State of Colorado

Department of Health Care Policy & Financing

Colorado 2004–2005 Focused Study on Access to Preventive Care for Persons With Disabilities

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Introduction

Adults with various types of disabilities in the United States have reduced access to routine screening and experience lower utilization of preventive health care services than recommended by the U.S. Preventive Services Task Force. One of the national Healthy People 2010[1-1] goals is to eliminate health disparities among different segments of the population, including disparities among persons with disabilities.[1-2]

The Colorado Department of Health Care Policy and Financing (the Department) is also committed to eliminating health disparities among persons with disabilities and ensuring the Medicaid members have access to preventive health care. According to the 2000 Colorado census, persons with disabilities represented 7.4 percent of the population ages 5 through 20, 15.9 percent of the age group 21 through 64, and 40.0 percent of the age group 65 years and older.

In 2002, a focused study was conducted for Colorado Medicaid. The study included analysis of administrative claims data from four lines of Medicaid business: the Colorado Medicaid Primary Care Physician Program (PCPP); the unassigned fee-for-service (FFS) program; and two Colorado Medicaid managed care organizations (MCOs)—Colorado Access (CO Access) and Rocky Mountain Health Plans (RMHP). The results indicated that there were opportunities to improve access to preventive care for adults with disabilities and recommendations were provided. Some of the recommendations were implemented by the health plans. The decision to conduct a follow-up for this focused study was made to determine if improvement in accessing preventive services occurred. The Department requested remeasurement of rates for access to preventive services and specific adult preventive services, including Pap tests for cervical cancer detection, mammography for breast cancer screening, and prostate specific antigen (PSA) testing for prostate cancer screening.

This focused study represents the first remeasurement period (July 1, 2003, through June 30, 2004) for State fiscal year (SFY) 2004. The Colorado Medicaid performance goal was to increase the preventive services and cancer screening rates by 10 percent, compared to the rates reported in the previous study. The methodology used to evaluate performance goals was based on the Quality Improvement System for Managed Care (QISMIC) methodology (see Section 3, Methodology, pg 3-1).

The methodology and analysis follow the 2002 baseline study, with additional analyses to show trended results.

Study Objective

The objective of this focused study was to provide a remeasurement of the preventive services screening rates among persons with disabilities in the Colorado Medicaid program. Access to preventive services and cancer screening rates for cervical, prostate, and breast cancer have been

measured and compared across Medicaid lines of business and also compared to the baseline measurements reported in the first study (Colorado Medicaid Access to Preventive Services for the Disabled Focused Study, June 2003).

Methodology

The population for this focused study consisted of adults with disabilities, 20 through 64 years of age, with at least 11 months of continuous eligibility for SFY 2004. A sampling was not performed; the entire eligible population of adults with disabilities was used. The disability status of the population was identified through State eligibility codes 05 and 25 (Aid to Needy and Disabled). At age 65 and over, eligibility codes changed to reflect Medicare enrollment, and adults with disabilities over age 65 could no longer be identified using the State Medicaid eligibility codes. For the FFS and PCPP populations, HSAG used the State enrollment data to identify members with a disability and calculate their continuous enrollment history. Both CO Access and RMHP identified their own members and submitted their populations to HSAG, along with administrative claims data for the services in this study.

Administrative data (i.e., claims and encounter data) from July 1, 2003, through June 30, 2004, were analyzed using a modified version of the 2004 Health Plan Employer Data and Information Set (HEDIS®) Technical Specifications developed by the National Committee for Quality Assurance (NCQA).[1-3] Prostate cancer screening is not a HEDIS measure; however, prostate cancer screening data were collected using administrative data. Access to preventive care was measured specifically through four measures described in Table 1-1. Due to the use of prostate cancer screening and a sample limited to the populations with disabilities, Medicaid benchmark comparisons were not used. However, the baseline and follow-up rates are comparable and both are included in this report.

Table 1-1—Preventive Service Study Indicators

Cervical Cancer Screening Rate	Women with disabilities, 21–64 years of age (as of June 30, 2004), who received 1+ Pap tests during the measurement year or the year prior
Breast Cancer Screening Rate	Women with disabilities, 52–64 years of age (as of June 30, 2004), who received 1+ mammograms during the measurement year or the year prior
Prostate Cancer Screening Rate	Men with disabilities, 51–64 years of age (as of June 30, 2004), who received 1+ PSA tests during the measurement year
Access to Preventive Service	Adults with disabilities, 20–44 or 45–64 years of age (as of June 30, 2004), who had one or more ambulatory or preventive care visits during the measurement year

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Caveats and Limitations

Analysis of administrative data (claims and encounter data) is subject to potential data biases, such as inaccurate or missing data elements. The impact of incomplete administrative data can be underreporting of preventive service rates. However, this potential impact is minimized by the fact that providers are reimbursed for conducting these preventive services on a fee-for-service basis, which means a provider must submit a claim for reimbursement. Nevertheless, the results from this study should be used with caution. Some additional caveats and limitations are noted in this study and include:

- Populations with disabilities have different patterns of health care resource utilization than their counterparts without disabilities; therefore, aggregate preventive service rates may not be comparable to the general Medicaid population.
- This study used only administrative data for analysis and did not include medical records to validate or supplement the administrative data. Even though the providers were reimbursed on a fee-for-service basis, it is possible that not all services were reported, or some claims may have been denied. The reported preventive service rates in this report are most likely a little lower than the actual rates.
- Several measures are based on HEDIS technical specifications, but the measures are not calculated using the exact method as HEDIS, nor are the measures audited. For example, this study used only those Medicaid members with a disability, while HEDIS uses the entire eligible Medicaid population. Therefore, rates presented in this report should not be compared to national Medicaid rates.
- The FFS and PCPP programs consisted of 80 percent (52 percent and 28 percent, respectively) of the entire eligible population for this focused study. Therefore, the overall Colorado Medicaid rates were primarily affected by the performance of these two populations.

Key Findings and Recommendations

This remeasurement of the provision of preventive care to Colorado Medicaid members with disabilities yielded mixed results and continues to show underuse of preventive services.

Table 1-2 summarizes the results of the analysis. The preventive visit rate was 48.6 percent, and cancer screening rates ranged from 8.1 percent (prostate cancer) to 23.3 percent (breast cancer). The screening rate for cervical cancer was 21.7 percent. Delivery of all recommended preventive services occurred only 25.0 percent of the time.

Table 1-2—Summary of Findings

Study Measure	CO Medicaid		RMHP		CO Access		PCPP		FFS	
	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)
Cervical Cancer Screening Rate	17.7 n=14,222	21.7 n=18,383	38.8 n=1,326	47.1 n=698	26.4 n=2,818	35.1 n=3,528	29.2 3,584	30.6 n=5,393	3.4 n=6,494	8.8 n=8,764
Breast Cancer Screening Rate	20.0 n=4,767	23.3 n=6,019	49.9 n=377	58.3 n=228	35.1 n=903	46.4 n=1,092	36.0 n=1,058	34.6 1,632	2.7 n=2,429	6.4 n=3,067
Prostate Cancer Screening Rate	5.5 n=3,735	8.1 n=4,466	11.2 n=250	23.1 n=143	7.0 n=611	13.5 n=631	15.9 n=731	16.2 n=1,024	0.8 n=2,144	3.0 n=2,668
Preventive Visit Rate	39.3 n=27,248	48.6 n=34,981	78.0 n=2,355	87.8 n=1,222	67.2 n=4,884	91.3 n=5,828	63.0 n=6,525	62.9 n=9,818	11.0 n=13,484	24.4 n=18,113
ANY Preventive Service Rate	18.1 n=17,958	22.3 n=22,872	40.4 n=1,576	49.4 n=842	28.7 n=3,429	39.5 n=4,167	31.2 n=4,315	32.5 n=6,426	3.2 n=8,638	8.3 n=11,437
ALL Preventive Services Rate	19.4 n=27,248	25.0 n=34,981	43.1 n=2,355	53.0 n=1,222	30.1 n=4,884	45.0 n=5,828	34.1 n=6,525	35.0 n=9,818	4.2 n=13,484	12.0 n=18,113

The Colorado Medicaid performance goal was to increase the preventive services and cancer screening rates by 10 percent, compared to the rates reported in the previous study. For example, the rate for breast cancer screening in SFY 2002 was 20.0 percent, indicating 80.0 percent did not receive the service (i.e., opportunity for improvement). The performance goal was to reduce the 80.0 percent opportunity for improvement by a minimum of 10.0 percent (i.e., 8.0 percentage points), such that the rate for SFY 2004 should be at least 28.0 percent (20.0 percent + 8.0 percent = 28.0 percent).

A detailed review of the results indicates that Colorado Medicaid rates increased overall. However, only the preventive services visit rates measure met the goal. The preventive services visit rates improved significantly across all Medicaid provider groups, except for the PCPP. The significant increase in the preventive visit rates (from 67.2 percent to 91.3 percent) among CO Access Medicaid members is notable.

RMHP had the highest rates across all measures, followed by CO Access. Moreover, except for the PCPP group, RMHP, CO Access, and the FFS program showed consistent improvement on all screening and preventive visit rates compared to baseline scores. Only RMHP met the performance goals for all study measures.

In 2003, the MCOs began interventions based on the results from the baseline study. The results from this focused study show additional interventions continue to be necessary to achieve optimal results. Specifically, key findings from this study are summarized below, along with appropriate recommendations:

- **Finding:** Nearly half of the Colorado Medicaid members with disabilities had no preventive health visits. Preventive health visits became a covered benefit for the Medicaid population while this study was being conducted. This barrier may be reduced in the future as a result of this changed benefit.

  Recommendation: A review of the interventions initiated in response to the SFY 2002 study suggests that both the Department and managed care plans focused interventions on increasing the number of members with disabilities receiving appropriate cancer screenings. HSAG recommends the following:

  - Continue to study barriers to care and develop interventions that mitigate their impact (e.g., transportation, access to facilities, and member and provider perceptions).
  - Involve members with disabilities in the planning of outreach activities.
  - Develop partnerships with community advocates for persons with disabilities to facilitate the coordination of preventive services and increase utilization.

- **Finding:** Only 25.0 percent of Colorado Medicaid members with disabilities received all required services during the review period. Although this rate represents a significant increase from SFY 2002 (19.4 percent), it continues to suggest that the delivery of preventive services is incomplete.

  Recommendation: HSAG recommends the following:

  - Work with providers to ensure medical equipment and facilities are accessible for members with disabilities.
  - Collaborate with other public and private agencies to coordinate the delivery of preventive services and screenings.
  - Consider incentive payments to providers and health plans that meet State-defined performance criteria.

- **Finding:** Cervical and breast cancer screening rates were significantly higher for both RMHP and CO Access in SFY 2004, and both met the performance goal of a 10 percent increase in the opportunity for improvement.

  Recommendation: The increases noted in the cervical and breast cancer screening rates among the health plans is likely related to the comprehensive interventions initiated after the baseline study. Both RMHP and CO Access targeted specific interventions at Colorado Medicaid providers and members with disabilities. HSAG recommends the following:

  - Continue intervention strategies currently in place at the managed care plans.
  - Expand outreach activities to include health plan and provider incentives based on performance.
  - Explore offering incentives to members with disabilities to encourage the use of the preventive services.
  - Continue to work with the Department to develop community partnerships that help coordinate services for Medicaid members with disabilities.

- **Finding:** Prostate cancer screening rates for men with disabilities enrolled in Colorado Medicaid continued to remain significantly lower than cervical or breast cancer screening rates. Overall, only 8.1 percent of eligible men received an annual prostate cancer screening. Only RMHP met the performance goal for prostate cancer screening.

  Recommendation: Although both the Department and health plans initiated interventions to increase breast and cervical cancer screening rates among Colorado Medicaid women with disabilities, there were no specific targeted interventions to improve prostate cancer screening among eligible men with disabilities. HSAG recommends the following:

  - Expand current breast and cervical cancer screening interventions employed by the Department and health plans to include prostate cancer screening. Specifically, health care delivery programs should identify men with disabilities who are eligible for prostate cancer screening and provide them with ongoing communications regarding the need for screening. Programs should also make lists available to providers of members with disabilities who have not received a prostate cancer screening.
  - Work with providers to ensure facilities are accessible to members with disabilities.
  - Identify and develop community partnerships with other agencies offering outreach services to men with disabilities.
  - Work with opinion leaders in the provider communities to help improve attitudes, beliefs, and practices relevant to PSA screening.

2. Background

Adults with various types of disabilities in the United States have reduced access to routine screening and experience lower utilization of preventive health care services than recommended by the U.S. Preventive Services Task Force. One of the national Healthy People 2010[2-1] goals is to eliminate health disparities among different segments of the population, including disparities among persons with disabilities.[2-2]

The Colorado Department of Health Care Policy and Financing (the Department) is also committed to eliminating health disparities among persons with disabilities and ensuring those Medicaid members have access to preventive health care. According to the 2000 Colorado census, persons with disabilities represented 7.4 percent of the population ages 5 through 20, 15.9 percent of the age group 21 through 64-year-old, and 40.0 percent of the age group 65 years and older.

Published literature and reports describe the prevalence of these health disparities and identify barriers to preventive services access for persons with disabilities. Diab and Johnston[2-3] describe an analysis of data (1998 and 2000) from the Behavioral Risk Factor Surveillance System in which they examined the relationships between level of disability and receipt of certain preventive health services. Women with disabilities received fewer Pap smears and clinical breast examinations. They concluded that severity of disability is related to receipt of certain preventive services and that receipt of a checkup is an important determinant of preventive health services. For almost all services and groups studied, preventive care remained below targeted goals for Healthy People 2010. However, the disparity in rates of mammography screening among women with disabilities compared to women without disabilities increased from a 6 percent difference in 1994 to a 14 percent difference in 1998, according to recent reports in 2004 and 2005.[2-4]

Data from the 1994 National Health Interview Survey on Disability[2-5] showed that women with mobility limitations were significantly less likely to receive Pap smears, breast exams, mammograms, and estrogen therapy to prevent bone loss (bone loss is associated with mobility-limiting conditions) than their nonlimited counterparts. In two reports, Iezzoni found that women with lower extremity mobility difficulties or major mobility impairments had lower odds ratios or rates for Pap smears and mammography.[2-6,2-7] The Association of State and Territorial Health Officers' Fact Sheet states that women over age 40 who have three or more functional limitations received mammograms less frequently than women with no functional limitations.[2-8] Shabas and Weinreb[2-9] investigated preventive health care in women with multiple sclerosis and found that, of 200 women, 50 percent did not get regular checkups and preventive services. Twenty-five percent did not have regular pelvic examinations, and 11 percent had not had a Pap smear within 3–5 years. A conference report and other studies using self-reported survey data show similar results.[2-6, 2-7, 2-10, 2-11, 2-12]

Lewis and others reported that adults with developmental disabilities, especially those living at home, received fewer preventive medical services in general. Havercamp, Scandlin, and Roth[2-13] found significant medical care utilization disparities for breast and cervical cancer screening among adults with disabilities compared to adults without disabilities. In particular, women with developmental disabilities had low utilization of breast and cervical cancer screening. They concluded that health promotion efforts must be specifically designed for this population.

Cervical Cancer Screening

Cervical cancer is one of the most successfully treatable cancers when detected early. Since the incidence of cervical cancer increases with age, it is important that women continue to have screenings even though earlier tests have been negative. With screening, a woman's lifetime risk of cervical cancer is estimated to be only 0.8 percent.[2-14] The American Cancer Society estimated that 10,370 cases of invasive cervical cancer will be diagnosed in the United States in 2005, and approximately 3,710 women will die from the disease.[2-15]

Breast Cancer Screening

Breast cancer is one of the most common types of cancer among American women. In the United States, there are currently more than 2 million women diagnosed with, and being treated for, breast cancer. There will be an estimated 211,240 new cases of invasive breast cancer in 2005 and 40,410 deaths.[2-16] In Colorado, the American Cancer Society estimates that nearly 2,580 new cases of breast cancer will be diagnosed and 480 women will die due to the disease.[2-17]

If detected early, the five-year survival rate for localized breast cancer is 96 percent.[2-18] Mammograms can detect breast cancer at an average of 1.7 years before the patient can feel a breast lump and are the most effective method for detecting breast cancer in the early stages—when it is most treatable. Screening costs are low relative to the benefits of early detection.

Prostate Cancer Screening

Prostate cancer is the most frequently diagnosed cancer in men in the United States, with an estimated 230,110 new cases and 29,900 deaths in 2004. It is the second leading cause of cancer death in men.[2-19] In 2005, the American Cancer Society estimated that approximately 232,090 new cases of prostate cancer will be diagnosed and about 30,350 men will die as a result of the disease.[2-20] Similar to national statistics, prostate cancer is the most commonly diagnosed cancer for men in Colorado and the second most common cause of cancer-related death. In Colorado, it is estimated that 2,540 new cases of prostate cancer were diagnosed in 2004 and 300 men died from the disease.[2-21] Earlier detection and new treatments have led to a general decrease in the death rates associated with prostate cancer, with a 26 percent decrease in prostate cancer mortality rates from 1990 to 1999 in Colorado.

Access to Preventive Services

Access to preventive care is critical to the ongoing diagnosis and treatment of health problems. Establishing a relationship with a primary care provider is essential to improve access to care for both adults and children. As such, the public health system continues to focus on identifying barriers to the use of existing health services and eliminating disparities in order to increase access to quality care. By breaking down barriers to care and improving access, health plans can increase preventive care and the successful management of disease processes.

Barriers to preventive services and screenings for people with disabilities include providers', members' and advocates' knowledge, attitudes, and beliefs; and insufficient or inadequate information, transportation, economic resources, and equipment and facilities. The Association of State and Territorial Health Officials (ASTHO) and others have identified widespread barriers and resource-related deterrents to improving access to preventive services for persons with disabilities.[2-8] These barriers include:

- Emphasis on disease-focused treatment, rather than health promotion/preventive services for people who have disabilities.
- Lack of appropriate equipment and facilities (mammography machines, adjustable gynecology exam tables) for people with physical or other limitations, inaccessible health care offices, and inadequate time for appointments.
- Higher cost of special care and equipment.
- Limitations to access due to mobility and financial resources.
- Insufficient transportation and/or support services to assist individuals in getting to health care appointments.
- Challenges in maintaining effective communication between purchasers, beneficiaries, and practitioners, including lack of availability of written materials in accessible formats, provision of sign language interpreters, and assistive listening technology.
- Lack of knowledge and understanding about preventive services among persons with disabilities and their advocates.
- Lack of continuity of care if an individual's practitioner or facility leaves his or her provider network, since health insurers are not required to have transitional provisions for people with disabilities.
- Inadequate knowledge about disability issues among some health care providers. Health care providers may mistakenly assume that persons with disabilities are not at risk for cervical cancer.
- Environmental barriers that reduce individuals' ability to participate in life activities, and environmental barriers that undermine physical and emotional health.
- Lack of systematic data documenting health problems among individuals with disabilities.
- Disparities in educational resources, lower wage jobs, and higher unemployment rates that disproportionately affect many people with disabilities and keep them from achieving optimal health status.

A focused study on use of preventive services among persons with disabilities was conducted in 2002 for Colorado Medicaid. The study included analysis of administrative claims data from four lines of Medicaid business: the Colorado Medicaid PCPP, the unassigned FFS program, and two Colorado Medicaid MCOs—CO Access and RMHP. The results indicated that there were opportunities to improve access to preventive care for persons with disabilities and recommendations were provided.

Following the first focused study released in June 2003, some of the recommendations were implemented by the health plans. These interventions are discussed in more detail in Section 4 of this report (Intervention Strategies). The interventions for RMHP and CO Access both centered on breast cancer screening and cervical cancer screening. The decision to conduct a follow-up for this focused study was to determine if improvement in accessing preventive services occurred based on these interventions, and whether or not additional interventions were necessary.

This focused study represents the first remeasurement period (July 1, 2003, through June 30, 2004) for SFY 2004. Based on QISMIC methodology the Colorado Medicaid performance goal was to increase the preventive services and cancer screening rates by 10 percent, compared to the rates reported in the previous study. The methodology and analysis follow the 2002 baseline study, with additional analyses to show trended results.

3. Methodology

This focused study represents the first remeasurement period (July 1, 2003, through June 30, 2004) for SFY 2004. The methodology and analysis follows the baseline study, with additional analysis to show trended results and discussion of the interventions conducted by the MCOs and the Department.

The population for this focused study consisted of adults with disabilities, 20 through 64 years of age, with at least 11 months of continuous eligibility for SFY 2004. Sampling was not performed; the entire eligible population of adults with disabilities was used. The disability status of the population was identified through State eligibility codes 05 and 25 (Aid to Needy and Disabled). At age 65 and over, eligibility codes change to reflect Medicare enrollment, and adults with disabilities over age 65 could no longer be identified using the State Medicaid eligibility codes.

For the FFS and PCPP populations, HSAG used the State enrollment data to identify members with a disability and calculate their continuous enrollment history. Both CO Access and RMHP identified their own members and submitted their populations to HSAG, along with administrative claims data for the services in this study. Appendix B contains the specific ICD-9-CM and CPT-4 codes used to select the administrative claims, along with instructions given to CO Access and RMHP on how to identify their eligible population.

The purpose of this focus study is to remeasure access to preventive care after the implementation of interventions. Using QISMIC methodology, the Colorado Medicaid performance goal was to increase the preventive services and cancer screening rates by 10 percent, compared to the rates reported in the previous study. For example, the rate for breast cancer screening in SFY 2002 was 20.0 percent, indicating 80.0 percent did not receive the service (i.e., opportunity for improvement). The performance goal was to reduce the 80.0 percent opportunity for improvement by a minimum of 10.0 percent (i.e., 8.0 percentage points), such that the rate for SFY 2004 should be at least 28.0 percent (20.0 percent + 8.0 percent = 28.0 percent).

A detailed review of the results indicates that Colorado Medicaid rates increased overall. However, only the preventive services visit rates measure met the goal. The preventive services visit rates improved significantly across all Medicaid provider groups, except for the PCPP. The significant increase in the preventive visit rates (from 67.2 percent to 91.3 percent) among CO Access Medicaid members is notable.

Access to preventive care was measured specifically through four measures described in Table 3-1 below.

Table 3-1—Preventive Service Study Indicators

Cervical Cancer Screening Rate	Women with disabilities, 21–64 years of age (as of June 30, 2004), who received 1+ Pap tests during the measurement year or the year prior
Breast Cancer Screening Rate	Women with disabilities, 52–64 years of age (as of June 30, 2004), who received 1+ mammograms during the measurement year or the year prior
Prostate Cancer Screening Rate	Men with disabilities, 51–64 years of age (as of June 30, 2004), who received 1+ PSA tests during the measurement year
Access to Preventive Service	Adults with disabilities, 20–44 or 45–64 years of age (as of June 30, 2004), who had one or more ambulatory or preventive care visits during the measurement year

Administrative data (claims and encounter data) from July 1, 2002, through June 30, 2004, were analyzed using a modified version of the 2004 HEDIS Technical Specifications developed by NCQA.3-1 HEDIS is the most widely used set of performance measures in the managed care industry.

The modifications to the HEDIS specifications were to allow for changes in the measurement year. In addition, the study included only members with disabilities, and the prostate cancer screening measure is not a HEDIS measure. Due to these differences, Medicaid HEDIS benchmarks were not used as comparisons for these measures. However, the baseline and follow-up rates are comparable and both are included in this report. Statistical significance between baseline and follow-up (or remeasurement) was determined using standard chi-squared testing.

Caveats and Limitations

Analysis of administrative data (claims and encounter data) is subject to potential data biases, such as inaccurate or missing data elements. The impact of incomplete administrative data can be underreporting of preventive service rates. However, this potential impact is minimized by the fact that providers are reimbursed for conducting these preventive services on a fee-for-service basis, which means a provider must submit a claim for reimbursement. Nevertheless, the results from this study should be used with caution. Some additional caveats and limitations are noted in this study and include:

- Populations with disabilities have different patterns of health care resource utilization than their counterparts without disabilities; therefore, aggregate preventive service rates may not be comparable to the general Medicaid population.
- This study used only administrative data for analysis and did not include medical records to validate or supplement the administrative data. Even though the providers were reimbursed on a fee-for-service basis, it is possible that not all services were reported, or some claims may have

been denied. The reported preventive service rates in this report are most likely a little lower than the actual rates.

- Several measures are based on HEDIS Technical Specifications, but the measures are not calculated using the exact method as HEDIS, nor are the measures audited. For example, this study used only those Medicaid members with a disability, while HEDIS uses the entire eligible Medicaid population. Therefore, rates presented in this report should not be compared to national Medicaid rates.

4. Intervention Strategies

The previous SFY 2002 focused study[4-1] provided a list of recommendations, which are summarized in Table 4-1.

Table 4-1—Summary of Recommendations from SFY 2002 Colorado Medicaid Access to Preventive Services for the Disabled Focused Study

Possible Interventions		
Provide lists of Medicaid members with disabilities to providers, particularly FFS providers.	Conduct a targeted education/ awareness campaign among providers who have high numbers of members with disabilities.	Consider expanding the network of providers in areas where African-American populations cluster.
Provide performance profiles on preventive services, tools/data collection instruments, and financial incentives to FFS providers to track and report preventive services provided.	Consider differential incentive payment to providers and plans that meet state-determined preventive service goals.	Consider ways to capture disability status among the dual-eligible Medicaid-Medicare population, and include this group in future studies and interventions.
Conduct additional focused studies to identify barriers (e.g., transportation) and test interventions.	Identify and develop partnerships with community outreach agencies that are effective in providing services to men with disabilities to increase PSA screening rates.	Develop and implement a preventive services registry for persons with disabilities.
Expand the FFS provider panel to include additional nurse and mid-level practitioners.	Provide incentives to subpopulations with disabilities, particularly men.	
Conduct an awareness campaign for FFS providers promoting home care preventive services.	Develop partnerships and contracts with case management services.	

The health plans conducted various interventions after the first focused study report released in June 2003. In the fall of 2003, RMHP identified all members who had not received a mammogram during the past two years and those who had not received a Pap smear in the past three years. RMHP made three attempts to call each member and encourage her to have the screening tests and to inquire about any barriers to care. Members who could not be reached by telephone received a letter from the medical director reinforcing the importance of the screening tests and encouraging members to receive them. RMHP also used birthday communication reminders, member screening profiles, and updated both member and provider health plan materials. RMHP repeated these intervention strategies in the fall of 2004.

At CO Access, a 10-item action plan was developed. Intervention action items included adopting and disseminating guidelines to members and providers, updating the member handbook with

screening requirements, continuing reminders for cervical cancer screening and mammography tests, and continuing annual provider profiling for mammography tests. In addition, CO Access published articles in the Provider Bulletin and mailed age-appropriate birthday reminders to members at open enrollment. Only one item had not been initiated at the time of this report: exploring the potential for creating incentives to members and providers to encourage access to preventive care services.

Neither health plan targeted prostate cancer screening for their interventions; both concentrated their interventions on breast cancer screening and cervical cancer screening. The rates for these two indicators increased significantly from the baseline rate, demonstrating that effective interventions could be implemented.

The Department, in conjunction with HSAG, developed educational posters/calendars outlining the importance of preventive screenings. These were distributed to providers in the Primary Care Program Plan throughout the state.

Based on the findings of the SFY 2004 remeasurement study, the Department, health plans, and providers have opportunities to improve preventive services rates.

5. Findings

The findings presented in this section highlight the results from the first remeasurement of the SFY 2002 Access to Preventive Care for the Disabled study. In general, the analysis follows the methodology used in the baseline study; however, additional analyses have been added that compare the results between the two studies.

The final study population was composed of 34,981 members, 20 to 64 years of age, who met the State eligibility criteria for persons with disabilities. Table 5-1 describes the demographic characteristics of this population statewide and is segmented by program (i.e., FFS, PCPP, and MCO). Fifty-three percent of the Colorado Medicaid population with disabilities identified for this study were women. With the exception of FFS, the gender distribution across programs was similar, with females constituting a larger proportion of the eligible population. The average age among the eligible population of persons with disabilities was 43.5 years. The FFS population had the highest proportion of older members, while the PCPP had the greatest proportion of younger members. RMHP and CO Access had approximately equivalent numbers of younger and older members.

Table 5-1—Characteristics of Study Population for SFY 2004

Demographics	CO Medicaid	RMHP	CO Access	PCPP	FFS
Total Cases	34,981	1,222	5,828	9,818	18,113
Age					
Mean Age in Years	43.5	43.0	43.6	42.2	44.3
20–44 Years	48.2% N = 16,864	49.4% N = 604	48.3% N = 2,813	53.3% N = 5,231	45.4% N = 8,216
45–64 Years	51.8% N = 18,117	50.6% N = 618	51.7% N = 3,015	46.7% N = 4,587	54.6% N = 9,897
Gender					
Male	46.5% N = 16,263	41.2% N = 504	38.8% N = 2,260	43.8% N = 4,297	50.8% N = 9,202
Female	53.5% N = 18,718	58.8% N = 718	61.2% N = 3,568	56.2% N = 5,521	49.2% N = 8,911

Overall, the total number of cases identified for the current study had increased since the baseline study was conducted in SFY 2002. The increase was primarily seen in the FFS and PCPP populations. Only RMHP experienced a decrease in its eligible population, dropping from 2,355 members in SFY 2002 to 1,222 members in SFY 2004. Gender and age distributions were similar for both studies.

Overall Findings

Overall, the remeasurement of Colorado's members with disabilities showed improvement. Table 5-2 presents a comparative summary of the statewide findings. For all study measures, a greater proportion of Medicaid members with disabilities received services during the current review period (July 1, 2003, to June 30, 2004) compared to the baseline study (July 1, 2001, to June 30, 2002).

Cervical cancer screenings increased significantly, from 17.7 percent in SFY 2002 to 21.7 percent in SFY 2004, representing a 4.0 point increase. Likewise, breast and prostate cancer screenings also significantly increased from SFY 2002 to SFY2004 (3.3 percent change and 2.6 percent change, respectively). Additionally, a larger proportion of members received at least one preventive health visit in SFY 2004 (48.6 percent) than in SFY 2002 (39.3 percent).

Table 5-2—Statewide Summary of Findings

Indicators	CO Medicaid			
	SFY 2002 (%)	SFY 2004 (%)	Change in Rate	Performance Goal
Cervical Cancer Screening Rate	17.7	21.7	4.0*	Not Met
Breast Cancer Screening Rate	20.0	23.3	3.3*	Not Met
Prostate Cancer Screening Rate	5.5	8.1	2.6*	Not Met
Preventive Visit Rate	39.3	48.6	9.3*	Met

*The difference between the rates was statistically significant (*p-value* < 0.05).

The Colorado Medicaid performance goal was to increase the preventive services and cancer screening rates by 10 percent, compared to the rates reported in the previous study. For example, the rate for breast cancer screening in SFY 2002 was 20.0 percent, indicating 80.0 percent did not receive the service (i.e., opportunity for improvement). The performance goal was to reduce the 80.0 percent opportunity for improvement by a minimum of 10.0 percent (i.e., 8.0 percentage points), such that the rate for SFY 2004 should be at least 28.0 percent (20.0 percent + 8.0 percent = 28.0 percent). However, only the preventive health visit rate met the goal. A detailed review of the results indicates that, while the Colorado Medicaid rates increased overall, small declines in rates were experienced by one health care delivery program.

Table 5-3 and Figure 5-1 present comparative summary findings by program. RMHP, CO Access, and the FFS program showed consistent improvement on all screening and preventive visit rates, including a significant increase of 24.1 points in the preventive visit rate for CO Access. RMHP experienced the highest rates among all study measures. There were slight decreases in the prostate cancer screening and preventive visit rates for PCPP.

Table 5-3—Summary of Findings, by Program

	Cervical Cancer Screening			Breast Cancer Screening			Prostate Cancer Screening			Preventive Visit Rate		
	SFY 2002 (%)	SFY 2004 (%)	Change in Rate	SFY 2002 (%)	SFY 2004 (%)	Change in Rate	SFY 2002 (%)	SFY 2004 (%)	Change in Rate	SFY 2002 (%)	SFY 2004 (%)	Change in Rate
RMHP	38.8 n = 1,326	47.1 n=698	8.3*	49.9 n=377	58.3 n=228	8.4*	11.2 n=250	23.1 n=143	11.9*	78 n=2,355	87.8 n=1,222	9.8*
CO Access	26.4 n=2,818	35.1 n=3,528	8.7*	35.1 n=903	46.4 n=1,092	11.3*	7.0 n=611	13.5 n=631	6.5*	67.2 n=4,884	91.3 n=5,828	24.1*
PCPP	29.2 n=3,584	30.6 n=5,393	1.4	36.0 n=1,058	34.6 n=1,632	-1.4	15.9 n=731	16.2 n=1,024	0.3	63.0 n=6,525	62.9 n=9,818	-0.1
FFS	3.4 n=6,494	8.8 n=8,764	5.4*	2.7 n=2,429	6.4 n=3,067	3.7*	0.8 n=2,144	3.0 n=2,668	2.2*	11.0 n=13,484	24.4 n=18,113	13.4*
CO Medicaid	17.7 n=14,222	21.7 n=18,383	4.0*	20.0 n=4,767	23.3 n=6,019	3.3*	5.5 n=3,735	8.1 n=4,466	2.6*	39.3 n=27,248	48.6 n=34,981	9.3*

*The difference between the rates was statistically significant (*p-value* < 0.05).

Figure 5-1—Cancer Screening and Preventive Visit Percentage Point Change in Rates from Baseline (SFY 2002) to Remeasurement (SFY 2004)

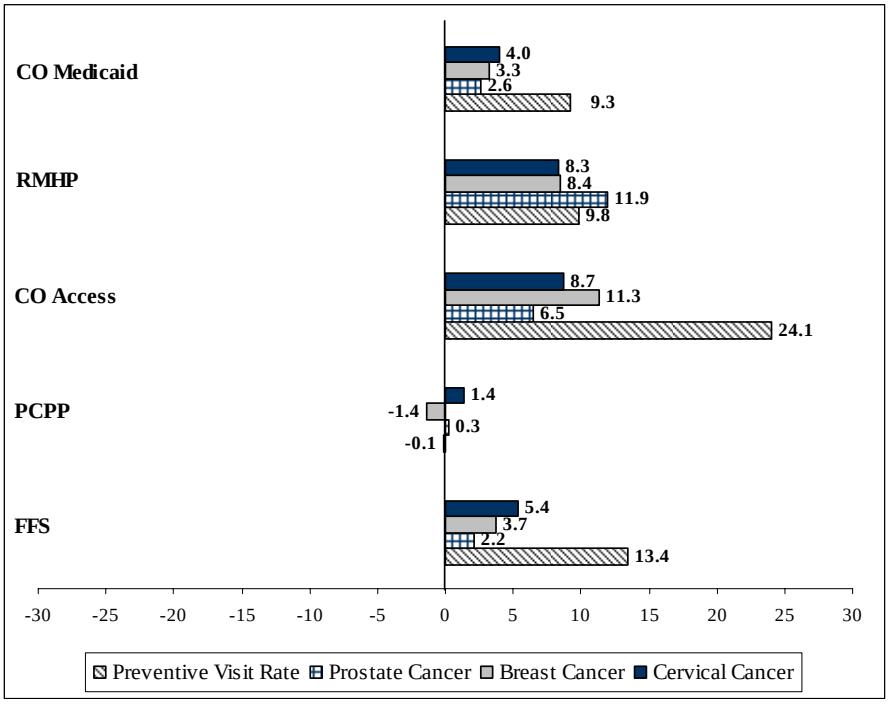


Table 5-4 summarizes the performance of each health care delivery program and indicates whether the performance goals were met for each measure. Overall, only the preventive health visit rate achieved the proposed performance goal. While CO Access met three of the performance goals (cervical cancer screening, breast cancer screening, and the preventive health visit rate), RMHP met or exceeded all study performance goals; it was the only Medicaid program to meet the goal for prostate cancer screening.

Table 5-4—Summary of Performance Goal Findings

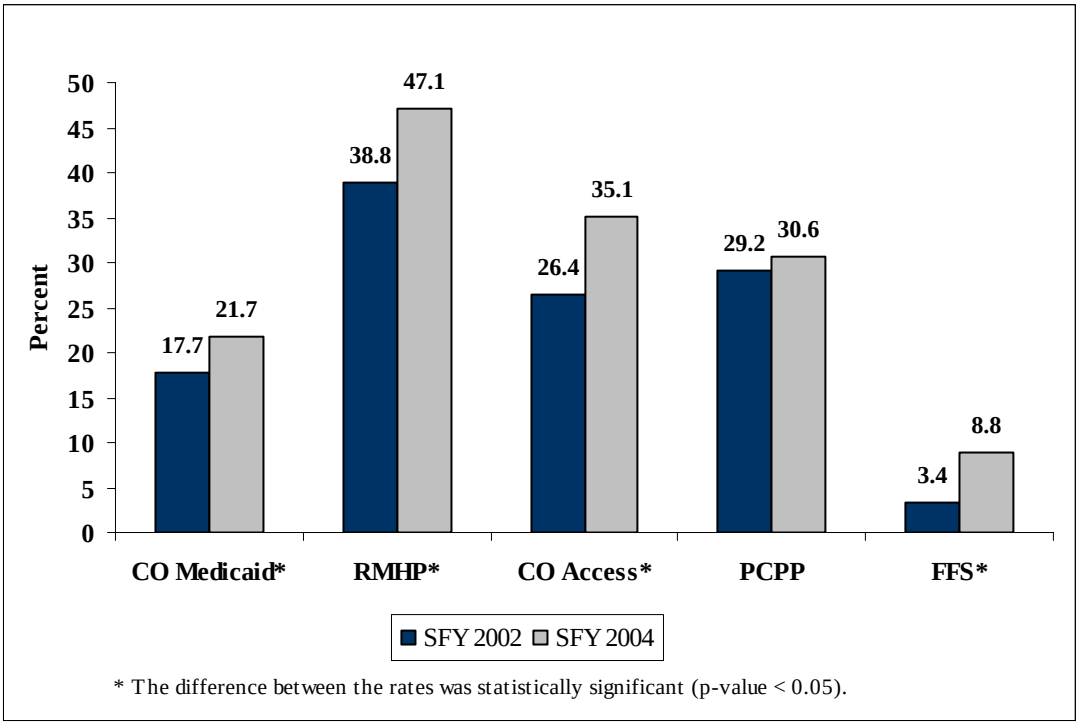
	Cervical Cancer Screening			Breast Cancer Screening			Prostate Cancer Screening			Preventive Visit		
	SFY 2004 Goal	SFY 2004 Rate	Goal Met	SFY 2004 Goal	SFY 2004 Rate	Goal Met	SFY 2004 Goal	SFY 2004 Rate	Goal Met	SFY 2004 Goal	SFY 2004 Rate	Goal Met
RMHP	44.9	47.1	Met	54.9	58.3	Met	20.1	23.1	Met	80.2	87.8	Met
CO Access	33.8	35.1	Met	41.6	46.4	Met	16.3	13.5	Not Met	70.5	91.3	Met
PCPP	36.3	30.6	Not Met	42.4	34.6	Not Met	24.3	16.2	Not Met	66.7	62.9	Not Met
FFS	13.1	8.8	Not Met	12.4	6.4	Not Met	10.7	3.0	Not Met	19.9	24.4	Met
CO Medicaid	25.9	21.7	Not Met	28.0	23.3	Not Met	15.0	8.1	Not Met	45.4	48.6	Met

Cervical Cancer Screening

The cervical cancer screening measure reported the percentage of women with disabilities who received one or more cervical cancer screenings during the measurement year or the year before the measurement year. Eligible women had to be 21 through 64 years of age as of June 30, 2004, and continuously enrolled in FFS, the PCPP, or the same MCO during the measurement year.

Figure 5-2 illustrates program comparisons of Colorado cervical cancer screening rates for both the baseline (SFY 2002) and remeasurement (SFY 2004) studies. For the Colorado Medicaid population overall, 21.7 percent of women with disabilities received a cervical cancer screening within the last two years. This represents a statistically significant increase from SFY 2002 (17.7 percent).

Figure 5-2—Cervical Cancer Screening Rates for Women 21–64 Years of Age with Disabilities



* The difference between the rates was statistically significant (p-value < 0.05).

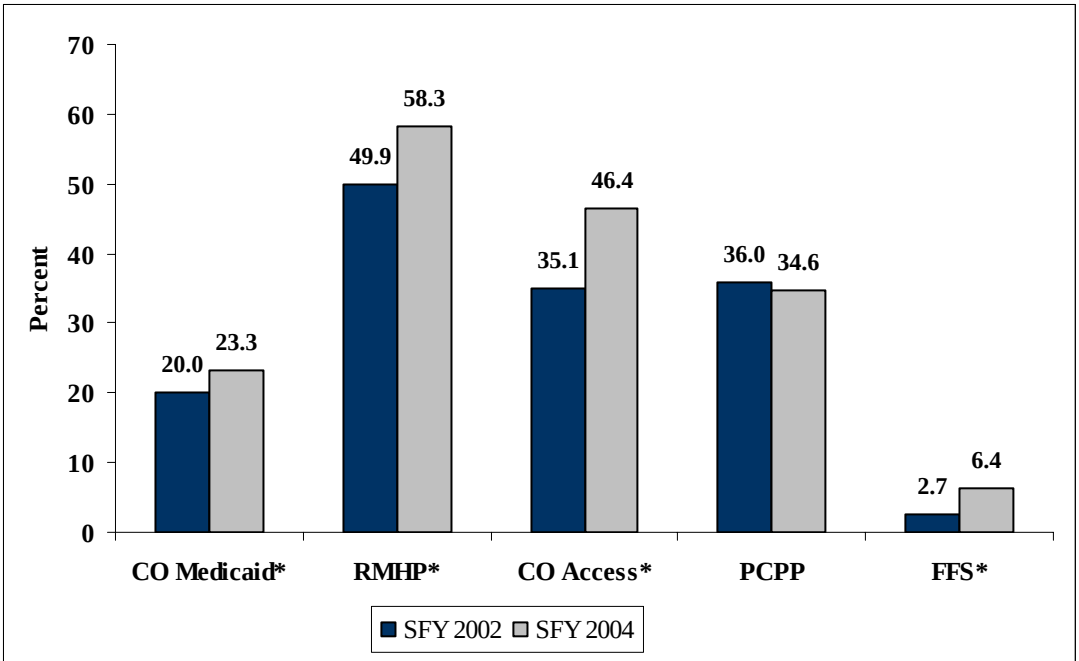
The highest rate for cervical cancer screening was shown by RMHP (47.1 percent), followed by CO Access (35.1 percent). Although the FFS population displayed the lowest rate (8.8 percent), there was statistically significant improvement in its performance. While the PCPP showed an increase in the level of screening, changing from 29.2 percent in SFY 2002 to 30.6 percent in SFY 2004, this change was not statistically significant. Despite the noted screening rate increases, only RMHP and CO Access met the performance goal of achieving a 10 percent reduction in the number of women with disabilities failing to obtain a cervical cancer screening.

Breast Cancer Screening

The breast cancer screening measure calculated the percentage of women with disabilities who had a mammogram during the measurement year or the year before the measurement year. Eligible women had to be 52 through 64 years of age as of June 30, 2004, and continuously enrolled in FFS, the PCPP, or the same MCO during the measurement year.

Figure 5-3 presents the breast cancer screening rate by program for both the baseline and remeasurement studies. For the Colorado Medicaid population, 23.3 percent of the eligible women with disabilities received a mammogram within the last two years; this is up 3.3 points from the baseline study (20.0 percent) and statistically significant. RMHP continued to have the highest rate (58.3 percent) among the four programs, while the unassigned FFS group had the lowest rate (6.4 percent). The PCPP was the only program to experience a slight decline in mammography rates, from 36.0 percent in SFY 2002 to 34.6 percent in SFY 2004. Among the four health delivery programs, only RMHP and CO Access met the goal for improvement from baseline rates. All noted rate changes were statistically significant at the 95 percent confidence level, except for the PCPP.

Figure 5-3—Breast Cancer Screening Rates for Women 52–64 Years of Age with Disabilities



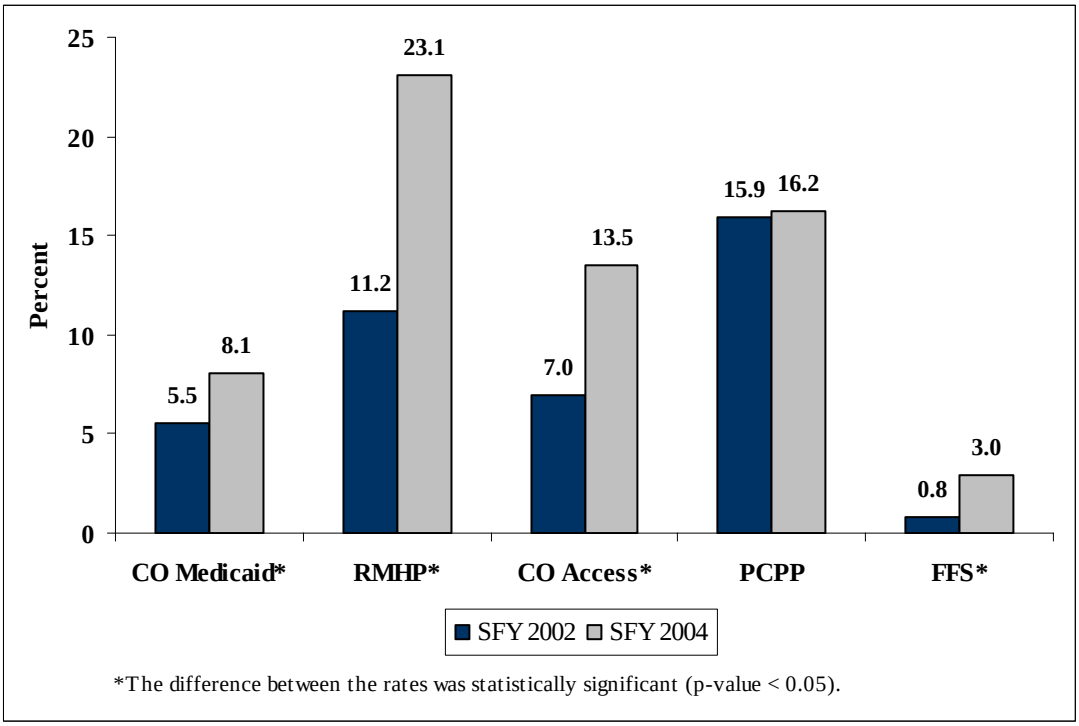
*The difference between the rates was statistically significant (p-value < 0.05).

Prostate Cancer Screening

The prostate cancer screening measure calculated the percentage of Medicaid men with disabilities who had a PSA test during the measurement year. Eligible men had to be 51 through 64 years of age as of June 30, 2004, and continuously enrolled in FFS, the PCPP, or the same MCO during the measurement year.

Figure 5-4 presents prostate cancer screening rates by program for both the baseline and remeasurement studies. Statewide, only 8.1 percent of the eligible men with disabilities in the Colorado Medicaid population received an annual PSA screening; this is up 2.6 points from SFY 2002 (5.5 percent). RMHP had the highest screening rate among the four programs (23.1 percent), followed by the PCPP (16.2 percent). FFS exhibited the lowest performance (3.0 percent).

Figure 5-4—Prostate Cancer Screening Rates for Men 51–64 Years of Age with Disabilities



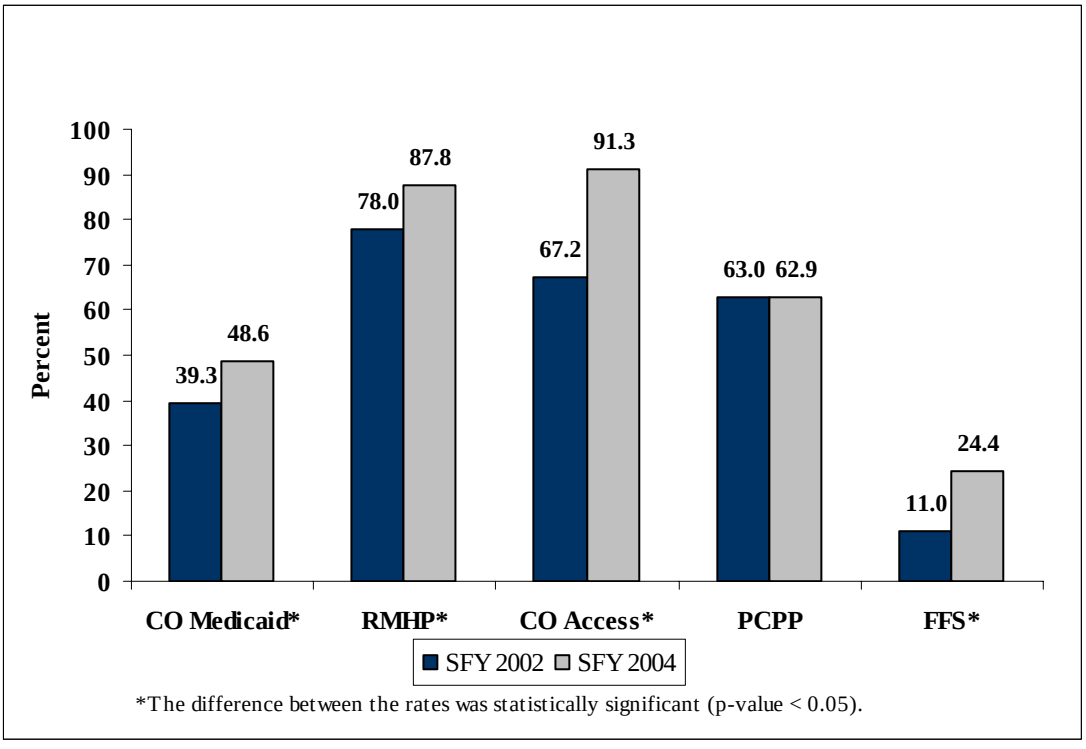
All noted rate changes were statistically significant at the 95 percent confidence level, except for the PCPP. Only RMHP met the improvement goal of a 10 percent increase in the opportunity for improvement.

Access to Preventive Services

The preventive visit measure reported the proportion of Medicaid members with disabilities who had one or more ambulatory or preventive health visits during the measurement year. This measure included all members with disabilities 20 through 64 years of age as of June 30, 2004, who were continuously enrolled in FFS, the PCPP, or the same MCO during the measurement year.

Figure 5-5 illustrates the preventive visit rate by program for the baseline and remeasurement studies for members 20 through 64 years of age. Overall, 48.6 percent of Medicaid members had at least one preventive health visit during the measurement year. This increase represented a significant change of 9.3 points from the SFY 2002 rate (39.3 percent). Among the four health care delivery programs, CO Access had the highest preventive visit rate (91.3 percent), followed by RMHP (87.8 percent). While the FFS population continued to exhibit the lowest preventive visit rate, this program experienced a significant increase of 13.4 points, from 11.0 percent in SFY 2002 to 24.4 percent in SFY 2004. In general, all programs showed significant improvement in their rates, except for the PCPP. The preventive visit rate for PCPP members exhibited no change between the review periods. All of the programs met or exceeded the performance goals, except for the PCPP.

Figure 5-5—Percentage of Members with Disabilities Who Had at Least One Preventive Visit (20–64 Years of Age)

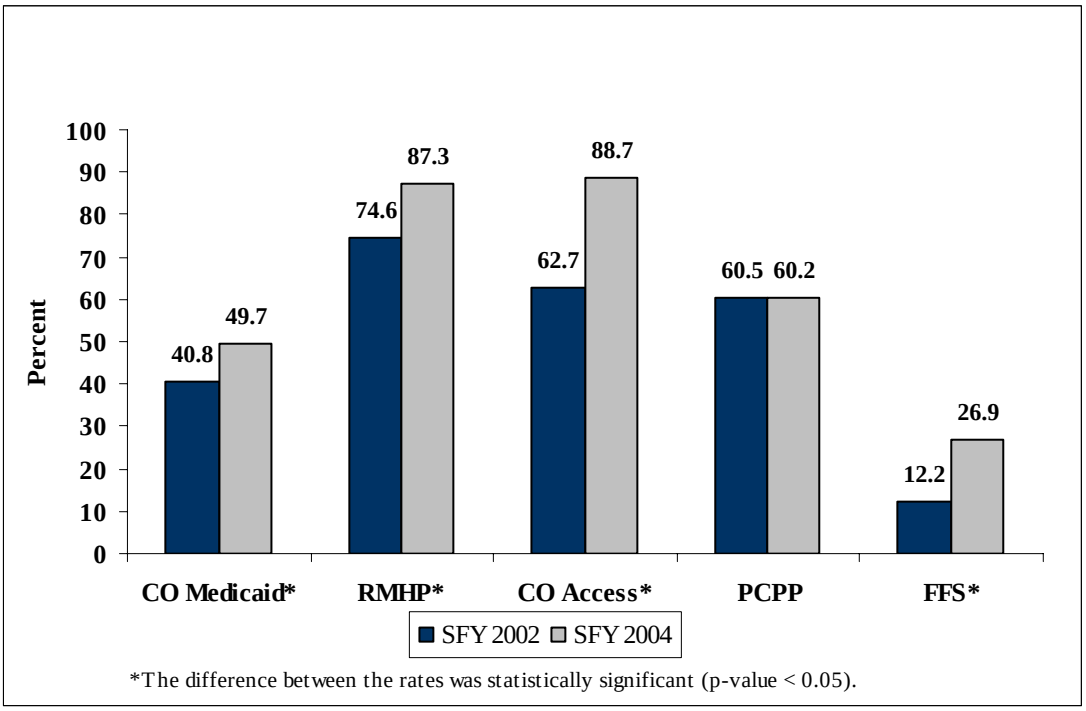


*The difference between the rates was statistically significant (p-value < 0.05).

As with the other measures, the FFS members accounted for more than half of this measure's population. As such, the low rate associated with the FFS program negatively impacted the Colorado Medicaid rate. The overall Colorado Medicaid rate would increase from 48.6 percent to 74.5 percent if the FFS population is excluded from the analysis.

The preventive visit rates in Figure 5-6 and Figure 5-7 separate the preventive visit rates into two age categories. These figures indicate that 49.7 percent of the population under 45 years of age, and 47.5 percent of the population 45 through 64 years of age, had at least one visit during the measurement year. For both age breakouts, CO Access exhibited the highest rates (88.7 percent and 93.6 percent, respectively), while the FFS program had the lowest rates (26.9 percent and 22.4 percent, respectively).

Figure 5-6—Percentage of Members with Disabilities Who Had at Least One Preventive Visit (20–44 Years of Age)

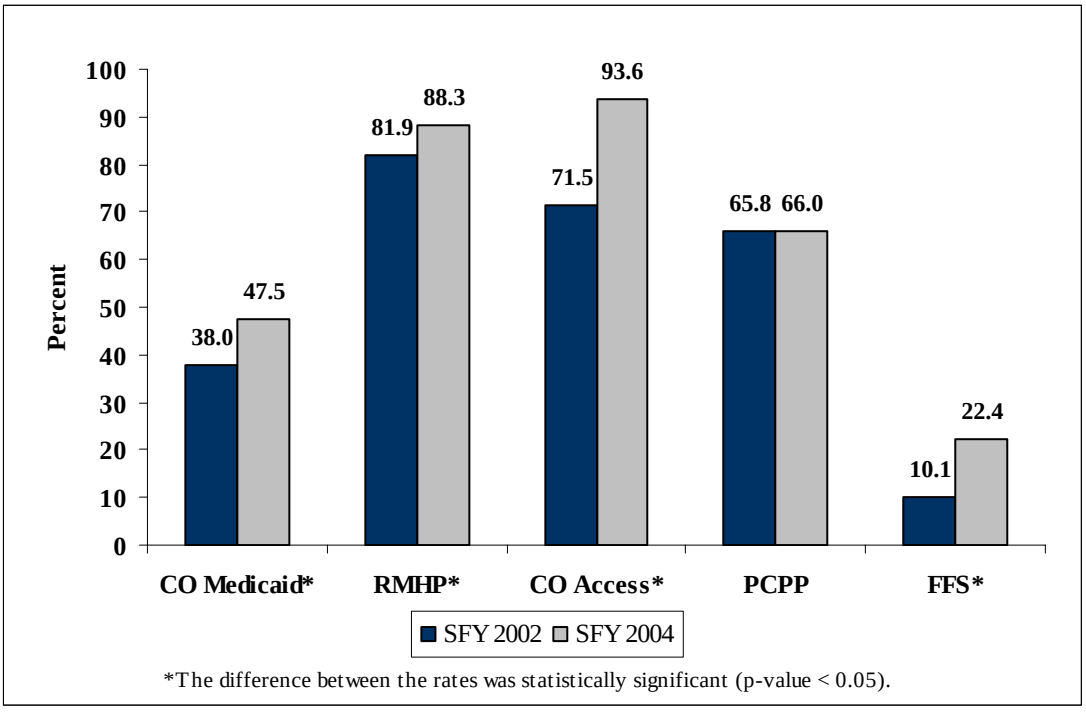


*The difference between the rates was statistically significant (p-value < 0.05).

All programs exhibited statistically significant improvement in rates among 20– through 44-year-old members, except for the PCPP. Further, the increases noted for RMHP, CO Access, and FFS programs all exceeded the performance goal.

Similar to members 20 to 44 years of age, three of the four health care delivery programs showed statistically significant improvement in the preventive visit rates for 45– through 64-year-old members (Figure 5-7 below). Only the PCPP reported no significant change in its rate. The increases noted for RMHP, CO Access, and the FFS population exceeded the performance goal of an increase of 10 percent in the opportunity for improvement.

Figure 5-7—Percentage of Members with Disabilities Who Had at Least One Preventive Visit (45–64 Years of Age)



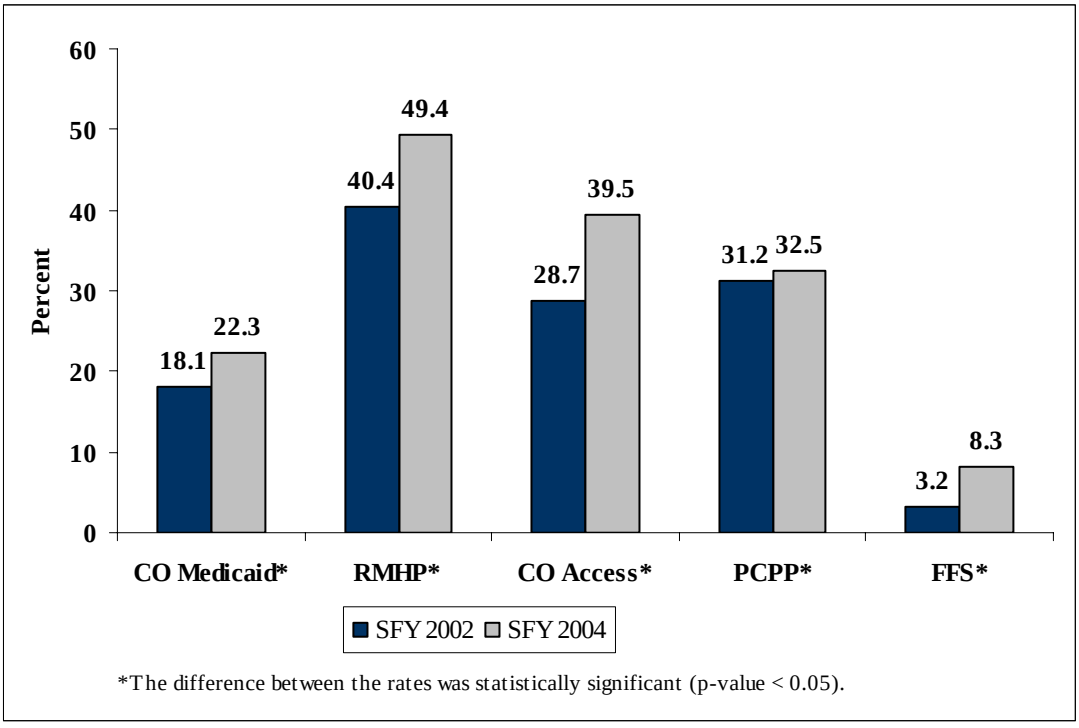
*The difference between the rates was statistically significant (p-value < 0.05).

ANY Preventive Service Rates

Figure 5-8 presents the proportion of members with disabilities who received a cancer screening preventive service for which they were eligible, regardless of the visit type. An eligible service is one that is appropriate to the age and gender of the member. The two eligible cancer screening services for women are cervical cancer and breast cancer screening. The eligible cancer screening service for men is prostate cancer screening.

For the Colorado Medicaid population, 22.3 percent of the members with disabilities received a cancer screening preventive service during the measurement year. This rate was higher than the rate during the baseline review period (18.1 percent). RMHP had the highest screening rate (49.4 percent), while the FFS group continued to have the lowest screening rate (8.3 percent). All plans experienced significant improvement in their rates, except for the PCPP; its rate only increased slightly from 31.2 percent in SFY 2002 to 32.5 percent in SFY 2004.

Figure 5-8—Percentage of Members with Disabilities Receiving ANY Eligible Cancer Screening Service

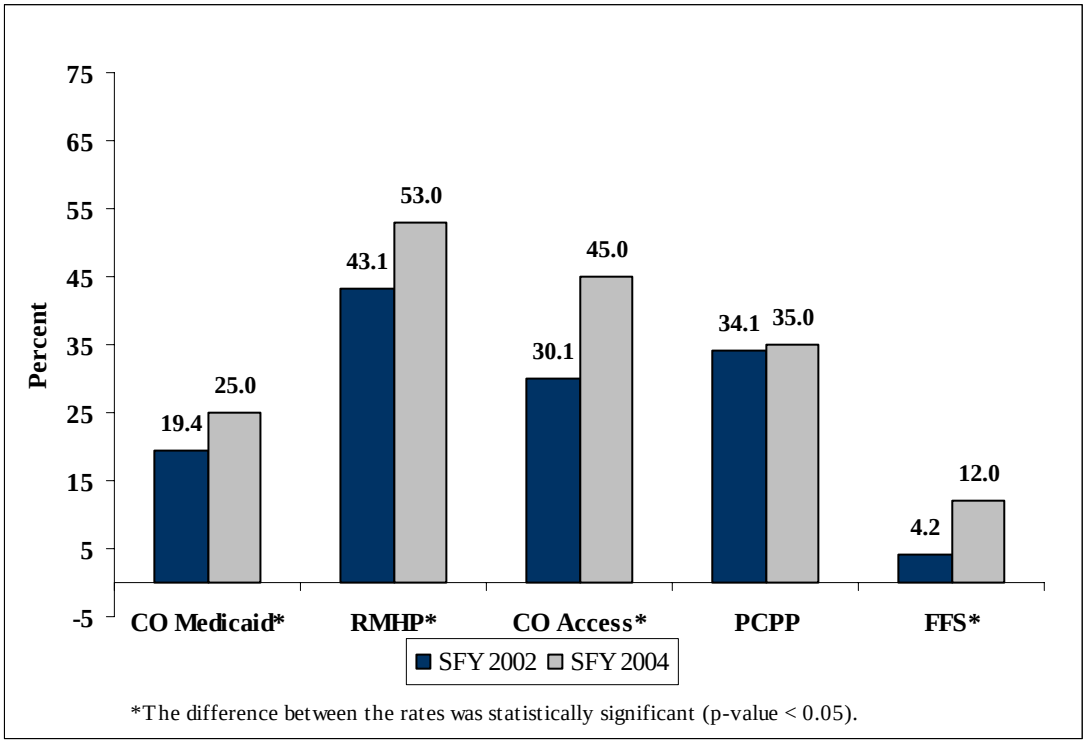


*The difference between the rates was statistically significant (p-value < 0.05).

All Appropriate Services

Optimal preventive service delivery provides all age-appropriate services to members regardless of the visit type. Figure 5-9 presents rates by program for members with disabilities receiving all appropriate services. Despite an increase since the SFY 2002 rate (19.4 percent), the proportion of Colorado Medicaid members receiving all appropriate services remained low (25.0 percent). RMHP continued to have the highest rate (53.0 percent), while the FFS group continued to have the lowest rate (12.0 percent). All programs experienced significant improvement in their rates, except for PCPP.

Figure 5-9—Percentage of Members with Disabilities Receiving ALL Appropriate Services



*The difference between the rates was statistically significant (p-value < 0.05).

6. Conclusions and Recommendations

This remeasurement of the provision of preventive care to Colorado Medicaid members with disabilities yielded mixed results and showed continued underuse of preventive services. Table 6-1 summarizes the results of the analysis. The preventive visit rate for SFY 2004 was 48.6 percent, and cancer screening rates ranged from 8.1 percent (prostate cancer) to 23.3 percent (breast cancer). The screening rate for cervical cancer was 21.7 percent. Delivery of all recommended preventive services occurred 25.0 percent of the time.

Table 6-1—Summary of Findings

Study Measure	CO Medicaid		RMHP		CO Access		PCPP		FFS	
	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)	SFY 2002 (%)	SFY 2004 (%)
Cervical Cancer Screening Rate	17.7	21.7	38.8	47.1	26.4	35.1	29.2	30.6	3.4	8.8
Breast Cancer Screening Rate	20.0	23.3	49.9	58.3	35.1	46.4	36.0	34.6	2.7	6.4
Prostate Cancer Screening Rate	5.5	8.1	11.2	23.1	7.0	13.5	15.9	16.2	0.8	3.0
Preventive Service Visit Rate	39.3	48.6	78.0	87.8	67.2	91.3	63.0	62.9	11.0	24.4
ANY Preventive Service Rate	18.1	22.3	40.4	49.4	28.7	39.5	31.2	32.5	3.2	8.3
ALL Preventive Services Rate	19.4	25.0	43.1	53.0	30.1	45.0	34.1	35.0	4.2	12.0

Overall, only the preventive services visit rates measure met the goal for an increase of 10.0 percent in the opportunity for improvement. The preventive services visit rates improved significantly across all Medicaid provider groups, except for PCPP. The significant increase in the preventive visit rates (from 67.2 percent to 91.3 percent) among CO Access Medicaid members was commendable.

RMHP, CO Access, and FFS showed consistent improvement on all screening and preventive visit rates. RMHP had the highest rates, and was the only health delivery program to meet all performance goals. Although not statistically significant, PCPP was the only Medicaid program to experience some declines in performance since the baseline study.

In 2003, the MCOs began interventions based on the results from the baseline study. The results of this focused study show additional interventions are necessary to achieve optimal results. Specifically, findings from this study are summarized below, along with appropriate recommendations.

- **Finding:** The unassigned FFS population continues to represent approximately half of the eligible Colorado Medicaid members with disabilities. Overall, this program services twice the number of eligible members assigned to the PCPP and three times the number of members assigned to the largest managed care plan. Despite moderate improvement across preventive services and screenings, the combination of this program's comparatively low rates and large population negatively impact the State's overall performance. Further, differences in demographic composition of the FFS population with disabilities (i.e., older and more male) make it difficult to draw robust comparisons to the managed care or PCPP programs.

  Recommendation: From SFY 2002 to SFY 2004, the FFS population increased by 34.3 percent. With the continued growth in the proportion of Colorado Medicaid-eligible members with disabilities enrolled in the FFS program, it is increasingly important to track performance on preventive service measures for that population separately from managed care and the PCPP. HSAG recommends the following:

  - Target members with disabilities to receive health promotion materials outlining the various preventive services available. Specifically, focus on those members eligible to receive specific preventive screenings, including breast, cervical, and prostate cancer screenings.
  - Continue current marketing interventions that target provider offices.

- **Finding:** Nearly half of the Colorado Medicaid members with disabilities had no preventive health visits. Further, of the remaining members who had at least one preventive health visit during the review period, nearly one-quarter (*20.7 percent*) received none of the required services. This may reflect continued barriers to, or the inadequate delivery of, preventive care services.

  Recommendation: A review of the interventions initiated in response to the SFY 2002 study suggests that both the Department and managed care plans focused interventions on increasing the number of members with disabilities receiving appropriate cancer screenings. However, with the large number of members having received no services or incomplete services, outreach efforts should also focus on increasing the accessibility of preventive services. HSAG recommends the following:

  - Continue to study barriers to care and develop interventions that mitigate their impact (e.g., transportation, access to facilities, and member and provider perceptions).
  - Involve members with disabilities in the planning of outreach activities.
  - Develop partnerships with community advocates for persons with disabilities to facilitate the coordination of preventive services and increase utilization.

- **Finding:** Only 25.0 percent of Colorado Medicaid members with disabilities received all required services during the review period. Although this rate represents a significant increase from SFY 2002 (19.4 percent), it continues to suggest that the delivery of preventive services is incomplete.

  Recommendation: HSAG recommends the following:

  - Work with providers to ensure medical equipment and facilities are accessible for members with disabilities.
  - Collaborate with other public and private agencies to coordinate the delivery of preventive services and screenings.
  - Consider incentive payments to providers and health plans that meet State-defined performance criteria.

- **Finding**: Cervical and breast cancer screening rates were significantly higher for both RMHP and CO Access in SFY 2004, and both met the performance goal of a 10.0 percent increase in the opportunity for improvement. For cervical and breast cancer screening and preventive health visits, only CO Access exhibited significant improvement across all study indicators. Significant increases across all study indicators were noted for the FFS program as well; however, only the preventive visit goal was met.

  Recommendation: The increases noted in the cervical and breast cancer screening rates among the health plans are likely related to the comprehensive interventions initiated after the baseline study. Both RMHP and CO Access targeted specific interventions for Colorado Medicaid providers and members with disabilities. These interventions included the following elements: phone and mail reminders for women eligible for cancer screening, ongoing birthday reminder communications (RMHP/CO Access), member screening profiling (RMHP), provider screening profiling (RMHP/CO Access), and updates to member and provider health plan materials, e.g., provider handbooks and member handbooks. (RMHP/CO Access). Interventions by the Department focused on targeting provider offices with educational posters/calendars outlining the importance of preventive screenings. HSAG recommends the following:

  - Continue intervention strategies currently in place at the managed care plans.
  - Expand outreach activities to include health plan and provider incentives based on performance.
  - Explore the possibility of offering incentives to members with disabilities to encourage the use of the preventive services.
  - Continue to work with the Department to develop community partnerships that help coordinate services for Medicaid members with disabilities.

  In addition to the recommendations above, HSAG suggests that the Department consider adopting the quality improvement activities employed by the health plans. It appears that the combined interventions (provider education through profiling and promotion of guidelines, and multiple reminders to members) had a positive impact on improving cancer screening and preventive visit rates among Medicaid members with disabilities who were enrolled in the health plans.

- **Finding:** Prostate cancer screening rates for men with disabilities enrolled in Colorado Medicaid continued to remain significantly lower than cervical or breast cancer screening rates. Overall, only 8.1 percent of eligible men received an annual prostate cancer screening. All Medicaid health programs exhibited an increase in the prostate cancer screening rates in SFY 2004. Only RMHP met the performance goal for prostate cancer screening.

  Recommendation: Although both the Department and health plans initiated interventions to increase breast and cervical cancer screening rates among Colorado Medicaid women with disabilities, there were no specific targeted interventions to improve prostate cancer screening among eligible men with disabilities. HSAG recommends the following:

  - Expand beyond the current breast and cervical cancer screening interventions employed by the Department and health plans to include prostate cancer screening. Specifically, health care delivery programs should identify men with disabilities who are eligible for prostate cancer screening and provide ongoing communications regarding the need for screening. Programs should also make lists available to providers of members with disabilities who have not received a prostate cancer screening.
  - Work with providers to ensure facilities are accessible to members with disabilities.
  - Target men with disabilities to receive health promotion materials related to PSA screening.
  - Identify and develop community partnerships with other agencies offering outreach services to men with disabilities.
  - Work with opinion leaders in the provider communities to help improve attitudes, beliefs, and practices relevant to PSA screening.

Moving forward, an initial step for consideration would be to work with existing programs and services, such as the Colorado Cancer Coalition and its annual conferences.[6-2] In other states, initiatives to improve cancer screening rates frequently involve cancer coalitions and the department of public health. For example, the State of Michigan,[6-3] with funding from the Centers for Disease Control and Prevention, has launched a multimedia advertising campaign to raise awareness about the importance of early detection and treatment of breast and cervical cancer and to increase overall cancer screening rates. In northern Virginia, the National Rehabilitation Hospital Center for Health and Disability Research is conducting grant-funded research (project SHIELD) to explore barriers to providing preventive health care for people with physical disabilities. The project includes a tool kit of information for people with disabilities to use when they visit medical providers.

There are opportunities to continue this work, to learn from successful initiatives and programs, to expand the interventions, and to collaborate with external stakeholders and coalitions. Additional strategies for addressing the needs of Colorado Medicaid members with disabilities include the following:

- Identify and address access and attitudinal barriers to screening services.
- Determine and disseminate home care options for preventive services, and consider exceptional needs coordinators[6-4] as case managers for persons with severe disabilities.
- Identify the subpopulation with the most severe disabilities and design performance improvement strategies.
- Educate and empower family and other caregivers and advocates about the importance of preventive care services.

A multidisciplinary and priority-directed plan could help improve preventive care and services for Medicaid members with disabilities in this diverse and vulnerable population. It is recommended that the Department consider working with providers, health plans, advocacy organizations, and the Colorado Cancer Coalition to design and implement a collaborative performance improvement project to improve preventive care and services for Medicaid members with disabilities. Furthermore, because health disparities are important to the national agenda, the Department could also consider the feasibility and benefits of collaboration with the Centers for Medicare & Medicaid Services, the Center for Health Care Strategies, Inc., and the Agency for Healthcare Research and Quality, and/or the Institute for Health Care Improvement.

Appendix A. Endnotes

1-1 Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the nation to achieve over the first decade of the new century. Healthy People 2010 is published by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, and was created by scientists both inside and external to the U.S. government.

1-2 U.S. Department of Health and Human Services, *Healthy People 2010*. Washington, DC: 2000, pp.11–16.

1-3 NCQA. *HEDIS® 2004 Technical Specifications*. Washington, D.C., 2001. Available at: http://www.ncqa.org/hedis/.

2-1 Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the nation to achieve over the first decade of the new century. Healthy People 2010 is published by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, and was created by scientists both inside and external to the U.S. government.

2-2 U.S. Department of Health and Human Services, *Healthy People 2010*. Washington, DC: 2000, pp.11–16.

2-3 Diab ME, Johnston MV. Relationships between level of disability and receipt of preventive health services. *Arch Phys Med Rehabil*, 2004;85(5)749–57.

2-4 Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, U.S. Department of Health and Human Services. Healthy People 2010, September 6, 2001, and December 2004.

2-5 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. *National Health Interview Survey on Disability*. 1994. Available at: http://www.cdc.gov/nchs/about/major/nhis_dis/nhis_dis.htm. Accessed on December 17, 2004.

2-6 Iezzoni LI, McCarthy EP, Davis RB, Siebens H. Mobility impairments and use of screening and preventive services. *Am J Public Health*, 2000;90(6):955–61.

2-7 Iezzoni LI, McCarthy EP, Davis RB, Harris-David L, O'Day B. Use of screening and preventive services among women with disabilities. *Am J Med Qual*, 2001;16(4):135–44.

2-8 Association of State and Territorial Health Officials. Fact Sheet: Access to Health Promotion Activities for Individuals with Disabilities. May 2003. Available at: http://www.astho.org/pubs/GeneralDisabilityFactSheet2.pdf. Accessed on December 17, 2004.

2-9 Shabas D, Weinreb H. Preventive health care in women with multiple sclerosis. *J Womens Health Gend Based Med*, 2000;9(4):389–95.

2-10 Chan L, et al. Do Medicare patients with disabilities receive preventive services: A population-based study. *Arch Phys Med Rehabil*, 1999;80(6):642–6.

2-11 Cheng E, et al. Mobility impairments and use of preventive services in women with multiple sclerosis: observational study. *BMJ*, 2001;323(7319):968–9.

2-12 Managed Care Disability Conference – Final Summary, April 17, 2002. Serving Persons with Disabilities in Medicaid Managed Care: Assuring Continuity, Quality and Cost Effectiveness. Conference co-sponsored by HRSA and CMS.

2-13 Havercamp SM, Scandlin D, Roth M. Health disparities among adults with developmental disabilities, adults with other disabilities, and adults not reporting disability in North Carolina. *Public Health Reports*, 2004 July-Aug; 119(4):418–26.

2-14 National Committee for Quality Assurance. *The State of Health Care Quality. 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003:29.

2-15 American Cancer Society. Detailed Guide: Cervical Cancer. *What are the Key Statistics About Cervical Cancer?* Available at: http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_cervical_cancer_8.asp?rnav=cri. Accessed on March 9, 2005.

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3-1 NCQA. *HEDIS® 2004 Technical Specifications.* Washington, D.C., 2001. Available at: http://www.ncqa.org/hedis/.

4-1 Colorado Medicaid Access to Preventive Services for the Disabled Focused Study, June 2003.

6-1 It should be noted that RMHP had the highest proportion of Whites (76.1 percent vs. 37.9 percent at CO Access); other published studies indicate increased access to preventive services among Whites as compared to minority groups.

6-2 Colorado State Cancer Conference, August 11–12, 2005. Contact heather.tolby@state.co.us.

6-3 Michigan Cancer Consortium. Available at: http://www.michigancancer.org. Accessed on March 31, 2005.

6-4 Managed Care Disability Conference – Final Summary, April 17, 2002. Panel Discussion III: Developing a Network of Providers with Relevant Experience. Conference cosponsored by HRSA and CMS.

Appendix B. File Layout

In 2002, a focused study was conducted for Colorado Medicaid. The study included PCPP, the unassigned FFS program, and the two Colorado Medicaid managed care organizations. The purpose of the study was to determine to what extent the Colorado Medicaid population with disabilities received appropriate access to preventive services. The managed care organization and PCPP results, although similar to national rates, were low. The FFS rates were even lower for all of the measures. The decision to conduct a follow-up for this focused study was based on these results, which indicated there was an opportunity to improve access to care for persons with disabilities by reinforcing education to both members and providers on the importance of preventive services.

This focused study is a follow-up to the baseline study. It is the first remeasurement period (July 1, 2003, through June 30, 2004) for SFY 2004. The study questions are: To what extent does the Colorado Medicaid population with disabilities receive appropriate access to preventive services? Has access improved since the baseline study conducted for 2002?

The methodology and analysis will follow the baseline study, with additional analysis to show trended results. The initial goal was to achieve a 10 percent reduction in the number of Colorado Medicaid members with disabilities who do not receive the screening services identified in this focused study.

Each plan followed these steps to create the data for HSAG:

1. Select all members born **before** July 1, 1983.
   This will ensure the sample includes only those who are 20 years of age or older during the measurement year.

2. Determine those members in Step 1 (above) who were currently enrolled in your health plan as of June 30, 2004 (the last day of the measurement year).

3. Determine the number of months of eligibility each member in Step 2 had between July 1, 2002, and June 30, 2002. Each month's eligibility can be stored as a 0/1 field (0 = Not Eligible, 1 = Eligible) in the file, or you may provide one field called ELGMOS = total of the 0/1 fields.

4. If you have "home grown" codes, you should provide a crosswalk table of internal codes with ICD-9-CM and CPT-4 codes.

Note: Every member identified above should have at least one record in the submitted data file, whether or not a visit was identified. Members with more than one visit should have a record for <u>each</u> visit.

The following file layout should be used for this focused study. This file can be in ASCII or dBase IV. If you need to submit using another file format, contact Tom Miller at 602.745.6263, or e-mail tmiller@hsag.com.

Table B-1—File Layout for the 2004 Colorado Focused Study on Access to Care for Medicaid Members With a Disability

Field Name	Type	Description
planname	String	Health Plan Name
memid	String	Member ID
first	String	Member's First Name
mid	String	Member's Middle Initial
last	String	Member's Last Name
gender	String	Member's Gender
dob	Date	Member's Date of Birth
aid	String	Member's Category of Aid
Jul03	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Aug03	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Sep03	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Oct03	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Dec03	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Jan04	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Feb04	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Mar04	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Apr04	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
May04	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
Jun04	Integer	0/1, 0 = Not Enrolled, 1 = Enrolled in Health Plan
dos	Date	Date of Service
setting	String	Service Setting = Ambulatory, Inpatient or Outpatient
prov_nam	String	Provider Name
provid	String	Unique Provider ID
icd1	String	Primary Diagnosis (ICD-9-CM codes)
icd2	String	Secondary Diagnosis (ICD-9-CM codes)
icd3	String	Other Diagnosis (ICD-9-CM codes)
icd4	String	Other Diagnosis (ICD-9-CM codes)
Additional ICD-9-CM codes can be added here.		
cpt1	String	Primary Procedure Code (CPT-4 codes)
cpt2	String	Secondary Procedure Code (CPT-4 codes)
cpt3	String	Other Procedure Code (CPT-4 codes)
cpt4	String	Other Procedure Code (CPT-4 codes)
cpt5	String	Other Procedure Code (CPT-4 codes)
cpt6	String	Other Procedure Code (CPT-4 codes)
Additional CPT-4 codes can be added here.		

Note: Additional diagnoses and procedure codes (ICD-9-CM and CPT-4 codes) may be added as needed; if a member has 12 CPT-4 codes, then please add cpt7 – cpt12 in the database.

The data should only be for the members identified in the focused study population and include all relevant claims/encounters for those members between **July 1, 2002, and June 30, 2004**. Relevant claims/encounters are identified at the end of this document.

Each claim/encounter/date of service should be a **new** record on the file. For example, if a member has three visits in the period, then the member should be listed three times in the database. If a member has no visits, then the member should have one record in the database, listing everything except visit information.

Table B-2—Claims and Encounters for the 2004 Colorado Focused Study on Access to Care for Medicaid Members With a Disability

ICD-9-CM and CPT-4 Codes Needed for Cervical Cancer Screening
These codes include contra-indications or exclusions codes.
ICD-9-CM Codes
68.4 – 68.8, 91.46 V76.2
CPT-4 Codes
51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262,58263, 58267, 58270, 58275, 58280, 58285, 58290 – 58294, 58550, 58551, 58552 – 58554, 58593, 58594, 58951, 59135, 59525,88141 – 88145, 88147, 88148, 88150, 88152 – 88156, 88158, 88164 – 88167, 88174, 88175
Revenue Code
923
ICD-9-CM and CPT-4 Codes Needed for Breast Cancer Screening
These codes include contra-indications or exclusions codes.
ICD-9-CM Codes
85.41 – 85.48, 87.36, 87.37 V76.11, V76.12
CPT-4 Codes
76090, 76091, 76092 19180, 19200, 19220, 19240
Revenue Codes
401, 403
ICD-9-CM and CPT-4 Codes Needed for Prostate Cancer Screening
CPT-4 Codes
84152, 84153, 84154
ICD-9-CM Codes
V76.44
ICD-9-CM and CPT-4 Codes Needed for Adults' Access to Care
CPT-4 Codes
92002, 92004, 92012, 92014 99201 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99350 99301 – 99303, 99311 – 99313, 99321 – 99323, 99331 – 99333 99385 – 99387, 99395 – 99397, 99401 – 99404, 99411, 99412 99420,99429, 99499
Revenue Codes
510 – 519, 520 – 529, 770, 771, 779, 982, 983