

Targeted Investments 2.0 Program

TIP Measure Details Guide:

Cervical Cancer Screening (CCS)

The AHCCCS Targeted Investments Program (TIP) Quality Improvement Collaborative (QIC) evaluates TI-participating Providers' performance on select quality measures and assists providers in performance improvement efforts. This guide is for TI-participating providers to help them understand the Cervical Cancer Screening (CCS) measure. CCS is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure designed and maintained by the [National Committee for Quality Assurance \(NCQA\)](#).

Why It Matters

Cervical cancer can be detected in its early stages by regular screening. Due to the success of cervical cancer screening in the U.S., dramatic decreases have been observed in both mortality and incidence of invasive cervical cancer. The current incidence rate is 6.9 cervical cancer cases per 100,000 women per year in the U.S., and the mortality rate associated with cervical cancer is 2.3 deaths per 100,000 per year.¹ The National Cancer Institute (NCI) estimated that there were 13,240 new cervical cancer cases and 4,170 related deaths in 2018.²

Human papillomavirus (HPV) causes virtually all cases of cervical cancer and associated precancerous lesions.³ Cervical intraepithelial neoplasia, known as CIN, is a precancerous condition where abnormal cells are found on the surface of the cervix.⁴ There are three stages of CIN, with the likelihood of becoming cancer and spreading to nearby normal tissues increasing from stage 1 to stage 3. Although vaccines to prevent most HPV infections that can cause cervical cancer are available, those who have been vaccinated should continue to be screened regularly.⁵ Three screening strategies can detect cervical precancers and cancers: cytology testing, high-risk HPV (hrHPV) testing and cytology supplemented with HPV screening (cotesting).

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cytology alone in women 21–29. Screening with hrHPV testing is not recommended for women younger than 30 because it results in more harms than benefits. The USPSTF recommends three cervical cancer screening strategies starting at age 30: cytology alone, hrHPV testing alone or cotesting every 5 years.⁶

What We Measure

Cervical Cancer Screening: The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Your performance is reported as a percentage calculated as the $\frac{\text{numerator}}{\text{denominator}}$.

Please note: This measure tracks cervical cancer screening using 3- and 5-year look-back periods, aligned with standard age-based screening recommendations. It first checks whether a cervical cytology test was performed within the past 3 years. For members aged 30–64 who have not had a cervical cytology during this period, the measure then looks for cervical cancer screenings (HrHPV test alone or cervical cytology + hrHPV co-test) within the past 5 years, relative to the report period end date.

TI Area of Concentration	Denominator Definition	Numerator Definition
Adult PCP	Members aged 24 to 64 years old as of the report period end date.	Members in the denominator who received a cervical cancer screening, either: <ul style="list-style-type: none"> • Cervical cytology within the last 3 years (ages 24–64), or • High-risk HPV (hrHPV) testing within the last 5 years (ages 30–64), or • Cervical cytology + hrHPV co-test within the last 5 years (ages 30–64).

What Is the Reporting Period?

- A HEDIS® measure’s reporting period is a continuous 12-month window.
- TIP Provider Dashboards show your organization’s performance on the selected measure for 12 consecutive, overlapping report periods, where each report

period is a 12-month period ending in the month and year shown on the X-axis. Your performance levels for 12 report periods are provided so you can track how your performance changes across time.

- TI incentive payments are based on your performance for the Federal Fiscal Years (October 1st to September 30th).

Which Members Are in my Denominator?

To understand the members that you are accountable for and who are attributed to you (i.e., in your denominator) for this measure, you need to know the denominator definition (above), as well as the AHCCCS member population assessed, and the attribution method used.

Member Population Assessed

- Members enrolled in one of the seven AHCCCS Complete Care (ACC) health plans
- Members with SMI enrolled in an ACC Regional Behavioral Health Agreement (RBHA) health plan are included

Member Population Exclusions

- ACC and ACC-RBHA members who utilized hospice services, received palliative care, or died
- ACC and ACC-RBHA members who have a diagnosis indicating absence of cervix or a history of hysterectomy with no residual cervix

Attribution Methods

- In TI 2.0 Year 4, attribution is done at the billing and servicing provider ID level. For a detailed explanation about the provider IDs used and examples, please see the [TI 1.0 Provider Identification Methodology video](#) and [slides](#).
 - If you have any questions about the billing and servicing provider IDs used for your organization, please contact the AHCCCS Targeted Investments team (targetedinvestments@azahcccs.gov).
- Attribution is re-evaluated each month for all report periods displayed on the dashboard. The attribution method used is specific to each AOC. Review the attribution method specific to the TI AOC you are enrolled in:

TI Area of Concentration	Attribution Method
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<p>Adult PCP</p>	<ul style="list-style-type: none"> ● PCP attribution is based on claims and PCP-member assignments. ● Members are attributed to the PCP with whom they have the strongest relationship, as documented by claims, considering the frequency of visits, MCO PCP assignment, and the member’s most recent PCP visit if multiple relationships exist. If no established relationship is documented, members are attributed to their MCO-assigned PCP. The most recent member assignments are used. ● These assignments are provided monthly by health plans and AHCCCS. Milestone performance is calculated based on member-level attribution aggregated to the Organizational (Tax ID) level for participating sites.
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What Services Qualify for the Numerator?

Billing Codes

- TI 2.0 Year 4 use HEDIS® Measurement Year 2023 measure definitions.
- Due to licensing agreements, we are not able to publish a list of all qualifying services codes. However, we can direct you to resources containing the billing codes.
 - Please see these Arizona Health Plan Measure Guides. You do not have to be contracted with the plan to access these resources.
 - United Healthcare - [HEDIS® MY 2023 Reference Guide](#)
 - Mercy Care – [HEDIS® Guide](#)
 - Definitions Only - Banner University Family Care - [HEDIS® Guide](#)
 - For more information on HEDIS measures or to get your own license, see the [NCQA HEDIS® site](#).
 - Value sets and codes used in HEDIS 2024 (Measurement Year 2023) measure calculations are available at no cost. Download the 2023 Quality Rating System (QRS) HEDIS Value Set Directory from the [NCQA store](#).

What Services Do Not Qualify for the Numerator?

Any procedure code not listed in the previous section does not qualify.

How Do I Document Services to Get Credit on the Measure?

TI performance measurement relies on claims data. Hybrid chart review does not apply.

What Is My TI Performance Target?

The table below shows the TI target set for the CCS measure. For your organization’s specific target, please see your dashboard or the email received from the AHCCCS TI team.

TI Area of Concentration	Measure	Target
Adult PCP	CCS	45% 57%

How Were the Performance Targets Determined?

Please see the [TIPQIC website](#) for details on target setting.

Additional TIP Guides

Please see the other [TIP measure Details Guides](#) on our website, as well as [best Practice Audit Guides](#). For example, TIP Best Practice Audit: Building Capacity for Performance Excellence provides best practices for an organizational QI system, which is needed to optimize your organization’s QI efforts for this measure.

Questions? Contact the ASU TIPQIC Team (TIPQIC@asu.edu) or AHCCCS Targeted Investments Team (targetedinvestments@azahcccs.gov) with questions or to request further assistance.

References

1. American Cancer Society. 2018b. Key Statistics for Cervical Cancer. Last modified January 4, 2018. <https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html>
2. National Cancer Institute. 2018a. SEER Cancer Stat Facts: Cervical Cancer. (October 12, 2018) <https://seer.cancer.gov/statfacts/html/cervix.html>
3. American Cancer Society. 2018a. Cancer Facts & Figures 2018. Atlanta: American Cancer Society. Last modified December 11, 2017. <https://www.cancer.org/cancer/cervical-cancer/detection-diagnosis-staging/survival.html>
4. National Cancer Institute. 2018b. NCI Dictionary of Cancer Terms—CIN. (October 12, 2018) <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/cervical-intraepithelial-neoplasia>
5. U.S. Preventive Services Task Force. 2018. “Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement.” JAMA 320(7):674–86. (October 12, 2018) [doi:10.1001/jama.2018.10897](https://doi.org/10.1001/jama.2018.10897)
6. Fontham, E., T.H. Andrew, M.D. Wolf, T.R. Church, R. Etzioni, C.R. Flowers, A. Herzig, C.E. Guerra, et al. 2020. “Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update from the American Cancer Society.” CA: A Cancer Journal for Clinicians 70 (5): 321–46. <https://doi.org/10.3322/caac.21628>