

Mathematica Policy Research 2015-05-06_PIP-Webcast

Hello, everyone, and thank you for attending today's webinar, Advancing Oral Health Through Quality Improvement, Performance Improvement Projects for States and Health Plans, Planning Considerations.

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Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget, as well as your slide area by clicking on the maximize icon at the top right of the widget panel or by dragging the bottom right corners of the panel or slide area.

A copy of today's slide deck is available in the resource list widget, indicated by the green folder icon at the bottom of your screen.

If you have any technical difficulties, please click on the help widget. It has a question mark icon and covers common technical issues. However, you can also submit technical questions through the Q&A widget.

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If you have any questions for presenters during the webcast, you can click on the Q&A widget at the bottom of the console and submit your question. We will address as many questions as possible during this session. If a fuller answer is needed or we run out of time, your question will be answered later via email. We do record all questions received during the webcast.

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Finally, CMS requests that you submit your feedback on this webinar using the survey widget. It has a checklist in the icon and the survey will automatically pop up at the end of this webcast. If you need to leave before the webcast ends, please click on the widget to submit feedback. If you are unable to provide your feedback today, you can view the on demand recording of the event and access the survey widget there. Again, the on demand recording will be available approximately one day after the webcast, and can be accessed using the same audience link that was sent to you following registration.

Additionally, this webinar will be posted on the CMS website in approximately three weeks. An on demand version of the webcast will be available approximately one day after the webcast, and can be accessed using the same audience link that was sent to you following registration.

Now I'd like to introduce Laurie Norris, Senior Policy Advisor and Coordinator at CMS. Laurie, you now have the floor.

Thank you, Bryce, and good afternoon everyone. Welcome to today's webinar.

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Which is the first of two that CMS will host this month focusing on performance improvement projects as a way to improve delivery of dental and oral health services to children enrolled in Medicaid and CHIP. We're really thrilled that we have over 865 people registered for today's webinar, and our audience is truly a wide range of folks. We have state Medicaid and CHIP agency leadership and staff. We have Medicaid and CHIP health and dental plan leadership and staff. We have providers, provider organizations, academic institutions. We have safety net providers. And we have a variety of other stakeholders working hard to improve children's oral health. We really appreciate all of you taking the time to join us today and for your continued interest and partnership in improving children's oral health.

Our primary purpose today is to introduce you to some new tools that CMS is about to publish. We are about to release two new manuals and a template focusing on developing and implementing performance

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

improvement projects with an oral health focus. One manual is intended for use by state Medicaid and CHIP programs, and the other is intended for use by Medicaid and CHIP health plans. There's also a PIP template which is the same for both manuals.

In today's webinar we will focus on, in particular, on the process for planning an oral health performance improvement project. In the second webinar, which will be held on May 20th, in two weeks, we will continue the discussion with a focus on PIP implementation considerations.

So why is this important? Well, more than half of all children enrolled in Medicaid get their health services through managed care. And many of those receive dental services also through a managed care delivery system. A Performance Improvement Project is a tool that is specifically used in managed care delivery systems. By creating these manuals and this template, CMS is hoping to continue our support for states in improving their delivery of oral health services to children and specifically to use these Performance Improvement Projects as effective tools for making those improvements.

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So during today's webinar you will hear four speakers. I am your first speaker, and I will start by framing today's topic within the context of the CMS Children's Oral Health Initiative. And then we'll hear from Roopa Mahadevan from the Center for Health Care Strategies. She will introduce you to our soon-to-be-published manuals. Roopa is a Program Officer at the Center for Health Care Strategies. She contributes to programs focused on improving quality, reducing disparities in care, and enhancing cost effectiveness for Medicaid and CHIP beneficiaries. Prior to joining the Center for Health Care Strategies, Roopa worked in a number of capacities including health policy, clinical and epidemiological research, and community-based international public health. Roopa received a Bachelor's degree in Biology and a Master's degree in Psychology, both from Stanford University.

Next we will hear from Kim Elliot of Arizona Medicaid. Dr. Elliot is the administrator of the Clinical Quality Management Unit of the Arizona Health Care Cost Containment System, which is the Arizona Medicaid and CHIP agency. She has been with AHCCCS since 2001, and prior to joining AHCCCS she was the Director of Prevention and Wellness for one of Arizona's largest Medicaid health plans. Kim has her doctorate in Health Sciences, a Master's in Organizational Management, and a Bachelor's in Business Administration, and she's certified by the National Association for Health Care Quality as a professional in health care quality.

And finally we'll hear from Gretchen Thompson, with the Health Services Advisory Group, or HSAG. HSAG serves as the external quality review organization for Arizona Medicaid, as well as for other states. Gretchen is an executive director for HSAG, where she is responsible for overseeing the EQRO activities in multiple states and previously provided oversight of the Performance Measure Validation and Performance Improvement Project Validation Teams. Ms. Thompson has more than 17 years of experience in Medicaid and has worked in a number of different delivery systems, including managed care, fee for service, long-term care, physical health and behavioral health. She has a strong background in federal and state health care policy, data systems and processes, financing, quality assessment, and performance improvement.

So we look forward to hearing from all of them, but first I wanted to offer some introductory remarks about the context – to create the context for you today – about the Children's Oral Health Initiative in Medicaid. I did want to remind you that we will pause after each speaker to take a few questions from our listeners, so if you think of a question while one of our speakers is speaking, please go ahead and type it into the Q&A box, and we will get to them between each presentation.

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So, I hope you are all aware that CMS has underway a Children's Health Initiative. We are striving, with the help of states, to increase by ten percentage points by 2015, by this year, the percentage of Medicaid-

Mathematica Policy Research 2015-05-06_PIP-Webcast

enrolled children who received a preventive dental service. We started the initiative in 2010, and we set the baselines in 2011. We are focusing on children ages 1 to 20. And the national baseline was 42%, so what we're striving to achieve nationally is 52%. We have also set baselines and goals for each individual state, and those are available through the link that appears on the slide.

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So this chart reflects our progress between 2000 and 2013. Preventive dental services are reflected in the red line. So as you can see, we have been and continue to make progress, but so much more needs to be done. Currently, fewer than half of all Medicaid-enrolled children are receiving a preventive dental service, or really any dental service for that matter, that's the blue line on this chart, in any given year.

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So this slide depicts the progress of individual states on their individual goals and targets between 2011 and 2013, which is the first two years of the initiative. On the left are the states that have made really good progress. The green line in the middle that says "two year goal", that's where we were hoping states would be by the end of 2013. And you can see that about 12 states actually exceeded that, including Montana, which exceeded the five-year goal in the first two years of the project.

On the right are states that, we are sorry to say, regressed. That means they showed worse performance in 2013 than they did in 2011. And we had seven or eight states that were in that situation.

Nationally we made a two percentage point gain over these two years, when our goal was to make a four percentage point gain. So overall nationally our progress has been slower than we would have liked.

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So here you can see the 2013 performance levels for each individual state. If you look at the left-hand side of the graph, you'll see that we have 16 states that have broken the 50% mark on providing preventive dental services to enrolled children. Our highest performing state is Connecticut, which served 59.5% of kids in 2013.

But if you look at the right-hand side of the graph, you will see that ten states are still serving fewer than 40% of enrolled children, including four states that have not even broken the 30% barrier. And those states are Ohio, Florida, Wisconsin, and North Dakota.

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So at CMS, as I said earlier, we very much value your partnership in working to help us improve the performance of the Medicaid program. So at the same time that we've been setting all these goals, we have been wrapping up our efforts to support states in meeting those goals. And this slide shows you four soon-to-be-released tools that we hope will be supportive of states.

The first tools are the Performance Improvement Project manuals and template, which will be released in the next few weeks and which we'll be discussing today and on May 20th.

The second is a series of issue briefs for state policy leaders concerning early childhood caries. The briefs will discuss what it is, how it impacts children on Medicaid, and how states can improve their policies to approach it as a chronic disease more than as a drill-and-fill opportunity. And we will be hosting a webinar on May 27th to introduce those tools.

The third item is a set of web-based training modules to help states improve their collection and reporting of data on the CMS Form 416, which is the form through which we collect all of the dental performance data from states. And that tool we expect to be released in July.

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

And lastly we're developing a Medicaid dental contracting tool kit which will help states leverage their contracts with health plans and dental plans to get the most out of their Medicaid dollars.

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So some of the tools and learning opportunities we have provided over the last few years include the Keep Kids Smiling Strategy Guide published in 2013, which I hope many of you are familiar with. It includes an overview of the Medicaid and CHIP children's dental benefit and a collection of effective strategies and approaches to improving the use of dental services by a variety of states. And this guide is available on the dental page at Medicaid.gov at the link that's shown on this slide.

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So we also produce quarterly CMS learning labs in cooperation with the Medicaid CHIP state dental association. Some of the topics that we've covered are shown here on the slide. The slides and recordings are available on Medicaid.gov, as well as on the MSDA website. And we hope that if any of these are of interest to you, you will go ahead and take a look at them if you missed them.

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Just a few other things. We want to make sure that everyone is aware that there is a national dentist locator tool that's available for anyone who is looking for a Medicaid or CHIP participating dentist in their community. This tool will help you with that. We have really been encouraging community-based organizations and physicians to use this tool to help families locate Medicaid participating dentists in their community. There is this cute little widget that you can download from the website on the slide here and post on your own website which will help families access this tool very easily.

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We've also produced a number of oral health education materials for families. We call them our Think Teeth series. These are available for free and can be ordered in bulk from CMS. There's a couple of examples shown here on the slide. They're available in both English and Spanish, and we encourage you to order them and use them with the families that you serve.

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We have also produced a flyer for parents of children with special health care needs to help them understand how to locate and work with a dentist who can meet their child's individual needs. And that is also available at the link on this slide.

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We've also – we have a child core measure set that we use to compare apples to apples across all state Medicaid programs. This is something that is for all of a child's health, not just oral health, but there are two oral health measures in the child's core set. And those two measures are explained on this slide.

One of them is focused on preventive dental services, which is exactly what we're talking about in our oral health initiative goal. The other focuses on sealants on permanent molars for children ages six to nine. We just added this measure to the measure set, and we are asking states to begin to report on it in January of 2016. Information about the core set can be found at the link on this slide.

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So to help states achieve their goals on the Oral Health Initiative, we have asked them to develop oral health action plans. And we've been working with a number of states to do that. The states that we have

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

received plans from so far are depicted in blue on this slide. In addition, we are working with Utah, Kansas, and Florida to develop their action plans now, and we expect those to be completed very soon. So those three additional states will be turning blue shortly.

So that's an overview of the CMS Oral Health Initiative and our progress to date, and how these manuals that we're about to release fit into that effort.

We do have a couple of minutes now to take a couple of questions. I'm going to have to ask my colleague at the Center for Health Care Services, Roopa, if she can see if there are any questions. I'm having technical difficulties at my end.

Sure, happy to do that, Laurie. One question is whether state oral health action plans are available on the CMS website for others to look at or learn from.

Yes. Yes. On the Dental page of Medicaid.gov, if you can navigate yourselves there, and scroll down, there is a paragraph that deals with the state oral health action plans, and most of them have been posted. I think there are three or four that aren't up yet, but most of them are available for everyone to look at.

Great. Thank you. Another question is, do you have any advice for states, or do you know of any best practices or projects that are looking at preventive oral health services that might be provided by non-dental providers, which complicates the ability for that data to be tracked at the state level?

Oh, sure. So this question goes to what is a dental service and how we collect our data. And in the CMS 416 data, the dental services that we're tracking and preventive dental services is only for, as the questioner seems to understand, is only services provided by dental providers, dentists, dental hygienists, dental therapists, that sort of provider. We know that physicians are increasingly important in terms of preventing oral health disease in young children and maintaining oral health in children, and we very much encourage states to work with their physicians and to reimburse physicians for doing this care. We do collect this data as well on a separate line on our 416 form. And we do examine that data and track it internally. It's true that it's not part of this particular initiative, but we do examine it, and once in a while we publish it. I'm sorry I didn't include a slide with that today. But it is something that we have thought about incorporating into future efforts and sort of focuses with states as we go forward. And there are certainly states working in this area in the Keep Kids Smiling Strategy Guide you will see some states highlighted. The one that comes to mind in particular right off the top of my head is North Carolina. North Carolina has done incredible work in this area.

Great. Thanks. And we have time for one more question, it's around the variance. So why is there – why do you surmise there is so much variance in oral health performance rates across states? But beyond that, are there some strategies that seem to be working for states to improve those?

Wow, that's a big question. It's true there is a wide variation across states, although I have to say that over the last four years that variation has been narrowing somewhat. More states have been moving up into the middle range, you know, serving between 40 and 45% of children. And we do have a few stragglers. And we do have a few standouts. I think those states that have managed to really improve their systems have done a few things. They have focused on great cooperation amongst their plans, like between their health plans and their dental plans. They have ruthlessly streamlined their administrative processes for dentists, both their credentialing processes, their signing processes, their ability to provide customer service to dentists. They have just done an excellent job with that, so that dentists feel that the system is friendly to them. And they have also felt friendly to the beneficiaries. They have gotten to know the beneficiaries. They have done exemplary outreach and have made it clear that they are there to serve the beneficiary and have been perceived as helpful in terms of locating dentists and helping to make appointments, and getting transportation set up and that sort of thing. So there are states where the systems work well across silos and where they can just work together well and eliminate sort of red tape in the system. I would say it's really important.

Mathematica Policy Research 2015-05-06_PIP-Webcast

Some of you may be expecting me to mention reimbursement rates. And while that is important, it is not a deal breaker. We have some states, such as Washington State, that do an excellent job with not the best reimbursement rates. And we have other states I won't mention that have terrific reimbursement rates and don't do all that well in serving kids. So rates are important, we certainly agree with that. But there's so much else that goes into the package.

So I think my time is up for questions. Thanks for those great questions, and I'm going to turn it over to Roopa now, or back to Roopa, for your part of the presentation. Roopa?

Great. Thank you, Laurie. Hello everyone. I'll be providing a high-level overview of oral health Performance Improvement Projects, or PIPs, and sharing some strategies for states to think about as they design their oral health PIP programs and work with programs towards advancing oral health care for children and youth in their state.

What I'm going to share today includes just a small slice of the guidance and information that's covered in much more detail in the resources that Laurie mentioned are being released later this month, the Oral Health PIP template, the Oral Health PIP Manual for states, and the Oral Health PIP Manual for health plans. So do check that out when those become available.

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So what are Performance Improvement Projects? And forgive me for those in attendance who already know about PIPs or have conducted them before, but we thought this background might be helpful overall. As you might already be aware, PIPs are projects designed to bring about improvement in a specific health care area, clinical, or otherwise. They involve identification of quality measures, implementation of a quality improvement intervention, and systematic measurement and re-measurement to evaluate the impact of the intervention on the identified measures.

They can be conducted in any health care area, behavioral health, post partum care, diabetes, asthma, cultural competency, medical record review, oral health, and so on. And the focus of today's webinar overall is to highlight how state Medicaid programs can effectively use PIPs to advance oral health in particular.

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PIPs, much like other quality improvement projects, are conducted when a gap in quality is identified and a concerted effort is needed to close the gap or improve quality overall. They are most commonly conducted by health plans due to a contractual requirement with the state Medicaid agency. However, any health plan can pursue a PIP. By health plan here I mean MCOs, managed care organizations, PIHPs, Prepaid Inpatient Health Plans, non-comprehensive MCOs that manage carved-out services like dental or behavioral health for example. Or prepaid ambulatory health plans. Notably, though, only MCOs and PIHPs in particular are bound by federal regulation to conduct PIPs.

While the health plan conducts the PIP, i.e., implements a quality improvement intervention, the state provides the vision and the overall oversight for the work conducted by the individual health plans.

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States can decide whether to mandate only MCOs and PIHPs or other plans as well to conduct PIPs. While states may want uniformity across all plans, it may also want to consider what is feasible given other requirements in contracts with those plans.

States can require PIPs in multiple areas as well. For example, it may choose to require a Performance Improvement Project in postpartum care for some plans and oral health for others. Or the state can give

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

the health plan a choice among several topics. Further, if it wants to, a state can also mandate multiple PIP projects in different areas, diabetes, asthma, well child visits, and so forth, for the same health plan.

In all of these decisions, the state has to think through bandwidth, the bandwidth of the state to provide effective oversight of each health plan, as well as the bandwidth of the health plans themselves to take on another project atop existing contract requirements and/or quality obligations. For both states and health plans, an important consideration in this is the role of external quality review organizations, or EQROs. EQROs are required by federal regulation to validate the PIPs of MCOs and PIHPs based on CMS protocols. So this resource already exists in many states.

But beyond this mandate, and for other health plans pursuing this kind of quality improvement, EQROs can also be very helpful through various stages of PIP planning and implementation, particularly around data collection and analysis. We'll hear more about this during the presentation from Gretchen Thompson of HSAG later today.

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As mentioned, PIPs can be used in many areas, and states are increasingly doing so in the area of oral health. Where health plans may already be focusing their QI choices in areas such as asthma, well child visits, diabetes and so forth, states have the opportunity to bring oral health to the top of the radar of health plans and to facilitate action-oriented improvement through PIPs. PIPs are a good option as they are likely familiar to health plans, particularly MCOs and PIHPs, and because they allow you to work toward specific measure improvement, for example, those being tracked by CMS through the 416 Form.

For states who are interested in developing an oral health PIP program, there are a few key planning steps listed here that I'll go through in more detail on the next few slides.

The first is understanding the oral health landscape and opportunities for improvement in your state.

The second is involving stakeholders in the development of the program to ensure a mutual commitment to the goals, as well as to ensure that the PIP program is in touch with the reality of what's happening at the level of provider, patients, and communities.

The third is defining the parameters or scope of the program.

Fourth is determining the specific aim you'd like the PIP to address.

And fifth is maximizing the interest and capacity of health plans to participate in the PIP program meaningfully.

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A good place to start in your planning is comparative data. What does your state's Medicaid oral health performance look like? Understand how your state and your health plans stack up against other states and plans with similar delivery systems against commercial markets and in light of the goals set by CMS as elucidated by Laurie earlier. This will give you a sense of where you are and where you have the potential to go with your oral health PIP program.

Next, consider within your system where you should focus the efforts of the PIP.

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Look at your key measures of oral health. Use the CMS 416 measures, for example, which you already report to CMS, and identify which aspects of the oral health delivery system might benefit from concerted attention. Are there particular services, applications of dental sealants for example, that are particularly

Mathematica Policy Research 2015-05-06_PIP-Webcast

underutilized? How does the distribution of providers in network, or the way that they are paid, impact performance? What do the members who are getting high-quality oral health care look like, and who are those who are not? Are they of a particular age group or race ethnicity? Do they live in a particular part of a state or type of neighborhood? And are there trends based on how long the child or youth has been enrolled in Medicaid or whether him or her is eligible via foster care or disability status?

In addition, what particular health markers are important predictors of dental utilization, for example, how are children with special health care needs, those who suffer from childhood obesity or those who are at higher risk for caries performing on your key oral health measures? These are all important questions to consider as you identify the scope of your PIP program.

Also pay attention to health care plan characteristics and provider characteristics that can impact who you choose to participate in the program and the type of guidance and support you'll want to provide them once you start implementing.

Another key step is the involvement of oral health stakeholders. There may be multiple high-opportunity areas and narrowing them down will require input from those invested in the oral health delivery system. Particularly important to get this input early on in the stages of developing your program. It will help you design a program that's practical, timely, and in line with the needs of your members. Use private meetings, public forums, surveys, and your website to get feedback from your health plans, providers, provider associations, consumers, oral health coalitions, public health and child surveying agencies, community organizations, and so forth. It's also a good idea to create a PIP advisory committee that includes representatives from these stakeholders.

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These stakeholder discussions can help you narrow down other particulars of the PIP program. An important one is the focus area. It's going to be key to narrow your broad goal or interest in the PIP program into a targeted focus area that health plans can maximize resources toward. For example, you may know that you want to improve utilization of preventative services, but for which children? Is there a particular part of the state in which you want to focus?

Or your PIP goal might not have a particular oral health service in mind, but rather want to address something broad like racial and ethnic disparities. Here, perhaps, you provide the health plan with a choice of focusing on the disparities they see in their own organization. Or you only mandate PIP for health plans in the state where you do see the greatest opportunities to address racial and ethnic disparities.

So as you can see, a lot of the decisions around the scope of your PIP program are closely tied with what your data shows you, but also with what your knowledge is of the health plans and their capacity.

Another decision point is around performance measures. The choice of measures is important because that's the currency by which the PIP is evaluated. So think about measures that you and the health plan already collected and how those can be improved on. It's better to lean on measures that are already being collected and reported on, such as those used in the Form CMS-416 reporting, those in the child core set, and/or those that have national benchmarks like those endorsed by the Dental Quality Alliance.

Another important component is performance expectations. Consider whether you want to choose a minimum level, for example an absolute rate of 45%, or a relative rate of improvement, for example a 20% improvement on utilization measures with your plan. Again, a lot of this will be decided by what your market already looks like and what some of those early stakeholder sessions tell you about your health plans.

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Mathematica Policy Research 2015-05-06_PIP-Webcast

All these decisions culminate in some sense to the formation of the PIP aim. The PIP aim gives direction to the health plans and what the goal of the PIP is, and it should indicate the desired change, the degree of improvement, and the period of time over which its change is expected to occur.

It's important to use smart principles when designing this aim. Make sure the aim is specific, measurable, attainable, realistic, and time bound. A weak aim, for example, is, improve utilization of preventive services among young children. A stronger one is, in 12 months increase the percentage of six to nine-year-old members who receive a dental sealant on a permanent molar tooth by ten percentage points.

And as I've mentioned before, there's going to be options here for states to build in flexibility and decide how prescriptive they want to be with health plans around these.

Particular areas where states can be a little less prescriptive are around the specific focus area, for example the sub-population, the number and type of performance measures plans are expected to collect, as well as the time line.

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So while health plans are often contracted to conduct PIPs, meaningful engagement may take some concerted effort on the part of the states. PIPs can be very time intensive and they need protected staff time, routine data collection analysis, potentially new partnerships with external entities, and broad-based quality improvement building capacity at the health plan level. So consider the following strategies, align with existing quality measurement programs, for example, if state resources and health plan resources are already going towards medical-oral collaborations, new community-based forms of prevention, and workforce, that might be a good place to conduct a PIP as well.

Also think about how you're sharing information with plans and how that might build interest and incentivize improvement. Share performance of specific health plans. Share benchmarks. But also have key legislation or support from state leaders and champions also help get plans and other stakeholders excited in the PIP effort.

Another important thing to emphasize is that a PIP is not a single, burdensome, QI project, but rather a way for plans to build QI capacity overall. And a way to operationalize this is by providing plans with technical assistance and resources. For example, key data analysis tools, suggestions for intervention options, training opportunities and/or peer learning through collaboratives, and also the support of EQROs. And we're going to be hearing very shortly from an EQRO perspective directly on that.

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So to summarize, these are some of the key steps involved in the early planning stages of the oral health PIP program. As Laurie mentioned, there are plenty of CMS resources out there now, as well as a sort of swell in terms of opportunities to focus on oral health now more than before, and we hope that you take advantage of three particular resources there; the Medicaid Oral Health PIP template, the Oral Health PIP Manual for States, as well as the Oral Health PIP Manual for Health Plans, in bringing about the kind of change you want to see in your oral health delivery system.

And with that I will pass the mic back to Laurie to see if there are any questions. Thank you all so much.

Thank you, Roopa.

And I am still technically hampered here, so can I ask you to facilitate your own couple of questions? Are you able to see the Q&A box?

Yes I am.

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

Okay. Thank you.

Give me a couple minutes here.

There is one question, and Laurie, I might ask you to actually answer this one, and that is, have there been any partnerships with the Dental Quality Alliance in measure development between CMS and the DQA and how can states benefit from that?

Sure, that's a great question. Yes, CMS has been a participant on the Dental Quality Alliance since its inception. And we just, in January of this year, announced that we adopted one of the Dental Quality Alliance measures, the sealant measure, for children ages six to nine into our child core set of quality measures. And that's the one that I mentioned just a few moments ago that is a Dental Quality Alliance measure. And it's been endorsed by the National Quality Forum.

Great. Thank you. Another question is around school-based health centers and the degree to which they conduct the PIPs. So like I mentioned earlier, PIPs can actually be pursued as a generic quality improvement effort by any organization. To our understanding, though, school-based health centers, unless contracted through managed care arrangements with the state, may not be technically required to conduct PIPs. But that is certainly something that we can do more research on and get back to you around.

So, Laurie, I think we can now move on to the next presentation.

All right. So let's move to Dr. Elliott from Arizona Medicaid. Dr. Elliott?

Hi. Thank you. If you could go on to the next slide please.

I'm going to talk a little bit about our oral health PIP that we did in Arizona. It's a little bit older, but it's really the principles that we're talking about, how to plan a performance improvement project. So Arizona has approximately 1.6 million members, over half of which are children, in our Medicaid program. Over 90% are in managed care, and we contract with 15 managed care organizations, and we also have a small population of fee-for-service, which is enrolled in our American Indian health plan, which is managed by the state.

Some of the things that we do as a state Medicaid program to drive improvements and interventions for oral health is implementation of performance improvement projects. We've formed dental work groups. We changed policy to allow for dental home assignments or to allow for fluoride varnish to be applied in a primary care physician's office.

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Contracted provider networks is really kind of key in how we manage our dental benefits. It includes things, such as, health plan credentialing for Access registered providers that can provide the dental health services to our members. And it's important to note that in Arizona we are not an any-willing providing state, so if the oral health professional is not contracted with the managed care organization or registered with the state, they would not be able to participate in providing oral health services to our Medicaid members.

And we do have a very comprehensive dental benefit for children, and we have equal benefits, the same benefit, whether they're enrolled in Medicaid or in our CHIP program. We also require that our managed care organizations pay a fee-for-service rate to the dental or oral health professional, so we don't allow capitation arrangements for oral health services. We also monitor waiting lists for health plan provider participation to make sure that members are able to get in and have easy access to care, and if that isn't the case, we ensure that those networks are reviewed and more providers are added to the network.

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

Currently Access has over 3,500 licensed dentists in Arizona, and over 1,500 of those are registered with the Medicaid program. So we do have a substantial number of oral health professionals that are willing and ready to serve Medicaid members.

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For a performance improvement project, it's one of the most enjoyable events, I think that we do as a Medicaid program, because it really provides one of those few opportunities where you can really think through what needs to be done and how you're going to get there. So what we do is we follow the requirements, of course, that are in the Balanced Budget Act, so PIPs are mandatory components. And what we do is we really look at our data, our trends, and what kinds of services we're seeing where there could potentially be gaps in care or services. And then we look at what the evidence base is. Are we within the standards of care? Are the interventions and activities we're doing, are they effective or relevant in what is happening in a standard of care practice? And what does the research or literature show regarding, in this case, oral health? What are our potential options from a performance improvement perspective? And are there actionable interventions that can be implemented that we haven't already done or aren't currently using? So it's not enough just to do an intervention. It really needs something that is actionable and can be implemented by our managed care organizations.

And then we also pay a little bit of attention to, what is the focus of the Centers for Medicare and Medicaid Services? If it's a priority for Medicaid at the CMS level, it's really a priority for us, and we need to work on improvement opportunities that will really drive performance in those areas.

And then we also pay a lot of attention to, if we do implement interventions and performance improvement projects, will they really make a difference? Will they improve outcomes for our members? Will they improve the quality of life? Will it be an increase in the costs to our program, and if so are those good costs? And also will it increase member satisfaction, such as improving access to oral health services.

And then we also want to make sure that anything we do from an intervention standpoint is measurable, if there's accurate, reliable, and valid data available to be able to do the measurement, because otherwise you won't know if what you're doing from an intervention standpoint is making a difference or not.

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So we did implement a children's oral health performance improvement project, and I think it's really important to understand what drove us to do that because we did this over ten years ago. The data indicated that we really were not meeting the standard requirements that CMS had established for us, so we really needed to implement some different interventions that would really make a difference in what we were doing. So oral health was becoming a really big focus for Centers for Medicaid Services, some of it driven by some bad outcomes out on the East Coast, and also because the rates were not going up as they really should when you put a lot of focus on a particular topic.

And then we also recognized that our current activities and interventions that our health plans had implemented really weren't changing the performance level or the outcomes for our members. So what we were doing really wasn't effective.

We also did a little bit of literature and research on what other states were doing, what the standards of care were, what other people were having good successes with. But also we were looking at what wasn't working in other states, so that we could design our performance improvement project around those types of ideas.

We also really wanted to pay attention to what our stakeholders were saying. So was it an important issue for our stakeholders? Was it an important issue for our providers? And, of course, we always have to pay attention to the legislature at the state level as well.

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

So we also wanted to develop and implement new interventions that could really improve outcomes, increase utilization, and also improve satisfaction. So it wasn't just busy work. We really wanted to create a performance improvement project that would end up meeting the three basic components of satisfaction, utilization, and outcome improvement. So we also checked, of course, to make sure there was a readily available data source to monitor and track improvement. If you can't measure it, you don't know whether you're being successful in what you're doing.

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We implemented the performance improvement project in 2003. Baseline measurement contract year was, of course, 2002. And the purpose of our PIP was to increase the rate of annual dental visits. The population included our Medicaid and our CHIP population, and we also included our developmentally disabled population, which is a long-term care contractor for us. We did focus on the ages of three through eight years old, and the goal was to achieve 57% of our members under the age of 21 years receiving an annual dental visit. We also designed our PIP around nationally-recognized methodologies, so we did select HEDIS, so that we would be able to compare our results with those of other organizations that were measuring it. Then we did re-measurements in 2005, 2006, 2007 and 2008.

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We did convene a work group to discuss the scope of the PIP, identify barriers, identify opportunities. And the work group consisted of health plans, representatives, the Arizona Academy of Pediatrics, the Arizona Dental Association, community stakeholders such as First Things First, which is a legislatively-driven group in Arizona, a governor's school readiness board, and many other alliances. And we also included county and state public health representatives.

We did schedule regular meetings to work on the performance improvement project from a collaborative perspective. And all data measurements were done by the states using data and encounters that were submitted by our health plans.

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So our initial measurement for this PIP, our rate was 50.2% of our members had received a dental visit. At the end of our PIP, 65.4% of our members received a dental visit, which is a relative increase of 25.3%. And all of our health plans did show significant and sustained improvements throughout the PIP. It moved us up into the 90th percentile of all Medicaid programs for children one through twenty years old.

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I just wanted to stress again that we really worked a lot on collaboration and measurements and the types of interventions we focused on were really things that were very doable by our managed care organizations, but also included provider involvement such as report cards, no show logs, that our health plans had worked on, and, of course, recruiting additional providers to the dental networks.

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And this just gives you a little bit of the data comparison to show how we did in comparison to the HEDIS national means, the Form CMS-416 results, and as well as our long-range goal of 57%, which we did exceed.

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And this slide just gives you a little bit of a look at how we did compared to the Form CMS-416 report during that time period, and we, overall, did pretty well. Not as well as we probably would have liked to, but the relative increase in performance was very successful for us.

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

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And this is our comparison to the HEDIS annual dental visits through 21 years of age. And in that slide you can see that we performed well above other HEDIS reporting states.

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So the lessons learned. We really need a high level of communication. It's really imperative. You need to have the level of support from your administration as a state agency, as well as high level support at the health plan level from their administrators. There needs to be some program oversight. There needs to be contractual expectations and accountability. And you have to have critical relationships with stakeholders in the community.

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Of course we continue to work on this particular topic. It's an area that continues to need improvement, and I'm not going to go through all the things that we're currently doing, but this information will be available to you.

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I'm going to turn it back over to Laurie for questions and answers.

Thank you much, Dr. Elliott, and I can actually see the questions this time so I will facilitate this part.

One question for you is how did you encourage providers to submit the no show logs?

Actually that was work done by our managed care organizations, and they worked with primarily the larger practices of oral health professionals and worked directly within the provider relations and the maternal child health coordinators to encourage the providers to submit no show logs, so that the health plan could do direct follow up with those members to remind them of certain things like cancelling appointments, scheduling appointments, and perhaps working with them to get a different oral health professional, if there was some reason why they couldn't make it to that particular office.

Thank you. Boy the questions are just rolling in here. Well, given your experience over the years with this particular PIP's program, what would you say you've identified as the things that floated to the top as best practices?

I think the things that floated to the top were really taking a look at network and capacity, so making sure that you have enough geographically placed providers to meet the needs of the population. I think also really working with the providers to ensure that they understood about the benefit, that transportation was available, and that it really was an important issue for access to the Medicaid program. But I think also working with the different associations and stakeholders because as long as they're aware that you're really working on this initiative, they are more than willing, in most cases, to put their support behind it to their association members. So those things helped a lot. I would say going forward above and beyond the PIP, I think the things we're seeing as most effective right now is real things like dental home, where you can actually assign members to specific providers for more direct outreach.

Thank you. Your state has a lot of Spanish-speaking residents. Have you considered using promotoras or some other particular approach to reach that community in particular?

Many of our community health centers are federally qualified health centers, and many of the larger provider groups do utilize promotoras as part of their program. In our state right now they are not Medicaid reimbursable, but through some of the different payment modernization efforts that we have underway, there will be a lot more leeway, not necessarily to directly reimburse those individuals, but

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

through some of the initiatives in reimbursement based on outcomes, so yes, they are highly utilized in our state but there isn't a real good way to pay for their services at this point in time.

How did you, and I suspect maybe this was your health plan, so to the extent you know how your health plans did this, how did they actually find the families that weren't using services? How did they locate them? How did they get them into care?

Well, actually, that's a really good question. What they do is they look at their encounters in their clinic system to identify families who have utilized or not utilized services, and their focused efforts for outreach are on those that have not utilized services. So it may not be 100% current information, but, you know, health plans receive claims relatively quickly, much more quickly than a state receives a counter information, so they're able to identify things relatively quickly. And as long as the contact information that's provided to them from the state is relatively good, they are able to communicate with those members and encourage them to receive services.

I think we have time for one last question at this point. Concerning how you measured the improvement in this performance improvement project, did you use only the HEDIS annual dental visit measure or did you also have a measure that looked specifically at preventive services?

We used two measurements, actually, to measure our success. The one official measure we used for the PIP was the HEDIS measure, so that was not specific to preventive, it was just utilization measure. Then we also, of course, measured ourselves and performance compared to the Form CMS-416 data, and we did look at the preventive visit line as well on there.

So you used both?

Correct. The official reporting, though, was the HEDIS measure.

Okay. Well thank you, Dr. Elliott. That was terrific, and there are at least a dozen questions we didn't get to, so hopefully we'll have some time at the end of the webinar for some more questions for you. But let's turn now to Gretchen.

Thank you. Good afternoon, everyone. A portion of this webinar will focus on how the state EQRO can support state and health plan efforts to implement useful and effective PIPs.

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The External Quality Review program is federally required for managed care programs, so any state that operates a managed care program is required to have some sort of external quality review. And the External Quality Review Organization, or EQRO, may perform mandatory and optional activities which are outlined in the federal regulations. Mandatory activities include a review of compliance with state and federal standards, validation and performance measures, as well as validation and performance improvement projects. Obviously the focus of this webinar today is the performance improvement project itself, and this discussion is about how the EQRO can provide assistance not only in terms of validation, but all the technical assistance steps that could occur along the way.

Performance Improvement, or PIP, validation is a mandatory activity and technical assistance is considered an optional activity.

And a state performs PIP validation or conducts its own PIP, as in the state of Arizona. But most states utilize the EQRO to perform PIP validation and other associated technical assistance activities.

To access services from the EQRO, it's really up to the state to determine how they use their EQRO in their state. States have the flexibility in constructing their EQRO contract in any way they'd like, and just

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

like a Medicaid program, no two EQRO contracts are alike. HSAG is an EQRO in 13 states, and we conduct performance improvement project validations for 12 of those states.

States may determine the level of involvement of their EQRO, and the level of involvement ranges from reporting results only in an EQR technical report to full facilitation of work groups and conducting various PIP activities and technical assistance activities at each of the PIP stages.

States may also have their EQRO calculate PIP indicator rates for interim and final measurement if they choose to do that. But typically they just have the EQRO validate the rates recorded at the interim and final measurements.

Just to give you some perspective on the focus of oral health topics, HSAG annually validates more than 400 PIPs. Of those 400 PIPs, however, 15 are focused on oral health, and only 2 of the 12 states where HSAG is an EQRO and validates the performance improvement projects, 2 of those states currently require dental health PIPs.

Other states may have oral health initiatives under way, however, those PIPs are not submitted to HSAG through a validation.

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So the EQRO can help. One of the initial stages of the PIP is kind of the initial fact-finding mission. So the EQRO can assist in generating and/or analyzing data. So, as I had mentioned before, the EQRO can be available to calculate rates, if the state so chooses that, or they can at least look at the rates that are currently being calculated, either at the health plan level or state encounter data, or review existing reports that the health plans and the states produce from performance measures, or HEDIS reports, or compliance reports, or even access analyses. If the state were, for instance, to conduct access analysis on the accessibility of dental providers, that might be an indication that perhaps this is what is impacting our oral health initiative.

From that we want to look at how the state is performing overall. So identifying opportunities for improvement. So comparing rates to other health plans, comparing rates to national ranks and percentiles, so looking at HEDIS national Medicaid percentile rates, or looking at some of the other performance measure indicators that are out there, for instance the Form CMS-416 measure related to dental. And there's – EQROs can help us in defining if there are any disparities based on race and ethnicity, geography, age, gender, anything that could be potentially causing the PIP rate, the outcome itself, to be less than stellar.

The EQRO can facilitate work groups, and this is where the EQRO can be very, very useful. We conduct this activity in about seven different states where we facilitate work groups with the health plans and not only look at individual health plan performance, but then look at the statewide performance as a whole. And this is where a state may tap into their EQRO expert to help facilitate these work groups.

And then lastly, once it is identified that the state needs to pay more attention to oral health, and they've identified and determined their priorities and initiatives related to oral health, the quality strategy should be updated to reflect the new priority and the state's direction as it relates to oral health. And the EQRO can be very helpful on this effort as well.

Next slide, please.

As the state has identified its initiatives related to oral health – I think we skipped a slide. Please go back one.

It's going to be necessary to structure the methodology. And the health plans themselves can structure their own methodology, of course, at the state's direction, but the EQROs can also assist with this

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

particular activity. This is really kind of forming the foundation of the PIP, and its part of the PIP planning process. So identifying an appropriate study topic, defining the PIP aim and main objectives. And as Roopa had indicated earlier, it should be a smart aim, which should also be aligned with the state's goals and objectives for oral health initiatives, as well as a timeline for conducting those performance improvement projects, and then defining the population to be studied. Sometimes there can be an effort to look at the population as a whole, or if, during the fact-finding mission the state or health plan has identified that there's a particular area that requires performance improvement, they may narrow the focus of the PIP or the population to be studied within the PIP.

Once that has occurred, then selecting the performance measures to evaluate performance is very important. As we had talked about earlier, some of the national measures that are currently available to study oral health improvements are the CHIPRA core set, the PDENT measure, which is the preventive dental measure, as well as the dental sealant measure, which are part of the CHIPRA core set. And then the HEDIS annual dental visit, as Kim had talked about, is also another widely-available and widely-used measure for folks to use in their dental health PIPs.

In the two states that have chosen oral health initiatives for their performance improvement project that HSAG validates, both of them have chosen the PDENT measure, which is administratively collected using the Form CMS-416 methodology.

Next, if a state decides that it wants to choose state-specific measures, it can do that. Of course they'd have to define the inclusion criteria and the numerator and denominator specifications. And these cases are very important. We had one incident where we're validating PIPs that were submitted by federal health plans in a given state. And it was a state-designed measure. And what we had uncovered is that several of the health plans were not able to collect several of the codes that were used for the numerator specifications. So you want to be very careful that anything in your denominator has the potential to be in your numerator.

Defining the period of performance, of course, to be evaluated is certainly part of the methodology in building the foundation of the PIP. And then lastly, defining the sampling and data collection plan and statistical testing. This is another area where the EQRO can be very useful to ensure that the data collection methodology and statistical testing is appropriate for the study and that it's based on the data being collected and based on the size of the population or the sample. If you anticipate that you're going to have a very small population, there are certain types of statistical testing that are more useful, for instance, Fischer's Exact, which are going to be more useful in telling you whether or not your improvement that you've achieved is meaningful.

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After the foundation of the study has been built through the methodology, the EQRO can assist with the initial data analysis, so studying the data generated through the research phase and identifying barriers that have impacted performance to date. This is where a lot of the current PIP technical assistance and PIP technical assistance facilitation has occurred at HSAG. What we want to look at is, what changes can we make that will result in improvements? And we have done so by providing process mapping, which is a quality improvement tool to illustrate how a current processes is being administered. And we have found that it's most effective when the health plans conduct this type of process mapping from the perspective of the Medicaid recipient.

From the process mapping, we often help health plans with conducting failure mode and effective analysis. And this is used to determine where the process of failure does occur or might occur in the future. And it's very useful to pinpoint interventions that would most likely affect the overall process so that the intervention can have the desired effect on outcomes. And, again, these types of process mapping and failure mode effects analysis, and these types of activities, are very useful and can be done and facilitated both at a group level, at the health plan level, for instance at quarterly meetings, or at the individual MCO level, either face to face or telephonically or through a webinar.

Mathematica Policy Research 2015-05-06_PIP-Webcast

Once that has occurred, we can help verify intervention evaluation strategies. And this is a really important process. We want to ensure that the health plan uses some sort of mechanism to test the successfulness of the intervention, either through a survey, interim claims analysis, focus group, whatever it might be, we want to ensure that the health plan has a good, strong process in place where they can determine the return on investment for the intervention. This is such an important strategy, yet this is where we see, probably, health plans fail most because they identify an intervention based on a barrier that they think they have identified, and they don't test the successfulness of the intervention early on. They wait until the annual re-measurement and determine lie, oh, gosh, this intervention didn't work. And if you test it earlier on, you'll be able to determine whether or not that intervention is actually having the desired effect.

So, for instance, if you developed an intervention to give dentists report cards that show their performance with dental sealants, for instance, you want to choose a way to evaluate whether or not the report cards are actually being used by the dentists and whether or not they're even useful for the provider. You can check that through a survey, or a follow-up phone call with the dentist to say, "Hey, we provided you with this report card. Have you had a chance to review it? Do you find this report card useful or effective? Is it helpful to you in your practice?" If not, then you bring that back to the drawing board and determine what other type of intervention could be useful. Something to use as a mechanism to evaluate that intervention if you were to say, well, we mailed out 80% of all dentists have received this report card, that doesn't exactly tell you the usefulness or the effectiveness of using that report card in that particular intervention strategy. So it's really important that you use a mechanism identifying some way of testing the successfulness of the intervention.

Lastly, assisting with subsequent data analysis. So as you have identified and defined your data collection methodology and statistical testing tool in the previous foundational elements of the PIP, it's important to use it. It's important to test it, and to certainly ask your EQRO any questions that you might have about using the appropriate statistical testing to ensure that it's still appropriate for the data that has been collected.

And we also want to know that interpreting the results, if improvement was made, was it due to the intervention. So this is something that's going to have to be documented in the PIP. And if no improvement was made, we would expect that the health plan would walk through the process mapping, or failure mode analysis more, to determine where the failure may have occurred.

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So after the PIP is underway, a validation check is needed. And this is where people are most familiar with how the EQRO can be involved in PIP validation. And it is just that. The actual validation of the performance improvement project to ensure that it's actually studying what it's supposed to study and that the interventions have the potential to drive real improvement. For instance, I have seen PIPs that come in where health plan staff has identified the transient population as being a barrier and that persons do not reside in the same place for more than six months. Yet the intervention that they've identified is mailers to send out to people to educate them on the particular project being studied. That's not useful. So we want to know that the interventions have the potential to drive real improvement.

Another piece that we'll be looking at through the process of PIP validation is does the health plan appropriately interpret the results and use lessons learned to drive enhanced interventions? If they've identified an intervention that hasn't been successful, have they gone back and taken a look at that particular intervention to determine where did it go wrong and what intervention might be a better intervention to drive health outcomes? And did the health plan achieve real and sustained improvement, and what are the plans for standardizing any successful interventions? These are the types of things that we ultimately will ask the health plans through the PIP validation process. Did the health plan use appropriate quality improvement tools to determine how to drive improvement? And is it evident that the health plan learned from the quality improvement tools and techniques it used about what's impacting health outcomes?

Mathematica Policy Research 2015-05-06_PIP-Webcast

EQROs work with their states to identify the most appropriate PIP validation strategy. HSAG has several different PIP validation strategies that are based on the CMS protocols for PIP validation. Some strategies use an annual validation, and other strategies are using a more rapid cycle improvement methodology where the PIPs actually are submitted on a quarterly basis, or semi-annual basis, so that the EQRO has an opportunity to evaluate the types of interventions and the intervention evaluation strategies that health plans are using.

Once the PIP has been validated and the results have been delivered to the state, the EQROs can work with the state, as well as the health plan staff, to discuss PIP outcomes and the efficacy of intervention. This is where we talk about best practices, so we focus on Health Plan A, for example, and the types of intervention strategies that they used, and whether or not those particular intervention strategies could be applied and useful to help Plan B, for instance.

We talk about the pitfalls that the health plans experience and also try to figure out if those pitfalls are unique to the health plan or if they are a process of the actual system. Ultimately, you want any type of interventions and oral health initiatives to have lasting and sustained results. And ultimately you want to know that these are system changes that have occurred that are going to drive change and drive improvement for a longer period of time well after the PIP is actually over. So these types of discussions are extremely helpful with the state and health plan staff to really focus on what worked and what did not.

And then finally where the EQRO can be helpful and is often most used is in the reporting of the aggregate results. So these might be in individual MCO PIP reports, aggregate PIP reports, annual EQRO technical reports, and any of the recording that the states need to produce the findings of the PIP and health initiatives to CMS, as well as the public at large, and it might be through regular reports or presentations. It's really up to the states to decide how they want to use the EQRO in the process of communicating what the PIP outcomes were.

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This is how the EQRO can be most effective, and I'm going to turn it back to Roopa or Laura to field questions.

Thank you so much, Gretchen.

So I think that was a lot to absorb, but I think what I got out of it was that the EQROs are true experts in quality improvement and data analysis and they are really important partners for states in developing these performance improvement projects and working with the plans to make sure that the approaches, the interventions selected are effective and valid. And there's so much that goes into this. My head is a little full right now, and I have a feeling that many of our audience are feeling a little overwhelmed because nobody is asking you any questions, Gretchen. But we have received a number of other questions that I think would go probably to Dr. Elliott, or maybe to Roopa. So I'm going to suggest that I just field some more questions now. I'll just put them out there, and whoever from our panel feels they have an answer to offer, please go right ahead.

So here's a question, I think probably for Dr. Elliott specifically about Arizona. What steps do you take or do you plan to take to encourage, especially pediatric dentists, to participate in your managed care program? Have you looked at those numbers? Do you know that of those licensed – that high percentage of licensed dentists that are signed up in your plans' networks, do you have a lot of pediatric dentists or is that an issue in your state?

I would say that there is not a humungous number of pediatric dentists in Arizona. But I do know that we work very closely with the Dental Association to encourage more and more of the pediatric dentists to register with Access so that our health plans can contract with them. I also am aware that at least one of our managed care organizations has historically really strengthened their use of pediatric dentists so that members would primarily be seen by pediatric dentists. We don't have any policies that would say one

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

way or another whether that makes sense or not because clearly general dentists have as much value in our system as pediatric. But I think all of our managed care organizations welcome pediatric dentists. But whether they can encourage more, it really is dependent on how many are willing to participate in Medicaid.

Thanks, Dr. Elliot. Roopa, do you have a question?

Yeah, so this is around EQROs, so this is directed to you, Gretchen. One is, and this one I can take, a couple of people are asking about the cost of using EQRO services, so I just wanted to add that states, if they're using EQROs to help validate the PIPs of MCOs or PIHPs, can get an administrative match, matching dollars, from CMS to use EQRO services. So that's one thing.

The other question, Gretchen, was how can folks find EQROs in their state?

Probably the best way is to contact the Medicaid program. If you have a Medicaid managed care program in your state, you will have an EQRO. If you do not have a Medicaid managed care program in your state, you will not have an EQRO. The state Medicaid agency, however, if you do not have an EQRO in that state, will probably have some organization that they contract with for technical assistance in other types of reporting. HSAG, for instance, is in a few states where we are not an EQRO, but we are kind of a data collection and data analysis organization that the states will use even though they don't have a managed care program.

Great. And another question is around sort of the mode in which a lot of the technical assistance is delivered. So you provided a lot of great information on the types of TA offered across the various stages of PIP development. What were the sort of best vehicles for delivering that? Was it virtual trainings, learning collaborative, peer-to-peer training opportunities for health plans, specific tools, webinars? What seems to be most effective? And then I might just piggyback that with a question directed to Kim because Arizona did not really use EQRO support, you know, how did you supplant the resources that an EQRO could offer at the state level in terms of data analytics? So if, Gretchen, you could answer first, and then Kim, you could talk about that a little bit, that would be helpful.

Sure. We've used a variety of methods, and I think that the method that's best and most appropriate really has to do more about the topic itself. So, for instance, face-to-face collaboration and facilitating more groups obviously works best in face to face. It just does. But when it came time to technical assistance on an individual health plan model, we have used webinars, we have used just regular teleconferences, face-to-face as well. One state in which we work, they have quarterly meetings where we are on site at two of the quarterly meetings, and we provide a technical assistance session the two days before the quarterly meeting where we have staff on site at the state agency and health plans to make appointments to come in and receive face-to-face technical assistance. And many times they will bring in their data and we'll pour over the data with the PIP technical experts on site. So it just depends on the type of technical assistance that's being asked.

Great. And Kim, if you could talk a little bit about what the load was in terms of providing adequate oversight at the state level, and maybe, you know, how you perhaps distributed some of the data analytic work from the state level to the health plans to sort of help you with all of that.

Sure. I think what's really important to note is we were a managed care state since 1982, so we had many, and really much more oversight processes, for a managed care organization in our program within our state agency before the Balanced Budget Act came into play so that established how we would use the EQRO for some of this management and oversight and measurement work. So we do use our EQRO, and we're currently using them to run some of our performance measures until we get our system transitioned over to the new vendor. However, because we have such good relationships with our managed care organizations, and we have many deliverables that come in, including those related to performance improvement projects and performance measures, we really have well-established processes to monitor, review and take corrective action when it's necessary. And also our language in our contract and in our policy manuals that really support the oversight that needs to occur. So that was really

**Mathematica Policy Research
2015-05-06_PIP-Webcast**

the primary driver for our decision not to contract out many of the oversight processes that we do in our state related to quality. It was because we already had well-established systems and trained staff that worked this type of stuff on a day-to-day basis. It doesn't mean that we won't use them more in the future for performance improvement projects and other things because that's clearly always an option. And we do use our managed care organizations to do lots of data measurement, but more for self-monitoring purposes, so that they can report in their deliverables quarterly to us, how their performance is improving or whether it's not improving, and if it's not improving, what they're doing on a quarterly basis, a much more proactive approach, to change their interventions, activities or processes to further drive improvement.

Thank you very much to both of you.

So this is Laurie, again. I want to thank you Roopa, Kim, and Gretchen. And please join me, all of you, in thanking our terrific speakers. We've learned so much today about planning a performance improvement project, what it is, the type of collaborations that are helpful. We've learned that the essential steps are to understand variation in oral health care in your state, to involve your oral health stakeholders, to define the scope of the oral health PIP, to determine the PIP aim, and to maximize health plan participation. And then we've learned terrific information about what happened in Arizona over a long period of working with performance improvement projects on oral health with terrific success. And then, of course, Gretchen really helped us understand how the EQROs can support states to achieve their goals through this particular tool.

So I hope we're on the upcoming webinar slide – yes. Next slide, please.

So before we close I wanted to call your attention to two more webinars that we'll be hosting this month. I hope to come back in two weeks for another look at the performance improvement projects. We will be publishing our manuals and templates before then. You will get copies of those if you register for the May 20th webinar, so please come back for that and we'll focus on implementation considerations. And then please think about joining us on May 27th for a look at how we can use Medicaid policy levers to support more patient-centered and effective approaches to the prevention and management of early childhood caries.

I wanted to leave you with our contact information for myself and the other speakers today. Feel free to get in touch with any of us if you have further questions. Those of you who posted questions in the Q&A box, we will email you an answer if we didn't get to your question.

So thank you again everyone. This has been a fantastic afternoon together. I'm going to turn the mic back over to Bryce to close out our webinar.

This concludes our webinar for today. Please submit feedback to the presentation team using the survey in your browser window when the event concludes. If you are unable to provide your feedback at this time, you can view the on-demand recording of the event and access the survey widget there. The on-demand will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

Any future topics or discussion points can also be shared with the team using the Mac Quality TA at cms.hhs.gov mailbox. Thank you.