2026 PIP Submission Completion Instructions
Oregon Statewide Oral Health PIP

Use these instructions as a guide to complete the PIP Submission Form. Each section provides detailed information in orange font on the documentation requirements for each step. Do not document anything in this form to complete your PIP submission, the PIP Submission Form provided must be used. If you need a copy, please contact HSAG.

Step 1: Select the PIP Topic. The topic must be selected based on data that identifies an opportunity for improvement or mandated by the State. The goal of the project should be to improve member health, functional status, and/or satisfaction.	
PIP Topic	**Enter title of PIP. For example, "Improving Childhood Immunizations"**
State-Mandated Topic	☐ **Yes** **Check "Yes," the statewide PIP topic is state-mandated.** ☐ **No**

Step 2: Define the Aim Statement(s). Defining the Aim statement(s) helps set the focus and framework for the PIP.
Enter the Aim statement(s) in the space provided.
• **The Aim statement(s) must include either the specific proposed intervention(s) or the phrase "targeted interventions."** • **The Aim statement(s) must be documented in clear, concise, and measurable terms.** • **The Aim statement(s) must clearly specify the population for the PIP within the statement(s).** • **The Aim statement(s) must be answerable through the performance indicator and data collection methodology.** **Examples:** 1. **Do targeted interventions increase the percentage of children 15-30 months of age who complete the Combo 10 vaccine series during the reported remeasurement period?** 2. **By December 31, 2027, Health Plan ABC will use targeted interventions to increase the percentage of members 15 to 30 months of age who complete the Combo 10 vaccine series from 64.2% to 75.0%.**

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the Aim statement(s) and indicator(s) apply.	
Does the population follow HEDIS or CMS Core Set measure specifications?	
☐ **Yes:** Move to Step 4. **If the PIP is based on a HEDIS or CMS Core Set measure and the CCO is following the applicable specifications for the PIP, check "Yes" and move to Step 4.** ☐ **No:** Complete the applicable sections below. **If the PIP is not based on a HEDIS or CMS Core Set measure, check "No" and complete Step 3.** ***Note, if the population is based on State-defined specifications, attach, or include a link to the specifications in the PIP Submission Form and complete the table below.***	
Population definition	**Describe the population included in the PIP. If the PIP focuses on a specific race/ethnicity, this must also be documented.**
Enrollment requirements (if applicable)	**Document the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gaps in enrollment.**
Member age criteria (if applicable)	**Document the age/age range and anchor date.**
Exclusion criteria (if applicable)	**Document all criteria that excludes members from the population.**
Diagnosis/procedure/pharmacy/billing codes <u>used to identify the eligible population</u> (if applicable)	
Document the diagnosis/procedure/pharmacy/billing codes necessary to identify the eligible population. ***Note, these are not codes for numerator positive hits for the performance indicator. Only codes used to identify members for the population (i.e., diabetes codes, asthma codes, SMH/BH diagnosis codes, etc.) must be listed here.***	

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with accepted principles of research design and statistical analysis.

Was sampling used?

☐ **Yes: If sampling was used to select members of the population (denominator) for the PIP, check "Yes" and complete Step 4.**

☐ **No: If the entire eligible population was used for the PIP and no sampling was used, check "No" and move to Step 5.**

Does the sampling methodology follow HEDIS or CMS Core Set measure specifications?

☐ **Yes:** Leave the table blank and move to Step 5.

If the PIP is based on a HEDIS or CMS Core Set measure and the CCO is following the specifications for sampling, check "Yes" and move to completing Step 5.

☐ **No: If the PIP is not based on a HEDIS or CMS Core Set measure and sampling was used, check "No" and complete the table below for each measurement period reported and each performance indicator.**

Performance Indicator Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
Enter the baseline date range. **Example: 01/01/2025-12/31/2025**	**Enter title of performance indicator (same as in Step 5).** ***Note, each performance indicator will need to be represented in the table.***	**Enter the sampling frame size. The sampling frame is the universe of members of the identified PIP population from which the representative sample is drawn.**	**Enter the sample size determined from the sampling methodology used.**	**Enter the margin of error and confidence level for the sampling methodology used (i.e., 95% confidence level and +/- 5% margin of error).**

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with accepted principles of research design and statistical analysis.				
Enter the Remeasurement 1 date range. **Example: 01/01/2026–12/31/2026**				
Enter the Remeasurement 2 date range. **Example: 01/01/2027–12/31/2027**				
In the space provided, describe in detail the methods used to select the sample.				
Use sampling methods that allow for representativeness of the sample according to subgroup, geographic location, or health status and the generalization of results to the population. Ensure the sampling method used protect against bias.				

Step 5: Select the Performance Indicator(s). The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.	
Performance Indicator(s) ***For each performance indicator, follow the directions below.***	
Measure Description	**Enter a description of the performance indicator.** **Example: "The Percentage of Children 15 to 30 Months of Age Completing the Combo 10 Vaccine Series"**
Numerator Description	**Enter the description of the numerator.** **Example 1: Total number of eligible members 15 to 30 months of age who completed the Combo 10 vaccine series during the measurement period.** **Example 2: Total number of members from the denominator who completed the Combo 10 vaccine series during the measurement period.**
Denominator Description	**Enter the description of the denominator.** **Example: Total number of eligible members 15 to 30 months of age as of December 31st of the measurement period.**
Baseline Measurement Period	**Example: 01/01/2025-12/31/2025 (All known measurement period dates must be completed)**
Remeasurement 1 Period	**Example: 01/01/2026-12/31/2026**
Remeasurement 2 Period	**Example: 01/01/2027-12/31/2027**

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each performance indicator were valid and reliable.
Data Sources
Does the PIP follow HEDIS or CMS Core Set methodology?
☐ **Yes:** Leave Step 6 blank and move to Step 7. **If the PIP is based on a HEDIS or CMS Core Set measure and the CCO/vendor is following the specifications for data collection, check "Yes" and move to Step 7.** ☐ **No** **If the PIP <u>is not</u> based on a HEDIS or CMS Core Set measure, check "No" and complete Step 6. The sources of data must be clearly specified by checking all appropriate boxes, providing descriptive information when necessary, and attaching required information, when applicable.** ***Note, if State-defined specifications were used, attach, or include a link to the specifications in the data collection process section below.***
☐ **Manual Data** **(Select all that apply, if applicable)**

Data Source:	**Record Type:**	**Other:**
☐ Paper medical record abstraction	☐ Outpatient	☐ Blank copy of data collection tool attached (required for manual record review)
☐ Electronic health record abstraction	☐ Inpatient	
	☐ Other, please explain in narrative section	

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each performance indicator were valid and reliable.		
☐ **Survey Data** **(Select all that apply, if applicable)**		
Fielding Method: ☐ Personal interview ☐ Mail ☐ Phone with Computer-Assisted Telephone Interviewing (CATI) script	☐ Phone with Interactive Voice Response (IVR) ☐ Internet ☐ Other _____	**Other Survey Requirements:** Number of waves: _____ Response rate: _____ Incentives used: _____
☐ **Administrative Data** **(Select all that apply, if applicable)**		
Data Source: ☐ Programmed pull from claims/encounters. ☐ Supplemental data ☐ Electronic health record query	☐ Complaint/appeal ☐ Pharmacy data ☐ Telephone service data/call center data. ☐ Appointment/access data	☐ Delegated entity/vendor data_____ ☐ Other_____

Data Elements Collected	
Elements	**Document clear definitions of the data elements collected. For example, service completed for numerator positive hit, race/ethnicity, age, gender, etc.**
Codes **(Codes can be attached separately)**	**Include codes, such as ICD-10 and CPT codes that were used to identify and collect administrative data for the performance indicator(s). These are codes that represent a numerator positive hit for the performance indicator(s).**

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each performance indicator were valid and reliable.
Data Collection Process
In the space provided, describe the step-by-step data collection process.
Document that OHA collects and provides statewide PIP performance indicator data to the CCO. The CCO is not required to document the step-by-step data collection process because the process is conducted by OHA.

Step 7a: Performance Indicator Results. Enter the results of each performance indicator(s) by completing the table below. The *p* value must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.	
Instructions: • **In the table below, enter the performance indicator results including the measurement period, numerator, denominator, and rate. Ensure the data are reported accurately, matching the data provided by OHA for each annual measurement period.** • **Document the rate to at least two decimal places.** • **For each remeasurement period, indicate whether there was any improvement compared to the baseline by checking "Yes" or "No."** • **Statistical testing must be conducted for each remeasurement period, comparing remeasurement results to baseline results.** • **For the OHA-selected PIP performance indicator, EDV-A-A, the CCO will report statistical testing results from a Chi-square test or Fisher's exact test, using the number of emergency department (ED) visits as the numerator and then number of member months as the denominator. Document the type of two-tailed statistical test used.** • **Document the *p* value to four decimal places (i.e., 0.1234).** • **Indicate if the *p* value represents statistically significant change (p value of <0.05) by checking either "Yes" or "No."** • **All data reported in the table below should match the data provided by OHA to the CCO.**	
Performance Indicator(s) Measure Description:	**For each performance indicator, enter the measure description from Step 5 here.**

Step 7a: Performance Indicator Results. Enter the results of each performance indicator(s) by completing the table below. The *p* value must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Measurement Period Dates	Performance Indicator Measurement Period	N: ED Visits	D: Member Months	Rate: (ED Visits / Member Months) x 100,000 (2 or more decimal places)	Comparison to Baseline			
					Improvement	Statistical Test Used	*P* Value (4 decimal places)	Statistically Significant Change
Example: 01/01/2025–12/31/2025	Baseline				N/A for baseline			
Example: 01/01/2026–12/31/2026	Remeasurement 1				☐ Yes ☐ No*			☐ Yes ☐ No
*If improvement was not achieved, document possible reason(s) for the lack of improvement, lessons learned, and next steps.		If there was a decline in performance, the CCO must acknowledge the decline, document potential reasons for the decline and lessons learned, and next steps planned to address the decline with quality improvement strategies/interventions.						
Example: 01/01/2027–12/31/2027	Remeasurement 2				☐ Yes ☐ No*			☐ Yes ☐ No
*If improvement was not achieved, document possible reason(s) for the lack of improvement, lessons learned, and next steps.		If there was a decline in performance, the CCO must acknowledge the decline, document potential reasons for the decline and lessons learned, and next steps planned to address the decline with quality improvement strategies/interventions.						

N = Numerator; D = Denominator

Step 7b: Data Analysis and Interpretation of Results. CCOs must indicate if there were identified factors that threatened the validity and/or comparability to baseline. If yes, CCOs must provide a description of the identified threats in the space provided.	
Baseline Performance Indicator Results	
Threat(s) to Validity?	☐ **Yes:** Complete description in space provided. ☐ **No:** Move to Step 8.
Description of identified threats to validity.	**If "Yes" is checked, document the identified factor(s) for baseline that threatened the validity of the data reported.** **Examples of factors that may threaten validity include but are not limited to the following:** • **Change in demographic population.** • **Acquiring another health plan's members** • **A change in data collection plan staff or processes.**
Remeasurement 1 Performance Indicator Results	
Threat(s) to Validity?	☐ **Yes:** Complete description in space provided. ☐ **No:** Move to comparability threats.
Description of identified threats to validity.	**If "Yes" is checked, document the identified factor(s) for Remeasurement 1 that threatened the validity of the data reported.**
Remeasurement 1 Threats to Comparability to Baseline?	☐ **Yes:** Complete description in space provided. ☐ **No:** Move to Step 8.

Step 7b: Data Analysis and Interpretation of Results. CCOs must indicate if there were identified factors that threatened the validity and/or comparability to baseline. If yes, CCOs must provide a description of the identified threats in the space provided.	
Description of identified threats to comparability.	**If "Yes" is checked, document the identified factor(s) that threatened the comparability between baseline and Remeasurement 1.** **Examples of factors that threaten comparability include but are not limited to the following:** • **A change in the data collection methodology** • **Different lengths for measurement periods**
Remeasurement 2 Performance Indicator Results	
Threat(s) to Validity?	☐ **Yes**: Complete description in space provided. ☐ **No:** Move to comparability threats.
Description of the identified threats to validity.	**If "Yes" is checked, document the identified factor(s) for Remeasurement 2 that threatened the validity of the data reported.**
Remeasurement 2 Threats to Comparability to Baseline?	☐ **Yes:** Complete description in space provided. ☐ **No:** Move to Step 8.
Description of identified threats to comparability.	**If "Yes" is checked, document the identified factor(s) that threatened the comparability between baseline and Remeasurement 2.**

Step 8: Improvement Strategies. Interventions must target the identified barriers to improvement.		
Quality Improvement (QI) Team		
List the QI team members and their roles and responsibilities for the PIP.	**Team Member Name**	**Role and Responsibility**
	Document the name of each PIP team member (Add more rows as needed)	**Describe the team member's roles and responsibilities for the PIP.**

QI Tools	
Describe the QI tools used to identify barriers to improving performance indicator results. CCOs must attach a copy of the completed QI tools or provide a description of the tools used.	
If a tool in this section was used, a description must be included in the space below. (Select all that apply)	**If a tool in this section was used, a copy of the completed tool must be provided as an attachment with the PIP submission. (Select all that apply)**
☐ Brainstorming ☐ Member and/or Provider Input ☐ Relevant, plan-specific data analyses ☐ Other	☐ Fishbone Diagram ☐ Five Why's ☐ Process Mapping ☐ Failure Modes and Effects Analysis (FMEA)
Description of Tool(s) Used	**If an option from the left was selected, document a detailed description of the process used to identify barriers.**

Step 8: Improvement Strategies. Interventions must target the identified barriers to improvement.
Intervention Results **After completing the table below, a Step 8 Intervention Worksheet for <u>each intervention listed in the table must be completed to the point of intervention progression at the time of the annual PIP submission</u>. <u>As part of completing Step 8, CCOs are required to submit all intervention worksheets in progress with the PIP Submission Form for the annual validation.</u>**
Barriers/Interventions Table: In the table below, list interventions and document the associated barrier(s) addressed by each intervention.

Intervention Title	Barrier(s) Addressed
Document the title of the intervention. **Examples:** • **Targeted member outreach through texting campaign.** • **Financial incentive upon completion of vaccine series.** **(Add additional rows as needed)**	**Lack of member knowledge and understanding of required vaccines for children 15-30 months of age.**

For the purposes of a PIP, CCOs should consider testing no more than five interventions over the course of a PIP.

Standard operating quality improvement activities/actions/processes should not be used as interventions for PIPs. CCOs should develop new actions and strategies to address the identified and prioritized barriers/gaps within processes/opportunities for improvement.

The goal should be to make a fundamental change that results in meaningful and sustained improvement.