Primaris
Healthcare Business Solutions

2019 External Quality Review
Performance Improvement Projects

UnitedHealthcare

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MoHealthNet

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1.0 Purpose and Overview

1.1 Background

The Department of Social Services, MO HealthNet Division (MHD) operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care (herein after stated "Managed Care"). MHD contracts with MO HealthNet Managed Care Organizations (MCOs), also referred to as "Health Plans," to provide health care services to Managed Care enrollees.

Managed Care is operated statewide in Missouri in the regions: Central, Eastern, Western, and Southwestern. One of the most important priorities of Managed Care is to provide a quality program that leads the nation and is affordable to members. This program provides Medicaid services to section 1931 children and related poverty level populations; section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. As of May 2019, the total number of Managed Care enrollees in MHD were 605,907 (1915(b) and CHIP combined). This is a decrease by 14.94 % in comparison to the enrollment data available for the end of SFY 2018.

UnitedHealthcare is one of the three MCOs operating in Missouri (MO) that provides services to individuals determined eligible by the state agency for the Managed Care Program on a statewide basis. MHD works closely with the MCO to monitor the services being provided to ensure goals to improve access to needed services and the quality of health care services in the Managed Care and state aid eligible populations are met, while controlling the program's cost.

UnitedHealthcare's services are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various on-going methods including, but not limited to, MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review. An External Quality Review Organization (EQRO) evaluates MCOs annually, as well. MHD has arranged for an annual, external independent review of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract. The federal and state regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b).

Primaris Holdings, Inc. (Primaris) is MHD's current EQRO, and started their five-year contract in January 2018. The External Quality Review (EQR) 2019 covers the period of Calendar Year (CY) 2018.

An EQR means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or their contractors furnish to Medicaid beneficiaries.
Quality, (42 CFR 438.320 (2)), as it pertains to external quality review, means the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through:

- Its structural and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based-knowledge.
- Interventions for performance improvement.

Access, (42 CFR 438.320), as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).
Timeliness: Federal Managed Care Regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must consider the urgency of the need for services.

1.2 Description of Performance Improvement Projects (PIPs)

A statewide performance improvement project (PIP) is defined as a cooperative quality improvement effort by the MCO, MHD, and the EQRO to address clinical or non-clinical topic areas relevant to the Managed Care Program. *(Ref: MHD-Managed Care Contract 2.18.8 (d) 2).* MHD requires the contracted MCO to conduct PIPs that are designed to achieve, through ongoing measurements and interventions, a significant improvement, sustained over time, in clinical care and nonclinical care areas. The PIPs are expected to have a favorable effect on health outcomes, member satisfaction, and improved efficiencies related to health care service delivery. (Ref: MHD Managed Care Contract 2.18.8 (d)).
Completion of PIPs should be in a reasonable period (a CY), to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.
The PIPs shall involve the following (Ref: 42 Code of Federal Regulations (CFR) 438.330 (d)):

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

During CY 2018, MHD required UnitedHealthcare to conduct two (2) PIPs:

- Clinical: Improving Childhood Immunization Rates (Combo 10).
- Nonclinical: Improving Access to Oral Healthcare.

2.0 Methodology for PIP Validation

Primaris followed guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, EQR Protocol 3, Version 2: Validating Performance Improvement Projects. Primaris gathered information about the PIPs through:

Documents submission: UnitedHealthcare submitted the following documents for review. The review period was from April 25-May 25, 2019. However, the final HEDIS® rates were submitted in June 2019:

- PIP (clinical): Improving Childhood Immunization Rates Combo 10.
- PIP (non-clinical): Improving Access to Oral Healthcare.

Interview: The following UnitedHealthcare officials were interviewed on May 09, 2019 to understand their concept, approach and methodology adopted for the PIPs. Technical Assistance was provided for improvement, correction, and additional information:

- Lisa Overturf, RN, CPHQ, Associate Director, Clinical Quality for Missouri
- Angela Edmondson, Clinical Quality Consultant, Government Program Accreditation
- Tammy M. Biggerman, MS, QSD Project Analyst (QPA)
- Elsa Corona, QSD Project Analyst (QPA)
- Surya Teja Padala, Software Engineer OGS Technology Services

PIPs validation process includes the following activities:

1. Assess the study methodology.
2. Verify PIP study findings (Note: Not conducted, optional as per EQRO protocol 3)
3. Evaluate overall validity and reliability of study results.

Activity 1: Assess the Study Methodology.

1. Review the selected study topic(s): Topic should address the overarching goal of a PIP, which is to improve processes and outcomes of health care provided by the MCO. It should reflect high-volume or high-risk conditions of the population.

2. Review the study question(s): The study question should be clear, simple and answerable. They should be stated in a way that supports the ability to determine whether the intervention has a measurable impact for a clearly defined population.

3. Review the identified study population: The MCO will determine whether to study data for the entire population or a sample of that population.

4. Review the selected study indicators: Each PIP should have one or more measured indicators to track performance and improvement over a specific period of time. All measured indicators should be:

- Objective;
- Clearly defined;
- Based on current clinical knowledge or health services research;
- Enrollee outcomes (e.g., health or functional status, enrollee satisfaction); and
- A valid indicator of these outcomes

5. Review sampling methods (if sampling used): It should be based on Appendix II of the EQR protocols for an overview of sampling methodologies applicable to PIPs.

6. Review data collection procedures: Ensure that the data is consistently extracted and recorded by qualified personnel. Inter-Rater Reliability (the degree to which different raters give consistent estimates of the same behavior) should be addressed.

7. Review data analysis and interpretation of study results: Interpretation and analysis of the study data should be based on continuous improvement philosophies and reflect an understanding that most problems result from failures of administrative or delivery system processes.

8. Assess the MCO's Improvement strategies: Interventions should be based on a root cause analysis of the problem. System interventions like changes in policies, targeting of additional resources, or other organization wide initiatives to improve performance can be considered.

9. Assess the likelihood that reported improvement is "real" improvement:

- Benchmarks for quality specified by the State Medicaid agency or found in industry standards.
- Baseline and repeat measures on quality indicators will be used for making this decision.

Note: *Tests of statistical significance calculated on baseline and repeat indicator measurements was not done by EQRO. These results are provided by the MCO.*

10. Assess the sustainability of documented improvement.

Real change is the result of changes in the fundamental processes of health care delivery and is most valuable when it offers demonstrable sustained improvements. Spurious is "one- unplanned accidental occurrences or random chance."

Review of the re-measurement documentation will be required to assure the improvement on a project is sustained.

Activity 2: Verify Study Findings (Optional).

MHD may elect to have Primaris conduct, on an ad hoc basis, when there are special concerns about data integrity. *(Note: this activity is not done by EQRO and written as N/A).*

Activity 3: Evaluate and Report Overall Validity and Reliability of PIPs Results.
Primaris will report a level of confidence in its findings as follows:

- High confidence = the PIP was methodologically sound, achieved the SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- Confidence = the PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible = The PIP methodology was not executed as approved, or for reasons beyond control of MCO.

3.0 Findings

3.1 PIP Clinical: Improving Childhood Immunization Status (CIS Combo 10)

In December 2010, the Department of Health and Human Services launched Healthy People 2020 (HP2020) in order to attain longer life expectancy, improve health quality, and promote better quality of life. HP2020's set goal is to target 90% of children to receive all individual vaccines. Over the past few years, completion rates of childhood vaccines have met HP2020 levels, however completion rates of children under the age of 2 receiving all vaccines is low at about 66%. This leaves children at risk for preventable diseases during a vulnerable time in life (Kurosky, Davis, and Krishnarajah 2016). Kurosky et al. 2016, also suggests that appropriate vaccination coverage is linked to improved health outcomes and lower costs. Childhood immunization programs also thwart large-scale outbreaks of diseases that are easily preventable by vaccine. Subsequently, the hindered disease prevalence reduces the associated rates of morbidity and mortality. Thus, sustaining and increasing vaccination rates is pivotal to the prevention of many diseases.
UnitedHealthcare works in accordance with Missouri HealthNet Childhood Immunization Initiative to increase vaccination coverage of children 2 years of age and older, improve vaccine delivery, and increase vaccination accessibility by providing healthcare benefits

and coverage for the required vaccines. For the purpose of this PIP, UnitedHealthcare assessed Childhood Immunization Status (CIS Combo 10), for the following vaccinations by their second birthday (Table 1).

Table 1. CIS Combo Number of Doses by Vaccine

CIS Combo 10	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
No. of Doses	4	3	1	3	3	1	4	1	2	2

The Missouri Department of Health and Social Services' Bureau of Immunization Assessment and Assurance has cited that Missouri's completion rate for 2-year-old immunization has remained between 69-71% for the series completion.

3.1.1 Description of Data Obtained

Aim: By Dec 31, 2018, increase children ages two (2) and under, receiving CIS (Combo 10) vaccines by 3 percentage points from the baseline year (CY 2017).

Study Question: Will implementing the interventions for UnitedHealthcare eligible members increase the number of children ages two (2) and under receiving CIS (Combo 10) vaccines by 3 percentage points?

Study Indicator: The percentage of children 2 years of age who had four Diphtheria, Tetanus and acellular Pertussis (DTaP); three Polio (IPV); one Measles, Mumps and Rubella (MMR); three Hemophilus influenza type B (HiB); three Hepatitis B (HepB); one Chicken Pox (VZV); four Pneumococcal conjugate (PCV); one Hepatitis A (HepA); two or three Rotavirus (RV); and two Influenza (flu) vaccines on or by their second birthday.

Sampling: There will be no sampling; the entire eligible population is measured as per the 2018 HEDIS® Technical Specifications.

Baseline Data: Since UnitedHealthcare's contract with MHD went into effect on May 01, 2017, the baseline year includes only a period of 8 months of administrative data (May 01-Dec 31, 2017) for the eligible members. UnitedHealthcare has reported this as "interim," which has been accepted as baseline by Primaris for the purpose of validation of the PIP.

Methodology: UnitedHealthcare uses ClaimSphere, HEDIS®-certified software to generate the CIS (Combo 10) measure rates. The study uses the 2018 HEDIS® Technical Specifications for CIS (Combo 10) measure coinciding with the appropriate measurement year, as described below.

Denominator: All UnitedHealthcare's Managed Care eligible members meeting the following specifications are included:

- Children who turn 2 years of age during the measurement year.
- Continuous enrollment 12 months prior to the child's second birthday.
- No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
- Enrolled on the child's second birthday.

Numerator: The members who meet the eligibility requirements above and receive the combination of immunizations in the measurement period.

Intervention and Improvement Strategies: The interventions implemented by UnitedHealthcare are listed in Table 2 that address at least one of the following three barriers. The barriers are categorized as Member, Provider, and System barriers (Figure 1).

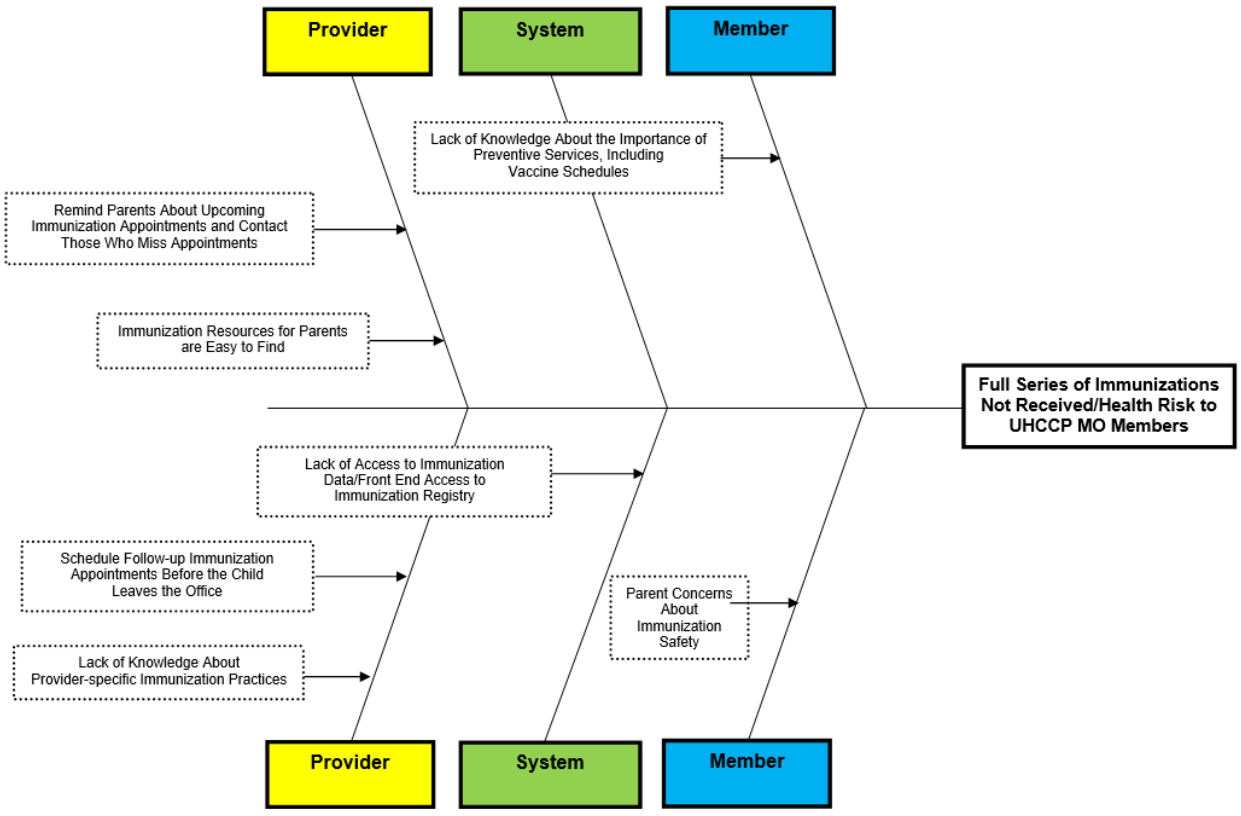


Figure 1. United Healthcare CIS Combo 10 Barriers

1. A lack of knowledge about the importance of preventive services, including recommended vaccine schedules.
2. A lack of knowledge about provider-specific immunization practices.
3. A lack of access to immunization data.

Table 2. Implemented Interventions for CIS Combo 10 PIP

Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
1. Health First Steps Program	1			May 2017– December 2018
2. Baby Blocks Program	1			May 2017– December 2018
3. Custom EPSDT Reporting and Analysis			3	July 2017– December 2018
4. EPSDT Member Outreach Calls	1			Mid-July 2017
5. EPSDT Billing & Coding Guide for Providers		2		Developed September 2017, Reviewed with Providers September 2017– December 2018
6. Review of PCOR Data with Providers		2		November 2017– December 2018
7. Rose International (Call Center) Member Outreach Calls	1			May 2018– December 2018
8. EPSDT Provider Education – Quality Department "Push"		2		May 2018–June 2018
9. Jordan Valley Mission Distinction Program (Grant Award)	1			Month of May 2018
10. EPSDT West IVR Calls	1			July 2018– December 2018
11. UHCCP MO Participation in State-wide Back to School Events	1			July 2018–August 2018
12. CIS/IMA Pre-season Data Collection Project		3		July 2018–August 2018

Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
13. Immunization Data "Deep Dive" Analysis			3	August 2018
14. CPC Provider Engagement Assessment		2		August 2018– December 2018
15. Annual Preventive Services Mailing	1			September 2018
16. Request to state – ShowMeVax			3	August 2018
17. Request to State – Historical Immunization Data			3	August 2018
18. CPC Collaboration with and Attendance at DHSS Bureau of Immunization Trainings/Events	1	2		CY 2018

3.1.2 PIP Results

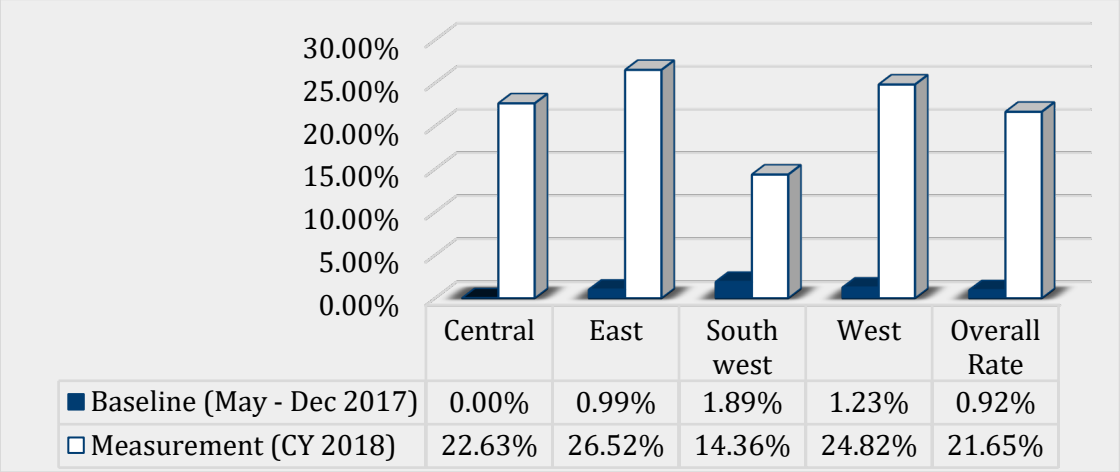
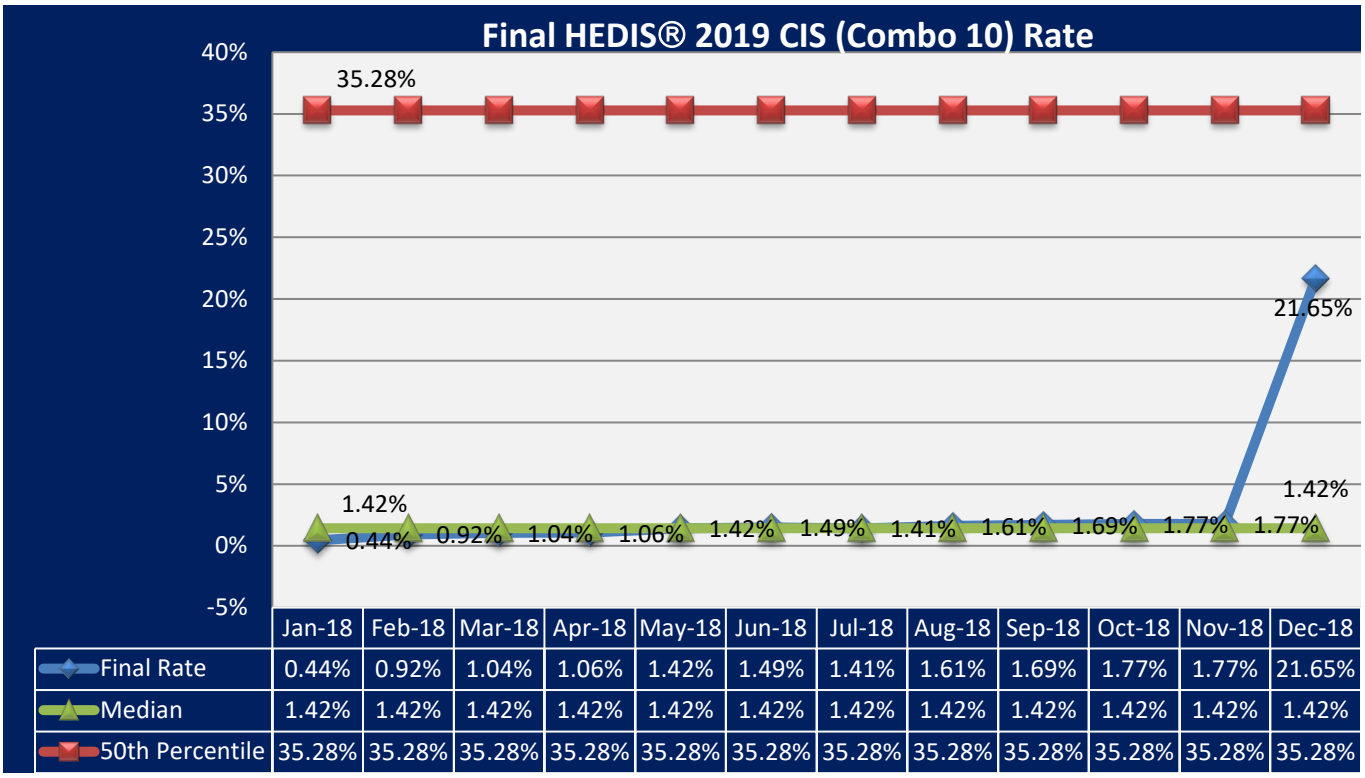


Figure 2. HEDIS® CIS Combo 10 Rates

The statewide rate for CIS Combo 10 during the baseline year (May-Dec 2017) was 0.92%. It has increased to 21.65% during the measurement year (CY 2018) which is a rise by 20.73 percentage points. Due to the maturity of the UnitedHealthcare in MO and the technical specifications for this measure (children who turn 2 years of age during the measurement

year and are continuously enrolled for 12 months prior to their 2nd birthday) data is limited for CY 2017 and reflects a significantly low rate. Primaris will not comment on the performance of the PIP as UnitedHealthcare did not operate for an entire year in MO during CY 2017. (Figure 2). It is for the same reason test for statistical significance is not done. Figure 3 represents a run chart with monthly progress in the CIS Combo 10 rate after various interventions were applied throughout the CY 2018.



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Final Rate	0.44%	0.92%	1.04%	1.06%	1.42%	1.49%	1.41%	1.61%	1.69%	1.77%	1.77%	21.65%
Median	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%	1.42%
50th Percentile	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%	35.28%

Figure 3. Run Chart-HEDIS® CIS Combo 10 rate

3.2 PIP Nonclinical: Improving Access to Oral Healthcare

According to the Missouri Coalition for Oral Health, oral health in Missouri is poor and the need for a change is great. The State of Missouri has a five year (2015-2020) oral health plan that seeks to improve the oral health of all Missourians through education, prevention, and leadership. According to the National Oral Health Surveillance System[1], the State of Missouri has lower dental visit rates, more tooth loss, and higher oral cancer rates among adults than those observed nationally. The Southeast region of Missouri has the lowest dental visit rates and the highest rates of tooth loss among older Missourians in the state.

[1] https://nccd.cdc.gov/oralhealthdata/rdPage.aspx?rdReport

The U.S. Department of Health and Human Services (HSS) reports that caries is the most prevalent infectious disease in our nation's children.[2] More than 40 percent of children have caries by the time they reach kindergarten. Missouri residents, however, who are served by community water systems receive the optimal amount of fluoridated water than the national average (Missouri Oral Health Plan 2015-2020). Current national data reveals that about 74.6% of Missourians are receiving optimally fluoridated water. The Healthy People 2020 objective is 79.6%.

According to the Henry J. Kaiser Family Foundation policy brief "The Impact of Medicaid and State Children's Health Insurance Program (SCHIP) on Low Income Children's Health" (February 2009) found that in the area of oral health, critical inadequacies in children's access have emerged. Inadequacies in the supply and distribution of oral health care providers nationally, including a shortage of pediatric dentists, are compounded in Medicaid and SCHIP by low participation among dentists and the disproportionate burden of oral disease in the low-income population. Less than 30 percent of children in Medicaid obtain any dental care in a year and only 25 percent receive preventive dental care–half the corresponding rates for privately insured children.

Currently there are 99 counties in Missouri that have been designated by the federal government as Dental Health Professional Shortage Areas (DHPSA). Approximately 26% of Missourians live within a DHPSA.

The Centers for Medicare and Medicaid Services (CMS) require the states to submit an annual Early and Periodic Screening, Diagnostic, and treatment (EPSDT) report (form CMS-416). This report collects and provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as, "initial or periodic screens required to be provided according to a state's screening periodicity schedule." From the completed reports, trend patterns and projections are developed for the nation and for individual states or geographic areas, from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care.

3.2.1 Description of Data Obtained

Aim: By December 31, 2018, increase the percentage of preventive oral health services in members 2–20 years of age by 3 percentage points (ADV), 1-20 years of age by 3.33

[2]The Kaiser Commission on Medicaid and the Uninsured: Dental Coverage and Care for Low-Income Children: The Role of Medicaid and SCHIP. August 2007. The Henry J. Kaiser Family Foundation.

percentage points (CMS 416 Preventive Services), and 6-9 years of age by 3.33 percentage points (CMS 416 Oral Sealants).

Study Questions:

1. Will implementing the list of interventions for UnitedHealthcare MHD eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3 percentage points for the measurement year?
2. Will implementing the list of interventions for UnitedHealthcare MHD eligible members from the ages of 1 through 20 years of age increase the number of children who receive an annual dental visit for a preventive service by 3.33 percentage points per year from CY 2018 (HEDIS® Year 2019) through Data Year 2022 (HEDIS® Year 2023)?
3. Will implementing the list of interventions for UnitedHealthcare MHD eligible members from the ages of 6 through 9 years of age increase the number of children who receive the application of an oral sealant to at least one permanent molar by 3.33 percentage points per year from Data Year 2018 (HEDIS® Year 2019) through Data Year 2022 (HEDIS® Year 2023)?

Study Indicators:

1. The rate of eligible members from the ages of 2 through 20 who have had at least one dental visit as measured by the HEDIS® 2019 (data from CY 2018) Annual Dental Visit (ADV) total rate through the administrative method of measurement.
2. The rate of eligible members from the ages of 1 through 20 who have had at least one preventive dental service as measured in the Centers for Medicare and Medicaid Services (CMS) 416 report for the HEDIS® Year 2019 (data from CY 2018).
3. The rate of eligible members from the ages of 6 through 9 who have had an application of an oral sealant to at least one permanent molar as measured in the CMS 416 report for the HEDIS® Year 2019 (data from CY 2018).

Study Population: All UnitedHealthcare MHD eligible members from the ages of 1 through 20 in the measurement year.

Sampling: There is no sampling. The entire eligible population is measured as per the HEDIS® 2018 Technical Specifications and applicable CMS 416 methodology.

Baseline Data: Since UnitedHealthcare's contract with MHD commenced on May 01, 2017, the baseline includes only a period of 8 months of administrative data (May 01-Dec 31, 2017) for the eligible members (Table 3).

Table 3. Baseline Rates (May 01-Dec 31, 2017)

Study Indicators	Rates (%)	Benchmark (%)
HEDIS® ADV	35.10	59.43 (NCQA 50th percentile)
CMS 416 Preventive services	26.47	32.66 (2016 CMS 416 report)
Members receiving sealants	9.53	13.51 (2016 CMS 416 report)

Methodology: UnitedHealthcare uses ClaimSphere, a HEDIS® -certified software engine to generate the HEDIS® ADV measure rates. The study uses the HEDIS® 2018 Technical Specifications for the Annual Dental Visit (ADV) measure coinciding with the appropriate measurement year, and the applicable CMS 416 methodology for the Preventive Service and Oral Sealant measures, as described below:

Denominator

1. HEDIS® ADV Rate–all UnitedHealthcare MHD eligible members from the ages of 2 through 20 as of December 31 of the measurement year.
2. Preventive Service–all UnitedHealthcare MHD eligible members from the ages of 1 through 20 as of December 31 of the measurement year.
3. Oral Sealant Application–all UnitedHealthcare MHD eligible members from the ages of 6 through 9 as of December 31 of the measurement year.

Numerator

1. HEDIS® ADV Rate–all UnitedHealthcare MHD eligible members from the ages of two 2 through 20 who have had at least one dental visit in the measurement year.
2. Preventive Services – all UnitedHealthcare MHD eligible members from the ages of 1 through 20 who have received at least one preventive service in the measurement year.
3. Oral Sealant Application – all UnitedHealthcare MHD eligible members from the ages of 6 through 9 who have had an application of an oral sealant to at least one permanent molar in the measurement year.

Intervention and Improvement Strategies: The interventions implemented by UnitedHealthcare listed in Table 4 address at least 1 of the following 4 barriers identified. The 4 barriers are categorized as Member, Provider, and System barriers (Figure 4):

1. A lack of knowledge by the membership of the need for dental care.
2. A lack of knowledge by the membership of dental care access.
3. A lack of information flow to the dental and medical providers.

4. A lack of outreach activities related to dental care for the membership.

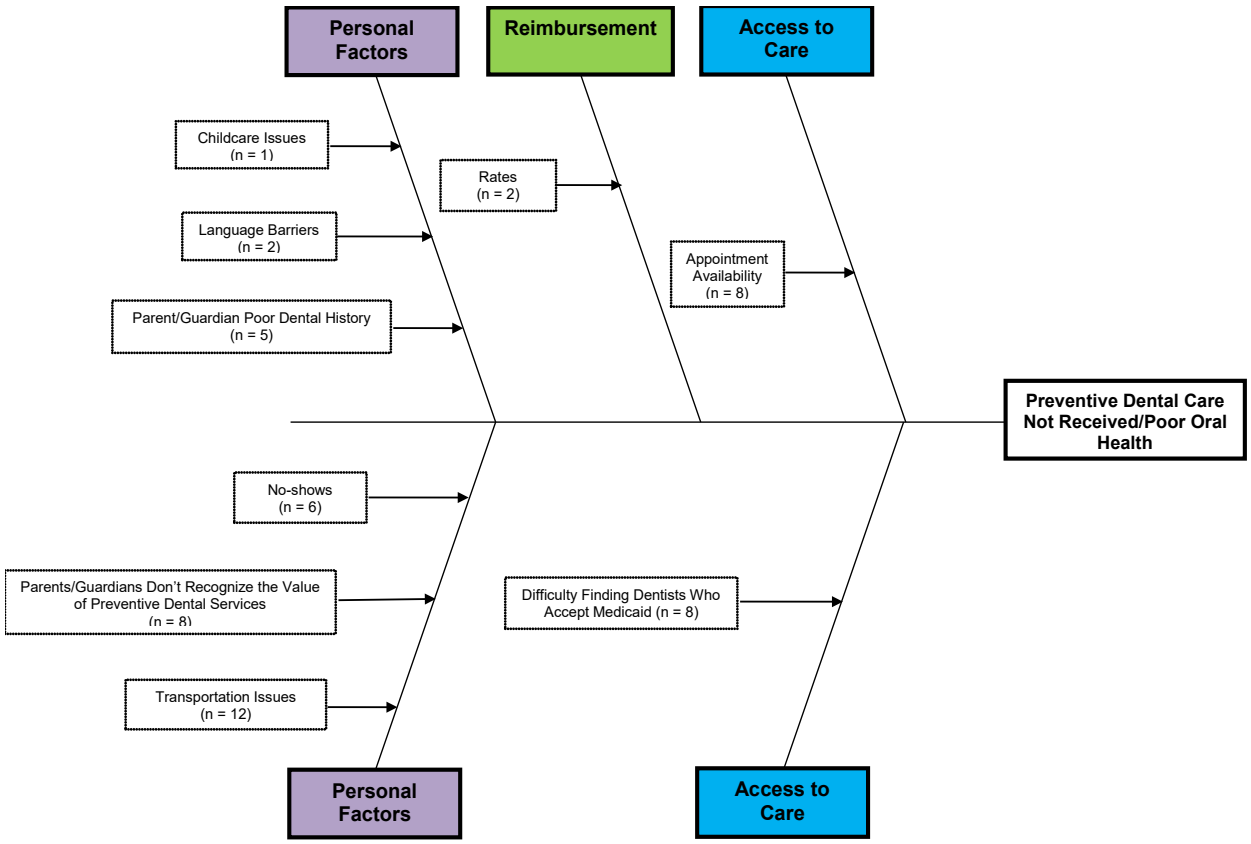


Figure 4. Barrier Analysis

Table 4. Implemented Interventions for Oral Health PIP

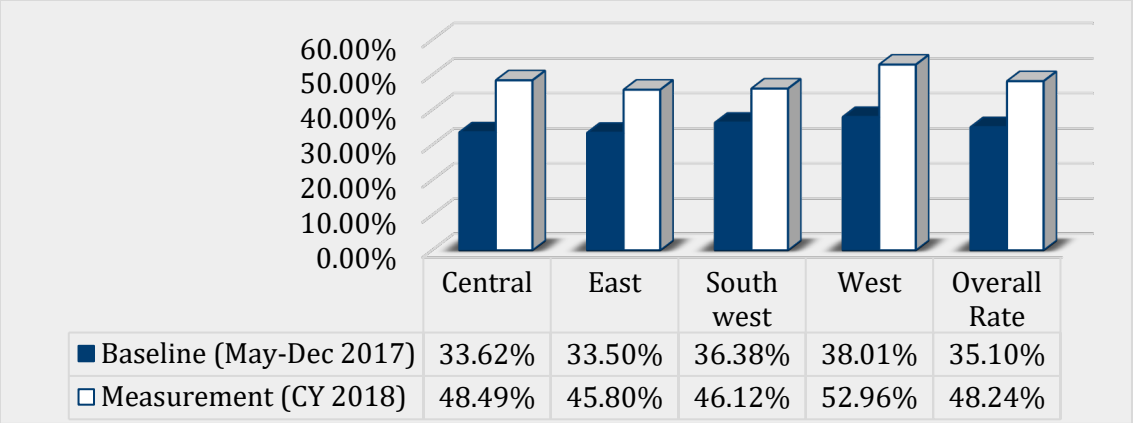
Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
1. National Children's Dental Health Month Events	1, 2	3		February 2018
2. Provider Feedback - Barriers to Preventive Dental Services		3		February 2018
3. Health Talk Newsletter – "Smile. sealants prevent cavities."	1, 4			Spring 2018 Edition
4. Practice Matters Newsletter – "Get Updated Clinical Practice Guidelines" (Preventive Pediatric Health Care Screening)		3		Spring 2018 Edition

Intervention	Barrier(s) Addressed			Implementation Date(s)
	Member	Provider	System	
5. Jordan Valley Mission Distinction Program (Grant Award)			1, 2, 3	May 2018
6. Letter of Support for MO DHSS and ODH			3	June 4, 2018
7. Dental Interactive Voice Recording (IVR) Calls	4			March, May, August, October 2018
8. ADV Reminder Added to EPSDT Member Outreach Calls	4			March 2018 – December 2018
9. Rose International (Call Center) – EPSDT Gaps in Care Addressed	4			March 2018– December 2018
10. UHCCP MO Participation in State-wide Back to School Events	1, 2			July 2018–August 2018
11. HealthTalk Newsletter – "Toothache?"	1, 4			Summer 2018 Edition
12. Practice Matters Newsletter– "Reducing Missed EPSDT Appointments"		3		Summer 2018 Edition
13. ADV Member Mailing	1, 4			October 2018
14. ADV Member Rewards Program	2, 4			October 2018 – December 2018
15. Monthly Clinical Collaboration with Dental Vendor (SkyGen)			1, 2, 3, 4	CY 2018
16. Health Plan Participation on State Dental Task Force			3	Began December 2018

3.2.2 PIP Results

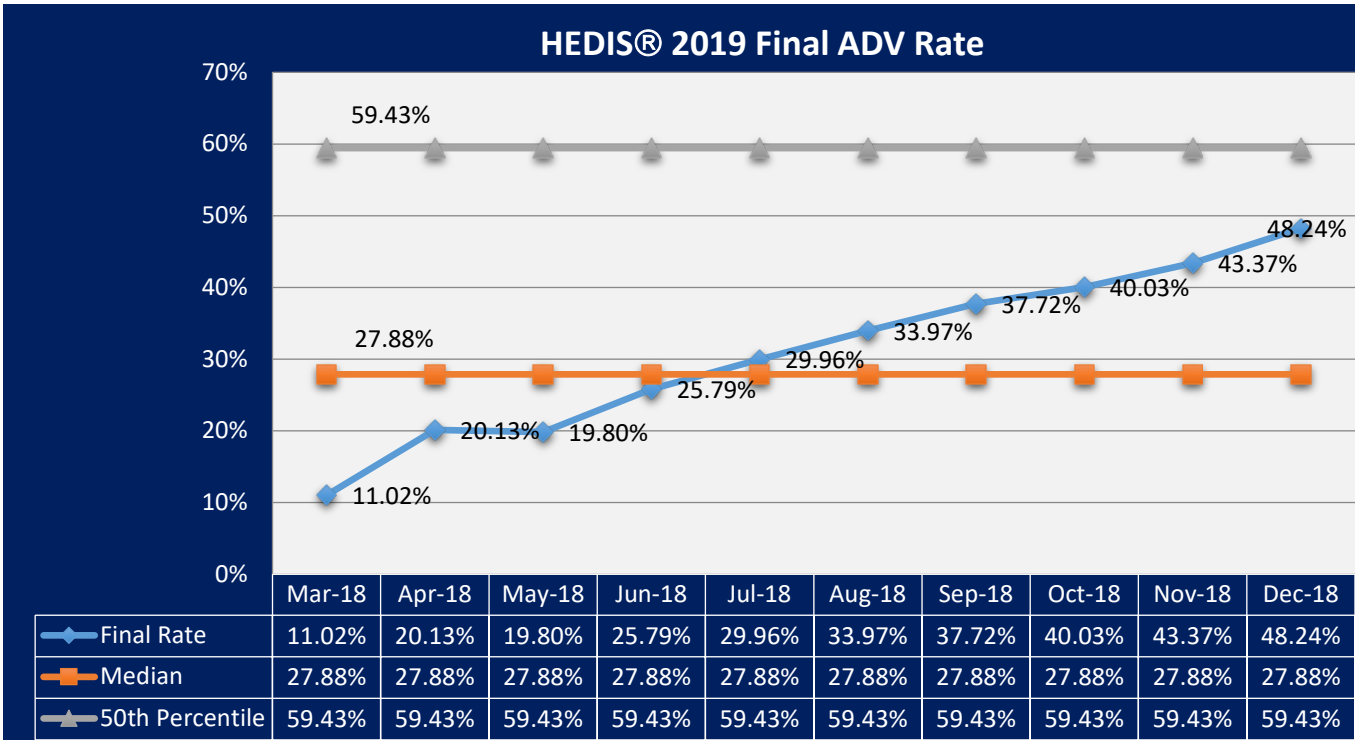
1. HEDIS® ADV rates

There is an increase in ADV rates for all the four regions (Figure 5). The statewide ADV rate has increased from 35.10% (CY 2017) to 48.24% (CY 2018), which is an increase by 13.14 percentage points. The significance could not be stated because of lack of data for the entire baseline CY 2017.



	Central	East	South west	West	Overall Rate
Baseline (May-Dec 2017)	33.62%	33.50%	36.38%	38.01%	35.10%
Measurement (CY 2018)	48.49%	45.80%	46.12%	52.96%	48.24%

Figure 5. HEDIS® ADV Rates



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Final Rate	11.02%	20.13%	19.80%	25.79%	29.96%	33.97%	37.72%	40.03%	43.37%	48.24%
Median	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%	27.88%
50th Percentile	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%	59.43%

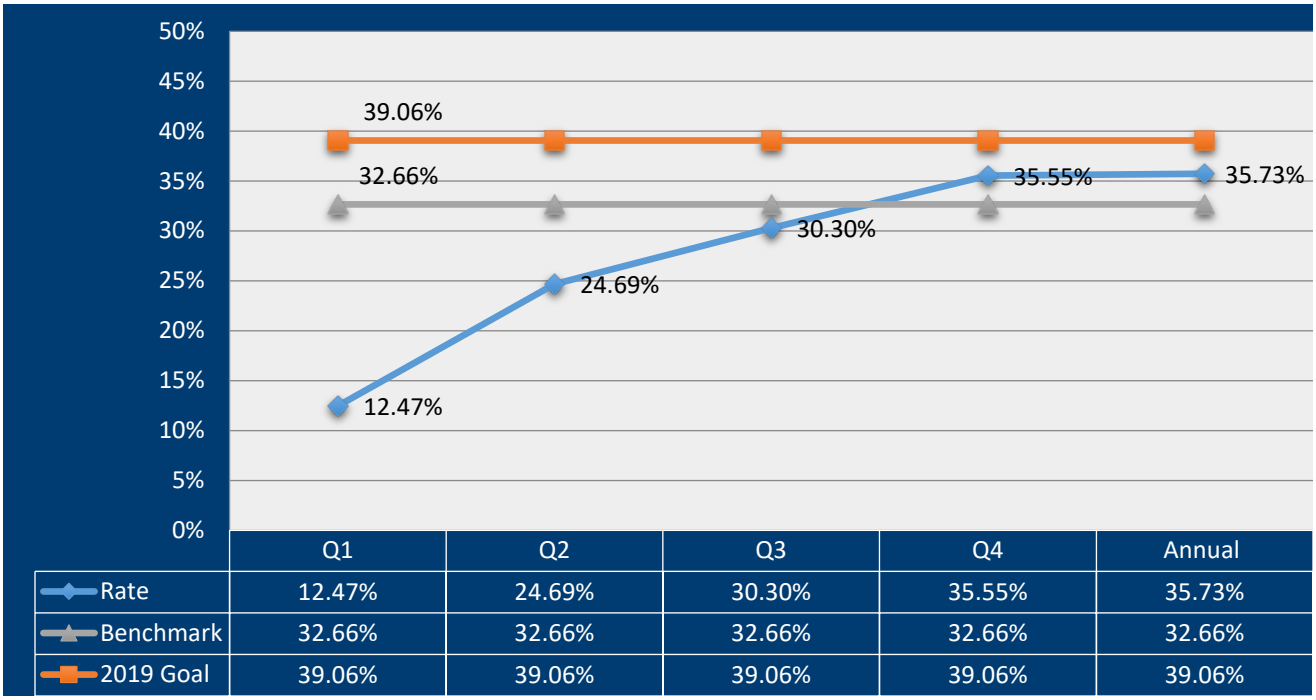
Figure 6. Run Chart-HEDIS® ADV Rate

Figure 6 represents a run chart with monthly progress in the ADV rate after various interventions were applied throughout the CY 2018.

2. CMS 416 Preventive Services

A significant improvement (23.26 percentage points) in the rate of members who met the eligibility requirements and received at least one preventive service in the measurement year is noted between Q1 2018 (12.47%) and by end of measurement year (overall rate

35.73%). This exceeds the 2016 MO CMS 416 Annual Report benchmark of 32.66% (Figure 7). The overall rate of members who received CMS 416 preventive services in CY 2018 (35.73%) compared to the rate in baseline year (26.47%) shows an increase by 9.26 percent points. This is an improvement, but significance could not be stated because of lack of data for the entire baseline CY 2017.



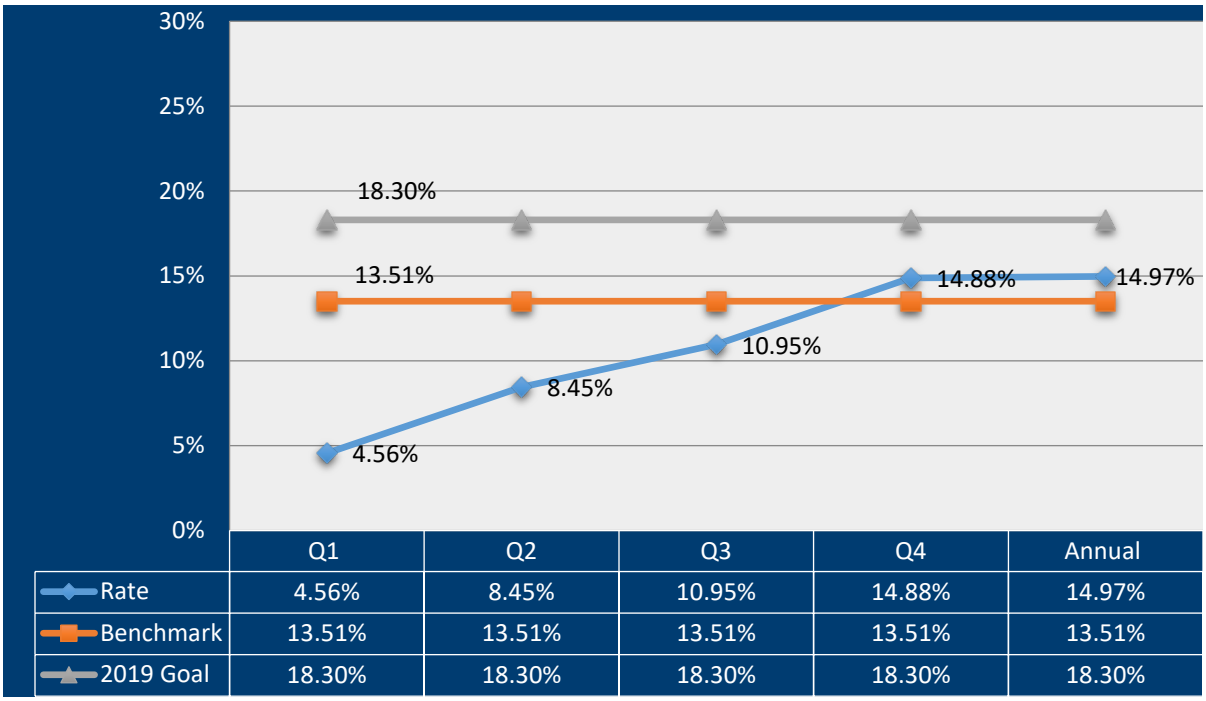
	Q1	Q2	Q3	Q4	Annual
Rate	12.47%	24.69%	30.30%	35.55%	35.73%
Benchmark	32.66%	32.66%	32.66%	32.66%	32.66%
2019 Goal	39.06%	39.06%	39.06%	39.06%	39.06%

Figure 7. 2018 CMS 416 Preventive Service Rate

Figure 7 represents a run chart with quarterly progress in CMS 416 preventive service rate after various interventions were applied throughout the CY 2018.

3. CMS 416 Oral Sealant

A significant improvement (10.41 percentage points) in the rate of members who met the eligibility requirements and had an oral sealant applied in the measurement year is noted between Q1 2018 (4.56%) and by end of the measurement year (overall rate 14.97%) exceeding the 2016 MO Annual CMS 416 Report benchmark of 13.51% (Figure 8).
The overall rate of members who received CMS 416 oral sealant in CY 2018 (14.97%) compared to the overall rate in the baseline year (9.53%) shows an increase of 5.44 percent points. This shows an improvement, but significance could not be stated because of lack of data for the entire baseline CY 2017.



	Q1	Q2	Q3	Q4	Annual
Rate	4.56%	8.45%	10.95%	14.88%	14.97%
Benchmark	13.51%	13.51%	13.51%	13.51%	13.51%
2019 Goal	18.30%	18.30%	18.30%	18.30%	18.30%

Figure 8. 2018 CMS 416 Oral Sealant Rate

4.0 Overall Conclusions

PIPs Score

The aim of the CIS Combo 10 PIP is met. The aim for the Oral Health improvement PIP is met. All the three indicators used to measure oral health have shown an increment by more than 3 percentage points.

Primaris assigns a score of "not credible," for both the PIPs. The decision was made on the basis that UnitedHealthcare did not have data for the full year which could have served as the baseline for the measurement year. Therefore, it would not be ideal to compare baseline data of 8 months with measurement data of 12 months.

4.1 Strengths and Weaknesses

Strengths

- UnitedHealthcare expressed their willingness to learn the correct methodology for PIP during Technical Assistance session. They responded by providing updates/additional information/corrections and tried to align with the expectations of EQRO.

- HEDIS®/CMS 416 quality indicators are measured on a monthly/quarterly basis and the data is depicted in the run charts. This shows the regular monitoring/progress of the results.
- Barrier analysis is done around the three categories-Member, Provider, and System. The interventions are designed to address at least one of three barriers.

Weaknesses

- The PIPs did not meet all the required guidelines stated in CFR/MHD contract (Ref: 42 Code of federal Regulations (CFR) 438.330 (d)/MHD contract 2.18.8 d 1):

Table 6: PIPs' Evaluation based on CFR guidelines

CFR Guidelines	Evaluation
Measurement of performance using objective quality indicators	Partially Met
Implementation of system interventions to achieve improvement in quality	Met
Evaluation of the effectiveness of the interventions	Not Met
Planning and initiation of activities for increasing or sustaining improvement	Met

- Annual evaluation of HEDIS®/CMS measures were used as quality indicators, which is a requirement for performance measure reporting by MHD/CMS (Centers for Medicare and Medicaid Services)/NCQA (National Committee for Quality Assurance). The indicators were not specifically chosen to measure the impact of interventions.
- Interventions could not be linked to the measured quality indicators. Multiple interventions were implemented throughout the CY 2018 and the impact of any individual intervention could not be judged. Thus, UnitedHealthcare will not be able to decide the follow up activities/interventions for next year based on these results.

4.2 Quality, Timeliness and Access to Healthcare Services

Improving CIS

- UnitedHealthcare works in accordance with Missouri HealthNet Childhood Immunization Initiative to increase vaccination coverage of children 2 years of age and older, improve vaccine delivery, and increase vaccination accessibility.
  In July and August 2018, the Clinical Practice Consultants (CPCs) conducted pre-season data collection for the CIS/IMA (Immunizations for Adolescents) measures

in anticipation of the HEDIS® 2019 Hybrid season. A sample of medical records was requested from each CPC's assigned providers based upon the applicable HEDIS® Technical Specifications to assess compliance with documentation practices (evidence of gap closure). The CPCs engaged providers and their staff during this process to assess the culture of immunization within their practices, as well as provide further education and identify opportunities for improvement ("10 Ways to Create a Culture of Immunization Within Your Pediatric Practice", CDC 2017). UnitedHealthcare conducted an immunization "deep dive" in July and August 2018 to validate immunization data quality and flow and the following was noted:

- Rates were being calculated correctly based on available data and the current 2018 technical specifications.
- Validation of combo vaccines are being attributed correctly (i.e., Pediarix)
- Current data from the state is available in SMART (UnitedHealthcare's data warehouse) and being ingested into ClaimSphere.
- Rates are trending similarly to other new MCOs.
- Historical immunization data (CY 2016) was not received from the state until February 2019.
- Incorrect and/or invalid CPT codes were identified in the immunization registry.

Improving Oral Healthcare

- UnitedHealthcare provides comprehensive dental care as a part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. All dental services are covered, including diagnostic care, as well as all necessary treatment and follow-up care with no limits on services or costs. Dental benefits are covered for all members from birth through age 20 and for all pregnant women. Non-pregnant members who are 21 or older do not have any dental benefits unless there are chronic conditions related to oral health (e.g., cancer, trauma related to oral health, diabetes).
- UnitedHealthcare sponsored a series of community outreach events in support of National Children's Dental Health Month in February 2018. UnitedHealthcare quality team engaged providers (i.e., FQHCs, PCPs, Dentists, staff) in discussions about barriers they believe impact UHCCP MO HealthNet members receiving preventive dental services.

4.3 Improvement by UnitedHealthcare

- UnitedHealthcare conducted PIPs for the first time under MHD contract. Therefore, Primaris cannot comment on any improvement related to methodology or the process adopted for these PIPs.
- Although the baseline for the entire CY 2017 is not available, leading to inability to measure statistical significance, an increase in the quality indicators from the previous year has been identified:
  - The CIS Combo 10 has increased from 0.92% to 21.65% (NCQA 25th percentile 27.75%).
  - The statewide ADV rates have increased from 35.10% to 48.24% (NCQA 50th percentile 59.43%).
  - The overall rate for CMS 416 preventive services increased from 26.47% to 35.73% (2016 CMS 416 annual report benchmark 32.66%).
  - The overall rate for CMS 416 oral sealant increased from 9.53% to14.97% (2016 CMS 416 annual report benchmark 13.51%).

5.0 Recommendations

PIPs Approach

- Primaris recommends UnitedHealthcare to follow CMS EQRO protocol 3[3] and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015[4], for guidance on methodology and approach of PIPs to obtain meaningful results.
- UnitedHealthcare must refine their skills in the development and implementation of approaches to effect change in their PIP.
- The aim and study question(s) should be stated clearly in writing (baseline rate, % increase to achieve in a defined period).
- PIPs should be conducted over a reasonable time frame (a calendar year) so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- The interventions should be planned specifically for the purpose of PIP required by MHD Contract.
- The results should be tied to the interventions.

[3]https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf
[4]https://www.medicaid.gov/medicaid/benefits/downloads/pip-manual-for-health-plans.pdf

- A request for technical assistance from EQRO would be beneficial. Improved training, assistance and expertise for the design, analysis, and interpretation of PIP findings are available from the EQRO, CMS publications, and research review.
- UnitedHealthcare must utilize the PIP's process as part of organizational development to maintain compliance with the State contract and the federal protocol.

Improvement in CIS rate

- According to the CDC, some children might be unvaccinated because of choices made by parents, whereas for others, lack of access to health care or health insurance might be factors. They may face hurdles, like not having a health care professional nearby, not having time to get their children to a doctor, and/or thinking they cannot afford vaccines. CDC recommends healthcare professionals to make a strong vaccine recommendation to their patients at every visit and make sure parents understand how important it is for their children to get all their recommended vaccinations on time. The Vaccines for Children (VFC) program helps reduce financial hurdles parents face when trying to get their children vaccinated and protected from vaccine-preventable diseases [5].
- CDC's Task Force on Community Prevention Services recommend that interventions could be developed around: increasing community demand for vaccination; enhancing access to vaccination services; and provider-based interventions. This could help to overcome vaccine noncompliance.[6]

Improvement in Oral Healthcare

- Dental caries-risk assessment, based on a child's age, biological factors, protective factors, and clinical findings, should be a routine component of new and periodic examinations by oral health and medical providers (American Academy of Pediatric Dentistry)[7].
- Promote school-based sealant programs aligned with the Centers for Disease Control's expert work group recommendations for school-based sealant programs.[8]
- Interprofessional Collaboration: Incorporate oral health improvement strategies across healthcare professions (such as medicine, nursing, social work, and pharmacy) and systems to improve oral health knowledge and patient care.[8]

[4]https://ivaccinate.org/states-with-the-worst-vaccination-rates/
[6]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927017/#b9-ptj4107426
[7]https://www.aapd.org/globalassets/media/policies_guidelines/bp_cariesriskassessment.pdf
[8]https://sboh.wa.gov/Portals/7/Doc/OralHealth/WSBOH-OH-Strategies-2013.pdf?ver=2013-11-19-094100-000

- Work Force: Develop health professional policies and programs which better serve the dental needs of underserved populations.[8]
- The strategies and actions stated in U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014–2017, serves as an excellent recommendation for UnitedHealthcare to improve oral health of their members.[9]

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765973/

Appendix A: PIP Validation Worksheet-CIS Combo 10

Date of evaluation: May 09, 2019

MCO Name or ID:	UnitedHealthcare
Name of Performance Improvement Project:	Childhood Immunization Status (Combo 10)
Dates in Study Period:	Jan 1, 2018-Dec 31, 2018
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO: 154,192 Medicaid/CHIP members included in the study: 3,206

Score: Met (M) /Not Met (NM) / Partially Met (PM) /Not Applicable (N/A)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	M	The Healthy People 2020 immunization and infectious disease goals target is 90% of children to receive all individual vaccines. Completion rates of childhood vaccines have met Healthy People 2020 levels over the past few years, however completion rates of children receiving all vaccines is low at about 66%. Missouri is ranked 21 out of 50 for Childhood Immunizations for children 19 to 35 months. Missouri's completion rate for 2-year-old immunization has remained between 69-71% for series completion.

1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M	The Childhood Immunization Status PIP includes all members who turn age 2 during the measurement year. In CY 2018, this represented a total of 3,206 members. Other member demographics that were taken into consideration included: • 65.50% MO HealthNet KIDS < 21 • 5.78% MO HealthNet Foster Children • 43.53% within the Aid Category MOHNET for Kids – Poverty • 21.48% within the Aid Category MO HealthNet Families – Child • 22.27% are African American
1.3. Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	The Childhood Immunization Status PIP includes members who turn 2 years old during the measurement year. Based upon the age of the population, members with specials needs related to mental health and substance abuse problems would not be included.
1.4. Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	M	The focus for the Childhood Immunization Status PIP is preventive services (as outlined in the periodicity schedule/EPSDT guidelines).
1.5. Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	The Childhood Immunization Status PIP includes members who turn 2 years old during the measurement year. Any member turning 2 years old, including those with special health care needs, was included in the study population.

Step 2: Review the Study Question(s)

Component/Standard	Score	Comments
2.1. Was/were the study question(s) measurable and stated clearly in writing? It should be stated in a way that supports the ability to determine whether the	M	UnitedHealthcare set to determine whether implementing the interventions increase the percentage of children ages 2 and under,

intervention has a measurable impact for a clearly defined population.		receiving CIS (Combo 10) vaccines.

Step 3: Review the Identified Study Populations

Component/Standard	Score	Comments
3.1. Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	Inclusion criteria for PIP Denominator: • Children who turn 2 years of age during the measurement year. • Continuous enrollment 12 months prior to the child's second birthday. • No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. • Enrolled on the child's second birthday.
3.2. If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	Data was collected for the Childhood Immunization Status PIP as defined by the HEDIS® 2018 technical specifications.

Step 4: Review Selected Study Indicator(s)

Component/Standard	Score	Comments
4.1. Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	UnitedHealthcare clearly defined and listed all indicators by aiming to measure the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Hemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines on or by their second birthday.

4.2. Did the indicators track performance over a specified period?	M	Run charts were submitted for the period of measurement year (CY 2018) with the monthly data depicted.
4.3. Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	PM	Indicator used in the PIP is a primary measure and the study questions are directly based on them. Primaris recommends that the PIPs should be designed such that the MCO has secondary measures as their focus/aim and interventions should be around those secondary measures, so that the impact of the interventions can be clearly assessed.

Step 5: Review Sampling Methods

Component/Standard	Score	Comments
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	N/A	There was no sampling; the entire eligible population is included as defined by the HEDIS® 2018 technical specifications and CMS 416 methodology.
5.2. Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	N/A	
5.3. Did the sample contain a sufficient number of enrollees?	N/A	

Step 6: Review Data Collection Procedures

Component/Standard	Score	Comments
6.1. Did the study design clearly specify the data to be collected?	M	Data was collected as defined by HEDIS® 2018 technical specifications.
6.2. Did the study design clearly specify the sources of data?	M	The data source for the Childhood Immunization Status PIP is as follows: HEDIS® CIS (Combo 10): administrative generated from ClaimSphere (HEDIS software engine).

6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	M	The study design includes the entire eligible population as defined by the HEDIS 2018® technical specifications and CMS 416 methodology.
6.4. Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	M	Data extracted from the primary data sources referenced above was imported into Excel spreadsheets for further analysis and creation of graph/charts for presentation of PIP findings.
6.5. Did the study design prospectively specify a data analysis plan?	M	The PIP template submitted to the state defines the data collection and analysis cycles as follows: Baseline Data Collection Period: May 1, 2017 through April 30, 2018. Primaris has considered baseline as May 1, 2017-Dec 31, 2017. Ongoing Data Collection Period: Q1 – January 1, 2018 through March 31, 2018. Q2 – January 1, 2018 through June 30, 2018. Q3 – January 1, 2018 through September 30, 2018. Q4 – January 1, 2018 through December 31, 2018.
6.6. Were qualified staff and personnel used to collect the data?	M	Qualified persons were involved in data collection. Names are listed in the report.

Step 7: Review Data Analysis and Interpretation of Study Results

Component/Standard	Score	Comments
7.1. Was an analysis of the findings performed according to the data analysis plan?	M	Childhood Immunization Status PIP findings were presented to the Quality Management Committee on a quarterly basis.
7.2. Were numerical PIP results and findings accurately and clearly presented?	M	UnitedHealthcare displayed results and findings clearly and accurately through tables and graphs with narratives.

7.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	N/A	Statistical significance was not tested this year as the baseline data for the entire year was not available for comparison. Due to the maturity of the health plan and the technical specifications for this measure (children who turn 2 years of age during the measurement year and are continuously enrolled for 12 months prior to their 2nd birthday) data is limited and reflects a low rate. There were no factors that threatened internal or external validity of the findings.
7.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	NM	There was no interpretation of the extent to which the interventions were successful. The information about follow up activities was not submitted. Primaris recommends including an analysis of each interventions potential impact on the specific indicator being measured.

Step 8: Assess Improvement Strategies

Component/Standard	Score	Comments
8.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	M	Barriers related to member, provider and system were targeted by the interventions. Additionally, the following three (3) barriers have been considered in the development of this PIP: • A lack of knowledge about the importance of preventive services, including recommended vaccine schedules • A lack of knowledge about provider-specific immunization practices • A lack of access to immunization data

8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	M	A list of interventions with the timings of implementation was provided.
8.3 Are the interventions culturally and linguistically appropriate?	M	Interventions were culturally and linguistically appropriate. For example, bi-lingual Call Center (Rose International) staff were available for member outreach. Interpreter services were utilized to support member outreach as well. Education materials were made available to members in both English and Spanish (highest % of members with primary language other than English). All documents submitted to the state for member outreach (i.e., call scripts) were approved as age and reading level appropriate.

Step 9: Assess Whether Improvement is "Real" Improvement

Component/Standard	Score	Comments
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	M	UnitedHealthcare utilized the same methodology for member eligibility, data collection, and analysis for the baseline year and measurement year.
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?	M	The is an increase in HEDIS®CIS Combo 10 rate by 20.73 percentage points.
9.3. Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	NM	The intervention could not be tied to the improvement.
9.4. Is there any statistical evidence that any observed performance improvement is true improvement?	N/A	It is too early in the life of this PIP to remark on real improvement because of the non-availability of data for the baseline year (8 months of data available vs 12 months).

Step 10: Assess Sustained Improvement

Component/Standard	Score	Comments
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	N/A	It is early in the life of the PIP to remark on sustained improvement.

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
1. Were the initial study findings verified upon repeat measurement?	N/A	

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Check one:

- ☐ High confidence in reported PIP results
- ☐ Confidence in reported PIP results
- ☐ Low confidence in reported PIP results
- ☒ Reported PIP results not credible

Summary

The aim of CIS Combo PIP is met. The increase in the CIS Combo 10 rate is of 20.73 percentage points exceeding the set aim of 3 percentage points, from the baseline year (CY 2017). However, the significance of this increase cannot be determined due to lack of data for the entire baseline year for comparison. The methodology adopted for the PIP is not sound. Multiple interventions are implemented throughout the measurement year. Impact of interventions and its usefulness is not evaluated.

Primaris assigns a score of "not credible." The decision is made on the basis that UnitedHealthcare does not have data for the full year which can serve as the baseline for the measurement year.

Appendix B: PIP Validation Worksheet-Improving Oral Health

Date of evaluation: May 09, 2019

MCO Name or ID:	UnitedHealthcare
Name of Performance Improvement Project:	Improving Oral Health
Dates in Study Period:	Jan 01, 2018-Dec 31, 2018
Demographic Information:	Number of Medicaid/CHIP enrollees in MCO: 154,192 Medicaid/CHIP members included in the study: 117,108

Score: Met (M) /Not Met (NM) / Partially Met (PM) /Not Applicable (N/A)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	M	The State of Missouri has a five year (2015-2020) oral health plan that seeks to improve the oral health of all Missourians through education, prevention, and leadership. According to the National Oral Health Surveillance System, the state of Missouri has lower dental visit rates, more tooth loss, and higher oral cancer rates among adults than those observed nationally. The Southeast region of Missouri has the lowest dental visit rates and the highest rates of tooth loss among older Missourians in the state.

1.2 Is the PIP consistent with the demographics and epidemiology of the enrollees?	M	The Improving Oral Health PIP includes all members ages 2–20 years of age. This currently represents: • 79.39% ages eighteen (18) and under. • > 27,000 between the ages of two (2) and five (5). • 43.53% within the Aid Category MOHNET for Kids – Poverty. • 21.48% within the Aid Category MO HealthNet Families – Child. • 22.27% are African American. • 4.19% are MO HealthNet Foster Care Kids. • 0.18% whose primary language is Spanish.
1.3. Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	M	Improving Oral Health PIP includes all members ages 2–20 and is inclusive of members with specials needs (i.e., mental health, substance abuse, acute/chronic illness and disease processes).
1.4. Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	M	The focus for the Improving Oral Health PIP is preventive services (as outlined in the periodicity schedule/EPSDT guidelines).
1.5. Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	M	The Improving Oral Health PIP includes all members ages 2–20 and is inclusive of members with specials needs (i.e., mental health, substance abuse, acute/chronic illness and disease processes).

Step 2: Review the Study Question(s)

Component/Standard	Score	Comments
2.1. Was/were the study question(s) measurable and stated clearly in writing? It should be stated in a way that supports the ability to determine whether the intervention has a measurable impact for	M	The three study questions were clearly stated and measurable (ADV, CMS 416 preventive services, CMS 416 sealant application). The interventions were designed with the

a clearly defined population.		aim to have an impact by 3 percent point on the ADV measure and 3.33% point for the other two CMS 416 measures.

Step 3: Review the Identified Study Populations

Component/Standard	Score	Comments
3.1. Were the enrollees to whom the study question and indicators are relevant clearly defined?	M	Denominators in the PIP: HEDIS ADV Rate – all UHCCP MO HealthNet eligible members from the ages of 2 through 20 as of December 31 of the measurement year. Preventive Service – all UHCCP MO HealthNet eligible members from the ages of 1 through 20 as of December 31 of the measurement year. Oral Sealant Application – all UHCCP MO HealthNet members from the ages of 6 through 9 as of December 31 of the measurement year.
3.2. If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	M	Data was collected for the Improving Oral Health PIP as defined by the HEDIS® 2018 technical specifications and CMS 416 methodology.

Step 4: Review Selected Study Indicator(s)

Component/Standard	Score	Comments
4.1. Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	M	HEDIS® ADV, CMS 416 preventive services, CMS 416 sealant application: are the three indicators used in the PIP.
4.2. Did the indicators track performance over a specified period?	M	Run charts were submitted for the period of measurement year (CY 2018) with the monthly data depicted.
4.3. Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	PM	Indicators used in the PIP are primary measures and the study questions are directly based on them. Primaris recommends that the PIPs should be designed such that the MCO has secondary measures as their

		focus/aim and interventions should be around those secondary measures, so that the impact of the interventions can be clearly assessed.

Step 5: Review Sampling Methods

Component/Standard	Score	Comments
5.1. Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	N/A	There was no sampling; the entire eligible population is included as defined by the HEDIS® 2018 technical specifications and CMS 416 methodology.
5.2. Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	N/A	
5.3. Did the sample contain a sufficient number of enrollees?	N/A	

Step 6: Review Data Collection Procedures

Component/Standard	Score	Comments
6.1. Did the study design clearly specify the data to be collected?	M	Data was collected as defined by HEDIS 2018® technical specifications and CMS 416 methodology.
6.2. Did the study design clearly specify the sources of data?	M	Data sources for the Improving Oral Health PIP are as follows: HEDIS ADV: administrative generated from ClaimSphere (HEDIS® NCQA-certified software engine) CMS 416 Preventive Service and Oral Sealant measures: administrative and enrollment data from the SMART Data Warehouse.
6.3. Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	M	The study design includes the entire eligible population as defined by the HEDIS 2018 technical specifications and CMS 416 methodology.
6.4. Did the instruments for data collection provide for consistent and	M	Data extracted from the primary data sources referenced above was imported into Excel spreadsheets for

accurate data collection over the time periods studied?		further analysis and creation of graph/charts for presentation of PIP findings.
6.5. Did the study design prospectively specify a data analysis plan?	M	The PIP template submitted to the state defines the data collection and analysis cycles as follows: Baseline Data Collection Period May 1, 2017 through April 30, 2018. (Primaris has accepted May 1, 2017-Dec 31, 2017 as the baseline). Ongoing Data Collection Period Q1 – January 1, 2018 through March 31, 2018. Q2 – January 1, 2018 through June 30, 2018. Q3 – January 1, 2018 through September 30, 2018. Q4 – January 1, 2018 through December 31, 2018.
6.6. Were qualified staff and personnel used to collect the data?	M	Qualified persons were involved in data collection. Names are listed in the report.

Step 7: Review Data Analysis and Interpretation of Study Results

Component/Standard	Score	Comments
7.1. Was an analysis of the findings performed according to the data analysis plan?	M	Improving Oral Health PIP findings were presented to the Quality Management Committee on a quarterly basis.
7.2. Were numerical PIP results and findings accurately and clearly presented?	M	UnitedHealthcare displayed results and findings clearly and accurately through tables and graphs with narratives.
7.3. Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	M	Statistical significance was not tested for HEDIS ADV measure as the data for comparison was not available. However, initial and repeat measurements for CMS 416 preventive services and CMS oral sealant rate was done and significant

		improvement was seen. There were no factors that threatened internal or external validity of the findings.
7.4. Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	NM	There was no interpretation of the extent to which the interventions were successful. The information about follow up activities is not submitted. Primaris recommends including an analysis of each interventions potential impact on the specific indicator being measured.

Step 8: Assess Improvement Strategies

Component/Standard	Score	Comments
8.1. Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	M	Barriers related to member, provider and system were targeted by the interventions.
8.2 Are the interventions sufficient to be expected to improve processes or outcomes?	M	A list of interventions with the timings of implementation was provided.
8.3 Are the interventions culturally and linguistically appropriate?	M	Interventions were culturally and linguistically appropriate. For example, bi-lingual Call Center (Rose International) staff was available for member outreach. Interpreter services were utilized to support member outreach as well. Education materials were made available to members in both English and Spanish (highest % of members with primary language other than English). All documents submitted to the state for member outreach (i.e., call scripts) were approved as age and reading level appropriate.

Step 9: Assess Whether Improvement is "Real" Improvement

Component/Standard	Score	Comments
9.1. Was the same methodology as the baseline measurement used when measurement was repeated?	M	UnitedHealthcare utilized the same methodology for member eligibility,

		data collection, and analysis for the baseline year and measurement year.
9.2. Was there any documented, quantitative improvement in processes or outcomes of care?	M	Quantitative improvement has been reported for all the three indicators, but its significance could not be assessed due to non-availability of data for the entire baseline year.
9.3. Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	NM	The intervention could not be tied to the improvement.
9.4. Is there any statistical evidence that any observed performance improvement is true improvement?	N/A	Primaris considered CY 2017 results as a baseline year and data was available only for 8 months. It was not reasonable to compare to CY 2018 data of 12 months.

Step 10: Assess Sustained Improvement

Component/Standard	Score	Comments
10.1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?	N/A	It is early in the life of the PIP to remark on sustained improvement.

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
1. Were the initial study findings verified upon repeat measurement?	N/A	

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Check one:

- ☐ High confidence in reported PIP results
- ☐ Confidence in reported PIP results
- ☐ Low confidence in reported PIP results
- ☒ Reported PIP results not credible

Summary

The aim for the Oral Health improvement PIP is met. All three indicators: HEDIS® ADV rate; CMS 416 preventive services; and CMS 416 sealant application, used to measure the improvement in oral health have shown an increase by more than 3.33 percentage points (which is the set aim/goal), from the baseline year (CY 2017). However, the methodology is not sound. Multiple interventions are implemented throughout the measurement year. Impact of any intervention and its usefulness is not evaluated.

Primaris assigns the score as "not credible." The decision is made on the basis that UnitedHealthcare did not have data for the full year which is the baseline for the measurement year. Therefore, it is not justified to compare baseline data of 8 months with measurement data of 12 months.