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**DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
Baseline	n/a	March 10, 2011	Initial version Uniform Managed Care Manual, Chapter 10.2.4, "Medicaid Managed Care and CHIP Performance Improvement Project Submission Instructions."
Revision	2.0	March 1, 2012	Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-12-0003.  "Applicability" is modified to include Medicaid Dental and to remove CHIP Perinatal as a separate program.  "Overview of the Protocol" is modified to conform to Chapter 10.2.5.  "Instructions" is modified to conform to Chapter 10.2.5.



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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Revision	2.1	September 15, 2012	<p>Chapter name is changed from “Medicaid Managed Care and CHIP Performance Improvement Project Submission Instructions” to “Performance Improvement Project (PIP) Submission Instructions.”</p> <p>Section III “Overview” is modified to clarify that PIPs should culminate in real or sustained improvement.</p> <p>Section IV “Instructions” is modified as follows:</p> <ul style="list-style-type: none"> <li>• “Performance Improvement Projects” is modified to clarify the due date for PIPs.</li> <li>• “Demographic Information” is modified to remove “type of study”</li> <li>• “1. PIP Topics” is modified to replace the elements to be addressed.</li> <li>• “2. PIP Questions” is modified to delete the element regarding rationale.</li> <li>• “3. PIP Performance Measure(s)/Indicator(s)” is modified to add additional elements.</li> <li>• “4. Clearly Define the Population for this PIP” is modified to add elements to be addressed.</li> <li>• “5. Use Sound Sampling Techniques for a Representative Sample” is modified to replace the elements to be addressed.</li> <li>• “7. Implementation of Intervention and Improvement Strategies” is modified to replace the elements to be addressed.</li> <li>• “9. Reported Real Improvement” is modified to replace the elements to be addressed.</li> <li>• “10. Sustained Improvement” is modified to replace the elements to be addressed.</li> <li>• “11. Defined Terms” is added.</li> </ul>



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Revision	2.2	September 1, 2013	<p>Section III “Overview of the CMS Protocols for Performance Improvement Projects (PIPs)” is modified to add 7A Root cause analysis and existing interventions.</p> <p>Section IV “Instructions” is modified as follows:</p> <ul style="list-style-type: none"> <li>• Language regarding the transition from fiscal year to calendar year is deleted.</li> <li>• “Performance Improvement Projects” is modified to require two rather than three PIPs and to clarify that one may be collaborative. Overarching goals are deleted and the timeline and due dates are revised.</li> <li>• Reporting due dates are removed. HHSC will provide due dates to the MCOs by April 15 of each year.</li> <li>• Activity 3 “Select PIP Performance Measure(s)/Indicator(s)” is modified to clarify the objectives and the required elements.</li> <li>• Activity 6 “Plan and Collect Reliable Data” is modified to clarify the strategy.</li> <li>• Activity 7A “Root Cause Analysis and Existing Interventions” is added and Activity 7 “Implement Intervention and Improvement Strategies” is renumbered as 7B and clarified.</li> <li>• Activity 8 “Analyze Data to Interpret PIP Results” is modified to clarify the elements to be addressed.</li> <li>• Activity 10 “Achieve Sustained Improvement” is clarified.</li> </ul>
Revision	2.3	July 15, 2014	<p>Revision 2.3 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042.</p> <p>Section IV “Instructions” is modified to change the due date for calendar year 2013 PIPs.</p>



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Revision	2.4	November 15, 2014	<p>Revision 2.4 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.</p> <p>Section I “Applicability of Chapter 10.2.4” is modified to add the Medicare-Medicaid Dual Demonstration.</p> <p>Section II “Background” is modified to use the acronym PIPs.</p> <p>Section III “Overview of the CMS Protocols for PIPs” is modified to use the acronym PIPs and to clarify item 7A.</p> <p>Section IV “Instructions” is modified to update the “PIPs” instructions, to remove Activity 1 requirement F and clarify that service area PIPs must follow the same criteria as program level PIPs, and to define sustained improvement for Activity 10.</p>
Revision	2.5	May 5, 2015	<p>Revision 2.5 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042.</p> <p>Section I “Applicability of Chapter 10.2.4” is modified to remove the Medicare-Medicaid Dual Demonstration.</p> <p>Section III “Overview of the CMS Protocol for PIPs” is modified to clarify that activities 1 through 7 are reported in the PIP plan and activities 8 through 11 are described in the PIP final report.</p> <p>Section IV “Instructions” is modified to clarify that activities 1 through 7 are reported in the PIP plan and activities 8 through 11 are described in the PIP final report, to clarify Collaborative PIPs, and to indicate the appropriate documentation for each report. In addition, Activity 1 questions are updated, Activity 4 “Clearly Define the Population for this PIP” is moved to be Activity 3 and the requirements updated, Activities 5 and 6 are updated, Activity 7 is renamed “Develop and implement intervention and improvement strategies” and the requirements updated, Activity 8 is updated, Activity 9 “Intervention Follow-up Summary” is added and subsequent activities are renumbered. Instructions for the Appendices are added.</p>
Revision	2.6	April 1, 2016	<p>Revision 2.6 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001.</p> <p>Section I “Applicability of Chapter 10.2.4” is modified to add the STAR Kids Program.</p>



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Revision	2.7	October 1, 2016	Section IV "Instructions" is modified to remove language regarding MCOs not currently conducting a collaborative PIP, to remove language regarding due dates, and to reference UCM Chapter 5.0 "Consolidated Deliverables Matrix" instead.
Revision	2.8	February 22, 2019	Revision 2.8 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.  Section IV "Instructions" is modified to indicate that collaborations may be with community organizations and provides guidance on what is considered a community organization.
Revision	2.9	August 15, 2019	Administrative changes are made as follows:  Appendix A is incorporated into Activity 7B, and Appendix C is incorporated into Activity 9.  Appendix B is renamed Appendix A, and Appendix D is renamed Appendix B.
Revision	2.9.1	September 16, 2019	Accessibility approved version
Revision	2.10	April 5, 2021	Revision 2.10 is modified to comply with updated federal protocols as follows: <ul style="list-style-type: none"> <li>Section III is modified to indicate ten total activities.</li> <li>Section IV "Select the PIP topic" is modified to include additional questions to meet federal requirements. "Define the PIP Questions" adds an example of an acceptable PIP aim statement. "Clearly Define the Population for this PIP" clarifies required elements for PIP sampling. "Select PIP Performance Measure(s)/Indicator(s)" clarifies the required elements to describe quantifiable measures. "Use Sound Sampling Techniques for a Representative Sample" clarifies required elements for measure sampling and intervention sampling. "Plan and Collect Reliable Data" clarifies required elements about data collection. "Develop and Implement Intervention and Improvement Strategies" includes details of the implementation strategy and examples of intervention tracking and monitoring. "Analyze Data to Interpret PIP Results" includes required elements to report in the final PIP report. Activity 10 is renamed to "Significant and Sustained Improvement" and combines elements of Activity 11.</li> </ul>



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Revision	2.11	May 16 2022	<p>Revision 2.11 is modified for additional guidance on the below activities:</p> <ul style="list-style-type: none"> <li>• Activity 1 contents are re-ordered to align with updates to UMCM chapter 10.2.5</li> <li>• Activity 2 clarifies that “interventions” should be reported and removes “improvement strategy”</li> <li>• Activity 4 clarifies that it must be specified if an outcome measure is used</li> <li>• Activity 6 contents are edited to align with the updated Activity 6 in UMCM chapter 10.2.5</li> <li>• Activity 7B is updated to include specific language for reporting a rationale when a rapid-cycle PDSA is not conducted.</li> </ul>
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<sup>1</sup> Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.



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## I. Applicability of Chapter 10.2.4

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, CHIP, STAR Kids, and STAR Health programs, and Dental Contractors providing Texas Medicaid and CHIP Dental Services. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to the CHIP Program and the CHIP Dental Contractors, unless the programs are identified separately. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and the Medicaid Dental Contractors, unless the programs are identified separately. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, dental maintenance organizations (DMOs), and any other entities licensed or approved by the Texas Department of Insurance.

The requirements in this chapter apply to all programs, except where noted.

## II. Background

The purpose of health care quality performance improvement projects (PIPs) is to assess and improve processes, and ultimately outcomes, of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

PIPs should target improvement in relevant areas of clinical and non-clinical services. The topics selected for the projects should reflect a significant portion of the enrollees (or a specified sub-portion of enrollees) and should have a potentially significant impact on enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served.

## III. Overview of the CMS Protocol for PIPs

- Select the PIP topics.
- Define the PIP questions.
- Select PIP performance measure(s)/indicator(s).
- Clearly define the population for the PIP.
- Use sound sampling techniques for a representative sample.
- Plan and deploy reliable collection of data.
- Develop and implement intervention and improvement strategies.  
Interventions should be based on the results of a root cause analysis.
- Analyze data to interpret PIP results.
- Plan for real improvement.
- Achieve sustained improvement.



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HHSC developed the PIP instruction document to reflect the CMS requirements for submission of a PIP. MCOs must use this document as a guide to ensure all of the mandatory requirements for completing each PIP are addressed.

Activities one through seven are reported in the PIP plan and activities eight through ten are described in the PIP final report. PIPs are meant to be developed over the specified time period of the study and should culminate in real and sustained improvement.

#### **IV. Instructions**

##### **PIPs**

The MCO is required to provide two PIPs per program served; however, the same PIP may be used for multiple programs. All PIPs are incorporated by reference into the contract. If HHSC and the MCO cannot agree on PIPs, HHSC will unilaterally select them.

Beginning in 2014, MCOs will conduct PIPs for at least two years to allow sufficient time for the interventions to impact health care outcomes. Beginning September 2014, the EQRO and HHSC will provide yearly individual conference calls with each of the MCOs that had a PIP that scored five percentage points or more below average on the PIP plans and/or progress report evaluations.

Calendar year 2014 PIPs will be continued rather than ending on December 31, 2014. MCOs will retire one 2014 PIP per program on December 31, 2015. The remaining 2014 PIP will be continued for one additional year, ending on December 31, 2016. This staggered approach will allow the MCOs to only have to develop one new PIP per program each year. The EQRO and HHSC, in consultation with each MCO, will select which PIP will be retired and which will continue for the third year. Each MCO must have a new PIP proposal before completing a PIP to ensure that it has two ongoing PIPs at all times.

Starting with the calendar year 2016 PIPs, all MCOs will be required to implement a collaborative PIP. MCOs will be given the option to conduct one PIP at the service area level in order to develop interventions that are concentrated on the needs of members in a particular geographic location.

Please see UMCM Chapter 5.0, "Consolidated Deliverables Matrix" for additional submission instructions. The EQRO will review and evaluate new PIP plans, PIP progress reports, and final PIP reports (completed PIPs with results). Beginning with progress report reviews for the 2014 PIPs, MCOs will be required to implement HHSC and EQRO recommendations to improve the PIPs. Beginning with the 2016 PIPs, all PIP plans must be revised and resubmitted, incorporating all EQRO recommendations, within 20 business days after the recommendations are received. The PIP progress reports will also need to include information about how each recommendation was implemented. If the MCO is not able to



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implement an EQRO recommendation, the MCO must submit an explanation and adequate justification for why the recommendation cannot be implemented within 5 business days of receiving the recommendation. HHSC and the EQRO will review the case and provide the MCO with the final decision.

**The following information should be included in each PIP plan submission using the template provided in Chapter 10.2.5 of the Uniform Managed Care Manual.**

**Demographic information**

- MCO name;
- Project leader’s name, title, telephone number, and e-mail address;
- PIP topic/name;
- Initiation date of the PIP; and
- Date the PIP report was submitted.

**Medicaid/CHIP Populations Addressed in PIP**

- Indicate the program, population size, and covered Service Area for each PIP topic.

**Collaborative PIPs**

Indicate whether or not the PIP is a collaborative PIP. If it is, provide the names of the MCOs, DMOs, community organizations and/or Delivery System Reform Incentive Payment (DSRIP) program collaborators. Community organizations must be not-for-profit organizations and cannot be an existing contractor of the health plan unless special approval is obtained from HHSC. Examples of community organizations include social service organizations addressing social determinants of health (for example, organizations addressing hunger/nutrition, homelessness, employment, etc.), schools, public health organizations, and Women, Infants, and Children (WIC) programs. HHSC reserves the right to determine whether or not a collaboration is appropriate and/or sufficient.

**Requested Documentation Submitted**

PIP plans should include a fishbone diagram for the root cause analysis and if it is a collaborative PIP, complete Appendix A.

**Activity 1. Select the PIP Topic**

All PIPs should target improvement in relevant areas of clinical care and non-clinical services. Study topics are selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services. The topics, over time, should address a broad spectrum of key aspects of Member care and services and include all enrolled populations relevant to the study topic (e.g., do not exclude certain Members such as those with special health care needs). Address the following elements:



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- A. What is the topic? Describe how the topic was selected. Include a description of the analysis of member needs, care, and services to select the topic, including:
  - i. Describe how your plan considered priority areas identified by HHSC and/or CMS when selecting the topic
  - ii. Describe how the plan considered performance on the CMS Child and Adult Core Set Measures when selecting the topic
  - iii. Describe how input from enrollees or providers who are users of or concerned with the services being addressed by the topic were considered.
  - iv. Describe how the topic selection considered addressing care of special populations or high priority services when selecting the topic
  - v. If the topic was required by the state, enter “Required by State”.
- B. Describe the characteristics of the members targeted using MCO data to identify health risks of the target population (including distribution of age, gender, and race/ethnicity) and utilization of services by the target population (including geographic location and functional status).
- C. What is the prevalence? What percentage of Members are affected?
- D. How does the issue affect Member health, functional status, or Member/Provider satisfaction?
- E. What are the potential consequences of the disease/condition this PIP addresses?
- F. Does this PIP address a high-risk population? If so, describe the population and the characteristics that identify members as high risk.
- G. Other comments or information

Topic selection for a service area PIP must follow the same criteria as program-level PIPs, where the denominator must include at least 100 Members and the topic must address a critical health issue, as determined by HHSC and the EQRO.

### Activity 2. Define the PIP Questions

Stating the questions helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. Address the following elements:

- A. State the problem to be studied as one or more clear, answerable questions. The response must clearly state the intervention(s), population, and time period of the PIP. Below is an example of a poor PIP question and a good PIP question:<sup>1</sup>

<sup>1</sup> [2019 CMS EQR Protocol 1](#) (page 30)



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	Example PIP aim statements	Critique
Poor PIP Aim Statement	Does the MCP adequately address psychological problems in patients recovering from myocardial infarction?	<ul style="list-style-type: none"> <li>The PIP intervention is not specified</li> <li>It is unclear how impact will be measured</li> <li>The population and time period are not clearly defined</li> </ul>
Good PIP Aim Statement	Will the use of cognitive behavioral therapy in patients with depression and obesity improve depressive symptoms over a six-month period during 2017?	<ul style="list-style-type: none"> <li>Specifies the PIP intervention (cognitive behavioral therapy)</li> <li>Defines the population (patients with depression and obesity) and time period (six-month period during 2017)</li> <li>Specifies the measurable impact (improve depressive symptoms)</li> </ul>

### Activity 3. Clearly Define the Population for this PIP

The selected project must represent the entire enrolled population to which the PIP study indicators apply. Once that population is identified, a decision must be made whether to review data for that entire population or use a generalized sample of that population. Also, the length of members' enrollment needs to be defined to meet the study population criteria. Address the following elements:

- A. What is the target population this PIP will address? Clearly describe inclusion and exclusion criteria.
- B. Does this PIP address the entire population or a sample? If the entire population will be studied, describe the data collection approach to capture all Members to whom the study questions apply. If a sample will be studied, describe how the sample represents the entire enrolled population to which the PIP study indicators (quantifiable measures) apply. Please be sure to address the following:
  - i. Describe how the sampling frame contained a complete, recent, and accurate list of the target PIP population. A sampling frame is the list from which the sample is drawn from.
  - ii. Describe how the representativeness of subgroups of the population (i.e. age groups, locations, or health status) were considered in the sampling methodology.
  - iii. Describe how the sampling methodology accounted for potential biases.

### Activity 4. Select PIP Performance Measure(s)/Indicator(s)

A study indicator is a quantitative or qualitative characteristic (variable) reflecting a discrete event (e.g., an older adult has/has not received a flu shot in the last 12 months) or a status (e.g., an enrollee's blood pressure is/is not below a specified level) that will be measured. The indicators should track performance and improvement over time. All indicators must be objective, clearly and



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unambiguously defined, measurable, and based on current clinical knowledge or health services research.

The objective of a PIP should be to improve processes and outcomes of care. For the purposes of this protocol, “outcomes” are defined as measures of patient health, functional status, or satisfaction following the receipt of care or services. The indicators should measure quantifiable changes in these outcomes using data available through administrative sources, such as HEDIS®, medical records, surveys, or other readily available sources. When possible, include a benchmark and state its source.

All quantifiable measures should address the following elements:

- A. Measure name
- B. Define the numerator
- C. Define the denominator
- D. Define the unit of analysis
- E. Is this a process measure? If yes, please describe the clinical evidence that indicates that the process being measured is meaningfully associated with the outcomes. If this is an outcome measure, please indicate N/A.
- F. Is this a standardized measure? If not, MCO/DMOs should address the additional elements below.

MCO/DMO-derived measures:

- A. Describe how the measure addresses accepted clinical guidelines relevant to the PIP question.
- B. Describe how the measure addresses an important aspect of care or operations that is meaningful to the MCO/DMO enrollees.
- C. Describe how the data sources allowed for reliable and accurate measure calculation.
- D. Describe how the variables of the measure available will be examined on at least a semi-annual basis.
- E. Describe how this measure captures changes in enrollee satisfaction or experience in care.
- F. Describe the strategy utilized to ensure interrater reliability for this measure.

Each PIP performance measure or indicator must address the following elements:

- A. Measure source (e.g., HEDIS, AHRQ, developed by MCO/DMO, CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified behavioral health clinics (CCBHC))
- B. Benchmark
- C. Source of Benchmark



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- D. Goal
- E. Numerator
- F. Denominator
- G. Rate/Rate Ratio
- H. Baseline Measurement Period Dates – include start and end dates

**Activity 5. Use Sound Sampling Techniques for a Representative Sample**

If measures and interventions target the entire population and no sample will be used for either, then go to Activity 6. However, please read the examples provided below carefully to determine whether a sample will be used or not.

**A. Measure(s)/Indicator(s)**

If measures are not for the entire study population and instead a sample will be used to select Members of the study, then proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The sampling methodology for hybrid measures must be reported unless the MCO is following the HEDIS® hybrid methodology and all hybrid processes are audited by an NCQA-certified auditor.

- i. Describe how a representative sample will be obtained for the measures. Describe the sampling methodology for each measure that does not address the entire population.
- ii. Describe the sample. Does it include a subset of the members? Does it include a subset of the network hospitals and/or providers? How was the sample selected?
- iii. How many members does the sample include? What percentage of the population does the sample represent?
- iv. Did the sampling frame contain a complete, recent, and accurate list of the target PIP population?
- v. Describe how the representativeness of subgroups of the population (i.e. age groups, location, or health status) were considered in the sampling methodology.
- vi. Describe how the sampling methodology accounted for potential biases.

Example: Does your measure include a subset of the member population, i.e., a sample of members is selected for medical record review? If yes, is this a HEDIS® hybrid measure and will the sampling methodology and record review process be audited by a NCQA-certified auditor? If yes, go to Activity 5A. If no, describe the sampling methodology addressing the questions above.

If sampling for a MCO/DMO-derived measure, a sampling methodology must be described. A sampling methodology does not need to be described for standardized measures, i.e., HEDIS®, PPE, PDI/PQI, etc.



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## B. Interventions

If an intervention is targeting a sample of the population, then describe the sampling methodology. If any interventions are for a sample of the study population, then describe how you will obtain a representative sample for your interventions. Describe the sampling methodology for each intervention that does not address the entire population.

- i. Describe the sample. Does it include a subset of the members? Does it include a subset of the network hospitals and/or providers? How was the study sample selected?
- ii. How many members does the sample include? What percentage of the population does the sample represent?
- iii. Did the sampling frame contain a complete, recent, and accurate list of the target PIP population?
- iv. Describe how the representativeness of subgroups of the population (i.e. age groups, location, or health status) were considered in the sampling methodology.
- v. Describe how the sampling methodology accounted for potential biases.

Example: Do your interventions address a sample of members, providers, or hospitals, e.g., the intervention targets the top five high-volume providers or top two high-volume hospitals? If so, please address the above questions and complete Activity 5B. If no, then go to Activity 6.

### Activity 6. Plan and Collect Reliable Data

Procedures used to collect data for a given PIP must ensure that the data collected on the PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. The strategy for developing a data collection plan should include the following:

- A. Describe the data collection plan. What data will be collected?
- B. What are the sources from which the data will be collected?
  - i. For administrative data, please describe how all encounters will be captured for each data source (e.g., inpatient data, primary care data, LTSS data, ancillary data, etc.).
  - ii. If EHR data was used, were patient, clinical, service, or quality metrics validated for accuracy and completeness, as well as, comparability across systems?
  - iii. For medical record review, please include a description and qualifications of the personnel, the process used for interrater reliability, and guidelines used to obtain and record the data collected.
- C. How will the data be collected? When will the data be collected?



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- D. What instruments will be used to collect the data? Describe their reliability and validity.
- E. Describe the data analysis plan. What statistical tests will be conducted in order to determine if changes in the measurement rates were statistically significant or not? Please report the associated p-value or confidence interval that will be used to determine if there is a statistically significant change in the rates. What software will be used to conduct the analyses?

**Activity 7. Develop and Implement Intervention and Improvement Strategies**

**A. Root Cause Analysis and Existing Interventions**

- i. Provide the results of the root cause analysis. The root cause analysis can be embedded in the template, or provided as an attachment.
- ii. Describe how the root cause analysis was used to develop interventions.
- iii. Chronologically list the intervention(s) that are already in place to address this topic. The interventions should represent the actions the MCO has been taking to improve the measure prior to the start of the PIP and are not to be included in the PIP interventions listed in Activity 7B. Information should:
  - provide a detailed description of the existing intervention(s);
  - provide the date each intervention was initiated; and
  - indicate if the existing interventions are still ongoing.

**B. Implement Intervention and Improvement Strategies**

The interventions listed in this activity should be new interventions that were developed based on the results of a root cause analysis and should not include interventions that were already in place prior to the start of the PIP (see Activity 7A). Interventions at the member, provider, and systems-level should be a part of the PIP. MCOs are encouraged to think about alternative payment models when designing interventions.

The improvement strategy refers to the overall approach for developing and implementing the selected interventions. Describe the improvement strategy utilized for this PIP and how the selected improvement strategy and each intervention selected are evidence-based. Describe how the rapid-cycle PDSA approach was utilized to test the selected improvement strategy, if applicable. If the rapid-cycle PDSA approach was not used, please indicate as such and provide a rationale.

For each intervention, address the following elements:

- i. Provide a detailed description of the planned intervention(s) and implementation plan. Include:
  - the intervention title;
  - the planned date of implementation;



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- whether the intervention is at the Member, Provider, or system level;
- a detailed description of the intervention; and
- expected impact of the intervention (as measured by number and percentage of members/providers targeted and reached).
  - Number targeted – provide the number of members/providers the intervention is targeting. For example, if the intervention is one-on-one meetings with high volume providers, provide the number of high- volume providers targeted to receive one-on-one meetings.
  - Percent targeted – provide the percentage of members/providers targeted. For example, if the intervention is one-on-one meetings with high volume providers, the numerator should be the total number of high-volume providers targeted. The denominator should be the total number of providers in the network who provide the services the PIP addresses.



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- Number reached – provide the number of members/providers the intervention reached. For example, it was planned to conduct one-on-one meetings with 50 high-volume providers. Provide the number of high-volume providers that actually received a one-on-one meeting.
  - Percent reached – provide the percentage of members/providers reached by the intervention. Using the example above, the numerator should be the total number high-volume providers who actually received a one-on-one meeting. The denominator should be the total number of high-volume providers who were originally supposed to receive a one-on-one meeting. For example, the intervention targeted 50 high-volume providers. However, one-on-one meetings were only conducted with 35 of those 50 high-volume providers. Therefore, the percent reached =  $(35/50) * 100 = 70\%$ .
- ii. What barriers from the root cause analysis does this intervention address?
  - iii. Describe how the intervention will be monitored for effectiveness throughout implementation. Include additional details about factors that will be tracked and monitored in order to determine the effectiveness of the implementation of the intervention. For example:
    - If the intervention focuses on telephonic outreach, plans should report the total number of attempted calls, number of successful calls, and number of returned calls. Also, plans should report the percentage of members reached who went in for a visit as well as the percent of members who were not reached but went in for a visit.
    - If the intervention focuses on mail-outs to members, plans should report the total number of mailings sent and returned/undeliverable mail. Also, plans should report the percentage of members reached who went in for a visit as well as the percent of members who were not reached but went in for a visit.
  - iv. Describe how the MCO will maintain ongoing communication with members and/or providers regarding the interventions.
  - v. Describe how providers will be informed and engaged throughout the intervention. Describe how provider involvement will be monitored.
- System interventions, e.g., educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives to improve



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performance are associated with improvement on quality indicators. Interventions that might have some short-term effect, but are unlikely to induce permanent change (such as a one-time reminder letter to physicians or beneficiaries) are insufficient.

Successful interventions involve qualified personnel and often require engagement with community-based collaborators to improve health outcomes for members. In addition, interventions addressing cultural awareness and socioeconomic considerations will have the most impact in diverse member populations. For each intervention list the name(s) and qualifications of personnel responsible for implementing the intervention, all individuals and/or organizations (other than MCOs) collaborating on the intervention, and describe how any cultural and/or linguistic considerations are addressed as part of the intervention.

For collaborative PIPs, MCOs should complete Appendix A.

**The following information should be included in each PIP Final report submission using the template provided in Chapter 10.2.5 of the Uniform Managed Care Manual.**

**Requested Documentation Submitted**

If it is a collaborative PIP, final reports should include Appendix B.

**Previous PIP Evaluation Recommendations**

MCOs are required to incorporate all EQRO recommendations, unless an exception has been granted via the process outlined in Section IV of this Chapter.

**Activity 8. Analyze Data to Interpret PIP Results**

The analysis of the study data should include a statistical analysis as well as an interpretation of the findings. The interpretation should describe if the intervention was successful or not and what follow-up activities are planned. Interpretation and analysis of the study data should be based on continuous improvement philosophies. Interpreting the data should include a discussion of the causes of less-than-optimal results. Any data issues should be discussed, including threats to reliability and validity, data collection issues, or other limitations. Include the following in the data analysis of the PIP results:

- A. For each measure described in Activity 4, restate the benchmark, goal for improvement, and baseline numerator, denominator, rate, and dates. For each measure, the MCO should report:
  - i. two or more re-measurements;
  - ii. whether or not the improvement was statistically significant (HHSC defines statistically significant at the 0.10 level of significance);



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- iii. the test used to determine statistical significance, e.g., chi-square analysis;
- iv. the P-value/Rate ratio;
- v. comparison of the baseline and re-measurements, i.e., time period represented by baseline measurement vs. time period represented by re-measurement, large changes in enrollment from baseline to re-measurement;
- vi. how the results were compared to other entities, such as overall performance in the state, different patient subgroups, provider sites, or MCOs/DMOs;
- vii. factors that may have influenced results;
- viii. barriers encountered during implementation and how those barriers were addressed; and
- ix. lessons learned from less than optimal performance and opportunities for improvement.

### **Activity 9. Intervention Follow-up Summary**

Through analysis and interpretation of results, the MCO should determine the effectiveness and sustainability of each intervention.

- A. For each intervention described in activity 7B, restate the intervention title, and whether the intervention is at the member, provider, or system level.

For each intervention, the MCO should report:

- i. start and end date of the intervention;
- ii. the results based on tracking and monitoring efforts for each intervention, including the number and percentage of members/providers targeted and the number and percentage of members/providers reached;
- iii. modifications that were made to the intervention to overcome barriers encountered;
- iv. results of communication with members, providers, and/or collaborators regarding the intervention; and feedback received from providers who were involved in the intervention and if/how interventions were modified based on provider feedback.

Successful interventions involve qualified personnel and often team with community-based collaborators to improve health outcomes for members. In addition, interventions addressing cultural awareness and socioeconomic considerations will have the most impact in diverse member populations. For each intervention discuss any changes in the personnel responsible for implementation of the intervention, describe contributions from non-MCO collaborators and the outcomes of those contributions, and discuss any modifications in cultural and linguistic considerations during the intervention.



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For collaborative PIPs, MCOs must complete Appendix B.

**Activity 10. Significant and Sustained Improvement**

Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement is the goal. Address the following elements:

- A. Was the PIP successful? Why or why not?
- B. Was there a true improvement? If so, discuss whether or not the improvement was a direct result of the intervention(s). Please specify which intervention(s) resulted in an improvement.
- C. Which measure or measures had a statistically significant improvement over baseline?
- D. What are the future plans for this topic?

Real change results from changes in the fundamental processes of health care delivery. If real change has occurred, the project should be able to achieve documented sustained improvement. Sustained improvement is defined as statistically significant improvement ( $p = 0.1$ ) over the baseline that is maintained or increased for at least one measurement period. A statistically significant improvement over baseline and in one more reporting period is required to show sustained improvement.

The MCO must describe which measurements met this criteria and how it will use the results from this PIP to achieve sustained improvement including how the results from this PIP will be used to achieve continued sustained improvement.

**Appendices**

**Appendix A**

Appendix A is only required for collaborative PIPs. Collaborative PIPs involve MCO and community-based collaborators with defined roles and specific functions to successfully implement the interventions. In addition, effective communication and unified efforts will have the most impact. In the table, discuss the collaborative interventions in detail, including each formal collaborators' role and responsibilities, why the collaborators were chosen, how and how often collaborators will communicate, and how efforts will be aligned. Add additional sections as needed.

**Appendix B**

Appendix B is only required for collaborative PIPs and is a supplement to the PIP final report. Collaborative PIPs involve MCO and community-based collaborators with defined roles and specific functions to successfully implement the interventions. In addition, effective communication and unified efforts will have the most impact. In the table, discuss any changes in each collaborator's role



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and responsibilities; changes in proposed communication methods, including frequency and type of meeting (in-person, telephonic, etc.); changes in how the efforts were aligned; and discuss the collaborative barriers and successes encountered. Add additional sections as needed.

## V. Defined terms

**Numerator:** The part of the denominator that meets the criteria being assessed.

**Denominator:** The event being assessed or the Members who are eligible for the service of care. Indicate whether all events or eligible Members are included or whether the denominator is a sample.

**Baseline Measurement Period Dates:** The time period covered by the initial assessment.

**Re-measurement Period Dates:** The time period covered by the re-measurement assessment.

**Benchmark:** NCQA defines “benchmark” as the industry measure of best performance against which the organization’s performance is compared. Include information on how you derived the benchmark as well as the benchmark rate.

**Source of Benchmark:** The benchmark may be a best practice in an industry or the best performance within a corporation with multiple organizations.

**Goals:** Should demonstrate the desired level of achievement for the measure within a reasonable time. Actual best practice does not have to be the basis for the goal, but the goal should reflect the level of achievement your organization has targeted. In addition, the goal should be quantitative and stated in numerical terms.