)*	**Numerator:** The total number of members receiving six or more well-child visits, on different dates of service, with a PCP during their first 15 months of life.
	Denominator: The eligible population

Indicator 2: Child and Adolescent Well-Care Visits (WCV)

Indicator 2: Percentage of children ages 3 years to 21 years who had one or more comprehensive well-care visits with a primary care practitioner (PCP) or an OB/GYN during the measurement period.	**Numerator:** The total number of members receiving at least one well-care visit with a PCP or OB/GYN during the measurement period.
	Denominator: The eligible population

Indicator 3: Annual Dental Visits (ADV)

Indicator 3: Percentage of children and adolescents ages 2 years to 21 years who received at least one dental visit during the measurement period.	**Numerator:** The total number of members receiving at least one dental visit during the measurement period.
	Denominator: The eligible population

Data Sources:
AHCCCS administrative encounter data and Contractor-specific claims will be used to identify indicator data.

Data Collection:
The study will be conducted via administrative data collection methodologies in alignment with the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications.

Confidentiality Plan:
AHCCCS, as well as its External Quality Review Organization (EQRO) and Contractors maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. AHCCCS employees and EQRO staff who analyze data for this project will have access to study data. Member names are never identified or used in AHCCCS reporting; requested data are used only for the purpose of performing health care operations, oversight of the health care system, or research.

Quality Assurance Measures:
For indicators based on standardized performance measures, Contractor-specific claims data and performance measure (indicator) calculations will be reviewed and validated by the EQRO in alignment with CMS Protocol 2.

Note: For CYE 2019, AHCCCS encounter data utilized for performance measure calculations will be thoroughly reviewed and validated by the EQRO to ensure calculations are accurate and complete.

Data Validation:
The data validation study compares allowable claims sent to the Contractors by rendering health care providers/facilities. Contractor-calculated performance measure (indicator) results will be validated by the EQRO in alignment with CMS Protocol 2.

Note: For CYE 2019, the data validation study compares allowable encounters sent to AHCCCS by the Contractors with performance measure (indicator) calculation and detailed validation conducted by the EQRO to ensure performance measure (indicators) calculations are accurate and complete.

Analysis Plan:
The study data will be analyzed in the following ways:

- The numerator will be divided by the denominator to determine the indicator rate.
- Results will be analyzed by overall aggregate (roll-up), line of business (roll-up), and individual Contractor.

Comparative Analysis:
For the purpose of comparative analyses, the following will be considered when applicable and meaningful to future improvement:

- Results will be compared with prior years to identify changes and trends.
- Individual Contractor results will be compared with each other, the statewide aggregate, and the NCQA Medicaid Mean.
- In the future, differences between overall baseline study results and overall re-measurement results will be analyzed for statistical significance and relative change.
- Results may be compared by age, as deemed appropriate.
- Results may be compared to the results of any other comparable studies, if available.

Limitations:
As of CYE 2020, AHCCCS has transitioned to Contractor-calculated performance measure rates reflective of calendar year measurement periods for the purposes of evaluating Contractor performance to support Managed Care Organization (MCO) oversight and External Quality Review (EQR) Annual Reporting. Analysis will be conducted in accordance with that outlined in the *Analysis Plan* and *Comparative Analysis* sections, with additional individual Contractor analysis findings included within the EQR Annual Report for the associated line of business.

CYE 2019 baseline year aggregate rates for ACC and KidsCare are calculated as an aggregate roll-up; whereas, beginning with 2020 performance measure calculations, Contractors will be calculating and reporting combined rates for the ACC and KidsCare populations.

Additional Considerations:
To account for the impact of the COVID-19 Public Health Emergency, this Performance Improvement Project is inclusive of two intervention years.

Performance Measures calculations and reporting are conducted in alignment with associated technical specifications; as such, changes in specifications from year to year may occur and shall be considered/notated when evaluating and trending performance over the lifespan of the Performance Improvement Project.

Works Cited

1. AAP Schedule of Well-Child Care Visits. (2017, June 27). Retrieved from https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
2. Adolescence: Preparing for Lifelong Health and Wellness. (2018). Retrieved from https://www.cdc.gov/grand-rounds/pp/2015/20150818-adolescent-wellness.html
3. Children's Oral Health | Division of Oral Health | CDC. (2018). Retrieved from https://www.cdc.gov/oralhealth/children_adults/child.htm

For general questions regarding this methodology, please contact Jamie Robin, AHCCCS Quality Improvement Manager, at Jamie.Robin@azahcccs.gov. For technical questions regarding this methodology, please contact Lindsey Irelan, AHCCCS Lead Quality Improvement Coordinator, at Lindsey.Irelan@azahcccs.gov.